Health and Wellbeing Board

Date: Wednesday 7 September 2022
Time: 1.30 pm
Venue: Committee Room 2, Shire Hall

Membership

Councillor Margaret Bell (Chair)
Councillor Jeff Morgan
Councillor Jerry Roodhouse
Councillor Isobel Seccombe OBE
Councillor Marian Humphreys
Councillor Julian Gutteridge
Councillor Howard Roberts
Councillor Jo Barker
Councillor Judy Falp

Warwickshire County Council Officers: Shade Agboola and Nigel Minns

Coventry and Warwickshire Integrated Care Board: Danielle Oum

Provider Representatives: Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Dame Stella Manzie (University Hospitals Coventry & Warwickshire), Dianne Whitfield (Coventry and Warwickshire Partnership Trust)

Healthwatch Warwickshire: Elizabeth Hancock

NHS England: Julie Grant

Police and Crime Commissioner: Emma Daniell (Deputy PCC)

Items on the agenda: -

1. General

(1) Apologies

(2) Appointment of Vice-Chair
The Board is asked to appoint a Vice-Chair.

(3) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

(4) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 4 May and Matters Arising 5 - 14

Draft minutes of the previous meeting held on 4 May 2022 are attached for approval.

(5) Chair's Announcements

Discussion items

2. Adult Social Care Reforms 15 - 22

The Health and Wellbeing Board is asked to consider and comment upon the programme of work underway to support Adult Social Care Reform in Warwickshire.

3. Health Visiting Paper 23 - 30

This item provides an update on the Health Visiting Service, detailing the best practice and innovation, the issues and challenges faced and it seeks the Board's support for proposed actions.

4. Better Care Fund (BCF) Annual Plan 2022/23 31 - 86

The Board is asked to consider and provide feedback on the Better Care Fund Policy Framework and Planning Requirements for 2022/23, also to consider arrangements for the approval of the final submission to NHS England.

5. Pharmaceutical Needs Assessment 87 - 242

One of the Board's statutory duties is to produce and approve the Pharmaceutical Needs Assessment (PNA). The purpose of the PNA is to inform commissioners about the potential need for pharmacy-based services in an area.

6. Healthwatch Warwickshire Annual Report 243 - 254

The Health and Wellbeing Board is asked to consider the annual report of Healthwatch Warwickshire.

7. Serious Violence Prevention Strategy 255 - 288

A discussion item which seeks the Board's endorsement of a number of recommendations on the Serious Violence Prevention Strategy.

Updates to the Board

8. Warwickshire Health and Wellbeing Partnerships 289 - 306

An update from each 'Place' on the progress made towards reducing inequalities in health and the wider determinants of health priority.

9. Levelling Up 307 - 312

For the Board to consider the newly published countywide approach to levelling up in Warwickshire, and the opportunity for greater alignment and synergy between Levelling Up, health inequalities and the wider work of the Health & Wellbeing Strategy.

10.	**Coventry and Warwickshire Integrated Health and Wellbeing Forum** The Board is asked to consider the purpose and plans for the Integrated Health and Wellbeing Forum (formally the Place Forum).	313 - 316
11.	**Coventry and Warwickshire Population Health Management Roadmap** An update on the Coventry and Warwickshire population health management road map.	317 - 358

Board Management

12.	**Forward Plan**	359 - 360

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

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The public reports referred to are available on the Warwickshire Web https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

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Health and Wellbeing Board

Wednesday 4 May 2022

Minutes

Attendance

Board Members

Warwickshire County Council (WCC)
Councillor Margaret Bell (Chair)
Councillor Jerry Roodhouse
Councillor Izzi Seccombe, OBE
Shade Agboola
Nigel Minns

Provider Trusts
Dame Stella Manzie (University Hospitals Coventry & Warwickshire (UHCW)),
Jagtar Singh (Coventry and Warwickshire Partnership Trust (CWPT))

Healthwatch Warwickshire (HWW)
Elizabeth Hancock

Borough/District Councillors
Councillor Jo Barker (Stratford-on-Avon District Council)
Councillor Marian Humphreys (North Warwickshire Borough Council)

Other Attendees

Councillors Judy Falp and John Holland (WCC), Rachel Barnes, John Cole, Gemma McKinnon, Marie Rooney, Ashley Simpson, Paul Spencer, Claire Taylor and Duncan Vernon (WCC Officers). Chris Bain (HWW), Sharon Atkins (Coventry City Council) and David Lawrence (Press)

1. General

(1) Apologies

Councillor Jeff Morgan (WCC), Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Dianne Whitfield (CWPT), Councillor Julian Gutteridge (Nuneaton and Bedworth Borough Council), Councillor Jan Matecki (Warwick District Council), Julie Grant (NHS England and Improvement) and Danielle Oum (Coventry and Warwickshire Integrated Care System).

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

None.

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 12 January 2022 and Matters Arising

The minutes of the Board meeting held on 12 January 2022 were approved as a true record and signed by the Chair.

(4) Chair's Announcements

The Chair reminded of the Board's priorities and especially the focus on children and young people's mental health and wellbeing. The agenda included a number of important items around infants, children and young people. She also welcomed to the meeting foundation year two doctors and a trainee GP who were observing.

The Chair advised that West Midlands Ambulance Service (WMAS) provided an update to the November 2021 meeting of the Adult Social Care and Health Overview and Scrutiny Committee (ASC&HOSC). The reported ambulance response times were not as would be desired and there were contributing factors, with delays in transferring patients at hospitals being a key issue and some services not being available at all times. She then attended the multi-agency Blue Light Collaboration Joint Advisory Board to raise the concerns and ask how this systemic issue could be tackled. Support from both senior police and fire representatives was received to collaborate to address this concern. At the April ASC&HOSC WMAS provided a further update, reporting a worsening position on ambulance delays and response times. There was a need to look at this issue as a system. One of the roles of the Board was to 'hold the ring' and ask partners to work together to improve services. Whilst WMAS was a regional organisation, the local system could be focussed on issues for Coventry and Warwickshire. With the Board's approval, Nigel Minns was asked to arrange a meeting of all relevant organisations to discuss this and to report back at the next Board meeting with potential options to improve the situation.

Several Board members spoke in support, making the following points:

- There was no blame, but a need for collaboration as a system to improve the current situation.
- The discussion should include the impact on service provision of allocating 400 staff to provide cover for the Commonwealth Games.
- The need for more data around calls for service and categories, as well as the potential for more community-based work.
- A breakdown of response times for each area.
- Providing details of the treatment/support required e.g. patients with mental health issues.
- The 'return to normal' for hospital appointments had not yet been achieved.
- Recognition of the efforts of all services and their staff in seeking to address the current challenges. These included patient flow and hospital discharge. The discussion should include what new things, including those which may be more radical could assist.
- The Chair recognised the work of acute trusts and also that hospital handover delays in Coventry and Warwickshire were less than for other parts of the region.

The Chair then referred to the health and wellbeing development session and the consensus for a focus on children and young people's mental health. An action plan was being produced which included a proposal for a Children and Young People's Partnership to be established,

as a formal sub-group of the Board. It was proposed to submit an item to the next Board meeting, to consider the terms of reference and membership for this partnership. The Chair suggested that the group could include board members and officers. The board confirmed formally its approval to this proposal.

Finally, the next development session of the Board would take place in July with a focus on children and young people's mental health.

2. Children's 0-5 Joint Strategic Needs Assessment

Duncan Vernon, Public Health Consultant introduced the Children's 0-5 Joint Strategic Needs Assessment (JSNA). It looked at the health needs of children aged 0-5 in Warwickshire and was aligned with 'The Best Start for Life policy vision' of 1,001 critical days for lifelong emotional and physical health, health needs during pregnancy and maternal health. Sections of the report focussed on:

- Local context, including the predicted population growth, ethnic diversity and impacts of deprivation.
- Health of children 0-5 – pregnancy and birth. This included parenting education, low birth weight and obesity, smoking in pregnancy and mental health data.
- Health of children 0-5 – early years. Improving data collection on breast feeding, data on childhood obesity, visually obvious tooth decay, vaccine coverage and issues associated with domestic abuse.
- Child hospitalisations. Findings from different waves of the pandemic, by area, gender, indices of deprivation and ethnicity. Further aspects on unintentional injuries, emergency admissions and reducing unintentional injuries, focussing on five key causes.
- Child deaths. This section covered key causes, the relationship to wider determinants of health and data on the 122 Warwickshire child deaths over the period 2017-21.
- Services for children 0-5. This reported on the proportion of new birth visits, infant reviews and the feedback from parents and carers of young children of the 0-5 public health nursing service. Further aspects on early education and childcare, school readiness and achieving a good level of development. There were known links between deprivation and school readiness. Reference to the WCC early years needs assessment, its data findings and those from the Joseph Rowntree Foundation. This section also outlined the support from Children and Families Services, with data on specialist help, early intervention and outreach services.
- Report recommendations. Six areas were outlined. These concerned increasing population growth and increasing diversity of needs, that deprivation and inequalities were a critical factor and there were key health promotion issues for all services to embed. There were opportunities to increase the role of early intervention and prevention, a need for closer alignment between services and an opportunity to establish a partnership to centralise the needs of children and to take forward the recommendations within the report.
- JSNA prioritisation. A two-year thematic work programme had been developed and was set out in the report. Some aspects had been completed. With the wider development of the ICS, it was proposed to undertake a further prioritisation exercise and the suggested approach was outlined.

A presentation was provided to pull out the key aspects of the report, based on the sections detailed above. Questions and comments were invited, with responses provided as indicated:

- The Chair praised the report and the detailed data it contained.
- Concern about drowning risks increasing due to the reduction in numbers of children learning to swim. This had been impacted by both the pandemic and potentially pool closures associated with increasing costs of heating them.
- The report contained a wealth of information. A concern that the gaps related to deprivation were widening. Points about the lack of a consistent geography as the areas covered by each JSNA differed from those served by the corresponding family centre. A need to join this up and to share data.
- There was concern about unintentional hospital admissions and cases of neglect. A question on how this was mapped from the various data sources available to ascertain levels of neglect.
- Regarding the focus on 0-5 services, this should be extended to include the period from conception. There was potential for more early intervention work and provision of information at an earlier stage. Otherwise, the known gaps in child development were likely to widen still further.
- The detailed action and delivery plans would be key and needed to show how they linked to the various other strategies.
- A comparison was drawn to a similar document from 2018, with virtually the same themes, but this report showed an increase in the gaps referenced above.
- Duncan Vernon responded to the points above. He referred to the risks of smoking in pregnancy as an example where the focus on conception to five was relevant. There were initiatives within the NHS long-term plan to encourage smoking cessation amongst pregnant women. The NHS and WCC worked together on such initiatives. He noted the important points around neglect, speaking about early help, the available, granular data, some of which was new. This wealth of data would enable comparison between services, making the case for closer partnership working and aligning geographies too.
- There was an important role for health visitors to identify potential issues at an early stage. Some people were not aware who their health visitor was. The Chair responded that this was another example where partnership working could ensure that services complemented each other. Jagtar Singh noted the points raised and the need for assurance. There were a number of challenges for the health visiting service, due to the pandemic and growing service demand. His trust used a ‘patient story’ approach to provide more information via videos of services and one could be produced for this service. He offered to meet with the councillor outside the meeting. This offer was welcomed, and a further concern was not having consistent health visiting staff. Jagtar Singh gave an example of attending a health visit, the challenges observed and need for wider interventions from other services to assist that individual.
- Chris Bain noted that the presentation made reference to risk factors, which included ethnicity and further context on this was sought. It was a complex picture and in areas of deprivation there tended to be a greater diversity of ethnicities. Duncan Vernon spoke about challenges in access to services, for example where English was not the person’s first language and also outcomes from accessing services. Chris Bain viewed this as significant, as reducing health inequalities was a key driver of integrated care. Access to services was essential to tackling inequalities and it was questioned if work was taking place to look at both provision of services and outcomes to start to tackle such health inequalities. A further response was provided about population health management and the potential uses of this data as the Integrated Care System became established. Duncan gave an example of the

work that provider trusts were doing towards the NHS long term plan aims around continuity of care for maternity services for expectant mothers from BAME backgrounds.

- Shade Agboola provided further information about the system response to address health inequalities, formulating a plan which had involved robust engagement with a variety of bodies. She spoke about the NHS Core 20+5 model which had been discussed at a previous board meeting. This identified the twenty percent most deprived population and certain 'plus' groups. In Warwickshire one of the plus groups within the Systems Inequalities Strategy recognised that ethnically diverse populations were disproportionately impacted and would experience health inequalities beyond those of most of the population. This plan would shortly be submitted and be followed by implementation.
- Councillor Roodhouse spoke about the process aspects and the work taking place in several different forums, including at 'place'. He gave examples of the different bodies involved and asked if there was a role for the WCC Children & Young People Overview and Scrutiny Committee (the OSC) to also keep an oversight and hold the system to account.
- Nigel Minns agreed that there was a need to be clear about the functions of the different groups. In his view, the OSC had a role to hold services to account. Health visiting was a service commissioned by WCC, so the OSC could ask for performance information, or a suggestion be made by the board for it to seek such an update. Thereafter, the OSCs findings about any service gaps or concerns requiring partners to work together could be fed back to the Board. He spoke of the role of the Board and those areas within this report which could be included within the terms of reference for the proposed Children's sub-group.
- Stella Manzie noted the higher rate of injuries involving children in Rugby. She offered to discuss this at UHCW to see if there had been any additional analysis. Stella also referred to a recent visit to UHCW by Danielle Oum, the ICS Chair. One of the areas discussed was the neonatal outreach service being provided by the three acute trust hospitals. This enabled very young babies to be discharged from hospital earlier, with substantial care and support packages at home. It was seen as a very positive development and had been well received so far.
- Nigel Minns referred to the Covid vaccination programme and the vocal opposition nationally by some people to the vaccination. He asked if this had reflected on uptake of other vaccination programmes. Duncan Vernon considered it was too early to tell and said there were slight differences in the delivery of other vaccines. The current public awareness of vaccinations may provide an opportunity for messaging and would be something the proposed children's sub-group could consider.

Resolved

That Health and Wellbeing Board:

1. Notes the contents of the 0-5 Joint Strategic Needs Assessment (JSNA).

Approves the publication of the 0-5 JSNA and the development of an associated action plan that will be monitored by the JSNA Strategic Group and the proposed new Children's group.

4. Coventry and Warwickshire Dementia Strategy

Claire Taylor from WCC Strategic Commissioning and Sharon Atkins from Commissioning at Coventry City Council gave a joint presentation to the Board to accompany a circulated report and appended draft Coventry and Warwickshire Dementia Strategy.

Following an extensive period of stakeholder engagement and further development of the strategy, Coventry and Warwickshire's Living Well with Dementia Strategy would go through formal approval processes at both councils in June/July 2022. Subject to those approvals, the strategy would be published and shared widely. The associated strategic delivery plan would include a range of actions to be undertaken across Coventry and Warwickshire, as well as actions specific to each area. The delivery plan for year one was currently being developed, with many of its actions underway already. The financial implications stated that many of the ambitions and priorities would utilise existing partner resources or involve bids for funding. WCC had allocated funding of £60,000 per annum to support development and implementation of the Dementia Strategy in Warwickshire.

The presentation outlined the process for developing the year one delivery plan and invited comments and suggestions to support development and delivery of the plan for 2022-2023.

Members of the Board made the following points:

- Amongst the South Asian community, dementia was not understood. There was a need to bear in mind health inequalities and to focus activity based on the data available. More information was sought about where people presented. An offer from CWPT to work together, especially to make its units and estate more dementia friendly. It was welcomed that prevention was at the heart of this strategy. Sharon Atkins provided further information about the funding available to address inequalities and an initiative in Coventry to provide additional support for the South Asian community. There was knowledge of which groups were less likely to access support and the offer to work with CWPT was welcomed.
- Councillor Seccombe was mindful that some people did not want a diagnosis, were fearful of it or could not see what difference a diagnosis would make. There were many different types of dementia with patients having varying needs. More information was sought about training, which was very important, especially for those working in a care environment. It was noted that the strategy had a lot of priorities and was questioned how people could be held to account with there being so many priorities. In response, the target within the plan (and that set by NHSE&I) was for 66.7% of people thought to have dementia to receive a diagnosis. This had not been achieved to date. Further points acknowledging the differing views of patients regarding diagnosis or perceived benefits and the support available.
- It was questioned if GP doctors were involved in the diagnosis aspects. There had been a scheme for GPs to be trained and provide community-based assessments, which was working well prior to the pandemic. GPs were now instructed not to participate in such initiatives which was a frustration. Reference was made to an assessment project in care homes for people who did not need GP interventions, and this was going well.
- A concern about the additional distress caused for dementia patients waiting outside hospitals due to ambulance handover delays.
- Training for care home staff was raised, especially for end-of-life care and how to speak to dementia patients appropriately. Increasingly with care being provided at home this extended to domiciliary care staff too. Such staff were working under significant pressure.

The views of patients at the end of their life may differ from those of family members. Reference to the measures of success within the strategy and whether this included the numbers of staff having dementia training for the end-of-life care pathway. A refresh of the dementia friendly communities would be welcome. Officers replied that 'training well' had been kept as a separate priority. There were five objectives which addressed many of the points raised by Board members. Details were provided of how this would be delivered across a range of providers and other partners. Having prioritised the objectives, the detail would now be added on how this would be delivered over the coming years and some work had already commenced. There was a range of training from awareness raising through to a specialist training offer.

- There was a training need for people to assist dementia patients in the community, including those discharged from hospital. This was acknowledged within the strategy but could be made more specific. A particular challenge was domiciliary care staff turnover. It would be possible to include a training requirement in providers' contracts. Reference was made to the dementia bus and a simulation used to give people an understanding of what dementia was like. It was acknowledged that training levels for staff in dementia care homes were not required to the level that would be perceived. An accreditation scheme was being considered where staff had to be trained to a prescribed level to receive the accreditation.
- Reference was made to the fitter futures programme, with a personal example used to show how this wasn't working despite considerable efforts from a local GP surgery. A parallel was drawn to other services considered not to be working, including those referenced during this debate. The Chair noted the points raised. She agreed that there was both a need to focus on dementia and to take dementia into account when providing all services.
- Councillor Roodhouse said he would welcome the reinvigoration of dementia friendly communities and linked to that a separate conversation on how to engage elected members and their communities. He spoke further about end-of-life care, the variation in premises accommodating residents with dementia and also staffing ratios. He then commented about the future design of care homes, the conversations needed when people were no longer able to stay at home and needed residential or nursing care, as well as the impacts for the family members caring for them. These areas could provide measures of success for the strategy.
- Sharon Atkins acknowledged the points raised and gave examples of care homes within the County which had good models of care and were not necessarily more expensive.
- The Chair drew the debate to a close, noting that an action plan was being produced. She stated that when looking at measures and outcomes it was helpful to show the impacts of the work undertaken. This would demonstrate how it had improved services for people with dementia and their carers. It was requested that a copy of the final action plan be circulated to the Board and that a follow up presentation be provided at the appropriate time showing the work undertaken during the first year of the strategy and the difference it had made.

Resolved

That the Health and Wellbeing Board:

1. Endorses Coventry and Warwickshire's Living Well with Dementia Strategy, prior to its submission for final approval to Cabinet.

2. Comments on the development of the year one delivery plan as set out above.

3. Special Educational Needs and Disabilities (SEND)

Rachel Barnes and Marie Rooney introduced this item which reported back on the joint Ofsted and the Care Quality Commission (CQC) inspection to judge the effectiveness of the local area in implementing the SEND reforms. This inspection covered a range of commissioners and service providers within Warwickshire, looking at the effectiveness of the local area holistically in delivering the desired outcomes.

The inspection report was published in September 2021. The report reminded of the positive action and commitment of leadership to improving outcomes for children and young people, also setting out positive key findings. However, the report also identified five areas that needed to be addressed, known as “significant areas of weakness” in the terminology of such reports. These were detailed in the report. There was a requirement to co-produce a Written Statement of Action (WSoA) outlining how improvements would be made. The draft WSoA was reviewed by the County Council’s Cabinet and approved by Ofsted and CQC, then published on the WCC website. Details were provided of the related action plan for each of the areas of weakness and its delivery was now underway. Reference was also made to the communications plan and governance arrangements in place, as well as the periodic self-evaluation framework. Progress to date was reported for each of the five improvement areas. The report’s financial implications set out the funding allocated by the County Council and CCG, together with an identified risk against schools' uptake of SEND training and options being prepared for consideration by the SEND steering group.

The Board discussed the following areas:

- The Chair recognised the amount of work which was being undertaken on this area.
- Details were requested of the website link for the service: https://www.warwickshire.gov.uk/send
- A discussion about the expected response from schools. There would be ongoing conversations working with, challenging and empowering each other. There were change agents and champions as well as links to the well-established structures. Reference to the endeavours to secure change agents and the rapid increase in take up from 40 to 85% of the consortia which were adopting the inclusion charter. A key aspect was continued conversations as personnel changed and creating a framework that went beyond the WSoA. It was envisaged that legislative changes would bring further requirements. There was a need to show that the required structures had been created.
- Stella Manzie commended the work being undertaken. She was aware of challenges elsewhere and understandable tensions between parent forums and councils. For children in the care system, social workers may not understand enough about special needs and may make incorrect judgements about parents. This highlighted an important training need.
- The Chair referred to area of weakness one which concerned waiting times for autism assessments. She spoke of the challenges and amount of work being undertaken. The measure for this area was the longest wait and there were a number of factors which impacted. However, some people were currently waiting up to four years for an assessment. There was a trajectory to reduce this timescale significantly.
- In response to a question, Marie Rooney outlined the work undertaken with staff and governors to establish a baseline of their confidence to meet the needs of SEND students. This was then compared to available data and parents’ perceptions to assess how well schools were able to meet the needs of pupils with additional needs.

Resolved

That the Health and Wellbeing Board comments as set out above on the outcomes from the Ofsted and CQC local area SEND inspection and endorses the progress made to date to deliver the Written Statement of Action.

5. Place Partnerships Report: Infants, Children and Young People

The Board received updates detailing the current and planned activity of each 'Place' Partnerships on the priority of 'helping our children and young people have the best start in life'. The Chair recognised the significant amount of work being undertaken in each area.

6. Forward Plan

An update on the Board's forward plan, detailing proposed agenda items for its formal meetings and the focus of the workshop sessions. It was noted that the next Place Forum was likely to be held in September to give time to assess how the ICS was embedding. The September Board agenda would include additional items to report back on the discussion about the ambulance service and the proposed children's board.

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Councillor Margaret Bell, Chair

The meeting closed at 3:40pm

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Adult Social Care Reforms and Warwickshire County Council's Approach

Update to Health and Wellbeing Board

7th September 2022

Warwickshire County Council

START WITH STRENGTHS

Social Care & Support

Adult Social Care Government Policy Reforms

- Market Sustainability and Fair Cost of Care Fund
- People at the Heart of Care: adult social care reform (CQC Oversight)
- Build Back Better: Our Plan for Health and Social Care (Care Cap)
- Health and social care integration: joining up care for people, places and populations (02/2022)

General Points

- High level ‘indications’ with detail emerging
- Multiple aspirations being articulated amongst requirements
- A landscape which doesn’t keep to timescales (e.g. LPS, Care Act (2014))
- Lots of National, Regional and Local ‘views’
- Section 18(3) the Care Act, Duty to meet needs for care and support, a significant risk
- Questions if the pace of delivery is realistic

Overarching Approach

- Strategic Director Lead: Nigel Minns
- Programme Manager: Mike Cooke-Jones
- Assistant Directors
  - Andy Felton – Care Cap
  - Becky Hale – Fair Cost of Care
  - Pete Sidgwick – CQC Oversight
- Cross cutting conversations, internal & external

Cost of Care Cap (Build Back Better)

- Lead: Andy Felton (Assistant Director Finance)
- Key Dates: Upper tier LAs Record Care Contributions from October 2023
- Key Deliverables: Defined new processes and systems, integrated with existing arrangements and appropriately resourced
- Key Challenges & Risks: Timescales generally, understand the volume of demand, recruiting additional staff with the right skills, unclear if all the costs will be covered, communication strategy
- Progress & Thinking: Available guidance has been reviewed, IT changes are key so early engagement progressing, financial modelling progressing to understand impact and required capacity and capability, operational impacts being considered

Fair Cost of Care (Market Sustainability)

- Lead: Becky Hale
- Key Dates: October 2022 (draft) February 2023 (final)
- Key Deliverables: Delivery of fair cost of care exercise and development of draft market sustainability plan
- Key Challenges & Risks: Extremely tight timescales, financial impact related to the outcome, impact on fee rates and impact on the MTFS
- Progress: Joint approach working with Coventry (and the region); national tools used; extensive market engagement; independent analysis of submissions for home care and care homes; continued work on draft market sustainability plan

CQC Oversight (People at the Heart of Care)

- Lead: Pete Sidgwick
- Key Dates: Establish CQC framework by spring 2022 and in shadow form from April 2023
- Key Deliverables: Local delivery of Care Act 2014 (part 1)
- Key Challenges & Risks: Understanding what / how delivery of the CA will be measured, national benchmarking, financial investment required.
- Progress & Thinking: We're working closely with CQC in enabling them to develop their thinking / framework. Where considering the potential areas of 'vulnerability' and good practice.

Programme arrangements

- Lead: Mike Cooke-Jones (Programme Manager)
- Key Dates/Deliverables: Two-year programme in place for 2022 to 2024. Focussing on delivering three key workstreams: Fair Cost of Care; Care Cap; CQC inspection.
- Key Challenges & Risks: Not all required detail is available; timescales out of our control; lots of National, Regional and Local ‘views’ and competing priorities influencing approach; availability of the right resources; system capability; funding arrangements understood.
- Progress & Thinking: Scoping and funding arrangements understood; progressing understanding and agreeing priorities,
projects, dependencies, constraints, outcomes, resourcing, delivery timeline and governance.

Health and Wellbeing Board

7 September 2022

0 - 5 Health Visiting Service update

1. Recommendation(s)

That the Health and Wellbeing Board:

1.1 Notes and endorses the best practice and innovation associated with the service

1.2 Notes and comments upon the issues and challenges the service is currently experiencing

1.3 Supports the short-term and long-term actions being taken locally by the Health Visiting Service and Commissioners to assist with and improve recruitment and retention as well as improve performance and mitigate the risks.

2. Background

2.1 The 0-5 Public Health Nursing Service protects and promotes the health and wellbeing of children and their families through the delivery of the Healthy Child Programme (0-5). This is a nationally mandated programme available to all infants and their families with prevention and early intervention at the heart. The service:

- Delivers the five health visitor mandatory contacts for all children between 0 and 5
- Helps parents develop and sustain a strong bond with children
- Encourages care that keeps children healthy and safe
- Protects children from serious disease, through screening and immunisation
- Reduces childhood obesity by promoting breastfeeding, healthy eating and physical activity
- Reduces smoking in pregnancy rates and support families to maintain smoke-free environments
- Identifies health issues early, including parent, infant and child mental health, so support can be provided in a timely manner
- Makes sure children are prepared for and supported in all child-care, early years and education settings and especially are supported to be ‘ready to learn at two, and ready for school by five’

2.2 The Health Visiting Service is key to delivering the Warwickshire Health and Wellbeing Strategy 2021-2026 priority 1 around helping children and young people to have the best start in life.

2.3 The Health Visiting Service has been commissioned by the Local Authority since 2017 following a change in government policy. Previously the service was commissioned and provided by the NHS.

2.4 The current contract was awarded to South Warwickshire NHS Foundation Trust (SWFT) in 2017 following a procurement process and the contract has been in place since 2018. The contract awarded was for 2 years plus 2 years. The contract has been extended for a further year in line with the Council's Contract Standing Orders (CSOs).and pursuant to Regulation 72(1) (c) Public Contracts Regulations 2015. The contract is therefore currently due to expire on 31 March 2023. Longer term commissioning options are currently being considered as part of planning for the re-procurement of the service.

3. Summary of Service Performance

3.1 The service is designed to meet a wide spectrum of needs for all children (birth - 5) within Warwickshire. There are some key areas that deliver intervention for children and families with more targeted needs, as well as delivering on the developmental reviews for all children in Warwickshire. Some of the targeted service areas that continue to support with these needs are:

- The Henry intervention supports families with healthy eating and nutrition
- Family Nurse Partnership supports very young parents and is reviewed nationally
- Breast feeding promotion supports mothers in continuing with breastfeeding.

3.2 Warwickshire Health Visiting Service continue to innovate and adapt their practice. Some examples of innovative practice are:

- Outcome Stars reporting empowers families by tracking their journey of change. This practice was shortlisted for the Nursing Times Award last year.
- Addressing increasing mental health needs with the employment of specialist Health Visitors with this expertise, including using Video Interactive Guidance (VIG) as an intervention to support attachment and prevention of escalating needs.
- The innovative work and research to address the smoking rates in the north of the County where rates are the highest.
- A self-weigh pilot in conjunction with Warwickshire's Children's Centres.

3.3 Developmental reviews and checks are mandated for all children (0-5). The performance of the contract is monitored against five Health Visitor mandated contacts/ Key performance indicators (KPIs):

- First visit – At 28 weeks pregnancy: Health Promoting Visit
- Second visit – At 10-14 days after birth: New Baby Review
- Third visit – At six to eight weeks old: Six-to-eight-week Assessment
- Fourth visit – At nine to 12 months old: One year Assessment

- Fifth visit: – At two to two and a half years' old: Two-to-two-and-a-half-year review

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3.4 The current performance data available indicates that the provider's performance in respect of qualified Health Visitor mandated contacts has declined from 2019/20 and 2020/21. There are several service challenges outlined in Section 5 which impact performance.

3.5 Table 1 below shows that there has been a downward trend for all the mandated contacts over the past year. The most significant decreases are New Birth Visits completed (as required within 14 days) have decreased from 62.2% in 19/20 to 52.7% on average last year. This is not meeting the target performance, however more than 90% of new babies are seen within 30 days of birth. The 6 to 8 week reviews are also down from 82.9% to 63.9% which is a significant drop, and again not within the target performance.

Table 1

Health Visiting Mandated Contacts Performance Data Yearly 2019-2022						
	Antenatal Contact	**New Birth Visit (Within the mandated 14 days)**	**New Birth Visit (within 30 days)**	**6-8 week review**	**12month review**	**2-2.5 year review**
KPI /*Target*	(*)	≥98%	≥98%	≥90%	≥85%	≥80%
2019-2020	2,280	62.2%	96.2%	82.9%	81.1%	79%
2020-2021	2,905	78.2%	95.2%	85%	86.7%	80.8%
2021-2022	1,170	52.7 %	94%	63.9%	81%	77%

*Number of mothers who received a first face-face antenatal contact with a Health Visitor at 28 weeks or above: This is unable to be collected as a percentage due to the difficulties in defining an adequate denominator.

3.6 Table 2 below shows that performance has declined throughout 2021-22 consistently by each quarter. The performance from quarter 1 (Q1) to quarter 4 (Q4) has declined for:

- New Birth Visits (within 14 days) from 66.2% to 49.4%,
- 6 to 8 week checks from 81.9% to 51%,
- 12 month reviews from 86% to 73%,
- 2- 2.5 year reviews from 84.9% to 77%

Table 2- Health Visiting Mandated Contacts Quarterly Performance Data 21/22

Quarter	Antenatal Contact	New Birth Visit (within 14 days)	Total Seen within 30 Days	6-8 week review	12 month review	2-2.5 year review
Q1	505	66.2%	95%	81.9%	86%	84.9%
Q2	161	50.8%	94%	65.2%	83.8%	82.5%
Q3	216	45.3%	92%	59%	80%	80%
Q4	288	49.42%	95%	51%	73%	77%

3.7 The impact on children and their families of this reduced performance is that a number of families are not receiving the mandated contacts either antenatally or at the 6 to 8 week review. 95% of families are still being seen for a new birth visit within 30 days of birth. In terms of additional mitigation:

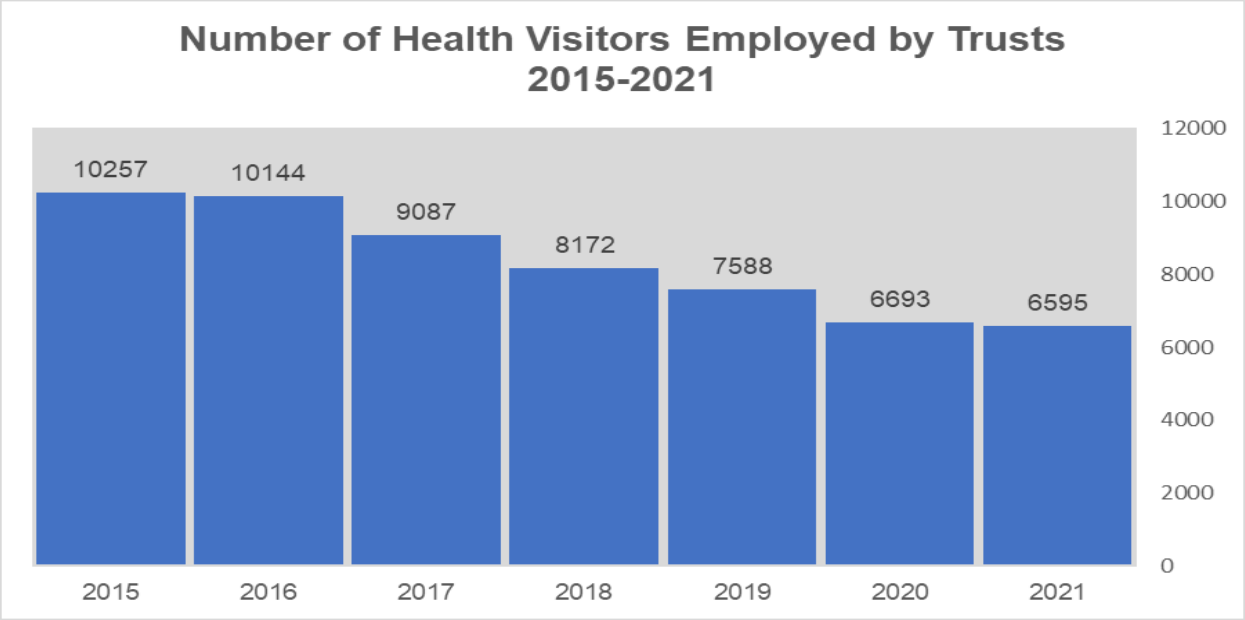
- Those children and families with additional needs, vulnerabilities and requiring targeted or specialist interventions are prioritised for visits antenatally and at 6 to 8 weeks.
- Families who have been assessed as requiring no additional intervention and are therefore following a universal pathway will not be visited antenatally or at 6 to 8 weeks. However, other health services do see the children at these key times i.e. midwives and GPs antenatally, and GPs undertake New Infant Physical Examinations (NIPE) and immunisations in surgery around 6 to 8 weeks.

4. Service Issues and Challenges

4.1 Recruitment and retention of qualified Health Visitors

There is a national shortage of qualified Health Visitors. Graph 1 below shows the decline in the number of qualified Health Visitors nationally in the NHS from 2015 to 2021. The peak is from the `Call to Action' when there were over 10,000 staff which has declined to around 7,000 to date. Factors that are believed to have contributed to the decline are recovery from the Covid19 Pandemic (staff retiring, leaving the service) and University courses not being viable due to lack of intake. Warwickshire's staffing situation mirrors the national picture. The numbers of Health Visitors in post in the local service are 68 with a permanently funded establishment of 86.

Graph 1 (Decline in Health Visiting Workforce)



Source: NHS Workforce Statistics, NHS Digital, March 2021

4.2 Increasing caseloads

The nationally advocated maximum caseload for a qualified Health Visitor is 250 children according to the Institute of Health Visiting. The caseloads in Warwickshire currently range between 289 to 759 children per Health Visitor (based on staff in post not establishment). The highest figure in Warwickshire is in Rugby and is due to the number of vacancies at present in that area. The lowest figure is in an area of significant deprivation in North Warwickshire. Teams are constructed with lower caseloads overall when the numbers of safeguarding cases are higher.

Even if the service was fully staffed, the caseload would be in excess of the national recommendation. In previous years by the end of August the caseloads have reached 390-400 in many areas of Warwickshire (there is an annual cycle as a significant number of children move onto School Nursing service in September each year).

4.3 Increasing population

The 0-5 years Joint Strategic Needs Analysis (JSNA) published in May 2022 identifies that the child population in Warwickshire is increasing. This is due to a

higher birth rate but also due to families moving into the area. The JSNA predicts that given current trends by 2043 there is likely to be an increase of the birth to 5 population of 17.7%.

4.4 Increasing complexity and level of need

As seen across many services for children and young people following the pandemic, the complexities and level of needs that families are experiencing have increased. Staff report that they are spending more time with families supporting around safeguarding, domestic abuse, mental health issues and cost of living worries. This means that what has been manageable in caseload numbers is now much harder to manage.

The NHS remains under considerable and seasonal pressures with surges in Covid taking place. This impacts on the service due to the increased level of sickness/ self- isolation required as well as restrictions in terms of social distancing remain in place at times.

5. Recovery/Restoration Plan

5.1 The provider (SWFT) and commissioner (the Council) co-developed a Joint Recovery Plan in Autumn 2021 to address the significant pressures on the service. The purpose of the plan was to mitigate risk to children and families, manage the ongoing service pressures and prioritise work both over the short-term and longer-term.

5.2 The Joint Recovery Plan has focussed on:

5.2.1 Short-term actions:

These were immediate actions agreed in December 2021 that were put into place over the following months, and included:

- The joint prioritisation of the five mandated contacts (as outlined above).
- Reviewing workforce capacity & skills mix including:
  - A review of the skill mix within the teams across the County e.g. introduction of 4 Band 5 roles, and increasing student numbers.
  - Collaborative working with partners, including the Council's Early Help teams, Midwifery and GPs
  - Using creative solutions to maximise reach including CHAT health, and amalgamating a duty service across teams

5.2.2 Long-term actions

There is recognition that some key actions and strategic responses are required in the longer term to ensure that the recovery of the service is sustainable. Actions are recommended in the following areas:

Workforce integration & Skills Mix

- Continuous recruitment in progress
- Engage with National work force planning via NHSE

Development of service offer

- Co-Production with parents to define service delivery outcomes
- Ensuring clinic slots are more available and accessible.

Early Help System Integration

- Further work required within the system around the development of early help.
- Commitment to Sector Led Improvement Tool

Scoping of needs

- JSNA completed and recommendations being pursued

Contract and governance

- In early 2023, an options appraisal will be developed between the Council to explore future commissioning and procurement options for this service, with regard to the new NHS provider selection regime.

5.3 The recovery plan is reviewed monthly involving service and commissioning leads and oversight from Assistant Directors for Commissioning, and Children & Families, and the Director of Public Health. Commissioners have been working with Health Visiting Managers towards reinstating services and improving the compliance with the mandatory contacts for all families. There is joint work underway to model the impact the above actions will have on contract performance over the next six to twelve months.

6. Financial Implications

6.1 The current value of the Health Visiting contract is £6,444,515 annually. This mandated service is funded from within the Public Health Grant.

6.2 Demand has increased for Health Visiting service because of the increasing needs around migration and the impact of the pandemic.

7. Environmental Implications

None

	Name	Contact Information
Report Author	Claire Groves Robert Sabin Sarah Foster Katy Coates	clairegroves@warwicskhire.gov.uk robsabin@warwickshire.gov.uk Sarah.foster@swft.nhs.uk Catherine.coates@swft.nhs.uk
Assistant Director/DPH	Shade Agboola Director of Public Health	shadeabboola@warwickshire.gov.uk
Strategic Director	Nigel Minns Strategic Director for People	nigelminns@warwickshire.gov.uk
Portfolio Holder	Cllr Margaret Bell Portfolio Holder for Adult Social Care and Health	margaretbell@warwickshire.gov uk

The report was circulated to the following members prior to publication:

Local Member(s): Not applicable – county wide paper
Other members: Cllrs Bell, Drew, Golby, Holland and Rolfe

Agenda Item 4

Health and Wellbeing Board

7 September 2022

Better Care Fund (BCF) Plan 2022/23

Recommendation(s)

The Board is recommended to:

1. Note the Better Care Fund Policy Framework and Planning Requirements for 2022/23;

2. Provide feedback on the draft Better Care Fund Narrative Plan, Planning Template and Capacity and Demand Plan for 2022/23 to ensure that these contribute to the wider Health and Wellbeing Board's prevention priorities as well as meeting the BCF national conditions; and

3. Confirm arrangements for a Sub-Committee of the Board to approve the final version of the Better Care Fund (BCF) Plan for 2022/23, for submission to NHS England.

1. Executive Summary

1.1 The Better Care Fund (BCF) is a programme spanning both local government and the NHS which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

Better Care Fund Policy Framework 2022/23

1.2 Earlier in the year, Health and Wellbeing Boards (HWBs) were advised that BCF policy and planning requirements would be published and that similar to the previous year, HWBs would be required to submit their BCF Plans to NHS England for approval.

1.3 The Better Care Fund 2022/23 Planning Requirements published on 19th July 2022, set out the template for Health and Wellbeing Boards (HWBs) to submit their annual plans for approval.

For 2022-23, BCF plans will consist of:

- A narrative plan
- A completed BCF planning template, including:
  - Planned expenditure from BCF sources.
  - Confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams.

  - – Ambitions and plans for performance against BCF national metrics.
  - – Any additional contributions to BCF section 75 agreements.
- An intermediate care capacity and demand plan.

1.4 The deadline for submission of the BCF plan to NHS England is 26th September 2022. Agreement is therefore sought for approval of the final version of the plan to be delegated to a Sub-Committee of the Health and Wellbeing Board, once it has been approved by the ICB and the Council.

National Conditions

1.5 The Better Care Fund Policy Statement for 2022-23 provides continuity to previous years of the programme. The policy framework outlines the four national conditions:

1. **A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board** - That a BCF Plan, covering all mandatory funding contributions has been agreed by Health and Wellbeing Board (HWB) areas and minimum contributions (specified in the BCF allocations and grant determinations) are pooled in a section 75 agreement (an agreement made under section 75 of the NHS Act 2006) by the constituent local authorities (LAs) and Integrated Care Boards (ICBs).

2. **NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution -** The contribution to social care from the ICB via the BCF is agreed and meets or exceeds the minimum expectation. In 2022/23 for Warwickshire the minimum contribution is £15.273m.

3. **Agreement to invest in NHS commissioned out-of-hospital services** - That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, while supporting integration plans. In 2022/23 for Warwickshire the minimum contribution is £12.206m.

4. **Implementing the BCF Policy Objectives** – National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:
   i. Enable people to stay well, safe and independent at home for longer.
   ii. Provide the right care in the right place at the right time.

1.6 For the first time, systems are also required to agree high level capacity and demand plans for intermediate care services, covering both BCF and non-BCF funded services. As a first step, areas are asked to jointly develop a single picture of intermediate care needs and resources across health and social care funded by the BCF and other sources for quarters 3 and 4 of 2022/23. These capacity and demand plans will need to be submitted with main BCF plans, but the content will not form part of the overall BCF assurance process.

1.7 The Coventry and Warwickshire Integrated Care Board ('ICB', previously known as Coventry and Warwickshire Clinical Commissioning Group) and the local authority are required to confirm compliance with the above conditions to the Health and Wellbeing Board. Compliance with the national conditions will be confirmed through the planning template and narrative plan. Spend applicable to these national conditions is be calculated in the planning template based on scheme-level expenditure data.

1.8 The ICB and local authority are also required to ensure that local providers of NHS and social care services have been involved in planning the use of BCF funding for 2022 to 2023. In particular, activity to support discharge funded by the BCF should be agreed as part of the whole system approach to implementing the Hospital Discharge Service Policy and should support an agreed approach for managing demand and capacity in health and social care. This continues to be achieved through the Better Together Programme and Joint Commissioning Board.

The Future of the Better Care Fund

1.9 The BCF Policy Framework announced that later this year NHS England along with the Department of Health and Social Care and the Department for Levelling Up, Housing and Communities will set out the policy framework for the BCF from 2023 onwards, including how the programme will support implementation of the new approach to integration at a place level, set out in the Health and Social Care Integration White Paper, as well as wider reforms. Local areas will be engaged in the development of this framework.

2. Financial Implications

Grant Funding to Local Government

2.1 **Improved Better Care Fund (iBCF)** – In advance of the 2022/23 financial year and publication of the BCF Policy Framework, the Health and Wellbeing Board at its meeting on 12th January 2022 reviewed and supported the list of schemes to be funded from the IBCF for 2022/23.

2.2 These schemes have now been assured against the Policy Framework and it has been confirmed that they continue to meet the required conditions of the grant.

2.3 The grant conditions remain broadly the same as 2021/22. The funding may only be used for the purposes of:

- Meeting adult social care needs.
- Reducing pressures on the NHS, including seasonal winter pressures.
- Supporting more people to be discharged from hospital when they are ready.
- Ensuring that the social care provider market is supported.

2.4 **Disabled Facilities Grant** - Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local authorities. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities.

2.5 Similar to previous years, the Disabled Facilities Grant continues to be allocated through the Better Care Fund through top tier authorities due to its importance to the health and care system and is pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and is an integral part of our integration plans, and strategic use of the DFG can support this. The amounts allocated to the District and Borough Councils are pass-ported straight to them and monitoring of expenditure takes place at the Heart Board, with assurance through the Housing Partnership Board, a sub-group of the Better Together programme, as decisions around the use of the DFG funding need to be made with the direct involvement of both tiers working jointly to support integration.

Financial contributions

2.6 Funding sources and expenditure plans:

		2022/23		
		Pooled Contribution	**Aligned Allocation**	**Total Budget**
		£'000	**£'000**	**£'000**
Minimum NHS ring-fenced from ICB allocation	ICB (SW Place)	20,154	61,290	**81,444**
	ICB (WN Place)	14,344	32,743	**47,087**
	ICB (Rugby Place)	8,286	18,091	**26,377**
Disabled Facilities Grant (DFG)		5,124	-	**5,124**
Warwickshire County Council Improved Better Care Fund (iBCF)		15,133	-	**15,133**
Warwickshire County Council		-	71,308	**71,308**
Total Pooled Contribution		**63,040**		
Total Additional Aligned Allocation			**183,432**	
Total Budget				**246,472**

* Notes:

1) The above table is rounded to £000's for summary purposes.
2) Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s). These additional contributions are not subject to

the conditions of the BCF but should be recorded in the planning template.

3) Please refer to the attached Appendix for more detail on funding contributions and spending plans.
4) All finances in the BCF Plan 2022/32 have been prepared by the Finance Sub-Group in which Finance Leads from both the Local Authority and ICB are represented.

2.7 Local Areas are also expected to keep records of spending against schemes funded through the BCF. This activity is led by Finance Leads at WCC and the ICB on the Finance Sub-Group which supports the Better Together Programme and assurance is through the Joint Commissioning Board. iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local authorities, working with the ICB, determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required through BCF reporting.

Mandatory funding sources

2.8 The following minimum funding must be pooled into the Better Care Fund in 2022/23:

Funding Sources	**2022/23**
DFG	£5,124,786
Minimum NHS Contribution	£42,782,742
iBCF	£15,133,281
Total	**£63,040,809**

Financial Implications

2.9 The programme and initiatives for its success are in part funded through national grants: Better Care Fund, Improved Better Care Fund and Disabled Facilities Grant (2022/23: £63m). The former comes from the Department of Health and Social Care through the ICB, while the latter is received by the local authority from Department for Levelling Up, Housing and Communities. All three are dependent on meeting conditions that contribute towards the programme and the targets, and that plans to this effect are jointly agreed between the Integrated Care Board and the Local Authority under a pooled budget arrangement.

2.10 Similar to previous years the County Council continues as the pooled budget holder for the fund.

2.11 The County Council also continues to align Out of Hospital service provision and funding with Coventry and Warwickshire Integrated Care Board to support closer integration as part of plans for moving to an Integrated Care System.

2.12 The iBCF is temporary. In order to counter the risk inherent in temporary funding, all new initiatives are temporary or commissioned with exit clauses. There are, however, a number of areas where the funding is being used to maintain statutory social care spending and this would require replacement funding if the Better Care Fund was removed without replacement. This risk is noted in Warwickshire County Council's annual and medium-term financial planning.

2.13 As in previous years, a Section 75 Legal Agreement will underpin the financial pooling arrangements. This cannot be signed until our Plan is nationally approved. In order to avoid under delivery and underspends, schemes and initiatives have to be entered into prior to the legal agreement being signed, but this is no different to previous years. The intention is that the Section 75 agreement will be drafted so that it can be signed by the partner organisations as soon as approval is granted.

3. Environmental Implications

None.

4. Supporting Information

Metrics

4.1 The BCF Policy Framework sets national metrics that must be included in BCF plans in 2022/23. Ambitions should be agreed between the local authority and the ICB and signed off by the HWB.

4.2 The framework retains two existing metrics which impact the local authority from previous years:

- effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation
- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

4.3 The measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population) introduced last year has also been retained. Areas need to agree expected levels of avoidable admissions and how services commissioned through the BCF will minimise these.

4.4 With regard to Discharge Metrics – Improving the proportion of people discharged from acute hospital to their usual place of residence has also been retained.

4.5 HWBs are no longer required to set targets relating to reducing length of stay measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days. Despite this there is an expectation

that local areas will continue to monitor their performance and so performance will be reported through the Joint Commissioning Board.

4.6 The proposed ambitions for 2022/23 and rationale are set out in the Planning Template and Narrative Plan.

4.7 Locally we will continue to monitor progress quarterly against the BCF metrics set out above through the Joint Commissioning Board and Coventry and Warwickshire Urgent and Emergency Care Board.

5. Timescales associated with the decision and next steps

5.1 Prior to review by the Health and Wellbeing Board, the BCF Plan for 2022/23 has been reviewed and approved by:

Organisation	Board	Date
Partnership	Joint Commissioning Board	17/08/22
WCC	People Directorate Leadership Team	31/08/22
WCC	Corporate Board	07/09/22
ICB	Finance and Performance Committee	07/09/22

5.2 Following review and feedback from the Health and Wellbeing Board, the BCF Plan for 2022/23 will then be reviewed and approved by:

Organisation	Board	Date
WCC	Cabinet	08/09/22
ICB	Board	21/09/22
Partnership	Health and Wellbeing Board Sub-Committee	22/09/22
Submission date		**26/09/22**

Regional and National Assurance

5.3 NHS England will approve BCF plans in consultation with the Department for Health and Social Care and the Department for Levelling Up, Housing and Communities. Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed. Assurance of plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives and will be a single stage exercise based on a set of key lines of enquiry. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. Once approved - NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Assurance activity	Date
BCF planning requirements received	19th July 2022
Optional draft BCF planning submission submitted to regional Better Care Manager	By 18th August 2022
BCF planning submission from local HWB areas	26th September 2022

(agreed by ICB and WCC) sent to national BCF Team at NHS England	
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26th September to 24th October 2022
Cross regional collaboration	1st November 2022
Approval letters issued giving formal permission to spend (NHS minimum)	30th November 2022
All section 75 agreements to be signed and in place	31 December 2022

Appendices

1. Appendix 1 – BCF Narrative Plan
2. Appendix 2 – BCF Planning Template
3. Appendix 3 – BCF Capacity and Demand Plan

Background Papers

1. None.

	Name	**Contact Information**
Report Author	Rachel Briden Integrated Partnership Manager	rachelbriden@warwickshire.gov.uk
Assistant Director	Becky Hale Chief Commissioning Officer (Health and Care)	beckyhale@warwickshire.gov.uk
Strategic Director	Nigel Minns Strategic Director for People	nigelminns@warwickshire.gov.uk
Portfolio Holder	Councillor Margaret Bell	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillors Bell, Drew, Golby, Holland and Rolfe

Integration and Better Care Fund (BCF) Plan

Better Care Fund Plan 2022/23 Submission – version 0.3 DRAFT

Health and Wellbeing Board (HWBB):

Warwickshire

National Condition 1: A jointly agreed plan

Planning Requirement 1 - A jointly developed and agreed plan

Key Line of Enquiry: Organisations involved in preparing the plan

The following organisations/partnerships have been involved in developing the schemes and joint integration activities as set out in this Better Care Fund (BCF) Plan for 2022/23 (and supporting BCF Planning Template), that will be submitted to NHS England for assurance:

- Representatives on the Warwickshire Joint Commissioning Board:
    - Commissioning, delivery and finance leads from children/young people and families (including Education), public health and adult social care from Warwickshire County Council (WCC);
    - Clinical, commissioning and finance leads from Coventry and Warwickshire Integrated Care Board (CWICB) previously known as the Coventry and Warwickshire Clinical Commissioning Group (CWICB);
    - Operational and contracting leads from South Warwickshire University NHS Foundation Trust (SWFT) and Coventry and Warwickshire Partnership Trust (CWPT);
    - Office of the Police and Crime Commissioner for Warwickshire, and Warwickshire Police Safeguarding Team;
    - Head Teacher representatives
- Acute Trusts (South Warwickshire University NHS Foundation Trust, George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust) and Coventry City Council through the Coventry and Warwickshire Urgent and Emergency Care Delivery Board.
- The five District and Borough Councils (Stratford Upon Avon District Council, Warwick District Council, Nuneaton and Bedworth Borough Council, Rugby Borough Council and North Warwickshire Borough Council) through the Better Care Fund Housing Partnership Board.
- Social care providers through mutual aid discussions, providers forums and targeted discussions related to specific schemes/initiatives.
- The Councils Learning and Development Partnership distribute a virtual newsletter every month to all commissioned providers. This is full of local and national updates and issues that are current to the provider market at a specific point in time. It also offers local training courses that the provider workforce is able to access.
- The Warwickshire Homecare Association Partnership acts as the spokesperson for domiciliary care providers and Commissioning colleagues have monthly meetings with the Association and contracted provider members. Ongoing dialogue also takes place regularly between the Association and the Council to share strategic updates and problem solve current issues.
- VCS organisations through Place Based Partnerships, the Warwickshire Ageing Well Programme and Board, neighbourhood Place Based Teams and Health and Wellbeing Board.

Warwickshire Health and Wellbeing Board members considered proposed schemes at their meeting on the 12th January 2022.

Key Line of Enquiry: How we have gone about involving these stakeholders

Preparatory Activity

In advance of receipt of the Better Care Fund Policy Framework and Planning Requirements, draft schemes, activities and priorities to be delivered through the Better Care Fund local delivery programme (the Better Together Programme) were discussed and agreed in meetings and through wider engagement between November 2021 and January 2022 with the partners listed above, ready for the start of the 2022/23 year.

Preparing the BCF Plan

Following receipt of the BCF Planning Requirements on the 19th July 2022 – the stakeholders represented on the Joint Commissioning Board and Coventry & Warwickshire Urgent and Emergency Care Board (listed above) have been re-engaged during August 2022 to reaffirm and update, where required, the schemes, activities, and metrics. In addition, during August the Warwickshire Care Collaborative Development Group, as part of the Coventry and Warwickshire Integrated Care System (ICS) have been involved in our BCF plans.

Approval of the BCF Plan

We are therefore pleased to confirm commitment to, and agreement by, all signatories of the plan. This includes the funding and spending proposals summarised in this plan (Local Authority, DFG, ICB minimum contribution and iBCF) and set out in more detail in the Planning Template.

Approval timetable

The following confirms the governance route for signing off the plan:

Organisation		Review and Decision / Approval Date
Wider Partnership	Joint Commissioning Board	17/08/22
WCC	People Directorate Leadership Team	31/08/22
WCC	Corporate Board	07/09/22
WCC	Cabinet	08/09/22
CW ICB	Integrated Care Board	21/09/22
Partnership	Health and Wellbeing Board – review, and approval	07/09/22 & 22/09/22
	Submission deadline	**26/09/22**

Responsibilities for preparing this plan

Accountable: Chief Commissioning Officer (Health and Care), Warwickshire County Council and South Warwickshire University NHS Foundation Trust

Responsible: Rachel Briden, Integrated Partnership Manager, WCC.

Consulted: All partners represented on the Warwickshire Joint Commissioning Board, Warwickshire County Council's Corporate Board and Cabinet, Coventry and Warwickshire ICB Executive Team and Board, Coventry and Warwickshire's Urgent and Emergency Care Delivery Board, Care Collaborative Development Group.

Informed: Warwickshire Health and Wellbeing Board

Document History

Version	Summary of changes	Author	Date
V0.1	Draft version shared within WCC	Rachel Briden	08/08/22
V0.2	Draft version shared with partners on the JCB & Regional Better Care Fund Manager for feedback	Rachel Briden	16/08/22
V.03	Includes feedback received from Regional Better Care Fund Manager and is the version for review and sign off by People DLT, Corporate Board, Cabinet and CWICB F&P Committee	Rachel Briden	25/08/22
V0.4	Final version for approval by the HWBB for submission to NHS England	Rachel Briden	

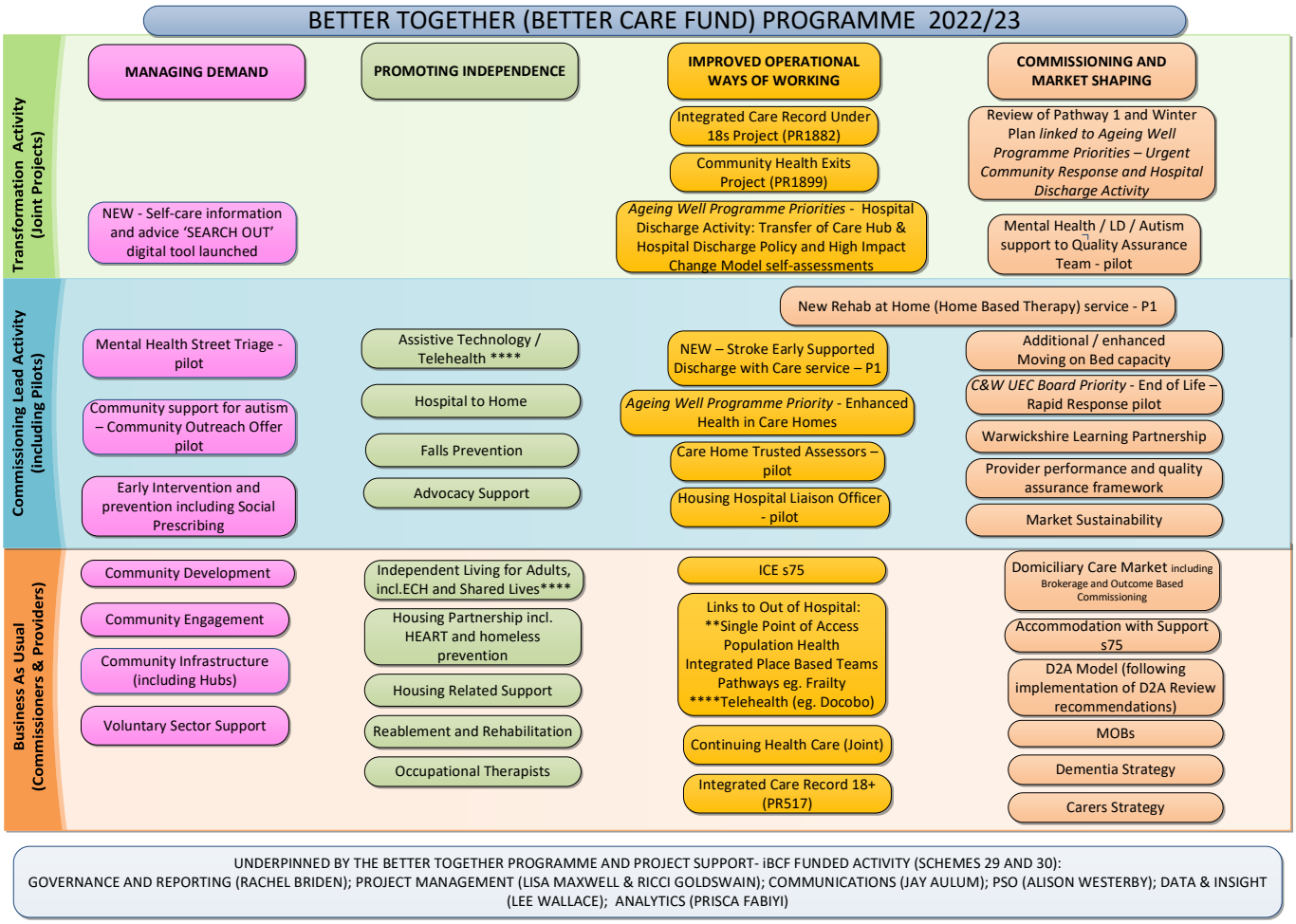
Executive Summary

Background

The Better Care Fund has been one of the key contributors over the last seven years towards building stronger partnerships and integration between the commissioners and providers of health and care services in Warwickshire. Despite significant pressures across the system including a continual reduction in social care resources and increasing acuity of need, partners have strived to make a sustained difference to the way services are organised and delivered. By working together the expertise and strengths within the system have been acknowledged and resulted in opportunities to be more innovative and reshape how services are commissioned and delivered. These foundations have enabled the services currently commissioned through the Better Care Fund to commence with plans to move responsibility into the geographical collaboratives of the new Coventry and Warwickshire Integrated Care System during phase 1 development.

Locally our BCF Plan for 2022/23 will continue to build on our long-term vision, as outlined in our original submission in 2015/16, our updated 2017-19 plan, and builds on the progress made from 2016-22.

The majority of schemes and activities in our BCF plan for 2022/23 continue on from previous years. The illustration below summarises the schemes in our BCF Plan, new activity and the links to NHS programme activity:



Joint Priorities for 2022/23

At the beginning of the year, the following new schemes were agreed to support the two BCF Objectives to 1. Enable people to stay well, safe and independent at home for longer and 2. Provide the right care in the right place at the right time:

1. Transformation project activity being delivered through the Better Together Programme:
    a. Extension of the integrated care record in WCC (already delivered for Adults in March 2022) for under 18s; and
    b. Streamlining access to social care for those patients requiring on-going support on exit from Community Health pathways (Home Based Therapy, Home First, Urgent Community Response or Stroke ESD)
2. Hospital Discharge improvement activity relating to trusted assessments, the High Impact change Model and transfer of care hub to be delivered through the System Operational Discharge Delivery Group facilitated by WCC through the Better Together Programme and assured through the Warwickshire Ageing Well Programme governance.

Key Changes since the previous BCF plan and how we will continue to implement a joined up approach to integrated services

As the new architecture for the Coventry and Warwickshire Integrated Care System have started to be implemented, increased focus on joint delivery (in addition to joint commissioning which has been in place for a while) has resulted in some of the duplication in previous years being removed, as operational and commissioning activity delivered through both the BCF and Ageing Well Programmes are now embedded in the new arrangements.

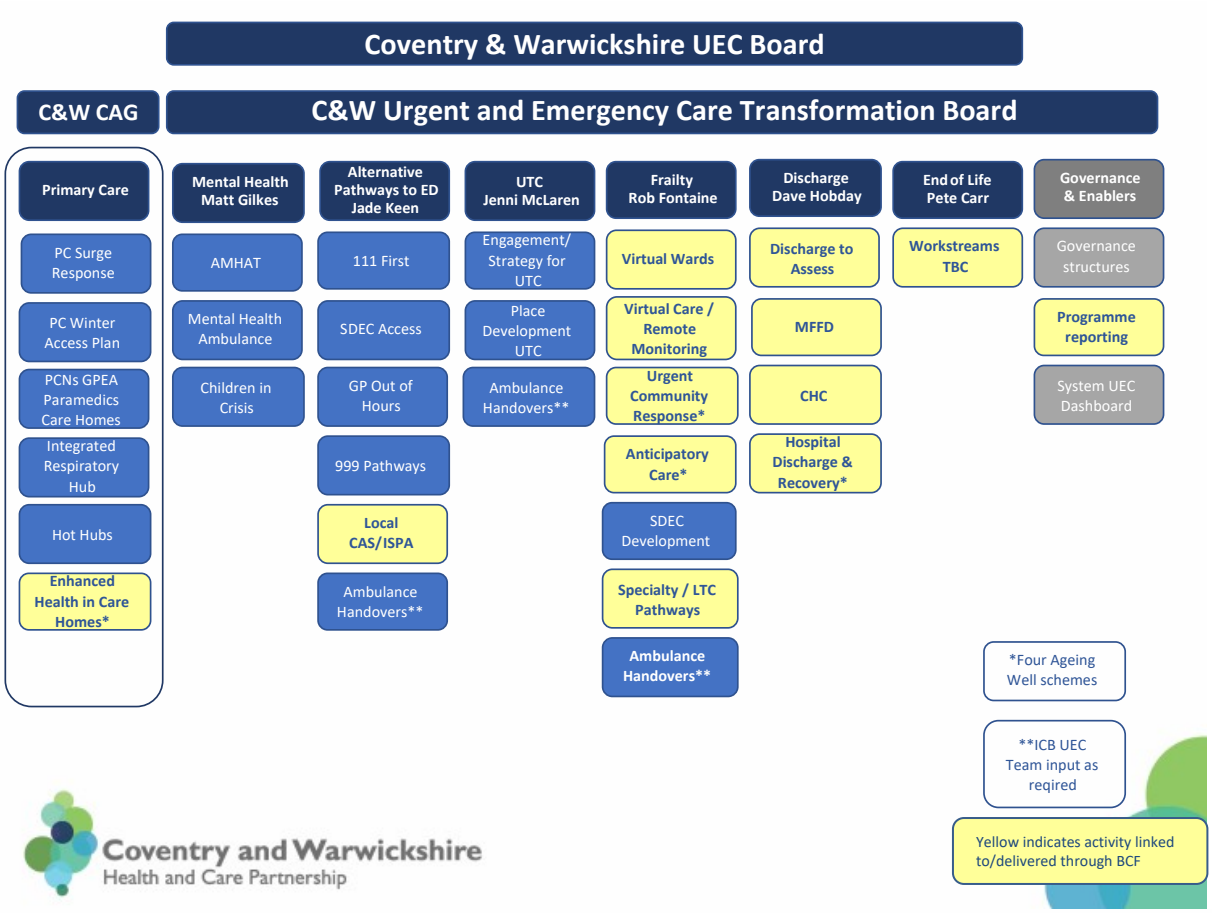
A good example of this is, through the Enhanced Health in Care Homes Ageing Well Programme workstream there has been considerable development of Telehealth Remote Monitoring (Docobo) in Coventry and Warwickshire

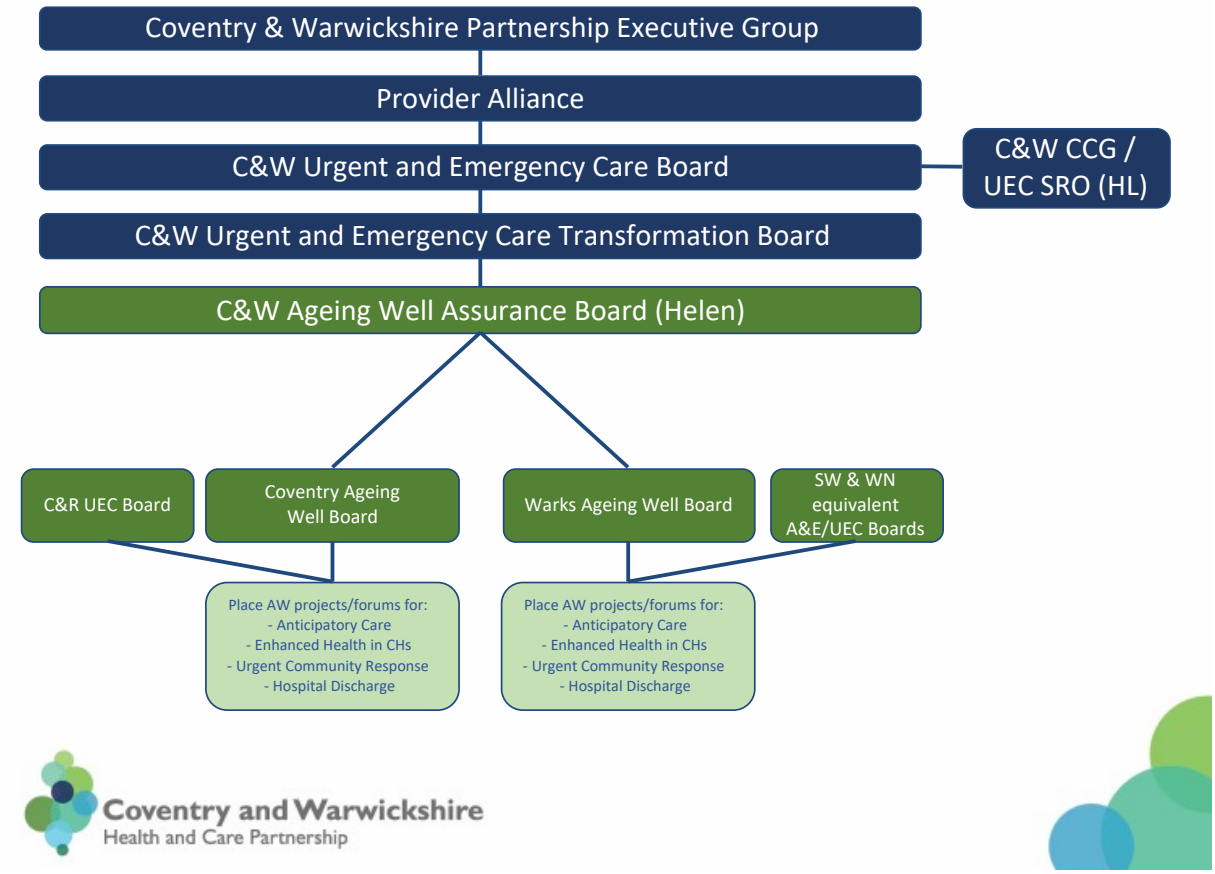
- This includes the roll out of Docobo in care homes for older people across Coventry and Warwickshire. It first worked with homes in North Warwickshire and following a very successful implementation is now also well-established and still growing in the Rugby and South areas of Warwickshire as well as getting underway more recently in Coventry and in care homes for younger age adults with disabilities in North Warwickshire.
- The table below shows summarises the current level of involvement by care homes for older people in Coventry and Warwickshire.

	Live Homes	Active Residents	Delivery Status
Warwickshire North Older People Care Homes	24	1036	89%
Warwickshire South Older People Care Homes	8	314	80%
Warwickshire Rugby Older People Care Homes	24	433	73%
Coventry Older People Care Homes	2	49	14%
Warwickshire North Disabilities Care Homes	19	96	95%
TOTAL	**77**	**1,928**	

- Deteriorating patients in care homes, has been built into Docobo and where this is in use the current response time to any alerts is around 96% within 2 hrs of the alert.
- Due to the success in care homes, Docobo at Home is also now being planned as part of the Anticipatory Care workstream in the Ageing Well Programme.
- Digital infrastructure has focussed on sign up to the data security and protection toolkit and the use of NHS mail. This supports the use of electronic proxy ordering of medicines which is also being rolled out across Warwickshire.

The key cross-cutting and joint priorities are highlighted in yellow in the illustration below, along with the ICS reporting arrangements:

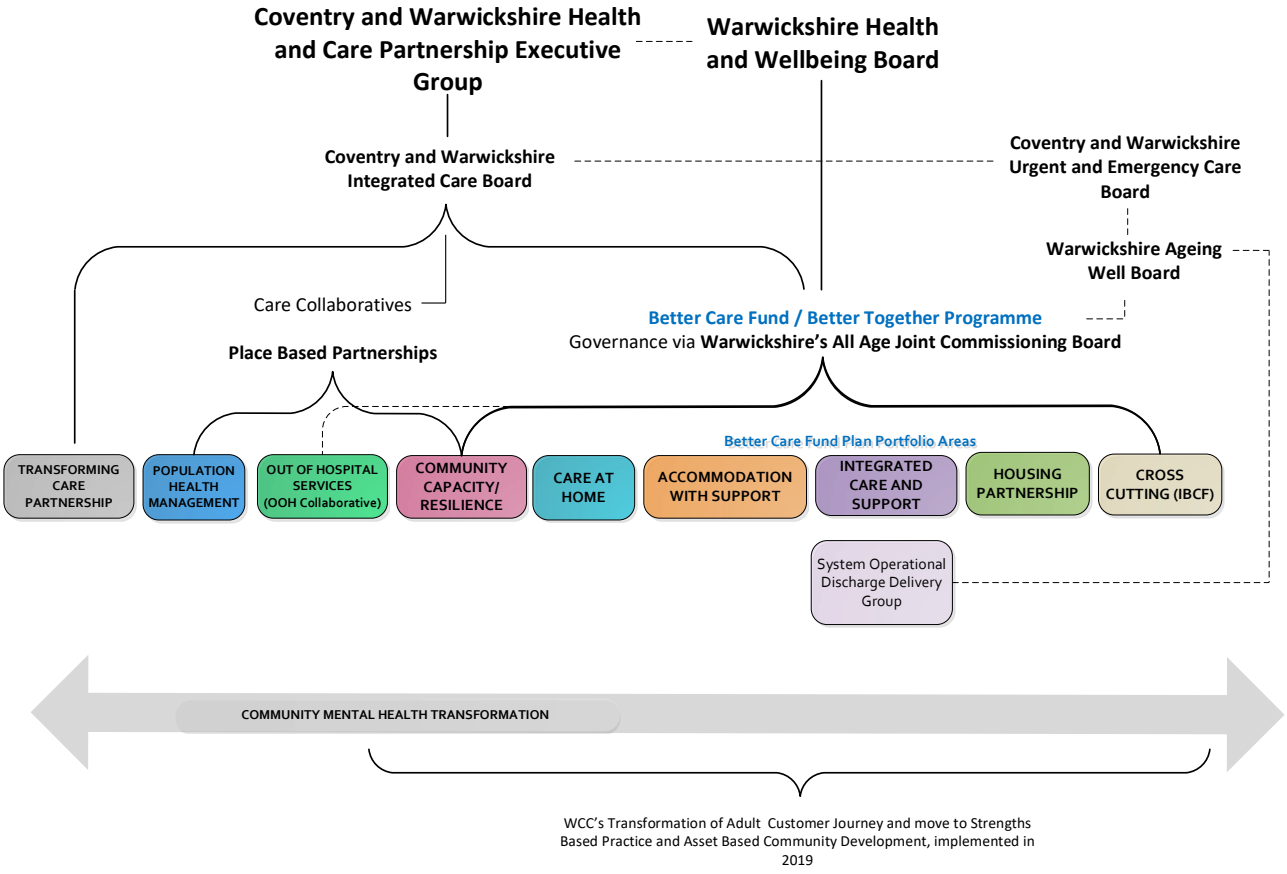

Coventry & Warwickshire UEC Board
C&W CAG
C&W Urgent and Emergency Care Transformation Board
Primary Care
PC Surge Response
PC Winter Access Plan
PCNs GPEA Paramedics Care Homes
Integrated Respiratory Hub
Hot Hubs
Enhanced Health in Care Homes*
Mental Health Matt Gilkes
AMHAT
Mental Health Ambulance
Children in Crisis
Alternative Pathways to ED Jade Keen
111 First
SDEC Access
GP Out of Hours
999 Pathways
Local CAS/ISPA
Ambulance Handovers**
UTC Jenni McLaren
Engagement/ Strategy for UTC
Place Development UTC
Ambulance Handovers**
Frailty Rob Fontaine
Virtual Wards
Virtual Care / Remote Monitoring
Urgent Community Response*
Anticipatory Care*
SDEC Development
Specialty / LTC Pathways
Ambulance Handovers**
Discharge Dave Hobday
Discharge to Assess
MFFD
CHC
Hospital Discharge & Recovery*
End of Life Pete Carr
Workstreams TBC
Governance & Enablers
Governance structures
Programme reporting
System UEC Dashboard
*Four Ageing Well schemes
**ICB UEC Team input as reqired
Yellow indicates activity linked to/delivered through BCF
Coventry and Warwickshire
Health and Care Partnership


Coventry & Warwickshire Partnership Executive Group
Provider Alliance
C&W Urgent and Emergency Care Board
C&W CCG / UEC SRO (HL)
C&W Urgent and Emergency Care Transformation Board
C&W Ageing Well Assurance Board (Helen)
C&R UEC Board
Coventry Ageing Well Board
Warks Ageing Well Board
SW & WN equivalent A&E/UEC Boards
Place AW projects/forums for:
- Anticipatory Care
- Enhanced Health in CHs
- Urgent Community Response
- Hospital Discharge
Place AW projects/forums for:
- Anticipatory Care
- Enhanced Health in CHs
- Urgent Community Response
- Hospital Discharge
Coventry and Warwickshire
Health and Care Partnership

Governance of the BCF Plan and implementation in Warwickshire

In Warwickshire the mechanism for joint health, housing and social care planning is through the Better Together Programme.

Governance of implementation of the Better Care Fund, BCF Plan and Better Together Programme is through the all age Warwickshire Joint Commissioning Board.



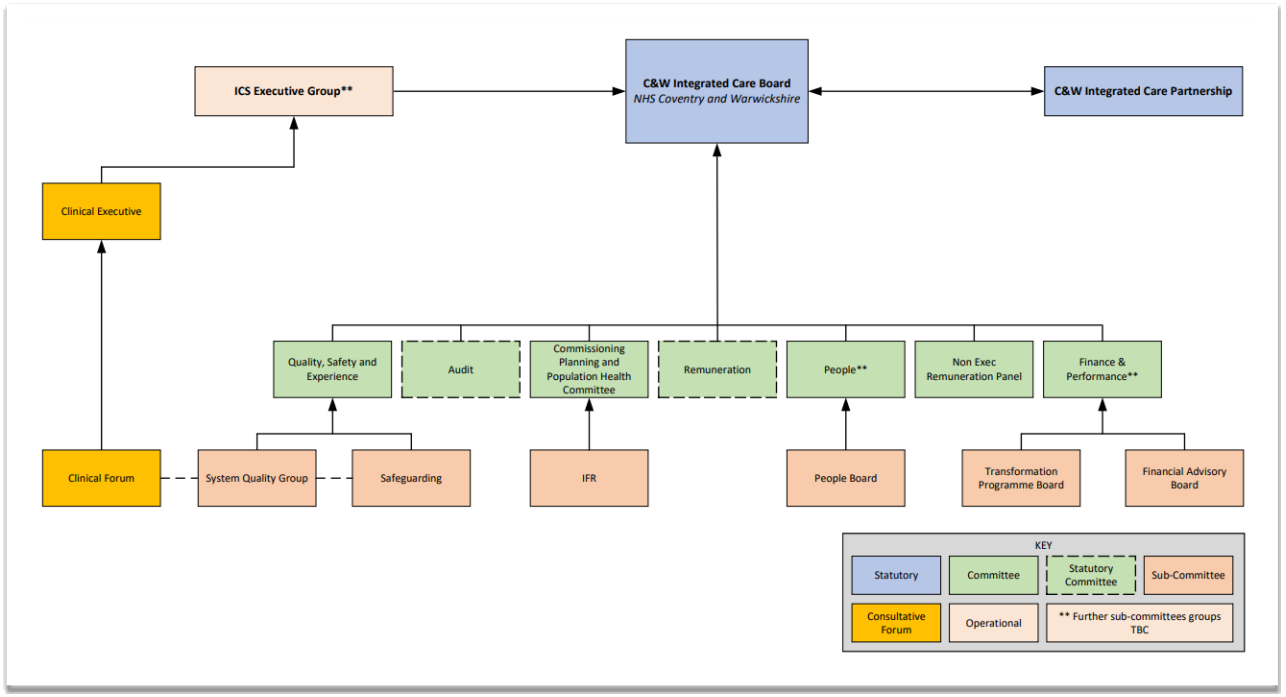
Our BCF Plan comprising of the pooled/aligned budgets, list of schemes, metrics and priorities outlined in the Planning Template and this Narrative Plan have been developed by the Joint Commissioning Board, as part of these wider partnership and system governance arrangements.

The Board is supported by a Finance Sub-Group (comprising of Finance Leads from the local authority and CWICB) which leads on scheme level spending plans for the pooled (base BCF) and aligned budgets, managing the impact of the end of the Covid-19 related Hospital Discharge Grant, risk share and associated Section 75 arrangements.

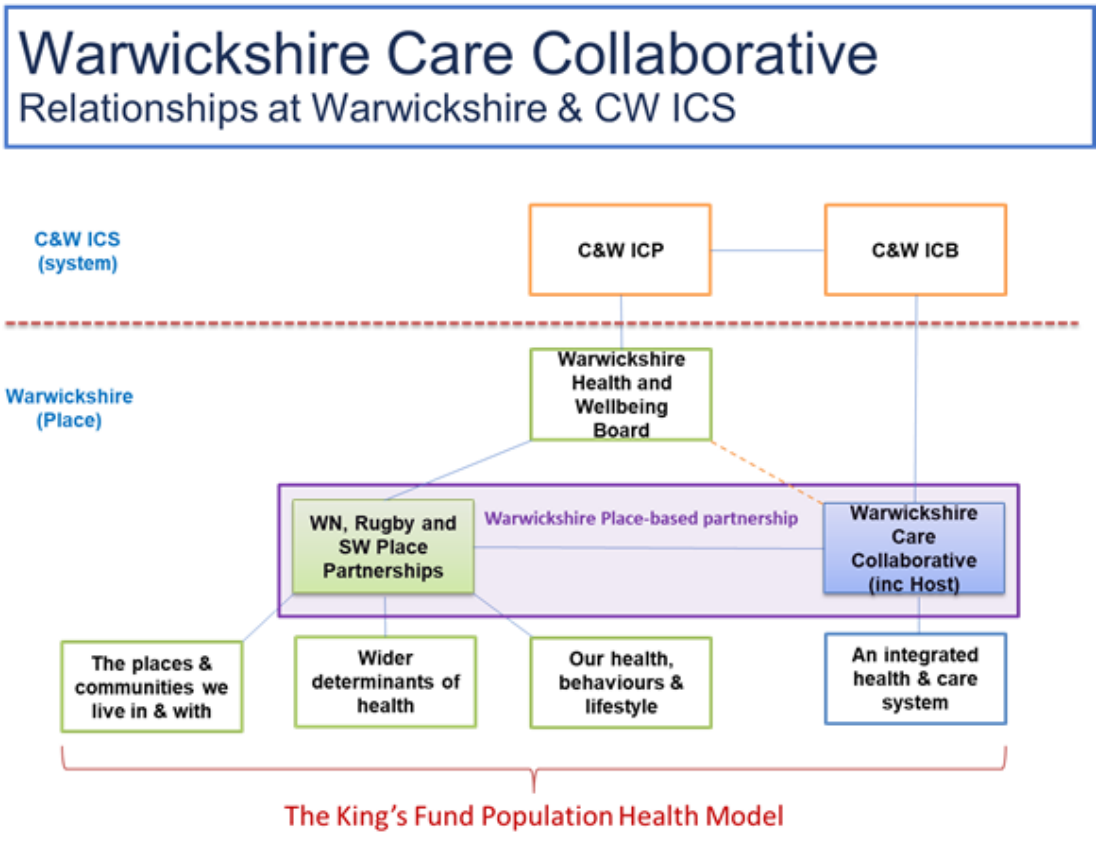
Integrated Care System governance arrangements

The illustrations below summarise the Coventry and Warwickshire Integrated Care System architecture, which are included in both Coventry and Warwickshire's separate BCF Plans and are endorsed by the two respective Health and Wellbeing Boards. *Please refer to **Appendix 2 – C&W ICS Functions and Decisions Map** – which sets out the governance arrangements that support collective accountability between partner organisations to the whole system.*

Coventry and Warwickshire



Warwickshire Places



Planning Requirement 2 - A clear narrative for the integration of health and social care

Key Line of Enquiry: Overall BCF plan and approach to integration

Health, social care and wider partners within Warwickshire and Coventry have previously through the BCF developed a variety of integrated and joint working arrangements, which have formed the foundation of the Coventry and Warwickshire ICS.

