The Bury Whole System strategy for Neighbourhood Working

BURY
INTEGRATED CARE
PARTNERSHIP

Part of Greater Manchester
Integrated Care Partnership

The Strategy for Borough – Lets Do It

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

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

The Lets Do It Strategy committed to a vision of integrated working and a strengths based approach in each of the 5 places in Bury. This is neighbourhood working.

Locality Plan Priorities for Health and Care

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

We work together across the Bury Integrated Care Partnership to :-	
1	Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas
2	Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention
3	Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care
4	Optimising Care in institutional settings and prioritising the key characteristics of reform

Neighbourhood Working – our principles

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- 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**.

Neighbourhood Working – our approach

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- 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,.

The Neighbourhoods

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.

North neighbourhood is the most affluent, with the highest average household income . 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.

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.

Within the Bury JSNA , we have profiles for each of the 5 neighbourhoods. We have placemats for each ward in each neighbourhood

Our Neighbourhood Model Focus

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- Implementation of the Live Well model
- Neighbourhood Leadership Teams (formerly public service leadership teams) connecting a range of public and voluntary organisations in places
- Integrated Health and Care Adult Teams (INTS)
- Neighbourhood approaches to supporting Childrens and Families
- Estates Strategy and Alignment Supporting the model in each of 5 places

Implementation of the GM Live Well model in Bury

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- The flagship initiative with the city-region is that of the Greater Manchester Live Well Model. Live Well is a cornerstone of the 10-year Growth & Prevention Delivery Plan and the Greater Manchester Strategy, aimed at reducing health, social, and economic inequalities across Greater Manchester
- The vision for Live Well is that by 2030 it will provide, “a comprehensive, connected, and equitable support system for all residents of Greater Manchester, fostering a supportive, inclusive, and thriving community environment. By integrating support, focusing on prevention, and promoting economic and social inclusion, 'Live Well' will ensure that every resident can live as well as possible”
- There are 4 key components of the model.
    - 1. The establishment of Live Well centres, spaces & offers
    - 2. Integration of support through an optimum Neighbourhood Model
    - 3. A resilient VCFSE eco-system
    - 4. A culture of prevention – with workforce and organisational development geared towards prevention
- To support the implementation of this approach NHS GM and GMCA have identified and created a £10m fund. This will sit alongside the £10m regional investment from DWP Economic Inactivity Trailblazer work.

Implementation of Live Well by 2030

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- ✓2026 - Live Well in Whitefield builds on some excellent community capacity, on a number of years of community capacity building and development, and recognises gaps in provision of public services particularly in Besses. A live well centre will be open in April, and other community assets are opening.
- ✓2027 - Live Well in Radcliffe will build out of not only exemplar community capacity but also the substantial opportunity of the hub, the enterprise centre, the school, and an improved provision in the GP Centre
- ✓2028 - Live Well in Ramsbottom – again building out of strong VCSE capacity and likely to require an articulation of the virtual network of centres and capacity in the town
- ✓2029 – Live Well in Prestwich - to build out of the opportunity of the Hub
- ✓2026-2030 – Live Well in Bury – a series of investments and projects increasingly described as joined up an integrated.

Live Well Hub: Services

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Services that could be increasingly available within the Live Well Hubs:

- Integrated Neighbourhood Team
- Adult Safeguarding
- Adult Social Care
- Revenue and Benefits
- Public Health
- Children and Young People
- Live Well Leisure
- Cafes
- Libraries

Neighbourhood Leadership Teams

(formerly public service leadership teams)

