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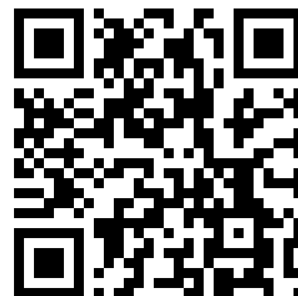

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Health and Wellbeing Board

Thursday, 11 July 2024 at 9.30am

in Council Chamber Council Offices
Market Street Newbury

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Date of despatch of Agenda: Wednesday, 3 July 2024

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Gordon Oliver on (01635) 519486
e-mail: gordon.oliver1@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk.

West Berkshire
COUNCIL

To: Councillor Heather Codling (Executive Portfolio Holder: Children and Family Services), Sarah Webster (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Councillor Jeff Brooks (Leader of the Council and Executive Portfolio Holder: Strategy and Communications), Councillor Patrick Clark (Executive Portfolio Holder: Adult Social Care and Public Health), Councillor Nigel Foot (Executive Portfolio Holder: Culture, Leisure, Sport and Countryside), Councillor David Marsh (Minority Group Spokesperson on Health and Wellbeing), Councillor Joanne Stewart (Shadow Portfolio: Adult Social Care; Integrated Health; Public Health), Prof Dr John Ashton (Director of Public Health for Reading and West Berkshire), Paul Coe (Executive Director - Adult Social Care), AnnMarie Dodds (Executive Director - Children and Family Services), Matthew Hensby (Sovereign Housing), Jessica Jhundoo Evans (Arts and Leisure Representative), Dr Janet Lippett (Royal Berkshire NHS Foundation Trust), Gail Muirhead (Royal Berkshire Fire & Rescue Service), Sean Murphy (Public Protection Manager), Dr Matt Pearce (Director of Public Health for Reading and West Berkshire), April Peberdy (Acting Service Director - Communities and Wellbeing), Rachel Peters (Voluntary Sector Substitute), Supt Andy Penrith (Thames Valley Police), Dr Heike Veldtman (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Helen Williamson (Berkshire Healthcare NHS Foundation Trust Substitute) and Fiona Worby (Healthwatch West Berkshire)

Also to: Gordon Oliver (Principal Policy Officer)

Agenda

Part I

Page No.

Standard Agenda Items 1

1 **Election of Chairman** — 7 - 8
To elect the Chairman of the Health and Wellbeing Board for the 2024/25 municipal year.

2 **Election of Vice-Chairman** — 9 - 10
To elect the Vice-Chairman of the Health and Wellbeing Board for the 2024/25 municipal year.

3 **Apologies for Absence** — 11 - 12
To receive apologies for inability to attend the meeting (if any).

4	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 2 May 2024.	13 - 20
5	**Actions arising from previous meeting(s)** To consider outstanding actions from previous meeting(s).	21 - 22
6	**Declarations of Interest** To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct. The following are considered to be standing declarations applicable to all Health and Wellbeing Board meetings: • Councillor Patrick Clark – Governor of Royal Berkshire Hospital NHS Foundation Trust, Governor of Berkshire Healthcare NHS Foundation Trust, and West Berkshire Council representative on the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership; and • Councillor Jo Stewart – spouse is Head of Contract Management at the Royal Berkshire NHS Foundation Trust.	23 - 24
7	**Public Questions** Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Meeting Rules contained in the Council's Constitution. (Note: There were no questions submitted relating to items not included on this Agenda.)	25 - 26
8	**Petitions** Councillors or Members of the public may present any petition which they have received.	27 - 28
9	**Membership** Purpose: To agree any changes to Health and Wellbeing Board membership.	29 - 30

Items for discussion

Strategic Matters

10 **West Berkshire's Annual Public Health Report 2024** 31 - 112
Purpose: To raise awareness and understanding of local health issues, highlight areas of specific concern, and to make recommendations for change.

11 **Health and Wellbeing Board Annual Report 2023/24** To Follow
Purpose: To present the Health and Wellbeing Board Annual Report 2023/24 for approval.

Operational Matters

12 **Changes to Pharmaceutical Services** 113 - 274
Purpose: To provide details of proposed changes to pharmaceutical services in West Berkshire and advise the Health and Wellbeing Board on the implications for the West Berkshire Pharmaceutical Needs Assessment.

13 **Local response to the cost of living crisis** 275 - 278
Purpose: To update the Health and Wellbeing Board on the collective response to the impact on residents in West Berkshire of the rise in the cost of living and consider how we build upon the response so far.

14 **Better Care Fund Monitoring Report - Q4 2023/24** 279 - 296
Purpose: To approve the Better Care Fund Monitoring Report for Q4 2023/24.

Other Information not for discussion

15 **Care Quality Commission Local Authority Assessment 2024** 297 - 300
Purpose: To provide an update on the recent Care Quality Commission's (CQC) Local Authority Assessment in West Berkshire.

16 **Health and Wellbeing Board Sub-Group Updates** 301 - 314
Purpose: To provide a summary of recent activities and future actions for each of the Health and Wellbeing Board Sub-Groups.

17	**Members' Question(s)** Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Meeting Rules contained in the Council's Constitution. (Note: There were no questions submitted relating to items not included on this Agenda.)	315 - 316

Standard Agenda Items 2

18	**Health and Wellbeing Board Forward Plan** An opportunity for Members of the Health and Wellbeing Board to suggest items to go on to the Forward Plan.	317 - 318
19	**Future meeting dates** • 12 September 2024 • 5 December 2024 • 6 March 2025 • 8 May 2025	

Sarah Clarke
Service Director: Strategy and Governance

If you require this information in a different format or translation, please contact Gordon Oliver on telephone (01635) 519486.

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Health & Wellbeing Board – 11 July 2024

Item 1 – Election of Chairman

Verbal Item

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Health & Wellbeing Board – 11 July 2024

Item 2 – Election of Vice-Chairman

Verbal Item

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Health & Wellbeing Board – 11 July 2024

Item 3 – Apologies

Verbal Item

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DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 2 MAY 2024

Members Present: Sarah Webster (Vice-Chair, in the Chair), Councillor Jeff Brooks, Councillor Heather Codling, AnnMarie Dodds, Sean Murphy, April Peberdy, Councillor Dominic Boeck (Substitute) (In place of Councillor Joanne Stewart), Councillor Vicky Poole (Substitute) (In place of Councillor Alan Macro), and Hannah Elder (Substitute) (In place of Jessica Jhundoo Evans)

Members Attending Remotely: Councillor Janine Lewis, Councillor David Marsh, Prof. John Ashton, Rachel Peters, Dr Heike Veldtman, Fiona Worby, and Dom Hardy (Substitute) (In place of Dr Janet Lippett)

Also Present: Zoe Campbell (Interim Service Lead Public Health and Wellbeing), Alison Foster (Royal Berkshire NHS Foundation Trust), Dr Heather Howells (BOB ICB) and Gayan Perera (Interim Intelligence Manager)

Apologies for inability to attend the meeting: Councillor Alan Macro, Councillor Joanne Stewart, Paul Coe, Jessica Jhundoo Evans, Dr Janet Lippett, Supt Andy Penrith and Helen Williamson

Absent: Matthew Hensby and Gail Muirhead

PART I

73 Minutes

The Minutes of the meeting held on 22 February 2024 were approved as a true and correct record subject to the following amendments and were signed by the Vice Chairman:

- Members had requested that the SEND Review be added to the Forward Plan for the September meeting.

It was noted that Paula Saunderson's question about Dementia Admiral Nurses had not been fully answered at the meeting. Members asked whether responses provided after the meeting were recorded.

Action: Gordon Oliver to confirm the process for recording written responses provided after the meeting and whether Paula Saunderson had received those written responses.

74 Actions arising from previous meeting(s)

Progress on actions from the previous meetings was noted.

Further updates were provided as follows:

- **218** – It was confirmed that this action had been dealt with at the time and could therefore be closed.
- **244 & 253** - The Board noted that updates on these actions would be addressed as part of the Cost of Living Update later on the agenda.

- **258** – a report template had been shared with the Volunteer Centre and would be used for future voluntary sector updates, so this action could be closed.
- **259** – it was confirmed that an information leaflet on vaping had been produced and had been shared with schools.

75 Declarations of Interest

There were no declarations of interest received other than the standing declarations set out in the agenda.

76 Public Questions

A full transcription of the public and Member question and answer sessions is available from the following link: Transcription of Q&As.

77 Petitions

There were no petitions presented to the Board.

78 Membership

It was noted that Andy Penrith had replaced Helen Kenny as the Thames Valley Police representative and Rachel Peters had replaced Garry Poulson as the voluntary sector representative.

79 Berkshire West Health Protection Board

April Peberdy (Interim Service Director – Communities and Wellbeing) presented the Berkshire West Health Protection Board report (Agenda Item 8).

It was noted that that lessons learned from the pandemic would be applied via the Health Protection Board. The proposed terms of reference were considered to cover all the relevant points and the proposed membership was considered appropriate.

In addition to the resolutions set out in the report, Councillor Jeff Brooks proposed that the Board should prepare an annual report to describe what it had considered, delivered, and achieved. This was seconded by Councillor Heather Codling.

RESOLVED that:

a) Establishment of a Berkshire West Health Protection and Resilience Partnership Board (HPRPB) be endorsed to provide assurance that robust arrangements are in place to protect the health of residents across Berkshire West (West Berkshire, Wokingham, Reading);

b) The draft Health Protection Board terms of reference be approved; and

c) The Health Protection Board be required to prepare an annual report.

ACTION: The Health Protection Board Annual Report be added to the Forward Plan

80 Berkshire Suicide Prevention Strategy

Zoe Campbell (Interim Service Lead Public Health and Wellbeing) and Professor John Ashton (Interim Director of Public Health) presented the report on the Berkshire Suicide Prevention Strategy (Agenda Item 9).

The following points were raised in the debate:

- Members asked if the West Berkshire Suicide Prevention Action Group (SPAG) had been consulted on the report. It was confirmed that the previous Consultant in Public

Health had liaised with the SPAG Chairman, but it was not known if he had been consulted on this report.

ACTION: Zoe Campbell to confirm if SPAG had been consulted and to ensure that SPAG and the Volunteer Centre were involved in future.

- The importance of bereavement counselling was highlighted in terms of providing short and long-term support to those affected by suicide. It was also noted that other areas had established Survivors of Bereavement by Suicide (SoBS) groups to provide mutual support. It was confirmed that both options would be explored by the new Director of Public Health and that SPAG was already looking at establishing a SoBS group.
- Members asked why female suicides were a priority when the rate of male suicides was three times higher. It was highlighted that female suicides were often victims of domestic abuse. Different factors affected different groups of people, so interventions had to be targeted. Suicide levels were highest amongst men in their 40s and this was often linked to a crisis in male identity.
- It was suggested that farmers may need particular support, since they had higher than average levels of suicide and poor mental health. There were also issues with deaths from farm accidents. It was suggested that a strategy for rural health may be appropriate in West Berkshire. Data analysis was underway to consider issues across West Berkshire. It was noted that Sweden had an ambition of zero farm deaths and had adopted a system of peer inspections, which had proved effective. Provision of support to gay men in rural communities was also flagged as being more difficult than in urban areas. It was suggested that all HWB sub-groups could consider rural aspects as part of their work.

ACTION: April Peberdy to consider how rural issues could be addressed.

- Members stressed the importance of marketing of services so people were familiar with the support that was available, as well as being able to provide that support within a reasonable timeframe. However, the strategy did not mention support or timelines for providing that support.
- Also, it was noted that the report focused on adults and did not mention children and young people. Voluntary sector organisations providing mental health support to young people had waiting lists of up to 18 months.
- It was suggested that a person taking their own life was a sign of system failure, and so the strategy needed to be more pro-active and focused on engagement.
- Officers acknowledged that there was more work to be done on the Strategy, but highlighted that there was lots of information on the Council's website and social media channels about the mental health support available in West Berkshire. It was suggested that the Mental Health Action Group and SPAG could work more closely in future.
- It was noted that the Berkshire Strategy was aligned with the National Strategy, which had children and young people as one of the five core areas.
- It was highlighted that Volunteer Centre West Berkshire ran mental health first aid and suicide prevention training courses.
- Members felt that the action plan needed additional work before it could be agreed.

ACTION: Officers to update the Suicide Prevention Strategy Action Plan in consultation with SPAG and bring this back to a future meeting for approval.

RESOLVED to:

- Request a progress report on the development and delivery of the 2024/25 West Berkshire action plan and proposal for a 2025/26 refresh in March 2025.
- Request assurance from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) that the spending plan for all age mental health transformation and service provision (now that the NHS England suicide prevention funding has ceased) is aligned to the Pan-Berkshire Suicide Prevention priorities, particularly bereavement support.
- Health and Wellbeing Board members to offer support for involvement of their organisations in the emerging West Berkshire multi-agency Suicide Prevention Group (currently the Suicide Prevention Action Group) to develop and implement the local action plan.

81 Building Berkshire Together Update

Alison Foster (Programme Director) provided the Building Berkshire Together Update (Agenda Item 10).

The following points were raised in the debate:

- Site tours of the existing hospital helped Members to understand the issues and helped the Trust to learn how best to engage and link with local communities.
- The Trust was keen to engage with local groups and attend events. Members were encouraged to email Alison Foster directly with details of any local community events (alison.foster@royalberkshire.nhs.uk).
- Transport and parking issues were highlighted as key concerns. It was suggested that patients would use public transport if it was convenient (e.g., a direct service from Newbury Bus Station). The Trust welcomed all feedback and confirmed that as part of the impact assessment process, it was considering how to mitigate the impacts of relocating the acute hospital on local communities within its catchment. This included making better use of local facilities such as the West Berkshire Community Hospital.
- Concern was expressed about the way in which the project was being approached, i.e., considering a replacement for the existing hospital rather than considering the sort of health system that would be needed in 30-40 years. It was noted that West Berkshire had an ageing population, which would lead to an increased demand for services. More people at end-of-life were choosing to die at home, and a better community health system would be needed to support this. The Trust was urged to consider multiple scenarios and be open to changes in working practices (e.g., consider what size hospital would be needed if there was significant investment in prevention; look at health spaces within communities; or consider the impact of a shift from surgical to medical interventions). The Trust confirmed that the hospital would follow a significant, multi-year transformation programme. The Trust had engaged with the wider health system in order to work out the right size of hospital for the future. They offered to provide a further update on this process to a future meeting. It was stressed that there would always be a need for an acute hospital, but there was a clear commitment to move to a more preventative model of care, as set out in the Primary Care Strategy. Much was dependent on the funding envelope. It was stressed that the bricks and mortar development was just one part of the set of system-wide solutions being considered.
- It was noted that the Berkshire West Place was engaged in a major programme to move services closer to patients. The hospital redevelopment project aimed to secure

funds to replace current infrastructure on the existing site, which was not fit for purpose. It was accepted that the Trust needed to do more to explain its clinical strategy.

- Members welcomed the level of engagement experienced at Stratfield Mortimer Parish Council and expressed a desire to engage other communities across West Berkshire in a similar way.
- The Trust confirmed that details of all engagement events were available on the Building Berkshire Together website and social media channels.
- Members recognised the need to identify a site for a new hospital, even if the final design might change over time, and asked about the timescales for the project. It was confirmed that work to identify potential sites was ongoing. Construction was scheduled to start in 2031. It was hoped that the project could be completed faster than 14 years, and elements would be brought forward where possible, but progress would be linked to funding rounds.

RESOLVED to note the report.

82 Local Response to the Cost of Living Crisis

Sean Murphy (Public Protection Manager) presented the report on the Local Response to the Cost of Living Crisis (Agenda Item 11).

The following points were raised in the debate:

- It was noted that the proposals for the latest round of the Household Support Fund had been signed off by the Executive Portfolio Holder. These included: assistance for food and energy costs; the goods scheme (replacement of beds, cookers, white goods, etc); food support for those in emergency accommodation; discretionary assistance for school holiday meals to 4,200 young people; and targeted support for pensioners, young carers and those leaving care. Also, £200,000 was being set aside to allow people to make applications directly to the Council for immediate support.
- A sum of £50,000 had been allocated to the joint fund with Greenham Trust. This had already issued grants to the value of £209,000 to local organisations.
- In terms of outstanding actions:
  - **244** - It was confirmed that Sovereign Network Group was represented on the local coordinating group.
  - **246** - Work on tackling the rising cost of living was now embedded in the work of the Public Protection Partnership and the impacts on health were well-recognised.
  - **253** - Further work was needed on promotion of where people could donate items with voluntary sector partners.
- It was felt that there were still people who were really struggling with the cost of living, but support mechanisms were well-established.
- The voluntary sector had welcomed the opportunity to engage and move forward with key deliverables.
- A request was made for the Public Health Team to have more involvement.

ACTION: Sean Murphy and John Ashton to discuss how the Public Health Team could be involved.

- Board Members were invited to provide input to the support that was being provided in West Berkshire. An invitation was also extended to Board Members to attend the coordination group.
- Thanks were expressed to Rachel Peters and Garry Poulson for their ongoing support.

RESOLVED to:

- Note the report
- Receive a further update to the next meeting.

83 Health and Wellbeing Board Dashboard

Gaya Perera (Interim Intelligence Manager) presented the item on the Health and Wellbeing Board Dashboard (Agenda Item 12).

The following points were raised in the debate:

- It was noted that the presentation was different to that in the agenda pack.
- Concern was expressed that some of the data was several years out of date. It was noted that more recent data was available locally, however, this did not allow for comparisons with national averages.
- Members indicated that they would like to see more granular data, particularly in relation to deprived areas, since this would guide the work of the Board and its Sub-Groups. It was confirmed that work was already being effectively targeted, but the need for high quality data was recognised.

ACTION: Gayan Perera to review data sources.

- Concern was expressed about data sources that referenced different timeframes. It was noted that pre- and post-pandemic situations were markedly different, so it was important to use current data.
- Members queried why Frimley data sources were being quoted.
- Members highlighted that data sets taken in isolation might lead to one conclusion, but when taken in the context of other factors, this might lead to a different conclusion.
- The public health intelligence function was currently shared with Reading, but it was confirmed that West Berkshire would develop its own intelligence function. This would allow for better integration of public health and corporate intelligence.
- During the pandemic, Directors of Public Health had been critical of the way in which data had been hoarded by local authorities.
- It was hoped that data captured through Primary Care Networks would become a rich source of intelligence.
- It was suggested that the Council should invest in intelligence capacity.

RESOLVED to note the report.

84 Delivery Plan Progress Report: Priorities 4 & 5

Dr Heather Howells (BOB ICP Clinical Lead for Mental Health) presented the Delivery Plan Progress Report: Priorities 4 and 5 (Agenda Item 13).

It was agreed that actions referred upwards to ‘Place’ and ‘System’ levels should be discussed at the Berkshire West Mental Health Board.

ACTION: Sarah Webster to discuss actions referred upwards to ‘Place’ and ‘System’ levels at the Berkshire West Mental Health Board.

RESOLVED to:

- note the report and the progress made to date;
- agree that the actions were still appropriate;
- agree the actions to be referred upwards to the ‘Place’ or ‘System’ levels;
- commit their respective organisations to delivering the agreed actions.

85 Better Care Fund Monitoring Report: Q3 2023/24

The Better Care Fund Monitoring Report: Q3 2023/24 (Agenda Item 14) was provided for information only.

RESOLVED to note the report.

86 Changes to Pharmaceutical Services

The Chairman presented the Changes to Pharmaceutical Services Report (Agenda Item 15).

The following points were raised in the debate:

- Although it had been intended to include the report for information only, Primary Care Support England had recently provided details of third party responses to the unforeseen benefits applications for new pharmacies at Gaywood Drive, Newbury and the Kingsland Centre, Thatcham.
- Members welcomed both applications. While there was official capacity at existing pharmacies, there was anecdotal evidence of additional need from residents.
- It was noted that Councillor Alan Macro had requested that the Board respond to the comments made in relation to the Gaywood Drive application, particularly in relation to parking.
- It was noted that previous pharmacies had failed in West Berkshire and it was highlighted that online pharmacies could offer significant benefits for some patients. Although it was recognised that these were not accessible to all patients, it was suggested that a more long-term approach was needed.
- Members were reminded of the presentation to the last Health and Wellbeing Board, which gave an assessment of the sustainability of pharmacies and the long-term strategic direction as set out in the Primary Care Strategy.
- It was noted that the large chains had bought numerous local pharmacies, but could no longer make their operations stack up financially, so they were closing stores. However, Pharmacy First meant that pharmacies were starting to pick up work previously undertaken by GPs. Pharmacists had previously played significant roles in harm reduction in relation to HIV and it was felt that pharmacists could play a more significant public health role in future.
- It was noted that there were challenges for rural residents accessing pharmacies, particularly where they were not digitally enabled and/or lacked transport.

- Healthwatch confirmed that they would be undertaking a study of the local pharmacy sector in the coming month, which would pick up aspects such as wait times and the impact of the Pharmacy First initiative.

RESOLVED to respond to Primary Care Support England on comments made in relation to the recent unforeseen benefits applications at Gaywood Drive and the Kingsland Centre, and to delegate the wording to the Director of Public Health in consultation with the Chairman of the Health and Wellbeing Board.

87 Health and Wellbeing Board Sub-Group Updates

The Health and Wellbeing Board Sub-Group Updates (Agenda Item 16) were provided for information only.

RESOLVED to note the report.

88 Members' Question(s)

A full transcription of the public and Member question and answer sessions is available from the following link: Transcription of Q&As.

89 Health and Wellbeing Board Forward Plan

The Board reviewed the Forward Plan (Agenda Item 18).

It was agreed that the following items should come to the next meeting:

- Hampshire Together Update
- Results of the Care Quality Commission review of West Berkshire Council's Adult Social Care Services.
- Director of Public Health Annual Report.

It was noted that the Women's Hub Project had not been implemented in Berkshire West and funding had been absorbed into the BOB ICB's deficit. NHS England had written to all ICBs to ask how funds had been spent – unspent funds would be clawed back. Healthwatch was interested to know what would happen in the second year of the project.

ACTION: Sarah Webster to ask ICB colleagues about plans for the Women's Hub and consider whether this could be picked up in the ICB Annual report.

It was suggested that a report be brought to a future meeting on how Tobacco Control and Vaping Legislation was being implemented at a local level, including awareness and education initiatives.

90 Future meeting dates

The dates of the future meetings were noted.

(The meeting commenced at 9.30 am and closed at 12.05 pm)

CHAIRMAN ……………………………………………….

Date of Signature ……………………………………………….

Actions arising from Previous Meetings of the Health and Wellbeing Board

Ref	Meeting	Agenda item	Action	Action Lead	Agency	Status	Comment
218	23/02/2023	Healthwatch Report - Asylum Seekers	Officers to look at the report's recommendations in the context of their statutory functions to see what improvements could be made.	Sean Murphy / Nick Caprara	WBC	Complete	This was dealt with at the time.
244	03/10/2023	Local Response to Cost of Living Crisis	Meet with Matthew Hensby to discuss the support that is available and to coordinate activity.	Sean Murphy	WBC	Complete	Sovereign Network Group is represented on the local coordinating group
245	03/10/2023	Financial Problems and Mental Health	Give further consideration to the potential for improved coordination and discuss this with relevant parties.	Helen Clark	ICB	In progress	Scheduled for discussion at the next meeting of the Berkshire West Mental Health Programme Board.
246	03/10/2023	Financial Problems and Mental Health	Review how the Public Protection Service could be involved in delivery of targets identified in the report.	Sean Murphy	WBC	Complete	Work on tackling the rising cost of living is now embedded in the work of the Public Protection Partnership and the impacts on health are well recognised
251	07/12/2023	Local Response to the Cost of Living Crisis	Share details of the Supper Club when available.	Jessica Jhundoo Evans	Corn Exchange	In progress	The Corn Exchange is currently fundraising for the Supper Club.
252	07/12/2023	Local Response to the Cost of Living Crisis	Promote the Panto Pay It Forward scheme and Supper Club to service users and voluntary sector partners.	Sean Murphy / Rachel Peters	WBC / VCWB	Complete	Details of the Panto Pay It Forward scheme were circulated after the last meeting and there was additional uptake as a result.
253	07/12/2023	Local Response to the Cost of Living Crisis	Discuss promotion of where people could donate items with voluntary sector partners.	Sean Murphy	WBC	Complete	This has been addressed in the Cost of Living Update to the July 2024 meeting.
254	07/12/2023	Local Response to the Cost of Living Crisis	Provide details of local charitable trusts in Tilehurst and Theale to Garry Poulson.	Cllr Alan Macro	WBC	Complete	Details have now been provided for both charities.
255	07/12/2023	Health and Wellbeing Board Annual Conference 2024	Programme a hot focus session on the links between poverty and health.	Gordon Oliver	WBC	Complete	This was picked up in the Hot Focus Session on Housing and Health held on 18 June 2024.
256	22/02/2024	Resilience of Community Pharmacies	Email David Dean re pharmacy issues at Downlands.	Cllr Heather Codling	WBC	Complete	BOB ICB Primary Care Team has been asked to support the practice manager to manage their scripts in a more efficient manner.
257	22/02/2024	Resilience of Community Pharmacies	Consider how best to cross-promote Pharmacy First and the Community Wellness Programme.	April Peberdy	WBC	Complete	Saleen and Juliana from Solutions4Health had a productive meeting with David Dean. Juliana is the Solutions4Health pharmacy lead and she is in contact with pharmacies regarding sharing information, etc. Solutions4Health will actively signpost people to pharmacies.
258	22/02/2024	Voluntary Sector Update	Discuss how best to integrate the voluntary sector with the HWB Sub-Groups.	April Peberdy / Rachel Peters	WBC / VCWB	Complete	A report template was shared with the Volunteer Centre and will be used for future voluntary sector updates
259	22/02/2024	Young People and Vaping	Liaise with Paul Graham about a letter to parents about the risks associated with vaping.	April Peberdy	WBC	Complete	An information pack has been produced and shared with schools
260	02/05/2024	Minutes	Confirm the process for recording written responses provided post-meeting and whether Paula Saunderson had received written responses to the outstanding questions.	Gordon Oliver	WBC	Complete	There is no mechanism for responses provided after the meeting to be recorded within the minutes, since the Q&A transcripts relate to what was said at the meeting and are published within 5 days of the meeting. In future, where there is a commitment to provide a response after the meeting, this will be recorded as an action and the action log will confirm if responses have been provided at the next meeting.
261	02/05/2024	Berkshire West Health Protection Board	Add the Health Protection Board Annual Report to the Forward Plan	Gordon Oliver	WBC	Complete	This has been added to the agenda for the meeting on 8 May 2025.
262	02/05/2024	Berkshire Suicide Prevention Strategy	Confirm if the West Berkshire Suicide Prevention Action Group had been consulted and to ensure that SPAG and the Volunteer Centre were involved in future	Zoe Campbell	WBC	Complete	Have followed up with Garry Poulson and will get an agenda item on a future SPAG meeting.
263	02/05/2024	Berkshire Suicide Prevention Strategy	Consider how health issues for rural communities could be addressed.	April Peberdy	WBC	In progress	To be considered by the local Suicide Prevention steering group under the leadership of the new Consultant in Public Health. This will also be considered for a future Hot Focus Session.
264	02/05/2024	Berkshire Suicide Prevention Strategy	Update the Suicide Prevention Strategy Action Plan in consultation with SPAG and bring this back to a future meeting for approval	Charlotte Pavitt	WBC	In progress	The Strategy and Delivery Plan are being updated and will be brought back to a future meeting for approval.
265	02/05/2024	Local Response to the Cost of Living Crisis	Discuss how the Public Health Team could be involved in the local response.	John Ashton / Sean Murphy	WBC	Outstanding	

Actions arising from Previous Meetings of the Health and Wellbeing Board

266	02/05/2024	Health and Wellbeing Board Dashboard	Review the data sources to provide more current data and more granular data related to deprived areas	Gayan Perera	Public Health Shared Team	**Complete**	The dashboard has been updated. It is proposed that this will be presented in full annually and by exception as data changes or indicators are added to reflect changing local priorities.
267	02/05/2024	Delivery Plan Progress Report: Priorities 4 & 5	Discuss actions referred upwards to ‘Place’ and ‘System’ levels at the Berkshire West Mental Health Board	Sarah Webster	ICB	**In progress**	This will be raised at the next meeting in July.
268	02/05/2024	Health and Wellbeing Board Forward Plan	Ask ICB colleagues about plans for the Women’s Hub and consider whether this could be picked up in the ICB Annual report.	Sarah Webster	ICB	**Complete**	This has been discussed with ICB colleagues and a response has been shared with Healthwatch.

03 July 2024

Health & Wellbeing Board – 11 July 2024

Item 6 – Declarations of Interest

Verbal Item

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Health & Wellbeing Board – 11 July 2024

Item 7 – Public Questions

Verbal Item

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Health & Wellbeing Board – 11 July 2024

Item 8 – Petitions

Verbal Item

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Agenda Item 9

MEMBERSHIP OF HEALTH AND WELLBEING BOARD

Name	Role/Organisation	Substitute
Cllr Jeff Brooks	Leader of the Council, Executive Portfolio Holder: Strategy and Communications	Cllr Vicky Poole
Cllr Patrick Clark	Executive Portfolio Holder: Adult Social Care and Public Health	
Cllr Heather Codling	Executive Portfolio Holder: Children and Family Services	
Cllr Nigel Foot	Executive Portfolio Holder: Culture, Leisure, Sport and Countryside	
Cllr Jo Stewart	Conservative Group Spokesperson for Health and Wellbeing	Cllr Dominic Boeck
Cllr David Marsh	Green Group Spokesperson for Health and Wellbeing	Cllr Carolyne Culver
Paul Coe	WBC Executive Director - Adult Social Care	Maria Shepherd
AnnMarie Dodds	WBC Executive Director - Children and Family Services	Rebecca Wilshire
Matt Pearce	Director of Public Health for West Berkshire and Reading	Steven Bow
Sean Murphy	WBC Public Protection Manager, Public Protection Partnership	
April Peberdy	Interim WBC Service Director – Communities and Wellbeing	
Jessica Jhundoo-Evans	Arts & Leisure Representative	Hannah Elder
Helen Williamson	Berkshire Healthcare NHS Foundation Trust	
Sarah Webster (Vice Chairman)	**Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (1)**	Helen Clark
Dr Heike Veldtman	Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (2)	
Fiona Worby	Healthwatch West Berkshire	Jamie Evans/ Mike Fereday
Gail Muirhead	Royal Berkshire Fire and Rescue Service	Stephen Leonard Paul Thomas
Dr Janet Lippett	Royal Berkshire NHS Foundation Trust	William Orr Andrew Statham
Matthew Hensby	Sovereign Network Group	Kate Rees
Supt. Andy Penrith	Thames Valley Police	
Rachel Peters	Voluntary Sector Representative	Bernie Prizeman

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West Berkshire's Annual Public Health Report 2024

Report being considered by:	Health and Wellbeing Board
On:	11 July 2024
Report Author:	John Ashton, Director of Public Health
Report Sponsor:	John Ashton, Director of Public Health
Item for:	Discussion

1. Purpose of the Report

The production of an annual report is a statutory duty of the Director of Public Health. Its purpose is to independently raise awareness and understanding of local health issues, highlight areas of specific concern, and to make recommendations for change.

2. Recommendation(s)

The Board is recommended to note and endorse the conclusions and recommendations noted within the report.

3. Executive Summary

3.1 As noted, it is a statutory duty of the Director of Public Health to produce an Annual Public Health Report to independently raise awareness and understanding of local health issues, highlight areas of specific concern, and to make recommendations for change.

3.2 Great achievements to date are noted throughout the report, particularly the Health in All Policies work programme that is evolving within West Berkshire.

3.3 The report clearly outlines a Public Health vision for West Berkshire and presents where we are now; what has been achieved; and the priorities moving forward for each of the three domains of Public Health: Health Protection; Health Improvement; and Healthcare Public Health.

3.4 Public Health has an emerging role as a key partner within the Integrated Care System, that coupled with this time of PH leadership transition gives us the opportunity to reflect and plan for future direction.

3.5 In moving forward, the report helpfully takes a look back to the history of Public Health which we can learn from.

3.6 The case for prevention is clearly made, as is our ambition to reduce the burden of disease and improve life expectancy. But in doing so, we must ensure we support a system that doesn't add further to the burden of maintaining health but instead one that builds resilience and enable people to "die young as old as possible".

4. Supporting Information

Please see attached report and slide deck.

5. Options Considered

5.1 N/A

6. Proposal(s)

6.1 N/A

7. Conclusion(s)

As required under the Health and Social Care Act, West Berkshire's Annual Public Health Report has been produced. The Health and Wellbeing Board is asked to note and discuss the conclusions and priority areas for action moving forward to inform the Council's and wider system vision for Public Health and action in the future.

8. Consultation and Engagement

This report was co-designed and developed with input across the Public Health Team.

9. Appendices

Appendix A – West Berkshire's Annual Public Health Report 2024

Appendix B – Slide deck

Background Papers:

As per footnotes within the report.

Health and Wellbeing Priorities Supported:

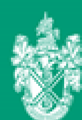
The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☒ Help families and young children in early years
☒ Promote good mental health and wellbeing for all children and young people
☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by setting out how a Public Health approach can be taken by West Berkshire Council and the wider going forward to realise health and wellbeing benefits and reduce inequalities, aligning completely to the priorities of the health and Wellbeing Strategy.

Public Health in West Berkshire

Our Ambitions, Our Journey



West Berkshire COUNCIL

Foreword by the Director of Public Health

It is my privilege to present the first public health annual report dedicated and singularly focused on the unitary authority of West Berkshire Council. Public health reports such as this have been produced for the best part of 200 years since the country's first Medical Officer of Health, William Henry Duncan, established the tradition in 1840s Liverpool. The long history of public health annual reports carries with it an acceptance of their independence from corporate or other influence; traditionally they have been presented to the annual public meeting of the Council, open to public and media scrutiny.

There was a gap, from 1974, following the abolition of the post of Medical Officer of Health and the movement of public health into the NHS during the reorganisation of local government, but this was short lived. In 1988 the new position of Director of Public Health (DPH) was established, and with it the renaissance of the annual report.

In the early 2000s the post of DPH was opened up to trained public health professionals from backgrounds other than medicine, and in 2014 public health was returned from the NHS to its spiritual home in local government. This was in recognition of the fact that most of the building blocks of health and wellbeing lie outside of and upstream from health services.

In recent years West Berkshire has operated as a unitary authority with the combined powers of a non-metropolitan county and district council; these powers include those to provide public health advice and protection for the citizens of the district, in this case currently under the leadership of a joint Director of Public Health for Reading and West Berkshire. Until now, public health annual reports have covered more than one council area in Berkshire West, this being the first to focus exclusively on West Berkshire.

This is a fantastic opportunity to reflect on the successes and achievements to date, shining a spotlight on the district. With a new Director of Public Health for West Berkshire taking up leadership in 2024, this is an ideal time to review our position and set out the priorities for the future.

Despite the period of recent uncertainty resulting from changes in Public Health leadership, there has been real progress and achievement in public health in the district. It is intended that this report will provide a comprehensive overview and the basis for

continuing improvement in the years ahead.

Children and Young People

Our focus on children and young people is aimed at producing the best start in life. We must continue to strive to improve health and wellbeing, prevent disease, develop resilience, and promote equality from before birth through adolescence and into young adulthood. The first thousand days of life (beginning at conception) are now recognised to be of crucial importance as building blocks to a stable confident and self-assured child able to realise its potential and have a happy life. Other way-markers on this journey include the avoidance of Adverse Childhood Events (ACE);[1] parenting support where needed; school readiness; the avoidance of school exclusion, which brings with it the potential of undesirable street influences; and readiness for adult life, higher and further education and the world of work.

Work with children and young people is the most effective and cost-effective approach to preventing ill health in later life. The COVID-19 pandemic has had a particularly damaging impact on children and young people, not least in relation to their socialisation at critical developmental stages and the effect on mental health, which may prove enduring without remedial support. Inequalities have widened, and in the specific area of vaccination against infectious disease, reduced coverage has left many vulnerable to diseases which we thought had been banished.

The Public Health Team in West Berkshire is mandated by the national Office of Health Improvement and Development (OHID) to commission specific programmes and services for children and young people from the ring-fenced public health budget, currently set at £6,481,369 for the year 2024-25. These services include health visiting and school nursing, Family Hub programmes, breast feeding support, early intervention services (for example dads' postnatal support and 'Every Child a Talker' programme) and wellbeing programmes in schools. Additionally, we fund the Emotional Health Academy and 'Time2Talk' youth counselling.

[1] Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence and include physical abuse; sexual abuse; emotional abuse; parental or household substance abuse; exposure to domestic violence; living with someone who has gone to prison; living with someone with serious mental illness; losing a parent through divorce, death or abandonment.

The approach of the Public Health Team has been and will continue to be that of working in evidence-based partnerships across the Council and beyond into the community. Our ambition is for West Berkshire Council to become a Public Health Organisation in which the health and wellbeing of residents is the ultimate outcome of all work. Activity encompasses Early Years, Public Protection, Children's Services, Education and Schools. We are part of the Children's Prevention and Early Help Partnership subgroup of the West Berkshire Health and Wellbeing Board, the Early Years Inequalities Group, the Berkshire west Safeguarding Children Partnership's West Berkshire Independent Scrutiny and Impact Group, the West Berkshire Child Exploitation Strategic Group, Parenting Network Meetings, and the Youth Offending Team Management Group (YOT).

Health Protection

Until the recent COVID-19 pandemic, health protection has received less emphasis compared to previous years, although support has remained available in the form of advice and guidance during outbreak situations, particularly focusing on schools and vulnerable residents.

Since 2020, our community outreach programme has taken preventive action to support the COVID-19 and influenza vaccination programmes, especially in spring and autumn. The flu vaccinations have been a significant aspect of our Stay Well in Winter Campaign, conducted in close collaboration with NHS services.

Preventing infectious diseases continues to be a public health priority, requiring collaborative efforts with health and social care, as well as action to improve vaccination uptake among individuals and communities to protect against disease.

Vaccinations still play a crucial role in safeguarding against preventable diseases such as measles, rubella, and polio. However, since 2013, there has been a decline in childhood vaccine uptake in England, a trend that has further worsened since the COVID-19 pandemic.

Sexual Health

Over the past year, we have worked with the voluntary sector on a HIV viral testing campaign, with the aim of increasing awareness of the importance of testing for HIV and increase the number of HIV tests that are done in West Berkshire. We have also been

working on extending our sexual health contracts; Emergency Hormonal Contraception, commonly referred to as the "morning-after pill," as well as Long-Acting Reversible Contraception (LARC). LARC methods encompass intrauterine devices (IUDs or coils) and contraceptive implants.

To support young people's sexual health, we have commissioned a new provider to deliver sexual health and relationship training to school staff, council staff and practitioners or volunteers who work with young people in the community. This will enable young people to have supportive conversations around sex and relationships with people they trust.

Working in collaboration with our sexual health service provider, we are updating the service to meet the demands of the post COVID-19 "new normal." This year they have revised their opening hours and have ensured that young people are able to access online STI testing.

Our focus for the next year is to review condom distribution, extend the national HIV testing week campaign by three months to increase HIV testing, review and support women's health hubs, and look to enhance links with substance misuse services and those supporting individuals with learning disabilities. Additionally, we aim to improve data collection and update our sexual health needs assessment.

Smoking cessation

Smoke Free Life Berkshire has been offering a tiered model of 'Stop Smoking' support across West Berkshire and Wokingham since 2021. This tiered approach allows clients to access the service with greater flexibility to meet individual needs and time commitments. As a result, more people have been setting quit dates and successfully quitting smoking compared with previous year. In the 2022-23 period, 710 people in West Berkshire set a quit date, of whom 469 (66%) remained smoke-free after four weeks. This success rate compares favourably with services across the country.

Drugs and Alcohol

West Berkshire has been working to reduce harm from drugs and alcohol through membership on the Combatting Drugs Partnership. The Partnership oversees delivery against the national outcomes framework and local investment and planning to improve

outcomes and support government ambitions set in the Government's Harm to Hope strategy, covering each of the three priorities to tackle demand; prevent supply; and offer world class treatment & recovery services and support.

As part of a strategic response to substance misuse, a multi-agency Substance Misuse Harm Reduction Partnership oversees the delivery of an integrated adult and young people drug and alcohol behaviour change service locally, commissioned by Public Health.

Suicide Prevention

The West Berkshire Implementation Action Plan is in the process of being revised to support the implementation of the Pan Berkshire Suicide Strategy 2021-2026. The local action plan will ensure that approaches are aligned with the new national strategy. This will facilitate local actions in prevention activity. Over the coming year, we will be commissioning suicide first aid training which will allow more people to spot the signs that someone might be at risk of suicide and able to intervene safely.

Ageing well and dementia

West Berkshire is experiencing a rapidly ageing population that is more marked than in some other areas of the country. It is therefore an especial priority to ensure that all residents have the opportunity of ageing well. A member of the Public Health Team chairs West Berkshire's multiagency Ageing Well Task Group (a sub-group of the Health and Wellbeing Board).

As regards older people in West Berkshire there has been a focus on falls prevention and reducing social isolation, targeting those more vulnerable residents at increased risk of poor health outcomes. Communications have been developed in a variety of formats for this group to enable them to receive information and to access services.

There has also been specific focus on supporting residents living with dementia and their unpaid carers and a dementia friendly community programme called 'Dementia Friendly West Berkshire '(DFWB) has been commissioned. This programme brings together statutory, voluntary and community partners, local businesses and residents to raise awareness and understanding of dementia in the community. The aim of this partnership is to promote the range of services for people living with dementia, reduce

social isolation and advocate for the inclusion of people with dementia in the activities of everyday life.

Population Health Care

The Public Health Team has been collaborating closely with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) to capitalise on opportunities for the NHS to prevent ill health and address inequalities. This collaboration includes funding a Community Wellness Outreach Service aimed at identifying individuals at risk of cardiovascular diseases (CVD) and improving access to the NHS Health Checks in underserved populations. The service will be delivered in community settings across West Berkshire.

Health in All Policies

In order to narrow the differences in health outcomes between groups of people in West Berkshire, the Council has committed to developing and embedding a Health in All Policies (HiAP) approach at a corporate level. This approach will better enable the entire organisation to address the structural issues that contribute to these health inequalities. To embed this approach, we have conducted a Local Government Association workshop on HiAP for senior leadership across the Council, focusing on how all service areas can contribute to the 'starting well' and 'ageing well' agendas. By doing so, we will strengthen our primary prevention efforts and begin to reverse the trend of increasing demand on health and social care services in the long run.

Community engagement

The Public Health Team has been actively involved in community initiatives aimed at improving health and wellbeing, fostering community resilience, and promoting community asset development. This has included initiatives like Memory Cafes. Additionally, the team has assisted in crafting the West Berkshire Co-production Framework in collaboration with staff, residents, and external partners. As part of this framework, a community mapping tool was devised to engage grassroots community groups and bolster place-based initiatives.

At a place level, voluntary organisations and community groups, along with vulnerable residents, have received support in accessing the Household Support Fund amid the

current cost of living crisis. This assistance extends to hard-to-reach groups, historically unheard or underserved populations. Through effective community engagement, easily accessible information, and clear guidance, individuals have been able to access resources such as food banks, heating assistance, and household goods.

Our Engaging and Enabling Local Communities Programme has provided valuable opportunities to listen to residents and communities, gather insights, and share vital public health information. As a public health team, we have established strong, trusted relationships with a wide array of Voluntary and Community Sector organisations in West Berkshire. These relationships are leveraged to facilitate the targeted delivery of programs such as Vaccine Outreach and Cardiovascular Disease (CVD) Health checks. By collaborating in this manner, vulnerable residents and communities receive better support in accessing essential services and enhancing their overall health and wellbeing.

The scope of work to protect and improve the health of the people we serve is broad and goes well beyond the usual narrow range of personal health and social care services. Inequalities seen in small pockets of deprivation in West Berkshire, along with the growing ageing population are of particular public health concern locally and should continue to be prioritised. This time of public health leadership transition within West Berkshire Council provides the opportunity to pause and reflect in order to plan the future direction of travel. The advancement of the Health in All Policies agenda in particular provides the opportunity to continue to move upstream towards action on the determinants of health and the maintenance of a full life by working at a place level, engaging with communities and mobilising community assets with the support of statutory agencies. Our role within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) provides us with the opportunity to work with colleagues in supporting the reorientation of the NHS towards a health service rooted in public health principles and grounded in population based primary health care. The social goal is for all to ‘die young as old as possible’ while reducing inequality and the prevalence of long-term conditions whilst maintaining independent living.

Prof. Dr John R Ashton C.B.E. Interim Director of Public Health Reading and West Berkshire 2023-2024.

Acknowledgments

It has been an immense privilege to act as the Interim Director of Public Health for West Berkshire for the past year and to work with such dedicated and committed colleagues. I am very proud of the members of the Public Health Team and their collaborators who have given so much of themselves in 2023/24. I would like to thank them for the support they have given to myself during my time here and trust that we have together put in place sound public health foundations for the people of West Berkshire.

I wish especially to acknowledge Mike Bridges and Charlotte Pavitt for their authorship of the report and Gayan Perera, Sabrina Kwaa and Nana Wadee for the insightful analysis contained within. I would also like to acknowledge and thank the following for their work in public health in West Berkshire and their contributions to this report.

Vikki Angel

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Elisabeth Gowens

Rachel Johnson

Gordon Oliver

April Peberdy

Nerys Probert

Kate Toone

Setting the scene

The History of West Berkshire Unitary Council

Initially established as the Newbury District Council under the Local Government Act 1972, West Berkshire Council replaced five preceding local authorities: Bradfield Rural District Council, Hungerford Rural District Council, Newbury Borough Council, Newbury Rural District Council, and Wantage Rural District Council. On April 1, 1998, the entity underwent the name change to West Berkshire Council and adopted the status of a unitary authority. Consequently, it absorbed the powers and functions previously held by the abolished Berkshire County Council within the district. The current council is divided into 24 wards represented by 43 Councillors.

Prior to the establishment of Berkshire County Council, Sanitary Districts were instituted in response to the Public Health Act of 1872. This legislation aimed to tackle public health issues through an organised and systematic approach to sanitation and public health administration. Sanitary districts were designated geographic areas tasked with implementing public health measures, encompassing sanitation, waste disposal, and disease control.

The Public Health Act of 1872 was a pivotal component of the 19th-century movement to enhance public health and sanitation, addressing prevalent unsanitary conditions in urban areas. Empowering local authorities, the act facilitated measures to prevent disease spread, regulate housing conditions, and oversee sanitation infrastructure.

The landscape of public health administration underwent evolution over time, resulting in changes to local government structures. Notably, the establishment of sanitary districts led to the development of contemporary local government frameworks and health authorities and legislative developments and reforms continued to shape the health and sanitation systems in England and Wales.

In particular, the 2013 Health and Social Care Act marked a significant milestone in the evolution of health and social care in England. One notable change brought about by the act was the transfer of public health responsibilities from the National Health Service (NHS) to local government authorities. This shift aimed to integrate public health efforts

more closely with other local services and empower local authorities to address the specific health needs of their communities.

The Context of Public Health in West Berkshire in 2024

The Victorian foundations of local public health work lay in the registration of births and deaths, the notification of infectious disease, and advice to town and borough councils. Today we would describe those early environmental efforts to prevent and respond to infectious disease as falling within the category of health protection, encompassing the many external threats to health whether they be biological, chemical, radiological or arising from natural or man-made disasters. These threats also include behavioural determinants such as violence or the pernicious effects of commercial determinants praying on human weakness in the form of addictions including those to alcohol, nicotine and gambling. Today Public Health broadly consists of three domains of action: Health Protection (as described); Health Improvement; and the Healthcare Public Health.[2]

Health Protection protects the population from health threats, emergencies and disasters. The development of emergency response plans; guidance on the management of public health emergencies such as infectious disease outbreaks, natural disasters or chemical incidents

Health Improvement includes health promotion campaigns and awareness raising about healthy lifestyles (on topics such as nutrition, physical activity, sexual health, smoking and substance use), disease prevention and the importance of vaccinations. It also includes influencing and ensuring all of the right building blocks for health are in place such as resilient and connected communities and social networks; stable jobs; good pay; quality housing; and good education.

Healthcare Public Health ensures health services are of consistently high quality and evidence-informed and value-based and address issues of effectiveness, efficiency and equity, and includes the emerging proactive of population health management and care.

[2] What is Public Health? - FPH - Faculty of Public Health

Health Protection

The Covid-19 pandemic that began in 2019/20 as the most devastating threat to global public health in 100 years, not only resulted in millions of premature deaths and led to a long tail of long covid ill health, but also had a profound impact on the public understanding of public health. This understanding has included an awareness of the importance of maintaining vigilance over the enduring challenge of protection against novel viral and other types of infectious disease. Local authorities in particular, with their proud tradition of work in this area, have been alerted to the importance of continuing to build resilience in the health protection function for which they have responsibility.

Until the pandemic it is fair to say that health protection had generally received less priority than pre-1974, although support had remained available in the form of advice and guidance in outbreak situations, particularly focusing on schools and vulnerable residents.

Since the pandemic it has become a priority to build on the lessons of Covid and to strengthen the health protection function while continuing with established programmes to combat infectious disease. Our community programme has taken preventive action to support the COVID-19 and influenza vaccination programmes. Vaccinations continue to play a crucial role in safeguarding against preventable diseases such as measles, rubella, and polio. A particular current challenge is to rebuild trust in vaccination programmes that was badly damaged by vaccination sceptics during the pandemic to the detriment of child health. This is well illustrated by the current return of measles, a serious childhood infection that can lead to death and lifelong disability.

Health Improvement

During the 1970's there developed a momentum for a revival of public health that had been eclipsed by the application of science-based advances in medicine and therapeutics and that had led to the rise of hospital medicine to the detriment of both prevention and primary health care. The resulting New Public Health stressed the importance of reorientation health systems away from hospitals towards public health and primary and community care with a particular emphasis on recognising that most care is provided at home in the form of self-care with family and community support.

Key elements of this were captured in the concept of Health Improvement, a broad-based approach aimed at enabling people to have more control over the determinants of ill health, an approach that saw health as a resource for everyday life rather than an end in itself. At its heart was to be public engagement and multidisciplinary working.

This fresh approach was expressed in clear terms by the World Health Organisation in its Ottawa Charter of 1986 which called for the building of policies that support health; the creation of supportive environments to protect health and make the healthy choices the easy choices; the strengthening of community action; the development of personal skills and the reorientation of health services. Coming up to forty years on from Ottawa progress has been made but it is salutary to note that since 2015 the proportion of NHS budgets spent on hospital work has continued to increase at the expense of public health, primary and community care.

Healthcare Public Health

Healthcare public health draws on core public health skills and science and applies them to the planning, commissioning and provision of health and social care services. It aims to improve population health by ensuring health services are of consistently high quality and especially that they are evidence-informed and value-based and aim to understand need and variation in order to address issues of effectiveness, efficiency and equity. This helps drive improvements in population outcomes and a reduction in health inequalities in a cost-effective manner.

With the emergence of Integrated Care Systems (ICSs) in 2022, there is even more impetus to establish sound healthcare public health practice at a local level. Collaboration is key to success and the involvement of a range of stakeholders from across the NHS and other agencies, organisations and communities is important to facilitate productive links between professionals, managers, policymakers, academic researchers and public/patient representatives.

The prevention of ill health

One of the most important lessons to have come from the advances in scientific medicine that began with the discovery of insulin and penicillin almost 100 years ago is

that by enabling people to live who might previously have died, the burden of disease may actually increase and with it the costs of maintaining people's health over many years. Examples of this include diabetes, cardiovascular disease, and HIV/AIDS. The message from this is that only by addressing the determinants of ill health in populations, so-called Primary Prevention, can we avoid ever increasing demands on national resources to be spend on treatment and care. In an age of much increased life expectancy and growing numbers of frail elderly preventing the preventable becomes an imperative.

Where primary prevention has its greatest potential to make a contribution is to be found in the first twenty-five years of life. From then onwards patterns have been established and disease processes may gather momentum. This becomes the territory of Secondary Prevention in which screening and the early identification and intervention of emerging problems is the bread and butter of Primary Medical Care, and Tertiary Prevention represented by the combined efforts of the health and social care system is aimed at enabling those with established conditions to continue to live as full and as long a life as possible.

Introduction: Public Health Comes Home

In the Victorian era the threat posed by pandemics of infectious disease galvanised local action, not least through the development of a broad-based public health movement based in town council areas. Typically, this consisted of a partnership of local politicians, businessmen, the churches, and the local press, together with enlightened medical practitioners who were interested in preventing disease. In the vanguard of this movement was the Health of Towns Association, which sprang up following the publication of Edwin Chadwick's Report on 'The Sanitary Conditions of the Labouring Classes', in 1842, and which drew attention to the high death rates in the nation's slums. Until that time, it had been assumed that because the urban economy was booming, as a result of industrialisation, life was better for everybody in the towns compared with the countryside.

The Health of Towns Association was formed at an inaugural meeting at Exeter Hall on the Strand in London, on 11 December 1844, described as being "an avowedly propagandist organisation, of capital importance."[3]

This early example of an evidence-based campaign to address the root causes of avoidable death, that fell disproportionately on the poor, was the beginning of a tradition that has extended down the years via the Quaker Rowntree reports on poverty in Victorian slums, to the Marmot reports on Inequality in Health today[3]. In the case of the work of the Health of Towns Association, its emphasis on disseminating facts and figures drawn from official reports; organising public lectures on the subject, reporting on the sanitary problems in districts; providing instruction on the principles of ventilation, drainage, and civic and domestic cleanliness whilst campaigning for parliamentary action to give powers of intervention to local authorities, led to the passing of the first Public Health Act in 1848.

This Act built on the innovative action of Liverpool in passing its own parliamentary 'Sanatory (sic) Act' in 1846 which enabled the town to appoint the country's first full time Medical Officer of Health. The 1848 enabling Act extended this power to the many other

[3] Ashton, J. (2019). Practising Public Health - An Eyewitness Account. Oxford University Press

towns and cities that followed suit over the next 20 or so years, until this became a requirement in the later Public Health Act of 1875.[4]

Report to the General Board of Health on a Preliminary Inquiry into the Sewerage, Drainage, and Supply of Water and the Sanitary Conditions of the Inhabitants of the Borough of Newbury

The 1852 report by William Lee Esq, Superintending Inspector, describes the Borough of Newbury as a "serious sanitary evil." The inquiry illustrates the living conditions of Newbury's residents and those in the surrounding rural areas. The report vividly portrays witness accounts detailing sanitary conditions such as sewage, drainage, lack of drinking water, overcrowding and flooding. It also highlights excessively high mortality rates resulting from preventable diseases among the inhabitants. These insights are gleaned from testimonies of residents, local medical practitioners, and statistical comparisons with other districts nationwide.

The report highlights that the town's health could be significantly improved through the actions of the local authority, comprising the Town Council and Improvement Commissioners. The suggested means include enacting the Local Improvement Act to provide water to local residents, ensuring adequate drainage for houses, abolishing cesspools, and supplying other essential requisites for good health.

The inquiry report delves into mortality rates and the root causes of diseases, emphasising the urgency of implementing preventive measures. The Local Improvement Act is proposed as a mechanism for vesting powers in the Town Council through the Local Board of Health. This stresses the vital role of Public Health today, emphasising the need for collaborative efforts across various sectors within our council. These efforts should underpin and inform the work of Housing, Social Care, Environmental Health, Regulatory Standards, and beyond. The report serves as a powerful reminder that Public Health remains essential in contemporary society, guiding preventative partnership initiatives crucial for the well-being of the community.

Annual public health reports such as this have represented not only a snapshot of population health at a moment in time, and a reference point for action, but also are documents of record for the future, of value to policy makers, practitioners and the public,

[4] Frazer, W.M. (1947). Duncan of Liverpool. An account of the work of Dr w. H. Duncan, Medical Officer of Health of Liverpool, 1847-63. Hamish Hamilton Medical Books, London

that enable us to learn from the past, to see how far we have come, and, hopefully, avoid repeating previous mistakes.

