Worcestershire County Council

Agenda

Health and Well-Being Board

Tuesday, 27 September 2022, 2.00 pm
County Hall, Worcester

This document can be provided in alternative formats such as Large Print, an audio recording or Braille; it can also be emailed as a Microsoft Word attachment. Please contact Democratic Services on telephone number 01905 843579 or by emailing democraticServices@worcestershire.gov.uk.

Find out more online:
www.worcestershire.gov.uk

worcestershire county council

worcestershire
countycouncil

Health and Well-Being Board
Tuesday, 27 September 2022, 2.00 pm, Council Chamber, County Hall

Membership

Full Members (Voting):

Cllr Karen May (Chairman)	Cabinet Member for Health and Well-being
Dr Sarah Raistrick (Vice Chairman)	NHS Herefordshire and Worcestershire Integrated Care Board
Simon Adams	Managing Director, Healthwatch Worcestershire
Liz Altay	Interim Director of Public Health
Cllr Christopher Day	Wychavon District Council
Cllr Lynn Denham	Worcester City Council
Kevin Dicks	District Local Housing Authorities
Sarah Dugan	Herefordshire and Worcestershire Health & Care NHS Trust
Mark Fitton	People Directorate
Cllr Adrian Hardman	Cabinet Member for Adult Social Care
Supt Rebecca Love	West Mercia Police
Cllr Nicky Martin	Wyre Forest District Council
David Mehaffey	NHS Herefordshire and Worcestershire Integrated Care Board
Cllr Nyear Nazir	Redditch District Council
Jo Newton	Worcestershire Acute Hospital Trust
Cllr Andy Roberts	Cabinet Member for Children and Families
Tina Russell	Worcestershire Children First
Jonathan Sutton	Voluntary and Community Sector
Simon Trickett	NHS Herefordshire and Worcestershire Integrated Care Board
Cllr Shirley Webb	Bromsgrove District Council
Dr Jonathan Wells	Primary Care Network Clinical Director
Gary Woodman	Executive Director, Worcestershire Local Enterprise Partnership (WLEP)

Agenda

Item No	Subject	Presenter	Page No
1	**Apologies and Substitutes**	Chair	

Agenda produced and published by the Assistant Director for Legal and Governance, County Hall, Spetchley Road, Worcester WR5 2NP

To obtain further information or a copy of this agenda contact Kate Griffiths, Committee Officer on Worcester (01905) 846630 or email: KGriffiths@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's website

Date of Issue: Friday, 16 September 2022

Item No	Subject		Page No
2	**Declarations of Interest**	Chair	
3	**Public Participation** *Members of the public wishing to take part should notify Legal and Democratic Services in writing or by e-mail indicating the nature and content of their proposed participation on items relevant to the agenda, no later than 9.00am on the day before the meeting (in this case 9.00am on 26 September 2022). Further details are available on the Council's website. Enquiries can be made through the telephone number/e-mail address listed in this agenda and on the website.*	Chair	
4	**Confirmation of Minutes**	Chair	1 - 8
5	**Health and Wellbeing Board Terms of Reference**	Chair	9 - 14
	Health and Wellbeing		
6	**Health and Wellbeing Strategy**	Dr Tanya Richardson	15 - 44
7	**Pharmaceutical Needs Assessment (PNA)**	Matt Fung	45 - 172
	Health and Social Care		
8	**Better Care Fund (BCF)**	Victoria Whitehouse	173 - 216
	Herefordshire and Worcestershire Integrated Care System		
9	**Integrated Care Board and Integrated Care Partnership Update**	David Mehaffey	217 - 222
10	**All Age Autism Strategy**	Laura Westwood	223 - 228
11	**Herefordshire and Worcestershire Learning from Lives and Deaths - People with Learning Disability (LeDeR) Annual Report**	Rachael Skinner	229 - 264
12	**Future Meeting Dates** **2022**		

Item No	Subject		Page No
	- **Public meetings** (Tuesday at 2pm) • 15 November 2022 **Private Development meetings** (Tuesday at 2pm) • 18 October 2022 **Proposed Dates 2023** **Public meetings** (All Tuesday at 2pm) • 14 February 2023 • 23 May 2023 • 26 September 2023 • 14 November 2023 **Private Development meetings** (All Tuesday at 2pm) • 24 January 2023 • 28 March 2023 • 20 June 2023 • 18 July 2023 • 17 October 2023		

Webcasting

Members of the Health and Well-being Board are reminded that meetings of the Health and Well-being Board are Webcast on the Internet and will be stored electronically and accessible through the Council's Website. Members of the public are informed that if they attend this meeting their images and speech may be captured by the recording equipment used for the Webcast and may also be stored electronically and accessible through the Council's Website.

This page is intentionally left blank

worcestershire county council

Minutes of the Health and Well-being Board

Council Chamber, County Hall

Tuesday, 24 May 2022, 2.00 pm

Present:

Cllr Karen May (Chairman), Simon Adams, Carole Cumino, Sarah Dugan, Mark Fitton, Cllr Adrian Hardman, Supt Rebecca Love, Ian Miller, Cllr Nyear Nazir, Dr Tanya Richardson, Cllr Andy Roberts, Tina Russell, Dr Ian Tait and Simon Trickett and Cllr Shirley Webb.

Also attended:

Hayley Durnall, Matt Fung, Esther Passingham, Dr Jonathan Wells.

649 Apologies and Substitutes

Apologies were received from Liz Altay, Dr Louise Bramble, Dr Richard Davies, Cllr Lynn Denham, Kevin Dicks, Dr Anthony Kelly, Jo Newton, Jonathan Sutton and Gary Woodman.

Dr Tanya Richardson attended for Liz Altay, Ian Miller attended for Kevin Dicks and Carole Cumino attended for Jonathan Sutton.

650 Declarations of Interest

Andy Roberts declared an interest in that he was a Member of the Governing Body of St Richard's Hospice.

Dr Ian Tait declared an interest in that he was the Vice Chairman of Herefordshire Health and Well-being Board.

Karen May declared an interest in that she was a Member of the Worcestershire Children First Board.

651 Public Participation

None

652 Confirmation of Minutes

The minutes of the last meeting held on 15 February were agreed to be a correct record of the meeting and were signed by the Chairman.

653 Health and Wellbeing Board Strategy Consultation Findings

Dr Tanya Richardson gave an update on the Health and Well-being Board Strategy consultation. 1627 responses had been received and the information was being supplemented by the rich findings from focus groups and an ethnographic study. All information would then be subject to in-depth analysis before the Health and Well-being Strategy, designed to run for the next 10 years, could be signed off.

The consultation responses showed that over 85% of people supported the suggested priorities; with the overall priority being around good mental health and wellbeing, supported by the wider determinants of healthy living at all ages, safe and healthy homes and quality local jobs and opportunities. The consultation responses would be considered in detail by the Health and Well-being Board members at its next development session, and the Health and Well-being Strategy would be published in November 2022.

The Chairman thanked all the Board members who had contributed to videos encouraging people to respond to the consultation and to everyone who had taken time to contribute.

RESOLVED that the Health and Wellbeing Board noted the update on the Strategy Consultation findings.

654 Data and Insights for Action

Matt Fung gave an update on the data and insights being collected, further to the Joint Strategic Needs report to the Board in November 2021. The data collected up to this point had been largely quantitative which gave an overview at population level, however moving forward more qualitative data was being collected which could give an insight about what people experienced and what was important to them. Ethnographic data was being collected from focus groups and consultations.

It was hoped that both qualitative and quantitative, as well as community information, would be used going forward, to change the way services were commissioned by identifying the needs in the population and then to create action plans for health improvement.

It was suggested that a Data for Action working group be set up so that when data sets were completed, stakeholders could be invited to share ways of using the data to drive change, within the relevant service or geographical area.

Comments made by the Board included:

- There was support for comprehensive data being available to inform decision making but there was frustration that the Joint

Strategic Needs Assessment (JSNA) continued to provide similar key messages, for example around health inequalities, but levelling up, such as with staffing resource, did not take place. It was hoped that in future the Integrated Care System could use the data to address health disparities

- In response it was noted that strategic approaches had been tried in the past but had not resulted in tangible results on the ground. There was now a challenge to providers and District Collaboratives to change things from the bottom up, with changes needing to be locally owned
- The District Collaboratives needed support so that people could be enabled to help themselves. Place shaping district work was important
- It was pointed out that community intelligence needed to be used carefully to ensure that those with the loudest voices were not heard above others and it was agreed that quantitative information needed to be considered in tandem with, and supported by, qualitative data
- It was acknowledged that the issue of distribution of resources was an important strategic question which the Integrated Care Board and NHS England needed to consider. New resources could be distributed based on need, rather than fairness, but it would be difficult to decide if existing resources should be re-distributed
- It was queried how the data could be made more accessible, as there sometimes appeared to be so much data that it was difficult for front line staff to know what to do with it. It was acknowledged that this was an area which needed more consideration, but it was hoped that the Data for Action Group would help on how to use the data.

RESOLVED that the Health and Well-being Board (HWB):

a) Agreed to set up a time limited "Data for Action" working group reporting to the HWB, the purpose of which will be to progress data for action and embed community insight and intelligence into system wide decision making processes; and

b) Noted progress to date relating to the:
- **JSNA work programme and top line indicators;**
- **Worcestershire Insights Hub;**
- **Statutory Pharmaceutical Needs Assessment; and**
- **Community intelligence qualitative research.**

655 Children and Young People Strategic Partnership Update and Children and Young People's Plan

Tina Russell gave an update on the Children and Young People's Strategic Partnership, a Sub-group of the Health and Wellbeing Board . The Membership and terms of reference of the group had been reviewed over

the past 12 months and honest conversations had been had about what the group had been achieving.

The Children and Young People's Plan was being renewed, and contained overarching key measures for both the Children and Young People's Partnership and its sub-groups. The sub-groups were involved in shaping it, as well as discussing how the details of the plan were to be actioned, and it also recognised the priorities of the Health and Wellbeing Strategy. As a public document, every effort had been made to keep it simple. A young people's version would be developed to be more accessible.

It was explained how important it was to balance the needs of all children in Worcestershire with its vulnerable children, with both groups having clear outcomes. The universal offer was being assessed, as well as the need for a more targeted offer, to prevent the numbers of vulnerable children, from increasing.

Hayley Durnall and Emma Brittain, as Co-Chairs of the Early Help Partnership, explained that there was an Early Help Strategy which included commissioning the 0-19 Starting Well Services (parenting, school nursing and health visiting) working to reduce health disparities. Key Performance Indicators were being closely monitored with forums supporting the Early Help Partnership, to enable an assessment to be made against outcomes. Progress would be reported back to the Strategic Partnership. Next steps included solidifying the 'best start for life' offer across Worcestershire and developing Family Hubs, with a partnership approach.

Reference was also made to the Children and Young People's Mental Health Transformation Plan and the further development of the 0-25 Strategy and service, which importantly incorporated SEND.

Tina Russell was confident that the Children and Young People's Partnership received a high volume of up to date and consistent information, including the Healthwatch Children and Young People report, the Early Help survey, Supporting Families First data, as well as information from social work assessments. However, there was less confidence about whether the information was being successfully responded to; for example, ensuring commissioning timescales were correct and money being invested in the right way to support hard to reach families, specifically those impacted by substance misuse.

The Cabinet Member for Children and Young People, whilst supportive of the analytical approach, commented that he felt that data was not a replacement for hearing directly from young people. Councillors were supportive of listening, identifying local issues within the County and working to break cycles of problems within families.

In response to a comment that there was confusion about what services were available and how they could be accessed, even by GPs, it was explained that although some families were confident and preferred to

access information online, hard copies of directories had been produced a year ago and an updated version would be considered. There was a virtual Family Hub, and various Early Help support events had also been organised. With changes in the workforce, messages about how to access services needed to be repeated frequently.

RESOLVED that the Health and Well-being Board:

a) **noted for information the summary of the work of the Children & Young People's Strategic Partnership; and**
b) **approved the content of the refreshed Children & Young People's Plan 2022-23.**

656 Update on the Development of the Worcestershire Voluntary and Community Sector (VCS) Alliance

Carole Cumino introduced the report, explaining that The Voluntary and Community Sector (VCS) helped to deliver the Health and Wellbeing Strategy priorities. NHS England had given instructions that local VCS Alliances should be formed but it was recognised locally as a necessary action for making the VCS equal partners in the work that was being done in the County. The focus would be on ensuring there would be a direct link into all pieces of work and that there was a clear rationale for who was involved so that the VCS could be involved at system, place and district levels.

Esther Passingham, the Worcestershire VCS Strategic Lead, was employed by the Chamber of Commerce and funded by the County Council and NHS. She explained that a start had been made on mapping the numbers of community volunteer groups but it was a big piece of work which needed to be constantly updated as the groups changed frequently. The Here2Help Directory listed a certain number of voluntary organisations but depended on the Organisation themselves to upload their details.

The Alliance would be made up of around 20 organisations so it was small enough for decisions to be made and the various representatives would be encouraged to feed back to other VCS organisations who worked in a similar sector. It was suggested that there were too many organisations to work effectively at a Countywide Level and communication and joint working would work better at District Collaborative level.

A Board Member felt that the culture of approach of the different voluntary organisations needed to be understood; whether they were connectors and co-ordinators who signposted people to those who could help or whether they were working directly with groups who needed support, such as specific families. The Council needed to understand the different groups to be able to provide the support that they needed, and to know what was being achieved by the various groups. Voluntary groups could be offered training by the County Council to help with working towards common goals, and although the Council should not be too controlling, there would be a set of values which all voluntary groups should sign up to. If money was to be allocated to groups, it was understood that it would come with a list of expectations and conditions.

The Chairman thanked the VCS for everything they did.

RESOLVED that the Health and Well-being Board noted the progress on the development of a new Worcestershire Voluntary and Community Sector Alliance in line with national requirements.

657 Worcestershire Executive Committee Update

Sarah Dugan explained that the Worcestershire Executive Committee (WEC) was still evolving and assessing its actions to ensure it would be adding value. The WEC had agreed some working principles with the HWB and the emerging District Collaboratives. The WEC was currently overseeing some urgent priorities but also supporting the development of the new ways of working with programmes of work across the whole of Herefordshire and Worcestershire, such as the People Board and the Mental Health Collaborative. The WEC would be keen to help with the implementation of any issues or projects suggested by the HWB and it was confirmed that the WEC acknowledged the work of the VCS and supported the Alliance paper.

RESOLVED that the Health and Wellbeing Board noted the progress to date relating to the establishment and activity of the Worcestershire Executive Committee and that evolution of the arrangements was ongoing.

658 Health and Wellbeing Board Governance Review

Mark Fitton explained that the Board was being asked to approve the updated membership and voting proposals to enable the terms of reference to be agreed by Council, and the role of the sub-groups would support the delivery of the Health and Wellbeing Strategy. The creation of the Integrated Care Board meant that the situation was evolving at system, place and district levels and the Health and Wellbeing Board Membership needed to reflect the wider determinants of health not just health and social care. It was proposed that the suggested membership be reviewed in 12 to 18 months and if approved the updated terms of reference would go to full Council for ratification.

Members made the following comments:

- The representative from the housing authorities thanked the Board for the opportunity for all District Councils to be represented, and other Board Members welcomed the inclusivity of adding to the membership,
- It was a statutory duty of the Board to agree the Better Care Fund expenditure, which was a shared NHS and Council budget, so it made sense for the Board to have an accountability balance,
- It was pointed out that the agenda report should say a Non-Executive Director with responsibility for health inequalities, and an ICB Executive Director.
- It was asked why District Collaboratives were not mentioned and it was explained that the groups worked at different levels. The Health Improvement Group would become the Being Well Worcestershire

Strategic Group and would work at a sub-strategic level along with the District Collaboratives.

RESOLVED that the Health and Well-being Board (HWB):

a) **approved the HWB membership and voting proposals at paragraph 12 of the agenda report, to enable revised Terms of Reference to be submitted to Council; and**
b) **agreed the role of HWB sub-groups set out at paragraph 15 of the agenda report to support delivery of the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy (HWBS).**

659 Better Care Fund

Mark Fitton described a break-even position for the 2021/2022 Better Care Fund (BCF), with an uplift of 5.6% for 2022/2023 giving a budget of £69.5 million. The budget had already been approved by the CCG.

No manager was in post in Worcestershire to manage the BCF, so the Herefordshire Manager had been asked to oversee both funds. Officers had done well to be able to balance the budget as there was a risk of the fund being overspent. With any overspend the risk was shared equally between the CCG and the County Council.

RESOLVED that the Health and Wellbeing Board approved the 2022/2023 Better Care Fund budget and the BCF 2021/2022 Outturn, in line with national requirements.

660 COVID-19 Health Protection Board Quarter 4 Update

Hayley Durnall updated the Health and Wellbeing Board about the Health Protection Board (HPB) Outbreak Control Plan. The HPB was no longer operating as a COVID-19 Board. Community COVID-19 testing had ceased, although it was still available to eligible patients and health and care staff. The Local Outbreak Response Team had changed to match reduced demand but a response could be quickly organised if required, in response to any variants of COVID-19. There was a further £4.2 million from the Contain Outbreak Management Fund to be spent in 2022/23, with over £2 million allocated to maintain the level of response, and a contingency available to increase the level of response if necessary.

RESOLVED that the Health and Wellbeing Board noted the delivery of Worcestershire's Outbreak Control Plan, the arrangements for governance and the current situation of Local Outbreak Response Team operation.

661 Future Meeting Dates

It was noted that the next public meeting would be 11 July at 10.00am.

Public meetings (Usually Tuesday at 2pm)
- 11 July 2022, Monday 10.00am
- 27 September 2022
- 15 November 2022

Private Development meetings (All Tuesday at 2pm)
- 21 June 2022
- 18 October 2022

Chair's Comment

The Chairman thanked two members of the Board who were standing down. Dr Anthony Kelly who had been a member of the Board since February 2014 and Dr Ian Tait who had been a member since July 2020. Sincere thanks were given for their contributions to the Board over the years.

The meeting ended at 3.40pm.

Chairman …….

Worcestershire Health and Wellbeing Board (the Board) Terms of Reference

Legal standing

1. The Board is constituted as a Committee of the County Council. The Health and Social Care Act 2012 includes a clause that provides for the disapplication of legislation that relates to such Committees in order to recognise that Health and Wellbeing Boards are unusual in comparison to other Section 102 Committees in having officers, and members from Clinical Commissioning Groups and local Healthwatch.

2. The Board does not have delegated authority to take decisions of behalf of member organisations. However, all organisations are encouraged to abide by the collective decisions of the Board. In the event of a dispute the Board:

- will attempt resolution locally
- may engage external mediation
- may escalate the issue to NHS England
- may refer the issue to the Secretary of State.

Purpose

3. The Board is a system leadership partnership, bringing together the organisations responsible for improving health and wellbeing and reducing health inequalities across Worcestershire.

Aims

4. The Board will:

- Work collectively to improve the health and wellbeing of the local population, with a focus on reducing inequalities
- Support integrated place-based working, ensuring system leaders work collectively with, and on behalf of, the local population to reflect their needs
- Establish a shared understanding of health and wellbeing in Worcestershire and the County's health and social care needs
- Ensure that there is long-term action across a range of partners, embracing the whole life course, focussing on prevention and influencing the determinants of health and wellbeing
- Ensure continuous improvement in health and wellbeing outcomes, quality and value for money of health, social care and related children's services
- Lead strategic planning and drive commissioning of NHS, public health, social care and related children’s services
- Influence how partners use their resources to organise and provide services and to support the strategic plans of the Integrated Care System
- Ensure effective arrangements are in place to protect the public against infectious diseases and other threats to health through preventive efforts, robust planning and an effective response to outbreaks and incidents

- Support the work of the Adults Safeguarding Board and Children's Safeguarding Partnership to ensure that effective arrangements are in place for safeguarding adults and children
- Become a forum for public discussion and accountability of strategies, policies, services and activities that influence health and wellbeing and health, and social care services.
- Develop a co-operative approach around major service and system change.

Approach

5. To do this the Board will:

- Prepare and produce a Joint Strategic Needs Assessment (JSNA) to provide a clear statement of health and wellbeing in Worcestershire, and the County's health and social care-related needs
- Share the JSNA with the Integrated Care Partnership to inform the Integrated Care Strategy, in accordance with the Local Government Agency guidance appended to the Health and Care Bill 2022
- Develop a joint local Health and Wellbeing Strategy; based on the JSNA assessment and in response to the Integrated Care Strategy, to provide a framework for how these needs are to be addressed
- Develop a clear understanding of current and future funding, activity and expenditure across health and social care, and opportunities for service change
- Promote integration between commissioners of NHS, public health, and social care services for the advancement of the health and wellbeing of the local population. Providing advice, assistance, or other support in order to encourage partnership arrangements such as developing of agreements to pool budgets or make lead commissioning arrangements under section 75 of the NHS Act.

Membership

6. The Chairman and Vice Chairman of the Board will be appointed by the Leader of the County Council from amongst voting members. Voting members are required to fully represent the views of their organisation; even if this results in them abstaining from voting.

Organisations with voting rights will be:

County Council: (6)

- **Cabinet member for Health and Wellbeing***
- **Cabinet member for Adult Social Care***
- **Cabinet member for Children and Families***
- Director of Adult Services (People)
- Director of Children's Services
- Director of Public Health

NHS: (6)

- **Accountable Officer from the Integrated Care Board (ICB)***
- **ICB Non-Executive Director for Health Inequalities ***
- **ICB Executive Director of Strategy, System Development and Integration***
- Primary Care Network (PCN) Clinical Director representative
- Worcestershire Acute Hospitals NHS Trust Representative
- Herefordshire and Worcestershire Health and Care NHS Trust Representative

Wider representation: (6)

- **Healthwatch Worcestershire Board member***
- Member or Chief Executive representative appointed by each District Council
- Local Enterprise Partnership (LEP) representative
- Voluntary Community and Social Enterprise (VCSE) Alliance Board representative
- West Mercia Police representative
- Chairman of the Worcestershire Strategic Housing Partnership (to represent local housing authorities)

7. Voting members are denoted above (*****).

8. Additional representatives from the County Council, ICB and other organisations may be invited to attend at the discretion of the Chairman, but may not vote.

9. All members (whether voting or not) will be required to provide a named substitute of relevant seniority to take their place if they are unable to attend a meeting.

Sub-groups and other relationships

10. The Board will maintain a number of sub-groups to lead on one or more of the aims above, chaired by a member of the Board and reporting to it bi-annually. They are not formal committees or sub-committees of the Council and will not meet in public. An outline of their roles and membership is included in the attached **Appendix A.**

- JSNA Working Group
- Being Well in Worcestershire Strategic Group
- Health Protection Group
- Children and Young People's Strategic Partnership

11. The Board may form time limited working groups to complete focused actions where relevant. They are not formal committees or sub-committees of the Council and will not meet in public. They should report on progress to the Board or an appropriate sub-group.

12. The Board will maintain a dialogue and receive reports, enabling it to formally comment and contribute to key strategies and activities, from key groups across the Integrated Care System. These include the:

- Integrated Care Partnership Assembly
- Worcestershire Executive Committee
- Integrated Commissioning Executive Officer's Group (ICEOG)
- Worcestershire Safer Communities Board
- Worcestershire Strategic Housing Partnership
- Worcestershire Safeguarding Adults' Board
- Worcestershire Safeguarding Children's Partnership.

Decision-making and quorum

13. Decisions of the Board will be made by consensus wherever possible. If a consensus cannot be reached the Chairman will call for a vote from amongst those voting members present at the time. The Chairperson will have a second or casting vote in the case of equality of votes.

14. Meetings will be quorate if at least three voting members (or their substitutes) are present including at least one elected Member from the County Council and one ICB member.

Public participation

15. Formal Board meetings will be held in public except where the Board is required to consider items of a confidential or exempt nature in which case the press and public may be excluded from that part of the meeting. The Access to Information Rules will apply to all formal meetings of the Board. Board development sessions are not formal meetings of the Board and will be held in private.

16. Up to 20 minutes of each meeting will be given over to public participation in the form of questions or comment up to a maximum of three minutes per participant. Questions or comments will normally be limited to items relevant to the agenda except at the discretion of the Chairman. The nature and content of participation should be submitted by 9.00am the working day before the meeting date to the Head of Legal and Democratic Services. Questions or comments will be heard but will not be followed by a debate. The Chairman will follow up with a written response within 28 days.

Declarations of Interest and Code of Conduct

17. All voting members of the Board and substitutes are required to register their Disclosable Pecuniary Interests as required under the Localism Act 2011 and the Council's Code of Conduct.

18. Members of the Board are expected to:

- Attend meetings or send a substitute
- Work collaboratively in pursuit of the aims of the Board, and take collective responsibility for decisions made

- Ensure that their own contribution and the business of the Board is conducted in a way which is consistent with the Nolan Principles of Public Life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- Come with a mandate to represent and feedback to their respective organisation(s)
- Honour any commitments made insofar as they relate to their own organisation(s)
- Balance the interests of the population of the County as a whole against the interests of specific geographical areas.

Frequency of meetings and support

19. Meetings of the Board will generally be held quarterly with additional meetings to be arranged at the discretion of the Chairman.

20. The Board will also hold private sessions to support its own development.

21. Administration for the Board will be provided by the County Council's Assistant Director for Legal and Governance.

This page is intentionally left blank

worcestershire countycouncil

HEALTH AND WELL-BEING BOARD
27 SEPTEMBER 2022

WORCESTERSHIRE JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2022-2032

Board Sponsor
Councillor Karen May, Cabinet Member with Responsibility for Health and Wellbeing

Author
Dr Tanya Richardson, Senior Public Health Consultant

	(Please click below then on down arrow)
Priorities	
Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	Yes
Other (specify below)	

Safeguarding

Impact on Safeguarding Children	No
If yes, please give details	
Impact on Safeguarding Adults	No
If yes, please give details	

Item for Decision, Consideration or Information
Decision

Recommendation

1. **The Health and Wellbeing Board is asked to approve and commit to the final draft of the Worcestershire Joint Local Health and Wellbeing Strategy 2022-2032 (the Strategy).**

2. **The Health and Wellbeing Board is asked to note the next steps and support the creation of action plans to support the delivery of the Strategy.**

Background

3. Following the annual Joint Strategic Needs Assessment (JSNA) in 2019, a working group was formed in Summer 2020 to review identified health needs and considerations. The Health and Wellbeing Board reviewed evidence and local data throughout 2021 and concluded that the overarching priority for its 10-year strategy should be good mental health and wellbeing.

4. Members of the Health and Wellbeing Board, supported by the Public Health team, planned a detailed and far-reaching public consultation to gather the views of residents, partners and stakeholders to ensure that the Strategy is driven by the needs and experiences of those who live and work in Worcestershire.

5. A formal 12-week consultation survey closed on 2nd May 2022, which asked a series of questions to gather views and gauge agreement with the vision, priority and supporting areas. In addition to the survey, which was shared widely through the County, 30 focus groups were commissioned from a range of community groups and organisations.

6. The survey received 1,627 responses within the 12-week period. Respondents reflected both positive and negative sentiments towards the survey questions. Quantitative analysis of the responses demonstrated strong agreement with the proposed vision and priority areas. Common topic areas across all the comments received were explored further by analysts, highlighting further areas for discussion and development. Findings were presented to the Health and Wellbeing Board for review, via a comprehensive development session.

7. Following this process, the Health and Wellbeing Board agreed that the Strategy would be developed with one priority of good mental health and wellbeing, supported by action on the wider determinants of health: healthy living at all ages, Safe, thriving and healthy homes, communities and places, and Quality local jobs and opportunities.

8. The Strategy was then shaped utilising consultation feedback, working with Health and Wellbeing Board members and key partners to appropriately address comments received.

Worcestershire Joint Local Health and Wellbeing Strategy

9. The Strategy focuses on early intervention and prevention, action on the wider determinants of health and tackling health inequalities through collective action and partnership working.

10. The Strategy outlines the Health and Wellbeing Boards commitment to improve mental health and wellbeing, supporting people to live well in good health for as long as possible, particularly those who have poorer health outcomes. The Health and Wellbeing Board will champion collective action to ensure children to have the best start in life, young people will have hope and aspiration for the future, and residents live longer, more independent lives in good health, with fewer people going on to need care and support which is vital to supporting good mental health and wellbeing.

11. The final Strategy is available in **Appendix 1.**

12. A set of detailed plans with clear actions, milestones and timescales will be developed, with support of Health and Wellbeing Board members and partners across the Worcestershire system. These plans will outline how the strategy will be delivered and more specific sets of outcomes and performance indicators will be developed to assess the impacts of this Strategy.

13. Action plans will be driven by the best available evidence, local need, previous learning, and findings from the strategy consultation. We will use population, whole system approaches, however, the Health and Wellbeing Board will ensure focus and target areas and communities which need it most.

14. A range of outcomes and indicators will be used to measure the impact of this Strategy, this will be a mix of local data, engagement, feedback and case studies. The outcomes framework embedded in the Strategy will be monitored by the Health and Wellbeing Board and will continue to be reviewed and updated to ensure it uses the most relevant and best quality data available.

Next Steps

15. The Strategy will be implemented and monitored by the 'Being Well Strategic Group', supported by the Being Well Delivery Group. These groups will work with other boards, partnerships and forums across the system to recognise ongoing action and may task or delegate as appropriate, in support of the plans. Progress in implementing the Strategy will be regularly reported to the Health and Wellbeing Board.

16. Health and Wellbeing Board champions will support the development and delivery of actions plans. Supported by continued engagement with stakeholders, partners and the public to support the implementation of the Strategy and action plans.

17. The newly formed Integrated Care Partnership (ICP) is responsible for joining up services across the NHS, Local Authority, and voluntary and community sector partners to meet the health needs of the population. Through its clear focus on improving mental health and wellbeing, this Health and Wellbeing Strategy will form a significant part of Integrated Care Strategy that the ICP will be publishing in December 2022.

Legal, Financial and HR Implications

18. As appropriate

Privacy Impact Assessment

19. There are no privacy issues to report.

Equality and Diversity Implications

20. The approach to the development of the strategy and its public consultation was designed with equality, diversity and inclusion in mind. A Joint Impact Assessment has been completed and full screenings completed for equality and public health impact, and environmental sustainability impact.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
Liz Altay, Interim Director of Public Health
Tel: 01905 846503
Email: laltay@worcestershire.gov.uk

Supporting Information

- Appendix 1 - Worcestershire Joint Local Health and Wellbeing Strategy

Background Papers

In the opinion of the proper officer (in this case the Director of Public Health) the following are the background papers relating to the subject matter of this report:

DRAFT

Worcestershire Joint Local Health and Wellbeing Strategy

2022-2032

Being Well IN WORCESTERSHIRE

Contents

Version 1 November 2022

Foreword

I am delighted to launch Worcestershire's Health and Wellbeing Strategy for 2022-2032.

This strategy is a call to action; to accelerate our efforts to improve mental health and wellbeing and prevent mental ill-health in Worcestershire.

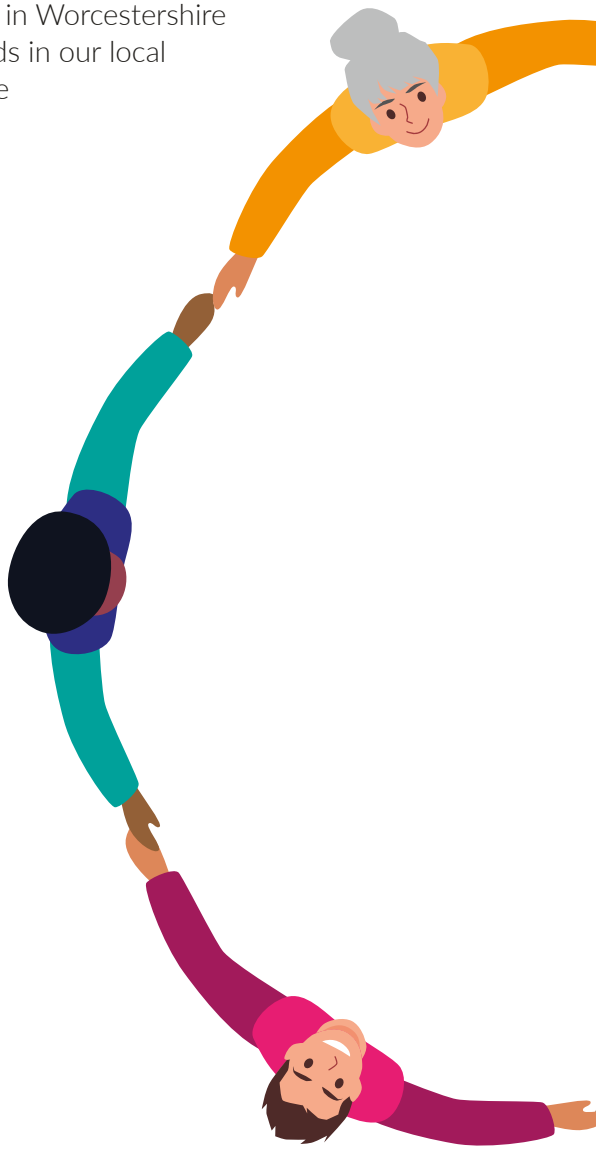
We will do this by taking collective action on the things we all need to have good mental health and wellbeing. We want our children to have the best start in life, our young people to have hope and aspiration for the future, and all of us to live longer, more independent lives in good health, with fewer people going on to need care and support.

Prevention is the key to these efforts. We need to prevent people becoming unwell in the first place, prevent the escalation of illness if it occurs, and ultimately prevent dependency on the health and social care system.

We know that the Covid-19 pandemic has affected all of us in different ways and has widened inequalities in health outcomes between the best and worst off in our county. We will maintain a relentless focus on addressing these disparities, enabling people to be socially and financially independent and able to meet the challenges that arise over the coming years.

My thanks go to every one of you who responded to our consultation and helped to shape this strategy. We will continue to engage with people who live and work in Worcestershire over the lifetime of the strategy to ensure we adapt to the changing needs in our local communities. We have a huge task ahead of us. Please join me and all the members of the Health and Wellbeing Board as we work together to make a difference to the health, wellbeing, and prosperity of everyone in Worcestershire.

Councillor Karen May, Cabinet Member with Responsibility for Health and Wellbeing and Chair of Worcestershire's Health and Wellbeing Board



Section 1: Developing the Health and Wellbeing Strategy

This section explains what the Joint Local Health and Wellbeing Strategy is and who the Health and Wellbeing Board are.

What is the Health and Wellbeing Board?

The Health and Wellbeing Board (HWB) brings together the organisations responsible for improving health and wellbeing in Worcestershire. Its members include elected councillors and officers from County and District Councils, representatives from Worcestershire Children First, Local NHS organisations including the Integrated Care Board (ICB), Primary Care Networks (PCN), Herefordshire and Worcestershire Health and Care NHS Trust, and Worcestershire Acute Hospitals NHS Trust, the local voluntary and community sector, Healthwatch Worcestershire, the Local Enterprise Partnership and West Mercia Police. It also has a range of sub-groups that focus on specific age groups or topics and issue such as the Children and Young People's Strategic Partnership and the Being Well Strategic Group.

More information about the HWB can be found on the **County Council website**.

What is the Health and Wellbeing Strategy?

The Health and Wellbeing Strategy is a document that outlines the health and wellbeing priorities for a local area. In this Strategy, we have set out what we need to focus on to improve the health and wellbeing of the people who live and work in Worcestershire. This is based upon the best available evidence as detailed in our Joint Strategic Needs Assessment (JSNA).

The Strategy sets out a vision and key priorities for our partnership work to improve health and wellbeing and reduce inequalities over the next 10 years. It is a 'living document' that will evolve and adapt to changing needs as it is implemented through shorter term action plans. These detailed action plans will include appropriate outcome measures to monitor progress over time.

The HWB and its Strategy sets the strategic direction for many other strategies, forums and committees across Worcestershire, and ensures resources are utilised in the best way possible and to benefit those with the greatest needs.

How do we work with the Integrated Care System?

The newly formed Integrated Care Partnership (ICP) is responsible for joining up services across the NHS, Local Authority, and voluntary and community sector partners to meet the health needs of the population. Through its clear focus on improving mental health and wellbeing, this Health and Well Being Strategy will form a significant part of Integrated Care Strategy that the ICP will be publishing in December 2022.

Section 2: How we can improve health and wellbeing

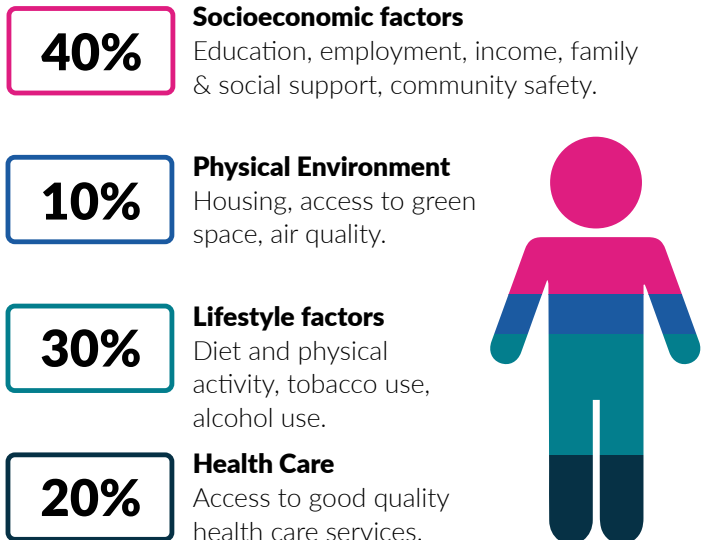
The HWB has used the best available evidence to identify what our population needs, and which evidence-based approaches could work to improve health and wellbeing and prevent poor health. These health approaches were used in the development of this strategy and will be used to deliver the strategy. This includes a focus on prevention, the wider determinants of health and tackling health inequalities. These approaches are explained below and require working together and integrating with communities and partner agencies across all of Worcestershire.

Wider determinants of health

Many factors contribute to our health and wellbeing and only around 20 percent relate to good quality health care services.

The wider determinants of health are a diverse range of social, economic and environmental factors which have an influence on our health. These include our education, employment, housing, neighbourhood and community, as well as the lifestyles we follow. Factors like deprivation, low income and poor housing mean that some people experience poorer health and reduced quality of life. These potentially avoidable health inequalities have been exacerbated throughout the covid-19 pandemic, often most impacting those who already experience worse health outcomes.

The HWB will consider these factors to help achieve its vision and priorities over the next 10 years.



[Adapted from an illustration of the impact of healthcare and non-healthcare factors on a person's health. Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014).]

Reducing health inequalities

Health inequalities are unfair and avoidable differences in health across the population and between different groups of people. They are socially determined by factors beyond an individual's control. The COVID-19 pandemic has had a disproportionate effect on people from different ethnicities, and those in specific jobs, such as front-line care, transport and hospitality, and those living in deprived areas, therefore making existing inequalities worse.

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs better than the national average. However, there are some areas in Worcestershire where people's health is worse than expected, and the average measures reported at County and District council level mask the differences in health outcomes experienced by some communities. For example, people living in more deprived areas have a shorter healthy life expectancy meaning they live more of their life in ill health than those living in more affluent areas.

Spotlights on our communities

Throughout this Strategy we have included spotlights on some of the activity in the local community. Initiatives, activities, and funding change over time as they are reflective of local need.

Prevention and early intervention

Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible.

Focusing our energy and resources on prevention and early intervention will mean fewer people go on to develop specialist health and care needs. For example, by identifying the needs of children, young people and their parents early we can prevent poor outcomes later in life. This approach can prevent needs escalating to a point that requires specialist interventions such as child protection and adult social care. Similarly, if we provide advice, guidance and support regarding the needs of older people we can prevent avoidable admissions to hospital and help maximise independence in later life.

In the words of the late Desmond Tutu:

"There comes a point where we need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in."

Prevention triangle

Prevention approaches can be divided into three categories (prevent, reduce, delay) as shown in the triangle below. These aim to firstly target activities at the whole population to prevent health needs, then in more targeted groups, reduce the risk and impact of health needs. At the top of the triangle, we can target support even further to manage high risk and long-term health needs. These categories describe the type of intervention that could be provided and who they might be best suited to.

Delay: taking action to support individuals and families to manage long term health needs, preventing complications and improve, as much as possible, people's quality of life. For example, rehabilitation programmes to support people with a mental health condition to return to or stay in work.

Reduce: taking action to reduce the impact of problems at the earliest possible stage. Stop them getting worse and/or targeting actions at groups who have an increased risk of developing needs. For example taking measures to reduce high blood pressure, support for families affected by substance misuse.

Prevent: taking action to prevent problems and reduce risk before they even happen across the whole population. For example, vaccination programme or supporting people to make healthier choices through, education programmes about healthy eating and being active.

Spotlight: Health and Housing in Worcestershire

Housing associations, Local Authorities and the NHS in Worcestershire have come together to create a unique role to improve health outcomes through housing. A new post 'Head of Housing and Health Partnerships' has been created and will work across organisations to reach as many as 200,000 people living in social housing across the county. Work will include a focus on mental health in the community, rough sleeping and homelessness and providing health and care job opportunities for residents. The project will also explore wider areas, such as reducing pressures on adult social care and NHS services, enabling longer term independent living and focusing on reducing health inequalities.

Section 3: Health and wellbeing in Worcestershire

This section explains the journey so far, why we chose mental health and wellbeing and shows some of the local Worcestershire evidence.

The journey so far

The HWB started considering its new Strategy in the summer of 2020, following an update on latest health needs outlined in the updated Joint Strategic Needs Assessment (JSNA).

The HWB reviewed evidence and needs of Worcestershire and identified possible priorities for the new strategy. The possible priorities were based on the evidence from the JSNA, the opportunities for system wide action on prevention and inequalities, and ability of the HWB to address the challenges presented by each priority. The development was also informed by engagement with almost 40 voluntary and community sector organisations. Following this, a public consultation was launched to hear your views on the priorities, further information about this consultation is in section four.

Why focus on mental health and wellbeing?

The World Health Organisation definition of mental wellbeing is 'a state where everyone is able to realise their potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.'

We know that good mental health and wellbeing is an important part of all our experiences in life and that it is something that affects other areas of our health too. Better mental health and wellbeing is linked to improved physical health and living longer in better health. It also protects us from some mental and physical health conditions as it increases our resilience, helps us make healthy choices and improves our relationships and quality of life.

Our mental health and physical health are interconnected. Having good mental and physical health and wellbeing is the key to enable people to live happy, prosperous and independent lives. Research shows that people with mental ill health are more likely to have a preventable physical health condition such as heart disease. Nearly one in three people with a long-term physical health condition also has a mental health condition, most often depression or anxiety.

Poor mental health also affects the economy, from lost employment to additional costs to health and public services. It is estimated that lost productivity, benefits payments, and costs to the NHS from mental ill health are around £70 billion a year in England.

Poor mental health is becoming more common. A nationwide survey of children and young people estimated that one in eight of 5 to 19-year-olds were likely to be experiencing mental ill health. Poor mental health when we're younger can mean an increased risk of mental ill health when we're older and developing unhealthy behaviours, such as performing poorly in education, substance misuse, self-harm and suicide.

Worcestershire picture

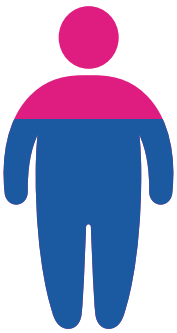
The infographic below shows some of the evidence that helps us understand the mental health and wellbeing of people who live and work in Worcestershire.

Depression 2020/21

73,197 people (**14.7%**) in Worcestershire Adults 18+ (QOF) which is higher than the England rate of **12.3%**

By **2032** the number of **people aged 85+** is set to increase by **61%** from **17,700** in 2021 to **28,500** in 2032

Almost **two thirds** (**64.2%**) of adults are **overweight or obese.** This is similar to the national average of **63.5%** (2019/20)



80% **of children and young people** felt that the pandemic has had a negative impact on their emotional wellbeing.**

4370 people are currently living with **dementia** in Worcestershire (2020 PHOF) Public health profiles

In June 2022 there were **11,015** people claiming **unemployment** benefits in Worcestershire, yet employers are reporting vacancies are harder to fill* (March 2020, **8,305**, June 2020 **18,510** June 2021**15,345**)

37,469 households in Worcestershire (**14.5%**) are thought to be living in **fuel poverty**, the figure for England is **13.2%** (2020)

7% of adults reported they had not been able to find **mental health and wellbeing support*****

*74% of respondents reported they had a vacancy that they were funding hard to fill. Herefordshire and Worcestershire Chamber of Commerce Quarterly Economic Survey report (Q1 2022)

**Worcestershire Healthwatch Report 2022 (202 responses)

***Worcestershire Healthwatch Survey in 2020 (170 out of 1450 responses)

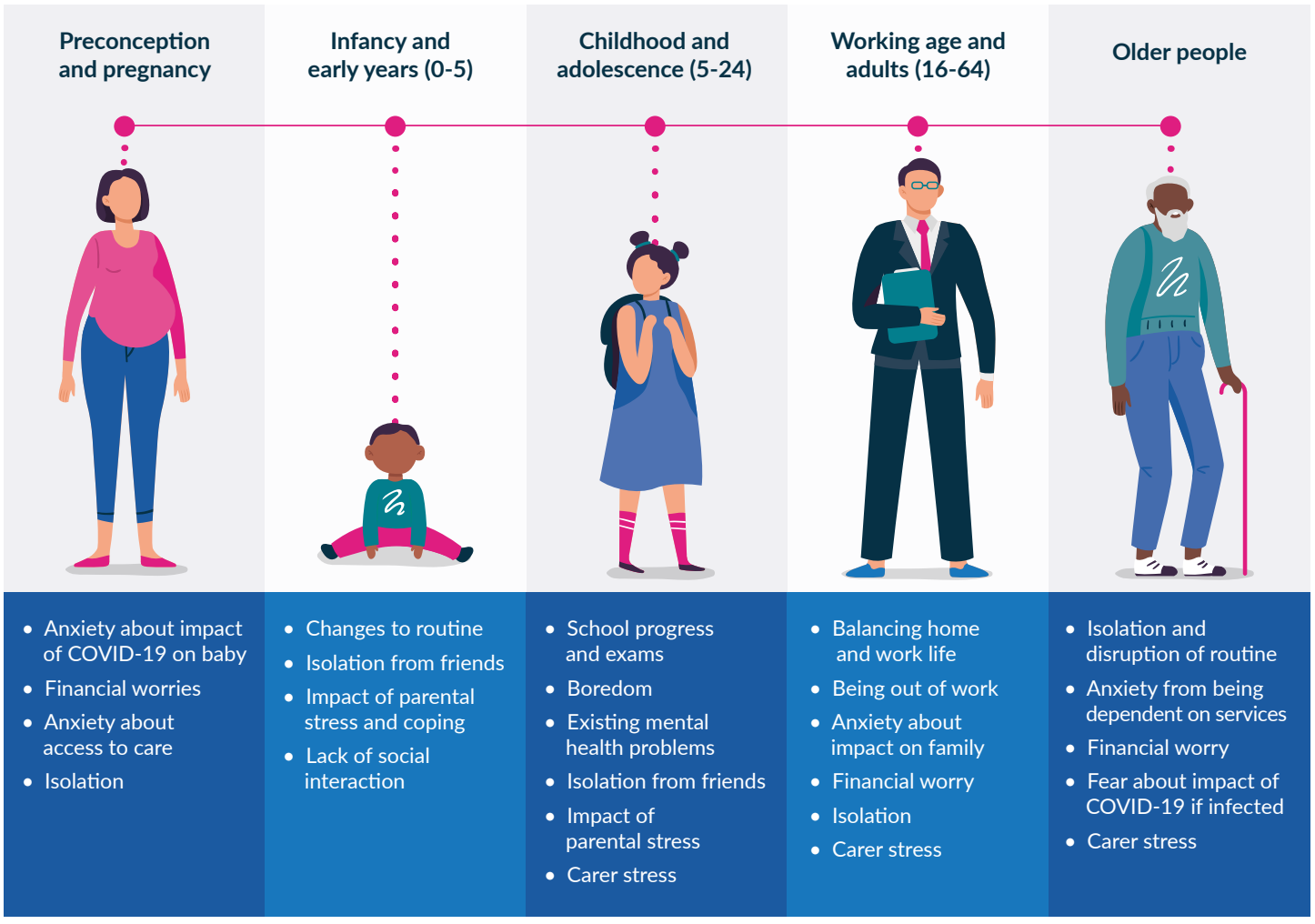
The impact of COVID-19 pandemic

Before COVID-19 there was already a persistent gap in life expectancy and in the number of years people lived in good health between the most and least affluent areas. COVID-19 has exacerbated existing health inequalities and certain groups have experienced disproportionate effects on their mental health. We also do not fully understand the effects of long COVID-19 on our population.

Whilst the negative impacts of COVID-19 are significant, there have also been some positive impacts. Communities have responded to COVID-19 by supporting one another in new ways. More people are recognising the importance of both their physical and mental health and are more willing and able to talk about mental health and wellbeing than ever before.

It is important to remember that COVID-19 is not the only infectious disease that can impact our health and wellbeing.

Here are some of the ways COVID-19 has affected us:



10 Different impacts of COVID-19 across the life course (Adapted from LGA and PHE Health Matters Image)

Spotlight: Inspire Community Café, Redditch

Karen has spent the last 10 years running grass-roots community projects on an estate in Redditch. During lockdown she opened the Inspire Community Café with some local volunteers, purchased a van, and organised a food parcel scheme that reached over 400 vulnerable people. Now, following the ease of lockdowns, the café continues to provide formal and informal mental health support and a range of community activities, befriending and support groups.

Section 4: Capturing community views

This section looks at how we captured community views and involved you in the development of the Strategy.

The consultation

We wanted to make sure that the Health and Wellbeing Strategy is driven by the needs and experiences of the people who live and work here. We have taken several approaches to find out what 'being well' means to the residents of Worcestershire.

We asked people to respond to a formal consultation survey on the development of the Strategy. The consultation was shared widely throughout the county, to individuals, partners, communities, and voluntary organisations. It asked respondents to share their views on the proposed priorities and vision; what 'being well' means to them; and thoughts on the impact of the COVID-19 pandemic.

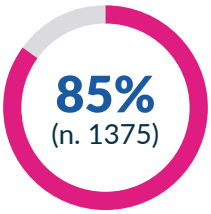
Over the 12-week period, the consultation survey received 1627 responses (online and paper copies). Of those completed, 97% were from residents and 3% were from organisations which included: Voluntary and Community Sector (VCSE), Public Sector, Health, Leisure and Education.

In addition to the formal consultation, we have undertaken research in the community with a variety of groups and organisations to understand the lived experiences of many different Worcestershire residents. The results from all this engagement work will continue to inform the development of action plans which will support the delivery of the Strategy. The HWB is committed to ongoing engagement in the community, with findings being used to refine action plans and support the Strategy as it evolves over the 10-year period.

Consultation findings: what you said

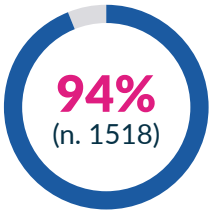
The public consultation ran from February 7th – May 6th 2022 and received 1627 responses.

Your thoughts on our proposed priorities:

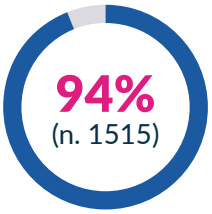


strongly agree or agree with '**good mental health and wellbeing**'

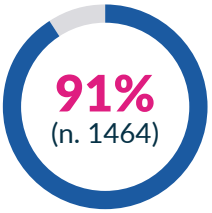
The Health and Wellbeing board have identified the following 3 things that we all need to **be well in Worcestershire**, we asked how much you agreed with these topics:



strongly agree or agree with '**healthy living at all ages**'



strongly agree or agree with '**safe, thriving, and healthy homes, communities and places**'



strongly agree or agree with '**quality local jobs and opportunities**'

*(n.) = the number of responses to the question

Being well & COVID-19

Being well means different things to different people! You told us that these 3 things are the most important:

Physical health / ability
96% (n.1541)

Access to healthcare
87% (n.1395)

Mental health / self-care
85% (n.1374)

80% (n.1288) think that COVID-19 has decreased the health and wellbeing of people living and working in Worcestershire – the following 3 things have been most negatively affected:

Social isolation and relationships
88% (n.1424)

Mental health & wellbeing
88% (n.1412)

Physical health
66% (n.1057)

What else is important to you...

We analysed your responses and these are the things that you said are **important to you.**

Information & advice

- Accessible and inclusive information and advice to support wellbeing.
- Knowing what information is available and where to find it.

"...people may need access to advice and help to understand how they can remain healthy when their routines suddenly change."

Accessing services

- Being able to access health and wellbeing services in a variety of ways.
- Having services that are tailored to individual needs.
- Clear communication between services and the public.

"Physical access to community facilities, particularly for those unable to access the internet (although increased online access is a positive, particularly for those with mobility/access issues.)"

The rising cost of living

- Healthy living- the cost of healthy food and access to physical activities.
- Homes & communities- rising costs impacting household budgets.
- Jobs & opportunities- quality jobs, support to find employment, the cost of public transport.

"The world looks like a different place, post-Covid, and a less safe, less predictable, less familiar one."

Reliable & affordable transport

- Access to safe, reliable, and affordable public transport particularly in rural areas to support employment and access to services.
- Good infrastructure for safe active travel.

"Transport is a real issue for rural communities. where I live if you don't drive it's very difficult to get to work."

Physical health

- Having good physical health and mental health.
- Access to affordable physical activity opportunities in your local community and at work.

"Physical and mental health are linked. Poor physical health can lead to poor mental health and vice versa. Both needs to be addressed."

Your local environment

- Opportunities to access well-maintained recreational and green spaces.
- Enjoying the benefits of being outdoors and protecting your local environment and countryside.

"Our environment, countryside and heritage play a significant and often underestimated role to promote health and wellbeing."

Measuring progress

- Understanding how priorities will be achieved and measured.
- Remaining flexible to meet changing needs of the population.

"...it needs a cohesive practical delivery plan, delivering a local service to local people. It also needs a good prevention strategy."

Your feedback will...

- Inform the development of the Strategy and its action plans.
- Shape the Board's commitment to ongoing engagement.
- Put Worcestershire resident's views at the centre of the 10 year Strategy.
- Be shared with all HWB partners.

Findings analysed from **1627 responses**

Section 5: Our Health and Wellbeing Strategy

This section outlines our vision and priorities for the Health and Wellbeing Strategy.

Vision and priorities

Based on all the evidence and feedback from the consultation in sections three and four, the HWB concluded that the overarching priority for its new 10-year Strategy should be mental health and wellbeing, supported by action in areas that we all need to be well in Worcestershire which are: healthy living at all ages; safe, thriving and healthy homes, communities and places; and quality local jobs and opportunities.

Our Vision

The vision of the HWB is 'working together for better health and wellbeing in Worcestershire'.

Our Priorities

The HWB wants to focus its new Strategy on good mental health and wellbeing, supported by action on the wider determinants of good mental health and wellbeing outlined here.

Our Priority: Good mental health and wellbeing

This Strategy demonstrates the important role mental health and wellbeing plays in all aspects of our health; that's why we want to improve mental health and wellbeing for everyone in Worcestershire. We will continue to support work across the wider health and wellbeing agenda that contributes to better mental health and wellbeing.

We will work together across the system to improve mental health and wellbeing, supporting people to live well in good health for as long as possible, particularly those who have poorer health outcomes. This means we all have a role to play, public, private, and voluntary and community sector as well as everyone who lives and works in Worcestershire.

The consultation findings highlighted several areas that are important to you. From tailored and accessible information and advice through to specialist mental health services and support. We recognise the issues in accessing the services and support we need to have good mental health and wellbeing. It also recognises the significant impact that the COVID-19 pandemic and rising cost of living has had and continues to have on mental and physical health. The HWB will continue to work with system partners to assure these issues are being addressed.

There is a wealth of existing work already being delivered across the system that contributes to improved mental health and wellbeing, and we will continue to recognise this as an important part of achieving our vision and priorities.

Providing support at individual, community and societal levels, with action at every stage of life, and in the places where people are born, raised, live, learn and work can help to prevent poor mental health and wellbeing.

A whole system approach that places greater emphasis on prevention is critical to improve mental health and wellbeing in Worcestershire.

YOU SAID

"There are many individuals who are struggling at the moment and will increasingly struggle as circumstances (e.g., cost of living etc.) get more difficult"

"Good mental health and wellbeing is the foundation upon which people can build happy and productive lives and relationships"

"Mental health and wellbeing is a community back bone… health and wellbeing is my highest priority"

Spotlight: Now We're Talking

The Now We're Talking (NWT) campaign started in 2018 to raise awareness of the NHS Healthy Minds Service and wider mental health support. The NWT campaign has forged strong links with partner organisations and is the face of mental health communications in Herefordshire and Worcestershire. Their recent video campaign 'acting together to prevent suicide' hopes to reduce the stigma surrounding mental health and highlight where to get support.

Other recent campaigns include mental health signposting, initiatives around art, nature, and sport as well as outreach with schools and colleges and at public events.

Spotlight: The Five Ways to Wellbeing

The Five Ways to Wellbeing is a great tool for improving our mental wellbeing. It captures a range of evidence-based approaches to building and maintaining good mental wellbeing for the whole population, from infancy into older age. There are a range of local initiatives that support the Five Ways to Wellbeing including:

Connect:

- Approaches like the Good Neighbour Networks and the Stay Connected Pledge are keeping communities connected.
- Local initiatives, like Pershore Wellbeing Hub, provide a range of information and support to improve wellbeing and connect.

Be active:

- Free resistance bands and exercise leaflets are available for the over 50s through the Living Well for Longer programme.
- Physical activity and leisure opportunities are available for all ages and abilities across the Districts.

Take notice:

- Worcestershire has a wealth of arts, nature, and cultural opportunities.
- Our museums offer a variety of collections and exhibitions covering centuries of the county's history.

Keep learning:

- Free and low-cost adult and family courses are available online and in local community venues.
- The Herefordshire and Worcestershire Wellbeing and Recovery College offers courses to give people the tools and skills they need on their wellbeing and recovery journey.

Give:

- The NHS, Here2Help, and our volunteer centres all provide opportunities to 'give' across the county.
- Benefits include enhancing skills, improved wellbeing, opportunities to socialise, an significant range of societal benefits.

Our ambitions for good mental health and wellbeing:

1. We will take a whole population approach to improving mental health and wellbeing and preventing mental ill-health across Worcestershire.

This includes:

- Promoting good mental wellbeing and resilience (the ability to cope with challenges).
- Preventing mental ill-health (including spotting the signs and intervening early).
- Supporting access to appropriate services and support including recovery from mental ill-health.
- Tackling the stigma around mental ill-health.
- Providing accessible and inclusive information, advice and support in appropriate formats.
- Responding to factors which are affecting mental health and wellbeing, for example the current cost of living, relationships and loneliness.

2. We will continue to align and support local partnership strategies that contribute to improving mental health and wellbeing.

This includes:

- Sharing data, intelligence, and resources.
- Working collaboratively, improving integration and communication.
- Contributing to the work of other relevant groups for example of the Mental Health Collaborative.

3. We will maintain our commitment to reducing inequalities by focusing on:

- People living in deprived areas.
- People with poorer health outcomes including those with severe mental illness.
- People living with disabilities, co-morbidities, and long-term health conditions.
- People facing multiple disadvantages including those experiencing homelessness, refugees, and traveller communities.
- People who misuse drugs or alcohol.

4. We will continue to engage with local communities over the lifetime of this Strategy.

This includes:

- Having ongoing and meaningful conversations about mental health and wellbeing.
- Ensuring lived experience insights are central to decision making and service delivery.
- Feeding back to the community about the impact of their views.

Supported by: Healthy living at all ages

Mental and physical health go hand in hand, and it is important to improve health and wellbeing across the life course. Healthy living at all ages aims to ensure that everyone is supported to make healthy choices, particularly supporting those most vulnerable. This includes supporting people to maintain a healthy weight, to do more physical activity, limit alcohol intake and quit smoking.

Positive early experience is vital to ensure children are ready to learn, ready for school and have good life chances. As children grow and develop, it is both the physical environment around them and the social environment they experience that supports their development.

It is vital to give every child the best start in life; ensuring good physical and mental health before and during pregnancy is important for both mother and baby.

Its important we keep active and healthy throughout our working lives. Having a workplace and lifestyle which supports our health and wellbeing is vital to achieve this. We will work with all partners to respond to factors which impact our adult lives and affect our mental and physical health and wellbeing.

We want to focus on improving the life experience and outcomes for all children and young people in Worcestershire as building resilience preventing and reducing risk from an early age will have long life benefits. We will do this working alongside the Children and Young People's Plan.

We know that resilient children do better at school, better in adolescence and grow up to be resilient adults; and in turn resilient parents will support their children well through childhood and adolescence.

Appropriate and timely experiences and support for young people on their journey to adulthood is essential to ensure future health and wellbeing. Supporting and enabling adults and to live well and take responsibility for their own health and wellbeing enables us to reach our potential and stay well through life's tough times.

We will support those children, families, and individuals facing adversity, including those living in the most deprived communities to prevent, reduce and delay poor health and to work towards tackling inequalities.

As we get older, looking after your mental and physical wellbeing can help to slow down age-related functional decline and reduce the need for specialist care. To support people to age well, we need to maintain independence in the home and ensure the best possible outcomes for older people, Carers and those living with co-morbidities or long-term health conditions (for example, dementia).

Preventing loneliness for all ages has a significant impact on many aspects of our physical and mental health. We can promote opportunities to spend time with others, like physical activity or intergenerational activities, which can have a positive impact across the life course.

Healthy lifestyles combined with wider preventative measures like vaccinations, health screening or early intervention services, we can all start well, live well and age well.

Spotlight: Social Prescribing – Children, Adolescents, and Families

The Social Prescribing Children, Adolescents and Families (CAF) service supports children and young people aged 8 – 18 years and their families. The CAF team was set up in response to the issues facing families and young people in our most disadvantaged areas within North Bromsgrove District. The programme has been set up by the Bromsgrove and District Primary Care Network (PCN) and is delivered by Onside. A similar service has been developed in Droitwich, Ombersley the Rurals PCN, and by Wyre Forest Network of Independent Practices (WFNIP) and Wyre Forest Health Partnership.

A care coordinator and social prescriber provide non-medical holistic support on a 1-1 basis with issues such as education, mood, anxiety, family relationships, loneliness, exercise.

"The Social Prescriber has been a great support with school and been able to talk things through privately outside of family. She has been someone to vent to after my mother's death and phone calls when needed were useful. I feel less stressed with school, less overthinking and feel more positive. She is a helpful and down to earth Social Prescriber." – Young Person W. Barnt Green Surgery.

Spotlight: Health walks

The Worcestershire Health Walks programme offers free short group walks led by trained volunteers. Health Walks take place across the county and are a great way to explore our Green Flag award winning parks and green spaces.

"After having a Cardiac Arrest walking has become important to maintain my fitness. It gets me out and about and, being a walk leader, a purpose for getting up and getting moving. Although I lead the Group, it's not my Group – we all take responsibility for each other. I like how everyone has a different story and to hear about other people's lives."

Lickey End, Bromsgrove Health Walk Volunteer

You said:

"There are obvious times in one's lives when things may dramatically change, such as employment, pregnancy, when people may need access to advice and help to understand how they can remain healthy when their routines suddenly change."

"I think that if you are emotionally well, this enables you to embrace physical challenges, and it motivates you to engage in physical activity."

Our ambitions for healthy living at all ages

1. We will support people to start well, live well and age well so they can live a greater proportion of their lives in good health.

This includes:

- Enabling children and families to access the services and support they need for good mental health and wellbeing, from pre-conception through to adulthood. Including enhanced support for children and families facing adversity, disadvantage or with poorer or emerging physical and mental health needs
- Supporting early years and educational settings to effectively promote good mental health and wellbeing.
- Working with partners to enable people to work for as long as they want and are able to.

2. We will enable people to improve and maintain their own health and wellbeing and make healthy lifestyle choices.

This includes:

- Understanding the barriers to healthy lifestyles at different stages in life and for our most vulnerable groups.
- Promoting physical activity and social opportunities that are accessible for everyone.
- Promoting good oral health and encouraging people to eat healthier andmaintain a healthier weight.
- Encouraging people to reduce their alcohol consumption, stop smoking and tackle substance misuse.
- Deliver effective vaccination and screening programmes that reach all groups of our population.

3. We will support people to live healthy and independent lives for longer, with appropriate support and care available when they need it.

This includes:

- Providing effective and accessible services to those who need them.
- Delivering the right support for people during life transitions like illness, job loss, pregnancy, divorce, or retirement.
- Providing support for people living with long term health conditions, co-morbidities, and disabilities.

Supported by: Safe, thriving and healthy homes, communities and places

As we discussed in section two, the wider determinants of health have a great impact on our lives. Whether we live in cities, towns or rural areas, the communities we live in really matter for our wellbeing. With 85% of our county being classed as rural, and urban areas having good access to parks, open spaces and public rights of way, there are many opportunities which support healthier lifestyles.

Communities make a vital contribution to health and wellbeing. The assets within communities, such as skills and knowledge, social networks and community organisations are all building blocks for good health. This will also connect people with wellbeing opportunities in their communities including arts, culture, and physical activity.

Having a safe and secure home in good physical condition can promote good mental health and wellbeing. In contrast, exposure to housing insecurity or affordability issues may contribute to poor mental health. The HWB will support existing partnerships who already aim to improve the amount of good quality affordable housing in Worcestershire to meet the needs of the population now and into the future.

The wider natural and built environment (including access to green space, leisure opportunities and active transport) can also influence our health and wellbeing. The COVID-19 pandemic has made many of us more aware of how much we value our outdoor spaces for our health and wellbeing

People can face multiple disadvantages depending on where they live. Families in the most deprived areas are less likely to have access to green space, and people who live near poorly maintained green space are less likely to use it.

Crime and antisocial behaviour are more prevalent in deprived areas as well as feelings of loneliness, lack of a sense of community and belonging, and poorer social networks.

We can change how we think about the relationship between our surroundings and our health, enabling residents to have access to the things they need to live a healthy life in their community.

Spotlight: Asset Based Community Development

An Asset Based Community Development (ABCD) approach places the emphasis on identifying and connecting the resources that already exist in communities. Building on community strengths and connections can enhance health, wellbeing and resilience, enabling people to participate in and benefit from community groups and activities.

A network of Community Builders has been employed through District Councils and community partners to focus on growing neighbourhood connections and supporting resident led actions.

A small group of local mums were supported by a Community Builder to set up and lead a new "Stay and Play" parent and toddler group up on the Abbeydale estate in Redditch. The first stay and play session had 20 families attending and there has been a wealth of positive feedback:

"This has given me purpose and focus, I was worried at first but I'm getting more confident each week, it has improved my anxiety and mental health because I feel like I'm doing something that is making people happy and can socialise again."

YOU SAID

"It's important to work toward improving and maintaining a healthy environment in the home and in the local community"

"People need to feel safe in their own homes and communities. They need to feel valued and included within their community....and that they are not alone"

Spotlight: Repair Cafés

Repair Cafés (RCs) are a community led initiative helping society to reduce their waste, forming an opportunity for social cohesion and the learning of new skills. People can bring broken items to be mended while they wait, allowing the opportunity to watch and help with the repair and have a drink and chat in the café. Volunteers are central to the initiative.

"I have at least two or three enquiries each week from community groups who ask for help and advice in starting their own RC. They are so inclusive and not only enable people to put their practical skills to good environmental, economic and social use but provide an opportunity for these skills to be passed on to a new generation. RCs bring people together from all kinds of backgrounds and cultures - they're a win-win community initiative" Repair Café Malvern Hills

Spotlight: Community Transport

Community Transport plays an important role in the county's Passenger Transport network and most schemes are run by the voluntary and community sector with volunteers being at the heart of the services.

