Neighbourhood Health Plans in Greater Manchester

Part of Greater Manchester Live Well

Draft Template v0.3

November 2025

Part of Greater Manchester Integrated Care Partnership

1.0 Introduction

1.1 Profile of locality – demographics & JSNA

Bury is a Borough in Greater Manchester with a population of c195,000 residents and a GP registered population in excess of 205,000. 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%.

The five neighbourhoods are North, East, West, Whitefield, and Prestwich. North neighbourhood is the most affluent, with the highest average household income (c£46,600). Conversely, East and West neighbourhoods are far more deprived, with parts of these neighbourhoods (particularly Bury town centre, Radcliffe, and the M66 corridor) within the most deprived ten percent of areas in England. Average household income in East and West neighbourhoods is around £36,900 – almost £10,000 less than in North neighbourhood. Whitefield and Prestwich neighbourhoods sit roughly in the middle of these figures, although there are still pockets of relatively high deprivation, particularly in Whitefield.

The demographics of the neighbourhoods vary significantly. North neighbourhood has the oldest age profile, with around 10% of residents over the age of 75. East and Prestwich neighbourhoods have a much younger age profile, with more than 20% of residents in these neighbourhoods under the age of 15.

Life expectancy in North neighbourhood is around 82 years, four years longer than the 78 years in East neighbourhood. In terms of healthy life expectancy, the average resident of North neighbourhood is expected to reach age 67 in good health, whereas in East neighbourhood this figure is only 59 years. West, Whitefield and Prestwich neighbourhoods are closer to the borough-wide average of 63 years of healthy life expectancy.

Note that this data was last reviewed in 2023. New neighbourhood profiles are currently being developed and will be available as part of the refreshed Bury Joint Strategic Needs Assessment (JSNA) shortly.

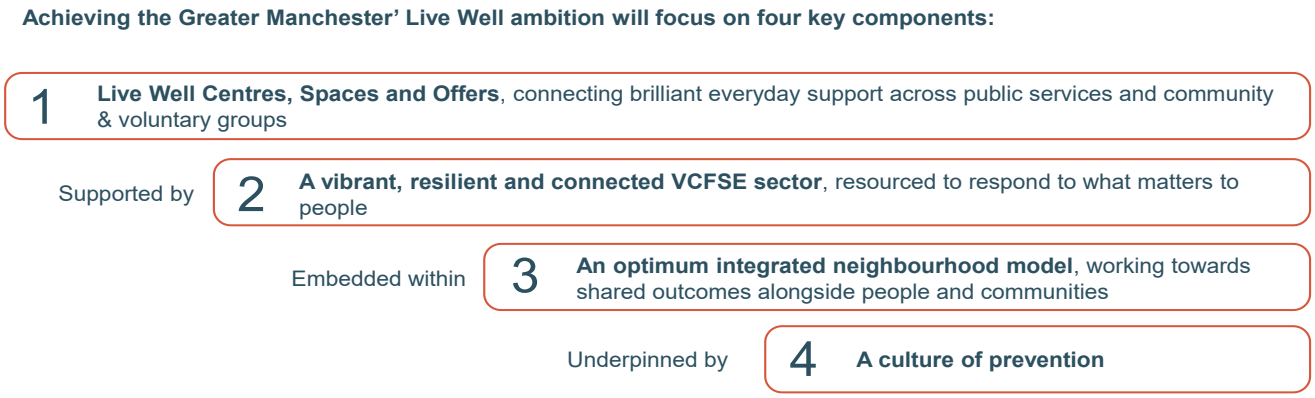
The leading causes of death in Bury are cardiovascular diseases and cancers. The main causes of disability are musculoskeletal conditions and mental illness. Diabetes and liver disease are increasing as causes of disability and death. Health outcomes across Bury are somewhat less equal than across England as a whole. This likely reflects the diversity of population that Bury contains, ranging from urban to rural and affluent to deprived.

According to the 2021 census results, the majority of Bury's resident population identified their ethnic group within the high-level “White” category, which is 1.9% higher than the national figure of 81% for England. However, this is changing with a trend towards non-white ethnic groups making up a higher proportion of the population. This is broadly consistent with the national trend. The proportion of people identifying as “Asian” has seen the highest increase from 7.2% in 2011 to 10.6% in 2021. The East Neighbourhood has a comparatively higher proportion of Asian residents. The South of the borough has a significant Jewish community which is fairly geographically concentrated whose community spans Salford and Manchester.

Bury has a strong and diverse voluntary sector with over 26,229 volunteers and 1,249 voluntary, community and faith sector groups. The (VSCE) comprises mainly small and micro groups with comparatively few medium scale VCSE organisations in the Borough.

There are positive examples of partnership working between the public and VCSE sectors and across health and social care. A recent Local Government Association peer review described integration between health and social care at operational and strategic levels, and our current model of neighbourhood working as “both enviable and exemplary”, and “the best any of us have seen and something to promote beyond Greater Manchester”. We have 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’ who are responsible for delivering our locality ‘Let’s Do It’ strategy (appendix 1a).

2.0 Live Well and the Neighbourhood Model in Greater Manchester

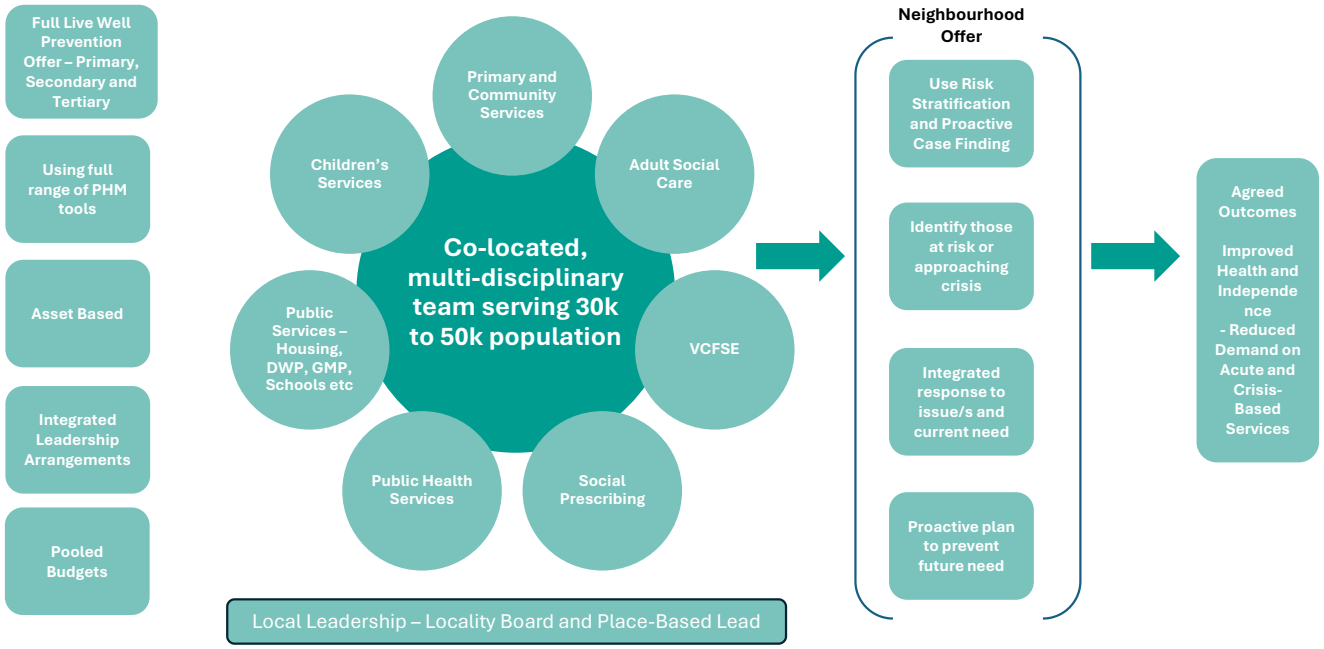


Neighbourhood working in Greater Manchester is based on a different relationship between public services and residents. It is the establishment of multi-agency teams working on geographical footprints of 30-50k population where front-line public service staff know each other, can work collaboratively, and can understand the strengths and assets of residents.

We are creating models of integrated and person-centred services with a focus on the delivery of joined up multi-agency working addressing segmented cohorts of the population to reduce, delay, or eliminate risk of escalated harm, poor outcomes, and unnecessary use of costly, reactive public service spend.
It is an all-age, all public and voluntary service model. It includes integrated health and care teams: primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods

And representatives from the:
- Council
- DWP
- Voluntary Services
- GMP
- GMFRS
- Housing providers

The **key features** of the neighbourhood model are shown below:



The neighbourhood model in Greater Manchester is based on **these conditions.**

1. Strong Relationships	These are the foundation – based on trust, mutual support and leadership for people and place (not organisation)
2. A Clear Vision	A vision for neighbourhood and place that articulates the benefits and enables 'buy in'
3. A Community Led, Shared Approach – Pride in Place	A partnership of equals –community leadership and participation – based on strengths and different conversations
4. A Shift in Power and Resources	As close to those affected by decisions as possible – empowering people and neighbourhoods with greater autonomy and agency – backed up by resources
5. A Culture of Permission to Lead and Act	Built on relationships, shared learning and psychological safety
6, Alignment and Co-Working	Aligned boundaries, co-location, joined up strategic and operational conversations
7. Based on Intelligence, Impact and Insight	Drawing on the insight, experience and expertise of communities; the right intelligence and insight architecture and systems in place and neighbourhood
8. Continuous Improvement	Through systematised approach to learning across GM and 10 localities – and feedback on successes and challenges

Enabled by a strategic centre pursuing a vision for prevention and Live Well

Partners in Greater Manchester have also developed a set of Live Well Hallmarks – including those relating to the neighbourhood model. These are intended to support local areas in shaping and strengthening their own approaches. They can be found here: https://gmpcca.wordpress.com/wp-content/uploads/2025/09/hallmarks-version-1.pdf

For the first time, the NHS requires each place to develop Neighbourhood Health Plans in 2026/27. The strengthened role of Place Partnerships in Greater Manchester gives us the opportunity to accelerate the implementation of neighbourhood working.

3.0 Locality Neighbourhood Structure

3.1 Neighbourhood Geographies – including alignment with PCNs

Within Bury, there are 5 neighbourhoods, North, East, West, Prestwich and Whitefield. Whitefield and Prestwich neighbourhoods have coterminous boundaries of PCN's whereas North, East and West neighbourhoods are not coterminous and have 2 PCNs serving the 3 towns/neighbourhoods. The working relationship across the PCN's and neighbourhoods is underpinned by a memorandum of understanding, regular communication, and a shared ambition of working together more efficiently, and improving health outcomes . The Clinical Directors of the neighbourhoods and PCN's are all currently undertaking a bespoke leadership development programme together to strengthen our clinical system leadership capability across the Borough.

Figure 1 shows the neighbourhood geography in the Bury Locality.

Figure 1: Bury Neighbourhoods

3.2 Location/s of Live Well Centres and spaces

Bury's new exemplar Live Well Centre will be The Ark, a former Pupil Referral Unit (PRU) located in Whitefield. It has many advantages as a Live Well centre:

- Its proximity to an area of social economic disadvantage
- Its proximity to the children's centre at Ribble Drive Primary School
- The availability of an existing building and site available for conversion, including a reception area, classroom sized rooms, kitchen, sports hall, green space and parking.

The Bury Public Service Reform Steering Group considered the potential location for the exemplar Live Well implementation and Whitefield was chosen for the following reasons:

- Whitefield is relatively under resourced in terms of voluntary, community and faith sector enterprise (VCFSE) capacity.
- Parts of Whitefield (especially Besses which is the more deprive part of the neighbourhood) has limited public service presence.
- Area of higher deprivation and associated challenges.
- Community Safety challenges but with an established partnership action already happening in response including GMP's in Operation VARDAR.
- An established and mature Public Service Leadership Team.
- There is a coterminous Primary Care Network and examples of positive joined up working across health, care and the VCSE including recent work on improving responses to people who have co-occuring mental health and drug and alcohol problems.
- Support from Bury social housing providers.
- In its social economic make up – with areas of poverty close to areas of affluence – it is a microcosm of the borough as a whole.
- The opportunity to connect public service reform and the Live Well development to economic regeneration through the Whitefield masterplan.

The GM commitment is to have a Live Well centre in each neighbourhood across GM, including the 5 in the borough of Bury, by 2030. The Ark is first phase of delivering this and will inform the development of a live well offer in each of the other 4 neighbourhoods Bury.

3.3 Scope of the Neighbourhoods

In April 2019, we established 5 Integrated Health and Social Care Neighbourhood Teams (INTs) made up of Adult Social Care and Adult Community Nursing teams being co-located under single leadership arrangements. Each Neighbourhood has a part-time GP Clinical Lead, a full-time professionally registered Neighbourhood Lead (Social Worker, Nurse or Therapist) and a Neighbourhood Support Officer.

