AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Dear Member/Colleague

Health and Wellbeing Board

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

Date:	Thursday, 12 June 2025
Place:	Committee Rooms A&B
Time:	4.30 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board are asked to consider whether they have an interest in any of the matters on the Agenda, and if so, to formally declare that interest.

3 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which the Board is responsible.

Approximately 30 minutes will be set aside for Public Question Time, if required.

4 MINUTES OF PREVIOUS MEETING *(Pages 5 - 12)*

The minutes of the meeting held on 18th March 2025 are attached.

5 MATTERS ARISING

6 WIDER DETERMINANTS OF POPULATION HEALTH

a FOOD AND HEALTH STRATEGY *(Pages 13 - 20)*

Presentation support by Lee Buggie, Public health specialist and Francesca Vale, Public health Practitioner food and health

b SCHOOL READINESS *(Pages 21 - 42)*

Gill Mirabitur Early Years Advisor to support this item

7 THE OPERATION OF THE HEALTH AND CARE SYSTEM

a BCF UPDATE *(Pages 43 - 54)*

Adrian Crook Director of Community Commissioning will support this item,

b HEALTH PROTECTION ANNUAL REPORT *(Pages 55 - 60)*

8 BEHAVIOUR AND LIFESTYLE DETERMINANTS OF HEALTH

a SEXUAL HEALTH NEEDS ASSESSMENT *(Pages 61 - 118)*

Sophie French, Public Health Specialty Registrar to support his item

9 PLACE BASED PERSON CENTRED APPROACH

There are no items for consideration under this quadrant.

a **LIVE WELL UPDATE** *(Pages 119 - 124)*

Will Blandamer Executive Director, Health and Adult Care and Deputy Place Lead - NHS GM, to support this item

10 **GM POPULATION HEALTH BOARD FEEDBACK**

Jon Hobday, Director of Public Health to provide a verbal update.

11 **URGENT BUSINESS**

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Agenda Item 4

Minutes of: **HEALTH AND WELLBEING BOARD**

Date of Meeting: 18 March 2025

Present: Councillor T Tariq (in the Chair)
Councillors E FitzGerald, J Lancaster, T Pilkington, J Southworth and S Walmsley

Will Blandamer, Dr Cathy Fines, Jon Hobday, Jeanette Richards, Adrian Crook. Kath Wynne-Jones, Ruth Passman, Helen Tomlinson

Also in attendance: Chris Woodhouse, Lee Buggie, Josh Ashworth (Democratic Services)

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: Councillor A Arif, Councillor L Smith, L Ridsdale, Nawaz and Willmott

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HWB.89 APOLOGIES FOR ABSENCE

Apologies for absence are noted above.

HWB.90 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HWB.91 PUBLIC QUESTION TIME

There were no public questions asked at the meeting.

HWB.92 MINUTES OF PREVIOUS MEETING

It was agreed:

That the minutes of the meeting held on 16th January 2025 be approved as a correct record.

HWB.93 MATTERS ARISING

There were no matters arising.

HWB.94 WIDER DETERMINANTS OF POPULATION HEALTH

a ANTI POVERTY UPDATE

Jon Hobday Director of Public health provided a verbal update on the Household Support Fund, highlighting a significant funding reduction of £326,000 for the period from April 2025 to March 2026.

The Anti-Poverty Steering Group is currently reviewing the allocations and refreshing the associated action plan to mitigate the impact of this reduction. Leadership for the Anti-Poverty Strategy has been transferred to Chris Brown in Revenues and Benefits, with updates expected from him in future meetings.

Councillor Walmsley voiced disappointment regarding the reduced funding and stressed the need to allocate resources effectively to the most vulnerable groups, avoiding perceptions of deserving versus undeserving populations.

Councillor Tariq expressed concern about the potential health impacts of this funding reduction and urged the inclusion of health impact assessments to understand the implications thoroughly.

The committee emphasized the importance of addressing the broader consequences of the funding decrease, especially on health outcomes, in future meetings.

It Was Agreed:

- The Update Be Noted
- Chris Brown will provide updates on the Anti-Poverty Strategy and action plan revisions in subsequent meetings.
- Future meetings will include discussions on the impacts of funding reductions on health and other key areas.

b **CRIME AND SAFETY PLANS**

Chris Woodhouse Strategic Partnerships Manager provided an update on the new three-year Community Partnership Plan, which aligns with Greater Manchester's initiatives, focusing on population health and safety. The plan takes a preventative approach, addressing health inequalities and community safety through place-based solutions.

Dr Cathy Fines Greater Manchester NHS Bury, raised concerns about children within complex safeguarding. Chris clarified that children's needs are addressed across CSP and safeguarding initiatives to ensure a seamless transition. Adrian Crook highlighted gaps for children transitioning to adulthood without disabilities, emphasizing the need for better support systems.

Will Blandamer assured the committee of Bury's excellence in addressing serious crime and integrating health and care systems. Councillor Walmsley emphasized health involvement in CSP decisions, especially regarding domestic violence and safeguarding.

Key issues discussed included cuckooing, youth transitions, and unreported crimes. The need to link CSP activities to health inequalities was emphasized, with proposals for measurable outcomes and annual reporting mechanisms.

Action points included Chris liaising with GMP for better representation, and ensuring routine updates from CSP to highlight connections to health inequalities.

It Was Agreed:

- The update be noted
- Have crime and safety plans as an item moving forward

HWB.95 THE OPERATION OF THE HEALTH AND CARE SYSTEM

a BCF PROGRESS REPORT Q3

Adrian Crook, Director of Adult Social Services and Community Commissioning gave an overview of the Better Care Fund Quarterly Report and performance against key objectives for Quarter 3.

It was agreed:

1. To note the content of the Quarter 3 reporting submission.
2. That the Better Care Fund 2024/2025 Quarter 3 reporting submission be Approved by the Health and Wellbeing Board

b BCF PLANNING SUBMISSION 25-26

Adrian Crook, Director of Adult Social Services and Community Commissioning, presented the report on the Better Care Fund (BCF) 2025/2026 submission.

Key areas of funding allocation were discussed, including intermediate care schemes, falls pick-up service, integrated neighbourhood teams, and protection of services from budget cuts.

Kath Wynne Jones highlighted the importance of accurate data collection and appropriate care pathways.

Adrian Crook emphasized the goal of reducing A&E attendances and hospital admissions through integrated working teams.

Will Blandamer Executive Director for Health and Adult Care assured transparency in the construction of discharge capacity and the recognition of dependency.

It was Agreed:

- The report be noted
- The Board reviewed the submission and agreed to sign off the Bury Better Care Fund 2025/2026 plan.

HWB.96 BEHAVIOUR AND LIFESTYLE DETERMINANTS OF HEALTH

a PHYSICAL ACTIVITY FRAMEWORK - OVERVIEW OF WORK

Lee Buggie public health specialist provided an overview of the new strategy, focusing on the physical framework around Greater Manchester (GM) and its principles. The strategy is designed to be simple, with a local focus and lens.

The framework aims to link existing strategies since 2020, including the "get bury moving" strategy. The framework underpins the strategy and aims to link various initiatives. The next steps are to endorse the strategy to go live and get all partners on board.

Councillor Tariq: raised concerns about mitigating challenges during winter periods, especially with the clock changes. He highlighted specific areas like Pimhole and Fishpool that need more support and attention for wellbeing and infrastructure improvements.

Councillor Pilkington: asked about the steps taken to involve different demographics in the framework's success. Lee Buggie responded by detailing events at mosses centre and Radcliffe fc, noting the need to consult young people more thoroughly.

Jeanette Richards executive director for children's services emphasized the importance of co-production and understanding the services available to young people. She highlighted concerns about the lack of physical activity among young girls and the need to create safe spaces for them.

Helen Tomlinson: mentioned the need for safe places for young people to hang out, linking to the Community Safety Partnership (CSP) plan. She stressed the importance of creating opportunities for young people to engage in physical activities.

Councillor Tariq suggested introducing a young person's version of a Fitbit to encourage physical activity through competitive step counting.

Councillor Lancaster supported the idea of competitive step counting initiatives and discussed the potential benefits.

Jon hobday discussed sustainability and initiatives like walking and cycling, emphasizing the need for ongoing engagement with various groups.

Councillor Walmsley shared success stories of school street initiatives and red routes for cyclists, noting the positive feedback from cyclists about safety.

Councillor Fitzgerald suggested using cameras on school streets to fund initiatives, mentioning the potential for these measures to pay for themselves.

Lee Buggie mentioned the use of ANPR cameras in Oldham and the potential for similar investments in Bury. He discussed the costs and benefits of these cameras and the need for sophisticated software.

It Was Agreed:

- The Update Be noted

HWB.97 THE EFFECT OF PLACE AND COMMUNITY ON HEALTH AND WELLBEING

a VCSE / VOLUNTEERING CONTRIBUTION TO HEALTH

Helen Tomlinson, the Chief Officer for the VCFA, provided an overview of the VCSE sector and its significant contribution to health and well-being. She emphasized the diversity and complexity of the sector, highlighting the various types of voluntary organisations and their unique contributions.

Helen compared the statistics of Bury with those of Greater Manchester (GM) to provide a broader context. She mentioned ongoing research and the need for revised state sector figures to better understand the current state of the sector. This comparison aimed to show how Bury's numbers fit within the larger GM framework and the importance of updated data.

Helen discussed that the voluntary sector in Bury is incredibly diverse, with organisations varying in nature, size, and focus. Helen explained that these groups come together based on geography, shared experiences, or common identities. For example, some organisations are geographically based, while others form around peer support for shared experiences or specific identities like disability groups. This diversity demonstrates the complexity and interconnectedness of the voluntary sector.

Helen highlighted several key points specific to Bury. According to a recent resident survey, 25% of people engage with voluntary community sector (VCS) groups around sports and physical activity, indicating strong community involvement in these areas. Additionally, Bury has a high volunteering rate, with one in three people volunteering, reflecting a robust culture of volunteering. Notably, the Black or Black British community in Bury has a 62% engagement rate in volunteering, significantly higher than the Greater Manchester average of 32%.

Helen discussed the national context, emphasizing the voluntary sector's widely recognized contribution to health and well-being. The sector's deep-rooted presence in communities allows it to address complex needs and social determinants such as poverty. She shared an example of a visit to Trust House, where the multifaceted support provided includes food banks, housing, and welfare benefits, highlighting the sector's comprehensive approach to community support.

Helen provided several examples of local organisations to illustrate the diversity and impact of the voluntary sector in Bury:

- **One Step Bury**: This organisation collaborates with statutory services to provide support through physical activity, leading to positive outcomes for individuals.
- **Speakeasy**: Specialising in support for individuals with speech impairments, Speakeasy offers specialist speech and language therapy, enhancing confidence and assertiveness.
- **Radcliffe Food Club**: This organisation has developed a sustainable food provision model, moving away from traditional food banks and creating a community hub for various services.
- **Margaret Haes Riding Centre**: Offering programmes for children and adults with physical and learning disabilities, this centre provides free services to young people after assessment.
- **Jigsaw**: A member led organisation that promotes fun, freedom and independence for disabled people in Bury.
- **Bury Relics:** Provide both community and competitive walking football for people from the Bury area

Helen discussed several enablers and opportunities for the voluntary sector:

- **Team Bury**: A strategic enabler focusing on local elements and community strengths.
- **Memorandum of Understanding (MOU)**: A formal agreement with public sector partners to enhance collaboration and align strategies.
- **Investment Approach**: Creating investment opportunities aligned with strategic outcomes, including leveraging social value from large contracts.
- **GM Level Event**: Highlighting the role of the voluntary sector in bringing power closer to communities and improving collaboration with statutory services.

Helen emphasized the importance of collaboration between the voluntary and public sectors to improve health and well-being. She recognized the voluntary sector's critical role in addressing social determinants and complex community needs, underscoring the sector's value in creating healthier, more resilient communities.

It Was Agreed:

- The update be noted
- Helen be thanked for her continued hard work

b OUTCOMES FRAMEWORK UPDATE

c LOCALITY PLAN UPDATE

Will Blandamer, Executive Director for Health and Adult Care, provided an overview of the Locality Plan for the Board. This document outlines the strategy for the health and care system in Bury for the next three years. The strategy has been developed through workshops and consultations with public services and other stakeholders, ensuring a comprehensive and collaborative approach.

The strategy development process began with the initial version presented to the Locality Board in February. It was subsequently refined with input from various stakeholders, including public services and community representatives, to ensure a comprehensive and inclusive approach. The strategy aligns with NHS funding guidance, the NHS Darsi review, and the 10-year forward view, providing a robust framework for future health and care initiatives.

Four Key Priorities:

1. **Population Health and Health Inequalities:** Focus on improving overall health and addressing disparities through targeted interventions.
2. **Prevention, Reducing Prevalence and Proactive Care:** Emphasizes early intervention to reduce demand on services, promoting proactive health measures.
3. **Transforming Community Care in Neighbourhoods:** Integration of health and care services at the neighbourhood level to create a seamless and accessible system.
4. **Optimising Care:** Ensuring high-quality care in hospitals and other institutions, enhancing patient experiences and outcomes

Challenges:

- **Historic Gaps in Mental Health Funding:** Addressing under-resourced services to meet community needs.
- **Strengthening Primary Care Capacity:** Ensuring robust and effective first points of contact for patients.
- **Prioritizing Prevention and Early Intervention:** Mitigating health issues before they become severe.
- **Enhancing Co-Design and Co-Production:** Ensuring services meet the actual needs of the community through collaboration with service users.

- **Managing Financial Challenges:** Optimizing secondary care to maintain a sustainable and efficient healthcare system.

During the discussion, the importance of addressing population health inequalities was emphasized, highlighting the need to reduce disparities and promote equitable health outcomes. The necessity for clear and measurable Key Performance Indicators (KPIs) was also discussed, as these metrics are crucial for tracking progress and ensuring accountability. Additionally, the ongoing collaborative efforts with the Locality Board and other stakeholders were discussed, stressing the importance of working together to ensure the successful implementation of health initiatives.

It was agreed:

- the report be noted, acknowledging the comprehensive efforts and strategic direction outlined in the Locality Plan.

HWB.98 GM POPULATION HEALTH BOARD FEEDBACK

Jon Hobday, Director of Public Health, Submitted a paper highlighting the works of the Greater Manchester Population Health Board Feedback, for information only for the Board to review.

It was agreed:

- That the update be noted.

HWB.99 URGENT BUSINESS

There was one item of urgent Business brought to the committee by Jon Hobday Director of Public Health.

Jon advised the committee of the production of a Pharmacy Needs Assessment. This assessment will be developed in collaboration with Greater Manchester (GM) to ensure it meets regional needs and standards.

COUNCILLOR T TARIQ
Chair

(Note: The meeting started at Time Not Specified and ended at 6.32 pm)

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Health and Wellbeing Board: Food Health

Lee Buggie: Public Health Specialist

Francesca Vale: Public Health Practitioner Food and Health

June 2025

Bury Food Strategy & Food Partnership

- **Bury Food Partnership** launched the **Bury Food Strategy – Eat, Live, Love Food** (2021), following its endorsement by the Health & Wellbeing Board. It has since been integrated as part of the wider Bury Council 2030 Let's Do It Strategy for the future of our borough.
- From the outset **Bury Food Partnership** has adopted whole systems thinking, and prides itself on being a positive space to connect, challenge and help shape the way Bury sources and provides good food for all – people, climate and nature. 80+ cross sector members, interested in healthier and sustainable food.
- Bury became a **Sustainable Food Places** (SFPs) network member (2021), using SFP themes to collate partner activity across the food system - from farm to fork.
- Awarded the prestigious **SFPs Silver Award for Bury (2024**), the first in Greater Manchester.
- Bury took part in the **EU Cascades Cities peer learning programme**, partnered with Copenhagen world leaders in food system transformation – the True Value of Food.
- Bury Schools Catering Service fully embraced these insights, achieving the **Food for Life Silver** and **Green Kitchen** awards in 2024.

Food System Achievements in 2025

- **Free School Meals Auto Enrolment :** As part of Bury Council's work to support families and schools in accessing all available funding, a FSMs auto-enrolment service has been implemented for families currently receiving Council Tax and/or Housing Benefit.
- Since auto-enrolment meal uptake for **FSMs increased by 18.4% in Bury Catering managed schools**. 6281 meals were ordered in the week before Easter, compared to 7439 meals in the week after auto-enrolment, giving an extra 1158 meals. This equates to an **extra 232 children** receiving FSMs. Rev's and benefits will repeat the process at the Oct 2025 Census.

- **Greater Manchester Market Partnership:** Bury is a driver in developing this new partnership to strengthen markets across the region, fostering economic growth, enhancing community engagement, and supporting culture and tourism.
- Supported by the National Association of British Market Authorities and National Market Traders Federation (advocates for market sustainability and amplify traders' voices). Stakeholders include Bolton and Manchester markets, and the GMCA. Launched with the **Love Your Local Market** campaign in May.
- **EU Clever Food Peer Learning Programme:** Bury visited Milan (home of the Urban Food Policy Pact), to deep dive into collective catering models, strategic use of procurement and the connection with farmers and producers and rural and urban linkages. New learnings to be a catalyst for further activity.

Right To Grow (RTG)

Fundamentally, **Right to Grow** allows the public to grow food in public spaces. There are conditions of course, but the aim is for UK councils, like Bury, to encourage community food growing.

A RTG working group has organically developed over the past 18 months, co-designing the RTG pathway and lease agreement has taken inputs from Bury Council Legal, Ground Maintenance, Public Health, Incredible Edible, The Wildlife Trust, Parks and Countryside, Bury VCFA and local volunteers as codesigned and collective effort.

There are many positive effects associated with growing food locally, examples include:

- Increased access to seasonal, nutritious, climate and nature friendly foods
- Reduced inequalities around healthy food access
- Improved mental and physical wellbeing through activity in nature
- Engaged citizens connected to their local green spaces
- Formation of new connections and friendships

Bury Community Growing | Bury Directory

Fast Food Take Aways & High Fat, Salt Sugar (HFSS)

- The built environment in which we live, and work influences the choices we make around food. Eat, Live, Love Food (2020) highlighted that the density of fast-food take aways in Bury was high, at **127.3 per 100,000 residents.** Fast forward to 2025 and that figure is now **165.7 per 100,000** and **Bury is 17th across all England's districts and UA's.**
- **Locally:** The fast-food take away matrix has been **co-designed** with performance teams from Bury LA and Primary Care along with Bury's school nurse network via National Childhood Measurements (NCMP) plus Bury planning policy officers and development management. **Inequalities are at the centre of the matrix design** as its rank's the population per 1000 on a range of markers / LSOA 1-120 (1 being the best and 120 worst) and via IMD.
- **Regionally :** Addressing **Commercial Determinants of Health (CDoH)** has been identified as a key priority for the Greater Manchester Public Health Leadership Group (GMPHLG) along with Housing and Health and Fairer Health for All. **Pan-GM Principles has been proposed** – providing a set of agreed standards to help ensure a level of consensus across local authority owned policies and implementation / HFSS food and drink using the **Nutrient Profiling Model (NPM).**
- **Nationally: Plans to ban TV advertising** for products high in fat, salt and sugar (HFSS) **before 9pm will be delayed until January 2026**, following concerns from food and media brands and confusion over enforcement guidelines The delay to the ban, which was to have come into effect from October, comes as ministers prepare to amend legislation to ensure brand-only advertising.

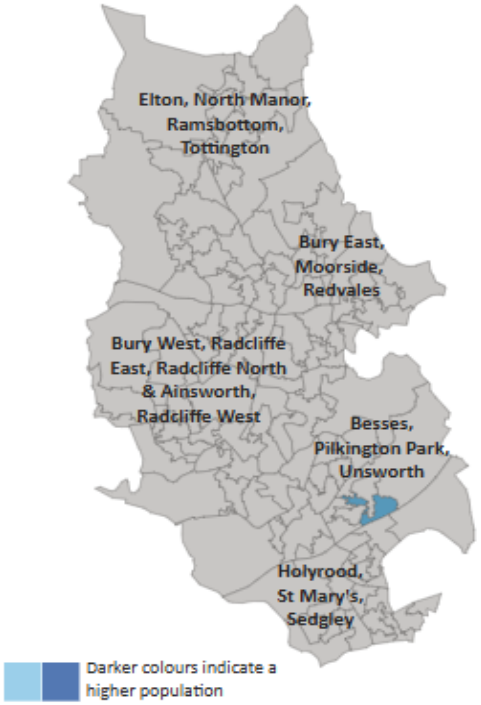
Fast Food Take Away Matrix

Bury Council

LSOA Code: E01004941

Postcode: All

Population



Index of Multiple Deprivation (IMD) Decile	Value
Living Environment Decile	8
Index of Multiple Deprivation (IMD) Decile	3
Income Deprivation Affecting Older People (IDAOPI) Decile	3
Income Deprivation Affecting Children Index (IDACI) Decile	3
Income Decile	3
Health Deprivation and Disability Decile	3
Employment Decile	3
Education, Skills and Training Decile	3
Crime Decile	4
Barriers to Housing and Services Decile	5

- The Bury 021A LSOA sits within the Whitefield neighbourhood - Besses ward.
- The total population of this LSOA is 1874.
- There are 1 premise(s) classed as A5 Hot Food Take Aways.
- Of the children that took part in the National Child Measurement Programme (NCMP) for 2020-23, 20.7% of children in Reception in this LSOA were classed as overweight or very overweight, and 22.2% of children in Year 6 in this LSOA were classed as overweight or very overweight. Please note only state schools are included in the NCMP.
- The IMD Decile score for this location is 3 (1 being the most deprived and 10 being the least deprived decile).
- There are 0 school(s) in this LSOA.
- This LSOA is ranked 50 out of 120 LSOA's for obesity prevalence in those aged 18+, based on the rate per 1,000 population*. The LSOA ranked 1 has the highest rate of obesity prevalence.
- This LSOA is ranked 77 out of 120 LSOA's for Type 2 diabetes prevalence in those aged 17+, based on the rate per 1,000 population*. The LSOA ranked 1 has the highest rate of Type 2 diabetes prevalence.

*CAVEAT: The data sets these measures are calculated from are subject to opt-outs. Bury has an opt out rate of 5.48% and so actual figures are likely to be higher.

Food Podcast

https://open.spotify.com/episode/2SnJpDwqO3wogoCiCClHZ6?si=KMdE4xcLRECjtjsCrphiDw

NHS Greater Manchester Integrated care

Bury Council

Thank You – Any Questions

l.buggie@bury.gov.uk

June 2025

Good Level of Development 2024 EYFSP

HEALTH AND WELLBEING BOARD

GILL MIRABITUR – EARLY YEARS ADVISOR

G.MIRABITUR@BURY.GOV.UK

The Importance of Achieving a Good Level of Development

High-quality early education benefits all children, both during their early childhood and later in their schooling. It is particularly beneficial for children from disadvantaged backgrounds and for children with SEND, and these benefits continue into secondary school.
‘*Best Start in Life Part 1 – Ofsted updated Oct 2024’*

Bury Council

It is also an indicator for the future.

What is the Early Years Profile and Good Level of Development?

- Children coming to the end of their reception year will be assessed against 17 Early Learning Goals.
- Some of these goals are used to calculate Good Level of Development known as GLD.
- The Early Years Profile should be used to inform practice in the next Key Stage.

More details of how this is done on the next slide – for reading.

What is the Early Years and Foundation Stage Profile? (EYFSP)

Every year children who are in their last term of Reception undergo the EYFSP. This is a statutory assessment carried out by the qualified teacher in Reception. Where families exercise their right to defer their child's take up of reception places, the profile will be completed by the child's Early Years Key Person – unless the child will continue to defer and start in reception a chronological year late. Deferment for children with SEND is on the rise. In Bury there are very few 'true' deferments purely based on a child not being statutory school age. Availability of placements in specialist schools or Resourced Provision is impacting on the rates of deferring children.

All children are assessed across all areas of learning and development: These are called The Early Learning Goals (ELGs) of which there are 17. These are split into 2 sections known as Prime Areas and Specific Areas.

Prime Areas of Learning

- Communication and Language (COM)
- Physical Development (PHY)
- Personal, Social and Emotional Development (PSE)

Specific Areas

- Literacy (LIT)
- Mathematics (MAT)
- Understanding the World (UTW)
- Expressive Arts and Design (EXP)

Each of these are then broken down into 2 or 3 strands of which the children are measured against making up the 17 ELGs. It is widely regarded that continued success in the Prime Areas will support achievement in the Specific Areas.

Bury Council

Bury Professionals must have **a commitment to every individual child**. Lower GLD result are most prevalent where disadvantage, EAL and SEND are a factor. Poor GLD results are **magnified in neighbourhoods where there are multiple factors of Inequality.**

Neighbourhoods with less experience of these factors, are less equipped to meet individual children's needs despite overall result being good.

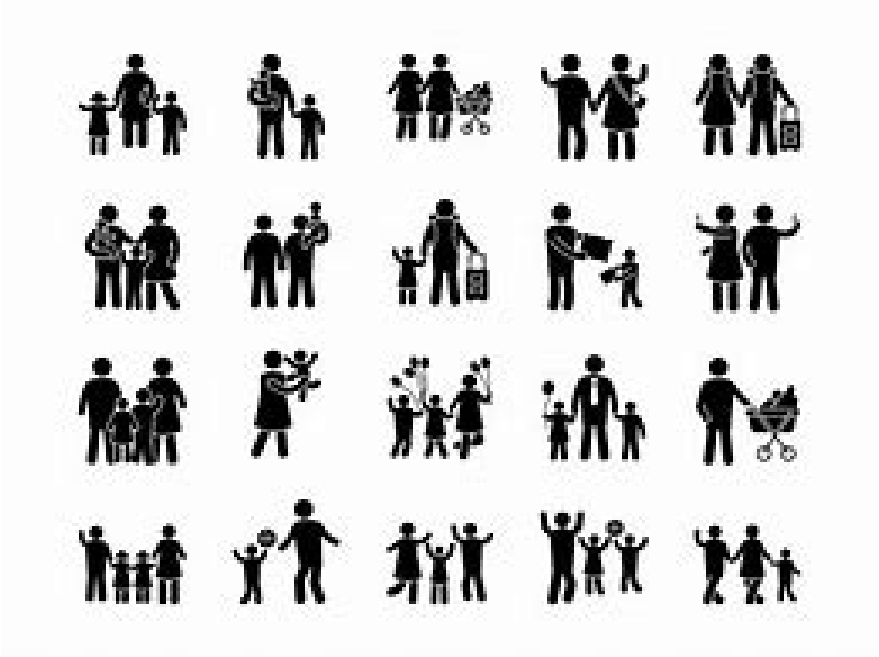
Neighbourhoods who have a deep understanding of these factors are better equipped to meet the needs of their communities.

This is **a whole service approach** including Family Hubs, Early Years Settings, Schools, Live Well Centres and Health Professionals to tackle some of the inequality.

Achieving GLD is not solely the responsibility of the School

It is in fact

Everybody's Business to ensure families can access services therefore wrapping around the families and their children.



What Factors Feed into Early Years Foundation Stage Profile?

- Ante-natal support for both parents.
- Parent and Carer bond with baby/child
- Connectivity to Community and Services
- Access to the Healthy Child Programme to ensure early identification and intervention.
- Accessing quality Early Years Provision
- Children accessing the right 'type' of provision for them. Some children thrive in a large nursery environment whilst others do better with childminders. Sufficiency of a range of types of provision ensuring choice is available impacts on GLD . The cost-of-living crisis, recruitment and retention in the sector and post-Covid experience continue to impact on the sustainability of the sector. This is a concern as narrowing the availability of types of provision impacts on children's development.
- Accessing quality universal, targeted and specialist support
- Taking up 2-year-old funded places
- Accessing quality Reception classes in schools where senior leaders understand the age range and schools understand the communities they serve

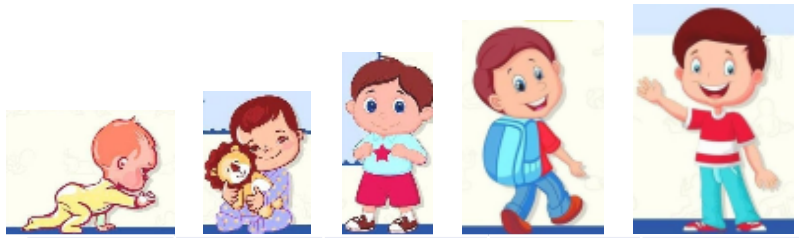
What does successful Early Years Provision go on to affect beyond the Education System?

- Improved life chances meaning less draw on Local Services.
- Connected citizens who contribute more than they draw on resources.
- Connected families who feel well equipped to support their child's learning and development in the home and community. Which continues beyond the phase.

Bury Council

2023/24 Cohort of Children Assessed with EYFSP – curtesy of GMCA

- "These statistics report on teacher assessments of children's development at the end of the early years foundation stage (EYFS), specifically the end of the academic year in which a child turns 5" [2]
- Children included in the 2023/24 data were born between September 1st, 2018, and August 31st, 2019. The youngest of them would, therefore, have been **around 6 months old when Covid arrived, the oldest 1.5 years old.**
- These children turned **2 years old** between September 1st, 2020, and August 31st, 2021. Therefore, they may have been impacted by 2020/21 restrictions on EY provision and, if eligible, may have only had a reduced 2yr FEEE offer.
- Likewise, any mandatory health checks for this cohort might have been disrupted due to the pandemic. This means that children in this cohort might have missed their 9 month or 2-2.5 health check, or been offered a phone call instead of an in-person visit.



	9-month-old visit		2-Year-old FEEE	Funded childcare	Reception
Date of Birth	**Aged 0-1**	**Aged 1-2**	**Aged 2-3**	**Aged 3-4**	**Aged 4-5**
1 Sept 2012 - 31 August 2013					GLD 17/18
1 Sept 2013 - 31 August 2014					GLD 18/19
1 Sept 2014 - 31 August 2015				17/19	~~GLD 19/20~~
1 Sept 2015 - 31 August 2016			17/19	18/20	~~GLD 20/21~~
1 Sept 2016 - 31 August 2017		17/19	18/20	19/21	GLD 21/22
1 Sept 2017 - 31 August 2018	17/19	18/20	19/21	20/22	GLD 22/23
1 Sept 2018 - 31 August 2019	**18/20**	**19/21**	**20/22**	**21/23**	**GLD 23/24**
1 Sept 2019 - 31 August 2020	19/21	20/22	21/23	22/24	GLD 24/25
1 Sept 2020 - 31 August 2021	20/22	21/23	22/24		
1 Sept 2021 - 31 August 2022	21/23	22/24			
1 Sept 2022 - 31 August 2023	22/24	23/25			

[2]Description of the Early years foundation stage profile: Early years foundation stage profile results, Academic year 2021/22 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

Time during covid restrictions

The Picture in Bury Education

Bury Council

Bury Early Years Providers Ofsted measured 100% at good or above in October 2024. This is an improvement on 2023 where the figure was 97.4% in November 2023

Bury Primary Schools Ofsted measured at good or above – 89.3% December 2024, however Ofsted are now ceasing to give one word inspection results. This is a decline since 2023 where the figure was 91.7%,. Ofsted's score card contains an area for Early Years.

