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, 4 September 2025
Place:	Microsoft Teams Meeting
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 12th June 2025 are attached.

5 MATTERS ARISING

6 WIDER DETERMINANTS OF POPULATION HEALTH

a ANTI-POVERTY UPDATE *(Pages 13 - 24)*

Update from Chris Brown Head of Revenues and Benefits

7 THE OPERATION OF THE HEALTH AND CARE SYSTEM

a PHARMACY NEEDS ASSESSMENT *(Pages 25 - 172)*

Update provided by NHS colleagues

b CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT *(Pages 173 - 208)*

Update from Steven Senior Consultant in Public Health (Healthcare Public Health & Health Protection)

c SEND AGENDA UPDATE *(Pages 209 - 248)*

Update from Deborah Glassbrook SEND Improvement Advisor

d BCF UPDATE *(Pages 249 - 256)*

Update From Adrian Crook Director of Community Commissioning

8 BEHAVIOUR AND LIFESTYLE DETERMINANTS OF HEALTH

a **SMOKING UPDATE** *(Pages 257 - 270)*

Update From Lee Buggie Public Health Specialist and Lizzie Howard Tobacco Control Officer

b **WINTER VACCINATION CAMPAIGN UPDATE** *(Pages 271 - 274)*

Update From Steven Senior Consultant in Public Health (Healthcare Public Health & Health Protection)

9 **THE EFFECT OF PLACE AND COMMUNITY ON HEALTH AND WELLBEING**

a **PREVENTION FRAMEWORK / NATIONAL HARMFUL PRODUCT TOOLKIT** *(Pages 275 - 312)*

Update from Jon Hobday Director of Public Health

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: 12 June 2025

Present: Councillor T Tariq (in the Chair)
Councillors L Smith, T Pilkington, A Arif, J Southworth and E FitzGerald

Also in attendance: Will Blandamer, Adrian Crook, Jon Hobday, Lee Buggie, Francesca Vale, Steven Senior, Rachel Davis, Dr Cathy Fines, Ruth Passman, Kath Wynne-Jones, Sian Grant, Gill Mirabitur, Sophie French

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

Apologies for Absence: Councillor S Walmsley, J Richards and L Ridsdale, Chris Woodhouse, Joanna Fawcus

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HWB.100 APOLOGIES FOR ABSENCE

Apologies for absence are noted above.

HWB.101 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HWB.102 PUBLIC QUESTION TIME

There were no public questions asked at the meeting.

HWB.103 MINUTES OF PREVIOUS MEETING

It was agreed:

That the minutes of the meeting held on 13th March 2025 be approved as a correct record.

HWB.104 MATTERS ARISING

There were no matters arising.

HWB.105 WIDER DETERMINANTS OF POPULATION HEALTH

a FOOD AND HEALTH STRATEGY

Lee Buggie, Public Health Specialist, and Francesca Vale, Public Health Practitioner, provided an update on various initiatives and achievements around the Food and Health Strategy. Francesca began by discussing the growth of the partnership, highlighting their award for the township, which was the first in Greater Manchester. She also mentioned their recognition in Westminster and shared insights from their visit to Copenhagen, where they learned about the city's educational program that ensures 90% of food is organic.

Francesca then moved on to discuss the implementation of auto-enrolment for free school meals, which has benefited 200 children. She emphasized the need to address thresholds and universal credit to further improve the program. David Catterall's role in overseeing the Greater Manchester market partnership was also highlighted, focusing on school catering and working with other markets across the region.

The Right to Grow campaign was introduced, aiming to utilize unused council land for community growing projects. Legal teams have drafted a lease agreement for community growing, and a community growing page has been created to map sites for groups to use. The Fast-Food Takeaway Matrix, part of their food health strategy, was discussed, providing recommendations for fast food takeaways based on specific criteria. The Licensing Matrix, which links to the Fast-Food Takeaway Matrix, was also mentioned as a tool for considering healthier options for takeaways.

During the Q&A session, Councillor Tariq thanked Francesca for her contributions and acknowledged the hard work of David Catterall and Andrew Cowen. He also mentioned an upcoming visit on the 8th and 9th of July to showcase their food partnership event.

Councillor Smith inquired about the criteria for the Right to Grow campaign and whether there is a limit on the number of approvals. Lee Buggie responded that it would depend on council resources and public liabilities. Councillor Smith also inquired about using non-green spaces for town centre regeneration, to which Lee replied that they are considering all applications and public liabilities. Councillor Smith requested the involvement of children and young people in future initiatives.

Will Blandamer thanked the presenters and emphasized the importance of linking their initiatives to health scrutiny and the free school meals program. Councillor Pilkington asked about the difference between the Right to Grow campaign and the Incredible Edible initiative. Francesca explained that the Right to Grow campaign is led by the same force behind Incredible Edible and aims to be more robust and sustainable.

Councillor Southworth inquired about the support available for these initiatives, while Councillor Fitzgerald discussed the food partnership's access to food from farms and the role of community groups in making meals with food from food banks.

Actions and Agreements:

- The update provided by Francesca Vale and Lee Buggie was noted and appreciated.
- Further exploration of the Right to Grow campaign's criteria and potential expansion to non-green spaces will be undertaken.
- The involvement of children and young people in future initiatives will be considered.
- Continued collaboration with partners in Stockport and Salford to improve the free school meals program.

b **SCHOOL READINESS**

Gill Mirabitur Early Years Advisor delivered a presentation on the importance of early education, describing it as the “best part of life.” She provided an overview of the Early Years Foundation Stage (EYFS) and the process used to assess children’s development through the Early Years Profile, which informs the Good Level of Development (GLD) measure.

Gill emphasised the need for a whole-system approach, where all professionals across Bury take collective responsibility for improving outcomes for children, particularly in

neighbourhoods facing greater challenges. She highlighted that while Bury has at times outperformed national averages in GLD, there remain significant disparities between groups particularly among boys, children with English as an Additional Language (EAL), and those with Special Educational Needs and Disabilities (SEND).

The presentation included borough-wide data comparisons, showing year-on-year trends and the widening gender gap. Gill noted that EAL children often catch up by Key Stage 2, but early years outcomes remain a concern. She also acknowledged the complexity of data collection, as many children fall into multiple overlapping categories.

Councillor Tariq welcomed the presentation and shared a personal reflection on the stigma some families feel when sending children to early years settings. He raised concerns about the long-term cost implications for schools if early years gaps are not addressed. Gill agreed, noting that early intervention is both more effective and more economical than later remediation.

Councillor Fitzgerald expressed support for the progress made in Whitefield SEND provision and highlighted the value of local hubs in supporting EAL children. She referenced a school in her ward with 36 languages spoken and noted that while EAL children often catch up, poverty and other contextual factors must also be considered.

Councillor Smith raised the issue of school readiness, particularly for children whose parents return to work early. She stressed the importance of the first 1000 days of life and the need for coordinated support to ensure children are developmentally prepared for school.

Jon Hobday Director of Public Health acknowledged the volume of data available and emphasised that the evidence base for effective interventions is strong. He encouraged the Board to work together to ensure these interventions are implemented consistently across the system.

In response, Gill outlined ongoing work with GMCA, including support for multilingual children and the development of cultural capital training. She also referenced the EYAT model and the need to spotlight physical development as a key area for improvement.

It Was Agreed

- The Board noted the presentation and thanked Gill Mirabitur for her comprehensive update.
- It was agreed that a follow-up report and action plan would be brought back to the Board within six months, focusing on targeted support for EAL, SEND, and disadvantaged groups in early years settings.

HWB.106 THE OPERATION OF THE HEALTH AND CARE SYSTEM

a BCF UPDATE

Adrian Crook, Director of Adult Social Services and Community Commissioning, provided an overview of the latest performance report. He has held the post since 2015 and outlined the scope of services delivered.

The report highlighted key performance metrics, including four measures related to avoidable admissions, where an algorithm narrowly missed the target by 10%. Intermediate care services also fell just short of the benchmark by 0.9%, though falls prevention met its target and was supported by a best practice case study.

Residential admissions have remained steady despite a 5% population growth, which is not currently reflected in departmental metrics. The urgent and school rapid response service, funded through the Better Care Fund (BCF), continues to be the busiest and highest performing, handling approximately 350 cases per month.

The Q4 performance and integrated reports were positively received, with input from eight external experts. Kath-Wynne Jones noted that indicators in specific areas are expected to improve before July. From 1st July, data will be refined to exclude certain cohorts, allowing for more accurate performance tracking.

Positive developments were also reported in dementia care, supported by the Pathway Data Frontrunner Programme, and the "Getting It Right First Time" initiative, which uses tailored metrics to monitor the flow of elderly patients. Fairfield Hospital was recognised as the top performer nationally in this area.
Councillor Pilkington emphasised the importance of embedding preventative measures across all services. The urgent care service, based at Textile Hall and limited to Bury residents, remains a key access point. Will Blandamer confirmed that site-specific data is available, and Dr. Fines reported a significant cultural shift, with staff now welcoming rapid response calls.

Kath Wynne Jones added that the borough is currently ranked second nationally in terms of performance, with a notable reduction in hospital deaths. A community event at Fairfield's canteen was highlighted as an example of integrated support for primary care, helping to build confidence in delivering new models of care.

It Was Agreed

- The report be noted

b **HEALTH PROTECTION ANNUAL REPORT**

Steven Senior, Public Health Consultant, presented the Health Protection Annual Report, highlighting key achievements and ongoing challenges across infection control, vaccination, and environmental health. Over the past year, 77 common outbreaks were recorded, including COVID-19, flu, and D&V, with 16 outbreaks managed in care homes. A total of 90 outbreaks were reported overall, with additional isolated cases in schools.

The team has strengthened infection control through risk-based audits and joint visits with adult social care. Environmental monitoring, including air quality assessments near Pilsworth landfill, continues to ensure public safety. Templates are being developed to support care homes in managing Legionella risks.

Vaccination efforts were bolstered by a successful MMR catch-up campaign in response to a local outbreak. NHS GM secured 800 MMR doses, with 35% administered to residents from the most deprived areas, helping to reduce health inequalities. The Local Vaccine Assurance Group continues to support uptake, particularly among older adults.

Hospital-acquired infections and antimicrobial resistance are decreasing, supported by improved medicines optimisation. The report also noted the importance of maintaining capacity, with only 1.4 FTE staff currently delivering this essential work. Concerns were raised about potential staffing changes due to ICB restructuring.

It Was Agreed

- The Board **noted** the Health Protection Annual Report and acknowledged the significant work undertaken to protect public health across the borough.

HWB.107 BEHAVIOUR AND LIFESTYLE DETERMINANTS OF HEALTH

a SEXUAL HEALTH NEEDS ASSESSMENT

Sophie French, Public Health Registrar presented the sexual health needs assessment Bury ranks in the lower half nationally for several sexual health indicators. The assessment identified disparities in access, testing, and outcomes, with a focus on reducing inequalities and improving service delivery. Sophie discussed presented eight recommendations.

Eight Key Recommendations:

1. **Align Stakeholders:** Share the STI Prioritisation Framework to unify efforts, especially for underserved groups.
2. **Promote Chlamydia Screening:** Focus on women in deprived areas, ensuring consistent delivery across localities.
3. **Introduce 4CMenB Vaccination:** Prevent up to 40% of gonorrhoea cases through targeted immunisation.
4. **Boost HPV Vaccination Uptake:** Restore pre-pandemic levels, leveraging the streamlined school-age schedule.
5. **Support DoxyPEP Use:** Increase confidence among clinicians and patients with updated guidance for high-risk groups.
6. **Expand Mpox Vaccination:** Scale up routine vaccination as supply grows, improving prescribing practices.
7. **Raise Shigellosis Awareness:** Target GBMSM communities, including trans women and marginalised groups.
8. **Continue Opt-Out HIV Testing:** Maintain implementation across ORB and oversee related immunisation programmes.

Cllr Pilkington raised concerns about digital access and testing coverage, noting commissioning complexities.

Will Blandamer & Jon Hobday praise the report's clarity and ambition, with Jon stressing the need for funding to support implementation.

It Was Agreed

- The Board noted the assessment and endorsed further work to explore implementation and funding opportunities.

HWB.108 PLACE BASED PERSON CENTRED APPROACH

a LIVE WELL UPDATE

Will Blandamer, Executive Director of Health and Adult Care and Deputy Place Lead for NHS Greater Manchester, introduced the item by highlighting the significant progress Bury has made in developing its neighbourhood working model. Each of the five neighbourhoods is increasingly working in a collaborative and integrated way, with strong relationships forming across services. An emerging model of family hubs is taking shape, aligning with the national NHS direction of travel towards multi-disciplinary public service delivery.

The voluntary, community, and faith sector (VCFA) continues to play a crucial role in this transformation. There is growing capacity and momentum within the VCFA, supported by initiatives such as the Bury Fund and broader public service reform efforts. Bury is seen as being well advanced in this space, with its approach aligning closely with the Greater Manchester vision for integrated care and community empowerment.

A key development is the "Live Well" model, part of Andy Burnham's public service reform agenda. Each locality is invited to define its own Live Well approach, supported by a £10 million investment fund. This model combines advice, guidance, and community strengthening, and Bury is actively working through its options to shape a localised version of Live Well that reflects its strengths and priorities.

Helen Tomlinson from the VCFA shared insights from other boroughs and emphasised that Bury's approach, while distinct, can build on this learning. She highlighted the importance of not just having a central hub, but also ensuring that the surrounding "spokes" including faith-based and community spaces are supported and aligned. The VCFA is well placed to complement and enhance the Live Well offer, and there is a strong emphasis on ensuring that community voice is embedded in the model.

Councillor Fitzgerald queried whether the £10 million Live Well investment is a one-off or recurring fund. Helen responded that further clarification is needed, particularly around whether funding can be carried over and how different aspects of the fund might be leveraged to create additional social value. Councillor Tariq added that the Greater Manchester Integrated Care Partnership, led by Andy Burnham, is committed to playing a leading role in transforming lives through this initiative.

It Was Agreed

- The report be noted

HWB.109 GM POPULATION HEALTH BOARD FEEDBACK

Jon Hobday, Director of Public Health, provided an update from the Greater Manchester Population Health Board.

It was agreed:

That the update be noted.

HWB.110 URGENT BUSINESS

There was no urgent business.

COUNCILLOR T TARIQ
Chair

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

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Let's Tackle Poverty & HSF update Health and Wellbeing Board

4th Sept 2025

Agenda Item 6a

Background

- A lot of good work being undertaken
- Hard working and committed officers trying to make a difference
- Solid foundations within our community and voluntary links

- Are we sufficiently outcome driven
- Are we connecting our services?
- Are we drawing on the lived experience of residents / partners?
- Are we too passive and Bury-centric in our approach to direct support?

Bury Council

How are we changing this?

- Full-service redesign of Revenues and Benefits
- Creation of the Supportive Collection Team:
  - Welfare Support team embedded within existing Collection teams
  - Change in ethos….LET's Engage – LET's Enable – LET's Support
  - Improved engagement and performance
- Implementation of Resident Access Plan
  - Transform our service delivery model from a primarily back-office approach through creation of a meaningful and proactive wrap around advice and support offer '*in the place*'
  - Achieved through the establishment of permanent service presence in locations across the borough.
  - In a face-to-face environment, ensure any and all available, relevant support measures are explored and provided regardless of any singular reason for service access.
  - Allied with development in our telephony and digital offers this will maximise welfare, support and collection opportunities and resolution at the first point of contact for residents.

Bury Council

Resident Access Pilots

Current Drop-Ins

Prestwich Library

- **Start Date:** Thursday, 15th May
- **Time:** Every Thursday, 12:30 PM – 4:30 PM

- **Bury Library**
  - **Start Date:** Friday, 6th June
  - **Time:** Every Friday, 10:30 AM – 1:30 PM

Future Drop-Ins

- **Bury Town Hall, Ramsbottom** and **Radcliffe**

Providing support with…

•Crisis support

•Council Tax

•Housing Benefits & Council Tax Support

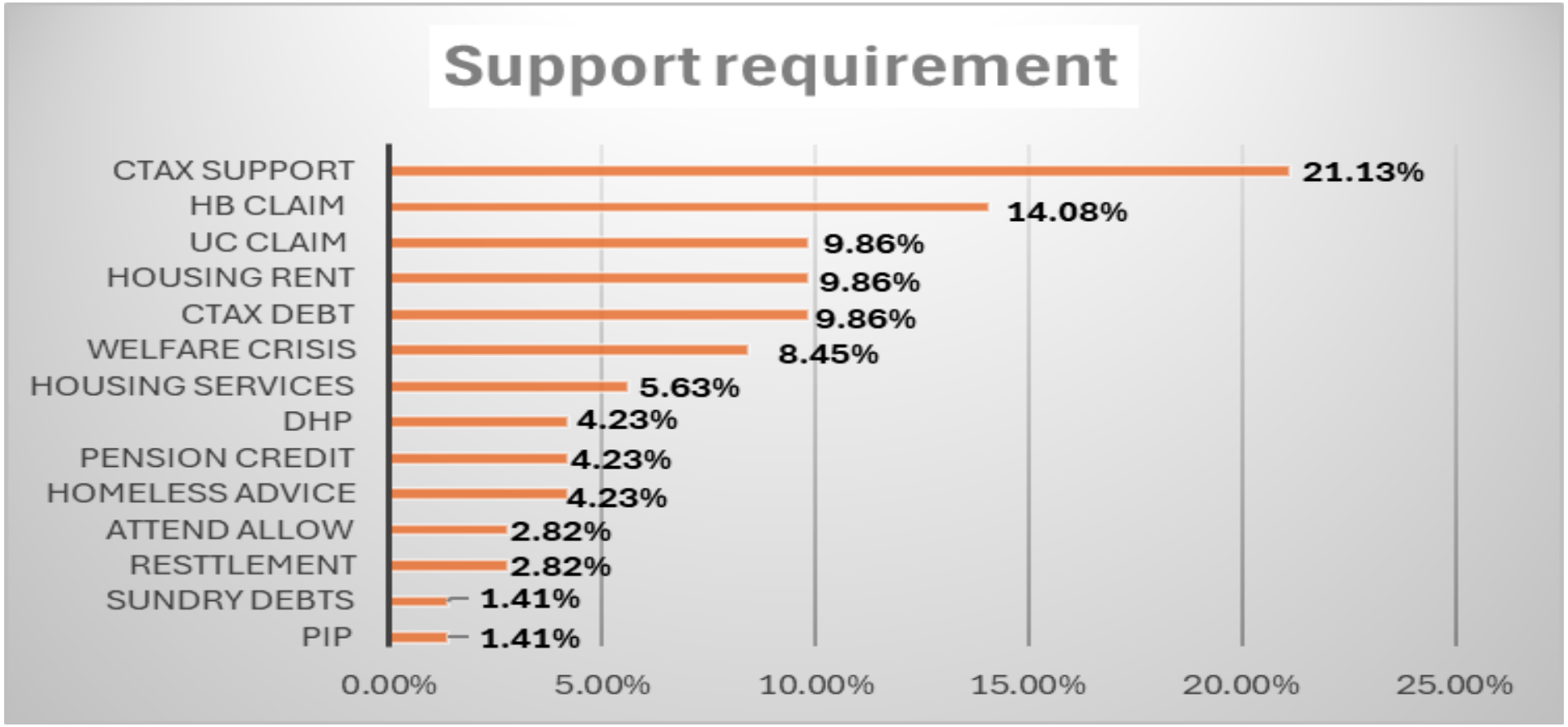
•Housing Rents

•Income maximisation & help to claim benefits including PIP

•Adult Social Care bills

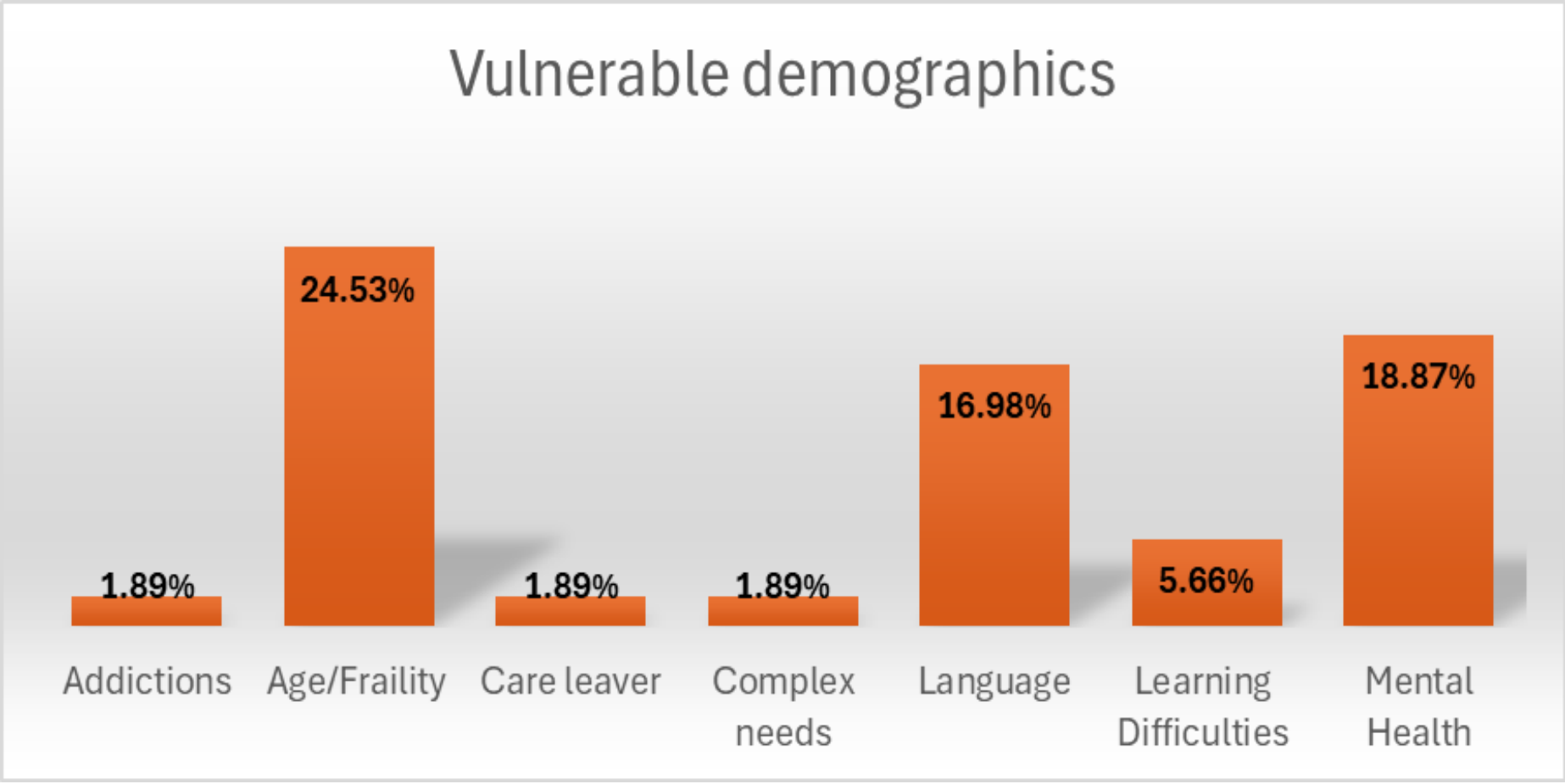
Bury Council

Early results



Bury Council

Early results

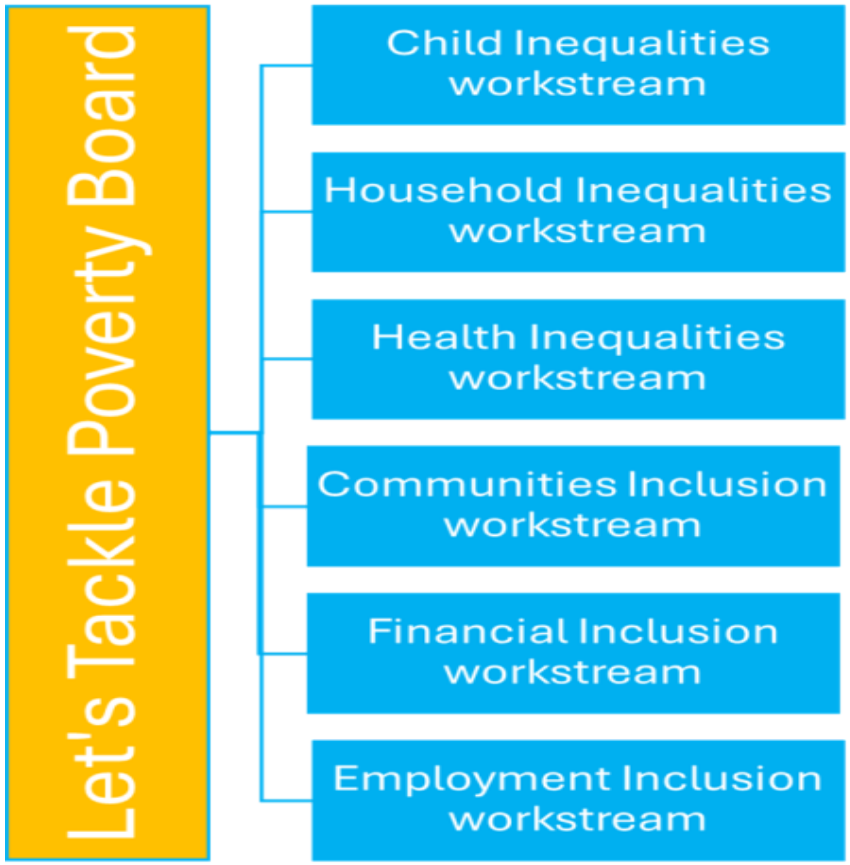


Bigger opportunities - proposal

An overarching 4 year Let's Tackle Poverty Strategy from April '26:

- Relevant strategies act as outcome drivers
- Key initiatives become pivotal enablers
- Outcome driven
- Inclusive
- Collaborative
- Consultative
- Commission Resolve Poverty to collaborate on design and implementation

Improved structure and governance



- New set of focused workstreams
  - Outcome driven
  - Workstream leads
  - Team Bury representation
- Governance through new Let's Tackle Poverty Board
  - Member chair
  - Supported by relevant leads
  - Team Bury representation

Bury Council

Resolve Poverty offer

Strategy development

- Phase 1: Scoping
- Phase 2: Lived experience engagement
- Phase 3: Anti-poverty strategy development including robust governance and accountability for partnership working

Strategy implementation and strategic partnership

- Phase 4: Strategy implementation and strategic partnership working

Total cost £29,532 – Fully funded through HSF 2025/26.

Bury Council

Household Support Fund 2025/26

- Last round of HSF before replacement by CRF
- 18% decrease in funding
  - Holiday Free School Meals
  - Summer and Winter Crisis Funds
  - Targeted support to key vulnerable groups
- However, more emphasis on prevention & change in approach required

Bury Council

Preventative Pilot Schemes

- Growing Together Radcliffe - Incentivised cooking on a budget courses
- Bury Council Private Sector Housing - Improving energy affordability for vulnerable residents
- Bury Adult Learning – Incentivised budgeting and cookery courses
- Citizens Advice - Provision of debt and welfare rights advice and support and community outreach work.
- Bury VCFA - Support for warm spaces and building preventative provision within the sector
- Bury Council Homeless Prevention – Capacity building for early intervention and preventative support work
- Trust House Bury - Capacity building and provision of budgeting courses
- Jewel - Incentivised employment and skills training
- Age UK Bury - Capacity building to allow expansion of service and support to our older residents

Bury Council

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Bury Council

Classification Open / Closed	Item No.

Meeting:	Bury Health and Wellbeing Board
Meeting date:	4th Sep 2025
Title of report:	Bury Pharmaceutical Needs Assessment (PNA) report
Report by:	Shenna Paynter, Public Health Specialist Presented by Steve Senior, Public Health Consultant, & NHS GM Community Pharmacy Integration and Commissioning Team Board Member- Jon Hobday, Director of Public Health
Decision Type:	Decision- Acceptance of the Bury PNA before statutory 60 day stakeholder consultation period.
Ward(s) to which report relates	Bury Wide

Executive Summary:

1.1 The purpose of this report is to share the final draft of the Bury Pharmaceutical Needs Assessment report with the HWB Board members for approval, before it goes to a statutory 60-day stakeholder consultation.

1.2 The Pharmaceutical Needs Assessment (PNA) is a legal document which each Health and Wellbeing Board must publish every 3 years. It details the location and accessibility of pharmacies in the area (Bury) and which services they provide. The nationally produced Pharmaceutical needs assessment information pack (updated July 2025) provides further details. The PNA for Bury presents a picture of community pharmacy need and provision in Bury and links to Bury's Joint Strategic Needs Assessment (JSNA).

1.3 The PNA is also used by commissioners and pharmacy contractors to determine whether a pharmacy can help improve the health of the local population through commissioned or provided services.

1.4 The PNA 2025-2028 has been developed by NHS Greater Manchester Integrated Care on behalf of Bury's Health and Wellbeing Board using a standard methodology

in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Service) Regulations 2013, as amended. It replaces the Bury Pharmaceutical Needs Assessment (PNA) previously published in 2023.

1.5 A steering group was established to lead a comprehensive engagement process to inform the development of the PNA. The group undertook a public survey and sought information from pharmacies, Bury Council, NHS GM, Community Pharmacy Greater Manchester (CPGM) and NHS commissioning boards (NHSCB), to identify issues in service provision and to meet local health needs and priorities.

1.6 The PNA includes information on:

- Pharmacies in Bury and the services they currently provide including dispensing, providing advice on health, medicines reviews and local public health services.

- Other local pharmaceutical type services, including dispensing appliance contractors (DAC).

- Relevant maps relating to Bury and providers of pharmaceutical services in the HWB area. In the PNA Bury is divided into five integrated neighbourhood profiles as described in the Bury JSNA
  - Bury East
  - Bury North
  - Bury West
  - Prestwich
  - Whitefield

- Potential gaps in provision that could be met by providing alternative pharmacy services, or through opening more pharmacies, and likely future needs.

2. Recommendation(s)

Based on all available information, the PNA has found no current or future gaps in the provision of essential, advanced, or enhanced pharmaceutical services across Bury. The existing pharmacy coverage meets the population's needs during and outside normal working hours, and no improvements or additional services have been identified as necessary. It is recommended that the HWB accept this final Bury 2025-2028 PNA before it goes to a statutory 60 day stakeholder consultation and following which the PNA will be published under the direction of this Board.

3. Key considerations:

3.1 Introduction/ Background:

Bury's Health and Wellbeing Board (HWB) has a statutory responsibility to publish and keep up to date the PNA for Bury.

It will be used by NHS commissioning bodies to

- inform which NHS funded services need to be provided by community pharmacies and dispensing appliance contractors
- decide whether new pharmacies or services are needed
- aid decision making about the relocation of existing pharmaceutical premises in response to applications by providers of pharmaceutical services
- inform the commissioning of locally enhanced services delivered from pharmacies to address any gaps in health care provision

Providers of pharmaceutical services will also use the PNA to inform their applications to provide pharmaceutical services by demonstrating that they are able to meet a pharmaceutical need as set out in the PNA.

3.2 Key Issues for the Board to consider:

The PNA concluded no gaps in current pharmaceutical services had been established. This is clearly demonstrated by the following points:

- Bury has 21 pharmacies per 100,000 population, which is more than the England (18) and equal to the Greater Manchester (21) averages.
- Most residents live within 1.0 miles of a pharmacy.
- Most residents can access a pharmacy within 20 minutes either by walking, public transport or driving.
- The location of pharmacies within each of the five neighbourhoods and across the whole HWB area.
- The number and distribution of pharmacies within each of the five neighbourhoods and across the whole HWB area.
- The choice of pharmacies covering each of the five neighbourhoods and the whole HWB area.
- 92% of respondents to the public survey had not had any difficulty in accessing a pharmacy of their choice.
- 93% of respondents to the public survey had not had any difficulty in accessing a pharmacy due to location.
- 82% of responders said the opening hours of pharmacies in Bury do not cause a problem

- Bury has a choice of pharmacies open across range of times including early mornings, evenings and the weekend.
- Bury pharmacies offer a range of pharmaceutical services to meet the requirements of the population.

Therefore

- No current gaps in the need for provision of essential services during normal working hours have been identified.
- No current gaps in the provision of essential services outside normal working hours have been identified.
- No current gaps in the provision of advanced and enhanced services have been identified.
- No gaps in the need for pharmaceutical services in specified future circumstances have been identified.
- No gaps have been identified in essential services that if provided either now or in the future would secure improvements, or better access, to essential services.
- No gaps have been identified in the need for advanced services that if provided either now or in the future would secure improvements, or better access, to advanced services.
- No gaps in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances have been identified.

Community impact/links with Community Strategy

To identify how pharmaceutical service provision can help tackle the need of Bury's local population, we have used HWB minutes from 16/01/2025 meeting. The HWB have also identified priorities in the locality plan update for 2025 to address issues which will help drive the changes recommended in Bury's Let's do it! strategy. The priorities identified by the HWB that are related to pharmaceutical services provision are:

1. Increase annual physical activity
2. Management of obesity and healthy weight
3. Reduce smoking prevalence
4. Harm reduction from drugs and alcohol

5. Health protection – immunisations and vaccinations
6. Increase in pharmacy first uptake

The major conditions board have also identified the following major conditions as priorities:

7. Cardiovascular disease
8. Respiratory disease (COPD and Asthma)
9. Cancers
10. Musculoskeletal conditions

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

> *A public authority must, in the exercise of its functions, have due regard to the need to -*
>
> (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
>
> (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
>
> (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*
Population characteristics and health needs are assessed in section 4.5 of the PNA. The following patient groups with one or more of the following protected characteristics have been identified as living within the HWB's area: ➢ Age ➢ Sex ➢ Being pregnant or on maternity leave	

- Disability
- Gender reassignment
- Being married or in a civil partnership
- Race which includes colour, nationality, ethnic or national origins
- Religion or belief
- Sexual orientation

The section also focusses on the health issues, setting out how pharmacies can support the specific needs of the population as defined by the protected characteristics in equality legislation.

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

Legal Implications:

To be completed by the Council's Monitoring Officer

The Health and Social Care Act 2012 transferred responsibility for the developing and updating of PNA's to the Health and Wellbeing Boards, making it their statutory duty to publish and keep updated the PNA.

Failure to comply with the statutory duty of publishing and updating the PNA will result in increased scrutiny, negative impact on reputation, impact on commissioning services and identification of current gaps in pharmaceutical services.

The PNA is of particular importance to NHS England & Improvement who since 1st April 2013 (and as identified in the Health and Social Care Act 2012) is responsible for maintaining pharmaceutical lists.

The PNA is a key document in making decisions with regard to applications made under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

Financial Implications:

To be completed by the Council's Section 151 Officer

There are no costs associated with the PNA report at this stage. (the production of the PNA has a cost which is covered by the public health budget).

There are no financial implications for the authority. From a wider viewpoint if no gaps are identified in the PNA then there will be no financial implications to the wider health economy.

Report Author and Contact Details:

Shenna Paynter, Public Health Specialist s.paynter@bury.gov.uk

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Background papers:

- Bury Pharmaceutical Needs Assessment 2025-2028
- Appendix One – Glossary
- Appendix Two – BOR PNA steering group TOR FINAL v01 291124
- Appendix Three – Public survey results -Bury
- Appendix Four – Pharmacy survey results
- Appendix Five – Locally Commissioned services
- Appendix Six – Bury Pharmacies
- Appendix Seven – Advanced services
- Appendix Eight – Community Pharmacy Opening Hours
- Appendix Ten - Maps
- Appendix Eleven – GP Practices
- Appendix Twelve – One mile boundary pharmacies

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning
BOR	Bury, Oldham and Rochdale's Health and Wellbeing Boards/local authority
COPD	Chronic Obstructive Pulmonary Disease
CPGM	Community Pharmacy Greater Manchester
DAC	Dispensing Appliance Contractor
HWB	Health and Wellbeing Board
NHS	National Health Service
NHSCB	NHS Commissioning Board
NHSGM	NHS Greater Manchester

PNA	Pharmaceutical Needs Assessment
TOR	Terms of Reference.

Bury Health and Wellbeing Board
Pharmaceutical Needs Assessment
2025 to 2028

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1 Executive Summary

1.1 Introduction

A Pharmaceutical Needs Assessment (PNA) is a comprehensive assessment of whether current and future pharmaceutical services meet the needs of the local population.

- Bury's Health and Wellbeing Board (HWB) has a statutory responsibility to publish and keep up to date the PNA for Bury. The PNA for Bury presents a picture of community pharmacy need and provision in Bury and links to Bury's Joint Strategic Needs Assessment[1] (JSNA).
- It will be used by NHS commissioning bodies to
  - inform which NHS funded services need to be provided by community pharmacies and dispensing appliance contractors
  - decide whether new pharmacies or services are needed
  - aid decision making about the relocation of existing pharmaceutical premises in response to applications by providers of pharmaceutical services
  - inform the commissioning of locally enhanced services delivered from pharmacies to address any gaps in health care provision
- Providers of pharmaceutical services will also use the PNA to inform their applications to provide pharmaceutical services by demonstrating that they are able to meet a pharmaceutical need as set out in the PNA.

The PNA includes information on:

- Pharmacies in Bury and the services they currently provide including dispensing, providing advice on health, medicines reviews and local public health services.
- Other local pharmaceutical type services, including dispensing appliance contractors (DAC).
- Relevant maps relating to Bury and providers of pharmaceutical services in the HWB area.
- Potential gaps in provision that could be met by providing alternative pharmacy services, or through opening more pharmacies, and likely future needs.

This document has been prepared by NHS Greater Manchester (NHS GM) on behalf of Bury's Health and Wellbeing Board (HWB) in accordance with the NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013, as amended. It replaces the Pharmaceutical Needs Assessment (PNA) previously published in 2022.

A steering group was established to lead a comprehensive engagement process to inform the development of the PNA. The group undertook a public survey and sought information from pharmacies, Bury Council, NHS GM, Community Pharmacy Greater Manchester (CPGM) and NHS commissioning boards (NHSCB).

The data and analysis that is presented in the PNA is supported by a number of appendices, please note there is no appendix 9 in this iteration of the PNA.

Bury has a population of 193,855 (2021 Census). Between 2023 and 2033 the Bury population is estimated to increase by 5,798 (ONS mid-2018 population estimate). This includes a 15.4% increase in those aged 65 and over, with an additional 5,617 adults in this age bracket, which will have implications for the commissioning of services.

To identify local health needs and assess current pharmaceutical services provision, Bury is divided into five integrated neighbourhood teams as described in the Bury directory[2]:

- Bury East
- Bury North
- Bury West
- Prestwich
- Whitefield

[1] Joint Strategic Needs Assessment - Bury Council

[2] The Bury directory - Neighbourhood profiles

Information regarding local provision of pharmaceutical services was made available by NHS CB, Bury Council, NHS GM and CPGM. Other relevant nationally available data was gathered through providers such as ONS and NHSBSA. This was analysed by the NHS GM Medicines Optimisation Team on behalf of the Steering Group.

As part of the PNA process there is a statutory provision that requires consultation of at least 60 days to take place to establish if the pharmaceutical providers and services supporting the population in the HWB area are accurately reflected in the final PNA document. Bury Council ran a stakeholder consultation and the responses received were used to inform the final conclusions which were collated and are now published as part of this PNA.

1.2 Results

Bury has 41 pharmacies (37 walk-in and 4 distance selling pharmacies) providing a range of essential services, advanced services, and locally commissioned services (including NHSCB enhanced services) on behalf of Bury Council and NHSCB. All pharmacies in Bury have NHSCB contracts, there are no Local Pharmaceutical Service (LPS) Contracts.
There are four Pharmacies with 100-hour contracts, opening hours may vary due to new regulations as described in section 3.6.4. There are no dispensing doctors or dispensing appliance contractors (DAC) in Bury, but residents of Bury can access dispensing and services associated with appliances from a regular pharmacy contractor or through DACs elsewhere within England.
There have been pharmacy closures since the last PNA; one in Ramsbottom and one in Radcliffe East, where service provision has been absorbed by existing providers.
The PNA concluded no gaps in current pharmaceutical services had been established. This is clearly demonstrated by the following points:

- Bury has 21 pharmacies per 100,000 population, which is more than the England (18) and equal to the Greater Manchester (21) averages.
- Most residents live within 1.0 miles of a pharmacy.
- Most residents can access a pharmacy within 20 minutes either by walking, public transport or driving.
- The location of pharmacies within each of the five neighbourhoods and across the whole HWB area.
- The number and distribution of pharmacies within each of the five neighbourhoods and across the whole HWB area.
- The choice of pharmacies covering each of the five neighbourhoods and the whole HWB area.
- 92% of respondents to the public survey had not had any difficulty in accessing a pharmacy of their choice.
- 93% of respondents to the public survey had not had any difficulty in accessing a pharmacy due to location.
- 82 % of responders said the opening hours of pharmacies in Bury do not cause a problem
- Bury has a choice of pharmacies open across range of times including early mornings, evenings and the weekend.
- Bury pharmacies offer a range of pharmaceutical services to meet the requirements of the population.

1.3 Stakeholder Consultation

As part of the PNA process there is a statutory provision that requires consultation of at least 60 days to take place to establish if the pharmaceutical providers and services supporting the population in the HWB area are accurately reflected in the final PNA document. Bury Council's consultation ran from 15th July 2022 until 13th September 2022. The responses received were used to inform the final conclusions which were collated and are now published as part of this PNA.

1.4 Conclusions

Considering the totality of the information available, the HWB considered whether the location, number, distribution and choice of pharmacies covering each neighbourhood, including the whole of Bury HWB area providing essential and advanced services during the standard core hours currently meet the needs of the population.

The HWB has not received any significant information to conclude otherwise or any future specified circumstance that would alter that conclusion.

Based on the information available at the time of developing this PNA:

- No current gaps in the need for provision of essential services during normal working hours have been identified.
- No current gaps in the provision of essential services outside normal working hours have been identified.
- No current gaps in the provision of advanced and enhanced services have been identified.
- No gaps in the need for pharmaceutical services in specified future circumstances have been identified.
- No gaps have been identified in essential services that if provided either now or in the future would secure improvements, or better access, to essential services.
- No gaps have been identified in the need for advanced services that if provided either now or in the future would secure improvements, or better access, to advanced services.
- No gaps in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances have been identified.

2 Introduction

This document has been prepared by NHS GM on behalf of Bury's Health and Wellbeing Board (HWB) in accordance with the NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013, as amended. It replaces the Pharmaceutical Needs Assessment (PNA) previously published in 2022.
In the current NHS there is a need for the local health partners, NHSCB, Bury Council, Bury pharmacies and other providers of health and social care, to ensure that the health and pharmaceutical needs of the local population are met through the appropriate commissioning of services.
There is also a need to ensure that those additional services commissioned by Bury Council or NHSCB from Bury pharmacies are promoted to Bury's population to improve their uptake.
The current providers of pharmaceutical services in Bury are well placed to support the HWB in achieving the required outcomes identified as the health priorities outlined in its strategy.
Glossary and acronyms are provided in Appendix One.

2.1 Purpose of a PNA

The purpose of the PNA is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a HWB's area for a period of up to three years, linking closely to the joint strategic needs assessment (JSNA). Whilst the JSNA focusses on the general health needs of the population of Bury, the PNA looks at how those health needs can be met by pharmaceutical services commissioned by NHSCB and LAs.
If a pharmacist or a dispensing appliance contractor wants to provide pharmaceutical services, they are required to apply to NHSCB to be included in the pharmaceutical list for the HWB's area in which they wish to have premises. In general, their application must offer to meet a need that is set out in the HWB's PNA, or to secure improvements or better access similarly identified in the PNA. There are however some exceptions to this e.g. applications offering benefits that were not foreseen when the PNA was published ('unforeseen benefits applications').
As well as identifying if there is a need for additional premises, the PNA will also identify whether there is a need for an additional service, or whether improvements or better access to existing services are required. Identified needs, improvements or better access could either be current or will arise within the lifetime of the PNA.
Whilst the PNA is primarily a document for NHSCB to use to make commissioning decisions, it may also be used by Local Authorities (LA's) and Integrated Care Systems (ICSs). A robust PNA will ensure those who commission services from pharmacies and dispensing appliance contractors (DACs) are able to ensure services are targeted to areas of health need and reduce the risk of overprovision in areas of less need.

2.2 HWB duties in respect of the PNA

In summary Bury HWB must:

- Produce an updated PNA which complies with the regulatory requirements.
- Publish PNAs on a three-yearly basis.
- Publish a subsequent PNA sooner when it identifies changes to the need for pharmaceutical services which are of a significant extent, unless to do so would be a disproportionate response to those changes; and
- Produce supplementary statements in certain circumstances.

2.3 Background and legislation

2.3.1 National Legislation

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 state that every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish every three years and keep up to date a statement of the need for pharmaceutical services in its area, otherwise referred to as a pharmaceutical needs assessment (PNA). From July 2022, the NHS Greater Manchester Integrated Care Board (GM ICB) is responsible for managing the Community Pharmacy Contractual Framework and is expected to refer to the PNA when making decisions about market entry for new service providers, as well as in the commissioning of enhanced services from pharmacies.
GM ICB will work to deliver the strategy set by our Integrated Care Partnership (ICP). It will support the ten place-based partnerships in Greater Manchester (Bolton, Bury, Heywood Middleton and Rochdale, Manchester, Oldham, Tameside, Trafford, Salford, Stockport and Wigan) as part of a well-established way of working to meet the diverse needs of our citizens and communities.
The aim of the Bury PNA is to describe the underlying need for and current provision of pharmaceutical services in Bury, to ensure that the minimum statutory requirements for PNAs are met, to identify systematically any gaps in services and, in consultation with stakeholders, make recommendations on future development.
The preparation and consultation on the PNA should take account of the HWB's Joint Strategic Needs Assessment (JSNA) and other relevant local strategies to prevent duplication of work and multiple consultations with health groups, patients, and the public.
Each PNA, published by the HWB will have a maximum lifetime of three years. HWBs will also be required to publish a revised assessment when significant changes to the need for pharmaceutical services are identified unless this is considered a disproportionate response.
PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England, and the commissioning of services from pharmacies by the LA and other local commissioners

2.3.2 Effect on health and service provision due to financial pressures.

Negotiations on the 2024/25 CPCF, which includes negotiations on the Pharmacy Quality Scheme (PQS), were paused when the 2024 general election was announced and resumed in January 2025. (Community Pharmacy England, 2025) The new CPCF was announced in April 2025 and the PNA is updated to reflect any new information.

Community pharmacies are working harder than ever, in terms both of the volume of prescriptions they dispense and the range of NHS clinical services delivered. Yet they are struggling financially following years of real-terms funding cuts and many have been forced to close. Urgent action is required to stabilise the pharmacy network and realise opportunities for reform and service improvement. In line with the broad shifts envisaged for the NHS 10 Year Health Plan, community pharmacies – properly resourced - can dramatically improve access to primary care and do more to prevent ill-health and reduce health inequalities. (National Pharmacy Association, 2025)

In November 2024, NPA members in England, Wales and Northern Ireland voted overwhelmingly in favour of 'collective action'. No firm timetable has yet been set for the action, which might include serving notice on opening hours above the minimum required by their contract – meaning fewer pharmacies will be open in the evenings and at weekends. (National Pharmacy Association, 2025)

Currently, there is no agreed timeline for the implementation of 'collective action' and there is no detail on any specific impact that this action may have on pharmaceutical service provision. However, action may include serving notice on opening hours above contract minimums, ceasing free services such as free deliveries and free MDS packs, serving notice on locally commissioned services in the interests of patient safety and to refuse DHSC requests for data collection above that required by the pharmacy contract. Once this detail is agreed upon and available, there will need to be further assessment to establish if any gaps are created within the PNA. With the announcement of the new

CPCF in April 2025, any decisions relating to the implementation or holding off from 'collective action' will be monitored to support development of the PNA.

2.3.3 Mandatory 60-day stakeholder consultation

As part of developing their PNA, HWBs must undertake a consultation for a minimum of 60 days. The 2013 Regulations list those persons and organisations that the HWB must consult. This list includes:

- Any relevant local pharmaceutical committee (LPC) for the HWB area
- Any local medical committee (LMC) for the HWB area
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area
- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area
- Any NHS trust or NHS foundation trust in the HWB area
- NHS England
- Any neighbouring HWB

2.3.4 Circumstances under which the PNA is to be revised or updated

It is important that the PNA reflects changes that affect the need for pharmaceutical services in Bury. Where the HWB becomes aware that a change may require the PNA to be updated then a decision to revise the PNA will be made.

Not all changes to pharmaceutical services will result in a change to the need for services. Where required, the HWB will issue supplementary statements to update the PNA as changes take place to the provision of services locally.

2.4 Scope of the PNA

The pharmaceutical services to which each PNA must relate are all the pharmaceutical services that may be provided under arrangements made by NHSCB for –

- the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list
- the provision of local pharmaceutical services under a Local Pharmaceutical services (LPS) scheme; or
- the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the NHSCB with a dispensing doctor).

Pharmaceutical services are defined by reference to the regulations and directions governing pharmaceutical services provided by community pharmacies (which may be LPS providers), dispensing doctors and appliance contractors.

Whether a service falls within the scope of pharmaceutical services for the purposes of the PNA depends on who the provider is and what is provided:

For **dispensing practices,** the scope of the service to be assessed in the PNA is the dispensing service. However, as there are no dispensing GP practices in Bury, these are not considered in the document.

For **appliance contractors** the scope of the service to be assessed in the PNA is the dispensing of appliances and the provision of appliance use review (AUR) and stoma appliance customisation (SAC). This means that, for the purposes of the PNA, it is concerned with whether patients have adequate access to dispensing services, including dispensing of appliances, AURs and SACs where these are undertaken by an appliance contractor but not concerned with other services appliance contractors may provide.

For **community pharmacy contractors** the scope of the services to be assessed in the PNA is broad and comprehensive. It includes the essential, advanced and enhanced service elements of the pharmacy contract whether provided under the terms of services for pharmaceutical contractors or under LPS contracts.

Other providers may deliver services that meet a particular pharmaceutical service need although they are not considered pharmaceutical services under the relevant regulations. It is therefore important

that these are considered as part of the assessment because they may reduce the need to deliver further services.

2.5 Minimum requirements for the PNA

Schedule 1 of the NHS 2013 Regulations state that the PNA must include, as a minimum, a statement of the following:

- **Necessary services** - pharmaceutical services which have been assessed as required to meet a pharmaceutical need. This should include their current provision (within the HWB area and outside of the area) and any current or likely future gaps in provision.
- **Relevant services** - services which have secured improvements, or better access, to pharmaceutical services. This should include their current provision (within the HWB area and outside of the area) and any current or future gaps in provision.
- **Other NHS services**, either provided or arranged by a LA, NHSCB, an NHS Trust or Foundation Trust which either impact upon the need for pharmaceutical services, or which would secure improvements, or better access to, pharmaceutical services within the area.
- **A map** showing the premises where pharmaceutical services are provided.
- **An explanation** of how the assessment was made.

3 How the assessment was undertaken

3.1 Development of the PNA

The process of developing the PNA has included the requirement to involve and consult people about changes to health services. The specific legislative requirements in relation to development of PNAs were considered.

3.1.1. PNA steering group

The HWB has overall responsibility for the publication of the PNA and the Director of Public Health is the HWB member who is accountable for its development. Bury's HWB established a PNA steering group, the membership of which ensured that all the main stakeholders were represented.
The steering group has been responsible for reviewing the PNA to ensure it meets the statutory requirements. The steering group approved all public facing documentation. The membership and the terms of reference for the steering group are provided at Appendix Two.
The steering group included representation from the following groups:

- Representatives from the NHS Greater Manchester Community pharmacy integration and commissioning portfolio team.
- Representatives from Bury local authority public health team with links to the communications and engagement team.
- Representative from NHS Greater Manchester Primary Care Contracts Team.
- Representative from the Local Pharmaceutical Committee (LPC).
- Representative from Healthwatch.

3.1.2 PNA localities

This PNA describes the needs for the population of Bury. It considers current provision of pharmaceutical services across five neighbourhoods in the Bury HWB area as described in the JSNA and are approved by the steering group for use in this PNA.
The PNA uses the current system of Bury ward boundaries split across the five neighbourhoods. This approach was taken because:

- The current JSNA and Bury Locality Plan Refresh describes population health needs using these neighbourhoods
- This grouping of wards into neighbourhoods reflect the localities which are already in use by Bury Council.
- Most available healthcare data is collected at ward level and wards are a well-understood definition within the general population as they are used during local parliamentary elections.

The five neighbourhoods and the wards within them are:
North

- Ramsbottom
- North Manor
- Tottington
- Elton

East Bury

- Moorside
- Bury East
- Redvales

West

- Bury West
- Radcliffe North & Ainsworth
- Radcliffe East
- Radcliffe West

Prestwich

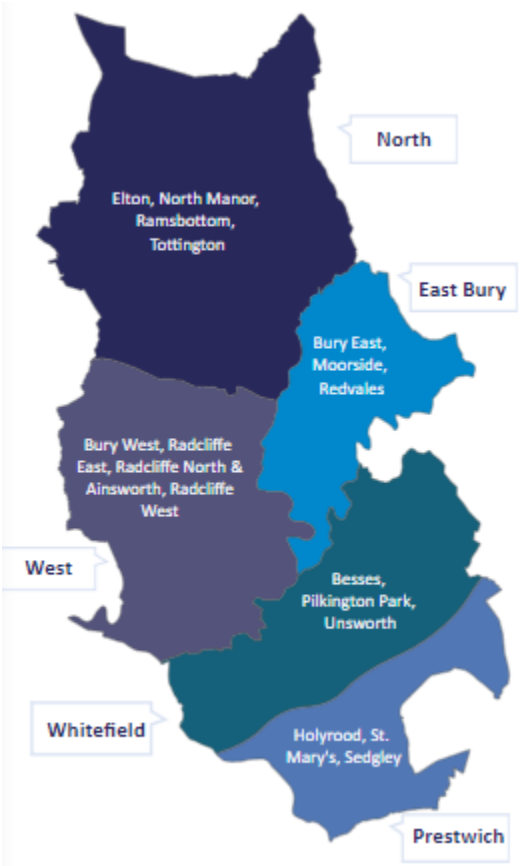
- St. Mary's

- Holyrood
- Sedgley

Whitefield

- Unsworth
- Besses
- Pilkington Park

Map 1 - Bury neighbourhoods and wards



Source - https://theburydirectory.co.uk/neighbourhood-profiles accessed 13/02/2025

3.1.3 Contractor questionnaire and patient survey

A standardised contractor questionnaire and patient survey were developed by a GM PNA steering group, with representation from all 10 LA's, CPGM and NHS GM. The questionnaire and survey were approved by the Bury steering group. These were promoted to pharmacy contractors and the public between January and March 2025. They aimed to identify additional relevant information from service providers and to identify how the public currently and in the future, want to interact with pharmacy services. Once completed the results of both were analysed.

Bury Council were involved in promoting the public survey to as wide an audience as possible through the existing channels available to them. Healthwatch supported this by taking the survey into community groups and assisting people with responding.

CPGM and NHS GM were asked to help promote the pharmacy contractor survey.

3.1.4 Other sources of information

The content of the PNA including demographics, neighbourhoods and background information was approved by the steering group. In looking at the health needs of the local population, the Bury JSNA[3],

[3] Joint Strategic Needs Assessment - Bury Council accessed 07/02/2025

Bury Councils 'Let's Do It! strategy'[4] – the Strategy for the borough until 2030, and other health data were considered.
Information was gathered from NHSE, NHS GM and Bury Council regarding:

- The size and demography of the population across Bury.
- Whether there is adequate access to pharmaceutical services across Bury.
- Different needs of different districts within Bury.
- Pharmaceutical services provided from outside the HWBs area which affect the need for pharmaceutical services in Bury.
- Other NHS services provided in or outside its area which affect the need for pharmaceutical services in Bury.
- Likely changes or developments that might affect the need for pharmaceutical services including changes to the size of the population, the demography of the population, and risks to the health or wellbeing of people in its area.

3.1.5 Consultation

The statutory 60-day consultation commenced on 15th July 2022 and ran until 13th September 2022. There were 5 responses. A report outlining areas of feedback from the consultation can be found in appendix 13 but the main themes were around opening hours and cross-border consideration.
The list of stakeholders consulted included the following groups:

- Community Pharmacy Greater Manchester (CPGM).
- Bury Local Medical Committee (LMC)
- Pharmacies and DAC's on the pharmaceutical list in Bury.
- Healthwatch Bury and any other patient, consumer, and community groups in the area with an interest in the provision of pharmaceutical services in the area.
- NHS trusts and NHS foundation trusts in the area (Northern Care Alliance (NCA) NHS Foundation Trust).
- NHS commissioning bodies.
- Neighbouring HWBs. (Bolton, Salford, Manchester, Rochdale, Blackburn with Darwen, and Rossendale).

3.2 JSNA and Locality strategy

Bury JSNA discusses the characteristics and identified health needs of the whole population living within the HWB area, but there are more detailed documents which underpin the themes and identify populations and health inequalities which need addressing.

3.2.1 Bury's JSNA

Bury's JSNA discusses the characteristics and identified health needs of the whole population living within the HWB area. It focuses on broad topics:

1. Life course – starting well, living well and ageing well.
2. Wider Determinants of Health – Crime, education, housing, environment, income and work and the labour market.
3. Neighbourhood profiles.
4. Interactive tools with updated information and intelligence.
5. Census 2021.

However, there are more detailed documents which underpin the themes and identify populations and health inequalities which need addressing.

[4] Let's Do It! strategy accessed 07/02/2025

3.2.2 Bury's Let's Do It! Strategy – the strategy for the borough up to 2030

This goal for Bury is 'to stand out as a place that is achieving faster economic growth than the national average, with lower than national average levels of deprivation' both of which are wider determinants of health and health inequalities.

Bury will measure progress to achieving this ambition by tracking seven core outcome measures on an annual basis:

1. Improved quality of life
2. Improved early years development
3. Improved educational attainment for our young people
4. Increased adult skill levels and employability
5. Delivering inclusive economic growth
6. Delivering carbon neutrality by 2038
7. Improved digital connectivity

3.3 Focus of the PNA

The Health and Wellbeing Board discuss these documents and approve actions to take forward to address the needs of the population of Bury. The HWB have identified health priorities as stated in HWB minutes from 16/01/2025 meeting[5]. The HWB have also identified priorities in the locality plan update for 2025 to address issues which will help drive the changes recommended in Bury's Let's do it! strategy. The priorities identified by the HWB that are related to pharmaceutical services provision are:

1. Increase annual physical activity
2. Reduce smoking prevalence
3. Management of obesity and healthy weight
4. Harm reduction from drugs and alcohol
5. Health protection – immunisations and vaccinations
6. Increase in pharmacy first uptake

The major conditions board have also identified the following major conditions as priorities:

7. Cardiovascular disease
8. Respiratory disease (COPD and Asthma)
9. Cancers
10. Musculoskeletal conditions

[5] Health and Wellbeing Board - Bury Council

3.4 Patient and public engagement

To gain the views of patients and the public on pharmaceutical services, a GM standardised survey was developed by a GM PNA steering group. The survey was hosted by Greater Manchester Combined Authority (GMCA) on their GM Consult webpage and was available from 4th February 2025 to 21st March 2025. The results of the survey are found in Appendix 3.

There were 71 responses to the Bury public survey. This only represents 0.04% of Bury's population (aged 16 years and over); we can only take this as a general picture of public opinion. Map 2 below shows the spread of responses to the public survey.

The lack of response to the public survey may indicate that residents in Bury may not see access to pharmacies as an issue and therefore not worth taking the time to complete the survey, but this assumption is not proven. Of the 71,

79% of the responders were female.

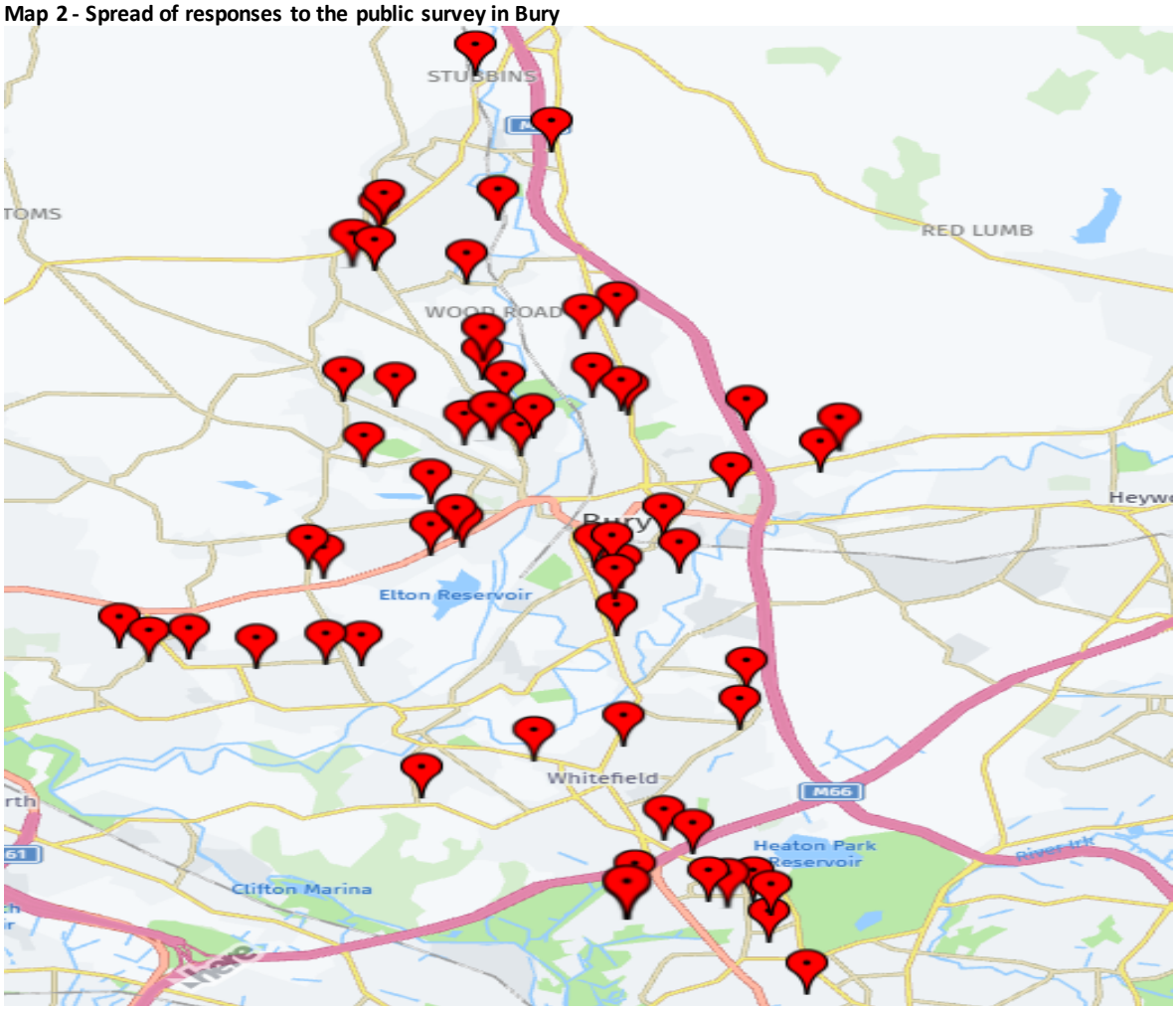
30% of respondents were over the general age of retirement of 65 years and over.

23% of respondents consider themselves to have a disability.

80% of people considered themselves to be 'White British'.

As the sample size is small, direct comparisons between the respondents and the general demographics of the Bury Borough in terms of population density, gender, age, or ethnicity would be statistically invalid, but are used as indicative information of the Bury population in this PNA.

Map 2 - Spread of responses to the public survey in Bury



3.4.1 Choice of Pharmacy

92% of respondents to the public survey had not had any difficulty in accessing a pharmacy of their choice and 86% used one pharmacy regularly.

From all the respondents, the two most selected reasons for using one pharmacy regularly were that the pharmacy was near to home or their doctors which 28% of these respondents accessed by walking and 63% by car either as a driver or passenger.

3.4.2 Access to Pharmaceutical Services

The location of pharmacies does not cause a problem for 93% of the responders and the opening hours do not cause a problem for 82% of respondents. For the 13 respondents who had a problem with the opening times, eight had an issue with their nominated pharmacy not opening on the weekend. They were not aware that some pharmacies had extended opening times and where these pharmacies were located. Any campaign to increase use of pharmacies for self-care, should include providing information on the location and opening times of pharmacies that provide extended hours. 92% of respondents had no difficulty in accessing a pharmacy of their choice and 43% of respondents were able to travel to their chosen pharmacy in 6 – 10 minutes.

3.4.3 Development of Pharmacy Services

82% of respondents felt that it was essential or fairly important that their pharmacist be able to provide clear advice on prescription and over the counter medicines and this guided their choice of pharmacy. 79% of respondents were also very satisfied or satisfied that the pharmacist offered advice when they needed it. Pharmacist and their staff should be primarily focussed on patient safety, of which delivering information to patients is a main feature. Regular conversations with clients around their medication and health status are taking place already but should be improved in pharmacies as this increases the understanding of medications and develops improved public confidence in the ability of pharmacy staff. Patients should also be encouraged to ask questions and understand that pharmacists are a good source of information about the medication they take.
82% (58) of respondents were either satisfied or very satisfied with the overall service they receive from their pharmacy/pharmacies overall. With 2 being unsatisfied and 2 were very unsatisfied.
Respondents were provided with an opportunity to comment on which other pharmacy services they would like their pharmacy to offer. 10 respondents provided an answer to this question, and the comments received included a minor skin conditions service, a blood testing service, a stoma products service and to provide advice when medication is not available.

3.5 Contractor engagement

A GM PNA steering group was established, where a GM standardised contractor survey was developed and agreed. The survey was published to contractors on PharmOutcomes on 3rd February 2025 for a period of 4 weeks and the results are presented in Appendix Four. The contractor survey provided an opportunity to validate the information provided by NHSCB in respect of the hours and services provided.
The survey was promoted by CPGM to all contractors and they also supported the uptake of the survey through individual phone calls to outstanding contractors. Responses were received from 41 pharmacies, a 100% response rate, which is a significant increase compared to the previous PNA. This helps to provide a complete picture of pharmaceutical service provision in Bury and can be used alongside data provided by NHSCB to support decisions for the PNA.

3.5.1 Advanced services

See information contained in section 6.0.

Data from the NHS Business Services Authority show that the main providers of appliance use reviews and stoma customisation services are DACs. In the 12-month period, December 23 to November 24 (latest data on 1st March 2025), 1461 AURs were provided to Greater Manchester residents with 500 of these delivered in the individual's home.

Table 1 - Number of pharmacies in Bury commissioned to provide (c) or claiming for providing (p) each service

Advanced Service	Number of Pharmacies	Commisioned (C) or Provided (P)	Comments
Pharmacy First Service (PFS)	41	**P**	Commenced on 31st January 2024. Replaced 2 elements of CPCS.
Flu Vaccination Service	33	**P**	Annually from Autumn to March.
Pharmacy Contraception Service (PCS)	33	**P**	Commenced on 24th April 2023, from 1st December 2023, the service expanded to include both initiation and on-going supply of OC. From October 2025 to include supply of EHC.
Hypertension Case-Finding Service	37	**P**	From 1st October 2021.
New Medicine Service (NMS)	40	**P**	
Smoking Cessation Service (SCS)	24	**P**	From 10th March 2022
Appliance Use Review (AUR)	0	**C**	Provided by DACs
Stoma Appliance Customisation (SAC)	0	**C**	Provided by DACs
Lateral Flow Device Service (LFD)	24	**P**	From 6th November 2023. For eligible patient groups.[6]

3.5.2 Enhanced and locally commissioned services

According to data provided by commissioners the following information is available:

Table 2 - Number of pharmacies providing enhanced and locally commissioned services

Commissioner	Service	Number of Pharmacies Providing Service FYTD 24/25
Bury Council	Emergency Hormonal Contraception**	18
Bury Council	Supervised Methadone/Buprenorphine Consumption	17
Bury Council	Needle Exchange	6
NHS GM ICB	Palliative Care Medicine Stockholding	3*
NHS GM ICB	Minor Ailment Service (MAS)	23
NHS GM ICB	Minor Eye Conditions Service (MECS)	27
NHS GM ICB	COVID medicines delivery - Medicines supply following referral via NHS Mail	2

*Claim for outdated medicines.
** From October 2025, supply of EHC added to Advanced Service Pharmacy Contraceptive Service.

Full details of which pharmacies are commissioned can be found in Appendix Five.

3.5.3 Non-NHS services

Pharmacy owners can opt to provide other services which are not directly commissioned. These can either be free to the client or the pharmacy staff can charge a fee.
Examples of such services are prescription delivery services or medication reminder tools.

3.6 Pharmaceutical services

The services that a PNA must include are defined within both the NHS Act 2006 and the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended (the 2013 regulations).
Pharmaceutical services may be provided by:

- A pharmacy contractor who is included in the pharmaceutical list for the area of the HWB
- A pharmacy contractor who is included in the local pharmaceutical services (LPS) list for the area of the HWB
- A DAC who is included in the pharmaceutical list held for the area of the HWB
- A doctor who is included in a dispensing doctor list held for the area of the HWB

[6] https://cpe.org.uk/national-pharmacy-services/advanced-services/lfd-service/

NHSCB are responsible for preparing, maintaining and publishing the pharmaceutical list. It should be noted, however, for Bury HWB there are no dispensing doctors within the HWB's area. Bury does not have any DACs within the borough boundaries either.
Contractors may operate as either a sole trader, partnership, or a body corporate. The Medicines Act 1968 governs who can be a pharmacy contractor, but there is no restriction on who can operate as a DAC.

3.6.1 Pharmaceutical services provided by pharmacy contractors

Unlike for GPs, dentists and optometrists, NHSCB does not hold contracts with pharmacy contractors. Instead, they provide services under a contractual framework, details of which (their terms of service) are set out in schedule 4 of the 2013 regulations and in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (the 2013 directions). The underpinning elements of the contractual framework, which align to national health plans, are reviewed regularly to allow service changes and payment to pharmacy contractors for delivering services which target national priorities.
Negotiations on the 2024/25 CPCF, which includes negotiations on the Pharmacy Quality Scheme (PQS), were paused when the 2024 general election was announced and resumed in January 2025. The most recent version the Community Pharmacy Contractual Framework (CPCF) for 2024 to 2025 and 2025 to 2026[7] was released in April 2025.
Pharmacy contractors may provide three types of services that fall within the definition of pharmaceutical services. These are as follows:

- **Essential services** – all pharmacies with NHS contracts (see Appendix Six for complete list) must provide these services. Further details can be found on the CPE website[8]:
  - Dispensing of medicines
  - Dispensing of appliances
  - Repeat dispensing and electronic repeat dispensing (eRD)
  - Disposal of unwanted medicines
  - Public health (Promotion of healthy lifestyles)
  - Signposting
  - Support for self-care
  - Discharge Medicines Service (DMS)
  - Healthy Living Pharmacies

- **Advanced services** – pharmacies may choose whether to provide these services or not (see Appendix Seven). If they choose to provide one or more of the advanced services, they must meet certain requirements and must be fully compliant with the essential services and clinical governance requirements:
  - New Medicine Service (NMS)
  - Appliance Use Review (AUR)
  - Stoma Appliance Customisation (SAC)
  - Flu vaccination Service
  - Lateral Flow device (LFD) service
  - Hypertension case finding service
  - Smoking Cessation Service (SCS)
  - Pharmacy contraception service (PCS)
  - Pharmacy first service

- **National and Local Enhanced services** – In December 2021, provisions were made within the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 for a new type of Enhanced service, the National Enhanced Service (NES). Under this type of service, NHS

[7] https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2024-to-2025-and-2025-to-2026/community-pharmacy-contractual-framework-2024-to-2025-and-2025-to-2026
[8] https://cpe.org.uk/national-pharmacy-services/

England commissions an Enhanced service that is nationally specified. This requires NHS England to consult with Community Pharmacy England on matters relating to the service specification and remuneration for the service.

This differs from a Local Enhanced Service (LES) that should be locally developed and designed to meet local health needs and for which NHS England would consult with Local Pharmaceutical Committees. A NES allows the agreement of standard conditions nationally, while still allowing the flexibility for local decisions to commission the service to meet local population needs, as part of a nationally coordinated programme.[9]

The current list of National enhanced services offered by NHSCB in the Bury area are:

- COVID-19 vaccination service

The current list of Local enhanced services offered by NHSCB in the Bury area are:

- Minor Ailment Service (MAS)
- Minor Eye Conditions Service (MECS)

Underpinning the provision of all these services is the requirement on each pharmacy to participate in a system of clinical governance requirements as set out within the 2013 regulations and includes[10]:

- A patient and public involvement programme
- A clinical audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff management programme
- An information governance programme
- A premises standards programme
- Patient safety incident reporting

The Pharmacy Quality Scheme (PQS) also forms part of the Community Pharmacy Contractual Framework (CPCF), which supports delivery of the NHS Long Term Plan and rewards community pharmacy owners that achieve quality criteria in the three domains of healthcare quality: clinical effectiveness, patient safety and patient experience. Negotiations on the 2024/2025 CPCF were paused when the last general election was called. The negotiations have since commenced and the new CPCF was announced in April 2025.

3.6.2 Locally commissioned services

Locally commissioned community pharmacy services can be contracted via several different routes and by different commissioners. These services no longer fall within the definition of enhanced services or pharmaceutical services as set out in legislation and therefore should not be referred to as enhanced services. For the purposes of this document, they are referred to as locally commissioned services.

Bury Council and NHS GM ICB may also commission services from pharmacies and dispensing appliance contractors (DACs). However, these services fall outside the definition of pharmaceutical services. In particular, the commissioning of several services that have been designated as public health services were transferred to local authorities.

These services are included within this assessment where they affect the need for pharmaceutical services, or where the further provision of these services would secure improvements or better access to pharmaceutical services.

These services meet current identified needs for what would be pharmaceutical services if commissioned by NHS CB and should be considered as relevant to the pharmaceutical needs of Bury. Guidance, examples, and templates of locally commissioned can be found on the CPE website.[11]

[9] https://cpe.org.uk/national-pharmacy-services/national-enhanced-services/

[10] https://cpe.org.uk/quality-and-regulations/clinical-governance/

[11] https://cpe.org.uk/lpcs-and-local/locally-commissioned-services/

Services commissioned by Bury Council are:

- Sexual Health Services:
  - Emergency contraception
- Substance misuse services including:
  - Needle exchange (NX)
  - Supervised Consumption of prescribed medication for dependence (SC)

Services commissioned by NHS GM IC:

- Palliative Care Medicine Stockholding
- Minor Ailments Service (MAS)
- Minor Eye Care Service (MECS)
- COVID medicines delivery - Medicines supply following referral via NHS Mail

3.6.3 Non-commissioned added value services

Community pharmacy contractors also provide private services that improve patient care but are not commissioned directly by NHSCB or LAs. Examples of these include home delivery service, blood glucose measurements and weight loss programmes.
Pharmacists are free to choose whether to charge for these services but are expected to follow standards of governance if they do. As they are private services, they fall outside the scope of the PNA.

3.6.4 Contracted Opening Hours

NHS England has overall responsibility for administering opening hours for pharmacies, however since 2023 this responsibility has been delegated to the Integrated Care Boards (ICBs).

A pharmacy normally has 40 core contractual hours (or 100 for those that have opened under the former exemption from the control of entry test), which cannot be amended without the consent of NHS England, together with supplementary hours, which are any the additional opening hours, which can be amended by the pharmacy subject to giving five weeks' notice (or less if an ICB consents). A pharmacy may also have more than 40 core hours where it has made an application based on that higher number, and NHS England (or the ICB) agreed to that application, in this case, the pharmacy cannot amend these hours without the consent of the ICB.

Between April 2005 and August 2012, some contractors successfully applied to open new premises based on being open for 100 core opening hours per week (referred to as 100-hour pharmacies), which means that they are required to be open for 100 hours per week, 52 weeks of the year (apart from weeks which contain a bank or public holiday, or Easter Sunday).

In 2023 regulations were laid to make changes to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 that added provisions for rest breaks, reduction of core hours for 100-hour pharmacies (to not less than 72 core opening hours each week), requirements to change core opening hours and local hours plans.

There are four pharmacies in Bury with 100-hour contracts and the updated regulations for 100-hour pharmacies state that any existing core opening hours must remain that are:
- Monday to Saturday between 5pm and 9pm (no rest breaks are permitted during this time).
- Sunday between 11am and 4pm (rest breaks are permitted between 11am and 4pm on a Sunday), and
- Sunday's total opening hours (i.e. the existing, total core opening hours on Sundays must remain).
i.e. the reduction of total core opening hours per week to not less than 72 is conditional on maintaining the above core opening hours.

The proposed opening hours for each pharmacy are set out in the initial application . If the application is granted the pharmacy is then contracted to open during the opening hours identified in the application. The contractor can subsequently apply to NHS GM ICB to change their core opening hours or notify a change in their supplementary hours.
NHS GM ICB will assess the application against the needs of the population of the HWB area as set out in the PNA to determine whether to agree to the change in core hours or not. If a contractor wishes to change their supplementary opening hours, they are obliged to notify NHS GM ICB of the change, giving at least three months' notice.

The new CPCF, which was confirmed in April 2025, outlines the amendment of regs' test for changing the days and times of core opening hours. The key points form the CPE briefing[12] are as follows:
▪ Changing core opening hours remains an application process – the ICB must approve any proposed change.
▪ The total number of core opening hours must remain the same (another provision applies for applications to reduce the number of core opening hours).
▪ The new/proposed core opening hours must better meet the needs of patients and likely users of the pharmacy.
▪ A pharmacy owner's evidence of the economic viability of their current opening hours may be considered by the ICB.
▪ The PLPS Regulations (Terms of Service) must be amended first – only then will this change be effective/apply.
▪ The Pharmacy Manual will be revised accordingly.

3.6.5 Closure of Pharmacy Premises

Community pharmacy contractors who no longer wish to provide NHS services from their NHS pharmacy premises must provide their local NHS ICB area team with adequate notice.
Generally, contractors must give at least 3 months' notice to the local area team in advance of the date on which they intend to cease providing pharmaceutical services. The exception is for contractors with 100 core hours in which case six months' notice is required.

Pharmacy opening hours in Bury HWB's area can be found on NHS.uk website under NHS Services.[13] From 9th November 2020, under the NHS Terms of Service, contractors must ensure that the profile for their pharmacy is comprehensive and accurate .[14] Appendix Eight provides details as to the spread of opening times across each neighbourhood and by ward.

Since the last PNA there has been the closure of 2 standard contract pharmacies in Ramsbottom and Radcliffe East. However, a change in location of one pharmacy means that all wards in Bury now have a community pharmacy premises within their boundary.

3.6.6 Local pharmaceutical services

Local pharmaceutical services (LPS) are a local alternative to the nationally negotiated terms of service. It can be used by NHS England when there is a need to commission a service from a pharmacy contractor to meet the needs of a patient group or groups, or a particular locality. For the purposes of the PNA the definition of pharmaceutical services includes LPS.
There are no LPS contractors within the Bury area.