Schemes are active in identifying vulnerable people and providing a tailored service which can build confidence, reduce loneliness and support people to remain independent.

"Community Transport has given me back my independence"

For example, community transport in Wyre Forest and North Worcestershire helps people of all ages from Students to Pensioners with appointments at medical centres or hospitals, lunch clubs, day centres or shopping trips covering over 400 journeys a week.

Our ambitions for safe, thriving and healthy homes, communities and places:

1. We will continue to improve access to healthy, safe, affordable, and warm homes that support a better quality of life and good mental health and wellbeing.

This includes:

- Supporting people on low incomes to keep their homes warm and well-insulated.
- Working to reduce the number of people at risk of homelessness.
- Helping people to live more independently and assist in reducing pressures on the health and social care sectors.
- Supporting the delivery of the Housing Strategy and collaborating on policy.

2. We will work to improve our communities and places, making sure good mental health and wellbeing is at the centre.

This includes:

- Working to reduce crime and antisocial behaviour and promoting community safety.
- Enhancing community connectedness and enabling communities to develop local solutions through an asset-based approach.
- Ensuring a range of local and affordable activities and events are available to people of all ages.

3. We will continue to protect our environment and promote the positive benefits it has for our mental health and wellbeing.

This includes:

- Maximising the usage of and access to green space and outdoor activities.
- Providing safe and accessible opportunities for active and sustainable travel.
- Understanding and addressing air quality and climate change in Worcestershire.

Supported by: Quality local jobs and opportunities

Jobs and opportunities are influential for our mental health and wellbeing. They matter for health directly, as well as underpinning other factors that influence health and wellbeing such as income or social networks.

A quality job is important for mental health and wellbeing and provides an income and opportunity to make social connections. 'Quality' work is defined as having a safe and secure job with good working hours and conditions, supportive management and opportunities for training and development. This also includes opportunities to improve health and wellbeing of employees in the workplace.

Conversely, low-quality work including low job security or low job satisfaction is associated with worse health outcomes such as prolonged stress. Low-quality work is unequally distributed across society, reflecting broader inequalities.

Research suggests that volunteering and acts of giving and kindness can help improve your mental wellbeing. Volunteers make a significant contribution to improving the lives of people in our county. There are many opportunities to volunteer locally through our voluntary infrastructure organisations and system partners. We need to ensure that support mechanisms are in place including appropriate training.

Worcestershire has relatively high employment, but still faces challenges. After more than doubling in 2020, claimant count unemployment has fallen steadily over 2021 but remains 33% higher than before the pandemic. The impact has been greatest on young people with 4.1% of those aged 18-24 now claiming unemployment related benefits.

Our aim is for Worcestershire to be a prosperous county with quality local jobs and opportunities.

Unemployment has many negative consequences on health and wellbeing such as being a source of stress, a cause of poverty, associated with unhealthy coping behaviours such as smoking and drinking. People who are unemployed have twice the rate of common mental health conditions, and unemployment is associated with an increased risk of mortality and morbidity.

For people living with a mental health condition, learning disability or problematic alcohol or drug use, it is disproportionately difficult to find a job or remain employed. Enabling people to obtain or retain work and volunteer opportunities is a crucial part of the economic success and wellbeing of every community and industry.

YOU SAID

"A job -be it paid or voluntary – contributes to a person's sense of worth and value..."

"Here we need to make sure that opportunities are open to all, people who are furthest away from the job market can present with multiple complex needs..."

Source: PHE Health Matters

Spotlight: Suicide Prevention and Workplaces

As part of the Herefordshire & Worcestershire Suicide Prevention Programme, an initiative has been rolled out to encourage and support employers and employees to raise awareness about suicide and support available, tackle mental health stigma, and embed suicide prevention within the company culture.

A mental health and wellbeing resource hub for businesses, including a downloadable suicide prevention policy has also been created. A high number of local businesses have enrolled in the initiative including those from Manufacturing, Social Work, Construction and Agriculture.

Herefordshire and Worcestershire Fire Service is one organisation benefitting from the learning and resources offered by the scheme. Resources have been shared with stations across the counties and the service is being supported to explore training opportunities for staff.

Spotlight: The Youth Hub, at The Hive

The Youth Hub is a career advice drop-in facility for young people based at The Hive, Worcester.

The Hub is aimed at 15- to 24-year-olds and provides a 'one stop shop' to support young people in finding the right career path: providing 1-1 advice with a dedicated advisor, employability workshops and training.

"The young person had a real desire to work but has struggled since leaving school to maintain employment due to his learning difficulties. The Career Advisor explored a number of options – the young person completed a course and 20-hour placement which will give him great experience to gain paid employment."

It is a partnership between Worcestershire County Council, The Department of Work and Pensions and The Worcestershire Local Enterprise Partnership.

Our ambitions for quality local jobs and opportunities:

1. We will work to improve access to quality jobs, training, and volunteering opportunities.

This includes:

- Enabling access to suitable training opportunities directly through workplaces and via apprenticeships, internships, further and higher education and courses within communities.
- Supporting activity to strengthen and increase the number and variety of volunteering opportunities across the system.
- Recognising access issues and barriers for all ages, including access to reliable and affordable public transport.

2. We will work with businesses and organisations to support people to develop within their jobs, or in getting back to work.

This includes:

- Supporting people with mental and physical health conditions, disabilities or those facing multiple disadvantages to get back to and remain in work.
- Enabling opportunities for in-work development, contributing to the future workforce.

3. We will work with businesses and organisations to promote inclusive, healthy, and productive workplaces.

This includes:

- Ensuring workplaces are health promoting environments and that people are supported with poor mental health, long term health conditions and disabilities.
- Supporting employers to build and retain a healthy, inclusive, and diverse workforce.
- Protecting people from adverse working conditions that can damage health.
- Encouraging flexibility to enable people to balance work and family life.

Section 6: From strategy to action

This section explains how we plan to deliver and measure progress on the Strategy.

Delivering the Strategy

To achieve our vision, action is required by a range of different organisations, communities, and individuals from across the system. It is essential to work together to ensure the Strategy is implemented. Board members, statutory, private and voluntary sector organisations, communities, families and individuals all have a role to play in delivering action plans and achieving outcomes.

A set of detailed plans with clear actions, milestones and timescales will be developed, outlining how the strategy will be delivered. Action plans will be driven by the best available evidence, local need, previous learning, and findings from the strategy consultation. We will use population, whole system approaches, however, we will ensure we focus and target areas and communities which need it most.

It is important that this Strategy are informed by both robust evidence and people's views and experiences. As such, the HWB is committed to ongoing engagement and supporting co-production and community-led approaches.

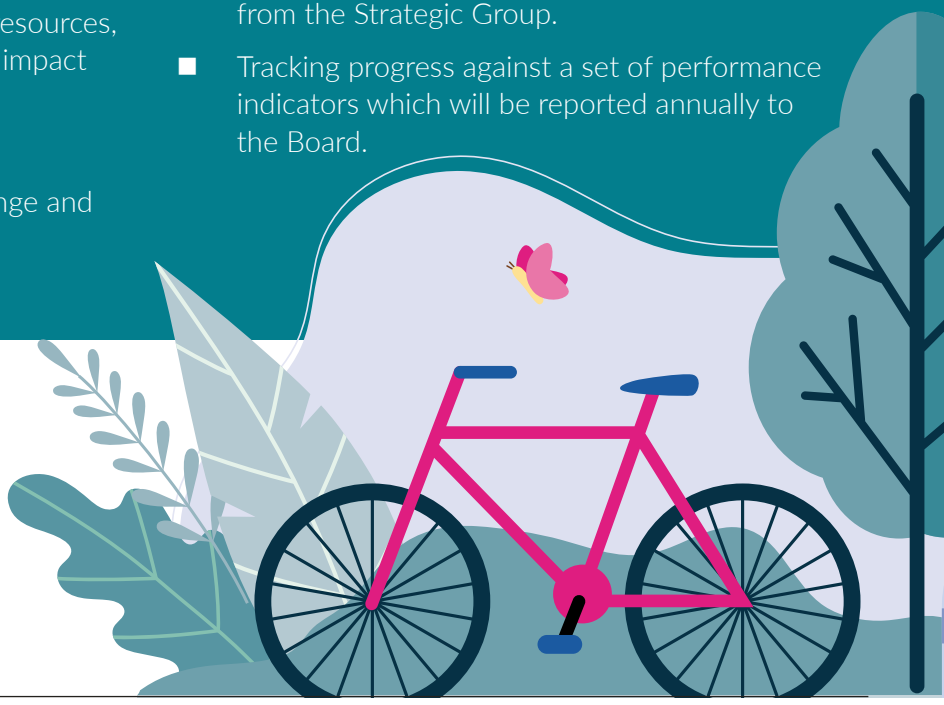
Measuring progress

The Board will support implementation by:

- Ensuring that the Strategy is widely available and raising awareness of it at every opportunity.
- Providing leadership and advocacy.
- Seeking participation and contributions from our public, private, health, voluntary and community sector, and education partners.
- Facilitating debate on difficult issues.
- Building relationships and enabling partner organisations to align policies, services, resources, and activities to increase their collective impact on health and wellbeing.
- Promoting examples of good work.
- Overseeing progress and offering challenge and support where necessary.

The Board will hold statutory partners to account for implementation of the Strategy by:

- Delegating to the 'Being Well Strategic Group' the responsibility to agree a set of detailed plans with clear actions, responsibilities, milestones, and timescales. The Being Well Delivery Group may task and delegate to other boards, partnerships, and forums where appropriate and agreed by the HWB.
- Receiving progress reports against action plans from the Strategic Group.
- Tracking progress against a set of performance indicators which will be reported annually to the Board.



The outcomes framework

A range of outcomes and indicators will be used to measure the impact of this Strategy, we will use a mix of local data, engagement, feedback and case studies.

The diagram below has been developed from a model produced by 'What Works Wellbeing' to combine the best available national and local data sources. This outcomes framework

will give an overall view of the progress and improvement towards delivering the Strategy . Monitoring these measures will help to inform local decision-making, helping us better understand the wellbeing of Worcestershire, and how we can act to improve it.

This framework will be monitored by the board and will continue to be reviewed and updated to ensure it uses the most relevant and best quality data available. More specific sets of outcomes and performance indicators will form part of the action plans to assess the impacts of this Strategy. Particularly through aligning with ongoing work to develop an outcomes framework to support the wider focus of the Integrated Care System. We are also seeking better ways to reflect mental health outcomes in children and young people. The diagram below shows the priorities and indicators that will be measured throughout the life of the strategy on key aspects of health and wellbeing that contribute to our vision. These measures are a mix of national and local measures, more detailed and varied measures will be embedded into action plans to continuously monitor data to show our progress.

Measures

We want to achieve...	Determinants	Measures
Good Mental Health and wellbeing	Adult wellbeing Adult mental health Child mental health	Personal wellbeing** Depression prevalence and incidence* Hospital admissions as a result of self-harm*
We will support this through...	**Determinants**	**Measures**
Healthy living at all ages	■ Best start in life ■ Healthy behaviours ■ Loneliness ■ Overall health	School readiness (end of reception)* Physical activity, alcohol, smoking* Obesity* Loneliness* Healthy life expectancy*
Quality local jobs and opportunities	■ Education ■ Employment ■ Income ■ Deprivation	Not in Education, Employment or Training (NEET)* Unemployment rate** Median gross weekly pay** Children in low-income households* Overall Index of Multiple Deprivation Score*
Safe, thriving, and healthy homes, communities, and places	■ Natural environment ■ Homes ■ Community ■ Crime and security	Use of parks and open spaces*** Fine particulate pollution* Homelessness reduction duty* Satisfaction with local area*** Sense of belonging*** Volunteering*** Violent crime***

Measures in this table are taken from a variety of local and national sources:
*Public Health Outcomes Framework (PHOF)
**Office for National Statistics Nomis (ONS NOMIS)
***Worcestershire County Council Viewpoint Survey

Glossary:

Asset Based Community Development (ABCD): ABCD is an approach to sustainable community-driven development. It builds on the assets that are found in the community and mobilises individuals, associations, and institutions to come together to realise and develop their strengths.

Health disparities and health inequalities: Unfair and avoidable differences in health across the population and between different groups of people. Terms are used interchangeably.

Health and Wellbeing Board (HWB): The HWB oversees the new system for local health commissioning. It leads on the strategic planning and co-ordination of NHS, Public Health, Social Care, and related Children's Services.

Integrated Care Systems (ICS): Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

Joint Strategic Needs Assessment (JSNA): An annual statutory report that provides a summary of the latest public health data and information for Worcestershire, it also identifies emerging issues for the county.

Whole Population Approach: Is aimed at improving the health outcomes of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across an area while also reducing health inequalities.

Bibliography:

Department of Health & Social Care. (2018) Prevention is better than cure. Our vision to help you live well for longer.

Faculty of Public Health and Mental Health Foundation. (2016) Better Mental Health for All: A Public Health Approach to Mental Health Improvement. London: Faculty of Public Health and Mental Health Foundation.

GOV.UK. (2019) Health matters: Prevention - a life course approach.

Healthwatch Worcestershire. (2020) Covid-19 People's Experience of Health and Social Care Services Report.

Healthwatch Worcestershire (2022). Young People's Health and Emotional Wellbeing Report.

NHS Digital. (2020) Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey.

NHS Hereford and Worcestershire Health and Care Trust. Now We're Talking for Healthy Minds.

NHS. 5 steps to mental wellbeing.

Office for Health Improvement & Disparities. (OHID) Wider Determinants of Health.

The King's Fund. Broader determinants of health: Future trends.

The King's Fund. (2022) What is a population health approach?

What Works Wellbeing & Happy City. (2017) Understanding Local Needs for Wellbeing Data.

Worcestershire County Council. Health and Wellbeing Board.

Worcestershire County Council. InstantAtlas Worcestershire

Worcestershire County Council. Joint Strategic Needs Assessment (JSNA) Summaries.

This page is intentionally left blank

worcestershire countycouncil

HEALTH AND WELLBEING BOARD
27 SEPTEMBER 2022

PHARMACEUTICAL NEEDS ASSESSMENT 2022

Board Sponsor
Liz Altay, Interim Director of Public Health

Author
Matthew Fung, Public Health Consultant

Priorities	
Mental health & wellbeing	Yes
Being Active	No
Reducing harm from Alcohol	No
Other (specify below)	

Safeguarding	
Impact on Safeguarding Children	No
If yes please give details	
Impact on Safeguarding Adults	No

If yes please give details

Item for Decision, Consideration or Information
Decision

Recommendation

1. **The Health and Wellbeing Board (HWB) is asked to approve:**

    a) **the 2022 pharmaceutical needs assessment (PNA) for publication; and**
    b) **recommendations as noted in the PNA, including convening a Herefordshire and Worcestershire working group to focus on pharmacy services.**

Background

2. The HWB has responsibility for developing and updating PNAs (mandated in the Health and Social Care Act 2012). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs.

3. Due to COVID-19 pressures, the Department of Health and Social Care (DHSC) announced that the requirement to publish renewed PNAs in April 2021 would be suspended until October 2022.

Process taken to develop the PNA

4. A PNA working group was convened on 10 September 2021, and subsequently met on a regular basis to ensure the production of a robust PNA by October 2022. Members of the working group included representatives of:

    - Worcestershire County Council
    - NHS England West Midlands Region: NHS England is responsible for commissioning services under the national community pharmacy contract, for determining applications for pharmacy contracts,
    - Worcestershire Local Pharmaceutical Committee (LPC): This is the local statutory representative committee (LRC) for community pharmacies in Worcestershire.
    - Worcestershire Local Medical Committee (LMC): LMCs are statutory representative committees of general practitioners (GPs) who plan and provide health care in the community.
    - H&W Integrated Care Board (ICB, formally known as H&W Clinical Commissioning Group (CCG)): ICBs have responsibility for planning and commissioning health services.
    - Local Professional Networks (LPNs): The LPNs are intended to provide clinical input into the operation of NHS England West Midlands Region and local commissioning decisions.
    - Healthwatch Worcestershire: Healthwatch Worcestershire is the independent consumer champion for the public, patients and users of health and social care services in Worcestershire.

5. A draft PNA was developed and published for consultation for the statutory 60 day period from 13 June 2022 until 12 August 2022. Consultation was undertaken fully according to requirements, including Worcestershire residents, pharmacy and GP representatives, NHS representatives and neighbouring Health and Wellbeing Boards.

6. The consultation comments were thoroughly considered and incorporated into the document as appropriate.

7. The PNA working group approved this draft on 9 September 2022.

Methodology

8. The report was compiled from a variety of sources, including:

    - information on current provision of Pharmaceutical Services from commissioners and providers;
    - findings from a public survey gathering information about views on current provision of pharmaceutical services;
    - surveys of pharmacies and dispensing practices; and
    - focus groups of under-represented populations.

9. The focus groups were a new innovation aimed at gaining insights and data from populations who tend to be under-represented in traditional surveys, including

people with experience of substance misuse; people with long term health conditions; older people over the age of 75 years living independently; refugees and asylum seekers; carers; people with sensory impairments; people with mental health conditions and young people aged between 18-25 years.

10. The main findings and illustrative quotes from the focus groups were presented in relation to some areas of exploration: Access to pharmacy services, Impact of the COVID-19 pandemic: Advice and information: experiences of medication dispensing: access to and experience of other pharmacy services and experiences of these.

11. A variety of insights were obtained from the focus groups, for example: increased use of online and delivery services may be a positive legacy of the Covid-19 pandemic; pharmacists are well regarded, and participants valued their expertise in relation to advice on prescribed and over the counter medications; some lack of awareness of what services are available from pharmacies; (in some cases) a need to address barriers to accessing pharmaceutical services.

12. These quotes are not intended to be representative but give a flavour of the kind of comments received: **“I think they've come a long way in the last few years and then if you want to talk to a pharmacist, I think they all have private rooms now. So, you don't have to have those conversations in the middle of, you know a big queue of people”, “I think you’ve got to be prepared to be a little bit creative…It's not one size fits all for any of us…there are places that can just use a little bit of a brain and it doesn't take them any longer [to make their service accessible] once they've twigged.”, “Thankfully my local Pharmacy handled the crisis very efficiently, but it could definitely have been worse”**

Key Findings

13. Selected key findings from the report include:

    - This PNA concludes that currently there are sufficient numbers of pharmacies and that they are geographically accessible to the majority of the population of Worcestershire. However, the review does highlight potential reductions in access for rural locations, those reliant on public transport particularly during the weekends and those in full time employment and younger residents who were more likely to report using the pharmacy after 18:00pm.
    - The review highlights the importance of offering a range of access including online or telephone ordering and also the non-commissioned delivery service provided by some pharmacies.
    - Service users regarded pharmacists as knowledgeable and approachable professionals and experts in prescribed and over the counter medicines. Pharmacy services were praised for their continued professional service during the Covid-19 pandemic. Many of the pharmacies reported that they would provide additional services (advanced, additional, disease specific, screening and vaccination services) if they were to be commissioned.
    - Awareness of additional services offered by pharmacies was highlighted as a potential limiting factor to make better use of existing services offered. Effective communication with the public when advertising services and providing information should be considered with awareness of potential barriers within the local population served. These may include language / literacy barriers, digital exclusion and visual or hearing impairments.

- Health and wellbeing priorities proposed by the HWB and the NHS long term plan for integrated care are highlighted alongside current and future health and wellbeing needs of the Worcestershire population. Greater emphasis is put on topics where there is an opportunity for community pharmacies to meet the need including smoking cessation, screening, vaccination, management and assessment services, and further utilising the pharmacy service to address health needs of the population.

Recommendations of the PNA

14. The recommendations of the PNA are as follows:

    - Commissioners to continue considering how pharmaceutical service providers can address and respond to patient need as identified through the focus groups, engagement survey, paying particular consideration to access issues and accessibility of information about pharmacy services.
    - Commissioners and pharmaceutical service providers should consider how best to communicate with the public about services provided by community pharmacies. The formation of Herefordshire and Worcestershire Integrated Care System (ICS) provides an opportunity to consolidate and simplify provision of pharmacy information to the public.
    - Commissioners to encourage the integration of pharmacy with the wider healthcare economy to create coherent, system-wide services and pathways.
    - All providers of pharmaceutical services should consider language accessibility, including translation and interpreting services for people whose first language is not English, and staff training to increase awareness of the needs of different people using the service
    - The role of pharmacies in the prevention and management of CVD risk factors could be strengthened through commissioning related services.
    - Pharmacies should be aware of how to signpost to other service providers (including, where relevant, voluntary/community sector organisations, other pharmacies providing advanced/enhanced services).
    - Pharmacy workforce strategy should be considered by the local system to ensure current and future pharmaceutical service demand can be met.
    - A working group to be convened to monitor and implement these recommendations.

Legal, Financial and HR Implications

15. There are no legal, financial or HR implications arising from this report. Any future financial implications with regard to procurement of a new self-service data system will be considered by Worcestershire County Council as required.

Privacy Impact Assessment

16. There is no required privacy impact assessment at this stage.

Equality and Diversity Implications

17. An Equality Relevance Screening has been completed in respect of these recommendations. The screening did not identify any potential Equality considerations requiring further consideration during implementation.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
Name: Matthew Fung, Public Health Consultant
Tel: 01905 845040
Email: mfung@worcestershire.gov.uk

Supporting Information

1. PNA 2022 main document
2. PNA 2022 appendices – available online

This page is intentionally left blank

Worcestershire Pharmaceutical Needs Assessment 2022

October 2022

Produced in accordance with the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013

Contents

Executive Summary

This is the third pharmaceutical needs assessment (PNA) prepared on behalf of the Worcestershire Health and Well-being Board (HWB). The document is structured in three sections, Parts A, B and C. Part A of the assessment evaluates the current provision of pharmaceutical services within Worcestershire. Part B summarises the current and future health and well-being needs of the Worcestershire population. Part C then determines gaps in provision by considering Part A (Current provision) and Part B (Population health needs). It also highlights opportunities for service development.

To review the current provision of pharmaceutical services within Worcestershire, the PNA assesses if there are sufficient pharmacies for the population of Worcestershire, if they provide sufficient services for the population of Worcestershire, and if they are sufficiently accessible for the population of Worcestershire. This assessment considers the population per pharmacy, maps the geographical locations of services, and collates service user (online survey and focus groups) and provider (online survey) views.

This PNA iteration concludes that currently there are sufficient numbers of pharmacies and that they are geographically accessible to the majority of the population of Worcestershire. However, the review does highlight potential reductions in access for rural locations, those reliant on public transport particularly during the weekends and those in full time employment and younger residents who were more likely to report using the pharmacy after 18:00pm. The review highlights the importance of offering a range of access including online or telephone ordering and also the non-commissioned delivery service provided by some pharmacies.

Service users regarded pharmacists as knowledgeable and approachable professionals and experts in prescribed and over the counter medicines. Pharmacy services were praised for their continued professional service during the covid-19 pandemic. There was high satisfaction with the range of services offered and many of the pharmacies reported that they would provide additional services (advanced, additional, disease specific, screening and vaccination services) if they were to be commissioned. Awareness of additional services offered by pharmacies was highlighted as a potential limiting factor to make better use of existing services offered. Effective communication with the public when advertising services and providing information should be considered with awareness of potential barriers within the local population served. These may include language / literacy barriers, digital exclusion and visual or hearing impairments.

Health and wellbeing priorities proposed by the Health and Wellbeing Board and the NHS long term plan for integrated care are highlighted alongside current and future health and well-being needs of the Worcestershire population. Greater emphasis is put on topics where there is an opportunity for community pharmacies to meet the need including smoking cessation, screening, vaccination, management and assessment services. Consideration to the variation in need between districts and populations is addressed. Recommendations to evolve the pharmacy service in Worcestershire include focusing on effective and inclusive communication methods to raise awareness of available services; continuing to address barriers to access such as transport and opening times; adapting to new technologies to evolve service, whilst considering digital inclusion; and further utilising the pharmacy service to address health needs of the population.

Introduction

This is the third pharmaceutical needs assessment (PNA) prepared on behalf of the Worcestershire Health and Well-being Board (HWB) and builds on the previous two assessments from 2015 and 2018. There have been a number of changes to pharmaceutical services since the publication of the 2018 PNA which are reflected in this latest assessment. Whilst the dispensing of prescriptions continues to be an essential provision, pharmaceutical services extend to promoting health and wellbeing, acting as a community hub for health information and advice, and offering face to face appointments for a range of health issues, treatments, and vaccinations.

We are excited to present in this PNA the findings from a number of bespoke focus groups, set up specifically with the task of hearing directly from a range of people in the community. This level of insight has provided a unique opportunity to understand more fully the experiences of some of Worcestershire's communities and highlights the opportunities and challenges for pharmacy provision. The PNA presents an opportunity for representatives of community pharmacy and service commissioners to explore together how the development of "pharmaceutical services" can further help to deliver the new priorities of the HWB in Worcestershire. The information included throughout is the most current available as at Oct 2022.

This introductory section of the assessment will begin by describing what a PNA is. It will then outline the aims of the PNA and explain the legislative foundation for its content and publication. The members of the PNA working group are listed along with details of the process of development. Finally in this section, the 7 statements of assessments that are required by legislation are stated with a summary of the applicable findings from this review.

What is a Pharmaceutical Needs Assessment?

A Pharmaceutical Needs Assessment (PNA) is a process of reviewing pharmaceutical service need and provision within counties in England. This assessment reviews the location and specific provision of services across Worcestershire. The development of this PNA was achieved through various engagement activities to ensure valuable input was obtained from key stakeholders whilst ensuring the 2013 regulations for engagement were met. These activities have included:

1. Regular working group meetings
2. Distribution of contractor questionnaires
3. Distribution of public questionnaires
4. Focus groups of population groups who are often under-represented in responses to public questionnaires

Current pharmaceutical services locally include dispensing of prescriptions by community pharmacies, dispensing doctors and other providers, as well as a range of other services provided by community pharmacies. Details of providers of pharmaceutical services were obtained from NHS England and Herefordshire and Worcestershire LPC. The localities defined in the 2018 PNA were used as they were still relevant and would facilitate cross referencing with the PNA and use of geographic, demographic and health and social information.

The main aim of the PNA is to establish and review the current NHS pharmaceutical services provided to the local population ensuring that current and future services are of good quality, are easily accessible, meet local health and pharmaceutical needs and provide good use of NHS financial resources. The report identifies gaps in services, unmet needs, provides recommendations to the Health and Wellbeing Board, and NHS England/Improvement that can provide a basis for decisions

about future provision. Particularly this year the PNA will report on the impacts of the COVID-19 pandemic on the provision and accessibility of pharmaceutical services within Worcestershire.

The responsibility for producing PNAs (Pharmaceutical Needs Assessments) transferred from Primary Care Trusts (PCTs) to HWBs (Health and Wellbeing Boards) in 2012. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (The 2013 Regs) of April 2013 state that Health and Wellbeing Boards (HWB) must produce their first PNA by no later than 1st April 2015, and every 3 years thereafter. The last Worcestershire PNA was published in March/April 2018 and was due for refresh by April 2021. However, in light of the COVID-19 pandemic and subsequent pressure on resources, NHS England has extended the deadline for publication of the PNA to October 2022.

Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list, transferred from PCTs to NHS England from 1 April 2013. Under the Act, the Department of Health has powers to make Regulations. Regulations 3-9 and Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services)

The 2013 Regulations set out the legislative basis for developing and updating PNAs and can be found here: http://www.legislation.gov.uk/uksi/2013/349/contents/made

HWBs became statutory bodies from April 1, 2013. Each Local Authority (LA) has an HWB. The Worcestershire HWB is based at the Council Offices in Worcester. HWBs do not commission services directly but rather they oversee the system for local health commissioning. They have a wide remit across the health and care system, providing strategic oversight and bringing together all the local commissioners. The HWB must produce a Joint Health and Well-being Strategy (JHWS) based on the findings of a local Joint Strategic Needs Assessment (JSNA). LAs and Clinical Commissioning Groups (CCGs that are now Hereford and Worcestershire Integrated Care Board since July 1st 2022) have equal and joint responsibility for producing the JSNA. The JSNA and the JHWS inform the preparation of the PNA.

The content of PNAs is set out in Regulation 4 and Schedule 1 of The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The minimum content requirements for PNAs are:

1. The pharmaceutical services provided that are necessary to meet needs in the area
2. The pharmaceutical services that have been identified by the HWB that are needed in the area, and are not provided (gaps in provision)
3. The other services which are provided, which are not needed, but which have secured improvements or better access to pharmaceutical services in the area
4. The services that the HWB has identified as not being provided, but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area
5. Other NHS services provided by a LA, NHS England, a CCG or an NHS Trust, which affect the needs for pharmaceutical services
6. Explanation of how the assessment has been carried out (including how the consultation was carried out)
7. Map of providers of pharmaceutical services

The HWB has delegated responsibility for the development of the PNA to a working group. Members include representatives of:

- Worcestershire County Council (WCC) To ensure that services the Council provides meet the needs of residents and those who work in the county.
- NHS England West Midlands Region: NHS England is responsible for commissioning services under the national community pharmacy contract, for determining applications for pharmacy contracts, the commissioning of enhanced services for pharmacy, contract monitoring, pharmacy opening hours and pharmacy rota arrangements, unwanted medicines returned to pharmacies and their appropriate collection and disposal plus Electronic Prescription Service (EPS) support.
- Worcestershire Local Pharmaceutical Committee (LPC): This is the local statutory representative committee (LRC) for community pharmacies in Worcestershire.
- Worcestershire Local Medical Committee (LMC): LMCs are statutory representative committees of general practitioners (GPs) who plan and provide health care in the community.
- Clinical Commissioning Groups (CCGs): CCGs have responsibility for planning and commissioning health services.
- Local Professional Networks (LPNs): The LPNs are intended to provide clinical input into the operation of NHS England West Midlands Region and local commissioning decisions. They help to develop the community pharmacy role in supporting self-care, managing long term conditions, promoting medicines optimisation and developing services commissioned locally by local authorities and CCGs and highlighting inappropriate gaps or overlaps.
- Healthwatch Worcestershire: Healthwatch Worcestershire is the independent consumer champion for the public, patients and users of health and social care services in Worcestershire.
- For a full list of members and the Terms of Reference of the PNA working group see Appendices 1 and 2.

Process of PNA Development

Figure 1: Process of PNA Development

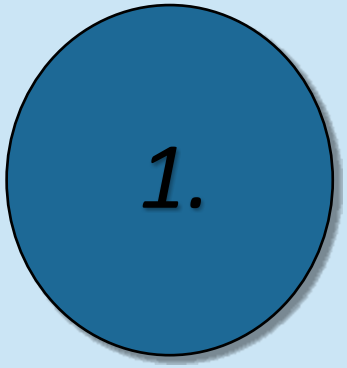
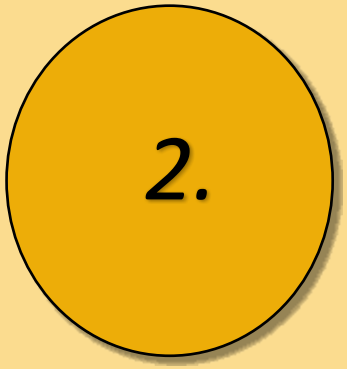
The picture of current service provision is presented in Part A of the PNA. The next section, Part B, looks at local health needs and priorities. Part C considers the summary of current provision of pharmaceutical services alongside the health needs of the population and identifies where current service provision may be deemed to be inadequate. This highlights potential gaps or "pharmaceutical needs". An additional element has been the collection of qualitative data from focus groups of

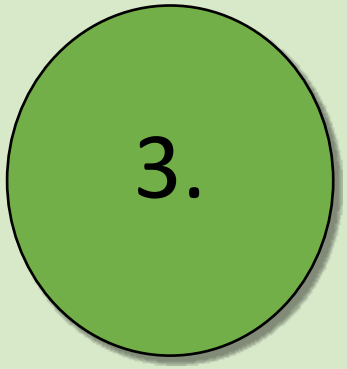
populations who are not always reached by traditional surveys. This has provided a rich source of information which can help in developing services.

The PNA then considers how the needs and service gaps that have been identified could be met by the provision and development or extension of existing pharmaceutical services. In this way the PNA acts as a steer for planning and commissioning of relevant future services including whether new pharmacies should be allowed to open, or GP practices allowed to dispense as defined within the Pharmaceutical Services Regulations. HWBs must consult during the process of developing the PNA for a minimum period of 60 days. The responses received during this period have been considered and incorporated into this report.

Assessments required within the pharmaceutical needs assessment (Regulations 2013)

NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (reg.4, schedule 1) provisions require certain assessments to be made within the PNA. These are described in the following table summary.

Statement	Description	Response
	<u>Current provision of necessary services</u> A statement of the pharmaceutical services that the health and wellbeing board (HWB) has identified as services that are provided: • In the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and • Outside the area of the HWBB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services)	It has been assessed that there is currently sufficient provision of pharmacies and dispensing GP practices through Worcestershire who deliver essential pharmaceutical services. There are 95 pharmacies and 21 dispensing GP practices in Worcestershire which serve a mixed urban and rural population of 598,070 people. This equates to one pharmacy per 6,295 people which is higher than the England average of one pharmacy per 5,056 people. When GP dispensing practices are included the difference with England is reduced, with one contractor per 5,154 people compared to one contractor per 4,605 people in England.
	<u>Gaps in provision of necessary services</u> A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied: • Need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area. • Will in specified future circumstances, need to be provided (whether or not they are located in the area of the HWBB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.	Travel time analysis indicates very good access to services by car (the entire population lives within a 30-minute journey by car to a pharmacy or GP dispensing practice but poorer access on foot or by public transport, particularly in more rural areas.

Statement	*Description*	*Response*
	<u>Current provision of other relevant services</u> A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided: • In the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area. • Have secured improvements, or better access, to pharmaceutical services in its area. • Outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area. • In or outside the area of the HWBB and, whilst not being services of the types described above, they nevertheless affect the assessment by the HWBB of the need for pharmaceutical services in its area	All the pharmacies surveyed offered the new medicine service. Based on contractor survey results (covering 70% of pharmacies), the provision of selected advanced services (appliance use review service, stoma appliance customisation, hypertension case finding, community pharmacist consultation service and flu vaccination service) varies across Worcestershire districts. This is due to differences in commissioning across the county. In general, a larger range of service were offered within the districts of Bromsgrove and Redditch, with a lower variety offered in Malvern Hills. There was a low provision of screening and vaccination services (apart from seasonal flu vaccinations) across the county, which may indicate that more of these should be commissioned where there is a need identified. Many of the pharmacies reported that they would provide the advanced, additional, disease specific, screening and vaccination services if they were to be commissioned.

Statement	*Description*	*Response*
	<u>Improvements and better access, gaps in provision</u> A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied: • Would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type in its area • Would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area	No such services have been identified in this assessment.
	<u>Other NHS services</u> A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG (Clinical Commissioning Group), an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect: • The need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or • Whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or	Locally commissioned Services include NHSE – Extended Care. NHSEI Midlands has extended the local enhanced service (LES) agreements for Tier 1 and 2 of the Extended Care Services for the financial year 2022/2023. The service is currently provided through Community Pharmacies contracted to NHS England & Improvement Midlands Region who have signed this local enhanced service agreement to provide this service.

	pharmaceutical services of a specified type, in its area	Worcestershire County Council commissions the following services from local designated pharmacies: 1. Needle and Syringe Exchange (through Cranstoun) 2. Supervised Methadone and Buprenorphine Consumption (through Cranstoun) 3. Emergency Hormonal Contraception (under Patient Group Direction (PGD) through the Worcestershire Health and Care Trust) and oral contraceptive services. 4. Disposal of patient used sharps (directly commissioned) Herefordshire and Worcestershire CCG commissions the following services: • Herefordshire Worcestershire Community pharmacy palliative care medicines hubs. • Urgent Access Medicines Scheme Analysis indicates adequate provision of these services across the county. These services are described in detail on page 9. The pharmacy survey indicates that pharmacies would be willing to provide the following additional services if commissioned: Healthy Start Vitamins (75% of pharmacies would provide), Stop Smoking Service (74%), Chlamydia Treatment Service (72%), Chlamydia Testing service (72%) and Vascular Risk Assessment Service (71%).
Statement	***Description***	***Response***

6.	<u>How the assessment was carried out</u>
	An explanation of how the assessment has been carried out, and in particular:
	• How it has determined what are the localities in its area.
	• How it has taken into account (where applicable)
	  ○ the different needs of different localities in its area, and
	  ○ the different needs of people in its area who share a protected characteristic; and
	• A report on the consultation that it has undertaken.
		The 2022 PNA has assessed pharmaceutical needs and service provision within Worcestershire at county and district level. Needs of different localities have been considered, and evidence and intelligence gathered on people with protected characteristics.
		
		This has been further enhanced through focus group findings within a number of community groups.
		
		A consultation report summary is provided in Appendix 12.

7.	<u>Map of provision</u> A map that identifies the premises at which pharmaceutical services are provided in the area of the HWBB	A number of maps have been provided in Appendices 9a-9h which detail the location of each pharmacy at a locality level and the location of dispensing GP practices across the county. In addition, in Part B there are maps showing pharmaceutical services in relation to travel times and rurality.

Part A

Necessary Services and Current Provision

The Part A section of the PNA begins by assessing the current provision of pharmaceutical services within Worcestershire. It does this by comparing population per pharmacy in each district to that of England. It then details the different types of contract and services that are provided throughout pharmaceutical services in the county. Geographical location of pharmaceutical services is then evaluated using SHAPE to produce a series of maps to illustrate various travel times to pharmacies and dispensing practices in Worcestershire.

Results from 3 online surveys devised to gather public, service-user, pharmacy and dispensing practices views on current provision are reported and results discussed. Finally, a series of seven focus groups were undertaken by Voluntary, Community and Social Enterprise (VCSE) organisations in Worcestershire. This is the first time this kind of data has been incorporated into the Pharmaceutical Needs Assessment for Worcestershire. It was intended both to provide an additional data source to triangulate findings from the surveys and also to gain a richer understanding of the perspectives of the population using these services.

Current Provision

To assess the adequacy of provision of pharmaceutical services, current provision by all providers has been reviewed. This includes providers and premises within Worcestershire and the contribution made by those that may lie outside in neighbouring Health and Wellbeing Board (HWB) areas but who provide the services to the population within Worcestershire.

Examples of this type of service provider are pharmacies, distance-selling pharmacies (those which provide pharmaceutical services but not face-to-face on the premises), dispensing appliance contractors and dispensing GP practices.

Table 1 shows population coverage for pharmaceutical services by council district. Worcestershire has 95 pharmacies (including 3 online and 7 100-hour), providing an average of one pharmacy per 6295 people per pharmacy, compared to 5056 in England. When GP dispensing practices are included the gap with England is reduced, with an average of one contractor per 5154 people compared to 4608 in England. At district level Worcester has the lowest population per pharmacy and Wychavon the highest.

GP dispensing practices are invaluable in improving access in rural areas, for example in the relatively rural Wychavon district, the addition of dispensing practices makes a significant difference in population per pharmacy.

Table 1: Number of pharmacies and dispensing practices by council district

	Pharmacies	Dispensing practices	Total contractors	Population per pharmacy (England=5056)	Population per contractor (England=4605)
Worcestershire	95 (including 3 online and 7 100-hour pharmacies)	21	116	6295	5154
Bromsgrove	15	3	18	6704	5586
Malvern Hills	14	4	18	5674	4405
Redditch	16 (including 2 online)	1	17	5348	5025
Worcester	20 (including 1 online)	1	21	5013	4784
Wychavon	14	9	23	9363	5714
Wyre Forest	16	3	19	6321	5319

Source: NHS digital, local data

Prescribing activity

Financial Year	Dispenser Account Type	Prescription Items dispensed	Actual Cost
2021/2022	Dispensing Doctor	2,114,584	£12,503,652.96
2021/2022	Personal Administration	162,143	£2,133,694.65
2021/2022	Pharmacy	9,323,264	£79,070,200.75

The dispensing figures are for the number of prescription items which are prescribed and dispensed within the same county in which the prescription was generated as an indicator of the volume of activity. Personally administered items are where GP practices can submit prescriptions for specific medicines only which are used in the course of practice-based treatments.

Table 2: Number and proportion of pharmacies open early and late on weekdays and open at weekends

	All Pharmacies	Open Early	Open Early %	Open Late	Open Late %	Open Sat	Open Sat %	Open Sun	Open Sun %
Bromsgrove	15	8	53.3%	11	73.3%	15	100.0%	3	20.0%
Malvern Hills	14	2	14.3%	3	21.4%	11	78.6%	2	14.3%
Redditch	16	10	62.5%	7	43.8%	11	68.8%	5	31.3%
Worcester	19	11	57.9%	5	26.3%	18	94.7%	3	15.8%
Wychavon	14	11	78.6%	5	35.7%	12	85.7%	3	21.4%
Wyre Forest	17	13	76.5%	10	58.8%	13	76.5%	5	29.4%
Worcestershire	**95**	**55**	**57.9%**	**41**	**43.2%**	**80**	**84.2%**	**21**	**22.1%**

* Open early: open at least one weekday before 9:00am, open late: open at least one weekday after 18:00pm.

- Over a half of pharmacies in Bromsgrove are open early at least one weekday, whilst almost three quarters are open late in the evening after 18:00 on a weekday.
- All pharmacies in Bromsgrove are open on Saturdays, although the proportion open on a Sunday is relatively low at 20%.
- Less than 15% of pharmacies in Malvern Hills are open early at least one weekday, just over 20% are open late in the evening after 18:00 on a weekday.
- Less than 80% of pharmacies in Malvern Hills are open on Saturdays, and less than 15% are open on a Sunday.
- Over 60% of pharmacies in Redditch are open early at least one weekday, whilst over 40% are open late in the evening after 18:00 on a weekday.
- Less than 70% of pharmacies in Redditch are open on Saturdays, and almost a third are open on a Sunday.
- Almost 60% of pharmacies in Worcester are open early at least one weekday, whilst just over a quarter are open late in the evening after 18:00 on a weekday.
- Almost 95% of pharmacies in Worcester are open on Saturdays, and less than 16% are open on a Sunday.
- Almost 80% of pharmacies in Wychavon are open early at least one weekday, whilst over 35% are open late in the evening after 18:00 on a weekday.
- Over 85% of pharmacies in Wychavon are open on Saturdays, and over 20% are open on a Sunday.
- Over three quarters of pharmacies in Wyre Forest are open early at least one weekday, whilst almost 60% are open late in the evening after 18:00 on a weekday.
- Just over three quarters of pharmacies in Wyre Forest are open on Saturdays, and almost 30% are open on a Sunday.

NHS pharmaceutical services

Pharmaceutical services are provided under arrangements made by NHS England for:

- The provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list.

- The provision of local pharmaceutical services under an LPS scheme. A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements.
- The dispensing of drugs and appliances by a person on a dispensing doctors list.

Pharmaceutical lists

If a person (a pharmacist, a dispenser of appliances, or dispensing doctor) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by NHS England. This is commonly known as the NHS "market entry" system.

Dispensing Doctors

A Dispensing Doctor is a General Practitioner (GP) who under regulation can dispense medication to patients in their care. Only the provision of those services set out in their pharmaceutical services terms of service (Schedules to the 2013 Regulations) is included within the definition of pharmaceutical services and relates only to the dispensing of medicines.

Distance selling (internet) pharmacies

Distance selling pharmacies do not have a local presence in the community as they do not have a community pharmacy premises that service users can readily access. They are internet based and as a result provide a service to users across the country irrespective of the locality in which the pharmacy is based.

Dispensing Appliance Contractors

Dispensing Appliance Contractors supply appliances such as stoma bags and accessories, continence bags and catheters and wound management dressings. They do not dispense medicines.

Community pharmacy contract

Community pharmacies, still often referred to colloquially as "chemists", provide pharmaceutical services under the NHS Community Pharmacy Contractual Framework(contract).

Essential services

A summary of the essential services is given below, more detailed information is provided in Appendix 8a.

Discharge Medicines Service

The Discharge Medicines Service (DMS) became a new Essential service within the Community Pharmacy Contractual Framework (CPCF) on 15th February 2021. This service, which all pharmacy contractors have to provide, was originally trialled in the 5-year CPCF agreement, with a formal announcement regarding the service made by the Secretary of State for Health and Social Care in February 2020.

Dispensing 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".

Dispensing 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. The Electronic Prescription Service (EPS) is also being implemented as part of the dispensing service.

Disposal of unwanted medicines

Pharmacies are obliged to accept back unwanted medicines from patients. The local NHS England and NHS Improvement team will make arrangements for a waste contractor to collect the medicines from pharmacies at regular intervals.

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 and NHS Improvement (NHSE&I). This generally involves the display and distribution of leaflets provided by NHSE&I.

Repeat Dispensing/electronic Repeat Dispensing (eRD)

At least two thirds of all prescriptions generated in primary care are for patients needing repeat supplies of regular medicines, and since 2005 repeat dispensing has been an Essential Service within the Community Pharmacy Contractual Framework (CPCF).

Managed repeats

The provision of regular medicines to patients is facilitated by a variety of different mechanisms and these repeat medication services offer benefits, choice and flexibility to patients.

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, for example other healthcare professionals or care providers when appropriate. The service also includes referral on to other sources of help such as local or national support groups.

Support for Self-Care

The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service.

Advanced services

Activity data for Pharmacy and Appliance Contractors by STP for Advanced Services for April-December 2021, Herefordshire and Worcestershire STP

Advanced Service	Pharmacy contractors	Appliance contractors
New Medicine Service (NMS) interventions declared	14332	0
Appliance Use Reviews (AURs) conducted in user's home	0	84
Appliance Use Reviews (AURs) conducted at premises	0	57
Stoma Customisation Fees	88	10279
Community Pharmacist Consultation Service (CPCS) Fees	5364	0
Community Pharmacy Hepatitis C Antibody Testing Service Fees	0	0
Community Pharmacy Completed Transactions for Covid-19 Lateral Flow Device Distribution Service	221366	0
Community Pharmacy Clinic Blood Pressure checks	11271 (started Oct 2021)	0
Community Pharmacy Ambulatory Blood Pressure Monitoring (ABPM)	59(started Oct 2021)	0
Community Pharmacy Seasonal Influenza Vaccination Advanced Service Fees	40203	0
Community Pharmacy Claims associated with initial local engagement in preparation for delivering GP referral pathway of the CPCS	0 (started late 2021, data to follow)	0

NB. 80% of pharmacies are in Worcestershire. Fees may not correspond exactly with the number of services provided but will give a good guide.

A short summary of the advanced services is given below, more detailed information is provided in Appendix 8a.

Appliance Use Review (AUR)

Appliance Use Reviews (AURs) can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. Alternatively, where clinically appropriate and with the agreement of the patient, AURs can be provided by telephone or video consultation, in circumstances where the conversation cannot be overheard by others (except by someone whom the patient wants to hear the conversation, for example a carer).

Community Pharmacist Consultation Service (CPCS)

The service, which replaced the NUMSAS and DMIRS pilots, connects patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy.

The service takes referrals to community pharmacy from NHS 111 (and NHS 111 online for requests for urgent supply and minor illness), Integrated Urgent Care Clinical Assessment Services and in some cases patients referred via the 999 service.

The CPCS aims to relieve pressure on the wider NHS by connecting patients with community pharmacy, which should be their first port of call and can deliver a swift, convenient and effective service to meet their needs.

As of August 2022, 91 of the 95 pharmacies in Worcestershire are registered for CPCS.

GP Community Pharmacist Consultation Service (GPCPCS)

From 1st November 2020, the CPCS was extended across England to include referrals from general practices for minor illness only as well as from NHS 111. Unlike NHS 111, GPs cannot refer patients for an urgent supply of a medicine or appliance).

The purpose of the GP CPCS is to reduce the burden on general practices by referring patients needing advice and treatment for certain low acuity conditions from a GP practice to a community pharmacist. The aim is for community pharmacists to work closely with the local GP teams to reduce pressure on GP appointments.

Flu Vaccination Service

Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015. Each year from September 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. The accessibility of pharmacies, their extended opening hours and the option to walk in without an appointment have proved popular with patients seeking vaccinations.

In the 2021/22 flu season, 52,902 flu vaccines were dispensed via pharmacies in the Herefordshire and Worcestershire STP area. It is estimated that nearly a quarter of all flu vaccines in the area were administered by pharmacies.

Hepatitis C testing service

The Community Pharmacy Hepatitis C Antibody Testing Service was added to the Community Pharmacy Contractual Framework (CPCF) in 2020, commencing on 1st September. The introduction of this new Advanced Service was originally trialled in the 5-year CPCF agreement, but its planned introduction in April 2020 was delayed by five months because of the COVID-19 pandemic.

Hypertension case-finding service

The Hypertension case-finding service was commissioned as an Advanced service from 1st October 2021. The 5-year Community Pharmacy Contractual Framework (CPCF) agreement reached in July 2019 included a plan to pilot case finding for undiagnosed cardiovascular disease.

As of August 2022, 60 of the 95 pharmacies in Worcestershire were signed up to provide this service.

New Medicine Service

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. It is designed to improve patients' understanding of a newly prescribed medicine for a long-term condition and to help them get the most from their medicines.

Research has shown that after 10 days, two thirds of patients prescribed a new medicine reported problems including side effects, difficulties taking the medicine and a need for further information. The New Medicine Service (NMS) has been designed to fill this identified gap in patient need.

Smoking Cessation Service

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.

As of August 2022, 14 of the 95 pharmacies in Worcestershire were signed up to provide this service.

Locally commissioned services

Pharmaceutical services for the purpose of a PNA do not include any services commissioned directly from pharmaceutical contractors by local authorities (LAs) or Clinical Commissioning Groups (CCGs). However, a decision was made by the PNA Working Group to include in the PNA all additional services. Further information is in Appendix 8a.

NHSE Commissioned Services

NHSE – Extended Care

NHSE Midlands has extended the local enhanced service (LES) agreements for Tier 1 and 2 of the Extended Care Services for the financial year 2022/2023. The service will be provided through Community Pharmacies contracted to NHS England & Improvement Midlands Region who have signed this local enhanced service agreement to provide this service

NHS England Midlands commission a service from pharmacies who have signed up to provide pharmaceutical advice and treatment through a Patient Group Direction (PGD) for specific conditions:

- Advice and treatment of simple UTI service for females aged 16-64 years (Tier 1)
- Acute bacterial conjunctivitis (ABC) service for children under 2 years. (Tier 1)
- Advice and treatment for suspected impetigo, infected insect bites and infected eczema. (Tier 2)

As of August 2022, there are 43 pharmacies in Worcestershire providing tier 1 services), of which 37 also provide tier 2 services. Further information on this service is given in Appendix 8a.

NHSE – COVID-19 Vaccination Programme

During the COVID-19 pandemic community pharmacies adapted to changing needs in the population and began providing COVID-19 vaccinations in addition to maintaining normal provision of services. The COVID-19 vaccination programme was hugely successful with community pharmacies having played a critical role delivering 8.9% of vaccinations in total (1,344,661 Overall total vaccinations delivered as of 24/08/22 in Worcestershire, of which 119.933 were delivered by community pharmacies). They have also helped to address vaccine inequalities and improve vaccination take-up through strong relationships within local populations. This service is evolving and adapting to need whilst the programme continues.

Local Authority Commissioned Services

A summary is provided below, further information is given in Appendix 8a.

Providing needle syringe programme

The service provides managed access to sterile needles and syringes, sharps containers and associated materials (including citric acid and swabs), in exchange for the return of used injecting equipment wherever reasonably practicable. This increases the availability of the service across the area and greater flexibility in terms of the hours that the service is available.

Supervised Consumption

Methadone and Buprenorphine are suitable substitutes for withdrawal from opiates and are beneficial in terms of harm reduction. This service allows pharmacists to supervise the consumption of methadone and buprenorphine to service-users at the point of such medicines being dispensed by the pharmacy ensuring that the correct dose has been administered to the service user and that it has been consumed in its entirety.

Emergency Hormonal Contraception (under Patient Group Direction (PGD) through the Worcestershire Health and Care Trust)

81 pharmacies provide EHC (listed in Appendix 8a). Those who wish to access this service should contact the pharmacy before visiting to make sure someone is on duty who is qualified to issue emergency contraception free of charge.

COC Service (Combined Oral Contraceptive)

There are 13 pharmacies signed up to provide the service (listed in Appendix 8a).

POP Service (Progesterone Only Pill)

12 pharmacies are signed up to provide this service (listed in Appendix 8a).

Disposal of patient used sharps (directly commissioned)

The aims of the service are to: reduce the risk of needle stick injury in the community, reduce the inappropriate disposal of patient's personal used sharps and to provide a safe, secure and convenient means of disposal of patient's personal sharps. 65 pharmacies were participating in this service in 2021/22.

Herefordshire and Worcestershire CCG commissioned services

Herefordshire Worcestershire Community pharmacy palliative care medicines hubs

All NHS community pharmacies will stock medicines commonly used in palliative care. NHS Herefordshire Worcestershire CCG has commissioned 35 NHS community pharmacies to always keep in stock an agreed list of medicines which may be accessed urgently if required. Having good and convenient access to these medicines means that patients can have the medicines at home they may need and if appropriate can remain in their place of choice.

Urgent Access Medicines Scheme

NHS Herefordshire and Worcestershire has commissioned 35 community pharmacies to keep in stock a particular antibiotic which is required to commence treatment promptly to treat an infection C. Difficile which would otherwise involve a hospital admission.

Access to Antiviral medicines for outbreaks of flu in the out of season period.

Nine NHS community pharmacies are commissioned to hold in stock a range of antiviral medicines which need to be accessed promptly to commence supportive treatment for early out of season outbreaks of flu.

Support for the safe management of medicines in quarantine/ isolated settings

NHS Herefordshire and Worcestershire CCG has commissioned using community pharmacies a service whereby patients are being managed in a self- contained setting to receive pharmaceutical advice and supply of medicines for short term conditions where self-care has been clinically appropriate.

Transportation of COVID-19 vaccines within NHS Herefordshire and Worcestershire ICS

To maximise the uptake and availability of vaccinations of COVID-19 a community pharmacy has transferred vaccine stocks between vaccination sites in line with national directives on COVID-19 vaccination movements thereby maintaining detailed cold chain requirements for vaccine integrity. This is a specific service commissioned by NHS Herefordshire and Worcestershire CCG which has played a significant role within the vaccine programme in both counties.

Healthy Living Pharmacy

The Healthy Living Pharmacy (HLP) concept was developed by the Department of Health with the aim of achieving consistent delivery of a broad range of health improvement interventions through community pharmacies to meet local needs, improve the health and well-being of the local population and to help reduce health inequalities. In 2020/21 as agreed in the 5-year CPCF, it is now an Essential Service requirement for community pharmacy contractors to become a HLP.

What is an HLP?

HLP is an organisational development framework underpinned by three enablers of:

1. Workforce Development – A skilled team to pro-actively support and promote behaviour change and improve health and wellbeing, including a qualified Health Champion who has undertaken the Royal Society for Public Health (RSPH) Level 2 Award 'Understanding Health Improvement', and a team member who has undertaken leadership training.
2. Engagement – Local stakeholder engagement with other health and care professionals (especially general practice), community services, local authorities and members of the public; and
3. Environment (Premises Requirements) – Premises that facilitate health promoting interventions with a dedicated health promotion zone.

The Pharmacy Access Scheme

In December 2016 the Government introduced the Pharmacy Access Scheme (PhAS). The stated aims are to support access where pharmacies are sparsely spread, and patients depend on them most. Qualifying pharmacies receive additional monthly payments (PhAS payments).

Geographical location of pharmaceutical services

A number of maps have been provided in Appendices 9a-9h which detail the location of each pharmacy at a locality level and the location of dispensing GP practices across the county.

Travel time to pharmacy and dispensing practice (maps)

Strategic Health Asset Planning and Evaluation (SHAPE) is a web enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy. SHAPE is managed by OHID (Office for Health Improvement and Disparities) within the Department of Health and Social Care. The SHAPE tool can be accessed at shapeatlas.net.

SHAPE has been used to produce a series of maps to illustrate various travel times to pharmacies and dispensing practices in Worcestershire. For each map, the areas shaded in green have access to a pharmacy or dispensing practice by car within each time period stated. Each number represents the total number of pharmacies/dispensing practices within that geographical area. Larger numbers indicate more pharmacies/dispensing practices in a given area.

We were not able to map travel times to pharmacies outside of Worcestershire, and we would expect there to be some cross border flows.

Table 3: Population within 5/10/20 minutes travel time by car to pharmacies/dispensing practices within Worcestershire

Travel time by car	Estimated Worcestershire population with access to a community pharmacy	Estimated Worcestershire population with access to a community pharmacy or dispensing practice
5 minutes	493,952	518,572
10 minutes	581,207	590,956
20 minutes	599,222	599,222

According to this analysis the entire population of Worcestershire lives within a 20-minute car journey to a pharmacy or GP dispensing practice. The following maps show the populations within a travel time or 5 or 10 minutes.

Figure 2: 5-minute travel time (car) to pharmacies/dispensing practices within Worcestershire

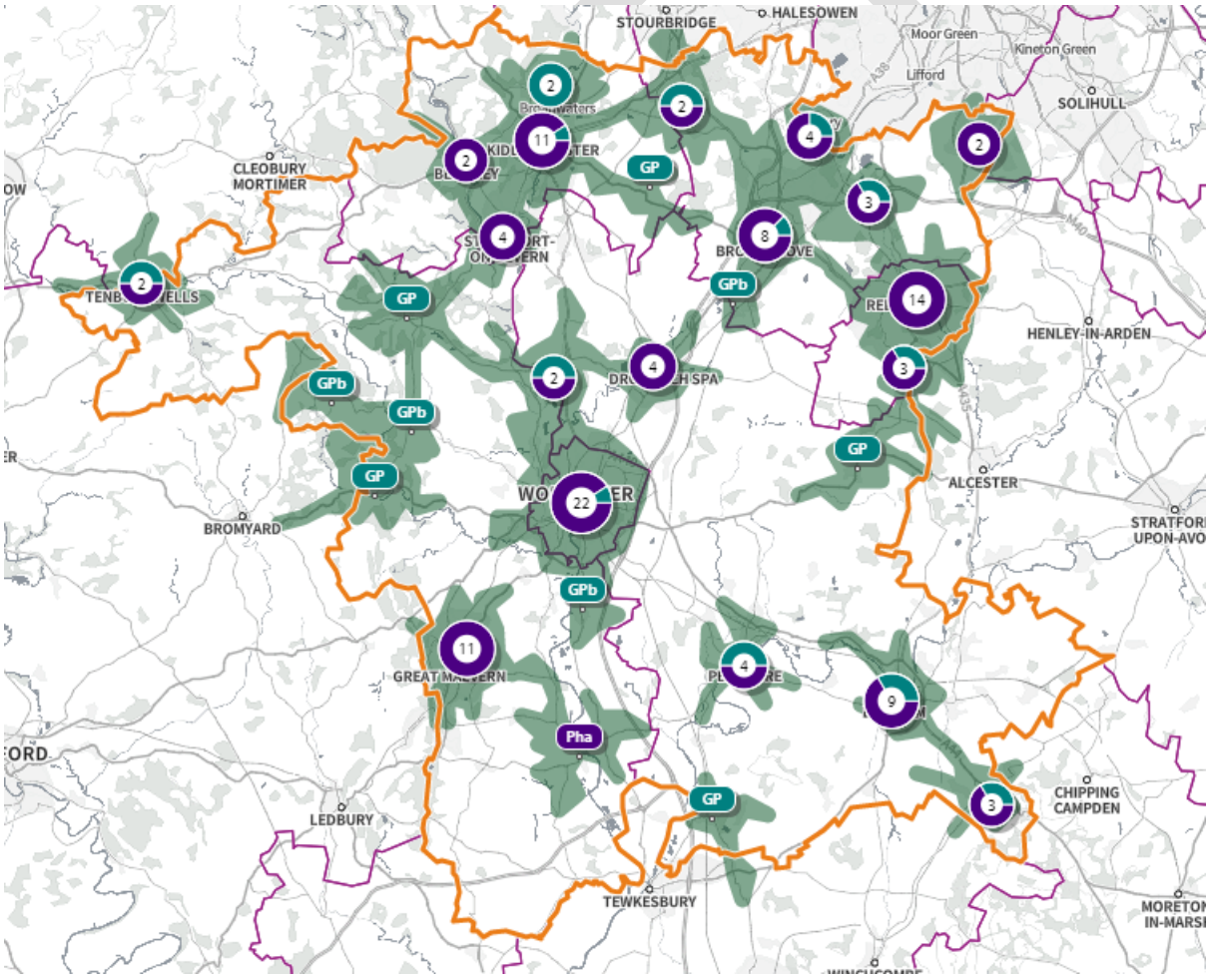


Figure 3: 10-minute travel time (car) to pharmacies/dispensing practices within Worcestershire

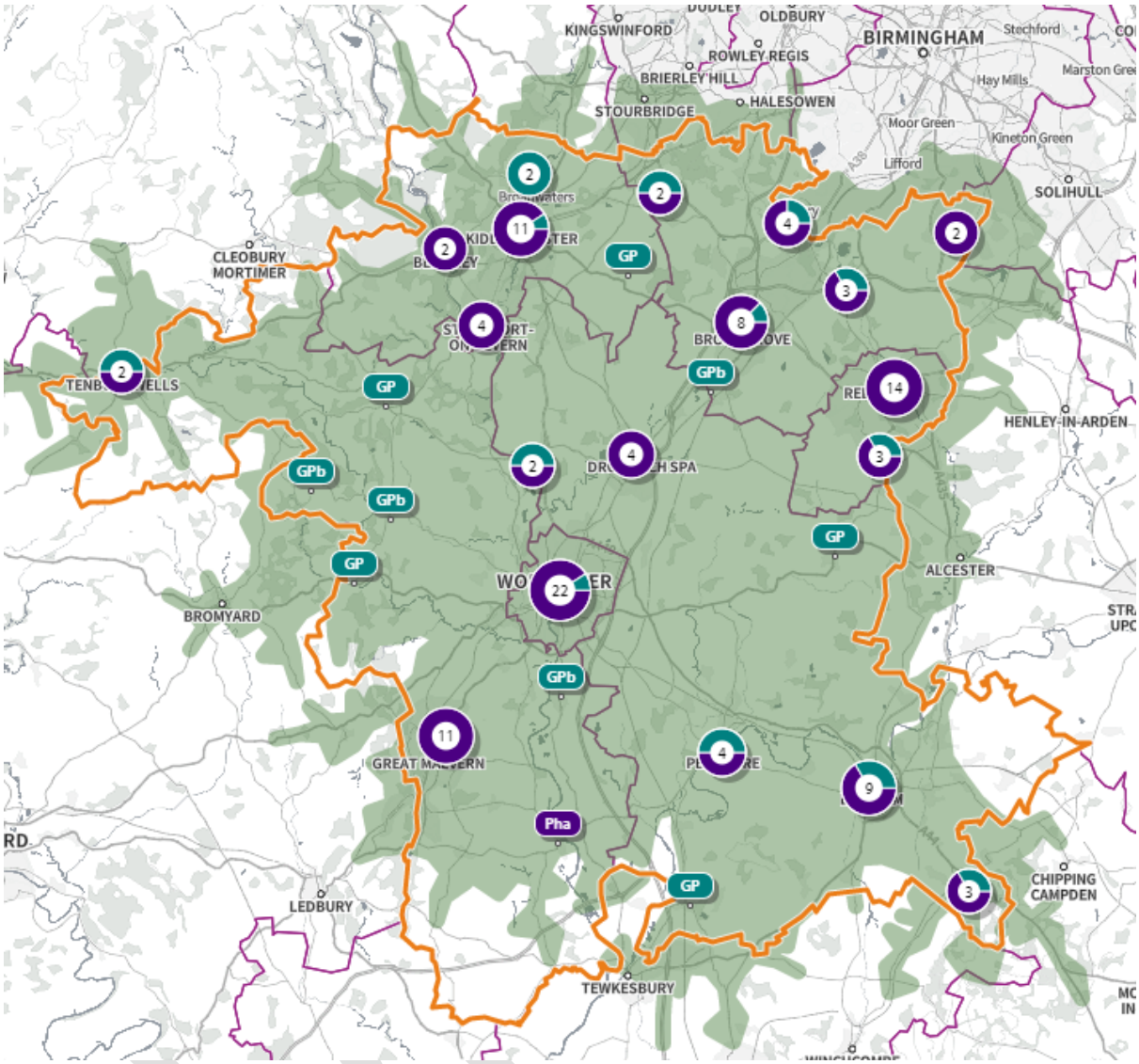


Figure 4: 5-minute travel time (car) to pharmacies within Worcestershire

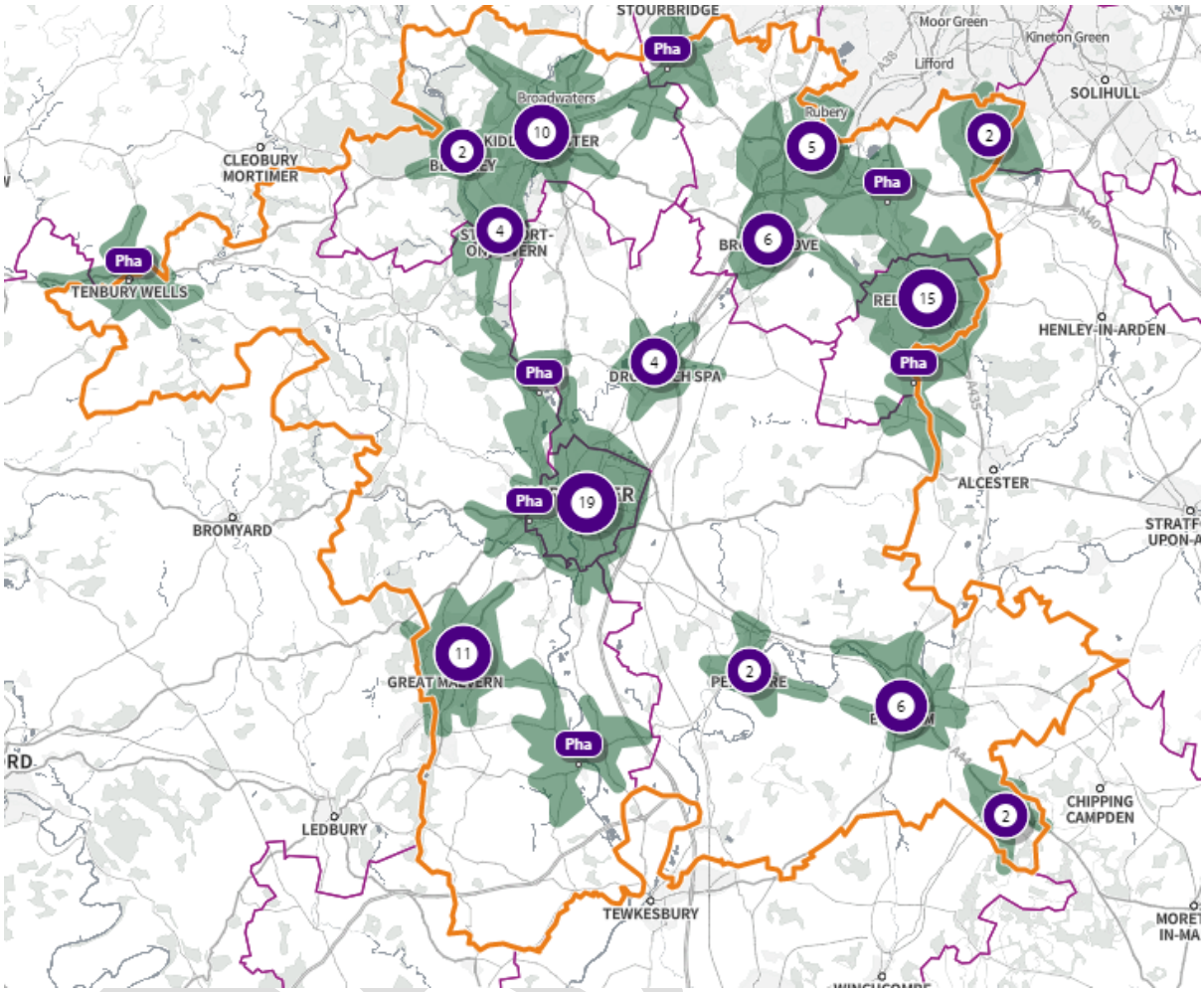
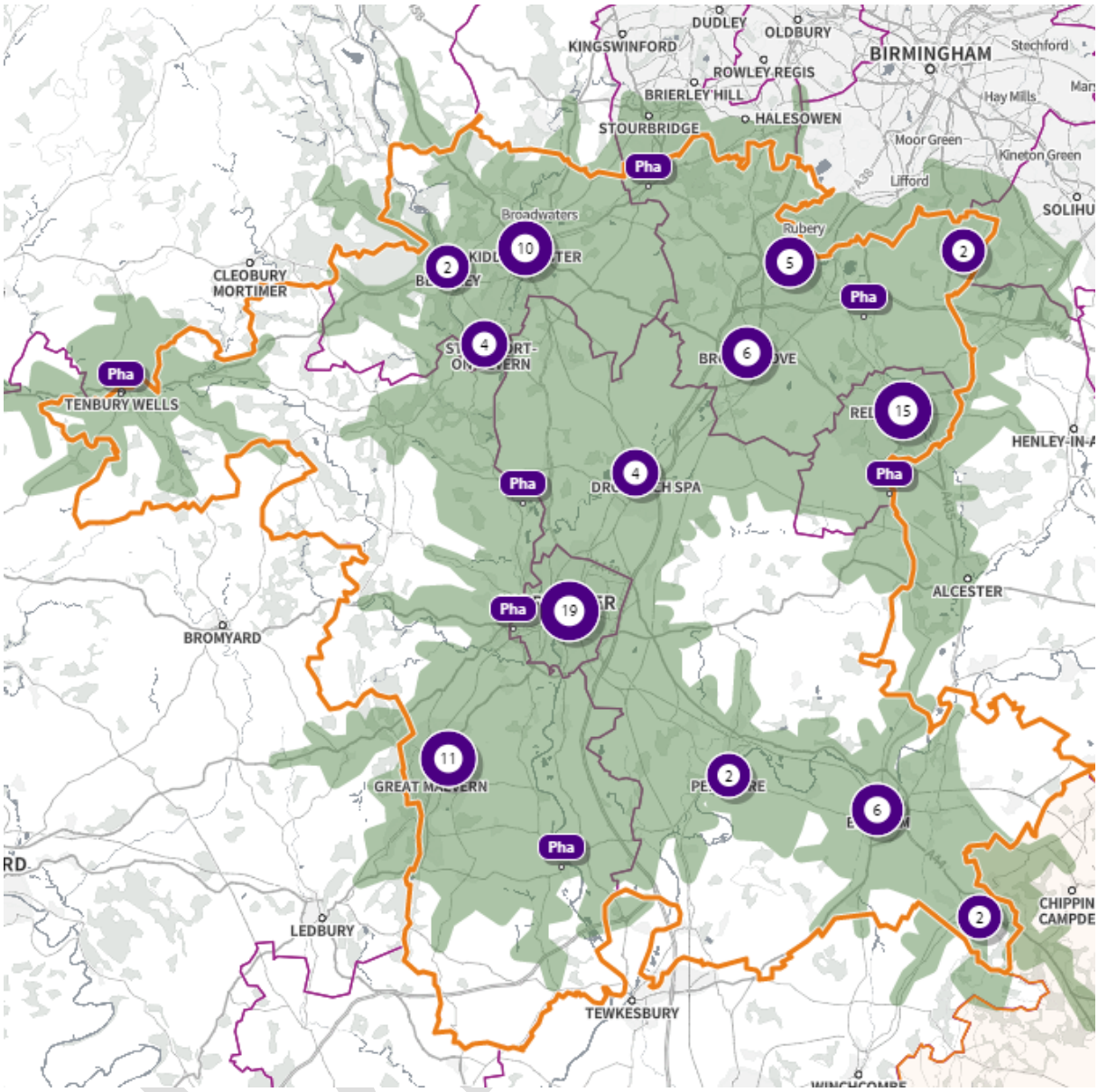


