Bury Council

Prevention and Wellbeing Strategy

Health and Social Care

2025-2030

What is Prevention and why have this Strategy?

This Prevention and Wellbeing Strategy sets the commitment from Bury Council to prevent, reduce and delay the need for adult care and support over the next 5 years.

Preventing, reducing and delaying the need for social care can change the direction of people's lives. To be successful, prevention needs everyone to act – as the root causes of care and support needs are much broader than the care system itself.

In its broadest sense, prevention is the action taken to stop an event/incident happening that usually has a negative impact.

Prevention, as defined in the Care Act 2014, is about the care and support system actively promoting independence and wellbeing. Intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible.

Skills for Care carried out research in 2019 and found that most adult social care employers define prevention in four main areas:

- Supporting people to live as healthily as possible, both mentally and physically
- Reducing the use of health services, including primary care, emergency services and hospitals
- Preventing or reducing the escalation of health issues
- Supporting people to remain as independent as possible.

The main outcomes for the individual from prevention might include but not limited to:

- Enhanced independence, including the ability to navigate prevention and community services, as well as effective self-care.
- Improved quality of life and wellbeing for individuals who require care and support, along with their carers.
- Reduced social isolation and loneliness.
- Delayed or decreased need for care and support.
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Prevention approach

Prevention approaches can be divided into three categories, prevent, reduce and delay. This approach ensures a process which both reduces and delays need.

Prevent

The first approach should be applied to everyone. A range of services, facilities and resources are provided that help avoid the need for care and support developing, by maintaining peoples independence, good health and promoting their overall wellbeing.

Reduce

The second approach is targeted at individuals at risk of developing care and support needs. Support may slow this process or prevent other needs from developing.

Delay

The third approach is aimed at people with established complex health, wellbeing and mental health conditions. To minimise the effects, support is provided to regain skills and to reduce their needs wherever possible.

When considering our prevention approach, we recognise that:

- Prevention is not an isolated principle; it is closely linked with wellbeing, empowerment, and partnership.
- It should be a continuous consideration, rather than a one-time action before more significant needs develop.

The duty to prevent needs from arising or increasing is separate from the duty to meet eligible needs

Prevention in an integrated System

Commissioners and practitioners have distinct roles in taking an effective approach to prevention within the local authority. However, there are also shared responsibilities. A joined-up approach to prevention is necessary at the local level, with each partner playing a role in an effective system.

The Social Care Institute for Excellence (SCIE) Prevention Wheel provides a framework for understanding and implementing preventative measures. It highlights different levels of prevention - primary, secondary, and tertiary - targeting various stages of need.

Why does Bury Adult Social Care need to focus on Prevention?

Bury has a population of 193,849 people across 5 different neighbourhoods as of the 2021 census (East, West, North, Prestwich and Whitefield). Bury is amongst the less deprived local authorities in Greater Manchester but internal inequalities vary significantly within and across neighbourhoods.

Bury's population has continued to age. Census 2021 results show that there has been an increase of 19.8% in people aged 65 years and over in Bury similar to 20.1% seen in England. There are 35,447 (18.3%) older adults in Bury, similar to England average of 18.4%. 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

The population is growing and more are expected to live longer. It is therefore important that we encourage people to be more proactive about their health and wellbeing to reduce or delay the need for care and support services in the future.

National snapshot of Adult Social Care and need for Prevention

In 2023/24, local authorities in England spent £23.3 billion on adult social care (net current expenditure). This represents the biggest area of council spending after education.

Several factors contribute to funding pressures on adult social care, including:

- **Local government finances**: the National Audit Office has highlighted that "local authority finances are under significant pressure" and "this pressure impacts on the funding available for adult social care."
- **Demographic pressures**: the number of older people (the group most likely to need social care) is rising faster than the population. There is also increased demand for care from working age adults. The Health Foundation has estimated an additional £8.3 billion will be required by 2032/33 just for adult social care to keep up with growing demand.
- **Increases in the National Living Wage**: the Nuffield Trust has estimated that the 6.7% increase to the NLW in 2025/26 will cost the adult social care sector around £1.85 billion.
- **Increasing costs of care**: rising costs due to increased complexity of needs has been ranked as the biggest area of concern in terms of financial pressures by directors of adult social services.

In addition, at the Autumn Budget 2024, the government announced changes to employer National Insurance contributions (NICs) from April 2025, including an increase in the employer NICs rate from 13.8% to 15%. The Nuffield Trust has estimated this will cost independent social care employers around £940 million in 2025/26, although there is some uncertainty around this estimate.

Bury Council Strategic Context

Bury Adult Social Care has made great progress in developing a strength-based approach to support adults to be as independent as possible, by supporting them in ways that work for them as an individual.