3.6.7 Distance selling pharmacies

Whilst most pharmacies provide services on a face-to-face basis, e.g. people attend the pharmacy to ask for a prescription to be dispensed, or to receive health advice, there is one type of pharmacy that

[12] https://cpe.org.uk/wp-content/uploads/2025/03/Briefing-010.25-Funding-Settlement-for-2024-25-and-2025-26.pdf accessed 14/04/2025
[13] https://www.nhs.uk/nhs-services/
[14] CPE

is restricted from providing services in this way. They are referred to in the 2013 regulations as distance selling premises (previously called wholly mail order or internet pharmacies).
Distance selling pharmacies are required to provide essential services and participate in the clinical governance system in the same way as other pharmacies; however, they must provide these services remotely. Such pharmacies are required to provide services to people who request them wherever they may live in England. Patients cannot walk into distance selling pharmacies.
There are four distance selling pharmacies in Bury, although residents may choose to use such pharmacies that are within or outside of the borough. Although these four pharmacies can provide a service nationally, dispensing data from ePACT2[15] shows that 60.7% of their items are issued to clients who have a Bury GP, and that a further 20.7% are issued to clients who have GPs in the neighbouring CCGs of Bolton, Heywood, Middleton and Rochdale, Manchester, East Lancashire, Blackburn with Darwin, and Salford. This indicates that the distance selling pharmacies in Bury can be classed as 'local' pharmacies.
The number of distance selling pharmacies in GM has increased from 15 to 51 over the last 2 years. This has created additional choice for residents to access pharmaceutical services through these pharmacies, both where they lie within and outside of the Bury boundary. This in turn, may decrease the demand on the traditional walk-in pharmacies.

Table 3 - Items (>0.1%) issued from Bury Distance Selling Pharmacies, Jan 2024 – Dec 2024 (Source: ePACT2)

Organisation/Locality where the prescription was issued	Number of items	% of total
NHS GREATER MANCHESTER ICB - Bury	250,296	60.7%
NHS GREATER MANCHESTER ICB - Stockport	38,133	9.2%
NHS GREATER MANCHESTER ICB - HMR	27,767	6.7%
NHS LANCASHIRE AND SOUTH CUMBRIA ICB - East Lancs	22,394	5.4%
NHS GREATER MANCHESTER ICB - Bolton	19,721	4.8%
NHS GREATER MANCHESTER ICB - Oldham	13,902	3.4%
NHS GREATER MANCHESTER ICB - Wigan	11,093	2.7%
NHS LANCASHIRE AND SOUTH CUMBRIA ICB - Blackburn with Darwen	5,979	1.4%
NHS GREATER MANCHESTER ICB - Manchester	5,185	1.3%
NHS GREATER MANCHESTER ICB - Salford	4,708	1.1%
NHS GREATER MANCHESTER ICB - Tameside	4,525	1.1%
NHS GREATER MANCHESTER ICB - Trafford	2,483	0.6%
NHS SOUTH YORKSHIRE ICB - Sheffield	1,457	0.4%
NHS WEST YORKSHIRE ICB - Bradford District and Craven	770	0.2%
NHS NORTH WEST LONDON ICB - North West London	733	0.2%
NHS CHESHIRE AND MERSEYSIDE ICB - Cheshire	652	0.2%

3.6.8 Pharmaceutical services through dispensing appliance contracts (DAC)

As with pharmacy contractors, NHS England does not hold contracts with DACs. Their terms of service are also set out in schedule 5 of the 2013 regulations.
DACs must provide the following services that fall within the definition of pharmaceutical services:

- Dispensing of prescriptions (both electronic and non-electronic), including urgent supply without a prescription
- Dispensing of repeatable prescriptions
- Home delivery service
- Supply of appropriate supplementary items (e.g. disposable wipes and disposal bags)
- Provision of expert clinical advice regarding the appliances
- Signposting

[15] https://www.nhsbsa.nhs.uk/access-our-data-products/epact2

Advanced services – DACs may choose whether to provide these services or not. If they do choose to provide them then they must meet certain requirements and must be fully compliant with their terms of service and the clinical governance requirements:

- Stoma appliance customisation
- Appliances use review

DACs are required to open at least 30 hours per week, and these are referred to as core opening hours. They may choose to open for longer and these hours are referred to as supplementary opening hours. There are no DACs in Bury therefore its population has appliances dispensed either from DACs outside the Bury area or from community pharmacies who provide the items they require.

Results from the contractor survey provided the following information in relation to appliances:

- 24 Pharmacies can dispense stoma appliances
- 27 pharmacies can dispense incontinence appliances
- 35 pharmacies can dispense dressings
- 12 pharmacies can dispense other types of appliances

Appliance dispensing services can be accessed through local pharmacy contractors, or via DAC's that are based outside of the area.

3.6.9 Pharmaceutical services provided by doctors

The 2013 regulations allow doctors to dispense to eligible patients in certain circumstances. As there are no dispensing doctors within the HWB's area this route of provision is not included in this document.

3.6.10 Hospital pharmacy

Hospital pharmacies affect the need for pharmaceutical services within its area. They may reduce the demand for the dispensing of essential service as prescriptions written in the hospital that are dispensed by the hospital pharmacy service. Fairfield General Hospital (part of NCA Foundation Trust), as with each of the NCA FT hospital sites, offers outpatient dispensing of hospital prescriptions.
In some exceptional circumstances medications may be supplied through secondary care pharmacy services rather than community pharmacy. An example of this may be when there is a national shortage of a particular medication, where secondary care pharmacies hold stocks as a priority from wholesalers. The prescription numbers generated are unlikely to be significant due to the low volumes generated in outpatients and shortages, versus long-term prescribing by GPs.

3.6.11 Other provision of pharmaceutical services

Pharmaceutical services are provided by other services. These can include arrangements for:

- Prison population
- Services provided in neighbouring HWB areas
- Private providers

The PNA makes no assessment of these services.

3.6.12 Other sources of information

Information was gathered from NHSCB and Bury Council regarding:

- Services provided to residents of the HWB's area, whether provided from within or outside of the HWB's area
- Changes to current service provision
- Future commissioning intentions
- Known housing developments within the lifetime of the PNA
- Any other developments which may affect the need for pharmaceutical services

The JSNA and Bury Council's 'Let's Do It! strategy' provided background information on the health needs of the population.

3.7 Consultation

A statutory consultation exercise was carried out over the Summer 2022 in accordance with the 2013 Regulations. The consultation took place from 15th July to 13th September 2022 for a period of at least 60 days, in line with regulations. This is based on Section 242 of the NHS Act 2006, which requires HWBs to involve users of services in:

- The planning and provision of services
- The development and consideration of proposals for changes to how services are provided
- Decisions affecting the operation of services.

The statutory consultees were written to and provided with a link to the council's web site where the draft PNA was published and invited to respond online. The draft PNA and consultation response form was issued to all compulsory stakeholders. The documents were posted on the council internet and publicised to the compulsory stakeholders.

The number of responses received totalled five and:

- all five thought that the explanation of the PNA was sufficient.
- all five thought that the PNA provided an adequate assessment of pharmaceutical services in the Bury area.
- all five thought that the PNA provided a satisfactory overview of the current and future pharmaceutical needs of the Bury population.
- Five thought that current pharmacy provision and services in Bury is adequate.
- all five agreed with the conclusion of the PNA.

Two made comments that needed addressing and these are detailed in the Appendix 13. No changes were made that altered the conclusions of this PNA.

4 Context in Bury

4.1 Overview

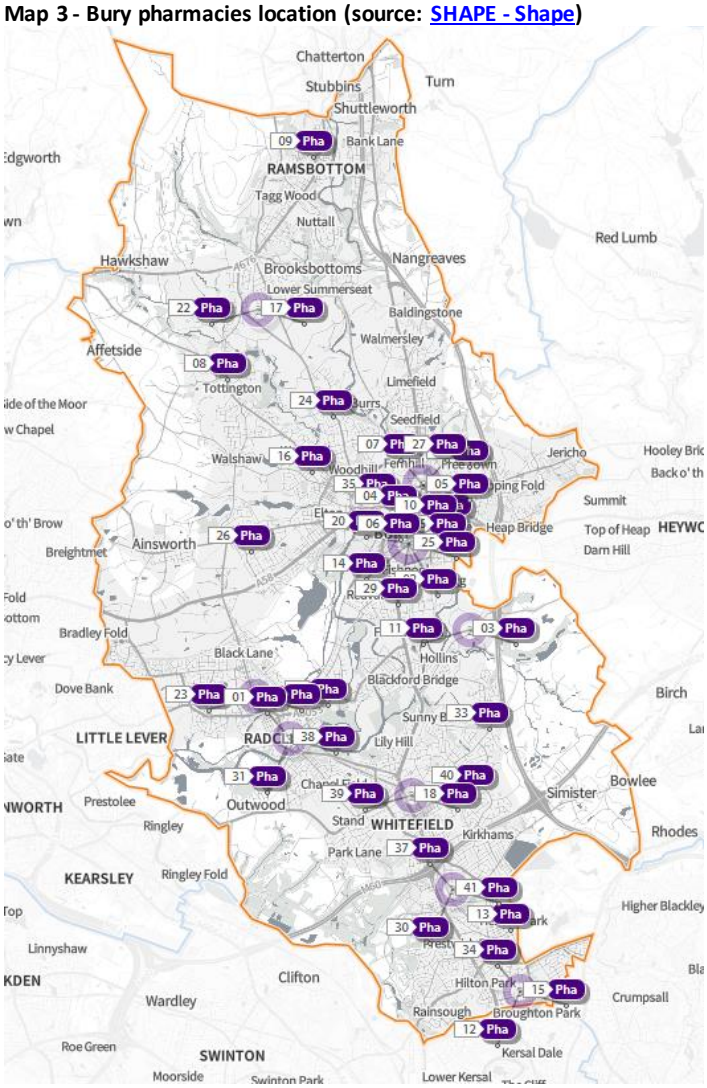
Bury Council is one of ten councils in Greater Manchester. It lies to the north of the city of Manchester. The borough is named after its largest town, Bury, but also includes the towns of Prestwich, Whitefield, Radcliffe, Tottington and Ramsbottom. The latest estimated population for Bury is 195,476 (ONS Crown copyright reserved – from Nomis on 13th February 2025) and spans 38 square miles (99 km^2).

Although some parts are contiguous with the city of Manchester, are highly industrialised and densely populated, the northern region between Tottington and Ramsbottom have areas covered by moorland and are sparsely populated.

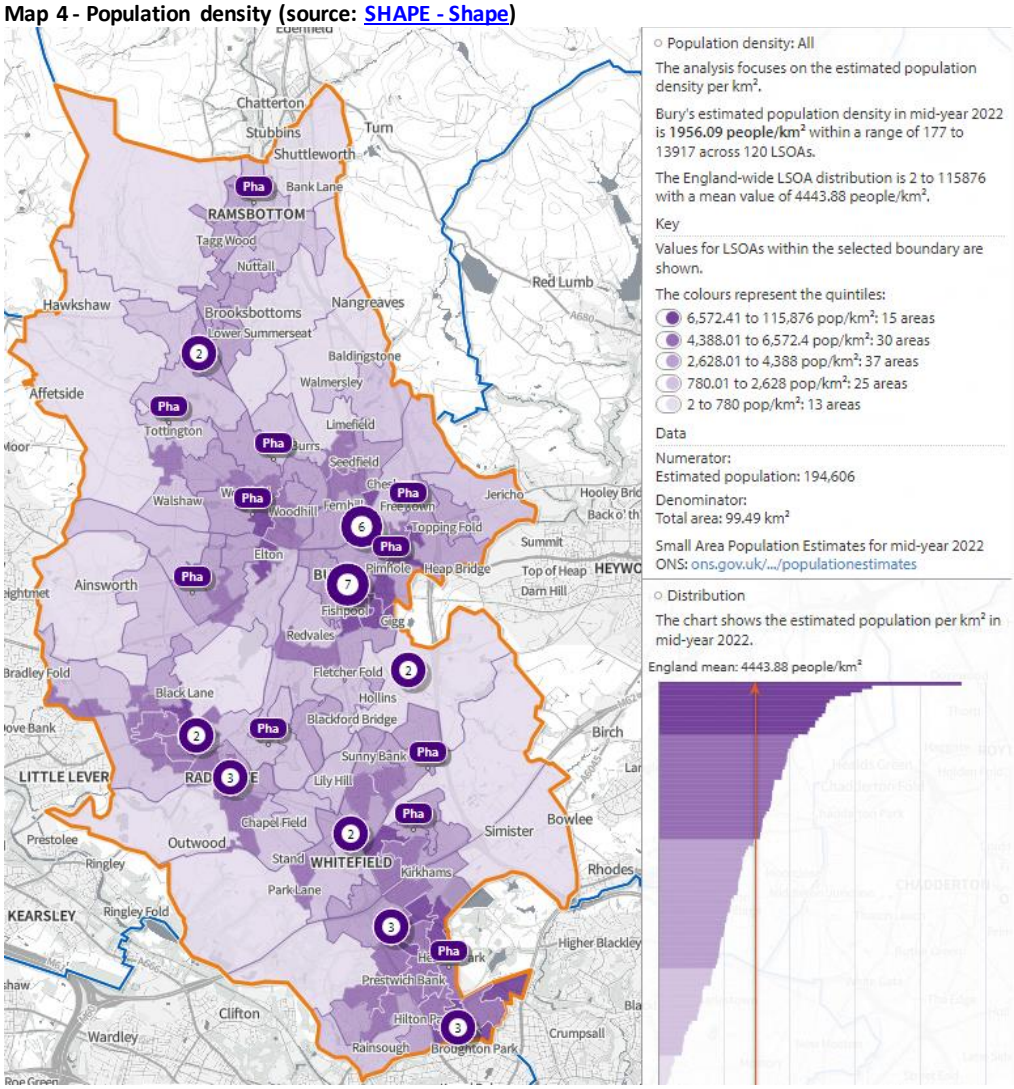
Bury Borough is bordered by Bolton to the West, Rochdale Borough to the East, and Manchester and Salford Cities to the South, all of which are part of the Greater Manchester conurbation. Two other council areas to the North also border Bury Borough. These are Blackburn with Darwen and Rossendale.

Map 3 details all community pharmacy premises locations in Bury and is considered as the statutory map for the purpose of the PNA and can be referenced to appendix 6 for the details for each pharmacy. Map 4 further details the premises mapped against the population density of Bury, where there is a clear correlation between pharmacy locations and more densely populated areas.

Map 3 - Bury pharmacies location (source: SHAPE - Shape)



Map 4 - Population density (source: SHAPE - Shape)



4.2 Current and Projected Population in Bury

Between the year 2023 and 2033 Bury will have (ONS 2018):

- a projected increase in total population of 5,798.
- a projected increase of 404 (3.6%) for babies and infants 0-4 years of age.
- a projected decrease of 1,117 (6.3%) for children 5-11 years of age.
- a projected decrease of 440 (2.9%) of young people aged 12-17 years.
- a projected increase of 1,333 (1.2%) in working-age adults aged 18-64 years.
- a projected increase of 5,617 (15.4%) older adults aged 65 years and over.

This creates a significant shift in the demographic composition of the Bury population.

4.2.1 Current Population in Bury

Table 4 - Proportion of total population by age group by Neighbourhood (Source: Neighbourhood Profiles | The Bury Directory)

Age Range	East Bury	North	West	Prestwich	Whitefield	Bury
0-14	21.2%	16.4%	18.0%	21.0%	17.9%	18.8%
15-24	12.1%	10.1%	10.7%	10.5%	10.2%	10.7%
25-64	52.7%	51.4%	52.3%	52.4%	52.3%	52.0%
65-79	10.6%	16.8%	14.3%	11.7%	14.1%	13.6%
80+	3.4%	5.4%	4.6%	4.4%	5.6%	4.6%
Total Population	37,440	43,098	43,624	35,950	33,774	193,885

*Note this may not match the Bury total due to rounding

Figure 1 – Population pyramid presenting the percentage composition by 5-year age group and gender of resident population in Bury compared with England (Source: Age | The Bury Directory)

East Bury Neighbourhood has a younger population then the rest of Bury Borough, having 21.2% of its population between 0-14 years (compared to Bury Borough total of 18.8%) and 12.1% of people aged 15- 24 (Bury 10.7%). Only 14% of the residents are aged 65 or over (Bury 18.2%).
Prestwich Neighbourhood also has a relatively younger population, having 21% of its population aged 0-14 years (compared to Bury Borough total of 18.8%) and 10.2% of people aged 15-24 (Bury 10.7%). Only 16.1% of the residents are aged 65 or over (Bury 18.2%).
North and Whitefield Neighbourhoods have the largest proportion of adults at the older end of the age spectrum with those aged 65 and over with 22.2% and 19.7%% respectively, where the total borough average is 18.2%.
West Neighbourhood has an age profile most like the Bury Borough average.
These population statistics can help commissioners deliver age-related services to the relevant areas.

4.2.2 Projected Population from 2023 to 2033 MYE

Figure 2 - Population projection for all ages in Bury from 2023 to 2033 (ONS, 2018) (source: Population Projections | The Bury Directory)

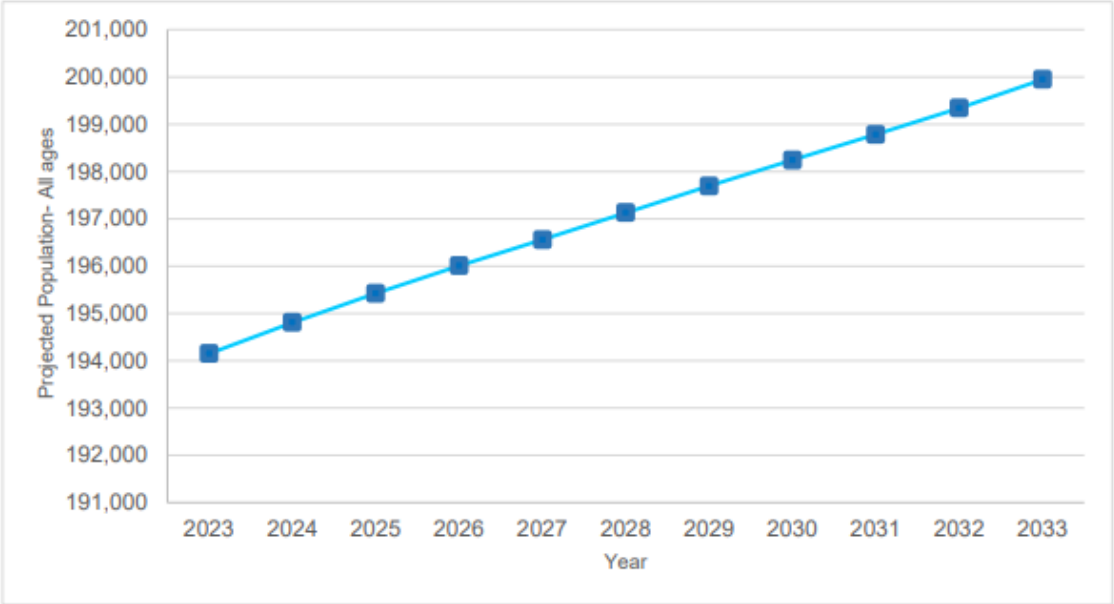


Table 5 - Projected total population by age group (source: ONS, 2018)

Age	Projected Population 2023	Projected Population 2033	Projected % increase from 2023 to 2033	% of expected total 2033 population
Younger People (0-17)	43,946	42,793	-3%	21%
Working ages (18-64)	113,817	115,150	1%	58%
Older people (65+)	36,384	42,001	15%	21%
Total Population	**194,148**	**199,946**	**3%**	**100%**

Figures may not sum because of rounding

Bury's total population is projected to increase by 3% from 2023 to 2033 but to understand what the impact of each group is for our commissioned services it is important to look at the underpinning figures.

Whilst the youngest age group of 0-17 years is expected to decrease by 3%, they will still account for approximately 21% of the total projected population by 2033.

By 2033, 58% of the projected population are expected to be in the working age ranges of 18- 64 years.

However, the most significant rise in population, both in terms of actual numbers and healthcare services they will require, is in the 65 years and over age group. There will be a projected increase of 15% by 2033, accounting for 21% of the total population of Bury Borough. This may have a significant impact on the types of service which are required across Bury Borough, as at this stage of the life, the need for health and social care begins to increase. This growth in older people, some of whom are likely to be living in isolation, will lead to greater levels of need for pharmaceutical services. This growth in the 65 and over age group should be borne in mind when new services are developed in the future.

4.3 Deprivation

The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas (Lower Super Output Areas (LSOAs)). These can then be aggregated to show local authority deprivation rankings. IMD is a combined measure of deprivation based on a total of 37 separate indicators, 13.5% of the scores are related to health indicators. It is important to consider deprivation factors as they

can impact on access to health care and pharmaceutical services should be designed and commissioned to ensure there is an equitable level of access in those areas of higher levels of deprivation.

East and Moorside are the most deprived wards in Bury and North Manor (deprivation decile 1), Tottington, Ramsbottom and Pilkington Park are the least deprived wards in Bury (deprivation decile 10). Please see table 6 for further information.

Table 6 – Bury Wards by Deprivation deciles[16]

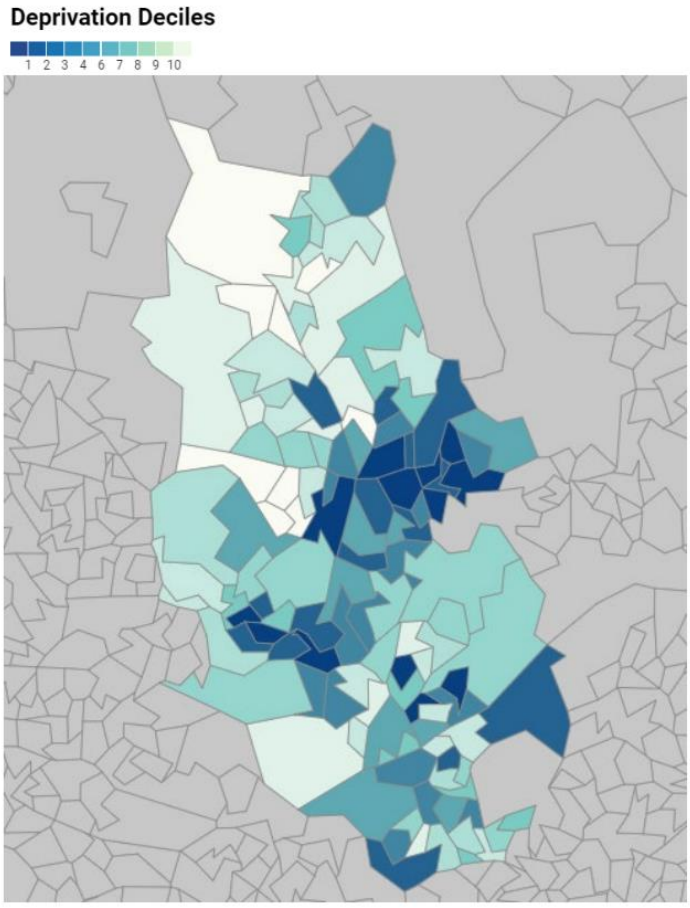
Ward	Deprivation Decile
East	1
Moorside	1
Radcliffe West	3
Redvales	3
Besses	4
Radcliffe East	4
St Mary's	6
Radcliffe North	6
Holyrood	7
Unsworth	8
Elton	8
Church	9
Sedgley	9
Pilkington Park	10
Ramsbottom	10
Tottington	10
North Manor	10

Created with Datawrapper

12 LSOAs in Bury are in the 10% most deprived in the country (shown in dark blue on map 5), with the lighter shades showing areas that have less deprivation. These areas of high deprivation are mostly found near Bury town centre, and in the Radcliffe and Besses areas (IMD 2019). However, there are smaller pockets of deprivation scattered around other wards in Bury.

[16] Bury Wards by Deprivation deciles

Map 5 – LSOAs in Bury showing their national deprivation decile based on ten groups ranging from '1% most deprived' (decile 1) to '10% least deprived' (decile 10) in England (Source: Deprivation | The Bury Directory)



4.4 Life expectancy

Females

The most recent data shows that life expectancy at birth for females has decreased to 81.3 years for the 3-year average during 2021-23 from 82.0 (2018-20) and is the same as the 3-year average during 2015-17 (81.3 years). This latest figure for 2021-23 is now below both the Northwest average of 81.6 years and the England average of 83.1 years.

Males

Life expectancy at birth for males has continued to decrease from 78.5 years in 2015-17, to 78.4 in 2018-20 and then to 77.5 years in 2021-23. This is now the same as the Northwest average (77.5 years) but below the England average (79.1 years).

Gender Gap

The gender difference has increased from a gap of 2.8 years in 2015-17 to 3.8 years in the latest data. This is a similar difference in life expectancy on average across England which is 4 years in favour of females. This indicates that services could be commissioned to help males maintain a healthy lifestyle.

Gap across wards (2016-20)

Life expectancy at birth varies by ward from the lowest in Moorside ward, East Bury Neighbourhood (73.9 years for males; 77.7 years for females) to the highest, 81.7 years, for males in Pilkington Park ward, Whitefield Neighbourhood. Whilst the highest life expectancy for females is in North Manor ward, North Neighbourhood at 85 years. This gives a variation within the Bury Borough of 7.8 years for males and 7.3 years for females. This variation can be seen in Table 7 below.

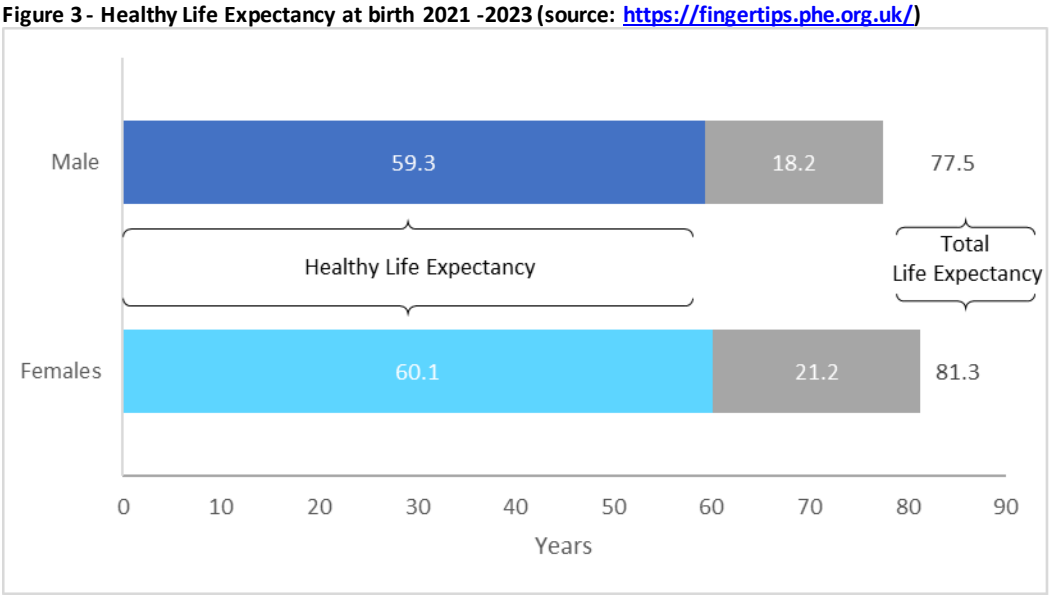
Table 7 - Life expectancy at birth by ward (2016-20) (Source: Fingertips | Department of Health and Social Care)

Neighbourhood	Ward	Females	Males
North	Elton	80.8	79.7
North	North Manor	85	81
North	Ramsbottom	84.7	81.2
North	Tottington	81.6	79.8
East Bury	Bury East	79.4	74.6
East Bury	Moorside	77.7	73.9
East Bury	Redvales	81.9	78.5
West	Bury West	83.6	80.9
West	Radcliffe East	83.3	77.7
West	Radcliffe North & Ainsworth	81	78.7
West	Radcliffe West	79	75.2
Prestwich	Holyrood	84.3	79.6
Prestwich	St Mary's	81.7	76.6
Prestwich	Sedgley	82.3	79.1
Whitefield	Besses	81.3	76.4
Whitefield	Pilkington Park	82.1	81.7
Whitefield	Unsworth	82.7	80.2

Healthy Life Expectancy

Healthy Life Expectancy (HLE) is the average number of years a person would expect to live in good health based on current mortality rates and reliant on how people self-report good health in response to a health question on a survey.

Figure 3 - Healthy Life Expectancy at birth 2021 -2023 (source: https://fingertips.phe.org.uk/)



Males and females in Bury can expect to live 18.2 years and 21.2 years of their expected life in relatively poor health. All the 65 or older age groups can expect to live in relatively poor health, highlighting another area for focussed service provision to support the health and wellbeing of this group.

4.5 Population characteristics health needs

The following patient groups with one or more of the following protected characteristics have been identified as living within the HWB's area:

- Age
- Sex
- Being pregnant or on maternity leave
- Disability
- Gender reassignment
- Being married or in a civil partnership
- Race which includes colour, nationality, ethnic or national origins
- Religion or belief
- Sexual orientation

This section also focusses on the health issues, setting out how pharmacies can support the specific needs of the population as defined by the protected characteristics in equality legislation.

4.5.1 Age

Age has an influence on which type of medicine and method of delivery is prescribed. Older people have a higher prevalence of illness and may take many medicines. The medicines management of older people is complicated by multiple disease, complex medication regimes and the ageing process affecting the body's capacity to metabolise and eliminate medicines from it. Ability to swallow at any age, but particularly in young children and older people with comorbidities, e.g. stroke, will also affect the type of medication available to treat a patient.

Pharmacy staff can support people to live independently by supporting optimisation of use of medicines, support with ordering, re-ordering medicines, home delivery to the housebound and appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people to take their medicines.

4.5.1.1 Children

Giving every child the best start is crucial to reducing health inequalities across the life course. What happens before and during pregnancy, in the early years and during childhood has lifelong effects on many aspects of health and wellbeing in adulthood from obesity, heart disease, mental health, educational achievement and economic status.

The babies, infants, children and young people population (0 to 17 years) of Bury is predicted to fall by 1,153 between the year 2023 and 2033 (ONS 2018). However, key themes in the Bury Let's Do It! Strategy are:

1. Improved quality of life
2. Improved early years development
3. Improved educational attainment for our young people

Starting life well through prevention and early intervention is a key priority. By improving maternal health, we could give our children a better start in life, reduce infant mortality and reduce the numbers of low-birth-weight babies and by taking better care of children's health and development we can improve educational attainment, reduce the risks of mental illness, unhealthy lifestyles, and hospital admissions.

4.5.1.2 Older people

There are 35,447 people aged 65 and over living in Bury, equivalent to 18.3% of the population (Census 2021). This compares to 18.4% of the population in England indicating Bury has similar proportion of older people compared to the national average. This varies between each ward in Bury, see Table 8 for further detail.

The greatest percentage increase in population numbers will be seen in those people aged 65 and over, with an increase of 15.4% between 2023 and 2033 (ONS 2018). This is a smaller increase than the England average of 21.4%, but it still represents a significant shift in the demographic of the Bury population.

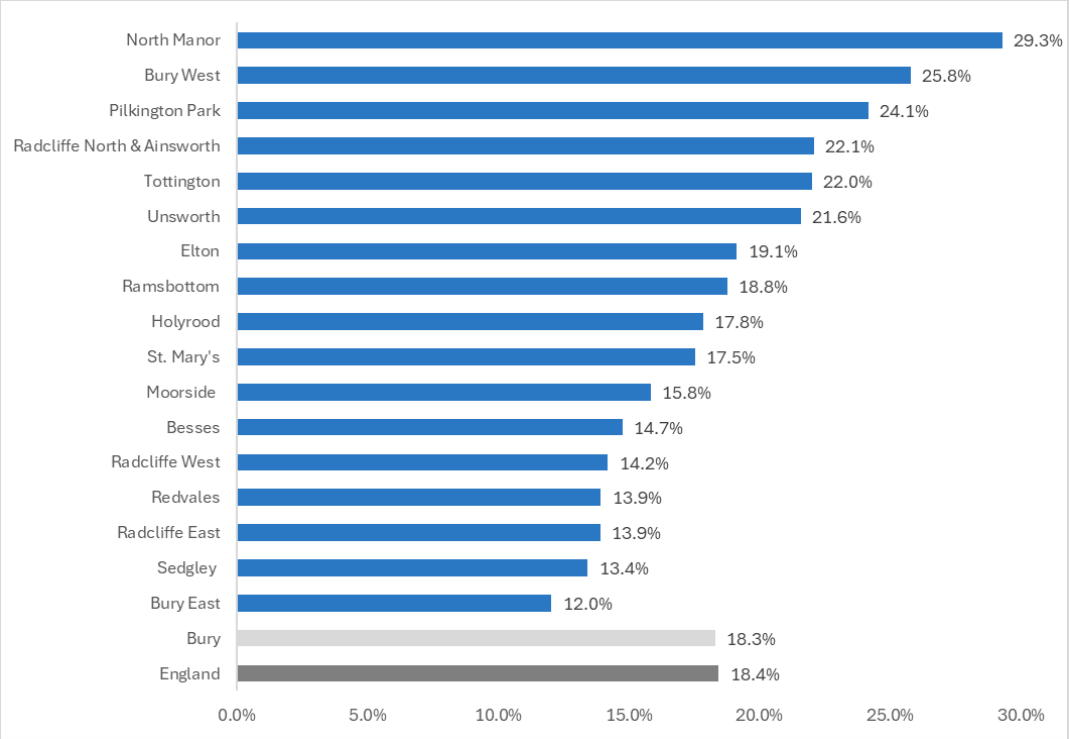
This increase in the older people will lead to growing demand for medicines and pharmacy services.

Older people living in isolation have a high incidence of suffering from loneliness. Social isolation and loneliness have a detrimental effect on health and wellbeing. Studies show that being lonely or isolated can impact on blood pressure and is closely linked to depression. The impact of this has cost implications for health and social care services. Investment is needed to ensure that voluntary organisations can continue to help alleviate loneliness and improve the quality of life of older people, reducing dependence on more costly services.
One of the key priorities of the Bury Let's do it! Strategy is to achieve a better quality of life for the residents of Bury and delivery of pharmaceutical services can help to achieve this. Pharmacy teams are often one of the few teams that people living in isolation have regular contact with.
Community pharmacies can support people to live independently by supporting optimisation of use of medicines, support with ordering, re-ordering medicines, home delivery to the housebound and appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people to take their medicines.

Independence is or could be supported by offering:

- Reablement services following discharge from hospital
- Falls assessments
- Supply of daily living aids
- Identifying emerging problems with people's health
- Signposting to additional support and resources

Table 8 - Proportion of population aged 65 years and over living in each ward in Bury as a percentage of the total population in that ward (ONS, 2021)



4.5.2 Sex

In Bury, the life expectancy from birth of men is 77.5 years and 81.3 years in women. The gap in life expectancy between females and males is 3.8 years.
Gender inequality is reported to exist in many aspects of society and refers to lasting and embedded patterns of advantage and disadvantage. About health and health and social care, men and women can be subject to differences in:

- Risks relating to the wider determinants of health and wellbeing.
- Biological risks of particular diseases.

- Behavioural and lifestyle health risks.
- Rights and risks of exploitation.

It is well documented that men are often less likely to access healthcare services. Community pharmacies are ideally placed for self-care by providing advice and support for people to derive maximum benefit from caring for themselves or their families.

The planning and delivery of health and social care services should consider the distinct characteristics of men and women in terms of needs, service use, preferences/satisfaction, and provision of targeted or segregated services (e.g. single sex hospital or care accommodation).

When necessary, access to advice, provision of over-the-counter medications and signposting to other services is available as a walk-in service without the need for an appointment. Community pharmacy is a socially inclusive healthcare service providing a convenient and less formal environment for those who do not choose to access other kinds of health services.

4.5.3 Long term health problems and disability

Most people suffer periods of ill health at some time, but these are usually temporary problems that do not have a sustained effect on day-to-day activities, such as going to work or socialising with friends and family. However, some health problems and disabilities are more serious because they are long-lasting and reduce a person's ability to carry out these activities.

People in some parts of Bury are more likely to report that that their day-to-day activities are limited due to a long-term health problem or disability than others. Table 9 details, by ward, where people have reported being disabled under the Equality Act or having a long term physical or mental health condition, and how this limits their day-to-day activities. Moorside had the highest number of Disabled under the Equality Act: Day-to-day activities limited a lot at 10.9%, with Ramsbottom the lowest at 6.2%.

Table 9 – Disability by ward (source: Disability | The Bury Directory)

Ward name	Disabled under the Equality Act: Day-to-day activities limited a lot	Disabled under the Equality Act: Day-to-day activities limited a little	Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited	Not disabled under the Equality Act: No long term physical or mental health conditions
Besses	8.7%	10.7%	6.9%	73.8%
Bury East	8.8%	9.8%	5.5%	75.9%
Bury West	7.7%	10.2%	7.8%	74.3%
Elton	7.5%	10.2%	7.4%	74.9%
Holyrood	7.5%	10.4%	7.5%	74.6%
Moorside (Bury)	10.9%	11.1%	6.1%	71.9%
North Manor	6.5%	10.7%	8.5%	74.3%
Pilkington Park	7.1%	10.0%	8.1%	74.8%
Radcliffe East	9.0%	10.8%	6.7%	73.5%
Radcliffe North & Ainsworth	10.0%	11.4%	7.1%	71.5%
Radcliffe West	9.3%	10.5%	6.4%	73.8%
Ramsbottom	6.2%	9.3%	8.6%	75.8%
Redvales	8.9%	9.8%	5.5%	75.7%
Sedgley (Bury)	6.7%	8.5%	6.0%	78.8%
St Mary's (Bury)	9.3%	10.7%	7.5%	72.5%
Tottington	7.8%	10.3%	8.0%	73.9%
Unsworth	7.8%	10.3%	7.6%	74.3%

People with disabilities often have individual, complex and specific needs. It is important that health and social care services can provide effective specialist services to meet such needs.

When patients are managing their own medication but need some support, pharmacists and dispensing doctors must comply with the Equality Act 2010. Where the patient is asse ssed as having a long term physical or mental impairment that affects their ability to carry out everyday activities, such as managing their medication, the pharmacy contract includes funding for reasonable adjustments to the packaging or instructions that will support them in self-care. Pharmacists can review patients to ensure that the number of medications and doses are optimised and that the patient is getting the best outcomes from the treatment. If further support is needed, then reasonable adjustments can be recommended such as compliance aids, multi- compartment compliance aids,

large print labels, easy to open containers or medication reminder alarms/charts. Each pharmacy should have a robust system for assessment and auxiliary aid supplies that adheres to clinical governance principles.

4.5.4 Race, ethnicity, and language

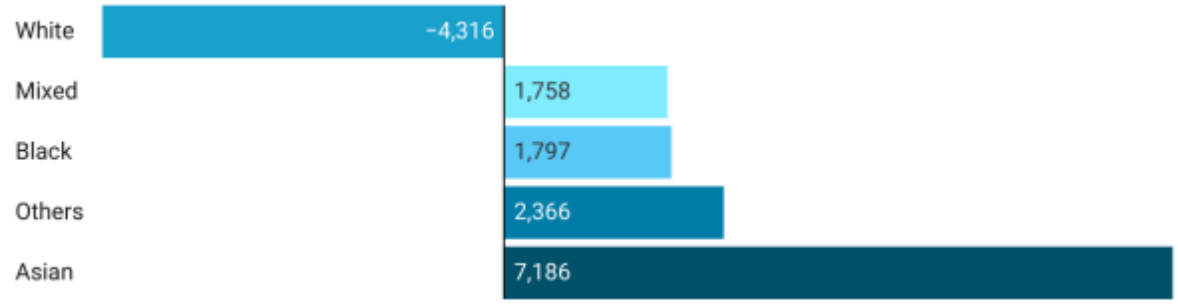
This data is taken from the census of 2011 and 2021 and demonstrates that Bury's ethnic group composition has changed. The proportion of people from white backgrounds has decreased to 82.9% between 2011 and 2021, with a proportional increase of 6.3% in minority ethnic backgrounds.

Table 10 – Percentage of population by broad ethnic categories in Bury and England for Census 2011 and 2021 (Source: Ethnicity | The Bury Directory)

Broad Ethnic Categories	Bury		England	
	2011	2021	2011	2021
White groups	89.2%	82.9%	85.4%	81.0%
Mixed	1.8%	2.6%	2.3%	2.9%
Asian	7.2%	10.6%	7.8%	9.7%
Black	1.0%	1.9%	3.5%	4.2%
Others	0.7%	1.9%	1%	2.2%

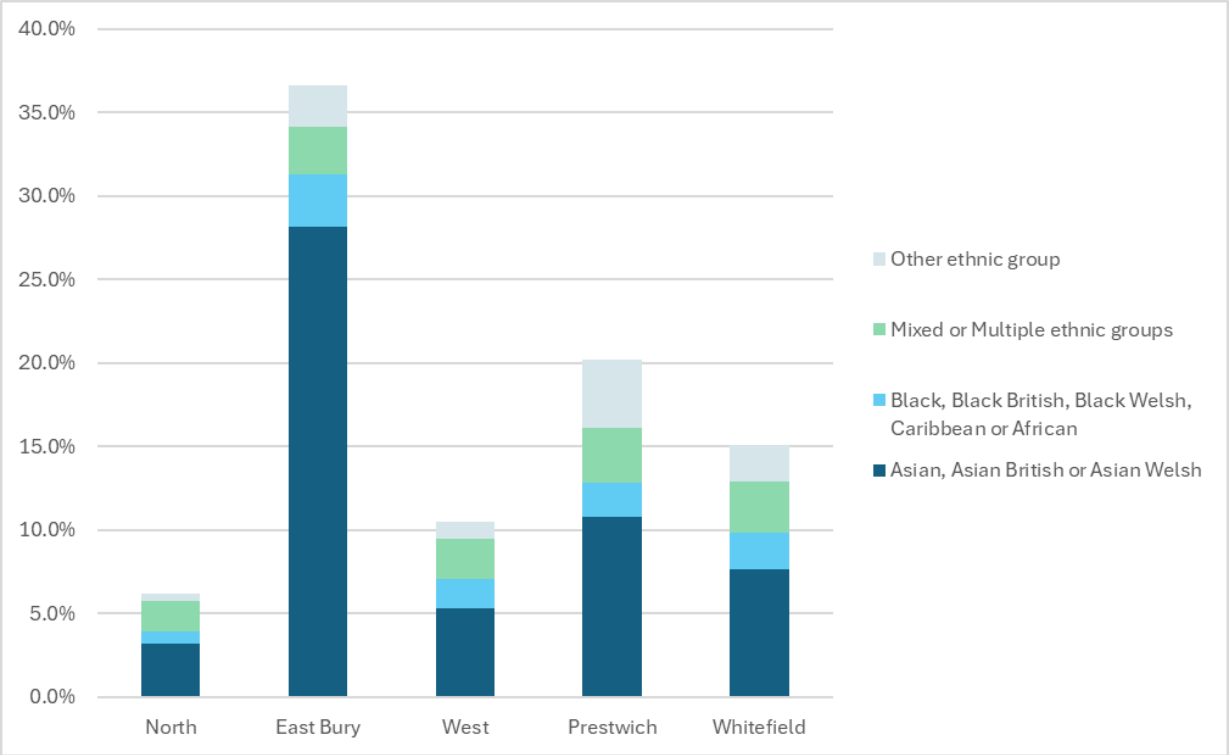
The largest increase has been seen in the Asian community with an additional 7,186 people over this time period (see figure 4). This data should be considered to ensure that all communities have appropriate access to the pharmaceutical services that are provided. In community pharmacy this may include access to translation services or staff members that are able to speak a variety of languages.

Figure 4 - Changes in broad ethnic categories between Census 2011 and Census 2021 (Source: Ethnicity | The Bury Directory)



Asian, Asian British/Asian Welsh make up the largest minority ethnic background group in Bury, accounting for 10.6% of the population. 51% of Bury's Asian, Asian British/Asian Welsh population are located within East Bury Neighbourhood with most of this group in East Bury ward (See Figure 6).

Figure 5 - Percentage of BME by Neighbourhood (source: Census 2021, ONS. Crown copyright)



The percentage of people that cannot speak English well or not at all in Bury is 1.7%; lower than the national average (1.9%), according to ONS data from the census in 2021. However, Table 11 below shows there are pockets where residents are above the national average. These are mainly in the East Bury neighbourhood where there is a high population of minority ethnic background living as shown above. Those residents may need support accessing and understanding services if they that cannot speak English well or at all.

Table 11 - Percentage of population who cannot speak English well or at all, by wards with a greater than England average (source: ONS, 2021)

Neighbourhood	Ward	% of population who cannot speak English well or at all	
		Census 2011	Census 2021
East Bury	Bury East	4.6%	5.8%
East Bury	Redvales	3.1%	4.6%
East Bury	Moorside	2.0%	3.6%
Prestwich	Sedgley	2.0%	2.0%
Bury		1.2%	1.7%
England		1.7%	1.9%

People from most ethnic minority groups report worse health and more limiting long-term illness than White British people. Some ethnic minority groups also experience worse child health, including higher rates of stillbirths, lower levels of childhood physical activity, and higher levels of obesity. Many of these issues are caused by differences in access to the building blocks of health: for example, levels of unemployment, poverty, and overcrowded housing are higher among South Asian and Black ethnic communities.[17] Community pharmacies are well-placed to provide easy access to healthcare services, often within the communities themselves.

4.5.5 Religion and belief

Little is known about inequalities in health between people of different faiths or no faith. Local data are not available, and faith is not captured in most NHS data sets. National data from the ONS suggest that people of Christian, Jewish, and Hindu faiths are most likely to say they are satisfied with their health. Christians, Hindus, and Sikhs also report better mental health. However, Muslim respondents reported worse physical health, and people of no faith are more likely to smoke. [18]

The religious beliefs, and non-belief, of Bury's population continues to diversify. In line with the rest of the country the borough has experienced an overall increase in the proportion of its population that does not identify with any religious belief.

The latest data from the 2021 Census showed that in Bury the religious belief group of Christians are the majority at 48.8% of the population compared to 46.3% for the average in England. Those with no religion identified accounted for 29.4% (36.7% England), with Jewish religion and Muslim religion populations accounting for 5.5% (0.5% England) and 9.9% (6.7% England) respectively.
Comparisons between the 2011 Census and the 2021 Census can be seen in table 12 below.

[17] https://theburydirectory.co.uk/storage/11596/Bury-Health-Ineqaulities-Position-Paper.pdf accessed 28/02/2025

[18] https://theburydirectory.co.uk/storage/11596/Bury-Health-Ineqaulities-Position-Paper.pdf accessed 28/02/2025

Table 12 - Percentage of religious belief groups in Bury and England, Census 2011 and Census 2021

Religion	2011		2021	
	Bury	England	Bury	England
Christian	62.7%	59.4%	48.8%	46.3%
Buddhist	0.2%	0.5%	0.3%	0.5%
Hindu	0.4%	1.5%	0.5%	1.8%
Jewish	5.6%	0.5%	5.5%	0.5%
Muslim	6.1%	5.0%	9.9%	6.7%
Sikh	0.2%	0.8%	0.3%	0.9%
Other religion	0.2%	0.4%	0.3%	0.6%
No religion	18.6%	24.7%	29.4%	36.7%
Religion not stated	6.0%	7.2%	4.9%	6.0%

It is important that health and social care services are aware of the need to respect and be sensitive to the preferences of people's religions and beliefs when delivering services, including:

- Practices around births and deaths.
- Diet & food preparation.
- Family planning and abortion.
- Modesty of dress.
- Same sex clinical staff.
- Festivals and holidays.
- Medical ethics considerations in accepting some treatments and end of life care.
- Pharmaceuticals, vaccines, and other medical supplies.

Pharmacies can provide advice to specific religious groups on medicines derived from animal sources and during periods of fasting.

4.5.6 Marriage and civil partnership

According to the 2021 Census in Bury, for residents aged 16 and over, 45.3% of people are married or in a registered civil partnership, 36.6% are single and have never married or registered a civil partnership, 11.6% are separated or divorced. There are 9,980 widowed people living in Bury.

Limited evidence is available on the health and social care needs of people in terms of marriage and civil partnership.

It is important that health and social care services are aware of and respectful of the legal equivalence of marriage and civil partnership when dealing with individuals, their partners and families. Consideration should also be given to those people in similarly committed and secure relationships, including civil partnership, and other long-term couple partnerships

Consideration should be given to signs of domestic violence; pharmacies can help to raise awareness of this issue and signposting to services/organisations that can provide advice and support.

4.5.7 Pregnancy and maternity

The number of live births in Bury has continued to reduce year on year from 2,228 in 2019 to 2,008 in 2022. Equivalent to the crude live birth rate dropping from 11.5 births per 1,000 population to 10.3 in 2022. There was however an increase in live births in 2023 (2,055) and the crude live birth rate increased to 10.5. This timeframe has also seen a slight increase in the number of females of childbearing age (15 – 44 years); increasing from 36,000 in 2020 to 36,700 in 2023.

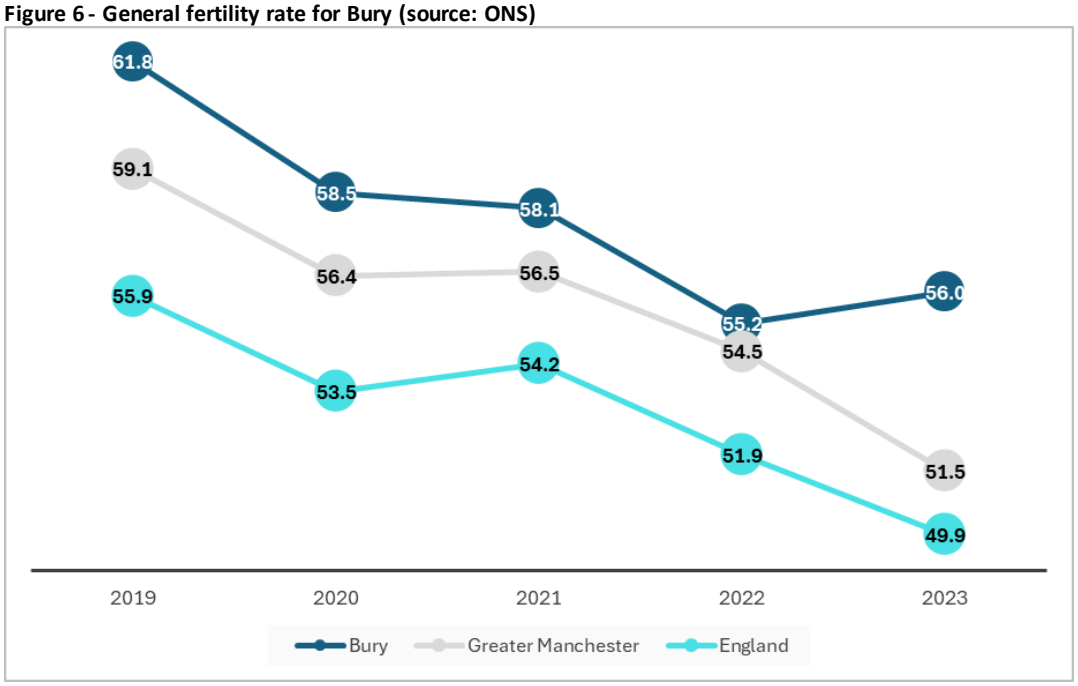
Table 13 - Live births for Bury 2019 to 2023 (source: ONS)

Year	Total population (thousands)	Female population (thousands)	Female population aged 15-44 years (thousands)	Total live births	Crude live birth rate	Genral Fertility Rate (GFR)
2019	193.8	98.8	36.0	2,228	11.5	61.8
2020	193.6	98.7	36.0	2,104	10.9	58.5
2021	193.9	98.8	36.1	2,098	10.8	58.1
2022	194.6	98.9	36.4	2,008	10.3	55.2
2023	195.5	99.1	36.7	2,055	10.5	56.0

Crude birth rate = Proportion of live births per 1,000 population (all ages)
General Fertility Rate (GFR) = number of live births per 1,000 women aged 15 to 44 years

The general fertility rate (GFR) in Bury is higher than that for England and Greater Manchester. Bury has had a decreasing general fertility rate (GFR) from 61.8 in 2019 to 55.2 in 2022. This was consistent with overall drops with England and Greater Manchester. However, the latest data available from 2023 shows that this has increased in Bury to 56.0 and is no longer in line with the Greater Manchester and England trends, which dropped to 51.5 and 49.9 respectively.

Figure 6 - General fertility rate for Bury (source: ONS)



Pharmacies can provide advice to pregnant women on a range of healthcare issues including medicines, vaccinations and self-care, where they have the expertise to advise on which medicines are safe for use in pregnancy and during breast feeding. They are also well-placed to provide support and treatment for smoking cessation during pregnancy.

4.5.8 Sexual orientation

An estimated 2.6% of the Bury's population aged 16 years and over identified as lesbian, gay, or bisexual in the 2021 Census, this compares to an England figure of 2.8%.
The key findings of research by LBGTQ+ charity Stonewall.org.uk[19] suggests that the LGBTQ+ population may be exposed to certain patterns of health risks, for instance:

- Half of LGBT people (52 per cent) said they've experienced depression in the last year.
- One in eight LGBT people aged 18-24 (13 per cent) said they've attempted to take their own life in the last year.

[19] LGBT in Britain - Health (2018)

- Almost half of trans people (46 per cent) have thought about taking their own life in the last year, 31 per cent of LGB people who aren't trans said the same.
- Forty-one per cent of non-binary people said they harmed themselves in the last year compared to 20 per cent of LGBT women and 12 per cent of GBT men.
- One in six LGBT people (16 per cent) said they drank alcohol almost every day over the last year.
- One in eight LGBT people aged 18-24 (13 per cent) took drugs at least once a month.
- One in eight LGBT people (13 per cent) have experienced some form of unequal treatment from healthcare staff because they're LGBT.
- Almost one in four LGBT people (23 per cent) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In the last year alone, six per cent of LGBT people – including 20 per cent of trans people – have witnessed these remarks.
- One in twenty LGBT people (five per cent) have been pressured to access services to question or change their sexual orientation when accessing healthcare services.
- One in five LGBT people (19 per cent) aren't out to any healthcare professional about their sexual orientation when seeking general medical care. This number rises to 40 per cent of bi men and 29 per cent of bi women.
- One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT.

Pharmacies can help to raise awareness of the issues discussed above and can provide advice to members of the LGBTQ+ community in relation to healthy lifestyle choices e.g. safe drinking levels, interactions and side effects of recreational drugs.

4.5.9 Gender reassignment

Data from Census 2021 shows 0.5% of the Bury population have a gender different than that registered at birth, which is in line with England (0.5%).

A 2018 Stonewall report[20] based on over 800 trans and non-binary people revealed the experiences of transgender individuals in the healthcare environment:

- When accessing general healthcare services in the last year, two in five trans people (41%) said healthcare staff lacked understanding of trans health needs.
- Three in five trans people (62 per cent) who have undergone, or are currently undergoing, medical intervention for their transition are unsatisfied with the time it took to get an appointment. Three in ten (28 per cent) are unsatisfied with the cost related to this intervention.
- More than one in ten trans people (11%) have gone abroad for medical treatment to alter their physical appearance, including buying hormones over the internet from other countries, with many citing the barriers they currently face in accessing medical treatment in the UK. A further 17 per cent of trans people are considering doing this.
- One in ten trans people (10 per cent) don't want any form of medical intervention – this includes 16 per cent of non-binary people who identify as trans, 10 per cent of trans men and four per cent of trans women. One in eight trans people (13 per cent) are unsure if they want some form of medical intervention.
- Half of trans people (52 per cent) have undergone or are currently undergoing medical intervention. Almost one in four trans people (23 per cent) have not yet undergone any, but want some form of medical intervention.
- Almost half of trans people (47 per cent) who want to undergo some form of medical intervention, but have yet to have it, say that long waiting times prevent them from accessing medical treatment. Nearly half (45 per cent) say they don't have the financial means to afford it (e.g. costs for treatments they've been unable to access on the NHS or travel expenses). One in four (24 per cent) fear discrimination from a healthcare service provider and the same

[20] https://files.stonewall.org.uk/production/files/lgbt_in_britain_-_trans_report_final.pdf?dm=1724230505 accessed 28/02/2025

percentage of trans people, 24 per cent, don't know how to access the form of medical intervention they want.

- One in four trans people who have undergone or are currently undergoing medical intervention are unsatisfied with the support they have received from their GP (24 per cent) and their gender identity clinic (23 per cent).
- Seven in ten trans people (71 per cent) who are accessing medical support for their transition are satisfied with the care they have received at those facilities. However, one in seven trans people (14 per cent) don't share this experience and are not satisfied with the care they received at the medical facility.

Acceptance of transgender people in general health and social care settings and gender specific health services (e.g. sexual health screening), and access to appropriate specialist gender identity services are often reported as problematic.

Research and analyses suggest that untreated gender dysphoria can severely affect the person's health and quality of life and can result in:

- Higher levels of depression, self-harm, and consideration or attempt of suicide.
- Higher rates of drug and alcohol abuse.

Pharmacies can provide necessary medicines and advice on adherence and side effects including the long-term use of hormone therapy. Pharmacies can provide advice to members of this community in relation to health and well-being and on raising awareness about issues relating to members of these communities as discussed above. Pharmacies should also be able to provide any LBGTQ+ people with signposting to relevant services.

5 Key health priorities for Bury

To identify how pharmaceutical service provision can help tackle the need of Bury's local population, we have used HWB minutes from 16/01/2025 meeting[21]. The HWB have also identified priorities in the locality plan update for 2025 to address issues which will help drive the changes recommended in Bury's Let's do it! strategy. The priorities identified by the HWB that are related to pharmaceutical services provision are:

1. Increase annual physical activity
2. Management of obesity and healthy weight
3. Reduce smoking prevalence
4. Harm reduction from drugs and alcohol
5. Health protection – immunisations and vaccinations
6. Increase in pharmacy first uptake

The major conditions board have also identified the following major conditions as priorities:

7. Cardiovascular disease
8. Respiratory disease (COPD and Asthma)
9. Cancers
10. Musculoskeletal conditions

By looking at each topic we can identify areas where pharmaceutical services already meet, or are able to be developed to meet, the objectives. Many of the CPCF and locally commissioned/ enhanced services are helpful to optimise the use of medicines thereby improving people's health, reducing medication interactions and reducing wastage e.g. New Medicines Service.

Further resources, including case studies, detailing types of pharmaceutical services which could be commissioned as potential solutions to Bury's health priorities can be found on the CPE website.[22] Guidance on the development of local services and resources are listed under the headings of:

- Guidance for commissioners on commissioning community pharmacy medicines optimisation services.
- Guidance on commissioning levels.
- Guidance on developing a service proposal.
- Community pharmacy England locally commissioned services database.
- Services case studies hub.
- Guidance on decommissioning of services.

5.1 Increase in Physical Activity

The LET's get Bury moving strategy is designed to ignite a passion for physical activity and well-being within our community. As we embark on this journey together, we envision a healthier, happier, and more vibrant Bury.[23] The strategy highlights the following key findings in relation to physical activity:

- Inactivity within our communities has remained steady between 2015/16 and 2021/22.
- 1 in 4 adults experience inactivity
- Over half of our children (53%) are not active enough
- Inactivity has worsened the most in the most deprived IMD deciles since the pandemic

Figure 7 demonstrates that 65% of adults in Bury were physically active in 2020/21, which was in line with the England average of 65.9%.

[21] Health and Wellbeing Board - Bury Council

[22] https://cpe.org.uk/lpcs-and-local/locally-commissioned-services/

[23] https://theburydirectory.co.uk/storage/13099/LETS-Get-Bury-Moving-Framework-2024.pdf accessed 19/03/2025

Figure 8 demonstrates that 47.1% of children and young people in Bury were physically active in 2021/22, which was in line with the England average of 47.2%.

Figure 7 - Percentage of physically active adults, Bury and England, 2015/16 – 2020/21 (Source: Physical Activity | The Bury Directory)

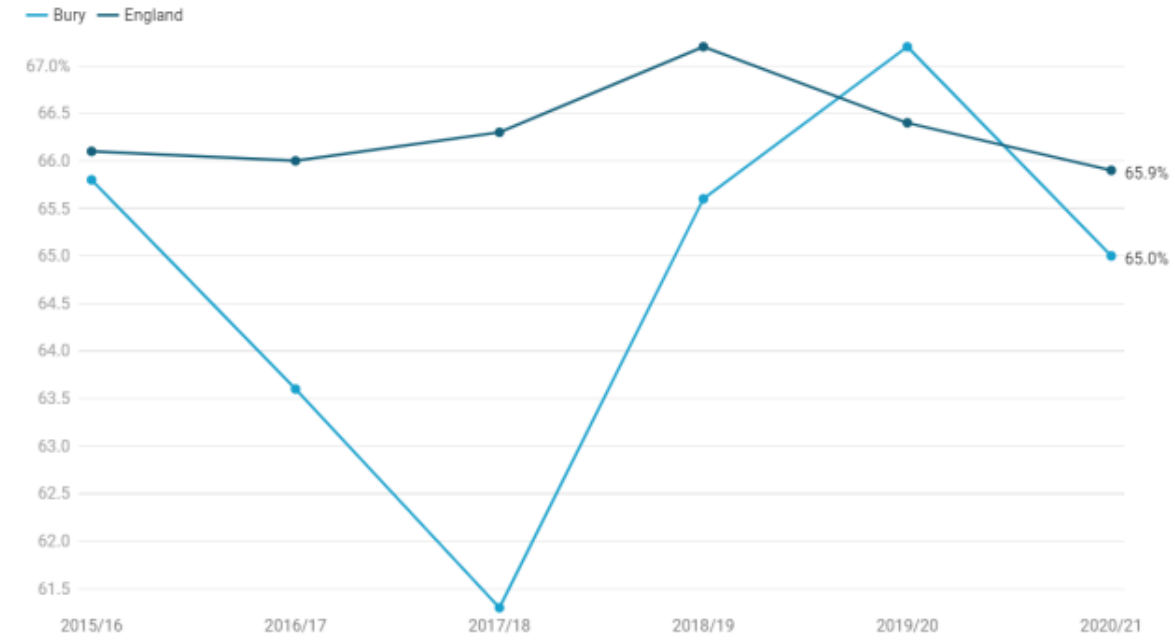
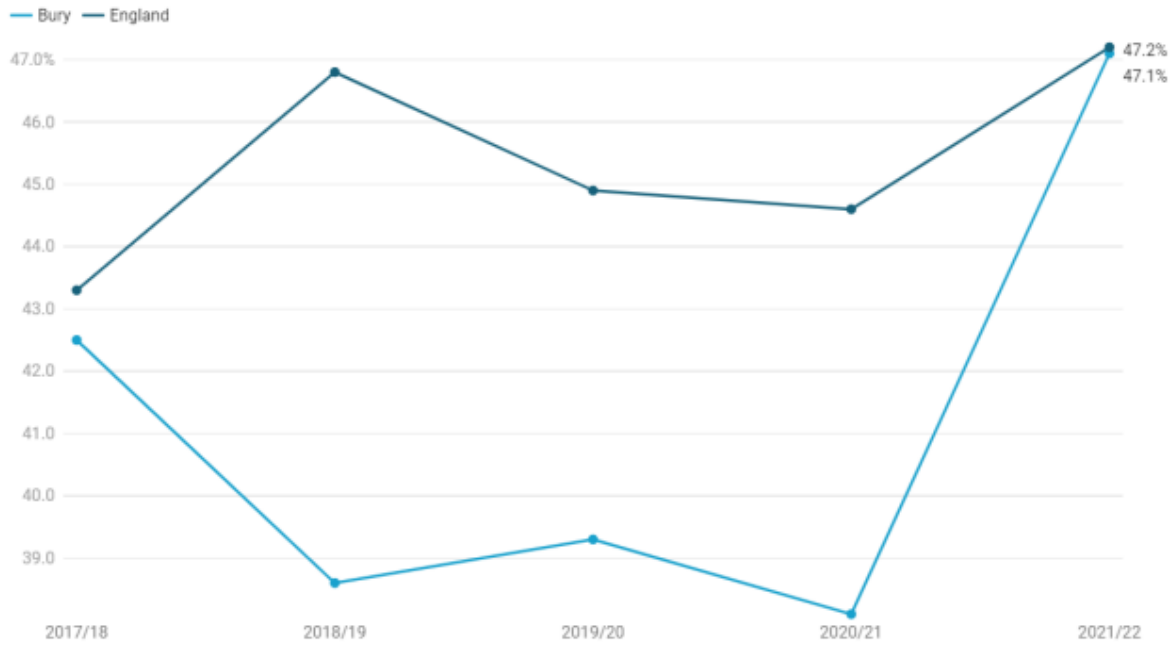


Figure 8 - Percentage of physically active children and young people, Bury and England, 2017/18 – 2021/22 (Source: Physical Activity | The Bury Directory)



How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support healthy lifestyles, including physical activity. Several existing essential services support the promotion of healthy lifestyles:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements of physical activity.

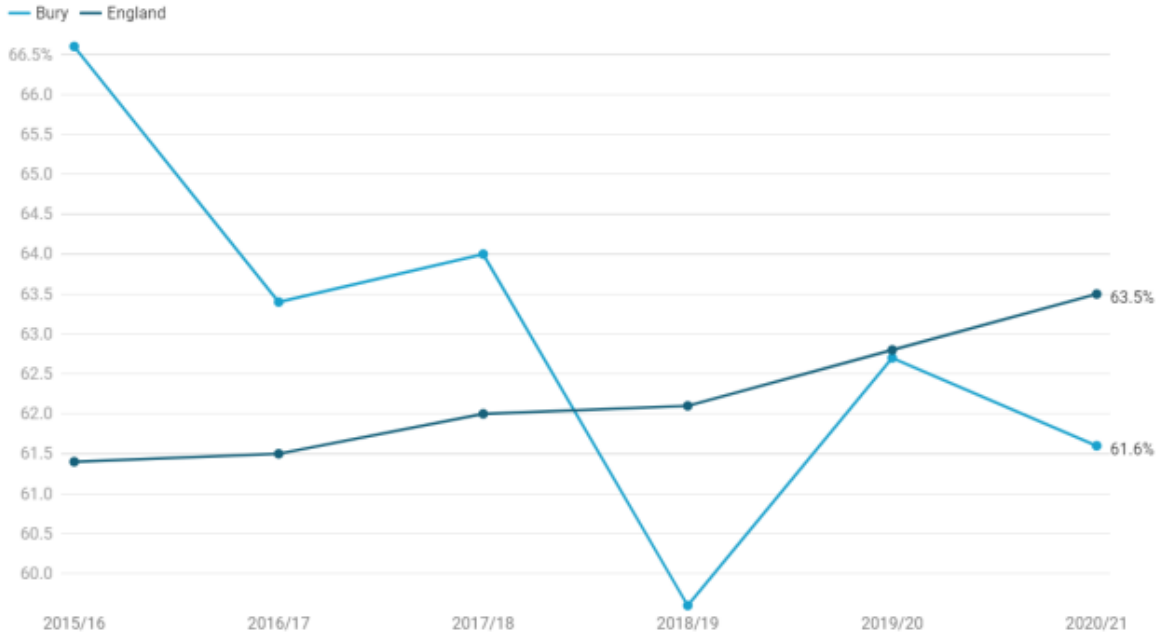
- Dispensing – staff can provide brief advice and interventions for healthy lifestyles when handing over medications to patients.

5.2 Management of Obesity and Healthy Weight

A healthy weight can be partly managed with physical activity as described in section 5.1. Other factors are also important, including a healthy and balanced diet. The Bury food strategy details how Bury can be at the forefront of promoting and celebrating good food for all, through a knowledgeable, connected, supported and vibrant food culture.[24]

Figure 9 shows that 61.6% of adults aged 18 or over were classified as overweight or obese in 2020/21, which was less than the England average of 63.5%.

Figure 9 - Percentage of adults 18+ classified as overweight or obese, Bury and England, 2015/16 – 2020/21 (Source: Physical Activity | The Bury Directory)



How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support healthy lifestyles, including a healthy and balanced diet and weight management. Several existing essential services support the promotion of healthy lifestyles:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements of weight management.
- Dispensing – staff can provide brief advice and interventions for healthy lifestyles when handing over medications to patients.

There is a future opportunity for community pharmacy to be involved in the delivery of specialist weight management pathways eg Tirzepatide, and commissioners may include community pharmacy in the delivery model for these services on a local level.

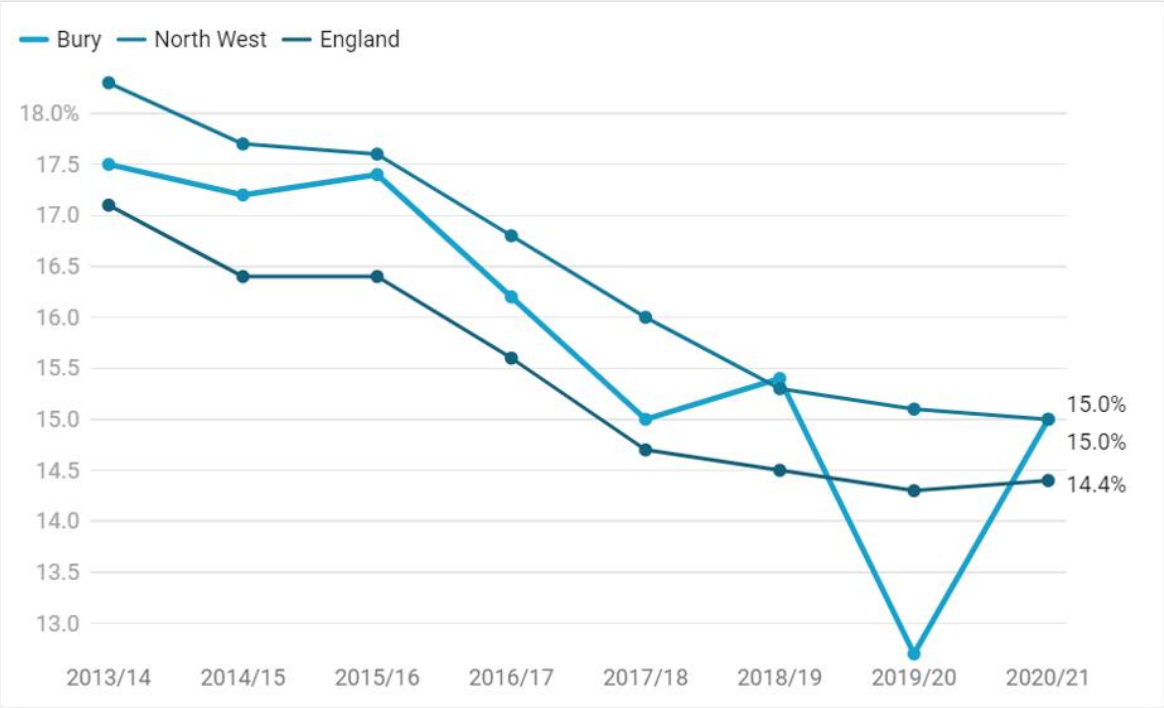
5.3 Reduction in Smoking prevalence

[24] https://theburydirectory.co.uk/storage/7175/Bury-Food-Strategy-PDF-AC.pdf accessed 19/03/2025

Smoking is the leading behavioural cause of death in Bury and causes a range of cancers, coronary heart disease and respiratory disease.[25]

Figure 10 shows that Bury had a smoking prevalence of 15.0% in 2020/21, which was in line with the North West average of 15.0% and slightly higher than the England average of 14.4%.

Figure 10 - Smoking prevalence by percentage, Bury, North West and England (2013/14 - 2020/21) (Source: Smoking | The Bury Directory)



How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support healthy lifestyles, including advice and treatment to help stop smoking. Several existing essential services support the promotion of healthy lifestyles:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to stopping smoking.
- Dispensing – staff can provide brief advice and interventions for smoking cessation when handing over medications to patients.

There is also a nationally commissioned advanced service for smoking cessation, which is offered by 24 pharmacies in Bury.

5.4 Harm Reduction from Drugs and Alcohol

Alcohol misuse is the fifth biggest cause of death, ill health, and disability across all ages, and the biggest cause among 15–49-year-olds in the UK.[26]

Table 14 shows that Bury had a standardised alcohol-related mortality rate of 49.7, greater than the North West (47.8) and England (38.5) rates.

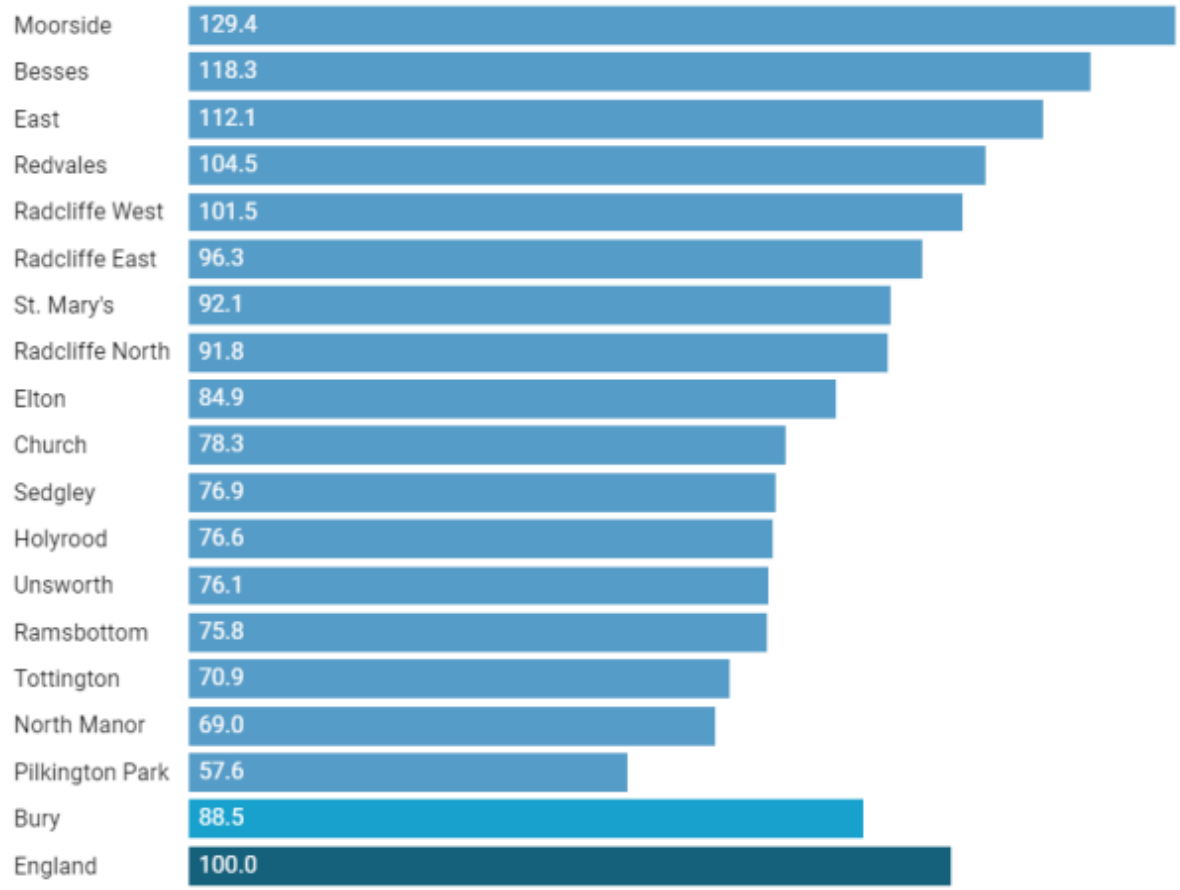
[25] https://theburydirectory.co.uk/smoking
[26] https://theburydirectory.co.uk/alcohol

Table 14 - Alcohol-related mortality (Persons) for Bury and England, 2021. Directly standardised rate – per 100,000 (Source: Alcohol | The Bury Directory)

Bury	England	Northwest
49.7	38.5	47.8

Figure 11 shows that there are 5 wards in Bury that had worse rates of hospital admissions than England for alcohol attributable conditions (Moorside, Besses, East, Redvales and Radcliffe West).

Figure 11 - Hospital admissions for alcohol attributable conditions *(Narrow definition)*, Wards in Bury, 2016/17 – 2020/21. Indirectly standardised ratio (per 100) (Source: Alcohol | The Bury Directory)



How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support healthy lifestyles, including advice in relation to alcohol consumption. Several existing essential services support the promotion of healthy lifestyles:

- Being a healthy living pharmacy).
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to alcohol consumption.
- Dispensing – staff can provide brief advice and interventions for alcohol consumption when handing over medications to patients.

There are also locally commissioned services for substance misuse including needle exchange (provided by 5 pharmacies) and supervised consumption of prescribed medication for dependence (provided by 15 pharmacies).

5.5 Health protection – Immunisations and Vaccinations

One of the key priorities from the Bury Locality plan update for 2025 is to improve immunisation and vaccination rates across the borough. This priority is supported by the data in table 15, which demonstrates a general decreasing trend in vaccination rates in Bury.

Most vaccinations show a worsening trend and also fall below the vaccination rates for England.

Table 15 - Population vaccination coverage by indicator (Source: https://fingertips.phe.org.uk/)

Indicator	Period	Bury (%)	England (%)
Rotavirus (1 years old)	2023/24	82.6	88.5
Dtap IPV Hib HepB (1 year old)	2023/24	88.3	91.2
Dtap and IPV booster (5 years old)	2023/24	78.3	82.7
Hepatitis B (1 year old)	2023/24	100.0	0.0
Hepatitis B (2 years old)	2023/24	88.9	0.0
Hib and MenC booster (2 years old)	2023/24	84.5	88.6
Hib and MenC booster (5 years old)	2017/18	92.2	92.4
MenB (1 year old)	2023/24	88.2	90.6
MenB booster (2 years old)	2023/24	82.4	87.3
MMR for one dose (2 years old)	2023/24	85.7	88.9
MMR for one dose (5 years old)	2023/24	93.2	91.9
MMR for two doses (5 years old)	2023/24	81.5	83.9
PCV	2023/24	91.4	93.2
PCV booster	2023/24	84.1	88.2
PPV	2022/23	64.5	71.8
HPV for one dose (12-13 years old)(Male)	2022/23	69.7	65.2
HPV for one dose (12-13 years old)(Female)	2022/23	79.4	71.3
HPV for two doses (13-14 years old)(Male)	2022/23	54.7	56.1
HPV for two doses (13-14 years old)(Female)	2022/23	62.4	62.9
Meningococcal ACWY conjugate vaccine (14-15 years old)	2023/24	72.6	73.0
Shingles (71 years)	2022/23	37.6	48.3
Flu (aged 65 and over)	2023/24	77.5	77.8
Flu (at risk individuals)	2023/24	40.0	41.4
Flu (2-3 years old)	2023/24	39.2	44.4
Flu (Primary school aged children)	2023/24	63.5	55.1

Trend for Bury
Increasing and getting better
No significant change
Decreasing and getting worse
No trend available

How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support health and wellbeing, including advice in relation to immunisations and vaccinations. Several existing essential services support the promotion of immunisations and vaccinations:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to immunisations and vaccinations.
- Dispensing – staff can provide brief advice and interventions for immunisations and vaccinations when handing over medications to patients.

30 Pharmacies in the Bury Borough provided an Influenza (Flu) vaccinations advanced service this flu season. Flu vaccinations help protect the elderly and most vulnerable from the flu virus and therefore

reduce hospital admissions, saving NHS time for clinicians to spend on other critically ill people and also saving money.
There is also a national enhanced service for COVID-19 vaccinations, which contractors can provide under certain criteria and has added extra capacity to the vaccination programme across Bury. Pharmacies have been willing and able to provide much needed services to their local population and can be relied upon to set up a service at short notice. As pharmacy staff have the skills to vaccinate, they could be used in future for other rapid roll-out schemes or mop up programmes under a PGD.

5.6 Increase in pharmacy first uptake

One of the key priorities from the Bury Locality plan update for 2025 is to increase pharmacy first uptake to help transform community care in our neighbourhoods.

In February 2025, community pharmacies in Bury received a total of 430 pharmacy first referrals which was the second lowest locality total in GM. Please note that this is a total activity figure and is not weighted for population size.