The work of the early pioneers of public health from the 1840s onwards was organised around the principle that came to be known as 'The Sanitary Idea' and focused on the separation of human, animal, and vegetable waste from food and water. Twenty years before the discovery of the germ theory of disease by Louis Pasteur in Paris, this led to concerted action on sanitation, cleanliness, scavenging, street paving, safe municipal water supplies, street washing and slum improvement. Over time, with the increased credibility of local government resulting from its effective action in tackling epidemic disease through these measures, other programmes of work became possible, including the creation of municipal parks as lungs of towns and cities, giving access to fresh air and exercise for industrial workers on their day of rest; municipal bath and washhouses; early examples of municipal housing; and other infrastructure initiatives such as gasworks and hygienic slaughterhouses.

The advent of safe household water supplies and mains sewerage systems together with the mass manufacture of soap by Lever Brothers on Merseyside, together with the new insights into the germ causation of infectious disease, paved the way for a shift from the sanitary focus of the early years to one on hygiene from the 1870s onwards. At the same time, personal health and social services such as health visitors, social workers, and community nurses began to emerge from their environmental roots in household inspection, based yet again in local government. Examples of specific initiatives included the health visitor movement that began in Salford in 1862; the first Society for the Prevention of Cruelty to Children, in Liverpool in 1883; and the first depot to provide milk to nursing mothers, in St Helens, in 1899. Innovation and rollout by local councils came thick and fast.

Despite this, an event of particular importance in the evolution of British public health came as a result of the Boer war from 1899 to 1902 when 40% of men who had volunteered for military service were deemed to be unfit to serve and concerns were expressed about how the nation would deal with the increasing military threat posed by Germany. An interdepartmental government enquiry into the "physical deterioration" of the nation led to a comprehensive programme of action:

- A continuing anthropometric survey;
- Registration of stillbirths;
- Studies of infant mortality;
- Centres for maternal instruction;
- Day nurseries;
- Registration and supervision of working pregnant women;
- Free school meals and medical inspection of children;
- Physical training for children, training in hygiene and mother craft;
- Prohibition of tobacco sales to children;
- Education on the evils of drink;
- Medicals on entry to work;
- Studies of the prevalence and effects of syphilis;
- Extension of the Health Visiting Service.

At the time, there were arguments over community versus family responsibilities for health and wellbeing, an echo of the contemporary debates about the so-called 'nanny state', but the interests of the nation prevailed and, with them, the establishment of the School Meal and School Health Services. Over 100 years on the range of local government initiatives looks impressive and comprehensive. Sadly, it was not to endure in the face of scientific medical advances and the increasing domination of hospital medicine as the therapeutic era based on pharmaceutical and other technical interventions took centre stage.

The widely accepted definition of public health as first coined by Charles Winslow, Dean of Public Health at Yale School of Public Health, in 1920, is that "Public Health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health"[5].

[5] Winslow, C. E.A. (1920). The Untilled Fields of Public Health, Science.

This comprehensive approach attracted widespread support after World War 1, building on the Boer War report but being extended to include Prime Minister Lloyd George's major programme of 'Homes Fit for Heroes'. When the Poor Law was abolished in 1929 and its responsibilities, including for the relief of poverty and for the workhouse hospitals, passed to local government, the era of local government public health reached a peak. At this point, the Medical Officer of Health was responsible for the traditional environmental services of water supply, sewage disposal, food control and hygiene; for the public health aspects of housing; for the control and prevention of infectious disease; for the maternity and child welfare clinics, health visitors, community nurses and midwives. He (sic) was also responsible for the tuberculosis (TB) dispensary and venereal disease (VD) clinic. Under his other hat he oversaw school health, to which was added the responsibility for the administration of the local hospital[6]. Some of the larger public health teams consisted of thousands of staff. What could possibly go wrong?

What happened next was in fact the advent of the new, therapeutic era, in public health with major scientific advances beginning with the discovery of insulin and the early antibiotics. Until this time, medical interventions made precious little difference to life expectancy and chronic ill health. Rather, the major improvements that had taken place and had led to dramatic falls in mortality from childhood and water and food-borne infections had come about as a result of improved living and working conditions; safe water and sanitation; increased agricultural productivity that had made cheap food abundantly available for the poor; the adoption of birth control leading to smaller families competing for scarce family resources and the beginnings of vaccination for a range of infections. These included the later BCG vaccination together with medication to control tuberculosis, one of the "captains of the men of death", along with epidemic pneumonia.

[6] Integrated care systems (ICSs) became legally established through the Health and Care Act 2022, on 1 July 2022

Berkshire County Council Public Health Report compiled by Gerard C. Taylor OBE County Medical Officer of Health

The 1923 Berkshire County Council Public Health Report reveals significant advancements in population health, attributed to the effectiveness of public health interventions, medical progress, improvements in sanitation infrastructure and favourable socio-economic conditions when compared to the previous Report to the General Board of Health in 1852.

From 1852 to 1923, the population of Newbury Borough steadily increased from 6,568 to 12,295. This demographic shift is ascribed to various factors, including an aging population, high birth rates, a decline in infantile mortality, and net migration. However, there was a notable decline in the number of men aged between 20 and 40, compared to women, both nationally and locally. This was a consequence of the significant loss of servicemen during the First World War (1914-1918). Subsequently, there was a spike, indicating a rise in the number of post-war babies being born in the 1920's. A reduction in mortality rates is credited to advancements in nutrition, hygiene, housing, sanitation, the control of infectious diseases, childhood immunisation, and other public health measures.

In 1918, arrangements were made for the implementation of a comprehensive scheme encompassing maternity and child welfare work, including the establishment of centres and clinics. By 1923, 63 percent of child births registered in the County were attended by a registered midwife, marking a significant increase compared to the pre-war years. In 1920 the first Council houses were built in Newbury in St George's Ave. Additionally, the West Berkshire Museum opened in Newbury in 1904, while the first public library opened in 1906, and the first cinema in 1910 bringing education, culture, art, entertainment and improvements to the physical and emotional wellbeing of the working-classes.

Epidemiological insights from the County Medical Officer of Health report highlighted prevalent diseases, including smallpox, measles, German Measles (Rubella), scarlet fever, whooping cough, diphtheria, typhus, enteric fever, and diarrhoea. Notably, during 1923, there were 71 notifications of infectious diseases in Newbury (32 cases) and the Rural Districts (39 cases), reflecting ongoing efforts to monitor and manage disease outbreaks.

The coming of the NHS in 1948 marked a dramatic change in emphasis with a widespread belief that public health had completed its historic task. It came to be believed that the future would be largely based around hospital medicine with a pill for every ill and extended possibilities for surgery posed by antibiotics preventing wound infections. This also marked the point at which medical careers between hospital medicine and general practice sharply divided and both public health and general practice went into a sharp decline.

By the time of the major local government reorganisation in 1974, the public health workforce was demoralised and struggling to recruit. Other professional groups such as social work, environmental health, and community nursing, were vying for their own professional space, away from the hierarchical leadership by the Medical Officer of Health, and the role was abandoned and reinvented as an administrative one in the NHS, that of Community Physician, one that was to be short lived.

The creation of new joint posts in the control of communicable disease between the NHS and local government in 1988 marked the beginning of the slow transfer back of public health to its proper home in local government. It was to take 27 years, until 2013, before this was implemented in full.

In the meantime, beginning in the 1970s there had been an increasing recognition internationally that countries may be on the wrong path with their infatuation with hospitals at the expense of public health and primary care, and that a rebalancing was necessary. The publication of the Alma Ata Declaration by the World Health Organisation in 1978 had called for a reorientation of health systems towards primary health care grounded in a public health framework which emphasised public participation and extensive partnership working with a focus on the need for cross-cutting policies that promote and improve health.

At the heart of these initiatives was the implication that our approach to health had been distorted not only by the undue emphasis on the role of hospitals in improving health but also the over-professionalisation of everyday maladies and the management of long-term conditions. This extended to the neglect of support for the overwhelming contributions of lay and self-care by individuals, family, friends and communities.

In addition, the limitations of the original 'sanitary idea' that drove public health in the nineteenth century have become apparent. Dumping sewage and chemical waste into the rivers and building tall chimneys to move air pollution beyond the city limits may solve problems in the short term but over time have led to our soiling our own planetary nest and contributed to global warming and the climate emergency.

The New Public Health that has emerged during the past thirty years puts emphasis on the ecological nature of the challenge facing us and stresses the need for us to live in a sustainable way in the habitats that nurture and protect us. This thinking has led to the reconnection of public health to town planning to which it was akin to a Siamese twin in previous times. Four principles of ecological town planning have been identified:

1. Minimum intrusion into the natural state with new developments and restructuring reflecting and respecting the topographic, hydrographic, vegetal, and climatic environment in which it occurs, rather than imposing itself mechanically on locations.
2. Maximum variety in the physical, social and economic structure and land use, through which comes resilience.
3. As closed a system as possible based on renewable energy, recycling and the ecological management of green space.
4. An optimal balance between population and resources to reflect the fragile nature of natural systems and the environments that support them. Balance is required at both administrative district and neighbourhood levels to provide high quality and supportive physical environments as well as economic and cultural opportunities[2].

This understanding has informed the development and adoption of the United Nations' Sustainable Development Goals to be attained by the year 2030 and to which the British government is a signatory. Although government endorsement is necessary for progress to be made with these ambitions, it is not sufficient, and it is likely that the concerted action of local authorities globally will be essential.

Table 1. The United Nations Sustainable Development Goals[7]

No poverty	Gender equality	Industry, innovation and infrastructure	Life below water
Zero hunger	Clean water and sanitation	Reduced inequalities	Life on land
Good health and wellbeing	Affordable and clean energy	Sustainable cities and communities	Peace, justice, and strong institutions
Quality education	Decent work and economic growth	Responsible consumption and production	Partnerships to achieve the goals

The lack of sustainability of the current path being followed together with the rapidly increasing demand for medical and social care in an ageing population was recognised in the UK in 2002. At that time, the then Chancellor of the Exchequer, Gordon Brown, invited banker, Derek Wanless, to review the case for bringing NHS funding up to the level of comparable European countries. In supporting the case for increased funds, Wanless and his team examined three scenarios based on: the status quo; the implementation of evidence based best practice universally across the present system; and the complete transformation of the NHS into one grounded in public health and full public engagement.[8]

Only under the last scenario could he justify increased funding; with both scenarios one and two the NHS was predicted to fall over either in 20 years or more slowly. Sadly, the significant increase in funds subsequently made available those 20 years ago was appropriated into a new hospital building programme together with large pay increases for NHS staff without the transformation envisaged. Now in 2024, a combination of these flawed decisions with the aftermath of the pandemic have brought the situation to a head. Time is short and the need for real change urgent. However, the experience of the COVID-19 pandemic has resonances with the cholera pandemics of the nineteenth

[7] United Nation. Sustainable Development Goals. Sustainable Development Goals | United Nations Development Programme (undp.org)

[8] Wanless, D. (2002) Securing our Future Health: Taking a Long-Term View. Wanless.pdf (yearofcare.co.uk)

century in that we have an opportunity to learn from that experience and build on the responses that were made.

The Organised Efforts of Society for Public Health in West Berkshire

In recent years the World Health Organisation has advocated a comprehensive set of 10 functions seen to be necessary to deliver a robust public health response:

1. Surveillance of population health and wellbeing (intelligence);
2. Monitoring and response to health hazards and emergencies (health emergency planning);
3. Health protection, including environmental, occupational, food safety and other threats;
4. Health promotion including action to address social determinants of health and health equity;
5. Disease prevention including the early detection of illness;
6. Assuring governance for health and wellbeing;
7. Assuring a sufficient and competent public health workforce;
8. Assuring sustainable organisational structures and finance;
9. Advocacy, communication, and social mobilisation;
10. Advancing public health research to inform effective intervention.

Under the Health and Social Care Act of 2012, the Director of Public Health (DPH) is accountable for the delivery of their authority's public health duties and is an independent advocate for the health of the population, providing leadership for its improvement and protection.

The Director of Public Health is a statutory officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning the three domains of public health; health improvement, health protection, and population health care and the holder of a politically restricted post by section 2(6) of the Local Government and Housing Act 1989, inserted by schedule 5 of the 2012 Act. (4)

The statutory functions of the Director of Public Health include a number of specific responsibilities and duties arising directly from Acts of Parliament - mainly the NHS Act 2006 and the Health and Care Act 2012 - and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered.

The most fundamental health protection duties of a DPH are set out in law and are described below. How these statutory functions translate into everyday practice depends on a range of factors that are shaped by local needs and priorities from area to area and over time.

Section 73A (1) of the 2006, inserted by section 30 of the 2012 Act gives the Director of Public Health responsibility for:

- All of their local authority's duties to take steps to improve the health of the people of their area;
- Any of the Secretary of State's public health and health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations; these include services mandated under regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act.

Health protection mandated functions include:

- Director of Public Health exercising their local authority's functions in risk assessing, planning for, and responding to, emergencies that present a threat to their area's public health.
- Preventing and controlling incidents and infectious disease outbreaks to protect their population.
- Carrying out public health aspects of the promotion of community safety.
- Taking local initiatives that reduce the public health impact of environmental and communicable disease risk.

The Director of Public Health has an overarching duty to ensure that the health protection system works effectively to the benefit of its local population.

From time-to-time other responsibilities are placed upon the public health function within the local authority, including those directed in relation to the deployment of the centrally

provided public health grant. At the moment, one such responsibility is that of collaborating with the NHS England and Office of Health Improvement and Disparities (OHID) approach to support the reduction of health inequalities in conjunction with the United Kingdom Health Security Agency (UKHSA). Most recently the establishment of Integrated Care Boards and Partnerships by the NHS is intended to bridge the gap in approach between prevention, treatment and care and reduce health inequalities. CORE 20 Plus 5 identifies the most deprived 20% of the population as the focus for action together with five clinical priority areas:

1. Maternity
2. Severe Mental Illness
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case finding.

The Public Health Vision for West Berkshire and the strategic context

This will be delivered within a wider strategic context and will contribute to the West Berkshire Council Strategy that aims to support: ***thriving communities*** *with a strong local voice, helping our residents to lead fulfilled and active lives*; ***more people enabled to be physically active*** *supported by the sports and leisure opportunities available in the District; and the* ***reduction of social isolation****, especially in rural areas and for young people.*

In addition, Berkshire West has a Joint Health and Wellbeing Strategy with a vision for Reading, West Berkshire and Wokingham that over the next ten years all people will live longer, healthier and more richer lives and we will reduce gaps in the differences of health outcomes between the richest and poorest parts of Berkshire West. West Berkshire's Public Health commitment compliments this vision and the five key priorities that were jointly agreed to have the greatest impact to health and wellbeing, as follows:

- Reduce the differences in health between different groups of people;
- Support individuals at high risk of bad health outcomes to live healthy lives;

- Help children and families in early years;
- Promote good mental health and wellbeing for all children and young people;
- Promote good mental health and wellbeing for adults.

Where are we now?

It is important to understand what the data is telling us in respect to health and wellbeing need now and in the future; how it varies within our own communities and compared with other areas; and which groups have greatest need in order to apply Public Health approaches most effectively. This section explores our population and communities in terms of age, deprivation and life expectancy. We then dive into the detail to understand what is driving what we are seeing in the numbers and in residents experience of living and working in West Berkshire.

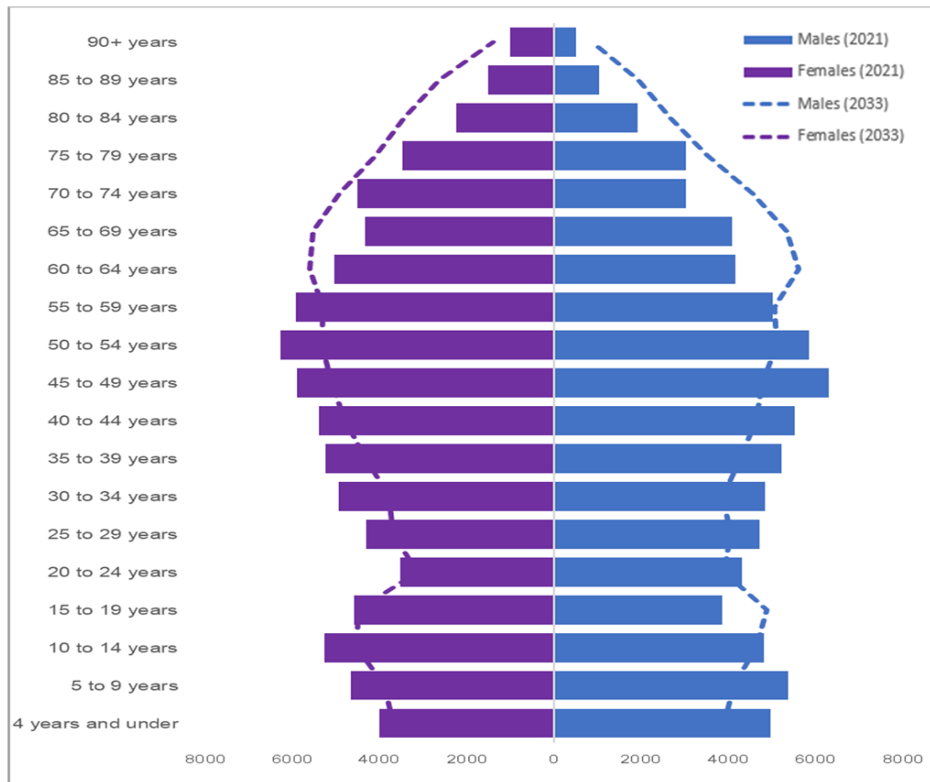
It is important to consider that while the data provides a useful aerial picture of the need in West Berkshire it is important to work with our partners and the communities themselves to really understand what is happening locally in order to organise support, interventions and services most efficiently and effectively.

> *"Statistics are patients with the tears wiped off."*

This pen picture gives a sense of the challenge facing us if we are to reduce the profound inequalities in health that face us and require us to address both risk factors and risk conditions to support healthy, long lives.

We can see from the following figures that overall West Berkshire is an affluent, healthy community with long life expectancy. However, there are pockets of deprivation and with that will come poorer health and wellbeing outcomes. In addition, we have an ageing population that again will bring challenges to the health and wellbeing of our communities. We must bear these challenges in mind in our public health approach locally.

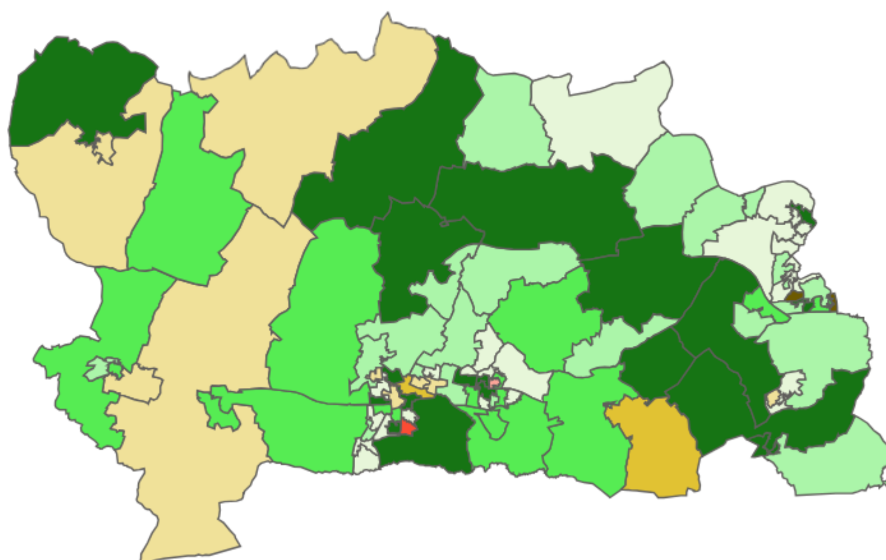
Figure 1: 2021 Mid-year population estimates[9] and 2033 projected population in West Berkshire, by age group[10].



[9] Office of National Statistics. Mid 2021 Population Estimates

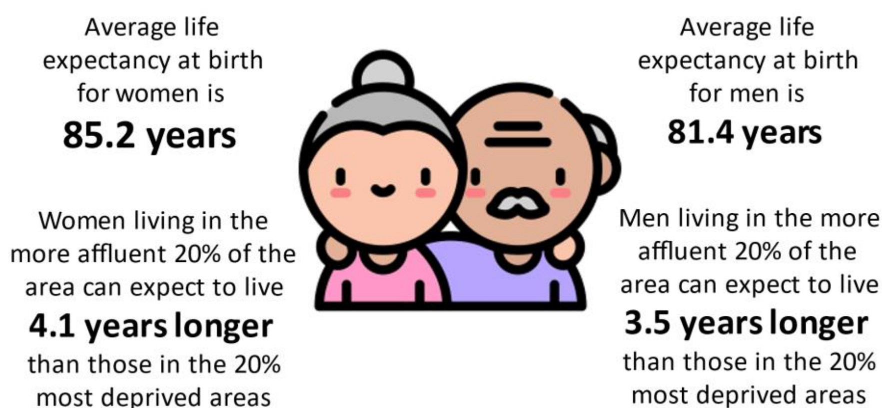
[10] Office of National Statistics. Subnational Population Projections for England: 2018-based

Figure 2: Overall deprivation in West Berkshire[11]



Life Expectancy at Birth. OHID Fingertips Tool. [Public Health Outcomes Framework - OHID (phe.org.uk)]

Figure 3: Average life expectancy at birth, by gender, in West Berkshire[12]



[11] GOV.UK. English Indices of Multiple Deprivation 2019
[12] Life Expectancy at Birth. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

West Berkshire demographic headlines[13]

- Based on the 2021 Census, **the population size of West Berkshire has increased by 4.9% from 153,800 in 2011 to 161,400 in 2021.** This is lower than the 6.6% increase in England over the same period but still a significant number of individuals requiring health and social care support and services.
- Between 2011 and 2021, **there has been an 8.6% increase in children and young people aged under 15** compared with a 5.0% increase in England over the same period; an 11.7% increase in adults aged 15-64 compared with a 3.6% increase; **and a 17.2% increase in people aged 65 years and over** compared with a 20.1% increase in England. Health and social care need is greatest in the very young and very old and therefore these higher than average in the case of children and large increase in rate of the elderly will see a significant impact on the demand for support and services.
- There are now **85,659 people aged 0-19 and 65,361 people aged 65 and over**. Among those aged 65 and over, 14,705 were aged 75 and over and 4,045 were aged 85 and over. By 2033, the number of people aged 85 and over is projected to increase to around 6,825.
- The **number of households has increased by 6.5% from 62,340 in 2011 to 66,400 in 2021**, an increase of 4,060 households. This is a comparable increase to the national increase of 6.2% during the same period in England.
- In 2021 27.0% (18,009) of households were one person households; this compares with 30.1% in England. Of those with more than one person **67.9% were single family households compared with 63.0% in England.** The remainder (5.1%) were a variety of household types including multiple person households (compared to 6.9% in England).
- **A higher percentage of people in West Berkshire were classified as white (91.9%) in the 2021 census compared with 81.0% in England** (and thus a much lower percentage (7.4%) classified as Asian, Black, or Mixed ethnicity compared with

[13] GOV.UK. English Indices of Multiple Deprivation 2019

16.8% in England). The proportion of Asian, Black, or Mixed Minority ethnic groups has increased by 2.9% since 2011 (3.2% in England).

- **95.2% of people in West Berkshire specified English as their main language in 2021** (90.8% England); 0.6% (968 people) could not speak English or speak English well (1.9% England).
- **91.2% of people aged 16 and over in 2021 identified themselves as heterosexual (compared to 89.4% in England)**, 2.3% as non-heterosexual (3.2% England).
- **14.7% of people in 2021 were classified as disabled under the Equality Act,** which is 23,726 people.
- **31.6% of households in 2021 were classified as deprived on one dimension of deprivation (education, employment, health, or housing), compared with a higher percentage of 33.5% in England.** This percentage difference between West Berkshire and England as a whole becomes more pronounced as you increase the dimensions of deprivation, indicating not only lower rates of deprivation in West Berkshire but also less complexity/fewer dimensions of deprivation locally. 10.2% were deprived on two dimensions (14.2% England); 2.0% were deprived on three dimensions (3.7% England); and 0.1% were deprived on all four dimensions, lower than England (0.2% England)
- **In total, 8,204 households (12.3%) were experiencing multiple deprivation** (deprived on two or more dimensions), much lower than the England average of 18.1%.
- **The most deprived areas of West Berkshire were located around main urban centre of Newbury.**
- **Life expectancy** for males in 2020-22 was 81.0 years, which is better than England at 78.9 years, and for females it was 84.6 years, which is higher than England at 79.0 years. Male life expectancy in the most deprived areas was 3.5 years lower than in

the least deprived areas (England 9.7 years lower); female life expectancy differed by 4.1 years compared with 7.9 years in England.[14]

The Way Ahead

Our strategic intentions as set out in this year's Public Health Report are the basis for our delivery plans and work with other council directorates and external bodies over the next three years. It is not possible for them to be set in stone as they will need to change and evolve in response the threats to health and the changing health needs of the population, changes in national policy and local priorities.

Health Protection

At a local level the work of Health Protection aims to anticipate, prevent, respond to, and mitigate risks and threats to health arising from communicable diseases and exposure to environmental hazards including chemicals and radiation. However, the broader health protection function extends to a wide range of external threats including those from commercial activities, whether legal or otherwise, and behaviours that involve violence and aggression. Everybody has a right to be protected from both infectious and non-infectious environmental hazards to health and it has long been a primary duty of government at different levels to safeguard the public in this respect.

The effective delivery of local health protection requires close partnership working between West Berkshire Council, Reading Council, Wokingham Council, the UK Health Security Agency (UKHSA), together with other local, regional, and national agencies and bodies, including the NHS. Over the past four years the national and local health protection response has been in the spotlight due to the COVID-19 pandemic. During this period, we have built up expertise, developed relationships and established systems to ensure an effective response to COVID-19 and other health protection threats. Building trust with our communities has been essential to providing an effective response. As we move forward in the recovery from the pandemic, we do so against a

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[14] Life Expectancy at Birth. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

backcloth of growing health inequalities and the imperative of responding to the climate emergency which will bring with it a range of new public health challenges.

COVID-19 is still circulating in the community, albeit in a more controlled manner, and the resurgence of other viral and respiratory illnesses, including influenza, is putting pressure on health and healthcare systems. The recent return of measles in the face of reduced population levels of protection with MMR vaccine should alert us to the importance of maintaining eternal vigilance against infectious diseases that we thought had been defeated.

Other risks and hazards are currently present and the circulation of Avian flu among the national poultry flock and wild birds is a warning of what could be possible should another novel virus migrate from livestock and become responsible for person-to-person spread. Additionally, the climate emergency is galvanising local authorities to ensure that they play their part in the sustained long-term threat to human populations and our ecosphere.

At the moment some aspects of the core functions and responsibilities of the Director of Public Health in West Berkshire including Environmental Health, Health Emergency Planning, Trading Standards and aspects of Community Safety (Violence Prevention), are not sitting within the remit of the Office of the Director of Public Health. It is intended that stronger functional links will be developed with these areas of work in the coming year.

The COVID-19 pandemic has worsened existing inequalities, especially affecting vulnerable communities. This includes challenges such as low vaccine uptake, impacting especially groups such as migrants, people in the criminal justice system, those with substance misuse, and the homeless. At-risk groups based on ethnicity or sexual orientation may also face inequality.

What we have achieved so far

Seasonal vaccination

The 'Be Well This Winter' service was designed to provide targeted outreach for those residents of West Berkshire who were most in need of support during the winter months in 2022/23. The Service aimed to reduce inequalities between groups with respect to

broad aspects of population health including vaccine uptake, cardiovascular outcomes and general wellbeing during the ‘cost of living’ crisis being experienced at the time, following extraordinary inflationary pressures upon the wider economy. The Service utilised a proportionate universalism approach, allowing it to target those most in need of support but also remaining available to the population of West Berkshire as a whole.

The Service was delivered in the form of support for the ‘Health on the Move’ van’, a mobile covid-19 vaccine delivery unit. Alongside this, ‘Be Well This Winter’ sessions enabled engagement with service users to signpost them to useful information outlets to support their health and wellbeing during wintertime.

Overall, this service proved to be of value in its contribution to reducing health inequalities amongst those most in need. It was able to deliver a significant number of covid-19 vaccines to those populations who are at the greatest risk of developing severe complications from respiratory infections. Large numbers of conversations were had, and relevant literature was distributed to residents signposting them to services such as CVD check-ups and cost of living support hubs.

The ‘Be Well This Winter’ programme serves as a reminder that targeted approaches to delivering public health interventions, when executed properly, can be an extremely useful in tool in ensuring that those most in need are provided with the means to support their health and wellbeing.

Protecting Children from Infections and Diseases – Measles in West Berkshire

Once celebrated as a triumph in Public Health, the World Health Organisation (WHO) declared that the UK had eliminated measles in 2017. This was short lived, and that status was rescinded a year later. Since then, there has been a resurgence of Measles in England and during the past year, significant increases in the incidence of cases in London and outbreaks in the West Midlands were reported. However, all regions in England have reported cases.

In West Berkshire, the number of unvaccinated pre-school children is less than 10%. Nevertheless, there is no room for complacency as neighbouring boroughs are some of the worst for vaccine uptake in the region. Due to the high transmissibility of the virus, it is anticipated that the situation will worsen before it gets better as most clinical cases

of preventable childhood infection are unvaccinated. This is notable as Measles is one of the most contagious vaccine-preventable diseases.

The cause of the increase in unvaccinated cases is twofold. The first being foreign travel and immigration with individuals entering the U.K. who did not receive the Measles Mumps and Rubella (MMR) combined vaccine in childhood. The second being the decline in vaccination coverage that can largely began with the discredited linking of childhood autism with MMR vaccination by Dr Andrew Wakefield. This was later compounded by irresponsible negative propaganda about vaccination by so-called 'anti-vaxers' during the Covid pandemic.

Uptake of MMR is low in areas of deprivation and in migrant and refugee populations. This has been made worse by vaccine hesitancy which has continued to spread, resulting in the rise of unvaccinated children and young adults. The clinical consequence of high levels of unvaccinated individuals is that the population becomes more susceptible to infection. Measles is not only a childhood disease and can be serious at any age. Those at high risk of severe illness and death are infants, pregnant women and individuals with compromised immune systems.

To ensure that more people are protected, it is important that we focus efforts to increase uptake of the MMR vaccine as part of the routine pre-school childhood immunisation programme as well as catching up older children and young adults who missed out previously. There is a call to action to reduce this threat with activity taking place at all levels:

- At a global level the World Health Organisation (WHO) has revitalised partnerships with other international health organisations to coordinate efforts to prevent severe illness and death caused by Measles.
- Nationally, the United Kingdom Health Security Agency (UKHSA) launched the MMR catch- up campaign. From January 2024, a national recall exercise will target unvaccinated and partially vaccinated children aged 6 -11 years (primary school age).
- Local awareness campaigns are being rolled out that focus on low vaccinated groups including schools and parent groups.
- GPs are being supported to improve MMR uptake using a regional MMR GP Toolkit.

- Targeted community and stakeholder engagement including media briefings led by local influencers and clinicians from under vaccinated communities.
- The local authority is ensuring it is in a state of readiness to ensure the manage potential outbreaks and minimise onward transmission of the measles virus.

Where are we now?

West Berkshire Health Protection Headlines[15]

- In West Berkshire, 95.3% of babies aged one year were vaccinated against a range of diseases including diphtheria, whooping cough, polio, meningitis, and pneumonia in 2022/23. This was higher than the England average of 91.8%. Among two-year-olds vaccination uptake was higher at 95.8% compared to 92.6% in England.
- In 2022/23, 93.9% of two-year-olds in West Berkshire were vaccinated against measles, mumps and rubella (MMR, one dose), compared to the lower England average of 89.3%. At five years of age, uptake for one dose was 96.5%, and 93.0% for two doses compared with 92.5% and 84.5% for England.
- In West Berkshire, 90.1% of girls aged 12-13 had received the HPV (Human Papilloma Virus) vaccination (one dose) in 2021/22, which helps protect against cervical and some other cancers including throat and anus, in both men and women and cancer of the penis in males. This compared with an uptake of 69.6% in England. Among girls aged 13-14, 90.5% received two doses compared with 62.4% in England. 90.0% of boys aged 12-13 in West Berkshire received the HPV vaccination (one dose) in 2020/21 compared with 62.4% in England.
- In 2021/22, 100% of boys and girls aged 14-15 in West Berkshire had received the MenACWY (meningococcal bacteria strains A, C, W and Y) vaccination, which helps protect against meningococcal meningitis, compared with 79.6% in England.
- Overall childhood vaccination uptake in West Berkshire is good, however local data suggests variation, with some areas, schools and groups of our population having much lower uptake compared to our overall average and the national average. For

[15] Population Vaccination Coverage. OHID Fingertips Tool. Public health profiles - OHID (phe.org.uk)

example, 1 dose of MMR in some of our primary schools locally may be a low as 50% or less.

- 77.2% of adults aged 65 and over in West Berkshire in 2020/21 had received the PPV Pneumococcal Polysaccharide Vaccine (PPV), which helps protect older people against diseases including bronchitis, pneumonia, and septicaemia (blood poisoning). This is higher than the England rate of 70.6%, but still means nearly a quarter of our over 65 age group are not vaccinated.
- In 2022/23, 59.9% of those considered to be at clinical risk under age 65 in West Berkshire were vaccinated against influenza; this was higher than the England average of 49.1% but still only just higher than half of our vulnerable population. Among the population of all those aged 65 and over the West Berkshire coverage was 86.5% compared with England at 79.9%.

STI Diagnosis[16]

- The rate of all new Sexually Transmitted Infections (STIs) diagnoses in West Berkshire in 2021 was 260 per 100,000 population (421 diagnoses from a population of 161,400), which is significantly lower than the England rate of 694 per 100,000 population. These lower local rates may be a result of a number of reasons including lower incidence but also poorer uptake of or access to services.
- Within this overall figure for sexual infection the diagnostic rates of syphilis (4.9 per 100,000) and gonorrhoea (29 per 100,000) were lower than the England rates of 15.4 and 156 per 100,000 respectively in 2021; the chlamydia detection rate among young people aged 15-24 in 2022 was 952 per 100,000, nearly half the England rate of 1,680 per 100,000.
- In 2022, there were 81 people aged 15-59 living with HIV. The diagnosed prevalence rate (0.88 per 1,000 population) was lower than England (2.34).
- In 2020-22, 0% of people aged 15 and over with HIV were diagnosed late, lower than the England average of 43.3%; the proportion diagnosed late was much lower than

[16] Health Protection Profile. OHID Fingertips Tool. Public health profiles - OHID (phe.org.uk)

the recommended national target of 50% which suggests good performance in West Berkshire

- In 2022, 28.9% of eligible people were tested for HIV, lower than the England average of 48.2%.

Our priorities moving forward

- Continuously strengthen our preparedness against future health protection threats and improve the quality of our services to protect health.
- Fulfil the assurance role of ensuring that appropriate health protection arrangements are in place to protect the health and wellbeing of the residents of West Berkshire.
- Ensure that organisational and system level governance arrangements are in place across Berkshire West through the Berkshire West Health Protection and Resilience Partnership Board (HPRPB).
- Ensure that environmental, biological, chemical, radiological, and nuclear threats and hazards are understood, and that health protection issues are addressed through close collaboration with Emergency Planning Teams, Environmental Health and other appropriate colleagues.
- Work proactively with Environmental Health, Emergency Planning, Trading Standards and the Communications Team on incident and outbreak investigation, response and management.

Wider Health Protection

An important part of the health protection function is that of protecting the population against a range of external threats and hazards that go well beyond infectious disease and are not intrinsically related to biology. Rather they are those that arise from the social, physical and economic environment and include those are commercially influenced and determined.

Most recently the World Health Organisation has begun to focus attention on what have come to be known as the commercial determinants of health. This includes an emphasis on industries such as those promoting drugs and alcohol, tobacco, gambling

and online media that play on inherent weaknesses and influence behaviour in ways that is often detrimental to mental and physical health and wellbeing.

Existing public health programmes including smoking cessation and the provision of substance misuse (drug and alcohol) services have addressed some of these threats but there is more that needs to be done. The recent appearance of the major problem of teenagers inhaling nitrous oxide from balloons and using cheap, disposable, flavoured vapes creating a new generation of nicotine addicts bring potential threats to physical health including neurological and heart disease problems in the future. In a situation like this downstream intervention with treatment services is necessary but insufficient to get to grips with a problem that requires national action as well as intervention locally for example through the work of Trading Standards bringing enforcement to bear on rogue retailers.

Other external challenges are a consequence of the way we plan and design housing and our local neighbourhoods to be fit for purpose for everyday living in ways that are supportive, safe and sustainable. The COVID-19 pandemic revealed how inadequate much of the housing stock is when coping with infectious disease and the trials of a lockdown in which many families had no access even to a balcony for fresh air let alone access to green space. The cumulative impact of these external hazards, combined with social and economic factors, means that the most vulnerable in society are at greatest risk of ill health.

What we have achieved so far

Throughout 2023 we have been working with our Planning Policy colleagues to develop a Health Impact Assessment policy and process for new developments in West Berkshire. By implementing a requirement for planning applicants to include Health Impact Assessments for developments over a given threshold, we aim to optimise the health benefits and minimise the potential harms, while maintaining a focus on reducing inequalities.

We will be implementing the newly developed Health Impact Assessment policy which requires the formal adoption of the West Berkshire Local Plan Review. While we await the adoption, we will be developing accompanying Health Impact Assessment templates and guidance for prospective developers. These will be tailored to the unique

needs of different environments and communities in the district, for example with a "priority checklist" for developments in different West Berkshire wards. Later in 2024 we will implement the Health Impact Assessment policy and start to promote the newly developed assets.

Where are we now?

Wider Health Protection[17]

- 11.3% of adults aged 18 and over in West Berkshire were current smokers in 2022, lower than the England average of 12.7%.
- 66 people died from lung cancer in 2021. The mortality rate (40.6 per 100,000) was lower than England (48.5 per 100,000).
- There were 61 alcohol-related deaths in 2021. The mortality rate (36.8 per 100,000) was similar to England (37.8 per 100,000).
- There were 13 deaths from drug misuse in 2018-20. The mortality rate (2.8 per 100,000) was nearly half the England rate (5.0 per 100,000).
- The rate of known domestic abuse related incidents and crimes in adults aged 16 and over in 2021/22 was 24.8 per 1,000, lower than the England average of 30.8 per 1,000.
- There were 3,256 violent crime offences in 2021/22 – the rate of offences (20.6 per 1,000) was lower than England rate of 34.9 per 1,000.
- There were 327 violent sexual offences in 2021/22 – the rate of offences (3.5 per 1,000) was higher than England (3.0 per 1,000).

[17] Public Health Outcomes Framework. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

Our priorities moving forward

- Work with planners, other council officers, the general public, and others to ensure the design of safe, supportive, and sustainable housing, neighbourhoods and communities.
- Through our Health in All Policies (HiAP) we will work with Development Control, Planning, Licensing and Trading Standards, and Environmental Health to reduce externally driven harms to the vulnerable.
- Develop a public health approach to violence prevention, using an evidence base to understand populations at risk and the impact of interventions.
- Work with local communities and Family Hubs to identify problems related to health and wellbeing and mobilise and support community assets in the battle against anti-health influences.
- Work with organisations across West Berkshire to develop a strategic approach to combatting the threat of addiction whether by alcohol, tobacco, drugs and other harmful substances, risky sexual activity, or gambling, supported by high quality, evidence-based services to reduce harm.
- Work with other bodies, organisations, and interested parties to reduce the hazards that increase the risk of falls in the vulnerable and the elderly.

Health Improvement

Health Improvement children and young people

The aim of health improvement for children and young people is to promote their physical, mental, and emotional well-being, to support them in achieving their full potential and leading healthy lives. This work includes initiatives aimed at preventing illness and injury, promoting healthy behaviours, and addressing any health inequalities or vulnerabilities that may exist. The overarching goal is to ensure that children and young people have the best possible start in life and are equipped with the resources and support they need to thrive and be resilient as they grow and develop.

Working with children and young people is the most effective and cost-effective way of preventing ill health in later life. In public health terms, this is where primary prevention, or preventing the causes of ill health in later life, has its best chance of success for the whole population. The COVID-19 pandemic has been particularly detrimental to children and young people and has widened inequalities. Many have lost opportunities for early development, missed out on crucial personal and social development, and experienced mental ill health. Mitigating the impact of the COVID-19 pandemic on children and young people will be critical over the next few years.

The broad aims for this stage of life have already been identified as:

- Planned parenthood
- The first 1,000 days of life beginning with conception
- Support for parenting
- Prevention of Adverse Childhood Experiences (ACEs)
- School readiness
- Prevention of school exclusions
- Readiness for the world of work and adult life.

Health Improvement Adults

The goal for improving adult health is to help people stay healthy and to live as full a life as possible as they become older. This requires supporting and encouraging behaviours that support both mental and physical well-being throughout adulthood. Health should be regarded as a resource for everyday life that maintains independence despite the inevitable biological decline that comes with age. Reducing the burden of long-term conditions which varies so much between geographic areas and population groups also reduces the strain on health and social services. This is a priority given the current ageing demographic of West Berkshire.

Improving health and wellbeing in adulthood is dependent of a wider range of factors, including those opportunities for behavioural change, through optimising the natural and built environment, personal development and work opportunities, social networks and communities backed up by accessible high quality clinical and social care services. Actions in these areas can reduce the risk of major groups of communicable disease such as cancer, heart disease, stroke, depressions, respiratory illness and diabetes

Achieving good mental and physical health in working age adults provides benefits in older age, promoting independence and reducing the demand on health and social care services.

The local public health team has a range of programmes and services designed to provide appropriate support to the adult population. This includes targeted health check-ups through the NHS, programs to help quit smoking, and services for supported weight management. We recognise the importance of different organisations including other council departments, the NHS, and wider civic partners, to work together to promote adult health. In addition to specific services commissioned from the public health grant the public health team has a convening and facilitating role in optimising concerted action focused on improving population adult health

What we did

Children and Young People

Our focus on children and young people is aimed at producing the best start in life. This begins before birth, the foundation being planned parenthood as far as this is possible to ensure that all babies are born into a nurturing, supportive and stress-free environment. West Berkshire Public Health has continued to commission, fund and develop various Public Health services, programs and initiatives for children and young people.

This includes the nationally mandated and integrated **0-19 years Public Health Nursing Service** (up to 25 for those with Special Educational Needs and Disabilities (SEND), including the provision of both Health Visiting and School Nursing. This is very much an "upstream" public health service that is community based and needs-led, with action based on the principles of proportionate universalism, i.e., it is universal in its reach but personalized and proportionate in response in order to meet need.

Health Visitors and School Nurses have a variety of roles. They act as leaders of the Healthy Child Programme (HCP) within multi-professional teams and care pathways. They ensure their service is integrated to support both a healthy pregnancy and children through to the age of 19 years (25 years for SEND individuals). Nurses work in

partnership with families to understand their needs and then where necessary arrange a programme of more intensive support as needed.

The HCP includes five mandated touch points (Antenatal, New Birth Visit, 6 – 8 weeks appointment, 9 – 12 months assessment and 2 – 2.5yrs assessment). As children enter the school system, the National Child Measurement Programme (NCMP) provides two additional touchpoints in Reception and Year 6.

The Public Health grant currently makes a significant contribution to the funding of Family **Hubs** in some areas of the borough. The funding is provided to support the objective of giving every child the best start in life, by

- Decreasing the attainment gap through focus upon school readiness.
- Support child health through a range of public health initiatives.

This work is delivered in the 3 Family Hubs (East, Central and West) and through outreach work to universal families, targeted groups and one to one support.

The work includes but is not limited to:

Antenatal – 4-week evening course covering wellbeing, feeding your baby, preparing for the birth, changes to relationships, one session is led by a RBH midwife and covers birth

***Postnatal and Dad's Postnatal* -** The dad's postnatal is a 2-hour evening session run jointly with a male Health Visitor. Both courses look at mental health and wellbeing, where to get support, sleep, weaning, common childhood illness, play and development

Flying Start - This was a series of 3 evening sessions which focused on the following areas:

1. Communication & Language
2. Developing a love of reading & phonics
3. Physical development & early writing skills

The aim is to guide parents in how best to prepare their child for starting school and support their learning at home.

Uptake of Vulnerable Two Entitlements - Working closely with the wider early years team the family hubs liaise with local early years provision identifying local available

places for families of vulnerable 2-year-olds. Taking families on visits to provision and encouraging uptake of the offer.

Every Child a Talker (ECAT) - ECAT focuses on supporting early years settings (e.g., nurseries, pre-schools, family hubs) to work on the following three aims:

1. Identifying and supporting children who may be at risk of delay.
2. Developing the knowledge and skills of practitioners.
3. Helping parents to understand the stages of development and how they can help their child.

ECAT is led by a teacher and an NHS speech and language therapist. Three cluster meetings are offered per term that focus on different topics. This helps to build practitioners knowledge and skills of the stages of development and how to help children who have speech, language, and communication difficulties.

Each setting has a lead practitioner for ECAT, but all practitioners understand that they have a role in supporting children's speech, language, and communication skills. Settings complete termly monitoring of all children so that they know the children who are struggling and can put support in place.

Reading together - Universal offer to families a programme of sessions via zoom to introduce good reading habits and support families to become readers.

Chatterbox - 5-week course for children who have a speech delay

Five ways to wellbeing and BOOST - These courses cover looking after oneself, building confidence, being assertive, managing anger and supporting positive change.

Best Start in Life – Digital Offer (1001 Days Platform)

The Best Start in Life is a digital platform providing convenient advice and information to families and new parents when they need it (Best Start in Life Vision). It is a centralised digital hub providing advice, tips, and answers to common questions, fostering a sense of support and community.

1-2-1 and group accredited **community breastfeeding support** is delivered by family Support Workers via Family Hubs. The service offers support to minimum of 170 new mothers each year. This is approx. 11% of the annual births in West Berkshire.

Family Hubs are not UNICEF Baby Friendly accredited, although they have attended UNICEF Baby Friendly training, and the service is aligned with UNICEF Baby Friendly guidance.

The service supports mothers to breastfeed up until 8 weeks (where appropriate), and longer where possible.

The Cooking & Nutrition (CAN) initiative has continued to support the Family Hubs in West Berkshire to deliver Cooking and Nutrition Programmes to supported families, for the third year running. This is a small-group 6-8 week course, helping to develop skills and confidence in the kitchen and with family nutrition – including weekly budgeting. One Family Hub has gone on to develop a Phase Two cooking course, working with the local cricket club, delivering ongoing practical cooking classes for those families who are keen to keep learning. In 2021-2022 we worked with 38 families, by the end of this round of courses we hope to have worked with 55.

The West Berkshire **Health and Wellbeing in Schools Programme** supports children and young people in developing their health literacy. This includes an emphasis on resilience, confidence and independence – and help to keep physically and mentally healthy. This is achieved through working closely and in partnership with schools to develop a whole school approach which extends to and including the wider school community.

Other work this year has included but is not limited to:

The West **Berkshire Youth Survey** was carried out in partnership with Berkshire Youth and the Office of the police and crime commissioner in January and February 2023 with over 6300 responses from academy and maintained secondary school students (approximately 50% of all students). reports were sent to town and parish councils in September 2023 and work is continuing to promote the findings of the survey. The data from the survey has been an extremely valuable tool in helping to shape strategies with youth provision. It has also been used by partners to successfully bid for funding to provide support and provision for young people. The survey will be repeated in January 2025.

Young Health Champions – The Young Health Champions Project has successfully created over 30 new young health champions, across 3 secondary schools in West Berkshire. Young health champions is a qualification and a movement set up by the Royal Society of Public Health. Once trained, our young health champions receive a level 2 certificate and then set about creating health campaigns in their schools. This year in March 2024 at our annual conference; the young health champions reported back on work that they had undertaken focussing on self-care and encouraging peers not to take up vaping.

Relationships, Sex and Health Education – We continue to lead the secondary network for subject leader providing support, advice and local and national updates to schools. We contribute to a primary network for school subject leaders. Over the last year we have provide direct support to 8 schools. We have briefed primary school headteachers on the upcoming Relationships, sex and health education curriculum review. Our Year 3 workshops have been delivered in 32 primary schools supporting the relationships and health curriculum. The workshops teach children about the Eat Well guide, 5 a day, food labels and added sugar and the 5 ways to wellbeing.

We have delivered a parent's workshop in a local secondary school about the challenges of social media, making the presentation available to other settings to use.

As well as this we have also joint commissioned sexual health CPD for school staff, professionals and volunteers.

Health and Wellbeing in Schools award – 3 school settings continue to work on their award and 2 new settings have signed up to complete our award this year. The Health and Wellbeing in schools award is a plan, do, review approach to whole school approaches to health and wellbeing in schools, based on Public Health England's 8 whole school principles. The award guides schools to identify priority areas to improve the health and wellbeing of their setting.

Vaping - We have helped worked with schools to develop policies for young people and vaping. This has included campaigns to encourage youngsters in not taking up vaping unless as a smoking cessation tool. We also commissioned continued professional development for professionals on youth vaping.

Risking it All - We have Commissioned and coordinated a theatre intervention project into schools that looks at exploitation and child drug and alcohol use and unhealthy relationships. The project was delivered into 9 local secondary schools in February 2024 reaching over 2000 students. 89% of students agreed that the performance helped improve their understanding of the issues raised in the performance.

Safer Streets - Working with Building Communities Together we are leading on the education element of the safer streets funding. Safer streets funding has been made available from the office of the police and crime commissioner to reduce anti-social behaviour in the Nightingales estate in Newbury. We are working with schools on a project to deliver workshops in schools to reduce anti-social behaviour and improve wellbeing and behaviour outcomes in students from schools in the catchment area of the Nightingales area of Newbury. We are commissioning a social skills programme to help support young people's emotional and social literacy in a bid to reduce Anti-Social Behaviour.

Youth Counselling

'Time to Talk West Berkshire' is commissioned to provide emotional and psychological support service for young people aged 11-25 and parents connected to West Berkshire.

Healthy Weight

Excess weight is a significant health risk and is associated with an increased risk of diabetes, heart disease and some cancers. Its impact is disproportionally spread, with those living in areas of disadvantage, and particular groups including some ethnic minorities and those with learning disabilities and mental ill-health impacted greatest.

We have updated our Healthy Weight Needs Assessment in partnership with Reading Borough Council. The aim of the assessment is to analyse data and interact with the community to understand their health needs better. We reached out in particular to about 350 individuals, and to healthcare providers, and professionals working with children and young people. This has allowed us to understand the concerns and preferences of our residents to guide our future initiatives. The finalised report on this work will be published through the Berkshire Health Observatory in early 2024.

In 2023 the Council commissioned a new Leisure provider, 'Everyone Active', to manage the leisure centres in West Berkshire. 'Everyone Active' will continue to deliver the well-established exercise on referral programme and promote this to our residents. As part of the new leisure contract, 'Everyone Active' will also be delivering a series of outreach physical activity programmes across the district, with a focus on the most vulnerable areas and groups of West Berkshire that may face additional challenges in accessing leisure facilities.

Smoking Cessation

In the year 2021-2022, 'Smoke Free Life Berkshire' helped 353 West Berkshire residents to quit smoking. This represents 54% of smokers who set a date to quit smoking. Prevalence of smoking in West Berkshire in 2022 was 11.3%, similar to the England average.

People employed in routine and manual occupations in West Berkshire are over twice as likely to be smokers compared with those employed in other occupations. Rates of smoking are even higher amongst people who are in treatment for substance misuse, where 72.3% of people smoke.

During the past 12 months the smoking cessation service has held marketing activities and campaigns at Ikea, Calcot, focusing on the staff working there; Two Saints Homeless Hostel, Newbury; Regency Park Hotel, Thatcham, and Best Western Hotel Calcot, supporting the resident refugees. Outreach workers have attended Newbury College on a monthly basis, Newbury Mosque, and have also supported West Berkshire Council information events in Thatcham and Lambourn.

Cardiovascular Disease **Health Check, Community Wellness Outreach Service.**

The Cardiovascular Disease Health Check, Community Wellness Outreach Service is aimed at identifying individuals at risk of cardiovascular disease and aims to improve access to NHS Health Checks in underserved populations.

The public health team has commissioned 'Solutions 4 Health' to deliver this service in community settings across West Berkshire. The service includes a community engagement programme with priority population groups that are disproportionately impacted by cardiovascular disease but are not currently well served by the universal

health check offer. Social prescribing of signposting to appropriate initiatives is offered to support ongoing lifestyle and behaviour change. By working collaboratively with voluntary associations and agencies, together with local employers, the engagement programme ensures that this programme reaches the right groups. By taking an asset-based approach the service will link in with, and build on, existing resources, networks and assets. This will avoid duplication and work to increase the sustainability of existing assets.

A further element of this engagement is to better understand the barriers to accessing universal services faced by different priority groups. Feedback from the community engagement is being used to further inform delivery of the service for priority groups.

Sexual Health

The public health team plays a crucial role in promoting good sexual and reproductive health by providing and commissioning advice, information, education, and services related to contraception, sexually transmitted infections (STIs), and HIV. The effective provision of these services prevents unplanned pregnancies and unnecessary abortions; psychological harm from sexual abuse; the spread of sexually transmitted infections; and potential complications including pelvic inflammatory disease, which can cause ectopic pregnancies and infertility.

While everyone who is sexually active may face the risk of sexually transmitted infection, certain groups are at higher risk. These young people, individuals from black and minority ethnic groups, gay, bisexual, and other men who have sex with men (MSM), those in multiple relationships, and those in the most disadvantaged areas. In West Berkshire, young people have the highest rates of sexually transmitted infection. Although they make up only 10% of the population, they represent a significant percentage of new cases.

In the past year, we have worked to extend the provision of emergency hormonal contraception (EHC) and long-acting reversible contraception (LARC) provision for another year pending a review of the commissioned services. We have worked in partnership with neighbouring local authorities to create a local sexual health action plan based on our main priorities. We are collaborating with our sexual health service

provider to update the service to meet post-COVID needs, closely monitoring service data to improve services.

Mental Health

The aim of public mental health is to promote mental health and wellbeing and prevent mental illness as far as this is possible. Good mental health is essential for making the most of our lives and goes well beyond the occurrence of major psychiatric breakdown. Developing a mentally resilient population of children and young people should be a top priority. Focusing on how you feel on the inside or how we are emotionally.

The public health team regularly provides information about things we can all do to support, improve and maintain good mental health. We routinely promote 'Every Mind Matters' and ' Five Ways to Wellbeing' materials during national mental health campaigns. The public health team also provides information on what to do if you are struggling with poor mental health by signposting local organisations that offer support for mental health. The ' mental health z card' produced by the team is a recognised source of information amongst key partner agencies.

This year the public health team worked with the library service to refresh the contents of the Wellbeing Bags that are available for loan at all West Berkshire libraries. The Wellbeing Bags include a selected mix of books, activities and ideas to help maintain health and wellbeing; they have been well received by our residents. Working with key stakeholders, the public health team has supported a project focusing on how mental health can be affected by financial difficulties. One outcome from this work was the development of a resource for schools about financial literacy and mental health. We have also updated the mental health z card to include information about where to access support for money worries.

For the first time, this year the public health team explored how creativity can improve mental health by launching a Poetry in Mind campaign during mental health awareness week in May. This involved our residents submitting their own poems which were themed around anxiety, socialisation and finding refuge. The public health team arranged for selected poems to be displayed in public spaces for other residents to read and enjoy. An event was held on World Mental Health Day at Shaw House, which allowed residents to talk about the benefits of expressing their emotions through poetry.