Bury has 1 specialist school, providing EYFS Education. This was the case at the 2024 EYFSP Data submission.

There are no private specialist schools in Bury providing EYFS Education. This was the case at the 2024 EYFSP Data Submission.

Some Bury Primaries have Resourced Provision. For the academic year 2023/2024 there were 14 Resourced Provision places allocated to reception children. 6 (42.8%) were in Whitefield, 4 (28.5%) in East, 3 (21.4%%) in North, 1 (7.1%) in West and none in Prestwich.

Borough Wide Data and Comparisons

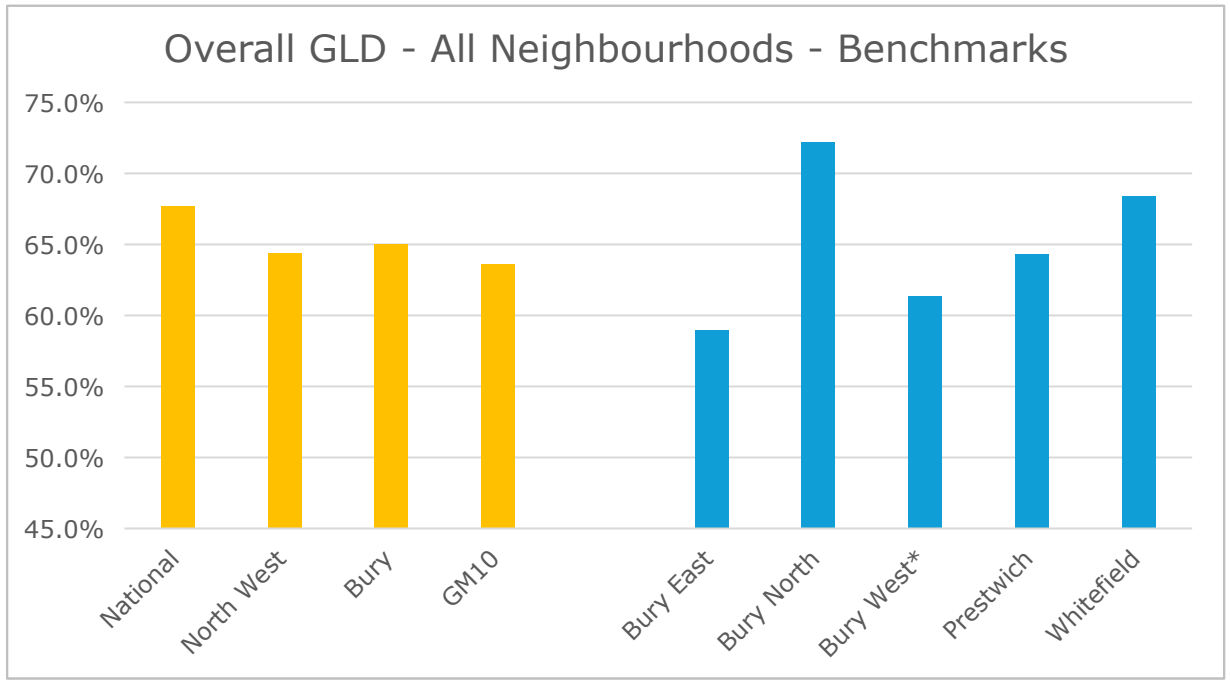
Bury Council

7. All Bury Neighbourhoods with National & Regional Results

A-Z Neighbourhood	
Area	Overall GLD
National	67.7%
North West	64.4%
Bury	65.0%
GM10	63.60%
Bury East	59.0%
Bury North	72.2%
Bury West*	61.4%
Prestwich	64.3%
Whitefield	68.4%

High to Low	
Area	Overall GLD
Bury North	72.2%
Whitefield	68.4%
National	67.7%
Bury	65.0%
North West	64.4%
Prestwich	64.3%
GM10	63.6%
Bury West*	61.4%
Bury East	59.0%

***inc. Millwood**



Commentary

- Bury's overall GLD results are -2.7% behind National. this gap has widened against the 2023 gap which was –+1.5%.
- Bury North and Whitefield have overperformed against National by +3.6% and +0.7% respectively. This is a change from 2023 where North overperformed by +4.1% and Whitefield underperformed.
- Bury as a whole underperformed when compared to National. However, overperformed when compared to North West England and the GM10.

Note: We are aware there can be discrepancies, for example high performing schools can mask lower performing schools when analysed at neighbourhood level. These details can be found in the full report.

Narrative - Overall GLD

The full report can be made available on request.

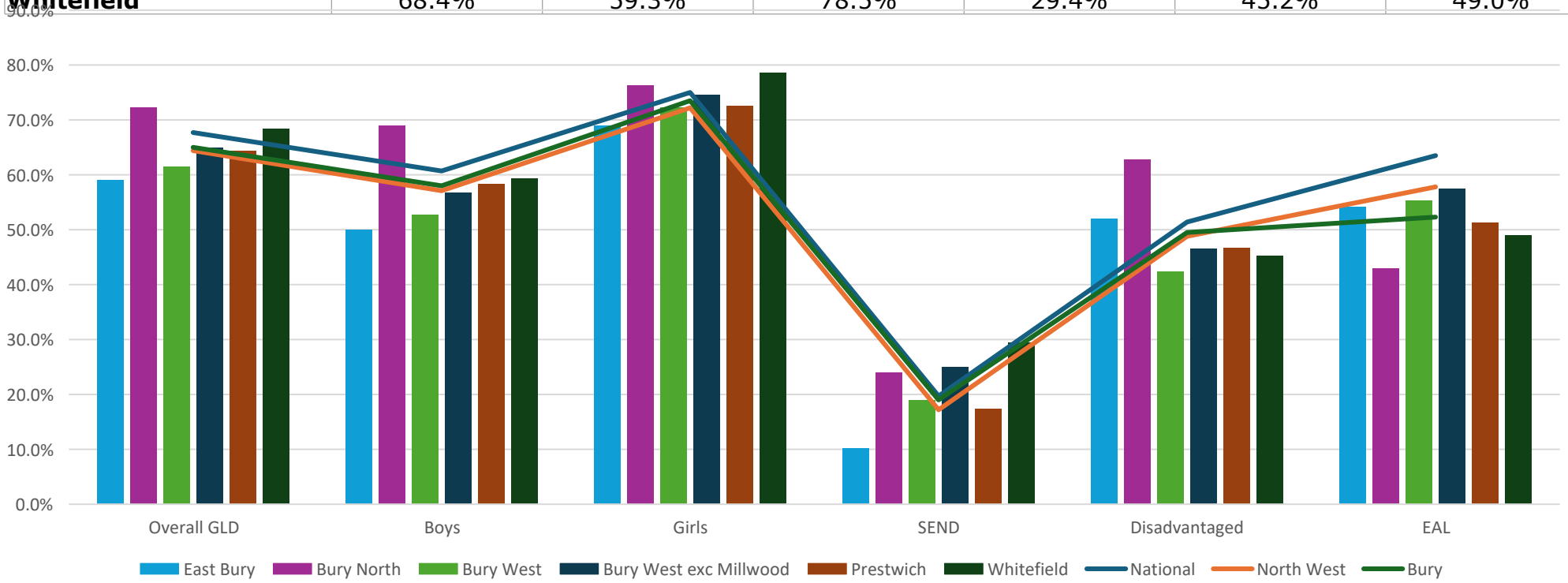
- Bury's overall GLD was –2.7% behind National, **which has widened** since the 2023 figures where the gap was –1.5%.
- Bury is –2.1% behind its Statistical Neighbours
- Bury **outperformed the GM10 GLD** by +1.4%.
- Bury **outperformed the North West by +0.6%.**
- **2 out of the 5 Neighbourhoods outperformed** the National GLD which were Bury North and Whitefield.
- There is a **widening gender gap** trend.
- **English as an Additional Language is the greatest concern** with the widest gap between National peers of -11.2% across Bury. This affects all 5 of the neighbourhoods and takes the 4 top places on Borough Comparisons and Immediate Issues ranking. A further spot is taken by EAL totalling half of the top ten issues. **This has been a recommendation for the last 3 years.**
- The **greatest strengths come from improvements in Disadvantage and SEND**. Bury North continues to perform well for Boys and Areas of Learning taking half of the top ten Borough Comparisons for Immediate Strengths.

Bury Council

2. Different Groups – Bury and Neighbourhoods to National & Regional - Benchmarking

How do the EYFSP figures for different groups for Bury and Neighbourhoods compare to National & Regional?

	Diff Groups - EYFSP 2024 - Nat & Reg & Bury & Neighbourhoods					
	Overall GLD	**Boys**	**Girls**	**SEND**	**Disadvantaged**	**EAL**
National	67.7%	60.7%	75.0%	19.7%	51.4%	63.5%
North West	64.4%	57.1%	72.2%	17.2%	48.8%	57.8%
Bury	65.0%	58.0%	73.5%	19.0%	49.5%	52.3%
East Bury	59.0%	50.0%	68.9%	10.2%	52.0%	54.1%
Bury North	72.2%	68.9%	76.3%	24.0%	62.8%	42.9%
Bury West	61.4%	52.7%	72.2%	18.9%	42.3%	55.3%
Bury West exc Millwood	64.9%	56.8%	74.5%	25.0%	46.5%	57.5%
Prestwich	64.3%	58.3%	72.6%	17.3%	46.7%	51.3%
Whitefield	68.4%	59.3%	78.5%	29.4%	45.2%	49.0%



Year on Year Data at National, Northwest, GM10, Statistical Neighbours, Borough and Neighbourhood Level

- National, North West, and GM10 GLD is increasing.
- Statistical neighbours plateaued for the last year. As Bury dropped, this gap has widened.
- Overall Bury dropped from 2023 and this was also seen in 3 of the 5 neighbourhoods.

2023	
Area	**Overall GLD**
National	67.20%
North West	64.30%
GM10	63.30%
Stat Neighbours	67.10%
Bury	65.70%
East Bury	60.00%
Bury North	71.30%
Bury West	66.10%
Prestwich	68.30%
Whitefield	65.60%

2022	
Area	**Overall GLD**
National	65.00%
North West	61.70%
GM 10	60.70%
Stat Neighbours	65.80%
Bury	63.30%
East Bury	57.30%
Bury North	68.60%
Bury West	65.00%
Prestwich	61.00%
Whitefield	67.40%

Difference 23 - 22	
Area	**Overall GLD**
National	2.20%
North West	2.60%
GM 10	2.60%
Stat Neighbours	1.30%
Bury	2.40%
East Bury	2.70%
Bury North	2.70%
Bury West	1.10%
Prestwich	7.30%
Whitefield	-1.80%

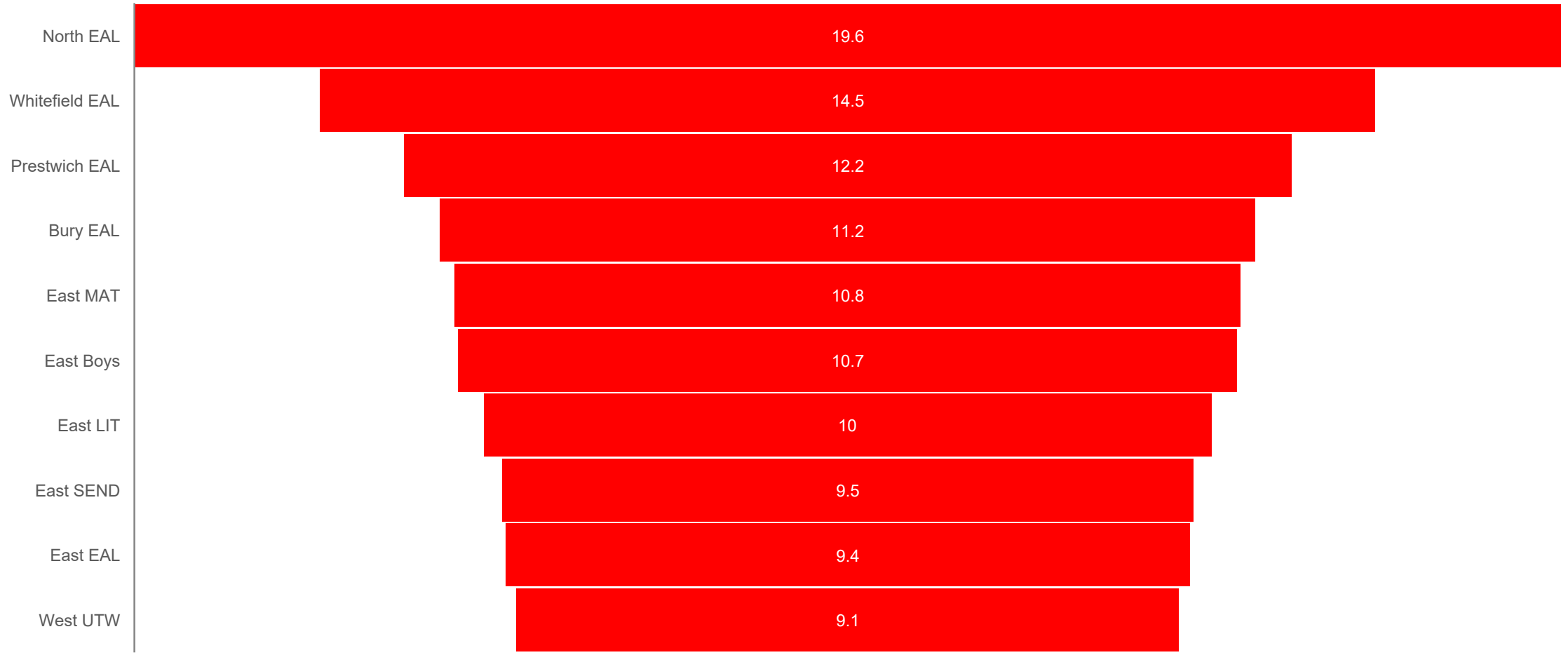
2024	
Area	**Overall GLD**
National	67.70%
North West	64.40%
GM10	63.60%
Stat Neighbours	67.10%
Bury	65.00%
East Bury	59.00%
Bury North	72.20%
Bury West	61.40%
Prestwich	64.30%
Whitefield	68.40%

2023	
Area	**Overall GLD**
National	67.20%
North West	64.30%
GM10	63.30%
Stat Neighbours	67.10%
Bury	65.70%
East Bury	60.00%
Bury North	71.30%
Bury West	66.10%
Prestwich	68.30%
Whitefield	65.60%

Difference 24 - 23	
Area	**Overall GLD**
National	0.50%
North West	0.10%
GM 10	0.30%
Stat Neighbours	0.00%
Bury	-0.70%
East Bury	-1.00%
Bury North	0.90%
Bury West	-4.70%
Prestwich	-4.00%
Whitefield	2.80%

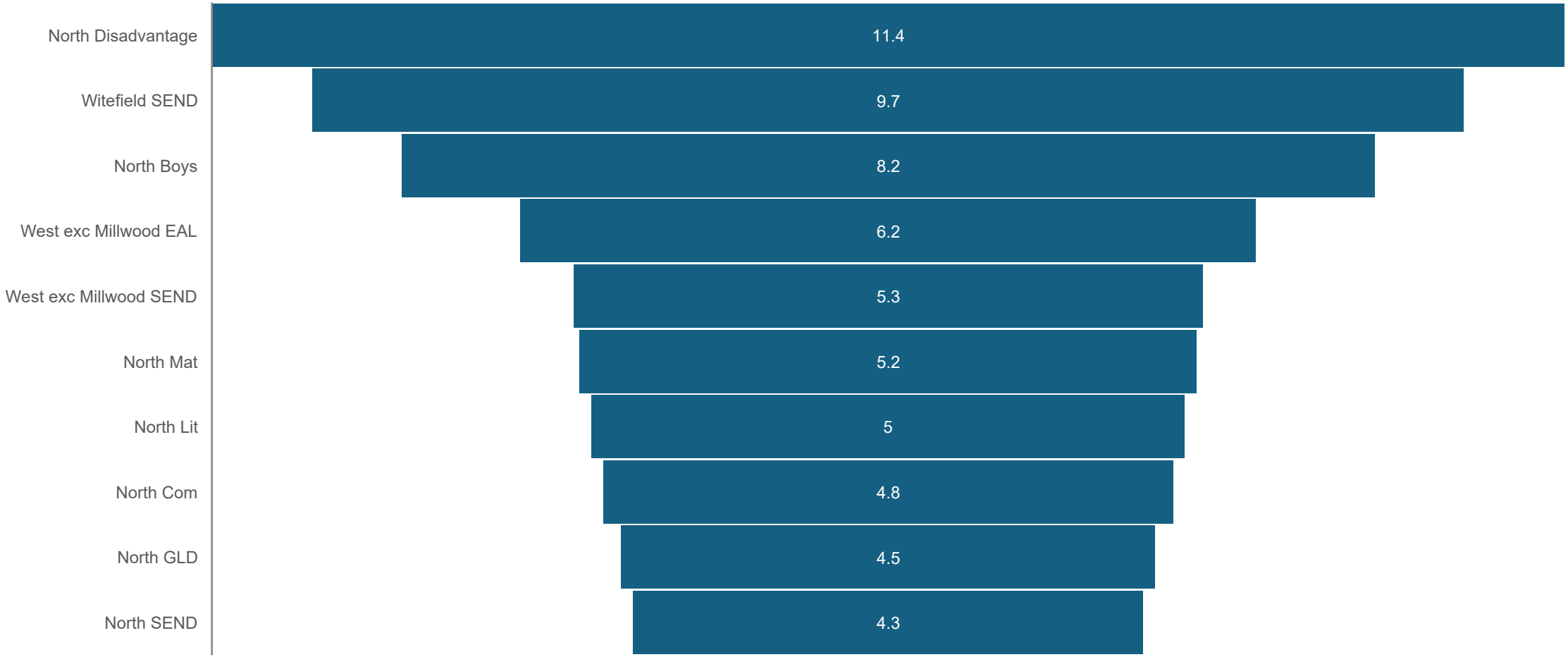
Borough Comparisons and Immediate Issues

Combined Priorities: How Bury has performed against national like for like



Borough Comparisons and Immediate Strengths – Ranked

Combined Priorities: How Bury has performed against national like for like



Headlines – Important to focus on groups rather than subjects

- In the red pyramid, 5 of the top 10 are English as an Additional Language and take the first 4 spots. Recommendations would be to strengthen at an educational level but also across the combined system considering families and community access to services.

How embedded do these communities really feel? How well represented are these communities across service staff?

- In the blue pyramid, we see improvements in disadvantage, SEND and boys, particularly in neighbourhoods where these have been identified as concerns from previous EYFSP data sets. What can we learn from these improvements and how can they be replicated in other neighbourhoods? Where there is strong performance from a particular school, what is happening in the school itself and the community surrounding it?

So, what's next in The Early Years Team?

GMCA Level, Borough Wide and Place Based

- EAL/Multilingualism raised with GMCA to be considered alongside the Greater Manchester Strategy for Communication and Language.
- EAL/Multilingualism to be included within Inclusion Practice via EYSEN and Inclusion and Communication Champions Networks.
- EY Response being considered and written. The EYA Team are delivering Cultural Capital Training to EYFS providers steering away from tokenistic delivery.
- EAL/Multilingualism to be spotlighted in Transition Process – setting into school.
- Data Sets and recommendations have been shared with Early Years Colleagues operating in these neighbourhoods.

How can the wider system support this?

- If EAL/Multilingualism is our biggest challenge, how can the system support this?
- How can we connect these communities to wider services thus improving other areas of concern, such as Physical Development?
- How can we support our Educational Providers from Family Hubs to settings to schools with this?
- What will be the legacy in the future if we do not address this?

Any questions?

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Agenda Item 7a

Bury Health and Wellbeing Board

Title of the Report	Better Care Fund (BCF) Improved Better Care Fund (IBCF) 24/25 End Of Year (EOY) Reporting Template
Date	2nd June 2025
Contact Officer	Hannah Dixon
HWB Lead(s) in this area	Will Blandamer Executive Director Health and Adult Care and Place Based lead Adrian Crook – Director Adult Social Care Lynne Ridsdale, Chief Executive

Executive Summary			
Is this report for?	Information	Discussion	Decision Y
Why is this report being brought to the Board?	To seek Health and Wellbeing Board retrospective sign off for the Bury EOY reporting template for the Better Care Fund 2024/2025. The deadline for submission to the NHSE Better Care fund team was 6th June 2025		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	The Better Care Fund primarily focuses upon: • Living Well with a Long-Term Condition • Reducing Length of Stay in hospitals • Improving and supporting Hospital Discharges • Prevention & Early Intervention		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	• Living Well with a Long-Term Condition • Reducing Length of Stay in hospitals • Improving and supporting Hospital		

	Discharges • Prevention & Early Intervention • Falls
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	(1) Note the content of the report. (2) Agree the retrospective submission of the EOY reporting template to BCF 2024/2025 as per the attached full reporting submission
What requirement is there for internal or external communication around this area?	None
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	The EOY reporting template has been collaboratively populated by relevant colleagues from within Bury Council and NHS GM Bury ICB.

Introduction / Background

1 Introduction and background

1.1 The final Better Care Fund (BCF) 2023/2025 Policy Framework and Planning Guidance can be found at: BCF https://www.gov.uk/government/publications/bettercarefund-policy-framework-2023-to-2025

This policy framework confirms the conditions and funding for the Better Care Fund (BCF) for 2023 to 2025.

1.2 Since 2015, the BCF has been crucial in supporting people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by 2 core objectives, to:

- enable people to stay well, safe, and independent at home for longer
- provide people with the right care, at the right place, at the right time

1.3 The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government

to agree a joint plan of how the funding will be spent to meet the core objectives. Indeed, 94% of local areas agreed that joint working had improved because of the BCF following a survey in 2022.

1.4 The plan is owned by the Health and Wellbeing Board (HWB) and governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

1.5 The BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services, as well as supporting the delivery of Next steps to put People at the Heart of Care. The BCF facilitates the smooth transition of people out of hospital, reduces the chances of re-admission, and supports people to avoid long term residential care. The BCF is also a vehicle for wider joining up of services across health and local government, such as support for unpaid carers, housing support and public health.

1.6 The delivery of the BCF will support 2 key priorities for the health and care system that align with the 2 existing BCF objectives:

- improving overall quality of life for people, and reducing pressure on urgent and emergency care, the acute sector, and social care services through investing in preventative services

- tackling delayed discharges from hospital and bringing about sustained improvements in discharge outcomes and wider system flow - these are set out in the 'BCF objectives and priorities for 2023 to 2025' section below

1.7 At the same time, NHS England and the LGA published the Planning Requirements for the BCF. These can be found at: BCF planning requirements,

1.8 The framework and guidance establish the key conditions and requirements of the Better Care Fund in 2023/2025.

2 BCF 2023/2025 Vision and Objectives

2.1 The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations. The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

2.2 The objectives, priorities and performance targets and what data we have to collect to report on are defined very clearly in the guidance: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025.

2.3 **Objective 1: to enable people to stay well, safe and independent at home for longer**

The priorities for health and social care are to improve quality of life and reduce pressure on urgent emergency hospital care, other acute care in the hospitals and adult social care services. This has to be achieved by everybody in the health and care system working together, including: collaborative working with the voluntary, housing and independent provider sectors and by investment in a range of preventative, community health and housing services and by supporting unpaid carers

2.4 **Objective 2: to provide people with the right care, at the right place, at the right time.**

The priorities for health and social care are to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow. This will be achieved by embedding strong joint working between the NHS, local government and the voluntary, housing and independent provider sectors

2.5 BCF metrics for 2024 to 2025

2.6 The four metrics to be reported on are:

Avoidable Admissions
Discharge to Normal Place of Residence
Falls
Residential Admissions

Metric	Definition	Actual Performance	Assessment of Progress	Challenges	Variance from Plan
Avoidable Admissions	Unplanned Hospitalisation	1137.8 (predicted)	Target not met	Challenges on data collection as data is released late by NHSE	Variance from plan is -157.9 (predicted). There have been more than predicted NEI admissions
Discharge to Normal Place of Residence	Discharged from acute hospital to normal residence	90.6% (predicted)	Target not met	Challenges on data collection as data is released late by NHSE	Variance from plan is 0.9%. It is thought that variance from plan is related to other acute site discharges mainly NMGH

Falls	Emergency hospital admissions due to falls in people aged 65 and over	2053.9 (predicted)	Target met	No challenges	Achieved by 16 (predicted)
Residential Admissions	Rates of permanent admissions to residential care	Measured annually 817	Target not met	Increased complexity of customers	Variance from plan

3.0 EOY 24-5 Finance and Output Report

3.1

Scheme Type	Planned Expenditure Annual £	Actual Expenditure Year to Date £	Planned Outputs Annual	Actual Outputs Year to Date.	Provider and Funding Stream
Reablement Service	3,716,984	3,716,984	840	840	LA via minimum NHS contribution
Staying Well Programme	88,100	88,100	0	0	LA via minimum NHS contribution
Programme Management	135,000	135,000	0	0	LA via minimum NHS contribution
Intermediate Tier	530,647	530,647	0	0	LA via additional NHS contribution
Rapid Response	910,500	910,500	0	0	LA via additional NHS contribution

Integrated Neighbourhood Teams	509,753	509,753	0	0	LA via additional NHS contribution
Protection of Social Care	950,317	950,317	36311	36311	Private sector via minimum NHS contribution
Protection of Social Care	950,317	950,317	21.4	21.4	Private sector via minimum NHS contribution
Protection of Social Care	950,317	950,317	20.3	20.3	Private sector via minimum NHS contribution
Protection of Social Care	950,317	950,317	14.5	14.5	Private sector via minimum NHS contribution
Assistive Technologies and Equipment	75,700	75,700	2300	2300	LA via additional NHS contribution
IBCF Building Resilience and Enabling Systems	5,781,385	5,781,385	10350	10350	Private sector via IBCF
IBCF Building Resilience and Enabling Systems	313,846	313,846	0	0	LA via IBCF
IBCF Building Resilience and Enabling Systems	1,533,217	1,533,217	0	0	LA via IBCF

Disabled Facilities Grant	2,265,064	2,265,064	170	170	LA via DFG
Primary Care Support	475,464	475,524	0	0	Private Sector via ICB discharge funding – goes live in September 24
GP in reach to Intermediate Tier	50,000	50,000	0	0	Private Sector via ICB discharge funding
Home From Hospital	105,660	105,600	0	0	Voluntary Sector via ICB Discharge Funding
Hospice	352,143	352,143	0	0	Voluntary Sector via ICB Discharge Funding
Additional G&A beds	416,733	416,733	160	160	Private Sector via ICB discharge funding
Care of vulnerable Adults - Fairfield Raid	711,109	711,109	0	0	NHS Mental Health via minimum NHS contributio n
Crisis Response Community	1,784,192	1,784,192	4200	4200	NHS community provider via minimum NHS contributio n

Intermediate Tier	2,267,401	2,267,401	0	0	NHS community provider via minimum NHS contribution
Integrated Neighbourhood Teams	571,312	571,312	0	0	NHS community provider via minimum NHS contribution
Falls Prevention	226,272	226,272	0	0	NHS community provider via minimum NHS contribution
Bury Local Care Organisation	937,225	937,225	0	0	NHS community provider via minimum NHS contribution
Protection of Social Care	274,912	274,912	10446	10446	Private Sector LA discharge funding
Protection of Social Care	274,912	274,912	6.2	6.2	Private Sector LA discharge funding
Protection of Social Care	274,912	274,912	5.9	5.9	Private Sector LA discharge funding
Protection of Social Care	274,912	274,912	4.2	4.2	Private Sector LA discharge funding

Reablement Service	682,846	682,846	0	363	LA and LA Discharge Funding
Nursing Home Training	20,091	20,091	0	0	Private sector via minimum NHS contribution
Alzheimers Society	82,765	82,765	0	0	Voluntary sector via Minimum NHS contribution
Nursing Home Training	49,077	49,077	0	0	Private Sector via additional NHS contribution
Stroke Association	60,000	60,000	0	0	Voluntary Sector via additional NHS contribution
VCSE Housing Support	40,000	40,000	0	0	NHS Mental Health Provider via ICB Discharge funding
Same Day Emergency Care Frailty Ward	342,000	342,000	0	0	NHS Acute Provider via ICB Discharge Funding
Integrated Intermediate Care	1,826,403	1,826,403	540	540	LA via minimum NHS contribution
Integrated Neighbourhood Teams	1,353,747	1,353,747	0	0	LA via minimum NHS contribution

4.0 Reporting and checkpoints

4.1 It is expected that performance on spend and the outputs aligned to the main BCF programme will be reported on a quarterly basis. The reporting requirements have now been finalised for EOY and have been submitted to NHSE Better Care fund Team.

5. Links to the Bury Locality Plan

5.1 The Better Care Fund proposals should not be read in isolation but should be seen as a constituent part of the Bury Locality Plan and ''Let's Do It' 2030 Bury Strategy which sets out the entirety of the local approach to Health and Social Care transformation.

Recommendations for action

- That the Health and Wellbeing Board note the content of the EOY reporting submission

- That the Bury Health and Wellbeing Board retrospectively approve the attached Better Care Fund 2024/2025 EOY reporting submission and ratify the decision to submit to the national Better Care Fund team for assessment.

Financial and legal implications (if any)

- These proposals relate to the use of financial resources

- These proposals have been developed in partnership with the Bury Council s.151 Officer and the Bury Director of Finance.

Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

- None

CONTACT DETAILS:

Contact Officer: Hannah Dixon

Telephone number: 07919 963 240

E-mail address: h.dixon@bury.gov.uk

Date: 2nd June 2025

Bury HWB EOY Template.xlsx

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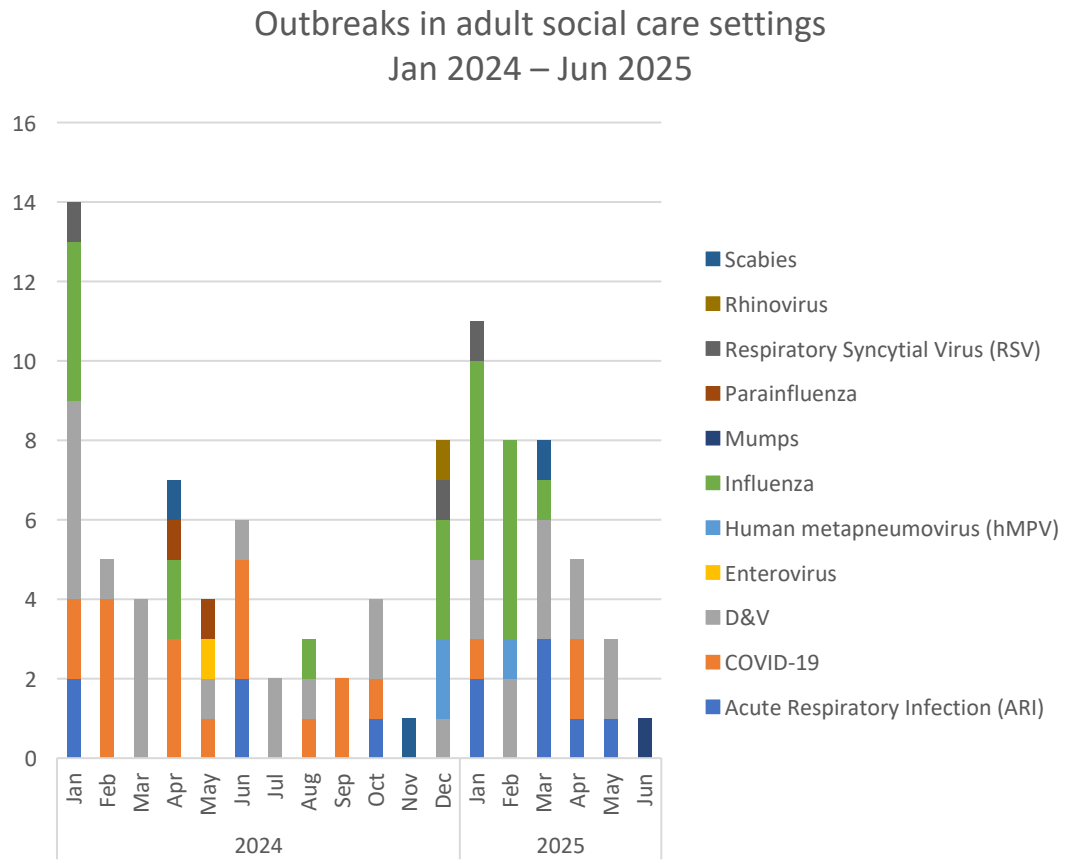
Bury Infection Prevention and Control Integrated Partnership (BIPCIP)
IPC Report May 2025
Annual Report Apr 24-Mar 25

Julie Parker
Head of Health Protection
Steven Senior
Consultant in Public Health

Current threats and issues

- **Adult social care:** 64 outbreaks from 1 April 2024 – 31 March 2025. Down from 77 for 2023/24. Most common: COVID-19, flu, D&V.
- **Schools and early years settings:** 16 reported outbreaks from 1 April 2024 – 31 March 2025. Most common: D&V, chickenpox.
- **Measles:** no confirmed cases in Bury between 1 April 2024 and 31 March 2025 (last confirmed case 20 March 2024). **But** increasing case numbers in Greater Manchester, including in neighbouring boroughs.
- **Antimicrobial resistant infections**: e.coli and c.difficile infections increasing, pseudomonas, klebsiella and MRSA infection rates flat or decreasing.



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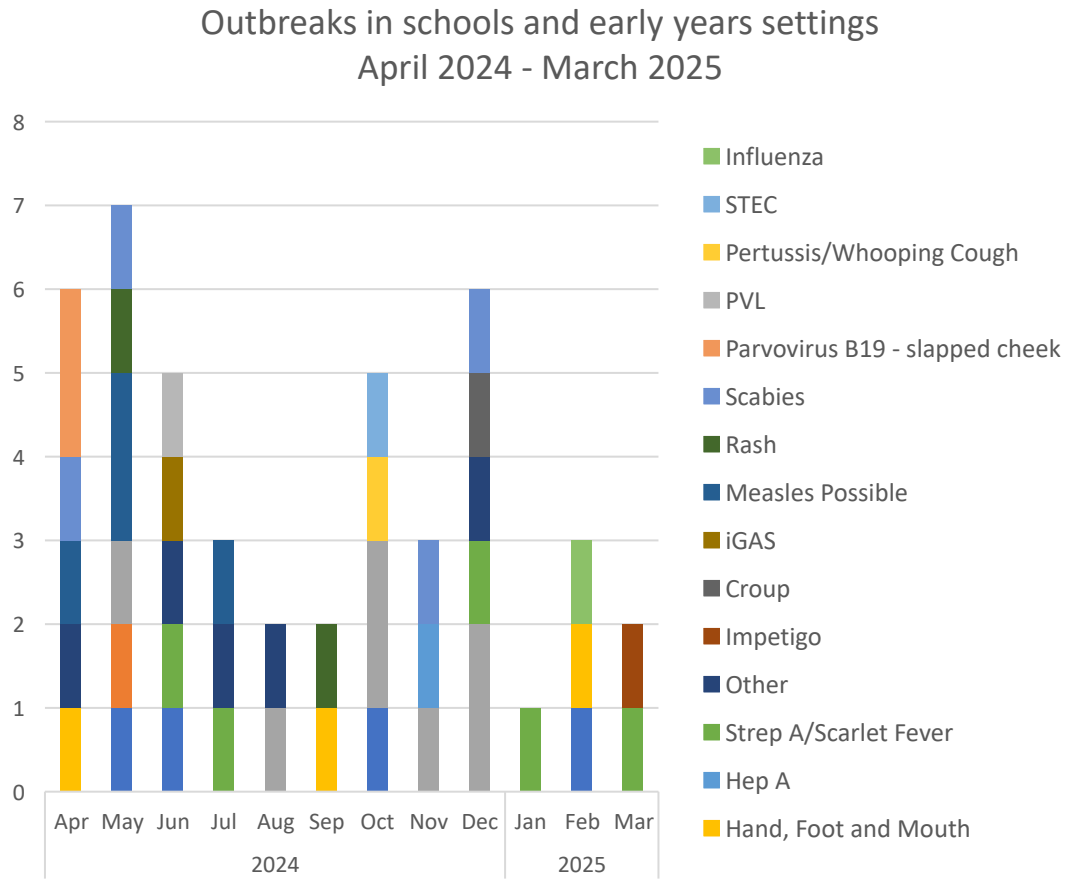
Current threats and issues (continued)

- **Schools and early years settings:** 16 reported outbreaks from 1 April 2024 – 31 March 2025. Most common: D&V, chickenpox.
- **Measles:** no confirmed cases in Bury between 1 April 2024 and 31 March 2025 (last confirmed case 20 March 2024). **But** increasing case numbers in Greater Manchester, including in neighbouring boroughs.
- **Extreme weather:** Limited risk of heatwaves or flooding in the short term. Monitoring Met Office warning system for advance notice.
- **Environmental hazards:** Reduced complaints from Pilsworth landfill site, reduced activity on site. Air quality monitoring suggested limited exposure to pollutants currently. Environment Agency is responsible for enforcement. The operator has recently submitted planning application to extend the site.



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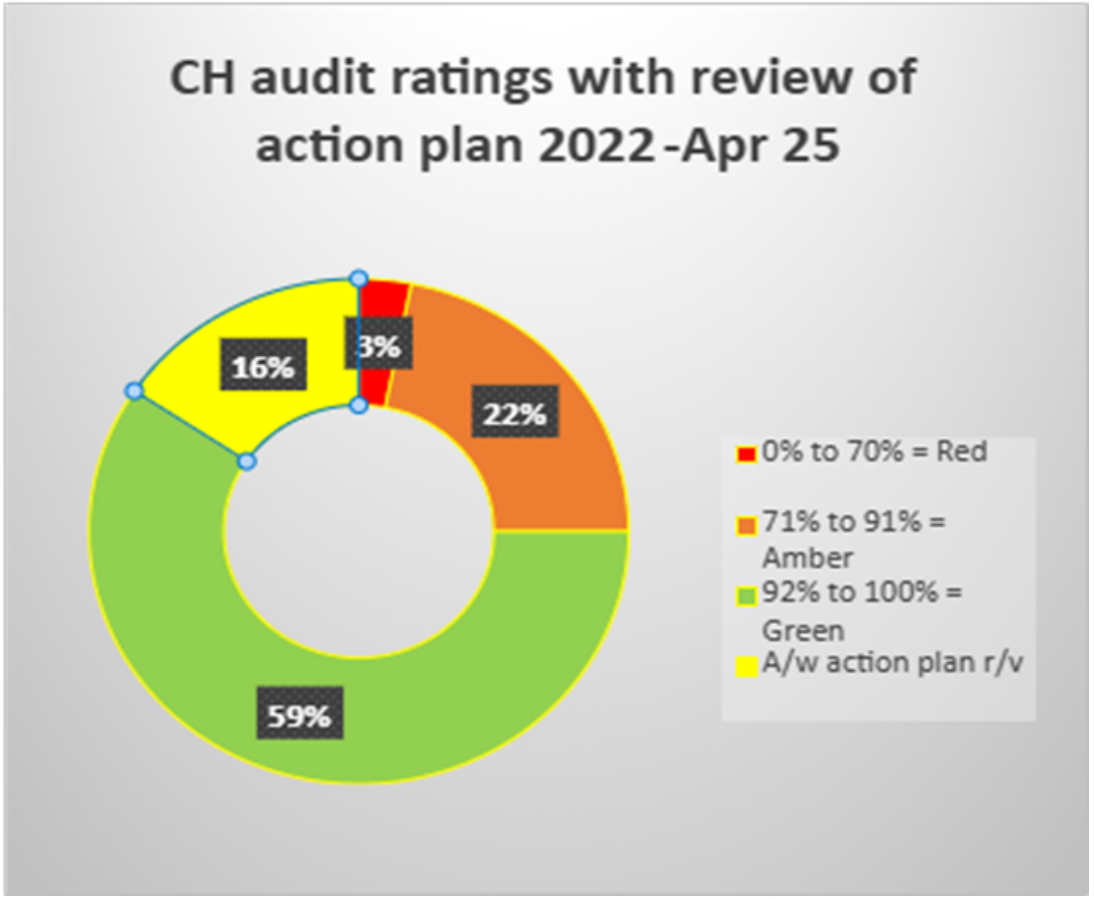
Activity

- **Outbreak response:** reactive infection control advice provided to 90 outbreaks.
- **Infection control audits:** 18 IPC audits or informal visits from April 24-March 25 (up 80% from 2023-24). Audits are prioritised for homes with highest risk (most outbreaks, known issues with IPC, or adverse CQC inspections). 26% increase in green ratings after audit and action plan review. Joint visits with adult social care staff where possible. Self-audit for low risk settings. Learning points shared including on Legionella risk, cleaning and disinfection- developing Cleaning Method Statement templates
- **Antimicrobial resistance:** Bury staff making a significant contribution to the GM AMR IPC group. Oral health care training rolled out to care homes.



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Activity

- **Measles response:** information and guidance sent to schools and early-years settings, general practices, council communications and local communities at highest risk of exposure and/or where MMR vaccine uptake is lower.
- Commissioned MMR catch up clinics on behalf of NHS Greater Manchester ICB. Over 800 MMR doses delivered plus over 300 other vaccinations. Uptake for Bury practices increased more than average for Greater Manchester.
- **Other immunisations:** working with GP Federation to promote uptake of pneumococcal, shingles, and RSV vaccines through GP practices.
- Scrutiny and assurance of all immunisations programmes through local vaccine assurance group

MMR catch up results

IMD decile	GP Fed	% of GP Fed	Bury PCN	% of PCN	Total	% of total
Most deprived 1	22	12%	460	39%	482	35%
2	48	25%	312	26%	360	26%
3	31	16%	250	21%	281	21%
4	13	7%	83	7%	96	7%
5	11	6%	0	0%	11	1%
6	15	8%	38	3%	53	4%
7	12	6%	5	0%	17	1%
8	21	11%	27	2%	48	4%
9	5	3%	3	0%	8	1%
Least deprived 10	11	6%	1	0%	12	1%
Total	189	100%	1179	100%	1368	100%

Ethnic category	GP Fed	% of GP Fed	Bury PCN	% of PCN	Total	% of total
Asian or Asian British	53	28%	334	28%	387	28%
Black or Black British	6	3%	156	13%	162	12%
White	81	43%	211	18%	292	21%
Mixed	7	4%	201	17%	208	15%
Other ethnic groups	43	23%	268	23%	311	23%
Not known	0	0%	9	1%	9	1%
Total	190	100%	1179	100%	1369	100%

Bury Council

Activity

- **Extreme weather planning:** action cards and communications shared with partners.
- **Other:**
- Supported ICB to get primary care networks to sign up to FFP3 mask fit test training.
- Updated IPC section on Bury Directory launched January 25 .
- Developed poster to improve CH staff awareness about outbreak processes.

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Sexual Health Needs Assessment

Oldham, Rochdale, Bury

12th June 2025

1. Introduction

What is a Health Needs Assessment?

Health Needs Assessments (HNA) assess how well the health and care needs of a local population are being met.[1] Regular HNAs are important as the needs of the population are ever-changing. This includes systematically reviewing trends in the supply and demand of services, as well as gathering a range of feedback. NHS, voluntary sector, and council-run services are all taken into consideration. This evidence helps to set priorities and recommend actions for improvement. HNAs are usually focused on a specific topic area or group, such as sexual health.

Existing local ***Sexual Health Needs Assessments (SHNA)*** include:

- Young Peoples SHNA: Bury (2023) [2]
- SHNA: Oldham Bury Rochdale (2020) [3]

What is sexual health?

Sexual health can be described as ***"…a state of physical, emotional, mental and social well-being in relation to sexuality"***. [4] Rather than just focusing on illness, this emphasises the need for a positive and respectful approach to sexuality and sexual relationships. This SHNA encompasses a wide range of topics, including sexually transmitted infections (STIs) and reproductive health, and explores recent changes within Oldham, Rochdale, and Bury (ORB).

Sex: Biological status as male, female, or intersex, assigned at birth based on physical characteristics.	**Gender Norms:** The cultural roles, behaviours, activities, and attributes expected of people based on their sex.
Sexual Orientation: A person's sexual, physical, and/or emotional attraction to another person, or lack thereof.	**Gender Identity:** An individual's sense of self as a man, woman, transgender, non-binary, or other gender identity.

Table 1: Definitions related to sex, gender, and sexual orientation.[5, 6]

Context

Sexual health affects everyone and therefore belongs on the national agenda. In 2024, **4.5 million consultations** were delivered by sexual health services in England. [7, 8] However, since 2013, **spending on local authority-funded sexual health services in England has been cut by 29%.**[7, 9]

In 2022, the Faculty of Sexual and Reproductive Health (FSRH) published the Hatfield Vision, outlining the stark challenges faced by sexual health services in the UK. [10] This was closely followed by the **Women's Health Strategy for England**, which set out the government's life course approach to improve the health of women and girls. [11] Greater Manchester (GM)

responded in 2023 with its own action plan, with scope for GM-wide and locality-specific strategies. [12]

Pressure to prioritise sexual health continues to build. In 2024, the FSRH released a Manifesto calling on the incoming Government to take action.[13] The evidence is clear: investing in sexual health is not only vital for the health and well-being of the nation, but also cost-effective. For example, **every £1 spent on contraceptive services is estimated to save £9** in the long run [14].

The goal is to improve sexual health access, experience, and outcomes for all. However, it is also vital to address the persistent **health inequalities** that exist. Where you live, your age, ethnicity, economic background, sexual orientation, gender identity, religion, mental and physical health, or any protected characteristic should not be a barrier to your sexual health.

This aligns with the **Public Health Outcomes Framework** (PHOF), which sets out a vision to:

1) Improve and protect the nation's health
2) Improve the health of the poorest, fastest [15]

The high-level outcomes are to increase healthy life expectancy overall, whilst reducing differences in **life expectancy and healthy life expectancy** between communities.
Sexual and reproductive health (SRH) plays a key role in this challenge. Prescribing of long-acting reversible contraceptives, under-18 conception rates, new STI diagnoses, and presentations with HIV at a late stage of infection are all indicators included in the PHOF. This SHNA analyses PHOF measures and other relevant data to assess local sexual health inequalities across ORB.

Spotlight on COVID-19

The COVID-19 pandemic was a challenging time for all health and care services, and SRH teams had to adapt to unpredictable circumstances. A reduction in SRH activity is captured in this report; for example, the data shows fewer contraception prescriptions during this time. In April 2020, the Association of Directors of Public Health (ADPH) published recommendations for the continuation of essential SRH services, acknowledging the potential short and long-term public health implications.[16]

SRH behaviours and expectations also shifted, and some of these changes have persisted post-pandemic. For example, although STI testing initially reduced, the pandemic subsequently accelerated the provision of online self-sampling. [17] Online appointments have also increased significantly, rising from 2% in 2017 to 40% of SH clinic consultations following COVID-19.[17] Although a rise in virtual services may improve accessibility for some, a lack of face-to-face appointments may potentially widen health inequalities, and therefore, services must be aligned with the needs of the local population.[17]

2. Demographics

Understanding the local population is vital to plan and adapt services to meet demand. This includes the capacity of service providers, which services to offer, and where to target interventions. This is particularly important for addressing inequalities. For example, across England, rates of new STI diagnosis remain consistently high in certain groups[17]:

- young heterosexuals aged 15 to 24 years
- black ethnic populations
- gay, bisexual and men who have sex with men (GBMSM)
- people residing in the most deprived areas

However, it is important to recognise that these groups are heterogenous, and individuals will vary widely in terms of sexual behaviour and risk. Intersectionality, which describes how characteristics interact, adds further complexity. This highlights the importance of working with service users with real life experience, and not just relying on statistics to design services.

Oldham, Rochdale and Bury

Oldham, Rochdale and Bury (ORB) have an estimated combined population of 671,362 people [18]. The population pyramid below shows the distribution of people in ORB by age and sex compared to England overall [19]. In keeping with national trends, there is a higher number of females in ORB, approximately 13,500 more than males.

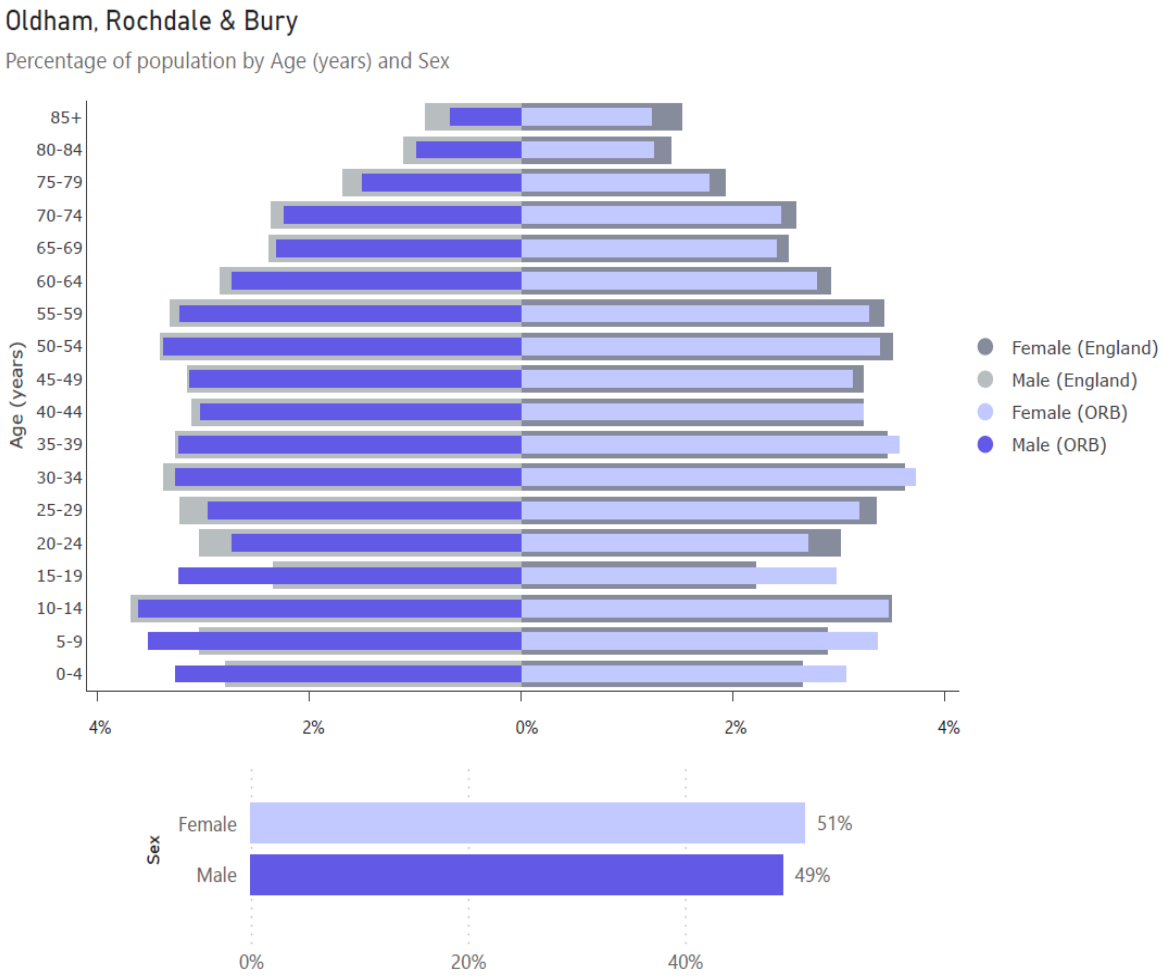


Figure 1.1: Oldham, Rochdale and Bury population pyramid based on 2021 census[19].

Deprivation

Each of the 10 local authorities in GM have neighbourhoods among the most deprived in the country, measured by the 2019 Index of Multiple Deprivation (IMD)[20]. This metric considers data related to income, employment, education, health, crime, barriers to housing and services, and living environment.

Rochdale and Oldham both rank within the top 10% most deprived local authorities in the country, whereas Bury is closer to the national average. Figure 1.2 shows IMD values across GM, and the map indicates deprivation across Bury, Rochdale and Oldham respectively (clockwise).

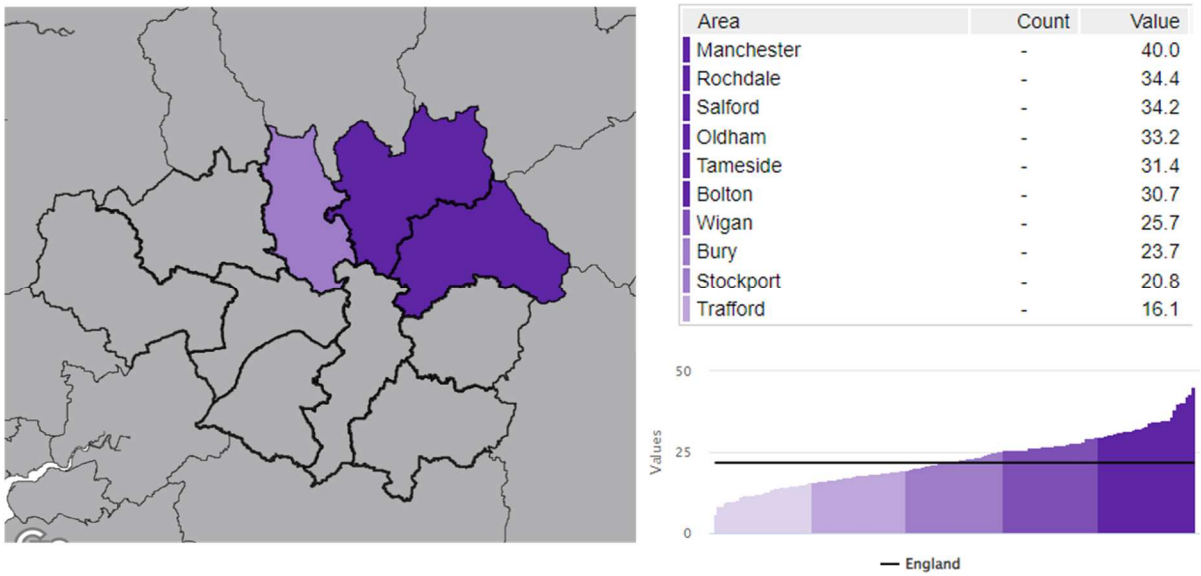


Figure 1.2: 2019 IMD score distribution for upper tier local authorities in England, map shaded by quintile for Oldham, Rochdale and Bury [21].

Life expectancy

The graph below represents Life Expectancy (LE) and Healthy Life Expectancy (HLE) within ORB compared to England. LE across ORB is lower than average, and in keeping with national trends males have a shorter LE than females. The proportion of years expected to be lived in good health in Bury is similar to the national average, but considerably worse in Oldham and Rochdale. HLE is an important indicator of morbidity and reflects demand on health and care services.

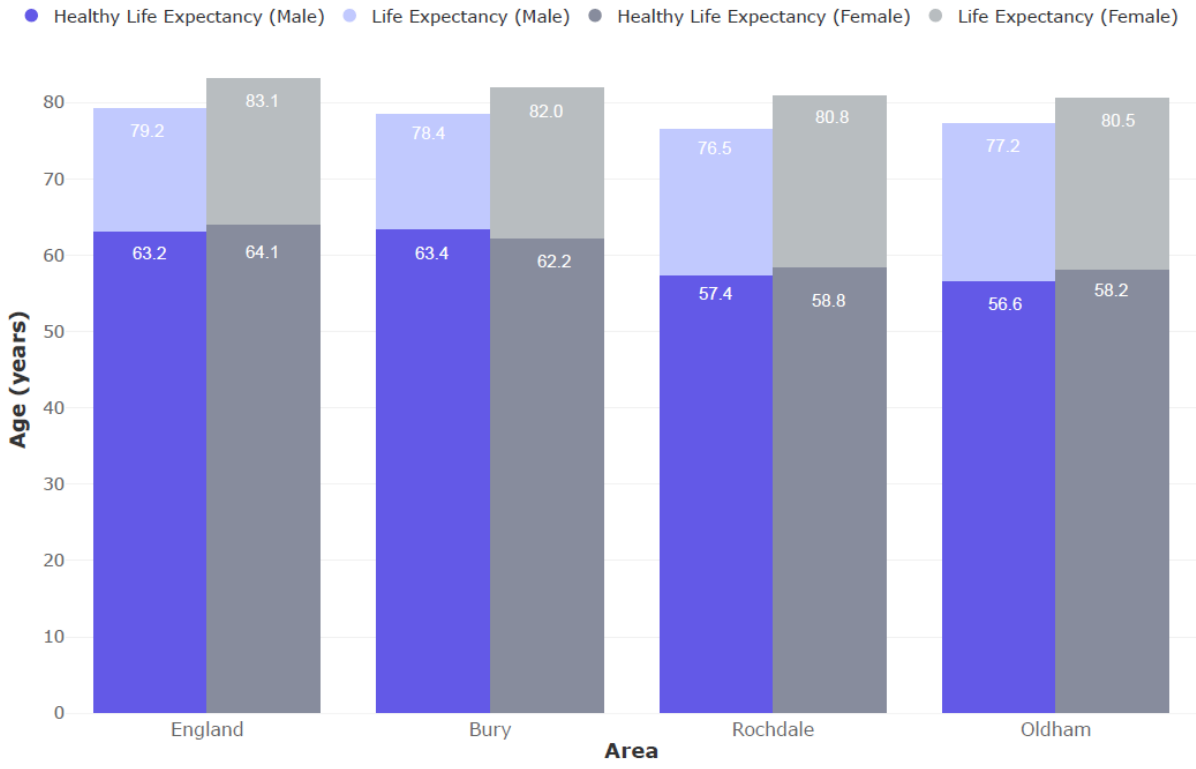


Figure 1.3: Life expectancy and healthy life expectancy by sex for ORB and England (2018-20)[21]

Oldham

Oldham's population was recorded as 242,100 in the 2021 census, and is expected to reach 261,000 by 2041.[22] Figures 1.4 and 1.5 demonstrated Oldham's relatively young population, with a higher proportion of residents aged under 20 compared to the national and GM averages. However, as the population ages, by 2041 the number of people over 65 years old is expected to increase by 30%. The majority of residents in Oldham identify as White ethnicity (68.1%), while the second largest group is Asian, Asian British or Asian Welsh (24.6%).