This document aligns with other key local Strategies and plans to ensure that it is consistent with the aspirations and outcomes which makes Bury a place where all people, regardless of their needs can strive. These Strategies and plans include:

- Bury Council's Let's Do It! Strategy
  Bury Adult Social Care are committed to delivering the Bury 'LETS' (Local, Enterprising, Together, Strengths) strategy for our residents and our workforce. Our mission is to work in the heart of our communities providing high-quality, person-centred advice and information to prevent, reduce and delay the need for reliance on local council support.
    - **Local:** Many of the actions needed to prevent illness and help people live happy, independent lives must be local. This means integrating public and voluntary services to improve our living environments. People should have access to a full range of services where they live to avoid excluding those who cannot travel easily. This is especially important in adult social care, where local services can provide tailored support to meet individual needs. According to the Care Act 2014, prevention is about promoting independence and wellbeing, intervening early to support individuals, and helping people retain their skills and confidence.
    - **Enterprising:** Preventing illness requires innovation and different thinking from both service providers and the public. We need to look beyond immediate needs to underlying problems. For example, frequent hospital visits may be due to poor housing conditions or loneliness affecting mental health. Addressing these issues requires courage and a willingness to work across boundaries. In adult social care, this means using data and evidence to implement effective prevention strategies that truly make a difference.
    - **Together:** Our approach to prevention must be collaborative. Interventions should reflect the priorities of our residents and service users. This involves working with communities and the voluntary, community, and faith sectors to ensure residents have a say in how services are delivered. Strengthening connections between different services and organisations within each neighbourhood is crucial, particularly in adult social care, where coordinated efforts can significantly improve outcomes.

- **Strengths:** Building on existing strengths in communities and individuals is essential. This means working with local organisations and businesses to offer services in more accessible ways and engaging with individuals to identify their strengths and interests. In adult social care, this approach helps create interventions that are more effective and empowering, leading to better overall wellbeing

The Adult Social Care Strategic Plan 2023-26

This plan sets out the Adult Social Care Department's roles and responsibilities on behalf of Bury Council. It explains who we are, what we do, how we work as an equal partner in our integrated health and social care system and identifies our priorities for the next 3 years which are:

To ensure our health and social care system remains sustainable within the available funding, we must explore new ways of providing preventative support and services.

It will focus on improvement and transformation, developing clear assurance mechanisms to enhance transparency and accountability to the communities in Bury.

As we refine the future of social care delivery, we will prioritise the involvement of those who receive our support and their carers, ensuring their voices are central, which are linked to this plan and our LET's principles.

Vision for Bury Adult Social Care

Our vision is to empower individuals to live their best lives by promoting independence and wellbeing. By promoting the efficient use of Adult Care services and proactively addressing health issues, we strive to prevent escalation and ensure a high quality of life for all residents in Bury.

Outcomes

- Empowering individuals to navigate prevention and community services, including effective self-care

- Enhancing the quality of life and wellbeing for those who need care and support, as well as their carers.
- Fostering connections to reduce social isolation and loneliness.
- Supporting people to delay or reduce the need for care and support.

What services do we offer that support prevention?

Bury Adult Social Care has a wide preventative offer to support the resident of the borough to be independent, safe, well and control of their lives.

Prevention Priorities

Priority 1- Providing timely advice when you need it

The Information and Advice duty of the Care Act 2014, applies to everyone in a Local Authority area, not just those people with care and support needs, or carers with support needs. This means that information and advice must be provided to people regardless of their eligibility for other services from Adult Care and Support.

Information and advice are essential for promoting preventative approaches. Regardless of if needs or eligible needs are identified, residents in Bury should receive information that helps them prevent or reduce the development of further problems, connect with their local community, and delay the onset of greater needs.

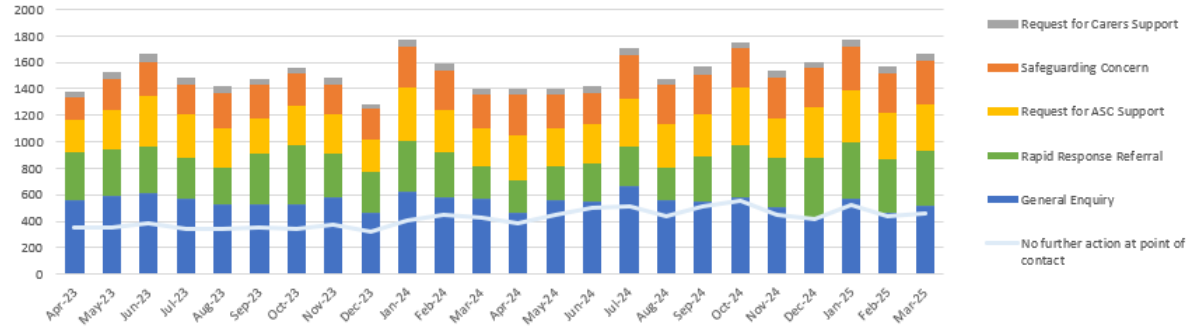
Similarly, carers should also be provided with information and advice to support them in the same way.

Information also has a role to play in any preventative measure offered. People are more likely to engage with the support being offered if they understand:

- Enabling people to make informed choices about their needs.
- Promoting choice and control to prevent or delay the need for care and support.

In Bury, the primary means of public contact to request support, information and advice is through our Connect and Direct office (CAD). A higher proportion of contacts resolved by CAD means that people's enquiries are being dealt with straightaway and not passed on to other teams.