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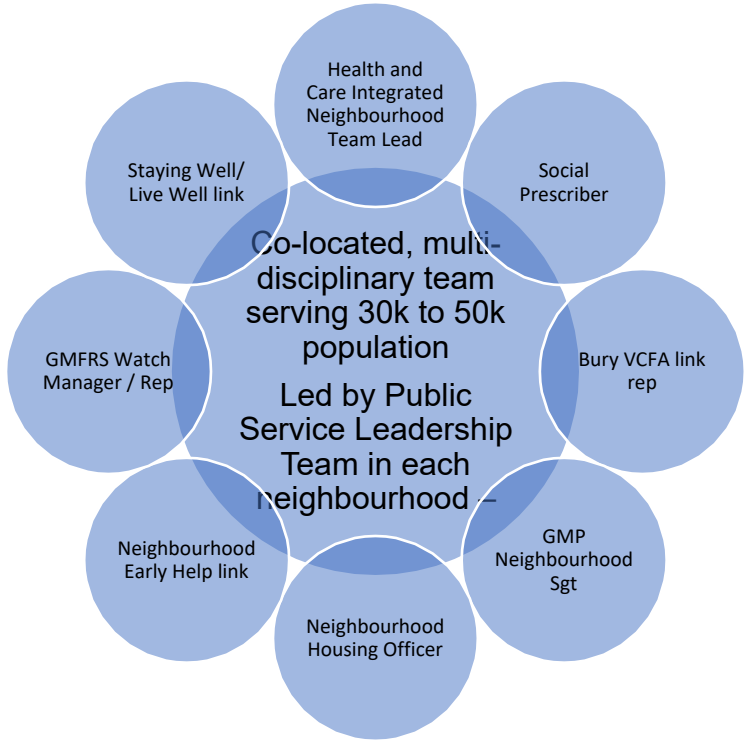
- ✓ We have stablished PSLT multi-agency teams working in each Neighbourhood. Include representatives from the Council, DWP, VCSE, GMP, GMFRS, Public . In addition it includes the operation (on the same footprint) of integrated health and care teams including primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods.
- ✓ Enables front line public service staff know each other, can work collaboratively with each other, and have a shared understanding of the community strengths in the place.
- ✓ Creates models of joined up and person-centered services, with a particular focus on the delivery of new joined up multi-agency working addressing segmented cohorts of the population in order to reduce, delay, or eliminate risk of escalated harm, poor outcomes, and unnecessary use of costly and reactive public service spend.



Integrated Neighbourhood Teams in Health and Care for Adults

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AIM:
To achieve improved health and wellbeing and reducing inequality in access and outcome for people and communities through the development of an integrated model of health and care planning and delivery at a Neighbourhood level.

FEATURES:

- Application of a consistent operating model across the neighbourhoods but with flexibility to plan and deliver services in response to local need.
- Co-located teams working together addressing needs of the population (including active case management)
- Embedding the principles of personalisation, and assets / strengths-based working with people and communities.
- Focus on prevention and avoiding, reducing and delaying the need for higher and costlier types of intervention.
- Focus on providing care at home / in the community wherever possible.
- Further integration of health and care services at a Neighbourhood level
- Clear service pathways and ‘offers’ for people according to need [Thrive model].
- Improved use of data and information technology to understand need, deliver services and connect people and the workforce specific to neighbourhood needs
- Connection to wider Public Service Leadership Teams in neighbourhoods.

Neighbourhood Integrated Health and Care Model: Our priorities

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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, adult social care, public health, care homes , community pharmacy and the voluntary sector.