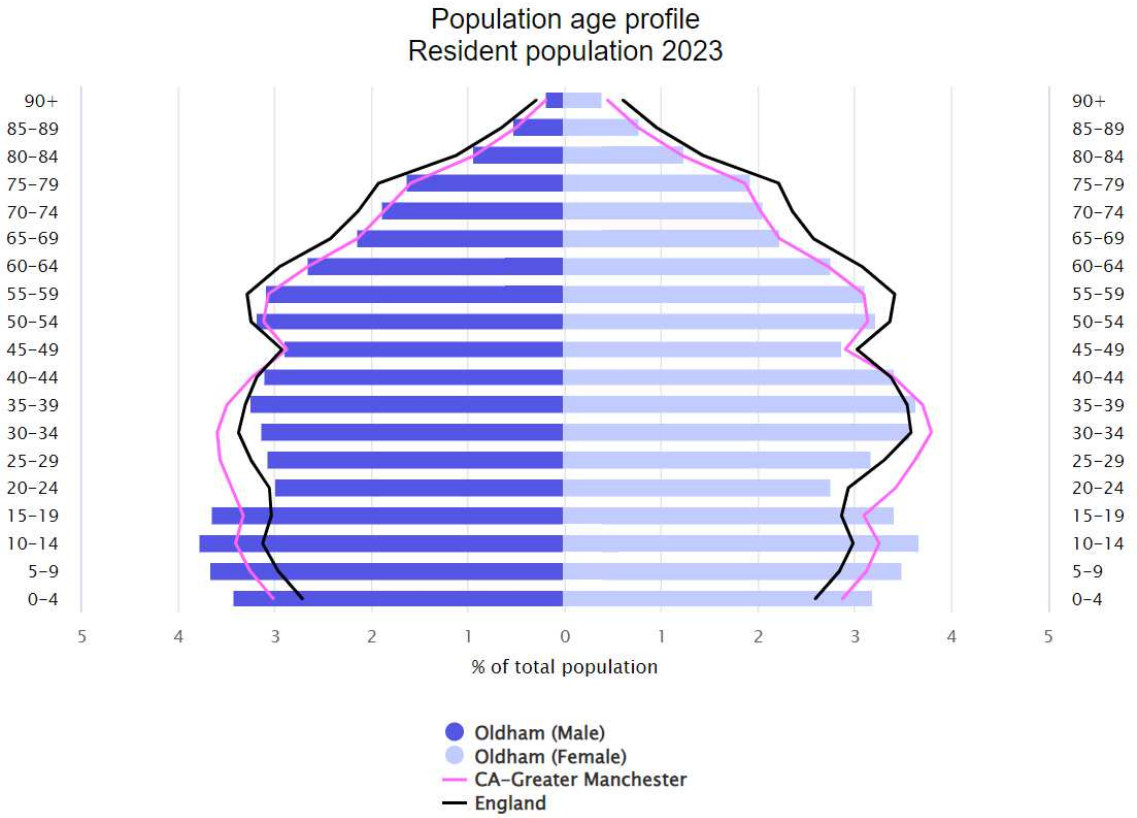


Figure 1.4: Population pyramid for Oldham [21]

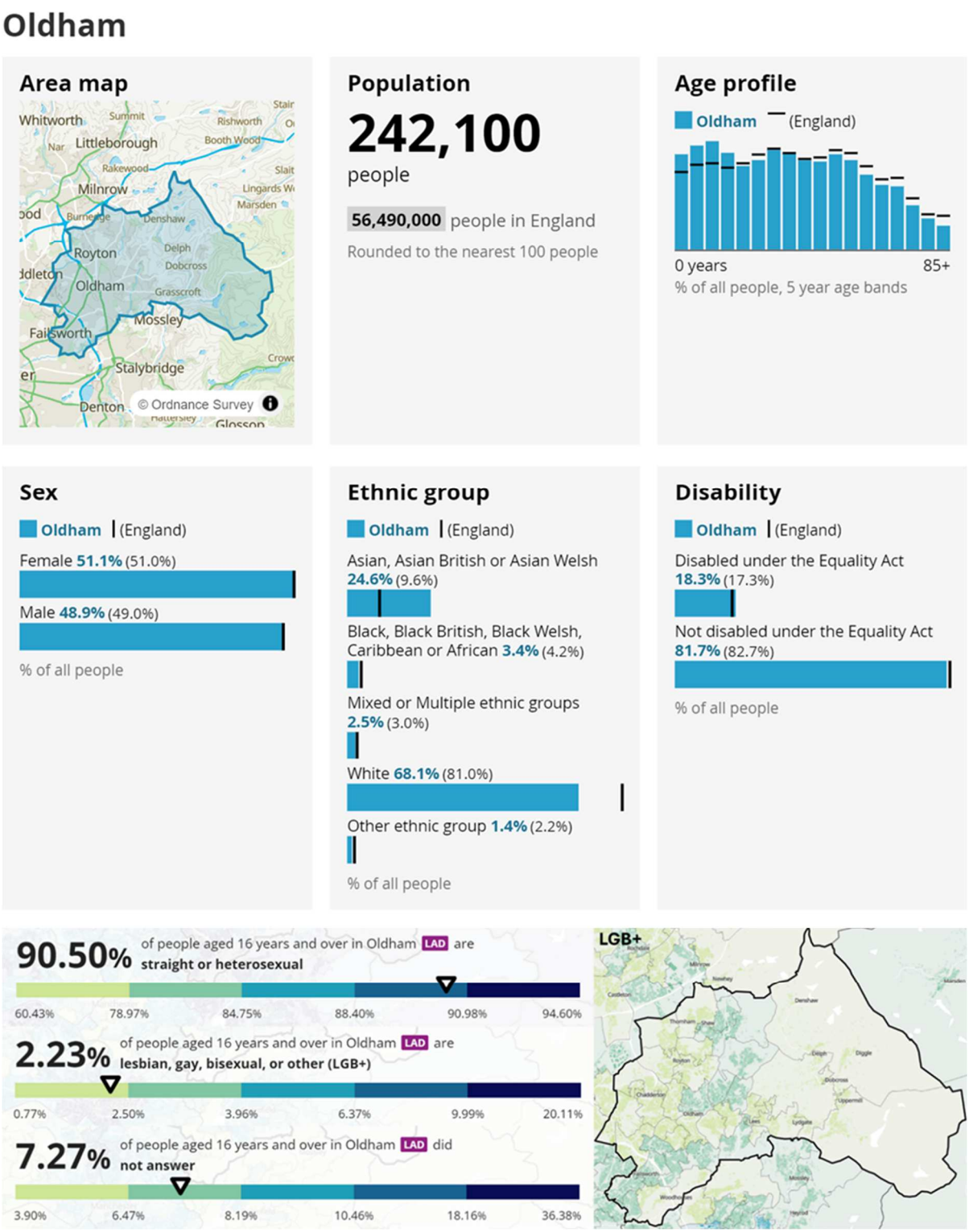


Figure 1.5: Demographic profile for Oldham: local authority boundaries, and population by size, age, sex, ethnic group, disability and sexual orientation. [(19)]

Figure 1.6 displays deprivation across Oldham as measured by the IMD for 2019. Each area represents approximately 1,500 residents or 650 households, and therefore more densely populated areas appear smaller[(23)]. Five of these small areas fall in the bottom 1% of overall IMD nationally. A 10-colour scale has been used to shade in each individual area according to

the level of deprivation. The lightest green represents the least deprived populations, and the darkest blue represents the most deprived.

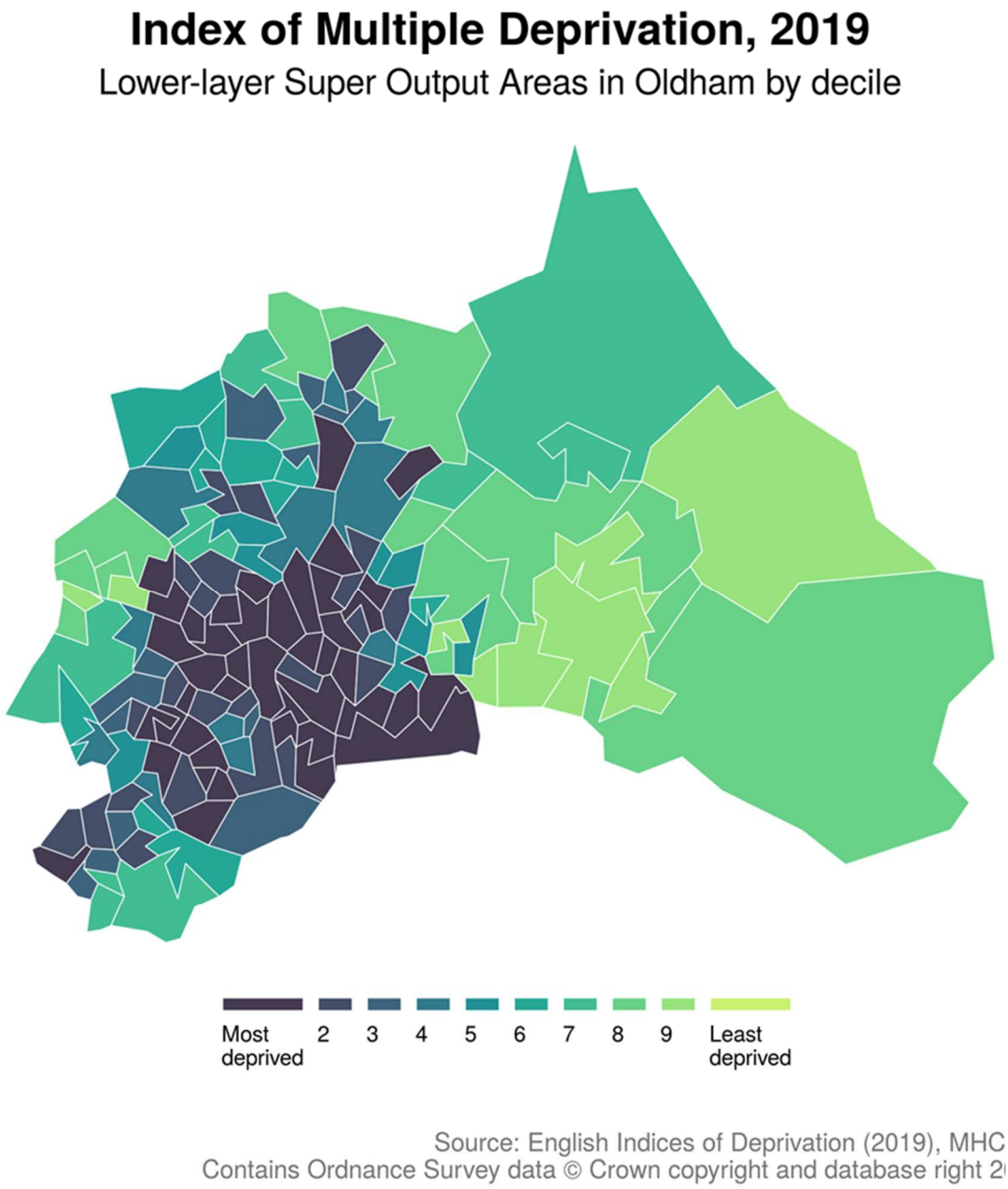


Figure 1.6: Indices of Multiple Deprivation within Oldham[23]

Rochdale

Rochdale's population was recorded as 223,800 in the 2021 census, and similar to Oldham is predicted to grow over the coming decades, particularly within the older age groups[24]. Figures 1.7 and 1.8 demonstrate that Rochdale also has a higher proportion of residents aged under 20 compared to the national and GM averages. Compared to Oldham, the proportion of ethnically Asian, Asian British or Asian Welsh residents in Rochdale is slightly lower (18.5%), but still higher than the national average (9.6%).

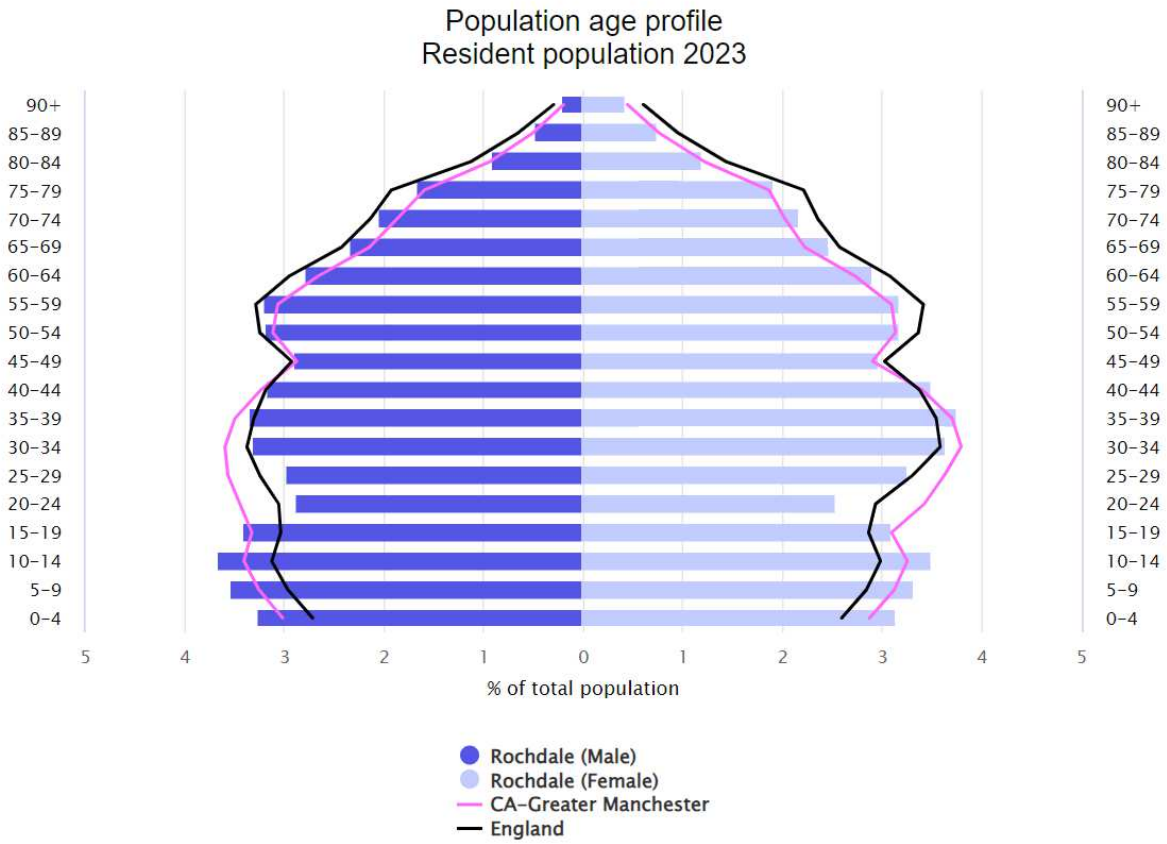


Figure 1.7: Population pyramid for Rochdale [21]

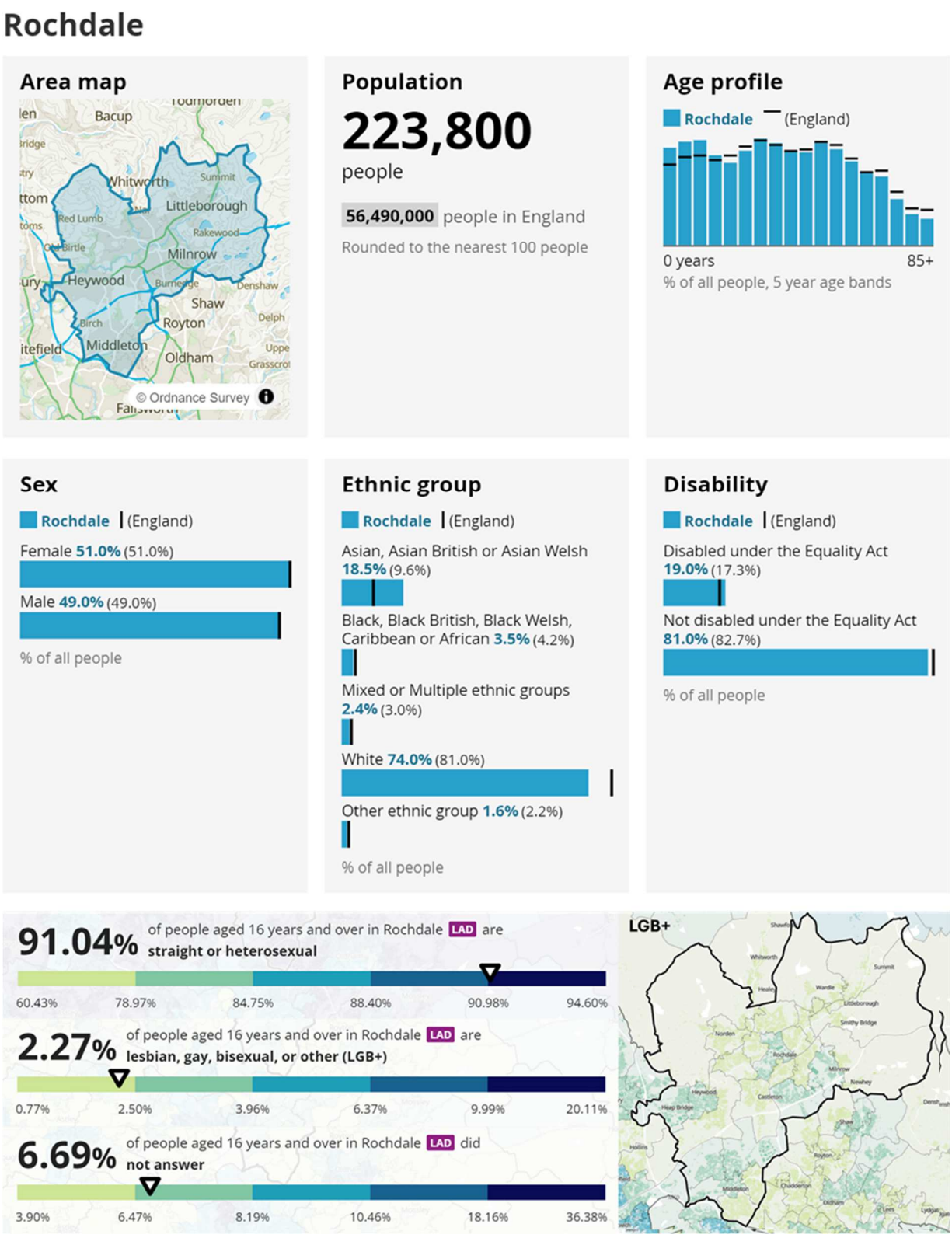


Figure 1.8: Demographic profile for Rochdale: local authority boundaries, and population by size, age, sex, ethnic group, disability and sexual orientation. [(19)]

Figure 1.9 displays deprivation across Rochdale as measured by the IMD for 2019. The darkest blue zones belong to the 10% most deprived areas in England. Both Rochdale and Oldham are

amongst the top 20 local authorities in England with the highest proportion of neighbourhoods within this category.

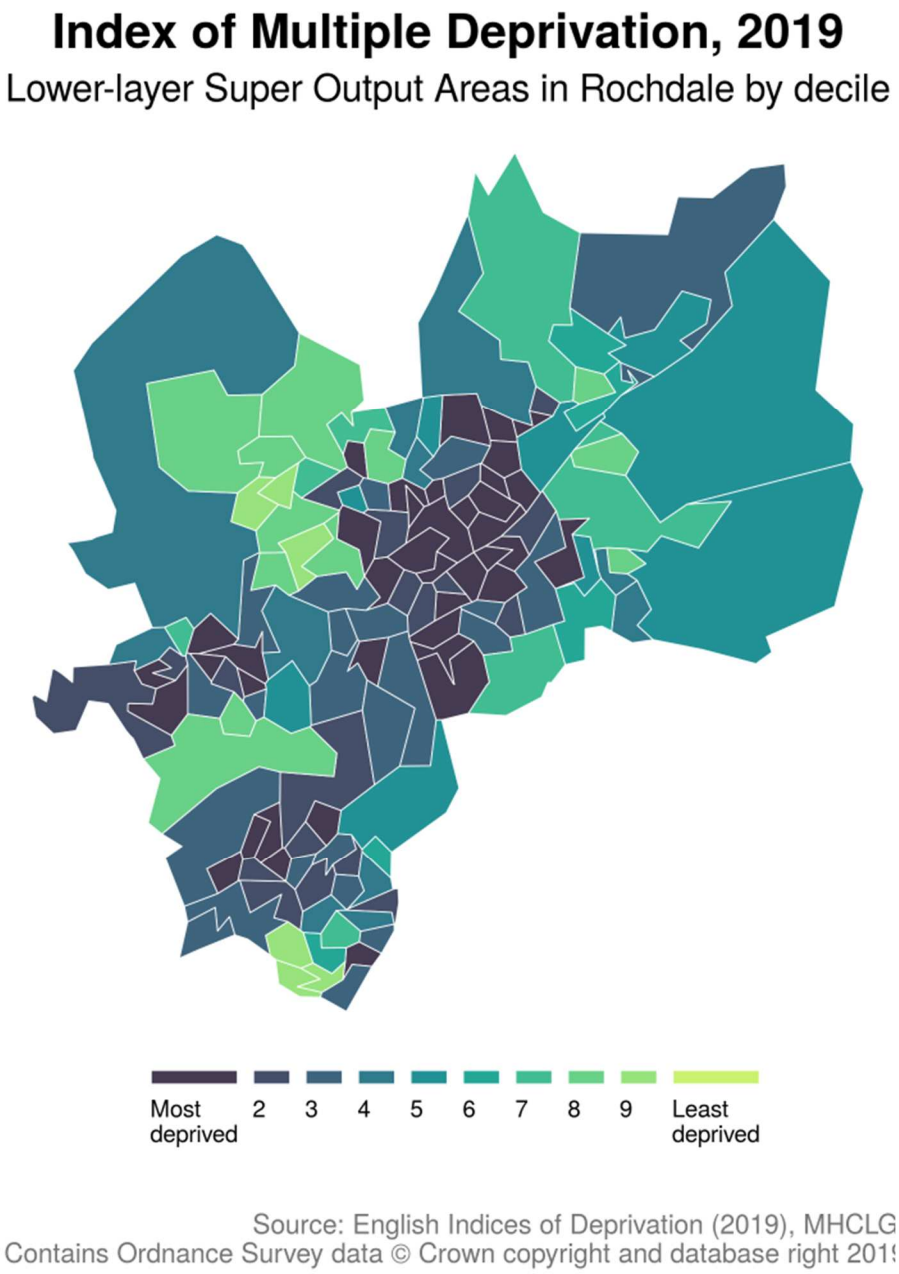


Figure 1.9: Indices of Multiple Deprivation within Rochdale[23]

Bury

Bury's population was recorded as 193,600 in the 2021 census, which is smaller than Oldham and Rochdale.[25] Although the population in Bury is predicted to grow over the next decade, it is projected to increase at a slower rate than the average for England. Figures 1.10 and 1.11 demonstrate that the distribution of ages in Bury is close to the national average, however a significantly smaller proportion of the population is ethnically Black, Black British, Black Wesh, Caribbean or African (1.9% vs 4.2%).

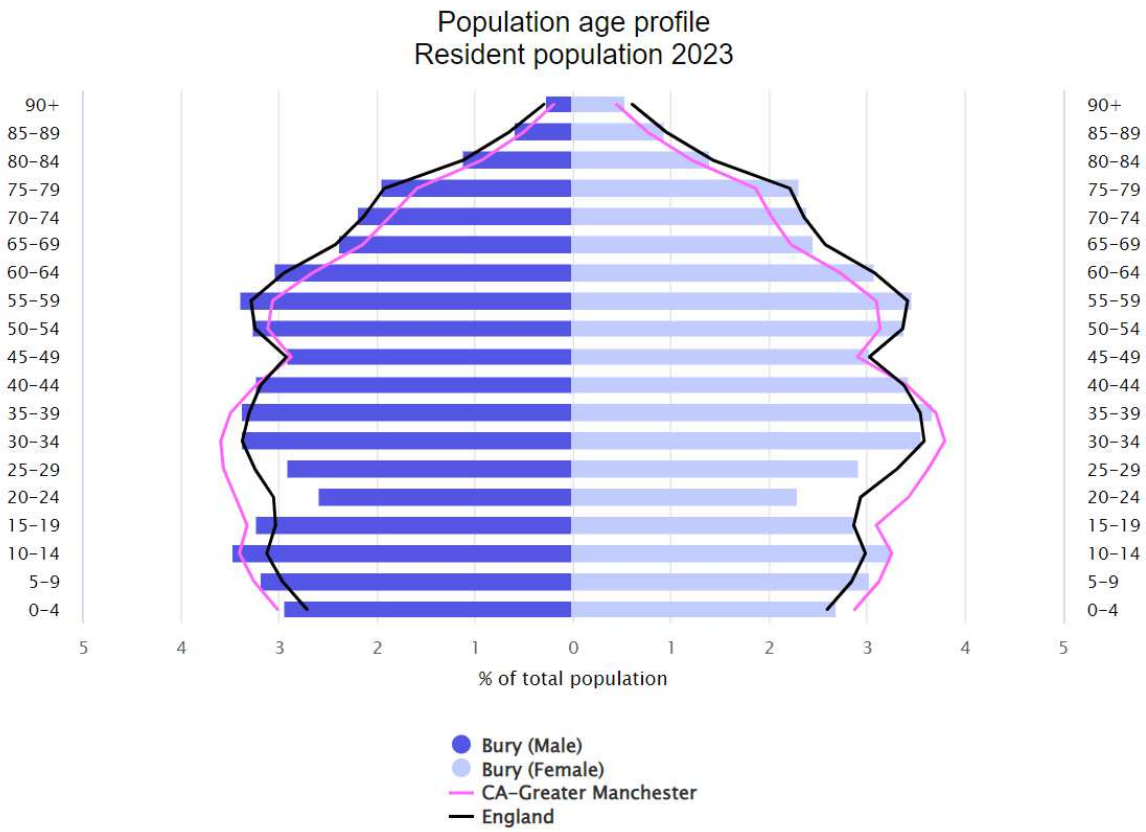


Figure 1.10: Population pyramid for Bury [21]

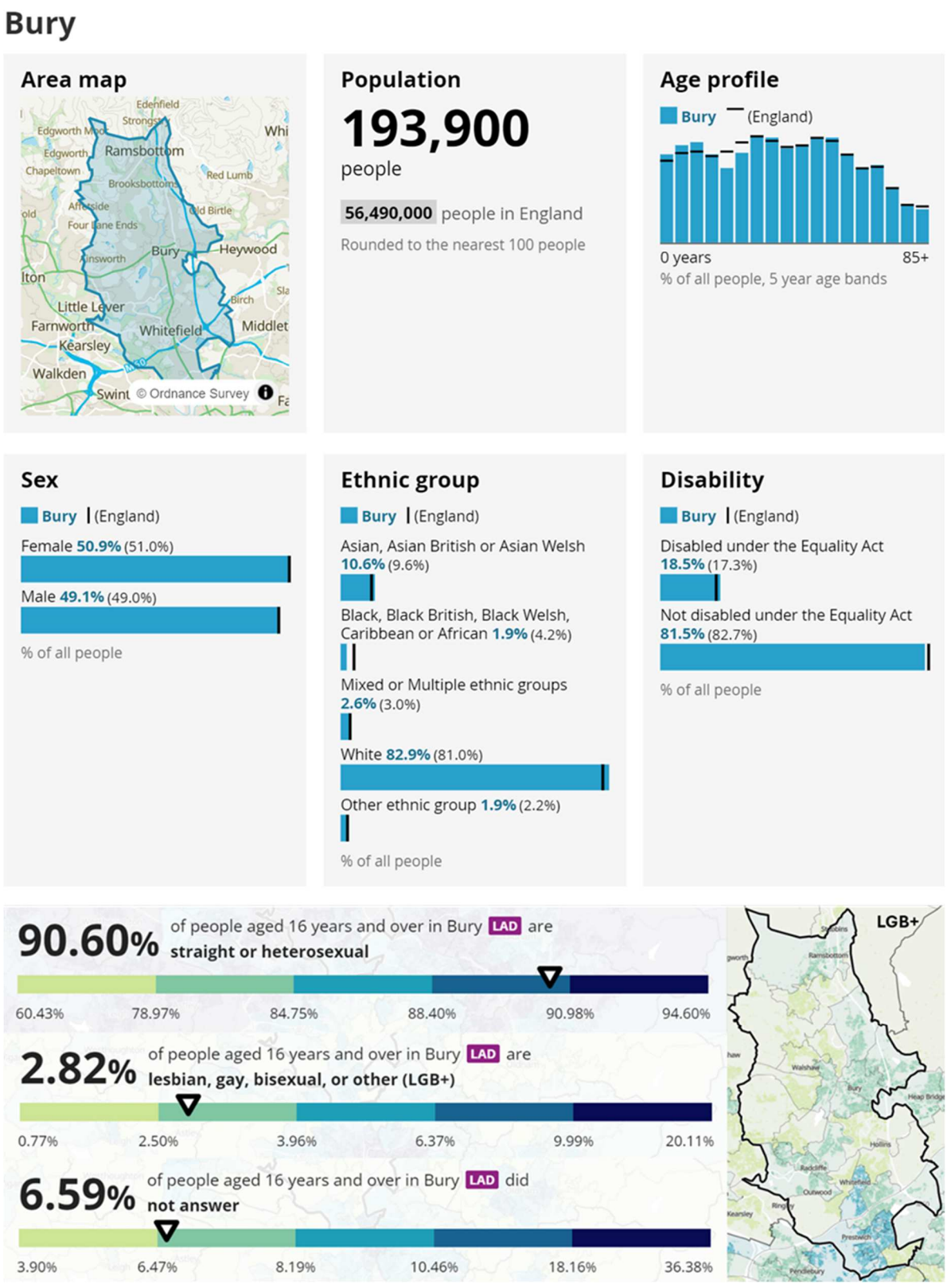


Figure 1.11: Demographic profile for Bury: local authority boundaries, and population by size, age, sex, ethnic group, disability and sexual orientation. [19]

Figure 1.12 displays deprivation across Bury as measured by the IMD for 2019. Out of the 10 local authorities that make up GM, Bury is the 8th most deprived, as shown in Figure 1.2.[21]

However, Bury is still slightly more deprived than the national average, as the North of England is generally has higher rates of deprivation than the South.

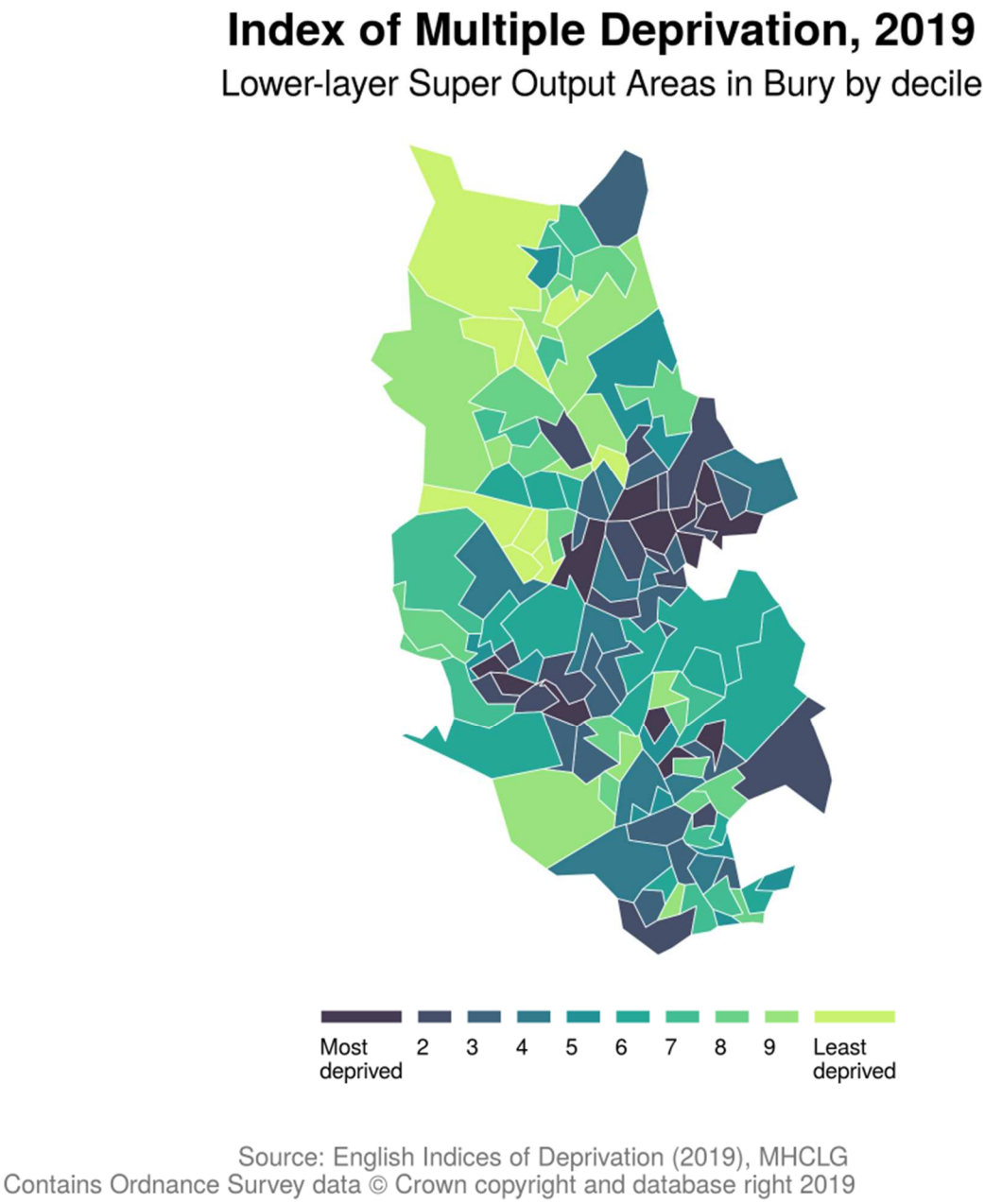
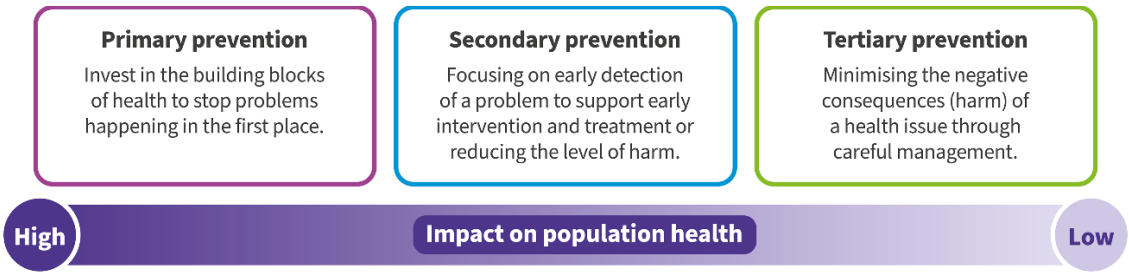


Figure 1.12: Indices of Multiple Deprivation within Bury[23]

3. Sexually Transmitted Infections

Sexually transmitted infections (STIs) are infections that are spread primarily through person-to-person sexual contact. A challenge for sexual health services is that many STIs are asymptomatic. Therefore, people may not know they have an STI, so they will not seek treatment and may inadvertently pass on an STI to others. However, even without any symptoms, STIs have the potential to cause significant harm, both to the reproductive system, sometimes leading to infertility, and to all other body systems. An additional challenge is the stigma associated with STIs, which can act as a barrier to people accessing services.