Figure 5: 10-minute travel time (car) to pharmacies within Worcestershire



Walking time

As one would expect, people living in or around urbanised or town areas generally have the best access to community pharmacy/dispensing practices on foot. Table 3 illustrates the population with access to a community pharmacy within each walk time period (taken from PHE SHAPE):

It shows that around 5/6 of the total population of Worcestershire lives within a 30-minute walking distance of a pharmacy of GP dispensing practice

Table 4: Estimated population living withing 5–30-minute travel time (on foot) to pharmacies and dispensing practices within Worcestershire

WALK TIME	ESTIMATED WORCESTERSHIRE POPULATION WITH ACCESS TO A COMMUNITY PHARMACY	ESTIMATED WORCESTERSHIRE POPULATION WITH ACCESS TO A COMMUNITY PHARMACY OR DISPENSING PRACTICE
5 minutes	135,476	154,452
10 minutes	266,179	297,127
15 minutes	350,797	380,164
20 minutes	423,075	450,744
30 minutes	466,786	494,136

(Total population 599,222- midyear estimate for 2020, ONS)

Figure 6: 5–30-minute travel time (on foot) to pharmacies and dispensing practices within Worcestershire

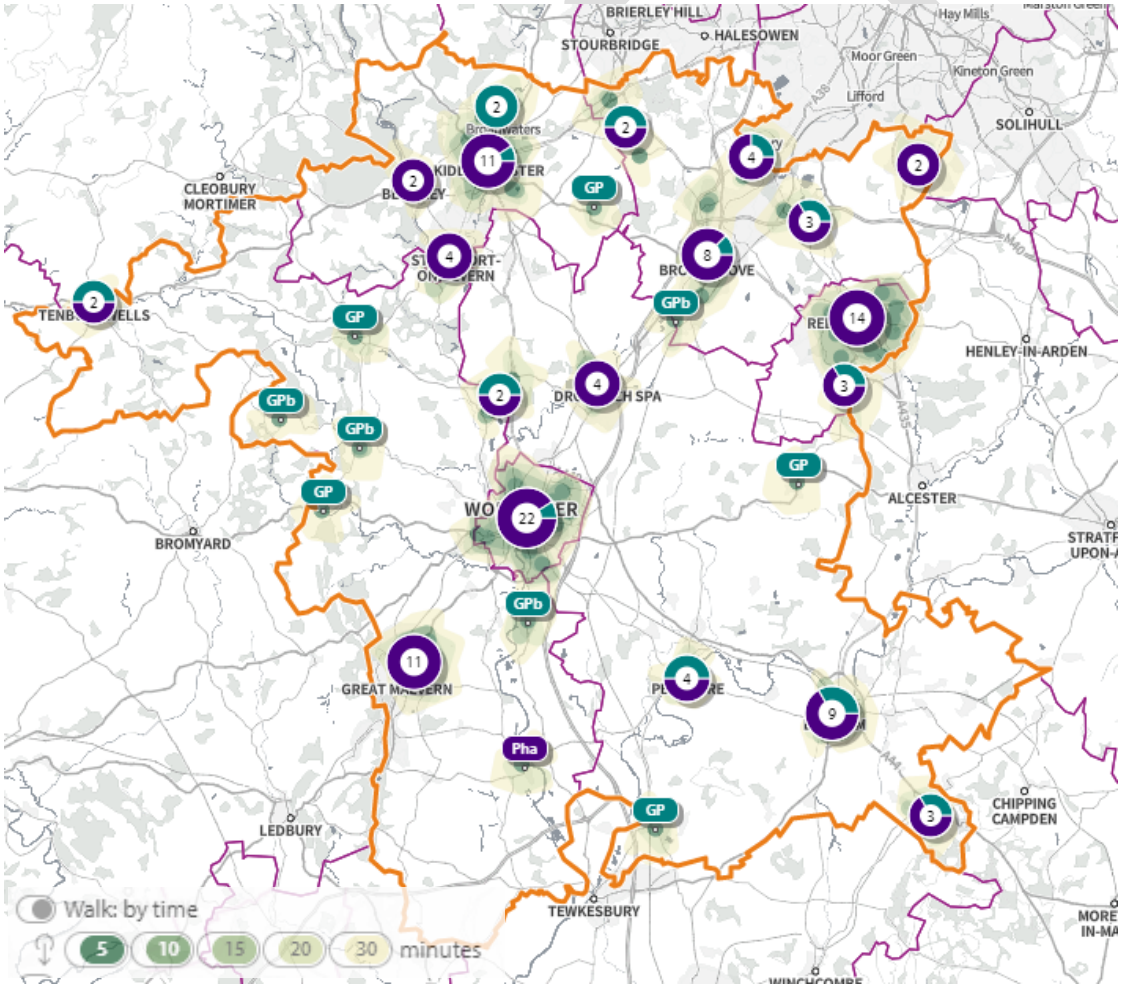
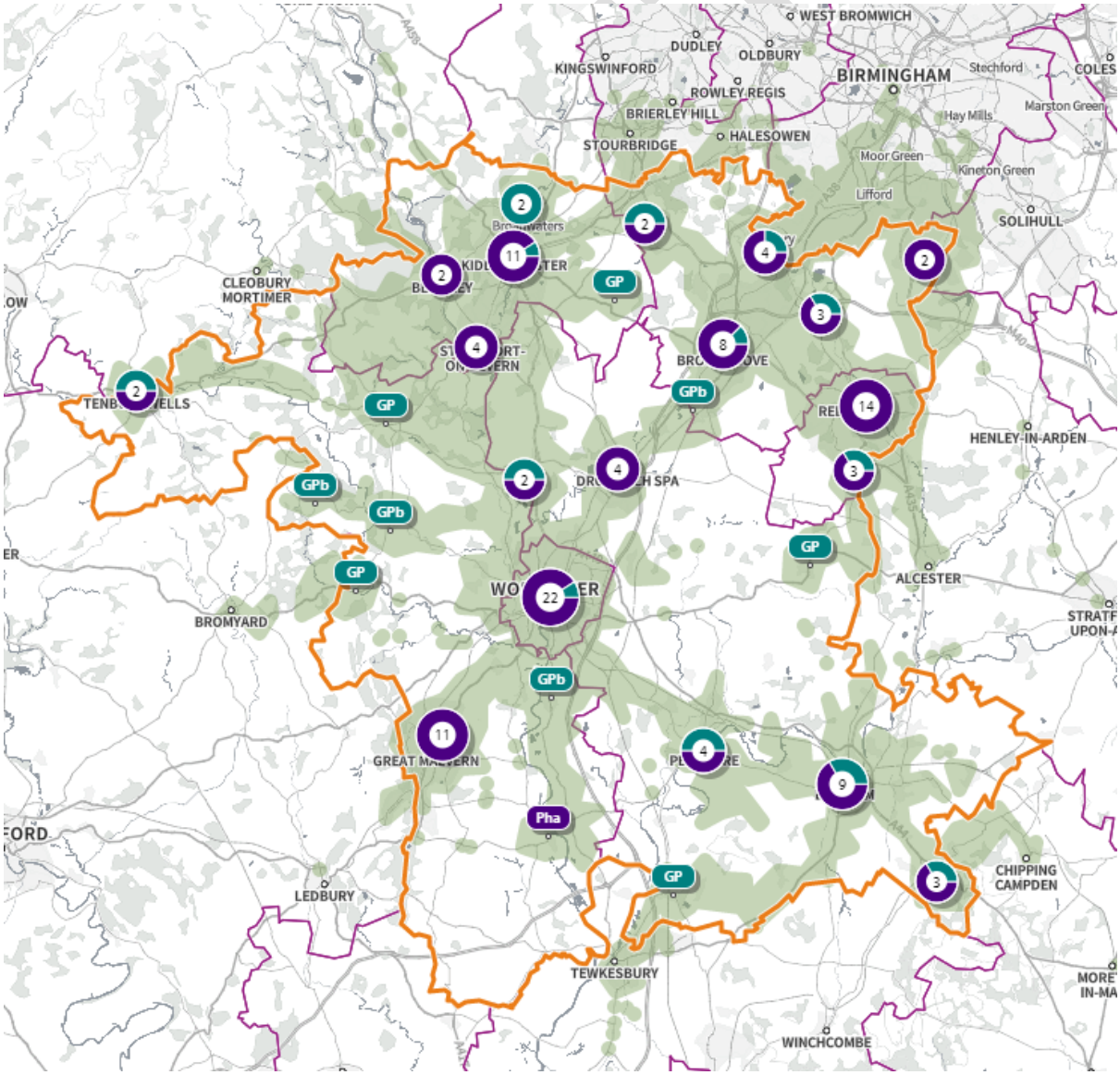


Table 5: 20–45-minute travel time by public transport (weekday morning) to pharmacies and dispensing practices within Worcestershire

TRAVEL TIME	ESTIMATED WORCESTERSHIRE POPULATION WITH ACCESS TO A COMMUNITY PHARMACY	ESTIMATED WORCESTERSHIRE POPULATION WITH ACCESS TO A COMMUNITY PHARMACY OR DISPENSING PRACTICE
20 minutes	530,005	542,024
30 minutes	569,433	579,333
45 minutes	586,093	591,437

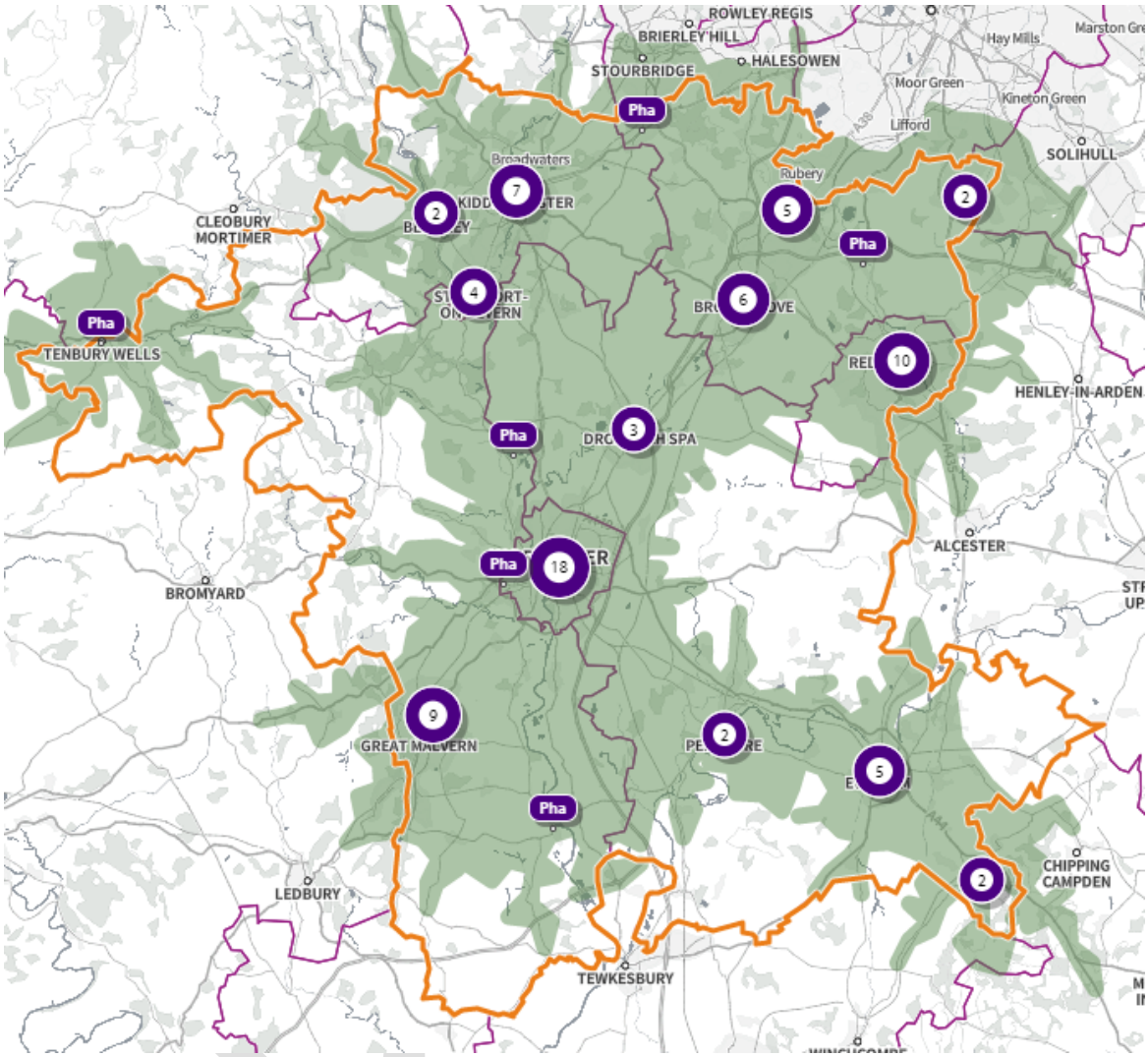
Figure 7: 30-minute travel time by public transport (weekday morning) to pharmacies and dispensing practices within Worcestershire



A total of 566,637 people live within 10 minutes travelling time by car of pharmacies that open on Saturdays, compared with 581,287 during the week. This is a 3% decrease.

The following maps relating to weekend opening only feature pharmacies as there are no dispensing practices that open at weekends.

Figure 8: Pharmacy open on Saturday within 10 minutes travelling time by car



A total of 480,873 people live within 30 minutes travelling time by public transport of pharmacies that open on Saturdays, compared with 581,287 during the week. This is a 17% decrease.

Figure 9: Pharmacy open on Saturday within 30 minutes travelling time by public transport

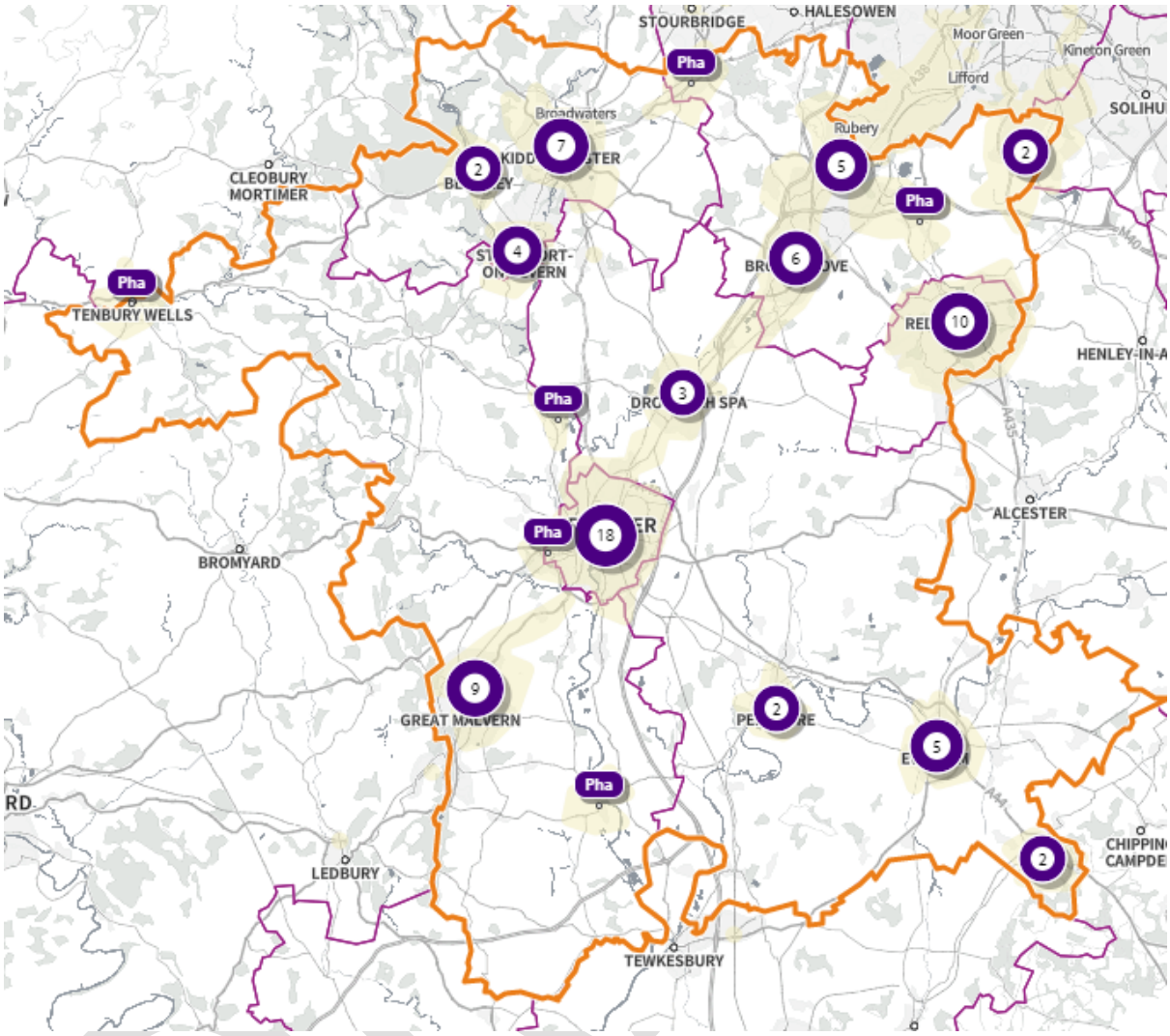


Figure 10: Pharmacy open on Sunday within 10 minutes by car

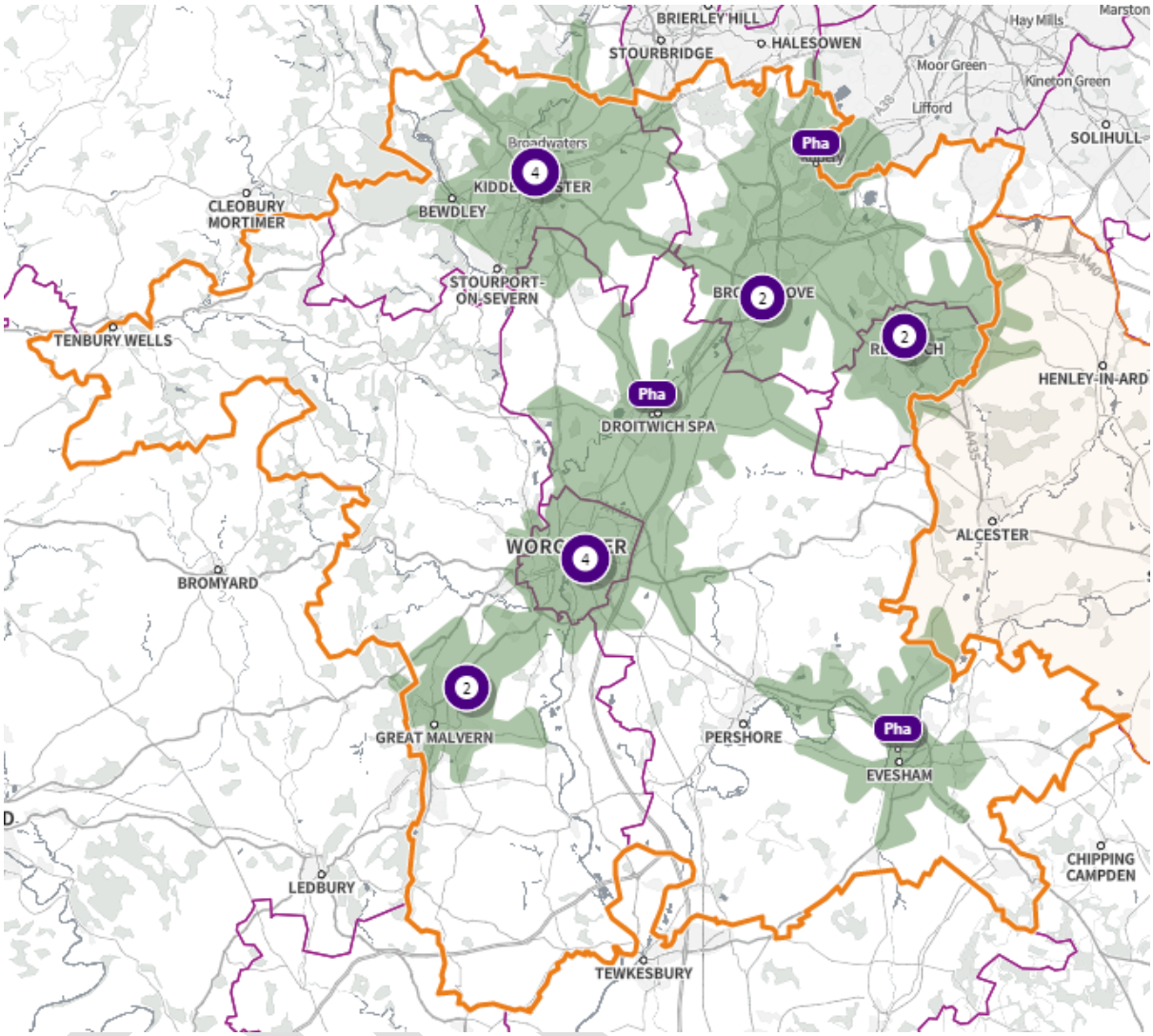
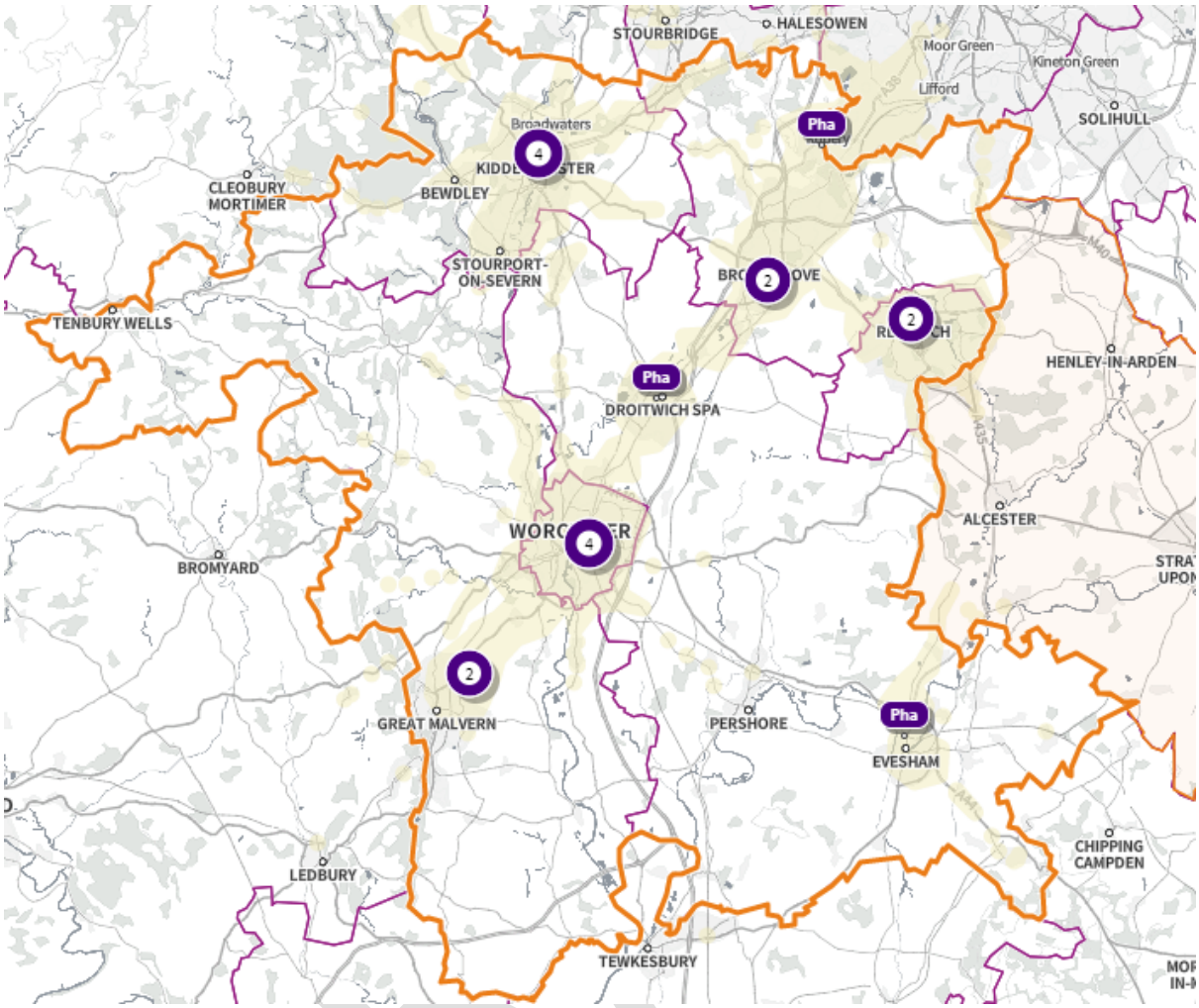


Figure 11: Pharmacy open on Sunday within 30 minutes by public transport



Rurality

NHSE are going to redetermine the Rurality Determination which is a separate statutory process which ultimately provides the information on eligibility to receive pharmaceutical services from a dispensing practice. At the time of updating this PNA, NHS England who are responsible for updating the Determination of Rurality as defined under the Pharmaceutical Services Regulations. are undertaking this exercise. This will either be available for reference within the PNA when completed or will be issued as a Supplementary Statement to the PNA.

In the meantime, the map at Figure 12 illustrates how dispensing practices help to cover the more rural areas of Worcestershire, as community pharmacies tend to be located in more urban areas.

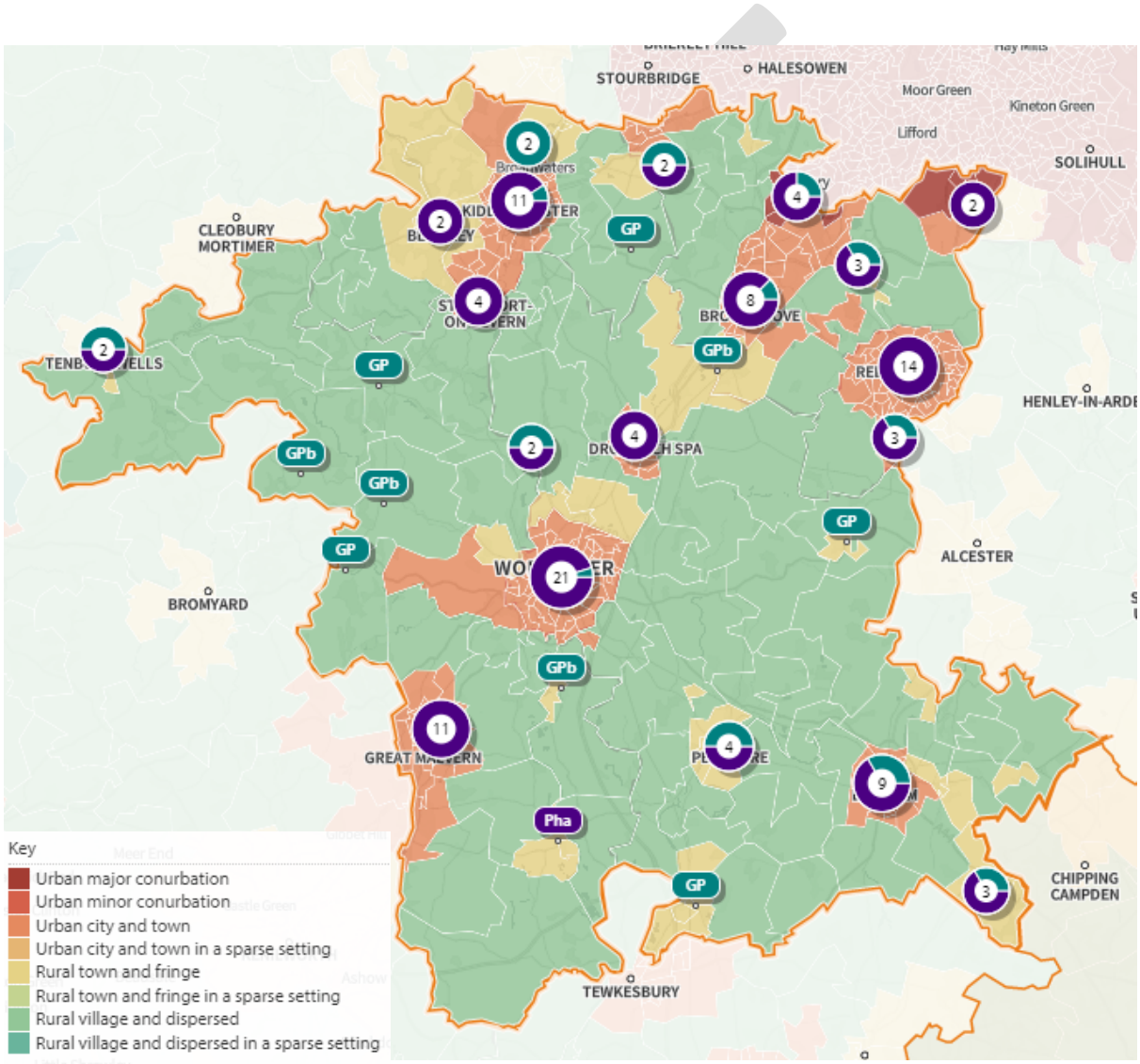


Figure 12: Pharmacy or dispensing practice by urban rural classification

Public and Service-user Views on Current Provision of Pharmaceutical Services

Public Survey: Executive Summary

- Worcestershire Pharmacy Services Public Questionnaire (see Appendix 3) was published online and asked people who use the services about their experience. The questionnaire was opened to public from 10 November 2021 until 31 January 2022. From Worcestershire there were a total of 915 responses.
- Most commonly, 58% of respondents used pharmacy once a month (high rurality and older age particularly) to primarily collect prescribed medicines. Most respondents said it took at least 10 minutes to collect medication (80%). Around ¾ of respondents found that there is a sufficient supply of medicines that they required. 82% of respondents were satisfied with the range of services offered by their community pharmacy or dispensing GP surgery. Over three quarters of respondents indicated that 'efficient and/or quick service' (89%), 'knowledge' (82%) and 'friendly staff' (81%) were the most important aspects of pharmacy service. 74% accessed a pharmacy within two miles of their home or work, High rurality was associated with travelling more than five miles. A large majority of respondents (87%) said that they know they can return any unused / unwanted medicines (except sharps) to either a community pharmacy or a dispensing GP surgery.
- Popular times to visit were Mon-Fri between 9:00am and 18:00pm, Sat am between 9:00am and 13:00pm. Higher % of use in employed people after 18:00pm, weekend use associated also with employed residents and students. 92% able to access pharmacy when convenient for them, 87% were able to find information on opening times.
- 75% of respondents were satisfied with the amount of information that they normally received about medication. Only 8% had used the new medicine service, 95% said that their experience with this service has been helpful. Residents' high confidence in the pharmacy team's knowledge in both prescribed and OTC medicines was reflected in residents reporting using the service to advise on buying over the counter medicines (OTC). Lower confidence was reflected in residents reporting using the internet and GP to advise on general health, lifestyle, and disease prevention.
- Additional services mostly accessed by residents were NHS flu vaccinations (32%) and Minor ailment advice to avoid a GP visit (24%), they were mostly unaware of Chlamydia testing and treatment (62%- though this is not currently commissioned) and supervised consumption (for treatment of substance misuse clients) (52%). If made available from pharmacies, most respondents said they would be very likely to use 'blood test service (30%) 'out of hours support' (23%), 'NHS health checks' (23%).
- Residents were satisfied with: Communication (93%), accessibility of building (92%) and distance (89%) – although this was more of a problem in rural areas
- Despite 92% of respondents reporting being able to access pharmacy when convenient for them, 22% reported problems with opening times. 27% reported problems with parking (more of a significant problem for long term health/disability) and 31% problems transport (more of a significant problem for long term health/disability)
- 87% of respondents collected their medicines from the pharmacy, 13% used a delivery service or relative to collect it for them. Residents with a long-term condition or disability along with older residents relied more on a delivery service and relatives to collect for them. There was also variation between the districts in the way respondents accessed their regular prescriptions if they were unable to attend the service in person. A delivery service was more widely used in the Wyre Forest District (19%) compared to the Malvern Hills district (5%).

When asked why they do not access a pharmacy, around a fifth (22%) of respondents said the pharmacy opening hours are not suitable and a sixth said either because have a disability, 12% said they have no transport access to pharmacy.

- During Covid-19 63% of residents used the pharmacy as they normally would (particularly low rurality areas). Change in use was associated with high rurality and age, 38% used changed to use the service by phone, particularly older age and those who reported having a long-term health condition or disability.

Public Survey: Report

Worcestershire Pharmacy Services Public Questionnaire was published online and asked people who use the services about their experience. The questionnaire was opened to public from 10 November 2021 until 31 January 2022. From Worcestershire there were a total of 915 responses.

- 52% of the respondents were females, 47% males and 1% preferred not to say.
- 92% of respondents were from a White English/Welsh/Scottish/Northern Irish/British background.
- 11% have children under the age of 16 years who live with them.
- Long term medical condition (e.g., diabetes) and a physical disability were the most frequently cited disability or long-term medical condition.

Results

Of the 915 respondents 627 provided a valid postcode, this was used to map the details of where respondents live (District, Level of IMD, Level of Urbanicity). The level of urbanisation was deduced from the total urban population numbers within each District from Office of national statistics data, 2001. Level 6 is the most rural, level 1 is the most urban. The level of IMD was determined using the: The English Indices of Deprivation data, 2019. Level 1 is the most deprived, level 10 is the least deprived.

The responses were segmented using pivot charts in Microsoft Excel to demonstrate:

- Where the respondents live (Districts)
- The age of respondents
- The level of Index of Multiple Deprivation Decile (IMD)
- The level of urbanicity (Urban Rural Classification)
- The presence of long-term health condition/disability.

The value of the data was shown as percentages within the pivot charts, this was then used to create various charts to present results. Within the charts, the co-efficient of Determination (R^2) was calculated to determine the strength of the relationship between two variables (*X* and *y* axis on the graphs). Whilst an R^2 value cannot prove causality, a high R^2 does indicate a correlation between the two variables and can be used to predict future relationships.

R^2 values are always between 0 and 1 and can be represented as a percentage that represents the variability of the results. For example, an R^2 value of 1 would indicate that the data perfectly fits the model, and any R^2 value less than 1.0 e.g., an R^2 value of 0.5 indicates that 50% of the variability in the outcome data cannot be explained by the model.

Figure 13 shows that there was variation in the percentage response from each of the districts. The highest response was from the district of Wychavon (28%) and the lowest was from the district of Wyre Forest (12%).

Figure 13: Percentage PNA public survey response by District

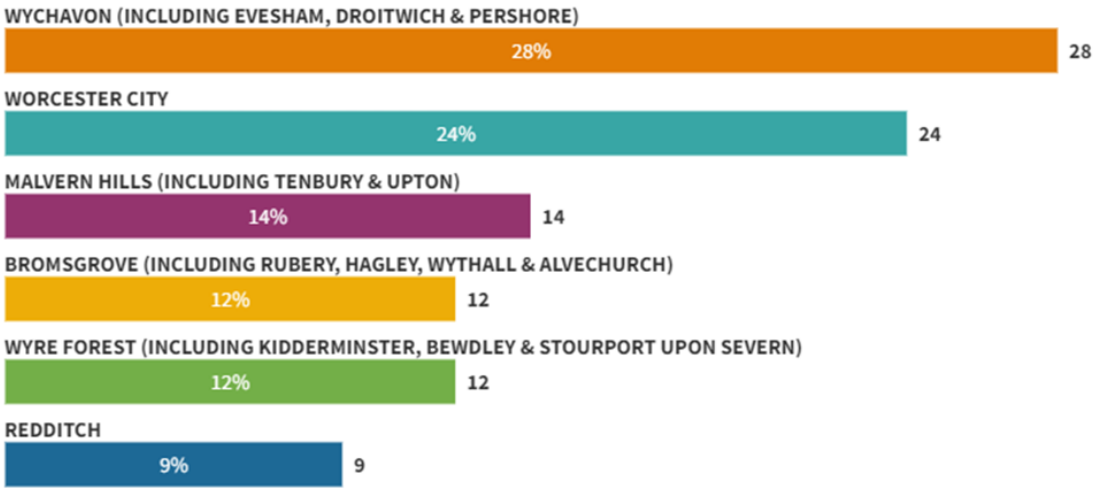


Figure 14 shows the spread of response across the levels of urbanicity across Worcestershire. There were not any responses from levels 1 or 2 (Most Urban). The highest response was from level 3 (33%) and the lowest from level 5 (14%).

Figure 14: Percentage PNA public survey response by level of urbanicity

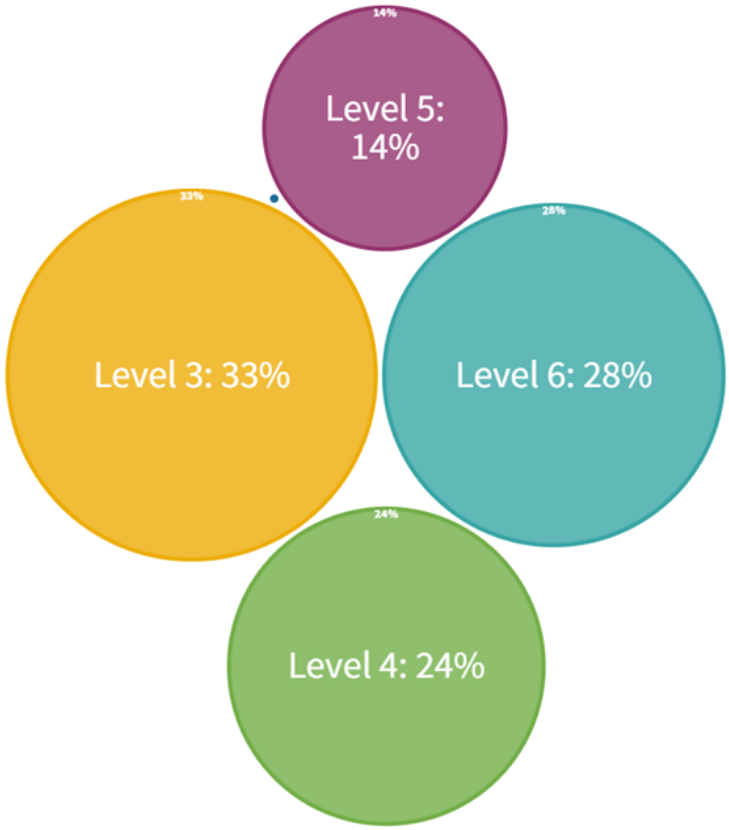
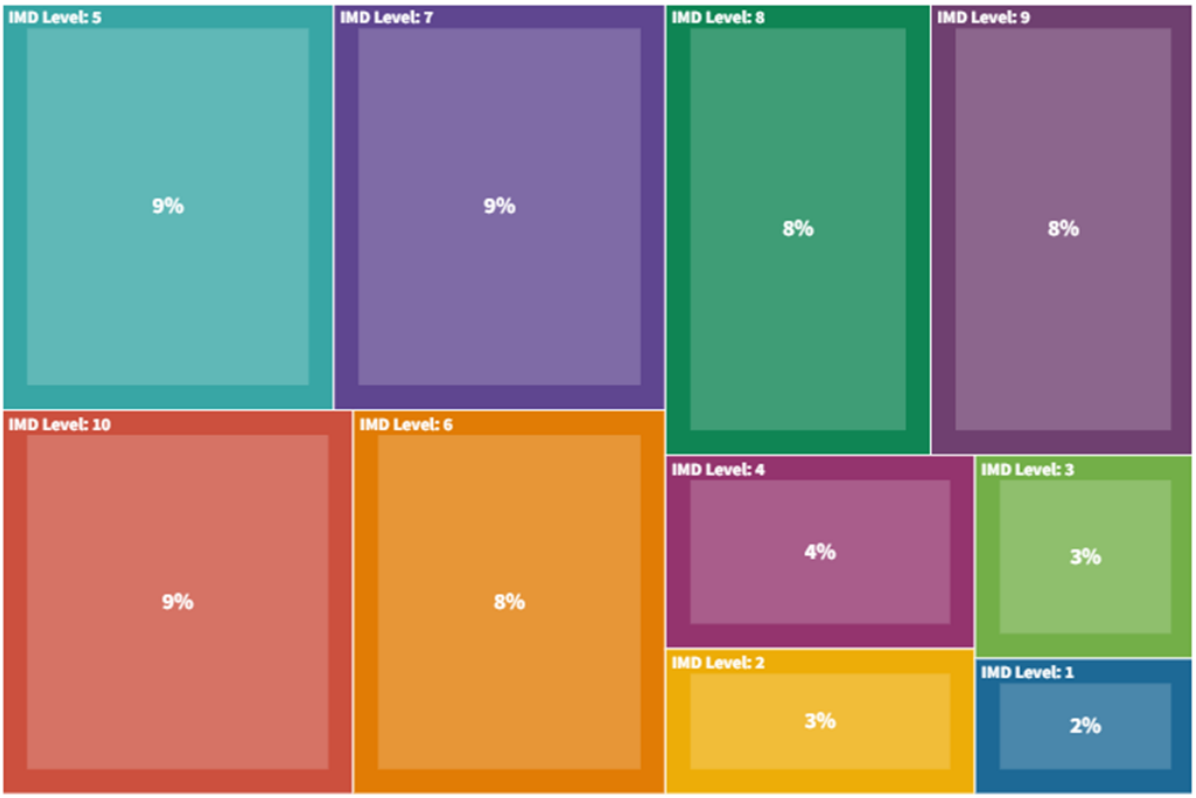


Figure 15 shows the data from responses across the levels of IMD. There are more responses from the higher IMD levels (least deprived) compared to the lower IMD levels (more deprived).

Figure 15: Percentage PNA public survey response by IMD



Of the 915 respondents 905 provided details of long-term health condition/ Disability, there were 661 without a long-term health condition/ Disability, and 246 that reporting a long-term condition/disability (figure 16).

Figure 16: Percentage PNA public survey response by long term health condition/Disability

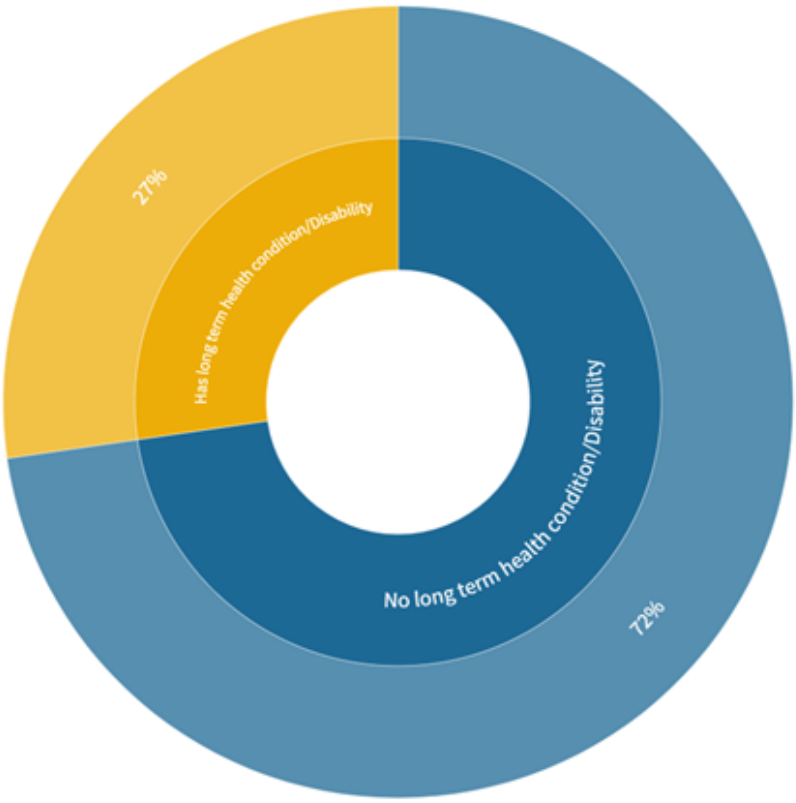


Figure 17 demonstrates the unequal spread across the different age ranges, there is under representation from people under 45 years of age.

Figure 17: Percentage PNA public survey response by Age

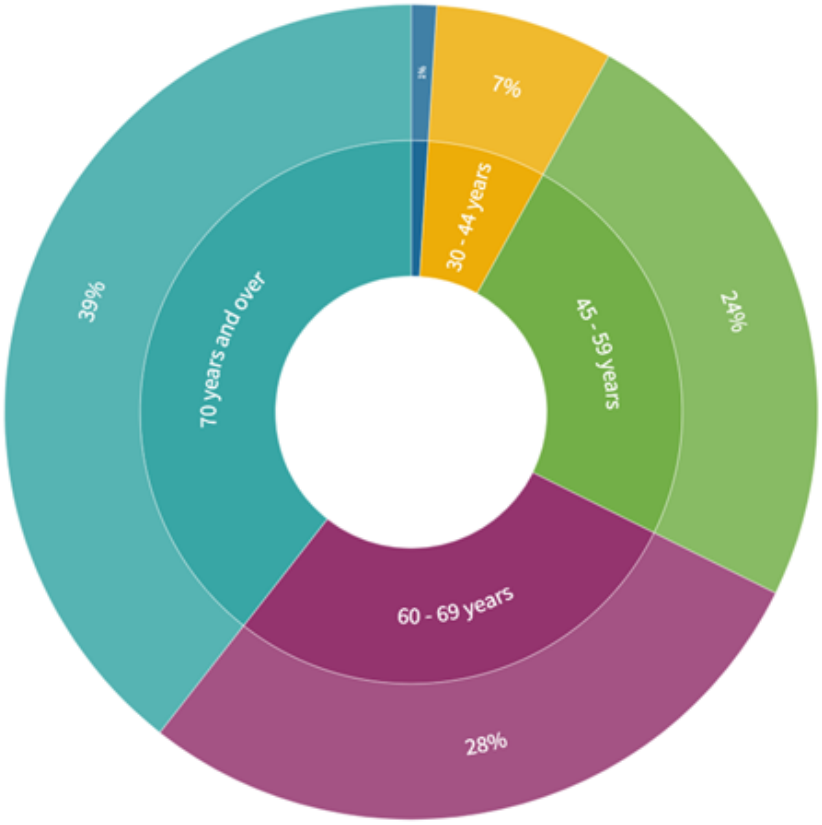
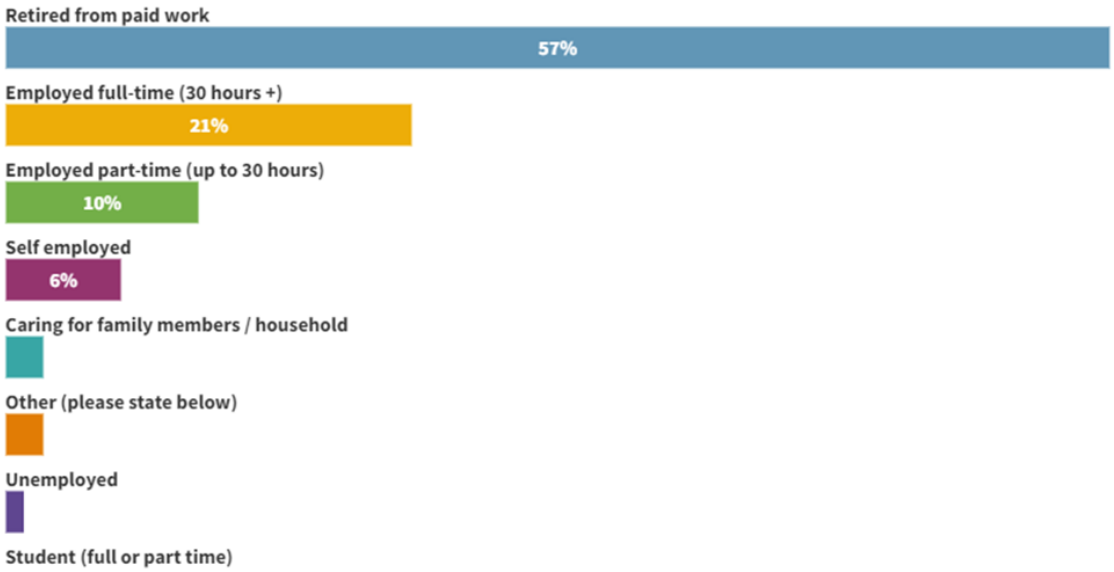


Figure 18 demonstrates the employment status of the respondents to the survey, the majority of which are retired from paid work (57%)

Figure 18: Percentage PNA public survey response by employment status



Note: The percentages are based on respondents to each question/statement. If respondents could select more than one answer to a particular question, the percentages may add up to more than 100%.

Access

WHY AND WHEN RESPONDENTS USE A COMMUNITY PHARMACY / DISPENSING GP SURGERY

By far the most common reason to access a pharmacy was for 'collecting prescription medicines' (94% of respondents) followed by 'buying over the counter (OTC) medicine' (54%) and 'getting advice and information on prescription or OTC medicines' (32%).

A total of 99 of respondents (11%) had used a pharmacy or dispensing GP at least once a week on average, 58% used one once a month and the rest (29%) used one less frequently. Those who lived in a high rurality location were more likely to use the pharmacy services once a month and were less likely to use the service once a week ($R^2 = 0.7$). Those of an older age were also more likely to use the pharmacy once a month ($R^2=0.5$).

USAGE DURING COVID-19

During Covid-19 restrictions, just two thirds (63%) used a pharmacy as they normally would and a quarter (24%) used it in a different way, while 13% did not use a community pharmacy or a dispensing GP surgery at all. Respondents from low rurality areas were more likely to continue using pharmacy services as normal during lockdown ($R^2 = 0.9$). Those from high rurality were more likely to change the way they accessed the service over lockdown ($R^2 = 0.9$). Older age was also correlated to likelihood of changing how they accessed services during lockdown ($R^2 = 0.9$).

Of the few (267) who responded about how they accessed a pharmacy service during the period of lockdown restrictions 38% said they accessed the services 'by phone', 35% said 'online' and 45% 'in person'. Those in high rurality areas were more likely to access services 'in person' ($R^2 = 0.8$), Those of higher age were more likely to use services 'by phone' ($R^2 = 0.9$). There was a higher percentage of people using phone service during lockdown that had a long-term health condition or disability.

As was the case pre-pandemic, 'collecting prescription medicines' was the main reason that most respondents (65%) accessed a pharmacy/dispensing GP surgery during lockdown. 20% accessed one for 'buying over-the-counter medicines.

DISTANCE, TRAVEL TIME AND ISSUES RELATING TO ACCESS

Just under three quarters of respondents (74%) accessed a pharmacy within two miles of their home or work while a fifth travelled between two and five miles and the rest (4%) travelled more than five miles to get to the nearest community pharmacy or dispensing GP surgery.

High rurality was associated with travelling more than five miles ($R^2 = 0.9$), low rurality was associated with travelling between one and two miles ($R^2 = 0.9$), For three quarters (77%), it was a less than a 15-minute journey to their nearest pharmacy, this was less likely for those in a high rurality area ($R^2 = 0.7$).

Whilst 68% of respondents usually travelled to the pharmacy by car, 44% walked and 10% cycled, or used a taxi or public transport.

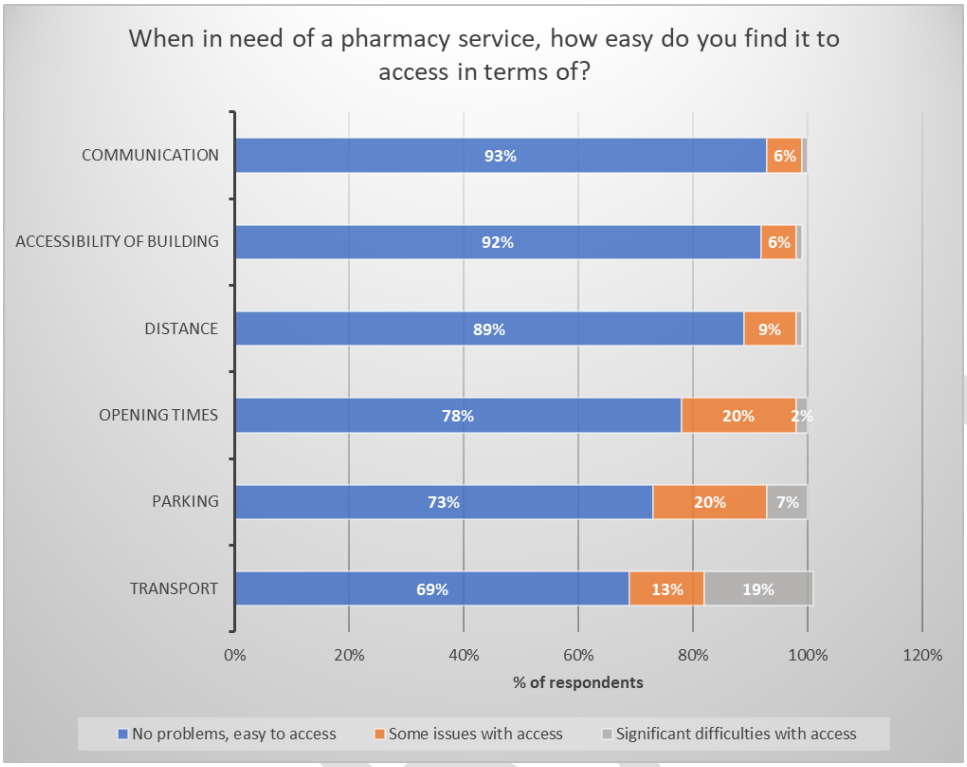
ISSUES WITH ACCESSIBILITY

A large majority of respondents found accessing pharmacy services were easy in terms of communication, accessibility of building and distance (Figure 19). There were some highlighted

problems with parking (27%) and opening hours (22%). A third of respondents highlighted a problem with transport (32%).

For respondents with a long-term health condition or disability, there were higher percentages in in reporting some or significant issues with: Distance (15%), Parking (24%), Building accessibility (11%), Communication (8%) and public transport (8%).

Figure 19: Ease of access to pharmacy services



Distance was more likely to reported as an issue for people in high rurality and higher age ($R^2 = 0.8$). Opening times were more likely to be reported as an issue for people living in high rurality areas ($R^2 = 0.9$) along with communication areas ($R^2 = 0.9$) and public transport ($R^2 = 0.9$).

Opening times and visiting times

The most popular times for visiting a pharmacy were between 9:00am and 13:00pm (52%) and between 13:00pm and 18:00pm (38%) on weekdays, or between 9:00am and 13:00pm on Saturdays (46%) see table 5.

Table 6: Pharmacy visiting times

When do you generally visit a community pharmacy / dispensing GP surgery?	Monday - Friday	Saturday	Sunday
Before 9:00am	3%	2%	0%
Between 9:00am and 13:00pm	52%	46%	8%
Between 13:00pm and 18:00pm	38%	13%	6%
After 18:00pm	6%	2%	1%
Never on this day	2%	37%	85%

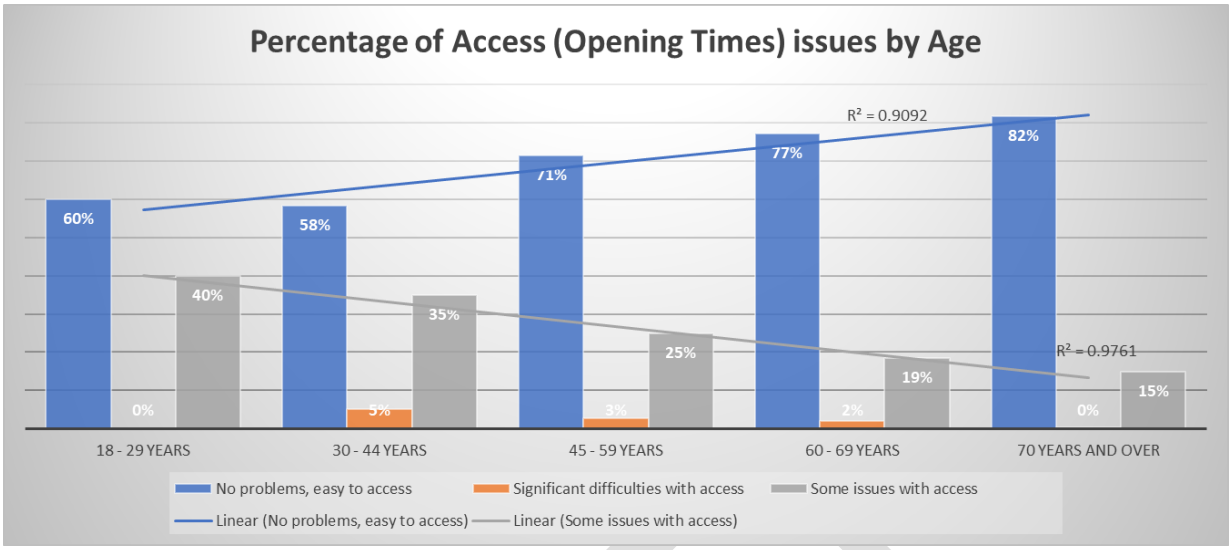
This did vary within the different age groups; older age was associated with using the pharmacy between 9:00am and 13:00pm Mon-Fri ($R^2 = 0.9$), whereas younger ages were associated with using the pharmacy between 13:00pm and 18:00pm Mon-Fri ($R^2 = 0.9$). Variation in times of use was also seen between the different employment statuses. There was a higher % of use after 18:00pm from those in full time employment, compared to other employment statuses.

Variation was also seen in the use of pharmaceutical services at the weekend, there as a higher percentage of students and employed respondents using the service at this time. Particularly on a Sunday, respondents in lower IMD were more likely to use the services on this day ($R^2 = 0.4$).

A large majority of respondents (92%) were able to access a pharmacy at least most of the time when convenient for them and 7% were sometimes able to access one at a convenient time, but 1% said they were never able to access a pharmacy at a time convenient. Around a tenth of respondents (14%) found some issues or significant difficulties with finding information on pharmacy opening times but the majority (87%) did not have any problems.

There was an obvious correlation between the percentage of reported issues with opening times and age. Higher age groups were more likely to report no issues with opening times ($R^2 = 0.9$), conversely lower age groups were more likely to report issues with opening times ($R^2 = 0.9$) See figure 21. This may be influenced by employment status.

Figure 20: Percentage of access (opening times) issues by age



Outside of normal hours

If they needed a pharmacy outside of normal hours, respondents looked out for information on opening times through:

1. Internet search (75%)
2. NHS.uk website (31%)
3. Pharmacy website (26%)
4. NHS 111 (11%)
5. Local directory, or local newspaper (less than 10%)

Advice and Information

Pharmacy leaflet

Over 63% of respondents indicated that they were not aware that their pharmacy produces a leaflet about the services that they provide, 19% knew about this but only 18% had actually seen a leaflet. This may have been influenced by guidance to reduce paper within the pharmacies to mitigate the spread of COVID-19 during 2021-2021.

Satisfaction with the service

75% of respondents were satisfied (very satisfied or fairly satisfied) with the amount of information that they normally received about medication from their community pharmacy or dispensing GP surgery. 4% were either very or fairly dissatisfied.

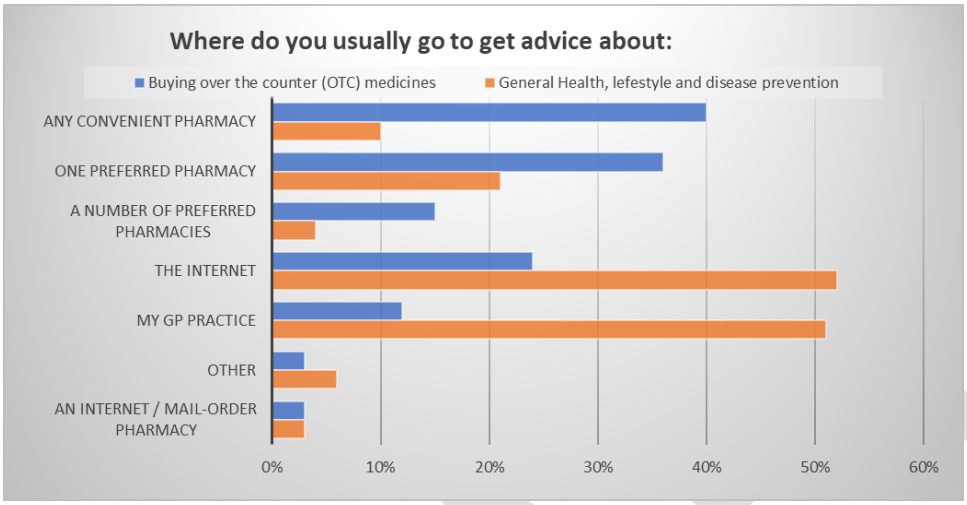
Of the 69 (8%) respondents who used a new medicine service provided by their pharmacy 66 (95%) said that their experience with this service has been helpful. Most of the respondents usually got advice about:

- Buying over the counter (OTC) medicines from
1. Any convenient pharmacy (40%)
2. One preferred pharmacy (36%)
3. A number of preferred pharmacies (15%)
- General health, lifestyle, and disease prevention from
    - The internet (52%)

- GP practice (51%)
- One preferred pharmacy (21%)

Although respondents used the internet or their GP mostly for getting advice, 84% were aware that a pharmacist can provide / offer advice on general health, lifestyle, and disease prevention.

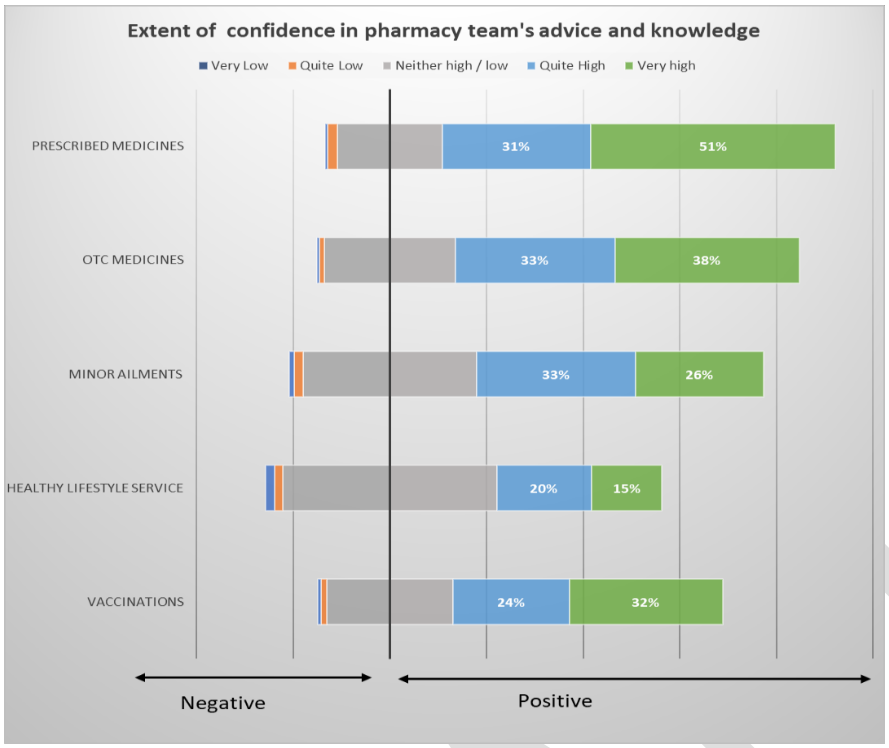
Figure 21: Where respondents usually get advice about Over the Counter (OTC) medicines and general health



Confidence in your pharmacy team's advice and knowledge

Respondents were asked to rate their confidence in their pharmacy team's advice and knowledge of services. Excluding respondents who answered, “not applicable,” the services that respondents had the highest levels of confidence in were: ‘prescribed medicines’ (82%) and ‘OTC medicines’ (71%). The level of confidence in pharmacy team’s advice and knowledge in ‘healthy lifestyle services,’ minor ailments and vaccinations were not so high, all were below 60%.

