Worcestershire County Council

Agenda

Health Overview and Scrutiny Committee

Friday, 13 January 2023, 10.00 am
County Hall, Worcester

All County Councillors are invited to attend and participate

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 Scrutiny on telephone number 01905 844965 or by emailing scrutiny@worcestershire.gov.uk

DISCLOSING INTERESTS

There are now 2 types of interests:
'Disclosable pecuniary interests' and 'other disclosable interests'

WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

NB Your DPIs include the interests of your spouse/partner as well as you

WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

NB It is a criminal offence to participate in matters in which you have a DPI

WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

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Health Overview and Scrutiny Committee
Friday, 13 January 2023, 10.00 am, Council Chamber

Membership

Worcestershire County Council	Cllr Brandon Clayton (Chairman), Cllr Salman Akbar, Cllr David Chambers, Cllr Lynn Denham, Cllr Adrian Kriss, Cllr Jo Monk, Cllr Chris Rogers, Cllr Kit Taylor and Cllr Tom Wells
District Councils	Cllr Sue Baxter, Bromsgrove District Council Cllr Mike Chalk, Redditch District Council Cllr Calne Edginton-White, Wyre Forest District Council Cllr John Gallagher, Malvern Hills District Council Cllr Frances Smith, Wychavon District Council (Vice Chairman) Cllr Richard Udall, Worcester City Council

Agenda

Item No	Subject	Page No
1	**Apologies and Welcome**	
2	**Declarations of Interest and of any Party Whip**	
3	**Public Participation** Members of the public wishing to take part should notify the Democratic Governance and Scrutiny Manager in writing or by email indicating the nature and content of their proposed participation no later than 9.00am on the working day before the meeting (in this case 12 January 2023). Enquiries can be made through the telephone number/email listed in this agenda and on the website.	
4	**Confirmation of the Minutes of the Previous Meeting** Previously circulated	
5	**Public Health Ring Fenced Grant and Public Health Outcomes** (Indicative timing: 10:05 – 10:50am)	1 - 32
6	**Health Inequalities and Impacts Resulting from the COVID-19 Pandemic** (Indicative timing: 10:50 – 11:35am)	33 - 46
7	**Work Programme** (Indicative timing: 11:35 – 11:45am)	47 - 52

Agenda produced and published by the Democratic Governance and Scrutiny Manager, County Hall, Spetchley Road, Worcester WR5 2NP. To obtain further information or hard copies of this agenda, please contact Emma James/Jo Weston 01905 844965,email: scrutiny@worcestershire.gov.uk

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

Date of Issue: Thursday, 5 January 2023

Item No	Subject	Page No

NOTES

Webcasting

Members of the Committee are reminded that meetings of the Health Overview and Scrutiny Committee 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.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
13 JANUARY 2023

PUBLIC HEALTH RING FENCED GRANT AND PUBLIC HEALTH OUTCOMES

Summary

1. The Health Overview and Scrutiny Committee (HOSC) will receive an update on the Public Health Ring Fenced Grant (PHRFG) and the associated Public Health outcomes.

2. The update will include areas of work which HOSC members have expressed interest in, including promoting active lifestyles, targeting rising levels of obesity, sexual health services and prevalence of alcohol use.

3. The Cabinet Member with Responsibility for Health and Wellbeing and the Director of Public Health have been invited to the meeting.

Background

4. As part of the HOSC's budget monitoring, the Committee receives information on the PHRG twice a year and was last updated at its meeting on 8 July 2022.

5. Members of HOSC will therefore be aware that the Public Health function nationally transferred to local authorities in 2013, and the Council receives an annual grant of approximately £30m.

Financial position

6. The PHRFG allocations for 2022/23 totalled £3.417 billion to local authorities. The value of the grant for the County Council totals £31,217,923, which was an increase of £853,016 from the 2021/22 value of £30,364,907. There has been no confirmed allocation for 2023/24 at the date of drafting this report.

7. The grant is ringfenced for use on Public Health functions, which may include public health challenges arising directly or indirectly from COVID-19. Details of the prescribed and non-prescribed functions that the grant can be used for were shared with HOSC in July 2022 and can be reviewed under 'Background Papers'.

8. The forecast outturn, as at the end of Quarter 2, for the PHRFG is provided in the financial update at Appendix A, and the current prediction is a forecast transfer from reserves of £2.969m which is a reduction compared with the original budgeted expectation of £3.765m.

9. Twice yearly updates on the PHRFG will continue to be provided to the HOSC.

Public Health Outcomes

10. An overview of the full range of Public Health Outcomes is provided in Appendix B, which is the latest Public Health Outcomes Framework for Worcestershire as at 19 December 2022. In addition, Appendix A provides a summary of performance and outcomes for most of the main local Public Health Services that are funded from the PHRFG.

Purpose of the Meeting

11. The HOSC is asked to:

- consider and comment on the information provided on the Public Health Ring-fenced Grant and Public Health outcomes;
- agree any comments to highlight to the Cabinet Member for Health and Wellbeing and/or to the Overview and Scrutiny Performance Board at its meeting on 30 January 2023; and
- determine whether any further information or scrutiny on a particular topic is required.

Supporting Information

Appendix A – PHRFG and Public Health Outcomes (Period 6 Financial Update and Outcomes)

Appendix B – Public Health Outcomes Framework Summary At a Glance 19/12/22

Contact Points

Emma James / Jo Weston, Overview and Scrutiny Officers, Tel: 01905 844964 / 844965. Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Democratic Governance and Scrutiny Manager) the following are the background papers relating to the subject matter of this report:

- Draft 2023/24 Budget discussed by Cabinet on 5 January 2023
  Agenda for Cabinet on Thursday, 5th January, 2023, 10.00 am - Worcestershire County Council (moderngov.co.uk)
- Agenda and Minutes of Health Overview and Scrutiny Committee on 8th July 2022

All agendas and minutes are available on the Council's website here.

PUBLIC HEALTH RING FENCED GRANT AND PUBLIC HEALTH OUTCOMES

Appendix A – Period 6 Financial Update and Outcomes

Health Overview and Scrutiny Committee, 13 January 2023

Introduction to Public Health Ring Fenced Grant (PHRFG) and Public Health Duties

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Public Health - Statutory Duties

- **Improve population health and well-being**
- **Have regard to narrowing health inequalities**
- Preparation of and participation in health protection arrangements and services against threats for health of local population
- Duty to improve public health according to the Public Health Outcomes framework
- To comply with NICE recommendations for treatments under PH functions
- Oral public health including water fluoridation
- Help to contribute to the health of the prison population
- Have regard to improving drug and alcohol services
- Provision of DPH and specialist team.

Public Health Ring Fenced Grant Allocation

2022-2023 £31.218m

Purpose of the Grant

"The grant will be ring fenced for use on public health functions. This may include continued public health challenges arising directly or indirectly from Covid-19"

- Payable to upper tier authorities to deliver public health duties under the Health and Social Care Act 2012
- Must be used only for meeting eligible expenditure
- Where main and primary purpose of the spend is public health
- Grant conditions continue to be specific and DPH & Director of Finance responsible for compliance return to government

Mandated Functions

As part of the grant conditions the below functions are mandatory:

- Open access sexual health services
- NHS health checks 5 yearly 40 - 74
- Weighing and measuring of children
- Healthy Child Programme (child development reviews) – health visitors/school nurses
- Public health advice to NHS
- Protecting the health of the local population

Financial Update (PHRFG)
As at Period 6

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Public Health – Forecast Outturn as at Period 6

Income/Expenditure 2022-23	BUDGET	FORECAST	VARIANCE
Income:			
Public Health Ring Fenced Grant	-31,217,923	-31,217,923	0
Contribution from Reserves	-3,765,000	-2,969,531	-795,469
TOTAL	**-34,982,923**	**-34,187,454**	**-795,469**
Expenditure:			
PH Strategic Functions	4,271,034	3,254,416	-1,016,618
Adults Other Services	2,251,137	2,946,496	695,359
Adults Public Health Services	11,443,266	11,755,994	312,728
Children's Other Services	2,315,000	2,089,639	-225,361
Children's Public Health Services	11,733,630	11,212,540	-521,090
Wider Determinants	2,968,857	2,928,370	-40,487
TOTAL	**34,982,924**	**34,187,455**	**-795,469**

Key Headlines

The main explanations for the budget variations are:-

- Public Health Strategic Functions underspend is due to an agreement to hold vacant positions within the staffing establishment to enable a £1.6m in year contribution to corporate savings, eligible within the Public Health Ring Fenced Grant (£0.8m) and COMF (£0.8m) .
- Adults Other Services overspend is due to in year funding of mental health reablement and Promoting Independent Living Service.
- Adults Public Health Services overspend is due to changes in the Health Checks contract to increase and target Health Checks.
- Children's Other Services underspend is due to maximising COMF funding for Youth Provision.
- Children's Public Health Services underspend is due to a delay in mobilisation of additional COMF funded Starting Well services.
- The Wider Determinants budget underspend is due to maximising COMF funding for Flu vaccinations.

COMF Grant Carry Forward

The total COMF funding carried forward from 2021/22 was £4.266m, this will be spent this financial year as shown below:

Spend Category	22/23
Compliance and Enforcement: Covid-19 Secure Marshals, support for events	137
Compliance and Enforcement: Evironmental Health Officers	193
Project Management, commercial support and other staffing	259
Other: Prevention, management of local outbreaks and data intelligence, surveillance and communications	1,322
Support for vulnerable groups and targeted community interventions	1,295
Testing - contingency	90
Tracing - loss to follow up to improve containment of local outbreaks	133
Adult Social Care Commissioners and Quality Team Covid Response	837
Total	**4,266**

Public Health 3 Year use of Reserves – P6

Reserves	22-23	23-24	24-25
	£'000	£'000	£'000
Sexual Health	321	121	0
Childrens Prevention & Early Intervention	1,240	1489	0
Mental Health Adults	303	229	0
Mental Health Childrens	550	497	49
Smoking Prevention	47	93	46
Maternity Support	94	126	31
Health Protection	33	33	33
Health & Wellbeing Information and Advice	70	40	40
Physical Activity	100	100	100
Health Inequalities	178	178	178
BRR agreed schemes	433	517	445
Family Conferencing	0	183	183
Youth Support	0	350	350
QI Project	70	140	0
Domestic Abuse	75	195	255
Total	**3,514**	**4,291**	**1,710**
Reserves c/f	**9,739**	**6,225**	**1,934**
Remaining reserves	6,225	1,934	224

There has been a recent agreement to fund £117k over two years to Arts and Health, funded by removal of QI Project.

Public Health Outcomes:

Public Health Outcomes Framework

Outcomes from Public Health Services

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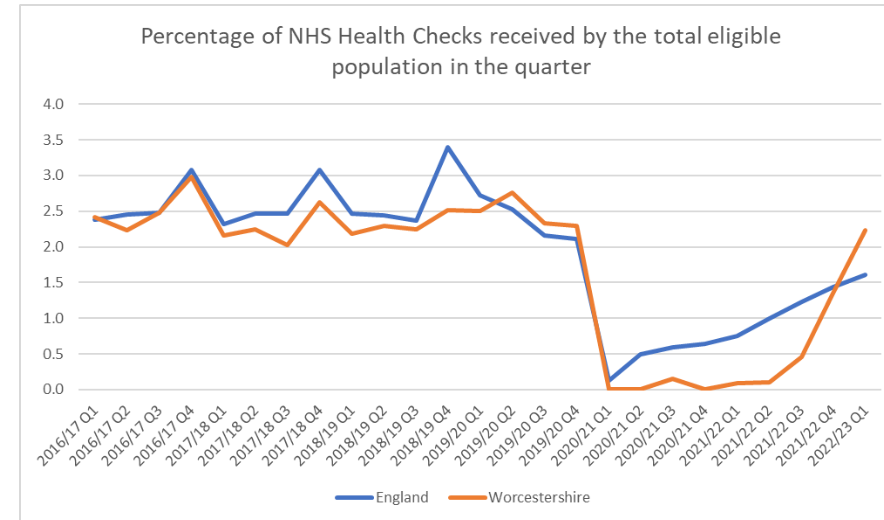
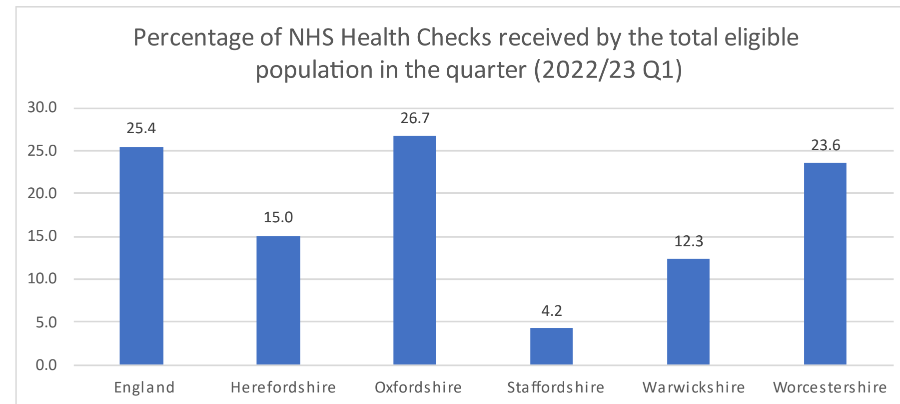
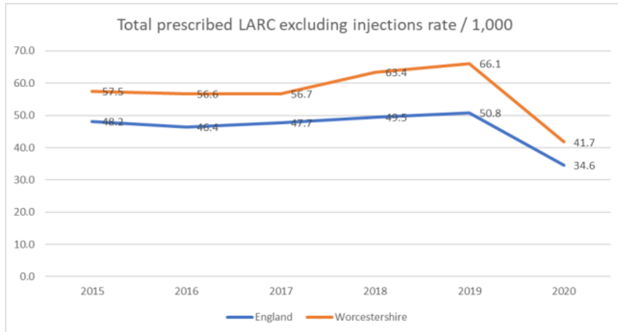
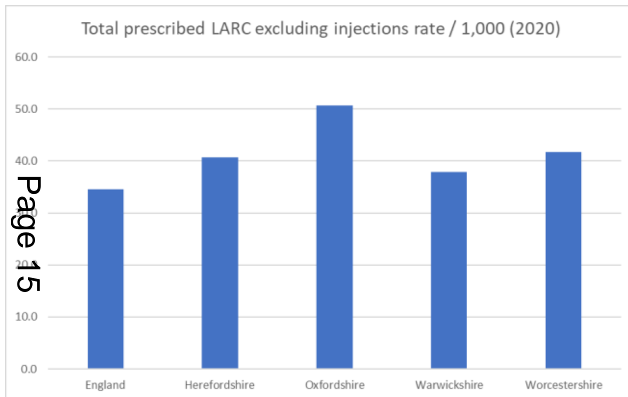
NHS Health Checks Programme

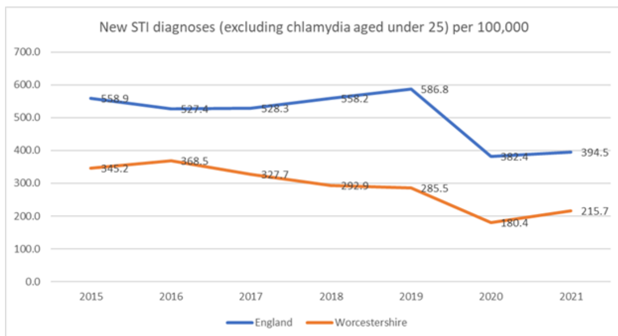
- Aims to help prevent heart disease, stroke, diabetes and kidney disease.
- Everyone between ages of 40 and 74, not already been diagnosed with above conditions, invited (once every five years) to have a check to assess risk
- Delivered through primary care and payments are structured to target population groups with highest risk of CVD
- Activity constrained by the Covid-19 pandemic
- Figures for the latest quarter (2022/23 Q2) 19,562 invitations and 4,588 health checks completed.
- Over the 4 years to 2022/23 Q1, 42,139 health checks were completed in Worcestershire, 23.6% of the eligible population, compared to 21.5% for England, this is better than three out of the four comparator local authorities.









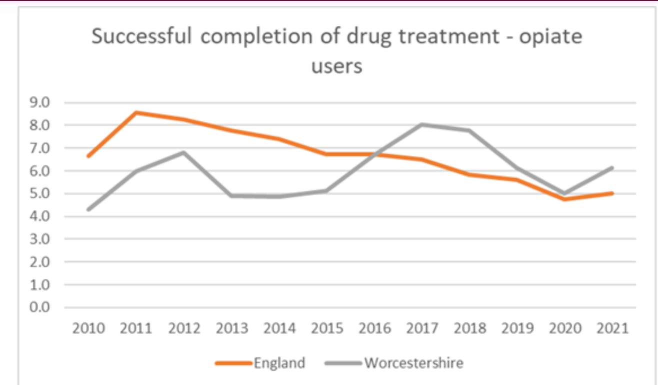


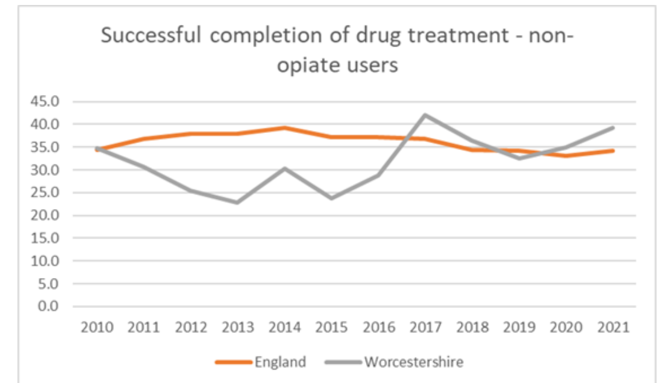
Worcestershire Integrated Sexual Health Service (WISH)

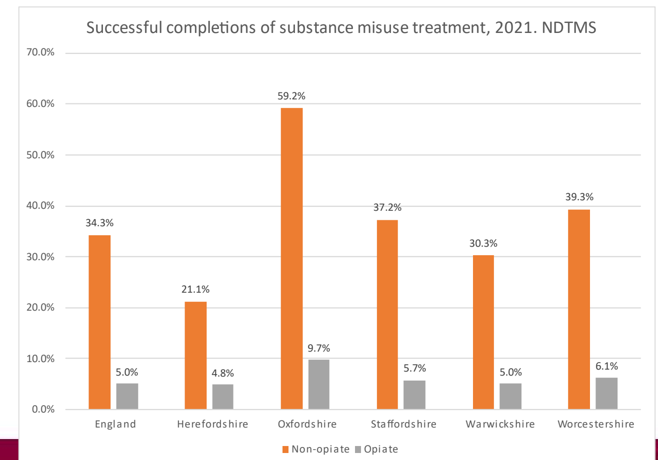
- Provides comprehensive open access sexual health services - including Sexually Transmitted Infection (STI) testing and treatment, partner notification and provision of contraception
- Prevalence of STIs is much lower than comparator authorities and national levels.
- HIV late diagnosis rates are similar to national levels
- Activity was constrained by the Covid-19 pandemic
- Long-acting reversible contraception (LARC) methods are highly effective. LARC is provided by GPs and WISH.
- LARC provision in Worcestershire remains above national values and most similar local authorities
- Teenage conception rates have significantly reduced over the last decade. From 32.8 in 2009 to 12.8 in 2020.

Drugs treatment

- Spending and outcomes on Drugs and Alcohol services are around the national average, and similar to statistical neighbours.
- Successful completion of substance misuse treatment after 6 months has been improving since 2015, remaining significantly better than national figures and similar local authorities.
- In 2020/21 there were 1211 people in treatment for opiates and 214 people in treatment for non-opiate drugs, and 190 for non opiate and alcohol combined.
- In Q1 2022/23 40% of opiate and 38% of non opiate clients were working after successful completion of treatment. 96% of opiate and 38% of non opiate clients reported no housing need. These outcomes are better than nationally.







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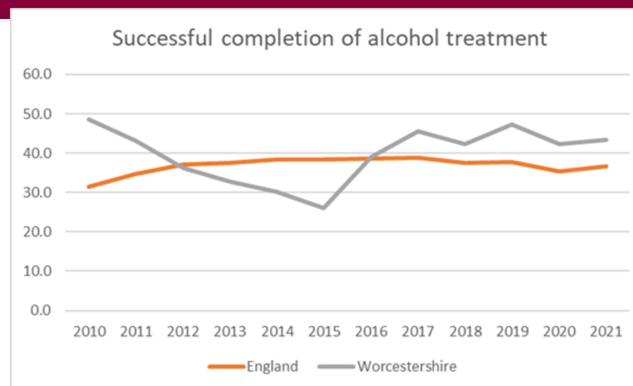
Alcohol treatment

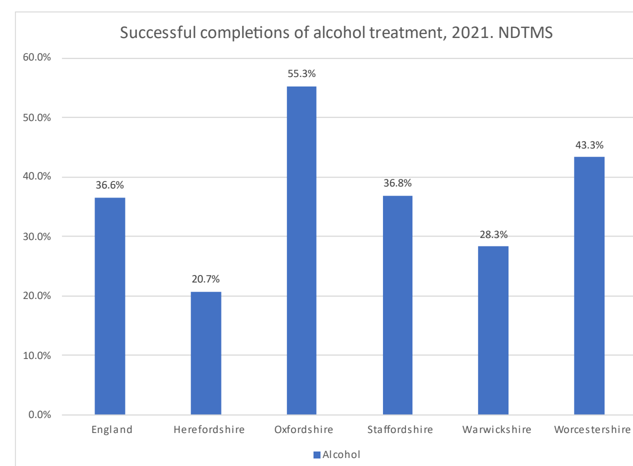
- Successful completion of alcohol treatment after 6 months has been improving in since 2015, remaining significantly better than national figures and better than most other similar authorities.

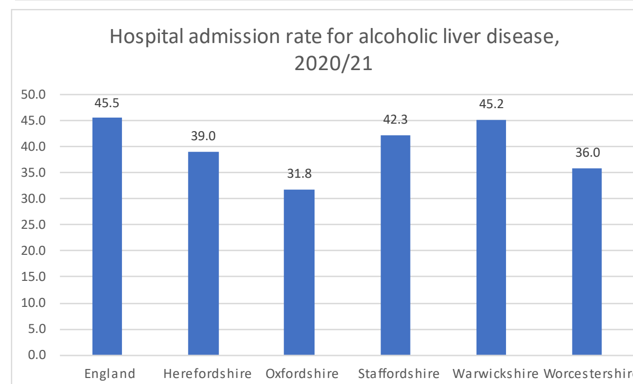
- The latest activity data for 2021 shows 43.3% of completions of alcohol treatment were successful, compared with 36.6% nationally.

- In 2020/21 there were 777 people in treatment for alcohol and 190 for non opiate and alcohol combined.