Ageing Well & Dementia

Falls prevention work includes ensuring an offer of seated exercise options for the prevention falls and to support residents who have fallen to regain strength and confidence. This includes working with our leisure provider, ‘Everyone Active’ for the delivery of a ‘Steady Steps’ programme, working with voluntary partners through our Ever Active Consortium for Love to Move, seated exercise and seated yoga classes across the district.

There is a danger that scarce public health resources are drawn into the provision of individual clinical and social interventions which are properly the responsibility of the National Health Service. The primary concern of public health in falls prevention must be in orchestrating and supporting the combined efforts of a range of partners from housing, town planning, environmental health together with community and neighbourhood groups to ensure that older people are living in safe environments where they can still live a full life without risk of injury.

Reviewing the local Falls Pathway with our partners. This must refocus away from individual interventions and create a practical public health framework for falls prevention grounded in public health principles of social and environmental as well as 1:1 action.

Setting up a weekly drop in Ageing Well Community Café at Theale Library that will incorporate social connection and activities along with providing opportunities for information sharing and active signposting.

Delivering a Nature for Health project that delivers integrational activities that encourage residents to be more physically active and socially connected out in nature.

Working with partners to expand the current offer of community led memory and friendship cafes across the district.

Working with a local arts provider to support engagement in their Ageing Creatively programme.

Where are we now?

Child and Maternal Health[18]

- 1,507 babies were born in West Berkshire in 2021.
- 5.6% of mothers smoked during pregnancy in 2022/23. This was lower than the England average of 8.8%.
- 1.6% of babies born in 2021 had a low birth weight (under 2,500 grams), lower than the England average of 2.8%.
- There were 18 infant deaths under one year of age in 2020-22. The infant mortality rate of 4.0 (per 1,000) was similar to the England rate of 3.9. 56.1% of babies were breastfed 6-8 weeks after birth in 2022/23, higher than the England average of 49.2%.
- 5,135 children aged 0-4 attended A&E in 2021/22 – the A&E attendance rate (1,097.8 per 1,000) was higher than the England rate (762.8 per 1,000).
- 240 children aged 0-5 were admitted to hospital for tooth decay and extraction in 2018/19-2020/21. The hospital admission rate (309 per 100,000) was higher than the England rate (221 per 100,000).
- 17.5% of Reception year children (aged 4-5 years) in 2022/23 were overweight or obese, lower than the England average of 21.3%; this proportion increased to 31.7% among Year 6 children (aged 10-11 years), again lower than the 36.6% in England, but still nearly a third of our 10-11 year olds.
- 48.8% of children and young people aged 5-16 were classified as being physically active in 2021/22, similar to the England average of 47.2%.
- There were 25 pregnancies in girls aged under 18 in 2021. The conception rate (8.3 per 1,000 females aged 15-17) was lower than the England rate (13.1).

[18] Child & Maternal Health Profile. OHID Fingertips Tool. Child and Maternal Health - OHID (phe.org.uk)

- In 2021, 17 under 18 pregnancies (68.0%) led to abortions (53.4% England). Among girls aged under 16, there were less than 5 pregnancies in 2021, and the conception rate (1.2 per 1,000 females aged 13-15) was significantly lower than the England rate (2.1).
- The hospital admission rate for alcohol-specific conditions among children under 18 was 37.5 per 100,000 in 2018/19-2020/21, this was higher than the England rate of 29.3 per 100,000.
- The hospital admission rate for substance misuse among young people aged 15-24 was 69.4 per 100,000 in 2018/19-2020/21, lower than the England rate of 81.2 per 100,000.
- 235 children and young people were admitted to hospital due to unintentional and deliberate injuries in 2021/22. The admission rates (per 10,000) were lower among children aged 0-14 compared with England (82.5 versus 84.3), and higher for young people aged 15-24 (127.9 versus 118.6).
- The hospital admission rate for self-harm among children aged 10-14 was 328.6 (per 100,000), higher than the England rate of 307.1. The rate for young people remained higher than the England rate, for young people aged 15-19 (797.3 per 100,000 for West Berkshire versus 641.7 for England) and those aged 20-24 (405.4 per 100,000 for West Berkshire versus 340.9 for England) in 2021/22.

Adult Health[19]

- In West Berkshire, 39.8% of eligible adults aged 40-74 who were offered an NHS Health Check, received a Health Check between 2018/19-2022/23, lower than the England average of 42.3%.
- 4.9% of people (17,549) in West Berkshire described their general health as ‘bad’ or ‘very bad’ according to the 2021 Census which is slightly lower than the England average of 5.2%.
- In 2021/22, 6.2% of adults aged 16 and over reported low levels of life satisfaction (England 5.0%), 5.9% reported low levels of worthwhile (England 4.0%), 8.3%

[19] Public Health Outcomes Framework. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

reported low levels of happiness (England 8.4%), and 20.5% reported high levels of anxiety (England 22.6%) –wellbeing outcomes were similar to England, with more people reporting low levels of worthwhile locally.

- 72.2% of adults over 19 years of age were found to be physically active in 2021/22, higher than the England average of 67.3%; 16.8% were defined as inactive, lower than the England average of 22.3%.
- In 2021/22 33.9% of adults aged 16 and over were eating the recommended '5-a-day' portions of fruit and vegetables, slightly higher, but largely comparable to the England average of 32.5%.
- In 2021/22, 61.3% of adults aged 18 and over were classified as overweight or obese, lower than in England (63.8%); 24.5% of these adults were obese compared with 25.9% in England.
- 13.9% of adults in West Berkshire were recorded with depression on GP registers in 2022/23 (13.2% England), 14.9% had hypertension (14.4% England), 5.9% had diabetes (7.3% England) – these were the three highest recorded long-term conditions.
- There were 270 emergency hospital admissions for intentional self-harm in 2021/22 in West Berkshire – the hospital admission rate (168.2 per 100,000) was slightly higher than the England rate (163.9 per 100,000).
- In 2020-22 there were 33 suicides among people aged 10 years old and over in West Berkshire, a rate of 7.9 per 100,000, lower than the England rate of 10.3 per 100,000.
- There were 2,149 hospital admissions for alcohol-related conditions in 2021/22 – this admission rate (1,303 per 100,000) was lower than the England rate (1,734 per 100,000).
- There were 61 deaths in under 75s from cancers considered preventable in 2021. The mortality rate (40.9 per 100,000) was lower than England (50.1 per 100,000).
- In the under 75s, there were 31 deaths from cardiovascular diseases considered preventable in 2021. The mortality rate (19.8 per 100,000) was lower than England (30.2 per 100,000).

- There were 11 deaths in under 75s from respiratory diseases considered preventable in 2021. The mortality rate (7.1 per 100,000) was less than half the England rate (15.6 per 100,000).
- 16.4% of adults reported a long-term musculoskeletal problem in 2022, lower than the England average of 17.6%.
- There were 565 emergency hospital admissions due to falls in people aged 65 and over in 2021/22. The admission rate (1,779 per 100,000) was lower than England (2,100 per 100,000).
- There were 150 hip fractures in people aged 65 and over in 2021/22 – 40 were among those aged 65-79, 105 in those aged 80 and over; the hip fracture rate in people aged 65 and over (500 per 100,000) was similar to England (551 per 100,000).

Our priorities moving forward

Children and Young People

- We will continue to advocate for evidence-based Policies, Programmes, and Practices for children and young people in West Berkshire and ensure that public health grant is invested optimally for their benefit. We have more evidence than any other generation about what is important and what works.
- We know that the building blocks of future health and lifetime success are laid in the earliest years of life and that this is the phase of life where primary prevention is most possible. Yet, despite all this evidence, too many babies, young children and families are currently being failed by fragmented health policies that fail to meet the scale of need.
- Increased population need with widening health inequalities means more children experience poor health and are being harmed by conditions that are largely preventable. The UK has some of the worst child health outcomes compared to other similar nations, with widening health inequalities (Royal College of Paediatrics and Child Health (2020) State of Child Health).

Healthy Weight

- The Public Health team will continue to work with our partners in the voluntary sector to deliver a range of physical activities for different target groups, under the 'Ever

Active' service. This service is provided by Get Berkshire Active, Age UK, Mencap and Berkshire Vision.

- We will continue to develop our free volunteer-led activity programmes, 'Run Together' and 'Wellbeing Walks', which maintain high levels of participation and deliver running and walking groups for all abilities.

Smoking

- 'Solutions4Health' will hold regular clinics at the following locations across West Berkshire; Kingsland Centre, Thatcham, Tesco, Pinchington Lane, Newbury and Sainsbury's, Calcot.
- We will continue to work on strengthening 'Solutions4Health' relationships with partners and will support West Berkshire Council's 'Smokefree Sidelines' campaign through the attendance of outreach workers at children's football tournaments held across West Berkshire.

Sexual Health

- We will continue to commission emergency hormonal contraception (EHC) and long-acting reversible contraception (LARC) provision. Working in partnership with our service provider we will meet post-COVID needs of our population closely monitoring and improving the service and delivering sexual health promotion.
- Our focus for the next year is to review condom distribution, expand HIV testing, review and support women's health hubs, and look to enhance links with substance misuse services and those supporting individuals with learning disabilities. Additionally, we aim to improve data collection and update our sexual health needs assessment.

Mental Health

- We will continue to work with partners to develop and deliver a mental health promotion programme and implement our suicide prevention strategy.
- We will promote the use of wider services that support emotional and mental wellbeing, such as libraries, leisure services and green spaces. This includes maximising opportunity by working smartly and imaginatively with health and community partners, to promote good mental health and wellbeing. Our aim is to build

on the success of our previous mental health grant scheme with a renewed focus away from covid-19. This will allow non-for-profit organisations to apply for small pots of funding for projects aimed at promoting good mental health.

- For the first time, the public health team is working on a new death literacy project, starting with a film screening during 'Dying Matters' (a campaign by Hospice UK to improve the quality of life and support for people who are dying or grieving) and working with partners to consider how to take this work forwards.
- We will continue our efforts to provide information and resources to residents and professionals about mental wellbeing and the importance of seeking early help for mental health issues. This will be achieved by promoting the 'Reading Well' books scheme, which supports individuals to understand and manage their health and wellbeing using helpful reading.
- Together with partners, we are working on a new 'life transitions' project, which will explore how our residents can maintain good mental health whilst they go through important transitions in life and the experience of loss, such as bereavement, becoming a parent or starting a new job.

Drug and Alcohol Services

- We will work in partnership to support the delivery of national ambitions to reduce drug use, drug-related crime, and drug-related deaths together with partners in education, employment and accommodation, treatment and criminal justice.
- We will work to prevent and minimise harm from alcohol and drug use among young people and adults. Our focus will be to improve referrals, capacity, quality and outcomes in treatment and recovery.

Leisure and activity physical health (sports and leisure)

- We will develop a new healthy lifestyle service for adult residents with learning disabilities. Unfortunately, adults with learning disabilities in the UK face a higher burden of poor health outcomes than their peers, with life expectancy being around 16 years lower. West Berkshire is no exception, and we are working to develop our health improvement offering for this population.

- We will be commissioning a 12-month pilot service, open to adults with learning disabilities and carers, which will focus on balanced diets and being physically active, in 2024. Our aim is to secure meaningful and well-paid employment for these groups.
- We will be reviewing how the public health team can best support the development of Council-funded supported employment programmes, working with vulnerable groups and residents to obtain and continue in good quality employment.

Aging well and dementia

- Work in partnership with the Local Integration Board in the development of additional Falls Prevention initiatives
- Work in partnership with West Berkshire Community Hospital and Royal Berkshire Hospital to use the Fall Proof resources to encourage physical activity and falls prevention for in patients on the wards
- Work in partnership with the Environment and Waste teams, Business Improvement District and VCS partners to explore how the national Refill scheme could be implemented locally to support improved hydration.
- Explore IT support sessions for older people in the community.

Healthcare Public Health

The Public Health Team has been collaborating closely with the Integrated Care Board to capitalise on opportunities for the NHS to prevent ill health and address inequalities. This collaboration includes funding a Community Wellness Outreach Service aimed at identifying individuals at risk of cardiovascular diseases (CVD) and improving access to the NHS Health Checks in underserved populations. The service will be delivered in community settings across West Berkshire.

Health Care Public Health or Population Based Health Management is the application of public health principles, including epidemiological methods, to the planning, provision and evaluation of health care in a defined population. Work with the NHS and the provision of specialist public health advice and leadership is a core part of the public health function in a local authority bringing to bear the tools and perspectives of public health practice on the provision of health and care. In West Berkshire until now with one

interim Director of Public Health covering both Reading and West Berkshire, and in the absence of a dedicated public health consultant for West Berkshire, this has been a stretch. The appointment of a permanent joint Director of Public Health together with a consultant for West Berkshire should go some way to alleviating this problem.

Intrinsic to the tools of public health is the epidemiological method with its basis in both quantitative and qualitative assessment and surveillance of health and wellbeing. This had its origins in the registration of births and deaths, official notification of cases of infectious disease and decennial household censuses that date from the earliest days of public health in the nineteenth century. The work of the early Medical Officers of Health was based on these systems of registration and notification to advise the local authorities of their day.

In more recent times, the importance of qualitative perspectives including the lived experience of individuals, families, and communities has been recognised as being as important as a purely numerical understanding, as have anthropological, sociological and other insights from social psychology and communication science in producing a full picture; commissioned and pure research are also important in answering specific questions and informing practical advances based on theoretical exploration. The limitations of a narrow, biological and quantitative perspective were shown up vividly both in the Ebola epidemic of 2014 and the recent COVID-19 pandemic when a failure to understand the spread of infection from a broader public health point of view led to delays in effective action and avoidable deaths.

The application of epidemiology in its various forms has a number of valuable applications including in the understanding of the priorities, working and effectiveness of health and social care. The public health perspective involves segmenting the way we look at populations into three: the whole population; populations at risk; and populations suffering from defined medical conditions where medical and social care can make a difference.

In general, the contribution from local government and its partners can be seen as its role in assuring the protection of the population's health by tackling the upstream determinants of health and disease by primary prevention while the contribution of the National Health Service hospitals and specialist clinics is largely one of tertiary

prevention. That is to say through providing specialist treatment to save life or mitigate the impact of serious ill health on everyday living.

Where the work of local government meets that of the NHS is in the secondary prevention work of primary health care through vaccination and screening programmes, and early intervention to prevent disease progression or to support rehabilitation in the community and continuing care through the partnerships of statutory and voluntary social efforts.

The NHS Long Term Plan highlights the opportunities for prevention at an earlier stage, supporting those at an early stage of illness from progressing and from systematically identifying opportunities to prevent ill health occurring. Public Health Teams in councils have continued working closely with the NHS on shared priorities, including prevention, addressing inequalities and health protection. This will continue to be an important part of our work stream.

The NHS organisational landscape has changed considerably over the last couple of years with the formation of the NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and the formation of the Integrated Care System (ICS) and the Integrated Care Partnership (ICP). (6). These new organisations provide opportunities for organisations to work more closely together to collectively improve the health of the local population and reduce inequalities. Public health expertise in these organisations is important to ensure services are designed to improve public health outcomes and reduce inequalities.

Our priorities moving forward

- Provide strong, visible public health leadership within the Berkshire West healthcare system to protect and promote health.
- Develop an integrated approach to generating and using public health evidence and intelligence in decision making within the NHS and across the Integrated Care Partnership (ICP).
- Promote a focus on prevention and inequalities in the commissioning and delivery of NHS functions, including strong links with the factors influencing health outcomes such as employment, education, housing and the environment.

- Work with the NHS to ensure good knowledge, systems and processes are in place for responding to health protection threats.
- Work from the bottom up at a community level with an Asset Based Community Development philosophy as far as possible, within a wider local authority and NHS strategic framework.

Commissioning

A significant portion of the West Berkshire Public Health Grant is allocated to externally contracted services provided by organisations outside of the council. The role of Public Health as the commissioner of services is to design the requirements of the service, find suitable organisations to deliver the service, monitor performance and work with those providing services on continuous improvement.

Externally commissioned services cover children's services, including health visiting, school nursing, drug and alcohol services, leisure services and specialist sexual health services and NHS Health Checks.

The external environment is rapidly changing with rising inflation, workforce challenges, and increased competition for organisations to deliver services. Our approach to commissioning must respond to these issues, and to use all the elements of the commissioning process to maximise public health outcomes. We have recently undertaken a comprehensive review of our investment of the public health grant to ensure that it is in full accordance with the mandate from the Office of Health Improvement and Disparities. In future investment decisions will be taken at a Public Health Development Board that has been established.

Research, evidence, and intelligence

Evidence and intelligence constitute the cornerstone and one of the bookends of public health. What we do is driven by understanding patterns of health and disease, identifying needs of our local population and prescribing those interventions that are most effective in improving health and wellbeing. We must also monitor and evaluate

the performance of our local services while understanding the economic impact of our decisions. Evidence gained from qualitative methods such as interviews and focus groups are just as important as analysis of quantitative data. We need to be using intelligence from those with the lived experience to inform the design of services and public health programmes.

There will always be gaps in understanding, and strong links with academic institutions, especially our local University of Reading. Such links have important benefits including the provision of educational and career opportunities for local people, providing a sustainable local pipeline of staff for local health, social care, and wellbeing services, and having ready access to appropriate research expertise to throw light on pressing issues.

Our priorities moving forward

- Work with partners across and beyond the council to develop a joined-up, evidence and intelligence function to support commissioning decisions.
- Build on new tools and techniques for data linkage, enabling measurement of the impact of a change in one part of the system on other parts.
- Work with stakeholders to develop the Joint Strategic Needs Assessment and Asset mapping, reflecting the priorities of the Integrated Care Partnership and Health and Wellbeing Board.
- Strengthen the evaluation of public health interventions delivered across the council and wider system, providing clarity on health and economic impact.
- Improve the experience of the public users of public health services with clear service offers and the increased ability of managers to be self-sufficient in access to intelligence resources through the use of tools such as Microsoft Power BI.
- Build relationships with academic institutions and research networks within the ICB to ensure development of a public health research programme within the council.
- Improve how we use information from those with lived experience to develop services and further embed the use of citizen science and understanding of the lived experience of local people.

Communications

Good communications are one bookend of a robust and effective public health function, the other being sound intelligence. Clear messaging and information are central to any modern public health service. We need to be visible in and trusted by our communities to achieve our objectives. It is important that the tone and content are right to ensure that the desired outcomes are achieved, whether this is informing, warning or advising. The use of multimedia was critical during the COVID-19 pandemic and its value should not be underestimated, nor conversely overused. Effective campaigns will help people better manage their own health.

Our priorities moving forward

- Work with council communications team to deliver a communications programme of awareness raising and information to the public.
- Send out adverse weather warnings via social channels and internal messaging channels, hot weather June to September and cold weather November to March using United Kingdom Health security agency (UKHSA) resources and supporting documents from the Adverse Weather and Health Plan.
- Continue to promote Covid-19 vaccine and, flu vaccine, and other messages via social channels and internal messaging channels using UKHSA resources.
- Continue to promote Measles, Mumps, and Rubella (MMR) vaccine using West Berkshire Council measles and MMR messaging plan and UKHSA resources.
- Strengthen our internal communication so other teams in the council understand the work of public health and opportunities for engagement.
- Use our learning from the COVID-19 pandemic of those approaches that work best with different groups in our local community.
- Use internal messaging channels (‘In the Know’, ‘Reporter’, ‘Residents Newsletter’)
- Continue to provide expert advice, underpinned by data and evidence, and informed by behavioural insights.

Diverse and skilled workforce

The skills and capacity of the West Berkshire Public Health Team and wider workforce are essential to the improvement of population health and delivery of all those programmes that protect and improve health.

Within the Public Health Team itself we are fortunate to have a highly skilled and motivated workforce. We have expertise drawn from a range of professional, including clinical and non-clinical, backgrounds and highly motivated staff many of whom are involved in professional public health training.

Our aim is to provide an escalator of opportunity, providing the environment and resources for individuals to develop skills, be inspired and realise their aspirations. We intend to build capacity and capability for public health both within the West Berkshire Public Health team and across the council with a programme of developmental opportunities.

We have a Public Health Workforce Development Officer who is funded one day a week by NHS England to support sustainable workforce development across the three Berkshire West Public Health Teams. The workforce development officer works closely with the named lead for Berkshire West public health workforce development (DPH Wokingham) who is the Thames Valley Public Health School Board representative, to support the planning and development of a skilled public health workforce to increase capacity and competence in public health and building on locally agreed priorities.

Over the last 12 months, the workforce development officer has facilitated several continued professional development (CPD) days aimed at supporting career development, enhancing skills, and expanding knowledge. Additionally, the Workforce Development Officer has supported ‘Get Active Berkshire’ and ‘Home-Start West Berkshire’ in applying for the Public Health Wider Workforce Development Educational Projects fund. Both organisations were successful in obtaining the funding, which is awarded to projects addressing the workforce needs of the wider public health arena within health and care, voluntary, and third-sector organisations.

Our priorities moving forward

- Continue to deliver workforce development training and opportunities to the Public Health Team and the wider workforce.
- Broaden our public health training offerings, building expertise to deliver high-quality public health training across the council and external stakeholders.
- Support all career stages, including the development of an apprenticeship program for those early in their careers and providing specialist training for aspiring consultants.
- Ensure that our ways of working foster a diverse workforce, where staff from all backgrounds feel equally valued and accepted.
- Develop innovative approaches to our training and development, positioning us as leaders across the system and as an employer of choice.
- Provide the necessary training and support to ensure strong leadership at all levels.

Building and maintaining a strong public health function

Strong foundations that enable both the public health function and specific public health services to be delivered effectively and efficiently are essential for the future.

Following the impact of the COVID-19 pandemic there are opportunities for West Berkshire to develop in line with modern public health values and aspirations to meet local need. There are opportunities for new ways of working in partnership that were built up during the pandemic.

To ensure that we have the best opportunity to deliver excellent public health services, we will continue to invest in services to promote, protect, prevent ill health and reduce inequalities.

What we did:

- Cross directorate working between communities, culture, libraries, leisure, adult social care and public health to maximise opportunities to improve health and wellbeing. Examples include a poetry project to improve creativity, wellbeing and social connection, outreach drug and alcohol recovery services in leisure centres.
- Develop a delivery plan for the Joint Berkshire West Health and Wellbeing Strategy
- Deliver a refurbished lido at Northcroft Leisure Centre to increase physical activity

opportunities.

- Partnership working between West Berkshire Council, BOB Integrated Care Board and Primary Care to develop a joint cardiovascular disease prevention outreach service.
- Set up an early years inequalities group to ensure children and young people have the best start for life.
- Nature for health activities for improving physical activity and social connection.
- Agreement for a Health in All Policies approach and Health Planning Protocol.
- Cross Council workshops on Health in All Policies and Systems Thinking.

Our priorities moving forward

- Make the biggest impact by addressing the building blocks of health, these are the natural and built environment in which we live, work, move, and play; the quality of the work we do and the resources available to us either through income or access to facilities to live a full life.
- Tackle health inequalities and ensure we have equal opportunities for all.
- Embed a Health in all Policies approach within West Berkshire Council and work in partnership to promote health and wellbeing at every opportunity.
- Tackle preventable cardiovascular disease through delivery of a community wellness outreach service, taking lifestyle support and health checks to communities.
- Continue to deliver on the joint Health and Wellbeing Strategy.

Conclusion

This report reflects on the public health advancements that have already been made across West Berkshire along with the benefits felt by our local communities. It also importantly sets out the ambitions for the West Berkshire Public Health Team, the wider council and for our partner organisations and local communities so we can work together to promote health and wellbeing for all whilst reducing the inequalities experienced by some groups of our society.

This is a challenging time for the public health team with the continued impact of the COVID-19 pandemic on physical and mental health which is becoming more apparent, affecting all age groups and disproportionately impacting those who are most disadvantaged. Simultaneously, many are struggling with the continued cost of living crisis.

Our Priorities

Moving forward, we will take a balanced approach to improving public health in West Berkshire. Action is needed at three levels: interventions that impact the whole population; targeted intervention for groups at risk of ill health; and support for those with established disease to prevent further ill health and enable people to live well and independently with established medical conditions. Particular focus on targeted interventions to tackle the inequalities we are aware of in West Berkshire will be key in the coming years, working closely with those communities affected to really understand and coproduce the solutions to the issues identified.

Embedding the Public Health Approach

Throughout this report we highlight the importance of working in partnership with other teams in West Berkshire and with other individuals, groups, bodies, and organisations outside it ('The Organised Efforts of Society') to achieve public health outcomes.

Taking this approach means that we can reach many more people than the Public Health Team can reach alone, and which statutory services may only scratch the surface of. It also provides the opportunity to influence the wider determinants of health – factors such as education, housing, employment, the built and natural environment, our social and community networks, and the roots of crime and violence – all of which are strongly

linked to health outcomes. This is where there is a significant opportunity to influence health and wellbeing outcomes and reduce health inequalities.

Evidence-based Decisions and Communications

We have also focused on high quality evidence-based decision making and strong communication – the bookends of public health. Evidence and intelligence underpin everything we do in public health and require a wide-ranging approach. We need to ensure we have this range, from generating new knowledge from research; to using new techniques to turn data from multiple sources into intelligence; to working with individual and local communities to understand their experience and use this to design services. Strong communications with our local communities have been vital in our response to the COVID-19 pandemic and we will continue to build on this experience.

High Quality Public Health Services

We will continue to commission and deliver public health services to our local communities, and this remains a vital part of our service delivery. Services include public health services such as health visiting, NHS health checks, specialist sexual health services, substance misuse services, smoking cessation and weight management services. Our workforce is key; building the skills and capacity of the Public Health Team and wider workforce is central to delivering our ambitions.

The West Berkshire Public Health Team welcomes the challenge of protecting and improving the health of our local people in the years ahead.

To quote Cicero "The Health of the People is the Highest Law'.

[20]

[20] Cicero. De-Legibus Book 3,3,8. Contained in Bentham's Book of Quotations ,1948.

Supporting documents

Milestone, A., Maragakis, L. (2023) Measles: What You Should Know. John Hopkins Medicine. https://www.hopkinsmedicine.org/health/conditions-and-diseases/measles-what-you-should-know Accessed 15.02.2024.

WHO (2023) A New Era in the Fight Against Measles and Rubella. https://www.who.int/news/item/22-02-2023-a-new-era-in-the-fight-against-measles-and-rubella Accessed 15.02.2024.

West Berkshire Annual Public Health Report 2024

Prof. Dr John R Ashton C.B.E. Interim Director of Public Health Reading and West Berkshire

West Berkshire
COUNCIL

Content

- Setting the scene
- Public Health comes home
- A Public Health vision for West Berkshire
- Health Protection; Health Improvement; Healthcare Public Health
  - Where are we now?
  - What have we achieved?
  - Priorities moving forward
- Conclusions and priorities

Source:

Setting the scene

- Public Health leadership transition within West Berkshire Council provides the opportunity to pause and reflect in order to plan the future direction of travel.
- Health in All Policies in particular provides the opportunity to continue to move upstream.
- Our role within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) provides us with the opportunity to reorientate towards population-based health care.
- It is important to understand the history locally and of the Public Health system to inform our future direction of travel.
- Today Public Health broadly consists of three domains of action: Health Protection; Health Improvement; and the Healthcare Public Health.
- Prevention is key, but in enabling people to live who might previously have died, the burden of disease may actually increase and with it the costs of maintaining people's health over many years.
- The social goal is for all to 'die young as old as possible' while reducing inequality and the prevalence of long-term conditions whilst maintaining independent living.

Source:

Public Health comes home

Public Health intervention dates back to Victorian movements. Sanitary Act 1846 and Annual Public Health reports emerge providing a snapshot of population health at a moment in time

1900s comprehensive programme to address physical deterioration and concern over military fitness

Public Health definition in 1920 – the science and art of preventing disease, prolonging life and promoting physical health

Progress in medical advances, vaccination and the emergence of the NHS In 1948 saw a shift in PH focus to hospital medicine

1988 and the creation of joint Control of Communicable Disease posts saw the start of the shift back to Local Government, completed in 2013.

A Public Health vision for West Berkshire

West Berkshire Council is committed to improving the health of everyone in West Berkshire. To support this Council vision, the Public Health team's commitment is summarised below:

- To develop and support population level interventions to protect and improve health that are based on high quality intelligence and evidence to inform best practice.
- To take a Place and Asset-based approach to working with local communities and develop a Community Orientated Health and Social Care System building on existing strengths to create a sustainable future.
- To maintain a relentless focus on reducing health inequalities.
- To work in partnership with all those who value the health and wellbeing of the people of West Berkshire.
- To commission and deliver evidence based, high quality, value for money, public health services.

Source:

Health protection – where are we now?

- High vaccine coverage
- Local variation and pockets of low uptake
- Poorer uptake of vaccination in older age
- Low levels of STI and HIV diagnosis – lower incidence, but possibly also poorer access and uptake
- Smoking and alcohol misuse rates in line with England but inequalities persist

Source:

Health improvement – where are we now?

- Child health
  - Higher rate of 0-4 year olds attending A&E compared to England
  - Higher rate of 0-5 year old admissions for tooth decay compared to England
  - Nearly a third of year 6 children are overweight or obese
  - High rate of alcohol related and self-harm hospital admissions for under 18s compared to England
- Adult health
  - Well over half (61.3%) of adults are over wight or obese
  - The three highest recorded long-term conditions locally were depression, hypertension and diabetes.
  - Mortality rate from preventable cancer; cardiovascular disease and respiratory disease was lower than the national average but we still saw over 100 deaths that were preventable in West Berkshire in 2021

Source:

Public Health function – priorities moving forward

- Make the biggest impact by addressing the building blocks of health, these are the natural and built environment in which we live, work, move, and play; the quality of the work we do and the resources available to us either through income or access to facilities to live a full life.
- Tackle health inequalities and ensure we have equal opportunities for all.
- Embed a Health in all Policies approach within West Berkshire Council and work in partnership to promote health and wellbeing at every opportunity.
- Tackle preventable cardiovascular disease through delivery of a community wellness outreach service, taking lifestyle support and health checks to communities.
- Continue to deliver on the joint Health and Wellbeing Strategy.

Source:

West Berkshire COUNCIL

Conclusion and priorities

- A balanced approach to improving public health in West Berkshire across three levels:
  - Interventions that impact the whole population;
  - Targeted intervention for groups at risk of ill health; and
  - Support for those with established disease to prevent further ill health and enable people to live well and independently with established medical conditions.
- Embedding the Public Health approach through partnership working to reach more people and address the wider determinants of health
- Advocate for evidence-based decisions and communications
- Continue to commission and deliver high quality Public Health Services

The West Berkshire Public Health Team welcomes the challenge of protecting and improving the health of our local people in the years ahead.

To quote Cicero "The Health of the People is the Highest Law'.

Source:

West Berkshire COUNCIL

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Changes to Pharamceutical Services

Report being considered by:	Health and Wellbeing Board
On:	11 July 2024
Report Author:	Gordon Oliver
Report Sponsor:	John Ashton
Item for:	Decision

1. Purpose of the Report

This report provides details of proposed changes to pharmaceutical services in West Berkshire and advises the Health and Wellbeing Board on the implications for the West Berkshire Pharmaceutical Needs Assessment.

2. Recommendation(s)

The Health and Wellbeing Board is asked to note the application for the for inclusion in a pharmaceutical list at Kingfisher Court, Newbury, RG14 5SJ in respect of distance selling premises by Halo Pharmacy Limited.

3. Executive Summary

3.1 The West Berkshire Health and Wellbeing Board has a duty to keep its Pharmaceutical Needs Assessment (PNA) under review in the light of any notifications of changes in provision of pharmaceutical services within the district.

3.2 Notification has been received from PCSE of an application for inclusion in a pharmaceutical list at Kingfisher Court, Newbury in respect of distance selling premises by Halo Pharmacy Limited.

4. Supporting Information

4.1 On 19 June 2024, notification was received from PCSE of an application for inclusion in a pharmaceutical list at Kingfisher Court, Newbury, RG14 5SJ in respect of distance selling premises by Halo Pharmacy Limited. A copy of the notification and associated application is provided in Appendix A.

4.2 As a statutory consultee, the Health and Wellbeing Board is invited to submit comments on the application within 45 days of the notification date (i.e., by 3 August 2024)..

4.3 Proposed opening hours are set out below:

	Core Hours	Total Hours
Monday	10:00-18:00	10:00-18:00
Tuesday	10:00-18:00	10:00-18:00
Wednesday	10:00-18:00	10:00-18:00
Thursday	10:00-18:00	10:00-18:00
Friday	10:00-18:00	10:00-18:00

Saturday	-	-
Sunday	-	-
Total	**40 hours**	**40 hours**

4.4 Distance selling pharmacies provide the same services as any other pharmacies, but patients either have to post their prescription to the pharmacy or ask their GP to send it electronically. The pharmacy then dispenses it and sends it to the patient via the post or a courier. There are many such distance-selling pharmacies currently operating across the country. These must provide essential services to anyone, anywhere in England, where requested to do so.

4.5 Essential Services will be provided remotely through the deployment of an approved website and patient app to enable any patient anywhere in England to request NHS Essential services without a face-to-face contact. The website, app and all other digital platforms for communication will be available uninterrupted at least during the opening hours of the premises. Full details of how essential services will be provided are set out in the Dispensary Standard Operating Procedures (included in Appendix A).

4.6 In addition to Essential Services, the application indicates that the new pharmacy will be accredited to provide the following Advanced and Enhanced Services:

- New medicines service
- Community pharmacy seasonal influenza vaccination
- Community pharmacist consultation service (now known as Pharmacy First)
- Care home service
- Home delivery service
- On demand availability of specialist drugs service

4.7 Only advanced services that can be provided remotely will be provided. The pharmacy does not intend to provide services that could require service users to come to the premises. If members of staff receive requests from a member of the public for provision of face-to-face services, the NHS Choices website will be used to find suitable service providers near to the patient and contact details will be provided.

5. Options Considered

The Board may choose to: respond to the consultation to indicate that it supports the application; that it does not object to the application; or that it opposes the application. Alternatively, the Board may choose not to respond.

6. Proposal(s)

6.1 Given that distance selling premises are required to serve patients anywhere in England, it is not considered that the application by Halo Pharmacy Limited for distance selling premises to be established at Hambridge Road, Newbury will have a material impact on existing pharmacies in West Berkshire.

6.2 A previous application was submitted by Halo Pharmacy Limited in respect of distance selling premises for Ground Floor Flat 1, 4 Hambridge Road, RG14 5SS, which was considered by the Health and Wellbeing Board. The Board agreed that a response be prepared by the Director of Public Health in consultation with the Chairman of the Health and Wellbeing Board to confirm that the Board had no objection to the proposal.

6.3 Given that the Board has already responded to the previous application, it is not considered necessary to make a response in relation to the new application.

7. Conclusion(s)

The proposed changes in pharmaceutical services have been assessed in accordance with national guidance and relevant legislation.

8. Consultation and Engagement

Local Ward Members have been informed of the application.

9. Appendices

Appendix A – Application for inclusion in a pharmaceutical list at Kingfisher Court, Newbury, RG14 5SJ in respect of distance selling premises by Halo Pharmacy Limited

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Background Papers:

West Berkshire Pharmaceutical Needs Assessment 2022-2025

Pharmaceutical Needs Assessments: Information pack for local authority health and wellbeing boards, DHSC, October 2021

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☒ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☐ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by ensuring that there are sufficient pharmaceutical services in the District to meet the needs of the local population.

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Appendix A - Application for inclusion in a pharmaceutical list at Kingfisher Court, Newbury, RG14 5SJ in respect of distance selling premises by Halo Pharmacy Limited

NHS England

Our Ref: ME3480 - CAS-310960-X5M2W2
To be quoted on all future correspondence

Primary Care Support England
PCSE Enquiries, P O Box 350
Darlington, DL1 9QN
Email PCSE.marketentry@nhs.net
Phone 0333 014 2884

Sent via email to all interested parties on the distribution list

19th June 2024

Dear Sir/Madam,

Re: Application for inclusion in a pharmaceutical list at Unit 25, Kingfisher Court, Newbury, RG14 5SJ in respect of distance selling premises by HALO PHARMACY LIMITED

We have received the above application, a copy of which is enclosed, and Buckinghamshire, Oxfordshire and Berkshire West ICB has completed its preliminary checks. We are now notifying interested parties of the application.

If you wish to make written representations on this application they should be sent to me at the above address within 45 days of the date of this letter i.e. by 3rd August 2024. You should note that any comments submitted will be shared with other interested parties and the applicant, and may be shared under the Freedom of Information Act as requested.

Buckinghamshire, Oxfordshire and Berkshire West ICB will consider all representations that are received and will arrange an oral hearing to determine the application if it identifies a matter on which it wishes to hear further evidence.

Please ensure you include our reference (see above) in the subject line of your email as this will help us file your representations with the correct application as quickly as possible.

I can confirm that no information that has been received in relation to this application is being withheld under paragraph 21(4), Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

Yours faithfully

Carl Hilland

Carl Hilland
Pharmacy Market Administrative Services Officer

NHS England

Primary Care Support England

NHS England's Privacy Notice describes how we use personal data and explains how you can contact us and invoke your rights as a data subject. We will protect your information in line with the requirements of the Data Protection Act 2018.

Chapter 18

Annex 1

Application Form

Application in respect of distance selling premises

Defined as "listed chemist premises, or potential pharmacy premises, at which essential services are or are to be provided but the means of providing those services are such that all persons receiving those services do so otherwise than at those premises." Only pharmacy contractors may apply to open distance selling premises.

Application for inclusion in a pharmaceutical list for the area of

West Berkshire (name of health and well-being board).

This is an application in respect of distance selling premises and as such is an excepted application under regulation 25 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Regulations).

Please complete this form as legibly as possible.

Applicants should note that information provided in this form may be disclosed where this application is required to be notified to other parties or in response to a request made under the Freedom of Information Act 2000. Applicants are referred to paragraph 21 of Schedule 2 of the Regulations which sets out NHS England or the relevant delegated integrated care board's responsibilities in relation to information provided in this application form which an applicant advises is confidential.

1 Information regarding the applicant

1.1 Full name and correspondence address of the applicant

This is the name of the legal entity applying, not the person who is completing the application.

HALO PHARMACY LIMITED 197-199 Gulson Road,Coventry,CV1 2HZ

Is this a personal address? Yes ☐ No ☑

1.2 Applicant's legal entity

I/we am/are applying as a:

(Please tick relevant box. Only one box may be selected. GPhC/PSNI registration numbers only need to be provided for pharmacy applications.)

Sole trader ☐ **My GPhC/PSNI registration number is**

Partnership ☐

Please list each partner and their GPhC/PSNI registration number:

Corporate Body ☑

Superintendent's name and GPhC registration number is	Mr. Philip Obomighie 2067022

1.3 Provision of fitness information required by Part 1, Schedule 2 of the Regulations

(Please tick relevant box)

I/We have provided the required fitness information on a previous occasion to NHS England or the relevant delegated integrated care board or, before 1 April 2013, to a home primary care trust, and there is no missing information. I confirm that the previously provided information remains up-to-date and accurate. ☑

Please set out below when and to whom the information was provided. If NHS England or the relevant delegated integrated care board cannot locate the information previously supplied after using reasonable efforts to locate it, you will be asked to provide it again. CAS-214985-B4S4J0 Re: Application for inclusion of Halo Pharmacy Limited in the pharmaceutical list at 3-5 Crown Mead, Bath Road, Thatcham, RG18 3JW – approval of fitness to practise information

I/We have already provided the fitness information on a previous occasion to NHS England or the relevant delegated integrated care board or, before 1 April 2013, to a home primary care trust, but there is missing information. I confirm that the remainder of the previously provided information remains up-to-date and accurate. ☐

Please indicate what information NHS England or the relevant delegated integrated care board already has and when and to whom it was provided, and confirm the missing information that is being provided. If NHS England or the relevant delegated integrated care board cannot locate the information previously supplied after using reasonable efforts to locate it, you will be asked to provide it again.

I/We have provided the required fitness information with this application. ☐

1.4 Relevant fee

I/we include the relevant fee for this application. ☐

2 Address of the proposed premises

A full address must be provided – 'best estimates' are not acceptable. The regulations do not allow the premises to be on the same site or in the same building as the premises of a provider of primary medical services with a patient list.

Unit 25, Kingfisher Court , Newbury , RG14 5SJ

These premises are currently in my/our possession*

* by rental, leasehold or freehold

Yes ☑ No ☐

3 Opening hours

3.1 Proposed core opening hours

Core opening hours must total 40 hours per week.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
10:00 - 18:00	10:00 - 18:00	10:00 - 18:00	10:00 - 18:00	10:00 - 18:00	Closed	Closed	40:00

3.2 Total proposed opening hours

The total opening hours includes the core hours and any supplementary opening hours.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
10:00 - 18:00	10:00 - 18:00	10:00 - 18:00	10:00 - 18:00	10:00 - 18:00	Closed	Closed	40:00

4 Pharmaceutical services to be provided at these premises

Essential services are to be provided (paragraphs 3 to 22, Schedule 4) ☑

If you are undertaking to provide appliances, specify the appliances that you undertake to provide (or write 'none', if it is intended that the pharmacy will not provide appliances).

Please give details of any advanced and enhanced services you intend to provide.

Please note that enhanced services are those commissioned by NHS England or the relevant delegated integrated care board. Do not include services which are commissioned by the local authority/council or any other commissioner.

Whilst advanced and/or enhanced services can be provided at the premises, this must not involve the provision of complementary essential services related to the advanced or enhanced service. For example, a supervised consumption enhanced service for methadone would require the pharmacy to dispense the methadone for consumption, and therefore a supervised consumption enhanced service cannot be provided from the premises as that would require the corresponding dispensing essential service to be provided to persons present at the pharmacy which is prohibited under the distance selling exception.

These details should include:

- confirmation that you are accredited to provide the services where that accreditation is a prerequisite for the provision of the services;
- confirmation that the premises are accredited in respect of the provision of the services where that accreditation is a prerequisite for the provision of the services; and
- a floor plan showing the consultation area where you propose to offer the services, where relevant. Where a floor plan showing the consultation area cannot be provided please set out the reasons for this.

Service	**Accredited to provide (Y/N/NA)**	**Premises accredited (Y/N/NA)**
New medicine service (NMS)	Y	Y
Community Pharmacy Seasonal Influenza Vaccination	Y	Y
Community Pharmacist Consultation Service (CPCS)	Y	Y
Hypertension Case Finding Service	Y	Y
Care Home Service	Y	Y
Home Delivery Service	Y	Y
On Demand Availability of Specialist Drugs Service	Y	Y

Floor plan showing consultation area

27b Kingfischer Court_HALO.pdf

5 Applications in relation to premises that are in close proximity to other listed chemist premises

This section should only be completed if the premises included in section 2 above are adjacent to, or in close proximity to, another pharmacy or dispensing appliance contractor premises.

In my/our view this application should not be refused pursuant to Regulation 31 for the following reasons:

6 Information in support of the application

6.1 Proposed premises that are on the same site or in the same building as the premises of a provider of primary medical services with a patient list.

This section should only be completed if the premises included in section 2 above are on the same site or in the same building as the premises of a provider of primary medical services with a patient list.

In my/our view this application should not be refused pursuant to Regulation 25(2)(a) for the following reasons:

7 Pharmacy procedures

7.1 Please explain how the pharmacy procedures used within the premises will secure:

(a) the uninterrupted provision of essential services during the opening hours of the premises, to persons anywhere in England who request those services, and

(b) the safe and effective provision of essential services without face to face contact between any person receiving the services, whether on their own or someone else's behalf, and the applicant or the applicant's staff.

7.2 Please describe the procedure that will be followed where a patient attends the premises and asks for one or more of the essential services.

7.3 If you are undertaking to provide advanced services at the premises please describe how you will do so without providing any element of essential services.

You must ensure that you provide sufficient information within this application form to satisfy NHS England or the relevant delegated integrated care board on the above points. You are not required to submit your standard operating procedures for the premises but if you do they will be circulated to interested parties unless NHS England or the relevant delegated integrated care board is satisfied that the full disclosure principle does not apply.

Essential Services will be provided remotely through the deployment of an approved Website and Patient App such as to enable any patient anywhere in England to request NHS Essential services without a face-to-face contact. The website + App + all other digital platforms for communication will be available uninterrupted at least during the opening hours of the premises.
2. Please see SOPs attached. These provide the overall framework for the provision of essential services in the Pharmacy.
3. Only advanced services that can be provided remotely will be provided. The pharmacy does not intend to provide services that could require service users to come to the premises.
3.2 Request for face-to-face service provision
If any member of staff receives a query from any member of the public, or patient or their carers that requests the provision of any Essential Service face to face on or in the vicinity of the premises then they must.
a. Inform the person that no face-to-face contact may occur between the patient or their representative and any member of staff.
b. Provide the person with a copy of our patient information leaflet that explains what services the pharmacy provides and why they cannot be carried out face-to-face.
c. Refer the person to the Responsible Pharmacist if they require any further explanation.
d. Establish where the person is in England and which services they require.
e. Explain that due to NHS Regulations we are unable to provide face-to-face provision of NHS Essential Services.
f. Use the NHS Choices website to find suitable service providers near to the patient and offer them their details to contact them (note this is not "signposting" as an NHS service and is simply providing proper patient care in accordance with GPhC standards).

8 Undertakings

By virtue of submitting this application I/we undertake to notify NHS England or the relevant delegated integrated care board within 7 days of any material changes to the information provided in this application (including any fitness information provided under paragraph 3 or 4, Schedule 2) before:

- the application is withdrawn,
- while the application remains the subject of proceedings, the proceedings relating to the application reach their final outcome and any appeal through the courts has been disposed of, or
- if the application is granted, I/we commence the provision of the services to which this application relates,

whichever is the latest of these events to take place.

I/We also undertake to notify NHS England or the relevant delegated integrated care board if I/we am/are included, or apply to be included, in any other relevant list before:

- the application is withdrawn,
- while the application remains the subject of proceedings, the proceedings relating to the application reach their final outcome and any appeal through the courts has been disposed of, or
- if the application is granted, I/we commence the provision of the services to which this application relates,

whichever is the latest of these events to take place.

I/We also undertake:

- to comply with all the obligations that are to be my/our terms of service under Regulation 11 if the application is granted, and
- in particular to provide all the services and perform all the activities at the premises listed above that are required under the terms of service to be provided or performed as or in connection with essential services.

The following only applies where the applicant is seeking to provide directed services. I/We:

- undertake to provide the directed services mentioned in this application if they are commissioned within 3 years of the date of grant of this application or, if later, the listing of the premises to which this application relates,
- undertake, if the services are commissioned, to provide the services in accordance with an agreed service specification, and
- agree not to unreasonably withhold my/our agreement to the service specification for each directed service I/we are seeking to provide.

I confirm that to the best of my knowledge the information contained in my/our application is correct.

Name PHILIP OBOMIGHIE

Position SUP'T PHARMACIST + DIRECTOR

Date 12/06/2024

On behalf of the company/partnership HALO PHARMACY LIMITED

Contact phone number in case of queries ....

Contact email number in case of queries ....

Registered office

197 - 199 GULSON ROAD, COVENTRY. CV1 2HZ

Please send the completed form to:

Email:

Post: Primary Care Support England, PO Box 350, Darlington, DL1 9QN

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Dispensary Standard Operating Procedures

HALODIRECT®

DISTANCE SELLING PHARMACY

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[Note: This is not a complete list of SOPs for the operation of the pharmacy. These SOPs are provided to demonstrate how essential services will be provided in a safe and effective manner without face-to-face contact with the patient.]

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DOCUMENT CONTROL SHEET

Title	Standard Operating Procedures
Authorised by	………………………… (Superintendent)
Approvals	………………………… (Superintendent)
Distribution	[HALODIRECT – PHARMACY]
Filename	Dispensary Standard Operating Procedures

DOCUMENT AMENDMENT HISTORY

A list of amendments made to these SOPs is available at the end of this document.

CONTACT DETAILS

For further information contact:

PHILIP OBOMIGHIE

Tel:

Mob:

E-mail:

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1. Introduction and Background to SOPs

Standard Operating Procedures (SOPs) are a written process that assures that good standards of Clinical Governance are achieved. The processes should be reviewed regularly with the aim of continually improving the working practice in the pharmacy and ensuring that it is a safe working environment.

It is the responsibility of each individual carrying out duties and using the SOPs to ensure that they understand the SOPs thoroughly and seek clarification from the Responsible Pharmacist (RP) where necessary. It is the responsibility of the RP to ensure that the SOPs are being adhered to and understood by all staff members using those SOPs. The RP must ensure competency is attained for the relevant SOPs before approval for using a particular SOP by staff members. Any amendments of the SOPs due to changes in contracts or the occurrence of any serious incidents should be reported to the Superintendent Pharmacist in writing, using the appropriate amendment form. Overarching responsibility of the content of the SOPs is that of the Superintendent Pharmacist.

The GPhC has set out principles for the purpose of creating and maintaining the right environment for Pharmacy staff to abide by, to ensure Pharmacies are safe and effective in their practice.

- **Principle 1:** The governance arrangements safeguard the health, safety and wellbeing of patients and the public.
- **Principle 2:** Staff is empowered and competent to safeguard the health, safety and wellbeing of patients and the public.
- **Principle 3:** The environment and condition of the premises from which pharmacy services are provided, and any associated premises, safeguard the health, safety and wellbeing of patients and the public.
- **Principle 4:** The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public.
- **Principle 5:** The equipment and facilities used in the provision of pharmacy services safeguard the health, safety and wellbeing of patients and the public.

In this document and SOPs, the pharmacy is referred to as “The Pharmacy”.

IMPORTANT NOTE RE GPHC GUIDANCE

THESE SOPS COVER THE PROVISION OF ESSENTIAL SERVICES UNDER THE NHS (PHARMACEUTICAL AND LOCAL PHARMACEUTICAL SERVICES) REGULATIONS 2013 (AS AMENDED). GPHC GUIDANCE ON THE PRESCRIBING AND DISPENSING OR CERTAIN CLASSES OF MEDICINES TO PATIENTS WILL BE RELEVANT TO ANY PRESCRIBING OR SUPPLY VIA PRIVATE PRESCRIPTION OR VIA ONLINE CONSULTATIONS, BUT THIS DOES NOT FORM PART OF THE REGULATIONS FOR THE DISPENSING OF NHS PRESCRIPTIONS AND IS NOT INCLUDED WITHIN THESE SOPS.

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1.1 Risk Assessment

There are different risks with providing any pharmacy service at a distance, including on the internet. The Pharmacy has a Risk Assessment which identifies risks and scores those risk (likelihood / impact score) to produce a Risk Matrix. The Risk Assessment does not form part of the SOPs, but feeds in to the content of the SOPs. Each review of the SOPs must be undertaken along with a review of the Risk Matrix.

1.2 Regular Audit

The Audit document does not form part of these SOPs, but should be referred to by the RP and Superintendent as part of any update.

The Audit document deals with:

- staffing levels and the training and skills within the team
- suitability of communication methods with patients, and between staff and other healthcare providers
- systems and processes for receiving prescriptions, including EPS.
- records of decisions to make or refuse a sale.
- systems and processes for secure delivery to patients
- information about pharmacy services on the website
- how to keep to the information security policy, Payment Card Industry Data Security Standard (PCI DSS) and data protection law
- feedback from patients and people who use our pharmacy services.
- concerns or complaints received, and
- activities of third parties, agents or contractors

1.3 Overriding Provisions Applicable to All SOPs

These SOPs are written in accordance with the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, 'the 'Regulations'.

All pharmacy staff must note that this pharmacy operates in accordance with specific approval under the Regulations and these premises are 'Distance Selling Premises'. In order to comply with our terms of service, this pharmacy will provide;

- The uninterrupted provision of essential services, during the opening hours of the premises, to persons anywhere in England who request those services.
- The safe and effective provision of essential services without face-to-face contact between any person receiving the services, whether on their own or on someone else's behalf, and the owner of this pharmacy or any member of staff either on or in the vicinity of the premises.

All staff must receive induction and training which includes training in the specific terms of service of Distance Selling pharmacies.

All staff must receive training that includes the provision of Essential Services and covers:

- Dispensing Medicines
- Clinical Governance
- Signposting
- Dispensing Appliances (NB if applicable only)
- Repeat Dispensing
- Promotion of Health Lifestyles
- Support for Self-Care
- Emergency Supply

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- Discharge Medicines Service
- SOPs as set out in this document.

All staff must be made aware that face to face contact between patients (or their representatives) is prohibited in respect of any and all Essential Services either on or in the vicinity of the premises.

Face to face contact with patients or their representatives either on or in the vicinity of the premises is only allowed in respect of the provision of services other than Essential Services.

Any reference to 'contact' with or 'contacting' a patient in relation to these SOPs means contact other than face-to-face contact either on or in the vicinity of the premises.

Where any SOP could be considered to imply that face-to-face contact with a patient or their representative may take place either on or in the vicinity of the premises, then this should be immediately referred to the Responsible Pharmacist (RP) before any further action is taken.

If the RP receives a query from any member of staff as detailed above, they must:

- Inform the member of staff that no face-to-face contact may occur between the patient or their representative and any member of staff either on or in the vicinity of the premises.
- Review the relevant SOP and consider whether or not any part of the wording should be changed to ensure that the obligations applicable to Distance Selling Pharmacies are adhered to.

1.4 NHS Mail, NHS.uk Entry and the NHS Digital Directory of Services

It is common for secure communication from NHS bodies to now be received via NHS mail. This includes notification of Market Entry applications and referrals for services such as the Discharge Medicines Service. It is therefore important that the NHS mail system is accessible and accessed every day by staff.

At least two members of staff (unless fewer than two are working at the pharmacy) must have live, linked NHSmail accounts to the premises specific NHSmail account. NOTE – the NHSmail account is not the same as the email address that may be set up by the pharmacy themselves and is assigned by NHSmail directly.

When the NHSmail account details are received for the first time the Pharmacy must register the email address with the MHRA so that Central Alerting System emails can be received on product defects / recalls.

The NHS Digital Directory of Services contains a profile for the pharmacy and the pharmacy must verify and update it at least once per quarter to ensure that the information contained in the profile is comprehensive and accurate. Diary notes should be made on the computer system to ensure this is done.

Similarly, the NHS.uk profile must be kept comprehensive and accurate and verified and updated at least once per quarter. The Pharmacy should carry this out at the same time as verifying / updating the NHS Digital Directory of Services.

NHSmail must be checked frequently and in any even not less than 3 times per day on days that the pharmacy is open.

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2. Our "Healthy Living Pharmacy"

We will operate as a healthy Living Pharmacy ("HLP").

The Superintendent Pharmacist will provide support and training to all staff members as part of our commitment to HLP.

Training will develop the pharmacy team skills so that all members of staff understand their role in pro-actively promoting health and wellbeing messages.

As a HLP we look to engage with both the community that we serve and the commissioner of our NHS services.

We take part in health promotion which is led by commissioners (such as NHS England, the CCG or the local authority) as well as promoting a healthy lifestyle message to our patients and signposting them to other relevant services when we can.

We have a "Health Promotion Zone" on our website and also provide healthy living advice on an opportunistic basis to patients.

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3. Procedures for NHS Essential Services

NHS Essential Services will be provided to any patient living in England who requests such services, this is made clear on the website and in the Practice leaflets. Any patient who approaches the Pharmacy at any time for an NHS Essential service will directed and signposted appropriately to use a non-face to face method.

3.1 Communication Channels

All communication regarding NHS Essential Services should be carried out using the most suitable non face to face method for the patient and the service being provided with particular consideration to maintaining confidentiality. This may be telephone, email, video-conferencing or other types of non face to face communications such as text messages.

The pharmacy has provision for both live audio and live video communication with patients and this must always be carried out in the specified confidential area of the pharmacy premises.

3.2 Request for face-to-face service provision

If any member of staff receives a query from any member of the public, or patient or their carers that requests the provision of any Essential Service face to face on or in the vicinity of the premises then they must;

- Inform the person that no face-to-face contact may occur between the patient or their representative and any member of staff.
- Provide the person with a copy of our patient information leaflet that explains what services the pharmacy provides and why they cannot be carried out face-to-face.
- Refer the person to the Responsible Pharmacist if they require any further explanation.
- Establish where the person is located in England and which services they require.
- Explain that due to NHS Regulations we are unable to provide face-to-face provision of NHS Essential Services.
- Use the NHS Choices website to find suitable service providers near to the patient and offer them their details to contact them (note this is not “signposting” as an NHS service and is simply providing proper patient care in accordance with GPhC standards).