Table 16 - GM wide pharmacy first consultation data by locality for February 2025 (Source: https://curator.gmtableau.nhs.uk/dashboard/gm-tableau-nhsgm-powerpoint-slides-slide-deck-filters-and-parameters)

Community Pharmacy Locality	Acute Otitis Media Flag	Acute Sinusitis Flag	Acute Sore Throat Flag	Impetigo Flag	Infected Insect Bites Flag	Shingles Flag	Uncomplicated UTI Flag	Total PF Clinical Pathways Delivered by CP	Total PF Minor Illness Delivered by CP	Total PF Referrals Completed Delivered by CP	Total PF Referrals Received by CP
Bolton	52	30	111	2	0	0	44	239	599	838	1069
Bury	21	11	61	3	1	3	37	137	188	325	430
Manchester	91	70	290	10	5	3	131	600	1118	1718	2240
Oldham	32	29	89	5	4	7	60	226	401	627	795
Rochdale	35	15	100	4	6	8	61	229	265	494	623
Salford	51	31	161	4	1	1	63	312	480	792	1047
Stockport	47	44	147	3	1	5	71	318	160	478	638
Tameside	16	15	61	3	0	1	40	136	134	270	379
Trafford	33	12	59	0	3	8	51	166	245	411	495
Wigan	18	41	91	5	1	7	56	219	166	385	519
Non-GM CP	2	26	67	1	0	0	9	105	354	459	504
Grand Total	398	324	1237	40	22	43	623	2687	4110	6797	8739

How can pharmacy contractors help?
All pharmacy contractors are commissioned to provide and are actively providing the pharmacy first service in Bury.
More work around communications and engagement with patients and the wider healthcare system may be required to help drive knowledge, understanding and access to this valuable service.

5.7 Cardiovascular Disease

Under 75 years of age mortality from CVD (Persons) in Bury (93.1 per 100,000 population in those aged under 75 years) is higher than England (76 per 100,000) average but similar to North West average (92.8 per 100,000).[27]

The directly standardised mortality rate from all CVDs for people over 65 in Bury is 1,050.1 per 100,000 population in 2021, lower than the average for the North West (1,092.9 per 100,000) and statistically similar to England average of 1021.4 points per 100,000.[28]

[27] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025
[28] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025

In its group of 16 statistical neighbours, Bury has the 5th lowest CVD mortality rate among people over 65, with the highest rate in Calderdale (1,250.5) and lowest in Bedford (885.3).[29] (See Figure 12)

Figure 12 - Directly age-standardised mortality rate from all CVDs in persons aged 65 years and over for Bury and its statistical neighbours per 100,000 population (Source: Ageing Well | The Bury Directory)

Local authority	Directly age-standardised mortality rate from all CVDs in persons aged 65 years and over per 100,000 population
Calderdale	1250.5
Doncaster	1188.9
Oldham	1178.9
Rotherham	1174.6
Kirklees	1144.3
Derby	1129.8
Rochdale	1112.6
Wigan	1109.7
Dudley	1099.2
Bolton	1062.4
St. Helens	1059.6
Bury	1050.1
Stockport	1034.3
Medway	1032.6
Swindon	1006.6
Bedford	885.3

How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support health and wellbeing, including advice in relation to cardiovascular disease. Several existing essential services support the treatment and prevention of cardiovascular disease:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to cardiovascular disease.
- Dispensing – staff can provide brief advice and interventions for cardiovascular disease.

38 pharmacies in Bury actively provide the New Medicine Service, which includes several long-term conditions in the cardiovascular category. Through identifying patients with these conditions and delivering this service pharmacists can help to improve adherence to treatments for these conditions, improving long term outcomes for patients with cardiovascular disease.

Pharmacy services also identify and manage risk factors for CVD, such as obesity and smoking, and help to support the prevention of cardiovascular disease.

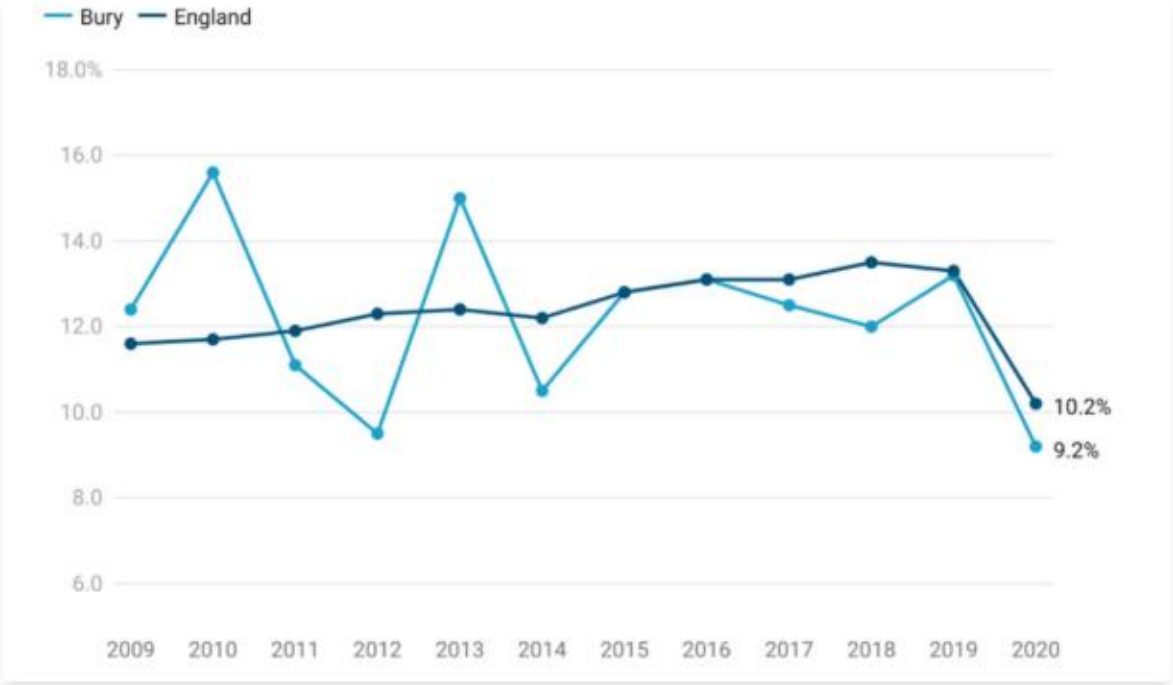
5.8 Chronic Respiratory conditions

Under 75 years of age mortality from respiratory disease (Persons) in Bury is 28.3 per 100,000 population in those aged under 75 years, similar to England average of 26.5 per 100,000 and lower than North West average of 35.3 per 100,000.[30]

Respiratory diseases account for 9.2% of all deaths in Bury's population of 65-74-year-olds, which is statistically comparable to England's average of 10.2% (Figure 13).[31]

[29] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025
[30] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025
[31] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025

Figure 13 - Percentage of deaths in 65-74 years of age with respiratory diseases as the underlying cause in Bury compared with England - 2009-2020 (Source: Ageing Well | The Bury Directory)



Mortality rate from respiratory disease, in persons over 65 years of age per 100,000 population for the year 2021 in Bury (471.3 per 100,000) is slightly higher than England average of 440.8 (although statistically similar) but lower than Northwest average of 529.2. Bury has the 6th lowest mortality from respiratory disease in its group of statistical neighbours with the highest mortality in St. Helens of 638.4 per 100,000 and lowest mortality in Stockport of 375.8 per 100,000 (Figure 14).[32]

[32] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025

Figure 14 - Directly age-standardised mortality rate from respiratory disease per 100,000 population, in persons over 65 years of age for Bury and its statistical neighbours (Source: Ageing Well | The Bury Directory)

Local authority	Directly age-standardised mortality rate from respiratory disease per 100,000 population, in persons over 65 years of age
St. Helens	638.4
Rochdale	605.0
Oldham	589.7
Rotherham	577.7
Wigan	572.2
Medway	571.2
Bolton	569.8
Calderdale	547.4
Dudley	505.0
Doncaster	477.7
Bury	471.3
Kirklees	470.0
Bedford	461.3
Swindon	442.8
Derby	388.2
Stockport	357.8

How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support health and wellbeing, including advice in relation to respiratory disease. Several existing essential services support the treatment and prevention of respiratory disease:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to respiratory disease.
- Dispensing – staff can provide brief advice and interventions for respiratory disease.

38 pharmacies in Bury actively provide the New Medicine Service, which includes several long-term conditions in the respiratory category. Through identifying patients with these conditions and delivering this service pharmacists can help to improve adherence to treatments for these conditions, improving long term outcomes for patients with respiratory disease.

Pharmacy services also identify and manage risk factors for respiratory disease such as smoking cessation and help to support the prevention and treatment of respiratory disease.

5.9 Cancer

Under 75 years of age mortality from cancer (Persons) in Bury (156.9 per 100,000 population in those aged under 75 years) is higher than England (121.5 per 100,000) and Northwest averages

(136 per 100,000). Amongst Bury's statistical neighbours, Bury has the highest premature mortality rate from cancer, with the lowest rate in Calderdale (117.6).[33]
Cancer contributes to 34.5% of all deaths in individuals aged 65-74 years in Bury, statistically like England's average of 38.2%.[34]

Figure 15 - Public health profile for cancer in Bury (Source: Fingertips)

Indicator	Period	Bury			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Deaths from all cancer, all ages, standardised mortality ratio	2016 - 20	–	2,449	106.8	100.0	132.2		82.7
Deaths from all cancer, under 75 years, standardised mortality ratio	2016 - 20	–	1,168	107.9	100.0	141.4		82.7
Percentage of deaths with underlying cause Cancer (All ages)	2020	→	504	23.1%	24.3%	19.7%		27.7%
Percentage of deaths with underlying cause Cancer (<65 yrs)	2020	→	109	31.8%	31.7%	22.3%		39.2%
Percentage of deaths with underlying cause Cancer (65-74 yrs)	2020	→	131	34.5%	38.2%	29.1%		52.1%
Percentage of deaths with underlying cause Cancer (75-84 yrs)	2020	→	165	24.2%	27.4%	20.0%		32.3%
Percentage of deaths with underlying cause Cancer (85+ yrs)	2020	→	99	12.7%	13.8%	10.2%		16.3%

How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support health and wellbeing, including advice in relation to cancer. Several existing essential services support the treatment and prevention of cancer:

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to cancer.
- Dispensing – staff can provide brief advice and interventions for cancer.

Pharmacy services also identify and manage risk factors for cancer such as smoking cessation and help to support the prevention of cancer.
Identifying patients at high risk of developing cancer in the future due to diet, obesity, smoking and other lifestyle factors and giving them information or signposting into other relevant services can help reduce the long-term outcomes for the residents of Bury Borough.

5.10 Musculoskeletal

22.8% of the Bury population report a long term musculoskeletal (MSK) problem, which is above the England average (18.4%) and the Northwest average (20.6%). (See figure 16)

Figure 16 - Public health profile for Musculoskeletal health in Bury (Source: Fingertips)

Indicator	Period	Bury			North West	England	England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage reporting a long-term Musculoskeletal (MSK) problem	2023	–	-	22.8%	20.6%	18.4%	30.3%		10.0%
Percentage reporting at least two long-term conditions, at least one of which is MSK related	2023	–	-	16.3%	15.3%	13.4%	24.2%		6.5%
Odds ratio of reporting a mental health condition among people with and without an MSK condition	2023	–	-	1.5	1.4	1.4	0.5		3.9
Back pain prevalence in people of all ages	2012	–	-	16.9%	17.3%	16.9%	21.4%		11.8%
Prevalence of hip osteoarthritis in people aged 45 and over	2012	–	8,906	11.1%	11.2%	10.9%	12.5%		9.6%
Prevalence of knee osteoarthritis in people aged 45 and over	2012	–	14,805	18.5%	18.8%	18.2%	21.4%		14.6%
Hip fractures in people aged 65 and over New data	2023/24	→	205	574	578	547	849		120
Rheumatoid Arthritis: QOF prevalence	2023/24	↑	1,448	0.8%	0.8%	0.8%	0.4%		1.3%

How can pharmacy contractors help?

Community pharmacies are well placed within local communities to promote and support health and wellbeing, including advice in relation to MSK. Several existing essential services support the treatment and prevention of cancer:

[33] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025
[34] https://theburydirectory.co.uk/ageing-well accessed 21/03/2025

- Being a healthy living pharmacy.
- Signposting – Staff can signpost patients to local initiatives or services in Bury.
- Public health (promotion of healthy lifestyles) – Support the mandatory health campaigns that may include elements relating to MSK.
- Dispensing – staff can provide brief advice and interventions for MSK.

38 pharmacies in Bury actively provide the New Medicine Service, which includes osteoporosis in the musculoskeletal category. Through identifying patients with these conditions and delivering this service pharmacists can help to improve adherence to treatments for these conditions, improving long term outcomes for patients with osteoporosis.

Medication reviews can identify prescribed or over the counter medication which may contribute to falls. Pharmacies should discuss adherence to prescribed medication or exercise regimes and promote healthy lifestyles which reduce the risk of accidental fractures.

6 Provision of pharmaceutical services

The most recent Community Pharmacy Contractual Framework (CPCF), including a breakdown of pharmaceutical services, is described in detail in section 3.6.1. It is noted that negotiations on the 2024/25 CPCF, which includes negotiations on the Pharmacy Quality Scheme (PQS), were paused when the 2024 general election was announced and resumed in January 2025. The details of the next CPCF were released in April 2025 and will be used for the purpose of analysis of provision of services.

The regulations governing the development of the PNA require the HWB to consider the needs for pharmaceutical services in terms of necessary and relevant services:

- **Necessary services** i.e. pharmaceutical services which have been assessed as required to meet a pharmaceutical need. This should include their current provision (within the HWB area and outside of the area) and any current or likely future gaps in provision.
- **Relevant services** i.e. services which have secured improvements, or better access, to pharmaceutical services. This should include their current provision (within the HWB area and outside of the area) and any current or future gaps in provision.

Necessary services, for the purposes of this PNA, are defined as:

- those essential services provided by pharmacies and DACs in line with their terms and contracted hours of service as set out in the 2013 regulations, and
- advanced services commissioned at the time of publication of the PNA that meet the requirements of the Bury population need.

Relevant services are

- Essential services provided by pharmacies outside of the standard core hours (known as supplementary hours) in line with their terms of service as set out in the 2013 regulations,
- Locally commissioned or enhanced services.

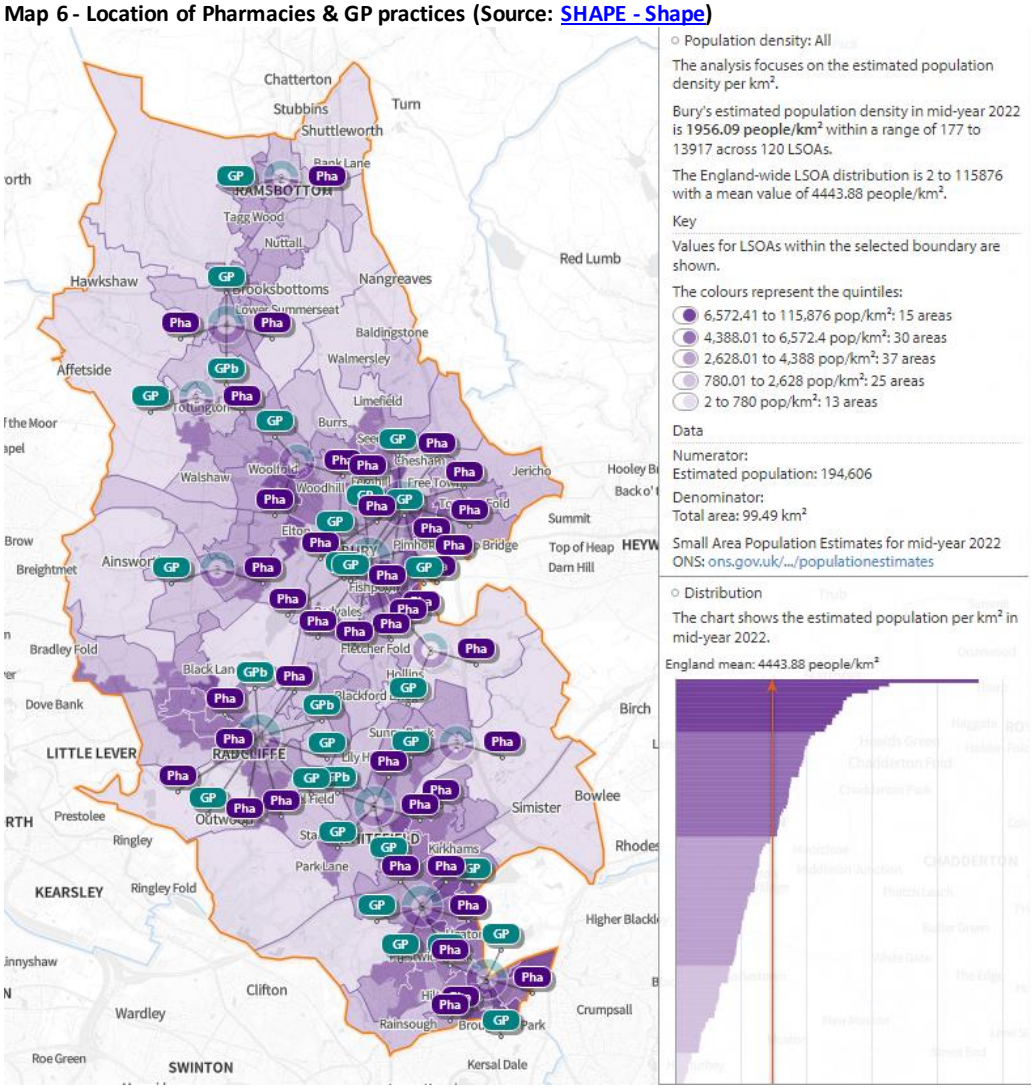
6.1 Necessary services - current provision within the HWB's area

There are 41 pharmacies included in the pharmaceutical list for the area of the HWB. This is made up of 33 with a standard 40-hour contract, four with a 100-hour contract (opening hours may vary due to new regulations as described in section 3.6.4.) and four listed as distance selling. There are no DACs, dispensing GP practices, and no LPS pharmacies in Bury.

Map 6 below (see Appendix Ten for a larger version), shows the location of premises providing pharmaceutical services and GP practices within the HWB's area. The details for each premises down to ward level can be found in Appendix Six, with an overview of opening hours for each premises down to ward level shown in Appendix Eight.

While not a statutory requirement, where maps within this PNA include the location of GP premises, they do so solely as a point of reference and to highlight proximity to pharmacies. Appendix Eleven provides an index of those GP surgeries.

Map 6 - Location of Pharmacies & GP practices (Source: SHAPE - Shape)



The number of pharmacies available per 100,000 population in Bury in 204/25 is 21, slightly less than in 2020/21 when it was 22 per 100,000 population (table 17). This reduction has been caused by an increase in population size coupled with a reduction in the number of contractors. Pharmaceutical services provision has been absorbed by the existing contractors and is consistent with the level from 2017/18.

Table 17 - Bury pharmacies 2017/18 to 2024/25 (source: EPACT2)

	Number of community pharmacies	Prescription items dispensed per month (000)s	Population (000)s Mid-Year 2023	Pharmacies per 100,000 population
2017/18	39	292	190	21
2021/22	43	315	194	22
2024/25	41	352	195	21

**This table includes distance selling pharmacies but excludes DACs. The number of distance selling pharmacies in 2024/25 is 4.*

From January 2024 until December 2024 approximately 15% of items dispensed by Bury pharmacies were prescribed by providers who were not Bury registered practices (see Table 18). Bury pharmacies dispense items for patients that are registered with GM GPs across the Bury border.

Table 18 - Items dispensed by Bury pharmacies for each ICB locality in Greater Manchester between January 2024 to December 2024 (source: EPACT2)

Registered provider	Total items dispensed by Bury pharmacies	Percentage of items dispensed by Bury pharmacies
Bolton	32,204	0.78%
Bury	3,504,221	85.15%
HMR	47,673	1.16%
Manchester	56,792	1.38%
Oldham	1,602	0.04%
Salford	71,461	1.74%
Stockport	1,546	0.04%
Tameside	1,329	0.03%
Trafford	637	0.02%
Wigan	1,022	0.02%
Other GM	19,132	0.46%
Distance	377,813	9.18%
Total	**4,115,432**	**100%**

**Appliance contractor items are excluded*

In 2024/25, Bury's average prescription items per month per pharmacy we as 8,585. This is similar to the Greater Manchester average but lower than the average for England (table 19). This indicates that the current number of pharmacies can cope with demand for prescription dispensing.
The number of pharmacies per 100,000 population in Bury is the same as GM (21), but higher than England (18). Based on historical pharmacy use this would indicate that the current number of pharmacies are sufficient for the current population.
The ability of each premises to cope with prescription dispensing demand is dependent upon a range of factors e.g. staffing levels, available space, use of robotics. As the aging population grows, demand is likely to increase and pharmacy will need to consider how it prepares for this.

Table 19 - Number of pharmacies and items dispensed per month nationally and locally for 2024/25 (April 2024 – December 2025) (source: NHS BSA and EPACT2)

	Number of community pharmacies	Prescription items dispensed per month (000)s	Population (000)s Mid-Year 2023	Pharmacies per 100,000 population	Average items per pharmacy per month
England	10,451	95,287	57,690	18	9,118
GM	623	5,507	2,949	21	8,840
Bury	41	352	195	21	8,585

6.1.1 Access to premises

Access can be defined by the location of the pharmacy in relation to where residents of the HWB area live and the length of time to access the pharmacy by driving (private car), using public transport or walking. 1 mile is used as an approximate for 20 minutes walking time, assuming that an average walking speed is 3mph. Of course, the speed will vary depending on the walking ability of the person and the terrain in the area.

Community pharmacists are easily accessible with over 11,600 community pharmacies in England located where people live, shop and work. The latest information shows that:

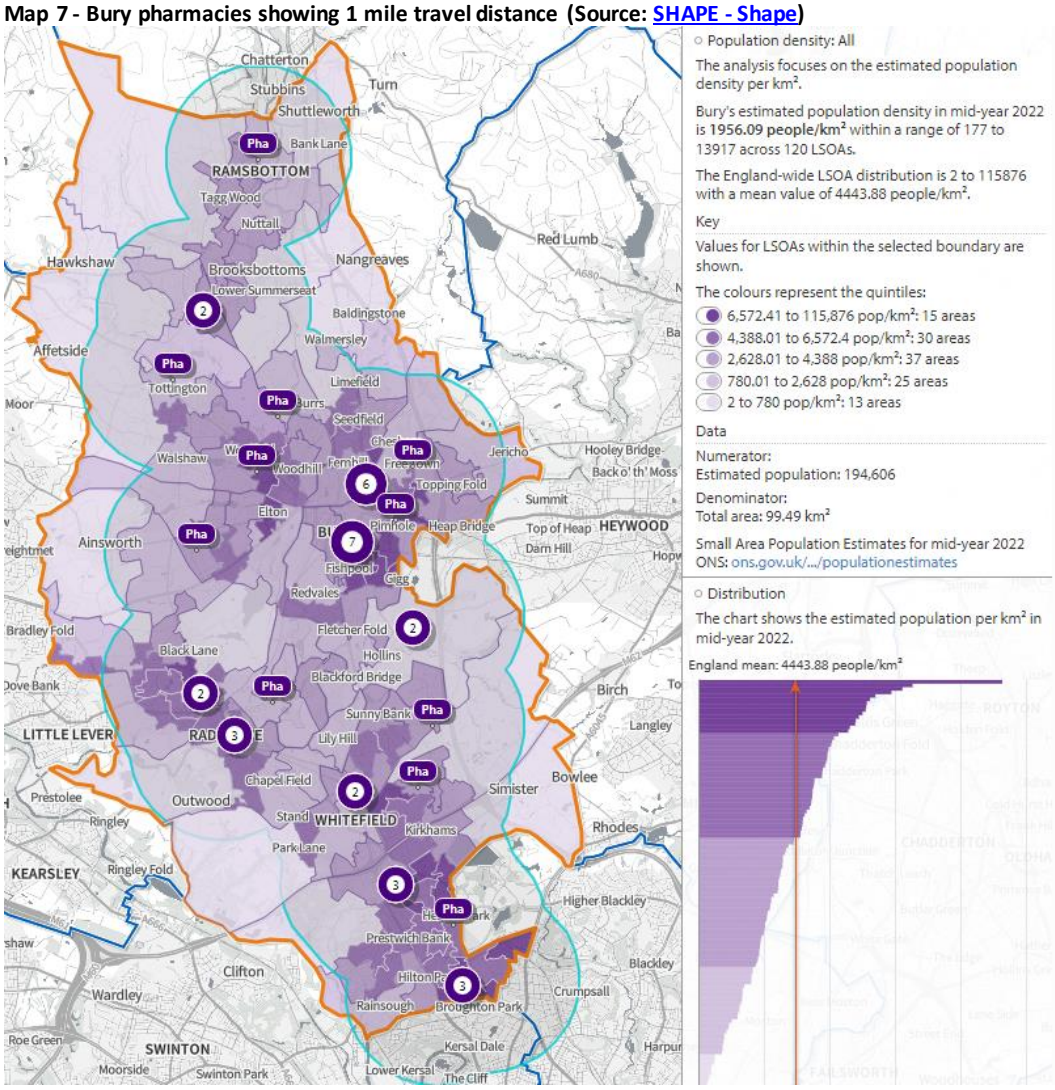
- 89% of the population in England has access to a community pharmacy within a 20-minute walk;
- Over 99% of those in areas of highest deprivation are within a 20-minute walk of a community pharmacy; and
- As the accessibility of community pharmacies is greatest in areas of higher deprivation, they may have an important role to play in reducing inequalities.

Community pharmacy is consequently a socially inclusive healthcare service providing a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service. Most pharmacies now have a private consultation area specifically for confidential or sensitive discussions.[35]

An updated Pharmacy Access Scheme (revised PhAS) began in January 2022, to continue to support patient access to isolated, eligible pharmacies. It is funded to no more than £20 million from the Community Pharmacy Contractual Framework (CPCF). Eligibility for PhAS continues to be based on both the dispensing volume of the pharmacy, and distance from the next nearest pharmacy, although there are changes to the detailed eligibility criteria.[36]

Map 7 indicates there are parts of Bury further than a mile away from their nearest pharmacy, although these tend to be in the least populated and more rural areas. Also, there are pharmacies within 1 mile of Bury boundaries that offer further access, see map 8 below for location of pharmacies in the neighbouring Boroughs.

Map 7 - Bury pharmacies showing 1 mile travel distance (Source: SHAPE - Shape)



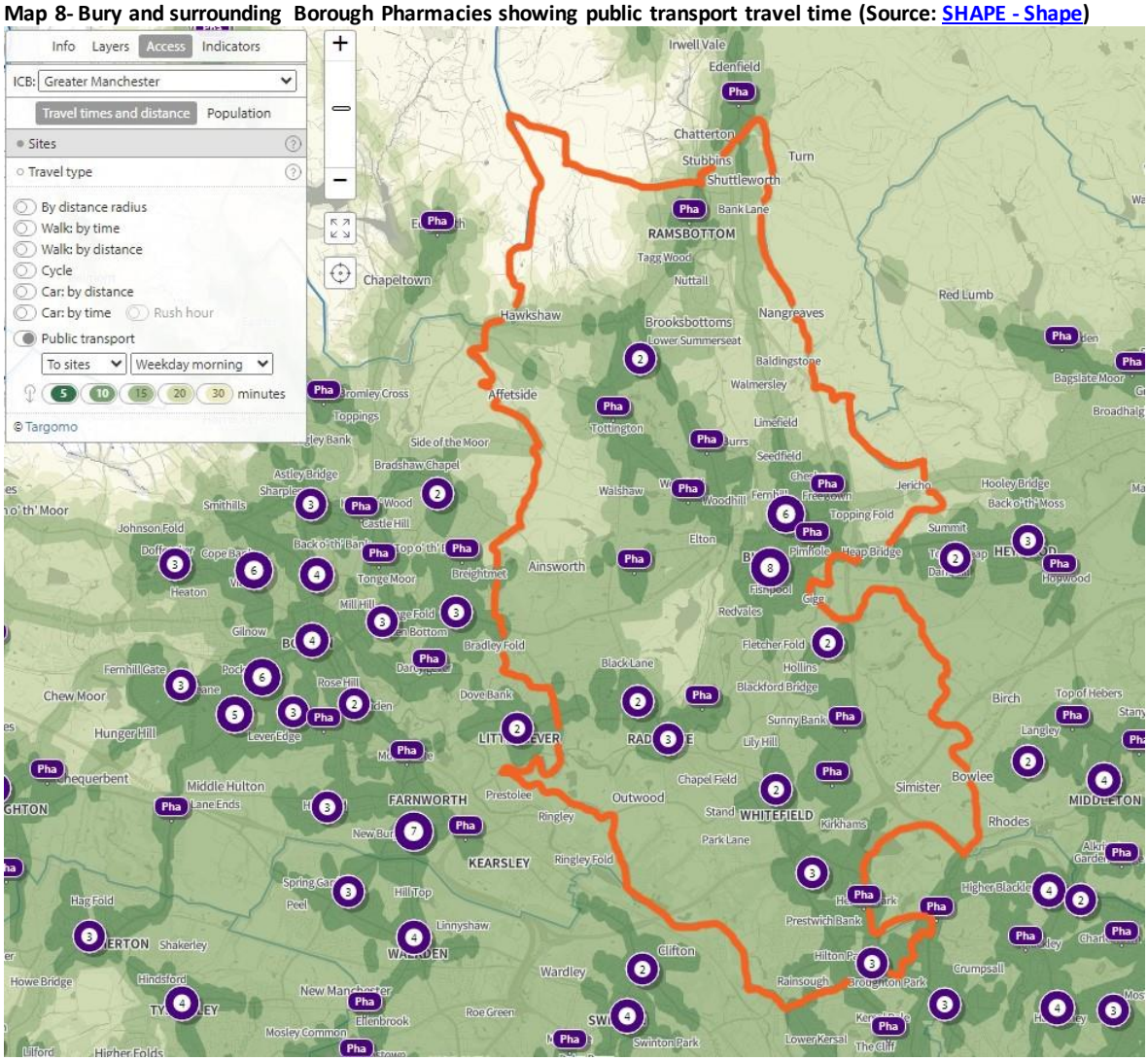
Map 8 below shows 20-minute travel time by public transport and indicates that most of the borough is accessible when using public transport. The area which indicates that public transport travel time is

[35] https://cpe.org.uk/learn-more-about-community-pharmacy/about-community-pharmacy/ accessed 11/03/2025

[36] https://cpe.org.uk/quality-and-regulations/the-pharmacy-contract/pharmacy-access-scheme-phas/ accessed 11/03/2025

greater than 20 minutes is located in the Northwest of Bury Borough, to the North of Hawkshaw. This area is rural and less densely populated, with limited housing in the area. There is also a pharmacy in a neighbouring borough that is accessible to this area.

Map 8- Bury and surrounding Borough Pharmacies showing public transport travel time (Source: SHAPE - Shape)



According to government statistics the percentage of households in the Northwest without access to a vehicle has fallen from 27% in 2002/03 to 24% in 2023[37] (see Table 23 in section 7.1 for Bury Census data). Although this is high compared to some national regions, it is in line with the national average (England 2023 average 22%, England-excluding-London 19%, London Only 42%). This is because the Northwest includes large city centres, such as Manchester and Liverpool where people are more likely to rely on public transport rather than have access to a vehicle, the value for Bury alone is not available.

Most of Bury's population should have access to a pharmacy within 20 minutes by car, walking or using public transport.

6.1.2 Correlation with GP practices

There are 41 community pharmacies, more than the 29 GP practices. In addition, all neighbourhoods have multiple pharmacies and there are pharmacies close to each GP practice, although practice list sizes, number of GPs and opening times may differ significantly between practices. At ward level, all wards now have a pharmacy within its borders, thanks to a re-location since the last PNA. There are also other pharmacies near the Bury borders, including its border with Bolton Local Authority area.

[37] https://www.gov.uk/government/statistical-data-sets/nts99-travel-by-region-and-area-type-of-residence accessed 11/03/2025

6.1.3 Access due to opening hours

When questioned about access due to opening hours, in general respondents felt it was important to have access to pharmacies seven days a week, Monday to Sunday during the hours of 9am to 6pm. When questioned about early morning opening on weekdays/Saturdays/Sundays, early evening and late evening opening on weekdays/Saturdays/Sundays, in general most respondents felt this was unimportant or not necessary.
Similarly with respect to bank holidays, in general most respondents felt that it was necessary to have some form of access during the day, in the morning and afternoon, but felt it was unimportant or not necessary with respect to access on a bank holiday in the early morning or evening.

The responses received are summarised in the table below:

	Essential	Fairly Important	Total of Essential and Fairly Important	Unimportant	Not necessary	Total of Unimportant and Not necessary	Not sure
Weekday: Early Morning (before 9am)	13%	20%	33%	24%	35%	59%	8%
Weekday: During the day	70%	17%	87%	3%	6%	9%	4%
Weekday: Lunchtime	24%	28%	53%	18%	21%	39%	8%
Weekday: Early evening between 6pm and 9pm	17%	37%	54%	15%	24%	39%	7%
Weekday: Late evening after 9pm	4%	25%	29%	23%	37%	60%	11%
Saturday: Early Morning (before 9am)	7%	23%	30%	23%	38%	61%	9%
Saturday: Morning	35%	34%	69%	6%	20%	26%	5%
Saturday: Afternoon	22%	35%	57%	12%	23%	35%	8%
Saturday: Evening after 6pm	7%	25%	32%	24%	32%	56%	12%
Sunday: Early Morning (before 9am)	8%	11%	19%	24%	44%	68%	13%
Sunday: Morning	13%	35%	48%	14%	28%	42%	10%
Sunday: Afternoon	11%	28%	39%	14%	37%	51%	10%
Sunday: Evening after 6pm	4%	15%	19%	23%	45%	68%	13%
Bank Holidays: Early Morning (before 9am)	7%	20%	27%	24%	40%	64%	9%
Bank Holidays: Morning	11%	31%	42%	20%	28%	48%	10%
Bank Holidays: Afternoon	8%	30%	38%	20%	32%	52%	90%
Bank Holidays: Evening after 6pm	4%	18%	22%	28%	37%	65%	13%

Tables 20, 21 and 22 along with appendix 8 detail the span of opening times for Bury pharmacies based on their core and supplementary opening hours[38]. They identify those that open 7 days a week, all day Saturday (open Monday to Friday), only half day Saturday (open Monday to Friday) and closed Saturday (open Monday to Friday) and those open before 8am and after 7pm (Monday to Friday).
The opening times are correct at the time of drafting the PNA and are taken from the official pharmaceutical list for GM. Full details of the opening hours for community pharmacies in Bury can be found on NHS Services[39].

Monday to Saturday opening

Seven walk-in community pharmacies open at 8:00 a.m. or earlier Monday to Saturday. The earliest opening is 6:00 a.m. (see Table 20).

25 of the 37 walk-in community pharmacies open on a Saturday morning, 12 of these 25 pharmacies close by 1:00 p.m. and 13 remain open until later during Saturday, with the latest time of closing being 10:00pm for three of these pharmacies.

In Bury North neighbourhood there is no pharmacy open before 9:00am or after 6:30pm on a weekday or before 9:00am and after 13:00pm on a Saturday and no pharmacies open on a Sunday. The Whitefield neighbourhood does not have a pharmacy that opens before 9:00am on a Monday to Saturday. However, members of the public can access pharmaceutical services from any other contractor within these hours.
The public survey had 45 responses from people whose postcode matched those in Bury North (BL0 & BL8 & BL9). 9 of these 45 (20%) residents complained of poor access due to opening times at their local pharmacy.

All other neighbourhoods have cover with at least 1 pharmacy remaining open during the weekday and Saturday evening, and on a Sunday.

Table 20 - Bury pharmacies open Monday to Saturday from 8:00 a.m. or earlier (source: NHSE&I)

Neighbourhood	Ward	Map Index	Trading Name	Postcode	Mon to Sat Opening Times	Comments
Bury East	Bury East	2	Asda Pharmacy	BL9 0RN	6:00am	
Bury East	Bury East	25	Medi Home Pharmacy	BL9 0RE	8:00am	Distance selling pharmacy - closed on Saturday
Bury East	Bury East	28	Pimhole Pharmacy	BL9 7BB	7:00am	
Bury East	Moorside	5	Boots the Chemist	BL9 5BY	8:00am	
Bury East	Moorside	6	Bury Healthcare Pharmacy	BL9 6DP	7:00am	
Bury East	Redvales	29	Postbox Pharmcare Limited	BL9 9AA	7:00am	Distance selling pharmacy - closed on Saturday
Bury West	Radcliffe East	31	Radcliffe Pharmacy	M26 2SP	8:00am	Opens at 9:00am on Saturday
Bury West	Radcliffe East	38	Well	M26 2SP	8:00am	Closed on Saturday
Prestwich	St Mary's	37	Tesco In-Store Pharmacy	M25 7BL	8:00am	

Nine pharmacies provide access to pharmaceutical services until 7:00 p.m. or later Monday to Friday; with eight pharmacies also providing until 7:00 p.m. or later Saturday (see Table 21).

Table 21 - Bury pharmacies open Monday to Saturday until 7:00 p.m. or later (source: NHSE&I)

Neighbourhood	Ward	Map Index	Trading Name	Postcode	Mon to Sat Closing Times	Comments
Bury East	Bury East	2	Asda Pharmacy	BL9 0RN	10:00pm	Closes at 9:00pm on Monday and Tuesday
Bury East	Bury East	28	Pimhole Pharmacy	BL9 7BB	10:15pm	Closes at 10:00pm on Monday and Saturday
Bury East	Moorside	5	Boots the Chemist	BL9 5BY	9:00pm	
Bury East	Moorside	6	Bury Healthcare Pharmacy	BL9 6DP	10:00pm	
Bury East	Moorside	36	Tesco In-Store Pharmacy	BL9 5BY	7:00pm	
Bury West	Radcliffe East	31	Radcliffe Pharmacy	M26 2SP	7:00pm	Closes at 4:00pm on Saturday
Bury West	Radcliffe West	1	Asda Pharmacy	M26 3DA	8:00pm	
Prestwich	St Mary's	37	Tesco In-Store Pharmacy	M25 7BL	8:00pm	
Whitefield	Unsworth	3	Asda Pharmacy	BL9 8RS	8:00pm	

[38] Data valid as at 11th March 2025
[39] https://www.nhs.uk/nhs-services/

Sunday opening

Nine of the 37 walk-in pharmacies open on Sunday and four of the five neighbourhoods have at least one pharmacy open for some hours. The Sunday opening hours across the borough range from the earliest opening time of 8:00am and the latest closing time of 7:00pm (see table 22).

83% of the respondents to the public survey were satisfied or very satisfied with the opening hours provided. Additionally, 54% of respondents had not used a pharmacy on a Sunday in the last year and felt it wasn't relevant to their needs.

Table 22 - Bury pharmacies open on Sunday (source: NHSE&I)

Neighbourhood	Ward	Map Index	Trading Name	Postcode	Sunday Opening Times	Sunday Closing Times
Bury East	Bury East	2	Asda Pharmacy	BL9 0RN	11:00am	5:00pm
Bury East	Bury East	4	Boots the Chemist	BL9 0QQ	11:00am	3:00pm
Bury East	Bury East	28	Pimhole Pharmacy	BL9 7BB	10:00am	7:00pm
Bury East	Moorside	5	Boots the Chemist	BL9 5BY	11:00am	5:00pm
Bury East	Moorside	6	Bury Healthcare Pharmacy	BL9 6DP	8:00am	6:00pm
Bury East	Moorside	36	Tesco In-Store Pharmacy	BL9 5BY	10:00am	4:00pm
Bury West	Radcliffe West	1	Asda Pharmacy	M26 3DA	10:00am	4:00pm
Prestwich	St Mary's	37	Tesco In-Store Pharmacy	M25 7BL	10:00am	4:00pm
Whitefield	Unsworth	3	Asda Pharmacy	BL9 8RS	10:30am	4:30pm

Changes to pharmacy contractors

Since the last PNA there has been the closure of 2 standard contract pharmacies and one pharmacy contract changed from a 100hr to a standard contract. Pharmaceutical services provision from these contractors has been absorbed locally by existing contractors. There are no further known changes anticipated at the time of writing the PNA.

6.1.4 Access to pharmaceutical services on public and bank holidays and Easter Sunday

NHSCB has a duty to ensure that residents of the HWB's area can access pharmaceutical services every day. Pharmacies and DACs are not required to open on public and bank holidays, or Easter Sunday, although some choose to do so. NHS England asks each contractor to confirm their intentions regarding these days and where necessary will direct a contractor or contractors to open on one or more of these days to ensure adequate access.

6.1.5 Access to Advanced Services

NHS GM has in place a Community Pharmacy Services Group which meets monthly to oversee the implementation and quality assurance of nationally and locally commissioned community pharmacy services and to act as a touch point for the Greater Manchester Primary Care Team, CPGM (the LPC for GM), Local Pharmacy Network (LPN). This work supports the successful implementation and engagement with both new and pre-existing community pharmacy services, helping to ensure that Manchester residents benefit from the wide range of services available.

6.1.5.1 Access to Appliance Use Review (AUR)

According to data from NHS England no pharmacies in Bury provided appliance use reviews.

Data from the NHS Business Services Authority show that the main providers of appliance use reviews and stoma customisation services are DACs. In the 12-month period, December 2023 to November 2024 (latest data on 1st March 2025), 1461 AURs were provided to Greater Manchester residents with 500 of these delivered in the individual's home.

6.1.5.2 Access to Pharmacy First Service (PFS)

Appendix Seven provides a list of pharmacies providing PFS advanced services.

The Pharmacy First service commenced on 31st January 2024[40], and involves pharmacists providing advice and NHS-funded treatment, where clinically appropriate, for seven common conditions (age restrictions apply):

Clinical pathway	Age range
Acute Otitis Media*	1 to 17 years
Impetigo	1 year and over
Infected insect bites	1 year and over
Shingles	18 years and over
Sinusitis	12 years and over
Sore throat	5 years and over
Uncomplicated urinary tract infections	Women 16-64 years

* Distance Selling Pharmacies will not complete consultations for Acute Otitis Media.

Consultations for these seven clinical pathways can be provided to patients presenting to the pharmacy as well as those referred electronically by NHS 111, general practices and others.

The service also incorporates the elements of the Community Pharmacist Consultation Service, i.e. minor illness consultations with a pharmacist and the supply of urgent medicines (and appliances), both following an electronic referral from NHS 111, general practices (urgent supply referrals are not allowed from general practices) and other authorised healthcare providers (i.e. patients are not able to present to the pharmacy without an electronic referral).

In the clinical pathway consultations with a pharmacist, people with symptoms suggestive of the seven conditions will be provided with advice and will be supplied, where clinically necessary, with a prescription-only treatment under a Patient Group Direction (PGD) or in one pathway, an over-the-counter medicine (supplied under a clinical protocol), all at NHS expense.

Currently (March 2025), all 41 Pharmacies in Bury are registered to provide the Pharmacy First Service. In the 3 months up to November 2024, 2167 PFS Clinical Pathway Consultations, 1686 Urgent Supply Consultations and 1211 Minor Illness consultations were provided.

6.1.5.3 Access to Lateral Flow Device (LFD) Service

The Lateral flow device tests supply service for patients potentially eligible for COVID-19 treatments (LFD service) was commissioned as an Advanced service from 6th November 2023. The NHS offers COVID-19 treatment to people with COVID-19 who are at risk of becoming seriously ill. To access treatment, eligible patients first need to be able to test themselves by using a lateral flow device (LFD) test if they develop symptoms suggestive of COVID-19. It is therefore important that they have LFD tests at their home **in advance of developing symptoms**, so they can promptly undertake a test. The LFD service was introduced to provide eligible patients with access to LFD tests.

[40] https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-first-service/

If a patient tests positive, they are advised to call their general practice, NHS 111 or hospital specialist as soon as possible. The test result will be used to inform a clinical assessment to determine whether the patient is suitable for and will benefit from National Institute for Health and Care Excellence (NICE) recommended COVID-19 treatments.

The full list of eligible patients aged 12 years and over that are eligible to access LFD tests via the service (because they are at risk of getting seriously ill from COVID-19 and therefore are potentially eligible for COVID-19 treatments) can be found in the NICE guidance: https://www.nice.org.uk/guidance/ta878/chapter/5-Supporting-information-on-risk-factors-for-progression-to-severe-COVID19

As part of the service, patient's eligibility for a supply of LFD tests must be confirmed.
Eligible patients should only receive one box of 5 LFD tests per consultation.

In the 3 months up to November 2024, 1348 LFD supply consultations were carried out.

6.1.5.4 Access to Community Pharmacy Seasonal Influenza Vaccination programme

According to data available at NHS Business Services Authority up to Nov 2024 (Latest available data 1st March 2025), 31 pharmacies in Bury are delivering this service for 2024/25, providing 13,347 vaccinations from September 2024 to November 24.

6.1.5.5 Pharmacy Contraception Service (PCS)

The PCS commenced on 24th April 2023, allowing the on-going supply of oral contraception (OC) from community pharmacies. From 1st December 2023, the service expanded to include both initiation and on-going supply of OC.
NHS community pharmacies are an accessible and convenient place for people to receive advice and support for contraception management.
The NHS Long Term Plan highlights the importance of NHS services complementing the action taken by local government to support the commissioning of sexual health services and exploring the future commissioning arrangements to widen access and create capacity where it is needed.

The Public Health England resource for commissioners highlighted the role community pharmacy can play supporting ongoing contraception. Appropriately trained and skilled community pharmacists can provide access to an ongoing supply of their oral contraception to relieve the burden on general practice and allow GPs to concentrate on more specialist services.

Supplies of oral contraception are made by a pharmacist via a Patient Group Direction (PGD). The aim of the Pharmacy Contraception Service (PCS) is to offer people greater choice and access when considering starting or continuing their current form of oral contraception.

Following the announcement of the new CPCF in April 2025, it has been announced that from October 2025, Emergency Hormonal Contraception is to be added to the Pharmacy Contraception Service (PCS). This in turn means that there will be no need from October 2025 for a Locally commissioned service for Emergency Hormonal Contraception as is currently the case.

Currently (March 2025) 34 pharmacies in Bury are registered to provide this service. In the 3 months up to November 2024, there were 49 initiation consultations and 231 on-going supply consultations.

6.1.5.6 Hypertension Case Finding Service

The Hypertension case-finding service was commissioned as an advanced service from 1st October 2021. It is described, in public-facing communications, as the NHS Blood Pressure Checks Service.
The service has two stages – the first is identifying people at risk of hypertension and offering them blood pressure measurement (a 'clinic check'). The second stage, where clinically indicated, is offering 24-hour ambulatory blood pressure monitoring (ABPM). The blood pressure test results will then be shared with the patient's GP to inform a potential diagnosis of hypertension.

Contractors opting to provide the service must undertake both stages of it, where clinically required, i.e. it is not possible to just undertake clinic BP readings and not ABPM.

Currently (March 2025) 37 pharmacies in Bury are registered to provide this service. In the 3 months up to November 2024, there were 2919 Community Pharmacy Clinic Blood Pressure checks and 422 Community Pharmacy Ambulatory Blood Pressure Monitoring (ABPM) consultations.

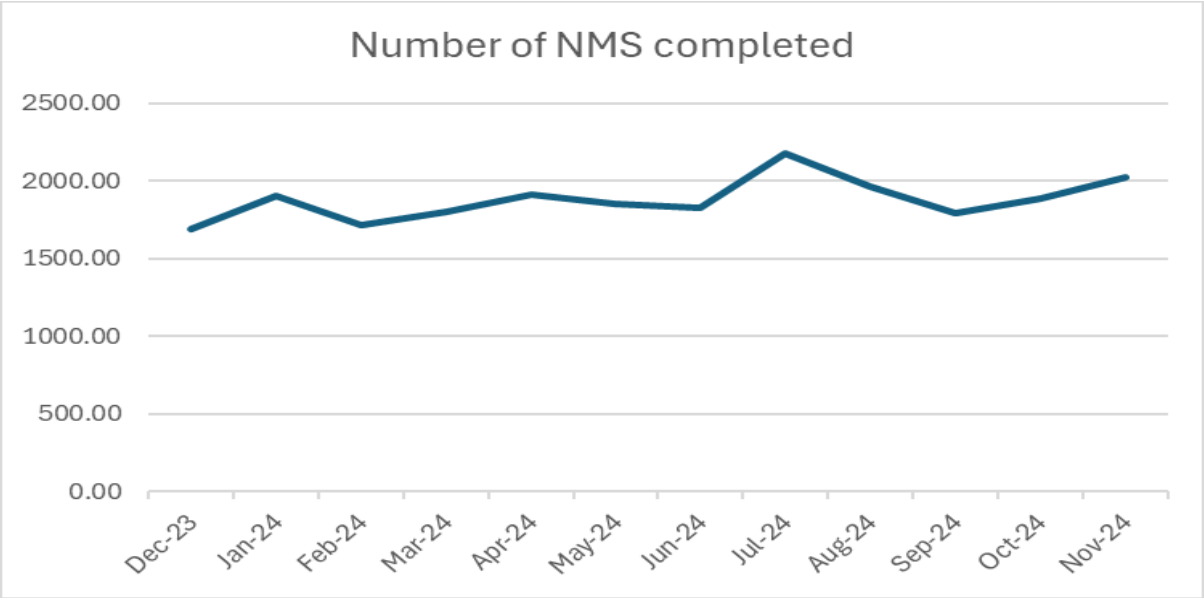
6.1.5.7 Access to New Medicine Service (NMS)

The service provides support for people, often with long-term conditions, newly prescribed a medicine to help improve medicines adherence and patient outcomes.
The primary aim of the consultation (which can be face-to-face or telephone-based) is the patient-centred identification of any problems either with the treatment (including any adverse drug reactions) or otherwise in relation to the patient's self-management of their long-term condition, and identification of any need of the patient for further information and support in relation to the treatment or the long-term condition. NMS is focused, from 1st September 2021, on the following conditions:

1. Asthma and COPD
2. Diabetes (Type 2)
3. Hypertension
4. Hypercholesterolaemia
5. Osteoporosis
6. Gout
7. Glaucoma
8. Epilepsy
9. Parkinson's disease
10. Urinary incontinence/retention
11. Heart failure
12. Acute coronary syndromes
13. Atrial fibrillation
14. Long term risks of venous thromboembolism/embolism
15. Stroke / transient ischemic attack
16. Coronary heart disease

Following the announcement of the new CPCF in April 2025, a new condition of **Depression** is to be added to the NMS service from October 2025.
Currently (April 2025), all 41 Pharmacies in Bury are registered to provide the Pharmacy New Medicines Service (NMS).
See Appendix Seven for those pharmacies that are providing NMS.

Figure 17 - NMS graph showing numbers carried out by Bury Pharmacies between Dec 23 and Nov 24



6.1.5.8 Access to stoma appliance customisation

Between December 2023 to November 2024, one Bury pharmacy provided 3 stoma customisations, however, a number will have been provided by dispensing appliance contractors outside the Bury area. Information provided by NHS England shows that there are eight DACs in the Greater Manchester area in March 2025, they provide an average 9667 stoma customisations each per month to patients nationally and locally. Some patients will access this service from DACs outside GM.

6.1.5.9 Access to Smoking Cessation Service (SCS)

The Smoking Cessation Service (SCS) has been an advanced service from 10th March 2022. This service has been designed to enable NHS trusts to undertake a transfer of care on patient discharge, referring patients (where they consent) to a community pharmacy of their choice to continue their smoking cessation treatment, including providing medication and support as required. The ambition is for referral from NHS trusts to community pharmacy to create additional capacity in the smoking cessation pathway.
Currently (March 2025) 24 pharmacies in Bury are registered to provide this service. In the 12 months from Dec 23 up to November 2024, 64 Smoking Cessation Service Consultations were provided.

6.1.6 Access to locally commissioned or enhanced services

6.1.6.1 Locally commissioned services by Bury Council

In March 2025, Bury Council commissioned three services from community pharmacies.
Local Authorities commission public health or preventative services.
Three services are directly commissioned:

- Emergency Hormonal Contraception
- Needle Syringe Exchange Programme
- Supervised Consumption Services

Following the announcement of the new CPCF in April 2025, it has been announced that from October 2025, Emergency Hormonal Contraception is to be added to the Advanced service - Pharmacy Contraception Service (PCS). This in turn means that the locally commissioned service for EHC should not be required from the October 2025 start date.

6.1.6.2 Locally commissioned services by NHS GM ICB

NHS GM ICB usually commission services related to a person's current disease state rather than for preventative care. In Bury there are three such services:

- Palliative care service medicine stockholder
- Minor Ailment Service

- Minor Eye Conditions Service

6.2 Necessary services: current provision out-side the HWB's area

In making its assessment the HWB needs to take account of any services provided to its population, which may affect the need for pharmaceutical services in its area. This could include services provided across a border to the population of Bury by pharmacy contractors outside their area, or by GP practices, or other health services providers including those that may be provided by NHS trust staff.
Patients have a choice of where they access pharmaceutical services, which may be close to their GP practice, their home, their place of work or where they go for shopping, recreational or other reasons. Consequently, not all the prescriptions written for residents of Bury were dispensed by the pharmacies within Bury. The Bury Council has borders with four Greater Manchester boroughs (Bolton, Salford, Manchester, Rochdale) and with Blackburn with Darwen and Rossendale.
26 pharmacies are located within one mile outside of Bury's boundary (appendix 12), providing good access to pharmaceutical services across the Bury border.
Prescribing and dispensing data shows that most items (85%, see Table 17) dispensed by Bury pharmacies are prescribed by Bury prescribers. Most of the remainder are dispensed in neighbouring HWB areas in GM.
It is not possible to identify the number of Bury residents who access enhanced services from pharmacies outside the HWB's area. This is due to the way that pharmacies are paid. However, residents of the HWB's area may access enhanced services from outside Bury. The same applies to locally commissioned services.

6.3 Other relevant services - current provision

Other relevant services are pharmaceutical services that are not necessary (see section 3.6 and section 8) but have secured improvement or better access to pharmaceutical services.
Other relevant services, for the purposes of this PNA, are defined as:

- Essential services provided by pharmacies outside of the standard core hours (known as supplementary hours) in line with their terms of service as set out in the 2013 regulations,
- Locally commissioned or enhanced services

6.3.1 Other relevant services within the HWB's area

Bury Pharmacies also provide essential and advanced services where they have supplementary hours in place. The totality of these hours covers early morning, evenings, Saturday and Sunday. Opening hours are available on NHS Services. The range of opening times is discussed in section 6.1.3 and is shown in Appendix Eight. Locally commissioned services are also detailed in section 6.1.6.

6.3.2 Other relevant services provided outside the HWB's area

Whilst there are pharmacies outside of the HWB's area providing pharmaceutical services during hours that may be regarded as providing improvement or better access, it is a choice of individuals whether to access these as part of their normal lives. None are specifically commissioned to provide services to the population of Bury HWB area.

6.3.3 Other relevant services

The HWB consider locally commissioned services as providing an improvement or better access to pharmaceutical services. The palliative care stockholding, Minor Ailment service, Covid Medicines Delivery Unit and Minor Eye Conditions Services are commissioned by NHS GM. Emergency hormonal contraception, needle syringe and exchange and supervised consumption are commissioned by the local authority.

6.3.4 Choice regarding obtaining pharmaceutical services

85% of items dispensed by Bury pharmacies are prescribed by Bury GP's. This may be due to people from other areas using a location near work for example, or through use of distance selling pharmacies in different areas of England.
As expected, a large proportion of the remaining items were prescribed in neighbouring HWB areas. Just as residents from Bury may choose to have prescriptions dispensed in neighbouring HWB areas, the same also applies in reverse.

6.4 Future provision – necessary and other relevant services

This section contains information on expected future housing and regeneration development which may impact on the future need for pharmaceutical services.

6.4.1 Housing and development

Bury Town Centre
There are plans for significant levels of development proposed in Bury Town Centre which will start to deliver new homes within the next 3 years. Around 2,500 new homes are in the pipeline for Bury town centre over the next 10-15 years, although it is expected the majority will be delivered beyond the 3-year timeframe of this PNA. The construction of Bury Flexi Hall is underway, and is scheduled to open in 2026, with plans to redevelop Bury interchange also being progressed. A further 13,000sqm commercial floorspace planned at Chamberhall, Bury.

Radcliffe
Around 650 homes are currently in the pipeline in Radcliffe Town Centre. This includes 134 dwellings at Green Street (currently under construction). 90 new homes at School Street Radcliffe, 30 at Station House (Bury Road) with a further 400 dwellings at the East Lancashire Paper Mill (ELPM), although this development will extend beyond the end of the PNA's 3-year time frame. A site at York Street, Radcliffe is currently under construction and will deliver 211 homes for rent. 900sqm of offices are currently under construction at Green Street in Radcliffe and the development of a new Radcliffe Hub is progressing which will provide a new leisure centre, library and community space, and is scheduled to open in 2026.

Prestwich Town Centre
The Prestwich Village regeneration plans include a new community hub, village square, a market hall, flexible retail and leisure spaces, outdoor spaces, a new travel hub and around 200 homes. This development will extend beyond the 3-year timeframe of the PNA.

Other developments
In terms of other larger scale developments, 268 homes at Waldmers Wood, Walmersley Old Road in Bury are currently under construction and 57 homes will be delivered at Mondi in Ramsbottom. 52 retirement apartments are also planned to replace the Fairways Lodge Hotel in Sedgley Park and are likely to be completed within the PNA timeframe. Around 6,500sqm of commercial floorspace at Hollins Brook Way, Bury (Pilsworth) is also in the pipeline at JD Sports at Pilsworth, including a new creche, office hub and sports facilities.

6.4.1.1 Places for Everyone

The adopted Places for Everyone (PfE) Plan sets housing and employment land supply targets and allocates strategic sites for housing and employment development across nine Greater Manchester boroughs. Policies set out measures to ensure the plan is supported by appropriate infrastructure, including PfE Policy JP-P6 which sets out measures related specifically to health provision.

For Bury the total PfE housing requirement is for 7,678 new homes from 2022-2039 – an overall average of 452 homes per year. It also allocates the following strategic sites for housing and employment development:

- JPA1.1 Heywood / Pilsworth (Northern Gateway) – around 1.2m sqm of industrial and warehousing space (across Bury and Rochdale) and around 200 new homes within Bury
- JPA1.2 Simister and Bowlee (Northern Gateway) – 1,550 new homes of which around 1,350 will be within Bury
- JPA7 Elton Reservoir – 3,500 new homes, of which around 2,100 are expected to be delivered by 2039.
- JPA8 Seedfield – around 140 new homes
- JPA9 Walshaw – around 1,250 new homes

Although the large strategic sites will take many years to build out, it is likely that development will commence within the three year PNA period.

The PfE policy also includes plans for a new Metrolink station as part of the Elton Reservoir allocation.

Further discussions may be required to further understand the healthcare needs, including the need for pharmaceutical services arising from the PfE strategic allocations as the masterplan and development of the sites progresses.

The Bury Housing Need and Demand Assessment (2020) identifies a need for around 578 additional units of specialist older person and 518 units of residential care by 2037.

Please note - the Housing Need and Demand Assessment is currently being updated.

6.5 Other NHS services

The following NHS services are deemed, by the HWB, to affect the need for pharmaceutical services within its area:

- Hospital pharmacies – reduce the demand for the dispensing essential service as prescriptions written in the hospital are dispensed by the hospital pharmacy service.
- Personal administration of items by GPs – as above this also reduces the demand for the dispensing essential service. Items are sourced and personally administered by GPs and/or practice nurses thus saving patients having to take a prescription to a pharmacy, for example for a vaccination, to then return with the vaccine to the practice so that it may be administered.
- GP out-of-hours service.
- Any other NHS services identified in the area

6.5.1 Hospital pharmacies

Patients attending hospital pharmacies, on either an inpatient or outpatient basis, may require prescriptions to be dispensed. There is an acute hospital and a mental health trust operating in the Bury Borough HWB's area,

- Fairfield General Hospital (part of NCA Foundation Trust which also includes Royal Oldham and Salford Royal).
- Pennine Care NHS Foundation Trust, which provides a range of mental health, learning disability, and autism services at several sites in Bury.

Should services be moved out of the hospitals and into the primary care setting then it is likely that this would lead to more prescriptions needing to be dispensed by pharmacies in primary care. However, it is likely that pharmacies will be able to absorb additional dispensing arising from this, should it happen.

6.5.2 Personal administration of items by GP practices

Under their medical contract with NHS England there will be occasion where a GP practice s personally administers an item to a patient.
Generally, when a patient requires a medicine or appliance their prescriber will electronically transfer or give them a prescription which they take to their preferred pharmacy. In some instances, the GP practice supplies the item against a prescription. This is referred to as personal administration because the item supplied is then directly administered to the patient by the GP or a clinical member of staff. This is different to the dispensing of prescriptions and only applies to certain specified items for example vaccines, anaesthetics, injections, intra-uterine contraceptive devices, and sutures.
For these items the practice will produce a prescription however the patient is not required to take it to a pharmacy, have it dispensed and then return to the practice for it to be administered.

6.5.3 GP out of hours service

Beyond the normal working hours of GP practices, there is an out of hours service operated as an initial telephone consultation where a clinician may attend the patient's home or request the patient access one of the clinics. The clinics and travelling clinicians have a stock of medicines and depending on the patient's requirement they may be given medicines from stock, or a prescription issued for dispensing at a pharmacy. GPs offer an OOH service from BARDOC (Bury and Rochdale Doctors On Call).
Prescriptions from out of hours services can be dispensed by pharmacies with longer opening hours. These pharmacies which are open seven days a week or for longer hours six days per week are listed in section 6.1.3 (Table 19, 20 and 21). There is a lack of extended hours pharmacies in Bury North Neighbourhood, where all pharmacies are open core hours during the week closing after 6pm, and only Saturday mornings (all closed after 1pm) at a weekend. This neighbourhood does have the least deprivation and has the highest vehicle ownership so they are more able to travel to a pharmacy further afield, however extension of opening hours from existing contractors in this location could be beneficial to residents.

6.5.4 Independent prescribing

In 2023/24, NHS England commissioned a pathfinder programme to explore the use of Pharmacist Independent Prescribers in NHS-commissioned services delivered by community pharmacy. NHS Greater Manchester has a small number of community pharmacies participating in the pathfinder programme which commenced in Q4 of 2024/25. NHS GM is testing 3 clinical models – minor illness (prescribing for patients who have accessed Pharmacy First advanced service but needed a p rescribing intervention), Respiratory (medicines optimisation for people with asthma and COPD) and Hypertension (initiating treatment for patients identified as hypertensive through the Hypertension Case-Finding advanced service and medicines optimisation for people on hypertensive medication).
NHS England has commissioned a formal evaluation of the pathfinder programme which will be published and shared with stakeholders in 2025/26.
Due to the limited number of pharmacies involved in the pathfinder programme in GM (n=10), there is not anticipated to be any significant impact on provision of community pharmacy services in GM in 2024/25 or 2025/26, however, dependent upon the success of the programme, the outcomes of the evaluation, and future NHS England commissioning considerations, this model of service delivery may expand in the future, and potentially within the lifetime of this PNA, at which point a further assessment may be required.

7 Districts for the purpose of the PNA

7.1 Overview

This assessment has taken a ward level approach to support the integration of public health data with other sources of information. The 17 wards were then aggregated into five neighbourhoods, as described in section 3.1.2. As each neighbourhood has slightly differing health needs, they are considered separately for the purposes of the PNA. Current residential and future proposed residential areas have been assessed for access to a pharmacy. Access to a pharmacy is based on walking, public or private transport times from the nearest pharmacy and the most recent census data from 2021 showing the percentage of residents with no car or van availability in each ward.

Table 23 - Car ownership by neighbourhood and ward (Source: ONS, Census 2021)

Neighbourhood	Ward	% with car or van availability	% no cars (Census 2021)	% no cars (Census 2011)
East Bury	Bury East	64%	36%	41%
East Bury	Moorside	67%	33%	37%
East Bury	Redvales	72%	28%	29%
West	Radcliffe East	73%	27%	28%
West	Radcliffe West	73%	27%	30%
Whitefield	Besses	74%	26%	29%
Prestwich	St. Mary's	77%	23%	25%
West	Radcliffe North & Ainsworth	80%	20%	23%
North	Elton	80%	20%	20%
Prestwich	Holyrood	80%	20%	23%
Prestwich	Sedgley	80%	20%	23%
Whitefield	Unsworth	82%	18%	20%
West	Bury West	82%	18%	18%
North	Ramsbottom	84%	16%	16%
Whitefield	Pilkington Park	85%	15%	16%
North	Tottington	88%	12%	12%
North	North Manor	89%	11%	12%

The percentage of Bury residents (2021) with access to a car or van averages at 78%.

The East Bury wards have the lowest average (68%) car ownership across the borough. This may be partly as they are closest to the town centre of Bury, with the facilities and public transport access that this offers, so they may not require transport to travel for work, or shopping. However, it is also the most deprived neighbourhood which may also impact this statistic.

The North neighbourhood wards have the highest average car ownership of 85%, with the highest percentage of car or van availability in North Manor (89%). The North neighbourhood has the poorest pharmacy accessibility due to opening hours; this may be a reflection of the population's accessibility via their own vehicles to other areas for their out of hours pharmacy supplies. Bury North is generally less densely populated than the other neighbourhoods and has the most rural locations in Bury (see Map 4).

7.2 East Bury Neighbourhood Profile

This profile provides an insight into the neighbourhood of East Bury, in relation to aspects that are more relevant to the provision of pharmaceutical services. For further profile information please see Neighbourhood Profiles | The Bury Directory. It is one of the five neighbourhoods within Bury, and it comprises of three wards: Moorside, Bury East and Redvales.

Population

There are around 37,500 people living in East Bury, which constitutes 19% of the total population in Bury. Around 38% of residents in East Bury are from a non-white background, which is significantly higher than the proportion in Bury and England.

Health and wellbeing

East Bury has 19.5% of residents with a limiting illness or disability, greater than the averages for Bury (18.5%) and England (17.3%).

East Bury Neighbourhood has a life expectancy of 80 for females and 76 for males, which are both less than the Bury and England averages.

East Bury has the lowest smoking prevalence at age 15 and is below the Bury and England average.

The highest cause of mortality and premature mortality in East Bury is circulatory disease for under 75-year-olds.

Results from the National Childhood Measurement Programme (NCMP) show that East Bury has a higher prevalence of obesity in all age groups compared to the Bury and England averages.

The highest long-term condition recorded prevalence level (all ages) is for hypertension (13.7%).

Chronic Obstructive Pulmonary Disease is the highest cause of emergency hospital admissions for long term conditions, followed by coronary heart disease.

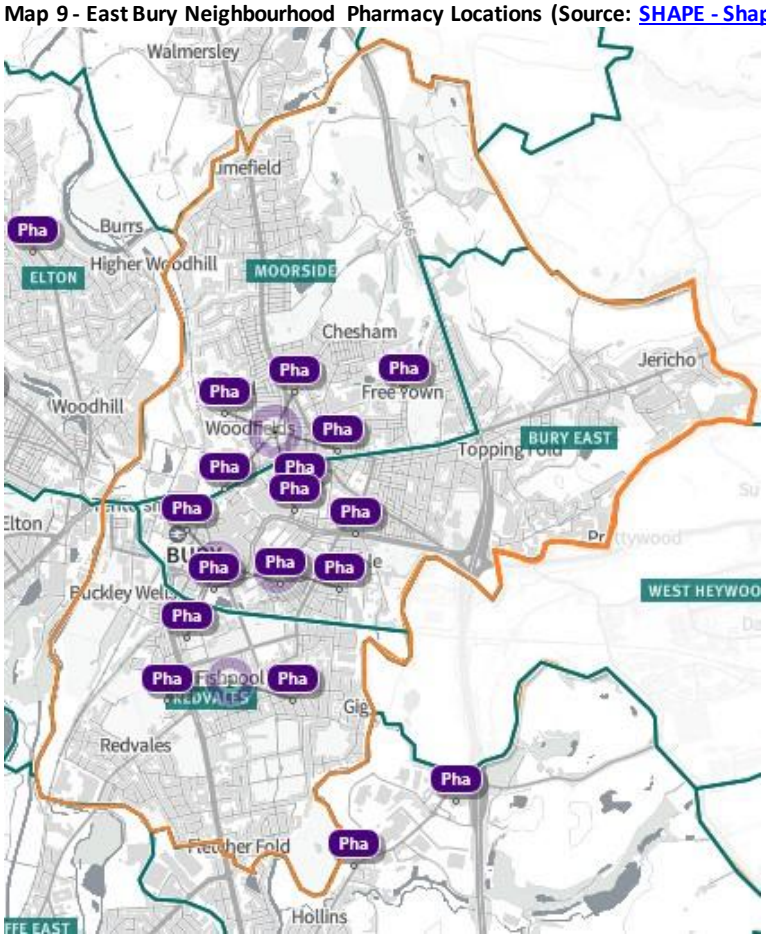
2.8% of the East Bury population provide unpaid care, which is in line with the Bury average (2.8%) and greater than the England average (2.6%).

Please note: In the absence of raw data, some percentages have been aggregated to provide a neighbourhood level figure

7.2.1 Access to a pharmacy in East Bury Neighbourhood

Map 9 shows that there are 15 pharmacies located within the East Bury neighbourhood, with pharmacies within all 3 wards. During Monday to Friday and at weekends there is satisfactory provision of pharmaceutical services across this Neighbourhood across a range of opening times. There are five with extended weekday hours and six that open on both Saturdays and Sundays. The population density is high and the area has the lowest average number of households with cars (range 64% to 72%), but this is the central area of Bury Town centre and the transport links are good.

Map 9 - East Bury Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



7.2.2 Future housing development in East Bury Neighbourhood

A small plot of land for 140 properties under PfE proposal is allocated in Moorside w ard at the Seedfield site and this will likely complete outside of this PNA cycle. There are currently 5 walk-in pharmacies in Moorside ward, with access to multiple other pharmacies in other wards, and good public transport links into Bury Town centre where more can be accessed. Bury Town centre lies within Bury East ward and there are plans for significant levels of development proposed in Bury Town Centre which will start to deliver new homes within the next 3 years. Around 2,500 new homes are in the pipeline for Bury town centre over the next 10-15 years, although it is expected the majority will be delivered beyond the 3-year timeframe of this PNA. The construction of Bury Flexi Hall is underway, and is scheduled to open in 2026, with plans to redevelop Bury interchange also being progressed. A further 13,000sqm commercial floorspace planned at Chamberhall, Bury. This area is well served by existing pharmacies and would not require any extra pharmaceutical service facilities within this PNA cycle.

7.3 West Neighbourhood Profile

This profile provides an insight into the neighbourhood of West, in relation to aspects that are more relevant to the provision of pharmaceutical services. For further profile information please see Neighbourhood Profiles | The Bury Directory. It is one of the five neighbourhoods within Bury, and it comprises of four wards: Bury West, Radcliffe East, Radcliffe West and Radcliffe North and Ainsworth.

Population

There are around 43,600 people living in West, which constitutes 23% of the total population in Bury. 9.5% of residents in West are from a non-white background, which is lower than the proportion in Bury (15.2%) and England (16.8%).

Health and wellbeing

West has 20.8% of residents with a limiting illness or disability, greater than the averages for Bury (18.5%) and England (17.3%).

West has a life expectancy of 82 for females and 79 for males, which are both in line with the Bury and England averages.

West has a smoking prevalence at age 15 in line with the Bury average and greater than the England average for regular smokers.

The highest cause of mortality in all ages is respiratory disease and the highest cause of premature mortality is circulatory disease for under 75-year-olds.

Results from the National Childhood Measurement Programme (NCMP) show that West has a prevalence of obesity in all age groups that is in line with the Bury and England averages.

The highest long-term condition recorded prevalence level (all ages) is for hypertension (15.6%).

Coronary heart disease is the highest cause of emergency hospital admissions for long term conditions, followed by Chronic obstructive pulmonary disease.

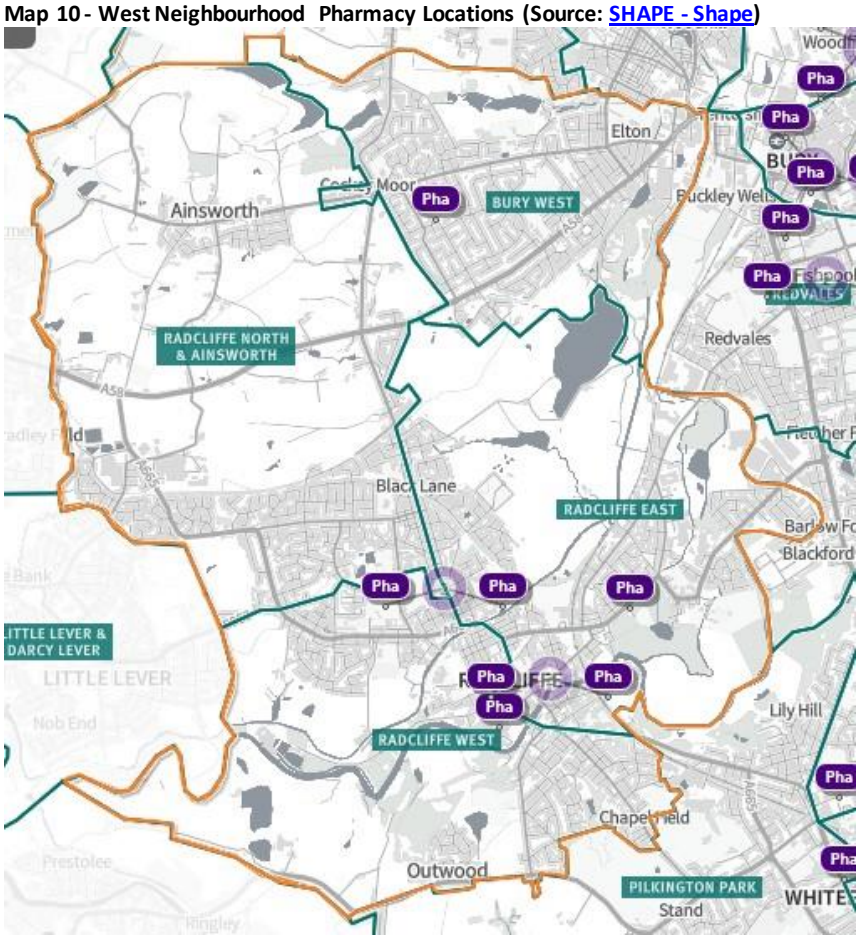
2.8% of the West population provide unpaid care, which is in line with the Bury average (2.8%) and greater than the England average (2.6%).

Please note: In the absence of raw data, some percentages have been aggregated to provide a neighbourhood level figure.

7.3.1 Access to a pharmacy in West Neighbourhood

Map 10 shows that there are 7 pharmacies located within the West neighbourhood. There is no pharmacy located within the Radcliffe North and Ainsworth ward, but there are pharmacies located in neighbouring wards and across the Bury border, maintaining access in this area within the 1-mile travel buffer. During Monday to Friday and at weekends there is satisfactory provision of pharmaceutical services across this Neighbourhood across a range of opening times. There are two with extended weekday hours and one that opens on both Saturdays and Sundays. The population density is lower compared to more central areas and the area has an average number of households with access to cars (range 73% to 82%).

Map 10 - West Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



7.3.2 Future housing development in West Neighbourhood

West neighbourhood has the largest proposed housing allocation under Places for Everyone at the Elton Reservoir Site, the majority of which falls in Radcliffe East Ward. There is a proposal for 3,500 houses to be built up 2039. Again, it is likely that this site will complete outside of the timeframe of this PNA. There are already multiple pharmacies which fall within a 1-mile radius of the proposed site. Also, a new metrolink station near the proposed housing would give good public transport access to both Radcliffe and Bury town centres where there are more health facilities.

Around 650 homes are currently in the pipeline in Radcliffe Town Centre. This includes 134 dwellings at Green Street (currently under construction). 90 new homes at School Street Radcliffe, 30 at Station House (Bury Road) with a further 400 dwellings at the East Lancashire Paper Mill (ELPM), although this development will extend beyond the end of the PNA's 3-year time frame. A site at York Street, Radcliffe is currently under construction and will deliver 211 homes for rent. 900sqm of offices are currently under construction at Green Street in Radcliffe and the development of a new Radcliffe Hub is progressing which will provide a new leisure centre, library and community space, and is scheduled to open in 2026.

This area is well served by existing pharmacies and would not require any extra pharmaceutical service facilities within this PNA cycle.

7.4 North Neighbourhood

This profile provides an insight into the neighbourhood of North, in relation to aspects that are more relevant to the provision of pharmaceutical services. For further profile information please see Neighbourhood Profiles | The Bury Directory. It is one of the five neighbourhoods within Bury, and it comprises of four wards: Ramsbottom, North Manor, Tottington and Elton.

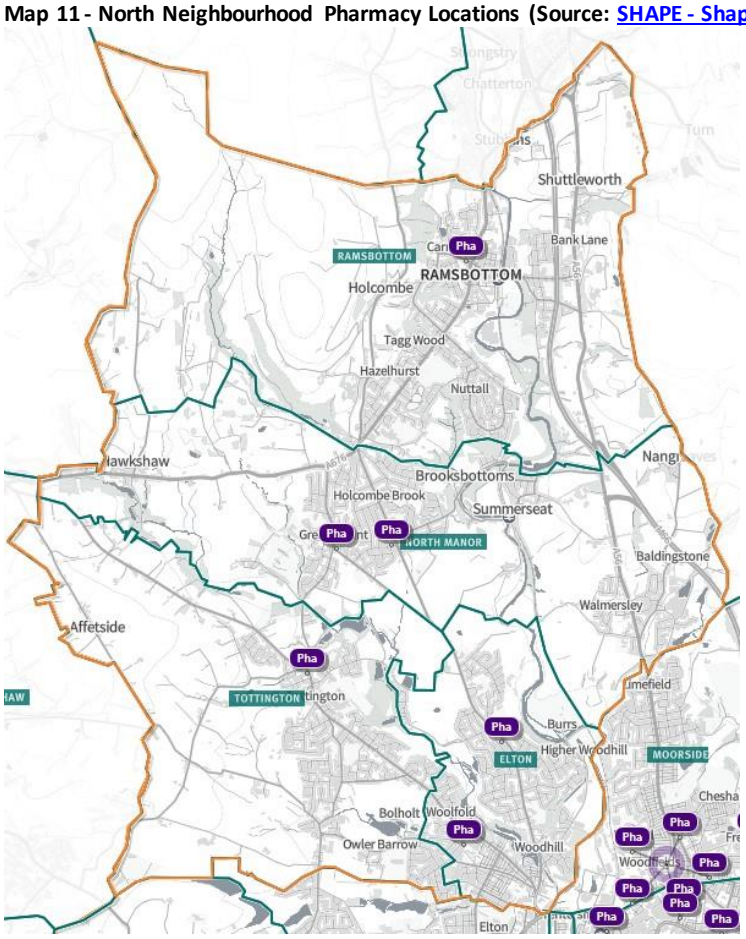
Population
There are around 43,100 people living in North, which constitutes 22% of the total population in Bury. 5.7% of residents in North are from a non-white background, which is lower than the proportion in Bury (15.2%) and England (16.8%).
Health and wellbeing
North has 17.1% of residents with a limiting illness or disability, less than the averages for Bury (18.5%) and England (17.3%).
North has a life expectancy of 84 for females and 81 for males, which are both greater than the Bury and England averages.
North has a smoking prevalence at age 15 greater than Bury and England averages for regular and casual smokers.
The highest cause of mortality in all ages is coronary heart disease.
Results from the National Childhood Measurement Programme (NCMP) show that North has a prevalence of obesity in all age groups that is below the Bury and England averages, except for reception age which is in line with Bury and England averages.
The highest long-term condition recorded prevalence level (all ages) is for hypertension (14.1%).
Stroke is the highest cause of emergency hospital admissions for long term conditions, followed by coronary heart disease.
2.8% of the North population provide unpaid care, which is in line with the Bury average (2.8%) and greater than the England average (2.6%).

Please note: In the absence of raw data, some percentages have been aggregated to provide a neighbourhood level figure.

