Herefordshire Council

Agenda

Health and wellbeing board

Date: **Monday 26 September 2022**

Time: **3.30 pm**

Place: **Plough Lane**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

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Agenda for the Meeting of the Health and wellbeing board

Membership

Chairperson	Councillor Pauline Crockett	Cabinet Member - Health and Adult Wellbeing
Vice-Chairperson	Jane Ives	Managing Director, Wye Valley NHS Trust
	Ross Cook	Corporate Director Economy and Environment
	Anna Davidson	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
	Darryl Freeman	Corporate Director for Children and Families
	Hayley Allison / Julie Grant	Assistant Director of Strategic Transformation / Head of Delivery and Improvement at NHS Improvement, NHS England
	Hilary Hall	Corporate Director Community Wellbeing
	Dr Mike Hearne	Managing Director, Taurus Healthcare
	Councillor David Hitchiner	Leader of the Council, Herefordshire Council
	Councillor Phillip Howells	Herefordshire Council
	Jane Ives	Managing Director, Wye Valley NHS Trust
	Matt Pearce	Director of Public Health
	Ivan Powell	Chair of the Herefordshire Safeguarding Adults Board
	Christine Price	Chief Officer, Healthwatch Herefordshire
	Councillor Elissa Swinglehurst	
	Councillor Diana Toynbee	Cabinet Member - Children and Families, Herefordshire Council
	Simon Trickett	Chief Executive/STP ICS Lead, NHS Herefordshire and Worcestershire CCG
	Councillor Ange Tyler	Herefordshire Community Safety Partnership / Cabinet member - Housing, Regulatory Services, and Community Safety
	Superintendent Edd Williams	Superintendent for Herefordshire, West Mercia Police
	Mark Yates	Chair of Herefordshire and Worcestershire Health and Care NHS Trust

Agenda

Pages

THE PUBLICS RIGHTS TO INFORMATION AND ATTENDANCE AT MEETING

1. INTRODUCTION

2. APOLOGIES FOR ABSENCE

To receive apologies for absence.

3. NAMED SUBSTITUTES (IF ANY)

To receive details of any member nominated to attend the meeting in place of a member of the board.

4. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest in respect of schedule 1, schedule 2 or other interests from members of the board in respect of items on the agenda.

5. MINUTES 11 - 16

To approve and sign the minutes of the meeting held on 21 July 2022.

6. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

For details of how to ask a question at a public meeting, please see:

www.herefordshire.gov.uk/getinvolved

The deadline for the receipt of a question from a member of the public is 21 September 2022 at 9.30 am.

To submit a question, please email councillorservices@herefordshire.gov.uk

7. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is 21 September at 9.30 am, unless the question relates to an urgent matter.

To submit a question, please email councillorservices@herefordshire.gov.uk

8. REPORT ON HEREFORDSHIRE PHARMACEUTICAL NEEDS ASSESSMENT 2022 17 - 140

This report seeks the approval of members for the publication of the 2022 Herefordshire Pharmaceutical Needs Assessment (PNA) on 1 October 2022 (the statutory deadline).

9. TOBACCO CONTROL 2022 141 - 218

The purpose of this report is to inform Health and Wellbeing Board on the recent publication of the 'The Khan review: Making smoking obsolete' (Appendix 1) and the findings from the recent smoking needs assessment (Appendix 2) and for the board to endorse the recommendations set-out within the report.

10. UPDATE ON THE WORK OF THE ORAL HEALTH IMPROVEMENT 219 - 318

PARTNERSHIP BOARD

This report updates the Health and Wellbeing Board on the work of the Oral Health Improvement Partnership Board and seeks approval of the recommendations contained within.

11. HEREFORDSHIRE'S BETTER CARE FUND (BCF) INTEGRATION PLAN 2022-23

The board will be invited to note and approve Herefordshire's Better Care Fund plan 2022-23.

Report paper to follow.

12. HEREFORDSHIRE FOOD CHARTER

A verbal update on the Herefordshire Food Charter, following up from a full paper on the Sustainable Food Places model that went to the Health and wellbeing board last December.

Sign The Charter - Herefordshire Food Charter

https://herefordshirefoodcharter.org.uk/sign-the-charter

13. COST OF LIVING REPORT SEPTEMBER 2022

A report on the actions Herefordshire Council and its partners are taking to protect people against higher costs.

Report paper to follow.

14. JOINT HEALTH AND WELLBEING BOARD STRATEGY UPDATE

A verbal update on the Joint Health and Wellbeing Strategy.

15. HEALTH AND WELLBEING BOARD WORK PROGRAMME 319 - 320

A work programme and report requirement details for review and prioritisation by the board.

16. DATE OF NEXT MEETING

The next scheduled meeting is:

17 October 2022 - Private Workshop: Health and Wellbeing Strategy Session
12 December 2022

The public's rights to information and attendance at meetings

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- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
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- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).
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Attending a meeting

Please note that the Shire Hall in Hereford, where the meeting is usually held, is where Hereford Crown Court is located also. For security reasons, all people entering the Shire Hall when the court is in operation will be subject to a search by court staff. Please allow time for this in planning your attendance at a meeting.

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Anyone is welcome to record public meetings of the council using whatever, nondisruptive, methods they think are suitable. Please note that the chairperson has the discretion to halt any recording for a number of reasons including disruption caused by the recording, or the nature of the business being conducted. Recording should end when the meeting ends, if the meeting is adjourned, or if the public and press are excluded in accordance with lawful requirements.

Anyone filming a meeting is asked to focus only on those participating actively.

If, as a member of the public, you do not wish to be filmed or photographed please let the democratic services officer know before the meeting starts so that anyone who intends filming or photographing the meeting can be made aware.

The reporting of meetings is subject to the law and it is the responsibility of those doing the reporting to ensure that they comply.

The council is making an audio recording of this public meeting. These recordings are made available for members of the public via the council's website unless technical issues prevent this. To listen live or to hear the entire recording once the meeting has finished navigate to the page for the meeting and click the larger blue arrow at the top of the agenda. To listen to an individual agenda item click the small blue arrow against that agenda item.

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Please do not allow any items of clothing, etc. to obstruct any of the exits.

Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

The chairperson or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the fire assembly point.

Herefordshire Council

The Seven Principles of Public Life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

Minutes of the meeting of Health and wellbeing board held in Conference Suite, Plough Lane on Thursday 21 July 2022 at 10.00 am

Board members present in person, voting:

Councillor Pauline Crockett (Chairperson)	Cabinet Member - Health and Adult Wellbeing
Hilary Hall	Corporate Services
Jane Ives (Vice Chairman)	Managing Director, Wye Valley NHS Trust
Matt Pearce	Public Health
Christine Price	Chief Officer, Healthwatch Herefordshire
Simon Trickett	Chief Executive/STP ICS Lead, NHS Herefordshire and Worcestershire CCG

Board members in attendance remotely, non-voting:

Dr Mike Hearne	Managing Director, Taurus Healthcare
Councillor David Hitchiner	Leader of the Council, Herefordshire Council

Note: Board members in attendance remotely, e.g. through video conference facilities, may not vote on any decisions taken.

Others present in person:

Ewen Archibald	Interim Assistant Director, All Ages Commissioning	Herefordshire Council
Marie Gallagher	Project Manager – All Age Commissioning	
Adrian Griffiths	Business Partner	Herefordshire Council
Susan Harris	Executive director of strategy and partnerships, and STP communications and engagement lead	Director of Strategy and Partnerships, Herefordshire and Worcestershire Health and Care NHS Trust (Rep Chair of the Trust)
Dr Frances Howie	Public Health Consultant	Herefordshire Council
David Mehaffey	Director for Integrated Care System Development	NHS Herefordshire and Worcestershire System
Amy Pitt	Service Director - Communities	Herefordshire Council

Others in attendance remotely:

35. INTRODUCTION

The chair drew the board's attention to supplements that had been added to the agenda due to formatting and collating challenges.

The chair also asked the board if it was happy to adjust the agenda so that Item 7 was first on the agenda. The board approved this request.

36. APPOINTMENT OF VICE CHAIRPERSON

The newly established Herefordshire and Worcestershire Integrated Care Board recommended Jane Ives (Managing Director, Wye Valley NHS Trust) as its candidate. The chair invited comments from the board, but there were none. The recommendation was proposed and seconded and Jane Ives was formally appointed as vice-chairperson of Herefordshire Health and Wellbeing Board.

Resolved: That Jane Ives be appointed vice-chairperson of the board for the remainder of the municipal year.

(The Chair then returned to the beginning of the agenda).

37. APOLOGIES FOR ABSENCE

Apologies were received from: Mandy Appleby, Ross Cook, Darryl Freeman, Lisa Arthur, Superintendent Edward Williams, Hayley Ann Alison, Anna Davidson, Cllr Toynbee, Stephen Brewster

38. NAMED SUBSTITUTES (IF ANY)

There were no named substitutes.

39. DECLARATIONS OF INTEREST

There were no declarations of interest.

40. MINUTES

David Mehaffey asked for it to be noted that he had attended the meeting of the 28th in person and not online as had been recorded in the minutes. It was also noted that Frances Howie's details were incorrect.

41. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions received from members of the public.

42. QUESTIONS FROM COUNCILLORS

No questions from councillors.

43. PROPOSED ADDITION OF A VOLUNTARY SECTOR REPRESENTATIVE POSITION TO THE BOARD MEMBERSHIP.

In the meeting of the 28th of March the question was raised if it was possible to add a voluntary sector representative to the membership of the board.
The board was informed that an addition to the board's membership of this nature would necessitate a change in the council's constitution and that the board was consulting with agencies from that sector before progressing any further and

would look to bring the item back to a future meeting. It was recommended that the board agrees to return to the discuss the item at a future meeting.

Resolved that: The board unanimously agreed to return to the item in a future meeting.

44. BETTER CARE FUND (BCF) YEAR END REPORT 2021-2022

The board received a report from Ewen Archibald (Service director for all ages commissioning), Marie Gallagher (Project manager) and Adrian Griffiths (Business manager). It was pointed out that the timescales meant the papers were presented on performance of the last year after they have been submitted. The documents had been reviewed and submitted by chief officers under delegated arrangements. Subject to any further view from the board the submissions have been approved by the Department of Health.

The board was told that there were six pools of funding within the better care fund, but only four of those were active and the other two were essentially dormant. All the national conditions had been met by Herefordshire in relation to BCF during the period. The great majority of targets set had been met in full, but one that hadn't was around maintaining low levels of admission to care homes, the target here was 408, but had actually reached 485.

This was driven by a huge and sustained demand for home care during the Covid and post-Covid period. The market had largely met that demand, but in some instances people had to be admitted into residential care when otherwise they would have been able to go home with a package of support. An increase in acute need of people going into hospital and being admitted to nursing straight from hospital was the other driving factor.

Good progress had been made with re-enablement and people living independently after 91 days of discharge. The BCF pools as a whole represent a very significant investment in cores services, particularly around integrated and core services. The very significant role of Talk Community was discussed in relation to this. Talk Community hubs had grown and helped create a very diverse and comprehensive system of integration and a wide range of services which support the objectives of the BCF plan.

It was stated that challenges remain from the residual effects of the impact of covid including ongoing demand going into hospital and continuing impact on the availability of the workforce. Recruitment both nationally and locally remains an issue.

An overview was also provided of the new BCF planning guidance and the timelines involved in submitting items to the board.

The board noted the plan had already been submitted and considered if there were any actions necessary to improve future performance and felt that embracing Talk Community would be a key element in maintaining good future performance.

The board enquired whether the people who went into residential care because they couldn't be supported with home care eventually got to go home or did they stay in residential care? This information would be useful in informing the demand and capacity plan for intermediate care.

The board asked if it would be possible to bring BCF details and information to the clinical practitioner forum (PCF) to enable a system-wide discussion, particularly on the areas where improvements could be made. The service director confirmed this would be fine.

Resolved: The Better Care Fund (BCF) 2021-2022 year-end template at appendix 1, as submitted to NHS England, was noted and reviewed, and the board would determine any further actions necessary to improve future performance.

Action: Adrian Griffiths to obtain data regarding people placed in residential homes from hospital and whether they eventually got a package of home care support.

45. JOINT HEALTH AND WELLBEING BOARD STRATEGY BRIEFING

Matt Pearce (Director of Public Health) gave a presentation and overview of the Health and Wellbeing Board Strategy document and stressed the importance of it being integrated within the Integrated Care Partnership. The key principles to be focused on were the needs of local communities, prevention and health inequalities.

It was noted that deadlines for the strategy development were tight, but existing information was available from engagement work carried out by Talk Community and Healthwatch and this could be built on to develop a robust strategy. The timeline for the strategy development was provided and it was explained that a Task and Finish Group would be set up to co-ordinate and guide progress.

The board expressed its support for the new strategy and note that it was a step forward from previous years when the focus had sometimes been more on strategy than actually delivery. The board also stressed the importance of ownership of tasks and people understanding their roles within the task and finish group.

Approved: The board support the development of the new health and wellbeing strategy and agree on the guiding principles process and timeline for the strategy development. The board also agrees the production of the strategy be delegated to a task and finish development group.

46. INTEGRATED CARE SYSTEM (ICS) DEVELOPMENT UPDATE AND INTEGRATED CARE PARTNERSHIP ASSEMBLY (ICPA) TERMS OF REFERENCE BRIEFING

Simon Trickett and David Mehaffey gave a detailed overview of the Integrated Care System (ICS) development update and gave a briefing on the terms of reference for the newly created Integrated Care Partnership Assembly (ICPA).

The board expressed its positivity about the new system and partnerships. The chair noted that this presented a great opportunity to share and learn from commonalities with Worcestershire and work together to get the best outcomes for the residents of both counties.

The board stated that previously there had been barriers that stopped it from working in an integrated way and the health and social care act 2022 had removed a lot of those barriers, ensuring there was now an opportunity to do things in a different way.

The board noted that this wasn't just about health and care, but the whole infrastructure including transport and housing. If these weren't handled right then the best health and care services in the world would not improve the inequalities and outcomes.

Resolved: The board consider the report in appendices 1 and 2 and commented on the terms of reference.

47. INEQUALITY GROUP UPDATE

Alan Dawson, provided an update (ahead of a detailed paper) on a plan for the inequality group and gave an update on its progress. The group had identified avoidable inequalities and agreed a number of principles including a system-wide understanding of inequalities and a focus on deprivation, vulnerable groups and best practice.

The board thanked the inequality group for the hard work it had been doing in driving this difficult subject forward and noted that it isn't just about life expectancy, but was also about the here and now.

The board also noted that when the paper comes back it needs to be clear about how it's going to set priorities on this in order to make the biggest impact. Inequality is a huge area and it simply won't be possible to deal with all of it.

48. HEALTH AND WELLBEING BOARD WORK PROGRAMME

Amy Pitt talked the board through the work programme for the next 12 months and discussed statutory requirements of the board that it needed to be mindful of.

49. DATE OF NEXT MEETING

The meeting ended at Time Not Specified **Chairperson**

Herefordshire Council

Title of report: Report on Herefordshire Pharmaceutical Needs Assessment

Meeting: Health and Wellbeing Board

Meeting date: 26 September 2022

Report by: Emma Lydall (Public Health Registrar)

Classification

Open.

Decision type

This is not an executive decision

Wards affected

All wards

Purpose

This report seeks the approval of members for the publication of the 2022 Herefordshire Pharmaceutical Needs Assessment (PNA) on 1 October 2022 (the statutory deadline). The statutory 60-day consultation period for this PNA ends on 29 September 2022. This will be subject to any amendments in relation to responses that may be received in the final days of the consultation period.

Recommendations

That:

a) **Members note the PNA consultation responses received to date.**

b) **Members are asked to note the consultation responses received to date (Appendix 1) and to delegate final approval for publication to the PNA working group, subject to any minor or technical amendments recommended by the working group.**

Alternative options

1. There are no alternative options. It is a statutory requirement of the Health and Wellbeing Board to publish a PNA on a 3-yearly basis.

Key considerations

2. The PNA provides an assessment of the current provision of pharmaceutical services across Herefordshire and whether this meets the needs of the population, identifying any potential gaps in service delivery.

3. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 state that Health and Wellbeing Boards (HWBs) must produce their first PNA by no later than 1 April 2015, and every 3 years thereafter. The last Herefordshire PNA was published in March/April 2018. However, in light of the COVID-19 pandemic, NHS England has extended the publication deadline to 1 October 2022.

4. The development of the 2022 PNA was achieved through various engagement activities to ensure input from key stakeholders, including:

    a. Regular working group meetings

    b. Distribution of public questionnaires

    c. Distribution of contractor questionnaires

    d. Formal consultation with statutory consultees

5. It has been assessed that there is currently sufficient provision of pharmacies and dispensing GP practices in Herefordshire, delivering essential pharmaceutical and dispensing services. There are 27 pharmacies and 10 dispensing GP practices, serving a mixed urban and rural population of 193,615 people. This equates to one pharmacy per 7,171 people, compared to the England average of one pharmacy per 5,056 people. When GP dispensing practices are included the gap with England is reduced, with one contractor per 5,233 people compared to one contractor per 4,605 people in England.

6. Travel time analysis indicates good access to services by car (the entire population of Herefordshire lives within a 20-minute journey by car to a pharmacy or GP dispensing practice) around 64% of the total population of Herefordshire live within a 30 minute walking distance of a pharmacy of GP dispensing practice. 66% of the population can access a community pharmacy or dispensing practice within 45 minutes by public transport on a weekday morning, but this proportion is reduced on weekends. On Sundays 7 of the 27 pharmacies in the county are open.

7. The Pharmacy Services Public Questionnaire was published online from 10 November 2021 until 31 January 2022, and asked people who use the services about their experience. From Herefordshire, there was a total of just 181 responses. Views expressed by this small self-selected sample are not representative of the wider Herefordshire population. For example, males, younger adults, unemployed adults and those living in rented accommodation are under-represented. Recommendations cannot be made exclusively on the basis of this survey. However, it is important to utilise this data to assess congruence with needs identified via other data sources.

8. A large majority of public survey respondents find accessing pharmacy services easy in terms of communication, accessibility of building and distance. However, respondents noted ‘some issues’ or ‘significant difficulties’ with access in terms of parking (32%), opening times (36%) and public transport (40%).

9. Most public survey respondents used pharmacies to obtain advice on buying over-the-counter medicines. However, they reported that they usually get advice about health, lifestyle and disease prevention from the internet or GP practice, despite 83% being aware that pharmacists can provide this.

10. Respondents were asked to rate their confidence in their pharmacy team's advice and knowledge of services. The services that respondents had the highest levels of confidence in were: prescribed medicines (79%) and OTC medicines (68%). Respondents had the lowest levels of confidence in the pharmacy team's advice and knowledge relating to healthy lifestyle services (41%). However, this data should be treated with caution since the survey made no distinction between dispensing and community pharmacies. Data may have been taken from respondents using a dispensing practice where there is no access to this advice.

11. The 2018 PNA made suggestions for potential future services that would optimise the ability of pharmacies to meet local health needs. A number of these suggestions have now been supported by national plans, some have been developed via local initiatives, whilst others have not been developed further (see appendix 2, table 12, page 80). The COVID-19 pandemic is likely to have affected progress in some areas.

12. The 2022 recommendations are based on a consideration of progress against the 2018 recommendations, mapping of current services, public feedback (via the survey), and the health needs of the population (identified using the Joint Strategic Needs Assessment and The Office for Health Improvement and Disparities regional profile).

13. A summary of the 2022 PNA recommendations is given below:

Recommendation	Who
Pharmacies should work with partners in the system to reduce vaccine inequalities, promoting the flu vaccine offer, particularly in deprived communities. Pharmacies should also contribute to other vaccination programmes.	Pharmacies PCNs Taurus Healthcare Local Authority Public Health Team
Flexibility around opening hours should be considered, including the option of extending existing contractors' opening hours on a locally commissioned rota basis.	Pharmacies Pharmacy Commissioning Lead
Encourage secondary care based pharmacy colleagues to begin to incorporate Discharge Medicines Services into their discharge processes. The focus should be on discharges for frail patients, those on high risk medicines and those whose primary diagnosis is shown to be a frequent cause of readmission before 30 days.	ICB/ICS and system partners
Pharmacies in areas of deprivation should be particularly encouraged to implement and promote blood pressure checks.	Pharmacies
Formation of a network of pharmacy Health Champions should be explored, in partnership with the local public health team. This could be utilised to achieve improved and consistent practice to maximise the health promoting role of community pharmacies.	Local Authority Public Health Team Integrated Care System (ICS) Pharmacy Lead for Herefordshire Local Pharmaceutical Committee
Clear pathways need to be established for the disposal of all sharps and waste medicines as part of a redefined service.	Pharmacy Commissioning Lead
Volunteer efforts initiated during COVID-19 lockdowns, to facilitate pharmacy access for those living in rural communities should continue where possible under the responsibility and discretion of the pharmacist/pharmacy.	Talk Community Local Authority Public Health Team

Ensure that pharmacies have access to up-to-date information about non-medical service directories, for example, social prescribing. Pharmacies should also be aware of key local issues such as fuel poverty, domestic violence and mental health.	Local Authority Public Health Team Health Champions Network
If child oral health is not identified as a national priority, local resource should be provided to enable pharmacies to give this support and advice on a voluntary basis.	Local Authority Public Health Team Health Champions Network
Consider increasing the availability of commissioned services such as: • weight management • pharmacotherapy and behavioural support for smoking cessation • NHS Health checks • This would reduce geographical barriers to these services and provide more convenient one-stop support, particularly in deprived communities. • Diabetes prevention programme	Commissioners across the system
Consider and further explore the availability and use of translation services in pharmacies. NHSE do not currently commission translation services for pharmacies to access. This is important now and will become more important as more clinical services develop and our populations change.	PNA Working Group (see below)

14. It will be important to ensure that the findings of this PNA are acted upon, with clear governance in place on their review. We suggest that the HWB review progress annually, and that a Herefordshire PNA Working Group is set up to explore further and progress the findings and recommendations from this PNA. This working group will work closely with a proposed Worcestershire PNA Working Group, to be discussed at the Worcestershire Health and Wellbeing Board on 27 September 2022.

Community impact

15. The PNA will be used by NHS England to consider applications to open new pharmacies, or to commission additional services from pharmacies. Local commissioners may also use information and evidence contained within the PNA to commission additional services from community pharmacies.

16. The pharmaceutical service in Herefordshire is provided by a variety of contractors that are appropriately located to meet the needs of the vast majority of the population. However, it is clear that the role of community pharmacies in preventing ill-health and supporting self-care could be strengthened through the existing pharmacy contractor base.

17. All pharmacies in Herefordshire are now Healthy Living Pharmacies (HLPs), ensuring that pharmacies have a workforce with the skills and opportunity to make an important impact on the health and wellbeing of the communities they serve.

18. Currently, the ratio of pharmacies to population is lower in Herefordshire than England and Herefordshire has a growing older population with greater need of these services. Services need to be aware of these changing demographics. Commissioners must also ensure that any additional services do not compromise the availability and quality of essential services.

Environmental Impact

19. The recommendations in this report would not have a significant environmental impact. However, ensuring adequate provision of pharmaceutical services promotes good stewardship of medicines. Medicines account for 25% of NHS greenhouse gas emissions.

Equality duty

20. The detail in the PNA pays due regard to this duty and the recommendations seek to deliver appropriate support for those who share protected characteristics.

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

22. A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Resource implications

23. Accepting the recommendations does not have direct resource implications. Commissioners will need to consider the recommendations in light of other budget priorities.

Legal implications

24. The Health and Social Care Act 2012 places a statutory duty on the council to improve the health of their population. The PNA is instrumental in supporting the discharge this duty.

25. Under s128A of the Health and Social Care Act 2012 it is the responsibility of Health and Wellbeing Boards to develop and update PNAs. Health and Wellbeing Boards are also required to assess the needs for pharmaceutical services in its area and publish a statement of its revised assessment.

26. Regulation 4 and Schedule 1 of the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2012 outline the minimum requirements for PNAs and Regulation 8 provides the requirements for consultation on PNAS.

Risk management

27. Significant reputational risk is attached to non-publication of the PNA by 1 October 2022. Mitigation is through accepting the recommendations of this paper.

Consultees

28. The PNA statutory consultation period began on 1 August 2022 and will close on 29 September 2022. This 60 day period will allow stakeholders time to review and comment on the draft PNA. So far, we have had a total of 12 responses from 3 contributors (appendix 1). All comments have been worked through. Almost all were actioned and changes can be seen in the revised PNA documents (appendix 2 and 3). All statutory consultees will receive a hyperlink to the final PNA.

29. An online survey (as described above) took place and the final report will be made available through that portal.

Appendices

Appendix 1. Consultation response log
Appendix 2. Herefordshire 2022 Pharmaceutical Needs Assessment (main document)
Appendix 3. Herefordshire 2022 Pharmaceutical Needs Assessment (report appendices)

Background papers

None identified

Report Reviewers Used for appraising this report:

Please note this section must be completed before the report can be published		
Governance	John Coleman	Date 15/09/2022
Finance	Click or tap here to enter text.	Date Click or tap to enter a date.
Legal	Alice McAlpine	Date 15/09/2022
Communications	Click or tap here to enter text.	Date Click or tap to enter a date.
Equality Duty	Click or tap here to enter text.	Date Click or tap to enter a date.
Procurement	mark cage	Date 15/09/2022
Risk	Click or tap here to enter text.	Date Click or tap to enter a date.

Approved by	Click or tap here to enter text.	Date Click or tap to enter a date.

Herefordshire Pharmaceutical Needs Assessment Consultation Response Log

Response Number	Response Date	Responder	Section of PNA	Consultation Response	Consideration given in revised draft	Decision to amend the PNA (y/n) and date
1	05/08/22	Practice Manager	Part A, Section 1 (Tables, maps and text)	On the draft PNA it states that the South & West PCN has 3 Dispensing Practices but it does however have 4 (5 if you included Peterchurch branch surgery). We have Ewyas Harold, Kingstone, Much Birch and Fownhope all being Dispensing Practices. It is possible that Fownhope has been put in the City PCN but that is not the case.	Clarification provided by Herefordshire Intelligence Team: 'Fownhope Medical Centre should be included in 'South & West' but not in the Hereford City. This is according to the SHAPE tool. Previously I used its postcode to lookup the PCN, which belongs to Hereford City. I have now re-calculated the figures accordingly. There are 10 dispensing practices, of these 3 have more than one branch: -Mortimer Medical Practice has two branches; Leintwardine & Orleton -Weobley Surgery has one branch: Staunton-On-Wye -Golden Valley Practice has one branch: Peterchurch' **Amendments made on page 14**	Yes 12/09/2022
2	11/08/22	LPC	Part C, Recommendations	Recommendations *say 'consider extending opening hours of*	**Amendments made on pages 82, 84 & 89**	Yes 12/09/2022

			(p.82, 84 & 89)	*pharmacies.'* This needs to be a commissioned ROTA if required and not for pharmacies to just open longer they only have to do 40 core hours a week (apart from handful of 100 hour pharmacies)		
3	11/08/22	LPC	Part C, Recommendations (p. 82 & 89)	Recommendations say *'Pharmacies in areas of high deprivation should be prioritised for the continued implementation of blood pressure checks.'* This is a national service open to all pharmacies - needs to be encouraged.	**Amendments made on pages 82 and 89**	Yes 12/09/2022
4	11/08/22	LPC	Part C, Recommendations (p. 86 , 88)	Recommendations say *'a network of pharmacy Health Champions must be established in partnership with the local public health team…'* Not sure this is a must - more that agreed local support and resources to align with any national NHSEI mandated promotional activity.	**Amendments made on pages 86 and 88**	Yes 12/09/2022
5	11/08/22	LPC	Part C, Recommendations (p. 85 & 89)	Recommendations *say 'Pharmacies should provide tailored opportunistic advice about child oral health and consider this issue for awareness campaigns, particularly in areas of high deprivation'* Campaigns are dictated nationally – local resources and support for some agreed additional campaigns possible.	**Amendments made on pages 85 and 89**	Yes 12/09/2022
6	11/08/22	LPC	Part A, Section 2 (p.33)	*'Patients across England can now download the NHS App which will allow them to order repeat prescriptions,*	**Amendments made on page 33**	Yes 12/09/2022

				check their patient record or book and manage GP appointments. GP practices will need to review some of their IT system settings to enable patients to access the app's full range of functions. This should be encouraged in order for patients to be able to order their medicines safely through this digital offer The Electronic Prescription Service (EPS) is also being implemented as part of the dispensing service.' This is personal choice – not sure the App bit fits in with dispensing. The EPS part is more relevant.		
7	11/08/22	LPC	Part A, Section 2 (p. 35)	Managed repeats should not be under essential services.	It is made explicit in the text that this is not an essential service, but as it is closely related to an essential service, we feel it fits best in this section. No amendment made.	No 12/09/2022
8	11/08/22	LPC	Part A, Section 2 (p. 34)	*'Public Health (Promotion of Healthy Lifestyles) Each financial year (1st April to 31st March), pharmacies are required to participate in up to six health campaigns at the request of NHSE&I.'* Needs to be clear that this is a total of 6 max as determined by NHSEi nationally. Any additional local arrangements as agreed through the LPC and would be voluntary.	**Amendments made on page 34**	Yes 12/09/2022
9	11/08/22	LPC	Part A, Section 2 (p. 36)	*'Community Pharmacy Claims associated with initial local engagement in preparation for delivering GP referral*	**Enquiry ongoing**	

				pathway of the CPCS (started late 2021, data to follow)' NHSEi have this data.		
10	02/09/22	NHS Contracts Manager for Boots UK Limited	Part C (p. 88)	*'Extended opening hours of pharmacies including weekends should be considered'.* The option of extending opening hours on locally commissioned rota basis to extend existing contractors hours as an 'out of hours' service should be explored in the first instance	**Amendments made on pages 82, 84 & 89**	Yes 12/09/2022
11	02/09/22	NHS Contracts Manager for Boots UK Limited	Part A (p. 28)	Urban/rural classification on the maps i.e. figure 12. It would be helpful it was clear what source had been used for the classifications given and, for the avoidance of doubt, how these compare to the areas currently classified as rural (controlled) for the purpose of the pharmaceutical regulations.	**Amendments made to page 28**	Yes 12/09/2022
12	02/09/22	NHS Contracts Manager for Boots UK Limited	Appendix 3b	Possibly due to the timing of production of this draft, the recent changes in the opening hours of a number of Boots pharmacies may not have been reflected in the draft PNA. These changes were notified to the NHS England team who should have a list of the current opening hours of our pharmacies.	**Amendments made to Appendix 3b**	Yes 12/09/2022

Link to 2018 Consultation response log Appendix H analysis of consultation responses May 2018 (herefordshire.gov.uk)

Herefordshire Pharmaceutical Needs Assessment 2022

Draft for consultation

August 2022

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

Contents

INTRODUCTION

This is the third Pharmaceutical Needs Assessment (PNA) prepared on behalf of the Herefordshire Health and Well-being Board (HWB).

What is a Pharmaceutical Needs Assessment?

A Pharmaceutical Needs Assessment (PNA) is a process of reviewing pharmaceutical service need and provision within counties in England. The development of this PNA was achieved through various engagement activities to ensure input from key stakeholders (ensuring the 2013 regulations for engagement were met). These activities included:

1. Regular working group meetings
2. Distribution of public questionnaires
3. Distribution of contractor questionnaires
4. Formal consultation with statutory consultees

Local pharmaceutical services are provided by community pharmacies, dispensing doctors and other providers. Details of pharmaceutical service providers were obtained from NHS England and Herefordshire and Worcestershire Local Pharmaceutical Committee (LPC).

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

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

The minimum content requirements for PNAs are:

1. The pharmaceutical services provided that are necessary to meet needs in the area

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

Roles and responsibilities

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

HWBs became statutory bodies from April 1, 2013. Each LA has a HWB. HWBs do not commission services directly but oversee the system for local health commissioning. The HWB must produce a Joint Health and Well-being Strategy (JHWS) based on the findings of a local Joint Strategic Needs Assessment (JSNA). The JSNA also informs the preparation of the PNA.

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

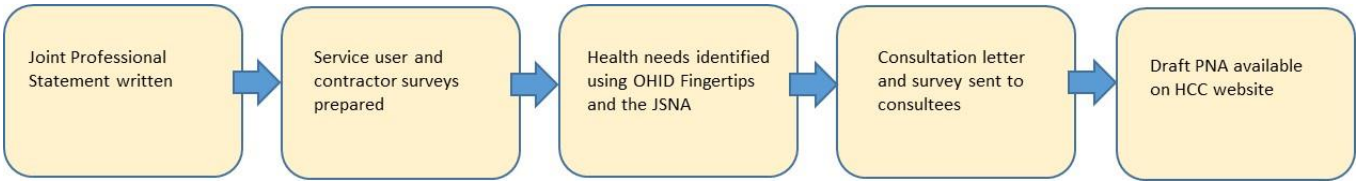
- Herefordshire County Council (HCC): Responsible for ensuring that services the Council provides meet the needs of residents and those who work in the county.
- NHS England West Midlands Region: NHS England is responsible for commissioning services under the national community pharmacy contract, for determining applications

for pharmacy contracts, the commissioning of enhanced services for pharmacy, contract monitoring, pharmacy opening hours and Electronic Prescription Service (EPS) support.

- Herefordshire and Worcestershire Local Pharmaceutical Committee (LPC): This is the local statutory representative committee (LRC) representing community pharmacies in Herefordshire and Worcestershire, working with others to improve the quality of health and well-being of the people in the two Counties.
- Herefordshire Local Medical Committee (LMC): LMCs are statutory representative committees of general practitioners (GPs) who plan and provide health care in the community.
- Clinical Commissioning Groups (CCGs): Formerly had responsibility for planning and commissioning health services.
- Local Professional Networks (LPNs): The LPNs are intended to provide clinical input into the operation of NHS England West Midlands Region and local commissioning decisions. They help to develop the community pharmacy role in supporting self-care, managing long term conditions, promoting medicines optimisation and developing services commissioned locally by local authorities and CCGs and highlighting inappropriate gaps or overlaps.
- Healthwatch Herefordshire: Healthwatch Herefordshire is the independent consumer champion for the public, patients and users of health and social care services in Herefordshire.
- For a full list of members and the Terms of Reference of the PNA working group see Appendices 1 and 2.

The Process of PNA Development

Figure 1: Process of PNA Development



Part A of the PNA presents current pharmaceutical service provision. Part B looks at local health needs and priorities. Part C considers the summary of current provision of pharmaceutical services alongside the health needs of the population and identifies where needs could be met by the development or extension of existing pharmaceutical services. In this way, the PNA informs the planning and commissioning of future services.

Relevant policy framework and strategic direction

A number of national strategies, frameworks, guidelines and local priorities support pharmacy involvement in meeting the population health needs that will be described in Part B. These are summarised in table 1.

Table 1: Relevant policies and strategies

National strategies and frameworks	Key points
Community Pharmacy Contractual Framework 2019-24	Describes new services which will be offered through community pharmacy Underlines the critical role of community pharmacy as an agent of improved public health and prevention
NHS Long Term Plan (NHS LTP)	Focusses on 5 areas: - **A new service model for the 21st century** (Pharmacists able to support the timely discharge of patients from hospital through the Discharge Medicines Service to help hospital flow and bed capacity) - **More NHS action on prevention and health inequalities** (Local pharmacies actively promote healthy lifestyle initiatives on priority areas such as smoking, obesity, and alcohol, alongside prescription-linked support) - **Further progress on care quality and outcomes** (Pharmacists can support early detection of serious conditions and improved survival by signposting patients to appropriate services) - **NHS staff will get the backing they need** (Pharmacies can serve as training locations for pharmacy students and newly qualified pharmacists)

	- **Digitally-enabled care to go mainstream across the NHS** (Pharmacies support the NHS LTP through repeat dispensing, most of which is carried out by the Electronic Prescription Service) - **Taxpayers' investment to be used to maximum effect**
Pharmacy Integration Fund	The pharmacy integration programme will pilot and evaluate new services with the intention of incorporating them into the national framework depending on pilot evaluations Priorities are determined by the NHS LTP
NICE guideline: community pharmacies, promoting health and wellbeing (2018)	Encourages partners to consider: - Work to help all community pharmacies become health and wellbeing hubs - Overarching principles of good practice for community pharmacy teams - Awareness raising and providing information, advice and education, behavioural support (based on relevant NICE guidance) - Referrals and signposting
Local strategies and priorities	**Key points**
Integrated Care System strategy	The ICS has 4 core objectives: - To ensure healthier, well connected and more resilient communities with targeted support to reduce health inequalities and inequities, preventing ill health - To provide high quality services through improving access to clinically effective treatments - To make the best use of resources, being exemplar employers and strengthening the local economy by employing local people, and investing in local businesses wherever possible - To promote a healthier physical environment, reducing our carbon footprint through positive action around our buildings, working practices and digital transformation
Herefordshire Joint Health and Wellbeing Strategy (JHWS) 2017 (currently being updated) Joint Strategic Needs Assessment (JSNA) 2017	The Health and Wellbeing Board identified four priorities based on the 2017 JSNA: - Giving our children a good start in life by maintaining a healthy weight and looking after their teeth.

Joint Strategic Needs Assessment (JSNA) 2021	- Supporting people with dementia to remain as independent as possible within their community, ensuring that people are well cared for when nearing the end of life. - Supporting the development of resilient communities, where people help each other to remain independent and in control of their own lives. - Keeping people warm so they are less likely to develop enduring health problems and become acutely ill when it is cold.

Information to be contained in pharmaceutical needs assessments (Regulations 2013)

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

Statement 1: Current provision of necessary services

A statement of the pharmaceutical services that the HWB has identified as services that are provided:

• In the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and

• Outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services)

It has been assessed that there is currently sufficient provision of pharmacies and dispensing GP practices in Herefordshire, delivering essential pharmaceutical and dispensing services. There are 27 pharmacies and 10 dispensing GP practices, serving a mixed urban and rural population of 193,615 people (ONS 2020 mid-year estimate). This equates to one pharmacy per 7,171 people, compared to the England average of one pharmacy per 5,056 people. When GP dispensing practices are included the gap with England is reduced, with one contractor per 5,233 people compared to one contractor per 4,605 people in England.

Statement 2: Gaps in provision of necessary services

A statement of the pharmaceutical services that the HWB has identified as services that are not provided in the area of the HWB but which the HWB is satisfied:

• need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;

• will in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

Travel time analysis indicates good access to services by car (the entire population lives within a 20-minute journey by car to a pharmacy or GP dispensing practice) but poorer access on foot or by public transport, particularly in more rural areas. On Sundays 7 of the 27 pharmacies in the county are open.

Statement 3: Current provision of other relevant services

A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided:

- In the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;
- Outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;
- Inside or outside the area of the HWBB and, whilst not being services of the types described here, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area

With respect to Advanced Services, based on pharmacy survey results (covering 61% of pharmacies), 2 pharmacies provide appliance use review service and stoma appliance customisation and this is linked to contractor supply issues and so further analysis is not possible at this stage. Nearly all responding pharmacies indicated that they provide a Community Pharmacist Consultation Service (CPCS), which includes the Urgent Medicines Supply Service" where there is an urgent need for a supply of regular repeat medicines; flu vaccination service and New Medicine Service.

Most of the pharmacies reported that they would provide the advanced, additional, disease specific, screening and vaccination services if they were to be commissioned.

Statement 4: Improvements and better access, gaps in provision

A statement of the pharmaceutical services that the HWB has identified as services that are not provided in the area of the HWB but which the HWB is satisfied:

- Would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type in its area
- Would, if provided in specified future circumstances (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area

This assessment identified the following services to be considered for commissioning, based on the health needs of the Herefordshire population:

- Weight management
- Behavioural support for smoking cessation in conjunction with pharmacotherapy support for patients. It should be noted that NHS England plan to commission a Smoking Cessation Service on discharge from hospital as well as a community based offer for patients to stop smoking. These need to be considered together in order to, as a system,

influence and promote delivery of stop smoking services from pharmacies to ensure sufficient capacity and patient choice.

- Diabetes prevention initiative
- NHS Health Checks, which are currently only available at GP practices, and therefore only available for those who are registered with a GP.

Statement 5: Other NHS services

A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG (Clinical Commissioning Group), an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect:

- The need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or
- Whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area

Locally commissioned Services include:

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

Herefordshire County Council commissions the following services from local designated pharmacies:

- Needle and Syringe Exchange (through Turning Point)
- Supervised Methadone and Buprenorphine Consumption, Needle Exchange, Naloxone (through Turning Point)
- Emergency Hormonal Contraception (under Patient Group Direction (PGD) through the Herefordshire sexual health services provider, Solutions 4 Health, who have an SLA in place for each pharmacy delivering EHC for which they are reimbursed by the provider.

Herefordshire and Worcestershire CCG commissions the following services:

- Herefordshire Worcestershire Community pharmacy palliative care medicines hubs
- Urgent Access Medicines Scheme

- Access to Antiviral medicines for outbreaks of flu in the out of season period
- Support for the safe management of medicines in quarantine/ isolated settings
- Transportation of COVID-19 vaccines within NHS Herefordshire and Worcestershire ICS

Analysis indicates adequate provision of most services across the county (see Section A). There are some areas currently under development or consideration where progress will be welcome. These include: hypertension case-finding (which is currently not available in North and West PCN;) needle and syringe exchange (only one pharmacy is providing this in Hereford City although this pharmacy is open 7 days a week;) and sharps disposal (not currently commissioned in Herefordshire pharmacies but being explored regionally in order to develop a more accessible, appropriate service for patients with a need for a quantitative system approach to understanding how much of medicines waste and sharps waste is safely and appropriate disposed of for which pharmacies can play a part.

The pharmacy survey indicated that most pharmacies would be willing to provide the following additional services if commissioned: Chlamydia Testing Service, Chlamydia Treatment Service, Not Dispensed Scheme, Gluten Free Food Supply Service (not via FP10), NHS Health Check (Vascular Risk Assessment Service), Healthy Start Vitamins, Schools Service, prescriber Support Service and Phlebotomy Service.

Statement 6: How the assessment was carried out

An explanation of how the assessment has been carried out, and in particular:

- How the localities were determined;
- How it has taken into account (where applicable) the different needs of different localities in its area, the different needs of people in its area who share a protected characteristic, and a report on the consultation that it has undertaken.

The 2022 PNA has assessed pharmaceutical needs and service provision within Herefordshire at county and PCN level where possible. Needs of different PCNs have been considered where

possible, and information has been reported on protected characteristics. A consultation report summary will be included in the final version of this PNA.

Statement 7: Map of provision

A map that identifies the premises at which pharmaceutical services are provided in the area of the HWB.

Part B contains maps showing pharmaceutical services in relation to travel times and rurality.

PART A

Part A comprises the following elements:

1. Current Herefordshire pharmacy and dispensing practice coverage and travel times
2. NHS pharmaceutical services

Current Herefordshire pharmacy and dispensing practice coverage and travel times

This sub-section contains tables and maps to illustrate pharmacy and dispensing practice coverage and travel times for the Herefordshire population. Strategic Health Asset Planning and Evaluation (SHAPE) has been used to produce maps showing various travel times to pharmacies and dispensing practices in Herefordshire. SHAPE is a web-enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy. SHAPE is managed by the Office for Health Improvement and Disparities (OHID) within the Department of Health and Social Care. For each map provided, the areas shaded in green have access to a pharmacy or dispensing practice within each time period stated. Each number represents the total number of pharmacies/dispensing practices within that geographical area.

Table 2 shows population coverage for pharmaceutical services by Primary Care Network (PCN). Herefordshire has 27 pharmacies, providing an average of one pharmacy per 7,171 people per pharmacy, compared to 5056 in England. When GP dispensing practices are included the gap with England is reduced, with an average of one contractor per 5,233 people compared to 4605 in England. North and West PCN has the lowest population per contractor (facilitated by the presence of dispensing practices), and South and West PCN has the highest population per contractor. Complete lists of pharmacies and dispensing practices in Herefordshire are provided in appendix 3 and 4. It should be noted that 3 of the 10 dispensing practices have more than one branch:

- Mortimer Medical Practice has two branches; Leintwardine & Orleton

- Weobley Surgery has one branch: Staunton-On-Wye

- Golden Valley Practice has one branch: Peterchurch

Table 2: Pharmaceutical service population coverage by Primary Care Network

				2020 Mid-Year Estimates	
Primary Care Network	Pharmacies	Dispensing Practices	Total Contractors	Population per pharmacy (England=5056)	Population per contractor (England=4605)
East	4	2	6	7,461	4,974
Hereford City	15		15	5,438	5,438
North and West	5	4	9	8,391	4,662
South and West	3	4	7	13,413	5,748
Total	**27**	**10**	**37**	7,171	5,233

Travel time by car

Table 3: Population within 5/10/15/20 minutes travel time by car to pharmacies/dispensing practices within Herefordshire

Travel time by car	Estimated Herefordshire population with access to a community pharmacy	Estimated Herefordshire population with access to a community pharmacy or dispensing practice
5 minutes	111,617 (58%)	128,878 (67%)
10 minutes	156,439 (81%)	176,899 (91%)
15 minutes	180,199 (93%)	188,477 (97%)
20 minutes	186,860 (97%)	193,615 (100%)

(Based on ONS 2020 mid-year estimate, total population 193,615)

According to this analysis, the whole of the population of Herefordshire live within a 20 minute car journey to a pharmacy or GP dispensing practice. The following maps show the populations within a travel time or 5 or 10 minutes.