In last year's plan we provided a summary of the extensive current arrangements in place for the BCF and wider services, including joint commissioning, partnerships, funding and strategies, lead commissioning arrangements and integrated approaches to quality assurance, training and market management. These arrangements continue with a joint commitment that the BCF for Warwickshire (and Coventry) will be one of the functions that transitions from the ICB to Care Collaboratives as part of phase 1 priorities. Proposals for how this will happen will be developed from quarter 3 of 2022/23.

Integrated commissioning is well embedded in Warwickshire supported by established integrated roles:

- A jointly funded (WCC/SWFT) Lead Public Health Consultant for Long Term Conditions, aligned to the Out of Hospital Collaborative acting as public health lead for delivery of the Health and Wellbeing strategy. Working alongside 3 existing jointly funded consultants supporting a more integrated proactive, preventative approach.
- A jointly funded (WCC/SWFT) Integrated Lead Commissioner for Integrated and Targeted Commissioning and Out of Hospital Services,
- An Integrated Commissioning team for People with Disabilities, (WCC/CWICB/Coventry City Council),
- An Integrated Partnership Manager responsible for the Better Care Fund on behalf of WCC and CWICB.

Within Warwickshire the commitment to integrate commissioning resource between the NHS and local authority was further strengthened with the joint appointment of a Chief Commissioning Officer (Health and Care) for Warwickshire County Council and South Warwickshire University NHS Foundation Trust on the 1st April 2022.

Through the BCF, a new co-production model was agreed and implemented in August 2021, to strengthen our local approach to collaborative commissioning and ensure services and support are co-produced with people with lived experience, promoting a focus on reducing health inequalities, particularly for people with protected characteristics. A framework of co-production providers has now been commissioned by Warwickshire County Council on behalf of NHS and local authority partners to support co-production activity and build capacity in the system.

Work continues across health and care partners to support development of the Coventry and Warwickshire Integrated Care System (ICS). The Integrated Care Board (ICB) and Integrated Care Partnership (ICP) are now formally constituted and there remains commitment to the establishment of 2 geographical care collaboratives as the system's primary "place-based partnerships". A key component of the ICS, these care collaboratives will be made up of the partnership of organisations responsible for organising and delivering health and care within Coventry and Warwickshire respectively. In Warwickshire the collaborative will be hosted by South Warwickshire University NHS Foundation Trust (SWFT).

The Care Collaboratives will be:

- The foundation for the integration of health, social care and public health services; and population health at Coventry level and Warwickshire level.

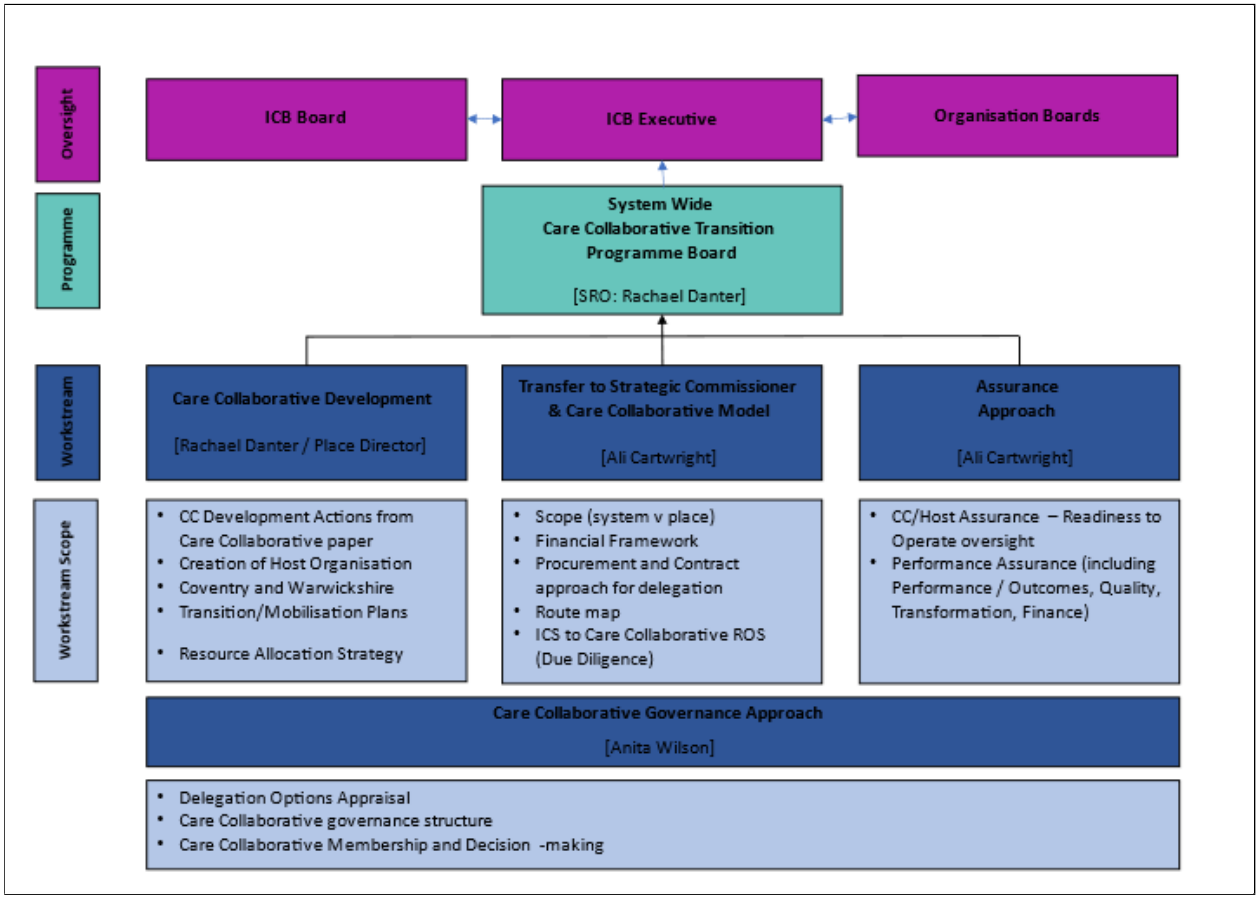
- The entities that the ICB will ultimately delegate the majority of NHS resource (from April 2023 subject to assurance of readiness to operate).
- Held to account by the ICB for the delivery of identified metrics/outcomes associated with functions and resources delegated to them.

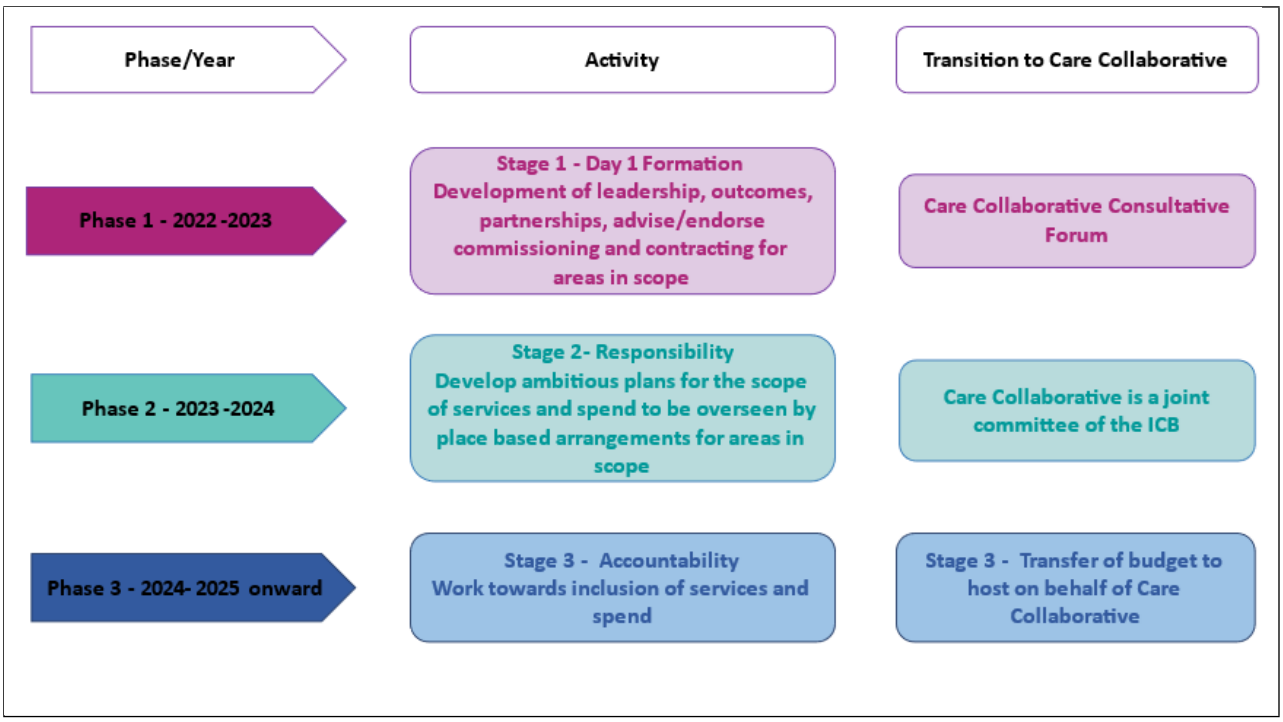
In Warwickshire we have endorsed the primacy of place and as such a key function of the Warwickshire Care Collaborative will be to support and enable integrated planning and delivery across the three place partnerships in Warwickshire North, Rugby and South Warwickshire; channelled through the NHS primary providers in those places.

Activity has been prioritised and is centred on supporting the following programmes of work:

1. Coventry and Warwickshire Care Collaborative Development Programme

Coventry and Warwickshire ICB are facilitating 3 workstreams focused on Care Collaborative development including transfer of responsibilities, governance and assurance. The workstreams are overseen by a Programme Board. An outline of the work programme is provided below alongside the current plans for phasing work and associated governance arrangements from the ICB to Care Collaboratives.





2. Warwickshire Care Collaborative Development Group

The Warwickshire Care Collaborative Development Group has been established to bring together partner representatives who will form part of the Warwickshire Care Collaborative. The group is taking action to shape the collaborative and support the establishment of the functional and governance arrangements required to take on delegated powers and functions from the ICB from March 2023 onwards. The group has a split agenda and split action plan to accommodate development of both the Care Collaborative and the Host arrangements.

A key part of the Warwickshire Care Collaborative action plan is the establishment of the Care Collaborative consultative forum/joint committee. This is currently planned for quarter 3 of this year as there are some key inter-dependencies with the Coventry and Warwickshire Care Collaborative work programme. Terms of reference and role profiles will be co-developed for the Care Collaborative partnership members.

For phase 1 (2022/23) the focus for geographical care collaboratives has been agreed as follows:

1. Urgent and Emergency Care,
2. Out of Hospital Services,
3. Continuing Healthcare, and
4. **the Better Care Fund.**

As a consultative forum the Care Collaborative will have its own plan linked to the Integrated Care Strategy and these areas of focus are core to this and will be creating the conditions for the delivery of place partnership priorities and plans to:

- improve outcomes across Warwickshire;
- ensuring a robust population health management approach;
- arrangements for performance and assurance; and
- effective partnership engagement including with the Voluntary and Community Sector, residents and communities.

3. Host Provider Development

The Warwickshire Care Collaborative host organisation will play a critical role in supporting the Warwickshire Care Collaborative to discharge its functions. The host will work in collaboration with the ICB, local providers of healthcare services, local authorities, and wider partners and will ultimately act as a prime convenor, integrator and facilitator. It will take on some functions delegated from the ICB on behalf of the Care Collaborative as mutually agreed between partners,

e.g., planning, commissioning and contracting for health and care services across the Warwickshire footprint but a key function will be to agree arrangements with NHS primary providers operating across Warwickshire to deliver functions locally, actively working as part of Place Partnerships.

The ICB has commissioned the Good Governance Institute to support the ICS in developing the host functions for the geographical care collaboratives.

4. Provider Collaborations

Provider Collaborations are being considered within the Coventry and Warwickshire ICS where there is a clear scope and benefit. A Coventry and Warwickshire Primary Care Collaborative has been created and a Mental Health Collaborative approach endorsed.

Changes to services commissioned through the BCF from 2022-23.

- Following a successful pilot in Warwickshire North place in 2021/22, implementation of a new Rehab at Home (Home Based Therapy) service. Re-design of D2A Pathway 2 bed-based therapy to Pathway 1 Rehab at Home (Home Based Therapy) in South Warwickshire and in September 2022 extension of this offer to Rugby place. These services are being commissioned by integrated commissioners working across WCC and SWFT as the NHS out of hospital provider on behalf of the ICB and involve rehab from NHS teams and domiciliary care commissioned by the local authority.
- As part of the wider changes to and centralisation of, Stroke services across the Coventry and Warwickshire ICS, introduction of a new Stroke Early Supported Discharge with Care pathway, for patients with low level needs requiring neuro therapy and domiciliary care. This addresses a known gap for the local population to date. Piloted in August with implementation planned for September 2022.
- This year, we are supporting more patient's to receive reablement starting on the same day as discharge, by expanding the commissioned hospital to home service to this service and will evaluate the impact on outcomes and service capacity (e.g. by reducing length of stay in the service).
- Additional night-time support needs have now been extended to more Extra Care Housing facilities, commissioned proportionate to the level of needs in the scheme and more person centred, with resources targeted flexibly, to reduce the risk of hospital admissions for schemes with high care hours.

Planning Requirement 2 - A clear narrative for the integration of health and social care

Key Line of Enquiry: How the plan will contribute to Equality and reducing Health Inequalities

Warwickshire has a robust approach to health inequalities that capitalises on the strategic and operational expertise of our cross-sector partners. Taking action to reduce inequalities at a system, county, place and organisational level occurs through the following mechanisms:

- Coventry and Warwickshire ICS Health Inequalities Strategic Plan
- Warwickshire Health and Wellbeing Strategy 2021-2026
- Director of Public Health Annual Report 2020/21
- Evidence and data gathering through Joint Strategic Needs Assessment (JSNA)
- Warwickshire County Council Equality Impact Assessment (EqIA)

System Approach (Coventry and Warwickshire)

System partners benefit from our Joint Strategic Needs Assessment (JSNA) approach when researching and targeting population health inequality, and commissioning and joint commissioning activities and services. By placing health inequality at the heart of our long-term approach to population health and wellbeing, we
drive the foundational principle of equity through every aspect of system working.

We share a Health and Care Partnership system with Coventry, and all strategy, prioritisation and implementation of work is endorsed through it. The Integrated Care System (ICS) has three core purposes:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and travel for money

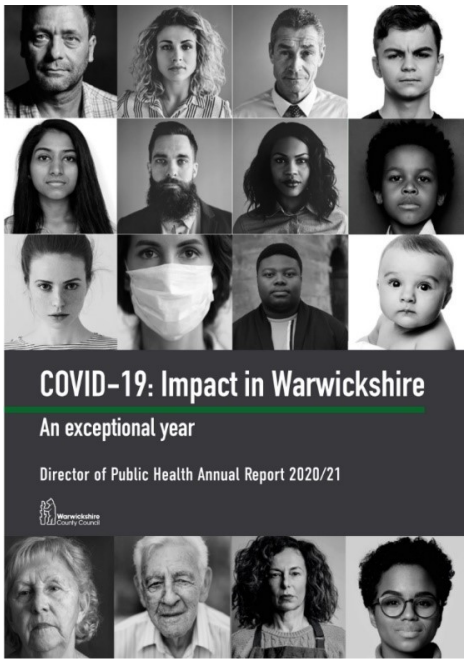
The recently agreed Health Inequalities Strategic Plan for Coventry and Warwickshire (2022-2027), sets out how, as a system, we will reduce health inequalities in Coventry and Warwickshire. The Strategic Plan outlines how it will take into account delivery of the key elements of the NHS Long Term Plan and the NHS CORE20+5 framework. As part of our CORE20+5 approach we will be working to improve the health of those in the 20% most deprived lower super output areas (LSOAS), plus inclusion health groups including gypsies, roma and traveller communities, people experiencing homelessness, newly arrived communities and for Warwickshire those experiencing difficulty in accessing services as a result of rural isolation.

Services and schemes commissioned through the BCF will support delivery of this Strategy, and in particular two of the Major Inequalities Work Programmes ***(please refer to pages 18 to 22 of Appendix 1 as part of the Supporting Information):***

- Long term conditions and prevention
- Urgent Care Development

As well as the 'Transient and newly arrived communities' Plus Group through the work of the Housing Partnership and the links to Assistive Technology, Virtual Wards with the Digital Transformation Strategy; and the Strengths / Asset based approach, self-management, social prescribing and personal health budgets with the Personalistion enabling workstreams.

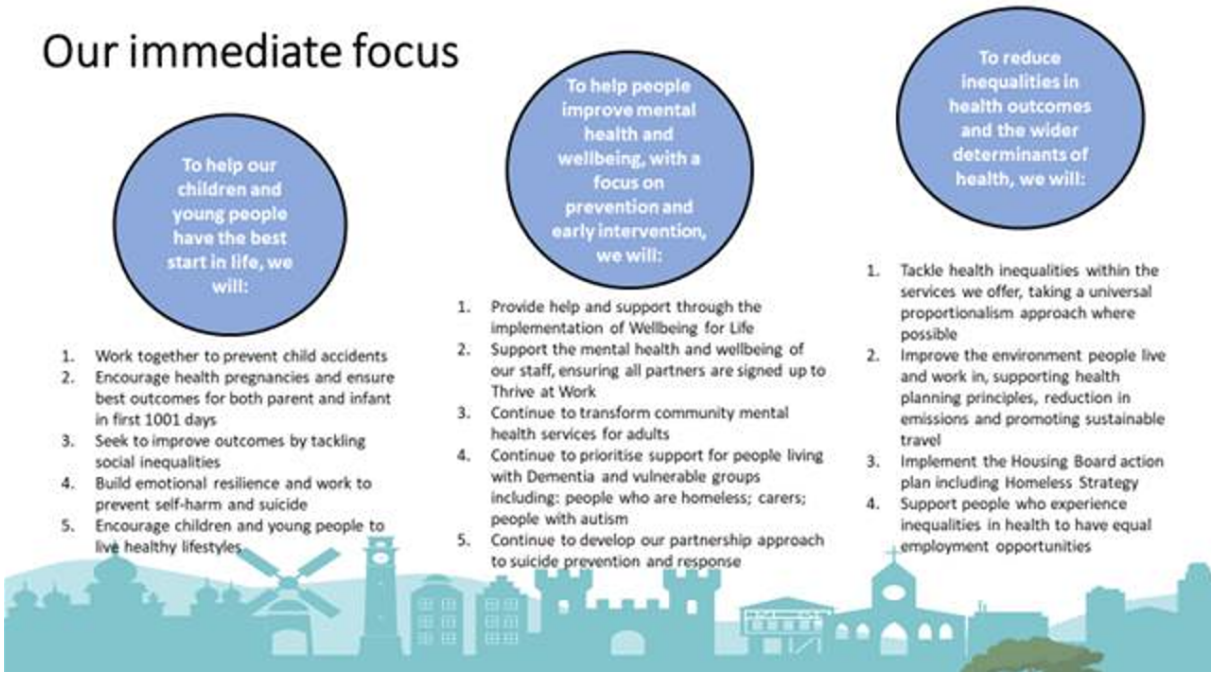
County level (Warwickshire)



COVID-19 and the necessary lockdown restrictions to control its spread have had an impact on our health, the economy, and how we function as a society. COVID-19 has replicated existing health inequalities with the burden falling on the most vulnerable, the most deprived and the more marginalised, and, in some cases, has increased them. Understanding both the positive and negative impact of COVID-19 will help us to recover from the pandemic and protect and improve the health and wellbeing of Warwickshire residents. Following the Coventry and Warwickshire COVID-19 Health Impact Assessment, the Director of Public Health Annual Report 20/21 focused on the impact of COVID-19 on health inequalities and a series of recommendations were endorsed by the Warwickshire Health and Wellbeing Board (HWBB) in March 2021.

One of the key recommendations in the report was to adopt a 'health in all policies' approach which has been endorsed by the HWBB; an implementation plan for WCC was endorsed by senior council leaders in July 2021. The implementation plan included three place-based workshops for Warwickshire's Health and Wellbeing Partnerships (Warwickshire North, Rugby, South Warwickshire. As well as this a HiAP website with open access has been developed and promoted, and WCC Public Health continue to promote an offer of support and direction to all colleagues as they begin to implement HiAP. There are a number of tools that can be used to help implement HiAP, including undertaking Health Equity Assessment Tool (HEAT). Within Warwickshire County Council HEAT has been embedded into the Equality Impact Assessment (EQIA), and therefore any EQIA form that is completed has a strong health inequalities section. Equality Impact Assessment (EQIA) is embedded in the commissioning cycle, giving assurance that spend and service targeting takes account of people and places at higher risk of falling outside traditional interventions. An audit of responses to the health inequalities section of the EQIA is currently underway and will help identify areas for improvement.

The Warwickshire Health and Wellbeing Strategy for 2021-26 lists 3 short term priorities on which we are focused. Health inequalities run through the strategy as a golden thread, however as inequalities increased through pandemic period, it is listed explicitly as a top priority. A public facing 'Monitoring Health Inequalities in Warwickshire' dashboard has been developed to monitor inequalities over time. This dashboard has been developed to display indicators around the HWBB priorities and is aligned to the King's Fund Population Health Framework.



The Better Together Programme is one of our local delivery programmes which support addressing the inequalities in the HWB Strategy and pilots/pump-primes new admission avoidance schemes. This is evidenced by for example the IBCF funding for the Community Outreach Offer for Adults with Autism, Dementia services, Carers support, an increasing focus on social prescribing and homelessness. Housing inequalities which impact health continue to be a key focus within our delivery plan, and the BCF Housing Action Plan outlines this.

Place (North, Rugby, South)

Warwickshire consists of three geographical places; Warwickshire North; Rugby; and South Warwickshire. Each place has its own distinct partnership mechanism, and interrogates, commissions, and oversees the tailored activity delivered around health inequalities specific to place. Data and intelligence drawn from 'geographical place' partners enables work specifically targeting people with protected characteristics to be wholly standard to how we address health inequalities. JSNA and Health Inequalities dashboard data is programmed into the forward plans for each place to ensure that the latest data and intelligence is shared and can be factored into local decision making., Health inequalities is a key priority for all three of these places.

What are the health inequalities and challenges in Warwickshire?

Overall health outcomes for Warwickshire are above the national average but they vary, with residents in more deprived parts living shorter lives and spending a greater proportion of their lives in poor health. In less deprived parts of the county males can expect to live over 9 years longer and females 5 years longer than those in more deprived areas. People are spending more of their later years in ill-health – over 18 years for men and nearly 20 years for women. There are avoidable differences in health outcomes, often linked to smoking, alcohol consumption, obesity and lack of physical activity.

Around one in four adults experience mental health problems, but the county has seen an improvement in the suicide rate. Levels of suicide in Warwickshire have historically been higher than the England average. However, following a large programme of work aimed at suicide prevention, local rates are now in line with the England average.

Warwickshire also has a growing older population. There are more people over the age of 65 than the national average (20.8% in Warwickshire and 18.4% for England) and those over 85 are

expected to almost double from 16,561 in 2020 to 30,132 in 2040. Although many people remain well, active and independent during later life, for others, increasing age brings an increasing chance of frailty, long-term medical conditions, dementia, terminal illness, dependency and disability (including falls). Importantly, COVID-19 has highlighted the importance of ethnic inequalities as well as socio-economic inequalities and the disproportionate impact that the virus, alongside control measures, have had upon people from Black and Minority Ethnic communities.

Of note, in our more deprived boroughs in the North of the County (Nuneaton and Bedworth and North Warwickshire), we can see a lower life expectancy, higher levels of adult obesity, a greater proportion of women smoking at the time of delivery, higher proportions of sickness absence, and higher rates of preventable mortality.

How is our plan contributing to reducing health inequalities in Warwickshire?

The BCF Plan is a vehicle for articulating how we will use system, county and place level mechanisms to cement health inequality work in strategic and operational planning. The Director of Public Health is a key member of the Joint Commissioning Board which oversees the Better Together Programme and BCF Plan, and this means that there is a robust connection between decision making bodies, allocation of BCF funds to address inequalities and frontline services. 'Live' learning about health inequality impacts on disproportionately disadvantaged groups features in discussions and decision making. This supports triangulation of the data held at system level, and, has a clear influence over BCF spend in recognition that pressures vary from place to place. We are continuing to make the connections with emerging tools and approaches across the system, as well as seeing the benefits of their use in the process of commissioning activity to meet needs.

An example of this is the use of the Health Equity Assessment Tool in the design of the new Home Based Therapy pathway, which was piloted first in the north of the county,
and enhancement of support for the wider determinants of health such as self-neglect around Hoarding.

Additionally, the Better Together (BCF) programme links with and contributes to other programmes of work to tackle inequalities:

- Coventry and Warwickshire COVID-19 Health Impact Assessment 2020
- Warwickshire COVID-19 Recovery Plans e.g. implementation of the Integrated Care Record Project Warwickshire County Council Plan 2020-25 e.g. enhanced Discharge to Assess model and reducing delays to discharge
- NHS Long Term Plan – 'Chapter 2: More NHS action on prevention and health inequalities'

Planning Requirement 3 - A strategy and joined up plan for Disabled Facilities Grant Spending

Key Line of Enquiry: Disabled Facilities Grant (DFG) spending and wider services

We can confirm that the total Disabled Facilities Grant of £5,124,786 has been pass-ported in full to the five borough and district councils in Warwickshire.

Disabled Facilities Grant (DFG)	2022/23 allocation
North Warwickshire	£794,560
Nuneaton and Bedworth	£1,652,119
Rugby	£717,236
Stratford-on-Avon	£961,444
Warwick	£999,427
Disabled Facilities Grant (DFG)	**£5,124,786**

The strategic approach to bringing together health, social care and housing

The HEART service was set up in 2016 to deliver improved health and social care outcomes and maximise people's independence in their own homes through:

- effective use of the Disabled Facilities Grant (DFG),
- prevention activity, including advice and information,
- provide equipment and major / minor adaptations,
- emergency support, and
- in 2020/21 expansion to include a countywide handy person service.

In Warwickshire, under the Regulatory Reform Order 2002 legislation, the DFG has also continued to be used for wider purposes. Warwickshire Housing Authorities have agreed harmonised financial assistance policies under an RRO, with additional financial assistance for removing category 1 housing hazards (Warm and Safer Homes Grants), small home safety grants, hospital discharge grants and enhanced help for DFG's above the statutory maximum.

Governance of the HEART Service is through a multi-agency HEART Board. Following the independent review of the HEART Service and supporting governance arrangements, Paul Smith, Director of Foundations was appointed as an Independent Chair of the HEART Board in April 2022. Areas of focus for the service outlined in the HEART Strategic Development Plan for 22-23 include: options around a self-serve model, implementation of a new ICT system and updating the Housing Assistance Policy.

Approach to bringing together health, care and housing services

The Housing Partnership Board, a sub-group of the Better Together Programme is the key delivery vehicle for the housing and homelessness related elements of the Warwickshire Health and Wellbeing Strategy 2021-2026 and Strategy Delivery Plan for 2021-23. The Housing Partnership is committed to delivering a joined-up approach across housing, social care and health to improve outcomes and reduce inequalities in health outcomes. System wide benefits of suitable and appropriate housing include helping the frail, elderly, those with more complex needs and specific vulnerable groups from being admitted to hospital, be discharged from hospital; and be supported to remain independent in their community.

To achieve this experience for every resident, the Housing Partnership Board maintains oversight of the following housing related activity which is delivered in partnership to support people to remain within their own homes for as long as possible or transitioning into more appropriate housing to maintain their independence by:

- Developing an integrated approach to Housing, Social Care and Health where housing solutions are embedded into health and social care pathways and efficiencies and effectiveness are maximised.
- Prevention and early intervention activities to enable people to remain happy, healthy and safe within their own homes and make more suitable housing choices before the point of crisis.
- Supporting people to smoothly transition into more appropriate housing.
- Improving choice and access to appropriate support, advice and information.
- Providing Housing Adaptations through effective use and monitoring of the Disabled Facilities Grant.
- Co-ordinating homelessness prevention activities and associated statutory duties.
- Implementing the housing related elements under Change 9 of the High Impact Change Model.

Activities of the Housing Partnership Board

As mentioned in last year's BCF Plan the joint (health, social care, VCS and housing) activities for 2022/23 are outlined in the Housing Partnership action plan. Some key deliverables in 21/22 included development of the countywide Homelessness Strategy, extension of the Preventing Homelessness Improving Lives service, expansion of the Housing Hospital Liaison offer to A&E and ED in acutes to support admission prevention and housing partnership involvement in development of the county's joint Safe Accommodation Strategy and provision, supporting Domestic Abuse.

Key joint areas of focus and changes for 2022/23 relate to addressing health inequalities through housing as outlined in the Health Inequalities Strategic Plan for Coventry and Warwickshire *(please **refer to Appendix 1 as part of the Supporting Information)*** and include:

- Housing support for refugees and asylum seeker / migrant communities
- Green homes: poor housing, damp and cold – support/grants and accessible preventative information
- Implementation of the Transforming care, Learning Disabilities and Autism Housing Plan
- Increasing access to Specialised Housing Schemes for adults with Learning or Physical Disabilities
- Re-design of Housing Related Support services, and
- Implementation of a Young Person's Protocol re: homelessness and young people

as well as for example, training for acute ward and discharge teams on Duty to Refer and homeless support and homeless prevention support as part of Early Discharge Planning (High Impact Changes 1 and 9).

WARWICKSHIRE cares Better Together

National Condition 4 - Implementing the BCF Policy Objectives

Planning Requirement 6 – An agreed approach to implementing the BCF Policy objectives, including a capacity and demand plan for intermediate care services

Key Line of Enquiry: Overarching approach to supporting people to remain independent at home

An integrated approach to commissioning and operational delivery to support people to be discharged to their usual place of residence (Pathway 0 & 1) or remain independent at home through the BCF is well embedded within Warwickshire. This is evidenced by:

- The 'Home First' approach, commissioning and delivery model which is in place across community NHS services and the local authority, aligned to our Discharge to Assess commissioning and operational model. Evidenced by: Strong performance against the 'discharge to normal place of residence BCF metric' (95.5% in 21/22 for all ages, 95.37% for Minority Ethnic, 95.47% for 61-80 and 90.53% for 81+).

- Consistently strong performance against the national Discharge to Assess metrics:

% patients discharged to	National D2A Target	Example for July 2022/23					
		All Age			65+		
		SW	WN	Rugby	SW	WN	Rugby
P0	50%	96.0%	84%	91.28%	93.10%	80%	83.48%
P1	45%	2.10%	12%	5.77%	3.60%	14%	11.41%
P2	4%	1.70%	3%	2.25%	3.10%	4%	4.20%
P3	1%	0.10%	1%	0.70%	0.30%	2%	0.90%

- Strengths Based Practice across Adult Social Care within Warwickshire County Council and Person-Centred Care in the NHS Out of Hospital Collaborative by South Warwickshire University NHS Foundation Trust. Out of Hospital Place Based (Community) Teams are aligned to PCNs, ensuring that community assets from local areas (e.g. social prescribers, voluntary/community sector, housing) are involved when making decisions about health/care.

- Promoting the use of digital tools and Telehealth or Assistive Technology in the community by NHS community and Adult Social Care including Care Homes to benefit both health and social care outcomes and early intervention are key to our offer e.g., *Docobo* and *MySense* as part of our carers offer for Dementia patients in their own homes.

- On the 31st March 2022, Warwickshire launched https://searchout.warwickshire.gov.uk/ to enable people to support themselves in their community without the need to contact health or social care services and enables health and care staff through place based asset based approaches support people to make use of local community resources to reduce health inequalities, including those with protected characteristics. This digital tool, along with Community Powered Warwickshire was delivered through the Better Care Fund Community Capacity and Resilience Portfolio with IBCF funds from previous year's plans.

- As a system, the 'Tribe' tool is also being evaluated as a potential tool to support people to remain independent for longer in their own homes, where a person/family/informal carer can enter the support requirements and a list of providers who might be able to support, as well as volunteers are matched.

- Warwickshire County Council jointly with Coventry City Council have led the development of a revised local Dementia Strategy in 2022. This strategy: Coventry and Warwickshire's Living Well with Dementia Strategy 2022 - 2027 highlights a number of areas for improvement priorities aligned to the national Well Pathway for Dementia and identifies the following 6 priority areas for the local system. 1. Reducing the risk of developing dementia, 2. Diagnosing Well, 3. Supporting Well, 4. Living Well, 5. End of life care, 6. Training Well. An estimated 11,500 people in Coventry and Warwickshire live with dementia, but only around 56% of these have a formal diagnosis.

- New work on Urgent Community Response; including support for un-paid carers for admission prevention. As a system, as part of the Ageing Well programme, NHS partners, the local authority and charity/voluntary sector are developing new ways of working, linked to the Frailty Assessment Areas in Emergency Departments and the Carers Services with support delivered through the Better Care Fund to reduce attendance, prevent admission and reduce length of stay.

- As part of our improvements to ensure as a system we are ***'providing the right care in the right place at the right time***' a review of demand and capacity modelling and capability within community health and social care services supporting discharges in Warwickshire was undertaken from November 2021 to February 2022. This review was carried out by an independent consultant supporting the Better Together Programme and System Operational Discharge Delivery Group.
    - The review built on the place based discharge dashboard (data shown by pathway and length of stay) available for system use since the beginning of the pandemic, and expanded in 2021 to include community health and care services. Through dashboards established and managed by the Better Together Programme resources, detailed data is already shared across the system on length of stay, outcomes, by age and ethnicity for exits from sub-pathways supporting discharge, to more effectively manage flow into and out of community services, and prevent blockages.
    - Through the Ageing Well - Hospital Discharge Workstream, the next step this year (in 22/23) is to develop real time demand and capacity data and capability, which is currently inconsistent across different community health and social care pathways (P0-3). Whilst options are being considered (not just for Intermediate Care, but all services to support P1-3 discharges), basic demand and capacity plans are in place and those for Intermediate Care are detailed in the BCF Capacity and Demand Template included as part of this submission.
- Preparations for delivery of anticipatory care are also being progressed by health and care partners engaged on the Ageing Well Programme's Anticipatory Care workstream.

Business as usual services funded through the core/base BCF and delivered through our BCF Plan which '***enable people to stay well, safe and independent at home for longer***' include:

- Domiciliary Care - continues to provide support to people leaving hospital and those already at home that have been identified as requiring some support with intimate personal care tasks and daily living activities. A geographical zonal model is in operation which comprises of a number of providers operating in a specific zone with an allocated percentage of business. Our domiciliary care market also supports the health pathways; Home Based Therapy and Stroke.
- The Integrated Community Equipment Service – which continues to develop and evolve to meet on-going pressures both within the community and also to support discharges, particularly due to the increased demand due to the C&W Accelerator site status to reduce the NHS elective surgery backlog.
- Out of hospital and intermediate care provision including HomeFirst (planned and urgent response), community nursing and the recently transformed therapy services supporting D2A Pathway 1 discharges (Home Based Therapy).
- The Falls Prevention pathway and single point of access for support for people identified as moderate and high risk of falls, implemented as part of last year's BCF plan.

- The HEART Housing Equipment Assessment and Response Team (refer to pages 17&18)
- In addition to social prescribing support delivered via PCNs, social Prescribing is also available for patients discharged home under P0 and P1, to support re-admission prevention with a focus on reducing health inequalities.

Our operational delivery approach to improving outcomes for people being discharged from hospital

The System Operational Discharge Delivery Group have also completed local joint assessment against the National Hospital Discharge Policy each time this has been refreshed and the latest version of the High Impact Change Model for managing transfers of care. This is completed at a Warwickshire system and place level. These activities were refreshed during July to August 2022 and there are four key follow on actions relating to the Hospital Discharge Policy:

Hospital Discharge Policy Requirement	**Planned HDG Actions**	**Links to planned HICM actions**
1. Transfer of Care Hub	a. Evolution of local MDT approach b. Pathway 1 review and recommendations under consideration c. New project to streamline operational processes and earlier notification of demand relating to NHS services enabled by domiciliary care at Project Proposal Stage d. Expansion of system wide data through the Enhanced Discharge Tracker and Discharge Services Review Dashboard to all pathways	Change 3 – MDTs Change 4 Changes 1, 2 – Responsive Capacity & 4 Change 2 – Effective Information Sharing and System view of flow and blockages
2. Single Co-ordinator / Point of Contact	a. New streamlined discharge referral processes in pilot across the system b. Streamlined access points into social care now in place c. Rehab at home support now merged	Change 1 Changes 3 and 4 Change 4
3. Case Management arrangements	a. New trusted assessment approach for community health exits in pilot b. Review of D2A P2 Nursing/CHC Assessment Beds underway including the role of Discharge Teams	Change 6 – Trusted Assessments to be extended wider than just Care Homes
4. More patients offered Rehab or Reablement	a. Review of capacity and demand - tools and capability completed b. New Rehab at Home and Stroke Rehab pathways commissioned	Change 2 – Capacity does not always match demand Changes 1, 2 and 4

Whilst there are examples of ‘Exemplary’ commissioning and operational activity in each place and across the county, the overall High Impact Change Model self-assessment identifies three key areas of focus, which are shown below.

Note: Change 8 is delivered via the Enhanced Health in Care Homes Ageing Well Programme Workstream and Change 9 via the Housing Partnership Board.

Warwickshire High Impact Change Model self-assessment	Not yet established Processes are typically undocumented and driven in an adhoc reactive manner	Plans in place Developed a strategy and starting to implement, however processes are inconsistent	Established Defined and standard processes are in place, repeatedly used, subject to improvement over time	Mature Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show	Exemplary Fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes
Change 1 - Early discharge planning					
Change 2 - Capacity and Demand Planning					
Change 3 - Multi-disciplinary working (MDTs)					
Change 4 - Home first Discharge to Assess					
Change 5 - Flexible Working Patterns					
Change 6 - Trusted assessment					
Change 7 - Engagement and Choice					
Change 8 - Improved discharge to care homes					
Change 9 - Housing					

Our approach to commissioning services to support Discharge to Assess and Home First

The local authority is the lead commissioner for the Out of Hospital Collaborative. This is through a joint funded Lead Commissioner post with South Warwickshire University NHS Foundation Trust. This post also leads on the commissioning of Discharge to Assess Services for Pathways 1 & 2. Commissioning of Pathway 3 continues to be shared between the local authority and the ICB.

The Warwickshire Joint Commissioning Board and Out of Hospital Collaborative commissioned a system wide review of Discharge to Assess in 2019, which following a pause during Covid-19 pandemic wave 1, was completed in 2020/21 and the recommendations implemented in 2021/22. Warwickshire has a well-established D2A offer that is collaborative in nature. It is built on principles of supporting people that have had an acute hospital stay to the most appropriate place, to ensure their recovery needs and ability to rehabilitate is maximised. D2A services in the South of the county have been in place since 2013. Since our last BCF Plan, the funds were secured to enable all of the recommendations from the review to be implemented.

In terms of priorities for 22/23:

1. a commissioning led review of Community Hospitals in South Warwickshire is in progress;
2. a joint review of Pathway 1 has been completed with associated proposals to support 2022/23 winter pressures endorsed;
3. a review of the different place based operational processes and disparities across Coventry and Warwickshire for D2A Pathway 2 Nursing is underway; and
4. to agree system wide commissioning intentions for D2A.

How BCF funded activity supports safe, timely and effective discharge

The detail in the Planning Template clearly sets out the number of schemes funded through the Better Care Fund which support safe, timely and effective discharge.

These range from core services in the ‘base BCF’ such as Reablement; Home First; a contribution to Domiciliary Care; Moving on Beds; Integrated Community Equipment etc to schemes funded from the Improved Better Care Fund which support implementation of the High Impact Change Model e.g. Trusted Assessors for Care Homes; Brokerage Support (Domiciliary Care Referral Team); Hospital Social Care Team Staff supporting an MDT approach for Out of Area Patients, Frailty Units in ED and Discharge to Assess Beds; the Hospital to Home Scheme; additional enhanced Moving on Beds etc. New for 22/23 is a small allocation to cover costs associated with the impact of self-neglect e.g. deep cleaning or clearing of properties due to hoarding, which is increasingly presenting as an issue preventing carers be able to access a property to provide either step-down or step-up care and support.

In addition, the resources funded from IBCF schemes 29 and 30 support delivery of discharge related improvement activity, analysis and data on behalf of the C&W system.

Key Line of Enquiry: Changes to our BCF Plan and local priorities in response to the Covid-19 pandemic and Covid-19 recovery plan

The health and care system in Warwickshire maintained and strengthened, its ‘discharge to assess’ model through the COVID19 pandemic by remaining aligned to its’ core principle of maintaining a person centred ‘home first’ approach. Lessons learned from the pandemic were included in the system wide review of discharge to assess in Warwickshire and helped inform the agreed changes and recommendations for the future commissioning and delivery model, from a bed based to home based rehab model.

The local authority’s relationship with our provider market was crucial too. Effective two-way communication and a clear focus on understanding the market, its pressures and the opportunities were key enablers to partnership preparedness and response. We continue to maintain a focus on engaging with and supporting the care market particularly with the pressures and demands it continues to face in relation to workforce. This is recognised in the draft workforce plan for adult

social care, draft market sustainability plan and some of the targeted activities we have undertaken, e.g., response to fuel crisis in domiciliary care.

As part of local Covid Recovery Plans, implementation of the Integrated Care Record across health and social care in Warwickshire was highlighted as a priority. As mentioned earlier, this was implemented in March 2022 for adults and the focus in 22/23 is to roll-out for Under 18s, to support health inequalities around mental health in young people exacerbated during the pandemic.

Planning Requirement 7 - Supporting unpaid carers

The All Age Carers Contract will go live in October 2022 with a redesigned model comprised of core funding through WCC to provide specific elements of support, that is proportionate to the carers needs;

- **Universal Offer** – information and advice, signposting and community inclusion
- **Targeted Adults** – Statutory Carers Assessment and Support Planning
- **Targeted Young Carers** – Carers Assessment and support planning

BCF funding has been invested within the contract model to enhance the core services and increase support for unpaid carers, which includes;

- **Innovation Fund** – Carers/providers are supported to access funding to promote innovation, local carer networks and place-based activities that support and maintain carers wellbeing. Supporting with initial investment to support carer groups - activities and innovation
- **Urgent and Planned Breaks -** Carers can access up to 36 hours of replacement care to support with short breaks
- **Digital support** – funding via IBCF to support the West Midlands region wide buy-in to digital offer to carers through Mobalise
- **Coproduction and Comms** – To support ongoing coproduction and continued engagement with carers, to support service development, peer review and the redesign of the Joint Carers Strategy
- **Delegated Assessments** – Provision of IT devices to contracted providers to undertake delegated assessment via Mosaic
- **Direct payments** – Supporting the funding of one off payments to carers to support them with maintaining their own wellbeing
- **Service Contingency** – Retained for discretionary use, service pressures, service pilots

Further work specifically to support unpaid carers through development of the wider out of hospital Urgent Community Response service will continue during 22/23.

	Budget	Agreed Planned Spend
Carer Breaks – Respite	Base BCF – minimum NHS contribution	£1,021,000
All Age Carers Contract Model	Aligned adult social care budget	£510,000
Carers Support	IBCF – W-IBCF Scheme 10	£281,000
Respite Charging Enables WCC to cease charging based on standard residential care protocols (which have regard to property wealth) and charge based on community care charging protocols (which do not consider property wealth). This change is proven to encourage respite take up and therefore prevent or reduce the likelihood of carer breakdown.	IBCF – W-IBCF Scheme 17	£250,000
Total		**£2,062,000**

Planning Requirement 7 - Meeting Care Act Responsibilities

Similar to previous years, £180k has been allocated from the IBCF scheme 11 to deliver Care Act Responsibilities relating to acute based service costs for hospital based advocacy, a contribution to maintain the block Independent Mental Health Advocacy (IMCA) provision and also provide SPOT IMCA provision. Similar to previous years £5.6m is allocated from the Base BCF – minimum NHS contribution for Reablement. This is detailed in the Planning Template.

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Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Warwickshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£5,124,786	£5,124,786	£0
Minimum NHS Contribution	£42,782,742	£42,782,742	£0
iBCF	£15,133,281	£15,245,281	-£112,000
Additional LA Contribution	£71,308,000	£71,196,000	£112,000
Additional ICB Contribution	£112,124,000	£112,124,000	£0
Total	**£246,472,809**	**£246,472,809**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£12,206,206
Planned spend	£23,141,000

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£15,273,989
Planned spend	£15,274,000

Scheme Types

Assistive Technologies and Equipment	£6,438,742	(2.6%)
Care Act Implementation Related Duties	£1,446,000	(0.6%)
Carers Services	£1,271,000	(0.5%)
Community Based Schemes	£5,302,281	(2.2%)
DFG Related Schemes	£5,124,786	(2.1%)
Enablers for Integration	£1,252,000	(0.5%)
High Impact Change Model for Managing Transfer of (	£1,034,000	(0.4%)
Home Care or Domiciliary Care	£49,306,008	(20.0%)
Housing Related Schemes	£629,000	(0.3%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£2,198,000	(0.9%)
Reablement in a persons own home	£5,662,000	(2.3%)
Personalised Budgeting and Commissioning	£14,326,000	(5.8%)
Personalised Care at Home	£56,521,000	(22.9%)
Prevention / Early Intervention	£382,000	(0.2%)
Residential Placements	£95,579,992	(38.8%)
Other	£0	(0.0%)
Total	**£246,472,809**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 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
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)	95.5%	95.5%	95.5%

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	596	620

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 (%)	94.2%

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: Warwickshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Warwickshire	£5,124,786
DFG breakdown for two-tier areas only (where applicable)	
North Warwickshire	£794,560
Nuneaton and Bedworth	£1,652,119
Rugby	£717,236
Stratford-on-Avon	£961,444
Warwick	£999,427
Total Minimum LA Contribution (exc iBCF)	**£5,124,786**

iBCF Contribution	Contribution
Warwickshire	£15,133,281
Total iBCF Contribution	**£15,133,281**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Warwickshire	£71,308,000	Aligned budget in the BCF Plan relating to older
Total Additional Local Authority Contribution	**£71,308,000**	

NHS Minimum Contribution	Contribution
NHS Coventry and Warwickshire ICB	£42,782,742
Total NHS Minimum Contribution	**£42,782,742**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Coventry and Warwickshire ICB	£32,743,000	Aligned out of hospital budget in the BCF Plan -
NHS Coventry and Warwickshire ICB	£61,290,000	Aligned out of hospital budget in the BCF Plan -
NHS Coventry and Warwickshire ICB	£18,091,000	Aligned out of hospital budget in the BCF Plan -
Total Additional NHS Contribution	**£112,124,000**	
Total NHS Contribution	**£154,906,742**	

	2021-22
Total BCF Pooled Budget	**£246,472,809**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
The minimum requirement for the pooled budget for Warwickshire's BCF is £63m. As a partnership in 2017, we took the decision to align further budgets to represent the majority of spend for all out of hospital services. In 2018/19 the total pooled and aligned budget for the BCF was £120m, in 2019/20, we continued to develop the transparency and visibility of costs and spend across the system, and as a result our budget increased bringing the total pooled and aligned budget to £189m. In 2020/21 this work continued to £192m and in 2021/22 totalled £209m. For 2022/23 the pooled bugdet is £63m and the aligned budget is £183m totalling £246m which is detailed in this plan.

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Warwickshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£5,124,786	£5,124,786	£0
Minimum NHS Contribution	£42,782,742	£42,782,742	£0
iBCF	£15,133,281	£15,245,281	-£112,000
Additional LA Contribution	£71,308,000	£71,196,000	£112,000
Additional NHS Contribution	£112,124,000	£112,124,000	£0
Total	**£246,472,809**	**£246,472,809**	**£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	£12,206,206	£23,141,000	£0
Adult Social Care services spend from the minimum ICB allocations	£15,273,989	£15,274,000	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

One or more Funding Sources have an underspend/overpend (see first table at top of this sheet)

						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	Domiciliary Care (base BCF)	Packages of care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£7,100,000	Existing
2	Reablement (base BCF)	Reablement - 95% of which supports hospital discharges	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£5,662,000	Existing
3	Integrated Community Equipment (ICE)	Community Equipment for social care	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,916,000	Existing
4	Moving on Beds (base BCF)	MOBs used primarily for social care and housing related step down	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£596,000	Existing
5	ICE - Health (base BCF)	Health equipment to support step down discharges and step up	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Private Sector	Minimum NHS Contribution	£4,367,742	Existing
6	Carers Breaks (base BCF)	Cares respite	Carers Services	Respite services		Community Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£1,021,000	Existing

7	Out of hospital - WN, Rugby and SW (base BCF)	OOH community step up and step down support	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£15,970,000	Existing
8	Discharge to Assess Beds - D2A (base BCF)	P2 step down beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum NHS Contribution	£1,308,000	Existing
9	Joint Funded Packages (base BCF)	Joint Funded Packages	Home Care or Domiciliary Care	Domiciliary care packages		Continuing Care		CCG			Private Sector	Minimum NHS Contribution	£2,606,008	Existing
10	Joint Funded Packages - base BCF	Joint Funded Placements	Residential Placements	Supported living		Continuing Care		CCG			Private Sector	Minimum NHS Contribution	£421,412	Existing
11	Joint Funded Packages - base BCF	Joint Funded Placements	Residential Placements	Care home		Continuing Care		CCG			Private Sector	Minimum NHS Contribution	£585,403	Existing
12	Joint Funded Packages - base BCF	Joint Funded Placements	Residential Placements	Nursing home		Continuing Care		CCG			Private Sector	Minimum NHS Contribution	£1,229,177	Existing
13	Disabled Facilities Grant (base BCF)	Passported to the Tier 2 District and Borough Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£5,124,786	Existing
14	W-IBCF 1- Hospital Social Care Team	Supporting timely discharges including to care homes	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£704,000	Existing
15	W-IBCF 2 - Housing Hospital Liaison & W-IBCF 9	Housing related support to support early discharge planning and	High Impact Change Model for Managing Transfer	Housing and related services		Social Care		LA			Local Authority	iBCF	£103,000	Existing
16	W-IBCF 3 - Hospital based Social Prescribing	Access to social prescribing on discharge to support re-admission	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	iBCF	£140,000	Existing
17	W-IBCF 4 - Trusted Assessments	Support for discharges into care homes and exits from intermediae	High Impact Change Model for Managing Transfer	Trusted Assessment		Social Care		LA			Local Authority	iBCF	£152,000	Existing
18	W-IBCF 5 - Domiciliary Care Referral Team	Brokerage of packages of care to enable discharge	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£75,000	Existing
19	W-IBCF 6 - Hospital to Home Service	Hospital to home, including falls prevention for the vulnerable	Community Based Schemes	Low level support for simple hospital discharges		Social Care		LA			Local Authority	iBCF	£444,000	Existing
20	W-IBCF 7 - Moving on Beds	Enhanced and additional Moving on Bed capacity	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£294,000	Existing
21	W-IBCF 8 - Integrated Community	Supports same day and urgent delivery cost pressures (health &	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	iBCF	£155,000	Existing
22	W-IBCF 10 - Carers support	Planned and emergency short breaks service, carers support grant,	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	iBCF	£281,000	Existing
23	W-IBCF 11- Advocacy	Acute based service costs for hospital based advocacy, contribution	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Charity / Voluntary Sector	iBCF	£180,000	Existing
24	W-IBCF 12 Occupational Therapy	Occupational Therapists in the community.	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	iBCF	£310,000	Existing

25	W-IBCF 13 End of Life Rapid Response	End of Life rapid response costs in the community (hospice	Personalised Care at Home	Physical health/wellbeing		Community Health		LA			Charity / Voluntary Sector	iBCF	£249,000	Existing
26	W-IBCF 14 - Falls Prevention	Contribution to falls care-coordination and Multi-Factorial Assessments	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		LA			NHS Community Provider	iBCF	£35,000	Existing
27	W-IBCF 15 - Mental Health Street Triage	Mental Health Street Triage	Community Based Schemes	Multidisciplinary teams that are supporting		Mental Health		CCG			NHS Mental Health Provider	iBCF	£263,000	Existing
28	W-IBCF 16 - Adults with Autism	Community Outreach Offer supporting Admission Prevention by	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		LA			Local Authority	iBCF	£280,000	Existing
29	W-IBCF 17 - Residential Respite Care Charging	Enables WCC to cease charging based on standard residential care	Carers Services	Respite services		Social Care		LA			Local Authority	iBCF	£250,000	Existing
30	W-IBCF 19 - Protecting older people community	Contributions to: Residential and nursing care fee rates	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£2,900,000	Existing
31	W-IBCF 20 - Protecting older people community	Contributions to: Care at Home fee rates	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£2,350,000	Existing
32	W-IBCF 21 - Protecting NHS budgets through	Contributions to: Extra Care Housing Waking Nights Cover	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£502,000	Existing
33	W-IBCF 22 - Provider Learning and Development	Funds provider (health and social care) support, training and learning and	Enablers for Integration	Workforce development		Community Health		LA			Local Authority	iBCF	£515,000	Existing
34	W-IBCF 24 wider support to maintain the	Develop, stabilise and strengthen the Provider Market	Enablers for Integration	Integrated models of provision		Continuing Care		CCG			Private Sector	iBCF	£375,000	Existing
35	W-IBCF 25, 27 and 28 - Demand pressures relating	Direct funding contributing towards budget pressures and	Community Based Schemes	Other	Community social care staffing	Social Care		LA			Local Authority	iBCF	£3,851,281	Existing
36	W-IBCF 26 - Dementia Support in the community	Dementia days ops, dementia navigators and dementia carer support	Care Act Implementation Related Duties	Other	Dementia services	Social Care		LA			Private Sector	iBCF	£475,000	Existing
37	W-IBCF 18, 29 & 30 Resources	Resources to support joint commissioning, the BCF Programme and	Enablers for Integration	Programme management		Social Care		LA			Local Authority	iBCF	£362,000	Existing
38	Domiciliary Care (WCC aligned budget)	Supports hospital discharges and community step up	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Additional LA Contribution	£13,925,000	Existing
39	Residential Care (WCC aligned budget)	Residential care long-term placements	Residential Placements	Care home		Social Care		LA			Private Sector	Additional LA Contribution	£38,867,000	Existing
40	Nursing Care (WCC aligned budget)	Nursing care long-term placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	Additional LA Contribution	£13,088,000	Existing
41	Direct Payments (WCC aligned budget)	DPs for adults (e.g. instead of dom care PoC)	Personalised Budgeting and Commissioning			Social Care		LA			Private Sector	Additional LA Contribution	£3,950,000	Existing
42	Carers (WCC aligned budget)	Carers schemes supporting admission prevention and long	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£510,000	Existing

43	Social Prescribing (WCC aligned budget)	Aligned to Strengths Based Practice and Community Assets	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£108,000	Existing
44	Contributions towards HEART staff and service,	Workforce additional costs to support the HEART service deliver	Housing Related Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£629,000	Existing
45	Falls Prevention (WCC aligned budget)	Falls care co-ordination and support for Moderate to High Risk	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		LA			NHS Community Provider	Additional LA Contribution	£119,000	Existing
46	Out of Hospital (ICB aligned budgets)	OOH community step up and step down support	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£40,302,000	Existing
47	Personal Health budgets (ICB aligned budgets)	PHBs to provide eg. domiliary care for patients with long term	Personalised Budgeting and Commissioning			Continuing Care		CCG			Private Sector	Additional NHS Contribution	£10,376,000	Existing
48	Residential Care placements (ICB aligned budgets)	Residential care long-term placements	Residential Placements	Care home		Continuing Care		CCG			Private Sector	Additional NHS Contribution	£5,417,045	Existing
49	Nursing care placements (ICB aligned budgets)	Nursing care long-term placements	Residential Placements	Nursing home		Continuing Care		CCG			Private Sector	Additional NHS Contribution	£30,666,096	Existing
50	Residential placements supported living	Supported Living placements	Residential Placements	Supported living		Continuing Care		CCG			Private Sector	Additional NHS Contribution	£2,405,859	Existing
51	Domicilary Care (ICB aligned budgets)	Domiliary care for patients with long term needs	Home Care or Domiciliary Care	Domiciliary care packages		Continuing Care		CCG			Private Sector	Additional NHS Contribution	£22,823,000	Existing
52	Social Prescribing (ICB aligned budgets)	Prevention activity to support admission avoidance and	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Additional NHS Contribution	£134,000	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: Warwickshire

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
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	214.7	186.2	191.1	169.8	Variance of 2.4% between Better Care Exchange data and local SUS feeds - therefore acceptable confidence in data. Warwickshire is maintaining a better annual level than the England value at 761	Winter plans in place (acute trusts, ICB and local authority) include include admission avoidance activity eg. investment in Community Urgent Response (2 hr and same day) and Community Therapy by the
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	212	187	192	170		

>> 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 (%)	95.8%	95.5%	95.2%	95.7%	1.5% variance in Better Care Exchange data and local SUS feeds - relatively good confidence in data. Warwickshire remains better performing that national, 95.5% to 92.6%. Therefore plan to maintain current performance but with added consistency as there is no evidence of seasonal patterns in this metric. Note: Slow start to discharge volumes in Q1	BCF schemes that support this metric: Market sustainability initiatives Daily multi-agency discharge team (MDT) working Following a sucessful pilot, the new Rehab at Home - Home-Based Therapy pathway (Pathway 1); and The new Stroke Early Supported Discharge with Care pathway (Pathway 1) Integrated Community Equipment
	Numerator	12,767	12,731	12,137	11,556		
	Denominator	13,331	13,330	12,752	12,075		
		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 (%)	95.5%	95.5%	95.5%	95.5%		
	Numerator	12,400	13,105	12,524	11,908		
	Denominator	12,979	13,717	13,109	12,464		

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	595.5	646.1	606.4	620.5	Actuals for 2020/21 and 2021/22 were impacted by the Covid-19 pandemic. The ambition for 2022/23 therefore reflects pre-pandemic levels which were consistently over 800 admissions per year, (where the target of 780 equates to an average 65	BCF schemes that support this metric: Market sustainability initiatives Daily multi-agency discharge team (MDT) working Following a sucessful pilot, the new Rehab at Home - Home-Based Therapy pathway
	Numerator	722	799	750	780		
	Denominator	121,235	123,673	123,673	125,709		

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 (%)	93.6%	91.7%	93.7%	94.2%	Actuals for 2020/21 were 323 of 345 discharges in the period Oct-Dec 2020 - 93.6% which was artificially inflated due to the emergency measures put in place during the pandemic. Performance in 2021/22 was 93.7% and reflects an	BCF schemes that support this metric: Reablement Service – where 95% of reablement capacity is currently utilised supporting hospital discharge Assistive Technology
	Numerator	323	275	298	291		
	Denominator	345	300	318	309		

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: Warwickshire

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
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	1. A jointly agreed BCF Plan has been agreed. 2. The HWBB was engaged in reviewing and developing the BCF Plan at its meeting on the 7th September and then approved it on the 22/09/22 3. An inclusive and partnership approach including a range of		
	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	1. Pages 19-23 of the Narrative Plan describes the local approach to integrated, person centre services. 2. Pages 9 &12 of the Narrative Plan describes the approach to collaborative commissioning and page 22 specifically relating to commissionng for D2A & Discharges. 3. Pages 13-16 of the Narrative Plan describe the local approach to reducing Health Inequalities and actions re: Core20Plus 5. A copy of the Cov & Warks ICS Health Inequalities Strategy is also provided as supporting information. 4. Changes as a result of the Covid-19 pandemic are detailed on pages 22 & 23 of the Narrative Plan.		
	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	1. Use of the DFG is agreed through the well established Housing Partnership Board and HEART Board. 2. Pages 17&18 of the Narrative Plan detail the approach to housing support and DFG, managed via the HEART service on behalf of the 6 councils in Warks. 3. The DFG has been passed in it's entirety to the 5 District and Borough Councils.		
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	1. Tab 5a. Expenditure shows that the forecast total spend and budget matches the £15.273m required contribution. A detailed breakdown of schemes		
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	Tab 5a. Expenditure shows that the forecast total spend and budget of £15.9m exceeds the £12.2m required contribution.A detailed breakdown of schemes		

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	1. Pages 19-22 of the Narrative Plan detail the approach to meeting the BCF objectives. 2. Tab 5a.- provides a detailed breakdown shows schemes which support Prevention/Early Intervention, Community Schemes, Support for the High Impact Change Model etc. 3. A completed Capacity and Demand Template has been		

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	1. Please refer to page 23 of the BCF Narrative Plan re: support to unpaid carers 2. Page 23 of the Narrative Plan also details the schemes to deliver Care Act Duties, Carer Support and Reablement, the amount and source of the funding.		
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	Please refer to the detail provided in Tab 6. To ensure the BCF metrics align with NHS and local authority ASCOF measures - Helen Lancaster, Director of System		

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Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Warwickshire

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)	85	85	85	85	77	85
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	564	561	485	490	434	506
2: Step down beds (D2A pathway 2)	175	165	185	165	164	166
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	23	28	26	26	29	26

Any assumptions made:	Data includes: P0-Hospital Based Social Prescribing activity P1-HomeFirst, Reablement, Rehab at Home (Home based therapy) and Stroke ESD with care P2-Step Down Therapy Beds including Campion Ward and Nicol Unit for SW, Arbury for

!!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
(Please select Trust/s.....)	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)						
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST		49	49	49	49	44	49
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE		12	12	12	12	11	12
GEORGE ELIOT HOSPITAL NHS TRUST		24	24	24	24	22	24
(Please select Trust/s.....)	1: Reablement in a persons own home to support discharge (D2A Pathway 1)						
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST		338	330	258	280	238	275
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE		82	95	93	72	78	83
GEORGE ELIOT HOSPITAL NHS TRUST		144	136	134	138	118	148
(Please select Trust/s.....)	2: Step down beds (D2A pathway 2)						
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST		102	87	85	94	84	89
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE		28	26	30	23	39	37
GEORGE ELIOT HOSPITAL NHS TRUST		45	52	70	48	41	40
(Please select Trust/s.....)	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)						
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST		7	8	8	8	8	8
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE		8	11	9	9	12	9
GEORGE ELIOT HOSPITAL NHS TRUST		8	9	9	9	9	9

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Warwickshire

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:	Data includes: VCS-Carers Emergency response - Pre registered carers can access up to 36 hours of support per year Urgent Community Response is provided by the integrated HomeFirst service which covers both non-urgent and urgent activity and is not separated and so is shown here under

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	6	6	6	6	6	6
Urgent community response	0	0	0	0	0	0
Reablement/support someone to remain at home	409	406	307	303	285	285
Bed based intermediate care (Step up)	2	2	2	2	2	2

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Warwickshire

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:	Data includes: VCS to support discharge -Hospital Based Social Prescribing commissioned provision P0-Urgent Community Response - is provided by the integrated HomeFirst service which covers both non-urgent and urgent activity and is not separated out and so is included under P1 below P1-HomeFirst, Reablement, Rehab at Home (Home based therapy) and Stroke ESD with care

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.	80	80	80	80	72	80
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	568	561	471	467	438	495
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	65	68	72	60	49	53
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	6	6	7	7	7	7

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Warwickshire

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:	Data includes: VCS-Carers Emergency response - Pre registered carers can access up to 36 hours of support per year Urgent Community Response is provided by the integrated HomeFirst service which covers both non-urgent and urgent activity and is not separated and so is included under Reablement/Support to someone to remain at home Reablement/Support to someone to remain at home - No capacity from the reablement service is included, as all

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.	6	6	6	6	6	6
Urgent Community Response	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	390	386	292	287	270	320
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	2	2	2	2	2	2

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Warwickshire

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)	£24,000,000
BCF related spend	£24,000,000

Comments if applicable	Intermediate Care is included in wider out of hospital block contracts, the total values of which are included here. Totals for base and aligned budgets plus IBCF specific schemes.

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Agenda Item 5

Health and Wellbeing Board

7 September 2022

Pharmaceutical Needs Assessment

Recommendation(s)

That Health and Wellbeing Board

1. notes and comments upon the contents of the Pharmaceutical Needs Assessment (PNA).

2. notes and comments upon the updates from the formal consultation to be given verbally at the meeting on 7th September 2022.

3. approves the publication of the PNA subject to any changes mentioned in the formal consultation verbal update.

1. Executive Summary

Purpose

1.1 This report notifies the Health and Wellbeing Board of the development of the Coventry and Warwickshire Pharmaceutical Needs Assessment (PNA), 2022 – 2025.

1.2 The purpose of the PNA is to assess local needs and identify gaps for pharmaceutical provision across Coventry and Warwickshire. It is a tool to enable Health and Wellbeing Boards (HWBs) to identify the current and future commissioning of services required from pharmaceutical service providers.

1.3 Coventry City Council and Warwickshire County Council HWBs approached the development of the 2022 PNA as a collaborative project, with one report being produced for both areas, as agreed at the Warwickshire Health and Wellbeing Board on Wednesday 6th January 2021. This replaces the 2018 PNA for both Coventry and Warwickshire.

1.4 The PNA is undergoing Formal Consultation from Thursday 23rd June 2022 until Monday 29th August 2022, with a statutory obligation for publication on 1st October 2022.

1.5 A verbal update on the outcomes of the Formal Consultation will be given at the Warwickshire Health and Wellbeing Board on 7th September 2022.

Background

1.6 The development of the PNA has been overseen by one multi-disciplinary steering group which includes representations from organisations across both Coventry and Warwickshire areas.

1.7 The process has been split into 4 stages:

- **Stage 1** – A project management approach was used to develop the PNA and so a steering group was established which met regularly during the development of the PNA.
- **Stage 2** – A pharmacy survey and a public survey were developed. The content was approved by the steering group and was undertaken in Feb/March 2022. Following the closure of the surveys the responses were analysed.
- **Stage 3** – A summary of current provisions and gaps in provision of pharmaceutical services was identified and fed into the draft report. The content was approved by the steering group.
- **Stage 4** – As required by legislation, a 60-day consultation is necessary during the process of producing this document.

1.8 The document includes the local picture for Coventry and Warwickshire, general health needs, pharmacy provisions and access, and information on pharmacy services. It offers conclusions and recommendations on pharmacy provision and includes the responses from the general public and community pharmacy survey as appendices.

Minimum Requirements

1.9 A statement of the following must be included in a PNA as a minimum, as set out in schedule 1 of the NHS 2013 regulations:

Requirement	How the requirement is met
Necessary Services	The PNA provides an understanding of essential services which are required to be provided by all pharmacies. Access to pharmacies is examined to help determine the current provision of necessary services.
Relevant Services	The PNA includes a section on each advanced service, including consideration into the distribution of providers and uptake of the service. Service recommendations have been made where appropriate.
Other NHS Services	In addition to the section on advanced services, the PNA includes a section on each Enhanced and Locally Commissioned Service, including consideration into the distribution of providers and uptake of the service. Service recommendations have

	been made where appropriate.
Map of pharmaceutical services	Maps have been provided for: • Pharmacies within the Health and Wellbeing Board area. These maps have been further broken down into the PNA defined localities. • Pharmacies against travel time. Maps for travel by car, public transport, and bicycle have been produced. • Pharmacies that are open on a Saturday between 9am – 1pm, identified as the most popular time to visit pharmacies by our public survey. • Maps for services where an understanding of location is necessary for the analysis.
Explanation of assessment	The PNA contains an introduction chapter which explains the background and requirements, and a chapter on the approach to the PNA which goes through the production process.

1.10 Where necessary, there will be supplementary information added throughout the PNA's lifespan of 3 years. This will ensure it keeps the document relevant, useful, and fit for purpose.

2. Financial Implications

2.1 There are no direct financial implications arising from this report. Once the PNA is published there will be financial implications for partners for the delivery of services against the assessed need. In relation to Warwickshire County Council commissioned services, any additional costs identified would have to be discussed with the appropriate commissioner and if agreed found within existing resources. If there are any changes to this position as a result of the consultation this will be reported as part of the verbal update at the meeting.

3. Environmental Implications

3.1 None.

Appendices

1. Appendix 1 – Coventry and Warwickshire Pharmaceutical Needs Assessment

2. Appendix 2 – Executive Summary for Warwickshire

Background Papers

1. No background papers

	Name	Contact Information
Report Author	Duncan Vernon Michael Maddocks	duncanvernon@warwickshire.gov.uk michaelmaddocks@warwickshire.gov.uk
Assistant Director	Shade Agboola – Director of Public Health	shadeagboola@warwickshire.gov.uk
Strategic Director	Nigel Minns Strategic Director for People	nigelminns@warwickshire.gov.uk
Portfolio Holder	Cllr Bell Portfolio Holder for Adult Social Care and Health	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillors Bell, Drew, Golby, Holland, and Rolfe

PHARMACEUTICAL NEEDS ASSESSMENT

Coventry City Council and Warwickshire County Council

2022 - 2025

DOCUMENT INFORMATION

Document Name:	Pharmaceutical Needs Assessment				
Published Date:	*Select published date*	Version:	1st	Release:	Draft
Author:	Coventry and Warwickshire PNA Steering Group				
Owner:	Coventry City Council & Warwickshire County Council				

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CONTENTS

ABBREVIATIONS

AUR.....Appliance Use Review
BAME.....Black and Minority Ethnic
CHWB.....Coventry Health and Wellbeing Board
CCG.....Clinical Commissioning Group
CVD.....Cardiovascular Disease
COPD.....Chronic Obstructive Pulmonary Disease
CPCF……Community Pharmacy Contractual Framework
DAC……Dispensing Appliance Contractors
DD……Dispensing Doctors
DH.....Department of Health
DSP……Distance Selling Pharmacy
EHC..... Emergency Hormonal Contraception
GP.....General Practitioner
HLP……Healthy Living Pharmacy
HLS……Healthy Lifestyle Service
HWB.....Health and Wellbeing Board
ICB……Integrated Care Board
ICS……Integrated Care System
IPMO……Integrated Pharmacy Medicine Optimisation
ISHS……Integrated Sexual Health Services
JSNA .....Joint Strategic Needs Assessment
LA……...Local Authorities
LMC……Local Medical Committee
LPC.....Local Pharmaceutical Committee
LSOA……Lower Super Output Areas
LTC……Long Term Conditions
NMS……..New Medicines Service
NHS BSA……NHS Business Services Authority
NHSE .....National Health Service England
NHSI……National Health Service Improvement
NICE……National Institute for Clinical Excellence
NUMSAS……..NHS Urgent Medicines Advanced Service
OOH……..Out of Hours
ONS……..Office of National Statistics
NRT..... Nicotine Replacement Therapy

PCN..... Primary Care Network
PHE……..……..Public Health England
PNA..... Pharmaceutical Needs Assessment
PSNC……..……..Pharmaceutical Services Negotiating Committee
SAC..... Stoma Appliance Customisation
STI..... Sexually Transmitted Infection
SWFT……..…….South Warwickshire Foundation Trust
UHCW……University Hospital Coventry & Warwickshire
UK ……..…….....…….. United Kingdom
WHWB……Warwickshire Health & Wellbeing Board

RECOMMENDATIONS

Taking into account current service provision and other factors that may affect need for pharmaceutical services in the future; the following recommendations have been put forward:

- Currently there is a sufficient provision of pharmacies. Supplementary statements will be produced by the Community Pharmacy Steering Group on behalf of both the Coventry and Warwickshire Health and Wellbeing Boards should there be a significant change across Coventry and Warwickshire or within localities. Significant new housing developments should also be considered.
- Consideration should be given to the increase in pressure on community pharmacies caused by the COVID-19 pandemic, particularly as the country enters a cost-of-living crisis.
- Consideration of any change within predominantly rural areas should be undertaken within the lifetime of the PNA.
- Consideration should be given to commissioning evening or weekend rotas if needed to support extended hours by general practice in addition to the current bank holiday rotas.
- There is an opportunity for more joined up work when it comes to signposting, both to and from community pharmacies. Community pharmacies should be continually consulted as to the best pathways for care. Patients, public, and other care settings should be provided with clear information on opening times, services offered (including provision of confidential consulting space), and alternative provisions when pharmacies are not open.
- Health Education England (HEE) training should be supported for prescribers in community pharmacies.
- The HEE Community Pharmacy Survey 2021 should be used when released later in 2022 to help understand community pharmacy workforce further, and support should be given to the delivery of an annual HEE Community Pharmacy Survey to build data and insight going forward, including use in the next PNA.
- Under the Hep-C service, pathways for referral to a confirmatory PCR test are currently under development. There is currently a limited pathway for PCR testing, so this pathway development should be supported.
- As the Smoking Cessation advanced service is a newly commissioned service pharmacies are still signing up to provide it. The number of pharmacies providing this service should be monitored whilst this initial sign-up is taking place.

- Partnership work needs to be done between Commissioners of Stop Smoking and Stop Smoking in Pregnancy locally commissioned services and pharmacies to identify the actions to increase activity across those pharmacies where behavioural support and prescribing is low, with a particular focus on areas of greatest need.
- Consideration should be given to the role of pharmacies within the NHS long term plan tobacco dependency commitment to deliver NHS funded tobacco dependence treatment services which includes inpatient, maternity, outpatients, and community settings.
- To achieve the national ambition outlined in the Drug Strategy 2021, more work will be required to improve the quality of services and expand the number of providers delivering supervised consumption and needle exchange programmes in Warwickshire. More work is required to map out the current provision to ensure there is fair and equitable provision countywide. Adequate provision will need to be sought in the more deprived areas and those with higher drug and alcohol prevalence. Individuals within these areas are more likely to have a range of health inequalities and poorer health outcomes.
- Within Coventry and Warwickshire work can be done to strengthen the pathways around the Stop Smoking in Pregnancy service (SSiPS), especially to encourage pharmacists to redeem and dispense the letters of recommendation. The SSiPS is commissioned separately to the generic Stop Smoking service, more promotion can be done between these 2 services to increase the number of pharmacies able to dispense NRT products to pregnant women.
- Local data shows that some Coventry residents are accessing Emergency Hormornal Contraception (EHC) in Warwickshire, this could be as Warwickshire doesn't have an upper age limit whereas Coventry does. Bringing the Integrated Sexual Health contracts together to one contract will enable the current pharmacy offers to be aligned, this will help to reduce service user confusion as to what is offered where and to whom.
- There are different sharps service collections in place which can be unclear to both the public and pharmacies, such as the service provided by PHS which also collects sharps. Because of this, the quantity of sharps collected by the locally commissioned service Sharps Disposal in Warwick District has been minimal. To help with this the following opportunities have been identified:
    - Provide clarification on the different services to clear up confusion for pharmacies and patients, including over the size of sharps containers accepted with the different services.

- Provide better communication between pharmacies who provide a sharps disposal service and GPs so better signposting can be done.

INTRODUCTION

PURPOSE OF THE PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

The purpose of the PNA is to assess local needs for pharmaceutical service provision across Coventry and Warwickshire. It should identify any gaps in service or unmet needs of the local population. It should also identify any services that pharmacies could provide to address these needs, and to promote Coventry and Warwickshire's population to improve uptake of these services. It is a tool to enable Health and Wellbeing Boards (HWBs) to identify the current and future commissioning of services required from pharmaceutical service providers.

Coventry City Council and Warwickshire City Council HWBs approached the development of the 2022 PNA as a collaborative project, with one report being produced for both areas. This decision was taken due to the interconnectivity of health and care systems across Coventry and Warwickshire, the joint recommissioning of several services which community pharmacies are involved in, and creating a consistency for a population who access services across both areas.

The 2022 PNA replaces the 2018 PNA for both Coventry and Warwickshire, which were done as separate reports.

BACKGROUND AND LEGISLATION

The responsibility for producing and updating PNAs was changed from Primary Care Trusts (PCTs) to Health and Wellbeing Boards by The Health and Social Care Act 2012. In 2013 this was followed by the NHS Pharmaceutical and Local Pharmaceutical Services Regulations introducing a statutory requirement on Health and Wellbeing Boards to publish and update a statement of needs for pharmaceutical services for their area. Local Authorities (LA) and Clinical Commissioning Groups (CCGs) have equal and joint responsibility for producing the Joint Strategic Needs Assessment (JSNA), through the HWB.

NHS England uses PNAs when assessing applications for opening new pharmacies, and to help make informed decisions on the commissioning of NHS funded services that are provided by local community pharmacies and other pharmaceutical providers.

A PNA published by a Health and Wellbeing Board has a maximum lifetime of three years, after which a new PNA will need to be produced.

HEALTH AND WELLBEING BOARD DUTIES IN REGARD TO PNA

Health and Wellbeing Boards work to improve health and wellbeing and reduce inequalities through partnership working and collaboration. Health and Wellbeing boards became statutory bodies on the 1st of April 2013 and every Local Authority has a Health and Wellbeing Board.

A revised PNA needs to be published within three years of a Health and Wellbeing Board producing their first assessment. If significant changes take place to the availability of pharmaceutical services the board are required to publish a revised assessment as soon as reasonably practical, unless producing a revised assessment would be a disproportionate response to those changes. If producing a revised assessment is deemed to be a disproportionate response, a supplementary statement should be produced. The board will publish subsequent PNAs every three years to comply with regulatory requirements.

SCOPE OF THE PNA

A PNA is defined as:

“The statement of the needs for pharmaceutical services which each HWB is required to publish by the virtue of section 128A of the 2006 Act(1) (pharmaceutical needs assessments), whether it is the statement of its first assessment or of any revised assessment, is referred to in these Regulations as a pharmaceutical needs assessment.” - http://www.legislation.gov.uk/uksi/2013/349/part/2/made

The PNA informs both professional bodies and the public about the need for pharmaceutical services, and will consider pharmaceutical services as all services delivered through pharmacies, dispensing doctors, or appliance contractors that are commissioned on a national or local basis in Coventry and Warwickshire.

EXCLUSIONS FROM THE PNA

Pharmacy provisions in prisons or in secondary care settings such as hospitals will not be considered as part of the PNA. Whilst the PNA does not assess pharmaceutical services in secondary care settings, it is important to ensure the smooth transition of patients moving in and out of hospital that creates the seamless continuity of support around medicines.

Distance selling of medicines and appliances that residents may use are not considered by the PNA. This is because they are available nationally and aren't localised to a LA, CCG, or NHS England area team. The service provision from these providers has therefore not informed the decision-making process in the PNA.

MINIMUM REQUIREMENTS FOR A PNA

A statement of the following must be included as a minimum, as set out in schedule 1 of the NHS 2013 Regulations:

Necessary services – services which have been assessed as required to meet a pharmaceutical need. This should include both their current provision (inside the Health and Wellbeing board area and outside of their area within a range that may affect the provision within the area), and any gaps, either current or likely to occur in the future.

Relevant services – services that have created better access to pharmaceutical services. This should include both their current provision (inside the Health and Wellbeing board area and outside of their area within a range that may affect the provision within the area), and any gaps, either current or likely to occur in the future.

Other NHS services – Services that either impact the need for pharmaceutical services or create better access to pharmaceutical services within the area. These are provided or arranged by a LA, NHS England, a CCG, an NHS Trust or Foundation Trust.

Map of pharmaceutical services – a map showing the places where pharmaceutical services are provided and assess the implications of distance to these places.

Explanation of assessment – an explanation of how the assessment was made, including details of the public and pharmaceutical surveys that have been undertaken.

APPROACH TO PNA

DETERMINING LOCALITIES

Warwickshire is a two-tier local authority and is made up of 5 district and borough areas with an area of 1975km^2, whereas Coventry is a single-tier authority with an area of 99km^2. The geographical size of Coventry is equivalent to one of the district or boroughs within Warwickshire. Coventry is a high density area with a population of approximately 3100 individuals per square kilometre. Warwickshire has pockets of high density population but also considerable rural areas, with a population of approximately 296 individuals per square kilometre.

Coventry will be considered as one locality and Warwickshire will reflect it's five districts and boroughs. These localities are used for many of the Local Authority and Health and Wellbeing Board resources and documents, and so creates logical cross referencing with the PNA. They also correlate with the new JSNA Geographies that were approved by the JSNA Strategic Group in June 2017.