7.4.1 Access to a pharmacy in Bury North Neighbourhood

Map 11 shows that there are 6 pharmacies located within the Bury North neighbourhood, located within all 4 wards. During Monday to Friday and at weekends there is satisfactory provision of pharmaceutical services across this Neighbourhood across the core opening times. However, provision is more limited outside these hours with no extended hours Monday to Saturday and no pharmacy open on a Sunday. This access remains the same as the previous PNA cycle. This area has the lowest population density in Bury Borough and it has the highest number of households with cars (range 84% to 89%), ensuring that current pharmaceutical provision is sufficient. However, an extension of opening hours would help to secure improved access in the neighbourhood.

Map 11 - North Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



7.4.2 Future housing development in North Neighbourhood

Under PfE there is a proposal for 1250 houses in Walshaw and the bulk of the area is in Tottington ward. This location falls within 1 mile of 4 pharmacies, although only 1 of these is in Tottington ward. Although the large strategic sites will take many years to build out, extending beyond the 3 year PNA cycle, it is likely that development will commence within the PNA period.
This area is well served by existing pharmacies and would not require any extra pharmaceutical service facilities within this PNA cycle.

7.5 Prestwich Neighbourhood

This profile provides an insight into the neighbourhood of Prestwich, in relation to aspects that are more relevant to the provision of pharmaceutical services. For further profile information please see Neighbourhood Profiles | The Bury Directory. It is one of the five neighbourhoods within Bury, and it comprises of three wards: Holyrood, St. Mary's and Sedgley.

Population

There are around 36,000 people living in Prestwich, which constitutes 19% of the total population in Bury. 16.2% of residents in Prestwich are from a non-white background, which is higher than the proportion in Bury (15.2%) and lower than the proportion in England (16.8%).

Health and wellbeing

Prestwich has 17.5% of residents with a limiting illness or disability, less than the average for Bury (18.5%) and more than the average for England (17.3%).

Prestwich has a life expectancy of 83 for females and 79 for males, which are both in line with the Bury and England averages.

Prestwich has a smoking prevalence at age 15 greater than the Bury and England averages for regular smokers.

The highest cause of mortality in all ages is coronary heart disease. The highest causes of premature mortality in the under 75 age group are circulatory disease and cancer.

Results from the National Childhood Measurement Programme (NCMP) show that Prestwich has a prevalence of obesity in all age groups that is below the Bury and England averages.

The highest long-term condition recorded prevalence level (all ages) is for hypertension (12.2%).

Myocardial infarction is the highest cause of emergency hospital admissions for long term conditions, followed by coronary heart disease.

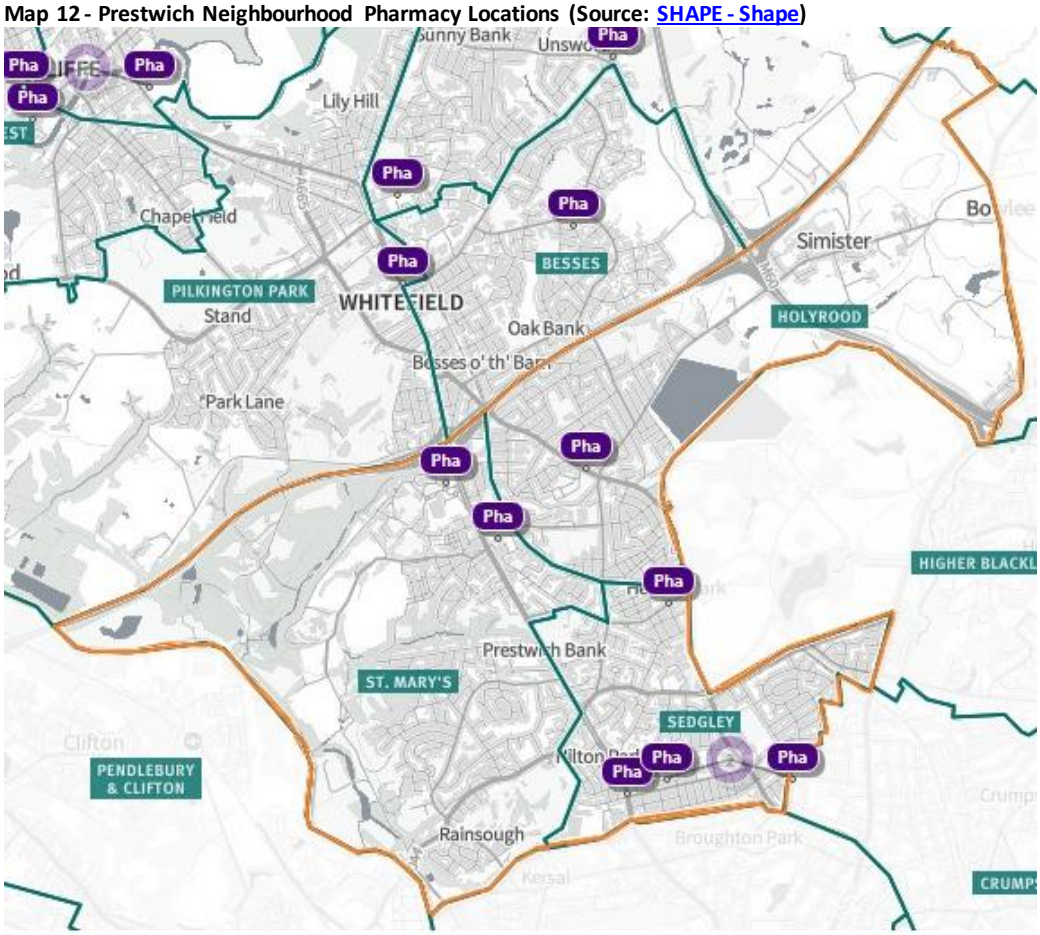
2.7% of the Prestwich population provide unpaid care, compared to the Bury average (2.8%) and the England average (2.6%).

Please note: In the absence of raw data, some percentages have been aggregated to provide a neighbourhood level figure.

7.5.1 Access to a pharmacy in Prestwich Neighbourhood

Map 12 shows that there are 7 pharmacies in the Prestwich neighbourhood, located within all 3 of the wards. Prestwich neighbourhood has access to pharmacies with extended opening hours during Monday to Saturday and one pharmacy is open on a Sunday. The population density is relatively high especially in Sedgely ward, but St. Mary's ward has a lower population density than the other wards. Vehicle ownership is average for the borough with a range of 77 to 80%.

Map 12 - Prestwich Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



7.5.2 Future housing development in Prestwich Neighbourhood

The Prestwich Village regeneration plans include a new community hub, village square, a market hall, flexible retail and leisure spaces, outdoor spaces, a new travel hub and around 200 homes. This development will extend beyond the 3-year timeframe of the PNA.

Under PfE there is a proposal for 1,350 homes at Simister. Although the large strategic sites will take many years to build out, extending beyond the 3 year PNA cycle, it is likely that development will commence within the PNA period.

This area is well served by existing pharmacies and would not require any extra pharmaceutical service facilities within this PNA cycle.

7.6 Whitefield Neighbourhood

This profile provides an insight into the neighbourhood of Whitefield, in relation to aspects that are more relevant to the provision of pharmaceutical services. For further profile information please see Neighbourhood Profiles | The Bury Directory. It is one of the five neighbourhoods within Bury, and it comprises of three wards: Unsworth, Besses and Pilkington Park.

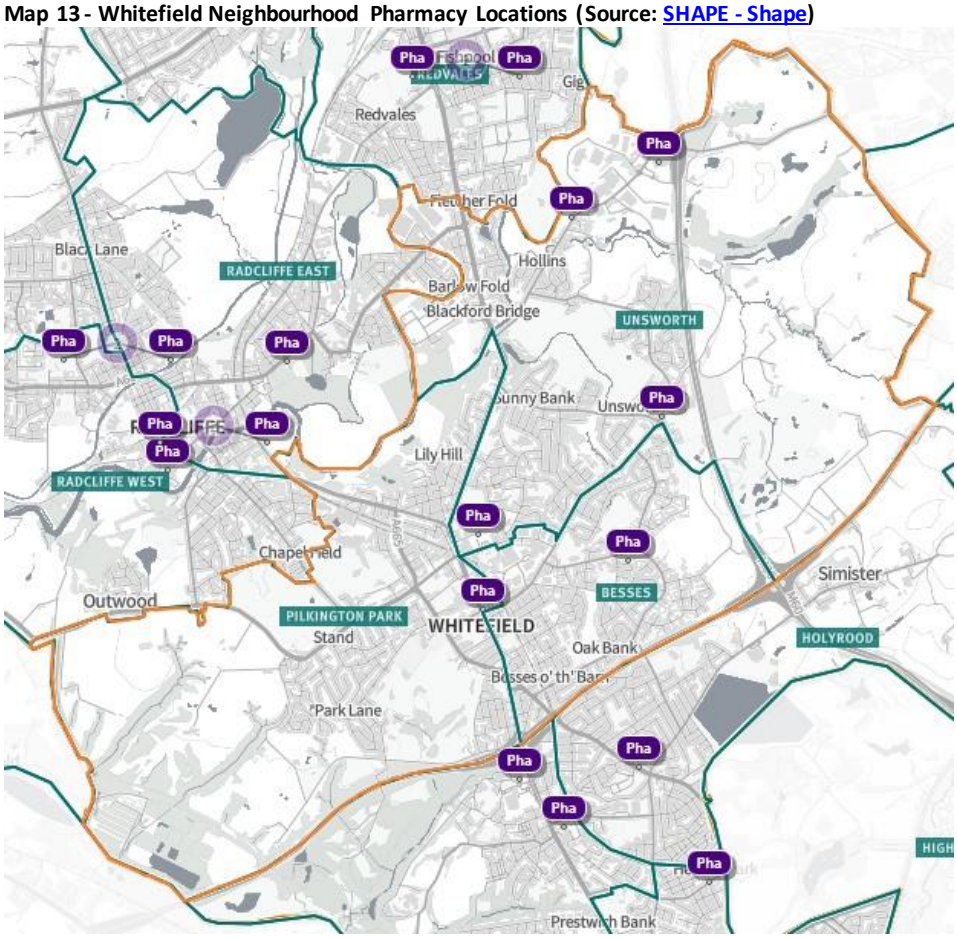
Population
There are around 33,800 people living in Whitefield, which constitutes 17% of the total population in Bury. 12.9% of residents in Whitefield are from a non-white background, which is less than the proportion in Bury (15.2%) and England (16.8%).
Health and wellbeing
Whitefield has 17.3% of residents with a limiting illness or disability, less than the average for Bury (18.5%) and equal to the average for England (17.3%).
Whitefield has a life expectancy of 82 for females and 79 for males, which are both in line with the Bury and England averages.
Whitefield has a smoking prevalence at age 15 greater than the Bury and England averages for regular smokers.
The highest cause of mortality in all ages is coronary heart disease. The highest causes of premature mortality in the under 75 age group are causes considered to be preventable.
Results from the National Childhood Measurement Programme (NCMP) show that Whitefield has a prevalence of obesity in all age groups that is above the Bury and England averages, except for year 6 which was lower.
The highest long-term condition recorded prevalence level (all ages) is for hypertension (15.1%).
Coronary heart disease is the highest cause of emergency hospital admissions for long term conditions, followed by myocardial infarction.
3.0% of the Whitefield population provide unpaid care, compared to the Bury average (2.8%) and the England average (2.6%).

Please note: In the absence of raw data, some percentages have been aggregated to provide a neighbourhood level figure.

7.6.1 Access to a pharmacy in Whitefield Neighbourhood

Map 13 shows that there are six pharmacies in Whitefield neighbourhood, located within all the wards. There is good pharmaceutical provision with one pharmacy open extended hours during Monday to Saturday and open on a Sunday, plus another three which open on a Saturday morning. This is satisfactory provision of pharmaceutical services across this neighbourhood. Most residential areas are all within the 1-mile travel buffer and all are within the 20-minute public transport time frame. The population density is like the Bury average and there is a higher-than-average number of households with cars (range 74% to 85%).

Map 13 - Whitefield Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



7.6.2 Future housing development in Whitefield Neighbourhood

There are no larger developments planned in this neighbourhood. This area is well served by existing pharmacies and would not require any extra pharmaceutical service facilities within this PNA cycle.

8 How pharmaceutical services can help support a healthier population

Pharmacies are well used by the public, employ clinically trained health care professionals and are freely accessible for the local population, some of whom may not access other health care services. As a minimum they must provide the essential services listed below, plus can then provide advanced and locally commissioned services to their customers. This gives commissioners scope for directing them to provide services for specific populations or health conditions and targeting the heal th needs which will most improve the population within the Borough.

8.1 Essential Services (ES)

The essential services within the most recent CPCF are listed below. These services must be offered by all pharmacy contractors during all opening hours of the pharmacy.

1. **Dispensing of medicines**
   Pharmacies are required to maintain a record of all medicines dispensed, and also keep records of any interventions made which they judge to be significant.[41]
2. **Dispensing of appliances**
   Pharmacists may regularly dispense appliances in the course of their business, or they may dispense such prescriptions infrequently, or they may have taken a decision not to dispense them at all. Whilst the Terms of Service requires a pharmacist to dispense any (non-Part XVIIIA listed) medicine "with reasonable promptness", for appliances the obligation to dispense arises only if the pharmacist supplies such products "in the normal course of business". [42]
3. **Repeat dispensing and eRD**
   Under the repeat dispensing service pharmacy teams will: dispense repeat dispensing prescriptions issued by a general practice, ensure that each repeat supply is required and seek to ascertain that there is no reason why the patient should be referred back to their general practice.[43]
4. **Healthy Living Pharmacies**
   The Healthy Living Pharmacy (HLP) framework is aimed at achieving consistent provision of a broad range of health promotion interventions through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.[44]
5. **Disposal of unwanted medicines**
   Community pharmacy owners are obliged to accept back unwanted medicines from patients.
6. **Signposting**
   NHS England will provide pharmacies with lists of sources of care and support in the area. Pharmacies will be expected to help people who ask for assistance by directing them to the most appropriate source of help.[45]
7. **Support for self-care**

[41] https://cpe.org.uk/national-pharmacy-services/essential-services/dispensing-of-medicines/ accessed 17/03/2025
[42] https://cpe.org.uk/national-pharmacy-services/essential-services/dispensing-of-appliances/ accessed 17/03/2025
[43] https://cpe.org.uk/national-pharmacy-services/essential-services/repeat-dispensing/ accessed 17/03/2025
[44] https://cpe.org.uk/national-pharmacy-services/essential-services/healthy-living-pharmacies/ accessed 17/03/2025
[45] https://cpe.org.uk/national-pharmacy-services/essential-services/signposting/ accessed 17/03/2025

Pharmacies will help manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS 111. Records will be kept where the pharmacist considers it relevant to the care of the patient.[46]

8. **Public health (promotion of healthy lifestyles)**
   Each financial year (1st April to 31st March), pharmacies are required to participate in up to six health campaigns at the request of NHS England. This generally involves the display and distribution of leaflets provided by NHS England.
   In addition, pharmacies are required to undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.[47]
9. **Discharge medicines Service (DMS).**
   From 15th February 2021, NHS Trusts were able to refer patients who would benefit from extra guidance around prescribed medicines for provision of the DMS at their community pharmacy. The service has been identified by NHS England's Medicines Safety Improvement Programme to be a significant contributor to the safety of patients at transitions of care, by reducing readmissions to hospital.[48]

Results from the GM standardised public survey for the Bury population show that with respect to pharmacy essential services 62% of respondents had used repeat dispensing in the last 3 months and 79% of respondents had collected regular prescription medication in the last 3 months.

8.2 Advanced Services

There are currently nine advanced services (Appendix Seven) within the most recent NHS CPCF. Community pharmacies can choose to provide any of these services if they meet the requirements set out in the Secretary of State Directions.

Current advanced services:

1. **Appliance Use Review (AUR)**
   AURs should improve the patient's knowledge and use of any 'specified appliance' by: establishing the way the patient uses the appliance and the patient's experience of such use, identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient, advising the patient on the safe and appropriate storage of the appliance and advising the patient on the safe and proper disposal of the appliances that are used or unwanted.[49]
2. **Pharmacy First Service (PFS)**
   The Advanced service involves pharmacists providing advice and NHS-funded treatment, where clinically appropriate, for seven common conditions.[50]
3. **Flu Vaccination Service**
   Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015.

[46] https://cpe.org.uk/national-pharmacy-services/essential-services/support-for-self-care/ accessed 17/03/2025
[47] https://cpe.org.uk/national-pharmacy-services/essential-services/public-health/ accessed 17/03/2025
[48] https://cpe.org.uk/national-pharmacy-services/essential-services/discharge-medicines-service/ accessed 17/03/2025
[49] https://cpe.org.uk/national-pharmacy-services/advanced-services/aurs/ accessed 17/03/2025
[50] https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-first-service/ accessed 17/03/2025

Each year from the autumn through to March, the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus.[51]

The accessibility of pharmacies, their extended opening hours and the option to walk in without an appointment have proved popular with patients seeking vaccinations.

4. **Pharmacy Contraception Service (PCS)**
   The PCS commenced on 24th April 2023, allowing the on-going supply of oral contraception (OC) from community pharmacies. From 1st December 2023, the service expanded to include both initiation and on-going supply of OC.[52]
5. **Lateral Flow Device Service (LFD)**
   The LFD service was introduced to provide eligible patients with access to LFD tests.[53]
6. **Hypertension Case Finding Service**
   Identify people aged 40 years or older, or at the discretion of pharmacy staff, people under the age of 40, with high blood pressure (who have previously not had a confirmed diagnosis of hypertension), and to refer them to general practice to confirm diagnosis and for appropriate management.
   At the request of a general practice, undertake ad hoc clinic and ambulatory blood pressure measurements. These requests can be in relation to people either with or without a diagnosis of hypertension.
   Provide another opportunity to promote healthy behaviours to patients.[54]
7. **New Medicine Service (NMS)**
   The service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence; it is focused on specific patient groups and conditions.[55]
8. **Stoma Appliance Customisation (SAC)**
   The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff.[56]
9. **Smoking Cessation Service (SCS)**
   This service has been designed to enable NHS trusts to undertake a transfer of care on patient discharge, referring patients (where they consent) to a community pharmacy of their choice to continue their smoking cessation treatment, including providing medication and support as required. The ambition is for referral from NHS trusts to community pharmacy to create additional capacity in the smoking cessation pathway.[57]

Results from the GM standardised public survey for the Bury population show that with respect to Pharmacy Advanced Services, 52% of respondents had used the NHS urgent medicine supply within the last 12 months or were planning to use the service in the future, 39% of respondents had used the NHS Pharmacy First Service within the last 12 months or were planning to use the service in the future, 58% of respondents had used the NHS Hypertension Service within the last 12 months or were planning to use the service in the future, 28% of respondents had used the NHS New Medicines

[51] https://cpe.org.uk/national-pharmacy-services/advanced-services/flu-vaccination-service/ accessed 17/03/2025
[52] https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-contraception-service/ accessed 17/03/2025
[53] https://cpe.org.uk/national-pharmacy-services/advanced-services/lfd-service/ accessed 17/03/2025
[54] https://cpe.org.uk/national-pharmacy-services/advanced-services/hypertension-case-finding-service/ accessed 17/03/2025
[55] https://cpe.org.uk/national-pharmacy-services/advanced-services/nms/ accessed 17/03/2025
[56] https://cpe.org.uk/national-pharmacy-services/advanced-services/sac/ accessed 17/03/2025
[57] https://cpe.org.uk/national-pharmacy-services/advanced-services/smoking-cessation-service/ accessed 17/03/2025

Service within the last 12 months or were planning to use the service in the future, 58% of respondents had used the NHS Flu vaccination Service within the last 12 months or were planning to use the service in the future, 11.2% of respondents had used the NHS Contraception service within the last 3 months or were planning to use the service in the future and finally 10% of respondents had used the NHS Smoking Cessation/stop smoking Service within the last 12 months or were planning to use the service in the future.

8.3 Locally commissioned services (LCS)

These services are commissioned to meet an identified need in the local population. Pharmacies may choose whether to provide a service or not. Depending on the service agreement used these services may or may not be accessible during all the pharmacies opening hours.

8.3.1 NHS GM ICB services

Minor Ailment Service

Provides advice and support to people registered with a Bury GP on the management of minor ailments, including where necessary, the supply of medicines for the treatment of the minor ailment, for those people who would have otherwise gone to their GP or other healthcare provider for a prescription.

Minor Eye Conditions Service (MECS)

The aims of the service are to improve access and choice for people with minor eye conditions who are seeking advice and treatment via the community optometry minor eye conditions service by:

- supplying appropriate medicines at NHS expense; and
- to improve health-inequalities for low-income families and equal access to medicines for self-care of minor eye conditions.

The pharmacy (or pharmacist/suitably trained pharmacy staff) will dispense medication directly to a patient who presents with a signed order on the agreed form written by an Ophthalmic Optometrist.

Palliative Care Stockholding Service

Stock holding of items which are required for patient use at short notice. However, the drugs may not be used very frequently and so may go out of date before used. Hence, not all pharmacies are needed to maintain stock, so a few that have longer opening hours and/or are strategically placed around the borough are contracted to deliver this service.

8.3.2 Bury Council locally commissioned services

Emergency Hormonal Contraception (EHC)

EHC is used in reducing unplanned or unwanted pregnancies. The drugs ulipristal and levonorgestrel are used for EHC, they are supplied under a Patient Group Direction (PGD) to women who meet the criteria for inclusion of the PGD and service specification. The drug can also be prescribed using an FP10 prescription. It may also be bought as an over-the-counter medication from pharmacies; however, this service is of value to those unable or unwilling to access a prescription or who are not able to purchase the medication.

Following the announcement of the new CPCF in April 2025, it has been announced that from October 2025, Emergency Hormonal Contraception is to be added to the Pharmacy Contraception Service (PCS). This in turn means that the locally commissioned service for EHC should not be required from the October 2025 start date.

Needle and syringe exchange services (NEX)

An integral part of the harm reduction strategy for drug users which aims to:

- Reduce the spread of blood borne pathogens e.g. Hepatitis B, Hepatitis C, HIV

- Be a referral point for service users to other health and social care services

There is evidence to support the effectiveness of needle exchange services with long term health benefits to drug users and the whole population. Needle Exchange service may be an access point for reaching and delivering other services to people who are injecting drug users but are not in contact with any other health service (e.g. Hepatitis C testing service).

Supervised consumption

This involves the client consuming methadone or buprenorphine under the direct supervision of a pharmacist in a community pharmacy.
It is a medicines adherence service which aims to:

- Reduce the risk of harm to the client by over or under usage of drug treatment.
- Reduce the risk of harm to the local community by the inappropriate use of prescribed medicines via the illicit drug market.
- Reduce the risk of harm to the community by accidental exposure to these prescribed medicines.

There is compelling evidence to support the effectiveness of supervised administration with long term health benefits to drug users and the whole population.

Results from the GM standardised public survey for the Bury population show that with respect to Pharmacy Locally commissioned Services, 6% of respondents had used the Emergency Hormonal Contraception Service within the last 3 months or were planning to use the service in the future, 45% of respondents had used the Minor Ailments service within the last 12 months or were planning to use the service in the future and 17% of respondents had used the Palliative Care Service within the last 12 months or were planning to use the service in the future.

9 Gaps in current provision of pharmaceutical services

Necessary services, for the purposes of this PNA, are defined as:

- those essential services provided by pharmacies and DACs in line with their terms and contracted hours of service as set out in the 2013 regulations, and
- advanced services commissioned at the time of publication of the PNA that meet the requirements of the Bury population need.

There are 41 such pharmacies providing pharmaceutical services in Bury. The spread of opening times including the core hours are provided in Appendix Six and Eight, which is supported by maps as detailed in appendix 10.

9.1 Gap Analysis Criteria

An assessment of whether there is a gap in pharmaceutical provision has been assessed using these criteria:

- All parts of the population should have general access to a physical community Pharmacy.
- Industrial and trading estates are not residential areas so will not form part of the gap analysis.
- Pharmacies located outside the borders of Bury within a one-mile buffer zone, will be recorded and can qualify as providers of access.
- In rural areas (Bury has 2 LSOA described as rural[58]) the population should be within 20 minutes' driving time or within a 5 miles radius of at least one of the above providers. If neither criterion is met, then this should be given further consideration as a possible gap.
- In all other wards in Bury, which are classed as urban areas, the population should be within 20 minutes' walking time (estimated at 1 mile) or 20 minutes' public transport time of a provider. If neither criterion is met, then this should be given further consideration as a possible gap.
- All pharmacies should open their minimum core hours each week.
- Weekend coverage by standard pharmacies (commonly about four hours on a Saturday morning) will be noted, but assessment of access to pharmacies will not be made utilising this, as it is difficult for NHSCB to effect changes in existing contracts for weekend opening hours.
- Areas of low car ownership in villages (where 15% or more of households are without cars) should be identified and examined for acceptable public transport access on weekdays (within 20 minutes' travel time). Public transport access in rural areas (mainly bus) should be commented on, although it should not form a criterion.
- The prospective needs of new build areas should be identified and considered where growth of 200 or more dwellings is planned in the period of the PNA.
- The projection of gaps in general access for new build areas in each locality should, as far as possible, apply the criterion of 20 minutes' drivetime in rural areas and the criterion of 20 minutes' public transport time in urban areas in the attempt to project the emergence of gaps in pharmaceutical services.

9.2 Gap Analysis – Location and times of opening

The HWB considered the following, drawn from data discussed in this PNA and the mapped provision of access to pharmacies:

- All five neighbourhoods have pharmacies within their border (See appendix 10 for maps).
- 85% of items dispensed in Bury Pharmacies were for people registered with a Bury GP practice (Table 18), indicating that most of the population do not need to travel outside of the borough to access pharmacy dispensing services.
- The number of pharmacies available per 100,000 population is 21 in Bury (Table 17). This is equal to GM (21), but higher than England (18) averages. Historical pharmacy use

[58] ONS https://geoportal.statistics.gov.uk/datasets/9dbf7613cbb147b8bb8627ddb3568cff_0/explore

coupled with a high number of pharmacies per 100,000 population, indicates that the current number of pharmacies is sufficient for the current population.

- Also, with 8,585 average items per month dispensed in Bury pharmacies (Table 19) being lower than GM (8,840) and England (9,118) figures, this also indicates that the current number of pharmacies can cope with demand for prescription dispensing.
- Map 4 showing the population density and the location of pharmacy premises indicates more pharmacies are in the most densely populated areas.
- Map 5 (showing the Index of Multiple Deprivation) show that the areas of high population density correlate to higher rates of deprivation, and therefore as with the previous statement, the pharmacies are in these areas.
- Maps 7 & 8 illustrate that most of the residents of the HWB area are within a 20-minute walk (approximately 1 mile) and/or a 20-minute public transport ride. In the small areas where this is not true there is a sparse population and car ownership is high (see Table 23).
- Considering the number, distribution and opening times of pharmacies within each of the five neighbourhoods (section 7), there is sufficient pharmaceutical provision within each of the neighbourhoods. Section 6.1.3 also describes the satisfactory spread and range of opening times available for pharmaceutical services in Bury.

9.3 Gap Analysis - Current service provision

- 81% said they were either satisfied or very satisfied when asked how they felt about the overall pharmacy service received.
- 93% of respondents to the public survey had not had any difficulty in accessing a pharmacy of their choice
- 82% of responders said the opening hours of pharmacies in Bury do not cause a problem
- 83% were satisfied or very satisfied with the opening hours of the pharmacy they used (Appendix 3).
- Overall results of the patient survey (Appendix 3).

9.4 Gap Analysis - Future Provision

- Sections 6.4 and 7 detail the proposed housing developments in Bury and detail any impact within the 3 year PNA cycle. Many proposed developments within this cycle propose less than the 200 properties, as outlined in the gap analysis criteria. Proposed larger developments will complete outside of the PNA cycle or fall within a 1 mile radius or 20 minute public transport time of a current Bury Pharmacy. Hence it is concluded that there is no immediate requirement for new pharmacy sites to be established.

9.5 Gap analysis - Conclusion

Considering the information outlined in this PNA, the HWB considers the location, number, distribution and choice of pharmacies covering each of the five neighbourhoods and the whole Bury HWB area providing necessary services to meet the needs of the current population.
Future provision of pharmaceutical services beyond 2028 will be reviewed during the next iteration of the Bury HWB PNA.

10 Improvements and better access: gaps in provision of pharmaceutical services

The HWB considers it is those services and times provided in addition to those considered necessary for the purpose of this PNA that should reasonably be regarded as providing either an improvement or better access to pharmaceutical provision.
The HWB recognises that any addition of pharmaceutical services by location, provider, hours or services may be regarded by some as pertinent to this consideration. However, the HWB consider the duty to be one of proportionate consideration overall.

Location and Opening Hours
The location of premises and choice of provider is not as extensive beyond the standard core hours across Bury borough. However, in each neighbourhood apart from Bury North (where there is no supplementary provision on a Sunday or late evenings on any day), there are pharmacies open beyond what may be regarded as standard hours, in that they provide pharmaceutical services during supplementary hours in the evening, on Saturday and Sunday. Consideration should be made to extending these hours if a request was submitted from a current pharmacy contracted and located within Bury North.
From the information available, the HWB consider the location, number, distribution and choice of pharmacies covering each of the five neighbourhoods who are providing essential and advanced services during the evening, on Saturday and Sunday, provides an improvement over standard contracted hours and better access which meets the requirements of the population.
The patient survey responses mentioned the lack of weekend opening hours and lack of opening hours outside of regular 'office hours', yet some respondents were unaware of the location of pharmacies in Bury Borough which had extended opening hours. Public awareness campaigns of local services and opening times could help improve this. The HWB therefore concludes there is no significant information to indicate there is a gap in the current provision of pharmacy opening times.

Future Gaps for access to pharmaceutical services
The plans for residential and commercial buildings in Bury identify several smaller developments that will not impact the PNA and larger developments that will complete outside the cycle of the PNA, it is concluded there is no requirement to open a new pharmacy in these areas. Where larger developments have been identified that will complete or part complete within the PNA cycle, there is no requirement for additional pharmacies due to existing provisions and acceptable travel times in these areas.

Locally commissioned services commissioned by the local authority or ICB, are regarded as pharmaceutical services for the purpose of this PNA.
The HWB consider these to provide both an improvement and better access to such services for the residents of Bury HWB area where such health needs have been identified and verified at a local level.

At the time of writing this PNA, the HWB has not identified, either itself or through consultation, any requirement to provide services already commissioned or to commence the provision of pharmaceutical services not currently commissioned.
Considering the totality of information available, the HWB consider the location, number, distribution and choice of pharmacies covering each of the five neighbourhoods and the Bury HWB area providing locally commissioned services to provide an improvement and better access for population. The HWB has not received any significant information to conclude otherwise currently or of any local future specified circumstance that would alter that conclusion.

11 Conclusions (for the purpose of Schedule 1 to the 2013 Regulations)

11.1 Current provision – necessary and other relevant services

As described in detail in section 6 and required by paragraphs one and three of schedule 1 to the Regulations, Bury HWB has had regard to the pharmaceutical services referred to in this PNA in seeking to identify those that are necessary, have secured improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.
Bury HWB has determined that while not all provision was necessary to meet the need for pharmaceutical services, most of the current provision was likely to be necessary as described in section 9 with that identified in section 10 as providing improvement or better access without the need to differentiate in any further detail.

11.2 Necessary services – gaps in provision

As described in section 9 and required by paragraph two of schedule 1 to the Regulations, Bury HWB has had regard to the following in seeking to identify whether there are any gaps in necessary services in the area of the HWB.

To assess the provision of essential services against the needs of our population we consider access (travelling times and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

11.2.1 Access to essential services during normal working hours

Bury HWB has determined that the travel times as identified in section 6.1.1 to access essential services are reasonable in all the circumstances.
Based on the information available at the time of developing this PNA, no current gaps in the need for provision of essential services during normal working hours have been identified.

11.2.2 Access to essential services outside normal working hours

In Bury there is good access to essential services outside normal working hours in four of the five neighbourhoods and across the HWB area. However, the exception being Bury North neighbourhood where due to population, deprivation and car ownership factors no extra service hours of provision are deemed necessary. This is due to the supplementary opening hours offered by other pharmacies across the borough. It is not expected that any of the current pharmacies will reduce the number of core opening hours and NHSCB foresees no reason to agree a reduction of core opening hours for any service provider except on an ad hoc basis to cover extenuating circumstances.
Based on the information available at the time of developing this PNA, no current gaps in the provision of essential services outside normal working hours have been identified.

11.2.3 Access to advanced and enhanced services

Insofar as only NHSCB may commission these services, section 3.5 of this PNA identifies access to enhanced and advanced services.
Based on the information available at the time of developing this PNA, no current gaps in the provision of advanced and enhanced services have been identified.

11.3 Future provision of necessary services

Bury HWB has not identified any pharmaceutical services that are not currently provided but that will, in specified future circumstances, need to be provided to meet a need for pharmaceutical services.
Based on the information available at the time of developing this PNA, no gaps in the need for pharmaceutical services in specified future circumstances have been identified.

11.4 Improvements and better access – gaps in provision

As described in section 10 and required by paragraph 4 of schedule 1 to the 2013 Regulations, Bury HWB has had regard to the following in seeking to identify whether there are any gaps in other relevant services within the five neighbourhoods and the area of the HWB.

11.4.1 Access to essential services – present and future circumstances

Bury HWB considered the conclusion in respect of current provision as set out at 11.1 above and the information in respect of essential services as it had done at 11.2. While it was not possible to determine which current provision of essential service by location or standard hours provided improvement or better access, the HWB was satisfied that some current provision did so.
Bury HWB has not identified services that would, if provided either now or in future specified circumstances, secure improvements to or better access to essential services.
Based on the information available at the time of developing this PNA, no gaps have been identified in essential services that if provided either now or in the future would secure improvements, or better access, to essential services.

11.4.2 Current and future access to advanced services

Based on the information available at the time of developing this PNA, no gaps have been identified in the need for advanced services that if provided either now or in the future would secure improvements, or better access, to advanced services.

11.4.3 Current and future access to enhanced services

NHSCB commissions two enhanced services (MAS and MECS) from pharmacies. It also commissions services from other non-pharmacy providers, principally GP practices.
Based on the information available at the time of developing this PNA, no gaps in respect of securing improvements, or better access, to enhanced services either now or in specified future circumstances have been identified.

11.5 Other NHS Services

As required by paragraph five of schedule 1 to the 2013 Regulations, Bury HWB has had regard to section nine considering any other NHS services that may affect the determination in respect of pharmaceutical services in the area of the HWB. This includes locally commissioned services, see section 3.5.2
Based on the information available at the time of developing this PNA, no gaps in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances have been identified.

11.6 How the assessment was carried out

As required by paragraph 6 of schedule 1 to the 2013 Regulations:
In respect of how the HWB considered whether to determine neighbourhoods in its area for the purpose of this PNA, see section 3 and section 7 and appendix 10.
In respect of how the HWB considered the different needs in its area, including those who share a protected characteristic, see sections 4.5.
In respect of the consultation undertaken by the HWB, see Appendix Thirteen.

11.7 Map of provision

As required by paragraph seven of schedule 1 to the 2013 Regulations, the HWB has published a map of premises providing pharmaceutical services in Map 3 (Section 4.1). Additional maps are also provided throughout and as listed in Appendix Ten.

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Appendix 1 – Glossary

A&E	Accident and Emergency	LGBT	Lesbian, Gay, Bisexual and Transgender
AIDS	Acquired Immune Deficiency Syndrome	LMC	Local Medical Committee
AUR	Appliance Use Review	LPC	Local Pharmaceutical Committee
BME	Black and Minority Ethnic	LPS	Local Pharmaceutical Service
CCG	Clinical Commissioning Group	LSOA	Lower Super Output Areas
CHD	Coronary Heart Disease	LTC	Long Term Condition
COPD	Chronic Obstructive Pulmonary Disease	MI	Myocardial Infarction
COVER	Cover of Vaccination Evaluated Rapidly	MMR	Measles, Mumps and Rubella
CPCF	Community Pharmacy Contractual Framework	MUR	Medicines Use Review
CPCS	Community Pharmacy Consultation Service	NEX	Needle and Syringe Exchange Services
CVD	Coronary Vascular Disease	NHS	National Health Service
DAC	Dispensing Appliance Contractor	NHSBSA	NHS Business Services Authority
EHC	Emergency Hormonal Contraception	NHSCB	NHS Commissioning Board
EPS	Electronic Prescription Service	NHSE	NHS England
ES	Essential Services	NICE	National Institute for Clinical & Healthcare Excellence
GCSE	General Certificate of Secondary Education	NMS	New Medicine Service
GFR	General Fertility Rate	NW	North West
GM	Greater Manchester	ONS	Office for National Statistic
GMJCT	Greater Manchester Joint Commissioning Team	OOH	Out of Hours
GP	General Practitioner	PCT	Primary Care Trust
HIV	Human Immunodeficiency Virus	PGD	Patient Group Direction
HWB	Health and Wellbeing Board	PHE	Public Health England
ICB	Integrated Care Board	PNA	Pharmaceutical Needs Assessment
ICS	Integrated Care Service	PQS	Pharmacy Quality Scheme
IMD	Index of Multiple Deprivation	SAC	Stoma Appliance Customisation
JHWS	Joint Health and Wellbeing Strategy	SAR	Standardised Admission Ratio
JSA	Jobseeker Allowance	SMR	Standardised Mortality Rate
JSNA	Joint Strategic Needs Assessment	STDs	Sexually Transmitted Diseases
LA	Local Authority	STIs	Sexually Transmitted Infections
LCS	Locally Commissioned Services	TB	Tuberculosis

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NHS
Greater Manchester

Bury, Oldham and Rochdale PNA Steering Group

Terms of Reference

28th November 2024

NHS Greater Manchester

Terms of reference

Terms of Reference

Name of Group	Bury, Oldham and Rochdale Pharmaceutical Needs Assessment (PNA) Steering Group
Reports to	Reports to the Health and Wellbeing Board (HWB) via the HWB Lead/HWB PNA Champion for each local authority
Bodies reporting to this Group	None
Chair	NHS Greater Manchester Pharmacist
Membership	Representatives from the NHS Greater Manchester Community pharmacy integration and commissioning portfolio team: • Portfolio Lead Pharmacist • Strategic Medicines Optimisation Pharmacist • Senior Medicines Optimisation Pharmacist Representatives from Bury, Oldham and Rochdale local authority public health team. Representatives from Bury, Oldham and Rochdale local authority communications and engagement team. Representative from NHS Greater Manchester Primary Care Contracts Team. Representative from the Local Pharmaceutical Committee (LPC). Representative from Healthwatch.
Function of the group	The primary role of the group is to advise and develop structures and processes to support the preparation of a comprehensive, well researched, well considered and robust pharmaceutical needs assessment, building on

NHS Greater Manchester,
The Tootal Buildings, 56 Oxford Street, Manchester M1 6EU
www.gmintegratedcare.org.uk

	expertise from across the local healthcare community. Establishing the group will also ensure that the views of the main stakeholders are considered throughout the process of writing the document.
Responsibilities/Actions	The NHS Greater Manchester team will lead the development of the PNA and will ask for support from all stakeholders during the process with regards to collating information and reviewing specific areas. The steering group will report directly to the HWB in line with the local authorities usual reporting structures. The HWB will need to decide how much it wishes to delegate to the steering group; for example, does it wish to sign-off the consultation version of the pharmaceutical needs assessment or will it delegate this to the group. The group will identify and report any issues and risks to the HWB that may jeopardise the successful completion of the PNA.
Outputs of the Group	The group will develop a PNA for Bury, Oldham and Rochdale HWB, meeting the statutory requirements specified in 'The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.
Frequency of Meetings	The group will meet via Microsoft teams, and will have email exchanges, as often as required to ensure successful completion of the PNA. As there is local experience of producing PNA's it may not be necessary for the steering group to meet monthly. As HWB's will have experience of producing a PNA, it may only be necessary for there to be a minimum of four meetings. The meeting frequency will be regularly reviewed to ensure that project timelines are met as the work progresses.

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Appendix Three – Public survey results - Bury

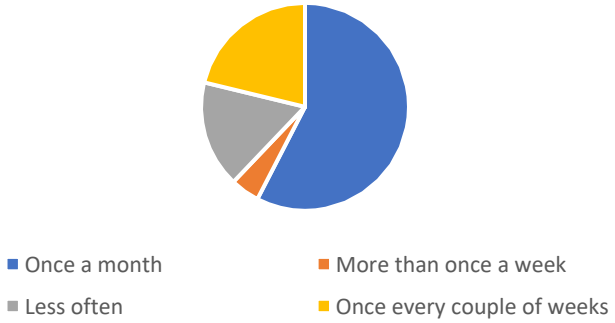
Survey ran 4th February 2025 to 21st March 2025.

There were 71 responses

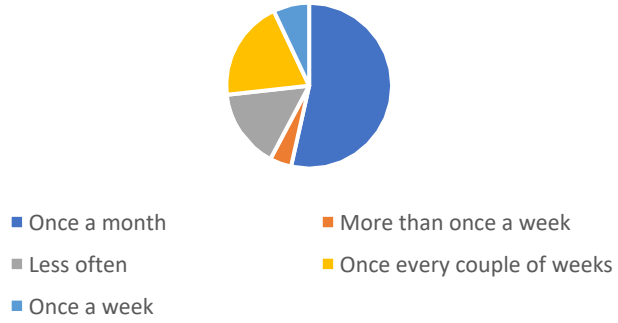
Q1 not included as had 100% yes response

Q2 & Q3 not included as ask postcode and where respondent lives due to use of Pan GM survey

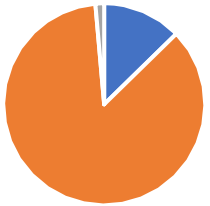
Q4. Why do you use a pharmacy?



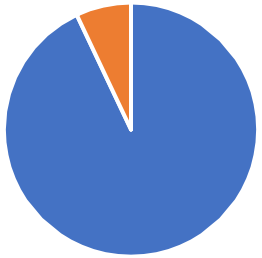
Q5. How often do you use a pharmacy?



Q6. Do you use one pharmacy or a number of pharmacies?



Q7. Do you have problems accessing a pharmacy due to location?



Q8. If you answered 'yes' to Q7, please explain why:

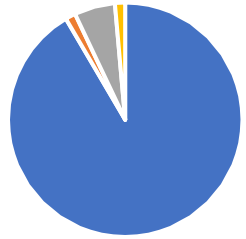
- Disabled mobility issues
- Mobility problems
- None within walking distance
- Parking issues due to new development in Prestwich
- Due to car park being closed in prestwich for redevelopment and other car park is full with people using the Met

Q9. Do you have problems accessing a pharmacy due to opening hours?

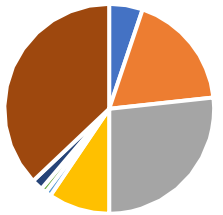
Q10. If you answered 'yes' to Q9, please explain why:

- When you pop there at lunch time but they close for one hour over lunch time or no pharmacist available 1-2pm.
- Not all open weekends
- I work Monday to Friday full time so weekends access work's better for me
- Local pharmacy not open on weekends
- Shut at weekends when best time to visit
- The pharmacy I use does not open at weekends, so i need to go in my lunch hour from work.
- Like them to be open longer hours. Order off the app so not sure how long it takes to arrive
- They are closed on a weekend
- Working
- I HAVE ISSUES GETTING MY MEDICATION AS THEY RUN OUT AT DIFFERENT DATES THEREFORE I AM BACK AND FORTH. AND NOW THEY DONT OPEN ON SATURDAYS.
- Not open on Sundays
- I only use a pharmacy that has good opening hours
- They open 9-6pm no out of hours service

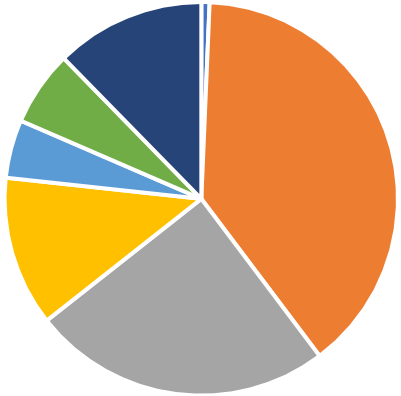
Q11. Do you have any difficulties accessing a pharmacy of your choice?



Q12. If you were unable to access your regular pharmacy, or they didn't have the things you need, what would you do



Q13. Thinking of the pharmacy you use most, tick as many of the following reasons for your choice

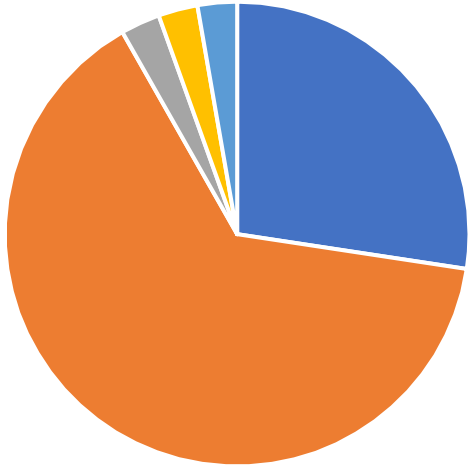


- Near to work
- Near to home
- Near to my doctors
- In town/ shopping area
- In the supermarket
- Good transport links
- Opening times

Q14. Thinking of the pharmacy you use most, tick as many of the following reasons for your choice

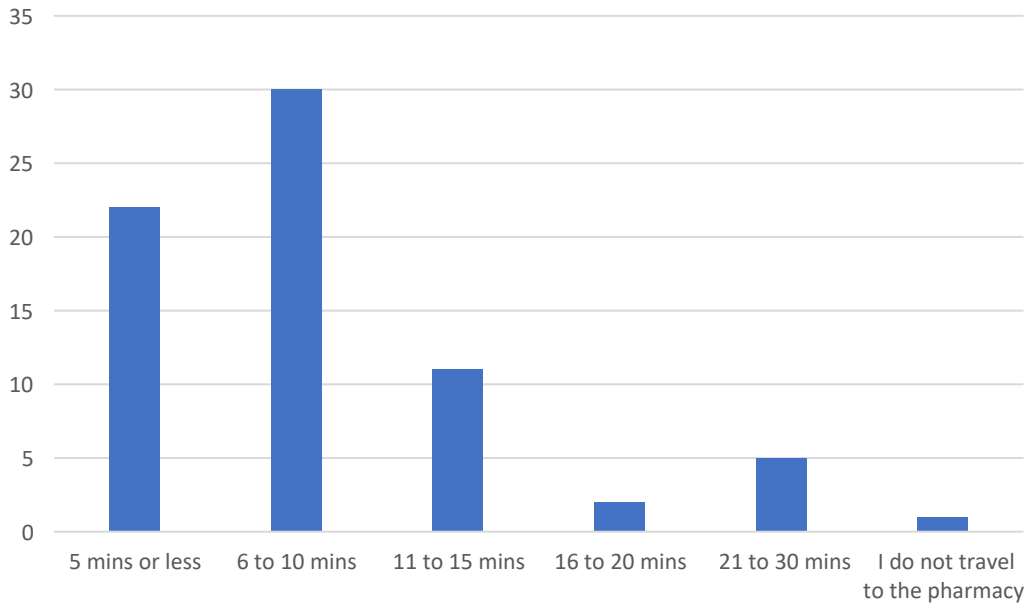
- I do not have to wait long for a walk-in service
- The staff respect my privacy
- The staff are friendly
- The staff are knowledgeable
- The staff speak my first language,
- They offer a prescription collection service
- They offer a delivery service
- They offer another service which I use, please explain why
- N/A I do not use a regular pharmacy

Q15. What is your usual method of travel when you visit a pharmacy?



- Walk
- Motor vehicle (driver or passenger)
- Bus
- Taxi
- I do not travel to a pharmacy

Q16. On average, how long does it normally take you to get to your pharmacy?



Q17. When thinking about the time a pharmacy is open, please tell us which of the following are important to you.

	Essential	Fairly Important	Total of Essential and Fairly Important	Unimportant	Not necessary	Total of Unimportant and Not necessary	Not sure
Weekday: Early Morning (before 9am)	13%	20%	33%	24%	35%	59%	8%
Weekday: During the day	70%	17%	87%	3%	6%	9%	4%
Weekday: Lunchtime	24%	28%	53%	18%	21%	39%	8%
Weekday: Early evening between 6pm and 9pm	17%	37%	54%	15%	24%	39%	7%
Weekday: Late evening after 9pm	4%	25%	29%	23%	37%	60%	11%
Saturday: Early Morning (before 9am)	7%	23%	30%	23%	38%	61%	9%
Saturday: Morning	35%	34%	69%	6%	20%	26%	5%
Saturday: Afternoon	22%	35%	57%	12%	23%	35%	8%
Saturday: Evening after 6pm	7%	25%	32%	24%	32%	56%	12%
Sunday: Early Morning (before 9am)	8%	11%	19%	24%	44%	68%	13%
Sunday: Morning	13%	35%	48%	14%	28%	42%	10%
Sunday: Afternoon	11%	28%	39%	14%	37%	51%	10%
Sunday: Evening after 6pm	4%	15%	19%	23%	45%	68%	13%
Bank Holidays: Early Morning (before 9am)	7%	20%	27%	24%	40%	64%	9%
Bank Holidays: Morning	11%	31%	42%	20%	28%	48%	10%
Bank Holidays: Afternoon	8%	30%	38%	20%	32%	52%	90%
Bank Holidays: Evening after 6pm	4%	18%	22%	28%	37%	65%	13%

Q18. Please tell us which of the following are important to you

	Essential	Fairly Important	Unimportant	Not necessary	Not sure
Convenient location	51	14	2	0	4
Parking	36	18	5	8	4
Friendly staff	41	16	5	6	3
Short waiting times	35	26	4	4	2
Private area to speak to the pharmacist	35	21	4	7	4
Seeing my regular pharmacist if I want to	18	22	15	11	5
Providing clear advice on my prescription and over the counter medicines	35	25	1	8	2
Being able to use it in an emergency	34	24	2	7	4

Q19. How satisfied are you with each of the following aspects of service at your regular pharmacy, from very satisfied to very unsatisfied?

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied	N/A
Being open when you need it	30	29	5	2	5
Location	44	21	1	1	4
Parking facilities	26	22	7	1	15
Knowledge of staff	38	19	2	1	11
Staff attitude	42	16	2	3	8
Waiting times	29	26	3	3	10
Private consultation areas	30	20	5	0	16
The pharmacist / pharmacy staff taking time to talk to you	29	22	3	1	16
The pharmacy having the things you need	30	25	4	1	11
The pharmacist offers advice when need	36	20	1	1	13
Overall pharmacy service	37	20	2	2	10
Physical access into the building	34	21	2	1	13
Being able to use it in an emergency	21	20	8	3	19

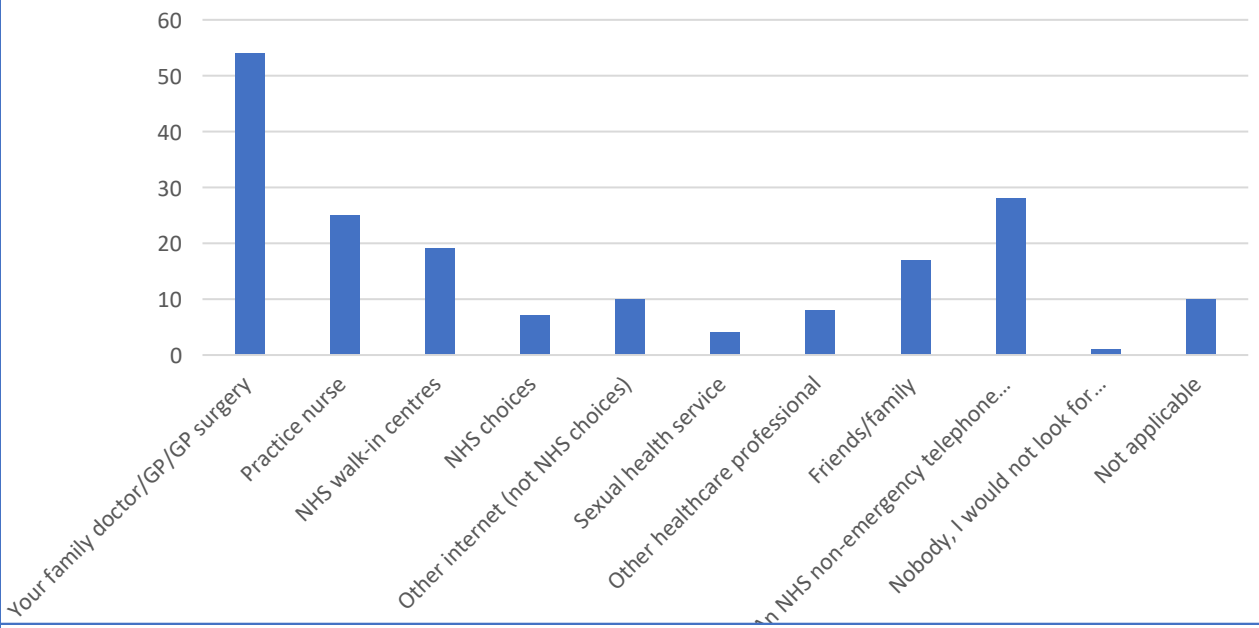
Q20. How often do you use any of the following services available from your pharmacy?

	Used in the last three months	Used in the last year	Not used in the last year but may need to use in the future	Not used in the last year and not relevant to my needs	I don't know what this is
Delivery of medicines to my home	14	2	13	37	5
Purchased Over the Counter medicines	39	19	3	8	2
Electronic Repeat Dispensing	44	1	2	18	6
Collection of regular prescription medicines	55	1	1	11	3
Collection of occasional prescription medicines	39	12	4	13	3
NHS Urgent medicine supply	15	8	13	25	10
Dispose of unwanted medication	5	7	19	35	5
Emergency Hormonal Contraception (morning after pill)	1	0	5	61	4
Chlamydia testing or treatment	0	0	4	63	4
Condom distribution service	0	0	6	61	4
Contraception	2	0	6	59	4
Pharmacy First Service	3	5	16	26	21
Minor Ailment Scheme (Access to certain free over the counter medicines to avoid a GP visit when eligible)	11	7	13	26	14
Stop Smoking Service	2	1	4	59	5
Substance Misuse Service e.g. Observed Consumption of Medication, needle exchange service	0	0	4	61	6
Early morning opening (before 9am)	5	6	13	44	3
Late night opening (after 7pm)	6	9	18	34	4
Saturday opening	26	16	11	16	2
Sunday opening	9	7	18	32	5
Bank Holiday opening	5	8	19	35	4

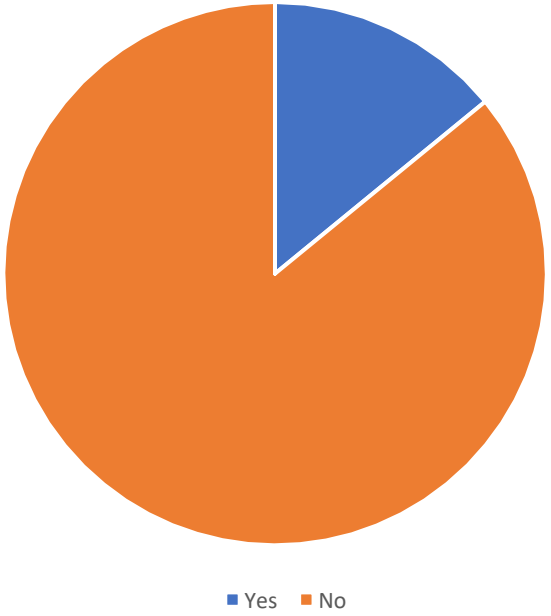
Q21. How often do you use any of the following services available from your pharmacy

	Used in the last three months	Used in the last year	Not used in the last year but may need to use in the future	Not used in the last year and not relevant to my needs	I don't know what this is
Blood Pressure Check	5	8	28	29	1
Lateral Flow Device (NHS Service)	0	4	16	47	4
Flu Vaccine	7	15	18	30	1
COVID Vaccine	8	12	19	31	1
New Medicine Service	4	2	14	30	21
Diabetes Screening	1	0	23	43	4
Healthy Weight advice	1	0	19	48	3
Health Tests, e.g. cholesterol	1	0	28	38	4
Long term condition advice	4	1	23	39	4
Sharps Bin Disposal	1	0	9	58	3
Palliative Care Medicines	0	1	11	57	2
Referral from NHS 111	1	3	18	45	4
Other	0	1	12	45	13

Q22. If you don't go to a pharmacy for any services, who or which organisation, if any, would you contact if you wished to get information:



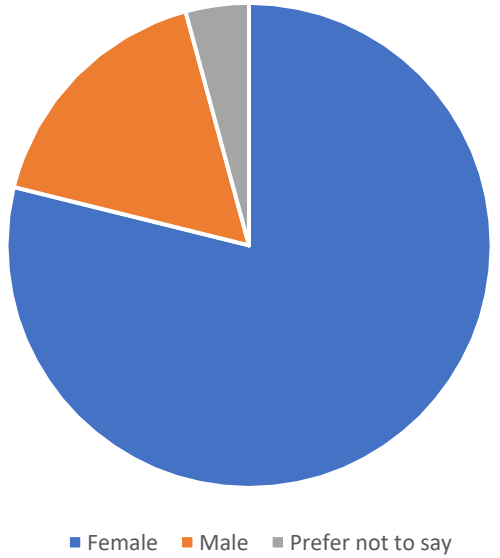
Q23. Are there any other services you would like your pharmacy to offer?



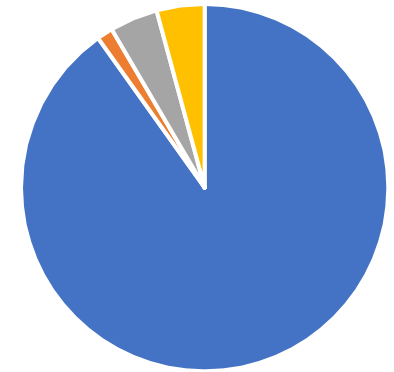
Q24. If Yes to Q23, please explain

- Minor skin conditions. They say they do but just refer you to GP.
- Weekend opening
- Basically be there to help as the GP never has appointments or the out of hours since they shut them
- Open on a Saturday
- I would like to know exactly what services they can provide. Perhaps some leaflets or posters in the pharmacy.
- Blood tests
- Pharmacy stopped delivery service but this was useful when working
- Products for Stoma
- It has been brought to my attention that our pharmacies across Bury are going to be unable to process repeat prescription orders. I think this is a real shame as my elderly parents rely on this service and it is not going to make getting their regular prescriptions very easy for either them or for myself to order them for them. It was a good service and such a shame that Bury GPs are stopping this.
- Advise when medication is not available

Q25. Gender

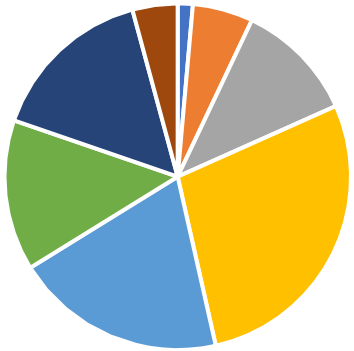


Q26. Do you identify with the sex you were assigned at birth? (e.g. Male or Female)



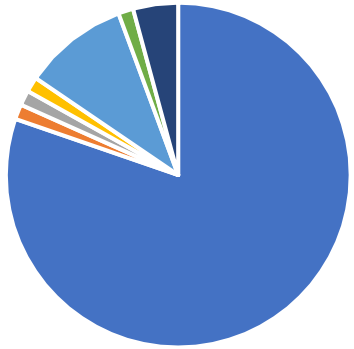
Yes No Prefer not to say Blank

Q27. Age



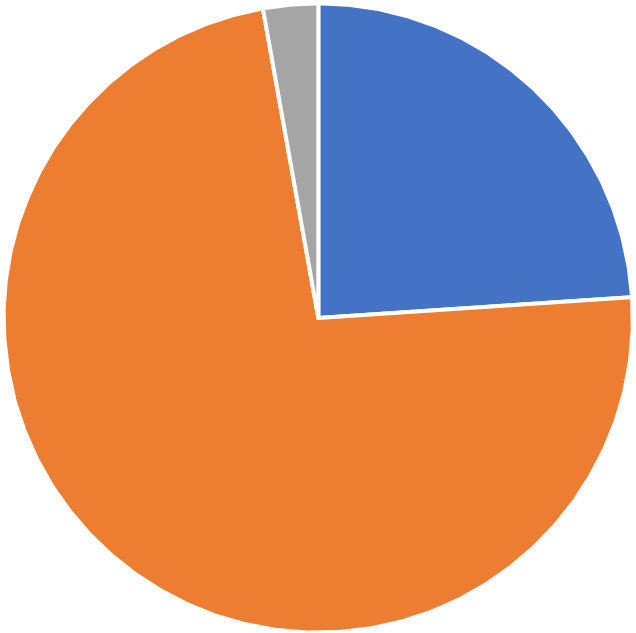
18-24 years 25-34 years 35-44 years 45-54 years
55-64 years 65-74 years 75+ years Prefer not to say

Q28. Ethnic origin



White: British
White: Irish
White: Other White
Mixed or Multiple ethnic groups: White and Black African
Asian, Asian British: Pakistani
Black, Black British: Other Black
Prefer not to say

Q29. Do you consider yourself to be disabled?

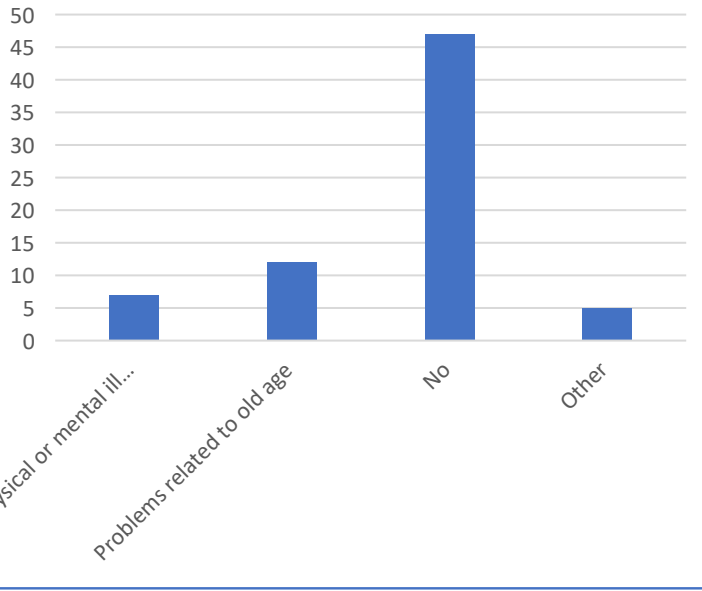


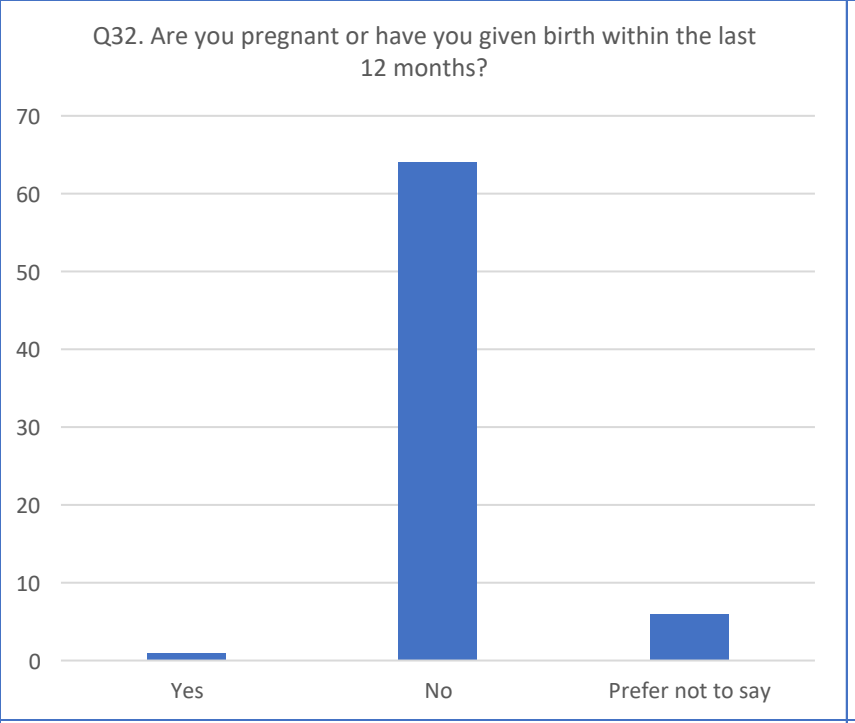
Yes No Prefer not to say

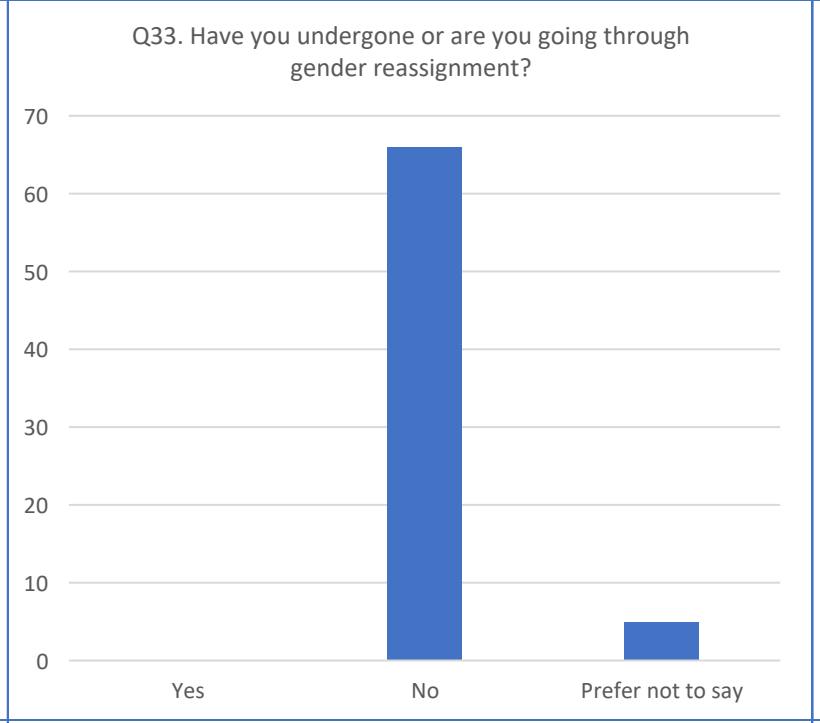
Q30. Please indicate your disability and/or long-lasting illness

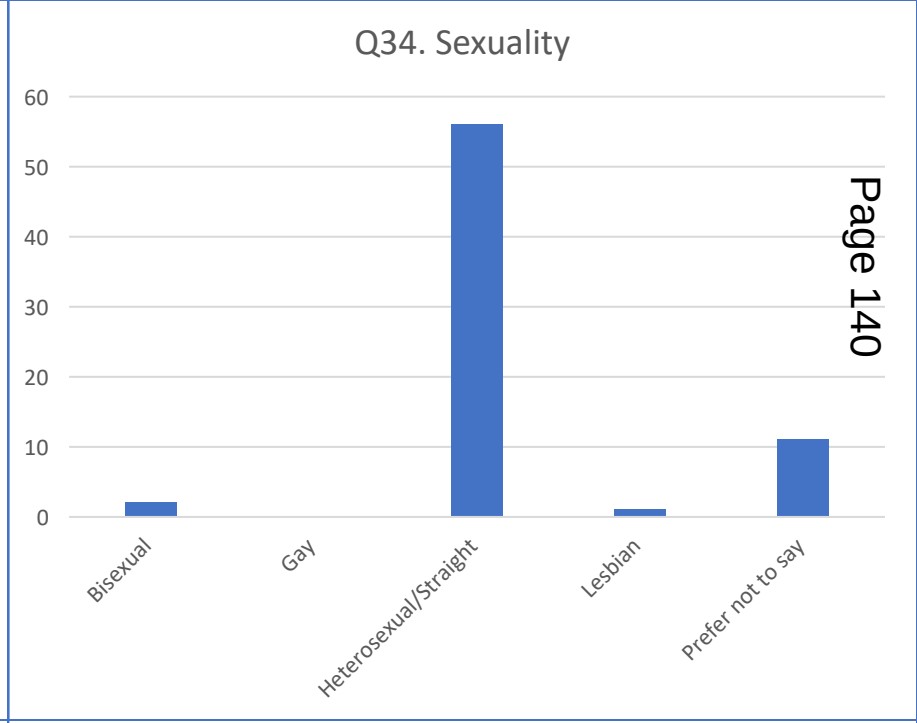
Hearing (e.g. due to deafness or partial hearing)
Mobility, such as difficulty walking short distances, climbing stairs, lifting and carrying objects
Learning or concentrating or remembering
Mental Health
Prefer not to say
Other

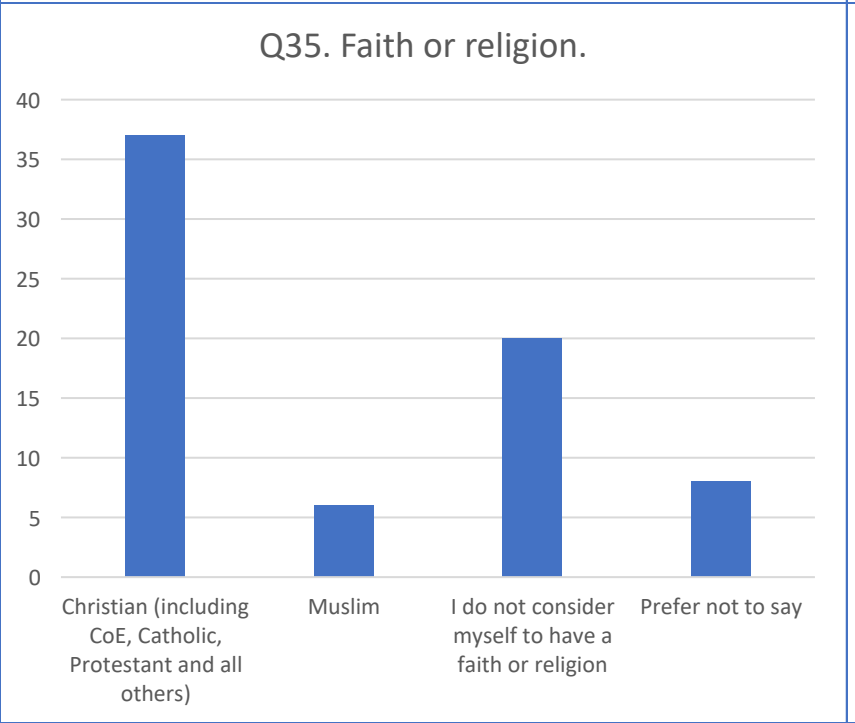
Q31. Do you look after, or give any help or support to family members, friends, neighbours or others?