Number of Adult Social Care (ASC) Contact Forms recorded each month.



This table shows the number of contacts the department receive each month from April 2023 and what they were about. It also illustrates the number resolved by our contact centre.

The information shows that this is a busy service and receives consistency 100 contacts per month higher than it was 2 years ago. General enquiries remain our highest request and where signposting is important for residents to access the information and advice which they need.

There are great opportunities for prevention and we understand the importance of providing the right information at the right time. These include:

- By providing information, advice, guidance and technology we believe we will support people to age well.
- Providing information, advice, and guidance is essential for promoting health and wellbeing. By focusing on individual strengths and needs, we ensure people have the resources to make informed decisions about what works best for them
- Considering the potential opportunities for contact with those who may benefit from preventative support, and where that first contact might be. This may come from an initial contact through the CAD via other professionals, or during an assessment of need or carers assessment.

- Using the CAD to proactively share information about prevention and preventative services.
- The Care Act 2014 emphasises that people have a better quality of life when they are healthy, independent, and in control. If they need help due to health or care needs, their experience is more positive when they have choices and can maintain control over their lives.

We will

- Provide high quality advice, guidance, and information which is easy for people to find, enabling people to maintain control and exercise choice at whatever point they are in their lives.
- Have a clear prevention offer that residents and access in accessible way.
- Enable people to engage with us in a way and at a time that suits them including online, email, web chat, telephone, and face to face.
- Review the function of the CAD and collect data when people make contact with us, to help better understand the needs of the local population and ensure we have the right services available to meet these needs and target inequalities.
- Continue to enhance the function of the Bury Directory as a central point for people to access information about organisations, communities and the voluntary sector to support with health and wellbeing.
- We will ensure that we have information available in arrange of formats, which is easy to find, being mindful that not everyone can use/has access to the internet, including people that have sensory impairments and working with Bury Blind Society.
- Continue to work closely with Bury Carers Hub to ensure we provide the right support, at the right time and at the right place for those with caring responsibilities.
- work closely with the VCFA to have a joined up approach to advice, guidance and information and ensure that we have a targeted plan to engage residents in Bury, that also caters to the diverse needs of our residents.

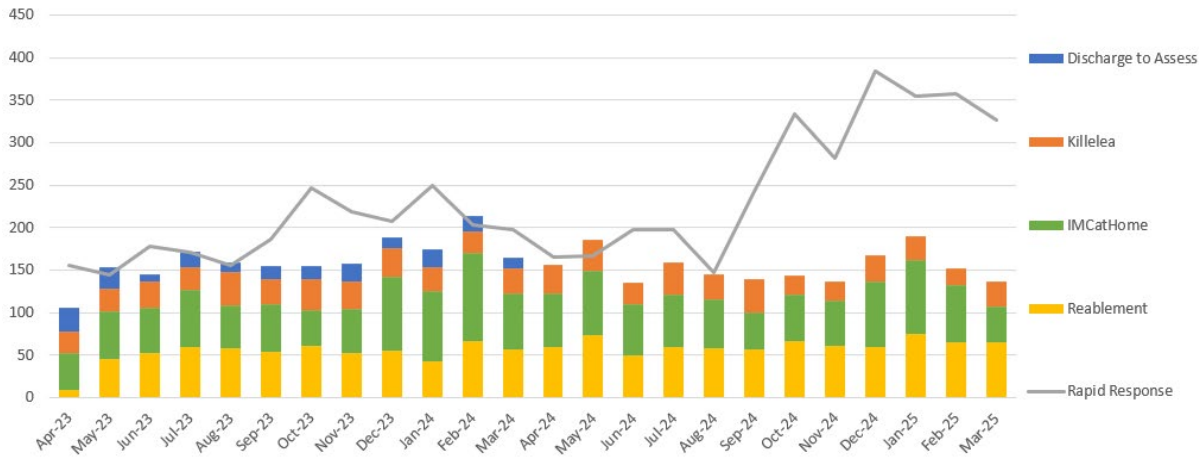
Priority 2- Promoting independence with early support and intervention

Adult Social Care services may be short-term or long-term. Short-term care refers to support that is time-limited with the intention of regaining or maximising the independence of the individual so there is no need for ongoing support. Long-term care is provided for people with complex and ongoing needs either in the community or accommodation such as a nursing home.