The localities are therefore defined as (Figure 1):

- Coventry
- North Warwickshire Borough
- Nuneaton & Bedworth Borough
- Rugby Borough
- Stratford-on-Avon District
- Warwick District

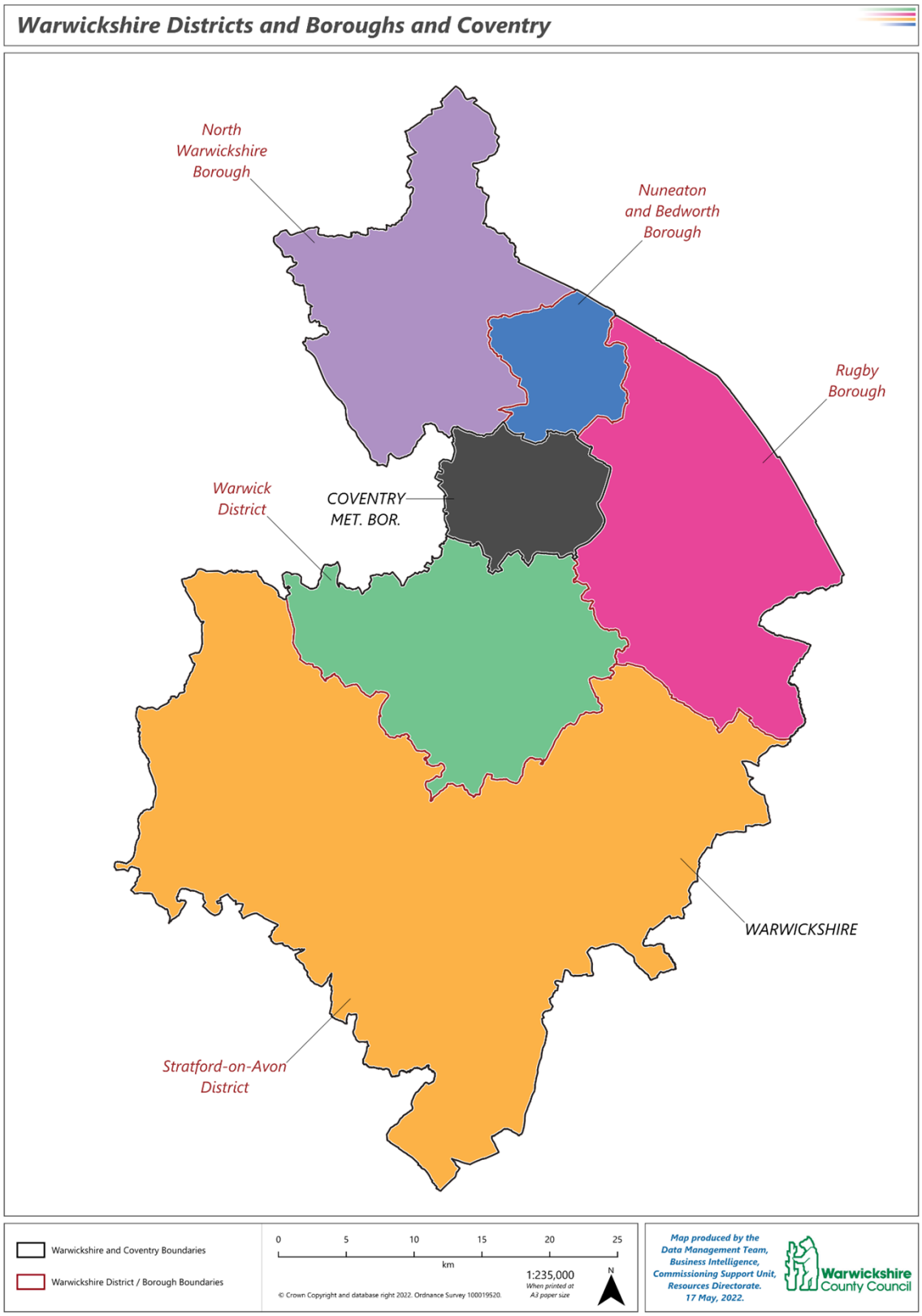

Figure 1: Map of localities

For the purpose of this PNA, LSOA's have been chosen as the unit of geography to capture more granular differences in needs and services. LSOA's are ideal for the PNA as they are small enough to distinguish different characteristics of areas within the localities of Coventry and Warwickshire, and large enough for statistical information to be meaningful.

Figure 2 shows the LSOA's within Coventry:

Figure 2: Map of LSOA's within Coventry
Source: SHAPE

Figure 3 shows the LSOA's within Warwickshire:

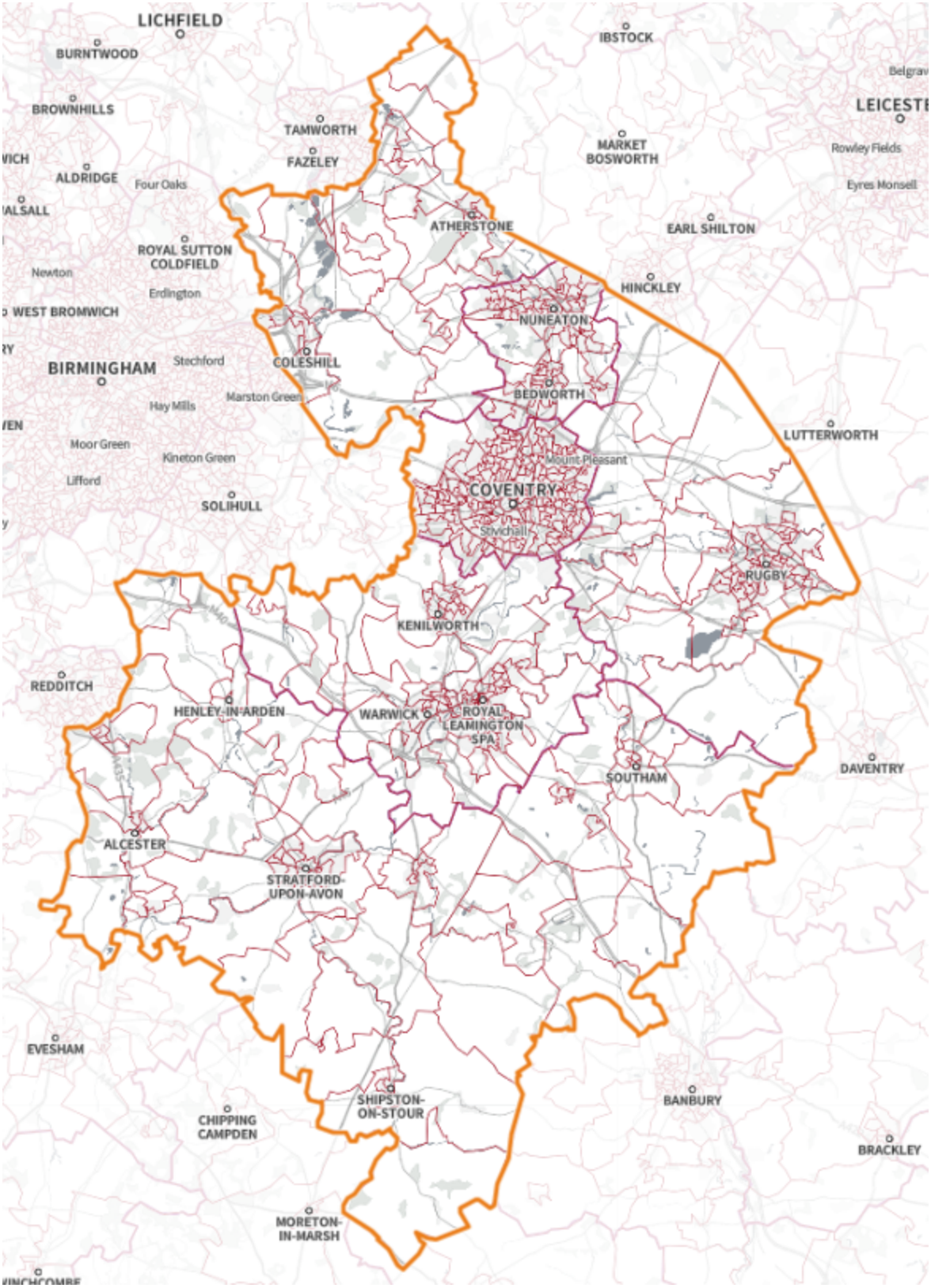

Figure 3: Map of LSOA's in Warwickshire
Source: SHAPE

PNA STEERING GROUP

The Health and Wellbeing Boards of Coventry and Warwickshire are approaching the development of the PNA as a collaborative project, with one report being produced to cover both Local Authorities, in accordance with the regulations.

The development of the PNA is being overseen by one multi-disciplinary steering group which includes representation from organisations for both the Coventry and Warwickshire areas such as the Warwickshire Local Pharmaceutical Committee (LPC), Coventry LPC, Healthwatch and local CCGs. The steering group has the following responsibilities:

- Reviewing the PNA to ensure it meets the statutory requirements.
- Approving all public facing documentation.
- Providing advice on the best method to integrate/align the PNA to the Joint Strategic Needs Assessment (JSNA).
- Providing advice and information to the Health and Wellbeing Boards about community pharmacies in the area.
- Providing advice and information to the Health and Wellbeing Boards about the potentials of community pharmacy to address health inequalities as addressed by the JSNA.
- Providing leadership in developing a single robust PNA across Coventry and Warwickshire.
- Ensuring the engagement and involvement of relevant people/bodies in the development of the PNA.

HOW THE ASSESSMENT WAS DONE

Pharmaceutical Needs Assessments were due to be renewed and published by Local Authority Health and Wellbeing Boards in April 2021. Due to the pressures in response to the COVID-19 pandemic, the Department of Health and Social Care announced that the requirement to publish renewed Pharmaceutical Need Assessments was suspended until October 2022.

The process of developing the PNA has taken into account the requirement to involve and consult with patients and professionals about changes to health services. All specific legislative requirements in relation to the development of PNAs were duly considered and adhered to.

Stage 1

A project management approach was used to develop the PNA and so a steering group was established which met regularly during the development of the PNA. The views of stakeholders were gathered through feedback in meetings, via telephone or feedback online via email.

Stage 2

A pharmacy survey and a public survey were developed to capture the views of Coventry and Warwickshire residents on the current pharmaceutical services provision available in Coventry and Warwickshire. The content of the surveys was then approved by the steering group. The surveys were undertaken in Feb/March 2022. Following the closure of the surveys the responses were analysed.

Stage 3

Following the initial data collection period, results were collated and analysed in April/May 2022 and a summary of current provisions and the gaps in provision of pharmaceutical services was identified and fed back into the draft report. The content of the PNA including demographics, localities and background information was approved by the steering group.

In addition to taking account of all views submitted from the stakeholders outlined above, this PNA considered several factors, including:

- The size and demography of the population across Coventry and Warwickshire
- Adequacy of access to pharmaceutical services across Coventry and Warwickshire
- Differing needs of individual localities within Coventry and Warwickshire
- NHS services provided in or outside Coventry and Warwickshire's area which affect the need for pharmaceutical services.
- If further provision of pharmaceutical services would secure better access to pharmaceutical services.
- The impact of predicted changes to the size of the population, the demography of the population and changing needs in the future which could lead to gaps in the provision of pharmaceutical services.

Stage 4

As required by legislation, a 60-day consultation is necessary during the process of producing this document.

INFORMATION SOURCES

Various sources of information have been used to identify the local need and the priorities for the PNA. These are:

- Joint Strategic Needs Assessments
- Coventry and Warwickshire Strategic Transformation Plan
- Patient Experience Survey
- Pharmacy Contractors Survey
- Office of National Statistics (ONS), Census data 2011
- Public Health Sources (i.e. Coventry City Council and Warwickshire County Council)
- Healthwatch Annual Report 2016/17

This data has been combined to provide a picture of the Coventry and Warwickshire population, their current and future health needs and how pharmaceutical services can be used to support the Coventry and Warwickshire Health and Wellbeing Boards to improve the health and wellbeing of the Coventry and Warwickshire population.

The following should be noted about the data in this PNA:

- We will receive new census data in July 2022, however due to the consultation timeline for report release before October 1st we will not receive this data in time to include in this report. Once we have received the 2022 census data, should the current picture and predications need updating, we will produce a supplementary statement noting any updates.
- There is a slight discrepancy between the pharmacies presented in the SHAPE mapping tool and the formal pharmacy list received for this PNA. Whilst we acknowledge the discrepancy, it has been decided that the SHAPE tool still reflects an accurate picture of need within Coventry and Warwickshire, and therefore it is appropriate to use.

EQUALITY ASSESSMENT

The Public Sector Equality Duty (PSED) was introduced via the Equality Act 2010. It ensures that Councils and other public bodies consider how different people will be affected by their activities and services.

The council must have due regard to the need to:

- Eliminate discrimination, harassment, and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic and people who do not share it.

PROCESS OF FORMAL CONSULTATION

Under the 2013 regulations, there is a requirement to consult at least once on a draft of the PNA during the process and this consultation period must last for a minimum of 60 days.

The regulations set out that Health and Wellbeing Boards must consult the following bodies at least once during the process of developing the PNA:

- Any Local Pharmaceutical Committee (LPC) for its area
- Any Local Medical Committees (LMC) for its area
- Any persons on the pharmaceutical lists and any dispensing doctors list for its area
- Any LPS chemist in its area
- Any Local Healthwatch organisation for its area
- Any NHS trust or NHS foundation trust in its area
- The National Health Service Commissioning Board (NHSCB) and any neighbouring Health and Wellbeing Boards.

OTHER RELEVANT WORK

JSNA

The JSNA[1],[2] provides the evidence base for understanding the needs of the local population. It is used to inform the Health and Wellbeing Strategy, along with specific commissioning decisions.

The JSNA contains a more complete analysis of health in Coventry and Warwickshire. In Warwickshire a place based approach to the JSNA was taken between 2017-2020, which focused on each of the 22 Warwickshire JSNA Geographies. Following that programme a thematic approach has been adopted.

Coventry undertook a place-based approach between 2018-2020 producing a citywide JSNA analytical profile, as well as profiles for each of the city's eight Family Hub reach areas. In addition to this, detailed statistical data and evidence is available in the Citywide Intelligence Hub which provides tools to compare and contract metrics and indicators.

HEALTH INEQUALITIES PLAN

Reducing health inequalities is core to the role of the Coventry and Warwickshire Integrated Care System (ICS). The ICS Health Inequalities Strategy sets out the system wide approach to tackling health inequalities based on the Kings Fund Model of Population Health. It recognises the importance of the wider determinants, healthy lifestyles, local communities and health and care services in reducing health inequalities. The ICS has adopted the Core20+5 framework[3] for health inequalities; in addition to populations living in the more deprived areas the ICS will specifically consider newly arrived and transient communities as these groups experience significant health inequalities. The strategy will be delivered by embedding reducing health inequalities across all programmes of work and prioritising resources to communities with the greatest needs.

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[1] https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1 (accessed May 2022)

[2] https://www.coventry.gov.uk/facts-coventry/joint-strategic-needs-assessment-jsna (accessed May 2022)

[3] https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/ (accessed May 2022)

INTEGRATED CARE BOARD (ICB)

As part of the Health and Care Act 2022, 42 Integrated Care Systems (ICSs) will be established in England on a statutory basis as of 1st July 2022. An ICS will include an Integrated Care Board (ICB) which is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS area. Once these are legally established the current Clinical Commissioning Groups (CCGs) will be abolished.

HEALTHWATCH

Healthwatch is there to listen and understand the needs, experiences and concerns of its local people and communities and how they experience health and social care services (such as dentists, GPs, hospitals, and community pharmacies). They take this feedback to NHS and other key decision makers to ensure they use feedback to improve services and standards of care. Healthwatch supports individuals through our information and signposting service to find reliable and trustworthy information about local services such as community pharmacy.

Healthwatch Coventry is provided by Voluntary Action Coventry, and the steering group is made up of individual local people and local voluntary organisations who set the topics and the direction of the Healthwatch work.

Healthwatch Warwickshire is an independent service for everyone who uses health and social care services in Warwickshire and is governed by a strategic board to ensure the legal and statutory obligations are met.

INTEGRATED PHARMACY MEDICINES OPTIMISATION (IPMO)

The NHS Five Year Forward View highlighted the need to communicate between organisations[4]. In order to address this need, the formation of Sustainability and Transformation Partnerships (STP) and the shift to Integrated Care Systems (ICS) occurred.

More work is needed to deliver the best patient outcomes from medicines and value to the taxpayer. This is a key priority for the Integrating NHS Pharmacy and Medicines Optimisation

[4] NHS England » NHS Five Year Forward View (accessed May 2022)

programme. This programme relies on the expertise of pharmacy professionals to systemically tackle the medicines optimisation priorities for the local population in an STP/ICS footprint[5].

Seven pilot sites were selected, one from each of the NHS regions. The main finding of these sites has been that for a successful local medicine optimisations programme a named system-wide lead supported by a collaborative senior leadership group with a pharmacy professional lead role sitting in the STP/ICS structure is essential[6].

The board meets regularly following several workstreams. Representation on the IPMO includes all the Chief Pharmacists from the Trusts, Head of Medicines Management of the CCG, Chief Executive Officer LPC, and Chair of LPN for Pharmacy.

From an IPMO perspective, the group have prioritised the following for the Coventry and Warwickshire system:

- Workforce/Training & Education
- Digital Medicines
- Clinical Pharmacy
- Aseptic Production
- Medicines Supply/Medicines Value
- Quality Improvement & Surveillance
- Medicines Safety & Governance
- Emergency Department – Reducing unnecessary attendance through Community Pharmacy (ED CPCS)
- Discharge Medicines Service (DMS)
- Single ICS Formulary

[5] https://www.england.nhs.uk/publication/integrating-nhs-pharmacy-and-medicines-optimisation-into-sustainability-and-transformation-partnerships-and-integrated-care-systems/ (accessed May 2022)

[6] https://www.buckslpc.org/wp-content/uploads/2020/11/IPMO_Guidance_Final.pdf (accessed May 2022)

LOCAL PICTURE

In this section we will be discussing the local demographics within Coventry and Warwickshire. We have identified key demographics that have an impact on community pharmacy usage such as:

- People aged 55+ are more likely to use community pharmacy on a regular basis
- People from ethnically diverse communities may require consideration when accessing pharmacy services, especially regarding the diversity of languages spoken across Coventry and Warwickshire
- People who live in areas of deprivation are more likely to have a shorter healthy life expectancy and are therefore more likely to need access to healthcare services earlier, including community pharmacy
- Areas of high population density will have higher demand for community pharmacy, so it is important to consider new housing developments as an indicator of population and population density
- In the lifetime of this PNA there is a cost of living crisis which may affect people being able to afford over the counter medications
- It was acknowledged in the public survey that car travel was the most popular way to access community pharmacies, therefore it is important to consider car ownership and potential change in travel choice due to the cost of living crisis

POPULATION

In 2020, the ONS estimated the usual resident population of Warwickshire to be 583,786 split between 288,334 **(49%)** males and 295,452 **(51%)** females. Within Coventry, the ONS estimated the population to be 379,387 persons, of whom 193,290 **(51%)** were males and 186,097 **(49%)** were females. When compared to England, Warwickshire has an older population, with **27%** of the population being aged 60 or over compared to **24%** in England. In comparison, Coventry has a younger population profile with **17%** of the population aged 60 or over and **37%** aged between 20-39. The age distribution varies across Warwickshire with more rural areas such as North Warwickshire and Stratford-on-Avon having older populations and Warwick District having a large population of those aged between 20-29 (24,331, 17%).

% Population

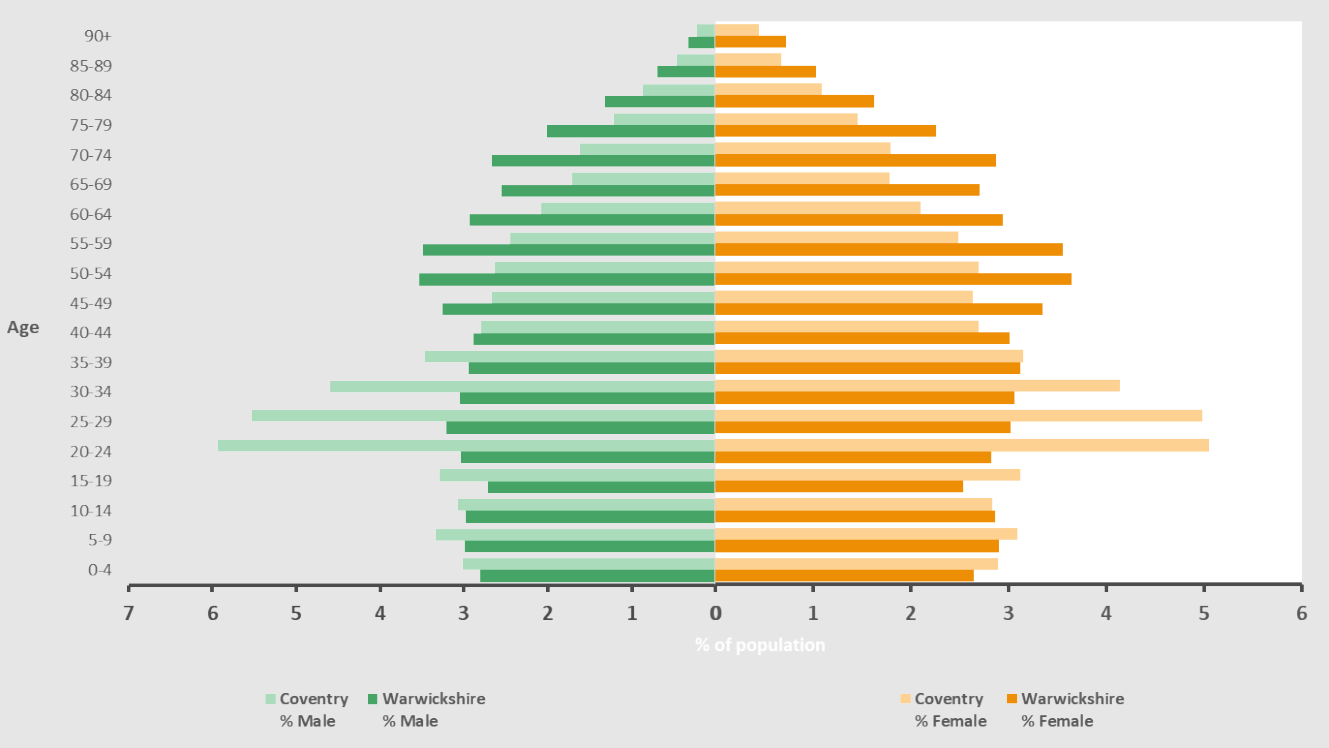


Figure 4: Mid 2020 Population estimates for males and females in Coventry and Warwickshire
Source: ONS Mid-year population estimates 2020

Age Group	Coventry	Warwickshire	North Warwickshire	Nuneaton & Bedworth	Rugby	Stratford-on-Avon	Warwick
0-19	25%	22%	21%	24%	25%	21%	22%
20-39	37%	24%	22%	25%	24%	20%	29%
40-59	21%	27%	28%	27%	27%	27%	25%
60+	17%	27%	28%	25%	24%	32%	24%

Table 1: Percentage age breakdown between localities
Source: ONS Mid-year population estimates 2020

In the three years to mid-2020, the population of both Coventry and Warwickshire increased but the drivers of this growth differed. In Coventry, net internal migration was negative at 9,550 meaning more people left to live elsewhere in the country than those who moved in. Net international migration into Coventry was far higher at 24,987 leaving Coventry with a population 15,437 higher in 2020 compared to 2017.

In Warwickshire, internal and international migration were both net positive, with internal migration making up 86% of the total net increase.

The population of both Coventry and Warwickshire are projected to increase in the future. By 2030, the population of Coventry is projected to increase to **419,366 persons (10.5%)** whilst Warwickshire is projected to increase to **630,395 (8%).** All districts within Warwickshire are projected to increase in population with the largest increases in North Warwickshire **(11%)** and Stratford-on-Avon **(12%)**.

2030 PROJECTED PERCENTAGE OF POPULATION (%)				
Age Group	**Coventry**	**+/- 2020**	**Warwickshire**	**+/- 2020**
0-19	25	+0.3	22	-0.4
20-39	36	-0.6	24	-0.4
40-59	21	-0.2	25	-2.1
60+	18	+0.4	30	+3.0

Table 2: percentage of projected population by age group in Coventry and Warwickshire
Source: ONS population projections (2020, reference period 2018)

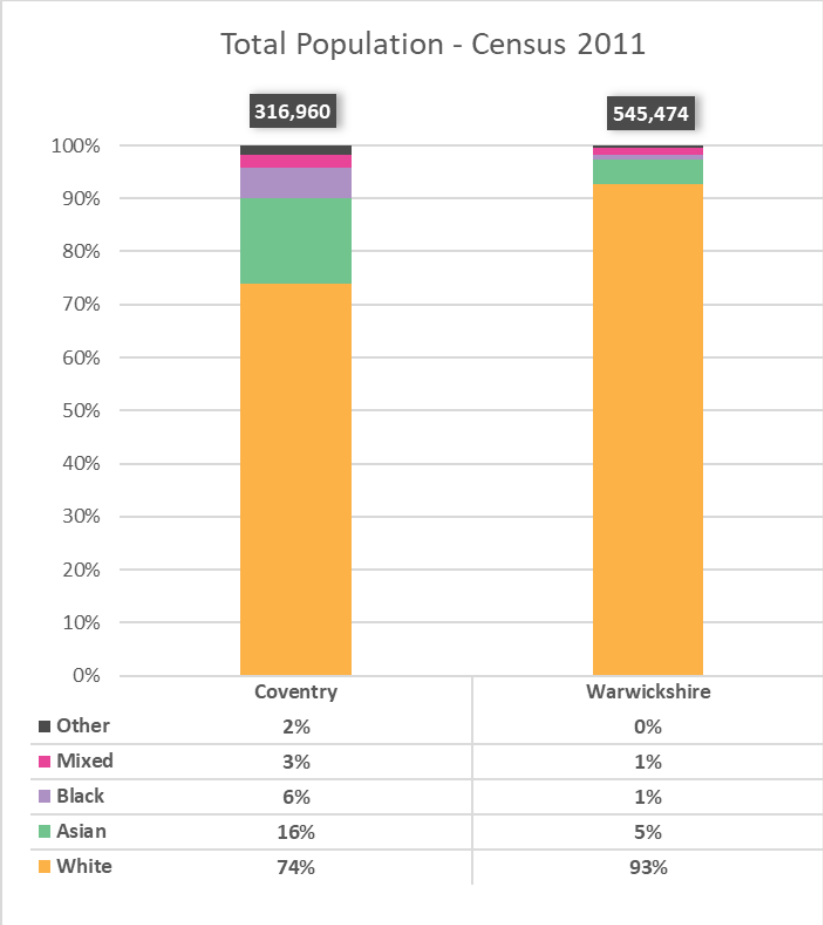
By 2030, there is projected to be a 3 percentage point increase in those aged 60 and over in Warwickshire, with a decline in those primarily in the 40-59 age group. This shows that Warwickshire has an aging population on average. Coventry, in contrast, has a projected population structure that shows little change.

It is worth noting that these population figures are based on census data with more recent indicators like GP registrations used to estimate the current and project the future population. Whilst there was a census completed in 2021, the most recent available data at the time of writing is from 2011. The further away from a census, the less accurate estimates based on this data become.

ETHNICITY

The Census (2011) is the most reliable study into the ethnicity composition of the population. Since this data is ten years old now, it should be viewed as a starting point whilst looking at other sources such as the school census. The School Census collects ethnicity data yearly which is provided by all state-funded schools in England. Comparing the 2011 Census data with the 2021 School Census, population changes in ethnicity can be estimated and projected. The population of Coventry is more ethnically diverse than the population of Warwickshire with 26% of the population reporting an ethnicity of non-white. (Figure 5),

compared with Warwickshire's 7%. This figure varies across Warwickshire with Rugby and Warwick reporting 10% and 9% respectively.



	Coventry	Warwickshire
Other	2%	0%
Mixed	3%	1%
Black	6%	1%
Asian	16%	5%
White	74%	93%

Figure 5: Total Population breakdown by Ethnicity
Source: Census 2011

When looking at the School Census ethnicity composition, it's important to remember that this is a function of which population groups are growing, either by having children or through migration, not a direct comparison to total population data. The 2021 school population is more diverse than the 2011 Census data, with Coventry reporting 44% non-white and Warwickshire 15%.

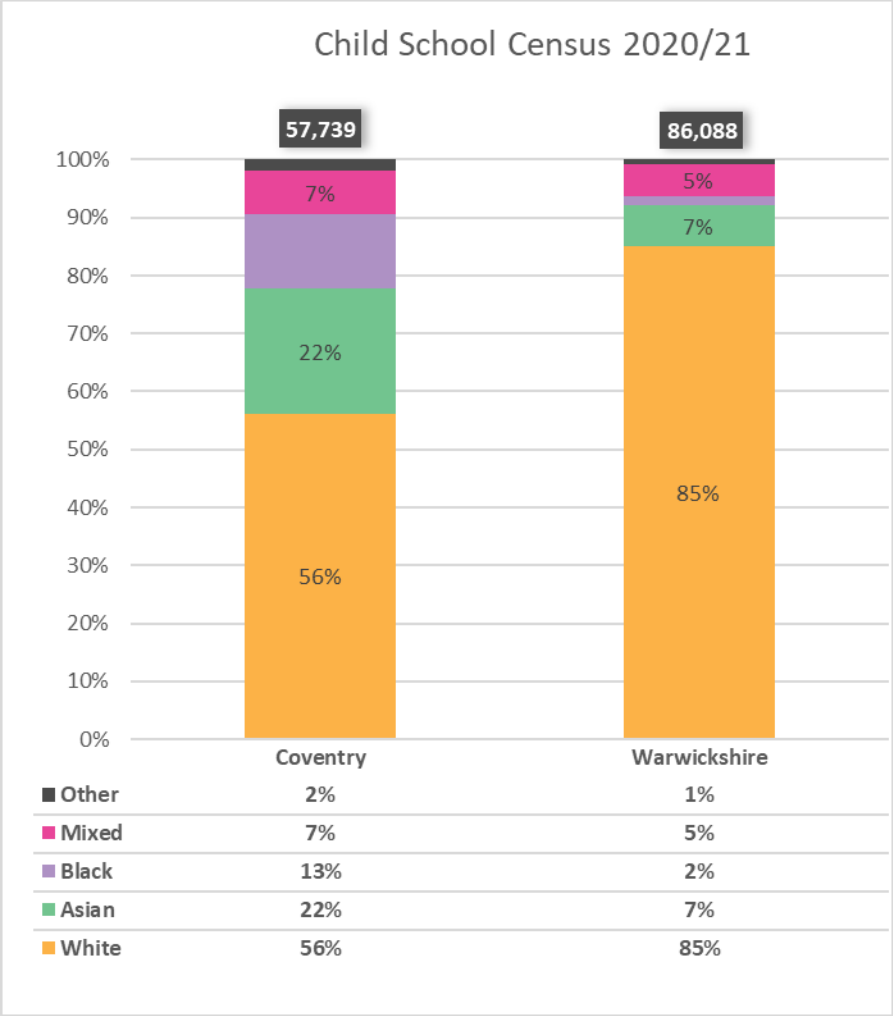


Figure 6: Child Ethnicity Breakdown
Source: Child School Census 2020/21

HOUSEHOLD LANGUAGES

The 2011 Census also recorded the main language spoken in each household. In Coventry in 2011, only 84.6% of households had all occupants over the age of 16 speaking English as their main language. By comparison, 95% of households in Warwickshire were within this category. Furthermore, in 8.7% of Coventry households and 2.4% of Warwickshire households, English was not the main language of any occupant. The 2011 Census demonstrated that in Coventry, Nuneaton and Warwick Panjabi was the other most utilised main language whereas in North Warwickshire, Rugby and Stratford this was Polish.

This diversity of language is somewhat reflected in the more recent data of the 2020/21 School Census in which the first languages of pupils were recorded. It was noted that in

Coventry, English was not the first language for 33.4% of pupils and in Warwickshire it was not the first language for 10.9% of pupils. This can be compared to England's national average of pupils who do not speak English as their first language of 19.3%

Our current survey demonstrated that a pharmacy that spoke multiple languages was not a high priority. However, as our survey underrepresents BAME groups, language diversity might be something important to consider in the future to maintain accessibility to all.

Main Language	Coventry		Warwickshire	
	number	%	number	%
All categories: English as a household language	128,592	100.0	231,005	100.0
All people aged 16 and over in household have English as a main language (English or Welsh in Wales)	108,756	84.6	219,506	95.0
At least one but not all people aged 16 and over in household have English as a main language (English or Welsh in Wales)	6,987	5.4	5,248	2.3
No people aged 16 and over in household but at least one person aged 3 to 15 has English as a main language (English or Welsh in Wales)	1,679	1.3	704	0.3
No people in household have English as a main language (English or Welsh in Wales)	11,170	8.7	5,547	2.4

Table 3: Main Language in a Household
Source: Census 2011

INDEX OF MULTIPLE DEPRIVATION

All the Lower-layer Super Output Areas (LSOAs) in England (32,844) can be ranked according to their Index of Multiple Deprivation score. This allows users to identify the most and least deprived areas in England and to compare whether one area is more deprived than another. There are 195 LSOAs in Coventry with an average population of 1,900 residents. An area has a higher deprivation score than another if there is a higher proportion of people living there who are classed as deprived.

A geographical area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. It is important to remember that not everyone

living in a deprived area is deprived, and that not all people experiencing deprivation live in deprived areas.

Figure 7 shows the LSOAs in Coventry ranked from most deprived to least deprived. The map shows particular areas of deprivation from the city centre into the North East of the city, as well as in the South East and pockets in the South West.

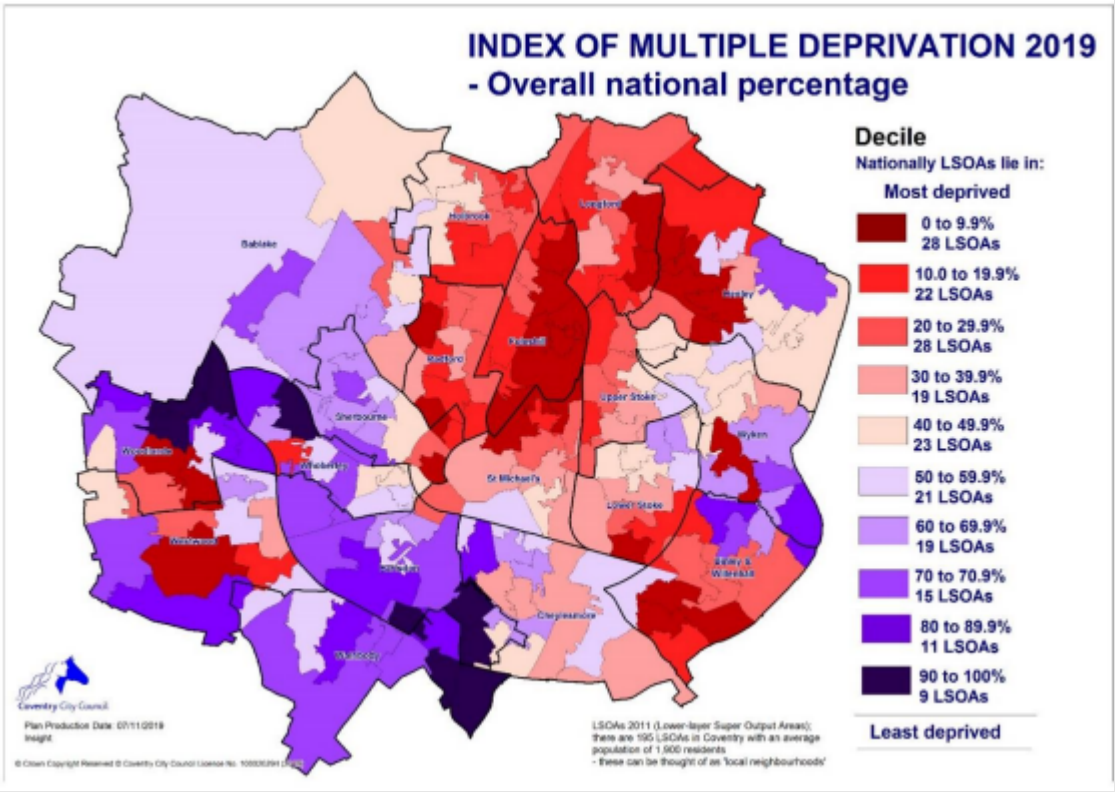


Figure 7: Coventry LSOAs by deprivation decile
Source: Index of Multiple Deprivation 2019

Figure 8 shows the LSOAs in Warwickshire ranked from most deprived (dark blue) to least deprived (light blue). The map shows particular areas of deprivation around North Warwickshire, Nuneaton and Bedworth, and Rugby.

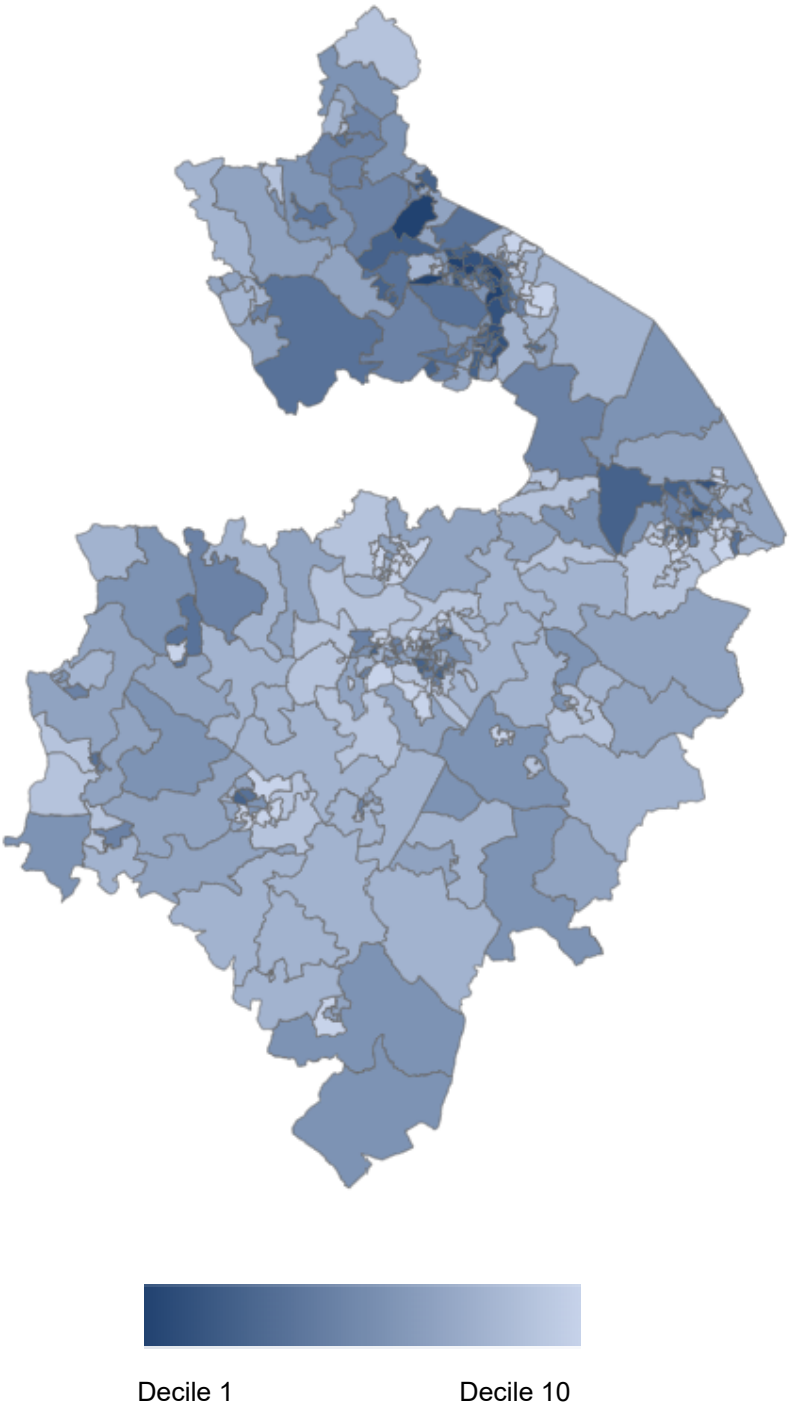


Figure 8: Warwickshire LSOAs by deprivation decile
Source: Index of Multiple Deprivation 2019

The SHAPE tool allows us to map pharmacies and other primary and secondary care settings across England. It also allows us to look at these with reference to the highest 20% of LSOAs on the IMD scale, Figure 9 shows us just these highest 20% of LSOAs.

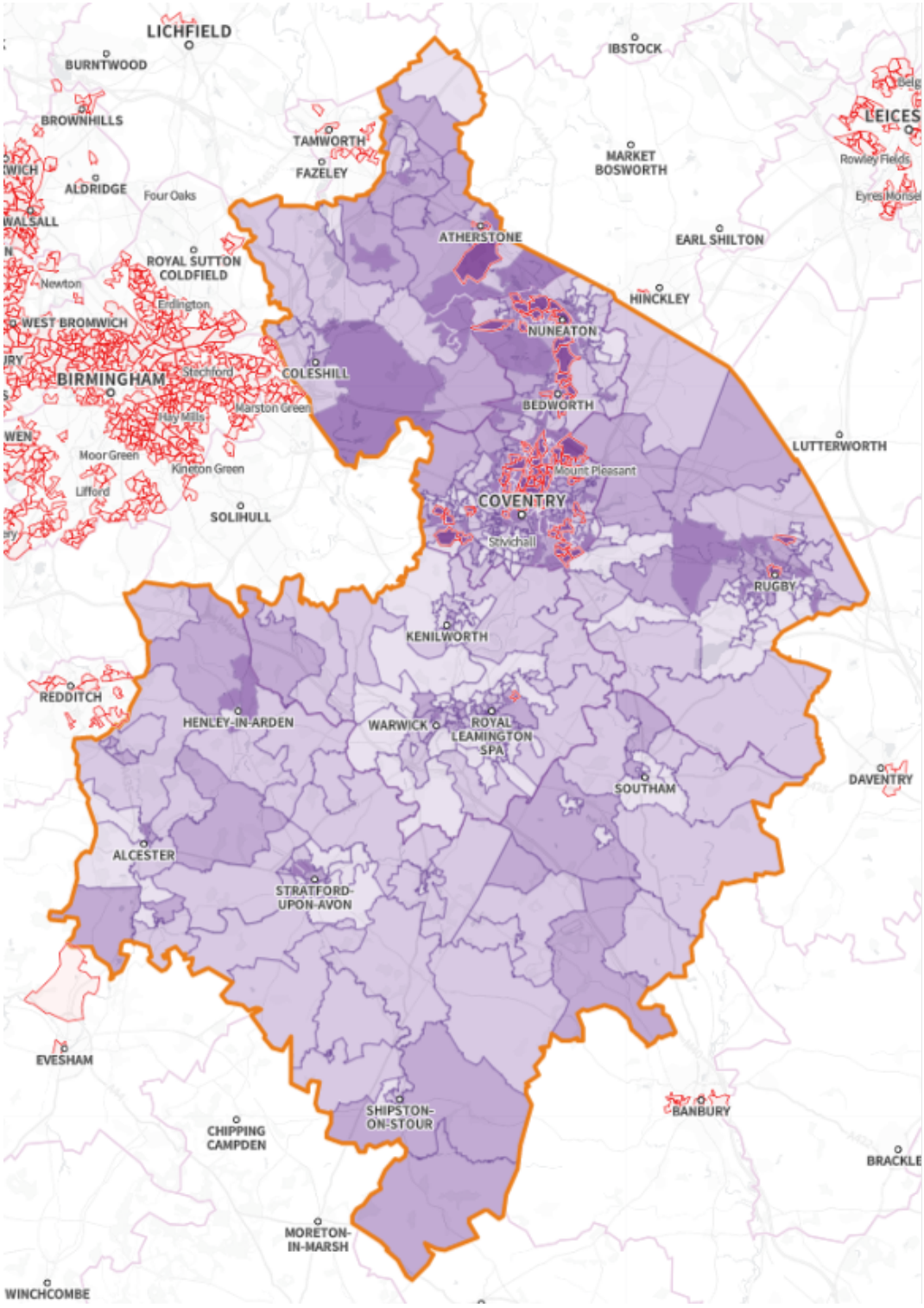


Figure 9: IMD with most deprived 20% in red outlines for Coventry and Warwickshire
Source: SHAPE

Figure 10 shows how IMD ranking has changed over time. An area which has “Fallen” by one or two deciles means that an LSOA has become relatively more deprived, where as an area

which has “Risen” by one or two deciles means that an LSOA has become relatively less deprived.

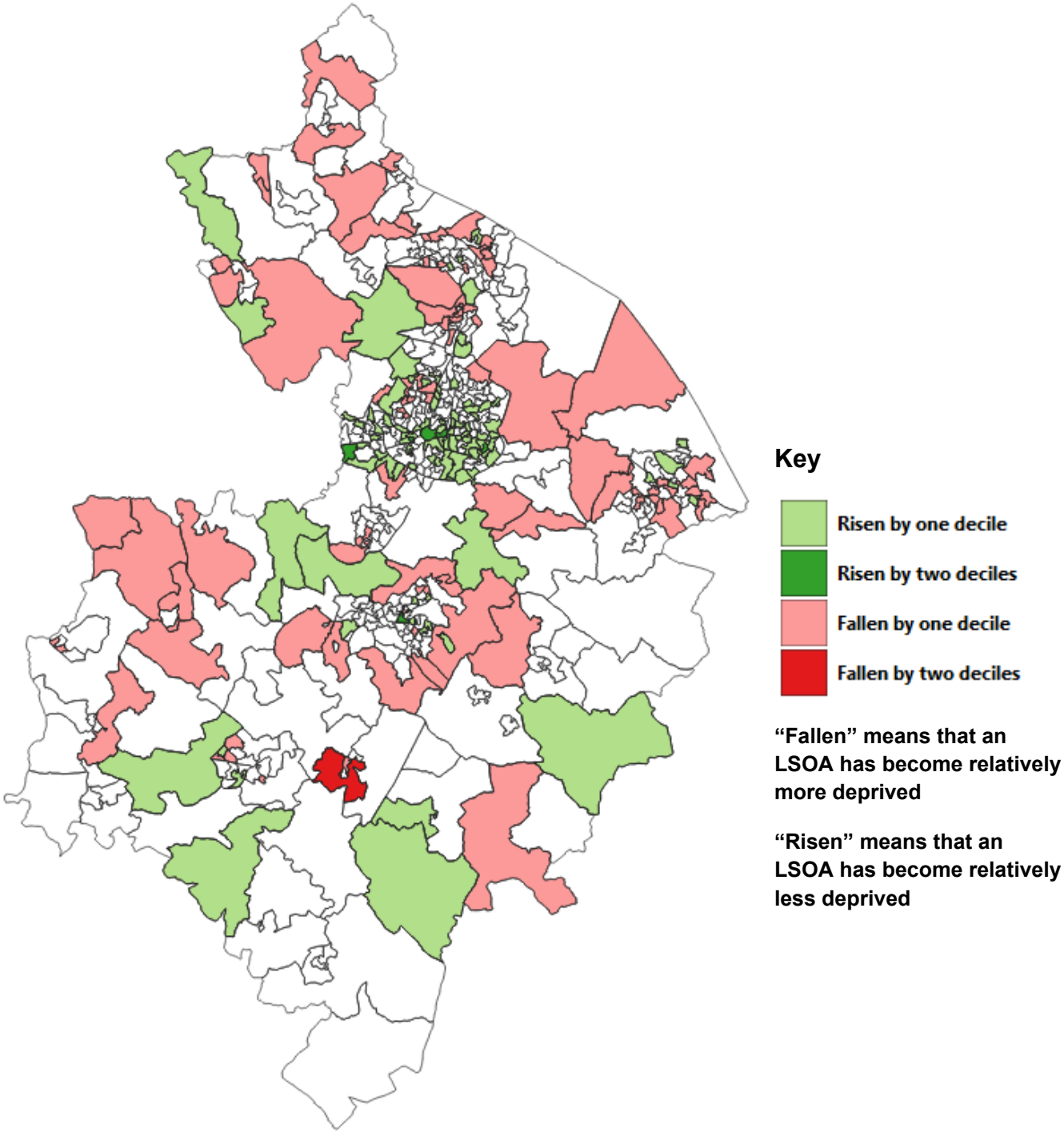


Figure 10: IMD change in Coventry and Warwickshire
Source: IMD 2015 & 2019

Figure 11 focuses on Coventry, where three-quarters of LSOAs have risen by at least one decile. There is a pattern of greatest relative improvement in areas around the city centre, including parts of Hillfields and Charterhouse, radiating Southwards to parts of Cheylesmore and Eastwards to parts of Stoke and Binley. These are also the areas that have seen most notable and persistent relative improvement since the IMD 2010.

More recently, since 2015, there has also been a concentration of relative improvement near the city centre to the West, in Chapelfields and by Holyhead Road and Allesley Old Road. The recent improvements are often found in areas where students live, suggesting that the increase in full-time students studying in the city has been a factor in the improving deprivation measures.

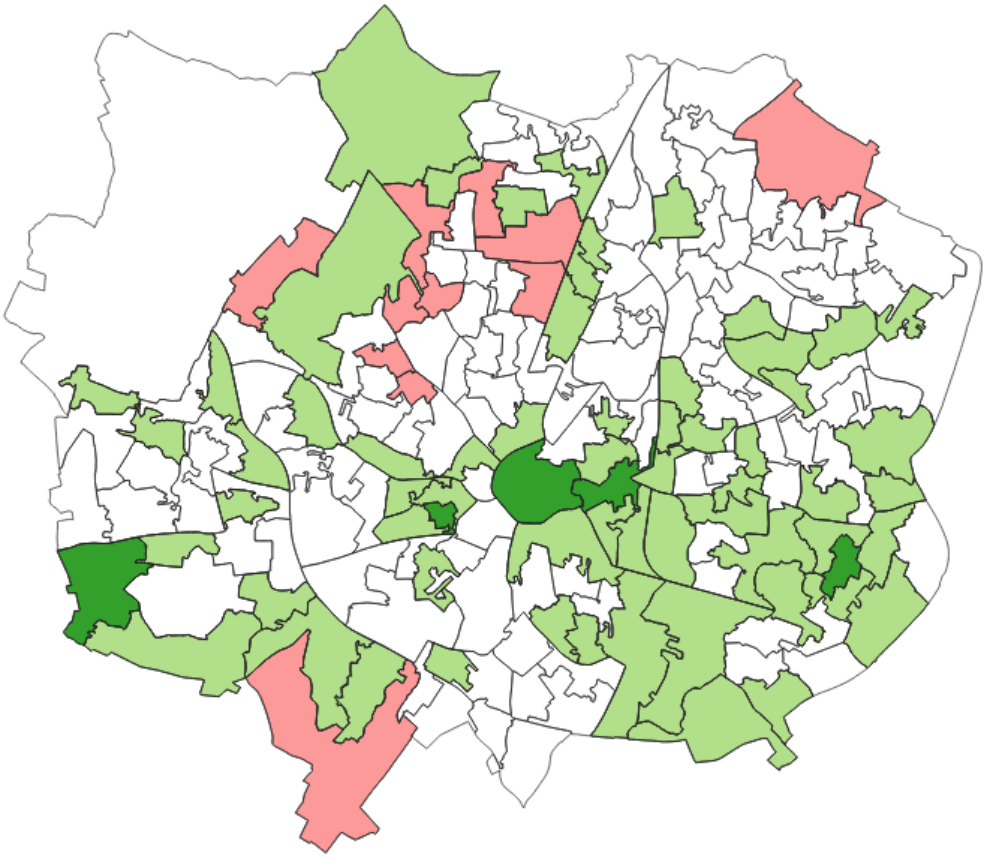


Figure 11: IMD change in Coventry
Source: IMD 2015 & 2019

Figure 12 shows the percentage of older people affected by income deprivation in Coventry and Warwickshire. Areas with a high percentage include areas within Coventry, Nuneaton and Bedworth, Rugby, and Leamington.

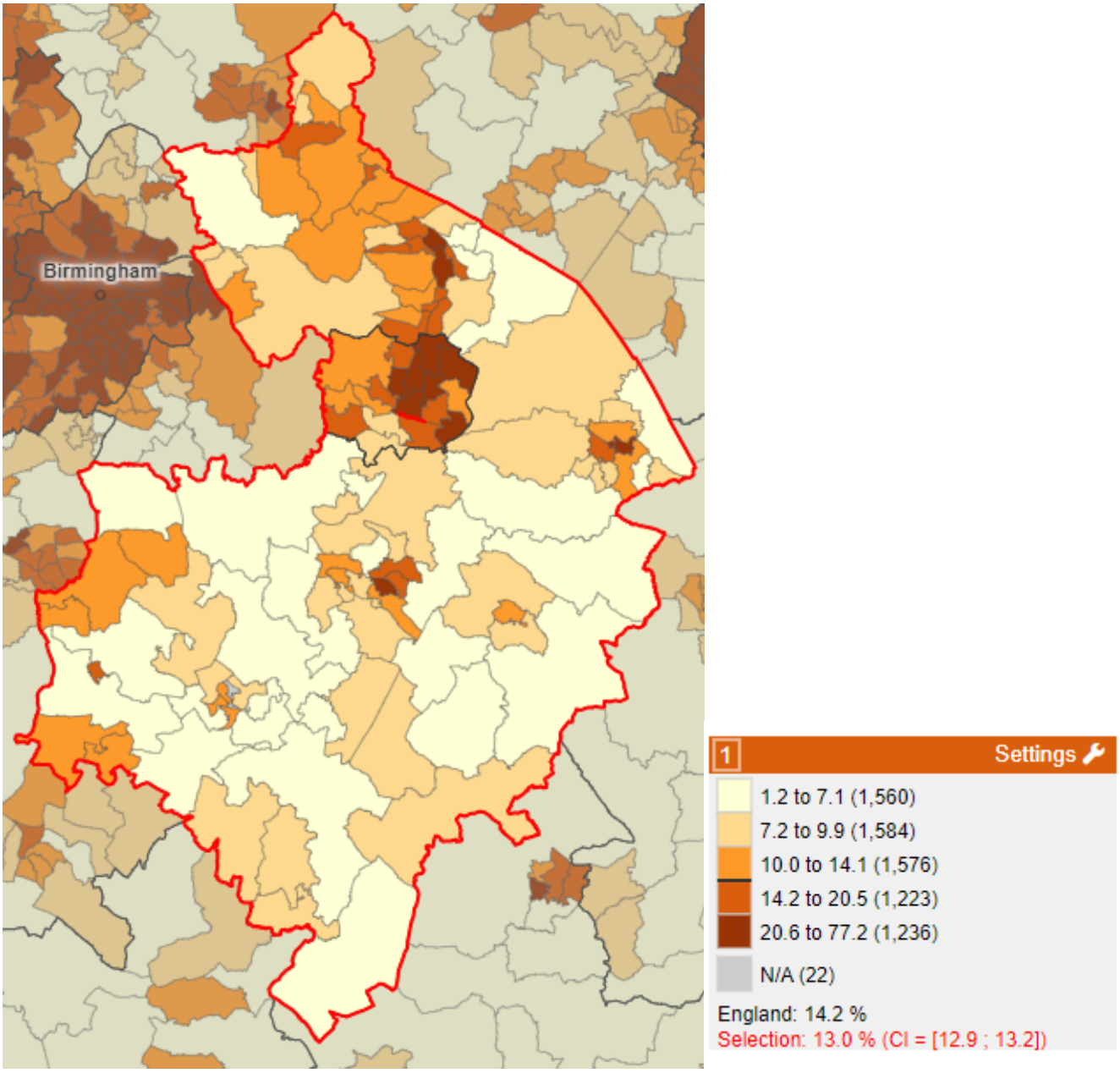


Figure 12: Percentage of older people affected by income deprivation
Source: SHAPE

RURAL DEPRIVATION INDEX FOR HEALTH

The Rural Deprivation Index of Health is a new index that is designed to be more targeted for relevance to healthcare than the Index of Multiple Deprivation. Figure 13 shows that there are fewer LSOAs in red for Coventry and Warwickshire to indicate the lowest (most deprived) 10% on the Rural Deprivation Index for Health than there are for the lowest 20% of the IMD. These areas are still concentrated in Coventry, Bedworth, Nuneaton and Atherstone.

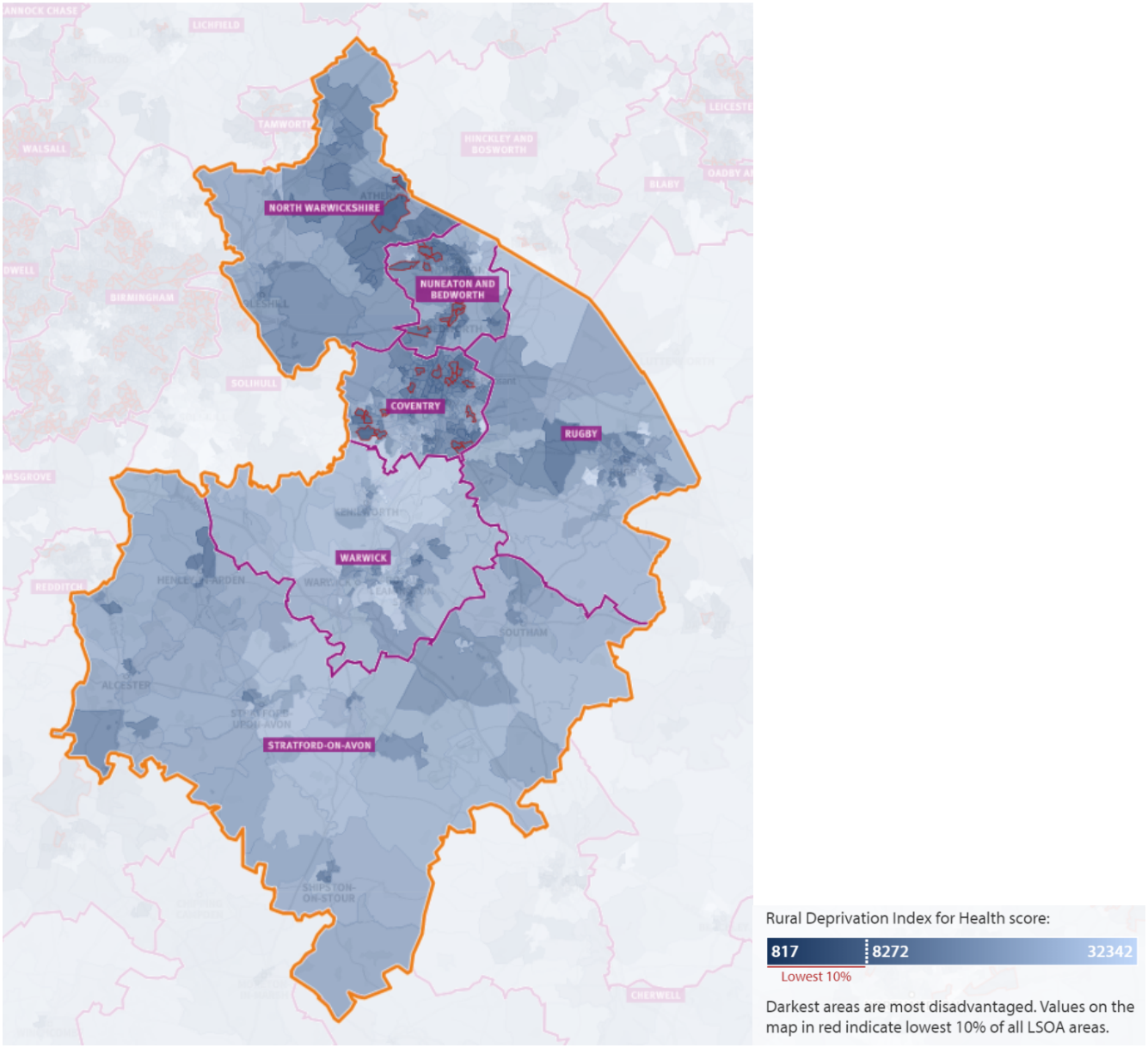


Figure 13: Rural Deprivation Index for Coventry and Warwickshire
Source: SHAPE

LIFE EXPECTANCY

Life expectancy, on average, has fallen during the year 2020 for both men and women in Coventry and Warwickshire. Between the years 2018-20 a man was expected to live to an age of 79.31 and a woman to 83.07. However, in 2020 this is now 78.3 years, and 82.7 years respectively for men and women. This is more noticeable in the male population, especially those in Coventry where a drop in 1.77 years is seen over the year 2020. As male sex is a known factor for COVID-19 mortality, this drop in life expectancy might be due to the impact of COVID-19.

The areas of increased deprivation (Coventry, Nuneaton, Bedworth, and North Warwickshire) continue to have the lowest life expectancy. The most deprived areas, in England, had more than double the mortality rate from COVID-19 when compared to the least deprived areas, for both males and females. Therefore, we can expect COVID-19 to have affected the life expectancy in these areas with increased deprivation.

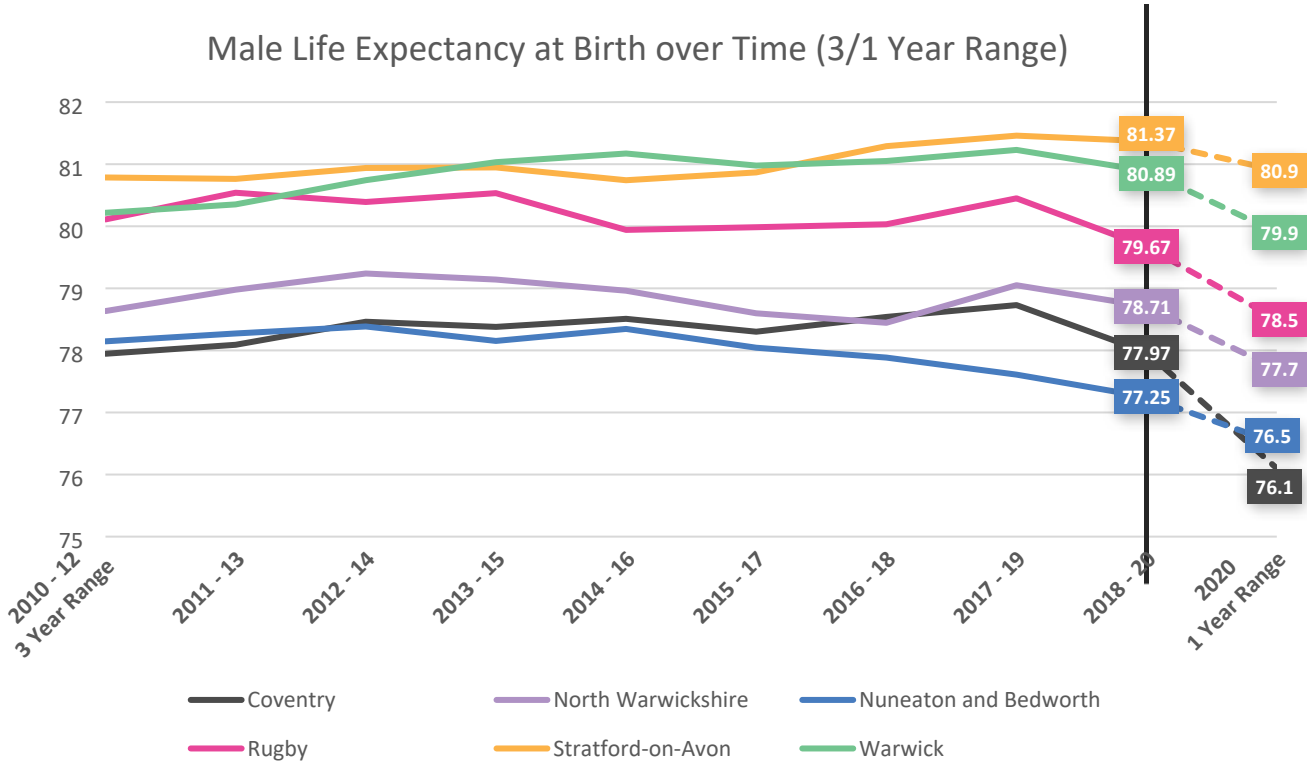


Figure 14: Male Life Expectancy at Birth over Time (3/1 Year Range)
Source: Fingertips

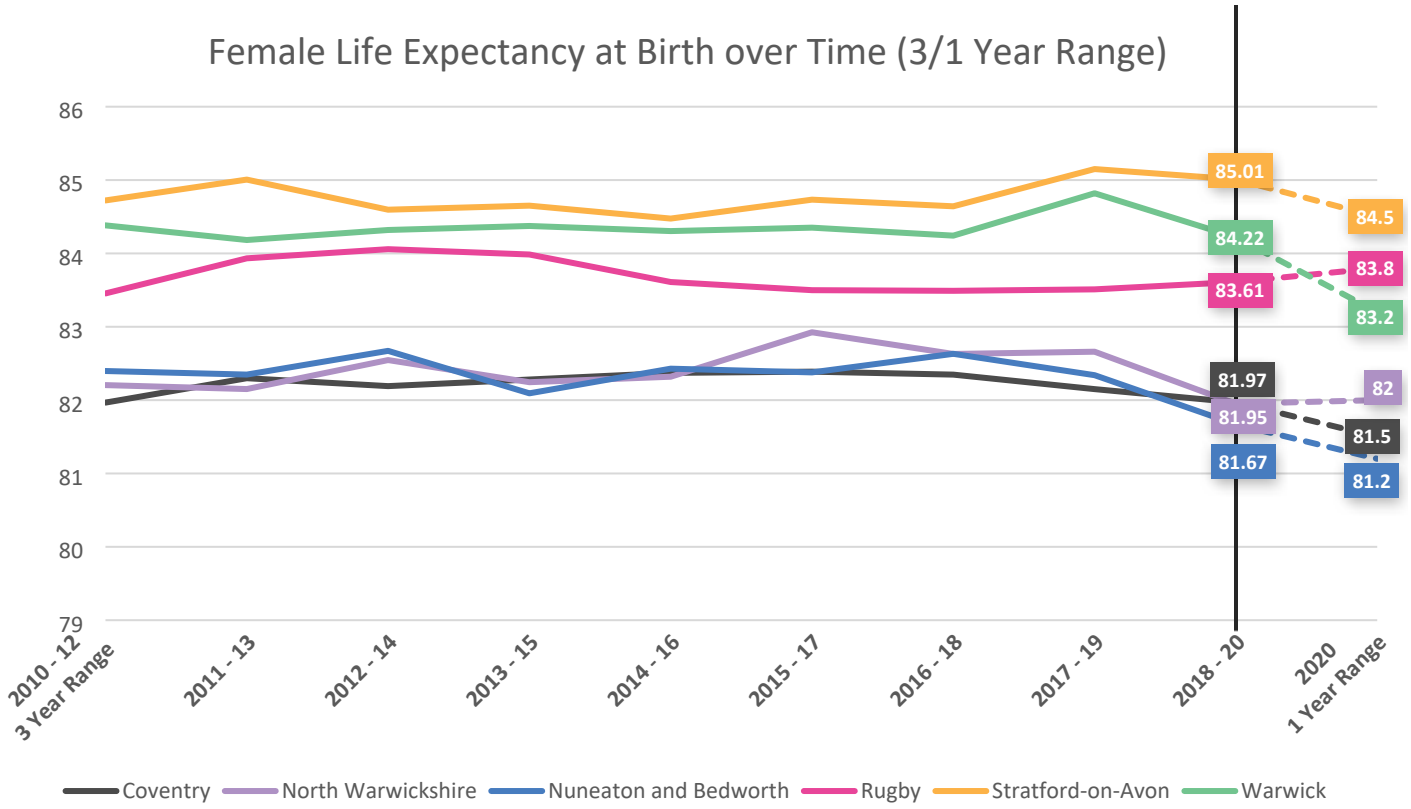


Figure 15: Female Life Expectancy at Birth over Time (3/1 Year Range)
Source: Fingertips

HOUSEHOLDS & HOUSING DEVELOPMENT PROJECTIONS

Table 4 shows the type and number of households across the 6 localities of this PNA. As seen in the population subchapter, Coventry has a high proportion of people aged 20 – 35 than Warwickshire, which can be seen in this figure with the high number of full-time student households in Coventry.

	Coventry	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford-on-Avon	Warwick
Single Family Household	**75,186**	**17,709**	**34,720**	**27,494**	**34,498**	**35,403**
Lone parent	17,449	2,407	5,708	3,865	4,019	5,053
All children non-dependent	5,053	899	1,735	1,190	1,486	1,705
Dependent Children	12,396	1,508	3,973	2,675	2,533	3,348
Married or civil partnership couple	37,696	9,904	18,939	15,243	19,898	19,657

All children non-dependent	7,204	2,007	3,680	2,245	3,097	3,077
Dependent Children	18,355	3,961	8,130	7,090	8,685	9,243
No Children	12,137	3,936	7,129	5,908	8,116	7,337
Cohabiting couple	11,071	2,911	5,492	4,451	4,444	5,690
All children non-dependent	587	179	263	183	187	191
Dependent Children	4,989	1,303	2,648	1,812	1,612	1,791
No Children	5,495	1,429	2,581	2,456	2,645	3,708
All aged 65 and over	8,970	2,487	4,581	3,935	6,137	5,003
One Person Household	**40,148**	**6,776**	**15,090**	**11,784**	**14,804**	**18,600**
Aged 65 and over	15,353	3,120	6,432	4,979	7,482	7,196
Other	24,795	3,656	8,658	6,805	7,322	11,404
Other Household Type	**13,258**	**1,327**	**2,901**	**2,597**	**2,626**	**4,676**
All aged 65 and over	302	66	136	123	176	138
All full-time Students	2,823	1	8	13	40	977
Other	6,009	708	1,570	1,558	1,621	2,331
With dependent children	4,124	552	1,187	903	789	1,230
Grand Total	**128,592**	**25,812**	**52,711**	**41,875**	**51,928**	**58,679**

Table 4: Types of Household by Locality
Source: Census 2011

Figure 16 shows the net housing completions by Fiscal Year and Local Authority since the last PNA in 2018. A high number of completions can be seen in Coventry and Stratford-on-Avon, with the lowest being in North Warwickshire.

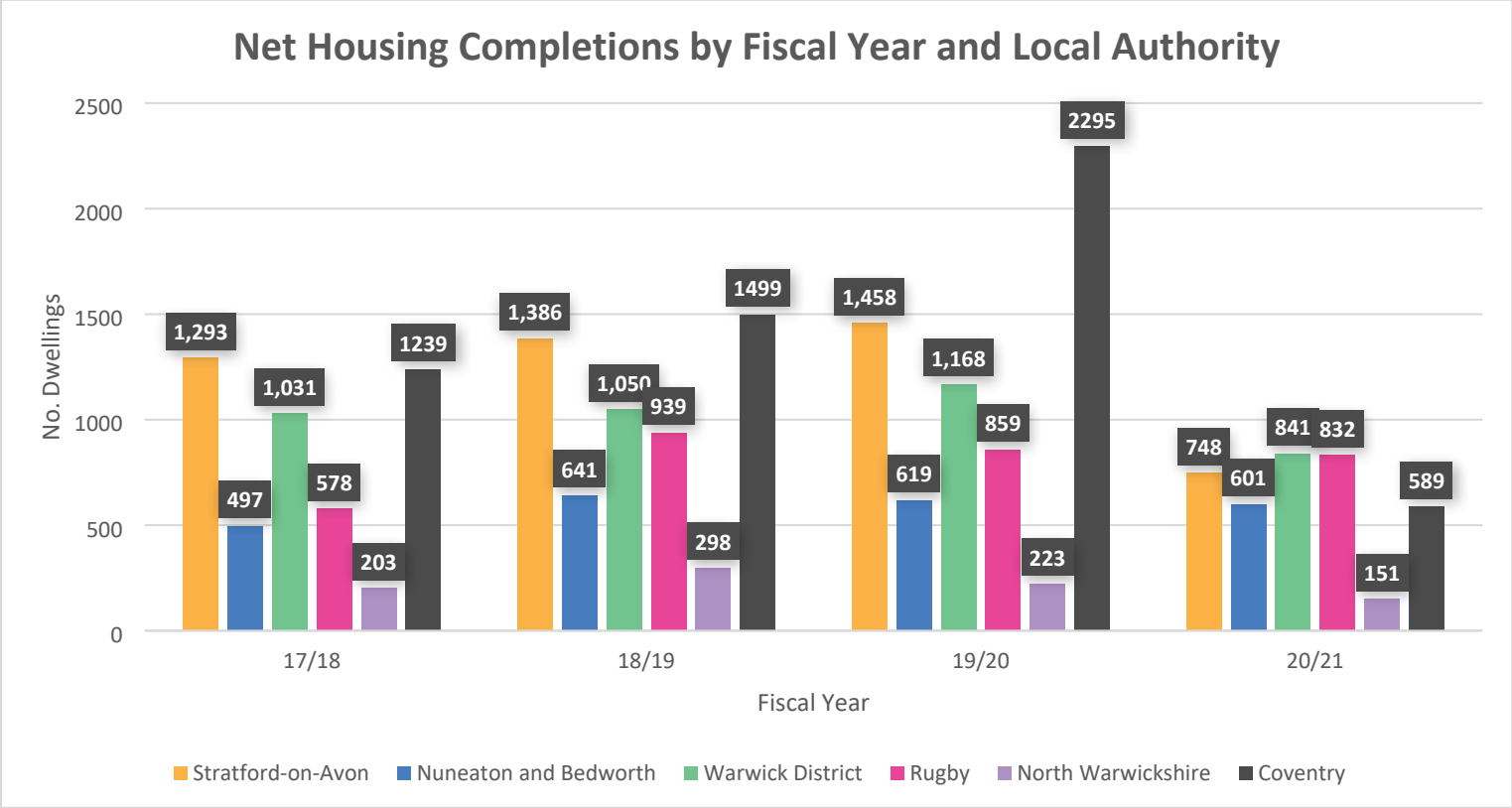


Figure 16: Net Housing Completions by Fiscal Year and Local Authority
Source: Authority monitoring reports from Warwickshire Boroughs and Districts & Coventry City Council website

Figure 17 shows the projected housing completions by Fiscal Year and Local Authority until 2028/29. Over the next 3 years there is a noticeable increase in completions in Coventry, and Nuneaton and Bedworth, whilst the number of completions in Stratford-on-Avon decreases over the next 3 years.

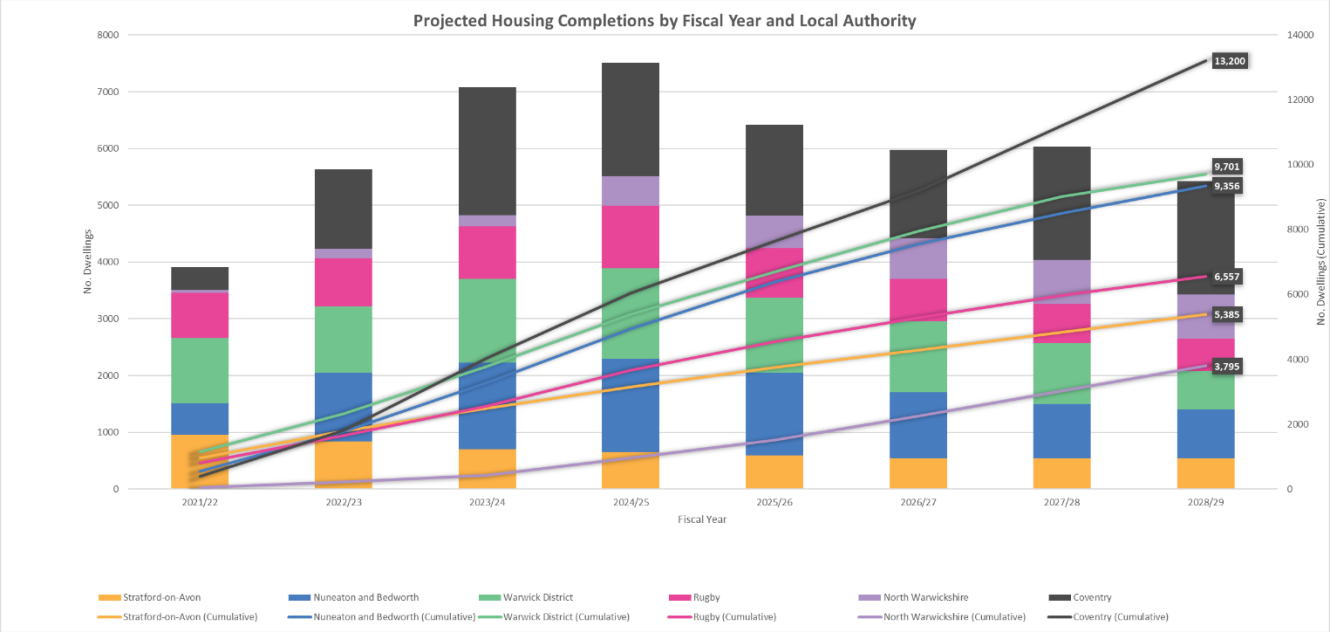


Figure 17: Projected Housing Completions by Fiscal Year and Local Authority
Source: Warwickshire Boroughs and Districts & Coventry City Council

Figure 18 maps the housing construction sites in Warwickshire and Coventry with 300 dwellings or more that have planning permission granted, or are to be started, to continue, or to be completed in the next five years. The circles map where these sites are, and the size and colour correlate to the size of the site. The largest site is located to the East of Rugby, with the next largest sites in the North West of Coventry, Lighthorne Heath in Stratford-on-Avon, and Lower Quinton in Stratford-on-Avon.

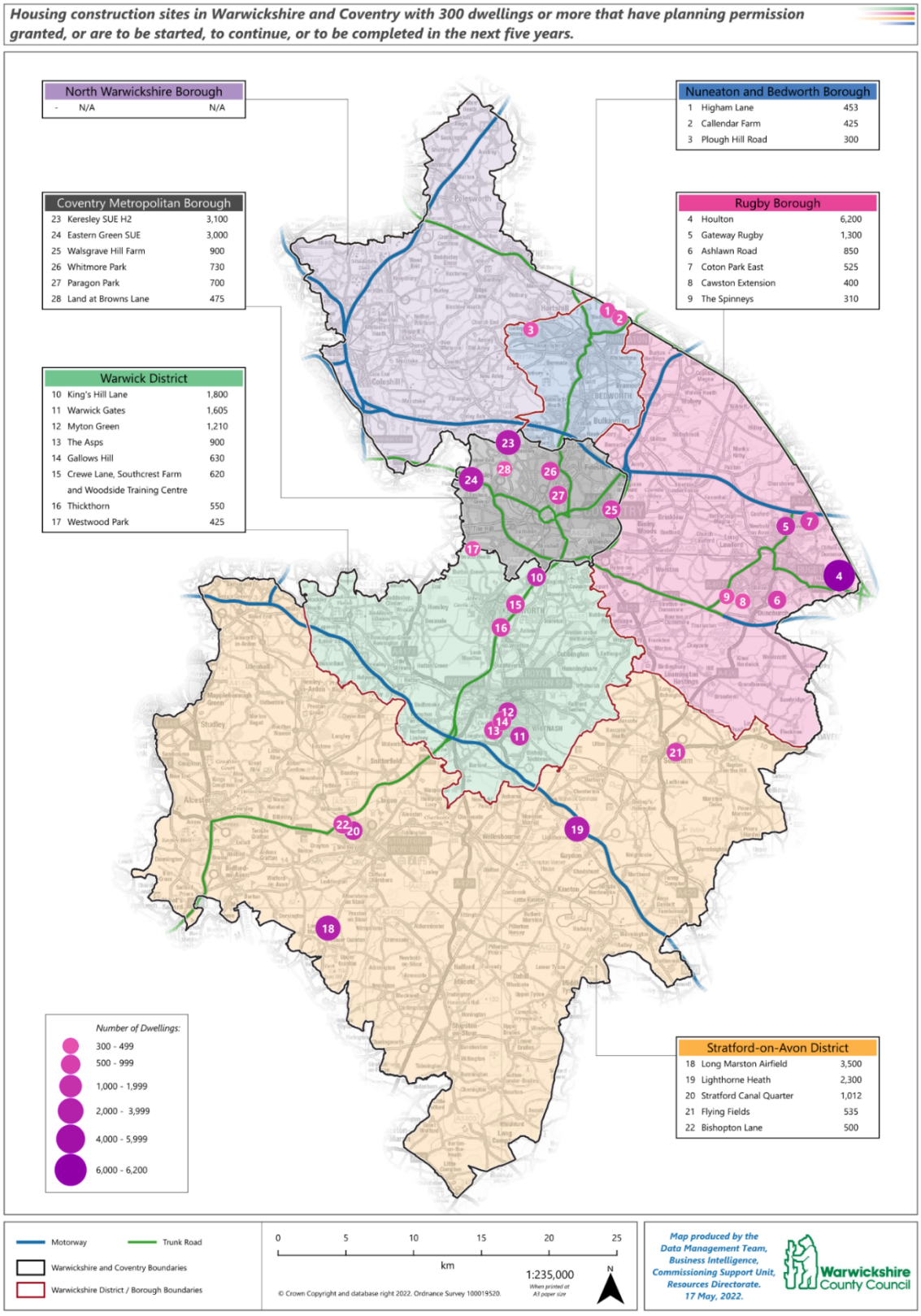


Figure 18: Housing Construction sites in Warwickshire and Coventry with 300 dwellings or more that have planning permission granted, or are to be started, to continue, or to be completed in the next five years
Source: Warwickshire Districts & Boroughs and Coventry City Council

COST OF LIVING CRISIS

A cost of living crisis started in the second half of 2021 and is rapidly accelerating in first half of 2022. There is no indication that the cost of living crisis will be fully resolved within the duration of this PNA period. While this is primarily around home energy, fuel for vehicles, and food, it is affecting all areas of spending and debt levels. Other areas of concern that have already been noted by the local branch of Citizens Advice are the cost of public transportation and the cost of prescriptions. There is a reported reduction in subscriptions to online services[7], as well as anecdotal reports of some cancellations of home Internet services.

Therefore, there are ongoing risks to access to pharmaceutical services via: the direct cost of prescriptions, the cost of physical access via car or public transport, as well as the cost of digital access to online pharmacies.

CAR OWNERSHIP

Consideration regarding car ownership is important due to accessibility of community pharmacy and the rising pressure of cost of living, including fuel prices. Our survey showed that 46.5% of respondents use cars/motorbike/van transportation, whilst 42% walk. This may certainly have an impact on how residents access pharmacies. Almost all of Warwickshire is within a 15-minute drive to a pharmacy, the exceptions being in South and Southeast of Stratford-on-Avon District, which are rural areas with low population density. The majority of Coventry is within a 5-minute drive to a pharmacy and all of Coventry is within a 15- minute drive. In addition to this most of these deprived areas in Coventry and Warwickshire are covered within a 16-minute cycle time.

With rising fuel prices, 44% of people have already driven their car less, and this is projected to increase. It is important to note that the 40-year high of inflation in April 2022 and the increase in petrol prices may lead the public to prefer to walk or take public transport[8]. 72% of respondents in a Savanta survey of 4,011 UK adults on 10 June 2022 said that they had cut down on car journeys to save money in the previous 6 months[9].