These teams represent the core health and care organisational and delivery structure at a neighbourhood level but each Neighbourhood has a wider partnership (including for example: GP practices, MH services, palliative care, adult therapies, community pharmacy, housing, care providers and VCSE organisations) which meet regularly.

Community-based mental health provision through the Living Well model is established on a neighbourhood footprint with Neighbourhood huddles established and PCN Mental Health Practitioners linking with GP practice neighbourhood clusters and MDTs and taking an active role in the wider Neighbourhood partnerships.

Each Neighbourhood also has a Public Service Leadership Team which connects the INTs with wider public service partners including housing, the local authority, public health, Greater Manchester Police (GMP), the Fire and Rescue Service (GMFRS) and the voluntary sector.

At present INTs have an adult focus but there are developing links with children and family services. Schools are clustered on a neighbourhood footprint and work is ongoing to plan how children's and family services can align with the neighbourhood model including the development of Family Hubs and children's multi-disciplinary teams.

4. Neighbourhood Governance

4.1 Neighbourhood governance and connection with Locality / Place Partnership

The strategic plan for Bury at place level is set out in the Bury's "Let's Do It!" strategy (Bury 2030). Let's Do It! is a strategic plan for economic growth, reducing deprivation, and boosting community power by fostering collaboration, building on local strengths, and putting people first to create a resilient, inclusive borough with better life chances for all residents. It focuses on areas like health, work, housing, and tackling inequalities. It's a framework for "Team Bury" (Council, partners, communities) to work together to achieve shared goals, using neighbourhood-focused approaches, innovation, and a strengths-based perspective.

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. Both include senior leadership from all partner organisations.

The Integrated Delivery Collaborative Board is the 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.

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.

There is an integrated approach, across the Council and Northern Care Alliance NHS Foundation Trust (NCA), to the operational management of the INTs and 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 Public Service Leadership Teams (see section 3.3)

Figure 2 describes the neighbourhood governance structure in the Bury Locality. This structure is designed to ensure:

- Effective management of operational services (INTs etc).
- Connectivity between neighbourhood working and the Borough's strategic health and care transformation programmes.
- More effective communication and information sharing between partners to support our locality ambitions.
- More joined up planning and delivery across public services and the VCSE both at place and neighbourhood level.
- Strategic leadership of the development of Bury's wider Neighbourhood model through the Public Service Reform Steering Group.

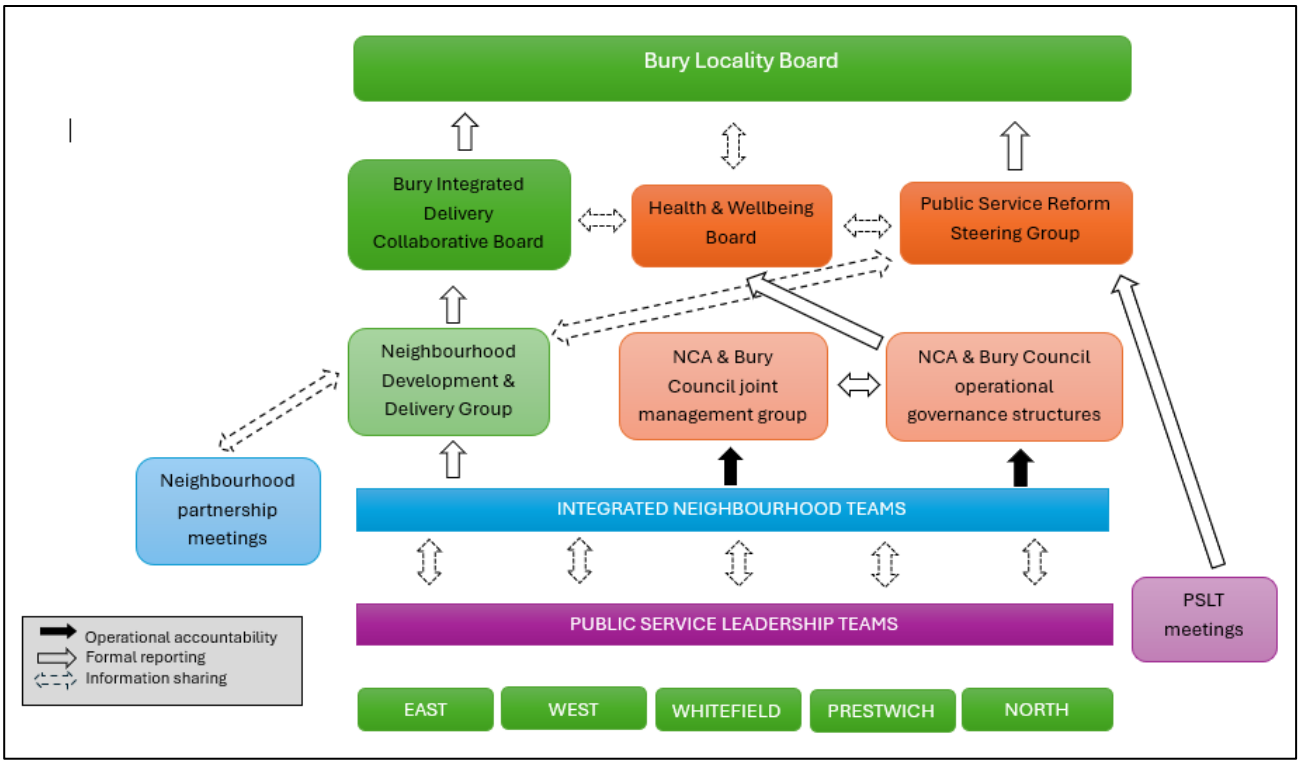


Figure 2: Bury Locality Neighbourhood governance structure

4.2 Neighbourhood clinical & professional leadership

Strategically we have two GPs who hold clinical leadership roles in health and care governance:

- Dr Cathy Fines - Associate Medical Director (GMICB Bury)
- Dr Kiran Patel – Medical Director (Bury GP Federation and Integrated Delivery Collaborative)

Each Neighbourhood has a part-time GP Clinical Lead, a full-time professionally registered Neighbourhood Lead who manages the Integrated Neighbourhood Team and a Neighbourhood Support Officer.

Neighbourhood	GP Lead	Neighbourhood Lead
Prestwich	Dr Richard Deacon	Clare Rayson
Whitefield	Dr Alistair Webley	Jane Wilson
North	Dr Wissam el Jouzi	Linda Prescott
West	Ade Rotowa	Janet Stanton
East	Dr Fazel Butt	Gemma Iliadis

Table 1: INT Leadership

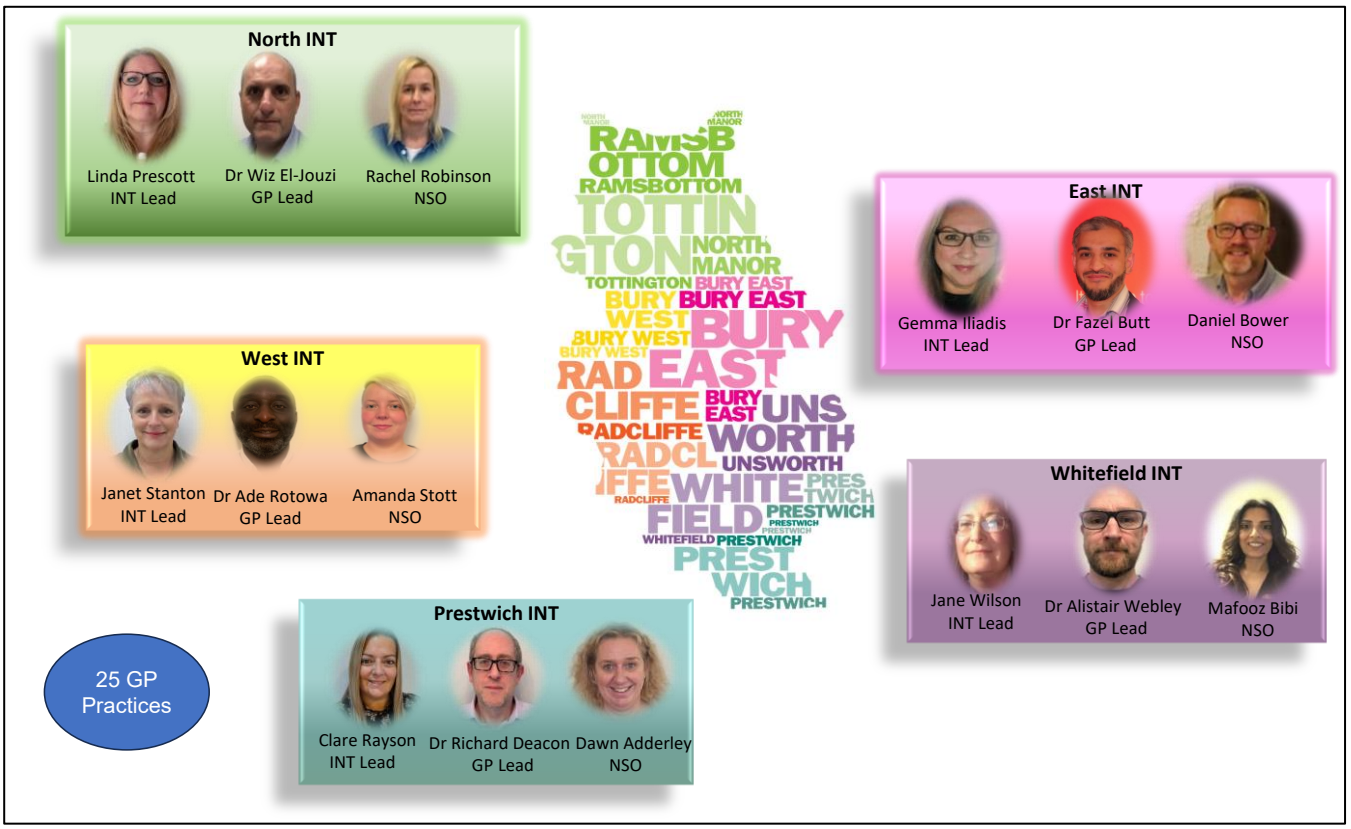


Figure 3: INT Leadership

The GP leads engage with their practice clusters, PCN managers and 4 PCN Clinical Directors through representation on the Bury GP Board, and informal networks.

Collaborative working with PCNs is supported by a memorandum of understanding between the PCNs and Neighbourhoods.

4.3 Primary Care leadership roles

Each health and care transformation programme also has a clinical lead:

- Dr Cathy Fines –Women and Children
- Nigget Saleem (Pharmacist) - CVD/Diabetes
- Dr Sanjay Kotegaonkar – Elective and Community
- Dr Simon Minkoff – Palliative & End of Life Care

The Bury Clinical & Professional Senate provides a forum for our Neighbourhood GP and clinical leads to work collaboratively with clinical and professional representatives from secondary care, mental health services and social care. For example, proposed new pathways of care or key provider policies and strategies are reviewed by the Clinical & Professional Senate.

4.4 Wider Neighbourhood partnership

There are monthly or bi monthly partnership meetings in all of the neighbourhoods. These

include: GP practices, MH services, ASC, District Nursing, adult therapies, community pharmacy, housing, care providers and VCSE organisations and provide an opportunity for information sharing, shared learning and contribution to planning at a Neighbourhood level. The intention is to strengthen these Neighbourhood partnerships to extend the breadth and depth of integrated working as set out in figure 8.

4.5 Public Service Leadership Teams

Each Neighbourhood also has a Public Service Leadership Team which connects the INTs with wider public service partners including housing, the local authority, public health, Greater Manchester Police (GMP), the Fire and Rescue Service (GMFRS) and the voluntary sector. Through the involvement of Council Policies offices these teams maintain links with Elected Members.

4.6 Alignment of other services and teams

Many services are delivered at a place level (e.g. specialist community heather services) because the teams are too small to be configured at neighbourhood level. However, some do connect with the Neighbourhoods e.g., the Specialist Community Palliative Care the team has identified a link worker for each Neighbourhood who attends the neighbourhood partnership meeting and acts as a point of contact.

4.7 How the VCSE, communities and those with lived experience are involved

4.7.1 VCSE

There is a local MoU with the VCSE in place – co-produced with the sector and public service commissioners and partners.

The MoU builds on both existing commitments of the national Civil Society Covenant and the GM Accord and is based on a shared principle of mutual trust, working together, and sharing responsibility. The MoU aims to develop further how Bury works together to improve outcomes for communities and citizens, acknowledging that there are power imbalances in relationships between the sectors and taking active and transparent steps to consider these to build trust and ensure progress as equal partners. The MoU also acknowledges that a single system approach to enabling the best outcomes for local people may require change in how services are delivered and that organisational boundaries should not be a barrier to this process.