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

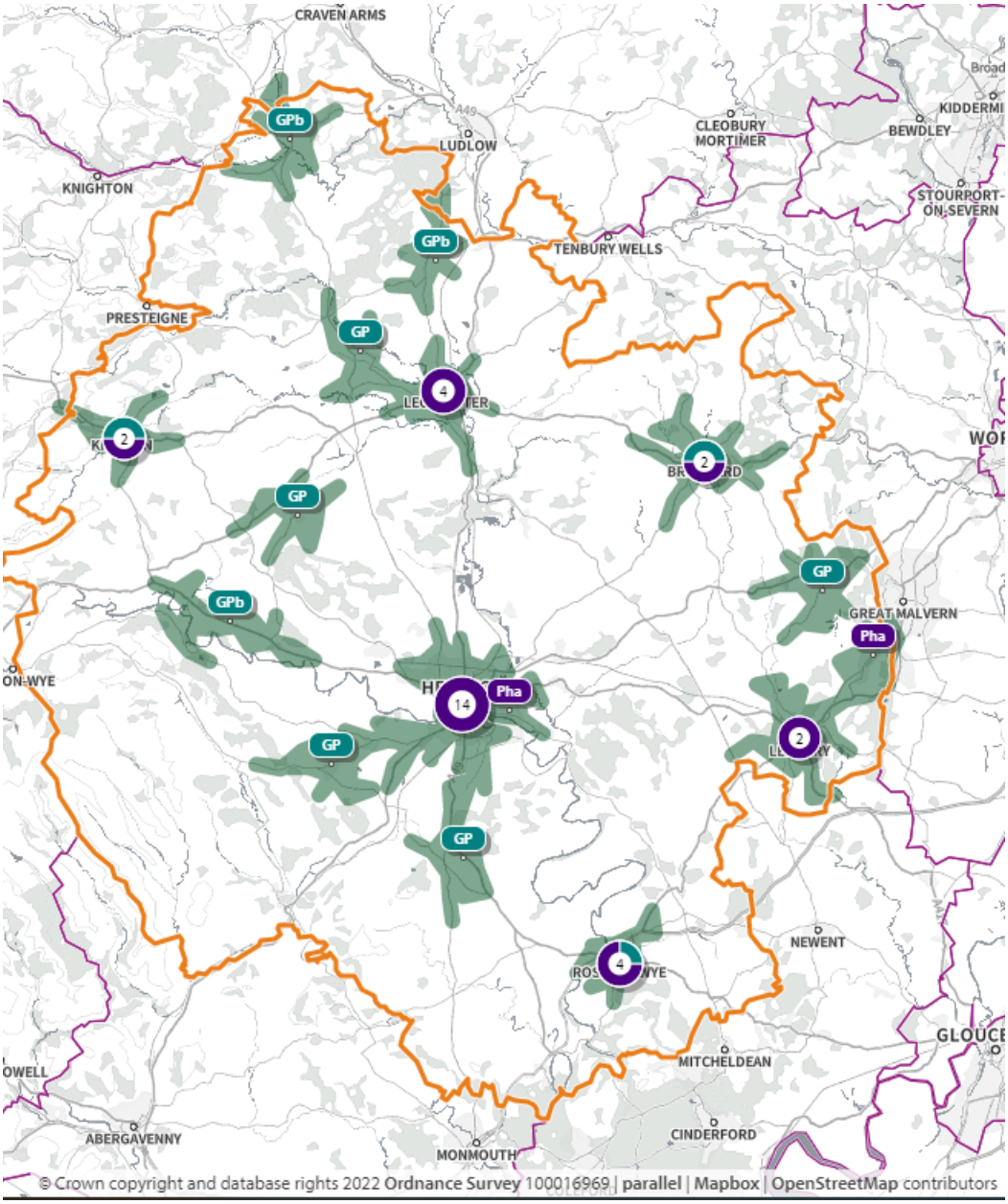


Figure 3: 10 minute travel time (car) to pharmacies/dispensing practices within Herefordshire

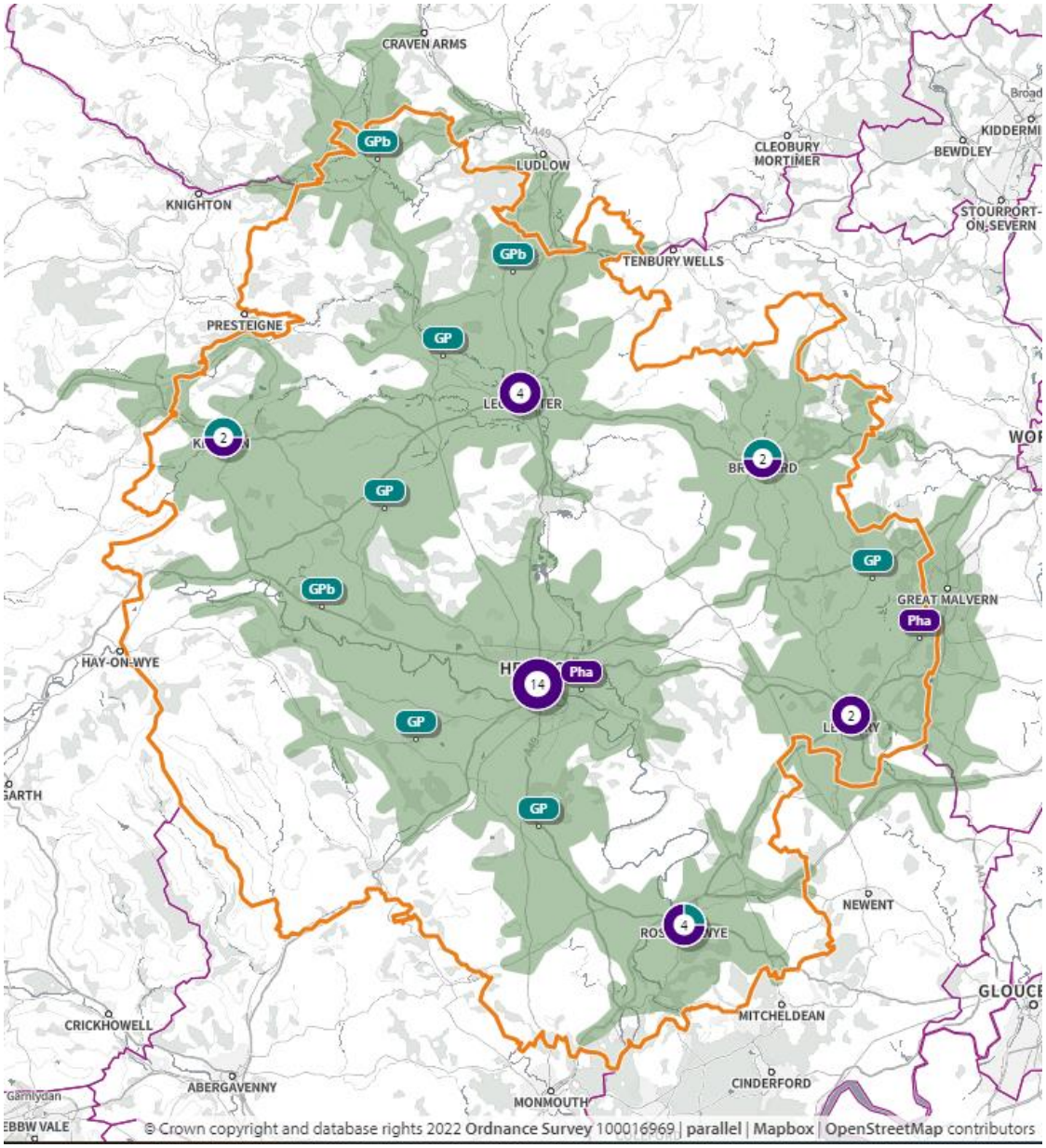


Figure 4: 5 minute travel time (car) to pharmacies within Herefordshire

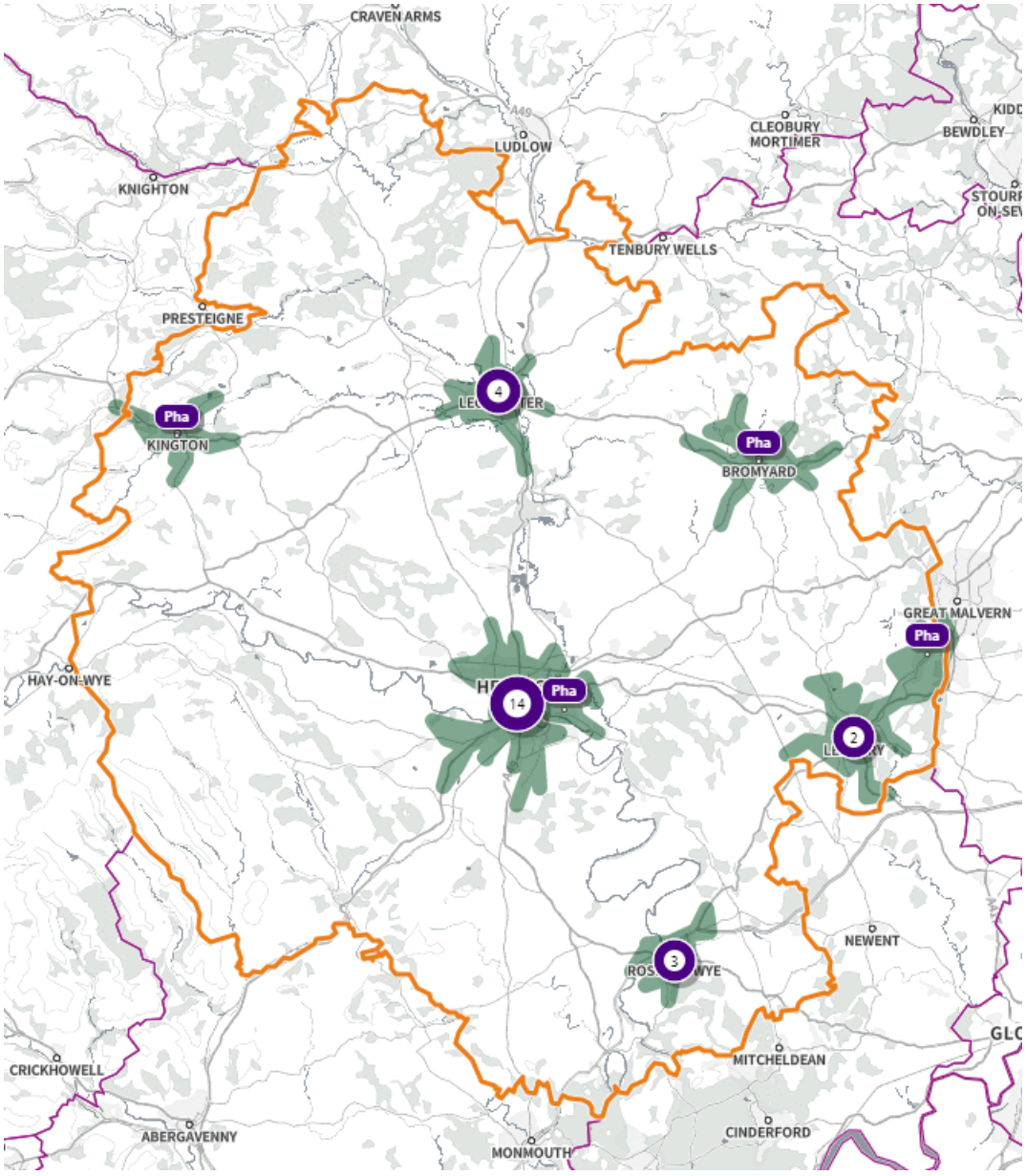
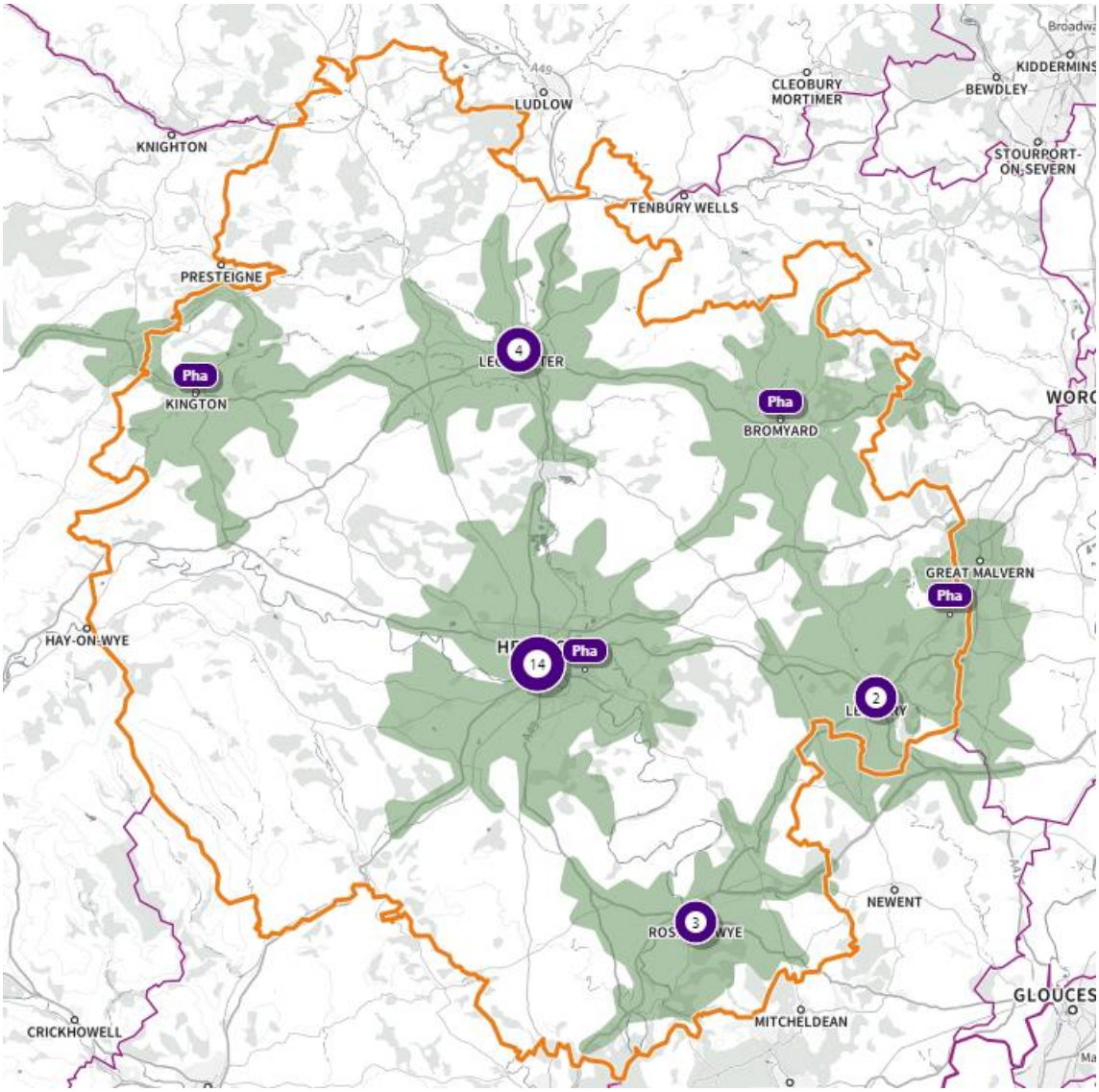

CRAVEN ARMS
LUDLOW
CLEOBURY MORTIMER
BEWDLEY
KNIGHTON
TENBURY WELLS
PRESTEIGNE
4
Pha
KINGTON
Pha
BROMYARD
GREAT MALVERN
Pha
HAY-ON-WYE
14
Pha
2
NEWENT
3
MITCHELDEAN
CRICKHOWELL
ABERGAVENNY
MONMOUTH
CINDERFORD

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



Weekend travel time by car

A total of 150,731 (78%) people live within 10 minutes travelling time by car of pharmacies/dispensing practices that open on Saturdays, and 92,914 (48%) on Sundays, compared with 176,899 (91%) during the week.

Figure 6: Pharmacies open on Saturdays within 10 minutes travelling time by car

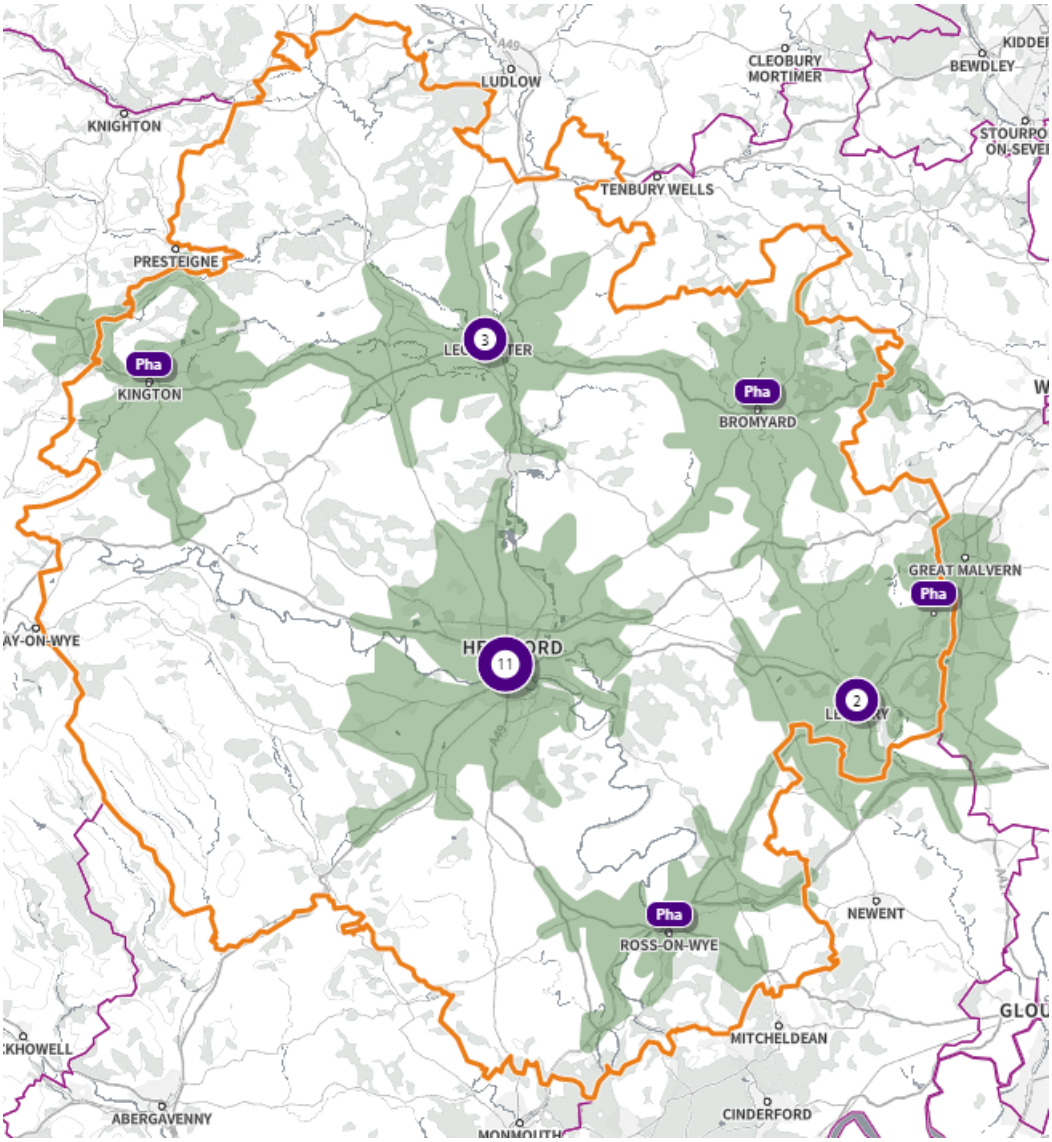
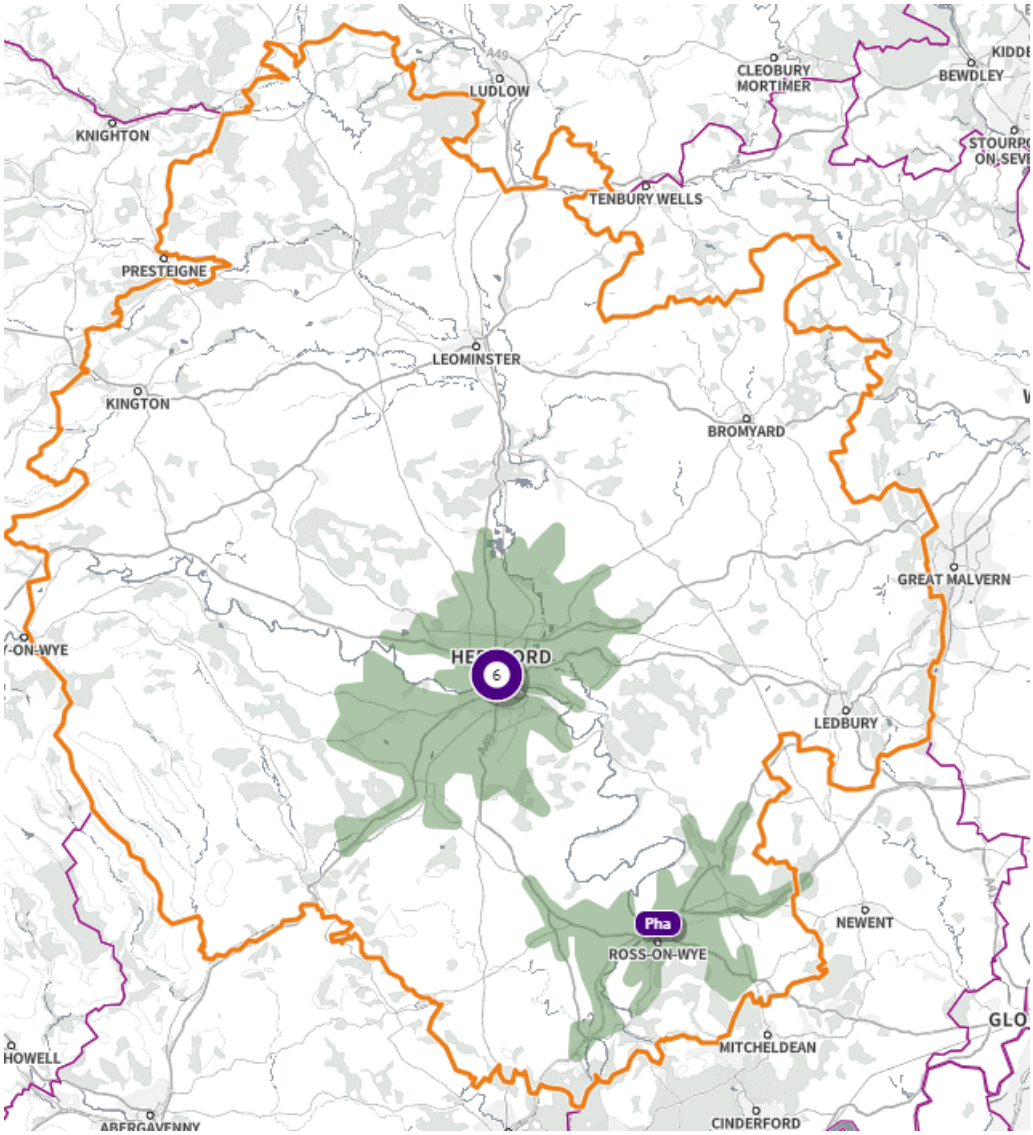


Figure 7: Pharmacies open on Sundays within 10 minutes travelling time by car



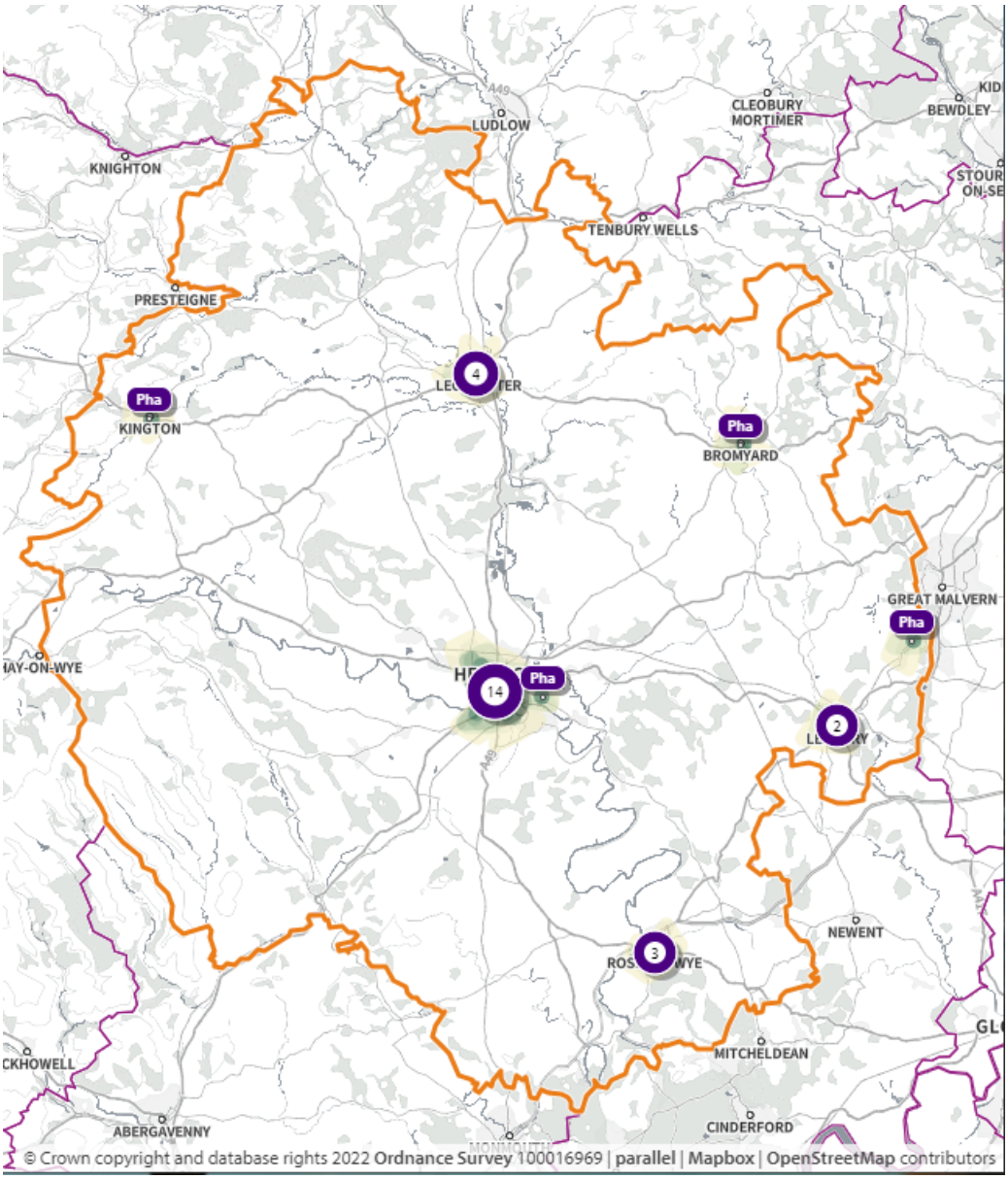
Travel time on foot

As one would expect, people living in or around urbanised or town areas generally have the best access to community pharmacy/dispensing practices on foot. Table 4 illustrates the population with access to a community pharmacy within each walk time period. It shows that around 64% of the total population of Herefordshire live within a 30 minute walking distance of a pharmacy of GP dispensing practice.

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

Walk time	Estimated Herefordshire population with access to a community pharmacy	Estimated Herefordshire population with access to a community pharmacy or dispensing practice
5 minutes	42,463 (22%)	53,661 (28%)
10 minutes	69,984 (36%)	81,182 (42%)
15 minutes	101,357 (52%)	113,939 (59%)
20 minutes	106,094 (55%)	118,676 (61%)
30 minutes	108,814 (56%)	123,523 (64%)

Figure 8: 5-30 minute travel time (on foot) to pharmacies and dispensing practices within Herefordshire



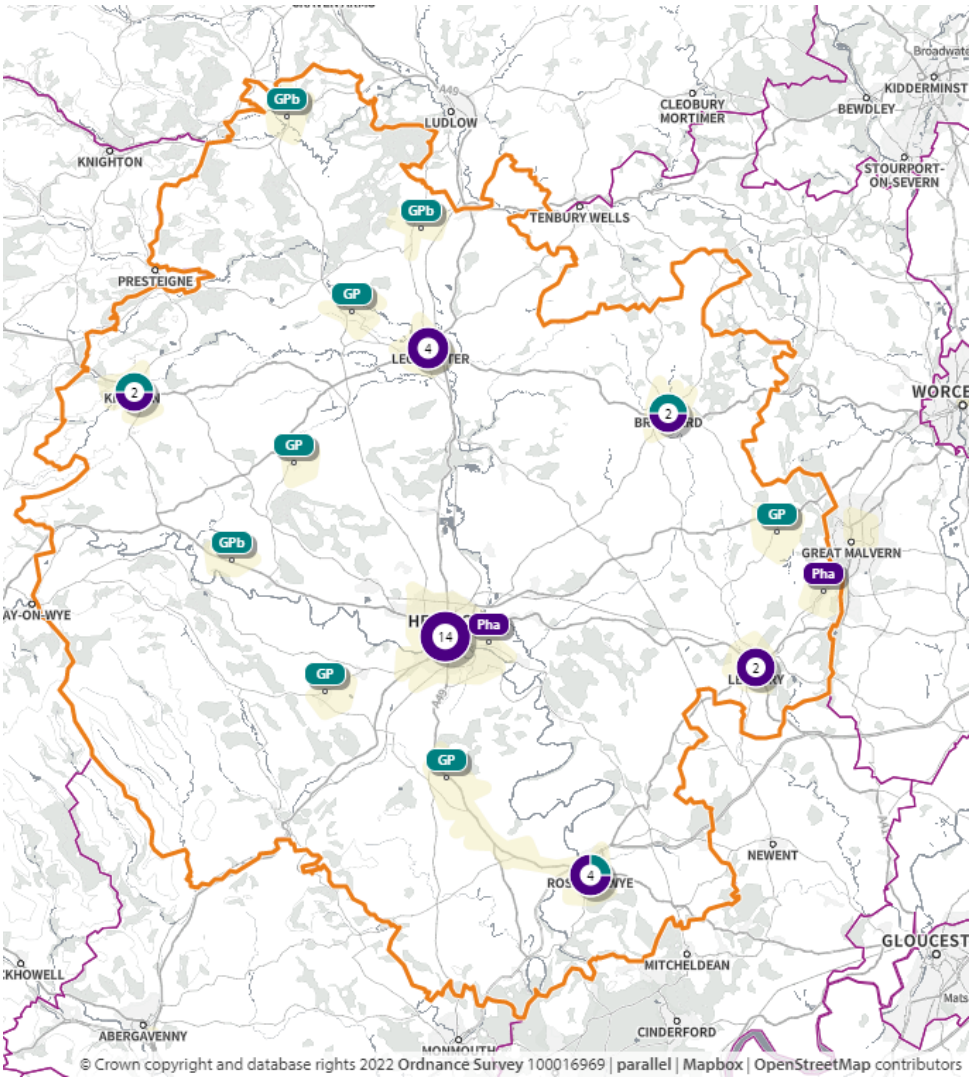
Travel time by public transport

Table 5 shows the population that can travel by public transport within 20-45 minutes on a weekday morning. 66% of the population can access a community pharmacy or dispensing practice within 45 minutes.

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

Travel Time	Estimated Herefordshire population with access to a community pharmacy	Estimated Herefordshire population with access to a community pharmacy or dispensing practice
20 minutes	106,094 (55%)	118,676 (61%)
30 minutes	108,814 (56%)	123,075 (64%)
45 minutes	110,493 (57%)	128,619 (66%)

Figure 9: Up to 30 minute travel time by public transport (weekday morning) to pharmacies and dispensing practices within Herefordshire



Weekend travel time by public transport

A total of 107,342 people live within 30 minutes travelling time by public transport of pharmacies that open on Saturday mornings, and 73,982 on Sunday mornings, compared with 123,075 during the week.

Figure 10: Pharmacies open on Saturday mornings within 30 minutes travelling time by public transport

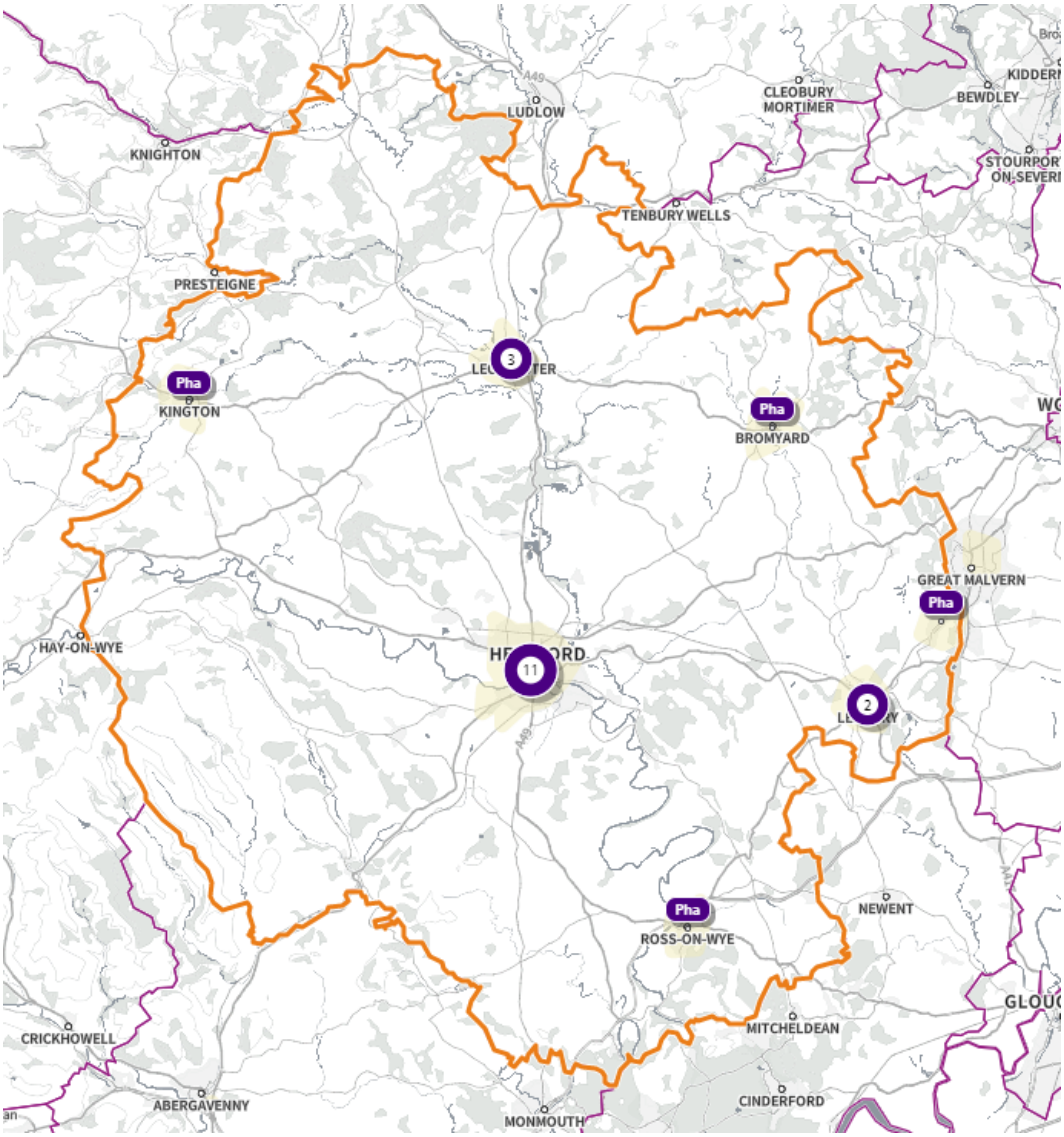
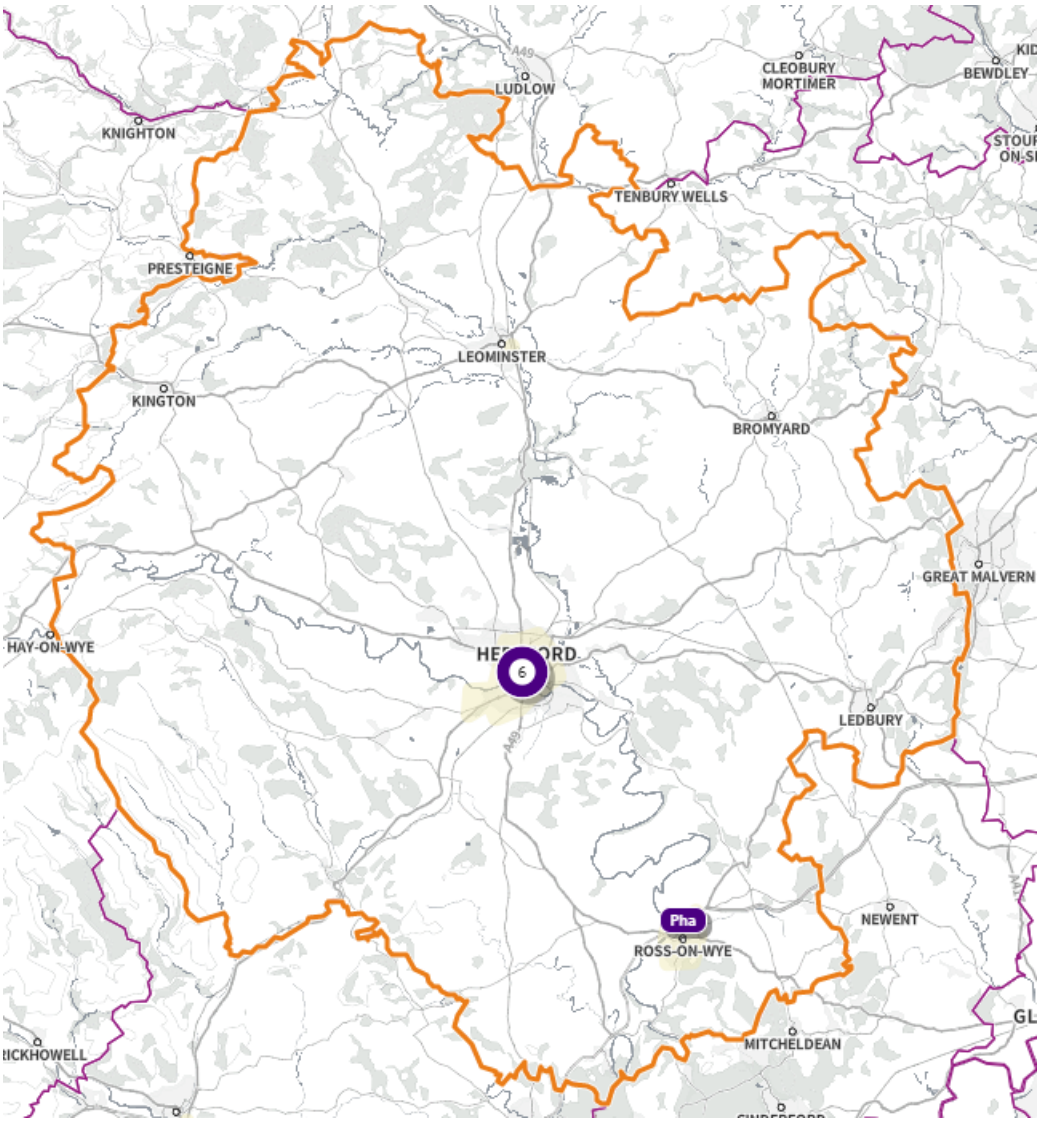


Figure 11: Pharmacies open on Sunday mornings within 30 minutes travelling time by public transport

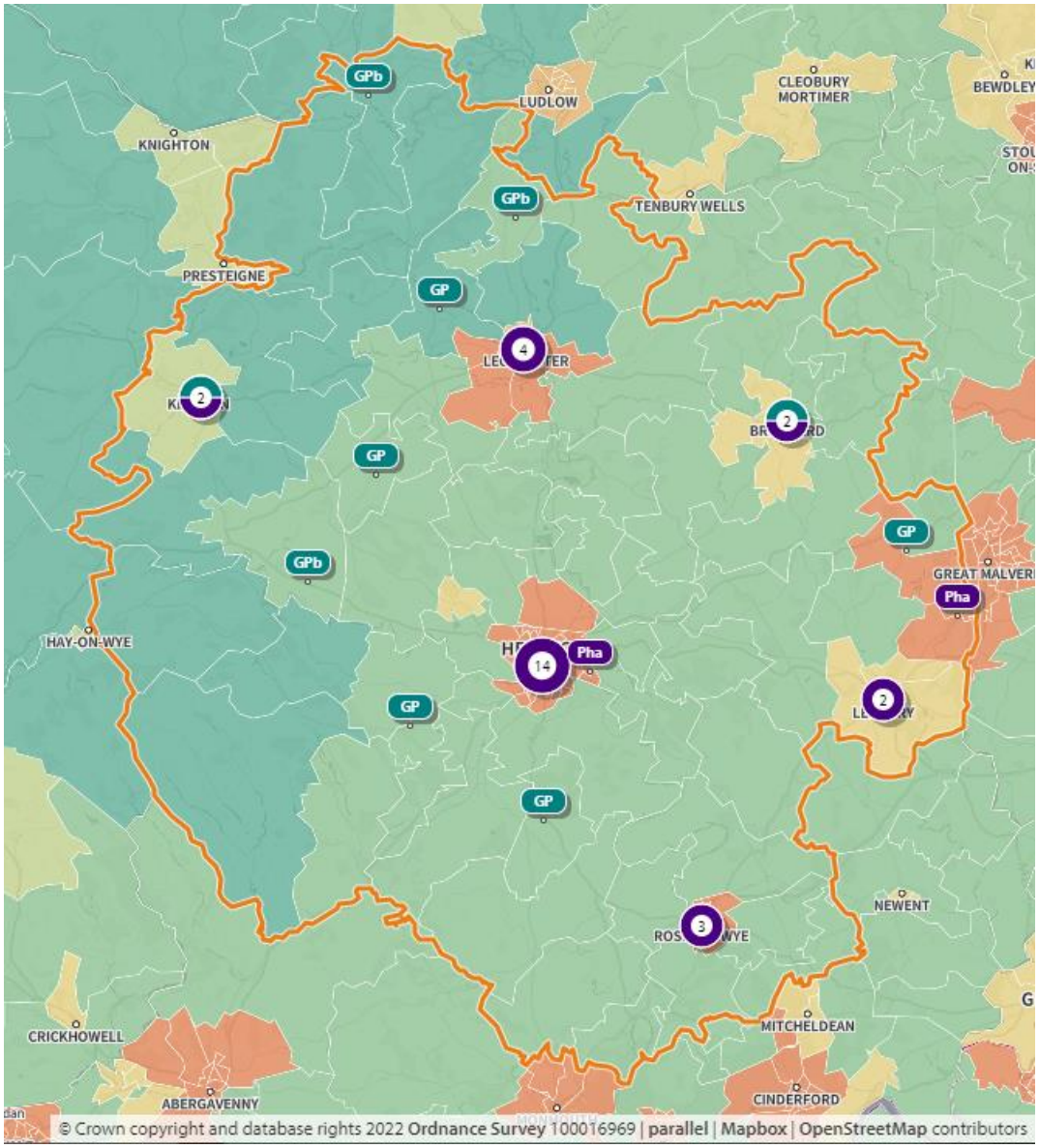


Rurality

Figure 12 illustrates how dispensing practices help to cover the more rural areas of Herefordshire, as community pharmacies tend to be located in more urban areas for dispensing services. For figure 12, rurality has been determined according to the ONS 2011 Rural Urban Classification. The NHS England Determination of Rurality delineate the areas in Herefordshire that are rural in character (also known as 'controlled localities'). The Rurality Review Regulations

prevent the awarding of community pharmacy contracts unless in exceptional circumstances and enable the provision of dispensing doctors.

Figure 12: Pharmacy or dispensing practice by urban rural classification



NHS Pharmaceutical Services

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

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

Pharmaceutical lists

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

Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations, a person who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis.

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

- Pharmacy contractors (individuals or companies)
- Dispensing appliance contractors (DACs); appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc. They cannot supply medicines.
- Dispensing doctors - medical practitioners authorised to provide drugs and appliances in designated rural areas only known as "controlled localities".

Dispensing Doctors

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

Dispensing doctors provide primary healthcare to people in rural areas. Only certain people are eligible to receive dispensing services from a dispensing doctor. Many live remotely from a community pharmacy and so dispensing doctors are allowed to dispense prescribed medicines.

Distance selling (internet) pharmacies

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

A distance selling pharmacy must not provide Essential Services to a person who is present at the pharmacy. However, the pharmacy must be able to provide Essential Services safely and effectively without face-to-face contact with staff on the premises. The pharmacy will receive prescriptions via the post or by electronic means (EPS) and then, after dispensing, will send items via courier or a delivery driver to the patient. The pharmacist can talk to the patient via the telephone. A distance selling pharmacy may provide Advanced and Enhanced Services on the premises, as long as any Essential Service is not provided to persons present at the premises.

Dispensing Appliance Contractors

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

The Community Pharmacy Contract

Community pharmacies, still often referred to colloquially as “chemists”, provide pharmaceutical services under the NHS Community Pharmacy Contractual Framework (contract). This consists of three sets of services:

1. **Essential Services**
2. **Advanced Services**
3. **Locally Commissioned and Enhanced Services**

Pharmacies must provide all Essential Services, but they can choose whether or not they wish to provide Advanced and Enhanced services.

Pharmacies nationally are a well-used part of the NHS system at community level. A recent audit by the Pharmaceutical Services Negotiating Committee showed that pharmacies in England provide 65 million consultations a year (PSNC, 2022). More than 1.2 million consultations a week take place in community pharmacies, for advice about symptoms or pre-existing medical conditions.

Essential services

Healthy Living Pharmacy

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

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

1. Workforce Development – A skilled team to pro-actively support and promote behaviour change and improve health and wellbeing, including a qualified Health Champion who has undertaken the Royal Society for Public Health (RSPH) Level 2 Award 'Understanding Health Improvement', and a team member who has undertaken leadership training.

2. Engagement – Local stakeholder engagement with other health and care professionals (especially general practice), community services, local authorities and members of the public; and

3. Environment (Premises Requirements) – Premises that facilitate health promoting interventions with a dedicated health promotion zone.

The adoption of HLPs marked a significant development for community pharmacy and its contribution to health promoting interventions. The HLP framework aims to improve people's health, help reduce health inequalities and ensures community pharmacy can continue to contribute to the Government's ambition of putting prevention at the heart of the NHS, as set out in the NHS Long Term Plan. It provides a mechanism for community pharmacy teams to utilise their local insight and experience in the delivery of high-quality health promoting initiatives. By requiring contractors to have trained Health Champions on site who pro-actively engage in local community outreach within and outside the pharmacy, HLPs have cemented the idea that every interaction in the pharmacy and the community is an opportunity for a health promoting intervention.

The HLP framework is primarily about adopting a change in culture and ethos within the whole pharmacy team. The HLP framework means community pharmacies can supplement their medicines optimisation role with an enhanced commitment to health promoting interventions in the pharmacy setting and engagement in community outreach activities.

Dispensing Medicines

Pharmacies are required to maintain a record of all medicines dispensed and any interventions made which they judge to be significant. The Electronic Prescription Service (EPS) is being

implemented as part of the dispensing service. Patients across England can also now choose to download the NHS App which will allow them to order repeat prescriptions, check their patient record or book and manage GP appointments.

Discharge Medicines Service

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

The DMS is a priority for implementation for the Herefordshire Worcestershire ICS with the potential to achieve significant system savings for those patients who can be followed up by the community pharmacist with their new prescription details and medicines management, following discharge. Patients who receive this service are less likely to be readmitted (5.8% vs 16% at 30 days) and spend fewer days in hospital when they are readmitted (7.2 days on average compared to 13.1 for patients who did not receive the service) (NHS England, 2022).

National Digital Integrated Care System (ICS) monies have funded Hospital NHS Trust Pinnacle Licenses enabling patient referrals for the DMS service. This step is not yet integrated into the hospital discharge systems, and patient information requires manipulation before sending the copy Electronic Discharge Summary (EDS) to the community pharmacy. Therefore, since the benefits of the DMS to the Herefordshire and Worcestershire system are incremental, it is important that secondary care based pharmacy colleagues begin to incorporate this into their discharge processes. The focus should be on discharges for frail patients, those on high risk medicines and those whose primary diagnosis is shown to be a frequent cause of readmission before 30 days.

Dispensing Appliances

Pharmacists may dispense appliances regularly, infrequently, or they may have taken a decision not to dispense them at all. Whilst the Terms of Service requires a pharmacist to dispense any (non-Part XVIIIA listed) medicine “with reasonable promptness”, for appliances, the obligation to dispense arises only if the pharmacist supplies such products “in the normal course of business”.

Disposal of unwanted medicines

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

The pharmacy must, if required by NHS England and NHS Improvement (NHSE&I) or the waste contractor, sort them into solids (including ampoules and vials), liquids and aerosols. Additional segregation is also required under the Hazardous Waste Regulations.

Public Health (Promotion of Healthy Lifestyles)

Each financial year (1st April to 31st March), pharmacies are required to participate in up to a maximum of six national health campaigns at the request of NHSE&I. This generally involves the display and distribution of leaflets provided by NHSE&I. Needs to be clear that this is a total of 6 max as determined by NHSEi nationally. Additional local campaigns may be agreed by the Local Pharmaceutical Council and contractors can participate voluntarily.

In addition, pharmacies are required to undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation. Opportunistic one-to-one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing.

Pharmacies will also get involved in six local campaigns a year, organised by NHS England. Campaign examples may include promotion of flu vaccination uptake or advice on increasing physical activity. In 2021/22, all pharmacies nationally participated in the following campaigns: Covid-19 vaccination campaign, winter vaccines, smoking cessation and weight management.

Repeat Dispensing/electronic Repeat Dispensing (eRD)

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

Under the repeat dispensing service pharmacy teams will:

- Dispense repeat prescriptions issued by a GP;
- Ensure that each repeat supply is required; and
- Seek to ascertain that there is no reason why the patient should be referred back to their GP

Originally this service was mainly carried out using paper prescriptions, but as the Electronic Prescription Service (EPS) has developed, the majority of repeat dispensing is now carried out via EPS release 2 and is termed electronic Repeat Dispensing (eRD). eRD is much more efficient and convenient but is only suitable for those patients who are on regular repeat medicines which are not subject to frequent changes for whatever reason.

Managed repeats

The provision of regular medicines to patients is facilitated by a variety of different mechanisms and these repeat medication services offer choice and flexibility to patients. In recent years, there has been much discussion by Clinical Commissioning Groups (CCGs) and general practices around medicines waste and the mismanagement of non-NHS repeat medication services such as “managed repeats”. Whilst a “managed repeats” service is not part of the Essential Services set out in the Community Pharmacy Contractual Framework nor is it in the terms of service, community pharmacy contractors regularly offer this type of service as a matter of goodwill and without charge to their patients, particularly those who are vulnerable, time poor and/or require assistance.