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[7] https://news.sky.com/story/more-than-four-in-five-britons-concerned-about-rising-cost-of-living-poll-for-sky-news-suggests-12614622 Accessed June 2022

[8] https://resoluationfoundation.org/publications/cap-off/ Accessed June 2022

[9] https://www.bbc.co.uk/news/business-61813857 Accessed June 2022

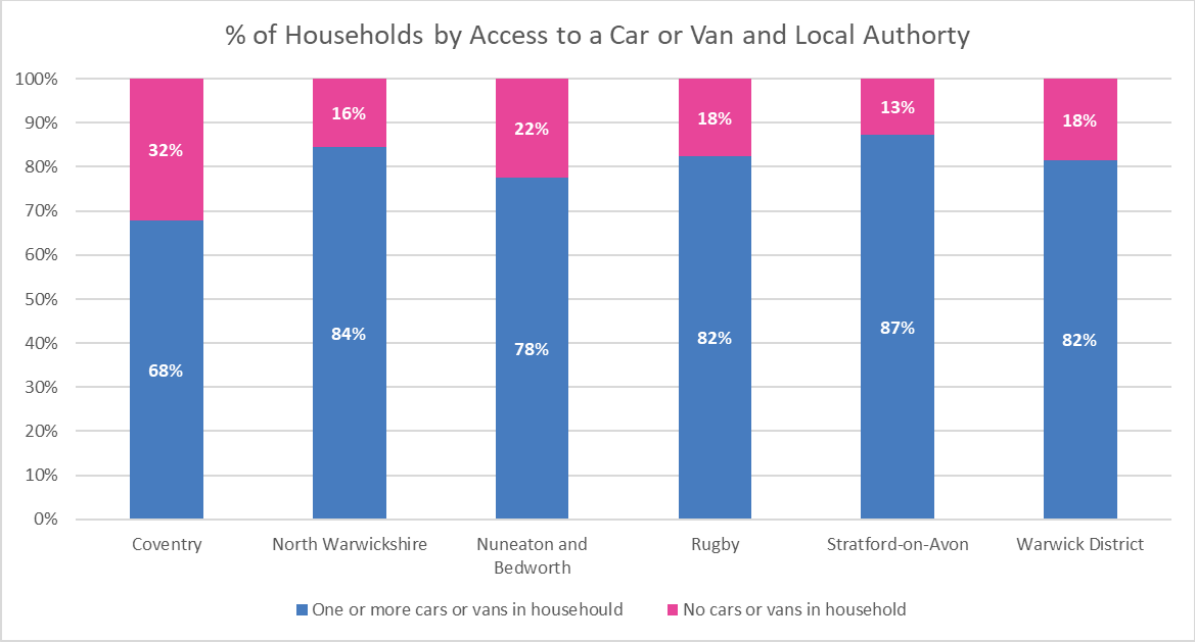

Figure 19: Percentage of households by access to a car or van and Local Authority
Source: Census 2011

GENERAL HEALTH NEEDS

PHYSICAL HEALTH

There are five conditions referenced within this section. How pharmacy supports these conditions is detailed in the “Pharmacy Provisions and Access” and “Pharmacy Services” chapters. What follows here is an overview of these conditions and the local rates across Coventry and Warwickshire.

Smoking

Smoking is the biggest cause of preventable deaths in England, accounting for more than 80,000 premature deaths each year.[10] Smoking prevalence in adults aged 18+ has been falling nationally. In 2020 in England smoking prevalence was at 12.1% of adults aged 18+. Warwickshire is the same as the England rate (12.1%) whilst Coventry is slightly higher at 13.1% of adults aged 18+[11].

There is a clear relationship between smoking prevalence and affluence. People living in the most deprived areas are more likely to smoke than those living in the least deprived areas. Smoking prevalence is higher for those in routine and manual, as opposed to managerial and professional occupations. Most marginalised populations have very high rates of smoking – those who access services for drug and alcohol dependency usually also smoke tobacco.

Smoking in pregnancy results in an increased risk of complications during labour and risk of miscarriage, premature birth, stillbirth, low birth weight, sudden unexpected death in infancy, and infant mortality. Table 5 shows the percentage of women smoking at the time of booking an appointment with their midwife. Compared to the England average, Coventry has a higher percentage and Warwickshire has a lower percentage.

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[10] https://www.warwickshire.gov.uk/health-improvement/smoking-tobacco-control/1#:~:text=Smoking%20is%20the%20biggest%20preventable,of%20adults%20in%20Warwickshire%20smoke. (accessed May 2022)

[11] https://fingertips.phe.org.uk/search/2020%20definition#page/3/gid/1000042/pat/402/par/E10000031/ati/401/are/E07000218/iid/93798/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0 (accessed May 2022)

Smoking in early pregnancy 2018/19

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	12.8	12.7	12.9
West Midlands region	–	-	14.5	14.2	14.7
Stoke-on-Trent	–	-	21.4	20.1	22.8
Telford and Wrekin	–	-	19.4	17.7	21.0
Walsall	–	-	18.1	16.9	19.3
Wolverhampton	–	-	17.1	15.8	18.3
Sandwell	–	-	16.3	15.2	17.3
Dudley	–	-	15.7	14.5	16.8
Herefordshire	–	-	15.1	13.3	16.8
Solihull	–	-	14.7	13.0	16.3
Shropshire	–	-	14.2	12.9	15.5
Worcestershire	–	-	14.2	13.3	15.1
Staffordshire	–	-	14.2	13.1	15.3
Coventry	–	-	14.0	13.0	15.0
Birmingham	–	-	11.6	11.1	12.0
Warwickshire	–	-	11.5	10.6	12.4

Table 5: Percentage smoking in early pregnancy
Source: Fingertips

In 2019/20 smoking was responsible for 506,100 hospital admissions[12]. This represents 4% of all hospital admissions during that time period. As smoking has an impact on various systems of the body it can be attributable to many diseases such as respiratory, circulatory and cancer. There are many methods to stop smoking, prescriptions being one of them. During 2019/20, 710 thousand prescription items were dispensed to help people stop smoking. Currently there is ongoing work to encourage people to stop smoking in hospitals and to support them in the community.

Alcohol

Alcohol misuse is when you drink in a harmful way or when you are dependent on alcohol. Men and women are advised not to drink more than 14 units of alcohol a week on a regular basis. Short term risks of alcohol misuse include accidents and injuries, violent behaviour, unprotected sex, loss of personal possessions and alcohol poisoning. Long term effects increase your risk for heart disease, stroke, liver disease, liver cancer, bowel cancer, mouth cancer, breast cancer and pancreatitis. As well as these serious problems, long-term alcohol

[12] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2020 (accessed May 2022)

misuse can lead to other problems such as unemployment, divorce, domestic abuse, and homelessness[13].

The rate for admission episodes for alcohol-related conditions per 100,000 has risen nationally from 473.2 per 100,000 in 2016/17 to 494.4 in 2018/19. Larger increases have been seen in both Coventry and Warwickshire over that period, with Coventry increasing from 578.9 per 100,000 in 2016/17 to 691.8 in 2018/19, and Warwickshire increasing from 452.1 per 100,000 in 2016/17 to 525.4 in 2018/19.

Substance Misuse

Substance misuse develops when a person continually takes a substance that changes the way that person thinks and feels. This includes drugs, alcohol, and food. The most commonly misused substances are stimulants, opiates, cigarettes, alcohol, and food. Misusing substances can affect both your physical and mental health, and can affect the way you behave, causing problems with relationships, jobs, and daily life[14].

The rate for hospital admissions due to substance misuse in 15-24-year-olds in England for 2018/19 to 2020/21 is 81.2 per 100,000. Coventry has a lower rate at 66.5 per 100,000, and Warwickshire has a similar rate of 83.8 per 100,000.

The number of people living with chronic Hepatitis C virus infection in England has fallen dramatically by 37% since 2015 to 81,000 in 2020, with many of those drawn from marginalised and underserved groups in society such as those who inject drugs. In Coventry and Warwickshire this decrease is largely driven by new treatments worked on by Change Grow Live (CGL) and University Hospital Coventry & Warwickshire (UHCW) to get drug users into treatment and completing their drug regimen. Despite this decrease it is still important to retain focus to control and minimise community transmission.

Healthy Weight

Being overweight or obese can increase the risk of developing a range of health problems such as coronary heart disease (CHD), type 2 diabetes, some cancers, stroke, as well as

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[13] https://www.nhs.uk/conditions/alcohol-misuse/ (accessed May 2022)

[14] https://www.bsmhft.nhs.uk/service-user-and-carer/service-user-information/common-mental-health-conditions/substance-misuse/ (accessed May 2022)

reducing life expectancy. The consequences of obesity can also have adverse social effects through discrimination and social exclusion.

The percentage of adults 18+ who are classified as overweight or obese in England has remained level over time, from 72.7% in 2016/17 to 72.1% in 2019/20. In Coventry it has also remained level, from 64.3% in 2016/17 to 65.4% in 2019/20, however in Warwickshire there has been a rise in levels, from 58.6% in 2016/17 to 63% in 2019/20.

Sexual Health

Teenage pregnancy and early motherhood have been associated with poor education attainment, poor physical and mental health, and deprivation. In England the under 18s conception rate per 1,000 females aged 15-17 is 13. In Coventry this is higher at 19.5, and in Warwickshire it is a similar level at 13.2.

The England rate for New STI diagnoses was increasing from 817 per 100,000 in 2016 to 917 per 100,000 in 2019. It then had a sudden fall in 2020 to 619 per 100,000 (possibly impacted by the pandemic). Warwickshire has seen a decrease from 651 per 100,000 in 2016 to 625 per 100,000 in 2019 before a similar fall to 422 per 100,000 in 2020. Coventry has also seen a decrease from 866 per 100,000 in 2016 to 786 per 100,00 in 2019 before a similar fall to 619 per 100,000 in 2020.

LONG TERM CONDITIONS

There are five long term conditions referenced within this section. How pharmacy supports these conditions is detailed in the Current Provisions and Services chapter. What follows here is an overview of these conditions and the local rates across Coventry and Warwickshire.

Cancer

One in every two people in England will be told they have cancer at some point in their lives. The NHS Long Term Plan[15] aims to help an extra 55,000 people each year to survive for five years or more following their cancer diagnosis by 2028. This will include improving national screening programmes, giving faster access to diagnostic tests, investing in cutting edge treatments and technologies, and making sure more patients can quickly benefit from precise, highly personalised treatments as medical science advances.

[15] https://www.longtermplan.nhs.uk/areas-of-work/cancer/ (accessed May 2022)

The percentage of deaths with underlying cause of cancer in all ages has stayed at a similar level nationally, with the percentage in 2016 being 28% and in 2019 27.9%. In 2020 this saw a decrease to 24.3%, perhaps due to access to health services during the pandemic. Warwickshire has shown a slight increase between 2016 (26.7%) to 2019 (28.1%) before seeing a similar drop in 2020 to 24.3%. Coventry has stayed at a similar level, with 27.1% in 2016 and 27.2% in 2019, before a similar drop in 2020 to 22.5%.

The Cancer in Coventry & Warwickshire report (2016)[16] highlighted that improved access to smoking cessation services particularly among vulnerable groups, the delivery of alcohol brief interventions in primary care and through commissioned services, and consideration of primary care services can improve access to screening programmes, particularly for vulnerable groups.

Cardiovascular Disease (CVD)

Cardiovascular disease (CVD) is an overarching term to describe all diseases affecting the heart and circulatory system, including coronary heart disease (CHD), angina, heart attack, congenital heart disease and stroke.

The England rate for under 75 mortality from all cardiovascular diseases in 2020 was 73.8 per 100,000 population. The Coventry rate was higher at 107.2 per 100,000 whilst the Warwickshire rate was similar to the England rate at 78.5 per 100,000.

CVD risk increases with age and men are more likely to develop CVD at an earlier age. The more CVD risk factors an individual has the higher their risk of developing CVD. There have been significant advancements in treating CVD and understanding the importance of lifestyle in CVD development. However, for a continued reduction in the rate of premature mortality from CVD, there must be a focus on prevention.[17]

Diabetes

Diabetes is one of the UK's biggest health issues and is currently rising. The impact and complications of diabetes can include blindness, amputations, and early death. Diabetes

[16] https://api.warwickshire.gov.uk/documents/WCCC-630-1186 (accessed May 2022)

[17] Narrowing the Gaps in Warwickshire (accessed May 2022)

costs the NHS nearly £10 billion a year, 80% of which is spent trying to manage avoidable complications[18].

Nationally the prevalence of diabetes in people 17+ has been increasing from 6.7% in 2016/17 to 7.1% in 2020/21. That pattern can be seen on a local level, with Warwickshire increasing from 6.4% in 2016/17 to 6.8% in 2020/21 and Coventry increasing from 6.7% in 2016/17 to 7% in 2020/21.

Mental Health

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health, life expectancy and better educational achievement. Coventry and Warwickshire Child and Adolescent Mental Health Services (CAMHS)[19] offers a comprehensive range of services that provide help and treatment to children and young people experiencing emotional or behavioural difficulties. Coventry and Warwickshire Partnership Trust, as well as other organisations across the area, offer a range of support for people aged 16+.

The estimated prevalence of common mental disorders of the population aged 16 and over in England is 16.9%. Coventry is higher than the England rate at 19.1%, whereas Warwickshire is lower at 14.8%.

Respiratory

Respiratory disease affects one in five people in England and is the 3rd biggest cause of death after cancer and cardiovascular disease. Both incidence and mortality rates are highest in more disadvantaged groups and areas of social deprivation, with this gap continuing to grow and leading to worse health outcomes. This in part is due to the most deprived communities having higher smoking rates, exposure to air pollution, poor housing conditions and more exposure to occupational hazards[20].

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[18] https://diabetescw.co.uk/ (accessed May 2022)

[19] https://cwrise.com/ (accessed May 2022)

[20] https://www.england.nhs.uk/ourwork/clinical-policy/respiratory-disease/ (accessed May 2022)

The under 75 mortality rate from respiratory disease in 2020 for England was 29.4 per 100,000 population. Coventry had a higher rate of 41 per 100,000 population, Warwickshire had a lower rate of 24 per 100,000 population.

COVID-19

In December 2019 a case of pneumonia from a new strain of coronavirus termed COVID-19 was detected. By March 2020 this virus had spread to 114 countries, led to 4291 deaths and a pandemic was declared[21].

In order to limit the spread of the virus, the Government implemented a range of infection control measures including isolation of cases and close contacts, closure of schools, as well as requiring restaurants, pubs and a range of other “close contact” businesses to close. There was also a limitation of gatherings of more than two people from separate households, and mandatory wearing of face coverings. The above came into effect in March 2020[22].

Throughout the pandemic these control measures were increased and relaxed over the course of a number of waves, before being gradually lifted. At the time of writing, national policy has shifted to an approach of “living safely with COVID-19”, with ongoing recommendations to: remain at home and avoid contact with others when unwell, wear a face covering in indoor public places and ensure they are well ventilated, and get fully vaccinated against COVID-19[23].

It is important to recognise how Community Pharmacies have supported the public during the COVID-19 pandemic; this includes remaining open and offering a face-to-face service throughout, supporting the testing and vaccination programme and offering advice to people who were not able to make a GP appointment.

COVID-19 has led to an increase in workload as there has been a significant increase in requests for healthcare advice. This has also been compounded by the decrease in workforce with the main cause being sickness from COVID-19 and self-isolation. This combination has led to increased pressure on staff and having to reduce services provided and at times

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[21] https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov (accessed May 2022)

[22] https://www.instituteforgovernment.org.uk/sites/default/files/publications/lifting-lockdown-how-approach-coronavirus-exit-strategy_1.pdf (accessed May 2022)

[23] https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19/covid-19-response-living-with-covid-19#living-with-covid-19 (accessed May 2022)

opening hours. The above has caused a negative impact on pharmacy team members' wellbeing[24]. This is important to bear in mind when the public depend so heavily on community pharmacies.

Vaccinations

The UK was the first country in the world to authorise the use of Pfizer and Oxford / AstraZeneca COVID-19 vaccines. The first ever COVID-19 vaccination outside clinical trials was administered at University Hospital of Coventry and Warwickshire on 8th December 2020[25].

From our survey only 15 of our 161 pharmacies that responded offer the COVID-19 vaccination. However, if commissioned an additional 104 pharmacies would provide this service. At the height of the pandemic, 24 pharmacies were delivering vaccinations.

Currently the vaccination scheme is expanding to include those aged 5-11 years old.

Figure 20 shows the count of the population ages 16+ who have not had any doses of a COVID vaccine, from GP registration data linked to NIMS, last updated 17th June 2022. The darker the area, the more people have not had any doses of a COVID vaccine, with the red areas being the highest 10% of areas.

[24] https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf (accessed May 2022)

[25] https://www.gov.uk/government/news/uk-marks-one-year-since-deploying-worlds-first-covid-19-vaccine (accessed May 2022)

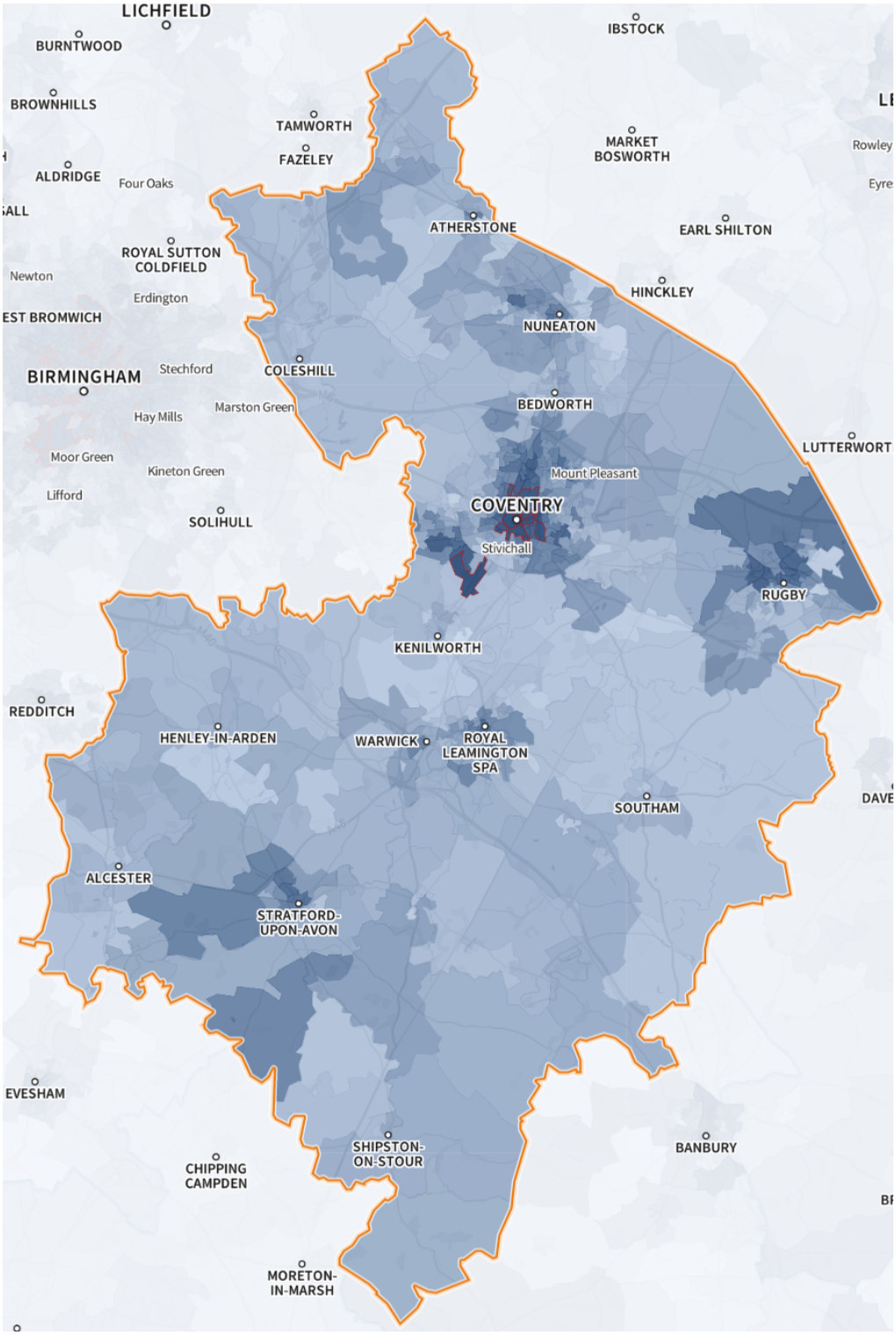

Figure 20: Count of population 16+ who have not received any doses of a COVID-19 vaccine
Source: SHAPE

Testing

In order to keep this virus under surveillance the Government supported testing and tracing. Lateral flow test kits were supplied to the public, some through pharmacies. For the majority

of the pandemic positive lateral flow tests were confirmed with a polymerase chain reaction test and social isolation ensued. Positive results would be reported to the NHS Test and Trace service, which also aided in contact tracing and providing isolation advice[26]. At the time of writing the distribution of free Lateral Flow Test kits from pharmacies has ended as the Governments leans away from mass COVID-19 testing, although some pharmacies offer to purchase.

Long COVID

The persistence of symptoms of COVID-19 for greater than four weeks after infection is referred to as long COVID, or post- COVID-19- syndrome[27]. A few of the most common symptoms include fatigue, shortness of breath, loss of smell and loss of taste. An estimated 1.3 million people living in private households in the UK (2.1% of the population) were experiencing self-reported long COVID as of 2 January 2022. Of these people, 63% report that the symptoms have impacted their day-to-day activities in a negative manner[28]. A recent review by UKHSA demonstrated that those who are vaccinated are less likely to report symptoms of long COVID than those who remain unvaccinated[29]. Specialist services that support those with long COVID continue to be a focus for the NHS.

For pharmacies, COVID-19 has led to an increase in workload as there has been a significant increase in requests for healthcare advice. This has also been compounded by the decrease in workforce with the main cause being sickness from COVID-19 and self-isolation. This combination has led to increased pressure on staff and having to reduce services provided and at times opening hours. The above has caused a negative impact on pharmacy team members wellbeing[30]. This is important to bear in mind when the public depend so heavily on community pharmacies.

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[26] https://www.gov.uk/guidance/nhs-test-and-trace-how-it-works#how-nhs-test-and-trace-helps-fight-the-virus (accessed May 2022)

[27] https://www.nhs.uk/conditions/coronavirus-covid-19/long-term-effects-of-coronavirus-long-covid/ (accessed May 2022)

[28] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/3february2022 (accessed May 2022)

[29] https://ukhsa.koha-ptfs.co.uk/cgi-bin/koha/opac-retrieve-file.pl?id=fe4f10cd3cd509fe045ad4f72ae0dfff (accessed May 2022)

[30] https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf (accessed May 2022)

It is important to note that people who have an underlying health condition are more at risk of developing long COVID. This may highlight the need for early intervention and prevention with health conditions through screening, health promotion and lifestyle campaigns.

Mental Health in COVID-19

COVID-19 has impacted mental health alongside physical health. A survey carried out by the mental health charity Mind during the months of March and May 2021 found that nearly half (46%) of adults say their mental health has got much worse since the beginning of the first national lockdown. Approximately one in six (16%) adults had accessed mental health services for the first time during the pandemic. Contributing factors to worsening of mental health include lack of personal contact with loved ones, loneliness and financial worries. Nearly half (48%) of those receiving benefits mentioned that their financial situation had worsened their mental health[31]. There is likely to be an ongoing mental health need after the pandemic as seen with previous coronavirus outbreaks (SARS &MERS) where there was a considerable prevalence of post-traumatic stress disorder, depression, and anxiety beyond 6 months[32].

Increasing mental health concerns may increase pressure on pharmacies with patients accessing health and wellbeing and lifestyle opportunities, with pharmacies supporting and signposting into other relevant services.

Health inequalities and COVID-19

Health inequalities are due to unequal distribution of social determinants of health such as housing and employment that reduces the ability to prevent illness or access appropriate treatment if it were to occur[33]. They are avoidable, unfair and systematic differences in health between different groups of people[34]. Health inequalities have been a focus for the government and the impact of COVID-19 on certain members of society has further demonstrated that they are important to address.

The increased mortality rate in Asian and Black ethnic groups compared to the previous years where it was higher in White ethnic groups conveys the effect of COVID-19. When accounting for the effect of sex, age, deprivation, and region, people of Bangladeshi ethnicity had

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[31] the-consequences-of-coronavirus-for-mental-health-final-report.pdf (mind.org.uk) (accessed May 2022)

[32] https://api.warwickshire.gov.uk/documents/WCCC-1350011118-2953 (accessed May 2022)

[33] A perfect storm - health inequalities and the impact of COVID-19 | Local Government Association (accessed May 2022)

[34] What are health inequalities? | The King's Fund (kingsfund.org.uk) (accessed May 2022)

approximately twice the risk of death than people of White British ethnicity. It is important to note that co-morbidities and occupation were not considered in this analysis[35]. The Black, Asian and minority ethnic account for 26.2% and 7.3% of the Coventry and Warwickshire population respectively from 2011 Census data.

People who live in more deprived areas have a higher diagnosis rate of COVID-19. The rate of death in the most deprived decile was 2.2 times the rate in the least deprived decile. This is greater than the baseline all-cause mortality rate difference between the most the deprived and least deprived from 2014-2018, demonstrating the impact of COVID-19.

Work was undertaken across Coventry and Warwickshire to ensure pharmacy provision of COVID-19 vaccinations matched need, specifically areas of low uptake/areas of deprivation.

[35] Disparities in the risk and outcomes of COVID-19 (publishing.service.gov.uk) (accessed May 2022)

PHARMACY PROVISIONS AND ACCESS

In order to assess the provision of pharmaceutical services within Coventry and Warwickshire current provision from all providers has been considered. This includes providers and premises within Coventry and Warwickshire, as well as the contribution made by those providers who may lie in neighbouring Health and Wellbeing Board areas but provide services to the Coventry and Warwickshire population.

COMMUNITY PHARMACY CONTRACTUAL FRAMEWORK

The NHS Community Pharmacy Contractual Framework[36] requires community pharmacies to contribute to the health needs of the population they serve. All NHS pharmaceutical service providers must comply with the contractual framework that was introduced in 2005. The contractual framework is formed of the following components:

- Essential Services – these must be provided by all contractors nationwide.
- Advanced Services – services that can be provided by contractors subject to accreditation requirements.
- Locally Commissioned and Enhanced Services – services commissioned either by the NHS (enhanced services) or Local Authorities (locally commissioned services) in response to the needs of the local population.

PHARMACEUTICAL LISTS

If a person (a pharmacist, appliance contractor, 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.

Under the NHS regulations, a person wishing to provide NHS pharmaceutical services must apply to the NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as

[36] http://archive.psnc.org.uk/pages/introduction.html (accessed May 2022)

applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis.

The following are included in a pharmaceutical list. They are:

Pharmacy contractors – community pharmacies and distance selling pharmacies (DSPs). DSPs must adhere to all regulations concerning all other pharmacies, however a distance selling pharmacy must not provide Essential services onsite to a person who is present at the pharmacy, but the pharmacy must be able to provide Essential services safely and effectively without face-to-face contact. Currently there are 7 distance selling pharmacies in Coventry, 2 in Nuneaton and Bedworth Borough, 2 in Stratford-on-Avon District and 1 in Rugby Borough.

Dispensing appliance contractors (DACs) – DACs are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages, etc. However, they do not dispense any medicines. There is 1 DAC in Coventry and 0 in Warwickshire.

Dispensing doctors (DD) – GP practices are allowed to dispense medicines and appliances to patients who live in an NHS England determined controlled locality (Rural Area) and live more than one mile from a community pharmacy. There are 23 dispensing GP practices within Coventry and Warwickshire, 11 in Stratford-on-Avon District, 5 in North Warwickshire Borough, 3 in Warwick District, 2 in Rugby Borough, 1 in Nuneaton and Bedworth Borough, and 1 in Coventry.

ACCESS TO PHARMACIES IN COVENTRY AND WARWICKSHIRE

Coventry and Warwickshire have 197 community pharmacies; 91 pharmacies in Coventry, 7 of which are distance selling pharmacies, and 106 pharmacies in Warwickshire, 5 of which are distance selling pharmacies.

Geographical Location

Figure 21 shows the location of pharmacies within Coventry and Warwickshire, and figures 22 - 27 show that at the locality level. Pharmacies are not evenly distributed throughout the localities, with great concentrations of pharmacies in central areas of each locality/borough, particularly in Coventry, Nuneaton and Bedworth, Rugby, and Warwick. These central area Lower Super Output Areas (LSOAs) are the most densely populated areas in the localities, and have the greatest deprivation as described in the Local Picture chapter.

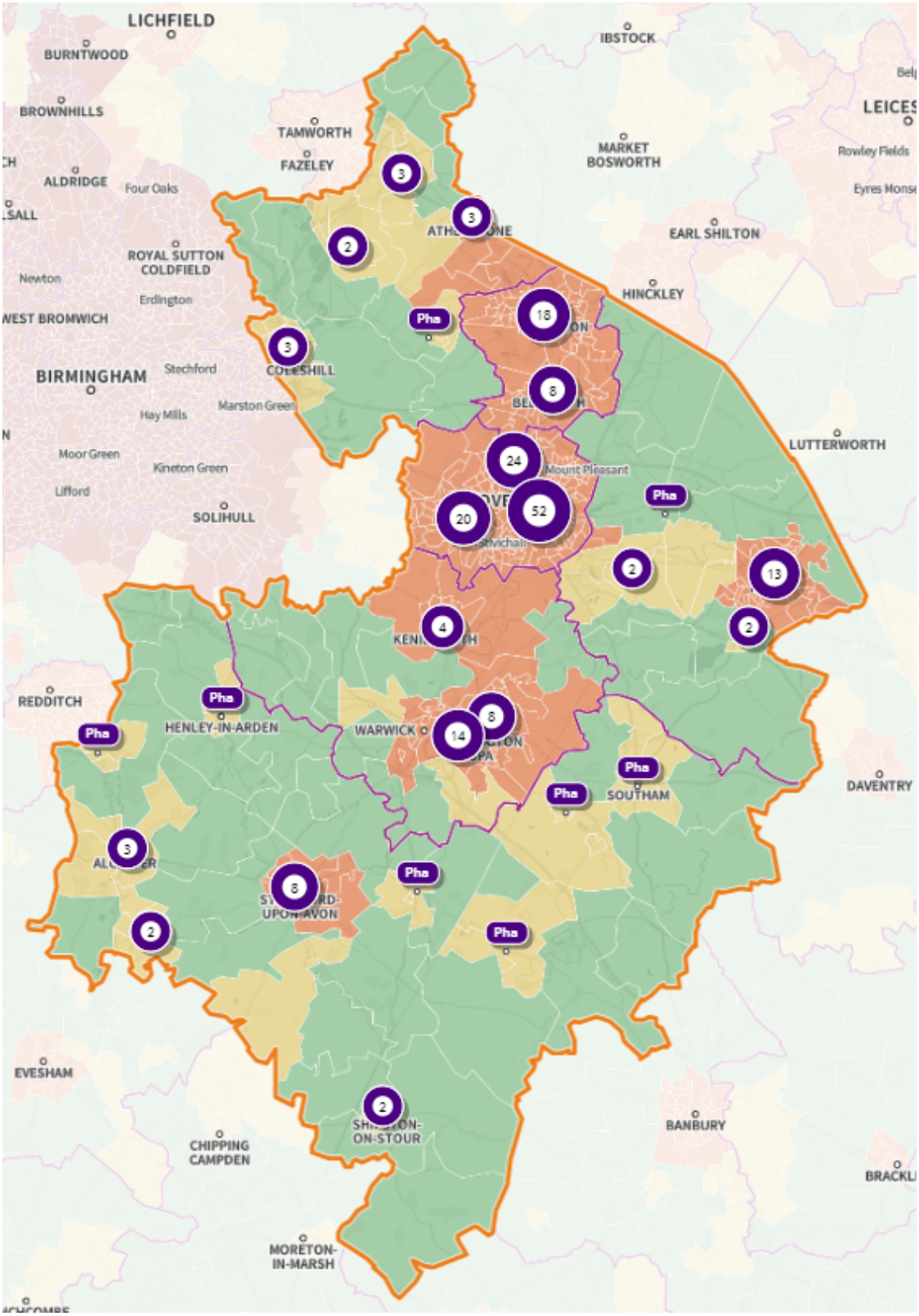


Figure 21: Location of pharmacies in Coventry and Warwickshire
Source: SHAPE

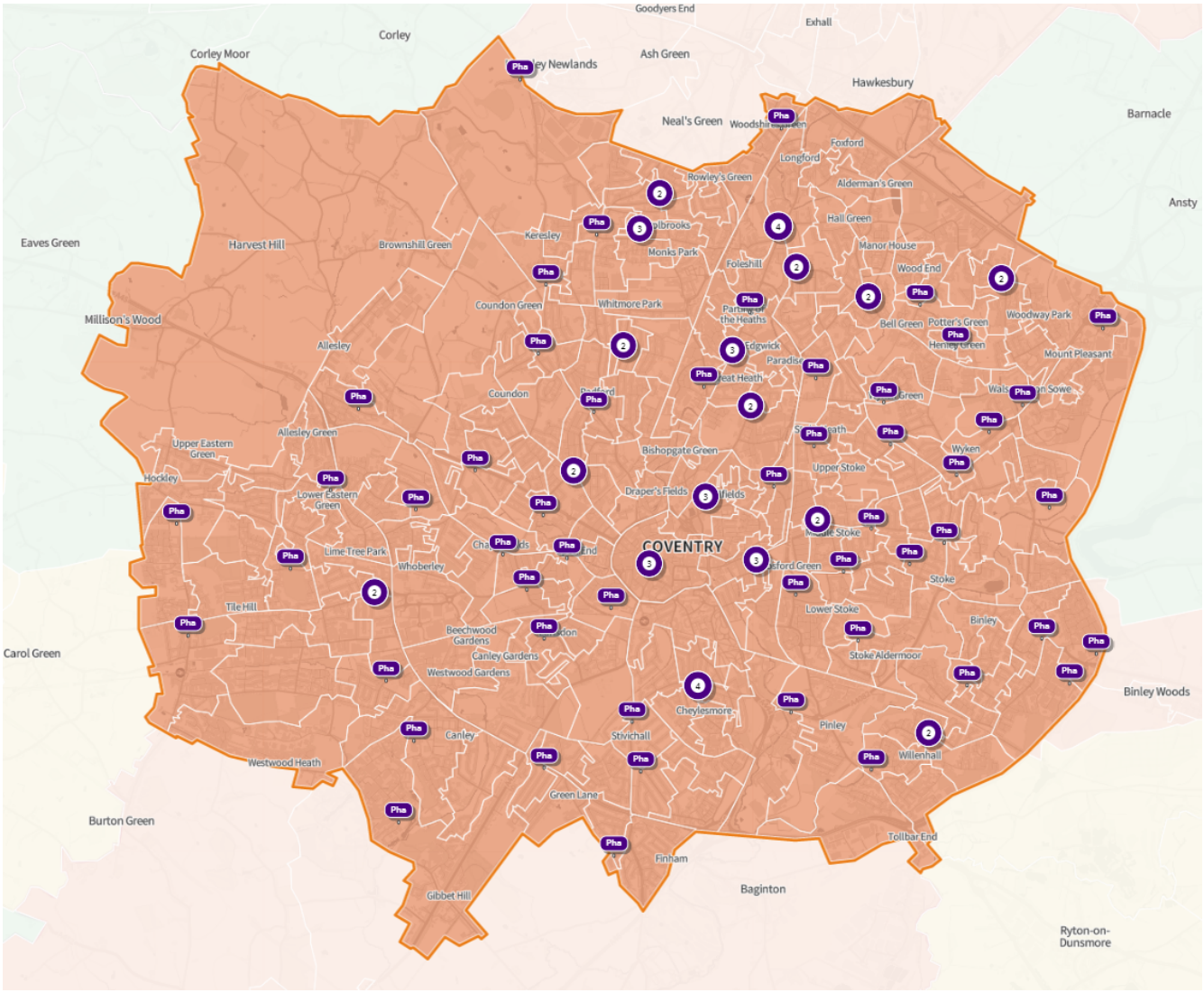


Figure 22: Location of pharmacies in Coventry
Source: SHAPE

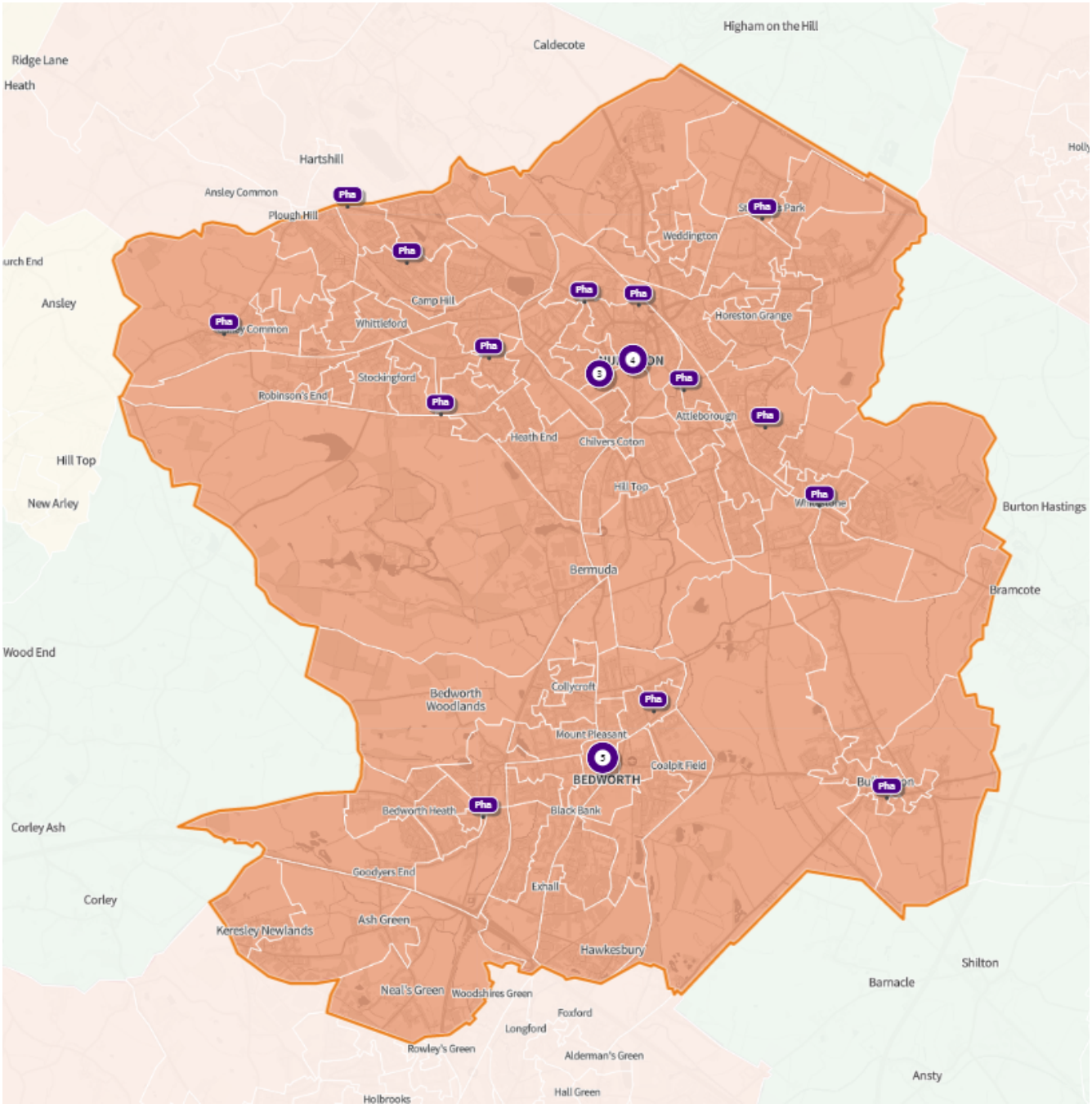


Figure 23: Location of pharmacies in Nuneaton and Bedworth Borough
Source: SHAPE

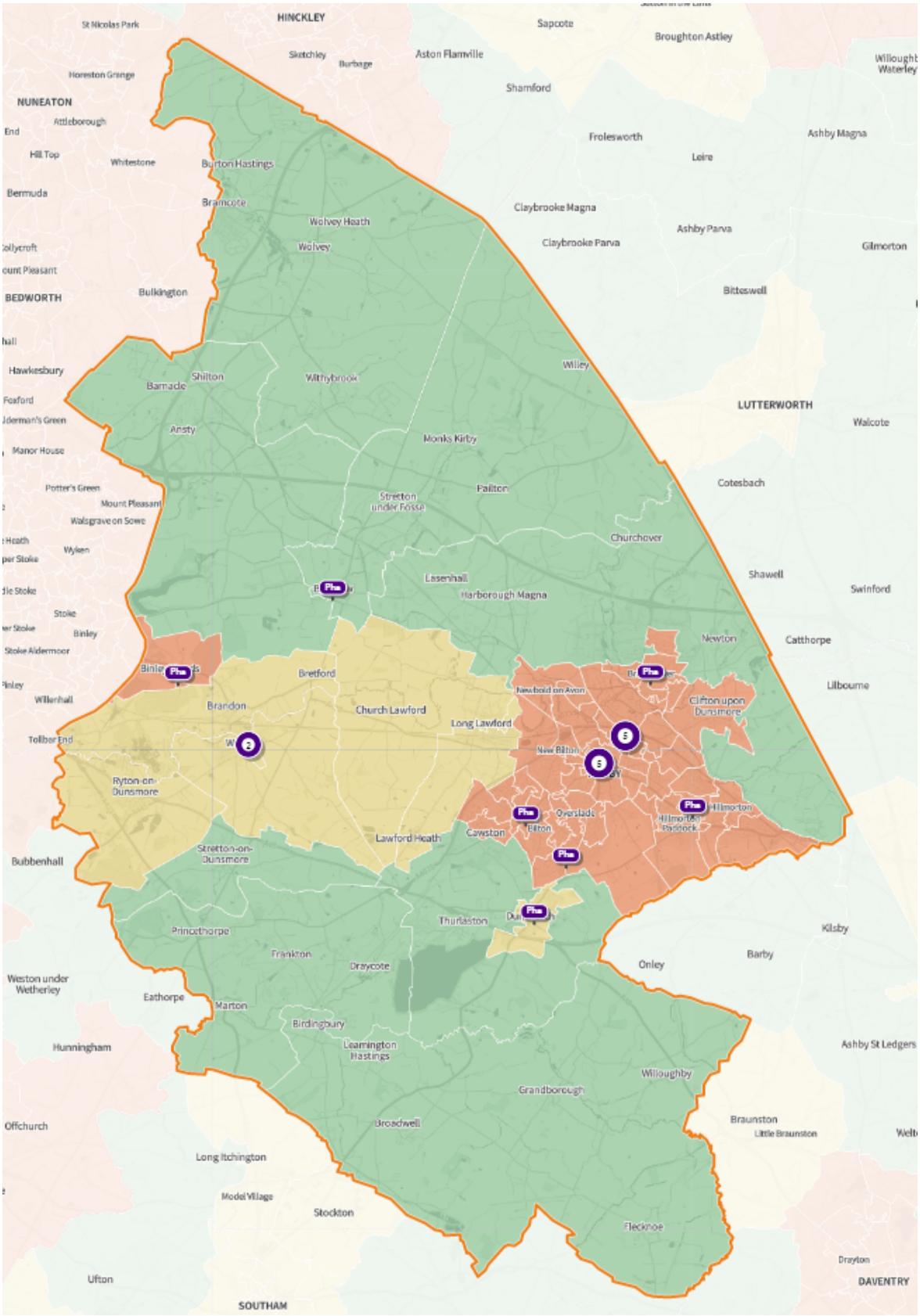


Figure 24: Location of pharmacies in Rugby Borough
Source: SHAPE

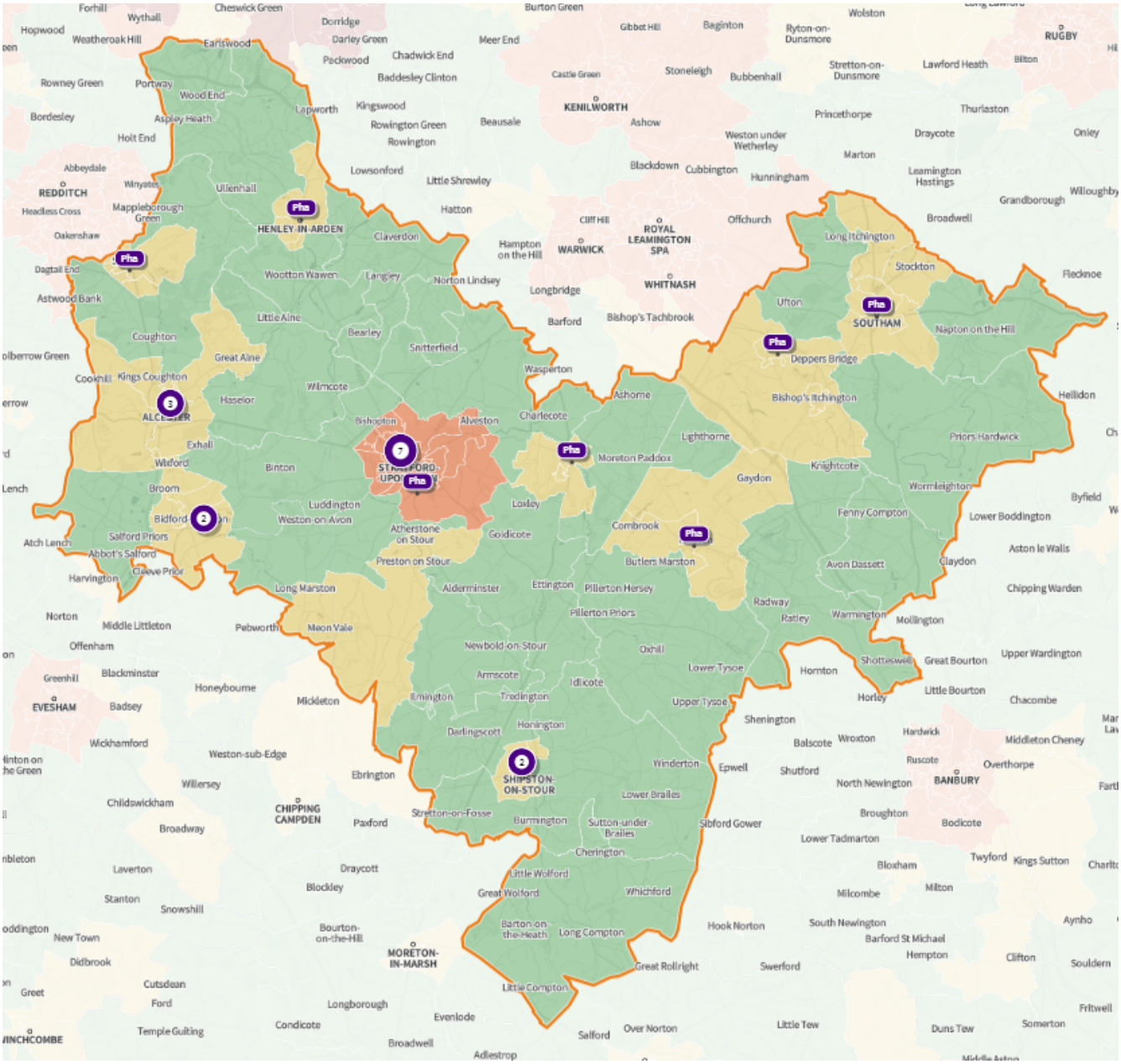


Figure 25: Location of pharmacies in Stratford-on-Avon District
Source: SHAPE

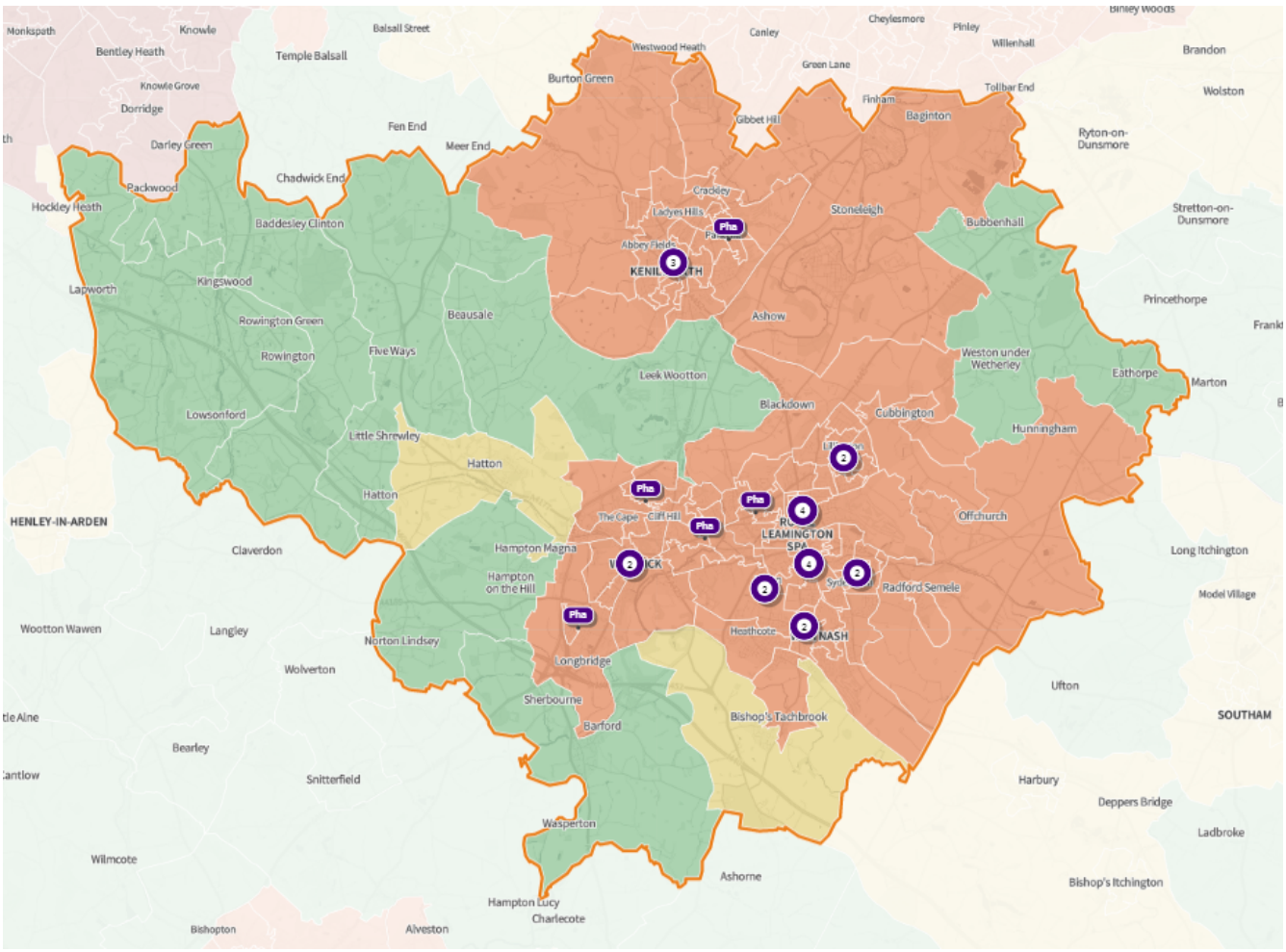


Figure 26: Location of pharmacies in Warwick District
Source: SHAPE

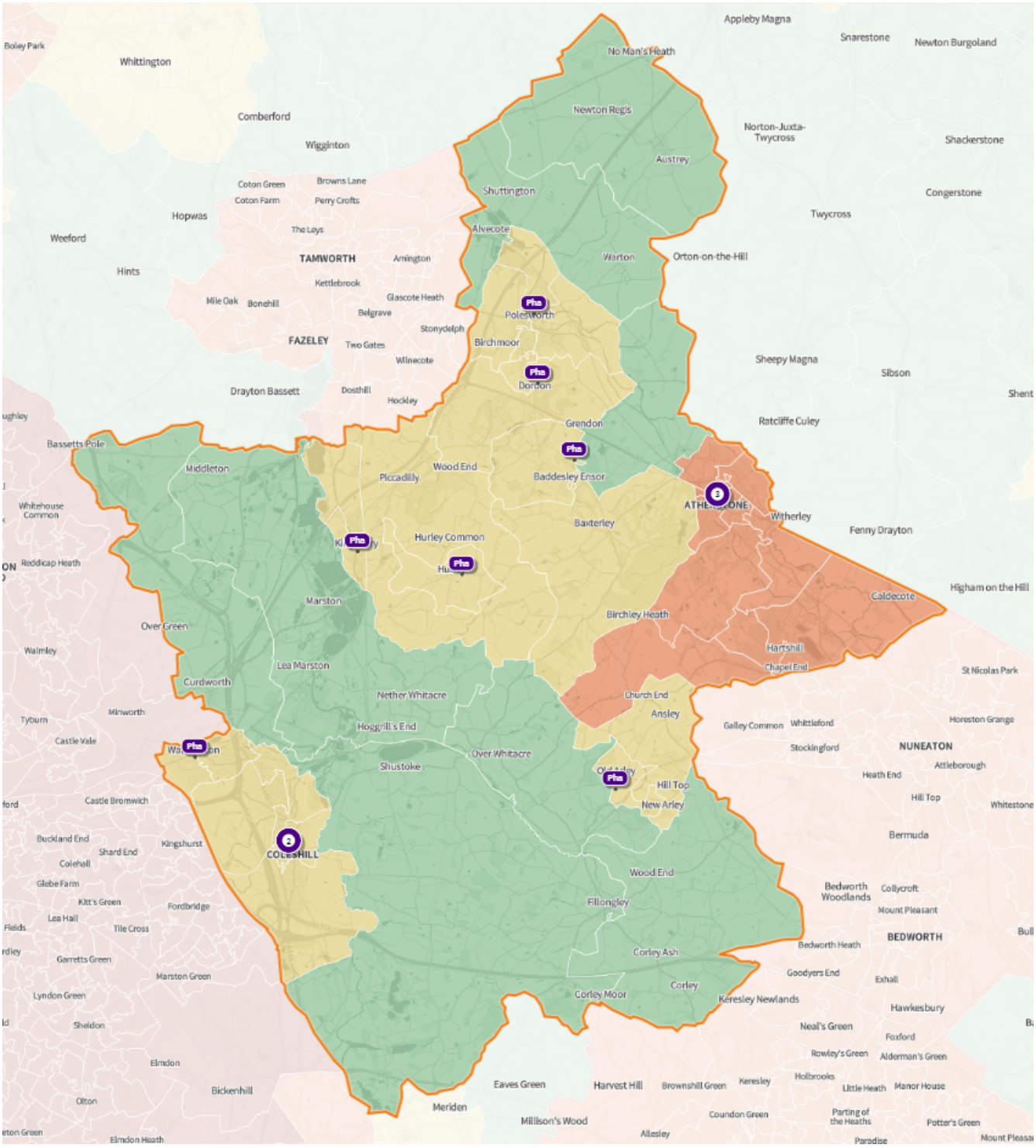


Figure 27: Location of pharmacies in North Warwickshire Borough
Source: SHAPE

Figure 28 shows access to pharmacies in relation to a 5- and 15-minute drive. The dark green areas are within a 5-minute drive to a pharmacy, and the light green are within a 15-minute drive to a pharmacy. Almost all of Warwickshire is within a 15-minute drive to a pharmacy, the exceptions being in South and Southeast of Stratford-on-Avon District, which are rural areas. The majority of Coventry is within a 5-minute drive to a pharmacy and all of Coventry is within a 15- minute drive.

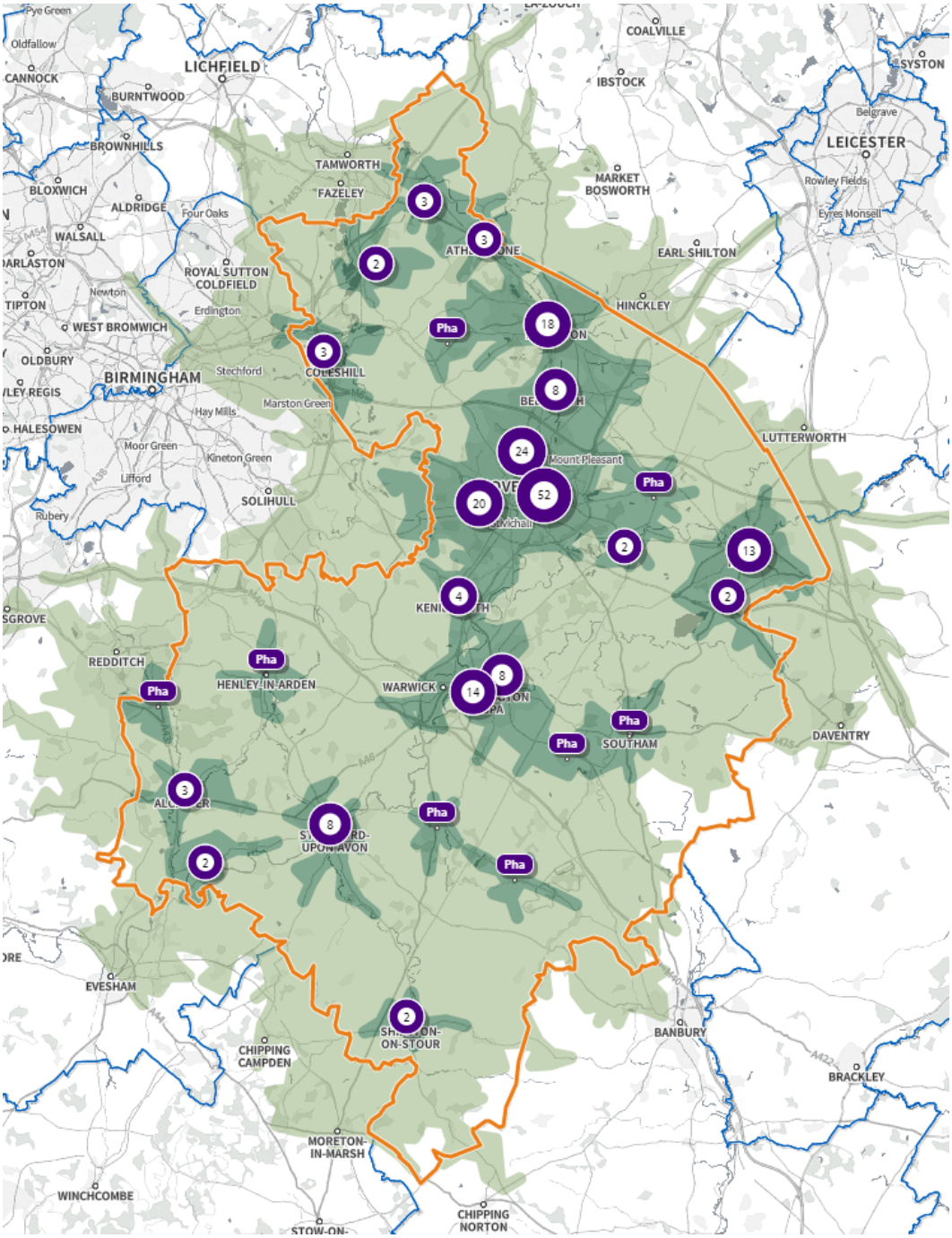


Figure 28: Location of pharmacies in relation to a 5 or 15 minute drive
Source: SHAPE

Figure 29 shows the access to pharmacies via public transport and the top 20% of IMD areas. The green areas represent a 15-minute journey via public transport to a pharmacy whilst the yellow represent a 30-minute journey. The red areas are the top 20% IMD areas. All of the lowest 20% IMD areas are within a 30-minute journey via public transport to a pharmacy. Those areas not within a 30-minute journey are predominately rural or uninhabited areas.

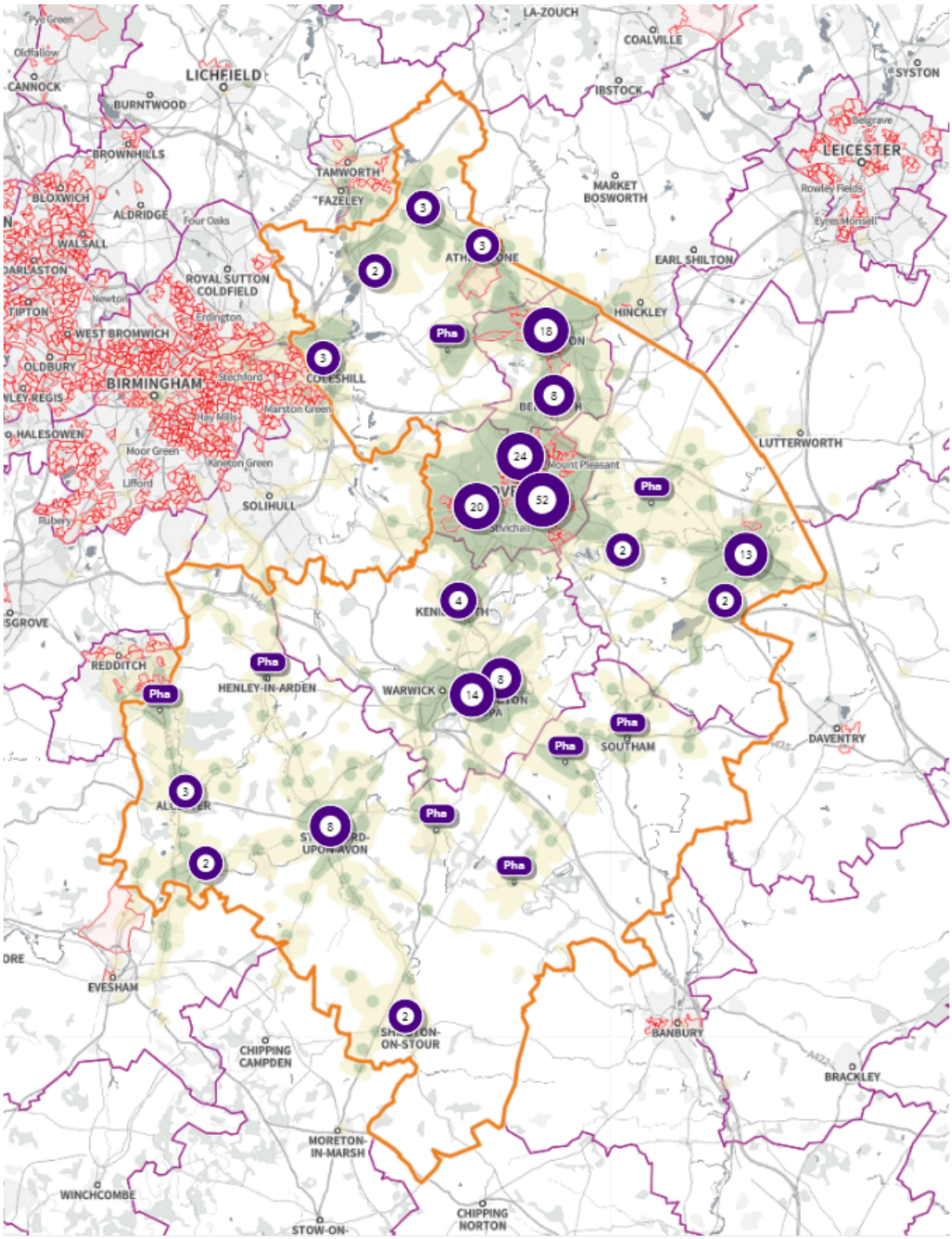


Figure 29: Location of pharmacies by public transport: 15 and 30 minutes
Source: SHAPE

Within Warwickshire there are 2 demand responsive services that provide a transport service for residents who cannot access public transport either due to mobility issues or live in an area with limited or no public transport. These services are:

- UBUS – operating in Stratford-on-Avon - https://www.stratford.gov.uk/people-communities/ubus--community-transport.cfm
- IndieGo – operating in Atherstone, Coleshill, Rugby, Hatton, and West Warwick - https://www.warwickshire.gov.uk/public-transport/indiego

From the 1,601 responses to the public survey, 46.5% of respondents said they would normally travel by car/motorbike/van to a pharmacy, and a further 42% said they would normally walk. Only 1.8% said they would use public transport. When asked about how long their travel usually takes, 74% said that it takes less than 15 minutes and 19% said it takes between 15 and 30 minutes. Only 1% of respondents said it takes more than 30 minutes to travel to their pharmacy.

Cycling Access

Figure 30 shows cycling time in relation to pharmacies. The light green indicates a 16-minute journey time, and the dark green indicates an 8-minute journey time. The red areas on the map indicate the top 20% most deprived areas according to IMD. All the top 20% most deprived areas in Coventry and Warwickshire are covered within a 16-minute cycle time apart from a small area near Atherstone.

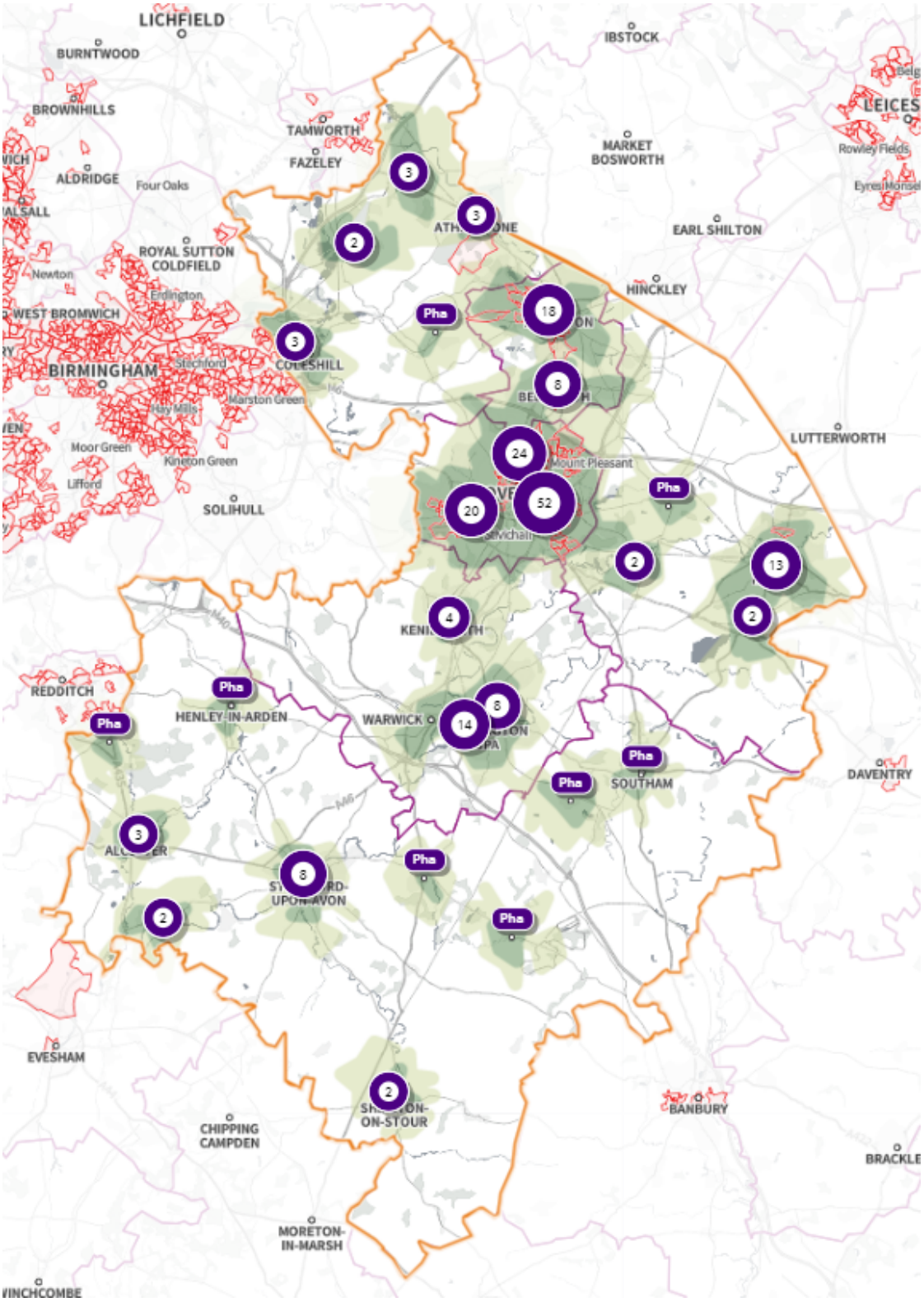


Figure 30: Location of pharmacies by 8 or 16 minute cycle
Source: SHAPE

Physical Access

The 2018 Coventry City Council PNA identified that out of the 72 responses received from the 2018 pharmacy survey, 96% of pharmacies allow parking within 50 metres of the pharmacy, and 82% within 10 metres of the pharmacy. There is a bus stop within walking distance of 99% of pharmacies. From the same survey it was analysed the 86% of pharmacies do not have any steps to climb to enter the premises, and 89% of respondents said that all areas of the pharmacy floor were accessible by wheelchair.

The 2018 Warwickshire County Council PNA identified that out of the 88 responses received from the 2018 pharmacy survey, 95.5% of pharmacies allow parking within 50 metres of the pharmacy and 88.6% within 10 metres of the pharmacy. There is a bus stop within walking distance of 98.9% of respondent's pharmacies. From the same survey it was analysed that 77.3% of pharmacies do not have any steps to climb to enter the premises, and 95.5% of respondents said that all areas of the pharmacy floor were accessible by wheelchair.

Open text comments in the public survey for this PNA noted difficulties with access to pharmacies car parking issues especially for older people or those with disabilities, physical access to the shop, and access for hidden disabilities.

Opening Time Analysis

Pharmacies are required to open between specific times by their terms of service. Most pharmacies are required to open for 40 hours per week, and these are referred to as core opening hours, but pharmacies may choose to open for longer, and these hours are referred to as supplementary opening hours. A pharmacy's opening hours are decided at the beginning of their contract, and it is most common for the vast majority to operate within or near regular working office hours, between 8am and 7pm, Monday to Friday.

Pharmacies wishing to amend any supplementary hours that they open additional to the core contractual hours must notify NHS England, giving at least three months' notice of the intended change. NHS England may consent to a shorter period of notice, but as that consent may not be forthcoming, they should try to ensure that plans are made sufficiently in advance. The discretion to permit less than three months' notice for changes to supplementary hours is most likely to be exercised where the pharmacy is seeking to align more closely, the pharmacy opening hours with the pharmaceutical needs in the neighbourhood for example, if a local surgery extends its hours. In this case, if the pharmacy intends to modify its supplementary hours to match the new hours of the surgery, NHS England may be keen to ensure this happens with minimal delay.

There is no requirement for NHS England to grant applications for changes to supplementary hours, the pharmacy has the right to amend hours, so long as three months' notice is given.

Since the introduction of the pharmaceutical contractual framework in 2005 community pharmacies do not need to participate in rota provision to provide access for weekends or during the evening.

In the public survey, when asked the question "are you able to access a pharmacy at times that are convenient to you?" 39% responded "Yes always", 47% responded "most of the time", 11% responded sometimes and 2% responded "never".

The most convenient time to visit a pharmacy as indicated in the public survey was between 9am and 1pm on Saturday (75%), followed by between 9am and 1pm on a Monday to Friday (61%), and between 1pm and 6pm on a Monday to Friday (48%). 28% said after 6pm Monday to Friday, with between 2%-4% indicating either before 9am or after 6pm on a Saturday or Sunday. 25-54-year-olds are less likely to agree that opening hours are always convenient for them whilst 75+ are more likely to say that opening hours are always convenient for them.

100 Hour Contracts and Extended Opening Hours Pharmacies

100-hour pharmacies are required in their contracts to be open and able to provide essential services for at least 100 core hours per week. In 2018 following a government review, pharmacies could no longer apply to have 100-hour contracts.

There are currently 16 100-hour pharmacies in Coventry and Warwickshire. These pharmacies are:

Coventry:

- A&M Pharmacies Ltd, CV4 9AE
- Asda Stores Ltd, CV3 4AR
- Boots UK Ltd, CV3 2SB
- Foleshill Healthcare Ltd, CV6 5JR
- Hyiris Ltd, CV6 6DX
- Tesco Stores Ltd, CV2 2SH
- Wellbeing (United Kingdom) Limited, CV4 9DR

Rugby Borough:

- Asda Stores Ltd, CV21 3EB
- Lloyds Pharmacy Ltd, CV22 6HU

- Tesco Stores Ltd, CV21 1RG

North Warwickshire Borough:

- Atherstone Pharma Ltd, CV9 1EU
- No.8 Group (Midlands) Limited, CV9 1BB

Nuneaton and Bedworth Borough:

- No 8 Pharmacy Ltd, CV12 8NF
- Pharmacyrepublic Limited, CV11 5NU

Stratford-on-Avon District:

- Avon Healthcare Ltd, CV37 6HJ

Warwick District:

- Asda Stores Ltd, CV31 1YD

These 100-hour pharmacies provide Coventry and Warwickshire with good access to pharmaceutical services on Saturdays, Sundays, and evening until late. They guarantee access to pharmaceutical services for 14/15 hours a day except on Sundays due to the Sunday Trading Act 1994.

Saturday Opening Hours

As of 1st June 2022, 137 out of the 197 community pharmacies in Coventry and Warwickshire are open on a Saturday (69.5%). 51 of these pharmacies are in Coventry, 23 in Nuneaton and Bedworth Borough, 21 in Warwick District, 18 in Stratford-on-Avon District, 15 in Rugby Borough, and 9 in North Warwickshire Borough. Of those pharmacies open on a Saturday, 64 of them are closed by 1pm. After 1pm the other 73 remain open with gradual closure over the remainder of the day.

Figure 31 shows the location of these pharmacies:

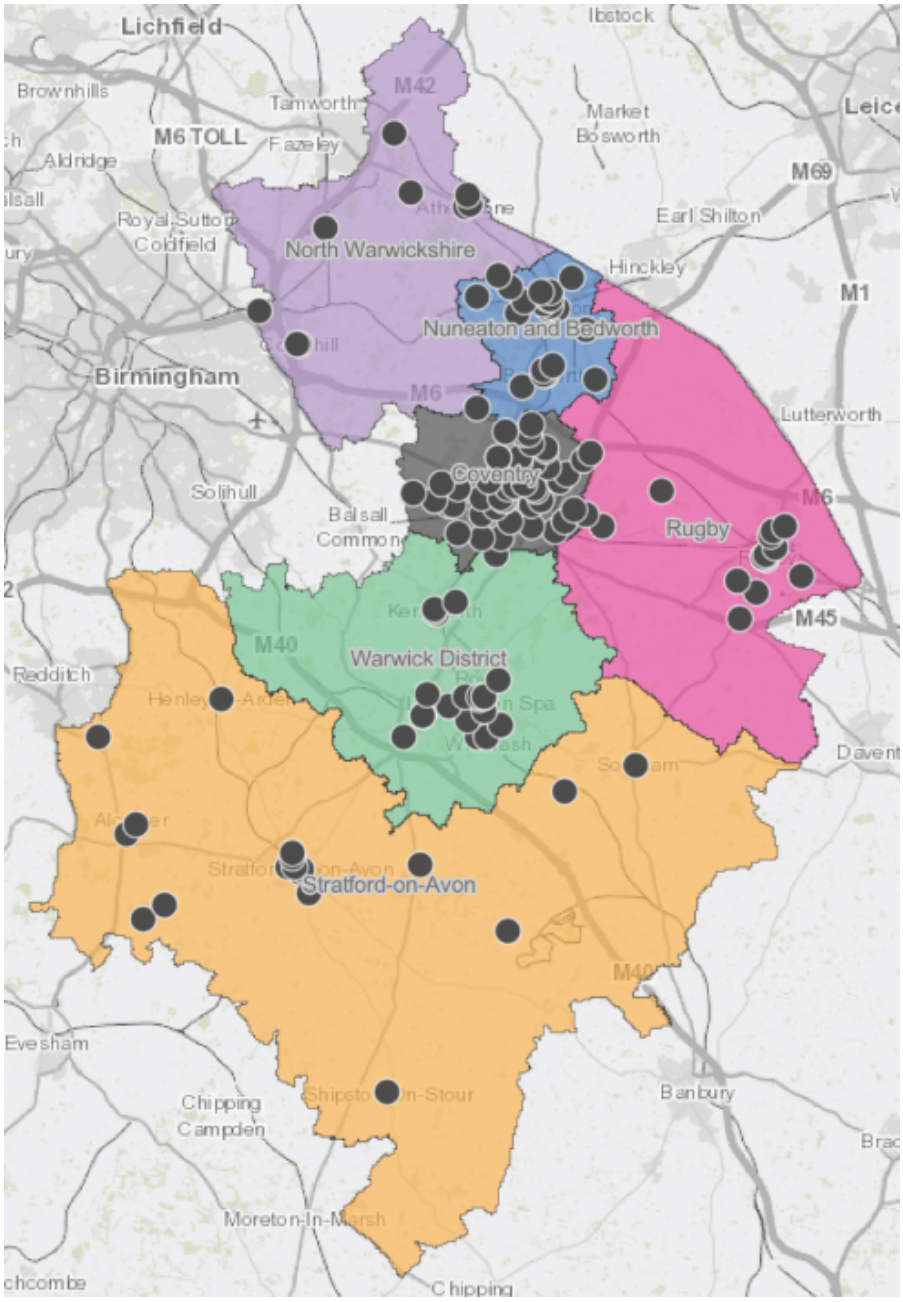


Figure 31: Location of pharmacies open on a Saturday
Source: LPS

Open text comments in the public survey noted difficulties with opening times for pharmacies including lack of weekend or ‘out-of-hours’ services locally and routine lunchtime/weekday closure for some respondents.

The survey reflected that the most popular time to visit a pharmacy was between 9am – 1pm on a Saturday (75%). `

Sunday Opening Hours

There are 14 community pharmacies in Coventry, 6 in Warwick District, 5 in Stratford-on-Avon District, 5 in Nuneaton and Bedworth Borough, 4 in Rugby Borough, and 2 in North Warwickshire Borough that are open on a Sunday, most open for 6 hours to comply with Sunday trading regulations.

Bank Holiday Provision

Some pharmacies choose to open on some bank holidays even though they are not required to do so. NHS England currently commissions rota services for main bank holidays as needed, usually for 3 hours per session. This enables patients to access pharmaceutical services on traditional bank holidays such as Christmas Day, Boxing Day, New Year's Day, and Easter Sunday. The Bank Holiday rota is available on NHS Choices and is accessible to view by the public.

Pharmacy Premises Facilities and Consultation Areas

The provision of Advanced Services is linked to the provision of consultation areas within pharmacies. In addition, The Disability Discrimination Act 1995, replaced by the Equality Act 2010, sets out a framework that requires providers of good and services not to discriminate against persons with a disability. It is expected that the pharmacy would make reasonable adjustments, if this is what is needed in order to allow the person to access the service.

The presence of consultation areas in many pharmacies presents an opportunity to commission pharmacies in new and potentially exciting ways to deliver new services. In some respects, this is already happening through commissioning enhanced and other locally commissioned services.

From the pharmacy survey, 99% of pharmacies in both Coventry and Warwickshire said they had consultation rooms, with the remaining being distance selling pharmacies. 91% in Coventry and 88% in Warwickshire said they have hand washing facilities, and 37% in Coventry and 34% in Warwickshire said they have toilet facilities.

Pressures on Pharmacies

Community pharmacies, as the most accessible healthcare locations in England, have played a crucial role during the COVID-19 pandemic, staying open throughout, and providing face-to-face healthcare services and information/advice to the public. This has bought with it an

increasing pressure, and as we continue life without COVID-19 related restrictions it is important these pressures are recognised, and work is done to adapt.

Responses to the public survey praised the response of community pharmacies during the Covid-19 pandemic:

"They were the only people you could see face-to-face during Covid"

"Their systems during the covid crisis made me feel safe when accessing their services."

However, responses also indicated that some measures impacted on people's ability to access the service:

"The shop is rather small, this was a problem during the pandemic"

"Because of social distancing they stayed well away from me, so I couldn't hear properly"

The PSNC Pharmacy Advice Audit 2021[37] showed that 114,898 patient consultations were recorded by 5,830 community pharmacies. This indicates that 17 consultations are done per day per pharmacy, or more than 100 per week. This would give 1.1 million informal consultations in community pharmacies in England each week, 58 million per year.

Almost half of patients recorded in these consultations reported that if they were not able to attend their local pharmacy, they would have visited their GP instead. This means that these consultations save more than 2 million GP appointments every month, or 24 million every year, equating to 74 appointments for each GP practice each week across the country. 70,000 people would have gone to an A&E or NHS walk-in centre each week if they couldn't have accessed their local pharmacy, equating to 3.3 million people per year.