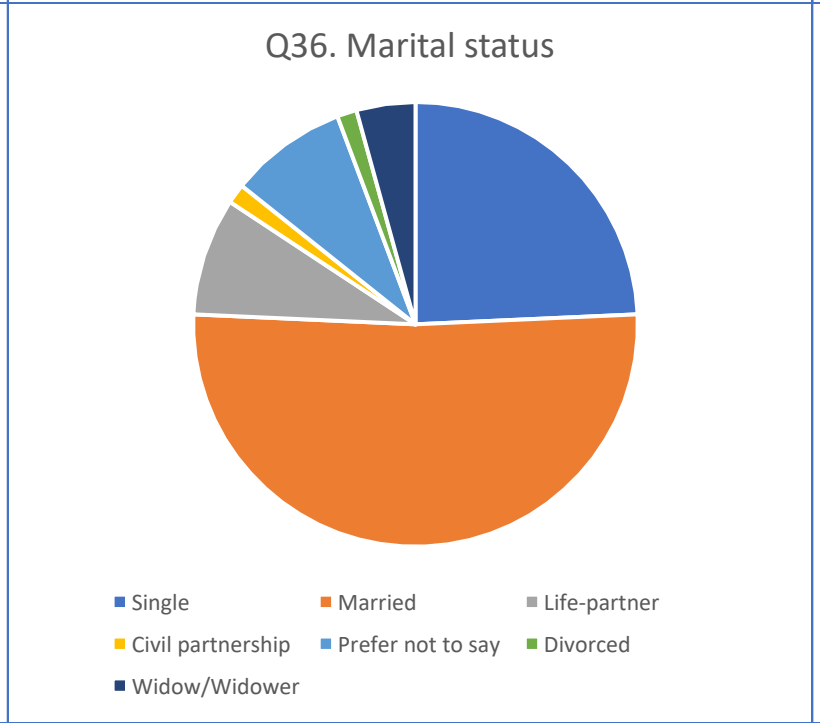


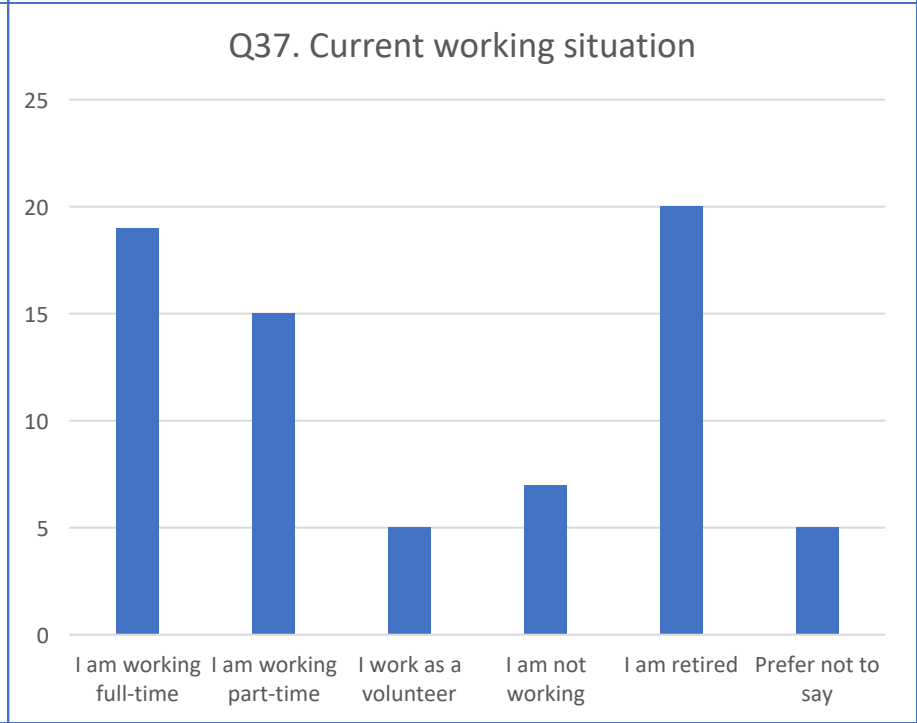

Q32. Are you pregnant or have you given birth within the last 12 months?
70
60
50
40
30
20
10
0
Yes
No
Prefer not to say


Q33. Have you undergone or are you going through gender reassignment?
70
60
50
40
30
20
10
0
Yes
No
Prefer not to say

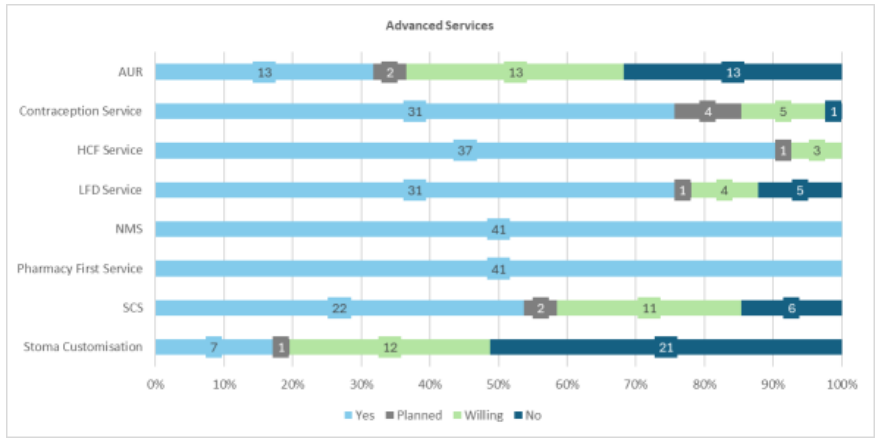

Q34. Sexuality
60
50
40
30
20
10
0
Bisexual
Gay
Heterosexual/Straight
Lesbian
Prefer not to say

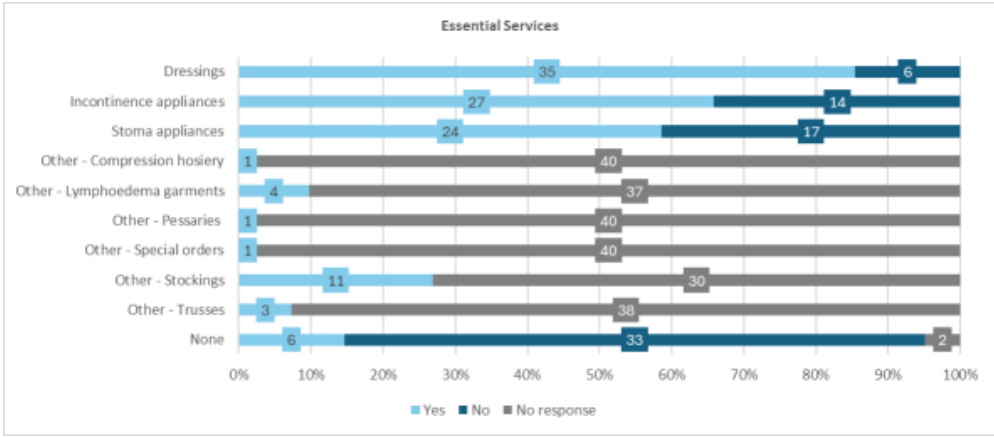

Q35. Faith or religion.
40
35
30
25
20
15
10
5
0
Christian (including CoE, Catholic, Protestant and all others)
Muslim
I do not consider myself to have a faith or religion
Prefer not to say

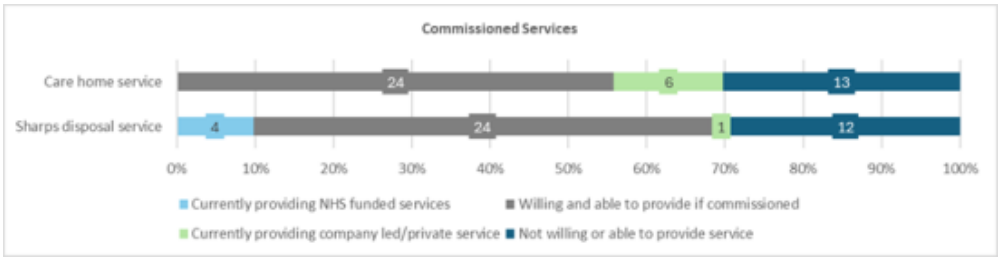

Q36. Marital status
Single
Married
Life-partner
Civil partnership
Prefer not to say
Divorced
Widow/Widower

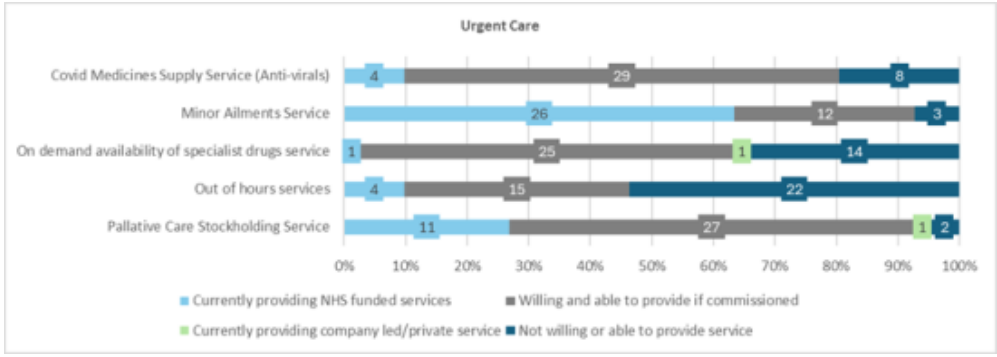

Q37. Current working situation
25
20
15
10
5
0
I am working full-time
I am working part-time
I work as a volunteer
I am not working
I am retired
Prefer not to say

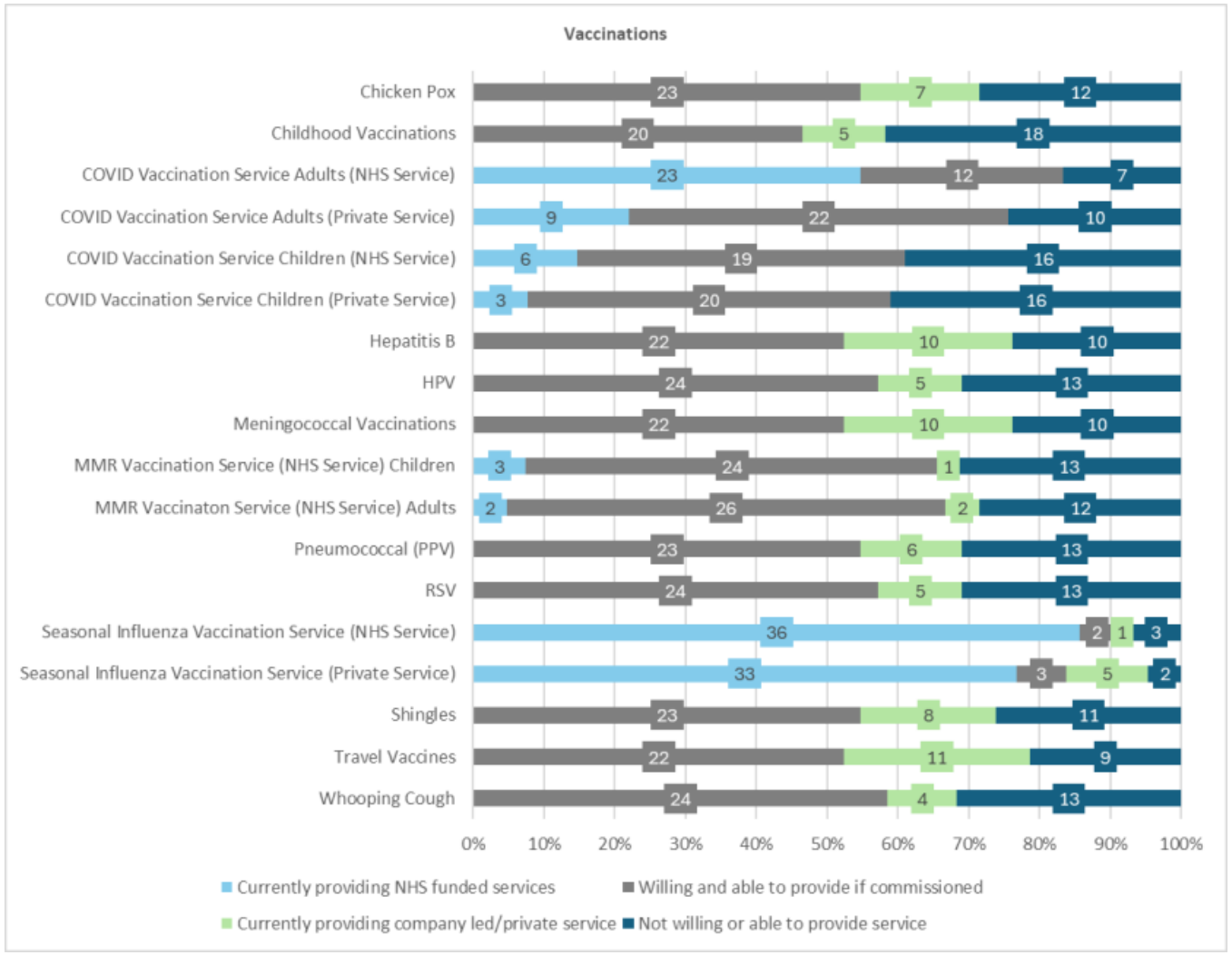
Appendix 4 – Pharmacy Survey Results

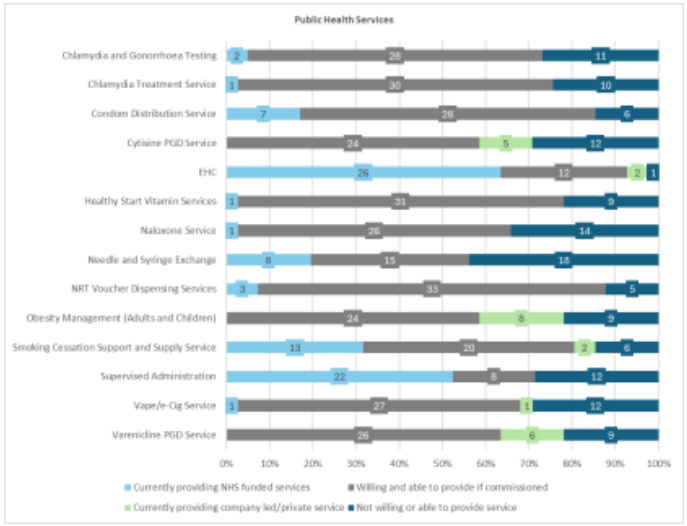


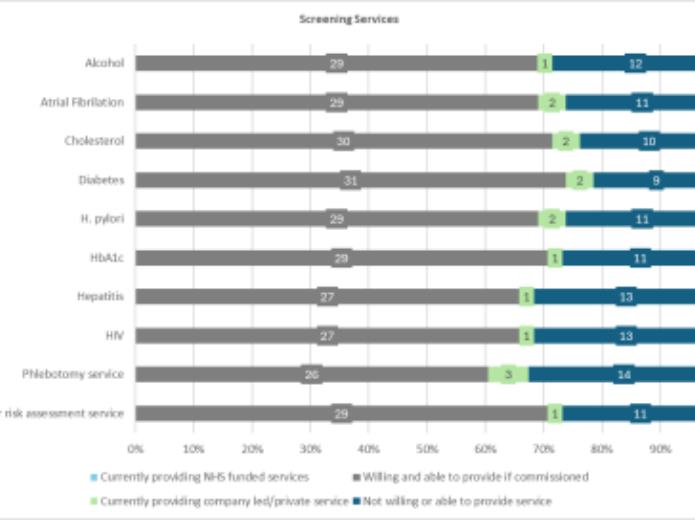


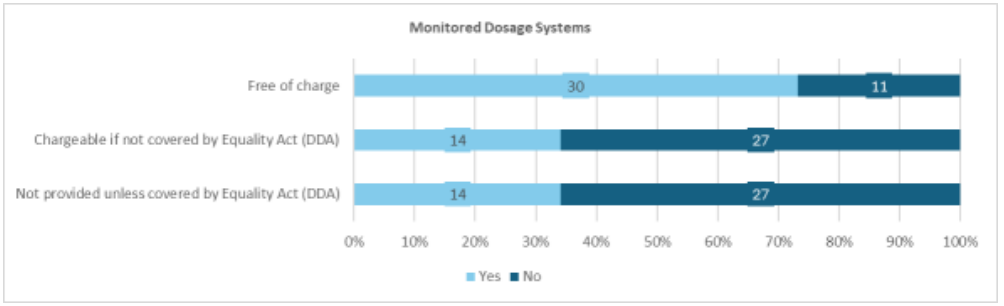


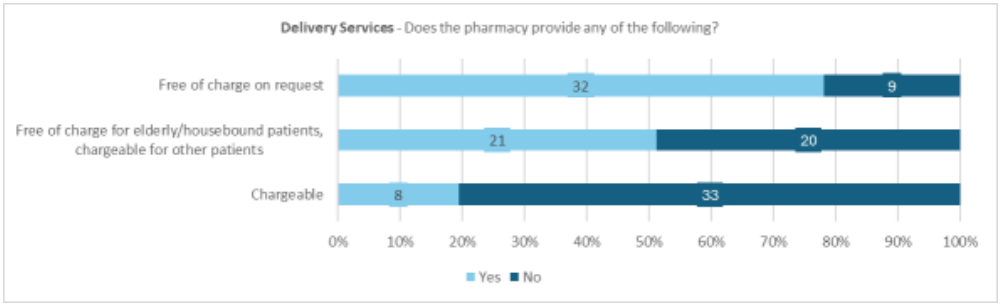


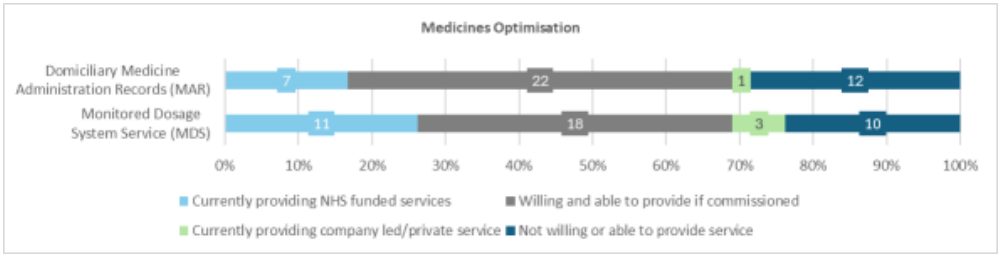

Vaccinations
Chicken Pox 23 7 12
Childhood Vaccinations 20 5 18
COVID Vaccination Service Adults (NHS Service) 23 12 7
COVID Vaccination Service Adults (Private Service) 9 22 10
COVID Vaccination Service Children (NHS Service) 6 19 16
COVID Vaccination Service Children (Private Service) 3 20 16
Hepatitis B 22 10 10
HPV 24 5 13
Meningococcal Vaccinations 22 10 10
MMR Vaccination Service (NHS Service) Children 3 24 1 13
MMR Vaccinaton Service (NHS Service) Adults 2 26 2 12
Pneumococcal (PPV) 23 6 13
RSV 24 5 13
Seasonal Influenza Vaccination Service (NHS Service) 36 2 1 3
Seasonal Influenza Vaccination Service (Private Service) 33 3 5 2
Shingles 23 8 11
Travel Vaccines 22 11 9
Whooping Cough 24 4 13
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Currently providing NHS funded services
Willing and able to provide if commissioned
Currently providing company led/private service
Not willing or able to provide service

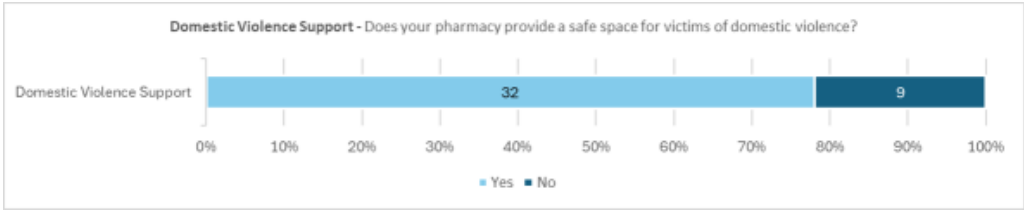

Public Health Services
Chlamydia and Gonorrhoea Testing 2 28 11
Chlamydia Treatment Service 1 30 10
Condom Distribution Service 7 28 6
Cytisine PGD Service 24 5 12
EHC 26 12 2 1
Healthy Start Vitamin Services 1 31 9
Naloxone Service 1 26 14
Needle and Syringe Exchange 8 15 18
NRT Voucher Dispensing Services 3 33 5
Obesity Management (Adults and Children) 24 8 9
Smoking Cessation Support and Supply Service 13 20 2 6
Supervised Administration 22 8 12
Vape/e-Cig Service 1 27 1 12
Varenicline PGD Service 26 6 9
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Currently providing NHS funded services
Willing and able to provide if commissioned
Currently providing company led/private service
Not willing or able to provide service

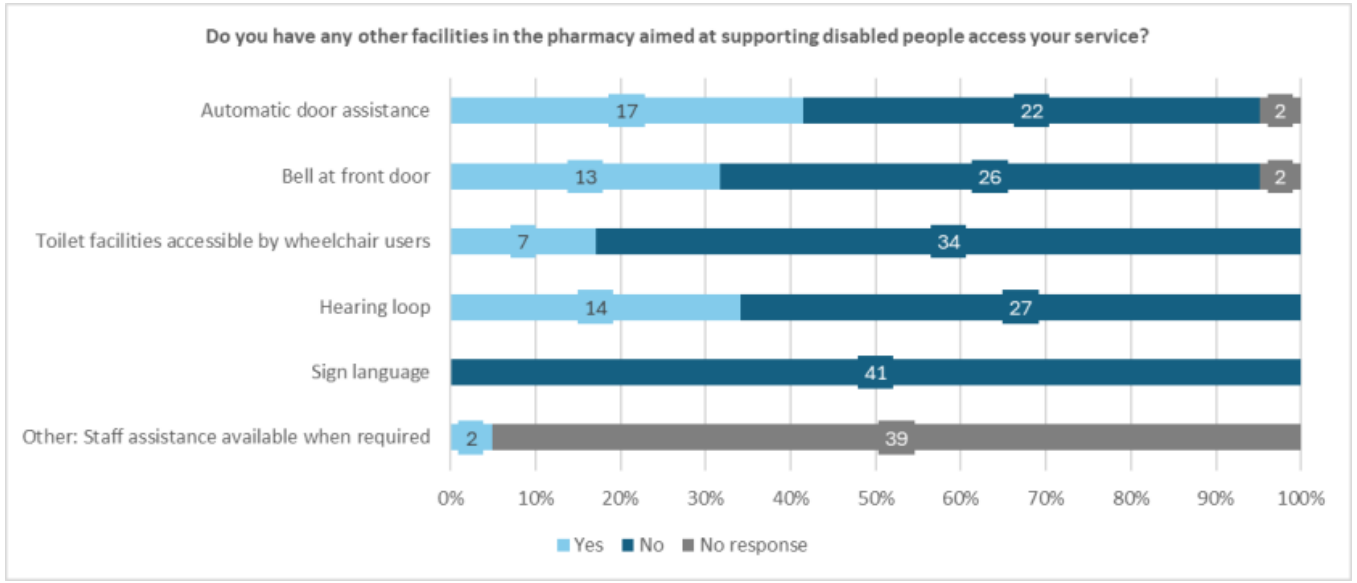

Screening Services
Alcohol 29 1 12
Atrial Fibrillation 29 2 11
Cholesterol 30 2 10
Diabetes 31 2 9
H. pylori 29 2 11
HbA1c 29 1 11
Hepatitis 27 1 13
HIV 27 1 13
Phlebotomy service 26 3 14
Vascular risk assessment service 29 1 11
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Currently providing NHS funded services
Willing and able to provide if commissioned
Currently providing company led/private service
Not willing or able to provide service

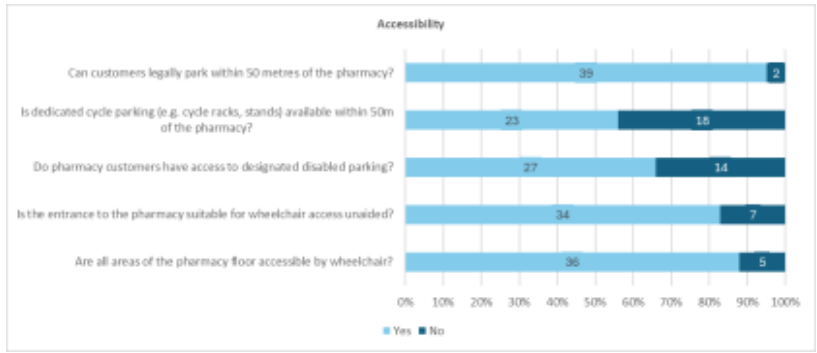

Monitored Dosage Systems
Free of charge
30
11
Chargeable if not covered by Equality Act (DDA)
14
27
Not provided unless covered by Equality Act (DDA)
14
27
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
No

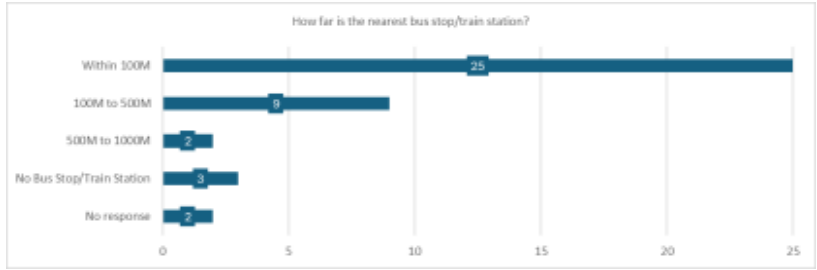

Delivery Services - Does the pharmacy provide any of the following?
Free of charge on request
32
9
Free of charge for elderly/housebound patients, chargeable for other patients
21
20
Chargeable
8
33
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
No

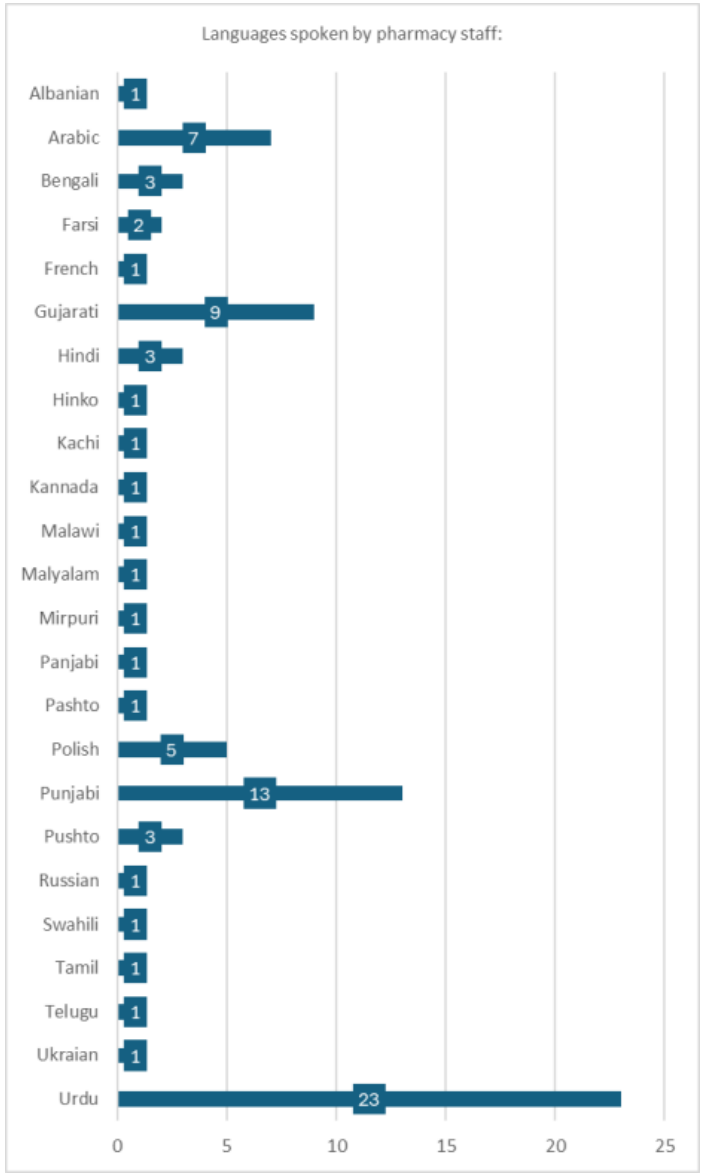

Medicines Optimisation
Domiciliary Medicine Administration Records (MAR)
7
22
1
12
Monitored Dosage System Service (MDS)
11
18
3
10
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Currently providing NHS funded services
Willing and able to provide if commissioned
Currently providing company led/private service
Not willing or able to provide service

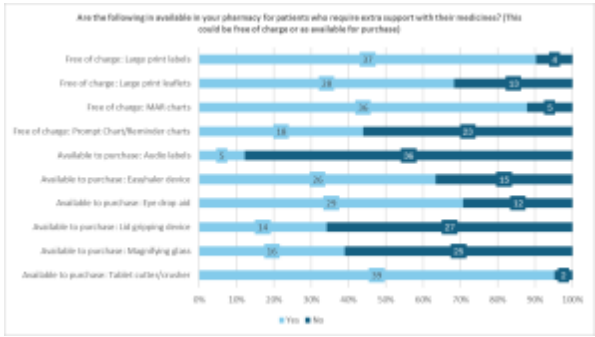

Domestic Violence Support - Does your pharmacy provide a safe space for victims of domestic violence?
Domestic Violence Support
32
9
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
No

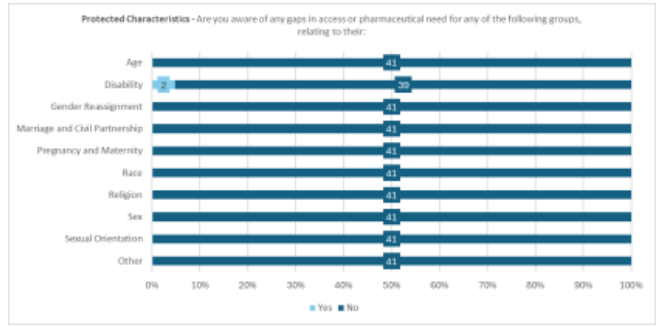

Do you have any other facilities in the pharmacy aimed at supporting disabled people access your service?
Automatic door assistance
17
22
2
Bell at front door
13
26
2
Toilet facilities accessible by wheelchair users
7
34
Hearing loop
14
27
Sign language
41
Other: Staff assistance available when required
2
39
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
No
No response

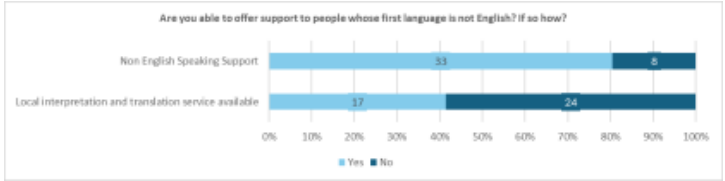

Accessibility
Can customers legally park within 50 metres of the pharmacy?
39
2
Is dedicated cycle parking (e.g. cycle racks, stands) available within 50m of the pharmacy?
23
18
Do pharmacy customers have access to designated disabled parking?
27
14
Is the entrance to the pharmacy suitable for wheelchair access unaided?
34
7
Are all areas of the pharmacy floor accessible by wheelchair?
36
5
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
No

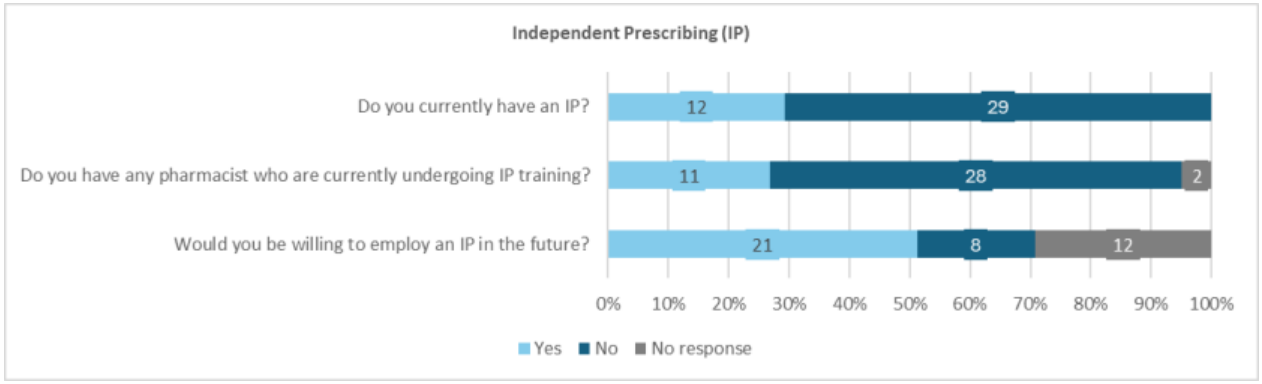

How far is the nearest bus stop/train station?
Within 100M
25
100M to 500M
9
500M to 1000M
2
No Bus Stop/Train Station
3
No response
2
0
5
10
15
20
25


Languages spoken by pharmacy staff:
Albanian 1
Arabic 7
Bengali 3
Farsi 2
French 1
Gujarati 9
Hindi 3
Hinko 1
Kachi 1
Kannada 1
Malawi 1
Malyalam 1
Mirpuri 1
Panjabi 1
Pashto 1
Polish 5
Punjabi 13
Pushto 3
Russian 1
Swahili 1
Tamil 1
Telugu 1
Ukraian 1
Urdu 23
0 5 10 15 20 25


Are the following is available in your pharmacy for patients who require extra support with their medicines? (This could be free of charge or as available for purchase)
Free of charge: Large print labels 37 4
Free of charge: Large print leaflets 28 10
Free of charge: MAR charts 36 5
Free of charge: Prompt Chart/Reminder charts 18 23
Available to purchase: Auxiliy labels 5 36
Available to purchase: Easyhaler device 26 15
Available to purchase: Eye drop aid 25 17
Available to purchase: Lid gripping device 14 27
Available to purchase: Magnifying glass 16 26
Available to purchase: Tablet cutter/crusher 38 3
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Yes No


Protected Characteristics - Are you aware of any gaps in access or pharmaceutical need for any of the following groups, relating to their:
Age 41
Disability 2 39
Gender Reassignment 41
Marriage and Civil Partnership 41
Pregnancy and Maternity 41
Race 41
Religion 41
Sex 41
Sexual Orientation 41
Other 41
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Yes No


Are you able to offer support to people whose first language is not English? If so how?
Non English Speaking Support 33 8
Local interpretation and translation service available 17 24
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Yes No



Scope of practice	
COPD	1
Hypertension	2
Asthma	2
Weight management	2
Travel clinic/vaccinations	2
Sexual health	1
Sexual dysfunction	1

Potential for increased demand - If there was increased demand for pharmaceutical services (e.g. dispensing, advanced and locally commissioned services) in your local area; through new housing developments, nearby pharmacies closing, etc. demand in your pharmacy may increase. With this in mind please select the option that best reflects your situation at the moment:	
We have sufficient capacity within our existing premises and staffing levels to manage an increase in demand in our area	32
We don't have sufficient premises and staffing capacity at present but could make adjustments to manage an increase in demand in our area	6
We don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand	3

If you have anything else you would like to tell us that you think would be useful in the formulation of the PNA, please include it here:
Recently, GP surgeries have altered their prescription ordering process, resulting in pharmacies being unable to directly order patients' prescribed medications. This change has significantly reduced access to essential monthly repeat medications for many patients. As a consequence, patients have gone without their medications for over two days, and prescriptions are often not arriving on time. This disruption also means we are unable to prepare blister packs for patients, as doing so would pose a safety risk.

Appendix 5 – Enhanced and locally commissioned services

Bury Council	EHC	Emergency hormonal contraception	GM ICB	PC	Palliative care medicines stockholding
Bury Council	SC	Supervised consumption	GM ICB	MAS	Minor ailment service
Bury Council	NE	Needle exchange	GM ICB	MECS	Minor eye condition service
			GM ICB	COVID	COVID medicines delivery - Medicines supply following referral via NHS Mail

Neighbourhood	Ward	Map Index*	Trading Name	Postcode	EHC	SC	NE	PC	MAS	MECS	COVID
East Bury	Bury East	2	Asda Pharmacy	BL9 0RN	✗	✗	✗	✗	✓	✓	✗
East Bury	Bury East	4	Boots the Chemist	BL9 0QQ	✓	✗	✗	✗	✓	✓	✗
East Bury	Bury East	10	Cohens Chemist	BL9 0SN	✓	✓	✗	✗	✓	✓	✗
East Bury	Bury East	20	IQ Pharmacy	BL9 0QL	✓	✓	✗	✗	✓	✓	✗
East Bury	Bury East	27	Moorgate Pharmacy	BL9 0NJ	✓	✓	✗	✗	✓	✓	✗
East Bury	Bury East	25	Medi Home Pharmacy	BL9 0RE	✗	✗	✗	✗	✗	✗	✗
East Bury	Bury East	28	Pimhole Pharmacy	BL9 7BB	✗	✓	✗	✓	✗	✗	✗
East Bury	Moorside	5	Boots the Chemist	BL9 5BY	✓	✗	✗	✗	✓	✓	✗
East Bury	Moorside	6	Bury Healthcare Pharmacy	BL9 6DP	✓	✗	✗	✗	✗	✗	✗
East Bury	Moorside	7	Bury Pharmacy	BL9 5AS	✗	✗	✗	✗	✗	✗	✗
East Bury	Moorside	19	Huntley Mount Pharmacy	BL9 6JA	✓	✓	✓	✗	✓	✓	✗
East Bury	Moorside	35	Strachan's Chemist	BL9 6LL	✓	✓	✗	✗	✓	✓	✗
East Bury	Moorside	36	Tesco In-Store Pharmacy	BL9 5BY	✗	✓	✗	✗	✓	✗	✗
East Bury	Redvales	14	Fishpool Pharmacy	BL9 9AX	✓	✓	✗	✗	✓	✓	✗
East Bury	Redvales	29	Postbox Pharmcare Ltd	BL9 9AA	✗	✗	✗	✗	✓	✗	✗
Bury North	Elton	16	Futurecare Pharmacy	BL8 1SW	✗	✗	✗	✗	✗	✗	✗
Bury North	Elton	24	Manor Pharmacy	BL8 1HS	✓	✗	✗	✗	✓	✓	✗
Bury North	North Manor	17	Gardners Chemist	BL8 4DD	✗	✗	✗	✗	✗	✓	✗
Bury North	North Manor	22	Manor Pharmacy	BL8 4DS	✗	✗	✗	✗	✗	✓	✗
Bury North	Ramsbottom	9	Cohens Chemist	BL0 9AJ	✓	✓	✗	✗	✗	✓	✗

Bury North	Tottington	8	Cohens Chemist	BL8 4AD	✗	✓	✗	✗	✗	✗	✗
Bury West	Bury West	26	Mile Lane Pharmacy	BL8 2JR	✗	✗	✗	✗	✓	✓	✗
Bury West	Radcliffe North and Ainsworth	23	Manor Pharmacy	M26 4FD	✓	✓	✓	✗	✗	✗	✗
Bury West	Radcliffe East	32	Radcliffe Pharmacy	M26 2RF	✓	✓	✗	✗	✓	✓	✗
Bury West	Radcliffe East	31	Radcliffe Pharmacy	M26 2SP	✓	✓	✓	✗	✓	✓	✓
Bury West	Radcliffe East	38	Well	M26 2SP	✓	✓	✗	✗	✓	✓	✗
Bury West	Radcliffe West	1	Asda Pharmacy	M26 3DA	✗	✗	✗	✓	✗	✓	✗
Bury West	Radcliffe West	21	JT Smith & Son	M26 4DJ	✗	✗	✗	✗	✗	✗	✗
Prestwich	Holyrood	41	Wise Pharmacies Ltd	M25 1NL	✓	✗	✗	✗	✗	✗	✗
Prestwich	Sedgley	12	Cohens Chemist	M25 0HT	✓	✗	✗	✗	✓	✗	✗
Prestwich	Sedgley	13	Dennis Gore Chemists	M25 1FX	✓	✗	✗	✗	✓	✓	✗
Prestwich	Sedgley	15	Formans Chemist	M25 0FX	✗	✗	✗	✗	✓	✓	✗
Prestwich	Sedgley	34	Sedgley Park Pharmacy	M25 9JY	✓	✓	✗	✗	✓	✓	✗
Prestwich	St Mary's	30	Prestwich Pharmacy	M25 1AY	✓	✓	✓	✓	✓	✓	✗
Prestwich	St Mary's	37	Tesco In-Store Pharmacy	M25 7BL	✗	✗	✗	✗	✗	✗	✗
Whitefield	Besses	40	Whitefield Pharmacy	M45 8NE	✓	✓	✗	✗	✓	✓	✗
Whitefield	Pilkington Park	18	Greenleaf Pharmacy	M45 6QJ	✗	✓	✗	✗	✓	✗	✗
Whitefield	Unsworth	3	Asda Pharmacy	BL9 8RS	✗	✗	✗	✗	✗	✓	✗
Whitefield	Unsworth	11	Cohens Chemist	BL9 8QA	✓	✗	✗	✗	✓	✓	✗
Whitefield	Unsworth	33	Rowlands Pharmacy	BL9 8JR	✗	✗	✗	✗	✓	✓	✗
Whitefield	Unsworth	39	Well	M45 7TA	✗	✓	✗	✗	✗	✓	✗

*Map index relates to map 3 (section 4.1)

Appendix 6 – Bury Pharmacies

Neighbourhood	Ward	Map Index*	Trading Name	Address of Contractor	Postcode	Contractor Type
East Bury	Bury East	2	Asda Pharmacy	Spring Street	BL9 0RN	Community - 100 hr
East Bury	Bury East	4	Boots the Chemist	32-36 The Mall	BL9 0QQ	Community - 40 hr
East Bury	Bury East	10	Cohens Chemist	Townside PCC, 3 Knowsley Place	BL9 0SN	Community - 40 hr
East Bury	Bury East	20	IQ Pharmacy	14 Princess Parade	BL9 0QL	Community - 40 hr
East Bury	Bury East	27	Moorgate Pharmacy	Moorgate PCC, 22 Derby Way	BL9 0NJ	Community - 40 hr
East Bury	Bury East	25	Medi Home Pharmacy	Remmets House, Unit 1, Lord Street	BL9 0RE	Distance selling
East Bury	Bury East	28	Pimhole Pharmacy	189 Rochdale Road	BL9 7BB	Community - 100 hr
East Bury	Moorside	5	Boots the Chemist	Unit 1 Woodfields Retail Park, Peel Way	BL9 5BY	Community - 100 hr
East Bury	Moorside	6	Bury Healthcare Pharmacy	46 Walmersley Road	BL9 6DP	Community - 100 hr
East Bury	Moorside	7	Bury Pharmacy	First Floor, 65 Canning Street	BL9 5AS	Distance selling
East Bury	Moorside	19	Huntley Mount Pharmacy	Huntley Mount Road	BL9 6JA	Community - 40 hr
East Bury	Moorside	35	Strachan's Chemist	Chesham Precinct, 166a Walmersley Road	BL9 6LL	Community - 40 hr
East Bury	Moorside	36	Tesco In-Store Pharmacy	Peel Way	BL9 5BY	Community - 40 hr
East Bury	Redvales	14	Fishpool Pharmacy	14 Parkhills Road	BL9 9AX	Community - 40 hr
East Bury	Redvales	29	Postbox Pharmcare Ltd	235 Market Street	BL9 9AA	Distance selling
Bury North	Elton	16	Futurecare Pharmacy	14a Whitelegge Street	BL8 1SW	Distance selling
Bury North	Elton	24	Manor Pharmacy	367 Brandlesholme Road	BL8 1HS	Community - 40 hr
Bury North	North Manor	17	Gardners Chemist	6 Vernon Road	BL8 4DD	Community - 40 hr
Bury North	North Manor	22	Manor Pharmacy	1 Brandlesholme Road	BL8 4DS	Community - 40 hr
Bury North	Ramsbottom	9	Cohens Chemist	7 Market Place	BL0 9AJ	Community - 40 hr
Bury North	Tottington	8	Cohens Chemist	12-14 Market Street	BL8 4AD	Community - 40 hr
Bury West	Bury West	26	Mile Lane Pharmacy	66 Mile Lane	BL8 2JR	Community - 40 hr
Bury West	Radcliffe North and Ainsworth	23	Manor Pharmacy	157-159 Ainsworth Road, Radcliffe	M26 4FD	Community - 40 hr
Bury West	Radcliffe East	32	Radcliffe Pharmacy	62 Cross Lane	M26 2RF	Community - 40 hr
Bury West	Radcliffe East	31	Radcliffe Pharmacy	47 - 49 Church Street West	M26 2SP	Community - 40 hr
Bury West	Radcliffe East	38	Well	Radcliffe PCC, Church Street West	M26 2SP	Community - 40 hr
Bury West	Radcliffe West	1	Asda Pharmacy	Riverside Retail Park	M26 3DA	Community - 40 hr
Bury West	Radcliffe West	21	JT Smith & Son	8-8a Ainsworth Road	M26 4DJ	Community - 40 hr
Prestwich	Holyrood	41	Wise Pharmacies Ltd	474 Bury Old Road	M25 1NL	Community - 40 hr
Prestwich	Sedgley	12	Cohens Chemist	St Gabriel's Medical Centre Pharmacy, 4 Bishop's Road	M25 0HT	Community - 40 hr

Prestwich	Sedgley	13	Dennis Gore Chemists	26 Whittaker Lane	M25 1FX	Community - 40 hr
Prestwich	Sedgley	15	Formans Chemist	12 Park Hill, Bury Old Road	M25 0FX	Community - 40 hr
Prestwich	Sedgley	34	Sedgley Park Pharmacy	33 Bury New Road	M25 9JY	Community - 40 hr
Prestwich	St Mary's	30	Prestwich Pharmacy	40 Longfield Centre	M25 1AY	Community - 40 hr
Prestwich	St Mary's	37	Tesco In-Store Pharmacy	Bury New Road	M25 7BL	Community - 40 hr
Whitefield	Besses	40	Whitefield Pharmacy	4 Albert Place	M45 8NE	Community - 40 hr
Whitefield	Pilkington Park	18	Greenleaf Pharmacy	166 Bury New Road	M45 6QJ	Community - 40 hr
Whitefield	Unsworth	3	Asda Pharmacy	Pilsworth Road	BL9 8RS	Community - 40 hr
Whitefield	Unsworth	11	Cohens Chemist	135 Croft Lane	BL9 8QA	Community - 40 hr
Whitefield	Unsworth	33	Rowlands Pharmacy	59 Parr Lane	BL9 8JR	Community - 40 hr
Whitefield	Unsworth	39	Well	Unit 1 Elms Square	M45 7TA	Community - 40 hr

*Map index relates to map 3 (section 4.1)

Appendix 7 – Advanced services

PFS	Pharmacy First Service (PFS)	**NMS**	New Medicines Service (NMS)
Flu	Flu vaccination service	**SCS**	Smoking Cessation Service
PCS	Pharmacy Contraception Service (PCS)	**LFD**	Lateral flow device service (LFD)
HCF	Hypertension case-finding service		

Neighbourhood	Ward	Map Index*	Trading Name	Postcode	PFS	Flu	PCS	HCF	NMS	SCS	LFD
East Bury	Bury East	2	Asda Pharmacy	BL9 0RN	✓	✓	✓	✓	✓	✓	✓
East Bury	Bury East	4	Boots the Chemist	BL9 0QQ	✓	✓	✓	✓	✓	✗	✓
East Bury	Bury East	10	Cohens Chemist	BL9 0SN	✓	✓	✓	✓	✓	✗	✗
East Bury	Bury East	20	IQ Pharmacy	BL9 0QL	✓	✓	✓	✓	✓	✓	✗
East Bury	Bury East	27	Moorgate Pharmacy	BL9 0NJ	✓	✓	✓	✓	✓	✓	✓
East Bury	Bury East	25	Medi Home Pharmacy	BL9 0RE	✓	✗	✗	✗	✗	✗	✓
East Bury	Bury East	28	Pimhole Pharmacy	BL9 7BB	✓	✓	✓	✓	✓	✓	✗
East Bury	Moorside	5	Boots the Chemist	BL9 5BY	✓	✓	✓	✓	✓	✗	✓
East Bury	Moorside	6	Bury Healthcare Pharmacy	BL9 6DP	✓	✗	✓	✓	✓	✓	✗
East Bury	Moorside	7	Bury Pharmacy	BL9 5AS	✓	✓	✓	✓	✓	✓	✗
East Bury	Moorside	19	Huntley Mount Pharmacy	BL9 6JA	✓	✓	✓	✓	✓	✗	✗
East Bury	Moorside	35	Strachan's Chemist	BL9 6LL	✓	✓	✓	✓	✓	✓	✓
East Bury	Moorside	36	Tesco In-Store Pharmacy	BL9 5BY	✓	✓	✗	✓	✓	✗	✓
East Bury	Redvales	14	Fishpool Pharmacy	BL9 9AX	✓	✓	✓	✓	✓	✓	✗
East Bury	Redvales	29	Postbox Pharmcare Ltd	BL9 9AA	✓	✗	✓	✓	✓	✓	✗
Bury North	Elton	16	Futurecare Pharmacy	BL8 1SW	✓	✗	✗	✓	✓	✗	✓
Bury North	Elton	24	Manor Pharmacy	BL8 1HS	✓	✓	✓	✓	✓	✗	✓
Bury North	North Manor	17	Gardners Chemist	BL8 4DD	✓	✓	✗	✓	✓	✗	✗
Bury North	North Manor	22	Manor Pharmacy	BL8 4DS	✓	✓	✗	✓	✓	✗	✗
Bury North	Ramsbottom	9	Cohens Chemist	BL0 9AJ	✓	✓	✓	✓	✓	✓	✓
Bury North	Tottington	8	Cohens Chemist	BL8 4AD	✓	✓	✓	✓	✓	✓	✓

Bury West	Bury West	26	Mile Lane Pharmacy	BL8 2JR	✓	✗	✗	✗	✓	✗	✓
Bury West	Radcliffe North and Ainsworth	23	Manor Pharmacy	M26 4FD	✓	✓	✗	✓	✓	✗	✓
Bury West	Radcliffe East	32	Radcliffe Pharmacy	M26 2RF	✓	✓	✓	✓	✓	✓	✓
Bury West	Radcliffe East	31	Radcliffe Pharmacy	M26 2SP	✓	✓	✓	✓	✓	✓	✓
Bury West	Radcliffe East	38	Well	M26 2SP	✓	✓	✓	✓	✓	✓	✗
Bury West	Radcliffe West	1	Asda Pharmacy	M26 3DA	✓	✓	✓	✓	✓	✗	✓
Bury West	Radcliffe West	21	JT Smith & Son	M26 4DJ	✓	✗	✗	✗	✓	✗	✗
Prestwich	Holyrood	41	Wise Pharmacies Ltd	M25 1NL	✓	✗	✓	✓	✓	✓	✗
Prestwich	Sedgley	12	Cohens Chemist	M25 0HT	✓	✓	✓	✓	✓	✓	✓
Prestwich	Sedgley	13	Dennis Gore Chemists	M25 1FX	✓	✓	✓	✓	✓	✗	✗
Prestwich	Sedgley	15	Formans Chemist	M25 0FX	✓	✓	✓	✓	✓	✓	✓
Prestwich	Sedgley	34	Sedgley Park Pharmacy	M25 9JY	✓	✓	✓	✓	✓	✓	✗
Prestwich	St Mary's	30	Prestwich Pharmacy	M25 1AY	✓	✓	✓	✓	✓	✓	✓
Prestwich	St Mary's	37	Tesco In-Store Pharmacy	M25 7BL	✓	✓	✓	✓	✓	✗	✗
Whitefield	Besses	40	Whitefield Pharmacy	M45 8NE	✓	✓	✓	✓	✓	✓	✗
Whitefield	Pilkington Park	18	Greenleaf Pharmacy	M45 6QJ	✓	✗	✓	✗	✓	✓	✗
Whitefield	Unsworth	3	Asda Pharmacy	BL9 8RS	✓	✓	✓	✓	✓	✓	✓
Whitefield	Unsworth	11	Cohens Chemist	BL9 8QA	✓	✓	✓	✓	✓	✗	✓
Whitefield	Unsworth	33	Rowlands Pharmacy	BL9 8JR	✓	✓	✓	✓	✓	✓	✓
Whitefield	Unsworth	39	Well	M45 7TA	✓	✓	✓	✓	✓	✓	✓

*Map index relates to map 3 (section 4.1)

Appendix 8 – Community Pharmacy Opening Hours

Neighbourhood	Ward name	Number of Pharmacies	Weekdays 8am or earlier	Weekdays AM	Weekdays PM	Weekdays 7pm or later	Weekdays Closed for lunch	Sat 8am or earlier	Sat AM	Sat PM	Sat 7pm or later	Sat Closed for lunch	Su
Bury East	Bury East	6	2	6	6	2	0	2	5	4	2	0	3
Bury East	Moorside	5	2	5	5	3	1	2	4	3	3	1	3
Bury East	Redvales	1	0	1	1	0	0	0	1	0	0	0	0
Bury North	Elton	1	0	1	1	0	1	0	1	0	0	0	0
Bury North	North Manor	2	0	2	2	0	1	0	1	0	0	0	0
Bury North	Ramsbottom	1	0	1	1	0	1	0	0	0	0	0	0
Bury North	Tottington	1	0	1	1	0	0	0	1	0	0	0	0
Bury West	Bury West	1	0	1	1	0	0	0	1	0	0	0	0
Bury West	Radcliffe North & Ainsworth	1	0	1	1	0	1	0	1	0	0	0	0
Bury West	Radcliffe East	3	2	3	3	1	0	2	1	1	0	0	0
Bury West	Radcliffe West	2	0	2	2	1	1	0	2	1	1	0	1
Prestwich	Holyrood	1	0	1	1	0	0	0	1	1	0	0	0
Prestwich	Sedgley	4	0	4	4	0	0	0	0	0	0	0	0
Prestwich	St Mary's	2	1	2	2	1	0	1	2	1	1	0	1
Whitefield	Besses	1	0	1	1	0	0	0	1	0	0	0	0
Whitefield	Pilkington Park	1	0	1	1	0	0	0	0	0	0	0	0
Whitefield	Unsworth	4	0	4	4	1	2	0	3	1	1	0	1

**There may be some variation in opening and closing times on certain days.*

This table does not include distance selling pharmacies. These pharmacies tend to be open between 9am and 6pm, and close for an hour at lunch time.

For full details of pharmacy opening hours please see NHS Services.

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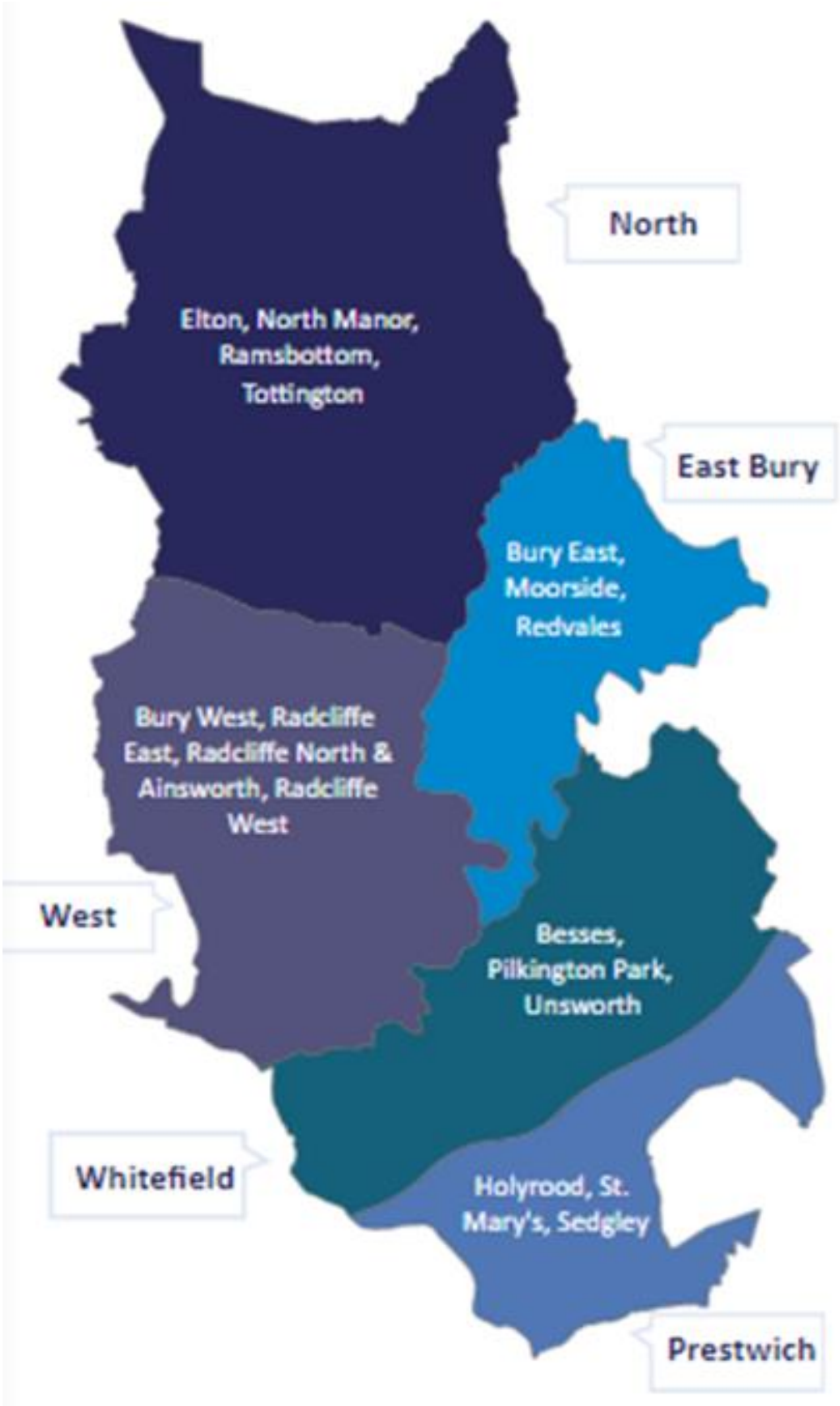
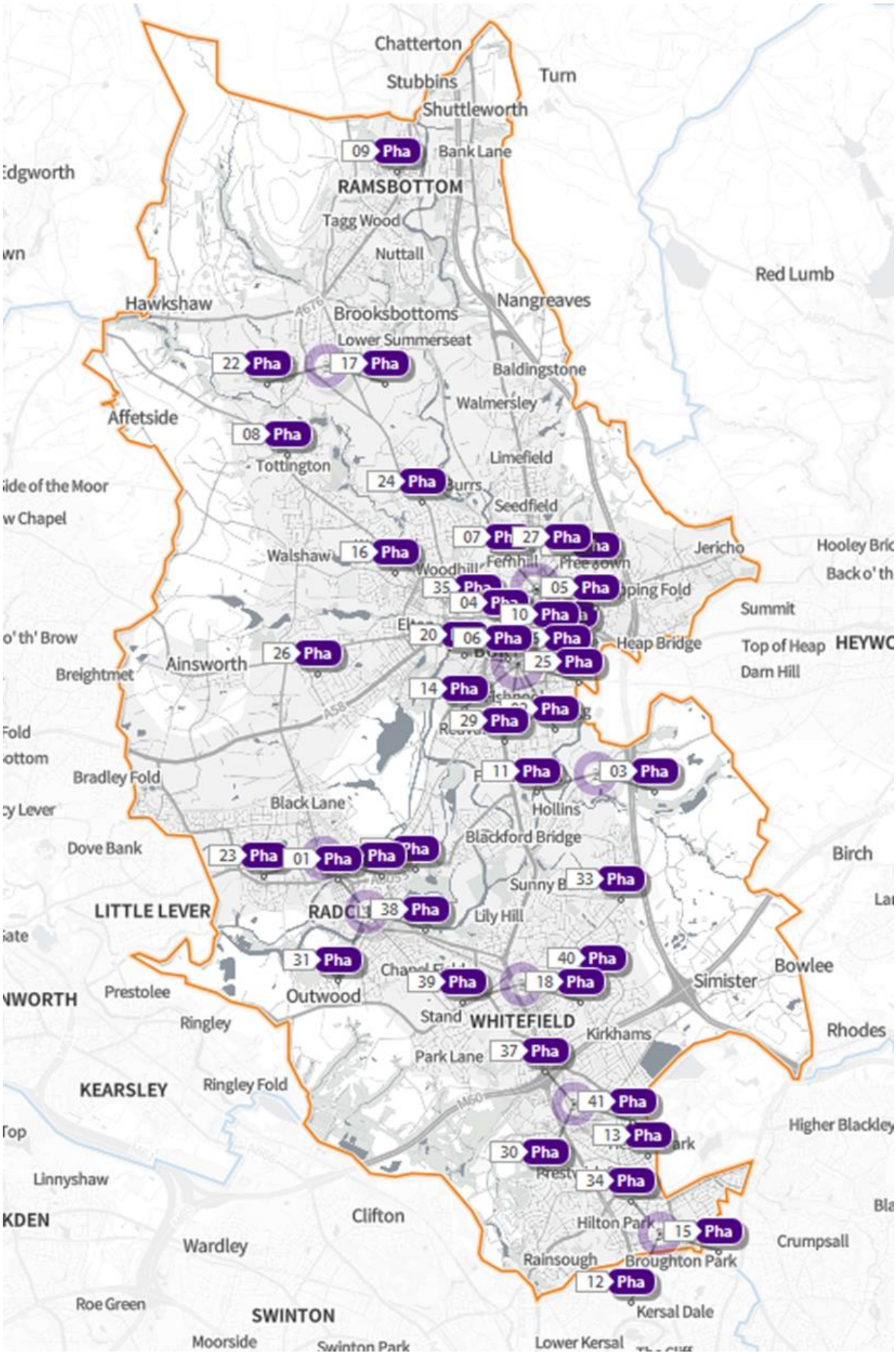
Appendix 10 – Maps

Map 1 -Bury neighbourhoods and wards

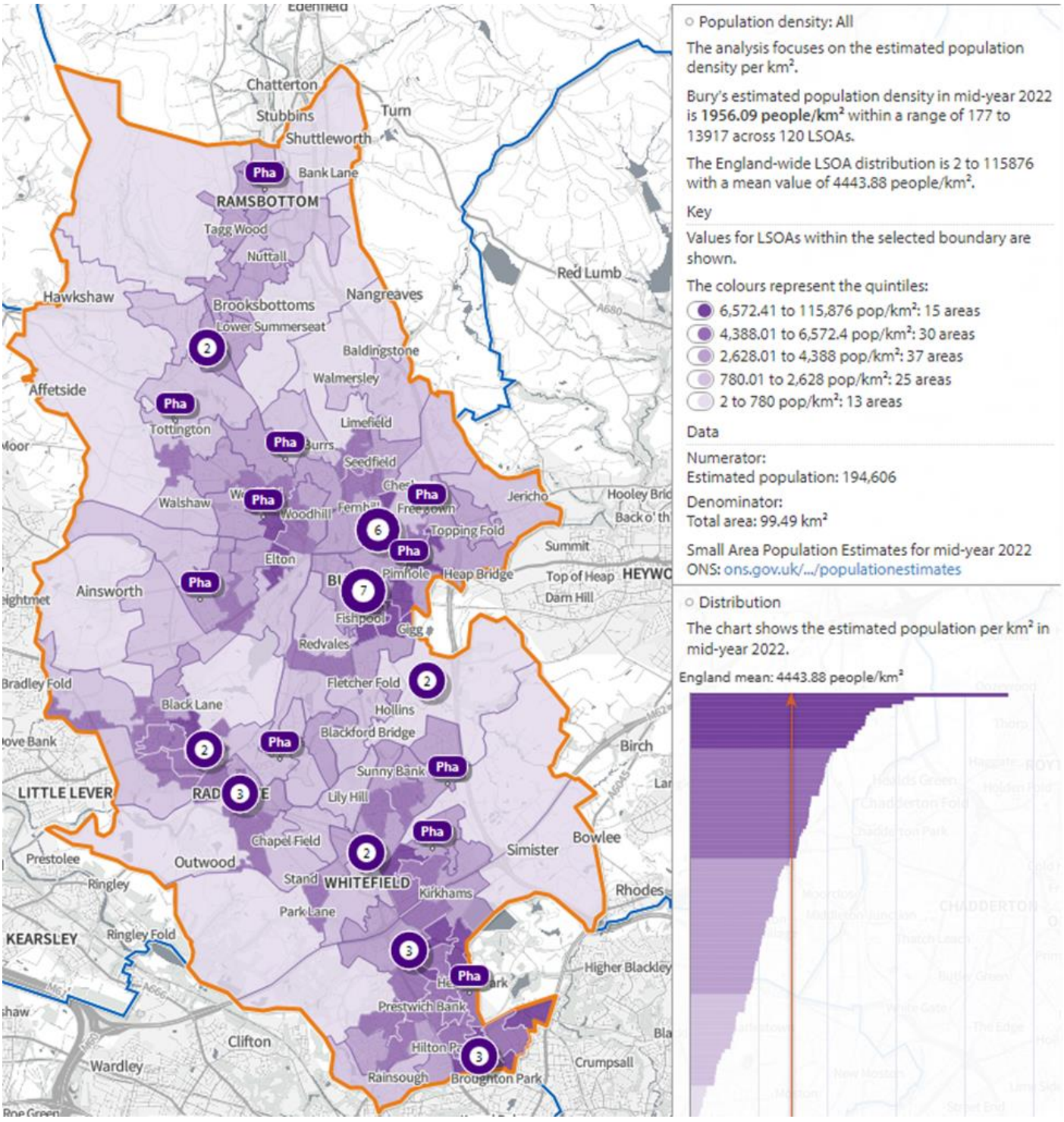


Map 2 - Spread of responses to the public survey in Bury

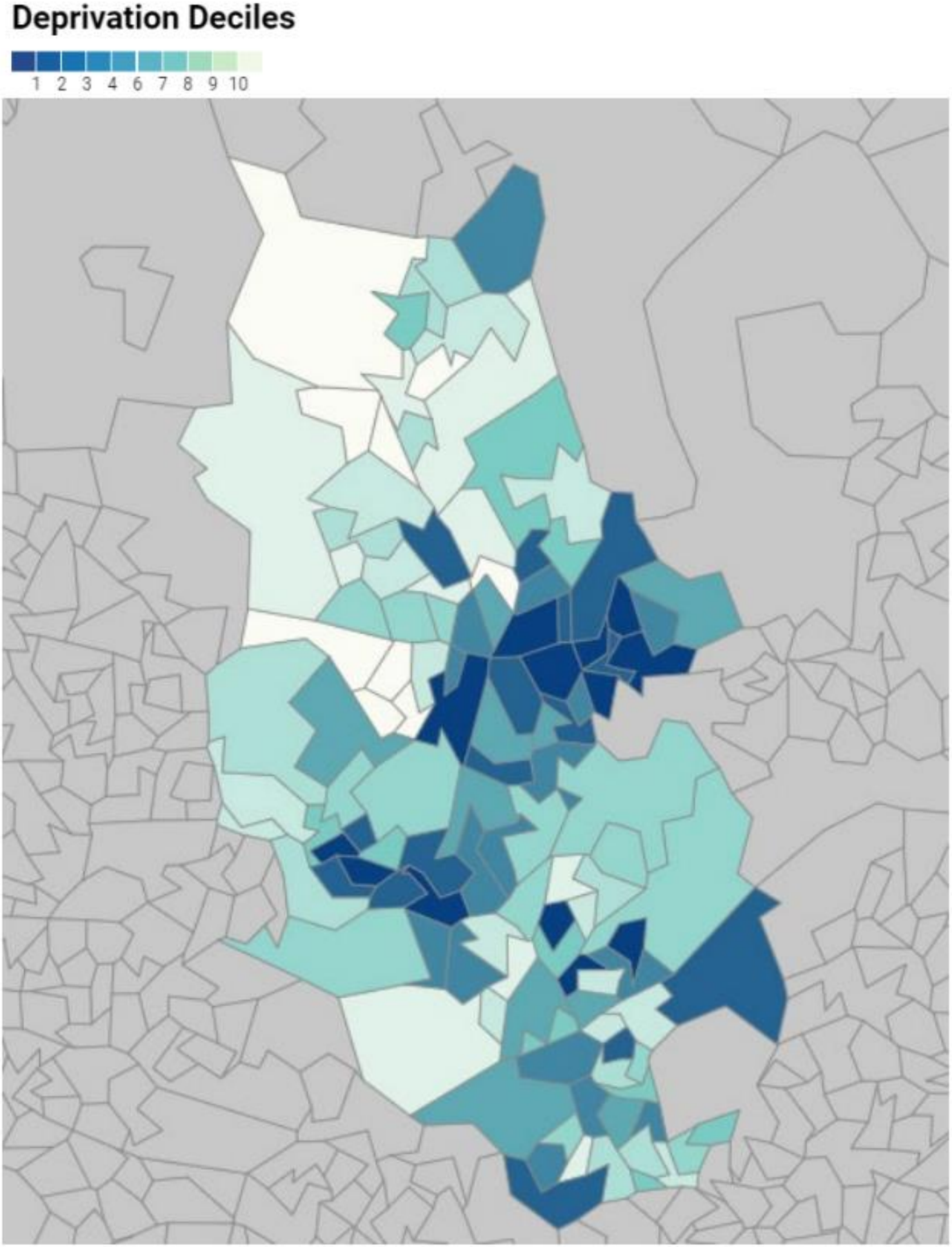
Map 3 - Bury pharmacies location (source: SHAPE - Shape)



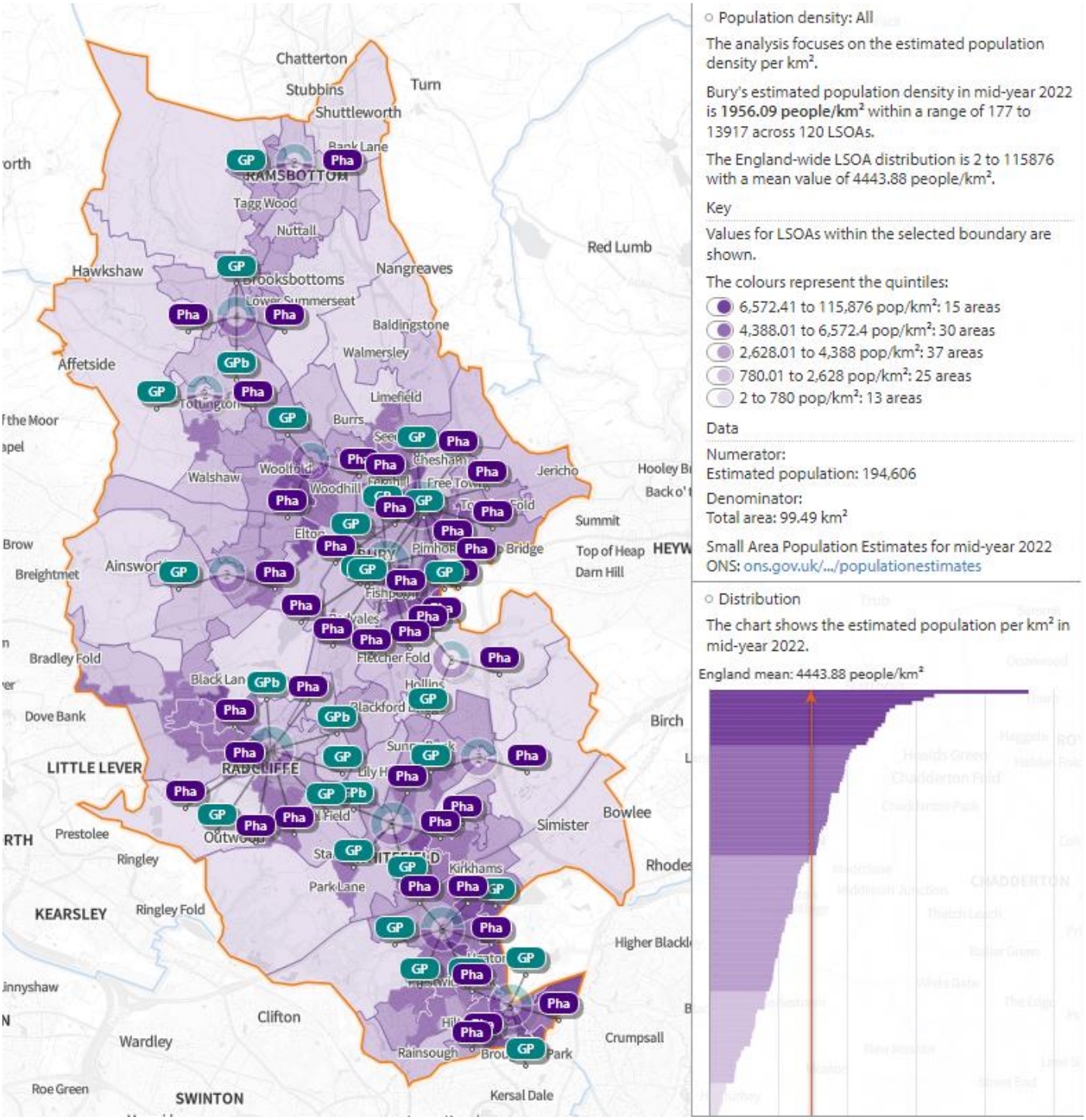
Map 4 - Population density (source: SHAPE - Shape)



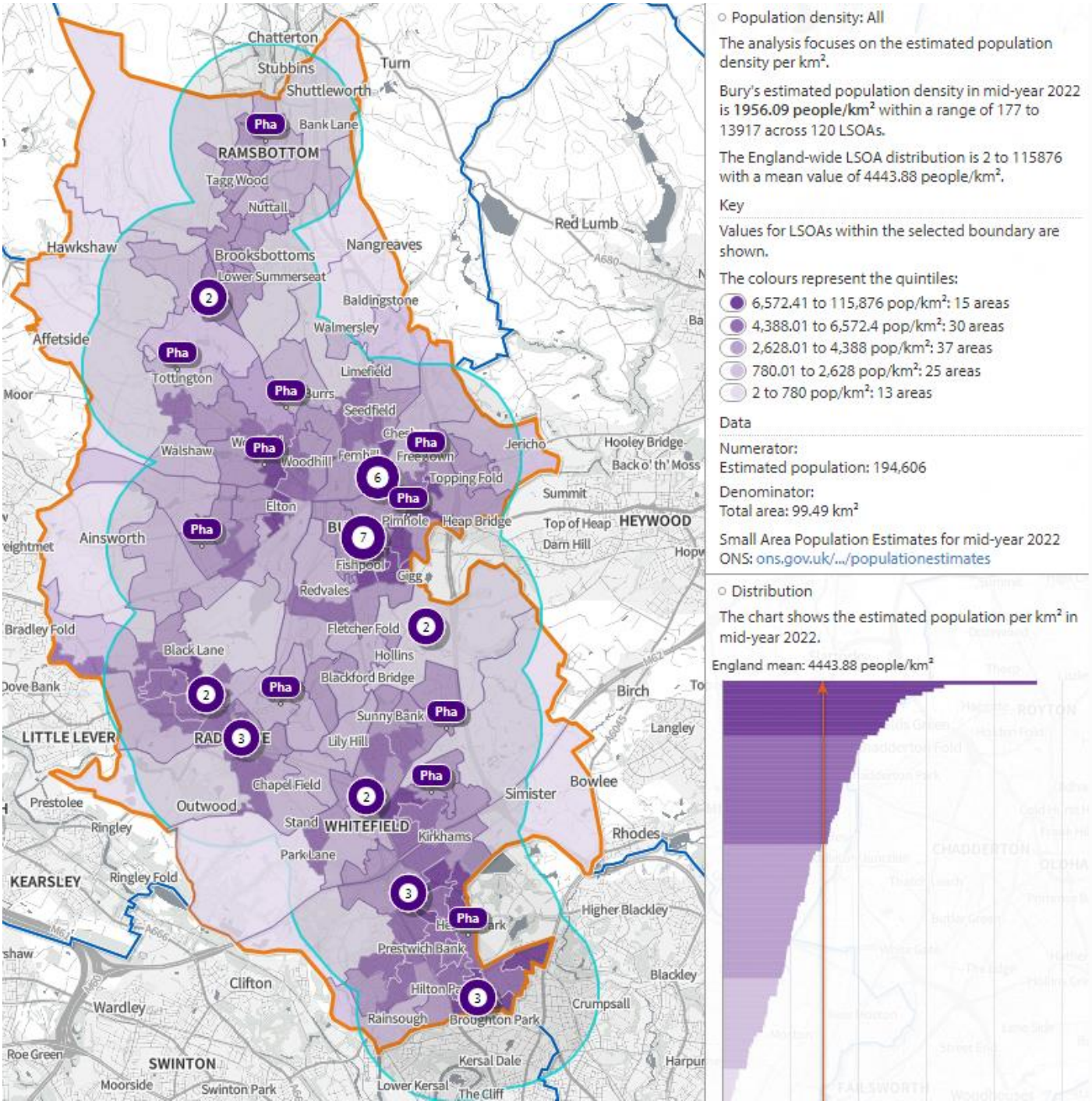
Map 5 – LSOAs in Bury showing their national deprivation decile based on ten groups ranging from '1% most deprived' (decile 1) to '10% least deprived' (decile 10) in England (Source: Deprivation | The Bury Directory)



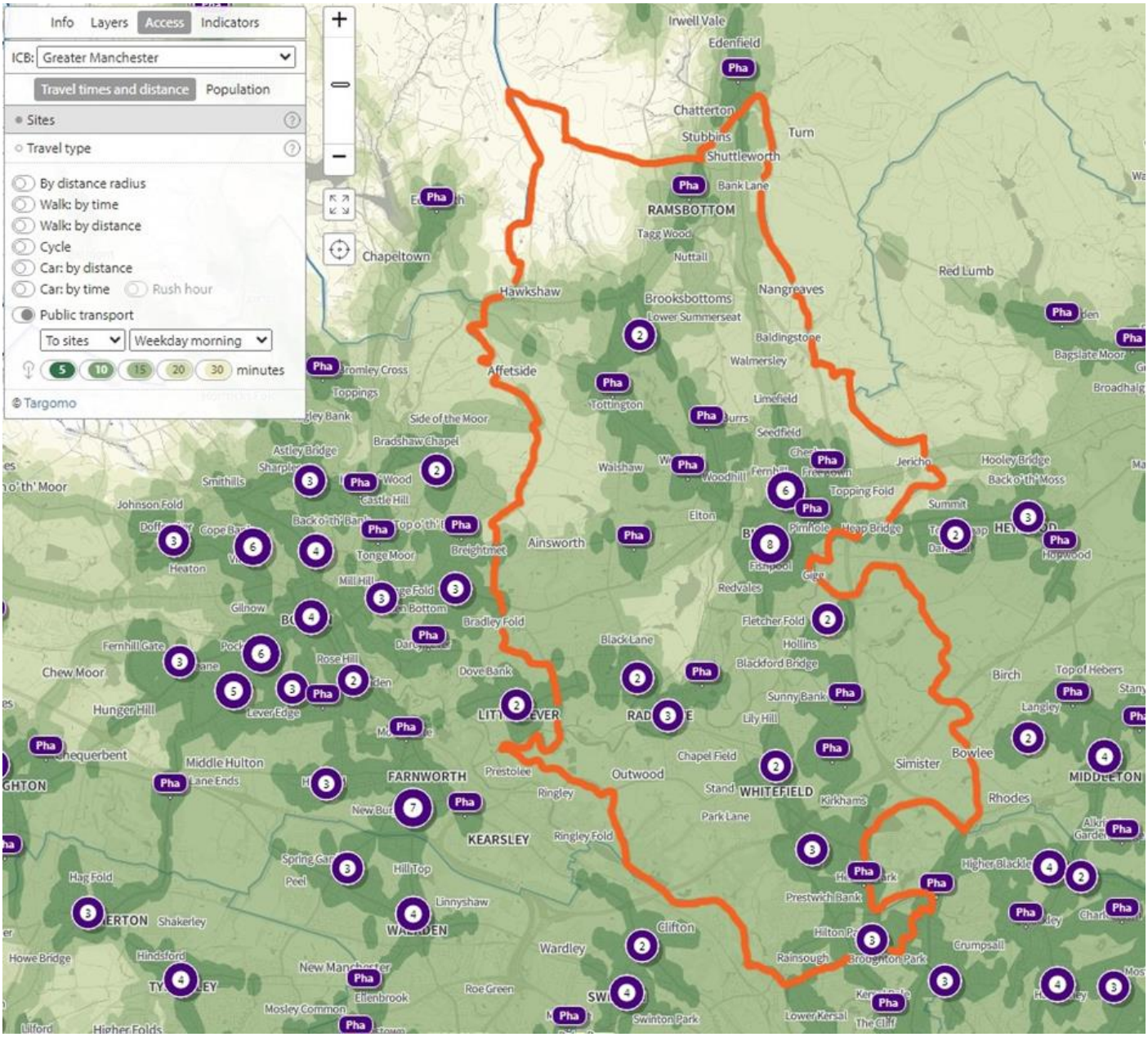
Map 6 - Location of Pharmacies & GP practices (Source: SHAPE - Shape)



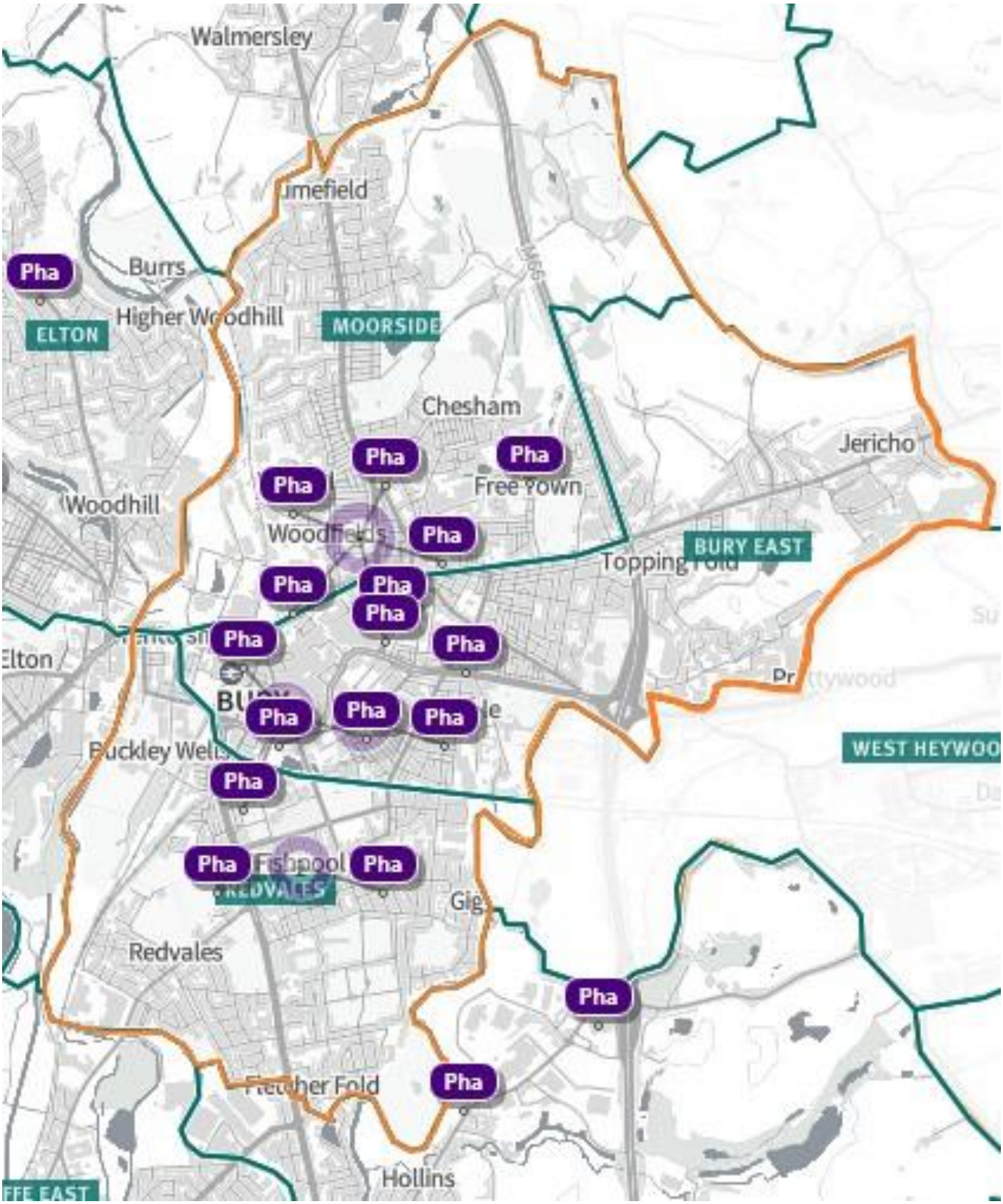
Map 7 - Bury pharmacies showing 1 mile travel distance (Source: SHAPE - Shape)



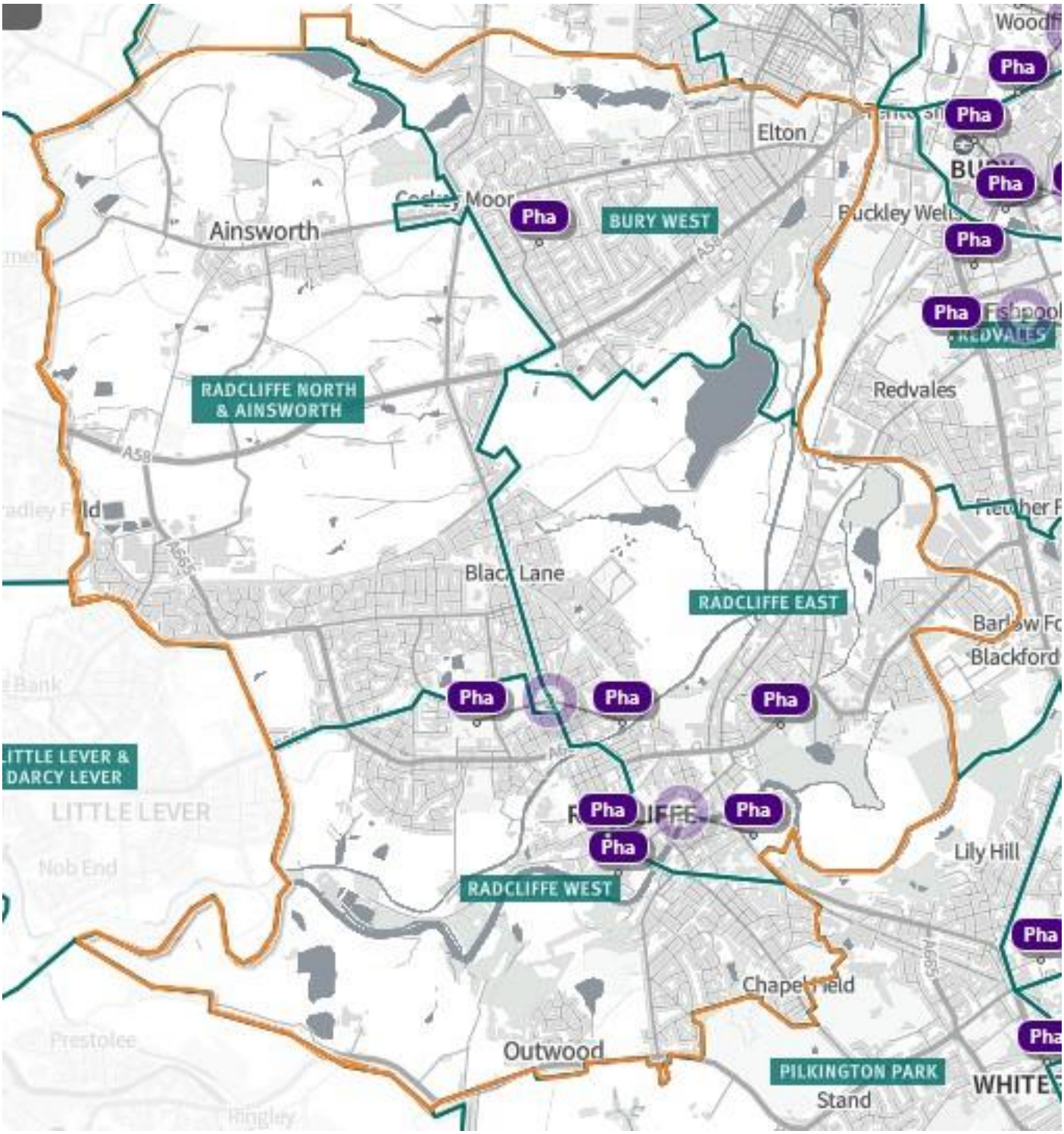
Map 8 - Bury and surrounding Borough Pharmacies showing public transport travel time (Source: SHAPE - Shape)