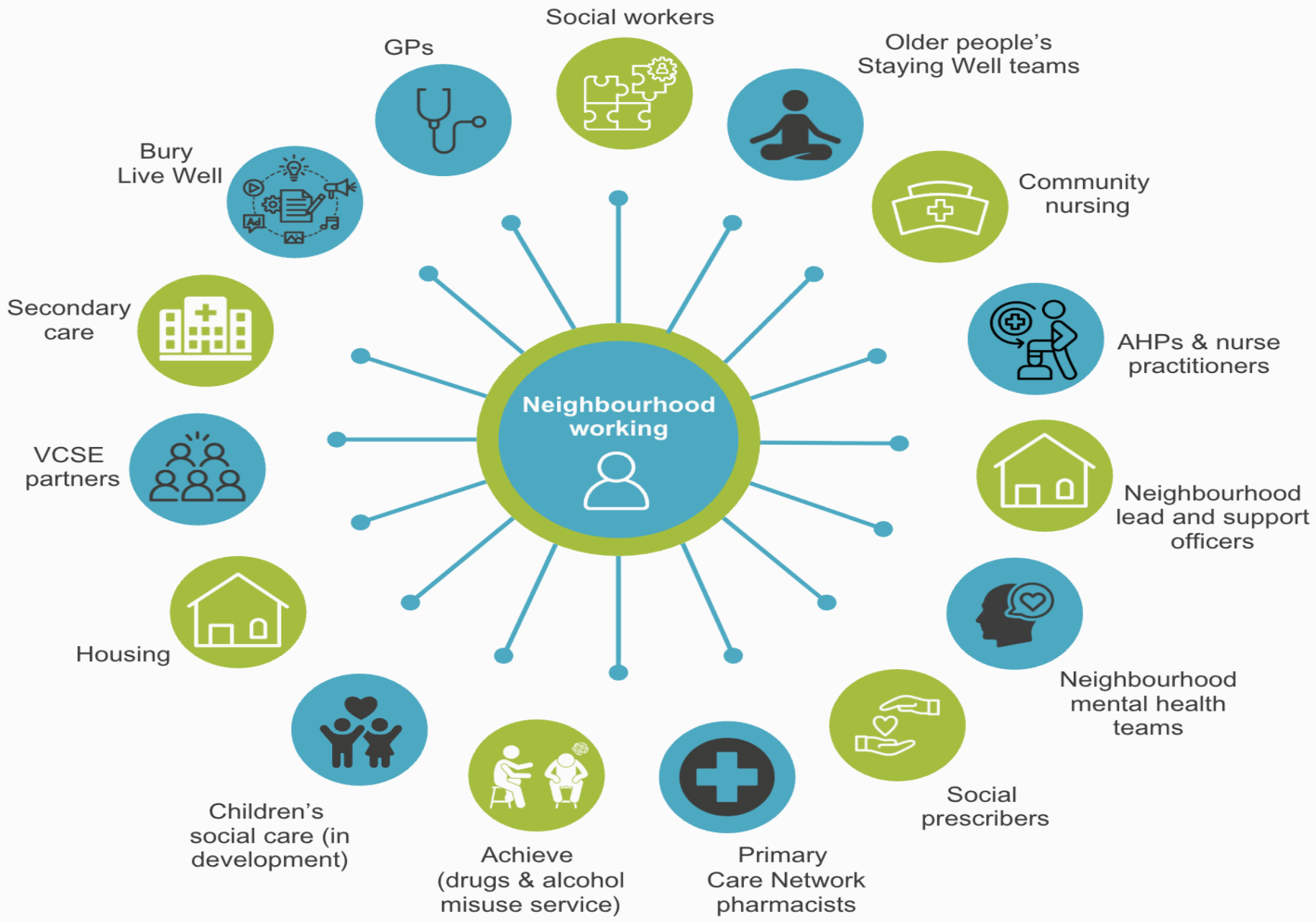
Integrated care delivery

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

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

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

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



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North INT


Linda Prescott
INT Lead


Dr Wiz El-Jouzi
GP Lead


Rachel Robinson
NSO

East INT


Gemma Iliadis
INT Lead


Dr Fazel Butt
GP Lead


Daniel Bower
NSO

West INT


Janet Stanton
INT Lead


Dr Ade Rotowa
GP Lead


Amanda Stott
NSO

Whitefield INT


Jane Wilson
INT Lead


Dr Alistair Webley
GP Lead


Mafooz Bibi
NSO

25 GP Practices

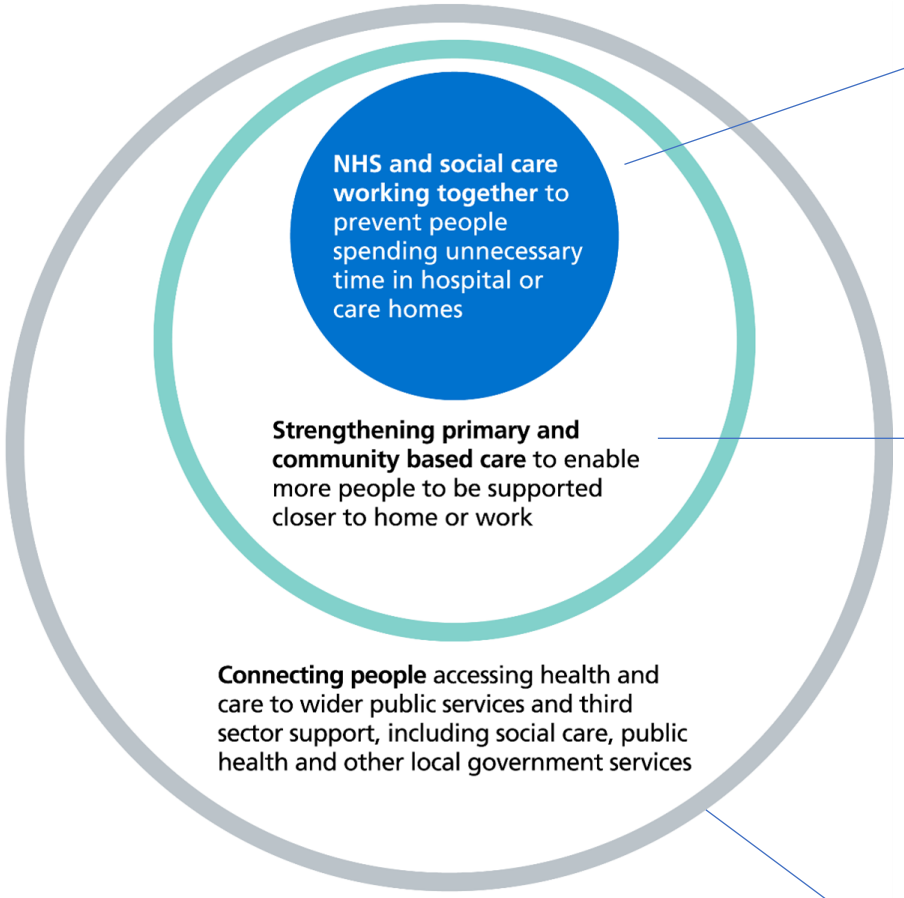
Prestwich INT


Clare Rayson
INT Lead


Dr Richard Deacon
GP Lead