The "PSNC Briefing 013/12: Summary of the results of PSNC's 2022 Pharmacy Pressures Survey"[38] identified several ways in which pharmacies are feeling pressure nationally. In the survey it was found that 92% of pharmacy business owners/head office representatives said that patient services were being negatively affected by the pressures on their business. Figure 32 shows a breakdown of the impacts of business pressure on patients

[37] https://psnc.org.uk/wp-content/uploads/2021/05/PSNC-Pharmacy-Advice-Audit-2021-A-summary-of-findings.pdf (accessed May 2022)

[38] https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf (accessed May 2022)

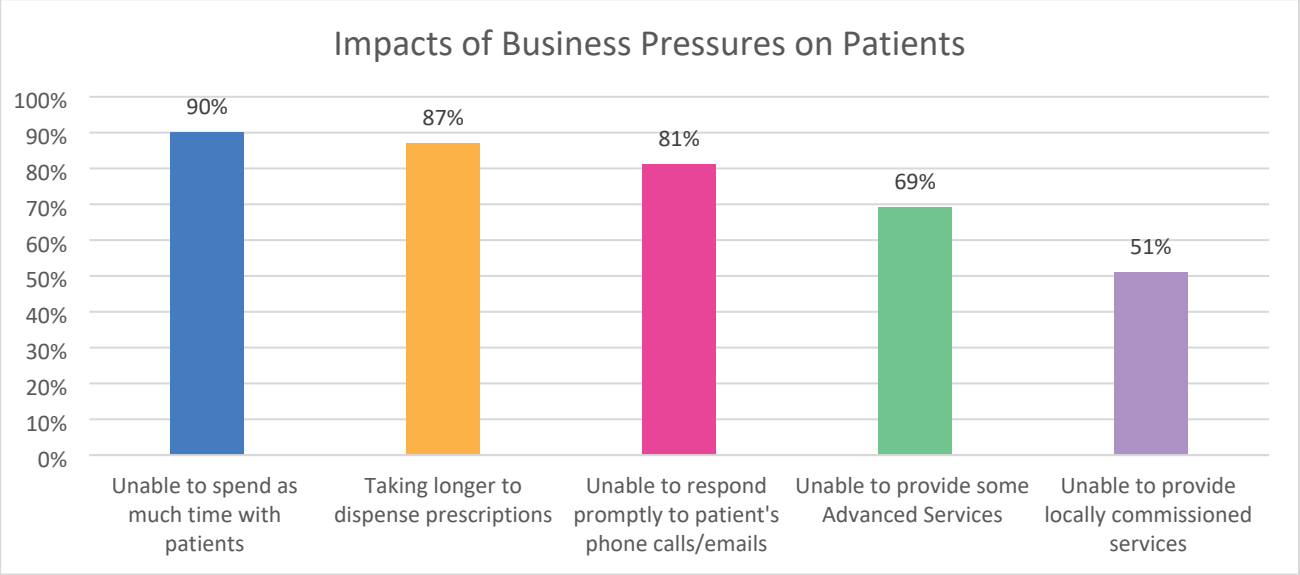


Figure 32: Impacts of Business Pressures on Patients
Source: https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf

Responses from pharmacy team members to the survey indicated that 67% of pharmacies are having to deal with medicine supply issues every day, 21% multiple times per week, and 9% weekly. No team members responded saying they never had an issue. The impact of medicine supply issues is shown in Figure 33:

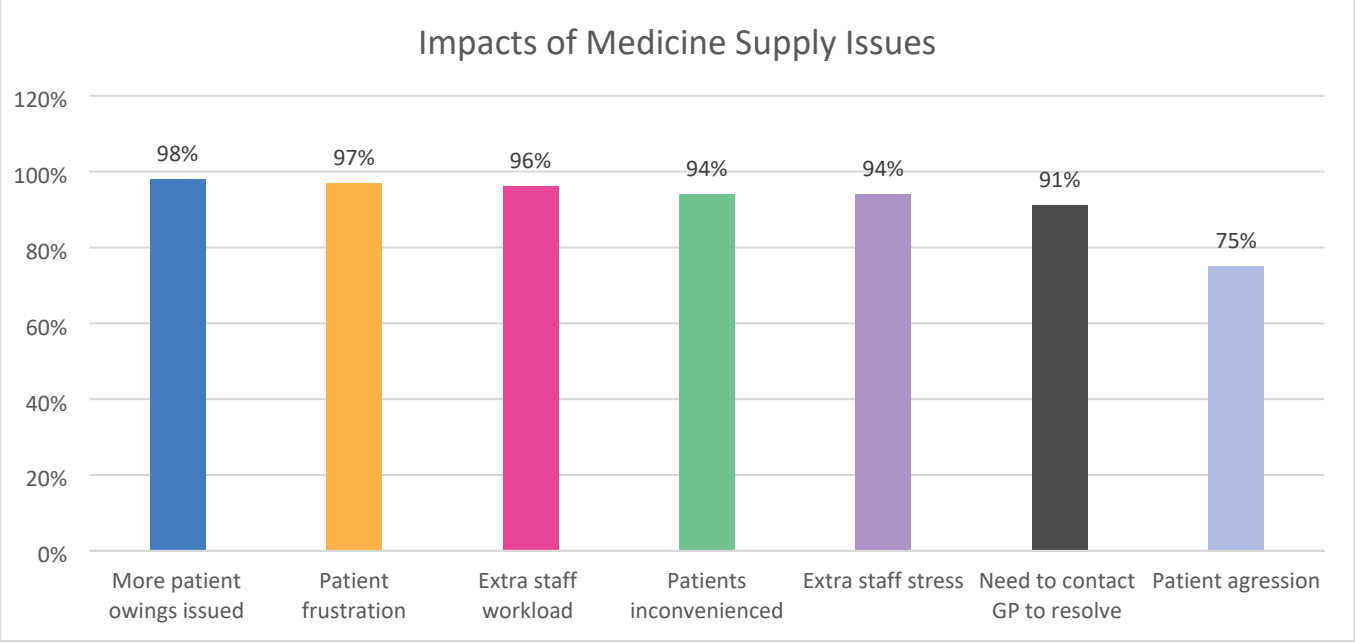


Figure 33: Impacts of Medicine Supply Issues on Patients
Source: https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf

Responses from pharmacy business owners/head office representatives reported that 91% of pharmacies were experiencing staff shortages, the most significant drivers of staff shortages being sickness and self-isolation related to COVID-19 (81%), difficulties in finding locums (77%), and difficulties recruiting permanent staff (72%). Figure 34 shows the impacts of staff shortages:

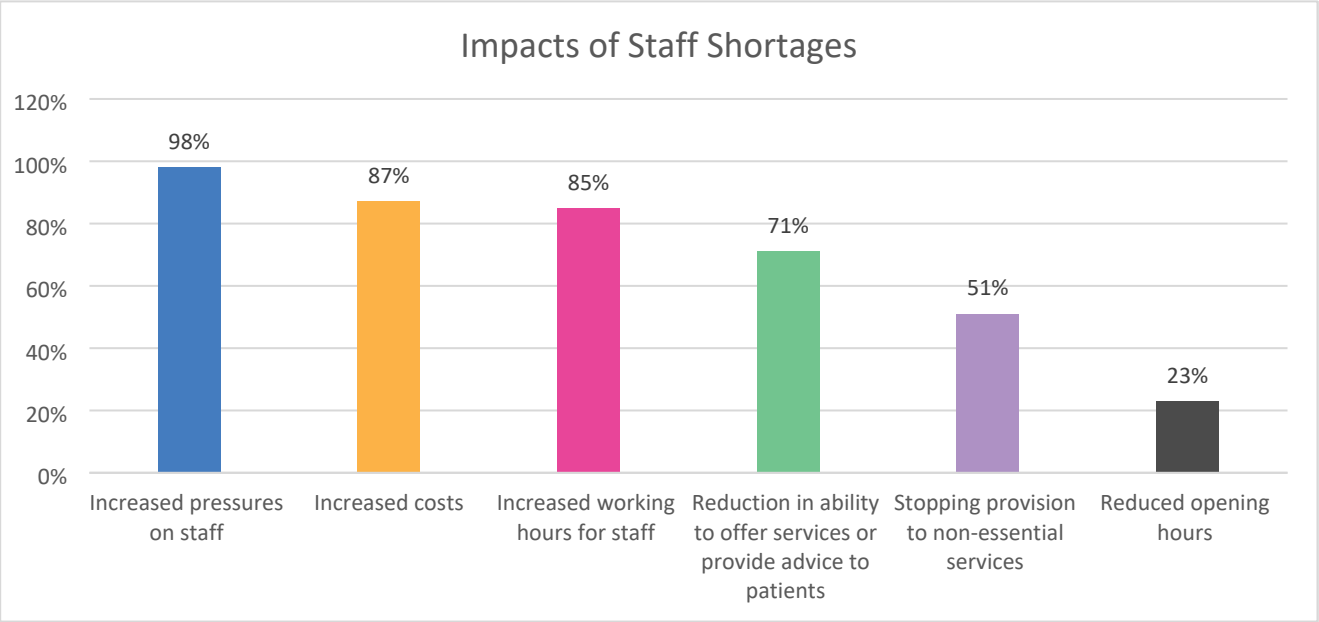
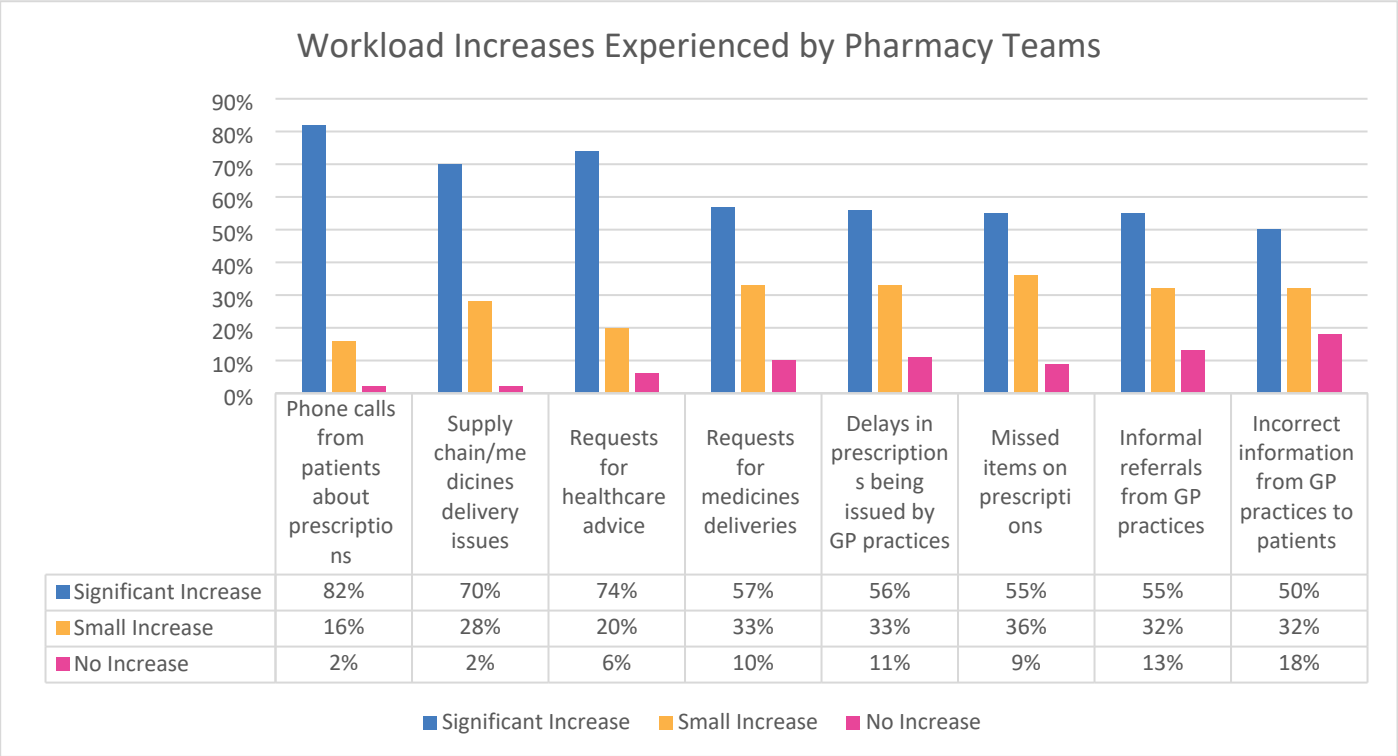


Figure 34: Impacts of Staff Shortages on Pharmacies

Source: https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf

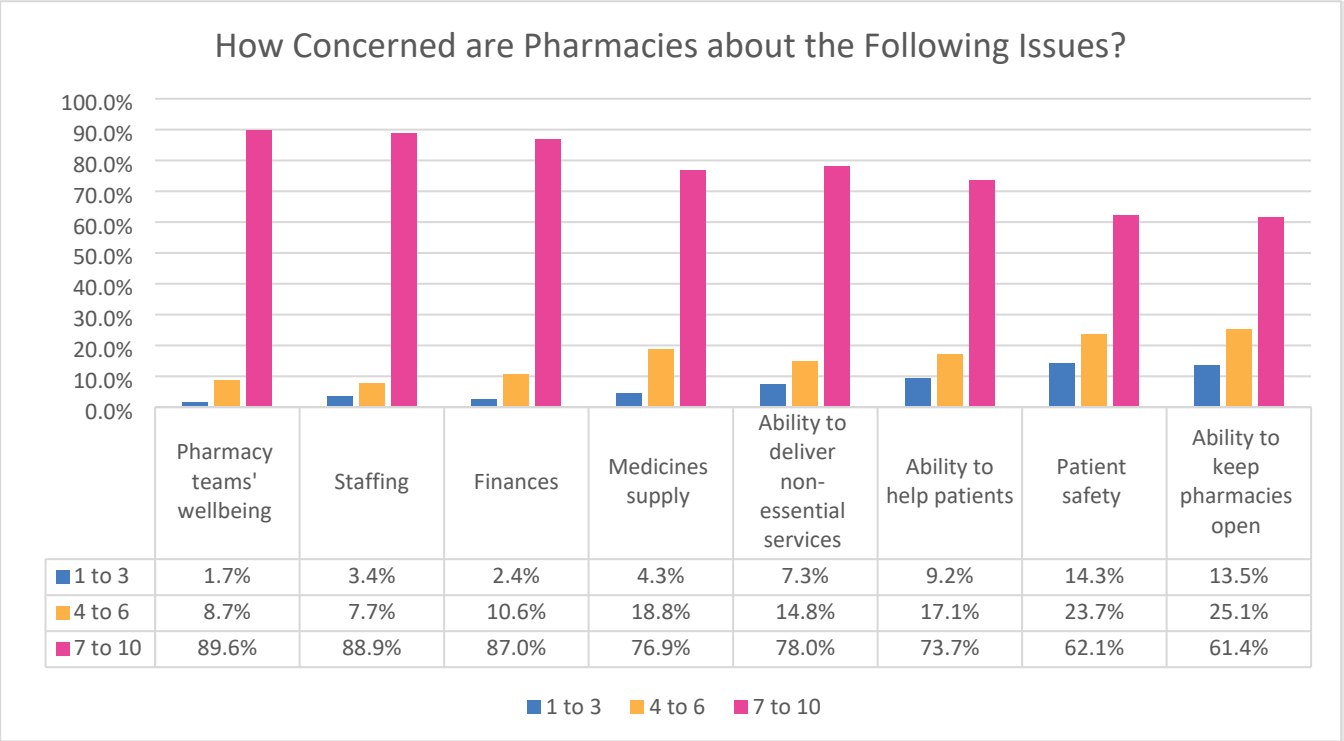
Significant pressures were recorded in a wide range of areas, including significant increases in patients displaced from GPs to pharmacies, and incorrect information being provided by GP practices to patients. This increased workload breakdown can be seen in Figure 35:



	Phone calls from patients about prescriptions	Supply chain/medicines delivery issues	Requests for healthcare advice	Requests for medicines deliveries	Delays in prescriptions being issued by GP practices	Missed items on prescriptions	Informal referrals from GP practices	Incorrect information from GP practices to patients
Significant Increase	82%	70%	74%	57%	56%	55%	55%	50%
Small Increase	16%	28%	20%	33%	33%	36%	32%	32%
No Increase	2%	2%	6%	10%	11%	9%	13%	18%

Figure 35: Workload Increases Experienced by Pharmacy Teams
Source: https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf

Looking ahead to the future, the pharmacy companies were asked in the survey to rate how concerned they were about a range of issues. This was done on a scale of 1 to 10, 1 being no concern, 10 being extremely concerned. Figure 36 shows the responses:



	Pharmacy teams' wellbeing	Staffing	Finances	Medicines supply	Ability to deliver non-essential services	Ability to help patients	Patient safety	Ability to keep pharmacies open
1 to 3	1.7%	3.4%	2.4%	4.3%	7.3%	9.2%	14.3%	13.5%
4 to 6	8.7%	7.7%	10.6%	18.8%	14.8%	17.1%	23.7%	25.1%
7 to 10	89.6%	88.9%	87.0%	76.9%	78.0%	73.7%	62.1%	61.4%

Figure 36: How concerned are pharmacies about the following issues?
Source: https://psnc.org.uk/wp-content/uploads/2022/04/PSNC-Briefing-013.22-Summary-of-the-results-of-PSNCs-2022-Pharmacy-Pressures-Survey.pdf

From analysis of the public survey undertaken for this PNA, when asked the question "When thinking about your pharmacy, what is most important to you?", 74% of respondents said "Efficient and quick service", 43% said "Friendly staff", and 32% said "Know and trust the Pharmacist/Team". The survey also indicated that respondents used the same pharmacy, with 60% saying they use the same pharmacy all the time, and 29% saying they use the same pharmacy most of the time. In the survey, pharmacies were praised for:

- Friendly, knowledgeable staff.
- The local nature of a pharmacy was helpful to some as was staff who knew them and their health.
- Continuity of staff.
- Advice about medication and wider health issues was welcomed and sometimes seen as an alternative to seeking a GP appointment.
- Good communication with GPs

"Fantastic, really friendly knowledgeable staff, I get reminders for reordering my prescriptions and notifications that they are ready to collect. When I have a new medicine prescribed the member of staff double checks with me that I understand the dosage and that the Dr has explained the reason for the new/changed medicine. They are 1st class."

"As a disabled person, with number health issues, my local pharmacy is literally a lifeline."

"Excellent customer service and satisfaction over a good number of years."

"Extremely helpful and easier and quicker to access than making a GP appointment."

"Friendly, knowledgeable and is a quick alternative to a GP. I am very happy with my pharmacist & team."

"I prefer to go to the local pharmacy, as it is more personal, as it is more personal than a large city-centre chain store, and it is near where I live. I really value the local service."

"I receive a very efficient and helpful service from my local pharmacy."

"The team are lovely, helpful, efficient, caring, and the service has always been absolutely brilliant."

"I was able to get immediate and effective advice from the Pharmacist at a time when there were no available appointments to see my GP"

However, issues were identified that match the themes from both the PSNC Audit and PSNC Survey, including:

- The length of time between ordering medicines and prescriptions being available – some respondents reported increases in more recent months.
- Prescriptions not being ready for collection leading to long queues or necessitating return visits to the pharmacy was a key issue.
- Items not stocked or missing with return visits required.
- Wrong items/out of date medication.
- System for finding prescriptions being disorganised.
- Impromptu or random pharmacy closure due to staff shortages including pharmacists.

"It can take up to 7 days from the time the pharmacy receives the script to being able to collect medication"

"Always have to wait for the prescription to be filled even when ordered 5 days before"

"Doesn't matter how far in advance you order medications they are never ready when you go to collect"

"Long queues outside chemist, lack of supplies a big issue repeat prescriptions so we have to go back several times to collect"

"Don't always have the tablets in stock"

"Seem to take ages finding my prescriptions (which had been sent directly to them from the GP) have a muddled system to find things"

"Recently been closed for time during day or all day as not enough staff"

"Pharmacist leaves the premises and staff are unable to give out prescriptions or sell things like lem sip"

"My pharmacy is usually very busy which can make it feel uncomfortable to ask for any additional time from the staff (with questions or for advice) as they are clearly under a lot of pressure"

"Closes randomly without notice due to lack of pharmacists. Do not answer phone."

From the public survey, collecting a prescription was the biggest reason why respondents usually access a pharmacy (93%), followed by buying over the counter medicines (that do not need a prescription) (57%), and getting advice and information on medication (31%).

Workforce

NHS Health Education England (HEE) produce pharmacist workforce data at National, Regional, and ICS geography level. Figure 37 shows the pharmacist workforce levels in Coventry and Warwickshire ICS in Trust, Practice, and Primary Care Networks (PCN). Between March 2019 and March 2022 Trust has increased their Pharmacist Workforce from 114 to 150, Practice has increased from 4 to 11 and PCN has increased from 0 to 66. There is currently no equivalent data on community pharmacies. The increase in numbers across Trust, Practice and PCN may cause concern as these increases may have come from workforce either leaving community pharmacies, or choosing to continue their training in a Trust, Practice, or PCN rather than in community pharmacies. There are a range of factors that contribute to this choice including training packages, salary, and financial security.

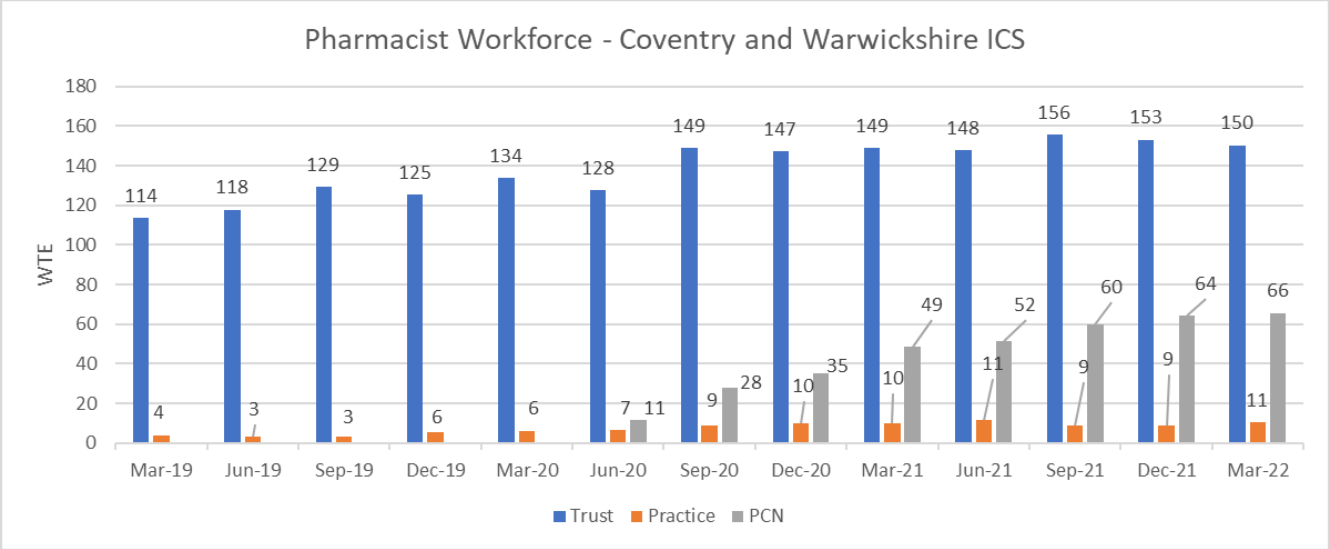


Figure 37: Pharmacist Workforce in Coventry and Warwickshire ICS
Source: HEE

HEE have undertaken a Community Pharmacy Workforce Survey in 2021, with results expected to be published in early 2022. This will form part of a Community Pharmacy dashboard that can be shared with external stakeholders via the HEE eProduct platform. The dashboard is in draft stage and has been shared within HEE for comments and recommended updates, with a view for publication in Summer 2022.

HEE are undertaking discussions to understand the possibility of undertaking an annual survey of community pharmacy workforce to support understanding of challenges and improve data completion/quality. This is at the early stage, however, there is an appetite for this to be taken forward as it has been discussed at the Midlands Pharmacy Workforce Network.

Conclusion on Access to Pharmacies

Pharmacies within Coventry and Warwickshire are well geographically distributed by population density and levels of deprivation. Opening hours indicate a good level of access during usual working hours, and on weekends and evenings across the Coventry and Warwickshire. Cross border availability of pharmaceutical services is also significant across Coventry and Warwickshire.

It will be important to monitor the pressures on pharmacies and how this may impact on the workforce, particularly with the cost-of-living crisis further impacting pressures that have built up due to the COVID-19 pandemic. Supporting surveillance through the annual HEE Community Pharmacy Workforce Survey will help to improve and understand data on this issue.

Consideration should be made to population increases and significant housing developments being built as described in the “Households & Housing Development Projections” section of the “Local Picture” chapter.

PHARMACY SERVICES

Community pharmacies provide a wide array of services that are defined/commissioned in different ways:

- Essential Services – services which all pharmacies must provide as part of the CPCF regulations.
- Advanced Services – services the CPCF regulations allow pharmacies to opt in to providing.
- Enhanced and Locally Commissioned services – Services that are either commissioned by NHS England (enhanced services) or commissioned by a CCG or Local Authority (locally commissioned services).

ESSENTIAL SERVICES

There are 9 essential services[39] which are summarised in the table below. All of the community pharmacies in Coventry and Warwickshire are required to provide these services as part of the CPCF regulations.

Essential Service	**Description**
Dispensing (Split into 2 different essential services - Medicines and Appliances)	The safe supply of medicines or appliances ordered on NHS prescriptions. Advice is given to the patient about the medicines being dispensed and information on how to use them safely and effectively. Records are kept of all medicines dispensed and maintained.
Repeat Dispensing	The management and dispensing of repeatable NHS prescriptions for up to one year, in partnership with the patient and prescriber. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before dispensing each supply the pharmacy will ascertain the patient's need for a repeat supply of a particular medicine and communicate any clinically significant issues to the prescriber.
Discharge	The Discharge Medicines Service (DMS) was added as a new Essential

[39] https://psnc.org.uk/services-commissioning/essential-services/ (accessed May 2022)

Medicines Service	service within the CPCF regulations on 15th February 2021. This service allows NHS Trusts to refer patients who would benefit from extra guidance around newly prescribed medicines to the DMS service at their community pharmacy. This service aims to be a significant contributor to the safety of patients transition from care, and aims to reduce readmissions to hospital.
Promotion of Health Lifestyles (Public Health)	The provision of opportunistic one to one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing. These groups include diabetic patients, patients at risk of coronary heart disease, especially those with high blood pressure, patients who smoke and patients who are overweight. Pharmacies must also support up to six local campaigns a year, organised by NHS England. Campaign examples may include topics such as promotion of flu vaccination uptake, healthy living, or stop smoking.
Disposal of unwanted medicines	Community pharmacies accept unwanted medicines from households and individuals which require safe disposal. The medicines are then safely disposed of by a waste contractor engaged by NHS England. Pharmacies are not under any obligation to accept sharps under the terms of this essential service. Needle and syringe programmes are a locally commissioned service.
Signposting	The provision of information provided by pharmacists and staff to refer patients to 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.
Clinical Governance	Adherence with clinical governance requirements is part of the terms of service for pharmacies, as set out in Part 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. These cover a

	range of quality related issues as set out in the following links: https://www.psnc.org.uk/wp-content/uploads/2013/07/Clinical_Governance_guidance_updated_final.pdf https://www.england.nhs.uk/publication/approved-particulars/ https://www.psnc.org.uk/wp-content/uploads/2013/07/service20spec20es8202020clinical20governance20_v1201020oct2004_.pdf https://psnc.org.uk/services-commissioning/psnc-briefings-services-and-commissioning/psnc-briefing-01514-changes-to-contractual-requirements-201415/

Dispensing

Table 6 shows the number of items dispensed in 2020/21 and 2021/22 in England and across Coventry and Warwickshire.

Area	Prescription items dispensed 2020/21	Prescription items dispensed 2021/22
England	1,016,445,333	1,042,674,399
Coventry and Warwickshire CCG	16,701,448	17,195,484
Coventry Place	6,641,168	6,814,810
Warwickshire (Rugby, Warwickshire North, and South Warwickshire places)	10,060,280	10,380,674

Table 6: Number of items dispensed in 2020/21 and 2021/22 in England, Coventry and Warwickshire
Source: NHS BSA

Results from the 1,601 respondents of the public survey showed that out of the essential services 86% of respondents were aware they could discuss prescriptions, 70% were aware they could get new prescriptions, 87% were aware of the disposal of old medicines service, and 65% were aware that the local pharmacy team can provide healthy living advice.

Cross Border Dispensing

The cross-border pharmacies help to service some areas in Coventry and Warwickshire. As noted in the pharmacy accessibility section of this PNA, the areas not covered by 15-minute drive time are largely rural with low population density. Figure 38 shows the provision from

pharmacies outside of the Warwickshire boundary (solid orange line) to a distance of 5km (dashed orange line). For more information on these pharmacies, please see the relevant PNAs.

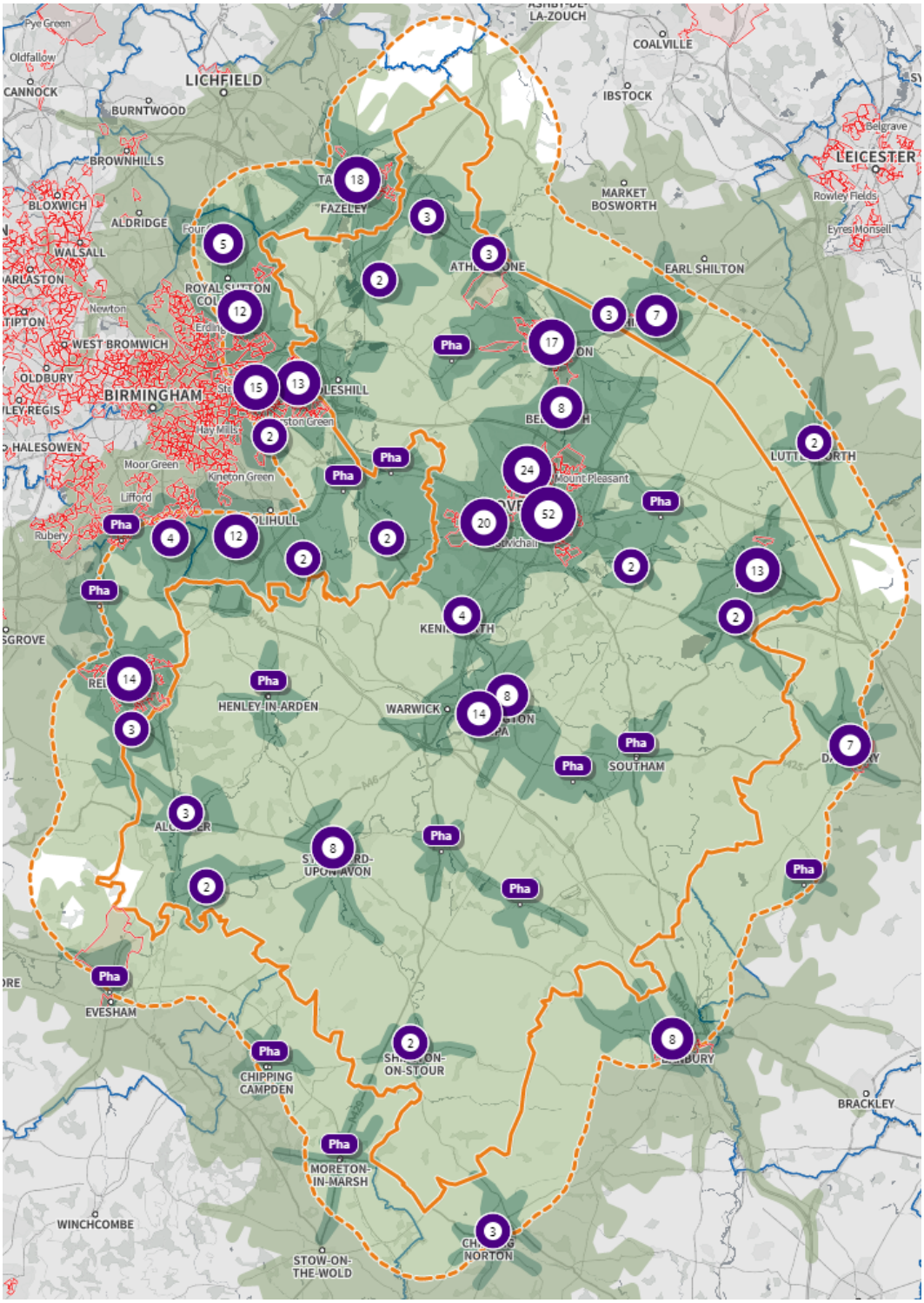


Figure 38: Location of pharmacies within Coventry and Warwickshire and within 5km outside of Coventry and Warwickshire Source: SHAPE

Appliances

Appliances can be dispensed by any pharmacy or appliance contractor and can be broadly categorised as stoma appliances, incontinence appliances, and dressings. There is 1 dispensing appliance contractor in Coventry and 0 in Warwickshire. Results from the pharmacy survey show that of the 161 pharmacies that responded to the survey, 159 (98%) dispense appliances.

Prevention and Health Promotion

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.

Where requested to do so by NHSE&I, each pharmacy must record the number of people to whom information is provided as part of one of these campaigns. NHSE&I can also ask for additional information in relation to the campaign.

Any additional information to be requested will initially be discussed with PSNC. The aim of requesting additional information will be to help to evaluate the impact of the campaign and to assist with future policy development. Contractors will be notified of the additional information which needs to be collected and supplied in advance of the campaign starting.

NHSE&I can request that the information on the campaign is provided to them electronically.

Conclusion on Essential Services

Essential Services are provided by all Coventry and Warwickshire pharmacy contractors. This includes dispensing of NHS prescriptions which is a fundamental service that is commissioned nationally by the NHS. As discussed with regard to pharmacy access, essential services appear to be accessible for the majority of Coventry and Warwickshire's population both geographically and at different times of day. Therefore, there are no gaps in the provision of essential services for Coventry and Warwickshire.

ADVANCED SERVICES

In addition to essential services, the CPCF allows community pharmacies to opt to provide any of 8 advanced services to support patients with the safe use of medicine following appropriate training or accreditation by NHS England.

New Medicines Service (NMS) –

This service provides support for patients with long term conditions who have been newly prescribed a medicine to help improve patient medicine adherence. It is initially focused on particular patient groups and conditions. Specific conditions/medicines are covered by the service, they are:

Asthma and COPD	Diabetes (Type 2)	Hypertension	Hypercholesterolaemia
Osteoporosis	Gout	Glaucoma	Epilepsy
Parkinson's disease	Urinary incontinence/retention	Heart Failure	Acute coronary syndromes
Atrial fibrillation	Long term risks of venous thromboembolism/embolism	Stroke/transient ischemic attack	Coronary heart disease

The service is split into three sections:

1. Patient Engagement
2. Intervention
3. Follow up

Patient Engagement – After a new medicine has been prescribed for a long-term condition, patients will be recruited to the service by prescriber referral or opportunistically by community pharmacy staff. Once the new medicine has been dispensed and information given about its use a patient will be offered to use the NMS. If accepted, a method and time will be agreed for the "Intervention" stage, usually between 7 and 14 days after patient engagement.

Intervention – The pharmacist and patient will have a discussion to assess adherence to the medicine(s), identify any problems, and determine the patient's need for further information and support. Further support and information will be provided by the pharmacist and where no problems have been identified a time for the "Follow up" stage will be agreed, usually 14 to 21

days after the “Intervention” stage. If problems are identified where the intervention of the patient’s prescriber is needed, the issue will be referred to them.

Follow up – The pharmacist and patient will again have a discussion to assess adherence to the medicine(s), identify any problems, and determine the patient’s need for further information and support. Further support and information will be provided by the pharmacist. If problems are identified where the intervention of the patient’s prescriber is needed, the issue will be referred to them.

The NMS is conducted in a private consultation area or via telephone or video consultation, which ensures patient confidentiality. Since the introduction of the NMS in October 2011, more than 90% of community pharmacies in England have provided it to their patients.

The optimal use of appropriately prescribed medicines is vital to the management of long-term conditions. The pharmacist is fundamental to this service as they can intervene and offer support and advice to patients who are newly prescribed a medicine that will be used to manage a long-term condition.

NHS BSA data shown in Table 7 shows the number of NMS interventions declared by community pharmacies between April 2021 – December 2021.

Area	Number of NMS interventions declared in the period January 2021 – December 2021 (inclusive).	Mean number per pharmacy in the period January 2021 – December 2021 (inclusive).
Coventry & Warwickshire	24,569	173
Nationally	1,640,036	202

Table 7: NMS interventions declared in Community Pharmacies
Source: NHS BSA

In the 2018 PNA Warwickshire had a mean number of NMS per pharmacy of 58 in 2016/17, and Coventry had 59. This therefore shows a significant increase over the past 3 years, which can also be seen nationally with the 2016/17 mean number per pharmacy being 74.

184 of the 197 community pharmacies (93%) in Coventry and Warwickshire provide an NMS service. 79 (87%) of those pharmacies who provide the NMS service are in Coventry, 105 (99%) are in Warwickshire.

Conclusion for NMS Service

A large proportion of the community pharmacies within Coventry and Warwickshire provide the NMS service. No gaps have been identified from the information available.

Appliance Use Reviews (AUR)

This service can be carried out by a pharmacist or a specialist nurse, in the pharmacy or at a patient's home, if more convenient. AURs should serve to improve the patient's knowledge and use of any 'specified appliance' by:

- Establishing the way the patient uses the appliance and the patient's experience of such use.
- By identifying, discussing, and assisting in the resolution of poor or ineffective use of the appliance by the patient.
- Advising the patient on the safe and appropriate storage of the appliance; and
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

NHS BSA data shown in Table 8 shows the number of AURs conducted at community pharmacies between April 2021 – December 2021.

Area	Number of AURs conducted at community pharmacies in the period April 2021 – December 2021 (inclusive).
Coventry & Warwickshire	171

Table 8: Number of AURs conducted at community pharmacies in Coventry and Warwickshire
Source: NHS BSA

In this time period there were no AURs conducted in user's homes.

Of the 161 pharmacies that responded to the pharmacy survey, 25% in Coventry and 11% in Warwickshire currently provide the AUR service.

Conclusion for AUR Service

Demand for the AUR service is lower than for other advanced services due to the much smaller proportion of the population that may be targeted. No current gaps in provision have been identified based on the information available. Coventry and Warwickshire residents may be receiving AURs from other national providers of appliances/AURs. The demands of the services should be assessed continually based on service models and demographic changes.

Stoma Application Customisation (SAC)

The service involves customisation of a quantity of more than one stoma appliance, based on the patient's measurements or template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. In order to provide this service certain criteria must be fulfilled, one of the main being the service must be provided from an 'acceptable locations' meaning:

- An area within the pharmacy that is distinct from the public area
- Is clearly designated as a private area whilst the service is being provided
- Is suitable and designated for the retention of the appropriate equipment for customisation
- Is suitable and designated for modification of the appliances
- That is suitable for the volume of customisation being undertaken at any given time.

NHS BSA data shown in Table 9 shows the number of Stoma Customisation Fees by community pharmacies between April 2021 – December 2021.

Area	Number of Stoma Customisation Fees in the period April 2021 – December 2021 (inclusive).
Coventry & Warwickshire	180

Table 9: Number of Stoma Customisation Fees by community pharmacies in Coventry and Warwickshire
Source: NHS BSA

Of the 161 pharmacies that responded to the pharmacy survey, 28% in Coventry and 8% in Warwickshire currently provide the SAC service.

Conclusion for SAC Service

Demand for the SAC service is lower than for other advanced services due to the much smaller proportion of the population that may be targeted. No current gaps in provision have been identified based on the information available. Coventry and Warwickshire residents may be receiving SACs from other national providers of stomas. The demands of the services should be assessed continually based on service models and demographic changes.

Seasonal Influenza (Flu) Vaccination

Each year the NHS runs a national seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus. These include people aged 65 years and over, pregnant women and those with certain health conditions. The aims of the service are to:

- Sustain and maximise uptake of flu vaccine in at risk groups by building the capacity of community pharmacies as an alternative to general practice.
- Provide more opportunities and improve convenience for eligible patients to access flu vaccinations.
- Reduce variation and provide consistent levels of population coverage of community pharmacy flu vaccination across England by providing a national framework.

There has been a local flu vaccination scheme in place since 2012 in Warwickshire and Coventry. From 2015/16 NHS England also commissioned flu vaccination scheme from community pharmacy as a new Advanced Service. All pharmacy contractors can choose to provide the Flu vaccination service. Eligible adults have the choice of getting their flu vaccine at a pharmacy from September to March each year. This service sits alongside the nationally commissioned GP vaccination service, giving patients another choice of venue for their vaccination and helping commissioners to meet their NHS vaccination targets.

Results from the pharmacy survey (Table 10) show that 132 of the 161 pharmacies who responded to the survey currently provide a seasonal influenza vaccination service (82%). In Coventry, 91% of the respondents to the pharmacy survey provide the vaccination service and in Warwickshire 86% provide the service. The public survey showed that 84% of respondents were either aware of, or had used the service, only 10% saying they were not aware of the service.

Vaccination Service	Currently Providing	Would provide if commissioned	Would provide privately	Wouldn't provide if commissioned
Seasonal Influenza Vaccination service	132	16	19	8

Table 10: Number of pharmacies providing, would provide, or wouldn't provide in Coventry and Warwickshire
Source: Pharmacy Survey for 2022 PNA

NHS BSA data shown in Table 11 shows the number of community pharmacy seasonal influenza vaccination advanced service fee.

Area	Number of community pharmacy seasonal influenza vaccinations in the period April 2021 – December 2021 (inclusive).
Coventry & Warwickshire	66,570

Table 11: Number of community pharmacy seasonal influenza vassincation advanced service fees.
Source: NHS BSA

Figure 39 shows the percentage of over 65-year-olds who received the flu vaccination between 1st September to the end of February in a primary care setting. The target percentage uptake of the flu vaccine each year is 75%. Until 2020/21, Coventry and England were below that target with Warwickshire being slightly under or on the target. In 2020/21 Coventry, Warwickshire, and England all achieved over 75% coverage, with Coventry at 78% and Warwickshire at 82.9%.

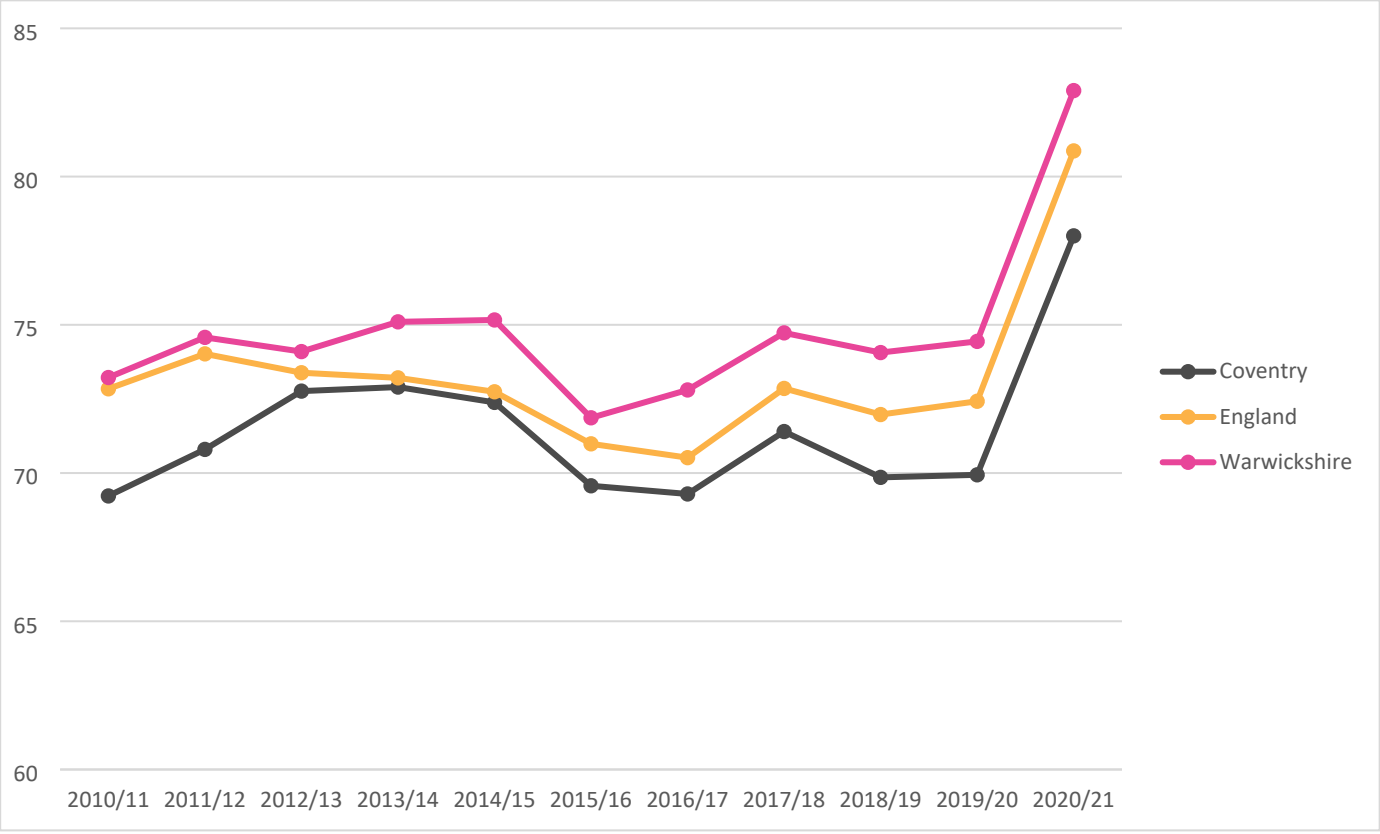


Figure 39: Percentage of over 65-year-olds who received the flu vaccine between 1st September to the end of February in a primary care setting
Source: Fingertips

Conclusion for Flu Vaccination service

There is adequate provision of this service in Coventry and Warwickshire. The Flu service is also accessible from GPs and other Healthcare providers. Pharmacies in Coventry and Warwickshire should continue to be encouraged to provide the flu vaccine. Flu immunisation is a cost-effective health protection intervention, which supports the prevention of the spread of infectious disease, reducing illness, and complications of flu, which, although a mild illness in most, can be fatal.

Community Pharmacist Consultation Service (CPCS)

The Community Pharmacist Consultation Service (CPCS) was launched on 29th October 2019, allowing referrals into community pharmacies from NHS 111. On 1st November 2020 this service was extended to GP CPCS which allowed general practices to refer patients for a minor illness consultation via CPCS, once a local referral pathway has been agreed. This service replaced the NUMSAS and DMIRS pilots.

The CPCS aims to relieve pressure on the wider NHS by connecting patients to community pharmacies which can deliver a swift, convenient, and effective service to meet their needs. Since this service was launched, an average of 10,500 patients per week are being referred for a consultation with a pharmacist following a call to NHS 111[40]. These patients may otherwise have gone to see their GP.

NHS BSA data shown in Table 12 shows the number of CPCS Fees by community pharmacies between April 2021 – December 2021.

Area	Number of CPCS Fees in the period April 2021 – December 2021 (inclusive).
Coventry & Warwickshire	6,837

Table 12: Number of CPCS Fees by community pharmacies in Coventry and Warwickshire
Source: NHS BSA

188 of the 197 pharmacies in Coventry and Warwickshire currently provide a CPCS service.

[40] https://psnc.org.uk/services-commissioning/advanced-services/community-pharmacist-consultation-service/ (accessed May 2022)

Conclusion for CPCS Service

There is a good provision of CPCS across Coventry and Warwickshire. No current gaps have been identified based on the information available.

Hepatitis C Testing Service

The Hepatitis C testing service focuses on the provision of point of care testing for Hepatitis C (Hep C) antibodies in people who inject drugs (for example people who inject illicit drugs such as steroids or heroin) but aren't yet accepting treatment for their substance use. Should an individual test positive for Hep C antibodies they are referred for a PCR confirmatory test and treatment. The aim of the service is to:

a) Increase the number of diagnoses of HCV infection
b) Permit effective interventions to lessen the burden of illness to the individual
c) Decrease long-term costs of treatment
d) Decrease onward transmission of HCV

This service was added to the Community Pharmacy Contractual Framework (CPCF) in 2020, starting on the 1st of September. This was originally trialled in the 5-year CPCF agreement[41], and its planned introduction in April 2020 was delayed due to the Covid-19 pandemic. This service is currently commissioned until 31st March 2023.

NHS BSA data shown in Table 13 shows the number of Hepatitis C Antibody Testing Service Fees by community pharmacies between April 2021 – December 2021.

Area	Number of Hepatitis C Antibody Testing Service Fees in the period April 2021 – December 2021 (inclusive).
Coventry & Warwickshire	9

Table 13: Number of Hepatitis C Antibody testing service Fees in Coventry and Warwickshire
Source: NHS BSA

[41] https://psnc.org.uk/contract-it/the-pharmacy-contract/cpcf-settlement-2019-20-to-2023-24/ (accessed May 2022)

Conclusion for Hepatitis C Testing Service

Pathways for referral to a confirmatory PCR test are currently under development. This should be supported to help develop the service as there is currently a limited pathway for PCR testing.

Smoking Cessation Advanced Service – Secondary Care to Community Service

NHS community pharmacies are a great place for patients to receive stop smoking advice and support. Through this service hospitals can refer patients to community pharmacy to continue the stop smoking journey they started in hospital.

The service:

- supports patients who started a stop smoking programme in hospital to continue their journey in community pharmacy upon discharge
- promotes healthy behaviours to service users

This service was commissioned in March 2022. There are currently 39 pharmacies delivering this service in Coventry and Warwickshire.

Additional smoking cessation pharmacy services:

- NRT (nicotine replacement therapy) voucher scheme: all clients who are part of a smoking cessation scheme will receive a voucher. The client will redeem this at a community pharmacy.
- Champix/Varenicline review and provision: this provision is specific to Coventry and operates under a Patient Group Directive (PGD)
- Psychosocial interventions: includes structured counselling, motivational enhancement, case management, care-coordination, psychotherapy and relapse prevention.

Conclusion for Smoking Cessation Service

As this is a newly commissioned service pharmacies are still signing up to provide it. The number of pharmacies providing this service should be monitored whilst this initial sign-up is taking place.

Hypertension Case-Finding Service

The NHS Community Pharmacy Blood Pressure Check Service supports risk identification and prevention of cardiovascular disease (CVD). There are currently 118 community pharmacies in Coventry and Warwickshire delivering this service.

This service will:

- identify people over the age of 40 who have previously not been diagnosed with hypertension (high blood pressure) and refer those with suspected hypertension for appropriate management.
- promote healthy behaviours to service users.
- refer people identified as likely to have high blood pressure to general practice, for ongoing care to manage their blood pressure.

This service was commissioned in April 2022.

Conclusion for Hypertension Case-Finding Service

There is a promising initial sign-up to this service as it has only been commissioned for 2 months at the time of writing this PNA. There is an opportunity to develop pathways for this from pharmacies straight through to lifestyle service for people who want support around lifestyle interventions.

ENHANCED AND LOCALLY COMMISSIONED SERVICES

The third set of pharmaceutical services from the CPCF that can be provided from pharmacies are Enhanced Services and Locally Commissioned Services. These services can only be referred to as Enhanced Services if they are commissioned by NHS England. Local services commissioned by CCGs or Local Authorities are referred to as Locally Commissioned Services.

These services are commissioned to meet an identified need in the local population and pharmacies can choose whether to provide these services.

Substance Misuse

Coventry and Warwickshire both commission needle exchange and supervised consumption for the management of drug action services. Coventry additionally commissions the notification of missed doses.

The overall aims of pharmacy services to drug users are to assist the service user to remain healthy, reduce risk, and provide service users with regular contact with a healthcare professional and help them access further advice or assistance. These are considered necessary services and pharmacies can act as an important primary access point for these service users. The service reduces the risk of drug-related death during the induction and titration stages of treatment, but also prevents diversion of prescribed medication. This service ensures frequent (usually daily) contact between the service user and the pharmacist especially during the early and more chaotic stages of treatment. This also allows the opportunity to monitor patients closely.

Needle Exchange

Needle exchange supplies injecting drug users access to sterile needles, syringes and other equipment and their safe disposal. Needle exchange delivery is based on the philosophy of providing injecting drug users with sterile needles and associated injection equipment at no cost. The aim of these services is to reduce the damage associated with using unsterile or contaminated injecting equipment.

The objectives of the pharmacy-based needle exchange service are to:

- Reduce the spread of blood-borne viruses associated with injecting drug use through the provision of injecting equipment.
- Reduce the rates of high-risk injecting behaviours by referring on to specialist services.
- Reduce the social and physical harms associated with injecting drug use, including promoting safer injecting practices.
- Increase and facilitate access to treatment services for clients who are not already engaged in structured treatment.
- Reduce the potential for unsafe disposal of used injecting equipment and therefore reduce the risks to public health.
- Maximise the benefits of accessing community pharmacies, such as general health improvement and signposting to other services.

Supervised Consumption

Supervised consumption/medically assisted treatment is a service used to ensure that patients with substance dependence take their medication at regular intervals. The service requires the pharmacist to supervise the consumption of the prescribed medicines at the point of dispensing in the pharmacy, ensuring that the correct dose has been administered to the patient.

Frequent contact between pharmacists and patients, following on from supervised consumption, means that pharmacists are well placed to monitor patient health. In addition to providing support and advice to substance misusers, trained pharmacists can communicate any non-attendance or other non-adherence. The risk of accidental overdose is also reduced, and the rehabilitation process is enhanced by helping patients stick to their treatment plan.

The objectives of the supervised consumption service are to ensure compliance with the agreed treatment plan by:

- Dispensing prescribed medication in specified instalments
- Ensuring each supervised dose is correctly consumed by the patient for whom it was intended, with privacy and dignity.
- Encourage uptake of vaccines and testing for blood borne viruses.
- To reduce the risk to local communities arising from:
- Over usage or under usage of medicines
- Diversion of prescribed medicines onto the illicit drugs market and accidental exposure to the supervised medicines

Notification of Missed Doses

On receipt of a patient referral to the NHS Discharge Medicines Service, the community pharmacy team undertake a pharmacist clinical check within 72 hours. The pharmacy reviews the prescription and identifies what is required, depending on the patient need. The community pharmacy team must also check any previously ordered prescriptions for the patient that are in the dispensing process or awaiting collection to see if they are still appropriate. Particular attention should be paid to electronic repeatable prescriptions as these could be pulled down from the system sometime after the patient has been discharged from hospital.

In Warwickshire there has been a reduction of the number of active pharmacies providing both the needle exchange and supervised consumption service and a reduction in the number of interactions (Table 14). The initial reduction between 2019/20 was likely due to the COVID-19 pandemic. This had continued into 2021/22. National data is not available to compare for needle exchange, but supervised consumption shows an opposite trend to the national picture, which shows a slight increase in the service.

	2018/19	2019/20	2020/21	2021/22

Number of pharmacies providing needle exchange	17	22	22	17
Number of needle exchange interactions	8,335	11,124	9,265	7,284
Number of pharmacies providing supervised consumption	46	52	46	40
Number of supervised consumption interactions	5,946	8,326	4,253	3,284

Table 14: Number of pharmacies in Warwickshire providing needle exchange and supervised consumption and interactions
Source: Pharmoutcomes

In Coventry the number of pharmacies providing the needle exchange and supervised consumption service has been static, with changes happening only when pharmacies close down (Table 15).

	2019/20	**2020/21**	**2021/22**
Number of pharmacies providing needle exchange	24	24	24
Number of needle exchange interactions	18,527	14,423	12,228
Number of pharmacies providing supervised consumption	69	69	69
Number of supervised consumption interactions	9,432	3,744	5,802

Table 15: Number of pharmacies in Warwickshire providing needle exchange and supervised consumption and interactions
Source: Pharmoutcomes

In Coventry 69 pharmacies provide the supervised consumption service and 24 provide the needle exchange service. This is shown in Figure 40, with pharmacies providing both supervised consumption and needle exchange in green, and those providing just supervised consumption in blue.

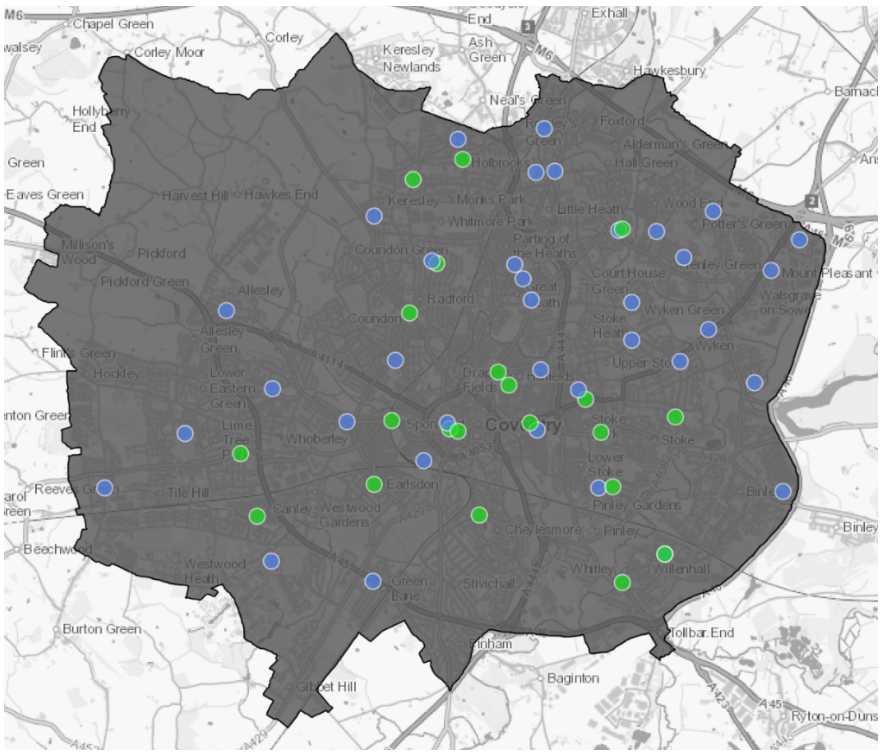


Figure 40: Pharmacies who provide the substance misuses service in Coventry
Source: Pharmoutcomes

Table 16 shows the provision of pharmacies who provide needle exchange, supervised consumption, or both services in Warwickshire. This is then mapped in figure 41, with the colours in the table corresponding to the coloured circles on the map.

	Both	Needle Exchange	Supervised Consumption	Total
North Warwickshire	3	1	4	8
Nuneaton and Bedworth	2	1	8	11
Rugby	2		6	8
Stratford-on-Avon	4	1	3	8
Warwick	4		7	11

Total	15	3	28	46

Table 16: Pharmacies who provide Needle Exchange, Supervised Consumption, or Both in Warwickshire
Source: Pharmoutcomes

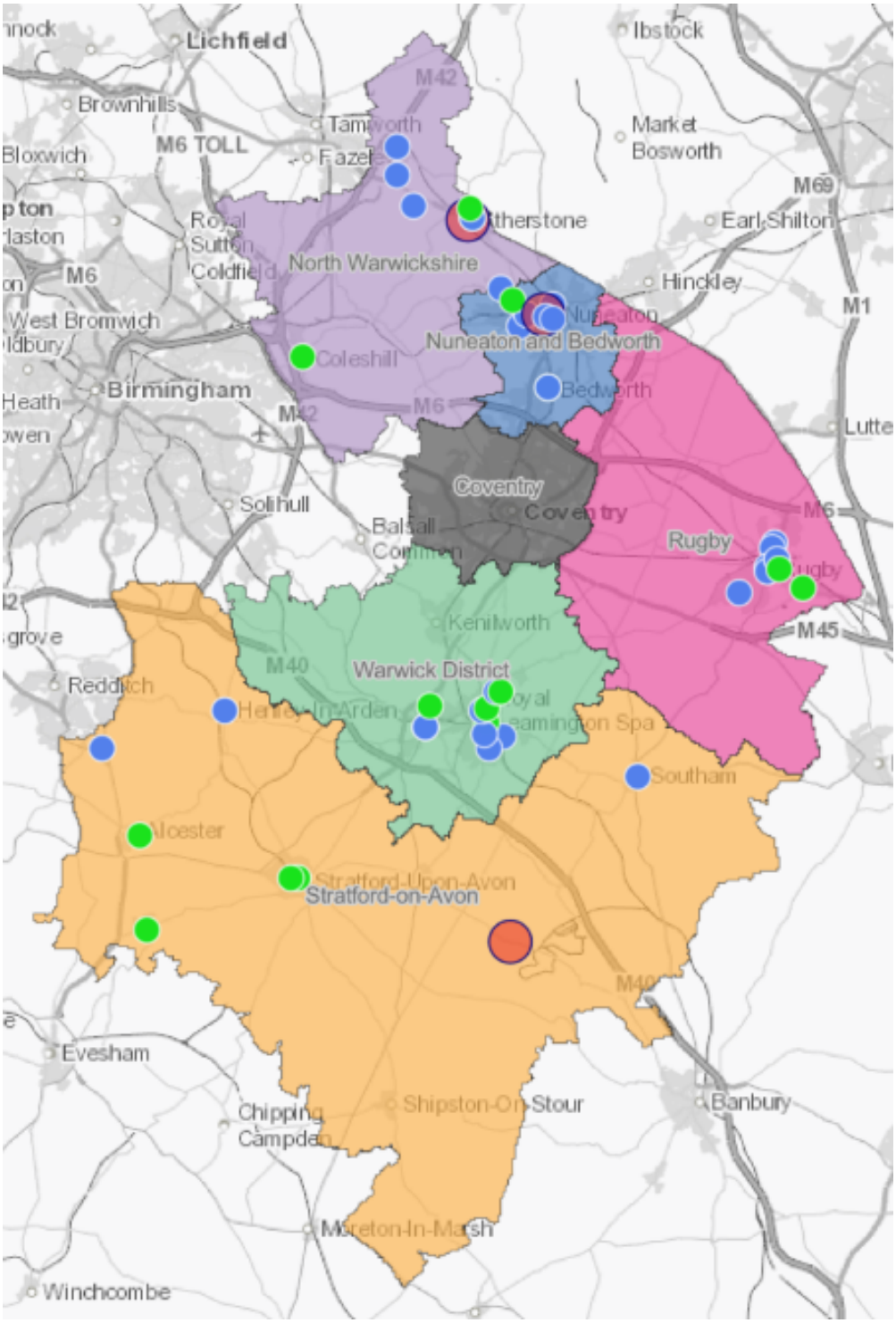


Figure 41: Pharmacies who provide Needle Exchange, Supervised Consumption, or Both in Warwickshire
Source: Pharmoutcomes

It should be noted that non-pharmacy providers throughout Warwickshire provide Substance Misuse services that include supervised consumption and needle exchange. Any planned increases in service provision should therefore take these providers into account.

Conclusion for Substance Misuse services

To achieve the national ambition outlined in the Drug Strategy 2021, more work will be required to improve the quality of services and expand the number of providers delivering supervised consumption and needle exchange programmes in Warwickshire. More work is required to map out the current provision to ensure there is fair and equitable provision countywide. Adequate provision will need to be sought in the more deprived areas and those with higher drug and alcohol prevalence. Individuals within these areas are more likely to have a range of health inequalities and poorer health outcomes.

Smoking Cessation

WCC commission community stop smoking service ‘Quit 4 Good’. Smokers can receive support to quit smoking via the GP, pharmacy or virtual offer from Everyone Health. Pharmacies providing this service can be found online - https://quit4good.warwickshire.gov.uk/

Coventry City Council commission Healthy Lifestyle Service to deliver a range of lifestyle interventions, including smoking cessation. Smokers can receive free one to one support over 12 weeks with a qualified health coach through the Healthy Lifestyle Service, as well as via their GP or local pharmacy. Information for Healthy Lifestyle Service can be found online: https://hlscoventry.org/our-services/stop-smoking/

The Stop Smoking Service is one where pharmacies provide support and advice to people who want to give up smoking. The delivery for the service helps reduce levels of smoking-related illness, disability, premature death, and health inequality.

The aims of the service are:

- Support the development of stop smoking services outside of GP surgeries.
- Enable supply of nicotine replacement therapies by appropriately trained non-physician health care professionals.

- Enable non-health care professionals who are offering intensive support to smokers to access nicotine replacement therapy as part of the support package.

In Coventry and Warwickshire, a total of 73 pharmacies provide the smoking cessation service.

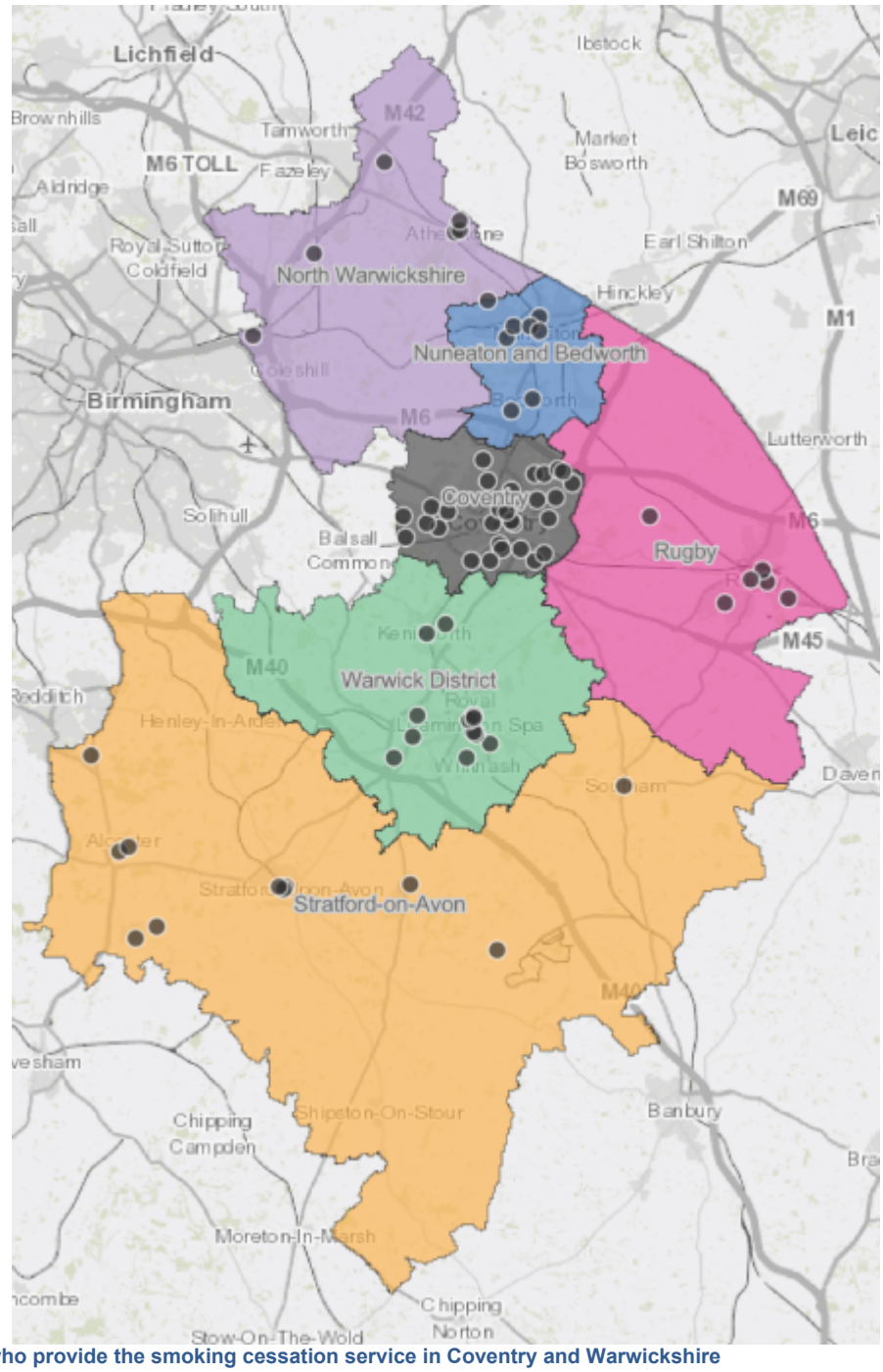


Figure 42: Pharmacies who provide the smoking cessation service in Coventry and Warwickshire
Source: Coventry City Council and Warwickshire County Council

Whilst 73 pharmacies are registered to provide the service, actual activity is an issue with many of the pharmacies.

In Warwickshire, under the contract for this service pharmacies are required to have 6 patients per year who set a quit date. An audit of services carried out showed that numbers are well below this figure for most pharmacies, and some have no activity at all.

In Coventry, there has been a significant drop in the amount of quits that pharmacies reported from 702 in 2019/20 to 261 in 2021/22. There isn't a minimum number of patients in order for the pharmacy to offer the service. Instead, the focus is insuring a good geographic spread of pharmacies including coverage within the more deprived neighbourhoods.

Conclusion for Stop Smoking Service

Partnership work needs to be done between Commissioners of SSS/SSiP services and pharmacies to identify the actions to increase activity across those pharmacies where behavioural support and prescribing is low, with a particular focus on areas of greatest need. Consideration should be given to the role of pharmacies within the NHS long term plan tobacco dependency commitment to deliver NHS funded tobacco dependence treatment services which includes inpatient, maternity, outpatients, and community settings.

Stop Smoking in Pregnancy Service (SSiPS)

Currently, all pregnant women from the booking appointment from all 3 trusts across Coventry and Warwickshire are referred to the Stop Smoking in Pregnancy Service.

In Warwickshire this service is commissioned by WCC and provided by SWFT. In Warwickshire, a specialist team of experienced stop smoking in pregnancy advisors provide a friendly, confidential service to help pregnant smokers and their families stop smoking. If nicotine replacement therapy is required the advisor completes a letter of recommendation which needs to be redeemed and dispensed from pharmacies. It is the same pharmacies involved in the smoking cessation service who are able to dispense NRT products. It should be noted that not all pharmacies take part in this service; a patient may visit a pharmacy to redeem their voucher to be told the pharmacy does not participate in the scheme. To access the service in Warwickshire https://quit4good.warwickshire.gov.uk/quit4baby

Similar to Warwickshire, in Coventry the SSiPS is commissioned as part of the Family Health and Lifestyles Service and sits separately to the Healthy Lifestyle Service. It has been highlighted that more promotion can be done to enable more pharmacies to dispense NRT products to pregnant women.

Conclusion for Stop Smoking in Pregnancy (SSiPS)

Within Coventry and Warwickshire work can be done to strengthen the pathways around the service, especially to encourage pharmacists to redeem and dispense the letters of recommendation. The SSiPS is commissioned separately to the generic Stop Smoking service, more promotion can be done between these 2 services to increase the number of pharmacies able to dispense NRT products to pregnant women.

Sexual Health Services

Community Pharmacy sexual health services in Coventry and Warwickshire are designed to improve access to key treatments including emergency hormonal contraception (“the morning after pill”). Providers of sexual health services also encourage clients to access mainstream contraceptive services and provide education on available contraception and the prevalence of sexually transmitted diseases.

At present, pharmacies in Warwickshire are not testing or treating for STIs. Pharmacies are signposting to the Integrated Sexual Health Service (ISHS) website where users can order a testing kit for Chlamydia online.

Coventry pharmacies do offer chlamydia testing as well as C-Card (condom distribution).

Supply of emergency hormonal contraception (EHC)

The service allows a client of any age to choose to attend an accredited Warwickshire pharmacy (operating within the parameters of a service level agreement and a current EHC PGD) to obtain EHC. Client privacy is of utmost importance, and the selection of each pharmacy will have been based on the assurance that they use approved private counselling area that complies with the requirements for provision of Advance services under the National Pharmacy Contractual Framework.

In Coventry and Warwickshire, a total of 82 pharmacies provide sexual health services.

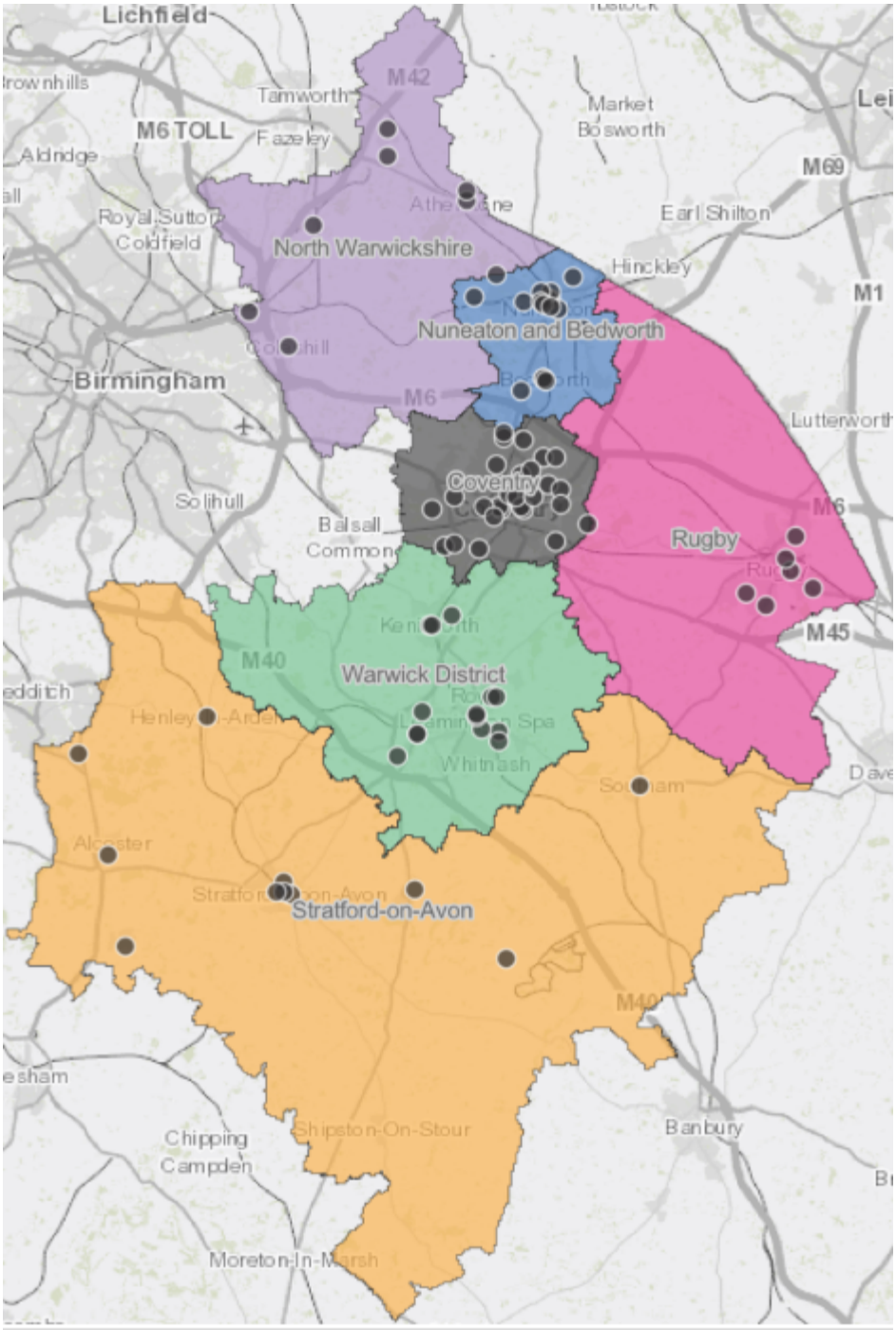


Figure 43: Pharmacies who provide the sexual health service in Coventry and Warwickshire
Source: Coventry City Council and Warwickshire County Council

During periods of 2020, some pharmacies stopped undertaking the EHC consultation and dispensing functions due to capacity of pharmacists, but also as the requirements include the need for private consultations in rooms away from the main shop area. A number of those were not available due to the lack of ventilation, or the spaces being too small to fall in line

with the 2m regulations. From 2021 onwards, the majority of the pharmacies signed up to undertake this work have reverted back to pre-pandemic activity levels.

Both Coventry and Warwickshire Integrated Sexual Health services are being renewed from 1st April 2024; it is hoped (going through final governance process) that there will be one contract awarded to cover the whole area, this will help to ensure the offer is the same across the two areas and reduce the current confusion on what is available and to whom.

It is fair to say that pharmacies should be playing an important part of the recommissioned service. Some of the key principles which the recommissioning will embed include reducing health inequalities and focussing on ongoing service improvement.

Conclusion for Sexual Health Services

Local data shows that some Coventry residents are accessing EHC in Warwickshire, this could be as Warwickshire doesn't have an upper age limit whereas Coventry does. Bringing the Integrated Sexual Health contracts together to one contract will enable the current pharmacy offers to be aligned, this will help to reduce service user confusion as to what is offered where and to whom.

End of Life (EoL) Medicines

Community pharmacies provide advice and stock an agreed list of medicines commonly used in palliative care for patients nearing the end of their life. Pharmacies are a convenient access point for these medicines throughout Coventry and Warwickshire. There are 4 community pharmacies in Coventry and 7 community pharmacies in Warwickshire who are currently commissioned to provide this service, and therefore guarantee to hold the stock of medicines. All pharmacies can order these medicines, although they are not guaranteed to have stock. The demand of these medicines may be urgent and/or unpredictable, the pharmacy contractor will therefore:

- Stock a locally agreed range of specialist medicines and make a commitment to ensure prompt access to these medicines at all times agreed with the CCG.
- Provide information and advice to the user, carer, and clinician. They may also refer to specialist centres, support groups or other health and social care professionals where appropriate.

This service is currently due to run until 31st March 2023.

Conclusion for End of Life Medicines Services

Pharmacies provide a convenient access to these medicines throughout Coventry and Warwickshire. No gaps have been identified in this service from the information available.

Sharps Disposal

The Sharps Disposal service currently collects any size of sharps container once per month. This will soon be moving to an on-request service where pharmacies contact the service when they need a collection.

This service only operates in Warwick District at the following pharmacies:

Birk and Nagra, CV31 1NL	Birk and Nagra, CV31 3AG	Birk and Nagra, CV31 2BB
Birk and Nagra, CV31 2DT	Birk and Nagra, CV31 2LY	Birk and Nagra, CV32 6DS
Birk and Nagra, CV34 6DZ	Boots Local, CV8 1JP	Boots the Chemist, CV34 4DH
Boots the Chemist, CV34 6RH	Mellors Pharmacy, CV34 4SA	Dudley Taylor Pharmacy, CV8 1JD
Ivens Dispensing Chemist, CV31 3BH	Leyes Lane Pharmacy, CV8 2DE	Lillington Pharmacy, CV32 7AG
Lloyds Pharmacy, CV32 7SH	Lloyds Pharmacy, CV32 4PN	Stratwicks Pharmacy, CV34 5RN

Conclusion for Sharps Disposal

There are different sharps service collections in place which can be unclear to both the public and pharmacies, such as the service provided by PHS which also collects sharps. Because of this, the quantity of sharps collected by this service has been minimal. To help with this the following opportunities have been identified:

- Provide clarification on the different services to clear up confusion for pharmacies and patients, including over the size of sharps containers accepted with the different services.

- Provide better communication between pharmacies who provide a sharps disposal service and GPs so better signposting can be done.

Warwick District Council is open to additional pharmacies becoming sharps return points so that they can expand the service offered to residents to return sharps.

HIV POC Testing

The HIV Point of Care Testing service in Coventry aims to increase the number of HIV tests taken in Coventry, especially in at-risk groups such as the black African population and Men who have Sex with Men (MSM). Pharmacy involvement means patients can access this service who may not have otherwise accessed it.

Pharmacies use the INSTI HIV-1/HIV-2 Antibody Point of Care blood spot Test (POCT) to screen for HIV antibodies. If a result is positive, patients must attend the Integrated Sexual Health Service for another blood test to have their HIV diagnosis confirmed.

There are 4 pharmacies in Coventry who provide the HIV POC Testing service. No gaps in this service have been identified.

Phlebotomy

Phlebotomy services are blood tests or blood taking. A prescriber such as a nurse or GP can issue a patient with a request to have bloods taken, and for convenience and speed this can now be done at a local pharmacy, avoiding queues at hospitals and GP surgeries. The bloods are sent off for analysis and the results are sent back to the prescriber. This provides access to phlebotomy services at a wider range of times and venues to suit the local community.

There are 17 pharmacies in Coventry who provide the Phlebotomy service. No gaps in this service have been identified.

Emergency Department (ED) to CPCS Pilot Coventry and Rugby

The ED to CPCS is an extension of the CPCS Advanced Service and is running as a pilot from 1st November 2021 to 30th September 2022. There are 21 pharmacies in Coventry and 5 pharmacies in Rugby taking part, they are:

Coventry		
Acorn Chemist – CV3 3DP	Asda Pharmacy – CV2 2PN	Bannerbrook Pharmacy – CV4 9AE
Boots UK Ltd – CV3 6TA	Chemicare – CV6 2HT	Chemycare – CV2 2GG
Clay Lane Pharmacy – CV2 4LJ	General Wolfe Pharmacy – CV6 5HP	Hillfields Pharmacy – CV1 5JF
Humber Pharmacy – CV3 1AT	Imperiun Pharmacy – CV6 4HF	Jhoots Pharmacy – CV6 1HQ
Jhoots Pharmacy Torcross – CV2 3NE	Lloyds Pharmacy – CV1 4FS	Lloyds Pharmacy Sainsburys – CV6 7NS
M Hussain Chemist – CV1 5AE	Mount Nod Pharmacy – CV5 7NJ	Styvechale Pharmacy – CV3 6FQ
Superdrug – CV1 1LF	Superdrug – CV1 1DL	Village Pharmacy – CV7 8JX
Rugby		
Lloyds Pharmacy in Sainsburys – CV22 6HU	Lloyds Pharmacy – CV21 3AQ	Paddox Pharmacy – CV22 5BP
Well Rugby Health & Wellbeing Centre – CV21 3HX	Rowlands – CV21 2AS	

In this service pharmacies will receive referrals to the NHS CPCS from the identified additional Urgent and Emergency Care (UEC) settings in the pilot areas, for Coventry this being University Hospital Coventry and Warwickshire (UHCW) and for Warwickshire this being the Urgent Treatment Centre (UTC) at the Hospital of St Cross.

Once the referral has been received by the pharmacy it will be actioned in the same way as referrals made in the CPCS Advanced Service. This will allow patients with low acuity minor illnesses and requests for urgent repeat medication supplies to be referred to the community pharmacies in the trial.

Conclusion for ED to CPCS Pilot

There will be further decisions made depending on the outcomes of the pilot during the evaluation.

NHS England Extended Care Service

The Community Pharmacy Extended Care Service is provided in 2 Tiers, and aims to provide eligible patients who are registered with a GP contracted to NHS England & Improvement Midlands Region with access to support for the treatment of the following:

Tier 1:

- Treatment of simple Urinary Tract Infections (UTI) in females (aged 16-years up to 65-years of age)
- Treatment of Acute Bacterial Conjunctivitis (for children aged 3-months to 2-years)

Tier 2:

- Treatment of Impetigo
- Treatment of Infected Insect Bites
- Treatment of Infected Eczema

The overall aims of the service are to:

- Educate patients to seek advice and treatment from the most appropriate healthcare setting
- Improve patient's access to advice and appropriate treatment for these ailments via community pharmacy
- Reduce GP workload for these ailments allowing greater focus on more complex and urgent medical conditions
- Educate patients with aim of reducing requests for inappropriate supplies of antibiotics
- Promote the role of the pharmacist and self-care
- Improve working relationships between doctors and pharmacists

50 pharmacies in Coventry and 61 pharmacies in Warwickshire currently provide UTI treatment under Tier 1 and 44 pharmacies in Coventry and 58 pharmacies in Warwickshire currently provide Acute Bacterial Conjunctivitis treatment under Tier 1.

33 pharmacies in Coventry and 41 pharmacies in Warwickshire currently provide Tier 2 treatments.

Conclusion for Extended Care Services

No gaps in this service have been identified from the information available.

CONCLUSION

COVENTRY

The PNA tells us that even though coverage of community pharmacies is adequate for our needs, all community pharmacy services could be more effectively integrated into local pathways to ensure maximum benefits for population level health and wellbeing. The pathway into community pharmacy should be clear and well communicated, allowing community pharmacies the opportunity to deliver appropriate services. Community Pharmacies can offer a suite of services commissioned locally and nationally. The direction of travel for service delivery through community pharmacies requires integration in terms of pathway design and infrastructure and for community pharmacies to be recognised as a member of the multi-disciplinary team along with other service providers in primary care.

As many community pharmacies are often located in deprived areas with high population density, they are an important first point of contact for patients seeking ad-hoc health advice alongside picking up regular prescribed medicines or purchasing over the counter medicines. It is important for pharmacies to continue to deliver healthy lifestyle campaigns to support the wider determinants of health, increasing awareness of local and national programmes which could positively impact the community's health and wellbeing.

There are many opportunities where community pharmacies can support all workstreams of the evolving ICS and improve health, wellbeing and reducing health inequalities. Key opportunities for the ICS exist around making the most of existing commissioned services (essential, advanced and locally commissioned services) particularly in relation to medicines optimisation.

There is capacity for community pharmacy to address local priorities described in the JSNA and forthcoming ICS strategy. Community pharmacies have close links with their communities and are therefore well placed to support CHWB to deliver their priorities.