3.3 Provision of Advanced or Enhanced Services

Any advanced or enhanced services provided by the Pharmacy will be such that can only be done remotely using the same identification and communication methods as described for the provision of Essential services without patients accessing the service at the premises.

3.4 Summary Care Record Access

The pharmacy has access to Summary Care Records via our system supplier. When delivering any essential service the pharmacy should, If appropriate, access the patient’s Summary Care Record to see if it assists in providing the service

To obtain consent to access the summary care record you can:

- ask the patient directly each time
- get extended permission to view – useful for patients with repeat prescriptions
- get permission to view by proxy – useful for care home patients

(check with RP for most suitable procedure)

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4. The Equality Act

Information in this section is taken from the PSNC Briefing Note on the Equality Act with additional wording specific to this pharmacy.

The Equality Act 2010 sets out a framework which requires providers of goods and services, not to discriminate against persons with a disability.

The first matter to consider is whether the patient has a disability. A person is regarded as being disabled, if they have a physical or mental impairment which has a substantial adverse effect on that person's ability to carry out day to day activities. The impairment must be either long term (that is, has lasted more than 12 months) or is expected to last more than 12 months or for the rest of the person's life (for example multiple sclerosis).

The legislation does not require a provider to carry out an assessment under the Equality Act – all that is required, is that the provider makes a reasonable adjustment, if this is what is needed in order to allow the person to access the service.

4.1 What do I need to Consider?

Whenever you are providing any service to a patient you should consider whether there is a reasonable adjustment that you can make that could remove or overcome any obstacle that the patient has to accessing services.

If a person is disabled, you must consider whether a feature of the way in which you provide the service means that the disabled person would not be able to access the service, whereas a non- disabled person would. For example, a patient with severe arthritis, who is unable to open child resistant containers, would be unable to access their medicines if all medicines supplied by the pharmacy are in child resistant containers.

The provider of the service must then consider whether any adjustment could be made, which would have the result of overcoming the obstacles to accessing the service. In this example, providing an easy open container would overcome the obstacles to accessing medicines. An alternative would be to ensure that there is a care worker available to open the child resistant container every time the patient is due to take a dose.

The provider will be in breach of the legislation if there is a reasonable adjustment available which he chooses not to make, causing the person to be unable to access the service. In the above example, it would be unreasonable for the pharmacist to provide a care worker to visit the patient to help with opening the containers, but it would be reasonable to expect the pharmacist to dispense medicines in an easy open container.

4.2 Practical ways of supporting patients

The majority of patients, including patients in a care home where professional care workers are engaged to assist with medication, do not require any additional support to enable them to access medicines. Patients with a disability may be able to access their medicines without additional support but for some, the pharmacist will need to make adjustments to overcome obstacles to the use of the service.

Before assuming that the patient requires an adjustment, it is important to establish from the patient, what their personal preferences are; it should not be assumed that a patient who has a disability wants a particular adjustment. Discussing the benefits and shortcomings of particular adjustments with the patient will allow the patient to reach their own decision.

Easy open containers and large print labels are common adjustments. For patients who are forgetful, a reminder chart, showing which medicines are to be taken at particular times during the day may assist – but the pharmacist would need to ensure the patient understands how the reminder chart works, and is able to use it correctly.

It is likely that requests for MDS will be made from a wider group of patients, and their carers / relatives, because of the convenience that MDS brings. Whilst there is no funding available from the NHS for MDS

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our policy is to provide MDS free of charge to any patient who requests it and where the pharmacist believes that MDS is a reasonable adjustment that would overcome an obstacle to accessing services.

Whichever adjustment is made to assist patients with a disability, it is essential that the pharmacist satisfies himself that the patient is able to understand and be able to benefit from the adjustment, without introducing additional risks. Therefore, if you have tried to explain an adjustment that you propose to make, but a patient does not understand that adjustment, then you should not proceed to introduce it as it would not effectively overcome the obstacle (i.e., it might solve one problem, but create another).

4.3 Patients who have care workers

Some patients have care workers engaged to provide support. The care worker may be engaged to assist the patient - in this case the care worker follows the directions of the patient receiving the care. For example, the patient would tell the care worker "I want a blue tablet and a green tablet" the care worker would help the patient to select the blue tablet and the green tablet. This may be appropriate if for example the patient is visually impaired, or if the patient has manual dexterity problems. If a care worker is engaged to assist the patient, the extent of this assistance will be recorded in the care plan.

Or the care worker may be engaged to administer the medicines – in this case the care worker makes the decision as to whether the patient needs medicines or not. To do this they must be able to read information whether that is from a reminder chart or the labels affixed to the medicine packaging. Administration does not necessarily mean putting the individual tablets into the patient's mouth. The key criterion is that it is the care worker who makes the decision as to whether there is a particular medicine due at a particular time. The patient may still be able to take the tablets from the packs themselves. If the care worker is engaged to administer the medicines, there will be a record made by the care worker of each administration.

The Care Quality Commission, the regulator of care worker organisations has two relevant standards linked to medicines. The key point from these outcomes is that the organisation providing the care worker must make sure they have sufficient staff with the right knowledge, experience, qualifications and skills to support the people that they are caring for.

If the care plan for the patient requires the care worker to 'assist' the patient as above, then the care worker should have the necessary skills to open containers, and hand the medicines to the patient (whether they are in MDS or original manufacturer's containers). The care worker would not be expected to decide whether a particular medicine must be administered at the particular time.

If, however, the care worker is expected to administer medicines (as recorded in the care plan), then the care worker should have the qualifications and skills to be able to interpret instructions on the medicines container, whether that is an MDS or a manufacturer's container that has been dispensed bearing the pharmacy dispensing label.

The skills that appear to be needed to administer medicines would include being able to read instructions on labels and interpret the dosage instructions.

The employer of the care worker should specify the boundaries as to whether the care worker will assist with or administer medicines and it is the obligation of the employer to ensure that the care worker has the requisite skills and qualifications to undertake the roles.

Carer organisations may benefit from seeking the assistance of a pharmacist to provide training to the care workers on interpreting dispensing labels, particularly for those care workers that are engaged to administer medicines. It should not be the case, that carer organisations simply rely on pharmacists to provide medicines in MDS as a matter of routine to lower the skills required of care workers.

If pharmacists believe that a patient has been provided with a carer who is not sufficiently skilled and qualified to provide the required level of support to the patient, then consideration ought to be given to using the raising concerns procedures (as required in the clinical governance section of the terms of service) to alert the Care Quality Commission.

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5. Contacting Patients by Phone or E-mail

5.1 Objective

Information about patients that is confidential must not be disclosed without consent other than where there is a legal requirement to do so or in exceptional circumstances. Patients must also provide their informed consent to receive services from the pharmacy.

A number of policies are relevant and must be considered within the pharmacy. These include:

- The *Data General Data Protection Regulations (GDPR)*,
- *Data Protection Act 2018*
- the '*Human Rights Act 1998*',
- the '*Common Law Duty of Confidentiality*' (Appendix 2) and
- The Pharmacy's '*Clinical Governance Policy'* provides thorough guidance on the steps necessary to ensure patient confidential information is never disclosed without consent except, if required to do so by law or in exceptional circumstances.

This SOP ensures:

- Safeguards are in place to confirm the identity of the patient by whatever means of contact is used.
- Confidential information is not disclosed to persons who are not approved to receive it.
- Details of children's carers or vulnerable adult carers are properly collected and stored.
- Ensure confidential information is not sent via an unsecure or inappropriate manner (e.g., leaving messages on voicemail)
- Communication is recorded and kept up to date.
- Notes of outcomes are maintained and form an auditable trail of communication between the pharmacy and the patient.

5.2 The Caldicott Committee Report

Review of patient-identifiable information, 1997 listed the following identifiers (or a combination of these pieces of information) that are appropriate for identification of the patient.

- Surname
- Initials
- Date of birth
- Postcode
- Sex
- National Insurance number
- Forename
- Address
- Other dates (e.g., diagnosis)
- Occupation
- NHS number
- Ethnic group
- Local identifier (e.g., SH account No. hospital or GP practice number)

5.3 Scope

This SOP looks at the procedure for safely contacting patients without face-to-face confirmation of their identity.

5.4 Responsibility

Dispensers, Technicians, Administration staff, Company driver, Pharmacists and Responsible Pharmacist.

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5.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

5.6 Risks

- Failure to properly identify the patient.
- Breach of confidentiality.
- Failure to secure consent prior to sharing confidential information.
- Incorrect of false information being provided.
- Communication difficulties (speech problems, language barriers).

5.7 Process

- Transactions can only be carried out following patient registration on the website or completing a paper registration form and posting back to the pharmacy. By registering, patients would provide consent to be contacted for the purpose of service provision.
- Upon registration, patients will be sent an automated e-mail confirming registration with the website and confirming their e-mail address.
- Patients have the opportunity to contact the Pharmacy if this information is incorrect and this allows a check of falsified information. (NB Also consider data protection issues)

5.8 Communication via e-mail/letter

Contact patients via their preferred method of communication where possible.

- Use the standard e-mail/letter template for communicating to patients to:
  - Advise of any delays in medication supply.
  - Advise when medicines are due for delivery.
  - Advise that patients may have their electronic prescription returned to the spine to be dispensed elsewhere if items are unavailable.
  - Advise about services, healthcare information or advice, promotional information or updates regarding services.
  - Sending a letter of apology following a complaint

These can be found in the company template folder.

Always record the date and details of any communication sent.

5.9 Communication via Phone / Live Audio

- There will be instances where you will need to speak with the patient, e.g.:
  - To advise of a clinical intervention.
  - To confirm when medication will be delivered.
  - To advise of a supply issue / medication delivery delay.
  - To investigate a complaint.
  - To confirm delivery address.
- Whenever contacting patients, have the patient’s registration details to refer to.

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- Prefix the phone number with 141, to withhold the Pharmacy phone number. This is not to protect the pharmacy's privacy, but to ensure that any person who sees the number on a phone screen cannot tell that the patient is receiving a call from the pharmacy.
- Ask to speak with the named person.
- Ask any combination of at least two of the security questions listed above as patient identifiers.
    - If you have any reason to doubt the identity of the patient, tell them that you will call back later and refer to the RP.
- If the patient is not there, tell the person who answers that you will call again later.
- Do not say who you are of where you are calling from until you are certain you are talking to the patient.
- Do not discuss the patient's details with any other person.
- Do not leave a voicemail indicating the purpose of your call.
- Do not leave a message about the patient's medication or order with another person unless the patient has given consent for this.
- Refer to the Responsible Pharmacist in situations where:
    - The patient has a carer.
    - The patient is unable to communicate on the phone.
    - There are any concerns about whether the person is the patient or their authorised representative.
- Log all conversations on the patient records, recording date and time and who you have spoken to and the details of the conversation.

5.10 Communication via Live Video

There will be instances where you will need to see the patient when speaking to them.

Whenever contacting patients, have the patient's registration details to refer to.

Check that you are speaking with the named person.

Ask any combination of at least two of the security questions listed above as patient identifiers.

- If you have any reason to doubt the identity of the patient, tell them that you will call back later and refer to the RP.

If the patient is not there, tell the person who answers that you will call again later.

Do not say who you are of where you are calling from until you are certain you are talking to the patient.

Do not discuss the patient's details with any other person.

Do not leave a message about the patient's medication or order with another person unless the patient has given consent for this.

Refer to the Responsible Pharmacist in situations where:

- The patient has a carer.
- The patient is unable to use the live video system.
- There are any concerns about whether the person is the patient or their authorised representative.

Log all conversations on the patient records, recording date and time and who you have spoken to and the details of the conversation.

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6. Online Order Receipt & Exemption Checking

6.1 Objective

To capture all orders, to then process promptly and professionally to ensure:

- Patient details are complete and accurate on registration.
- The order on the administration screen matches with the original prescriptions once received.
- Prescription charges have been collected and processed where they are due.
- Prescription charge exemption is verified with scanned/posted evidence and records maintained.
- A message is sent to advise the patient the order has been received and is being dealt with
- Orders are all captured and not missed.
- Prioritising of orders by their despatch date. Dependent on the patients chosen delivery date.

6.2 Scope

All online services including the following:

- Healthcare products purchased online in their basket.
- Requests for dispensing Private Prescriptions.
- Requests to collect and dispense NHS Prescriptions.
- Requests to dispense a prescription received in the post.
- Any requests from the "contact us" section of the website.

6.3 Responsibility

Dispenser, Technicians, Administrative staff, Pharmacist and Responsible Pharmacist (RP).

6.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

6.5 Known Risks

- The payment process is not complete.
- Exemption details are not accurate.
- Prescription may be a forgery.
- Prescription is not received in the post.
- Technical issues with the online order processing.
- Inability to contact the patient.

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6.6 Process

6.7 Order receipt

A patient consents to using our service by registering on our website.

Any orders received should be printed and will contain the following details:

- Full name
- Full address
- Date of birth
- Gender
- Tel. number
- E-mail address
- Ordered items from their basket
- Order reference (system generated)
- Customer Account Ref (system generated)

6.8 Pharmacists Checks

Check all details on the order are appropriate and legal.

- The Pharmacist is to perform an assessment of the WWHAM responses from the online questionnaire for all non-prescription medicine orders (GSL and P) along with registration details (age and gender) to use their professional knowledge and judgment to ascertain the appropriateness of the product wishing to be purchased.
- The supply of any medicine must be made either by or under the direct supervision of the pharmacist on duty.
- Make all necessary checks to establish whether the intended user is the person requesting the product.
- Consider if it is appropriate to access the patient's summary care record to consider the products ordered against the information contained within the summary care record.
- Ensure that PIL's are available for all the products and sufficient information is available to the intended user. If necessary, contact the patient by telephone or e-mail to gain further clarification of the symptoms and their understanding of the use of the product. If a product is not suitable for a patient explain the reasons and respond accordingly, either recommending an alternative product, or referring if necessary.
- Patients would receive a delivery note (Fig 1) with their despatched order, advising that the pharmacist can be consulted by contacting them by telephone or e-mail.
- Ensure that the product selected by the patient is suitable for the symptoms described.
- Check the items ordered are appropriate for the intended user, taking into consideration their age, gender, contraindications, online consultation notes, Sale of Medicines Protocol and supply of items with the potential of abuse. Take particular care with POM to P switches, quantities of product ingredients being purchased, particularly Paracetamol and Codeine. Refer to SOP 'Online supply of pseudoephedrine and ephedrine containing products' and SOP 'Pharmaceutical and Legal Assessment' for further guidance.
- For any interventions refer to SOP 'Interventions and Problem solving' for further guidance.
- For any product recommendations received through e-mail, or phone conversations; ensure that enough information (using WWHAM as a baseline) has been gathered to allow for an informed decision on choosing the most appropriate product to recommend.
- If the patient would benefit from a face-to-face consultation with a pharmacist, then refer the customer to the Signposting section of the website to advise them of the pharmacies in their area.
- The website has safeguards in place to avoid purchases of multiple P medicines, multiple pseudoephedrine or ephedrine containing products, etc. If the case arises of a need to refund due to unsuitability of treatment, credit the card used for the online purchase.

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THE PHARMACY

Please refer to the Product Information Leaflet SOPS enclosed with each product for further information about the product. Our Pharmacist is always available to answer any questions about your medicines and offer support and guidance. **E-mail:** services@halodirect.co.uk or **Tel: 0845 xxxxxxxxxx** (during office hours)

Fig 1. Sample of a Delivery Note (details TBC)

6.9 Prescription Order Processing

6.10 Administration Checks

- **Check all prescriptions received in the post against printed and written prescription reception forms.** Check the corresponding prescription has been received in the post and match with the received and printed order by confirming the unique voucher number, patient name, address and DOB.
- Prescriptions should be received within 5 working days. If the prescription has not been received within this period, then the patient should be contacted to ensure it has been posted. If the prescription has been lost in the post, the patient should contact their GP to obtain a new prescription.
- **Check the patient's details on the prescription**. They should include:
  - Full name
  - Address including postcode
  - Date of birth
  - If the wrong prescription has been received for a patient, then refer to the RP before contacting the patient.
  - If the prescription is illegible or missing details, then refer to the RP before contacting the prescriber.
- **Check the prescriber has signed the prescription and it is in date**. If the prescription is not signed or out of date, then refer to the RP and/or return the prescription to the surgery.
- **If the prescription is for Repeat Dispensing (RA/RD) ensure all information and forms are present and correct.** Ensure that the prescriber has signed the RA copy and that the correct number of RD copies is enclosed. Create a Repeat Dispensing file for the patient if this is their first batch of prescriptions or add it to their existing file.
- **Check to see if any items will require ordering**. Specials or unusual items may need to be ordered in and may take longer than the usual delivery time period. If this is the case, contact the patient to inform them of the reason for a possible delay and expected delivery date of their items.
- Contact the customer if their chosen delivery address cannot be found on the Royal Mail address search engine and refer to the RP if the address appears illegitimate.
- Check the payment details have been processed correctly for each transaction via the online payment system.
- For NHS Prescriptions where appropriate check the reverse of the prescription is completed correctly.

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- Advise the patient that they may have their electronic prescription returned to the spine to be dispensed elsewhere if items are unavailable.

6.11 Exempt NHS Prescriptions

- The reverse of the prescription should be fully completed in black ink other than for age related exemptions where the age is printed on the prescription form.
- In order to secure exemption of or remission from prescription charges when presenting a prescription form to a pharmacy, or appliance contractor, the patient, or a person on his behalf, must complete the declaration on the back of the prescription form.
- If this is not the case or there is some information missing, then contact the patient to request missing information.
- Where patients do not have evidence or where there is doubt over whether the evidence provided is genuine or appropriate, the "Evidence not Seen" box on the back of the prescription should be marked with an X by pharmacy staff. Pharmacy staff should not refuse to dispense items on the basis that the patient does not provide evidence of their entitlement to free prescriptions.
- Where no satisfactory evidence of exemption has been provided patients should be informed that checks to prevent and detect fraud are routinely undertaken by the NHS.
- satisfactory evidence includes evidence derived from a check, known as a real time exemption check, of electronic records that are managed by the NHS BSA for the purposes (amongst other purposes) of providing advice, assistance and support to patients or their representatives in respect of whether a charge is payable under the Charges Regulations.
- Where evidence of exemption is required or provided by the patient it can be sent to the pharmacy for verification via the delivery driver and then returned to the patient. The PMR system should be updated to reflect that necessary check has been carried out and a note of when the next check is required should be entered onto the system. The Regulations require a patient to produce 'satisfactory evidence' to confirm exemption. Where appropriate (i.e., for deliveries made other than by the pharmacy's delivery driver), the patient may scan or fax copies of the evidence to the pharmacy (or use the postal / courier service, but see NOTE below) and the pharmacy can note that the evidence provided was not in original format. It is for the pharmacist in charge to determine if the evidence is satisfactory or not and, if not, then cross the 'Evidence not Seen' box.
- The PSNC advises that If a valid certificate of exemption has been provided as evidence, for example a medical exemption certificate or pre-payment certificate, and noted on the PMR along with the certificate's expiry date, it is not necessary to ask the patient to provide proof again within the validity of that certificate. Patients claiming exemption because they receive Income Support or Jobseeker's Allowance (income-based) should be asked to provide evidence on each occasion to ensure their continued entitlement.
- ensure that the required information is duly entered into the records managed by the Information Centre that are accessible as part of the Electronic Prescription Service (if either it is not already recorded in those records or a check, known as a real time exemption check, has not produced satisfactory evidence)

NOTE: Verification of Declarations of Prescription Exemptions

- Where a patient uses the postal system to provide evidence of exempt status then the patient should be advised to use Special Delivery Postal Services or our own courier service. The pharmacy should cover the cost of any postal / courier for the patient and return documents the same way.

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ADDITIONAL NOTES

- There is no question of refusing to dispense the prescribed item to patients who sign an exemption claim but do not provide evidence. If patients are unsure whether they are entitled to free prescriptions, you should advise them to pay for their prescriptions and send them a receipt (FP57), in case they want to claim a refund later.
- You will not be held responsible if patients do not provide evidence, or if they provide evidence which is false. If you are in any doubt as to whether the evidence is genuine or appropriate, you should mark the 'Evidence not seen' box on the back of the prescription form with an 'X'.
- You are in no way responsible for the accuracy of the patient's declaration; this remains the responsibility of the patient.

6.12 NHS Business Services Authority Guidance

The NHSBSA provides the following guidance to those involved in the dispensing process [adjusted to reflect distance selling pharmacy Regulations). All contact with patients will be via non face-to-face methods.

- DO
  - encourage your patients to check that they are entitled before claiming free prescriptions. A patient booklet and other resources are available at: www.nhsbsa.nhs.uk/freeprescriptions
  - make sure patients are certain that they are entitled before they complete the declaration on the prescription form. If they are not sure, ask them to pay, issue an FP57 receipt and explain that if they can later confirm that they are entitled, they can claim a refund within three months.
  - ask to see evidence of patients' entitlement and check the expiry date on any certificates you're sent. If a patient can't provide proof, mark the 'Evidence not seen' box on the prescription and remind them that their entitlement could be checked at a later date.
  - explain to patients with qualifying long term medical conditions, pregnant women and those who have had babies in the last 12 months that they must have a valid medical or maternity exemption certificate to be entitled to free prescriptions. To apply for a certificate, they will need to contact their GP, midwife or health visitor.
  - remember that patients who currently pay for their prescriptions may benefit from buying a prescription prepayment certificate or applying for the NHS Low Income Scheme. Visit www.nhsbsa.nhs.uk/healthcosts for more information.
- Don't:
  - make assumptions. Remember that not all benefits entitle patients to free prescription and patients with long term medical conditions like diabetes or epilepsy may not have medical exemption certificates. Even if you have seen a patient's exemption certificate before, it may have expired since then.
  - hurry the patient (or their representative). Give them time to read the declaration on the prescription form and information materials.
  - forget that if a patient makes an incorrect claim, intentionally or otherwise, they could have to pay a penalty charge of up to £100 - as well as the original prescription charge(s). An additional charge of up to £50 may apply if they don't pay on time.
  - turn a blind eye. If you suspect that a patient is fraudulently claiming free NHS prescriptions, visit www.reportnhsfraud.nhs.uk or call the NHS Fraud and Corruption Reporting Line.

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6.13 Coronavirus and influenza vaccinations and immunisations

The Pharmacy will not administer medicinal products to patients, but it should be noted that - No charge is payable in respect of the supply or administration to an eligible person of a medicinal product used for vaccination or immunisation against coronavirus or influenza virus whether or not the medicinal product is supplied or administered to that person in accordance with such a patient group direction or protocol.

The pharmacy should check the current eligible persons list for up to date guidance.

6.14 Paid NHS Prescription

- Check the prescription to confirm how many charges are due.
- Check to see if any fees have been paid and if so, was the correct amount paid?
- Contact the patient to arrange payment using the secure payments system using the “customer not present” option.
- If no fees have been paid or there is a discrepancy between fees paid and those due, the patient should be contacted and directed to pay the appropriate fees via the online payment system.
- The reverse of the prescription should be fully completed.
- If an item is available and cheaper to buy consult the pharmacist.

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7. Pharmaceutical & Legal Assessment

7.1 Objective

All prescriptions or orders need to be valid and clinically appropriate for the patient. They must:

- Be safe and appropriate.
- Be Legally valid, allowed on that particular prescription type and not blacklisted.
- Be for licensed indications and dosages with the Prescriber contacted for out of licence use.
- Have all interventions recorded.

7.2 Known Risks

- Poor handwriting on handwritten prescriptions.
- Similar names of medicines.
- Interactions or errors that are not identified.
- New or unfamiliar drugs

7.3 Scope

This SOP provides guidance for the pharmaceutical assessment of all NHS prescriptions, Private Prescriptions and sale of non-prescription medicines. For Controlled Drugs prescriptions and sales of non-prescription medicines, the specific SOP relating to that topic should be referred to as well.

7.4 Responsibility

Dispensers, Technicians, Pharmacists and Responsible Pharmacist. Only those members of the pharmacy team who have been considered competent and have appropriate training can carry out this procedure.

7.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

If as a result of the review any changes to the SOP are deemed necessary, these must be approved by the Superintendent Pharmacist.

7.6 Process

7.7 Pharmacist Checks

Where appropriate you may need to contact the patient or carer to gain further information to help assess the appropriateness of treatment, e.g., finding out the weight of a child for calculating the recommended dosage for children's medicines. The list below provides a guide of the key points to pay attention to when the Pharmacist performs the pharmaceutical check.

- Age of patient.
- Gender of patient.
- Weight of the patient
- Whether the patient is pregnant or breastfeeding.
- The relevant clinical condition.

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- Patient Medication Record (PMR) notes e.g., Allergies.
- Interactions with other drugs, foods, supplements or disease states
- Dose and dose changes.
- Strength and strength changes.
- Formulation.
- Route of administration.
- Contra-indications.
- New medicines.
- Quantity and interval prescribed or purchasing.
- Monitoring requirements.
- Whether Medication is appropriate for the patient.
- Consideration of any adjustments required under the Equality Act 2010

Where a prescription is not appropriate in your professional judgement, take the appropriate steps to ensure you consider all your options before coming to a decision.

- Is there guidance available for out of licence use?
- Consequences to the patient of not supplying.
- Consequences of supplying.
- Acting in the patient's best interests of care.
- Reference to reference books and data sheets.
- Discuss with the prescriber.
- Contact the patient to gain further information over the phone.

Clinical interventions must be recorded in the 'Interventions and Referrals section of the patient notes. Record as much information as you feel relevant, as referring back to it at a later date may prove useful. Also make a note in the patient's PMR. Refer to SOP 'Intervention and Problem Solving' for further guidance.

The list below provides a guide of the key points to pay attention to when the Pharmacist performs the Legal check. Where appropriate you may need to contact the patient, prescriber or carers to gain further information.

- Has the reverse of the prescription been completed?
- Is the prescription legally valid?
- Is the prescription genuine?
- Are all the patient details complete?
- Is the medication reimbursable by the NHS?

7.8 Summary Care Record Access

If appropriate, access the patient's Summary Care Record to evaluate the prescription received against the information contained within the record.

7.9 Items Requiring Measuring and Fitting

Where a prescription is received for an item that requires measuring or fitting the patient should be contacted and informed that these items are not available from this pharmacy as we do not provide a measuring and fitting service. Patients should be signposted to at least two other providers of the service in their area. (see signposting SOP)

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8. Interventions and Problem Solving

8.1 Objectives

This SOP is designed to ensure that any interventions that are identified in the Pharmaceutical & Legal assessment SOP are dealt with promptly, professionally and appropriately. Always be aware that:

- Patient safety must always be the priority.
- The nature of the pharmacy as a Distance Selling Pharmacy means that it is not always possible to provide the same services as normal retail pharmacies.
- Customer confidence and good patient relationships should always be maintained.
- Good working relationships with other health care professionals should always be maintained.

8.2 Scope

This SOP covers the events that may occur during the dispensing process.

8.3 Responsibility

Pharmacist and Responsible Pharmacist and all other members of staff

8.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

8.5 Process for Prescription Issues

- **Issues re prescriptions must always be referred to the RP.**
- **Ensure you start by checking that you have contact details for the patient.**
- When contacting the prescriber, try to speak with them, but if they are unavailable then consider speaking with an alternative prescriber from that practice if appropriate.
- Record the details of the intervention in the 'Intervention & Referrals' book, and also make a note in the PMR.
- If you can resolve your query by speaking with the patient over the phone and it is a clinically significant intervention, then record this in the 'Interventions & Referrals' book and make a note in the PMR.
- If a decision has been made not to dispense, then telephone the patient to advise the patient as to the reason and refer them to the prescriber. You should not in any way undermine the trust the patient has in the prescribing Doctor. The intervention should be logged in the 'Interventions and Referral' book.
- If the prescription has no other items on the prescription, return the prescription back to the prescriber with the intervention details attached.
- If the prescription contains other items, then endorse the item that cannot be dispensed as N/D (Not dispensed). Proceed to send a copy of the intervention report to the prescribing Doctor if appropriate.
- If you are working alongside an ACT, attach a note to the prescription of the outcome of the intervention and stamp and sign the prescription in the usual way to confirm a clinical assessment has been performed.

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8.6 Matters Relating to Distance Selling Queries

- This pharmacy operates under the Regulations and Terms of Service applicable to distance selling pharmacies. Where any patient requests the provision of an essential service in a face-to-face manner at the premises (which includes in the vicinity of the premises) then this request must be refused.

- A refusal to provide a service that a patient believes they are entitled to receive may surprise patients. It is important to explain to patients that this type of pharmacy is not permitted to provide essential services in a face-to-face manner.

- Do not use phrases such as "essential services" when speaking to patients as this will be confusing. Instead, discuss the specific service that is being requested and explain why it cannot be provided. You may also provide a copy of our Information Leaflet which also provides an explanation of the rules that apply to the pharmacy.

8.7 Patient Queries and Issues

- Ensure you have contact details for the patient.
- Refer the query to the RP.
- If you need to contact a prescriber, then ensure that all relevant information is available before you make contact.
- Keep the patient informed of what you are doing. People normally don't mind waiting for answers if they are being kept informed.
- Discuss the query with the patient.
- Make sure you understand what the patient's position is – i.e., Do you understand their query properly? Repeat the query to the patient to ensure you have the correct understanding but ensure that you don't come across as patronising. Tell the patient that you want to repeat the query in order to ensure that you have understood it properly.
- If you can reach agreement on the appropriate action, then record the agreed action and ensure it is carried out and that all relevant staff are aware of what has been agreed.
- Consider leaving appropriate notes if another RP might be involved in the query at any stage.

8.8 Serious Shortage Protocols

(see PSNC website for further details)

What are SSPs?

Legislation has been passed that will allow for an emergency measure called the Serious Shortage Protocol (SSP) to be put in place to help manage supply if there is a serious shortage of one or more medicines.

The intention is that an SSP will be issued only if a medicine has been judged by the Minister to be in serious short supply. The SSP will set out a clear protocol for community pharmacists to follow if they are unable to source that medicine for patients who have been prescribed it. The protocol will say what other prescription medicines could be dispensed, without the pharmacist needing to go back to the prescriber. For example, pharmacists might be able to:

• Dispense a reduced quantity of medicine.

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• Dispense an alternative dosage form.
• Dispense a therapeutic equivalent; or
• Dispense a generic equivalent.

The SSP will specify exactly what alternative quantity, or pharmaceutical form, or strength, or therapeutic equivalent or generic equivalent could be supplied by the pharmacist and under what circumstances.

It is important to understand that an SSP will only be introduced for a medicine if there is judged to be a serious shortage of that medicine. The SSP will only apply to that specific medicine and it will set out clearly what alternatives, for example, a different formulation (e.g., capsules rather than tablets,) pharmacists can dispense. GPs will be notified when an SSP has been put in place so that prescribers will know what adjustments may be being made to their patients' medicines.

The introduction of SSPs does not mean that pharmacists will be empowered to make changes to patients prescribed medicines more widely. Each SSP will apply to a specific medicine, with specific alternatives allowed to be dispensed within a specific time period.

NOTE

- You must follow the protocol in all cases.
- You should notify the provider of primary medical services on whose patient list the patient is of the supply in accordance with the SSP instead of in accordance with the prescription form or repeatable prescription.
- the requirements to act with reasonable promptness in are to be read as requirements to act "within a reasonable timescale". What is reasonable will be judged on the individual circumstances.
- Pharmacists must refuse to supply against the original prescription if a serious shortage protocol is in effect and alternative provision has already taken place.
- The RP must use their professional judgement to decide whether it is "reasonable and appropriate" to supply in accordance with the protocol, instead of the original prescription.

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9. Selection, Labelling and Assembly

9.1 Objectives

The aim of this SOP is to ensure:

- Safe working systems
- Accurate selection, labelling and assembly of products.
- That the prescribed product is selected from the shelf (dispensing from the prescription and not from the labels).
- The correct quantity is dispensed.
- The PIL is included with the medicine.
- The product has enough shelf life when in use by the patient.
- The packaging is appropriate for the contents.
- The label is placed on the correct product.
- Consideration is given to the Equality Act.

9.2 Risks

- Assembling medication from the labels, not from the prescription.
- Label print may be too small for patient to read.
- Similar medication names or packaging.
- Split boxes have not been marked.
- Incorrect product selection.
- Not enough shelf life on the product.
- If the product has not been stored correctly so the quality is compromised.
- Incorrectly labelled boxes.

REMEMBER: MANY DISPENSING ERRORS ARE CAUSED BY PRODUCTS WITH SIMILAR NAMES BEING INCORRECTLY CHOSEN FROM THE SHELF!

9.3 Scope

This SOP deals with the selection labelling and assembly of all prescriptions and non-prescription medicines.

9.4 Responsibility

Dispensers, Technicians and pharmacists.

9.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate. If as a result of the review any changes to the SOP are deemed necessary, these must be approved by the Superintendent.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

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9.6 Process

9.7 Prescription/Non-Prescription Order Selection

- The prescription/online order should be referred to before and during the selection of the product.
- Read the prescription, NOT the labels when selecting products.
- Products should be selected from the top / front, as stock rotation would mean that newer stock is placed at the bottom / back.
- Check the product has enough shelf life on it for the usage period.
- The prescription must be signed and dated.
- Check if the 'days of treatment' box has been ticked.
- Contact the patient if you know there is a stock shortage, or the item is a special order. Advise the patient of the anticipated date by when the prescription can be fulfilled.
- Check the patient has enough medication to last the duration of treatment.

9.8 Prescription Labelling

If the bar code scanner is used, then many of the fields below will be populated by the PMR system. You should still check the details to ensure that they are correct.

- Select the correct prescription type from the PMR.
- Check the prescription for:
  - Patient name, address and DOB. Double check before selecting a patient from the list.
  - The Prescribers signature.
  - Check the reverse of the prescription has been completed appropriately.
  - Any anomalies or missing information or notes or added information.
- Amend any details like change of name or address as appropriate.
- Perform a thorough search for patients not listed to avoid duplicate records being generated.
- If the patient is not listed, create a new patient record.
- Enter the prescriber details.
- Check the notes for any allergies or information to take into consideration.
- Check PMR notes for any reference to a disability or requirement for alternate methods of dispensing, e.g., MDS or large type labels.
- Enter the prescriptions items in the order that they appear on the prescription.
- Add a note to the prescription to advise the Pharmacist of any changes to treatment, dose, strength etc.
- Check the BNF statutory and cautionary warnings appear on the label.
- Add a note to the prescription to advise the Pharmacist of any drug alerts or interactions.
- Pay attention to any notes about allergies, brand preferences etc. Add these notes if they appear on the prescription or order message.
- Review the prescription summary screen and order stock as appropriate.
- Generate labels.
- Endorse the prescription and then stamp with the Pharmacy address stamp.
- Place the generated labels and prescription in the appropriate coloured basket with the selected stock, taking care to select with reference to the prescription and not the labels.

9.9 Prescription Assembly

- Select the prescription for assembly.
- Ensure you have a clear workspace in which to assemble items.
- Read the prescription and check the patient and medication details correspond.
- Ensure the medication remains in date for the duration of treatment.
- Calculate/measure/count the quantity required.

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- If you have sufficient stock, place the selected items in the relevant coloured dispensing baskets with the prescriptions.
- Select one item at a time.
- Be alert to similar packaging used by generic manufacturers. These can be highlighted using Caution Stickers.
- Be aware of any medication that is brand specific to the patient type or condition.
- Check the stock is in good condition.

9.10 Falsified Medicines Directive (as appropriate)

From 9th February 2019, market authorisation holders were required to add safety features on all new packs of prescription medicines placed on the market in Europe:

- a unique identifier (UI) in the form of a 2D data matrix (barcode) which can be scanned at various points along the supply chain to determine its authenticity; and
- an anti-tamper device (ATD).

The Pharmacy will apply any new regulation or guidance introduced by the UK to combat the use of fake medicines as this directive no longer applies in England.

9.11 Split Packs

- If you need to split packs, use a suitable container to repack the medication in:
  - Ensuring that any split packs already present are used up first and then using an un-split pack to make the remaining count volume unless they are from a different manufacturer and appear different as this may confuse the patient.
  - Ensure that the blisters in the pharmacy contain the expiry date and the batch number and are kept in the original pack.
  - Mark all split packs with 'X' using permanent marker on each panel of the pack.

9.12 Liquids

- Leave the stock bottle visible on the draining board if too large or with the basket to allow the Pharmacist / Technician to check against.
- Take time to measure the liquid volume taking care the line of the meniscus is parallel with the volume required.
- When mixing antibiotics etc. follow the manufacturer's instructions to prepare the medication.
- Write the date of opening on the bulk liquid bottle and on its carton.
- A 5ml spoon, oral syringe or a liquid measure should be provided as appropriate. Check the patient age contact the patient or their representative if in doubt about which to provide.

9.13 Bulk Packs

- Use a tablet counter to count out the required quantity of medication. Do not handle medication directly - use latex gloves or tweezers. Leave the bulk pack with the prescription and transfer the medication to a clean tablet bottle.
- If bulk packs are split this should be indicated by marking the pack with an 'X' with ink/marker pen. The mark must be easily seen by any future user of the pack. Mark the ends of the box to assist with identifying the pack as "split".
- Child resistant lids should be used unless it is not appropriate to do so and approved by the RP.
- Make a note on the prescription and PMR notes if the patient requests not to receive child resistant containers or if they have difficulty opening the container.

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9.14 Cytotoxics

- Cytotoxics must only be counted using a triangle especially for that purpose.
- Wash the triangle after each use.
- Ensure child resistant closures are used where appropriate.
- Ensure cytotoxics are not dealt with by pregnant staff.

9.15 Valproate Medicines and Females of Childbearing Age

- Valproate medicines must not be prescribed to women or girls of childbearing potential unless they are on the pregnancy prevention programme (PPP).
- All women and girls who are prescribed valproate should contact their GP and arrange to have their treatment reviewed.

9.16 Dispensed by checks

- Ensure that a patient information leaflet (PIL) is supplied. If you do not have a PIL you should download and print one.
- Consider what additional information can be provided to the patient to ensure that they understand how to take their medicines properly and how to get the most from their medicines.
- Attach labels to medicines on an appropriate area.
- Flag labels appropriately for small containers or items to ensure all the relevant information is present for the patient to read and for the pharmacist/ACT to check.
- Refer to the prescription again to check each label on each item corresponds and is correct.
- Mark the 'Dispensed By' box with your initials to indicate the dispensed medication has been checked by the dispensing person.
- Place the basket in the designated prescription checking area.
- Ensure FMD codes are present for later scanning out process.

9.17 Additional Procedures Re Insulin

When a prescription for insulin products is received the pharmacy must check if the patient has an 'Insulin Passport' to record the patient's current insulin products and if not then supply one.

When prescriptions of insulin are prescribed, dispensed or administered, healthcare professionals should cross-reference available information to confirm the correct identity of insulin. Where there is a discrepancy between the Insulin Passport, a patient's notes or current understanding of insulin therapy, it should be reconciled and the information in the Insulin Passport updated.

9.18 Endorse/Code the Prescription

- The electronic endorser must be used for all endorsing unless the RP indicates otherwise for any reason.

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10. EPS Nomination and Information[1]

Our access to the EPS system is provided and maintained by our IT supplier and we have signed up to the Priority Services Register (which provides priority access to electricity, water and gas supplies) in order to ensure that it is constant and reliable. In the event of any system outage refer immediately to the RP so that the system supplier can be contacted.

10.1 Objectives

- To ensure that patients are given sufficient information regarding EPS nomination to properly inform their decision.
- To ensure that information regarding nomination is delivered in a consistent and impartial manner in order that no patient or contractor is disadvantaged in any way.
- To ensure that nominations are captured, recorded and changed appropriately, accurately and promptly.

10.2 Scope

- This procedure covers the capture, recording and changing of EPS nominations.

10.3 Training Requirements

- All pharmacy colleagues must have completed this SOP and relevant training with the RP before being able to set an electronic patient Nomination.
- All pharmacy colleagues must be confident how to explain to patients/appropriate representatives about the EPS generally (see leaflet that can be provided to patients) and the nomination process.
- The pharmacist on duty is responsible for the supply of any medicines to a patient.

10.4 Which patients are suitable for Nomination?

- Patients receiving regular medication
- Patients who have their medicine delivered from the same pharmacy.
- Patients wishing to use our Repeat Prescription Service.

10.5 Which patients are less suitable for Nomination?

- Patient who receives prescription infrequently.
- Patients who receive their medicines from multiple different pharmacies.
- Patients who work away or travel regularly.

10.6 Process

10.7 What if there is no access to the EPS?

- Provide the patient with the details of other pharmacies in the relevant area who may be able to dispense the prescription.
- Consider making an urgent supply at the request of a prescriber (see SOP); or
- Contacting the prescriber and ask for the urgent provision of a non-electronic prescription form.

[1] EPS information and procedures are tailored from PSNC recommendations

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- When considering requesting a non-electronic prescription check with the patient first to ensure that the timescales involved are acceptable to them bearing in mind that the medication cannot be dispatched until the original prescription is received for the final check.

10.8 Capturing the nomination

Nomination forms are available on the website. If a patient requests information about nominating a dispenser or the EPS service in general give them the following information:

- EPS involves the electronic transmission of prescriptions safely and securely.
- any dispensing contractor operating EPS can be nominated.
- patients are not restricted to nominating a dispensing contractor located close to their GP practice.
- where patients use their nominated dispensing contractor, their prescription will be sent automatically to that dispensing contractor.
- if the patient chooses not to use their nominated dispenser for a particular prescription, they must make that clear at the time of requesting the prescription.
- patients can change their nominated dispensing contractor at their GP practice or any dispensing contractor at any time. This includes when they are part way through a repeat dispensing cycle, any prescriptions which have not been downloaded before the change of contractor will be accessed by the new nominated contractor.
- The NHS App can also be used to nominate a pharmacy contractor
- patients do not have to receive their prescriptions via the Electronic Prescription Service, however, if it is not used, services associated with it (such as nomination) cannot be used.

10.9 Notes

- The patient will be able to nominate one community pharmacy and one dispensing appliance contractor.
- You may not assume that a patient who has used the pharmacy's repeat prescription service will choose to nominate it. Explicit consent and nomination is required.
- Do not offer the patient any inducement such as (but not limited to) discounts or loyalty points in order to gain the nomination. You must not influence the patient's choice in any way.
- There is no minimum age applicable to nomination. Judgement will be needed to determine if it is appropriate to set a nomination. A nomination can be requested by a representative provided they have the patient's consent.
- Once the patient has made their choice ask them to complete and sign a nomination consent form. This form should be stored securely on the PMR to provide evidence of the patient's selection.
- Remember any nominations that were collected prior to the pharmacy going EPS "live" must be re-confirmed with the patient.
- Find the patient's record using the patient's name, registered address, date of birth and gender or, if available, the NHS number.
- Set the nomination as requested by the patient. Repeat if the patient wants to nominate a pharmacy and an appliance contractor.
- If the pharmacy cannot dispense the prescription due to an inability to access the Electronic Prescription Service then we must still take all reasonable steps to ensure that the medication is provided in a reasonable timeframe, which may include;
    - Signposting to another pharmacy in the same area as the patient (NB check in advance if that pharmacy is able to access the system)
    - Consider "urgent supply"

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- Consider asking for a written prescription from the prescriber – but NB ask the patient if that works for them in terms of the time taken for that prescription to reach the pharmacy.

10.10 Changing the nomination

- If a patient requests that a nomination is changed, inform them that outstanding prescriptions not collected by the original nominee will be transferred to the new one.
- If the patient has a repeatable prescription inform them the best time to change the nomination is soon after they have collected the last repeat. If they change before, it is possible the original nominee will already have collected the next repeat.
- To make the change find the patient's record and replace the old nomination with the new one. The patient should complete a nomination request form.
- A repeatable prescription can only be issued electronically where it is being sent to a patient's nominated pharmacy. Patients can choose to change their nominated pharmacy before the expiry of the repeatable prescription. In this case, all outstanding issues which have not been downloaded will be transferred to the new nominated pharmacy. This is different from the paper based repeat dispensing system where all issues must be obtained from the same pharmacy.
- The patient can change their own nomination via the NHS app

10.11 Cancelling the nomination

- By default, prescriptions will go automatically to the nominated dispenser.
- If a patient asks who they have nominated, you must look it up and give them the information even if it is not this pharmacy.
- Nomination can only be removed if customer has given us consent. See the EPS Nomination Withdrawal Form
- If a patient's nomination is changed part way through an electronic repeat dispensing cycle, all prescriptions that have not been downloaded will be transferred to the new nomination. If a nomination is removed part way through an electronic repeat dispensing cycle the patient will need to go back to their GP to obtain a new prescription.

10.12 Using the nomination

- By default prescriptions will go automatically to the nominated dispenser. If at any time a patient wishes anything different to happen they must inform the prescriber at the time of requesting the prescription.
- If a patient asks who they have nominated you must look it up and give them the information even if it is not this pharmacy.

10.13 Time Scale

- All nomination setting, changing and cancelling requests must be dealt with within one working day of the request being made.

10.14 Responsibility

- Any member of staff authorised by the practice and who has an individually registered Smartcard with a User Role Profile that allows access to the Personal demographic Service (PDS) may capture, record and change patient nominations.

10.15 Review

This SOP will be reviewed annually and whenever there are any changes in the EPS service. The SOP will also be reviewed following any critical incident.

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11. EPS Dispensing Process

11.1 Objective

Safe dispensing of EPS prescriptions.

See Repeat Dispensing SOP for additional details re EPS Repeat Dispensing

11.2 Scope

This SOP describes the procedures which should be followed for the retrieval and dispensing process for Electronic Prescription Service (EPS) Release 2 prescriptions in England.

11.3 Procedure

Accessing EPS - Log on with Smartcard and passcode

To access EPS the user should log on using their Smartcard and passcode.

11.4 Download electronic prescriptions

Patients must have nominated the community pharmacy for their electronic prescriptions to be automatically retrieved or manually pulled down by that pharmacy using the Electronic Prescription Service. The Nominated prescriptions, once generated and electronically signed by the prescriber, are sent to the spine and these can be downloaded by the pharmacy. They can also be downloaded by technicians, dispensing assistants and locums providing they have the correct Role Based Access Control associated to their Smartcard. If the prescription is unable to be located then there could be a number of reasons for this, including the fact that staff training may be required, the prescription may be post-dated or there may be technical issues and these should be investigated.

There are three ways a prescription can be retrieved:

1. Where the prescription is flagged for a nominated pharmacy, that pharmacy can download the prescription at any time. Prescriptions will be automatically downloaded once daily (normally first thing in the morning).
2. If the patient posts their token to the pharmacy, or it is collected on behalf of the patient from the surgery; the barcode on the prescription token may be scanned, in order to 'pull down' the prescription to the pharmacy system, this will be more usual for acute prescriptions.
3. The barcode on the prescription token may be entered manually.

Different situations may occur when a patient sends a prescription token to the nominated pharmacy and the following steps should be followed:

11.5 If a patient posts a prescription token to this pharmacy

The prescription may already have been downloaded, dispensed and awaiting medication delivery, or the barcode on the prescription may need to be scanned and the prescription retrieved from the spine. If the prescription has already been downloaded then when the barcode is scanned, the system will alert the user. The pharmacy may wish to consider if staff should check whether the prescription is bagged up first or whether the token should be scanned first and the system used to locate the prescription.

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11.6 If a patient contacts the pharmacy and requests a delivery without a prescription token

- Ensure patient's details are confirmed and checked carefully. (This will be the usual process for repeat prescriptions where the patient has not seen the prescriber).

- Print dispensing token if necessary
  - When a prescription token has not been issued, a dispensing token may be required to be printed in the following situations:
    - To support the clinical check/accuracy checking process.
    - For exemption declaration purposes (all except for age exemptions – under 16 years and over 60 years of age).
    - When a prescription has been downloaded by us, as their nominated pharmacy but we are unable to fulfil it (for example if the item is out of stock) on advising the patient of a stock issue over the phone, the patient may wish to try elsewhere. In this case the prescription is released back to the spine, the patient is advised over the phone that the prescription can be accessed at another EPS Release 2 enabled pharmacy. **The entire prescription must be returned back to the spine and not just the items which are out of stock.**

- The dispensing token must also be sent to the patient when we are unable to fulfil the prescription so it can be presented elsewhere.

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11.7 Perform professional clinical check

The pharmacist should perform the clinical check.

Any prescriptions with hand written amendments made by the prescriber will need to be referred back to the prescriber for either a new electronic prescription correctly written, or a non-EPS prescription.

11.7.1 Summary Care Record Access

If appropriate, access the patient's Summary Care Record to evaluate the prescription received against the information contained within the record.

11.8 Produce labels for items on prescription and record exemption status

Once the electronic prescription has been downloaded,

select the items which need dispensing and

print the appropriate labels

If the prescription charge exemption status is known then this should be entered accurately at the time of dispensing.

Check labels to ensure they are appropriate (ie no abbreviations).

A prescription with any additional information recorded in the directions areas of the prescription e.g. preservative free, specific brand etc. will need to be referred back to the prescriber for either a new electronic prescription correctly written, or a non-EPS prescription, in order to ensure correct payment.

Assemble items on prescription in line with the *Selection, Labelling and Assembly SOP.*

11.9 Perform accuracy check

Check against the prescription/dispensing token (not against dispensing labels). The supply of all medicines must be supervised by or carried out by the pharmacist in charge.

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11.10 Issue prescription items

The prescription should be bagged in accordance with the “Bagging-Up” SOP and delivered in accordance with the appropriate delivery SOP.

11.11 Record the status of prescription items

To complete the dispensing process, the whole prescription needs to be completed and each item should be marked as ‘**dispensed**’ or ‘**not dispensed**’.

‘Dispensed’ indicates the prescription item and quantity has been fully dispensed and delivered to the patient.

‘Not dispensed’ indicates there is no possibility of the item being dispensed.

There are two intermediate status markers which can be used:

With dispenser – partial: this indicates that part of the prescription item has been dispensed and will be completed when stocks become available.

With dispenser – owing: this indicates none of the prescription item has been dispensed and the item is likely to be issued at a later date.

Endorsements should be added electronically, as appropriate, and ensure that this is done accurately for correct payment from the NHS Prescription Services.

11.12 Send dispense notification to the spine

The exemption status information may need to be updated if this wasn’t initially known. The spine should be updated after each dispensing event has taken place (only once the patient has received part or all of their prescription). The dispense notification (DN) must not be sent until the prescription has been completed.

Where the Pharmacy dispenses an electronic prescription or makes an urgent supply without a prescription, the Pharmacy must send the form duly completed by or on behalf of the patient, if one is required under regulation 3(3)(b) or (c), (5C) or (5E) of the Charges Regulations in respect of that prescription (which may be the associated EPS token), to the NHS BSA.

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All final checks must be performed by the pharmacist on duty

11.13 Top tips for EPS

- Make sure you get all non-age exempt patient to sign a token – this includes each issue of a repeat dispensing regime.
- Setting up the system to print dispensing tokens with one click speeds up the process of printing tokens and preparing Release 2 prescriptions in the pharmacy considerably.
- Dispensers should find a location to store Prescribing and Dispensing Tokens separately to the FP10s to ensure they can be bundled and sent separately from the FP10s at the end of the month when claiming from the reimbursement agency.

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- You can print a prescription or dispensing token for the patient if they ask for a copy whenever required and send it to them by post.

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12. Prescription Owings

12.1 Objectives

Customers need to be informed of any stock shortages as soon as possible. They also need to be aware of the options available to them so that they can make an informed decision. Every attempt should be made to satisfy the patient that all efforts are made to obtain stock and rectify the shortage. The process will ensure that all patients will receive an owing slip generated using the PMR for items that contain owings.

12.2 Scope

The process for selection, labelling, and assembly of all prescriptions (NHS and private) except those for oxygen, special orders or monitored dosage systems.

12.3 Responsibility

Dispensers, Technicians, ACT's, Pharmacists and RP.

12.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

12.5 Process

- **Contact the patient/representative** – advise them of the nature of the owing, the estimated time of availability, and/or manufacturing/out of stock issue.
- If the patient does not want to wait for stock to become available then arrange for the prescription to be returned to them or returned to the NHS spine if EPS.
- Order sufficient stock.
- Generate owing labels using PMR and affix to owing slips – mark the owing slips with any relevant information including the patient contact details and 'CD' if it is a controlled drug. Note that owings slips may be provided electronically to patients
- Attach pharmacy and patient copy of owing slip to completed prescription.
- Store prescription and completed medication in the relevant place for owings.
- Stock arrives for prescription – update stock levels.
- Dispense owing and endorse prescription – ensure to dispense the owing following dispensing SOPs and with reference to the prescription.
- Mark owing slip to indicate owing is complete.
- Continue to Bagging Up SOP.

In a situation where it is clinically important that the patient receives part of the owing before the rest of the stock arrives, the following procedure must be followed:

- Attach the pharmacy copy of the owing slip to the prescription.
- Attach the patient copy of the owing slip to the dispensing bag - ensure this contains the estimated date of delivery of the remaining medication and continue to Bagging Up SOP.
- File the prescription in the relevant place for owings.
- When stock arrives follow procedures for owings.

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- Remember - If there is likely to be a clinically significant delay in dispensing the medication then refer to the Intervention & Problem Solving SOP for guidance.

12.6 Owings for CDs

All owings for CDs should have 'CD' marked on the owing slip and the customer should be contacted and informed that their prescription must be successfully delivered within 28 days.

Safe custody requirements should always be considered during the dispensing and owing process for CDs.

12.7 Owings that cannot be delivered

If an owing has been unsuccessfully delivered and the Prescription Delivery SOP has been followed then prescription will be stored for a period of 2 months. If it has not been successfully delivered at this point the following procedure should be followed:

- Prescription should be marked as 'not delivered' on PMR.
- Any suitable medication should have the labels removed and be returned to stock – medication is suitable to return to stock if the expiry date and batch number are still visible and the product has an acceptable shelf life.
- Any medication that is not suitable to be returned to stock should be discarded in a DOOP container.
- Prescriptions where no items have been dispensed should be returned to the prescriber, otherwise they should be given to the RP to annotate appropriately.

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13. Accuracy Check

13.1 Objectives

This process is to be followed after the proceeding SOPs and before packing any medicines for sending to the patient. This SOP is essential to ensure:

- Accuracy and quality in the proceeding processes.
- Adherence to the Proceeding SOPs.
- Any errors are identified and recorded as near misses.
- The checks of medication, quantity, strength, form, dose, expiry, and PIL are made.
- Ensure the 'dispensed by' checks have been performed.
- Ensure the correct bulk packs have been used.
- Ensure that split packs have been marked and dated in the case of liquids.
- Ensure that the split packs have the right medication inside them, taking care with the strength.
- To ensure that the supply of all medicines is supervised by or carried out by the pharmacist in charge.
- Ensure adjustment required due to disability have been made (Equality Act)

13.2 Risks

- Self-checking by the pharmacist.
- Distractions or interruptions.
- Unfamiliar or new medication, patients, or prescribers.
- Medication/items may be dispensed incorrectly; Similar looking packs may have been dispensed in error due to them being stored incorrectly. Similar sounding names may have been confused and selection of the wrong product may result.
- Medication may be out of date.
- Split packs may have the wrong products inside.
- Split packs may not have been marked and considered full packs.

13.3 Scope

The accuracy check of all NHS and private prescription dispensed, except monitored dosage systems.

13.4 Responsibility

Pharmacists and approved ACT's.