Figure 22: Extent of confidence in pharmacy team's advice and knowledge



SUPPORT SERVICES

Contracted additional services

Respondents were asked about their awareness of the additional services that some pharmacies may be contracted to provide in addition to dispensing services (Figure 24).

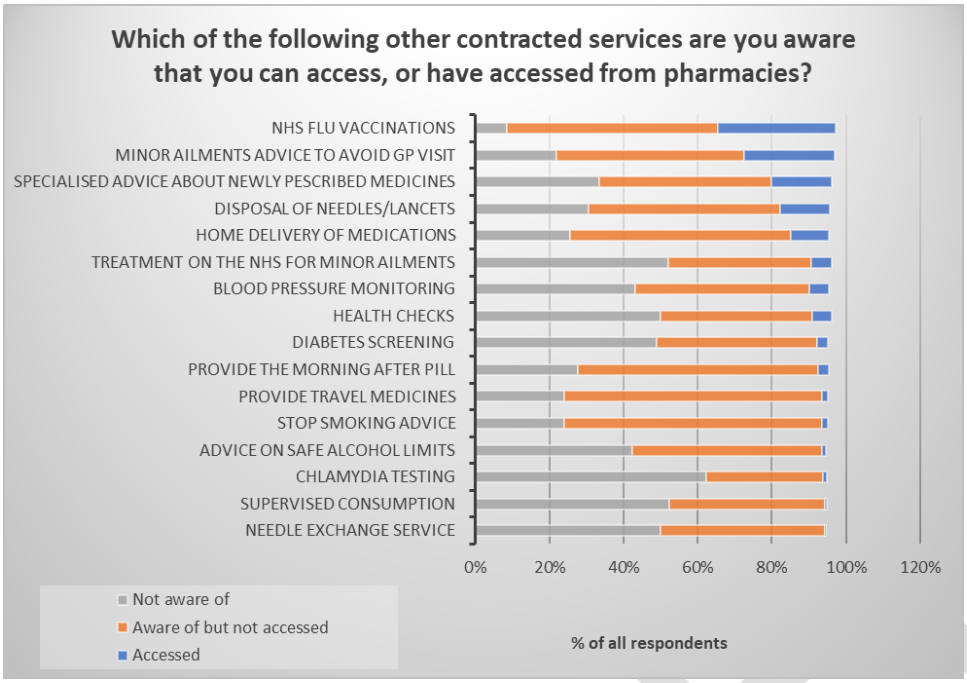
The additional services that most of the respondents accessed from pharmacies are:

- NHS flu vaccinations (32%)
- Minor ailment advice to avoid a GP visit (24%)
- respondents were mostly aware of but had not accessed were:
- Stop smoking advice (70%)
- Provide travel medicines (70%)

The services that respondents were mostly not aware of were:

- Chlamydia testing and treatment (62%). This is not currently commissioned in Worcestershire.
- Supervised consumption (for treatment of substance misuse clients) (52%)

Figure 23: Respondents' awareness of additional pharmacy services



If made available from pharmacies, most respondents said they would be very likely to use 'blood test service (30%) 'out of hours service' (23%), 'NHS health checks' (23%). (See figure 25)

Figure 24: % likelihood of using additional services if available

	Very likely	Likely	Neither likely or unlikely	Unlikely	Very unlikely
Blood test service	30	35	15	9	7
Out of hours service	23	37	21	10	6
Health checks	23	33	20	10	11
Wider Vaccinations	22	37	18	10	9
Managing long term conditions	21	31	26	12	7
NHS Blood pressure Management	20	34	20	12	12
Childrens Vaccinations	6	9	19	14	47
NHS Regular contraception	5	5	15	11	57
Weight Management	5	5	15	11	57
NHS stop smoking report	3	3	17	8	63

Created with Datawrapper

Dispensing: Collecting dispensed medicine

81% of respondents said that they take regular prescription medication.

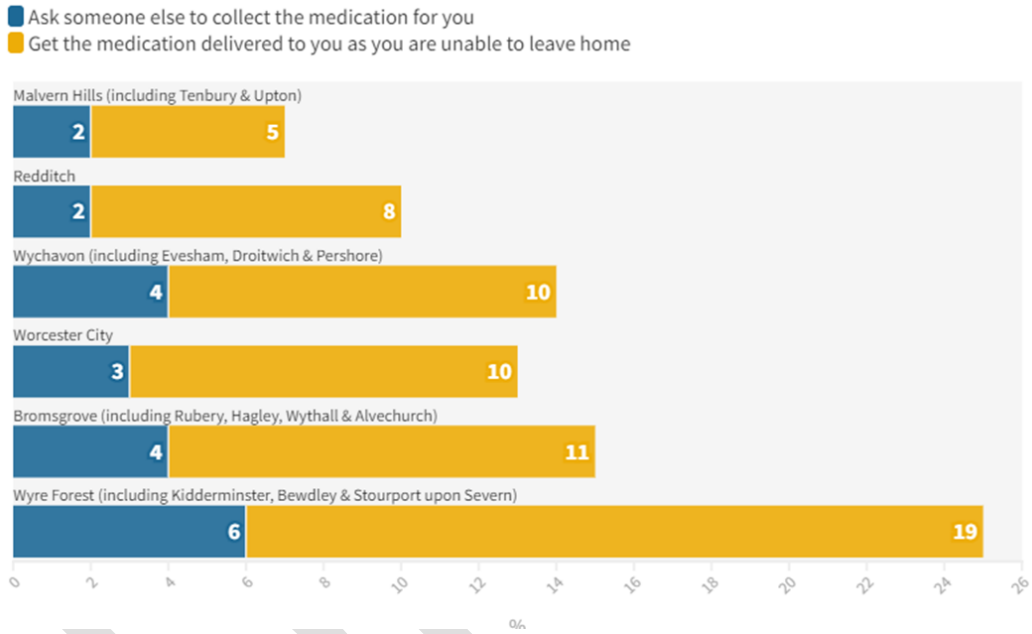
Whilst the majority (68%) called into collect the medication at a convenient time for them, some respondents (19%) collected medication when the pharmacy tells it is ready, a small minority either

get the medication delivered as they were unable to leave home (10%) or asked someone else to collect it (3%). This was mainly a relative (63%), or delivery service (23%).

For respondents with a long-term health condition or disability a much lower percentage (51%) were able to call into the pharmacy when it was convenient for them, they reported a higher percentage of using a delivery service (22%) or by asking someone to collect for them (7%). A delivery service was also used more in the older age groups ($R^2 = 0.9$).

There was also variation between the districts in the way respondents accessed their regular prescriptions if they were unable to attend the service in person. (See Figure 26). A delivery service (non-commissioned service) was more widely used in the Wyre Forest District (19%) compared to the Malvern Hills district (5%)

Figure 25: Access via delivery to Pharmacy services for regular prescriptions by districts



Respondents mostly get their prescriptions dispensed by a preferred pharmacy or from their dispensing GP surgery (92%). A small proportion get them done by any convenient pharmacy or from an internet/mail-order pharmacy (7%).

Accessing a community pharmacy or dispensing GP surgery

When asked why they do not access a pharmacy, around a fifth (22%) of respondents said the pharmacy opening hours are not suitable and a sixth said either because have a disability, 12% said they have no transport access to pharmacy.

Those respondents who said they had visited a community pharmacy/dispensing practice on behalf of someone else to collect their medication, said this was because:

- Patient does not have transport to access the pharmacy (25%)
- Pharmacy opening hours are not suitable for the patient (22%)
- Patient cannot access the pharmacy because of a disability (27%)

Most of the respondents said it took 10 minutes or less to collect medication (80%), while for some respondents it took longer (15% - 11 minutes or more). A small proportion (5%) of respondents said that they returned to collect the prescription later.

Unwanted medicine

A large majority of respondents (87%) said that they know they can return any unused / unwanted medicines (except sharps) to either a community pharmacy or a dispensing GP surgery.

What respondents usually do with out-of-date, unused, or unwanted medicines:

- Return them to a community pharmacy or dispensing GP surgery (71%)
- Throw away with household rubbish (25%)
- Store them in the house or pour liquids down the sink (11%)

Sufficient supply of medicine and the range of services offered

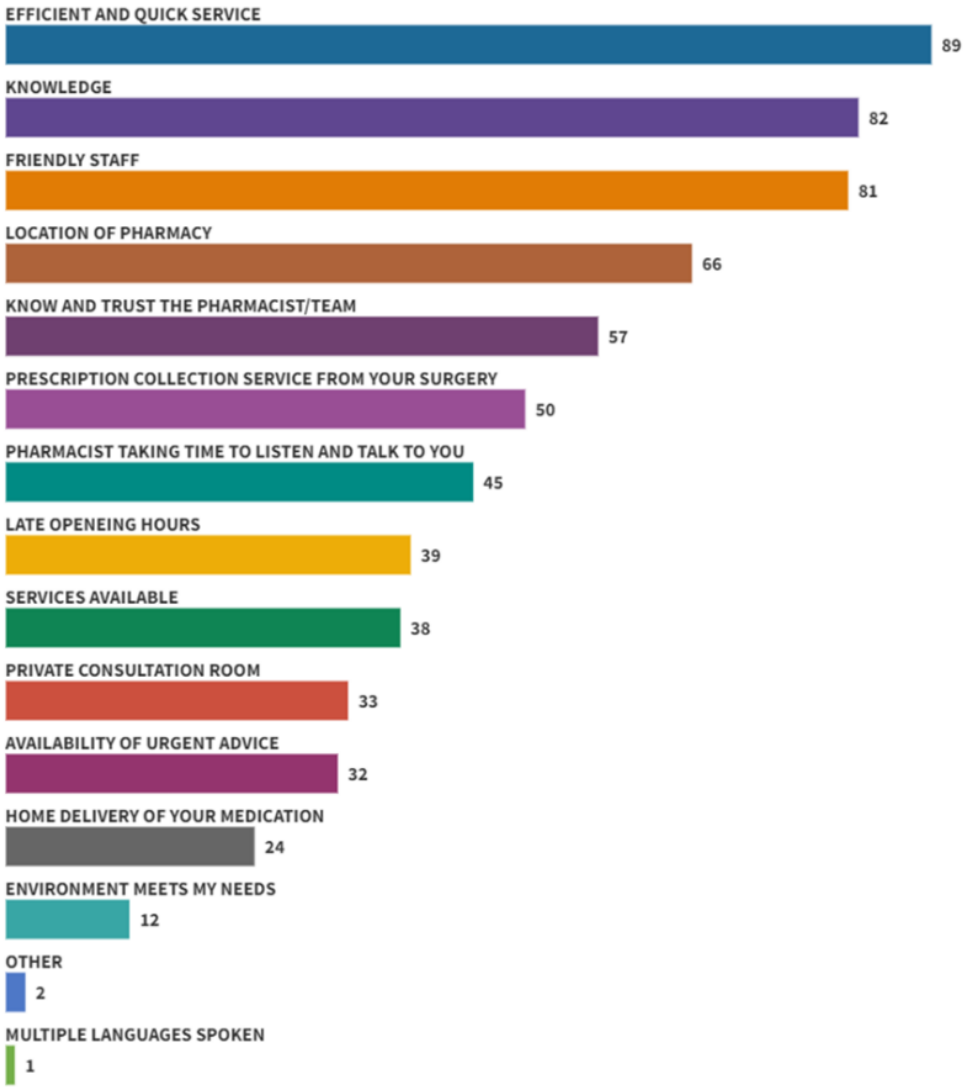
Around 76% of respondents agreed (strongly agree or agree) that their community pharmacy or dispensing GP surgery has a sufficient supply of medicines that they need.

82% of respondents were satisfied (very satisfied or satisfied) with the range of services offered by their community pharmacy or dispensing GP surgery.

Overall thinking about the community pharmacy or dispensing GP surgery

Over three quarters of respondents indicated that 'efficient and/or quick service' (89%), 'knowledge' (82%) and 'friendly staff' (81%) were the most important aspects of pharmacy services. Fewer respondents selected 'home delivery of your medication' (24%), 'environment meets their needs (e.g., dementia friendly, learning disability friendly, physical space)' (12%) and 'multiple languages spoken' (1%) as important, although in Redditch this was higher at 5%.

Figure 26: % Importance of various aspects of pharmacy services



Pharmaceutical focus groups (Qualitative research)

Introduction

A series of seven focus groups were undertaken by Voluntary, Community and Social Enterprise (VCSE) organisations in Worcestershire during March and April 2022. This is the first time this kind of data has been incorporated into the Pharmaceutical Needs Assessment for Worcestershire. This was intended both to provide an additional data source to triangulate findings from the survey and also to gain a richer understanding of the perspectives of the population using these services.

Although focussed on predefined topics, the participants have shared personal and sometimes wide-ranging views on their experiences of accessing pharmacy services and some of the issues raised go beyond the responsibility of pharmacies themselves and link to wider system issues. These are recorded here for reference and as an accurate reflection of the data generated from the focus groups.

In addition, the relative strengths and limitations of this data source are discussed at the end of this section.

Pilot Group

As this research was using an untried technique, a focus group pilot session was undertaken by Healthwatch Worcestershire in February 2022. Questions were trialled in a group of 8 residents of a hostel in Worcester, which has accommodation for around 50 single homeless men and women.

This pilot was invaluable in informing the approach and questions used in the subsequent research. Key reflections included:

- The topic guide was quite extensive and needed to be used flexibly in bringing questions for discussions in the group
- Language used in questions for discussion may need to be adapted to individual groups
- The format and running of the group should be adapted to different groups of participants in order to support a positive atmosphere and encourage engagement
- A standardised reporting template would be beneficial – this was produced for the main groups

The findings of this group have been integrated into the main analysis below. Although it was run as a pilot, the format was sufficiently similar, and results were clearly reported so as to make it appropriate to analyse together. As with the other groups, there were common themes (albeit presented from the particular perspective of those participants) as well as some unique issues which are highlighted separately.

Main Focus Groups

Organisations and group characteristics

A range of VCSE organisations were approached to recruit participants to undertake focus groups. They were selected on the basis of recruiting participants from a broad range of demographics and life circumstances but who were considered to be under-represented in other data sources. The group characteristics and a more detail overview of the participants is summarised in Table 6 and Figures 28 and 29.

Methods

Recruitment of participants

Participants were recruited through existing forms of contact with the organisations. Some groups provided incentives to attend including one offering a £10 voucher. Others supported attendance through the provision of transport and the use of widely accessible locations, some of which were already familiar to participants.

Running the groups

A mix of in-person and online focus groups were run. One organisation had a hybrid with one participant joining online due to travel problems on the day. One organisation ran individual, in-person interviews in place of focus groups. This reflected concerns about risk to participants during the pandemic. Facilitators from each organisation ran the groups and submitted a report summarising the main points of discussion including recommendations. They were also requested to provide a transcript for independent analysis.

Analysis

The documents analysed for this report were the summary reports submitted by facilitators. This consisted both of summary points from discussions as well as illustrative quotes. As such, this analysis is a synthesis both of participant contributions but also of the initial analysis undertaken by focus group facilitators in their reporting.

Quirkos (qualitative analysis software) was used to analyse findings documented in these reports and were drawn together to form the main findings below.

An inductive thematic analysis approach was employed with sections of text assigned to newly generated codes which were then reviewed and grouped together into broader themes (which are shown in Figure 30). These were presented according to five areas of interest which organisations were asked to explore with participants.

Each focus group report was added with existing codes applied or new ones generated where needed. The final themes therefore reflect the sum of all groups though the analysis presented below also highlights issues specific to different groups.

Focus Group Characteristics

Each focus group was convened to gather perspectives from underrepresented groups in the main survey. The theme of each group and a description of the group participants is summarised below.

Table 7: Focus group themes and descriptions of the groups

Code	Target group	Group description
FGP	Pilot Group People with experience of substance misuse	• 8 participants • Face-to-face focus group • All with experience of substance misuse and currently residing in hostel accommodation
FG1	People with long term health conditions, e.g. diabetes, COPD including participants from BAME groups	• 10 participants • Face-to-face focus group • All report some health issue or disability including cognitive impairment, impaired mobility and fatigue.
FG2	Older people over the age of 75 years living independently	• 10 participants • Face-to-face focus group • 5/10 report some health issue or disability
FG3	Refugees and Asylum Seekers	• 10 participants • Individual face-to-face interviews • None reported existing health issues or disability • All were refugees
FG4	Carers including participants from BAME groups	• 10 participants • Online focus group • 2/10 report some health issue or disability • All were carers
FG5	People with sensory impairments including participants from BAME groups	• 12 participants • Face-to-face focus group with one online participant • All report having visual impairment
FG6	People with mental health conditions to include participants from BAME communities	• 10 participants • Online focus group • All report some mental health condition: Depression (4), Anxiety/panic attacks (4) eating disorder (1) Post Traumatic Stress Disorder (1) • Note all participants 18-25 years
FG7	Young people aged between 18-25 years including participants from BAME groups	• 10 participants • Online focus group • 1/10 report having depression

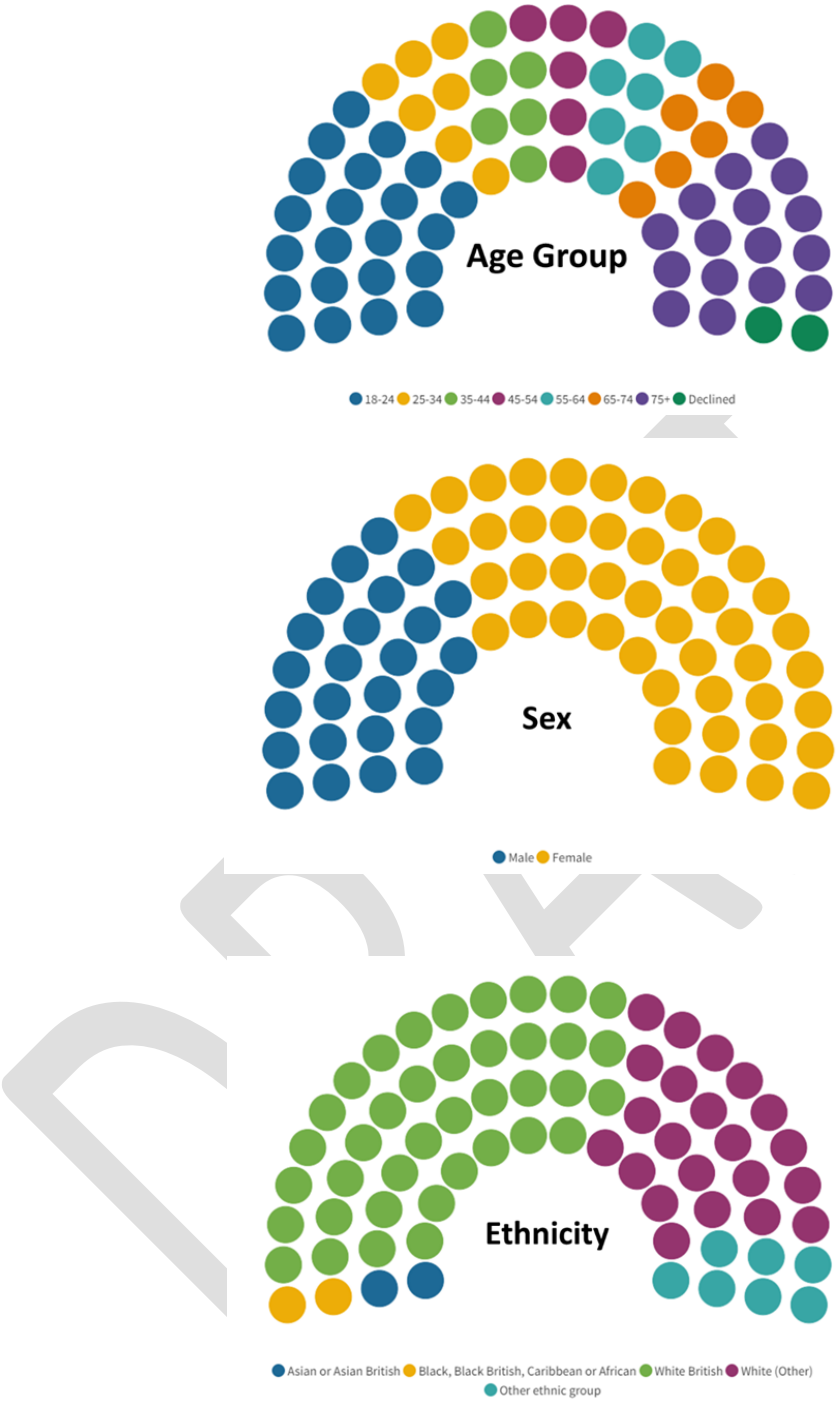


Figure 27: Age, Sex and Ethnicity characteristics of participants across all groups (excluding pilot)

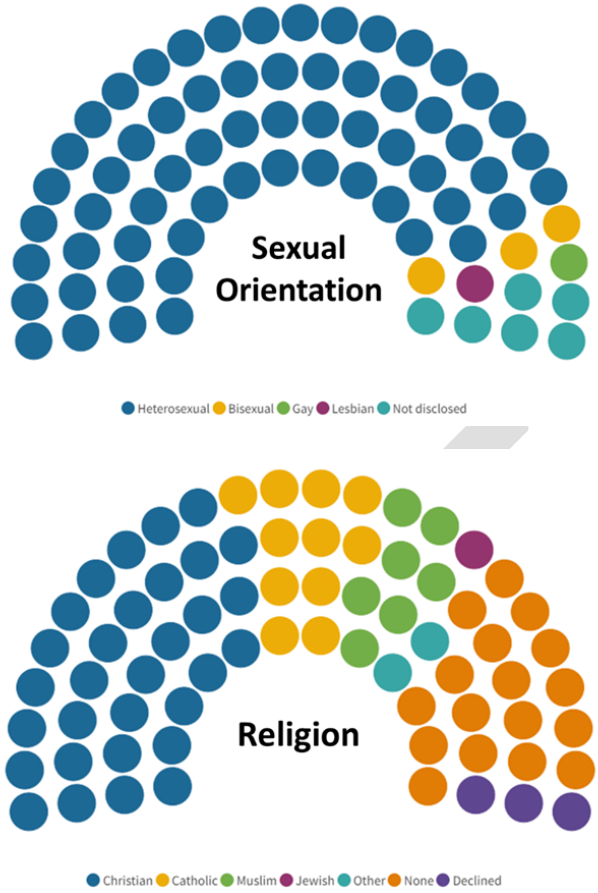


Figure 28: Sexual orientation and religion across all focus groups (excluding pilot)

The focus groups achieved an appropriate mix of participant characteristics. There was a wide range of ages in the sample with clustering in young adults and older adults, reflective of the target population of specific groups. There was a greater proportion of women (65%) than men in the sample and this was generally reflected in individual groups too.

There is representation from a range of BAME backgrounds though the largest non-white British group was those from other white (Eastern European) backgrounds (31%) primarily reflecting the sample from FG4 and FG6. Representation from a range of religions was achieved and additionally from non-heterosexual orientations (6% of the total sample).

A full summary of the participant characteristics including a breakdown of individual groups is shown in Appendix 6b.

Overview of thematic analysis

The main themes identified in the analysis were grouped according to five pre-defined areas to explore. In addition, a specific group collating recommendations from each focus group was included. These are described in more detail in this next section of the report.

The main findings and Illustrative quotes are presented in relation to five key areas of exploration set out in the focus group topic guide:

- **Access to pharmacy services:** How do participants experience accessing pharmacy services?
- **Impact of the COVID-19 pandemic:** What were their experiences of pharmacy services during the pandemic?
- **Advice and information:** What are their experiences of accessing health and lifestyle advice through pharmacies?
- **Dispensing:** What are their experiences of medication dispensing, particular in regard to prescription medications?
- **Other services:** Do they access any other pharmacy services and what are their experiences of these? Are there barriers to accessing these?

1 Access to pharmacy services

Key findings

- **Location determines accessibility by different forms of transport**
- **The environment of the pharmacy influences experiences and privacy is valued**
- **Pharmacists are held in high regard as knowledgeable and approachable professionals**
- **Barriers to access can be identified and reasonable adjustments made to improve equity**
- **Technology is playing an increasing role in how people of all ages access pharmacy services**
- **A wider range of opening hours are valued by some participants**
- **Disruptions to pharmacy opening can have a significant impact for those who rely on time critical services (such as daily medication dispensing)**

The location of pharmacies has important implications for their accessibility and an important determinant of which pharmacy people choose to use. Inadequate public transport links may be a major barrier to access for some people. For those driving, provision of parking was an important consideration.

> **"It depends where you are. You choose the nearest one to where you are."** *FG5*

Other valued the co-location of pharmacies with other services. These included having them located with GP practices but also located with other shops which meant visits could be combined with other activities.

> **"I prefer to tie it in with supermarket or other shopping to make it more of a pleasant and enjoyable experience"** *FG4*

Whilst opening hours suited many participants, others highlighted the challenges for some working people along with concerns about accessing services outside of normal working hours. This included those who did variable shift work where flexibility to attend at a wider range of times was particularly

important. In addition, some participants in the pilot group highlighted the impact of unexpected closures of the pharmacy they relied on for daily medication collection.

The environment of the pharmacy also has a strong influence on the experience of using them. For some participants including some of those with mental health conditions, busy environments were very challenging, and they valued having smaller, quieter pharmacies. Furthermore, participants expressed the importance of having private spaces to discuss sensitive issues.

> **"I think they've come a long way in the last few years and then if you want to talk to a pharmacist, I think they all have private rooms now. So, you don't have to have those conversations in the middle of, you know a big queue of people"** *FG1*

More general concerns about privacy were raised in one of the focus groups in relation to how personal information was required to be shared in an open space with other people overhearing this when collecting prescriptions. Whilst raised only in one group, there was wide agreement in that group that this was a concern.

> **"There was particular concern regarding the apparent lack of discretion and potential breach of GDPR at dispensing counters and other areas within chemists whereby the disclosure of personal data including name, address, medical condition, symptoms and other matters of a personal and sensitive nature were often disclosed at full volume and with the risk of strangers in close proximity hearing such information and discussions held."** *FG4 Facilitator comment*

Privacy was specifically raised in the context of methadone dispensing discussed in the pilot group. Although private spaces should be available in pharmacies, they were not always offered for use and so supervised medication was taken in public spaces instead. It was also highlighted that reducing the length of time between arrival at the pharmacy and dispensing of methadone might improve the experience and some participants wondered if medication could be prepared in advance to facilitate this.

> **"People described that they were not offered a private space to take supervised medication, and felt uncomfortable doing this in front of other people using the pharmacy"** *FGP Facilitator Comment*

Many participants reported very positive experiences of interaction with pharmacists. There was evidence that some felt a personal connection to the pharmacy and that pharmacists were perceived as being approachable, knowledgeable and polite professionals. Having continuity of contact with an individual pharmacist was also valued by some participants across multiple focus groups. For many, good customer service experienced by themselves or reported by others was seen as a strong determinant of their overall experience and could influence the choice of pharmacy used.

> **"Very nice, very professional."** *FG3*

Some participants reported negative experiences, and these could sometimes result in a change in the pharmacy used. A more general comment from participants from the pilot groups was their experience of feeling stigmatised. This may be symptomatic of wider experiences of societal stigma in relation to substance misuse but appeared to be an important determinant of their experience in a service that some of them were accessing very frequently for supervised medication.

> **"So judging. They get your notes, it says you're on meth …. they look down their noses at you"** FGP

In addition to transport issues, a number of barriers to accessing pharmacy services were highlighted. Language barriers could prevent people from accessing services themselves and they may rely on friends and family to collect medications for them or support them to use other services. This included issues around literacy as well as spoken English.

> **"In the beginning, when I moved to UK, I did not speak English, so I did not use it"** *FG3*

> **"Some said this wasn't helpful for anyone who can't read – a suggestion was made for TV monitors in the waiting area providing spoken information about services available"** *FGP Facilitator Comment*

Some specific challenges were highlighted for those with visual impairment. These included limitations to the provision of written information in Braille and some reported poor experiences in pharmacies where reasonable adjustments were not made or they felt stigmatised. These highlight more general concerns about how pharmacies can make reasonable adjustments to make their services more accessible to those with a range of different circumstances and needs.

> **"I think you've got to be prepared to be a little bit creative…It's not one size fits all for any of us…there are places that can just use a little bit of a brain and it doesn't take them any longer [to make their service accessible] once they've twigged."** *FG5*

Some participants accessed pharmacy services in part or in whole through telephone and online methods. Online ordering appeared to be increasingly popular and was perceived as being relatively easy to use and could be more efficient. Others valued telephone access both for ordering medications but also seeking pharmacy advice.

2 Impact of the COVID-19 pandemic

Key findings

- **Pharmacy services continued to be provided with a high degree of continuity**
- **Specific problems arose for those with limited social support**
- **Increased use of online and delivery services may be a positive legacy**

Overall, it appears that participants pharmacy services to have responded well during extremely challenging circumstances. Despite some concerns about whether medication supplies would be disrupted, this did not happen, though some products including alcohol hand gel were frequently out of stock.

> **"In all honesty, knowing how much I rely on my medication every day, I was afraid"** *FG7*

> **"Thankfully my local Pharmacy handled the crisis very efficiently, but it could definitely have been worse"** *FG6*

The main negative impacts included longer queues at pharmacies and difficulties communicating with personal protective equipment (PPE). Furthermore, disruption to other services such as General Practice may have introduced some delays in accessing medications. Difficulties were encountered however by those with limited social support as they may not have had friends or family who could collect medications on their behalf if they were self-isolating or shielding.

> **"It was hard to see a doctor. I had temperature and doctor say – stay at home, but I need medicine and I did not have a friend to help. I must go to pharmacy, but you cannot enter if you have temperature. What can you do in such situation?"** *FG3*

Adaptations during the pandemic supported access to pharmacy services. In particular, there was an increased use of online services and delivery services for medications. Some perceived this as a positive legacy of the pandemic and felt more confident using these services.

3 Advice and information

Key findings

- **Pharmacists are well regarded, and participants valued their expertise in relation to advice on prescribed and over the counter medications**
- **Some saw pharmacists as a preferable alternative to GPs for advice on minor health issues**

Participants reported seeking additional advice about their medications including any specific consideration around when or how to take them, and also for advice about over the counter (OTC) medications. They perceived medication reviews as happening at a distance by GPs and some wondered if their pharmacist would be well placed to help review repeat prescriptions face-to-face.

Pharmacists are also perceived as representing a good alternative to GPs for advice on minor medical problems. Participants often reported having sought such advice and had good experiences with this. This included advice for themselves as well as other family members.

> **"I think generally you know, pharmacists are very, very helpful and especially if you don't want to trouble the doctors for minor things, they go in there and also they might bring up all the medication you are on, and they will advise you"** *FG1*

> **"If my children or I have a flu or something simple I do not call GP, I go to the pharmacy"** *FG3*

However, some expressed uncertainty about the level of training that staff they met at the counter had. They wished to have greater reassurance about the level of knowledge regarding medical advice if they were to feel more confident in seeking advice from a less familiar source.

> **"...This was deemed to potentially provide assurance and confidence that general advice and information or recommendations for over-the counter medication was knowledgeable and accurate"** *FG4 Facilitator Comment*

The advantages appeared to be the immediate accessibility. Privacy concerns may be a barrier for some though whilst others appeared unaware of what advice could be sought. In addition, some participants reported having had negative experiences with NHS 111 and expressed a preference to be able to seek out of hours pharmacy advice directly.

> **"I don't know if they do this just, you can't ring the pharmacy can you, to get advice?"** *FG1*

Key findings

- **A range of methods are used to order repeat prescription medications, and each may better suit different people**
- **Delivery was a valued service for some, but this is not a commissioned service outside of a limited period during the pandemic**

Dispensing of medications was perceived as a key role of the pharmacy for the majority of participants. Many of them were prescribed repeat medications by their GP to collect from pharmacies. There were a range of methods to order repeat medication from their GP practice with some preferring one method over another. This perhaps reflects a more general finding that different ways of accessing any aspect of pharmacy services may be valued by different people.

> **"Some preferred to order through an online company/site and found it very easy to do. This cut down on the number of trips needed… Some of the group agreed they still preferred putting their paper repeat prescription into the box in the doctors and then collecting from the pharmacy a few days later."** *FG2 Facilitator comment*

There appeared to be a growing use of online and telephone ordering reported by the older participants since the onset of the pandemic and this was generally considered to be easy and more convenient. However, some concerns were raised about whether some people would not be able to access these due to lack of internet connectivity or skills.

Some reported frustration with having to go multiple times to collect repeat medications if prescription dates were not aligned, prescriptions were not received at the pharmacy or medication was not in stock. Furthermore, some reported they valued longer prescription durations to reduce collection frequency.

> **"Following a recent illness, the number of tablets I need to take has increased. I asked my GP to put these onto a 3-month prescription rather than monthly. This has been better than having to collect every month"** *FG2*

One focus group mentioned concerns that the brand of medication dispensed could change without notice, with inhalers given as an example. This was perceived as sometimes being an issue of cost saving.

Medication delivery was also frequently mentioned, and this appeared to be very important to some participants who were not able to attend the pharmacy independently. Delivery services were valued but some problems were reported with missed deliveries. As a non-commissioned service, there appears to be inconsistency in how it is offered and whether there is a charge.

> **"I love the delivery service, straight to my door. Absolutely great."** *FG5*

Some specific dispensing issues were raised that would impact disabled users. Some participants with visual impairment reported that dispensing labels would sometimes cover Braille on medication boxes. Another reported difficulty in removing medication from blister packs due to problems with find hand movements. Finally, some benefited from having compliance aids prepared by the pharmacy but there appeared to be some uncertainty amongst participants about who was eligible for this and how it could be arranged.

5 Other services

Key findings

- **Participants reported limited use of other pharmacy services**
- **Lack of awareness of what is available may in part contribute to this**
- **Vaccination and blood pressure checks were amongst the most commonly reported services used**

Participants generally saw pharmacies as primarily being for the sale and dispensing of medications. Many of the participants reported having repeat prescriptions and some collected medications for others or had medication collected for them.

> **"It was identified that the main factor for accessing pharmaceutical services for all in attendance was primarily for the issuing/collection of prescriptions and the purchase of over-the counter medication"** *FG4 Facilitator Comment*

They reported fairly limited use of other services within the pharmacy which may in part reflect a lack of knowledge about what is available. Awareness of what services were available varied across the groups. Whilst some felt that they did have need of these additional services, others expressed these could be beneficial to them if they were more aware of what was available. Pharmacies were seen as potentially reflecting an alternative to accessing services through the GP.

> **"I didn't realise there's so many services they could do."** *FG1*

> **"None of the participants were aware of the general health and lifestyle advice or disease prevention"** *FG3 Facilitator Comment*

> **"All participants knew that pharmacies offer vaccinations and immunizations; advice for minor illnesses; advice on sexual health; disposal of unwanted medicines; information and advice on lifestyle services; prescription"** *FG5 Facilitator Comment*

Amongst the services most frequently mentioned were vaccinations and blood pressure checks, whilst accessing contraceptive advice was also mentioned by one participant. Again, privacy concerns may be a barrier to wider uptake of some more sensitive services.

> **"Some participants choose to get their vaccinations at the pharmacist because it is less busy and available quicker than at their GP surgery"** *FG5 Facilitator Comment*

6 How participants felt their experiences of accessing pharmacy services could be improved

Group facilitators generated a summary of recommendations to improve pharmacy services from the perspective of the focus group participants and should not be read as the recommendations of the PNA itself. The summary presented below integrates suggestions across all groups, some of which were duplicated in multiple groups.

These covered aspects of pharmacy services but also wider system issues including prescribing in primary care.

6.1 Increase awareness of additional services offered by pharmacies

- This was a common theme through all groups and was considered a significant limiting factor to making better use of existing services offered
- Ideas to share information included through direct advertising on prescription bags, leaflets/posters in GP surgeries, TV adverts, apps and online adverts on YouTube/TikTok

6.2 Address barriers to accessing pharmacy services

- Ensure pharmacies are located at a reasonable distance and accessible by public transport
- Consider the impact of language barriers on access to services – some participants suggested the use of translation apps to support understanding
- Flexible opening hours meeting different needs and align staffing with busiest periods
- Ensure privacy and confidentiality is maintained including in relation to sharing of personal details at counters
- Ensure adequate provision and awareness of private spaces to support confidence in sharing personal concerns and for sensitive issues including supervised medication
- Busy spaces can be challenging for some groups – a variety of smaller and larger pharmacies is valued by some participants
- Some participants expressed a preference to access out of hours pharmacy support direct rather than through NHS 111
- Some are not aware of the high level of training and qualification pharmacy staff have and would like reassurance on this to feel more comfortable in seeking additional advice

6.3 Ensure information is accessible

- Be aware of issues of language and literacy barriers when advertising services and providing information
- Specifically relating to written information for those with visual impairment
- This includes physical written materials and the design of websites and apps to facilitate the use of screen readers
- Recognising that some may experience digital exclusion and so multiple ways of accessing information (including offline options) are required

6.4 Convenience of repeat prescription medications could be improved by…

- Continuing to develop digital solutions to improve ease of ordering medications in primary care
- Continuing home delivery including for those in most need of it

6.5 Continue to focus on providing high quality customer service

- Ensure changes in brands of medication dispensed are clearly communicated
- Ensure changes to opening times or unexpected closures are communicated to those who rely on critical services e.g., supervised medication
- Multiple groups highlighted that their experience of customer service was important to their choice of pharmacy. Building a relationship with the pharmacist was important for some, for example where they had regular contact such as for supervised medication
- Whilst many reported very positive experiences, the few negative experiences often resulted in participants switching pharmacies, which may be less accessible in other ways
- Some participants

- Pharmacists are well liked, trusted and respected professionals and this status opens the door to engaging in a wider range of health promoting services

Key messages from focus groups data

1 Location, transport links and opening hours influence accessibility of pharmacies

Participants use different modes of transport to attend pharmacies. How easy these are to access is determined by their location (including distance), parking availability and public transport links. For some, additional extended opening hours would be welcomed to ensure working people can attend pharmacies. Unexpected changes to opening hours can be very disruptive to those requiring critical supervised medication.

2 High quality customer service is an important determinant of the overall experience of using pharmacy services and privacy is also valued

The experience of interactions with pharmacy staff was seen as an important determinant of which pharmacy participants used. Pharmacists are widely seen as approachable and knowledgeable professionals whose expertise may be underused currently. Positive experiences were often associated with developing personal connections to individual pharmacies. In addition, the environment of the pharmacy can influence the experience of users. Providing a private space to discuss more sensitive issues is valued and maintaining privacy around supervised medication was also considered very important. Less busy pharmacies may suit some people better including some of those with mental health conditions or visual impairment. More generally, some participants expressed concerns about privacy and confidentiality when sharing personal details at counters.

3 Telephone and online access supported by medication delivery provides an important alternative to attending in person

Beyond attendance in person, participants made wide use of telephone and online access. The latter has particularly developed as a result of the COVID-19 pandemic. Positive experiences of online access were reported across groups including older participants and highlights a potential area of further development. For those who find attending pharmacies in person more challenging, the addition of medication delivery is valued.

4 Pharmacies can provide a valuable alternative to GP practices for advice on minor medical conditions and potentially for reviews of medication

Pharmacies are already seen as a good alternative to GPs for advice on minor medical conditions. Some participants have also received advice relating to their prescribed medications, but it was suggested that this could be an area for further development.

5 Other services currently have limited use and increasing use may be dependent on greater awareness and ensuring privacy can be maintained for sensitive consultations

Awareness of the range of other pharmacy services varied across participants but generally the level of use of these services was reported to be low. Some of this may reflect a lack of awareness of what is available, whilst others perceive that they have no need of these services currently. In general, the services which are accessed are considered to be more convenient alternatives to GP practices and there may be scope to increase awareness of some of these.

6 Reasonable adjustments supporting access to pharmacy services for groups with different needs

Each participant group shared particular experiences and issues relating to accessing services.

For pilot group participants with experience of substance misuse, pharmacies can be a critical resource and they may have very frequent contact. Stigma can be experienced, and this is also reported by some participants in relation to their interactions with pharmacies. Steps taken to maintain privacy around supervised medication are valued. Building relationships through consistent engagement with individual pharmacists was valued.

For older participants, transport could be an issue and they were more likely to benefit from telephone/online ordering and delivery, though some valued attending in person and the personal connection to pharmacies. This has relevance in the continuity of service provided as well as ensuring adequate public transport provision. In addition, whilst some may experience difficulties with online provision, the majority of older participants reported positive experiences of this.

For those who did not speak English fluently, this could be a major barrier to attending. Whilst some were content with friends or family attending on their behalf, this may limit their access to other services (for example women accessing contraceptive services). Access and provision of information was also an issue raised by those with visual impairment, who reported specific issues of accessibility with written information as well as the importance of adjustments in-store to support them in accessing required services.

For this with mental health conditions, they may regularly use pharmacies to collect medications but may experience some difficulties in certain environments, particularly those that were very busy. They valued pharmacists showing an insight into their experiences and would welcome wider mental health awareness and mental health first aid training.

Finally, for younger participants, they reported being occasional pharmacy users. They expressed the importance of having accessible information particularly about OTC medications and other services relevant to their needs. Some expressed that information may be best provided through online media including via social media platforms.

Strengths and limitations

These focus groups provide rich qualitative data from several under-represented groups in other PNA data sources. They closely resemble some of the findings from other parts of the PNA, adding additional strength to these. They also help to illustrate some of the particular experiences and concerns of members of our local population in relation to accessing pharmacy services. Having seven groups allowed common themes to emerge across them, as well as highlighting some of the diversity of experiences and perspective of different groups.

In terms of limitations, as with most in-depth qualitative data, participants are a small and non-representative sample of the population as a whole. Therefore, they should not be considered as generalisable to the population but rather that the findings are considered alongside other data sources. In addition, the analysis was undertaken at the level of the focus group reports rather than the individual transcripts and coded by a single person. This was felt to be appropriate to the purpose here and the findings reflect a synthesis of the summarised views of each group.

Finally, participants have expressed views on aspects that are beyond the scope of pharmaciesF83 themselves as well as perspectives that may not be reflective of what is actually provided. These remain important in accurately reflecting what was shared and informing wider system working. In addition, where there are misperceptions about services provided, this is perhaps highlighting issues of public awareness, the extent of which might be further explored in the wider population.

Pharmacy Survey: Executive Summary

Responses were received from 68 (72%) pharmacies within Worcestershire. Accessibility within pharmacies surveyed was overall of a high standard. 96% (65/68) had doors that were accessible for customers using pushchairs, wheelchairs or walking frames. Three quarters had free parking, and 72% had disabled parking available. Additionally, 51% of the pharmacies had adjusted or made alterations to enable physical access to the pharmacy. There was a wide variety of languages spoken in addition to English within the pharmacies.

A large majority (65/68) of pharmacies could provide a consultation room that was able to have the door closed, with 95% of these having hand washing facilities close or near to it. The survey did highlight that only 28% of the pharmacies had access to toilet facilities, and that only 46% had a hearing loop available.

100% of responding pharmacies provided the New Medicine Service. Other services that were reported frequently being offered were Community Pharmacist Consultation Service (CPCS) (96%) and the Flu Vaccination Service (82%). 47% currently offer Hypertension Case finding, with a further 32% being able to offer this service in the next 12 months. The variation of available services reflects differences in commissioning throughout the county.

The common theme throughout the pharmacy survey was that a high percentage of pharmacies would be willing to provide additional services if they were to be commissioned. This was true across other, disease specific, screening and vaccination services. Commissioning of services should be proportionate for local public health needs. Smoking Cessation (12%) and Alcohol Management (4%), Sexual health (4%), and needle exchange (4%) were highlighted by pharmacies as being required locally to be commissioned.

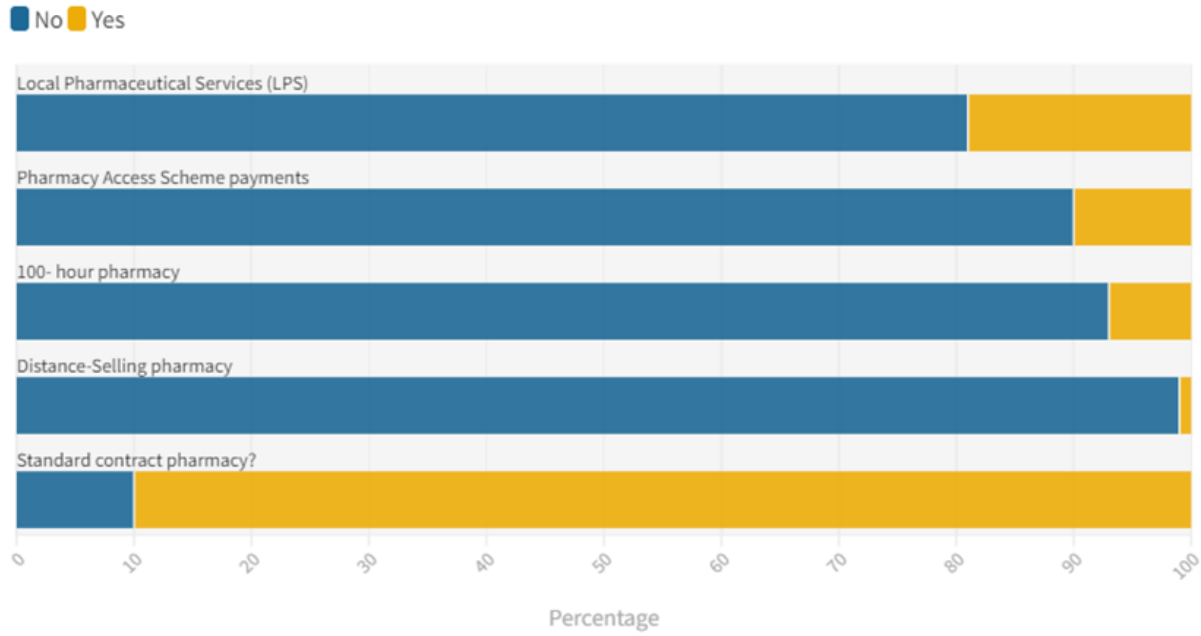
Pharmacy Survey: Report

Worcestershire County Council conducted an online Pharmacy Survey to gather vital information from local pharmacies to best inform the Pharmaceutical Needs Assessment. The questionnaire ran from Monday 14th March to Sunday 29th April 2022.

About the respondents:

- Responses were received from 68 (72%) pharmacies within Worcestershire.
- 90% of the pharmacies that responded were a ‘standard contract pharmacy’
- 19% were Local pharmaceutical services (LPS)

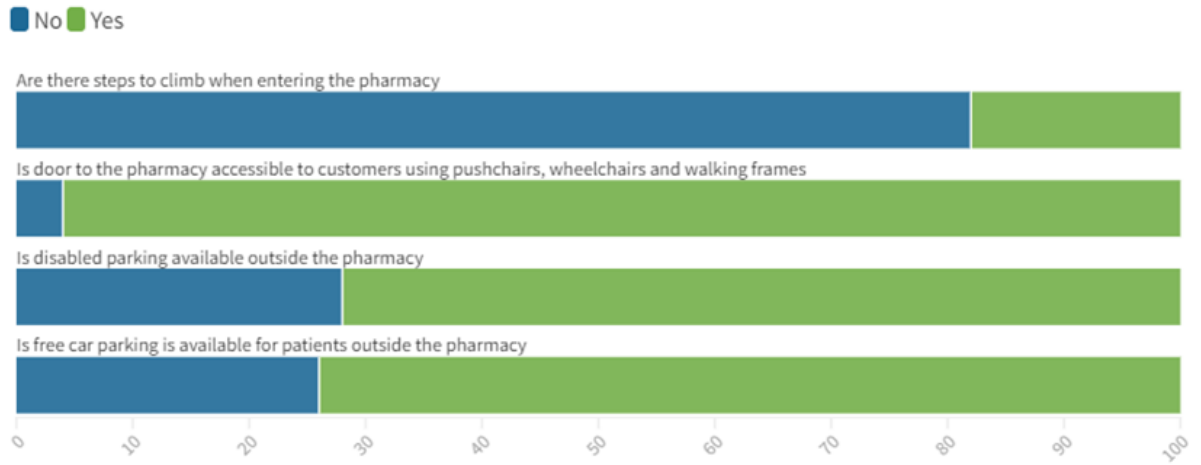
Figure 29: Types of contracts of respondents



Access

- The majority of the pharmacies surveyed were accessible to customers using pushchairs, wheelchairs and walking frames (96%).
- 74% had free car parking available outside the pharmacy, and 72% had disabled parking available outside the pharmacy.
- Only 18% had steps to access the pharmacy.

Figure 30: Access to pharmacy

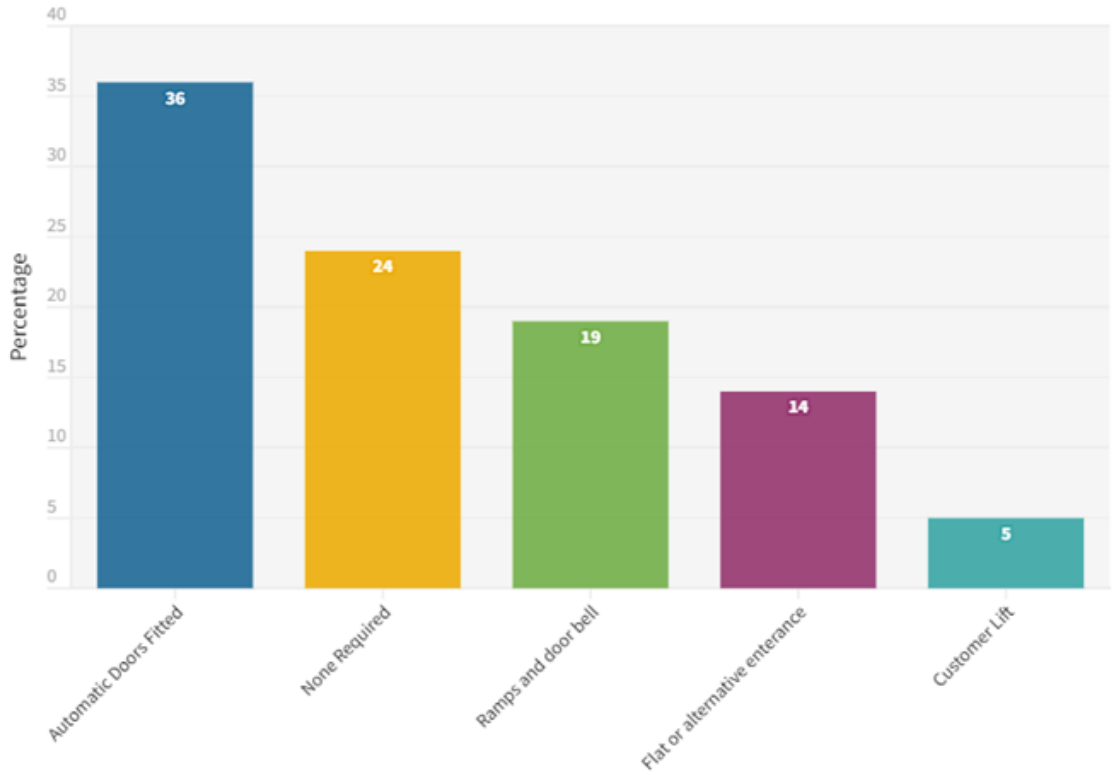


Physical Access

- 51% of the pharmacies had adjusted or made alterations to enable physical access to the pharmacy.

- Examples of adjustments made to enable physical access; 36% had automatic doors fitted, 19% had ramps and a doorbell, 14% had a flat or alternative entrance, 5% had a lift.
- 24% reported no adjustments were required.

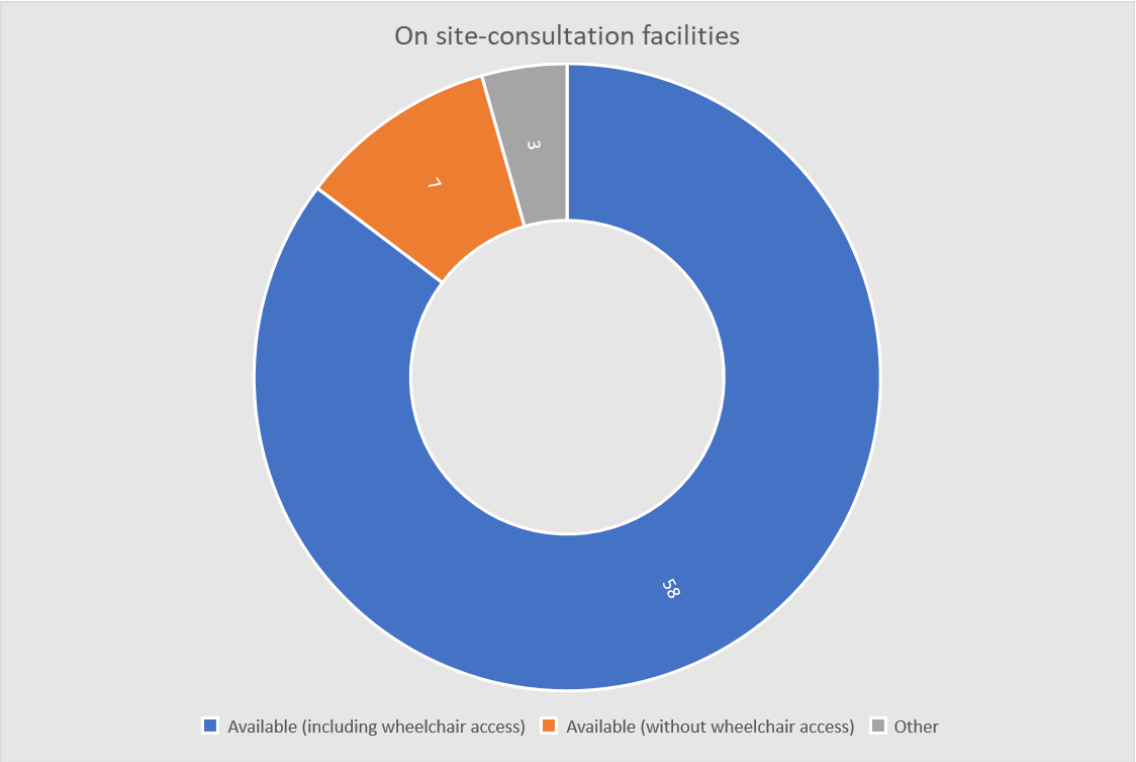
Figure 31: Adjustments made to improve physical access to the pharmacy



On-site consultation facilities

- 58 of the pharmacies reported that there is a consultation room with wheelchair access.
- 6 reported having a consultation room without wheelchair access, a further pharmacy reported that wheelchair access was planned before April 2023.
- The remaining pharmacies that reported no access to a consultation room; 1 reported being a distance pharmacy, 1 being too small and finally 1 gave no reason.
- 100% of the consultation rooms could be closed.

Figure 32: Onsite Consultation Facilities



- During consultations 95% had access to hand-washing facilities either inside or close to the consultation area.
- 28% of patients attending for consultations had access to toilet facilities.
- 95% of pharmacies were willing to undertake consultations in patient's home/other suitable site.
- Only 46% of pharmacies had a hearing loop in the available.

Languages Spoken with Worcestershire's pharmacies

Advanced Services available within Pharmacies in Worcestershire

- 100% of responding pharmacies provided the New Medicine Service. Other services that were reported frequently being offered were Community Pharmacist Consultation Service (CPCS) (96%) and the Flu Vaccination Service (82%).
- Infrequently offered advanced services were Appliance Use Review Service (18%) and Stoma Appliance Customisation Service (26%).

Other services offered by pharmacies

a. The most common services currently being providing by the surveyed pharmacies were Supervised Administration Service (78%), Home Delivery Service (59%), Emergency Supple Service (59%), Sharps Disposal Service (52%) and Extended Care Tier One (UTI) (46%) (Figure 36).
b. The five most reported services that would provide if commissioned were: Healthy Start Vitamins (75%), Stop Smoking Service (74%), Chlamydia Treatment Service (72%), Chlamydia Testing service (72%) and Vascular Risk Assessment Service (71%) (Figure 37).
c. The most popular to be provided privately were Care Home Service (60%), Sharps Disposal Service (43%), Contraceptive service (not EHC) (24%), Oral Contraceptive supplies (24%) and Language Access Service (22%) (Figure 38).

d. And the most likely not to be provided even if commissioned were: Out of hours service (40%), Phlebotomy Service (32%), Schools Service (29%), Language Access Service (29%) and Care Home Service (28%) (Figure 39).

Figure 33: Services currently providing

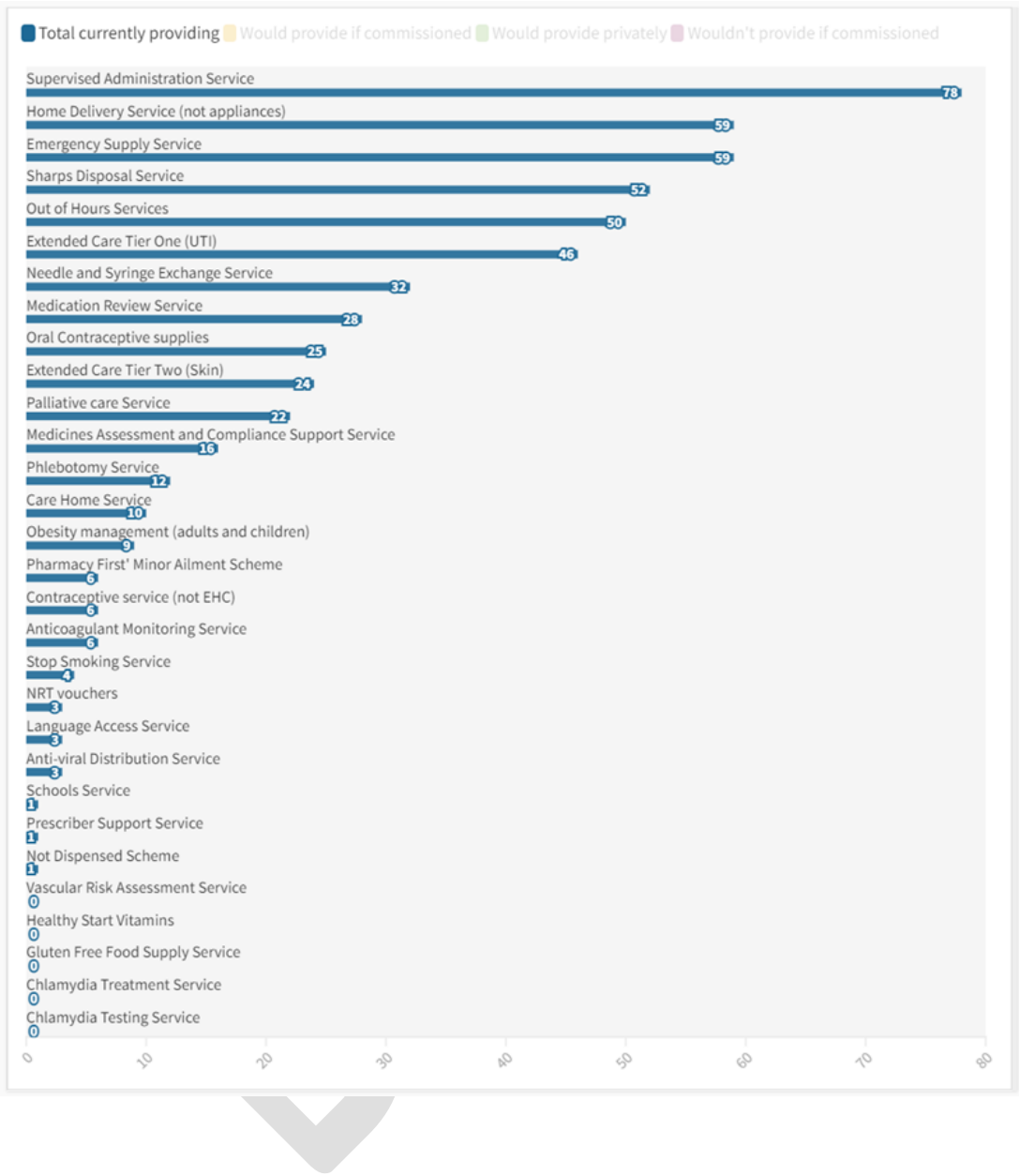


Figure 34: Services that would be provided if commissioned

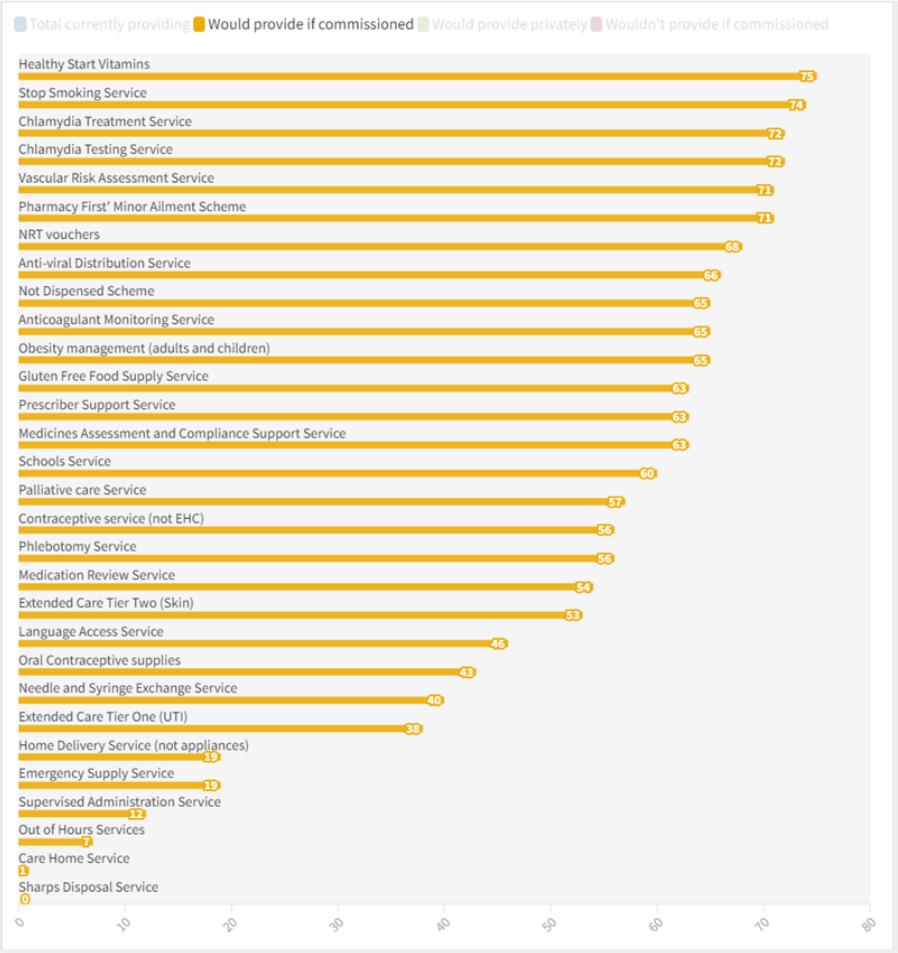


Figure 35: Services that would be provided privately

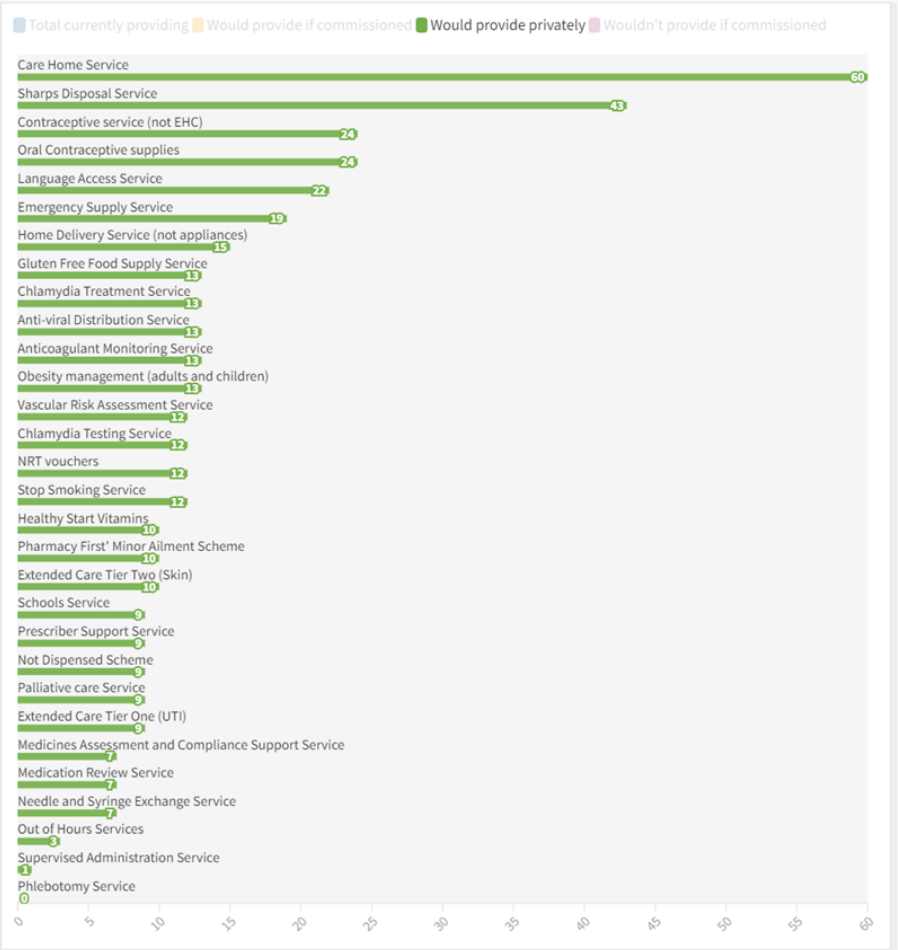
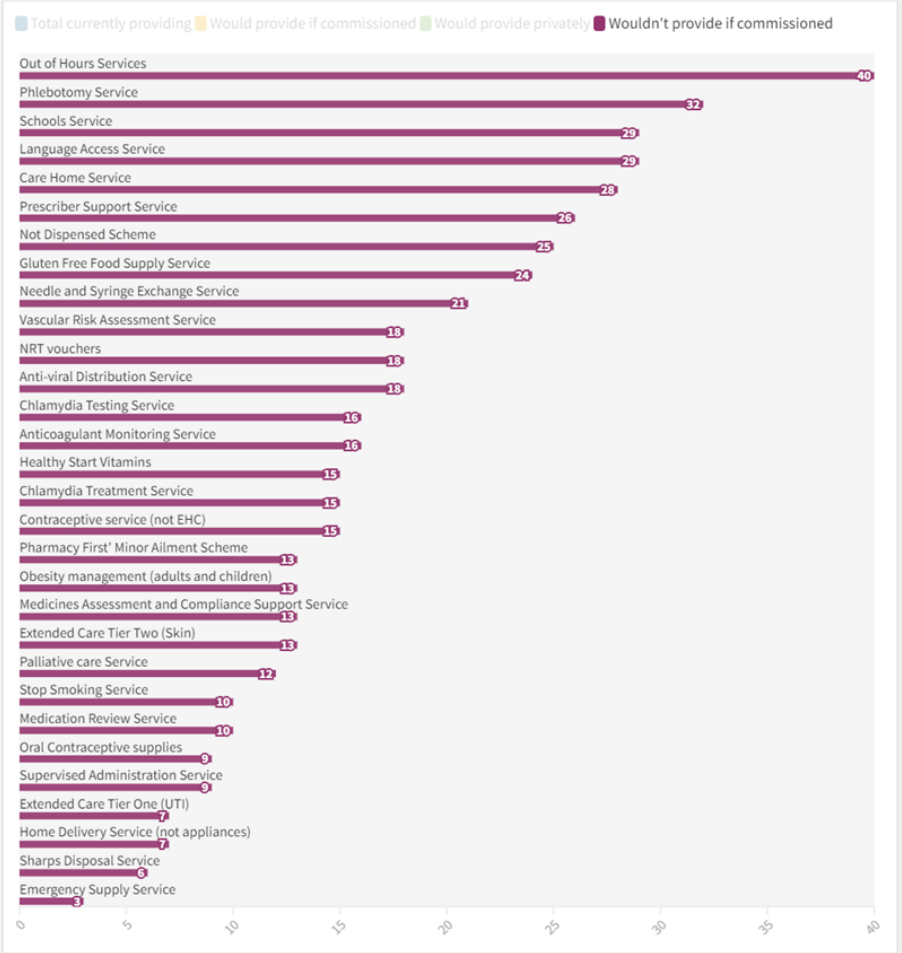


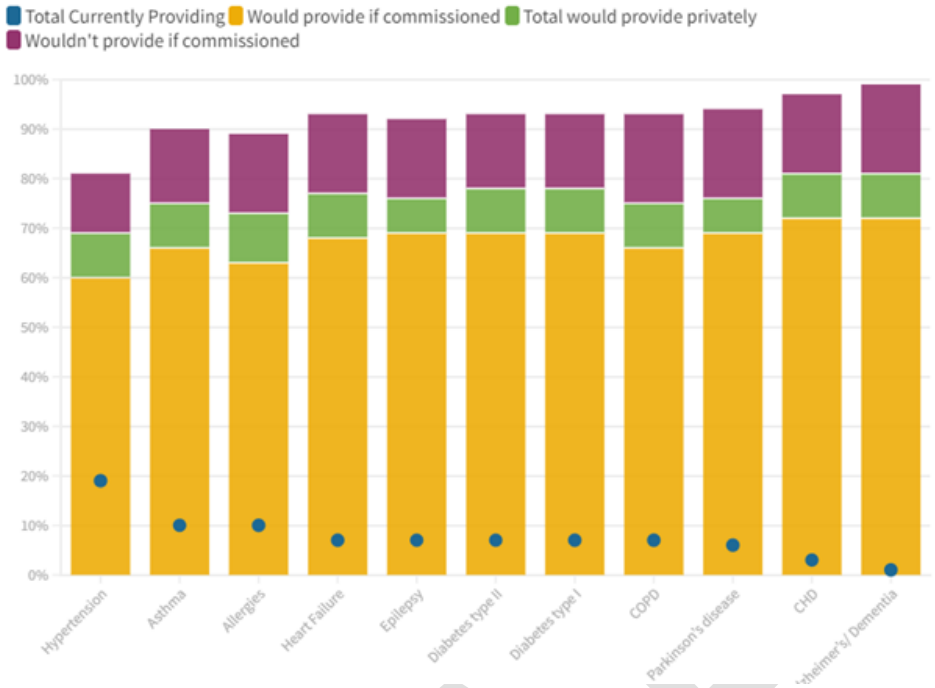
Figure 36: Services that wouldn't be provided if commissioned



Disease Specific Services

- Overall, there was a low provision for the disease specific services. The majority of the services were only provided by 10% or less of the pharmacies, with the exception of the hypertension service which was provided by 19% of pharmacies.
- A high percentage ranging from 63% to 72% of the pharmacies reported that they would provide the disease specific services if they were to be commissioned.