Local commissioning organisations should continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care. Any commissioning of services or initiatives in community pharmacies should be informed by the evidence base and evaluated locally ideally using an evaluation framework that is planned before implementation.

Pressures on community pharmacies have increased due to the COVID-19 pandemic, and this pressure may increase over the next few years due to the cost-of-living crisis. This should

be carefully monitored to understand how this may change community pharmacy provision, and provide support should that be needed.

There is good access for community pharmacies in Coventry, with 51 of the 97 pharmacies in Coventry being open on a Saturday and the majority of pharmacies being within a 5 minute drive, and all pharmacies within a 15 minute drive. There is opportunity to do more joined up work when it comes to signposting, both into community pharmacies (providing clear information on opening times and services offered) and out of pharmacies (best pathways for care).

It is important to emphasis prevention, early intervention, and early help to protect and maintain people's health and independence. The Coventry Health and Wellbeing Board consider community pharmacies to be a key health and wellbeing resource and recognise that they offer potential opportunities to support health improvement initiatives and work closely with partners to promote health and wellbeing.

The public engagement process revealed a high level of satisfaction on the part of respondents.

WARWICKSHIRE

Whilst the PNA concludes that there is an adequate provision of pharmaceutical services in Warwickshire to serve the needs of the population, there is an opportunity to encourage community pharmacies to be part of service pathways. The pathway into community pharmacy should be clear and well communicated, allowing community pharmacies the opportunity to deliver appropriate services. Community Pharmacies can offer a suite of services commissioned locally and nationally. The direction of travel for service delivery through community pharmacies requires integration in terms of pathway design and infrastructure and for community pharmacies to be recognised as a member of the multi-disciplinary team along with other service providers in primary care.

Community pharmacies can serve as an important first point of contact for people seeking health advice as well as collecting prescriptions and buying over the counter medication. Many pharmacies can be found in high density, deprived areas and have important links out into the communities they serve. It is important for pharmacies to continue to deliver healthy lifestyle campaigns to support the wider determinants of health, increasing awareness of local and national programmes which could positively impact the community's health and wellbeing.

Local commissioning organisations should therefore continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care.

Pressures on community pharmacies have increased due to the COVID-19 pandemic, and this pressure may increase over the next few years due to the cost-of-living crisis. This should be carefully monitored to understand how this may change community pharmacy provision and provide support should that be needed.

There is good access for community pharmacies in Warwickshire, with 86 of the 106 pharmacies in the county being open on a Saturday and almost the entirety of the county being with a 15-minute drive of a pharmacy. There is opportunity to do more joined up work when it comes to signposting, both into community pharmacies (providing clear information on opening times and services offered) and out of pharmacies (such as best pathways for care).

The changing population needs for healthcare and in particular the demands of an increasing ageing population with multiple long-term conditions mean there are some significant challenges to overcome in the drive to improve health and well-being in Warwickshire. To meet these challenges, there will need to be a much greater emphasis on prevention, early

intervention, and early help to protect and maintain people's health and independence. The Warwickshire Health and Wellbeing Board consider community pharmacies to be a key health and wellbeing resource and recognise that they offer potential opportunities to support health improvement initiatives and work closely with partners to promote health and wellbeing.

There are opportunities to develop the contribution of community pharmacies across all the currently commissioned services. Any commissioning of services or initiatives in community pharmacies should be informed by the evidence base and evaluated locally ideally using an evaluation framework that is planned before implementation.

There is capacity for community pharmacy to address local priorities described in the JSNA and evolving ICS. Community pharmacies have close links with their communities and are therefore well placed to support WHWB to deliver these priorities.

The public engagement process revealed a high level of satisfaction on the part of respondents, with particular praise for the part they played in the COVID-19 pandemic.

APPENDICIES

APPENDIX 1 - PHARMACY SURVEY

Out of 197 pharmacies, 161 responses to the Pharmacy Professionals survey were received. Of these, Coventry had 76 responses (47%) and Warwickshire had 85 responses (53%).

Table 17: Number of responses to the Pharmacy Professionals Survey by District / Borough

District / Borough	Number of Responses
Coventry	76
North Warwickshire	13
Nuneaton & Bedworth	22
Rugby	13
Stratford-on-Avon	15
Warwick	22

Table 17: Number of responses to the pharmacy professionals survey by district/borough

Of the 161 pharmacies who responded to the survey, 159 had consultation rooms (98%), with the remaining being distance selling pharmacies. There were hand washing facilities at 142 of the pharmacies (88%), and toilet facilities at 54 pharmacies (34%).

Offsite consultations were available at 75 pharmacies (47%)

Almost all pharmacies dispensed appliances (159, 98%).

The number of pharmacies providing advanced services is shown in figure 44.

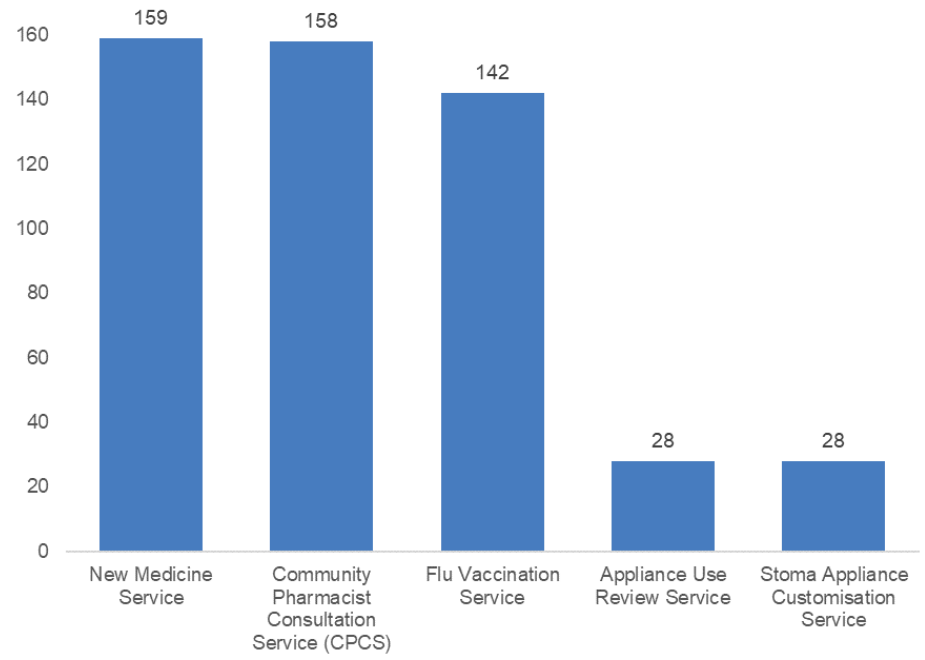


Figure 44: Number of pharmacies providing advanced services

A list of other services provided by pharmacies are shown in Table 18. Pharmacies were able to select more than one option for each service. The home delivery service was the most commonly provided service (97 pharmacies), along with supervised administration service (93 pharmacies) and emergency supply service. There were a number of services provided by fewer than 5 pharmacies, however for all of these, there were over 100 pharmacies who said they would provide the service if commissioned.

Service	Currently Providing	Would provide if commissioned	Would provide privately	Wouldn't provide if commissioned
Home Delivery Service (not appliances)	97	50	18	6
Supervised Administration Service	93	43	6	15
Emergency Supply Service	88	63	15	2
Emergency Contraceptive Service	78	70	18	4
NRT vouchers	78	69	18	7
Extended Care Tier 1 (UTI)	74	60	12	9
Sharps Disposal	68	70	18	12

Service				
Extended Care Tier 2 (Skin)	59	74	12	14
Stop Smoking Service	58	80	17	11
Medication Review Service	38	108	19	6
Needle and Syringe Exchange service	34	79	20	31
Extended Care Tier 3 (ENT)	22	103	20	16
Medicines Assessment and Compliance Support Service	20	109	21	16
Phlebotomy Service	20	90	20	34
Pharmacy First Minor Ailment scheme	19	126	19	3
Not Dispensed Scheme	18	111	18	13
Care Home Service	17	89	19	37
Contraceptive Service (not EHC)	15	129	21	7
Obesity Management (Adults and Children)	15	126	21	8
Chlamydia Testing Service	12	119	20	13
Chlamydia Treatment Service	12	122	21	10
Anti-viral Distribution Service	10	117	21	18
Language Access Service	10	101	21	29
Gluten Free Food Supply Service (not via FP10)	9	115	20	18
Healthy Start Vitamins	8	121	19	17
Out of Hours Service	5	88	16	48
Anticoagulant Monitoring Service	4	130	23	14
On Demand Availability of Specialist Drugs Service	4	111	19	27
Schools Service	4	103	20	33
Prescriber Support Service	2	114	43	25

Vascular Risk Assessment Service	1	131	21	13

Table 18: Number of Pharmacies providing other services

In terms of disease specific services, not many pharmacies were already providing these services, the highest being hypertension with 25 currently providing. However for each disease specific service, over 100 pharmacies would provide if commissioned (Figure 19).

Disease Specific Service	Currently Providing	Would provide if commissioned	Would provide privately	Wouldn't provide if commissioned
Hypertension	25	109	17	9
Allergies	12	118	23	11
Asthma	12	122	20	9
Diabetes Type 1	10	122	21	10
Diabetes Type 2	10	123	20	9
CHD	9	121	20	10
COPD	9	122	20	10
Depression	9	118	19	15
Epilepsy	8	119	19	14
Heart Failure	8	120	20	11
Parkinson's Disease	8	122	19	12
Alzheimer's / Dementia	7	121	19	13

Table 19: Number of Pharmacies providing Disease Specific Services

Similarly with screening services, there are not many pharmacies currently providing these services, however the majority would provide if commissioned (Table 20)

Screening Service	Currently Providing	Would provide if commissioned	Would provide privately	Wouldn't provide if commissioned
Diabetes	13	111	28	11
Cholesterol	5	117	26	15
HIV	3	104	23	26
Alcohol	2	116	23	18
HbA1C	2	115	23	20
Gonorrhoea	1	112	24	22
H. Pylori	1	115	23	22
Hepatitis	1	108	24	25

Table 20: Pharmacies providing Screening Services

In terms of vaccination services, the majority of pharmacies offer the seasonal influenza vaccine service (132) however only small numbers currently provide other vaccinations (Table 21)

Vaccination Service	Currently Providing	Would provide if commissioned	Would provide privately	Wouldn't provide if commissioned
Seasonal Influenza Vaccination service	132	16	19	8
Pneumococcal	22	94	28	22
COVID 19	16	104	24	24
Travel Vaccinations	10	99	39	20
Meningococcal	9	103	13	26
Hepatitis (at risk workers or patients)	8	99	33	26
HPV	7	95	33	27
Childhood vaccinations	3	99	28	33

Table 21: Pharmacies providing Vaccination Services

In terms of non-commissioned services, the majority of pharmacies offer collection of prescription from GP practices (137) as well as monitoring dosage systems free of charge on request (135), and many also provide delivery of dispensed medicines free of charge on request (105). For the delivery of dispensed medicines, it is worth noting that most of these pharmacies will deliver free of charge to elderly, vulnerable or housebound patients only (Table 2)

Vaccination Service	Currently Providing	Would provide if commissioned
Collection of prescription from GP practices	137	21
Monitoring Dosage Systems - free of charge on request	131	26
Delivery of dispensed medicines - free of charge on request	105	52
Delivery of dispensed medicines - with charge	65	78
Monitoring Dosage Systems - with charge	15	125

Table 22: Pharmacies providing Non-commissioned services

When asked if there is a particular need for a locally commissioned service in your area, the two most common responses are minor ailments service or community Pharmacy Consultation service (17) and also a Phlebotomy service (11).

APPENDIX 2 - PUBLIC SURVEY

Background

A Pharmacy Services User Survey was conducted across Coventry and Warwickshire in March 2022. The survey was conducted on-line with access to the survey promoted via posters in all community pharmacists. Users were asked to scan a QR Code which took the respondent to the survey hosted on Coventry City Council's Let's Talk platform.

1,601 responses were available for analysis. The response for each of the council areas is seen below:

Which area do you live in?		
	Sample Percent	Population Percent
Coventry	27%	39%
Warwick District	22%	15%
Stratford on Avon District	19%	14%
Rugby Borough	13%	12%
Nuneaton and Bedworth Borough	11%	14%
North Warwickshire Borough	7%	7%
Other	1%	

Table 23: Responses to the public survey by area

The sample under-represents Coventry and Nuneaton and Bedworth and over-represents Warwick and Stratford Districts.

Compared to the population the sample was also non-representative by

- 25–54-year-olds were under-represented
- Older age groups were over-represented
- Only 25% of the respondents were male
- BAME groups were under-represented with 91% in the whole sample being of White British origin.

Survey Contents

The survey asked a range of questions about respondents use of pharmacy services both in-store and online. For those who mostly visited a pharmacy store – access issues were discussed and for on-line users the benefits for them of this approach was examined.

Additionally, socio-demographic information about the respondent was recorded. This allows for an analysis of responses to questions about service use across age, employment status, ethnicity, disability status etc.

This report will examine the responses to the pharmacy use questions for the whole survey and identify variations from this by location, age, ethnicity etc where they occur.

Frequency of Use

On average how frequently do you use a pharmacy?	
	Percent
More than once per week	2%
Once per week	8%
Once or twice a month	39%
Once or twice every other month	41%
Once or twice per year	8%
I don't know	1%

Table 24: Answers to the question "On average how frequently do you use a pharmacy?"

- Respondents from Warwick District were more likely to attend once or twice every other month (51.6%)
- Employed people were more likely to visit 1 or 2 times per year
- Retired people were less likely to visit 1 or 2 times per year
- 25–54-year-olds were more likely to visit 1 or 2 times per year
- 75+ were less likely to visit 1 or 2 times per year
- People with disability were less likely to visit 1 or 2 times per year

Travel to Pharmacy

How would you normally travel to the pharmacy you usually use?	
	Percent
Car/Motorbike/Van	46.5%

Walk	42.0%
I have my medicines delivered	6.8%
Other	1.8%
Public Transport	1.8%
Cycle	1.1%

Table 25: Answers to the question "How would you normally travel to the pharmacy you usually use?"

- Fewer people walk in Stratford District
- Retired people were more likely to use a car
- People with disabilities were less likely to walk and more likely to use a mobility scooter

Distance travelled to Pharmacy

How long does it usually take you to travel to your pharmacy?	
	Percent
Between 15 and 30 minutes	19%
I have my medicines delivered	5%
Less than 15 minutes	74%
More than 30 minutes	1%

Table 26: Answers to the question "How long does it usually take you to travel to your pharmacy?"

- Respondents from Coventry were less likely to travel 15-30 minutes (10.5%)
- 25–54-year-olds were less likely to travel 15-30 minutes

Pattern of Use

What best describes your use of a pharmacy?	
	Percent
I use the same community pharmacy all of the time	60%
I use the same community pharmacy most of the time	29%
I use several different community pharmacies	8%
I use a combination of community pharmacies and online/internet pharmacies	3%
I use online/internet pharmacies all of the time	1%

Table 27: Answers to the question "What best describes your use of a pharmacy?"

- Employed respondents are more likely to use a range of pharmacies
- 25–54-year-olds are less likely to use the same pharmacy all of the time
- 75+ are more likely to use the same pharmacy

What do people use the Pharmacy for?

We gave respondents a range of pharmacy uses to choose from, and they could select as many as appropriate, hence the percentages add up to more than 100%.

For what reasons do you usually access a pharmacy?	%
To collect a prescription(s)	93%
To buy over the counter medicines (that do not need a prescription)	57%
To have a vaccination including flu booster/Covid vaccines	25%
To buy over-the-counter medical devices and other health-related products e.g plasters, bandages etc.	28%
To get advice and information on medication	31%
To get advice and information on healthy lifestyles and disease prevention	3%
To get Covid related advice/information	3%
To access a NHS or public health service	6%
Other	6%

Table 28: Answers to the question "For what reasons do you usually access a pharmacy?"

- Rugby respondents were more likely to buy over-the-counter medical devices and other health-related products e.g., plasters, bandages etc.
- Coventry respondents were more likely to access an NHS or public health service
- Others noted were mostly Blood Tests which wasn't offered as an option in the survey

Most important services

Respondents were asked to choose their top 3 services most important to them.

When thinking about your pharmacy, what is most important to you?

	%
Efficient and quick service	74%
Location of pharmacy	45%
Friendly staff	43%
Know and trust the Pharmacist/Team	32%
Late opening hours	24%
Pharmacist takes time to listen and talk to me	19%
Services available	13%
Availability of urgent advice	10%
Home delivery of medication	9%
Other (please specify)	3%
Multiple languages spoken	0%

Table 29: Answers to the question "When thinking about your pharmacy, what is most important to you?"

- Respondents from Coventry were more likely to value late opening
- Respondents from Stratford District were less likely to value late opening
- Employed people value late opening
- Retired people were less likely to value late opening
- 75+ were less likely to value late opening
- 75+ were more likely to value home delivery
- Disabled respondents were more likely to value home delivery

Use of Services

Respondents were asked to identify from a list of services those they are aware of, those which they have used and which they may be interested in using in the future?

	I am aware of this service but have not used it	I have used this service	I am not aware of this service but I would be interested in using this service in the future
Disposal of old medicines	40%	47%	11%
Discuss your prescription medicines	38%	48%	10%
New prescription medicines	31%	39%	22%
Use of medical devices e.g. blood pressure monitor	51%	11%	30%
Emergency supply of medication	38%	21%	34%

Advice on healthy living	60%	5%	24%
Stopping smoking advice	75%	3%	8%
Sexual health services	68%	2%	14%
Blood tests	31%	18%	42%
Vaccinations including flu/Covid	46%	38%	10%
Travel vaccines	52%	6%	30%
Health tests e.g. cholesterol, blood pressure check	46%	7%	37%

Table 30: Percentages of people aware of certain services

- Stratford-based respondents were more likely (18%) to have not been aware of the service to discuss prescription medications but would be interested in doing this in future
- Warwick-based respondents were more likely (41%) to be aware but not used blood test services
- 25–54-year-olds were less likely to have used medicines disposal but more likely to think they might use the service
- 25–54-year-olds were less likely to be interested in smoking cessation advice
- Asian/Asian British were more likely to not be aware of medicines disposal services but would be interested in using this service in the future
- Male respondents were less likely to have used the sexual health services but more likely to have used health tests

Opening Hours

When would be the most convenient time for you to visit a pharmacy?				
	Before 9am	Between 9am and 1pm	Between 1pm and 6pm	After 6pm
Monday to Friday	9%	61%	48%	28%
Saturday	3%	75%	36%	4%
Sunday	2%	43%	24%	3%

Table 31: Answers to the question "When would be the most convenient time for you to visit a pharmacy?"

Are you able to access a pharmacy at times that are convenient to you?	
	Percent
Most of the time	47%

Yes always	39%
Sometimes	11%
Never	2%

Table 32: Answers to the question "Are you able to access a pharmacy at times that are convenient to you?"

- Employed respondents were more likely to cite opening hours as an access barrier, more likely to prefer Mon-Fri opening before 9am, less likely to prefer 9-1pm, less likely to agree that opening hours are always convenient for them favouring only sometimes
- Retired respondents were less likely to cite opening hours as an access barrier, less likely to prefer Mon-Fri opening before 9am, more likely to prefer 9-1pm, and more likely to find opening hours always convenient for them
- 25–54-year-olds face some access issues due to opening hours, are less likely to agree that opening hours are always convenient for them favouring only sometimes and use online services because of later opening hours
- 75+ are more likely to say opening hours are fine and more likely to find opening hours always convenient for them

Use of Online/Internet Pharmacy Services

Have you used or accessed online/internet pharmacy services?	
	Percent
No	80%
Yes	17%
Not sure	3%

Table 33: Answers to the question "Have you used or accessed online/internet pharmacy services?"

Why do/did you chose to use online/internet pharmacy services?	
	% of those who use Online
Home delivery of medication	51%
Efficient and quick service	48%
Services available	19%

Other (please specify)	18%
Late opening hours	8%
Availability of urgent advice	5%
Knowledge	5%

Table 34: Answers to the question "Why do/did you chose to use online/internet pharmacy services?"

- 25–54-year-olds were more likely to use online services because of later opening hours

Communication of advice

The advice was well communicated to you (e.g. spoken, written down)	
	Percent
Definitely agree	55%
Somewhat agree	18%
Neither agree nor disagree	9%
Somewhat disagree	3%
Definitely disagree	2%

Table 35: Answers to the question "The advice was well communicated to you (e.g. spoken, written down)

Did the advice offered meet your expectations?

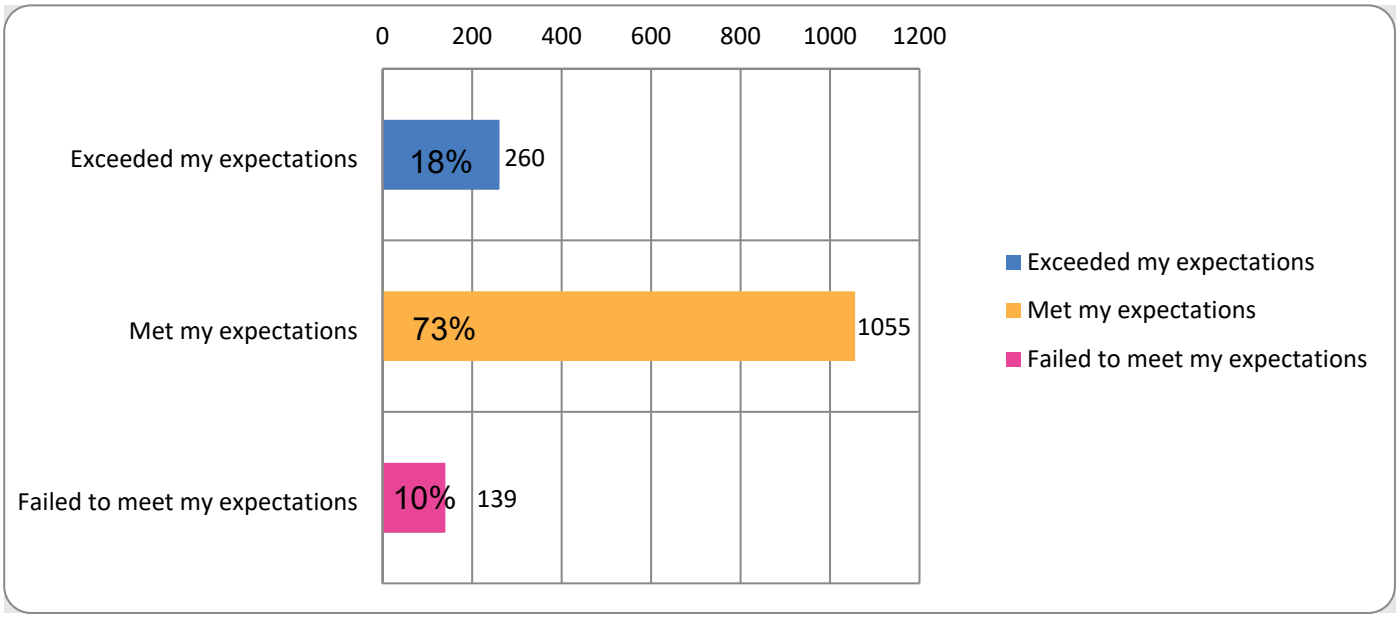


Figure 45: Answers to the question "Did the advice offered meet your needs?"

In total, 90% of respondents felt the advice they received from their Pharmacy met or exceeded their expectations.

APPENDIX 3 – PUBLIC SURVEY QUESTION FEEDBACK

Introduction

The final open ended question of the pharmacy needs assessment survey recorded 564 comments. Using Nvivo software, comments were coded and themed and are presented below. They reflect a mixture of positive, negative, and more neutral statements or suggestions made by participants. Sentiment analysis using Nvivo indicated there was a broadly similar number of comments coded as 'positive' to those coded 'negative'.

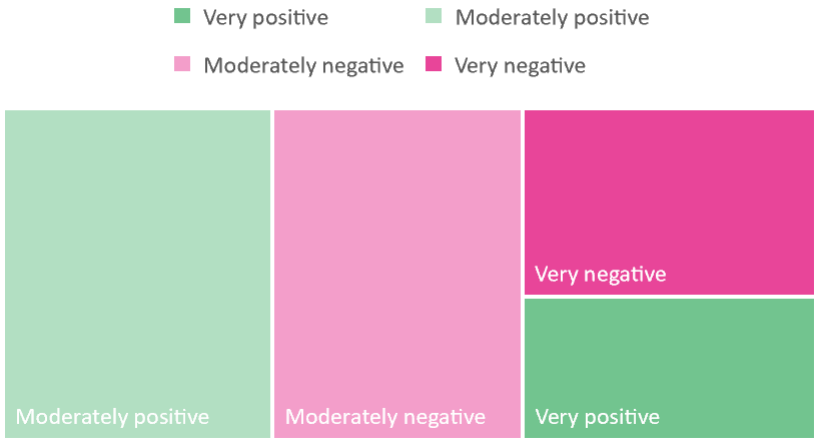


Figure 46: Sentiment analysis (using Nvivo) 'Is there anything else you want to tell us about your recent experience of using pharmacies

Summary

In general, the things people liked and valued about their local pharmacy included;

- Good customer service – friendly and knowledgeable staff – for some this included the time to get to know customers and their needs and continuity of staff.
- Efficiency in handling prescriptions (including repeat prescription systems) was appreciated. Respondents liked systems that were streamlined and worked around their different needs e.g., prescriptions being ready to collect or a reliable delivery service if that wanted that. Easy to use repeat prescription arrangements were also valued.
- Pharmacists were for some viewed as a positive alternative to making GP appointments. They were valued for their knowledge relating to medication queries and wider health issues.
- The availability of other services like blood tests and vaccines was also helpful to some respondents.

On the flipside, it was largely when the above didn't happen that respondents raised concerns about the service of their local pharmacy. These typically were as follows;

- Prescription handling problems – these included issues at all stages of the prescription journey from ordering repeats to collection/delivery. A frequent concern was that prescriptions were not ready for collection or had items out of stock. This caused long waits or necessitated return visits to complete the prescription which respondents found frustrating.
- There seemed considerable variation in the way prescriptions, including repeats, were handled (e.g., some notified 'prescription ready' others did not, some delivered others did not). It was not always clear people were using, or aware of, the method that would best suit their needs.
- Experiencing staff as rude, dismissive, or feeling like an inconvenience to them.
- Opening times did not always meet customer needs. Respondents sometimes found routine (e.g., lunchtime) and random closures (due to staff shortages) frustrating.
- Respondents observed how busy some of their local pharmacies were and felt there was a lack of capacity in some areas where demand from the local population had increased. Access to the pharmacist was not always possible.
- Respondents sometimes reported that when they sought additional health advice as per NHS recommended pathway to self-care, staff including pharmacists were unwilling to offer advice preferring instead to refer to GP services.

The following table provides more detailed information about the comments made in relation to this question including identified themes and sample quotations for illustration.

Theme	Explanation	Examples for illustration
Generic positive experiences	There were many positive comments relating to the general experience of pharmacies. People liked; • Friendly, knowledgeable staff. • The local nature of a pharmacy was helpful to some as was staff who knew them and their health. • Continuity of staff mattered to some respondents. • Advice about medication and wider health issues was welcomed and sometimes seen as an alternative to seeking a GP appointment. • Efficiency in prescription handling including ready for collection and notification that it was ready e.g., text was valued.	*"Fantastic, really friendly knowledgeable staff, I get reminders for reordering my prescriptions and notifications that they are ready to collect. When I have a new medicine prescribed the member of staff double checks with me that I understand the dosage and that the Dr has explained the reason for the new/ changed medicine. They are 1st class"* *"As a disabled person, with numerous health issues, my local pharmacy is literally a life line"*

	• Good communication with GP was appreciated Some of the above are expanded in the themes set out below.	*"Excellent Customer Service and Satisfaction Over a Good Number of Years."* *"Extremely helpful and easier and quicker to access than making a GP appointment."* *"Friendly, knowledgeable and is a quick alternative to a GP* *I am very happy with my pharmacist & team."* *"I prefer to go to the local pharmacy, as it is more personal than a large city-centre chain store, and it is near where I live. I really value the local service"* *"I receive a very efficient and helpful service from my local pharmacy."*
Prescription handling issues	Issues identified by respondents about how the pharmacy handles prescriptions, included: • The length of time between ordering medicines and prescription being available – some respondents reported increases in more recent months • A key issue was prescriptions not ready for collection leading to long queues or necessitating return visits to the pharmacy. • Items not stocked or missing – return visits required. • Wrong items/out of date medication. • System for finding prescriptions disorganised.	*"It can take up to 7 days from the time the pharmacy receives the script to being able to collect medication"* *"Always have to wait for the prescription to be filled even when ordered 5 days before"* *"Doesn't matter how far in advance you order medications they are never ready when you go to collect"* *"Long queues outside chemist ,lack of supplies a big issue repeat*

	• Respondents liked measures that saved them time e.g., prescription ready notifications, good communication between GPs and pharmacies, delivery services if desired. • Communication issues between GP and pharmacy (see repeat prescription theme).	*prescriptions so we have to go back several times to collect"* *"Don't always have the tablets in stock"* *"Seem to take ages finding my prescriptions (which had been sent directly to them from the GP) have a muddled system to find things"*
Repeat prescription process	There appeared to be a range of ways in which respondents and pharmacies dealt with repeat prescriptions e.g., through the GP, a pharmacy or 'pharmacy to my door' arrangements. There were also different methods to arrange these e.g., online/telephone/automated. Some pharmacies delivered while some did not. There was a sense some respondents didn't always know if there were alternatives to their current arrangements that might work better for them (e.g., a delivery service) Both positive and negative comments were made; • As above, respondents valued more streamlined processes where the system worked on time and without errors. • Communication differences between GP and pharmacy were highlighted but good communication was appreciated. • Problems with the POD service were also noted by some respondents.	*"I get reminders for reordering my prescriptions and notifications that they are ready to collect."* *"I really appreciate my pharmacy's arrangement for ordering repeat prescriptions online and then having them delivered within 1 or 2 days."* *"I prefer to get prescriptions delivered to my home and like this service. I would like my GP surgery to allow prescription reordering online (and more communication generally by email. Phones aren't accessible for everyone)."* *"Pharmacy used to reorder prescription when needed, now have to spend 30 mins + phoning pod every month totally pointless system."* *"Endless problems between pharmacy and GP regarding repeat prescriptions, each*

		accusing the other of failures." *"Contradictory advise about prescriptions and when they can be on repeat and collected"*
Staff capacity	Some respondents reported how busy their pharmacy always seemed to be • Understaffing especially at busy times resulting in long queues. • Difficult to 'pop in' in to pharmacy if time was limited – ended up in repeat visits. • Some noted increases in this more recently and linked it to housing growth in the area. • Impromptu or random pharmacy closure due to staff shortages including pharmacist. • Unable to dispense if pharmacist is not present (e.g., lunch or absent). • Access to confidential space was sometimes compromised. Respondents reported being less confident to ask for pharmacy advice in busy periods.	*"Queues seem longer these days"* *"My chemist is always very busy. For an area like Earlsdon it is not enough."* *"The Boots chemist in Shipston on Stour is inadequate in its size to support the present population and will only get worse as the population grows."* *"have noticed they have got much busier over the last few years due to increase of new estates in the area"* *"Very understaffed with long wait times. Have to visit in lunch hour so sometimes takes my whole lunch break"* *"Recently been closed for time during day or all day as not enough staff"* *"Pharmacist leaves the premises and staff are unable to give out prescriptions or sell things like lem sip"* *"My pharmacy is usually very busy which can make it feel uncomfortable to ask*

		for any additional time from the staff (with questions or for advice) as they are clearly under a lot of pressure"
Routine opening times	Respondents reported issues relating to accessing services outside of standard week-day opening: • Lack of week-end or 'out of hours' services locally • Routine lunchtime/weekday closure was inconvenient for some respondents	*"My usual and nearest pharmacy is not open at weekends."* *"Closest pharmacy closed on a Saturday and had to get prescriptions resent to another pharmacy for collection"* *"Only issue is limited weekend and no late night access."* *"My local pharmacy closes for lunch every day - this can sometimes be inconvenient and results in a second journey."* *"My local Lloyds pharmacy has limited opening hours so I travel into town to collect my prescriptions from boots which is 3mile drive rather than a 5min walk."* *"The biggest issue for me is the convenience of being able to pick up prescriptions outside working hours."*
Customer service/staff attitudes/availability of pharmacist	These included both positive (as noted above) and negative experiences of staff in pharmacies; • Many respondents valued the friendly and efficient manner of the staff with which they had contact. • Continuity of staff was mentioned and/or time to get to know customers.	*"I am very happy with my pharmacist & team."* *"The team are lovely, helpful, efficient, caring and the service has always been absolutely brilliant."* *"Having a pharmacy that knows my family makes*

	• Respondents sometimes experienced staff as rude and/or unhelpful in some outlets. • Specifically, access to the pharmacist was valued but not always possible – they were sometimes either absent due to staffing issues or tended to remain behind the scenes. • Where the pharmacy had a dedicated phone line, this was not always staffed, and respondents reported issues getting through causing frustration with the service.	*things so much easier. They know our needs and I trust them."* *"I have confidence in the team at my local pharmacy and that is priceless"* *"Lacking in customer service skills at times."* *"I wish they were friendly like they used to be..."* *"Pharmacies near to me forget they are there to provide a services, customers seem to get in their way"* *"There appears to be no permanent pharmacist: the pharmacist changes from day to day."* . *"Closes randomly without notice due to lack of pharmacists. Do not answer phone."* *"Trying to ring the pharmacy to request my prescription delivery is frustrating. They rarely answer the phone and my husband a cancer patient has to walk up to the pharmacy to order our medication. I am disabled and find it difficult to go there."*
Medication and health advice offered in pharmacies	Respondents made several points relating to medication and health advice; • Valued dealing with medication queries including liaison with GP. • Medication review service	*"He has been very helpful and professional about my questions and requests for guidance"* *"Happy with my pharmacist*

	was helpful. • Useful and seen as an alternative to GP and trusted source of information and advice. However, respondents sometimes experienced an unwillingness of some pharmacists to give actual advice, or they lacked the time or were not visible to do this.	*especially regarding medication queries"* *"I use the pharmacy more than my GP as they are more approachable."* *"I was able to get immediate and effective advice from the Pharmacist at a time when there were no available appointments to see my GP"* *"Too often the advice is to go and see the doctor"* *"I understand pharmacists aren't doctors but they are usually very unwilling to offer any medical advice and seem to default to making a doctor's appointment. I get this hesitancy, but why offer advice when they are unwilling to give it."*
Additional services	Respondents highlighted several areas where they valued additional services or mentioned services they would like available; • Blood tests where available • Vaccine service especially flu and Covid • Sharps drop off Smoking cessation and weight management sessions	*"Blood test service is great"* *"I am disappointed that pharmacies do not offer a sharps drop off service"* *"I would like to see the service of blood tests and other vaccines"* *"More pharmacies should provide more NHS services like tests etc."* *"I had a flu jab at the local pharmacy for the first time a few months ago and it was so much more*

		convenient and easier to arrange than via a GP practice. I hadn't previously been aware of this service via a pharmacy" *"Pharmacy staff have been exceptionally helpful by setting up weekly 'weight loss' guidance & monitoring sessions."*
Access to a pharmacy	Several respondents noted difficulties getting to a pharmacy including: • Difficulties if you didn't have a car • Relying on public transport meant access was more limited • Car parking issues especially for older people or those with disabilities • Physical access to the shop e.g., for pushchairs • Access for hidden disabilities • Areas that were without a pharmacy despite sizable local population	*"It would be useful if I could walk to a pharmacy and not have to use public transport."* *"In my rural village the pharmacy is attached to the GP Surgery which is extremely convenient for all residents especially those who do not drive"* *"Because it is based by a surgery the same parking is used. Access is usually difficult. There is no alternative parking nearby."* *"There is no pharmacy at all in Weddington, or Horeston Grange or any of the multiple new housing estates on the east side of Nuneaton: That is shocking !"* *"Not friendly for pushchairs"* *"Complete lack of understanding re hidden disabilities and access needs"*

Young people	There were several comments both positive and negative which mentioned services for young people, particularly in relation to sexual health and emergency contraception	*"some young people have been turned away from the pharmacy or there is no one available to support the young person."* *"Botterills Pharmacy, Queens Road, Nuneaton - amazing with EHC for young people"* *"Emergency contraception for young people is often hard to access. Young people have been asked to pay when there is not a chemist working."*
Covid-19 response	Reference was made to the pandemic; • Pharmacies were praised for continuing to provide a service during the pandemic and adapting to requirements. • The small nature of some outlets was sometimes a problem • Queues outside of shops happened because of social distancing measures • Some measures impacted on people's ability of access the service.	*"They were the only people you could see face-to-face during Covid"* *"Their systems during the covid crisis made me feel safe when accessing their services."* *"The shop is rather small, this was a problem during the pandemic"* *"Because of social distancing they stayed well away from me, so I couldn't hear properly"*
Specific dispensing issue – blister packs	Reference was made to the pandemic; • Pharmacies were praised for continuing to provide a service during the pandemic and adapting to requirements. • The small nature of some outlets was sometimes a problems • Queues outside of shops happened because of social distancing measures • Some measures impacted on people's ability of access the	"Pharmacy services in kenilworth have withdrawn provision of blister packs. Some care agencies will not give check controlled medications unless they are in blister packs." "It's very difficult to get blister packs or dossett boxes filled" "Some will prescribe in

	service.	blister packs, some will not, and some will deliver, and some will not. I feel that all pharmacies should have the same approach to ensure that some in the county are not left without access to services that others have.”
Questionnaire/survey comments	A small number of comments related to the survey design • Some questions did not offer the options required by respondents • One comment felt questions were skewed to urban populations and did not deal with rural matters	

Figure 47: Is there anything else you want to tell us about your recent experience of using pharmacies

Pharmaceutical Needs Assessment (PNA) Executive Summary for Warwickshire

Introduction

The purpose of the PNA (refer to Appendix 1) is to assess local needs and identify gaps for pharmaceutical provision across Coventry and Warwickshire. It is a tool to enable Health and Wellbeing Boards (HWBs) to identify the current and future commissioning of services required from pharmaceutical service providers.

Coventry City Council and Warwickshire County Council HWBs approached the development of the 2022 PNA as a collaborative project, with one report being produced for both areas. This replaces the 2018 PNA for both Coventry and Warwickshire.

Whilst the full PNA considers the pharmaceutical provision for both Coventry and Warwickshire, this executive summary will focus on the provision in Warwickshire.

A revised PNA needs to be published every three years by the Health and Wellbeing board. If significant changes take place to the availability of pharmaceutical services, the board are required to publish a revised assessment as soon as reasonably practical.

As a minimum, the following must be considered in a PNA:

- **Necessary services** – services which have been assessed as required to meet a pharmaceutical need.
- **Relevant services** – services that have created better access to pharmaceutical services.
- **Other NHS services** – services that either impact the need for pharmaceutical services or create better access to pharmaceutical services within the area.
- **Map of pharmaceutical services** – a map showing the places where pharmaceutical services are provided and assess the implications of distance to these places.
- **Explanation of assessment** – an explanation of how the assessment was made, including details of the public and pharmaceutical surveys that have been undertaken.

Approach to the PNA

When determining localities to be used within this PNA it was decided that Coventry will be considered as one locality and Warwickshire will reflect its five districts and boroughs. The localities are therefore defined as:

- Coventry
- North Warwickshire Borough
- Nuneaton & Bedworth Borough
- Rugby Borough

- Stratford-on-Avon District
- Warwick District

The development of the PNA has been overseen by one multi-disciplinary steering group which includes representations from organisations for both the Coventry and Warwickshire areas.

The process has been split into 4 stages:

- **Stage 1** – A project management approach was used to develop the PNA and so a steering group was established which met regularly during the development of the PNA.
- **Stage 2** – A pharmacy survey and a public survey were developed. The content was approved by the steering group and was undertaken in Feb/March 2022. Following the closure of the surveys the responses were analysed.
- **Stage 3** – A summary of current provisions and gaps in provision of pharmaceutical services was identified and fed into the draft report. The content was approved by the steering group.
- **Stage 4** – As required by legislation, a 60-day consultation is necessary during the process of producing this document.

Other Relevant Work

The JSNA provides the evidence base for understanding the needs of the local population. In Warwickshire a thematic approach has currently been adopted.

Reducing health inequalities is core to the role of the Coventry and Warwickshire Integrated Care System (ICS). The ICS Health Inequalities Strategy sets out the system wide approach to tackling health inequalities based on the Kings Fund Model of Population Health.

As part of the Health and Care Act 2022, 42 Integrated Care Systems (ICSs) will be established in England on a statutory basis as of 1st July 2022. This will include an Integrated Care Board (ICB) which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services. This will replace the current Clinical Commissioning Groups (CCGs).

Warwickshire Healthwatch works to listen and understand the needs, experience, and concerns of local people and communities and take that feedback to NHS and other key decision makers. This ensures NHS services include this feedback to improve services and standard of care.

More work to achieve the best patient outcomes from medicines is a key priority for the Integrated Pharmacy Medicines Optimisation (IMPO).

Local Picture

Key demographics have been identified within Warwickshire that have an impact on community pharmacy usage. They are:

- People aged 55+
- People from ethnically diverse communities
- People who live in areas of deprivation
- Areas of high population density
- People affected by the cost-of-living crisis
- Car owners
- People with long term conditions (which is looked at in more detail under “General Health Needs”)

In 2020, the ONS estimated the usual resident population of Warwickshire to be 583,786 (split 49% male and 51% female). Warwickshire has an older population compared to England.

The population of Warwickshire is expected to increase, with the age group split expected to stay similar except for an increasing 60+ population.

Looking at the 2011 Census data 7% of the Warwickshire population reported an ethnicity of non-white. Comparing that with the 2021 School Census data the school population is more diverse, with 15% reporting non-white. Life

The Index of Multiple Deprivation (IMD) shows particular areas of deprivation around North Warwickshire, Nuneaton and Bedworth, and Rugby, with an increase in deprivation across the county between 2015 and 2019.

The areas of increased deprivation continue to have the lowest life expectancy which has declined during 2020 for both men and women.

A cost-of-living crisis started in the second half of 2021 and is rapidly accelerating in first half of 2022. There is no indication that the cost-of-living crisis will be fully resolved within the duration of this PNA period. While this is primarily around home energy, fuel for vehicles, and food, it is affecting all areas of spending and debt levels. There is a risk to ongoing access to pharmaceutical services via: the direct cost of prescriptions, the cost of physical access via car or public transport, as well as the cost of digital access to online pharmacies.

General Health Needs

There are five conditions referenced with physical health in the PNA.

Smoking – In 2020 12.1% of adults aged 18+ smoked in Warwickshire. There is a clear relationship between smoking prevalence and affluence. People living in the most deprived areas are more likely to smoke than those living in the least deprived areas. Compared to the England average, Warwickshire has a lower percentage of women smoking at the time of booking an appointment with their midwife.

Alcohol – Larger increases of alcohol-related conditions per 100,000 have been seen in Warwickshire, increasing from 452.1 per 100,000 in 2016/17 to 525.4 in 2018/19.

Substance Misuse – Warwickshire has a similar rate to that of the England average for hospital admission due to substance misuse at 83.8 per 100,000.

Healthy Weight – In Warwickshire the percentage of adults 18+ who are classified as overweight or obese has risen, from 58.6% in 2016/17 to 63% in 2019/20.

Sexual Health – In Warwickshire the under 18s conception rate per 1,000 females aged 15-17 is similar to the England average at 13.2 per 1,000.

There are five long term conditions referenced in the PNA.

Cancer – Warwickshire has shown a slight increase in deaths with underlying cause of cancer in all ages between 2016 (26.7%) to 2019 (28.1%) before seeing a drop in 2020 to 24.3%.

Cardiovascular Disease – The Warwickshire rate for all cardiovascular diseases was 78.5 per 100,000, similar to the England rate.

Diabetes – Warwickshire has seen an increasing prevalence of diabetes in people 17+ from 6.4% in 2016/17 to 6.8% in 2020/21.

Mental Disorders – Warwickshire's prevalence of common mental disorders in the population aged 16+ is 14.8%, which is lower than the England rate.

Respiratory Disease – Warwickshire has a rate of under 75 mortality from respiratory disease in 2020 of 24 per 100,000 population, which is lower than the England average.

It is important to recognise how Community Pharmacies have supported the public during the COVID-19 pandemic.

COVID-19 has led to an increase in workload as there has been a significant increase in requests for healthcare advice. This has also been compounded by the decrease in workforce with the main cause being sickness from COVID-19 and self-isolation.

Currently 15 pharmacies provide COVID-19 vaccinations. At the height of the pandemic 24 pharmacies in Coventry and Warwickshire provided the COVID-19 vaccination.

Work was undertaken across Warwickshire to ensure pharmacy provision of COVID-19 vaccinations matched need, specifically areas of low uptake/areas of deprivation.

Pharmacy Provisions and Access

The NHS Community Pharmacy Contractual Framework (CPCF) requires community pharmacies to contribute to the health needs of the population they serve. The contractual framework is formed of the following components:

- Essential Services – these must be provided by all contractors nationwide.

- Advanced Services – services that can be provided by contractors subject to accreditation requirements.
- Locally Commissioned and Enhanced Services – services commissioned either by the NHS (enhanced services) or Local Authorities (locally commissioned services) in response to the needs of the local population.

There are 106 community pharmacies in Warwickshire, 5 of which are distance selling pharmacies. Additionally, there are 22 dispensing doctors.

Pharmacies are not evenly distributed throughout the localities, with great concentrations of pharmacies in central areas of each locality, particularly in Nuneaton and Bedworth, Rugby, and Warwick.

Almost all of Warwickshire is within a 15-minute drive to a pharmacy, the exceptions being in South and Southeast of Stratford-on-Avon District, which are rural areas.

From the 1,601 responses to the public survey, 46.5% of respondents said they would normally travel by car/motorbike/van to a pharmacy, and a further 42% said they would normally walk.

In the public survey, when asked the question “are you able to access a pharmacy at times that are convenient to you?” 39% responded “Yes always”, 47% responded “most of the time”, 11% responded “sometimes” and 2% responded “never”.

There are currently 3 100-hour pharmacies in Rugby Borough, 2 in North Warwickshire Borough, 2 in Nuneaton and Bedworth Borough, 1 in Stratford-on-Avon District, and 1 in Warwick District.

As of 1st June 2022, 86 community pharmacies in Warwickshire are open on a Saturday. 23 of these are in Nuneaton and Bedworth Borough, 21 in Warwick District, 18 in Stratford-on-Avon District, 15 in Rugby Borough, and 9 in North Warwickshire Borough.

There are 22 community pharmacies in Warwickshire that are open on a Sunday. 6 in Warwick District, 5 in Stratford-on-Avon District, 5 in Nuneaton and Bedworth Borough, 4 in Rugby Borough, and 2 in North Warwickshire Borough.

The PSNC Pharmacy Advice Audit 2021 indicates that 1.1 million informal consultations happen in community pharmacies in England each week, 58 million per year. Almost half of patients recorded reported that they would have attended their GP if the community pharmacy had not been available, meaning these consultations save more than 2 million GP appointments every month, or 24 million every year.

The PSNC briefing on the pharmacy pressures survey found that 92% of pharmacy business owners/head office representatives said that patient services were being negatively affected by the pressures on their business, with 90% saying they were unable to spend as much time with patients and 87% saying it is taking longer to

dispense prescriptions.

91% of pharmacies said they were experiencing staff shortages, with 98% saying these increased pressures on staff and 87% saying it increased costs.

When asked how concerned pharmacies are about issues in the future on a scale of 1 (no concern) to 10 (extremely concerned), 89.6% indicated 7 to 10 (extremely concerned) for their Pharmacy teams' wellbeing, 88.9% indicated 7 to 10 for staffing issues, and 87% indicated 7 to 10 for finance issues.

NHS Health Education England (HEE) data indicates an increase in pharmacist workforce numbers in Trust, Practice, and Primary Care Networks (PCN). There is currently no equivalent data on community pharmacies. The increase in numbers may cause concern as this increase may have come from workforce leaving community pharmacies.

HEE have undertaken a Community Pharmacy Workforce Survey in 2021, with results expected to be published in 2022. They are also undertaking discussions to understand the possibility of undertaking an annual survey of community pharmacy workforce to support understanding of challenges and improve data completion/quality.

Overall, pharmacies within Warwickshire are well geographically distributed by population density and levels of deprivation. Opening hours indicate a good level of access during usual working hours, and on weekends and evenings. Cross border availability of pharmaceutical services is also significant.

Pharmacy Services

Community pharmacies provide a wide array of services that are defined/commissioned in different ways:

- Essential Services – services which all pharmacies must provide as part of the CPCF regulations.
- Advanced Services – services the CPCF regulations allow pharmacies to opt in to providing.
- Enhanced and Locally Commissioned Services – services that are either commissioned by NHS England (enhanced services) or commissioned by a CCG or Local Authority (locally commissioned services).

Essential Pharmacy Services

There are 9 essential services that all community pharmacies are required to provide as part of the CPCF regulations, these are:

- Dispensing of Medicines and Dispensing of Appliances (2 different services)
- Repeat Dispensing
- Discharge Medicines Service
- Promotion of Healthy Lifestyles
- Disposal of Unwanted Medicines

- Signposting
- Support for Self-Care
- Clinical Governance

In 2021/22 Warwickshire dispensed 10,380,674 items.

Essential Services are provided by all Warwickshire pharmacy contractors. Therefore, there are no gaps in the provision of essential services.

Advanced Pharmacy Services

In addition to essential services, the CPCF allows community pharmacies to opt to provide any of the 8 advanced services:

New Medicines Services (NMS) – The NMS service provides support for patients with long term conditions who have been newly prescribed a medicine to help improve patient medicine adherence. 105 (99%) of the community pharmacies in Warwickshire provide an NMS service. No gaps have been identified from the information available.

Appliance Use Reviews (AUR) – The AUR service should serve to improve the patient's knowledge and use of any 'specified appliance'. Of the 161 pharmacies that responded to the pharmacy survey, 11% currently provide an AUR service in Warwickshire. Demand for the AUR service is lower than for other advanced services due to the much smaller proportion of the population that may be targeted. No current gaps in provision have been identified based on the information available.

Stoma Application Customisation (SAC) – The SAC service involves customisation of a quantity of more than one stoma appliance, based on the patient's measurements or template. Of the 161 pharmacies that responded to the pharmacy survey, 8% of pharmacies in Warwickshire provide an SAC service. Demand for the SAC service is lower than for other advanced services due to the much smaller proportion of the population that may be targeted. No current gaps in provision have been identified based on the information available.

Seasonal Influenza (flu) Vaccination – Of the 161 pharmacies who responded to the survey, 86% of pharmacies in Warwickshire provide a vaccination service. No gaps have been identified with the information currently available for this service.

Community Pharmacy Consultation Service – CPCS was launched on 29th October 2019, allowing NHS 111 and general practices to refer patients for a minor illness consultation via CPCS, once a local referral pathway has been agreed. 104 community pharmacies (98%) in Warwickshire provide the CPCS service. No gaps have been identified with the information currently available for this service.

Hepatitis C Testing – The Hepatitis C testing service focuses on the provision of point of care testing for Hepatitis C antibodies in people who inject drugs but aren't yet accepting treatment for their substance use. The service is currently commissioned until 31st March 2023. Pathways for referral to a confirmatory PCR test are currently under development. This should be supported to help develop the

service as there is currently a limited pathways for PCR testing.

Smoking Cessation Advanced Service – The smoking cessation advanced service allows hospitals to refer patients to community pharmacy to continue the stop smoking journey they started in hospital. This service was commissioned in March 2022, and there are currently 15 pharmacies in Warwickshire signed up. The number of pharmacies providing this new service should be monitored whilst this initial sign-up is taking place.

Hypertension Case Finding Service – The Hypertension Case Finding Service supports risk identification and prevention of cardiovascular disease (CVD). There are 60 community pharmacies in Warwickshire delivering this service. There is a promising initial sign-up to this service as it has only been commissioned for 2 months at the time of writing this PNA. There is an opportunity to develop pathways for this from pharmacies straight through to lifestyle service for people who want support around lifestyle interventions.

Enhanced and Locally Commissioned Services

Warwickshire currently has the following enhanced and locally commissioned services:

Substance Misuse – In Warwickshire 43 pharmacies offer supervised consumption and 18 offer needle exchange. There has been a reduction in the number of active pharmacies providing both services which goes against the national data which shows a slight increase in both services.

Stop Smoking Service – The Stop Smoking Service (SSS) locally commissioned service provides support and advice to people who want to give up smoking. 43 pharmacies in Warwickshire are signed up to provide this service. Partnership work needs to be done between commissioners of SSS services and pharmacies to identify the actions to increase activity across those pharmacies where behavioural support and prescribing is low, with a particular focus on areas of greatest need.

Stop Smoking in Pregnancy Service (SSiPS) – This service provides support for pregnant women from all 3 trusts across Coventry and Warwickshire to stop smoking. The same 43 Warwickshire pharmacies as the SSS are signed up to provide this service. Work can be done to increase the number of pharmacies to redeem and dispense these letters of recommendation and NRT products to pregnant women.

Sexual Health Services – At present, pharmacies in Warwickshire are not testing or treating for STIs. Pharmacies are signposting to the Integrated Sexual Health Service (ISHS) website where users can order a testing kit for Chlamydia online. Pharmacies in Warwickshire do offer Emergency Hormonal Contraception (EHC). The combining of the Integrated Sexual Health contracts will help to reduce service user confusion as to what service is offered where and to whom.

End of Life Medicines – There are 7 community pharmacies in Warwickshire who are currently commissioned to deliver End of Life Medicines. Pharmacies provide a

convenient access to these medicines throughout Warwickshire. No gaps have been identified in this service.

Sharps Disposal Service – Delivered in Warwick District with 17 community pharmacies currently part of this service. Better clarification and communication could support this service. The Warwick District Council are also open to more pharmacies signing up.

Emergency Department (ED) to CPCS – This is a pilot as an extension of the CPCS Advanced Service and allows referrals from the identified additional Urgent and Emergency Care (UEC) settings identified in the area. There are 5 pharmacies in Rugby taking part. Warwickshire should continue to support the running of the pilot, outcomes of the pilot, and decisions by its sponsors.

Community Pharmacy Extended Care Service – This service is provided in 2 tiers. Tier 1 provides treatment of simple Urinary Tract Infections (UTI) in females aged 16-65, and treatment of Acute Bacterial Conjunctivitis for children aged 3-months to 2-years. Tier 2 provides treatment of Impetigo, Infected Insect Bites and Infected Eczema. In Warwickshire 61 pharmacies provide UTI under tier 1, 58 pharmacies provide Acute Bacterial Conjunctivitis under tier 1, and 41 pharmacies provide tier 2 treatments.

Recommendations

- Currently there is a sufficient provision of pharmacies. Supplementary statements will be produced by the Community Pharmacy Steering Group on behalf of the Warwickshire Health and Wellbeing Board should there be a significant change across Warwickshire or within localities. Significant new housing developments should also be considered.

- Consideration should be given to the increase in pressure on community pharmacies caused by the COVID-19 pandemic, particularly as the county enters a cost-of-living crisis.

- Consideration of any change within predominantly rural areas should be undertaken within the lifetime of the PNA.

- Consideration should be given to commissioning evening or weekend rotas if needed to support extended hours by general practice in addition to the current bank holiday rotas.

- There is an opportunity for more joined up work when it comes to signposting, both to and from community pharmacies. Community pharmacies should be continually consulted as to the best pathways for care. Patients, public, and other care settings should be provided with clear information on opening times, services offered (including provision of confidential consulting space), and alternative provisions when pharmacies are not open.

- Health Education England (HEE) training should be supported for prescribers in community pharmacies.

- The HEE Community Pharmacy Survey 2021 should be used when released later in 2022 to help understand community pharmacy workforce further, and support should be given to the delivery of an annual HEE Community Pharmacy Survey to build data and insight going forward, including use in the next PNA.

Health and Wellbeing Board

15 September 2022

Healthwatch Annual Report

Recommendation(s)

1. To note and receive the Report

1.0 Key Issues

1.1 Service Delivery

1.2 Future Priorities

2.0 Annual Report

2.1 The Healthwatch Warwickshire Annual Report was completed and circulated on 30th June 2022 to all key stakeholders including WCC, Healthwatch England, the CQC, and to NHS and voluntary organisations. The Report included details of all activities undertaken between 1st April 2021 and 31st March 2022 and will be taken as having been read by Members.

Today's Report to the Health and Wellbeing Board will also refer to initiatives that have developed in 2022 after the period covered by the published Annual Report.

2.2 Service Delivery

2.2.1 Throughout the period between 1st April 2021 and 31st March 2022 Healthwatch Warwickshire (HWW) has continued to comply with guidance issued by Healthwatch England, Public Health England and NHS E/I. The guidance initially stipulated that face to face activities, such as public engagement events and Enter and View, should be discontinued due to the Covid-19 pandemic. The Guidance continues to be reviewed and updated and HWW has adapted its activities to remain compliant with it

The offices of HWW at 4-6 Clemens Street, Leamington Spa have, on the whole, remained closed since 24th March 2020, but normal face to face activities have gradually been reintroduced.

2.2.2 The top priority always has been to continue the delivery of a full range of services to the public. Since the 1st April 2021 HWW has continued make provision for:

- Home based office working for all staff. The arrangements have included providing the full range of mobile IT facilities and carrying out the

necessary risk assessments. This has given staff the option to work from Home or to work from the Offices.

- Arrangements for the support and wellbeing of staff (including the adoption of 'Thrive at Work' practices and principles).
- The delivery of the telephone-based signposting and advice service for the public
- The continued development and improvement of the facility on the website for the public to express concerns
- Established a space on the website to give the current advice and information from the Government, WCC and NHS providers. The information on the website is updated on a daily basis
- Regular contact with all key partners to keep them advised about developments in our operational arrangements

2.2.3 HWW has published 10 reports relating to the improvements people would like to see to health and social care services. These have included highlighting local people's experiences relating to South Warwickshire Community Beds, hospital discharge, NHS Dentistry, living with diabetes, and the rights of people who are deaf or living with hearing loss.

All published reports are available on HWW's website and have been used to try and ensure that decisions about health and social care provision are properly informed by the lived experiences of patients, carers, and other residents.

For example, as part of HWW's involvement in the Diabetes Strategy Group views on what support technology can offer were gathered. As a result of HWW's work there are now plans in Warwickshire to trial the rollout of wearable technology for diabetic patients.

HWW are also named partners in national reports such as the Newton/CCN report on the Reform of Adult Social Care and a range of projects being developed by the University of Warwick Medical School.

2.2.4 All statutory and regulatory requirements such as the Annual Accounts, GDPR compliance, and Companies House Returns have been completed and signed off ahead of time.

2.3 Future Priorities

2.3.1 To continue and further develop HWW's work to find out more about the lived experiences of people needing or using health and social care services.

2.3.2 Helping to ensure that the lived experiences of those people and communities who are seldom heard are properly considered by those who commission and provide health and social care services

2.3.3 HWW will continue to engage positively with the Integrated Care System at all levels to ensure that voice of patients continues to be properly heard across the whole system.

HWW is already working pro-actively with the Integrated Care Board, the Integrated Care Partnership, and the Care Collaboratives.

This is clearly of great significance to Patients and Public, however our focus will very much remain on Place, Neighbourhood, and local levels where people most directly connect with health and social care services.

We are also working with colleagues in Healthwatch Coventry to try and ensure there is an effective Healthwatch Service across the whole system.

2.3.4 HWW are extending the focus of existing projects and developing new projects on:

- Carers and the impact of events such a hospital discharge on their health and wellbeing
- Barriers to accessing health & care services experienced by those living with deafness or hearing loss
- Gaining a better understanding of the experiences of those from LGBT+ communities
- The lived experiences of those accessing services such as people living with eating disorders or learning disabilities
- Access issues relating to NHS Dentistry

3.0 Financial Implications

3.1 The current range and quality of reports and activities cannot be sustained from within the current contract payment. This has necessitated the carefully planned use of reserves for non-recurring project based expenditure.

HWW are required to maintain a level of reserves to secure an orderly shutdown or contract novation in the event of the Healthwatch Contract not being renewed. The reserves position will therefore be kept under careful review by the Board of Directors which may have some implications for future project working.

4.0 Environmental Implications

4.1 None.

5.0 Timescales associated with the decision and next steps

5.1 Paragraph 1.

Background papers

1. Presentation

	Name	Contact Information
Report Authors	Liz Hancock Chris Bain	elizabeth.hancock@geh.nhs.uk chris@healthwatchwarwickshire.co.uk Tel: 01926 453964

healthwatch Warwickshire

Annual Report
Health & Wellbeing Board
7th September 2022

Performance Report: How we are working

- All staff now have the option of working from home
- Virtual Board Meetings and Volunteer Forums
- Public facing services maintained
- Engagement strategy with all key partners implemented
- Health & Social Care Forum delivered
- Statutory reporting completed ahead of time
- Financial stability maintained

healthwatch Warwickshire

Performance Report: Activity May – July 2022

- 208 Engagement activities reaching 2,571 people
- 73 individual pieces of feedback
- 28 new Twitter followers, we now have 1,669
- Facebook Page Likes increased by 50 to 411.
- 3,217 users visited our website, 3,120 of them being new users
- Our mailing list is now at 1,210

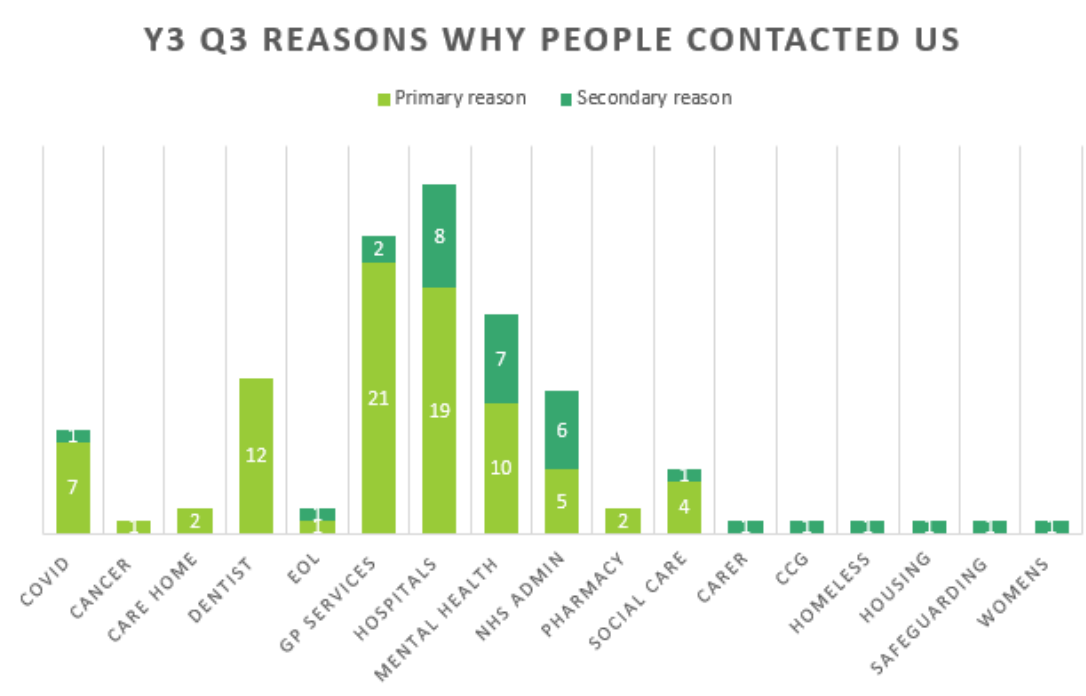
Our Influencing role May – July 2022

- *We attended 51 strategic meetings including:*

➢ *Integrated Care Board*
➢ *Integrated Care Partnership*
➢ *Adult Social Care & Health Overview & Scrutiny Committee*
➢ *Health & Wellbeing Board*
➢ *Coventry & Warwickshire Health & Care Partnership*
➢ *3 x Place Partnerships*
➢ *Regional Healthwatch (West Midlands)*

Emergent Trends

Taken from performance report – enquiry feedback



Top 4 areas

1. Hospitals (27)
2. GP services (23)
3. Mental Health (17)
4. Dentists (12)

Taken from annual report

Top 4 areas

1. Hospitals (89)
2. GP services (87)
3. Dentists (40)
4. Covid vaccines/testing (9)

healthwatch Warwickshire

Future Priorities

- Access to services – face to face, digital exclusion
- Health inequalities
  - In terms of both service provision and health outcomes
  - driven by who you are and where you live
- Delays in Assessments, diagnostics, treatments
- Erosion of community Mental Health Services
- NHS Dentistry

healthwatch Warwickshire

Remove assumptions and bias

Communication

Kindness of one person

Safe spaces and trusted relationships

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Agenda Item 7

Health and Wellbeing Board

7 September 2022

Serious Violence Prevention Strategy

Recommendations

That the Health and Wellbeing Board agrees to:

1. Endorse the Warwickshire Serious Violence Prevention Strategy and will work collaboratively with the Safer Warwickshire Partnership Board and Local Criminal Justice Board to support delivery of the strategic priorities set out in the strategy and delivery plan.
2. Endorse the adoption of a public health approach to serious violence prevention as set out in “A whole system multi agency approach to violence prevention”, published by Public Health England.
3. Work with lead officers across named statutory agencies to support the establishment of a delivery fund to ensure the objectives set out in Warwickshire Serious Violence Prevention Strategy delivery plan are achieved and are affordable within current budgets/resources.
4. Work in partnership to develop a training and awareness programme for front line health practitioners on the Duty and how to identify and refer those at risk of serious violence.
5. Support the Safer Warwickshire Partnership Board in the development of and response to Serious Weapon Homicide Reviews that are coming into force as part for the above act.

1.0 Executive Summary

1.1 The Police Crime, Sentencing and Courts Act 2022 introduced a Statutory Duty for named partner agencies to address the root causes of serious violence. The duty incorporates the requirement for the following agencies to collaborate with each other to prevent and reduce serious violence which includes a duty to plan together to exercise their functions so as to prevent and reduce serious violence in their area (including domestic abuse and sexual offences). Each agency will be accountable for their activity and co-operation.

- Police,
- Local councils,
- Fire and Rescue
- Local health bodies and Integrated Care Boards, and
- National Probation Service

1.2 Education Authorities and Youth Offending Services must be consulted in the preparation of a local Serious Violence strategy and the strategy may direct them to carry out a particular action

1.3 In exercising their duty, each agency must identify the kinds of serious violence that occur in their area, identify (so far as it is possible to do so) the causes of that violence and prepare and implement a strategy for exercising their functions to prevent and reduce serious violence.

1.4 The Duty does not specify a 'lead' organisation or person whose responsibility is to coordinate activity or prescribe a structure within which specified authorities are expected to work. Draft government guidance on the Duty states that it is for the specified authorities to come together to decide on the appropriate lead and structure of collaboration for their area. The Duty is intended to create the right conditions for authorities to collaborate and communicate regularly, to use existing partnerships to share information and take effective coordinated action in their local areas.

1.5 The government narrative had been referred to as a "Public Health Approach" to serious violence prevention.

1.6 Public Health England, in its publication, "A whole system multi agency approach to violence prevention", sets out three levels of violence prevention:

- primary prevention (preventing violence before it happens);
- secondary prevention (an immediate response to instances of violence); and
- tertiary prevention (focusing on long term care and support).

1.7 Investment at a national level has been aligned to areas with high levels of serious violence.

1.8 Warwickshire's profile means that national funding has not been available to the county to develop the range of interventions to prevent serious violence. However, the county is surrounded by areas such as West Midlands, Coventry, Thames Valley and Leicestershire. As a result, Warwickshire has become a net importer of serious violence, often driven through the drug related criminality which fuels territory-based violence, personal feuds and violent conflict

1.9 It is recognised that prevention is at the core to any successful Public Health approach to violence reduction. It requires a long-term commitment by a range of agencies, individuals and communities to prevent the physical and psychological damage that violence can cause for individuals, families, our communities and wider society.

1.10 Taking a preventative approach will also support action towards all three Health and Wellbeing Board priorities, including *helping our children and young people have the best start in life*.

1.11 By adopting a long-term approach, predicated on public health and community safety outcomes, Warwickshire has a greater chance to deliver and support families and young people to prevent violence now and for future generations.

1.12 Interventions to address serious violence are defined as universal (aimed at a general population); selected (targeted at those more at risk); and indicated (targeted at those who use violence).

1.13 The Warwickshire Serious Violence Prevention Model, which is set out in the Serious Violence Prevention Strategy (Appendix 1), combines these universal and selected interventions, supporting those most impacted by serious violence whilst creating a climate where serious violence is not tolerated, thereby protecting future generations.

1.14 The strategic priorities include this universal, selected and indicated approach with the objectives of:

- Preventing Violence before it happens.
- Responding to emerging or immediate risks of serious violence.
- Developing long term support within communities.

1.15 In preparing the Strategy the partner agencies are required to consult with each educational authority, prison authority and youth custody authority for the area and the relevant consultation has taken place. The Strategy which includes the Model as set out above, has also been shared across a wide range of partner agencies and adopted by the Safer Warwickshire Partnership Board, including the Education Authority, Youth Justice Service and National Probation Service. The next step is the development of a multi-agency delivery plan, including the identification of resources, through the Integrated care System a Levelling up agenda to deliver key programmes.

1.16 The delivery plan will include how agencies work together to demonstrate that the Statutory Duty as set out above has been delivered. Officers are developing an Annual Assurance Statement that captures partnership activity.

1.17 The intention is that the Safer Warwickshire Partnership Board will work with key stakeholders to maximise the resources available and, importantly, to use their influence across partner organisations to deliver the Serious Violence Prevention Model Strategy.

1.18 The Safer Warwickshire Partnership Serious Organised Crime Strategic Group will act as the lead group to agree the priorities and delivery plan to ensure that the Warwickshire Serious Violence Prevention Strategy and Model is embedded and delivered.

1.19 A key part of demonstrating that the Statutory Duty is being met will be training of frontline practitioners to:

- Understand the duty and what is includes.
- Recognise the signs related to a individual, group or family being affected by serious violence

- Where to get advice and support
- Where to refer cases that a single agreed process.

1.20 Health partners are key in the development of the training and identifying key frontline staff who will benefit. This can cover a range of services across the health care sector from Family Nurse Practitioners, Local Maternity and Neonatal Services, to primary care and NHS Trusts.

1.21 In addition to the Statutory Duty set out above, The Police Crime Sentencing and Courts Act 2022 has introduced Serious Weapon Homicide Reviews. Where a review partner (which will be defined by the Secretary of State but is anticipated to include the Chief Officer of Police, a County and District Council and an Integrated Care Board or Local Health Board) considers that the death of a person was or is likely to have been a qualifying homicide which occurred in England or Wales then the review partner must join with other review partners to conduct a review into the person's death.

1.22 A qualifying homicide is one where the person was aged 18 or over and the death, or events surrounding it, involved the use of an offensive weapon. An offensive weapon includes but is not limited to knives, guns or corrosive substances.

1.23 Officers are currently working with colleague in the West Midlands Violence Reduction Unit to undertake desk top exercises in the Autumn 2022 to ascertain how the requirement will be met and resources required.

2.0 Financial Implications

2.1 There are no capital implications related to the delivery of the Warwickshire Serious Violence Prevention Strategy.

2.2 There are revenue implications for delivery the Serious Violence Statutory Duty as set out on paragraph 2.7 below.

2.3 The Home Office will require partners to demonstrate how they have met the duty and the steps they have taken to both prevent and respond to the serious violence. This is best achieved by a co-ordinated, multi-agency, countywide approach.

2.4 Warwickshire County Council Community Safety Team will take the lead on behalf of partner agencies and use existing resources to provide an evidence base of the progress made in meeting the Statutory Duty.

2.5 However, there will be resource implications across all of the statutory partners to support:

- Training of frontline practitioners on the Serious Violence Duty, as set out above.

- Establishing a multi-agency commissioning fund to deliver serious violence intervention programmes, including;
  - a county wide mentoring provision,
  - addressing underlying health based causal factors such as trauma and adversity, chronic ill health, loss or bereavement,
  - developing specific support for 18-25year olds who are seeking a pathway away from violent conflict.

2.6 Lead officers within the local authority are seeking to establish a delivery fund, on behalf of all statutory partners, over a three-year period commencing April 2023, with a contribution from all named statutory partners, including Police, local authorities, fire and rescue authorities, Youth Offending Service, National Probation Service, Integrated Care Boards (ICB) and Education providers. The funding will ensure a collaborative approach in meeting the Statutory Duty to prevent and reduce serious violence across all named partners.

2.7 It is anticipated that a partnership commissioning fund in the region of £100-150,000 per annum will be required for a three-year period to deliver the key programmes set out in 2.5 above. Discussions are taking place with partner organisations to establish a commission fund and will continue through the rest of this financial year.

2.8 There will be no revenue implications to any organisation until the commissioning fund is established. Any spend will be limited to the fund available within each financial year.

2.9 The Office of the Police and Crime Commissioner for Warwickshire has indicated a willingness to consider a match funding proposal if there is a strong indication from other statutory partners to equally contribute.

2.10 The Police Crime Sentencing and Courts Act 2022 set out a requirement for local authorities to carry out Serious Weapon Homicide Reviews for all cases of homicides of post 18year olds. The process for these reviews has not been determined. However, there will be a financial implication for partner agencies in meeting the requirements. Officers will aim to minimise the costs of these reviews and provide an update of the financial implications for the beginning of the 2023/24 financial year to the Safer Warwickshire Partnership Board.

3.0 Environmental Implications

3.1 None

4.0 Supporting Information

4.1 The supporting information is contained within the Warwickshire Serious Violence Prevention Strategy, adopted by the Safer Warwickshire Partnership Board in June 2022.

4.2 Whilst Warwickshire records significantly lower levels of knife and gun offences, the impact of drug markets through county lines is a growing issue, affecting a number of communities across the County. This is of particular concern in areas where there are high levels of health, societal, educational attainment, causal crime and safeguarding risk factors, or where those risk factors are increasing.

4.3 Analysis set out in the Strategy identifies Super Output areas which are most at risk of being impacted by serious violence. These areas mirror the emerging priorities for community safety partnership agencies.

4.4 Case study analysis has also identified a number of consistent underlying causal factors for those involved in serious violence. The analysis highlights the following commonalities:

- A history of domestic violence and/or abuse in the family.
- Exposure to violence within their peer group and wider community.
- Reference to substance misuse, whether personally or within the family.
- Experience of bereavement or long-term chronic ill-health in the family.
- Victimisation including victim of crime or bullying.

5.0 Timescales associated with the decision and next steps

5.1 The Warwickshire Serious Violence delivery plan will be developing in the Autumn 2022. This will be led by the Warwickshire Serious and organised Crime Strategic Group

5.2 The Safer Warwickshire Partnership Board is holding a multi-agency conference on 13th October to help shape the delivery plan and gain partnership support to establish a co-commissioning fund.

5.3 Officers will be developing the first Annual Assurance Statement in the Spring 2023, setting out how the Serious Violence Statutory Duty is being met.

Appendices

Appendix 1 – Warwickshire Serious Violence Prevention Strategy

Background Papers

1. Home Office - Serious Violence Duty Preventing and reducing serious violence Draft Guidance for responsible authorities - www.gov.uk/government/publications/serious-violence-strategy

	Name	Contact Information
Report Author	Jonathon Toy	jonathontoy @warwickshire.gov.uk
Assistant Director	Scott Tompkins Assistant Director for Communities	scotttompkins@warwickshire.gov.uk

Strategic Director	Mark Ryder Strategic Director for Communities Nigel Minns Strategic Director for People	markryder@warwickshire.gov.uk nigelminns@warwickshire.gov.uk
Portfolio Holder	Councillor Bell Portfolio Holder for Adult Social Care & Health	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Cllr Andy Crump Councillors Drew, Golby, Holland and Rolfe.

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Warwickshire Serious Violence Prevention Strategy

A long-term approach partnership approach to address the causes of violence

Who should read this strategy? -

This strategy has been written so that it accessible to an individual, agency, business, organisation or community group who want to:-

- Understand the causes of serious violence
- Understand the roles that key agencies can have to prevent violence recuring
- Use their skills and experience to make a difference to tackle serious violence and create opportunities for those affected by it to make positive life choices.

It is fully recognised that no one agency alone can prevent 'Serious Violence'. Our strategy highlights the importance of a combined, sustained effort on behaviour of key organisations, built on strong community foundations. Only by adopting an approach whereby, "**preventing serious violence is everyone's responsibility",** will we make the fundamental differences that are required for current and future generations impacted by serious violence.

Why do we need a long-term violence prevention approach?

Prevention is at the core to any successful violence reduction approach. It requires a long-term commitment by a range of agencies, individuals and communities to prevent the physical and psychological damage that violence can cause for individuals, families, our communities and wider society.

By adopting a long-term approach, predicated on public health and community safety outcomes, as set out in our Warwickshire Violence Prevention Model below, we stand a greater chance to deliver and support families and young people to prevent violence now and for future generations.

What Does our Data tell us?

Warwickshire is one of the safest places to live in the country. Our cases of serious violence involving a weapon remain low within the West Midlands region and compared nationally. However, there are underlying risk and causal factors which highlight challenges for the county. The following section sets out the data analysis and how those underlying factors are impacting across the county.

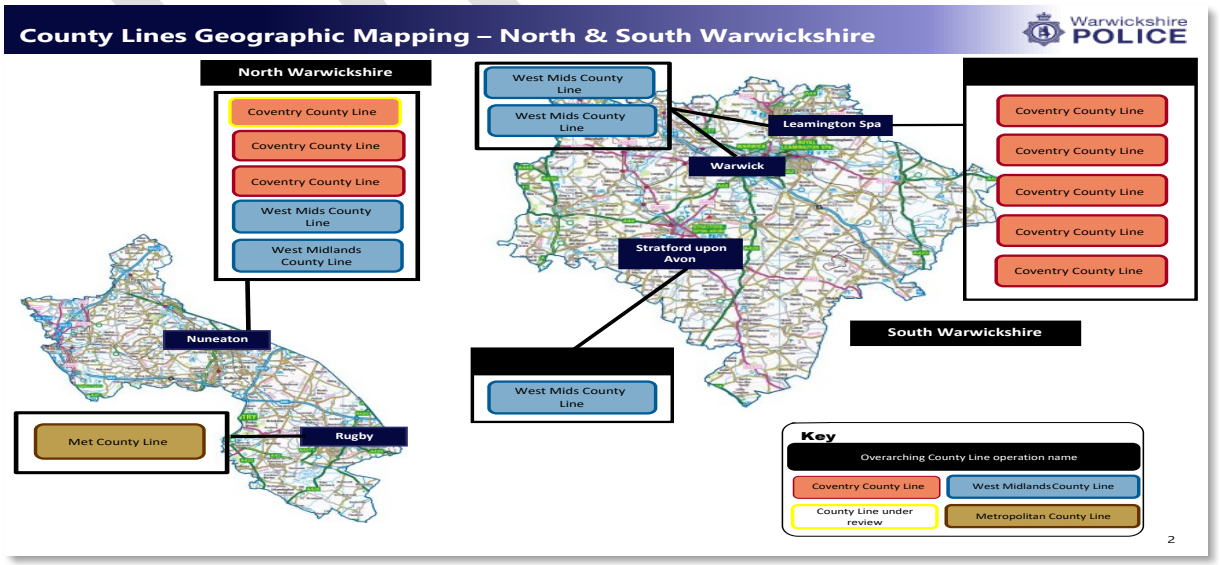
Warwickshire compared to National and Regional Trends

County Lines

County lines is defined as the movement of drugs from one area to another for financial gain. County lines often involves the exploitation of people, either through couriering drugs from one area to another, by involving people in the operating of the local market or by exploiting vulnerable people, taking over their home, or coercing or controlling people so that they are forced into a criminal or violent lifestyle.

Nationally it has been estimated that there are around 2,500 county lines operating across England. The majority of county lines originate from large metropolitan areas, with those orchestrating lines, running routes in multiple areas. The county lines profile has changed over the past 5 years. As county lines become established, local bases are set up, often by moving key individuals into an area and local people are actively recruited. These newly established bases are used to expand the county line network, so that local towns and villages become affected.

In Warwickshire, there are on average around 15-18 known county lines operating at any one time. The vast majority of these county lines come from Coventry, Birmingham and the West Midlands region. (See Map 1) However there are county lines from other Metropolitan areas operating in Warwickshire, such as London and Manchester. Since 2020, a series of successful police operations has contained the number of lines and Warwickshire Police work closely with the West Midlands Regional Organised Crime Unit to disrupt county lines activity.

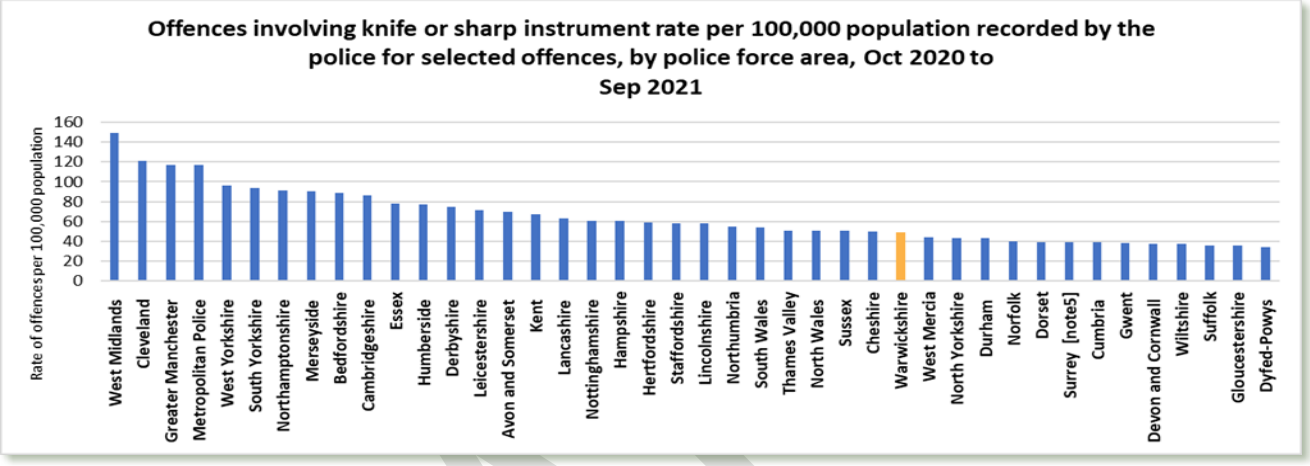


Map 1 – Illustrative map of county lines operating across Warwickshire

Knife Crime

In the period October 2020- September 2021, the highest rate for Knife Crime Offences recorded in England and Wales was in West Midlands Police Force with 149 offences per 100,000 population. West Midlands Police Force is consistently the force with the highest rate of these offences in England and Wales.