In light of these challenges, plus the wide range of STIs and people affected, the public health response is complex.[26] Categorising actions into primary, secondary, and tertiary prevention is a helpful way to simplify this. These strategies adapt according to the time, place, person, and STI.



Level of Prevention	Example	Rationale
Primary	Vaccination	Reduce the spread of STIs
Secondary	Screening	Detect asymptomatic STIs
Tertiary	Treatment	Reduce the harm caused by STIs

Figure 2.1: Examples of the 'three levels of prevention'. [27]

The UK Health Security Agency (UKHSA) is the government agency responsible for public health protection across England, including threats from infectious diseases such as STIs.[28] Historically, their main goal was to reduce the prevalence of STIs, focusing on reducing the number of infections. However, not only are STI rates increasing, but so are their harmful effects.[17]

In October 2024, UKHSA published the 'STI Prioritisation Framework' to assist the planning and provision of local sexual health services, which has been applied to this SHNA.[17] This framework shifted towards preventing adverse health outcomes caused by STIs, focusing on reducing health inequalities. The first step in the framework is to take a closer look at the local disease burden. The following chapter looks at STI trends in ORB and places a spotlight on key emergent themes.

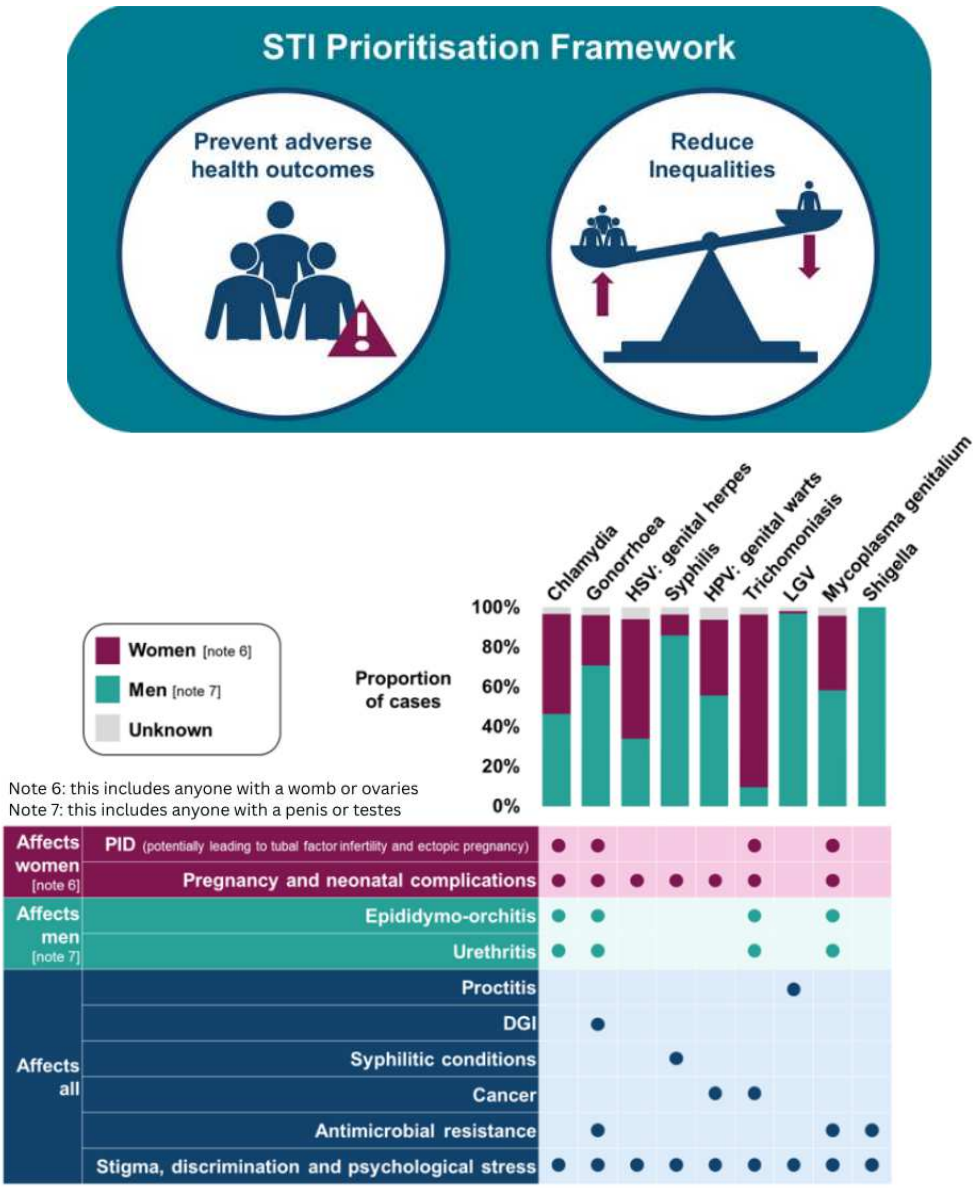


Figure 2.2: Vision of the STI Prioritisation Framework and summary of STI-related adverse health outcomes by pathogen (DGI = Disseminated gonococcal infection). [17]

Background

Rates of new STI diagnoses vary by age, gender, ethnicity, sexual orientation, geographical location, and socioeconomic status. For example, the highest rate of new STIs amongst women is between 15 and 24 years old, whereas for men, rates peak between 20 and 29.[29] Diagnoses of new STIs are higher in older men than older women, and bacterial STI diagnoses specifically are more common amongst GBMSM and people of black ethnicity. [29]

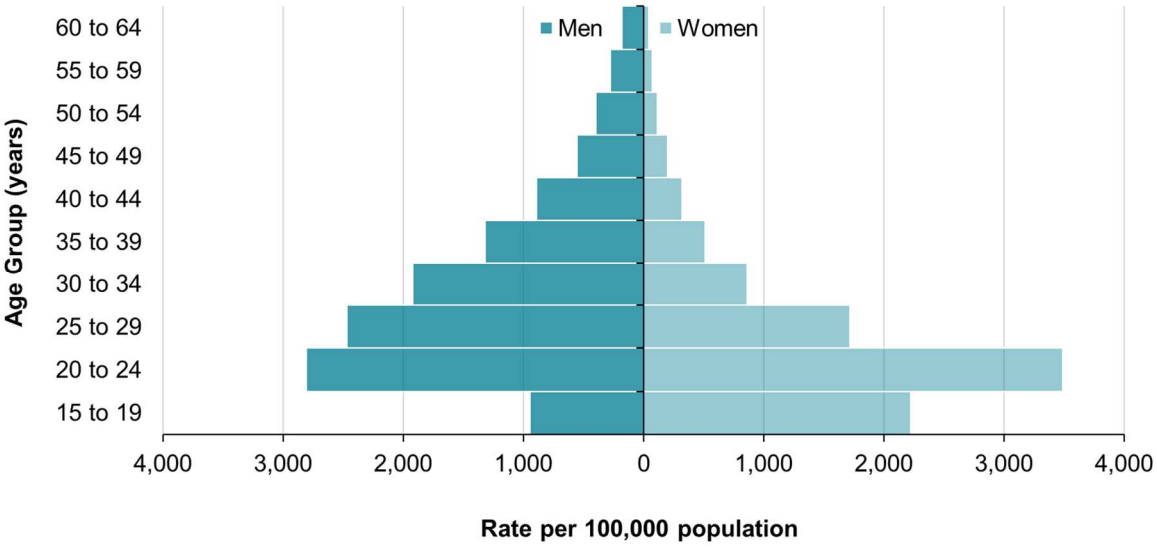


Figure 2.3: Rates of new STI diagnoses by gender and age group: England, 2023.[29]

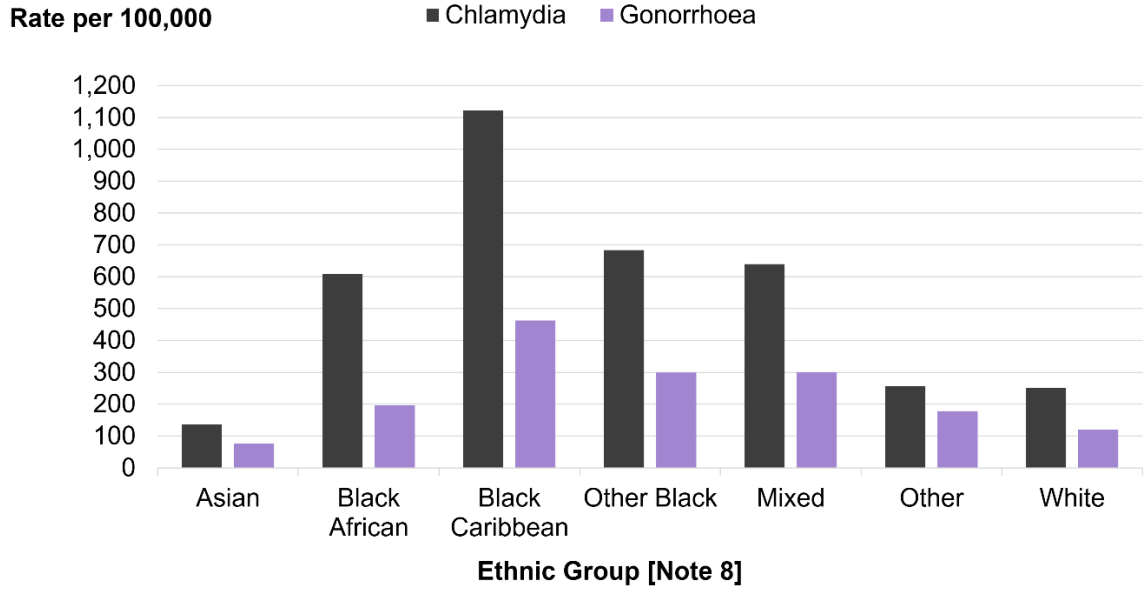


Figure 2.4: Rates of chlamydia and gonorrhoea diagnoses among England residents accessing SH services by ethnicity, 2023 (note 8: the ethnic categories above are as specified by the Office for National Statistics.[29]

The rate of STI diagnoses in ORB has been consistently lower than the English average for the last decade. However, not everyone with an STI will get tested, and therefore, disease prevalence is likely to be significantly higher than the figures presented. In keeping with national trends, the number of STIs diagnosed in ORB in 2024 decreased compared to the previous year. [8]

Figure 2.6 shows that STI testing rates are below average in ORB, potentially leading to a sizeable burden of undetected disease.[21] There was a pronounced dip in STI testing towards the start of the COVID-19 pandemic, but subsequently rates have recovered and continued to rise.

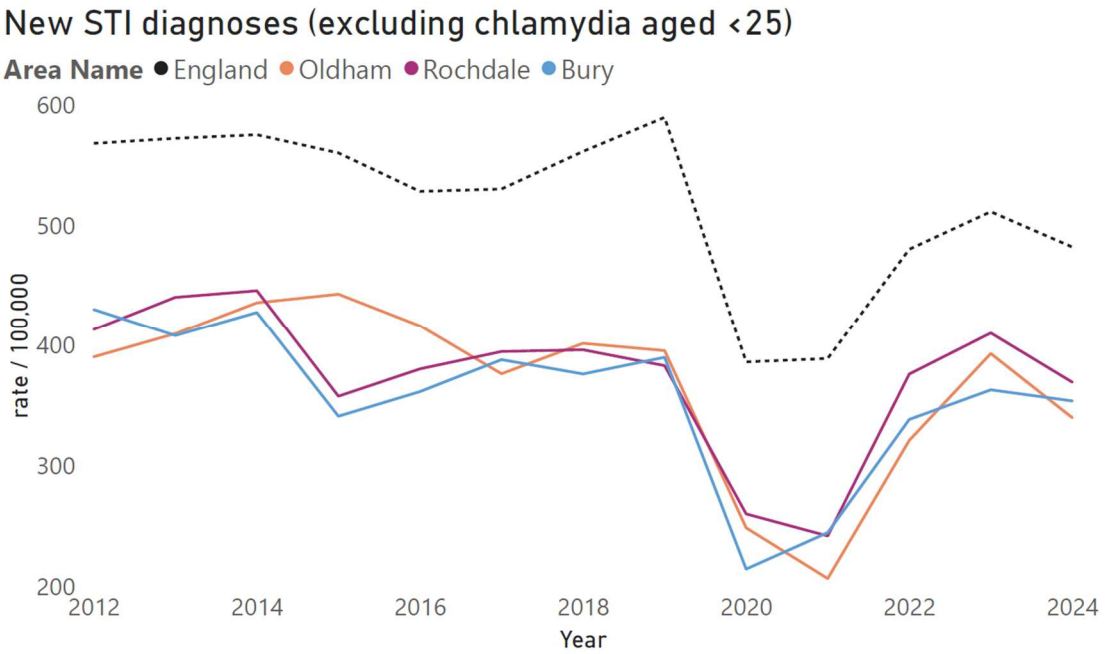


Figure 2.5: New STI diagnoses (excluding chlamydia <25) per 100,000. [21]

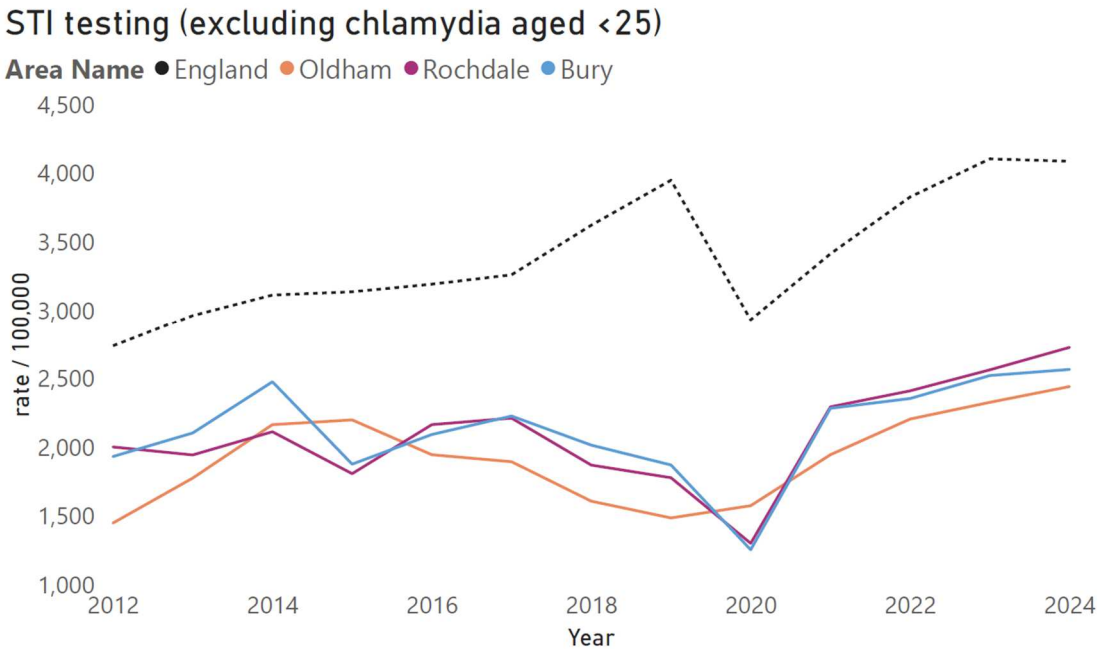


Figure 2.6: STI testing rate (excluding chlamydia <25) per 100,000. [21]

Chlamydia

Chlamydia is the most common STI in England, and represented 46.3% of new STI diagnoses in 2024.[8] This explains the exclusion of chlamydia detection from certain statistical reports, specifically under 25 years, as the high rates would eclipse the rest of the data. Comparing Figure 2.7 to Figure 2.8 demonstrates the discrepancy between different age groups. In Oldham, for example, the overall diagnostic rate peaked at just over 600, whereas for 15 to 24-year-olds the peak was closer to 5,000. Chlamydia detection peaks in the early 20s for both men and women; however, rates are higher amongst women before the age of 25 and amongst men subsequently. [29]

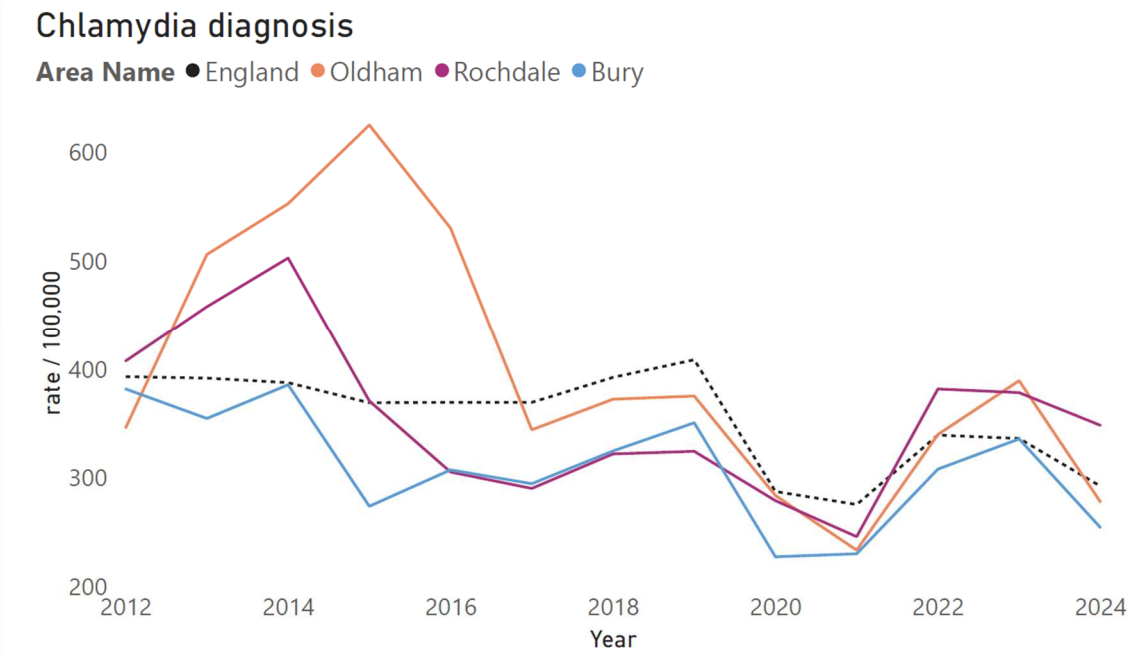


Figure 2.7: Chlamydia diagnostic rate per 100,000 persons. [21]

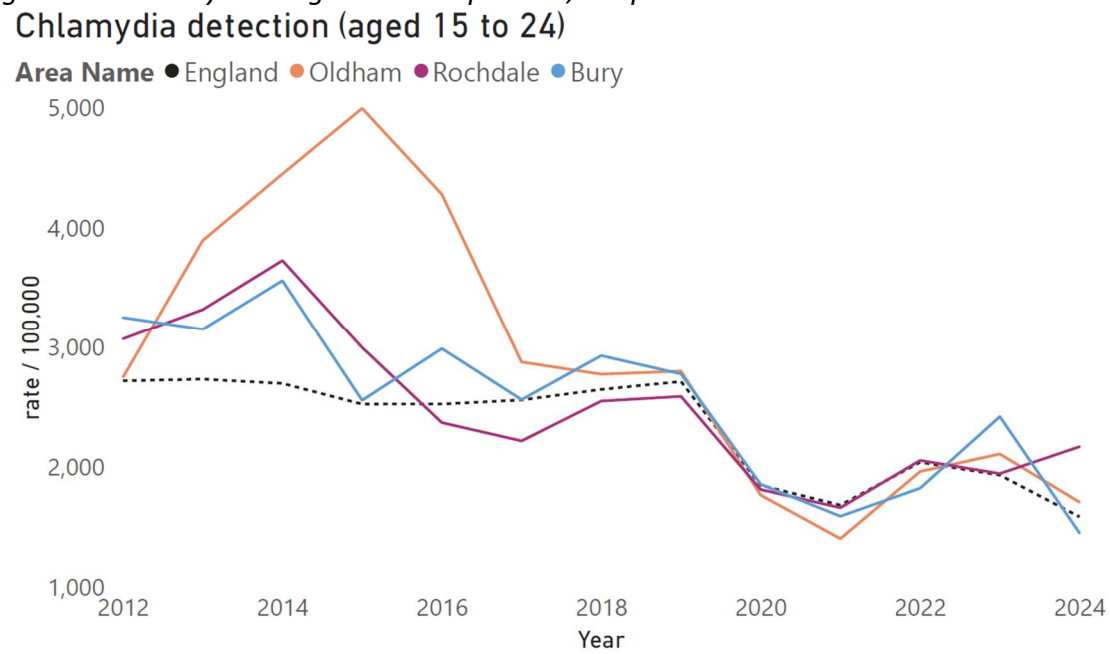


Figure 2.8: Chlamydia detection rate per 100,000 persons aged 15 to 24.[21]

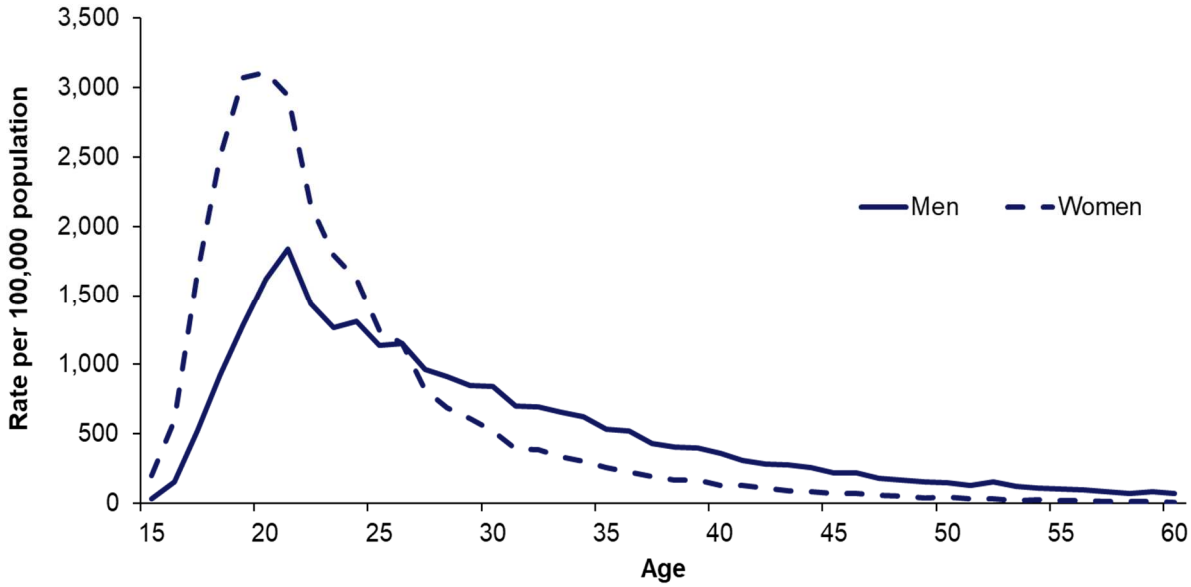


Figure 2.9: Rates of chlamydia diagnoses by gender and age, England, 2023.[29]

Spotlight- changes to the National Chlamydia Screening Program

Chlamydia can be treated with antibiotics; however, many people never experience any symptoms and therefore do not seek help. An untreated chlamydia infection can have serious consequences, such as Pelvic Inflammatory Disease (PID) in women, which can negatively impact fertility.[30] Early detection and treatment can reduce long-term harm; therefore, screening for asymptomatic cases is an important public health measure.[31]

First rolled out in 2003, the National Chlamydia Screening Program (NCSP) was initially offered opportunistically to women and men under 25 years of age.[32] In 2021, the NCSP criteria were restricted to women, changing focus to reduce reproductive harm from untreated infections.[30] This aligns with the STI Prioritisation Framework's shift towards prevention of adverse health outcomes.

For these guidelines, 'women' refers to cisgender women, transgender men, non-binary (assigned female at birth), and intersex people with a womb or ovaries.[30] Men are still able to get tested if they report symptoms or sexual contact with a partner diagnosed with chlamydia, but are no longer proactively offered a test without a clear indication.[30] The policy change also focused on strengthening partner notification, re-testing, and reducing time to treatment for all.[29]

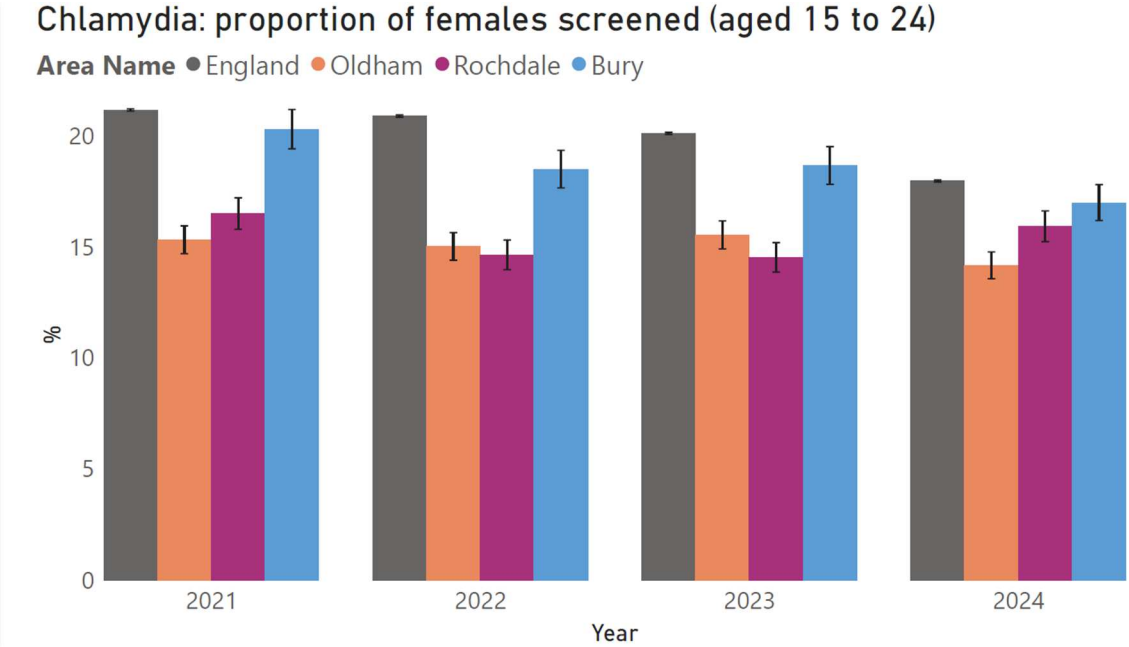


Figure 2.10: Chlamydia proportion of females aged 15 to 24 screened.[8]

Nationally, there was a 10.7% decrease in the number of chlamydia tests amongst 15 to 24-year-old women between 2023 and 2024, and therefore, more work needs to be done to improve NCSP uptake.[8] This is particularly important as the programme contributes to reducing health inequalities. Although test coverage is relatively similar based on deprivation, detection rates are highest amongst young women living in the most deprived areas of England, as demonstrated by Figure 2.11. [29]

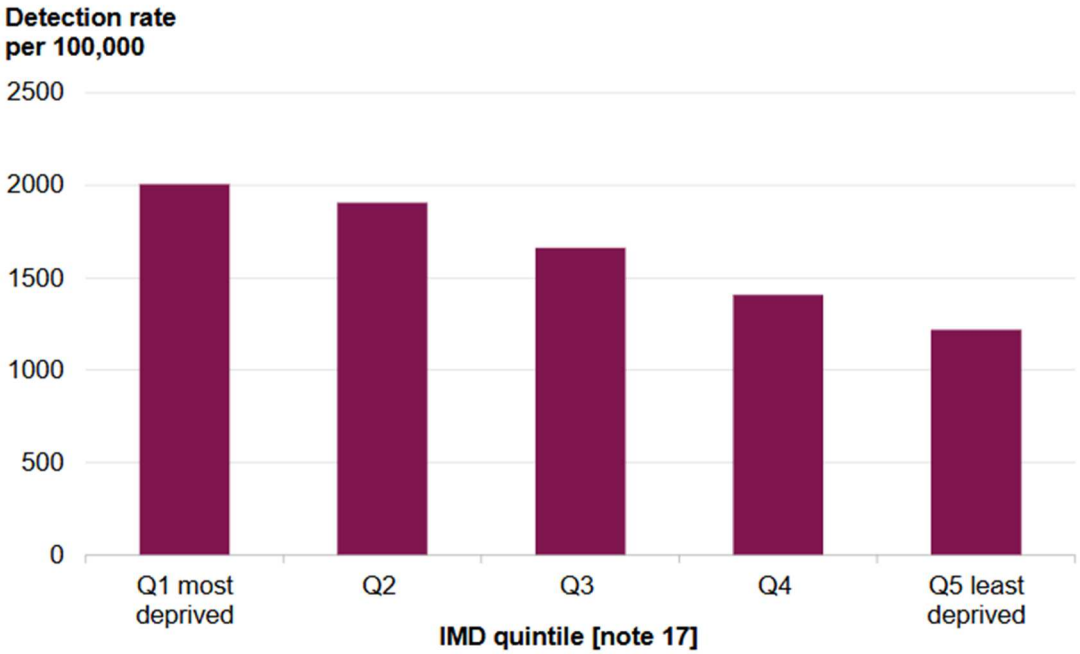


Figure 2.11: Chlamydia detection rates among women aged 15 to 24 years by IMD quintile, 2024, England (Note 17: IMD is based on the location of residence of the person tested)[8]