Signposting

NHS England provide pharmacies with lists of sources of care and support in the area. Pharmacies will be expected to help people who ask for assistance by directing them to the most appropriate source of help, for example, other healthcare professionals or care providers when appropriate. The service also includes referral on to other sources of help such as local or national support groups.

Support for Self-Care

Pharmacy staff provide advice to enable people to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service. Pharmacies help manage minor ailments and common conditions, by the provision of advice and the sale of medicines. This includes assisting referrals from NHS 111. Records will be kept where the pharmacist considers it relevant to the care of the patient.

Advanced Services

Data for the provision of Advanced Services is currently only available on a Sustainability and Transformation Plan (STP) footprint. It should be noted that the data presented below includes both Herefordshire and Worcestershire pharmacies, with 80% of the pharmacies located in Worcestershire.

During 2022/23, NHSE is requiring a new Smoking Cessation Discharge Service for patients, and this will be a new area for Advanced Services. The NHS Smoking Cessation Service in community pharmacy will allow NHS trusts to refer patients to a pharmacy of their choice so they can receive continuing treatment, advice and support with their attempt to quit smoking when they are discharged. The Smoking Cessation Service connects acute NHS trusts with primary care by using the accessible network and skills available within community pharmacies that have registered to deliver the service.

Table 6: Activity data for Pharmacy and Appliance Contractors by STP for Advanced Services for April - December 2021, Herefordshire and Worcestershire STP

Advanced Service	Number of activities - Pharmacy contractors	Number of activities - Appliance contractors
New Medicine Service (NMS) interventions declared	14332	0
Appliance Use Reviews (AURs) conducted in user's home	0	84
Appliance Use Reviews (AURs) conducted at premises	0	57
Stoma Customisation Fees (this service is largely linked to the supplier of choice of these products i.e. through a dispensing appliance contractor but can be provided by a pharmacy)	88	10279
Community Pharmacist Consultation Service (CPCS) Fees	5364	0
Community Pharmacy Hepatitis C Antibody Testing Service Fees	0	0
Community Pharmacy Completed Transactions for Covid-19 Lateral Flow Device Distribution Service	221366	0
Community Pharmacy Clinic Blood Pressure checks	11271 (started Oct 2021)	0
Community Pharmacy Ambulatory Blood Pressure Monitoring (ABPM)	59 (started Oct 2021)	0
Community Pharmacy Seasonal Influenza Vaccination Advanced Service Fees	40203	0
Community Pharmacy Claims associated with initial local engagement in preparation for delivering GP referral pathway of the CPCS	0 (started late 2021, data to follow)	0

NB: 80% of pharmacies are in Worcestershire

New Medicine Service

This service provides support for people with long-term conditions (LTCs), who are newly prescribed a medicine, to help improve adherence. It is focused on specific patient groups and conditions and is designed to improve patients' understanding of a newly prescribed medicine. Research has shown that after 10 days, two thirds of patients prescribed a new medicine report problems, including side effects, difficulties taking the medicine and a need for further

information. The New Medicine Service (NMS) has been designed to fill this identified gap in patient need.

The conditions eligible for the service are:

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

The service is split into three stages, which are:

1. Patient engagement – Following the prescribing of a new medicine for the management of a LTC, patients will be recruited to the service by prescriber referral or opportunistically by the community pharmacy staff.

2. Intervention – The pharmacist and patient will have a discussion either face-to-face in the pharmacy's consultation room or via telephone or video consultation. The pharmacist will assess the patient's adherence to the medicine(s), identify problems and determine the patient's need

for further information and support. The NMS intervention interview schedule will normally be used to guide this conversation. The pharmacist will provide advice and further support and where no problems have been identified, will agree a time for the follow up stage, typically between 14 and 21 days after the intervention stage. If problems are identified and it is the clinical judgement of the pharmacist that intervention by the patient's prescriber is required, the issue will be referred to them.

3. Follow up – The pharmacist and patient will again have a discussion either face-to-face in the pharmacy's consultation room, or via telephone or video consultation, covering similar areas as in stage 2. The NMS follow-up interview schedule will normally be used to guide this conversation. The pharmacist will provide advice, further support or referral where necessary.

Appliance Use Review (AUR)

Appliance Use Reviews (AURs) can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. Alternatively, where clinically appropriate and with the agreement of the patient, AURs can be provided by telephone or video consultation.

AURs should help patients better understand and use any specified appliance by:

1. Establishing the way the patient uses the appliance and the patient's experience of use
2. Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance
3. Advising the patient on the safe and appropriate storage of the appliance; and
4. Advising the patient on the safe and proper disposal of appliances that are used or unwanted

Stoma Appliance Customisation Service (SAC)

This service involves the customisation of stoma appliances, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff.

If on the presentation of a prescription for such an appliance, a community pharmacy contractor is not able to provide the service, the prescription must be referred to another pharmacy contractor or provider of appliances. If the patient does not consent to the referral, the patient must be given the contact details of at least two pharmacies or suppliers of appliances who are able to provide the appliance or the stoma appliance customisation service. The local NHS England team may provide this information, or it may be established by the pharmacist.

NHS Community Pharmacist Consultation Service (Minor Illness and Urgent Repeat Medicines Supply Pathways)

Since 2016, the Pharmacy Integration Fund has funded and tested several operational service models throughout England that can be used to enhance a community pharmacy's role in urgent care provision. Using the evidence from these pilots, the Community Pharmacist Consultation Service (CPCS) was commissioned as an Advanced Service from 29 October 2019, with the expectation that additional strands to the service would continue to be tested and developed in the future.

When the service commenced, referrals to community pharmacies were made by NHS 111 or Integrated Urgent Care Clinical Assessment Services (IUC CAS). Further referral routes have been piloted for inclusion in the service and will continue to be developed. In line with the ambitions set out in the NHS Long Term Plan, this service is expected to relieve pressure on urgent and emergency care (UEC), by referring patients to a consultation with a community pharmacist where otherwise they would have attended a GP appointment, GP out of hours appointment or A&E, having run out of regular medicines or requiring support with minor illness. The service will also help to tackle elements of existing health inequalities by providing urgent access to patients who are not registered with a GP.

Hepatitis C Testing Service

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

The service is focused on provision of point of care testing for Hepatitis C (Hep C) antibodies to people who inject drugs (i.e. individuals who inject illicit drugs, e.g. steroids or heroin), but who have not yet accepted treatment for their substance use. Where people test positive for Hep C antibodies, they will be referred for a confirmatory test and treatment.

Hypertension Case-Finding Service

The Hypertension case-finding service was commissioned as an Advanced Service from 1st October 2021. The 5-year CPCF agreement included a plan to pilot case finding for undiagnosed cardiovascular disease. In 2020, NHSE&I commenced a pilot whereby pharmacies offered blood pressure checks to people 40 years and over. In some pharmacies within the pilot, where the patient's initial blood pressure reading was elevated, they would be offered 24 hour ambulatory blood pressure monitoring (ABPM), which is the gold-standard for diagnosis of hypertension.

Following the initial findings of the pilot, the Department of Health and Social Care (DHSC) and NHSE&I proposed the commissioning of a new Hypertension case-finding service, as an Advanced Service, in the Year 3 negotiations.

Participating Community Pharmacies provide 2 levels of service:

Stage 1: Pharmacy "clinic check" – checks those who self-present or are referred to identify people at risk of hypertension

Stage 2: Pharmacy 24hour ambulatory blood pressure monitoring (ABPM) for those who require this second stage

Eligibility criteria:

- Adults ≥ 40 years with no diagnosis of hypertension
- By exception, < 40 years with family history of hypertension (pharmacist's discretion)
- Approached or self-requested 35-39 years old (pharmacist's discretion)
- Adults specified by a general practice (clinic and ambulatory blood pressure checks)

Exclusion criteria:

- Those unable to give consent, under 40 years old, or people who have their blood pressure regularly monitored by a healthcare professional

10 Pharmacies in Herefordshire provide this service (1 East Herefordshire, 7 Hereford City, 0 North and West, 2 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 5.

Flu Vaccination Service

Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015. Each year (September through to March), the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus.

During 2020 to 2021, in response to the COVID-19 pandemic, an expanded offer was made which enabled those aged 50 to 64 years to receive the flu vaccine as part of an NHS funded programme. This offer continued for this age group, as a temporary measure, for the 2021 to 2022 programme.

In 2021/22 the following groups were eligible for flu vaccination:

• All children aged 2 to 15 (but not 16 years or older) on 31 August 2021

• Those aged 6 months to under 50 years in clinical risk groups
• Pregnant women
• Those aged 50 years and over
• Those in long-stay residential care homes
• Carers
• Close contacts of immunocompromised individuals

• Frontline health and social care workers (HSCWs) should receive a vaccination provided by their employer

For 2022/23, the NHS flu vaccination programme will only be offered to patient groups eligible in line with pre-pandemic recommendations specifically:

- all children aged 2 or 3 years on 31 August 2022
- all primary school aged children (from reception to Year 6)
- those aged 6 months to under 65 years in clinical risk groups
- pregnant women
- those aged 65 years and over
- those in long-stay residential care homes
- carers
- close contacts of immunocompromised individuals
- frontline staff employed by the following types of social care providers without employer led occupational health schemes:
    - a registered residential care or nursing home
    - registered domiciliary care provider
    - a voluntary managed hospice provider
    - Direct Payment (personal budgets) or Personal Health Budgets, such as Personal Assistants

.

Locally commissioned services

Pharmaceutical services for the purpose of a PNA do not include any services commissioned directly from pharmaceutical contractors by LAs or CCGs. However, a decision was made by the PNA Working Group to include in the PNA all additional services that were provided by local pharmacies to provide a complete picture of commissioning and to help guide future local commissioning decisions.

It must be stressed that these services cannot be taken into account when considering applications for entry onto the pharmaceutical list. Such services may have been commissioned locally by CCGs and LAs in order to meet the needs of their population.

Smoking Cessation Pharmacotherapy Service

This service has been designed to enable NHS trusts to refer consenting patients to a community pharmacy, to continue their smoking cessation treatment. Medication is provided by the pharmacy and behavioural support and support is provided by the Healthy Living Service. The ambition is for referral from NHS trusts to community pharmacy to create additional capacity in the smoking cessation pathway.

The aim of the service is to reduce morbidity and mortality from smoking, and to reduce health inequalities associated with higher rates of smoking. The objective is to ensure that any patients referred by NHS trusts to community pharmacy for the Smoking Cessation Service receive a consistent and effective offer, in line with NICE guidelines.

In Herefordshire, 13 pharmacies currently provide pharmacotherapy via an e-NRT voucher service (2 East Herefordshire, 7 Hereford City, 3 North and West, 1 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 6.

Sexual Health - Emergency Hormonal Contraception (under Patient Group Directive)

Accredited community pharmacies currently offer emergency hormonal contraception (EHC). This service provides consultation and a free supply of Levonorgestrel under a Patient Group Directive (PGD). The service aims to reduce the number of unwanted pregnancies and terminations for eligible women aged 13 years and over and also provide advice on STIs and contraception and signposting to other sexual health services. When dispensing EHC, a practitioner is required to discuss long-acting reversible contraception (LARC), ongoing contraception and chlamydia testing at two weeks post unprotected sex.

14 pharmacies in Herefordshire currently provide this service (3 East Herefordshire, 7 Hereford City, 3 North and West, 1 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 6.

Needle and Syringe Exchange Service

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

The service will help reduce the transmission of blood borne viruses (BBVs) such as HIV and Hepatitis C amongst injecting drug users by providing service-users with convenient access to sterile injecting equipment and a facility for the safe disposal of used equipment. There is also an opportunity for the pharmacy staff to provide advice on harm reduction. The service aims to reduce the rate of needle sharing, promote safe injecting practices, ensure safe disposal of used injecting equipment, and provide a point of referral into the specialist drug and alcohol service.

6 pharmacies in Herefordshire currently provide this service (2 East Herefordshire, 1 Hereford City, 2 North and West, 1 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 6.

Supervised Consumption Service

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

The aims of the service are to:

1. Increase service-user compliance with the prescribing regime they are on as part of the agreed treatment plan
2. Increase retention in structured drug treatment
3. Reduce the overuse or underuse of prescribed opiates substitutes
4. Reduce the diversion of prescribed medications onto the illicit drug market
5. Advise the service user and liaise with the Drugs and Alcohol teams

22 pharmacies in Herefordshire currently provide this service (3 East Herefordshire, 13 Hereford City, 4 North and West, 2 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 6.

Disposal of patient used sharps

The aims of the service are to: reduce the risk of needle stick injury in the community, reduce the inappropriate disposal of used sharps and to provide a safe, secure and convenient means of disposal. Participating Service Providers accept sharps containers from patients and store them safely until collected by the nominated disposal service in accordance with the Environment Agency Waste Regulations. **This service is not currently commissioned in Herefordshire through community pharmacies.**

There are several options available to Local Authorities who are responsible for the collection and safe disposal of used sharps but pharmacy can be a key element of the service since pharmacies are well accepted for this service in general. Regionally at the time of writing there is a review of waste medicines and including sharps into revised arrangements for waste medicines disposal and used sharps disposal which are subsequently collected from community pharmacies (as one option for the sharps element) . The follow up to this PNA must ensure a revised service meets the needs of local population and must take an improved quantitative approach in general to understanding and is commissioned appropriately.

Herefordshire and Worcestershire Formerly CCG commissioned services

Herefordshire and Worcestershire Community Pharmacy Palliative Care Medicines Hubs

All NHS community pharmacies stock medicines commonly used in palliative care. NHS Herefordshire Worcestershire CCG has commissioned 35 NHS community pharmacies to keep in stock an agreed list of medicines which may be accessed urgently if required. Having convenient access to these medicines may enable patients to remain at home if they choose.

The list of medicines which pharmacies are asked to keep in stock are agreed with the CCG and in line with the Herefordshire Worcestershire Drug Formulary and current Prescribing Guidance. Equitable access across both counties is a key factor in the number and location of the pharmacies that are commissioned to provide these services.

12 pharmacies in Herefordshire currently provide this service (2 East Herefordshire, 6 Hereford City, 2 North and West, 2 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 7.

Antiviral Medicines Access (Out-Of-Season Flu Outbreaks)

Early outbreaks of flu are frequent in care home settings. Before the national prescribing arrangements permit routine prescribing through GP practices, a specific clinical assessment of the patient is undertaken and arrangements made to access these medicines via pharmacies. Equitable access across both counties is a key factor in the number and location of the pharmacies which are commissioned to provide these services.

3 pharmacies in Herefordshire currently provide this service (0 East Herefordshire, 1 Hereford City, 1 North and West, 1 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 7.

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

NHS Herefordshire and Worcestershire CCG commissioned a service whereby patients in a self-contained setting could receive pharmaceutical advice and supplies of medicines for short term conditions.

This has included support in the following circumstances:

1. An outbreak of COVID-19 on an isolated agricultural farm with a number of agricultural workers affected

3. Persons residing under refugee status, seeking asylum or from specific countries in closed settings.

Working closely with other healthcare professionals, community pharmacy has provided pharmaceutical advice and supplied medicines over the counter, within a governance framework (including secure handover and advice on use in the quarantine setting). **One Herefordshire and one Worcestershire-based pharmacies were commissioned to provide this service for both counties.**

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

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

Nationally Commissioned Services

Community Pharmacy Extended Care Service

NHS England Midlands commission this Enhanced Service from pharmacies who have signed up to provide pharmaceutical advice and treatment through a PGD for specific conditions.

The Community Pharmacy Extended Care Service (Tier 1) aims to provide eligible patients who are registered with a GP contracted to NHSE&I Midlands Region with access to treatment for the following:

• Simple UTI in Females (for those aged 16-64 years)
• Treatment of Acute Bacterial Conjunctivitis (for children aged 3 months to 2 years)

12 Pharmacies in Herefordshire provide this service (2 East Herefordshire, 7 Hereford City, 2 North and West, 1 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 8.

The Community Pharmacy Extended Care Service (Tier 2) aims to provide eligible patients who are registered with a GP practice contracted to NHSE&I Midlands Region with access to treatment for the following:

• Treatment of Impetigo
• Treatment of Infected Insect Bites
• Treatment of Infected Eczema

12 Pharmacies in Herefordshire provide this service (2 East Herefordshire, 7 Hereford City, 2 North and West, 1 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 8.

The following features apply to these services:

- Consultation is free, patients may be asked to purchase OTC products as per NHS Guidelines.

- Pharmacists can supply prescription only medicines as part of the service where clinically indicated under the terms of a PGD. If patients receive medication, it will be free to those exempt from prescription charges (including those with a pre- payment certificate), whilst those who pay for prescription will need to pay an NHS Levy.
- The PGDs have strict inclusion and exclusion criteria. Pharmacist will refer onwards for treatment when necessary.

Community Pharmacy Clostridium Difficile Management Hubs

NHS Herefordshire and Worcestershire has commissioned 35 community pharmacies to keep in stock a particular antibiotic (vancomycin) required to treat infection with C. Difficile. This allows the patient to remain at home where appropriate, by prompt access to this specific antibiotic which is required to be started promptly in therapy.

12 Pharmacies in Herefordshire provide this service (2 East Herefordshire, 6 Hereford City, 2 North and West, 2 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 8.

COVID-19 Vaccination Service

This service has been provided by pharmacies across Herefordshire and Worcestershire, delivering in excess of 131,000 COVID-19 vaccinations this year (in addition to providing influenza vaccinations). Further pharmacy sites are being proposed to add capacity to the COVID-19 vaccination programme for autumn 2022.

3 Pharmacies in Herefordshire have provided this service (1 East Herefordshire, 2 Hereford City, 0 North and West, 0 South and West). A list of pharmacies signed up to provide this service is shown in Appendix 8.

PART B

Local Need

Part B of the PNA summarises the current and future health and well-being needs of the Herefordshire population, focussing on issues where there may be an opportunity for community pharmacies to meet needs.

Part B is comprised of the following sections:

1. Overview of Herefordshire population health needs
2. Public and service user views on current pharmaceutical service provision
3. Pharmacy contractor survey
4. Dispensing practice survey

Overview of Herefordshire population health needs

The following information was identified from within the 2021 Joint Strategic Needs Assessment (JSNA) and the regional health profile produced by the Office for Health Improvement and Disparities (OHID).

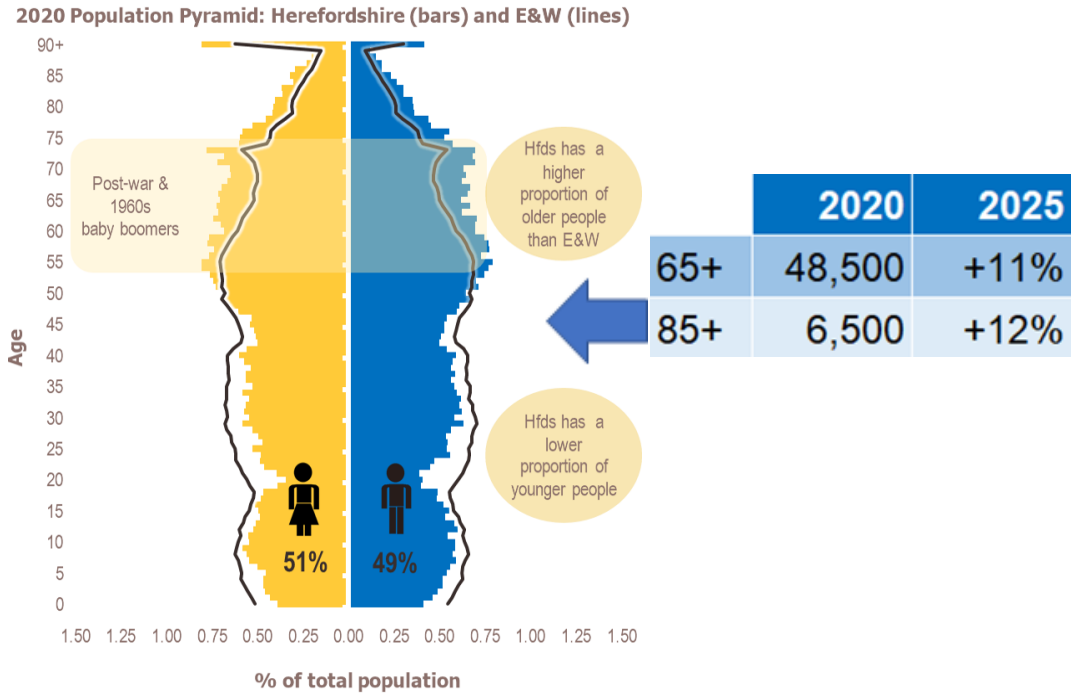
Characteristics of Herefordshire

The Office for National Statistics (ONS) released the first results from the Census 2021 on 28 June 2022. This reported that **Herefordshire's resident population was 187,100 in 2021** (ONS, 2022). This was 3,600 more people than in 2011 (up by 2.0%), which is a slower rate of growth than England & Wales (6.6%). With 86 people per square kilometre, Herefordshire had the fourth lowest population density out of all county level authorities in England.

Over half of the population live in areas defined as 'rural'. Just under a third of the population live in Hereford city (61,500 people), and just under a fifth in one of the three largest market towns of Leominster (12,400), Ross (11,200) and Ledbury (9,900).

The county has a relatively older age structure compared with nationally with a quarter of the population aged 65 or over. The county also has higher proportions of older working age adults (mid-forties to the age of 64), but lower proportions of younger working age adults (from the age of 16 to mid-forties). Hereford city has a much younger profile than the county as a whole, with relatively high proportions of young adults and young children. The most rural areas have relatively more people of older working and early retirement age (50-70 year olds). The market towns and other areas (including larger villages like Colwall and Credenhill) have a profile more similar to the county overall. Numbers of older people are set to continue growing at a higher rate than the younger age groups.

Figure 13: Herefordshire 2020 population pyramid (source: Herefordshire Council Intelligence Unit)



In 2019, Herefordshire council commissioned Edge Analytics to develop estimates of the future population of Herefordshire considering the impact of planned house-building. This presented the findings from two scenarios of how the future population of the county might develop - (i) a population projection which assumes that recent trends in births, deaths and migration will

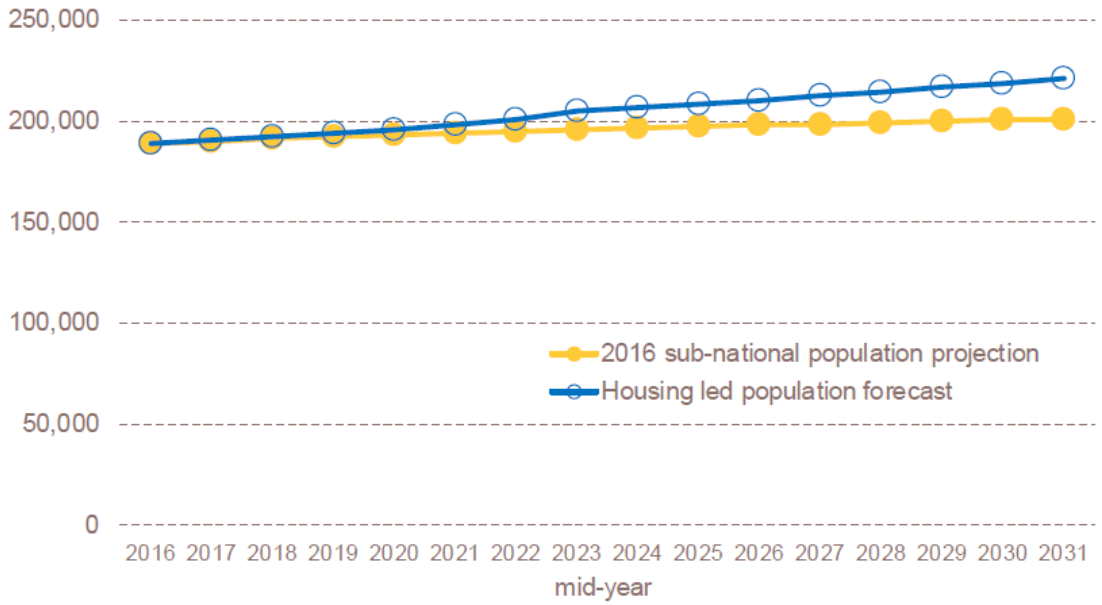
continue over the projection period and (ii) a housing development-led scenario that considers the impact of planned house-building on the population. (The former is referred to as a **projection** and the latter as a **forecast**).

According to this analysis, if recent trends in births, deaths and migration were to continue, the total population of Herefordshire was projected to increase from 189,500 people in 2016 to 201,200 by 2031 (an increase of six per cent) - this is equivalent to around 800 additional residents per year over 15 years (see figure 14).

However, there are more deaths than births in Herefordshire, and so migration is the sole driver of population growth. This is largely driven by housing and other national policies. Incorporating the impact of assumed housing development on population growth, the total population of the county is forecast to be 221,500 people by 2031 – an estimated 19,800 more people than in the absence of housing development. This is a forecast increase of 17% between 2019 and 2031, equivalent to around 2,100 additional residents per year.

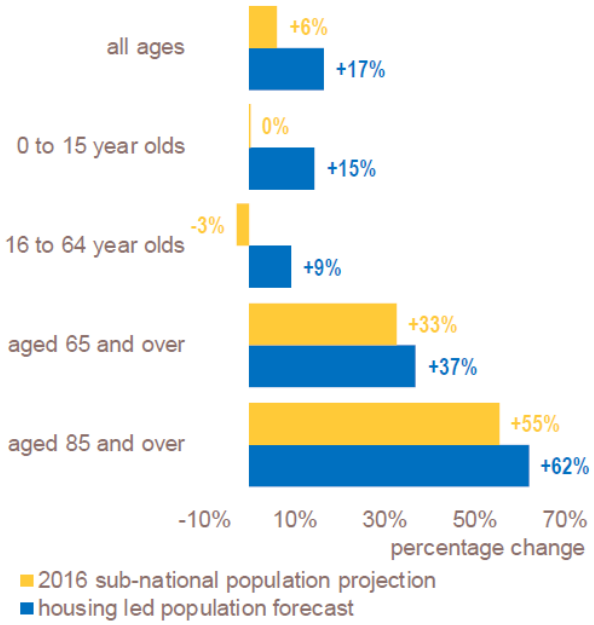
However, it should be noted that the recently released results from the 2021 Census suggest that current population numbers are lower than predicted and differ to the mid-year 2020 estimate (ONS, 2022). Further uncertainty is introduced by the inward migration of refugee and other migrant populations (e.g. Afghan, Syrian, and Ukrainian).

Figure 14: Herefordshire population growth (source: Herefordshire Council Intelligence Unit)



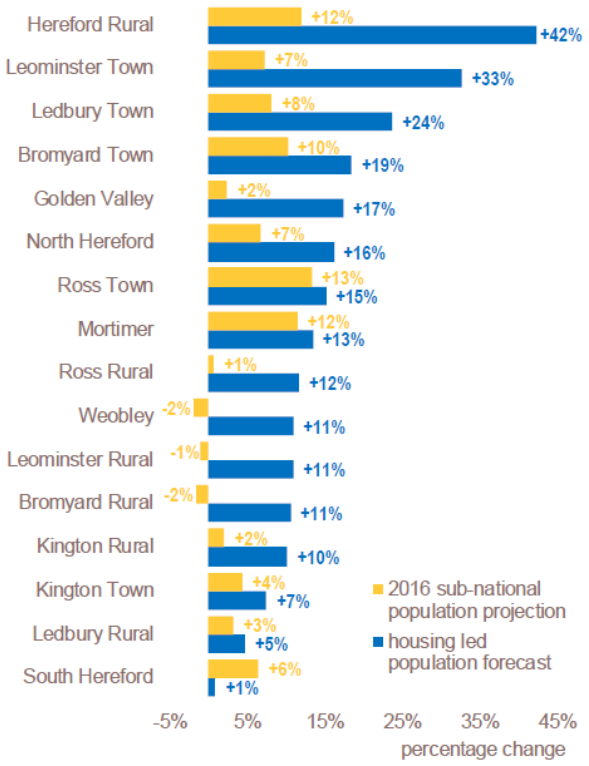
Although the overall population of Herefordshire is expected to increase, if the recent trends in births, deaths and migration were to continue, the numbers of children are expected to remain relatively static and the working age population is predicted to decrease slightly, while the numbers of people aged 65 and over are set to increase. However, the ensuing increase in levels of net inward migration to meet extra housing supply over this 15-year period may have a greater impact on the future numbers of children and working age people, with forecast increases of 15% and 9% respectively between 2016 and 2031. Assuming that housing growth targets will be met, all age groups are forecast to increase; however, the county will still have a similarly ageing profile.

Figure 15: Age stratified anticipated population growth by 2031 (source: Herefordshire Council Intelligence Unit)



Levels of population change will vary across the county and are closely related to the level of house building activity in an area relative to the size of the population within that area. The Hereford rural locality will yield the largest growth by 2031, both in terms of numbers of new dwellings and relative change in the population (+42%). Leominster town and Ledbury town are also expected to see relatively large increases in the population (+33% & +24% respectively).

Figure 16: Locality-specific anticipated population growth by 2031 (source: Herefordshire Council Intelligence Unit)



Ethnicity

The most recent ethnicity data source available remains the 2011 Census, until new data emerges from the 2021 Census later this year. In 2011, Herefordshire had a higher proportion of individuals who identify as being White British (93.7%) compared to England and Wales (80.5%). The largest ethnic groups in Herefordshire apart from the White British were the Black, Asian and Minority Ethnic group at 6.4% and the White Other group at 4.5%.

Table 7: Summary of 2011 Herefordshire ethnicity data (source: 2011 Census)

Persons	Herefordshire		England & Wales
	Number	%	%
All residents	183,477	100	100
White English, Welsh, Scottish, Northern Irish, British	171,922	93.7	80.5
White other (incl. Irish, Gypsy & Traveller)	8,247	4.5	5.4
Black, Asian and minority ethnic	11,555	6.4	19.5
Non-white	3,308	1.8	14.1
Mixed/multiple ethnic group	1,270	0.7	2.2
Asian/Asian British	1,439	0.8	7.5
Black/African/Caribbean/Black British	331	0.2	3.4
Other ethnic group	268	0.1	1.0

Deprivation

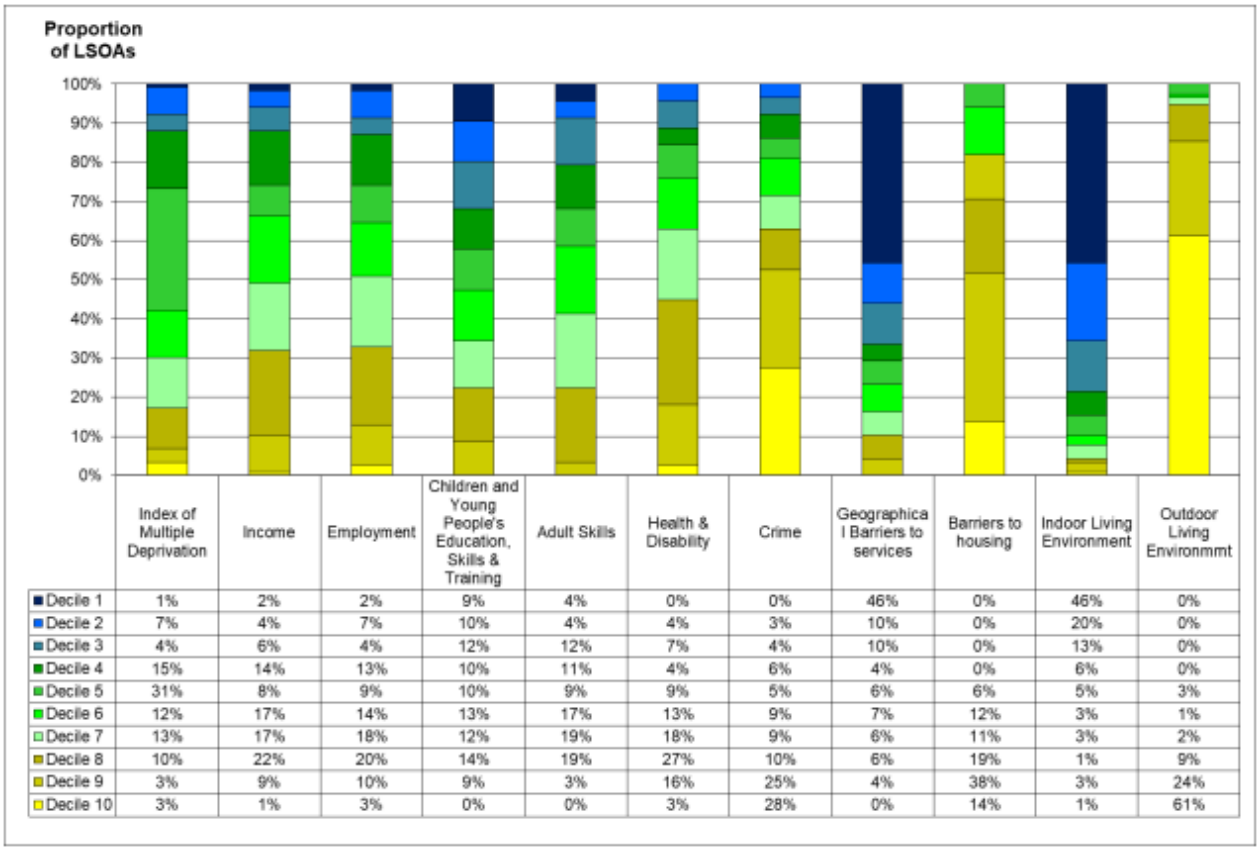
Herefordshire has on average, relatively low levels of overall multiple deprivation. However, Herefordshire is one of England's most rural counties and rural areas pose different types of challenges for the people who live there compared to urban areas. The Index of Multiple Deprivation is known to be skewed towards identifying deprivation in an urban context (e.g. Burke and Jones, 2019). In rural areas, the most common types of deprivation relate to housing and physical access to services. Deprivation can be a hidden feature of rural communities as it is often dispersed amongst more affluent households.

The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas of approximately 1500 residents called Lower Super Output Areas (LSOAs). It is a combined measure of deprivation based on a total of 37 separate indicators that have been grouped into seven

domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area.

11 of Herefordshire's 116 LSOAs are in the most deprived 25% across England. The most deprived domains in Herefordshire are the **indoor living environment** and **geographical barriers** with 46% of LSOAs being amongst the 10% most deprived nationally (see figure 17). The next most deprived domains are the children and young people's education and skills and adult skills sub-domains.

Figure 17: Distribution of Herefordshire LSOAs by deprivation domains. (Source: Herefordshire Council Intelligence Unit)



	Index of Multiple Deprivation	Income	Employment	Children and Young People's Education, Skills & Training	Adult Skills	Health & Disability	Crime	Geographical Barriers to services	Barriers to housing	Indoor Living Environment	Outdoor Living Environmmt
Decile 1	1%	2%	2%	9%	4%	0%	0%	46%	0%	46%	0%
Decile 2	7%	4%	7%	10%	4%	4%	3%	10%	0%	20%	0%
Decile 3	4%	6%	4%	12%	12%	7%	4%	10%	0%	13%	0%
Decile 4	15%	14%	13%	10%	11%	4%	6%	4%	0%	6%	0%
Decile 5	31%	8%	9%	10%	9%	9%	5%	6%	6%	5%	3%
Decile 6	12%	17%	14%	13%	17%	13%	9%	7%	12%	3%	1%
Decile 7	13%	17%	18%	12%	19%	18%	9%	6%	11%	3%	2%
Decile 8	10%	22%	20%	14%	19%	27%	10%	6%	19%	1%	9%
Decile 9	3%	9%	10%	9%	3%	16%	25%	4%	38%	3%	24%
Decile 10	3%	1%	3%	0%	0%	3%	28%	0%	14%	1%	61%

Note: Percentages show the proportion of Herefordshire's LSOAs within each national decile of deprivation. Deciles range from 1, representing the most deprived 10% of LSOAs up to decile 10, representing the least deprived 10%.

Excluding the indoor living environment and geographical barriers sub-domains, which largely affect the rural areas, the most deprived areas are urban (within Hereford city and the market

towns); south Hereford city contains more areas that feature within the top 25% most deprived areas in England for most of the domains/sub-domains than any other area, followed by north Hereford city and Leominster. LSOAs that feature most frequently include 'Golden Post-Newton Farm', 'Hunderton' and 'Redhill-Belmont Road' in south Hereford and 'Leominster - Ridgemoor' in Leominster. Golden Post – Newton Farm' in south Hereford is the most deprived area in Herefordshire and is the only area of the county within the 10% most deprived in England. The least deprived areas are located north of the river within Hereford and in rural areas surrounding the city, in Ross-on-Wye, and Ledbury.

Figure 18: Areas of highest deprivation in Herefordshire (Source: Herefordshire Council Intelligence Unit)

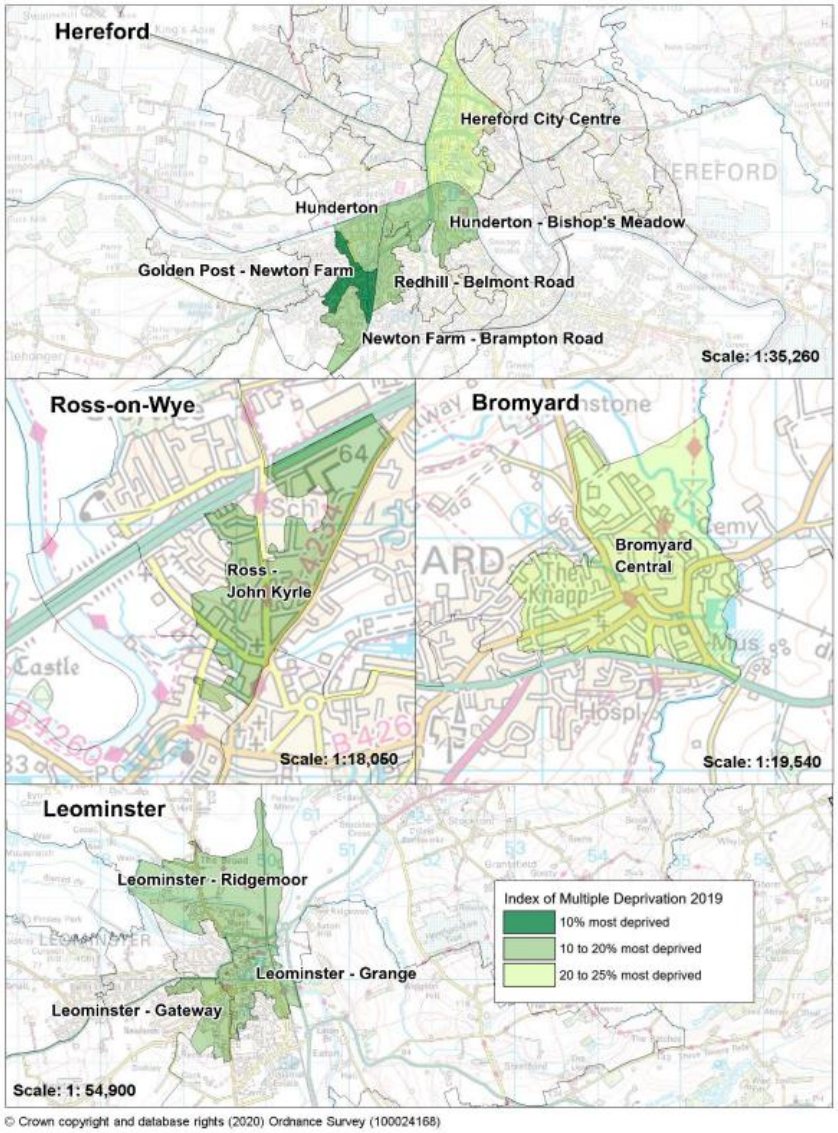
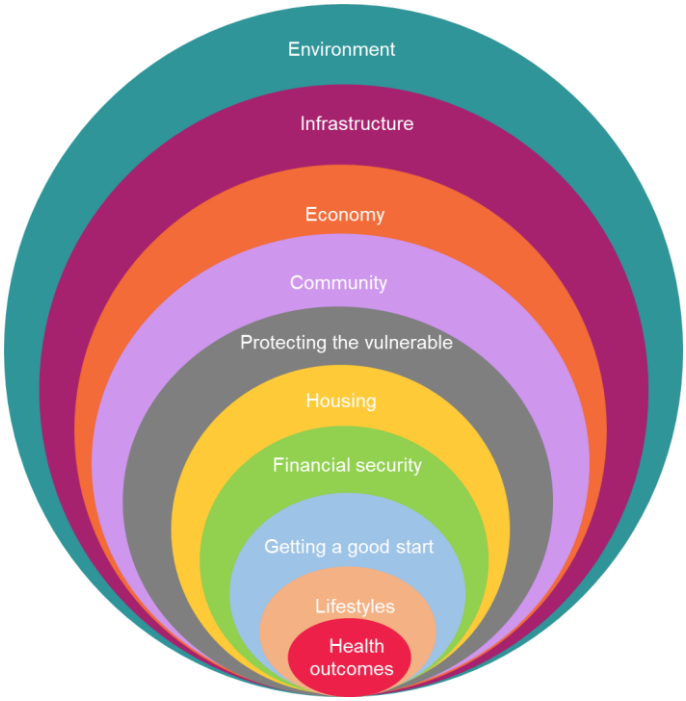


Figure 19: Comparison of the types of deprivation affecting urban and rural Herefordshire: rural areas are amongst the most deprived in England in terms of indoor living environment and access to services (source: Herefordshire Council Intelligence Unit)

Health and Well-being Priorities

The Joint Strategic Needs Assessment (JSNA) is a continuous assessment of current and future health, care and well-being needs of the population drawing on many sources of evidence. The 2021 JSNA is structured such that it starts at the macro level of the environment, infrastructure and the economy, then moves on to community and individual circumstances like getting a good start in life, financial security and lifestyles (see figure 20).

Figure 20: Structure of the Herefordshire 2021 JSNA, recognising the importance of the wider determinants of health (source: Herefordshire Council Intelligence Unit)



This sub-section will aim to focus on health needs within the levels where local pharmacies hold potential for positive impact. The information provided is taken from the **2021 Herefordshire JSNA** and **regional profiles** provided by the **Office for Health Improvement and Disparities**. The whole regional health profile for Herefordshire can be found in appendix 9.

A. Protecting the vulnerable

Multiple Complex Vulnerabilities

The JSNA highlights interconnections between many of the risks to both physical and mental well-being: generational, adverse childhood experiences (ACEs), substance misuse, exploitation, crime, financial insecurity. These multiple complex vulnerabilities (MCVs) increase the risk of leading chaotic lifestyles and dying prematurely. Although few in number, people with MCVs consume a disproportionately high amount of resources across multiple services. At the start of the pandemic around 150 individuals with MCVs were identified by strategic partners, most of whom will have had at least one adverse childhood experience.

Domestic Abuse

An estimated 4,900 women and 2,400 men aged 16-74 were victims of domestic abuse in Herefordshire during the year April 2019 to March 2020. Domestic abuse offences have been increasing steadily over the last 3 years, and in 2020/21 there were almost 2,200 offences recorded in Herefordshire by the police. The majority of DA is between partners, with 4% of adults having experienced this type of abuse, and 1.9% of adults experiencing abuse from family members. Women are also most likely to be victims of all types of DA.

B. Housing

Fuel poverty

In 2019, 17% (14,000) of Herefordshire households suffered fuel poverty on the new 'low income, low energy efficiency' measure. This is higher than the national average of 13%. Rural households are at greater risk of the combination of excess cold and low income. In 2019, 27% of properties in the owner occupied sector and 25% in the private rented sector were rated as having a serious hazard, largely due to excess cold and presence of fall hazards.

Related to this, the excess winter deaths index for Herefordshire showed 27.7% more deaths occurring in the winter months than the non-winter months. This is higher than the regional and national rates (18% and 17.4% respectively).

C. Getting a good start

Child health and wellbeing

- The percentage of mothers who are smokers at the time of delivery in Herefordshire is 11.5%. This is higher than the regional and national rates (10.6% and 9.6% respectively)

- The infant mortality rate in Herefordshire is 6.4 per 1000. This is higher than the regional and national rates (5.6 and 3.9 per 1000 respectively)

- In 2019/20 26% of Reception children and 34% of Year 6 were overweight. Obesity doubled between Reception (10%) and Year 6 (20%). Children in the most deprived areas are twice as likely to be obese as those in the least deprived areas, but there are no areas of the county where fewer than 12% of 11 year-olds are obese.

- Child oral health is significantly worse than across England, with a third of 5 year-olds showing visible signs of decay in 2018/19. There has been little change over last 10 years and Herefordshire compares unfavorably even with other unflouridated areas. Poor oral health and oral diseases disproportionally affect people who are disadvantaged, vulnerable or socially excluded.

- The JSNA reported that only a fifth of children had 5+ portions of fruit and veg 'yesterday' according to survey results. Secondary pupils who are eligible for free school meals are less likely to eat vegetables most days (36% vs. 52%).

- Under 18s admission episodes for alcohol-specific conditions in Herefordshire is 41.6 per 100,000. This is higher than the regional and national rates (24.9 and 29.3 per 100,000 respectively).

D. Healthy Lifestyles

Lifestyles and associated health issues in Herefordshire are generally better than nationally, but there is significant variation, often linked to areas of multiple deprivation.

- The percentage of adults that are overweight/obese is 67%. This is higher than the regional and national rates (66.8% and 63.5% respectively)

- 20% of adults in Herefordshire are physically inactive

- Smoking rates are lower than nationally. However, there are still 20,000 smokers across the county, with those in the most deprived areas twice as likely to smoke, and to die from smoking related conditions, than those in the least deprived. Adult smoking

prevalence in routine and manual occupations is 28.6%. This is higher than the regional and national rates (23.3% and 24.5% respectively)

- Following the national trend, alcohol-specific hospital admissions continue to rise, with 600 seen in 2019/20.

- People from the most deprived areas remain twice as likely be admitted to hospital and 50% more likely to die prematurely due to alcohol than those in the least deprived.

- The estimated diabetes diagnosis rate in Herefordshire is 70.1%. This is lower than the regional and national rates (86.3% and 78.0% respectively)

Mental Health

- The estimated dementia diagnosis rate in Herefordshire is 51.0%. This is lower than the regional and national rates (58.1% and 61.6% respectively)
- 10% of adults have a poor wellbeing score (on the Warwickshire Edinburgh Mental Wellbeing scale)
- 28% of Herefordshire adults rate their anxiety levels as 6-10 (where 10 is completely anxious). Covid-19 increased anxiety for 45% of adults and 40% of school-children locally. More likely amongst women, housing association renters and disabled people.
- 25% of primary and 48% of secondary/FE age pupils had low/medium-low mental well-being scores in summer 2021. Emotional well-being and resilience is lowest amongst teenage girls.
- Around 4,900 young people are living with a parent with severe mental health issues.
- 65% of those affected by flooding in 2019/20 said it had affected their mental health, and 85% were worried about being flooded again in the future.

- The number of Herefordshire patients diagnosed with depression increased by 13% (to 19,850) between March 2020 and November 2021.

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

The Pharmacy Services Public Questionnaire was published online and asked people who use the services about their experience. The questionnaire (see appendix 10) was open to the public from 10 November 2021 until 31 January 2022. From Herefordshire, there were a total of just 181 responses. Views expressed by this small self-selected sample **are not** representative of the wider Herefordshire population. For example, males, younger adults, unemployed adults and those living in rented accommodation are under-represented. Recommendations cannot be made exclusively on the basis of this survey. However, it is important to utilise these data to assess congruence with needs identified via other data sources.

Please note that throughout the survey results, the proportion of respondents selecting each answer option may add up to greater than 100% for some questions, as respondents were able to select more than one option that applies to them.

Respondent Characteristics

- 68% of the respondents were female, 30% were male and 2% preferred not to say.
- 45% were aged 45-59 years, 48% were over 60 years and 19% were aged 18-44.
- 95% of respondents were from a White English/Welsh/Scottish/Northern Irish/British background.
- 19% had children under the age of 16 years who live with them.
- 85% either owned their home outright, or were purchasing on a mortgage. People living in rented accommodation were under-represented.
- 61% had a long term medical condition (e.g. diabetes) and 46% had a physical disability.
- 65% were employed, 31% were retired, 4% were 'other' or caring for family. Students and unemployed citizens were not represented amongst the respondents.