The MoU is built on a Bury first approach, utilising the skills, experience and expertise within the locality and broader VCSE sector before bringing in external agencies and supporting spaces to deepen a shared understanding between the sectors by engaging in forums, networks, peer learning opportunities, shadowing and knowledge exchange schemes.

We have identified a number of key enablers to ensure the success of the MoU including:

- Communication and culture - ensuring all partners and their workforce feel valued and respected.
- Improved data and intelligence sharing - to improve planning, design and outcomes for residents.
- Ensuring a financially resilient and appropriately resourced VCSE sector.
- Recognising and capturing learning to build best practice and ensuring the voice of the

VCSE sector and local communities are heard and valued in strategic governance and decision-making boards and groups in Bury.

The work includes ongoing involvement of the VCSE sector in the delivery, monitoring and future revisions of the Bury “Let's Do It Strategy” and the Bury Locality Plan; representation on a number of partnerships including Locality Board (which also includes a focused agenda item at each meeting from a VCSE organisation), PSR Board, IDC, Community Safety Partnership, Children’s Safeguarding Board, Health and Wellbeing and Mental Health Programme Boards, to name a few.

Strategic representation of the VCSE is predominantly through the Local Infrastructure Organisation (LIO), Bury VCFA, however the Live Well programme in Bury offers the opportunity to explore wider representation and increase VCSE leadership opportunities in local governance arrangements.

4.7.2 Neighbourhoods and Live Well

As has already been described, each Neighbourhood has a partnership group made of representatives from health, care and local VCSE providers. These groups are a space for building relationships, sharing information and insight about the needs of the communities and informing the identification of health and care priorities in the Neighbourhoods.

In planning and developing the proposal we need to be true to the principles of LET’S Do It! and Live Well and work with the local community to understand their needs, hopes and expectations. This is essential – to operate as a Live Well centre it needs to be ‘owned’ by the community. There has already been some engagement with residents on what Live Well could mean in Whitefield via insight work delivered through the VCFA (Voluntary, Community & Faith Alliance).

Local people have been involved people in a number of ways – through roundtable conversations, working with existing networks such as Community Connectors, through VCSE sector pulse check surveys and engaging through existing community events. Residents’ surveys and engagement sessions have also been facilitated by local elected members and Onward Homes, a key housing provider in the area.

As Live Well progresses, our ambition is to create a number of community representative places on the neighbourhood leadership teams in addition to a Live Well ‘reference group’ of VCSE leaders from each neighbourhood with the aim of ensuring existing strengths and assets are being utilised, developed in response to need, and are connected into Live Well Hubs/Spaces and vice versa. In addition, we will involve those with lived experience or community groups representing them, in our Bury Fund grant making panels with the intention that 50% of panel members are community reps (including a young persons’ rep), aligning to our MoU commitment of ensuring the voice of the VCSE sector and local communities is heard and valued in the development of neighbourhoods.

In September 2025 Bury held an inaugural Armed Forces Covenant Conference with a specific focus on Live Well through the lens of the armed forces communities and veterans. This was to also consider alignment with the national VALOUR programme of support for these groups (to align VALOUR nationally, with Live Well regionally and LETS into neighbourhoods).

4.7.3 Wider engagement and co-production work

In addition to this recent programme-specific engagement work, other engagement work includes:

- An extensive range of engagement and co-production work with Parents, carers and children & Young people as part of the SEND improvement programme.
- Listening events with people with lived experience to inform the development of the new Bury mental health strategy.
- An active Older People's Network which informs the development of policy and strategy.
- The development of the Bury Council LD strategy with People First.
- The establishment of a new autism co-production network.
- The development of a new dementia co production network.

Speakeasy, originally part of Sport England's *I Will If You Will* pilot supporting women and girls in 2016, works with people diagnosed with aphasia resulting from conditions such as stroke, brain injury and dementia. The group first co-designed an accessible walking route in Clarence Park, ensuring features like surface quality, inclines, toilets and health-literacy needs reflected what mattered most to service users' wellbeing and ability to be active. In 2025, Speakeasy and Bury Public Health partnered again to expand this approach, mapping two additional park-based walks, supported by wider system investment from Transport for Greater Manchester and the Department for Transport. The programme will now extend across multiple neighbourhoods in Bury, with potential for Greater Manchester-wide aphasia-friendly walking routes. The resulting maps will be shared with health and community partners to support broader use and promote inclusive, accessible activity.

Bury Council and housing staff highlighted the lack of menopause support available for women in the workplace and local communities, leading to a co-designed approach to improve provision. A mapping exercise confirmed limited existing support, prompting senior leadership—including the Chief Executive—to join listening events and shape a new model of menopause wellbeing. Bury Live Well staff were trained to deliver tailored daytime and evening drop-ins covering HRT, sleep, nutrition, hormones, physical activity and peer support, which quickly gained strong interest from both council staff and local GP practices. Growing community demand led the Live Well service to expand from two to five trained menopause coaches and move delivery into neighbourhood venues, widening access for residents. GP-focused webinars are now being developed to extend support further across Primary Care Networks, with an average of 12 women from diverse backgrounds attending each session, demonstrating a sustainable and community-led approach to health creation.

4.8 Finance

The locality has a budget of £70m devolved from GMICB, which is encompassed within a section 75 agreement with Bury Council. The Locality Board is a delegated sub-committee of the NHS GM board (as well as operating as the apex of senior partnership leadership in the health and care system, jointly chaired by the Leader of the Council and the Senior GP in the borough) and receives monthly budget updates and formal quarterly reporting. The budgets cover Community Services including the Better Care Fund, inpatient and community Mental Health services, Continuing Healthcare and Primary Care.

At a Neighbourhood level the INTs are operationally resourced through the NCA and Bury Council. We have no plans at this stage to delegate budgets to neighbourhood level.

Work on neighbourhood health and care priorities is partly supported through the locality GP contract – Locally Commissioned Services Framework. This has provided targeted funding to GP practices to meet agreed Neighbourhood level targets, typically in relation to secondary prevention and reducing health inequalities.

4.9 Risk management

Individual provider organisations are responsible for the management of their own organisational risks in line with their own standard governance procedures. Where providers are commissioned by the NHS risks are routinely reported and reviewed as part of standard contract reporting and management arrangements. Locality programme, system and strategic risks are managed in line with the NHS GM Risk Management Policy.

In Bury, all the health and care transformation programmes maintain a risk register which includes key risks to programme delivery and where relevant operational risks relating to service provision. These are regularly reviewed by the relevant programme board, committee or group. For the Neighbourhood programme the responsible group is the Neighbourhood Development & Delivery Group.

A consolidated locality risk register is regularly reviewed by the Bury Risk and Scrutiny Group to ensure consistency and compliance with the NHS GM Risk Management Policy. Risks scoring 12 or more are routinely reported to Bury Integrated Delivery Board and the Bury Locality Board. Local risk management procedures are described in the Bury Risk Management Standard Operational Procedure. Where required risks are escalated to GMICB programme board or executive in line with the NHS GM Risk Management Policy.

4.10 How implementation, monitoring and evaluation of the plan will be overseen

The table below outlines the governance for the 5 pillars of the neighbourhood Portfolio, which will ensure implementation and evaluation of it's own delivery plan and outcomes.

Programme	Lead	Governance
Live Well	Will Blandamer	Public Service Reform Board/Locality Board
Neighbourhood Leadership Teams	Chris Woodhouse	Public Service Reform Board
Integrated Health and Care Adult Teams	Kath Wynne-Jones	Neighbourhood Design and Delivery Group and IDC Board/Locality Board
Neighbourhood approaches to supporting Children's and Families	Jeanette Richardson	Public service Reform Board/Childrens Strategic Partnership Board
Estates strategy	Claire Postlethwaite	Strategic Estates Group

Table 2: Neighbourhood programme governance

A quarterly Portfolio Board will be established to ensure alignment of the strategic ambition of the 5 neighbourhood programmes

Quarterly neighbourhood delivery collaborative workshops are already in place to bring together teams working on the delivery of different the components at an operational level.

We have 3 key priorities with regard to outcomes set development:

1. Work with key partners to agree the main 'neighbourhood' indicators which will be monitored to inform planning and evaluate impact with specific reference to population health through a Neighbourhood dashboard (developing list above) in the context of the outcomes set in development at GM
2. The development of indicators and targets for GP practice clusters to monitor delivery against Neighbourhood level priorities that form part of the locality GP contract – Locally Commissioned Services Framework.
3. Work with GMICB and NCA data and intelligence teams to develop an integrated dashboard to track activity at a patient level to understand the impact of active case management through Neighbourhood MDTs mirroring work that has been done in Bolton.

We are aware that an outcomes framework is in development at GM relating to neighbourhood delivery, connected to the National Neighbourhood Health Implementation Programme. Our local framework will be finalised once we have seen the outputs of this work.

5.0 Operating Model

5.1 Introduction

The Model of Neighbourhood working is a cornerstone of the Locality plan – the strategy for the health and care system in the Borough.

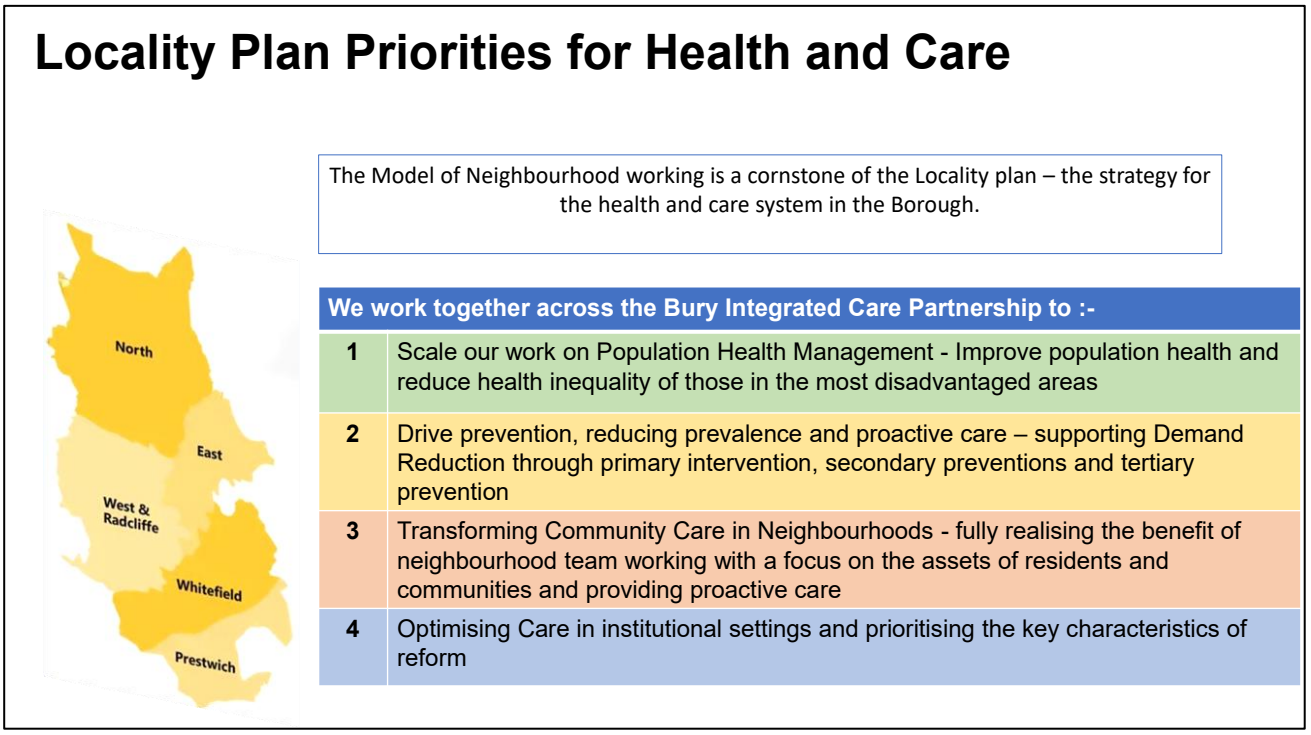


Figure 4: Locality Plan priorities

We have developed a number of key principles with regard to neighbourhood working which include:

- The neighbourhood level is 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
- 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**.

Our approach to neighbourhood working includes:

- 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 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
- Better organised public services but with a shared approach to engaging communities and residents differently.
- A mechanism to allow us to respond to Borough, GM, or national priorities – e.g. how to improve school readiness.

We have 5 pillars to our neighbourhood plan which are outlined below.