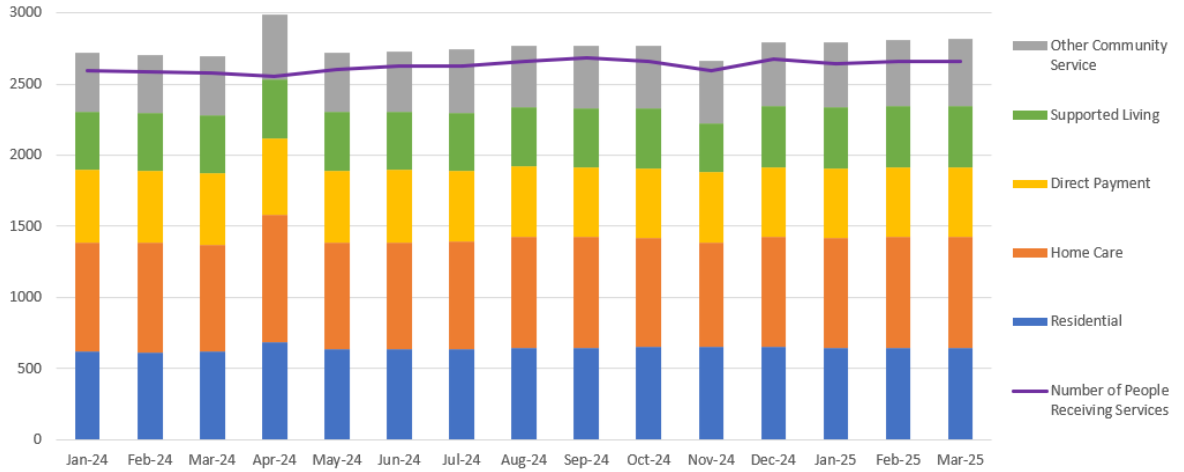
Intermediate Care in Bury provides a range of services employing both NHS and Council Staff. These services include Intermediate Care Beds (36 at Killelea), Intermediate Care at home therapy, Reablement home support and Rapid Response. The service includes 29 dedicated Discharge to Assess Beds at Heathlands plus many others across the borough.

Following the implementation of the Health and Social Care Act 2022 changes were made to the way patients were to be discharged from hospital and discharge to assess and intermediate care assessment became the preferred route for patients leaving hospital and the development of the IMC @ Home service this has increased service demand and has increased in size.

Number of Intermediate Care (short-term) services completed each month.



Number of Long-term Adult Social Care services open on the 1st of each month.



This snapshot illustrates the number of people we support in our various service types- short and long term.

The first chart shows the number of people supported in our intermediate care services. These services aim to prevent, reduce, and delay the need for long term care and support so the busier they are the better.

Key highlights in the charts are:

- There have been a reduced number of people through Killelea due to the high acuity over the winter months.
- Whilst it was envisaged the number would increase from Q 3 in 2025, there were also a reduction in referrals into the service.
- Whilst a drop in flow through intermediate care bed based services is concerning, the referrals to the home based service (Reablement) increased significantly to the highest recorded in Q4 in 2025, it did not impact on flow out of the hospital as the department purchased alternative domiciliary capacity from the independent sector to mitigate this.
- Q4 in 2025 has shown to have increased dependency, within the bed-based service, due to the local hospital ensuring people do not decondition when admitted, this has led to more people returning home with Reablement and IMC@home and the more dependant people requiring a bed base.
- Rapid Response activity has stabilised at higher levels due to the success of the Hospital at Home service, which supports more people and avoids hospital admissions. This helps maintain individuals in the community and speeds up recovery, reducing the need for ongoing Social Care services.
- Significant collaboration with primary care and local care homes has led to Rapid Response being the first point of call before ambulances. Additionally, the Northwest Ambulance Service (NWAS) has increasingly utilised Rapid Response for falls within Bury.

Overall service use is shown in the second which shows service use increasing but at a slow and steady rate. Despite the increase in assessments taking place, this demonstrates the effectiveness of our services that support people to maintain or regain their independence.

In Bury, projections for future capacity required across the Intermediate Care services have been completed.

	Future projections		**% Increase on overall averages per year**		**% of referrals to admissions conversion rate**
	Referrals	Admissions	Referrals	Admissions	
Killelea	727.57	383.86	49.91%	8.64%	52.76%
Reablement	977.99	669.24	2.91%	0.74%	68.43%
Rapid Response	4601.95	4163.81	21.14%	48.55%	90.48%
IMC at Home	1364.20	945.69	50.69%	69.99%	69.32%

The projections indicate an increase in complexity for Intermediate Care services due to more Rapid Response and IMC at Home referrals and admissions. Clinical

oversight and intervention will be necessary. The data supports the 'Home First' approach, emphasising investment and expansion of community services to ensure adequate resources and capacity to meet demand.

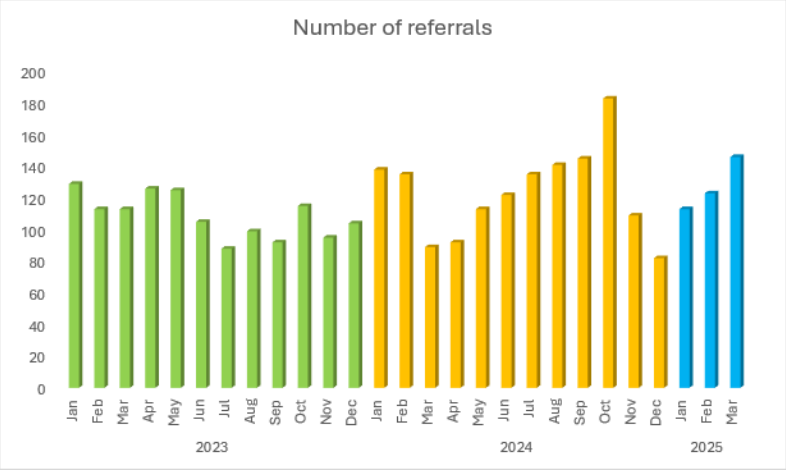
Older Peoples Staying Well Team

The Older Peoples Staying Well Team are a prevention/ intervention service that use the ‘Quality of Life tool’ to have a holistic conversation with people (over 50 years) in their own home. This allows them to identify what is going well and what is not in a person’s life.