Access

Why and when respondents use a community pharmacy/dispensing GP surgery

By far the most common reason to access a pharmacy was for 'collecting prescription medicines' (94% of respondents), followed by 'buying over the counter (OTC) medicine' (55%) and 'getting advice and information on prescription or OTC medicines' (34%).

A total of 10 of respondents (8%) had used a pharmacy or dispensing GP at least once a week on average, 64% used one once a month and the rest (28%) used one less frequently.

Usage during COVID-19

During Covid-19 restrictions, just over two thirds (68%) used a pharmacy as they normally would and a fifth (19%) used it in a different way, whilst 13% did not use a community pharmacy or a dispensing GP surgery at all.

Of the small number (42) who responded about how they accessed a pharmacy service during the period of lockdown restrictions 27% said they accessed the services 'by phone', 15% said 'online' and 77% 'in person'.

Distance, travel time and issues relating to access

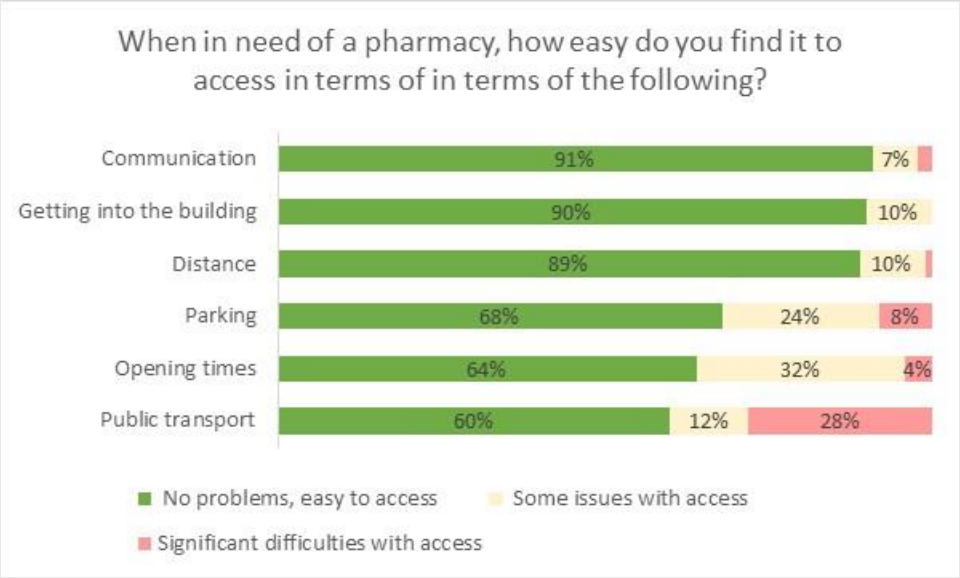
Around half of respondents (52%) accessed a pharmacy within two miles of their home or work, 31% travelled between two and five miles and 17% travelled more than five miles to get to the nearest community pharmacy or dispensing GP surgery.

80% of respondents usually travelled to the pharmacy by car, 31% walked and 7% cycled. Only one respondent used public transport (these options add up to greater than 100% as respondents were able to select multiple answers).

A large majority of respondents found accessing pharmacy services were easy in terms of communication, accessibility of building and distance (Figure 21). However, some respondents noted 'some issues' or 'significant difficulties' with access in terms of:

- Parking (32%)
- Opening times (36%)
- Public transport (40%)

Figure 21: Ease of pharmacy access in Herefordshire



Opening and visiting times

The most popular times for visiting a pharmacy were between 9am and 1pm (45%) and between 1pm and 6pm (42%) on weekdays, or between 9am and 1pm on Saturdays (40%) (see table 8).

Table 8: Pharmacy visiting times

When do you generally visit a community pharmacy / dispensing GP surgery?	Monday - Friday	Saturday	Sunday
Before 9am	1%	2%	1%
Between 9am and 1pm	45%	40%	18%
Between 1pm and 6pm	42%	17%	5%
After 6pm	10%	2%	2%
Never on this day	2%	39%	74%

A majority of respondents were able to access a pharmacy when convenient most of the time (58%) or all of the time (28%), and 14% were sometimes able to access one at a convenient time. 16% found some issues or significant difficulties with finding information on pharmacy opening times but the majority (85%) did not have any problems.

Access outside normal hours

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

1. Internet search (77%)
2. NHS.uk website (31%)
3. Pharmacy website (17%)
4. NHS 111 (8%)
5. Local directory, or local newspaper (less than 10%)

Advice and Information

Pharmacy leaflet

61% of respondents indicated that they were not aware that their pharmacy produces a leaflet about the services that they provide, 21% knew about this, but only 18% had actually seen a leaflet. This may have been influenced by guidance to reduce paper within the pharmacies to mitigate the spread of COVID-19 during 2021-2022.

Satisfaction with the service

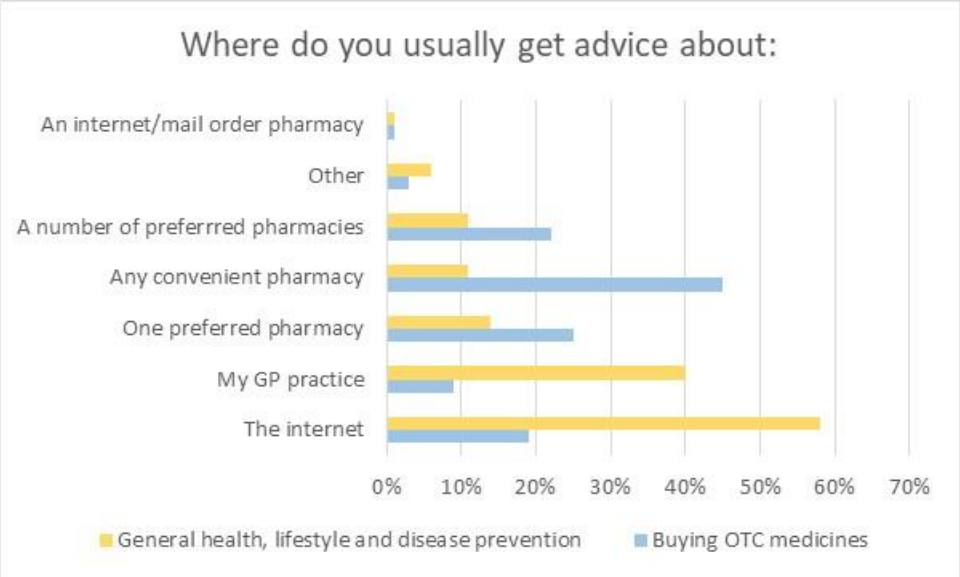
72% of respondents were very satisfied or fairly satisfied with the amount of information that they normally received about medication from their community pharmacy or dispensing GP surgery. 4% were either very or fairly dissatisfied.

Only 13 (7%) respondents had used a new medicine service provided by their pharmacy, 12 found it helpful.

Advice about over the counter (OTC) medicines

Most respondents used pharmacies to obtain advice on buying OTC medicines. However, they reported that they usually get advice about health, lifestyle and disease prevention from the internet or GP practice, despite 83% being aware that pharmacists can provide this.

Figure 22: Where respondents usually get advice about Over the Counter (OTC) medicines and general health



Confidence in your pharmacy team's advice and knowledge

Respondents were asked to rate their confidence in their pharmacy team's advice and knowledge of services. The services that respondents had the highest levels of confidence in were: prescribed medicines (79%) and OTC medicines (68%). Respondents appear to have had the lowest levels of confidence in the pharmacy team's advice and knowledge relating to healthy lifestyle services (41%), however this should be treated with extreme caution since the survey made no distinction between dispensing and community pharmacies. Data may have been taken from respondents using a dispensing practice where there is no access to this advice.

Figure 23: Extent of confidence in pharmacy team's advice and knowledge

Contracted additional services

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

The additional services that were most frequently accessed were:

- NHS flu vaccinations (35%)
- Minor ailment advice to avoid a GP visit (31%)

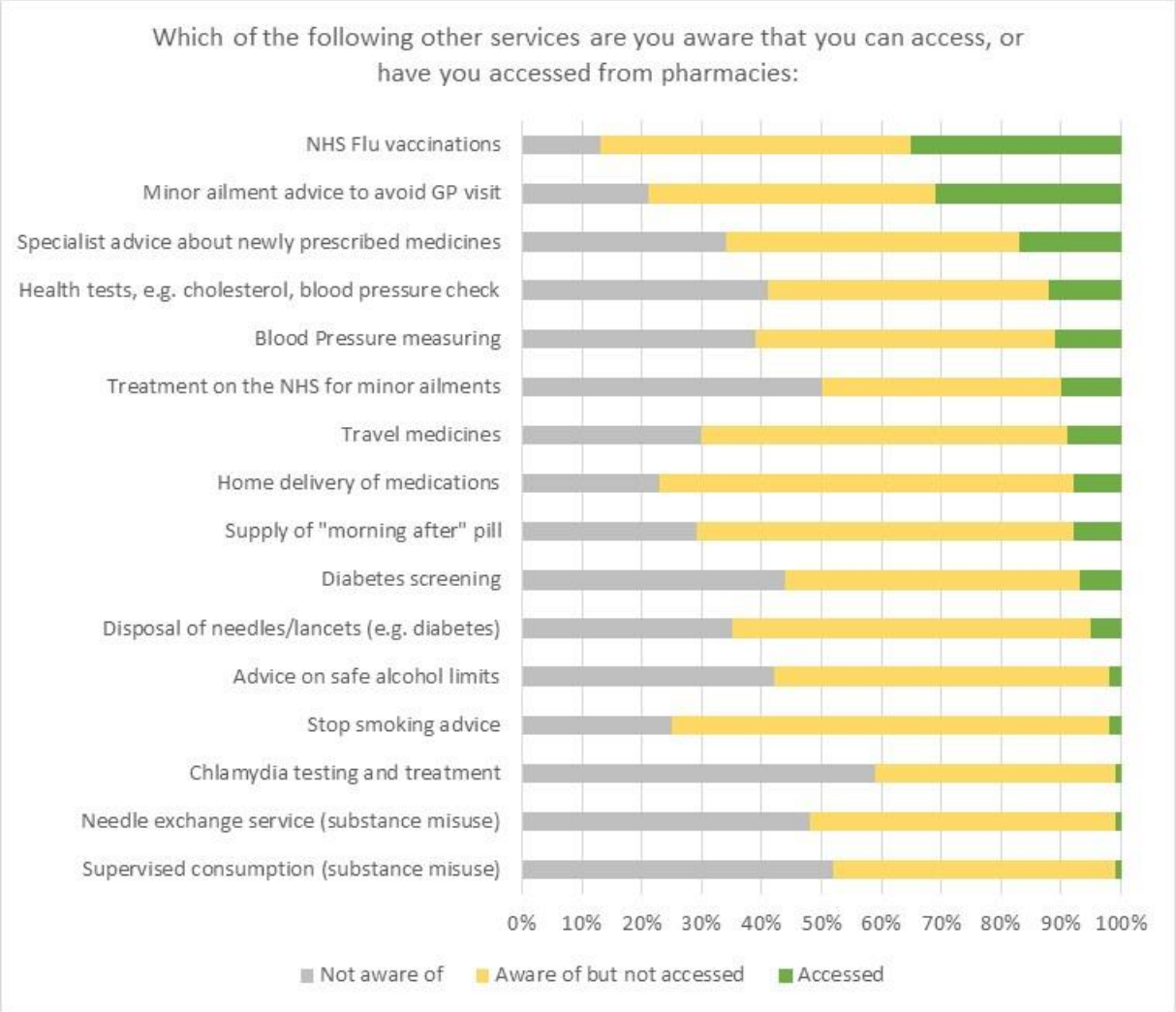
The additional services that respondents were most aware of but had not accessed were:

- Stop smoking advice (73%)
- Home delivery of medications (69%)

The additional services that respondents were least aware of were:

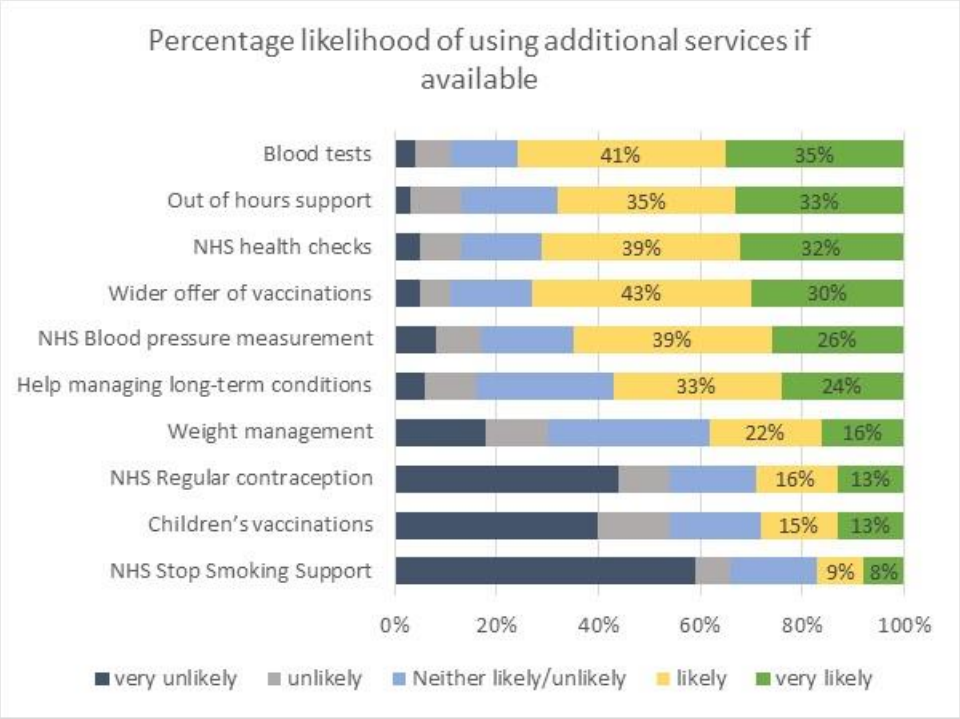
- Chlamydia testing and treatment (59%) (this service is not commissioned)
- Supervised consumption (for treatment of substance misuse clients) (52%)
- Treatment on the NHS for minor ailments (50%)

Figure 24: Respondents' awareness and access of additional pharmacy services



If made available from pharmacies, more than 50% of respondents said they would be very likely or likely to use blood tests, out of hours support, NHS health checks, wider offer of vaccinations, NHS blood pressure measurement and help managing long term conditions. More than 50% of respondents said they would be very unlikely or unlikely to use NHS stop smoking support, children's vaccinations and regular contraception. However, it is likely that these services are actually not applicable to a large proportion of the respondents and so finding should be treated with caution.

Figure 25: Percentage likelihood of using additional services if available



Unwanted medicine

A large majority of respondents (88%) said that they know they can return any unused/unwanted medicines (except sharps) to either a community pharmacy or a dispensing GP surgery. However, although 72% return them, 25% throw them away with household rubbish and 7% dispose of them via the sink.

Pharmacy Contractor Survey

Herefordshire County Council conducted an online Pharmacy Survey to gather information from local pharmacies to inform the Pharmaceutical Needs Assessment. The questionnaire was available from Monday 14th March to Sunday 29th April 2022 (see appendix 11).

Respondents

- Responses were received from 17 (61%) pharmacies within Herefordshire.

- All of the pharmacies that responded were 'standard contract' pharmacies (6 pharmacies also had a Local Pharmaceutical Services (LPS) contract).
- Hereford city had the lowest response rate and is therefore under-represented in the survey results.

Table 9: Survey response rates

Primary Care Network	Number of pharmacies	Number of pharmacies responded
East	4	3
Hereford City	15	8
North and West	5	4
South and West	3	2
Total	**27**	**17**

Access and equality

All of the pharmacies that responded to the questionnaire (17) said that the door to the pharmacy is accessible to all customers, including those who use pushchairs, wheelchairs and walking frames. There is disabled parking available outside at most of the pharmacies (15) and some pharmacies have free parking available for their patients (12). Two pharmacies said that there are steps to climb when entering the pharmacy.

Eleven pharmacies, including one of the two pharmacies that have steps to climb when entering have made adjustments or alterations to enable physical access such as automatic doors, ramps or wider and spacious entrances for wheelchair/mobility scooters. Fewer than half (8) pharmacies have a hearing loop installed. There are some pharmacies that have staff who can speak languages other than English.

Table 10: Pharmacies with staff who speak languages other than English

Language	PCN
Polish	Hereford City (6 pharmacies), East (1 pharmacy) and North and West (1 pharmacy)
Chinese	Hereford City (1 pharmacy)
Urdu, Pashto, Hindi, Romanian, Portuguese	Hereford City (1 pharmacy)
Welsh	Hereford City (1 pharmacy)
British Sign Languages	North and West (1 pharmacy)
Punjabi	East (1 pharmacy)
Spanish	East (1 pharmacy)

Consultation facilities

On site consultation facilities

All the pharmacies that responded (17) have a closed room for consultation.

- 16 have a consultation room with wheelchair access
- 10 have hand-washing facilities inside the consultation area and 4 have these close by
- 6 have toilet facilities for patients attending for consultations

Off-site consultation facilities

- 8 pharmacies are 'willing to undertake consultations in patient's home/ other suitable site and one of these has access to an off-site consultation area.

Services

Advanced services

All but one pharmacy (16) that responded to the survey provide 'new medicine' and 'community pharmacist consultation' services. 15 pharmacies provide 'flu vaccination service'. 'Hypertension case finding' service is provided by 6 pharmacies and a further 9 will provide this service within next 12 months. None of the pharmacies provide 'stoma appliance customisation service' currently, however, one pharmacy will provide this service in the next 12 months but activity is

noted through the supply route which in the majority is currently through Dispensing Appliance Contractors.

Table 11: Number of pharmacies providing *advanced* services

	No. providing	Will provide in the next 12 months
New Medicine Service	16	0
Appliance Use Review service	2	1
Stoma Appliance Customisation service	0	1
Flu Vaccination Service	15	2
Community Pharmacist Consultation Service (CPCS)	16	1
Hypertension Case Finding	6	9

Other services

The most popular services currently being providing by the surveyed pharmacies are:

- Home Delivery Service for prescribed products (13) (not an NHS commissioned service)
- Emergency Supply Service (11)
- Emergency Contraception Service and Extended Care Tier One (UTI) (9)
- Supervised Administration Service (9)

The following services are currently **not** provided by the pharmacies. However, if these services were to be commissioned most of the pharmacies indicated they would provide them:

- Chlamydia Testing Service – 16
- Chlamydia Treatment Service – 16
- Not Dispensed Scheme – 16
- Gluten Free Food Supply Service (not via FP10) -15
- NHS Health Check (Vascular Risk Assessment Service) -15
- Healthy Start Vitamins - 15
- Schools Service - 14
- Prescriber Support Service - 13

- Phlebotomy Service - 12

Disease Specific Medicines Management Service

- 1 Herefordshire pharmacy (located in Hereford City PCN) provides all services related to Disease Specific Medicines Management
- 1 Herefordshire pharmacy (located in East PCN area) currently provides all services related to Disease Specific Medicines Management with the exception of Alzheimer's/dementia, Epilepsy and Parkinson's disease
- 3 pharmacies currently provide Medicine Management Services for hypertension.

13 pharmacies said they would provide these services if commissioned.

Screening Services

Pharmacies were asked about screening services for alcohol misuse, HIV, HbA1C, H. Pylori, and Gonorrhoea, hepatitis, cholesterol and diabetes.

- 2 pharmacies (one located in Hereford City and the other in North & west PCN) currently provide cholesterol and diabetes screening services.
- **At least 10 pharmacies would be willing to provide most of the screening services if commissioned (2 pharmacies would provide privately).**
- Hepatitis and HIV screening are the services that pharmacies would be least likely to provide if commissioned or privately.

Vaccination services

The number of pharmacies currently providing vaccination services are as follows:

- Seasonal Influenza Vaccination – 16
- Covid-19 – 3
- Hepatitis (at risk workers or patients)' – 3
- HPV – 1

- Pneumococcal – 4
- Travel vaccinations – 1
- Childhood vaccinations - 0
- Meningococcal - 0

The majority of pharmacies indicated that they would be willing to provide these services if commissioned or privately. However, pharmacies were least likely to say they would provide Hepatitis (at risk workers or patients), HPV, Meningococcal and Pneumococcal vaccination services.

Other services

None of the pharmacies that responded currently provide 'Independent Prescribing' or 'Medicines Optimisation' services. **Fourteen pharmacies said they would provide 'Independent Prescribing service' and 15 pharmacies would provide Medicines Optimisation service' if commissioned, 2 pharmacies would provide both of these services privately.**

Non-commissioned services

A number of pharmacies provide non-commissioned services:

- Collection of prescriptions from GP practices - 15
- Delivery of dispensed medicines and Monitored Dosage Systems (free of charge on request) - 15
- Delivery of dispensed medicines-with charge 6 pharmacies
- Monitored Dosage Systems, with charge, is not currently provided by any pharmacy

Dispensing Practices Survey

Herefordshire County Council conducted an online Dispensing Practices Survey to gather information to inform the Pharmaceutical Needs Assessment. The survey was available from Monday 14th March to Sunday 29th April 2022 (see appendix 12).

Respondents

6 out the 10 Herefordshire dispensing practices completed the online survey. Four of these are located in South and West PCN area. One is in the North and West and one is in the Hereford City PCN area.

Access and equality

- 5 dispensaries have a bus stop within 100 metres of the premises.
- All 6 have free on-site parking, disabled parking, and an accessible entrance for pushchairs, wheelchairs and walking frames.
- No dispensaries indicated that they are open on weekends
- 4 dispensaries have a hearing loop
- 1 dispensary has staff speaking Arabic (Fownhope Medical Centre in Hereford City PCN). 1 dispensary has staff speaking Polish (Weobley & Staunton-on-Wye Surgeries in North and West). 1 dispensary has staff speaking French and British Sign Language (Much Birch Surgery in South and West).
- All dispensaries indicated that they have the access to translation services.

Services

- 4 practices dispense all types of appliances. A further practice dispenses all but stoma and incontinence appliances.

- 5 have clinical pharmacists working at the practice for an average of 10 hours a week.

Non-commissioned services

The following non-commissioned services are provided:

- Delivery of dispensed medicines (free of charge on request) – 4 practices
- Monitored Dosage Systems (free of charge on request) – 4 practices
- No practices provide delivery of dispensed medicines (with charge) or Monitored Dosage Systems (with charge)

PART C

Assessment to determine gaps in provision and opportunities for service development

Parts A and B of this PNA have summarised the current position in terms of provision of pharmaceutical services by contractors and the local needs which might be met by pharmaceutical services. Part C aims to identify if there are any gaps in provision and opportunities for service development.

Key areas of progress since the 2018 PNA and current recommendations

The 2018 PNA made suggestions for potential future services that would optimise the ability of pharmacies to meet local health needs. A number of these suggestions have now been supported by national plans, some have been developed via local initiative, whilst others have not been developed further. The COVID-19 pandemic is likely to have affected progress in some areas. Table 12 shows the potential future services identified in the 2018 Herefordshire PNA and our current position.

Table 12: Progress around potential future services suggested in the 2018 PNA

2018 PNA suggested future services	Progress update
Stop Smoking Service Ensure pharmacies are commissioned to provide both behavioural support and pharmacotherapy services i.e. one stop service.	There is now a national effort to enable pharmacies to offer smoking cessation support. However, it needs to be ensured that sufficient behavioural support is available in the community, as well as pharmacotherapy, in line with evidence-based recommendations. Behavioural support is currently provided by the Healthy Living Service.
Blood Pressure Checks	NHS England commissioned a blood pressure check service in 2021. It will be important to facilitate delivery of this service through as many pharmacies as possible.
Domiciliary Flu Vaccination Service	NHS England flu service specification now permits domiciliary flu vaccinations for eligible groups. PCN Direct Enhanced Services contract requires community pharmacies and GP practices to work together on managing flu vaccinations together for their populations.
Healthy Living Pharmacies	All pharmacies are HLP as part of terms of service.
Healthy Living Network Integration of HLP Level 1 pharmacies in to Hereford Council "Healthy Living Network" programme	This is now part of the pharmacy core contract
Pharmacy First Minor Ailments Service	National Department of Health Policy on self-care and purchase of over the counter medicines has influenced next steps on this. GP CPCS and the extended PGD services for certain conditions e.g. insect bites/ impetigo should continue through local commissioned arrangements.
Integrated medicines Optimisation NHS Net addresses	NHS NET email addresses are in place for all pharmacies. The Discharge Medicines Service is now the national lever towards supporting patients when they leave hospital. However there remain concerns over patients who require longer term support on re-packaged medicines.

Develop integrated medicines optimisation services for people who are cared for in more than one setting	
Raising profile of public information on community pharmacy based services	Care Navigation Service (signposting service for self-care) has now been implemented. Further work is needed to increase the availability of information on services provided by pharmacies.
Weight Management a) Advice & brief interventions on weight management, healthy eating & exercise, b) Pharmacy-based weight management service	This was not developed further
Provision of Naloxone	This was not developed further
Screening & Diagnostics •Pharmacy based screening and/or diagnostics e.g. -NHS Health Checks -Blood-borne virus testing -Spirometry	Pilot projects have been carried out, but this area has not yet been developed further.
Diabetes Prevention Programme	Pilot projects have been carried out, but this area has not yet been developed further.

Current recommendations in relation to the 2018 PNA:

- Whilst pharmacies are now contractually obliged to work with primary care to provide Flu vaccinations for their populations, we know that many vaccine inequalities remain. Pharmacies should promote the flu vaccine offer, particularly in deprived communities. Pharmacies should also contribute to other vaccination programmes.

- Blood pressure checks are now being commissioned throughout England and pharmacies in Herefordshire are beginning to implement this service. Pharmacies in areas of deprivation should be particularly encouraged to implement and promote this service.

- All pharmacies in Herefordshire are now Healthy Living Pharmacies (HLPs) with NHS net addresses. Each HLP is required to have a Health Champion who has undertaken the Royal Society for Public Health (RSPH) Level 2 Award 'Understanding Health Improvement'. A communication network should be explored to ensure frequent communication between the Health Champions and the Herefordshire Local Authority Public Health Team.

Key findings from public and contractor engagement and current recommendations

Although the response rates to our surveys were low and not representative of the Herefordshire population, the findings around access and public confidence are informative and may support recommendations to maximise the potential of pharmacies to meet health needs.

Table 13: Findings and opportunities suggested by public and contractor engagement

Assessment of access	Opportunities/considerations
Pharmaceutical services are provided by appropriately located contractors, delivering services over an appropriate period to allow reasonable access for the majority of people in Herefordshire. It has been assessed that there is currently sufficient provision of pharmacies and dispensing GP practices throughout Herefordshire who deliver essential pharmaceutical services. There are 27 pharmacies and 10 dispensing GP practices in Herefordshire, equating to one contractor per 5233 people (compared to one contractor per 4605 people in England as a whole). Mapping of locations of pharmacies and travel times by car to pharmacies has demonstrated that access to pharmacies is adequate across the county, where residents have access to a car. According to our analysis, the whole of the population of Herefordshire live within a 20 minute car journey to a pharmacy or GP dispensing practice. Around 64% of the total population of Herefordshire live within a 30 minute walking distance of a pharmacy of GP dispensing practice. 66% of the population can access a community pharmacy or dispensing practice within 45 minutes by public transport on a	The ratio of pharmacies to population is lower in Herefordshire than England and Herefordshire has a growing older population with greater need of these services. Services need to be aware of these changing demographics. NHSEi should consider this in relation to future applications for new services from the existing contractor base. There is demand and possible associated need with community pharmacies opening later and out of normal working hours. Flexibility around opening hours should be considered, including the option of extending existing contractors' opening hours on a locally commissioned rota basis. Public transport, parking and opening times appear to be issues in some places at some times.

weekday morning, but this proportion is much reduced on weekends. A large majority of public survey respondents found accessing pharmacy services were easy in terms of communication, accessibility of building and distance. However, respondents noted 'some issues' or 'significant difficulties' with access in terms of: • Parking (32%) • Opening times (36%) • Public transport (40%) All of the pharmacies that responded to our questionnaire said that the door to the pharmacy is accessible to all customers, including those who use pushchairs, wheelchairs and walking frames. There is disabled parking available outside at most of the pharmacies and some pharmacies have free parking available for their patients. There is currently no sharps disposal service in pharmacies in Herefordshire.	Areas of high rurality are very dependent on dispensing practices although patient choice to travel exists. These contractors do not provide advanced and locally commissioned services. Access to these services is therefore likely to be sub-optimal for these populations. Clear pathways need to be established for the disposal of all sharps and this is currently being addressed at regional level through its review of waste medicines and sharps disposal.

Assessment of public awareness and confidence	Opportunities/considerations
Most public survey respondents used pharmacies to obtain advice on buying OTC medicines. However, they reported that they usually get advice about health, lifestyle and disease prevention from the internet or GP practice, despite 83% being aware that pharmacists can provide this. Respondents were asked to rate their confidence in their pharmacy team's advice and knowledge of services. The services that respondents had the highest levels of confidence in were: prescribed medicines (79%) and OTC medicines (68%). Respondents had the lowest levels of confidence in the pharmacy team's advice and knowledge relating to healthy lifestyle services (41%). 61% of respondents indicated that they were not aware that their pharmacy produces a leaflet about the services that they provide.	This evidence of patient choice in terms of seeking healthy lifestyle advice is likely to be due to the perceived role of pharmacies as being primarily experts in pharmaceutical medicines. Considerable work is needed to increase public awareness and confidence around the role of pharmacies to provide healthy lifestyle support in relation to smoking cessation, physical activity, achieving a healthy weight and alcohol consumption. The Herefordshire Public Health team could support pharmacies in their Healthy Living functions, encouraging professional networks and providing information to the HLP Level2 Health Champions about the current priority outcome metrics. This area of work has stalled through Covid-19.

Current recommendations in relation to the 2022 public and contractor engagement surveys:

- Work should be undertaken to increase public awareness and confidence around the ability of pharmacies to provide healthy lifestyle support.

- Flexibility around opening hours should be considered, including the option of extending existing contractors' opening hours on a locally commissioned rota basis.

- Clear pathways need to be established for the disposal of all sharps.

- During COVID-19 lockdowns, volunteer agencies (e.g. Talk Community) assisted rurally dispersed communities with pharmacy access. Continuation of these efforts would facilitate access, particularly for those without car access. However, this requires a careful system response with pharmacist discretion; compliance with complex medicines regulations and patient safety paramount.

Key findings relating to health needs identified within the 2021 JSNA and regional health profile (OHID) and current recommendations

Part B of the PNA highlighted relevant information from the 2021 Joint Strategic Needs Assessment (JSNA) and the regional health profile produced by the Office for Health Improvement and Disparities (OHID) around health needs in Herefordshire. The JSNA includes important information about inequalities in the wider determinants of health, some of which cannot be directly influenced by pharmacies. However, for many issues, there is an opportunity for community pharmacies to meet needs. These have been selected and tabulated below.

Table 14: Health needs and opportunities identified within the 2021 JSNA and regional health profile (OHID)

Health Needs	Opportunities/considerations
1. Protecting the vulnerable	
Multiple Complex Vulnerabilities	A Complex Adult Referrals Matrix approach can contribute to positive outcomes for adults and greatly aids meaningful communication between services. Pharmacies must be aware of and able to refer to wider support services.
Domestic violence	Pharmacies can play an important role increasing awareness of the signs of domestic abuse, and providing a confidential safe space to enable signposting to vital support services.
2. Housing	
Fuel poverty	Pharmacies can play an important role identifying those who may be at risk of fuel poverty, awareness raising, and providing a confidential safe space to enable signposting to vital support services. This may help to reduce the excess winter deaths that occur in Herefordshire.
3. Getting a good start	
Smoking in pregnancy	Herefordshire Healthy Living Service provide behavioural support. Current access to maternity stop smoking services may be hindered by geographical barriers. There is a national effort to enable pharmacies to sign up to offer

	pharmacotherapy and behavioural support services combined. Increasing the provision and awareness of stop smoking services in pharmacies could increase uptake and reduce the percentage of mothers who are smokers at the time of delivery in Herefordshire.
Child oral health	If child oral health is not identified as a national priority, local resource should be provided to enable pharmacies to give this support and advice on a voluntary basis.
4. Healthy lifestyles	
Overweight/obesity Physical inactivity Alcohol misuse Smoking	Pharmacies are an important community asset and their role in improving health and wellbeing could be maximised through the provision of targeted opportunistic advice to address these issues. Level 2 Health Champions could provide a network to promote good practice. The availability of commissioned services could also be increased. For example, there may be a need for pharmacies to provide behavioural support for smoking cessation. Pharmacies may also be commissioned to provide weight management services. These were recommended in 2018 PNA but not taken forward. NHS Health Checks for those aged 40 – 74 years are designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Many of these conditions are linked to lifestyle and the NHS Health Check provides an opportunity to deliver advice and signposting interventions as well as referral for medical consideration. Pharmacies may be commissioned to provide NHS Health Checks.
Diabetes under-diagnosis and prevention	Services could be commissioned provide blood glucose screening and subsequent referrals. Since the 2018 JSNA, Herefordshire pharmacies have worked on a pilot diabetes prevention project. This could be a potentially valuable service to deliver through a pharmacy-based programme, utilising the skill mix in pharmacy.
5. Mental health	
Dementia under-diagnosis	The projected age structure of the population is likely to mean that under-diagnosis becomes more problematic. Pharmacies could have a valuable role in identifying and

	referring those who may be at risk. Relationships with customers who are carers may be an important enabler in this.
Poor mental well-being	Pharmacies must be aware of and able to refer to wider support services, such as social prescribing.

Current recommendations in relation to the 2021 JSNA and regional health profile (OHID):

- Ensure that pharmacies have access to up-to-date information about non-medical service directories, for example, social prescribing. Pharmacies should also be aware of key local issues such as fuel poverty, domestic violence and mental health.

- Maximise the role of Healthy Living Pharmacies to support healthy lifestyles. For example, Level 2 Health Champions could provide a network that models and promotes good practice in relation to providing opportunistic, tailored healthy living advice.

- Pharmacies should provide tailored opportunistic advice about child oral health and consider this issue for awareness campaigns, particularly in areas of high deprivation.

- Increase the availability of commissioned services such as weight management and behavioural support for smoking cessation. This would reduce geographical barriers to these services and provide more convenient one-stop support, particularly in deprived communities.

- Consider commissioning blood-glucose screening and diabetes prevention programmes to address current under-diagnosis in Herefordshire.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

This PNA has found that the level of access to pharmaceutical services currently commissioned across Herefordshire generally meets the needs of the population, as described in the findings. The pharmaceutical service in Herefordshire is provided by a variety of contractors that are appropriately located to meet the needs of the vast majority of the population. However, it is clear that the role of community pharmacies in preventing ill-health and supporting self-care could be strengthened through the existing pharmacy contractor base.

All pharmacies in Herefordshire are now Healthy Living Pharmacies (HLPs), ensuring that pharmacies have a workforce with the skills and opportunity to make an important impact on the health and wellbeing of the communities they serve. However, an interesting finding of this PNA is that some of the respondents to the small sample in the public survey currently report having less confidence in the ability of pharmacies to provide healthy living advice compared with the GP, highlighting the need for us to increase awareness about the skills and services on offer at pharmacies. It should be noted however, that we do not know the proportion of respondents who would usually use a dispensing practice rather than a community pharmacy. As dispensing practices are not commissioned to provide additional services, this may have influenced responses.

Dispensing practices are of utmost importance to reduce geographical barriers to dispensing services in areas of high rurality. However, these areas have reduced access to Advanced, Enhanced and Locally Commissioned Services that may be provided by community pharmacies.

Currently, the ratio of pharmacies to population is lower in Herefordshire than England and Herefordshire has a growing older population with greater need of these services. Services need to be aware of these changing demographics. Commissioners must also ensure that any additional services do not compromise the availability and quality of essential services.

Table 15: Summary recommendations of the 2022 PNA

Recommendation	Who
Pharmacies should work with partners in the system to reduce vaccine inequalities, promoting the flu vaccine offer, particularly in deprived communities. Pharmacies should also contribute to other vaccination programmes.	Pharmacies PCNs Taurus Healthcare Local Authority Public Health Team
Flexibility around opening hours should be considered, including the option of extending existing contractors' opening hours on a locally commissioned rota basis.	Pharmacies Pharmacy Commissioning Lead

Encourage secondary care based pharmacy colleagues to begin to incorporate DMS into their discharge processes. The focus should be on discharges for frail patients, those on high risk medicines and those whose primary diagnosis is shown to be a frequent cause of readmission before 30 days.	ICB/ICS and system partners
Pharmacies in areas of deprivation should be particularly encouraged to implement and promote blood pressure checks.	Pharmacies
Formation of a network of pharmacy Health Champions should be explored, in partnership with the local public health team. This could be utilised to achieve improved and consistent practice to maximise the health promoting role of community pharmacies.	Local Authority Public Health Team Integrated Care System (ICS) Pharmacy Lead for Herefordshire Local Pharmaceutical Committee
Clear pathways need to be established for the disposal of all sharps and waste medicines as part of a redefined service.	Pharmacy Commissioning Lead
Volunteer efforts initiated during COVID-19 lockdowns, to facilitate pharmacy access for those living in rural communities should continue where possible under the responsibility and discretion of the pharmacist/pharmacy.	Talk Community Local Authority Public Health Team
Ensure that pharmacies have access to up-to-date information about non-medical service directories, for example, social prescribing. Pharmacies should also be aware of key local issues such as fuel poverty, domestic violence and mental health.	Local Authority Public Health Team Health Champions Network
If child oral health is not identified as a national priority, local resource should be provided to enable pharmacies to give this support and advice on a voluntary basis.	Local Authority Public Health Team Health Champions Network
Consider increasing the availability of commissioned services such as: • weight management • pharmacotherapy and behavioural support for smoking cessation	Commissioners across the system

• NHS Health checks • This would reduce geographical barriers to these services and provide more convenient one-stop support, particularly in deprived communities. • Diabetes Prevention	
Consider and further explore the availability and use of translation services in pharmacies. NHSE do not currently commission translation services for pharmacies to access. This is important now and will become more important as more clinical services develop and our populations change.	PNA Working Group (see below)

This PNA has identified important recommendations for change and has highlighted previous recommendations that were not taken forward in light of the COVID-19 pandemic and associated pressures. Going forward, it will be important to ensure that the findings of this PNA are acted upon, with clear governance in place on their review. We suggest that the Health and Wellbeing Board review progress annually, and that a Herefordshire PNA Working Group is set up to explore further and progress the findings and recommendations from this PNA.

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APPENDICES

Appendix 1. Herefordshire Pharmaceutical Needs Assessment Development Working Group Membership

Member	Job Title	Organisation
Matthew Fung (Chair)	Public Health Consultant	Worcestershire County Council
Cameron Russell	Advanced Public Health Practitioner	Worcestershire County Council
Kim Elliott	Research Project Manager, Management Information Analytics & Research	Worcestershire County Council
Dr James Rankin	General Practitioner (Partner)	Local Medical Committee (LMC), Pershore Medical Practice
Fiona Lowe	Chief Officer, Community Pharmacy Herefordshire & Worcestershire	Herefordshire & Worcestershire Local Pharmaceutical Committee (LPC)
Margaret Reilly	Engagement Officer	Healthwatch Worcestershire
Christine Price	Chief Officer	Healthwatch Herefordshire
Satyan Kotecha	Local Professional Network (LPN Pharmacy) Chair	NHS England, K&K Healthcare Ltd
Dr Frances Howie	Public Health Consultant	Herefordshire County Council
Darren Plant	Commissioning Manager – Pharmacy/Optometry	NHS England and NHS Improvement West Midlands
Alison Rogers	Governance Pharmacist Medicines Commissioning Team	Herefordshire & Worcestershire Clinical Commissioning Group
Jane Freeguard	Associate Director of Medicines Commissioning	Herefordshire & Worcestershire Clinical Commissioning Group

Appendix 2. PNA Working Group terms of reference

Date	10/09/2021
Background	1. In 2009 all PCTs were required to prepare a Pharmaceutical Needs Assessment (PNA), for publication by February 2011, to present a picture of pharmaceutical service provision, reviewing access, range and adequacy of service provision and choice of provider. 2. The PNA is an assessment of the need for a type of service rather than a service provided by a particular type of contractor. Pharmaceutical services can be provided by Dispensing Doctors, Dispensing Appliance Contractors, Local Pharmaceutical Service Contractors as well as Community Pharmacies 3. PNAs are used to guide decisions on which NHS funded services need to be provided by local community pharmacies and other providers. 4. PNAs are also relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications by applicants and existing NHS contractors can be open to legal challenge if not handled properly. As a consequence it is important to have an up to date and locally relevant PNA. 5. The NHS regulations of April 2013 state that responsibility has transferred (from PCTs) to Health & Wellbeing Boards (HWB) to produce their first PNA no later than 1st April 2015. Board-level sign-off is required alongside a period of public consultation beforehand. An update is due every 3 years thereafter – for Worcestershire this was 31 March 2018. 6. Due to COVID-19 pressures, the requirement to publish the most recent PNA was agreed nationally to be suspended until October 2022. 7. The content of PNAs is set out in Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The PNA must contain: • A statement of the pharmaceutical services provided that are necessary to meet needs in the area; • A statement of the pharmaceutical services that have been identified by the HWB that are needed in the area, and are not provided (gaps in provision); • A statement of the other services which are provided, which are not needed, but which have secured improvements or better access to pharmaceutical services in the area; • A statement of the services that the HWB has identified as not being provided, but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area;

	• A statement of other NHS services provided by a local authority, the NHS Commissioning Board (NHS England), a Clinical Commissioning Group (CCG) or an NHS Trust, which affect the needs for pharmaceutical services; • An explanation of how the assessment has been carried out (including how the consultation was carried out); • A map of providers of pharmaceutical services. 8. The development of the PNA will take into account the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy – and present information about current and future provision of services.
Working group	9. The purpose of the PNA working group is to ensure that a robust Pharmaceutical Needs Assessment (PNA) is published by 1/10/2022. 10. The PNA Development Working Group will agree the project plan and assure itself that the PNA meets the requirements of The Health and Social Care Act 2012 and NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 and is in line with DH guidance. 11. The PNA Development Working Group will develop a robust Pharmaceutical Needs Assessment to satisfy control of entry regulations
Membership	12. The working group will include: Matthew Fung Public Health Consultant, Worcestershire County Council Cameron Russell Advanced Public Health Practitioner Satyan Kotecha LPN Chair Jane Freeguard Head of Medicines Commissioning Fiona Lowe – LPC Chair Alison Rogers – H&W CCG Christine Price – Healthwatch Worcestershire Margaret Reilly Healthwatch Herefordshire Darren Plant NHSE/I Frances Howie- Consultant in Public Health, Herefordshire County Council 13. Other members with relevant expertise will be co- opted by invitation as appropriate

Principles and behaviours	14. Members of the Working group are expected to: • Attend meetings or send a substitute where possible. • Work together and take collective responsibility for decisions except where that conflicts with other roles. • Honour any commitments made insofar as they relate to their own organisations.
Meeting frequency	15. Meetings of the working group will be scheduled as required. 16. Papers and documents should for discussion should be sent to Matthew Fung or Janette Fulton. Documents will usually be circulated 1 week in advance of meetings.
Relationship to other groups	17. The PNA Working Group will provide reports to other groups, including the JSNA working group & Health and Wellbeing Board(s).