For the same period, Warwickshire Police Force recorded 49 offences per 100,000 population for offences involving a knife or sharp instrument. See Graph 1 below.

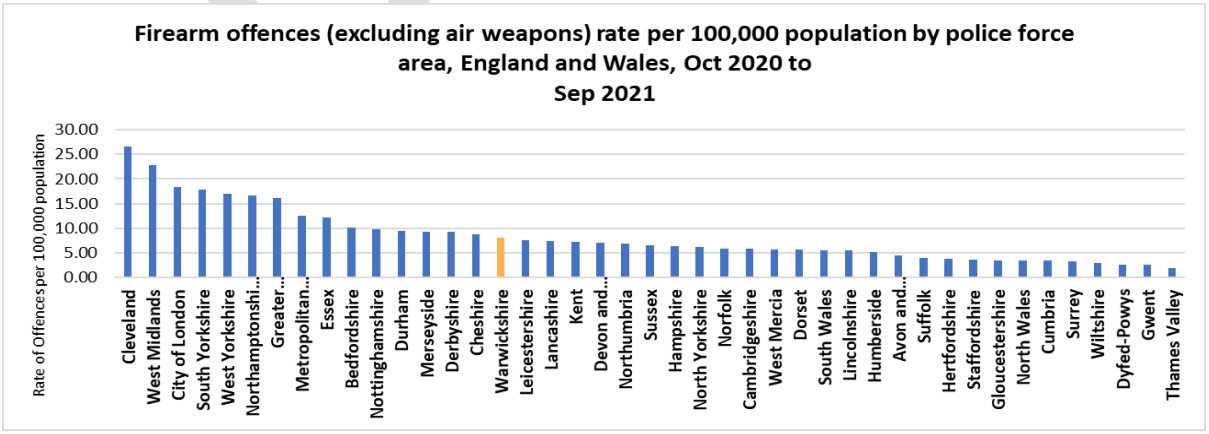


(Graph 1 Recorded Offences involving a knife or sharp instrument October 2020 – September 2021 per 100,000 population by police force areas), Source: ONS 'Crime in England and Wales Police Force Area Data Tables, Jan 2022[1]

Firearm Offences

Nationally the use of a firearm, whether it has been fired, used as a blunt instrument against a person or used as a threat, has fallen in the last year October 2020-September 2021) compared to the previous 12 months.

Nationally there has been a 9% reduction in volume of firearm offences per 100,000 population and 3% in the West Midlands during that period. Cleveland Police recorded the highest volume of firearm offences, (26.5) whilst the Metropolitan Police Force has the highest number of offences at 1,123 (see graph 2 below)



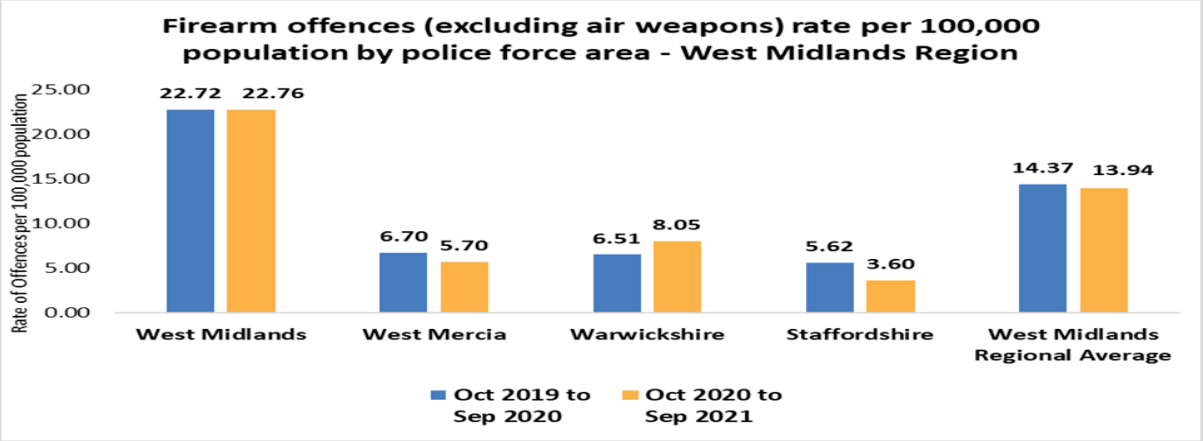
[1] [1]*https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables*

(Graph 2 – Firearm offences Oct 2020- September 2021, per 100,000 population by police force area in England and Wales) , Source:ONS 'Crime in England and Wales Police Force Area Data Tables, Jan 2022[2]

Warwickshire has low rates of both volume of firearm offences and the number of offences per 100,000, when compared Nationally and in the West Midlands Region.

However, Warwickshire is the only area in the West Midlands which has seen increases in recorded offences. The rate of offences has also increased from 6.5 offences to 8 offences per 100,000 population in the last 2 year period. This is in comparison to 22.7 offences per 100,000 in West Midlands Police Force which has remained the same for both years (see Graph 3 below). In the year ending September 2021 Warwickshire recorded the 3rd highest volume of firearm offences for the West Midlands region.

The number of recorded offences in Warwickshire during October 2020 to September 2021 increased by 9 offences, from 38 in the previous 12 months to 47 offences.



(Graph 3 – based on data from Office of National Statistics Table: Rate of firearm offences (excluding air weapons) per 100,000 population by police force area, Jan 22.) , Source:ONS 'Crime in England and Wales Police Force Area Data Tables, Jan 2022[3]

Causal Factors

Alongside the crime data set out above, we have taken the opportunity to look deeper into the underlying factors that create an environment where violent conflict can become established. These causal, or risk factors, fall under four headings:-

- **Health and societal risk factors** – this includes the level of social and economic deprivation, access to free school meals
- **Educational attainment factors** – the data is drawn from a range of data related to health care, educational attainment, pupil absenteeism and exclusion rates
- **Causal crime risk factors** – this data covers recorded incidents of anti-social behaviour, drug offences, violent offences and domestic abuse incidents

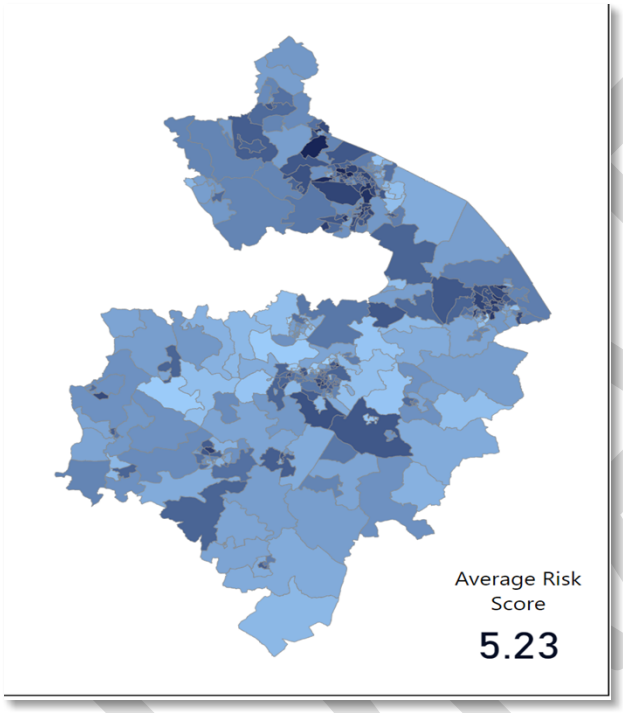
[2] [2]*https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables*

[3] [3]*https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables*

- **Safeguarding risk factors** – the final set of data includes child in need cases per area across domestic abuse, parental mental health and parental substance misuses as well as behavioural and safeguarding concerns.

The data has been assessed across the three-year period from 2017/18 to 2019/20. The risk indicators have been aggregated to produce an average risk index for each local area, with 1 being the lowest and 10 the highest.

Map 2 below, illustrates the areas in Warwickshire where there are high risk factor scores, with darker areas having the highest rates, against an average score of 5.3. The table sets out those areas which have consistently recorded the highest score or, in the case of Bede Bedworth Town Centre, where the score has increased to 10 in the 2019-20 12 month period.

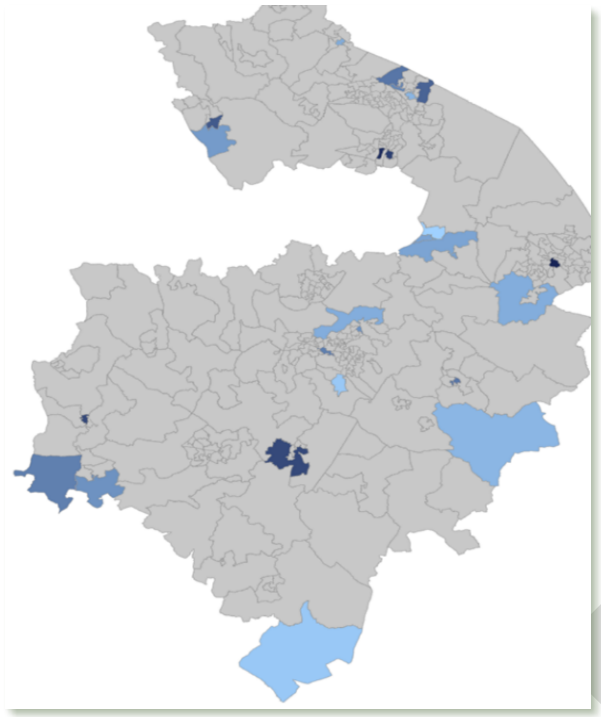


Aggregated

LSOA	17-18	18-19	19-20	Average
Bar Pool North & Crescents	10.00	10.00	10.00	**10.00**
Camp Hill Village & West	10.00	10.00	10.00	**10.00**
Mancetter South & Ridge Lane	10.00	10.00	10.00	**10.00**
Kingswood Grove Farm & Rural	10.00	9.00	10.00	**9.67**
Atherstone Central - Centre	9.00	9.00	10.00	**9.33**
Hill Top	10.00	9.00	9.00	**9.33**
Lillington East	10.00	9.00	9.00	**9.33**
Middlemarch & Swimming Pool	10.00	9.00	9.00	**9.33**
Bede Bedworth Town Centre	9.00	8.00	10.00	**9.00**

Map 2 and Table 1 - Areas where there are high risk factor scores, against an Countywide average score of 5.3

As part of our review of the causal risk factors we looked at the areas that have had the biggest increases across the three-year period. Map 3 and Table 2 highlights the 6 areas in Warwickshire which had a risk score increase of 3 or more.



Lower Super Output Areas	Average Risk Score			
	17-18	18-19	19-20	Change
Thurlaston	1	3	6	**5**
Crown North East	3	4	6	**3**
Southam North	4	5	7	**3**
St Nicholas East & The Long Shoot	5	5	8	**3**
Wedding South West & River	3	5	6	**3**
Weddington North	4	5	7	**3**

Map 3 and Table 2 - Areas in Warwickshire which had a risk score increase of 3 or more

Causal factors – case Analysis

A recent assessment of 23 cases referred to the Warwickshire Serious Organised Crime Interventions Group has highlighted that:-

- In one in three cases there is a history of domestic violence and/or abuse in the family.
- Over half of those referred had been exposed to violence within their peer group and wider community.
- Approximately a quarter of cases had reference to substance misuse, whether personally or within the family.
- One in five cases made reference to bereavement or long term chronic ill-health in the family.
- In one third of cases, the person referred had been a victim of crime or bullying.

These findings are consistent with other similar research on cases referred to Serious Violence Reduction Programmes, nationally and internationally.

Summary

Whilst Warwickshire records significantly lower levels of knife and gun offences, the impact of drug markets through county lines is a growing issue, affecting a number of communities across the County. This is of particular concern in areas where there are high levels of health, societal, educational attainment, causal crime and safeguarding risk factors, or where those risk factors are increasing.

Developing programmes and projects in those areas which have a long-term impact in reducing these risk factors will be key in delivering serious violence prevention for local communities.

Our Vision

"For Warwickshire to be a place where people, across all walks of life, work together to tackle the causes and consequences of serious violence, through collaboration, and to create a network of support so that the cycle of serious violence is broken."

Our Definition of Serious Violence

We have adopted the World Health Organisation definition of violence as follows

> *"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."*
> Krug et al, ed. World report on violence and health. 2002, World Health Organisation: Geneva

(A whole-system multi-agency approach to serious violence prevention HM Government Oct 2019[4]

However, our definition will include **coercive and/or controlling behaviour and financial abuse** which are part of the underlying causes of violence, as set out in this Strategy. This will ensure our approach aligns with other key strategies which address other forms of violence such as Domestic Violence Abuse and Violence Against Women and Girls.

In the 2018 Serious Violence Strategy[5], the government set out serious violence as including "specific types of crime such as homicide, knife crime, and gun crime and areas of criminality where serious violence or its threat is inherent, such as in gangs and county lines drug dealing. It also includes emerging crime threats faced in some areas of the country such as the use of corrosive substances as a weapon".

What our strategy covers

Warwickshire's Serious Violence Prevention Strategy includes:-

- **Domestic Abuse** - domestic abuse is abusive behaviour of a person towards another if both are aged 16 or over and are personally connected to each other. Behaviour is abusive if it consists of any of the following:
    - physical or sexual abuse
    - violent or threatening behaviour

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862794/multi-agency_approach_to_serious_violence_prevention.pdf)

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

- controlling or coercive behaviour
- economic abuse (which is behaviour that substantially affects a person's ability to either acquire, use or maintain money or other property, or obtain good or services)
- psychological, emotional, or other abuse.

- **Sexual Offences** - Sexual abuse encapsulates various forms of crime like rape and sexual assault, sexual harassment, online grooming, and domestic abuse or violence. Sexual abuse is when someone is forced, pressurised, or tricked into taking part in (or witnessing/watching) any kind of sexual activity with another person. Examples of sexual abuse include:
  - unwanted touching
  - indecent exposure
  - being forced to look at sexual pictures or videos
  - sexting
  - child pornography.
- **County Lines** – (the exploitation of individual, families or groups, through a network of drug supply from one area to another, carried out by organised criminal networks)
- **Violence involving a weapon** (including knife crime, gun crime and corrosive substances)
- **Street gangs** - including feuds, disrespect, territory-based violence
- **Serious violent acts driven through social media** – (either using threats or coercion or using social media to promote serious violent conflict)
- **The Causal factors of serious violence** – our strategy sets out the underlying factors that directly impact on serious violence. These factors, can relate to an **Individual** (such as experiences of violence, bullying, bereavement or loss), **Family** (for example domestic violence, violence against women and girls, family breakdown or chronic ill health within a family member), **Peer** (such as conflict or feuds between peer groups), **School** (low attendance, engagement or educational attainment), and **Community** (for example poor housing, environmental neglect, poot transport links, high levels of unemployment).

Our core principles – A Trauma Informed Approach to serious violence prevention

Public Health England, in its publication, “A whole system multi agency approach to violence prevention” (see footnote 4), sets out three levels of violence prevention:

1. primary prevention (preventing violence before it happens)
2. secondary prevention (an immediate response to instances of violence) and

3. tertiary prevention (focusing on long term care and support).

Interventions to address violence are defined as universal (aimed at a general population); selected (targeted at those more at risk); and indicated (targeted at those who use violence).

The Warwickshire Serious Violence Prevention Model, which is described in detail below, combines these universal and selected interventions, supporting those most impacted by serious violence whilst creating a climate where serious violence is not tolerated, thereby protecting future generations. (see Diagram 1 below)

A Trauma Informed Approach to Serious Violence Prevention

At the core of our Model is a Trauma Informed Approach to serious violence prevention.

Trauma-informed, is a strengths based framework that is grounded in an understanding of and response to, the impact of trauma. It emphasizes physical, psychological, and emotional safety for those affected by serious violence, and creates opportunities to rebuild a sense of control and empowerment.

Our Trauma Informed approach to Serious Violence Prevention:-

- **Realises** the widespread impact of trauma for individuals, families, peer groups, schools and local communities affected by serious violence, and understands potential paths for recovery;
- **Recognises** the signs and symptoms of trauma in clients, families, staff, and others affected by serious violence;
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatisation
- **Resists Re-traumatisation** of those we work with and our staff.

The following diagram illustrates our Warwickshire Trauma Informed Violence Reduction Framework, developing a range of Trauma Informed programmes that can:-

- Prevent serious violence by working across our partners to identify those most at risk of violence due to previous trauma and adversity.
- Respond to immediate issues by offering trauma informed support across our partnership services.
- Adopting a long-term approach, by embedding trauma informed practice at a school and community level.

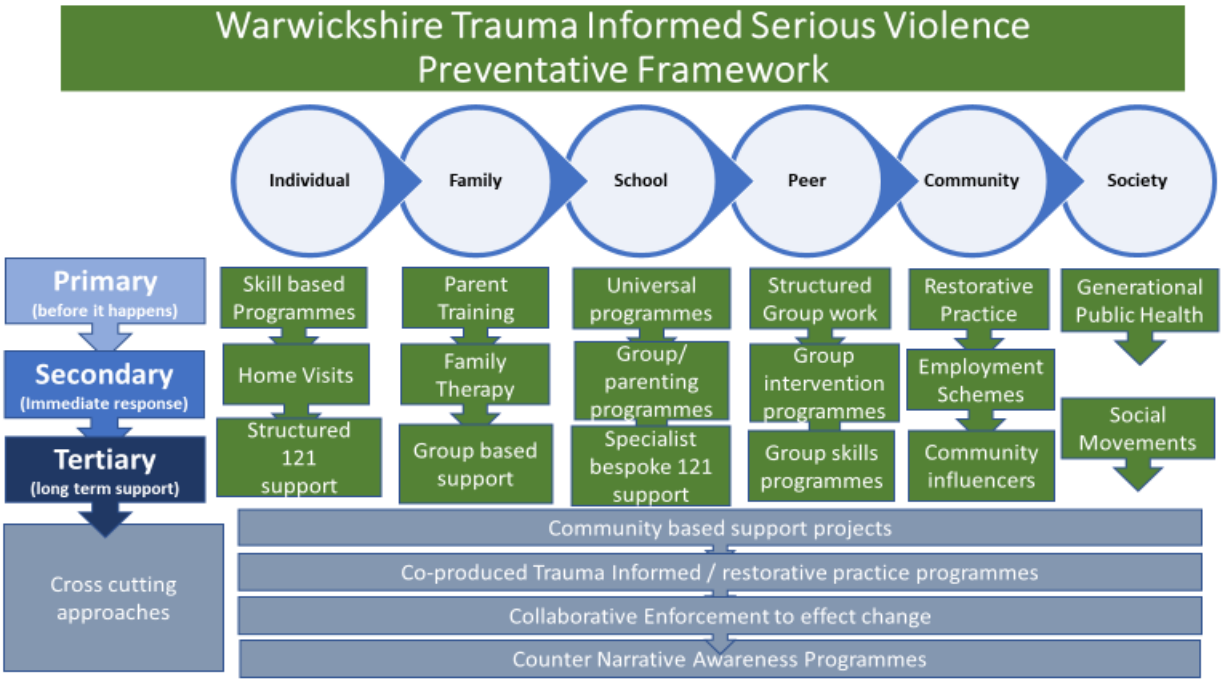


Diagram 1 – Trauma Informed Serious Violence Preventative model

A Statutory Duty to Prevent Serious Violence

The Police, Crime, Sentencing and Courts Act 2022, sets out a Statutory Duty for named services to share data, intelligence and knowledge to understand and address the route causes of serious violence. The Duty states that the following agencies should *"work together to identify and publish what actions they need to take collectively to reduce violent crime"* (including domestic abuse and sexual offences) and will be accountable for their activity and co-operation.

- Police,
- Local councils,
- Fire and Rescue
- Local health bodies such as NHS Trusts and Integrated Care Boards,
- National Probation Service and
- Education representatives and
- Youth Offending Services.

The Duty is intended to create the right conditions for authorities to collaborate and communicate regularly, to use existing partnerships to share information and take effective coordinated action in their local areas.

It is recommended that the partnership takes a Public Health Approach to tackling and preventing serious violence.

Serious Weapon Homicide Reviews

In addition to the above Duty, the Act has introduced Serious Weapon Homicide Reviews. The Act makes provisions into the circumstances of certain homicides where the victim was aged 18 or over and the events surrounding their death involved or were likely to have involved the use of an offensive weapon.

An offensive weapon includes but is not limited to knives, guns or corrosive substances.

These reviews adopt a similar approach to Domestic Homicide Reviews, by looking at the involvement of key agencies and the lessons learnt that could prevent similar tragic deaths occurring. Warwickshire will seek to be an early adopter of this approach, benefitting from the learning at the earliest opportunity.

The Warwickshire Violence Prevention Model

The Warwickshire Serious Violence Model is based on well researched Public Health approaches to violence reduction, combined with current safeguarding principles.

Our model is described in the following diagram and is based on:

- **The 5 C's approach** – Collaboration, co-production, co-operation in data intelligence and sharing, a counter narrative, embedded in a community consensus approach are recognised by Public Health England as core elements to any violence prevention approach
- **Trauma and Adversity -** Led by Public Health Wales, there is strong evidence of the association between childhood adversity and poorer physical and mental well-being across a person's life, through childhood, adolescence and into adulthood. The evidence shows that adverse experiences can have a negative impact on child and adolescent brain development, which are associated with a variety of health harming behaviours in adolescence that can impact on physical and mental health and well-being. There is evidence to suggest many who have adverse experiences will have been exposed to other adversities during childhood, including those related to structural and social inequalities, poverty, bereavement, loss and discrimination. Our model assesses these experiences, developing interventions that can have a long-term positive impact in a person's emotional and social development.
- **Understanding Risk and Protective factors** – Alongside trauma and adversity, risk and protector factors enable agencies to recognise the risks in a person's life and the positive elements that can be built on. This approach acts as a counter narrative to the issues that a person affected by serious violence may present, building on the positive abilities, or relationships, that can keep them safe.
- **Contextual Safeguarding** – Professor Carlene Firmin developed an approach to safeguarding which looks beyond their individual and family dynamics, by exploring, their peer, school and wide community relationships. Each context is weighted, for each individual, looking at the risks and protective characteristics.

- **Capricorn Framework** – developed by Public Health England, the Capricorn Framework recognises the opportunities for collaborative approaches to prevent offending and re-offending by children, by looking at primary (or 'upstream') causes of offending, as well as secondary (or 'downstream') causes.

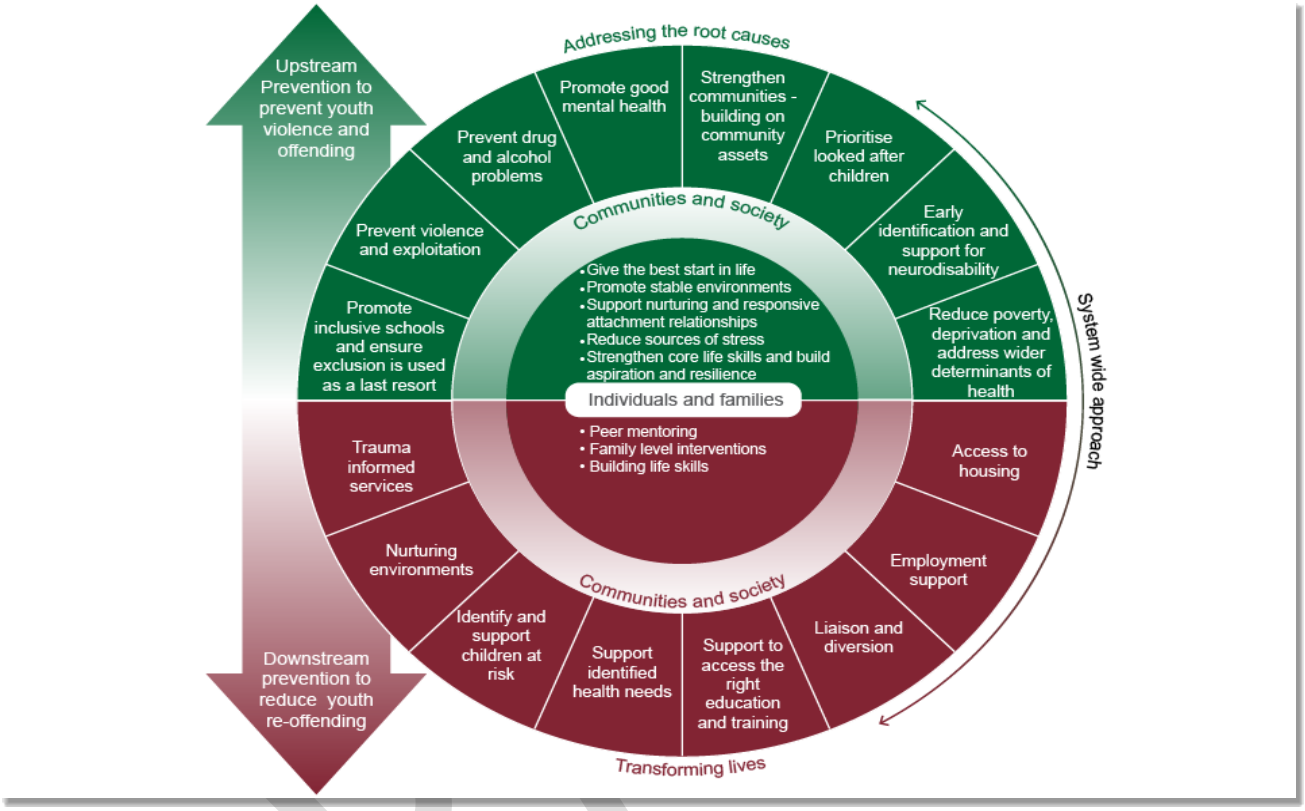
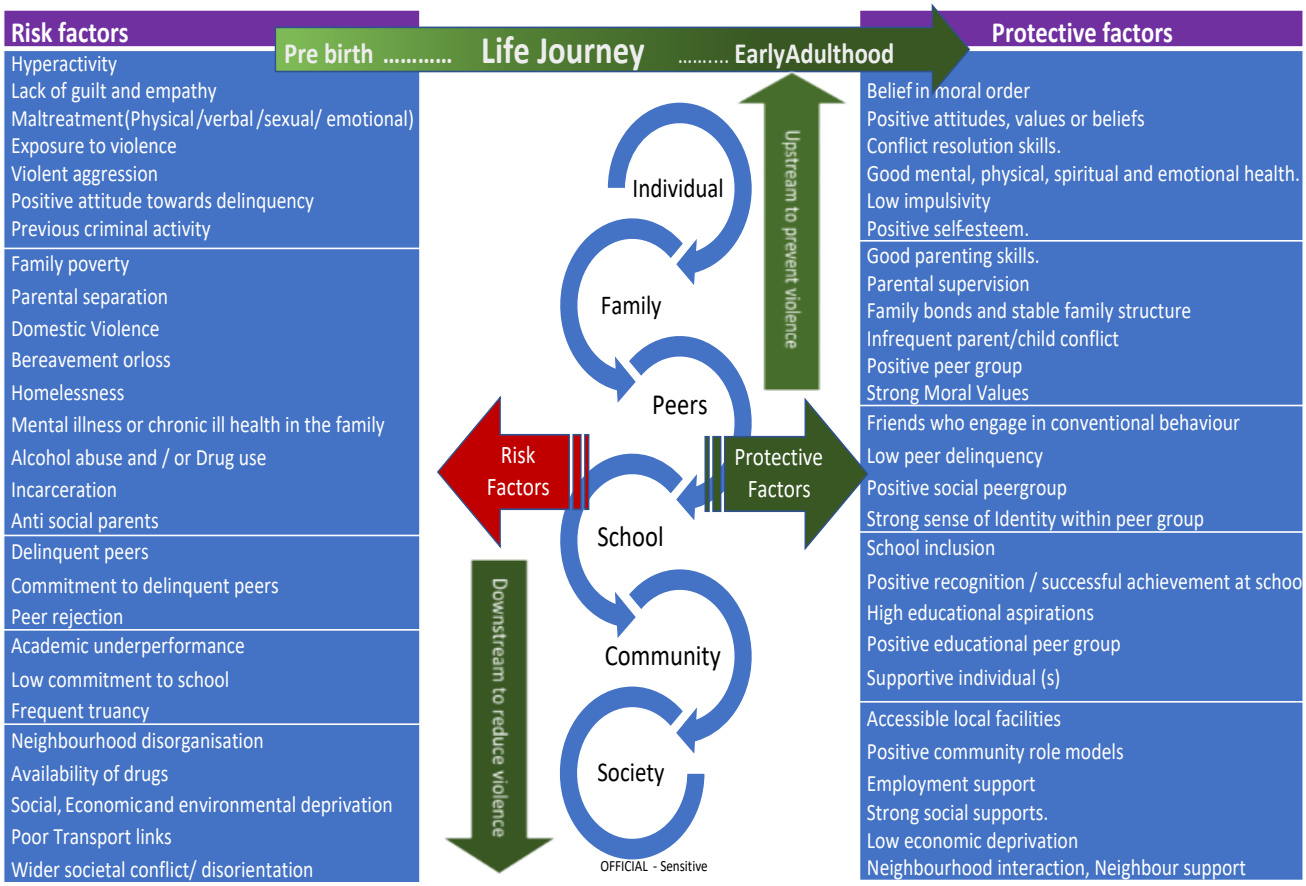


Figure 2 (Capricorn Framework – PHE 2019)

The following two diagrams illustrates how we have combined these approaches to create our Warwickshire Violence Prevention Model.

Diagram 3 – Public Health Approaches to Violence Prevention

Diagram 4 – Warwickshire Violence Prevention Model



In summary we will use the Warwickshire Serious Violence Model to:-

	Developing a serious of universal, targeted, and intensive interventions that prevents people becoming involved in

Prevent Serious Violence before it happens	county lines, group, or gang violence, carrying, or using a weapon or becoming involved in social media that leads to violent conflict.
Respond to emerging or immediate risks of serious violence	Co-ordinating a response, led by criminal justice, safeguarding, education and community safety leads to reduce the immediate threat of county lines, gang or group violence or weapon related violence.
Long Term Support	Co-produce a series of interventions that offer routes out of county lines or violence conflict, strengthen communities to create an environment where serious violence is recognised and challenged; collaborate with health colleagues to embed violence prevention at the core of the long-term approach to the determinants of health.

Setting out our long-term Strategic Approach

Warwickshire partners want this strategy to be different. We want to bring it to life so those that read it recognise the importance of a preventative approach and the role they can have in delivering it.

In order to do that we have taken a series a real-life case studies of people affected by serious violence and merged them into one, life journey. Each chapter sets out part of that journey from early years to adulthood. Each chapter uses the Warwickshire Violence Prevention Model to define the issues, identify the opportunities and what we will do to make a difference, collaboratively.

We fully recognise that a number of the challenges we face are both generational and societal. Basing them on a real life journey, we can start to see how we can affect change by defining the problem, identifying the causes, delivering interventions at the right time with the maximum impact, and bringing what works to scale, for the benefit of communities across Warwickshire.

Aim – our aim is to use the Strategy as an awareness raising training programme with key partners across health, criminal justice, police, educational providers, children and families and community organisations so that they can recognise the crucial role they play in violence prevention.

Chapter 1 "The journey in the life of……"

0-5 My early years

"My early years? To be honest you are the first people to ask me that.

It's a bit like a jigsaw puzzle. I've heard what people have said about my first few years. My mum was young when she had me, 17 I think, she had lots of issues, mostly drugs and alcohol. When she was up she was like really up, but there were lots of dark times, I remember them. My dad, well I can't say much about him. I had an older sister and my grandmother. I remember being safe with them.

What I do remember is being cold and hungry, I remember being frightened when we weren't allowed in the house. I remember being frightened when my dad came round, the fights and the beatings. I remember being beaten when I wet the bed and I remember when the front door was smashed in by the police and crying when social workers came to take us away. I remember the times we were evicted, not all of them, but I remember my sister crying and being scared at night in the places we lived. They were never a home.

I cannot see these things clearly, but I still feel them, being cold, frightened and hungry, unwanted. I suppose that's why I did what I did to survive."

Defining the issues and opportunities

Collaboration- Recognising the factors related to adversity and trauma. Opportunity for collaboration across agencies to address drug, alcohol and domestic abuse through a single co-ordinated response

Co-production – Importance of co-produced, co-ordinated heath care support with front line staff able to recognise the risks within the family

Co-operation – key information shared across all agencies to better assess risk and protective factors

Counter Narrative – stable and safe accommodation could have provided the opportunity for co-ordinated support. Missed opportunity to work with other supportive family members. Provide direct support for the father through DV perpetrator programmes

What we will do to make a difference

Countywide

Train all front-line family health providers to recognise Aversity and Trauma and Contextual Safeguarding

Create a single front door for lone parents 16-24 with complex needs

Ensure that those residing in DA safe Accommodation are supported with financial, practical, social and emotional support

Commission an all-age drug and alcohol service that focuses on early intervention, prevention and appropriate treatment provision

Local

Create locally based emotional support programmes for extended family carers

Assess local community assets to ensure there are accessible facilities offering social, practical, and emotional support for young parents and carers.

Chapter 2

5-11 My primary years

"I remember my first day at school. Yeah, that was special. It felt like an escape. My sister took me cos she was a few years older and my mum was having one of her dark times. I tried real hard to make friends, I wanted to be someone people liked; that wanted to be my friend. It was important. Yeah I was physical, but not violent.

I did well in my first year. I loved art and I was told I was gifted. That was a big thing, I still remember it. It was in the second year when I started to get bullied. It was my clothes to start with, then people said I smelled. That hurt. After a while it got the better of me, so I started to deal with it, to fight back. I got labelled, but I also got different friends, more loyal. Some of them are still my friends now. My Gran got called in, like every few weeks. Then I got suspended. I stopped doing art cos it didn't fit with the image I had….I wanted.

My Gran died when I was 9. I don't want to talk about that.

Mum had a new boyfriend and he was good for her. She started getting straight and we stopped having lots of different people in our house, night and day. Her boyfriend? I didn't like him and after a while my sister starting to stay out, stayed at friends, even though he would go searching for her. I missed her but she had her life and I couldn't protect her."

Defining the issues and opportunities

Collaboration- collaboration between schools, children, families and health providers to ensure that emotional support for young people affected by trauma is accessible at the point of need.

Co-production – issue of bullying connected to challenges within the family, financially and emotionally that require a co-produced intervention. Opportunity to universally address bullying and the impact of a young person at risk.

Co-operation – review how intelligence is shared across agencies from a contextual safeguarding perspective so that a wider range of agencies can be involved in determining risks for the whole family.

Counter Narrative – opportunity to focus on the positive characteristics and provide additional support in school and at a community level could have developed stronger self-esteem.

Community Consensus – involvement in community based programmes offer an opportunity to develop pro-social friendship groups.

What we will do to make a difference?

Countywide

Develop a training and awareness toolkit for all educational providers to recognise the signs associated with adverse experiences which can harden trauma and the impact of trauma.

Establish an advice and support service for schools and college staff to discuss emerging trends and issues

Define an accessible emotional support programme for young people and families affected by loss.

Work with Street Doctors to introduce First Aid, Knife Awareness sessions for year 6 and year 7 groups.

Local

Ensure that practical support for families is easily accessible and does not create stigma.

Local intelligence sharing across early years and primary education, local authorities and children and family services so that practical and emotional support can be provided by local services.

Create local Serious Violence Prevention Community Forums, engaging with community and voluntary sector organisation to develop and deliver local intervention programmes.

Chapter 3

11-16 – Shaping my identity

"My first year at secondary school was tough, bit of an initiation I suppose. I got robbed to start with, school bag, money, my shoes. Mum got angry and reported them at first, to the school and the Police. Nothing changed. I wasn't the only one.

By the second year me and my friends started forming our own alliances with some of the older kids. They got me a bike and I did some work for them to pay them back, nothing heavy. We looked out for each other. Yeah, there were a group of us, boys and girls. That's one thing you lot have got wrong you know. You always focus on the boys when its often the girls that bring things on.

By year 9 I had a rep. I did a few things I wont lie. But I was earning money and I was current. That's something else you lot need to understand; what it means to be current. By the time I was 15 I had a plan. I stayed at school. I could of got expelled but I'm not stupid. I made sure school worked for me.

My mum? She had two other kids with her man. I was close to the oldest. He was 5 or 6 by the time I was in year 10. He looked up to me and I looked out for him. Then mum got cancer. Her man said I should take care of her, but I wasn't invested in her like that. My sister moved back in to help out. She was 18 then, had a kid on the way. But she moved back for mum. She told me what mum's boyfriend did to her. That's when things really turned. I got my friends over, even some of the olders, we dragged him out the house and beat him, in the middle of the street. Police got called. But no one said anything, not even my mum. What did I feel? An adrenaline rush, that's what's I felt. I got fixed on it, for the first time in my life I felt alive.

Defining the issues and opportunities

Collaboration- Emerging issue of services working in isolation as they address issues as they arise. Opportunity to collaborate between the school, community organisations, target youth support, police and health agencies to design interventions that can be delivered within and outside of the school setting

Co-production – Opportunity of co-produced support between health providers and family nurse partnership to support families with complex health needs.

Co-operation – co-operation between police and educational establishments to share low level intelligence on incidents that could lead to an escalation in risk, including violence through social media

Counter Narrative – Opportunity to build on the positive relationship with younger sibling(s). Opportunity to involve the wider peer group in programmes focused on the positive strengths.

Community Consensus – Local communities are best placed to identify patterns of behaviour that could lead to escalation in violence. There is an opportunity to provide community and voluntary sector leads with greater knowledge of the signs to look out for and where to seek advice and refer.

What we will do to make a difference?

Countywide

Embed the Warwickshire Whole School Approach to Violence Prevention across all Secondary Schools in the County

Introduce the "Mentor in Violence Programme" for Schools to invest in for both staff and pupils (see below)

Expand the Warwickshire "Identity Programme" for both parents and young people (see below)

Review the commissioned provision of Mental Health and Emotional Support Services for children and young people to ensure it is accessible and responsive to those most at risk of becoming involved of serious violence

Embed the Warwickshire Violence Prevention Model across agencies and expand the attendees at SOCJAG interventions to include schools and key health providers.

Review our social media and cyber educational programmes to ensure they focus on violence prevention and risks of exploitation

Local

Carry out a review of local community and voluntary provision that young people and parents with complex health needs can be sign posted to.

Identify local community and voluntary sector providers that would run sessions within the school environment.

Chapter 4

16-21 Becoming an adult?

To be honest, once I finished school things got mad. I got my GCSE's, including Maths and English. I got signed up for college. But, in reality, it was all about my friends, what we did on road, the parties, earning money, staying current. Yeah, we smoked and took stuff. But we weren't like those nitties. We carried stuff, set up houses, carried phones, got paid for all sorts of work. Fed's were all over us, but there we were a crew so they couldn't pin anything.

I first got stabbed when I was 16. I was dumb. Wrong place with the wrong people. But it helped my rep. I posted selfies of me in the hospital with the stiches in leg. Yeah I've been stabbed three times, but back then it's like I was invincible. When we got to about 18-19 some of my friends wanted out. There was a lot of beef over that. Some of the olders stepped in. One of my friends was called out. He got stabbed by others in our group. He was lucky to survive. That's when it all started to fall apart then. We didn't know who to trust. So we kept it tight, between 3 or 4 of us and started to recruit our own youngers.

Arrested? Yeah I got arrested lots of times. Most of them just go NFA'd. I had a number of people who worked with me, from social services I think or the youth offending team . Most of them were busy and they changed every few months. Some of them described me as being "exploited"! Like seriously, who do you think has exploited me? There was one worker, she was good but then when I got to over 18 that all stopped. Seems that being 18 changes you. By then I had left home. I was mainly sofa surfing and if I didn't have anywhere to stay I paid for a hostel. I learnt to drive, bought a car and some nights slept in that. When I was 20, I got arrested on the M1 with a kilo of coke and £5,000 in cash. I had a younger in the car, 14, 15 years old. He took the main rap. But I still got time.

Prison? Yeah prison was hard. Too much time locked in a cell. I wasn't ready for that. That's when I got into drugs, not like addicted, just to get through the days so I didn't have to think much.

Defining the issues and opportunities

Collaboration- Issues of multiple interventions that are time limited, with no long term consistency. Opportunity for NHS Trusts and mentoring agencies to work together supporting young people up age 24 who have a stabbed/gun shot injury

Co-production – Issue of how intervention and enforcement agencies work together to co-design targeted interventions pre and post custody. Issue of co-produced intensive support programmes for 17-24 year olds.

Co-operation – Opportunity for sharing intelligence across enforcement, criminal justice and intervention providers to better assess escalating risks so that interventions can be more targeted.

Counter Narrative – Opportunity to build in the entrepreneurial/business skills that have been developed, to create legitimate employment or business opportunities.

Community Consensus – Opportunity of working with local communities to better understand the local dynamics that are affecting serious violence and in designing local solutions.

What we will do to make a difference

Countywide

Establish a Community Violence Navigators Programme that can be rolled out in local areas affected by serious violence

Establish a Warwickshire based programme of youth workers linked to NHS Trusts to support any young person, aged 14-25, who have suffered a serious violence injury.

Establish a sustainable Countywide Serious Violence Exit programme based on the principles of the Boston Ceasefire Model(see below).

Expand our Fair Chance employability and skills offer for young people affected by serious violence so that they are both work ready and successful in seeking employment opportunities

Local

Establish a local employment opportunities scheme or employment placements for young people at risk of becoming involved in serious violence.

Identity local funding opportunities for training programmes for young adults.

Train community-based Violence Interrupters in key local areas affected by serious violence.

Chapter 5

21 plus- Moving on?

I did just over 2 years. By the time I came out my friends had moved on. Seems I wasn't current anymore I got put into an AP, cos I refused to go home. I did some work, nothing heavy, just to earn some money. I got arrested few times, returned to prison and re-released. By the time I was 23-24 I had enough. So, I got some night work on the railways. It was alright until they did a random drugs test, then I was let go. I got my CSAS card through my Probation Worker. Respect to her. I'm back at college now training to be a painter/decorator and working for a construction company. Seems I'm quite good at it. My Probation Worker said she would get some counselling, but turns out I'm not eligible. I'm not bothered.

Did I mention I had a kid? Yeah, he's 5 now. That changed a lot. My sister has helped bring him up so I didn't lose touch. She's got her own place now, she's training to be a nurse. I'm also seeing someone, its good, we argue but I don't know any relationship where there isn't some heat every now and then.

Mum? Her man left her just after she got sick. But she's clean, she's been clean for a few years. She works in a home supporting older people. She's doesn't get paid much but she's got a new man, whose got his own kids and he's good for her. I don't go round.

My younger brother? I still keep an eye out for him. He's between schools right now, but he needs to make his own choices.

I still see some of my friends, we meet up for a smoke. Most have moved on but those that haven't we still stay close to. You cannot just walk away you know! When you think about it, there a lot you cannot just walk away from.

What would I change in my life? I don't know, no one ever asked me that before. I don't know how to answer. What would you change?

Defining the issues and opportunities

Collaboration- Opportunity to strengthen the relationships between secure estate, Probation and local employers to create skills and educational opportunities for those exiting serious violence lifestyles

Co-production – Issue of increased threats, intimidation and violence against those seeking to exit a group. Opportunity to co-produce a programme between Police, criminal justice and front line services to reduce conflict before it escalates.

Co-operation – Issue of how criminal justice agencies safely share information on clients with employees to enable better support within the work place and employment opportunities to be maintained.

Counter Narrative – The positive influence of having a child is a key opportunity for change and reinforcing the positive opportunities of change.

Community Consensus – Opportunity of working with local communities, including local businesses to establish employment pathways, with the result of creating positive role models.

What will we do to make a difference

Countywide

Invest in a Warwickshire Mentoring Programme to train local people to become skilled mentors to provide long-term support.

Establish a countywide Business Entrepreneurs programme directly focused on young adults affected by serious violence.

Establish a dedicated support service to support employers who are willing to offer employment or volunteering opportunities for young people affected by violence.

Establish a multi-agency serious violence interventions team, targeting support for those seeking to exit serious violence lifestyles, including practical, social and emotional support.

Establish a Warwickshire Conflict Mediation Service with the aim of reducing the conflict between group or within groups to enable people to exit safely.

Embed the Caring Dads programme across the county

Local

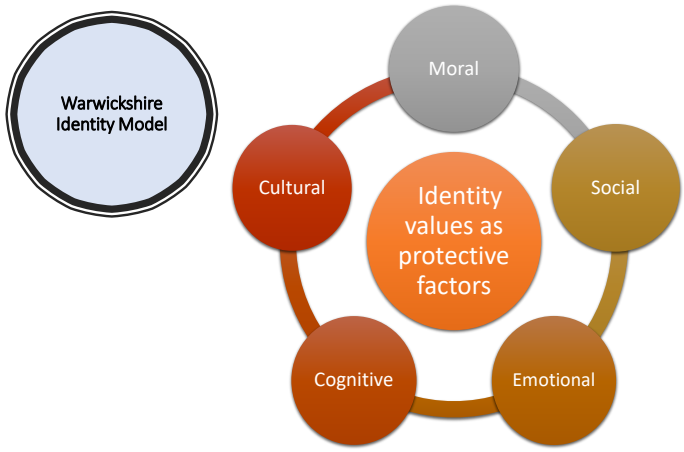
Work with local Business Improvement Districts and Growth Hubs to expand the employment and skills opportunities as a pathway for those looking to exit serious violence lifestyles.

Working with local colleges to review the vocational educational courses so they are accessible to young adult offenders.

Warwickshire Identity Model

The Warwickshire Identity Model has been designed in partnership with voluntary organisations, schools and Public Health colleagues. The model can be used by front line workers and is designed to both assess and challenge young adults on five dynamics which shape their identity. It can also be used in working with parents to help them in understanding and influencing the identity of their young adults.
The aim is to help young adults to explore what influences them and how they can evaluate what makes them the person they are and the person they want to be. The 5 dynamics are:-

- **Moral** – Understanding the Moral Values they have and why they are important. Through reviewing what is morally acceptable by exploring different moral dilemmas creates the opportunity to reset their Moral Compass for themselves but also in terms of those around them.
- **Social** – Exploring how current social issues shape and influence them. Debating social issues creates the opportunity to understand different perspectives and how they can influence societal changes.
- **Emotional** – Understanding what influences our emotions, recognising the importance of those influences and how to channel them in positive ways. Defining Emotional Intelligence and developing skills to recognise how others are affected by their own emotional journey.
- **Cognitive** – Recognising how others are affected by their actions, or how others perceive them. Reflecting on how their actions or perceptions impact on others creates the opportunity for changing their approach to confrontational or challenging situations
- **Cultural** – Exploring their cultural journey and how their journey is different to that of their parents, siblings and peers. Taking the opportunity to value and celebrate that journey, rather than reflecting on the issues or confrontation that it has or could create.



Boston Ceasefire Model

The Boston Ceasefire Model is a problem-orientated police model originally designed to reduce gun violence in the US city of Boston. The Model was originally based on two strategic approaches: to co-ordinate enforcement agencies to maximise every opportunity to disrupt those involved in gun violence; to develop interventions that deter violence, referred to as “pulling levers”. The Model was introduced in other US cities and in the UK in the mid 2000’s. Research has highlighted that the Model has a value as part of a sustained multi-faceted violence intervention programme.

Principle of the “pulling levers” approach is:-

- Target gangs/groups directly involved in violence
- Reach out to those involved, as a group or individual, with an offer of help to move away from a lifestyle of violence
- Re-enforce the message that violence will not be tolerated. This message is given from authorities and local community leads
- Co-ordinate enforcement action against those who chose to continue with violent conflict

In the UK, this approach was delivered by a series of “Call-In’s” involving partnership organisations, key community influencers and the voice of those affected by violence. The offer of support formed part of other criminal justice interventions, rather than delivered separately. This has increased compliance and resulted in better outcomes.

Warwickshire Serious Violence Prevention - Whole Schools Approach

A whole school approach is vital for the sustainability of a County Line and Serious Violence Prevention Model. In essence the ambition is to take every opportunity to embed programmes within the fabric of the school, educationally, socially and culturally, to provide young people and parents with the skills to recognise the risks and have the support to make alternative choices to prevent violence.
The aim of the model is:-
"To support young people to make positive choices, to recognise the risk and long term consequences of county lines and provide specialist support for those young people at risk of being exploited by county lines and serious violence associated with county lines".
Nationally there are a wide range of whole school programmes available. This evidence is strongest where there is:-

- ✓ A core theme, or core programme which remains central and committed to its original objective.
- ✓ The core theme, or core programme is sustained over a number of years.
- ✓ The schools approach is part of a wider, community response to violence prevention, where local partners and community leaders co-produce the programme.

The Warwickshire Whole Schools approach works with the Senior Leadership Team of a school, College or Trust to design a structured programme that supports teachers, students and parents, based on the issues that the school is facing. The programme can be delivered through a universal offer, aimed at groups of students and parents who are affected by gangs, knife crime or county lines, or through bespoke 121 support. Where the opportunity allows, the programme directly involved local community organisations and businesses with the aim of developing local interventions or pathways out.

Warwick Community Impact Operations Group CIOG

Following two county lines related murders in 2020, the South Warwickshire Community Safety Partnership established a partnership to identify those most vulnerable to exploitation through county lines and also develop a range of local disruption tactics to prevent criminal networks establishing drug supply networks in local areas.

Since the group was established 309 individuals have been identified, many of which received positive partnership interventions.

One example of the success of the group relates to a vulnerable male who was being exploited by a County Lines from Coventry. His flat was cuckooed using a combination of violence and the promise of free drugs. Warwickshire Police made a number of arrests at the property and support services were able to engage with the victim supporting him to access a 12 month rehab placement out of area. As a result this person has relocated and now volunteers at the hospital where he recovered.

How we will deliver the Strategy

The Safer Warwickshire Partnership Board is the strategic board which sets the ambitions and priorities for the county to reduce crime and the fear of crime. However, as we have highlighted above, delivering a long-term approach to serious violence prevention requires collaboration across other strategic partnerships and the co-production of programmes.

The Health and Wellbeing Board is a crucial strategic partnership. Our intention will be for these two boards to co-design our approach, maximising the resources available and, importantly, to use their influence across partner organisations to deliver the Serious Violence Prevention Model set out in this strategy.

In 2021 the Safer Warwickshire Partnership undertook a review of the Board, setting out three long term strategic ambitions:-

- Addressing the root causes of violence
- Safer, Healthy and Empowered Communities
- Tackling discrimination in all of its forms

Preventing serious violence is a key priority for the Safer Warwickshire Partnership and this Strategy is critical in achieving the ambitions that have been set.

The following structure sets out our partnership approach in preventing serious violence.

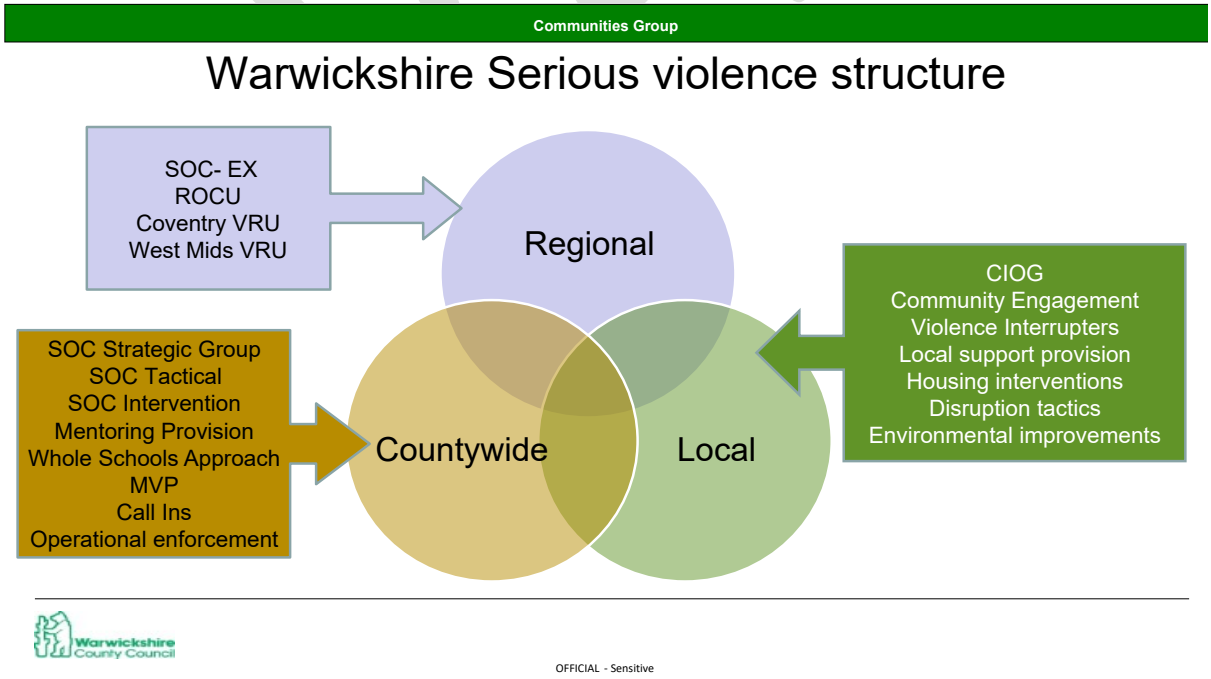
- **Warwickshire Serious Organised Crime Strategic Group** – Sets the partnership priorities and delivery plan to ensure that the Warwickshire Serious Violence Prevention Model is delivered.
- **Warwickshire Serious Violence Tactical Group** – Police and criminal justice led fortnightly meetings to assess the most up to date threat and harm from county lines and gang violence. The meeting reviews the impact of county lines operating across Warwickshire, those involved and the partnership disruption tactics. In addition, the meeting identifies key individuals or groups who affect others or are at risk of being affected into county lines and violent conflict.
- **Warwickshire Serious Violence Interventions Group** – The Interventions Group receives referrals from the Tactical group, local community safety groups, Youth offending Service, National Probation Service, Exploitation and Safeguarding groups, partner agencies and schools. Referrals can be on individuals involved in, or at risk of becoming involved in, serious violence, or groups who are engaged in violent conflict. The Interventions Group includes a range of partner agencies and community organisations who assess each referral using the Warwickshire Serious Violence Interventions Model as set out above. Bespoke interventions are designed with the aim of supporting the individual or group into positive lifestyles
- **Local Community Safety Partnership Violence Prevention Operational Groups** – Each of the 4 Community Safety Partnerships across the County have established local operational groups based on the local challenges related to serious violence. These vital Operational groups use a Problem Solving

approach to identify those most at risk of county lines or group conflict, develops a series of disruption tactics and develops locally based interventions, or routes out. Individuals or groups who are assessed as emerging threats are referred to The Warwickshire Serious Violence Tactical or Interventions Group, as appropriate.

Our Structure

Our structure for delivery is aimed to maximises the resources at our disposal and ensure that the those who need support can access it consistently across the county. The following Venn diagram illustrates our structure. It is based on the interdependences of working regionally, countywide and locally.

- **Regionally** – to ensure that Warwickshire benefits from regional resources and importantly uses its influence to ensure that regional programmes do not adversely impact on communities across the county.
- **Countywide** – to develop programmes that are cost effective and consistent across Warwickshire. A number of programmes such as Mentoring Provision, gang conflict resolution services, parenting support, access to well being services or a universal Whole Schools Approach are best developed and delivered at a county level
- **Locally** – local community safety partnerships are best placed to understand the local issues and dynamics with local communities. Developing disruption programmes. developing local educational or employment schemes, local, environmental improvement or community responses are best delivered at a local level.



Outcome Measures –

The following draft outcome measures and will be formalised through the consultation process. Our ambition is to align the outcome measures with key strategies to ensure we maximise the partnership opportunities. The diagram below illustrates the connection between Warwickshire Community Safety Strategies and National strategies and plans.

On agreement of the Outcomes and delivery plan will be developed. This will be shared across the Community Safety Strategic Boards, but will be the responsibility of the Warwickshire Serious Organised Crime Strategic Group to ensure delivery.

The structure of the delivery plan will be based on the three overarching priorities and the actions or activities will be shared, rather than individual agency. The following table is an illustrative guide to the delivery plan. The plan will be in place by late Autumn 2022 and reviewed quarterly.

	Preventing violence before it occurs	Immediate response to Serious Violence	Longer Support within communities
Training			
Early Identification/ Interventions			
Targeted Interventions/ support			
Specialist Support			
Enforcement			

Overarching Outcomes

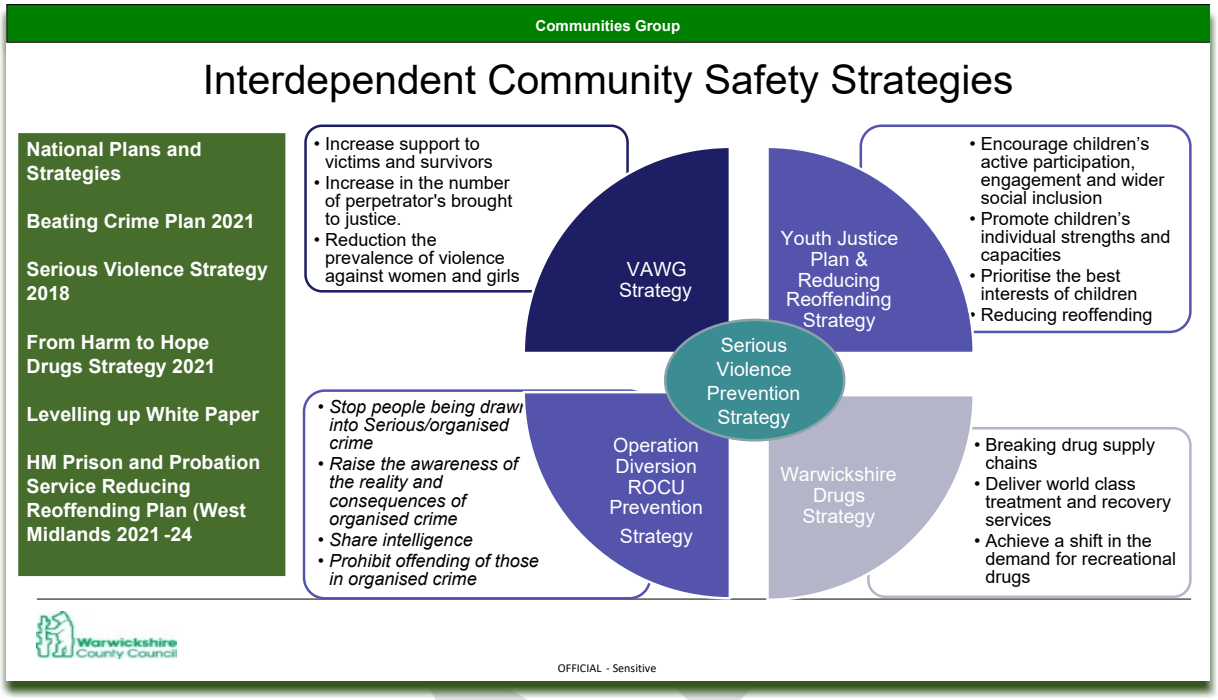
Safer Warwickshire Partnership Board agreed three overarching strategic ambitions. This strategy is directly relevant to the ambition, “Tackling the Causes of Violence”.

The draft outcomes for this strategy are as a follows:-

- Implementation of preventative measures to reduce adversity and trauma
- Embedding Contextual Safeguarding Across all community safety partners
- Improving our response to violence prevention training and awareness of front line practitioners
- Improving our assessment and referral processes for those affected by or at risk of serious violence
- Embed a Public Health Approach to address serious violence
- Establish a cross partnership commissioning fund to key serious violence preventions programme

OUTCOME:- To ensure that all of the Community Safety Partnership Boards, Health and Well Being Board, Safeguarding and Criminal Justice Board, recognise their role in serious violence prevention and co-produce

interventions that can have a long term impact to addressing the causes of serious violence.



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Agenda Item 8

Health and Wellbeing Board

7 September 2022

Health and Wellbeing Partnerships

Recommendation

That Health and Wellbeing Board notes the update from each place-based Health and Wellbeing Partnership in Warwickshire.

1. Executive Summary

1.1 The focus of this report is health inequalities.

Warwickshire North

1.2 Warwickshire North (WN) Place is well established and has made significant progress over the last year working collaboratively with a shared focus around the needs and aspirations of our local population. WN Place has a diverse population and George Eliot Hospital, Primary Care Networks (PCNs), third sector partners and County and Borough Council partners are working together to ensure we are working with and for local people to improve health outcomes and reduce inequalities.

1.3 Wide ranging activities are in progress across WN in relation to health inequalities:

- Population Health Management is focusing on interventions (Helping Everyone Achieve Long Term Health (HEALTH) Passport) for a cohort of pre-diabetic, obese adults with one additional acute condition, a history of smoking and living with high or medium levels of deprivation
- A scheme designed to provide health coaching and non-judgemental support to high intensive service users who have frequent contact with A&E and unplanned admissions, and may also be calling West Midlands Ambulance Service (WMAS) 999 more often than expected.
- GEH with Public Health has completed pathway needs assessment for homeless patients, resulting in six recommendations currently being explored with GEH teams.
- The WN Place team have produced an interactive web-paged dashboard for all partners to utilise, demonstrating multiple metrics across a number of areas related to the King's Fund Population Health model.
- The Health Equity Pilot Project (HEPP aims to strengthen local partnerships and System leadership capability through working collaboratively to address health equality. The aim of the project is to

engage with families within the Nuneaton Central JSNA area to understand the barriers (perceived/actual) that prevent uptake of healthy lifestyles campaigns (Wellbeing for Life) and services (Change Makers) to support management of childhood weight.

- A project is being managed by the Local Maternity & Neonatal System lead to address rising levels in obesity in pregnancy.
- A new model of provision is being developed for smoking cessation in pregnancy and a 9-month Vape pilot for pregnant smokers aims at total smoking cessation at 12 weeks, vaping not encouraged beyond this period.
- Children North East (CNE) are working across Warwickshire Council to carry out Poverty Proofing activities as part of the wider 'Tackling Social Inequalities in Warwickshire Strategy 2021-30' being carried out across the county. CNE will deliver two intervention projects within WN – GEH's Maternity department and North Warwickshire Borough Council's Leisure department.

Further details of all Place activities are provided in the appendix 1 to this report.

South Warwickshire

1.4 Priorities for 2022/23 are focused on improving the population's health and wellbeing through the application of the four quadrants of the Kings Fund Model Population Health Management Approach whilst ensuring health inequalities is a golden thread that runs through all activities.

1.5 Launching an early adopter scheme for the Tribe app; defined cohorts in the areas of Shipston and South Leamington have been agreed with the ultimate aim of helping further develop support for vulnerable and isolated people in their local communities.

1.6 Warwick District Council and WCC have submitted a Levelling Up Bid designed to address air pollution in Leamington Spa thereby tackling health inequalities and respiratory illness (the latter being one of SW Place's priorities for 22/23)

1.7 WDC has submitted its investment plan for the Shared Prosperity Fund to further develop a health and wellbeing centre designed to address inequalities in Lillington, through which services will be developed which focus on addressing respiratory inequalities.

1.8 Other proposals seek in the investment plan focus on preparing a Health Inequalities Fund bid focusing further efforts on the Lillington LSOA area.

1.9 Following completion of the Place Development Programme an intervention has successfully been developed and a health inequalities funding bid submitted, to provide care coordination to children awaiting a CAMHS appointment and identified the need and secured Place funding for an engagement event with the VCSE sector.

1.10 Worked with Act on Energy to develop a communication, sharing tips to encourage people to think about how to save energy at home, to help people across South Warwickshire plan to keep warm and well this coming winter.

Further details of all Place activities are provided in the appendix 2 to this report.

Rugby

1.11 Homelessness projects in Rugby Borough:

- Rugby Place has established a task and finish group led by the Head of Compassionate Communities to engage with young people in Rugby and understand the service available to support young people and opportunities/gaps.
- The Public Health team in partnership with Hope4, P3 and Homeless Link are hosting an Experts by Experience group to understand how the actions and services in place as outlined in the Preventing Homelessness in Warwickshire Strategy are impacting on homeless people in Warwickshire.
- The SWFT Community Physical Health Nursing service and the CWPT Community Mental Health service for the homeless are working in partnership to deliver care using a mobile mini-van with facilities and chance to carry out physical health checks, currently working in the North and Rugby.
- A Needs Assessment for Homeless Patients in University Hospitals Coventry & Warwickshire NHS Trust (UHCW) was completed, and business case developed, conversations to take place at place and system level.
- Rugby Borough Council have a newly appointed Outreach Officer who will work as part of the Hospital- Housing Liaison Service.

1.12 NHS LTP Tobacco Dependency Programme and expansion of stop smoking service provision in Rugby:

- Quit 4 Good – community stop smoking service – provided by GP/Pharmacies. New additional offer of virtual support from Everyone health for smokers in Rugby and Warwickshire north is live and being promoted to residents new phone line/email on -warwickshire.gov.uk.quit4good
- Tobacco dependency programme – to be offered to smokers admitted to hospital, pregnant women and those who access specialist mental health and learning disabilities services. UHCW/St Cross due to start delivering August 2022.
- Tobacco control partnership for Coventry and Warwickshire – scoping projects in Rugby and Warwickshire North to prevent young people smoking/vaping and tackle illicit sales.

1.13 Further details of all Place activities are provided in the appendices to this report.

Appendices

1. Appendix 1; Warwickshire North Place Update – August 2022
2. Appendix 2 - South Warwickshire Place Update – August 2022
3. Appendix 3: Rugby Place Update – August 2022

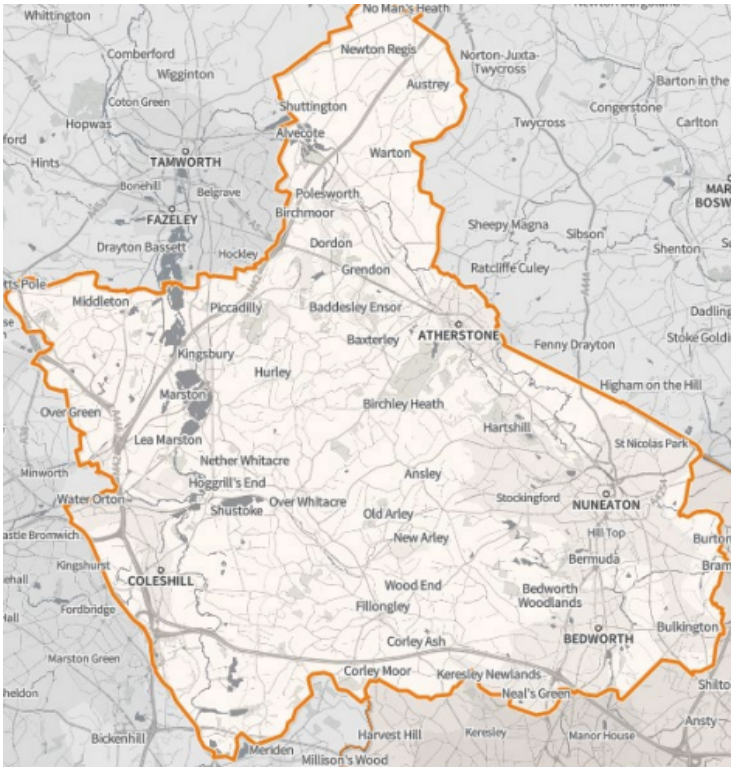
	Name	Contact Information
Report Authors	Steve Maxey, Jenni Northcote, Mannie Ketley, Chris Elliott,	Steve.maxey@northwarks.gov.uk Jenni.northcote@geh.nhs.uk Mannie.ketley@rugby.gov.uk Chris.elliott@warwickdc.gov.uk

Health and Wellbeing Board

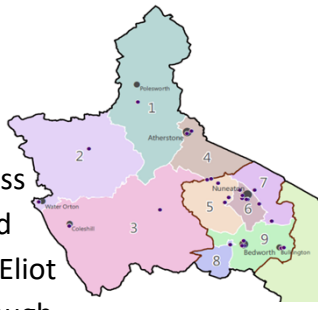
Warwickshire North Place Update

Health Inequalities

August 2022



'Helping you to help yourself; there for you when you need us'



Warwickshire North (WN) Place is well established and has made significant progress over the last year working collaboratively with a shared focus around the needs and aspirations of our local population. WN Place has a diverse population and George Eliot Hospital, Primary Care Networks (PCNs), third sector partners and County and Borough Council partners are working together to ensure we are working with and for local people to improve health outcomes and reduce inequalities.

Examples below focus on some of the work achieved and continuing to progress across WN in relation to health inequalities.

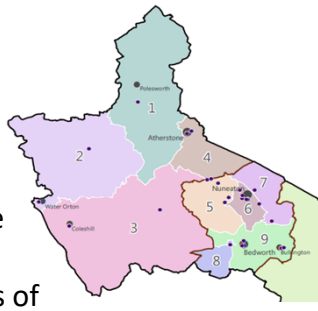
- **Population Health Management (PHM) Programme**

  - WN PHM programme is focusing on interventions for a cohort of pre-diabetic, obese adults with one additional acute condition, a history of smoking and living with high or medium levels of deprivation
  - Proposed intervention is via Helping Everyone Achieve Long Term Health (HEALTH) Passport, helping individuals reduce their clinical risk factors through lifestyle changes by a personalised care plan in five areas of focus:
    - Smoking status
    - Body Mass Index
    - Physical activity
    - Alcohol intake
    - Diet quality

- **High Intensity Users**

  - Designed to provide health coaching and non-judgemental support to service users who have frequent contact with A&E and unplanned admissions, and may also be calling West Midlands Ambulance Service (WMAS) 999 more often than expected. The service uses A&E case finding to proactively engage individuals that are using the department on more than 12 occasions over a rolling 12 months to offer support. The service aims to deliver the following outcomes using the NHS Rightcare HIU principles of non-judgmental support and personalised care planning:

    - George Eliot Hospital (GEH) A&E case finding using health care professional led clinical review
    - Improved experience of care for individuals through proactive phone contact to offer support
    - Improved quality of care by developing personalised care plans and an integrated approach
    - Reduced usage of unscheduled care by supporting individuals to engage with alternative services through proactive support



- From June 2020 to October 2021, of the 81 cases identified, 50 were monitored and 31 received significant input. The impact tracking for those who received individual input demonstrated indicative savings of over £67,000.

- A common theme in case studies has been that these users feel supported through the alternative services they are now accessing, including social prescribers, high intensity case managers, 'Change, Grow, Live' Drug and Alcohol Recovery services and mental health services. The case studies demonstrate how personalised care plans, developed in partnership with these people, enable them to manage their needs without attending A&E.

- **Needs Assessment for Homeless Patients**

  - GEH with Public Health has completed pathway needs assessment for homeless patients, resulting in six recommendations currently being explored with GEH teams:

    - Commission a Pathway Light Team at GEH to support and co-ordinate the care and discharge of people who are homeless admitted to the hospital or attending A+E. An alternative is to commission a Pathway team which can cover GEH from one of the other Warwickshire sites

    - Implement a weekly multidisciplinary team meeting to plan the management of patients who are homeless involving both community and hospital teams

    - Review the provision of Substance Misuse and Alcohol Dependence service input to GEH, by developing agreed protocols for the management of drug and alcohol withdrawal syndromes, and exploring the provision of in-reach to the Trust from community drug and alcohol services

    - Review the provision of Mental Health assessment and treatment services for people who are homeless and presenting at, or admitted to, GEH by developing improved links and joint working with mental health services and explore the provision of Mental Health in-reach services to GEH inpatients.

    - Commission a community engagement and support organisation to ensure that patients who are discharged from GEH are able to access and use community services, maintain their tenancy, register with a General Practice, and attend follow up appointments including those at the outpatient services.

- GEH to instigate a programme to improve the identification, recording and coding of the housing status of people who are using their services. A programme of education for staff regarding homelessness and health should be implemented, in order to increase motivation and understanding of the importance of accurate data recording. This should include education regarding the legally required 'Duty to Refer Notification' being sent to the local authority housing department for all patients who are homeless or at risk of homelessness within 56 days, in order for assistance to be provided.

- **Warwickshire North Dashboard**

  - The WN Place team have produced an interactive web-paged dashboard for all partners to utilise, demonstrating multiple metrics across a number of areas related to the King's Fund Population Health model.
  - This supports WN with reviewing progress across the Place, leading to increased visibility for Key Performance Indicators and improved collaborative working with Place partners. It will enable us to change how we address performance and target our PHM framework.
  - Elements included in the dashboard under Wider Determinants of Health:
    - Adult obesity
    - Child obesity
    - Air pollution
    - Child poverty
    - Housing affordability
    - Internet access
    - Living conditions
    - Life expectancy
    - Rough sleeping
    - Smoking
    - Unemployment
    - Young people in employment, education or apprenticeships

- **Health Equity Pilot Project (HEPP)**

  - HEPP aims to strengthen local partnerships and System leadership capability through working collaboratively to address health equality. Approximately £32,000 seed funding from NHS England for a local project.

  - The aim of the Warwickshire project is to engage with families within the Nuneaton Central JSNA area to understand the barriers (perceived/actual) that

prevent uptake of healthy lifestyles campaigns (Wellbeing for Life) and services (Change Makers) to support management of childhood weight.

- WCC community engagement officers have been carrying out surveys with parents and carers at three local Nuneaton schools, generating findings around attitudes towards child weight management Change Maker service.
- In addition to this, an online survey was also made available. In order to gather more in-depth insight, interested parents and carers have now been invited to follow this up with an interview, which is being carried out by Coventry University.
- The engagement period finished mid-May 22. Following which a report of findings will be generated by Coventry University and will go on to help inform the commissioning cycle for Change Makers in Warwickshire.

- **Obesity in Pregnancy**
  - Local authority funding is increasing for this, especially in WN where rates are higher
  - Project being led by Local Maternity & Neonatal System lead

- **Smoking Cessation in Pregnancy**
  - The development of a new model of provision
  - CLeaR Model: Challenge, Leadership & Results for tobacco control
  - Project being led by Local Maternity & Neonatal System lead

- **Smokers who decline stop smoking services: Ethnographic Research**
  - Approximately 15 field studies with pregnant smokers who declined SSIP support
  - Ethnographers met with participants and their families in their own home
  - Aim of research to understand barriers and factors around non-engagement with services
  - Dissemination and collaborative response workshop on 29th September
  - Research findings paper due Q3 22/23

Vape pilot for pregnant smokers

- From 15th July, e-cigarettes are included in the 12-week Stop Smoking in Pregnancy service offer, for eligible participants.
- Available to over-18s booked at GEH, and resident in Warks North

- Will run for approx. 9 months
- Pilot aim is total smoking cessation at 12 weeks, vaping not encouraged beyond this period
- Partnership research evaluation with Bath & NE Somerset LA, led by Coventry University
- **8 participants signed up in first month of pilot**

- **Poverty Proofing**

  - Children North East (CNE) are working across Warwickshire Council to carry out Poverty Proofing activities as part of the wider 'Tackling Social Inequalities in Warwickshire Strategy 2021-30' being carried out across the county. As the founders and national leads on the Poverty Proofing agenda, CNE will work across Warwickshire to deliver four large poverty proofing inventions and a programme of training.

  - Two of these interventions are within WN – GEH's Maternity department and North Warwickshire Borough Council's Leisure department.

  - There are five key phases of the programme: training and initial consultation with staff; scoping exercise; consultation; report with recommendations; and review visit.

- **Levelling Up**

  - Work underway with Purpose Coalition to produce collaborative impact reports that link through to the health and wellbeing theme in 'Levelling Up'.

  - Intention is to increase opportunities in identified areas, with 19 of the 22 identified lower super output areas being in Warwickshire North Place

  - Hooked into 'Team Warwickshire' work.

South Warwickshire Place Update August 2022

Spotlight on Health Inequalities – since our last update we have….

Confirmed our priorities for 2022/23 and baselined our high level plan which is focused on improving our population's health and wellbeing through the application of the four quadrants of the Kings Fund Model Population Health Management Approach whilst ensuring **health inequalities** is a golden thread that runs through all our activities

Launching an early adopter scheme for the **Tribe app** is likely to move into delivery in Q4; defined cohorts in the areas of Shipston and South Leamington have been agreed with the project working group with the ultimate aim of helping further develop support for vulnerable and isolated people in their local communities:

Cohort 1 (Shipston): Post Pandemic - mental health with particular focus on new parents who did not have access to usual services due to lockdown and high number of covid cases

Cohort 2 (South Leamington): Older People - via ECH Queesnway Court, supporting increased access to services that may help prevent health deterioration

Done things to **create opportunities for our local communities through Levelling Up** such as**:**

*Warwick District Council and WCC have submitted a Levelling Up Bid designed to address air pollution in Leamington Spa, thereby tackling health inequalities and respiratory illness (the latter being one of SW Place's priorities for 22/23)

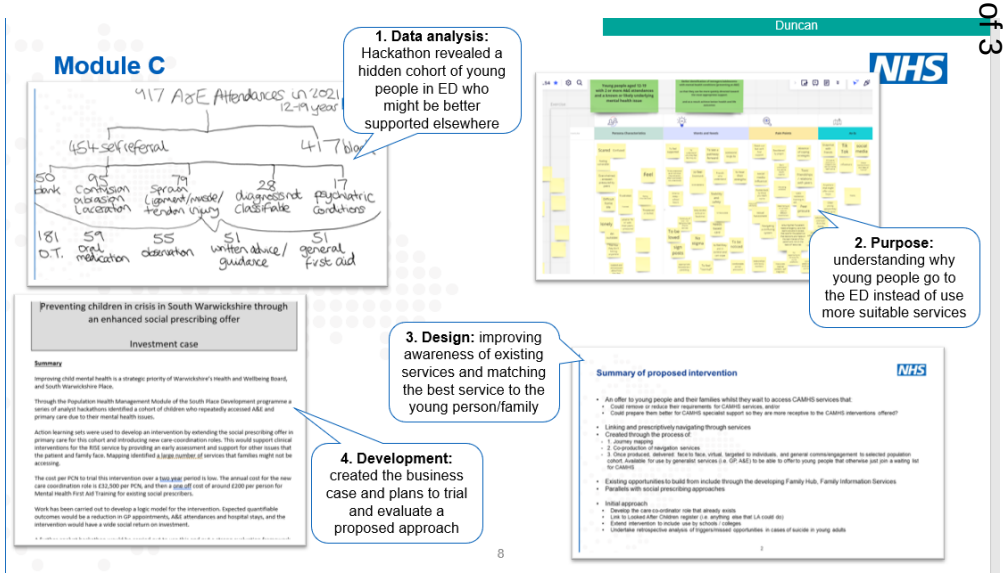
*WDC has submitted its investment plan for the Shared Prosperity Fund to further develop a health and wellbeing centre designed to address inequalities in Lillington, through from which we will look to develop services which focus on addressing respiratory inequalities. Other proposals seek in the investment plan focus on

*Preparing a Health Inequalities Fund bid focusing further efforts on the Lillington LSOA area.

*Built on South Warwickshire University Foundation Trust's Impact Report co-produced with the Purpose Coalition by being invited to contribute two case studies in the recently published report on **NHS Leadership: Tackling Health Inequalities**, which shines a spotlight on how NHS and local partners have produced tailored responses to their population needs in order to boost social mobility by ensuring everyone has access to the health and care services they need

Spotlight on Health Inequalities – since our last update we have….

Spent time understanding what our collective roles are across the organisations that make up our Place, holding an **organisational development workshop with our Place Delivery Group**, and completing the **Place Development Programme**. Through the latter, we have successfully **developed an intervention and submitted a health inequalities funding bid** to provide care coordination to children awaiting a CAMHS appointment and **identified the need and secured Place funding** for an engagement event with the VCSE sector.



Worked with **Act on Energy** to develop a communication sharing tips to encourage people to think about how to save energy at home, to help people across South Warwickshire plan to **keep warm and well** this coming winter such as:

1. Turn your thermostat down by 1 degree. Most people won't notice the difference – and an extra jumper can always help
2. And while we're on heating….set your timer to come on 15-30 minutes before you need it and switch off 30 minutes before you leave or go to bed
3. Switch to low energy lightbulbs. Yes, we know people have been banging on about this for years, but it really does work. LEDs use about 90% less energy than standard bulbs. They are more expense to buy – but last up to 12 times longer

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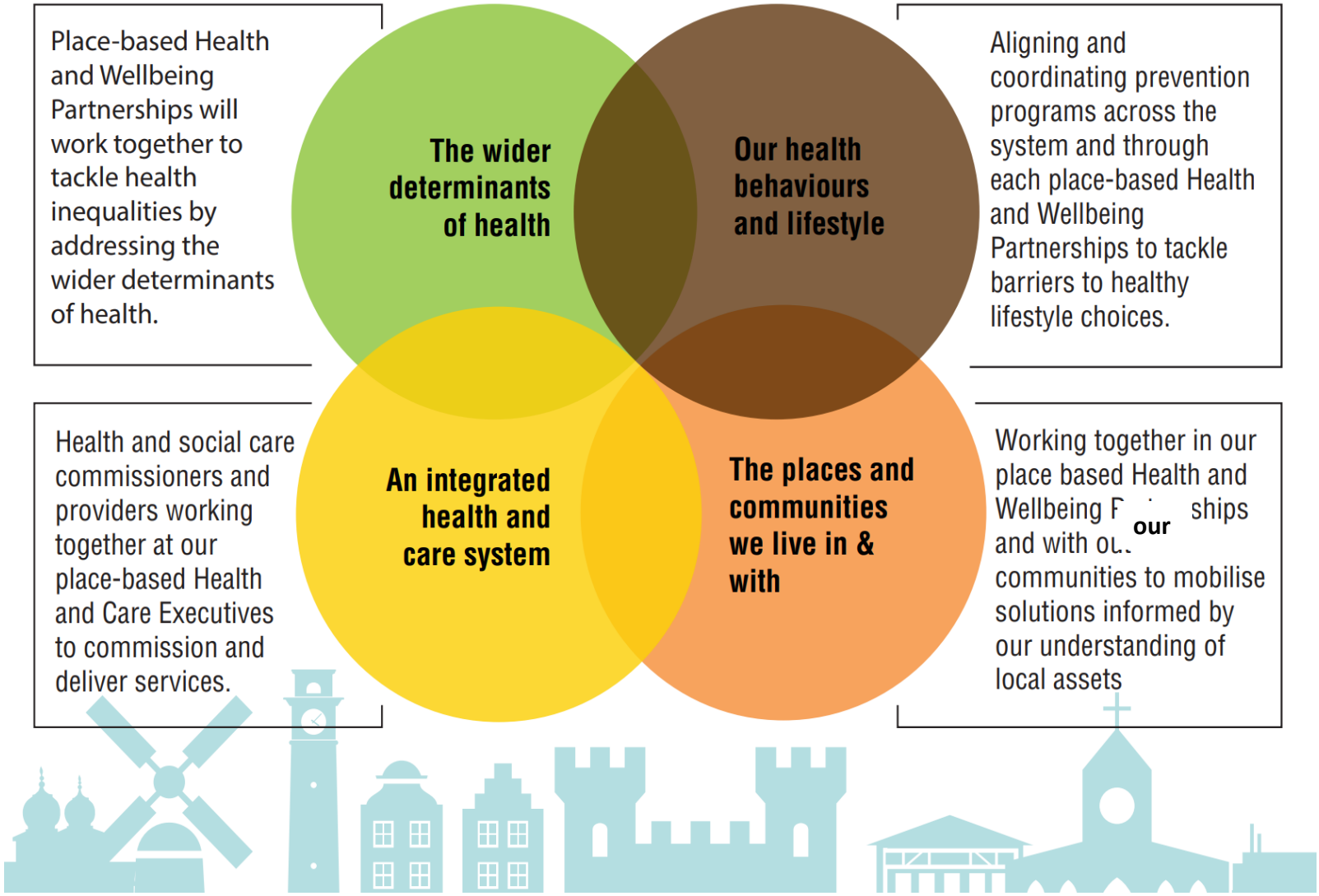
Rugby - Population Health Framework

Our long-term strategic ambitions:

People will lead a healthy and independent life.