- The hospital admission rate for alcoholic liver disease is 36 per 100,000, significantly below the national value of 45.5







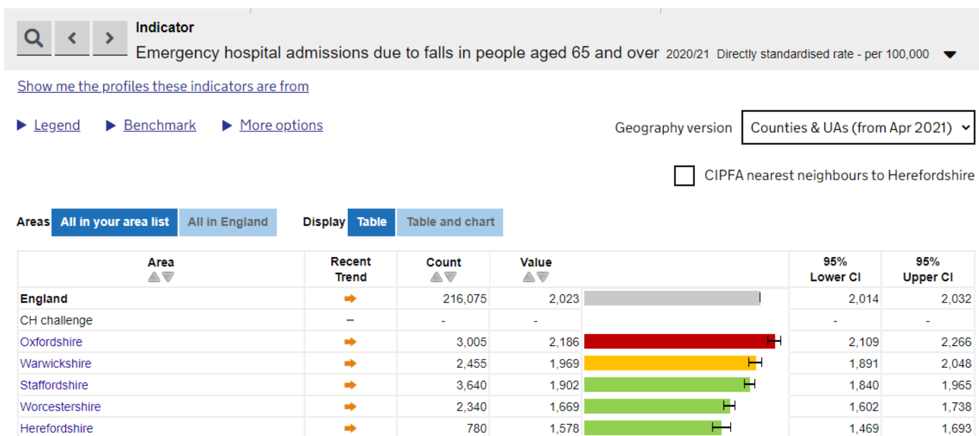
Lifestyle and behaviour change service

- The Lifestyle Service supports service users to make positive changes to their lifestyle (diet, physical activity, smoking, alcohol)
- Lifestyle advisors are embedded within General Practice
- Service outcomes for 2021/22:
  - Percentage of those signed off that have achieved an improvement in at least one health measure = 100%
  - Percentage that have increased their physical activity levels = 91%
  - Percentage that have reduced their BMI = 79%
  - Percentage that have quit smoking = 6%
  - Percentage of those that have maintained achievement of main health goal at 12 months = 82%

Lifestyle Service participants		2021/22
No. of people referred to the service		2188
No. of people who have had contact with an advisor		1874
No. of people accessing for support with…	Diet	421
	Physical Activity	243
	Smoking	229
	Alcohol	76
	Weight Management	1159
	Mental Wellbeing	160

Falls prevention

- Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes
- The Strong and Steady service aims to reduce falls in older people, through the co-ordination and delivery of evidence based strong and steady exercise classes
- The Strong & Steady programme activity shown on the right contributes to falls prevention measured by hospital admission (below)
- Admission rates in Worcestershire are below the national level, and similar to comparable areas



Indicator
Emergency hospital admissions due to falls in people aged 65 and over 2020/21 Directly standardised rate - per 100,000

Show me the profiles these indicators are from

Legend | Benchmark | More options | Geography version: Counties & UAs (from Apr 2021)

CIPFA nearest neighbours to Herefordshire

Areas: All in your area list | All in England — Display: Table | Table and chart

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England		216,075	2,023	2,014	2,032
CH challenge	–	-	-	-	-
Oxfordshire		3,005	2,186	2,109	2,266
Warwickshire		2,455	1,969	1,891	2,048
Staffordshire		3,640	1,902	1,840	1,965
Worcestershire		2,340	1,669	1,602	1,738
Herefordshire		780	1,578	1,469	1,693

Strong & Steady	2021/2022				
	Q1	Q2	Q3	Q4	Total
Total Referrals	72	160	119	213	**564**
Total amount of people attending first session	340	45	143	109	**637**
Total amount of people attending 10 sessions	8	15	29	79	**131**
Total amount of people attending 15 sessions or more	0	96	34	46	**176**
Number of active strong & steady classes	25	52	58	56	**191**

Starting Well Service (0-19s Prevention)

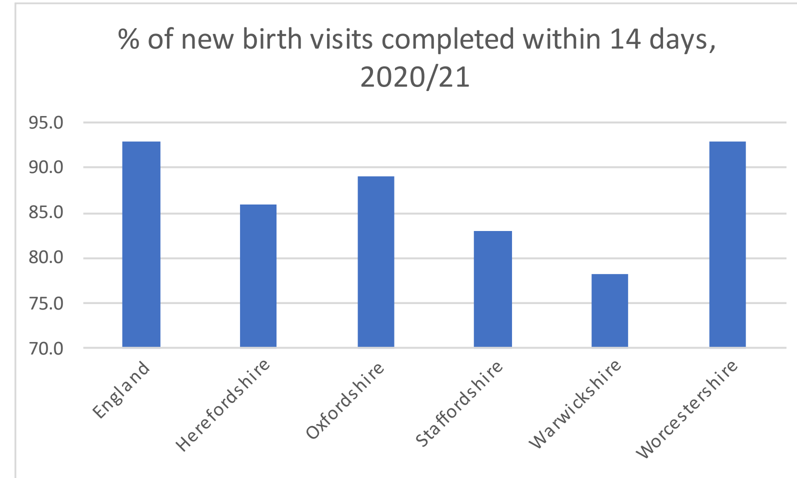
- All infants and their families are eligible to receive a visit led by a health visitor within the first two weeks from birth – which is known as the **New Birth Visit (NBV).** This visit forms part of the Healthy Child Programme of support. In 2020/21 Worcestershire performed significantly better than similar counties. (Latest activity data (2021/22): 5081 visits were completed within 14 days, 90% of all visits)

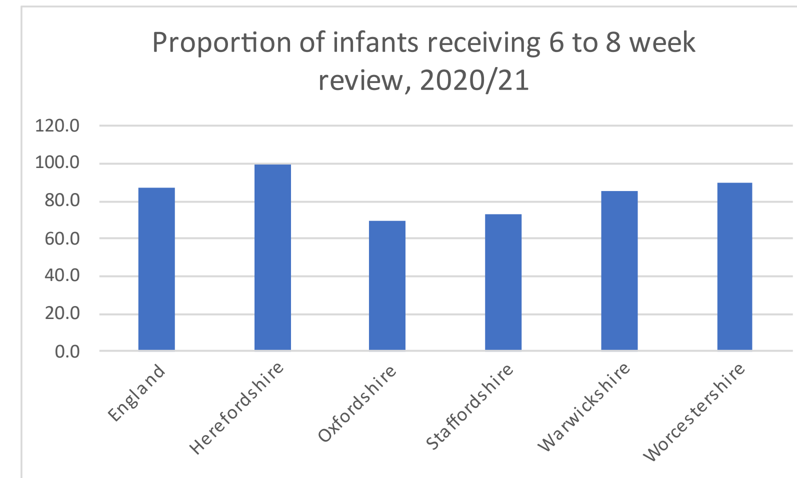
- The **6-to-8-week review** is also an opportunity for support with breastfeeding if required, and allows an assessment of mother's mental health. In 2020/21 Worcestershire performed significantly better than similar counties. (Latest activity data (2021/22): 5121 infants received a 6-to-8 week review, 91.4% of all infants)

- **Breastfeeding** has considerable health benefits for infant and mother. In 2019/20, breastfeeding prevalence was similar to England but lower than similar local authorities.

- **Parenting** support - Total Number of all parents receiving Face to Face or Group Parenting Support = 3,154 in 2021/22

- The service provides 12 month and 2.5 year developmental reviews. **Children's progress** is measured in the five domains of communication, gross motor, fine motor, problem solving and personal-social skills. The proportion of children at or above the expected level of development at age 2.5 is higher than England and comparator local authorities.





Domestic Abuse

- The rate of domestic abuse-related incidents and crimes in West Mercia is similar to nationally in 2020/21 at 30.4 per 100,000 (England=30.3)
- New duties under Domestic Abuse Act 2021. All governance and required statutory processes are up and running.

Domestic Abuse Advice and Support Service (DAASS)

- 29 new units of safe accommodation are being sourced through the District Council's with 15 secured by end of Q2 2022/23

	Group Work	Helpline Support	One to One Support	Refuge	Male Victim Service
Referrals	630	1139	187	224	70
Entered Service/ Support	432	1139	112	44	42

- **DRIVE (Domestic Abuse Perpetrator Programme)**
  - funded by the PCC and Public Health. In 2021/2 Drive dealt with:
    - 104 perpetrators
    - 109 associated victims for whom there were 253 associated children
- **Domestic Abuse Training (WCC Staff and partners)**

  Q1 2022/23 report:
    - April – July 2022
    - Module 1 – 5 sessions/ 78 attendees
    - Module 2 – 4 sessions/ 54 attendees
    - Module 3 – 4 sessions/ 39 attendees

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Office for Health Improvement & Disparities

Public Health Outcomes Framework - at a glance summary

Worcestershire

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Key

Significance compared to goal / England average:

Significantly worse	Significantly lower	Increasing / Getting worse	Increasing / Getting better
Not significantly different	Significantly higher	Decreasing / Getting worse	Decreasing / Getting better
Significantly better	Significance not tested	Increasing	Decreasing
		No significant change	Could not be calculated

Notes

- Indicators that are shaded blue rather than red/amber/green are presented in this way because it is not straightforward to determine for these indicators whether a high value is good or bad.
- The Change from previous column shows whether there has been a change in value compared to the previous data point. Statistically significant changes highlighted in this column have been calculated by comparing the confidence intervals for the respective time points. If the confidence intervals do not overlap, the change has been flagged as significant.
- Recent trend refers to the analysis done in the Fingertips tool which tests for a statistical trend. Changes in this column are calculated using a chi-squared statistical test for trend. This is currently only available for certain indicator types; full details are available in the tool.
- Increases or decreases are only shown if they are statistically significant. Where no arrow is shown, no comparison has been made. This may be due to the fact that the required data to make the comparison is not available for the time point, or that no confidence interval values are available for the indicator.

A. Overarching indicators

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
A01a - Healthy life expectancy at birth	All ages	Male	2018 - 20	65.3	63.1	Years	–	→
A01a - Healthy life expectancy at birth	All ages	Female	2018 - 20	66.2	63.9	Years	–	→
A01b - Life expectancy at birth	All ages	Male	2020	79.6	78.7	Years	–	→
A01b - Life expectancy at birth	All ages	Female	2020	82.9	82.6	Years	–	→
A01c - Disability-free life expectancy at birth	All ages	Male	2018 - 20	64.7	62.4	Years	–	→
A01c - Disability-free life expectancy at birth	All ages	Female	2018 - 20	63.7	60.9	Years	–	→
A02a - Inequality in life expectancy at birth	All ages	Male	2018 - 20	7.90	9.70	Years	–	→
A02a - Inequality in life expectancy at birth	All ages	Female	2018 - 20	5.60	7.90	Years	–	→
A02c - Inequality in healthy life expectancy at birth LA	All ages	Male	2009 - 13	11.8	-	Years	–	–
A02c - Inequality in healthy life expectancy at birth LA	All ages	Female	2009 - 13	11.5	-	Years	–	–
A01a - Healthy life expectancy at 65	65	Male	2018 - 20	11.3	10.5	Years	–	→
A01a - Healthy life expectancy at 65	65	Female	2018 - 20	12.9	11.3	Years	–	→
A01b - Life expectancy at 65	65	Male	2020	18.5	18.1	Years	–	↓
A01b - Life expectancy at 65	65	Female	2020	20.9	20.7	Years	–	↓
A01c - Disability-free life expectancy at 65	65	Male	2018 - 20	10.7	9.84	Years	–	→
A01c - Disability-free life expectancy at 65	65	Female	2018 - 20	10.6	9.87	Years	–	→
A02a - Inequality in life expectancy at 65	65	Male	2018 - 20	4.30	5.20	Years	–	→
A02a - Inequality in life expectancy at 65	65	Female	2018 - 20	3.10	4.80	Years	–	→

B. Wider determinants of health

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
B01b - Children in absolute low income families (under 16s)	<16 yrs	Persons	**2020/21**	**13.0**	**15.1**	%	↑	→
B01b - Children in relative low income families (under 16s)	<16 yrs	Persons	**2020/21**	**16.5**	**18.5**	%	↑	→
B02a - School readiness: percentage of children achieving a good level of development at the end of Reception	5 yrs	Persons	**2018/19**	**72.0**	**71.8**	%	↑	→
B02a - School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	5 yrs	Persons	**2018/19**	**51.5**	**56.5**	%	→	→
B02b - School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	**2018/19**	**82.0**	**81.8**	%	↑	→
B02b - School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	**2018/19**	**65.5**	**70.1**	%	→	→
B02c - School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	5 yrs	Persons	**2018/19**	**82.2**	**82.2**	%	→	→
B02d - School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	5 yrs	Persons	**2018/19**	**72.8**	**72.6**	%	↑	→
B03 - Pupil absence	5-15 yrs	Persons	**2020/21**	**4.56**	**4.62**	%	–	→
B04 - First time entrants to the youth justice system	10-17 yrs	Persons	**2021**	**56.3**	**146.9**	per 100,000	↓	→
B05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known	16-17 yrs	Persons	**2020**	**5.88**	**5.48**	%	↑	→
B06a - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	Persons	**2020/21**	**83.5**	**78.3**	%	↑	→
B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	18-69 yrs	Persons	**2020/21**	**65.0**	**58.0**	%	–	→
B08a - Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	16-64 yrs	Persons	**2021/22**	**4.28**	**9.86**	Percentage points	–	→
B08a - The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64)	16-64 yrs	Persons	**2021/22**	**71.9**	**65.5**	%	–	→
B08b - Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	18-64 yrs	Persons	**2020/21**	**72.9**	**70.0**	Percentage points	–	→
B08b - The percentage of the population who are in receipt of long term support for a learning disability that are in paid employment (aged 18 to 64)	18-64 yrs	Persons	**2020/21**	**4.99**	**5.14**	%	→	→
B08c - Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate	18-69 yrs	Persons	**2020/21**	**62.9**	**66.1**	Percentage points	–	→
B08c - The percentage of the population who are in contact with secondary mental health services and on the Care Plan Approach, that are in paid employment (aged 18 to 69)	18-69 yrs	Persons	**2020/21**	**15.0**	**9.00**	%	–	–
B08d - Percentage of people in employment	16-64 yrs	Persons	**2021/22**	**76.2**	**75.4**	%	→	→
B09a - Sickness absence - the percentage of employees who had at least one day off in the previous week	16+ yrs	Persons	**2018 - 20**	**1.65**	**1.92**	%	–	→
B09b - Sickness absence - the percentage of working days lost due to sickness absence	16+ yrs	Persons	**2018 - 20**	**0.88**	**1.02**	%	–	→