Appendix 3a. List of community pharmacies in Herefordshire

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	Boots Uk Limited	Boots The Chemist Ltd	9 High Street		Ledbury	HR8 1DS
	First Health Midlands Ltd	Bromyard Pharmacy	35 High Street		Bromyard	HR7 4AF
	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
	B& H Jagpal Ltd	Healthpoint Pharmacy	Fletton House, Walwyn Road		Colwall	WR13 6QG
Hereford City WBC	L Rowland & Co (Retail) Ltd	L Rowland & Co Belmont	Eastholme Avenue	Belmont	Hereford	HR2 7XT
	L Rowland & Co (Retail) Ltd	L Rowland & Co Hampton Dene	Gorsty Lane		Hereford	HR1 1UN
	Avicenna Retail Ltd	Taylors Pharmacy	1-2 St Owens Mews	St Owens Street	Hereford	HR1 2JB
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	L Rowland & Co (Retail) Ltd	L Rowland & Co Westfaling St	100 Westfaling Street		Hereford	HR4 0JF
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	Tesco Stores Ltd	Tesco Instore Phamacy - Belmont	Abbotts Mead Road	Belmont	Hereford	HR2 7XS
	Tesco Stores Ltd	Tesco Instore Pharmacy - City	1 Fryzer Court	Bewell Street	Hereford	HR4 0BW
	W m Morrisons Supermarkets plc	Wm Morrison Pharmacy	Station Approach		Hereford	HR1 1DN
	Wye Valley Pharmacy Ltd	Wye Valley Pharmacy	42c Holme Lacy Road		Hereford	HR2 6BZ
North & West	Boots Uk Limited	Boots The Chemist Ltd	18 Corn Square		Leominster	HR6 8LR
	Sumedha Pharma Ltd	Kington Pharmacy	42 High Street		Kington	HR5 3BJ

	Matrix Primary Healthcare Ltd	Leominster Pharmacy Ltd	21/23 West Street		Leominster	HR6 8EP
	Rees W s & B (Chemists) ltd	W.S. & B Rees Chemists	20 High Street		Leominster	HR6 8LZ
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD
	Gorgemead Limited	Cohens Chemist	Pendeen Surgery	Kent Avenue	Ross-on-Wye	HR9 5AH

Appendix 3b. Herefordshire pharmacy opening hours

Final PCN (May 2021)	Pharmacy Name	Opening Hours Mon-Fri	Opening Hours Saturday	Opening Hours Sunday
East Herefordshire	Day Lewis Pharmacy (ex S & J Briggs)	09:00 - 18:00	09:00 - 13:00	Closed
East Herefordshire	Bromyard Pharmacy	9:00 - 13:00, 13:20 - 18:30	9:00 - 13:00, 13:20 - 17:30	Closed
East Herefordshire	Boots The Chemist Ltd	09:30 - 16:30	09:30 - 16:30	Closed
East Herefordshire	Healthpoint Pharmacy	0900-1800	0900-1230	Closed
Hereford City WBC	L Rowland & Co Hampton Dene	10:00 - 13:00, 14:00 - 17:30	Closed	Closed
Hereford City WBC	L Rowland & Co Belmont	10:00 - 13:00, 14:00 - 18:30	10:00 - 13:00	Closed
Hereford City WBC	Taylors Pharmacy	09:00 - 18:00	09:00 - 13:00	Closed
HMG (Hereford Medical Group)	Tesco Instore Phamacy - Belmont	08:00 - 19:00	08:00 - 19:00	10:00 - 16:00
HMG (Hereford Medical Group)	Asda Stores Ltd	08:00 - 23.00	07:00 - 22:00	11:00 - 16:00
HMG (Hereford Medical Group)	Boots The Chemist Ltd	8.00-18.00	8.00-18.00	10.00-16.00
HMG (Hereford Medical Group)	Wye Valley Pharmacy	09:00 - 17:30	Closed	Closed
HMG (Hereford Medical Group)	Lloyds Pharmacy Ltd	08.00-21.00	08.00-20.00	10:00 - 16:00
HMG (Hereford Medical Group)	L Rowland & Co Westfaling St	9:00 - 13:00, 14:00 - 18:00	Closed	Closed
HMG (Hereford Medical Group)	Wm Morrison Pharmacy	09:00 - 13:30, 14:30 - 20:00	09:00 - 13:30, 14:30 - 19:00	10:00 - 16:00
HMG (Hereford Medical Group)	Chave & Jackson Ltd	09:00 - 17:30	09:00 - 17:30	Closed

HMG (Hereford Medical Group)	Chandos Pharmacy	08:30 - 18:00	Closed	Closed
HMG (Hereford Medical Group)	Day Lewis Pharmacy	08:45 - 13:00, 14:00 - 18:00	09:00 - 12:30	Closed
HMG (Hereford Medical Group)	Tesco Instore Pharmacy - City	08:00 - 19:00	08:00 - 17:00	Closed
HMG (Hereford Medical Group)	Hereford Pharmacy	7.30 - 19.00	8.00 - 13.00	8.00-10.00
North & West	Leominster Pharmacy Ltd	09:00 - 18:00	09:00 - 17:30	Closed
North & West	Boots The Chemist Ltd	09:30 - 16:30	09:30 - 16:30	Closed
North & West	W.S. & B Rees Chemists	09:00 - 17:30	09:00 - 14:00	Closed
North & West	Kington Pharmacy	09:00 - 18:15	09:00 - 14:00	Closed
North & West	Westfield Walk Pharmacy	0900-1900	0900-1200	Closed
South & West	Boots The Chemist Ltd	09:30 - 16:30	09:30 - 16:30	10:00 - 16:00
South & West	Benjamins Pharmacy	09:00 - 18:30	Closed	Closed
South & West	Cohens Chemist	08:30 - 18:00	Closed	Closed

Appendix 4. List of Dispensing Practices in Herefordshire

PRACTICE NAME	ADDRESS 1	ADDRESS 2	ADDRESS 3	POST CODE
Cradley Surgery	Cradley	Malvern	Worcester	WR13 5LT
Fownhope Medical Centre	Lower Island Orchard	Fownhope	Hereford	HR1 4PZ
Golden Valley Practice	The Surgery		Ewyas Harold	HR2 0EU
Peterchurch Surgery (branch of Golden Valley Practice)	The Surgery	8-9 Closure Place	PETERCHURCH	HR2 0RS
Kingstone Surgery		Kingstone	Hereford	HR2 9HN
Kington Medical Practice	Eardisley Road		Kington	HR5 3EA
Much Birch Surgery			Much Birch	HR2 8HT
Nunwell Surgery	10 Pump Street		Bromyard	HR7 4BZ
The Marches Surgery	Westfield Walk		Leominster	HR6 8HD
The Mortimer Medical Practice - Kingsland	Kingsland		Leominster	HR6 9QL
The Mortimer Medical Practice - Leintwardine	High Street	Leintwardine	Craven Arms	SY7 0LQ
The Mortimer Medical Practice - Orleton	Millbrook Way	Orleton	Ludlow	SY8 4HW
Weobley Surgery	Gadbridge Road		Weobley	HR4 8SN
Staunton-On-Wye Surgery	Staunton-on-Wye		Hereford	HR4 7LT
Tenbury Surgery	34 Teme Street		Tenbury Wells	WR15 8AA

Appendix 5. Advanced Services for which pharmacy-level data is available

Hypertension Case-Finding Service

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
Hereford City WBC	Avicenna Retail Ltd	Taylors Pharmacy	1-2 St Owens Mews	St Owens Street	Hereford	HR1 2JB
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	Tesco Stores Ltd	Tesco Instore Phamacy - Belmont	Abbotts Mead Road	Belmont	Hereford	HR2 7XS
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
	Gorgemead Limited	Cohens Chemist	Pendeen Surgery	Kent Avenue	Ross-on-Wye	HR9 5AH

Appendix 6. Locally Commissioned Services for which pharmacy-level data is available (Local Authority Commissioned)

Smoking Cessation Pharmacotherapy Service (e-NRT vouchers)

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	First Health Midlands Ltd	Bromyard Pharmacy	35 High Street		Bromyard	HR7 4AF
	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
Hereford City WBC	L Rowland & Co (Retail) Ltd	L Rowland & Co Belmont	Eastholme Avenue	Belmont	Hereford	HR2 7XT
	L Rowland & Co (Retail) Ltd	L Rowland & Co Hampton Dene	Gorsty Lane		Hereford	HR1 1UN
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	L Rowland & Co (Retail) Ltd	L Rowland & Co Westfaling St	100 Westfaling Street		Hereford	HR4 0JF
North & West	Sumedha Pharma Ltd	Kington Pharmacy	42 High Street		Kington	HR5 3BJ
	Matrix Primary Healthcare Ltd	Leominster Pharmacy Ltd	21/23 West Street		Leominster	HR6 8EP
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
South & West	Gorgemead Limited	Cohens Chemist	Pendeen Surgery	Kent Avenue	Ross-on-Wye	HR9 5AH

Sexual health - Emergency Hormonal Contraception (under Patient Group Directive)

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
North & West	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk		Leominster	HR6 8HD
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
HMG (Hereford Medical Group)	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	Avicenna Retail Ltd	Taylors Pharmacy	1-2 St Owens Mews	St Owens Street	Hereford	HR1 2JB
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	Boots Uk Limited	Boots The Chemist Ltd	9 High Street		Ledbury	HR8 1DS
East Herefordshire	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
	B& H Jagpal Ltd	Healthpoint Pharmacy	Fletton House, Walwyn Road		Colwall	WR13 6QG

Needle and Syringe Exchange Service

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	Boots Uk Limited	Boots The Chemist Ltd	9 High Street		Ledbury	HR8 1DS
	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
HMG (Hereford Medical Group)	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA
North & West	Sumedha Pharma Ltd	Kington Pharmacy	42 High Street		Kington	HR5 3BJ
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX

Supervised Consumption Service

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	Boots Uk Limited	Boots The Chemist Ltd	9 High Street		Ledbury	HR8 1DS

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
	First Health Midlands Ltd	Bromyard Pharmacy	35 High Street		Bromyard	HR7 4AF
	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
Hereford City WBC	L Rowland & Co (Retail) Ltd	L Rowland & Co Belmont	Eastholme Avenue	Belmont	Hereford	HR2 7XT
	L Rowland & Co (Retail) Ltd	L Rowland & Co Hampton Dene	Gorsty Lane		Hereford	HR1 1UN
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	L Rowland & Co (Retail) Ltd	L Rowland & Co Westfaling St	100 Westfaling Street		Hereford	HR4 0JF
	Tesco Stores Ltd	Tesco Instore Phamacy - Belmont	Abbotts Mead Road	Belmont	Hereford	HR2 7XS
	Tesco Stores Ltd	Tesco Instore Pharmacy - City	1 Fryzer Court	Bewell Street	Hereford	HR4 0BW
	W m Morrisons Supermarkets plc	Wm Morrison Pharmacy	Station Approach		Hereford	HR1 1DN
	Wye Valley Pharmacy Ltd	Wye Valley Pharmacy	42c Holme Lacy Road		Hereford	HR2 6BZ
North & West	Boots Uk Limited	Boots The Chemist Ltd	18 Corn Square		Leominster	HR6 8LR
	Sumedha Pharma Ltd	Kington Pharmacy	42 High Street		Kington	HR5 3BJ
	Matrix Primary Healthcare Ltd	Leominster Pharmacy Ltd	21/23 West Street		Leominster	HR6 8EP
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD

Appendix 7. Herefordshire and Worcestershire Formerly CCG commissioned services for which pharmacy-level data is available

Herefordshire and Worcestershire Community Pharmacy Palliative Care Medicines Hubs

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
	B& H Jagpal Ltd	Healthpoint Pharmacy	Fletton House, Walwyn Road		Colwall	WR13 6QG
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	W m Morrisons Supermarkets plc	Wm Morrison Pharmacy	Station Approach		Hereford	HR1 1DN
North & West	Sumedha Pharma Ltd	Kington Pharmacy	42 High Street		Kington	HR5 3BJ
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
South & West	Boots UK Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD

Antiviral Medicines Access (Out-Of-Season Flu Outbreaks)

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD

Appendix 8. Nationally Commissioned Services for which pharmacy-level data is available

Community Pharmacy Extended Care Service Tier 1 (UTI and Eye)

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	First Health Midlands Ltd	Bromyard Pharmacy	35 High Street		Bromyard	HR7 4AF
	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
Hereford City WBC	Avicenna Retail Ltd	Taylors Pharmacy	1-2 St Owens Mews	St Owens Street	Hereford	HR1 2JB
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	W m Morrisons Supermarkets plc	Wm Morrison Pharmacy	Station Approach		Hereford	HR1 1DN
North & West	Rees W s & B (Chemists) ltd	W.S. & B Rees Chemists	20 High Street		Leominster	HR6 8LZ
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
South & West	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD

NHS Community Pharmacist Consultation Service (Minor Illness and Urgent Repeat Medicines Supply Pathways)

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	First Health Midlands Ltd	Bromyard Pharmacy	35 High Street		Bromyard	HR7 4AF
	B& H Jagpal Ltd	Healthpoint Pharmacy	Fletton House, Walwyn Road		Colwall	WR13 6QG
Hereford City WBC	L Rowland & Co (Retail) Ltd	L Rowland & Co Belmont	Eastholme Avenue	Belmont	Hereford	HR2 7XT
	L Rowland & Co (Retail) Ltd	L Rowland & Co Hampton Dene	Gorsty Lane		Hereford	HR1 1UN
	Avicenna Retail Ltd	Taylors Pharmacy	1-2 St Owens Mews	St Owens Street	Hereford	HR1 2JB
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	Boots Uk Limited	Boots The Chemist Ltd	42-43 Bewell Street		Hereford	HR4 9AA
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Day Lewis PLC	Day Lewis Pharmacy	96 Grandstand Road		Hereford	HR4 9NR
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	L Rowland & Co (Retail) Ltd	L Rowland & Co Westfaling St	100 Westfaling Street		Hereford	HR4 0JF
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	Tesco Stores Ltd	Tesco Instore Phamacy - Belmont	Abbotts Mead Road	Belmont	Hereford	HR2 7XS
	Tesco Stores Ltd	Tesco Instore Pharmacy - City	1 Fryzer Court	Bewell Street	Hereford	HR4 0BW
	W m Morrisons Supermarkets plc	Wm Morrison Pharmacy	Station Approach		Hereford	HR1 1DN
	Wye Valley Pharmacy Ltd	Wye Valley Pharmacy	42c Holme Lacy Road		Hereford	HR2 6BZ
North & West	Boots Uk Limited	Boots The Chemist Ltd	18 Corn Square		Leominster	HR6 8LR
	Sumedha Pharma Ltd	Kington Pharmacy	42 High Street		Kington	HR5 3BJ
	Matrix Primary Healthcare Ltd	Leominster Pharmacy Ltd	21/23 West Street		Leominster	HR6 8EP
	Rees W s & B (Chemists) ltd	W.S. & B Rees Chemists	20 High Street		Leominster	HR6 8LZ

	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk		Leominster	HR6 8HD
South & West	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD
	Gorgemead Limited	Cohens Chemist	Pendeen Surgery	Kent Avenue	Ross-on-Wye	HR9 5AH

Community Pharmacy Extended Care Service Tier 2 (skin services advise and treat suspected impetigo, infected insect bites and infected eczema)

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
North and West	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk		Leominster	HR6 8HD

Community Pharmacy Clostridium Difficile Management Hubs – improved access to Antibiotic Therapy

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
East Herefordshire	First Health Midlands Ltd	Bromyard Pharmacy	35 High Street		Bromyard	HR7 4AF
	NI Wade	Day Lewis Pharmacy (ex S & J Briggs)	2 Sear House	Bye Street	Ledbury	HR8 2AA
Hereford City WBC	Avicenna Retail Ltd	Taylors Pharmacy	1-2 St Owens Mews	St Owens Street	Hereford	HR1 2JB
HMG (Hereford Medical Group)	Asda Stores Ltd	Asda Stores Ltd	Belmont Road		Hereford	HR2 7JE
	H Shackleton Ltd	Chandos Pharmacy	2/3 Chandos House	St Owen Street	Hereford	HR1 2PR
	H Shackleton Ltd	Chave & Jackson Ltd	6/7 Broad Street		Hereford	HR4 9AE
	Hereford Hub Retail Ltd	Hereford Pharmacy	The Pharmacy Unit, Station Medical Centre,	Station Approach	Hereford	HR1 1BB
	Lloyds Pharmacy Ltd	Lloyds Pharmacy Ltd	In Sainsbury - Barton Yard		Hereford	HR4 0AG
	W m Morrisons Supermarkets plc	Wm Morrison Pharmacy	Station Approach		Hereford	HR1 1DN
North & West	Rees W s & B (Chemists) ltd	W.S. & B Rees Chemists	20 High Street		Leominster	HR6 8LZ
	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
South & West	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD
	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD

COVID-19 Vaccination Service At April 2022

Final PCN (May 2021)	Contractor	Pharmacy Name	Address	Address 2	Area / Town	Postcode
North & West	H.G.Clewer Ltd Pharmacy	Westfield Walk Pharmacy	Westfield Walk			HR6 8HD
	Boots Uk Limited	Boots The Chemist Ltd	5 Market Place		Ross-on-Wye	HR9 5NX
South & West	First Health Midlands Ltd	Benjamins Pharmacy	The Community Hospital	Alton Street	Ross-on-Wye	HR9 5AD

Appendix 9. Herefordshire regional Health Profile

Local Authority Health Profiles - Data - OHID (phe.org.uk)

Appendix 10. PNA Public Questionnaire

Pharmaceutical Needs Assessment (snapsurveys.com)

Appendix 11. PNA Pharmacy Questionnaire (Herefordshire & Worcestershire)

PNA Pharmacy Questionnaire 2022 (google.com)

Appendix 12. PNA Dispensing Practice Questionnaire (Herefordshire & Worcestershire)

PNA Dispensing Practice Questionnaire 2022: Herefordshire and Worcestershire (google.com)

Herefordshire Council

Title of report: Tobacco Control 2022

Meeting: Health and wellbeing board

Meeting date: 26/09/2022

Report by: Public Health, Senior Public Health Commissioner

Classification

This is an open report.

Decision type

This is not an executive decision

Wards affected

All (All Wards);

Purpose

The purpose of this report is to inform Health and Wellbeing Board on the recent publication of the 'The Khan review: Making smoking obsolete' (Appendix 1) and the findings from the recent smoking needs assessment (Appendix 2) and for the board to endorse the recommendations set-out within the report.

Recommendations:

That:

a) **Health and Wellbeing Board welcomes the publication of Javed Khan's Independent Review into smoking and supports the development of an action plan to help make smoking obsolete in Herefordshire;**

b) **Health and Wellbeing Board acknowledge the findings from the recent smoking needs assessment and commit to supporting Herefordshire to become SmokeFree;**

c) **Health and Wellbeing Board actively support the need for a whole system approach to smoking at primary, secondary and tertiary prevention levels, and**

Further information on the subject of this report is available from
Dr Frances Howie, , email: frances.howie@herefordshire.gov.ukl

d) Health and Wellbeing Board member organisations are asked to actively promote and engage in activity to work towards making smoking obsolete in Herefordshire, including supporting the establishment of a working group to produce an action plan reporting into the board annually.

Alternative options

1. Do nothing – this is not advised due to the impact smoking has on poorer health outcomes and widening health inequalities, in addition to the increasing demand smoking related ill-health places on the health and social care system.

Key considerations

2. Virtually every indicator of disadvantage is associated with higher smoking rates. As a result, the health and financial impact of smoking is borne disproportionately by the most disadvantaged and marginalised in society.

3. Smoking therefore drives and exacerbates wider inequalities with people living in the most deprived areas and are four times more likely to smoke than those living in the least deprived areas.

4. In 2019, the government set an objective for England to be SmokeFree by 2030, meaning only 5% of the population would smoke by then. Without achieving this objective, the government will simply not meet its commitment “to extend healthy life expectancy by five years by 2035” and fulfil the ambition to save more lives as part of a new 10-Year Cancer Plan

5. The government commissioned an independent review into tobacco control in England which identified a number of recommendations that would enable Government to achieve its objective of being SmokeFree by 2030 and this was published 25 August 2022. In total, the report outlined 15 recommendations which can be broadly categorised in the following:

    i. Increased investment

    ii. Increase the age of sale

    iii. Offer vaping as a substitute to smoking

    iv. Improve prevention in the NHS

6. The government will consider these and take forward key recommendations within the forthcoming Health Disparities White Paper due to be announced imminently, and the development of a Tobacco Control Plan later in the year

7. Herefordshire has made good progress in reducing smoking rates across the county by working in partnership across all our organisations. Smoking prevalence in Herefordshire is currently 11.7% which remains lower than the national and regional average. However, whilst this progress is positive and should be commended, smoking remains the leading cause for differences in life expectancy in the county, and there are challenges within certain population groups.

8. Herefordshire Smoking Needs Assessment 2022 states that: in 2019/20 13.9% of pregnant women smoke at time of delivery and in 2018/19 15.1% of women in early pregnancy smoke which is higher than the national 12.8%.

9. Smoking prevalence in routine and manual workers is also at 28.6% which is higher than the county average, and highlights the need for renewed efforts to focus support to these groups.

10. Adults with severe mental illness (40%) and long term mental health conditions (28.2%) are also much more likely to smoke in Herefordshire than the general population. Although similar to the national average, Herefordshire ranks fourth worst out of 14 nearest neighbours.

11. Over 50% of smokers wanted to stop smoking, with the main drivers for this being current and future health concerns, and the cost of smoking. It is projected that on average smokers spend £1945 each year on tobacco in Herefordshire, and in total, £37.42 million (legal and illicit) across the population.

12. More recently additional work streams to support the NHS Long Term Plan, Tobacco Dependency element have started to gather pace presenting a further opportunity to support smokers within secondary care. These require hospital trusts to start patients on Nicotine Replacement Therapy at discharge and transfer to a community facing smoking cessation service.

13. However, achieving the SmokeFree objective requires a broad, cohesive and coordinated system wide approach across all prevention levels – primary (stopping people from starting smoking), secondary (harm reduction and cessation opportunities at every opportunity) and tertiary (breaking the cycle of addiction).

14. This approach needs to be aligned to changes in national legislation and policies, although a national Tobacco Control Plan and Health Disparities White Paper were expected but the formation of a new government is expected to delay this.

Community impact

15. In addition to the health impact there is also an impact on economy, community and the local health and social care system. In Herefordshire alone, it is estimated that smoking costs the county £47 million due to costs associated with lower productivity, health care, social care and fire costs. It is currently estimated that 1859 hospital admissions were attributed to smoking in 2019.20.

16. The Khan Review states the importance of preventing children from starting smoking. Tobacco Smoke (second-hand smoke) can directly affect the health of children, but that also, children who grow up in homes where adults smoke, are 3-4 times more likely to smoke as adults. Furthermore, around 66% of all smokers become addicted to tobacco by the time they reach eighteen years old.

Environmental Impact

17. Making Smoking obsolete in Herefordshire, and achieving Smoke Free status will have a significant impact on the environment, reducing the polluting effect of cigarette litter (plastics, heavy metals and other toxins) on land and water courses. There would also be a reduction in activity required by Herefordshire Council in order to collect and deal with cigarette litter. It is estimated that around 4 tonnes of cigarette litter (66% cigarette butts) are dropped on the streets of Herefordshire every year, and 9 tonnes of waste created overall, most of which ends up in landfill[1]. Tackling the issue of smoking supports both the smoker and wider population health improving the conditions for people to live healthier lives.

[1] ASH: Ready Recknor - https://ash.org.uk/resources/view/ash-ready-reckoner

18. The burden on the NHS will be significantly reduced and in turn so will the huge carbon footprint of smoking. Smoking materials are a major contributor to accidental fires, smoking related fires result in annual losses of 58.9K.

Equality duty

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

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

19. Tobacco use, primarily in the form of smoking cigarettes correlates with deprivation. It adds to and amplifies health inequalities, and reduces the life expectancies of smokers, and in many cases, the people who live with them. Supporting the commitment for Herefordshire to make smoking obsolete through evidence-based recommendations will reach groups within the population who are more at risk of smoking, ensuring equity of support and avoiding discrimination.

Resource implications

20. There are no resource implications to this report.

Legal implications

21. This report is for the Health and Wellbeing to note and promote. Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners and therefore the recommendations as set in the recommendations are in line with the functions of the Health and Wellbeing Board as set out in paragraph 3.5.24 of the council's constitution.

Risk management

22. There are no specific implications arising out of this report.

Consultees

None

Appendices

Appendix 1 – Kahn Review summary and key points

Appendix 2 – Smoking Needs Assessment for Herefordshire

Background papers

None identified

Report Reviewers Used for appraising this report:

Please note this section must be completed before the report can be published		
Governance	Click or tap here to enter text.	Date Click or tap to enter a date.
Finance	John Coleman	Date 15/09/2022
Legal	Click or tap here to enter text.	Date Click or tap to enter a date.
Communications	Click or tap here to enter text.	Date Click or tap to enter a date.
Equality Duty	Click or tap here to enter text.	Date Click or tap to enter a date.
Procurement	Mark Cage	Date 15/09/2022
Risk	Click or tap here to enter text.	Date Click or tap to enter a date.

Approved by	Click or tap here to enter text.	Date Click or tap to enter a date.

[Note: Please remember to overtype or delete the guidance highlighted in grey]

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

Herefordshire Council

The Khan review: Making smoking obsolete

1.0 Purpose

The purpose of this report is to inform Health and Wellbeing Board on the recent publication of the *'The Khan review: Making smoking obsolete'* and that the board endorse the recommendations set-out within the report

2.0 Background

Virtually every indicator of disadvantage is associated with higher smoking rates. As a result, the health and financial impact of smoking is borne disproportionately by the most disadvantaged and marginalised in society. Smoking therefore drives and exacerbates wider inequalities with people living in the most deprived areas are four times more likely to smoke than those living in the least deprived areas.[1]

In 2019, the government set an objective for England to be Smokefree by 2030, meaning only 5% of the population would smoke by then. Without achieving this objective, the government will simply not meet its commitment "to extend healthy life expectancy by five years by 2035" and fulfil the ambition to save more lives as part of a new 10-Year Cancer Plan.

3.0 Summary of Kahn Review

The government commissioned an independent review into tobacco control in England which identified a number of recommendations that would enable Government to achieve its objective of being Smokefree by 2030. In total, the report outlined 15 recommendations which can be broadly categorised in the following:

3.1 Increased Investment

- Invest £125 million per year in interventions to reach a Smokefree 2030.
- Within this, £70 million per year should be ring-fenced for stop smoking services.
- The preferred option to fund the full range of measures is a 'polluter pays' industry levy on profits from cigarette sales.
- A Smokefree society would save the NHS £2.4 billion, lift around 2.6 million adults out of poverty, and create large productivity gains in the workforce and across the economy.

3.2 Increase the age of sale

- It is recommended that the age of sale is increased from 18, by one year, every year until no one can buy a tobacco product in this country.

3.3 Offer vaping as a substitute for smoking

- Healthcare professionals must be provided with accurate information about the benefits of vaping.
- All smokers should be offered vapes to help them quit smoking. The government should accelerate the path to prescribed vapes and provide free Swap-to-Stop packs in deprived communities.
- Young people must be prevented from taking up vaping by making vapes less appealing and accessible. Vapes should only ever be used a quit tool.

[1] ONS likelihood of smoking four times higher in England's most deprived areas than least

3.4 Improve Prevention in the NHS

- All the existing commitments in the NHS Long Term Plan must be met.
- The Very Brief Advice (VBA), model must be used to offer smokers treatment. All smokers in primary or secondary care should receive VBA by their clinician or health professional.
- All hospitals should integrate 'opt-out' support and treatment for all smokers into routine care.
- Hospital trusts must report their progress in annual reports.
- Broader NHS messaging should be targeted to encourage people to stop smoking.

The government will consider these and take forward key recommendations within the forthcoming Health Disparities White Paper due to be announced this summer, and the development of a Tobacco Control Plan later in the year

4.0 Local Context

Herefordshire has made good progress in reducing smoking rates across the county by working in partnership across all our organisations. Smoking prevalence in Herefordshire is currently 11.7%[2] which remains lower than the national and regional average. However, whilst this progress is positive and should be commended, smoking remains the leading cause for differences in life expectancy in the county, and there are challenges within certain population groups such as pregnant women where current smoking prevalence is higher than the national and regional average at 11.5% (SATOD). Smoking prevalence in routine and manual workers is also at 28.6% which is higher that the county average.[3]

In Herefordshire alone, it is estimated that smoking costs the county £47 million due to costs associated with lower productivity, health care, social care and fire costs[4]. It is currently estimated that 1859 hospital admissions were attributed to smoking in 2019.20.[5]

5.0 Brief overview of work being undertaken to date in this area

- Herefordshire Smoking Cessation Service is funded by Public Health providing evidenced based support in the community for people wanting to stop smoking. As part of this service, pharmacies can sign up to the council contracting framework to dispense NRT to smokers following support from the Smoking Cessation Service.
- Public Health have provided additional interim investment to increase support available for pregnant smokers funding a maternity support worker and NRT supply. Ongoing funding needs to be considered.
- Additional maternity support worker post funded by WVT is in the process of being recruited.
- Smoking in pregnancy task and finish group established and will report back progress against SIP action plan to the H&W Maternity Transformation group /LMNS Board. Worcestershire PH chair.
- CLeaR assessment deep dive of H&W maternal smoking support carried out informing the SIP action plan.
- Further support is being developed following the roll-out of the NHS Tobacco Dependency pathways which is a key requirement from the NHS long term plan.
- Tobacco Dependency Steering Group has been established to support NHS LTP pathway development.

[2]Fingertips https://fingertips.phe.org.uk/profile/tobacco-control/data
[3] Fingertips tobacco control profile (https://fingertips.phe.org.uk/static-reports/tobacco-control/at-a-glance/E06000019.html?area-name=Herefordshire)
[4] Ash Ready Reckoner 2022. ASH Ready Reckoner 2022 - Action on Smoking and Health
[5] OHID Finger tips - https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/ati/402/are/E06000019

- Some pharmacies signed up to provide Community Pharmacy Advanced Service, to support the discharge from care although a limited number across H&W.
- Broader CLeaR assessment across tobacco control needs to be considered.
- A tobacco needs assessments is currently being developed jointly between Worcestershire County Council that will inform local actions to further reduce tobacco dependency.
- The Government is expected to publish a Tobacco Control Strategy in late 2022.

6.0 Recommendations for the Board

1. That the Health and Wellbeing Board welcomes the publication of Javed Khan's Independent Review into smoking

2. Health and Wellbeing Board supports the recommendations from the Kahn review and the resulting actions to help make smoking obsolete in England and Herefordshire

3. Health and Wellbeing board member organisations are asked actively promote and engage in activity to work towards making smoking obsolete in Herefordshire.

Herefordshire Council

The Khan Review: Independent review into smokefree 2030 policies

Four critical recommendations are boxed in red. These are 'must dos' for the government to achieve a smokefree England by 2030 , around which all other interventions are based.

Part 1: Invest Now

REC 1: Urgently invest £125m per year in interventions to reach smokefree 2030.

Option 1: Additional funding from within government
Option 2: A 'polluter pays' industry levy
Option 3: A corporation tax surcharge

Part 3: Quit for Good

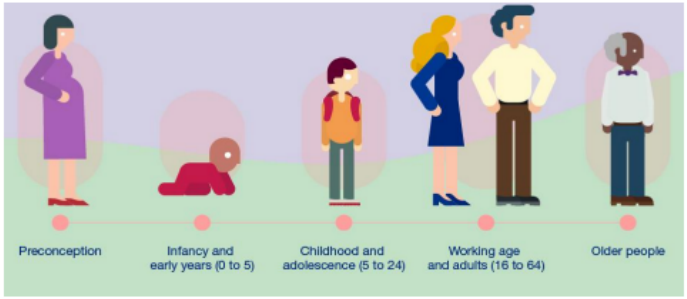
REC 8: Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.

REC 9: Invest an additional £70 million per year into 'stop smoking services', ringfenced for this purpose.

REC 10: Invest £15 million per year in a well-designed national mass media campaign, supported by targeted regional media.

Part 2: Stop the Start

REC 2: Raise age of sale of tobacco by one year, every year.



The image above shows **the lifecycle of a smoker**. From smoking in pregnancy and the impact on the unborn baby, to old age, where 2/3 lifetime smokers will likely die from smoking. Interventions are needed at all stages of a person's life.

REC 3: Substantially raise the cost of tobacco duties (more than 30%) across all tobacco products, immediately. Abolish all duty free entry of tobacco products at our borders.

REC 4: Introduce a tobacco licence for retailers to limit where tobacco is available.

REC 5: Enhance local illicit tobacco enforcement by dedicating an additional funding of £15 million per year to local trading standards.

REC 6: Reduce the appeal of smoking by radically rethinking how cigarette sticks and packets look, closing regulatory gaps and tackling portrayals of smoking in the media.

REC 7: Increase smokefree places to de-normalise smoking and protect young people from second-hand smoke.

Part 4: System Change

REC 11: The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care

REC 12: Invest £15m per year to support pregnant women to quit smoking in all parts of the country.

REC 13: Tackle the issue of smoking and mental health.

REC 14: Invest £8m to ensure regional and local prioritisation of stop smoking interventions through ICS leadership.

REC 15: Invest £2 million per year in new research and data, including investing £2 million in an innovation fund.

[ICS Tobacco Dependance infographic]

Version 1

Date: July 2022

Authors: Madeleine Spinks & Hannah Khwaja

Email: info@dataorchard.org.uk

SMOKING AND VAPING RESEARCH IN HEREFORDSHIRE AND WORCESTERSHIRE

Executive Summary

Introduction

The public health teams at Worcestershire County Council and Herefordshire Council commissioned Data Orchard CIC to research smoking and vaping in Herefordshire and Worcestershire, to inform a needs assessment for community smoking and tobacco control services and interventions across the two counties.

This report summarises the findings of the research done April to June 2022.

Aims of research

The aim of the desk research and analysis was to collate as much relevant epidemiological and demographic data on prevalence, attitudes and behaviours related to smoking and vaping from a variety of national and local sources. This included identifying the impact of smoking (smoking-attributable hospital admissions/deaths), incidence of smoking-related disease and the prevalence of smoking in Herefordshire and Worcestershire and how this varies across and within demographics, communities, and geographies.

The aim of the public engagement was to gain insight into attitudes and behaviours related to smoking and vaping, using the following lines of enquiry:

- Smoking/vaping behaviours, frequency, and key drivers to do so
- Attitudes to smoking and vaping (society, peers, family)
- Attitudes to quitting (society, peers, family)
- Barriers towards quitting and what might help to remove these
- Any experiences in trying to quit smoking: what worked, what didn't
- Support needed to quit in detail (who/how, location, convenient times, travel)

Key findings from desk research

The prevalence rates of smoking in Herefordshire and Worcestershire are similar to national rates and are following the national downward trend. Prevalence of smoking in 15-year-olds was lower in Herefordshire (6%) compared to nationally (8%) but higher in Worcestershire (10%).

The following population groups are potential areas of focus for which Herefordshire and Worcestershire perform worse than the national average and/or worse than 50% or more of their CIPFA nearest neighbours.

Herefordshire	• Routine and manual occupations • Adults with serious mental illness • Adults with a long-term mental health condition • Pregnant women – smokers at time of delivery • Pregnant women – smokers in early pregnancy
Worcestershire	• Young people (15-year-olds) • Adults with a long-term mental health condition • Adults admitted to treatment for substance misuse – non-opiates • Pregnant women – smokers in early pregnancy

The national prevalence rate for vaping is 7%, but no prevalence rates are available for the two counties for adults. Recent local data shows that 15% of 15-year-olds in Herefordshire had tried vaping and 19% of 15-year-olds in Worcestershire.

Key findings from the public engagement

The public engagement gathered views from 400 people via an online survey and 175 people face-to-face in Herefordshire and Worcestershire about smoking, vaping, and quitting. A range of people were targeted in the face-to-face engagement - particularly those who were more likely to smoke or vape according to the prevalence rates.

Profile of respondents

The demographic profile of the respondents compared to the population show that they were more likely to be:

- female or non-binary/other
- non-heterosexual
- working age
- have a disability/long-term health condition
- be unemployed or unable to work due to health or disability
- not live in owner occupied homes (i.e. renting, staying with family or friends or in temporary accommodation)

57% of respondents described themselves as smokers, 21% as vapers, 24% as ex-smokers, 6% as non-smokers and 1% as ex-vapers.

Those who described themselves as smokers were more likely to be non-heterosexual, working age, not in employment, unable to work due to health or disability, have a disability or long-standing health condition, and be in rented accommodation compared to the overall respondent base.

Those who described themselves as vapers were more likely to be younger, female, and staying with family or friends compared to the overall respondent base.

Those who described themselves as ex-smokers were more likely to be older, not have a disability or long-term health condition, be in work, and own their own home.

Key drivers for smoking

The top three reasons given for motivating people to smoke were friends/social aspects, coping with stress, and for enjoyment. Nearly all smokers in the public engagement started smoking in their teenage years.

Motivation to quit smoking

At least half of smokers would like to quit, with a much lower proportion not wanting to stop at all. Most smokers had tried to quit but had been unsuccessful.

Top motivations for giving up smoking were concerns about their future health, smoking being too expensive and to a lesser extent, their health already being affected.

What leads to successful quitting?

Nicotine replacement, e-cigarettes/vaping, willpower, and support from friends and family were most commonly identified as having helped ex-smokers quit smoking. Activities to replace the habit were helpful to ex-smokers, and several ex-smokers mentioned that the Allen Carr method worked for them. Most people quit smoking over the age of 25 and it mostly took more than one attempt.

What would help people to quit smoking?

Accessing support from a GP, a pharmacy or online were the most frequently stated factors that would help people to quit smoking by online respondents. Most of the people engaged face-to-face gave other reasons, mainly related to willpower and a strong personal motivation and determination to break the habit.

What stops people from quitting smoking successfully?

Nicotine replacement measures and e-cigarettes not being effective were the most common reasons given by those who had been unable to quit smoking successfully. Other reasons

given were a mixture of support not being available locally or not at convenient time, ongoing stress, and not having the willpower to quit.

Key drivers for vaping

The main motivations for vaping were as an alternative to smoking, to cope with stress, and boredom. Most also vaped because it helped them to socialise, and their friends vaped too. Many mentioned that it takes a while to master the technical aspects of vaping, which can be a barrier to using e-cigarettes to help give up smoking. Some people (mostly smokers) perceived vaping to be bad for one's health.

What would help people to quit vaping?

Most vapers did not want to quit, but the most commonly mentioned factors that would help with quitting were support to change habitual behaviour, being less stressed, or if vaping was proven to be a significant health concern.

What stops people from quitting vaping?

The main reasons given for not quitting vaping were a lack of motivation to do so and that it has helped people to stop or reduce their smoking, with the next most frequently mentioned being that they were addicted to nicotine.

1. Introduction

The public health teams at Worcestershire County Council and Herefordshire Council commissioned Data Orchard CIC to collect, analyse and interpret quantitative and qualitative data regarding smoking and vaping from a cross section of the Herefordshire and Worcestershire population, to inform a needs assessment for community smoking and tobacco control services and interventions across the two counties.

Data Orchard CIC combines specialist skills in research, statistics, and data, with a passion for making the world a better place socially, economically, and environmentally. Our mission is to enable organisations to use data for better decisions and greater impact.

This report summarises the findings of the desk research and quantitative analysis conducted in April, and the public engagement conducted in May and June 2022.

2. Methodology

2.1 Desk research

The aim of the desk research and analysis was to collate as much relevant epidemiological and demographic data on prevalence, attitudes and behaviours related to smoking and vaping from a variety of national and local sources. This included identifying the impact of smoking (smoking-attributable hospital admissions/deaths), incidence of smoking-related disease and the prevalence of smoking in Herefordshire and Worcestershire and how this varies across and within demographics, communities, and geographies.

Unless otherwise stated, data was obtained from the Office for Health Improvement and Disparities public health profiles accessed in April 2022. Further information was sourced from a range of local and national datasets including the Office for National Statistics (ONS), Action on Smoking and Health (ASH), Public Health England (PHE) and Herefordshire and Worcestershire councils.

Research questions:

- What is the prevalence of smoking and vaping in Herefordshire and Worcestershire and how does this compare with other areas?
- What are the trends in smoking related hospital admissions, deaths, and uptake of smoking cessation services?
- What are the characteristics of people who smoke?

2.2 Public engagement

The aim of the public engagement was to gain insight into the attitudes and behaviours related to smoking and vaping, using the following lines of enquiry:

- Smoking/vaping behaviours, frequency, and key drivers to do so
- Attitudes to smoking and vaping (society, peers, family)
- Attitudes to quitting (society, peers, family)
- Barriers towards quitting and what might help to remove these
- Any experiences in trying to quit smoking: what worked, what didn't
- Support needed to quit in detail (who/how, location, convenient times, travel)

2.2.1 Target groups

The research aimed to engage with approximately 160 people face-to-face, either in focus groups or interviews at locations that people already frequent or groups that they may already attend. Contact was made with many local organisations who support particular groups of people, asking for help in either hosting a focus group or encouraging people to take part.

The types of people who were targeted in the qualitative research were smokers, ex-smokers and vapers who may also be:

- People with mental health problems
- People whose first language is not English
- People who are homeless or in emergency accommodation
- People who inject drugs
- Pregnant mothers and expectant fathers
- LGBTQIA+ communities
- Refugees and asylum seekers
- Young people (under 25 years)

2.2.2 Focus groups

Five focus groups were run in the two counties: in the South Wye and centre of Hereford, one in the Community larder in Ross-on-Wye and two in Worcester (the Hive, St John's youth centre). Overall, 29 participants attended the focus groups which were where the following groups of people meet:

- People seeking employment
- People receiving support for learning English
- LGBTQ+ group
- 18–25-year-old care leavers
- Those in need of food and other essential supplies

2.2.3 Interviews

146 face-to-face interviews were conducted across Herefordshire and Worcestershire at a variety of locations targeted towards the desired groups of people. These included outside pubs, vaping shops, supermarkets and near places where routine and manual workers were employed.

2.2.4 Online survey

An online survey was run for six weeks in April and May to understand broader attitudes to smoking and vaping. A prize draw of local shopping vouchers was offered to encourage responses and it was widely publicised on social media. 400 responses were obtained from participants living across Herefordshire and Worcestershire.

3. Results

3.1 Desk research

3.1.1 Smoking and vaping prevalence

In 2020, approximately 18,000 adults in Herefordshire and 53,000 adults in Worcestershire were current smokers according to Annual Population Survey (APS) national statistics. At 11.7% and 11.1% respectively, the rates in both counties were similar to the national average of 12.1% (Figure 1) and, following national trends, had declined in the preceding five years (by 2.3% in Herefordshire and 6% in Worcestershire). More recent figures from the GP Patient Survey (GPPS) in 2020-21 suggest a marginally higher prevalence of 13.1% in Herefordshire and 14.3% in Worcestershire, similar to a national average of 14.4%. The Quality and Outcomes Framework (QOF) in 2019-20, which reports prevalence in adults aged 15 and over (rather than 18 and over), gives slightly higher figures again at 15.4% for Herefordshire and 15.5% for Worcestershire, with a national average of 15.9% and declining trends over the previous five years.

Data from 2014-15 suggests that in Herefordshire, prevalence of smoking in 15-year-olds was lower than the national average and all of its top-ranked CIPFA nearest neighbours. In contrast, smoking prevalence in 15-year-olds in Worcestershire was higher than the national average and four of its five top-ranked CIPFA nearest neighbours (

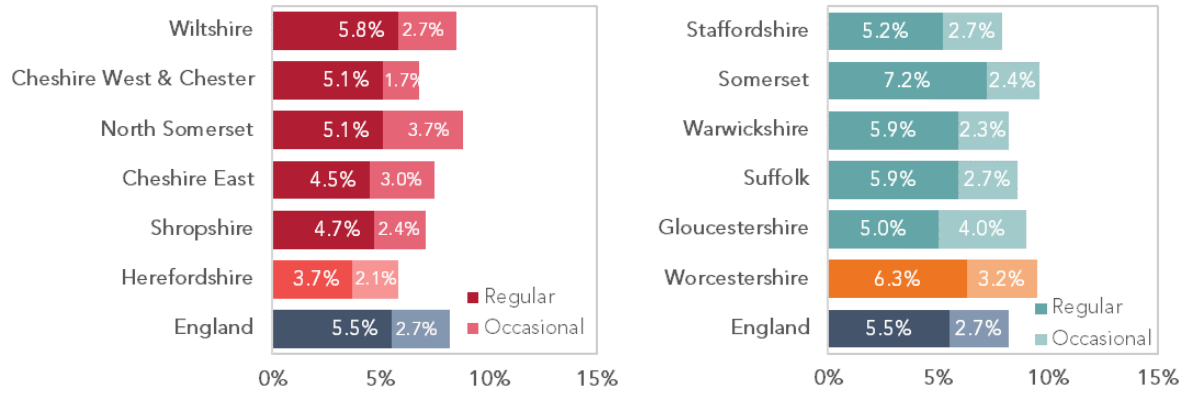


Figure 2) (PHE 2016).

Across Great Britain, 7.1% of adults used e-cigarettes in 2021, up from 5.7% in 2016 (ASH 2021). Region-specific data is not available. In 2014-15, 15.1% of 15-year-olds in Herefordshire and 18.9% in Worcestershire had tried e-cigarettes at least once, compared with a national average of 18.4% (PHE 2016); however, vaping practice and market development has changed significantly since this time.

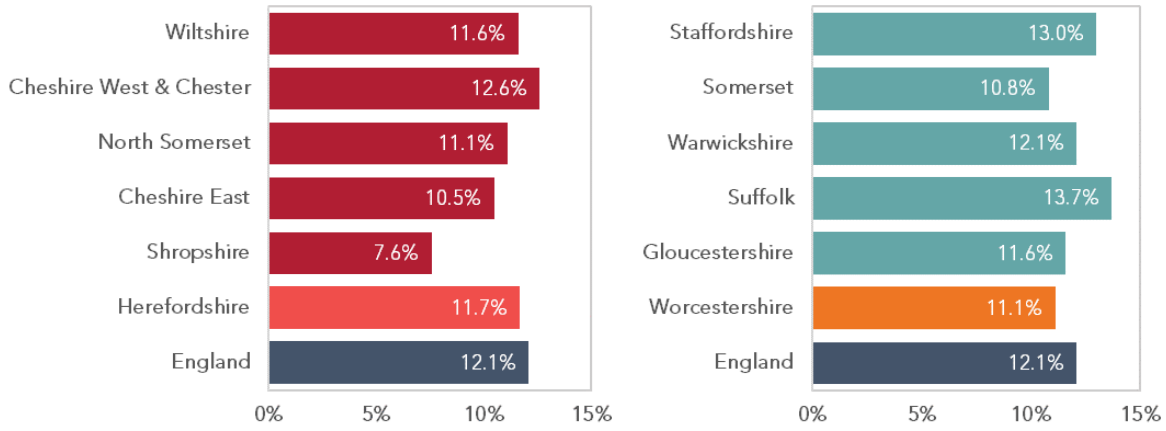


Figure 1: Smoking prevalence in adults in **(a)** England, Herefordshire, and Herefordshire's top-ranked CIPFA nearest neighbours and **(b)** adults in England, Worcestershire, and Worcestershire's top-ranked CIPFA nearest neighbours in 2020.

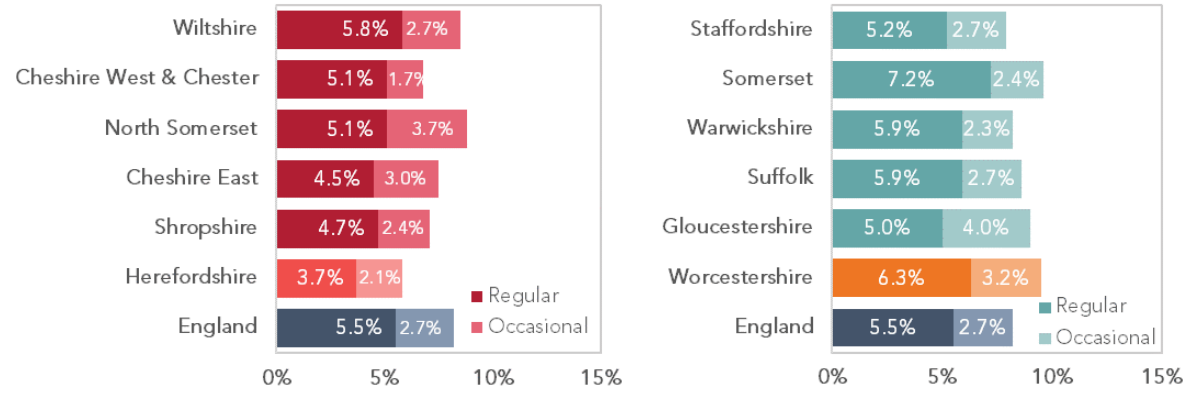


Figure 2: Smoking prevalence in 15-year-olds in **(a)** England, Herefordshire, and Herefordshire's top-ranked CIPFA nearest neighbours and **(b)** England, Worcestershire, and Worcestershire's top- ranked CIPFA nearest neighbours in 2014-15.

3.1.2 Characteristics of people who smoke

Age

Nationally, people aged 25-34 years had the highest proportion of smokers in 2019 (19%) and over 65 the lowest (7.8%). Data from the monthly UCL Smoking Toolkit Study indicates a large increase in smoking among the under-35s since the pandemic – up from 18% in 2019 to 24% in 2021 (PHE 2021).

In 2021, vaping was most prevalent among 35–44-year-olds (10.1%), followed by 45–54-year-olds (8.6%) and 25–34-year-olds (8.1%) nationally. Vaping was least common in the 18-24 and 55 and over age brackets (5% and 5.4% respectively). A youth survey in 2020 found a prevalence of 4.8% in 11–18-year-olds (McNeill et al. 2021).

In Herefordshire, 98% of Year 6 pupils said they had never smoked before and 1% of pupils had tried vaping once or twice (Herefordshire Council 2021). In secondary schools, reported prevalence of smoking and vaping were both higher, with 85% of pupils having never smoked before and 11% having tried vaping once or twice. 4% of pupils had smoked in the last seven days and 5% of pupils vaped sometimes or more often. This trend follows through into further education (FE), with 70% of students saying they had never smoked before, and 23% of students having tried vaping once or twice. 8% of FE students had smoked in the last seven days and 7% vaped sometimes or more often.

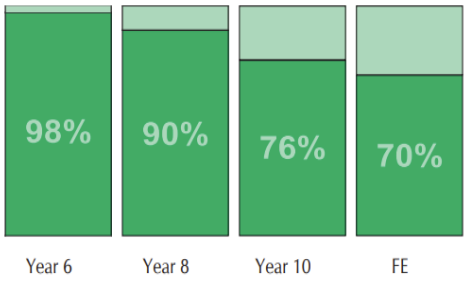


Figure 3: Proportion of students in Herefordshire who reported that they had never smoked in 2021. From Herefordshire Council Children & young people's quality of life survey 2021.

In Worcestershire, 97% of boys and 98% of girls in Year 8 reported never having smoked before (Worcestershire County Council 2021). 91% of both boys and girls in Year 8 reported never having vaped. No students answered that they had smoked in the last seven days or that they smoked at least 'occasionally', and 2% reported that they vaped at least sometimes. In Year 10, numbers reporting having never smoked before were lower, comprising 87% of boys and 85% of girls. Similarly, numbers having never vaped before were reduced to 77% of boys and 73% of girls. 3% of boys and 5% of girls in Year 10 answered that they smoked at least 'occasionally' and 7% of boys and 12% of girls reported vaping at least sometimes.

Economic status, qualifications, and employment

In England, smoking is more prevalent in the unemployed (26.4%) than in the employed (14.5%) or economically inactive (12%).

Nationally, smoking is more prevalent in those in routine and manual occupations (24.5%) than in intermediate (15.4%) or managerial and professional (9.7%) occupations. This trend is reflected in both Herefordshire and Worcestershire, but is more severe in Herefordshire, where smoking in routine and manual occupations has a prevalence of 25% (worst amongst CIPFA nearest neighbours; range 11.1-25%) compared with 18% (fourth best among CIPFA nearest neighbours; range 16.2-27.2%) in Worcestershire.

In England in 2019, smoking was more prevalent in those with no qualifications (28.3%) than in those with GCSE grades A*-C or equivalent (20%), GCE A levels or equivalent (15.6%), higher education (12.8%) or a degree or equivalent (7.3%).

In adults in England, smoking and vaping are both more common amongst those in NRS social grades C2DE (skilled working class, working class, and non-working; 15.5 and 8.1% respectively) than in those classified as ABC1 (upper middle, middle middle, and lower middle class; 10.6 and 6.3%). In contrast, smoking and vaping prevalence in 11–18-year-olds was found to be higher in grades ABC1 (7.1 and 5.3%) than C2DE (5.7 and 3.5%).

Ethnicity

In England, smoking is most prevalent in adults of mixed ethnicity (19.5%) and White ethnicity (14.4%) compared with Black (9.7%), Asian (8.3%) and Chinese (6.7%) ethnic groups.