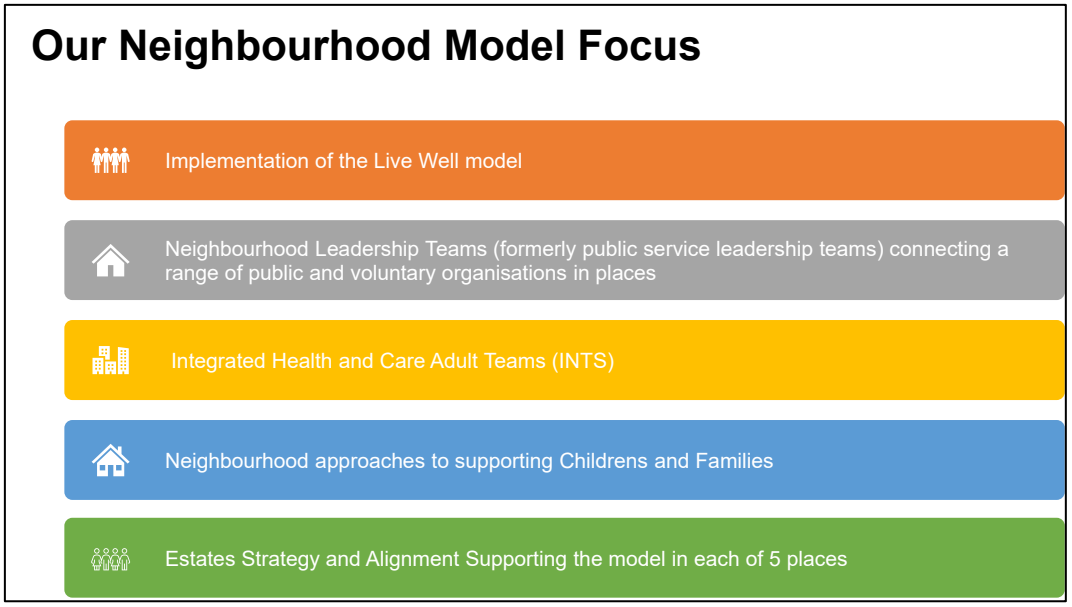


Figure 5: Neighbourhood model components

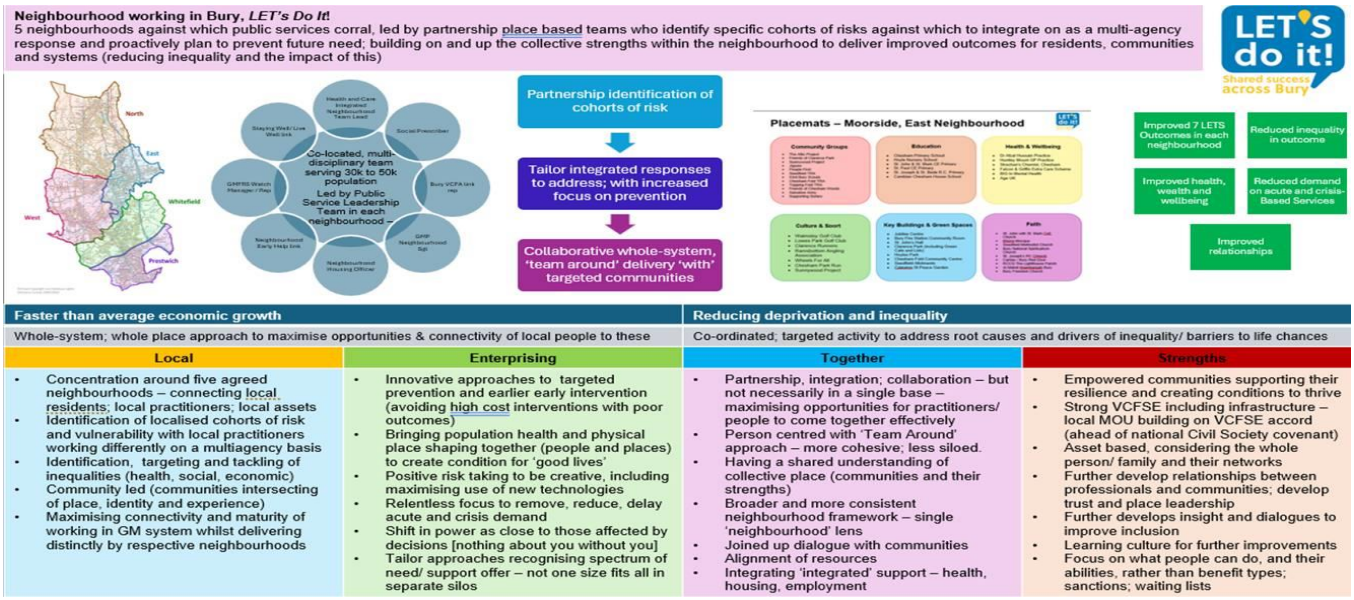


Figure 6: Bury's approach to neighbourhood working

5.2 How neighbourhoods interact with/relate to Live Well Centres and Spaces and the broader neighbourhood offer

Starting with Whitefield and the development of our exemplar Live Well Centre it is envisaged that Live Well centres and spaces will be an integral part of our Neighbourhood ecosystem in line with the GM Live Well and Neighbourhood model. The aim is to develop live well offers in out neighbourhoods aligned with Integrated Neighbourhood Teams to provide an offer to our communities based on the thrive model. See figure 7 below.

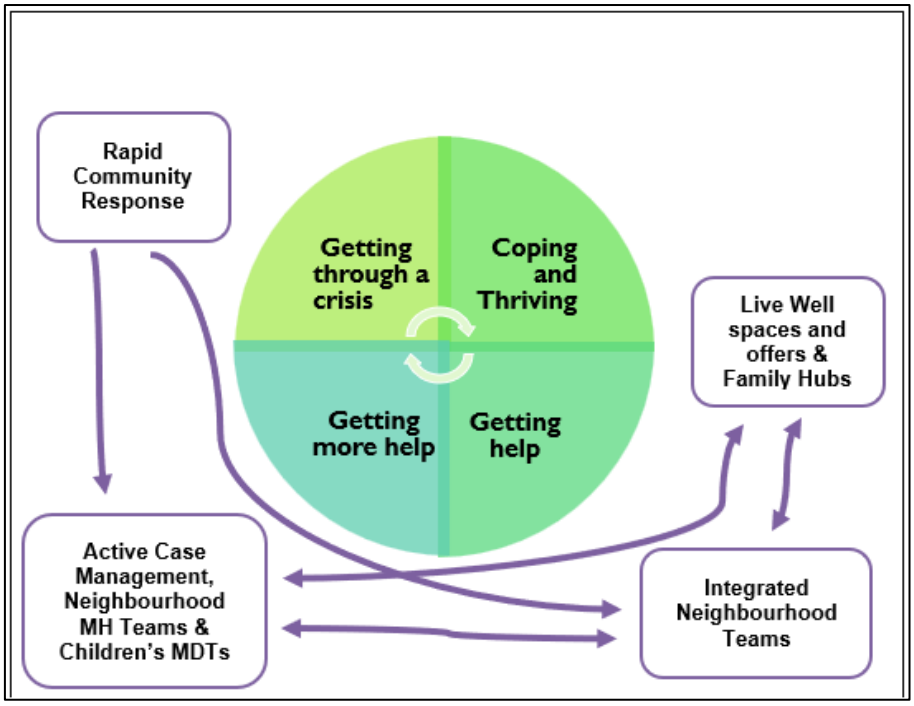


Figure 7: Thrive model in neighbourhoods

We have Public Service Leaderships Teams in each of the 5 Neighbourhoods, creating relationships between public services and voluntary and community capacity in the place and working to address particular cohorts of risk and harm.

Schools are clustered on a Neighbourhood footprint and there are for example Neighbourhood based SENCO communities of practice. We also have the model of family hubs in development, predicated on the 5-neighbourhood footprint but in practice delivered at a much more local community level (for example Chesham).

This work – to join up public services, to create opportunities for public services to know each other and work more effectively together, and for public services to have a shared knowledge of the assets and voluntary and community capacity in the place is one of the key pillars of public service reform in Bury. A core component of this work is the leadership provided by the Bury Voluntary Community and Faith Alliance (Bury VCFA) - creating the conditions for a movement, administering investment capacity, and challenging public services in the way they work. But it is also about the incredible array of community and voluntary groups in the borough, some large some small, and the contribution they make to people's lives. The VCSE sector and the community work of faith groups and organisations is integral to Bury's Live Well neighbourhood model of working, demonstrated through the commitments in the Bury VCSE/Public Sector MoU, signed by the Bury VCSE Leadership Group and Locality Board partners in September 2025.

5.3 Health and care in neighbourhoods: The national ambition

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

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

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

In Bury, we have all of the building blocks in place, but need to do more to systematise, scale and spread our work.

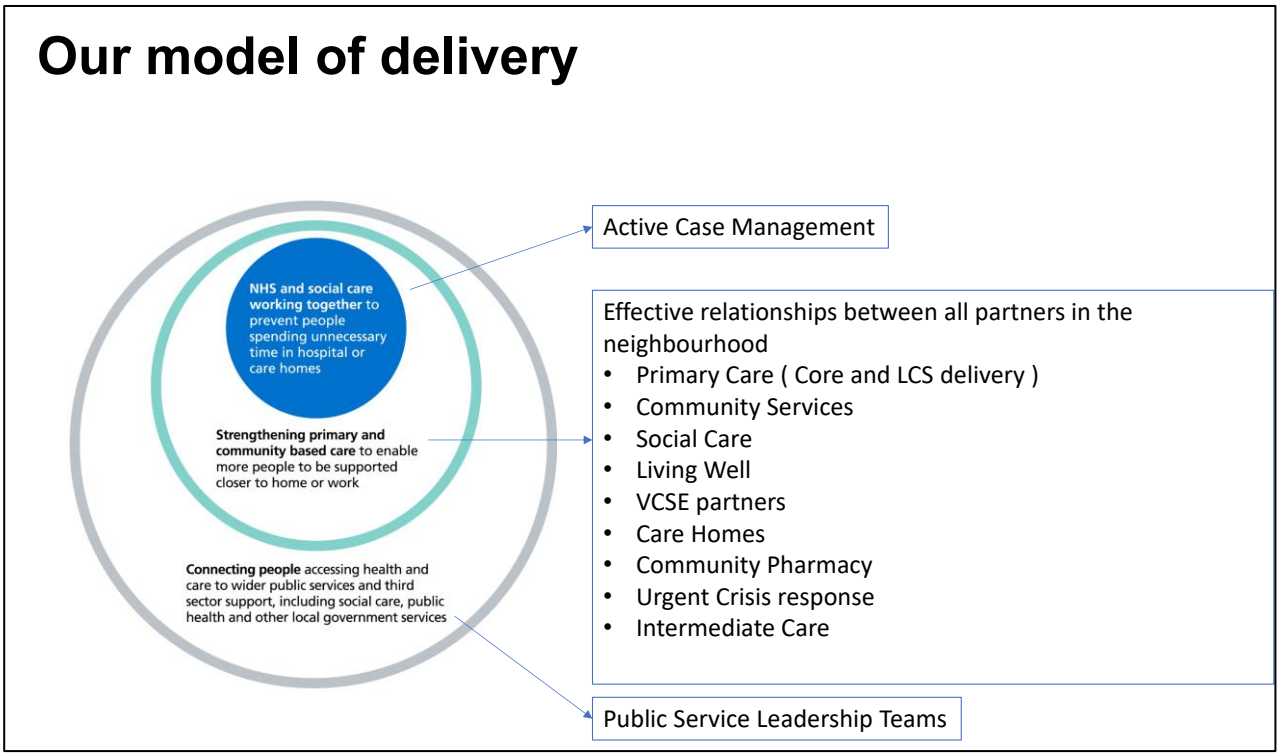


Figure 8: National neighbourhood model

5.3.1 Population Health management using risk stratification and supporting vulnerable populations to reduce health inequalities

Bury's LET'S Do It strategy is a health inequalities strategy. A major aim is to improve quality of life as measured by inequalities in life expectancy. Other aims address many of the building blocks of health, such as improving educational outcomes or economic growth that benefits everyone. Bury's Health and Wellbeing Board acts as a standing commission on health inequalities in the borough. It uses the Greater Manchester Population Health Framework to organise its work.

Bury's Prevention Framework (Appendix 1c) is designed for everyone—residents, professionals, and partners—to work together in preventing illness, promoting wellbeing and reducing inequalities. It focuses on taking early action to help people stay healthy and safe, reducing demand on urgent care and tackling health inequalities by addressing factors like housing, education and employment. The framework aligns with national, regional and local strategies, including Bury's LETS Do It! 2030 vision and is built around three types of prevention: primary (stopping problems before they start), secondary (detecting and treating issues early) and tertiary (managing long-term conditions to prevent complications). Prevention happens at both individual and population levels and follows a life course approach—Start Well, Live Well, Age Well, to ensure opportunities for health improvement at every stage of life. Guided by principles of being Local, Enterprising, Together, and Strengths-based, the framework highlights current initiatives such as anti-poverty strategies, smoking cessation, cancer screening, and heart disease management.

Work is going on to refresh the JSNA, including neighbourhood profiles, to inform planning and prioritisation based on need and inequality.