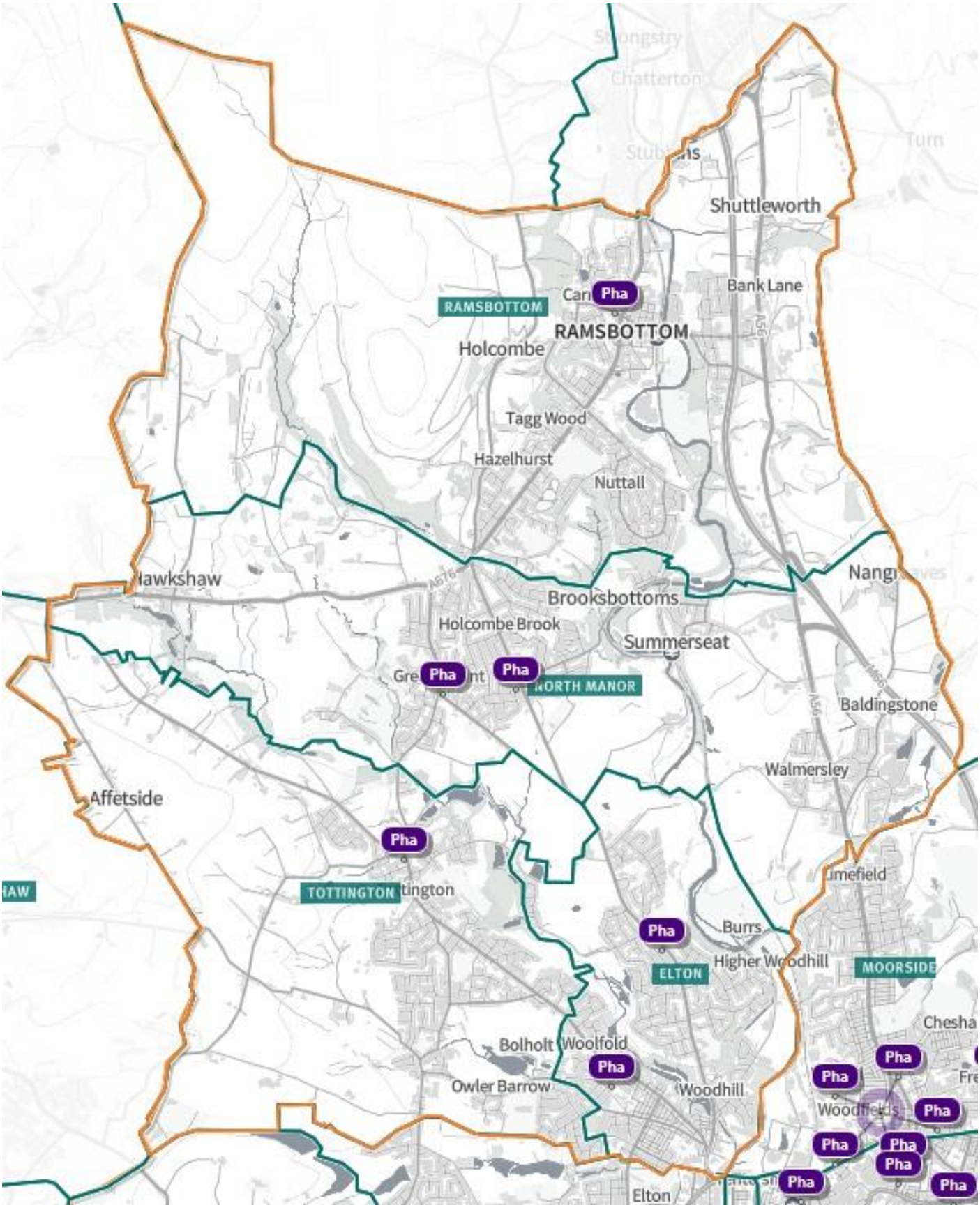
Map 9 - East Bury Neighbourhood Pharmacy Locations (Source: SHAPE - Shape**)**



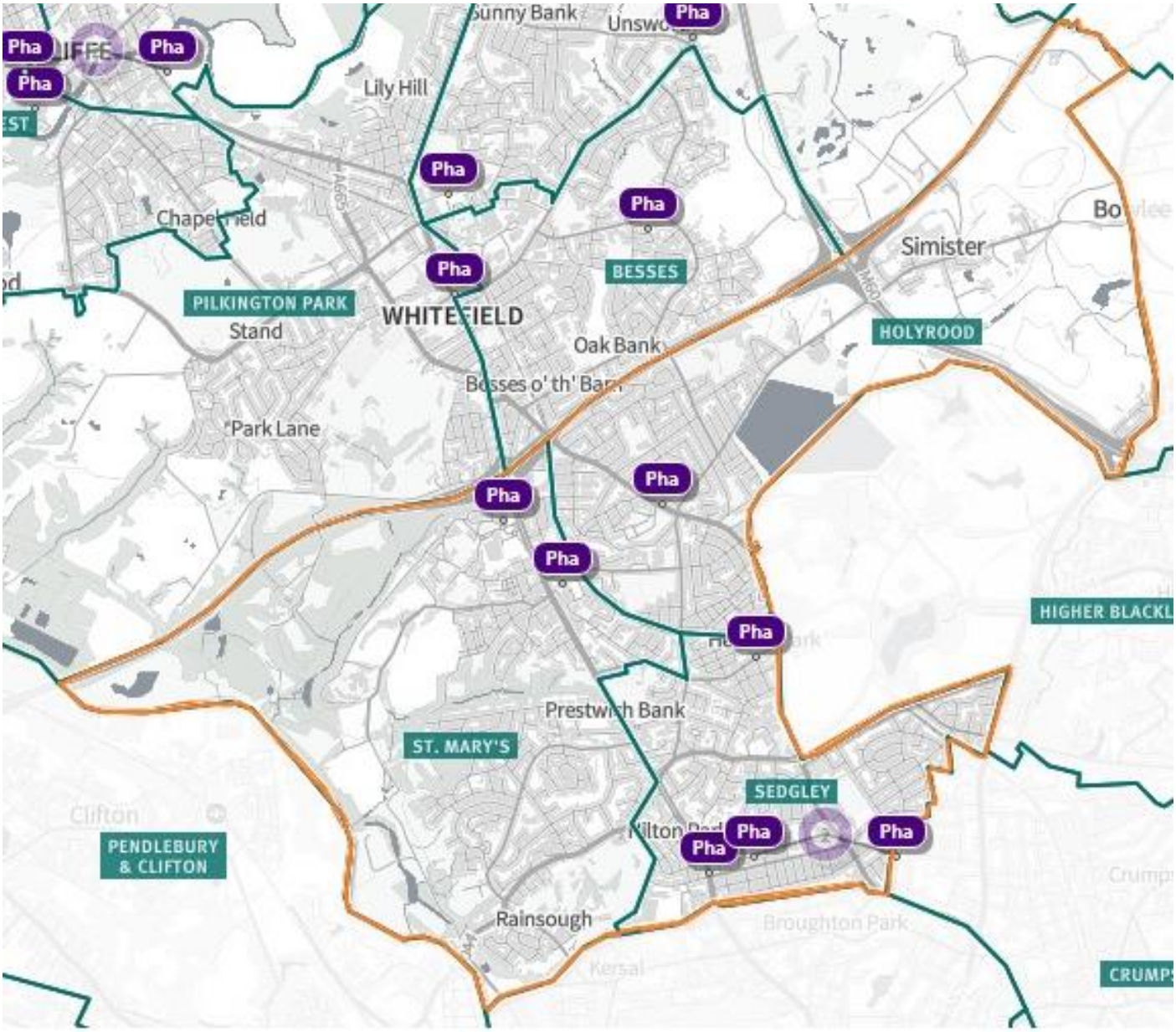
Map 10 - West Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



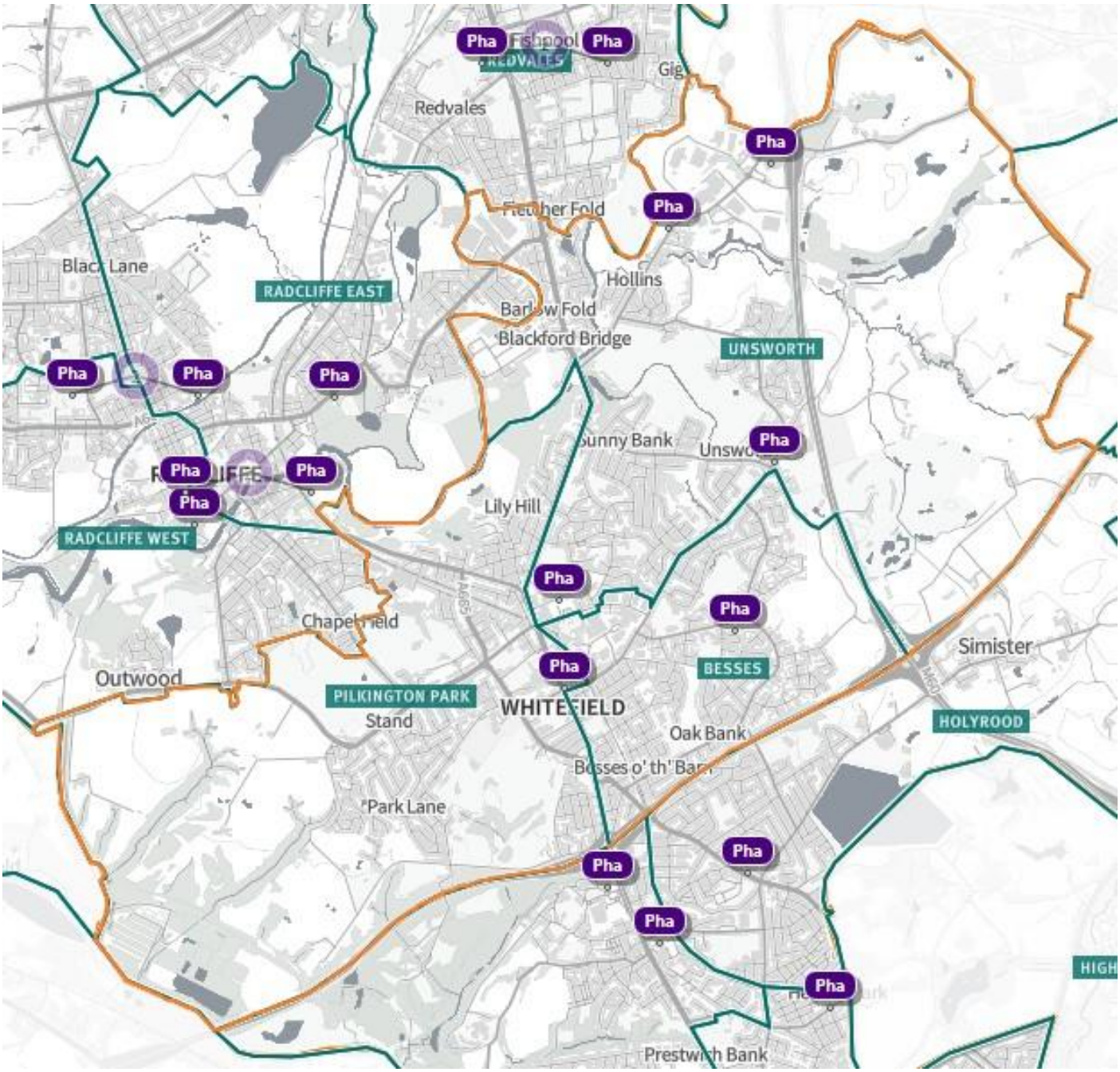
Map 11 - North Neighbourhood Pharmacy Locations (Source: SHAPE - Shape**)**



Map 12 - Prestwich Neighbourhood Pharmacy Locations (Source: SHAPE - Shape**)**



Map 13 - Whitefield Neighbourhood Pharmacy Locations (Source: SHAPE - Shape)



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Appendix 11 – Bury GP Practices

Neighbourhood	Ward	GP Surgery	Address	Postcode
Bury East	Bury East	Knowsley Medical Centre	9/11 Knowsley Street	BL9 0ST
Bury East	Bury East	Peel GPs	Townside Primary Care Centre, Knowsley Street	BL9 0SN
Bury East	Bury East	Ribblesdale Medical Practice	Townside Primary Care Centre, Knowsley Street	BL9 0SN
Bury East	Bury East	Rock Healthcare Limited	Moorgate Primary Care Centre, 22 Derby Way	BL9 0NJ
Bury East	Bury East	Townside Primary Care Centre	Knowsley Street	BL9 0SN
Bury East	Bury East	Tower Family Healthcare: Minden Family Practices	Moorgate Primary Care Centre, 22 Derby Way	BL9 0NJ
Bury East	Moorside	Huntley Mount Medical Centre	Huntley Mount Road	BL9 6JA
Bury East	Moorside	Walmersley Road Medical Practice	110 Walmersley Road	BL9 6DX
Bury North	Elton	Woodbank Surgery	2 Hunstanton Drive	BL8 1EG
Bury North	North Manor	Garden City Medical Centre	1A Garden City, Holcombe Brook	BL0 9TN
Bury North	North Manor	Tower Family Healthcare: Greenmount Medical Centre	9 Brandlesholme Road	BL8 4DR
Bury North	Ramsbottom	Ramsbottom Medical Practice	Carr Street	BL0 9DD
Bury North	Tottington	Tower Family Healthcare: Tottington Medical Practice	16 Market Street	BL8 4AD
Bury West	Bury West	Mile Lane Health Centre	Mile Lane	BL8 2JR
Bury West	Radcliffe	Monarch Medical Centre	65 Cross Lane	M26 2QZ
Bury West	East	Radcliffe Medical Practice	Radcliffe Primary Care Centre, 69 Church Street West	M26 2SP
Bury West	East	Red Bank Group Practice	Radcliffe Primary Care Centre, 69 Church Street West	M26 2SP
Bury West	East	Rock Healthcare Limited: Radcliffe Primary Care Centre	69 Church Street West	M26 2SP
Bury West	East	Tower Family Healthcare: Spring Lane Surgery	15-17 Spring Lane	M26 2TQ
Prestwich	Holyrood	Greyland Medical Centre	468 Bury Old Road	M25 1NL
Prestwich	Holyrood	The Birches Medical Centre	Polefield Road	M25 2GN
Prestwich	Sedgley	St Gabriel's Medical Centre	4 Bishops Road	M25 0HT
Prestwich	Sedgley	Whittaker Lane Medical Centre	Daisy Bank, Whittaker Lane	M25 1EX
Prestwich	St Mary's	Fairfax Group Practice	Prestwich Health Centre, Fairfax Road	M25 1BT
Prestwich	St Mary's	Longfield Medical Practice	Prestwich Health Centre, Fairfax Road	M25 1BT
Whitefield	Pilkington Park	The Uplands Medical Practice	Whitefield Health Centre, Bury New Road	M45 8GH
Whitefield	Unsworth	Blackford House Medical Centre	137 Croft Lane	BL9 8QA
Whitefield	Unsworth	The Elms Medical Centre	Green Lane	M45 7FD
Whitefield	Unsworth	Unsworth Medical Centre	Parr Lane	BL9 8JR

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Appendix 12 – One mile boundary pharmacies

Name	Address	HWB Area	Postcode
Geloo Brothers Ltd	365 Bolton Road	Blackburn with Darwen	BL7 0AZ
A1 Pharmacy	491 Radcliffe Road	Bolton	BL3 1SX
Cohens Chemist	193-195 Bolton Road	Bolton	BL4 9BX
Cohens Chemist	Breightmet Health Centre, Breightmet Fold Lane	Bolton	BL2 6NT
Cohens Chemist	1 Market Street	Bolton	BL3 1HH
Cohens Chemist	118 High Street	Bolton	BL3 1LR
Harwood Pharmacy	Harwood Medical Centre, Hough Fold Way	Bolton	BL2 3HQ
Market Pharmacy	45 Brackley Street	Bolton	BL4 9DS
Maxwell's Chemist	830 Bury Road	Bolton	BL2 6PA
Medifix Pharmacy	601 Bury Road	Bolton	BL2 6HZ
Well	Farnworth Health Centre, Frederick Street	Bolton	BL4 9AL
Higher Crumpsall Pharmacy	248 Middleton Road	Manchester	M8 4WA
Tesco Instore Pharmacy	Cheetham Hill Road	Manchester	M8 5DP
Well	183-187 Victoria Avenue	Manchester	M9 0RB
Wellfield Pharmacy	Wellfield Medical Centre, 53-55 Crescent Road	Manchester	M8 9JT
Wise Pharmacy	376 Cheetham Hill Road	Manchester	M8 9LS
Bowness Pharmacy	26 Bowness Road	Rochdale	M24 4WT
Internet Pharmacy	120 Bury New Road	Rochdale	OL10 4RG
Cohens Chemist	7 Argyle Parade	Rochdale	OL10 3RY
Rowlands Pharmacy	3A Lakeland Court, Wood Street	Rochdale	M24 5QJ
Scout Moor Pharmacy	9 Market Street	Rossendale	BL0 0JQ
Broughton Pharmacy	86 Devonshire Street	Salford	M7 4AE
Newbury Place Pharmacy	Newbury Place Health Centre, 55 Rigby Street	Salford	M7 4NX
Peak Pharmacy	716 Bolton Road	Salford	M27 6EW
Peak Pharmacy	The Health Centre Pharmacy, 659 Bolton Road	Salford	M27 8HP
Pharmacy 24	118 Devonshire Street	Salford	M7 4AE

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Annual report of the Bury, Oldham, and Rochdale Child Death Overview Panel 2025

Including data for 2022/23 – 2024/25

Dr Steven Senior

Consultant in Public Health

Chair of the Bury, Oldham, and Rochdale Child Death Overview Panel.

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Executive summary

- The Bury, Rochdale, and Oldham Child Death Overview Panel (CDOP) reviews all deaths of children normally resident in the three local authority areas.

- This report provides an analysis of deaths reported to CDOP and reviewed by CDOP in 2022/23, 2023/24, and 2024/25. It also includes demographic data on the population of children in Bury, Rochdale, and Oldham, as well as data on important contributors to child mortality, such as rates of premature births, child poverty, and homelessness among families with children.

- Birth rates in Bury, Rochdale, and Oldham have fallen since 2016 but remain above average for England. The Office for National Statistics projects that the numbers of children living in the three local authority areas will be similar in 2030 to 2023.

- Child death rates have tended to be higher than average for England in Oldham and Rochdale while rates in Bury have been similar to the England average. Numbers and rates of death fell in Oldham between 2022/23 and 2024/25 and increased in Bury and Rochdale between 2023/24 and 2024/25. These increases are not statistically significant and are likely to reflect random year-to-year fluctuations.

- Children living in areas of higher deprivation continue to be more likely to die, as are children from Asian ethnic background (potentially because they are more likely than White children to grow up in areas of deprivation). Rates of child poverty and homelessness have increased sharply since 2020/21 in all three areas covered by this report.

- Along with the effects of poverty, CDOP continues to identify known, modifiable risk factors in its reviews of child deaths. Modifiable factors were identified as contributing to 70% of deaths reviewed by CDOP between 2022/23 and 2024/25. The most common category of modifiable factor were factors relating to the social environment and factors relating to service provision (present in 36% and 38% of deaths reviewed respectively).

- The most common modifiable risk factors identified in reviews of child deaths included:

    - **Smoking, alcohol misuse, and substance misuse** during pregnancy and in the household;
    - **High maternal BMI** was identified as a factor in 22 deaths (14% of all deaths reviewed), 14 of which occurred before the baby was 28 days old.
    - **Unsafe sleeping arrangements**, which were linked to one third of deaths categorised as sudden unexplained child deaths. Unsafe sleeping arrangements often co-occurred with alcohol use by one or both parents; and
    - **Consanguinity** (parents closely related) was a factor in 24 deaths reviewed (15% of all deaths). The most common category of death identified for these deaths were ‘chromosomal, genetic, and congenital anomalies’ (14 of 24 deaths). Consanguinity was a factor in 56% of deaths in this category.

Summary of recommendations

Based on the analysis of deaths reported to and reviewed by CDOP, as well as of the publicly available data presented above, this report recommends that:

- **Child poverty:** Health and Wellbeing Boards should note the worsening in measures of child poverty and to work with local partners to ensure that local antipoverty plans address increases in childhood poverty.

- **Smoking, alcohol, and substance misuse:** Health and Wellbeing Boards, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:
    - Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
    - Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.

- **Safe sleeping arrangements:** Health and Wellbeing Boards, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. Safeguarding partnerships should ensure for children who have additional vulnerabilities that are captured in child protection or child in need plan.

- **Consanguinity:** Health and Wellbeing Boards should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.

- **Maternal healthy weight and nutrition:** reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. Health and Wellbeing Boards should assure themselves of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

1. Introduction and background

The CDOP Annual Report is prepared to inform Child Death Review (CDR) Partners about local patterns and trends in child deaths, any lessons learned, actions taken, and the effectiveness of the broader child death review process. The report highlights relevant and modifiable factors contributing to the infant (under one year of age) and child (age 1-17 years) mortality rate in Bury, Rochdale, and Oldham. It also highlights.

The Bury, Rochdale, and Oldham CDOP is one of four CDOPs that make up the Greater Manchester (GM) CDOP Network:

- Manchester CDOP
- Bury, Rochdale & Oldham CDOP
- Bolton, Salford & Wigan CDOP
- Tameside, Trafford & Stockport CDOP

2. The Child Death Overview Process

The Bury, Rochdale, and Oldham Child Death Overview Panel (CDOP) reviews all deaths of children normally resident in the three local authority areas. This includes only live births and excludes stillbirths and legally terminated pregnancies. The panel may also review deaths of non-resident children who died in the local authority area. The panel operates under the Child Death Review Statutory and Operational Guidance.[1] The chart below, taken from this guidance summarises the child death review process, and where CDOP sits in this process:

[1] Department for Health and Social Care (2018) Child Death Review Statutory and Operational Guidance (England).

Figure 1: The child death review process

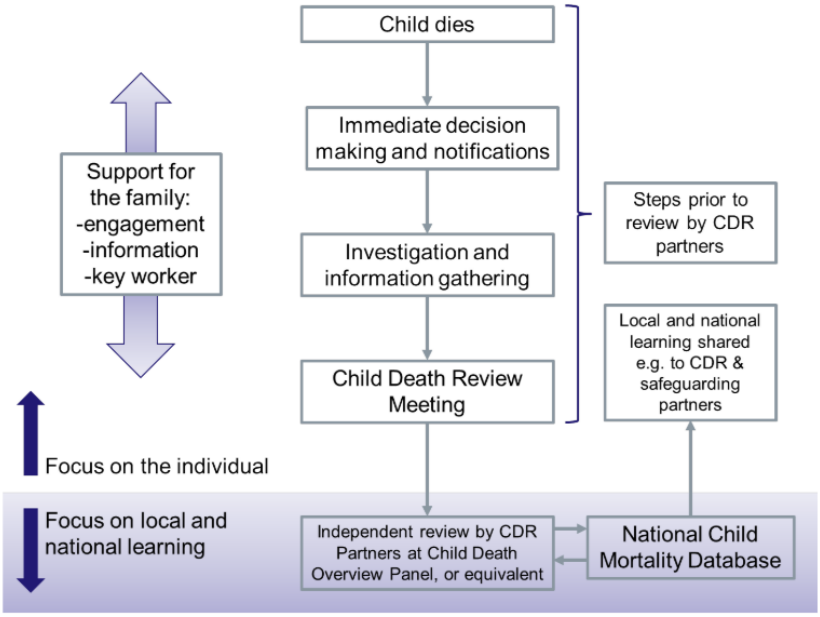


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

As illustrated in figure 1, the focus of CDOP is on local and national learning. This involves looking for patterns between deaths and common 'modifiable factors' - things that could be changed to prevent future deaths. The purpose of CDOP is not to assure the preceding steps in the child death review process or to check that actions identified in reviews of specific cases have been taken. CDOP is accountable to the Health and Wellbeing Boards of the three local authority areas. Reports are also shared with local safeguarding partnerships. A full list of CDOP responsibilities is presented in Appendix A.

3. Contents of this report

This report contains:

a. An overview of the demographics of children in Bury, Oldham, and Rochdale, including numbers of live births, fertility rates, and factors relating to child health such as rates of premature births, low birth weight, and poverty indicators.
b. A summary of publicly available child mortality statistics.
c. A description of numbers of deaths *notified* to CDOP between 1st April 2022 and 31st March 2023 and 1st April 2024 and 31st March 2025.
d. Analysis of deaths *reviewed* by the CDOP between 1st April 2022 and 31st March 2023 and 1st April 2024 and 31st March 2025.
e. Recommendations for Health and Wellbeing Boards in Bury, Rochdale, and Oldham.

It is important to note that due to the length of the child death review process, deaths reviewed each year may not have happened or been notified to the panel in that year.

This report contains analysis of three financial years' CDOP data, 2022-23, 2023-24 and 2024-25.

4. Data protection

Data about children who die and the circumstances of their death is shared anonymously with the CDOP members. The panel is a confidential environment and panel members are aware of their obligation to treat information shared in meetings in confidence. Panel members and observers are required to sign confidentiality agreement. Every care has been taken in this report to make sure that no child can be identified from the data presented. Due to the personal nature of the underlying data it cannot be shared more widely.

5. Demographics of children and Young People in Bury, Oldham, and Rochdale

5.1 Population statistics

Table 1 provides the overall number of children aged 0-17 in Bury, Oldham, and Rochdale in the 2021 census. Children make up a higher proportion of the overall population in Oldham (25.6% of the population) than in Rochdale (24.3%) or Bury (22.6%). However, this can vary within local authorities.

Table 1: Numbers of 0-17 year olds in Bury Oldham and Rochdale by sex (Census 2021)

Sex	Bury		Oldham		Rochdale	
	No.	%	No.	%	No.	%
Female	20,156	10.4%	29,196	12.1%	25,063	11.2%
Male	21,597	11.1%	29,789	12.3%	26,774	12.0%
Total	43,852	22.6%	61,953	25.6%	54,361	24.3%

Table 2 shows a breakdown of the ethnicities of children in each local authority area. Oldham has the highest proportion of children belonging to Black and ethnic minority backgrounds (47.87% of children), followed by Rochdale (38.82%) and Bury (16.93%). Across all three areas the largest ethnic minority category was 'Asian, Asian British, or Asian Welsh' although within this there was variation in what proportion identified as Pakistani, Bangladeshi, and other Asian backgrounds. Note: the total numbers of children in table 1 and 2 do not match. This is due to demographic data missing in the census data for a small number of children.

Table 2: Numbers of 0-17 year olds in Bury Oldham and Rochdale by ethnic category (Census 2021)

Ethnic category	Bury		Oldham		Rochdale	
	No.	%	No.	%	No.	%

Asian, Asian British or Asian Welsh	6,782	15.45%	21,700	35.02%	13,840	25.33%
Black, Black British, Black Welsh, Caribbean or African	1,164	2.65%	3,410	5.50%	3,164	5.79%
Mixed or Multiple ethnic groups	2,688	6.12%	3,321	5.36%	2,914	5.33%
Other ethnic group	1,186	2.70%	1,235	1.99%	1,289	2.36%
White	32,067	73.07%	32,300	52.13%	33,424	61.18%
Grand Total	**43,887**	**100.00%**	**61,966**	**100.00%**	**54,631**	**100.00%**

Population projections from the Office for National Statistics (ONS) suggest that the 0–17-year-old population is expected to be broadly stable up to 2030, with forecast increases of between 1% and 3%. However, these projections are based on 2018 population estimates, and projections depend on accurately predicting birth rates, which may change.

Table 3: Population projections for 0-19 year olds (ONS, 2018-based)

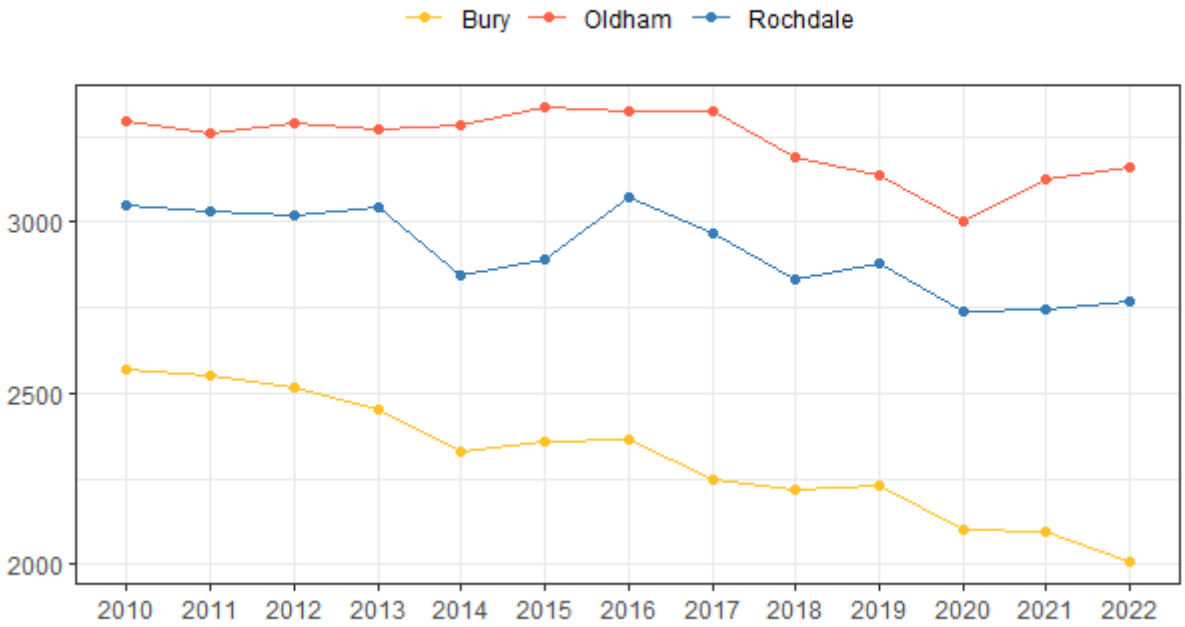
Area	Bury	Oldham	Rochdale
2023	35,490	48,641	43,977
2030	35,875	49,219	45,203
% Growth	1.1%	1.2%	2.8%

5.2 Births

Figure 2 shows the number of live births in Bury, Oldham, and Rochdale by year from 2010 to 2022. Numbers of births fell in all three areas over the 12-year period. The biggest fall was in Bury, where the number of live births fell from 2,571 to just over 2,008 (a 22% reduction in live births). The smallest fall was in Oldham, where the number of births fell from around 3,300 to 3,158 (around a 4% decrease).

Figure 2: Live births

Live births 2010 to 2022

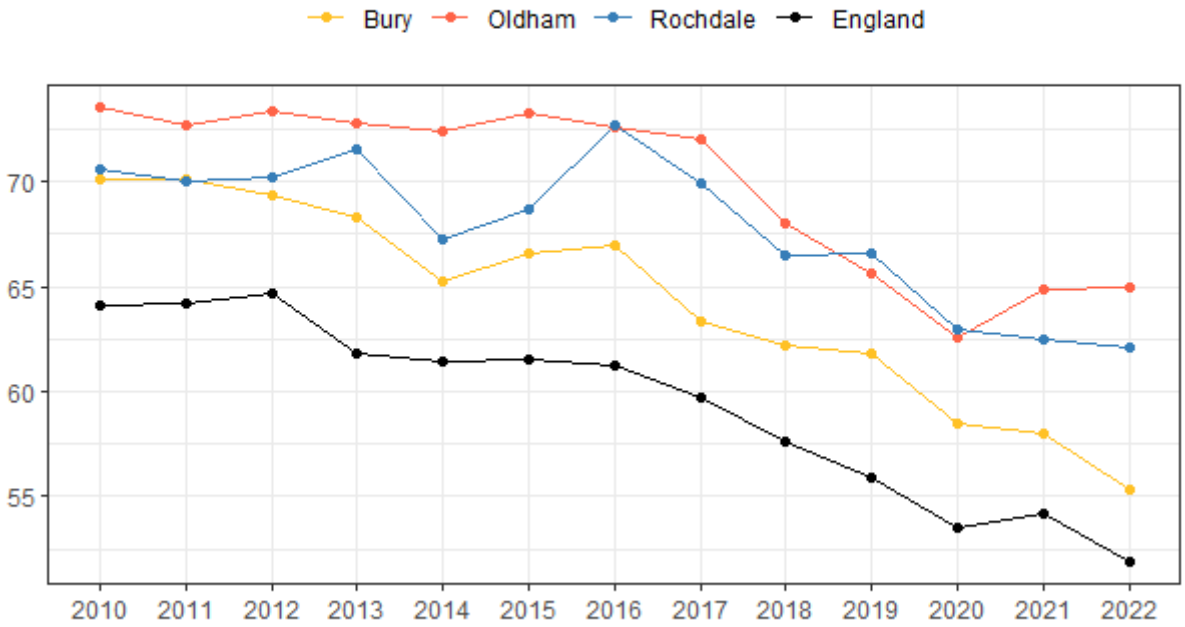


Source: Fingertips (Office for Health Improvement and Disparities).

The general fertility rate gives a measure of the number of births relative to the number of females aged 15 to 44 (as very few births are to females aged under 15 or over 45). Figure 3 shows the general fertility rate for Bury, Rochdale, Oldham, and England for the same 12-year period. The national fertility rate fell from around 64 per 1,000 women per year in 2010 to 52 in 2022 (a 19% decrease). General fertility rates were higher in Bury, Rochdale, and Oldham than England over the whole period. However, fertility rates fell more sharply in Bury, reducing the gap in general fertility rates from 6 births per 1,000 females aged 15-44 to 3.4 births per 1,000 females aged 15-44. General fertility rates only fell by 12% in Rochdale and Oldham, with Oldham's general fertility rate increasing slightly from 2020.

Figure 3: General fertility rate

Birth rate per 1,000 females aged 15 to 44 years 2010 to 2022



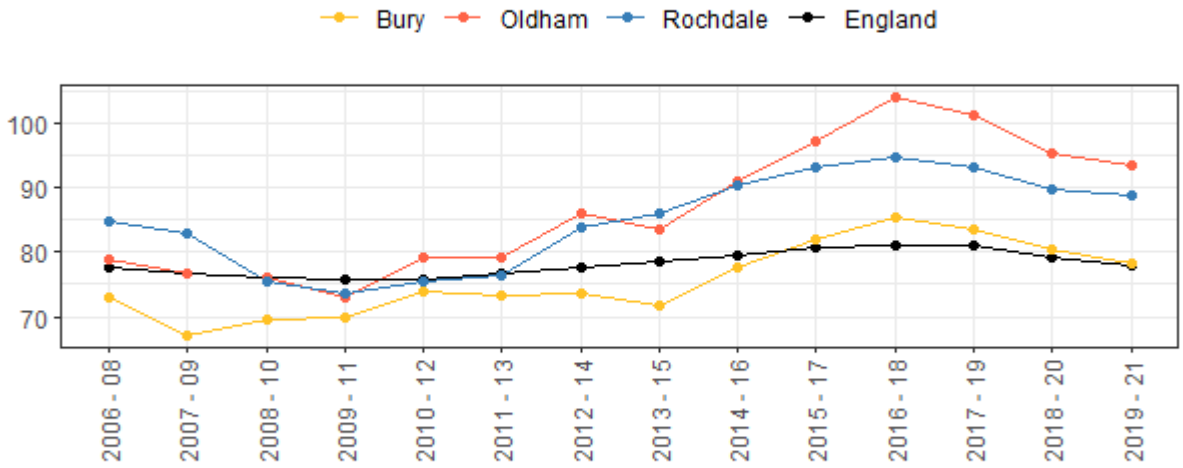
Source: Fingertips (Office for Health Improvement and Disparities).

Babies born prematurely (before 37 weeks of gestation) often experience a range of poor health and other outcomes including higher risk of death. As well as being a cause of poor health in children, premature births are associated with poor maternal health, particularly smoking in pregnancy.

Rates of premature births are higher in Oldham and Rochdale than Bury and England. And while premature birth rates have remained roughly the same in Bury and England, rates of premature birth have increased in Oldham and Rochdale, starting from the 2010-12 period.

Figure 4: Babies born prematurely (before 37 weeks gestation)

Crude rate per 1,000 births 2018/19 to 2022/23



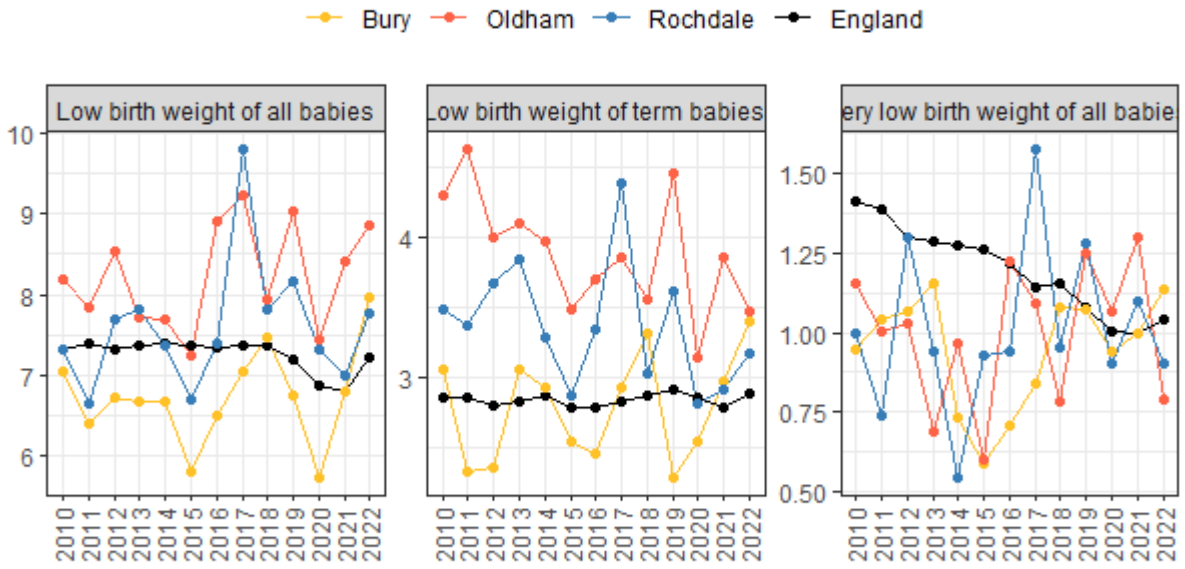
Source: Fingertips (Office for Health Improvement and Disparities). Crude rate of premature live births (gestational age between 24-36 weeks) and all stillbirths per 1,000 live births and stillbirths.

Children born at low birth weights (less than 2.5 kg) are also at higher risk of dying and poor health. Premature birth is one cause of low birth weights so separate indicators are available for babies born after 37 weeks of gestation as well as for all babies. Figure 5 shows babies born at less than 2.5kg as a percentage of all live births (left panel) and of all births of babies born after at least 37 weeks gestation (middle panel). The right panel shows the percentage of all babies born at very low birth weight (less than 1.5kg).

The numbers involved for Bury, Rochdale, and Oldham are small in each year and the data are noisy as a result. Rochdale and Oldham have tended to have a higher proportion of babies born at low birth weights, whereas Bury has tended to be similar to the national average, although the proportion of babies born at low birth weight increased in Bury for at least the three most recent years' data (2020 – 2022). While England saw a decrease in the proportion of babies born at very low birth weight, no such trend exists for Bury, Rochdale, or Oldham.

Figure 5: Low birth weight babies

Percent of all births, 2014/15 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Babies are considered low birth weight if they weigh less than 2,500g at birth and very low birth weight if they weigh less than 1,500g. Babies are considered born at term if they are born after 37 weeks of gestation.

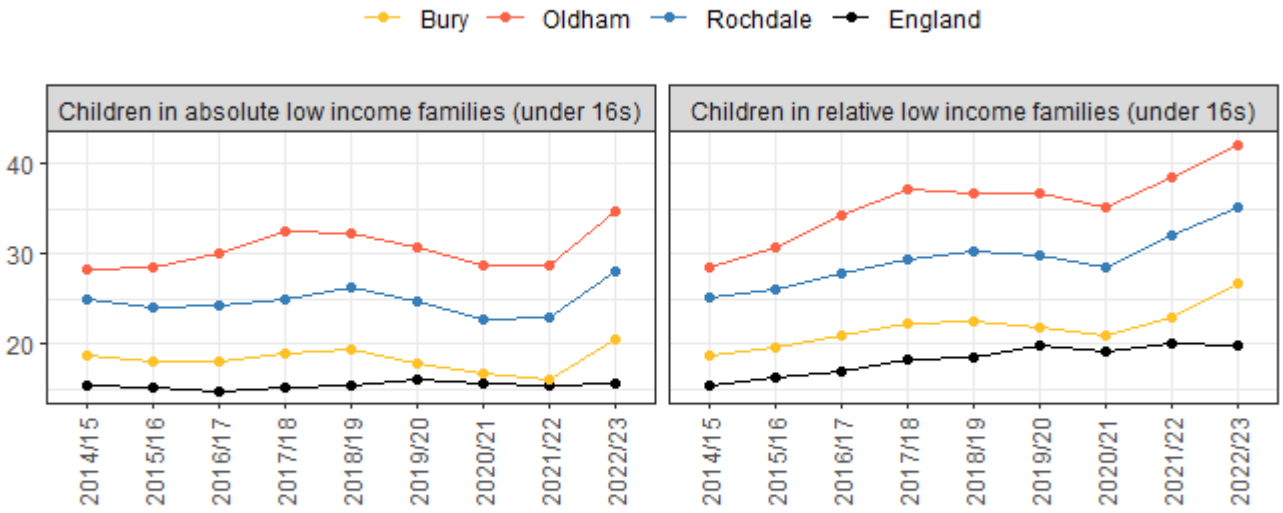
5.3 Poverty and children in care

Poverty is a major cause of child deaths and poor health. Families living in poverty often lack access to the basic building blocks of health, such as good quality housing, good diets, safe outdoor environments in which to plan and be physically active. Poverty also causes stress and mental illness, increasing the risk of childhood neglect or abuse or domestic violence. Families on low incomes are also more likely to be exposed to environmental hazards such as air pollution. And access to healthcare also tends to be worse for people living in poverty.

Figure 6 shows the proportion of children living in low-income families. Low income can be defined in absolute or relative terms. A household is in relative low income if household receives less than 60% of the median household income. A household in absolute low income is one which receives less than 60% of the median household income in 2010/11, updated to match inflation. This is designed to assess how low-income households are faring with reference to inflation. Figure 7 shows the number of households with children who are registered homeless per 1,000 households with children. Both child poverty and homelessness indicators have worsened markedly since 2020/21. Figure 8 shows the numbers of children in care per 10,000 children. All three local authorities covered in this report have a greater proportion of children in care than the national average, particularly Rochdale. Bury and Oldham saw increases between 2018/19 and 2021/22 which reflect a national trend. In the most recent data (2023/24) Rochdale and Bury's rates of children in care remain stable or decline slightly, while Oldham's rate increased markedly.

Figure 6: Proportion of children in low income families

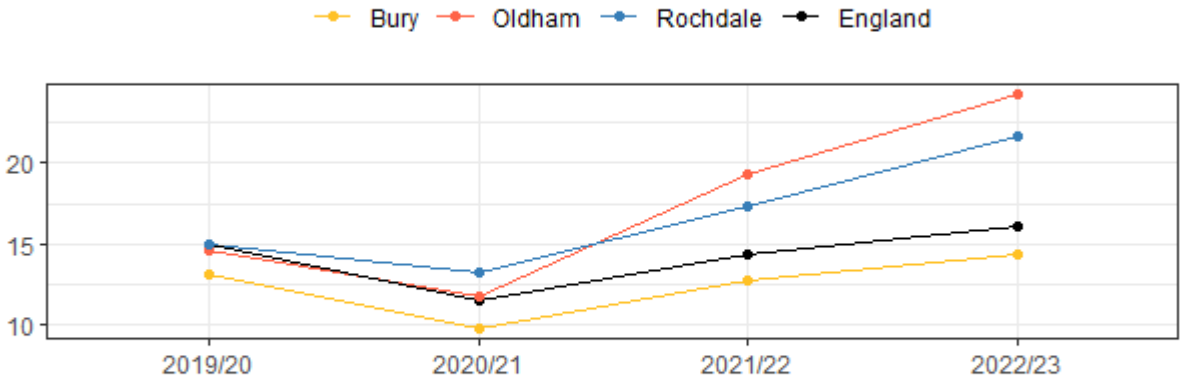
Percent, 2014/15 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Percentage of children (under 16 years) in a local area. Absolute low income is defined as a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in 2010 to 2011. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income.

Figure 7: Homeless households with children

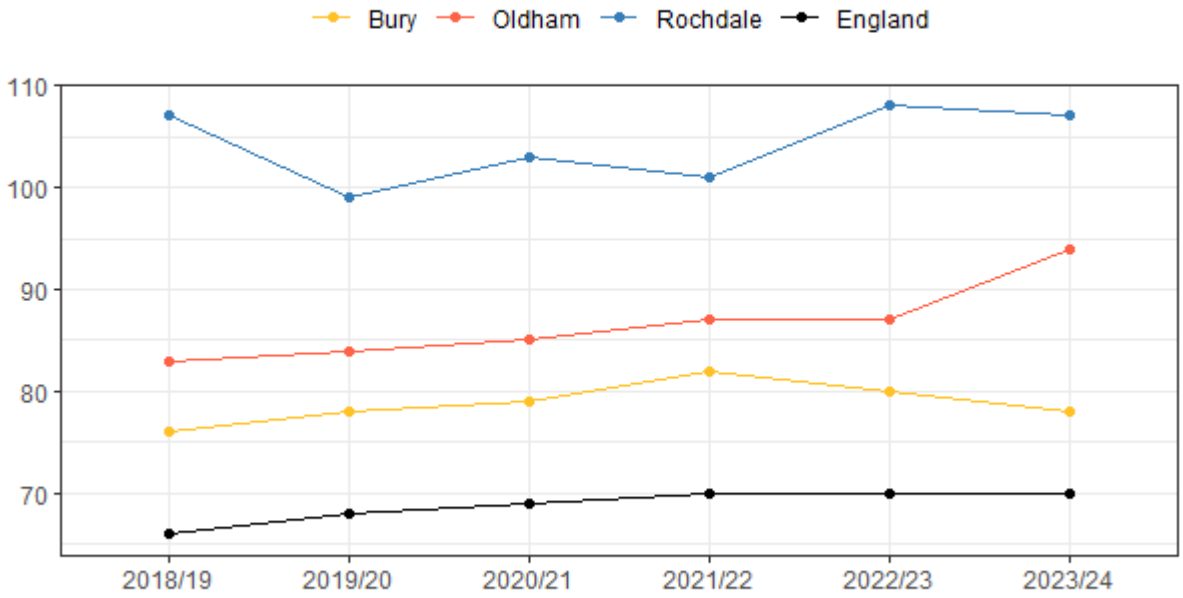
Rate per 1,000 households with children 2019/20 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Households including one or more dependent children owed a prevention or relief duty under the Homelessness Reduction Act, crude rate per 1,000 estimated households that include at least one dependent child. Children are dependent if they're under 18 and living at home. An 18 year old can also count as dependent if they're in full time education or can't support themselves for other reasons, and they live at home.

Figure 8: Children in care

Rate per 10,000 children 2018/19 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Children looked after at 31 March on the given year as a rate per 10,000 population aged under 18 years.

6. Mortality statistics

Figure 9 shows mortality rates for children aged 1 to 17 years, the infant mortality rate which reflects deaths in those aged 0 to 1 year old, the neonatal mortality rate which covers deaths in babies aged 0 to 28 days old and the post-neonatal mortality rate which covers deaths of babies aged 29 days to 1 year old. Due to the small numbers of deaths covered, trends are harder to discern.

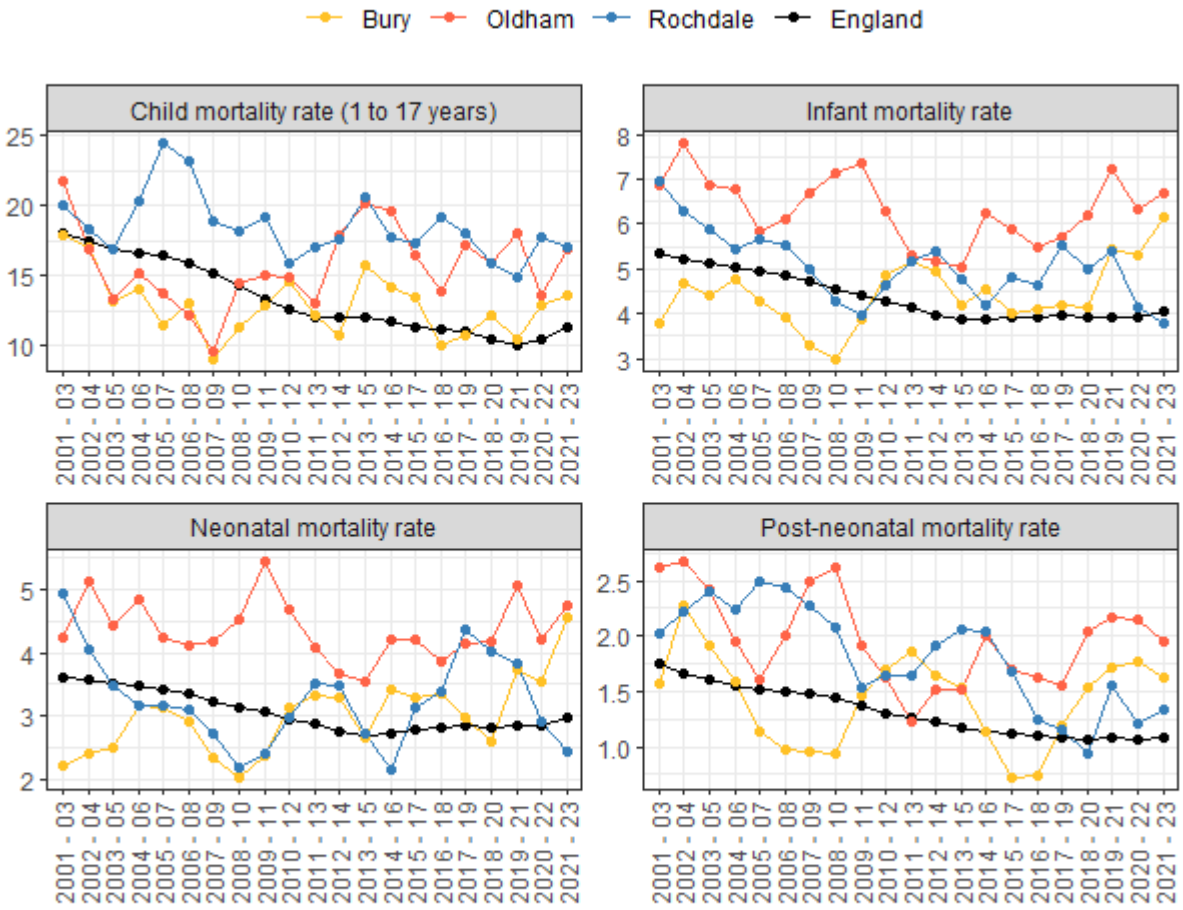
Oldham and Rochdale's child mortality rates have been higher than the national average in every period whereas child mortality in Bury has been closer to the national average, although the 2020-22 and 2021-23 periods saw increases in Bury's child mortality rate.

Infant mortality rates in Oldham have been consistently higher than the national average, and both neonatal and post-neonatal mortality has contributed to this. Infant mortality in Rochdale appears to fall between 2001-03 and 2009-11 before levelling off and then falling again in 2020-22 and 2021-23. Infant mortality in Bury was below or similar to the England average between 2001-03 and 2009-11 after which it has roughly followed the national trend until 2019-21 when infant mortality rates start to increase.

Figure 10 shows the rate of deaths and serious injuries among children aged 0 to 15 years in road traffic accidents. These appear to have decreased slightly up to 2012-14 after which they have remained stable across all three areas.

Figure 9: Child, infant, neonatal, and post-neonatal mortality rates

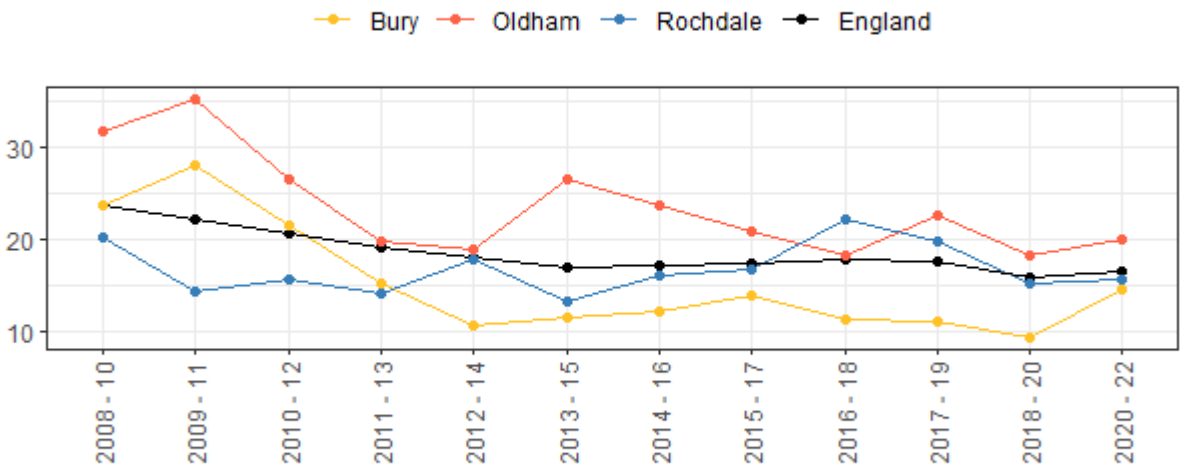
Rate per 1,000



Source: Fingertips (Office for Health Improvement and Disparities). Child mortality rate: number of deaths in children aged 1 to 17 years per 1,000 population aged 1-17. Infant mortality rate: number of deaths in babies aged under 1 year per 1,000 live births in the same year. Neonatal mortality rate: the number of deaths in the first 28 days of life per 1,000 live births. Post-neonatal mortality rate: the number of deaths in babies aged 29 days to 1 year per 1,000 live births.

Figure 10: Children aged 0-15 killed or seriously injured in road traffic accidents

Rate per 100,000 children 2008-10 to 2020-22



Source: Fingertips (Office for Health Improvement and Disparities). The number of children aged 0-15 years that were killed or seriously injured in road traffic collisions per 100,000 population aged 0-15 years. Rolling three year averages.

7. Notified deaths

7.1 Notified by local authority area of residence and year of death

Table 4 shows the numbers of deaths reported to the Bury, Rochdale, and Oldham CDOP by local authority of residence and financial year in which the child died. As the number of deaths is related to the size of the population, the table also provides the population aged 0-17[2], the child mortality rate per 100,000 children, and 95% confidence intervals for the rate. Death numbers and rates are shown graphically in figures 11 and 12.

Table 4: deaths and death rates reported to CDOP by local authority and year

Financial year	Local authority	deaths	population	rate per 100k	95% confidence interval	
2022/2023	Bury	15	43,841	34.2	19.1	56.4
2023/2024	Bury	12	43,965	27.3	14.1	47.6
2024/2025	Bury	19	44,039	43.1	26	67.3
2022/2023	Oldham	35	62,401	56.1	39.1	78
2023/2024	Oldham	23	62,995	36.5	23.1	54.8
2024/2025	Oldham	20	63,667	31.4	19.2	48.5
2022/2023	Rochdale	16	55,556	28.8	16.5	46.7
2023/2024	Rochdale	15	56,376	26.6	14.9	43.8
2024/2025	Rochdale	19	57,289	33.2	20	51.8

Due to the small numbers of deaths, differences between local authority areas and between different years are not statistically significant and could be due to chance variation. That important caveat aside, numbers and rates of deaths fell in Oldham between 2022/23 and 2024/24. Numbers and rates of deaths increased in Bury and Rochdale between 2023/24 and 2024/25.

[2] Population data were derived from the ONS mid-year population estimates tool. Population estimates were not available for 2024/25 so populations were estimated by extrapolating population growth from 2021/22 to 2023/24 in each area to the following year.

Figure 11: deaths reported by financial year of death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25

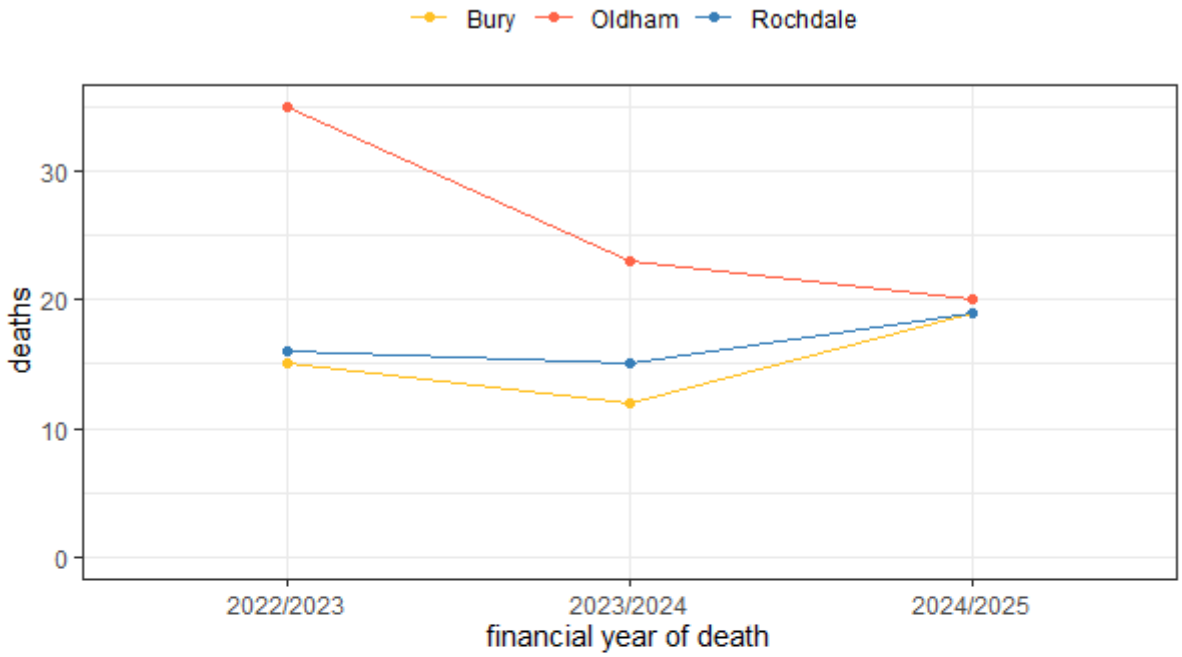
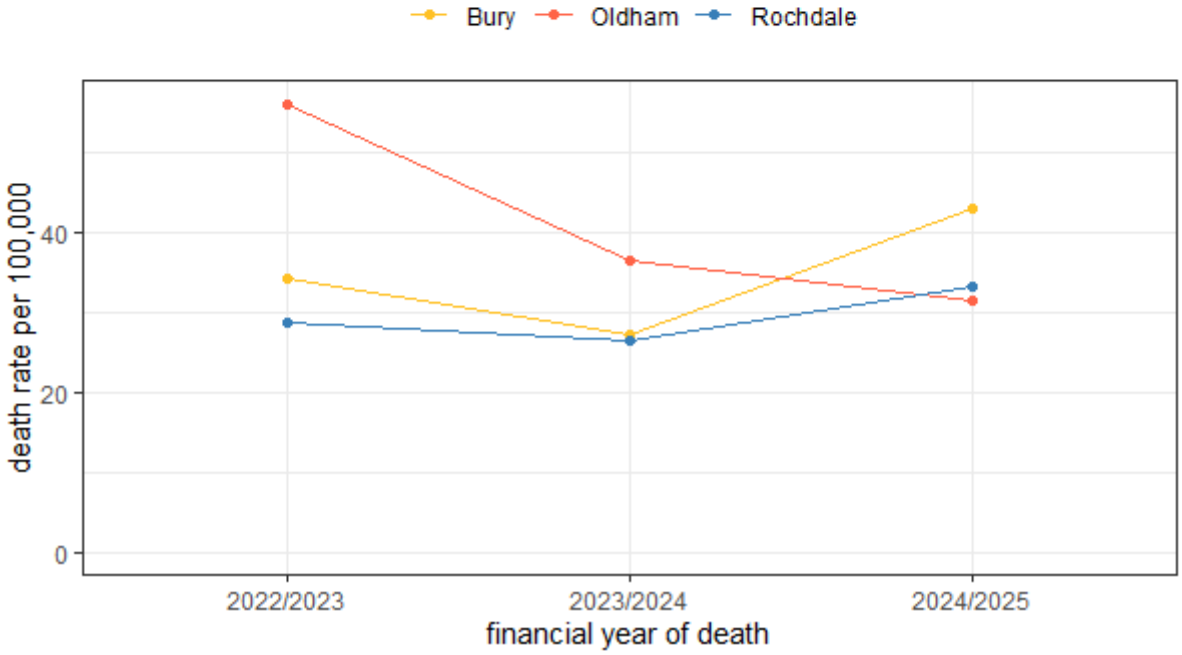


Figure 12: deaths rates per 100k by financial year of death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.2 Notified deaths by gender and year of death

Table 5 shows deaths and death rates per 100,000 children by year and gender, combined across Bury, Rochdale, and Oldham. Numbers of deaths and death rates were similar between male and female children. A slight decrease in the number of deaths reported between 2022/23 and 2023/24 was seen in both male and female children, followed by a slight increase in Female deaths in 2024/25. However, this decrease may still be due to chance variation, rather than a meaningful reduction in child mortality rates. Figure 13 presents death rates by gender and financial year in which the child died.

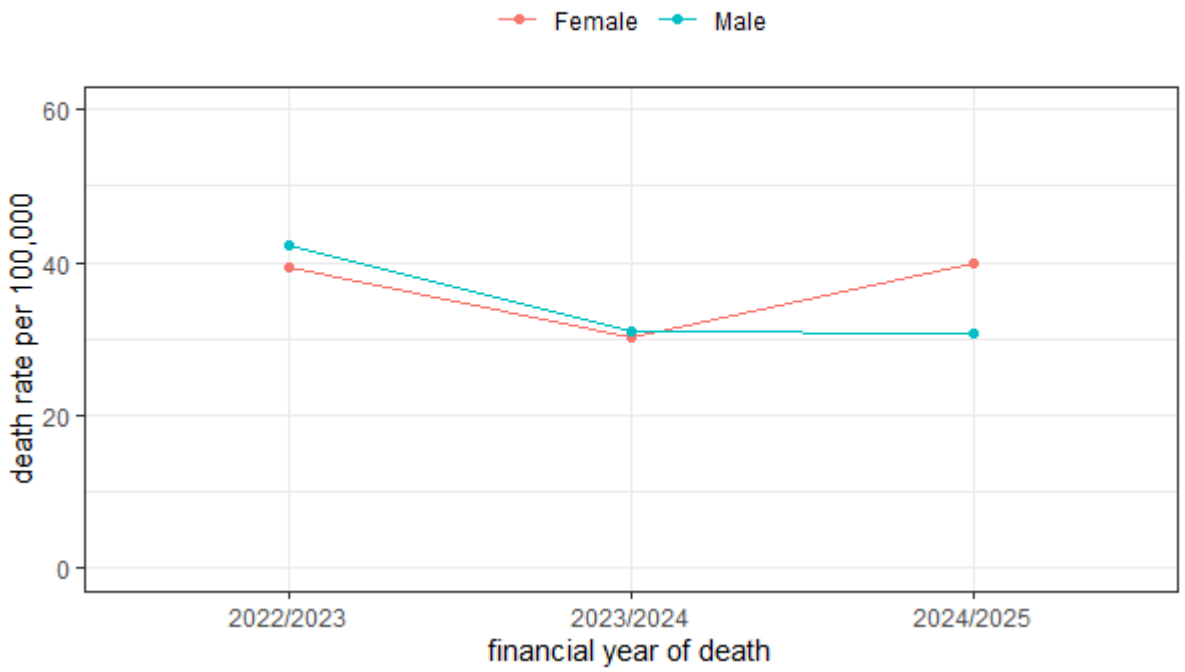
Table 5: deaths reported to CDOP by gender and year

Bury, Rochdale, and Oldham 2022/23 – 2024/25

Financial year	Gender	Deaths	Population	Rate per 100k	95% confidence interval	
2022/2023	Female	31	78,854	39.3	26.7	55.8
2023/2024	Female	24	79,524	30.2	19.3	44.9
2024/2025	Female	32	80,316	39.8	27.2	56.2
2022/2023	Male	35	82,944	42.2	29.4	58.7
2023/2024	Male	26	83,812	31	20.3	45.4
2024/2025	Male	26	84,679	30.7	20.1	45

Figure 13: deaths rates per 100k by gender and financial year of death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.3 Notified deaths by age at death

Table 6 shows numbers of deaths reported in Bury, Rochdale, and Oldham between 2021/22 and 2023/24. Because numbers of deaths are small, the data are presented for all three years and all three areas combined. These data are presented graphically in figure 14[3].

Numbers and rates of deaths were significantly higher in children aged under 1 year, consistent with national data that this is the time when the risk to a child's life is highest. Death rates were significantly higher among children aged 5-9 or 10-14.

Table 6: Deaths reported by age group

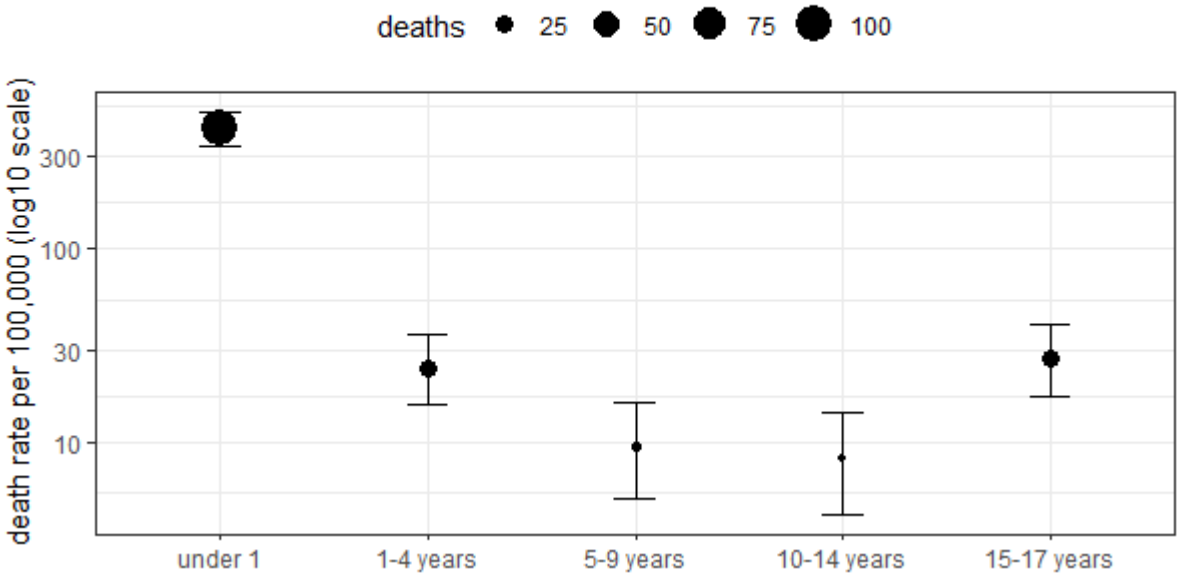
Bury, Rochdale, and Oldham, 2021/22 to 2023/24

Age group	Deaths	Population	Rate per 100k	95% confidence interval	
under 1	101	23,929	422.1	343.8	512.8
1-4 years	25	102319	24.4	15.8	36.1
5-9 years	13	136,543	9.5	5.1	16.3
10-14 years	12	144,386	8.3	4.3	14.5
15-17 years	23	84,709	27.2	17.2	40.7

[3] Due to the much higher mortality rate in children under 1, this graph uses a logarithmic scale for death rates. This makes variation in death rates in older children easier to see.

Figure 14: deaths rates per 100k by age at death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.3 Notified deaths by ethnicity

Table 7 shows death numbers and approximate rates[4] by ethnic category for Bury, Oldham, and Rochdale from 2021/22 to 2023/24. Death rates are presented graphically in figure 15.

Although there were more deaths among White British children, death rates were higher for most other ethnic groups. Small numbers mean that in most cases the apparent higher cases may be due to chance variation, except for children of Asian and 'other' ethnic backgrounds where death rates appear to be significantly higher than for their White British counterparts.

Table 7: Deaths and approximate rates by broad ethnic background

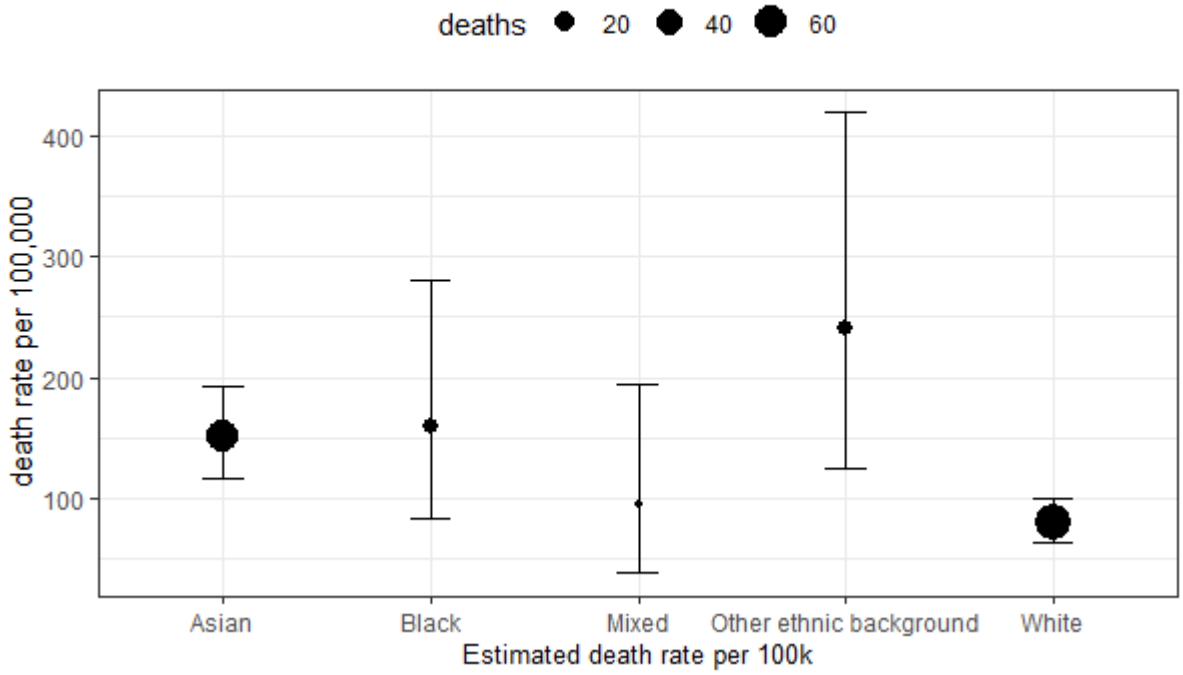
Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Ethnic category	Deaths	Population	Rate per 100k	95% confidence interval	
White	78	97,087	80.3	63.5	100.3
Asian	63	41,672	151.2	116.2	193.4
Black	12	7,484	160.3	82.8	279.6
Other ethnic background	12	4,993	240.3	124	419.1
Mixed	7	7,398	94.6	37.9	194

[4] Mid-year population estimates are not available by ethnicity and age. The nearest data that are available are from the 2021 census which gives an age and ethnicity breakdown of the census population. The rates have been calculated by dividing the number of deaths in each ethnic category over the three years 2021/22 to 2023/24 by three times the combined 0-17 populations for Bury, Rochdale, and Oldham.

Figure 15: deaths rates per 100k by age at death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.4 Notified deaths by deprivation

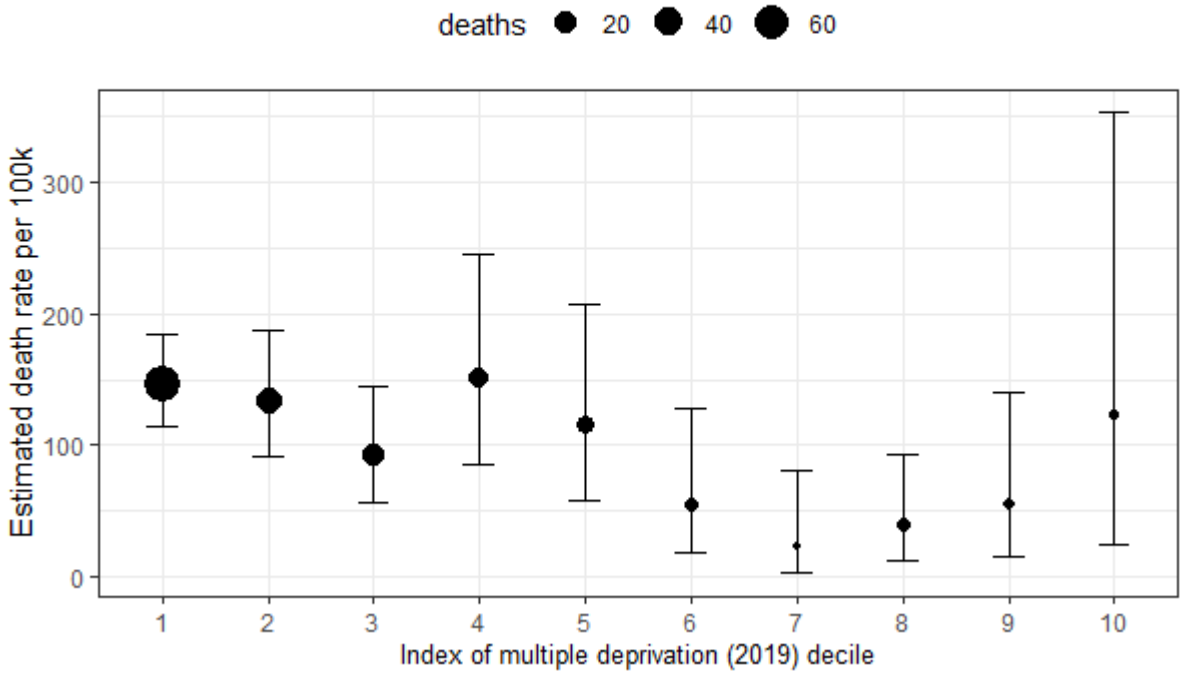
The Index of Multiple Deprivation gives a measure of the deprivation experienced by populations living in small areas (lower super output areas, with populations of around 1,500). Table 8 shows the number of notified deaths by decile of deprivation. More children died in areas of higher deprivation than in less deprived areas. However, the combined population of Bury, Rochdale, and Oldham is more deprived than England as a whole. This is reflected in greater numbers of children living in deciles 1, 2, and 3. Nevertheless, death rates were higher in the more deprived areas than in less deprived areas. This reflects the effects of poverty and higher rates of low birth weight, homelessness, and other risks described in section 5 above in these areas. These data are presented graphically in figure 16.

Table 8: Deaths and death rates by decile of deprivation, Bury, Rochdale, and Oldham, 2021/22-2023/24

IMD (2019) decile	Population aged 0-17	Deaths	Rate per 100k	95% Confidence interval	
1 (most deprived)	49,084	72	146.7	114.8	184.7
2	24,689	33	133.7	92	187.7
3	20,425	19	93	56	145.2
4	10,606	16	150.9	86.2	244.7
5	9,488	11	115.9	57.8	207
6	9,066	5	55.2	17.8	127.6
7	8,558	2	23.4	2.6	80.9
8	12,474	5	40.1	12.9	92.7
9	7,202	4	55.5	14.9	140.3
10 (least deprived)	2,431	3	123.4	24.8	352.9

Figure 16: deaths rates per 100k by age at death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



8. Analysis of deaths reviewed

8 .1 Numbers of deaths reviewed

This section describes the activity of the Bury, Rochdale, and Oldham CDOP for the financial years 2021/22, 2022/23, and 2023/24 in terms of numbers of child deaths reviewed.

Because the deaths reviewed in these years happened between 2017/18 and 2022/23 and the population denominators changed over that time, it is not appropriate to express numbers of deaths as rates. For this reason this section only counts of deaths reviewed are presented.

Table 9 gives the number of deaths reviewed by the local authority area in which the child was living at the time they died and the financial year in which the death was reviewed.

Table 9: Numbers of deaths reviewed by local authority and year reviewed

Year reviewed	Bury	Oldham	Rochdale	Total
2022/23	8	19	8	35
2023/24	15	18	17	50
2024/25	21	34	17	72
Total	44	71	42	157

Due to the variable length of the child death review process, many CDOP reviews do not happen in the year in which the child died. Table 10 shows the numbers of deaths reviewed by year the child died and the year the CDOP review was completed.

Table 10: Numbers of deaths reviewed by year reviewed and year of death

	Year reported						
Year reviewed	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Total
2022/23	1	9	14	11	0	0	35
2023/24	2	1	15	15	17	0	50
2024/25	0	0	2	3	45	22	72
Total	3	10	31	29	62	22	157

Table 11 shows the number of child deaths notified to CDOP and the number of child deaths reviewed each year for 2022/23 to 2024/25.

Table 11: Numbers of deaths notified to CDOP and reviewed by CDOP by year

Year	Deaths notified	Deaths reviewed
2022/2023	66	35
2023/2024	50	50
2024/2025	58	72

The number of child deaths notified to CDOP exceeded the number of deaths reviewed in 2022/23 and in previous years. This was a result of both limited CDOP officer capacity, limited panel time, impacts of COVID-19 on child death review processes in 2020 and 2021, and delays in receiving key information from partners. This led to a backlog of unreviewed cases has built up.

In response CDOP panel meetings for Bury, Rochdale, and Oldham have been extended from half days to full days. This has increased the numbers of cases reviewed per panel to 25 in March 2025. This contributed to the increase in cases reviewed in 2023/24 and in 2024/25 when 14 more cases were closed than were notified. If continued, this provides capacity to review up to 100 cases per year.

As of the 31st of March 2024, the backlog stood at 156 cases. This was a decrease of 12 from the same date in 2024. Assuming the panel can continue to close 25 cases per panel, the backlog should decrease by around 40 cases per year. It is worth noting that the 'backlog' will never reach zero as it includes cases for which the panel is awaiting information from partners, including where inquests are ongoing.

8.2 Demographics of deaths reviewed

Table 12 presents the numbers of child deaths reviewed by the Bury, Rochdale, and Oldham CDOP. Table 13 presents the numbers of child deaths reviewed by the Bury, Rochdale, and Oldham CDOP by ethnic category.

Table 12: Number of deaths reviewed by age and gender

Bury, Rochdale, and Oldham, 2021/22 – 2022/23

Age Group	Female deaths	Male deaths	Total
0-27 days	25	21	46
28-364 days	15	28	43
1-4 years	8	9	17
5-9 years	6	6	12
10-14 years	7	12	19
15-17 years	7	13	20
Total	25	21	46

Table 13: Number of deaths reviewed by ethnicity

Bury, Rochdale, and Oldham, 2021/22 - 2022/23

Ethnic category	Deaths reviewed
White	80
Asian	52
Black	10
Mixed	8
Other ethnic background	4
Ethnicity not known	3
Total	157

8.3 Deaths reviewed by category of death, pre-existing conditions, and learning disability

All CDOP panels use a standard set of categories of death to describe the broad cause of death based on the information available to them. A list of the standard categories of death is provided in Appendix B. The most common category of death was ‘chromosomal, genetic, and congenital anomalies’. This category includes deaths due to extra copies of chromosomes, single gene disorders, cystic fibrosis, congenital heart anomalies, and neurodegenerative conditions. Although this was the most common cause when deaths across the three areas were combined and for Oldham and Rochdale, the most common category of death for Bury was ‘perinatal and neonatal event’. This was the second most common category of death for Oldham and Rochdale. This category includes deaths due to extreme prematurity and its consequences, such as lung or intestinal diseases.