Dawn Adderley
NSO

Implementing the national approach



Active Case Management

Effective relationships between all partners in the neighbourhood

- Primary Care (Core and LCS delivery)
- Community Services
- Social Care
- Living Well
- VCSE partners
- Care Homes
- Community Pharmacy
- Urgent Crisis response
- Intermediate Care
- Secondary Care

Public Service Leadership Teams

Desired outcomes

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

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

Next Steps for INTs

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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.

Neighbourhood Team Working for Children and Families

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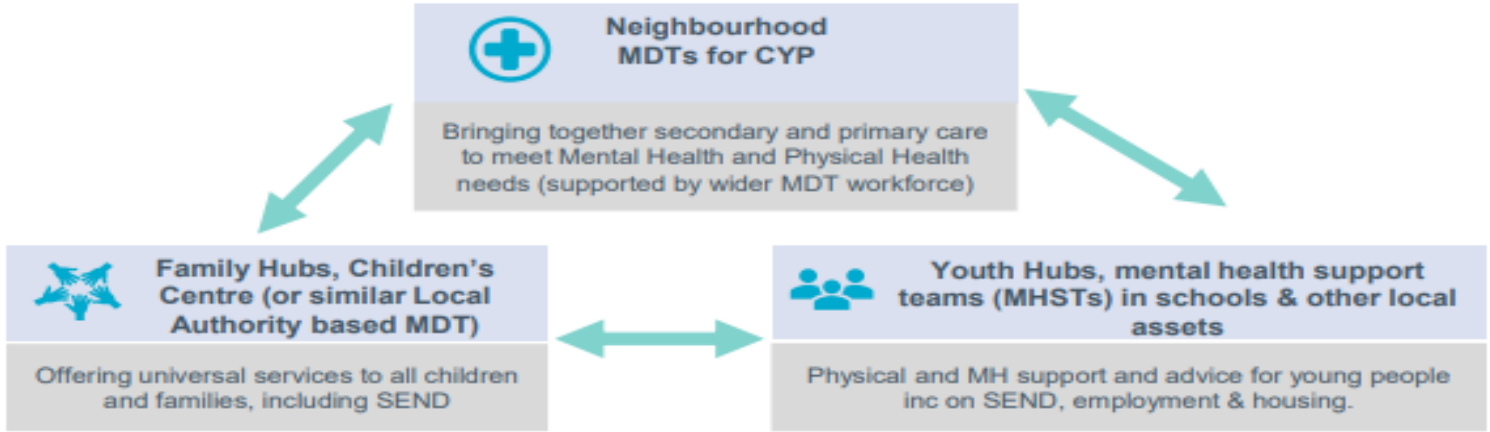
NHS England