There is work going on across the borough to reduce inequalities continues through:

- Ongoing delivery of the anti-poverty strategy, including food support, digital inclusion, support with bills and employment programmes.
- Launch of the Bury Tobacco Control Alliance which focuses on prevention, supporting smokers to quit, reducing HIs and effective enforcement, with priority cohorts identified e.g. routine and manual workers, those with serious and enduring mental health and mothers smoking at time of delivery.
- Improving diet through the Sustainable Food Places Framework.
- Improving vaccine uptake.
- Improving sexual health services for sex workers through ongoing outreach, screening and contraceptive support in sex work settings.
- Improving care for coronary heart disease.
- Expanding neighbourhood-level support through Live Well hubs.
- Refresh of the JSNA to guide future decision making.

Next steps include developing detailed plans for each life stage to deliver neighbourhood and borough-wide actions that help all residents live healthier, happier lives.

To improve outcomes for the 20% most deprived populations identified by the Index of Multiple Deprivation (IMD), as a Locality we have already started to adopt a targeted, community-led approach, in part through the development of the Live Well programme which includes:

1. Mapping and understanding need using IMD data and layering it with health, housing, and access data to identify local challenges and assets in neighbourhoods.
2. Strengthening trust through local partnerships by building on relationships with community groups, faith networks, and voluntary sector organisations. Community connectors and health champions are supporting co-design and delivery for selected conditions e.g. CVD and diabetes.
3. Delivering tailored services in familiar, accessible settings such as schools and community centres which are culturally appropriate and also address wider issues like housing, employment, and food insecurity.
4. Empowering communities through co-production and investing in leadership, skills, and capacity with support from the VCSE infrastructure body. This is at the heart of the GM Live Well model.
5. Monitoring, evaluating, and adapting solutions using real-time data and feedback. Outcomes will be shaped around what residents value, not just traditional service metrics.

This approach will ensure equitable, locally informed solutions that reflect and respond to the needs of communities.

The public service leaderships teams (PSLTs) have identified cohorts of need / risk / vulnerability in each of the 5 neighbourhoods. This is based on data and insight from PSLT partners Plans in relation to these are at different levels of maturity.

Table 4 details these cohorts for each neighbourhood.

Neighbourhood	Priority cohorts / needs identified
East	• Individuals susceptible to cuckooing and hoarding. • Victims of Domestic Abuse particularly under 21 and repeat victims. • Individuals struggling with poor mental health. • High intensity service users and Frequent ED attendance.
	• High number of single-family households (compared to Borough average) and one-persons households of those aged 65+ struggling with social isolation/ vulnerability. • Digital exclusion especially among older people in Hawkshaw & Shuttleworth wards. • Low-income households including those vulnerable to debt in Elton Ward
Prestwich	• Financially and medically vulnerable older adults (85+) facing isolation and chronic health risks. • Low-income households with young children.
West	• Households with long-standing addictions, including older adults. • Individuals who are at risk of isolation because of concerns about drug use and criminality in the community (and risk of such individuals being susceptible to exploitation e.g. through cuckooing). • Younger individuals moving into the area with multiple existing needs around alcohol and mental health.
Whitefield	• Socio-economically vulnerable families, particularly in Besses and Southern Unsworth. • Older teenagers without local, inexpensive youth-related offer who become involved with criminality including e-bikes and associated robbery and burglaries (particular focus on Besses). • Smoking rates, particularly in routine and manual labourers and those residing social housing, plus working with children and young people on prevention (including vaping).

Table 4: priority cohorts identified by PSLTs

Bury has a Major Conditions Board (MCB) that meets monthly with representatives from the Neighbourhoods, NHS GM ICB, Public Health and providers. The Board has oversight and provides assurance of the delivery of the cancer, CVD, dementia, diabetes, falls/frailty and respiratory programmes.

In 2026-27, the cancer programme in Bury will focus on 2 tumour groups where Bury has been identified as an outlier for early diagnosis - lung and colorectal. As a Locality and through neighbourhoods we will focus on patient and clinician education to increase awareness of signs and symptoms of all cancers, but with a particular focus on these priority tumour groups. Through connections with our PSLTs we will amplify GM Cancer Alliance comms campaigns and target these where we know we have unwarranted variation for late-stage diagnoses.

The CVD/diabetes work programme will continue to build on work related to structured diabetes education, Hybrid Closed Loop, diabetes care processes and the optimisation of hypertension and lipid management. Where work would benefit from a neighbourhood approach, as it has done with diabetes, we will target activity as appropriate.

Bury's Public Health Team published a paper in September 2025 with the purpose of critically

examining the role, limitations, and appropriate use of risk stratification in healthcare. The paper sets out some of the limitations of predictive risk stratification and potential risks including: false negative and false positive results resulting in over treatment, waste, and harm. It highlights the need for proper technical and ethical appraisal of any potential risk stratification tool before adoption and ongoing assessment of benefit, harm, and costs. We are currently exploring what this means for our risk stratification approach.

In Bury some practices have access to the Ardens GEM risk stratification tool. The GP record (EMIS) can be used to identify cohorts of need by applying tools such as the Electronic Frailty Indec (eFI) and EARLY (patients who require palliative care). QRISK is used with individual patients.

5.3.2 Modern General Practice

As a Borough we have created a local General Practice Strategy which is delivered through the Bury GP Board and is delivering improved access for patients.

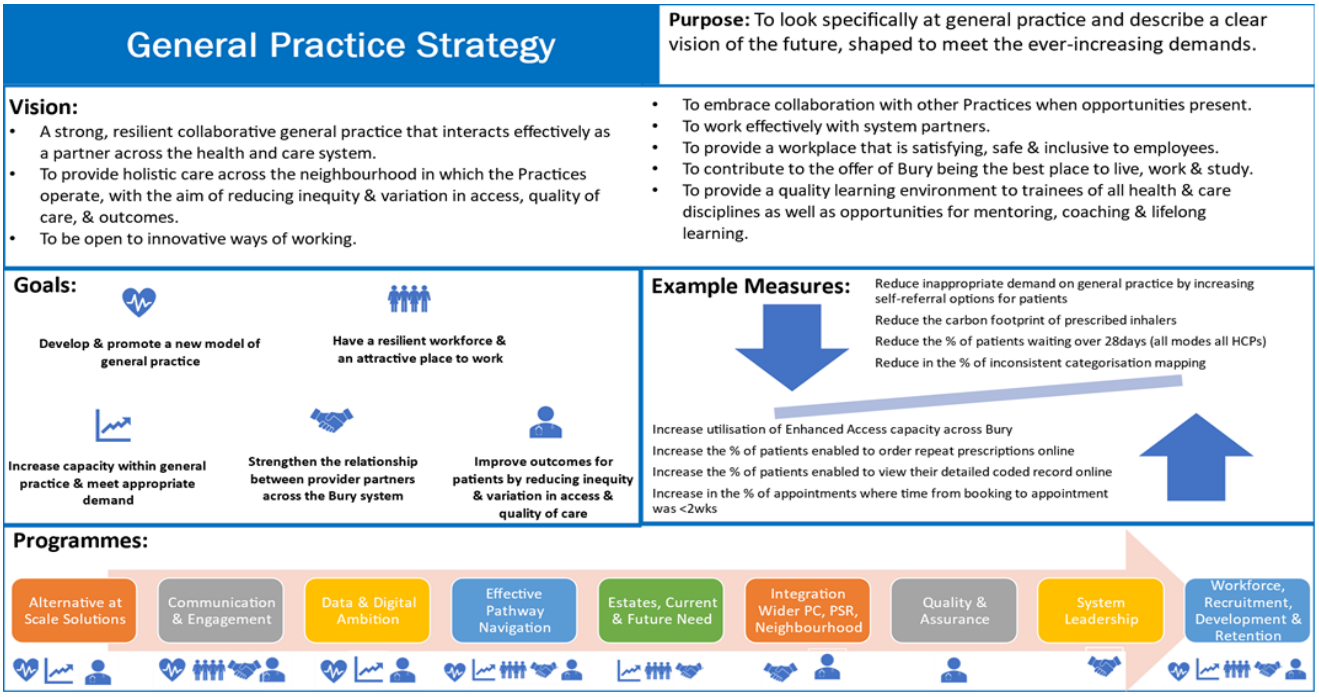


Figure 9: National General Practice Strategy

A range of services have been developed offering additional accessible appointments including:

- Women's Health Hub – 277 appointments offered to Whitefield patients requiring LARC's (addressing an identified inequality in access issue).
- Nearly 15,000 additional appointments offered through winter via Surge and Acute Respiratory Hubs (ARH). Evidence suggests that these clinics reduced attendances across A&E and BARDOC and released pressure on Primary Care in the process.
- Enhanced Access – nearly 40,000 appointments offered across the borough.

Patients are now accessing services differently:

- 65% of 13yo+ are now registered for the NHS App, an increase of 6%.

- Prescription requests via this method have increased by 50%, driven by the phased roll out of Patient Led Ordering. This work also supports embedding the GM GP Practice & Community Pharmacy Interface principles document intended to improve communication and reduce the administrative burden of repeat prescription requests. (214,956 in 2023/24 to 323,327 in 2024/25)

We have implemented the capacity and access improvement programme:

- As part of the Modern General Practice - Digital telephony, simpler online requests and faster care navigation, assessment and response 100% of practices are now enabled for online patient registration.
- It's easier for a patient to register with a GP surgery (moving house, new baby) and reduces administrative burden on practices.

Utilisation of wider primary care provision

- Referrals to pharmacy increased by 192% (2193 in 2023/24 to 6418 in 2024/25).
- Community Urgent Eye Service activity increased by 18%.

There are a range of roles now employed through ARRS including Clinical Pharmacists, First contact physiotherapists, Physician associates, Social Prescribers, Mental Health Practitioners Nursing Associates, General Practice Assistants, Digital and Transformation Leads and also General Medical Practitioners.

GP collective action has prompted positive inroads to reduce bureaucracy. However, ongoing work is needed to continue to progress required changes through Primary Care/Secondary Care Interface.

We are expanding our cross working across organisational boundaries with GP's providing cover supporting intermediate care facilities and Consultants reaching into the community and care homes.

Bury has historically delivered neighbourhood level interventions designed to reduce unwarranted variation between GP practices thereby contributing to a reduction in health inequalities via The Bury Locally Commissioned Service (LCS). Under the LCS model, all practices within a neighbourhood are required to meet a minimum threshold of achievement for the neighbourhood to receive payment, strengthening collective responsibility and shared outcomes.

For 2025–26, the LCS focused on two priority areas: Chronic Obstructive Pulmonary Disease (COPD) and frailty. Previous years priorities have included: bowel cancer screening, dementia care, dual diagnosis, frailty, falls prevention, respiratory disease and adverse childhood experiences. In the current year the focus is on reducing the risk of exacerbation among patients with COPD, identification and management of frailty and roll-out of EPaCCs.

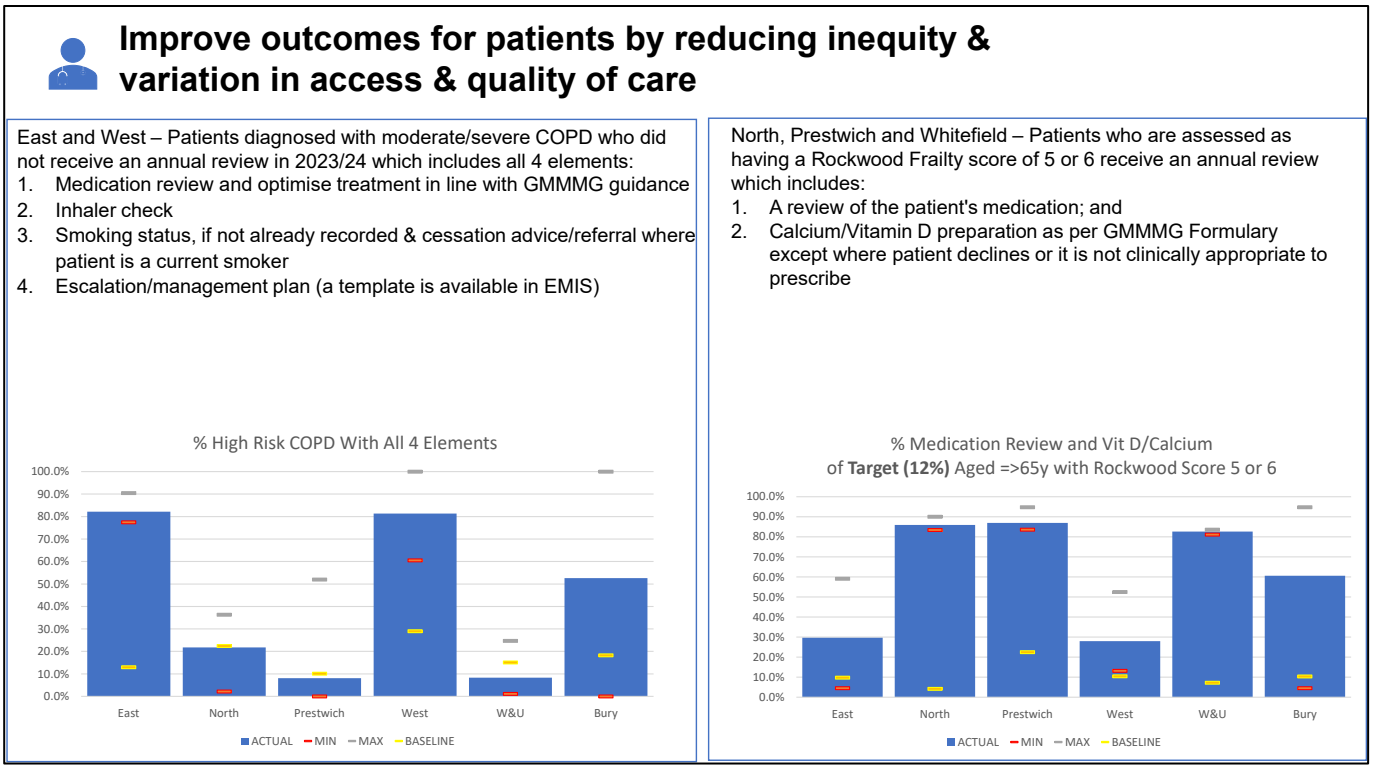


Figure 10: LCS impact

The future of our neighbourhood-based, primary care-led work in this area is dependent on GMICB decisions on the form and funding of BeCCoR Phase 3 and specifically whether there will be the ability to fund general practice to focus on agreed local and neighbourhood level priorities in relation to (secondary) prevention and reducing inequalities and unwarranted variation as we have done in recent years.