13.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

13.6 Process

REMEMBER: THE ACCURACY CHECK IS IMPORTANT. IT IS NOT JUST ABOUT GLANCING AT A COLLEAGUES WORK. THIS IS THE FINAL CHECKS BEFORE THE MEDICINE GOES TO THE PATIENT. EVEN WHEN THE PHARMACY IS BUSY IT IS IMPORTANT TO MAKE TIME TO CARRY OUT THIS CHECK CAREFULLY

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AND WITHOUT INTERRUPTION. THE DISPENSING PROCESS MUST BE CARRIED OUT UNDER THE SUPERVISION OF THE PHARMACIST ON DUTY.

FOR ANY SELF-CHECKING MAKE SURE YOU TAKE A “MENTAL BREAK” BETWEEN DISPENSING AND CHECKING – NOBODY THINKS THEY MAKE MISTAKES!!

- Ensure the dispenser or technician has marked the ‘dispensed by’ box.
- Check that all the prescriptions in the basket are for the same patient, by checking the name, address and DOB.
- Check the patient name and address on the labels against the prescription(s).
- Ensure the name and address on the bag label, correspond with the details on the prescription.
- Refer to the prescription and check each item in the basket corresponds and is correct. Pay attention to the following details:
- Check whether the patient requires any modification to normal dispensing process due to a disability (eg large type labels)

13.7 Product Checks

- Product name, quantity, strength and form.
- Check multiple packs of the same strength.
- Check the content of all the items against the prescription and carton.
- Take special care with split packs and similar looking packs and brands.
- Visually check the contents of the dispensed medication against the bulk packs of tablets, ensuring split packs have been marked.
- If dispensing liquids, check against the stock bottle/original bottle where relevant, and that the bottle has been marked with the date opened, on the bottle and corresponding carton.
- Check the medication will remain in date during its period of use.
- Check the packs contain the relevant PIL, if they don’t, print one off from www.medicines.org.
- Ensure warning cards are included, e.g. Lithium, Warfarin, Steroid and Methotrexate.

13.8 Label Checks

- Check the label against the prescription paying special attention to
  - patients’ name,
  - medication name, strength, quantity, form, dosage and
  - any warnings and cautionary information.
- Ensure the label has been placed on the inside pot, unless the size of pack does not allow.
- Ensure that the label has not obscured the product name, strength and form. Feed back to the dispenser on the most appropriate way to place the label. Ensure flagging of labels occurs where necessary.
- Initial the ‘checked by’ box on the label once the above accuracy checks have been completed.
- Consider if large text labels are required for patients with poor sight (check PMR)

13.9 Prescription Checks

- Ensure the correct endorsements have been recorded on the prescription and make any required changes
- Check the reverse of the prescription has been completed.
- Include spoons, measuring cups, or oral syringe as appropriate.
- If an error has been identified to have occurred in the assembly or labelling stage, refer back to the dispenser/technician involved to correct as soon as possible. Record as a near miss in the ‘Near Miss Log’. Ensure reviews of near miss incidents are performed on a regular basis.

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- Once you are happy that the *clinical check* and *accuracy check* has been performed on the prescription products, you may then proceed to the *bagging up* process straight away.

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14. Emergency Supply and Urgent Supply

Whilst the Distance Selling nature of the pharmacy is such that Emergency Supply is unlikely to occur as often as in a retail pharmacy, all staff must be aware of the procedures to be followed in the event of such a request.

14.1 Objectives

In an emergency Pharmacists are able to supply a POM without a prescription to a patient if requested by the following:

- Prescriber (Urgent supply at the request of the prescriber).
- Patient (Emergency supply at the request of the patient).

14.2 Risks

- Emergency request not genuine.
- Prescriber not genuine
- Prescription not fulfilled within 72 hours.
- Change of treatment regime.

14.3 Scope

The following is a list of prescribers that can authorise an emergency supply under certain conditions.

UK registered Prescribers:

- Doctor, Dentist, Supplementary Prescriber, Community Practitioner Nurse Prescriber, Nurse Independent Prescriber, Optometrist Independent Prescriber, Pharmacist Independent Prescriber.

EEA or Swiss registered prescribers:

- Doctor or Dentist.

14.4 Responsibility

Dispensing Assistants, Dispensing Technicians, Accuracy Checking Technicians, Pharmacists.

14.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

14.6 Process

14.7 Urgent supply at the request of a prescriber

The following conditions must apply to the request made by a prescriber:

- **Prescriber**

  The Pharmacist must be satisfied that the request is from the appropriate authorised prescriber, see list above. It is likely that, for repeat customers, the details of the prescriber will be known

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to pharmacy staff and included on the PMR system. The RP should still carry out appropriate checks on professional registers in order to satisfy themselves that the request is a legitimate one.

- **Emergency**

  The Pharmacist is satisfied that a prescription cannot be supplied immediately due to an emergency.

- **Prescription**

  The Prescriber agrees to provide a written prescription within 72 hours.

- **Directions**

  The medication is supplied in accordance with the prescriber's directions.

- **Controlled Drugs**

  An emergency supply cannot be provided for a Schedule 1, 2 or 3 CD except Phenobarbital for epilepsy by a UK registered prescriber.

  EEA prescribers cannot request an emergency supply of any Schedule 1 - 5 CD.

- **Records**

  An entry must be made in the POM register on the day of supply with the following details:

  - The date the supply was made.
  - The name, quantity, strength and form of the medicine.
  - The name and address of the prescriber requesting the emergency supply.
  - The name and address of the patient for whom the medication is supplied.
  - The date on the prescription.
  - The date on which the prescription is received in the Pharmacy.
  - The amount charged to the patient, if required.
  - The nature of the emergency (i.e. the reason for request).

In urgent cases, it may be possible for the prescriber to request verbally that an alternative be dispensed on the agreement that a new prescription will be supplied within 72 hours.

14.8 Summary Care Record Access

If appropriate, access the patient's Summary Care Record to evaluate the request received against the information contained within the record.

14.9 Emergency supply at the request of a patient.

The following conditions must apply to the request made by a patient:

- **Interview**
  The Pharmacist must interview the patient. The interview may not be by way of face to face contact and must be by other means, e.g., telephone, Live video.
- **Immediate Need**
  The Pharmacist must be satisfied that there is an immediate need for the medicine and that a prescription cannot be obtained from the prescriber.
- **Previous Treatment**
  The patient has been previously prescribed the medicine by an authorised prescriber. If the patient is requesting a medication which they have not previously been prescribed they must be referred to the appropriate prescriber.

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- **Dose**
  The dosage is correct and appropriate for the patient.
- **Controlled Drugs**
  Phenobarbital may be supplied to patients registered with a UK prescriber only for the treatment of epilepsy.
- **Duration of Treatment**
  For Phenobarbital and Schedule 4 and 5 CDs: Maximum quantity that will allow up to 5 days treatment.

- **Other POMs:** Maximum quantity that will allow up to 30 days treatment unless the medicine is:
  - Insulin, ointment/cream or an inhaler for asthma: supply the smallest pack available.
  - Oral Contraceptive: supply a full treatment cycle.
  - Liquid preparation of an antibiotic for oral administration: supply the smallest quantity that will provide a full course of treatment.

- **Records**
  An entry must be made in the POM register on the day of supply and include the following details:
  - The date the supply was made.
  - The name, quantity, strength and form of the medicine.
  - The name and address of the patient for whom the medication is supplied.
  - The amount charged to the patient if required.
  - The nature of the emergency (i.e. the reason for request).
- **Labelling**
  The label for the dispensed medicine must contain the words “Emergency Supply”.

14.10 Faxed Prescriptions and Prescriptions Received in Non-Standard Forms

A faxed prescription does not fall within the definition of a legally valid prescription because it is not written in indelible ink, and has not been signed by an appropriate practitioner. A faxed prescription can confirm that at the time of receipt a valid prescription is in existence, however, prescribers should now use other methods (such as scans via secure NHS mail) to send these requests.

Prescriptions send as attachments, even via NHS email are also not legally valid and should be considered in the same manner. These types of prescriptions and faxes are referred to here as “non-standard”

The pharmacy cannot dispense against non-standard prescriptions and instead should use the Emergency Supply procedures if supply is required urgently.

- **Payments for Emergency Supplies at the Request of the Patient**
  Emergency supplies should be priced on the same basis as private prescriptions, subject to the professional judgement of the pharmacist on duty. It is company policy to charge for emergency supplies. However if the patient is able to send a prescription form to cover the item supplied within five working days you may offer a full refund. It is our policy to never refuse treatment only because of an inability to pay and the RP must use their professional judgement to assess each situation that arises.

As detailed above the patient should be interviewed over the phone. Payment can be processed via the website or over the phone. The pharmacist may wish to consider the following before providing an emergency supply at the request of the patient:

- You should consider the medical consequences of not supplying.

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- You should identify the patient by documentary evidence or personal knowledge.
- You should identify the prescriber who prescribed the medicine on a previous occasion.
- You should ask the patient whether the doctor or dentist has stopped the treatment
- You should ask the patient if any other medicines are being taken at the same time to check drug interactions.
- An emergency supply should not be made if the item requested was prescribed more than six months prior to the request.
- Give less than 30 days' supply if this is appropriate.

Under legislation enacted in November 2008 it is now permissible to make an emergency supply to patients previously prescribed a POM (excluding all Scheduled CDs i.e. 1-5) by an EEA/Swiss registered prescriber (including Dentists). Prescribers from these countries can also request an emergency supply for a patient. In this case the original prescription must be provided to the pharmacy within 72 hours

14.11 Delivery of Urgent and Emergency Supply Items

Given the nature of a request of this type, the Pharmacy should prioritise delivery of the medication to the patient. For local deliveries the driver should be specially informed of the fact that the items are "URGENT" and for any items delivered by courier, the company must be informed that items must be delivered ASAP by the quickest route possible. The Pharmacy must not charge additional fees to the patient even if these are incurred in the delivery process.

Refer to relevant delivery SOP for further information on the delivery process.

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15. Supply in Accordance with a PTP

15.1 Objectives

"PTP" means a pandemic treatment protocol, which is a protocol—

(a) relating to the supply of a prescription only medicine to be used for the prevention of or as a treatment for a disease that is, or in anticipation of it being imminently, pandemic; and

(b) approved in accordance with regulation 247 of the Human Medicines Regulations 2012(4) (exemption for supply in the event or anticipation of pandemic disease);".

15.2 Risks

Emergency request not genuine.
Prescriber not genuine

15.3 Responsibility

Dispensing Assistants, Dispensing Technicians, Accuracy Checking Technicians, Pharmacists.

15.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

15.5 Process

The following conditions must apply to the request

- Message received via a secure service approved by NHSCB
- Message must amount to an order for the supply of a drug
- The order must be in accordance with the PTP

In any case where such an order is believed to have been received the order should be referred to the RP.

The RP must check the relevant PTP to ensure compliance with its particular terms.

If a person who is entitled to be supplied with the relevant drug under the protocol requests the drug in accordance with that order then the pharmacy must, with reasonable promptness, provide that drug and follow the delivery process relevant for the class of drug ordered.

The RP should (and if requested to do so by the person being supplied must)

- Provide an estimate of the time the drug will be ready and delivered.
- If the drug is not ready by the time then provide a revised estimate of when the drug will be ready and continue to update the patient on this time should the estimate change.
- Contact the patient to confirm dispatch of the medication.

In addition to the normal requirements, the dispensing label on the packaging of the product supplied must also contain the additional wording shown below;

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THIS PRODUCT IS BEING SUPPLIED IN ACCORDANCE WITH THE [INSERT NAME] PANDEMIC TREATMENT PROTOCOL

And insert the name of the relevant protocol.

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15.6 Refusal to Supply under PTP

The pharmacy may refuse to provide an order for a drug that is or is purportedly in accordance with a PTP where—

(a) The RP reasonably believes it is not a genuine order for the person who requests ,or on whose behalf is requested, the provision of the drug;

(b) providing it would be contrary to the RP's clinical judgement;

(c) The RP or other persons are subjected to or threatened with violence by the person who requests the provision of the drug, or by any person accompanying[2] (see footnote re "accompanying") that person; or

(d) the person who requests the provision of the drug, or any persona accompanying[3] (see footnote re "accompanying") that person, commits or threatens to commit a criminal offence.

The pharmacy must refuse to provide, pursuant to a PTP, an order for a drug that is or is purportedly in accordance with the PTP where P is not satisfied that it is in accordance with the PTP.

Any refusal to supply must be noted on the patient and / or pharmacy record system.

15.7 Summary Care Record Access

If appropriate, access the patient's Summary Care Record to evaluate the prescription received against the information contained within the record.

[2] As a DS pharmacy patients will not be attending in person and accompanying should be considered in terms of another person who may contact the pharmacy about the patient.
[3] As a DS pharmacy patients will not be attending in person and accompanying should be considered in terms of another person who may contact the pharmacy about the patient.

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16. Bagging-Up

16.1 Objectives

This SOP will ensure:

- The correct products are placed in the prescription bag
- The completed prescription bag is stored in the correct location
- Any split packs, bulk packs of medication remaining after the dispensing process are returned to the appropriate area.

This SOP is essential to ensure the correct medication is packed with the correct bag label and corresponding delivery label. It is to ensure that the medicines are stored and then dispatched under the correct conditions for that particular medicine. It also ensures that the patient receives any relevant information in relation to their treatment in the form of the delivery note, owing labels, PIL and help and advice leaflets and any relevant service leaflets that the patient may benefit from.

16.2 Risks

- Wrong bag label placed on wrong bag.
- The contents of the bag mixed with the contents of another patient's bag.
- The original pot/container being bagged as well.
- The contents are not complete and not bagged.
- The additional labels indicating storage requirements have not been used, resulting in chilled items or CD not being stored correctly.
- Multiple bags not being marked appropriately so rendering an "undelivered" status.

16.3 Scope

This SOP covers the procedure for packing and labelling of all NHS and private prescription orders, and all online orders for non-prescription medicines, except monitored dosage systems.

16.4 Responsibility

Dispensing assistants, Dispensers, Technician and Pharmacists.

16.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

16.6 Process

- Ensure that the basket contents have all been checked; indicated by the 'checked by' box being marked.
- Ensure that any bulk packs have been removed and are at no risk of being bagged up as well.
- Ensure that the contents of the basket are labelled for the patient as detailed on the prescription and correspond with the delivery note being placed in the bag.
- Check that the delivery label matches the patient details on the prescription, order voucher and medicine bag.

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- Check that FMD codes have been printed properly on the bag
- In the case of non-prescription orders; ensure that the contents of the basket contain the products as per the order and against the corresponding delivery note.
- Ensure that all medicines have been supplied with Patient information leaflets and any relevant advice leaflet in relation to health promotion, whether it is general advice to all patients and/or targeted specific advice based on patient's disease state.
- In the case of owed medication, attach an owing label to the delivery note with an estimation of when the medication will become available.
- Ensure that a return address for the pharmacy is marked onto the package.
- Mark the package with the words 'Urgent Medical supplies' but do not describe exactly the contents of the package.
- Place a 'Private & Confidential' label on the package.
- Label the parcel according to the required storage conditions i.e. 'store in a refrigerator 2-8*C'.

16.7 Choice of Packaging

- Choice of packaging will depend on the nature of the items being delivered and the appropriate level of protection must be used to ensure that the item can withstand the normal rigours of the delivery process.
- All packaging must have the tamper proof seals provided in the pharmacy attached to the packaging so that any tampering with the packaging will be evident.
- Medicine for local delivery which is not fragile and to be delivered by the delivery driver can be packaged in the using the pharmacy bags supplied for standard prescription items.
- DO NOT use normal cardboard boxes. When cardboard boxes are required ALWAYS use the re-enforced boxes that are purchased for delivery purposes.
- For postal items, either:
  - At the very least - padded envelopes even for non-fragile items as this will help to ensure the integrity of the manufacturers packaging.
  - For most items - bubble wrap and where necessary, polystyrene filler, placed within a cardboard box. **use the re-enforced cardboard boxes**
- Large or any fragile medicines should be packed into the re-enforced cardboard boxes with bubble packaging and filling material to protect from damage.
- Coldchain items should be bubble wrapped and placed in Styrofoam filled re-enforced cardboard boxes and kept in the DELIVERIES FRIDGE (rather than the storage fridge) with the "FRAGILE" and "FRIDGE LINE" stickers attached. The courier company will transport the boxes in vans with cold chain sections that protect the integrity of the box ("cold ship" packaging) and are fully monitored – typically at 2 to 8 degrees Celsius range- (see delivery SOP). Pharmacy staff should be aware that some thermolabile products can be damaged by excessive cold as well as heat. Items such as ice packs can cause freezing in medicines which is damaging to them and such items <u>must not be used</u>.

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17. Order Delivery

17.1 Scope

The process for delivery of prescriptions to the patient's chosen address and the provision of information and advice to patients to whom drugs are supplied about the safe keeping of drugs and return of unwanted medicines.

17.2 Objective

This SOP will ensure that:

- Prescriptions are delivered safely and securely
- A robust audit trail is maintained
- Medication is properly delivered
- Patients are aware of missed deliveries and can easily arrange re-delivery.
- Patients receive information on safe keeping and return of unwanted medicines.

17.3 Risks

- Delivery to the wrong person/address.
- Missed deliveries.
- Deliveries of CDs.
- Multiple deliveries of medication.
- Full quantity not supplied.

17.4 Responsibility

Dispensing Assistants, Dispensing Technicians, Accuracy Checking Technicians, Pharmacists, Delivery Drivers.

17.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

17.6 Choice of Delivery Method

For items **other than** cold chain / "fridge line" items, local deliveries (up to 30 miles radius, but may be extended at the discretion of the RP) the delivery driver should deliver medication. Outside this area Royal Mail should be used unless the prescription is for a controlled drug, in which case the nominated controlled drugs courier should be used (see SOP for Delivery of Controlled Drugs), or the items are fridge lines, in which case the cold chain courier should be used (see below).

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17.7 Process

17.8 Preparation for delivery

1. **Ensure that prescriptions for delivery are securely bagged and appropriately labelled.**

2. **Complete the Delivery Driver Record Pad with the:**

   - Patient name and address (a bag label can be used) and alternate delivery address if appropriate
   - Any messages for the patient/representative
   - Authorisation has been obtained to deliver to a third party, if appropriate, in writing.

3. **Pack the prescription bag and any other items for delivery securely in the appropriate outer packing.** Ensure that all relevant paperwork and any notes from the pharmacist are included.

4. **Send a confirmation message to the patient via their preferred method of non face to face communication to let them know that their items are ready for delivery and confirm the estimated delivery time.**

17.9 Inclusion of Information on Storage and Return

The pharmacy Terms of Service state that a pharmacy must provide appropriate advice to patients to whom drugs are supplied about the safe keeping of drugs and return of unwanted medicines.

For new patients, written information on safe storage and the returns process should be included with new deliveries. Patients should also be directed to the pages on the pharmacy website that provide details on the safe storage and return of unwanted medicines.

17.10 Transfer to the Delivery Driver

- Ensure that the pharmacist on duty is available to supervise the handing over of all items for delivery.
- Ensure that any special instructions for the delivery are included with the packaging.
- Ask the delivery driver to check the details on the delivery sheet correspond to the deliveries.
- Ensure the delivery driver completes all the sections on the delivery sheet including their name and the date.
- Ensure that any deliveries for fridge items and CDs are taken out of storage when appropriate.
- Ensure the delivery driver is notified of any messages for the patient or representative.
- Make and retain a copy of the delivery sheet until the original has been returned by the delivery driver. The original must be returned to the pharmacy on the same day.
- Ensure the deliveries are placed in the delivery vehicle and are stored securely and out of sight. The delivery vehicle must be locked at all times when left unattended.
- At hand-over to the driver / courier ensure that any current falsified medicines regulation or guidance is followed.

17.11 Delivery of prescription to patient or representative address

- The delivery driver must not enter the patient or representative's home unless invited to do so at the time.
- The patient should be referred to the pharmacist should they have any query about how to use their medication safely and appropriately.

1. **Ask the patient/representative for their name and address.**
2. **Check the patient name and address against the prescription and the bag label.** Patient confidentiality should be maintained at all times, especially if delivering to a representative.
3. **Where appropriate ask the patient or representative to complete the reverse of the prescription.**
4. Hand the medication to the patient or representative.

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5. **Ask the patient or representative to sign their details on the delivery sheet**. If they are unable to sign the delivery sheet the delivery driver should sign on their behalf with their consent and write a note explaining the reason the patient or representative could not sign.
6. **If necessary, collect any medication returns**. Always use the Patient Returned Medication Tray that is available in the delivery vehicle. Refer to the Patient Returned Medicines SOP for further guidance.

17.12 Successful delivery

Once the deliveries are completed, return the delivery sheets to the pharmacy on the same day. The delivery sheets must be stored safely for a minimum of 3 months.

17.13 Unsuccessful Delivery

1. If the patient or representative is not able to receive the delivery of their medication, complete the 'attempted delivery' form and post it through the letterbox. The form will have details for arranging re-delivery.
2. The prescription and medication must be returned to the pharmacy on the same day and the pharmacist informed of the unsuccessful delivery.
3. The pharmacy should follow up the unsuccessful delivery by contacting the patient to arrange a second delivery time.
4. **DO NOT:**
    - Post the medication through the letter/post box.
    - Leave the medication in the porch or any other out building.
    - Leave the medication at an unauthorised address.

17.14 Delivery of a prescription via Royal Mail (Not for Cold Chain or CDs)

1. Follow preparation for delivery process. The pharmacist should contact any patients for whom there are relevant messages or counselling required.
2. Ensure that the pharmacist on duty is available to supervise the handing over of all items for delivery.
3. Print and attach relevant Royal Mail Signed For delivery labels using the Royal Mail online business account and attach securely to outer packaging.
4. Ensure a return address is printed clearly on the outer packaging.
5. Confirm details of all prescriptions to be delivered.
6. Make a note of all Tracking numbers for prescriptions being delivered by Royal Mail on Delivery Log sheet.
7. Ensure Royal Mail driver signs Delivery Log sheet for all prescriptions being accepted for delivery. Store Delivery Log sheet for a minimum of 3 months from dispatch date.
8. Email patients dispatch confirmation with their Tracking number when the prescriptions have left the premises.
9. All deliveries will require a signature from the patient to confirm receipt of their prescription.

17.15 Unsuccessful Delivery via Royal Mail

In the event of an unsuccessful delivery, Royal Mail will leave a 'Sorry We Missed You' card, stating the date and time of the attempted delivery. The patient can then either choose to collect and sign for their medicines at their local post office, or rearrange delivery for a convenient time by telephone or email.

17.16 Cold chain delivery via courier

Explanatory Notes:

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See "Bagging Up" SOP for cold chain packaging guidance

All cold chain deliveries must be carried out by couriers with verified and approved cold chain procedures. A list of approved cold chain couriers is available within the Pharmacy and will be updated from time to time. Each approved courier meets stringent criteria to ensure a fully monitored and dedicated cold chain service.

Specialist cold chain courier service will ensure the integrity of the cold chain and the maximum stability of thermo-liable drugs by packing, transporting and delivering in such a way that their integrity, quality and effectiveness are always preserved. This is a dedicated, fully monitored and temperature controlled delivery service.

Any breach of cold chain conditions will be notified to the driver and any affected delivery will be cancelled with the pharmacy informed of the cold chain breach.

CURRENT (NOMINATED) COLD CHAIN COURIER COMPANY IS…………………

ALTERNATE COLD CHAIN PROVIDER……………………………….

Staff should confirm with the RP if wishing to use a courier company other than the NOMINATED courier above.

1. Ensure any items for cold chain delivery via courier are stored in the fridge and accompanying items are appropriately marked with a fridge line sticker. Accompanying items should include a note to explain that fridge items will be delivered separately to the rest of their items to enable the cold chain to be maintained.

2. Ensure that the pharmacist on duty is available to supervise the handing over of all items for delivery.

3. A delivery should be booked using the couriers specified Cold Chain Services (refer to booking procedure with courier in the "cold chain courier" folder),

4. Select a delivery maintaining 2– 8°C unless the item requires shipping at a different temperature.

5. The cold chain item should be kept in the fridge until the courier arrives to accept the delivery.

6. Confirm with the courier that the delivery will be maintained at the booked temperature range.

7. Confirm details of all prescriptions to be delivered.

8. The courier must scan a barcode sticker for each item. The pharmacy retains a copy of the barcode which is also the tracking number.

9. Make a note of all Tracking numbers for prescriptions being delivered by the courier on Delivery Log sheet.

10. Ensure courier signs Delivery Log sheet for all prescriptions being accepted for delivery.

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11. Remove items from the DELIVERY FRIDGE and match against the delivery log and place a copy of the barcode sticker on the packaging.

12. At hand-over to courier scan the aggregated FMD code (the system will disaggregate the unique identifiers and forward them to the NMVS for decommissioning)

13. Give all fridge line deliveries to the courier.

14. Store Delivery Log sheet for a minimum of 3 months from dispatch date.

15. Contact the patient and dispatch confirmation with their Tracking number when the prescriptions have left the premises. Live tracking with estimated ETA is available via the courier website.

16. All deliveries will require a signature from the patient to confirm receipt of their prescription.

17.17 Unsuccessful cold chain delivery via courier

In the event of an unsuccessful delivery, the courier will leave a 'Missed Delivery' card, stating the date and time of the attempted delivery along with details of how to contact the courier to arrange the redelivery. The patient can then rearrange delivery for a convenient time by telephone or Internet.

We operate to a 48 hour maximum window for cold chain deliveries and the courier will keep the cold chain intact until successful delivery for up to 48 hours. After 48 hours the items will be returned to the pharmacy and the pharmacy will contact the patient to rearrange delivery.

17.18 Breach of Integrity of Cold Chain

The courier ensures temperature integrity throughout the supply chain, from point of collection & goods-in to pharmaceutical storage to final delivery.

The cold chain service is a dedicated, fully monitored and temperature controlled delivery service. However, in the event of any breach in the integrity of this service, the system automatically alerts the delivery driver that the cold chain has not been kept intact.

Where such an event occurs, the courier is instructed to leave a 'Missed Delivery' card and also inform the pharmacy that the delivery was unsuccessful due to a breach of the cold chain. The pharmacy must arrange for immediate re-delivery of the items via courier and the return of the items that have failed to be delivered to the pharmacy by the courier. items subject to a cold chain breach may not be re-used and must be segregated from the pharmacy stock.

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18. Safe and Effective Storage of Medicine

18.1 Objectives

- Understand how to maintain an effective cold chain for chilled items.
- Evidence that pharmaceuticals are continuously stored within the manufacturer's product license specifications.
- Ensure that refrigerators are maintained and operated correctly to ensure that the temperature is within the recommended guidelines (between 2°C and 8°C).
- Correct procedures are followed if there is a breach of the cold chain storage conditions.
- Stock is properly rotated

18.2 Risks

- Incorrect storage of medicines which require cold storage.
- Use of domestic refrigerators is a risk as they do not maintain and equal temperature within the appliance.
- There is a risk of the refrigerator failing to maintain within the required temperature range, due to power failure or a refrigerator breakdown.
- If the refrigerator temperature is not being monitored and recorded daily this results in a failure to identify any faults with the refrigerator or breach of cold chain.
- Dispensing or supplying short dated or expired medication.

18.3 Scope

Receiving and storage of ambient medicines including Sch 2 & 3 CD's and the recording of the Pharmacy fridge temperature.

18.4 Responsibility

Dispensers, Technicians, Pharmacists and Responsible Pharmacist.

18.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

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18.6 Process

Authorised Dispensary Staff

Before signing for receipt of medicinal goods:

- Check that the number of outer packages which you are signing for matches the delivery documentation, and that the outer packages are for your pharmacy.
- Check that refrigerator packages are accounted for.
- Where a discrepancy arises, amend the documentation before signing.
- Containers which were not ordered should not be received and should be taken back by the wholesaler.

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Pharmacists

Also refer to 'Controlled Drugs: Receipt & Storage'. Before signing for receipt of schedule 2 or 3 controlled drugs (CD)'s:

- Open the outer packaging (usually an envelope or blue bag) to view the items.
- Confirm the name, quantity, strength, formulation and expiry date of the product matches the documentation you are signing for.
- Check that the manufacturer's tamper-evident seal is intact.
- If you receive Items that were not ordered or where the manufacturer's tamper-evident seal is not intact, the wholesaler should be contacted immediately to seek further guidance on their returns policy. If they advise not to accept then do not sign for the delivery and hand it back to the delivery driver.
- Where a discrepancy arises, amend the documentation before signing where necessary.
- Make an entry into the CD register for any schedule 2 CD received immediately (or in exceptional circumstances, by the next day).
- Check the running balance is correct for the specific CD.
- Store schedule 2 CDs in the CD cupboard making sure that products with the longest expiry are placed behind the same product with a shorter expiry.
- Store schedule 3 controlled drugs (unless exempted) in the controlled drugs cupboard.
- Lock the cupboard and secure the CD key.

18.7 Checking the order and putting away the stock

- Fridge items should be dealt with as a priority.
- Work in a clear and uncluttered space.
- Place the contents of a medicines container onto the work space.
    - Group multiple packs of the same medicine together.
    - Check each medicine against the invoice.
    - Check the expiry date of medicine received.
    - Isolate medicines from the order which have been ordered in error.
    - Isolate medicines from the order which are short-dated or expired.
    - Isolate medicines which are leaking or damaged.
    - Make a note of items ordered which are missing from the order.
    - Keep invoices for 6 years.
    - Store fridge items in the fridge, making sure those products with the longest expiry are placed behind the same product with a shorter expiry.
    - Do not place items directly against the cooling plate to avoid freezing the product.
    - Where possible allow a finger width between each group of products.
- Store all other items in the appropriate area making sure that products with the longest expiry are placed behind the same product with a shorter expiry.
- Repeat until all containers have been emptied.

18.8 Returning medicines ordered in error

- Locate and complete the applicable returns documentation.
- Obtain prior authorisation for the return of the medicines if applicable.
- Return the medicines to the supplier delivery driver when it is next practicable to do so.
- Ensure that the delivery driver signs the applicable documentation and a copy is retained in the pharmacy.
- When the credit note is received indicate this on the returns documentation.

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18.9 Dealing with missing items

- Locate and complete the applicable missing medicines documentation.
- Ensure that the supplier delivery driver signs the applicable documentation and a copy is retained in the pharmacy.
- Re-order the missing medicines where necessary.
- When the credit note is received indicate this on the missing medicines documentation.

18.10 Date checking & stock rotation

- Using the current date checking matrix:
  - Record details on the quarterly date checking matrix.
  - Fill in the applicable year.
  - Fill in the applicable quarter.
  - Fill in the schedule with the week commencing (w/c) dates.
  - Amend the areas of the pharmacy to be checked according to the requirements within the pharmacy remembering that all medicines must be covered by the date checking matrix.
  - Include over-the-counter medicines within the date checking matrix.
- All pharmacy stock must be date checked every 3 months according to the schedule.
- Remove all the pharmacy stock from the area which is to be date checked.
- Wipe and clean the date check area.
- Check the expiry date for the products.
- Isolate any pharmacy stock with an expiry of less than 1 month. Also isolate any stock which would expire before it could be fully used if it were dispensed now – for example where the pack is for a quantity for more than a month's supply such as a triple pack.
  - Make a record of this stock for stock check purposes and write off the stock.
  - Dispose of this stock following the 'Safe & Effective Disposal of Medicines' SOP.
  - For any other pharmacy stock which will expire within the next 4 months, write down details and batch numbers– Record the details in the Date expiry table for the appropriate month.
- Use a small sticky coloured label to "flag" the short dated stock.
- Return remaining stock to the shelf making sure that stock with the shortest expiry date is placed where it will be used first.
- Complete the date checking matrix by signing to declare that the pharmacy stock has been date checked for that area.
- On a monthly basis check the relevant monthly expiry table for products expiring in that month.
  - Locate and remove any products which have not been dispensed in the interim.
  - Make a record of this stock for stock check purposes and write off the stock.
  - Dispose of this stock following the 'Safe & Effective Disposal of Medicines' SOP.

18.11 Temperature and environment

- Medicines must be stored according to individual manufacturers' requirements and away from direct sunlight, heat source or moisture.
  - Items requiring storage between 2-8°C must be stored in the refrigerator.
  - Items requiring storage in a "cool dry place" or below 15°C must be stored under these conditions or otherwise in a refrigerator.
  - Where possible products should be stored in the body of the fridge, not on the floor, drawers, in the door, or near to a freezer compartment. This is especially important for

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high-risk cold chain products such as insulin and vaccines. The fridge should not be overloaded or packed too tightly to allow the flow of cold air.

- Food and drink must not be stored in the pharmacy fridge.
- Where items have been stored in adverse conditions then the stability of the product must be considered in light of the duration of time that the medicine was exposed to adverse temperatures.
- Contacting the manufacturer for further information may be necessary.
- Medicines considered to be unstable must be written off and disposed of.

On a daily basis:

- Check the fridge temperature and record the maximum and minimum temperature into the 'Fridge Temperature Record Chart'.
- 'Fridge Temperature Record Charts' should be retained for the life of any product which has been stored within. In practice this means that the records may need to be kept for years.
- Reset the thermometer following the manufacturer's instruction.
- Where the temperature falls outside of the 2-8°C range then assess the maximum length of time that the medicines have been exposed to temperatures outside of the recommended range.
- Record any findings and actions taken on the record chart along with details of who performed the actions.

Cold chain breaches

It is the professional judgement of the RP on duty to determine if the cold chain has been breached sufficiently to make supply of the medications inappropriate or unsafe.

The length of time that the product has been out with the guideline temperature should be a factor in consideration.

Contact the manufacturers of each medicine for guidance on the stability of the medicine, as they may not be suitable for supply to patients. Supply of a medicine that has not been stored in accordance with the manufacturer's storage requirements will be outside of the product licence for the medicine. The Responsible Pharmacist must use their professional judgement to determine if such a supply is appropriate.

- Medicines considered to be unstable must be written off and disposed of following SOP 'Safe & Effective Disposal of Medicines'.

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19. Controlled Drugs: Receipt and Storage

19.1 Objective

The safe and secure receipt and storage of controlled drugs in the Pharmacy.

19.2 Scope

This SOP, therefore, covers only those CDs which are in Schedules 2, 3, 4 and 5, with the exception of Sativex spray.

19.3 Responsibility

Dispensers, Technicians, Pharmacists and Responsible Pharmacist.

19.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure

19.5 Process

19.6 Accepting schedule 2 and 3 CD's in the Pharmacy

- The RP must accept Schedule 2 and 3 CDs.
- All stock received should be physically checked. The stock must be in good condition and tamper seals must be intact.
- The expiry date must be checked. Different types of stock will have different expiry times, but you should not accept any stock that has less than 12 months unexpired shelf life unless it is for a specific prescription and will be dispensed and used by the patient prior to expiry.
- Check that the correct item has been ordered and delivered.
- Check the quantity ordered matches the quantity delivered and the quantity on the invoice.
- If all details are correct then sign the delivery note and return this to the driver.
- If the delivery is incorrect, damaged or short dated refer to section below '*Dealing with an incorrect/damaged delivery.*'
- Enter all relevant CD stock into the CD register as soon as possible (on the same day)
  - Include the invoice number in the entry in the CD register — this is useful for tracking any errors in entry or discrepancies.
  - Carry out a stock check and verify the balance in the CD cabinet; enter the new balance (the sum of the existing stock plus the new stock)
  - If there is a discrepancy refer to SOP 'Controlled Drugs Stock balance checks'.
- Items subject to Safe Custody Regulations must be stored in the CD cabinet immediately — this includes ALL Schedule 2 CDs and certain Schedule 3 CDs. Refer to the 'Medicines, Ethics & Practice Guide' for a comprehensive list of CD schedules.

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19.7 Dealing with an incorrect /damaged delivery

- If the order contains incorrect stock, stock with a broken tamper-evident seal, damaged or short-dated stock, contact the wholesaler immediately before accepting the delivery from the driver and confirm the returns policy for incorrect/damaged stock.

19.8 Delivery

- Follow the guidance issued by the wholesaler regarding the returns procedure and/or claims procedure if damaged or incorrect stock is received, completing any necessary paperwork.
- If the damaged stock involves a broken bottle of a CD liquid (for example Oxycodone solution):
  - Refer to section "Damaged stock that cannot be returned to the wholesaler".
- If the delivery driver is unable to return the stock immediately and it has to be accepted by the pharmacy, enter any stock into the CD register if there is a legal requirement to do so.
  - Annotate the register using an asterisk (*) and explanatory footnote to state that the item is awaiting return to the wholesaler and include a reason
  - Record full details in the pharmacy interventions book.
- Store any stock that is to be returned to the wholesaler and is subject to the safe custody requirements in the CD cabinet
  - Separate from normal dispensing stock
  - Place in a bag and clearly label to show that it is awaiting return to the wholesaler
- Other CD stock, not requiring storage in the CD cabinet, and awaiting return to the wholesaler should be stored on the Returns Shelf (Quarantined area marked with red tape)
- Check whether the damaged/incorrect stock needs to be re-ordered urgently — in order to fill a prescription, for example.
- Re-order replacement stock and contact the patient, if necessary, to advise them of any likely delay in filling their prescription.
- Manually update any stock levels held on the pharmacy automatic ordering system to reflect the correct stock levels, if appropriate.

19.9 Collection of incorrect /damaged stock by the wholesaler

The pharmacist must supervise this process

- Confirm the identity of the delivery driver from the wholesaler.
- Check that the paperwork supplied by the wholesaler is correct and is for the item and the quantity that was incorrectly ordered or sent.
- Remove the items from the CD cabinet (or other location); remove from the labelled bag and reconfirm the item and quantity to be returned.
- Complete the paperwork, and sign and print name as appropriate.
- For CDs recorded in the CD register, enter the quantity of CDs returned to the delivery driver— include the reference number on the paperwork for audit purposes.
- Confirm that the balance of the product indicated in the CD register matches the actual balance of stock remaining in the CD cabinet.
- Manually update any stock levels held on the pharmacy automatic ordering system to reflect the correct stock levels, if appropriate.

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19.10 Damaged stock that cannot be returned to the wholesaler

- This includes damaged stock of liquid CDs.
- Contact the wholesaler immediately (refer to the Pharmacy Tel. directory) before accepting the stock and confirm what the policy is for damaged stock that cannot be returned.
- If the wholesaler insists that the pharmacy accepts the stock due to the delivery driver not being authorised to return any damaged stock, the product must be treated as pharmacy stock and a claim for credit raised with the wholesaler.
- Stock of Schedule 2 CD liquids that is damaged needs to be disposed of in the presence of an authorised witness as soon as possible.
- The authorised witnesses for this pharmacy can be contacted.
- Refer to the SOP "CD: Disposal of pharmacy stock)" for the disposal (including denaturing) of damaged CD stock that cannot be returned to the wholesaler.

19.11 RP not signed in

The RP will be signed in during core and supplementary hours, but there may be an occasion when a wholesaler attempts delivery outside of these hours when other pharmacy staff are still on the premises carrying out other activities.

- Delivery **cannot** be accepted unless the RP is signed in and in control of the process.
- If there is no written authority and/or the wholesaler will not leave CDs without the presence of a pharmacist, contact the RP to establish the time when they will be in control of the pharmacy.
- Contact the wholesaler to inform them that delivery cannot be accepted at the present time and give an approximate time when the RP will be in control of the pharmacy.
- If there has been an attempted delivery of CDs in the absence of the RP, notify the RP as soon as they are present in the pharmacy that there has been an attempted delivery.

19.12 Storage of CDs

- The Responsible Pharmacist takes **overall** responsibility for the CD key and the RP should have the key on them throughout the working day.
- In this pharmacy, CDs are stored in the CD Cabinet.
- The CD cabinet must be kept locked at all times.
- Prescriptions awaiting collection that contain CDs requiring safe custody must be stored in the CD cabinet until collection by the delivery driver, including medicines dispensed in a compliance aid.
- Out-of-date CD stock and unwanted patient CDs requiring safe custody must be clearly marked and segregated from the regular stock.
- The CD cabinet must not indicate on the outside that CDs are contained within.
- At the end of the working day, the CD key is placed in an envelope, signed by the authorised key holder (RP), dated and sealed and handed to the Pharmacy Manager.
- The key is then stored in the safe.
- At the start of the next working day, the CD key holder (RP) should confirm that the envelope has not been tampered with, before opening.

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20. Controlled Drugs: Dispensing

20.1 Objective

This SOP looks at the supply of schedule 2, 3, 4 and 5 CDs against prescriptions. This process is intended to be read alongside the Medicine, Ethics and Practice Guide, which gives an in-depth explanation of the legal requirements around the dispensing of CDs.

20.2 Scope

The SOP looks at the dispensing of schedule 2, 3, 4 and 5 CDs against a NHS prescription, private prescription or a requisition.

20.3 Responsibility

Dispensers, Technicians, Pharmacists and Responsible Pharmacist.

20.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

20.5 Process

20.6 Receipt of Prescription

- Refer to the factsheet in Appendix 7 ‘Controlled Drugs - legal requirements’ for guidance on the legal requirements for CD prescriptions.
- Refer also to the factsheet in Appendix 8 ‘Controlled Drugs - practical guidance’.
- Refer to the normal dispensing SOPs as they form the basis of the dispensing process.
- Confirm the prescription is legally correct and on the correct type of prescription form.
- If the prescription has any legal requirements missing, is out of date, or is written on the incorrect prescription form then contact the prescriber as per SOP ‘Interventions and Problem Solving.
- If the error is a typographical error that can be amended then the pharmacist can proceed as follows:
    - The only changes that pharmacists can make are:
        - minor spelling mistakes;
        - minor typographical mistakes (this may include, for example, a number being substituted for a letter or two letters being inverted but where the prescriber’s intention is still clear); and/or
        - Where the total quantity of the CD/number of dosage units is specified in either words or figures but not both, a pharmacist can add either the missing words or figures as required (but not both)
    - In doing this, pharmacist must exercise due diligence and be satisfied that the prescription is genuine and the CD is being supplied in accordance with the intention of the prescriber. The prescription must be amended in ink or otherwise indelibly and the pharmacist must mark the prescription so that the amendment is attributable to

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him or her, for example by signing the amendment. If there is more than one amendment on the same prescription, each amendment must be marked.

  - Where an amendment is made by one pharmacist and another pharmacist makes the supply, the Home Office has advised that the second pharmacist should also mark the amendment to indicate that he is also satisfied and it is attributable to him as well.

- Check that there is sufficient stock of the CD(s) to fulfil the prescription. Follow guidance from SOP 'Prescription Owings'.
- Ensure that the reverse of the prescription has been completed with payment/exemption details. If incomplete, then from reference to the patient's registration documentation, and sign as the representative, if applicable. If proof of exemption has not been provided contact the patient to obtain a copy of this for the records.
  - The driver is then required to sign in the appropriate blue box on NHS prescriptions on collection of Schedule 2 and 3 CDs for delivery.

20.7 Summary Care Record Access

If appropriate, access the patient's Summary Care Record to evaluate the prescription received against the information contained within the record.

20.8 Legal and clinical check of the prescription

- If the prescriber is unknown, contact the prescriber to confirm the validity of the prescription.
- Do not use the telephone number on the prescription — use an alternative source to independently verify the telephone number.
- This pharmacy uses:
  - Directory enquiries: 118 118.
  - NHS Choices website to verify prescriber details.
- If there is any doubt over the authenticity of the prescription, always contact the prescriber in the first instance for advice.
- Minor typographical amendments can be amended by the pharmacist only.
  - See above "Receipt of prescription"
- Prescriptions requiring amendment by the prescriber must be returned to the prescriber for amendment, or a replacement prescription requested.
  - If a replacement prescription has been provided, the incorrect prescription should be destroyed and placed with confidential waste unless it is to be returned to the prescriber.
- If the prescription for a Schedule 2 or 3 CD requests more than thirty days supply, assess the need to verify with the prescriber that there is a genuine clinical need and contact the prescriber if necessary.
  - Update the patient's medication record and make an additional record in the pharmacy intervention book.
  - Include the reasons why more than thirty days supply is considered appropriate.
  - Include details of any conversation with the prescriber, if appropriate.
- If the prescription is presented for dispensing more than two to three weeks after the appropriate date, confirm with the prescriber that there is still a clinical need for the item(s).
- Complete a clinical check of the prescription.

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20.9 Labelling and dispensing

- Label and dispense the medicine as per SOP 'Selection, Labelling & Assembly'
    - Break the tamper-evident seal to confirm that the contents of the package are as described if a whole pack is to be supplied.
- Clearly mark any packs that have been split as part of the dispensing process.
- Accuracy check (as per SOP 'Accuracy Check') the prescription and then place in a clear transparent labelled bag, marked with a CD alert sticker.
- Items awaiting collection by the delivery driver/courier that are subject to safe custody requirements must be stored in the CD cabinet until collection.
    - Place a CD alert sticker on the prescription form and store this with other prescription forms awaiting collection.
    - Store any Monitored Dosage Systems containing CD items subject to Safe Custody Regulations in the CD cabinet until delivery is due.
    - Complete the relevant CD delivery manifest paper work (Appendix 5) as per SOP 'Order Delivery'.

20.10 Record-keeping (for Schedule 2 CDs)

- Make an entry in the CD register as soon as possible when issuing to a delivery driver (ensuring that all entries in the CD register are in chronological order).
- Refer to SOP 'Controlled Drugs Record Keeping' for further guidance.
  In this pharmacy, a record of Schedule 2 CDs supplied on a private prescription is recorded in both the CD register (required) AND additionally in the prescription-only register (good practice).

20.11 Delivery to patients

Refer to SOP 'Controlled Drugs Delivery' for further guidance.

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21. Controlled Drugs: Delivery

21.1 Objective

To ensure the safe and secure delivery of Controlled Drugs to patients.

21.2 Scope

The delivery of CDs via our company staff and passing of parcels to authorised couriers for delivery.

21.3 Responsibility

Delivery Drivers, Dispensers, Technicians, Pharmacists and Responsible Pharmacist.

21.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

21.5 Delivery of Schedule 2 & 3 CDs

A robust audit trail is essential when controlled drugs are involved. The delivery can be made to a person who is not the patient (the patient must have given authorisation for a representative to take receipt of CDs on their behalf). A Controlled Drugs Delivery Sheet must also be filled in for CD deliveries in addition to the Delivery Log sheet.

- CDs should be in a separate bag to any other medication being delivered and the bags should be attached together.
- CDs and any other medicines on that patient's delivery must be stored in the lockable compartment of the delivery van and out of sight.
- The delivery van must be kept locked at all times when the driver is not in the vehicle.
- The delivery driver/courier should sign the back of the prescription as the representative when accepting the CD for delivery.
- The delivery driver/courier must check the identity of the person accepting the delivery to ensure that it is the patient or authorised representative (passport, driving licence or government approved photo ID card are acceptable forms of ID). A delivery cannot be left with anyone who is not the patient or their authorised representative.
- Any falsified medicines rules introduced by the UK must be followed
- All entries in the CD register should be made when the medication leaves the pharmacy premises. The delivery driver/courier should be entered as the 'person collecting'.
- The prescription should be retained in the pharmacy until the delivery driver returns the appropriate paperwork signed by the patient or representative to confirm successful delivery or the patient signature is confirmed online if delivered by courier.

21.6 Successful Schedule 2 & 3 Delivery

The delivery driver/courier must check the identity of the person accepting the delivery to ensure that it is the patient or authorised representative. A delivery cannot be left with anyone who is not the patient or their authorised representative.

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For all successful deliveries the Controlled Drug delivery sheet signed by the patient or online courier delivery record should be cross-referenced with the prescription and CD register prior to the prescription being processed as part of the end of day procedure.

21.7 Unsuccessful Schedule 2 & 3 Delivery via pharmacy driver

Unsuccessful deliveries sent with a pharmacy driver must be returned to the pharmacy on the same day and entered back into the CD register where appropriate with an explanation. These must then be secured in the CD cabinet where appropriate.

21.8 Unsuccessful Schedule 2 & 3 Delivery via courier

Unsuccessful deliveries sent with a courier should be returned to the pharmacy on the same day and entered back into the CD register where appropriate with an explanation. These must then be secured in the CD cabinet where appropriate. Where the time of attempted delivery means that the return cannot be made on the same day, the courier will store the drugs at their approved warehouse overnight.

When a failed delivery occurs, the tracking service will notify the pharmacy and the patient of the failed delivery so that delivery can be re-arranged for the patient at the next convenient time or returned to the pharmacy.

21.9 Note re Use of Couriers for Controlled Drugs Deliveries

The courier has pharma grade specialist facilities to meet specific quality and validation requirements for healthcare products. This includes Home Office licensed controlled drug stores.

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22. Controlled Drugs: Collection and Disposal of Patient Returns

22.1 Objective

To ensure the legal requirement around the correct records keeping, storage and method of destruction are complied with for patient returned CDs.

22.2 Scope

The collection and disposal of patient returned CDs including schedule 2, 3, 4 and 5 drugs.

22.3 Responsibility

Delivery Driver, Dispensers, Technicians, Pharmacists and Responsible Pharmacist.

22.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

22.5 Patient Returned Medication

- This service is available to all patients living in England.
- Patients or their representatives may not return and medicines directly to the pharmacy and must follow the procedures set out in this SOP.
- Patients should be referred to the ‘Returning unwanted medication’ page on the website for information.
- To arrange the return of unwanted medicines to the Pharmacy the patient must telephone and speak to a member of the dispensary team. For controlled drugs this should always be the pharmacist on duty.
- The process for returning medication should be explained to the patient.
- Each return will be made by booking an appointment for the pharmacy’s driver to visit the patient’s home to collect the returned medication or by sending the appropriate packaging to the patient to arrange for return by Royal Mail – Note the Royal Mail website refers to a prohibition on carrying “controlled drugs” but this refers only to illicit controlled drugs and not those supplied under the direction of a physician.
- Ensure the patient understands that any sharps and clinical/contaminated waste cannot be returned and they should follow local procedures for disposing of them.
- Ensure the patient knows that cytotoxic and hazardous waste, as well as CDs, must be separated if possible before returning to pharmacy.
- Patients should be advised to mark the package of unwanted medication “Z Returns” to allow them to be easily identified. The packaging should not identify the contents as being controlled drugs (or any other drugs).
- Appropriate packaging should be sent to patients to return hazardous medicines as return of such medicines in inadequate packaging may be unsafe.
- Advise patient of their other options to dispose of unwanted or expired medication if they cannot arrange a suitable time for collection. Patients are permitted to return medication to their local pharmacy if required.

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22.6 Process

22.7 Return by Royal Mail

The pharmacist must

- Speak to the patient about the return and clarify the items being returned.
- Assess the items for suitability for return by Royal Mail
- If items are suitable for return by Royal Mail then make a note on the PMR and arrange to send the appropriate packaging to the patient for safe return (refer to bagging up SOP for appropriate packaging)
- If items are not suitable for return by Royal Mail (eg clinical or contaminated waste) then provide the patient with details of their local procedures for disposal.
- Send the packaging to the patient along with the instructions for appropriate packing of the goods
- Contact the patient to ensure that the packaging has been received
- Provide signposting to other pharmacies where the patient prefers to dispose of unwanted medicines locally.

22.8 Handling Patient-Returned CDs from Delivery Driver

Drivers need to:

- Be aware that they cannot accept patient returns from patients without prior arrangement. The driver should notify the patient to follow the "returning unwanted medication" process as set out on the website.
- Ensure that appropriate packaging is within the van prior to starting the journey as the patient may not have requested the correct type or there may be a requirement for additional packaging.

Pharmacy staff need to:

- If CDs have been identified, immediately on receipt from the driver, secure them in a bag, clearly marking on 'Patient-returned CDs for destruction' and include the date of return; place the bag in the CD cabinet away from pharmacy stock until they can be destroyed.
- As soon as possible, Refer to the 'Returned medicines form' to make the entry in the 'Patient returned CD register', to record the CD that require destruction at a later date.

22.9 Sorting patient-returned Schedule 2 and 3 CDs

- Unwanted patient-returned medicines that include CDs must be handled in the pharmacy by the Dispenser, Technician, Pharmacist or the Responsible Pharmacist only.
- The designated returns area must be used to process all returns.
- Always use the correct Personal Protective Equipment (gloves, apron and mask)
- Empty the bag or container out onto a clear, enclosed surface — never remove medicines by putting a hand directly into the bag (in case sharps are present).
    - If sharps are present contact the local Environment Agency Officer.
- Immediately prior to destruction, identify any Schedule 2 CDs because records will need to be made in the register "Controlled Drugs — record of destruction of returned medicines", or equivalent (but NOT the main CD register).

22.10 Record keeping for patient-returned Schedule 2 CDs

- Enter details of the name, form, strength and quantity of the Schedule 2 CD in the CD returns register together with the date the drugs were returned, and where available, the name and address of the patient and the role of the person returning the drugs (if not the patient).

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- State the details of the destruction — the name and position of the person carrying out the destruction together with the name and position of the witness. Both need to sign and date the register to verify the destruction.
    - Retain the records for the minimum number of years as specified by the local AO.
- Destroy all patient identifiable information (for example, the patient's name and address) by disposing of confidentially, for example, shredding in a suitable shredder, incinerating or by obliterating the information with an indelible pen or stamp.
    - This includes information on dispensing labels, monitored dosage system or compliance devices, and so on.

22.11 Denaturing and disposal of patient-returned Schedule 2, 3 and 4 CDs

- The denaturing procedure should be carried out by one person and witnessed by another; the destruction of Schedule 2 patient-returned CDs must be recorded.
- Put on appropriate protective clothing (gloves, apron and mask, for example)
- Remove any patient-returned CDs awaiting destruction from the CD cabinet.
- Denature CDs using an approved CD denaturing kit.
- Follow the instructions on the denaturing kit.
- Return the denaturing kit containing the CDs to the CD cabinet until denaturing is complete (guidance on this should be in the denaturing kit's instructions).
- The CD denaturing kit (or denatured drug) should be placed in the DOOP Storage area (quarantined from normal stock marked with red tape).
- Dispose of gloves, apron and other disposable protective clothing with the pharmacy's clinical waste.
- Wash hands thoroughly.
- Re-order additional denaturing kits if required.
- In the event of untoward events such as spillage or a needle stick injury, refer to the section "Needle stick injury and emergencies" in the SOP 'The safe and effective disposal of medicines'.

22.12 Patient-returned CDs that form part of a dispensing incident

- Patient-returned CDs that form part of a dispensing incident will need to be retained in the pharmacy for the duration of time specified by the local AO.
    - Refer to SOP "Dealing with incidents".
    - Retain the medicine involved according to the SOP 'Controlled Drugs: Record keeping' for CDs but do NOT destroy.

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23. The Safe and Effective Receipt and Disposal of Medicines

23.1 Explanatory Note (see PSNC website)

The Pharmacy will comply with all relevant waste management legislation, including:

- **Registration of their conditional exemption to store waste pharmaceuticals returned from households and by individuals, with the local office of the Environment Agency (in line with the requirements of paragraph 39 (1) of the Waste Management Licensing Regulations 1994 (as amended). Registration of the conditional exemptions does not currently incur a charge.**

- **Securely storing waste medicines (including those which are special waste) which have been returned to the pharmacy from households or by individuals for no longer than six months and not exceeding 5 cubic metres in volume at any time.**

- **Retaining Special Waste consignment notes (and any associated lists or schedule) on a register for a period of not less than three years.**

- **Retaining descriptions and transfer notes for at least two years.**

- **Registration of the pharmacy/company as a waste carrier with the local Environment Agency office if the pharmacy/company carries waste medicines from peoples' homes/residential homes back to the pharmacy.**

Staff must be made aware of the risk associated with the handling of waste medicines and the correct procedures used to minimise those risks

Appropriate protective equipment, including gloves, overalls and materials to deal with spillage, should be readily available close to the storage site.

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23.2 Purpose

This SOP has been designed to ensure the safe and effective receipt and disposal of returned medication with the aim to minimise any harm to staff involved in the process.

As the pharmacy will collect unwanted medicines it will have the necessary regulatory approvals for carrying waste in place prior to the commencement of services.

This SOP does **not** cover the topic of dealing with waste controlled drugs – these are dealt with in two separate SOPs.

'Controlled Drugs: Disposing of Patient Returns'.
'Controlled Drugs: Disposal of Pharmacy Stock'.