Table 14: Numbers of death by category of death, Bury, Rochdale, and Oldham, 2021/22 - 2023/24

Category of death	Bury		Rochdale		Oldham		Total
	n	%	n	%	n	%	
Chromosomal, genetic and congenital anomalies	6	13.6	12	28.6	25	35.2	43
Perinatal/neonatal event	9	20.5	5	11.9	19	26.8	33
Sudden unexpected, unexplained death	7	15.9	4	9.5	4	5.6	15
Trauma and other external factors, including medical/surgical complications/error	5	11.4	3	7.1	7	9.9	15
Acute medical or surgical condition	6	13.6	4	9.5	3	4.2	13
Malignancy	3	6.8	4	9.5	3	4.2	10
Infection	1	2.3	4	9.5	3	4.2	8
Chronic medical condition	1	2.3	2	4.8	4	5.6	7
Deliberately inflicted injury, abuse or neglect	2	4.5	4	9.5	1	1.4	7
Suicide or deliberate self-inflicted harm	4	9.1	0	0	2	2.8	6
Total	44	100	42	99.9	71	99.9	157

As shown in table 15 of the 157 deaths reviewed over the three years from April 2022 to March 2025, 79 were of children with pre-existing medical conditions. This represents 50.3% of all deaths. This does not mean that the pre-existing medical condition was the cause of death, though this is likely to be the case for those deaths categorised as due to chronic medical conditions or chromosomal, genetic and congenital anomalies.

Table 15: Deaths reviewed where a pre-existing medical condition was present

Bury, Rochdale, and Oldham, 2022/23 - 2024/25

Pre-existing medical condition	Deaths	Percent
Yes	79	50.3%
No	36	22.9%
Not known	23	14.6%
Not Applicable	19	12.1%

Table 16 shows the numbers and percentage of deaths by whether the child had a diagnosed learning disability. In many cases (over 40%) this is category was not applicable, in most cases because the child was too young for a learning disability to be diagnosed: of the 65 child deaths where learning disability status was ‘not applicable’, 30 were neonates aged under 28 days, 31 were aged under 1 year, and 4 were aged 1-4 years old.

Table 16: Deaths reviewed by whether the child had a diagnosed learning disability

Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Learning disability	Deaths	Percent
Yes	22	14%
No	40	25.5%
Not known	30	19.1%
Not applicable	65	41.4%

8.4 Deaths reviewed by presence of contributing factors

The main purpose of CDOP is to identify factors that contributed to the deaths of children reviewed with a focus on common modifiable factors that could be changed to prevent other children from dying in future.

Potentially modifiable factors contributing to deaths are grouped into four 'domains':

- **Domain A:** factors intrinsic to the child, such as low birth weight, genetic or chromosomal abnormalities, or poor maternal health.
- **Domain B:** factors in social environment including family and parenting capacity. This includes smoking, drug use, and domestic violence in the household as well as wider social risks, such as issues with peer groups or at school.
- **Domain C:** factors in the physical environment, such as inadequate or absent safety equipment or access to open water.
- **Domain D:** factors in service provision, such as when a service fails to follow its procedures and guidance, or when two or more services fail to communicate or work together appropriately.

However, the presence of these factors does not necessarily mean that factor could have been modified in that case. CDOP makes a judgement on whether each factor was modifiable or not. Table 17 presents numbers and percentages of deaths where modifiable factors were identified by CDOP.

Table 17: Deaths reviewed by modifiable factors contributing to deaths

Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Factors present	Any factors	Domain A	Domain B	Domain C	Domain D
Absent	47 (30%)	107 (68%)	100 (64%)	127 (81%)	97 (62%)
Present	110 (70%)	50 (32%)	57 (36%)	30 (19%)	60 (38%)

Potentially modifiable factors contributing to deaths were identified in 110 (70%) of 129 deaths reviewed by the Bury, Rochdale, and Oldham CDOP between April 2022 and March 2025. Factors in domain B (relating to the social environment) and domain D (relating to service provision) were most common, identified in 36% and 38% of deaths respectively.

Table 18 shows the proportion of deaths reviewed where potentially modifiable factors were identified broken down by age group. This shows some variation in which domains potentially modifiable factors identified fell into by age group, however the small numbers of deaths in each age group over the three years means that any variations need to be treated with caution. The relative scarcity of factors relating to the physical and social environments in neonatal deaths is plausible as many of these children never leave hospital following birth. Factors intrinsic to the child, such as prematurity, congenital or genetic disease, or poor maternal health (smoking, high BMI) are more common in this age group, identified in 50% of cases reviewed. Factors relating to the social environment (such as smoking, alcohol

misuse, drug use, or domestic violence) were more common in children who died between 28 days and 9 years, identified in 75% of deaths in children aged between 5 and 9. Factors relating to the physical environment, such as lack of appropriate safety features were also most commonly identified in deaths of children aged 5 to 9 years, found in 41.7% of cases reviewed. Factors relating to service provision were identified in a similar proportion of all deaths. These typically relate to delays in care, failure to follow appropriate protocols, and poor communication between agencies.

Table 18: Deaths reviewed by age group and modifiable factors present

Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Age Group	deaths	Domain A factors present		Domain B factors present		Domain C factors present		Domain D factors present	
		n	%	n	%	n	%	n	%
0-27 days	46	23	50	9	19.6	4	8.7	19	41.3
28-364 days	43	14	32.6	23	53.5	11	25.6	12	27.9
1-4 years	17	3	17.6	7	41.2	3	17.6	9	52.9
5-9 years	12	3	25	9	75	5	41.7	4	33.3
10-14 years	19	3	15.8	5	26.3	4	21.1	6	31.6
15-17 years	20	4	20	4	20	3	15	10	50

Specific modifiable factors: maternal over/under weight

Both high and low maternal bodyweight is associated with increased risk of child death. Mechanisms involved include higher risk of birth asphyxia in children of mothers with BMIs greater than 30 and at higher levels of obesity increased risk of congenital anomaly.[5]

High maternal BMI was identified as a factor in 22 deaths (14% of all deaths reviewed), 14 of which occurred before the baby was 28 days old and a further 6 occurred before the child's first birthday. 10 of 22 deaths where high maternal BMI was recorded were categorised as 'chromosomal, genetic, and congenital anomalies' and 7 of 22 were categorised as 'perinatal or neonatal events'.

Specific modifiable factors: consanguinity

Genetic relatedness (consanguinity) between parents increases the risk of congenital abnormalities and early child death. This is in part due to the higher risk of severe autosomal

[5] Thornton et al (2023) Non-linear associations of maternal pre-pregnancy body mass index with risk of stillbirth, infant, and neonatal mortality in over 28 million births in the USA: a retrospective cohort study; Johannsen et al (2014) Maternal overweight and obesity in early pregnancy and risk of infant mortality: a population based cohort study in Sweden.

recessive diseases (where two copies of the disease-causing gene are needed for the disease to occur)[6].

Table 19 shows deaths reviewed broken down by whether the parents of the child were known to be blood relatives. Of the 157 deaths reviewed by CDOP over the three years from 2022/23 to 2024/25, 24 (15%) were of children born to parents who were known to be blood relatives. Parental relatedness was not known for a further 33 deaths (21% of deaths reviewed). Deaths of children whose parents were related involved children who died at all ages. The most common category of death identified for these deaths were 'chromosomal, genetic, and congenital anomalies' (14 of 24 deaths). Of 43 deaths reviewed that were categorised as due to this cause, 24 (56%) were in children whose parents were known to be close relatives.

Table 19: Deaths reviewed where parents were known to be blood relatives

Bury, Rochdale, and Oldham, 2022/23 - 2024/25

Are parents blood relatives	n	%
No	100	64
Not known / not applicable	30	19
Yes	24	15

Specific modifiable factors: smoking, alcohol, and substance misuse

Smoking, alcohol misuse, and substance misuse are risk factors for poor child and adult health. All three continue to be identified in reviews of child deaths across Bury, Rochdale, and Oldham.

Table 20 provides numbers of deaths where parental smoking, alcohol misuse, or substance misuse were identified. Data on these factors is not always recorded, so the numbers below should be taken as a minimum and are probably an underestimate. Smoking by the children who died is not reliably recorded but data are available on children who had known drug or alcohol misuse issues.

Smoking during pregnancy was identified by CDOP in 7 deaths (5% of those reviewed by the panel) between 2022/23 to 2024/25. All these deaths involved children aged under 6 months old. Smoking in the household (not necessarily during pregnancy) was identified in 23 deaths. Maternal smoking was identified in 21 deaths, paternal smoking in 11 deaths, and both parents smoking in 12 deaths. Alcohol and substance misuse in parents were less common and were identified in 8 and 13 deaths.

[6] Olubunmi et al (2019) A review of the reproductive consequences of consanguinity.

Table 20: Deaths where smoking, alcohol, or substance misuse issues were identified

Bury Oldham and Rochdale, 2022/23 – 2024/25

Modifiable factor	n	%
Mother smoked during pregnancy	10	6.4
Mother smoked	29	18.5
Father smoked	17	10.8
Both parents smoked	14	8.9
Mother had an alcohol misuse issue	12	7.6
Father had an alcohol misuse issue	12	7.6
Both parents had an alcohol misuse issue	6	3.8
Mother had a substance misuse issue	8	5.1
Father had a substance misuse issue	16	10.2
Both parents had a substance misuse issue	4	2.5
Child had drug or alcohol issue	4	2.5

Specific modifiable factors: unsafe sleeping arrangements

There were 6 deaths where unsafe sleeping practices were identified. Five of these deaths were categorised as ‘sudden unexpected, unexplained death’ by CDOP, and made up 33.3% of 15 deaths in this category. The remaining death was categorised as due to a chromosomal, genetic, or congenital anomaly.

All 6 deaths were in babies aged 28-364 days old. In 4 of the 6 deaths where unsafe sleeping arrangements were noted there was also smoking in the household. In 5 of 6 deaths one or both parents were believed to be misusing alcohol.

The tendency of these risk factors to co-occur suggests that a combined strategy for tackling them may be appropriate.

9. Recommendations

Based on the analysis of deaths reported to and reviewed by CDOP, as well as of the publicly available data presented above, this report recommends that:

- **Child poverty:** Health and Wellbeing Boards should note the worsening in measures of child poverty and to work with local partners to ensure that local antipoverty plans address increases in childhood poverty.

- **Smoking, alcohol, and substance misuse:** Health and Wellbeing Boards, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:
    - Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
    - Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.

- **Safe sleeping arrangements:** Health and Wellbeing Boards, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. Safeguarding partnerships should ensure for children who have additional vulnerabilities that are captured in child protection or child in need plan.

- **Consanguinity:** Health and Wellbeing Boards should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.

- **Maternal healthy weight and nutrition:** reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. Health and Wellbeing Boards should assure themselves of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

Appendix A: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

- to collect and collate information about a child's death, seeking relevant information from professionals and where appropriate family members.
- to analyse the information obtained, to confirm or clarify the cause of death, to determine any contributing factors, and to identify any learning arising from the child death review process.
- that may prevent future death.to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths and will promote the health safety and well-being of children.
- to notify the relevant locality's Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected.to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it is identified there are any errors or deficiencies in an individual child's registered cause of death.
- to provide specific data to NHS digital through the National Child Mortality Database.
- to produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, and any lessons learnt, and actions taken and the effectiveness of the wider child death review process.
- to contribute to local, regional, and national initiatives to improve learning from child death reviews including where appropriate approved research carried out within the requirements of data protection.

Appendix B: CDOP categories of death

Category	Name & description of category
1	**Deliberately inflicted injury, abuse, or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
2 (i)	**Suicide (where the panel feels the intention of the child was to take their own life)**
2 (ii)	**Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)**
2 (iii)	**Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)**
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** Deliberately inflicted injury, abuse, or neglect (category 1).
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).
8 (i)	**Immaturity/Prematurity related**
8 (ii)	**Perinatal Asphyxia (HIE and/or multi-organ failure)**
8 (iii)	**Perinatally acquired infection**
8 (iv)	**Other (please specify)**
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).

Local Area SEND Partnership Priority Impact Plan

July 2025 Stocktake

July 2025

Bury Council

NHS Greater Manchester Integrated Care

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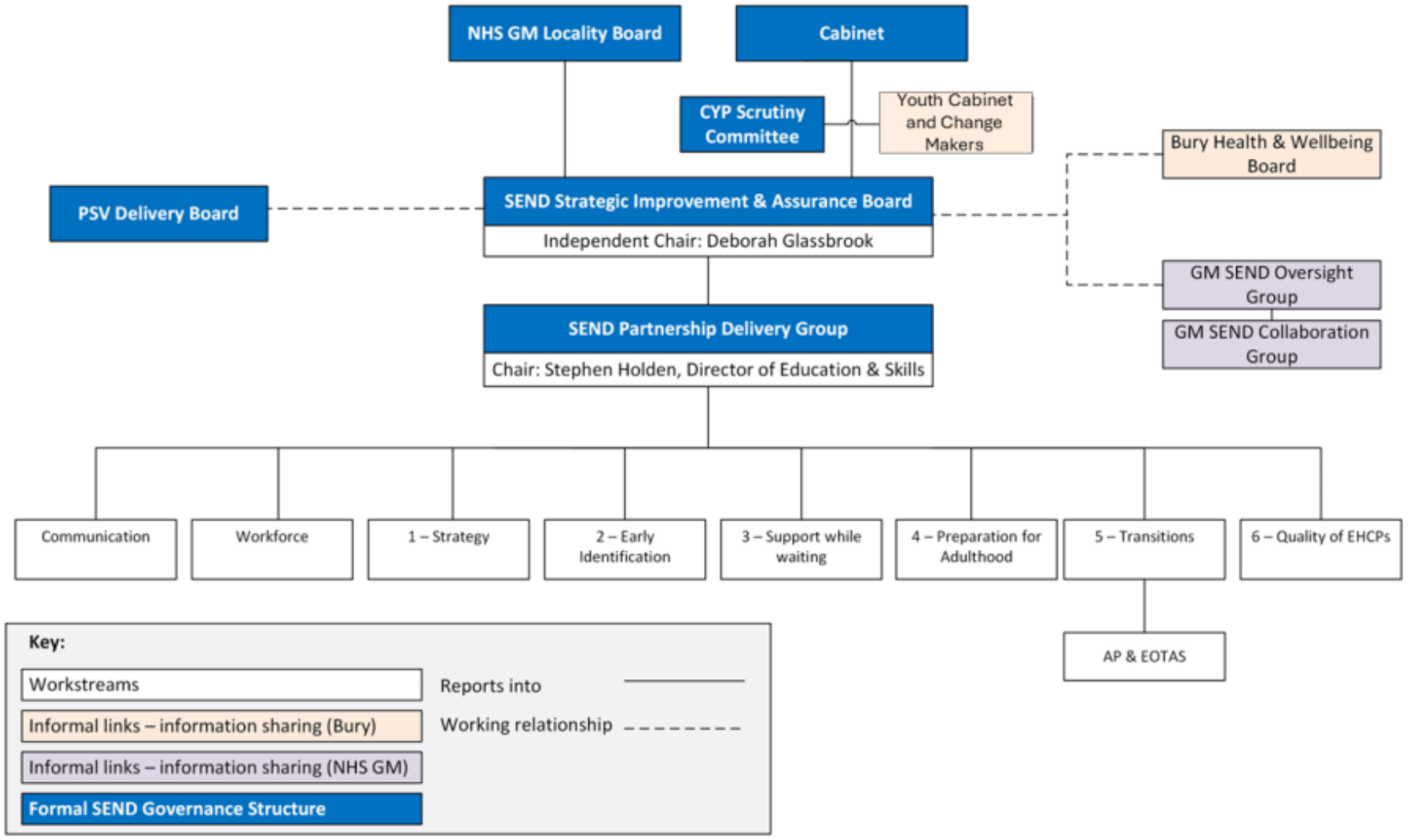
NHS Greater Manchester Integrated Care

Bury Council

1. Executive summary

SEND Strategic Improvement and Assurance Board – Local Area Governance Overview

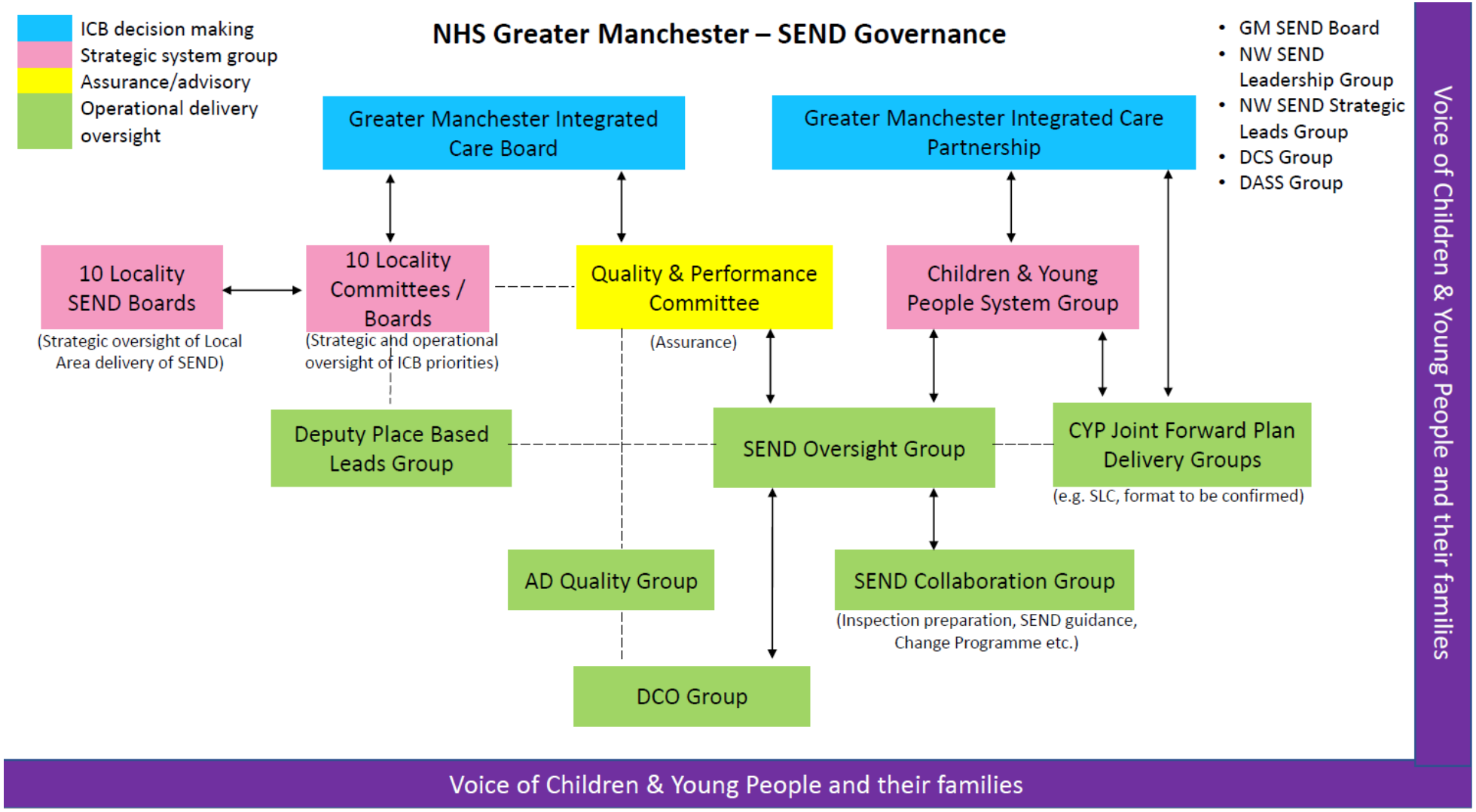
Bury Local Area SEND Governance



NHS Greater Manchester Integrated Care

Bury Council

NHS Greater Manchester – SEND Governance



NHS Greater Manchester Integrated Care

Bury Council

Executive summary

In Bury we have progressed the strategic alignment of the 6 priority areas and 3 areas for improvement, supporting us to understand how different elements of the system are interconnected and foster a more collaborative approach across the partnership. These insights have shaped our focus during the last 6 months of our improvement plan, aimed at delivering better outcomes for children and young people with SEND, and their families. We have taken significant and positive action but also recognise that there is still more to do to ensure every child, young person and their families receives the support they need, when they need it.

The December Stocktake and deep dive activities have been instrumental in evaluating the current state and defining key next steps.

Strengths

We are very proud of the contributions made by groups of children and young people. Their voices, experiences, and aspirations have been at the heart of our work, shaping our priorities and driving our commitment to meaningful change. Our approach is grounded in the reality of our system—its strengths, its challenges, and its potential.

- Progress on the journey of developing our strategic partnerships, providing support and challenge and shifting the culture from silos to enhanced inter and intra-organisational collaborative working
- Strategic developments have been finalised or are nearing completion, laying the groundwork for long-term improvements across the SEND system
- Strengthening early identification and enhanced support whilst waiting for Health services
- Improving EHCP quality & initial increases in capacity and capability
- Strengthened transitional arrangements to promote joined up planning across services, including those preparing for adulthood

Priorities and development areas

- Availability of data, reporting, defining clear, measurable outcomes
- Ability to meet increasing demand and complexity of need across the system
- Strategic alignment, shared accountability
- Ongoing challenge of developing workforce capacity, consistency, and skills alongside delivering transformation and change
- Historical legacy & shifting national policy and reform (current landscape)

Local Area Partnership development

Over the course of our improvement, our partnership has made significant efforts in our commitment to deepen collaboration, building trust, and aligning efforts across the SEND system. This progress reflects a shared commitment to improving outcomes for children and young people with SEND in Bury.

Successes:

- We have actively worked closely with early years providers, schools, and post-16 settings to foster a more inclusive and responsive educational environment.
- Bury2Gether established as a key partner, and a commitment and start of the journey to establishing a more authentic and valued relationship with parents.
- Cross-sector collaboration has progressed, with clearer roles, shared priorities, and more integrated planning, through re-establishments of our joint commissioning group and multi-agency panels have enhanced coordination, though there is still work to do
- Deliberate efforts to improve how we communicate with stakeholders and act on feedback. Mechanisms such as a survey, listening events, and feedback loops are helping us to start to become more responsive and transparent.

Priorities and development areas:

- Deepen co-production and engagement in some parts of our overall system including in relation to some aspects of NHS commissioning, enhancing integration and joint working, particularly around transitions and PfA
- Creating a culture of collaboration: building and sustaining trust with families through visible action and accountability and timey responses to concerns, feedback
- Continue investing in workforce development across the system to build confidence and capability in inclusive practice, through targeted training and resources to meet increasing levels of demand
- Embed consistent early identification / support pathways across settings

Engagement & coproduction with children and young people

Across the partnership, we have created spaces for children and young people to contribute to our improvement journey, placing their voices at the heart of everything we do. Children and young people with SEND in these groups are becoming **active partners** in shaping the services that affect their lives. As a partnership we will expand on this work to create a cultural shift in moving from consultation to coproduction, doing so wherever we can, and with an increasingly broad number of children and young people. This change not only affirms their autonomy but also builds trust and confidence in the services designed to support them and there is a sense of optimism about their future among the children and young people who have contributed

Key achievements

- Young people feel listened to and are making their own decisions and are optimistic about careers, relationships and independence.
- Coproduction of the Local Area SEND Strategy
- Improved engagement and visible senior leaders and an appreciation that the partnership are working hard to support them:
- Strengthened communication and engagement, described as very good and clear
- Feeding SEND voices into the wider participation work
- Changemaker group, driven by passionate children & young people, which they love!
- Some young people feel listened to and are making their own decisions and are optimistic about careers, relationships and independence.
- Good examples of professionals speaking directly to them, not just their parents

Areas for development

- Easing financial worries about the future and improved communication of the work being done behind the scenes
- Current Changemakers group reflects only a small number of children and young people

Changemaker priorities

- Develop training for professionals on engaging students with SEND and promoting early identification safety and effective support
- Create a “School Survival Guide” tailored for children and young people with SEND
- Broaden engagement and improve transparency to ensure all voices are heard

2. Progress summary – impact measures and milestones for each Priority Theme

Theme 1 – PIP1 – Strategy

Impact of PIP to date

The process of developing and co-producing the SEND strategy for the borough was helpful in confirming the outcomes for children's and young people we are seeking, our priorities, our programme of work, and the importance of co-production, and has thus informed our delivery against priorities across the breadth of the programme. Having recently been finalised, we are shortly to circulate the strategy to all partners and stakeholders in the borough. This will be part of and complement the strengthened and improved communication and engagement mechanism, including specifically the relaunch of the local offer.

The work of the SIAB is increasingly informed by a variety of feedback mechanisms capturing the voice of children and families, and via direct engagement with children and young people for example in the quality of EHC plans is perhaps more important to parents/carers than receiving a plan within the 20-week timescales that is not of high quality.

Governance routes are clear for the work of SIAB across the partnership including the ICB and there is evidence of utilisation of governance to effect prioritised action and change – for example in some NHS waiting times.

Changes we need to make in the next phase of the programme

Further work is required to demonstrate more clearly to children and families the impact of the strategic framework, and we also need to more clearly articulate the sense of the strategic framework with its focus on outcomes for children and young people operating as a golden thread through all other associated strategy and policy documentation – the graduated approach, the relaunched SENCA network, the workforce strategy.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. Strategic vision for Bury SEND improvement coproduced and approved 2. Improvements in communications through increased comms on Local Offer and through feedback loops such as 'You said , We are Doing' 3. Programme governance approaching maturity; now able to propose changes to drive long-term sustainability	1. Much progress developing data/intelligence on the progress/impact of the improvement plan, but further work and coproduction required to reach maturity over next 6 months 2. Generally off track in terms of the impact of strategic changes/improvements due to delays to some workstreams	• In the last year, received 14.4 request for an assessment per 1,000 4–19-year-olds. This is the same as the North West rate, showing that we are performing in line with many of our comparators. • Data on impact is currently unavailable, with a survey to collect views of children and families set to be carried out in the near-term.

Theme 1 – AFI1 – Communication

Impact of AFI to date

Foundations are now in place to enable the communication improvements identified, with the appointment of a SEND Comms and Engagement Officer, temporary CYP Comms Manager & interim Head of Comms since the last stock take. An interim comms strategy and comms working group have been established to enable insights and the voice of service users, parents and carers to co-produce the comms strategy and drive delivery. Two newsletters have been produced and a third is due for publication with improved curation and production. A programme of regular updates to the Local Offer is in implementation and publicised via social media pages to provide opportunities for corporate/mass comms activity and dialogue.

While there has been an uplift in comms and engagement activity via mass communication methods, a challenge remains around direct relationships and networks. This is being approached in multiple ways:

- A set of standards has been written into the interim comms strategy with the SEND delivery group, with SIAB asked on an ongoing basis to provide insight for embedding those;
- A standing item has been added to the SIAB agenda to ensure all board members take away a shared understanding of the key messages arising and specific calls-to-action;
- A stakeholder mapping exercise is proposed as part of the ongoing board development to understand connections, networks and what support might be needed for board member dialogues with those groups (as well as spotting and addressing gaps).

Changes we need to make in the next phase of the programme

The proposal for the Changemakers having a social media presence has been agreed in principle and is in research to understand what is possible while ensuring safeguarding and proper use. The work to mainstream communication and develop the culture of proactive updates and dialogue, and prioritising that as part of the work (and not an add-on) must be prioritised so that all areas of the system are clear with all about what they do, providing updates and information, and sharing their successes as well as being transparent about the challenges.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. Initial comms approach & framework (i.e. strategy) now in place, driving better use of the Local Offer, council website, and other channels – newsletter and Facebook page. Full comms strategy due by August 2. The voices of children in the Changemakers group and parents in the Bury2Gether steering group included in the co-design of the strategy	1. Delay in the publishing of a timeline for change to share with families, due to waiting on the development of the strategic elements 2. A full SEND Comms strategy has been delayed similarly 3. A more coordinated, systematic, and two-way approach is required for continually gathering the feedback and experience of parents/families	• They are making young people's voices heard and are validating their thoughts and feelings" • "[I like] being a mouthpiece for young people with additional needs and disabilities" • "I appreciate all the effort you have put into the group and help and support you have offered." *Young person* • Substantial reduction in the number of complaints received from parents, compared to late 2023/early 2024. We have received 28 parent complaints so

Theme 1 – AFI3 – Workforce

Impact of AFI to date

A high-level workforce strategy, informed by best practice, has been developed to define the required training levels for specific staff cohorts. An implementation plan is in development. The programme sets a clear framework, though it's too early to assess impact. Work is underway to complete a stocktake of current training provision, with assessment of demand by competency level and comparison of training uptake against cohort size and identify gaps in provision.

Whilst our implementation plan is under development, training remains at the heart of our efforts to support inclusive practice and continuous learning. As part of this commitment, Changemakers will be designing training for school staff on how to effectively engage with and support young people with additional needs and disabilities in education. This important work is set to begin in the summer term.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. New Workforce Strategy and Learning and Development plan developed and approved 2. Good engagement in a programme of induction and CPD sessions run with SENCOs over the spring and summer terms	1. Impact of new strategy and plan behind timeline due to delays 2. Low engagement in staff training programme delivered by Oak Learning Partnership	It is currently not feasible to collect data points to demonstrate impact, as the strategy has yet to be implemented. We have developed a framework for training of staff across the council and NHS, which is delivering positive impact. A programme of induction sessions has been run with SENCOs, and further 'Strategic Priorities for SENCOs' sessions have been run. A session was also run by the EHC team on Annual Reviews. This is accompanied by a growing set of supporting information to give SENCOs information and advice. 12 new sessions will be run in the summer term; responding directly to the feedback from SENCOs, and available to all practitioners not just SENCOs. Engagement with training for schools has been lower than target. Currently 36% of education settings are engaging with training provided by the Oak Learning Partnership.

Theme 2 – PIP2 – Early identification and support

Impact of PIP to date

There has been a notable increase in statutory compliance across the Local Offer, with the rollout of an enhanced Graduated Approach Toolkit and targeted CPD leading to growing uptake in schools. The development of Section 23 notifications and follow-up support has strengthened early identification pathways. Inclusion Services have been redesigned to include a community of practice model and expanded capacity. An expanded SEND Health Visiting Service, using additional funding from Bury Council, is receiving very positive feedback from families.

Changes we need to make in the next phase of the programme

The next phase focuses on implementing a new integrated, graduated model for early assessment, identification, and intervention. This model relies on strong partnerships with schools, families, and communities, and is sustained by a commitment to CPD. The recent Parent/Carer survey highlights the importance of an accessible local offer to parents' understanding of the support. A key innovation is reimagining our EPS through a Communities of Practice (CoP) model. Though still early, we are already seeing stronger school engagement, partnerships, and a shared drive for change. These successes are informing plans to expand CoP across SEND services and align with key local authority functions like School Attendance, Admissions, and the Virtual School. Statutory Assessment and Review teams will also join the 'Team Around the School' model. Additionally, we will relaunch our SENCO networks in-house from September 2025, maintaining borough-wide collaboration while integrating more targeted support aligned with Bury's strategic priorities.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. Increased statutory compliance across the local offer 2. Enhanced Graduated Approach Toolkit, supported by targeted school CPD and growing uptake across settings 3. Development of Section 23 notifications and follow up support 4. Redesign a of Inclusion Services, incl. a community of practice (CoP) model and increased service capacity 5. Establishment of dedicated SEND HV team using increased Health Visitor capacity	1. Capacity to keep the Local Offer consistently updated, mitigating actions are now in place. These include the introduction of dedicated communications support and a compliance audit to drive improvements in content quality, accessibility, and user experience 2. Limited evidence of a Graduated Approach, not yet fully embedded across Bury services. This has been acknowledged, and targeted mitigation actions are underway	• Increase from 33% to 42% of SENCOs reporting that over 50% of staff are using the Toolkit, with an overall increase in confidence in using it. Reports of Toolkit being embedded increased from 38% to 42%. • Attendance rates for children with SEND were 91.6% for the academic year 2024-2025 • 0% of parents are satisfied/very satisfied with the early identification of their child's SEND needs. 57% of parents surveyed found the local offer somewhat or very useful • 30% of new EHCPs are for children aged 11+ years, down from 54% in 2023 & growth in the proportion of secondary school age children supported at SEN Support • Extremely positive feedback on new face-to-face

Theme 2 – PIP3 – Access to support

Impact of PIP to date

Waiting times for NHS services have consistently been flagged by young people and families, in Bury and nationally. SIAB has been routinely updated on steps taken to improve the position. Broadly access to Community Physio, Community OT, and Core CAMHS services are consistent across GM. Speech and Language therapy services have been challenged but improvement is evident and supported by the implementation of Can-do app well regarded by parents. Community Paediatric waiting times remain challenging, but this has been highlighted with NCA and local transformation work and waiting time initiative work is having an impact.

Progress is being made but we recognise this is a key factor for parents and providers and commissioners strive to improve at every opportunity. We understand progress is hard to recognise when the waiting times remain too long.

Data on the uptake of the use of padlets across a range of subjects have been routinely reported to SIAB and all NHS organisations are challenged on impact.

Changes we need to make in the next phase of the programme

The most significant challenge is the waiting time for Autism and ADHD assessment via CAMHS for young people. SIAB have been updated on the ICB wide proposals for the ND pathway, including access to an ND Hub. This is due for implementation in October – work is progressing to ensure he ND hub proposition is properly co-produced.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. Average waiting time reduction in some areas 2. Several evidence-based services now available to families while waiting for support 3. Launch of NHS GM Adult ADHD consultation (update to June SIB)	1. Some of the challenges for waiting times remain, with demand pressures and financial position of providers and commissioners, as well as availability of work, impacting these 2. Implementation of the GM specified ND pathway arrangements	In terms of % children's waiting less than 18 weeks for an appointment, as of April 2025 • Children's Occupational Therapy – 48% (4/10 in GM) • Paediatrics – 63% (6/10 in GM) • Physio – 60% (5/10 in GM) • SALT – 23% (9/10) (up from 9% in August 24)

Theme 2 – PIP6.1 – EHC Plans

Impact of PIP to date

Bury has maintained strong statutory compliance with EHCP timelines while progressing quality improvements, particularly in respect of new assessment. To tackle common QA issues—such as unclear aspirations and limited social care input a new EHCP template has been introduced to improve clarity and completeness, CPD has been delivered on writing legally compliant EHCPs to all SEND Officers, and an EHC Link Officer for Social Care has been appointed to strengthen contributions and compliance.

Insights during our improvement journey highlight both barriers and enablers to achieving embedded, sustained change in both outcomes and experiences. Quality of Education, Health and Care (EHC) plans is often valued more by parents/carers than simply meeting the 20-week statutory timeframe.

Changes we need to make in the next phase of the programme

- There is a need to strengthen our partnership working in this area to ensure shared ownership of outcomes.
- Improve messaging and engagement with partners, families, and communities.
- Expand Training and Quality Assurance: Build staff confidence and consistency through ongoing professional development and robust QA processes.
- Improve Data Use and Impact Tracking: Develop clearer milestone indicators and use data to drive continuous improvement.
- Balance Timeliness with Quality: Prioritise meaningful support and outcomes over meeting statutory deadlines alone.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. Successful recruitment into EHC Team, incl. Team Manager and recruitment to senior case officer structure and case officer 2. Improved data quality, to include compliance from services in respect of the EHCNA 3. High levels of statutory compliance with the 20-week timeframe have been sustained, whilst quality improvements have been underway 4. Written processes and procedures have been developed and embedded in accordance with the statutory framework and supported by training to all staff	1. Capacity and capability remain challenges 2. Embedding induction and training has required significant time and capacity 3. Audit activity has been compromised by low volume audits and partnership commitment 4. Historical legacy continues to impact user trust and has placed additional pressure on service capacity 5. Timely communication remains an area of concerns, systems are currently being explored to address this	• Average 20-week compliance this year – remains above 90%: in the top quartile of local authorities nationally and markedly better than at the point of inspection (2023 full calendar year: 74%) • Invision 360 report highlights evidence of early improvements in quality, including a substantial reduction in plans audited as “inadequate” and an increasing proportion of plans rated as “good”. • Positive qualitative feedback is indicative of early signs of improvements, from some services users and settings

Theme 3 – PIP4 – Preparing for adulthood

Impact of PIP to date

Improvements to the information and guidance available has been improved, with the creation of factsheets and development of the local offer site that aligns with information from comparable authorities. Significant progress has also been made for individuals transitioning to adult social care, highlighted by the establishment of a PFA transition team, which facilitates a smoother shift into adult care services.

Although progress has been made in improving information about Preparing for Adulthood (PfA) and in developing guides for annual reviews, we are still working to ensure that this information is effectively integrated into annual reviews at the correct times. This effort is in parallel with other initiatives aimed at updating the EHCP and review documentation, as well as establishing quality assurance processes for these reviews.

Changes we need to make in the next phase of the programme

Effective communication and collaborative partnerships will be vital for the next stage of this initiative, ensuring that PfA is meaningfully addressed within reviews, with educational institutions playing a crucial role in enhancing pathway planning. This is closely linked to the EHC team's ability to quality assure reviews; the feedback mechanisms established will be instrumental in driving necessary changes.

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. Preparing for Adulthood pathway and factsheets developed, tested, and launched with settings. 2. Dedicated ASC team becoming well embedded 3. Preparing for adulthood local offer redesigned and updated with pathway information 4. Mapping and audit of existing provision to inform future commissioning discussions.	1. The target that preparation meetings take place for all children with an EHC plan at age 14 is not being met due to EHC team capacity challenges 2. Communication to SENCO's and difficulties accessing the SENCO network – this should be improved next year with bringing the SENCO network inhouse. 3. Staff changes within Children Services have occasionally disrupted momentum 4. Lack of parent attendance at co-production meetings around design adult social care transition policies	• "[PfA staff member] has been brilliant – very understanding and helpful to me and my daughter, giving support whenever he can." *Parent* • PFA team working with all 17yrs old on PfA tracker. Current caseload 72 with 30 LD cases. • 72% of 19-year-olds previously supported at SEN Support in Bury qualified to level 2 (England average 65%); 34% of those with an EHCP (England 30%). • 40% of 19-year-olds previously supported at SEN Support in Bury qualified to level 3 (England average 35%); 21% of those with an EHCP (England 14%). • Amongst top 50 LAs nationally for all the measures above.

Theme 3 – PIP5 – Transitions

Impact of PIP to date

All primary schools are now consistently inputting data into the 6 into 7 software, and secondary schools are accessing this, enabling a more standardised approach to transition and the exchange of quality information . The current service level is due to end in September 2026, with no identified funding to sustain it beyond that point. Despite the potential for this platform to support transitions from PVI nurseries to primary, and from secondary to further education, financial constraints cast doubt on continued and expanded use. Further support has been provided by education services in our continued endeavor to improve the effectiveness of transition (e.g. sharing of best practice events, portage support group, planned MA transition for parents, summer support sessions delivered from the Family Hub, targeted support from the Virtual School and Youth Service).

Additionally, all relevant health agencies have implemented Standard Operating Procedures for transition, and a system for ongoing quality assurance is planned to ensure these remain effective, including SEND Health visiting & School Nursing. MDT led meetings are in operation for children and young people with complex health needs and epilepsy however, health partners have indicated that current capacity limits their ability to deliver this. All health services are beginning conversations about health transitions from year 14 onwards.

Changes we need to make in the next phase of the programme

- Evolve Bury's transition best practice guide to incorporate health and social care for use by education partners
- Understanding the cohorts of CYP in receipt of a statutory plan and those at SEN support, as well as the interdependencies across service areas
- QA to measure effectiveness of Transition Standard Operation procedures in practice
- Mitigate to further reduce EHCP figures

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. All primary schools are inputting transition data into 6into7, and all Secondary Schools have access. 2. Identification of further transitional support for schools, families and young people, however impact needs to be established 3. Standard Operating Procedures established across all health services	1. Pupil Pathways (software developer) are still developing this functionality for expanding 6into7 for use at other points in transition. However, it is not clear if there are available resources to invest in this software. 2. Slight decline in the percentage of children and young people in education & training aged 16-17, from 85% in March 2025, from 88% in 2024. A recent parent survey is indicative that 18% were satisfied with the support they received through transitions, it is unclear if these pupils were subject to a statutory plan or receive SEN Support	• 100% of school settings using the 6into7 platform. • Attendance rate for children with SEND in year 7 is now 92%, from a baseline of 89% • Recent feedback from ILACS inspection, identified transitions for children in care are planned sensitively and timely, in ensuring best outcomes for children • Achievement for children with identified SEND in RWM measures at the end of Primary school and Secondary school (A8) above national average.

Theme 3 – PIP6.2 – EHC Plans

Impact of PIP to date

Key stage transfer amendments were largely completed within statutory timelines, supporting smoother transitions. Over 70% of EHCPs had a completed annual review in 2024–25, reflecting strong engagement. Improved data systems now enable comprehensive tracking of review activity, while newly developed procedures—aligned with statutory requirements and supported by staff training and CPD—are strengthening consistency and accountability across the service. Notifications for key stage transfers for the forthcoming academic year have been issued in advance to enable timely planning and preparation, with a new template introduced to ensure that Annual Reviews address all aspect of the EHCP and are supported by evidence.

Changes we need to make in the next phase of the programme

Whilst the number of EHC Plans which have had a review completed is now understood, within a 12-month period, this is a single performance indicator. The focus next will require the maintenance and strengthening of data, to understand statutory compliance with annual review timescales and a focus on quality of outcome and experience. Ensuring timely communication is an urgent issue for addressing, as well as ensuring sufficient capacity required for sustained improvement.

Area of strengths	Areas for development	Selected data points to illustrate impact to date
1. Most key stage transfer amendments, involving a placement change, were completed in accordance with the statutory transfer timelines. 2. Annual review data is indicative that in the academic year 24-25, 66% of EHCPs had a completed review involvement, albeit timeliness or quality is not established 3. Development and improved use of data systems for tracking and reporting systems, and which now include all annual review involvements 4. Written processes and procedures have been developed in accordance with the statutory framework and supported by training to all staff	1. Workforce capacity and capabilities remain a challenge, against meeting the current levels of demand, though refinement of processes, training, recruitment are mitigating this, further resource is required. 2. Annual reviews are reliant on sufficiency across the system. 3. Data quality on annual review timeliness has been a longstanding challenge and resource intensive. A revised annual review plan to achieve statutory compliance is in development to determine priority areas and greater statutory compliance, including notifications 4. Historical legacy continues to impact user trust and has placed additional pressure on service capacity 5. Timely communication remains an area of concerns, systems are currently being explored to address this	Key Data Summary of completed reviews within a 12-month period: • Total number of EHCPs due : 2,549 • Annual reviews currently overdue: 862 (34%) - either not started or in process • Reviews either completed or not yet due: 1,687 (66%)

NHS Greater Manchester Integrated Care

Bury Council

Theme 3 – AFI2 – Alternative Provision (AP) & Education otherwise than at school (EOTAS)

Impact of AFI to date

The co-production and formal approval of the EOTAS policy by the Council marks a significant step in ensuring inclusive and consistent educational provision. Comprehensive training for case officers has enhanced understanding and implementation of the policy, while the establishment of a multi-agency panel ensures that all EOTAS requests are considered through a collaborative and holistic lens.

The formation of the AP Strategy Group and the drafting of a strategic framework demonstrate a proactive approach to improving outcomes for learners requiring alternative education pathways. Robust systems for the oversight of placements have been implemented, supported by targeted training, ensuring quality assurance and safeguarding standards are consistently upheld across all provisions.

Changes we need to make in the next phase of the programme

- Further work is required to effectively plan new EOTAS packages and systematically review existing ones to ensure they deliver strong educational outcomes and support clear progression routes for learners.
- Complete and publish the draft AP Strategy. A new ILP format has been launched for AP placements but now requires consistent implementation to ensure focus on outcomes.
- Explore opportunities to broaden the range of Alternative Providers available locally and in surrounding areas to better meet diverse learner needs and improve access to quality provision

Areas of strength	Areas for development	Selected data points to illustrate impact to date
1. EOTAS policy has been co-produced and approved by the Council, training has been delivered for case officers regarding policy and practice, and all EOTAS requests are considered by a multi-agency panel. 2. AP strategy group has been established and a strategy drafted. 3. Systems for oversight of placements are in place and embedded and training has been provided.	1. AP strategy is in draft and further consideration required by strategy group to complete. 2. Short term intervention AP has been requested from providers but further procurement may be required on an ongoing basis. 3. Ongoing work is now being supported with regard to development and implementation of EOTAS packages	• There are currently 69 children in registered or unregistered AP. We were at 65 in July 2024 and 32 in February 2024. • Case officers report better understanding of EOTAS, S19 and EHE • Improved processes will result in better quality packages and outcomes for young people • Issues raised by parents regarding FSM, transport, school nursing and Connexions advice have been addressed. • Wider range of providers available with work ongoing to develop this further.

3. Next phase of the programme

Principal current risks within the programme

PIP/AFI	Risk	Raised	Potential impact	Mitigation
PIP2	Qualified main grade EPS availability/capacity risks provision of the EPS service	Nov 2024	Families' expertise and experience is not as embedded in the improvement process for the EPS and families do not feel that their experience is taken on board on how SEND services can be improved.	Further consultation has been conducted in respect of the EPS offer with families with a good response (54 families). Development of service plan running to 2028 to set the EP offer to parents and carers.
PIP2/PIP4	Lack of capacity in key service professionals responsible for providing updated on the Local Offer creates a risk that updates will not be made in a timely way.	Oct 2024	The local offer is a key tool to enable families to drive forward the support of their children and to ensure it is as easy as possible to navigate the system. The quality of the local offer impacts both of these.	Comms and engagement officer has introduced new processes to support timely updates in content and routes for escalation when needed.
PIP3	Health services for children and young adults have long waiting times, reduced follow-up capacity, & staffing shortages (esp community paediatrics, CAMHS, SALT). This is undermining service stability and limiting the positive impact of recent improvements, especially with no long-term plan for 18–25 Autism and ADHD pathway.	Oct 2024	Wait times means SEND CYP do not receive the services at the time they need them, which has a particularly significant impact on those who will be transitioning in the next 12 months	Where appropriate local staffing has been agreed in the short term to ensure the stability of services. The issues have been raised to Greater Manchester level and are being discussed and form part of ongoing reviews. Local programmes of work focusing on waiting times have
PIP5	12-into-13 solution: Communication challenges with 6-into-7 provider impacting on the ability to progress with wider age solutions.	May 2025	A key enabler for this area is at risk of delivery, impacting on the quality of service being provided to families.	Delivery Group to chase provider for response and escalate as required. If no response alternative solutions are to be pursued.
PIP6	Limitations and issues with the EHCP data system, risking the ability for teams and management to plan effectively and prioritise how to best meet demand.	May 2025	Inability for services to best utilise the limited resource available to be directed to those cases and families that are most in need.	Additional staff currently working through data issues, with expected completion date in June.
PIP6	Lack of capacity in the LA SEND team to tackle demand and deliver improvements; including working with parents and schools on improvements and provision.	Nov 2024	Potential negative impact on either operational delivery or delivering improvements to timescales.	Resourcing and team development.

Note: full risks register in Appendix.

The next 6 months will see a shift in the programme to focus on sustaining change

Following our review of progress to date and a thorough assessment of current risks, our focus over the next six months will be on consolidating gains, addressing identified gaps, and embedding sustainable improvements.

Key priorities include:

Implement mitigation plans for high-priority risks

Re- assess and revise some PIPs/AFIs based on our honest self-assessment of impact to date and forward challenges and future priorities

Condense and /rationalise current impact/milestone measures into a more concise, manageable set of regular programme data to provide regular and more effective intelligence about programme impact

Develop a sustainable governance model that ensures the improvement journey continues beyond the Monitoring Inspection

Embed strategic developments and maintain momentum in key areas, including;

Strengthening support for families during waiting periods.

Advancing the Local Offer and ensuring it is accessible, helpful and supported by a local offer live event in the autumn term

Embedding the Communities of Practice model to support shared learning and ensure more effective partnership working

Enhancing transitions to ensure they are timely, well-planned, and coordinated across services

Improving communication to keep stakeholders informed of progress and impact

APPENDIX A:

RAG-rated progress update for each Priority Impact Plan and Area for Improvement

Guide to PIP/AFI progress updates

The progress updates in the following section provide a short summary including updates in progress since the previous reports that were submitted to SIAB.

The summary is to supplement the more detailed PIP reports that SIAB have received for each of the areas in since the last stocktake in December.

Each summary is accompanied by a RAG status that has been identified by the Programme Management Office and reviewed and approved by officer leads in each area.

RAG status are defined under the following definition:

- Green: on track to deliver the defined scope on time
- Amber: on track to deliver the defined scope but with a short delay, or defined scope is at risk but with clear mitigations in place
- Red: off track in delivering the identified scope with no clear mitigating plan, or original scope will be delivered but with significant delay

PIP1 – Strategy

Objective: Leaders across the partnership should ensure that the SEND strategy continues to be implemented to improve the lived experiences of children and young people with SEND. This should be overseen by shared strategic governance to ensure that the pace of improvement is maintained.

Summary of progress: A draft strategic vision is currently being co-produced with Bury2Gether and the Change Makers to produce this vision that creates a golden thread across the work. The need for a thorough co-production phase for overall vision has somewhat delayed the effective communication of the strategy, although this work is set to take begin in June. An initial review of the QA framework has been completed but further co-production work is scheduled for later this summer to enhance the framework. The co-production work with Bury2Gether has been delayed but is now set to take place in July.

PIP ACTIONS

Ref	Action	Date	RAG	Note and mitigations (R/A only)
1.1a	Create SEND Strategy on a page – distil existing strategy, ensuring clear focus on preparation for adulthood, transitions, child voice and a social model of disability	Sep 25		A strategic vision document is being co-designed.
1.1b	Working with Bury2Gether, co-produce a mechanism for ensuring parental feedback is gathered about families' experiences and used to inform the Board's analysis of progress.	Sep 25		Survey completed May 25 with analysis to follow
1.1c	Ensure clear governance for SEND improvement, including escalation route for SEND Improvement & Assurance Board within the local area High level governance arrangements.	April 25		
1.1d	Review the QA Framework and develop robust dataset to track progress and impact.	Jan 25		QA framework reviewed and revised – data set developed
1.1e	Effective communication of strategy to all stakeholders, professionals, children and families.	June 25		Delayed following the delay in developing the strategic vision.

PIP2 – Early identification

Objective: Leaders across the partnership should work collaboratively and effectively to improve the early identification of children and young people's SEND as part of the graduated approach. In particular, they should urgently improve: i) CYP access to E/H/SC to improve early identification of needs; and ii) CYP and professionals' access to an effective, well-resource educational psychology service.

Summary of progress: Work is progressing on the post-16 section of the Graduated Approach Toolkit, with a Task and Finish group established to set timelines and clarify responsibilities, while schools and SENCOs, supported by Manchester University, are actively identifying and addressing implementation barriers through research and feedback mechanisms. Alongside this, enhancements in governance, staffing, CPD, and service models—including a significant expansion in the SEND Health Visitor team and the rollout of a new Community EP service—are contributing to improved support structures and data-informed planning across the system.

PIP ACTIONS

Ref	Action	Date	RAG	Note and mitigations (R/A only)
2.1a	Improve and embed the use of the Graduated Approach to identifying and meeting need across the local area.	Sep 25		Graduated Approach toolkits now complete and work ongoing to embed in settings.
2.1b	Develop an outreach offer across all settings and embed a consistent borough wide approach to early identification and intervention.	July 25		Outreach approach developed, with work ongoing to embed approach and assess impact.
2.1c	Complete revision of the Local Offer and develop systems to monitor ongoing use/access.	July 25		Updates continue to Local Offer, including monthly monitoring.
2.1d	Increase SEND and wider Health Visitor Capacity.	Aug 25		Additional funding enabled the creation of 1 WTE 8a Lead Nurse role & 4.76 WTE Band 6 SEND Health Visitors.
2.1e	Review the allocation and use of top-up funding to ensure equity and quality of support provided to children with additional needs.	Mar 25		Governance established through the multi-disciplinary resource panel, meeting weekly to ensure equitable decision making and governance in top-up funding allocation.
2.1f	Review effectiveness, reach and access routes/pathways of Early Years support.	Jan 25		

PIP2 – Early identification

PIP ACTIONS				
Ref	**Action**	**Date**	**RAG**	**Note and mitigations (R/A only)**
2.2a	Work with parents and carers, including Bury2Gether to co-produce a service specification for a Bury community EP service, with a comprehensive development plan.	Sep 25		Progress made in recruitment to the EP service, helping to maintain statutory timeliness and roll out a free offer of non-statutory support to schools and families and communities.
2.2b	Develop a comprehensive training and consultation offer to Bury educational and community settings based upon recently carried out surveys with key stakeholders.	Oct 24		New free Community EP service model developed after consultation with schools and parent groups and CYP.

PIP3 – Access to support while waiting for assessment (1/2)

Objective: Leaders across the partnership should improve the quality and availability of support for children, young people and their families while they wait for specialist assessments including: i) CYP waiting for a speech and language therapy assessment and subsequent intervention; ii) CYP waiting for a community paediatric assessment and subsequent intervention; and iii) CYP on a neurodevelopmental pathway for an assessment of ADHD or autism.

Summary of progress: Significant progress has been made in reducing waiting times across several paediatric services, though challenges remain, particularly within Community Paediatrics and CAMHS ND pathways, prompting system-wide transformation efforts. Bury has taken a proactive role in responding to the GM-wide initiative to implement a new ND model of care, with a strong emphasis on early intervention, co-production with families, and local adaptation within a standardised GM framework. The Bury ND Hub proposal has been approved, and mobilisation is underway, including provider engagement, pathway integration, and recruitment planning, with full implementation expected by Q3 2025.

PIP ACTIONS

Ref	Action	Date	RAG	Note and mitigations (R/A only)
3.1a	Clinical and operational managers will review SLCN pathways and will develop implementation plans that will identify opportunities to reduce waiting times from referral and assessment to intervention and the support offered as part of this pathway.	April 25		Progress and sustainability of waiting time reductionsin evidence in several services, including paediatric physiotherapy, paediatric OT, and improving picture for SLT.
3.1b	Clinical and operational managers will review Community Paediatric pathways and will develop implementation plans that will identify opportunities to reduce waiting times from referral and assessment to intervention and the support offered as part of this pathway.	Aug 25		Complete but continuing concern about waiting times.
3.1c	Clinical and operational managers will review CAMHs pathways and will develop implementation plans that will identify opportunities to reduce waiting times from referral and assessment to intervention and the support offered as part of this pathway.	Aug 26		Action has been focused on the development of the new GM care pathway model, with Bury participating in a codesign process.
3.1d	Develop needs-led approaches: implement a need led Neurodevelopmental Profiling toolkit for advice and guidance (including support whilst waiting).	Jan 26		Development of a toolkit and other elements of an ND hub complete, and ND profiling training currently being sourced.
3.1e	Increase the use of evidence-based interventions across all age ranges as part	Aug 25		Four evidence-based interventions made available

PIP3 – Access to support while waiting for assessment (2/2)

PIP ACTIONS				
Ref	**Action**	**Date**	**RAG**	**Note and mitigations (R/A only)**
3.1f	Develop transparent analysis of children waiting and on therapeutic pathways.	Aug 25		Waiting times have been analysed, with quarterly information set to be shared across the system by August ’25.
3.1g	Development of 18-25 ADHD and Autism pathway.	Sep 25		The application for urgent award to Optimise Healthcare for 2025-26 has been approved by NHS GM. The commissioned service specification will include integrated ADHD and Autism pathways
3.2a	Consult and engage with children and families to gather views on what would help regarding support whilst waiting.	June 25		A number of services are now available that were not previously available. Engagement sessions being developed to help shape the Hub offer. Feedback from B2G and wider parents has influenced the development of a range of webinars. However, further work is required to ensure that this offer is understood and accessible for all parents; work is ongoing in this area.
3.3b	Expand the range of support padlets and promote usage via Partnerships and local offer.	Dec 24		

PIP4 – Preparing for Adulthood

Objective: Leaders across the partnership should improve preparation for adulthood from the earliest ages for all children and young people with SEND in Bury. This should include a well understood and co-produced strategy to embed preparation for adulthood effectively across the partnership.

Summary of progress: Good progress on PIP. Further improvement work has been completed on annual reviews of Education, Health and Care plans, implemented through a phased transfer review cycle to increase statutory compliance and ensure reviews reflect Preparation for Adulthood needs and outcomes are considered as part of plans, through process/template changes and training for SENCOs. The PfA (Preparation for Adulthood) section within the Local Offer has been re-written and published, incorporating the data from the factsheets which can be easily accessed and details a variety of pathways, with work progressing to EHCP review PfA prompts into the Local Offer.

PIP ACTIONS

Ref	Action	Date	RAG	Note and mitigations (R/A only)
4.1a	Complete needs analysis of cohort together with mapping of local provision and its quality, consulting with young people, parents/carers to identify gaps and to inform future commissioning priorities.	March 26		Needs analysis of the Preparing for Adulthood (PfA) cohort completed, as well as coproduction and service mapping.
4.1b	Ensure Local Offer includes planning for adulthood and information about access to higher education.	July 25		The PfA section within the local offer has been re-written and published, incorporating the data from rewritten factsheets which can be accessed for details on a variety of pathways.
4.1c	All EHCPs reference planning for adulthood preparations for all children from the age of 14 and above (at Y9 review) to appropriately identify those who will need the Planning for Adulthood Pathway.	June 25		All new EHCP plans have the PFA section included as part of the new template. In the upcoming phase transfer window (2026), 619 more plans (based on current live plans) will also have PfA reflected in them by March 31st, 2026.
4.1d	Establish transitions to provide support in preparing for adulthood, to progress into employment and training, apprenticeships and Supported internships.	Feb 26		Now complete following Deep Dive; further improvements to transitions will result from completion of action 4.1e.
4.1e	Embed Planning for Adulthood Pathway.	Feb 26		PfA was included in training delivered to SENCOs regarding the new EHCP annual review paperwork.

PIP5 – Transitions

Objective: Leaders across the partnership should establish and implement a strategic approach to high quality transitions for children and young people with SEND from Birth to 25.

Summary of progress: Key transition support has been implemented and is in the process of being embedded; this includes the digital solution and MDT meetings across education, health and social care, for children with complex needs. Transition conversations have commenced, and there is now a quarterly transition clinic held in Community Paediatrics and monthly transition MDT meeting held in CCNT. A new team in Adult Social Care has been launched to support children transferring from child to adult services. All primary schools and secondary schools are inputting transition data into 6into7, although cost concerns remain around the longer-term sustainability of the system.

PIP ACTIONS

Ref	Action	Date	RAG	Note and mitigations (R/A only)
5.1a	Implement electronic solution ("6into7") to delivering personalised pupil pathways for transition and inclusion between primary and secondary schools.	March 27		It is reported that all primary schools are inputting transition data into 6into7, and all but one secondary school are using it.
5.1b	Co-produce with parents & carers best practice guidance & tools across the partnership, incorporating a graduated response.	Mar 25		
5.1c	Expand 6into7 for use at other points of transition: Early Years into Primary School, secondary school to college, college to adult life.	Sep 26		Still improvements to be made to ensure that schools are using it for more detailed sharing, with further investigation in set for 2025. Cost concerns affect long-term sustainability of system.
5.1d	Develop an enhanced transition pathway for children supported by SEND Health Visitors transitioning to being supported by the School Nursing Service.	Sep 25		Transition Standard Operating Procedures (SOPs) have been established across health services.
5.1e	Embed MDT meetings for children & young people being supported by the complex needs nurse (CCNT), Epilepsy Specialist Nurse, Continuing Health Care and District Nursing service.	June 25		Transition conversations have commenced, Quarterly transition clinic held in Community Paediatrics and monthly transition MDT meeting held in CCNT.
5.1f	All Health Services to begin conversations with children & young people at 14 years about transition to adult health services.	June 25		These conversations are taking place and being recorded.

PIP6 – EHC plan process

Objective: Leaders across the partnership should further improve the quality of the statutory EHC plan process. This should include: i) improving the quality of advice received from professionals as part of the needs assessment process; ii) improving the timeliness and quality of updated EHC plans following annual reviews; iii) improving appropriate social care contributions to EHC plans so that children and young people's social care needs are reflected more accurately; and iv) improving the focus on preparation for adulthood in children and young people's EHC plans so that their experiences and outcomes improve.

Summary of progress: Good progress made on PIP. EHC assessment advice contributions demonstrate compliance with the statutory assessment process. The EHCP contributions form on the system is now being used as reports are written. This process is taking place monthly as data quality on Liquidlogic is being quality assured before it is added to the scorecard. SENCOs are receiving training on new EHC plan template, which reflect needs and outcomes related to PfA. Training and quality of advice training for officers in the process of being rolled out and embedded.

PIP ACTIONS

Ref	Action	Date	RAG	Note and mitigations (R/A only)
6.1a	Ensuring more timely advice from professionals, particularly social care, through better use of more robust portal.	Dec 25		Portal now in place and being used by officers; training around compliance/quality of advice rolled out to officer – data on compliance under refinement
6.1b	Review the QA framework to ensure a robust single and multi-agency approach to audit and assurance and implement actions as required.	Sep 26		
6.1c	Review how the voice of children & young people is captured in, and used to inform, their plans and reviews and implement necessary actions.	Sep 25		Graduated approach progressing and a process review is underway; AFI1 will drive wider comms and engagement.
6.1d	Training on how to prepare a high quality EHCP with SMART outcomes.	Sep 25		
6.2a	Review the EHC Assessment and Review Team to ensure there is sufficient capacity for new EHCPs and to review and amend existing EHCPs, including a recovery plan to address current deficits.	Sep 25		Staffing numbers have increased, although new staff require training to be able to effectively support review process.
6.2b	Training for SENCos on writing EHC assessment requests and delivering person-centred Annual Reviews.	Sep 25		

AFI1 – Communications

Objective: Leaders across the partnership should improve communication to professionals, parents and carers and children and young people so that their strategies, actions and impact are better understood and that trust in the SEND system improves. The partnership should ensure that the local offer is updated regularly to provide parents, carers and other stakeholders with sufficiently accurate information.

Summary of progress: A communications framework and steering group have been established to co-produce a long-term strategy, with key activities like newsletters and vlogs already in progress, supported by a new communications officer. The Changemakers group is actively contributing, with recent and upcoming sessions focused on the communications strategy, the Local Offer, and feedback on SEND-related topics. The full communications strategy is now targeted for completion by August 2025.

AFI ACTIONS				
Ref	**Action**	**Date**	**RAG**	**Note and mitigations (R/A only)**
7.1a	Review local SEND system communications.	June 25		Co-production visit held with Changemakers group, focussing on the comms strategy. Further sessions covered the Local Offer site's usability and statistics and gathered young people's views on EHCPs and SEN support. Findings presented to SIAB board.
7.1b	Develop a SEND Communication Strategy, using work to date on the Communication and Engagement Plan.	Sep 25		An initial framework has been developed to guide current communications, and to provide space to co-produce a longer-term communication strategy without detriment to delivering more immediate impact through comms activities.
7.2a	Complete revision of the Local Offer and develop system to monitor ongoing use/access.	June 25		Revised Local Offer launched and SEND newsletter resumed Oct 2024; newly recruited communications officer supporting working to monitor use and troubleshooting access issues.
7.2b	Ensure parents/carers understand the refreshed Transport Policy.	Sep 25		Policy updates and policy guidance provided and included in the survey that took place in May.

AFI2 – AP and EOTAS

Objective: Leaders across the partnership should continue to develop the range of suitable AP available to children and young people in Bury. Leaders should further embed the improved oversight of AP and EOTAS packages in Bury. They should publish the refreshed policy for EOTAS, providing support so that this policy is clearly understood.

Summary of progress: An Alternative Provision providers forum has been held, and providers have been asked to provide details of early intervention programmes that they can deliver in order to support young people to remain in school. Further training has taken place with case officers with regard to the EOTAS policy, Section 19 duties and Alternative Provision duties. A new format for an individual learning plan has been shared with providers and incorporated into the referral process in order to ensure that all placements have clear outcomes.

AFI ACTIONS				
Ref	**Action**	**Date**	**RAG**	**Note and mitigations (R/A only)**
8.1a	Develop and finalise AP Strategy 2024-26, including Section 19 responsibilities and EOTAS.	Sep 25		AP strategy has been co-designed and is going through a period of final review and updating. Section 19 policy amended to ensure coherence with EOTAS policy.
8.1b	Rationalise existing processes to ensure single oversight of pupil placement, commissioning and quality assurance for AP and EOTAS.	Sep 25		Completed in October.
8.1c	Co-produce and confirm EOTAS Policy.	Sep 25		Co-produced EOTAS policy approved. Further training has taken place with case officers regarding the EOTAS policy, Section 19 duties and Alternative Provision duties
8.1d	Improve processes for considering new EOTAS package and reviewing existing ones through the annual review process.	June 25		Decision making on EOTAS status is now taken by a multi-agency panel and processes are in place to address issues raised through the co-production.
8.2a	Complete needs analysis.	Sep 25		Completed in January
8.2b	Renew procurement and update directory with new providers.	Sep 25		Completed in November – providers added to revised directory which has been re-issued.

AFI3 – Workforce development

Objective: Leaders across the partnership should work collaboratively to create a partnership-wide workforce development strategy. This should focus on coordinating training support and guidance to improve health, social care and education professionals' ability to identify, assess and meet the needs of children and young people with SEND, from birth to 25.

Summary of progress: Progress on the action is being made, although challenges remain around building a workforce that can deliver on the vision for the future. Several engagement and co-design activities have taken place over the last 9 months to progress these areas, with the partnership pressing forward with strategic areas of workforce development that will deliver early impact.

AFI ACTIONS				
Ref	**Action**	**Date**	**RAG**	**Note and mitigations (R/A only)**
9.1a	Map current training offer across the partnership in relation to identification and meeting the needs of children with SEND and evaluate its effectiveness.	Sep 25		
9.1b	Develop Partnership Workforce Strategy.	June 26		A workforce strategy has been developed and approved. The strategy will continue to be developed to broaden its focus to the school workforce and the 'informal' workforce.
9.1c	Develop Partnership Learning & Development Plan.	Dec 25		Changemakers designing training for school staff on how to work with and talk to young people with additional needs and disabilities in education. This work is beginning in the summer term.

APPENDIX B:

Full risk register (June SIAB)

Risks – full risk register from June SIAB meeting (1/3)

PIP/ AFI	Area	Description	Date raised	Mitigation	Mitigation type	Latest update
PIP1	QA	Low number of auditors impacting on the timeliness of feedback from the QA process	23 April 2025	QA improvement processes to be put in place	Reduce	
PIP1	Capacity	Comms capacity gap potentially risks delivery to timescales of key activities within this area. This risks the delivery of impact in this area.	01 October 2024	Recruitment to key roles has been completed, but the level of communication and engagement required still puts pressure on partnerships ability to deliver ongoing and consistent communication support; a communications working session is planned for 28th to agree an ongoing plan to drive forward communications.	Avoid	
PIP1	Strategy one-pager	Strategy one-pager is delayed as further updates on strategy is required first, which was not built into the origianl plan. This risks the delivery of impact in this area.	01 November 2024	Approach to developing the one-pager to be simplified to focus on the original intention: documenting the key priorities built from the input and feedback we have received from children and families; and a single pager that captures the strategic elements of the SEND system and developments. This will be followed by a more holistic strategy to be delivered by the end of the year.	Reduce	Draft of the strategic vision is in development.
PIP2	Graduated Approach	Graduate Approach Toolkit updates delayed due to lack of capacity across different partner teams to provide updates for their specialist areas. This risks delivery timelines and delays the toolkits effecivness in supporting all families.	01 November 2024	Following the deep dive a Graduated Approach Toolkit improvement plan has been created.	Acknowledge	Updates have increased on the Graduated Approach toolkit and this is having a positive impact. A long term solutions to improvement and content development is still required and will be due for discussion at the Theme 2 board in May.
PIP2	EPS service specification co-production	Qualified main grade EPS availability/capacity risks provision of the EPS service	01 November 2024	Further consultation has been conducted in respect of the EPS offer with families with a good response (54 families). Development of service plan running to 2028 to set the EP offer to parents and carers.	Reduce	
PIP2	Workforce	Inability to recruit suitably qualified and capable staff to key vacancies within the current funding	23 April 2025			
PIP2 / PIP4	Local Offer	Lack of capacity in key service professionals responsible for providing updated on the Local Offer creates a risk that updates will not be made in a timely way.	01 October 2024	Comms and engagement officer has introduced new processes to support timely updates in content and routes for escalation when needed.	Avoid	Updates have increased on the local offer and this is having a positive impact. A long term solutions to improvement and content development is still required and will be due for discussion at the Theme 2 board in May.

Note: closed risks not included in this table

Risks – full risk register from June SIAB meeting (2/3)

PIP/ AFI	Area	Description	Mitigation	Mitigation type	Latest update
PIP3	Demand and capacity challenges in health teams	Loss of follow-up capacity to help mitigate the long wait times currently for the NCA, Community Paediatric services and Children's SALT. Long CAHMS waiting times risk children receiving the mental health care and support they need. Workforce deficits of registrars in the community paeds team and CAMHS, risking stability of these services. Demand grows for health services and there are staffing shortages in several health services; lack of long-term solution for 18-25 Autism and ADHD pathway beyond this year. This could impact on the ability of services to deliver key support. Collectively the demand challenges risk limiting the imapct wider improvements are having for children and families.	Where appropriate local staffing has been agreed in the short term to ensure the stability of services. The issues have been raised to Greater Manchester level and are being discussed and form part of ongoing reviews. Local programmes of work focussing on waiting times have	Transfer	For all areas no longer term plan has been agreed at this stage and continues to be discussed at Greater Manchester Level. Good progress being made on reducing waiting times; these will continue until waiting times reach target levels.
PIP3	ND Pathway	Parents are not receiving the desired feedback from CAHMS/Paedeatrics and are being bounced around the system. This is risking the ability to deliver the outcomes in this area.	This issue to be built into the new model	Reduce	
PIP5	12-into-13 service	12-into-13 solution: Communication challenges with 6-into-7 provider impacting on the ability to progress with wider age solutions.	Delivery Group to chase provider for response and escalate as required. If no response alternative solutions are to be persued.	Avoid	Confirmation that this solution is not available. Initial alternatives have been identified but these are in development and it is unclear at this stage if these alternatives meet all of the requirements.
PIP6	Data systems	Limitations and issues with the EHCP data system, risking the ability for teams and management to plan effectively and prioritise how to best meet demand.	Additional staff currently working through data issues, with expected completion date in June.	Reduce	Data cleansing activity is currently taking place and due for completion in May.
PIP6	LA SEND team capacity	Lack of capacity in the LA SEND team to tackle demand and deliver improvements; including working with parents and schools on improvements and provision.	Resourcing and team development.	Reduce	While initial recruitment and team development has been completed further work is required. A new business case is in development for further workforce investment.

Note: closed risks not included in this table

Risks – full risk register from June SIAB meeting (3/3)

PIP/ AFI	Area	Description	Date raised	Mitigation	Mitigation type	Latest update
PIP6	Partnership Engagement	Risk that current membership and involvement in the QA process is not fully representative and this will impact on the effectiveness of the work.	01 November 2024	Partnership commitment / revised audit membership across all partner agencies	Avoid	The continued focus of the QA development has been focussed on the EHC team and process due to the opportunity to make significant improvements in this area first. This will be expanded to deliver a greater level of cross partner working during the late spring/early summer.
PIP5	5.1a - Implement electronic solution ("6into7") to delivering personalised pupil pathways	The LA have funded the software for three years: 2024, 2025, 2026. The SLA with Pupil Pathways (The Software Provider) is due to finish August 2026 for Year 6 into 7. At this point schools would collectively have to fund any continuation of the SLA. Indications are, that schools would be unwilling to do this. The three-year cost for SixIntoSeven was £30,000.	01-Jun-25			
PIP5	5.1c - Expand 6into7 for use at other points of transition	Even if the software owners develop this area, it is unclear whether funding can be committed to this.	01-May-25			
PIP5	5.1e - Embed MDT meetings for CYP	MDT meetings are held for CYP categorised as complex and for CYP with epilepsy. There is not capacity within the system to incorporate a wider cohort.	01-Jun-25			

Note: closed risks not included in this table

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Agenda Item 7d

Bury Health and Wellbeing Board

Title of the Report	Better Care Fund (BCF) 2025/26 Quarter 1 (Q1) Reporting Template
Date	4th September 2025
Contact Officer	Hannah Dixon – Commissioning Manager
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 Q1 reporting template for the Better Care Fund 2025/26. The deadline for submission to the NHSE Better Care fund team was 15th August 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
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 Q1 reporting template to BCF 2025/26 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 Q1 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) 2025/2026 Policy Framework and Planning Guidance can be found at: BCF Better Care Fund policy framework 2025 to 2026 - GOV.UK

This policy framework confirms the conditions and funding for the Better Care Fund (BCF) for 2025 to 2026.

1.2 For 2025 to 2026, the objectives of the BCF reflect the government's commitment to reform via a shift from sickness to prevention and from hospital to home. These shifts are also consistent with commitment to reform by developing a 'neighbourhood health service', based on more responsive, preventative and co-ordinated care in people's homes and local communities.

1.3 The BCF achieves this by requiring local authorities and integrated care boards (ICBs), to develop and agree plans in collaboration with other local partners to meet the overall objectives of the BCF.

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 In line with the government's vision for health and care, the Better Care Fund policy framework sets out the vision, funding, oversight and support arrangements, focused on 2 overarching objectives for the BCF in 2025-26:

- reform to support the shift from sickness to prevention
- reform to support people living independently and the shift from hospital to home

1.6 At the same time, NHS England and the LGA published the Planning Requirements for the BCF. These can be found at: BCF Planning Requirements 25-26

2 BCF 2025/2026 Conditions, Objectives and Metrics

Better Care Fund policy framework 2025 to 2026 - GOV.UK.

2.1 National Conditions

Both local authorities and ICBs must comply with the BCF national conditions. Grant conditions for local authorities of each component grant of the BCF will reflect these national conditions. The national conditions outline steps HWBs must take to deliver on the BCF objectives.

The national conditions for the BCF in 2025/2026 are:

- jointly agreeing a plan
- implementing the objectives of the BCF
- complying with the grant conditions and the BCF funding conditions
- complying with the oversight and support processes

2.2 Objectives

The two objectives for the BCF in 2025 to 2026 are:

- **Objective 1**: To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
- **Objective 2**: To support people living independently and the shift from hospital to home – including help to prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

2.3 BCF metrics for 2025 to 2026

The three metrics to be reported on are:

- **Emergency Admissions** – No changes to 25/26 BCF plan metric goal
- **Delayed Discharge** – 25/26 metric goal has been updated with the Regional BCF Team to meet a local condition that was attached to the 25/26 planning approval
- **Residential Admissions** – 25/26 metric goal has been updated following a data quality audit which found some short-term placements were recorded as permanent admissions

Metric	Definition	Actual Performance	Assessment of Progress	Challenges	Variance from Plan
Emergency Admissions	Emergency admissions to hospital for people aged 65+ per 100,000 population	**Rate** - 1385 – (Apr 25) **Admissions -** 540 (Apr 25)	On track to meet goal	Only 1 month data available	**Achieved by (Apr 25):** **Rate**: -111 **Admission**: -40.1
Delayed Discharge	Average length of discharge delay (LDD) for all acute adult patients	**Avg LDD** - 1.07 (Apr 25) **Avg LDD** –1.07 (May 25)	On track to meet goal	Only 2 months of data available	**Achieved by:** **April 25:** -0.63 **May 25:** -0.07
Residential Admissions	Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Number of admissions** – 43 (Q1 - unpublished)	On track to meet goal		**Achieved by:** **Q1** -19

2.4 Metric Performance Comparison

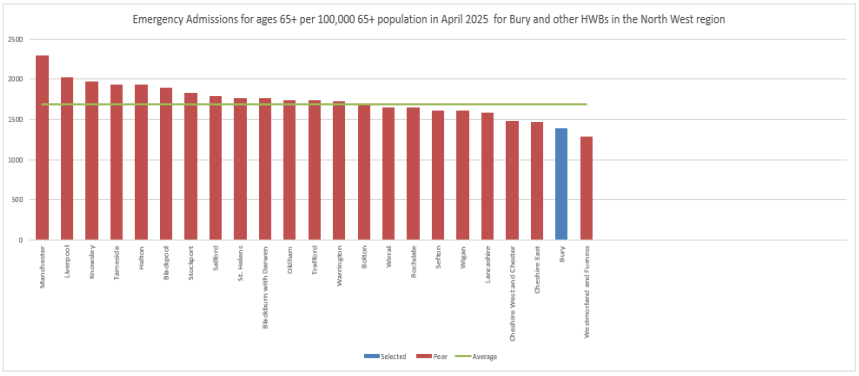
Emergency Admissions for ages 65+ per 100,000 65+ population

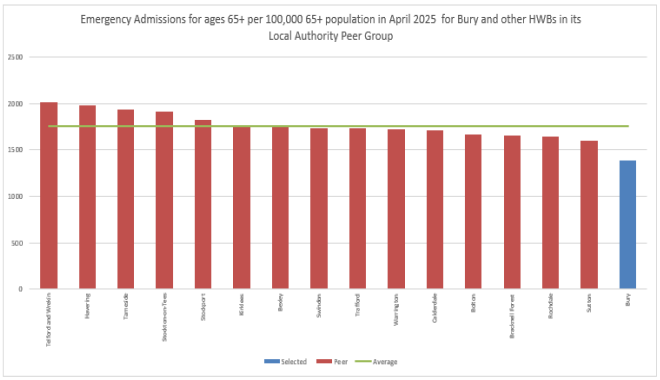
Notes:
The latest month of data has been removed for all unplanned hospital admission data. This is due to a timeliness issue making the lastest month appear lower.
Due to excel formatting, dates might be written as 01/03/2025, however this includes data for the month itself

Select an Area	Bury
Select a Date	April 2025
Select a Metric	Emergency Admissions for ages 65+ per 100,000 65+ population

This is the latest date for this metric

In the month of April 2025 Bury there were 1385 Emergency Admissions for ages 65+ per 100,000 65+ population for residents of Bury. This was lower than the region North West (1688), and lower than for England as a whole (1682). Bury were lower than their peer group average (1753)



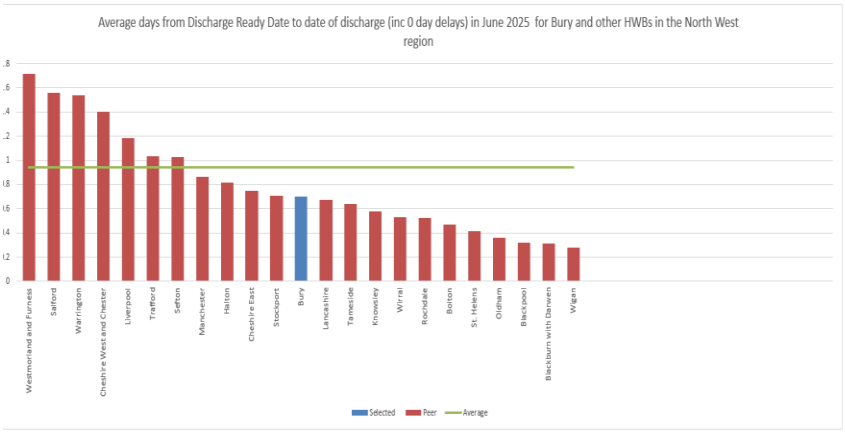


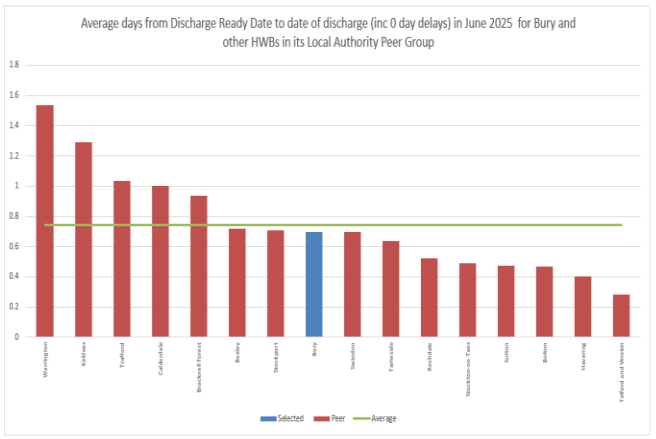
Average days for discharge ready date to date of discharge (including 0 days):

Select an Area	Bury
Select a Date	June 2025
Select a Metric	Average days from Discharge Ready Date to date of discharge (inc 0 day delays)

This is the latest date for this metric

In the month of June 2025 Bury there were 0.70 Average days from Discharge Ready Date to date of discharge (inc 0 day delays) for residents of Bury. This was lower than the region North West (0.95), and lower than for England as a whole (0.82). Bury were lower than their peer group average (0.74)





There is no published data for residential admissions currently.