The pattern is similar in young people, with 15-year-olds from White (9.2%) and mixed (9%) ethnic groups found to be more likely to smoke than those of Asian (2.6%), Black (2.4%) or other (2.9%) ethnicity in 2014-15 (Health & Social Care Information Centre 2015).

Gender

In both Herefordshire and Worcestershire, smoking prevalence is higher in men (14.1% and 12.3%, respectively) than in women (10.5% and 9.4%), reflecting national trends.

National data also suggests that vaping is more common in men (8.1%) than in women (6.2%) (ASH 2021).

Homelessness

Approximately 77% of people who are homeless smoke (Homeless Link 2014). Research suggests that the quantity they smoke is also very high, averaging more than 20 cigarettes per day compared to 11 cigarettes per day in the general population (Groundswell 2016, ONS 2017). In 2020-21, around 1100 households in Herefordshire and 2290 in Worcestershire were homeless or potentially homeless (Herefordshire Council 2021; Worcestershire County Council 2021).

Location & accommodation

In Herefordshire, smoking prevalence is generally lower than the national average in rural and semi-rural areas, with higher prevalence recorded in Hereford and market towns (Herefordshire Council 2017).

Compared with other measures of inequality, area deprivation (which combines factors such as income, employment, health, and education within an area) has been found to have

the greatest impact on someone's likelihood of smoking (ONS 2018). In 2016, persons living in the 10% most deprived areas of England were more than four times more likely to smoke than those living in the least deprived areas (ONS 2018). Less than 1% of the population in Herefordshire and around 5% of the population in Worcestershire live in areas that are in the 10% most deprived areas in England (Department for Communities and Local Government 2019).

People living in rented accommodation were more than three times more likely to smoke than those who weren't renting in 2016 (ONS 2018).

Mental health

In Herefordshire and Worcestershire, 40% and 37% of adults with serious mental illness were found to smoke in 2014-15 respectively, more than triple the prevalence in the general populations of each county. Although similar to the national average, Herefordshire ranks fourth worst out of 14 nearest neighbours for which this data is available.

	Smoking prevalence (%)	National smoking prevalence (%)	Difference from national	CIPFA rank (/16)	CIPFA range Smoking prevalence (%)
Herefordshire					
Adults with serious mental illness (2014-15)	40	40.5	Similar	11 (/14)	32.6 – 43.8
Adults with a long-term mental health condition (2020-21)	28.2	26.3	Similar	13	19 – 33.4
Adults with anxiety or depression (2016-17)	22.6	25.8	Similar	8	12.3 – 29.5
Worcestershire					
Adults with serious mental illness (2014-15)	37	40.5	Better	2	35.1 – 42.9
Adults with a long term mental health condition (2020-21)	26	26.3	Similar	13	19.3 – 27.9

Adults with anxiety or depression (2016-17)	22.5	25.8	Better	4	19.3 – 28.3

Mental health impacts of the COVID-19 pandemic have also influenced smoking behaviour in current smokers. A new nationwide survey of 2,000 current smokers has found that nearly half (45%) have been smoking more since the first lockdown began. Key reasons reported are due to being bored in the lockdowns (43%) or the COVID-19 pandemic making them more anxious (42%) (PHE 2021).

Pregnancy

In 2019-20, 13.9% of mothers in Herefordshire and 11% in Worcestershire were known to be smokers at the time of delivery, compared with a national average of 10.4% (NHS Digital 2021). In Herefordshire, this is an increase from 8.9% in 2015-16 (Herefordshire Council 2017).

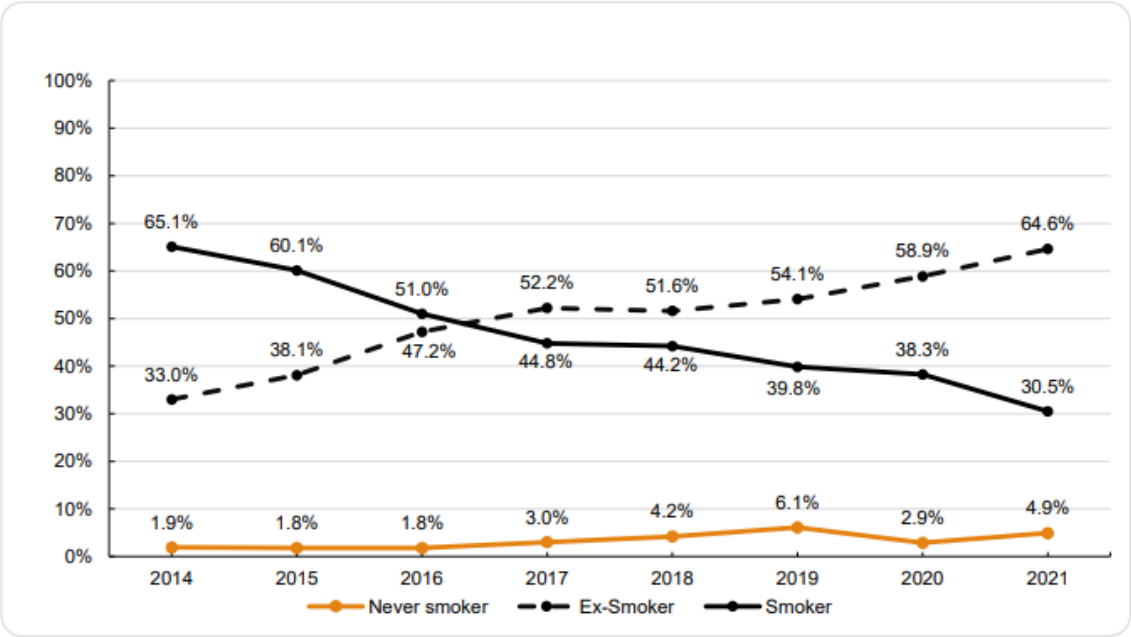
15.1% of pregnant women in Herefordshire and 14.2% in Worcestershire were found to smoke in early pregnancy in 2018-19, both significantly higher than the national average (12.8%). Herefordshire's prevalence ranks fourth worst among its CIPFA nearest neighbours (range 9-18.9%), while Worcestershire sits in the middle (range 10.9-18.1%).

Previous smoking behaviour

64.6% of current vapers are ex-smokers and 30.5% of vapers also currently smoke (ASH 2021). The main reason given by ex-smokers for vaping is to help them quit (36%) and then prevent relapse (20%). Similarly, the main reasons given by current smokers for vaping is to cut down (26%), help them quit (17%) and prevent relapse (14%).

11.9% of 11-18-year-olds in England report that they vape in order to quit smoking (McNeill et al. 2021).

Fewer than 1% of those who have never smoked are current vapers.



Unweighted base: GB adult vapers 2014, n=498; 2015, n=614; 2016, n=667; 2017, n=669; 2018, n=738; 2019, n= 854; 2020, n=787, 2021, n=826).

Figure 4: Current e-cigarette users (vapers) by smoking status. From ASH Use of e-cigarettes (vapes) among adults in Great Britain 2021.

Refugees, asylum seekers and other migrants

National figures show that overall, migrant men are more likely to smoke than UK-born men (19% vs 16%), whereas migrant women are less likely to smoke than UK-born women (10% vs 13%). Smoking is particularly prevalent in migrants from EU8 and EU2 countries, with 34% of men and 22% of women smoking (Migration Observatory 2019). In migrants from EU14 countries, smoking prevalence is 18% in men and 12% in women.

As of June 2021, an estimated 9% of the population of Herefordshire (approximately 17,000 people) and 10% of the population of Worcestershire (approximately 61,000 people) had a country of birth outside of the United Kingdom (ONS 2021).

Around half of migrants in Herefordshire are from Europe, with 24% from EU14 countries, 12% from EU8 countries and 12% from EU2 countries. In Worcestershire, 16% of migrants are from EU14 countries, 28% from EU8 countries, and 13% from EU2 countries.

60 Syrian refugees have been resettled in Herefordshire and over 100 in Worcestershire since 2016, and Herefordshire has agreed in principle to resettle a further 35 individuals from the Middle Eastern and North Africa (MENA) region (Herefordshire Council 2022). Worcestershire has also resettled 30 Afghan refugees since 2021 and agreed to welcome 200 more individuals in the coming years.

20% of male and 5% of female migrants born in the MENA region and 16% of male and 2% of female migrants born in South Asia smoke (Migration Observatory 2019).

As of December 2019, just 5 asylum seekers were living in the Herefordshire and Worcestershire CCG area (Midlands and Lancashire Commissioning Support Unit 2020).

Sexual orientation

In England, smoking is more prevalent in those of bisexual (19.8%) and gay or lesbian (19.8%) sexual orientation than in those of heterosexual or straight sexual orientation (14.6%) (ONS 2021). Based on data from 2016-2018, around 0.6% of the population in Herefordshire and 1% of the population in Worcestershire were of bisexual orientation, and 0.3% and 0.8% were of gay or lesbian sexual orientation, respectively (ONS 2020). More recent data is not available at local authority level but suggests that in the West Midlands, around 1.3% of the population are of bisexual orientation and 1.5% of gay or lesbian sexual orientation (ONS 2022).

Substance misuse

Smoking prevalence in adults admitted to treatment for substance misuse is significantly lower than the national average in Herefordshire. These figures may be inaccurate as it is captured at the point of assessment for drug and alcohol treatment (so may not be disclosed) and possibly not updated during treatment.

In Worcestershire, smoking prevalence is similar to the national average in adults admitted for treatment for opiate and alcohol misuse, but significantly worse for those treated for non-opiate misuse.

	Smoking prevalence (%)	National smoking prevalence (%)	National quintile (1st = best, 5th = worst)	CIPFA rank (/16)	CIPFA range Smoking prevalence (%)
Herefordshire					
Adults admitted to treatment for substance misuse – opiates (2019-20)	49.0	70.2	1st	2 (/14)	42.5 – 83.3
Adults admitted to treatment for substance misuse – non-opiates (2019-20)	40.9	62	1st	4 (/15)	30 – 88.9

	Smoking prevalence (%)	National smoking prevalence (%)	National quintile (1st = best, 5th = worst)	CIPFA rank (/16)	CIPFA range Smoking prevalence (%)
Adults admitted to treatment for substance misuse – alcohol (2019-20)	37.5	43.9	2nd	8	12.3 – 29.5
Worcestershire					
Adults admitted to treatment for substance misuse – opiates (2019-20)	72.6	70.2	3rd	8	50.7 – 90.9
Adults admitted to treatment for substance misuse – non-opiates (2019-20)	75.0	62	4th	11	48.9 – 85.7
Adults admitted to treatment for substance misuse – alcohol (2019-20)	40.1	43.9	3rd	2	34.4 – 58.5

3.1.3 Smoking support service usage and quit rates

In 2020-21, 27.5% of adults in Herefordshire and 28.9% of adults in Worcestershire were ex-smokers – higher than the national average of 27.1%, and more than twice as high as their percentage of current smokers.

More than half (52.7%) of adult smokers in Great Britain in 2019 said they wanted to quit, with 21.1% of current smokers intending to quit within the next three months at the time of interview (ONS 2020). Two-thirds of smokers with a mental health condition report wanting to quit, but face greater barriers to cessation, often smoke more and are more addicted (ASH 2019). National data suggests quit rates are higher amongst those in managerial and professional occupations than in intermediate or routine and manual occupations (Figure 5).

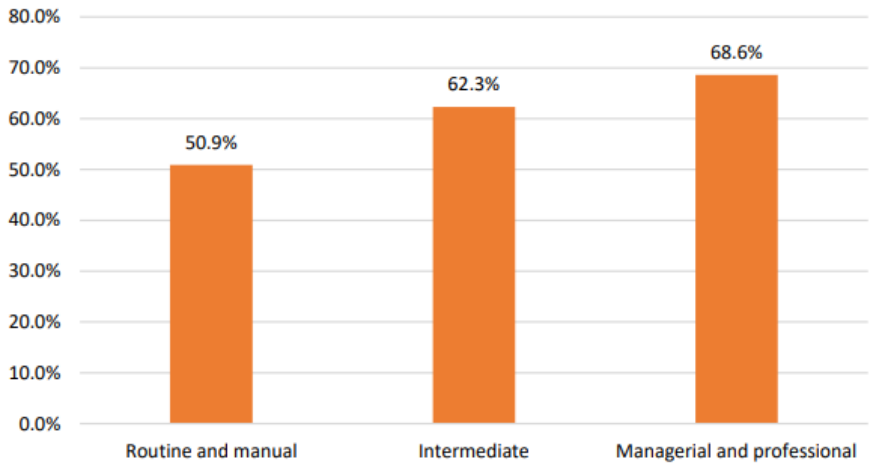


Figure 5: Percentage of cigarette smokers who quit by socio-economic classification. From ASH Health Inequalities Briefing 2019 based on data from ONS Adult smoking habits in the UK: 2016

E-cigarettes are now the most popular aid used by smokers to help them quit; in 2020, 27.2% of people used a vaping product in a quit attempt, compared with 15.5% using NRT and 4.4% using varenicline (McNeill et al. 2021). Evidence suggests that vaping is nearly twice as effective as nicotine replacement therapy in helping smokers to quit in a Stop Smoking Service setting in England (Hajek et al. 2019). In 2019, 50% of vapers agreed with the statement 'Vaping is a medicine that I use in order to address my smoking addiction' (ASH 2021). The current evidence base is clear that when conducted safely, vaping is far less harmful than smoking, although the effects of long-term e-cigarette use are yet to be fully determined (CRUK 2021).

Smoking cessation services in Herefordshire and Worcestershire

Since early 2020, Herefordshire Council has provided a universal Stop Smoking service that offers free, expert personal support to anyone living in the county or registered with a Herefordshire GP, and that can provide NRT/medication for up to 12 weeks. This can be accessed through self-referral as well as via health professionals, including through maternity services. Prior to the COVID pandemic, there were eligibility criteria attached to the service, and anyone wishing to access stop smoking support had to be referred. The eligible groups were:

- Pregnant smoker or their partner
- Patients with a Q risk score greater than 10 as identified via an NHS Health check
- Patients awaiting an operation
- High-risk patients identified via QoF e.g. mental illness, substance misuse, cardiovascular disease, COPD, asthma, diabetes, lung cancer
- Staff from Wye Valley NHS Trust/H&W Health Trust

Worcestershire County Council offers targeted smoking cessation services to pregnant women and their household members. Pregnant smokers are identified through an opt-out pathway within the maternity booking process (all pregnant women with a CO reading over 4 at booking are referred to the service). Three smoking advisors are based within the maternity hubs at Worcester, Kidderminster and Redditch and are embedded within the locality midwifery teams. Support is provided through one-to-one appointments, where service users can obtain NRT at the point of contact. Appointments are held within both clinic and community settings to meet the needs of the service users. In June 2022, a new postnatal smoking service started delivering support to women and other members of the household with an infant under 12 months. NRT is offered at point of contact. Support is also available via Lifestyle Advisors, who can help with behaviour change in relation to a range of health and wellbeing issues including smoking but cannot offer NRT. This service can be accessed by referral from a GP.

Service usage and quit rates in Herefordshire and Worcestershire

In Herefordshire, the number of smokers setting a quit date in 2019-20 was significantly lower than the national average (1,853 vs 3,512 per 100,000 respectively). This ranks Herefordshire fourth worst amongst its CIPFA nearest neighbours (range 669-6,482 per 100,000). The number of prescriptions for nicotine replacement products was 5,129 per 100,000, significantly lower than the national average (11,781 per 100,000). 28.2% of those that set a quit date had successfully quit at their 4-week follow-up. However, the number of people accessing Stop Smoking support increased during the pandemic when the service became universally available (from 571 in 2019-20 to 790 in 2021-22), and early indications suggest that quit rates have improved (Herefordshire Council 2022). The proportions of people referred to the service for different reasons has also changed since the onset of the pandemic, with pregnant smokers increasing from around one third to around half of referrals, and the percentage of people referred due to long term conditions decreasing significantly (Figure 6). The proportions of people from areas of differing levels of deprivation has remained consistent from 2019 to 2022, averaging 46% from more deprived areas (deprivation quintiles 1 and 2), 18% from less deprived areas (Q4 and Q5) and 35% in the middle (Q3). Public Health England also state that there has been an increase in the number of people trying to quit smoking during the pandemic, with over a third of smokers attempting to quit in the three months up to June 2021.

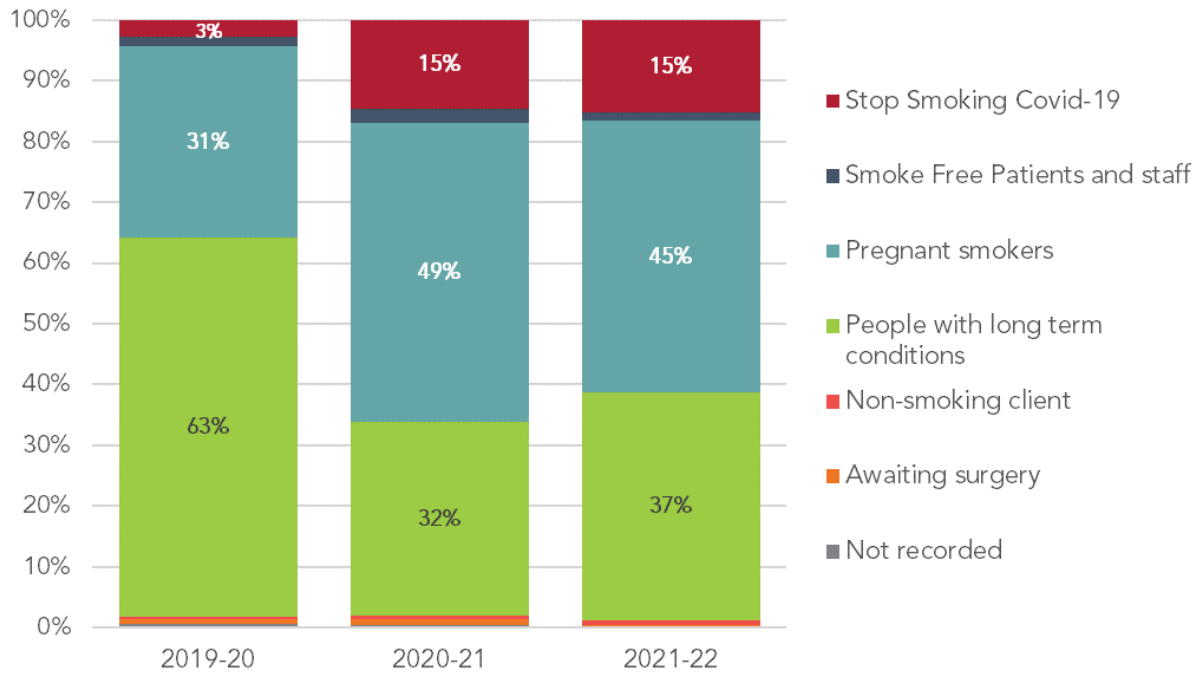


Figure 6: Percentage of clients referred to the Herefordshire Stop Smoking service by referral category. Data from Herefordshire Council 2022.

Published data from 2019-20 show that significantly fewer smokers set a quit date in Worcestershire (871 per 100,000) compared to the national average (3,512 per 100,000) and CIPFA nearest neighbours (range 503-6,557 per 100,000). However, this is due to the provision of a targeted rather than universal/population-wide Stop Smoking service. 127 people (14.6% of those that had set a quit date) had successfully quit at their 4-week follow-up.

In Worcestershire, 334 pregnant women set a quit date in 2021-22 (Worcestershire County Council 2022). Based on 5,571 maternity bookings in 2020-21 and an estimated 14% of women smoking in early pregnancy (in previous two years), the number setting a quit date represented just under half of pregnant women estimated to be smoking. 36.2% were successful in quitting smoking at 4 weeks, compared with 37.5% amongst the general population, and a further 21.2% were successful at 12 weeks. 82.3% of pregnant women setting a quit date were aged 18-34, 13.5% were aged 35-44 and 4.1% under 18. The majority were of White British (84.1%) or other White background (10.2%). A significant proportion were employed in routine and manual occupations (39.8%) or were long-term unemployed or sick/disabled and unable to work (27.5%). 65 household members of pregnant women (90.8% of whom were men) also set quit dates in 2021-22, 38.5% of whom were successful at 4 weeks and a further 16.9% at 12 weeks.

In Herefordshire, 159 pregnant women were referred to the Healthy Lifestyle Stop Smoking Service between January 2019 and February 2020. Based on 1,522 pregnancies in 2019 and an estimated rate of smoking in early pregnancy of 15% (2018-19), this represented over two-thirds of all pregnant women who smoked in Herefordshire. 28% of those referred accessed the service, but of these, 64% only attended one appointment and 36% quit on their own. 20% of those who accessed the service attended three or more appointments and only 11% successfully quit using the service (equivalent to 3% of the total number of people referred). Feedback from the service suggested that some users preferred to cut down/quit on their own and that many would prefer to be seen at home instead of having to travel for appointments.

3.1.4 Smoking-related hospital admissions and deaths

Both Herefordshire and Worcestershire have similar or lower rates of smoking-attributable hospital admissions and mortality compared with the national average, although in some cases figures are higher than the majority of their CIPFA nearest neighbours.

Smoking-related mortality in Herefordshire has fallen from 235 per 100,000 persons in 2015 to 167 per 100,000 in 2019-20 and is lower than nationally, although hospital admissions have remained stable (Herefordshire Council 2021). Similarly, smoking-related mortality in Worcestershire has fallen from 239 per 100,000 persons in 2016 to 165 per 100,000 in 2019-20. Neonatal mortality rates are significantly worse than the national average in both Herefordshire and Worcestershire.

	N per 100,000 persons	National *n* per 100,000 persons	Difference from national	CIPFA rank (/16)	CIPFA range *n* per 100,000 persons
Herefordshire					
Smoking-attributable hospital admissions (2019-20)	1,340	1,398	Similar	12	816-1672
Smoking-attributable mortality (2017-19)	167	202	Better	9	123-208
Smoking-attributable mortality from heart disease (2017-19)	29	29	Similar	15	19-30

	N per 100,000 persons	National *n* per 100,000 persons	Difference from national	CIPFA rank (/16)	CIPFA range *n* per 100,000 persons
Smoking-attributable mortality from stroke (2017-19)	9	9	Similar	8	7-10
Smoking-attributable mortality from cancer (2017-19)	69	90	Better	3	60-94
Stillbirth rate (2018-20)	290	390	Similar	5 (/15)	230-480
Neonatal mortality rate (2018-20)	480	280	Worse	15 (/15)	180-480
Worcestershire					
Smoking-attributable hospital admissions (2019-20)	1426	1398	Similar	10	949-1609
Smoking-attributable mortality (2017-19)	165	202	Better	3	159-229
Smoking-attributable mortality from heart disease (2017-19)	22	29	Better	1	22-36
Smoking-attributable mortality from stroke (2017-19)	8	9	Similar	4	8-10
Smoking-attributable mortality from cancer (2017-19)	75	90	Better	4	71-100
Potential years of life lost due to smoking related illness (2016-18)	1,046	1,313	Better	3	1021-1538
Stillbirth rate (2018-20)	410	390	Similar	16	230-410

	N per 100,000 persons	National *n* per 100,000 persons	Difference from national	CIPFA rank (/16)	CIPFA range *n* per 100,000 persons
Neonatal mortality rate (2018-20)	400	280	Worse	15	180-410

3.2 Public engagement

The results for the public engagement are not presented by county, as it is too complex to draw conclusions of results collected by three different methods and by county. There were also too few respondents per different target group to differentiate by county; and there were no differences by geography found in the responses or discussion held in the two counties.

3.2.1 Online survey respondents

The majority of the 400 respondents to the online survey described themselves as current smokers (55%) or ex-smokers (24%) (Figure 7). This is higher than the prevalence in the population.

60% identified as female, 39% male, and 1% non-binary (higher rate of females than in the population).

Most respondents identified as straight/heterosexual orientation (92%), with 4% identifying as bisexual, 2% gay or lesbian and 1% pansexual. So a higher proportion of online survey respondents identified as LGBTQ+ compared to the population.

People aged 45-64 were best represented in the survey responses (50%), followed by those aged 25-44 (33%) (Figure 8). Fewer than 5% of respondents were aged 24 and below or 75 and above. Working age respondents were over-represented in the survey compared to the population in the two counties.

Most respondents spoke English as their main language (98%), and the majority were White English/Welsh/Scottish/Northern Irish/British (93%) or Other White background (3%). This reflects the population in Herefordshire and Worcestershire.

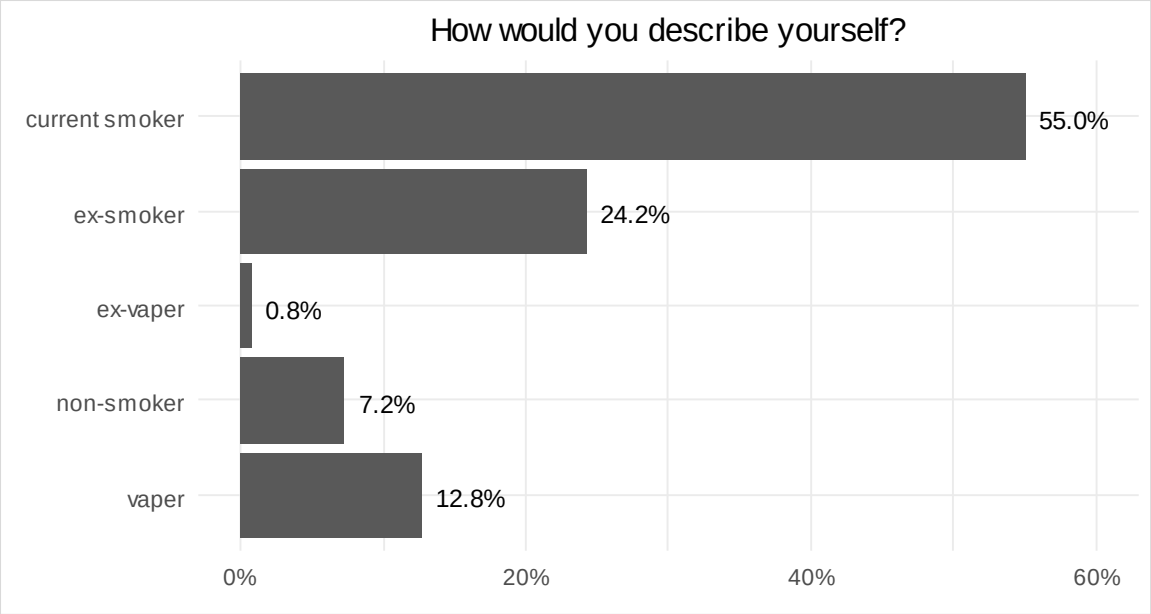


Figure 7: Responses to the online survey question 'How would you describe yourself?' (*n* = 400).

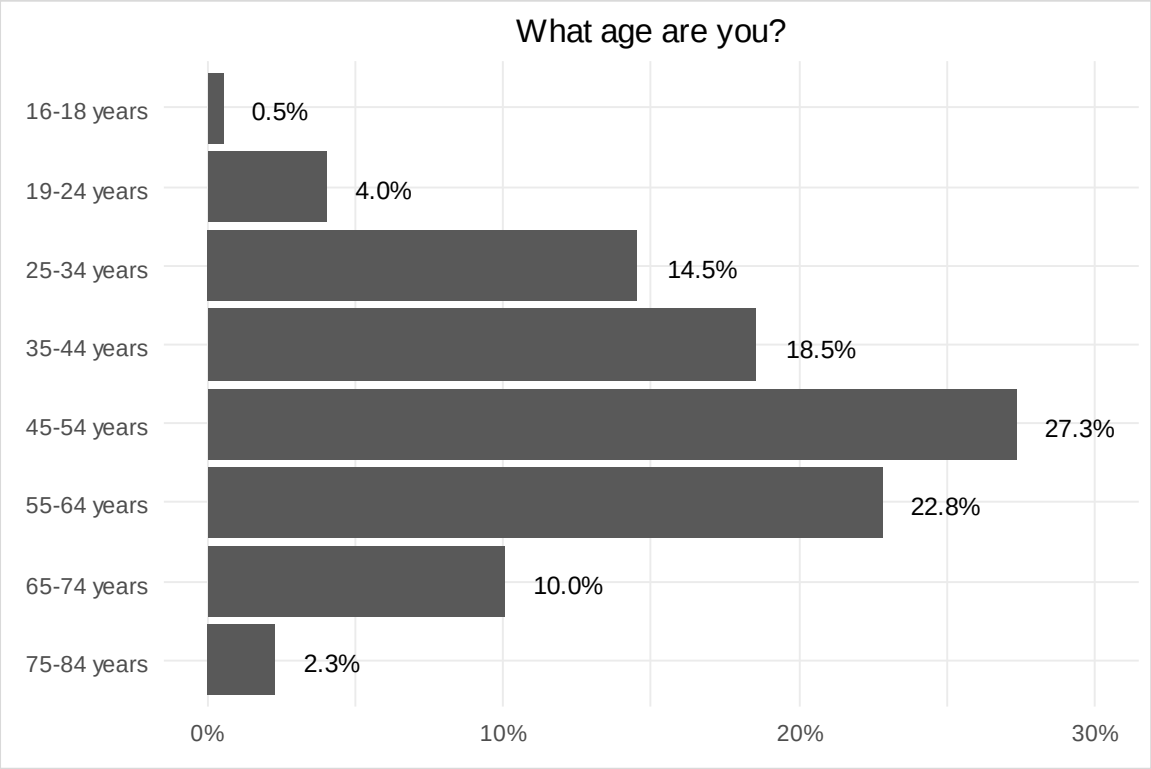


Figure 8: Responses to the online survey question 'What age are you?' (*n* = 400).

Approximately two-thirds of respondents were currently in employment (57% employees and 10% self-employed) (Figure 9). This is fairly similar to the population as a whole. The remainder of respondents were most commonly not working due to long-term ill-health or

disability (13%) or because they were retired (11%). However, these rates for not able to work or retired are lower than the rates for wider population. Almost half of respondents (47%) reported having long-standing health conditions or disability, which is higher than the wider population.

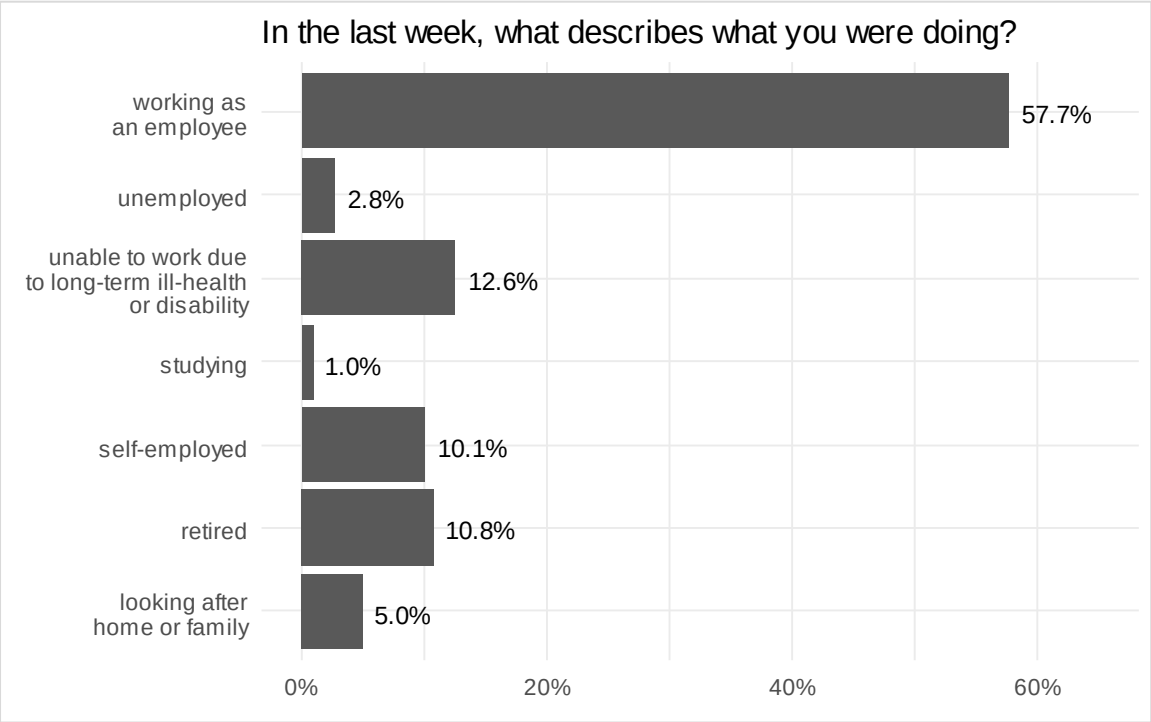


Figure 9: Responses to the online survey question 'In the last week, what describes what you were doing?' (*n* = 400).

Most were currently staying in their own home (50%) or in a rented house/flat (45%) (Figure 10). Respondents were much more likely to be renting or staying with friends or family than the wider population.

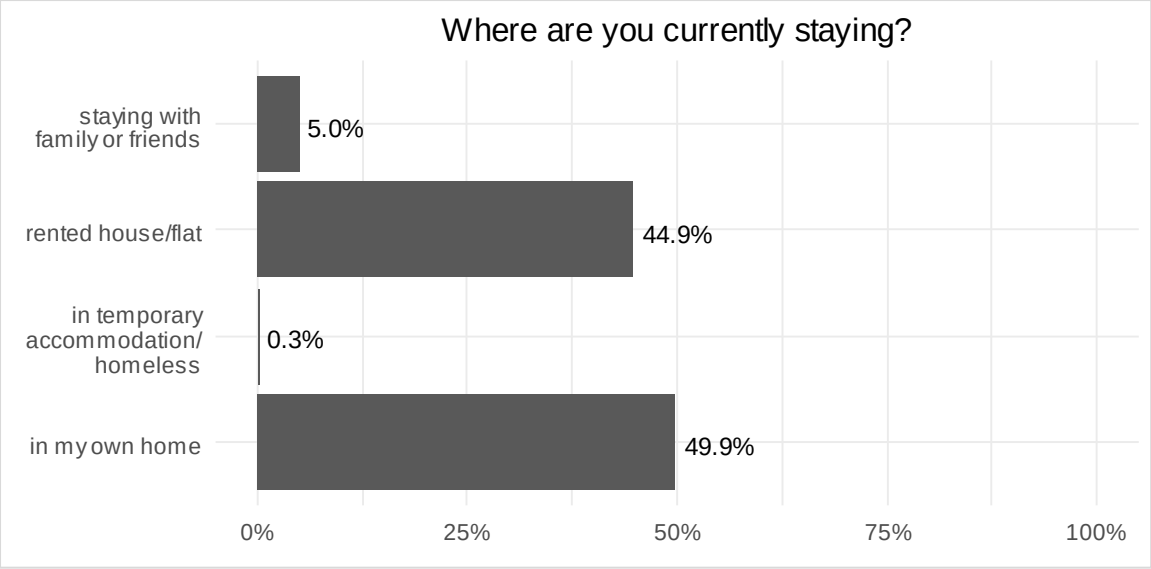


Figure 10: Responses to the online survey question 'Where are you currently staying?' (*n* = 400).

Respondents were distributed across Herefordshire and Worcestershire, with concentrations around Hereford and Leominster in Herefordshire, and Worcester, Malvern and Kidderminster in Worcestershire (Figure 11).

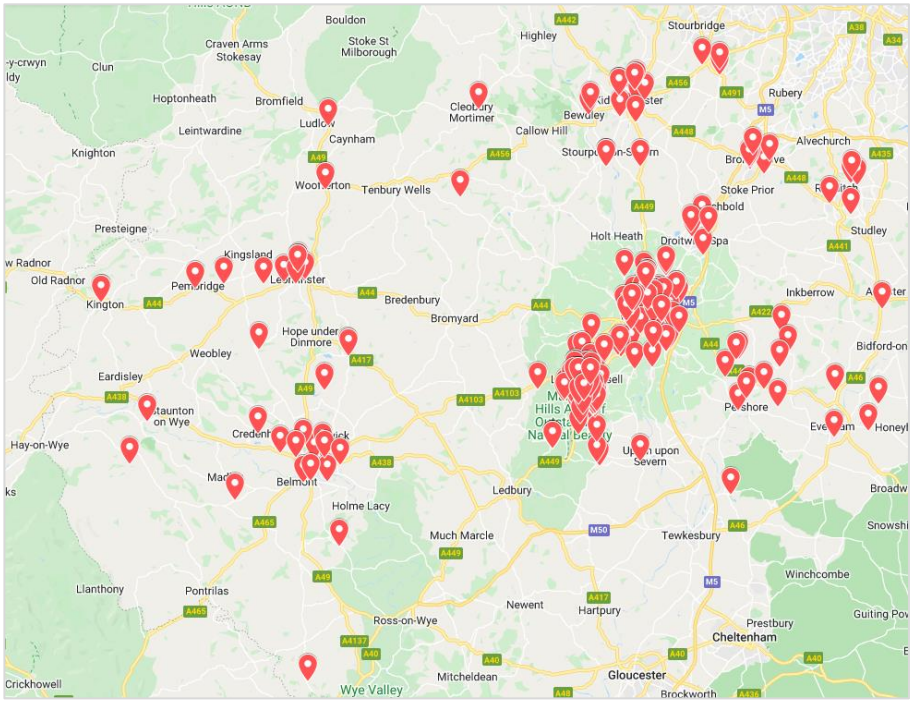


Figure 11: Map of postcodes of online survey respondents across Herefordshire and Worcestershire.

Pharmacies/chemists, supermarkets, and doctors' surgeries/medical centres were the most commonly mentioned places that people use to shop or access services (Figure 12). A

number of respondents also mentioned shopping or accessing services online. Malvern was the most frequently mentioned geographical area, with specific locations identified including Barnard's Green, Malvern Retail Park and Malvern Link. Respondents also mentioned accessing services in Worcester, Pershore, Bromsgrove and Droitwich in Worcestershire, and Leominster, Hereford, Kington and Ledbury in Herefordshire.

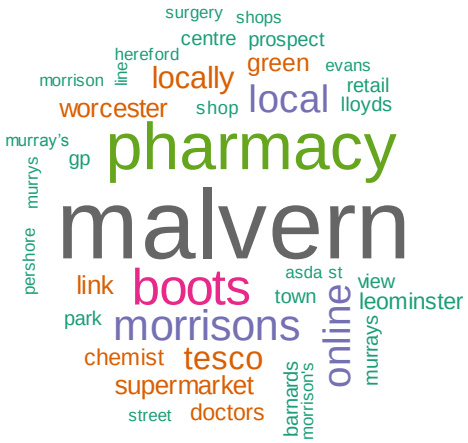


Figure 12: Word cloud of most common words used in response to the question 'Where do you usually shop or access services?' (*n* = 353). The larger the word, the more frequently it was used.

3.2.2 Interview respondents and focus group participants

64% of the 146 interview respondents identified as smokers, 43% as vapers, 25% as ex-smokers and 2% as ex-vapers, with one non-smoker. A few pregnant women were also interviewed but it was difficult to find pregnant women smoking in public.

Approximately half of the 29 focus group participants identified as current smokers; mostly roll-ups, with several pipe-smokers, and a couple that smoked marijuana too. 24% identified as vapers; 21% as ex-smokers; several identified as ex-vapers and 7% as non-smokers.

50% of those who were engaged via interviews or focus groups identified as male, 45% female and 4% as non-binary or other.

37% were aged 16-24 years; 32% aged 45-64; 24% aged 25-44; and 7% aged 65-84. This was a younger age profile compared with the wider population.

58% were in work (employee or self-employed); 12% unemployed; 12% students; 11% unable to work due to ill-health or disability; 6% retired; 1% looking after home or family. This represented a higher proportion of people who were not working compared to the population.

45% lived in rented accommodation (higher than in the population), 20% in their own home, 31% were staying with family or friends and 4% in temporary accommodation/homeless. This represented a much higher proportion who stay in rented accommodation, with family and friends or in temporary accommodation/homeless compared with the population.

46% of the interview respondents said they had a long-standing health condition or disability, much higher than in the population.

90% stated they are White British, 5% White Other and 5% other ethnicities. 90% spoke English as a first language. This represented a higher proportion of non-White British ethnicities compared with the wider population.

63% of focus group participants described themselves as heterosexual and 37% as lesbian, gay, bisexual, or pansexual. This was a much higher proportion of LGBTQ+ compared with the population.

Personal circumstances disclosed during the discussions were: previously homeless, ex-offender, heavy alcohol consumer, mental health issues, drug user, unpaid and full-time carer for family member, previously in care as a child/young person.

Interviews and focus groups were conducted in a range of locations in Herefordshire and Worcestershire as shown in the map (Figure 13: Map of home postcodes of respondents engaged via interviews or focus groups across Herefordshire and Worcestershire.). Interviews were at a variety of locations targeted towards the desired groups of people including outside pubs, vaping shops, supermarkets and near places where routine and manual workers are employed. Focus groups were located at places where particular groups of people already receive support from organisations.

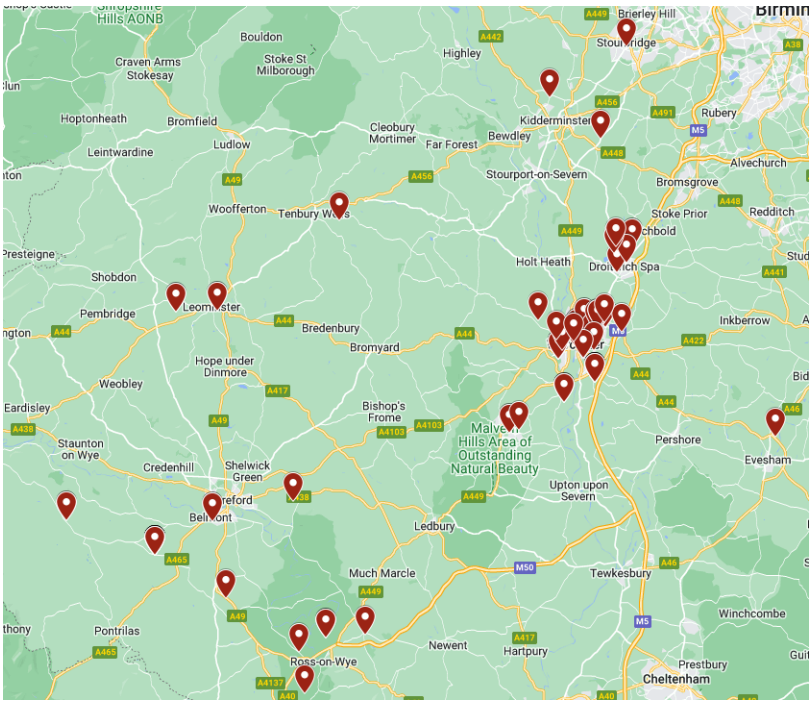


Figure 13: Map of home postcodes of respondents engaged via interviews or focus groups across Herefordshire and Worcestershire.

3.3 Smokers and attitudes to smoking

3.3.1 Profile of smokers

220 of the online survey respondents were current smokers - just over half - with a higher proportion of those interviewed and the focus group participants (65%).

58% of the online respondents who were current smokers were female, 41% were male and 1% were non-binary, similar to the overall proportion of survey respondents. The profile of smokers for those engaged face-to-face, was similar to all engaged in this way: half identified as male, just under half as female and 3% as non-binary or other.

All respondents who currently smoke were much more likely to identify as LGBTQ+ compared to ex-smokers, vapers or non-smokers.

Around half of the online respondents who were current smokers were between the ages of 45 and 64. 31% were between the ages of 25 and 44, and 5% under 25 - similar to the overall profile of all respondents. Those who were interviewed or took part in the focus groups who were current smokers had a younger age profile with a third aged 16-24 and a quarter aged 25-34, as per the overall profile of those engaged face-to-face.

Online respondents who currently smoke were more likely to have a long-standing health condition or disability (60%) than ex-smokers (33%), vapers (35%) or non-smokers (24%). A similar pattern was noted among those interviewed and focus group participants.

Of the online respondents, current smokers were more likely to be retired (14%), unable to work due to long-term ill-health or disability (19%) or be unemployed (4%) than ex-smoker, vaper, or non-smoker respondents. They were least likely to be working as an employee (46%) or self-employed (9%) and most likely to be renting (56%) or in temporary accommodation/homeless (1%). This pattern was not observed among those interviewed and in focus groups.

3.3.2 Age and motivation for smoking

Most smokers (70% of online survey participants, 87% of those interviewed, nearly all the focus group participants) were between the ages of 12 and 19 when they started smoking (Figure 14). Friends smoking, coping with stress, enjoyment and boredom were factors that were most likely to have played a part in motivating respondents to smoke based on the online surveys (Figure 15). A similar pattern emerged in the interviews except that 'helps me socialise' was mentioned by around one third of participants. Keeping weight down and helping concentrate/stay alert were least likely to have influenced smoking.

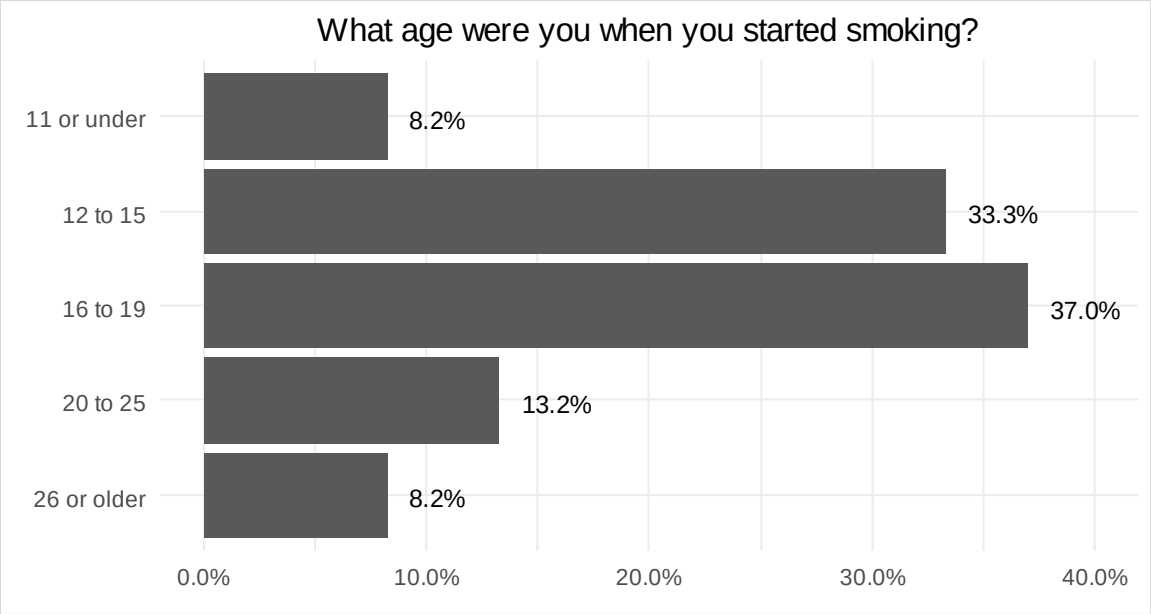


Figure 14: Responses to the online survey question 'What age were you when you started smoking?' (*n* = 220).

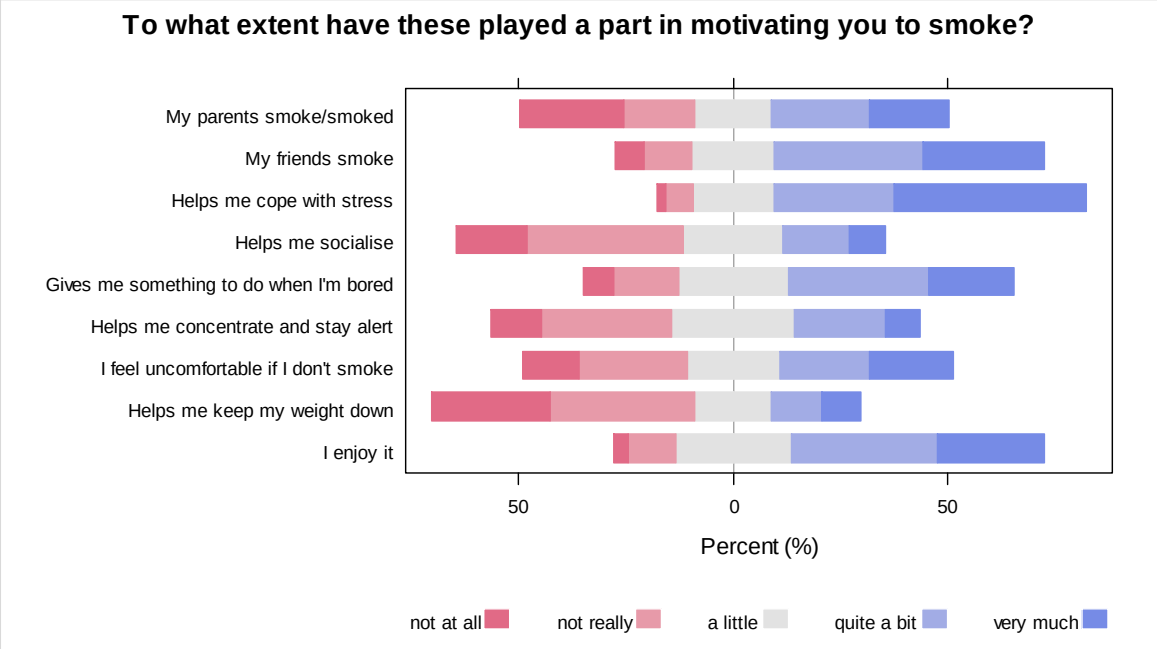


Figure 15: Responses to the online survey question 'To what extent have these played a part in motivating you to smoke?' (*n* = 220).