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

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



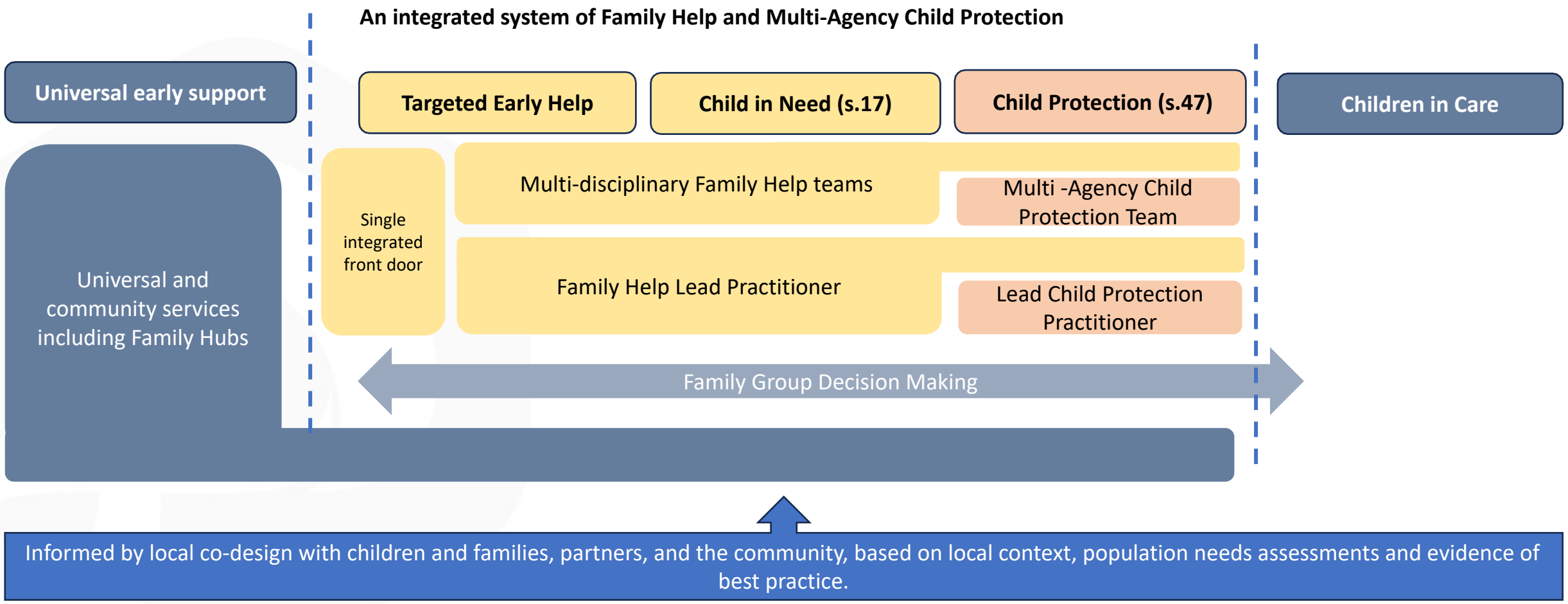
Shared colleagues will 'glue' the system together and help with shared learning.

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

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

Local design of an end-to-end system of support and protection to rebalance the system towards prevention whilst keeping

Designing a system locally to meet the needs of the population with effective, integrated and joined up services with partners.



Families First Partnership

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The Families First Partnership (FFP) programme comprises three key reform strands - implementing Family Help, Multi-agency Child Protection Teams and Family Group Decision Making.

FFP Reforms

Family Help

- Family Help will take place at the heart of communities, bringing together local services under a combined, multi-disciplinary practice.
- It will wrap support around the whole-family at the earliest opportunity – using the expertise of multi-disciplinary practitioners.
- Family Help will ensure consistency of relationships between children, families and their lead practitioner;
- One plan will be adopted for children and families, but adapt as needs change.

Multi Agency Child Protection Teams (MACPTs)

- Multi-agency child protection is a system where the right decisions are made at the right time for children, bringing experts together across agencies.
- MACPTs should seek to protect all children from actual or likely significant harm, inside and outside of the home, including online.
- MACP should also engage and empower parents, family networks and others in a transparent and compassionate way to care safely for their children, wherever this is possible.

Family Group Decision Making

- Family group decision-making (FGDM) is a voluntary process that enables a family network to come together and make a family-led plan.
- The plan will include offering practical support to parents and carers, whilst prioritising the safety and wellbeing of the child.
- FGDM helps to ensure a family network is engaged and empowered to participate in decision-making while a child and their family is receiving help, support or protection.