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
B10 - Killed and seriously injured (KSI) casualties on England's roads	All ages	Persons	**2020**	**48.1**	**86.1 $**	per billion vehicle miles	–	→
B11 - Domestic abuse-related incidents and crimes	16+ yrs	Persons	**2020/21**	**30.4 @**	**30.3**	per 1,000	–	–
B12a - Violent crime - hospital admissions for violence (including sexual violence)	All ages	Persons	**2018/19 - 20/21**	**23.5**	**41.9**	per 100,000	–	→
B12b - Violent crime - violence offences per 1,000 population	All ages	Persons	**2021/22**	**28.9 ~**	**34.9 ~**	per 1,000	↑	↑
B12c - Violent crime - sexual offences per 1,000 population	All ages	Persons	**2021/22**	**2.91 ~**	**3.03 ~**	per 1,000	→	↑
B13a - Re-offending levels - percentage of offenders who re-offend	All ages	Persons	**2019/20**	**26.3**	**25.4**	%	–	–
B13b - Re-offending levels - average number of re-offences per re-offender	All ages	Persons	**2019/20**	**4.70**	**3.74**	per re-offender	–	–
B13c - First time offenders	10+ yrs	Persons	**2021**	**128.1**	**166.3**	per 100,000	↓	↓
B14a - The rate of complaints about noise	All ages	Persons	**2019/20**	**2.33 $**	**6.37 $**	per 1,000	–	↓
B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	All ages	Persons	**2016**	**4.06**	**5.50**	%	–	–
B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	All ages	Persons	**2016**	**7.48**	**8.48**	%	–	–
B15a - Homelessness - households owed a duty under the Homelessness Reduction Act	Not applicable	Not applicable	**2020/21**	**8.52 ~**	**11.3**	per 1,000	–	↓
B15c - Homelessness - households in temporary accommodation	Not applicable	Not applicable	**2020/21**	**0.51 ~**	**4.03**	per 1,000	–	→
B16 - Utilisation of outdoor space for exercise/health reasons	16+ yrs	Persons	**Mar 2015 - Feb 2016**	**14.2**	**17.9**	%	–	→
B17 - Fuel poverty (low income, low energy efficiency methodology)	Not applicable	Not applicable	**2020**	**14.5**	**13.2**	%	–	–
B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like	18+ yrs	Persons	**2019/20**	**49.6**	**45.9**	%	–	→
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	18+ yrs	Persons	**2018/19**	**28.7**	**32.5**	%	–	↓
B19 - Loneliness: Percentage of adults who feel lonely often / always or some of the time	16+ yrs	Persons	**2019/20**	**22.5**	**22.3**	%	–	–
1.01i - Children in low income families (all dependent children under 20)	0-19 yrs	Persons	**2016**	**14.1**	**17.0**	%	→	↑

C. Health improvement

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
C01 - Total prescribed LARC excluding injections rate / 1,000	All ages	Female	2020	41.7	34.6	per 1,000	→	↓
C02a - Under 18s conception rate / 1,000	<18 yrs	Female	2020	12.8	13.0	per 1,000	→	→
C02b - Under 16s conception rate / 1,000	<16 yrs	Female	2020	1.78	2.03	per 1,000	→	→
C03a - Obesity in early pregnancy	Not applicable	Female	2018/19	23.3	22.1	%	–	–
C03c - Smoking in early pregnancy	Not applicable	Female	2018/19	14.2	12.8	%	–	–
C04 - Low birth weight of term babies	=37 weeks gestational age at birth	Persons	2020	2.79	2.86	%	→	→
C05a - Baby's first feed breastmilk	Newborn	Persons	2018/19	59.6	67.4	%	–	→
C06 - Smoking status at time of delivery	All ages	Female	2021/22	10.8	9.10	%	↓	→
C07 - Proportion of New Birth Visits (NBVs) completed within 14 days	<14 days	Persons	2021/22	90.2	82.6	%	↓	↓
C08a - Child development: percentage of children achieving a good level of development at 2 to 2½ years	2-2.5 yrs	Persons	2021/22	87.6	80.9	%	→	↓
C08b - Child development: percentage of children achieving the expected level in communication skills at 2 to 2½ years	2-2.5 yrs	Persons	2021/22	91.8	86.2	%	↓	↓
C08c - Child development: percentage of children achieving the expected level in personal social skills at 2 to 2½ years	2-2.5 yrs	Persons	2021/22	95.2	90.8	%	–	–
C09a - Reception: Prevalence of overweight (including obesity)	4-5 yrs	Persons	2019/20	- ^	23.0	%	–	–
C09b - Year 6: Prevalence of overweight (including obesity)	10-11 yrs	Persons	2019/20	- ^	35.2	%	–	–
C10 - Percentage of physically active children and young people	5-16 yrs	Persons	2020/21	43.1	44.6	%	–	→
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	<15 yrs	Persons	2020/21	68.1	75.7	per 10,000	↓	→
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	0-4 yrs	Persons	2020/21	93.4	108.7	per 10,000	→	→
C11b - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	15-24 yrs	Persons	2020/21	91.0	112.4	per 10,000	→	→
C12 - Percentage of looked after children whose emotional wellbeing is a cause for concern	5-16 yrs	Persons	2020/21	36.1	36.8	%	→	→
C14b - Emergency Hospital Admissions for Intentional Self-Harm	All ages	Persons	2020/21	174.5	181.2	per 100,000	→	→
C15 - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	16+ yrs	Persons	2019/20	57.2	55.4	%	–	→
C16 - Percentage of adults (aged 18+) classified as overweight or obese	18+ yrs	Persons	2020/21	64.2	63.5	%	–	→
C17a - Percentage of physically active adults	19+ yrs	Persons	2020/21	67.2	65.9	%	–	→
C17b - Percentage of physically inactive adults	19+ yrs	Persons	2020/21	21.5	23.4	%	–	→
C18 - Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)	18+ yrs	Persons	2020	11.1	12.1	%	–	–
C19a - Successful completion of drug treatment - opiate users	18+ yrs	Persons	2020	5.00	4.74	%	→	→
C19b - Successful completion of drug treatment - non-opiate users	18+ yrs	Persons	2020	35.0	33.0	%	→	→
C19c - Successful completion of alcohol treatment	18+ yrs	Persons	2020	42.4	35.3	%	→	→
C19d - Deaths from drug misuse	All ages	Persons	2018 - 20	4.19	5.02	per 100,000	–	→
C20 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	18+ yrs	Persons	2021/22	25.2	37.4	%	→	→

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
C21 - Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.	All ages	Persons	**2020/21**	**465.2**	**455.9**	per 100,000	→	↓
C22 - Estimated diabetes diagnosis rate	17+ yrs	Persons	**2018**	**80.1**	**78.0**	%	–	→
C23 - Percentage of cancers diagnosed at stages 1 and 2	All ages	Persons	**2019**	**58.4**	**55.0**	%	→	→
C24a - Cancer screening coverage: breast cancer	53-70 yrs	Female	**2021**	**66.4 ~**	**64.1 ~**	%	↓	↓
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	25-49 yrs	Female	**2021**	**73.2 ~**	**68.0 ~**	%	↑	↓
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	50-64 yrs	Female	**2021**	**77.5 ~**	**74.7 ~**	%	→	↓
C24d - Cancer screening coverage: bowel cancer	60-74 yrs	Persons	**2021**	**65.1 ~**	**65.2 ~**	%	↑	↓
C24e - Abdominal Aortic Aneurysm Screening Coverage	65	Male	**2020/21**	**46.7 ~**	**55.0 ~**	%	↓	↓
C24m - Newborn Hearing Screening: Coverage	<1 yr	Persons	**2020/21**	**98.1**	**97.5 ~**	%	–	→
C24n - Newborn and Infant Physical Examination Screening Coverage	<1 yr	Persons	**2020/21**	**98.0**	**97.3 ~**	%	–	–
C26a - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	40-74 yrs	Persons	**2017/18 - 21/22**	**93.7**	**63.3**	%	–	
C26b - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	40-74 yrs	Persons	**2017/18 - 21/22**	**32.5**	**44.8**	%	–	↓
C26c - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	40-74 yrs	Persons	**2017/18 - 21/22**	**30.4**	**28.4**	%	–	↓
C27 - Percentage reporting a long-term Musculoskeletal (MSK) problem	16+ yrs	Persons	**2021**	**17.7**	**17.0**	%	–	↓
C28a - Self-reported wellbeing - people with a low satisfaction score	16+ yrs	Persons	**2020/21**	**- &**	**6.06**	%	–	–
C28b - Self-reported wellbeing - people with a low worthwhile score	16+ yrs	Persons	**2020/21**	**- &**	**4.38**	%	–	–
C28c - Self-reported wellbeing - people with a low happiness score	16+ yrs	Persons	**2020/21**	**7.79**	**9.21**	%	–	→
C28d - Self-reported wellbeing - people with a high anxiety score	16+ yrs	Persons	**2020/21**	**21.0**	**24.2**	%	–	→
C29 - Emergency hospital admissions due to falls in people aged 65 and over	65+ yrs	Persons	**2020/21**	**1669**	**2023**	per 100,000	→	↓
C29 - Emergency hospital admissions due to falls in people aged 65-79	65-79 yrs	Persons	**2020/21**	**753.6**	**936.6**	per 100,000	→	↓
C29 - Emergency hospital admissions due to falls in people aged 80+	80+ yrs	Persons	**2020/21**	**4322**	**5174**	per 100,000	→	↓
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method	6-8 weeks	Persons	**2021/22**	**47.6**	**49.3**	%	–	–

D. Health protection

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
D01 - Fraction of mortality attributable to particulate air pollution (new method)	30+ yrs	Persons	2020	4.96	5.64	%	–	–
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Persons	2021	953.1	1334	per 100,000	↓	→
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Male	2021	510.4	859.8	per 100,000	↓	→
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Female	2021	1226	1762	per 100,000	↓	→
D02b - New STI diagnoses (excluding chlamydia aged under 25) per 100,000	All ages	Persons	2021	215.7	394.5	per 100,000	↓	↑
D03b - Population vaccination coverage: Hepatitis B (1 year old)	1 yr	Persons	2021/22	100.0	- x	%	–	→
D03c - Population vaccination coverage: Dtap IPV Hib (1 year old)	1 yr	Persons	2021/22	95.7 *	91.8 *	%	↑	→
D03d - Population vaccination coverage: MenB (1 year)	1 yr	Persons	2021/22	95.4 *	91.5 *	%	↑	→
D03e - Population vaccination coverage: Rotavirus (Rota) (1 year)	1 yr	Persons	2021/22	94.6 *	89.9 *	%	↑	→
D03f - Population vaccination coverage: PCV	1 yr	Persons	2019/20	95.7 *	93.2 *	%	→	↑
D03g - Population vaccination coverage: Hepatitis B (2 years old)	2 yrs	Persons	2021/22	100.0	- x	%	–	→
D03h - Population vaccination coverage: Dtap IPV Hib (2 years old)	2 yrs	Persons	2021/22	96.4 *	93.0 *	%	↑	→
D03i - Population vaccination coverage: MenB booster (2 years)	2 yrs	Persons	2021/22	93.3 *	88.0 *	%	–	→
D03j - Population vaccination coverage: MMR for one dose (2 years old)	2 yrs	Persons	2021/22	94.1 *	89.2 *	%	↑	→
D03k - Population vaccination coverage: PCV booster	2 yrs	Persons	2021/22	93.7 *	89.3 *	%	↑	→
D03l - Population vaccination coverage: Flu (2 to 3 years old)	2-3 yrs	Persons	2021/22	57.8 *	50.1 *	%	↑	↓
D03m - Population vaccination coverage: Hib and MenC booster (2 years old)	2 yrs	Persons	2021/22	93.7 *	89.0 *	%	↑	→
D04a - Population vaccination coverage: DTaP and IPV booster (5 years)	5 yrs	Persons	2021/22	91.2 *	84.2 *	%	↑	→
D04b - Population vaccination coverage: MMR for one dose (5 years old)	5 yrs	Persons	2021/22	95.9 *	93.4 *	%	↓	→
D04c - Population vaccination coverage: MMR for two doses (5 years old)	5 yrs	Persons	2021/22	91.5 *	85.7 *	%	→	→
D04d - Population vaccination coverage: Flu (primary school aged children)	4-11 yrs	Persons	2021	72.9 *	57.4 *	%	–	→
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	12-13 yrs	Female	2020/21	92.5 *	76.7 *	%	→	↑
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	12-13 yrs	Male	2020/21	88.3 *	71.0 *	%	–	↑
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	13-14 yrs	Female	2020/21	75.0 *	60.6 *	%	↓	↑
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	14-15 yrs	Persons	2020/21	88.7 *	80.9 *	%	↑	↓
D05 - Population vaccination coverage: Flu (at risk individuals)	6 months-64 yrs	Persons	2021/22	59.7 *	52.9 *	%	↑	↓
D06a - Population vaccination coverage: Flu (aged 65 and over)	65+ yrs	Persons	2021/22	85.7 *	82.3 *	%	↑	↑
D06b - Population vaccination coverage: PPV	65+ yrs	Persons	2020/21	74.2 *	70.6 *	%	→	↑
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)	71	Persons	2019/20	51.0 *	48.2 *	%	–	↓
D07 - HIV late diagnosis in people first diagnosed with HIV in the UK	15+ yrs	Persons	2019 - 21	37.5 *	43.4 *	%	–	→
D08a - Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	All ages	Persons	2019	66.7	82.0	%	–	→
D08b - TB incidence (three year average)	All ages	Persons	2018 - 20	3.04	7.96	per 100,000	–	→
D09 - NHS organisations with a board approved sustainable development management plan	Not applicable	Not applicable	2015/16	50.0	66.2	%	→	→
D10 - Adjusted antibiotic prescribing in primary care by the NHS	All ages	Persons	2021	0.91 *	0.74 *	per STAR-PU	–	↑