Participants in the focus groups and interviews were also asked what motivated them to keep smoking.

Over 80% of participants mentioned that they were influenced by having friends who smoke and/or that smoking helped them to socialise. Several participants mentioned a sense of belonging, feeling part of a tribe of fellow-minded people - a sense of belonging, that it

builds rapport, and is a great leveller regardless of where or who they're having a smoke with (work, pubs, clubs, theatre). A couple of participants mentioned that it can defuse a potentially violent situation in the streets or in prison e.g. ask for a light.

"At school it gives the feeling of 'one of us' and as you get older it helps you connect with other people."

"When I was working at X, all the smokers used to know what was going on as we used to talk outside - the non-smokers didn't know what was going on as they didn't talk so much together. Same in relationships - strong if you smoke together!"

"I work behind the bar so the only time I met the payroll manager was in the smoke shed, which was cool."

"I started my first job being much younger than my colleagues and didn't feel like I knew anything and was terrified on my first day, but could only confess that feeling to some of them in the smoke shed!"

Enjoyment of smoking was also frequently mentioned by over 80% of those interviewed or in focus groups. Most of the smokers in the focus groups mentioned the force of habit, with smoking being associated with particular situations like with a cup of tea on a break from work, with a glass of wine or beer, after a meal, in social situations, or post-coital.

"Like the ritual of roll-ups/pipes. Sometimes will do it even though I can't light up."

"Addicted to the habit not the nicotine. I smoked the same brand, ritual to find the pack of ciggies, make a cup of tea, sit in my favourite spot on the step to have a break. "

"Just habit. Not even enjoying except for the first one."

"Use tobacco for other purposes."

Over half of participants mentioned that smoking helped them to cope with stress. Some of the stressors mentioned by participants were unemployment, being a full-time/unpaid carer, abuse, debt problems, homelessness, and bereavement. Participants indicated that

smoking helped them to feel like they were escaping from that situation and having to deal with it.

"Calms me down. I received a letter about my debt recently and I went through a pouch of tobacco and a bottle of Jack Daniels, which helped for a bit."

"Helps me cope with stressful social situations - I go for a smoke if I want to get away from people and go outside."

"More accessible than a therapist. Particularly at the moment with the massive increases in the cost of living"

Several participants reported being influenced by their work environment (chef, bar staff, factory work) smoke and smoke breaks were part of working routine, where you get to know people regardless of job role and find out information.

"Hospitality sector - most people smoke on their breaks. LGBTQ+ people more likely to work in this sector too."

Several participants (particularly those in focus groups who were unemployed) mentioned that boredom and not having enough to do motivates them to smoke.

Several participants mentioned that smoking helps them to cope with low mood or mental health issues (anger, sadness, depression, anxiety).

"I'd like to stop but can't give up until I've received help for my mental health. I've been waiting for primary care for 7 years."
[participant with ADHD, autism, PTSD]

Several felt that smoking was less harmful than other addictions and/or that the way they smoked or their other lifestyle choices mitigated the risks.

"I gave up alcohol and drugs. Smoking keeps me from self-harming or worse, and helps keep me on the level. Semi-acceptable addiction compared with drugs or self-harming."

"Smoking pipes and cigars is not as harmful as smoking cigarettes as I don't inhale."

"My only vice. I don't drink alcohol."

3.4 Quitting smoking

3.4.1 Profile of ex-smokers

97 online survey respondents and 35 of those who were engaged face-to-face identified as ex-smokers. Ex-smoker respondents had a similar gender profile to all respondents, but less likely to be aged under 25.

Ex-smokers were more likely to be in work or studying compared to all respondents and to smokers. They were less likely to be unable to work due to long-term ill-health or disability or unemployed compared with to all respondents and to smokers.

Online respondents who were ex-smokers were most likely to live in their own home compared with current smokers, vapers and non-smokers.

42% of online respondents who were ex-smokers had given up smoking more than 5 years ago, 32% between 1 and 5 years ago and 26% within the last year (Figure 16). 88% of respondents gave up when they were between the ages of 25 and 64 (Figure 17). Around one-third of respondents were able to quit on their first attempt, with another third taking 2-3 attempts and the remainder taking more than 4 attempts (Figure 18).

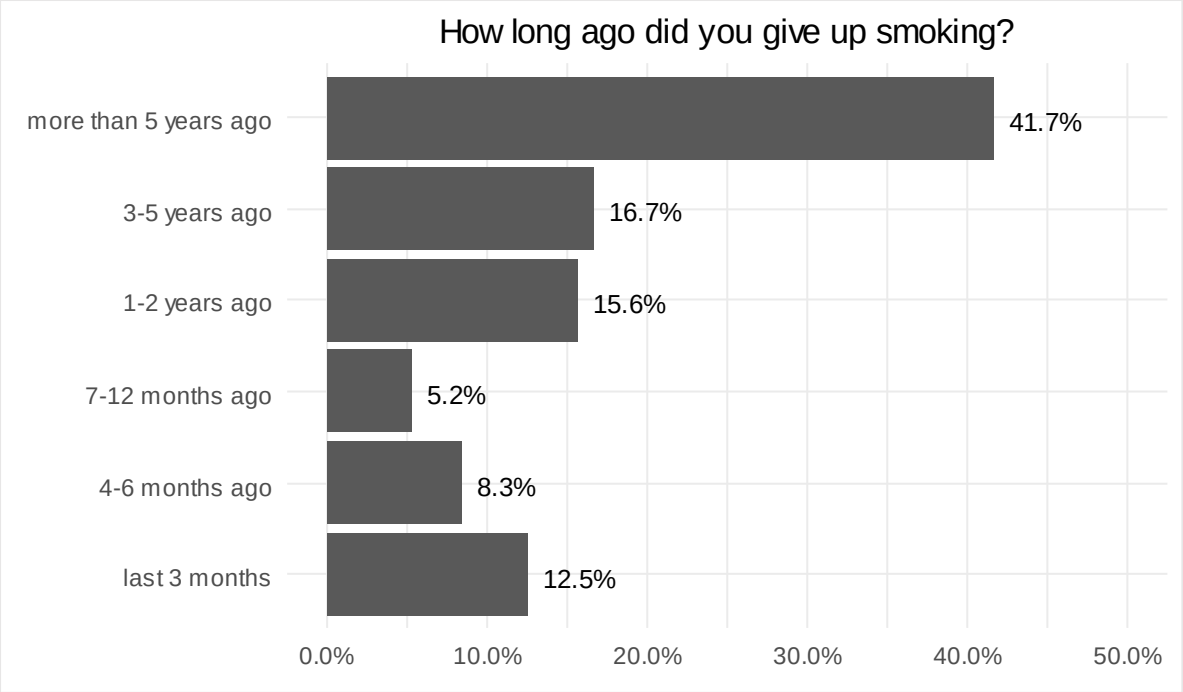


Figure 16: Responses to the online survey question 'How long ago did you give up smoking?' (*n* = 97).

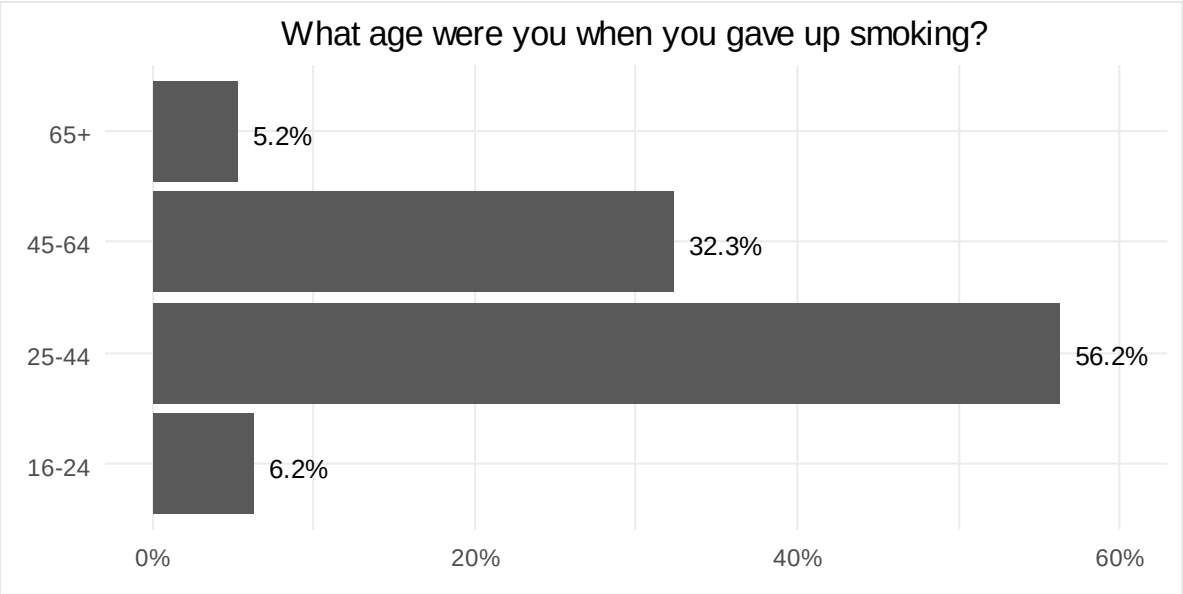


Figure 17: Responses to the online survey question 'What age were you when you gave up smoking?' (*n* = 97).

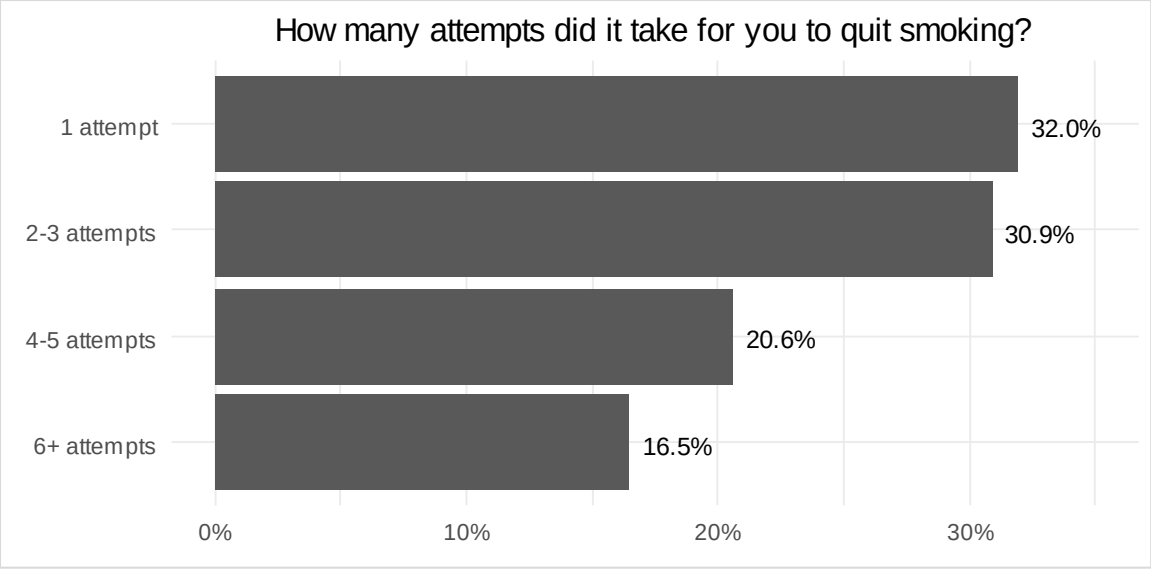


Figure 18: Responses to the online survey question 'How many attempts did it take for you to quit smoking?' (*n* = 97).

3.4.2 Attitudes and motivation to stop smoking

Just under two-thirds (61%) of current smokers responding to the online survey said that they would like to quit. 26% said 'maybe', and 13% did not want to quit. Half of those interviewed and in focus groups said they would like to try and quit smoking. a quarter were unsure and a quarter said they did not want to quit.

Including those who were currently trying, 89% of online survey respondents who were current smokers had attempted to quit at least once, with most having tried a couple of times and given up (Figure 19). Only just over half of those who were interviewed and in focus groups had tried to quit but given up trying and a third said they hadn't ever tried to quit.

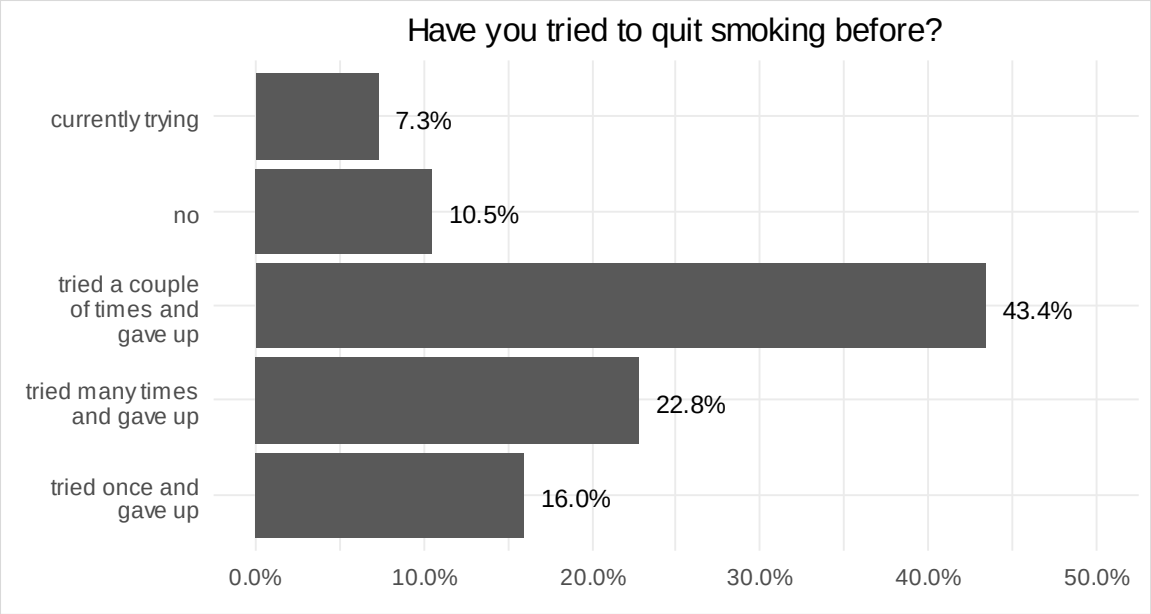


Figure 19: Responses to the online survey question 'Have you tried to quit smoking before?' (*n* = 220).

Almost two-thirds of online survey respondents wanted to quit because they were worried about their future health, and nearly half already had smoking-related health issues (Figure 20). Over two thirds of those engaged face-to-face wanted to quit for their future health, One-fifth of all respondents (online and in person) wanted to give up smoking for their family's health.

"When my grandmother died of lung cancer, most people in my family stopped smoking and started vaping."

"My dad was a heavy smoker but gave up (as did I) after he had 3 heart attacks."

"Tipping point was walking up a hill with my 9 year old son going to school - I was wheezing and thought I'm done, I need to give up!"

Only a couple of participants had tried to quit due to COVID-19.

"I have been trying to give up for decades. Finally did after getting really ill from Covid and thought 'I can't breathe, so I can't have a cigarette.' No point. Felt like I was dying."

Between 60 and 65% of all respondents who wanted to quit was because smoking was too expensive. Some participants from both the online survey and interviews mentioned pressure from their partner/family. Some were put off by the smell of smoke, disliking the smell of it in their house and so were only smoking outside. One quitter said kissing her husband now tasted disgusting, so she asked him to stop smoking too, and he did.

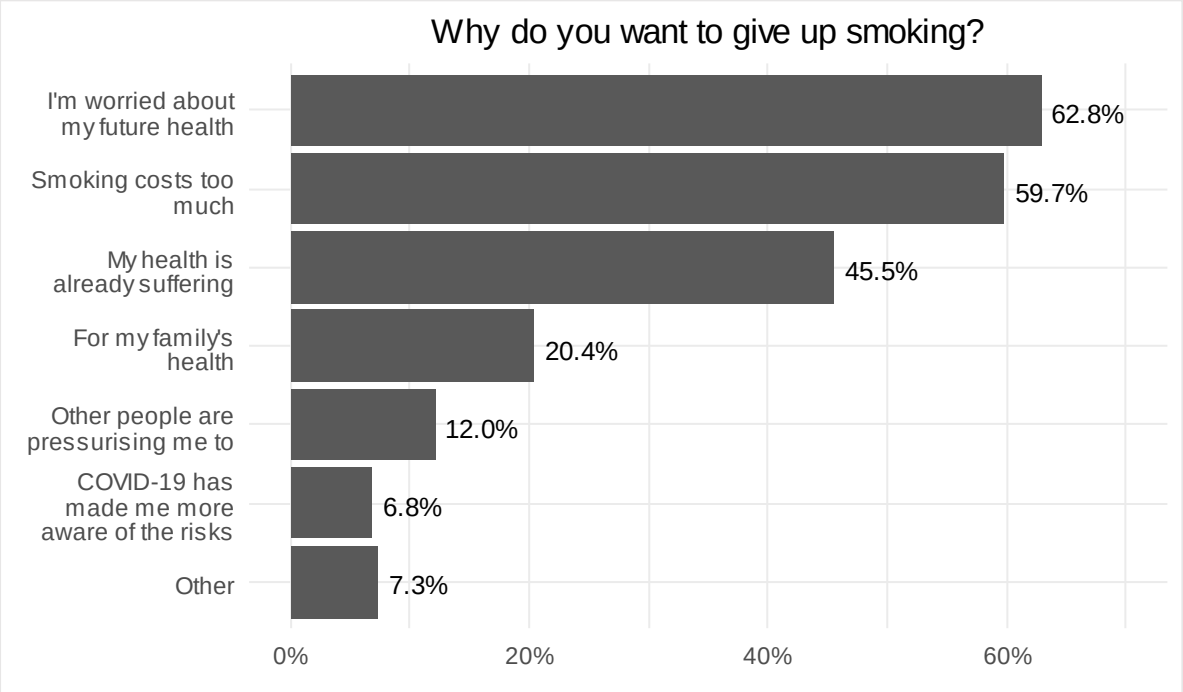


Figure 20: Responses to the online survey question 'Why do you want to give up smoking?' (*n* = 191).

A trans male participant said that he was advised not to smoke while having transition health care (testosterone and before operations). He did cut down but didn't stop smoking completely. Trans females are also apparently advised to do so. There was a discussion as to whether this was just general 'healthy lifestyle' advice or whether they would be at higher risk. This led onto a discussion about doctors and nurses having to advise people to stop smoking as a standard response - despite in some cases being smokers themselves.

3.4.3 What helped or would help people to give up smoking

A variety of factors helped online survey respondents to quit smoking. The most commonly mentioned were nicotine replacement, support from friends and family, e-cigarettes/vaping and the expense of smoking (Figure 21). About half of those interviewed or in focus groups who had quit smoking, were helped by e-cigarettes/vaping and a lower proportion by nicotine replacement.

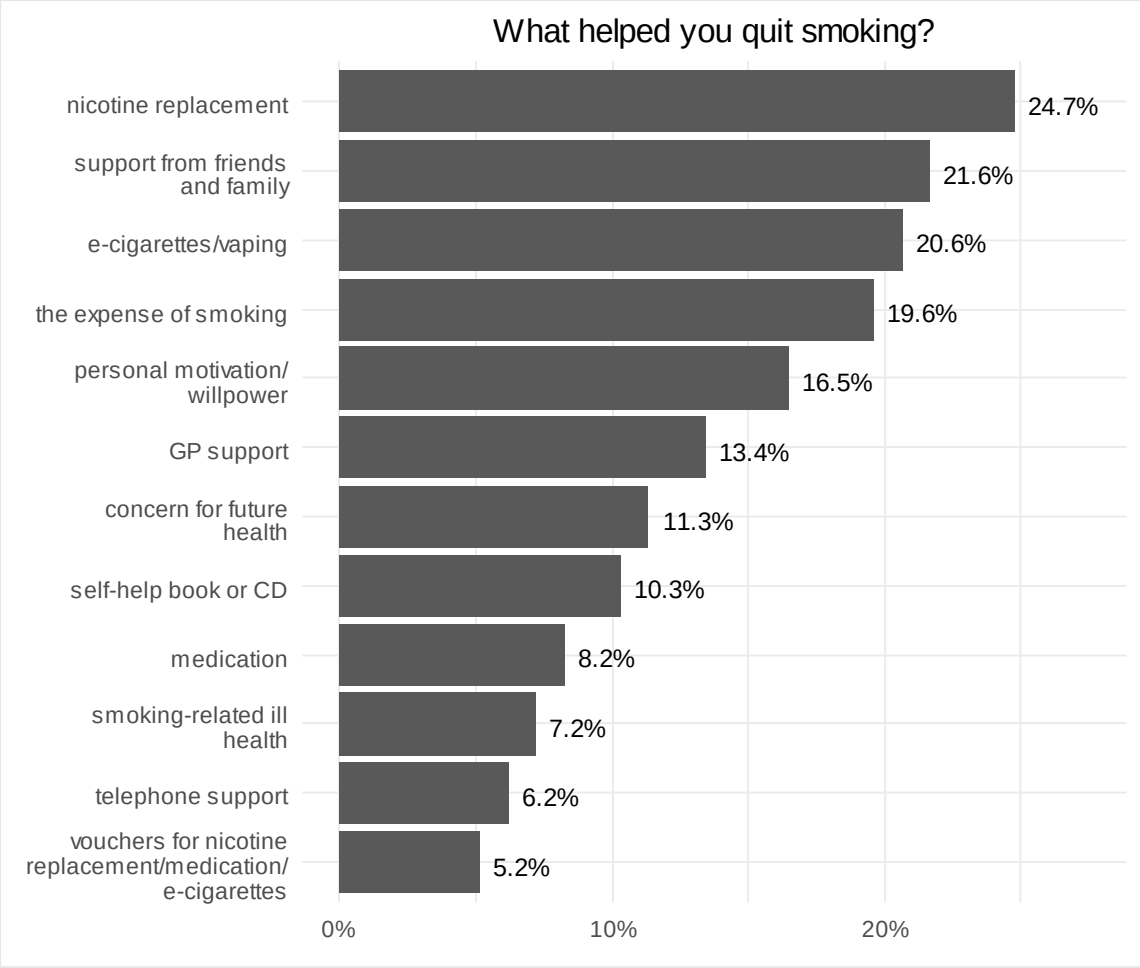


Figure 21: Responses to the online survey question 'What helped you quit smoking?' (*n* = 97).

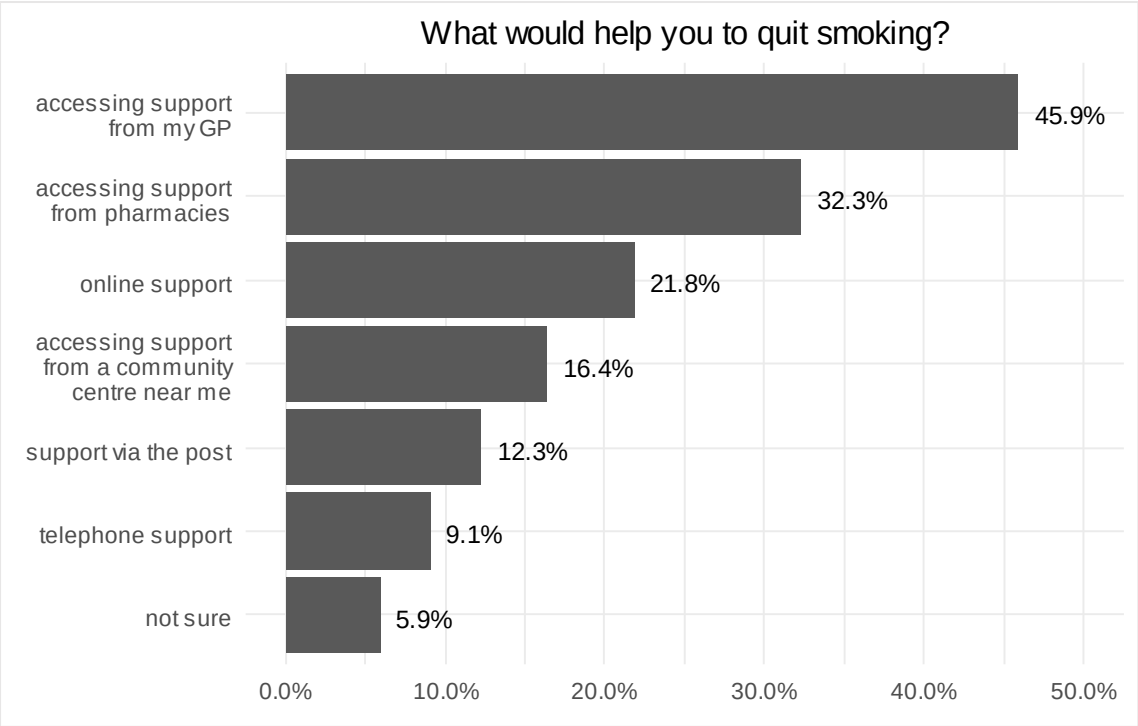


Figure 22: Responses to the online survey question 'What would help you to quit smoking?' (*n* = 220).

Online respondents (including current and ex-smokers) were most likely to say that accessing support from their GP, a pharmacy or online would help them to quit (Figure 22). Accessing support from a GP was stated by a fifth of those interviewed and only 13% said online support would help them to quit. Most interviewed or in focus groups gave other reasons - mainly willpower or wanting to quit in the first place.

"I hate smoking. And it's so expensive to stop smoking. And little help from doctors makes it so hard."

"More help is needed for this addiction, help is available for drugs and alcohol."

"Would be nice to get help from NHS."

"Can't get a GP appointment unless an emergency so unlikely to get one to help stop smoking."

"Got a letter from the GP saying they weren't going to be offering smoking cessation support even though the CCG expects it?"

"My GP thinks it's fine but not my dentist."
[pipe smoker]

One participant had been trying to quit for years but as yet not managed to do so successfully, despite *"hating the addiction and habit of it"*, having emphysema, and having had part of a lung removed. They had tried vaping, hypnotherapy, and nicotine replacement therapy. The only thing that seemed to really help was jogging – doing 'Couch to 5K' in 6 weeks – but they then got injured and couldn't jog any more.

One participant who gave up smoking due to COVID-19 during lockdown said most of her friends still smoke, which is difficult – *"I may need to find new friends"*.

Three interview participants and six online survey respondents said that the Allen Carr method helped them to quit successfully after trying other methods. Seven had read his book, and one attended an in-person workshop after her father had successfully quit using his method. All interview participants who used the Allen Carr method mentioned having a better understanding of the psychology behind why they smoked which helped them break the habit and remain ex-smokers.

When asked for any other comments about quitting smoking, a common theme amongst responses in both the online survey and interviews/focus groups was the need for strong personal motivation to quit.

“It is doable if you really want to do it. But there is an entire industry feeding off the fact that too many people don’t really want to stop.”

“It's hard and being preached to makes you less inclined to give up.”

“I have tried for about thirty years and I was okay when I quit but when a crisis happened I used to return to them as I did not have a back up plan. This time I am on my tenth month and use nicotine chewing gum and this eases the withdrawal symptoms.”

“It's up to the smoker to decide. The addiction is such that the smoker needs to want to in their own mind. They have to want to themselves pressure over costs, from peers etc will not sway them for the long term.”

"I knew the risks but continued nonetheless - even watching my mum die of lung cancer - I went straight outside and smoked. Didn't want to give in to people telling me what to do as I want to live in a liberal and non-judgmental society. Even having given up smoking, I'm not anti-smoking - I've made my peace with it and don't need it anymore."

Breaking the habit and associated activity was the key for many.

“Break the habit and association with certain activities like on a break with a cup of tea."

“It was really hard, but the hardest is the habit (not the smoking) and it is mostly in your head. Humans are creatures of habit.”

“Some people find it quite easy to quit but for others it is very difficult and this should not be underestimated by clinicians.”

“Stop smoking bootcamp - take time away from usual routine, change of scene. Like lockdown.”

A number of respondents mentioned needing more support and cheaper nicotine replacement options. There was also a mixed picture of success with nicotine replacement - it had helped a couple of people but not all. Similarly, several people have partners who are now vaping instead of smoking, but had tried vaping and did not get on with it so continued to smoke.

"My partner tried nicotine replacement medication but it was really difficult to get it between shifts and where we live."

"Champix tablets may have helped a bit to replace the buzz you get from smoking but stopped them after 3 weeks. It took 12 weeks to break the habit – using the Allen Carr book really helped. You've got to prepare yourself mentally."

"Was buying nicotine replacement patches and vaping liquid but expensive... I only smoke rolled tobacco, one small pouch a week is cheaper than replacement nicotine."

"Nicotine replacement worked for me, but my pet hate is the instructions or 'guidance' of what stage you should be at and when - off-putting. Need to find your own way. My husband and I still occasionally use them to stop the cravings, even after 2 years."

Several also mentioned the association of stress and mental health with how empowered they feel to quit smoking.

"I can quit when I want but tend to start again when stressed. When the stress eases and I feel more positive I can quit more easily."

"Because my parents smoked and my mother's severe illness is directly related to smoking, I had never had the desire to smoke - hated it. Friends wouldn't offer me one despite most of them being smokers. I wouldn't date anyone who smoked etc. During my teens my anxiety rapidly increased and I would have nightmares that I needed a cigarette and that I was desperately searching for my cigarettes. These became more regular, intense and stress inducing into my early 20's and when I was 23 I started smoking and the dreams stopped. When I quit smoking I sometimes manage for 6 months-1 year but my nightmares and general anxiety increase and I cannot cope with it because of my inability to get back to

sleep. Lack of sleep makes my depression and dissociation very bad. Mental health is key to my choice to smoke and to continue."

Other suggestions about what has helped or would help people stop smoking from interviews and focus groups included:

- Replacement activities: art, hobby, doing something to occupy the hands or mind (not television), going to the gym, jogging, crocheting, 'being busy', working with animals.
- Mindfulness, 5-finger technique and elastic band snapping.
- Meditation to reduce anxiety or give the same feeling of solitude and calm.
- Stop selling it in shops - there was some debate about whether this would be effective or not as it wouldn't stop people from getting it on the black market if they really wanted it. Pipe tobacco bought online without being asked to prove age. Participants mentioned smoking all sorts of things when they couldn't get tobacco (tea, pine needles, lawn grass, paper). *"He'd smoke the Bible he would."*
- Being supported not to smoke by workplaces e.g. previously HGV driver and never smoked in the cab. One focus group participant suggested employers provide games to play at work in breaks to break the habit of having a smoke on a break.
- Free starter kits for vaping.
- Help people build their self-esteem so they make healthier choices.

"I feel it's a very serious addiction but support is not there as it is with illegal drugs."

"More help should be available as with other addictions."

"Spend a day with someone with COPD"

"I think smoking/vaping can almost be considered a form of self-harm, as you know it's bad for you and damaging, but you keep doing it anyway. I definitely felt that the more self-esteem, happiness and care for myself I felt, the less I wanted to smoke. I also would use smoking/vaping as an appetite suppressant as I had some unhealthy ideas on how to stay thin when I was more mentally ill. Ultimately, I think people can be supported to stop smoking/vaping if they have better self-esteem and genuinely care

about their health, wellbeing, and future. Also, if they are taught healthy coping mechanisms and made to feel worthy and important!"

"So much choice on stop smoking, I have no idea what to try and it's not exactly cheap to try out to find it's not right and you throw it away. Testers would be good so then know what to buy."

3.4.4 What didn't help people to quit

Nicotine replacements and e-cigarettes not being effective were the most common reasons given for being unable to quit successfully by online survey participants (Figure 23). Similarly, a quarter of those who were interviewed or in focus groups said nicotine replacement didn't work and just under a third said e-cigarettes didn't work.

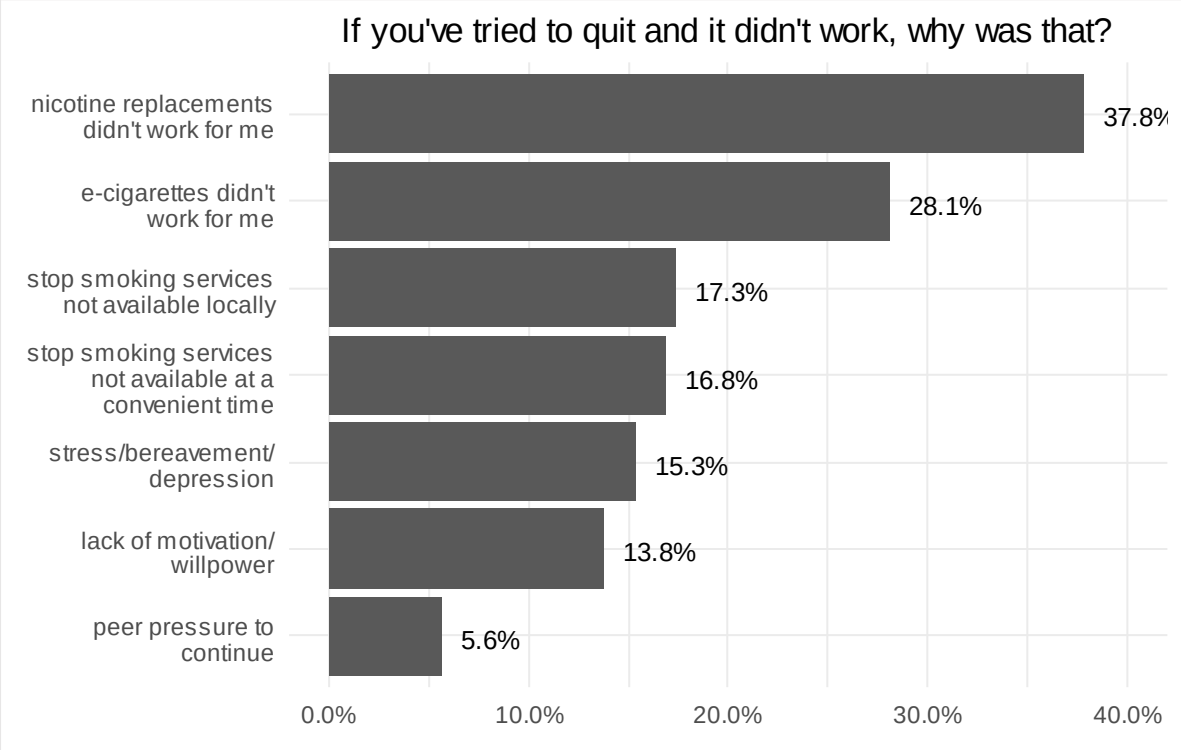


Figure 23: Responses to the online survey question 'If you tried to quit and it didn't work, why was that?' (*n* = 196).

Other reasons that people could not or did not want to quit smoking that were mentioned in focus groups included:

"*Lack of willpower and stress*"

- Enjoying it too much, particularly the social aspects; there was the perception that smokers are nicer people, more fun and more tolerant (even expressed by an ex-smoker).

"When I was working at X, all the smokers used to know what was going on as we used to talk outside - the non-smokers didn't know what was going on as they didn't talk so much together. Same in relationships - strong if you smoke together!"

"I will be boring if I stop smoking. Parties with smokers are much more fun."

"Only treat/vice - I enjoy it. I don't drink alcohol. Don't smoke at work during the day but have one with a cuppa when I get home and then after a meal. 'Mum's having her pudding now'."

- Cost did not seem to be as much of a barrier for current smokers who did not want to quit. Several mentioned that they'd promised themselves that they'd give up smoking once a packet of cigarettes reached a certain price (e.g. £2 or £5) but still didn't stop even after it reached £10 a packet.
- Health warnings on cigarette packets did not motivate people to quit.

"Just laugh at the scary pictures on the packets."

"You have to decide - horrible pictures don't help."

- People found it difficult to break the habit/routine of smoking, such as after meals, when out socially, when bored, unemployed or just having *"nothing to do with my hands"*.

"My parents didn't smoke but my boyfriend did. Going on holiday, I brought back cheap cigarettes. Gave up for 6 years but then I had a car accident. The doctor advised to smoke to cope with injuries. I used to belong to a stop smoking group (to get off work too) which didn't help. Bought books and CDs but only the one by Pat Worder and Allen Carr helped. My trigger used to be when making a phone call."

- Knowing the risks is not enough to stop people smoking. One participant said that cancer used to be perceived as terminal in the past, but now many are treatable so *"if I get cancer, I will probably survive"*. Another participant had a grandmother who smoked all her life into her 70s but died a week after stopping smoking.
- Smoking is not as socially acceptable now as when many of the participants started smoking – however, feeling judged by society isn't necessarily a barrier. It makes some people even more determined to stay a smoker, encouraged by other smokers.

"Labelling people as addicts makes them think they can't help themselves and is a good excuse for many, rather than 'you can do this if you want to'."

3.5 Vapers and attitudes to vaping

3.5.1 Profile of vapers

51 of the 400 online respondents identified as vapers. A higher proportion of respondents who were vapers were female compared with the overall distribution amongst respondents.

61 of those engaged face-to-face were vapers, who were more slightly more likely to be non-binary/other compared to the overall profile of those engaged face-to-face.

The age profile of online respondents who vaped was slightly younger (43% aged under 44) compared to all respondents (38%). The age profile of those engaged face-to-face who were vapers was much younger (just over half) compared with all those engaged face-to-face, smokers and ex-smokers.

Respondents and participants who were vapers were more likely to be in work compared with smokers. Vapers were less likely to be retired compared with smokers, ex-smokers or non-smokers. They were less likely to be unable to work due to long-term ill-health or disability than current smokers, but more likely than ex-smokers. They were less likely to have a long-term limiting illness or disability compared to the overall profile of those who were engaged.

3.5.2 Age and motivation for vaping

82% of online survey respondents started vaping when they were over 25 (Figure 24). However just under half of those interviewed and in focus groups started vaping in their late teens. Online survey respondents were most likely to have been motivated to vape as an alternative to smoking, followed by coping with stress and boredom (Figure 25). Online

respondents were least likely to have been motivated to vape because their parents or friends did. Nearly all those interviewed and in focus groups started vaping as an alternative to smoking, with most also doing so because it helps them socialise and because their friends vape. About half also vape to cope with stress and 'gives me something to do when I'm bored' but to a lesser extent than the online survey respondents - possibly because of the different age profile.

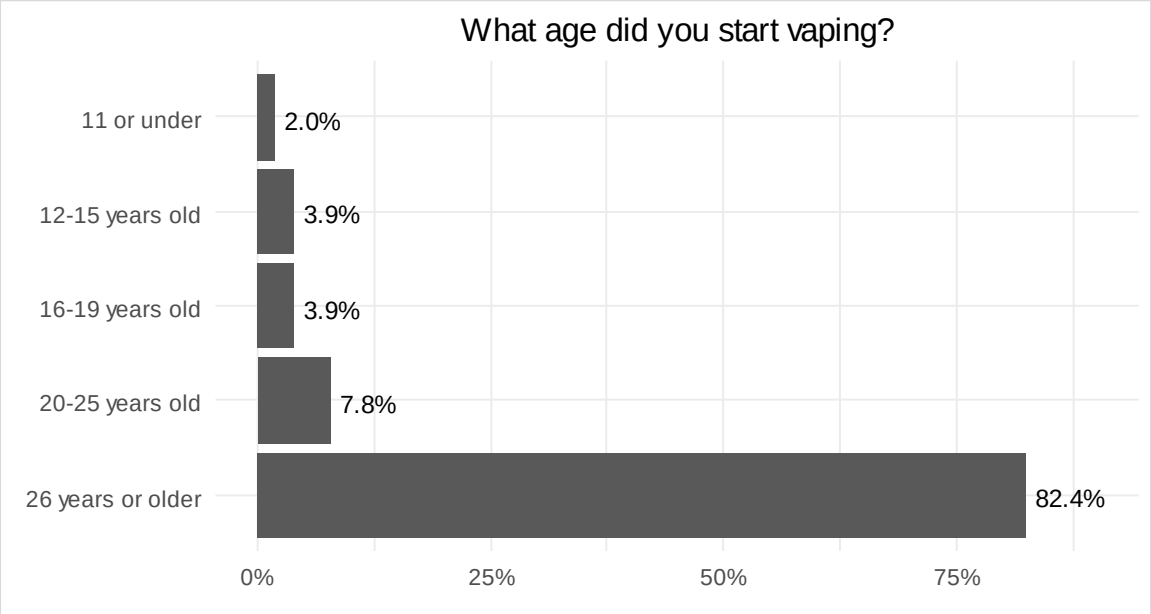


Figure 24: Responses to the online survey question 'What age did you start vaping?' (*n* = 51).

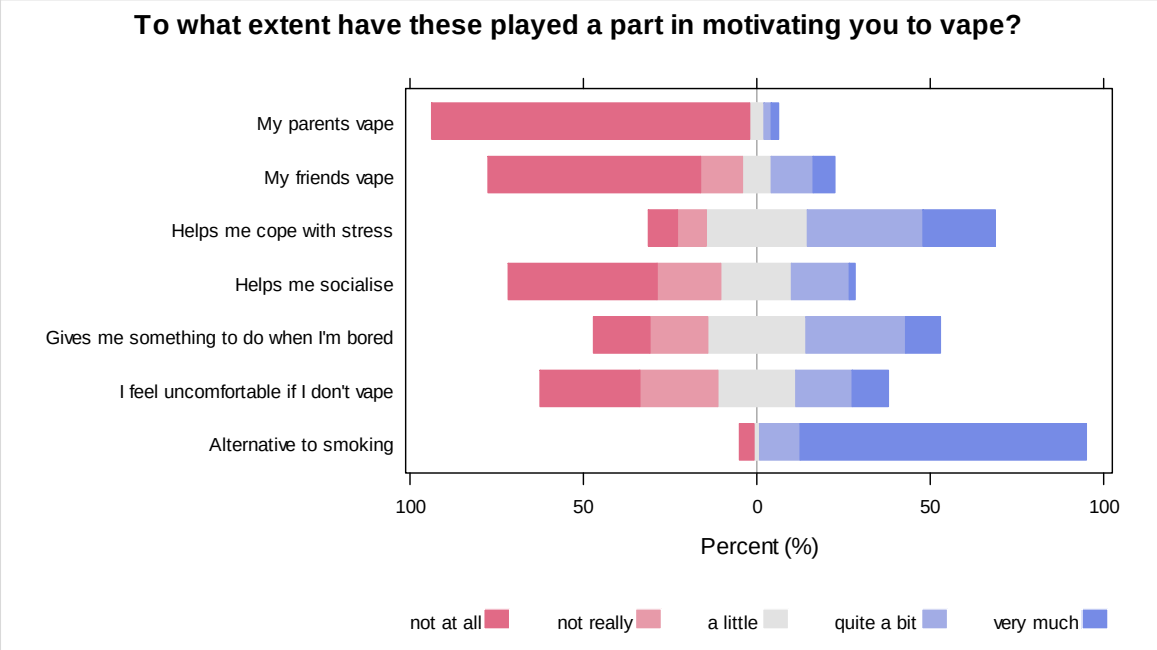


Figure 25: Responses to the online survey question 'To what extent have these played a part in motivating you to vape?' (*n* = 51).

"Flavours are nice and vape tricks are fun to do."

It takes a while for people to master the technical aspects of vaping so some people persevere and others not. One participant who spent time in prison said smoking was banned so they all had to convert to vaping. Vaping equipment was then used for negotiation and trading to keep him safe, whereas cigarettes had been used previously.

"Tried vaping for 12 months, gave up, gave me a dry throat. Husband was a heavy smoker and gave up, has been vaping ever since."

"I started vaping to stop me smoking but also from eating sweet things. I like the sweet flavours."

There are some perceptions that vaping is bad for you, if not worse than smoking - popcorn or bubble lung[1] was mentioned. People also mentioned that it was cheaper to keep smoking, particularly for pipe-smokers.

"Vapes have all sorts of ingredients in them which are unregulated or untested - you know where you are with tobacco."

Several people also mentioned that *"you can continually vape and inside the house rather than coming to the end of a cigarette and having a break from sucking stuff into your lungs"*. This was a source of contention with those living in the same household. It is also perceived as just replacing one habit with another - albeit less damaging.

[1] https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/does-vaping-cause-popcorn-lung

3.6 Quitting vaping

3.6.1 Profile of ex-vapers

Only 4 people identified themselves ex-vapers, two of whom were aged between 35 and 44 and two between 45 and 54 years old. Two were men and one a woman. Two had long-standing health conditions or disability. All were currently working as an employee.

They had all started vaping as a means to quitting smoking. Two respondents had quit 1-2 years ago and one had quit in the last 3 months. Two had taken 2-3 attempts to quit and one had taken just one attempt.

3.6.2 Attitudes and motivation to stop vaping

Half of current vapers said that they would like to quit, one had tried quitting vaping but were unsuccessful, and the rest did not want to quit. Many of these respondents used vaping as a way to stop themselves from smoking cigarettes and so did not want to quit as they felt vaping was a better option than smoking.

"I'm vaping as the lesser of two evils. It helps me to regulate my mood and nicotine dependence without smoking."

"A lot cheaper and a good substitute for cigarettes."

"I could not give up smoking until I found vaping."

"Helped me quit smoking after over 15 years!"

"I needed the motion of smoking but I couldn't bear the taste and smell of tobacco and burning."

"Unless there is hard evidence that vaping is worse than cigarettes it should be fine. Especially as mechanism used for people to quit smoking cigarettes. What is bad is teenagers in school using vaping when they've never even smoked. Causing a nicotine addiction so early on. More understanding of nicotine addiction needs to be spread to young people who only vape to socialise/fit in."

3.6.3 What helped or would help people to give up vaping

Respondents suggested that it would help them to quit if they had support to change habitual behaviour, if they were less stressed, or if vaping was proven to be a significant health concern (Figure 26). Around one third of respondents said that the fact that vaping helps them not to smoke is stopping them from giving up vaping, while a quarter mentioned that they were addicted to nicotine (Figure 27).

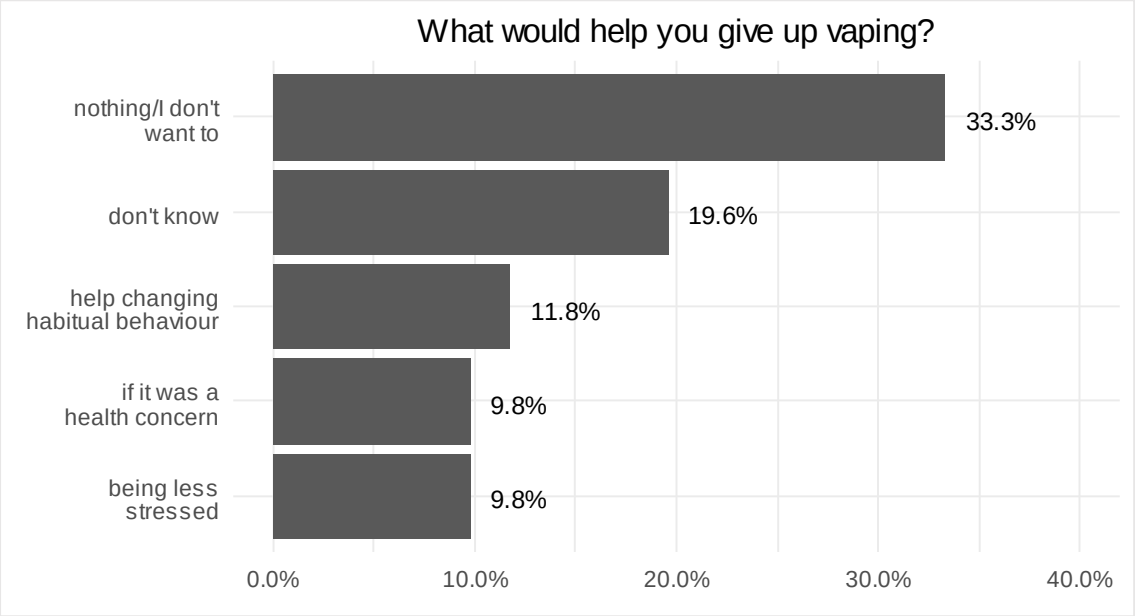


Figure 26: Responses to the online survey question 'What would help you give up vaping?' (*n* = 51).