23.3 Scope

This procedure deals with the disposal of medicines, except Schedule 2, 3, 4 and 5 CDs.

23.4 Responsibility

Delivery Drivers, Dispensers, Technicians, Pharmacists and Responsible Pharmacist.

23.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

23.6 Process for Patients to Return Medication

- **Patient Returned Medication**
  - Patients or their representatives MAY NOT return and medicines directly to the pharmacy and must follow the procedures set out in this SOP.
  - This service is available to all patients living in England.
  - Patients can be referred to the 'Returning unwanted medication' page on the website for information.
  - To arrange sending medication back to the Pharmacy the patient must telephone and speak to a member of the dispensary team.

- **Patients may**
  - Arrange collection by the Pharmacy driver at an appointed time, or
  - Send unwanted medication back to the Pharmacy via courier (at the pharmacy's cost), or Royal Mail (subject to risk assessment of contents by the RP in advance) or,
  - The Pharmacy can arrange for medication to be collected by our specialist waste management contractor.
  - Advise patient of their other options to dispose of unwanted or expired medication if none of these options is suitable for them (signposting to local pharmacies).

- **Explaining the Process to Patients**

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- Check which patient or patients the medication belonged to.
- Check the relevant PMR to identify any hazardous / dangers drugs or items that have been dispensed and could potentially form part of the return.
- Ask the patient to identify the type of medication being returned.
- If there is any item considered dangerous, such as a cytotoxic, inform the patient that we will collect items using the specialist waste management contractor and arrange for that collection to take place at a convenient time.
- Go through the "unwanted medicines card" (available from the PSNC website) over the phone with the patient

Returning your unwanted medicines to this pharmacy	
TEXT TO SAY TO PATIENT "In order to protect the safety of our staff, customers and the environment, when returning your unwanted medicines to this pharmacy, please take a moment to answer these quick questions. You must be able to answer all the questions with a "**Yes**" in order for our staff to accept your unwanted medicines. Please tell our pharmacy staff if there are any questions to which you've answered "**No**"."	
Are you returning **only** medicines?	Yes☑ No☑
Are you sure there are **no** needles or other sharps in the bag/container?	Yes☑ No☑
Are you sure there is nothing else that may affect the health and safety of our staff?	Yes☑ No ☑

Staff should go through the following list with patients:

✓	**Yes we can accept**	×	**No sorry we can't accept**
✓	Any unwanted medicines including:	×	Needles or other sharps
✓	Tablets	×	Chemicals
✓	Creams	×	Veterinary products
✓	Liquid medicines	×	Dialysis kits
✓	Powders	×	Paints
✓	Inhalers	×	Solvents
✓	Ampoules	×	Oil
✓	Ointments	×	Batteries
✓	Capsules	×	Pesticides or other garden chemicals
		×	Anything else which is not a medicine

Patients should be advised to contact their local council for advice on the safe disposal of products that the Pharmacy cannot accept.

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- Ensure the patient understands that any sharps and clinical/contaminated waste cannot be returned and they should follow local procedures for disposing of them.
- Ensure the patient knows that cytotoxic and hazardous waste, as well as CDs (see separate SOP), must be separated if possible before the unwanted medication is collected.
- Arrange for suitable packaging to be sent to the patient to place returned medication in to.
- Patients should be advised to mark the package of unwanted medication to "Z Returns" to allow them to be easily identified.

23.7 Process for accepting patient returns by the Driver

- Confirm that a collection of unwanted medication for disposal has been booked. Returns without a booking should only happen in exceptional circumstances as this increases the chance that the proper process for segregation of medicine has not been followed.
- Ensure you are fully equipped with the utensils in your vehicle to accept unwanted medication as patients may have placed unwanted medication into incorrect bags
- Wear appropriate protective clothing where there is a requirement to handle any returned waste.
- Identify any controlled drugs (check with the pharmacist if necessary); segregate these and place in a labelled clear bag for the pharmacist for denaturing and disposal. For further guidance read SOP Controlled Drugs: Disposal of Patient returned medication'.
- Identify any sharps and ask the customer to take these back if it safe to do so, signposting to the most appropriate route of disposal.
- Identify any cytotoxic or other hazardous waste (check with the pharmacist where necessary).
- Identify any flammable waste and store separately until this can be removed by the waste contractor.
- Where large quantities of the same medicine are being returned, then report this to the pharmacist as this could indicate a compliance issue requiring intervention.
- Complete the 'Patients Returns Sheet' detailing the patients name and address, also if relevant their representatives name.
- Store returned medicines in the quarantine area of the van for transport.
- The returnable items can be taken back to the pharmacy for destruction.
- Ensure medicines are not visible in the vehicle at all times

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23.8 Patient Returned Medication

- This service is available to all patients living in England.
- Patients or their representatives may not return and medicines directly to the pharmacy and must follow the procedures set out in this SOP.
- Patients should be referred to the 'Returning unwanted medication' page on the website for information.
- To arrange the return of unwanted medicines to the Pharmacy the patient must telephone and speak to a member of the dispensary team. For controlled drugs this should always be the pharmacist on duty.
- The process for returning medication should be explained to the patient.
- Each return will be made by booking an appointment for the pharmacy's driver to visit the patient's home to collect the returned medication or by sending the appropriate packaging to the patient to arrange for return by Royal Mail – Note the Royal Mail website refers to a prohibition on carrying "controlled drugs" but this refers only to illicit controlled drugs and not those supplied under the direction of a physician.

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- Ensure the patient understands that any sharps and clinical/contaminated waste cannot be returned and they should follow local procedures for disposing of them.
- Ensure the patient knows that cytotoxic and hazardous waste, as well as CDs, must be separated if possible before returning to pharmacy.
- Patients should be advised to mark the package of unwanted medication "Z Returns" to allow them to be easily identified. The packaging should not identify the contents as being controlled drugs (or any other drugs).
- Appropriate packaging should be sent to patients to return hazardous medicines as return of such medicines in inadequate packaging may be unsafe.
- Advise patient of their other options to dispose of unwanted or expired medication if they cannot arrange a suitable time for collection. Patients are permitted to return medication to their local pharmacy if required.

23.9 Return by Royal Mail

The pharmacist must

- Speak to the patient about the return and clarify the items being returned.
- Assess the items for suitability for return by Royal Mail
- If items are suitable for return by Royal Mail then make a note on the PMR and arrange to send the appropriate packaging to the patient for safe return (refer to bagging up SOP for appropriate packaging)
- If items are not suitable for return by Royal Mail (eg clinical or contaminated waste) then provide the patient with details of their local procedures for disposal.
- Send the packaging to the patient along with the instructions for appropriate packing of the goods
- Contact the patient to ensure that the packaging has been received
- Provide signposting to other pharmacies where the patient prefers to dispose of unwanted medicines locally.

23.10 Disposal of returned medicines

- Use the specialist waste management company to provide safe and secure disposal of unwanted medicines by collection of unwanted medicines from patients and residential homes.
- Unwanted medicines collected by the driver must be sorted and placed in disposal units / containers provided by the NHSCB or a waste contractor retained by the NHSCB ready for waste management services to collect.

23.11 Hazardous medicines

A list of medicines classed as hazardous that need to be handled with care and separated for disposal can be found at:

- http://www.cdc.gov/niosh/docs/2012-150/pdfs/2012-150.pdf

23.12 Controlled drugs

Refer to SOP Controlled Drugs: Disposal of Patient Returns).

23.13 Expired pharmacy waste

- Ensure date expired stock is clearly marked and stored separately from other pharmacy stock.
- Sort pharmacy waste according to the process outlined below.
- Dispose of pharmacy waste according to the process outlined below.

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23.14 Disposal of unwanted medicines – Process for Pharmacy Staff

- If you have not already done so, wear appropriate protective clothing – gloves, apron and masks.
- For patient returned CDs see SOP 'Controlled Drugs: Disposal of Patient Returns'.
- For pharmacy expired CDs see SOP 'Controlled Drugs: Disposal of Pharmacy Stock'.
- Destroy all patient identifiable information either by shredding or by obliterating patient identifiable information. The use of marker pens is not permitted as this is not always reliable.
- For sharps received unintentionally:
  - Do NOT remove needles from syringes – place the whole syringe into the sharps container.
  - Dispose of sharps in an appropriate sharps container – where possible it is good practice to use:
  - Purple lid sharps container for sharps contaminated with cytotoxic or cytostatic hazardous medicines.
  - Yellow lid sharps container for sharps contaminated with non-hazardous medicines
  - Orange lid for sharps which are not contaminated with medicines.

- **For liquid medicines:**
  - Do not decant liquids from bottles into the waste container as the mixing of incompatible liquids into a single container could result in fire, release of fumes or explosion and harm to your staff or even prosecution could result.
  - Empty bottles that have contained liquids should also be placed into the waste medicine container as they will contain a residue of medicine.

- **For solid dosage forms:**
  - Do not 'deblister' i.e. remove individual tablets or capsules from blister packaging before placing the waste medicines into the waste disposal container. (This could be regarded as 'waste treatment' which could require a licence).
  - For tablets or capsules contained within bottles – place the whole bottle into the waste container.
  - Where applicable remove the blister strips from the outer cardboard carton and place the intact blister strips into the waste container.
  - Disposable MDS strips should be placed intact into the waste container.
- Separate any hazardous medicines or chemicals and dispose of in accordance with guidance from your waste contractor.
- Dispose of gloves and apron if applicable.
- Thoroughly wash hands.

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23.15 Dealing with full containers

- When full, seal the disposal container and store in a safe place, away from empty containers, ready for collection. Full disposal containers awaiting collection are located in the quarantined storage area.
- If the waste containers are full and the collection date is not in the near future, contact waste collector's co-ordinator to arrange a collection (check with RP for waste management company contact details).
- Make a record of the waste consignment on the appropriate form. This is kept in the filling cabinet.
- Complete the required information on the consignment note for hazardous waste. You can either list each item of hazardous waste individually or use a standard continuation sheet.

- Complete the waste transfer sheet (for non-hazardous waste).
- Check that the number of containers has been correctly completed.
- Copies of all documentation supplied or completed by the pharmacy or approved waste collector, including the consignment note (for hazardous waste) and the waste transfer note (for non-hazardous waste) must be kept for three years.

Disposal of controlled drugs

This SOP does not cover the disposal of controlled drugs – see separate SOP.

23.16 Needle stick injury and emergencies

- Wear gloves when assisting an injured person.
- Encourage the wound to bleed and wash it under running water.
- Keep the offending sharp for analysis.
  The injured person should attend the nearest accident and emergency department immediately.
  Record the accident in the pharmacy's accident book which is located in the filling cabinet.
- Make an initial report to the insurance company if appropriate. Contact details for the insurance company are in the filling cabinet.

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24. Support for Self-Care, Signposting and Health Promotion

24.1 Scope

The scope of this SOP will include guidance for the provision of self-care to patients and their families, including signposting to appropriate supporting organisations and promotion of a healthy lifestyle including health campaigns.

24.2 Objective

Implementing this SOP will ensure:

- Ensure Services are provided without face to face contact between pharmacy staff and the patient or their representative.
- Enhanced access and choice for patients who want to care for themselves and their families.
- Provision of appropriate advice to people including carers to help them to self-manage a self-limiting or long term condition.
- Provision of information and advice to people who require assistance of appropriate health and social care providers or support organisations.
- Increased patient and public knowledge and understanding of key healthy lifestyle and public health messages.
- Opportunistic provision of health promotion advice to encourage patients to take action to improve their health.
- Patients manage their condition by being more knowledgeable about treatment options
- Patients contact and access further care and support.
- Reduction in inappropriate use of health and social care services.
- To ensure compliance with the Pharmaceutical Services Regulations.

24.3 Applicable to:

Dispensing Assistants, Dispensing Technicians, Accuracy Checking Technicians, Pharmacists.

24.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

24.5 Support for Self Care

24.6 Service Description

The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

24.7 Aims and intended service outcomes

- To enhance access and choice for people who wish to care for themselves or their families.

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- People, including carers, should be provided with appropriate advice to help them self-manage a self-limiting or long-term condition, including advice on the selection and use of any appropriate medicines.
- People, including carers, are opportunistically provided with health promotion advice when appropriate, in line with the advice provided in "Promotion of healthy lifestyles" service.
- People, including carers, are better able to care for themselves or manage a condition both immediately and in the future, by being more knowledgeable about the treatment options they have, including non-pharmacological ones.
- To minimise inappropriate use of health and social care services.

24.8 Patient Identification

- Identification can take three forms, namely, passive, active, or as part of the repeat (or normal) dispensing process.
- **Active patients** will be those who have chosen to access the Lifestyle Questionnaires via the website or returned them by post and who are then identified from the results as patients to whom further information should be sent, or who should be called to follow up on the results and offer additional support and information. All patients who have prescriptions dispensed or purchase medicines from the pharmacy will be asked to fill in the Lifestyle Questionnaire which will ask for details such as existing medical conditions, height, weight and also lifestyle questions such as whether a patient is a smoker and how much exercise they normally have on a weekly basis.
- **Passive patients** are those where the identification happens as part of another interaction with the patient, but where the patient does not appear to be actively seeking additional assistance. For example, the dispensing of a prescription which identifies the patient as having high blood pressure / diabetes etc.
- **As part of repeat dispensing process / medicine sale or during any other interaction with a patient** staff should record the information provided by patients on the PMR system. Where a patient provides information that indicates that they would benefit from support for self-care they should be recorded as a 'target patient' and the appropriate information that is relevant to them should be provided and should include:
  - treatment options, including advice on the selection and use of appropriate drugs which are not prescription only medicines; and
  - on changes to the patient's lifestyle.

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24.9 Service outline

- Upon receipt of a request for help with the Support for Self-Care, including treatment of minor illness and long-term conditions, pharmacy staff should consider available resources and provide general information and advice on how to manage illness.
- If appropriate, access the patient's Summary Care Record to see if it assists in delivery of the service.
- Advice should be backed up, as appropriate, by the provision of written material such as leaflets.
- When such a request is received, the pharmacist should be informed and a record kept of the request.
- Advice (and requests for advice) must operate without face-to face interaction (eg telephone, Live video, via the website).
- The pharmacist should provide advice on the appropriate use of non-prescription medicines which can be used in the self-care of the relevant minor illness and / or long-term conditions.
- Remember that when giving this advice you should also consider healthy lifestyle interventions opportunistically when appropriate, in a similar manner to that provided in "Promotion of healthy lifestyle" service.

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- Where appropriate the pharmacist should signpost patients to other health and social care providers, when appropriate (in line with the service provided in "Signposting").
- Records of advice given, products purchased or referrals made will be made on a patient's pharmacy record when the pharmacist deems it to be of clinical significance. However, it is good practice to record details of these interactions even where the interaction does not appear to be of clinical significance.

24.10 Other Provider Organisations and Support Details

Details of local health and social care providers to whom patients can be referred as well as contact details for local patient and support groups can should be provided to patients via written mailshots, flyers sent with prescription deliveries, our website and by telephone or email.

24.11 Health promotion zone on our website

The website allows patients to access pharmaceutical services via our interactive page.

Explaining the Interactive Page to Patients

The interactive page is promoted on the website so that when a patient first visits the website they are signposted to a range of up to date materials that promote healthy lifestyles.

The Superintendent Pharmacist is responsible for ensuring that a reasonable range of materials are accessible via the interactive page and that they address a reasonable range of health issues.

The health promotion zone may also includes details of current health campaigns and other information to promote healthy lifestyle choices as well as providing access to the Lifestyle Questionnaire that is used to target health information to patients.

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24.12 Signposting

Service Description

To minimise inappropriate use of health and social care services and support services, patients who require further support, advice or treatment which cannot be provided by the pharmacy, on other health and social care providers or support organisations who may be able to assist the person must be given sufficient information to enable them to access those services. Where appropriate, this may take the form of a referral.

Aims and intended service outcomes

- To inform or advise people who require assistance, which cannot be provided by the pharmacy, of other appropriate health and social care providers or support organisations.
- To enable people to contact and/or access further care and support appropriate to their needs.
- To minimise inappropriate use of health and social care services and support services

24.13 Patient Identification

- Identification can take place during any interaction that the patient has with the pharmacy staff. In particular, staff should consider the results from the identification of patients for the promotion of healthy lifestyles and those who have filled in the Lifestyle Questionnaire on the website.

- Staff should always consider that in order to minimise inappropriate use of health and social care services and of support services and person who:
  - requires advice, treatment or support that we cannot provide; but

- we are aware of another provider of health services who is likely to be able to provide that advice, treatment or support.

We must provide the patient with contact details of that provider and, where appropriate, refer the person to the provider. At least two providers should be identified if this is possible.

24.14 Items Requiring Measuring and Fitting

Where a prescription is received for an appliance or stoma appliance customisation or any item that requires measuring or fitting the patient should be contacted and informed that these items are not available from this pharmacy as we do not provide a measuring and fitting service. Patients should be signposted to at least two other providers of the service in their area. (see signposting SOP)

24.15 Referral Notes

Where appropriate, a referral may be made by means of a written referral note. The RP will consider each case and decide whether this is appropriate or not and what form any referral note should take.

24.16 Records

Staff should create and keep a record of any information given or referral made and mark an appropriate follow-up date on the PMR system (to be confirmed in each case by the RP).

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25. Promotion of Healthy Living, Lifestyle & Health Campaigns

- If it is appropriate to provide healthy living and lifestyle advice, the pharmacist should provide any advice necessary and within their area of competency. Where advice is provided it should be recorded on an Intervention & Referral form as part of the PMR. Where this advice includes information in a NHS England campaign this should be recorded.

- If it is not appropriate to provide advice the patient should be referred to the appropriate health or social care provider or support organisation. Where advice cannot be provided it should be recorded on an Intervention & Referral form along with the referral organisation.

- This is known as a "prescription linked intervention".

25.1 Service Description

The provision of opportunistic healthy lifestyle advice and health advice to patients receiving prescriptions who appear to:

- have diabetes; or
- be at risk of coronary heart disease, especially those with high blood pressure; or
- who smoke; or
- are overweight, and
- pro-active participation in national/local campaigns, to promote public health messages to pharmacy users during specific targeted campaign periods.

25.2 Aims and intended service outcomes

To increase patient and public knowledge and understanding of key healthy lifestyle and public health messages so they are empowered to take actions which will improve their health.

To target the 'hard to reach' sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.

25.3 Identification of patients for promotion of Healthy Lifestyles

Identification can take three forms, namely, passive, active, or as part of the repeat (or normal) dispensing process.

Active patients will be those who have chosen to access the Lifestyle Questionnaires via the website or returned them by post and who are then identified from the results as patients to whom further information should be sent, or who should be called to follow up on the results and offer additional support and information. All patients who have prescriptions dispensed or purchase medicines from the pharmacy will be asked to fill in the Lifestyle Questionnaire which will ask for details such as existing medical conditions, height, weight and also lifestyle questions such as whether a patient is a smoker and how much exercise they normally have on a weekly basis.

Passive patients are those where the identification happens as part of another interaction with the patient, but where the patient does not appear to be actively seeking additional assistance. For example, the dispensing of a prescription which identifies the patient as having high blood pressure / diabetes etc.

As part of repeat dispensing process (or during any other interaction with a patient) staff should record the information provided by patients on the PMR system. Where a patient provides information that indicates that they would benefit from promotion of healthy lifestyles they should be recorded as a 'target patient' and the appropriate information that is relevant to them should be provided.

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Leaflets will be delivered to patients with their medication. Those identified as having medical conditions such as diabetes, coronary heart disease, COPD, Asthma, high blood pressure, smokers, overweight individuals, etc. or being at risk from them or other conditions will also receive targeted campaigns. The website, app and email newsletters will also be used to promote healthy lifestyles via the health promotion zone.

Summary Care Record Access - If appropriate, access the patient's Summary Care Record to see if it assists in identifying what areas to provide advice on.

25.4 Health Campaigns & Community Engagement Exercise

Terms of Service require participation in up to 6 campaigns per financial year, but you should agree to take part in all campaigns where practicable.

The Pharmacy will take part in national health campaigns to promote public health messages to patients across England. This will be achieved by sending out leaflets with prescriptions during specific targeted campaign periods and providing additional advice and learning resources via the website on the health promotion zone.

The pharmacy will also take part in at least one approved community engagement exercise in relation to the promotion of health living each financial year.

Patients will be directed to the learning resources via email, text and other non face-to-face communication so that they are aware of the campaign.

Patients should also be assessed for participation in at least one clinical audit and whichever of the following that the NHSCB specifies—

(i) a clinical audit carried out in a manner which is compatible with the NHSCB's arrangements for the receiving and processing of data from the audit, or

(ii) a policy based audit (to support the development of the commissioning policies of the NHSCB) carried out in a manner which is compatible with the NHSCB's arrangements for the receiving and processing of data from the audit.

We will also offer help and support on our website and direct patients to appropriate links for the health campaigns. This will ensure that patients across the UK are able to easily access information about health campaigns at all times.

The Pharmacy will use the opportunity when dispensing prescriptions for patients who have conditions such as diabetes, heart disease, obesity and high blood pressure, to offer health advice over the phone or provide them with leaflets about their conditions. Patients will also be able to speak to the pharmacist regarding information about the campaigns. Advice and help will be available to patients during opening hours of the pharmacy and patients can access information on our pharmacy website at all times. This ensures the uninterrupted provision of the service to patients across England.

Pharmacy Staff Should

- When a campaign is started:
  - Identify relevant patients that may benefit from additional information during the campaign or the specified clinical audit by cross referencing with the PMR system and advertising the campaign on the website at the "Public health Campaigns" page.
  - Arrange for relevant leaflets to be included with deliveries to relevant patients.
  - Mark each relevant patient's PMR with the marker that shows that they are receiving

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information as part of the campaign.
- Ensure that the website has the relevant links updated as each new campaign starts

- A record of the advice given must be recorded onto the PMR system and patients will be reviewed on their conditions at regular intervals throughout the year.
- Recording of advice given should be done in a format similar to that of the MUR form (Intervention and Referral), and the consultation will be carried out over the phone or via video call.
- Record numbers of patients who have taken part in the campaign
- Record keeping ensures the safe and effective continuity of care for patients without the need for face to face contact.
- Provide feedback on the clinical audit in the manner specified in the program guidelines, including anonymised information which is reasonably requested by the NHS

25.5 Process

- Remember it is important to maintain patient confidentiality at all times. Where sensitive or confidential information needs to be discussed with the patient, any member of staff making the call should use a private area to prevent other members of staff overhearing.
- All support for self -care, signposting and health promotion should be carried out by either telephone or email and attempt to assist the patient using the following SOP or refer them to the 'Health Info' section of the website if the appropriate information is posted.
- Answers to questions posed during all interactions must be recorded on the PMR system
- Leaflets regarding current campaigns should be sent (as appropriate) with prescription or P Med deliveries
- Email messages should promote the targeted campaigns that the Pharmacy is involved in and encourage the patient to complete the Lifestyle Questionnaire on the website.
- All patients who have prescriptions dispensed or purchase medicines from the pharmacy will be asked to fill in the Lifestyle Questionnaire which will ask for details such as existing medical conditions, height, weight and also lifestyle questions such as whether a patient is a smoker and how much exercise they normally have on a weekly basis.

25.6 Minor Ailments

- Follow WWHAM questions to ensure all necessary information is acquired.
- **Consult with the pharmacist if necessary** – refer to the Medicines Sales SOP for information on when this may be appropriate.
- Give any appropriate advice that you are trained competent to give as well as suggesting appropriate products. If you are unsure about anything always consult the pharmacist.
- Record any appropriate consultations in the Interventions and Referrals book.
- Complete manual order with all relevant fields.

25.7 Long Term Conditions

- **If it is appropriate to provide advice the pharmacist should provide any advice necessary and within their area of competency.** Where advice is provided it should be recorded on an Intervention & Referral form. Any advice given should always aim to include counselling on healthy lifestyle as well as management of the long-term condition.
- If it is not appropriate to provide advice the patient should be referred to the appropriate health or social care provider or support organisation (see Signposting SOP). Where advice cannot be

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provided it should be recorded on an Intervention & Referral form along with the referral organisation.

- For specific groups of patients (those with diabetes, at risk of coronary heart disease, especially those with high blood pressure, and patients who smoke or who are overweight) the pharmacists must provide advice without face-to face interaction (eg telephone, Live video, via the website). Such advice should be backed up, as appropriate, by the provision of written material such as leaflets.

25.8 Identification of patients for Support with Long Term Conditions

Identification can take three forms, namely, passive, active, or as part of the repeat (or normal) dispensing process.

Active patients will be those who have chosen to access the Lifestyle Questionnaires via the website or returned them by post and who are then identified from the results as patients to whom further information should be sent, or who should be called to follow up on the results and offer additional support and information. All patients who have prescriptions dispensed or purchase medicines from the pharmacy will be asked to fill in the Lifestyle Questionnaire which will ask for details such as existing medical conditions, height, weight and also lifestyle questions such as whether a patient is a smoker and how much exercise they normally have on a weekly basis.

Passive patients are those where the identification happens as part of another interaction with the patient, but where the patient does not appear to be actively seeking additional assistance. For example, the dispensing of a prescription which identifies the patient as having high blood pressure / diabetes etc.

As part of repeat dispensing process (or during any other interaction with a patient) staff should record the information provided by patients on the PMR system. Where a patient provides information that indicates that they would benefit from promotion of healthy lifestyles they should be recorded as a 'target patient' and the appropriate information that is relevant to them should be provided.

Leaflets will be delivered to patients with their medication. Those identified as having medical conditions such as diabetes, coronary heart disease, COPD, Asthma, high blood pressure, smokers, overweight individuals, etc. or being at risk from them or other conditions will also receive targeted campaigns. The website, app and email newsletters will also be used to promote healthy lifestyles.

Summary Care Record Access - If appropriate, access the patient's Summary Care Record to see if it assists in identifying what areas to provide advice on.

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26. Discharge Medicines Service ("DMS")

PREPARED WITH REFERENCE TO NHS ENGLAND GUIDANCE DOCUMENT and PSNC GUIDANCE

26.1 Service Description

When NHS patients are discharged from hospital or there is, for other reasons, a transfer of care of them between different providers of NHS services, community pharmacies may be asked to perform a three stage service in respect of the patient, principally linked to changes in medication. The second and third stages of this service are linked to the first prescription presented post-discharge or post-transfer. Issues of concern may be raised by the pharmacy contractor not only with the patient or their carer but also with their general practitioner.

Under the DMS the pharmacy must provide assistance and support to, and in respect of, an NHS patient

(a) recently discharged from hospital who is referred to the pharmacy for advice, assistance and support in respect of the patient's medication regimen by the staff of the hospital in which the patient stayed; or

(b) who is otherwise referred to the pharmacy for advice, assistance and support in respect of the patient's medication regimen by the staff of an NHS trust or NHS foundation trust as part of arrangements linked to the transfer of care between different providers of NHS services.

The service allows and requires the pharmacy to help not only the patient directly, but also (within the bounds of confidentiality) their carers and also provide them with assistance and support.

The service is designed in 3 Stages, where each Stage builds on the last to provide additional support if required to the patient or, where appropriate their carer.

The pharmacist must use their clinical judgement when considering their actions and recommendations in respect of the service and consider the duty of confidentiality to the patient when involving a carer in discussions about the patient and their medication regimen.

If the DMS referral requesting that the pharmacy provides the DMS includes circumstances in which the pharmacy is not to provide, or is to cease to provide the DMS service, then the Pharmacy is not to, or is to cease to, provide the DMS in those circumstances (for example, X's or Y's admission or re-admission to hospital).

26.2 Aims and intended service outcomes

- optimise the use of medicines, while facilitating shared decision-making
- reduce harm from medicines at transfers of care
- improve patients' understanding of their medicines and how to take them following discharge from hospital
- reduce hospital readmissions

26.3 Process

Every day the RP must check the pharmacy's NHS mail system, PharmOutcomes and Refer to Pharmacy for referrals to the DMS. Pharmacy contractors must consider any communication in the following form and manner as constituting a referral: "Any written patient information received by a community pharmacy via secure electronic message from an NHS trust or other provider of NHS services concerning a patient's discharge to usual primary care services and their medicines regimen".

26.4 Consent

Obtain and record the informed consent from the patient prior to provision of the service using the consent form. As part of obtaining consent discuss the requirements for data sharing. Inform the patient that any information discussed as part of the service may be shared with their GP.

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26.5 DMS Stages

It is expected that all patients referred to the pharmacy will receive all three stages of the service. Note that stages 1, 2 and 3 of the service may occur in parallel and first contact with the patient (as defined in the NHS Discharge Medicines Service toolkit) could happen at any stage in the process.

26.6 DMS Stage 1

The community pharmacy receives a discharge referral. A clinical review is undertaken by a community pharmacist following receipt of a patient referral. The community pharmacy team may contact the referring NHS trust contact or the PCN pharmacy team to discuss any concerns (eg an important medicine the patient usually takes is omitted on the discharge referral) and to seek clarification about the discharge referral.

26.7 Considering the appropriateness of any medication changes prior to discharge

- DMS requests will not necessarily all be in the same form.
- Summary Care Record Access - If appropriate, access the patient's Summary Care Record to see if it assists in providing the service
- The pharmacist must review the actions requested in the DMS and consider whether the actions requested are, in the pharmacists clinical judgement, appropriate.
- For actions that are considered appropriate the pharmacist must;
  - Use the information in the referral, to compare (as far as possible) the patient's medicines at discharge to those they were taking before admission to hospital.
  - Check any prescriptions issued to be dispensed to assess whether any changes are appropriate and identify any areas of concern.
  - Where necessary, discuss changes that may be appropriate or raise any issues of concern identified, to the extent that in accordance with the pharmacist's clinical judgement, it appropriate to do so with—
    (i) the staff of the hospital or other provider of NHS services that made the referral, and
    (ii) any provider of primary medical services on whose patient list the patient is; and
  - keep and maintain records of the DMS referrals received and of any actions taken, as appropriate (in particular, to support delivery of stages 2 and 3 of the service).

REQUIRED ACTIONS AS PER NHSE GUIDANCE

26.8 DMS Stage 2

The community pharmacy receives the first prescription following discharge. The pharmacist or pharmacy technician will ensure medicines prescribed post-discharge take account of the appropriate changes made during the hospital admission. If there are discrepancies, the pharmacy team will try to resolve them with the general practice, utilising existing communication channels. Alternatively, the community pharmacist may refer the patient to the PCN pharmacy team for a Structured Medication Review or other intervention.

If the pharmacy receives either a written or electronic prescription (or repeatable prescription) or EPS token and the pharmacy as received a request for Stage 2 of the DMS service either from Stage 1 or

- Even without a referral to Stage 2, the pharmacy receives such a prescription as described above and the pharmacy is aware as a result of an earlier referral to Stage 2 or Stage 3 that this is the

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first prescription for a medicinal product following the patient's discharge from hospital, or a transfer of the patient's care from another NHS service provider, AND

- The pharmacy is aware that either the patient, or their carer wishes the pharmacy to provide Stage 2 of the DMS service then the pharmacy must provide the following service as part of Stage 2

Then the pharmacist must:

- Review / perform a further review of any prescription
- Summary Care Record Access - If appropriate, access the patient's Summary Care Record to see if it assists in providing the service.
- Specifically consider if in your clinical judgement appropriate account has been taken to any changes in the medication regimen during the patient's stay in hospital or prior to the transfer of the DMS from another pharmacy.
- Where you see areas of concern, raise those issues as appropriate with the patient's GP
- Keep and maintain records of the DMS referrals received and of any actions taken, as appropriate (in particular, to support delivery of stage 3 of the service).

26.9 DMS Stage 3

The NHS Discharge Medicines Service should also be used as an opportunity to engage with patients about their medicines on a shared decision-making basis. Whether the patient or their carer makes contact themselves for advice, a referral is received from an NHS trust on discharge or a prescription is received following prescribing changes, the pharmacist or pharmacy technician should take the opportunity to establish the patient's understanding of their condition(s), their associated medications and how each medicine can be best administered to get optimum benefit and reduce unwanted side effects.

The community pharmacy checks the patient's understanding of their medicines regimen. The pharmacist or pharmacy technician will hold a discussion, adopting a shared decision-making approach, with the patient (or the carer if appropriate) to check their understanding of their post-discharge medicines' regimen. The pharmacist or pharmacy technician will identify any adherence, clinical issues, outstanding questions or needs the patient may have regarding their medicines.

26.10 Additional advice, assistance and support

When the pharmacy either receives a prescription (in whatever form) or has been made aware via a referral to the DMS that a prescription is the first prescription for a medicine that has been made following the patient's discharge from hospital, or where the patient's care has been transferred from another NHS service provider, the following steps must be followed:

- Summary Care Record Access - If appropriate, access the patient's Summary Care Record to see if it assists in providing the service
- Arrange a live video call or audio call with the patient (or where appropriate and bearing in mind the duty of confidentiality their carer to;
    - Assess the patient / carer understanding of the medicines that the patient should be taking
    - The patient should have received a copy of the prescribed medication from the hospital which lists the medication you are taking. This must match the discharge prescription when written.
    - If changes have been made to the patient's medication regimen, clearly explain the changes.
    - Offer such advice, assistance and support as is appropriate in your clinical judgement in respect of the medicines being taken and the medication regimen overall.

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- Think about high risk medicines or those where the treatment is more complex and where extra advice and support should be provided – e.g. anticoagulants
- Discuss common or expected side effects
- Discuss the use of medication apps which can be downloaded and may help the patient stick to their treatment plan.
- If injectables have been prescribed and the patient is considered to be able to self-administer these, then have they received appropriate training from their GP practice nurse or hospital?
- Inform the patient / carer about
  - The disposal service offered in respect of unwanted drugs (see separate SOP). This is particularly relevant to medicines which may still be in the patient's home but may no longer be prescribed.
  - Any other pharmaceutical services that the patient or their carer may benefit from following their stay in hospital and / or the transfer of care from another NHS pharmacy

- Follow up
  - Where you identify any areas of concern then to the extent it is appropriate to do so in your clinical judgement, contact the patient's GP to discuss the concerns and consider any appropriate action plan to deal with the concerns.
- In every case it is important to keep and maintain records of the above discussions, concerns and actions taken as part of providing this service and these will also assist in service evaluation processes.

26.11 Things to Consider Across the Stages

This is not intended to be an exhaustive list, but the pharmacist should consider;

- Appropriateness of the medication prescribed. Whilst bearing in mind that changes are likely to have been consultant led and seen by the patient's GP, the pharmacy can offer valuable insights and consider areas that the hospital or GP may not have considered such as stock availability.
- Blister Packs – Are blister packs appropriate for the patient?
- Compliance Aids - Ensure that the patient is able to use devices before supplying them:
- Certain devices may have been used by the patient whilst on the ward (e.g. for self-administration), the patient may be given the device to take home with them to use at home.

26.12 Risks

- Changes in treatment not properly identified.
- Poor understanding of medicines prescribed
- Risk of patient harm from lack of understanding
- Availability of high quality live video link at the patient's home
- Poor communication of medication changes between NHS care providers

26.13 Responsibility

Pharmacists and Pharmacy Superintendent.

26.14 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

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The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

26.15 Typical process (subject to patient / medication requirements)

Whilst NHSE guidance suggests that many areas of the process below are suitable for "pharmacy technicians" to carry out, the overlapping nature of the requirements means that the pharmacist should take responsibility for all stages of the process.

STAGE 1 – BEFORE PRESCRIPTION RECEIVED
Check each day for any new referrals
If appropriate check the patient's SCR
Check for clinical information and actions contained in the referral which need to be undertaken. Details of what to look for are outlined in the toolkit which accompanies this service guidance.
Check any previously ordered prescriptions for the patient 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.
Check the referral to compare medicines prescribed before discharge with those prescribed post discharge. Specifically consider any ▪ High risk medicines. ▪ Newly started respiratory medication, including inhalers. ▪ Medication requiring follow-up, eg blood monitoring, dose titration. ▪ Patients prescribed medicines that have potential to cause dependence (eg opioids). ▪ Those for which doses vary/change, either increasing or decreasing over time.
Consider if the patient is "high risk" eg ▪ People taking more than five medications, where the risk of harmful effects and drug interactions is increased. ▪ Those who have had new medicines prescribed while in hospital. ▪ Those who have had medication change(s) while in hospital. ▪ Those who have experienced myocardial infarction or a stroke due to likelihood of new medicines being prescribed. ▪ Those who appear confused about their medicines on admission/when getting ready for discharge, and have already needed additional support from a healthcare professional. ▪ Those who have help at home to take their medications. ▪ Those patients who have a learning disability.

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CHECK FOR ■ changes to quantity ■ changes to dosage ■ changes in formulations ■ changes to the frequency at which the medicine should be administered ■ changes to the frequency at which the medicine will be prescribed ■ interactions and contraindications relating to the changed medications ■ appropriateness.
CHECK FOR ■ newly prescribed medication, including considering whether medicines are intended to given long-term or have been initiated for short-term use ■ discontinued medication (including removing medicines no longer needed) ■ planned changes to medicine (eg antibiotics stopped after course is completed) ■ changes to medicine administration route ■ concerns highlighted by the NHS trust, eg intentional non-adherence ■ bloods or other tests needed to ensure safety or check for efficacy.
Identify any issues or concerns and discuss with other healthcare providers at the hospital or patient's GP surgery
Make a record of all actions
STAGE 2 – UPON RECEIPT OF FIRST PRESCRIPTION
If appropriate check the patient's SCR
Check the referral to compare medicines prescribed before discharge with those presented on the prescription
Review the recommended action from Stage 1 of the referral
Specifically consider if in your clinical judgement appropriate account has been taken to any changes in the medication regimen during the patient's stay in hospital or prior to the transfer of care from NHS service provider.
Consider if it is appropriate to make an appointment to provide the Stage 3 service to the patient or their carer. If a telephone or video call appointment is arranged ask the patient/carer to have all their medicine(s) with them at the time of that appointment
Make a record of all actions
STAGE 3 – PATIENT / CARER INVOLVEMENT
Each day check the pharmacy diary for any appointments due and appointment reminders to make.
In advance of the intervention: • Review the patient's medication and actions from Stage 1 and 2 as appropriate • If appropriate check the patient's SCR • Send a reminder to the patient / carer
The service should preferably take place via a live video link, but can also be provided by phone if a video link is not available if that is still appropriate. All discussion must take place in a private area where they cannot be overheard by other staff members.

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Welcome the patient/carer onto the service and make them feel at ease.
Confirm identity of the patient by using questions such as date of birth and postcode (see separate SOP on confirming identity)
Confirm the patient consents to their information being shared and that they understand the nature of the service.
Explain that this is not a test of the patient / carer's knowledge and that it is a service being provided to them to help them with their health care needs
Ask the patient / carer about their understanding of their medicines and how they believe they should be taken and any changes that have been made
LISTEN - do not use phrases like "Do you take one of these at night to help you sleep". Instead ask questions like "when do you take this tablet and what does it do?" Make notes as you go along. When you understand what the patient or carer believe you can use these notes at the next stage.
Compare this list of medicines with those provided or intended at discharge and record any discrepancies.
Go through all medicines and medication charts with the patient (carer or relative as required), highlighting medicines which have stopped, started or changed. Specifically focus on areas where there appeared to be poor understanding.
Use the information gathered and recorded on each medicine and agree with the patient the appropriate action to resolve any issues: You can **Resolve with the patient** minor issues that were able to be discussed and explained during the service. You can **Contact the GP** where the issue requires an amendment from the GP or intervention of GP practice staff You can **Contact the hospital** where the issue requires hospital intervention Involve the patient /carer in the decision making process and ensure that they agree with the recommended steps to be taken.
If no issues with the patient's medication have been identified dispense required medication in accordance with the relevant SOP for dispensing and counsel as to any changes made by hospital.
Consider and compliance aids required
Consider if it is appropriate to discuss any common or expected side effects from new medication or interactions
Discuss other services available from the pharmacy that the patient and / or their carer might benefit from accessing. Ensure that, where appropriate, the patient understands that these services can be provided to them at no cost.
Consider medicine wastage as patients may have previously received identical medication that may already be in their home:
Explain the Disposal of Unwanted Medicines Service and direct the patient to the relevant page on the website for information.

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Ask the patient if they have any further questions or information requirements and confirm the agreed actions and the date and time of the follow-up if required
Consider if a further review is required and if so arrange the appointment and note it in the diary
Ensure any information obtained during the service is recorded accurately on the patient's electronic record.

26.16 Service Examples from NHS Toolkit for Reference

Case study - Providing relevant clinical information

Mrs Ballantyne was admitted to hospital after falling at home. While in hospital, her medicines were discontinued. Prior to discharge, all her usual medicines were restarted except for furosemide (prescribed for heart failure) as her sodium levels were still low. She was referred to the NHS Discharge Medicines Service with a request to restart furosemide when her blood tests were normal. The community pharmacy contacted Mrs Ballantyne and she agreed to get a blood test the following week at her surgery. The blood test results were normal. The pharmacist already had a prescription for furosemide and this was then dispensed.

26.17 Examples of the NHS Discharge Medicines Service process

Example 1

Mrs Patel was referred to her community pharmacy on discharge. The community pharmacist reconciled the medicines with the pharmacy patient medication record and noted that Adcal D3 and GTN spray were missing. The community pharmacist then contacted Mrs Patel and discovered that she had forgotten to take these items into hospital and therefore was not given these medicines. The community pharmacist checked that these medicines were still indicated and did not interact with the new medicines prescribed, and then advised Mrs Patel to continue with the Adcal D3 and to use her GTN spray as needed.

Example 2

Mr Barrett, 90 years old, lives alone has also been referred to the community pharmacy on discharge. On reconciling his medication, the community pharmacist noticed that metformin was missing from his discharge information. The community pharmacist contacted the NHS trust and discovered that it had been withheld due to acute kidney disease. However, recent blood results were normal and therefore Mr Barrett should restart the medicine. The community pharmacist worked with the PCN clinical pharmacist to arrange a new prescription. Mr Barrett was contacted and the community pharmacist arranged a discussion with Mr Barrett to coincide with the collection of his dispensed medicines and ensure he understood his medicines regimen.

Example 3

Mr Fisher was referred following a long stay in hospital. He had several changes to his medicines which were clearly documented on the discharge information. The community pharmacy technician updated Mr Fisher's patient medication record. They noted that there was a prescription for Mr Fisher on the NHS Spine which accurately reflected his post-discharge medicines regimen. This was dispensed and delivered to the patient. A telephone discussion was also arranged by the community pharmacy technician to check Mr Fisher's understanding of his changed medication and for any adverse events.

26.18 Examples where normal flow of patients through the service may not be appropriate

1. A referral is received for a new patient: Where a referral is received for a patient who is new or unknown to the pharmacy, the pharmacy contractor may then need to contact the NHS trust and/or the

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patient for more information; and to check that the patient wishes to continue using this pharmacy for the DMS.

2. Patient uncontactable or withdraws consent following completion of stage 1: Where stage 1 of the service has been delivered but the patient withdraws consent to receive the service, or the first prescription post-discharge is not received by the pharmacy contractor to complete stage 2 of the service and no contact is made by the patient, reasonable attempts must be made by the pharmacy contractor to contact the patient using the contact details set out in the referral. In this scenario, it is possible that the patient has been readmitted to hospital, admitted to a care home or has died. Where the pharmacy contractor is unable to reach the patient (or the patient has been readmitted to hospital or admitted to a care home), the pharmacy contractor should share any findings of concern from stage 1 of the service with the patient's general practice.

3. Patient uncontactable or withdraws consent following completion of stage 1 and stage 2: Where stages 1 and 2 of the service are provided by the pharmacy contractor but the pharmacy contractor is unable to contact the patient to complete stage 3 of the service, reasonable attempts must be made by the pharmacy contractor to contact the patient using the contact details set out in the referral. In this scenario, it is possible that the prescription may have been collected by the patient or a representative and either: the patient was unable to discuss their medicines at the point of collection; or the patient/carer does not attend an agreed consultation; or the patient/carer refuses to take calls from the pharmacy contractor; or that the patient/carer states that they do not wish to engage with a consultation about their medicines. Where the community pharmacy is unable reach the patient or the patient withdraws consent to receive the service at this point, the pharmacy contractor should share any findings of concern from stages 1 and 2 of the service with the patient's general practice.

4. Patient moves community pharmacy after stage 1 of the service has been provided: The situation may occur where stage 1 of the service has been delivered by a pharmacy contractor and that pharmacy contractor subsequently finds out that the patient wishes to use a different pharmacy contractor for the provision of the service. The first pharmacy contractor should contact the second pharmacy contractor and offer to send them, via a secure electronic message (eg to the pharmacy contractor's premises specific NHSmail account) and with the patient's consent, the referral information received from the NHS trust and any relevant information and/or findings identified during stage 1 of the service. The same approach could be taken if another pharmacy contractor contacts the first pharmacy contractor to inform them that the patient has asked them to dispense the first prescription post discharge.

5. Temporary community pharmacy closure means that the complete service cannot be provided: Where a temporary community pharmacy closure of one week or more means that a pharmacy contractor cannot provide the service, reasonable attempts must be made by the pharmacy contractor to contact the patient using the contact details set out in the referral. The pharmacy contractor should inform the patient of the situation and identify another pharmacy contractor to refer the patient for completion of the service. In these circumstances, the pharmacy contractor should contact the identified pharmacy contractor and offer to share, via secure electronic message (eg to the pharmacy contractor's premises specific NHSmail account) and with the patient's consent, the referral information received from the NHS trust and any relevant information and/or findings identified during stages 1 or 2 of the service if already provided.

27. Near Miss

27.1 Objective

To promote good dispensing practice and reduce the risk of customer harm, by preventing dispensing errors. The Near Miss Log should be used as a learning tool to reduce near misses and improve patient safety.

27.2 Scope

To detail the procedure to be followed for all dispensing errors found in the pharmacy before medication is dispatched to the patient.

27.3 Risks

- Near misses not reported resulting in the problem re-occurring.
- Near misses not resolved appropriately and damaging the reputation of the Pharmacy.
- Failing to identify a near miss resulting in patient harm.

27.4 Responsible

Dispensing Assistants, Dispensing Technicians, Accuracy Checking Technicians, Pharmacists and Pharmacy Superintendent.

27.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

27.6 Process

A Near Miss is any error discovered during the dispensing process before the prescription is delivered to the patient.

27.7 Near Miss Identified

- Once identified the Near Miss should be corrected following dispensing SOPs and the checking process restarted to ensure there are no further errors
- ALL Near Misses should be recorded on the Near Miss Log by the person who made the error, reflecting on why the error was made.

27.8 Near Miss Reviewing

- The Near Miss Log should be reviewed weekly to identify any common themes or trends in the near misses that occur and an action plan made to address any issues identified and improve pharmacy practice.
- The Near Miss Logs should be reviewed monthly with the Pharmacy Superintendent to ensure best practice is followed and highlight the need to change any practice within the pharmacy.

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28. Customer Complaints

28.1 Objectives

This SOP is designed to help deal with customer complaints in a professional and timely manner to avoid unnecessary escalation.

28.2 Risks

The risks of not dealing with customer complaints appropriately may result in damaging the reputation of the Pharmacy and failings to provide the highest level of customer care.

28.3 Scope

This SOP has been designed to comply with legislation and therefore must be adhered to where complaints arise relating to the provision of NHS services by the pharmacy business.

Legitimate complaints could include issues related to the provision of the NHS services – such as attitude of staff on the phone or drivers or even having to be owed medication.

This SOP may also be used for private complaints – for example a complaint arising from the sale of a herbal supplement or an Online Doctor purchase.

This SOP does NOT apply to:

- A complaint made by an employee about their employment.
- A repeat complaint which has already been previously investigated under these procedures or any previous relevant complaints procedure.
- A complaint which relates to an alleged failure to comply with Freedom of Information Act 2000.
- A complaint made directly by a Responsible Body (local health authority, NHS body, HSC organisation, primary care provider or independent provider).

Where a complaint is related to a dispensing error or incident, refer also to the SOP 'Dealing with an incident'.

28.4 Responsibility

Responsible Pharmacist, Pharmacy Manager and Superintendent Pharmacist.

28.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

28.6 Duty of Candour

Health professionals must be open and honest with patients when things go wrong. This is also known as 'the duty of candour'.

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

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This means that healthcare professionals must:

- Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- Apologise to the patient (or, where appropriate, the patient's advocate, carer or family);
- Offer an appropriate remedy or support to put matters right (if possible); and
- Explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.

Health and care professionals must also be open and honest with their regulators, raising concerns where appropriate.

They must support and encourage each other to be open and honest and not stop someone from raising concerns.

28.7 Process

- **Handling of customer complaints**
  - Patients or their representatives must not access the pharmacy directly to make any complaints. Any person seeking to do so must be provided with the contact details of the pharmacy and asked to make all communication via non face to face channels.
  - Always ensure that a customer complaint is escalated to a senior member of staff or pharmacist.
  - Complaints about pharmaceutical services should be referred to the Responsible Pharmacist or Pharmacy Superintendent.
  - Every effort should be made to rectify the complaint as soon as possible with the welfare of the customer being the first priority.
  - Always attempt to resolve the complaint on the telephone, rather than by email, to avoid miscommunication. In the event of a serious incident the patient may be visited at their home if they desire.
  - Accurate and contemporaneous records of all communication should be kept for future reference.
  - Advise patients that they can complain directly to NHS England and provide them with contact details to do so.

- **Receiving a complaint**
  - Receive complaints with respect and courtesy.
  - Treat complaints as confidential.
  - Accept complaints made orally or in writing or if made electronically.
  - Establish whether the complainant has grounds for making a complaint.
  - NB – in practice this may be instantly apparent without the need for analysis or further questioning to establish. However if analysis is required then in order to have grounds for a complaint an affected person must have been affected by an action, omission, or decision of the pharmacy OR must have received services (private or NHS/HSC) from the pharmacy.
  - If there are no grounds for complaint and the pharmacy does not need to proceed with the complaint.

  Once grounds for complaint have been established – confirm whether the complaint is being made by the affected person or by a representative.

- Where the complaint is made by a representative, determine if:

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- The affected person has died
- The affected person is a child and there are reasonable grounds for the complaint to be made by the representative.
- The affected person lacks mental or physical capacity to complain directly and there are reasonable grounds for the complaint to be made by the representative.
- The affected person has requested that the representative acts on their behalf.
- The complaint has been referred from the CCG, Health Board or another HSC organisation following a complaint which they received directly from the affected person or representative.

Where none of these conditions apply, then the pharmacy does not need to proceed with the complaint, however a written notification must be supplied to the representative stating the reasons for not proceeding.

- Check whether the complaint has been made within the time limit

  In **England** – a complaint is valid for up to 12 months after the event OR up to 12 months after the complainant realised that they had an issue to complain about.

  However (applicable across the UK) - If the pharmacy is satisfied that there are good reasons for not making the complaint within the time limit AND it is still possible to investigate the complaint effectively and fairly then the time limit does NOT apply.

  Where the time limit has lapsed and the exception does not apply then the pharmacy does not need to proceed with the complaint. A written notification should be supplied to the representative stating the reasons for not proceeding.

  Irrespective of time limits, the Pharmacy should always try to investigate any complaint made as it is vital for the public and the profession that patients can trust in the services they receive from the pharmacy and feel confident that any problems they may raise are taken seriously. The pharmacy must not attempt to 'hide behind' time limits when dealing with complaints.

- Where appropriate – relay details of the complaint to the indemnity provider (e.g. NPA Insurance). Keep them informed of developments as they arise.

- The pharmacy should also supply contact details for organisations that can provide independent advice and support with making the complaint.

- **Dispensing errors**
  - Attempt to resolve the complaint by talking to the customer on the telephone. NB the person dealing with the complaint must be aware that no Essential Services may be provided via face to face contact.
  - The customer should be given a chance to voice their concerns with your full attention.
  - Always apologise to the customer if the level of service is not up to their expectations or our high standards.
  - Do no try to transfer the blame or admit Liability.
  - In the event of a dispensing error try to establish the following information:
    - Who is the patient?
    - What is the nature of the error?
    - Who dispensed and checked the incorrect item?
    - Has any of the incorrect medication been taken?
    - If so, how much and has there been any ill effects?
    - Is there likely to be a clinically significant interaction with any of the patients prescribed medication?
  - If any incorrect medication has been taken the pharmacist must contact the prescriber and the Pharmacy Superintendent to agree upon action to be taken.

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- Where possible the incorrect medication should be returned to the pharmacy for inspection and the packaging retained for 2 years.
- A new supply can be made using the original prescription where appropriate.
- Advise the customer that all complaints will be reported to the Pharmacy Superintendent and investigated accordingly.
- Establish whether a response from the Pharmacy Superintendent is required.

All customer complaints must be reported to the Responsible Pharmacist and Pharmacy Superintendent.

- It is important to establish if SOPs have been followed in the process leading up to the customer complaint.
- After an audit of the complaint practice should be assessed to prevent the incident from re-occurring.

- **Delivery of Damaged Medication**

  - If a patient contacts The Pharmacy to report that a prescription has been delivered and the medication was damaged in transit the patient should be advised to return the medication to the Pharmacy as it was received. Returns must be made in accordance with the relevant SOP and cannot be made in person, ie no face to face contact may occur between the patient or their representative and the pharmacy.
  - The RP can inspect the medication when it is received and if satisfied they can authorise it to be redispensed and deliver.
  - The patient should be contacted by telephone to advise them of the new delivery date.
  - If the medication is urgent then the RP should contact the prescriber about the possibility of issuing a new prescription to ensure the medication arrives in a timely fashion.
  - A record should be made on the patients PMR of the details of the incident and the resolution. An Intervention sheet should also be filled in.

- **Non-Arrival of Dispatched Medication**

  - If a patient contacts the pharmacy regarding the non-arrival of medication that has been dispatched from the warehouse Royal Mail should be the first point of contact.
  - Using the tracking number specific to that patient Royal Mail should be able to locate the package and advise when it will be delivered, this should be relayed to the patient.
  - If Royal Mail has lost the parcel, the RP should contact the prescriber to explain the situation and arrange a new prescription to allow re-dispensing of the medication.
  - Telephone the patient to apologise and explain the situation to them. Inform them of the new expected delivery date.
  - If the parcel has not been delivered within 15 days of dispatch a claim should be opened with Royal Mail for the value of the parcel.
  - A record should be made on the patients PMR of the details of the incident and the resolution. An Intervention sheet should also be filled in.

Establishing whether the complainant has grounds to make a complaint

- Dealing with an oral complaint over the phone

  - Oral complaints may be received by phone. Where possible try to resolve the complaint by:
  - Listen carefully to the complaint.
  - Respond politely to the complaint.
  - Using appropriate tone to convey understanding and sympathy.
  - Where possible investigate and deal with the complaint immediately i.e. “on the spot” balancing disruption to the pharmacy with delay for the patient.

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- Consider whether the pharmacy is at fault or is partially at fault. Where you are satisfied that there is cause for the complaint or a mistake has been made consider a careful apology where appropriate being careful **not** to admit the consequences of the cause for complaint (i.e. that a dispensing error has led to clinical condition x, y and z).
  - I am sorry that you have cause for complaint.
  - We are sorry that we have made a mistake.
- Where it is unclear whether there is cause for a complaint or if a mistake has been made:
  - I'm sorry that you are upset

- Where an oral complaint is received over the phone **and** resolved to the satisfaction of the complainant immediately or within the next working day then no further action is required. NB staff will often find the information they gain from complaints resolved useful in improving service quality.
- If the oral complaint received by phone has **not** been resolved then:
  - A written record of the oral complaint must be made.
  - The complainant must be supplied with a copy of this written record.
  - The remainder of this formal complaints procedure applies.
- Dealing with a written complaint, an electronic complaint or an unresolved oral complaint

  Where a complaint relates to the actions of more than one NHS body; the complaints manager should notify the other bodies involved and co-ordinate and co-operate, sharing information and meeting where required to consider the complaint and to agree on the best approach to investigation and resolution. A lead organisation should be identified and it may be possible to divide aspects of a complaint between organisations. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

  - Carefully read the details of the complaint.
  - England only - Where the complaint is related to the provision of NHS services_then record the date the complaint was received and the subject of the complaint into the NHS Complaints Record: England (NPA product available from NPA Sales - CRB001).