Local data shows significant variation in detection rates within ORB, some of which may be related to deprivation, alongside many other factors such as accessibility of testing, attitudes, and awareness. [31]

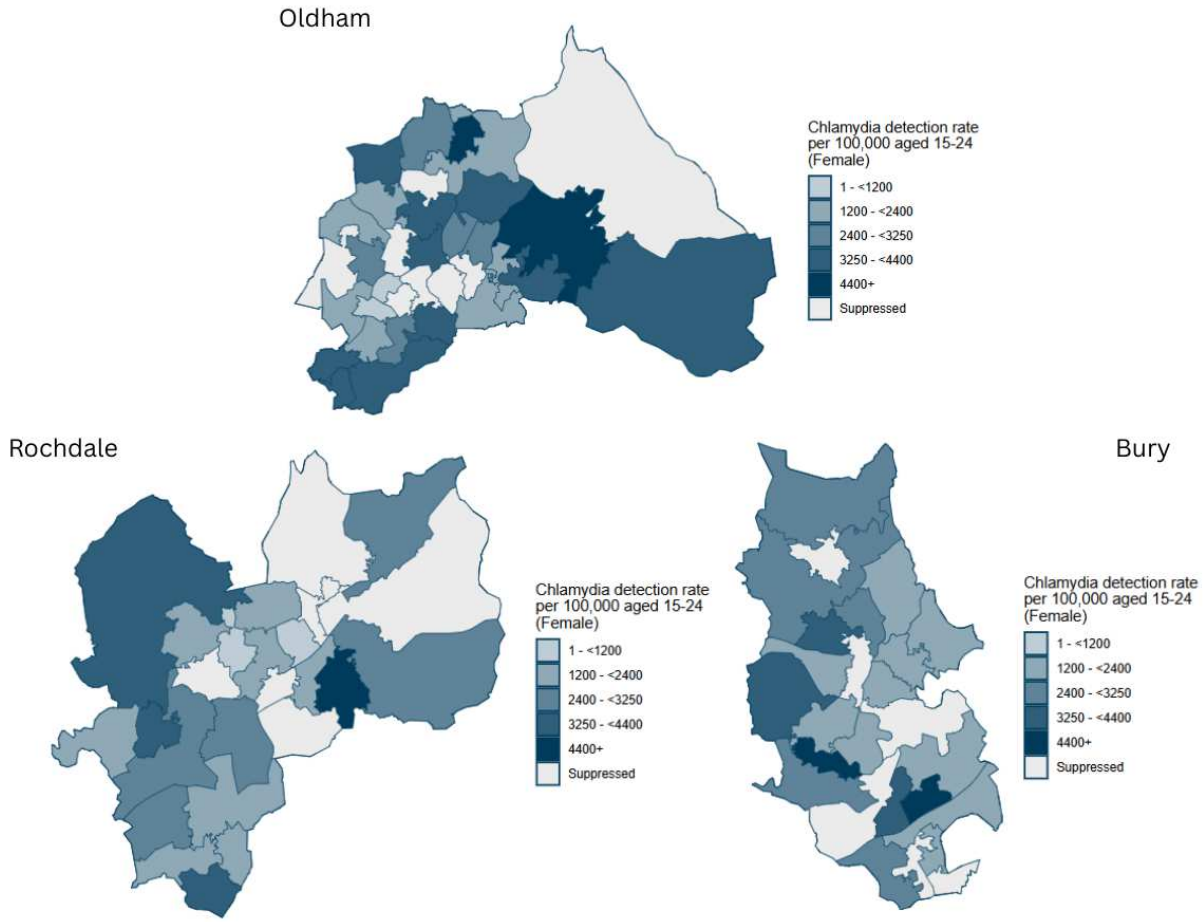


Figure 2.12: Map of chlamydia detection rate per 100,000 females aged 15 to 24 in Oldham, Rochdale, and Bury by Middle Super Output Area, 2023. [31]

Gonorrhoea

Gonorrhoea rates in England more than doubled over the last decade.[21] This trend has been mirrored within ORB, however, local rates remained below the national average.[21] The number of gonorrhoea diagnoses in England amongst men has consistently stayed 2 to 3 times higher than amongst women.[29] Figure 2.14 shows that the excess cases in men can be attributed to persistently high rates after age 20, when corresponding rates in women drop dramatically.[29]

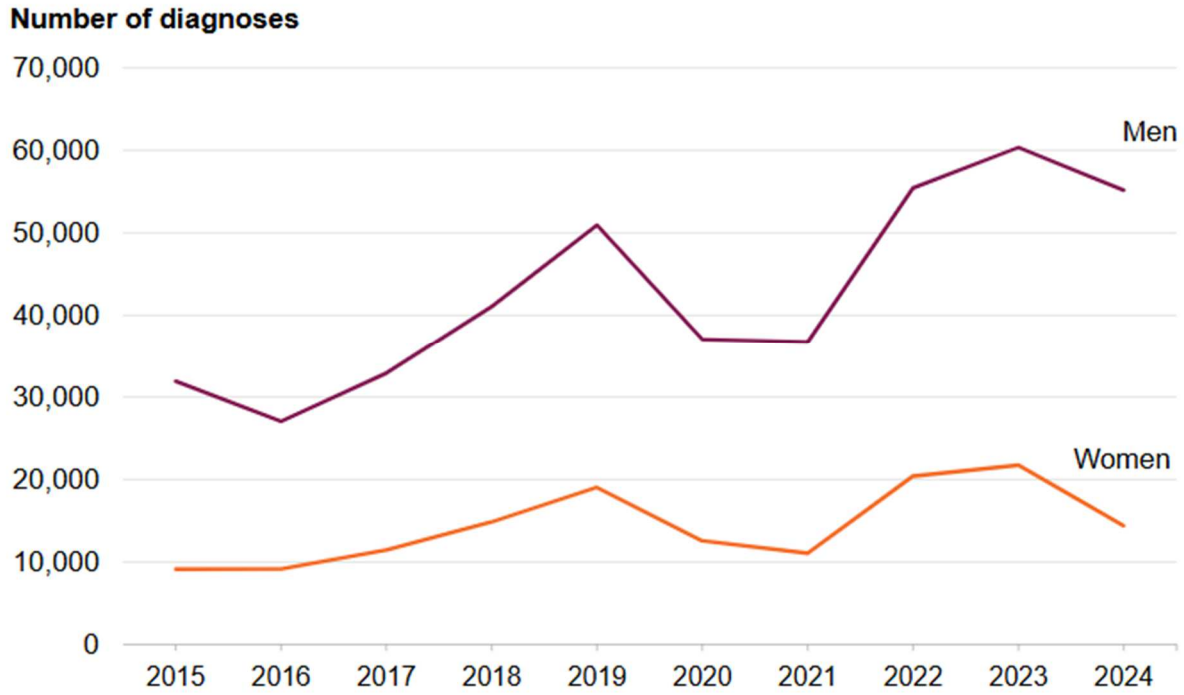


Figure 2.13: New gonorrhoea diagnoses by women and men among England residents accessing SH services, 2015 to 2024.[8]

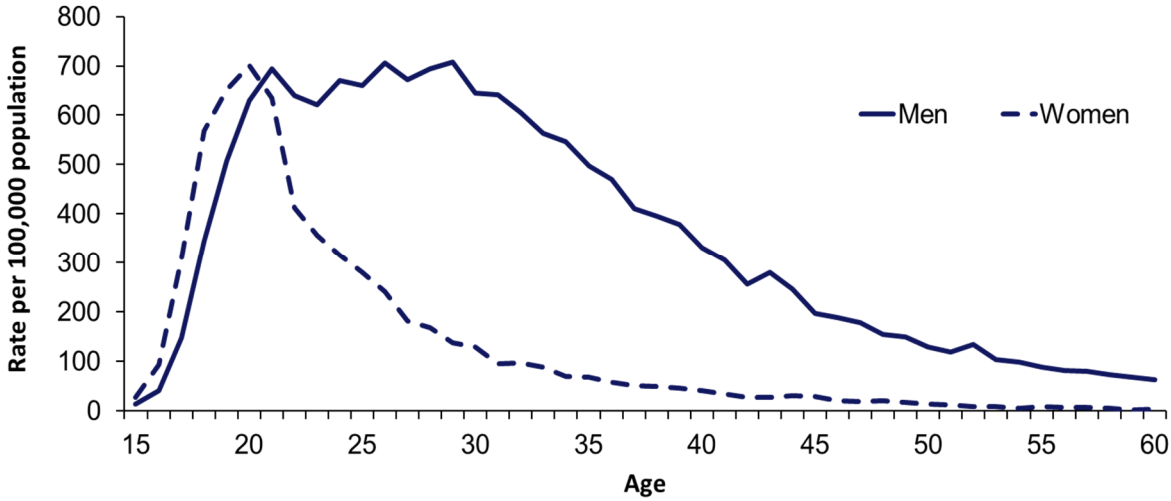


Figure 2.14: Rates of gonorrhoea diagnoses by gender and age, England, 2023.[29]

In 2023, the rate of gonorrhoea diagnoses increased by 7.5% in the general population and 9.4% amongst GBMSM, reaching the highest number since records began in 1918.[29] Gonorrhoea remained the second most commonly diagnosed STI in England in 2024, accounting for 19.7% of STI diagnoses.[8] However, the total number of gonorrhoea diagnoses decreased by 15.9%, with the greatest reduction seen in the 15-24 age group of 36.3%. [8] It is too soon to know whether this trend will continue, meanwhile antibiotic resistance is a growing at an alarming rate.[8]

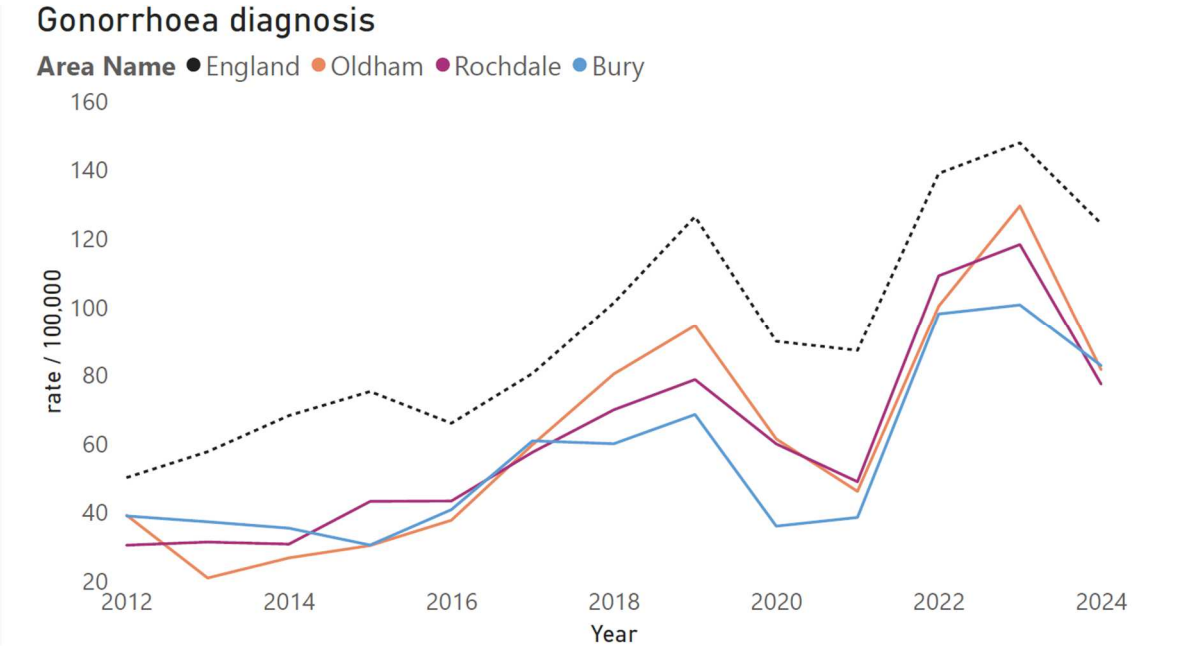


Figure 2.15: Gonorrhoea diagnostic rate per 100,000. [21]

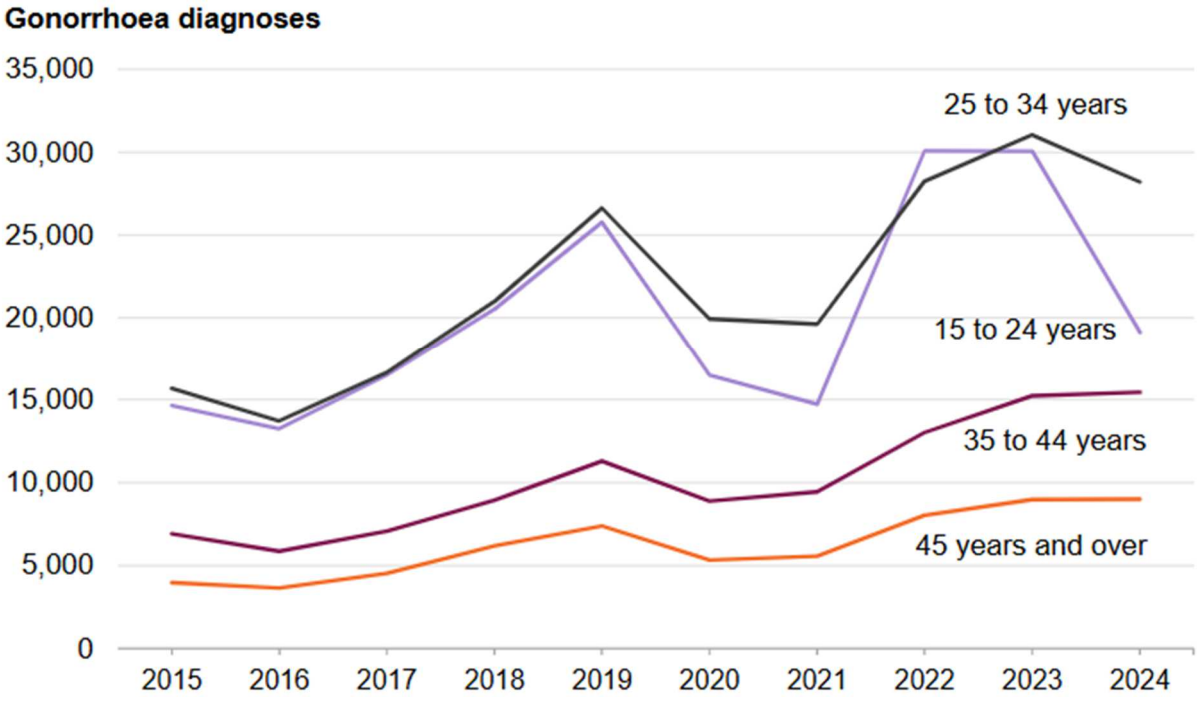


Figure 2.16: Number of gonorrhoea diagnoses by age group, 2015 to 2024.[8]

Spotlight- Super gonorrhoea & vaccination

Gonorrhoea is associated with significant morbidity globally, including reproductive complications such as pelvic inflammatory disease and infertility, and severe neonatal eye infections that may lead to blindness.[33, 34] Gonorrhoea can be transmitted even if an infected person experiences no symptoms, and also increases the risk of HIV transmission 5-fold.[33, 34]

The WHO has considered *Neisseria gonorrhoea* a high-priority pathogen since 2017 due to increasing antibiotic resistance, and highly resistant strains have been dubbed 'super gonorrhoea' .[33-35] UKHSA have already reported 14 cases of ceftriaxone-resistant gonorrhoea

in the first 5 months of 2025, which is greater than the number of cases reported for the whole of 2024 (13 cases).[36] A significant challenge posed by *Neisseria gonorrhoeae* is reinfection. Natural infection is not protective, therefore, repeated reinfection with gonorrhoea is common.[29, 33] Figure 2.18 shows that reinfection is disproportionately high amongst GBMSM.[33]

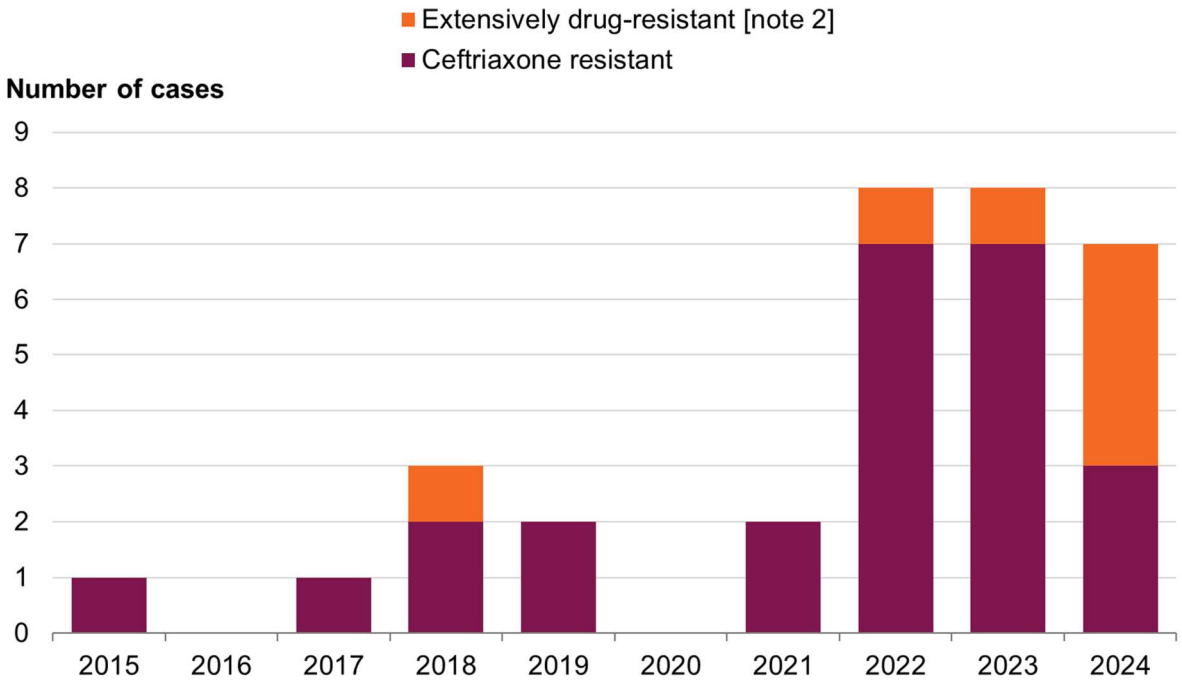


Figure 2.17: Number of confirmed cases of infection with ceftriaxone-resistant N. gonorrhoeae in England, January 2015 to August 2024. (Note 2: Extensively drug-resistant (XDR) infections are resistant to both first and second-line treatment options and to other antibiotics.) [37]

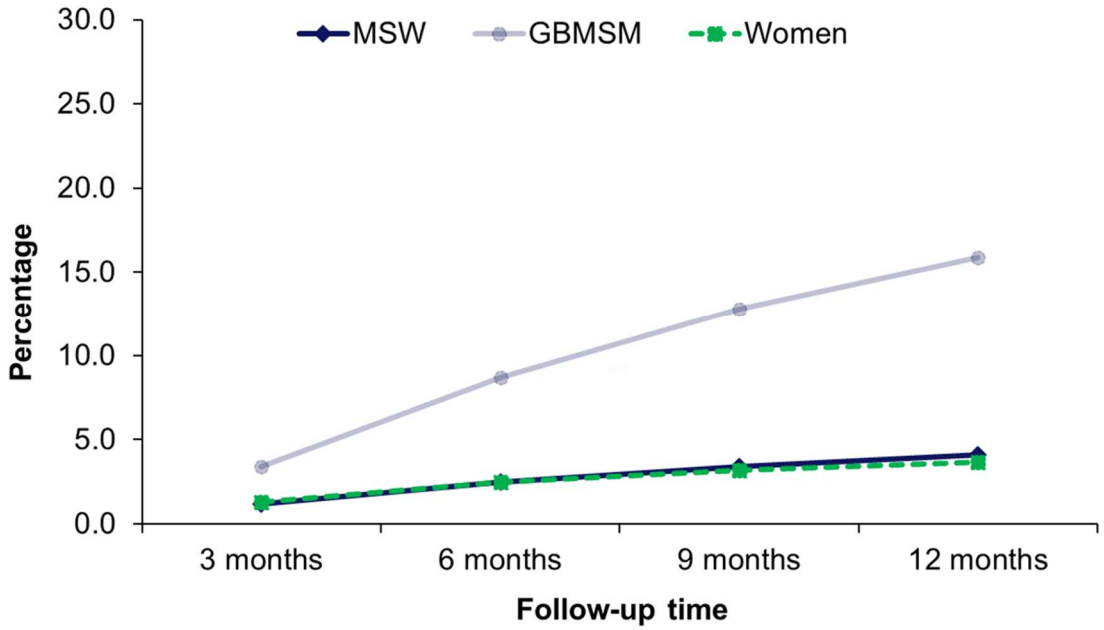


Figure 2.18: Repeat infection with gonorrhoea, England, 2019 to 2023.[29]

In 2023, the Joint Committee on Vaccination and Immunisation (JCVI) advised a targeted vaccination program to reduce infections within high-risk groups. [33] The proposed vaccine 4CMenB was not specifically designed to prevent gonorrhoea and is administered as a routine childhood vaccination to prevent meningococcal disease. [33] As the intended target, *Neisseria meningitidis* is closely genetically related to *Neisseria gonorrhoea*, the vaccine offers 40% protection against gonorrhoea. [8, 33]

In May 2025, the NHS announced the world's first vaccine program to protect against gonorrhoea.[8, 38] The nationwide rollout is due to commence in September 2025, and some SH services will begin vaccinations in early August. [8] Eligible patients will include GBMSM with a recent history of multiple sexual partners. To maximise the public health impact, people will also be offered mpox, hepatitis A and B and HPV vaccinations when attending their appointment.[36] Analysis suggests that if high uptake of the vaccine is achieved and sustained, up to 100,000 cases of gonorrhoea could be averted, saving the NHS £7.9 million over 10 years. [36, 39]

Human Papilloma Virus

Of the 100-plus types of Human Papilloma Virus (HPV) that infect the skin and mucous membranes, the majority are self-limiting and do not cause any symptoms.[40] However, certain strains, such as 16 and 18, persist and can increase the risk of HPV associated cancers. This includes some mouth and throat cancers, cancers of the anus and genital areas, and up to 99% of cervical cancers.[40, 41] Safe sex practices, such as condom use, cannot completely prevent the risk of infection, as HPV can spread via skin-to-skin contact. [42]

The current HPV vaccine has been shown to prevent 90% of cervical cancer cases, and cervical screening saves approximately 5,000 lives a year.[43] In November 2023, NHS England committed to eliminating cervical cancer by 2040.[43] As the incidence of cervical cancer is 65% higher in the most deprived compared to the least deprived quintile, core to NHS England's ambition is achieving equitable uptake of screening and vaccination.[43]

The HPV vaccine has been offered routinely to all girls in year 8 since September 2008, incorporating year 8 boys from September 2019.[40] The programme was also extended to include GBMSM in the preceding April.[40] Figure 2.19 reflects the increase in HPV vaccination coverage upon including boys and the drop in vaccination rates in response to COVID-19, which is yet to recover to pre-pandemic levels.[21]

In September 2023, the routine schedule (with certain exceptions) changed from two doses to one, as emerging evidence demonstrated equal effectiveness.[44] To mitigate inequalities in uptake, from December 2024, clinicians in specialist SH services have also been able to use the national stock to vaccinate eligible individuals opportunistically. [41]

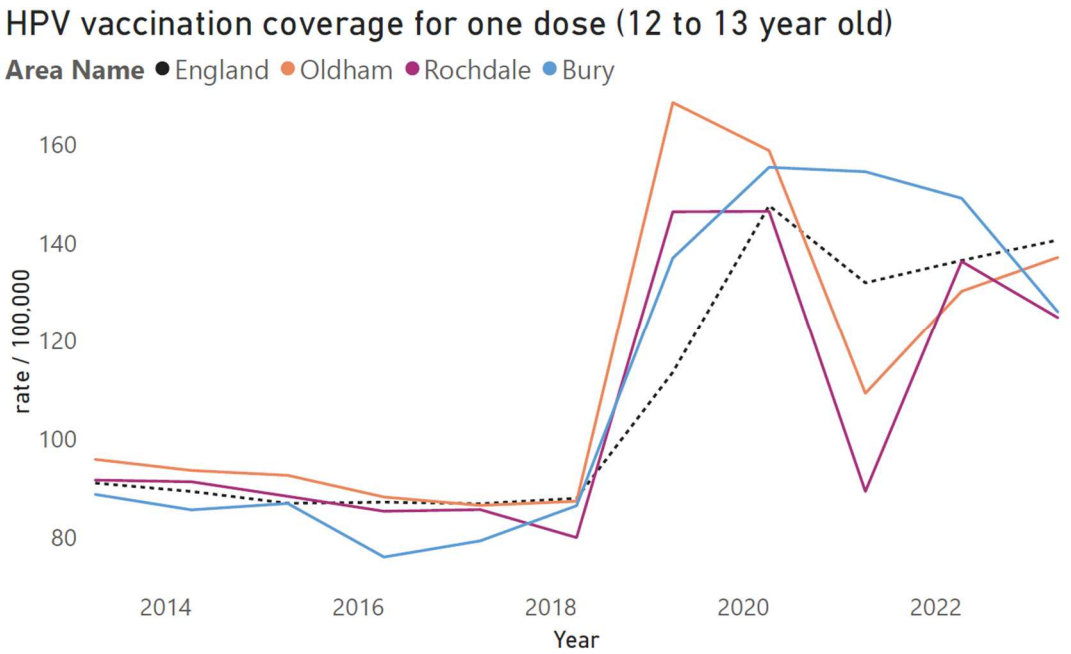


Figure 2.19: Population HPV vaccination coverage for one dose (12 to 13 years old) % females. *(21)*

Genital warts

In 2023, the first episode of genital warts represented 6.5% of STI diagnoses in England, and the total number of diagnoses has remained relatively stable since 2020.[29] Over the last decade, new diagnoses of genital warts have remained more common amongst men than women.[29] The quadrivalent HPV vaccine protects against HPV 6 and 11, which are the main causes of genital warts.[29] The protective effect of HPV vaccination is particularly evident in younger age groups who have been offered the vaccine since the national programme began.[31]

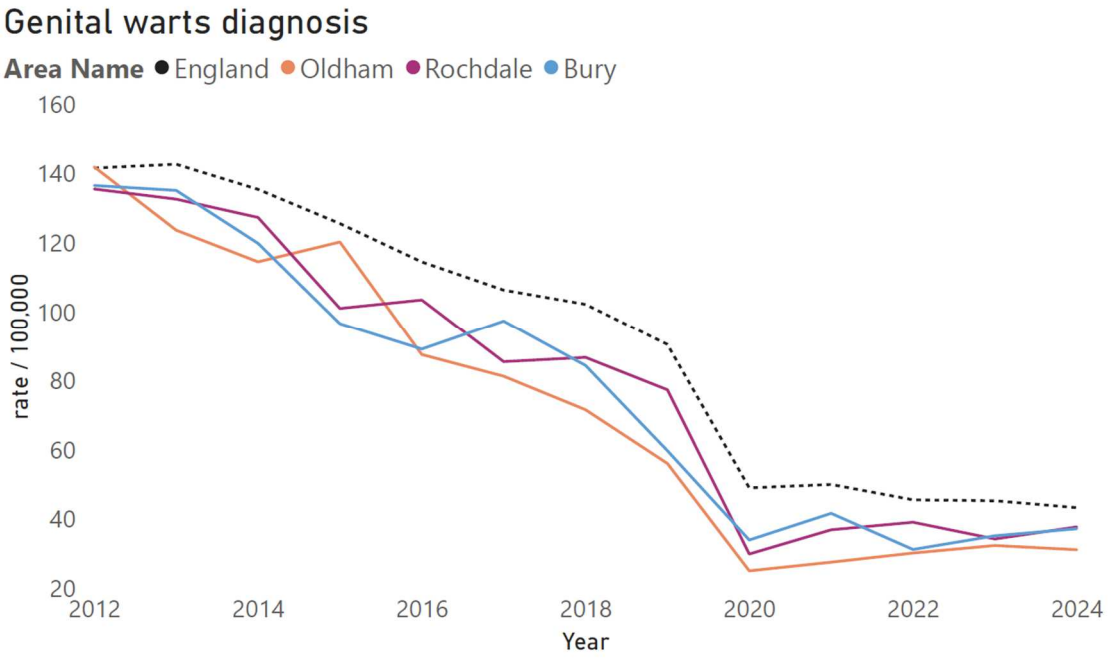


Figure 2.20: Genital Warts diagnostic rate per 100,000. *(21)*

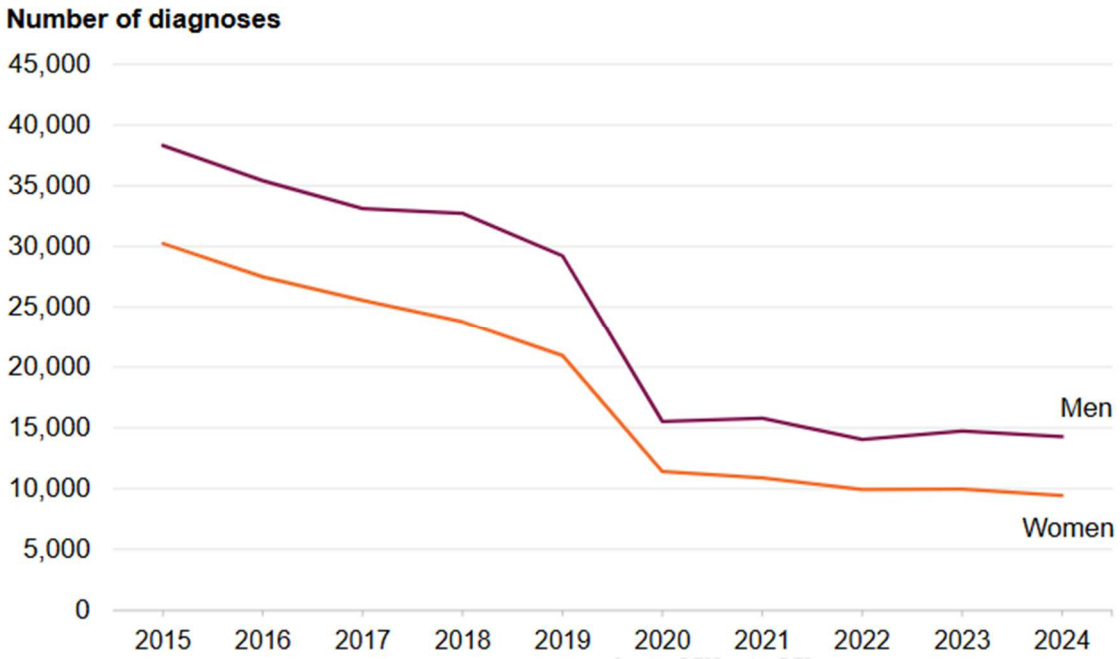


Figure 2.21: New diagnoses of genital warts (first episode) by women and men among England residents accessing SH services, 2015 to 2024.[8]