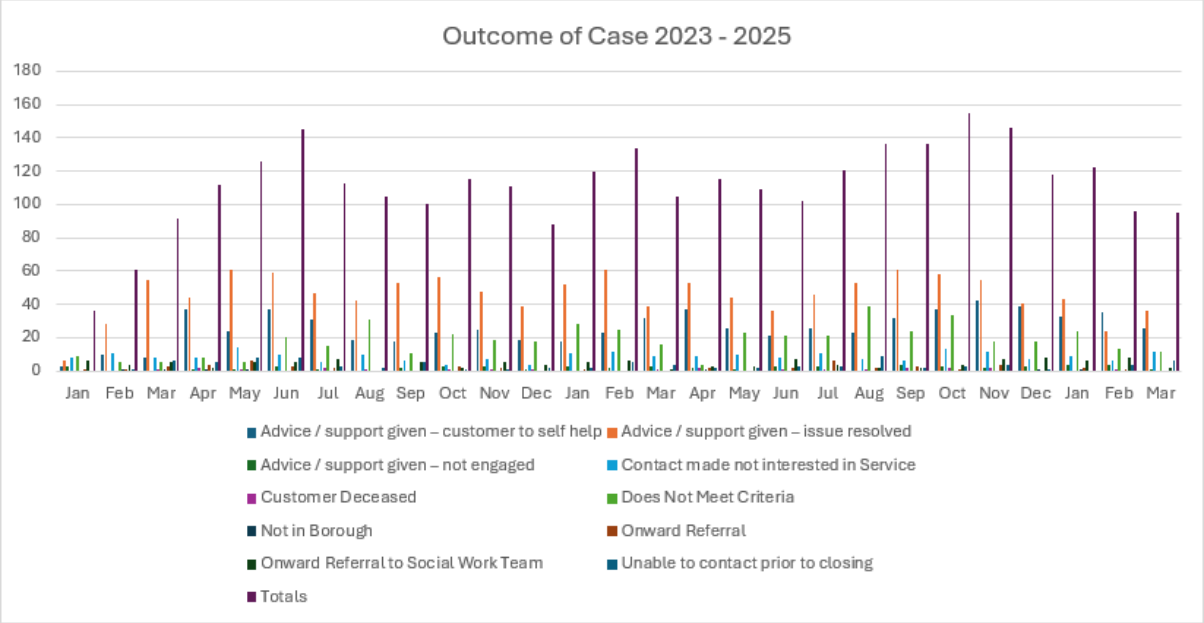
The team refer, signpost and support into relevant services, enabling the person to take control of their own health and wellbeing.

Key functions of the team are:

- Integral part of the Active Case Management MDT
- Meet weekly with services including GPs to help resolve patients issues and support with maintain wellbeing.
- All the team are trusted assessors to assess for and order minor adaptations and small pieces of equipment.
- Able to respond to low level referrals from Disability Services and the Community Therapy Team (Falls Service) at duty stage supporting them to keep waiting lists down.
- Rockwood Frailty Score trained and information provided to GPs following every home visit. This has supported PCNs with neighbourhood priorities and meeting targets.
- Close partnership working with social work teams ensuring referrals for low level cases that potentially could be deflected away from needing a care packages if they can intervene.
- Facilitate courses in Help Yourself to Wellbeing, Nutrition & Hydration and Dementia Awareness for staff and our customers, which looks at things such as behavioural change, healthy eating and managing stress / long term health conditions.
- Link closely with community assets and social prescribers to identify residents that would benefit from early intervention and reduce social isolation.



Referrals consistently have remained high and is testament to the strength of the team and the demand across the borough for older people to access service to improve their health and wellbeing.



The above table evidences most outcomes which people came with who had their issues resolved and good referral rates to social work teams for specific interventions that are required.

Enabling people to retain, regain, and extend their wellbeing and independence is at the very core of prevention. Building a borough where people can live and age well means incorporating a preventative agenda throughout our services.

This will mean different things for different people, based on their own care needs. Some people will be able to avoid the need for intensive adult social care services their whole life, others may be able to delay it until much later, while some will have lifelong needs with the potential to increase their independence gradually.

Integrated Neighbourhood Teams (INTs)

Integrated Neighbourhood Teams (INTs) are at the centre of Bury's plans to bring together health, social care, and voluntary/third sector services in the community. The core functions of the INTs are to deliver and co-ordinate person centred care through detailed assessment of clinical, social and environmental needs working with the individual to plan and enable independency, whilst achieving personal goals and fulfilling aspirations.