E. Healthcare and premature mortality

Indicator	Age	Sex	Period	Value	Value (England)	Unit	Recent trend	Change from previous
E01 - Infant mortality rate	<1 yr	Persons	**2018 - 20**	**5.08**	**3.90**	per 1,000	–	→
E02 - Percentage of 5 year olds with experience of visually obvious dental decay	5 yrs	Persons	**2018/19**	**17.5**	**23.4**	%	–	↓
E03 - Under 75 mortality rate from causes considered preventable (2019 definition)	<75 yrs	Persons	**2020**	**128.2**	**140.5**	per 100,000	→	→
E04a - Under 75 mortality rate from all cardiovascular diseases	<75 yrs	Persons	**2020**	**64.4**	**73.8**	per 100,000	→	→
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition)	<75 yrs	Persons	**2020**	**26.2**	**29.2**	per 100,000	→	→
E05a - Under 75 mortality rate from cancer	<75 yrs	Persons	**2020**	**123.3**	**125.1**	per 100,000	→	→
E05b - Under 75 mortality rate from cancer considered preventable (2019 definition)	<75 yrs	Persons	**2020**	**50.7**	**51.5**	per 100,000	→	→
E06a - Under 75 mortality rate from liver disease	<75 yrs	Persons	**2020**	**18.4**	**20.6**	per 100,000	→	→
E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition)	<75 yrs	Persons	**2020**	**16.6**	**18.2**	per 100,000	→	→
E07a - Under 75 mortality rate from respiratory disease	<75 yrs	Persons	**2020**	**28.2**	**29.4**	per 100,000	→	→
E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition)	<75 yrs	Persons	**2020**	**16.6**	**17.1**	per 100,000	→	→
E08 - Mortality rate from a range of specified communicable diseases, including influenza	All ages	Persons	**2020**	**7.49**	**8.25**	per 100,000	→	→
E09a - Premature mortality in adults with severe mental illness (SMI)	18-74 yrs	Persons	**2018 - 20**	**81.6**	**103.6**	per 100,000	–	→
E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI)	18-74 yrs	Persons	**2018 - 20**	**341.7**	**389.9**	%	–	→
E10 - Suicide rate	10+ yrs	Persons	**2019 - 21**	**12.0**	**10.4**	per 100,000	–	→
E11 - Emergency readmissions within 30 days of discharge from hospital	All ages	Persons	**2020/21**	**- x**	**15.5**	%	–	–
E12a - Preventable sight loss - age related macular degeneration (AMD)	65+ yrs	Persons	**2020/21**	**73.5**	**82.0**	per 100,000	→	→
E12b - Preventable sight loss - glaucoma	40+ yrs	Persons	**2020/21**	**7.15**	**9.20**	per 100,000	→	→
E12c - Preventable sight loss - diabetic eye disease	12+ yrs	Persons	**2020/21**	**2.31**	**0.92**	per 100,000	→	→
E12d - Preventable sight loss - sight loss certifications	All ages	Persons	**2020/21**	**31.1**	**29.2**	per 100,000	→	↓
E13 - Hip fractures in people aged 65 and over	65+ yrs	Persons	**2020/21**	**686.7**	**528.7**	per 100,000	↑	→
E13 - Hip fractures in people aged 65-79	65-79 yrs	Persons	**2020/21**	**263.5**	**219.3**	per 100,000	↑	→
E13 - Hip fractures in people aged 80+	80+ yrs	Persons	**2020/21**	**1914**	**1426**	per 100,000	↑	→
E14 - Excess winter deaths index	All ages	Persons	**Aug 2019 - Jul 2020**	**17.2**	**17.4**	%	–	→
E14 - Excess winter deaths index (age 85+)	85+ yrs	Persons	**Aug 2019 - Jul 2020**	**28.1**	**20.8**	%	–	→
E15 - Estimated dementia diagnosis rate (aged 65 and over)	65+ yrs	Persons	**2022**	**51.8 ***	**62.0 ***	%	→	→

Accompanying indicator value notes

symbols	Data note
*	Value compared to a goal (see below)
~	Aggregated from all known lower geography values
$	Value is modelled or synthetic estimate
^	Value suppressed due to incompleteness of source data
&	Value missing due to small sample size
x	Value missing in source data
@	LAs are allocated the rate of the police force area within which they sit
[a]	Value not published for data quality reasons

Thresholds for indicators that are compared against a goal

Indicator Name	Green	Amber	Red
D03c - Population vaccination coverage: Dtap IPV Hib (1 year old)	>= 95%	90-95%	< 90%
D03d - Population vaccination coverage: MenB (1 year)	>= 95%	90-95%	< 90%
D03e - Population vaccination coverage: Rotavirus (Rota) (1 year)	>= 95%	90-95%	< 90%
D03f - Population vaccination coverage: PCV	>= 95%	90-95%	< 90%
D03h - Population vaccination coverage: Dtap IPV Hib (2 years old)	>= 95%	90-95%	< 90%
D03i - Population vaccination coverage: MenB booster (2 years)	>= 95%	90-95%	< 90%
D03j - Population vaccination coverage: MMR for one dose (2 years old)	>= 95%	90-95%	< 90%
D03k - Population vaccination coverage: PCV booster	>= 95%	90-95%	< 90%
D03l - Population vaccination coverage: Flu (2 to 3 years old)	>= 65%	40-65%	< 40%
D03m - Population vaccination coverage: Hib and MenC booster (2 years old)	>= 95%	90-95%	< 90%
D04a - Population vaccination coverage: DTaP and IPV booster (5 years)	>= 95%	90-95%	< 90%
D04b - Population vaccination coverage: MMR for one dose (5 years old)	>= 95%	90-95%	< 90%
D04c - Population vaccination coverage: MMR for two doses (5 years old)	>= 95%	90-95%	< 90%
D04d - Population vaccination coverage: Flu (primary school aged children)	>= 65%		<65%
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	>= 90%	80-90%	< 80%
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	>= 90%	80-90%	< 80%
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	>= 90%	80-90%	< 80%
D05 - Population vaccination coverage: Flu (at risk individuals)	>= 55%		< 55%
D06a - Population vaccination coverage: Flu (aged 65 and over)	>= 75%		< 75%
D06b - Population vaccination coverage: PPV	>= 75%	65-75%	< 65%
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)	>= 60%	50-60%	< 50%
D07 - HIV late diagnosis in people first diagnosed with HIV in the UK	< 25%	25-50%	>= 50%
D10 - Adjusted antibiotic prescribing in primary care by the NHS	<= mean England prescribing (2013/14)		> mean England prescribing (2013/14)
E15 - Estimated dementia diagnosis rate (aged 65 and over)	>= 66.7% (significantly)	Similar to 66.7%	< 66.7% (significantly)

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
13 JANUARY 2023

HEALTH INEQUALITIES AND IMPACTS RESULTING FROM THE COVID-19 PANDEMIC

Summary

1. The Health Overview and Scrutiny Committee (HOSC) will receive an overview of health inequalities and impacts resulting from the COVID-19 pandemic.

2. As well as being part of the HOSC's work programme, health impacts of the pandemic was also highlighted at a meeting of Council in January 2022 through a Notice of Motion and Council agreed that the HOSC should be asked to consider the issues raised (details of the Council meeting can be found in the background papers of this report).

3. The Cabinet Member with Responsibility for Health and Wellbeing and the Director of Public Health have been invited to the meeting.

Background

4. The impacts of COVID-19 have not been felt equally across the population and has exacerbated existing health inequalities, with elevated risk including:

   - Pre-existing disease
   - Risk of exposure
   - Experience of lockdown
   - Changes in provision or access to health, social care, and essential services
   - Socio-economic status
   - Socio-economic consequences
   - Ethnicity.

5. Locally, several ethnic groups have had high numbers of cases and data suggests a strong relationship between death from COVID-19, older age, and male gender. During the first 18 months of the pandemic to September 2021, there was a clear elevated risk of infections amongst non-white British groups (full details in supporting information):

   i. Any other Black/African/Caribbean group
   ii. Other ethnic groups
   iii. African
   iv. Any other Asian background
   v. Indian
   vi. Any other Mixed Background
   vii. Pakistani

6. There is also some evidence of a relationship between deprivation and death from COVID-19 in the older age group (65-plus) and that the death rate may have been higher in urban areas. Unfortunately, local data on the ethnicity of those who have died is incomplete meaning this analysis is not possible. In Worcestershire, a person's COVID-19 vaccination status has been highly associated with their level of deprivation, as measured by where they live, and several ethnic groups have a lower uptake.

Long COVID

7. An estimated 2.2 million people living in private households in the UK (3.4% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first confirmed or suspected coronavirus (COVID-19) infection that were not explained by something else) as of 6 November 2022.

8. Long COVID symptoms adversely affect the day-to-day activities of 1.6 million people (75% of those with self-reported long COVID), with 370,000 (17%) reporting that their ability to undertake their day-to-day activities had been "limited a lot".

9. As a proportion of the UK population, the prevalence of self-reported long COVID was greatest in people aged 35 to 69 years, females, people living in more deprived areas, those working in social care, those aged 16 years or over who were not working and not looking for work, and those with another activity-limiting health condition or disability.

10. Estimates for Worcestershire are not available but if prevalence reflected national levels the county would have 20,000 people with long Covid, of whom 15,000 having symptoms which adversely affected their day-to-day activities.

Indirect impacts of COVID-19

11. Other impacts associated with COVID-19 are those indirectly caused by the pandemic which include:

    Education

    a. The impact of missed education has disproportionately fallen on those children living in areas of enduring transmission and from poorer backgrounds. Pupils that are disadvantaged tend to have lower educational attainment than their peers – this is termed the disadvantage gap. The gap occurs because disadvantaged pupils tend to have less access to technology, spend less time learning and have reduced support from parents and carers.

    b. Experiences of teaching and learning during the pandemic were diverse, but disadvantage and deprivation appear to be most associated with less effective learning and overall learning losses.

    Alcohol consumption

c. In July 2021 Public Health England (PHE) published a report on the trends in alcohol consumption and harm. The findings show an increase in total alcohol-specific deaths, driven by an unprecedented annual increase in alcoholic liver disease deaths above levels seen pre-pandemic.

d. Despite pubs, clubs and restaurants closing for approximately 31 weeks during the national lockdowns, the total amount of alcohol released for sale during the pandemic was still similar to the pre-pandemic years which suggests people were drinking more at home.

Physical Activity

e. Nationally, a reduction in physical activity levels has been seen, particularly for people in Black and Asian groups and lower socioeconomic groups.

f. The 2021/22 National Child Measurement Programme data indicates that the proportion of Year 6 children in Worcestershire who are overweight or obese has increased from the 2018/19 level from 36.1% to 38.7% for boys and 29.3% to 33.0% for girls. This could be a consequence of reduced physical activity and poorer diet (rates for reception children have remained largely unchanged).