5.3.3 Standardising community health services

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

Early work has commenced to review and align Locality services across the NCA FLP. This work is focusing on contract alignment across NCA FLP footprint to reduce variation and address inequalities and will support service transformation. The NCA has commenced a series of Community Services Reviews looking at demand management and pathway improvement. Aiming to standardise service delivery and reduce any variation. Six reviews have been completed to date on - Dietetics, Paediatric Speech and Language Therapy (SALT), District Nursing, Community Diabetes, Adult SALT, Intermediate Care and a planned future review for Muscular Skeletal Services (MSK).

Realising a 'neighbourhood health service' that delivers more care at home or closer to home is a key national and local priority. Standardising community services is identified as one of the 6 key components to deliver. We are taking every opportunity to ensure that community

services are connected into the neighbourhood delivery model where appropriate, with some services such as District Nursing already organised on a neighbourhood footprint alongside adult social care.

As part of our neighbourhood health programme we will continue our transformation of community health services to support our locality ambitions.

5.3.4 Standardising community mental health services

Bury priorities for Mental Health align to the GM Mental Health and Wellbeing Strategy. Core to this is the transformation of community services and the creation of Neighbourhood Mental Health Teams (the 'Living Well model'). The aim is to support more people with serious mental health problems to have their needs met in a holistic way and lead fulfilling lives by strengthening community-based mental health provision. In Bury we are doing this through the establishment of Neighbourhood MH teams (based on the Living Well model) comprising PCFT clinical staff and VCSE link and peer support workers aligned to our Neighbourhoods.

Living Well offers:
- Community mental health support for adults that focuses on people's strengths, to help them recover and stay well as part of their community.
- A connected front door to community service, offering mental health and practical support (such as housing, employment, financial support).
- Support for people who may have previously been excluded from services because their needs are too complex for primary care and not complex enough for traditional secondary care services.
- A multi-disciplinary neighbourhood approach, with additional mental health expertise and support for primary care professionals.
- An approach to fulfilling the expectations of the National Community Mental Health Framework, adopted from Lambeth who launched the model 15+ years ago.

Key features of the neighbourhood mental health team include:
- Jointly delivered by the VCSE and PCFT.
- Aligned to the Neighbourhood model with huddles aligned to neighbourhoods.
- Workforce model includes PCN MH Practitioners who attend Neighbourhood MDTs and can pick up referrals directly from the MDT.
- VCSE link workers and peer support workers can connect people with a wide range of community support including VCSE, employment, housing, benefits etc. Links with Social Prescribing are developing.
- Have initial conversations rather than clinical assessments, involving people in their care.
- Hold dedicated consultant-led clinics for new patients, providing early access to psychiatric assessment and intervention.
- Provides an older age adults offer in NMHT's preventing the need for assessment in specialist older adult services.
- Provides a single point of access for all referrals into secondary care MH services – streamlining referral pathways for GPs.
- Enables patients to be stepped up into CMHTs and specialist services and stepped down.
- GP Connect – provides GPs with direct access to advice from psychiatry.

So far the CMHT restructure has been implemented. Bury are the first Living Well Team within PCFT to provide the following:
- Operate huddles across all neighbourhoods

- Provide an older age adults offer
- Have initial conversations as recommended in the LW Handbook
- Transferred our CMHT Assessment Team into LW to improve patient journey & experience
- Commenced a step up / step down pathway to ensure seamless transition between services

5.3.5 Neighbourhood Multi-disciplinary Teams

Bury has 5 Integrated Neighbourhood Teams (INTs) made up of Adult Social Care and Adult Community Nursing teams co-located under single leadership arrangements. Each Neighbourhood has a part-time GP Clinical Lead, a full-time professionally registered Neighbourhood Lead and a Neighbourhood Support Officer.

In addition, a AHP and Nurse liaison worker work across the Neighbourhoods. They have the flexibility to take on a key worker role for people who have been referred into active case management and also play a key role in liaising with wider secondary care services and developing referral pathways into Active Case Management. For example, they have been involved in:

- Working with Fairfield General Hospital (FGH), wards and departments to promote Active Case Management which has resulted in increased referrals. Meetings are arranged with the medical directorate to promote the INTs and ACM.
- Working with North Manchester General Hospital (NMGH) wards and departments to promote Active Case Management.
- Developing responses to high intensity service users and particularly people who have high numbers of attendances at FGH ED – working with the ED Team and MH Liaison.
- Working with Ambulance Services**,** meetings completed with Hatzola and NWAS to promote the INTs and ACM. There is a pilot ongoing with the North West Ambulance Service to establish a referral pathway to ACM for identified high intensity service users.

5.3.6 Active Case Management MDTs

As part of the Active Case Management (ACM) process there are MDT meetings linked to each GP practice in the Neighbourhoods (figure 11). Together the MDT coordinates care for individuals to improve independence, prevent, reduce and delay by improving access to the right service at the right time ensuring a person-centred and strength-based approach.

Patients referred for ACM are discussed at an MDT which supports care planning, identifies a key worker and agrees the most appropriate intervention(s) based on the needs and goals of the patient.

The MDT includes:

- The GP or clinical representation from the patient's registered practice.
- Neighbourhood GP Lead
- Neighbourhood Lead
- PCN MH practitioner
- PCN Social Prescriber
- District nurse
- Adult Social Care
- Nurse and / or AHP Liaison Practitioner
- GP practice or PCN pharmacist

Other services may be invited where appropriate including:

- Housing
- Drug / Alcohol services
- Representative from the Council's Live Well and Staying Well Teams.

Around 100 people per month are referred into Active Case Management. The cohorts include:

- Older people with frailty
- People with poorly managed long-term conditions
- Complex adults with multiple health and social needs
- High intensity service users

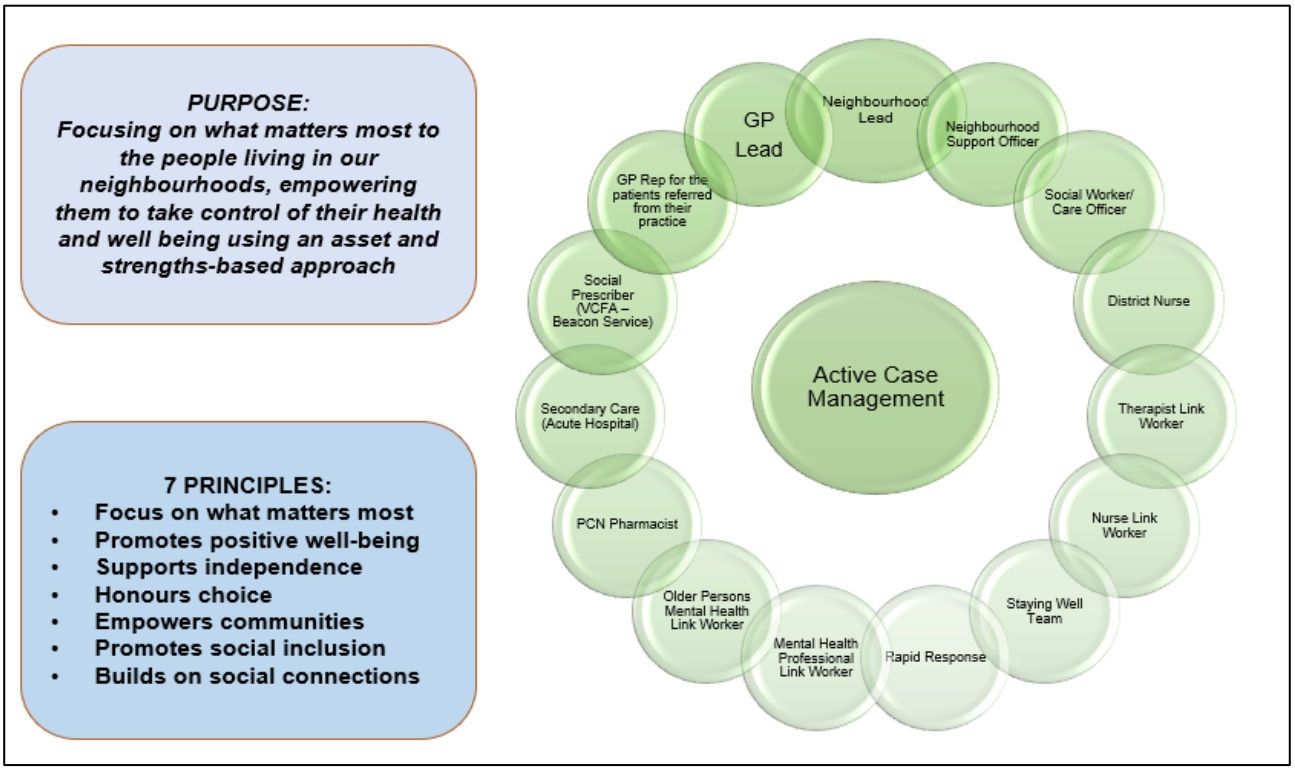


Figure 11: Active case Management

Whilst the INT's are focused on health and care delivery, the INT leads play a role throughout all the pyramid of need (figure 12).

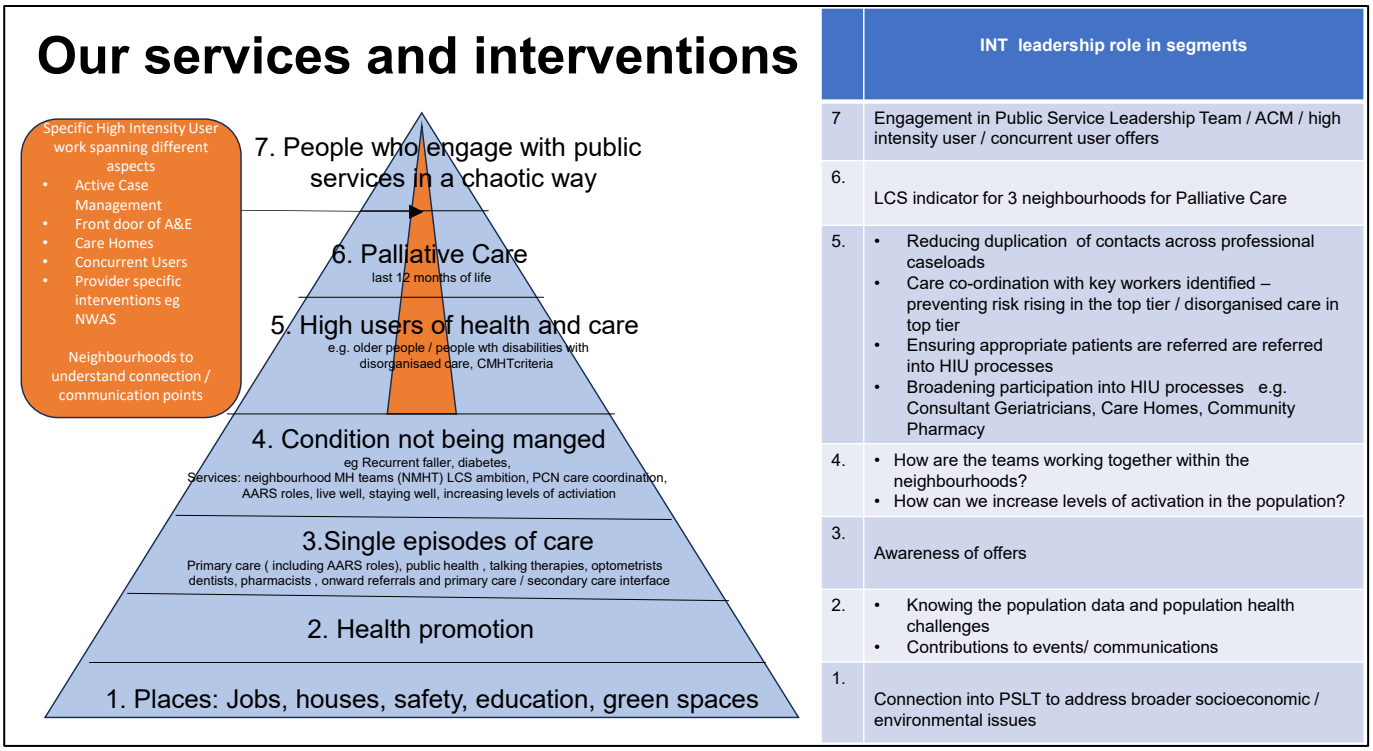


Figure 12: Services and interventions

5.3.7 Integrated intermediate tier with a 'home first ' approach and Urgent neighbourhood services

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

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

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

Outcomes between April 2024 and now include:

- Numbers on DKAFH: Reduced from 60 to 44
- Total Days on DKAFH list: Reduced from 1000 to 534
- 95% to be discharged to their own home - over 65 years from medical wards: increased from 91% to 93%

- % of beds occupied by patients with a LoS over 21 days : reduced from 23.5% to 12.5%

In Bury we have a strong foundation of an urgent neighbourhood service within our intermediate tier of services. Our Rapid Response Team provide our Urgent Crisis Response (UCR) service, which incorporates Hospital at Home, Rapid Response and the Falls pick-up service. December saw the highest number of referrals come into UCR (Rapid Response and Hospital at Home) with circa 500 referrals. Of the circa 500 referrals, nearly 50 came from Care Homes. The ability to receive referrals via Adastra has now been activated, and the team are consistently overachieving the GM and National 2-hour response measure. The team are continuing to work with NWAS to improve referral activity via Adastra and will explore further options for reducing the variation in service usage between mid-week and weekends. This work is also supported by the NCA Call B4 Convey and SPOA.

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

Since October 2022, Burys Hospital at Home (H@H) service has supported over 3,000 patients in their own residences, avoiding an equivalent number of hospital attendances or admissions. This has been especially valuable for frail patients, who face greater risks from hospitalisation including deconditioning, falls, and hospital-acquired infections and are often subject to longer stays or discharge to care settings.

A patient shared:

"*I feel fortunate to receive care at home. Hospitals can be overwhelming when I'm unwell. Being treated in my own space allows me to feel at ease and reassured by the skilled professionals looking after me."*

The Consultant Practitioner role was newly introduced within the Hospital at Home service and has played a pivotal role in shaping the service. In addition to managing a growing caseload, the team operates across both hospital and community settings, establishing strong, collaborative relationships with hospital teams, Same Day Emergency Care (SDEC), and consultants.

This integrated approach has enabled the safe management of patients with higher acuity needs in their own homes, individuals who would previously have required hospital admission. The Hospital at Home model offers clinical care at home through face-to-face visits, remote monitoring, and virtual consultations with healthcare professionals, including consultants.
Our Hospital at Home Consultant Practitioner released a national publication on "The importance of a comprehensive geriatric assessment for older people admitted onto a virtual ward."

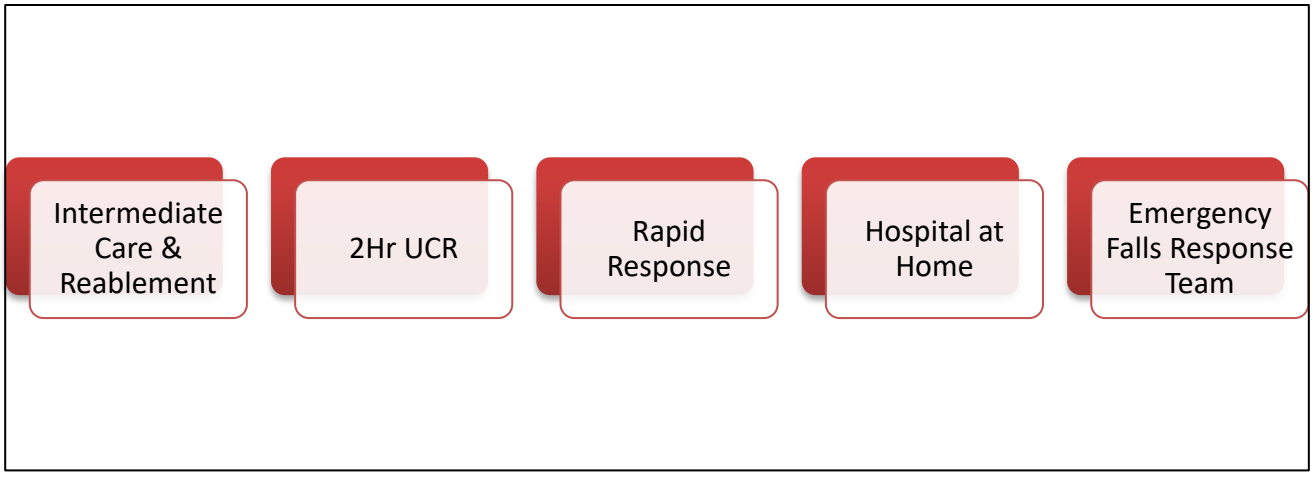


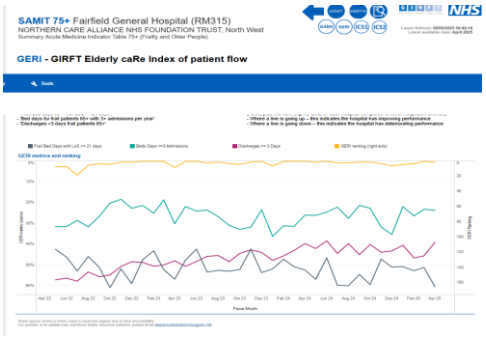
Figure 13: The intermediate tier

The Geriatrician consultants based at Fairfield General Hospital have and continue to play a key part in a series of new initiatives, reaching out into the community to provide a system wide 'Home First' approach and cultural change, to facilitate patients remaining in their homes. This, in turn, eases pressure within Urgent Care and, most importantly, ensures people can receive the right care, at the right time, in the right place. This work also underpins the UEC Planning Guidance for 2025-26, emphasising the shift from hospitals to community to improve patient outcomes and system efficiencies.

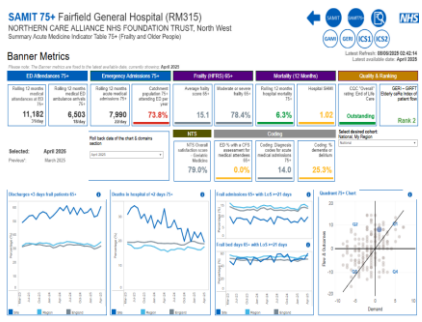
Some examples of this are:

- ☑ The Consultant geriatricians provide clinical expertise and oversight for the Hospital at Home patients, through collaborating in MDTs to develop care plans and providing expert advice and interventions contributing to improved patient care.
- ☑ A care home test of change has been established as an integrated approach with FGH consultants and healthcare professionals in-reaching into two Bury care homes, supported by primary care, Mental Health and Community service colleagues.
- ☑ An offer of Geriatrician in-reach into Neighbourhoods to improve links and integrated working.
- ☑ Support provided to community teams to manage more acutely unwell patients via Frailty SDEC.

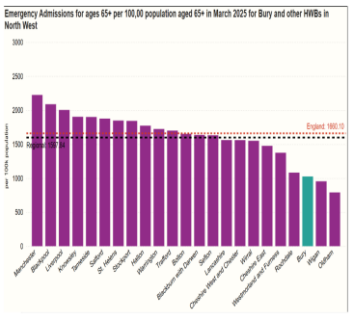
Hospital Data/ Performance



Data taken from the SAMIT 75+ (GERI – GIRFT Elderly care Index of patient flow) from April 22 the ranking has risen so that from Dec 22 FGH has been consistently at the top of the GERI ranking, and even when there are slight drops is able to recover this to be consistently no.1 of the participating Trusts.



This data shows FGH currently 2nd in the country however the big data news is that frail people discharged within 3 days has consistently increased over the past 2 years, and deaths in hospital have reduced enormously.



Comparison to regional and England Average.

In the month of March 2025 there were 1025 emergency admissions for ages 65+ per 100,000 population aged 65+ for residents in Bury. This was lower than the region Northwest (1598) and lower than England as a whole (1660). Bury were lower than their local authority peer group average (1554).

Caveat: Until July 2025, SDEC activity is inaccurately being coded as an admission when it may not be, so the ranking could be much better than recorded.

Figure 14: Outcomes

One of our local priorities has been to enhance the provision of health and care services within care homes. This initiative aligns with the Enhanced Health in Care Homes (EHCH) Framework, aiming to ensure residents receive the right care, at the right time, in the right place. Our approach includes strengthening community-based services and delivering proactive, in-reach and support from healthcare professionals directly into care homes.

In addition, we are committed to equipping care home staff with the appropriate training and competencies to improve skill sets. This upskilling aims to reduce pressure on the broader health system, including Community Services, NWAS conveyances, Emergency Department attendances, and hospital admissions.

What have we done?

- ☑ Developed a one-page document for Care Home Staff advising them who to contact in the first instance when a resident becomes unwell.
- ☑ Bury care homes and primary care participated in a proof of value led by Health Innovation Manchester Re: SafeSteps Falls prevention app and Restore. This work has been referred to as the blue-print in GM and also received a “Health Tech Award 2024 for “Best use of digital for Social Care for achieving a 57% reduction in ambulance call outs.
- ☑ System workshop held on 30th October 2024 represented by FGH consultants, care home managers, commissioning, general practice, community and HMR and NMGH colleagues. This workshop was scheduled to enable colleagues to come together to build relationships, connections and strengthen system thinking/ working in relation to the enhanced health in care homes framework [EHCH]. Highlighting any potential collaborative opportunities to strengthen our current system model, supporting people in our care homes. A test of change has been completed with two care homes to improve pro-active and personalised care and provide training and development support for care home staff in line with the EHICH framework, working with the education facilitator and NCA Learning and Development Team.

5.4 Development priorities for our health and care integrated neighbourhood teams

The NHS 10 year plan is reflective of our local ambition. We have made progress made on integrated neighbourhood working through our active case management approach and single line management arrangements, connected to the reform of wider public services. We have had a relentless focus on addressing population health and health inequalities and will continue to so. We will also focus on increasing connectivity across the age spectrum.

We have strengthened primary care capacity and enabled a shift of services from hospital to the community. Where possible we have utilised technology – as evidenced in our adoption as a GM pilot of dementia care planning records using the GM Care Record, though we still have more to do.

Moving forwards, we will deepen our processes and relationships that enable integration, and have a stronger focus on the shift of diagnostic capacity and outpatient provision out of hospital, supported by digital and estates strategies.

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

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

Priorities:

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

Connecting System Partners

Over the last six months we have strived to bring local system partners together as well as colleagues from neighbouring localities (HMR, NMGH) to strengthen partnership working and to promote our service offers at a local level, obtaining and sharing good practice, amongst considering opportunities for further improvements. This has been done via a series of community cafes and system workshops including, Prevention, Hospital at Home, High Intensity Service Use and Care Homes.

Figure 14: connecting our system partners

5.5 How community engagement will take place to enable continuous improvement.

As Live Well progresses, the ambition is to create a number of community rep places on the neighbourhood (Public Service) leadership teams in addition to a Live Well 'reference group' of VCSE leaders from each neighbourhood with the aim of ensuring existing strengths and assets are being utilised, developed as need demands, and are connected into Live Well Hubs/Spaces and vice versa.

In addition, we will involve those with lived experience or community groups representing them, in our Bury Fund grant making panels with the intention that 50% of panel members are community reps (including a young persons' rep), aligning to our MoU (as described in section 4.2 commitment of ensuring the voice of the VCSE sector and local communities is heard and valued in the development of neighbourhoods.

5.6 Neighbourhood enablers

5.6.1 Estates plan

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. The programme of work and timelines are currently being determined.

5.6.2 Digital maturity, integration and data sharing

Bury is aiming to deliver a digitally enabled, neighbourhood-led model of integrated care. 65% of people aged 13+ are now registered for the NHS App and Bury is ranked eighth out of 27 localities within the Northwest for uptake. On the back of this we have an active programme of rolling out patient led ordering of medication across our Neighbourhoods.

However, we recognise that digital exclusion is a limiting factor for some parts of our population – for example, this has been identified by our North neighbourhood Public Service Leadership Team as a priority area to address for parts of the community in that area.