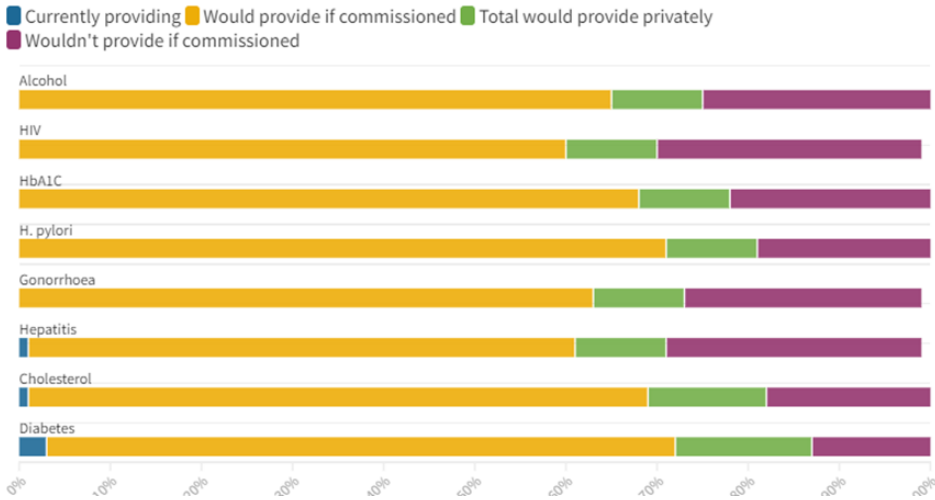
Figure 37: Disease Specific Services



Screening Services

- There was very low provision of screening services reported from the pharmacies as these are not commissioned within the county. Only 3% offered diabetes screening as a service, followed by 1% offering Cholesterol, and 1% providing Hepatitis screening.
- A high percentage ranging from 63% to 71% of pharmacies reported that they would provide the screening services if they were to be commissioned.

Figure 38: Screening Services

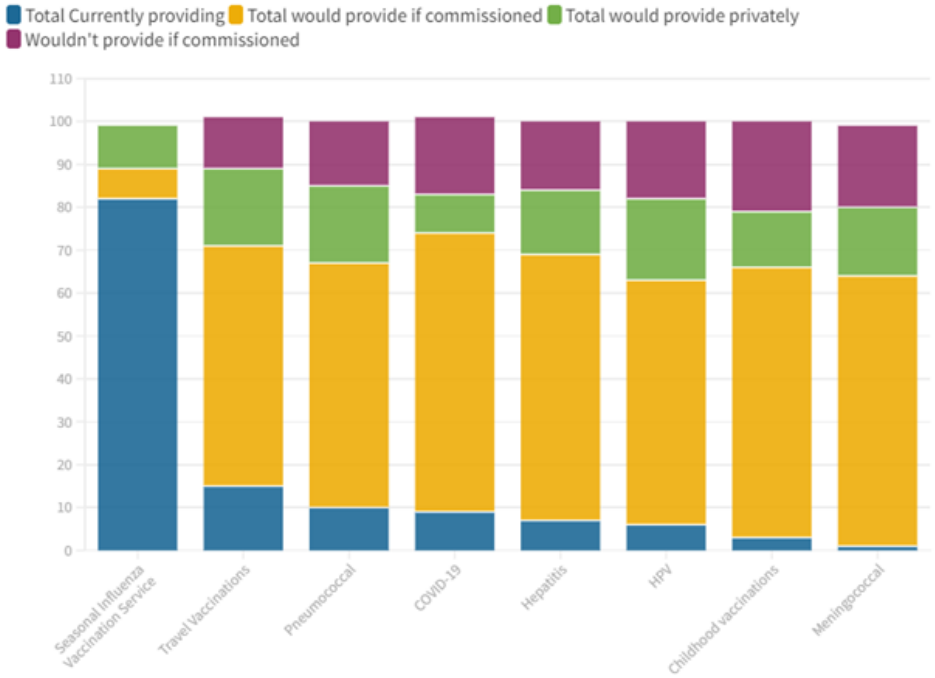


Vaccinations

- 82% of the pharmacies provided a seasonal flu vaccination service.
- There were low numbers of other vaccinations service reported again as these are not currently commissioned within the county.

- A high percentage ranging from 56% to 65% of pharmacies reported that they would provide other vaccinations if they were to be commissioned.

Figure 39: Vaccination Service



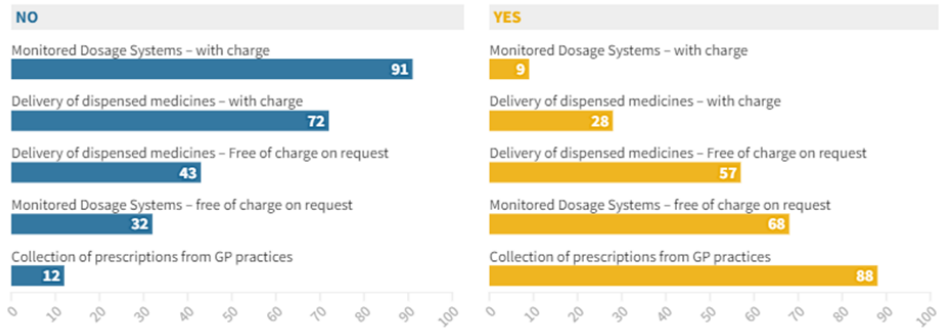
Other Services

- Only 1% of the pharmacies currently provides the Independent Prescribing Service, but 66% would provide if commissioned.
- Only 1% of the pharmacies currently provides a medicines optimisation service, but 74% would provide if commissioned.
- Where the private service is provided the therapeutic areas covered are Travel-Antimalarials and Erectile Dysfunction.

Non commissioned services

- The most commonly provided non-commissioned services were collection of prescriptions from GP (88%), free of charge monitored dosage systems (68%) and delivery of dispensed medicines (57%)

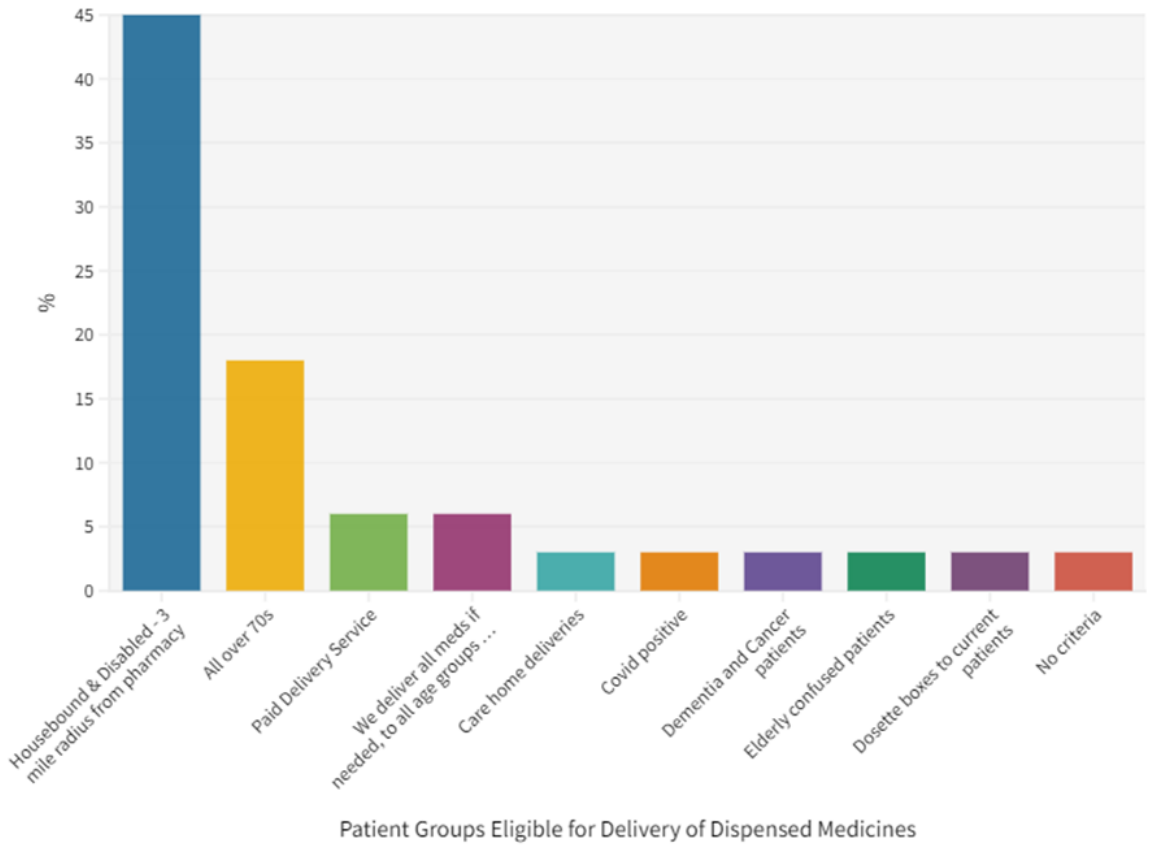
Figure 40: Non-Commissioned Services



Patients Eligible for Delivery Service

- Housebound and disabled patients were most commonly reported as being eligible for a non-commissioned prescription delivery service (45%)
- 18% of pharmacies offered this service to all over 70s despite not being commissioned.

Figure 41: Patients Eligible for Delivery Service



Local Need

- Smoking Cessation (12%) and Alcohol Management (4%), Sexual health (4%), and needle exchange 4% were highlighted by pharmacies as being required locally to be commissioned.

Dispensing Practices Survey: Report

Worcestershire County Council conducted an online Dispensing Practices Survey to gather vital information from local pharmacies to best inform the Pharmaceutical Needs Assessment. The questionnaire ran from Monday 14th March to Sunday 29th April 2022.

About the respondents:

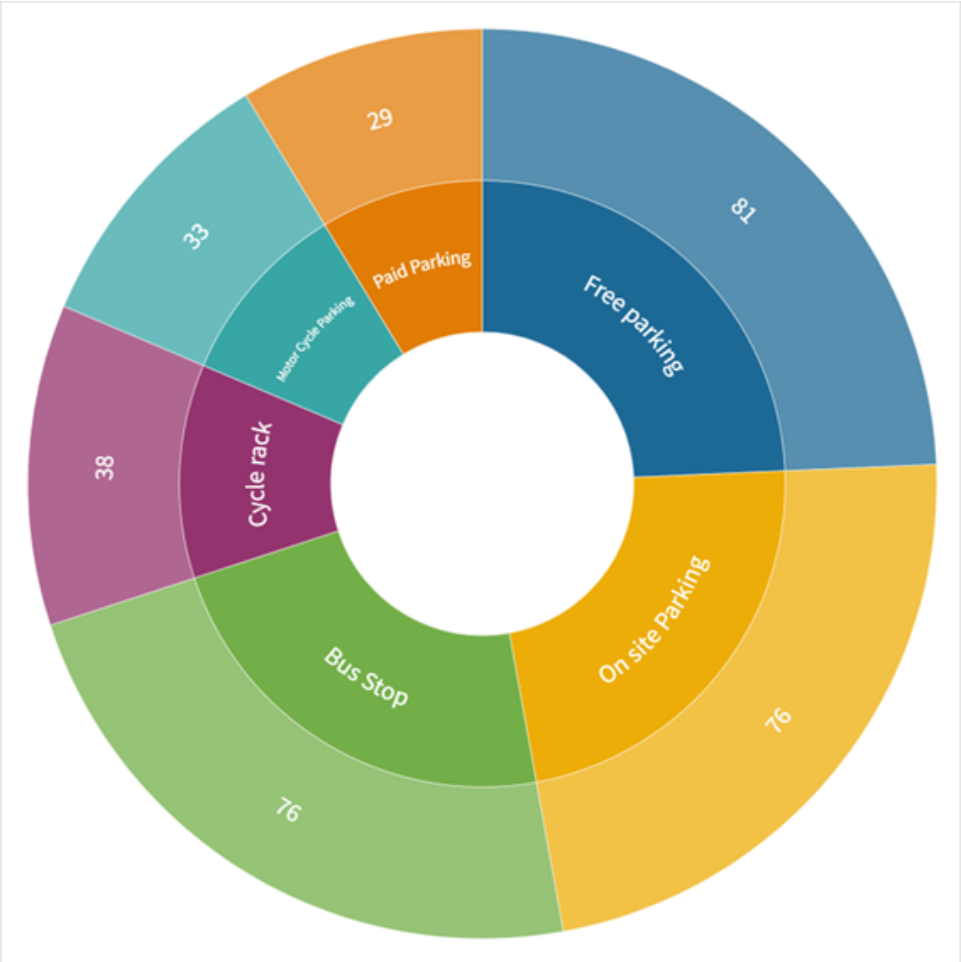
- Responses were received from 21 (100%) dispensing practices within Worcestershire.

Transport

- Figure 43 gives an overview of the transport facilities available around the 21 practices that were surveyed.
- Around three quarters of the practices provided free, onsite, and disabled parking facilities.

- 76% reported a bus stop within 100 meters of the premises.

Figure 42: Transport facilities



Accessibility and equality

- 20/21 of the dispensing practices had doors that were accessible to prams, wheelchairs and walking frames. Limited room for expansion has limited any improvement works within the practice that has limited accessibility.
- Only 1 practice had steps leading up to it, and 71% of the dispensing pharmacies had a hearing loop available. All 21 of the surveyed dispensing practice were compliant with the 2010 Equalities Act.
- 6 practices reported intending to complete improvements to access such as COVID friendly environment and also installation of automation to dispense medicines.
- 4 practices stated that in addition to English other languages were spoken by staff. These included Bengali, Hindi, Punjabi, Polish, Czech, Russian, and Slovakian.

Opening hours

- 13/21 practices were open after 18:00pm

Figure 43: Extended Opening Hours

- None of the practices were open on a Saturday or Sunday, 1 practice did have a 24/7 prescription collection machine.

Services

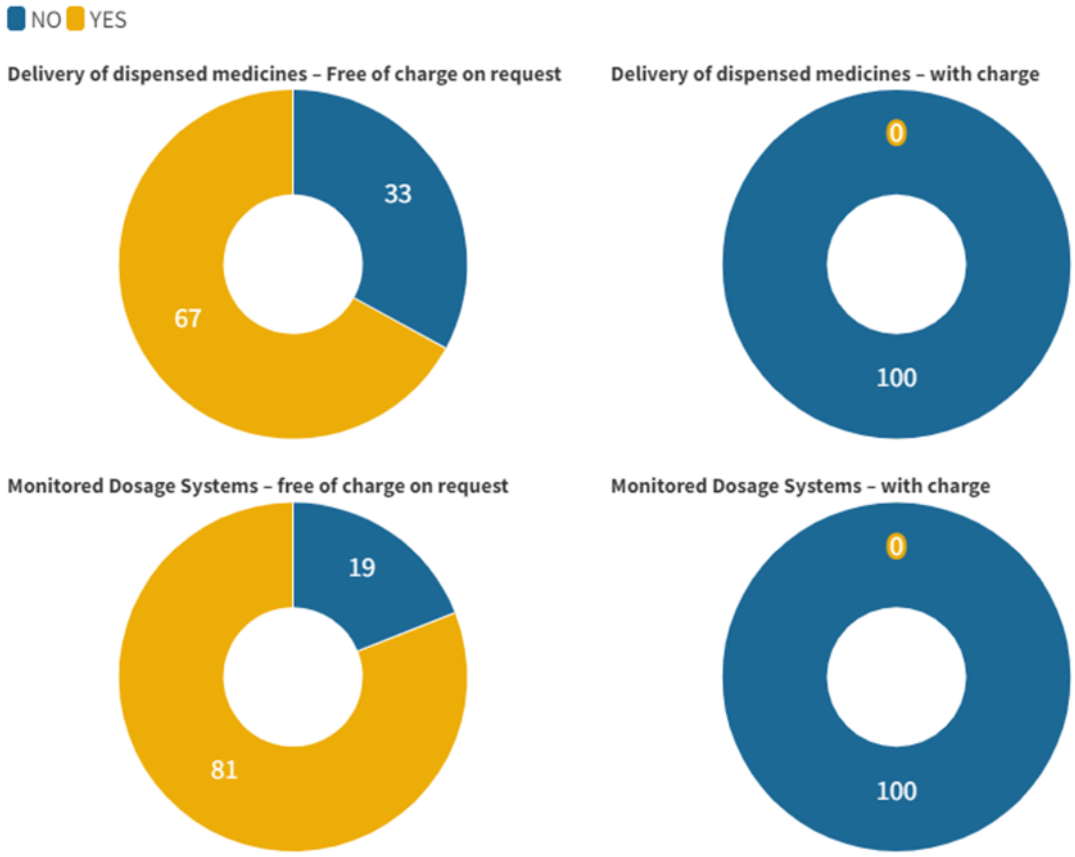
- 90% (19/21) had a clinical pharmacist working at the practice
- 71% dispensed all appliances.
- Many therapeutic areas were covered within the Independent Prescribing Service/Medicines Optimisation Service, see Figure 49.

Figure 44: Areas covered in Independent Prescribing Service/Medicines Optimisation Service

Delivery Services

- None of the practices charged for either the delivery of dispensed medicines or monitored Dosage systems.
- 67% of practices offered delivery of medicines without charge and 81% offered monitored Dosage systems.

Figure 45: Delivery of dispensed medicines



- Monitored dosage systems provided included dosette boxes, NOMAD system, and weekly packs, additionally some practices offered pill cutters and Mars sheets for patients.
- 14 practices detailed eligibility for delivery of dispensed medicines. Inclusion for 4 practices was anyone who required it, 5 practices used to be housebound, 2 being elderly.

Part A conclusions

Part A of the assessment evaluates the current provision of pharmaceutical services within Worcestershire. It does this in 3 parts. Firstly, by comparing population per pharmacy, then by mapping geographical locations, and finally by collating service user and provider views. Firstly, it compared the population per pharmacy in each district to that of England. It established that within Worcestershire the rate is one pharmacy per 6,295 people. This is higher than the England average of one pharmacy per 5,056 people. When GP dispensing practices are included the gap with England is reduced, with one contractor per 5,154 people compared to one contractor per 4,605 people in

England. It was concluded that there is currently sufficient provision of pharmacies and dispensing GP practices through Worcestershire.

Part A then mapped the geographical location of pharmaceutical services (Appendices 9a-9h), this information was used to investigate travel time to pharmacies and dispensing practices using the Strategic Health Asset Planning and Evaluation (SHAPE) tool. According to this analysis the entire population of Worcestershire lives within a 20-minute car journey to a pharmacy or GP dispensing practice. It also shows that around 5/6 of the total population of Worcestershire lives within a 30-minute walking distance of a pharmacy of GP dispensing practice. It concluded that people living in or around urbanised or town areas generally have the best access to community pharmacy/dispensing practices on foot. It also concludes that dispensing practices help to cover the more rural areas of Worcestershire, as community pharmacies tend to be located in more urban areas. To complete the assessment of geographical location, SHAPE was used to collate travel times to pharmacies and dispensing GP practices at the weekend. This analysis revealed that there was a 3% decrease in people living within 10 minutes travelling time by car of pharmacies that open on Saturdays and a 17% decrease in people living within 30 minutes travelling time by public transport of pharmacies that open on Saturdays.

To complete Part A, results from 3 online surveys and seven focus groups were presented. The public survey reported a high level of approval with; the range of services offered (82%), the efficiency of service (89%), knowledge (82%), communication (93%), accessibility of building (92%) and staff friendliness (81%). High levels of satisfaction were reported in ability to access pharmacy when convenient for them (92%) and 87% were able to find information on opening times. 75% of respondents were satisfied with the amount of information that they normally received about medication and overall, 95% said that their experience with this service has been helpful. Focus groups reported that pharmacists are widely seen as approachable and knowledgeable professionals whose expertise may be underused currently. Positive experiences were often associated with developing personal connections to individual pharmacies.

Problems in access were reported with Parking (27%) and with Opening times (22%) both were more of a significant problem for those with long term health/disability suggesting there may be inequalities between user groups. Pharmacies and dispensing GP practices reported that 74% had free car parking available outside the pharmacy, and 72% had disabled parking available outside the pharmacy. Focus groups also highlighted the challenges for some working people along with concerns about accessing services outside of normal working hours. In depth analysis showed that those in full time employment and younger residents were more likely to report using the pharmacy after 18:00pm.

68% of respondents usually travelled to the pharmacy by car, 44% walked and 10% cycled, or used a taxi or public transport, 31% of respondents reported problems with transport. This was also an issue highlighted in the focus groups, inadequate public transport links may be a major barrier to access for some people. This may be more present at weekends as there is a 17% decrease in people living within 30 minutes travelling time by public transport of pharmacies that open on Saturdays. 76% of dispensing GP practices reported a bus stop within 100 meters of the premises and 38% provided a cycle rack for users. Focus groups emphasise for users that drive the provision of parking and location of the setting were important considerations.

When asked why they do not access a pharmacy, around a fifth (22%) of respondents said the pharmacy opening hours are not suitable and a sixth said either because have a disability, 12% said they have no transport access to pharmacy. Focus groups reported that language barriers could prevent people from accessing services themselves. This included issues around literacy as well as

spoken English. Pharmacies reported that 96% of them were accessible to users requiring wheelchairs and walking frames and a large variety of spoken languages other than English were reported. However, only 46% of pharmacies had a hearing loop in the available. Focus groups work also suggested at less busy pharmacies may suit some people better including some of those with mental health conditions or visual impairment.

13% of survey respondents used a delivery service or relative to collect medications for them. Residents with a long-term condition or disability along with older residents relied more on the delivery service and relatives to collect for them. The delivery service is more widely used in the Wyre Forest District (19%) compared to the Malvern Hills district (5%) suggesting provision of such services must be proportional to local need. Focus groups reported that medication delivery was frequently mentioned and appeared to be very important to some participants who were not able to attend the pharmacy independently.

A large majority (65/68) of pharmacies could provide a consultation room that was able to have the door closed. Privacy was highlighted as a potential barrier from the focus groups, with methadone dispensing discussed in the pilot group. Although private spaces should be available in pharmacies, focus groups reported they were not always offered for use and so supervised medication was taken in public spaces instead. Providing a private space to discuss more sensitive issues is valued and maintaining privacy around supervised medication was also considered very important.

Whilst 82% of the residents surveyed were satisfied with the range of services offered, there was limited knowledge and use of other services within the pharmacy from the focus groups and from the resident survey. Supporting data shows that despite 100% of responding pharmacies providing the New Medicine Service, only 8% of residents had used it. Effective communication with the public when advertising services and providing information should be considered with awareness of potential barriers within the local population served. These may include language / literacy barriers, digital exclusion and visual or hearing impairments.

Other services that were reported frequently being offered were Community Pharmacist Consultation Service (CPCS) (96%) and the Flu Vaccination Service (82%). Other common services reported as being offered were: Supervised Administration Service (78%), Home Delivery Service (59%), Emergency Supple Service (59%), Sharps Disposal Service (52%) and Extended Care Tier One (UTI) (46%). Many of the pharmacies reported that they would provide additional services (advanced, additional, disease specific, screening and vaccination services) if they were to be commissioned.

During the Covid-19 pandemic, 63% of residents used the pharmacy as they normally would (particularly low rurality areas). Change in use was associated with high rurality and age. There was a 38% change in using the service by phone, particularly older age and those who reported having a long-term health condition or disability. Findings from the focus groups reported that online ordering appeared to be increasingly popular and was perceived as being relatively easy to use and could be more efficient. Telephone access both for ordering medications but also seeking pharmacy advice was also reported. Future provision of these services may need to be prioritised during the ongoing pandemic and its effects on vulnerable residents.

PART B

Local Need

Part B of the PNA summarises the current and future health and well-being needs of the Worcestershire population. It begins by highlighting health and wellbeing priorities proposed by the Health and Wellbeing Board and the NHS long term plan for integrated care. Part B then describes the characteristics of Worcestershire including current and projected populations, ethnicity and deprivation within the county. Areas of Concern and Changing Needs are then presented. Greater emphasis has been put on topics where there is a greater opportunity for community pharmacy to meet the need. Finally, Part B summaries future and current health needs and provides a summary specific to each district within the county.

Relevant Strategies and Plans:

1. *Health and Well-being Priorities*

Worcestershire Health and Wellbeing Board (HWB) is required to develop a strategy including a vision and priorities for improving the health and wellbeing of people who live and work in Worcestershire. For the 2022 - 2032 Strategy, which is currently out to consultation, the HWB has proposed good mental health and wellbeing as the main priority, supported by action in areas that we all need to **'Be Well in Worcestershire'**. The supporting areas are:

- Healthy living at all ages
- Safe, thriving and healthy homes, communities and places
- Quality local jobs and opportunities

2. *Integrated Care System*

The NHS Long Term Plan confirmed that all parts of England would be served by an integrated care system from April 2021, building on the lessons of the earliest systems and the achievements of earlier work through sustainability and transformation partnerships and vanguards.

NHS Herefordshire and Worcestershire Clinical Commissioning Group was established on 1 April 2020 following a merger of NHS Herefordshire CCG, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG. The CCG is formed of 80 member GP practices and is responsible for buying health services for 800,888 people across Herefordshire and Worcestershire

Characteristics of Worcestershire

The following sections provides a summary of the current and future demographics in Worcestershire including population breakdown by age group, deprivation and ethnicity, as well as population projections by age group to help look forward to future need.

A summary of current and future needs specific to Worcestershire is then included, followed by needs that are specific to each of the districts within Worcestershire as each district has different characteristics and different demographics, leading to differences in specific needs.

Worcestershire County

Current population

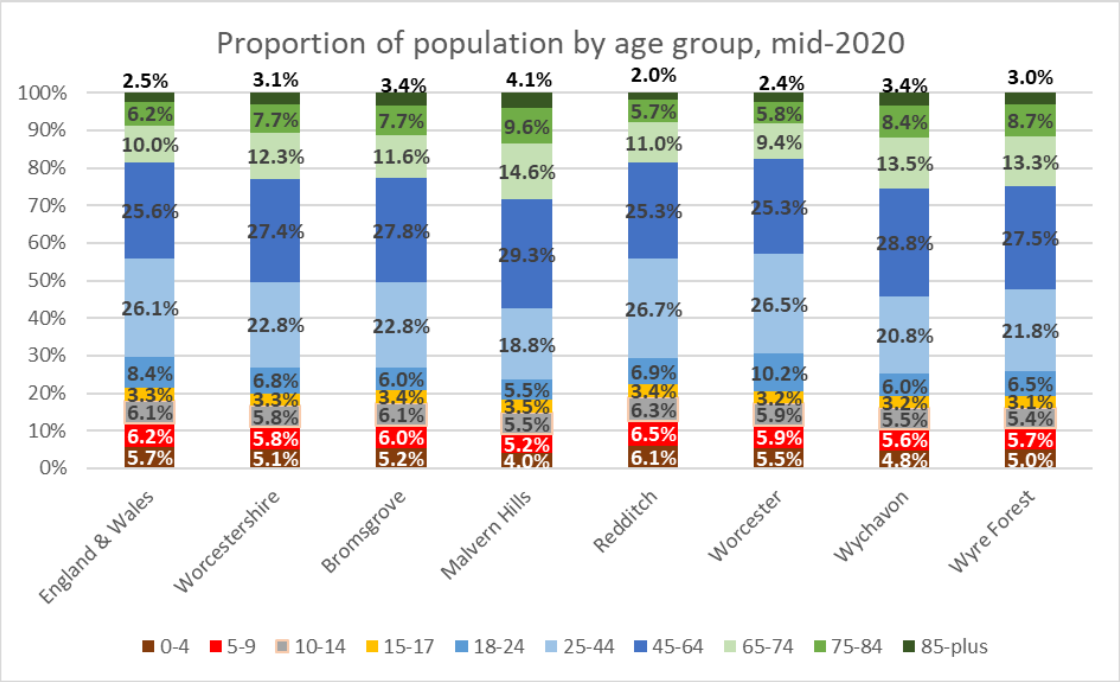
The current resident population in Worcestershire according to ONS 2020 population estimates is around 598,100. The district population breakdown shows that Wychavon has the highest population at over 131,000, whilst Malvern Hills has the lowest population at less than 80,000.

Table 8: Population estimates for Worcestershire and districts, 2020

Name	All ages
England & Wales	59,719,72
Worcestershire	598,070
Bromsgrove	100,569
Malvern Hills	79,445
Redditch	85,568
Worcester	100,265
Wychavon	131,084
Wyre Forest	101,139

Source – 2020 ONS mid-year estimates

Figure 46: Population breakdown by age group for Worcestershire and Districts, 2020



Source – 2020 ONS mid-year estimates

Population breakdown by age group shows that Worcestershire has a higher proportion of population in older age ranges (65-plus) compared to England & Wales as a whole, with a lower proportion of children, most notably among younger children.

In January 2022 the combined population of the ten Primary Care Networks (PCNs) within Worcestershire is around 612,300 people. This number could potentially include people living outside the border of Worcestershire but registered with a GP within the Worcestershire PCNs.

Ethnicity

Table 9: Ethnicity breakdown for Worcestershire, Census 2011

	Worcestershire numbers	Worcestershire percentage	England & Wales percentage
All categories: Ethnic group	**566,169**	100.0%	100.0%
Total - White	**542,058**	**95.7%**	**86.0%**
White: English/Welsh/Scottish/Northern Irish/British	522,922	92.4%	80.5%
White: Irish	3,480	0.6%	0.9%
White: Gypsy or Irish Traveller	1,165	0.2%	0.1%
White: Other White	14,491	2.6%	4.4%
Total - Mixed/multiple ethnic group	**7,045**	**1.2%**	**2.2%**
Mixed/multiple ethnic group: White and Black Caribbean	3,150	0.6%	0.8%
Mixed/multiple ethnic group: White and Black African	592	0.1%	0.3%
Mixed/multiple ethnic group: White and Asian	2,053	0.4%	0.6%
Mixed/multiple ethnic group: Other Mixed	1,250	0.2%	0.5%
Total - Asian/Asian British	**13,741**	**2.4%**	**7.5%**
Asian/Asian British: Indian	3,634	0.6%	2.5%
Asian/Asian British: Pakistani	4,984	0.9%	2.0%
Asian/Asian British: Bangladeshi	1,316	0.2%	0.8%
Asian/Asian British: Chinese	1,601	0.3%	0.7%
Asian/Asian British: Other Asian	2,206	0.4%	1.5%
Total - Black/African/Caribbean/Black British	**2,372**	**0.4%**	**3.3%**
Black/African/Caribbean/Black British: African	767	0.1%	1.8%
Black/African/Caribbean/Black British: Caribbean	1,275	0.2%	1.1%
Black/African/Caribbean/Black British: Other Black	330	0.1%	0.5%
Total - Other ethnic group	**953**	**0.2%**	**1.0%**
Other ethnic group: Arab	236	0.0%	0.4%
Other ethnic group: Any other ethnic group	717	0.1%	0.6%
All except White British	**43,247**	**7.6%**	**19.5%**

Source – Census 2011

The most recent ethnicity data source available remains the 2011 Census, until new data emerges from the 2021 Census later this year. In 2011, Worcestershire has a higher proportion of individuals who identify as being White British (92.4%) compared to England and Wales (80.5%). In

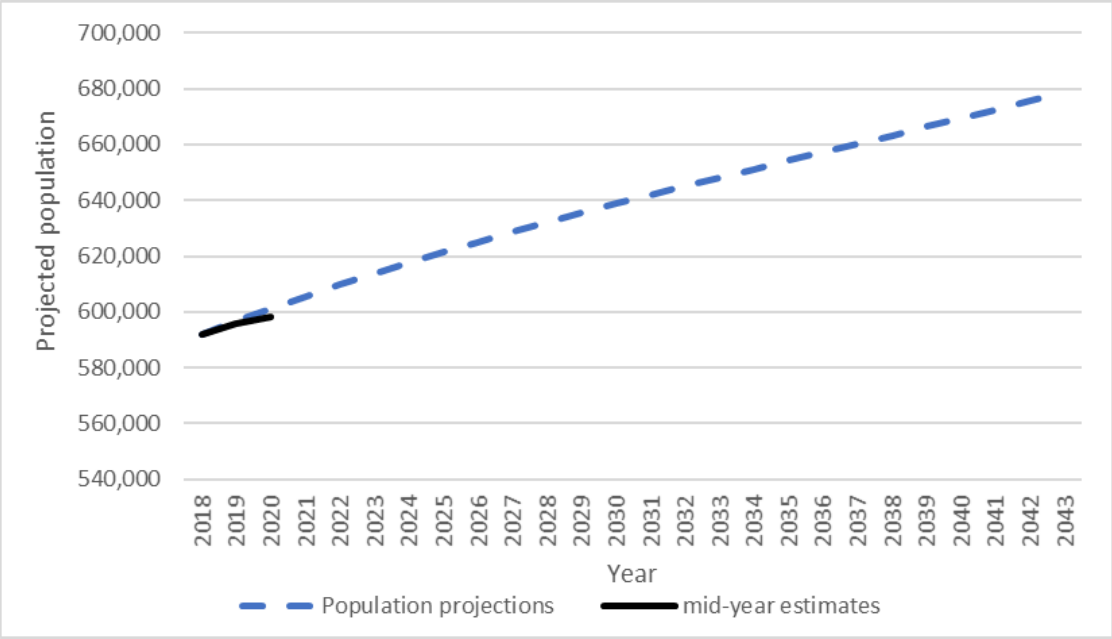
Worcestershire, there are a lower proportion of individuals who are not White British, at 7.6% (43,247 people) compared England and Wales (19.5%).

This largest ethnic groups in Worcestershire apart from the White English/Welsh/Scottish/Northern Irish/British are the White: Other group at 2.6%, and the Asian/Asian British: Pakistani group at 0.9%. The proportion of White Gypsy or Irish Travellers in Worcestershire is twice that of the national rate at 0.2% compared to 0.1% in England, which equates to 1,165 people.

Projected population

The following section describes how the population of Worcestershire is projected to grow assuming that observed trends in births, deaths and migration continue. Data is taken from Office of National Statistics (ONS) projections which is trend based, and as such does not predict the impact that changes in housing policy or rates of housebuilding, changes in local or national economy, or changes in internal or international migration may have.

Figure 47: Projected population for Worcestershire, 2018-2043



Source – ONS population projections, 2018 based

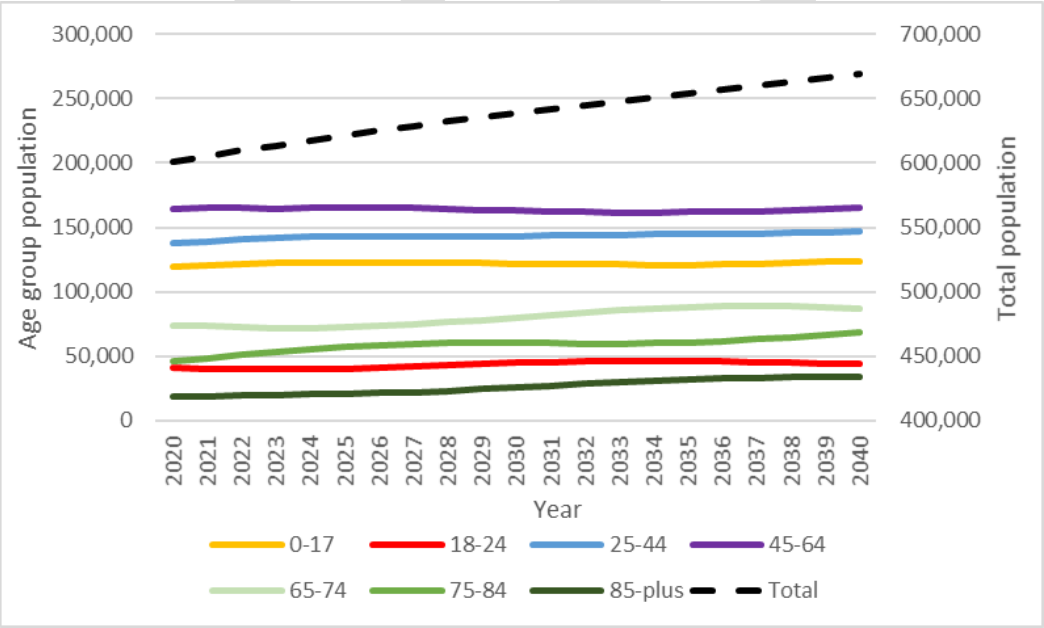
Table 10: Projected population for Worcestershire by 5-year increments, 2020-2040

	ONS estimate	ONS estimate	*Projected 5 years*	*Projected 10 years*	*Projected 15 years*	*Projected 20 years*
Year	**2018**	**2020**	**2025**	**2030**	**2035**	**2040**
Population	592,057	598,070	*621,309*	*638,783*	*654,234*	*669,457*
Population increase since 2020			23,239	40,713	56,164	71,387
Population percentage increase since 2021			3.9%	6.8%	9.4%	11.9%

Source – ONS population projections, 2018 based

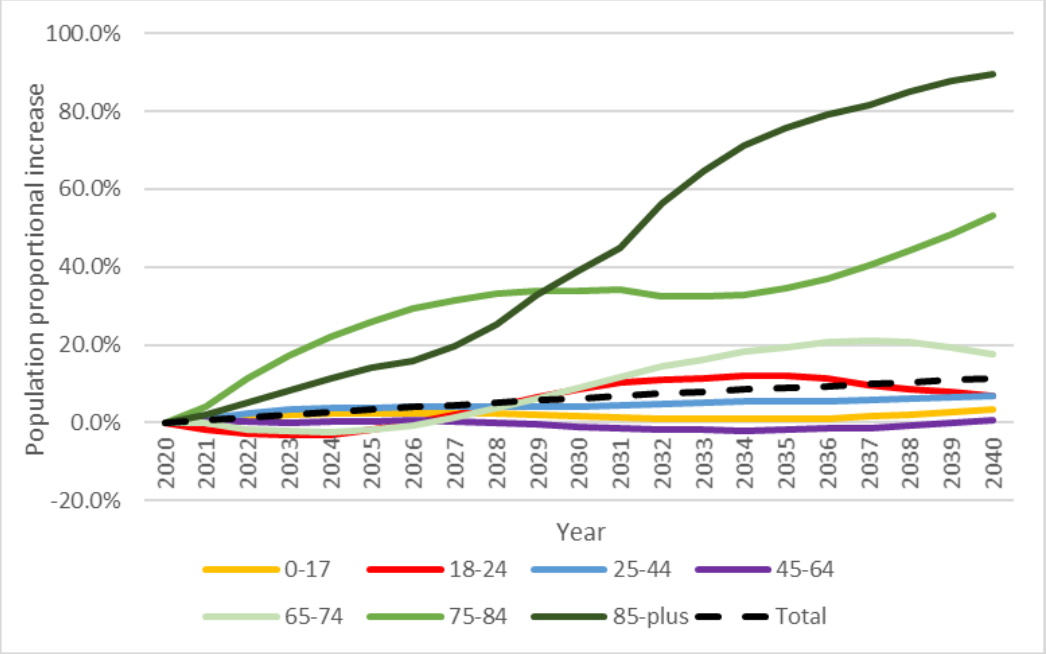
The total population in Worcestershire is projected to increase by over 71,000 persons in the next 20 years, equating to an increase of almost 12%. There is variation in the projected increase by age group, but the largest increases are projected to be in the 65-plus age ranges.

Figure 48: Projected population numbers by age group, 2020-2040



Source – ONS population projections, 2018 based

Figure 49: Projected percentage population change by age group, 2020-2040

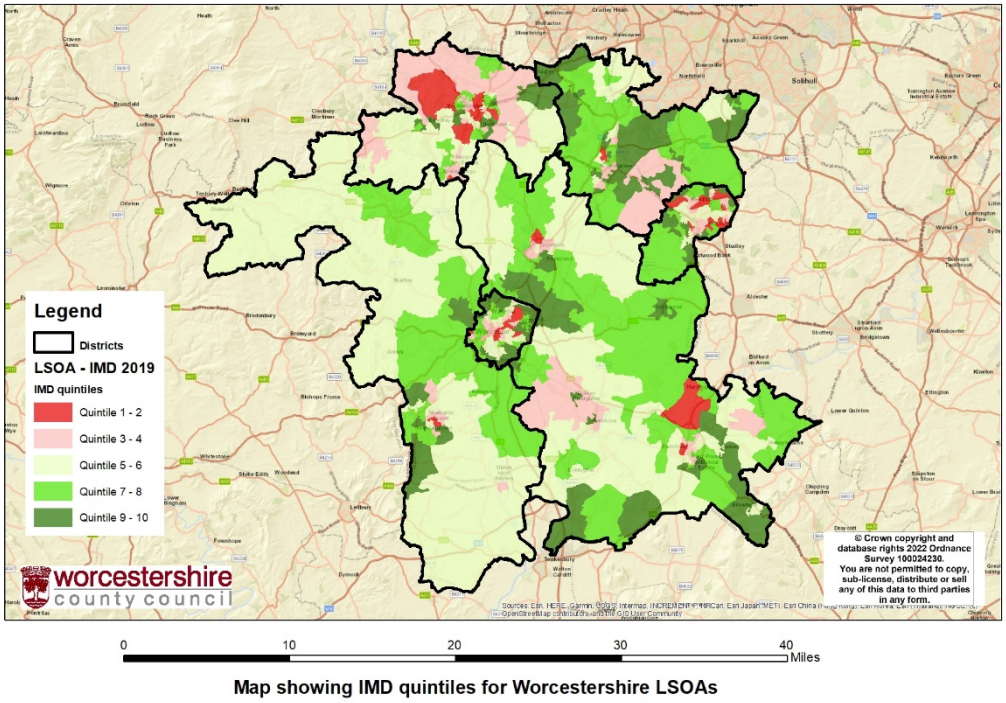


Source – ONS population projections, 2018 based

The number of people aged 65-plus in Worcestershire is projected to increase by around 51,000 in the 20 years up to 2040, representing an increase of almost 37%. The 75-plus population is projected to increase by over 59% (over 38,000 persons), whilst the projected increase in the 85-plus age range is particularly pronounced, at almost 90% (over 15,800 persons). The rise in the 85-plus age group is projected to be particularly prevalent between 2027 and 2034.

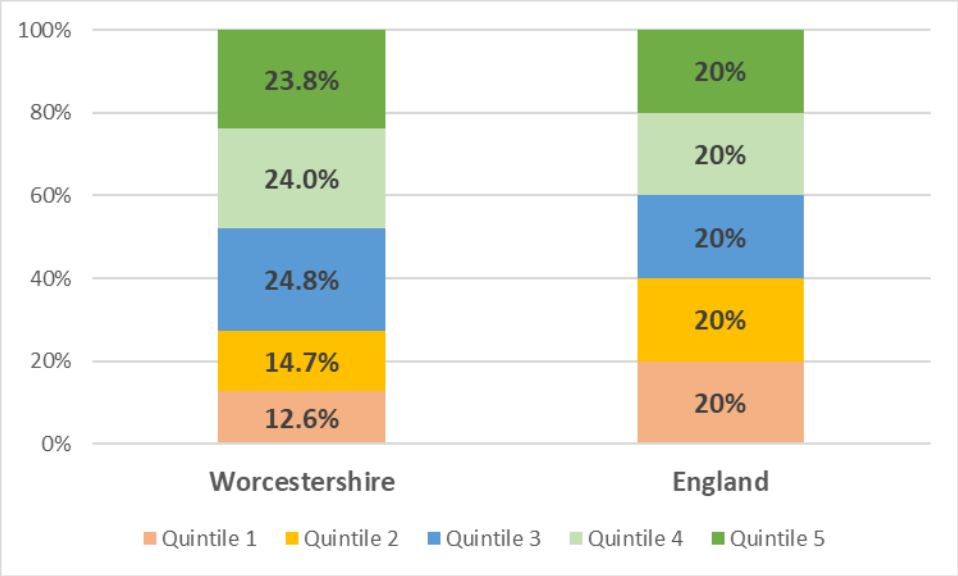
Projected changes in other age groups are much lower over the same time frame, and in some age groups a decline is projected – the 45-64 age group shows a decline across many years of the projection, for example, and is projected to be around the same level in 2040 as it is in 2020.

Figure 50: Map of Index of Multiple Deprivation 2019 (Quintiles) by LSOA (Lower Super Output Areas) - Worcestershire



Map showing IMD quintiles for Worcestershire LSOAs

Figure 51: Population Proportion by IMD 2019 (Quintiles) - Worcestershire



Source – Indices of Deprivation, 2019

Almost 13% of the population in Worcestershire live in the lowest quintile

There are a number of different ways to compare deprivation at Local Authority level, as the IMD was derived for small areas and there are several ways of aggregating up to district and county level. Three methods of aggregating up to district and county level are summarised below: -

- Average rank - Population weighted average of the combined ranks for the LSOAs in a larger area. This measure is calculated by averaging all of the LSOA ranks in each larger area after they have been population weighted. The 'average rank' scores for the larger areas are then ranked, where the rank of 1 (most deprived) is given to the area with the highest score. (For the purpose of calculating the score for the larger area, LSOAs are ranked such that the most deprived LSOA is given the rank of 32,844.)
- Average score - Population weighted average of the combined scores for the LSOAs in a larger area. The average score summary measure is calculated by averaging the LSOA scores in each larger area after they have been population weighted. The resultant scores for the larger areas are then ranked, where the rank of 1 (most deprived) is given to the area with the highest score.
- Proportion of Lower-layer Super Output Areas (LSOAs) in most deprived 10% nationally - Proportion of a larger area's LSOAs that fall in the most deprived 10% of LSOAs nationally. The score is the proportion of the larger area's LSOAs that fall in the most deprived 10% of LSOAs nationally. The scores for the larger areas are then ranked, where the rank of 1 (most deprived) is given to the area with the highest score. (Larger areas which have no LSOAs in the most deprived 10 per cent of all such areas in England have a score of zero for this summary measure).

Table 11: IMD ranking for Worcestershire, 2015 and 2019

	IMD - Rank of average rank	IMD - Rank of average score	IMD - Rank of proportion of LSOAs in most deprived 10% nationally
IMD 2015	110	111	98
IMD 2019	105	105	86

Source – Indices of Deprivation, 2019. Ranking out of 151 upper tier local authorities where 1 is the most deprived.

Worcestershire was ranked 105 out of 151 upper tier local authorities using the average rank method, compared with 110 in 2015, with very similar rankings in 2015 and 2019 using the average score method.

The county was ranked 86 for the proportion of LSOAs in the most deprived 10%, compared with 98 in 2015. Worcestershire can therefore be described as slightly "more deprived" in comparison with other upper tier local authorities in England in 2019 than it was in 2015 using this particular measure.

Table 12: IMD ranking for Worcestershire districts, 2019

District	IMD Average Score 2019 Rank	2019 Rank of proportion of LSOAs in most deprived 10%
Bromsgrove	268	195
Malvern Hills	192	159
Redditch	107	86
Worcester	135	69

Wychavon	197	195
Wyre Forest	109	111

Source – Indices of Deprivation, 2019. Ranking out of 317 local authority districts where 1 is the most deprived.

Redditch is ranked just below Wyre Forest and is the "most deprived" district in Worcestershire using the average score measure. Redditch and Worcester are in the lowest ranked (most deprived) 100 local authorities using the proportion of LSOAs in the most deprived 10%.

Figures from the Department of Work and Pensions suggest that just over 18,000 children aged 15 and under in Worcestershire are living in relative low-income families, defined as a family in low income Before Housing Costs (BHC) in the reference year. A family must have claimed Child Benefit and at least one other household benefit (Universal Credit, tax credits or Housing Benefit) at any point in the year to be classed as low income.

Provision of pharmaceutical services must accommodate the projected changes in demography and age over time and the potential impact of the social determinants on local populations health.

Areas of Concern and Changing Needs

Various indicators across injuries and ill-health, child health, behavioural risk factors, health protection, health care and premature mortality were analysed for Worcestershire and the districts. Indicators that were significantly below the national average for Worcestershire or districts were identified.

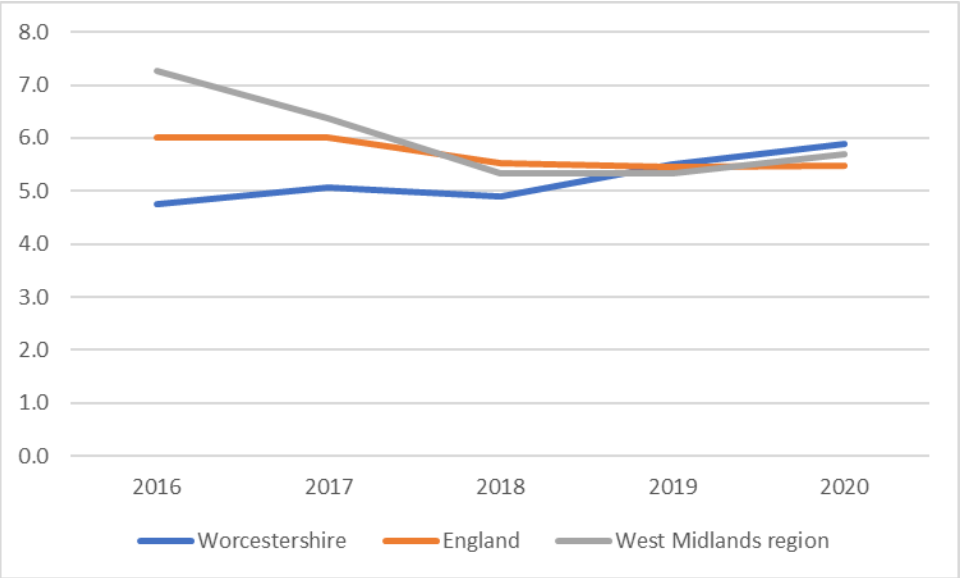
16–17-year-olds not in education, employment or training (NEET) or whose activity is not known

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. The indicator is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work.

The Government recognises that increasing the participation of young people in learning and employment not only makes a lasting difference to individual lives but is also central to the Government's ambitions to improve social mobility and stimulate economic growth.

To support more young people to study and gain the skills and qualifications that lead to sustainable jobs and reduce the risk of young people becoming NEET, legislation was included in 2013 to raise the participation age as contained within the Education and Skills Act 2008. This required that from 2013 all young people remain in some form of education or training until the end of the academic year in which they turn 17.

Figure 52: Proportion of 16–17-year-olds not in education, employment or training (NEET) or whose activity is not known – Worcestershire



The proportion of 16–17-year-olds who are not in education, employment or training (NEET) or whose activity is not known has increased in Worcestershire in recent years and in 2020 stands at 5.9%, compared to the national average of 5.5%. The proportion of 16–17-year-olds who are NEET was lower or similar to the national average up to the 2020 value, which is significantly higher than the national average.

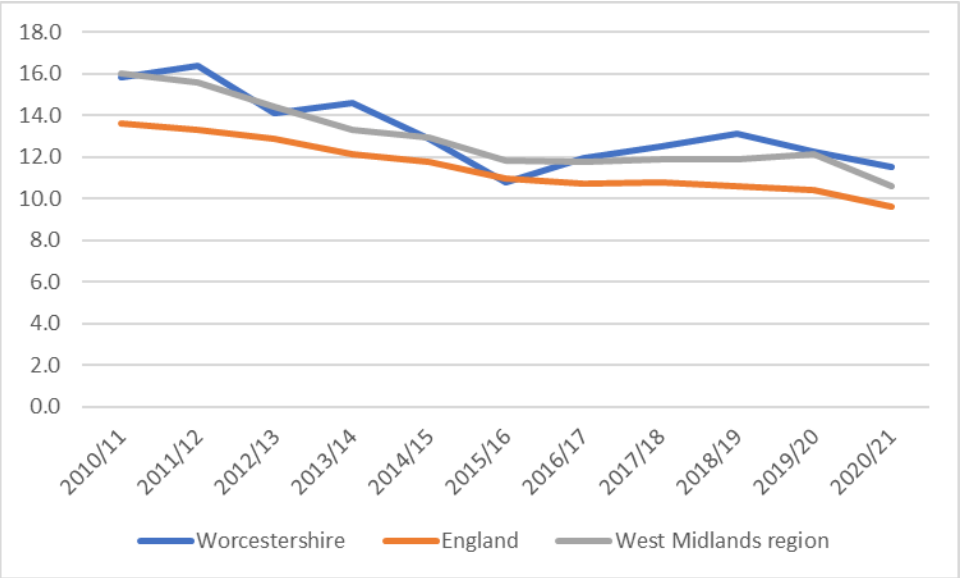
Smoking status at time of delivery

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes.

Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birthweight and sudden unexpected death in infancy.

Figure 53: The proportion of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status - Worcestershire



The proportion of mothers that were smokers at time of delivery has decreased in Worcestershire over the time period since 2010-11 but has consistently been significantly higher than the national average. The proportion of mothers that were smokers at time of delivery in Worcestershire was 11.5% compared to the national average of 9.6%.

Although the proportion of mothers that were smokers at time of delivery in Worcestershire as a whole is significantly higher than the national average, no individual district within Worcestershire recorded a value significantly higher than the national average.

Smokers that have successfully quit at 4 weeks

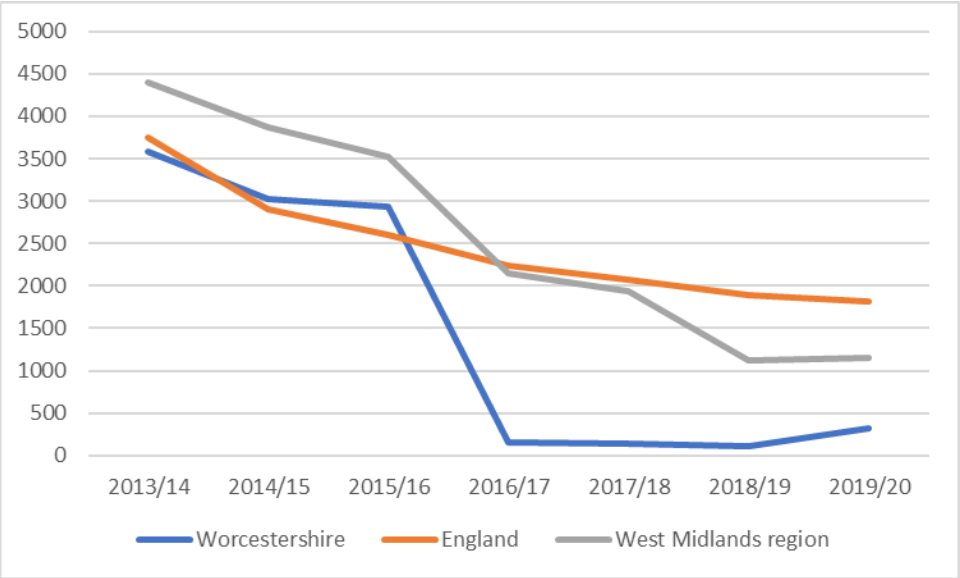
Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking is a modifiable behavioural risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

Successful quitters are those smokers who successfully quit at the four-week follow-up. A client is counted as a 'self-reported 4-week quitter' when assessed four weeks after the designated quit date, if they declare that they have not smoked, even a single puff on a cigarette, in the past two weeks. This information is collected on NHS Stop Smoking returns in line with requirements from the Department of Health.

This indicator measures the number of self-reported successful quitters at 4 weeks, as a proportion of the population aged 18-plus who currently smoke.

Figure 54: Smokers that have successfully quit at 4 weeks – Worcestershire



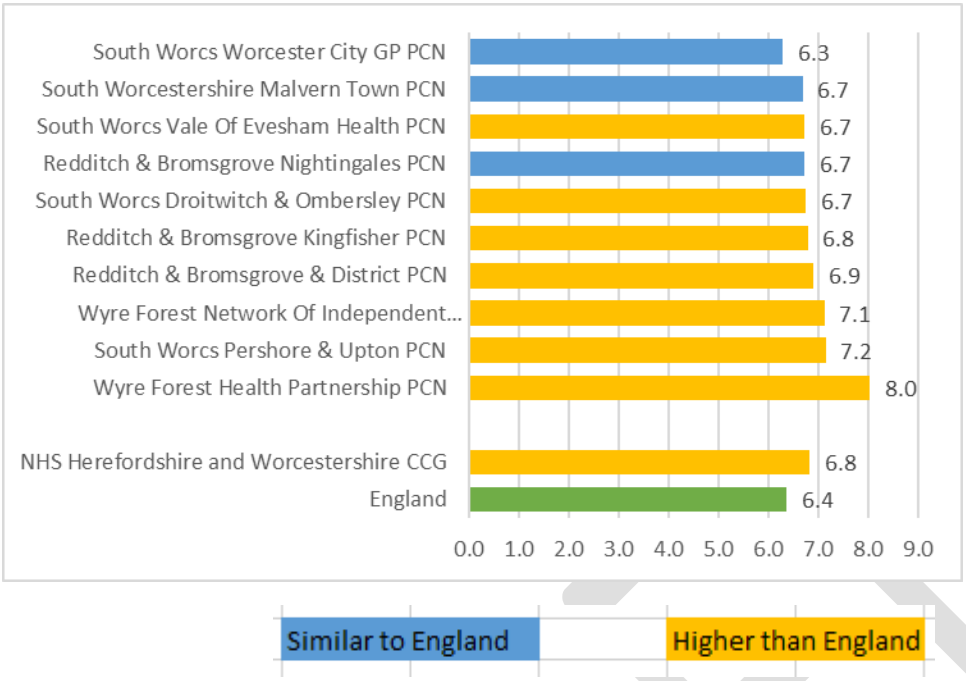
The proportion of smokers that had successfully quit at 4 weeks in Worcestershire was similar to the national average up to 2015-16 before a dramatic observed decline in the following year, with rates still very low in the county. In 2019-20 the rate of smokers that had successfully quit after 4 weeks in Worcestershire stands at 327 per 100,000 smokers aged 16 and over, significantly worse than the national average of 1,808 per 100,000 smokers aged 16 and over.

Asthma

Asthma is a common condition which responds well to appropriate management, and which is principally managed in primary care. This indicator set was originally informed by the British Thoracic Society (BTS)/SIGN guidelines which were published in early 2003. In keeping with the other indicators, not all areas of management are included in the indicator set in an attempt to keep the data collection within manageable proportions.

The indicator measures the percentage of patients aged 6 years and older with asthma, excluding those who have been prescribed no asthma-related drugs in the previous twelve months, as recorded on practice disease registers from all registered patients aged 6 years and older. Many pharmacies offer asthma inhaler use and advice.

Figure 55: The percentage of patients aged 6 years and older with asthma - Worcestershire



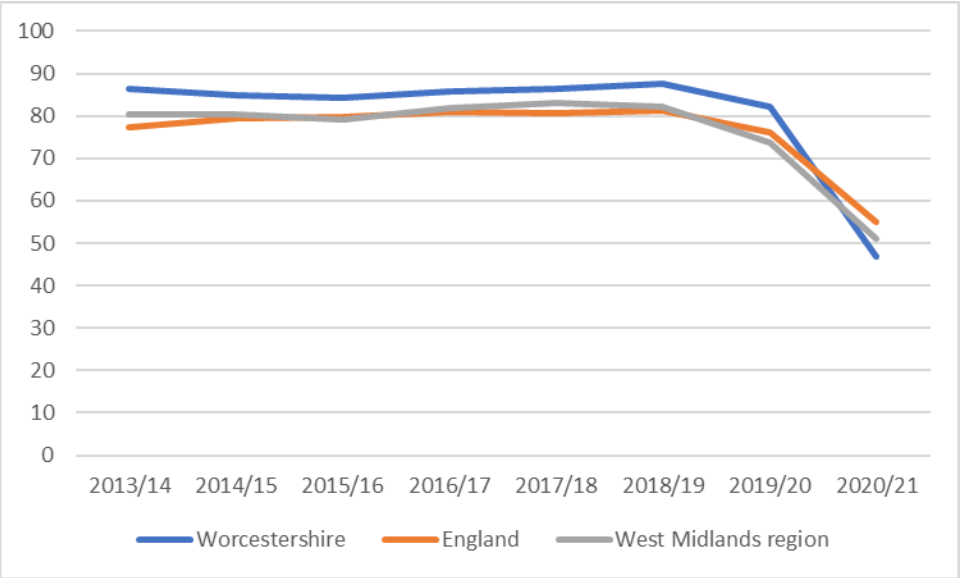
Data is only available at CCG and PCN level rather than county and district level for asthma prevalence. The proportion of patients aged 6-plus with asthma in Herefordshire and Worcestershire PCN in 2020-21 was 6.8%, significantly higher than the national average of 6.4%. Proportions of patients with asthma were significantly higher in PCN's within the districts of Wychavon, Redditch, Bromsgrove, and Wyre Forest.

Abdominal Aortic Aneurysm Screening - Coverage

Abdominal aortic aneurysm (AAA) screening aims to reduce AAA related mortality among men aged 65 to 74. This indicator provides an opportunity to incentivise screening promotion and other local initiatives to increase coverage of AAA screening. Improvements in coverage would mean more AAAs are detected in a timely manner.

Pharmacies have a role in aiding in the prevention of patients getting an AAA. High blood pressure and high cholesterol increase the risk in people getting an AAA, whilst maintaining a healthy weight can help reduce the chances of getting an AAA or prevent it getting bigger.

Figure 56: The proportion of men eligible for AAA screening who are conclusively tested – Worcestershire



The proportion of men eligible for AAA screening who were conclusively tested in Worcestershire has been consistently higher than the national average up until the most recent data in 2020-21 which saw a significant reduction in the proportion. A notable decline was also seen in both national and regional figures due to the effects of the Covid-19 pandemic on number of screenings.

The proportion of men eligible for AAA screening who were conclusively tested in Worcestershire in 2020-21 was 46.7%, significantly lower than the national average of 55.0%.

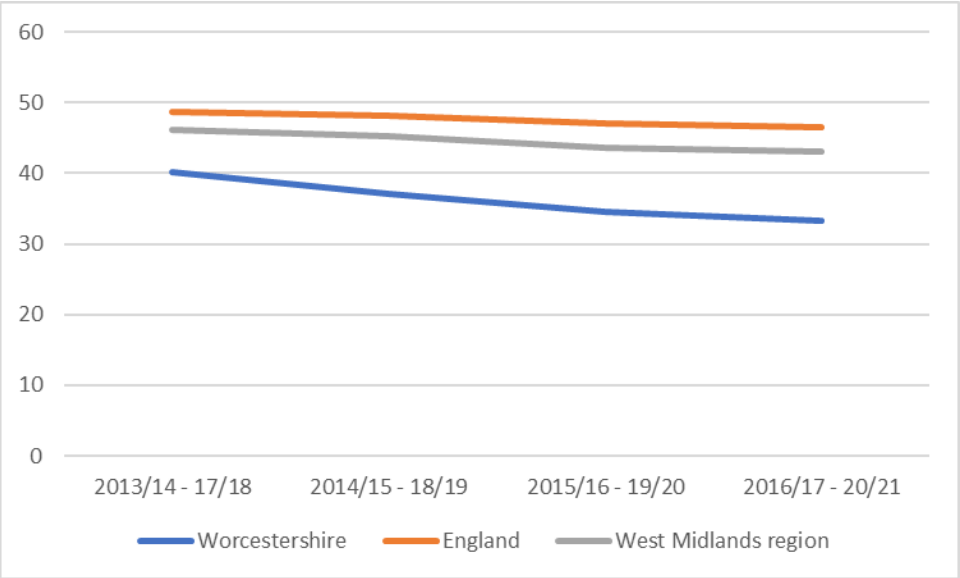
AAA screenings were significantly lower than the national average in Bromsgrove, Redditch, Worcester and Wyre Forest.

Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions.

Local authorities have a legal duty to make arrangements to provide the NHS Health Check programme to 100% of the eligible population over a five-year period and to achieve continuous improvement in uptake. This data demonstrates the cumulative progress made by local authorities in NHS Health Checks received by the eligible population.