28.8 Acknowledging a complaint

- Acknowledge the complaint in writing within 3 working days (**Wales 2 days)** after the complaint is received. Where appropriate this can be done immediately after the complaint is received.
- The acknowledgement should:
  - Be conciliatory.
  - Confirm the issues raised in the complaint.
  - Offer to discuss issues with a member of the complaints staff or a senior member of staff.
  - Provide information about sources of independent advice and support (see appendix 3)
  - Indicate that a full response will be provided within (**Scotland and Northern Ireland** - 10 working days) (**Wales** – 20 days) (**England** – no statutory period – suggested 20 days).
- **England Only** - At the time of the acknowledgement there must be an offer to discuss the following at an agreed time:
  - How the complaint will be handled.
  - The likely response period for when the completion of the investigation and the final response will be sent to the complainant.

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- Where the complaint is related to the provision of NHS services then record the agreed response period into the NHS Complaints Record: England (NPA product available from NPA Sales - CRB001).
- If the complainant unwilling to discuss– then the pharmacy must notify the complainant in writing of those details.

- **Investigation**
  - Take steps to investigate the complaint efficiently and effectively, interviewing colleagues where necessary and establishing a clear factual timeline of events.
  - Inform the complainant about the progress of the investigation where this is reasonably practicable.
  - Where the response period from the date the complaint was received has passed and the pharmacy is not yet in a position to respond to the complaint – then a written notification must be sent to the complainant with an explanation of the reason for the delay.

- **Reporting the outcome to the complainant**
  - Following the completion of the investigation – a report of the outcome must be sent to the complainant in writing as soon as practicably possible.
  - Include within the report:
    - An explanation of how the complaint has been considered.
    - An indication that concerns have been addressed following full and fair investigation.
    - The conclusion of the investigation and any relevant remedial action.
    - Confirmation of whether the pharmacy is satisfied that if any action is required then this has been taken or will be undertaken.
    - An apology where things have gone wrong.
    - Ombudsman where the complaint relates to NHS service provision (HSC services in Northern Ireland).
    - The signature and details of a named senior member of staff. (**In England** the Responsible Person or someone authorised by the Pharmacy Business to perform the functions of the Responsible Person must sign this document).

- **The report must be:**
  - Clear.
  - Accurate.
  - Balanced.
  - Simple and easy to understand.
  - Free from technical terms or if these must be used clearly explained.

- **England only -** Where the complaint is related to the provision of NHS services then record the following into the NHS Complaints Record: England (NPA product available from NPA Sales - CRB001):
  - The outcome of the complaint.
  - The date the report of the outcome was sent to the complainant.
  - Whether or not the outcome was sent to the complainant within the agreed response period.
  - Whether or not the pharmacy consider the complaint well-founded.

- If the complaint is a not related to the provision of NHS services – then depending upon the nature of the complaint referral to an appropriate body should be considered. For example if the complaint relates to a private PGD then the Independent Medical Agency or Care and Quality Commission or if a complaint relates to unsafe packaging then refer to the MHRA or the manufacturer.
- Follow up action

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If applicable, consider:

- Review and amendment of SOPs following the procedure outlined in the SOP 'Review and notification of standard operating procedures'.
- Train or brief staff. In some cases you may need to consider using the disciplinary process.

- **Record Keeping**

Retain all the following for 10 years (suggested) from the date of completion of the action.

- Correspondence.
- Copies of response sent to the complainant.
- Evidence.
- Details of complainant consent.

28.9 Reporting (Applicable only to NHS or HSC service related complaints)

England only

- In April of each year prepare an annual report for the last 12 months ending on 31st March.
- The report must contain:
  - Number of complaints received.
  - Number of complaints which the pharmacy decided were well founded.
  - The number of complaints referred to the Parliamentary and Health Service Ombudsman.
  - A summary of
    - The subject matter of the complaints received.
    - Important matters arising from the complaints received.
    - Actions to improve services from complaints received.
- A copy of the annual report must be sent to NHS England as soon as reasonably practicable.
- A copy of the annual report must be made available for any person upon request.

PSNC have a template form which can be used for annual reporting. This is available from the PSNC website at www.psnc.org.uk .

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29. Dealing with an Incident

29.1 Objective

The purpose of this SOP is to provide a guide to dealing with incidents when they occur and to look at how the damage can be minimised.

29.2 Scope

An incident that occurs in the Pharmacy or in relation to deliveries that are being made by employed staff members. Where a complaint has been made then the incident is also subject to the procedures detailed in the SOP 'Dealing with complaints'.

29.3 Responsibility

Responsible Pharmacist and Superintendent Pharmacist.

29.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

29.5 Process

29.6 Extremely serious or urgent incidents

- Quickly assess the nature of the incident and decide if the circumstances are serious or urgent enough to merit to immediate cessation of sale or supply of medicinal products or closure of the registered pharmacy. *(e.g. if the responsible pharmacist is suddenly taken ill).*
- Consider if the emergency services need to be contacted and contact them where necessary by dialling 999.

29.7 Investigation and recording of an incident

- The following should be investigated and recorded:
  - Date and time of actual incident.
  - Location of the incident if outside the pharmacy premises.
  - Nature of the incident.
  - Factual account of the incident.
  - Name of the pharmacy staff member making the record.
  - Role/job title of the pharmacy staff member making the record.
  - Nature of any alleged involvement in the incident being recorded.
  - Cause of the incident.
  - Actions which could have prevented the incident from occurring in the first instance.
- Where applicable the following should also be investigated and recorded:
  - Name and address of patient(s) affected.
  - Gender of patient(s) affected.
  - Age of patient(s) affected.

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- Name and address of prescriber.
- Nature of harm alleged to have been caused to the patient(s) by the incident.
- Name(s) of any pharmacy staff allegedly involved in the incident.
- Role/job title of any pharmacy staff allegedly involved in the incident.
- Name of the responsible pharmacist on duty at the time of the incident.

29.8 Possible contributing factors

- Details of medicines or devices involved in the incident – where applicable:
  - Name.
  - Strength.
  - Formulation.
  - Dose.
  - Batch number.
  - Expiry.
  - Other relevant information.
- Retain medicines, labels or devices where possible.
- Print off PMR records where possible.

29.9 Reporting an incident

- Where an incident concerns a medication error resulting in potential or actual harm to the patient – ensure that the prescriber is informed if this hasn't already been done and make a record that the prescriber has been informed.
- Depending upon the nature of the incident assess whether details of the incident and investigation should be reported to any of the following for follow up and make a record that this has been reported to:
  - The Superintendent Pharmacist.
  - The Primary Care Organisation or Regional Health and Social Care Board (RHSCB) in NI.
  - The indemnity insurance provider.
  - The National Patient Safety Agency (using the eForm found at www.npsa.nhs.uk/eform) *(As part of clinical governance and the pharmacy contract – community pharmacies in England and Wales are obliged to report patient safety incidents to the NPSA).*
  - All complaints must be reported to the PSO via the Incident Reporting System.
  - Changes to the PSI reporting arrangements in 2014/15.
    - In order to help meet NHS England's objectives to improve patient safety, it has been agreed that:
      - there must be an increase in the number of patient safety incidents reported by community pharmacies to the NRLS; and
      - from the implementation date, reports submitted to the NRLS will have to identify the pharmacy making the report.

      The requirements for patient safety incident reporting by community pharmacy contractors are set out in the Approved Particulars. The existing Approved Particulars will be amended from the implementation date to require the identification of pharmacies making reports to the NRLS.

      The Approved Particulars will also be amended to clarify which patient safety incidents should be reported to the NRLS. At present the Approved Particulars

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require that all patient safety incidents must be reported to NRLS. This will be amended to clarify that patient safety incidents that did or could have led to patient harm must be reported. Incidents where there was no implied or actual patient harm, for example picking errors that are identified and corrected during the pharmacy's checking procedures, will not be required to be reported to the NRLS.

The superintendent pharmacist must ensure that the new reporting requirements are met from the date that the Approved particulars are changed and ideally before that date.

See http://psnc.org.uk/contract-it/essential-service-clinical-governance/patient-safety-incident-reporting/

29.10 Learning from an incident

- Identify actions which would prevent this incident occurring in the future and where appropriate review the appropriate Standard Operating Procedure and if necessary implement changes following the steps outlined in SOP 'Review and notification of standard operating procedures' to prevent an occurrence carry out a Root Cause Analysis.
- Assess whether it is necessary to train or retrain staff and if so implement training and record that it has been undertaken.
- Assess whether it is appropriate to formally discipline staff and if so implement disciplinary action after taking appropriate employment advice.

Assess if there is a Health and Safety issue which needs to be resolved.

29.11 Feedback over the phone or in writing

- Where the incident leads to a complaint then refer to SOP 'Customer complaints'.
- Consider the use of a careful apology where appropriate being careful **not** to admit the consequences of an incident (i.e. that a dispensing error has led to clinical condition x, y and z).
- Where it is unclear whether there is cause for a complaint or if a mistake has been made:
    - I'm sorry that you are upset.
- Where you are satisfied that there is cause for the complaint or a mistake has been made:
    - I am sorry that you have cause for complaint, or I am sorry that we have made a mistake.

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30. Review and Notification of Standard Operating Procedures

30.1 Objective

To ensure SOPs are reviewed and improved in a timely manner and following any changes in the Pharmacy workflow, staffing level, volume of dispensing and following any serious incidents or events that are an outcome of any Clinical Governance audits for safer working environments.

30.2 Scope

This SOP applies to the working SOPs relevant to this Pharmacy only.

30.3 Responsibility

It is the responsibility of all staff who work in the Pharmacy to report to the Responsible Pharmacist any incidents/events or near misses a soon as possible to enable the RP to assess, report and take action to avoid reoccurrences. It is the responsibility of the RP to report any changes required to the SOPs and for the overall responsibility of the Superintendent Pharmacist to approve and implement changes to the SOPs.

30.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

30.5 Process

30.6 Reviewing the SOPs (RP)

- Each SOP should be reviewed at least once every two years or
  - following any event that may affect patient safety
  - when new legislation or guidance is introduced which affects what needs to be included within a certain SOP.
- Read carefully through the SOP.
- Identify if there are any sections which need updating.
- If there are no changes necessary and the SOP remains fit for purpose then mark the review box with a signature and date to indicate that the SOP has been reviewed.
- Record on the SOP the date for the next scheduled review – this should be a maximum of two years from the current review date.

30.7 Changing the SOPs (RP)

- Keep existing paper versions of SOPs for 15 years from the date they were last effective and keep copies of electronic SOPs indefinitely.
- Mark the existing SOP to indicate that they are no longer in effect.
- In a new copy of the SOP make any amendments or updates which are necessary to ensure that the SOP remains fit for purpose – be careful that any amendments will not result in a breach of the law or any existing good practice requirements.

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- Mark the new SOP to indicate:
    - Date of preparation.
    - The name of the person establishing the new SOPs.
    - The signature of the person establishing the new SOPs.
- Apply a new progressive version number for the new SOP.
- Arrange for pharmacy staff to read the SOP and to sign and date the SOP record sheet.
- Notify the superintendent pharmacist or a person in a position of authority of the review and any consequential changes to the pharmacy procedure, as soon as is reasonably practicable, by completing the 'SOPs Amendment Form' in Appendix 1.

30.8 Notification of the SOPs (RP)

- Inform all relevant staff of any new SOPs or amendments to existing SOPs.
- Ensure that all SOPs are readily available within the pharmacy premises for consultation by pharmacy staff.
- Make arrangements to ensure that all pharmacy staff including occasional staff have read and understood the SOPs applicable to their work and that they have signed and dated the SOP record sheet.
- Signpost new pharmacy staff and casual staff (including locums) to the location of the SOPs within the pharmacy and ensure that they have read and understood the SOPs applicable to their work and that they have signed and dated the SOP record sheet.

30.9 Temporary amendments and deviation from the SOPs (RP)

*Responsible Pharmacist or nominated advisory pharmacist**

The nominated advisory pharmacist is the pharmacist who is available to provide advice and available to be contacted in the absence of the responsible pharmacist.

- In exceptional circumstances where it would be impossible or professionally inappropriate to conform with the procedures outlined in a SOP the pharmacy may temporarily deviate from the procedure without following the formal procedures outlined in the points above.
- Any temporary amendment must be authorised by:
    - The Responsible Pharmacist on duty (whether present or officially absent from the pharmacy premises).
    - The nominated pharmacist providing advice to the pharmacy team in the absence of the Responsible Pharmacist.
- The pharmacist authorising the amendments is professionally responsible for the amendments and must ensure that:
    - Any amendments comply with legal and professional requirements.
    - the procedure is signed and dated to indicate it is subject to temporary amendment.
    - the reason for the temporary amendment is recorded.
- The temporary changes must be communicated to appropriate members of the pharmacy team and, if not authorised by the Responsible Pharmacist, then to the Responsible Pharmacist upon return to the pharmacy.
- Following the resolution of the exceptional circumstance then the SOPs revert back to their original constitution.
- Consider the need for a formal review of SOPs following procedure above.

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31. The Responsible Pharmacist

The Health Act 2006 requires by law that every registered Pharmacy premises has a Responsible Pharmacist (RP) in charge to operate and that the supply of medicines must be made either by or under the direct supervision of a registered pharmacist.

31.1 Objective

That the Pharmacy and Pharmacist is compliant with legislation and abides by the regulations governing RP duties and that staff are aware also of the implications of RP presence and even absence from the Pharmacy Premises.

31.2 Scope

This SOP covers the implications of RP presence and absence from this registered pharmacy premises.

31.3 Responsibility

The Dispensers, Delivery Drivers, Technicians, Pharmacists and Responsible Pharmacist and Superintendent Pharmacist.

31.4 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

31.5 Process

- The RP must be fully aware of the limitations on face to face contact that must be adhered to by this Distance Selling Pharmacy.
- The RP has a statutory duty to make sure SOPs are in place that allows the safe and effective running of a pharmacy. These procedures must be maintained and reviewed regularly.
- The RP must make an accurate contemporaneous record showing that they are the RP of a pharmacy for a particular day and time.
- In certain situations the RP may need to be absent from the pharmacy to carry out their work. In this case they would still be the RP of the pharmacy however they will need to follow the guidance relating to absence of the RP. Another pharmacist must always be present if the RP is going to leave the premises for any reason.
- The RP must display a notice stating their name, GPhC registration number and a statement to show they are the RP at that pharmacy at that time.

31.6 Start of shift procedures

- Clearly display your RP notice as detailed above.
- Make sure the Pharmacy RP Record is up to date and check for any absences in the past 24 hours.
- Make an entry into the Pharmacy RP Record including your name, GPhC registration number and the date and time you are taking on the RP duties.

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- Make sure you are satisfied that the pharmacy SOPs cover the legal requirements to run the pharmacy safely and effectively and you have read, understood and signed all relevant procedures.
- Check for any notes or messages from the previous RP and contact them if there are any outstanding issues that need resolving.

31.7 End of shift procedures

You should stop being the RP if:

- Another pharmacist is going to assume the duties of RP immediately after you.
- The pharmacy is shutting at the end of the day and no further activities will require supervision by a pharmacist.
- You no longer feel able to undertake the duties of RP in the pharmacy. In this case you should contact the Pharmacy Superintendent immediately.

31.8 Remove the RP notice from display

Leave any notes or messages for the next RP and contact them if there are any outstanding issues that need resolving. If the pharmacy is not closing and the next pharmacist is not immediately available to take up the duties of RP, the current RP should remain at the premises until another pharmacist can assume the duties of RP and the Pharmacy Superintendent should be contacted.

Make an entry into the Pharmacy RP Record showing the date and time you ceased to be the RP.

31.9 Absence of the RP

As a Distance Selling pharmacy, we must provide uninterrupted service throughout the opening hours of the pharmacy. For this reason, the RP is not allowed to leave the premises in the same way as an RP at a non-Distance Selling pharmacy is allowed to (for up to 2 hours per day) **unless another pharmacist is present.**

The Pharmacy will have a second pharmacist available during the core and any additional hours that it operates. If, for any reason, the RP is required to leave the premises or wishes to take a break (as per Working Time Directive) then the second pharmacist must sign in as the RP.

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32. Preparing for the absence of the RP

- Ensure the 2nd Pharmacist is aware of your leaving and the length of time you will be absent for.
- Check the Pharmacy RP Record and calculate the maximum amount of time that the RP can be absent from the pharmacy.
- Continue to clearly display your RP notice.
- Make an entry into the Pharmacy RP Record to show the date and time your absence started and the reason for your absence.
- Inform the pharmacy team what time you expect to return to the pharmacy and how they can contact you in your absence.
- The RP should be able to return with reasonable promptness and remain contactable by the pharmacy team during their absence or arrange for another nominated pharmacist to provide advice in their absence.
- The pharmacy team must be instructed that in the absence of a RP the second pharmacist is responsible for the operation of the pharmacy

32.1 During the absence of the RP

- All of the pharmacy team must adhere to the pharmacy procedures set down by the RP.
- Monitor the time that the RP has been absent.
- If the absence exceeds 2 hours:
  - The second pharmacist must assume the role of RP and the Superintendent Pharmacist should be contacted and informed that there is only one pharmacist on duty.
  - The pharmacy must contact the RP for additional instructions and the estimated time of return.

32.2 Roles and responsibilities

32.3 Pharmacy Superintendent

- Professionally accountable for all pharmaceutical aspects of the business.
- Sets the overarching standards and policies for the provision of pharmacy standards within the business.

32.4 Responsible Pharmacist

- Must ensure the safe and effective running of the pharmacy for which they are appointed RP.
- Responsible for the processes governing the dispensing, selling and supplying of medicines.
- Responsible for ensuring that appropriate SOPs are in place and are being reviewed when required.
- Must ensure that the standards and policies set by the Pharmacy Superintendent are implemented and amended where necessary.
- Must ensure the role is within their professional competence.
- Must comply with the RP regulations
- Remains subject to the directions of the Pharmacy Superintendent.
- Must personally supervise the sale and supply of all medicines

32.5 Known Risks

- Unforeseen circumstances leading to sudden and immediate loss of the Responsible Pharmacist on duty.

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			Receiving a prescription in the post or collected from surgeries	Labelling and assembling of a prescription	Handing dispensed prescriptions to delivery driver
RP present			Y	Y	Y
RP absent up to 2 hrs. – 2nd pharmacist present			Y	Y	Y
RP absent: more than 2 hrs.- 2nd pharmacist becomes RP			Y	Y	Y

Initial Checks
Are all members of the team present?
Are the computer systems working properly?
Are you aware of messages left by the previous RP?

Display Notice
Have you displayed your RP notice and entered your presence on the website admin panel?

Records
Have you completed the Legal RP Record?

Procedures
Have you located the pharmacy SOPs?
Do the SOPs cover the legal requirements needed to operate the pharmacy safely and legally?
Do the SOPs need to be reviewed or amended?
Have you informed the pharmacy team how to contact the Superintendent Pharmacist if you are not contactable?
Are the pharmacy team aware of the procedures which must be followed in your absence?

Miscellaneous
CD keys must be under the personal control of the Pharmacists – Confirm
Have you checked the fridge temperature and log?

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33. Repeat Dispensing

33.1 Background

Repeat dispensing is designed to make it easier for patients that receive regular repeat medication that are stable on their medication.

33.2 Repeat Dispensing

Repeat Dispensing is a process by which patients are able to obtain repeat medicines without the need to contact their GP on each occasion. The supplies of medicines are managed by the patient's pharmacy of choice and the patient or representative must visit the same pharmacy for each supply under the service.

The prescriber produces a master 'repeatable' authorising prescription (annotated with RA) on a standard FP10 form and a set of identical 'batch' prescriptions on a standard FP10 form (annotated with RD). Both forms must be computer generated. Any handwritten amendments, including any additional medication added will invalidate the prescription.

33.3 The Authorising Form

The authorising form (RA) is the legally valid prescription and will give details of how many instalment the prescription contains. The standard expiry of an authorising prescription is one year from the date it was generated.

33.4 The Batch Form

The batch prescription (RD) is not a legal prescription and will not be signed by the prescriber. The RD enables the pharmacy to receive payment for the service under the directions of the authorising prescription. The prescriber's signature box is annotated with the number of the batch, e.g. 'repeat dispensing: 6 of 12'. The date on which the repeats were authorised is printed on all the batch issues.

33.5 Objectives

- To provide a framework for a safe on going repeat dispensing service which includes prompt attention to medication change or any other known changes in patient need.
- To promote the service to relevant patients
- To ensure that the master repeatable prescription and batch issues are stored safely.
- To ensure there is an effective audit trail for each master repeatable prescription and its associated batch issues.
- To ensure that all regular dispensary staff are appropriately trained in accordance with the local PCO arrangements, and that all part-time pharmacists, relief pharmacists and locum pharmacists who work in the pharmacy have also received appropriate training.
- To meet the legal requirements of the Repeat Dispensing service
- To offer a safe and effective service to patients without face to face contact
- Ensure that patients gain maximum benefit from their medication and reduce wastage of medicines.

33.6 Scope

This SOP looks at the procedure involved in processing NHS Repeat Dispensing of Prescriptions and is intended to support the training provided by the CPPE course on Repeat Dispensing.

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33.7 Responsibility

The Dispensers, Delivery Drivers, Technicians, Pharmacists and Responsible Pharmacist and Superintendent Pharmacist.

33.8 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

33.9 Process

33.10 Prescription Reception

Appropriate advice about the benefits of repeat dispensing must be given to any patient who:

- has a long term, stable medical condition (that is, a medical condition that is unlikely to change in the short to medium term); and,
- requires regular medicine in respect of that medical condition, including, where appropriate, advice that encourages the patient to discuss repeat dispensing of that medicine with a prescriber at the provider of primary medical services whose patient list the patient is on.

Such advice will be provided by the Pharmacy using its permissible methods of non face-to-face contact with patients.

On receipt of a repeatable prescription from the patient, either in the post or collected from the surgery for the first time, the pharmacy staff should ensure that the patient fully understands the Repeat Dispensing Process and is provided with a patient information leaflet that outlines the benefits of the service.

- Check to confirm if the patient has a long term, stable medical condition that requires regular medicine in the short to medium term and ensure relevant patients have the scheme explained to them.
- The pharmacy record card must be completed and attached to a RA and an entry made on each occasion a dispensing takes place.
- Any amendments to the RD, e.g. items not issued or change to expected interval must be recorded in the comment section of the pharmacy copy of the card.
- When a RA is accepted the details should be checked thoroughly to ensure that there are no omissions or errors which could prevent the dispensing of all the batch prescriptions.
- The RA should be retained in the pharmacy although it is the patient's choice whether they leave the RD with the pharmacy or retain them.

33.11 Pharmaceutical & Legal Assessment

Terms of Service states that a pharmacy must, when providing drugs in accordance with a repeatable prescription the importance of only requesting those items which they need. Patients should be so advised either by phone or through the inclusion of written information with delivered medication.

The pharmacist should telephone and speak with the patient before issuing a repeat and ensure:

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- They are taking or using, and likely to continue to take or use the medicine or appliances appropriately
- Advise the patient that they should only order items that they need
- Check that the patient is not suffering any side effects which may suggest they need a review of their medication
- Check that the patient's regimen has not been changed since the prescriber authorised the repeatable medication.
- Check that there has not been any change to the patient's health since prescription was authorised
- Provide advice and encourage patients with long term, stable medical conditions to discuss repeat dispensing of their medicine with their prescriber.

Any interventions, referrals (to the patient's GP or otherwise) or refusal to supply decisions which are deemed to be clinically significant should be recorded on the Intervention and Referral Form which must be shared with the patient's GP.

The prescriber must have signed the RA. The RDs will not be signed but will be numbered as appropriate. The RA will detail the specific number of issues and, if appropriate, the dispensing interval.

The dispensing interval does not have to be set by the prescriber; however they may choose to specify one. Unless a specific prescribing interval is specified by the prescriber, it is up to the Pharmacist to use their professional judgement when to dispense the next supply for the patient. The pharmacist must be satisfied that the supply of medicines is clinically appropriate. All medicines may be prescribed under the Repeat Dispensing arrangement except Schedule 1, 2 & 3 controlled drugs. Temazepam and Phenobarbital cannot be prescribed. Other Schedule 4 Controlled Drugs may be prescribed, however the first dispensing must be within 28 days of the appropriate date

Refer to additional SOPs for further guidance on dispensing procedures.

When the last RD is dispensed, a note should be attached to the delivery note to advise the patient that a new repeatable prescription and batch issues will be required for further supplies. If required instruct patient to visit GP for another RA and RDs.

33.12 Practice Guidance

Once a repeatable prescription has been issued, patients taking part must obtain the entire period of treatment included on their prescriptions from the same pharmacy.

The use of repeat dispensing by patients is voluntary and with agreement with their prescriber, patients can choose to use their existing method of obtaining repeat prescriptions or repeat dispensing. Due to the exchange of information about medication between the prescriber and the pharmacy, the patient must give consent before participating in this service. This safeguards the patient's information and complies with current guidelines on data protection. The patient's agreement is recorded on the appropriate form by sending by e-mail to the patient and retaining a record in the pharmacy of their completed form.

33.13 Prescription Filing

The filing box should be checked on a monthly basis and any RAs where the expiry date has been reached prior to all RDs being dispensed should be forwarded to the Prescription Pricing Division (PPD), at the end of the month. Any remaining RDs should be returned to the prescriber.

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33.14 End of Month Procedure

Items dispensed within the repeat dispensing scheme should be included within your Prescription Collection Service (PCS) figures when reported on the month end documentation.

All processed RD prescriptions must be submitted to the PPD for payment as part of the normal end of month procedure.

The RA must be submitted to the PPD once all RDs have either been dispensed or expired or the medication is no longer required.

The pharmacy copy of the Customer Record Card should be crossed through and the date that the repeatable prescription was sent to the PPD and number of batch issues remaining detailed in the comments column.

Any information relating to items not dispensed should be recorded in the comments section of the pharmacy record card.

33.15 Repeat EPS Dispensing[4]

When a prescriber issues an electronic prescription for repeat dispensing using their EPS Release 2 prescribing system, in addition to the information found on a standard EPS Release 2 prescription, this electronic repeatable prescription contains:

- the intended interval between each issue of the repeatable prescription
- how many times the repeatable prescription can be issued

Any patient suitable for a repeat prescription could be suitable for electronic repeat dispensing.

This includes but is not limited to:

- Patients on stable therapy
- Patients with long term conditions
- Patients on multiple therapy e.g. hypertension, diabetes, asthma etc.
- Patients that can appropriately self-manage seasonal conditions.

Whilst all the above patient groups are suitable for electronic repeat dispensing the additional functionality allows the patient suitability to be broadened based upon clinical assessment.

33.16 How do you produce an electronic repeat dispensing prescription?

Producing an electronic repeat dispensing prescription is very similar to producing a normal EPS Release 2 prescription.

In some systems this involves an upfront choice to produce an electronic repeat dispensing prescription. Different systems may use different wordings, for example:

- Electronic repeat dispensing
- Batch prescribing
- Repeatable prescriptions

In other systems the prescription items are chosen first and the prescription type is then set as repeat dispensing template. Please see your prescribing systems' training manual for specific details.

[4] https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf

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An electronic repeat dispensing prescription can contain up to four items, the same number as on a normal EPS Release 2 or FP10 prescription. Multiple electronic repeat dispensing prescriptions can be issued.

All the items on an electronic repeat dispensing prescription must be in the dictionary of medicines and devices (dm+d) to be suitable for electronic prescribing. This is the same as a normal EPS Release 2 prescription.

An example of good practice for electronic repeat dispensing is to include messages to the patient and dispenser within the electronic prescription to remind them there is no need to reorder the prescription at the prescribing site until the end of the electronic repeat dispensing prescription. For example: Please collect your prescription every 28 days from your nominated pharmacy, there is no need to reorder from your GP until the final issue has been fulfilled.

33.17 What is a repeat authorisation token?

A repeat authorisation token is a master copy of the prescription.

As well as the standard information found on all tokens, such as patient demographics and prescriber details, a repeat authorisation token states:

- items;
- number of issues;
- interval; and
- end date.

This is usually held by either the patient or the dispenser.

A repeat authorisation token can be issued by the prescribing site if the patient requires a copy of their prescription. This allows the patient to attend an alternative dispensing site to collect an issue without changing their nomination or requesting a copy from the prescribing site, and provides information on what has been prescribed and the number of issues. The dispenser does not require the paper repeat authorisation token to dispense or claim a repeat dispensing issue.

33.18 Do I need to issue a Repeat Authorisation Token?

No, the mandatory repeat authorisation token, given to the patient at the start of a repeat dispensing prescription, is optional when issuing a repeat dispensing prescription in the Electronic Prescription Service. If the patient requests a copy of the repeat authorisation token, then the prescriber can issue one at the time of prescribing or at a date in the future within the duration of the prescription. Until system suppliers have made functional changes to their systems, the repeat authorisation token may continue to default to printing, but after 1 November 2014 it will be optional to send this to the patient.

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34. Information Governance

34.1 Scope

Systems and procedures that process personal data of individuals including the PMR system. See GPhC guidance on confidentiality for more information.

34.2 Objective

This SOP will ensure that The Pharmacy complies with relevant guidelines and the law concerning Data Protection and confidentiality.

34.3 Risks

- Personal data is revealed without patient consent.
- Personal data is not properly acquired, stored, or maintained.
- Data is not properly protected

34.4 Applicable to:

- Dispensing Assistants.
- Dispensing Technicians.
- Accuracy Checking Technicians.
- Pharmacists.
- All other colleagues.

34.5 Responsible:

- Pharmacists.
- Pharmacy Superintendent.

34.6 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

34.7 Confidentiality

You must respect and protect people's dignity and privacy.

- Take all reasonable steps to prevent accidental disclosure or unauthorised access to confidential information. Never disclose confidential information without consent unless required to do so by the law or in exceptional circumstances.
- You must use information you obtain in the course of your professional practice only for the purposes you were given it, or where the law says you can.
- You must make sure you provide the appropriate levels of privacy for patient consultations. This applies even though we are contacting patients in a non face to face way.

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34.8 Data Protection

The PSNC has published detailed guidance on its website which should be referred to along with this SOP in the first instance for data protection queries.

Legal framework governing the processing of Personal Data

The current data protection legislation in the United Kingdom is the Data Protection Act 1998 (the "**Act**"), and with effect from 25 May 2018, will implement the General Data Protection Regulations ("**GDPR**") (for so long as the GDPR is in effect in the United Kingdom) and any successor legislation to the Act and the GDPR, specifically the Data Protection Bill once it becomes law (together the "**Data Protection Laws**"). The Data Protection Laws govern the processing of Personal Data (as defined in the Data Protection Laws). Staff must complete any mandatory training issued from time to time relating to information security, data protection and/or the General Data Protection Regulations.

Key definitions

"Personal data" is any information relating to an identifiable person who can be directly or indirectly identified in particular by reference to an identifier.

"Special categories of data" includes genetic data, health data, and biometric data where that data is processed to uniquely identify a customer.

"Processing" means any operation or set of operations which is performed on Personal Data or sets of Personal Data. This includes, but is not limited to, the collection, recording, organisation, storage, alteration, adaptation, retrieval, use, consultation, dissemination, or otherwise making available of Personal Data.

In relation to a customer's Personal Data, you should comply with the following (where applicable):

1. **You must process the Personal Data lawfully, fairly and in a transparent manner**
   The pharmacy practice leaflet is available on the website and a copy of the leaflet can be sent to customers upon request. The leaflet contains a data protection statement which explains to the customer who is processing their Personal Data and the purposes for which their Personal Data will be processed.

2. **Only collect Personal Data for specified, explicit and legitimate purposes and do not further process the Personal Data in a manner that is incompatible with the original purpose(s) for which it was collected**

   You should only use the customer's Personal Data for the purpose for which it was originally provided and for no other purposes. The Personal Data should be adequate, relevant and limited to what is necessary in relation to the purposes for which it is processed
   You should only access a customer's Personal Data if you have a need to do so, and even then, you should only do so to the extent necessary to achieve the relevant purpose.

   Do not record and/or store Personal Data that you do not need.

   Data should be anonymized where possible.

3. **The Personal Data should be accurate and, where necessary, kept up to date**
   Every reasonable step must be taken to ensure that Personal Data that is inaccurate, taking into account the purposes for which that Personal Data is processed, is erased or rectified without delay.

   You should ensure that you record a customer's Personal Data accurately. When contacting a customer using the Personal Data that they have provided you should confirm that their details are accurate.

4. **The Personal Data should be kept in a form which permits identification of customers for no longer than is necessary for the purposes for which the Personal Data is processed**
   Customer records should not be kept for longer than is necessary.

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The relevant retention periods are set out on the GPhC website.

5. **Personal Data should be processed in a manner that ensures appropriate security of the Personal Data, including protection against unauthorised and unlawful processing and against accidental loss, destruction or damage, using appropriate technical and organisational measures**

Personal Data should be protected against unauthorised or unlawful processing and against accidental loss, destruction or damage.

Data Security in the Pharmacy

The patient medication record ("**PMR**") system should only be accessed by a registered Pharmacist (or colleagues under his or her direct supervision who require access).

All staff must log into the PMR system using a specific ID number and password. You must not allow unauthorised colleagues (e.g. non-dispensing staff) to access the PMR system. The password for accessing the pharmacy system should be changed on a regular basis and should not be easy to guess (e.g. it should not be a pharmacist's date of birth).

You must ensure that the log-in terminal for the PMR system is located in an area of the pharmacy that cannot be accessed by anybody other than authorised persons and that the screen cannot be viewed by anybody other than the authorised persons. You should ensure that you make appropriate use of a password-protected screen-saver to prevent others being able to view customer information and you should clear customer information from the screen before accessing another patient's medical record.

All manual files relating to customers of the pharmacy should be kept in a secure location at the pharmacy under lock and key when unattended and keys should be held in a secure place.

When collecting health data from a customer over the telephone, you should be aware that you may be overheard and if necessary take additional steps to protect the customer's privacy, for example, by taking the conversation into a separate consultation room, where available (or at least out of earshot of other colleagues).

All pharmacy customer Personal Data is confidential and must not be disclosed to any other colleague(s) not involved with the customer's care.

If a third party service provider may have access to customer Personal Data (e.g. in the case of a third party that is providing maintenance services in respect of the internal pharmacy system), you should first of all refer the matter to the Superintendent Pharmacist – a contract should always be in place with the third party, that contains adequate data protection provisions to ensure that customer Personal Data is protected. This will usually be in the form of a master agreement or a data processing agreement.

When disposing of confidential information (including spare dispensing labels) and/or customer Personal Data, you need to do so in such a manner that the customer can no longer be identified, for example, by shredding it.

You should not send customer Personal Data by fax.

Disclosing Customer Data

Customer Personal Data is confidential and, at no point, should it be disclosed other than as permitted by the data protection statement in the pharmacy practice leaflet and/or with the customer's express (usually written) consent which must be given prior to the disclosure being made. In the event a customer provides their consent to you verbally, you must keep a record of the consent provided, detailing who provided the consent, why they provided their consent, how they provided their consent and when they provided their consent.

If you are not sure whether you have the customer's consent to share their information for a particular purpose, or the purpose is not specified in the pharmacy practice leaflet, you should

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contact the customer and obtain their consent. You should keep a record of their consent (if it is provided). If the customer does not provide their consent, then you should not process their Personal Data for that purpose.

If you believe there is another lawful basis for processing the customer's Personal Data, other than consent, you should reach out to the Data Protection Officer.

The GDPR introduces enhanced rights for individuals. These are set out below with instructions on how to deal with a request from an individual to exercise any of these rights.

Right to be informed

Customers have a right to be informed about the collection and use of their Personal Data, at the time at which their data is collected. You must provide the customer with information including: the purposes for the processing of their Personal Data, retention periods of their Personal Data and who their Personal Data will be shared with. Any new uses of a customer's Personal Data must be brought to their attention. If the customer already has this information, then you do not need to provide it to them again.

Right of access

Customers have a right to access the Personal Data held about them and supplementary information. This right allows customers to be made aware of and to verify the lawfulness of the processing of their Personal Data. Customers have the right to obtain:

- Confirmation that their Personal Data is being processed;
- Access to their Personal Data; and
- Other supplementary information

You should not charge the customer to respond to such requests, although a reasonable fee can be charged where the request is manifestly unfounded or excessive (e.g. if it is repetitive). You may also charge a fee to respond to requests for further copies of the same information. Any fee must be based on the administrative cost of providing the information.

You should verify the identity of the customer that is making the request, using 'reasonable means'. If the request has been made electronically, you should provide the information in a commonly used electronic format.

A request from a customer should be made in writing (email is acceptable). The customer does not have to provide you with a reason for requesting the information. You should log the request on the PMR system.

You or the Superintendent Pharmacist must also notify the Data Protection Officer of the subject access request as soon as it is received.

Subject access requests must be responded to without delay and at the latest within one (1) month of receipt. Where the request is particularly complex or there are numerous requests from the customer, this time frame may be extended by a further two (2) months, but the customer should be informed of the extension (including reasons) within one (1) month.

Any request that is made by a third party for information relating to a customer should be referred to the Superintendent Pharmacist, and notified to the Data Protection Officer as soon as the request is received.

The pharmacy may receive a request from a third party for access to a deceased customer's records. You should refer all such requests to the Superintendent Pharmacist, and notify the Data Protection Officer as soon as the request is received.

Right to rectification

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Customers have a right to have inaccurate information held by the pharmacy corrected, or, completed if it is incomplete. Inaccurate information is information which is incorrect or misleading as to any matter of fact. You can accept such requests verbally or in writing.

You should take reasonable steps to satisfy yourself that the Personal Data held by the pharmacy is accurate and to rectify the Personal Data if necessary. You should take into account any information provided by the customer. A record of the mistake should be kept with the rest of the customer's Personal Data.

It is good practice to restrict the processing of the customer's Personal Data whilst the accuracy of their Personal Data is being checked.

If you are satisfied that the data is accurate, then you should inform the customer and let them know that the data will not be amended.

If we have disclosed the customer's Personal Data to others, then we must contact each recipient and inform them of the rectification or completion of the customer's Personal Data, unless this proves impossible or involves disproportionate effort. If we are asked, we must also tell the customer about these recipients.

Always refer such requests to the Superintendent Pharmacist as soon as they are received from a data subject.

Right to erasure

This is otherwise known as the "right to be forgotten".

Customers may make a request to have any Personal Data that we hold on them deleted. They may make the request verbally or in writing. You must deal with such requests promptly and within one (1) month from receipt.

Customers have the right to have their personal data erased if:

•the Personal Data is no longer necessary for the purpose which it was originally collected or processed;

•we are relying on consent as our lawful basis for holding the Personal Data, and the customer withdraws their consent;

•we are relying on legitimate interests as our basis for processing, the customer objects to the processing of their Personal Data, and there is no overriding legitimate interest to continue the processing;

•we are processing the Personal Data for direct marketing purposes and the customer objects to that processing;

•we have processed the Personal Data unlawfully (i.e. in breach of the lawfulness requirement of the 1st principle);

•we have to do it to comply with a legal obligation; or

You should tell other organisations about the erasure of Personal Data, if the customer's Personal Data has been disclosed to them.

The right to erasure does not apply if the processing is necessary for one of the following reasons:

•to exercise the right of freedom of expression and information;

•to comply with a legal obligation;

•for the performance of a task carried out in the public interest or in the exercise of official authority;

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•for archiving purposes in the public interest, scientific research, historical research or statistical purposes where erasure is likely to render impossible or seriously impair the achievement of that processing; or

•for the establishment, exercise or defence of legal claims

The right to erasure will not apply to special category data:

•if the processing is necessary for public health purposes in the public interest (e.g. ensuring high standards of quality and safety of health care and of medicinal products or medical devices); or

•if the processing is necessary for the purposes of preventative or occupational medicine (e.g. where the processing is necessary for the working capacity of an employee; for medical diagnosis; for the provision of health or social care; or for the management of health or social care systems or services). This only applies where the data is being processed by or under the responsibility of a professional subject to a legal obligation of professional secrecy (e.g. a health professional).

You should refer such requests to the Superintendent Pharmacist as soon as they are received.

Right to restrict processing

Customers have the right to request the restriction or suppression of their Personal Data in certain circumstances (where they have a particular reason for wanting the restriction). When processing is restricted, you are permitted to store the Personal Data but you may not use it. The customer can make the request verbally or in writing.

Customers have the right to request that we restrict the processing of their Personal Data in the following circumstances:

•where the customer contests the accuracy of their Personal Data and you are verifying the accuracy of the Personal Data;

•the Personal Data has been unlawfully processed (i.e. in breach of the lawfulness requirement of the first principle of the GDPR) and the customer opposes erasure and requests restriction instead;

•we no longer need the Personal Data but the customer needs us to keep it in order to establish, exercise or defend a legal claim; or

•the customer has objected to us processing their Personal Data (where the grounds for processing are in the public interest and/or legitimate interests), and we are considering whether our legitimate grounds override those of the customer.

You must not process the restricted data in any way except to store it unless:

•you have the customer's consent;

•it is for the establishment, exercise or defence of legal claims;

•it is for the protection of the rights of another person (natural or legal); or

•it is for reasons of important public interest.

If the Personal Data has been disclosed to other organisations, then we should notify each recipient of the restriction of the Personal Data unless this proves impossible or involves disproportionate effort. If asked, you must inform the customer about these recipients.

In many cases the restriction of processing is only temporary. If you lift the restriction, you must inform the customer before you lift the restriction.

You must refer any such requests to the Superintendent Pharmacist.

Right to data portability

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Customers are entitled to obtain and reuse their Personal Data for their own purposes across different services. This will only apply where we are the controller of the data, and where the processing is based on consent or, for the performance of a contract and where processing is carried out by automated means.

You must provide the Personal Data in a structured, commonly used and machine readable form. Open formats include CSV files. Machine readable means that the information is structured so that software can extract specific elements of the data. This enables other organisations to use the data.

The information must be provided free of charge.

If the customer requests it, you may be required to transmit the data directly to another organisation if this is technically feasible.

You should refer such requests to the Superintendent Pharmacist.

Right to object

Customers have the right to object to:

•processing based on legitimate interests or the performance of a task in the public interest/exercise of official authority (including profiling);

•direct marketing (including profiling); and

•processing for purposes of scientific/historical research and statistics.

You should ensure that such objection is recorded on the PMR and actioned. Always refer such requests to the Superintendent Pharmacist.

If a customer objects to their Personal Data being processed for a particular purpose, you should carefully explain the implications of objecting (including, if applicable, being unable to dispense their prescription) and record such objection. You should not force the customer into providing their consent

Response times

All requests from a customer should be responded to without delay and at the latest within one (1) month of receipt. Where the request is particularly complex or there are numerous requests from the customer, this time frame may be extended by a further two (2) months, but the customer should be informed of the extension (including reasons) within one (1) month. You should discuss with the Superintendent Pharmacist and/or the Data Protection Officer before extending the time frame to respond to a request, as there may be other considerations that need to be taken into account.

Where the customer has made a request for rectification of their Personal Data, erasure of their Personal Data, a restriction on processing, or data portability, and you refuse the request you must explain the reasons for your decision and inform them of their right to make a complaint to the Information Commissioner's Office ("**ICO**") to enforce their rights through a judicial remedy. A record should be kept on our internal system(s) of the customer's request regarding their Personal Data.

If you refuse to deal with a request for rectification, erasure or a restriction on processing because the request is manifestly unfounded or excessive, you will be required to justify your decision to the customer and/or you can charge a "reasonable fee" to deal with the request. You must explain the reasons for your decision and inform them of their right to make a complaint to the ICO to enforce their rights through a judicial remedy if you request a reasonable fee and/or additional information to identify the customer.

Before rejecting a request, you should discuss with the Superintendent Pharmacist and/or the Data Protection Officer, as there may be other considerations that need to be taken into account.

Personal data breaches

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All Personal Data breaches must be notified to the Superintendent Pharmacist and the Data Protection Officer as soon as you become aware of a breach or suspected breach, as there are time limits within which the ICO must be notified. You should provide the Superintendent Pharmacist and the Data Protection Officer with all relevant information and all assistance required in connection with a breach or suspected breach. You should not take any steps yourself to notify customers or the ICO.

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35. Dealing with Drug Alerts and Recalls

35.1 Objectives

The aim of this SOP is to create:

- An effective procedure for dealing with Drug Alerts and Recalls.
- To ensure best practices are abided by.
- To ensure that stock subject to a recall is not dispensed to patients or sold in the pharmacy.

35.2 Risks

- The subject stock may still be used in the pharmacy.
- Patients may have already received subject stock.

35.3 Scope

This SOP deals with Drug Recalls and Alerts.

35.4 Responsibility

Dispensers, Technicians and Pharmacists.

35.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

35.6 Process

Recalls – Healthcare Professionals' Responsibilities.

MHRA Drug Alerts are distributed via the Department of Health's Central Alerting System (CAS) and the pharmacy and personnel are all registered with access to this service and will receive email alerts via the NHS mail service. CAS is an electronic cascade to Pharmacy Departments in NHS Hospital Trusts via Regional Pharmaceutical Officers, to Private Hospitals via the National Care Standards Commission, to Community Pharmacists, General Practitioners and Dental Surgeons, as appropriate via local Action Teams (IAT's).

Further details regarding CAS can be found at the following link

https://www.cas.dh.gov.uk/Home.aspx

Licence holder led recalls are usually addressed direct to recipients of the affected batch(es), or via notices on delivery notes from wholesale dealers. Whichever form the recall takes, the principals of this section apply.

"What am I supposed to do with the information?"

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The Drug Alert will contain an outline of what actions should be taken; this may also be followed up with further details from the licence holder in a subsequent communication. Recipients of recall notices should have in place local procedures that identify the actions that need to be taken in response to each recall notice, whether a DMRC Drug Alert or a licence holder recall.

Instructions within Drug Alerts need to be acted upon appropriately, examples of each class of Drug Alert are given at the end of this SOP

The actions which should be taken are as follows:

1. Read the Alert and identify who it is intended for.

2. Identify the Class of the Alert.

   The timescales specified on Drug Alerts are for advice to give some indication of the priority with which action should be taken.

3. Check if you have had any stock of the affected product using the information provided in the Drug Alert. Each Drug Alert gives distribution dates as well as batch and expiry information. If, based on the information provided, it is unlikely that you have had any of the affected products, you do not need to do anything else, e.g. if you have not had any deliveries since the date of first distribution of the product, you are unlikely to have any stock.

4. If you have stock of the affected product, place this in the specially designated quarantine area and inform all staff about the details of the recall. Stock should also be deducted from the stock levels in the computer system.

   Consider outstanding orders and recent deliveries, these may have been dispatched before the recall notice was issued

5. If you have supplied products for stock to other organisations ensure that they are aware of the recall, e.g. care homes or other organisations or wholesaling to other organisations.

6. For patient level recalls check dispensing records, and identify patients who have received the affected batches.

   If you are not able to identify batch numbers or suppliers from your records you may need to contact every patient who has received the named product since the date of first distribution.

   If a patient level recall is needed, the licence holder may also consider public announcements.

   You may need to be prepared to provide replacement stock for the patient, and may need to make arrangements for new prescriptions; in certain circumstances you may need to consider making an emergency supply (see the current edition of Medicines Ethics and Practice published by the Royal Pharmaceutical Society of Great Britain for further information).

7. If you have problems or queries regarding the recall you should contact the licence holder via the contact details given on the Drug Alert.

8. If you have problems with the quality of the text, or other transmission issues, you should contact the next level of the cascade up from you. You should ensure that you know who this is, e.g. for community pharmacists and GPs this will usually be the local Action Teams.

9. If neither of the above is able to help, you should contact the DMRC.

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10. Advice within medicines drug alerts should not override professional judgment in making decisions in the best interest of their patient.

11. The RP involved in cascading or responding to drug recalls should ensure that they fully document any action that they take with regards to a recall.

Note of Drug Alert or Recalls

Drug Alerts have the following classifications:

- Class 1 Action Now (including Out of Hours).
- Class 2 Action within 48 hours.
- Class 3 Action within 5 days.
- Class 4 Caution in use.

Drug Alerts Classes 1 to 3 will be augmented with the words "Medicines Recall" in the title.

An additional classification, "Drug Safety Information" has been introduced for Pharmacovigilance alerts. Drug Safety Information messages should be disseminated immediately upon receipt during working hours to the health professionals specified.

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36. Facilitating Remote Access

36.1 Objectives

The aim of this SOP is to create:

- To facilitate and improve remote access to pharmaceutical services for patients

36.2 Risks

- Ensuring that services to be accessed remotely are appropriate for remote access

36.3 Scope

All relevant services

36.4 Responsibility

Superintendent Pharmacist

36.5 Review

The SOP will be reviewed at least once every two years by the Pharmacy Superintendent and changes made to reflect new legislation if appropriate.

The SOP will be reviewed following a critical incident.

An entry should be made into training records for each employee that has read, understood and agreed to follow this Standard Operating Procedure.

36.6 Process

At least every 6 months the SP must

- Review the previous Remote Access Plan
- Consider and relevant changes in technology that could facilitate remote access to pharmaceutical services.
- Review the use of remote access by patients to existing services
- Review feedback from users of the services that have been accessed remotely
- Update the Remote Access Plan to discuss with other pharmacy staff members and the providers of the IT solutions for the pharmacy
- Agree processes and timescales for any changes to remote access
- Produce a communications plan to be sent to patients about proposed changes

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37. Pharmacy Staff SOP Acknowledgment and Update Log

NOTE TO PHARMACY TEAM
THIS PAGE SHOULD BE INSERTED AT THE BEGINNING OF EACH SOP AND FILLED IN AND UPDATED AS REQUIRED

Record of SOP Updates and Reviews:

Insert page at the end of each SOP and add extra lines as required

Title of SOP	Update or Review?	Date Carried Out	Carried Out By	Confirm Update Provided to Staff Members	NOTES
1.					
2.					
3.					

I confirm that I have read and understood the following SOP:

Insert page at the end of each SOP and add extra lines as required

Title of SOP	Name	Signature	Position	Date of Completion	RP Authorisation
4.					
5.					
6.					

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38. Appendices

38.1 Appendix 1 SOP Amendment Form

SOP Amendment Form

Name of SOP:

Details of Amendment:

Requested From:	**Position:**
Signed:	**Date:**

....

For Office Use Only

Details of Amendment:

Approved By	**Position:**
Signature:	**Date:**

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FULL SOP / GUIDANCE NOTES NOT PROVIDED AS NOT RELEVANT TO REG 25 APPLICATION. CAN BE PROVIDED ON REQUEST

38.2 Appendix 2 A Guide to Confidentiality

A Guide to Confidentiality

38.3 Appendix 3 Pseudoephedrine and Ephedrine

Pseudoephedrine and Ephedrine:

38.4 Appendix 4 Daily Delivery Manifest

Daily Delivery Manifest

To be completed for all deliveries to patient's home or representatives, in order of route.

38.5 Appendix 5 Controlled Drug Record Sheet

Controlled Drug Record Sheet

38.6 Appendix 6 Fridge Temperature Record Chart

38.7 Appendix 7 NPA Guidance on Controlled Drugs Legal Requirements

NPA Guidance on Controlled Drugs Legal Requirements

38.8 Appendix 8 Controlled Drugs Practical Guidance

Controlled Drugs - practical guidance

Appendix 9 Record of Destruction of CD Stock

38.9 Appendix 10 Supply of Methotrexate

Supply of Methotrexate

Guidance Notes

38.10 Resources and Other Information

NPA resources

38.11 Appendix 11 Supply of Anticoagulants

Supply of Anticoagulants

38.12 Child and Vulnerable Adult Protection Policy

DOCUMENT AMENDMENT HISTORY

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Revision No.	Originator of change	Date of change	Change Description

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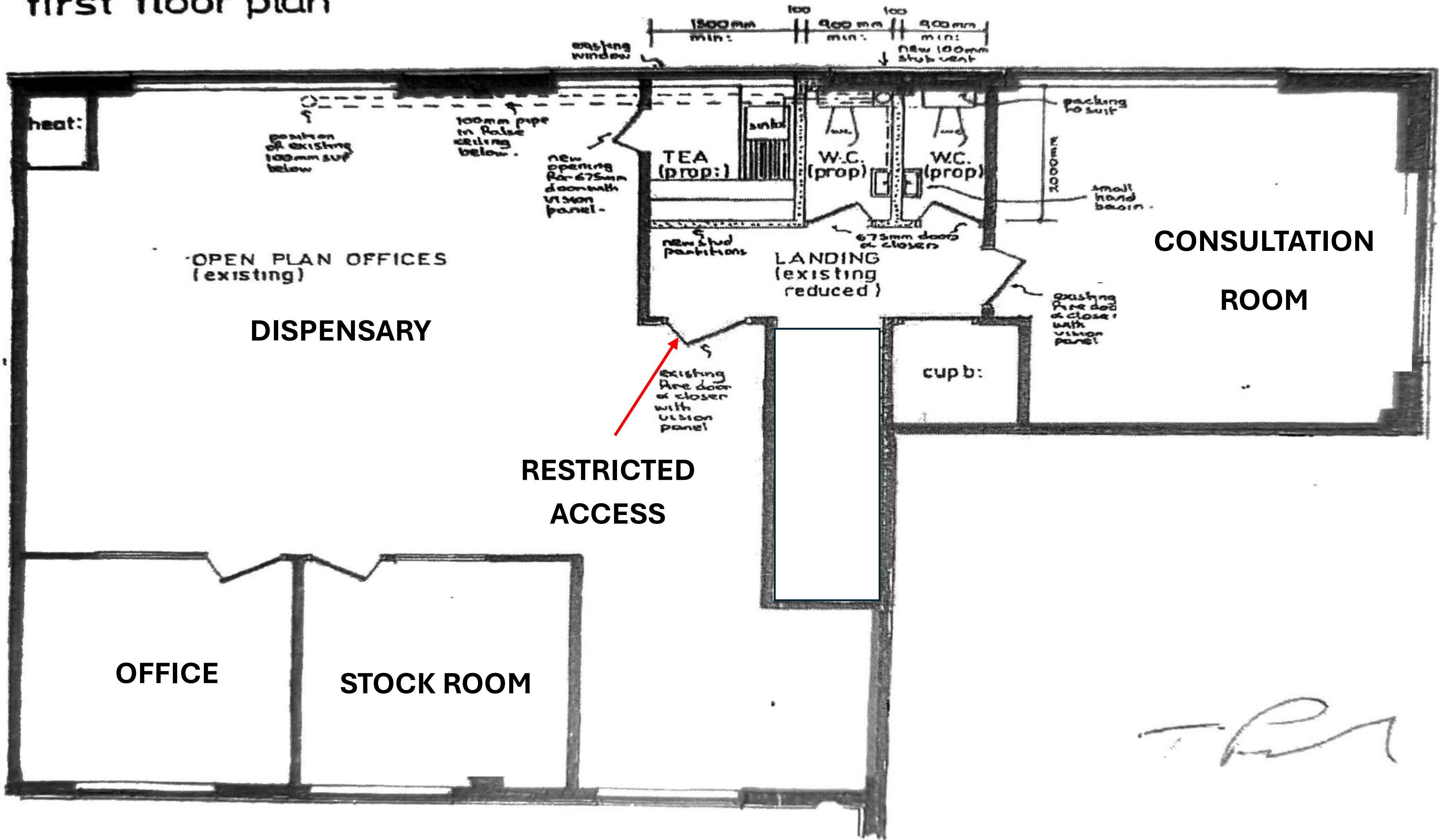
first floor plan
heat:
OPEN PLAN OFFICES
(existing)
DISPENSARY
TEA
(prop:)
sink
W.C.
(prop)
W.C.
(prop)
LANDING
(existing
reduced)
CONSULTATION
ROOM
cup b:
RESTRICTED
ACCESS
OFFICE
STOCK ROOM
1500mm min:
100
900mm min:
100
900mm min:
existing window
new 100mm stub vent
100mm pipe in false ceiling below.
new opening for 675mm door with vision panel -
new stud partitions
675mm doors & closers
packing to suit
small hand basin
existing fire door & closer with vision panel
see o-s. sheet for location

How we will involve patients in decisions on pharmacy applications

When we receive an application to move an existing pharmacy or to open a new pharmacy we must write to:

- nearby pharmacies
- in some cases, nearby doctors' surgeries
- the Health & Wellbeing Board which is a committee of the borough, county or city council, and
- the local Healthwatch organisation, which exists to represent local patients in general

We send them a copy of the application and invite them to make comments within 45 days. Comments can be made by letter or email.