Mental health

g. There is evidence from both national and local level data of a decline in mental wellbeing during the pandemic. These changes have not been equally experienced across the population with those in deprived areas and certain ethnic groups being particularly affected.

h. Direct effects to mental health include those due to bereavement and long Covid, indirect effects from the measures implemented to control the virus such as lockdowns and school closures.

12. Further information about health inequalities resulting from the COVID-19 pandemic in Worcestershire and nationally, is included at Appendix 1

Conclusion

13. The analysis shows significant inequalities in Covid-19 infection, death and vaccination, at both national and local level. In terms of wider impacts to health and wellbeing such as in mental health, education and alcohol consumption, national research and local evidence indicates that people in deprived groups have been most affected.

Equality and Diversity Implications

14. This Report has summarised some of the known impacts of the COVID-19 pandemic as reported previously in the Joint Strategic Needs Assessment for Worcestershire, including impact on health inequalities and differential risk.

Purpose of the Meeting

15. The HOSC is asked to:

- consider and comment on the information provided on health inequalities and impacts from the COVID-19 pandemic, specifically, consideration should be given to the multiple risks facing our Worcestershire's most deprived populations including higher risk of disease, higher risk of mortality, and lower vaccination uptake.
- agree any comments to highlight to the Cabinet Member for Health and Wellbeing
- determine whether any further information or scrutiny on a particular topic is required.

Supporting Information

Appendix 1: Inequalities due to the Covid-19 pandemic

Specific Contact Points for this report

Matthew Fung, Public Health Consultant, Tel: 01905 845040
Email: mfung@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Democratic Governance and Scrutiny Manager) the following are the background papers relating to the subject matter of this report:

- Agenda and Minutes of the Health Overview and Scrutiny Committee on 9 March 2022 and the 3 November 2021
- Agenda and Minutes of Council on 13 January 2022

All agendas and minutes are available on the Council's website here.

Appendix 1: Inequalities due to the Covid-19 pandemic

The impacts of COVID-19 have not been felt equally across our population and exacerbated existing health inequalities, with elevated risk including:

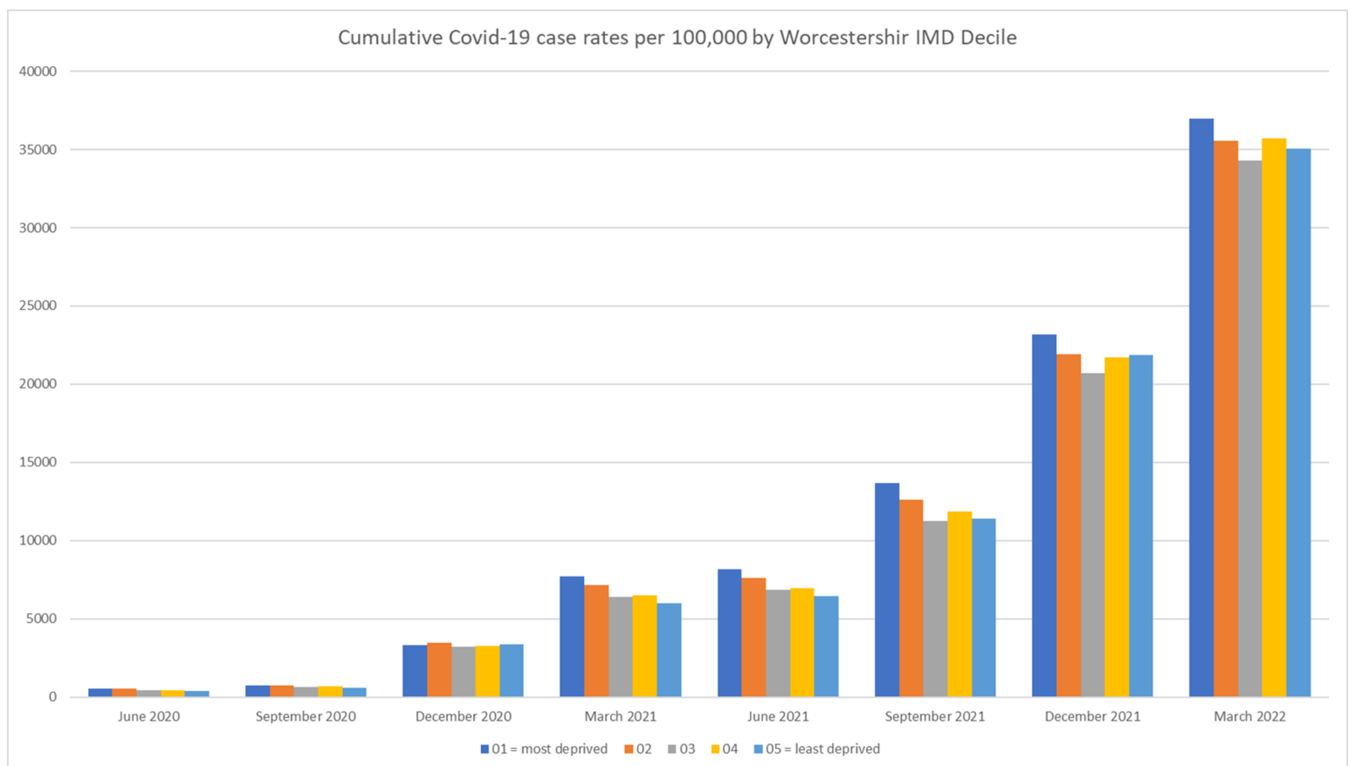
- Pre-existing disease
- Risk of exposure
- Experience of lockdown
- Changes in provision or access to health, social care and essential services
- Socio-economic status
- Ethnicity

Local data suggests a strong relationship between mortality due to COVID-19 and older age and a clear relationship between higher mortality and level of deprivation.

In the following sections we consider inequalities in the key measures of infection, mortality and vaccination before looking at wider inequality issues arising from the pandemic.

Infection

The chart below shows that inequalities in covid infection rates by deprivation have persisted throughout the pandemic – the most deprived have had the highest levels of infection:



The widest differences by deprivation were seen in the early stages of the pandemic. Differences between the most and least deprived were reduced after vaccination commenced, and as the Omicron variant became widespread in late 2021. In general,

the biggest differences occurred when the health impacts of contracting COVID-19 were greatest.

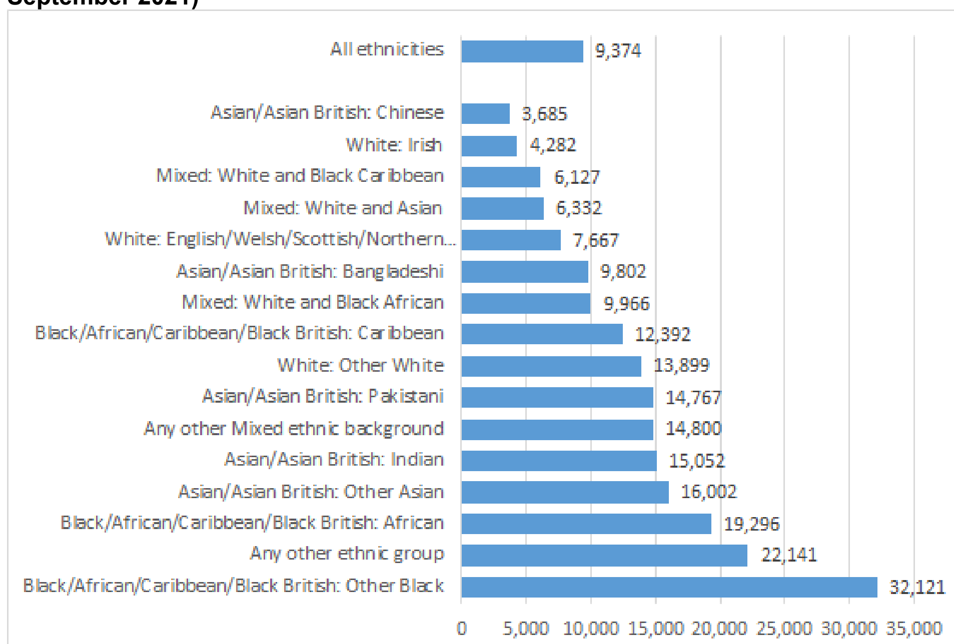
The difference in case rates between IMD 1 (most deprived) and IMD 5 (least deprived) is given in the table below:

March 2020	6%
June 2020	40%
September 2020	27%
December 2020	0%
March 2021	29%
June 2021	26%
September 2021	20%
December 2021	6%
March 2022	6%

Infection rates varied considerably by ethnic group, as shown below. While this data is over a year old it remains relevant as it covers a period in which the health impacts of the pandemic where most acute. In Worcestershire, several ethnic groups have had high numbers of cases. These include:

- Any other Black/African/Caribbean group
- Other ethnic groups
- African
- Any other Asian background
- Indian
- Any other Mixed Background
- Pakistani

Cases in Worcestershire per 100,000 population by ethnic group (beginning of the pandemic up to 7th September 2021)

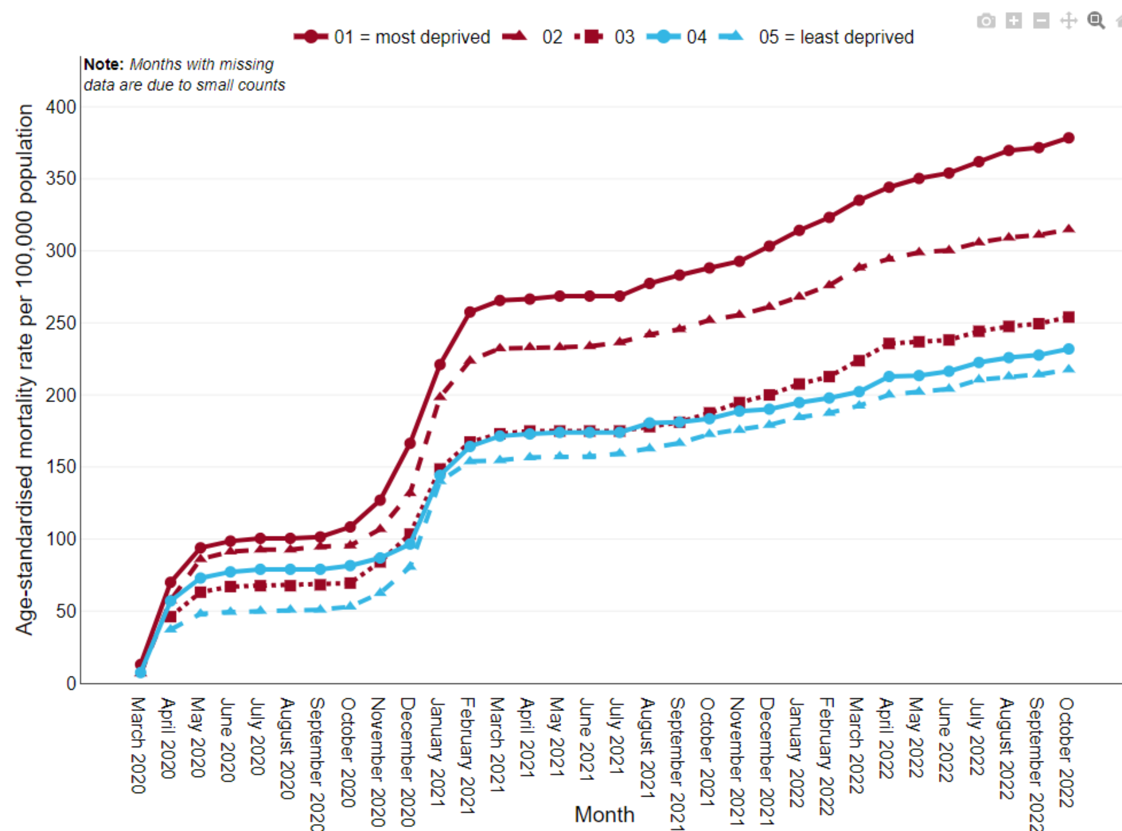


Mortality

There are clear inequalities in mortality by deprivation of residence, which have persisted throughout the pandemic. These inequalities have arisen as a combination of higher infection rates in deprived communities, as well as greater susceptibility to severe illness (for example, due to greater incidence of long-term conditions in deprived communities).