Figure 57: The rolling 5-year cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check – Worcestershire



The cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check has been consistently significantly lower in Worcestershire than the national average. The proportion in Worcestershire in 2016-17 to 2020-21 was 33.2%, significantly lower than the national average of 46.5%.

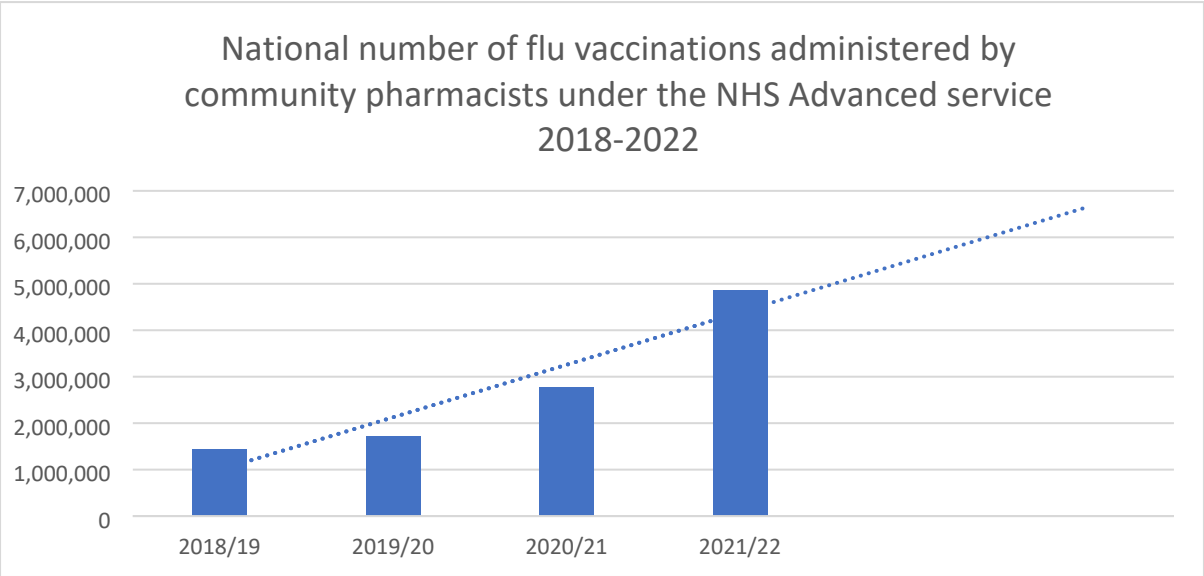
Flu vaccinations

Flu vaccinations are important because:

- more people are likely to get flu over the winter as fewer people will have built up natural immunity to it during the COVID-19 pandemic
- if you get flu and COVID-19 at the same time, research shows you're more likely to be seriously ill
- getting vaccinated against flu and COVID-19 will provide protection especially for more vulnerable people and those around them for both these serious illnesses

The flu vaccination service provided by pharmacies has significantly increased each year both nationally and locally. Nationally the number of flu vaccinations administered by community pharmacists under the NHS Advanced service grew by 75% in 2021/22 compared to the previous year.

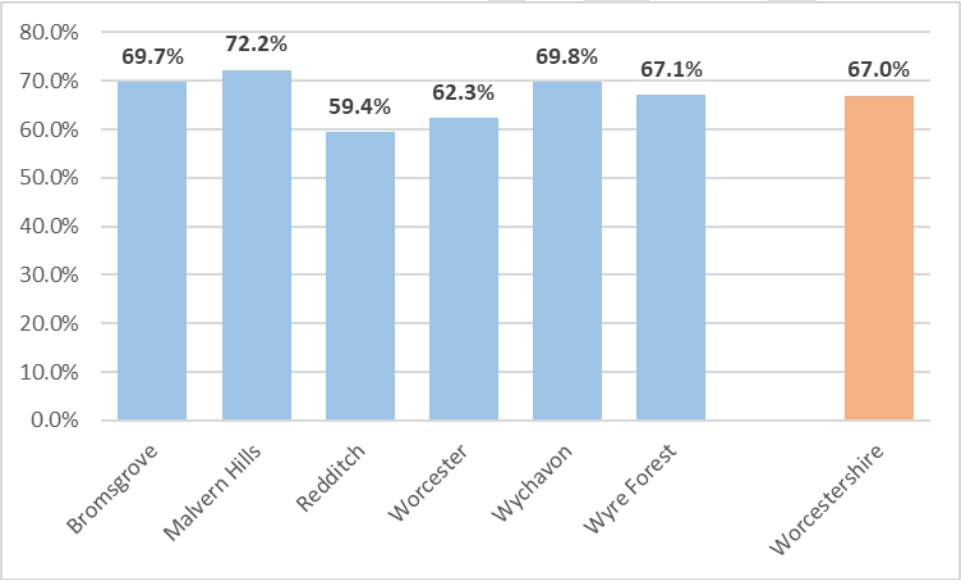
58 National number of flu vaccinations administered by community pharmacists under the NHS Advanced service 2018-2022



Source – PSNC Flu vaccination statistics

In Hereford and Worcestershire approximately 80% of pharmacies provide flu vaccinations. Pharmacies in Herefordshire and Worcestershire STP area administered 52,902 flu vaccines in the 2021/22 flu season representing almost a quarter off all vaccines delivered across the counties.

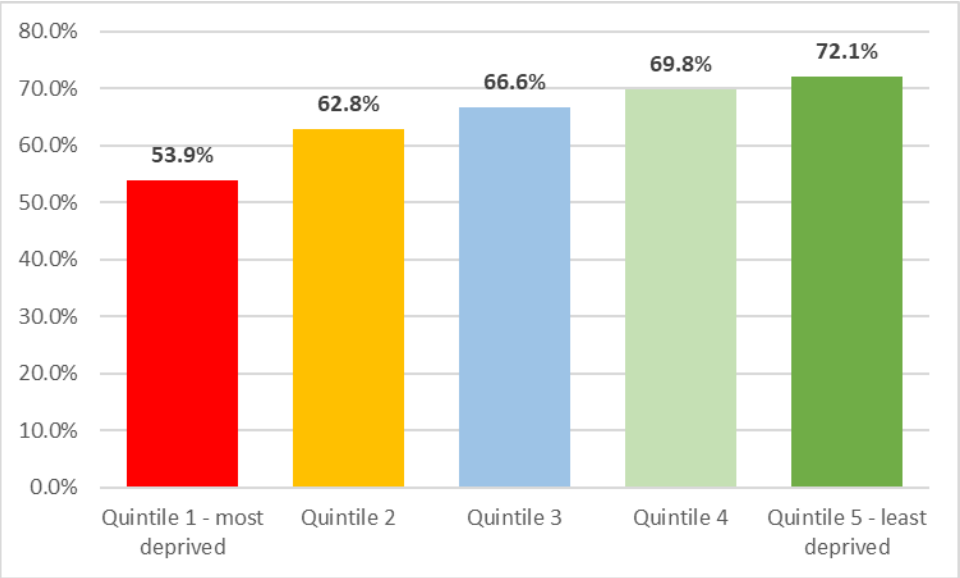
Figure 59: Proportion of eligible people receiving the flu vaccination during the Winter 2021 season – Worcestershire and districts



Source – NIMS, 2021 flu vaccine uptake report

67% of eligible people in Worcestershire have received the flu vaccine in Winter 2021. The districts of Redditch and Worcester both have lower proportions of eligible people receiving the vaccination at just over 59% and just over 62% respectively.

Figure 60: Proportion of eligible people receiving the flu vaccination during the Winter 2021 season – Worcestershire IMD quintiles



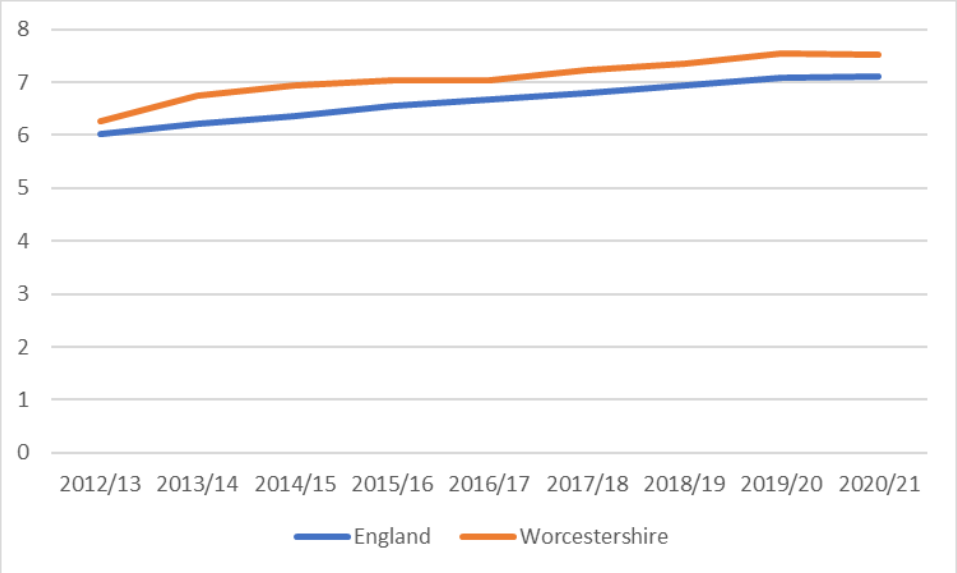
Source – NIMS, 2021 flu vaccine uptake report

The proportion of people in the most deprived quintile in Worcestershire is less than 54%. This compares to 67% overall, and over 72% in the least deprived quintile.

Diabetes QOF prevalence among people aged 17-plus

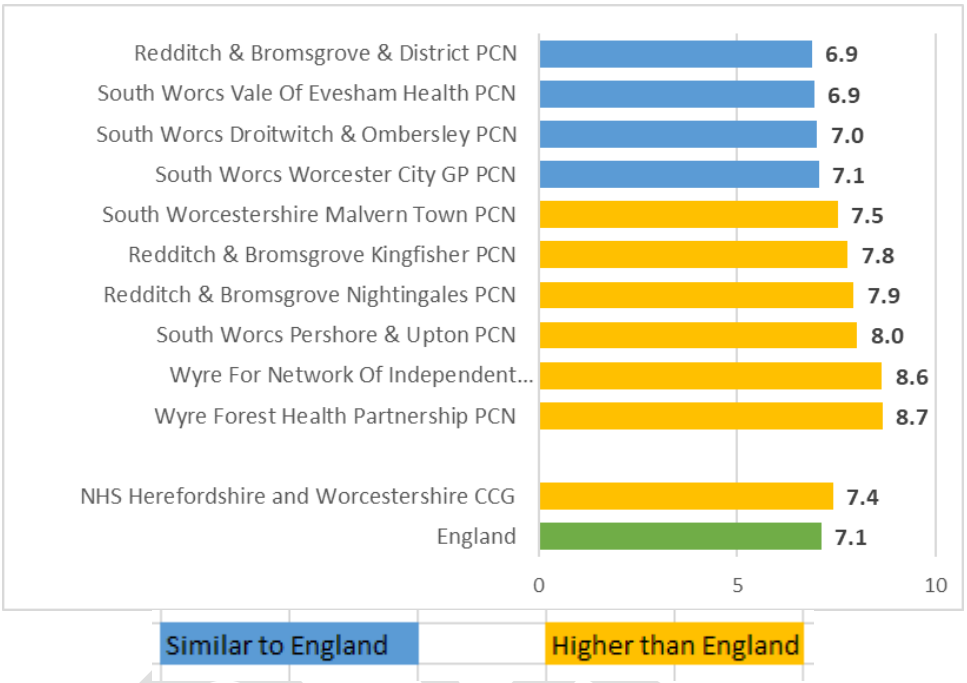
Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over three million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. This indicator measures the percentage of patients aged 17 years and over with diabetes mellitus, as recorded on practice disease registers.

Figure 61: Percentage of patients aged 17 years and over with diabetes mellitus



The proportion of patients aged 17 years and over with diabetes mellitus is higher than the national average and has been in the second highest quintile in England since 2013-14. In 2020-21 the percentage of patients aged 17 years and over with diabetes mellitus in Worcestershire was 7.5% compared to a national average of 7.1%.

Figure 62: Percentage of patients aged 17 years and over with diabetes mellitus – Worcestershire PCNs



PCNs in Wyre Forest, Wychavon, and Redditch have rates of patients aged 17 years and over with diabetes mellitus statistically higher than the national average.

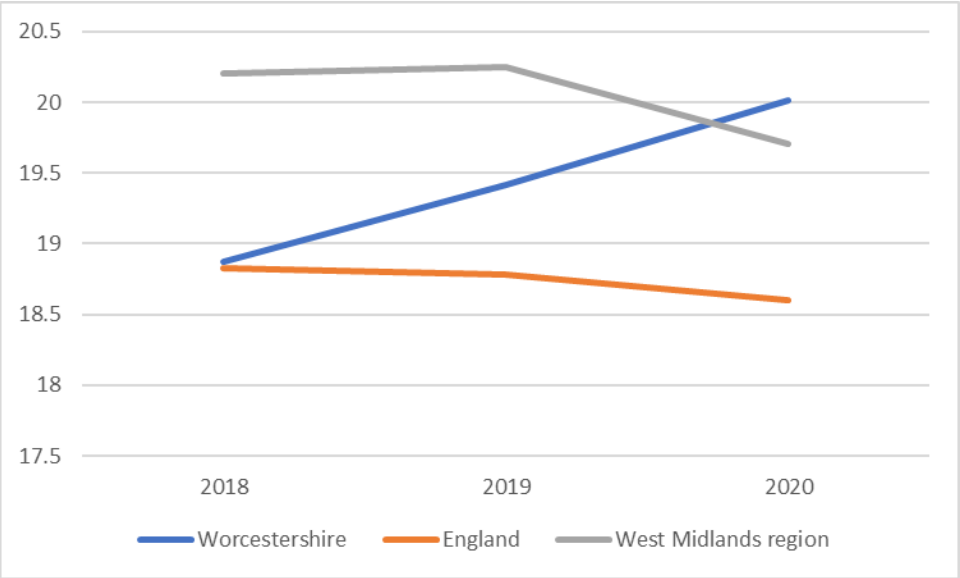
Percentage reporting a long term Musculoskeletal (MSK) problem

In England low back and neck pain was ranked as the top reason for years lived with disability and other musculoskeletal (MSK) conditions was ranked as number 10 (Global Burden of Disease for England: international comparisons - GOV.UK (www.gov.uk)). MSK conditions are known to impact quality of life by increased pain, limiting range of motion and impacting the ability to take part in daily life such as attending work.

This indicator shows the amount of people reporting long term MSK pain in England. It can be used to compare reported MSK prevalence rates across the country and can be used in combination with other indicators on the Musculoskeletal Diseases profile to build a bigger picture of MSK in local areas.

Pharmacies have a role in helping patients who suffer from back pain and joint pain in offering advice, advising, administering appropriate medication and aiding healthy behavioural changes.

Figure 63: The percentage of people aged 16+ reporting an MSK condition, either long term back pain or long-term joint pain - Worcestershire



The percentage of people aged 16+ reporting an MSK condition, either long term back pain or long-term joint pain in Worcestershire was similar to the national average up until 2020. The proportion of people reporting an MSK condition in Worcestershire has been increasing, and in 2020 was 20.0%, significantly higher than the national average of 18.6%.

The percentage reporting a long-term Musculoskeletal (MSK) problem is higher than the national average in Redditch and Wyre Forest.

Chlamydia proportion aged 15 to 24 screened

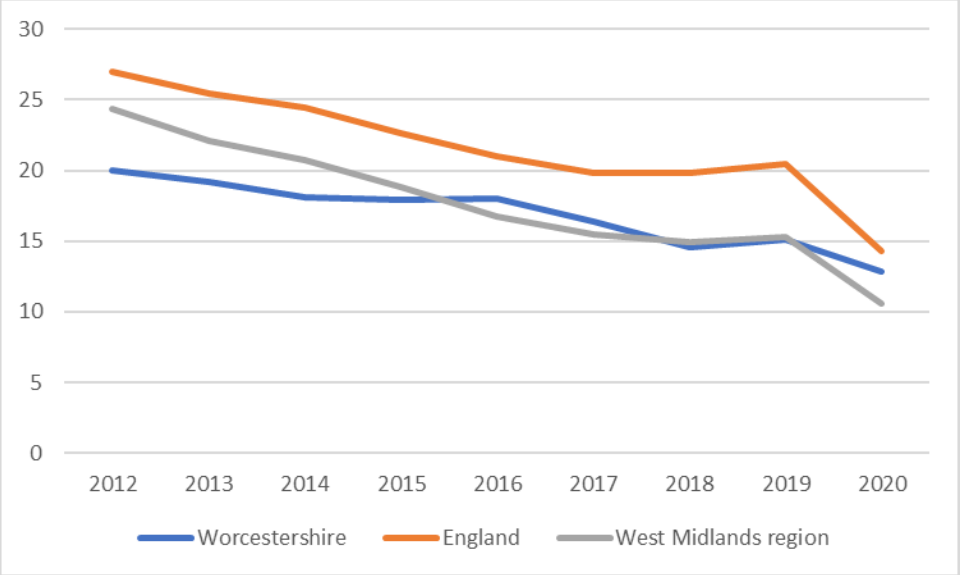
Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group.

By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing chlamydia associated complications, and also reduce the amount of time someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. In June 2021 changes to the programme were announced with a focus on reducing reproductive harm of untreated infection through opportunistic screening offered to young women aged under 25 years. This indicator relates to data until December 2020.

Pharmacies have a potential role to play in helping patients with chlamydia given the potential of extending future sexual health-based services, as well as administering treatment and medicines.

Figure 64: Chlamydia proportion aged 15 to 24 screened - Worcestershire



The proportion of people aged 15 to 24 screened has been consistently significantly below the national average since 2012. Rates in Worcestershire and in England as a whole have fallen over the time frame and the decline is directly due to the Covid 19 pandemic (STI rates remain a concern despite fall in 2020 - GOV.UK (www.gov.uk)). In 2020 the proportion of 15–24-year-olds screened for chlamydia in Worcestershire was 12.8%, significantly below the national average of 14.3%.

Proportions of people aged 15-25 being screened for chlamydia is significantly lower than the national average in all of the Worcestershire districts with the exception of Worcester City.

Chlamydia detection rate in people aged 15 to 24

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility.

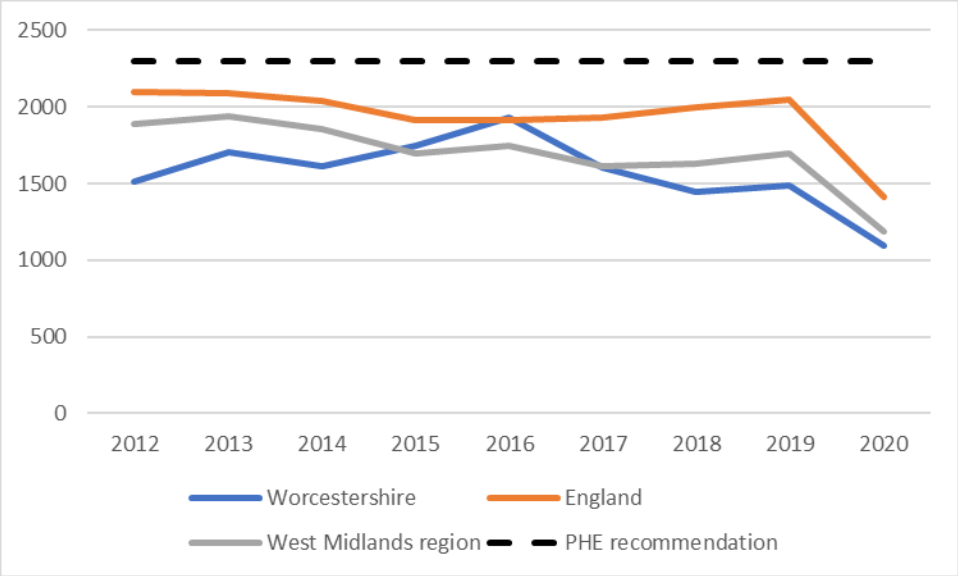
The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. In June 2021 changes to the programme were announced with a focus on reducing reproductive harm of untreated infection through opportunistic screening offered to young women aged under 25 years. This indicator relates to data until December 2020 when the NCSP offered screening to all young people under 25.

The chlamydia detection rate among under 25-year-olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission. An increased detection rate is indicative of increased control activity; the detection rate is not a measure of morbidity.

Public Health England (PHE) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15 to 24. The recommendation was set as a level that would encourage high volume screening and diagnoses, be ambitious but achievable, high enough to encourage community screening, rather than specialist sexual health clinic only

diagnoses, and would be likely to result in a continued chlamydia prevalence reduction, according to mathematical modelling.

Figure 65: Chlamydia detection rate per 100,000 population aged 15 to 24 - Worcestershire



Chlamydia screening in Worcestershire has declined in the past few years, most notably since 2016. This is in line with national and regional trends which are below the recommended detection rate, and is directly due to the Covid 19 pandemic[1]. Screenings in Worcestershire in 2020 are significantly below the PHE recommendation of 2,300 per 100,000, at 1,097 per 100,000 population aged 15-24, and are also below the national average of 1,408 per 100,000.

Chlamydia detection rate is significantly lower than the PHE recommendation of 2,300 per 100,000 in all of the Worcestershire districts.

Infant mortality rate

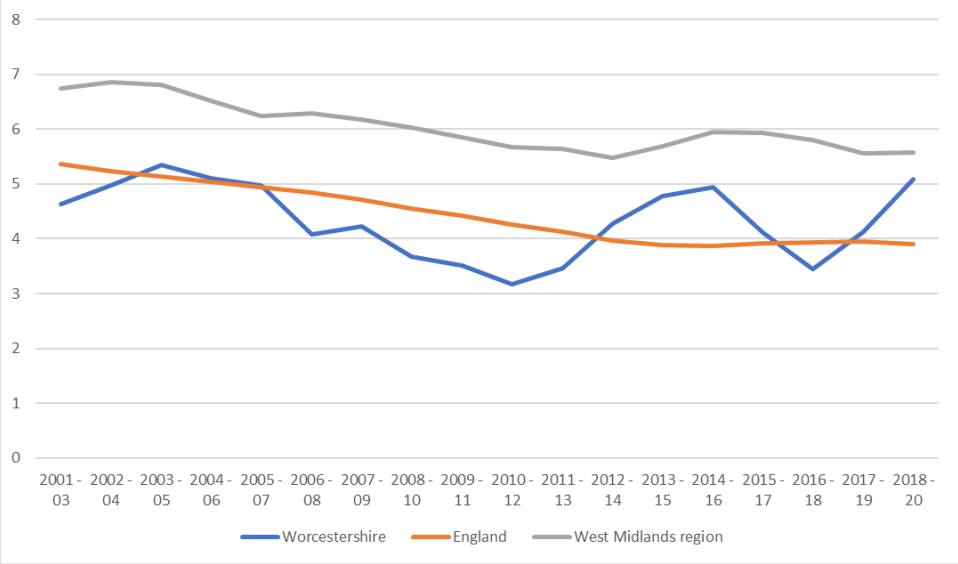
Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.

Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health (Healthy Lives, Healthy People: Our Strategy for Public Health November 2010)

Infant deaths under 1 year of age per 1000 live births - Worcestershire

[1] STI rates remain a concern despite fall in 2020 - GOV.UK (www.gov.uk)

Figure 66: Infant deaths under 1 year of age per 1000 live births - Worcestershire

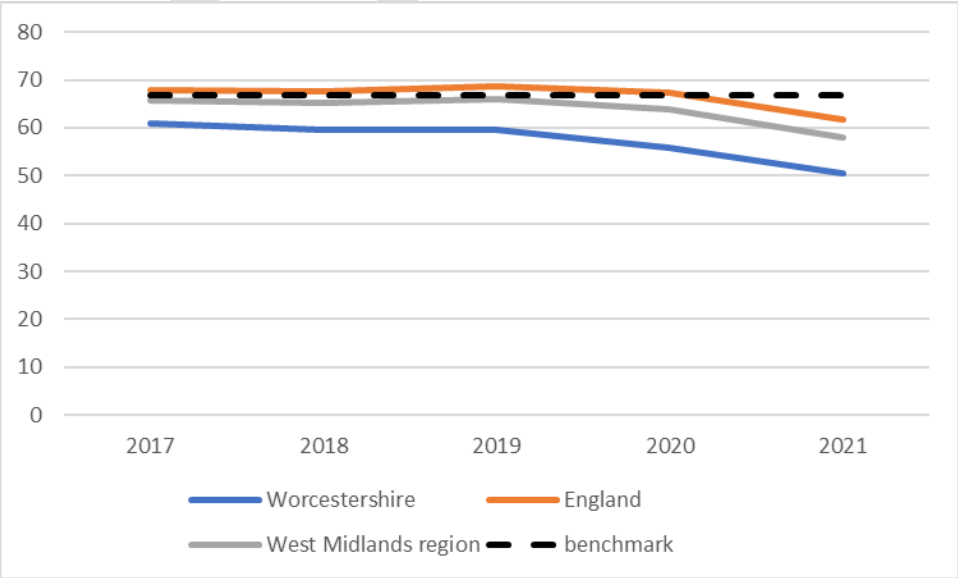


Infant mortality rate in Worcestershire has increased notably in recent years. For most of the time frame since 2001-03, infant mortality rate in Worcestershire has been lower than the national average but has increased to be significantly worse than the national average in 2018-20. The infant mortality rate in Worcestershire in 2018-20 was 5.1 per 1000 live births, compared to the national average of 3.9 per 1000 live births. Infant mortality rate is significantly higher than the national average in Bromsgrove.

Estimated dementia diagnosis rate (aged 65 and over)

This indicator is to increase the number of people living with dementia who have a formal diagnosis. The rationale is that a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes. The definition looks at the rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia. Significance is determined by the nonoverlapping of confidence intervals with the benchmark that has been set of 66.7%.

Figure 67: Estimated dementia diagnosis rate (aged 65 and over) - Worcestershire



The rate of dementia diagnosis in Worcestershire has been consistently below the national averages since 2017. The recent decline in the rate is in line with national trends, but in 2021 the rate of dementia diagnosis was significantly below the benchmark of 66.7%, at 50.5%. This is also lower than the national average of 61.6%. The rate of dementia diagnosis is significantly lower than the national average in all Worcestershire districts.

Hip fractures

Hip fracture is a debilitating condition – only one in three sufferers return to their former levels of independence and one in three ends up leaving their own home and moving to long-term care . Hip fractures are almost as common and costly as strokes and the incidence is rising. In the UK, about 75,000 hip fractures occur annually at an estimated health and social cost of about £2 billion a year.

The average age of a person with hip fracture is about 83 years with about 73% of fractures occurring in women. There is a high prevalence of comorbidity in people with hip fracture [2]. The National Hip Fracture Database [2] reports that mortality from hip fracture is high - about one in ten people with a hip fracture die within 1 month and about one in three within 12 months.

The National Institute for Health and Clinical Excellence (NICE) has produced a quality standard that covers the management and secondary prevention of hip fracture in adults (18 years and older). The standard is designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness for fragility fracture of the hip or fracture of the hip due to osteoporosis or osteopenia.

Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people. This indicator therefore has sub indicators for ages 65-79 and 80+ disaggregated into males and females in the Public Health Outcome Framework data tool. Inclusion of this indicator in the Public Health Outcomes Framework will encourage prioritisation of such interventions.

Pharmacies have a role in supporting people who have suffered hip fractures, for example, in helping with medicines reviews, offering discharge medicines service, and support for fall services,

Figure 68: Emergency Hospital Admission for fractured neck of femur in persons aged 65 and over, directly age standardised rate per 100,000 - Worcestershire

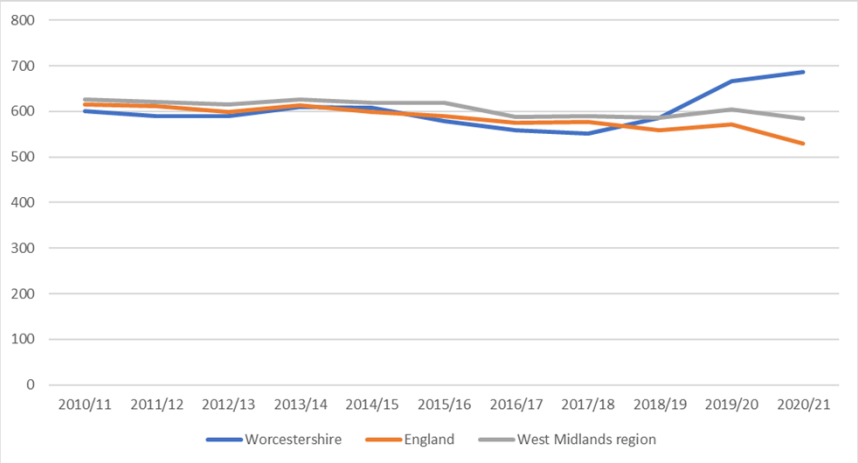
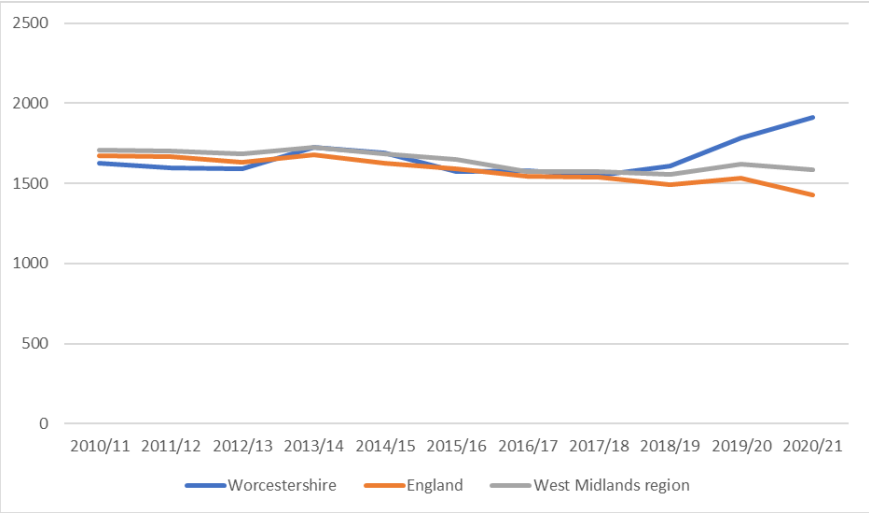


Figure 69: Emergency Hospital Admission for fractured neck of femur in persons aged 80 and over, directly age standardised rate per 100,000 - Worcestershire



Rates of hip fractures in Worcestershire have been similar to the national average for both 65-plus and 80-plus age range up until the last two years, which have seen an increase in rates leading to values significantly above the national average. The rate in Worcestershire among the 65-plus age group in 2020-21 was 686 per 100,000 population compared to the national average of 529 per 100,000 population, and in the 80-plus age group the rate in Worcestershire was 1,914 per 100,000 population compared to the national average of 1,426 per 100,000 population. Rates of hip fractures are significantly higher than the national average in all Worcestershire districts with the exception of Worcester. Full profiles including breakdowns of population and demographics, areas of concern and changing need, and a summary of pharmaceutical services and need are presented in Appendix 10.

Table 13: Indicators where Worcestershire and districts perform poorly compared to national average

Indicator		Bromsgrove	Malvern Hills	Redditch	Worcester	Wychavon	Wyre Forest
Injuries and Ill Health	Hip fractures	✓	✓			✓	✓
	Estimated dementia diagnosis rate (aged 65 and over)	✓	✓	✓	✓	✓	✓
Behavioural Risk Factors	Smokers that have successfully quit at 4 weeks						
	Admission episodes for alcohol-related conditions			✓			✓
	Admission episodes for alcohol-specific conditions - Under 18s					✓	
	Percentage of adults classified as overweight or obese			✓			✓
	Percentage of physically active adults			✓			
Child Health	Smoking status at time of delivery						
	Infant mortality rate	✓					
Wider Determinants of Health	16-17-year-old NEET						
	Gap in employment rate between those with a long-term health condition and the overall employment rate					✓	✓
	Homelessness - households owed a duty under the Homelessness Reduction Act				✓		
	Loneliness: Percentage of adults who feel lonely often / always or some of the time				✓		✓
Health Improvement	Cancer screening coverage - bowel cancer			✓	✓		✓
	Cancer Screening Coverage – Breast cancer	✓			✓		
	Cancer screening coverage - cervical cancer				✓		
	Percentage of 40-74 population offered an NHS Health Check who received an NHS Health Check						
	AAA Screening Coverage	✓	✓		✓		✓
	Percentage with a long term MSK problem		✓				✓
	Blood pressure			✓			
Health Protection	Chlamydia detection rate – age 15-24	✓	✓	✓	✓	✓	✓
	Chlamydia proportion screened - age 15-24	✓	✓	✓		✓	✓
	HIV late diagnosis	✓		✓			
	Flu vaccinations			✓	✓		
Healthcare and Premature Mortality	Under 75 mortality rates from causes considered preventable			✓			
	Under 75 mortality rates from all cardiovascular diseases				✓		
	Emergency readmissions within 30 days of discharge from hospital			✓	✓		
	Asthma						
	Proportion with diabetes			✓		✓	✓
Totals		8	6	13	11	7	12

Table 13 presents the breakdown of indicators across the districts within Worcestershire. Whilst there is much variation between the districts there are common themes underperforming in indicators across the county:

1. Estimated dementia diagnosis rate (aged 65 and over)
2. AAA Screening Coverage
3. Chlamydia detection rate – age 15-24
4. Chlamydia proportion screened - age 15-24

Table 13 also demonstrates the variation in the number of indicators that are being underperformed, for example Redditch has the highest number (13) followed by Wyre Forest (12) and Wychavon (11).

Part B Conclusions

Worcestershire is in general not a deprived county. There are however 13% of people that live in the most deprived quintile. Social determinants of health may influence health seeking behaviour in deprived populations. Deprivation may also limit access to transport and increase digital poverty. Community pharmacies are often located in some of the most deprived and challenging communities and can be the first point of contact for individuals who may traditionally be hard to reach for health services. This provides an opportunity to engage, signpost and build trust within these communities. Projected changes in demography and age should also be considered when evolving the current service.

Part B identifies several areas of concern within Worcestershire, they include:

- Infant mortality rate
- Indicators around smoking, including smoking status of mother at time of delivery and smokers who have successfully quit after 4 weeks
- Indicators focussing on chlamydia, including the proportion aged 15-24 screened and the detection rate within the same age group.
- Physical indicators including the proportion of adults reporting a long term Musculoskeletal (MSK) problem and the proportion of emergency hospital admissions among people aged 65-plus for hip fractures.
- Some screening and detection rates for condition affecting older people, including estimated dementia diagnosis rate and Abdominal Aortic Aneurysm Screening coverage.
- Proportion with diabetes
- Proportion of the eligible population aged 40-74 receiving an NHS Health Check

At a district level, Redditch, Wyre Forest and Worcester City in particular had a relatively high number of areas of concern highlighted. As well as those already highlighted at the county level, these include:

- Under 75 mortality rates from causes considered preventable, percentage of overweight and obese adults, percentage of physically active adults, and alcohol-related admission episodes in Redditch.
- Percentage of adults aged 18-plus classified as overweight or obese, alcohol-related admission episodes, bowel cancer screening coverage, and the gap in the employment rate between those with a long-term health condition and the overall employment rate in Wyre Forest.

- Cancer screening coverage including for bowel cancer, breast cancer and cervical cancer, as well as under 75 mortality rates from all cardiovascular diseases in Worcester.
- In addition, Wychavon has a high level of admission episodes for alcohol-specific conditions among under 18s

PART C

Parts A and B of this PNA have summarised the current provision of pharmaceutical services and the local needs which might be met by pharmaceutical services. Part C aims to identify if there are any gaps in provision and opportunities for service development. The PNA should form a foundation for discussions between local representatives of contractors and local commissioners. Local pharmaceutical services should also be assessed in the context of national and local healthcare strategies which may affect their implementation and delivery. Part C provides an outline of these strategies and then goes on to identify local findings and recommendations from Parts A and B.

Community Pharmacy Contractual Framework 2019-24

The Department of Health and Social Care, NHSE&I, and the Pharmaceutical Services Negotiating Committee have agreed a new Community Pharmacy Contractual Framework. The joint document describes a vision for how community pharmacy will support delivery of the NHS Long Term Plan (LTP), which includes:

- Commitment of almost £13 billion to community pharmacy through its contractual framework recognising the contribution that community pharmacies make towards the delivery of the NHS LTP
- Alignment with the GP contract, providing 5-year stability and reassurance to community pharmacy
- Builds upon the reforms started in 2015 with the introduction of the Quality Payments Scheme to move pharmacies towards a much more clinically focused service
- Confirms community pharmacy's future as an integral part of the NHS, delivering clinical services as a full partner in local Primary Care Networks
- Describes new services which will be offered through community pharmacy including the new national NHS Community Pharmacist Consultation Service
- Underlines the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community
- Recognises that an expanded service role is dependent on optimising the use of pharmacist capacity, and will maximise the opportunities of automation and developments in information technology
- Continues to prioritise quality in community pharmacy and to promote medicines safety and optimisation
- Underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme; and
- Commits to reforms to reimbursement arrangements to deliver smoother cash flow, and fairer distribution of medicines margin and better value for money for the NHS

Pharmacy Integration Fund & NHS Long Term Plan

The Pharmacy Integration Fund (PhIF) was established in 2016 to accelerate the integration of:

  - Pharmacy professionals across health and care systems to deliver medicines optimisation for patients as part of an integrated system;
  - Clinical pharmacy services into primary care networks building on the NHS Five Year Forward View and NHS Long Term Plan

The continued work of the pharmacy integration programme needs to build on what has already been delivered and support these priorities ensuring the continued development of the evidence base that informs future commissioning in line with these priorities for transformation.

The community pharmacy contractual framework (CPCF) agreement for 2019 – 2024 sets out the ambition for developing new clinical services for community pharmacy as part of the five-year commitment. The pharmacy integration programme will pilot and evaluate these services with the intention of incorporating them into the national framework depending on pilot evaluations. The GP contract for 2019 – 2024 also set out a plan to develop a "pharmacy connection scheme" for community pharmacy.

The NHS Long Term Plan (NHS LTP) published January 2019 is now the driver for determining the priorities for the Pharmacy Integration Programme. The ambition in the NHS Long Term Plan to move to a new service model for the NHS sets out five practical changes that need to be achieved over the five-year period 2019 to 2024:

- Boosting "out of hospital care" to dissolve the historic divide between primary and community health services
- Redesign and reduce pressure on emergency hospital services
- Deliver more personalised care when it is needed to enable people to get more control over their own health
- Digitally enable primary and outpatient care to go mainstream across the NHS
- Local NHS organisations to focus on population health and local partnerships with local authority funded services and through new Integrated Care Systems (ICSs) everywhere.

The NHS must continually move forward so that in 10 years' time we have a service fit for the future. The NHS LTP is a plan for the NHS to improve the quality of patient care and health outcomes. The plan focuses on building an NHS fit for the future by enabling everyone to get the best start in life, helping communities to live well, and helping people to age well, and covers the following areas:

- A new service model for the 21st century
- More NHS action on prevention and health inequalities
- Further progress on care quality and outcomes
- NHS staff will get the backing they need
- Digitally enabled care to go mainstream across the NHS
- Taxpayers' investment to be used to maximum effect

The role of pharmaceutical services in the implementation of the NHS LTP: Key areas of action for the NHS LTP

1. A new service model for the 21st century:

1. Expanded community health teams will be required under new national standards to provide support to people in their own homes as an alternative to in-hospital care
2. Over the next five years, every patient will have the right to online 'digital' GP consultations
3. The LTP sets out action to ensure patients get the care they need, fast, and to relieve pressure on A&Es
4. Building on recent gains, in partnership with local councils' further action to cut delayed hospital discharges will help free up pressure on hospital beds

The clinical role of community pharmacists will be enhanced, with pharmacists able to support the timely discharge of patients from hospital through the Discharge Medicines Service to help hospital flow and bed capacity.

2. Stronger NHS action on prevention and health inequalities:

- Wider action on prevention will help people stay healthy and also moderate demand on the NHS

- The LTP funds evidence-based NHS prevention programmes, including to cut smoking; to reduce obesity, to limit alcohol-related A&E admissions; and to lower air pollution
- NHSE will base its five-year funding allocations to local areas on more accurate assessment of health inequalities and unmet need and every local area across England will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years

Local pharmacies actively promote healthy lifestyle initiatives on priority areas such as smoking, obesity, and alcohol, as well as providing opportunistic prescription-linked support.

3. Further progress on care quality and outcomes

The LTP builds on the NHS Five Year Forward View's focus on cancer, mental health, diabetes, multimorbidity and healthy ageing including dementia. It also extends its focus to children's health, cardiovascular and respiratory conditions, and learning disability and autism, amongst others.

By 2028 the Plan commits to dramatically improving cancer survival, partly by increasing the proportion of cancers diagnosed early, from a half to three quarters

Local pharmacies are often the first point of contact between a patient and the health service, and local pharmacists possess clinical and service knowledge to effectively signpost patients. Pharmacists are a key part of the workforce in supporting early detection and improved survival from serious conditions by signposting patients to the appropriate service perhaps earlier than they would have presented without speaking to a pharmacist.

4. NHS staff will get the backing they need

- The LTP sets out action to expand roles and careers to reflect future needs.
- There is a move towards more primary care and generalist skills to complement specialised hospital-based care.

Local pharmacies play a key role in the future workforce, such as serving as training locations for pharmacy students and newly qualified pharmacists.

5 & 6. Digitally enabled care will become mainstream across the NHS / best use of investment

- In ten years' time, care will look very different. The NHS will offer a digital first option for most, allowing for longer and more productive face to face consultations. When ill, people will increasingly be cared for their own home, with remote monitoring of wearable devices. People will be helped to stay well, to recognise symptoms early, and to manage their own health guided by digital tools.

Worcestershire community pharmacies continue working towards a digital first future. Community pharmacies support the NHS LTP through repeat dispensing, most of which is carried out by the Electronic Prescription Service.

Local strategic developments

Local pharmacies should continue to play a key role in prevention of ill health and premature mortality, whilst having a lens on reducing health inequalities. There are several new strategic developments in the local system which align with priorities of the NHS LTP. A new joint health and wellbeing strategy (JHWS) has been developed for Worcestershire (awaiting formal Health and Wellbeing Board signoff). The strategy will be in place for the next 10 years.

The draft 2022 JHWS identified good mental health and wellbeing as a local priority in Worcestershire.

This is supported by:

- Healthy living at all ages
- Safe, thriving and healthy homes, communities and places
- Quality local jobs and opportunities

H&W Integrated Care System (ICS) priorities and strategy, and work on reducing health inequalities.

The ICS has 4 core objectives:

1. To ensure healthier, well connected and more resilient communities with targeted support to reduce health inequalities and inequities, preventing ill health
2. To provide high quality services through improving access to clinically effective treatments
3. To make the best use of resources, being exemplar employers and strengthening the local economy by employing local people, and investing in local businesses wherever possible
4. To promote a healthier physical environment, reducing our carbon footprint through positive action around our buildings, working practices and digital transformation.

NICE guideline: community pharmacies, promoting health and wellbeing (2018)

NICE published a guideline in August 2018[2] about the role of community pharmacy in promoting health and well-being. These guidelines summarised evidence and best practice across the following themes which partners are encouraged to consider:

1. Work to help all community pharmacies become health and wellbeing hubs
    a. gradually integrating into existing care and referral pathways

2. Overarching principles of good practice for community pharmacy teams
    a. Use an integrated approach
    b. Ensure consistent, high-quality services tailored to local communities and not based solely on commercial interest
    c. Address health inequalities
    d. Tailor approaches and use knowledge of the local community, making the most of staff skills
    e. Promote community pharmacies
    f. Ensure community pharmacies are an integral part of NHS primary care services
    g. Proactively seek opportunities to promote physical and mental health and wellbeing

3. Awareness raising and providing information
    a. Ensure awareness raising campaigns and information is in line with NICE's guidelines on behaviour change: individual approaches

4. Advice and education
    a. Offer advice and education as the opportunity arises in line with NICE's guidelines on behaviour change
    b. Opportunistically advise on how to improve general health and wellbeing

5. Behavioural support
    a. Offer individual approaches to behaviour change in line with NICE guidelines on obesity, weight management, preventing excess weight and obesity prevention.

6. Referrals and signposting
    a. Consider establishing formal referral processes with pharmacies and services providers, and base triage and referrals on agreed tools that do not need reassessment by other provide

[2] https://www.nice.org.uk/guidance/ng102/chapter/Recommendations#awareness-raising-and-providing-information

Local Findings & recommendations

A huge amount of evidence has been compiled and synthesised to assess the pharmaceutical needs of Worcestershire. As demonstrated by contractor questionnaires and focus groups, pharmacies currently provide a highly integral role in supporting the health needs of people in Worcestershire.

Findings from this needs assessment together with opportunities for service development are tabulated below.

Access to pharmaceutical services

Assessment	Opportunities / considerations
Pharmaceutical services are provided by appropriately located contractors, delivering services over an appropriate period to allow reasonable access for most people in Worcestershire. It has been assessed that there is currently sufficient provision of pharmacies and dispensing GP practices throughout Worcestershire who deliver essential pharmaceutical services. There are 95 pharmacies and 21 dispensing GP practices in Worcestershire which serve a mixed urban and rural population of 598,070 people. This equates to one pharmacy per 6,295 people which is higher than the England average of one pharmacy per 5,056 people. When GP dispensing practices are included the gap with England is reduced, with one contractor per 5,154 people compared to one contractor per 4,605 people in England. There is a good mix of independent, supermarket and multiple pharmacy contractors providing a good level of choice for dispensing pharmaceutical services. Density of pharmacies, as one might expect, are largely related to density of population (e.g., greater numbers in Worcester & Kidderminster). Dispensing practices are uniformly dispersed across Worcestershire and provide access to medicines in the more rural parts of the County, contributing to the provision of an integrated countywide prescription medicines service together with their pharmacy colleagues. Mapping of locations of pharmacies and travel times by car to pharmacies has demonstrated that access to pharmacies is good across the county, where residents have access to a car. Where a car is available, we believe that most residents can access community pharmacy within 15 minutes by car. Within 20 minutes travelling by car, the vast majority of residents in Worcestershire should be able to access a community pharmacy between 09:00am-17:00pm (though many pharmacies open for longer hours).	There are opportunities to leverage further the good levels of access to community pharmacy through different commissioning models and inclusion of community pharmacy in more pathways. Seeking such opportunities is recommended by NICE guideline NG102.

Where residents are physically able, the majority can access community pharmacy within 30 minutes of their home address by foot. However, some residents will choose to visit pharmacies in neighbouring authority areas. Around a quarter of respondents reported some issues with access in relation to parking. However, most pharmacy contractors and dispensing GP practices indicated that they provided free and disabled parking. Pressures on car parking will be variable depending on day and time of visit. Arguably pressure on car parks will be reduced during non-core times (i.e., pharmacies with extended opening). Most pharmacies indicate that they are accessible to wheelchairs, pushchairs and walking frames. Around 88% of pharmacies do not have steps to enter premises. No specific issues with access were identified currently for people of a particular race or culture (around 7% of service user survey responses), who are pregnant or who are a particular gender. Pharmacy contractors make an important contribution to services that are not remunerated or reimbursed and are not contracted services, but which are appreciated and relied upon by some service users. An example of this is the prescription home delivery service provided by many contractors which improves access to services particularly for the housebound and those with restricted mobility.	
Although the majority of respondents stated they were satisfied with community pharmacy or GP dispensers' opening times a significant proportion (around 22%) reported some issues with opening hours.	There is demand and possible associated need with community pharmacies opening later and out of normal working hours. This may provide pharmacies with additional business, as well as being beneficial to patients and the wider health and care system.

What is the extent to which current service provision is adequately responding to the changing needs of the community?

Assessment	Opportunities / considerations
95% of pharmacies in the pharmacy survey were willing to undertake consultations in patient's home/other suitable site.	This prompts consideration of whether this facility could be further utilised.
The Covid-19 pandemic may have changed the way in which people access pharmacies. During Covid-19 restrictions, just two thirds (63%) used a pharmacy as they normally would and a quarter (24%) used it in a different way, while 13% did not use a community pharmacy or a dispensing GP surgery at all. The focus groups indicated an increased use of online services and delivery services for medications. Some perceived this as a positive legacy of the pandemic and felt more confident using these services.	The pandemic increased the use of online provision with pharmacists having access to teams/zoom. This may enable online consultations with the pharmacist. This could be built on and may be of particular benefit to vulnerable groups and residents in rural areas.
There is an increase in the population of Worcestershire and in particular the numbers of people in the older age groups, who may have multiple long-term conditions, is predicted (Office for National Statistics population projections indicate a 59% increase in people 75 years and older between 2020 and 2040, whilst the projected increase in the 85-plus age range is particularly pronounced, at almost 90% (over 15,800 persons). This means there are some significant challenges to overcome in the drive to improve health and well-being in Worcestershire. The majority of the population is 'white British' with increasing numbers of black, Asian and minority ethnic groups.	Demand on existing services such as flu vaccinations are already increasing year on year. Consideration should also be given to the predicted increased number of those eligible (Those aged over 50). Services need to be aware of changing demographics and an increase in the black, Asian and minority ethnic group population.

Public health services provided by community pharmacies

Assessment	Opportunities / considerations
Over 84% of patients knew that they could approach their pharmacist for general health advice on disease prevention.	This highlights a level of trust in pharmacy services and advice. Supported by focus groups reporting that pharmacists were widely seen as approachable and knowledgeable professionals whose expertise may be underused currently. This may indicate underutilised potential within community pharmacy to deliver additional advice and services.
Flu vaccination is an extremely important preventative measure that continues to need more work by partners to achieve the highest possible coverage in eligible and vulnerable groups.	Uptake in over 65s has increased markedly in Worcestershire from 74.8% in 2019/20 to 83.7% in 2020/21, with a similar rate of increase nationally. Between April and December 2021, pharmacies in Herefordshire and Worcestershire administered 40,203 flu vaccinations and the number is increasing. Approximately 80% of pharmacies provide flu vaccinations. Consideration should also be given to the predicted increased number of those eligible (Those aged over 50)

Service quality improvement

Assessment	Opportunities / considerations
The majority of patients stated they waited less than 10 minutes to have a prescription dispensed and a minority were waiting more than this.	If the role and services offered by community pharmacy were to be extended it would be important that this does not impact on current pharmaceutical provision.

Other findings

Assessment	Opportunities / considerations
A theme emerging from public and service user engagement was a desire for clear information on opening times, services offered and alternative provision when pharmacies are not open.	Clarity of provision of information is deemed to be of importance to patients and the public. GP surgeries, YLYC website and pharmacies themselves all have a role in facilitating access to information about the services offered at pharmacies.
A large majority of respondents (87%) said that they know they can return any unused / unwanted medicines (except sharps) to either a community pharmacy or a dispensing GP surgery. Around 71% of survey respondents return their unwanted medicines to community pharmacy or dispensing GP practice (an improvement on the 2018 finding of 60%). However, a significant number of people stated that they were currently disposing of unwanted medicines through their household rubbish (25%), down the sink or storing them in their home (11%).	There is a cohort of people in Worcestershire who may benefit from improved awareness that unwanted or out of date medicines can and should be disposed of through their pharmacy.

Part C conclusions

Health and wellbeing priorities proposed by the Health and Wellbeing Board and the NHS long-term plan for integrated care, along with current and future health and well-being needs of the Worcestershire population are considered in Part C of the PNA. Part C highlights the role of pharmaceutical services evolving far beyond dispensing prescriptions. They play a significant role in the community in the prevention of ill health and premature mortality, whilst having a lens on reducing health inequalities.

Pharmacies present an opportunity for secondary prevention particularly in challenging/deprived areas where populations can be difficult to reach. Aswell as patients with long-term conditions who are in regular contact to collect their prescribed medicines, pharmacies can be the first point of contact for individuals who may seek ad-hoc and unplanned health advice. The pharmacy team is well placed to support people to reduce their risks through healthy behaviours using a making every contact count (MECC) approach. Pharmacies can act as a community hub for health information and advice, signposting and promoting services to meet individual and community needs.

The potential topics where there is an opportunity for community pharmacies to meet both the local need and the ICS and JHWS priorities include smoking cessation services, screening services, vaccination services, management of conditions, and assessment services. Whilst there are commonalities across the districts of Worcestershire in terms of need, there is also variation between districts and populations which is highlighted in Part C to be considered when evolving the service at a local level.

Overall Conclusions

It is evident that pharmacies are integral to the health and wellbeing needs of people in Worcestershire. This PNA has found that the level of access to pharmaceutical services currently commissioned across Worcestershire continues to generally meets the needs of the population, as described in the findings. The pharmaceutical service in Worcestershire is provided by a variety of contractors that are appropriately located to meet the needs of the vast majority of the population. However, it is clear that the role of community pharmacies in preventing ill-health and supporting self-care could be strengthened. There are also a number of opportunities to improve the provision of pharmaceutical services and experience that people have of pharmaceutical services in Worcestershire.

There are a number of key findings from the extensive focus group work conducted as part of this report. Focus groups found that pharmacists are held in high regard, are seen as knowledgeable and approachable professionals, and being experts on prescribed and over the counter medicines. Maintaining sufficient access in terms of opening times and location is important, but barriers to access need to continually be identified and addressed (e.g., parking and transport). As technology progresses, this is changing the way people of all ages access pharmaceutical services. Feedback from focus groups suggested that a range of methods are used (and should be available) to order repeat prescriptions and possibly consider remote consultations. Reducing the frequency of medication collections would be valued by pharmaceutical service users, where possible.

Focus group participants reported that pharmacy services continued to be provided with a high degree of continuity during the covid-19 pandemic. There were specific issues noted from certain groups with limited social support, such as the ability to collect medications whilst having to isolate. However, the increased use of online and delivery services are a positive legacy from pandemic disruption.

Beyond prescribing, participants saw pharmacists as a preferable alternative to GPs for advice on minor health issues. However, participants reported limited use of other pharmacy services which presents a potential opportunity through raising awareness and communications. Where other services were reported as being accessed, vaccination and blood pressure checks were amongst the most commonly reported services used.

Public, patient and service-user surveys revealed a high level of satisfaction on the part of respondents. Although the response rate was good for this type of survey, this does only provide a sample of views from the population. For instance, 82% of respondents are satisfied with the range of service offered by community pharmacies or dispensing GPs, 78% were content with opening times, but 22% reported some issues. Most access a pharmacy within 2 miles of home or work, but this distance increases with rurality, and most usually travel by car. It is unsurprising with an increasing number of cars on the road that over a quarter of respondents experienced parking issues, but opportunities should be sought to improve parking provision, and perhaps more importantly to promote alternative methods of travel. Of significant note, for respondents with a long-term health condition or disability, there were higher percentages reporting issues relating to physical access.

This PNA concludes that there are sufficient pharmacies serving Worcestershire with good accessibility via walking or public transport. Whilst there are pharmacies in each district open at weekends, just under a quarter of survey respondents suggested some issues with opening times. With varying availability of advanced services across the county, core and wider services offered by pharmacists should continue to be promoted to raise awareness of how pharmacies can support health needs. Results of this assessment suggest that most pharmaceutical needs can be met by the existing network of community pharmacies. However, a continued assessment of need is recommended, particularly as the population of Worcestershire changes, and in areas of higher deprivation and populations of higher health need.

Recommendations

The following recommendations are proposed to strengthen the provision of pharmaceutical services in Worcestershire:

1. Commissioners to continue considering how pharmaceutical service providers can address and respond to patient need as identified through the focus groups, engagement survey, paying particular consideration to access issues and accessibility of information about pharmacy services.

2. Commissioners and pharmaceutical service providers should consider how best to communicate with the public about services provided by community pharmacies (including health promotion messages in line with NICE guideline NG102). The formation of H&W ICS provides an opportunity to consolidate and simplify provision of pharmacy information to the public.

3. Commissioners to encourage the integration of pharmacy with the wider healthcare economy to create coherent, system-wide services and pathways.

4. All providers of pharmaceutical services should consider language accessibility, including translation and interpreting services for people whose first language is not English, and staff training to increase awareness of the needs of different people using the service (e.g., dementia awareness, learning disability awareness, deaf awareness, sight loss and others). Pharmacies should ensure that their communications with the public meet the Accessible Information Standard.

5. The role of pharmacies in the prevention and management of CVD risk factors could be strengthened through commissioning related services.

6. Pharmacies should be aware of how to signpost to other service providers (including, where relevant, voluntary/community sector organisations, other pharmacies providing advanced/enhanced services)

7. Pharmacy workforce strategy should be considered by the local system to ensure current and future pharmaceutical service demand can be met.

8. A working group will be convened to monitor and implement these recommendations.

This page is intentionally left blank

worcestershire countycouncil

HEALTH AND WELL-BEING BOARD
27 SEPTEMBER 2022

WORCESTERSHIRE BETTER CARE FUND PLAN 2022/2023

Board Sponsor
Mark Fitton – Strategic Director, People. Worcestershire County Council
Simon Trickett - Chief Executive, NHS Herefordshire and Worcestershire ICB

Author
Victoria Whitehouse – Better Care Fund Commissioning Manager

Priorities	
Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	No
Other (specify below)	

Safeguarding	
Impact on Safeguarding Children	No
If yes please give details	
Impact on Safeguarding Adults	Yes
If yes please give details	

The Better Care Fund supports the timely, safe and appropriate discharge of patients from the Acute and Community Hospitals.

Item for Decision, Consideration or Information
Information and assurance

Recommendation

1. **The Health and Well-being Board is asked to approve Worcestershire's Better Care Fund Plan 2022/2023; BCF Planning Template, Narrative Plan and Capacity & Demand Template.**

Background

2. The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires integrated care boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006). The use of BCF mandatory funding streams; NHS minimum contribution, Improved Better Care Fund grant (iBCF) and Disabled Facilities Grant (DFG) must be jointly agreed

by integrated care boards and local authorities. These are to reflect local health and care priorities, with plans signed off by health and wellbeing boards. BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund.

3. Worcestershire's BCF plan 2022/23 details the local approach to integration over the financial year with plans to achieve the metrics set nationally. The plan builds on the services and schemes set up within Worcestershire's health and social care system. This is to provide consistency and to continue to develop and review progress on providing joined up care at the right time and in the most suitable setting. The plan strives to support individuals to remain in their own homes for longer, increase their independence and reduce need for hospital admission or long-term care.

4. An Executive Summary of Worcestershire's plan is available to view within **Appendix 2** of the narrative plan.

5. The Disabled Facilities Grant (DFG) continues to be allocated through the BCF as a ringfenced grant. As Worcestershire is a two-tier authority, this is passported to the six district councils. The district councils will continue to meet their statutory duty to provide adaptations in line with integration plans. In March 2022, the government produced new guidance on the delivery of the Disabled Facilities Grant (DFG), which brings together existing policy frameworks, legislative duties and powers, and recommended practice, in one place. This guidance is for local authorities in England on how to deliver DFG-funded adaptations to serve the needs of local older and disabled people.

6. A section outlining the plans for the DFG in Worcestershire for 2022/23 and outcomes achieved during 2021/22 is available to view within the narrative plan in **Appendix 2**.

Better Care Fund 22/23 Planning Timeline

7. BCF planning 2022/23 requirements were published on 27 July 2022 with a requirement to submit plans on the 26 September 2022.

8. A draft version of The Better Care Plan Template and the Narrative Plan was submitted to the Regional BCF Manager on 22 August 2022. This provided the opportunity to receive observational feedback.

9. Feedback returned on 1 September 2022 by The BCF Team, Skills for Care and Foundations and the plans were subsequently updated to reflect the observational queries.

10. BCF Plans were discussed and signed off at ICEOG on 12 September 2022.

11. BCF Plans alongside this report were distributed virtually to Health and Wellbeing Board Members on 14 September 2022 allowing members opportunity to comment on the plans by 22 September 2022. This was due to the unavoidable deadline to submit plans to NHS England in advance of the scheduled HWB board meeting on 27 September 2022.

12. In line with requirements, BCF Plans were submitted to NHS England / The Better Care Team on 26 September 2022.

13. A regional assurance process will be undertaken by 24 October 2022, with approval letters expected to be received by 30 November 2022.

Better Care Fund 2022/23 Planning Requirements

14. For 2022/23, BCF plans must consist of:

    - A completed narrative template which is reproduced at **Appendix 2**
    - A completed BCF planning template to include
        - planned expenditure from BCF sources
        - confirmation that national conditions of the fund are met,
        - specific conditions attached to individual funding streams
        - ambitions and plans for performance against BCF national metrics
        - any additional contributions to BCF section 75 agreements.

      Which are included at **Appendix 3.** NOTE: there is a known fault on the cover page of the plan affecting the metrics tab in the checklist. This will not impact the plan submission.
    - A completed intermediate care capacity and demand plan, which is not be subject to assurance, details of which can be seen in **Appendix 4**

15. The four national conditions for BCF 2022/23 mostly remain the same as they were in 2021/22 with an update on national condition four. These are:

    1. A jointly agreed plan between local health and social care commissioners, signed off by the HWBB.
    2. NHS contribution to adult social care at HWBB level to be maintained in line with the uplift to NHS minimum contribution.
    3. Invest in NHS commissioned out-of-hospital services.
    4. Implementing the BCF policy objectives:
        - Enable people to stay well, safe, and independent at home for longer
        - Provide the right care in the right place at the right time.

16. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2022/23. The metrics for the BCF in 2022/23 are:

Avoidable admissions to hospital	Unplanned hospitalisation for chronic ambulatory care sensitive conditions
Residential Admissions	Older adults (65 and older) whose long-term care needs are met by admission to residential and nursing care per 100,000 population.
Effectiveness of reablement	Proportion of older people (65 and older) still at home 91 days after discharge from hospital into reablement or rehabilitation services
Discharge to usual place of residence	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence

Funding Contributions – 2022/23

17. *NHS Minimum Contribution* - In line with national guidance and national condition 2 (as detailed in paragraph 12), the 2022/23 Better Care Fund for Worcestershire demonstrated 5.66% growth on the NHS's Minimum Contribution (£2.37 million), giving a total value of the BCF of £69,456,193, as shown in **Table 1**.

Details of the BCF schemes and forecast year end outturn can be seen at **Appendix 1.**

Table 1 – BCF Allocation for 2022/23 compared to 2021/22

	Year			
Funding Contributions	**21/22**	**22/23**	**Movement**	**%**
	£	**£**	**£**	
CCG Minimum Contribution	41,896,797	44,268,156	2,371,359	5.66%
Disabled Facilities	6,163,577	6,163,577	-	0.0%
* iBCF	18,465,125	19,024,460	559,335	3.03%
BCF Total	**66,525,499**	**69,456,193**	**2,930,694**	

* *Including £2.38m "Winter Pressures" allocation*

18. There has been inflation of 3% applied to the *Improved Better Care Fund* (iBCF) which is allocated to local authorities for 2022/23, this now stands at £19 million (increase of £0.56 million). The Health and Well Being Board are asked to note that in line with national guidance issued in 2020/21 the Council has re-classified the Winter Pressures funding of £2.38m as part of the iBCF.

19. *Disabled Facilities Grant* (DFG) - This Grant has been passported to District Councils in accordance with the national allocated amounts as set out in **Table 2**.

Table 2 – DFG Allocations per District Council for 2022/23

District Council	**£**
Bromsgrove	1,036,273
Malvern Hills	682,875
Redditch	952,377
Worcester	780,221
Wychavon	1,251,934
Wyre Forest	1,459,897
TOTAL	**6,163,577**

2022/23 BCF Period 4 Forecast Outturn

20. The 2022/23 BCF forecast outturn is currently reporting breakeven against the budget (£69,456,193), with further detail on a scheme-by-scheme basis at **Appendix 1**.

Legal, Financial and HR Implications

21. The government's mandate to the NHS for 2022/23, issued under section 13A of the NHS Act 2006, sets an objective for NHS England to ringfence funding to form the NHS contribution to the BCF. The planning requirements set allocations (published on the NHS website) from this ringfence to ICBs, and in turn from ICBs to their HWB areas, and apply conditions and requirements to their use. The council is legally obliged to comply with grant conditions, which have been complied with.

22. The agreed budget will be managed through a section 75 agreement between the council and NHS Herefordshire & Worcestershire, which is currently in place until 31 March 2023.

23. Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 and 276 of the NHS Act 2006) to exercise certain local authority functions and for local authorities to exercise various NHS functions. The parties entered into a section 75 agreement in exercise of those powers under and pursuant of the NHS Regulations 2000.

24. The iBCF is paid directly to the council via a Section 31 grant from the Department of Levelling Up, Housing and Communities (DLUHC). The Government has attached a set of conditions to the Section 31 grant to ensure it is included in the BCF at local level and will be spent on adult social care. The council are legally obliged to comply with the grant conditions set.

25. The Worcestershire BCF is a ring-fenced grant. It has been agreed that any over or underspend will be jointly attributable to NHS Herefordshire and Worcestershire and to Worcestershire County Council.

26. There are no HR implications within this report

Privacy Impact Assessment

27. Non arising directly from this report

Equality and Diversity Implications

28. An Equality Relevance Screening has been completed in respect of these recommendations. The screening did not identify any potential Equality considerations requiring further consideration during implementation.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report

Victoria Whitehouse, Better Care Fund Commissioning Manager - People Directorate
Tel: 01905 643574
Email: Vwhitehouse@worcestershire.gov.uk

Richard Stocks, Senior Finance Business Partner
Tel: 01905 846514
Email: Rstocks@worcestershire.gov.uk

Supporting Information

- Appendix 1 – BCF Schemes and Forecast Year End Outturn
- Appendix 2 – BCF Narrative Template
- Appendix 3 – BCF Planning Template NOTE: there is a known fault on the cover page of the plan affecting the metrics tab in the checklist. This will not impact the plan submission.
- Appendix 4 – Capacity & Demand Planning Template

Background Papers

In the opinion of the proper officer (in this case the Interim Director of Public Health and Strategic Director, People) the following are the background papers relating to the subject matter of this report:

2022 to 2023 Better Care Fund Policy Framework - https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023/2022-to-2023-better-care-fund-policy-framework

Better Care Fund (BCF)

Scheme	Line in s75	BCF £	iBCF £	DFG £	Total budget for 2022/23 £	Forecast outturn £	Variance £
Revenue Schemes from NHS H&W contributions (stay in NHS H&W)							
General Rehab Beds	Community Health Services	12,794,133	0	0	12,794,133	12,794,133	0
Intermediate Beds	Community Health Services	1,849,772	0	0	1,849,772	1,849,772	0
Neighbourhood Teams	Community Health Services	7,822,779	0	0	7,822,779	7,822,779	0
Onward Care Team	Patient Flow Centre	714,149	0	0	714,149	714,149	0
Worcestershire IP Unit- Pathway 2	Adult Recovery Services	5,160,828	0	0	5,160,828	5,160,828	0
Total	**Total**	**28,341,660**	**0**	**0**	**28,341,660**	**28,341,660**	**0**
Funding tranfser from NHS H&W to Local Authority							
Pathway 1(UPI)	Adult Recovery Services	4,353,030	0	0	4,353,030	4,353,030	0
Pathway 1+	Adult Recovery Services	0	0	0	0	0	0
Rapid Response Social Work Team	Hospital & Rapid Response Assessment	370,800	1,263	0	372,063	372,063	0
Pathway 3 (SPOT DTA)	Beds for Admission Prevention & Patient flow	1,826,225	719,894	0	2,546,119	2,546,119	0
External placement contingency (Winter Pressures)	Beds for Admission Prevention & Patient flow	0	758,548	0	758,548	758,548	0
ASWC in Community Hospitals, Resource Centres and DtA Beds- Onward Care Team	Hospital & Rapid Response Assessment	471,275	504,000	0	975,275	975,275	0
Carers	Carers	1,158,022	101,978	0	1,260,000	1,260,000	0
Implementation of the Care Act - additional demand for Home Care	Older People Care Act Eligible Services	2,178,997	298,942	0	2,477,939	2,477,939	0
LD Complex Cases	LD Complex Cases	803,500	0	0	803,500	803,500	0
WCES	Integrated Community Equipment Service	1,762,000	0	0	1,762,000	1,762,000	0
Disabled Facilities Grant	DFCG	0	0	6,163,577	6,163,577	6,163,577	0
GP attached Social Workers	Adult Recovery Services	310,400	0	0	310,400	310,400	0
NHS Investment in Care Homes		0	0	0	0	0	0
Total		**13,234,249**	**2,384,625**	**6,163,577**	**21,782,451**	**21,782,451**	**0**
20/21 Recurrent Growth	Adult Recovery Services	48,390	0	0	48,390	48,390	0
21/22 Growth	Adult Recovery Services	2,283,545	0	0	2,283,545	2,283,545	0
22/23 Growth	Adult Recovery Services	360,312	0	0	360,312	360,312	0
iBCF		0	16,639,835	0	16,639,835	16,639,835	0
Total Growth to be allocated		**2,692,245**	**16,639,835**	**0**	**19,332,082**	**19,332,082**	**0**
		15,926,494	**19,024,460**	**6,163,577**	**41,114,533**	**41,114,533**	**0**
TOTAL BCF		**44,268,154**	**19,024,460**	**6,163,577**	**69,456,193**	**69,456,193**	**0**

This page is intentionally left blank

Cover

Health and Wellbeing Board

Worcestershire Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

How have you gone about involving these stakeholders?