Active Case Management (ACM) in Bury's health and care neighbourhoods is a proactive approach designed to improve the health and wellbeing of residents. It involves integrated teams working together to provide personalised care and support for individuals with complex health and social care needs. Beyond supporting the overall vision for health and care in Bury, there is a range of more specific objectives that ACM through the INTs will seek to achieve.

Some of the benefits of the ACM process are:

- **Self Care and help**- People are empowered to self-care and to maintain or improve their own health and wellbeing are supported to live independently and at home for longer have more positive experiences of receiving and directing their care and support
- **Personalised Care Planning**: Developing tailored care plans that address the specific needs of each individual.
- **Integrated Services**: Coordinating services across health and social care providers to ensure seamless support.
- **Proactive Support**: Identifying and addressing issues early to prevent health crises and hospital admissions.
- **Multidisciplinary Teams (MDTs)**: Bringing together professionals from various disciplines to collaborate on patient care .

This approach aims to help people live healthier, happier lives by providing comprehensive and coordinated care.

Comments on INTs

The programme has led to closer working and relationship building across all parts of the health and social care system. By working closer we are able to react more quickly to the needs of our most vulnerable patients.
Professional's feedback

Having a group of professionals from different services working together really makes a difference for the customer. I know that everyone who attends the meeting want to ensure the best outcomes for the person being discussed and strives to do what they can to assist and support whenever possible
Professional's feedback

Having the support from this service felt like having the weight lifted from my shoulders, after being provided with respite care for my husband made a big difference to our lives.
Service users feedback -

Having support from the service and putting in place care for my adult son has meant my own mental health felt so much better supported, you understood the pressure that I was under in my role and your help was invaluable.
Service users feedback

We will

- Support more people to stay in their own homes, building on work with partners to improve support when people leave hospital and timely access to adaptions, equipment and technology.
- Explore community solutions to support people to maintain their homes.
- Work with district and borough partners to ensure homes are built for an aging population and for those who access care and support.
- Ensure our commissioning practices remove barriers and provide solutions to independence for all
- Understand what current and future need will look like across different markets, mapping and building on existing community assets
- Ensure that people can access a range of personalised support that reflects their own choices and circumstances, including finding new approaches to improve on the ways we have traditionally delivered care and support
- Increase the visibility of the joint health and care performance indicators for staff so that Integrated Neighbourhood Teams are supported in the activities.

Priority 3- Promoting and driving Technology Enabled Care (TEC) and artificial intelligence.

There continues to be significant advances in the use of technology to improve people's lives. This applies to individual support for people to remain in their own homes, reduce risk of falls across all settings and much more. There are also developments which will support care organisations themselves to improve services.

Technology Enabled Care (TEC) refers to any technology used to support someone's care. The TEC Team in Bury provide the technology that keeps individuals safe at home. Devices they provide include dispersed alarm units (box and button alarms), smoke detectors, falls detectors, bed and chair sensors, GPS watches and medicine reminders

Key benefits of TEC are:

- increasing independence and therefore confidence
- managing or minimising risk
- supporting and reassuring family and carers
- reducing the need for a care package
- preventing hospital admission

- supporting early hospital discharge
- delaying or preventing the need for residential care

Below are relative statistics to highlight the amount of money spent between April 2024-March 2025, and the money saved through the deployment of TEC to residents.

Incurred costs of devices
Amount of devices provided: 489 devices, totalling £58,769.54 in cost
Average device quantity per user: 4 devices per user (3.8, rounded)
Range of device cost, per customer: £19.99 - £878.36
Average cost per customer: £332.91
Average device cost: £120.18

Common devices provided	Percentage of total devices
Lifeline digital dispersed alarm unit	21% (105 devices)
Falls detector	20% (100 devices)
Smoke detector	18% (87 devices)
Universal sensor*	13% (65 devices)
Bed sensor	6% (27 devices)

*Universal sensors are provided as door sensors, but also along side other devices, such as bed and chair sensors.
Savings – April 2024-March 2025

Type of savings	Amount
Reductions in care (cash in hand savings)	£10,130.34
Deflected care costs (adult social care)	£1,393,938.54
Deflected care costs (Health)	£39,251.84

There is a significant return on investment (ROI), based on these figures.
Range of ROI:-86% to 11,448%
Average ROI: 3,361%
Highest ROI:11,448% (£223.12 of equipment, which lead to a £25,766.56 saving
Using Average ROI, and Average investment, the saving attributed would be: £11,189.11 per service user

Comments on the TEC service

"I'm so grateful for the service, it's truly been a lifesaver, and I cannot express to you how much it means to me to have the devices."
Dispersed alarm unit and Alexa (medicine reminder) service user

"You and the team do amazing work! I'm so glad that I'm able to stay at home."
Dispersed alarm unit, falls detector and door sensor user

"All the devices work well, and I'm really happy with the service."
Relative of epilepsy sensor service user

"The bed sensor allows the family to support the service user. Without it, we would struggle to support them."
Relative of service user with dispersed alarm unit and bed sensor

"The TEC team were, at short notice, and in an emergency, to support a discharge from hospital by installing a dispersed alarm unit and falls detector. We cannot thank them enough for supporting the service user and our social work team."
Social worker, Bury Council

"It's been life changing for our family, knowing that I can use my mobile to see where they are, and the service user can still be independent."
Spouse of GPS device user

Artificial intelligence for Adult Social Care in Bury

Technology has the potential to revolutionise the way we work and deliver preventative services. We want to embrace technology and innovation to empower staff and support residents to live the best life they can and remain independent, resilient, and well for as long as possible.