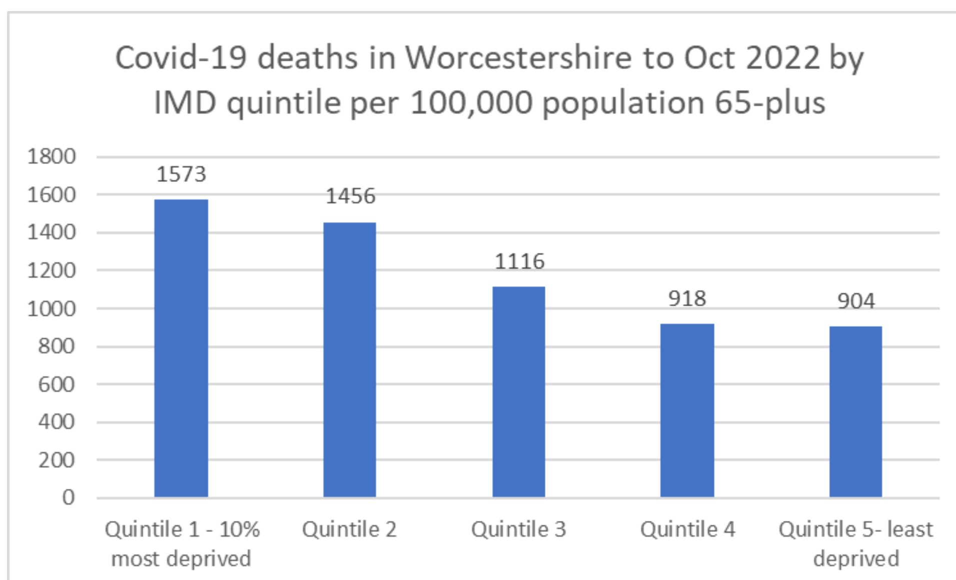
The chart below shows a clear link between case rates and deprivation of residence in Worcestershire.

Cumulative age-standardised mortality rate per 100,000 population, for deaths involving COVID-19 in Worcestershire by deprivation quintiles within Worcestershire, all ages, March 2020 to October 2022



NB. Worcestershire IMD quintiles

When looking at the over 65 population where the majority of deaths occurred, the impact was far greater for those living in relatively deprived areas, in which the mortality rate was around 50% higher than in the least deprived areas.



NB. Deaths with an underlying cause of Covid-10, national IMD quintiles

Worcestershire data on mortality rates by ethnicity is not available. National research suggests that there were significant differences in mortality rates for ethnic groups with particularly high rates in the Pakistani and Bangladeshi ethnic groups.

According to the Office for National Statistics, males in the Pakistani ethnic group have had the highest rate of death involving COVID-19, 3.8 times higher than males in the White British ethnic group; this was followed by Pakistani males (2.6 times) and Black Caribbean males (2.0 times); females in the Bangladeshi ethnic group had the highest rate of death involving COVID-19, 2.8 times higher than females in the White British ethnic group, followed by Bangladeshi females (2.3 times) and females in the Black Caribbean ethnic group (1.7 times). (data from 1 March 2020 to 22 February 2022)

It is well established that COVID-19 had a particularly harmful effect on older people, and also that males had higher death rates than females, as shown in the table below:

Covid-19 Mortality rate per 100,000, Worcestershire, March 2020 to October 2022

Age Group	Male	Female	Persons
<55	18.4	11.1	14.7
55 - 64	158.1	110.1	133.8
65 - 74	424.9	239.9	330.2
75 - 84	1327.2	929.5	1115.5
85 and over	4814.9	3254.3	3838.2

Vaccination

Vaccination against COVID-19 has proved to be very effective in preventing illness and death, but there are inequalities in take up according to deprivation and ethnicity.

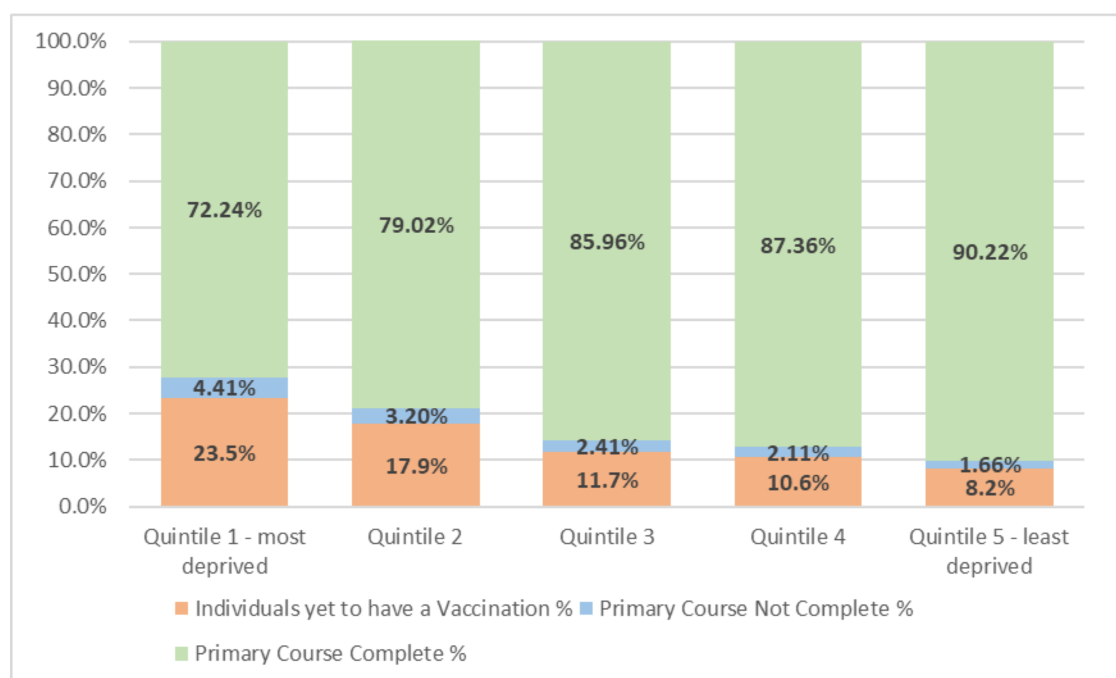
The following sets out COVID-19 vaccination data for Worcestershire by district, deprivation and ethnic group.

Vaccination Inequalities by District (age 12+)

LA Name	Individuals	Individuals yet to have a Vaccination	Primary Course Not Complete %	Primary Course Complete %
Bromsgrove	75,717	10.8%	2.2%	87.1%
Malvern Hills	71,272	10.3%	2.2%	87.6%
Redditch	75,303	19.0%	3.1%	78.0%
Worcester	93,963	16.3%	3.1%	80.7%
Wychavon	115,021	11.1%	2.1%	86.9%
Wyre Forest	90,979	11.8%	2.7%	85.6%
Worcestershire	**522,255**	**13.1%**	**2.6%**	**84.4%**

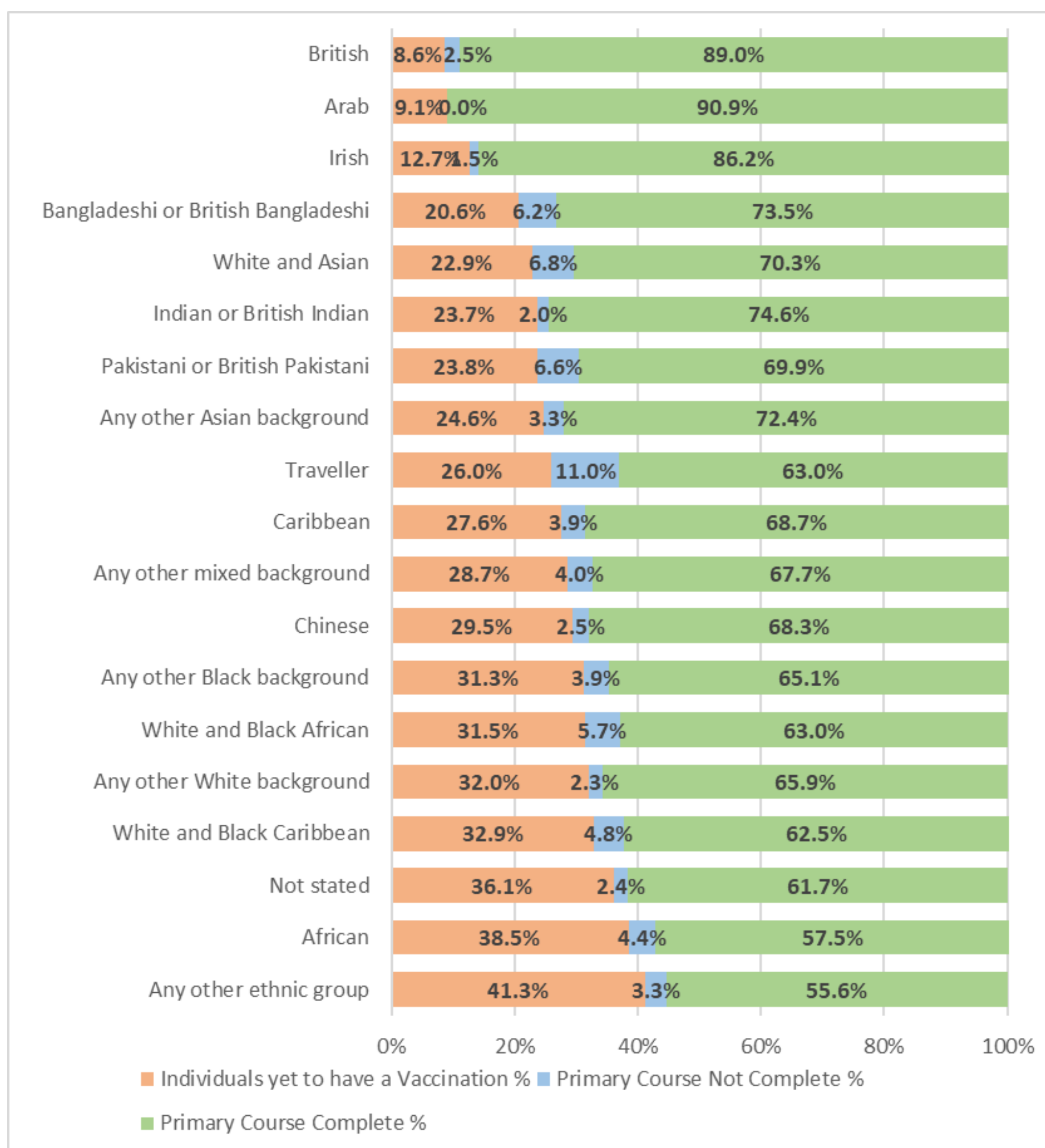
Vaccine Inequalities by Deprivation (age 12+)

The data shows a strong link between deprivation and vaccination status, with those in the most deprived areas being three times as likely to not be vaccinated as those in the least deprived areas.



Vaccine Inequalities by Ethnicity (age 12+)

There is significant inequality in vaccination rates by ethnicity in Worcestershire with non- white British groups having lower rates, as shown in the graph below:



The table below shows how the above rates translate into numbers of people.

Ethnic Category	**Individuals Count**	**Individuals yet to have a Vaccination %**
British	37456	8.6%
Arab	<10	9.1%
Irish	291	12.7%
Bangladeshi or British Bangladeshi	193	20.6%
White and Asian	255	22.9%
Indian or British Indian	1154	23.7%
Pakistani or British Pakistani	1141	23.8%
Any other Asian background	791	24.6%

Traveller	19	26.0%
Caribbean	260	27.6%
Any other mixed background	513	28.7%
Chinese	441	29.5%
Any other Black background	270	31.3%
White and Black African	220	31.5%
Any other White background	14181	32.0%
White and Black Caribbean	460	32.9%
Not stated	11510	36.1%
African	744	38.5%
Any other ethnic group	2113	41.3%

It should be noted that vaccination rates amongst the most vulnerable populations are much better than the above data suggests– for example it is estimated that 2.6% of those aged 80 and over in Worcestershire are unvaccinated.

Long Covid

According to the Office for National Statistics (Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK - Office for National Statistics (ons.gov.uk):

- An estimated 2.2 million people living in private households in the UK (3.4% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first confirmed or suspected coronavirus (COVID-19) infection that were not explained by something else) as of 6 November 2022

- Long COVID symptoms adversely affected the day-to-day activities of 1.6 million people (75% of those with self-reported long COVID), with 370,000 (17%) reporting that their ability to undertake their day-to-day activities had been "limited a lot".