Ongoing discussions and system wide meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the BCF 22/23 plan. Information and data are shared across the system to inform the BCF planning to consider how organisations and providers are meeting the BCF outcomes and metrics. Stakeholders include but are not limited to Herefordshire & Worcestershire Health & Care Trust, NHS Herefordshire & Worcestershire ICB, Primary Care Networks, Worcestershire Healthwatch, voluntary and community organisations, members of the Worcestershire Strategic Housing Officers Group along with Worcestershire council stakeholders.

Engagement and involvement has been through a variety of system and internal meetings, including the Integrated Commissioning Executive Officers Group as part of developing the Integrated Care System in Herefordshire and Worcestershire.

Executive Summary

This should include:

- *Priorities for 2022-23*
- *Key changes since previous BCF plan*

The Better Care Fund guidance 2022/2023 sets out national conditions which are the key requirements for the Better Care Fund Plan 2022/2023.

1. A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
2. NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
3. Invest in NHS commissioned out – of – hospital services.
4. Implementing the BCF policy objectives.

The BCF guidance also sets out the national metrics to be included within the BCF 22/23 plans.

Avoidable admissions to hospital	Unplanned hospitalisation for chronic ambulatory care sensitive conditions
Residential Admissions	Older adults (65 and older) whose long-term care needs are met by admission to residential and nursing care per 100,000 population.
Effectiveness of reablement	Proportion of older people (65 and older) still at home 91 days after discharge from hospital into reablement or rehabilitation services
Discharge to usual place of residence	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence

Key System Priorities and ambitions for 2022/2023:

- Hospital Discharge and Flow
- Development of an Integrated Care System
- Care Market Development
- Management of Social Care Demand
- Intermediate Care

1. Although Length of Stay (LOS) is no longer a metric within the BCF plan, it is still a priority to maintain acute trust LOS performance, continue to improve Community Hospital LOS and achieve best practice Pathway 1 LOS. The system is to agree targets where not achieving best practice and communicate and link to delivery of actions in overall plan.

2. To agree the future of an intermediate care service with all system partners.

3. Capacity planning for 22/23 for Pathway 1, ensuring capacity meets predicted demand aligned to discharge requirements. Also to complete a review of the wrap around care service pilot which supports people to return home from hospital with a period of 24/7 wrap around care. It aims to provide people with the opportunity to make decisions about their long-term service needs whilst in their home environment.

4. To embed pathway 3 and effective use of the Intensive Assessment Rehabilitation Unit (IAR) beds to ensure maximum use of reablement opportunities for those still requiring use of bed-based care.

5. Analyse flow across the system and identify opportunities to deliver integrated approaches where there is benefit to flow and efficiency and supports a home first approach.

6. Development of a long-term homelessness pathway.

The system priorities are interlinked and rely on each partner to work collaboratively for success throughout the system.

Within the 21/22 BCF plan, it was highlighted that a significant level of funding had been committed to support the removal of delay and within the D2A pathways. The system continues to focus on these areas throughout 22/23:

- Continuation of of the council's reablement service (Home-first). This is to meet the increased demand for 22/23 for Pathway 1 to enable people to be discharged within 24 hours in line with the National Discharge Targets. The emphasis on supporting people to go home and to remain at home should have an impact on reducing admissions to long term care. Following the pilot of the Wrap Around Care Service, this will require consideration for long term investment to support discharge to usual and residential admissions.

- Sustaining the delivery of the Onward Care Team. The team is in place and continues to practice a multi-disciplinary approach to identify the correct discharge pathway and care and support plan. This will continue to improve length of stay in the acute hospital and ensure national hospital discharge targets are achieved.

- Further development and review of Pathway 3 to reduce the use of care home provision through the Intensive Rehabilitation and Assessment (IAR) Unit. This will continue to support people who require bed-based reablement to return home.

- Development of a long-term Intermediate Care Service which facilitates effective partnership working and the ability to analyse flow across the system. This will identify opportunities to integrate services where there are benefits to flow and efficiency, following a short-term model of delivery.

Improved Better Care Fund Allocation:

In addition to the main BCF resources and plans, the improved better care fund (iBCF) allocation for Worcestershire Adult Social Care in 2022-2023 includes funding to be spent for the following purposes:

a) meeting adult social care needs
b) reducing pressures on the NHS including seasonal winter pressures
c) supporting more people to be discharged from hospital when they are ready
d) ensuring that the social care provider market is supported

The formal allocation of the iBCF is established as part of the BCF budget setting process, £1m of the total contribution has historically been transferred to the Herefordshire & Worcestershire Clinical Commissioning Group (CCG). This continues to be transferred to NHS Herefordshire & Worcestershire ICB to assist with pressures on the NHS in the relevant areas. The remainder of the grant is used to meet adult social care needs and ensuring that the market is supported, examples of these include:

- Financially supporting the domiciliary care market with the aim to avoid hospital admissions (metric 8.1), and increasing patient flow across the system
- Funding permanent recruitment within the Onward Care Team streamlining hospital discharge and reducing DToC
- Additional investment in the community reablement service with the aim of preventing / delaying admission to long term care or hospital. This supports metric 8.5 (Clients remaining at home after 91 days following hospital discharge).
- Use to fund pressure of externally purchased Pathway 3 placements, whilst long term care planning for clients.

BCF funding is used for key core social care and NHS community services - operational social work, integrated discharge, community health and care services short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community.

Key changes since the previous BCF Plan

Overall, the BCF plan remains focussed on supporting hospital discharge but it is evolving to bring in more activities to prevent admissions to hospital and to long-term care placements. As outlined above, there will be a review on the Wrap Around Care Service and the impact it has on supporting discharge to usual residence and avoiding residential admissions. This will require further consideration for long term investment. Also, there will be development of the long-term plan for intermediate care services within Worcestershire. Recruitment has been a national challenge which has had an impact on the entirety of the adult health and social care sector. The recovery and stability of the care market following Covid 19 will continue to have an impact on services funded through the BCF and will be an area of increased focus.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Worcestershire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports.

Oversight and responsibility for the Better Care Fund is embedded within the Senior Leadership Teams of both the People Directorate within the County Council and NHS Herefordshire and Worcestershire ICB formally Herefordshire & Worcestershire CCG. In each organisation, this is led by Chief Officers, who can maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery.

The senior leaders of the two organisations formed the Worcestershire Integrated Commissioning Executive Officers Group (ICEOG). The aims of ICEOG is to progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents. Review on progress of commissioned services and activity and formal decision making takes place at monthly meetings. ICEOG provides quarterly reports of the progress and ambitions for integration priorities within Worcestershire to the Health & Wellbeing Board.

The governance arrangements continue to support collaborative working between health and social care services to increase joint working and alignment of commissioning arrangements. They seek to develop and implement appropriate and effective integrated commissioning plans in accordance with the priorities, outcomes and budgets set by the respective governing bodies and the Health and Well-being Board.

A Joint Health and Welling Being Strategy is currently in development and with the establishment of a new Integrated Care System for Herefordshire and Worcestershire it brings a timely opportunity for the new strategy to inform and deliver action at both the system and place level.

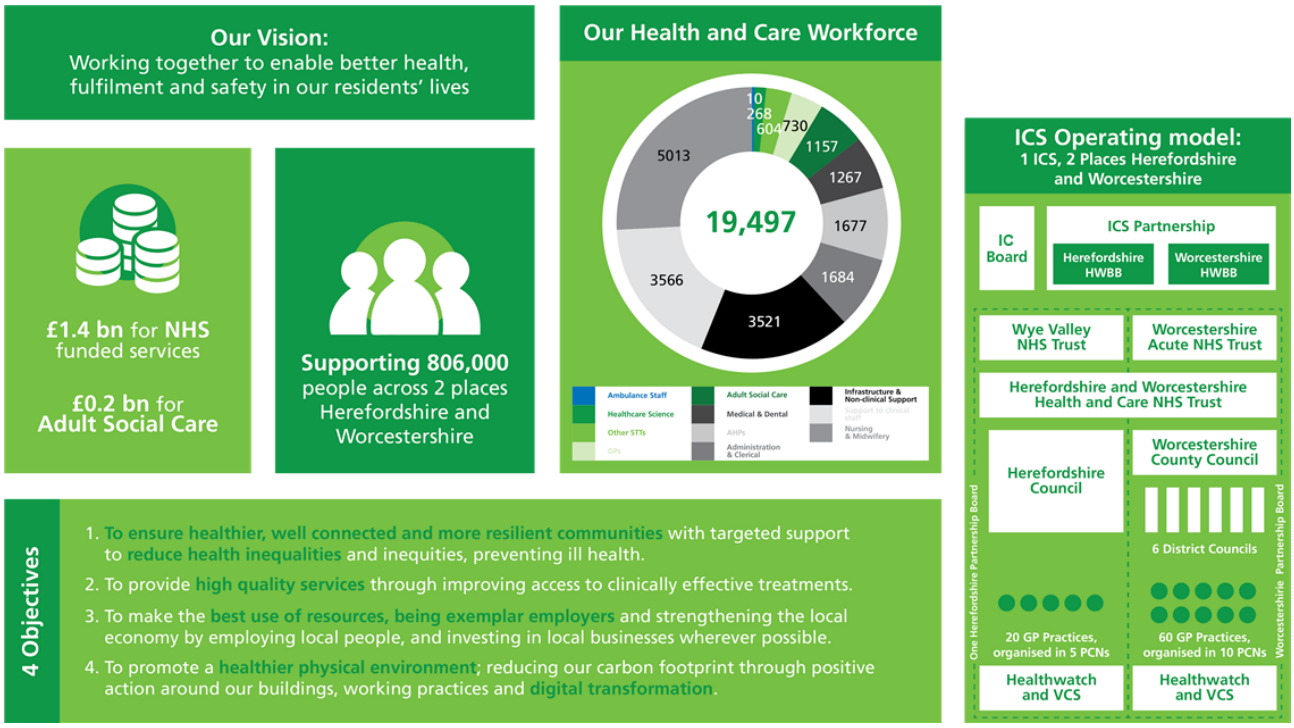
The coronavirus (COVID-19) pandemic has had a profound impact on our health and wellbeing, affecting outcomes across the life course. It has shone a light on some of the health and wider inequalities that persist in our society and it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. A new strategy therefore presents an opportunity to include our aspirations and priorities for tackling inequalities as part of our recovery recognising that many of the causes of ill-health are deep rooted in society.

Indicative timescales for the development of the strategy are summarised below with the aim to publish the final strategy in March 2023 for implementation in April 2023, under the following guiding principles:

- The priorities in the strategy will be based on need, supported by actions based on evidence of effectiveness.
- Prevention (in all its forms) will be at the heart of all we do
- A ‘proportionate universalist’ approach – something for everyone and more for those who need it the most
- The strategy will focus on areas where partnership action adds value and there is commitment across the system
- Narrowing health inequalities as a core aim
- The strategy is developed in close collaboration and consultation with residents and local partners from health, social care, local authorities and voluntary sector.

The Herefordshire and Worcestershire Integrated Care Partnership Assembly will be a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. The Partnership Assembly will include representatives from NHS Herefordshire and Worcestershire, the two local authorities, and other partners across the two counties such as NHS providers, public health, social care, housing services, and voluntary, community and social enterprise (VCSE) organisations. It will focus on the wider determinants of health, including housing, education and leisure, and will be responsible for developing an integrated care strategy which will set out how the wider health needs of the local population will be met.

he following infographic gives an outline of the composition of our system resources, priorities, and governance:



Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- *Joint priorities for 2022-23*
- *Approaches to joint/collaborative commissioning*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.*

Joint priorities for 2022-23 include: -
-Enhancing and integrating our intermediate care service to ensure a seamless approach to admission avoidance and prevention
-An integrated homelessness pathway for individuals admitted to hospital

-An integrated mental health offer for residents in Worcestershire

During 22/23, work will continue with our health colleagues to look at how we prepare for the proposed Intermediate Care Framework from NHS E/I. The Framework describes how we will support people after a hospital admission or a crisis event in the community (including rehabilitation, reablement and recovery) including the Core20PLUS target population cohort; therefore, it will support both hospital discharge and admission avoidance services. Whilst there are good intermediate care services across Worcestershire, there is room for improvement specifically how we integrate and work more collaboratively regarding hospital avoidance and prevention services, this will result in a seamless approach for our residents and enable us to work more closely to provide the right care at the right time. The key aims we aspire to (in line with the proposed national framework) are:

1. Person-centred and in partnership with carers
2. Home based by default
3. Therapy led
4. 7 days a week
5. Integrated across health and social care – jointly commissioned, based on population needs
6. Includes those at end of life and those with cognitive impairment
7. Truly multi-disciplinary – joint workforce planning
8. Outcomes driven – services focussed on continual improvement through use of local data intelligence
9. Reduces workload for primary care
10. One size does not fit all – local innovation encouraged

For individuals admitted to hospital who have become homeless due to a changing health need or are already a rough sleeper, a pathway is in place, however due to the increased demand and complex need this pathway needs to be expanded and fully integrated across health and social care to support the pressures across the system and enable medically optimised individuals to move into suitable accommodation in a timely manner.

A s75 agreement between health and social care mental health service ended and further work is needed to ensure that whilst this formal agreement isn't in place, residents are still able to access a service which is easy to navigate, utilises the skills and expertise of both health and social care professionals and provides the best possible outcomes for individuals. Work is currently being undertaken with key stakeholders including people who use services to enhance our current offer through the reduction of duplication and improved collaboration. This aspiration over the next year is to combine key policies and procedures, look at co-locating staff and share resources to provide a better experience for individuals.

The collaborative integration approach is evidenced through a number of services or initiatives, which include, but are not limited to the services below.

Integrated Equipment

The Worcestershire Community Equipment Service (WCES) is central to the delivery of the prevention and wellbeing priorities of the ICS and develops its service in line with changing demand in social and health care. WCES provides equipment to support individuals to get home from hospital quickly, rehabilitate once home from hospital, stay home and avoid hospital admission, and increase their function and independence to live well whilst they are at home. WCES delivers the equipment within 24 hours of request if required to meet an urgent need and has adapted its working patterns to meet the time demands of discharge to assess and increased reablement activity. Clinical expertise within the service reviews and changes the type of equipment available to prescribers and offers advice, training and support to our clinical prescribing community to ensure best practice of selection and application of community equipment. Clinical experts scrutinise and assure on all requests for non-standard equipment to ensure only essential purchases of specialist items are made and equipment is re-used wherever possible.

Working directly with clinical prescribers, from provider services in health and care across the county at place and neighbourhood level, WCES sources the best value equipment to meet clinical and functional need, considering quality, and re-use/recyclability. This facilitates patients with increasingly complex health and care needs to remain at home and be supported at home on discharge, having their equipment needs changed and updated as their conditions progress or changes to ensure the right equipment is in place at the right time to support the right care for the individual.

WCES monitors the reason for equipment need from its clinical prescribers and the discharge pathway the equipment is required for if applicable, evidencing the increased demand for rapid access to specialist equipment to support system flow and get people home with the appropriate support. WCES provide standard equipment to clinical teams at their bases, so it is ready to issue immediately to meet an individual need and have systems to restock and replenish that equipment frequently.

The service continues to see an increase in both client numbers and overall equipment spend. The increase evidences the on-going focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge. The service continues to see a shift towards urgent need over routine need, and a change in types of equipment requested to more complex and expensive individual items, including increased bariatric equipment.

WCES provide monthly performance data to its stakeholders to show its monthly activity; number of urgent and routine requests, activity across the discharge pathways including end of life and admission prevention, spend on categories of equipment including data on actual purchase versus use of recycled equipment.

Virtual wards

The system is continuing to develop its approach to virtual wards, which is now as part of the National Virtual Wards Programme. The system continues to develop the relationships between NHS providers, including primary care, secondary care, and social care. Scoping is currently taking place in Worcestershire for the implementation of virtual wards for Frailty, COPD, and Heart Failure.

Flow and Discharge dashboard

The system is now using a system wide flow and discharge dashboard for Worcestershire that supports ongoing monitoring and identifies areas for improvement, including the use of SHREWD and the Patient Tracker. This supports targeted intervention, both on an operational basis and also through tactical review to adjust resource distribution across the pathways.

Falls prevention (Digital Technology)

The system is supporting innovative projects, such as the Falls Technology Project. The project involves Worcestershire County Council, Herefordshire Council and NHS Herefordshire and Worcestershire ICB in commissioning, procuring, and delivering technology which will enable professionals to engage in evidence-based conversations about risk reduction in relation to falls. The work will also support the Health and Well-being priority to ensure Worcestershire residents are healthier, live longer and have a better quality of life, remain independent for as long as possible.

Key to the successful delivery of the plan are health and social care initiatives to support admission avoidance and timely discharge, including 2-hour response service and investment in pathways, aiming to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing hospital admissions and support discharges.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- *Enable people to stay well, safe and independent at home for longer*
- *Provide the right care in the right place at the right time*

Please use this section to outline, for each objective:

- *The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care*
- *How BCF funded services will support delivery of the objective*

Plans for supporting people to remain independent at home for longer should reference

steps to personalise care and deliver asset-based approaches

implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches

multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Worcestershire County Councils People Directorate strategy is a single strategy for people and communities, with a clear aim and a focus on outcomes for people. The strategy was developed and co-produced with people, staff and partners to meet need by maximising the use of assets, resources and the workforce. A central theme is to enable people to stay well, safe and independent at home for as long as possible. The Commissioning strategy is aligned to the Adult Social Care strategy and references developing a Person-Centred Approach, Shaping Services and Shaping an Effective Market. These principles will support and promote people's independence. The Commissioning Strategy and Market Position Statement are directly aligned to the Council's Corporate Plan and Joint Strategic Needs Assessment. Collaborative commissioning is already being delivered through initiatives such as SEND (SEND Strategy), Carers (Commitment to Carers and Carers Strategy) and Assistive Technology (Falls Technology).

Enabling people to stay well, safe and independent at home for longer is delivered through the following services A key service is the Reablement service which offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting through a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model. Pathway 1 (Home) being the optimum pathway with a £4m investment to expand this service to enable more people to return home, where safe to do so, and reduce the number of people sent to a bed-based facility. Worcestershire County Council have also commissioned the Domiciliary Care sector to deliver a Reablement Focussed Approach which complements the Reablement Service, further enabling people to maximise their independence and enabling optimum flow across the whole system.

There are also 12 Neighbourhood Teams in Worcestershire. These are multi-disciplinary teams comprising of health and social care professionals who work within local communities providing care, support and rehabilitation to prevent hospital admission or in support of people being discharged from hospital. The NICE reablement guidelines have been adopted and the teams also take an asset based, person centred approach wherever possible. The teams are also involved in development of the frailty-based population health approach, in readiness for delivery of anticipatory care framework and are also tasked with the implementation of virtual wards.

Underpinning the wider Reablement service and Neighbourhood teams is the innovative use of the DFG, the reinvigoration of the Worcestershire Community Equipment Service (WCES) and the Independence at Home service, which supports people with low level need. Services such as Suicide Prevention are enabling people to remain safe whilst supporting people to remain well is a key priority of the system and forms a central theme to the new Health and Wellbeing strategy. The BCF in Worcestershire will also continue to fund the delivery of targeted services such as People Like Us (PLUS) which works across Worcestershire to support anyone aged 18 upwards who is experiencing loneliness or isolation, Lifestyle advisors and an Enhanced Weight Management Service.

The system across Worcestershire will continue to develop an Asset based community development (ABCD) approach recognising, identifying and harnessing existing 'assets' where ever possible and will make stronger, system wide, connections in respect of the population health management approach.

Whilst still early days, the Public Health within WCC has been working with the ICS on specific population health management approaches. This includes using population health management approaches to identify and reduce risk in patients with pre-diabetes. A local primary care PHM tool has been produced which will help to understand population health and needs within Worcestershire. The ICB datalake is a system which will pool health and social care data from across the ICS and will enable even more population health management approaches going forward.

The system is trialed an intermediate care service approach from September 2021 which has a home first focus and we have seen that on the whole, most people have received appropriate levels of care in their own homes in a timely manner, done in a collaborative way with partners across the system to maximise the use of all available resources. At an operational level the service is working with services users and their carers to promote their strengths, making sure people are valued and have meaningful input into arrangements for their discharge plans. We have also introduced multi-agency triage hubs to agree timely discharges which has helped to eliminate delays in allocating capacity and reduced length of stay in hospital. This collaboration has enabled us to move and flex resources around the system to target key areas of pressure in the system to maximise flow.

The trial has enabled collaboration between partners and providers to create a single trusted assessment document, with an emphasis on a description of care needs, not prescription of pathways to encourage the promotion of the discharge to assess model, recognising that people are best assessed in their own environments which tailors to their strength. The trusted assessment has enabled us to streamline the processes and reduce hand-offs between partner organisations, ensuring ownership and accountability for decision making and care provision, which in turn has supported us to improve communication with service users and families, and providers.

As part of the intermediate care trial, we have reviewed our discharge home to assess model (Pathway 1), and are now able to not only look at supporting people home with a standard reablement/care offer, but also a wraparound care service, 24/7 to enable people to go home who would ordinarily have remained in hospital. This trial underpinned by a collaborative leadership approach which has enabled us to break down barriers between organisations and come together with a shared focus on home first. This has also helped to change behaviours and cultures which have previously been a barrier to consistently achieving the right outcomes for people.

Over the course of the trial, the discharge to assess model for patients unable to return home (Pathway 3) has also been reviewed, and we are now looking at making changes to the offer to ensure patients are able to have long term care planning assessments done in an environment most conducive to their needs. We also have a pathway that supports patients with very complex care needs to leave hospital care to have their assessments completed.

There is system agreement to continue with the collaborative approach and the scope of the service is set to be broadened to include all areas of intermediate care service provision funded via the BCF, including preventing admission to hospital, with the aim of aligning them under a single leadership framework with associated budgets and clear governance arrangements to provide accountability at system level. The transformation programme, which will include a review of the current service against the high impact change model is being worked up for agreement with system leaders.

The system has been following the '100- day challenge' to adopt national processes to make a significant difference on facilitating a timely and effective discharge and improve the care for patients. The 10 initiatives of this challenge align with the outcomes of the High Impact Change Model for managing transfers of care. The 100-day challenge will lead to recommendations for the ongoing improvement and monitoring that Worcestershire may need around discharge. Following a self-assessment, Worcester has reported a good level of maturity across a lot of the areas. There are areas highlighted where the system is still developing and establishing plans to meet these outcomes and recommendations for improvement.

Supporting Unpaid Carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers

Replacement Care

BCF funding is used within adult replacement care for block purchase arrangements with care homes. This is to the value of just over £1.5m pa. This includes individuals who are older people, who have mental health needs, learning disabilities, physical disabilities, and sensory impairments as well as some specific dementia replacement care beds. Worcestershire County Council also fund replacement care which is not within care homes but is within the individuals home provided by domiciliary care agencies and personal assistants. Care can also be provided outside the home. Care can be paid for and organised by adult social care, or the individual can organise it via choice of a direct payment, so the DP recipient can manage their own personal care budget.

Replacement care enables unpaid carers to have a break from time to time to enable them to recharge, this has been a real issue to achieve during lock down and covid. It is important to take a break and to care safely, so carers don't put themselves at risk in any way. This type of provision also contributes to reducing carer breakdown, enables the carer to have a life of their own and time to look after their own physical and mental health and wellbeing.

Carer Direct Payments.

Worcestershire County Council (WCC) contracts with the Carers Hub to carry out Carer Assessments on behalf of the council. There is an entitlement for the assessment of carers needs and to establish how these needs can be met. An approach is used called the 'Three Conversations Model' which uses a 'strength-based approach'. This means carers are put at the centre of the process, identifying a carers' own skills and strengths and what support is available to them in their community. This helps to inform the plan of how to meet the needs of both the carer and the cared for.

The 3 Conversations model will help identify which areas of a carer's life are being significantly impacted because of the necessary care they provide, and the best way to meet those areas of need. Universal services, direct support to the cared for and support for the carer (via the Carers Hub) will meet the carer needs. However, for some carers there may be other unmet needs. A Personal Budget can be allocated to meet eligible needs, which is paid for by Adult Social Care and is predominantly taken as a Carer Direct Payment. BCF fund contributes to the Carer Direct Payments to the value of £71,200 pa. This funding contributes to meeting eligible needs in line with the Care Act.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

In Worcestershire, the DFG is passported out to the District Councils to meet their statutory housing duties. Each District Council is responsible for their own Housing Assistance Policy to make local needs and DFG is used in accordance with these policies.

The 6 District Councils and the County Council have jointly procured a Home Improvement Agency. The countywide home improvement agency service promotes independent living by providing information and advice, adaptations and improvements in the home environment which enable older and disabled people to remain living independently using mandatory grants, discretionary grants, financial assistance, advice and support. In 2021/22 the service received 4225 enquiries and assisted 224 households with a major adaptation, plus a range of other services and grants to enable people of all ages to regain or retain their independence and carry on living in the community which contributes directly to Objectives in the BCF Plan: Enabling people to stay well, safe, and independent at home for longer. These services include:

- **Housing options**: for customers where a move to more suitable accommodation may be appropriate. This service has saw an 80% increase in referrals in 21/22.
- **Mandatory Disabled Facilities Grant** (DFG): adaptations to homes range from a stairlift to an extension providing a ground floor bedroom and bathroom.
- **Ceiling Tracking and Hoists:** in a recent change in policy, the district councils now fund all installations rather than just those where it is part of larger grant works.
- **Home Repair Assistance**: financial assistance to ensure that vulnerable persons remain in their homes in safe, warm and healthy conditions.
- **Hospital Discharge Scheme**: there was a 46% increase in referrals to this fast-tracked and non-means tested works to the home to enable earlier hospital discharge where problems in the home are identified necessary adaptations/equipment/deep clean as a possible reason for delayed discharge which directly contributes to Metric 4: Discharge to usual place of residence.
- **Dementia Dwelling Grant**: assistance providing items such as night lamps, touch lamps, dementia clocks, illuminated switches and key safes to help people with memory loss or a diagnosis of dementia to manage their surroundings, retain their independence and reduce feelings of confusion.
- **Trusted Assessor trained staff**: The service has trained their staff to Trusted Assessor Level 4. This will enable the trained staff to assess low level major adaptations and free up the time of the Community Occupational Therapy team to focus on the more complex cases. The agency and the districts are currently working with the Occupational Therapy team to put the necessary processes and oversight into place which will enable the Trusted Assessors to start work.

In addition to the service elements funded through the Better Care Fund, the home improvement agency also provides the following services.

- **Information and advice**: This Worcestershire County Council funded service provides promotes independent living through information, advice and signposting to provide solutions in the home to meet a disabled person's needs in a timely way.
- **Minor adaptations/handyperson**: funded by Worcestershire County Council to provide adaptations which are easily installed and do not require structural changes to the home. Theses can include items such as grab rails, stair rails and external rails.
- **Able to pay customers**: Award winning research undertaken by Worcestershire County Council highlighted that there were 63 self-funding pick-ups for the financial year through to end of September 2019. These are people placed in residential care whose own funding runs out during

their placement and this then being taken over by social care funding at a cost of £32,922.50 pw (£1.7m per year). The new service being launched this year enables customers to privately fund adaptation works to their property with the full support of the agency. https://adaptivehomesolutions.co.uk/

- **Health through Warmth**: The agency has again been successful in securing funding from Foundations Independent Living Trust which benefits customers with specified health conditions to assist them with heating when funding cannot be found elsewhere.

The district councils have employed a new Collaboration Manger to lead work on work to develop a long term strategic plan co-designing a collaborative approach across housing, health and social care to create a single service pathway for customers who need assistance with aids and adaptations to live independently.

The service has a 95% target for improving customer wellbeing. Customers are asked whether they felt that there had been an improvement in their wellbeing as a result of the adaptation/assistance. For 21/22 the service achieved 97.37%, and for Q1 22/23 this rose to 100%.

The service is also targeted on the number of customers who had their housing difficulty resolved after receiving housing advice with the target set at 80%. The 21/22 figures show a 70% success rate and in the first quarter of 22/23 this rose to 82%.

The service achieved the following outcomes in 2021/22

Facilitate timely discharge	192
Prevent an unplanned admission to hospital	184
Reduce pressure on informal carers	268
Reduce or delay increase in package of care	253
Reduce/prevent falls	2608
Remain/promote independence	2436
Enable to remain in own home	353

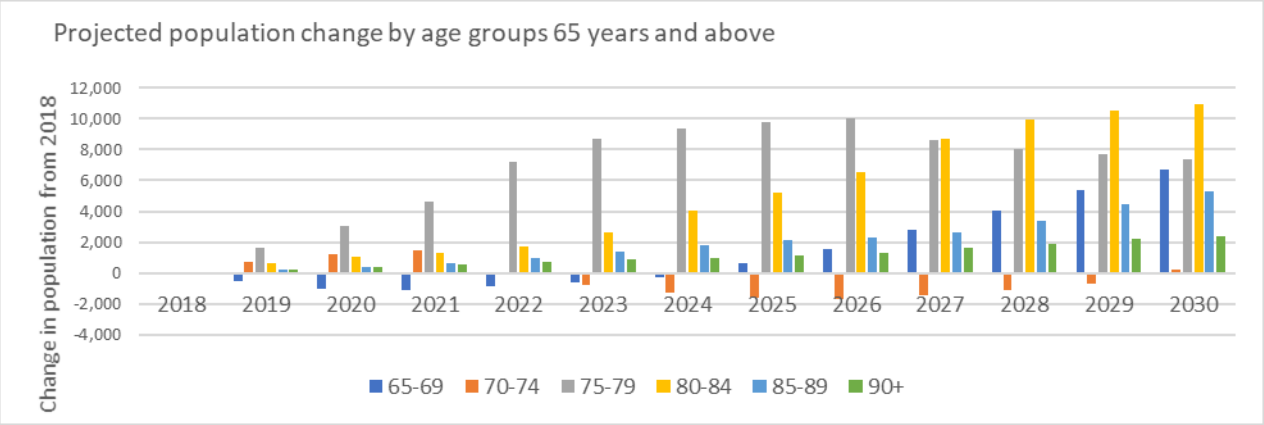
Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan*
- *How these inequalities are being addressed through the BCF plan and BCF funded services*
- *Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs better than the national average. However, there are often smaller places in Worcestershire where people's health is not good, and the average measures reported at County and district council level mask the differences in health outcomes experienced by some communities.

Worcestershire has a growing and ageing population. It is projected that the population is set to increase from 592,100 in 2018 to 638,800 in 2030. Most of the projected growth in the population is amongst those aged 65 and over, with this group overall projected to increase by 32,900 or 25% by 2030. There is particularly large projected growth for those aged 75 and over, with this group projected to grow. The growing and ageing population presents challenges in an increased likelihood of a lengthier stay in hospital and an impact on hospital discharge destination. The BCF plan aims to address these challenges through improved integrated discharge through the onward care team as part of the overall integrated care team. There is a focus on integrated and expanded community services and continuing reablement through discharge to assess and a home first approach and interventions to reduce hospital admissions.



(Source: Office for National Statistics, Subnational population projections for England: 2018-based projections by 26,100 or 44% by 2030)

The HWB and its Health and Wellbeing Strategy sets the strategic direction for many other strategies, forums, and committees across the Integrated Care System to ensure we can work together to achieve better health and wellbeing for Worcestershire. The new Strategy is currently out to public consultation and will set out a vision and key priorities for our partnership work to improve health and wellbeing and reduce inequalities in Worcestershire over the next 10 years. The Strategy will be a 'living document' that will evolve and adapt to changing needs and be implemented through shorter term action plans. The action plans will include appropriate outcome measures to monitor progress.

As part of the biggest legislative change impacting the NHS in the last decade, 42 Integrated Care Boards (ICB) / systems (ICS) have been created across England with a wide remit based on the idea that collaboration – between hospitals, GPs, social care, and others – is needed to improve local services and make the best use of public money. ICSs have been tasked with leading efforts to identify and reduce health inequalities in their area, alongside broad objectives to improve population health and contribute to social and economic development.

Herefordshire and Worcestershire ICB was established and commenced operation on 1st July 2022 and has ambitious plans to identify and reduce health inequalities. As part of this the NHS in Herefordshire & Worcestershire are implementing a number of plans focused on delivering the national ambition known as 'CORE20PLUS5'. This means we are working with communities to improve health outcomes in the most deprived 20% on the national population as identified by the national index of multiple deprivation (CORE20 component), identified local priorities of rurality, health literacy, people who are not registered with a GP and

mental health (PLUS component), within the 5 clinical areas of maternity, severe mental illness, respiratory disease, early cancer diagnosis and cardio-vascular disease.

The ICB is investing resources into these key areas, with delivery being through primary care working with partners from the district and county councils, voluntary sector, community groups and wider partners to understand the barriers in accessing health and care services and adjusting services accordingly. This approach has worked within the COVID vaccination programme, where Worcestershire has achieved one of the lowest uptake gaps across England between the least and most deprived communities at under 10%. The programme has been nominated for prestigious parliamentary and HSJ awards for this work with the approach being applied to address wider inequity in access out outcomes.

Progress against achievement of these aims will be held at the ICS board, with the aim of continually striving to embed the needs of underserved communities in all our services and ensure the ICS plays a significant part in reducing health inequalities.

Worcestershire County Council and its partners are committed to the Public Sector Equality Duty (and General Duties outlined in the Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people who share a relevant protected characteristic and those who don't. Ensuring we can evidence 'due regard' in our decision making in the design and delivery of services. It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation.

It is fundamental that individuals and groups are represented, involved and engaged in our activities and services. Partners will work to enable people to access services within the scheme/funded projects, and that support and guidance are provided where necessary to meet all needs, empowering individuals to be independent in the community wherever possible.

This page is intentionally left blank

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

			Checklist: Complete:
Health and Wellbeing Board:	Worcestershire		Yes
Completed by:	Victoria Whitehouse		Yes
E-mail:	VWhitehouse@worcestershire.gov.uk		Yes
Contact number:	01905 643574		Yes
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Tue 27/09/2022	<< Please enter using the format, DD/MM/YYYY	Yes
If using a delegated authority, please state who is signing off the BCF plan:	Simon Trickett & Mark Fitton		

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	NHS Herefordshire & Worcetsershire Chief Executive & Worcester	Yes
Name:	Simon Trickett & Mark Fitton	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Karen	May	Kmay@worcestershire.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Simon	Trickett	simon.Tricket@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Mark	Dutton	Mark.dutton@nhs.net	Yes
	Local Authority Chief Executive		Paul	Robinson	probinson@worcestershire.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Mark	Fitton	MFitton@worcestershire.gov.uk	Yes
	Better Care Fund Lead Official		Victoria	Whitehouse	vwhitehouse@worcestershire.gov.uk	Yes
	LA Section 151 Officer		Michael	Hudson	MHudson@worcestershire.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						Yes
						Yes
						Yes

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Worcestershire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£6,163,577	£6,163,577	£0
Minimum NHS Contribution	£44,268,156	£44,268,156	£0
iBCF	£19,024,460	£19,024,460	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£69,456,193**	**£69,456,193**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£12,579,754
Planned spend	£28,341,662

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£15,094,660
Planned spend	£15,926,494

Scheme Types

Assistive Technologies and Equipment	£1,762,000	(2.5%)
Care Act Implementation Related Duties	£18,117,774	(26.1%)
Carers Services	£1,260,000	(1.8%)
Community Based Schemes	£9,505,242	(13.7%)
DFG Related Schemes	£6,163,577	(8.9%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of	£0	(0.0%)
Home Care or Domiciliary Care	£0	(0.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£1,689,424	(2.4%)
Bed based intermediate Care Services	£23,109,401	(33.3%)
Reablement in a persons own home	£4,545,275	(6.5%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£0	(0.0%)
Residential Placements	£2,500,000	(3.6%)
Other	£803,500	(1.2%)
Total	**£69,456,193**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)				

Discharge to normal place of residence

2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.5%	90.8%	90.5%	89.8%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	476	592

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Worcestershire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Worcestershire	£6,163,577
DFG breakdown for two-tier areas only (where applicable)	
Bromsgrove	£1,036,273
Malvern Hills	£682,875
Redditch	£952,377
Worcester	£780,221
Wychavon	£1,251,934
Wyre Forest	£1,459,897
Total Minimum LA Contribution (exc iBCF)	**£6,163,577**

iBCF Contribution	Contribution
Worcestershire	£19,024,460
Total iBCF Contribution	**£19,024,460**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS Herefordshire and Worcestershire ICB	£44,268,156
Total NHS Minimum Contribution	**£44,268,156**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£44,268,156**	

	2021-22
Total BCF Pooled Budget	**£69,456,193**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Checklist
Complete:

- Yes
- Yes
- Yes
- Yes

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Worcestershire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£6,163,577	£6,163,577	£0
Minimum NHS Contribution	£44,268,156	£44,268,156	£0
iBCF	£19,024,460	£19,024,460	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£69,456,193**	**£69,456,193**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£12,579,754	£28,341,662	£0
Adult Social Care services spend from the minimum ICB allocations	£15,094,660	£15,926,494	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	General Rehab Beds	Intermediate Care Unit	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£12,794,134	Existing
2	Intermediate Beds	Intermediate Care Unit	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,849,772	Existing
3	Neighbourhood Teams	Scheme to reduce unnecessary hospital admissions or repeat GP	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£7,822,779	Existing
4	Onward Care Team	Scheme to enable discharge from hospital is timely and effective	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£714,149	Existing
5	Worcestershire IP Unit- Pathway 2	Intermediate Care beds- D2A pathway	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£5,160,828	Existing
6	Pathway 1(UPI)	P1 supports individuals to return home with support following a stay	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£4,353,030	Existing
7	Rapid Response Social Work Team	Provide out of hours / rapid response social work, responding to	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£370,800	Existing
8	Rapid Response Social Work Team	Provide out of hours / rapid response social work, responding to	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	iBCF	£1,263	Existing
9	Pathway 3 (SPOT DTA)	Provision of Pathway 3 (DTA), service in care homes.	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,826,225	Existing
10	Pathway 3 (SPOT DTA)	Provision of Pathway 3 (DTA), service in care homes.	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£1,478,442	Existing
11	Investment in Care Homes	Contribution towards increase demand	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum NHS Contribution	£2,500,000	New
12	ASWC in Community Hospitals,	Contributes towards costs of Hospital team who assist in facilitating	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£471,275	Existing
13	ASWC in Community Hospitals,	Contributes towards costs of Hospital team who assist in facilitating	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£504,000	Existing
14	Carers	Commissioned service responsible for, Short term support to enable	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,158,022	Existing
15	Carers	Commissioned service responsible for, Short term support to enable	Carers Services	Respite services		Social Care		LA			Local Authority	iBCF	£101,978	Existing
16	Implementation of the Care Act - additional demand	Contribution toward the increase demand for services following the	Care Act Implementation Related Duties	Other	Provision of Homecare	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,178,997	Existing
17	Implementation of the Care Act - additional demand	Contribution toward the increase demand for services following the	Care Act Implementation Related Duties	Other	Provision of Homecare	Social Care		LA			Private Sector	iBCF	£298,942	Existing
18	Complex Cases	Contribution towards the cost of S117 eligible clients.	Other		Funding specific S117 clients	Social Care		LA			Private Sector	Minimum NHS Contribution	£803,500	Existing
19	WCES	Loan of equipment to Worcestershire residents / those registered with a	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£1,762,000	Existing
20	Disabled Facilities Grant	Disabled Facilities Grant passported to District Councils to spend on	DFG Related Schemes	Adaptations, including statutory DFG grants		Other	DFG	LA			Local Authority	DFG	£6,163,577	Existing
21	GP attached Social Workers	Social Workers supporting Neighbourhood teams	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	Minimum NHS Contribution	£310,400	Existing
22	Pathway 1 +	P1 + supports individuals to return home with wraparound support	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£192,245	New
23	iBCF supporting pressurs on the NHS	iBCF Supporting Pressures on the NHS	Community Based Schemes	Other	Supporting Pressures on the NHS	Community Health		CCG			CCG	iBCF	£1,000,000	Existing
24	iBCF mitigating Social Care pressures	Expenditure covers a mixture of Homecare, Residential and	Care Act Implementation Related Duties	Other	Expenditure covers a mixture of Homecare &	Social Care		LA			Private Sector	iBCF	£15,639,835	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Worcestershire

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	Checklist Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	169.4	161.6	176.8	144.9	Plan to maintain 21-22 position	The priorities set out within the narrative plan identify ambitions to support Worcestershire residents to remain at home and maintain independence for as long as possible in order to meet this	
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
(See Guidance)	Indicator value	169	162	177	145			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	91.3%	91.7%	91.3%	90.7%	Q21-22 v Q1 22-23 growth calculated and applied to Q2- Q4 22-23	The ambition is to continue to improve performance to match the national average. Continual development of the integrated care team is outlined within the narrative plan.	Yes
	Numerator	10,656	10,661	10,390	9,860			
	Denominator	11,666	11,629	11,380	10,871			
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
(SUS data - available on the Better Care Exchange)	Quarter (%)	90.5%	90.8%	90.5%	89.8%			
	Numerator	10,156	10,163	9,911	9,387			Yes
	Denominator	11,224	11,191	10,957	10,448			Yes

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	475.8	573.8	572.4	592.0	Please note numerator is correct but rate is calculated here using a different population figure to ASCOF definition so rates will vary. Target set based on a 5% estimated increased around demand pressures.	Extensive scrutiny of all placements in long term care; all alternative provision considered as first option	Yes
	Numerator	654	806	804	845			Yes
	Denominator	137,439	140,470	140,470	142,738			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.8%	82.1%	80.8%	82.0%	Previous target maintained as challenging to meet due to increased complexity of people's needs	Concentrated efforts to ensure reablement needs prioritised	Yes
	Numerator	453	455	497	504			Yes
	Denominator	554	554	615	615			Yes

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Worcestershire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Checklist Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes				Yes
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes				Yes
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes				Yes
Agreed expenditure plan for all elements of the BCF	PR7	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes				Yes
Metrics	PR8	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes				Yes

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful definitions and where to go for further support. This sheet provides further guidance on using the Capacity and Demand Template.

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23.

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand
- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth quarters of 2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in the guidance tab for readability if required.

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign-off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance -
https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services

- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services at a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:
- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Worcestershire	
Completed by:	Victoria Whitehouse	
E-mail:	vwhitehouse@worcestershire.gov.uk	
Contact number:	01905 643574	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off	
If no, please indicate when the report is expected to be signed off:	Tue 27/09/2022	<< Please enter using the format, DD/MM/YYYY

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	NHS Herefordshire & Worcetsershire Chief Executive & Worceste
Name:	Simon Trickett & Mark Fitton

How could this template be improved?	

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Worcestershire

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	4844	4844	4844	4844	4844	4844
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	946	946	946	946	946	946
2: Step down beds (D2A pathway 2)	472	472	472	472	472	472
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	102	102	102	102	102	102

Any assumptions made:	

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	0: Low level support for simple hospital discharges - e.g. Voluntary or Community	2422	2422	2422	2422	2422	2422
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	473	473	473	473	473	473
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	2: Step down beds (D2A pathway 2)	236	236	236	236	236	236
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	3: Discharge from hospital (with reablement) to long term residential care (Discharge to	51	51	51	51	51	51

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Worcestershire

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	UCR growth in demand risng 7.2%

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	0	0	0	0	0	0
Urgent community response	829	829	829	829	829	829
Reablement/support someone to remain at home	72	72	72	72	72	72
Bed based intermediate care (Step up)	6	6	6	6	6	6

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Worcestershire

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	numbers for reablement/PW1 are based on the commissioned amount. There may be some variation due to vaca

Capacity - Hospital Discharge

Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	2324	2324	2324	2324	2324	2324
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	80	80	80	80	80	80
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	575	557	575	575	520	575
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	236	236	236	236	236	236
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	47.3	47.3	47.3	47.3	47.3	47.3

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Worcestershire

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Numbers for Reablement are based on the capacity remaining fully deployed for that service. There is not a ring fenced figure for the bed based intermediate care (Step up). This figure is based on the averaged monthly capacity amount in 21/22 which would be estimated to be the same accross Oct - March 23.

Capacity - Community

Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	5	5	5	5	5	5
Urgent Community Response	Monthly capacity. Number of new clients.	1201	1201	1021	1181	1181	1181
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	31	31	31	31	31	31
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	22	22	22	22	22	22

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Worcestershire

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£13,276,000
BCF related spend	£11,486,465

Comments if applicable	

worcestershire countycouncil

HEALTH AND WELL-BEING BOARD
27 SEPTEMBER 2022

ICS Development Update

Board Sponsor
David Mehaffey, Executive Director for Strategy and Integration, NHS Herefordshire and Worcestershire Integrated Care Board

Author
As above

	(Please click below then on down arrow)
Priorities	
Mental health & well-being	No
Being Active	No
Reducing harm from Alcohol	No
Other (specify below)	
Safeguarding	
Impact on Safeguarding Children	No
If yes please give details	
Impact on Safeguarding Adults	No
If yes please give details	

Item for Decision, Consideration or Information
Information and assurance

Recommendation

1. The Health and Well-being Board is asked to progress on the establishment of the Integrated Care System for Herefordshire and Worcestershire.

Background

2. The Health and Care Act 2022 was implemented on 1 July 2022, putting Integrated Care Systems on a statutory footing. Integrated Care Systems are constituted from four key elements:

a) **Integrated Care Board (ICB)** – the statutory NHS body that is accountable for the £1.5bn NHS financial allocation for Herefordshire and Worcestershire.

b) **Integrated Care Partnership (ICP)** – A new statutory joint committee between the ICB and the local authorities responsible for providing social care and public health services in the ICB area. As well as the statutory members, the ICP will bring together a much wider range of local partners from across

statutory and VCSE sectors to oversee production of the system's Integrated Care Strategy.

c) **Place-based partnerships** – Local partnerships based on upper tier local authority areas where general practice, community health services, social care, mental health service, acute services, VCSE partners and local authority services such as housing, community and environment can come together to focus on delivery of locally important priorities.

d) **NHS provider collaboratives** – strategic partnerships between NHS Trusts within and beyond the ICB geography to use the opportunity of scale to create more sustainable service models that improve performance and outcomes against core NHS standards.

3. Integrated Care Systems have been created with four key strategic aims in mind:

a) Improve outcomes in population health and healthcare
b) Tackle inequalities in outcomes, experience and access
c) Enhance productivity and value for money
d) Help the NHS to support broader social and economic development

4. By working as a partnership in a coherent system, we will be able to achieve these ambitions by:

a) **Working together** to focus on improving whole population health, not just on the treatment of specific illness or conditions and working to invest more in prevention and collectively addressing the wider determinants of health.

b) **Allocating resources to support collaboration** between partners, rather than competition between providers.

c) **Achieving benefits of scale** through system working, alongside the benefits of localism through Place-based and PCN working with district councils and VCSE partners.

d) **Collecting and sharing clinical and care information** more effectively so people only need to provide their information once in a way that can be shared appropriately, improving efficiency of care and reducing risk.

e) **Joining up data, intelligence and insight** more effectively to identify and tackle issues and enable a more proactive approach to implementing preventative action.

5. Now that the core infrastructure for the Integrated Care System has been established, in the coming months partners will be producing an overarching strategy and a detailed delivery plan (called a 5 year Joint Forward Plan) to outline which priorities will be selected for improvement and how these ambitions will be achieved.

The Integrated Care Board

6. All members of the ICB have been appointed and are now in post:

Non Executive Members	
Crishni Waring	Chair
Dr Sarah Raistrick	Engagement and Health Inequalities
David Wightman	People
Graham Hotchen	Audit
Vicky Morris	Quality
Executive Members	
Simon Trickett	Chief Executive
Dr Will Taylor	Chief Medical Officer
Dr Kath Cobain	Chief Nursing Officer
Mark Dutton	Chief Finance Officer
Partner Members	
Jane Ives	Managing Director – Wye Valley NHS Trust
Sarah Dugan	CEO - Herefordshire and Worcestershire Health and Care NHS Trust
Matthew Hopkins	CEO - Worcestershire Acute Hospitals NHS Trust
Paul Walker	CEO - Herefordshire Council
Paul Robinson	CEO - Worcestershire County Council
Dr Nigel Fraser	Chair - Taurus (Herefordshire's General Practice Federation)
Dr Nikki Burger	Clinical Director - Worcester City Primary Care Network

The Integrated Care Partnership

7. The core members of the statutory joint committee that will become the ICP met for the first time on 21st July and agreed the core operating model, terms of reference and membership model. It was agreed that the ICP will work on a Place-Based principle, where local ownership of key projects to improve health outcomes will be owned by the two Health and Wellbeing Boards. The ICB will own system wide projects that are focused on core delivery of health services which are commissioned with NHS funding.

8. The first meeting of the ICP with its full membership is scheduled to take place on 7th October 2022, from 12:00 to 14:00 via Microsoft Teams. To ensure the strong focus is maintained on Place-based working, it has been agreed that the ICP will be co-chaired by the two Health and Wellbeing chairs on a rotating basis, with Cllr Karen May chairing the meeting on 7th October. The focus of this meeting will be on reviewing progress and setting direction for the creation of the Integrated Care Strategy.

9. A further meeting of the ICP is scheduled for 14th December 2022. The focus of this meeting will be to approve for publication the first draft of the Integrated Care Strategy. During September to December a strategy working group will coordinate the work to produce the strategy for partners to review at the two meetings.

10. The Health and Wellbeing Strategies in each county will be used as the foundation for the Integrated Care Strategy with additional content being added to

address system-wide opportunities and any gaps required by national guidance that are not already covered in the HWBB strategies.

11. Furthermore, any existing partnership work that has a role or contribution to improving health outcomes and reducing health inequalities by addressing the wider determinants of health (such as work to combat drugs or improve housing), will be signposted within the Integrated Care Strategy. This approach will help to reduce duplication and overlap between related local initiatives.

The Integrated Care Strategy

12. National guidance has been produced jointly by the NHS and Local Government Association, and this has been published by the Department for Health and Social Care. The key requirements to include in the integrated care strategy are:

Shared outcomes	Those areas that are agreed following review of JSNAs and wider intelligence gathered during the preparation phase. It is anticipated that the outcomes will also address areas under consideration in the Integration White Paper.
Quality improvement	Requirements of the National Quality Board as set out in the national guidance produced for Integrated Care Systems.
Section 75 and joint working	Opportunities to pool health and social care funding (new guidance is expected in Spring '23), as well as other broader opportunities for joint working such as joined up data, co-located services, integrated teams, joined up strategies and plans.
Personalised care	A broad approach to looking at how people who rely on health and social care services have their needs met in a way that is specific to them, as well as specific initiatives such as personalised advice, self-directed support and new technology.
Disparities	Inequalities in health outcomes, access and experience; and should consider specific groups such as those outlined in the definition inclusion health.
Population health and prevention	How the system will industrialise proactive, evidence-based and data-driven interventions that focus on predictive prevention. This should cover primary, secondary and tertiary activities aimed at current and future needs, with focus on reducing loss of independence and reducing premature mortality.
Wider determinants of health	How services (such as housing, employment, economy, benefits, leisure, community and environment etc) that have a substantive role in influencing health outcomes of the population are integrated and involved at the heart of the integrated care system.
Health protection	How health protection issues such as infection prevention and control, antimicrobial resistance, vaccinations and immunisations, health protection hazards, EPRR and other health threats are identified, mitigated or managed across the ICS.
Role of anchor institutions	The role that all large organisations (not just those in the public sector) that are anchored in a community can play in supporting better health outcomes in the communities that they operate in.
Workforce	How the system will build the right-sized workforce with future-proofed roles and create a One Workforce culture covering recruitment, retention

	and staff development activities that enable more effective integration of services on the ground.
Data and information sharing	How the right digital infrastructure and platforms, with better analytics capability and joined up data will be used to identify opportunities for joining up of service delivery, improved productivity and efficiency. This should also include how the system will build public trust to enable better data sharing.
Research and innovation	How the system will identify, evaluate, implement and adopt at scale proven innovations to improve population health and reduce disparities.
All age focus	How the system will address around the needs of children, young people, their families and support healthy ageing – recognising that services provided to adults can affect their children and vice versa. This should include child safeguarding, including addressing cultural and technological barriers that prevent effective sharing of information.

Place-based Partnerships

13. At the HWB in February 2022, board members received and approved a set of principles for the HWB and Worcestershire Executive Committee (WEC), that would govern integrated place-based working across the council, NHS and wider local partners as part of the move to create the ICS. The principles incorporated a description of the HWB setting strategic direction for health and wellbeing across Worcestershire, and WEC overseeing the integrated delivery of place-based health and care, and primarily NHS priorities. Both are working to ensure that the principle of subsidiarity is followed, meaning that decisions are taken as closely to the individual as possible. Close co-operation between chairs and officers of the HWB and WEC is proving effective in ensuring streamlined governance and reduced duplication, ensuring their contributions result in a positive impact on the health and wellbeing of the population of Worcestershire.

14. A cornerstone of the new integrated way of working is the development of District Collaboratives. District Collaboratives are formed of Clinical Directors, who are leaders of their Primary Care Networks, working with District Councils across the county to agree how collaboration between the NHS and District Councils can deliver benefits for neighbourhoods and local communities. Districts and PCNs are working with a range of other partners, including representatives from the voluntary and community sector, Police, Children's services, NHS Trusts and building on existing infrastructure such as asset-based community development workers, to deliver tangible improvements for their population. As the new governance infrastructure is embedded, District Collaborative developments will feed into the Health and Wellbeing board via the Being Well Strategic sub-group.

Legal, Financial and HR Implications

15. Not applicable

Privacy Impact Assessment

16. Not applicable

Equality and Diversity Implications

17. Not relevant to this report.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
Name: David Mehaffey, Executive Director for Strategy and Integration, NHS Herefordshire and Worcestershire ICB
Email: david.mehaffey@nhs.net

Supporting Information

None

Background Papers

None

worcestershire countycouncil

HEALTH AND WELL-BEING BOARD
27 SEPTEMBER 2022

ALL AGE AUTISM STRATEGY UPDATE

Board Sponsor
Mark Fitton, Strategic Director, People

Author
Laura Westwood, Lead Commissioner

	(Please click below then on down arrow)
Priorities	
Mental health & well-being	Yes
Being Active	No
Reducing harm from Alcohol	No
Other (specify below)	
Safeguarding	
Impact on Safeguarding Children	Yes
If yes please give details	
Impact on Safeguarding Adults	Yes
If yes please give details	

Item for Decision, Consideration or Information
Consideration

Recommendation

1. **The Health and Well-being Board is asked to:**

   a) **Endorse that an updated All Age Autism Strategy is produced (2023-2026) across the Integrated Care System (ICS) footprint to reflect the partnership and strategic approach across Herefordshire and Worcestershire, with place-based elements;**

   b) **Endorse the strong all age approach of the Autism Strategy;**

   c) **Ensure appropriate officers, with decision making responsibility, across all organisations, participate and engage in the workstreams to shape and design the recommendations within the new strategy; and**

   d) **Receive a further report at a future meeting of the Board as part of the sign off process for the Autism Strategy; and support its delivery by signing off the implementation plan.**

Background

2. The new National Autism Strategy 2021-2026, published in July last year now incorporates both children and adults into the National Strategy ambitions. The areas of focus include:

    - Improving understanding and acceptance of autism within society.
    - Improving autistic children and young people's access into education and support positive transitions into adulthood.
    - Supporting more autistic people into employment.
    - Tackling health and care inequalities for autistic people
    - Building the right support in the community.
    - Improving support in criminal and youth justice systems

3. Our own most recent Worcestershire All-age Autism Strategy runs from 2019-22 in line with the expectation of a new National Strategy and now needs to be updated in line with the new national priorities.

4. We have an active Worcestershire multi-agency Autism Partnership Board that provides critical oversight and challenge to our Autism work and reports jointly to Health and Wellbeing Board and the Integrated Care System Learning Disability and Autism Programme Board.

Legislative context

5. The Autism Act 2009 is currently the only disability-specific legislation in England. The Act requires the Government to introduce and keep under review an adult autism strategy. The initial strategy was published in 2010 and refreshed in 2014. The statutory guidance is aimed at supporting the NHS and local authorities in implementing the strategy in areas such as staff training, identification and diagnosis, transition planning when people move from children to adult services, employment, and criminal justice.

6. The Special Educational Needs and Disability (SEND) Code of Practice (2015), continues to place duties on local authorities, NHS organisations and schools in respect of autistic children and young people. There is also a duty to provide services to disabled children under section 2 of the Chronically Sick and Disabled Persons Act 1970."

7. The Health and Social Care Act 2022 requires all CQC registered providers to undertake Mandatory Autism Training.

Strategy Development

8. The Integrated Care System Learning Disability and Autism Programme Board already brings together the aspirations of the two counties into one health related workstream. It brings to life and holds to account the local action plan delivering the national NHS 3-year plan via action plan. The ICS Assurance Board endorses the approach to create a joint strategy across the footprint. The two local Autism Partnership Boards also endorse the joint approach with local place-based sections within the strategy that enable specific work streams in each County (particularly around Children's services and education).

9. The ICS Board has good engagement across the health system including Autistic People and a paid Autism Champion role; the joint creation of a strategy will build upon and strengthen this. Co-production with Autistic People will need to be an integral part of the strategy development. The new strategy needs to be adopted across the ICS, and a systems approach used to ensure the delivery plan is owned and embedded into future practice and delivery routes. By signing up to the vision of the strategy at Health and Wellbeing Board level, opportunities to seek shared solutions to meet the priorities will become business as usual rather than a social care approach.

10. Work has been done to identify a workstream lead across the system for each priority within the National strategy alongside an additional priority chosen by Autistic People around Keeping Safe. This will ensure that there is a whole system approach to the development of the strategy. Priorities in bold will be led across the ICS, those not in bold will be Worcestershire based but link in with Herefordshire.

Priority	*Helping Autistic People to:- (taken from The national strategy for autistic children, young people and adults: 2021 to 2026 (Easy Read) (publishing.service.gov.uk)	Worcestershire Lead
Improving understanding and acceptance of autism within society.	Feel less isolated and lonely Be treated well in their community Feel understood by business and organisations Use reasonably adjusted public spaces Use reasonably adjusted public transport	Debbie Hobbs, National Autistic Society
Improving autistic children and young people's access into education and support positive transitions into adulthood.	Get the right help at school/college Have teachers who understand and can help Get support to live in their community Find work Access higher education	Mel Barnett, Director for All Age Disability, Worcestershire Children's First

	Get the mental health support that they need	
Supporting more autistic people into employment	Find and stay in work Have help to live well if they can't work	Still to be identified
Tackling health and care inequalities for autistic people	Live healthier and for longer Get help from an earlier age Not have to wait more than 13 weeks for help Get the Mental Health support that they need	Richard Keble, Programme Lead for Learning Disability and Autism, ICB
Building the right support in the community	Avoid admission to Mental Health hospital where possible Leave Mental Health hospital as soon as they are well Have access to good quality social care and housing	Laura Westwood, Lead Commissioner, Worcestershire County Council
Improving support in criminal and youth justice systems	Have reasonable adjustments made within the criminal justice system	Adrian Symonds, West Mercia Police
Keeping Safe	Be treated well in their community Have support for their families and carers to help to keep them safe Not have to experience hate crime, abuse, victimisation, or radicalisation	Carolyn Whippman, Senior Commissioning Officer, Herefordshire County Council

*These are the key outcomes taken from the National Easy read strategy. Our own strategic work and co-production is likely to identify more/different outcomes for people.

11. A working group has been set up to steer the workstreams to achieve the work in the plan below:-

Task	Timeframe
Engage: Establish a mechanism to identify and fully engage with all necessary stakeholders, ensure there is representation from all necessary stakeholders from Herefordshire and/or Worcestershire. Ensure work undertaken is co-produced and that autistic people and their parents and carers are involved, drawing on the real experiences of autistic people and their families.	August 2022 – April 2023

Establish baseline: Referencing the National Autism Strategy, and commissioning resources identify what baseline data is needed to understand the current position in Herefordshire and Worcestershire and identify how this data will be provided and measured going forward.	August – October 2022
Engagement Planning: Identify what engagement is needed and with whom for your priority	August – October 2022
Engagement and data collection: Information gathering, engagement through workshops, questionnaires, focus groups	November – December 2022
Data Analysis: Identify the story behind the data, the current trends/gaps, and the suggested priority areas to include in the autism strategy and action plan	December – February 2023
Collation and production: information collated into a cohesive strategy	March – April 2023

12. The Worcestershire Autism Partnership Board wanted Health and Wellbeing Board to be briefed on the work being done at this early stage in the Strategy Development to ensure that the whole system can engage with the strategy at the appropriate points.

Legal, Financial and HR Implications

13. **Legal –** The All-Age Autism Strategy will need to ensure that the system complies and support compliance with the Statutory Guidance Adult autism strategy: supporting its use - GOV.UK (www.gov.uk)

14. **Financial** – The strategy planning will map current spend and demand and action planning will need to consider resource (financial and HR) implications. There are likely to be implications around implementing the new Autism Mandatory training and it is likely that the demand mapping will demonstrate a need for more bespoke services. Herefordshire currently have an Autism Strategy Implementation budget of £25k per annum which is not in place for Worcestershire.

Privacy Impact Assessment

15. Will be completed as the strategy is developed

Equality and Diversity Implications

16. An Equality Relevance Screening will be completed with regard to the strategy.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
Laura Westwood, Lead Commissioner, Adult Social Care
Tel: 01905 846739
Email: lwestwood2@worcestershire.gov.uk

worcestershire countycouncil

HEALTH AND WELL-BEING BOARD
27 SEPTEMBER 2022

HEREFORDSHIRE AND WORCESTERSHIRE LEARNING FROM LIVES AND DEATHS- PEOPLE WITH LEARNING DISABILITY AND AUTISTIC PEOPLE (HW LEDER) ANNUAL REPORT 2021/22

Board Sponsor
Dr Sarah Raistrick, Non-Executive Member for Health Inequalities, Sustainability and Engagement, NHS Herefordshire and Worcestershire ICB

Author
Rachael Skinner, Deputy Director of Quality/ Deputy Chief Nursing Officer- NHS Herefordshire and Worcestershire ICB

Priorities	
Mental health & well-being	Yes
Being Active	Yes
Reducing harm from Alcohol	No
Other (specify below)	

Safeguarding	
Impact on Safeguarding Children	No
If yes please give details	
Impact on Safeguarding Adults	No

If yes please give details

Item for Decision, Consideration or Information
Information and assurance

Recommendation

1. **The Health and Well-being Board is asked to:**

   a) **Note the content of the HW LeDeR Annual Report for 2021/22 including progress against 2021/22 priorities.**

   b) **Note the publication of a 3 Year LeDeR Strategy during 2022, priorities in progress during 2022/23 and existing arrangements for the quarterly reporting of progress against agreed priorities.**

   c) **Note the next steps, to include the priority areas of focus for the remainder of 2022/23 and 2023/24.**

Background

2. People with a Learning Disability (LD) and autistic people continue to be amongst the most marginalised individuals within our local communities and experience some of the greatest health inequalities. The latest available national data confirms that the median age of death is 61 years, having only marginally improved by 1 year since the LeDeR programme began in 2017.

3. LeDeR is a national service improvement programme commissioned by NHS England. The programme was developed following a recommendation of the Confidential Inquiry into the Premature Deaths of People with Learning Disability published in 2013. The programme roll-out was phased across England and commenced in the Midlands during late 2017. The purpose of the programme is to retrospectively review the deaths of people with a learning disability, and since January 2022 the deaths of autistic people, in order to identify learning that can inform system change to prevent premature death and reduce health inequality.

4. The HW LeDeR Annual Report for 2021/22 is our third report of this nature. It outlines how as a collaborative partnership we have learnt from the outcomes of reviews and started to influence the shaping of services to achieve improvements in outcomes.

Key points of learning from 2021/22 data about the lives and deaths of people with a Learning Disability within our Integrated Care System

5. During 2021/22 insight was gained from the detail included within 52 notifications of death to HW LeDeR and 39 LeDeR reviews completed between 1 April 2021 and 31 March 2022. Some comparisons have been made with the latest available data from the national LeDeR report that publishes data for the calendar year 2021.

- In HW 46% of deaths were for people aged 65 or older. Across England this figure was 39%
- In HW 50% of people died in an acute hospital bed. Across England 61% died in an acute hospital bed.
- In HW for the calendar year of 2021 10% of all deaths reported to LeDeR were for COVID-19. Across England this figure was 20% of all notifications. This variance may be attributed to the HW ICS decision to support all people with LD living in a care setting to be vaccinated alongside older people in care settings.
- Reviews reflected very low numbers of people who had smoked or drank alcohol to excess.
- Late stage diagnosis of cancer continues to be too common.
- Annual Health Check-Learning Disability (AHC-LD) uptake has significantly improved. Those reviewed who had not been offered or engaged in an AHC were more likely to be living in non-LD specific Nursing Homes or living with a mild learning disability.
- Those who died from cardiovascular related disease were more likely to have a high Body Mass Index. Those with a high Body Mass index were more likely to be women with a mild or moderate learning disability.

Integrated Care System priority progress and achievements during 2021/22 to improve outcomes for people with a learning disability

- Annual Health Check-LD uptake again exceeded the national target (80% against a national revised target of 70%). This is important because the AHC provides vital opportunities to coordinate health and social care input, to check that cancer screening, vaccinations and other interventions are in place or to enable engagement to be supported.
- COVID vaccination uptake rate exceeded 90% and was comparable to the general population. An improvement in the uptake of flu vaccination, albeit marginal, was also apparent.
- Awareness raising events were held to share knowledge about the importance of good bowel health and break down barriers to having open conversations. Processes were put into place to ensure care workers know how best to support those who experience chronic constipation or who are eligible for bowel cancer screening.
- Public Health facilitated 'reasonable adjustment' education and specialist advocacy support for Lifestyle Advisor teams. This enabled healthy lifestyle and weight management services to provide personalised and effective support to people with a learning disability.