Location and timelines for Family Hub Implementation

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Neighbourhood	Location	Date of implementation
Bury	Redvales	
	Chesham	
Whitefield	Live Well Centre and Ribble Drive	
Prestwich		
North		
Radcliffe		

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

Estates Framework to support neighbourhood working

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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.

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Governance, Risks, Next Steps

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Governance for delivery

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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

Quarterly Portfolio boards will be established to align the strategic ambition of the 5 neighbourhood programmes

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

Risks

- Lack of shared understanding of neighbourhood model by all partners including council functions
- A risk of replacing psilo agency working with the psilo working of multiagency teams
- Limitations of estates strategy
- Capacity to implement the model, especially in the midst of organisational change in a number of key partner organisations
- Digital capability to support neighbourhood development
- Communication and engagement capacity and capability

Outcomes

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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 agreed once we have seen the outputs of this work.

Summary

There is a lot to be proud of relating to neighbourhood working in Bury which we need to celebrate.

There are multiple opportunities through national guidance (in relation to family hubs or neighbourhood working in the NHS 10 year plan) to build on a solid platform of integrated delivery in the borough.

We have opportunities to strengthen the connection between our work on neighbourhood leadership teams, integrated neighbourhood teams in health and adult care, and in neighbourhood model for children and families.

We have an opportunity to bind that together through the implementation of live well in each of our 5 places.

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Appendices

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The Health of our Population

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Demographic Profile Bury

Population
195,500
The total population of Bury (2023 ONS Mid-Year Estimates)

Deprivation
10%
The percentage of areas in Bury among the 10% most deprived areas in England (12 out of 120 LSOAs) IMD 2019

Life Expectancy
77.2 Years **80.9 Years**
(2020-2022)

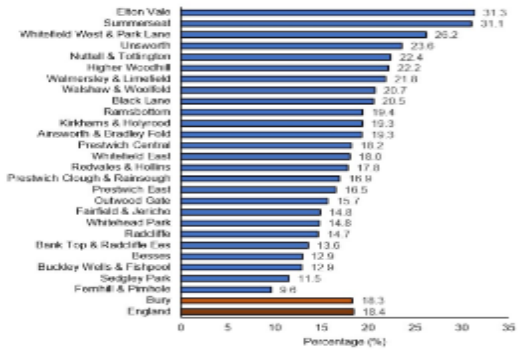
Growth
2.96%
The percentage that Bury population is expected to increase by 2033

The population of Bury is **195,500** (2023 ONS Mid-Year estimates). Bury has a relatively young population.
- **22.5%** aged under 18 years
- **59%** aged 18-64 years
- **18.5%** aged 65+ years

Since 2003, the most notable demographic change has been a **33% increase** in the 65+ years age group. In contrast, the growth in the under 18 and 18-64 years age groups has been more modest at **1.9%** and **3.9%** respectively.

35,447 (18.3%)

There are **35,447 (18.3%)** older adults aged 65 years and over in Bury, similar to England average of **18.4%**. Figure 1 below presents the proportion of population aged 65 years and over living in each Middle Super Output Area (MSOA) in Bury as a percentage of the total population in that MSOA (Census 2021).



Elton Vale (31.3%) and **Summerseat (31.1%)** have the highest proportion and **Fernhill and Pimhole (9.6%)** have the lowest proportion of older adults in Bury (Census, 2021).

Life expectancy at 65 years

17.4 Years **19.7 Years**

Life expectancy at 65 years of age measures how long an individual who has reached the age of 65 years can expect to live on average.
- **Life Expectancy at 65 Years – Male in Bury**: **17.4 years** (lower than the England average of **18.4 years**)
- **Life Expectancy at 65 Years – Female in Bury**: **19.7 years** (lower than the England average of **20.9 years**)

(Source: ONS, 2022)

Inequality in life expectancy at 65 years

6 Years **5.9 Years**

On average, those living in the most deprived areas of Bury can expect to live shorter lives than those in the least deprived.
- **Male in Bury**: The life expectancy gap between the most and least deprived decile is **6 years**, compared with **5.2 years** in England.
- **Female in Bury**: Thelife expectancy gap between the most and least deprived decile is **5.9 years**, compared with **4.8 years** in England. (Source: ONS, 2022)

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

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

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

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