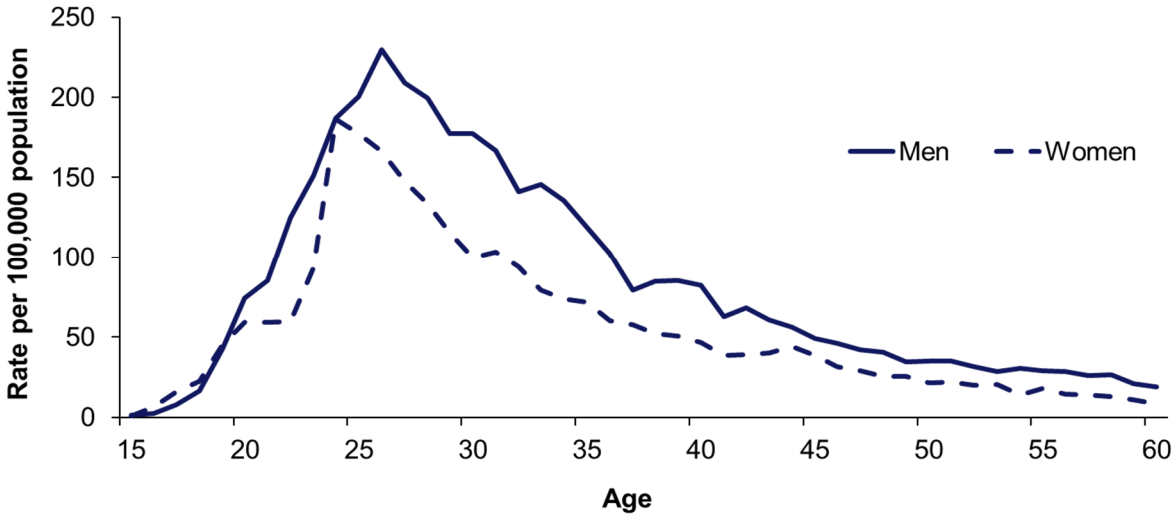


Figure 2.22: Rates of genital warts (first episode) diagnoses by gender and age: England, 2023.[29]

Genital Herpes

Genital herpes, caused by the Herpes Simplex Virus (HSV), is England's most common ulcerative STI. [3, 45] HSV type 1 primarily causes oral herpes but can also cause genital infections, whereas type 2 HSV is associated with genital infection almost exclusively.[45] Many HSV infections are asymptomatic, however, they may cause systemic disease in the immunosuppressed.[45] Compared to other STIs, testing for genital herpes has recovered relatively slowly since the disruption of 2020, remaining lower than pre-pandemic rates. [31] As HSV can lie dormant and reactivate several times a year, individuals may frequently return

for antiviral treatment to reduce the severity and duration of symptoms. [3, 46] New diagnoses of genital herpes are most common amongst young women and those identifying as heterosexual. [3, 29]

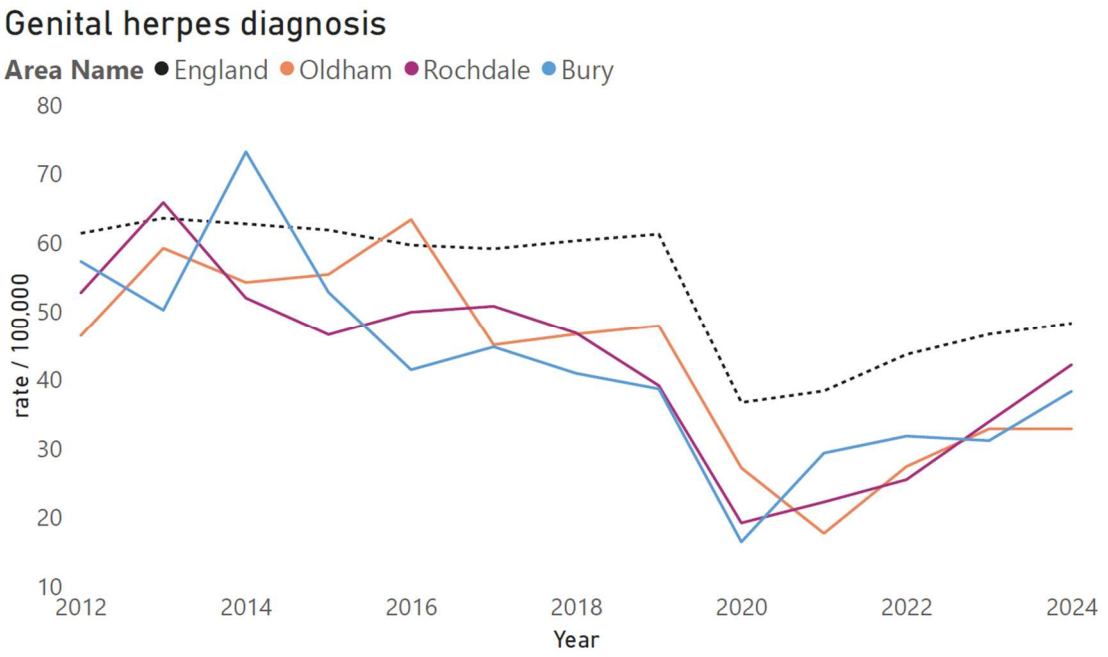


Figure 2.23: Genital herpes diagnostic rate per 100,000. [21]

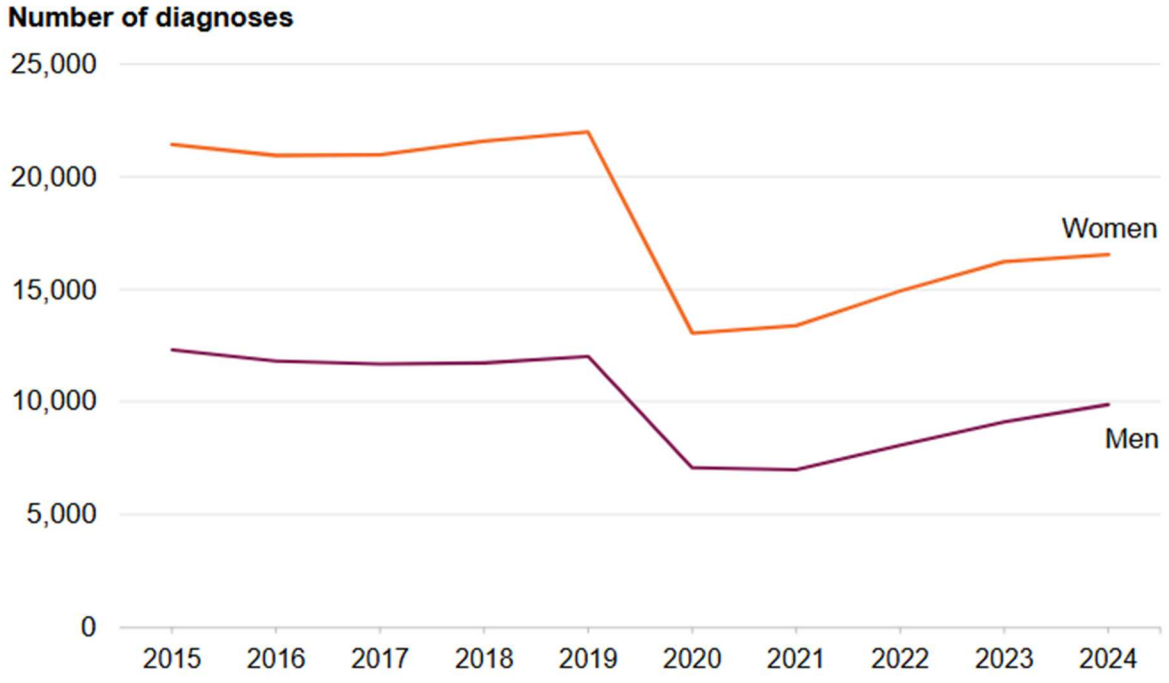


Figure 2.24: New diagnoses of genital herpes (first episode) by women and men among England residents accessing SH services, 2015 to 2024. [8]

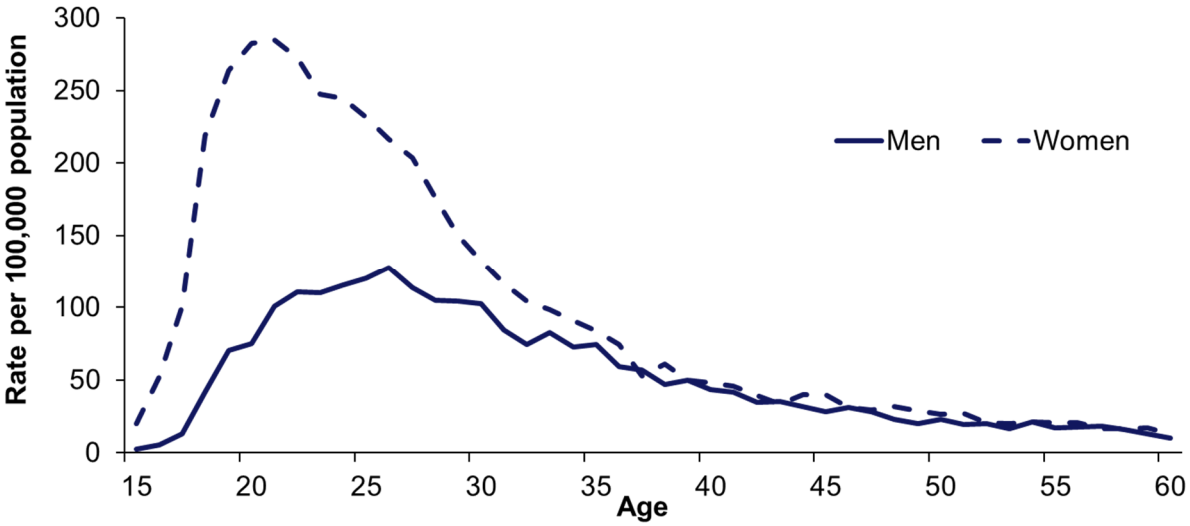


Figure 2.25: Rates of genital herpes (first episode) diagnoses by gender and age: England, 2023.[29]

Syphilis

Syphilis is one of the least common STIs in England, and a small decrease or increase in diagnoses can dramatically affect local trends.[21] The national picture is less impacted by small fluctuations and shows a steady increase in syphilis rates since 2020, and 2024 saw the largest annual number of syphilis diagnoses since 1948. [8, 29] This included an increase in acute infections and late-stage complications of syphilis. [8]

Approximately 76% of infectious syphilis diagnoses are among GBMSM, however, recent statistics show a larger proportional rise in syphilis amongst heterosexual men and women.[8, 29, 47] London is a geographical hotspot for syphilis, although outbreaks and clusters have also occurred in Brighton and Manchester.[48] The UKHSA has published a Syphilis Action Plan to address this increase, focusing on more frequent testing, partner notification, and raising awareness.[29, 48]

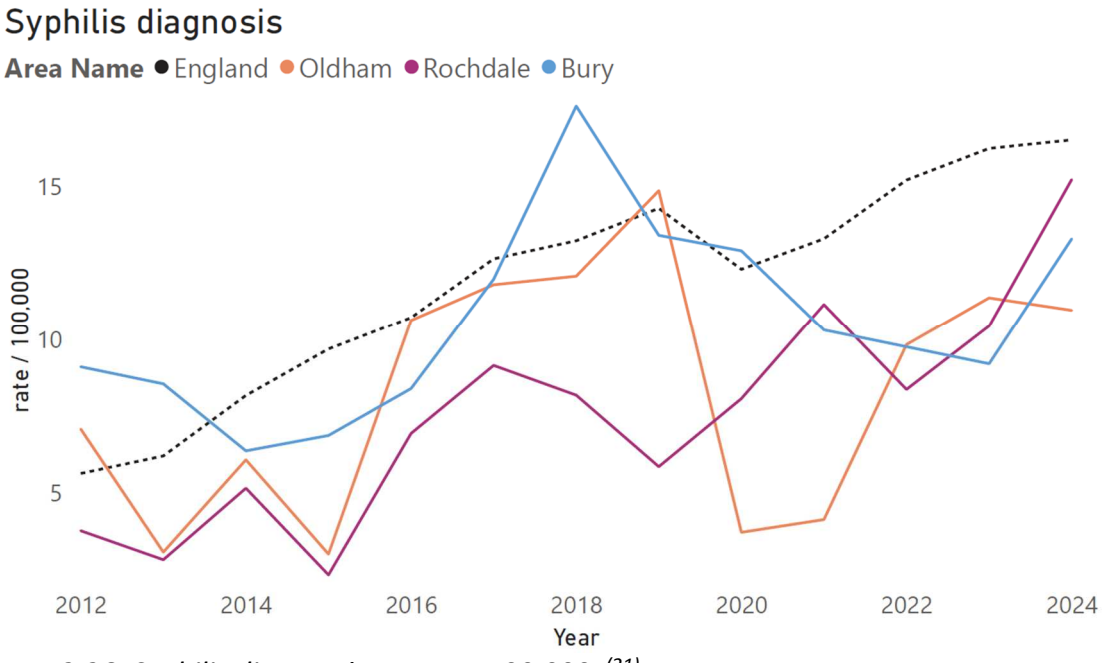


Figure 2.26: Syphilis diagnostic rate per 100,000. [21]

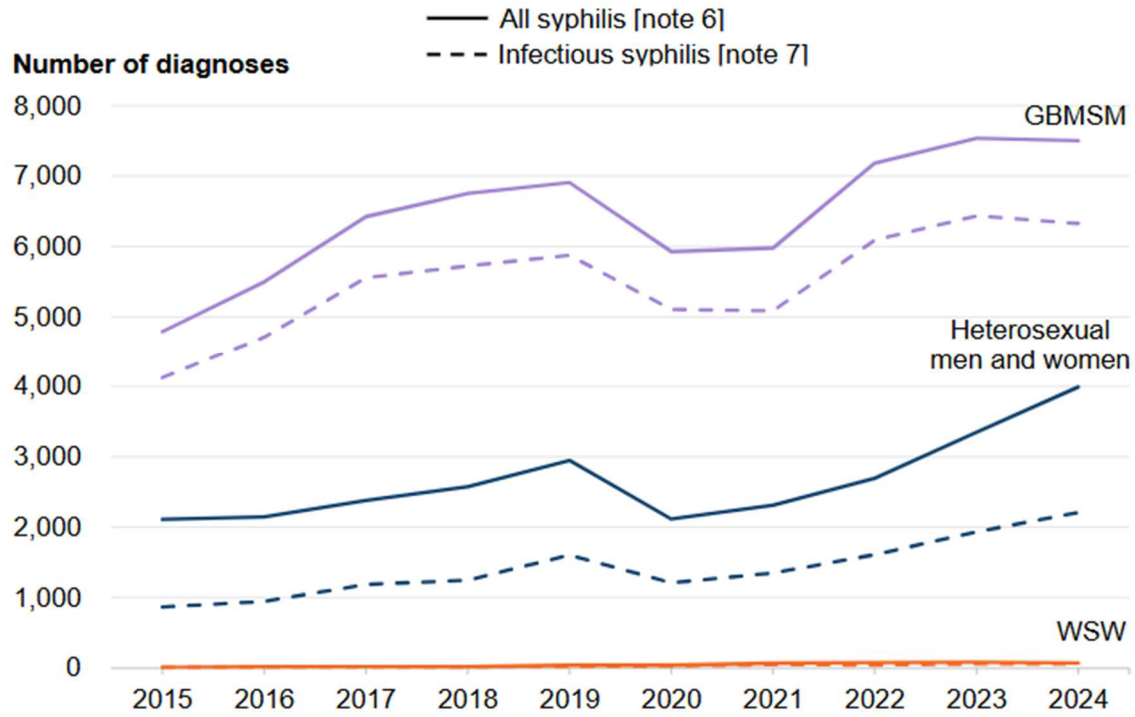


Figure 2.27: Number of diagnoses of syphilis among England residents accessing SH services, 2015 to 2024 (WSW = women who have sex with women. Note 6: includes infectious syphilis and late stage and complications of syphilis. Note 7: includes diagnoses of primary, secondary, and early latent syphilis.) [8]

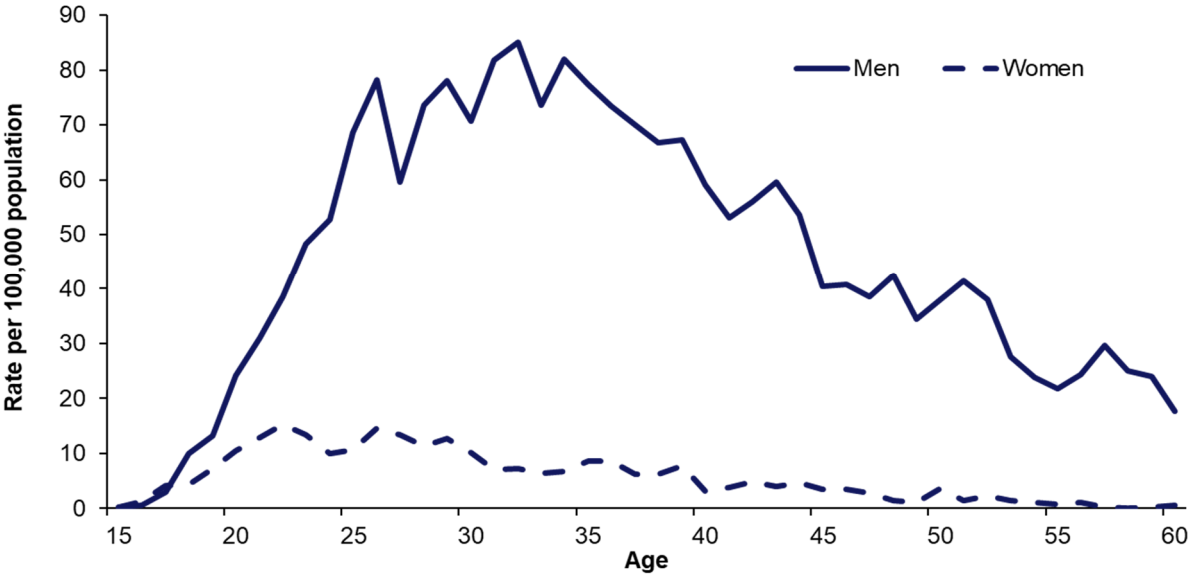


Figure 2.28: Rates of infectious syphilis (including primary, secondary and early latent diagnoses) by gender and age, England, 2023.[29]

DoxyPEP

A potential strategy to combat the rise in bacterial STIs, such as syphilis, is doxycycline as post-exposure prophylaxis (DoxyPEP). It is recognised that many patients choose to take antibiotics such as doxycycline before and/or after a sexual interaction to reduce the risk of STI transmission. However, in 2017, PHE and the British Association for Sexual Health and HIV (BASHH) published a joint statement that did not endorse the use of DoxyPEP for STIs. This recommendation was reaffirmed by UKHSA in 2021 due to the potential for antibiotic resistance to develop in STIs and other bacteria, posing a significant public health risk. [49, 50] However as research continues to emerge, the consensus around DoxyPEP may shift.[51]

Sexually transmitted Shigella

Shigellosis is an emerging STI within England that was recently added to Fingertip's SRH Profiles in June 2023.[31] Cases of sexually transmitted shigellosis increased by 13% in 2024 and there was a corresponding increase in extensively drug-resistant isolates. [51] As it presents with fever, abdominal pain, and diarrhoea, which may be bloody, many patients present to the GP or A&E rather than SRH services.[31] Most cases resolve without any intervention, however, complications may lead to hospital admission. Surveillance suggests that transmission is commonly associated with Chemsex (sexualised drug use) or multiple casual sexual partners amongst GBMSM.[31] However, intelligence indicates that only a minority of GBMSM are aware of Shigella and the associated risks, precautions and treatments.[31]

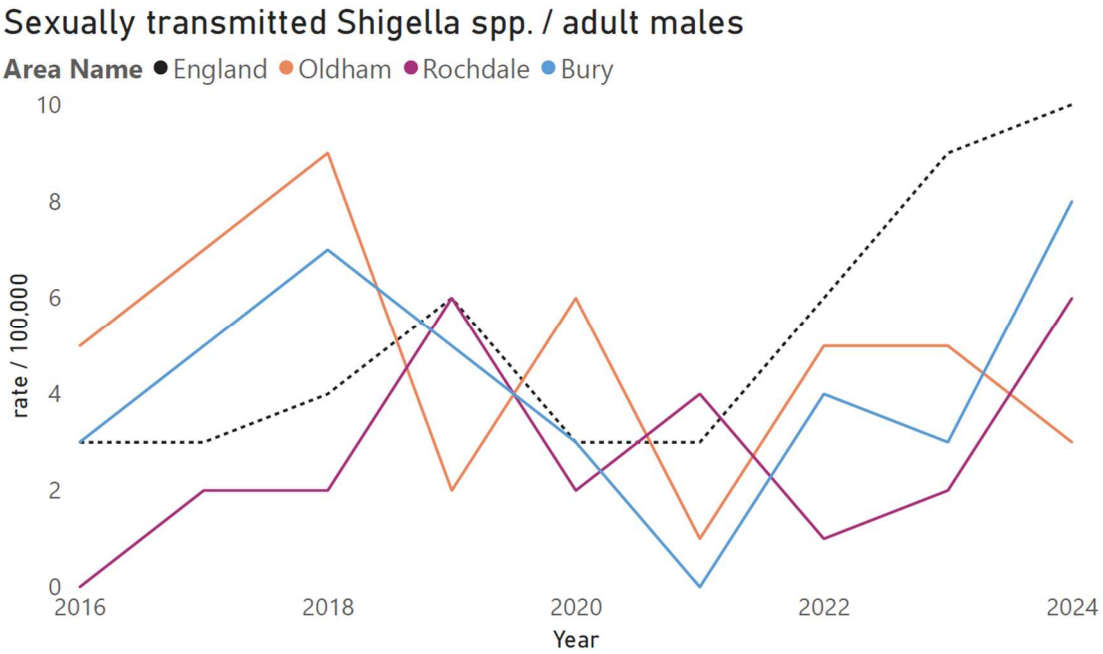


Figure 2.29: Rates of sexually transmitted Shigella in adult males [21]

Mpox

Mpox is caused by infection with the MPXV virus, which may be spread by close contact with lesions, respiratory droplets, contaminated material (such as bedding) or bodily fluids.[52] Therefore, sexual contact is a high-risk activity for MPXV transmission. Historically, mpox cases in England were rare and mostly linked to travel to countries where the virus was endemic. [52] An international outbreak in May 2022 led to sustained transmission in the UK, mainly affecting GBMSM. In response, targeted vaccination was offered to those at highest risk of mpox, including GBMSM and workers at risk of occupational exposure. [52]

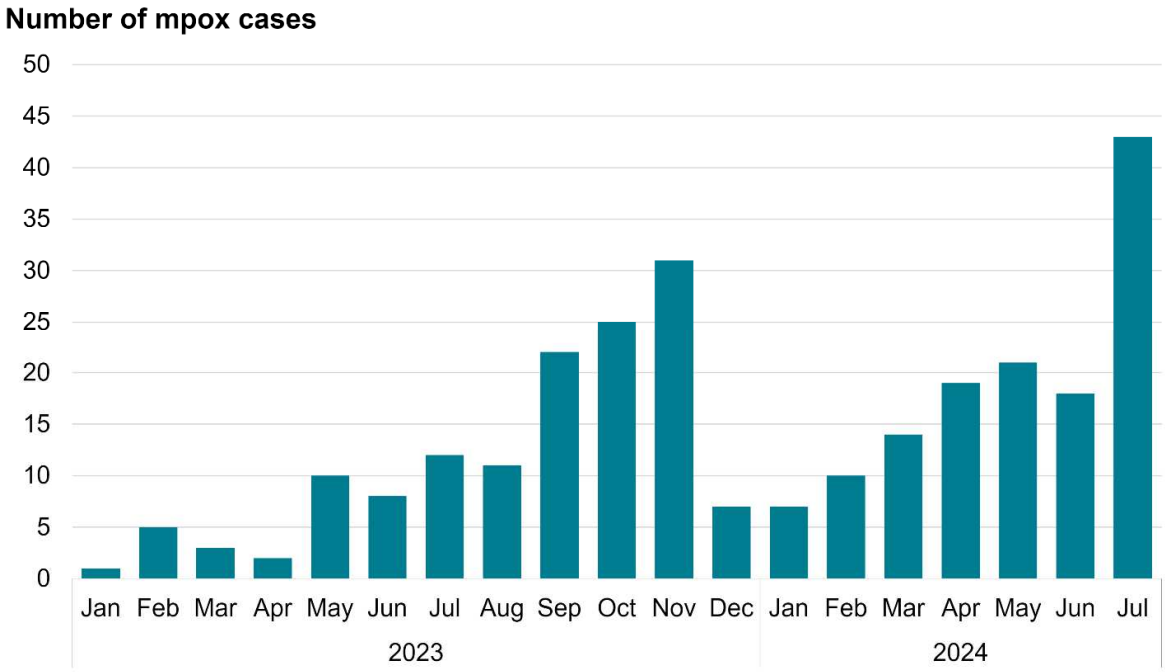


Figure 2.30: Mpox figures England. [53]

The national offer for reactive mpox vaccination ended in summer 2023.[54] However, due to clusters of locally transmitted cases, vaccination continued in London and Manchester. In November 2023, the JCVI recommended that a routine mpox vaccination strategy be developed nationwide. From February 2025, every region in England has been able to offer the mpox vaccine to residents at increased risk [55].

However, limited vaccine supply has resulted in logistical challenges.[56] As a temporary measure, SH services have used a much lower intradermal dose of the vaccine as a 'dose sparing' technique.[56] This has allowed healthcare professionals to vaccinate a greater number of at-risk patients in the short term.[56] As vaccine supply stabilises, clinics will return to offering full intramuscular doses.