6. During 2021/22 we published a 3 year HW LeDeR Strategy HW LeDeR Strategy 2022-2025 (herefordshireandworcestershireccg.nhs.uk) which sets out the collaborative and coproduced nature of our programme of work and includes the actions that we are taking during 2022/23. Areas of focus include:

- Annual Health Check uptake (particularly for 14-24 year olds and a core group of underserved individuals) and quality
- Mental Capacity assessment and Best Interest decision awareness
- Awareness and support to encourage the coproduction of ReSPECT plans
- Bowel cancer screening uptake

7. Progress against agreed actions is reported on a quarterly basis to NHS England, the ICS LDA Tackling Health Inequalities Board and the ICS LDA Assurance Board. AHC-LD uptake is also reported via the ICS Health Inequalities Collaborative dashboard. An annual plan for 2023/24 will be developed by January 2023.

Next steps

8. Coproduction through all layers of the Learning Disability and Autism programme has identified the following key priorities for the remainder of 2022/23 and into 2023/24:

- Uptake of COVID-19, Flu and Pneumococcal vaccination
- A continued focus on Annual Health Check uptake with an additional focus on strengthening quality and reducing variation

- Increasing the uptake of cancer screening and promoting good bowel health, building on the work commenced with bowel cancer screening.

9. During 2022/23 LeDeR reviews for autistic people without a learning disability will be completed for the first time. This will enable themed learning to emerge that will also need to be incorporated into improvement plans to reduce avoidable or premature deaths for this group of people within our local communities.

Legal, Financial and HR Implications

10. None apparent

Privacy Impact Assessment

11. Not applicable

Equality and Diversity Implications

The Learning Disability and Autism work programme aims to reduce discrimination and advance equality of opportunity and outcomes for and with people with a learning Disability or Autism. All commissioning decisions for service change that are informed by the outcomes of the LeDeR programme will be subject to a full Equality Impact Assessment.

Contact Points

County Council Contact Points
County Council: 01905 763763
Worcestershire Hub: 01905 765765

Specific Contact Points for this report
Rachael Skinner- Deputy Director of Quality / Deputy Chief Nursing Officer, NHS Herefordshire and Worcestershire ICB
Email: Rachael.Skinner2@nhs.net Tel: 01905 681999

Supporting Information

- Appendix One - Herefordshire and Worcestershire Learning from Lives and Deaths- People with Learning Disability and Autistic People (HW LeDeR) Annual Report 2021/22

Herefordshire and Worcestershire
Integrated Care System

Annual Report 2021/2022

Learning Disabilities Mortality Review **(LeDeR)** Programme (Herefordshire and Worcestershire)

June 2022

Rachael Skinner – Deputy Chief Nursing Officer and LeDeR Lead Area Coordinator

Imogen Mortiboys- Senior Reviewer and LeDeR Clinical Lead

Table of contents

1. Executive Summary

The programme to drive service improvement by Learning from the lives and deaths of people with a Learning Disability and autistic people for Herefordshire and Worcestershire (HW LeDeR) has been in place since 2017. This is our fourth year of the HW LeDeR programme and our third HW LeDeR annual report. This report summarises the insights we have taken from notifications and completed reviews, what the system focused on and achieved during 2021/22 to improve health outcomes and indicates where we could work together to enable further improvement.

Changes to the national programme during 2021/22 impacted on the timeliness of Review notification and completion and on the format of Reviews (and therefore the type of information collected). Toward the end of 2021/22 notifications could be made for autistic people who had a confirmed clinical diagnosis, for the first time. Anyone can make a notification LeDeR - Home

During 2021/22 the HW LeDeR programme significantly reduced the time taken to allocate a new case to a LeDeR Reviewer and to complete an Initial Review. This has helped to make learning available, to inform improvement measures, in a timelier way. The continued impact of the COVID-19 pandemic on our health and social care services at times delayed access to notes and limited the availability of key people to join multi-agency meetings to talk about more complex Focused Reviews.

The insight that we gained is taken from the detail in notifications made (52 during 2021/22) and Reviews completed (39 in 2021/22). It is important that we are cautious about trying to analyse themes as some data is based on a very small number of cases.

In gaining insight from notifications made to HW LeDeR and Reviews completed during 2021/22 we noticed the following:

- The median age of death was 61 for men and 62 for women. 46% were over 65 years of age when they died and 40% were aged 70 years or older
- Over 70% of those who died before the age of 50 had a profound level of learning disability
- Men were more likely to have mild or moderate learning disability (75% of men) and women more likely to have severe or profound learning disability (60%)
- People are as likely to die in an acute hospital bed than in their usual place of living (50:50)
- The top four recorded causes of death were pneumonia, cancer, cardiovascular disease and dementia.
- In many cases, based on the recorded cause of death, death was considered ‘avoidable’, that is associated with a condition believed to be preventable due to public health intervention or primary prevention, or amenable to treatment to prevent death.

Death from injury or accident were extremely low and LeDeR Reviews completed reflected extremely low numbers of people who smoked, used alcohol to excess or took unprescribed drugs.

- Less than one third of those who died from pneumonia were also considered to be frail. During 2021/22 HW system focused on supporting the uptake of vaccinations for COVID-19 and Flu. COVID-19 vaccination uptake was very good. Flu vaccine uptake improved but we want to do better next year.
- Late stage diagnosis of cancer and carcinomatosis (cancer that is widespread with no clear primary site) is too common. Screening uptake is similar to the general population but we need to do more to identify cancer earlier. Learning events planned for 2022/23 will help share best practice in best interest decision making so that decisions to refer a person for additional tests are informed by those who know the person best and consider a wide range of reasonable adjustments.
- Many of those who died from cardiovascular disease also lived with obesity or diabetes. We need to ensure that measures available enable people with a learning disability to benefit from healthy lifestyle advice and support
- The average age of death from end stage dementia was 58. We need to ensure that those supporting adults are aware of the possible signs of dementia and that access to dementia diagnosis is equitable.
- We do not yet know enough about how to improve the lives of people with a learning disability in HW who are Black, Asian or Minority Ethnic background, or autistic people. This is because we have only been notified of a very small number of deaths and have not yet been able to complete Reviews or identify learning themes.
- Reviews indicate that more people had an Annual Health Check (AHC). Annual Health Check uptake rates overall are high but some people in parts of our system are still missing out on this opportunity to ensure important aspects of health need are addressed and actions coordinated (this includes uptake of cancer screening, healthy lifestyle monitoring and vaccination).

This report sets out what we have noticed from the retrospective review of deaths and how we use information as insights to help inform improvements. We want to do more to support all partners across HW to take action to improve the health of people with a learning disability and autistic people, to enable healthier, happier and longer lives. Our system approach to Population Health Management will enable insight into the health needs of our local population so that people with a learning disability and autistic people are part of wider plans to tackle a range of factors that contribute toward health inequity.

During 2021/22 we published a 3 year HW LeDeR Strategy HW LeDeR Strategy 2022-2025 (herefordshireandworcestershireccg.nhs.uk) which sets out the collaborative and coproduced nature of our programme of work and includes the actions that we plan to take during 2022/23. In autumn 2022/23 we will coordinate a learning event where experts with lived experience and other stakeholders can contribute toward our system plan for improving health outcomes during 2023/24.

2. Introduction to the LeDeR programme and its delivery in Herefordshire and Worcestershire

The programme to enable Learning from the lives and deaths of people with a Learning Disability and autistic people (LeDeR) was initially established to support local areas to implement a consistent format for the review of deaths of people with a learning disability. The key principles of the programme are to identify learning from the review of people's lives after their death, for that learning to inform service improvement initiatives and for those initiatives to affect meaningful change in improving health and wellbeing outcomes for local people.

In March 2021 the first national LeDeR Policy was published. In the summer of 2021, the national LeDeR web-based platform transitioned to be hosted by South West Commissioning Support Unit and the format of reviews changed. From January 2022 the scope of the LeDeR programme included the receipt of notifications of deaths of autistic people who do not also have a learning disability. These changes to the national programme will impact on the nature of data available and therefore what and how we are able to make comparisons with data from previous years, including within this 2021/22 Annual Report.

All deaths continued to receive at least an Initial Review. Where there are areas of concern in relation to the care of the person who has died, or if it is felt that an identifiable feature is worthy of more detailed review as further learning could be gained, a more detailed Focused Review is undertaken.

LeDeR does not replace other statutory formats and processes for reviewing a person's death where concerns exist. On completion of the review (Initial or Focused), relevant learning informs recommendations and system actions. More detail about how we are confident that the Reviews that we complete are of a good standard, and how recommendations are scrutinised and then result in agreed action, can be found within our LeDeR Strategy HW LeDeR Strategy 2022-2025 (herefordshireandworcestershireccg.nhs.uk)

More information about the national programme can be found on the website for LeDeR hosted by NHS England https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/ .

This report provides an update on the progress and impact made across Herefordshire and Worcestershire during the period covering 1st April 2021 to 31st March 2022, the fourth full year of programme for our system. It builds on the achievements made through our partnerships and coproduction in previous years and reflects some of the extraordinary efforts of our partners to work together through another year that many will never forget, under the shadow of the COVID-19 pandemic.

3. Performance of Herefordshire and Worcestershire (HW) LeDeR

Notifications

Notifications of the deaths of people with a learning disability or autistic people registered with a Herefordshire or Worcestershire GP continue to be predominantly made by Community Learning Disability Nurses or Learning Disability Acute Liaison Nurses. During 2022/23 we received our first notifications from West Midlands Ambulance Service. Any person (for example GP, social worker, care setting manager or worker, family member) can make a notification by accessing LeDeR - Home

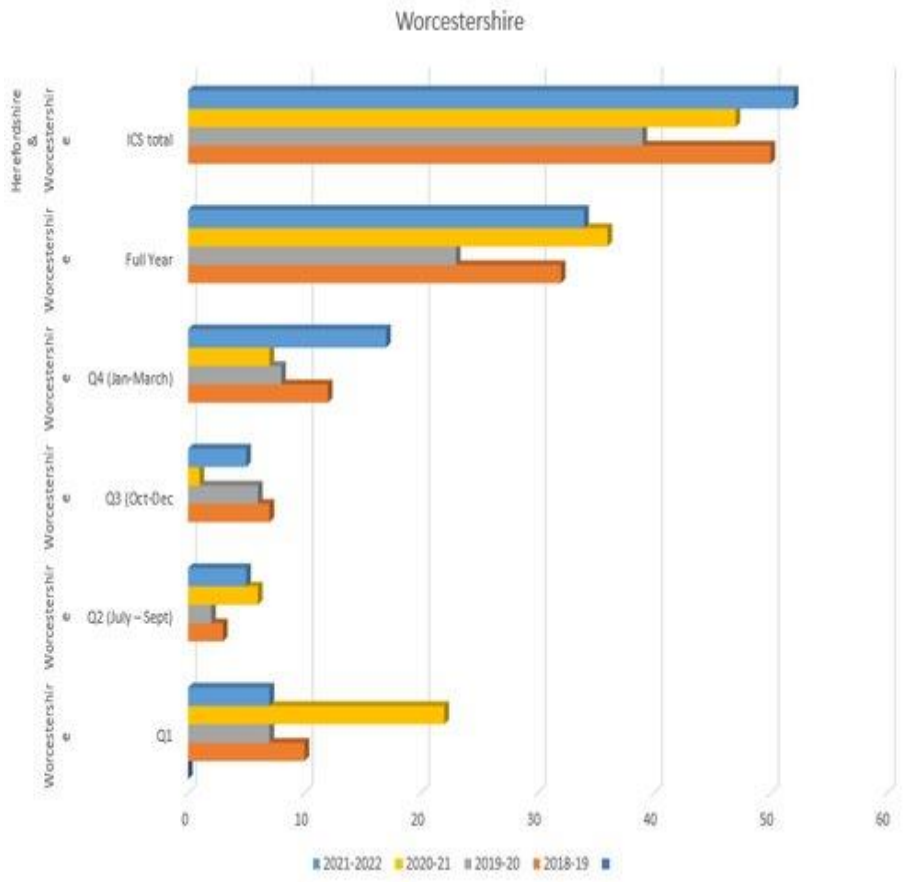
The pattern of notifications received by Herefordshire and Worcestershire is detailed in table 1 and figure 1. During 2021/22 we worked closely with all partners to refresh awareness of LeDeR to ensure that all parts of our system understand the importance of making LeDeR notifications, to increase our confidence that we are taking every opportunity to learn from people's lives and deaths.

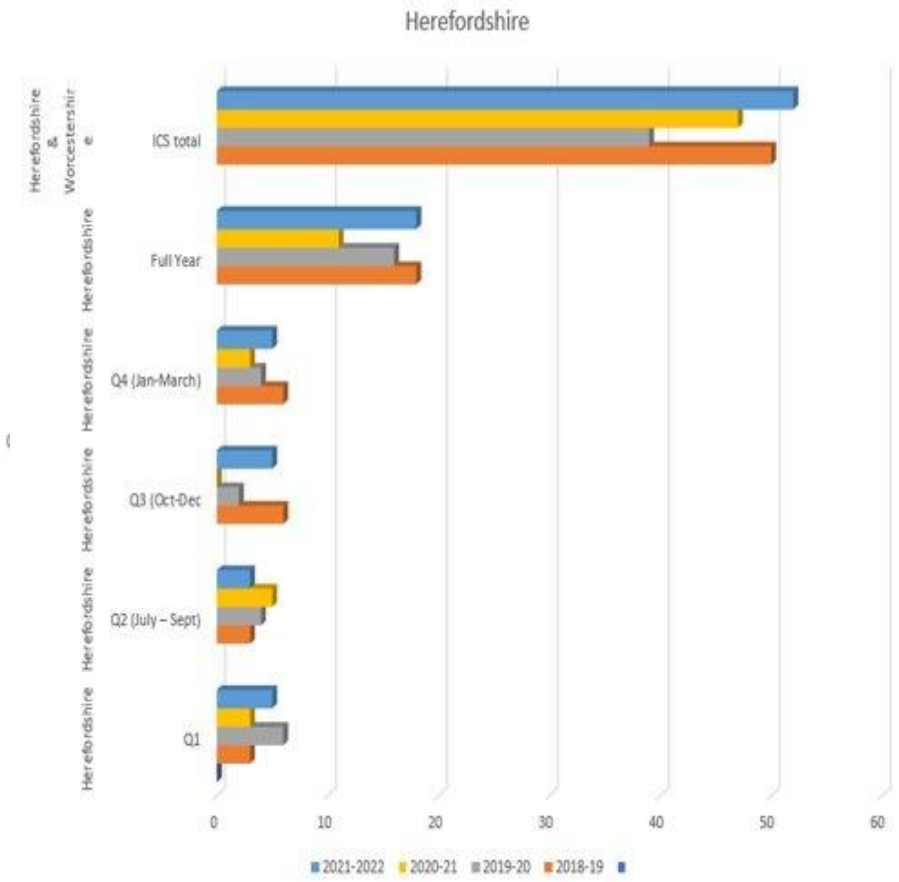
April to June 2020 and January to March 2022 saw unexpected variations in the numbers of notifications received, compared to patterns seen in previous years. COVID-19 accounted for much of the variation seen in April to June 2020. There is no clear explanation yet available for the variation in January to March 2022. Two notifications were received for autistic people as the scope of LeDeR changed to include autistic people from January 2022. We will need to await the completion of these reviews to understand any trends. The overall number of notifications is similar to most of the previous four years and most deaths occur in winter and spring months.

***Table 1**: Notifications made to Herefordshire and Worcestershire LeDeR. 2018/19 – 2021/22*

Herefordshire						Worcestershire						
Notifications received	Q1 (April – June)	Q2 (July – Sept)	Q3 (Oct-Dec	Q4 (Jan-March)	Full Year	Notifications received	Q1 (April – June)	Q2 (July – Sept)	Q3 (Oct-Dec	Q4 (Jan-March)	Full Year	ICS total
2018-19	3	3	6	6	**18**	2018-19	10	3	7	12	**32**	**50**
2019-20	6	4	2	4	**16**	2019-20	7	2	6	8	**23**	**39**
2020-21	3	5	0	3	**11**	2020-21	22	6	1	7	**36**	**47**
2021-2022	5	3	5	5	**18**	2021-2022	7	5	5	17	**34**	**52**

***Figure 1** Notifications made to Herefordshire and Worcestershire LeDeR. 2018/19 -2021/22*


Worcestershire
Herefordshire & Worcestershire
ICS total
Full Year
Q4 (Jan-March)
Q3 (Oct-Dec
Q2 (July – Sept)
Q1
0
10
20
30
40
50
60
2021-2022
2020-21
2019-20
2018-19


Herefordshire
Herefordshire & Worcestershire
ICS total
Full Year
Q4 (Jan-March)
Q3 (Oct-Dec
Q2 (July – Sept)
Q1
0
10
20
30
40
50
60
2021-2022
2020-21
2019-20
2018-19

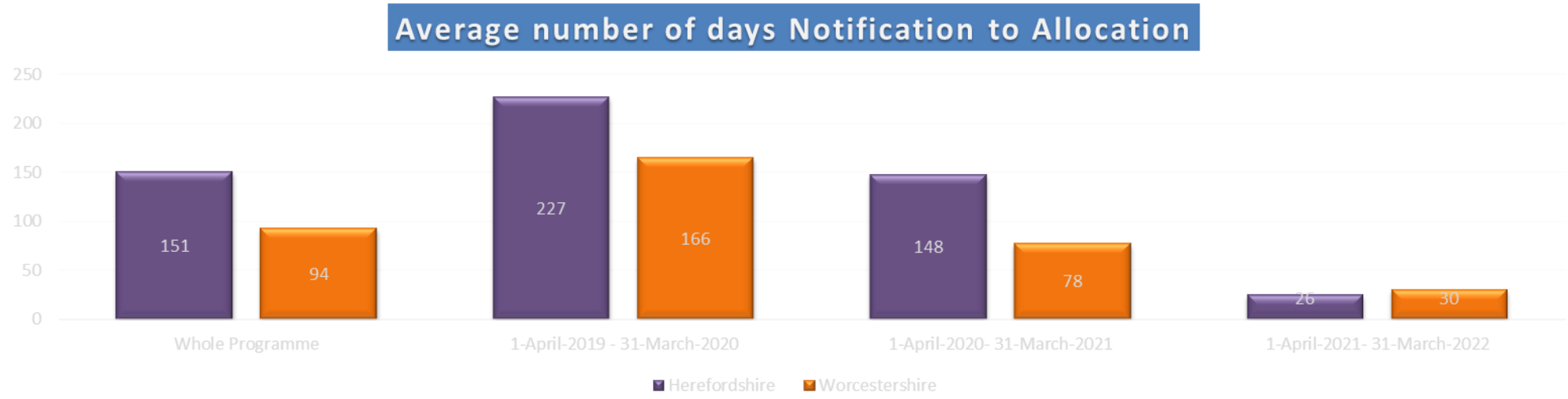
The timely allocation of notified deaths to a LeDeR Reviewer (within 3 months)

During 2021/22 we added to our substantive LeDeR Reviewer team. This enabled 100% of notifications to be allocated to a LeDeR Reviewer within the required timeframe of 3 months.

This is a big improvement on performance for 2020/21 where only 60% of notifications were allocated to a Reviewer within 3 months.

Across 2021/22 over 90% of notifications were allocated to a LeDeR Reviewer within one month of the case becoming visible to HWCCG.

Figure 2 - Average number of days to allocation



LeDeR Reviews

Review completion by type

In March 2021 a LeDeR Policy was introduced. This outlined the new format of reviews. Initial Reviews would be the standard for most notifications. Where the notification, or initial gathering of information, indicated a concern (for example a safeguarding alert) or a condition that required a more detailed review (for example the death of a person who had been detained under the Mental Health Act in the previous 5 years or the death of an autistic person) then a Focused Review would be undertaken.

During 2021/22 39 Reviews were approved as complete. Some of these reviews were commenced before the review format changed. For notifications received during 2021/22 there have been 6 identified as requiring a Focused Review. None of these Focused Reviews have as yet been completed.

The Timely Completion of Reviews (within 6 months)

As part of the LongTerm NHS Plan CCGs are monitored for the number of reviews that are completed within 6 months of notification.

Herefordshire and Worcestershire LeDeR are committed to ensuring that reviews are completed within 6 months. Where cases are open to the Coroner's Office or subject to Safeguarding processes, NHS Trust Serious Incident investigation, Complaints processes or Child Death Overview processes it is rare that LeDeR Reviews can be completed within this timescale. It is important that Reviews are informed by all relevant and available detail and so completion must take the outcome of other processes into account.

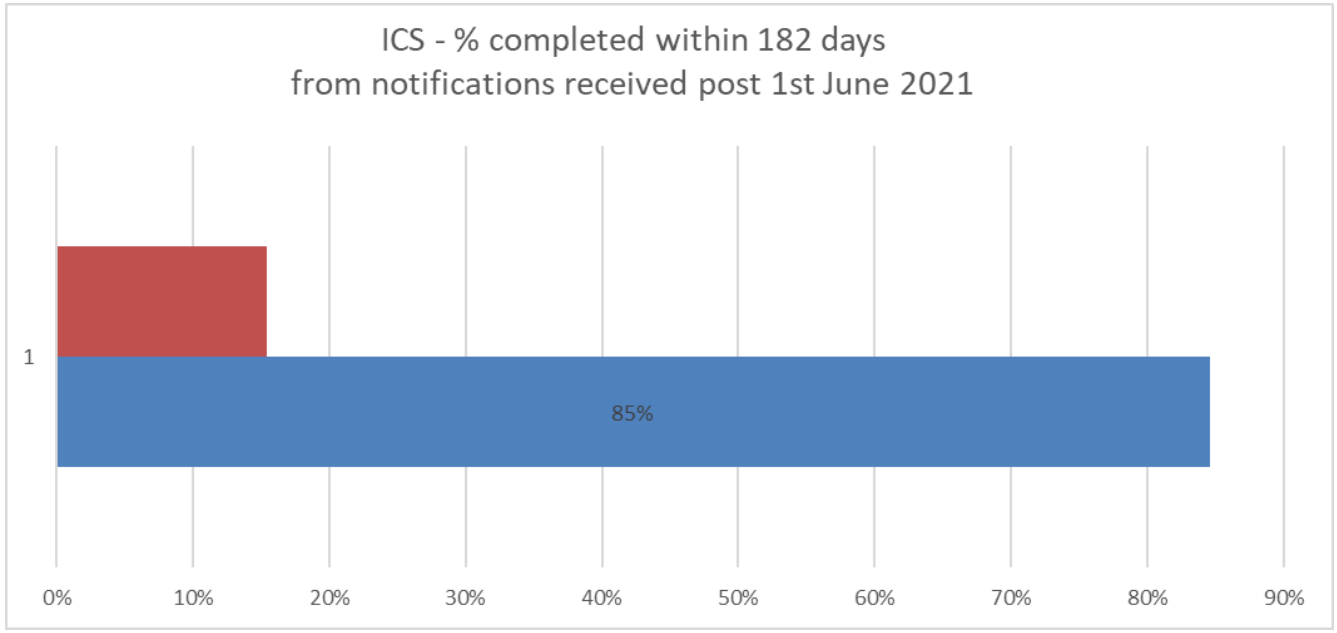
Delays with the completion of LeDeR Reviews have been experienced during 2021/22 due to changes impacting on the availability of the national LeDeR platform and the format of LeDeR Reviews, but also due to the continued impact of the COVID-19 pandemic on the availability of Primary Care and Acute Hospital Care clinicians to provide access to notes, conclude organisation specific mortality reviews and contribute to multi-agency meetings and processes. When we undertake a Focused Review we ensure that we make time to have conversations with all key health and social care workers involved in someone's life and care, so that we can make sure we are identifying any learning that will help influence improvements in services and outcomes for local people.

Due to the transition of the LeDeR platform hosting arrangements no notifications received for April 2021 were visible to each Integrated Care System until June 2021. This created some additional unexpected delays.

For Reviews completed within 2021/22 50% (20 Reviews from 39 Reviews completed) were approved within 6 months. Of the 19 Reviews completed in more than 6 months; 7 were completed by the Commissioning Support Unit after additional support was provided to address the backlog created by the pause in LeDeR Review System availability (notifications made from end of March to end of May 2021); 3 Reviews were subject to Coroner's Inquest; 5 Reviews were completed within 7 months.

For Reviews notified in 2021/22, and visible to HWCCG from June 2021, 85% of Reviews completed were approved within 6 months.

Figure 3- For notifications made from 1st June 2021 time to completion - % within 182 days



4. Learning from LeDeR Reviews

Generating learning from the information and recommendations provided by notifications and completed LeDeR Reviews is the main focus of the LeDeR programme for Herefordshire and Worcestershire system. It enables us to understand the experience of local people, recognise good practice and supports us to understand if we are making progress over time about the things that we want to improve.

4.1 Reflections on the characteristics of deaths notified to LeDeR Herefordshire and Worcestershire.

Age profile of notifications

*Table 2 - age group at death as a percentage of all notifications made during 2021/22 (** denotes number too small to be meaningful)

Age bracket	4-17 yrs	18-24 yrs	25-49 yrs	50-64 yrs	65 yrs and above
England (last available for 20/21	7%	4%	16%	35%	37%
ICS	6%	2%	16%	32%	46%
Male	*	*	6%	20%	22%
Female	*	*	10%	12%	24%

What does this tell us about the age of death within our system?

The percentage of deaths reported to H&W for those aged17 years or younger is similar to that for England and the percentage of young adult deaths is smaller but this difference is marginal and based on very small numbers.

The percentage of individuals aged 25-29 years and 50-64 years on notification of death is similar to the England position. For those aged 65 years and above the percentage is greater than the England position. The percentage of people aged 65 years and over at time of death has increased to 46% and is greater than the England position. 40% of all deaths were aged 70 or above.

Generally, many people whose lives are reviewed by the LeDeR programme in our ICS are able to live long and happy lives. We will continue to do all that we can to address the modifiable factors that help people achieve this.

Average and median age of death for notifications made in 2021/22

	Median age of death (excluding death before age 17 years)	Average age of death (excluding death before age 17 years)
Men	61	62
Women	62	59

The median age of death for men and women is similar to the England figure reported by the LeDeR programme in 2021.

Age of death and level of disability

For those who die before their 50th birthday, over 70% had a severe or profound level of learning disability.

Level of disability	Mild	Moderate	Severe	Profound
Age range at death	55-71 years	37-84 years	48-77 years	25-53 years

The gender profile of notifications

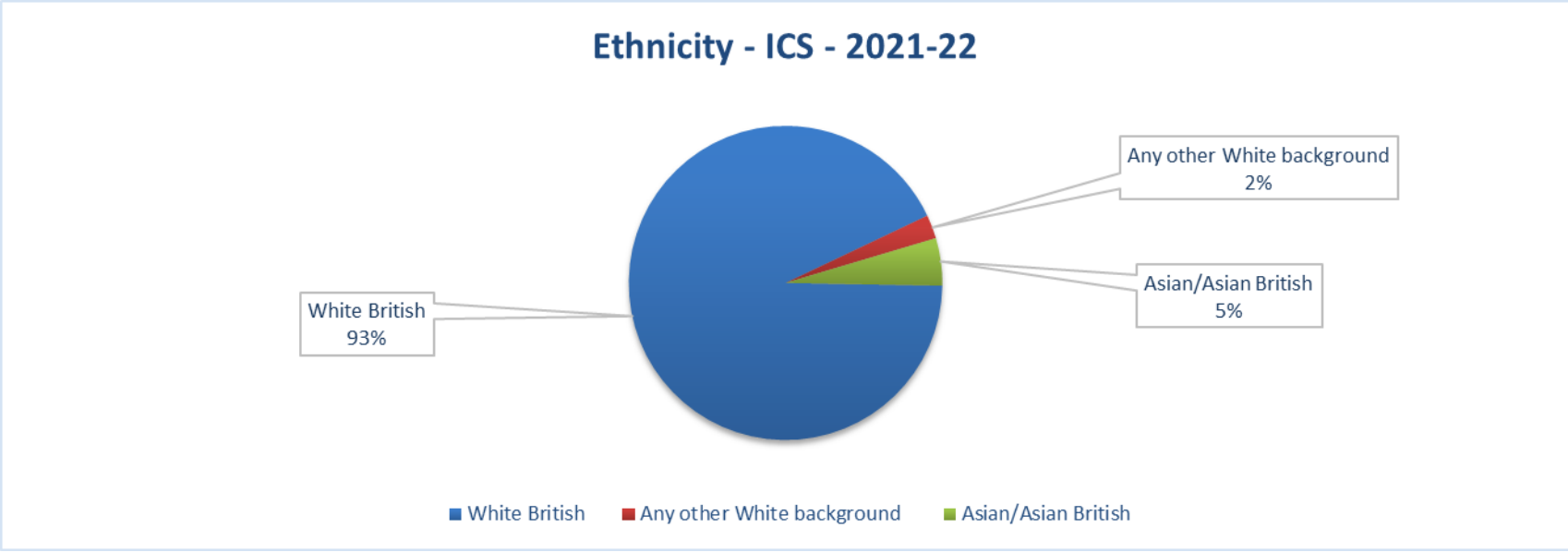
The percentage of notifications during 2021/22 that were of men or women was very similar- 54% men (28 notifications) to 46% women (24 notifications). This ratio was reflected across all groups of age range. In previous years HW LeDeR has received more notifications for men than for women but variation is accounted for by relatively small numbers of cases.

Men and women were not represented equally across the range of level of disability. This may be important if we want to influence health improvement measures for a specific gender group.

	Mild or Moderate learning disability	Severe or Profound learning disability
Men	75%	25%
Women	40%	60%

The ethnicity profile of notifications made to H&W LeDeR

Figure 4 ethnicity recorded on notification or on completion of Review during 2021/22



The ethnicity profile of notifications made to HW LeDeR has remained consistent with the profile over the course of the programme since 2017.

The HW general population is 97% white British with 0.5% of Asian or Black origin. Available data, to understand the ethnicity profile of people with a learning disability or autistic people in our ICS, is not sufficiently accurate and so we are unable to confirm if the pattern of notifications is reflective of our expected local population.

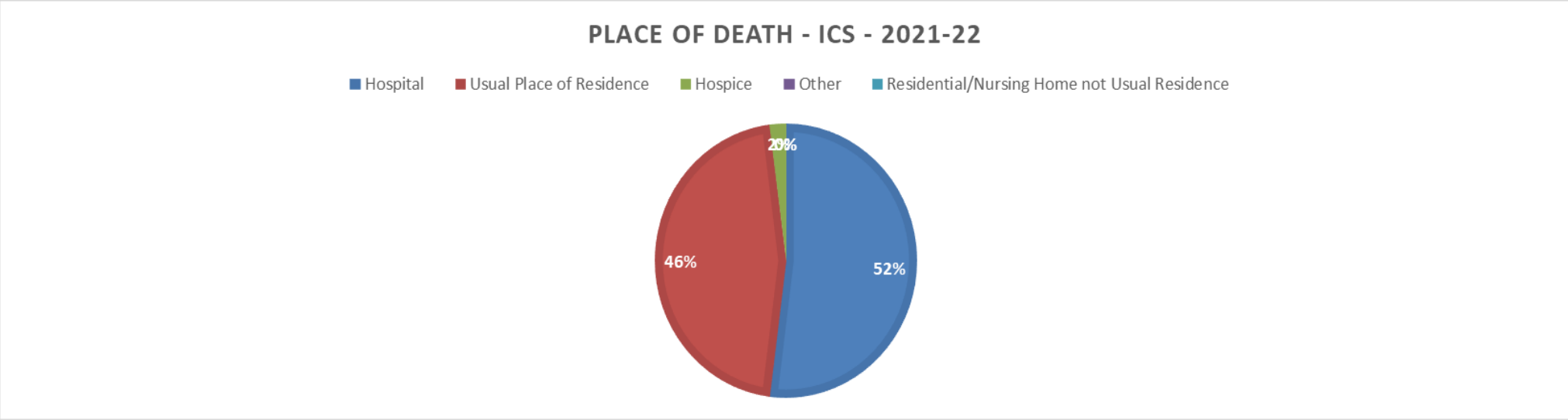
From all notifications received for H&W LeDeR since 2017, 25% of those aged 24 years or younger reported the persons ethnicity as Asian, White and Black African, White and Black Caribbean or other. As an ICS we need to do more to ensure that are receiving notifications for our whole community and try to understand more about the potential impact of ethnicity on the health equity and life chances of people with a learning disability or autistic people.

Place of death

Just over half of all notifications indicate that the person died in an acute hospital bed. Improvements in supporting people to die in their 'usual place' have been sustained for Worcestershire. LeDeR Reviews continue to show examples of satisfactory experience that could have been improved if the person was supported to die in their usual bed with those who know and love them close by.

This year, people whose death was notified to LeDeR from Herefordshire were as likely to die in an acute hospital bed as in their usual place of living. The small increase in deaths occurring in a hospital bed may be linked to improved reporting within that sector, but case numbers are very small and so firm conclusions cannot be made.

Figure 5 recorded place of death on notification during 2021/22



4.2 Learning from the outcomes of completed reviews – key data

Data from completed LeDeR reviews are collated into a matrix to support us to notice patterns worthy of further analysis.

Causes of death

Cause of death, as listed on death certification, is compiled into themes once the LeDeR Review has been completed, to ensure that data is accurate. Where an underlying condition is felt to have been a significant contributory factor in the persons death this is reflected (for example end stage dementia might be listed within themed analysis as opposed to pneumonia).

Figure 6 - most frequently reported cause of death for people with a learning disability

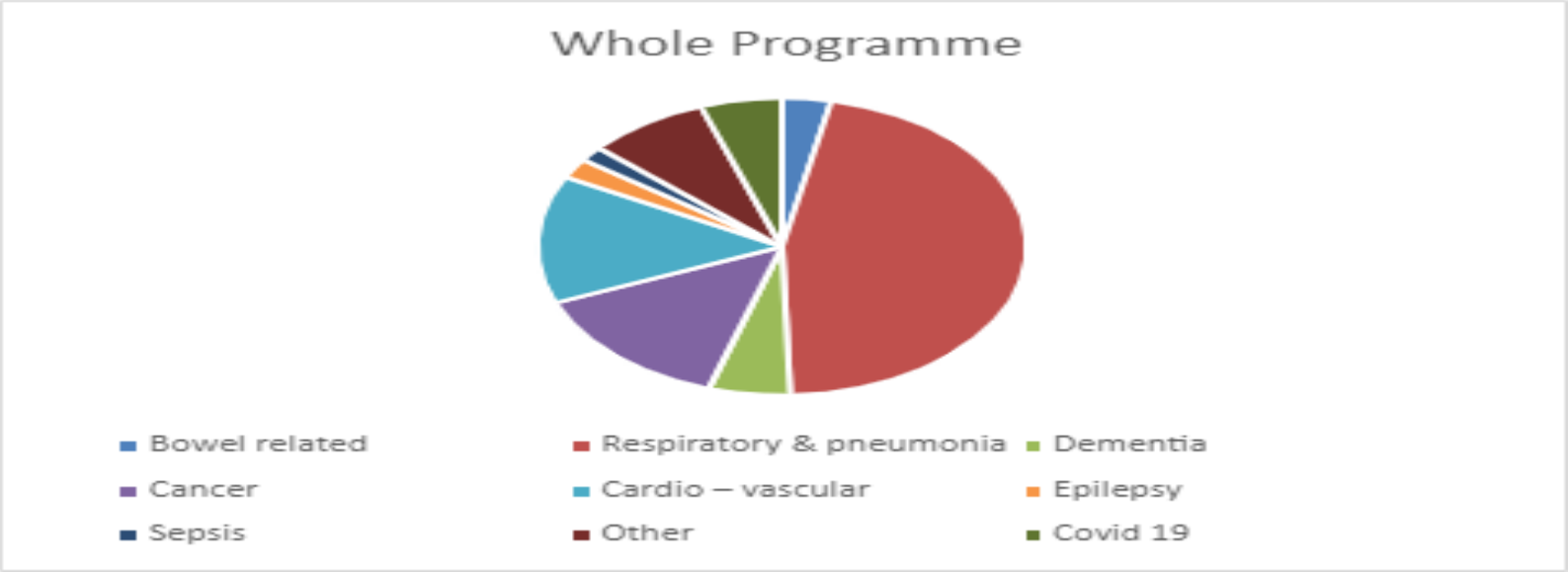
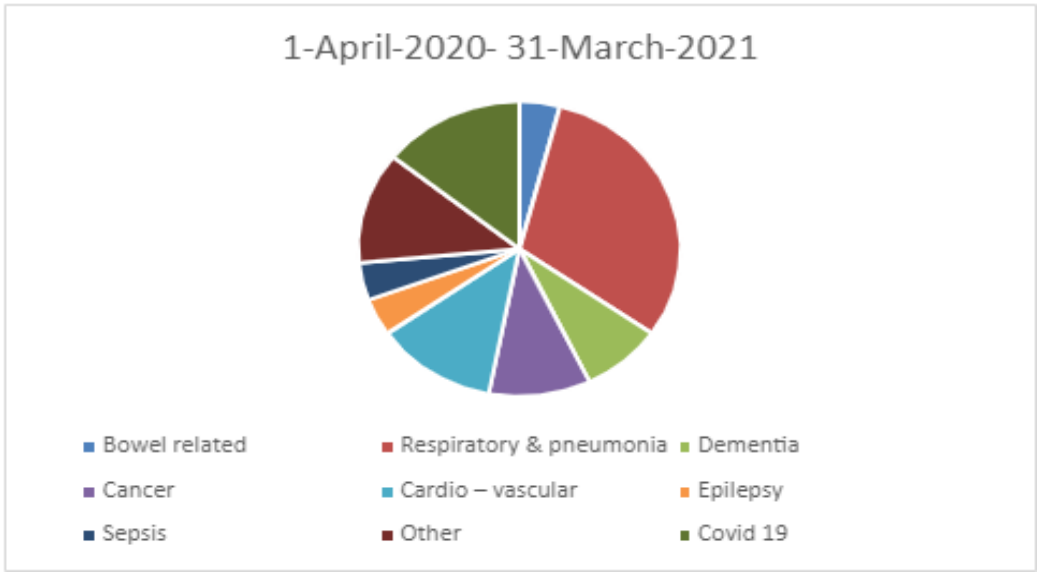
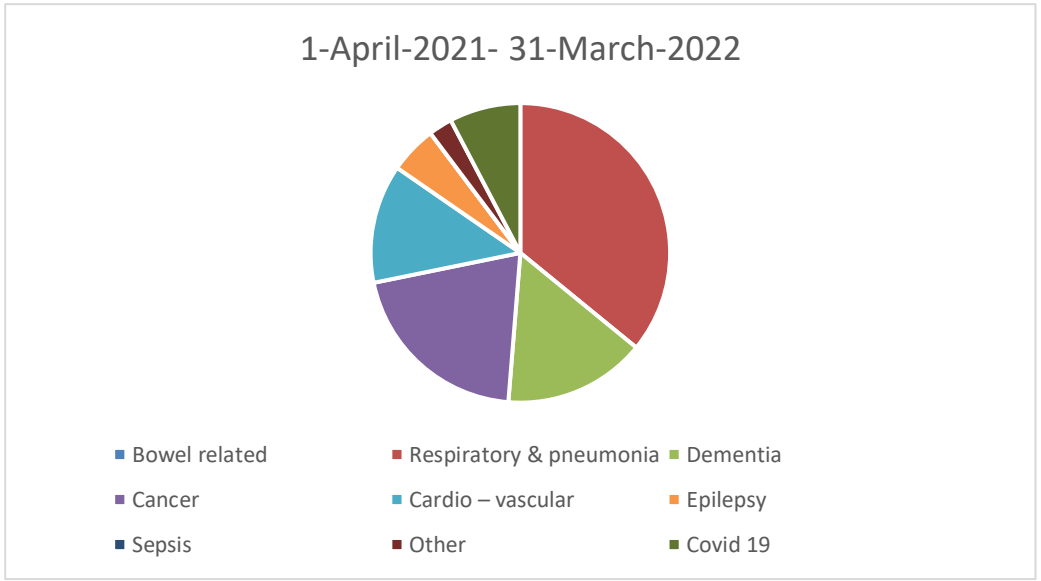


Figure 7 & 8- most frequently reported cause of death for people with a learning disability for 20/21 and 21/22





What does this tell us about the cause of death for people with a learning disability across our ICS?
Cause of death themes for each county are not reported here as some themes reflect very low numbers or single figures.

Respiratory system related deaths

Pneumonia continues to be the most frequently reported cause listed on death certification. Deaths related to COVID-19 reduced significantly this year. COVID-19 deaths, although very small in number, continued to reflect previous themes of moderate learning disability, living in care setting with history of cardio-vascular health needs. No Reviews completed during 2021/22 indicated that poor care was contributory. 27% of those who died from pneumonia were also noted to be very frail. For 15% the underlying cause of pneumonia was believed to be aspiration.

What action did we take during 2021/22?

We had a key focus this year on supporting the uptake of vaccination for COVID-19, Influenza and pneuomococcal infection. This reflects recent learning from a Scottish Learning Disability Observatory study on reducing deaths from Pneumonia in the learning disability population. HW ICS supported a decision to enable people with a learning disability of all ages living in communal residential settings to be prioritised for COVID-19 vaccination alongside older adults. This influenced earlier access to booster doses for people with learning disability living in residential settings. Vaccination status is checked as part of the Annual Health Check and support to make reasonable adjustments made. COVID-19 vaccination rates were again equitable to the general population and Influenza vaccination rates improved this year. The small number of people who were notified to LeDeR because they died of COVID-19 during 2021/22 had each received all eligible doses of vaccine. Pulse Oximetry at Home and a proactive COVID Management Service was also available during 2021/22 and ICS guidance specifically encouraged the use of close monitoring for those with a learning disability who tested positive.

What action will we take going forward?

We will continue to focus on the importance of vaccination and do all that we can to enable uptake. We will each case of pneumonia against recommended best practice to determine any emerging themes. We will continue to support care settings to identify deterioration early so that necessary intervention isn't started too late. We will also work with partners to review how we support good oral health and to review the Specialist Dental pathway following the conclusion of a Review related to full dental extraction.

To date no reviews have identified a gap in dysphagia assessment or in plans/ guidance to support safe eating and drinking to reduce the risk of aspiration. We want to ensure that this continues.

Cancer related deaths

Deaths related to cancer and cardio-vascular disease account for the next two most frequently recorded causes of death notified to HW LeDeR

Deaths where the cause is listed as due to cancer remain fairly static and reflect a broad range of primary tumour sites. In the general population deaths due to cancer are most commonly lung and bowel cancer. For people with a learning disability late stage cancer diagnosis is not uncommon and for around a quarter of all cancer deaths notified to HW LeDeR the primary site of the cancer could not be identified. Where a primary cancer site could be identified bowel and breast cancer are those most frequently reported to HW LeDeR. An equally low proportion of deaths from cancer have been reported to HW LeDeR for lung, pancreatic, renal and lymphoma.

What action did we take during 2021/22?

Cancer screening access for people with a learning disability appears to be comparable to that of the general population. LeDeR Reviews have indicted that more people could be supported to access bowel screening if they, and the care staff that support them, knew more about what screening involves and were supported to complete it. This year we started to test how many more people would access bowel screening if they were contacted in the year before their screening was due and received extra information and support to make reasonable adjustments. We also led an education event that included information on the importance of accessing bowel screening.

What action will we take going forward?

We want to understand screening uptake in more detail as uptake for breast and bowel screening will be a key priority over the next 2-3 years. Early cancer detection is a key priority for the NHS and we want to make sure that people with a learning disability and autistic people have equitable access to measures being taken to increase this early recognition. We will work through our ICS Cancer Leads, and with other systems that form part of the West Midlands Cancer Alliance, to inform the further roll-out of the NHS Galleri test over the next 3 years.

Heart disease and stroke related deaths

Deaths where the cause of death is listed as due to cardio-vascular disease also remain static however many deaths were consistent with individuals who had a recorded high Body Mass Index or diabetes. Over the course of the programme 20% of completed reviews recorded the presence of obesity. 3 out of every 4 individuals with obesity had a mild or moderate learning disability and 2 out of every 3 were women.

What action did we take during 2021/22?

Public Health funded additional advocacy support to enable Lifestyle Advisor teams to make reasonable adjustments to improve the measures that can be offered to people with a learning disability who need advice and guidance to reduce their body weight. LeDeR Reviews indicate that most people who had a history of heart disease or who were prescribed medication that may affect their cardio-vascular health had a good level of monitoring by their GP, including support to have regular blood tests. Community Learning Disability Teams, who are working to ensure that medication prescribed for mental health needs or distressing behaviour is appropriate and proportionate, will continue to promote best practice in the monitoring of cardio-vascular health.

What action will we take going forward?

Referrals to the Lifestyle Advisor groups for weight management of people with learning disability were low. We need to understand why this was and what measures would be most effective in providing the right support. Through the use of an Annual Health Check template, and ICS work to further enhance Population Health Management, we will be able to better understand how many people with a learning disability have cardio-vascular disease. This will support plans for improving earlier recognition and intervention for obesity and cardio-vascular disease.

Dementia
Deaths recorded as related to dementia are a smaller proportion of all deaths compared to the extent of dementia related recorded deaths in the general population. The average age of death for those with end stage dementia was 58 years; Most people also had Downs Syndrome. We want to be sure that people with a learning disability have equitable access to diagnosis services

Other causes of death

Very low numbers of deaths are recorded as being due to sepsis or Sudden Death in Epilepsy (SUDEP) / epilepsy related. Bowel obstruction related deaths have significantly reduced since the first year of the programme. A review of interventions across both counties has continued to be the focus of a Priority Action Group

What action did we take this year?

We continue to want to focus on ensuring that no-one experiences premature death due to avoidable bowel impaction. A learning event took place early in 2022 and will be followed up by a further event linked to Learning Disability Awareness week 2022. LeDeR Reviews and care staff conversations told us that those supporting people with a history of constipation did not always know how to use laxatives effectively. People also said that they were sometimes embarrassed to talk about poo and care staff said they found it difficult to support people in a way that also respected their privacy. A Healthy Bowel Management plan template and education about lifestyle choices to support bowel health is being promoted by Community Learning Disability Teams, working with Continence Team colleagues.

What action will we take going forward?

We will roll-out the use of the Healthy Bowel Management plan more widely and link this work to the promotion of bowel cancer screening.

Whilst the numbers of people in our ICS experiencing Sudden Death in Epilepsy is low, care staff and families who experienced this were not aware of the possible risk of sudden death. We want to do more to raise awareness of SUDEP and help people plan or prepare for this possibility. We will also ensure that any deaths listed as related to Epilepsy are reviewed against a best practice checklist.

The overall grading of care provided

During 2021/22 the system of undertaking Reviews and the Review template changed. Reviews no longer require a decision to grade the overall standard of care provided to the person. Where care falls short of the expected standards of good practice, and this was suspected as influencing the cause or timing of death, a more detailed Focused Review may be completed. Due to changes in the Review format occurring partly within 2021/22 no Focused Reviews were fully completed ahead of the end of March 2022. At the time of the report (June 2022) 6 individual cases are being considered as requiring Focused Reviews and 3 of these have been considered by the HW LeDeR Learning into Action Group membership and are near completion. No Focused Reviews have yet indicated care so poor that there are clear factors that may have avoided death.

In early 2021 the Coroner concluded an inquest for a lady who died in 2018 following a full dental extraction. Following the Inquest a Regulation 28 Report to Prevent Future Deaths was issued. The Inquest identified failings in the care home to monitor, recognise and respond to deterioration following Rachel's discharge from hospital after the dental extraction Rachel-Johnston-2021-0090-Redacted.pdf (judiciary.uk).

What action did we take during 2021/22?
HW LeDeR held a further round table event in April 2021 to share final learning identified from each partner organisation's review. Training and support to embed assessment and monitoring tools, to identify and respond to deterioration early was promoted across the ICS as part of a programme to Enhance Health In Care Homes.

What more will we do going forward?
Health Checkers (Experts by Experience) will lead a review of the Specialist Dental pathway to review improvements that were made following Rachel Johnstons death.

During 2021/22 Herefordshire were selected to be part of a LeDeR funded programme , coordinated by the West Midlands Academic Health Science Network, to test tools for identifying deterioration within Supported Living settings for people with a learning disability. During 2022/23 we will evaluate, build on and extend this work to cover Herefordshire and Worcestershire.

The underlying health conditions of people whose deaths were notified to H&W LeDeR Programme

During 2021/22 the template and format for LeDeR Review changed which influenced the extent to which underlying conditions were recorded and captured. All Reviews completed for HW LeDeR include review of the GP notes and underlying health conditions listed in the GP summary are transferred onto a recording spreadsheet, irrespective of whether the condition was felt to be associated with the cause of death.

Figure 9 – Ratio of recorded underlying health conditions detailed within completed LeDeR Reviews across 2020/21 and 2021/22

What does this tell us about underlying health conditions and their contribution to premature or avoidable death?

For 2020/21 the percentage of notifications received that reflect a long-term health condition for individual's with a Learning Disability residing within our ICS appeared to be high and many reflected multiple co-morbidities. This may have been a reflection of a good standard of health surveillance through General Practice that recognises and records long term conditions for people with a learning disability, compared with the average position across England.

For Reviews completed during 2021/22 the most frequently recorded long term conditions continued to be constipation, mental illness, epilepsy, dysphagia and cardio-vascular disease. A mental health diagnosis (or the proxy of a prescribed medication associated with mental illness) was less frequently recorded in Reviews completed during 2021/22. This may be related to efforts to promote appropriate prescribing and reduce

over-medication (STOMP). The percentage of completed reviews for those with obesity reduced significantly this year. This may be because 2020/21 reflected COVID-19 related deaths where obesity appeared to be a consistent underlying condition.

What did we do during 2021/22?

Our work to support good quality Annual Health Checks has focused on promoting the use of a template that recognises these commonly reported underlying health conditions, to ensure early recognition and support links to health promotion measures in the person's Health Action Plan.

During 2021/22 the ICS has made great steps in supporting General Practice to work with partners to improve health by having a greater understanding of the most prevalent health need in their registered population to enable focused action (Population Health Management). The dashboard in development includes 'learning disability' and will enable Primary Care Networks (PCN- groups of General Practice surgeries working together) to understand the patterns of health needs for their learning disability population. This will support earlier intervention and help us move away from relying on understanding health need through the review of those who have already died. Our aim is to make addressing the health equity and needs of people with a learning disability everyone's business, not just the work of the LeDeR programme.

What will we do going forward?

Health surveillance data will inform Population Health Management that recognises local health need and empowers each PCN to work with partners in their locality to address health equity for those who may be more vulnerable to experiencing barriers to happy and healthy lives, including access to programmes aimed to support prevention, diagnosis, earlier intervention or treatment.

4.3 Learning from the outcomes of completed reviews - key themes in Review recommendations

During 2021/22 the format of Reviews changed and so the option and likelihood of multipole recommendations changed. Initial Reviews were limited to a make only 1 or 2 key recommendations. Where significant learning was to be gained a Focused Review would be triggered. No Focused Reviewed were completed to the point of Learning into Action membership approval during 2021/22 and so no new action plans were finalised. Detail of how we agree actions arising from learning recognised at Focused Reviews is included within our Strategy HW LeDeR Strategy 2022-2025 (herefordshireandworcestershireccg.nhs.uk)

Reviewers continued to be encouraged to make recommendations from the information made available to them when completing an Initial Review. As the Review template changed, we initiated a Reviewer checklist to prompt the identification of learning for themed areas of improvement that had previously been recognised. Themed areas of focus included Annual Health Check completion, the understanding and use of the Mental Capacity Act, the completion of ReSPECT plans and where they were completed.

New recommendations continue to be added to a tracker that has bene in place since the start of HW LeDER in 2017. The frequency with which a recommendation category is made, and the seriousness of the potential outcome enable recommendations for key priority areas for improvement to inform an annual Delivery Plan. The Delivery Plan for 2022/23 is embedded within our LeDeR Strategy. New themes and priorities that arise from this Annual Report will be considered at our Annual Report learning event in the autumn of 2022 and will inform our Delivery plan for 2023/24.

During 2021/22 the key areas of focus to support improvement were:

- equity of access to vaccinations (COVID-19, Influenza, Pneumococcal)
- supporting measures to improve the uptake and quality of Annual Health Checks and resulting Health Action Plans
- promoting bowel cancer screening, supporting reasonable adjustment and improving awareness of good bowel health
- improving practice in assessing and planning to meet the needs of people who cannot make decisions about care and health for themselves or without the right support (Mental Capacity assessment and best interest decisions)
- increasing awareness of the use of a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) for people with a learning disability and promoting its completion ahead of a last episode of care in a hospital

One of the ways that we can determine if the actions that we are collectively taking are making a difference for local people are through the extent to which the frequency of specific recommendations are made. Whilst we need to keep in mind that the overall number of recommendations reduced this year due to report format changes some changes have been noticed.

Reductions have been seen, compared to previous years, in the number of recommendations reported for:

- Mental Capacity assessment and Best interest decision making
- Gaps in Annual Health Checks being completed
- Annual Health Check recognition of gaps in screening uptake
- Completion of a ReSPECT plan
- Notification to and involvement of LD Liaison Nurses in Hospital admissions, Emergency Department Attendances or Outpatient appointments
- The use of a completed Hospital Passport during an inpatient stay

Some thematic areas have remained the same or have emerged as new areas for focused improvement:

- Processes for engaging a person and their carers if they fail to attend or respond to an invitation for an Annual Health Check
- Access to or offer of a Pneumococcal vaccine
- Reference to personalised approaches to managing obesity in a person's Health Action Plan
- ReSPECT form completion during a person's last episode of hospital care, by healthcare professionals who know the person least well. This impacts on the quality of detail and involvement of the person, their family and close carers.
- Support to enable a person to die in the preferred place of the individual and their family or carers
- The timely notification of and review of a care package when an individual's needs change (often due to deterioration in health or increase in dependency).
- Coordinated discharge planning to enable effective onward care when a person has had a stay in hospital, at the point that their medical care has been optimised

Updates on progressing plans to inform improvements in outcomes have bene reported after each quarter of 2021/22 to NHS England Regional Learning Disability and Autism Programme team, our ICS Learning Disability and Autism Tackling Health Inequalities Board and our ICS Learning Disability and Autism Programme Assurance Board. Table # summarises our key actions and what we have collectively achieved.

Table 3 – Actions and outcomes of Priority Action workstreams during 2021/22

Priority Action focus	Actions during 2021/22	What we achieved.
The uptake and quality of Annual Health Check completion.	The Priority Action Group, established earlier in the HW LeDeR programme, was coordinated during 2021/22 by a new LDA Programme Lead. The group continued to include a broad range of partners from Public Health, Primary Care, Learning Disability Community and Liaison teams, family carers and strong links to a consultative group of experts by experience. During 2021/22 the Group: • Aspired to support the system to achieve an uptake rate of 85%, 15% above the national expected target • Co-produced sustainable education and training materials to support Annual Health Check delivery. Materials were based on examples of national best practice and informed by local people's experience. Training uptake covered 100% of PCNs • Oversaw progress with the completion rates of Annual Health Checks by establishing and sharing frequent data updates on progress made. This involved PCN level data shared every two weeks to compare current position and progress made over time. • Informed recruitment for an Access Worker to enable our ICS to learn about and influence the factors that support people who have not engaged with Annual health Checks.	A co-produced learning resource available to all Primary Care staff across HW ICS. Coproduction of resources to promote autism awareness and autism -friendly environments across our ICS, starting in General practice. Herefordshire and Worcestershire ccg - Learning disability and autism By 31st March 2022 a completion rate across H&W of 80%, with 59% of GP Practices exceeding the aspirational 85% uptake target. 84% of individual GP Practices in HW exceeded the national uptake rate of 70%. The uptake rate across our Primary Care Networks ranged from 58-95%, with some of the highest areas of deprivation for our ICS achieving some of the lowest rates of uptake. Achievement of uptake rates, in the context of excessive demand across Primary care services and of the COVID-19 vaccine booster programme in the winter of 2021/22, exceeded what we thought might be possible. Uptake rates declined with age (75% for 18-24 year olds and 67% for 14-17 year olds) and we still have little understanding about uptake for people from Black, Asian and other ethnicity groups.

Priority Action focus	Actions during 2021/22	What we achieved.
Respiratory Conditions (focus on minimising transmission and maximising protection and modifiable factors)	Learning from COVID-19 continued to inform work with partners to provide support to minimise COVID-19 outbreaks in care settings, to reduce the severity of illness and to identify deterioration in order to ensure that people received timely treatment. During 2021/22 the COVID Management Service were able to monitor people with a learning disability within residential settings (highest area of risk) using Pulse Oximetry. An ICS agreement in 2020/21, to offer COVID vaccination to people with a learning disability in care settings, alongside older people in care settings in JCVI 1, enabled earlier access to a complete primary course of vaccination and access to booster doses. We worked together to continue to promote vaccination, have discussions to reduce fear and hesitancy and find solutions for those who would find vaccination difficult to tolerate. Vaccination Centres introduced 'Quiet Hour' sessions to support autistic people and others who found crowds difficult or needed more space and time to tolerate vaccination. We worked together to promote the Flu vaccination toolkit. Learning Disability Teams and GP's who embraced 'reasonable adjustments' were instrumental in facilitating vaccination for those with the most complex needs, including support to coordinate best interest decisions.	Maintained virtual LeDeR Learning into Action Group meetings and updates to engage and sustain partnerships during the pandemic. By early 2021/22 uptake rates for COVID vaccination exceeded 93%, comparable with rates for the general population and uptake rates of booster doses were comparable with the general population. Flu vaccine uptake to January 2021 for people with LD achieved 66%, an increase on previous years. For 2021/22 this marginally increased again to 68% across HW (with 2/3 of Primary Care Networks achieving uptake over 70% and Herefordshire achieving an uptake of 73%) We ensured that each completed LeDeR Review for someone who died from pneumonia checked if access to a Pneumococcal vaccine had been offered -this was found to be the case for over 80% of cases reviewed. All LeDeR Reviews for those who died from aspiration pneumonia identified a dysphagia assessment had taken place and a clear Eating and Drinking plan was available for those at risk of aspiration.

Priority Action focus	Actions during 2021/22	What we achieved.
Bowel	During 2021/22 we followed up on previous work to raise awareness of the factors that lead to bowel impaction for people with a learning disability and measures that can be taken to improve a healthy bowel. A learning event was held online in March 2022 (due to the extent of COVID-19 transmission at that time). This event was coproduced with experts by experience (individuals with LD and family carers) and involved a wide range of health and social care practitioners. Work commenced on supporting early intervention to engage in bowel screening in the 12 months ahead of an expected invitation. A Bowel Management Plan for those with a history of constipation was further reviewed and work commenced to ensure all people living across HW are able to benefit from this resource to inform their care and support.	No deaths were reported related to bowel impaction that was avoidable. Bowel cancer screening uptake in the learning disability population achieved an uptake rate of 67% compared to 62% for the general population in HW ICS. Whilst bowel screening uptake is favourable to uptake rates for the general population this still means that one third of people are not accessing tests for one of the highest areas of cancer for people with a learning disability. A further face to face learning event, to promote awareness and reduce embarrassment for talking about poo and bowels, will be held in the summer of 2022 around Learning Disability Awareness week. Following this event an impact evaluation will be undertaken to understand what changes people, care staff and families have made as a result of these learning events.

Priority Action focus	Actions during 2020/21	What we achieved.

MCA awareness	During 2021/22 we continued to ensure that LeDeR Reviews identified where there was learning regarding how mental capacity assessment and best interest decision making could impact on the identification and recognition of health need and on intervention to prevent deterioration and improve outcomes. Our local NHS Trusts worked together to ensure that clinicians had the right access to support to develop their awareness. Learning Disability Liaison Teams ensured that they continued to support awareness and decision making in individual circumstances. We worked together with Safeguarding Adult Boards to plan a learning event for the autumn of 2022 and commissioned Inclusion North to coproduce additional learning material to further promote awareness of the impact of involving people and their family/ carers in decisions that can improve the outcome for people's health.	Fewer recommendations were made from LeDeR Reviews to improve Mental Capacity Act awareness and decision making and good examples of coordinated multi-agency decision making were seen. NHS Trusts in Worcestershire worked together to further strengthen and make clear the way in which best interest decisions are communicated prior to dental extraction.

Priority Action focus	Actions during 2020/21	What we achieved.
ICS implementation	During 2021/22, in order to strengthen our local programme and adhere to the national LeDeR Policy we:	We received more LeDER notifications during 2021/22 that for any previous year.

of key aspects of the national LeDeR Policy and transition to a new national platform and Review format	• Appointed more LeDeR Reviewers into dedicated roles in HWCCG • Ensured that all Reviewers undertook training on the new LeDeR system and Review format • Supported Reviewers to prepare for undertaking LeDer Reviews for autistic people. • Ensured that processes for supervising and supporting Reviewers were maintained or strengthened • Worked with partners to plan for ways of further promoting LeDeR to ensure that all possible deaths (and therefore opportunities for learning) are notified to LeDeR. • We reintroduced multi-agency meetings ahead of Focused Review report scrutiny at LeDeR Learning into Action meetings to ensure that all involved had opportunity to benefit from the learning opportunity and ensure that all relevant learning was identified. • We worked closely with NHS England to inform improvement in the functioning of the new LeDeR platform • Committed to undertaking Focused Reviews for all autism notifications • Commissioned a short video to raise awareness and promote notifications to LeDeR for autistic people	We improved the extent to which Reviews were completed within 6 months. We retained confidence that the most complex LeDeR Reviews were able to extract learning to inform service improvement and of our processes for working alongside other statutory processes. We received our first notifications for autistic people (without additional learning disability).

5 Affecting meaningful change in Herefordshire and Worcestershire - Our Strategy for enabling Longer, Healthier and Happier Lives for local people and next steps

The capacity and opportunity to influence meaningful improvements for the health outcomes of people with a learning disability has always been the main driving force and key priority of LeDeR Reviewers and the members of HW LeDeR Learning into Action Group

and other key forums. We believe that the way that we work together to deliver HW LeDeR is in line with the NHS Patient safety Strategy to enable Insight through learning from the completion of Reviews, Involvement through key engagement and the coproduction of outputs alongside people with lived experience, to inform experienced based Improvement that matters to local people.

During 2021/22 we coproduced a LeDeR Strategy and on 31st March 2022 the final version of the HW LeDeR Strategy (2022-2025), including a Delivery Plan for 2022/23, was published HW LeDeR Strategy 2022-2025 (herefordshireandworcestershireccg.nhs.uk) . Progress with key actions in our Delivery Plan will be reported each quarter and we will monitor how these actions are influencing measurable outcomes by reporting a dashboard of indicators to our Assurance Board. The way that Groups and reporting work together across LeDeR and the Learning Disability and Autism Programme are shown in appendix one.

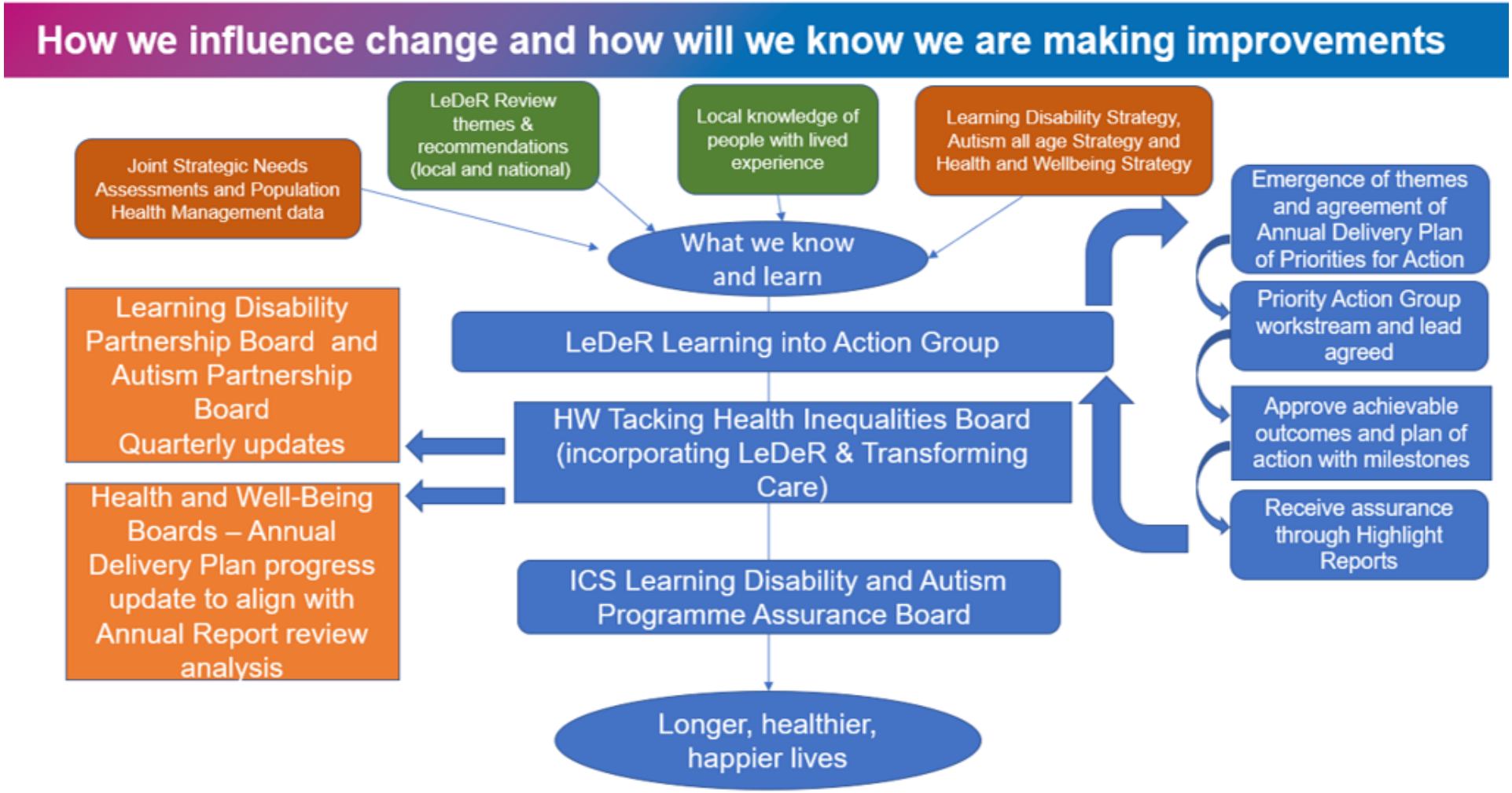
The NHS Priorities and Operational Planning guidance 2022/23 continues to direct a welcome spotlight on reducing the health inequalities experienced by people in our local communities, including people with a learning disability and autistic people.

The remit of Clinical Commissioning Groups, as a key partner and system leader during 2021/22 has been to continue to support partnership working to deliver the LeDeR programme. We believe we have achieved this. We have collaborated, during another extraordinary year, to start to see improvements across programme performance and key outcomes that experts with lived experience and family carers tell us are important to them.

From 1st July 2022 NHS Herefordshire and Worcestershire CCG will be abolished and NHS Herefordshire and Worcestershire Integrated Care Board will be formed. The local programme for LeDeR across H&W will have new opportunities to work together in an integrated way, across health and social care, to maximise benefit for our population.

HWCCG and the members of HW LeDeR Learning into Action Group and LDA Tackling Health Inequalities Board welcome the continued focus and emphasis on the health needs of those who experience health inequity and look forward to another successful year of improving outcomes so that local people can live longer, happier and healthier lives.

Appendix one – HW LeDeR within the context of the overarching Integrated Care System Learning Disability and Autism Programme



This page is intentionally left blank