We have a good track record of digital innovation and recent examples include:

- Working with Health Innovation Manchester on the prove of value project for the Electronic Dementia Care Plan.
- Roll-out of SafeSteps, a digital falls prevention app piloted with care homes and Primary Care, that supports early detection of deterioration in older people. Integrated into ward rounds, it reduced ambulance callouts by 57% and won a digital health award.

It is envisaged that promoting increased use if the Greater Manchester Care Record (GMCR) will be an important in supporting integrated working and we are aware that further work is required with our key system partners to optimise its potential. For example, we have an active programme of work to implement the use of EPaCCS across health and care partners involved in palliative care and Bury was one of the localities that worked with Health Innovation Manchester on the prove of value project for the Electronic Dementia Care Plan

Our current priorities include:

1. Working with GMICB and NCA data and intelligence teams to develop an integrated dashboard to track activity at a patient level to understand the impact of active case management through Neighbourhood MDTs, mirroring work that has been done in Bolton.
2. Promoting the wider use of GMCR including the shared care planning tools.
3. Further roll-out and embedding of EPaCCS.
4. Completing the roll-out of patient-led ordering of repeat prescriptions.
5. Working with Safesteps to submit a bid to the National Institute for Health and Care Research (NIHR) to evaluate the effectiveness and cost-effectiveness of Safe Steps in preventing falls and avoidable hospital use while capturing practical insights to inform future adoption.
6. Refresh of the JSNA Neighbourhood profiles.
7. Strengthen data sharing arrangements to support the operation of our existing Neighbourhood MDTs.

Our key Trusts (NCA and PCFT with GMMH) have started the process of commissioning new EPRs and this provides an important opportunity for improving data sharing and integration. However as with optimising the use of GMCR, achieving this will require support from the GMICB and Trusts to ensure that the opportunities are realised as decisions will be made at Trust level.

We are aware that NHS GM ICB has S251 approval to process GP and Social Care records to national secondary care and mental health datasets from Secondary Uses Service. This has been used to build a longitudinal patient record which can segment the GM population into various groups e.g. adults with multiple long-term conditions. NHS GM ICB have implemented tools such as the Combined Predictive Model, QRISK, Cambridge Multi Morbidity Score and the eFI. Work is underway to use the Analytics and Data Science Platform to support a Population Health Management approach.

We are keen to work with the GMICB DII team and learn from other localities to identify suitable approaches to risk stratification.

To support integrated working including at a neighbourhood level the following data sharing agreements are in place:

- Between the Bury GP Federation and Northern Care Alliance NHS Foundation Trust (NCA) to support the delivery of the Hospital at Home (virtual ward) services.
- Between the NCA and Bury Council covering the delivery of a range of integrated services including intermediate care, the hospital discharge team and Integrated Neighbourhood Teams.
- Between the GP Federation and all GP practices.

5.7 Alignment with Family Hubs

A model of family hubs is in development, predicated on the 5-neighbourhood footprint but in practice delivered at a much more local community level (for example Chesham). This programme of work is currently being finalised.

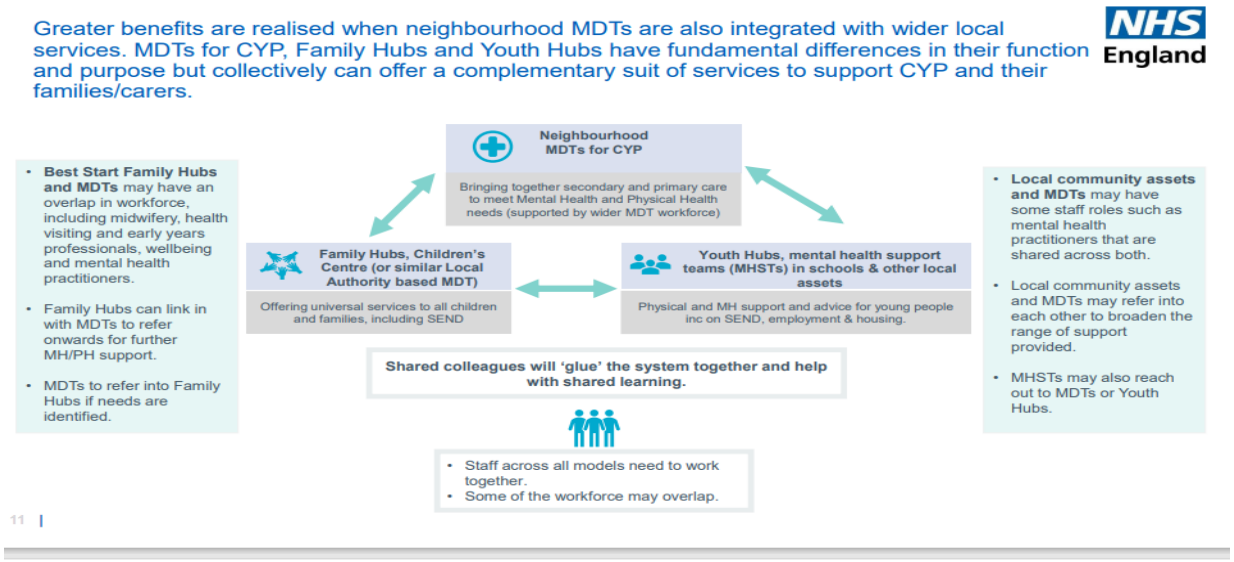


Figure 15: Children's MDTs – the national vision

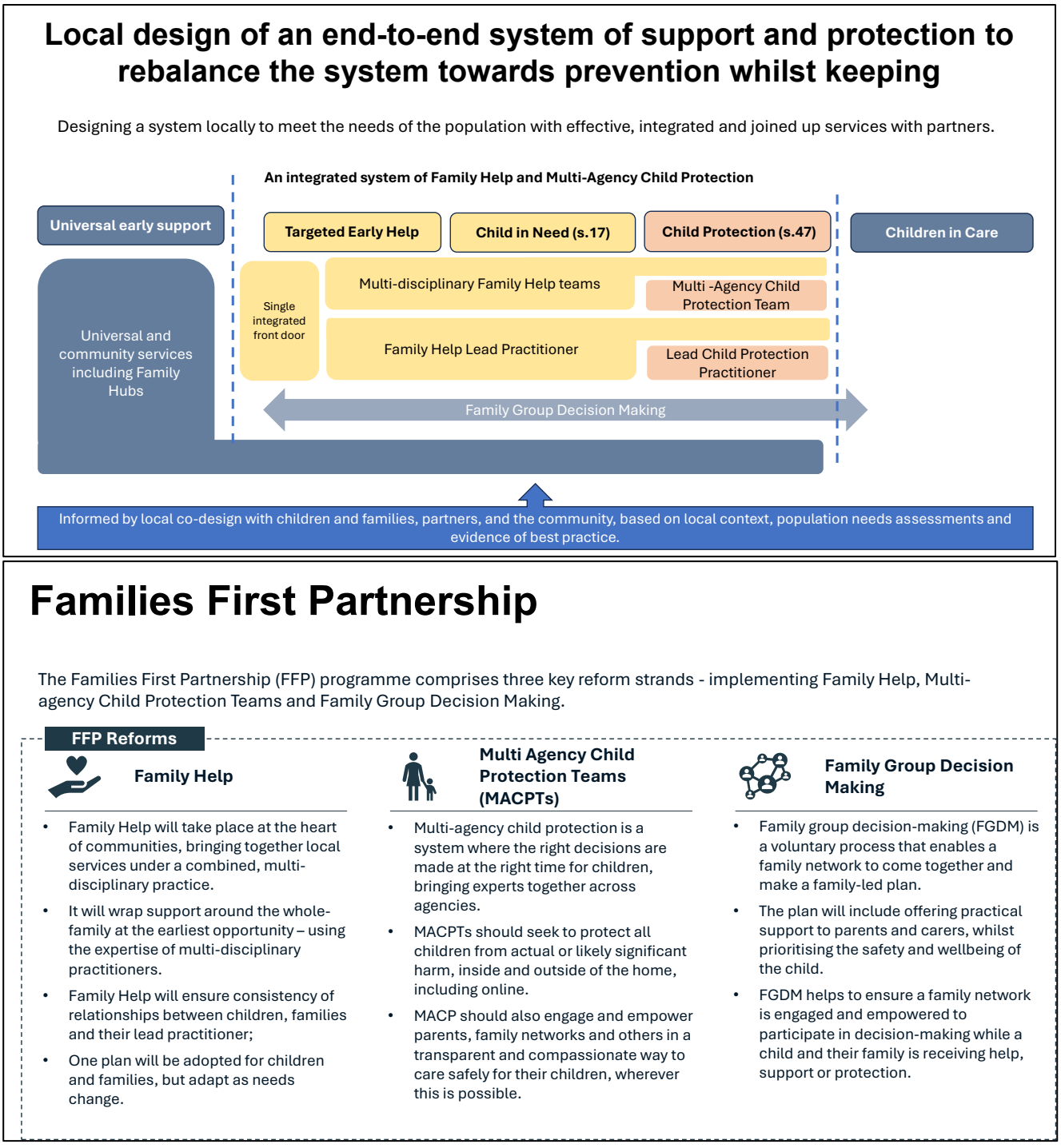


Figure 16: developing an end-to-end system of family support and safeguarding

5.8 Approach to enabling community led health creation

The scale and spread of a strengths-based approach is integral to the Bury Let's Do It! strategy and our VCSE sector plays a key role in promoting and delivering a community development approach to the health challenged in the Borough.

Bury has a vibrant VCSE with many organisations working at a grassroots level to improve the health and wellbeing of our communities. Our VCSE infrastructure body, the VCFA, provides a key role in supporting these organisations and our neighbourhood partnership group provide

an opportunity to build relationships and share learning.

The development of co-production networks like those described in section 4.7.3 have an important role to play in giving residents and people with lived experience a voice in shaping both strategy and services.

We are seeking to put a community led approach into practice in the development of the Whitefield Live Well Hub at the ARK (section 3.2). The intention is that this will be community-owned and led – via a successful asset transfer and its own staff and volunteer workforce.

5.9 How is learning and best practice shared across neighbourhoods in the locality

At a neighbourhood level learning and best practice are shared through Neighbourhood multi-agency partnership meetings and Public Service Leadership Team meetings.

Specific education programmes have been delivered linked to Neighbourhood health and care priorities. In some cases these have been targeted at specific professional groups but in most cases have been open to staff across all sectors. Examples from the last 3 year have included:

- End of life care for people with dementia.
- Dementia awareness.
- Co-occuring conditions [part facilitated by people with lived experience].
- Bowel cancer awareness.
- ACEs and trauma informed practice.
- Frailty awareness.
- EpaCCs.

The VCSE sector is represented across all 5 neighbourhood leadership teams (PSLT) via the local infrastructure organisation, Bury VCFA. Mechanisms are in place to share the two-way flow of information through hyper-local networks such as the Community Connectors and the wider VCSE sector through the Bury VCSE Leadership Group (both facilitated by Bury VCFA).

At place level Bury has established communication and engagement mechanisms for sharing learning and good practice including:

- Monthly GP webinars
- Quarterly GP engagement events
- Community café events
- A programme of themed system Neighbourhood workshops (recent themes include prevention and high intensity service users)
- Themed programmes of training and education – most recently on frailty and falls prevention.

5.10 The role of Neighbourhoods in emergency planning and winter preparedness

The neighborhood infrastructure in Bury plays a critical role in emergency planning and winter preparedness. Each year the Bury locality convenes a system-wide Winter Planning Sub-group (of the Bury Locality UEC Board). Which provides oversight and leadership in planning for winter and the Christmas holiday period.

The Neighbourhood Leads on the group provide updates on real time winter pressures being

experienced, provide a neighborhood perspective on locality plans and help to cascade the winter planning arrangements across the neighborhoods.

Neighbourhood Leads also contribute to NCA (community) and Bury Council (Adult Social Care) emergency preparedness, resilience and response (EPRR) and business continuity plans.

6 2026/2027 – Local Delivery of GM Commissioning Priorities

GM Commissioning Priority	Local Implementation Arrangements	Impact				
		Pop Health Improvement	Activity	Finance	Performance	Quality
Example – BeCCor Year 2, Housing, Population Health						

This section will be populated throughout February / March as the GM planning assumptions relating to commissioning intentions become clearer.

7 2026/2027 – Local Delivery Priorities

Local Delivery Priority	Rationale – e.g. ROI, Local Need etc	Impact				
		Pop Health Improvement	Activity	Finance	Performance	Quality

This section will be populated throughout February / March as the GM planning assumptions relating to commissioning intentions become clearer.

Appendices

1a. Bury LETs Strategy	lets-do-it-strategy.pdf
1b. Public Service Leadership Terms of Reference (TORs)	PSLT_ToR_v5.docx
1c. Prevention Framework	Bury Prevention Framework 2025.pdf