We want to use technology to empower and support people to do more for themselves and live the best life they can.

Bury Adult Social Care approach will be built around the following key themes:

- **Culture**–creating a culture where staff can be creative and embed technology as a core part of how we deliver services and aligned to our strengths-based approach.
- **Innovation**–continuously evolving and innovating to ensure new and emerging technologies are rapidly deployed where they can improve outcomes for Bury people.
- **Skills**–a skilled workforce that feels empowered and confident in using digital technology.
- **Data**–systematically encouraging and improving data sharing across the Health and Social Care department, with a strong focus on evaluation, data and insight.
- **People**–a person-centred approach with a continuous focus on user needs and co-design that is inclusive of groups that have typically been digitally excluded.

We will

- Support more people to stay in their own homes, building on work with partners to improve support when people leave hospital and timely access to TEC
- Champion the use TEC to enable people to maximise their independence and reduce reliance on services.

- Explore opportunities to enable people, carers and the social care workforce to understand the benefits of assisted technology.
- Use evidence and emerging guidance to explore and implement artificial intelligence and other technology solutions that enhance prevention service delivery efficiency and effectiveness.
- Have a modernised offer of care technology with a wide range of solutions available to support people's independence.
- Build staff confidence and skills in digital technology through a focussed programme of training and events
- Have a fair charging policy in place for technology.
- Develop case studies and stories and share data to showcase the impact of technology
- Relay the benefits of technology through testing and evaluating digital products to inform our digital offer. People will play a key part in this approach to ensure our digital offer is routed in their views and needs.

Priority 4- Neighbourhood Housing Support Services

'Neighbourhood Support Housing Services' provide short term, outcome focused interventions to vulnerable adults. These services will support individuals to build resilience and independence, improve health and wellbeing, ensure stability of accommodation, maximise income and support meaningful and economic activity.

The strategic aims of the service are to:

i promote prevention by reducing or delaying demand for health and social care services, and statutory homelessness services.
ii increase resilience by supporting people to achieve and sustain recovery, improve wellbeing and develop the capacity and confidence to live independently.
iii improve economic independence and reduce inequalities by supporting people to access employment, education and training and voluntary opportunities.
iv improve overall health outcomes for individuals and support engagement with health services
v Maximise income, through support to claim appropriate benefit entitlements and support to manage debts
vi reduce re-offending and support successful transition and integration back into the community

Increased homelessness and more people struggling to sustain their tenancies, strongly suggests that there is a need for the continuation of supported accommodation for single people and childless couples over 18 years old and floating support services for all residents of Bury, including single people, childless couples and families with dependent children. Floating support will be tenure neutral, which includes people that are living in social housing, private tenancies and those that are owner occupiers.

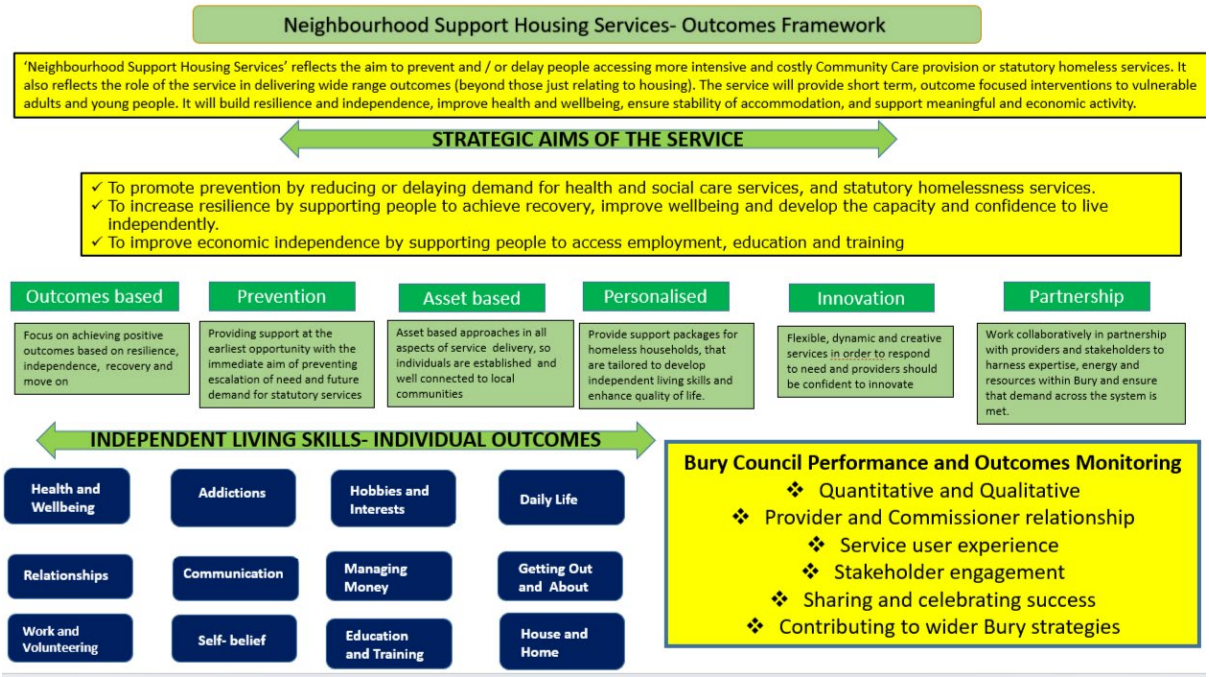
There has been a significant increase of single people that require tenancy related service and households that requires interventions to sustain their tenancies. Rough sleeping has increased locally, due numerous factors which include:

- Increase in the number of people with complex needs (mental health, substance misuse and offending behaviours)
- Expensive housing market in the borough contributing to lack of access to the private rented sector and finite support of social housing.
- Regional and local challenges regarding providing accommodation to increased asylum and refugee presentations due to government policy and leave to remain cases.
- Cost of living has increased which has meant that more households are struggling to sustain their tenancies.

There has been a general increase in homelessness presentations in Bury, which includes people that are eligible for Adult Social Care support. The reason for this increase in the incidence and presentation of homelessness cases includes:

- Complex and chaotic lifestyles can result in an inability to sustain tenancies and result in evictions. Most homeless people have experienced some combination of financial, emotional, health or substance abuse.
- Mortgage repossessions is increasing due to the cost-of-living crisis.
- Increased Private Rented Sector (PRS) evictions and Section 21 notices, mainly due to affordability issues
- The lack of available and affordable ‘move-on’ properties because of the limited housing supply in Bury.
- Lack of suitable properties for people that are discharged from hospital, especially those that have multiple needs (mental health, Substance misuse and offending behaviours).
- Significant lack of housing options for young adults that meet adult social care needs, due to lack of supply and affordability.

The service under Neighbourhood Housing Support is and continue to be outcomes based that focus on achieving positive outcomes based on resilience, independence, health, recovery, meaningful activity, and community connections. Below is the Outcomes Framework which will monitor outcomes to ensure that the principles of the services are referenced consistently.



We will

- Have conversations with people to discover what they want from life and the care, support and housing that will enable independence
- Ensure that commissioned services are working in all localities and tenures to ensure that people are supported to sustain their tenancies, especially those that are threatened with homelessness.
- Work closely with services that play significant role in prevention such as ensuring there is appropriate and adequate housing to meet the changing needs throughout life, planning for adaptations to homes, providing advice and support regarding benefits, the provision of leisure services and green spaces in our local communities.
- Work closely with housing colleagues and support the implementation of the housing strategy to ensure that there is suitable and local housing available for people as their health and wellbeing needs evolve.

Commissioning approach and intentions

Most of the social care budget is spent on external support and services to meet assessed needs. It is crucial to work closely with providers to ensure quality support that meets identified outcomes and offers good value for money for Bury. This requires changing how we shape, commission, and manage the market to focus on early intervention and prevention rather than crisis intervention.

By investing in preventative services, increasing the choice of care and support options available and providing the right accessible information and advice to allow people to plan, we can enable people to remain in their own homes and communities for longer and achieve the outcomes that matter to them.

We will

- Work collaboratively with providers to implement care technology to enhance people's care and support
- be innovative in our commissioning practices, developing new models of care in terms of technology, housing options and community based services to empower people to stay as independent as possible for as long as possible. This will mean a strengths based approach is taken to all our work
- Work closely with people who use services and their advocates to understand their needs and co-design models of preventative services.
- Include residents in planning for changing needs and ensuring appropriate data and evidence is available for this.
- identify better ways to gather experiences and feedback from a wide range of people, particularly reaching out to people whose voices and experiences we do not often hear to reflect the diversity of Bury.
- analyse and be clear about how we've used what you have told us, both good and bad, and what action we have or will take as a result
- invest in supported accommodation and work towards better use of the Disabled Facilities Grant (DFG).

To make sure that this strategy is delivered we will:

- have good governance around our ambitions and plans. Governance means the way in which we manage the business and how we achieve our stated commitments.
- to ensure successful implementation of this document, we will develop a work/action plan to support the delivery of this strategy that has clear ownership, timescales and accountabilities.
- Representatives from our co-production networks will be invited to be be part of our commissioning activities to inform the design and development of future prevention services.
- We will review our success and priorities with people or groups who have an interest in what we do and who are affected by our decisions.
- Additional scrutiny will be provided by CQC who will review our assurance and auditing systems and processes. We must demonstrate that we assess, monitor and drive improvement in the quality and safety of the services we provide including risk management systems.

Bury Council