- As a proportion of the UK population, the prevalence of self-reported long COVID was greatest in people aged 35 to 69 years, females, people living in more deprived areas, those working in social care, those aged 16 years or over who were not working and not looking for work, and those with another activity-limiting health condition or disability.

Estimates for Worcestershire aren't available but if prevalence reflected national levels we would have 20,000 people with long Covid, of whom 15,000 having symptoms which adversely affected their day-to-day activities.

People with learning disabilities

The COVID-19 pandemic has highlighted the impact of health inequalities and in people with learning disabilities, with rates of deaths being higher than other population groups. People with learning disabilities are likely to have had difficulty recognising symptoms of COVID-19, or following government advice about getting tested, self-isolation, social distancing and infection prevention and control. It may also be more difficult for people caring for them to recognise the onset of symptoms if these cannot be communicated.

Wider impacts of the pandemic

A number of wider impacts of the pandemic have been observed, largely as a result of lockdowns and other restrictions on social contact. Below we describe some of the main ones.

For further information on the health and wider impacts of COVID-19 please see the JSNA summaries for 2020 and 2021 which can be downloaded here:
JSNA Summaries, Worcestershire County Council

Mental Health

The pandemic has challenged mental health and wellbeing. Key points from the Worcestershire JSNA report 2022 Mental Health Needs Assessment impacts of the pandemic are given below:

There is evidence from both national and local level data of a decline in mental wellbeing during the pandemic. These changes have not been equally experienced across the population.

COVID-19 has been impacting mental health need directly. The pandemic has led to excess deaths and disrupted experiences of bereavement which may increase the risk of new mental health problems in the medium to long term.

A further direct impact is due to Long Covid, which is a continuing concern and a multidisciplinary response including mental health services forms part of the developing model of care.

However, perhaps the greater impact will come indirectly from the measures implemented to control the virus. Enforced isolation combined with the collective uncertainty and anxieties generated during the early pandemic have challenged the wellbeing of the whole population but affected people in very different ways, for example when considering the impact of school closures.

Whilst some of these impacts are largely limited to the periods of national restrictions, others are continuing to evolve. These include the impacts on employment, wider economic effects, and pressures on health services, that have had to adapt rapidly in extremely challenging conditions.

Existing inequalities in mental health have continued and widened in some cases: Young adults, women, people with a pre-existing mental or physical health condition, those experiencing loss of income or unemployment, those in deprived areas and some

ethnic minority populations were more likely to experience poor or worsening mental health.

Symptoms of anxiety and depression remain more common than the best pre-pandemic estimates with similar trajectories to psychological distress.

Education

The impact of missed education has disproportionately fallen on those children living in areas of enduring transmission and from poorer backgrounds. Pupils that are disadvantaged tend to have lower educational attainment than their peers – this is termed the disadvantage gap. The gap occurs because disadvantaged pupils tend to have less access to technology, spend less time learning and have reduced support from parents and carers.

Experiences of teaching and learning during the pandemic were diverse, but disadvantage and deprivation appear to be most associated with less effective learning and overall learning losses.

Research by the ONS found that remote learners in more deprived schools covered relatively less material than their in-class peers between April 2020 to June 2021.

They also found that according to teacher assessments pupils working from home covered less material than their peers in the classroom. This gap was wider for primary school pupils than secondary school pupils. Younger pupils' learning was more dependent on parental involvement than older pupils.

Nationally, the Key Stage 4 disadvantage gap index has widened in 2022 compared to 2020, from 3.66 to 3.84. It is now at its highest level since 2011/12. The Key Stage 4 disadvantage gap index measures the difference in grades between disadvantaged pupils (eg. free school meal eligible) and the rest.

The widening of the disadvantaged gap index may reflect the difficult circumstances that many pupils will have experienced over the last few academic years which saw various restrictions put in place in response to the COVID-19 pandemic (e.g. periods of lockdowns and tiers) that resulted in restricted attendance to schools and periods of home learning.

Alcohol consumption

In July 2021 Public Health England (PHE) published a report on the trends in alcohol consumption and harm. The findings show an increase in total alcohol-specific deaths, driven by an unprecedented annual increase in alcoholic liver disease deaths above levels seen pre-pandemic.

Despite pubs, clubs and restaurants closing for approximately 31 weeks during the national lockdowns, the total amount of alcohol released for sale during the pandemic was still similar to the pre-pandemic years which suggests people were drinking more at home.

Those people who typically bought the most alcohol pre-pandemic bought a lot more once the first lockdown happened. The PHE report states that there was a 58.6%

increase nationally in the proportion of the population drinking at increasing risk and higher risk levels between March 2020 and March 2021.
ONS (Dec 2022)

Evidence from survey data collected by the Department of Health and Social Care (DHSC) suggested that respondents were more likely to report increasing their alcohol consumption during the coronavirus (COVID-19) pandemic compared with previous years, with "a step-change around the time the pandemic began".

Alcoholic liver disease typically takes many years to develop. However, increases in alcohol consumption among those who have already been consuming alcohol at higher-risk levels can lead to rises in mortality in a short period of time, from what is known as "acute-on-chronic" liver failure. The DHSC's survey data suggested people who were already drinking at higher levels before the pandemic were the most likely to report increases in their alcohol consumption in 2020.

There were 9,641 deaths related to alcohol-specific causes registered in the UK in 2021, equivalent to 14.8 deaths per 100,000 people. That was 667 more deaths (a 7.4% increase) than in 2020, when there were 8,974 deaths, equivalent to 14.0 deaths per 100,000 people.

Alcohol-specific deaths have risen sharply since 2019. The 9,641 deaths registered in 2021 were 2,076 more than the 7,565 deaths registered in 2019, which is a rise of 27.4%. The alcohol-specific death rate rose from 11.8 to 14.8 per 100,000 over the same period. The number of deaths in 2021 is a record high in the data time series (beginning in 2001).

Alcohol-specific deaths only include those health conditions where each death is a direct consequence of alcohol (that is, wholly attributable causes such as alcoholic liver disease). It does not include all deaths that can be attributed to alcohol.

Physical Activity

Nationally, a reduction in physical activity levels has been seen, particularly for people in Black and Asian groups and lower socioeconomic groups.

The 2021/22 National Child Measurement Programme data indicates that the proportion of Year 6 children in Worcestershire who are overweight or obese has increased from the 2018/19 level from 36.1% to 38.7% for boys and 29.3% to 33.0% for girls. This could be a consequence of reduced physical activity and poorer diet. (The rates for reception children have remained largely unchanged)

For both reception and year 6, data for 2022 shows that rates of childhood obesity are higher in the more deprived areas of Worcestershire, and that the differences by deprivation have increased since the start of the pandemic.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
13 JANUARY 2023

WORK PROGRAMME

Summary

1. From time to time the Health Overview and Scrutiny Committee (HOSC) will review its work programme and consider which issues should be investigated as a priority.

Background

2. Worcestershire County Council has a rolling annual Work Programme for Overview and Scrutiny. The 2022/23 Work Programme has been developed by taking into account issues still to be completed from 2021/22, the views of Overview and Scrutiny Members and other stakeholders and the findings of the budget scrutiny process.

3. Suggested issues have been prioritised using scrutiny feasibility criteria in order to ensure that topics are selected subjectively and the 'added value' of a review is considered right from the beginning.

4. The HOSC will need to retain the flexibility to take into account any urgent issues which may arise from substantial NHS service changes requiring consultation with HOSC.

5. The Health Overview and Scrutiny Committee is responsible for scrutiny of:

    - Local NHS bodies and health services (including public health and children's health).

6. The scrutiny work programme was discussed by the Overview and Scrutiny Performance Board (OSPB) on 29 June and agreed by Council on 14 July 2022.

Dates of Future 2023 Meetings

- 10 February at 10am
- 13 March at 10am
- 18 April at 10am
- 10 May at 10am
- 15 June at 10am
- 10 July at 2pm
- 11 September at 2pm
- 11 October at 10am
- 13 November at 10am
- 7 December at 10am

Purpose of the Meeting

7. The HOSC is asked to consider the 2022/23 Work Programme and agree whether it would like to make any amendments. The Committee will wish to retain the flexibility to take into account any urgent issues which may arise.

Supporting Information

Appendix 1 – Health Overview and Scrutiny Committee Work Programme 2022/23

Contact Points

Emma James / Jo Weston, Overview and Scrutiny Officers, Tel: 01905 844964 / 844965
Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the Proper Officer (in this case the Democratic Governance and Scrutiny Manager), the following are the background papers relating to the subject matter of this report:

Agenda and Minutes for Overview and Scrutiny Performance Board 29 June 2022

Agenda and Minutes for Council 14 July 2022

All Agendas and Minutes are available on the Council's website weblink to Agendas and Minutes

SCRUTINY WORK PROGRAMME 2022/23

Health Overview and Scrutiny Committee

Date of Meeting	Issue for Scrutiny	Date of Last Report	Notes / Follow-up Action
13 January 2023	Public Health Ring Fenced Grant and Public Health Outcomes (including promoting active lifestyles, targeting rising obesity levels, prevalence of alcohol use during pregnancy etc.)		Six monthly update on PHRFG To include alcohol services and sexual health services
	Health Inequalities and Impacts Resulting from the Covid-19 Pandemic		To include Long Covid and cover the Notice of Motion from Council 13 January 2022
10 February 2023	Mental Health - the impact of COVID on children and young people - Dementia Services - Preventative measures, for example peri-natal mental health - Mental Health Needs Assessment (when complete)	21 September 2021 19 September 2018 (CAMHS)	Ongoing updates on restoration of services during the Covid pandemic have also been provided (from June 2020 - present)
	Update on Improving Patient Flow*	1 December, 17 October, 8 July, 9 May and 9 March 2022, 3 November and 18 October 2021	
	Update on Garden Suite Ambulatory Chemotherapy Service	19 July 2021	
13 March 2023	Physiotherapy Services		Suggested at 19 July 2021 Meeting
	Out of County Elective Surgery		Requested at 9 May 2022 meeting
March/April 2023	Update on the Integrated Care Strategy		Requested at 2 November 2022 meeting
Ongoing	Monitoring temporary service changes (and new ways of working) as a result of COVID-19	10 March 2021 19 July 2021	

Ongoing	Integrated Care System (ICS) Development	10 March 2021 12 January 2022	
Possible Future Items			
Early 2023 - TBC	Community Paediatric Services		Suggested at Agenda Planning 23 August 2022
Early 2023 - TBC	Screening (Cervical/Antenatal/Newborn/Diabetic Eye/Abdominal Aortic Aneurysm (AAA)/Breast/Bowel)		Suggested at 19 July 2021 Meeting
Early 2023 - TBC	Commissioning Arrangements under the ICS		To include the plans for the commissioning of Pharmacy, Dentistry, Optometry, Specialised Acute, New Arrangements for Mental Health, Specialist Mental Health and Prison Health
2023 - TBC	Community Pharmacies		Agenda planning September 2022
Early 2023 - TBC	Workforce	10 June 2022	Requested at 17 October 2022 Meeting
Early 2023 - TBC	Routine Immunisation		Suggested at 19 July 2021 Meeting
Early 2023 - TBC	Hospital at Home Service		Requested at 10 June 2022 meeting
TBC	Update on Dental Services Access		Requested at 9 March 2022 meeting
TBC	Dementia Services		Requested at 9 May 2022 meeting
TBC	End of Life Care		Requested at 10 June 2022 meeting
TBC	Onward Care Team		
TBC	Prevention		Suggested at 17 October 2022 Meeting
TBC	Glaucoma Services		Suggested at 17 October 2022 Meeting

April/May - TBC	Maternity Services (to monitor progress of the Acute Trust's Action Plan for improvement)	9 May and 17 October 2022 and 21 September 2021	Requested at 17 October 2022 Meeting
Standing Items			
TBC	Substantial NHS Service Changes requiring consultation with HOSC		
TBC	NHS Quality Accounts Quality and Performance		
TBC	Annual Update on Health and Wellbeing Strategy	17 October 2022	
TBC – January/July	Public Health Ring Fenced Grant (PHRFG) – Twice Yearly Budget Monitoring	8 July 2022	
TBC	Performance Indicators		
TBC	Annual Update from West Midlands Ambulance Service	27 June 2019	
TBC	Review of the Work Programme		

*Scrutiny of patient flow is a continuation of the Scrutiny Task Group in November 2021

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