Human Immunodeficiency Virus (HIV)

HIV is associated with significant mortality, morbidity and healthcare costs. HIV diagnosed prevalence is increasing across ORB in line with the national picture, which is likely due to the improved life expectancy of people living with HIV. [3, 31] People diagnosed promptly with HIV and who start anti-retroviral therapy (ART) early can expect near-normal life expectancy. Challenges remain, however, in the form of high rates of late HIV diagnoses and stark health

inequalities associated with HIV outcomes. GM is enrolled as a 'Fast Track City', an international initiative to end new cases of HIV by 2030, and has exceeded expectations.[57] Collectively, GM has achieved the '95:95:95' target (*see Figure 2.31)* 9 years ahead of schedule. [57]

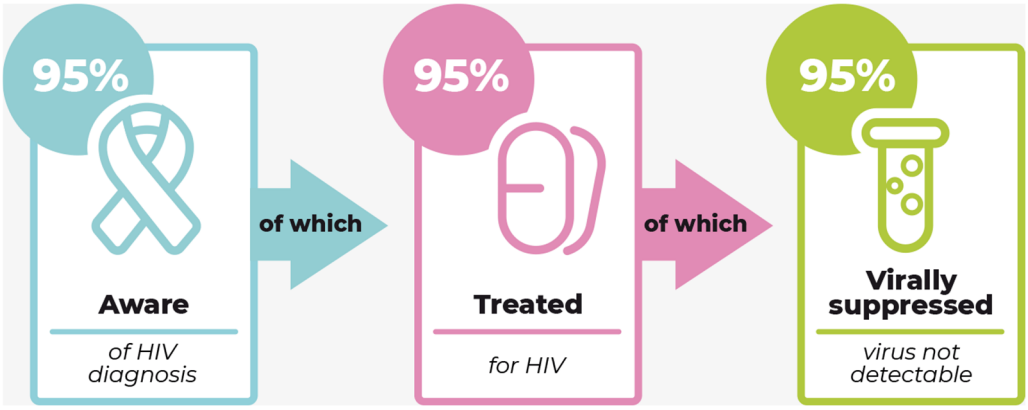


Figure 2.31: UNAIDS 95:95:95 target [58]

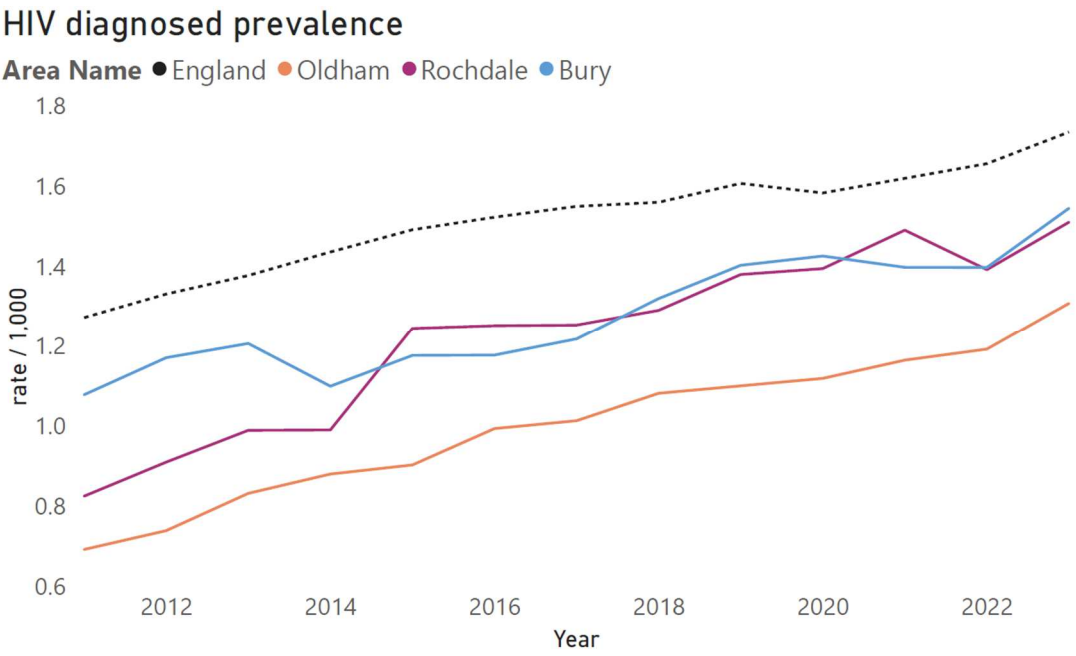


Figure 2.32: HIV diagnosed prevalence rate. [21]

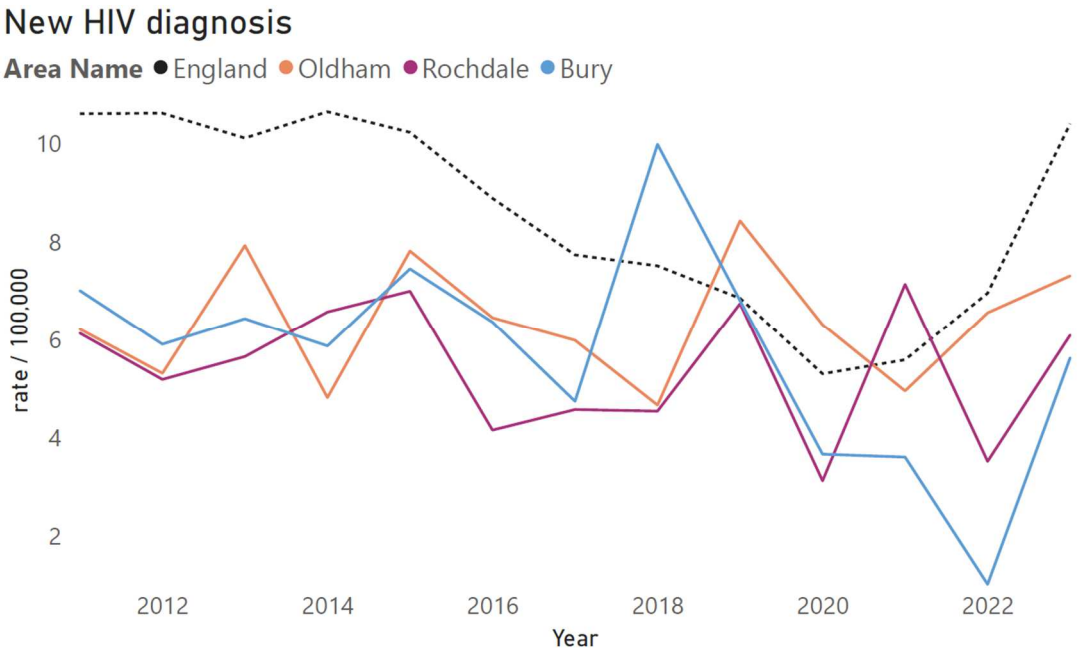


Figure 2.33: New HIV diagnosis rate. [21]

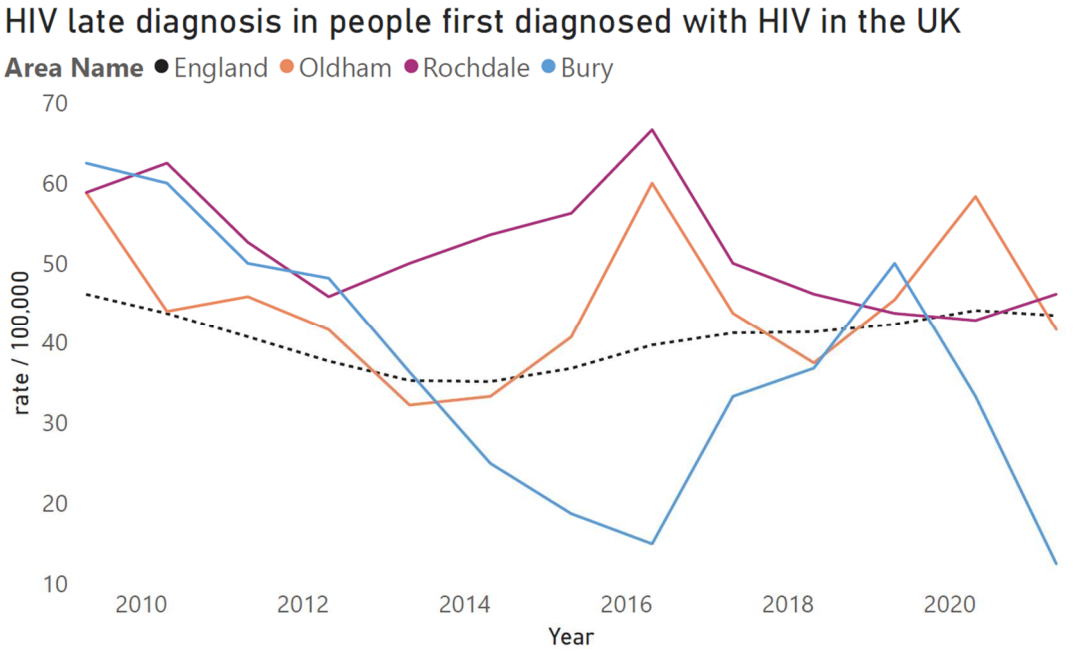


Figure 2.34: HIV late diagnosis in people first diagnosed with HIV in the UK- 3 year combined. [21]

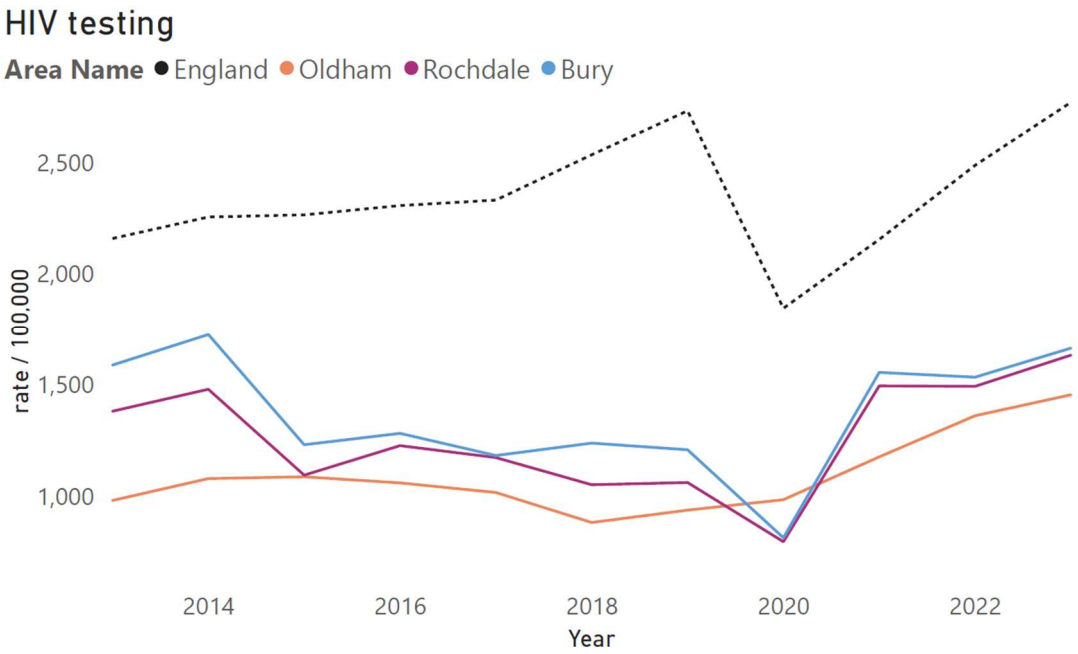


Figure 2.35: HIV testing coverage. [21]

Spotlight: Opt-Out Testing for Blood-Borne Viruses (BBV)

As part of the strategy to reduce HIV transmission, an opt-out BBV testing programme has been rolled out nationally. Anyone over the age of 16 who is already having a blood test at a participating ED is eligible for HIV, Hepatitis B and Hepatitis C testing. [57] The first wave included 34 EDs across the country, and due to high local prevalence, 4 of these sites were based in GM. Within ORB, in March 2025, the Royal Oldham Hospital and Fairfield General Hospital commenced the scheme.

PRELIMINARY RECOMMENDATIONS

1. Share the STI Prioritisation Framework amongst stakeholders to align common goals
2. Promotion of NCSP with a focus on women in areas of socio-economic deprivation
3. Implementation of a comprehensive 4CMenB vaccination to prevent gonorrhoea
4. Targeted strategy to increase the uptake of HPV vaccination to pre-pandemic levels
5. Educate professionals to monitor and counsel service users regarding DoxyPEP
6. To establish and expand routine mpox vaccination as the national supply increases
7. Campaign to raise awareness of Shigellosis amongst the GBMSM community
8. Continue the promotion and implementation of opt-out HIV testing across ORB

4. Reproductive Health

PENDING- this chapter will feature in the final report

5. Services

Not only do ORB work together to provide SRH services, but there is also widespread collaboration across GM. This has led to 'cross-charging' agreements between the 10 local authorities, which help integrate the SRH services by facilitating open access. These contracts are regularly reviewed to ensure cost effectiveness and fairness across the boroughs. This chapter will focus on recent changes in ORB, encompassing pharmacies, GPs, specialist SRH and midwifery services, and vital third-sector organisations.

Pharmacies

Community pharmacies are a cornerstone of health and well-being in our local communities. They are often more accessible due to their longer opening hours, convenient locations, and the ability to walk in without an appointment. The three core SRH services traditionally offered by community pharmacies have been:

1. **Advice and signposting**

Pharmacies have hyperlocal knowledge about the services in their area and can provide general sexual health advice, as well as items such as condoms and lubrication for safer sex.

2. **Chlamydia Screening & Treatment (CST)**

In community pharmacy settings, screening is now only proactively offered to women, unless there is an indication, such as being symptomatic or a partner of someone with chlamydia. [30]

3. **Emergency Hormonal Contraception (EHC)**

Community pharmacies in ORB offer EHC to women who request emergency oral contraception following unprotected sexual intercourse or potential contraception failure, within 72 hours.

Advanced Pharmacy Contraception

Progesterone Only contraceptive Pills (POP) have been available for purchase over-the-counter from pharmacies without a prescription since 2021.[59]
From Spring 2023, pharmacies have also been able to register for the ongoing monitoring and supply of oral contraception as part of an NHS initiative.[60, 61]
From December 2023, this NHS service was extended to include the initiation of oral contraception, subject to a confidential consultation with a specially trained pharmacist.[60, 61]

This service aims to improve access and provide greater choice for patients who do not need to be registered with a GP. Patients can access a Combined Oral Contraceptive (COC) or the POP free of charge, provided they satisfy the medical eligibility criteria.

In March 2025, the Department of Health and Social Care (DHSC) announced a significant expansion to the Pharmacy Contraception Service (PCS). [62] The change aims to reduce

regional variation and provide more equitable access by commissioning EHC supply and consultations nationally.[62]

General Practice

GPs provide a wealth of SRH advice alongside LARC and are a key point of access to refer to specialist SRH services. The graph below shows a downward trend in the rate of LARC prescribed by GPs in ORB over the last decade. This decline could be due to several factors, such as changing attitudes towards contraceptive choices. However, long waiting lists suggest that access is also a barrier.

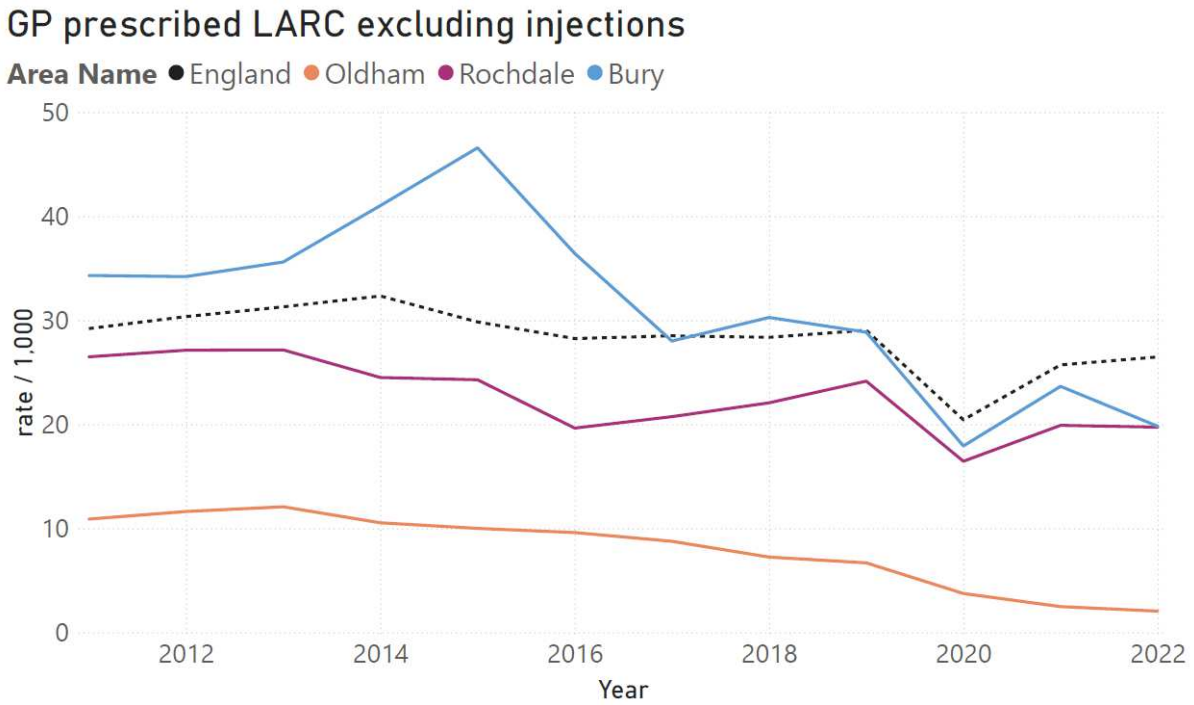


Figure 4.1: GP prescribed LARC (excluding injections) / 1000 [21]

Long-Acting Reversible Contraception

There is a variety of LARC methods to choose from, offered by different primary care and specialist SRH providers. LARC was highlighted as an issue of national concern in a 2023 Primary Care Women's Health Forum report, "On the brink- The reality of LARC provision in primary care".[63] Funding challenges, training and workforce issues, and reduced capacity have led many GP practices to cease or consider stopping the provision of LARC fitting in practice across the country.

Case study: General Practice

Bury has historically reported higher rates of GP-prescribed LARC (excluding injections) than Rochdale, Oldham, and England, as shown by Figure X. However, the number of practices in Bury offering LARC decreased by almost 50% in five years. As of May 2024, approximately 160 women were waiting for a coil, and 68 women were waiting for contraceptive implants in Bury. Bury's Public Health team has worked with HCRG to improve access to LARC in the short term and sustainably increase long-term LARC capacity in primary care. This involves highlighting training support, reviewing, and proposing amendments to the delivery model.

By October 2024, the list of women awaiting a coil fitting had reduced significantly to around 60. Despite this improvement, there was still a 3-month waiting list, and only 8 out of 26 GP practices in Bury were signed up to deliver LARC. As a result, 44% of Bury's population had no access to LARC within primary care, leading many women to seek routine LARC within specialist SRH services.

Specialist SRH services

Case study: Women's Health Hubs

In addition to supporting individual GP practices, ORB Public Health Teams have been working with local integrated care boards (ICB) to develop women's health hubs (WHH).[64] WHHs integrate women's health services in the community by bringing together healthcare professionals across a population footprint. By pooling expertise and resources, the WHH model aims to improve access to and experiences of care. This, in turn, will help to reduce health inequalities and improve women's health outcomes.

In October 2024, the Bury GP Federation opened a WHH in Prestwich. Held weekly on Sunday afternoon, the hub takes LARC referrals from any Bury GP practice that does not offer LARC. A similar Borough-Wide Primary Care Service is based in Littleborough, Rochdale.

The aim was to expand the service so that every Primary Care Network (PCN) in ORB has a WHH. However, recent governmental reports suggest the existing funding and operational model may be subject to change.[65] ORB and GM will adapt to continue working towards integrated community SRH services that reflect the life course approach to women's health.

Case study: Midwifery Services

ORB has recently worked with midwifery services to introduce LARC into the Royal Oldham Hospital. The aims of the service are to:

- Prevent unplanned pregnancy at a time when women are more likely to get pregnant
- Increase access to LARC at a time when it's convenient for women
- Support vulnerable people to access contraception when they may not ordinarily access sexual health services

Midwives will provide information about all contraceptive methods' suitability, risks, and possible side effects, failure rates to all women at 28 weeks of gestation. Women who are under the care of the Rochdale and Oldham Midwifery Enhanced Service (ROMES) will be offered implants before leaving the post-natal ward or being booked into a clinic.[66]

Bury women may also access Bolton or North Manchester Foundation Trusts for maternity care. Bury Public Health and HCRG are working with both organisations to link women to either Bury Primary Care or SRH services for their post-natal contraceptive needs. In addition, they are exploring training opportunities for midwives working with Bury women to provide post-natal contraception via a contraceptive implant, particularly to the most vulnerable women.

Sexual Health Hubs

Throughout ORB, most community SRH services are delivered by HCRG Care Group, which rebranded in December 2021 from its former name, Virgin Care. HCRG partners with the NHS and SH:24, an online sexual health service, to form 'The Sexual Health Hub'. [67, 68]

Figure 4.2: Sexual Health Hub logo for ORB[67]

A Sexual Health Hub is based in each locality, offering a mix of bookable and walk-in appointments:

- The Integrated Care Centre, Sexual Health Oldham, OL1 1NL
- Nye Bevan House, Rochdale, OL11 1DN
- Townside Primary Care Centre, 1 Knowsley Place, Bury, BL9 0SN

All of the Sexual Health Hubs offer a comprehensive range of services, including:

- Sexual health advice and guidance
- Express STI testing with no appointment needed
- Fittings for LARC
- Injectable contraception
- Oral contraception
- Emergency contraception – coils and pills
- Testing and treatment for STIs
- Condoms and lubricant
- PrEP (Pre-exposure prophylaxis) HIV prevention medication
- PEP – (Post-exposure prophylaxis) emergency HIV prevention medication
- HIV treatment and care
- Partner notification
- Hepatitis B vaccination
- HPV vaccination
- Psychosexual counselling (by GP referral)

The following community clinics can also offer appointments for asymptomatic screening and most forms of contraception:

- Failsworth Primary Care Centre, Ashton Road West, Failsworth, M35 0AD
- Middleton Health Centre, F1, Middleton Way, Middleton, M24 4EL
- Redbank GP, Radcliffe Primary Care Centre, 69 Church St W, Radcliffe, M26 2SP

Every week, one of the hubs offers Saturday appointments. HCRG has created signposting videos that walk service users through a visit to the Oldham and Bury hubs.

Figure 4.3: What to Expect: Oldham Integrated Sexual Health Service video. [67]

PaSH Partnership

PaSH is a collaboration of partners who are "Passionate about Sexual Health across GM", comprising BHA for Equality, George House Trust, and the LGBT Foundation[69]. The partnership delivers interventions to meet the changing needs of people at greatest risk of acquiring HIV, newly diagnosed with HIV, and living longer term with HIV. PaSH is commissioned across all 10 GM localities and aims to empower people to practice safer sex, whilst raising HIV awareness and improving access to services.

BHA for Equality	George House Trust	LGBT Foundation
Free & confidential sexual health services for Black, Asian, and Minority Ethnic communities.[70]	Free & confidential support, advice, and advocacy services for people living with HIV.[71]	Providing advice, support, and resources for LGBT people to take control of their sexual health and wellbeing.[72]

Figure 4.4: The PaSH Partnership organisations

Manchester Action on Street Health

MASH provides vital, confidential, and non-judgmental support to female sex workers across ORB.[73] Key areas of focus include sexual health, substance misuse, and safety**.** Recognising the severe health inequalities and social challenges faced by sex workers, MASH takes a trauma-informed and compassionate approach, ensuring access to essential services while advocating for safer working conditions.

Through strong partnerships with organisations like Turning Point, local Community Safety teams, Mental Health Services, and Sexual Health Services, MASH offers tailored support in various settings. In Oldham and Rochdale, assistance is available for both street and sauna-based sex workers, while in Bury**,** services are provided exclusively through saunas. In Q3 of 2024, MASH supported more than 80 ORB residents.

Figure 4.5: Manchester Action on Street Health

6. Engagement

- Qualitative data collected- analysis pending

Figure 5.1: Qualitative feedback survey poster designed by Voice-2-Voice Workers

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Bury
Council

Are you 16 - 25 years?

1. Sexual Health Research Questions

Early Break, HCRG sexual health services and public health are looking for you to tell us what you think about contraception and condoms.
Take part in the confidential survey and share your opinion.
We are looking for people living in Oldham, Rochdale and Bury aged 16-25 years.
This questionnaire is strictly confidential and will not ask for any identifiable information such as name, address etc. Thank you for answering questions to help improve services for young people in our area. This survey is for everyone, even if some questions don't apply to you. Quotes may be used in our report, but all responses are anonymous. We cannot get in touch with you, so if you need help, please visit thesexualhealthhub.co.uk

Next

1. What is your age?

- ◯ 16-20
- ◯ 21-25

2. Which of the following options best describes how you think of yourself?

- ◯ Man (Including Transgender Man)
- ◯ Woman (Including Transgender Woman)
- ◯ Non-binary
- ◯ In another way (please specify)

3. Is your gender identity the same as the gender you were assigned at birth?

- ◯ Yes
- ◯ No
- ◯ I prefer not to say

4. Which of the following options best describes you?

- ◯ Heterosexual or Straight
- ◯ Gay or Lesbian
- ◯ Bisexual
- ◯ Other sexual orientation not listed (please specify)

5. What is your ethnic group?

- ◯ White - English/Welsh/Scottish/Northern Irish/British
- ◯ White - Irish
- ◯ White - Gypsy or Irish Traveller
- ◯ Mixed Ethnicity - White and Black Caribbean
- ◯ Mixed Ethnicity - White and Black African
- ◯ Mixed Ethnicity - White and Asian
- ◯ Asian/Asian British - Indian
- ◯ Asian/Asian British - Pakistani
- ◯ Asian/Asian British - Bangladeshi
- ◯ Asian/Asian British - Chinese
- ◯ Black/African/Caribbean/Black British - African

- ◯ Black/African/Caribbean/Black British - Caribbean
- ◯ Arab
- ◯ Another ethnicity not stated (please specify)

6. Which Greater Manchester Borough do you live in?

- ◯ Oldham
- ◯ Rochdale
- ◯ Bury
- ◯ Other (please specify)

7. Where do you access information about sex and sexual health?

- ☐ School/college/university/education
- ☐ Family/friends
- ☐ Online (webpages)
- ☐ Online (social media)
- ☐ Sexual Health Clinics
- ☐ GP/Doctors

- [ ] Other (please specify)

8. Have you found any sexual health content or accounts on Social Media?

- ◯ No
- ◯ Yes (What are the key messages of the content you have seen?)

9. What contraception do you use (if any)?

10. What do you think the pros and cons of hormonal contraception are?

11. What contraception have you previously used (if any)?

12. How often do you use protection when you have sex?

- ◯ Most of the time
- ◯ Sometimes
- ◯ Rarely
- ◯ Not needed

13. How confident do you feel at using condoms with a partner?

- ◯ Confident
- ◯ Not Confident
- ◯ Other (please specify)

14. How effective do you think condoms are at protecting against unplanned pregnancy/STIs?

- ◯ Effective
- ◯ Not effective
- ◯ Unsure (please specify)

15. Are you concerned about unplanned pregnancies? (Please specify why you are/are not)

16. Are you concerned with contracting a sexually transmitted Infection (STI)? (Please specify why you are/are not)

17. What protection against STIs do you use (if any)?

18. Are you aware of the following HIV prevention medicines? (Please tick the relevant box)

- [ ] PrEP (Pre-Exposure Prophylaxis)
- [ ] PEP (post-exposure prophylaxis)
- [ ] Both
- [ ] None

19. Do you know where to access free condoms and other forms of contraception?

- ◯ Yes
- ◯ No
- ◯ Unsure

20. Where would you like to be able to access condoms from, if you could choose anywhere?

21. If there is anything else you would like to share, please do so in the comment box below.

Thank you for your participation. We greatly appreciate your time and valuable feedback.
Please rest assured that all information provided will remain strictly confidential and will only be used for the purposes of this survey. Your responses are important to us.
Please press Done when you have finished answering the survey.

DONE

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Agenda Item 9a

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Bury Locality Board			
Meeting Date	02 June 2025	**Action**	Consider
Item No.	7	**Confidential**	No
Title	Update on PSR and developing Bury's Live Well Offer		
Presented By	Will Blandamer, Deputy Place Based Lead, NHS GM Bury		
Author	Chris Woodhouse, Strategic Partnerships Manager, Bury Council		
Clinical Lead	Dr. Cathy Fines		

Executive Summary

This report builds on previous updates to Locality Board on the development of Bury's neighbourhood model, articulated and driven through the Borough's LET's do it! approach, and increasingly honing Bury's neighbourhood model to best position the locality to benefit from ongoing devolution opportunities. In particular, it sets out the development of proposals for the implementation of the GM Live Well initiative anchored into Bury's neighbourhood working approach..

Recommendations

To note the update report and support system commitment to furthering Bury's neighbourhood model through Live Well implementation

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities

Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
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	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Links to Locality Plan priorities	

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
EQIA in development and will be kept live						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

PSR and Live Well update to Locality Board – May/June 2025

1. Context

1.1 This report builds on previous updates to Locality Board on the development of Bury's neighbourhood model, articulated and driven through the Borough's LET's do it! approach, and increasingly honing Bury's neighbourhood model to best position the locality to benefit from ongoing devolution opportunities.

1.2 The way public services work together in our neighbourhoods, in integrated teams and in partnership with the voluntary sector has been described as innovative and brave by the Local Government Association and through work to refresh the LET's do it! strategy there has been a recommitment to this approach. Bury is strongly placed to further develop the neighbourhood model to deliver on national opportunities through the Prevention Demonstrator and Get Britain Working Demonstrator and within the region to embed Live Well principles locally.

1.3 The image below sets out a summary of integrated neighbourhood working in Bury. In recent months there has been the clarification and reiteration of what is meant by neighbourhood working to embed a consistent understanding. Neighbourhood working refers to the establishment of multi-agency teams working on geographical footprints of 30-50k population, created to ensure 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.

Integrated Neighbourhood Working in Bury

Joined up services across 5 identified neighbourhoods; working with communities to relentlessly focus on prevention and earlier early intervention; maximising local assets and spaces in each neighbourhood to enable people to thrive.

Bury's model of 'integrated support' with a neighbourhood focus by default:

North	East	West	Whitefield	Prestwich
Each neighbourhood has a Neighbourhood profile and analysis of need, identification of cohorts of risk to tailor and target integrated person-centred activity				
Co-located multidisciplinary teams in each neighbourhood, led by a Public Service Leadership Team, integrating 'integrated support' through a 'Team Around' approach. Includes housing engagement; health and care integrated leads; social prescribers; employment support; Live and Stay Well; po lice and fire neighbourhood leads; Family Help leads; public health; voluntary sector infrastructure representatives				
Joint delivery of strengthened Integrated Neighbourhood Team (INTs) (Adult Care and Health) model including social prescribin g and increasing alignment of mental health early intervention and prevention.				
Rapidly developing model of family hubs described by neighbourhood and delivering the prevention and early intervention strat egy for children and increasingly connected to schools				
Finalising the Live Well model and specifically within this the neighbourhood -based employment support model.				
Strengths based approach built on LETS Behaviours to further engagement, participation and reduce inequalities, eg co-designing interventions with lived experience groups.				
Collective insight of community assets and networks, with which to work with communities and connect people at place as examples of Live Well spaces, coordinated by Bury Volunta ry, Community and Faith Alliance				

1.4 The intent is create 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. 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. In addition it is presumed to include representatives from the Council, DWP, Voluntary Services, GMP, GMFRS, Housing providers and others.

1.5 Locally this is building on a strong base of collaboration and place based working:

Implementing Live Well in Bury

2.1 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

2.2 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"

2.3 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

2.4 Bury colleagues from across the public and voluntary sectors have been actively involved in GM Live Well shaping activity, including on 19th March 2025 at Gorton Monastery. 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.

2.5 Bury's implementation allocation for Live Well, based on demographic percentage of the regional population, will be £676k of which at least 50% (£338k) is to be allocated to the local VCFSE sector. In return for the reginal investment there is a need for the locality to sharpen the local vision for Live Well in the context of Neighbourhood working, which locally is through our LET's do it! approach, and specifically identify the location and delivery model of an exemplar/ 'flagship' Live Well centre in the locality with this to be in operation by the end of 2025/26.

2.6 Through Bury's Public Service Reform Steering Group which meets monthly under the direction of the nominated Live Well lead for Bury, activity had accelerated during the past month on bringing system partners to further shape a potential Live Well proposition. This had included a consideration of opportunities to maximise alignment between existing place based integration with evolving model of Family Hubs; further work to build on learning from the Aging in Place Pathfinder projects across the region; and new opportunities as they come to light – such as the recent national government announcement of VALOUR Centres of place based support to Veterans.

2.7 In consideration of potential flagship sites, a number of key considerations are being made:

- Provision shouldn't duplicate other functions (e.g Ingeus Neighbourhub in Millgate which could be seen as a Live Well space in its own right) but instead complement and connect via 'hub/spoke' arrangements
- It must feel 'of the community' and VCSE leadership to the building is important and we need to co-design it with the community – noting that at least 50% of the available funding is towards the live well exemplar.
- The need to focus on targeted not universal service provision and therefore respond to local need
- The need to recognize any given building can't house everything - there are some competing demands
- Maximise opportunities to bring staff from different sectors together, and it is likely to be a base for integrated team working, potentially as anchor tenants of the building.
- A building that is open and accessible and welcoming with an intention for this to be volunteer led
- A place that has a point of navigation to a multiplicity of services in the neighbourhood and in the borough including a digital component

- A place that is bookable from which public services can deliver on a drop in basis
- A place that is bookable and supportive of a range of voluntary service delivery, drop in, and meeting space.
- Recogntion that a building might operate differently in the day and in the evening, and at weekends, and this will vary by neighbourhood including consideration of cultural sensitivities and customs.

2.8 Activity is progressing at pace to further develop an implementation plan for Bury including:

1) Further shape the framework describing Bury's Live Well Model and identification of flagship site proposal to inform co-development with the local community and local VCFSE sector
2) Development of a high level implementation timeline
3) Furthering investment proposal with VCFSE as part of formal sign agreement of Memorandum of Understanding with the Sector.
4) Confirmation of non-recurrent and recurrent funding arrangements.
5) Establishment of high level risk and issues log.

2.9 A further verbal update will be provided at the June meeting given the dynamic nature of the development of Live Well implementation proposals currently and Implementation Leads from Greater Manchester will be attending Locality Board meetings across districts in the coming months.

Recommendations

3.1 That Locaity Board receives this update and consider opportunities as both a collective Board and system representatives to shape Live Well implementation in Bury.