In addition, the law requires us to involve patients in our decision-making. We may do this by sending copies of pharmacy applications to:

- city/district and county councillors covering the area involved
- the town or parish council covering the area. In areas which do not have a town or parish council we may instead contact prominent community, neighbourhood or residents' groups
- patient representative groups attached to nearby doctors' surgeries.

They will also be invited to make comments within 45 days.

When we send them a copy of an application we will also send notes to explain:

- what the application is about
- why they are being asked for comments
- what we will consider when making a decision, and
- what happens next after a decision is made.

Applications are not confidential. If they want, councillors or patient groups may share details with local people so they can also make comments within the same 45 day period.

Any comments we receive will be sent to the pharmacy applicant. They will have a chance to respond to us about those comments.

Most applications are decided using written information, including any comments received.

In general, we will not hold public meetings about pharmacy applications. This is because an applicant cannot be made to attend to respond directly to any questions from members of the public.

However, we may hold a hearing if we need more information before making a decision. Where written comments from councillors or patient groups suggest that

local people hold strong views, we will invite those councillors or patient groups to attend the hearing.

The hearing will be held in public so that (although members of the public will not be able to ask questions) they will be able to hear the arguments for and against the application. These will include any comments made by their representatives and the responses received.

All comments at the meeting will be taken into account in making a final decision on the pharmacy application.

Chapter 29

Annex 11

Distance Selling Premises Application

Application by Halo Pharmacy Ltd (the applicant) to open a distance selling premises at Unit 25, Kingfisher Court, Newbury RG14 5SJ.

Explanatory notes by Buckinghamshire, Oxfordshire and Berkshire West ICB

1. What is this application for?

The applicant wishes to open an NHS internet pharmacy at Unit 25, Kingfisher Court, Newbury RG14 5SJ. This type of pharmacy is referred to as 'distance selling premises' in the regulations and operates under strict rules which means it is not able to provide services face to face at the premises.

A pharmacy can only give patients medicines prescribed by NHS GPs if it has Buckinghamshire, Oxfordshire and Berkshire West ICB's permission. We give permission for this type of pharmacy where we are satisfied that they will be able to provide services safely and effectively without seeing the patient face to face. This type of pharmacy provides the same services as any other type of pharmacy but you can't, for example, take your prescription there to be dispensed or collect it once it has been dispensed. Instead you could post it to the pharmacy or ask your GP to send it electronically. The pharmacy would then dispense it and send it to you either via the post or a courier.

These notes explain the process we follow when deciding whether to give permission.

2. Why have I been sent a copy of the application?

You are being invited to make comments on the application before Buckinghamshire, Oxfordshire and Berkshire West ICB takes a decision on whether the pharmacy can go ahead. Any comments must be received before the end of the 45-day period mentioned in the letter.

Applications are not confidential. If you want, you may share details with anyone else who might be interested. They can also make comments within the same 45-day period.

Any comments we receive will be sent to the applicant. They will have a chance to respond to us about those comments.

When we come to make a decision, Buckinghamshire, Oxfordshire and Berkshire West ICB will consider any comments it has received and any response to those comments from the applicant.

3. How will Buckinghamshire, Oxfordshire and Berkshire West ICB decide whether to give permission for a new pharmacy?

Firstly we need to check to make sure the applicant is offering to provide services to anyone in England who may want to use them.

Then we look at how they say they will provide services without seeing the patient face to face. We need to check to make sure they are able to provide all the services you would expect from a pharmacy safely and effectively.

4. When will a decision be made?

We expect to make a decision by 18 October 2024.

5. What will happen if permission is given?

If we decide to give permission for the pharmacy to open, this does not automatically mean that it will happen. Other local pharmacies may be able to appeal against the decision. Appeals are dealt with at national level by NHS Resolution.

If no appeals are received or if they are rejected by NHS Resolution, the applicant would then have up to 12 months to open, although this could be extended to 15 months. If those deadlines were not met, then the permission would expire.

6. What if permission is refused?

The applicant would be able to appeal.

NHS England's Privacy Notice describes how certain services are provided on behalf of Integrated Care Boards and how personal data is used. It also explains how you can invoke your rights as a data subject. We will protect your information in line with the requirements of the Data Protection Act 2018.

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Cost of Living Update

Report being considered by:	Health and Wellbeing Board
On:	11 July 2024
Report Author:	Sean Murphy
Report Sponsor:	Sean Murphy
Item for:	Decision

1. Purpose of the Report

The purpose of this report is to update the Health and Wellbeing Board on the collective response to the impact on residents in West Berkshire of the high cost of living.

2. Recommendations

That the Health and Wellbeing Board:

(a) **NOTES** the report and the response of partners to date.

(b) **RESOLVES** that the Service Lead for Public Protection provide an update to the Board at its next meeting.

3. Executive Summary

3.1 The Board has now received four updates on the local response by the Council and voluntary sector partners to support residents facing challenges due to financial pressures. The most recent was on the 2nd May 2024. This report updates on matters since the May report was presented to Board.

3.2 In April 2024 the Office for National Statistics reported that the headline Consumer Price Index (CPI) rate in the year to May 2024 stood at 2.0%. This is in line with the Bank of England target and lowest rate for two years. The biggest contributor to the fall was the slowdown in the increase of food prices and reduction in energy costs. Services costs were up by 5.9% and owner-occupier housing costs by 6.7%.

3.3 For the period from 1st April 2024 to 30th June 2024 the 'energy price cap' was reduced to £1,690 per year, which amounts to a reduction of £238 per year (12%) for the typical household. For the period 1st July 2024 to 30th September 2024, it has been reduced further to £1,568 which is a further reduction of £122 per year for the average household. It is predicted that the cap could start to rise again in the next review period, but it is now significantly lower than the peak.

3.4 Fuel prices have fallen slightly since the last meeting. A typical cost for unleaded petrol is around 144p per litre and around 148p per litre for diesel in the Newbury area.

3.5 Whilst many of these baseline indicators show an improving situation, it is nevertheless the case that voluntary organisations and charities assisting those

struggling financially are reporting significant increases in demand for support and advice. This is also borne out by demand for personal / family grants from the Household Support Fund.

4. Update Report

Household Support Fund (HSF)

4.1 In March 2024, the Government announced that West Berkshire Council has been allocated **£694,849** to meet the stated aims of the Household Support Fund of supporting the vulnerable or those that cannot pay for essentials. The funding period for this round of funding runs from April until 1st October 2024.

4.2 At the last meeting of Health and Wellbeing Board, the Board was notified that the allocations for the grants were set to be approved by Individual Executive Decision. Those allocations were made on the 2nd May 2024 and the details can be found here: HSF May 2024.

4.3 The allocations included a combination of targeted support delivered in partnership with local voluntary organisations. This included help with white goods, furniture, carpets, utility costs and for pensioners and those in emergency accommodation. There was also a further allocation made to the joint Cost of Living fund with Greenham Trust to support the local voluntary sector further with new projects and increased demand. Finally, there was an allocation for four weeks of vouchers for those on free school meals for four weeks over the summer holiday period.

4.4 These allocations left a total of £202,849 to be administered in the form of individual grants by the Council with one eligible grant being permitted limited to £300 per family and £150 per individual. The total allocation was based on demand for 2023/24 and was felt to be sufficient to cover the six-month period.

4.5 The period for individual / family applications commenced after the decision on 2nd May 2024. Between then and the end June 2024 a total of 753 applications had been processed compared to 150 in the comparable period of 2023/24. Work is being undertaken to break down this data further and a verbal update will be available at Board. However, this unprecedented demand, if it continues at current pace, means that the remaining budget will be spent by halfway through the grant period.

Voluntary Sector Update

4.6 On 28thJune 2024, the joint 'Poverty and Cost of Living Hub' met to discuss the current situation with the Household Support Fund and demand on the voluntary sector providers. It was attended by a range of organisations as well as Greenham Trust and various Members and Officers from West Berkshire Council, including the Executive Portfolio Holder for Housing. The meeting was arranged by the Volunteer Centre.

4.7 The feedback from the voluntary sector indicated every rising demand for support and advice. There was also a discussion regarding the increased demand for HSF grants. It was felt that this in part was down to rising indebtedness exacerbated by costs over the autumn and winter months.

4.8 Contributions from partner organisations during and subsequent to the meeting included:

- The Community Resource Centre reported continued high demand for support under the essential household goods scheme. Of the 142 requests (an increase of 18% year ~~in~~ on year) for support 30 related to carpets and an arrangement was in place to get donations of new carpets form a major supplier but the fitting costs were a big expense. The CRC also reported a big demand for beds and mattresses and an increase in issues relating to damp and mould. The latter point was echoed by Citizens Advice West Berkshire.

- The West Berkshire Winter Homelessness Project 2023/24 provided 37 people with a total of 1,324 bed/nights. The age range of those assisted ran form nineteen years old to sixty with most of those supported being in their twenties and thirties. The partnership between the Council, CRC, Newbury Soup Kitchen, Loose Ends and Greenham Trust has now been evaluated and the findings will feed into future winter programmes.

- West Berkshire Homeless reported receiving between fifteen and eighteen requests for support per day. For the period of April-May, expenditure has risen from £2,835 to £13,879 in a two-year period. Demand remains high and to manage demand against income, maximum payments have been reduced to £20 on any one occasion and are now typically less than that. It is reported that 70% of those seeking support have children.

- Citizens Advice West Berkshire report a significant increase in demand for advice on debt with an increase in Q1 from 87 to 140 (61%) clients seeking support. After debt the largest increases were in financial services and capability (increase from 94 to 131 or 40%) and charitable support (increase from 51 to 75 or 47%). Housing support was up 27% from 99 to 126 clients. Examining the latter in more detail, many clients are renting privately and the biggest proportion had possession action issues that would appear to be linked to landlords needing to increase rents or selling properties.

- All organisation reported an ongoing increase in the number of cases involving mental health issues.

- Greenham Trust reported that at the current time the Cost of Living joint appeal had around £80K to support local charities in delivering against increased demand or for new projects.

4.9 There was also discussion around concerns being raised by residents about housing issues and in particular the levels of damp and mould reported. The offer was made for further support from the Public Protection Private Sector Housing Service to support awareness raising to help with prevention and increase reporting.

4.10 In summary, it was considered that although there was some improvement in inflation and energy costs that the numbers of residents facing indebtedness and housing issues were still rising as were demands for support from voluntary sector partners.

Public Donations

4.11 The issue of public donations has been raised at the previous Board meeting. The public can donate directly to the shared Cost of Living Appeal here West Berks Cost of Living Crisis Appeal – Greenham Trust.

4.12 Other routes to donation are the Newbury Community Resource Centre (NCRC Donate) for furniture, electrical equipment, cycles etc. as well as West Berkshire Foodbank (Donate food | West Berks Foodbank) for food, toiletries and household products and the Homestart Baby Bank for baby products https://home-startwestberks.org.uk/baby-bank/

5. Conclusions and Next Steps

The headline figures for inflation and energy costs are significantly better than they were 12-18 months ago. However, the evidence set out above suggests that for some residents and those organisations supporting them it is still very challenging. The increase in demand for Household Support Fund payments will be subject to further analysis and future reports will cover this. There is however a very good collective understanding of the issues facing residents and a desire to move to a position where residents in need are supported to have acceptable living and housing standards.

6. Appendices

None

Background Papers:

None

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☒ Help families and young children in early years
☒ Promote good mental health and wellbeing for all children and young people
☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by helping to mitigate the impacts of the cost of living increases.

Better Care Fund 2023-24 Year End Report

Report being considered by:	Health and Wellbeing Board
On:	11 July 2024
Report Author:	Maria Shepherd, BCF Integration Lead
Report Sponsor:	Councillor Heather Codling, Chairman of HWB
Item for:	Information

1. Purpose of the Report

The purpose of this report is for the Board to note the 2023/24 year end Better Care Fund (BCF) Report. The report was submitted to NHS England on 23rd May 2024 with the necessary sign off from the Chairman of the HWB.

2. Recommendation(s)

To note the Better Care Fund 2023-2024 end of year report.

3. Executive Summary

3.1 The Better Care Fund Policy Framework for 2023-25 provides continuity from the previous rounds of the programme and is a two-year plan.

3.2 The Better Care Fund is a pooled budget across Health and Social Care and sits within a Section 75 Agreement with the Integrated Care Board.

3.3 The Policy Framework requires systems to have a jointly agreed plan across Health and Social Care which demonstrates how it meets the two objectives: 1) enabling people to stay well, safe, and independent at home for longer, and 2) providing the right care at the right time in the right place.

3.4 The Policy Framework requires quarterly reports to be submitted, using a template to report on the performance against the five national metrics.

3.5 The five national metrics are:

1. Avoidable admissions - indirectly standardised rate of admissions per 100,000 population

2. Falls – Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. (This metric is new for 2023-25)

3. Discharge to usual place of residence – percentage of people, resident in HWB, who are discharged from acute hospital to their normal place of resident.

4. Residential Admissions – long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

5. Reablement – proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation service.

3.6 West Berkshire met the targets for Falls, Discharge to usual place of residence, and Reablement.

3.7 West Berkshire met the target for avoidable admissions in Q1 and Q4 but did not meet the target in Q2 or Q3. We will continue to work with Health partners to promote: Virtual Wards, Health checks, Multi-Disciplinary Team (MDT) meetings with health partners, Intermediate Care and Rapid Response (2 hrs and 2 day), Joy App, Carers Information and Advice, Out of Hospital services including night sitting, the Mental Health Street Triage and recruitment and retention of Social Workers and Occupational Therapists.

3.8 West Berkshire did not meet the target for permanent admissions to residential or nursing homes. The target relates to 205 new admissions, the year end outturn was 213 new admissions. We will continue to challenge the Acute Trusts as 60% of these admissions related to people coming out of hospital. (In 2022/23 it was 68%).

3.9 The other route of access for new admissions is through the Community, in 2023/24 there were 86 new admissions compared to 66 in 2022/23. This demand is likely to continue as West Berkshire has an ageing population and we are seeing individuals with increasing complexity.

4. Supporting Information

The formal governance for the Better Care Fund plan sits within the Locality Integration Board, a sub-group of the Health and Wellbeing Board.

5. Options Considered

None.

6. Proposal(s)

None – the report is for information only.

7. Conclusion(s)

The 2023-24 End of Year report must be signed off by the Chairman of HWB.

8. Consultation and Engagement

Heather Codling, Health and Wellbeing Board Chairman, Integrated Care Board and Locality Integration Board.

9. Appendices

Appendix A – 2023-24 End of Year Template

Background Papers:

Better Care Fund Plan 2023-25

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☐ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☐ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by driving health and social care integration, using pooled budgets.

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Better Care Fund 2023-24 Year End Reporting Template

1. Guidance for Year-End

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), working with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). An addendum to the Policy Framework and Planning Requirements has also been published, which provides some further detail on the end of year and reporting requirements for this period.

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting can be used by local areas, including ICBs, local authorities/HWBs and service providers, to further understand and progress the integration of health, social care and housing on their patch. BCF national partners will also use the information submitted in these reports to aid with a bigger-picture understanding of these issues.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:
Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added
Note on viewing the sheets optimally
To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and spend from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.

2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The latest BCF plans required areas to set stretching ambitions against the following metrics for 2023-24:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Westmorland and Cumbria (due to a change in footprint).

5. Income and Expenditure

The Better Care Fund 2023-24 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Additional Discharge Fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2023-24 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2023-24 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2023-24 in the yellow boxes provided, **NOT** the difference between the planned and actual income. Please also do the same for the ASC Discharge Fund.

- Please provide any comments that may be useful for local context for the reported actual income in 2023-24.

6. Spend and activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to year-end.

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	**Units**
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:

- **Actual expenditure to date in column K.** Enter the amount of spend to date on the scheme.
- **Outputs delivered to date in column N**. Enter the number of outputs delivered to date. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.
- **Implementation issues in columns P and Q.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column P and briefly describe the issue and planned actions to address the issue in column Q. If you answer no in column P, you do not need to enter a narrative in column Q.

7.1 C&D Hospital Discharge and 7.2 C&D Community

When submitting actual demand/activity data on short and intermediate care services, consideration should be given to the equivalent data for long-term care services for 2023-24 that have been submitted as part of the Market Sustainability and Improvement Fund (MSIF) Capacity Plans. We strongly encourage co-ordination between local authorities and the relevant Integrated Care Boards to ensure the information provided across both returns is consistent.

These tabs are for reporting actual commisioned activity, for the period April 2023 to March 2024. Once your Health and Wellbeing Board has been selected in the cover sheet, the planned demand data from April 2023 to October 2023 will be auto-populated into the sheet from 2023-25 BCF plans, and planned data from November 2023 to March 2024 will be auto-populated from 2024-25 plan updates.

In the 7.1 C&D Hospital Discharge tab, the first half of the template is for actual activity without including spot purchasing - buying individual packages of care on an ‘as and when’ basis. Please input the actual number of new clients received, per pathway, into capacity that had been block purchased. For further detail on the definition of spot purchasing, please see the capacity and demand guidance for the Q2 refresh, which can be found on the Better Care Exchange.

The second half is for actual numbers of new clients received into spot-purchased capacity only. Collection of spot-purchased capacity was stood up for the 2023-24 plan update process, but some areas did not input any additional capacity in this area, so zeros will pre-populate here for them.

Please note that Pathway 0 has been removed from the template for this report. This is because actuals information for these services would likely prove difficult for areas to provide in this format. However, areas are still expected to continue tracking their P0 capacity and demand throughout the year to inform future planning.

8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2023-24 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund
There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2023-24
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2023-24.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2023-24

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally. The 9 points of the SCIE logic model are listed at the bottom of tab 8 and at the link below.

SCIE - Integrated care Logic Model

HM Government

NHS England

Better Care Fund 2023-24 Year End Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist Complete:
Health and Wellbeing Board:	West Berkshire		Yes
Completed by:	Maria Shepherd		Yes
E-mail:	maria.shepherd@westberks.gov.uk		Yes
Contact number:	01635 519782		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Wed 29/05/2024	<< Please enter using the format, DD/MM/YYYY	Yes

When all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. I&E actual	Yes
6. Spend and activity	Yes
7.1 C&D Hospital Discharge	Yes
7.2 C&D Community	Yes
8. Year End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-24 Year End Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: West Berkshire

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off		Yes

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the year:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-24 Year End Reporting Template

4. Metrics

Selected Health and Wellbeing Board: West Berkshire

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning Q1	Q2	Q3	Q4	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	130.3	127.5	132.4	129.0	Not on track to meet target	The challenge is that the figures constantly change when NHS refresh/time of extraction. Previously BCF templates have been populated using data 1 month post quarter End. For Q1 we reported 130.2 against a plan	Met target in Q1 and Q4 however figures have changed since Q1. We have now agreed with the ICB that Berkshire West will report using data 1 month post quarter end to ensure there is consistency at place ie. For	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.4%	91.6%	91.1%	91.0%	On track to meet target	There appears to be an issue with data from Great Western Hospital. This is causing a discrepancy with local data vs National Data. (According to our Q3 BCF report the pre-populated nationla data was showing : Q1	According to the National data we have achieved this target.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,686.0	On track to meet target	This is new metric which was only introduced last year and the target relates to 531 people being admitted due to a fall. As a system we are trying to understand what schemes are having the most impact , we need to review	As of month 12 we are reporting 484 however as we have agreed as a system to use data 1 month post Q1 we are anticipating a further 30 people taking our total to 514 against a plan of 531.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				616	Not on track to meet target	he target of 616 relates to 205 new admissions. The final year end outturn was 640 per 100,000 population, which relates to 213 people admitted to a residential/nursing home, 8 more than our target. We must	It should be noted that we have seen a drop in admissions for those coming out of hospital compared to last year.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				85.0%	On track to meet target	During 2023/24 we reviewed who accessed reablement support with the aim of targeting reablement to those with clear reablement goals. This process changed was not implemented until Janauary 2024, hence	The final year end outurn is 88% (provisional). 151/171 clients reamained at home 91 days after dsicharge from hospital, of the 20 clients no longer living at home 15 had died and a further 5 werw now in long	Yes

Better Care Fund 2023-24 Year End Reporting Template

5. Income actual

Selected Health and Wellbeing Board: West Berkshire

Income

	2023-24				
Disabled Facilities Grant	£2,245,415				
Improved Better Care Fund	£806,499				
NHS Minimum Fund	£11,788,726				
Minimum Sub Total		£14,840,641			

	Planned		Actual			
NHS Additional Funding	£84,707		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£340,205		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£424,912				£424,912

	Planned 23-24	Actual 23-24
Total BCF Pooled Fund	£15,265,553	£15,265,553

Additional Discharge Fund

	Planned		Actual			
LA Plan Spend	£113,070		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£773,000		Do you wish to change your additional actual ICB funding?	No		
Additional Discharge Fund Total		£886,070				£886,070

	Planned 23-24	Actual 23-24
BCF + Discharge Fund	£16,151,623	£16,151,623

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2023-24	

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Expenditure

	2023-24
Plan	£15,971,413

Do you wish to change your actual BCF expenditure?	Yes	Yes

Actual	£15,641,203	Yes

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2023-24	Carry forward of unspent funding £150,000 . DFG uplifted by £180,210 in September 2023, not included in plan.	Yes

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: West Berkshire

Checklist													
							Yes			Yes		Yes	Yes
Scheme ID	**Scheme Name**	**Scheme Type**	**Sub Types**	**Source of Funding**	**Planned Expenditure**	**Q3 Actual expenditure to date**	**Actual Expenditure to date**	**Planned outputs**	**Q3 Actual delivered outputs to date**	**Outputs delivered to date (estimate if unsure) (Number or NA)**	**Unit of Measure**	**Have there been any implementation issues?**	**If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.**
1	Under 65 LD residential and supported living	Residential Placements	Care home	Minimum NHS Contribution	£1,580,091	£1,185,068	£1,580,091	24	16	21.5	Number of beds/placements	Yes	We are experiencing ongoing issues with a handful of providers requesting above inflation increases. We have a limited supply of providers in the LD market. This has been highlighted in our Market Position Statement as an area of need/concern. We are still in negotiation with our LD providers re; rates for 24/25.
3	Reablement	Home Care or Domiciliary Care	Domiciliary care packages	Minimum NHS Contribution	£454,734	£341,051	£454,734	11,131	14,300	19171	Hours of care (Unless short-term in which case it is packages)	No	
31	Reablement	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£307,300	£230,475	£307,300	7,522	9,664	12955	Hours of care (Unless short-term in which case it is packages)	No	
42	Memory and cognition over 65	Residential Placements	Nursing home	Minimum NHS Contribution	£49,138	£36,854	£49,138	1	1	0.9	Number of beds/placements	No	
53	Physical Support over 65	Residential Placements	Nursing home	Minimum NHS Contribution	£65,213	£48,910	£65,213	1	1	1.3	Number of beds/placements	No	
54	Physical Support over 65	Residential Placements	Care home	Minimum NHS Contribution	£16,835	£12,626	£16,835	0	0	0.3	Number of beds/placements	No	
6	LA Discharge Funding	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Local Authority Discharge Funding	£113,070	£113,070	£113,070	4,916	4,741	4767	Hours of care (Unless short-term in which case it is packages)	Yes	The LA has spent an additional £1.075m to support Hospital Discharge.
62	ICB Discharge Funding	Home-based intermediate care services	Reablement at home (to support discharge)	ICB Discharge Funding	£773,000	£773,000	£773,000	164	39	42	Packages	Yes	The LA has spent an additional £1.075m to support Hospital Discharge. The £773k has been used to fund 21,390 hours of home care and 42 packages.
66	Under 65 LD residential and supported living	Residential Placements	Care home	Minimum NHS Contribution	£946,922	£710,192	£946,922	14	10	12.9	Number of beds/placements	No	
7	Over 65's Care Homes	Residential Placements	Care home	Minimum NHS Contribution	£125,746	£94,310	£125,746	24	1	1.3	Number of beds/placements	No	
71	Over 65's Care Homes	Residential Placements	Supported housing	Minimum NHS Contribution	£254,344	£190,758	£254,344	3	2	2.7	Number of beds/placements	No	
8	Joint Care Pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Minimum NHS Contribution	£187,489	£140,617	£187,489	8,151	5,896	7904	Hours of care (Unless short-term in which case it is packages)	No	
81	Joint Care Pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Minimum NHS Contribution	£264,931	£198,698	£264,931	11,518	8,331	11169	Hours of care (Unless short-term in which case it is packages)	No	
82	Joint Care Pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	iBCF	£217,199	£162,899	£217,199	9,443	6,830	9157	Hours of care (Unless short-term in which case it is packages)	No	
83	Joint Care Pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Minimum NHS Contribution	£220,600	£165,450	£220,600	9,591	6,937	9300	Hours of care (Unless short-term in which case it is packages)	No	
84	Joint Care Pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Minimum NHS Contribution	£548,658	£411,494	£548,658	23,854	17,253	23131	Hours of care (Unless short-term in which case it is packages)	No	
9	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£2,065,205	£759,000	£2,065,205	325	185	83	Number of adaptations funded/people supported	Yes	The figure we reported in our plan for 23/25 was the number of referrals not actual DFG's awarded. As of the end of March 2024 we received 257 referrals but awarded 83 DFG's. Part way through 2023/24 we identified that our outstanding commitments would exceed the budget available. Therefore in August 2023
17	BHFT Contract	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Minimum NHS Contribution	£1,022,682	£767,012	£767,012	888	-	0	Hours of care (Unless short-term in which case it is packages)	Yes	Data on outputs still awaited from provider.
29	Out of Hospital Services - Intermediate Care - Discharge Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Minimum NHS Contribution	£616,231	£462,173	£462,173	108	-	0	Hours of care (Unless short-term in which case it is packages)	Yes	Data on outputs still awaited from provider.
31	Out of Hospital Service - Intermediate Care night sitting, rapid response	Home-based intermediate care services	Rehabilitation at home (to support discharge)	Minimum NHS Contribution	£852,235	£639,176	£639,176	181	-	0	Packages	Yes	Data on outputs still awaited from provider.
42	23/25 priority 1	Workforce recruitment and retention		Additional LA Contribution	£96,145	£72,109	£96,145		2	1.5	WTE's gained	No	Due to issues with permanent recruitment we are using agency Social Workers and Occupational Therapists within the Hospital Discharge Team to support Hospital Discharge and within our Locality Teams in order to help prevent hospital admissions.
43	23/25 priority 1	Workforce recruitment and retention		Minimum NHS Contribution	£117,401	£88,051	£117,401		1	1.4	WTE's gained	No	Due to issues with permanent recruitment we are using agency Social Workers and Occupational Therapists within the Hospital Discharge Team to support Hospital Discharge and within our Locality Teams in order to help prevent hospital admissions.
48	23/25 priority 1	Workforce recruitment and retention		Additional NHS Contribution	£84,707	£63,530	£84,707		1	1	WTE's gained	No	Due to issues with permanent recruitment we are using agency Social Workers and Occupational Therapists within the Hospital Discharge Team to support Hospital Discharge and within our Locality Teams in order to help prevent hospital admissions.

Better Care Fund 2023-24 Capacity & Demand EOY Report

7.1. Capacity & Demand

Selected Health and Wellbeing Board: West Berkshire

Estimated demand - Hospital Discharge

		Prepopulated from plan:							Q2 Refreshed planned demand				
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	117	88	129	123	110	83	129	95	105	105	105	95
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	53	44	47	46	50	42	56	44	49	49	49	44
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	14	25	14	10	12	12	14	14	15	15	15	14

Checklist

Complete:

Actual activity - Hospital Discharge

Actual activity (not spot purchase):

Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	Complete
Reablement & Rehabilitation at home (pathway 1)	Monthly acitivity. Number of new clients.	18	20	20	15	31	21	27	30	33	51	40	43	Yes
Short term domiciliary care (pathway 1)	Monthly acitivity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly acitivity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly acitivity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Actual activity - Hospital Discharge

Actual activity in spot purchasing:

Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	Complete
Reablement & Rehabilitation at home (pathway 1)	Monthly acitivity. Number of new clients.	81	92	86	62	84	88	62	60	55	53	35	43	Yes
Short term domiciliary care (pathway 1)	Monthly acitivity. Number of new clients.	0	0	0	0	0	0	0	0	0	9	21	22	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly acitivity. Number of new clients.	33	43	44	43	42	35	42	39	42	37	30	38	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly acitivity. Number of new clients.	17	14	12	11	13	21	15	13	18	29	31	29	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

7.2 Capacity & Demand

Selected Health and Wellbeing Board: West Berkshire

Demand - Community

Service Area	Metric	Prepopulated from plan:							Q2 refreshed expected demand				
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	138	138	138	138	138	138	138	138	138	138	138	138
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	101	112	116	96	99	95	96	104	86	97	92	89
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Actual activity - Community

Service Area	Metric	Actual activity:												Checklist Complete:
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	95	107	118	112	144	154	171	172	204	196	169	159	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	27	60	79	79	75	64	61	87	51	78	76	56	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Better Care Fund 2023-24 Year End Reporting Template

8. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: West Berkshire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	We have good partnership working arrangements across Health and Social Care and neighbouring Local Authorities, which are supported by the Berkshire West Place team working within BOB ICS.	Yes
2. Our BCF schemes were implemented as planned in 2023-24	Neither agree nor disagree	Some of our schemes eg. Falls and Self Care Programme were not delivered due to a lack of resources. These schemes will be carried forward into 24/25 .	Yes
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality	Agree	A lot of our schemes are business as usual.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	Checklist Complete:
Success 1	6. Good quality and sustainable provider market that can meet demand	We have good working relationships with our provider market and are able to meet demand for hospital discharges efficiently despite a challenging year with the cost of inflation.	Yes
Success 2	Other	We have achieved 3 out of the 5 National Metrics in the context of an exceeding challenging year with the rate of inflation and a growing population.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	Checklist Complete:
Challenge 1	7. Joined-up regulatory approach	Completing/accessing robust data to support the Demand and Capacity plans. Eg. In our Plan for 2023/25 an average/best guess figure was given for UCR activity in the community. Our partners in health have now revised these figures for demand : April, 102, 121, 132, 117,162,165,183,189,210,205,187 and 183 respectively. We believe that the gap between estimated demand and activity at least in part reflects historic issues with provider data. We are working with partners to improve and refine our demand modelling.	Yes

Care Quality Commission Local Authority Assessment 2024

Report being considered by:	Health and Wellbeing Board
On:	11 July 2024
Report Author:	Paul Coe
Report Sponsor:	Councillor Patrick Clark
Item for:	Information

1. Purpose of the Report

To provide an update on the recent Care Quality Commission's (CQC) Local Authority Assessment in West Berkshire.

2. Recommendation(s)

That West Berkshire Council's Adult Social Care (ASC) Department leads work to deliver the following actions:

(a) Develop and implement an action plan to progress issues identified through the assurance process. The plan will include engagement with relevant colleagues including Commissioning & Procurement, Human Resources, Digital and the Equality, Diversity and Inclusion Lead. Wider work with partners and stakeholders will take place.

(b) Incorporate CQC feedback into the updated ASC Strategy.

3. Executive Summary

3.1 The CQC's 'Local Authority Assessment' covers the work of the Council's ASC department, alongside some wider work by linked departments, notably Commissioning and Procurement. It also explores a range of partnership-working arrangements.

3.2 The CQC undertook a Local Authority Assessment of West Berkshire Council in February 2024. The assessment included a review of a large amount of information, interviews with a range of stakeholders, a site visit, and 'case tracking' activity.

3.3 CQC have now issued the report. It is available here:

West Berkshire Council: local authority assessment - Care Quality Commission (cqc.org.uk)

3.4 CQC makes provision for challenge. We have made no challenge.

3.5 The overall rating for West Berkshire Council is 'Good'. Options are 'Inadequate', 'Requires Improvement', 'Good', and 'Outstanding'.

3.6 A draft action plan has been developed.

4. Supporting Information

4.1 The Care Quality Commission introduced a new Assurance framework for Local Authorities in 2023. Five pilot inspections were conducted in late 2023. West Berkshire Council was one of three Local Authorities identified as the first tranche to be inspected.

4.2 The assessment has now taken place, and West Berkshire Council has been rated as 'Good'. The other two assessed authorities were also rated as 'Good'.

4.3 Other assessments have taken place and reports will be issued in due course.

5. Options Considered

5.1 Some Local Authorities/Care Providers lodge a dispute with CQC. This is not justified on this occasion.

5.2 The timing of a future visit is unknown, but a best estimate is 2-3 years. Consequently, work on improvements could be delayed. This is not recommended, although certain elements may be prioritised based on resource impacts.

6. Proposal(s)

6.1 West Berkshire Council prepared for the Assessment with a Task Group led by ASC, and including colleagues from Commissioning and Procurement, Finance, Legal Services, and Human Resources. The same group will now review the areas for improvement as summarised in the draft Action Plan. Additional colleagues will be engaged as needed, e.g. the EDI lead, Digital and Public Health.

6.2 ASC is due to refresh its Strategy. The CQC feedback will be incorporated into that process.

7. Conclusion(s)

The CQC's Local Authority Assessment of West Berkshire Council has been completed. The report has been received, with a rating of 'Good'. It identifies a number of areas for improvement which will require input from officers across the Council.

8. Appendices

None.

Background Papers:

None

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

- ☒ Reduce the differences in health between different groups of people
- ☒ Support individuals at high risk of bad health outcomes to live healthy lives
- ☐ Help families and young children in early years
- ☐ Promote good mental health and wellbeing for all children and young people
- ☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by ensuring that Council services respond to the needs of the local population, and that they are delivered in a partnership model with effective leadership and governance arrangements.

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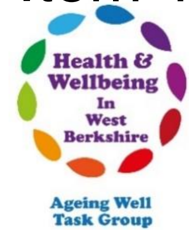
Agenda Item 16



Ageing Well Task Group

Update for HWB Steering Group

Current Activity

- Ageing Creatively Community Café has opened at Theale Library with excellent attendance from the first session. The café is open every Monday afternoon and offers a varied programme of activities, information sharing and social connection opportunities to residents over the age of 55. This has been a great piece of partnership working between Ageing Well partners including The Corn Exchange, WBC Library service and Public Health & Wellbeing, as well as local community contacts such as the local church, community groups, businesses and the GP surgery.
- Nature for Health worked in partnership with Age UK Berkshire and volunteers from the Shaw House Community Garden and held a well attended bug house building activity workshop for carers during Carers week. Carers were able to bring their cared for along to the workshop which made a real difference in supporting attendance.
- Action planning workshop held which identified 3 new areas of focus in addition to the existing Falls Prevention work. As previously mini task and finish groups are being set up to agree and deliver on specific actions
    - Older people's oral health
    - Changing the perception of ageing
    - Wider health and wellbeing prevention at an earlier age

Future Actions

- A number of possible falls prevention interventions have been researched and presented as potential uses of LIB funding for falls prevention. An update will be provided on the final decision in the next report.

Building Communities Together Partnership

Update for HWB Steering Group

Health & Wellbeing In West Berkshire
Building Communities Together Partnership

Current Activity

- The Partnership is due to meet on 16 July 2024.
- Current needs analysis to be completed which will inform the Partnership Plan (see 'Challenges').

Serious Violence

- The Reducing Serious Violence Steering Group last met on 5 June 2024 Chaired by Chief Inspector David Whiteaker.
- Under the Serious Violence duty, a yearly needs analysis will be completed by the end of the 2nd Qtr. 2024/25 alongside a review of the current plan (by the end of November 2024). This will inform the Serious Violence Strategy for 2025/26 (see 'Challenges').
- Quarterly report due in to the OPCC to compile TVP report for the Home Office.
- Focus for the next quarter is on reviewing the needs analysis for serious violence for West Berkshire to identify any new trends or areas of focus in our strategy / delivery plan, and identifying ways to sustain any interventions or posts that are externally funded as current Home Office funding will end in April 2025
- Funding confirmed for the serious violence co-ordinator post until November 2025 via OPCC grant funding.
- Key work being developed at the moment links to a repeat of the schools' survey; work to be done with schools re Drugs referral policy; and a focus on understanding more about the risk factor associated with schools exclusions.
- Further problem-solving work continues with The Nightingales Estate which has continued to be a hotspot for violence, albeit reducing. This also links to the Safer Streets work referenced below.

Safer Streets Fund

- SSF5 has faced a reduction in funding from the Home Office for 2024/25 but work on each of the five interventions continues.
- Project coordinator, Vicky Lees is now in post.
- Successfully interviewed 1 Safer Streets Guardian and the recruitment process has started.
- 2nd clear-up day scheduled for 30 July 2024.
- Leaflet in design to be distributed to residents in Greenham informing them of the project and activities.

Anti-Social Behaviour

- Work in this area is currently extremely limited – see 'Challenges'.

Prevent

- Annual Prevent benchmarking has highlighted areas where West Berkshire is not meeting its statutory duty.
- Prevent Risk Assessment is to be completed shortly.

- Next Prevent Steering Group scheduled 16 July.

Channel

- Channel Panel meeting held 12/06/2024.
- 1 case to be discussed and 1 new referral adopted.
- Channel Annual Assurance Statement has highlighted areas where WBC is not meeting its statutory duty.

Domestic Abuse

- 2024/25 funding confirmed for WBC under Part 4 of the Domestic Abuse Act 2021; MOU has been signed.
- Consultation on Domestic Abuse Strategy 2023-27 completed.
- Domestic Abuse Delivery Plan Workshop held to provide feedback on the proposed Delivery Plan.
- Domestic Homicide Review is being conducted.
- DHR Statutory Guidance Consultation response submitted.

Modern Slavery

- The next Modern Slavery and Human Trafficking Statement covering 1 April 2023 – 31 March 2024 will begin to be written and subject to sign off by Chief Executive.

Eastern Parish Conference

- Eastern Parish Conference took place on 21 May 2024 as a result of feedback from the District Parish Conference held in January 2024. The Conference focused on developing the working relationship between West Berkshire Council and the town and parish councils with attendees focusing on 3 questions: What is working well? Areas for Improvement and Next Steps/Action Plan.

Community Forums

- Report presented at Corporate Board for agreement on a formalised programme for Community Forums.
- Work underway to organise the next Community Forum.

Members' Community Bids

- The processing of claims from the last Members Bids Panel on 28/11/2023 continues.
- Funding of Members Bids for 2024/25 has been agreed.

Future Actions

- Future District Parish Conference scheduled for October.
- Organisation and delivery of Community Forums
- Domestic Abuse Strategy 2023-27 will be subject to approval by Executive once consultation closes.
- Serious Violence needs analysis to be completed and will inform the Serious Violence Strategy 2024/25.
- BCT Partnership needs analysis to be completed and will inform the Partnership Plan.
- Work to improve fulfilment of Prevent statutory duties.
- Work to improve fulfilment of Channel statutory duties.

Challenges
Current uncertainty around the provision of analytical work from the OPCC which will impact needs analysis work that needs to be done ahead of developing the Serious Violence Strategy 2024/25 and the BCT Partnership Plan.

Staffing pressures within BCT Team:

- Senior Community Co-ordinator Resolution post is currently vacant as the postholder is Acting BCT Team Manager. The majority of multi-agency anti-social behaviour related case work is no longer being done but any legislative requirements under the ASB, Crime and Policing Act 2014 are being prioritised.
- Equality Diversity and Inclusion Officer has recently resigned with only employee related work being addressed by HR. Remaining community related EDI work is currently 'on hold'.
- Senior Principal Officer is long-term sick.

Statutory Duties:

- Channel Annual Assurance Statement has highlighted that WBC is not meeting is statutory duty – this has been escalated.
- Annual Prevent benchmarking has highlighted areas where West Berkshire is not meeting its statutory duty. Areas for improvement have been identified and are to be addressed.
- Community Coordinator (Prevention) continues to fulfil the DA Safe Accommodation duty via overtime.

Children's Early Help & Prevention Partnership

Update for HWB Steering Group

Health & Wellbeing In West Berkshire

Children's Early Help & Prevention Partnership

Current Activity

Our last Children Prevention and Early Help Partnership, held on 10th June 2024, Rebecca Wilshire, new Service Director for Children's Social Care in West Berkshire Council picked up the chair of this Partnership.

Early Help System Guide

This is an annual review of each local authority Early Help System. This is not intended for a single service. It is a review of the network of services, process and interaction that aim to help children, young people, and their families at the earliest opportunity. The early help System Guide outlines a national vision and descriptor for a mature Early Help System that is shared by DLUHC and DfE. It is produced by the national Supporting Families programme led by the DfE.

The system guide was discussed with partners, and feedback was sort to support its completion and submission.

More information on the Early Help System Guide can be found here

Early Help Dashboard (Early Respond Hub)

A review of the Early Help Dashboard is reviewed at each meeting, this allows for scrutiny, oversight and appropriate challenge which support the development and delivery of early help. This evidence for Quarter 4 an increase in Early Response forms completed by Contact and Assessment (CAAS) and an increase in the timeliness of the forms, which is positive. Advice and Consultation was the highest outcome this quarter and 165 online referral forms was received. Parenting support was the highest referral reason. Engagement with Triple P session was at its highest this quarter and Child Mental Health was the significantly the highest risk factor followed b Parental Mental, poor school exclusion/attendance and Domestic Abuse.

Early Help Early Response Hub (ERH)

ERH have completed an Annual Report outlining their work over the last year, this report demonstrates several positive areas of development, the work within the hub continues to strengthen and is clearly having a positive impact on those families which they support.

Online Referral Forms

Following feedback on the online forms, changes have been made to make the form more accessible this was demonstrated in our last meeting and changes were welcomed.

Supporting Families

An update was provided from the Supporting Families Operational Group – claims for this year are slightly under the desirable claims available, ongoing work in this area continues. The current funding linked to Supporting Families ceases in March 2025.

Family Hubs
Family Hub update shared, covering the cohort of families who are supported, and the development of family hubs explored on widening the scope of this work and how better engagement can be achieved with wider services for those children six and above. Hub work is heavily focused on 0-5yrs / Early Years, and wider development will explore how Family hubs, in partnership with other partners delver a wider offer.

Challenges from the CPEHP
Capturing ethnicity of children open in Early Help: the system does not currently capture child's ethnicity and appropriate challenge about this and cultural sensitivity which will be explored further.

Future Actions

- Review the Terms of Reference for this group and update as required.
- Explore further development of Family Hubs and include wider partnership working.
- Continue to develop the Early Help Response Hub.

Rebecca Wilshire
Service Director, Children's Social Care
June 2024

Health Inequalities Task Force

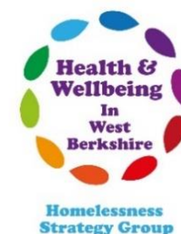
Update for HWB Steering Group

Current Activity

The health inequalities task force has been stood down. This was a recommendation from the hot focus session as it was agreed that actions to reduce inequalities should be addressed by all sub-groups rather than in isolation.

Future Actions

Actions to reduce inequalities and deliver on strategy priority one should be developed across all sub-groups and included in the delivery plan.



Homelessness Strategy Group

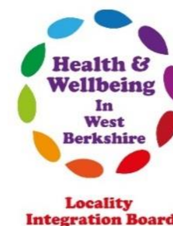
Update for HWB Steering Group

Actions and Updates from the last meeting:

- Rough sleeping numbers continue to rise and discussed need to ensure all voluntary sector partners signpost clients to our Outreach Service rather than intervening themselves.
- Two tenders are due to go live imminently to replace existing adult Homelessness Contract and the Young Persons Homeless Contract.
- Membership of the group was discussed as there has been sharp drop in representation from key partners – this will be an action for the next meeting.
- Winter Provision project feedback - report to come to next HSG.
- Creation of Migration Steering group - on similar lines to HSG to be implemented following embedding the new Migration Team in the operational structure.
- Homeless hub action remains outstanding action for ongoing growth discussion by sub-group.

Locality Integration Board

Update for HWB Steering Group



Current Activity

Regular updates on Community Wellness Outreach Service received.

ASC CQC inspection report

Healthwatch's annual work plan shared.

Starting to receive updates from all funded services/schemes within BCF – Connected Care & Dementia Care Adviser Service in June 2024

Huge amount of focus on: -
BCF year-end report – submitted to NHSE 23/5/24.
BCF refresh for 24/25 – submitted to NHSE 10/6/24, awaiting approval.

Future Actions

Review of all schemes within BCF

Continue to receive updates from schemes within BCF: MH Street Triage, Care Homes (RRAT), Out of Hospital Services (Intermediate Care)

Work with health partners on enhancing data for Demand and Capacity plans for Hospital Discharge and Admission Avoidance

Receive update on Pharmacy First

Mental Health Action Group

Update for HWB Steering Group – June 2024

Current Activity

- Work has been continuing with service users and others to co-design a Mental Health Forum to bring together voluntary sector organisations, service users and mental health service providers to share information and feed any issues into the Mental Health Action Group. We have, rightly, been challenged as to whether this is the best way of bringing in the service user voice, so we continue to investigate other options which could complement a Forum.
- A meeting to explore the impact of bereavement on mental health and any significant needs that are not currently being met, is to be held in July.
- We have continued to support the establishment of the Mental Health Integrated Community Service (MHICS) in West Berkshire. We actively participated in a workshop to explore ways in which the service can be truly integrated, between service providers and with the community.
- We are planning a meeting in September to explore what support is, and could be made, available for people with mental health challenges to fill in forms and in other ways deal with officialdom. This seems to be a big and growing problem which puts considerable pressure on a number of voluntary organisations.
- We posted a set of 'Reading Well' (formerly Books on Prescription) leaflets to all West Berkshire GP practices and shared digital assets with a project manager from Berkshire Healthcare Foundation Trust for onward sharing.
- As part of mental health awareness week, we promoted the benefits of physical activity and asked our residents to consider how movement made them feel.

Future Actions

- Discussions are planned with others doing work on digital inclusion with a view to identifying the various sources of support, and helping them learn from each other and possibly work collaboratively together.
- Discussing gaps, challenges and recommendations based on the draft state of the national mental health data report
- Work will continue on the other projects described above.

Health & Wellbeing In West Berkshire
Skills & Enterprise Partnership

Skills and Enterprise Partnership

Update for HWB Steering Group – June 2024

Current Activity

The SEP hasn't met since the last update provided to the HWBB in January. However, the update on planned actions is as follows:

	Planned Actions	**Progress at June 2024**
2.8.4	Extension of the Developing Life Skills' programme	The H&WB approved funding for this programme in 2022/23, which was delivered in secondary schools by the EBP. All sessions were completed by July 23, with a significant increase to 250 participants. The further funding bid for 2023/24 was discussed at the HWB Board, however there are currently no identified funds to support these activities in 23/24. Greenham Trust are providing continuing funding for part of the programme, but, at present, the offer to Schools has been reduced.
2.8.2	Enhanced delivery of a Work and Careers Fair – including participation by local schools and supporting the work on employment opportunities for people with learning disabilities	As previously reported, the 2023/24 annual Work & Careers Fair (the 'Destinations Expo') was successfully delivered on 12th October 2023 at Newbury College, with 1,200 young people from local secondary schools attending, and around 60 employers and other organisations exhibiting. Planning for the 24/25 Destinations Expo is well underway for 10th October 2024, with ambitious plans to increase attendance to 1,500 young people and to grow the number of employers and education providers exhibiting to 70. Recruitment of employers for the event is progressing well, and the meeting of the specific needs of students with SEND is embedded into the event.

1.4.6	Green skills and jobs – seeking funding opportunities to extend the successful project, currently delivered in other areas of Berkshire, to develop skills and employment opportunities for people with disabilities in the Green economy (Groundwork)."	Groundwork South have secured funding in Reading to deliver 3 x 6 week Green Skills and Employability starting in September 24, the courses gives the participant the opportunity to learn new skills and gain a City and Guilds Brushcutter and Strimmer qualification. Funding sources are still being sought for West Berkshire to support a project which benefits both the SEND community and the wider community by improving the mental health and wellbeing of the participants and increasing employment outcomes. Groundwork also have a mixed 'Green and Blue' project in development, which will be a longer project. The participants will learn about river safety, invasive species their removal, and how they can support their local volunteers and employment progression in the industry. Both projects have proven that outdoor working has increased the mental health and wellbeing to the participants and in turn some have gained employment into the Green industries.
1.4.7	Supported Internships – development of local provision of supported internships to enhance the employment routes for people with disabilities (Newbury College).	The College have been working with WBC and 'Ways into Work' in developing two approaches: first, through the NHS 'Route to Recruit' strategy (led by Ways into Work) and identifies placements at the Royal Berkshire Hospital. Second, is placement in local businesses which links to WBC's target for twelve placements, with eight high needs learners currently identified, starting from September onwards.
1.4.8	Employability sessions – extension of the support provided by DWP to local schools and colleges to enhance the understanding of employment options for young people. Particularly focussed on under-represented groups and on the wide range of routes to skills and future employment (DWP)	The DWP have been working with schools around Berkshire to deliver Employability Skills and have had some good feedback from those schools. Further details of West Berkshire activity to follow in the next quarter.

Future Actions

The SEP is continuing to work on the agreed actions outlined above.

Substance Misuse Harm Reduction Partnership

Update for HWB Steering Group

Health & Wellbeing In West Berkshire
Substance Misuse Harm Reduction Group

Current Activity

- The last meeting took place on 26th April 2024, the next meeting is scheduled to take place on 17th July 2024.
- The Partnership agreed that owing to OHID's national priority to reduce the stigma related to the use of drugs and alcohol including language used, the Partnership's name should be changed to Substance and Behaviour Harm Reduction Partnership.
- The invite list is continuing to evolve to ensure we have representation from all relevant partners across West Berkshire.
- The S&BHR plan is currently being drafted in line with the Health and Wellbeing Board Plan. All partners have been requested to add relevant SMART actions and owners of these. The action plan will be a 'live' document to be reviewed at each meeting.
- A local plan for Nitazene is currently in draught and being reviewed by East and West Berkshire DPH's. Once agreed, this will be shared with the Partnership.
- Solutions 4 Health are now able to offer vapes to clients as part of the Swap to Stop scheme, in line with West Berkshire's vaping position statement.
- A plan is in place for the spending of the Local Stop Smoking Service and Support Grant funding.
- Drug testing on arrest has been given Home Office Funding, West Berkshire residents detained by police at Loddon Valley may be referred for drug testing on arrest. There will be mandatory testing for certain offences such as DA.
- Via have highlighted alcohol use as being an unmet need within West Berkshire so are focusing on improving their alcohol pathway. They have recently launched 'Renew' which is 6 brief interventions around wellbeing.
- A local drug related death panel has been set up to meet quarterly from April 24.
- Via are providing drug testing kits with two Naloxone kits as standard to service users owing to Nitazene overdoses requiring a higher dose of Naloxone.

Future Actions

- The Drug and Alcohol Policy in schools is going to be reviewed and relaunched as it does not appear to be being utilised currently.
- A representative from the Community Wellness Outreach Programme will be invited to meetings moving forward.
- As we head into the summer holidays and festival season, plans to reduce potential harm related to alcohol and drug use among children and young people is required.

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Health & Wellbeing Board – 11 July 2024

Item 17 – Members' Questions

Verbal Item

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Health and Wellbeing Board Forward Plan (All meetings are on a Thursday, starting at 9.30am in the Council Chamber except where otherwise stated)

Item	Purpose	Action Required	Date Agenda Published	Lead Officer(s)	Those consulted
12 September 2024 - Board Meeting					
Hampshire Together Update	To provide an update on the Hampshire Toegether programme, which is developing proposals for how to invest between £700 million and £900 million in hospital services across Hampshire.	For discussion	03/09/2024	TBC	Health and Wellbeing Steering Group
Housing and Health Hot Focus Session	To present the outcomes of the Housing and Health Hot Focus Sessoin	For discussion	03/09/2024	April Peberdy	Health and Wellbeing Steering Group
Community Wellness Outreach - Progress Report	To provide an update on progress in implementation of the community wellness outreach programme.	For discussion	03/09/2024	April Peberdy	Health and Wellbeing Steering Group
Better Care Fund Plan 2024/25	To review and approve the changes to the previously approved Better Care Fund Plan for 2023-25, following publication of an Addendum to the Better Care Fund Policy Framework for 2024/25	For decision	03/09/2024	Maria Shepherd	Health and Wellbeing Steering Group
Joint Health and Wellbeing Strategy Delivery Plan	To agree the updated version of the Joint Health and Wellbeing Strategy Delivery Plan.	For decision	03/09/2024	Matt Pearce	Health and Wellbeing Steering Group
Delivery Plan Progress Report: Priority 2	To update on progress in implementing the actions set out in West Berkshire's Delivery Plan, focusing on the second priority: *'To support individuals at high risk of bad health outcomes to live healthy lives'*	For discussion	03/09/2024	April Peberdy	Health and Wellbeing Steering Group
Better Care Fund Monitoring Report - Q1 2024/25	To approve the BCF quarterly monitoring report for Q1 2024/25	For decision	03/09/2024	Maria Shepherd	Health and Wellbeing Steering Group
Buckinghamshire, Oxfordshire and Berkshire West ICB Annual Report	To present the ICB's draft annual report for 2023/24	For information	03/09/2024	Sarah Webster	Health and Wellbeing Steering Group
Hot Focus Session - Topic and Date TBC					
5 December 2024 - Board Meeting					
Pharmacy First Update	To provide an update on the implementation of the Pharmacy First initiative within West Berkshire.	For discussion	26/11/2024	Sarah Webster	Health and Wellbeing Steering Group
Delivery Plan Progress Report: Priority 3	To update on progress in implementing the actions set out in West Berkshire's Delivery Plan, focusing on the third priority to: *'Help children and families in early years'*	For discussion	26/11/2024	April Peberdy	Health and Wellbeing Steering Group
Better Care Fund Monitoring Report - Q2 2024/25	To approve the BCF quarterly monitoring report for Q2 2024/25	For decision	26/11/2024	Maria Shepherd	Health and Wellbeing Steering Group
Berkshire West Safeguarding Children Partnership - Annual Report for 2023/24	To present the annual report from the Safeguarding Children Partnership	For information	26/11/2024	TBC	Health and Wellbeing Steering Group
Safeguarding Adults Board for Berkshire West - Annual Report for 2023/24	To present the annual report from the Safeguarding Adults Board	For information	26/11/2024	TBC	Health and Wellbeing Steering Group
Hot Focus Session - Topic and Date TBC					
6 March 2025 - Board Meeting					
Berkshire Suicide Prevention Strategy Update	To receive an update on the Berkshire Suicide Prevention Strategy	For decision	26/02/2025	Maria Shepherd	Health and Wellbeing Steering Group
Better Care Fund Monitoring Report - Q3 2024/25	To approve the BCF quarterly monitoring report for Q3 2024/25	For decision	26/02/2025	Maria Shepherd	Health and Wellbeing Steering Group
Conference (April 2025)					
8 May 2025 - Board Meeting					
Delivery Plan Progress Report: Priorities 4 & 5	To update on progress in implementing the actions set out in West Berkshire's Delivery Plan, focusing on the fourth and fifth priorities to: *'Promote good mental health and wellbeing for all children and young people'*, and *'Promote good mental health and wellbeing for all adults'*	For discussion	28/04/2025	April Peberdy	Health and Wellbeing Steering Group
Berkshire West Health Protection Board Annual Report 2024/25	To present the annual report from the Berkshire West Health Protection Board	For information	28/04/2025	Matt Pearce	Health and Wellbeing Steering Group
Hot Focus Session - Topic and Date TBC					

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