Data Source - [DHSC Better Care Fund & Discharge Dashboard - DH eXchange]

3.0 Finance Report

3.1 The table below demonstrates that 23% of the planned income has been spent in Q1.

	2025-26		
Source of Funding	Planned Income	Updated Total Plan Income for 25-26	Q1 Year-to-Date Actual Expenditure
DFG	£2,576,737	£2,576,737	£273,000
Minimum NHS Contribution	£19,577,112	£19,577,112	
Local Authority Better Care Grant	£9,410,943	£9,410,943	
Additional LA Contribution	£0	£0	
Additional NHS Contribution	£2,136,317	£2,136,317	
Total	**£33,701,109**	**£33,701,109**	

	Original	Updated	% variance
Planned Expenditure	**£33,701,109**	£33,701,109	**0%**

		% of Planned Income
Q1 Year-to-Date Actual Expenditure	£7,862,091	**23%**

4.0 Reporting and checkpoints

4.1 It is expected that performance on spend and the metric goals aligned to the BCF programme will be reported on a quarterly basis. The reporting requirements have now been finalised for Q1 and have been submitted to NHSE Better Care fund Team.

5.0 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 Q1 reporting submission
- That the Bury Health and Wellbeing Board retrospectively approve the attached Better Care Fund 2025/2026 Q1 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

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

Date: 4th September 2025

Bury HWB Q1 25-26.xlsx

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Health & Wellbeing Board: Tobacco Control

Lee Buggie: Public Health Specialist &
Lizzie Howard: Tobacco Control Officer

September 2025

Smoke-Free 2030 Government Aims

- Create the first smokefree generation by prohibiting tobacco sales to those born on or after 2009
- Funding for local stop smoking services, £138 million annually
- Launch national campaigns and enforce underage sales laws
- Support 1 million smokers to 'Swap to Stop' using vapes
- Strengthen enforcement and accountability with new licencing scheme
- Tackle youth vaping and protect children from nicotine addiction- Disposable van ban: from 1st June

Greater Manchester's ‘Making Smoking History'

- Smokefree city-region by 2030 (<5% smoking prevalence)
- Hard-hitting campaigns and community engagement creating smoke free spaces
- Support from NHS Greater Manchester Integrated Care
- Focus on inequalities and co-production with local communities
- Significant reduction in smoking during pregnancy and youth smoking

NHS Greater Manchester Integrated care

Bury Council

Background in Bury

- Launch of **Bury's Tobacco Control Alliance** - 1st October. Leading the refresh of Bury's Tobacco Control Plan
- **Purpose:** System-wide partnership to reduce smoking prevalence and support Bury's Smokefree 2030 ambition
- **Partners:** Trading Standards, Bury ICB, Early Break, GM Police, MSH, Council services & wider stakeholders
- **Smoking in Bury:** 10.5% prevalence (2023/24) (slightly below national average of 11.6%). Remains leading cause of preventable illness, premature death, and life expectancy gaps
- Overall rates are reducing, **inequalities** in prevalence are increasing. The Alliance will address these widening inequalities through 4 workstreams:

Target Populations & Smoking Prevalence

- Renters from Bury Housing / housing associations: 29.6% ↑
- Never worked / long-term unemployed: 25.7% ↑
- Routine & manual occupations: 21.1% ↑
- Adults with long-term mental health conditions: 20.6% ↑
- Residents in areas of deprivation: 21.7% ↑
- Children & Young People
- Mothers smoking at time of delivery: 5.5% ↓

NHS Greater Manchester Integrated care

Bury Council

Overview of Local Stop Smoking Services and Support Grant (LSSSG) Implementation 2024/25

Funding:

- Fixed, ring-fenced grant for 5 years to support local stop smoking services.
- Bury allocation for 24/25 = £207,932.

Key Outcomes:

- Recruited 2 FTE Health & Wellness Coaches (smoking cessation focus) & 1 FTE Tobacco Control Officer to drive local tobacco control agenda
- **Youth education:** Commissioned Early Break to vaping harm sessions in schools and colleges; co-produced awareness posters
- **Workplace wellbeing:** Introduced sessions targeting routine & manual workers, linked to Bury Regeneration construction workers
- **Community Support:** Commissioned PaSH partnership to deliver VBA+ for LGBTQ+ & ethnic minority communities

NHS Greater Manchester Integrated care

Bury Council

Overview of LSSSG Implementation in Bury 2025/26

Funding:

Bury allocation 25/26: £209,301

Key Deliverables:

- **Expand youth campaign:** Extend to school nurses, Bury Care Leavers; include awareness of nicotine pouches “snus” and lunch & learn sessions for parents/ guardians
- **Smoke-free spaces:** Establish in schools, public areas, workplaces etc.
- **Stoptober campaign:** Use GP data to offer place-based support to all registered smokers, with weekly community drop-ins
- **Allen Carr Easyway Seminars (pilot):** Target routine & manual workers & residents IMD 1 & 2 postcodes
- **Bury FC collaboration**: Promote stop smoking support to fans and raise awareness in the community
- **Innovation through the Alliance:** Pilot new projects aimed at reducing smoking prevalence & health inequalities

NHS Greater Manchester Integrated care

Allen Carr's Easyway TO STOP SMOKING

Bury Council

Swap to Stop Bury Overview

2024/25 Implementation

- Delivered via Bury Live Well Service and Adullam Housing
- **Community based approach:** 8 drop-in clinics across all 5 neighbourhoods
- Distributed 133 Vape starter kits to local smokers,, supporting harm reduction and quit attempts

2025/26 Expression of Interest

- Submitted to extend participation in the national Swap to Stop scheme
- **Aim:** Broaden reach and strengthen delivery through partnership working (Alliance)

Pathway Expansion

- **Train the Trainer programme:** Primary care staff, Bury Council staff & VCSE partners trained in VBA+
- **Voucher scheme:** Enables wider distribution of free vape starter kits and light-touch quit support

NHS Greater Manchester Integrated care

Bury Council

Effective Enforcement across Bury

2024/25

- **Trading standards** seized over 7,000 illegal vapes, 2,000 packets of illicit cigarettes, with a street value of over £120,000

2025/26 (from April)

- Already seized 1,583 illegal vapes and 2,087 packets of illicit cigarettes, with a street value of £53,500

OPERATION AVRO
Fighting crime together

NHS Greater Manchester Integrated care

Bury Council

Recommendations

- **Endorse the creation of a Bury Tobacco Alliance** to coordinate local action and co-production.
- **Support targeted investment** (Swap to Stop) in high-prevalence groups and community-led interventions.
- **Advocate for smoke-free policies** in housing, schools, workplaces, and public spaces.
- **Champion innovation**, including Allen Carr seminars and youth vaping education.
- **Commit to regular updates** on smoking prevalence and inequalities as part of board agendas.

MAKE SMOKING HISTORY

Thank you
Any questions?

STOPTOBER

NHS Greater Manchester Integrated care

Bury Council

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Briefing Note

To	Health and Wellbeing Board Members
From	Lizzie Howard, Tobacco Control Officer & Lee Buggie, Public Health Specialist
Subject	Tobacco Control Update
Purpose	To provide an update on tobacco control activity in Bury and national policy developments
Decision required	None
Status	Not confidential

Recommendations:

The Health and Wellbeing Board is asked to:

- Endorse the creation of a **Bury Tobacco Alliance** to coordinate local action and co-production.
- Support **targeted investment (Swap to Stop)** in high-prevalence groups and community-led interventions.
- Advocate for **smoke-free policies** in housing, schools, workplaces, and public spaces.
- Champion **innovation**, including Allen Carr seminars and youth vaping education.
- Commit to **regular updates** on smoking prevalence and inequalities as part of board agendas.

1. National Policy Context: The Tobacco and Vapes Bill

The Tobacco and Vapes Bill 2024–25 was introduced in the House of Commons on 5 November 2024 and passed its third reading on 26 March 2025. It is currently at Committee Stage in the House of Lords (last update 31 July 2025). Subject to passage, the Bill will:

- **Create a smoke-free generation** by prohibiting sales of tobacco, herbal smoking products and cigarette papers to people born on/after 1 January 2009.
- **Strengthen youth vaping controls** via powers on product requirements (e.g., flavours, nicotine content limits for specific products, child-appealing packaging), advertising and promotion (including online), point-of-sale/display, and give-away/samples, alongside improved age-verification obligations.
- **Extend smoke-free** legislation to outdoor spaces (playgrounds, near schools, hospital campuses), subject to regulations.
- **Modernise enforcement**, introducing/enhancing fixed penalty notices, closure powers, seizure powers for oral tobacco/snus, cross-agency data sharing, and expanded registration/licensing.
- **Standardise offences** (e.g., proxy purchasing), tighten age-of-sale notices, and consolidate advertising controls across media and platforms.
-

Single use (disposable) vapes are banned from 1 June 2025. Trading Standards have powers to enforce, seize, and prosecute, supporting local youth vaping plans and illicit market disruption.

2. Bury Local Context and Tobacco Control Alliance

Bury will launch the Tobacco Control Alliance on 1 October 2025. This multi-agency partnership will lead the refresh of Bury's Tobacco Control Plan and provide a coordinated system-wide approach to reduce smoking prevalence and achieve Smokefree Bury by 2030.

The Alliance brings together Trading Standards, Bury ICB, Early Break, GM Police, Making Smoking History (MSH), Council services, and other partners. Its work is structured around four core workstreams:

- **Prevention**
- **Supporting smokers to quit**
- **Reducing health inequalities**
- **Effective enforcement**

The Alliance will focus on priority populations, including:

- Renters in social housing (29.6%)
- Residents who have never worked or are long-term unemployed (25.7%)
- Routine and manual workers (21.1%)
- Adults with long-term mental health conditions (20.6%)
- Residents in areas of deprivation (21.7%)
- Children and young people
- Mothers smoking at time of delivery (SATOD) (5.5%)

While overall smoking prevalence in Bury Adults (18+) is gradually reducing (10.5% in 2023/24), rates are rising in most target populations, except SATOD(Smoking At Time Of Delivery) , which is declining. This positive trend reflects progress in reducing smoking during pregnancy. Continued efforts such as the NHS smoke-free pregnancy incentive scheme are needed to maintain and build on this improvement.

The Bury Tobacco Control Alliance is well placed to translate the **Greater Manchester Making Smoking History strategy** into local action. The MSH strategy emphasises system-wide collaboration, targeted interventions to address inequalities, and a population health approach to support Smokefree ambitions. By aligning Bury's Alliance workstreams with MSH priorities, the Alliance can strengthen local delivery, ensure consistent messaging, and leverage regional resources to support cessation, prevention, and enforcement activities.

3. Local Stop Smoking Services and Support Grant (LSSSG)

The LSSSG is a ring-fenced grant paid to local authorities for five years to support local stop smoking services. Bury received £207,932 in 2024/25 and £209,301 for 2025/26, intended to expand services, build capacity, increase quit attempts, and improve outcomes.

The LSSSG has supported the Bury Live Well Service, which provides accessible, evidence-based

support through a place-based team of Health & Wellness Coaches across the borough's five neighbourhoods. During 2024/25, 489 people were referred for smoking cessation support, with 470 setting a quit date. Additional grant-funded posts include 2 full-time Health & Wellness Coaches focusing solely on smoking cessation and 1 full-time Tobacco Control Officer within Public Health, strengthening links with primary care, housing providers, and homelessness outreach.

2024/25 Outcomes:

- **Youth vaping education:** Commissioned Early Break to deliver presentations in primary and secondary schools and colleges. Over 15 sessions were delivered to students and teachers. Awareness posters on the harms of nicotine and illicit vapes were co-produced.
- **Workplace wellbeing sessions:** Introduced through Bury Live Well Service, targeting routine and manual workers, linked to Bury Regeneration construction projects.
- **VBA+ delivery across communities:** Commissioned PaSH partnership (BHA for Equality, George House Trust, and LGBT Foundation) to provide VBA+ sessions at community venues.
- **Digital health promotion campaigns:** Delivered locally and across Bury, using digital screens to highlight support for quitting smoking and the benefits of stopping.
-

2025/26 Deliverables:

- **Expand youth campaigns:** Early Break to extend work to school nurses, Bury Care Leavers, and update presentations to include other nicotine products such as pouches ("snus"). Introduce lunch-and-learn sessions for parents and guardians.
- **Smoke-free spaces:** Establish in schools, public areas, and workplaces, aligned with the Tobacco and Vapes Bill and GM Making Smoking History strategy.
- **Stoptober campaign:** Use GP data to text all registered smokers in Bury, offering place-based support with weekly community drop-ins across all five neighbourhoods.
- **Allen Carr Easyway Seminars (pilot):** Targeting routine/manual workers and residents in IMD 1 & 2 postcodes, this pilot offers an alternative, non-prescribed smoking cessation method using evidence based outside of traditional treatment pathways.
- **Bury FC collaboration**: Raise awareness among fans who may smoke, promoting local stop smoking services.
- **Alliance coordination and pilot projects:** The Tobacco Control Alliance will provide a forum to coordinate initiatives and may support pilot projects to further reduce smoking prevalence.

By linking local activity with the Greater Manchester Making Smoking History strategy, the Alliance can align priorities, share best practice, and ensure consistent, evidence-based approaches to smoking prevention, cessation, and enforcement. This partnership approach will be crucial in addressing inequalities and driving Bury toward its Smokefree 2030 ambition.

4. Swap to Stop Scheme

In addition to increasing investment in smoking cessation services, the government have introduced an innovative scheme called 'Swap to Stop'. This scheme aims to boost smoking cessation work at a grass roots level by providing up to one million vapes and starter kits across England, to enable services to support even more adult smokers to make a "quit" attempt.

133 vape starter kits have been distributed to those utilising 'Swap to Stop' in 2024/25 through our Bury Stop Smoking Service and Adullam Homes.

In 2025/26 we are in the process of expanding our pathway to include **vape kit vouchers** which will

be redeemable through the online portal (links received via email or text referrals).

Also the introduction of a **'Train the Trainer'** package is currently being developed by the PH team in order to widen the Swap to Stop offer. This will focus on training staff to provide Very Brief Advice (VBA)+ and Swap to Stop vaping kits to individuals identified as current smokers. VBA+ involves asking patients about their current smoking status and advising them on the best methods of stopping smoking available to them. Training will be provided for front line staff working throughout the four Primary Care Networks and Bury VCSE organisations. Individuals will be followed up at 4 weeks to record their quit status.

5. Tobacco Enforcement and Illicit Produce Seizures

Tobacco control enforcement continues to be a vital component of reducing the availability of illicit tobacco and vaping products across Bury. During **2024/25**, enforcement activity resulted in seizures with a total street value of **£120,000**, including:

- 39,660 illicit cigarettes (1,983 packs)
- 9.4 kg of illicit hand-rolling tobacco (188 packs)
- 7,425 illegal vapes, 4 kg of shisha, 28,000 pieces of hand-rolling tobacco packaging, and a hand-rolling tobacco mixing machine

Since the start of the current financial year (**1 April 2025**), early enforcement actions have already resulted in seizures with a total street value of **£53,500**, including:

- 1,583 illicit vapes seized
- 2,087 packs of cigarettes (41,740 sticks)
- 212 packs of hand-rolling tobacco (10.55 kg)

These figures demonstrate the continued commitment of Bury Trading Standards and partner agencies to tackling illicit tobacco and vaping products, protecting local communities, and reducing access to harmful products.

With the introduction of the **Tobacco and Vapes Bill**, local authorities will gain additional powers to strengthen enforcement, including restrictions on the sale of vapes and tobacco products, regulation of marketing, and improved oversight of retail compliance. This will complement ongoing enforcement activity and the work of the Bury Tobacco Control Alliance, helping to reduce smoking prevalence, support cessation, and protect populations most at risk from tobacco-related harm.

Winter Vaccinations Update

4 September 2025

Steven Senior

Consultant in Public Health

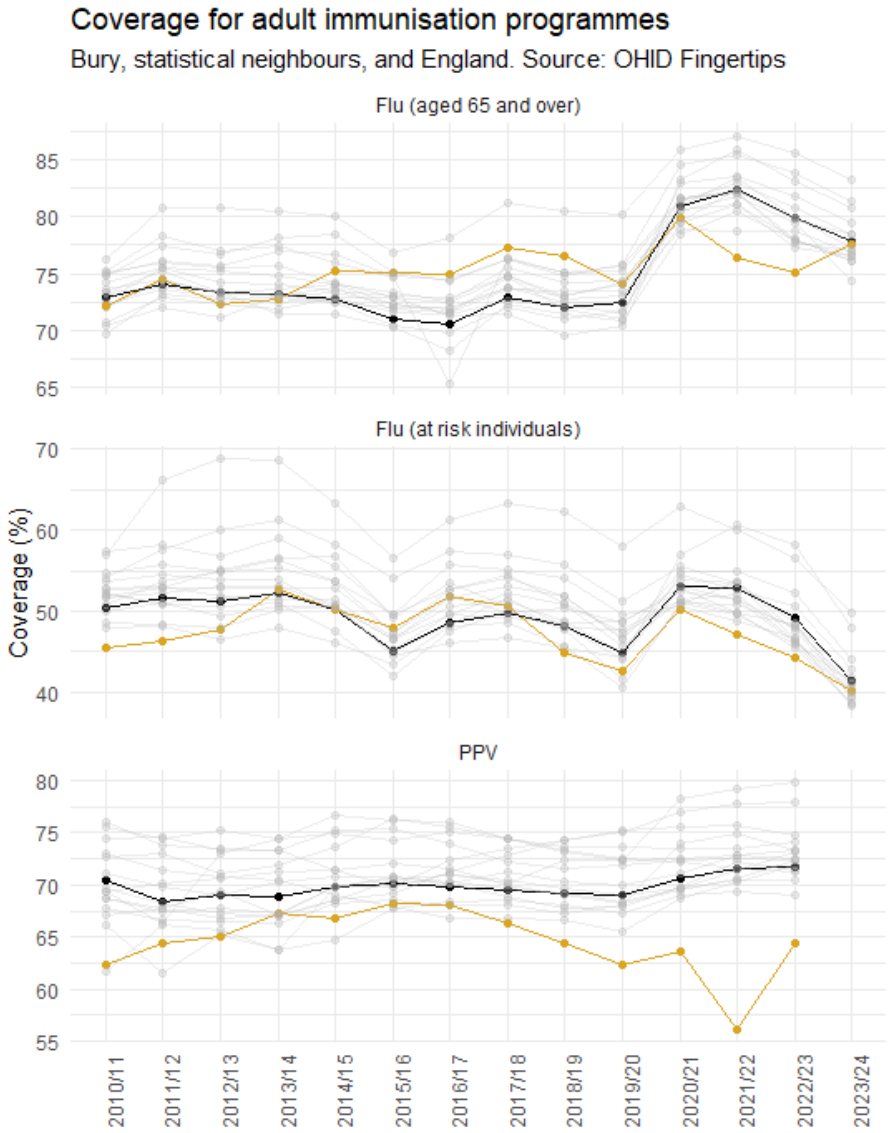
WHAT ARE THE MAIN 'WINTER' VACCINES?

- **Influenza:**
  - Seasonal virus normally circulating between December and February.
  - Causes significant pressure on hospitals and serious care home outbreaks.
  - Annual vaccine campaign starting September (children) and October (adults)
  - **Vaccine eligibility**: pregnant women, all children aged 2 or 3 years, school aged children (reception to year 11), children in clinical risk groups aged from 6, adults aged 18 to 65 in risk groups, all adults aged 65 and over.
- **COVID-19:**
  - Not yet seasonal – have seen waves at all times during the year. Currently in a prolonged period of relatively low circulation.
  - A wave in winter could add to hospital pressure and care home outbreaks.
  - Twice yearly campaigns in April and October.
  - **Vaccine eligibility**: adults aged 75 years and over, residents in care homes for older adults, individuals who are immunosuppressed aged 6 months and over.
- **RSV (respiratory syncytial virus):**
  - Seasonal virus normally circulating October – January.
  - Causes significant hospital admissions – mostly very young children and older adults.
  - One-off vaccine (no seasonal campaign).
  - **Vaccine eligibility**: pregnant women, adults aged 75-79.
- **Pneumococcal**
  - Common cause of bacterial pneumonia, can be secondary infection following infection with respiratory virus.
  - Causes substantial hospital admissions and deaths in older adults. Can cause severe care home outbreaks.
  - One off vaccine (no seasonal campaign)
  - Vaccine eligibility: people aged 65 and over (normally on turning 65).

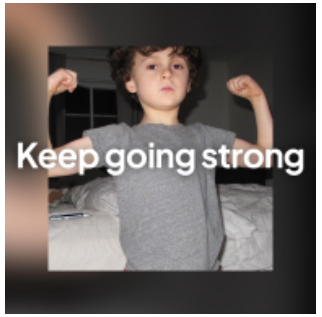
Bury Council

UPTAKE OF KEY VACCINES IN BURY

- **Influenza:**
  - 3rd/4th in Greater Manchester for older adults (improvement from 2022/23 – 2023/24) but declining uptake nationally.
  - 5th in GM for at risk adults.
- **COVID-19:**
  - 3rd/4th in GM for older adults, 5th for at risk adults.
  - Declining uptake nationally (Spring uptake normally lower than Autumn/Winter).
  - Eligible cohort reducing due to change in effectiveness of boosters (due to increasing population immunity).
- **RSV:**
  - 7th in GM for older adults, 2nd for pregnant women (though coverage only 30%).
- **Pneumococcal:**
  - Worst uptake in GM (2024/25 data not available, but improvement from 2021/22 – 2022/23). No more recent data available from ICB.
  - Working to improve uptake with GP Fed & practices focusing on care home residents and older adults.

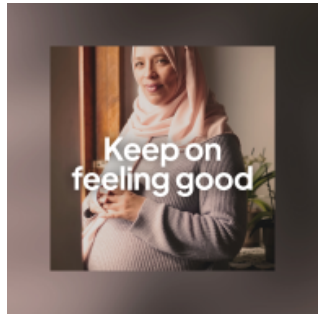


NHS GREATER MANCHESTER WINTER VACCINES COMMUNICATIONS CAMPAIGN



This winter keep your little one safe with a quick, painless nasal spray vaccine.

Flu can make your child very unwell. Make sure they get their nasal spray vaccine at school.



Winter viruses can harm you and your baby. Vaccination is a safe and effective way to protect you both.

Winter viruses can cause serious illness and long-term health problems.

NHS Greater Manchester

Keep them protected this winter

Search: NHS GM Winter vaccinations

Bury Council

Agenda Item 9a

Classification Open / Closed	Item No.

Meeting:	Bury Health and Wellbeing Board
Meeting date:	4th September 2025
Title of report:	Bury Prevention Framework
Report by:	Jon Hobday – Director for Public Health, Bury Council
Decision Type:	**Information/ Discussion** ***(delete as appropriate)***
Ward(s) to which report relates	**All**

DRAFT

Executive Summary:

This paper outlines the recently developed 'Bury Prevention Framework'. The purpose of the framework is to help partners, and the public understand what prevention is, why it is important, the different elements of prevention and the roles and responsibilities individuals and organisations can play. It also highlights the importance of prevention across the life course.

Recommendation(s)

That:

The Health and Wellbeing Board is asked to:

- Review and endorse the Prevention framework

Bury Prevention Framework

Who is this framework for?

This framework is for everyone.

We can all play a role in preventing illness and helping people stay well. This might be through work or in our private lives. This document explains what we mean by prevention and how the council, the NHS, and their partners will approach it.

Here are some examples of what this could look like in practice:

- A district nurse might notice that a patient's home is cold and damp and could refer them to support with heating bills and home improvements.
- A children's social worker might notice a child wheezing and have a conversation with the child's parents about getting them seen by a doctor to see if they have asthma and help them manage the condition.
- A GP might believe that a patient is socially isolated and lonely and refer to social prescribers who could link that person to activity groups that they might enjoy, and which would help them meet new people.

These examples have been deliberately chosen to show how opportunities for prevention span different professional contexts. This means working together.

What is prevention?

In health and social care, prevention means doing things to help people stay healthy and safe. It's about stopping problems before they start. For example, helping older people exercise so they stay strong and don't fall, or teaching children to brush their teeth so they don't need fillings or teeth taking out. It's about making sure everyone can live their best life without getting hurt or sick.

While the main goal of prevention is to help people live healthier and happier lives, it also has other benefits. Keeping people healthy and safe could reduce the number of people who need urgent medical care. For example, if fewer people get sick or hurt, hospitals won't be as busy, and hospitals can focus on helping those whose illness couldn’t be prevented.

When we help people stay healthy and avoid getting sick or hurt, we don't have to spend as much on expensive treatments and hospital stays. For example, helping people to stop smoking can prevent heart disease and lung cancer, which are more costly to treat. By investing in prevention, we can use healthcare money better and make sure there's enough for other important healthcare needs.

So, prevention not only makes life better for people, but it also helps health and social care services work better.

Why is prevention important?

The number of people needing health or social care has been growing quickly. Services have been struggling to keep up for some time. Some examples of this include:

- The proportion of people who wait more than four hours to be seen in type 1 Accident and Emergency departments has been stuck at between 50% and 60% since early 2022. (Nuffied Trust, 2025).
- The number of people on waiting lists for elective treatment grew by around one million between late 2021 and mid-2023 (Nuffield Trust, 2025).
- The number of people who said is not easy to contact their GP practice by phone has gone up, as has the number who said they never or almost never saw their preferred doctor (Nuffield Trust, 2024).
- The number of people needing help from adult social care has been rising steadily (King's Fund, 2025)

Health inequalities - unfair and avoidable differences in health between different parts of our population - exist because some people have worse access to the things needed to stay healthy. These include good homes, good jobs, a good education, and healthy living environments. Prevention, by tackling these issues, is essential to closing these gaps in health, a key aim in the LETS Do It! strategy.

This approach is also important because it fits with national, regional, and local strategies. These include:

- **The Government's Health Mission:** Preventing illness is an important part of the Government's commitment to building an NHS fit for the future. Shifting from "sickness to prevention" is one of the three big shifts the Government thinks are needed to make the NHS sustainable in the future (HM Government, 2024).
- **Greater Manchester plans and strategies:** Prevention is also central to several Greater Manchester strategies and initiatives, such as the GM Population Health Model (NHS Greater Manchester, n.d.)
- **Bury's 2030 strategy, LETS Do It!:** Prevention and early intervention run through the LETS Do It! strategy. The vision for integrated neighbourhood teams is that they should understand the needs of their neighbourhood population and be able to focus more on preventing people needing health and social care services (Bury Council, 2020).

Three types of prevention

- **Primary Prevention**: This is about stopping problems before they start. Examples include reducing air pollution to prevent asthma, getting people active to prevent heart disease, diabetes, and musculoskeletal problems, or vaccines to prevent diseases like measles.
- **Secondary Prevention**: This is about finding and treating problems early. For example, taking part in cancer screening programmes. It also includes treating 'risk factors' like high cholesterol or high blood pressure which increase the chances of developing diseases likes strokes or heart attacks.
- **Tertiary Prevention**: This is about helping people manage long-term health problems to prevent the worst outcomes. For example, helping someone with diabetes manage their blood sugar levels to prevent them becoming blind or needing amputations.

Prevention can happen at two scales

- **Individual -level prevention**: This is about helping one person stay healthy. For example, a doctor might give advice to a patient about stopping smoking, drinking less alcohol, exercising, or getting vaccines. Mostly these interventions don't benefit other people
- **Population-level prevention:** This is about helping a whole group of people stay healthy. For example, reducing air pollution, or reducing the availability of alcohol or unhealthy foods.

Both scales of prevention are important. While individual-level interventions for people who are at higher risk of getting ill often feel more important, **evidence shows that population level interventions often produce bigger benefits more cheaply**. This is because although the benefit to each person affected may be smaller, the number of people who benefit is much bigger (Rose, 1985).

The table in appendix A gives more examples of each type of prevention.

The importance of prevention across the life course

The life course approach to public health looks at how different things that happen to people throughout their lives affect their health. It recognises that things that happen to us build up over time and that there may be critical periods like pregnancy and early childhood where people might be more sensitive to certain risks (Wagner et al 2024).

For example, poor housing caused by poverty in childhood might lead to diseases like asthma, which might cause worse school attendance, which could lead to doing less well at school, which could lead to having fewer job opportunities or lower incomes as an adult, which can in turn lead to mental and

physical illnesses and worse diet, increasing the risk of developing multiple long-term conditions, and earlier onset of frailty.

This means it's important to consider opportunities at every stage in a person's life course.

- **Start well:** this might include checking whether a child has had their vaccinations (primary prevention, individual-level); reducing air pollution near schools by limiting traffic and idling cars (primary prevention, population-level); or screening for hearing loss in newborns (secondary prevention, individual-level).
- **Live well:** examples here might include limiting the availability of alcohol or unhealthy food (primary prevention, population-level) health checks to find people with high blood pressure or high cholesterol (secondary prevention, individual-level) or treating people with mental illness to stop their condition worsening (tertiary prevention, individual level).
- **Age well:** includes maintaining physical activity levels or reducing trip hazards to prevent falls (primary prevention, individual-level), improving housing quality and insulation to prevent cold-related deaths (population-level, primary prevention), or falls and fracture liaison services who work with people who have already had a fall or fragility fracture to prevent future falls (tertiary prevention, individual-level).

The principles behind our approach to prevention

The principles of the LETS Do It! strategy provide a foundation for 'doing' prevention.

- **Local:** Many of the actions we need to do to prevent illness and help people live happy, independent lives need to be local. This means joined up public and voluntary services working together to improve the places where we live. People need to have access to a full range of services where they live to avoid excluding people who cannot travel easily.
- **Enterprising:** Preventing illness may require innovation and different thinking both from service providers and the public. We will need to look beyond a person's immediate needs to the underlying problems. A person may be frequently attending hospital or their GP because their housing is cold or damp, or because loneliness is worsening their mental health. Working across boundaries to fix these problems will take courage. We will also need to be led by data and evidence on what works, as some approaches to prevention that appear to make sense don't work in practice.
- **Together:** Our approach to prevention needs to be done with, not to people. Interventions need to reflect our residents and service users' priorities. This will mean working with communities and the voluntary, community, and faith sector to make sure residents have a say in how

services are delivered. It also means strengthening connections between different services and other organisations within each neighbourhood.

- **Strengths:** This means building from what's already strong, both in communities and in individuals. Working with existing local organisations and businesses to offer services in more accessible ways and working with individuals to find out their strengths and interests and use these as a base for building interventions.

Examples of how we are currently using prevention

- **Anti-poverty strategy:** by targeting financial support to vulnerable groups like families with young children or elderly people living in poverty, the council and its partners helped to reduce the harm caused by the cost of living crisis. The links between poverty and sickness are strong and varied so tackling poverty prevents a range of physical and mental illnesses. This is a form of population-level primary prevention.

- **Planning and licensing:** the environment we live in influences our health in many ways, from direct exposure to pollution to limiting our choices of food and drink and how we travel. The council has developed an alcohol licensing matrix that helps us see where the harms from alcohol are greatest. This helps to make a case against awarding licenses to sell alcohol in the communities suffering the most harm from it. This is population level primary prevention of alcohol harms.
- **Behavioural factors:** Smoking remains the most important behavioural cause of illness, with around half of lifelong smokers dying of diseases caused by smoking (Action on Smoking and Health, 2024). By helping people to quit smoking, including by switching to vapes through our 'swap to stop' programme the council is preventing lung cancer and heart disease. This is individual-level primary prevention.
- **Cancer screening:** The national cancer screening programmes are designed to detect cancers early so they can be treated before they spread. But not everyone who is eligible for them takes part and fewer people living in deprived areas or from some ethnic minority communities take part. In the East Neighbourhood, GP practices worked together to promote bowel cancer screening. This led to increases in uptake of bowel screening, which is likely to prevent deaths from bowel cancer. This is individual-level secondary prevention.
- **Treating coronary heart disease**: People with coronary heart disease - where the arteries that take blood to the heart get clogged with fatty plaques - are at high risk of heart attacks and strokes. These can be prevented by taking medicine to lower blood pressure, lower blood cholesterol levels, and by quitting smoking. The NHS Greater Manchester Bury primary care commissioning team introduced an extra payment to incentivise GP practices to increase the number of patients with coronary

heart disease whose care had been optimised in this way. This is individual level tertiary prevention.

Next steps

We will develop plans which will explain in more detail how we will apply this across the life course:

- Start well
- Live well
- Age well

These plans will set out the mix of neighbourhood and Bury-wide initiatives designed to prevent illness and promote good health for all residents of our Borough at all ages.

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Appendix A: examples of different types of prevention

	Start well	Live well	Age well
Primary	**Population-level:** • Child tax credits to reduce childhood poverty preventing a range of illnesses. • Reduction in exposure to lead to prevent cognitive impairment • Adding fluoride to drinking water to prevent tooth decay **Individual-level:** • Supervised tooth brushing to prevent tooth decay • Vaccinations to prevent infectious diseases like measles, pertussis, or meningitis.	**Population-level:** • Smoking Bans to reduce exposure to second-hand smoke and prevent lung disease. • Workplace Wellness Programs that promote physical activity, healthy eating, and stress management in workplaces. • Planning measures to limit availability of unhealthy food and alcohol preventing heart disease, liver disease, and cancers. **Individual-level:** • Live Well services to help people stop smoking, eat better, drink less alcohol, and be more physically active.	**Population-level:** • Age-friendly environments reduce trip-hazards and provide places to rest to help older adults stay active. • Workplace Wellness Programs that promote physical activity, healthy eating, and stress management in workplaces. • Planning measures to limit availability of unhealthy food and alcohol preventing heart disease, liver disease, and cancers. **Individual-level:** • Vaccinations to prevent infectious disease like shingles, pneumonia, flu, COVID-19, or RSV. • Exercise classes for older adults to help them stay active and prevent falls.
Secondary	**Individual-level:** • Neonatal blood spot test to detect treatable conditions early • Newborn hearing check to identify hearing loss early to prevent developmental delay	**Individual-level:** • NHS Health Checks to identify and treat risks for cardiovascular disease and diabetes (high blood pressure, high blood glucose, high cholesterol, obesity, risky alcohol consumption). • Cervical cancer screening to detect cervical cancer early preventing deaths from cervical cancer.	**Individual-level** • Abdominal aortic aneurysm (AAA) screening is offered to men aged 65 to detect aneurysms (dangerous swellings) in the aorta - the artery that takes blood from the heart to most of the body. It prevents deaths from ruptured aortic aneurysms.
Tertiary	**Individual-level:** • Medicines for childhood asthma to prevent asthma attacks and deaths.	**Individual-level:** • Regular monitoring of blood sugar levels, medication, and lifestyle changes can help manage diabetes and prevent complications like amputations or blindness. • Physical therapy, medication, and counselling to help people manage chronic pain and improve their quality of life and help stay in work.	**Individual-level:** • Cardiac Rehabilitation for older adults who have had a heart attack, cardiac rehab helps them recover and prevent further heart problem. • Falls and fracture liaison services for people who have already had a fall or fragility fracture to prevent future falls.

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Community impact/links with Community Strategy

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

> *A public authority must, in the exercise of its functions, have due regard to the need to -*
>
> (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
>
> (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
>
> (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

Legal Implications:

To be completed by the Council's Monitoring Officer

Financial Implications:

To be completed by the Council's Section 151 Officer

Report Author and Contact Details:
Jon Hobday Director of Public Health, Bury Council - j.hobday@bury.gov.uk

DRAFT

Background papers:

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning

DRAFT

Addressing the three biggest killers

on a regional and local level

A toolkit to support regional and local decision makers to develop a coherent approach to reducing harm from alcohol and unhealthy food and drink, learning from tobacco.

June 2025

Greater Manchester Integrated Care Partnership
Humber and North Yorkshire Health and Care Partnership
Obesity Health Alliance
Alcohol Health Alliance
ash action on smoking and health

Foreword

"As Directors of Public Health in Humber and North Yorkshire and Greater Manchester we understand the harm caused by tobacco, alcohol and unhealthy food and drink in our communities. These harms are driven by powerful industries who distort the commercial and information environments to drive the sale of profitable, health-harming products. The burden is not felt equally – unhealthy commercial environments cluster in the most disadvantaged communities, widening health inequalities. These injustices must be met with a strong response from us as public health leaders.

The tactics used by the alcohol and unhealthy food and drink industry increasingly mirror those used by the tobacco industry and there is an overlap of harms when multiple harmful products are used together. Tobacco control provides lessons for our response to other harmful product industries – demonstrating how regulation, countering industry influence, and shifting public attitudes can lead to significant health gains. By developing a more coherent, joined-up approach, we can build on what's already working, avoid duplication, and deliver greater collective impact.

Moving from sickness to prevention is one of the three big reform shifts set out in the government's health mission. And this isn't just a public health priority – there is strong public backing for tougher action on harmful products, particularly when it comes to protecting children and reducing health inequalities.This toolkit sets out practical ways that regional and local policy makers can drive forward the response to the three biggest killers – from developing healthier advertising policies to creating healthier commercial environments for our residents. This toolkit focuses on the harmful products themselves and the commercial strategies that drive their consumption. It offers targeted, system-level solutions that complement and strengthen existing public health efforts.

Government delays on key national policies – such as the postponed restrictions on advertising of high fat, salt and/or sugar products – make clear the need for strong local and regional leadership. We must not wait. Local systems should advocate for faster action while taking bold steps to shape healthier commercial environments now."

Jilla Burgess-Allen,
Director of Public Health, Stockport Metropolitan Borough Council

Julia Weldon,
Director of Public Health, Hull City Council

Jon Hobday,
Director of Public Health, Bury Council

Peter Roderick,
Director of Public Health, City of York Council

Rachael Musgrave,
Director of Public Health, Wigan Council

About this document

This document is a practical toolkit to support regional and local policy makers to develop a coherent approach to the alcohol and unhealthy food and drink industries, learning from successful action on tobacco. It does not focus on actions that can be taken on tobacco, but on how lessons learnt from tobacco can be applied to alcohol and unhealthy food and drink. This toolkit sets out action to respond to the alcohol and unhealthy food and drink industries, it does not focus on harms caused by other industries, or on other causes of ill health such as physical inactivity.

How to use this document

Section 1

Why do we need a coherent approach to harmful products?

This section sets out the narrative argument and high-level evidence for a coherent approach to the three biggest killers.

Section 2

National, regional and local action

This section describes why action at all levels is important and broadly what the role of each level is in a coherent approach.

Section 3

A framework for action

This section sets out a high-level framework that can be used to guide action on a regional and local level.

Section 4

Enablers of a comprehensive strategy

This section describes the enablers of a comprehensive strategy to tackle harmful product industries on a regional and local level including:

- tackling inequalities
- funding prevention
- managing industry influence
- mobilising communities

Section 5

High impact actions for harmful products

This section describes the actions that can be taken regionally and locally to tackle harmful industries including:

- regulate advertising
- shape use and environment
- influence price and affordability
- communicate health messages
- provide treatment

Section 6

Step-by-step guide to developing your own strategic approach

This section is a guide to support you in developing your own approach based on work undertaken with Greater Manchester and Humber and North Yorkshire. This section also links to resources in the toolkit which can help on your journey.

Section 7

Key resources and supporting information

This section includes a list of links to useful information to support you in developing your own approach.

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Section 1 | Why do we need a coherent approach to harmful products?

The three biggest killers

Tobacco, alcohol and unhealthy food and drink are the three leading causes of ill health and early death in England. These harms are felt unequally in society[1], with the most disadvantaged communities experiencing the greatest harm, exacerbating inequalities in health[2]. Our neighbourhoods are flooded with unhealthy products which are readily available, affordable and made acceptable through marketing. This isn't about individual choice; it's about the environments created by the industries that produce and promote these health-harming products. The resulting ill-health places a huge burden on individuals and society, negatively affects the productivity of our workforce and increases the costs of delivering our health and social care system.

Tobacco, alcohol and unhealthy food and drink contribute to poor mental health and chronic diseases, including cancers, type 2 diabetes, cardiovascular disease, and dementia[1]. In addition to the significant impact on health and wellbeing for individuals, there is a burden on healthcare services caused by harmful products, including thousands of hospital admissions every year[3].

Figure 1: Prevalence, hospital admissions and deaths from the three biggest killers in England

12%
of adults smoke

Around 0.5m hospital admissions

192k deaths

65%
of adults live with overweight or obesity

Over 1.2m hospital admissions

Over 30k deaths

23%
of adults drink above low risk guidelines

Over 1m hospital admissions

Over 22.5k deaths

All data sourced from DHSC Fingertips except obesity hospital admissions (NHS Digital) and obesity deaths (2021 Global Burden of Disease study).

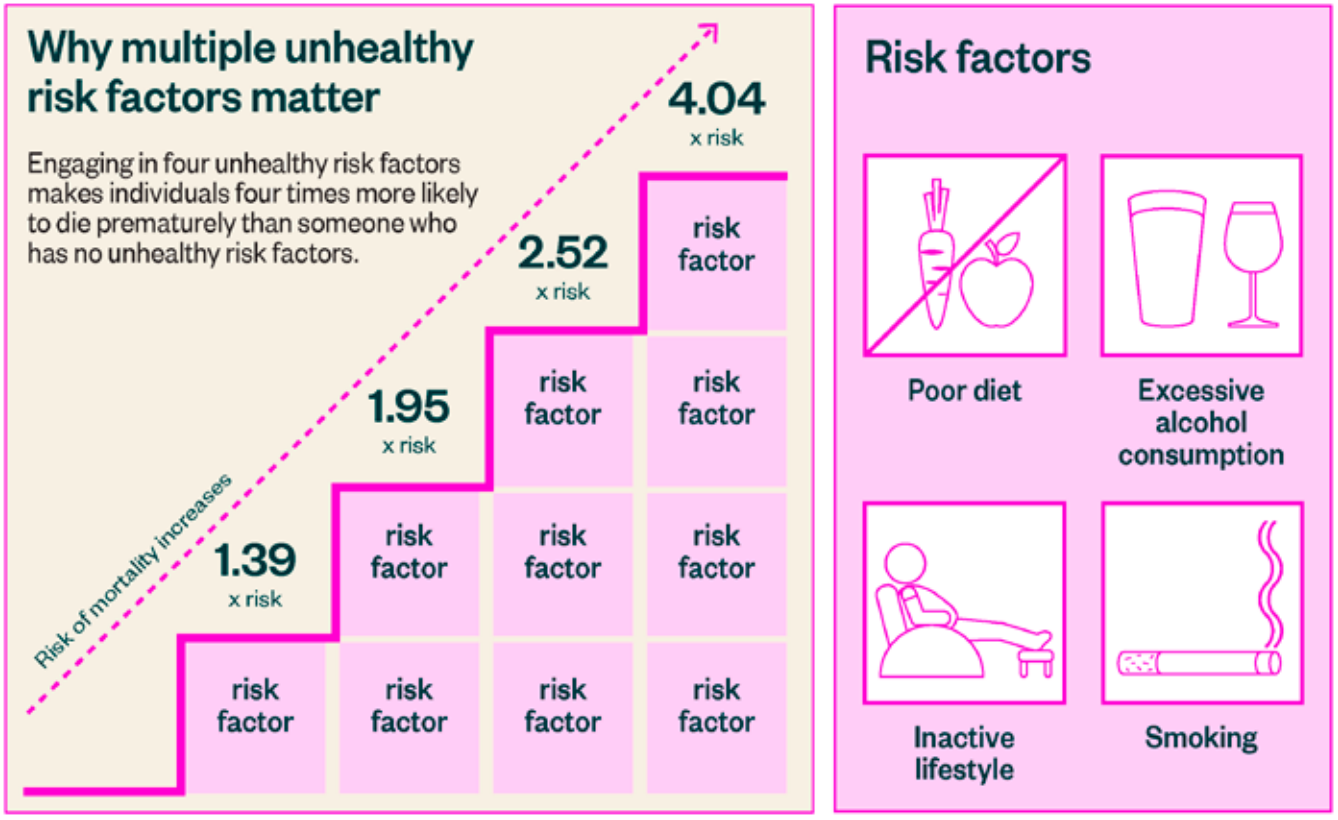
Deaths from alcohol refers to alcohol-related deaths.

Obesity is used here as a clinical term is for data purposes because this is what is collected and reported on, and is likely to be indicative of the wider problem of our unhealthy food and drink environment

Marketing practices by harmful industries often particularly target children and young people, to build brand recognition and develop social norms around the use of these products. For example, the alcohol industry uses marketing to normalise youth drinking[4].

There is an overlap in harms caused by tobacco, alcohol, and unhealthy food and drink. Harms multiply when there is more than one product involved. Evidence tells us that the harms from smoking, drinking excess alcohol and poor diet, as well as physical inactivity, make people four times more likely to die prematurely compared with someone without any of these risk factors[5]. The most disadvantaged people are also more likely to be affected by the harms of more than one product, exacerbating health inequalities.

Figure 2: **Table from The King's Fund "Multiple unhealthy risk factors: why they matter and how practice is changing"[5]**



Adapted from Khaw *et al.* 2008 (see report for full reference). Relative all-cause mortality risk shown applies after an average 11-year follow-up in a cohort of adults aged 45-79. Confidence intervals apply.

The role of industry

We also know that health-harming industries all use similar tactics. This 'playbook' of tactics, includes: distorting the science and messaging around risks and harms; discrediting professionals; using legal threats; positioning themselves as part of the solution; using proxies to communicate their messages; inappropriate use of corporate social responsibility, and giving incentives to politicians[6]. They are too able to influence public health policy; delaying, weakening or stopping policies that would not be in their commercial interests. Aside from tobacco, there has been a failure by successive national governments to fully regulate health-harming industries[7].

Public opinion

The public are supportive of action to create healthier environments and directly targeting health-harming industries, particularly for protecting health policy from their influence. Recently published opinion polling data from Action on Smoking and Health (ASH), the Obesity Health Alliance (OHA) and Alcohol Health Alliance (AHA) shows that 73% of people say the government has a role to play in protecting the public against harmful business practices, with 74% stating that when supporting businesses and improving public health are in conflict, government must prioritise health[8].

Image: © 2023. Provided by Impact on Urban Health licensed via a CC BY-NC-ND 4.0 license.

What can we learn from successful efforts to reduce smoking?

We can translate the lessons learned from addressing tobacco to accelerate progress on alcohol and unhealthy food and drink. Comprehensive tobacco control approaches have seen accelerated progress in declining smoking rates. Many national and international strategies on tobacco[9], alcohol[10] and unhealthy food and drink[11] call for similar activities to tackle harmful products, such as restricting the affordability, availability and promotion of these products.

A proportionate approach

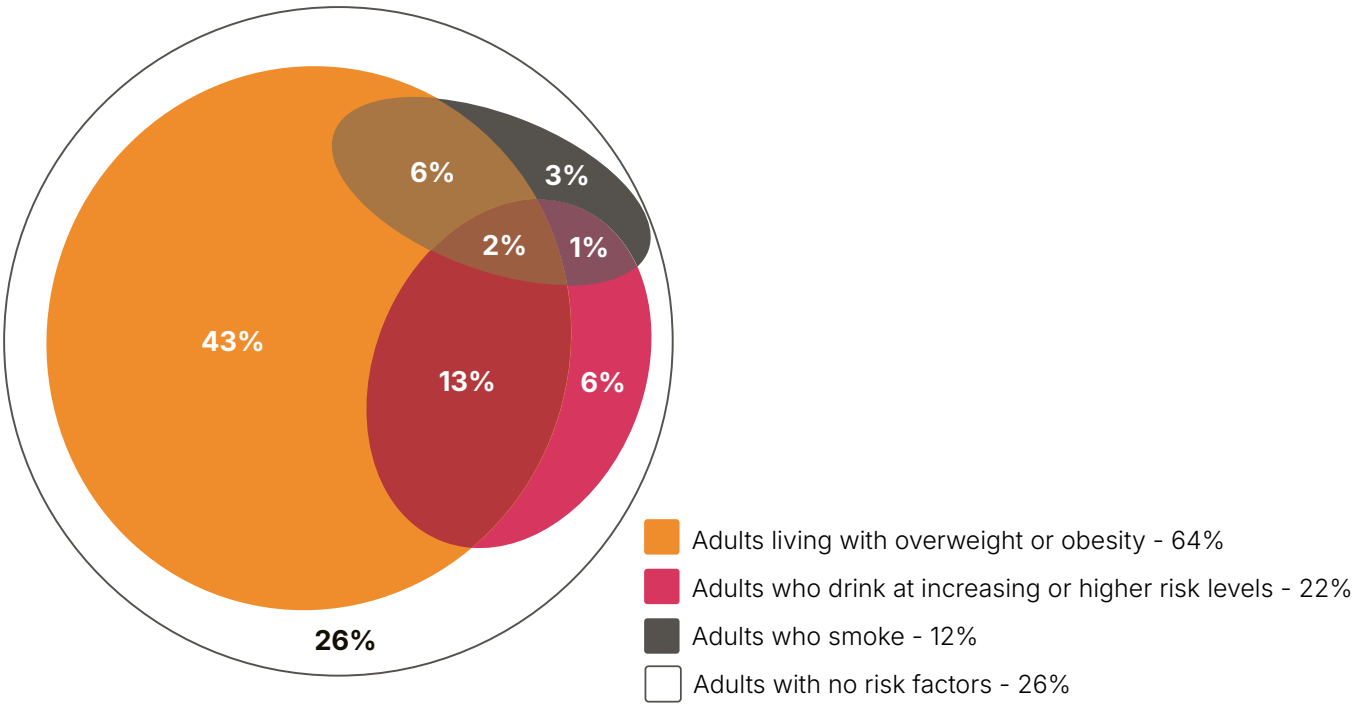
A proportionate approach recognises the overlapping harms and tactics but is flexible in response, due to the differences between these products in terms of their individual level harms. Tobacco is exceptionally harmful and will kill up to half of its long-term users[12]. Alcohol is a harmful product with regular consumption above the Chief Medical Officers' low risk drinking guidelines linked to harm. In addition to direct health impacts, alcohol is a contributory factor to wider social harms such as crime and violence. The situation with unhealthy food and drinks is nuanced, as the harm is caused by poor diet quality rather than individual products. It's important to communicate sensitively around alcohol and unhealthy food and drink, recognising the risk of stigmatising language and the risk of exacerbating eating disorders. In addition, the food and drink, and hospitality industries can play a positive role in our places – providing jobs and potentially contributing to social cohesion. Effective policy should manage harms while allowing responsible businesses to thrive.

Multiple risk factors and benefits of a coherent approach

Evidence suggests that there are associations between co-occurring risk factors, that risk factors exacerbate each other and worsen inequalities. For example, people with experience of alcohol misuse are 1.8-2.9 times more likely to smoke compared to the general population[13]. The number of people who have more than one risk factor is not routinely reported. To gain a picture of the prevalence of multiple risk factors, ASH undertook a snapshot analysis of the 2021 HSE data (Figure 2)[14]. Overall, 22% of adults in England had two or more risk factors. The prevalence of each of the pairs of risk factors was:

- 13% for overweight/obesity and increasing/higher risk drinking (equivalent to 5.6 million adults)
- 6% for overweight/obesity and smoking (equivalent to 2.5 million adults)
- 1% for increasing or higher risk drinking and smoking (equivalent to 0.6 million adults)
- 2% for all three risk factors (equivalent to 1.0 million adults)

Figure 3: **Co-occurrence of risk factors in adult population of England, 2021 (ASH analysis of HSE data)**



Pursuing a coherent policy approach to harmful products, recognising this overlap, should therefore reduce morbidity and mortality, reduce inequalities and reduce the burden on health and social care services.

Section 2
National, regional and local action

Leadership at all levels of government is critical to delivering a cohesive, interference-free policy approach to improving public health. This section describes the role of each level in the system. Specific examples of how different levels can work together are provided in the next section.

The role of national government

Nationally, strong leadership, cross-department collaboration and strategy, is necessary to set clear targets and funding priorities, and safeguard against health-harming industry influence[15]. This can be achieved by regulating industry through legislation and providing national leadership through policy positions and guidance.

The role of regional teams and Integrated Care Boards

Regional teams are ideally situated to provide overarching strategic approaches and support local areas in adapting policy to align to the needs of their populations. Regional Department of Health and Social Care and regional NHS England teams have a role in translating national guidance for local use and providing support to local delivery.

As set out in NHS England's Draft Model Integrated Care Boards (ICBs) Blueprint, ICBs have core functions that include understanding local context and developing long-term population health strategy[16]. The regional role should not be directive but provide a framework for action. For example, through co-producing strategies and guidance, and sharing best practice.

Some actions may make sense to coordinate across a regional footprint such as developing communications campaigns and pooling funding for some initiatives across a region for economies of scale.

The role of local government

Local authority powers in licencing and planning provide an opportunity to reshape environments around residents and push back against the harmful influence of big industries. Local authorities have a proud history of going further than national government on important public health issues, paving the way and making the case for national legislative change such as the smoking ban and the incoming unhealthy food advertising restrictions.

There is also power in collective lobbying by local health leaders on important public health issues such as minimum unit pricing (MUP) for alcohol, demonstrating to national government that these issues are having devastating impacts in local areas. Local teams are crucial in addressing health inequalities, monitoring outcomes, and piloting innovative programs for broader adoption[15].

Section 3
A regional framework for action

This framework is based on the national framework developed by ASH, OHA and AHA for the Holding us Back report[1]. It has been adapted for regional use through an iterative process of feedback from stakeholders from across the Humber and North Yorkshire and Greater Manchester ICB areas.

The framework can be used as a starting point for a regional or local strategy or action plan to respond to the alcohol and unhealthy food industries. It takes the elements of an effective local approach to tobacco, and applies this to alcohol and unhealthy food and drink, recognising that the same basic principles apply.

Figure 4: A regional framework for action on the three biggest killers

At the heart of the framework is a **comprehensive strategy** – this should be agreed at a regional level to guide an overarching approach. The strategy should be enabled by:

Tackling inequalities
Take action on diseases with a social gradient, tackle industry tactics targeting the most vulnerable in society, and develop interventions with a 'proportionate universalism' approach.

Funding prevention
Ringfenced, long-term funding to enable prevention efforts to reduce impact of harmful products.

Managing industry influence
Ensure that vested commercial interests do not undermine evidence-based policies designed to reduce the impact of harmful products, nor limit an organisation's ability to protect, promote and improve the health of its population.

Mobilising communities
Amplify the voices of those affected by the problem to rally support for action.

The following **high impact actions** are core to achieving the goal of reducing the harm caused by the three biggest killers. Each has been successful in reducing harm from tobacco, and lessons can be learnt for alcohol and unhealthy food and drink.

Regulate advertising
Use proportionate regulation of advertising and marketing across different media forms, to prevent promotion of unhealthy products.

Shape use and environment
Reduce access to harmful products, particularly by children, and regulate the environments they can be used in to prevent harm to individuals and those around them.

Influence pricing and affordability
Advocate upwards for taxes to raise prices of harmful products to reduce use or encourage product reformulation, and/or levies to fund prevention activities and use local levers to improve the affordability of healthier options.

Communicate health messages
Use evidence-based communications to raise awareness and inform people about the risks of harmful products and the benefits of engaging in healthy behaviours.

Provide treatment
Provide treatment services to those at risk of harm from these products to improve health and prevent further harm.

Section 4
Enablers of a comprehensive strategy

This section describes the elements of a comprehensive strategy for prevention across risk factors in more detail.

Developing a strategy to tackle harmful industries in a coherent way can help regional decision makers to understand where they are and where they need to get to. Many national and international strategies on tobacco[9], alcohol[10] and unhealthy food and drink[11] call for similar activities to tackle harmful products, such as restricting the affordability, availability and promotion of these products.

Traditional ways of developing and using evidence in developing public health strategies have not adapted to meet the challenge of the complex structural problems caused by harmful product industries[17]. Local and regional policy makers therefore need to consider using a broad, multidisciplinary suite of evidence in developing strategies to respond to this challenge.

It's also important for strategy development to consider the policies and strategies of the past and why they have failed. For example, in the case of obesity strategies, past failures may be due to too much focus on individual actions and not enough on the structural changes that can make the biggest difference[18].

A comprehensive strategy for tackling the three biggest killers should be underpinned by the enablers detailed on the following pages.

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Tackling inequalities

Take action on diseases with a social gradient, tackle industry tactics targeting the most vulnerable in society, and develop interventions with a 'proportionate universalism' approach.

We know that the damage cause by harmful products is not evenly distributed in society. Tobacco is responsible for up to half the difference in life expectancy between people in the highest and lowest socioeconomic positions[2]. Deaths caused by alcohol are more than twice as high in the most disadvantaged areas of England than in the least disadvantaged areas[19]. Even when more disadvantaged groups consume the same number of, or fewer, alcoholic units than less disadvantaged ones, they still experience worse harms in what is known as the alcohol-harm paradox[20].

Children from more disadvantaged backgrounds are more likely to be living with overweight or obesity and continue to live with them throughout adult life[21]. 46% of year 6 children in England who live in the most disadvantaged areas are currently living with overweight and obesity, compared to 26% in the least disadvantaged areas[22].

There are other important equity considerations for both alcohol and unhealthy food and drink, including differences in patterns of consumption and harm between people of different genders and ethnicities[23, 24].

Funding prevention

Ringfenced, long-term funding to enable prevention efforts to reduce impact of harmful products.

We know that most public health interventions are cost saving, with every pound invested yielding a return of £4 at a local level, and up to £10 at a national level for interventions such as legislation[25].

Most public health interventions locally and regionally are funded by a combination of the public health grant to local authorities, and money from ICBs. Local and regional strategies should set out clearly what areas of responsibility for delivery sit at what level and where funding should be drawn from.

An example of a regional joined up approach is Balance in the north east of England, which is a regional partnership working to tackle alcohol harm. It is funded through pooling local authority public health grant money from seven of the local authorities in the north east, thus enabling a joined up approach across this supra-local footprint.

Managing industry influence

Ensure that vested commercial interests do not undermine evidence-based policies designed to reduce the impact of harmful products, nor limit an organisation's ability to protect, promote and improve the health of its population.

There are multiple ways in which the health-harming industries undermine evidence-based policy in public health[26]. The tobacco industry has, in the past, funded education programmes to undermine public health efforts[27]. These activities have been limited by regulation in the UK, but they remain prominent for other health-harming industries. For example, the alcohol industry funds educational projects in schools to teach children about the harms of alcohol. These education programmes subtly undermine evidence-based messaging around alcohol, and serve to promote the alcohol industry's reputation as being part of the solution[28].

Unhealthy product industries also seek to undermine policy making processes. For example, analysis of documentation around the development of the Transport for London (TfL) policy on restricting marking for high fat, salt and/or sugar (HFSS) foods found that industry had a high level of access to the policy making process, thus giving them the ability to shape the process[29].

As a signatory to the Framework Convention on Tobacco Control (FCTC), governments at all levels in the UK are prohibited from engaging with the tobacco industry in policy making through Article 5.3 of the convention[30]. There has been significant work to embed the principles of Article 5.3 at all levels of government and ASH have produced a toolkit to support local decision makers in understanding their responsibilities under the convention[31]. We can learn from this approach and apply it to managing industry influence across other harmful industries.

The Association of Directors of Public Health (ADPH) network in Yorkshire and the Humber has developed a position statement on the Commercial Determinants of Health which recommends that areas should use good governance and conflict of interest resources to develop policies on partnerships with industries focused on the systematic exclusion of health-harming industry from the policy process. The ADPH has developed a Good Governance Toolkit, to support local authorities to manage their relationships with industry appropriately.

The Institute of Alcohol Studies has developed guidelines for interaction with the industry that recommend that interactions should be minimised and partnerships should be rejected.

Mobilising communities

Amplify the voices of those affected by the problem to rally support for action.

Engaging communities affected by unhealthy product industries is vital. We know that there is broad public support for more regulation of harmful industries. However, more could be done to engage the public in understanding the impact that the wider determinants, including commercial determinants, have on health. The work done in recent years by the Health Foundation and Frameworks demonstrates how the public currently perceive the issue of health, and how the issue could be reframed around 'building blocks' to better engage the public in the debate.

Mobilising communities can support the push back against industry. This can take a variety of forms such as supporting communities to have a voice in the media or through consultation processes, co-production of solutions and supporting people with lived experience to be peer supporters. The National Institute of Health and Care Excellence (NICE) recommends that communities be engaged in planning, designing, developing, delivering and evaluating local services and initiatives[32].

NHS Greater Manchester and the Greater Manchester Combined Authority worked with the young people's campaigning organisation Bite Back to understand young people's views on restricting unhealthy food and drink advertising on the city's transport network. They collected views and compiled them into a report and video, to support the policy making process. They have also undertaken a large consultation to understand residents' views on childhood obesity, finding that the accessibility and affordability of healthy food was a main driver of childhood obesity, and that junk food advertising targeting children was also a contributory factor. By mobilising communities and involving them from the start we can ensure that strategies respond to resident's needs.

Section 5
High impact actions for harmful products

This section describes the actions in the framework in more detail. Examples from tobacco policy and practice are included to inspire action on alcohol and unhealthy food and drink.

Regulate advertising

Use proportionate regulation of advertising and marketing across different media forms, to prevent promotion of unhealthy products.

What can we learn from tobacco policy?
Tobacco advertising is banned in all forms through legislation and regulation in the UK[33]. This covers TV advertising, billboards, in newspapers, at the point of sale, at sporting events and online. Additionally, product placement in TV programmes is banned, and tobacco products must be sold in plain packaging. This restriction of the marketing efforts of the tobacco industry has been highly effective in reducing smoking prevalence[34].

Evidence for action in alcohol and unhealthy food and drink
Alcohol marketing increases alcohol consumption. Studies have found that marketing increases underage drinking and affects drinking behaviours for adolescents and young adults[35, 36]. The World Health Organization (WHO) has called for alcohol marketing to be restricted[37].

There is a wealth of evidence showing the impact of unhealthy food advertising on purchasing, consumption and obesity[38]. Nesta's Policy Blueprint rated HFSS advertising restrictions as having a very high impact on obesity and high quality of evidence[39]. An evaluation of Transport for London's (TfL) ban on HFSS advertising found that the policy led to a decrease in the amount of unhealthy food and drinks purchased[40].

Best practice solutions
Policies can be introduced to restrict advertising for alcohol on local authority owned estates, and on transport networks. The charity Sustain has developed a toolkit to support local authorities who are seeking to introduce their own healthier advertising policy.

Introducing advertising policies is an opportunity to think broadly about risk factors and include multiple harmful product industries in the list of what is prohibited. For example, City of York Council has introduced an Advertising and Sponsorship policy that covers both HFSS foods and alcohol along with a variety of other health-harming industries (such as gambling).

Can action be taken locally or regionally?
As local authorities have control over what advertising they accept on their own property, these policies can be adopted on a local authority level. This can also help make the case for wider regional and national action on advertising for harmful products. Policies such as bus franchising and bus quality partnerships that are being rolled out widely will give combined authorities more control over the advertising space on networks allowing them to make these changes more easily. It may be helpful for regional bodies to set out broad position statements and be a conduit for sharing local best practice across regions.

Shape use and environment

Reduce access to harmful products, particularly by children, and regulate the environments they can be used in to prevent harm to individuals and those around them.

What can we learn from tobacco policy?
Reducing the availability of tobacco products has been key to the success of tobacco policy. Current legislation restricts smoking in enclosed public places and in cars with children. The Tobacco and Vapes bill, will require retailers to have a license to sell tobacco, placing further restrictions on easy availability of tobacco products through enabling enforcement on illicit tobacco sales and age of sale restrictions. Licensing has the potential to improve compliance with such restrictions, since non-compliance with requirements for one licenced activity (e.g. vape sales) could result in all licences held by a licensed person being challenged (e.g alcohol, tobacco and vapes).

Evidence for action in alcohol and unhealthy food and drink
The availability of alcohol and proximity to shops selling alcohol may be linked to the normalisation of alcohol and more permissive attitudes[41]. Strengthening restrictions on alcohol availability is one of the WHO's core policy recommendations in the SAFER strategy for reducing the harm caused by alcohol[10]. Studies have shown that stricter licensing policies for alcohol are associated with reduced crime and hospital admissions[42, 43] and that reducing hours of sale may reduce alcohol related harm[44].

Exposure to takeaway outlets is positively associated with consumption of takeaway food, and with increased Body Mass Index (BMI)[45]. Children in the most deprived areas are more likely to be exposed to fast food takeaways[46]. Studies have shown that school exclusion zones for fast food takeaways led to a reduction in exposure to marketing, and a reduction in BMI[47].

Best practice solutions
Local authorities can use their licensing powers to determine hours of sale and density of premises that sell alcohol. To support this process, Leeds council public health and licensing colleagues worked together to develop the Alcohol Licencing Data Matrix which is now in use across several local authorities. Local authorities can also introduce public space protection orders banning drinking of alcohol in specific areas where there has been a history of nuisance drinking[48]. However, this policy needs to be considered carefully due to limited evidence of effectiveness and the risk of stigmatising marginalised groups, such as people experiencing homelessness, possibly displacing them to less safe areas[44]. Public Health England (now the Office of Health Improvement and Disparities), has published guidance to support local authority public health teams to influence alcohol licensing decisions.

Local authorities can use their Local Plan and Supplementary Planning Documents to introduce policies to tackle unhealthy food and drink. For example, they can apply restrictions to new hot food takeaways, such as school exclusion zones. Local authorities can also work to improve the food provided through their own services, such as through school food improvement programmes or considering the options available in leisure centres. They can introduce award schemes to reward local businesses for making healthy changes to their food offer. For example, in Tower Hamlets the Food for Health Awards, organised between the Public Health, Environmental Health and Trading Standards teams, encourages local businesses to make changes to the way they prepare and cook food to make it healthier.

Can action be taken locally or regionally?
Most action that can be taken to shape use and the environment can be taken at a local authority level. However, regional bodies can support by setting a strategic direction and sharing best practice.

Influence price and affordability

Advocate upwards for taxes and minimum pricing policies to raise prices of harmful products to reduce use or encourage product reformulation, and/or levies to fund prevention activities, and consider actions that reduce the cost of good food for communities.

What can we learn from tobacco policy?
Increasing the cost of tobacco through taxation has been a highly successful strategy in tobacco policy[1]. While local areas do not have powers to tax harmful products, they can apply the principle of increasing or reducing costs to influence purchasing and consumption decisions.

Evidence for action in alcohol and unhealthy food and drink
Interventions to increase the price of alcohol are effective in reducing harm[49]. Minimum unit pricing (MUP), which sets a minimum price at which a unit of alcohol can be sold, was introduced in Scotland in 2018 and an evaluation found strong evidence that MUP was associated with a reduction in deaths attributable to alcohol[50]. Importantly, most prevented deaths were from the most disadvantaged groups, indicating that this policy can help to tackle alcohol-related inequalities.

Taxes can be an effective means to disincentivise purchasing and incentivise reformulation of unhealthy food and drink. The Soft Drink Industry Levy, applied to soft drinks containing sugar in the UK in 2018, led to a reduction in sugar in purchased drinks of 15g per household per week and a variety of likely health benefits as a result, whilst not requiring behaviour change nor harming soft drink sales[51]. It is also effective to incentivise the purchase of healthy food and drink. One systematic review found that price reductions, subsidies or financial incentives for healthy food purchases increased fruit and vegetable consumption[52]. Over time, it will be important to systematically increase the affordability, availability and marketing of healthier foods relative to unhealthy food, to make the healthier choice affordable for all.

Best practice solutions
Some local authorities, such as Newcastle City Council, have written a voluntary minimum price into the local statements of licensing policy for alcohol. This is important trailblazing for a policy that should be implemented nationally. Some regions have worked together as groups of Directors of Public Health to advocate for MUP nationally. This use of local voices to lobby national government for important policy changes has proven to be an effective advocacy method in the past, for example in the introduction of smokefree laws in the UK[53].

There are a variety of measures that local authorities can take to support and incentivise residents to purchase and/or consume healthy food. For example, through ensuring that all children who are eligible can access free school meals by introducing auto-enrolment. Fix our Food have produced a toolkit to support local authority areas in introducing auto-enrolment.

Can action be taken locally or regionally?
Lobbying national government for changes such as MUP may best be done through the collective power of local authorities coming together across a wider footprint. Changes such as widening access to free school meals can be introduced on a local authority level, but can also be taken forward with leadership regionally, such as the recent example of the Mayor of London funding free school meals for all children in primary schools in London[54]. Both Scotland and Wales have introduced universal free school meals in primary schools.

Communicate health messages

Use evidence-based communications to raise awareness and inform people about the risks of harmful products, and the benefits of engaging in healthy behaviours.

What can we learn from tobacco policy?
Evidence suggests that communications campaigns can have an impact on people's knowledge and awareness of the risks of smoking, and increase smoking cessation intentions. Smoking cessation campaigns have also been found to be cost-effective[55]. Importantly, communications campaigns can have an indirect effect. Campaigns that increase the public's knowledge of harmful products and increase the salience of those harms also increase the public acceptability of policy measures restricting the availability and use of harmful products[56].

Evidence for action in alcohol and unhealthy food and drink
The evidence for communications in alcohol and unhealthy food and drink is more mixed, with studies finding that there are some positive increases in knowledge and treatment seeking behaviour from health campaigns, but no decrease in consumption for alcohol, and low certainty evidence for a positive effect in consuming less unhealthy food and drink[55].

Best practice solutions
Evidence suggests that certain elements may improve the effectiveness of communications including:

- Using multiple modes/channels
- Including an interactive or tailored element (such as personalising emails)
- Sustaining campaigns and messages over time
- Messaging framed around de-normalising behaviour rather than fear[55]

Effective communications should follow the key principles of being actionable, accessible, relevant, timely, understandable and credible as set out in the WHO Strategic Framework for Effective Communications[57]. This might involve considering whether translation into different languages is needed or using NHS branding, where appropriate, to boost the credibility of communications.

Community driven approaches to health messaging can be effective, such as the Communities in Charge of Alcohol initiative from the Royal Society of Public Health. This initiative trains people to be Alcohol Health Champions, to support people affected by alcohol harms and address alcohol issues in their communities. This programme has been rolled out across local authorities in Greater Manchester.

Frameworks have produced toolkits to support framing around alcohol and childhood obesity to ensure that these topics are managed sensitively. It may also be helpful to start shifting health communications towards the wider determinants through using the Health Foundation's Building Blocks of Health Communications Toolkit.

Can action be taken locally or regionally?
Health campaigns can be cost-effective if organised across a regional footprint. For example, Balance, the regional alcohol partnership in the north east, runs mass media campaigns across the region.

Community led approaches can be effective at a local authority level, often utilising existing structures for resident involvement such as health champions or residents' associations.

Provide treatment

Provide treatment services to those already impacted by harmful products to improve health and prevent further harm.

What can we learn from tobacco policy?
Stop Smoking services have been highly effective in reducing smoking rates, and people are three times as likely to quit for good when they use a stop smoking service compared to going it alone[58]. These services rely on strong local and national tobacco control strategies, pathways and funding.

Evidence for action in alcohol and unhealthy food and drink
While evidence is mixed, weight management programmes are considered effective overall, at least in the short term, for reducing obesity in adult participants and NICE recommends their use when delivered in line with guidance[59]. The weight management treatment landscape is rapidly changing, with new drug options that show high levels of effectiveness in promoting weight loss and beneficial dietary changes, albeit at high cost and with significant side effects. Evidence suggests that both diet changes and weight loss are rapidly reversed when people cease taking medication[60]. These medical approaches are creating a need for tailored weight management services that enable patients to cease taking medication while avoiding a relapse to previous eating habits.

Alcohol screening, treatment and support services can be effective and cost-effective. The WHO recommends access to screening, brief interventions and treatment as one of the core elements of the SAFER strategic approach to reducing the harm from alcohol[10]. Greater Manchester have used the WHO's SAFER framework as the basis of their Alcohol Harms Strategy.

Best practice solutions
Both weight management services and alcohol dependency treatment are provided in local areas through a combination of funding from the public health grant through local authorities and ICBs at a regional level. Treatment services should be well resourced, equitable to access, tailored and non-stigmatising[1]. For alcohol, experts recommend universal hospital admission screening for alcohol, ensuring clinical staff are equipped with skills to screen people in a non-judgmental way, and putting in place multi-disciplinary Alcohol Care Teams to provide the best evidence-based care[61]. Some areas have commissioned services that holistically respond to multiple risk factors, for example combining smoking cessation and weight management.

Can action be taken locally or regionally?
A variety of different local and regional arrangements for the commissioning of specialist and community treatment services exist across England. Coordination across different local areas can be helpful depending on local priorities and geographies. Regional decision makers are often well placed to understand and coordinate different pathways for services across an ICB patch, and to set strategic goals that enable a more coherent approach.

Section 6 | Step-by-step guide to developing your own strategic approach

This section sets out steps to help you develop your own strategic approach to the harms of alcohol and unhealthy food and drink, learning from tobacco. This process has been developed iteratively with Greater Manchester and Humber and North Yorkshire. The steps described below have been tested and refined with stakeholders in the systems in both areas.

The guide can be used to inspire your own project planning and should be adapted as appropriate for the local context. Where relevant, resources are highlighted that can support each step of the process.

Case studies and the full suite of toolkit resources can be found on the ASH website's Three Biggest Killers Regional Toolkit section.

Step 1 | Finding people to lead and deliver the project

Acting on the three biggest killers will require concerted action driven forward by committed individuals. The first step in the journey is to identify where the work will sit in your structures and how it will be driven forward. It is helpful to have a senior champion or group who can sponsor the work and ensure accountability. For example, in Greater Manchester, the process is overseen by the Commercial Determinants of Health Squad, made up of senior representatives from across Greater Manchester's local authorities and NHS Greater Manchester.

Step 2 | Plan your approach

Set out how you will approach developing your response. Ensure that the project is integrated into planning processes for your organisation, such as strategic and operational plans, and individual objectives where appropriate. It can also help to understand the context that you are operating in and think about how to align the local framework narrative with the priorities of your organisation. At this stage think about your approach to mobilising your community, ensuring that the strategy is co-designed, and how you will monitor and evaluate your approach.

Step 3 | Assessing need

Undertake a needs assessment to better understand the regional and local impact of tobacco, alcohol and unhealthy food and drink. The needs assessment should set out key data on the three biggest killers from a range of sources. We have developed a template needs assessment document with some suggested data sources as a starting point, and there are likely to be local data sources you can draw on too such as your Joint Strategic Needs Assessments.

The data should be analysed locally and interpreted to be used in different ways that can support in making the case. For example, it can be used in a slide deck during presentations to get senior and political buy-in.

Think about how data can be used to best make the case. For example, senior figures in your ICB may be particularly interested in the cost savings of a strategic approach, and so highlighting data from the Institute of Alcohol Studies (IAS) and the ASH Ready Reckoner on the costs of alcohol and tobacco locally could be helpful here. Politicians might be interested in public attitudes to the policies proposed.

Resources to support this stage:

- Needs assessment template
- ASH Ready Reckoner
- Institute of Alcohol Studies cost of alcohol harm data
- Department of Health and Social Care public health data from Fingertips
- ASH, OHA and AHA opinion poll data on public support for policies

Step 4 | Stakeholder mapping

It's important to know who the key stakeholders are in the development and implementation of your local strategy including both professionals across the system, voluntary sector organisations and residents. We have provided a template for you to use to consider all the different people in the system who may need to input into the development of the strategy, be involved in implementing it, or will need to make the key decisions to support it.

Ensure that you have understood what different stakeholders will need to do as part of the process. For example, do they need to be involved in development of the strategy, or just informed? Do you need to keep them on side and make a strong case, or are they natural allies? It may be helpful to conduct a stakeholder analysis process with your small working or strategic group to help you decide how best to manage each group of stakeholders on your list.

You may also need to consider how best to manage industry stakeholders who might express an interest in being involved. You might find the good governance toolkit from the ADPH helpful in making this assessment.

Resources to support this stage:

- Stakeholder mapping and analysis template
- ADPH good governance toolkit

Step 5 | Asset and deficit mapping

Once you have the data on the problem, it can help to develop a picture of what is happening across your area to address alcohol and unhealthy food and drink. For this stage, organise a workshop with key topic leads for alcohol and unhealthy food and drink from across the region, use this as an opportunity to explain the project, and break down into sub-groups to collect local information on policies and services using the asset and deficit mapping template. You may need to hold a couple of workshops and circulate the template for people to add to.

Once you have collected the information you can analyse it to understand which areas of the framework have lots of activity happening, and where there are gaps. This process can help you develop an understanding of strengths and areas for development locally, which can then be addressed through your action plan.

Resources to support this stage:

- Asset and deficit mapping template

Step 6 | Build support

This step should be woven through the process, but is particularly important as you move into developing and implementing your local strategic approach. Consider how you can link in with what's going on locally, and who you need to get on side. Use the template slide deck with your local data and key results from asset mapping to demonstrate to key stakeholders why the work is needed and what it will involve. This is also an opportunity to understand what is working for you locally, where there is appetite and how you can best make the case.

Consider the co-benefits that your work could have, and the advocates you might not normally work with. For example, are there local retailers who feel the high street is becoming dominated by hot food takeaway businesses that lead to littering and predominantly create footfall on an evening when the shops have already closed?

You may also need to consider how close your audience is to the issues and whether some broad framing of the commercial determinants might support your argument. The Health Foundation's Building Blocks of Health communications toolkit might help with this.

Resources to support this stage:

- Tailorable slide deck setting out case for action

Step 7 | Develop and launch your framework

Bring everything you have learnt together to draw up your local response to the coherent framework that should be co-designed with communities. This should set out:

- The case for action including local data and key local strengths and areas for development
- Strategic priorities for action within the framework
- Action plan including when actions will be carried out, who is responsible and how success will be monitored
- Monitoring and evaluation plan

Step 8 | Implement, monitor and evaluate

Put in place clear structures for implementation, monitoring and evaluation such as:

- Setting out who is responsible for carrying out actions
- Regular reviews of progress
- Reporting structures
- Clear metrics to ensure it is clear when an objective has been achieved

Don't forget to celebrate success!

Ensure you celebrate milestones, no matter how small, and that people are recognised for their hard work.

Section 7
Key resources and supporting information

Below are key resources that can support in taking forward policies on the three biggest killers at a regional and local level.

- ASH, AHA and OHA report advocating for a coherent approach on a national policy level: Holding us Back: tobacco, alcohol and unhealthy food and drink
- Alcohol Health Alliance
- AHA Manifesto – Our Manifesto - Alcohol Health Alliance
- Obesity Health Alliance
- OHA Report – Turning the Tide Strategy – Obesity Health Alliance
- Action on Smoking and Health
- ASH – Article 5.3 toolkit
- Sustain - Healthier Food Advertising Policy toolkit
- The Health Foundation – Addressing the leading factors for ill health – a framework for local government action
- Association of Directors of Public Health Yorkshire and the Humber – Position Statement on Commercial Determinants of Health
- Association of Directors of Public Health – Good Governance toolkit
- Nesta – A blueprint to halve obesity in the UK
- Institute of Alcohol studies – Good governance in public health policy
- Department of Health and Social Care – Alcohol licensing: a guide for public health teams
- 'Killer Tactics' Report (ASH/OHA/AHA): Killer Tactics – ASH
- The Lancet Series - Commercial determinants of health
- The Health Foundation – Building Blocks of Health communications toolkit
- Fresh and Balance – regional partnership for alcohol and tobacco in the north east
- Frameworks – Alcohol framing toolkit and childhood obesity framing toolkit
- Fix our Food – Free School Meals Auto-enrolment Toolkit

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Obesity Health Alliance

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