People will be part of a strong community.

People will experience effective and sustainable services.



Rugby Place priorities 2020/21

- Mental health and wellbeing – Self-harm in young people
- Poverty and inequalities – Homelessness
- Health behaviours – Smoking
- COVID-19 Recovery
- Long term conditions – heart failure

Key drivers: Health and Wellbeing Board Strategy, NHS Long Term Plan, Public Health Outcomes Framework, place-based JSNAs, COVID-19

Rugby in focus – Children and Young People's Mental Health

- Following the first of three partnership development workshops facilitated by the LGA in January, a task and finish group has been established to explore methods to engage with young people in Rugby and understand the service available to support young people and opportunities/gaps.
- Led by the Head of Compassionate Communities a **Proposal for a Participative Narrative Inquiry (PNI) workshop to take forward the engagement and CYP MH work-stream at Rugby Place** was agreed at the workshop in January and the workshop was held at a secondary school in Rugby in May 2022.
- The workshop includd a strong cross-section of stakeholders from all sectors and young people. The model has previously been used local in collaboration with The Health Foundation, the West Midlands Respiratory Network and within UHCW. The session was a great success, excellent feedback from pupils, school staff and the wide range of partners who attended the session.
- Key actions from the meeting:
    - Develop the Ruby place offer for CYP mental health services – so all professionals understand services and support available which can then be communicated to professionals and the public - Small working group exploring options and mapping the offer for Rugby place – working with colleagues across the system to avoid duplication and understand how to add value at place.
    - Education representative on the Rugby HWB Partnership – Education lead has been nominated
    - How to continue to engage with schools and CYP – as a really useful model to replicate

Rugby - Progress on our wider priorities

Priorities	Outline of activity	Progress update
Poverty and inequalities – Homelessness	Homelessness projects in Rugby borough	• The Public Health team in partnership with Hope4, P3 and Homeless Link are hosting an Experts by Experience group to understand how the actions and services in place as outlined in the Preventing Homelessness in Warwickshire Strategy are impacting on homeless people in Warwickshire. This coproduction approach was piloted first in Rugby at the Hope4 centre on the 2nd August 2022. • The SWFT Community Physical Health Nursing service and the CWPT Community Mental Health service for the homeless are working in partnership to deliver care using a mobile mini-van with facilities and chance to carry out physical health checks, currently working in the North and Rugby. The team are currently expanding to include clinical support workers. • A Needs Assessment for Homeless Patients in University Hospitals Coventry & Warwickshire NHS Trust (UHCW) was completed, and business case developed, conversations to take place at place and system level. • Rugby Borough Council have a newly appointed Outreach Officer who will work as part of the Hospital- Housing Liaison Service.
Health behaviours – Smoking	• NHS LTP Tobacco Dependency Programme progress • Expansion of stop smoking service provision in Rugby	• Quit 4 Good – community stop smoking service – provided by GP/Pharmacies. New additional offer of virtual support from Everyone health for smokers in Rugby and Warwickshire north is live and being promoted to residents new phone line/email on -warwickshire.gov.uk.quit4good • NHS LTP tobacco dependency programme – progressing the programme for tobacco dependency service to be offered to smokers admitted to hospital, pregnant women and those who access specialist mental health and learning disabilities services. UHCW/St Cross due to start delivering August 2022. Comms and engagement to follow. • Tobacco control partnership for Coventry and Warwickshire – scoping projects in Rugby and Warwickshire North to prevent young people smoking/vaping and tackle illicit sales.

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Agenda Item 9

Health and Wellbeing Board

7 September 2022

Levelling Up and Health & Wellbeing in Warwickshire

Recommendations

That Health and Wellbeing Board:

1. Notes the newly published countywide approach to levelling up in Warwickshire, and
2. considers the opportunity for greater alignment and synergy between Levelling Up, health inequalities and the wider work of the Health & Wellbeing Strategy.

1. Executive Summary

1.1 On 2 February 2022 the Government published the Levelling Up White Paper, followed by the Levelling Up and Regeneration Bill in May 2022.

1.2 The White Paper outlines the Government's strategy to "spread opportunity and prosperity to all parts of the country" by 2030 through twelve national missions. This will also include stronger oversight of local government on performance against these missions.

1.3 Together with related national policy change for Education, Integrated Health and Social Care, Local Enterprise Partnerships (LEPs) and Sustainability, as well as anticipated changes in rural policy, this constituted a significant shift in national policy direction.

1.4 This agenda is relevant to all Health & Wellbeing Board partners as it aligns with the Board's priority of reducing inequalities in health and the wider determinants of health. The NHS Integrated Care System (ICS) for Coventry and Warwickshire has also produced a five year Health Inequalities Strategic Plan, which has adopted the CORE20+5 framework, whereby focus will be given to the 20% most deprived populations, plus other locally identified vulnerable groups including inclusion health groups; and on five specific clinical areas.

1.5 As such, there have been a range of responses from local health and wellbeing partners around Levelling Up. For example, South Warwickshire NHS Foundation Trust (SWFT) have engaged the Purpose Coalition and Coventry City Council has produced its own Levelling up approach. A number of reports on Levelling Up to have also been published within District & Borough Councils on Levelling Up.

1.6 Additional work has been underway to develop a countywide Levelling Up approach for Warwickshire with significant engagement with, and input from, key partners and stakeholders from across the county which we have called our '*Team Warwickshire' approach.*

1.7 Subsequently, on 14th July Warwickshire County Council's Cabinet approved the Countywide approach to Levelling up in Warwickshire and shared with all Team Warwickshire partners, Council Leaders and Members of Parliament.

1.8 The approach provides an overarching framework for Warwickshire to deliver against the twelve national missions, as well as informing and framing ongoing work to develop proposals for a devolution deal for Warwickshire to enable delivery against countywide and national levelling up priorities.

1.9 The final document has been shared with all key stakeholders and time is now dedicated during August and September to facilitating follow up discussion with key groups and bodies to maximise awareness and connections between Levelling Up and existing work

1.10 This report presents the final document to the Health & Wellbeing Board both for information and seeks to highlight the key synergies between Levelling Up and the broader Health & Wellbeing agenda.

2. Financial Implications

2.1 There are no direct financial implications associated with this report, but significant indirect ones that have long-term implications for the county.

2.2 There is significant funding available from Government via the Levelling Up Fund, UK Shared Prosperity Fund, Towns Fund and Community Renewal Fund, among others to support the Levelling up agenda. The Levelling Up and Team Warwickshire Approach will provide opportunities to coordinate activity and bids for funding to deliver the most effective inward investment into Warwickshire.

2.3 The Levelling Up approach will help with prioritising resource allocations (both revenue and capital) and in particular regeneration activity. Moving forward Levelling Up will be a key consideration in developing and prioritising any future pipeline of projects.

3. Environmental Implications

3.1 Sustainable Futures is one of the four agreed elements of our definition and both a cornerstone of what Levelling Up means in Warwickshire and a key part of any future devolution deal for the county.

4. Supporting Information

4.1 Key elements of the Levelling Up approach in Warwickshire include:

- **Evidence base** – covering national Levelling Up headline metrics and using Index of Multiple Deprivation to show countywide performance and local profiles including Lower Super Output Areas. (This can be found on our Levelling Up webpage).
- **Voice of Warwickshire** – results from asking just under 500 members of our residents' panel for their views on the Levelling Up agenda.
- **Local Definition of Levelling Up** – comprised of four elements: *fairness, reducing disparities, building community power* and *creating sustainable futures.*
- **Communities of Place** – 22 Lower Super Output Areas in Warwickshire that are in the most deprived 20% nationally, against the Index of Multiple Deprivation.
- **Communities of Interest** – using the evidence base we have identified communities and groups that need to be prioritised in the Levelling Up agenda for Warwickshire.
- A framework for complementary activity at countywide, place and community levels.
- Development of place plans at District & Borough level that will interface with ICS Place Partnership priorities.

4.2 Looking at the new approach together with the Health & Wellbeing Strategy and the Integrated Care System, some of the key synergies and opportunities for greater alignment are:

- Alignment of data set and intelligence around health inequalities and wider determinants at a county, place and community level.
- Links between Levelling Up and the Health & Wellbeing strategy priorities, as well as associated key strategies such as the Coventry & Warwickshire health inequalities strategy and Warwickshire Social Inequalities strategy.
- Related countywide strategies such as social inequalities, health inequalities and others that come under the direction of the Health & Wellbeing Board and contribute to the Levelling Up agenda.
- Strengthening of the concept of place-based working across the wider determinants of health. This could be an extension of earlier work on the Joint Strategic Needs Assessment and the existing local profiles.
- Strong links to the adopted Kings Fund model for population health in terms of maximising opportunities for Community Power in support of better health outcomes.

- Links between local Place Partnerships and the development of Levelling Up place plans for each District or Borough.

- Opportunities to work with specific communities and groups, targeting effort and resource where it is most needed.

- Opportunity to use levelling up to strengthen links and work on the wider determinants of health and vice versa.

5. Timescales associated with the decision and next steps

6.1 Presentation to the Health & Wellbeing Board today is seen as the beginning of an ongoing dialogue on Levelling Up.

6.2 Place plans will now be developed within each District & Borough between now and March 2023.

6.3 A series of short-term actions will also be mobilised over the next 6 months to embed the Levelling Up approach. This will include engagement with some of the agreed communities of place and interest.

6.4 Health & wellbeing is an anticipated theme for an emerging Devolution Deal for Warwickshire. Early thinking in this is underway, but the timescale for this is at least 6-12 months.

Appendices

1. Levelling Up approach for Warwickshire

Background Papers

1. WCC Cabinet July 14th, 2022, A Countywide approach to Levelling Up in Warwickshire

	Name	Contact Information
Report Author	Gemma McKinnon, George McVerry, Gereint Stoneman	gemmamckinnon@warwickshire.gov.uk, georgemcverry@warwickshire.gov.uk, gereintstoneman@warwickshire.gov.uk
Assistant Director	Shade Agboola Director of Public Health	shadeagboola@warwickshire.gov.uk
Strategic Director	Nigel Minns, Strategic Director for People	nigelminns@warwickshire.gov.uk
Portfolio Holder	Portfolio Holder for Adult Social Care & Health	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None.
Other members: Councillors Bell, Drew, Golby, Holland and Rolfe.

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Coventry and Warwickshire
Integrated Care Partnership

Executive Summary

1.1 This report outlines proposals for the establishment of Coventry and Warwickshire Integrated Health and Wellbeing Forum, which will replace the Coventry and Warwickshire Joint Place Forum.

1.2 The Forum will provide system leadership around the wider health and wellbeing agenda, and as such will contribute to achievement of the aims of the ICS, specifically tackling inequalities in outcomes, experience and access, and helping the NHS support broader social and economic development.

2. Background

2.1 In 2016 the two Health and Wellbeing Boards in Coventry and Warwickshire took the decision to work together collaboratively to drive improvement in health outcomes and the reduction of health inequalities. The Boards committed to meeting together as a 'Place Forum' to create the necessary system conditions and leadership for an uplift in prevention. They articulated a shared vision and principles for place-based system leadership in a joint Concordat, which underpinned their commitment to a programme of work around wellbeing. A key early achievement of the Place Forum was delivery of the Coventry and Warwickshire Year of Wellbeing in 2019, to raise the profile of local prevention opportunities and encourage people to be proactive about their own health and wellbeing.

2.2 In 2019 a new Health and Care Partnership Board was established to provide the formal leadership and set strategic direction for the Health and Care Partnership. This worked alongside the Place Forum, which continued to provide leadership on population health and wellbeing. The work of the Place Forum was developmental and took the form of informal workshops, under the leadership of the Health and Wellbeing Board chairs and with independent facilitation. The Health and Care Partnership Board met in public, chaired by the independent chair of the Health and Care Partnership.

2.3 Throughout the pandemic there were joint online meetings of the Place Forum with the Health and Care Partnership Board. These meetings were well-supported and valued as a key collaborative space for partners to progress a shared agenda around inequalities and population health. New connections were established, for example with Coventry and Warwickshire Local Enterprise Partnership, with increasing recognition of the need for an integrated response to the impact of the pandemic.

2.4 The collaboration between the Health and Wellbeing Boards and the work of the Place Forum has been recognised nationally as good practice by the Local Government Association and The King's Fund.

3. Future of the Place Forum

3.1 In November 2021 an online development session was held for Place Forum members to understand the statutory changes to the Integrated Care System and to consider the future role of the Place Forum in this context – alongside a new statutory Integrated Care Partnership. The meeting considered the added value that the Place Forum offered to the system, and how to shape its role and format within the emerging ICS governance arrangements.

3.2 Members expressed a desire to build on the strong partnership working in place through the Place Forum and Health and Care Partnership Board, and a continued commitment to working collaboratively. They valued the Place Forum and regarded its wide and inclusive membership as a key strength. They also identified a need for greater clarity about roles, responsibilities and accountability within the system, so that governance is coherent and can be described to the public, so they can understand where decisions are made and by whom.

3.3 There was consensus that:

- there is a continuing role for an advisory/consultative forum for the ICS
- the forum has a role in capturing a breath of views and perspectives from system partners, including those informed by local residents, and leading the agenda around engagement and co-production
- a return to face-to-face meetings would support the networking aspect of the forum.

3.4 In March 2022 the final meeting of the Place Forum in its current guise was held, pending the new statutory governance arrangements to be established for the Integrated Care System. It was an opportunity to reflect on the Place Forum journey to date and share proposals for future arrangements

4. Coventry and Warwickshire Integrated Health and Wellbeing Forum

4.1 Reflecting the outcomes of the Place Forum discussions, proposals were developed regarding the future of the Place Forum. It was suggested that it should be refreshed as follows:

- Name: C&W Integrated Health & Wellbeing Forum
- Purpose: Advisory role for the ICS and to reflect a breadth of views informed by working with local communities from across C&W
- Initial membership: Health and Wellbeing Boards (and Exec); ICP members; Care Collaborative and Place representatives
- Meeting frequency: 2-3 times per year

4.2 As the Integrated Care Partnership was established on 1 July, it was decided to defer the first meeting of the new Forum until early October. (Work is in progress to identify a date.) A subsequent meeting will be arranged for early February 2023. In future years it is expected that

there may be three meetings of the Forum, however scheduling will be reviewed as the cycle of business is developed.

4.3 Reflecting the developmental, system leadership role of the Forum, it is proposed that an independent facilitator is secured, who can provide external support and challenge to ensure that meetings add value to the system and provide a genuine opportunity for engagement of and between system leaders. This is a model that served the Place Forum well prior to the pandemic.

4.4 Work is in progress to develop the cycle of business, to ensure alignment between the work of the Integrated Care Partnership, ICB Board, the Health and Wellbeing Boards and the new Forum. This will provide clarity about the respective governance role and responsibilities of each of these groups and ensure a meaningful flow of business. The cycle of business will be developed in discussion with the chairs of the Health and Wellbeing Boards and the ICS, and senior executives from the local authorities and ICB, as part of their regular agenda-setting meetings for the Forum.

4.5 It is expected that a core part of the business of the Forum in October will be to contribute to the development of the Integrated Care Strategy.

Conclusion

Coventry and Warwickshire Place Forum established the conditions for strong partnership working between our Health and Wellbeing Boards and health and care partners. This collaborative approach is key to addressing the ICS ambitions for tackling health inequalities and improving population health outcomes. The proposed Coventry and Warwickshire Integrated Health and Wellbeing Forum offers a mechanism for continued collaboration that recognises, embraces and enhances the role and contribution of all partners. This wider partnership representation in the Forum is important as a guide for the Integrated Care Partnership in developing its Integrated Care Strategy.

Recommendation

Members are requested to **NOTE AND ENDORSE** the establishment of Coventry and Warwickshire Integrated Health and Wellbeing Forum as outlined in the report, with the Integrated Care Partnership as core members.

End of Report

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www.happyhealthylives.uk

Coventry and Warwickshire
Integrated Care System

Population Health Management Roadmap

2022 - 2027

Table of Contents

Foreword

As an emerging Integrated Care System (ICS), we set an ambitious vision in January 2020 to change the way we collectively understand our population and manage our resources for population health, putting positive outcomes for citizens at front and centre. Since then, we have been working to lay the foundations and begin to build our capability and capacity as a system to embed a population health management approach at every level – from neighbourhood to Place, from Care Collaborative to system.

The COVID-19 global pandemic demonstrated the urgency of this work. In the face of a public health emergency, we quickly learnt to work together and share data in a way we hadn't before to ensure that our COVID response was targeted and effective. The pandemic highlighted and increased inequalities in health outcomes and has rightly driven this up our agenda as a top priority for our ICS. Now more than ever we need robust, actionable insights about the needs of our whole population, and to work together proactively and innovatively to design care around those needs and reach out to those not able to access services, or experiencing inequalities in health care experience and outcomes. We need a population health management approach to shape proactive and anticipatory care, to inform prevention strategies, to target our resources and to better understand areas of pressure and risk.

Leaders in Coventry and Warwickshire health and care system recognise that we need to start to change the way we plan, design and deliver health and care, and that this is about more than a traditional focus on care pathways. Our vision for population health has profile and traction across the ICS, and encompasses the wider determinants of health, health behaviours and lifestyles, and the communities we live in and with. Our population health management (PHM) capabilities will enable us to understand our population and plan our health and care provision through that lens.

Over the past year, as we have taken part in the national PHM Development Programme, we have taken great strides forward in learning about what PHM looks like in practice and what it will take to make this our way of working in Coventry and Warwickshire. We have collaborated in new ways, begun to build new relationships right across the system, and have been given a glimpse of the impact that PHM could have on our population. Taking time out to do this in the midst of all the operational challenges of COVID escalation and recovery planning has not been easy, but feedback from senior leaders has confirmed that this has been the right thing to do. We have a real opportunity now to build on that activity and make this a change that lasts.

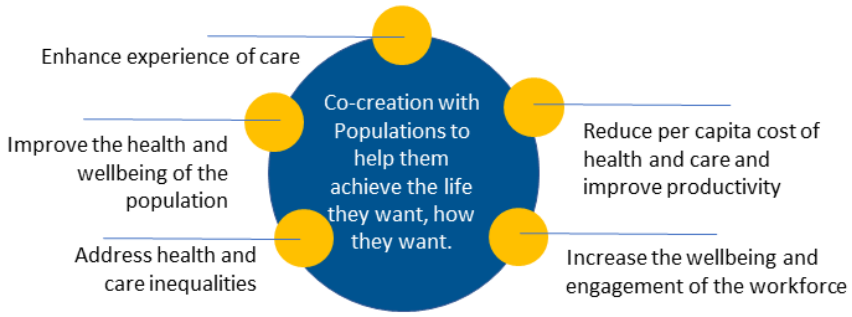
Our ICS Vision states: “We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence, and put people at the heart of everything we do”. If we are to genuinely take this whole population, whole person, whole life approach and shift to more proactive and preventative approaches, this must be underpinned by a commitment to embed PHM as ‘business as usual’ across each level of our Integrated Care System. This Roadmap sets out how we will do just that over the next five years.

Angela Brady,
Chief Medical Officer,
Coventry and Warwickshire ICB

Phil Johns
Chief Executive,
Coventry and Warwickshire ICB

Danielle Oum
Chair,
Coventry and Warwickshire ICS

Population Health Management - The Common Cause



Residents benefit from more proactive and personalised health and care services, a wider range of support to better manage their health and wellbeing.

Hardeep is 60 years old, lives alone, has type 2 diabetes , high blood pressure and struggles with low mood.

"My GP reached out to me and organised with me to see a health coach."

"Together we developed a plan to help me lose weight for my daughter's wedding."

"I joined a walking club and diabetes management course which I enjoy."

"I'm more confident & optimistic."

Clinicians benefit from move away from firefighting to proactive care, and towards early prevention serving as part of a broad multi-disciplinary team. Greater efficiency and impact.

Tasneem is a GP Partner in a deprived inner city area.

"Robust holistic data builds our understanding quickly and leads to confident action and measured improvements."

"We've developed great links with our local authority and voluntary sector groups - it's a real team effort."

"It's really about getting back to the best bits about working in healthcare."

Analysts benefit from using their skills and competencies to ensure data can be turned into intelligence to inform decision-making, giving real job satisfaction.

Sophie is an analyst based in an integrated care system.

"We are finding that there is less need to carry out analysis around activity and contracts, and more focus on working collaboratively across partners to enhance knowledge of residents in our area and their needs using PHM techniques."

"I support a proactive approach to helping patients manage their health and wellbeing in their own homes."

Local health and care service planners benefit from improved understanding of what residents need to plan services, allocate resources, achieve impacts and reduce health inequalities.

Derek is the Long-Term Conditions Lead for an integrated care system.

"Population needs are the joint focus. This helps us begin to break down barriers between organisations and funding streams."

"We use data to explore what the future might look like - and how we can get better value from the NHS pound by changing how we deliver services locally, avoiding duplication, and improving the working lives of our frontline staff."

This is Population Health Management.

Population Health Management – What is it and why is it important?

Explaining PHM

Population Health Management (PHM) improves population health through data-driven planning and delivery of proactive care, to achieve maximum impact. It employs analytical tools (e.g. segmentation, risk stratification, impactability modelling) to identify local 'at risk' groups of people; and brings multi-disciplinary teams together to use these insights to design and target activity to prevent ill-health, improve health outcomes and reduce inequalities.

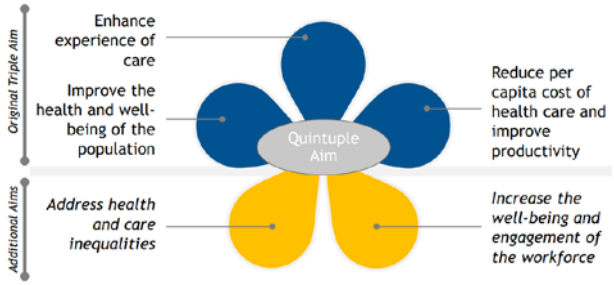
PHM analytical tools

Our Common Cause

Our PHM programme is the enabler to delivering the NHS quintuple aim[1], and the core purposes of the ICS:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money

[1]Quintuple Aim taken from nationally-developed Population Health Management Flatpack, NHS England, NHS Digital and Public Health England, September 2018



- help the NHS support broader social and economic development.

There are deep-rooted health inequalities within our populations in Coventry and Warwickshire, and we know that to tackle these we need to do things differently. Our experience during the COVID-19 pandemic showed us the potential of sharing data to support our care delivery and respond to need in vulnerable populations. But it also highlighted some of the practical challenges and deficiencies in our data quality and infrastructure, and our ability to use insights effectively.

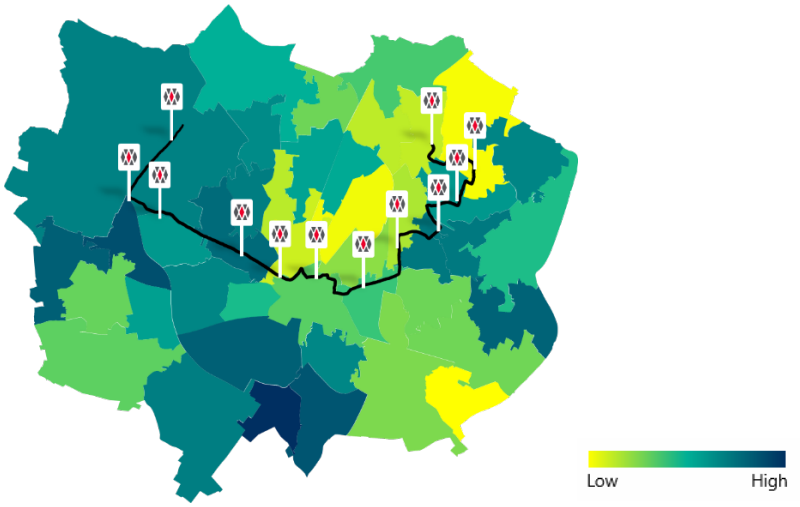
We are already seeing many examples of clinicians and commissioners taking a population health approach and thinking differently about how to plan and design care in an integrated way. **What our PHM programme seeks to do is to elevate this activity by providing the strategic infrastructure to enable Population Health approaches to be used consistently, and for this to become our 'business as usual' right across our integrated care system at every level – the way we are looking at health and care on a day-to-day basis.**

Health Inequalities – Our case for change

There are deep and increasing inequalities in health outcomes, access and experiences in our population. **Life expectancy** quantifies the differences between areas in the years of life lived; and therefore, illustrates well the health inequalities across Coventry & Warwickshire.

Within Coventry, along the number 7 bus route:

7.0 years is the difference in how long males are expected to live in two areas of Coventry, the gap increases to **10.1** years for females along the same route[2].



[2] https://fingertips.phe.org.uk/local-health#page/0/gid/1938133185/pat/402/par/E08000026/ati/3/iid/93283/age/1/sex/1/cat/-1/ctp/-1/yrr/5/cid/4/tbm/1

Within Warwickshire at Joint Strategic Needs Assessment level, according to the latest data, **6.7 years** is the difference in how long males will live in Bedworth and Kenilworth. There is a similar gap when we look at females (**6.1 years** between Newbold and Brownsover, and Rugby Rural South – both areas within Rugby Borough). [3]

We can start to tackle these inequalities by enabling actionable insights from rich and timely linked datasets, and working together to design care differently to meet the needs of our population – i.e. by taking a population health management approach.

Integrated Care System national requirements

The NHS Long Term Plan [4] set out a vision for new Integrated Care Systems (ICSs) everywhere, increasingly focused on population health. Population Health Management creates the conditions and foundation for delivery of these national ambitions and a shift away from reactive care towards a model embodying active management of population health.

Embedding PHM capability is now a core requirement of Integrated Care Systems. The Integrated Care Systems Design Framework [5] articulates an expectation that ICSs will:

- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will

[3] Source: Life Expectancy 2015-19 at JSNA level, Fingertips
[4] *The NHS Long Term Plan*, January 2019 https://www.longtermplan.nhs.uk/
[5] *Integrated Care Systems: Design Framework*, NHS, June 2021 https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.

- Establish Place-based partnerships as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health – with plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process. (In Coventry and Warwickshire this relates to our geographical Care Collaboratives.)

Timeline[6]:

By June 2022, to develop plans to put in place the systems, skills and data safeguards that will act as the foundation for PHM

By April 2023, to have in place the technical capability required for population health management, including:

- longitudinal linked data available to enable population segmentation and risk stratification;
- using data and analytics to redesign care pathways and measure outcomes, with a focus on improving access and health equity for underserved communities.

By April 2023, to put in place cross-system information governance arrangements, particularly between primary and secondary care and local government partners, that enable the safe and timely flow of information across the ICS and support the Integrated Care Board (ICB) to deliver its functions;

By April 2023, to appoint a clear analytical lead for the Intelligence Function, with the responsibility for putting in place clear reporting arrangements into ICB and Integrated Care Partnership (ICP) decision-making forums (and, where appropriate, Place-based decision-making forums), to ensure insight into population need is informing local strategies and transformation priorities.

[6] *2022/23 priorities and operational planning guidance*, NHS, December 2021

Our Vision for Population Health Management

We have developed a draft Vision for PHM which aims to provide a shared understanding of what it is that we are trying to embed as our way of working, and why. This is meaningful to those involved in this work so far, but we plan to develop it further through public and stakeholder engagement so that it is meaningful to everyone.

Our draft Vision for PHM is:

Empowering everyone to live well by joined-up, proactive, data-driven health and care

Why are we doing this?

We want to improve health and wellbeing outcomes.

PHM enables us to target better care and support for communities.

We focus on what matters to people - not just their illnesses.

Addressing wider social issues is key to reducing inequalities.

How do we do it?

We understand the current and future needs of communities.

We take a new partnership approach across health and care.

We listen to people to understand their physical, mental and social wellbeing needs.

We share data seamlessly between organisations to offer joined-up support.

What is the result?

We enable individuals to live as well as possible.

Our services are joined-up, tailored and sustainable, making best use of resources.

We promote independence and encourage proactive care.

We enable people to start well, live well and age well.

Our commitment as partners

Every part of our ICS has a role to play in embedding population health management as our 'business as usual'. In August 2020 we set out in our PHM Strategy some core values that underpin this way of working. These are further developed below. We need all partner organisations to make clear commitments about how we will work, commitments which transcend organisational boundaries and put positive outcomes for citizens front and centre. Our commitments are:

We involve patients and clinicians in decision-making and care design. This means all organisations building capacity for meaningful stakeholder engagement and co-production, and committing to move towards a personalised model of care.

We readily share data, whilst adhering to statutory requirements. This means all organisations contributing to and enabling the data and digital infrastructure required for population health management.

We are rigorous in ensuring quality in the data we collect and analyse. This means all organisations taking steps to improve data quality, and to support data testing and quality improvement as part of onboarding data to a digital platform for PHM.

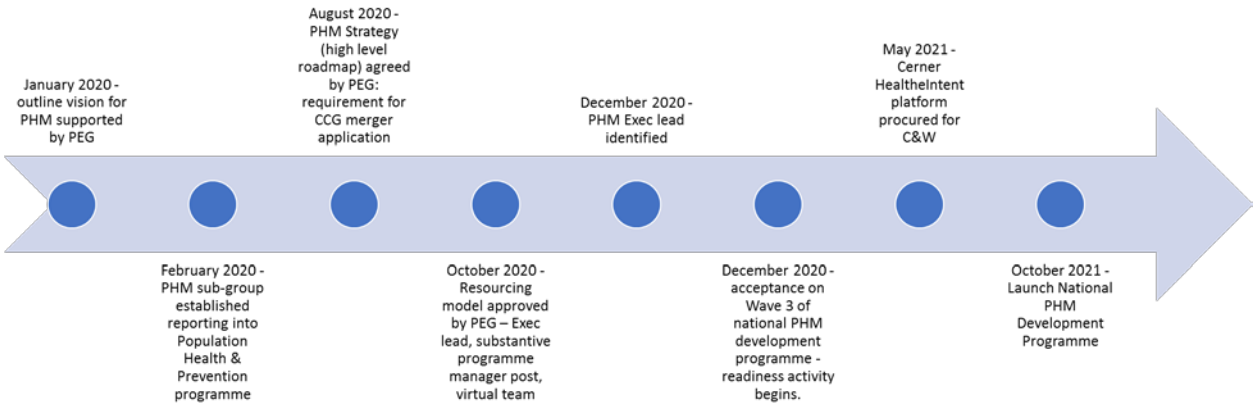
We use the insights we have available to deliver value for our population. This means all partner organisations committing to enable their analysts to work in a different, collaborative way to develop actionable insights about the needs of our population.

The needs of our population take priority over our organisational agendas. This means a commitment by decision-makers across the system to allocate resource and plan and design care collaboratively, based on population insights.

We share a common vision and are all committed to making this a reality. This means that the shared vision for population health which will be set out in the Integrated Care Strategy – informed by PHM – drives all of our collective activity.

We are open and transparent with each other and the public about decision-making. This means that we communicate the insights and evidence behind our decisions and make clear how we are using data to shape our services.

Our PHM Journey



Early progress

Since early 2020 we have been on a journey as a system to understand and begin to embed the required capacity and core capabilities for Population Health Management across our system. In August 2020 our system Partnership Executive Group approved a high level PHM Strategy which described an ambition to change the way we collectively understand our population and manage our resources for population health.

In recent years we have begun to see innovative examples of PHM in practice in our response to the COVID-19 pandemic and as our Places have developed their local plans, as outlined in the case studies that accompany this Roadmap[7], but the picture has been fragmented.

A key focus of activity since early 2021 has been preparation for and participation in Wave 3 of the National PHM Development Programme. At the start of the programme, we reviewed our PHM maturity against the national PHM Maturity Matrix[8] and set out our objectives. We found that, whilst there was commitment to PHM at the most senior level, and a desire to see PHM embedded at every level of our health and care system, there was not yet a widespread understanding across and within our partner organisations about PHM. Similarly, while we had procured a local PHM data platform, this lacked system-wide ownership and understanding of the benefits it could deliver.

Developing our PHM Roadmap

As the PHM Development Programme drew to a close in June 2020, we worked to develop a system-wide Roadmap, outlining how the ICS will continue to develop capability in population

[7] Case studies at annex 1
[8] PHM Maturity Matrix, shared with materials for national PHM Development Programme. See annex 2

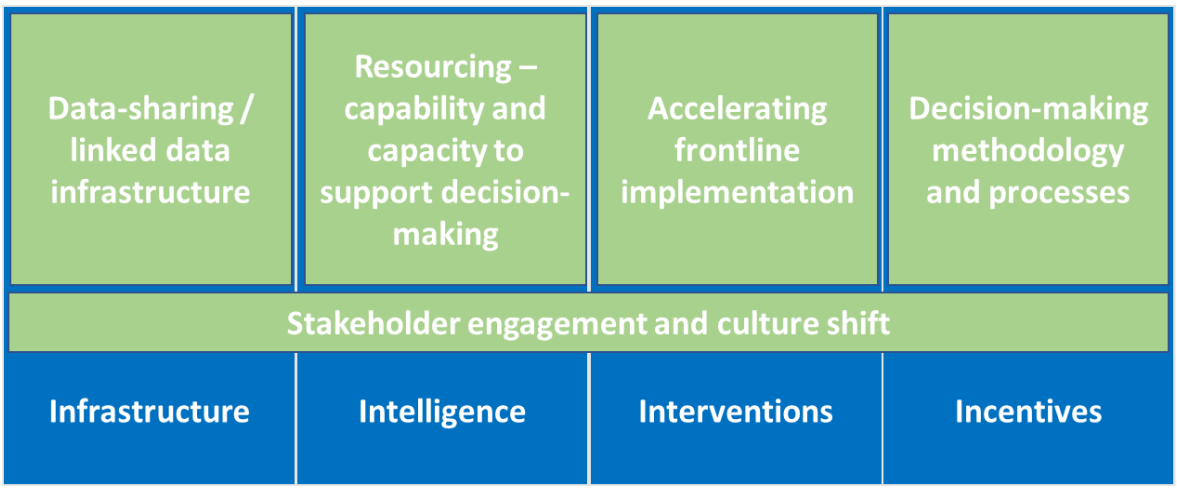
health management within and across partner organisations. This presents an opportunity to align strategic activity to sustain and scale PHM in Coventry and Warwickshire.

Our Roadmap has been developed by a core reference group, with oversight from the PHM Board and Population Health, Inequalities and Prevention Programme Board, and has been informed by a series of group and individual interviews with around 60 senior stakeholders across our system[9].

Our way of working: embedding PHM as "business as usual"

We want to see PHM embedded as business as usual across our system, and for population health to be everyone's business. This means that it will be built into strategic planning at all levels. Transformation activity across our system presents an opportunity to drive forward our ambitions for population health, and all of this should be underpinned (enabled and supported) by our PHM capability.

In 2021 we identified five key building blocks to be our priority areas of focus as we began to implement our PHM Strategy. These are aligned to the 4Is - the four, nationally-determined capabilities that ICSs should develop for PHM. Our Roadmap is framed around these capabilities, and builds on the progress we have made during Wave 3 of the National PHM Development Programme and existing PHM activity.



[9] See annex 3 for details of engagement to inform development of the Roadmap

Our focus going forward is on:

- Building the digital, data-sharing and leadership capability to enable PHM at all levels of our system.
- Developing analyst capacity and capability to support and enable use of actionable insights at all levels of the system.
- Putting PHM into practice, especially at Place and PCN level, to design and deliver targeted care and improve population health outcomes.
- Embedding a PHM approach in contracting and resource allocation within the new ICS arrangements.
- Engaging with stakeholders and generating interest in, and appetite for, population health management – bringing it to life with tangible examples of how taking this approach makes a difference.

What system leaders have told us

Key messages:

- Population health is the right approach – The King's Fund's population health model has profile within our ICS.
- Recognition of value of PHM in supporting shift to proactive, personalised and preventative care.
- The health inequalities agenda has traction – PHM should underpin efforts to tackle inequalities.
- PHM is currently seen as something separate, but it needs to be everyone's business.
- This means upskilling staff and embedding PHM across our workforce.
- Importance of bringing PHM to life with case studies, and articulating purpose and value.
- Care Collaboratives are a vehicle to enable us to support population health, and their priorities should be driven by PHM insights.
- PHM can have most visible impact at Place and PCN, and needs strong Place leadership and ownership.
- Start small and identify low hanging fruit – pick a small number of key priorities and do them well.
- Resources are finite – we need to shift them.
- PHM is already happening – it's just not recognised as such. There is a risk that we 'professionalise' PHM or make it too technical.

"We need to be honest about the issues we have and be willing to be radical about where we spend resource" (NHS Trust Chair)

"PHM and tackling health inequalities should be a core part of day job for all executives" (NHS Trust Chief Executive)

"PHM should be baked into our ICS decision-making structures" (ICB Chief Officer)

"For busy GPs, we need to show how it's a win for business, and not over-complicate it" (Primary Care leader)

"Health inequalities and PHM should be the golden thread running through everything we do" (Chief Nursing Officer)

"PHM is a way of working – not a 'thing'" (Consultant in Public Health)

Our Delivery Plan

Our Delivery Plan[10] sets out specific actions to spread, scale and sustain our population health management capabilities over the next five years. The high-level actions are outlined below, framed around the nationally-defined '4Is' of Infrastructure, Intelligence, Interventions and Incentives, with an underpinning enabling workstream of stakeholder engagement and culture shift.

It is important to recognise that these actions do not sit with one organisation or team, and are not just system-level actions. As the detailed plan shows, all ICS partners have a role to play across all of the capabilities.

A key focus for the implementation of the Roadmap will be the roll-out of our local digital data platform, which will – in time – provide a near real-time linked dataset across all Coventry and Warwickshire data systems. Data will be normalised and standardised, and the platform will provide PHM analytics self-service tooling. The contract for this platform includes an ongoing transformation support offer, enabling us to scale and sustain the learning from the PHM development programme through the early implementation of the data platform. This support will be aligned to our Delivery Plan, and in the short-term we have agreed a specific focus on:

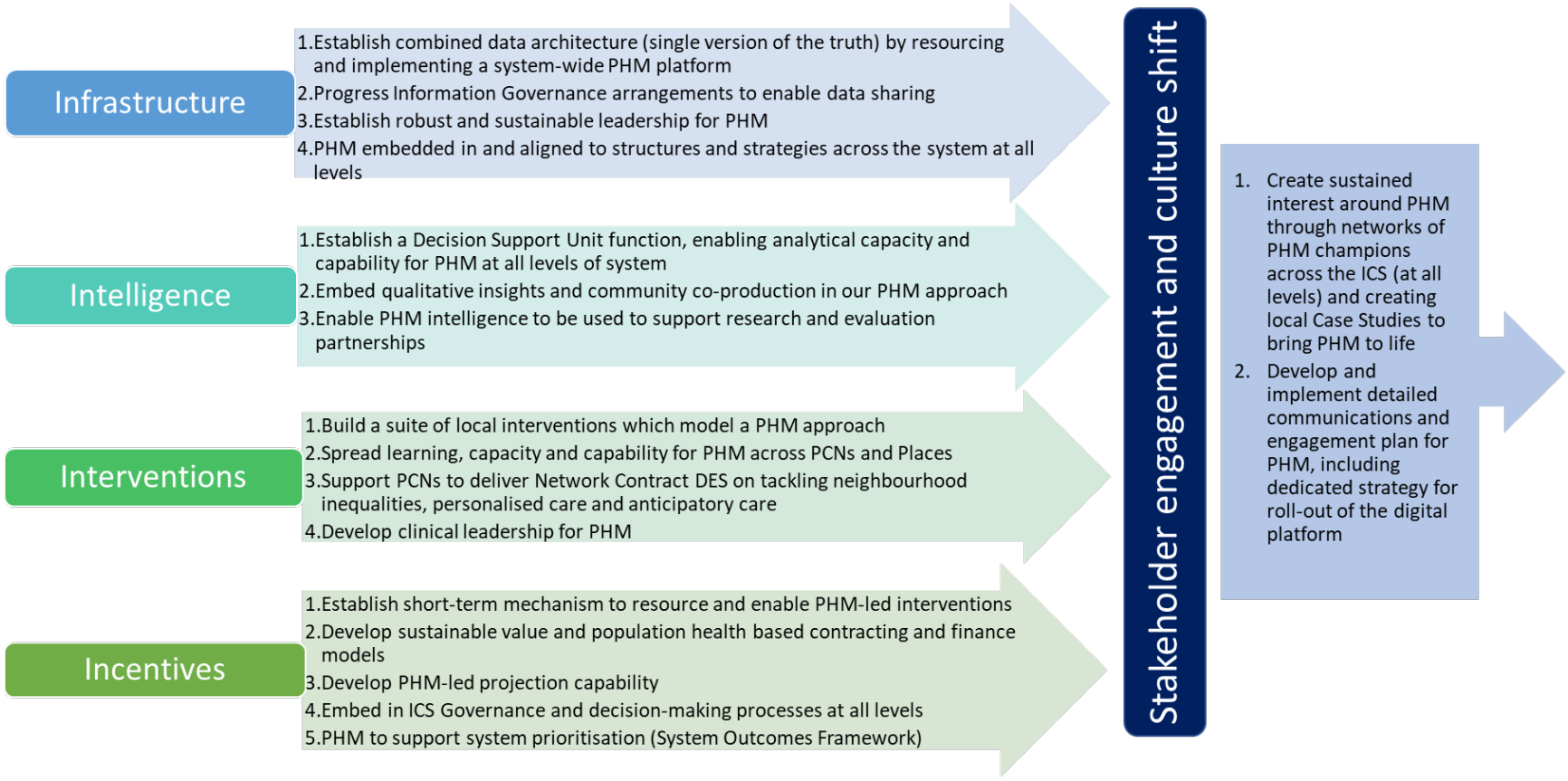
- continued support for the Place and Primary Care Networks that participated in Wave 3 of the National PHM Development Programme to progress their PHM-led interventions and embed and share learning;
- progressing system-wide actuarial coaching to support the development of a common local projection model to support resource and workforce planning; and
- building analytical support and capability, particularly in the area of evaluation of interventions.

Some of our learning from the PHM Development Programme was about the challenge for colleagues – both frontline clinical staff and senior leaders at system and Place – of committing time outside of the 'day job' to participate in lengthy workshops. This approach risks exacerbating the sense that PHM is something separate, novel and requiring a level of expertise. As we implement our Roadmap, we are seeking to shift this approach and to wrap support around existing priorities and activity, providing external expertise into that where it can add value. We also want to support colleagues across the system to recognise where they are already taking a PHM approach, and to amplify this activity.

In this way, we will seek to embed PHM as 'business as usual' and 'everyone's business' across our system.

[10] Full Delivery Plan at annex 4

Coventry & Warwickshire PHM Roadmap – high level actions



Our Governance Arrangements for PHM

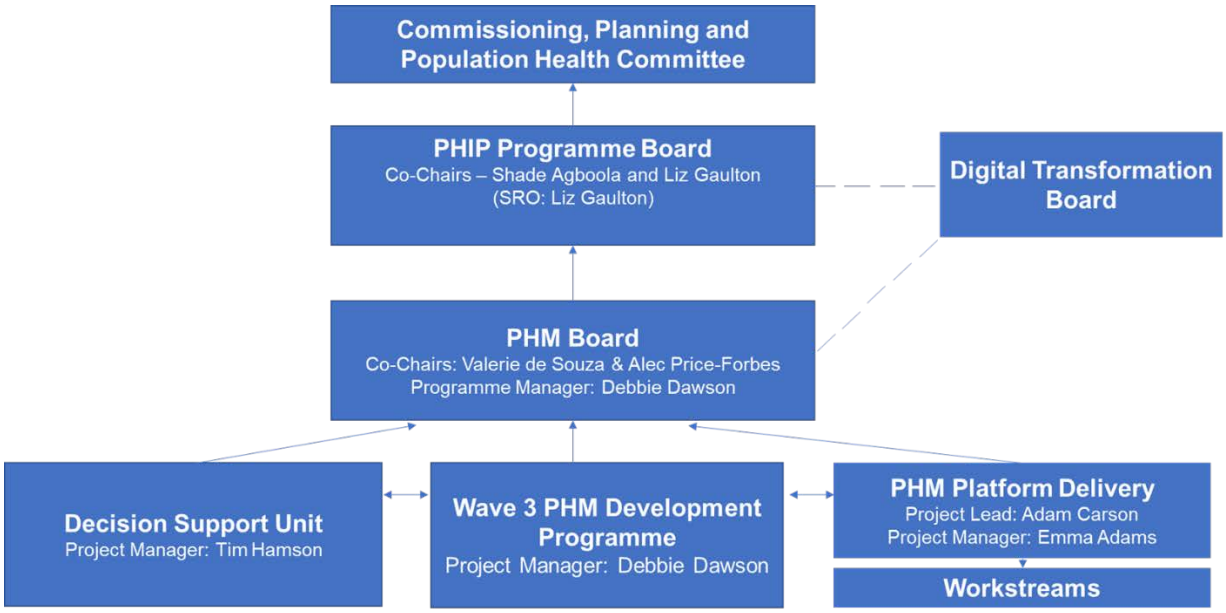
The PHM Roadmap will be approved and owned by Coventry and Warwickshire Integrated Care Board, with a clear commitment that this is how we are going to work as an ICS and that it will require whole system buy-in, at all levels, and is not a discrete activity delivered by one part of the system.

The current governance for the PHM programme is outlined below. Membership at all levels is broad, with representation from all ICS partner organisations.

The PHM Board will provide detailed oversight of the delivery of the PHM Roadmap. Its role is to lead the delivery of the vision and strategy for Population Health Management in Coventry and Warwickshire, and oversee implementation of the PHM programme and associated resource. Membership includes representation from Public Health, Adult Social Care, Data and Analyst leadership, Digital Transformation Board, Clinical Forum, Place PHM leads, Primary Care, Acute Providers and ICB Finance. Third party providers are invited as guests on a meeting by meeting basis, and excluded for private items. Members are encouraged to provide delegates where they are unable to attend, to ensure there is appropriate representation and involvement of all partners in Board decision-making.

The link with the Digital Transformation Board (DTB) is important, as this Board has responsibility for the system's overall digital strategy which is key to delivery of our PHM capabilities. The chair of the DTB also co-chairs the PHM Board.

The PHM Board reports into the Population Health Inequalities and Prevention Programme Board, which oversees the connected workstreams of the population health framework, inequalities, prevention and PHM. This Board reports for assurance into the Commissioning, Planning and Population Health Committee of the Integrated Care Board, which has oversight of development of PHM as one of its specific responsibilities.



Our resource commitment to PHM

Our PHM programme requires whole system commitment and resource. Outlined below are the current commitments, with identified risks. It should be noted that, in addition to the dedicated staff commitment identified below, PHM already benefits from the involvement of a large number of other professionals across all organisations, for whom supporting PHM implementation is a core part of their role.

Local PHM data platform contract		Dedicated staff resource commitment
Funding was committed via SWFT for 2 years to kickstart implementation of local PHM data platform		Chief Population Health and Inequalities Officer (fixed term - 1yr) - part of role
Contract for the platform includes significant transformation support offer aligned to the Roadmap		Population Health Transformation Officer (0.8) - part of role
Contract 2 + 8 years		PHM Coordinator (fixed term – 1yr)
		Head of Programme Delivery – Population Health Management Data Platform (fixed term – 2yrs) – to be appointed
		Business Intelligence PHM team (X3) – Head of BI, PHM; Senior Business Intelligence Manager – PHM; Analyst – PHM (vacant)
		Communications and Engagement Lead (PHM) (fixed term - 2yrs) – to be appointed
Total allocated	2 years' funding committed	£560k annual costs
Gaps / Risks	£14.5m funding gap over contract lifetime	Fixed term posts – unclear recurrent funding

There are some other PHM programme costs that are not yet budgeted for. These include recruitment of a designated Programme Clinical Safety Officer, and resourcing of an IT support function for the platform in order to support log-on requests, password help, diagnosing and solving software faults, and managing patient opt-outs.

Risks to delivery of our PHM Programme

	Risk	Mitigation
1.	Lack of understanding, commitment and ownership of PHM by system leaders.	Senior stakeholder interviews to inform development of a Roadmap to scale and sustain PHM, to be signed off by ICB. System Action Learning Sets as part of the PHM Development Programme (PHMDP).
2.	Resourcing: failure to secure required long-term funding for digital infrastructure.	PHM requirements embedded in Digital Transformation Strategy.
3.	PHM data platform implementation: failure to identify/recruit key project team members.	Funding for the positions agreed (January 2022) and recruitment commenced.
4.	PHM data platform implementation: risk that we cannot realise the intended benefits of the project within the initial two years of the contract.	Ongoing contract negotiations to extend the break period.
5.	Information governance: failure to secure agreement by partners to data-sharing.	IG lead identified and series of engagement workshops held to inform IG arrangement. Robust DPIA and related documentation approved by IGAG.
6.	Communications and engagement: failure in comms and engagement creating lack of awareness and understanding, and undermining support for the programme.	Support from system Comms and Engagement lead; explore potential to deploy funding for comms and engagement support to facilitate creation of and implementation of a comms and engagement plan for PHM.
7.	Fragmentation of PHM initiatives: impact on wider programme in terms of alignment, messaging and resourcing.	Work to ensure alignment of activity, nationally and locally.
8.	Capacity and willingness within system to deliver PHM core capabilities at time of transition and significant operational pressure.	PHMDP to build capacity and capability; Roadmap to be signed off by ICB identifying how this will be scaled and sustained.
9.	Analytical capability: mismatch of analyst skills.	PHMDP Analytical workstream and ongoing transformation support developing skills of system analysts. DSU function to be

		established, drawing on support of regional Decision Support Centre and network.
10.	Clinical engagement: system operational pressures impacting capacity of clinicians to engage with PHM programme.	PHMDP engaging clinicians and creating champions. Roadmap and PHM Data Platform early use cases to extend this further.

Annex 1 – Local Case Studies

PHM in action: Clinically Extremely Vulnerable as part of the response to COVID-19

Common Cause
Providing help to prevent people catching COVID-19 and to stay safe and well

Segment for Prioritisation, Risk Stratification

Those at **high risk** if they catch COVID-19.
A list of medical conditions was determined to **identify this group**, health patient databases from many organisations throughout the country were drawn together into one list called the **Clinically Extremely Vulnerable List.**

Action and Intervention Impactability

- Support those most at risk from COVID-19.
- By supporting them to stay at home.
- By ensuring this high risk group have food, their prescriptions and contact calls.
- And offering advice on any other areas they may need help with to stay safe and well.
- Prioritisation of calls was made on **impactability,** those with assisted bin collection contacted earlier for example.

Outcome

In March 2020:
- 14,000 people were contacted by telephone.
- 7,000 contact calls were made
- 2,000 food parcels were delivered
- 150 prescriptions were delivered

The lockdown started on March 26th 2020 with no preparation time the whole system was built and the first food parcel was delivered 9 days later on 4th April 2020

How this was achieved

- Clear Aim and clear population segment for focus, directed by government scheme and national press coverage.
- Cross–organisation and cross-team working
- Speed, given the highest priority
- Right team and right skills and people willing to 'move out of their usual jobs'
- Data sharing

PHM in action: Spirometry Waiting List Ordered by Deprivation

Common Cause
Providing COPD diagnosis to those affected negatively by inequalities first.

Segment for Prioritisation, Risk Stratification

Those who are on the waiting list for the diagnosis process spirometry used for COPD and who are living in the most deprived areas of Coventry.

Low deprivation groups of undiagnosed COPD population have a higher risk status of being found to have COPD, have more progressed disease and die earlier.

Action and Intervention Impactability

- For a limited time (May to June 2022) the waiting list was re-ordered from 'first come first served' to ordered by most to less deprived by Indices of multiple deprivation decile.

"I think this is a great idea, people from more deprived area usually present later with their health conditions and can't afford alternative routes to health care."

Outcome

- 34 of the 75 on the waiting list were in the 1-3 most deprived deciles (as at 14/4/2022).
- These 34 were seen first.

Consideration has been given to how the difference of an earlier diagnosis can be measured.

How this was achieved

- Openness to try new approaches.
- Willingness to move quickly to maximise opportunity.
- Right team and right skills.
- Data sharing, use of the openly available government tool to match postcodes to IMD deciles avoiding DPIA.

Annex 2 – PHM Maturity Matrix

PHM maturity matrix: core PHM capabilities overview

Infrastructure	Intelligence	Interventions	Incentives
Organisational and human factors such as dedicated systems leadership and decision making on population health and PHM **Digitised health & care providers** and **common integrated health and care record** **Linked health and care data architecture and a single** version of the truth **Information Governance** – whole system data sharing and processing arrangements that ensure data is shared safely securely and legally	**Advanced analytical tools** and software and system wide multidisciplinary analytical teams, supplemented by specialist skills **Analyses and actionable insight** – to understand health and wellbeing needs of the population, opportunities to improve care, manage risks and reduce inequalities **Alignment of multi-disciplinary analytical and improvement teams** to work with and advise providers and clinical teams **Development of a cross system ICS intelligence function** providing support to all levels of system	**Care model design** and delivery through' proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities **Community well-being** – asset based approach, social prescribing and social value projects **Citizen co-production** in designing and implementing new proactive integrated care models **Monitoring and evaluation** of patient outcomes and impact of intervention to feed into continuous improvement cycle	**Incentives alignment**– value and population health based contracting and blended payment models **Workforce development and modelling** – upskilling teams, realigning and creating new roles **Enabling governance** to empower more agile decision making within integrated teams

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PHM maturity matrix: Journey of development for building PHM capability

	Preliminary	Foundation	Advanced
Infrastructure	• Organisational and human factors such as dedicated system leadership and decision making on population health and PHM • Some linking of traditional data flows between primary and secondary care. • Information governance arrangements in place between commissioners and primary and secondary care providers to support analysis of population health. • No clear PHM vision shared across the system. • Individual and sporadic population health and health inequalities leadership. • Digitised health & care providers and common integrated health and care record plan in place • Linked health and care data	• Whole system linked primary, secondary, community, mental health care data available for direct care and care redesign, with plans to link wider data sources, including social care and other wider determinants – and an ICS-wide IG framework that allows analysis and identification for care purposes • Clear plans for converging shared care records with linked data for PHM • System wide IG arrangements which allow for analysis of de-identified patient level data for care design purposes and smooth re-identification for clinical purposes. • Development of a PHM data and analytics platform that provides insights to support strategic, operational and clinical decisions • Clear vision for PHM at system and place level, with some PCNs engaged and involved. • Clear multiprofessional leadership throughout the different tiers of the ICS, with named leads for health inequalities.	• Single integrated health and care record that features PHM insights, based on the linked data set. • Full flows of data from all health and social care sources available for direct care and care planning, including demonstrable efforts to link patient level information on wider determinants (housing, unemployment, income etc). • Information Governance- whole system data sharing and processing arrangements that ensure data is shared safely, securely and legally • Fully-fledged PHM data and analytics platform that is maintained by the ICS intelligence function and is well understood by decision-makers. • Cross system leadership and vision clearly articulated and embedded across the system, with a clear health inequalities responsibility.
Intelligence	• Traditional reporting, intelligence systems and analytical outputs acting at organisation level with limited clinical engagement. • Use of analytical teams and support units to provide population health analytical insight, but not in a systematic and consistent way across the system. • Costing and performance analysis is organisationally focused rather than patient focused. • Occasional assessment and monitoring of health inequalities data • Mapping the system analytical workforce and intelligence tools, with a view to formalising cross system analytical collaboration in an ICS intelligence function.	• Starting to use local linked data to segment and stratify population to understand needs of different patient groups and risk factors. The costs of different cohorts are understood now and in the future. • Some social determinants information being used alongside health data to examine inequalities questions. • Timely analyses and actionable insight to understand health and wellbeing needs of the population, opportunities to improve care, manage risk and reduce health inequalities, including support to PCNs • Population health costing data starting to be used for forecasting demand and risk to inform future payment and contracting models. • Agile and responsive ways of working across multi-disciplinary groups comprising clinical, improvement, analytical teams working hand in hand with providers	• Whole System Population Health Intelligence Function with multi-disciplinary analytical and finance teams with skills in predictive techniques that enables actionable insights to be regularly delivered to strategic, operational and clinical decision-makers equipped with advanced analytical tools and software • The intelligence function provides bespoke support to PCNs, places, the ICS and provider collaboratives where needed, and can direct these teams to the PHM data and analytics platform for the majority of their data needs. • Analysis which shows current and future costs of different cohorts, key risk factors (across health and wider social needs) and those patients who are at greatest risk of a deterioration in health and care. • Comparing current and predicted health status of the local population with achievable health and well-being outcomes and performance standards for populations of similar size, demography and epidemiology to understand mitigated scenarios

PHM maturity matrix: Journey of development for building PHM capability

	Preliminary	Foundation	Advanced
Intervention	• Limited engagement across primary and secondary care teams to integrate care around high need groups • Limited use of voluntary and third sector to respond to key patient groups and health inequalities. • Social prescribing and anticipatory care activity not linked to needs or inequalities analysis • Ad-hoc approach to co-production	• Care model design and delivery through proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities established between health and care providers including and with third sector involvement - to design proactive care models for different patient groups based on patient level analysis. • Integrated MDTs (all providers involved in care delivery to those patients within cohort) being supported to adopt rapid improvement cycles to implementanticipatory care interventions which includes social prescribing). • Personalised care plans in place for at risk groups andthose at the sharp end of health inequalities. • Population health analysis being used to inform shared workforce models between primary and secondary care. • Community wellbeing - asset based approach, social prescribing and social value projects • Citizen co-production in designing and implementing new proactive integrated care models	• Clearly defined care models in place for all population groups across vertically and horizontally integrated teams. • Clear working arrangements between PCNs, secondary care and voluntary and community sector partners withclear offers of support for specific patient groups. • Progress in reducing health inequalities is routinely monitored and iterated, leading to continuous improvement. • Making use of service-user tracking, patient activation outcomes, experience and utilisation measurement tools to enable partners to monitor, understand and influence how interventions impact on required outcomes and how workflow presents itself to build the future evidence base and continually learn
Incentives	• Basic population segmentation in place to understand needs of key groups with early insight into resource use.	• Whole population segmentation approach agreed by ICS and starting to be used to organise planning and delivery • Some system outcome metrics based around population segments • Payment models based around future health needs of the population, rather than organisations, in place for some cohorts and incentivise proactive and holistic support, collaborative workforce models and a community asset based approach. • Frictionless movement of workforce between settings in place to support specific care models • Enabling governance to empower more agile decision making within integrated teams	• System oversight metrics based around population segments and chosen to deliver agreed population health outcomes. • Payment models based around future health needs of the population, rather than organisations, in place across population groups • Contracting approaches encourage shared accountability for outcomes • Workforce planning performed across organisations, based on expected future need and representative of population • Incentives alignment – value and population health based contracting and blended payment models • Workforce development and modelling - upskilling teams, realigning and creating new roles

Annex 3 – PHM Roadmap Engagement, March – July 2022

	March	April	May	June	July
Board Leads for Health Inequalities					
Population Health and Inequalities Programme Board					
Population Health Management Board					
System Strategy and Planning Group					
PHM Development Programme – System, Place, Analytics and PCN Workstream Action Learning Sets					
Warwickshire Service Resilience & Recovery Forum					
Primary Care Development & Delivery Groups (system and Place)					
System Finance Advisory Board					
Shadow Integrated Care Board					
ICS Execs					
Digital Transformation Board					
PHM Platform Project Board					
Coventry and Warwickshire People Board					

In addition to the meetings above, the Roadmap was also informed by a series of individual and group interviews with senior leaders from across the system. This included: NHS Trust Chief Executives and Chairs; the ICB Chair, Chief Executive and Chief Officers; local authority senior

leaders – including Directors of Public Health and of Adult Social Care; NHS and local authority analyst and BI leads; NHS Finance Directors; Primary Care leaders; colleagues from local universities, voluntary and community sector and other partners.

Representatives of the following local organisations were involved in these meetings and interviews:

- Arden PCN
- Arden & GEM Commissioning Support Unit
- C&W Health and Care Partnership
- Coventry & Warwickshire CCG
- Coventry and Warwickshire Shadow ICB
- Coventry & Warwickshire Partnership NHS Trust
- Coventry and Warwickshire LMCs
- Coventry Central PCN
- Coventry City Council
- Coventry Marmot Partnership
- Coventry University
- George Elliott NHS Trust
- Healthwatch Warwickshire
- Innovate Healthcare Services
- North Warwickshire Borough Council
- Nuneaton North & South PCNs
- South Warwickshire NHS Foundation Trust
- Sowe Valley PCN
- University Hospitals Coventry & Warwickshire NHS FT
- University of Warwick
- Warwickshire County Council
- Warwick District Council
- Warwickshire North Place

Annex 4 – PHM Roadmap Delivery Plan

Infrastructure

1. Establish combined data architecture (single version of the truth) by resourcing and implementing a system-wide PHM data platform			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: PHM Platform SRO and PHM Platform Delivery Board Involved: Head of Programme Delivery – PHM Data Platform Digital Transformation Board ICS CCIO ICS CIO Arden GEM CSU GP practices PCN Clinical Directors Care Collaboratives Place Executives Finance Advisory Board Clinical Safety Officer (to be recruited) **Implementation of the local PHM data platform requires commitment of resource for onboarding of data from all ICS partners – specifically NHS provider trusts and Primary Care in the short term.**
PHM data and digital requirements underpinned by Digital Transformation Strategy.	Work to improve data quality and tackle digital barriers to analysts working inan integrated way, reviewing analytical tools and aligning where possible.	System-wide use of PHM platform at PCN/Place level for service redesign and identification of cohorts of patients eligible for PHM-based interventions.	
Resourcing and recruitment to posts to support local PHM data platform implementation.	Identify resource to secure continued implementation of digital platform beyond contract break.	The ability to use data insights from PHM platform to allocate resources to PCNs and Place via the Care Collaboratives to support interventions designed through analytical tooling.	
Onboarding of EMIS data to PHM data platform from primary care PCNs, aligned to the planned rollout.	Using PHM data platform for case identification of individuals amenable to interventions to improve direct patient care.	Onboarding of social care data and other data sources, e.g. pharmacies to PHM platform aligned to the planned rollout.	
Start the onboarding of acute and secondary care data to PHM data platform aligned to the planned rollout.	Review benefits of PHM data platform/ programme with pilot PCN cohort.		
Develop and deliver a Clinical Risk Management System across PHM services for C&W, signed off by a designated Programme Clinical Safety Officer (post yet to be filled).			
Resourcing of an IT support function for the PHM data platform to support log-on requests, password help, diagnosing and solving software faults and managing patient opt-outs.			

Infrastructure

2. Progress Information Governance arrangements to enable data sharing			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: system IG lead and Information Governance Advisory Group Involved: Data owners/data controllers Data Protection Officers Caldicott Guardians ICS Communications and Engagement lead
DPIA and accompanying IG documentation agreed for implementation of PHM data programme.	Local authorities included in DPIA to enable wider data sharing.	Wider health partners (eg Pharmacy, VCS providers, housing etc) included in data-sharing for PHM.	
Develop and put in place the recommendations from the IG workstream (opt-out process, new use case process, audit process).	Develop IG documentation for planning and research use cases.		
Develop and deliver communications and engagement plan for PHM data platform/programme roll-out, including public and LMC/GP engagement.			

Infrastructure

3. Establish robust and sustainable leadership for PHM			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Chief Officer, Population Health and Inequalities and PHM Board Involved: ICB Chair ICB Chief Executive ICB Chief Medical Officer ICS HR Director ICS Corporate Governance Team Clinical Forum/Clinical Executive People Board Care Collaboratives
PHM Roadmap approved by ICB.	Monitor progress against PHM Roadmap.	PHM is business as usual across all clinical care pathways, commissioning decisions, service redesign etc.	
Include oversight and decision-making for PHM in governance structure for statutory ICS, including reporting on Roadmap.	Review and refresh PHM governance as required.	PHM becomes a core competency for all staff.	
Leadership for PHM embedded in new system OD plan and core leadership competencies.	Training and coaching support for system leaders to deliver PHM.		
Agreed priority area(s) of focus for PHM activity in short-term across ICS.	Develop a prioritisation process for what we work on as a system, based on intelligence.		
Agree and resource long-term executive level leadership for PHM within ICS.	Leadership for PHM embedded in Care Collaboratives.		
Work with new Care Collaboratives to define a sustainable model for PHM leadership at Place.			

Infrastructure

4. PHM embedded in and aligned to structures and strategies across the system at all levels			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Chief Officer, Population Health and Inequalities and Population Health Transformation Officer Involved: System Strategy and Planning Group Care Collaboratives Population Health, Inequalities and Prevention Programme Board Inequalities Working Group Place Leadership Boroughs and Districts Clinical Forum and Clinical Executive People Board ICB Corporate Governance team
Establish PHM as key enabler in the delivery of ICS Health Inequalities System Plan.	Establish Care Collaboratives' leadership in driving and enabling PHM approaches in PCNs.	Establish PHM as underpinning ICS transformation work at system and Place.	
Develop Integrated Care Strategy with PHM and health inequalities at core.	Identify opportunities for PHM resource to align to major transformation programmes.		
Embed PHM capabilities in ICS Transition Progamme.			
Determine where responsibility sits at PCN/Place/Care Collaborative/ICS, and begin to devolve accountability/ decision-making.			
Identify opportunities for early PHM use cases aligned to clinical pressures in PCNs and secondary care.			
Embed PHM into the work of the Clinical Forum.			
Identify opportunities for ICS People Strategy to be informed by PHM insights.			

Intelligence

1. Establish a Decision Support Unit function enabling analytical capacity and capability for PHM at all levels of system			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: ICB Head of Business Intelligence - PHM Involved: Analyst Network Organisational BI leads Commissioning Support Unit System Strategy and Planning Group Care Collaboratives PHM Board People Board Universities Midlands Decision Support Network
Develop and agree our model for a DSU within the ICS.	Identifying and harnessing skills of SMEs across the system, including strategists and transformation leads (more than BI).	Multi-disciplinary working across organisations, bringing together analysts and other SMEs to provide insight.	
Develop an initial work programme of deliverables for the DSU.	Mechanism in place for agreeing the ongoing work plan for the DSU.	An established work plan is in place agreed across the ICS with a programme of analytical outputs.	
Look for opportunities to align some analyst resource to collaborative system-wide working and lessons learnt so far (e.g. Place Development Programme working).	Develop mechanisms (through DSU) for alignment and allocation of analyst resource for PHM work to support our system aims.	Have in place a robust mechanism for allocation of analyst resource to support collaborative system-wide PHM working.	
Integrated PHM capability/resource included in design of Care Collaboratives.	Development programme with support from partners such as the Strategy Unit.	Professional career development and a shared approach to CPD in place to support analysts across the system.	
Upskilling analysts using available transformation support: e.g. enabling to work with clinicians; building up consultancy and problem formulation skills; predictive analytics.	A programme of knowledge sharing and peer-to-peer learning in place.	Knowledge sharing, peer support, time-banking embedded as common practice.	
Building analytical community of practice including knowledge sharing.	Embedding standardised policies and practices across the ICS with a review mechanism in place.		
Agreeing and implementing standardised data policies and practices across ICS.			

Intelligence

2. Embed qualitative insights and community co-production in our PHM approach			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: ICS Comms and Engagement Lead Involved: Local authorities' communities teams ICS Involvement Network ICB Head of Business Intelligence - PHM Healthwatch (Coventry and Warwickshire) PPI network Voluntary and Community Sector Healthy Communities Together Partnership
PHM embedded in ICS Community Engagement Strategy.	Develop mechanism for capturing and using qualitative data to inform PHM insights.	Establish community co-production as consistent approach to care design and planning.	
Learn from and align with local authorities' work to strengthen approaches to listening to communities.	Community co-production of health solutions in PHM pilot activity.		
Analyst and coaching support to advance capability in understanding of PHM, including supported use of Intelligence dashboards/tools that will be provided through the PHM data platform.	Embed learning from Healthy Communities Together programme into PHM approach to co-production.		

Intelligence

3. Enable PHM intelligence be used to support research and evaluation partnerships			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: ICS CCIO Involved: People who have existing links with universities across all ICS organisations Universities Analyst network
Model PHM learning cycle through evaluation of PHMDP interventions.	Establish process for ongoing evaluation of PHM interventions.	PHM begins to be used for research and development purposes (supported by robust IG arrangements).	
Map existing links with universities.	Use PDSA-type cycle to evaluate PHM approach.		
	Explore opportunities for PHM to support research, through links to universities.		
	Work with universities to support upskilling of analysts (within analyst network) with research skills.		

Interventions

1. Build a suite of local interventions which model a PHM approach, to exemplify and ignite change (short-term goal)		How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	Coordinated by: Population Health Transformation Officer and PHM Coordinator Involved: Head of Programme Delivery – PHM Data Platform PCN Clinical Directors (Wave 3 participants) PHM leads (Consultants in Public Health) PHM Platform Delivery Board Analytics Workstream Place leadership/Care Collaboratives Personalisation Programme Manager Primary Care Delivery Group Clinical Forum/Clinical Executive
Scale PCN PHMDP interventions across member practices and to wider cohort, initially using updated snapshot dataset.	Demonstrate impact through ongoing evaluation of PHMDP, Place Development Programme and other PHM-led interventions, with a particular focus on impact on reducing inequalities.	
Support Warwickshire North Place in progressing the intervention for identified cohort developed through PHMDP through their Wider Determinants of Health delivery programme.	Embed new working arrangements between PCNs and wider partners (including community, social care, mental health, and secondary care teams) providing support for specific patient groups developed through PHM-led interventions.	
Work with Clinical Forum to identify opportunities for PHM approaches to support elective recovery and other immediate clinical pressures, with a focus on reducing inequalities.	Use local PHM Data Platform to monitor progress in reducing inequalities through the ICS Health Inequalities Strategic Plan.	
Work with Primary Care Delivery Group to identify opportunities to align PHM activity with Primary Care Strategy priorities.	Engage wider services (e.g. social care, VCS, community pharmacy) in design and delivery of interventions.	
Alignment with Personalisation Programme to model how PHM approach can be used to target personalised care interventions.	Selection and supported implementation of PHM data platform use cases.	
SW and Coventry participation in Place Development Programme.		

Interventions

2. Spread learning, capacity and capability for PHM across PCNs and Places			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Population Health Transformation Officer and PHM Coordinator Involved: Head of Programme Delivery – PHM Data Platform Communications and Engagement lead (PHM) – to be appointed PCN Clinical Directors PHM Platform Delivery Board Transformation support C&W Training Hub Primary Care Delivery Group Public Health Consultants
Share learning from and enable ongoing evaluation of PCN and Place interventions with consideration of monitoring/future evaluation of outcomes.	Offer all PCNs opportunity for transformation support for a PHM pilot programme.	Evaluate the impact of what we thought would be different in 5 years: PCNs are driving change in care models at Place.	
Support PCNs financially to engage in pilot PHM projects and as early PHM data platform adopters.	Develop local communities of practice around PHM.	PCNs and Places are organising care around the stratified populations they serve.	
Support PHM Fellow in Primary Care to share learning and champion PHM approach within primary care.	PHM champions advocating and driving change in practice – carrying the communications and engagement message forward.	Health need, not demand, determines investment at PCN and Place level.	
Programme of engagement with Primary Care to support roll-out of PHM data platform.	Ongoing coaching and support for Place leaders to build on learning from PHMDP and Place Development Programme.		
Identify the best Place to exemplify the use of the local PHM Data Platform and PHM at scale.			

Interventions

3. Support PCNs to deliver Network Contract DES on tackling neighbourhood inequalities, personalised care and anticipatory care			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Primary Care Delivery Group and Population Health Transformation Officer Involved: Head of Programme Delivery – PHM Data Platform Primary Care Delivery Group Primary Care Clinical Advisory Group Personalisation Programme Manager Inequalities Working group ICS Frailty Strategic Delivery Lead
Identify opportunities to drive PHM through Network Contract DES.	Identify and implement mechanisms to incentivise proactive and personalised care in primary care.	Use the linked data platform to meaningfully evaluate unwarranted variation and health inequalities.	
Promote examples of PHM in practice through PCN health inequalities activity.	PHM data platform used to enable and inform anticipatory care across the system.		
Build on learning from PHMDP about PCN support needs to map out support offer for primary care, utilising Personalisation programme resource allocation aligned to PHM transformation offer for pilot PCNs.			
Support submission of Anticipatory Care Plan to NHSE by 30 September, with clarity about how we will enable populational health management approaches to anticipatory care.			

Interventions

4. Develop clinical leadership for PHM			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Population Health Transformation Officer Involved: PHM Board Chief Medical Officer Clinical Forum/Clinical Executive Director of Primary Care NHS Clinical/Professional Leads Primary Care Delivery Group Primary Care Clinical Advisory Group Coventry and Warwickshire Training Hub People Board Care Collaborative leads
Role of PCNs to lead PHM in primary care articulated/identified.	Support PHM Fellow in Primary Care to help develop primary care leadership for PHM.	PHM becomes a core competency for all staff, including clinicians, and analysts.	
Embed PHM into PCN Clinical Director, Place leadership, and ICB leadership development.	Ongoing coaching and support for Clinical Directors as part of transformation support.		
Support PCNs to use PHM insight to inform delivery of additional roles.	Identify opportunities for PHM to support development and implementation of Clinical Strategy.		
Connect with new clinical/professional leads who have role to change pathways and support shift to more preventative/ community approach.	Ensure link across to acute trusts to support PHM working in neighbourhoods, communities and in hospitals.		
Leadership for PHM embedded in new system OD plan and core leadership competencies.			
Coaching and support for early adopter Clinical Directors as part of transformation support.			

Incentives

1. Establish a short-term mechanism to resource and enable PHM-led interventions			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**		Coordinated by: Chief Officer, Population Health and Inequalities and Directors of Finance Involved: Population Health, Inequalities and Prevention Board Health Inequalities Programme Managers Inequalities Working Group
Consider how can use non-recurrent HI funding to support and progress outcomes of PHM work.	Establish routes into investment resource to enable reactive/ proactive initiatives.		
Establish system-wide investment panel.	Create system-wide investment plan with mechanism to prioritise.		
2. Develop sustainable value and population health-based contracting and finance models			**How will we make this happen?**
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Directors of Finance and Population Health Transformation Officer Involved: Chief Finance Officer Chief Officer, Population Health and Inequalities Chief Officer, Planning and Performance PHM Lead, Warwickshire North ICB Head of Business Intelligence - PHM
Implement and evaluate pilot finance model for identified cohort in Warwickshire North Place, developed through PHMDP and support WN Place Readiness programme to embed PHM model.	Measure and evaluate success of the pilot model in Warwickshire North.	Shift funding to reflect outcomes of PHM activity.	
Identify the best Place to exemplify the use of the local PHM Data Platform and PHM at scale.	PHM informs outcomes-based commissioning, which underpins shift towards aligned incentives contracts.	Funding framework for Care Collaboratives underpinned by PHM.	
	Use PHM-led projections to understand future financing and investment in value-based care models.	Decisions about prioritisation / allocation of resource to be informed by PHM impactability modelling.	

Incentives

3. Develop PHM-led projection capability			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Directors of Finance Involved: Chief Finance Officer CCG Director of Business Intelligence ICB Head of Business Intelligence - PHM
Develop common local projection model to support resource and workforce planning, with external transformation support.		Embed projection modelling in ICS decision-making.	

4. Embed a focus on population health outcomes in ICS and organisational Board's decision-making, at all levels			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Population Health Transformation Officer and Chief Officer, Population Health and Inequalities Involved: System Strategy and Planning Group Chief Officer, Performance and Planning Corporate Governance Lead (ICB) ICS HR Director Care Collaborative leads
Leverage and integrate PHM activity within Transition workstreams.	Embed PHM in processes for planning, business cases and performance management.	Embed PHM in training for all NHS staff, and all system analysts, managers, and clinicians.	
PHM capabilities embedded in system OD plan.	Assurance framework for Care Collaboratives to include evidence of how PHM is driving and shaping their programmes of work.	Evaluate how PHM has informed and shaped the development of the care collaboratives.	
	Understand workforce resource implications of a more integrated PHM-based approach to delivering care.	Evaluate impact of understanding the workforce resource implications of a more integrated PHM- based approach to delivering care.	

5. PHM to support system prioritisation (System Outcomes Framework)			How will we make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Population Health, Inequalities and Prevention Programme Board Involved: Integrated Care Partnership ICB Care Collaboratives
Agree System Outcomes Framework, aligned to Integrated Care Strategy, with identification of some system outcome metrics based around population segments.	Agree whole ICS population segmentation approach and start to use this for planning and delivery.	Evaluate impact against agreed outcomes and key indicators.	

Stakeholder engagement and culture shift

1. Create sustained interest around PHM through networks of PHM champions across the ICS (at all levels) and creating local Case Studies to bring PHM to life			Who will make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Co-ordinated by: Comms and Engagement Lead (PHM) – to be appointed Involved: ICS Comms and Engagement Lead PHM Coordinator Population Health Transformation Officer Head of Programme Delivery – PHM Data Platform System, Place, and PCN leadership PHM Champions
Identify and establish network of champions from PHM Development Programme.	Expand networks, by identifying other PHM advocates.	Ongoing engagement with stakeholders and communication of successes and benefits as the programme develops.	
Create suite of local case studies exemplifying PHM impact on: inequalities; finance shift; outcomes for individuals; better use of workforce.	Linking with OD and workforce plan to build organisational skills in PHM.	Ongoing development and engagement of workforce.	
Begin to develop patient stories, using PHM data platform to track patient journeys.			
Start to involve and enthuse staff across participating organisations on the benefits of PHM.			

Stakeholder engagement and culture shift

2. Develop and implement detailed communications and engagement plan for PHM, including dedicated strategy for roll-out of the digital platform			Who will make this happen?
Short-term (2022/23)	**Medium-term (2023/24)**	**Long-term (5 years)**	Coordinated by: Comms and Engagement Lead (PHM) – to be appointed Involved: ICS Comms and Engagement Lead PHM Coordinator Population Health Transformation Officer Head of Programme Delivery – PHM Data Platform System, Place, and PCN leadership PHM Champions
Appointment of dedicated Comms and Engagement post to support roll-out of the PHM data platform.	Deliver communications and engagement plan for PHM.	Ongoing engagement with stakeholders and communication of successes and benefits as the programme develops.	
Identify local 'brand'/terminology for PHM.	Ongoing engagement with stakeholders to support onboarding of data to the PHM data platform.		
Co-produce PHM Vision and undertake stakeholder mapping.			
Create overarching communications and engagement plan for PHM that incorporates the public patient engagement process.			
Establish ICS PHM website presence.			
Articulate what PHM means for key stakeholders and what are the benefits.			
Develop and deliver strategy for PHM data platform roll-out, including public and GP engagement.			
Continue to socialise and promote the Roadmap at relevant Boards,			

Agenda Item 12

Warwickshire Health and Wellbeing Board Forward Plan 2022/23

Joint HWBB 13 October 22	*Coventry and Warwickshire Integrated Health and Wellbeing Forum*	
Health and Wellbeing Board Bulletin circulated November 9th		
	Discussion: Integrated Care Partnership Strategy	TBC
HWBB 11 January 23	Discussion items	
	Annual report: Health and Wellbeing Strategy	Nigel Minns / Gemma Mckinnon
	Annual report: Integrated Care Partnership Strategy	TBC
	Director of Public Health Annual Report 2022	Shade Agboola
	Suicide Prevention Strategy	Paula Jackson / Hannah Cramp
	Annual report: Homelessness Strategy	TBC
	Update items	
	Annual report: Warwickshire Safeguarding Board	Amrita Sharma
	Coventry and Warwickshire Integrated Health and Wellbeing Forum	TBC
	Warwickshire Health and Wellbeing Place Partnerships	Steve Maxey, Mannie Ketley, Chris Elliott
	Out of hospital progress update	Zoe Mayhew
	Better Care Fund - Metrics	Rachel Briden
	Integrated Care Board	Danielle Oum
Health and Wellbeing Board Bulletin circulated March 8th		
Joint HWBB Mar/April 23	*Coventry and Warwickshire Integrated Health and Wellbeing Forum*	
	Discussion: TBC	TBC
HWBB May 23	Discussion items	
	Joint Strategic Needs Assessment (JSNA) Children and Young People Mental Health	Duncan Vernon
	Progress report: Children and Young People Partnership	Nigel Minns
	Warwickshire Health and Wellbeing Place Partnerships	Steve Maxey, Mannie Ketley, Chris Elliott
	Update items	
	Coventry and Warwickshire Integrated Health and Wellbeing Forum	TBC
	Better Care Fund - Metrics	Rachel Briden
	Integrated Care Board	Danielle Oum

Health and Wellbeing Board Bulletin circulated July 5th		
Joint HWBB TBC	*Coventry and Warwickshire Integrated Health and Wellbeing Forum*	
	Discussion: TBC	TBC
HWBB September 23	Discussion items	
	Healthwatch Warwickshire Annual Report	Elizabeth Hancock / Chris Bain
	Director of Public Health Annual Report	Shade Agboola
	Better Care Fund – Annual Planning Report 2022/23	Rachel Briden
	Update items	
	Coventry and Warwickshire Integrated Health and Wellbeing Forum	TBC
	Warwickshire Health and Wellbeing Place Partnerships	Steve Maxey, Mannie Ketley, Chris Elliott
	Integrated Care Board	Danielle Oum