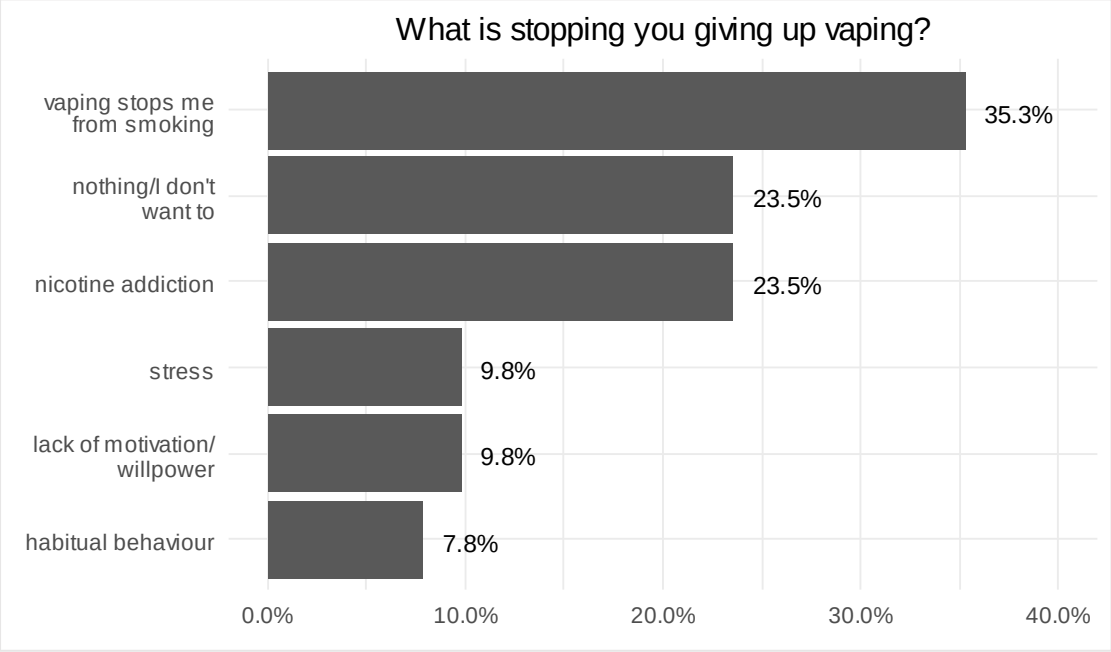


Figure 27: Responses to the online survey question 'What is stopping you giving up vaping?' (*n* = 51).

When asked what helped them to quit, respondents who identified as ex-vapers in the online survey mentioned willpower, having a heart attack, and making their own e-liquids, which enabled them to reduce the nicotine level gradually.

3.7 Non-smokers

3.7.1 Profile of non-smokers

29 online survey respondents identified as non-smokers. A higher proportion of respondents who were non-smokers were female (69%) compared with the overall distribution amongst respondents (60%).

Respondents who were non-smokers were less likely to have a long-standing health condition or disability (24%) than smokers (60%), ex-smokers (33%) or vapers (35%). 66% were currently working as an employee; 17% were self-employed; 10% were retired; and 3% were looking after their home or family. No respondents who identified as non-smokers were studying, unemployed, or unable to work due to long-term ill-health or disability.

A similar pattern was found with the 7 non-smokers who were interviewed or took part in the focus groups.

3.7.2 Motivation for not smoking

Most online survey respondents who were non-smokers stated that they didn't smoke for health reasons (66%) and/or never wanted to (59%). 14% of respondents thought they didn't smoke because they were not around people who smoke, and the same percentage because they tried it once or twice and didn't like it.

3.7.3 What would help people to give up smoking or vaping

When non-smokers were asked about helping people to quit smoking or vaping, the most mentioned response was that people have to want to do it.

"My husband was a big smoker 40 a day but gave it up 25 years ago. He had tried different things but in the end he just decided to give it up and that was that."

"They have to want to do it."

"They have to find their own reason else they won't succeed."

“Community pharmacies are a great place to be able to access at times and frequencies to suit individuals. No appointment needed, long opening hours and reliable advice from health professional.”

“I think a higher level of mentoring combined with nicotine replacement is needed. Checking in by phone/text. Perhaps a WhatsApp group for a network of people trying to quit or messenger group etc.”

“Talking to/videos of smokers /ex-smokers who now have the health conditions that are pictured on the packaging. Working in healthcare, you can see they are real, but speaking to friends who are smokers always thought the packaging was just 'scaremongering' and have the 'that won't happen to me' attitude.”

4. Key findings from public engagement

4.1 Current smokers

- Smokers are more likely to be unemployed, retired, and to have a long-standing health condition or disability (and be unable to work because of it) than ex-smokers, vapers or non-smokers.
- Smokers are more likely to be renting or in temporary accommodation/homeless or staying with friends and family than ex-smokers, vapers or non-smokers.
- Nearly all smokers started smoking during their teenage years.
- Socialising, friends, stress and enjoyment were the most frequently stated motivations to smoke.
- Of the online respondents, around 1 in 10 smokers do not want to quit and the same proportion have never tried to quit before. Of those engaged face-to-face, nearly a quarter do not want to quit and a third have never tried to quit before.
- Most smokers want to quit due to current or future health concerns and because smoking is too expensive.
- The most common reasons given for being unsuccessful in quitting are that nicotine replacements didn't work or e-cigarettes didn't work.
- Support from a GP, pharmacy or online were the most popular services that respondents felt would help them quit smoking, alongside willpower.
- Several smokers felt that smoking cessation services are not as readily available as support for drug and alcohol addictions.
- Several smokers felt that nicotine replacement, vaping liquid or other stop smoking medications were too expensive.
- Several smokers found it difficult to quit due to stress caused by their circumstances (unemployment, homelessness, debt) and/or poor mental health.

4.2 Ex-smokers

- Ex-smokers were more likely to be in work and less likely to be unemployed or unable to work due to long-term ill-health or disability compared with the overall profile of respondents. They were also more likely to live in their own home.
- Most ex-smokers had given up smoking more than 5 years ago.
- Most ex-smokers gave up smoking when they were between 25 and 64 years old
- Around one-third of ex-smokers were able to quit on their first attempt, with another third taking 2-3 attempts and the remainder taking more than 4 attempts
- Nicotine replacement, e-cigarettes/vaping, willpower, and support from friends and family were most commonly identified as having helped ex-smokers quit smoking.
- Several ex-smokers communicated the difficulty of quitting and the need for strong personal motivation to quit. Several mentioned using the Allen Carr method to successfully quit smoking.

4.3 Vapers

- Those who responded and were vapers were more likely to be women or non-binary/other compared with the overall profile of respondents.
- Vapers were more likely to have a younger age profile.
- Vapers were more likely to be in work compared with smokers, ex-smokers or non-smokers and less likely to be unemployed or unable to work due to long-term ill-health or disability.
- Vapers were less likely to have a long-term limiting illness or disability compared to the overall profile of those who were engaged.
- Using vaping as an alternative to smoking, coping with stress, and boredom, were the main factors that motivated people to vape; with most also doing so because it helps them socialise and their friends vape too.
- Approximately half of vapers wanted to quit, with around one third of respondents saying that the fact that vaping helps them not to smoke is stopping them from giving up, and just under a quarter identifying their addiction to nicotine

- Having support with changing habitual behaviour, being less stressed, and vaping being proven to be a significant health concern were identified as factors that would help people to give up vaping

4.4 Non-smokers

- In our sample, women were more likely to be non-smokers than men
- Non-smokers were less likely to have a long-standing health condition or disability than smokers, ex-smokers or vapers and none were unable to work because of a health condition
- None of the non-smokers were unemployed
- The majority of non-smokers felt that they didn't smoke for health reasons and/or never wanted to
- Several non-smokers felt that smokers had to really want to quit in order to be successful

5. Conclusions

Prevalence rates

Smoking is more prevalent in the following demographics compared with the general population average.

	Smoking	Vaping
More likely	• Men • 25-34 years of age • Highest qualifications GCSE grades A*-C or equivalent • NRS social grades C2DE (skilled working class, working class, and non-working) • Mixed ethnicity • Pregnant women • Migrant men • Bisexual, gay or lesbian sexual orientation	• Men • 25-54 years of age • NRS social grades C2DE (skilled working class, working class, and non-working)
Approximately twice as likely	• Unemployed • Routine and manual occupations • No qualifications • Long-term mental health condition • Anxiety or depression	• N/A
More than twice as likely	• Homeless • Serious mental illness • Substance misuse (opiates, non-opiates and alcohol)	• Ex-smokers • Current smokers

Potential priority groups

The following are potential areas of focus for which Herefordshire and Worcestershire perform worse than the national average and/or worse than 50% or more of their CIPFA nearest neighbours.

Herefordshire	• Routine and manual occupations • Adults with serious mental illness • Adults with a long-term mental health condition • Pregnant women – smokers at time of delivery • Pregnant women – smokers in early pregnancy
Worcestershire	• Young people (15-year-olds) • Adults with a long-term mental health condition • Adults admitted to treatment for substance misuse – non-opiates • Pregnant women – smokers in early pregnancy

Profile of respondents

The public engagement gathered views from 400 people via an online survey and 175 people face-to-face in Herefordshire and Worcestershire about smoking, vaping, and quitting. A range of people were targeted in the face-to-face engagement - particularly those who were more likely to smoke or vape according to the prevalence rates.

The demographic profile of the respondents compared to the population show that they were more likely to be:

- female or non-binary/other
- non-heterosexual
- working age
- have a disability/long-term health condition
- be unemployed or unable to work due to health or disability
- not live in owner occupied homes (i.e. renting, staying with family or friends or in temporary accommodation)

57% of respondents described themselves as smokers, 21% as vapers, 24% as ex-smokers, 6% as non-smokers and 1% as ex-vapers.

Those who described themselves as smokers were more likely to be non-heterosexual, working age, not in employment, unable to work due to health or disability, have a disability or long-standing health condition, and be in rented accommodation compared to the overall respondent base.

Those who described themselves as vapers were more likely to be younger, female, and staying with family or friends compared to the overall respondent base.

Those who described themselves as ex-smokers were more likely to be older, not have a disability or long-term health condition, be in work, and own their own home.

Key drivers for smoking

The top three reasons given for motivating people to smoke were friends/social aspects, coping with stress, and for enjoyment. Nearly all smokers in the public engagement started smoking in their teenage years.

Motivation to quit smoking

At least half of smokers would like to quit, with a much lower proportion not wanting to stop at all. Most smokers had tried to quit but had been unsuccessful.

Top motivations for giving up smoking were concerns about their future health, too expensive and to a lesser extent, their health already being affected.

What leads to successful quitting?

Nicotine replacement, e-cigarettes/vaping, willpower, and support from friends and family were most commonly identified as having helped ex-smokers quit smoking. Activities to replace the habit were helpful to ex-smokers, and several ex-smokers mentioned that the Allen Carr method worked for them. Most people quit smoking over the age of 25 and it mostly took more than one attempt.

What would help people quit smoking?

Accessing support from a GP, a pharmacy or online were the most frequently stated by online respondents. Most of the people engaged face-to-face gave other reasons, mainly related to willpower and a strong personal motivation and determination to break the habit.

What stops people quitting smoking successfully?

Nicotine replacement measures and e-cigarettes not being effective were the most common reasons given by those who had been unable to quit successfully. Other reasons given were a mixture of support not being available locally, or not at convenient time, ongoing stress and not having the willpower to quit.

Key drivers for vaping

The main motivations for vaping was as an alternative to smoking, coping with stress, and boredom,; with most also doing so because it helps them socialise and their friends vape too. Many mentioned that it takes a while to master the technical aspects of vaping which prevents some from continuing to use it to help give up smoking. Some people (usually smokers) perceive vaping to be bad for one's health.

What would help people quit vaping?

Support to change habitual behaviour, if they were less stressed, or if vaping was proven to be a significant health concern were given as reasons to quit vaping.

What stops people quitting vaping?

The main reason not to quit vaping is a lack of motivation to do so, or that it has helped people to stop or reduce their smoking, with the next most frequently mentioned being that they were addicted to nicotine.

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8. Appendix: Profile of respondents

Demographics by respondent category

Age (% of respondents)	ALL	Face-to-face	Online	Comment
16-24 years	14	37	5	Higher % with F2F
25-44 years	30	24	33	Lower % with F2F
45-64 years	45	32	50	Lower % with F2F
65-84 years	11	7	12	Lower % with F2F

Gender	ALL	Face-to-face	Online	Comments
Female	56	45	60	Lower % with F2F
Male	42	50	39	Higher % with F2F
Non-binary and other	2	4	1	Higher % with F2F

Long-standing health conditions or disability (% of respondents)	ALL	Face-to-face	Online	Comments
Yes	47	46	47	Similar
No	53	54	53	Similar

Ethnicity (%)	ALL	Face-to-face	Online	Comments
White British	93	90	93	Lower % with F2F
White Other	3	5	3	Higher % with F2F
Black, Asian, Mixed, Other	4	5	4	Higher % with F2F

Main language (%)	ALL	Face-to-face	Online	Comments
English	96	90	99	Lower % with F2F

Other	4	10	1	Higher % with F2F

Sexual orientation	ALL	Face-to-face	Online	Comments
Straight/ heterosexual	92	63	92	Lower % with F2F
Gay or lesbian	4	11	4	Higher % with F2F
Bisexual	3	19	2	Higher % with F2F
Pansexual	1	7	1	Higher % with F2F

Occupation (% of respondents)	ALL	Face-to-face	Online	Comments
Employed or self-employed	65	58	68	Lower % with F2F
Unemployed	6	12	3	Higher % with F2F
Looking after home or family	4	1	5	Lower % with F2F
Retired	9	6	11	Lower % with F2F
Studying	4	12	1	Higher % with F2F
Unable to work (health or disability)	12	11	13	Similar

Housing (% of respondents)	ALL	Face-to-face	Online	Comments
Own home (mortgage or owned outright)	42	20	50	Lower % with F2F
Rented house/ flat	45	45	45	Similar
Staying with family or friends	12	31	5	Higher % with F2F
Temporary accommodation /homeless	1	4	0	Higher % with F2F

Profile of all respondents by habit group

How would you describe yourself?	Smokers	Vapers	Ex-smokers	Ex-vapers	Non-smokers
Online survey respondents (n=400)	220	51	97	3	29

Face-to-face respondents (n=175)	109	42	42	5	5
TOTAL (575 individuals)	**329**	**121**	**139**	**8**	**34**
% of all individuals	**57%**	**21%**	**24%**	**1%**	**6%**

** Note that more than one option could be ticked*

Profile of online and interviewed respondents by habit group

Given that there were only 6 ex-vaper and 30 non-smoker respondents, it is not meaningful to present a breakdown by demographic group and by habit type here.

Age (%)	**Smokers (*n* = 313)**	**Vapers (*n* = 114)**	**Ex-smokers (*n* = 133)**
16-24 years	14	33	9
25-44 years	29	25	31
45-64 years	45	32	49
65-84 years	11	9	12

Gender (%)	**Smokers**	**Vapers**	**Ex-smokers**
Female	55	60	57
Male	44	39	42
Non-binary	1	1	1

Long-standing health conditions or disability (%)	**Smokers**	**Vapers**	**Ex-smokers**
Yes	58	42	34
No	42	58	66

Ethnicity (%)	**Smokers**	**Vapers**	**Ex-smokers**
White British	95	95	95
White Other	2	2	2

Black, Asian, Mixed, Other	3	3	4

Main language (%)	**Smokers**	**Vapers**	**Ex-smokers**
English	96	96	99
Other	4	4	1

Sexual orientation (%)	**Smokers**	**Vapers**	**Ex-smokers**
Straight/ heterosexual	89	98	98
Gay or lesbian	6	2	0
Bisexual	3	0	2
Pansexual	2	0	0

Occupation (%)	**Smokers (*n* = 313)**	**Vapers (*n* = 114)**	**Ex-smokers (*n* = 133)**
Working as an employee	48	67	67
Self-employed	8	6	10
Unemployed	6	2	2
Looking after home or family	5	2	3
Retired	12	6	7
Studying	4	9	6
Unable to work (health or disability)	17	8	5

Housing (%)	**Smokers**	**Vapers**	**Ex-smokers**
Own home (mortgage or owned outright)	31	33	65
Rented house/ flat	54	41	27
Staying with family or friends	12	25	8
Temporary accommodation /homeless	2	1	0

Herefordshire Council

Title of report: Update on the work of the Oral Health Improvement Partnership Board

Meeting: Health and Well-being Board

Meeting date: 26 September 2022

Report by: Consultant in Public Health

Classification

This report is open.

Decision type

This is not an executive decision

Wards affected

All Wards

Purpose

This report updates the Health and Well-being Board on the work of the Oral Health Improvement Partnership Board and seeks approval of the following recommendations.

I. Noting the comprehensive programme of work now underway to improve oral health in Herefordshire

II. Continuing to support a shared approach

III. Prioritising opportunities in all organisations for moving work forward.

Recommendation(s)

That:

a) The committee note the progress of the Oral Health Improvement Partnership Board; and

b) Adopt the recommendations set out the Oral Health Improvement Plan by their own organisations, and support the delivery of the plan at system level, wherever possible.

Alternative options

1. The alternative would be non-delivery of the Oral Health Improvement Plan. This would be detrimental to the health and well-being of local people, whose poor oral health is already identified as a cause of concern. Good oral health is integral to individual health, well-being and quality of life.

2. Non-delivery of the Oral Health Improvement Plan would disproportionally affect those who already experience poorer health outcomes and would therefore widen health inequalities. Populations at greater risk of poor oral health include those people who live in areas of higher social deprivation; have learning disabilities; experience mental health problems; need adult social care; are part of black and minority ethnic groups; and are looked after children.

Key considerations

3. Oral health within the county is of concern. Directors of Public Health in Herefordshire have drawn attention to this for many years, through their annual reports, and through Joint Strategic Needs Assessments. The council's county plan too has identified this as a priority area for action.

4. The oral health of the local population remains worse than regional and national averages and this has not changed. The impact of Covid 19 here as elsewhere has been to delay access to treatment and an additional pressure locally is the shortage of NHS dentists. This situation continues and has recently worsened with five practices ceasing to contract with the NHS.

5. It is important to build a clear programme of work which takes a whole system approach, including at scale prevention of oral ill-health as well as the commissioning of new services. At a time of budget pressure, different system partners have been able to access one-off funding for specific initiatives, but members of the Health and Well-being Board are asked to build delivery of the Improvement Plan into their own planning.

6. An Oral Health Needs Assessment was completed by the Public Health Team in 2019, bringing together data on oral health and developing recommendations for change which were drawn into an action plan. This is attached as Appendix 2. This work was halted for two years, due to Covid 19.

7. The Oral Health Improvement Partnership Board was re-started in 2021, and now meets quarterly. It is well attended, with a public health consultant in the chair, and membership drawn from system partners including Healthwatch and NHS England commissioners.

8. The Oral Health Improvement Partnership Board receives an updated action plan at each meeting, taken from the initial needs assessment. The most recently updated plan is included as Appendix 1 of this report for information.

9. Attention is drawn below to recent and promising areas of progress, across the life course.

10. At system level, work is underway to commission a new dental service locally and a small working group has been set up. Internal governance sign-off to procure two medium sized dental practices in Hereford City in underway at NHSE, and additional activity is also going to be offered to willing existing contractors.

11. This will take into account some of the findings of a Healthwatch survey on dental services earlier in the year, which highlighted access issues, but also agreement to the overall proposal to commission services in Hereford City. However, it should be noted that recruitment of dentists to Herefordshire has been historically problematic.

12. For children and young people, delivery of a comprehensive 'Time to Shine' programme to improve children's oral health is continuing as below.

13. Evidence based supervised tooth brushing programmes are in place and have been enthusiastically taken up by early years settings. Funding has been secured for 30 settings and the first 20 of these are now live, with a focus on settings in areas of higher deprivation. 725 children between the ages of 2 and 5 are now brushing everyday as part of this initiative. Engagement sessions with parents have also taken place.

14. A 'Brush, Book, Bed' pack has been made available to libraries and this initiative aims to give every child aged 3 a pack including a toothbrush and book. 3,000 packs have been ordered, and 1,868 have been delivered.

15. Free online training for improving the oral health of children has been developed and is available for all to access. So far, this has been completed by 221 people: 46 parents; 175 professionals (of which 111 were early years professionals) and two Dental Nurses. It has so far evaluated well, and evaluation of impact on behaviour is to be carried out as a follow-up.

16. A 4-6 month oral health check has been commissioned for all babies, focussing on weaning and oral health. 87% of 4 – 6 month olds have been visited.

17. All primary schools in Herefordshire have received dental pack resources and are using them as teaching aids in delivering good oral health messages to children.

18. For adults, an audit of compliance with NICE quality standards on oral health in care homes has taken place. Seventy one homes responded, including homes for older adults, and for those with learning disabilities. Responses showed that although overall compliance with the three standards was good, attention is needed to improve the assessment of mouth care needs on admission.

19. This is being followed up by focused staff training and by the development of oral health champions in care homes. The training package has been developed through strong partnership working between public health, Wye Valley NHS Trust, and the Adult Social Care Quality team. The aims of the training are to empower care staff in all care settings to be confident and competent to perform mouth care to a recognised standard, and to be able to recognise and escalate suspected changes in mouth health, so as to improve the oral and overall health and well-being of the residents. The training will be followed up by evaluation considering changes in knowledge and practice.

Community impact

20. Distribution of the resources via libraries enhances their role as trusted sources of health information.

21. The Oral Health Improvement Plan addresses the needs set out in the Oral Health Needs Assessment.

22. The plan makes specific reference to engaging with children who are looked after by the Council and links with foster carers for training opportunities are currently being explored.

Environmental Impact

23. This report is considered to have minimal environmental impact.

Equality duty

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

A public authority must, in the exercise of its functions, have due regard to the need to –

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it

25. . The detail in the Oral Health Improvement plan has due regard to this duty, and a programme of work is planned and underway which seeks to deliver appropriate support for those who share protected characteristics.

Resource implications

26. The Oral Health Improvement Plan includes elements of delivery with long-term funding implications. Accepting the recommendations of this report does not in itself have resource implications, but it is understood that full implementation has funding implications which will need to be considered by each organisation. Creative solutions will be needed including the re-prioritisation of existing budgets and applications for additional funding whenever opportunities arise, across the system.

Legal implications

27. This report is for noting and seeking broad agreement to support the objectives determined from the report.

28. The recommendations are in accordance with the functions of the Health and Wellbeing Board set out in paragraph 3.5.24 of the council's constitution.

29. There are no specific legal implications arising out of this report. Risk management

30. Accepting the recommendations of this paper carries no risk for the constituent organisations of the Health and Well-being Board.

31. However, not endorsing the work of the Oral Health Improvement Board carries performance risk for the Council, which has identified children's oral health improvement as a priority, and reputational risk for the NHS and Council, who have responsibilities for the oral health of the local population.

Consultees

32. The Oral Health Improvement Plan was not subject to consultation. However, views of a recent Healthwatch engagement exercise have been taken into account in updating the Plan. This included an on-line survey of over 600 people and a number of focus groups. Healthwatch remain part of the Partnership Board and will be able to managing feedback.

Appendices

Appendix 1 is the updated Oral Health Improvement Plan, for information.
Appendix 2 is the full Oral Health Needs Assessment from 2019

Background papers

None identified.

Report Reviewers Used for appraising this report:

Please note this section must be completed before the report can be published		
Governance	John Coleman	Date 15/09/2022
Finance	Click or tap here to enter text.	Date Click or tap to enter a date.
Legal	Click or tap here to enter text.	Date Click or tap to enter a date.
Communications	Click or tap here to enter text.	Date Click or tap to enter a date.
Equality Duty	Click or tap here to enter text.	Date Click or tap to enter a date.
Procurement	Click or tap here to enter text.	Date Click or tap to enter a date.
Risk	Click or tap here to enter text.	Date Click or tap to enter a date.

Approved by	Click or tap here to enter text.	Date Click or tap to enter a date.

[Note: Please remember to overtype or delete the guidance highlighted in grey]

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

Herefordshire Oral Health Improvement Action Plan (2020-2023)

Herefordshire Council - Public Health Team

Revised 30/08/2022: For discussion Oral Health Improvement Partnership Board September 5th 2022

Updated September 8th 2022

HEREFORDSHIRE ORAL HEALTH IMPROVEMENT ACTION PLAN (2020-2023)

1) BUILDING HEALTHY PUBLIC POLICY

Key action	Planned activity	By who	Milestone Note: 2020 milestones adjusted to 22 due to Covid delay	Progress update
1A. Ensure the OHIP is endorsed by executive committees in Herefordshire Council and Health and Well-being Board partners	Obtain approval from Herefordshire Council's Cabinet and Management Board Share the plan with partners identified as key stakeholders for achieving the OHIP aim and objectives	HC PHT	By end of Mar 2020 OHIG to review quarterly	**June 2022** Completed. Management Board via DPH 2020/21. Health and Well-being Board discussion 2022, to review in September 2022. **September 22** Agenda item at HWB Board in September 22.
1B. Ensure oral health is included in the Joint Strategic Needs Assessment (JSNA)	Engage with HC Intelligence Unit, to identify drafting and publication timelines for the JSNA and discuss oral health content	HC PHT	OHIG to review quarterly	June 2022 Completed. In revised JSNA published Dec 2021.

1C. Advocate for inclusion of oral health promotion within all health and wellbeing policies, strategies and commissioning	In partnership with public health colleagues and wider professionals to identify opportunities for inclusion of oral health across relevant work streams e.g. smoking, substance use and NHS Health Checks	HC PHT	OHIG to review quarterly	June 2022 On-going, review of training materials in early stages. **September 2022** Still on-going, to review opportunities as new service specifications are prepared for the main public health contracts.
1D. Influence early years and adult social care settings to adopt healthy food and drink policies	Share latest guidance (NICE/PHE) and online resources with early years and adult social care leads and providers to inform policy development and implementation	HC PHT	OHIG to review quarterly	June 2022 On-going, on work-plan for two public health practitioners. **September 2022** On-going and being delivered by the two PH practitioners who have fixed term contracts until March 23.
1E. Support the implementation of smoke-free policies across public, private and voluntary/sector organisations	Provide system-leadership and role modelling for smoke-free policies and ensure proactive communication of messaging around smoke-free settings.	All OHIG members	OHIG to review quarterly	June 2022 Not yet progressed. National Tobacco Control Strategy publication imminent, with local Strategy to be developed from that. **September 2022**

				Update on this is now an agenda item for HWB Board in September, with a recommendation to form a system wide tobacco control group.

2) CREATING SUPPORTIVE ENVIRONMENTS

Key action	Planned activity	By who	Milestone	Progress update
2A. Increase the provision of healthy food and drink in early years, children's and all settings that the local authority reaches wider public sector settings	Influence key settings to reduce availability of sugar sweetened beverages/snacks in high sugar and increase offer of healthy alternatives (including provision of free plain drinking water) Develop healthy vending guidance for all settings that the local authority reaches Encourage primary and secondary schools to engage with the 'Healthy schools rating scheme' (Department for Education)	HC PHT HC EYT	OHIG to review quarterly	June 2022 Oral health promotion in selected nurseries and primary schools in progress. **September 2022** Continues as above.
2B. Introduce targeted supervised tooth brushing (STB) in targeted early years and children's settings	Conduct market engagement exercise to inform future commissioning decisions Commence procurement/service development process to deliver required provision	HC PHT	By end of Apr 2020/22 By end of Sept 2020/22	June 2022 Oral health promotion in selected nurseries and primary schools in progress. **September 2022** Continues to be delivered by PH practitioner and update given at September meeting of OHIB. By December, this will be in place at 31 settings which were selected for being areas with higher levels of social deprivation.
	Conduct market engagement exercise to inform future commissioning decisions	HC PHT	By end of Apr 2020/22	June 2022

2C. Introduce targeted provision of toothbrushes and toothpaste (i.e. through health visitors and food banks)	Commence procurement/service development process to deliver required provision		By end of Sept 2020/22	Oral health promotion in selected nurseries and primary schools in progress. Health visiting and food banks under consideration. **September 2022** Options being considered by PH, but there is no ear-marked budget for this. Sponsorship has been found to be unworkable through Council regulations. Food bank visit being planned to consider what is needed.
2D. Support adult care settings to improve the oral health of their clients	Increase the number of settings adopting relevant NICE guidelines and complying with CQC standards for improving oral health in adult care settings Encourage oral health to be reflected in all relevant policies and commissioning activity	HC PHT/ HC QT	OHIG to review quarterly	June 2022 Care home audit against NICE guidelines underway with follow up training work planned. Review of relevant policies and commissioning activity yet to be actioned. **September 2022**

				Audit complete and training sessions planned with materials ready. First session 30/9/2022. Relationships to enable ASC commissioning amendments is being established.

3) STRENGTHENING COMMUNITY ACTION

Key action	Planned activity	By who	Milestone	Progress update
3A. Engage with individuals/groups to explore oral health needs and barriers and facilitators to good oral health	To coincide with introduction of oral health improvement programmes locally, conduct targeted engagement with the following priority groups (or those who work with or support these groups) – • Looked After Children • Children or adults with a physical or learning disability • Children who are home-schooled • Adults in social care settings	HC PHT HH	By end of Sept 2020/22	June 2022 Not yet progressed. Care home staff being engaged through care home audit. **September 2022** Care home staff engaged now through the training offer following on from the audit. Active connections being made now by PH practitioner with LAC and home schooled children.
3B. Explore opportunities to develop oral health champions to promote oral health in key organisations and community settings.	Engage with multi-sector stakeholders* to identify options for developing oral health champions, who will receive training and support to be able to deliver evidence-based oral health messages to individuals, families and communities. ** For example - Talk Community Hubs, Healthwatch Herefordshire, Homeless Outreach and more broadly with early years, health and social care settings.*	HC PHT HH	By end of Jun 2020/22	June 2022 Early years oral health champions in place. Care home champions being identified through the care home audit. Training materials review being planned. **September 2022** Being taken forward now in care homes as well as in early years

				settings. Champions to be identified through the care home training session.
3C. Explore the feasibility of a 'Oral Health Community Fund', to support the third sector to improve oral health and reduce oral health inequalities	To coincide with the introduction of oral health improvement programmes, identify opportunities for developing a grant based funding scheme or oral health resource programme for voluntary and community organisations.	HC PHT HH	By end of Sept 2020/22	June 2022 Not yet progressed. **September 2022** Not yet progressed and working in a challenging financial environment. To be discussed at the HWB Board.

4) DEVELOPING PERSONAL SKILLS

Key action	Planned activity	By who	Milestone	Progress update
4A. Increase the oral health literacy of children and adults across Herefordshire	Undertake social marketing campaigns to promote the importance of oral hygiene, access to dental services and applications of fluoride varnish	HC PHT and Comms	Bi-annually	June 2022 Additional 4 month health visitor check now commissioned and library campaign on brushing in place. Dental practice work not yet progressed. **September 2022**
	Provide dental practices (both NHS providers and private) with guidance on improving the oral health literacy of patients	HC PHT NHSE/I LDC	Ongoing	

				Social marketing aimed at families continues with strong engagement from libraries. Dental practice approach to be considered by PH practitioner in the next work period (Sept – March.)
4B. Increase oral health promotion and signposting to NHS dental services by front line professionals in early years and educational settings	Provide oral health training (according to PHE's 'Delivering better oral health') to wider professionals across early years and schools Share online resources and latest guidance (NICE/PHE) with key multi-agency partners in early years and schools	HC PHT	OHIG to review quarterly	June 2022 Progressed via additional health visitor contact at 4 months and early years and schools work in selected settings. **September 2022** HV contacts continue and their effectiveness will be reviewed in the needs assessment and service redesign for the new 0-19s contract, from April 2024. This will include both health visiting and school nursing. 112 staff in Early Years settings have been trained.

4C. Increase the oral health knowledge and skills of professionals within adult social care settings	Provide oral health training to (according to PHE's 'Delivering better oral health') professionals working in adult social care settings	HC PHT	OHIG to review quarterly	June 2022 In progress via care home audit. **September 2022** Training planned and includes links for further on-line guidance.
	Share online resources and latest guidance (NICE/PHE) with all adult social care settings i.e. residential and nursing homes and domiciliary providers			

5) REORIENTING HEALTH SERVICES

Key action	Planned activity	By who?	Milestone	Progress update
5A. Engage with NHS England and NHS Improvement to ensure access to good-quality NHS dental services.	Review quarterly NHS Dental Statistics (obtained from NHS Digital and NHS Business Services Authority), to monitor access levels for children and adults in Herefordshire	HC PHT NHSE/I	OHIG to review quarterly	June 2022 Data to be presented at OHIG for review. Health and Well-being Board presentation by NHSEI in March 2022. **September 2022** Discussed at OHIB and indicators agreed. Continued issues with poor access, despite efforts to recruit to dentistry. In the past year, five practice have ceased NHS
	Engage with the Local Dental Network (NHS England and NHS Improvement) to gain insight and understand best practice around improving NHS dental access.			

				work and access continues to worsen. NHSE have sourced additional funding for more paediatric sessions at the community service based on Wye Valley Trust, and additional admin support. Work is beginning for the commissioning of a new contract based in Hereford City, building on the findings of the Healthwatch survey.
5B. Engage with NHS England and NHS Improvement to increase the use of fluoride varnish in local NHS dental practices across Herefordshire	Expectation to provide fluoride varnish is reiterated to NHS dentists as a core universal offer and monitoring of its delivery is undertaken at end of year review meetings with providers and contract monitoring visits. Engage with the Local Dental Network (NHS England and NHS Improvement) to gain insight and understand best practice around increasing use of fluoride in dental practices. Raise awareness of fluoride varnish and preventative measures with members of the public.	HC PHT NHSE/I LDC HH	OHIG to review quarterly	June 2022 Not yet progressed. **September 2022** NHSE/UKSHA colleagues are sourcing a national specification but it is understood that options need to be explored, including the separate commissioning of a nurse led service, with clinical governance from a qualified dentist. No ear-

				marked budget yet for this.
5C. Engage with dentists to increase awareness and support behaviour change related to common risk factors.	Deliver Making Every Contact Count (MECC) training for dental practices (both NHS providers and private).	HC PHT NHSE LDC	OHIG to review quarterly	June 2022 Not yet progressed. **September 2022** Not yet progressed but initial work is being done on the County smoking cessation pathway.
	Develop stronger referral pathways between dental practices (both NHS providers and private) and public health services i.e. stop smoking services.			
5D. Introduce a targeted community-based fluoride varnish programme for children and young people most at risk of poor oral health	Conduct market engagement exercise to inform future commissioning decisions	HC PHT NHSE/I	By end of Apr 2020/22	June 2022 Not yet progressed. **September 2022** Not yet progressed but it is understood that options need to be explored. It is noted that we are working in a challenging financial environment.
	Commence procurement/service development process to deliver required provision	HC PHT	By end of Sep 2020/22	June 2022 Not yet progressed. **September 2022** Options appraisal and available budget needs to be clarified before progress can be made.

KEY PERFORMANCE INDICATORS

To inform the performance management of the OHIP, as part of quarterly meetings the OHIG will routinely monitor, a range of key performance indicators (see table below). Measurable improvements in each of the key performance indicators listed, is deemed to contribute to the OHIP Objectives and longer term to the overall OHIP Aim.

Key performance indicators	OHIP Objectives	OHIP Aim
Rate (%) of fluoride varnish applications in children (3-16 years)	Increase the access of and exposure to fluoride	Improve oral health and reduce oral health inequalities in Herefordshire,
Number of targeted settings providing a supervised tooth brushing programme		

Number (%) of targeted oral health packs distributed		particularly in children, older people in residential care settings and those in high risk groups. **Aim measured by –** • Local results of Public Health England's dental epidemiological programme i.e. % of 5 year olds with decayed, missing or filled teeth • Local trends in dental extractions under general anaesthetic (aged up to 18 years)
Number (%) of primary/secondary schools engaged with Healthy schools rating scheme	Improve dietary behaviours and reduce consumption of sugar, alcohol and tobacco	
Number (%) early years settings adopting healthy food/drink policies		
Number settings adopting smoke-free policies		
Number (%) of children (1-18 years) accessing NHS Dental Services	Improve uptake and access to NHS dental care	
Number (%) Looked After Children receiving NHS dental check		
Number (%) of adults accessing NHS Dental Services		
Number of dental practices who have received 'Making Every Contact Count training'	Ensure prevention is at the core of NHS dental services	
Number (%) of NHS Dental practices who show an increase in their fluoride varnish rates each quarter		
Number of professionals (across children's and adults services) trained in oral health promotion	Ensure oral health is considered in all relevant settings and policies	
Number (%) residential care settings adopting relevant national guidelines/achieving CQC standards		

Herefordshire Council

Herefordshire Oral Health Needs Assessment

Version - FINAL

Herefordshire Council - Public Health Team

September 2019

CONTENTS

If you need help to understand this document, or would like it in another format or language, please contact us on 01432 261944 or e-mail researchteam@herefordshire.gov.uk

ABBREVIATIONS

BAME – Black, Asian and Minority Ethnic
CCG – Clinical Commissioning Group
CDS – Community Dental Service
COHIPB – Child Oral Health Improvement Programme Board
COT – Courses of Treatment
DAC – Dental Access Centre
D_3MFT/d_3mft – Decayed, missing and filled teeth
GDP – General Dental Practitioner
GDS – Community Dental Service
HC – Herefordshire Council
IMD – Index of Multiple Deprivation
JSNA – Joint Strategic Needs Assessment
LAC – Looked After Children
LDC – Local Dental Committee
LGA – Local Government Association
LSOA – Lower Layer Super Output Area
NDEP – National Dental Epidemiology Programme
NHS – National Health Service
NHSE – NHS England
NICE – National Institute of Health and Care Excellence
OHNA – Oral Health Needs Assessment
ONS – Office for National Statistics
PHE – Public Health England
PHOF – Public Health Outcomes Framework
STP – Sustainability and Transformation Partnership
UDA – Unit of Dental Activity
UTLA – Upper Tier Local Authority

GLOSSARY

D_3mft/D_3MFT

A commonly used indicator of tooth decay and treatment experience in a population - (d), missing due to decay (m) and filled due to decay (f) teeth (t) in a population. In five year old children this score will be for the baby or first teeth or dentition and will be in lower case letters (dmft). In twelve year old children this score reflects the adult or permanent teeth or dentition and will be in upper case letters (DMFT).

Unit of Dental Activity (UDA)

Units of Dental Activity (UDAs) are a measure of the amount of work done during NHS dental treatment. More complex dental treatments count for more UDAs than simpler ones. For example, an examination is 1 UDA, fillings are 3 UDAs, and dentures are 12 UDAs.

Course of Treatment (CoT)

Dental care is provided to patients as CoT, and reflects –

- An examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment
- The provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient

OVERVIEW

Despite national improvements in oral health over the last few decades, many people across England and Herefordshire experience preventable oral diseases that impact on their everyday life. Oral health is therefore an important public health issue both nationally and locally.

Herefordshire Council and local authorities across England have a clear responsibility for improving the oral health of both children and adults and reducing inequalities in oral health. To inform local priorities and action, national guidance recommends that local authorities undertake an oral health needs assessment.

This document therefore fulfils this requirement, by comprehensively describing the standard of oral health of people living in Herefordshire and providing a detailed overview of current oral health care services locally.

Based on the best available intelligence, this assessment has found that the standard of children's oral health in Herefordshire is poor, and is poorer than both the regional and national picture. For example, just under a third of 5 year olds locally experienced preventable tooth decay in 2016/2017. Significantly this figure has remained broadly unchanged in the last 10 years.

Areas of good practice for preventing and addressing poor oral health in children and adults are evident across Herefordshire. Despite this, local challenges clearly exist in ensuring everyone has equitable access to dental care and preventative interventions for improving oral health.

To address these identified local issues and gaps, this document proposes 10 key recommendations. Each recommendation has been informed by national policy and guidance.

It is envisaged that future action and activity for improving oral health will be led by Herefordshire Council's Public Health Team and undertaken in collaboration with key local and regional organisations e.g. Healthwatch Herefordshire and Public Health England.

INTRODUCTION

Oral health reflects the 'standard of the oral and related tissues, which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment' [1 - pg.55]. Good oral health is therefore integral to an individual's overall health, well-being and quality of life [2].

Over the last forty years, the oral health of both children and adults in England has significantly improved [3,4]. Despite this marked inequalities remain and many people continue to experience the negative physical, emotional and social impacts associated with poor oral health and oral disease.

Oral health problems of substantial concern include dental caries (tooth decay), periodontal (gum) disease and oral cancers [5,6]. Importantly, these diseases and almost all oral health problems are either largely preventable or can be treated in their early stages.

The causes of poor oral health and inequalities in oral disease are complex. A broad range of interacting biological, socio-behavioural, psychosocial, societal and political factors contribute to a person's risk of experiencing poor oral health outcomes [3,7,8].

Most oral diseases share modifiable risk factors common to the four leading non-communicable diseases; cardiovascular disease, cancers, respiratory diseases and diabetes [9,10]. These common risk factors include unhealthy diets (high in sugar), tobacco use and alcohol consumption.

Crucially, for both children and adults, poor oral health can cause significant pain and discomfort, making it difficult to eat, drink, communicate and socialise normally [5,11,12]. In addition, poor oral health places a considerable financial burden on individuals and wider society. This is because treating oral diseases is often complex and costly, and those experiencing poor oral health are more likely to be absent from education or employment.

Over the last decade, an increasing national emphasis has been placed on the importance of improving population oral health [8,13,14]. A range of key organisations both within and outside of the social care system, are therefore actively engaged and contributing to this national agenda at a regional and local level e.g. local authorities, Public Health England (PHE), NHS England (NHSE) and the Local Government Association (LGA).

NATIONAL CONTEXT – ENGLAND

Following the introduction of the Health and Social Care Act 2012, the responsibility for improving population oral health and reducing oral health inequalities in England was conferred to local authorities (unitary and upper tier) [3,4,6,15].

Consequently, since April 2013 and in partnership with PHE, NHSE and Clinical Commissioning Groups (CCGs), local authorities have been required to –

1) Secure the provision of oral health surveys in order to facilitate:
   - The assessment and monitoring of oral health needs
   - Planning and evaluation of oral health promotion programmes
   - Planning and evaluation of the arrangements for the provision of dental services
   - Reporting and monitoring of the effects of any local water fluoridation schemes

2) Secure the provision of oral health improvement programmes (to the extent that they consider appropriate in their area)

3) Participate in any oral health survey conducted or commissioned by the Secretary of State

4) Make proposals with regard to water fluoridation schemes, including a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals

The commissioning of NHS dental services (including the totality of primary, secondary and unscheduled or urgent dental care), became and remains the responsibility of NHSE as part of the 2012 act. Furthermore, expert and specialist dental public health advice is provided by PHE for both local authorities and NHSE.

NATIONAL POLICY DRIVERS

A number of national policies and frameworks exist, which drive the agenda and ambition for improving population oral health and reducing oral health inequalities in England –

- The NHS Outcomes Framework [16] and Public Health Outcomes Framework [17] set out the desired health and well-being outcomes for adults and children in England. Both frameworks include indicators related to oral health, enabling regional and local benchmarking and progress to be monitored over time.

- An extensive range of national guidance and toolkits have been published by PHE and the National Institute of Health and Care Excellence (NICE) – See appendix A. Collectively, these present the evidence base of 'what works' for improving oral health at an individual and population level, and provide recommendations for organisations across the system.

- In 2016, PHE in partnership with a range of stakeholders, established the Child Oral Health Improvement Programme Board (COHIPB). The COHIPB action plan (2016-2020), aims to improve the health of all children and reduce the oral health gap for disadvantaged children [18].

- The NHS Long Term Plan (2019), places a major focus on the role and importance of preventing ill-health [19]. The plan includes commitments around improving the oral health of children and increasing NHS support (including dental services) for those with learning disabilities or autism and people living in care homes.

LOCAL CONTEXT - HEREFORDSHIRE

In 2017, the Joint Strategic Needs Assessment (JSNA) for Herefordshire, reported that the prevalence and severity of oral disease in children (aged 5 years), was worse than both the West Midlands and England position [20]. Consequently, concerns raised about the standard of children's oral health locally, led to Herefordshire Council undertaking the following strategic activity during 2018/2019 (see figure 1 below) –

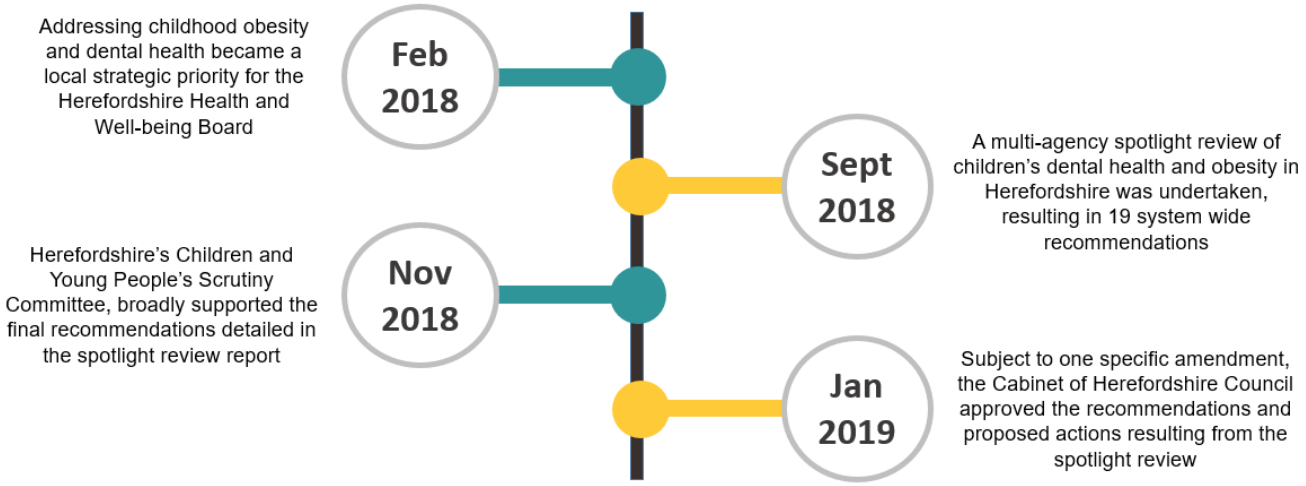


Figure 1 – Herefordshire strategic activity related to children's oral health (2018/2019)

One of the recommendations approved by the Cabinet of Herefordshire, was the requirement for a local Oral Health Needs Assessment (OHNA) to be conducted [21]. The Director of Public Health had identified this as a crucial step in determining the local strategic approach for improving oral health.

Given that a local assessment of the population's oral health hadn't previously been undertaken and a local strategic plan was yet to be developed, Cabinet agreed that an OHNA should be completed for Herefordshire.

ORAL HEALTH NEEDS ASSESSMENT – PURPOSE AND PROCESS

To fulfil the statutory requirement to assess a population's oral health needs and to inform oral health improvement activity, NICE recommend local authorities undertake OHNAs [22].

An OHNA is a cyclical process of –

"describing the oral health of a population, ascertaining their needs, measuring the capacity of existing services to meet these needs and where gaps exist, identifying new or alternative ways in which such gaps can be prioritised and filled" (pg18)

In 2014, NICE published guidance to support local authorities to conduct OHNAs, develop a local strategic direction for oral health improvement and deliver effective community based interventions [15].

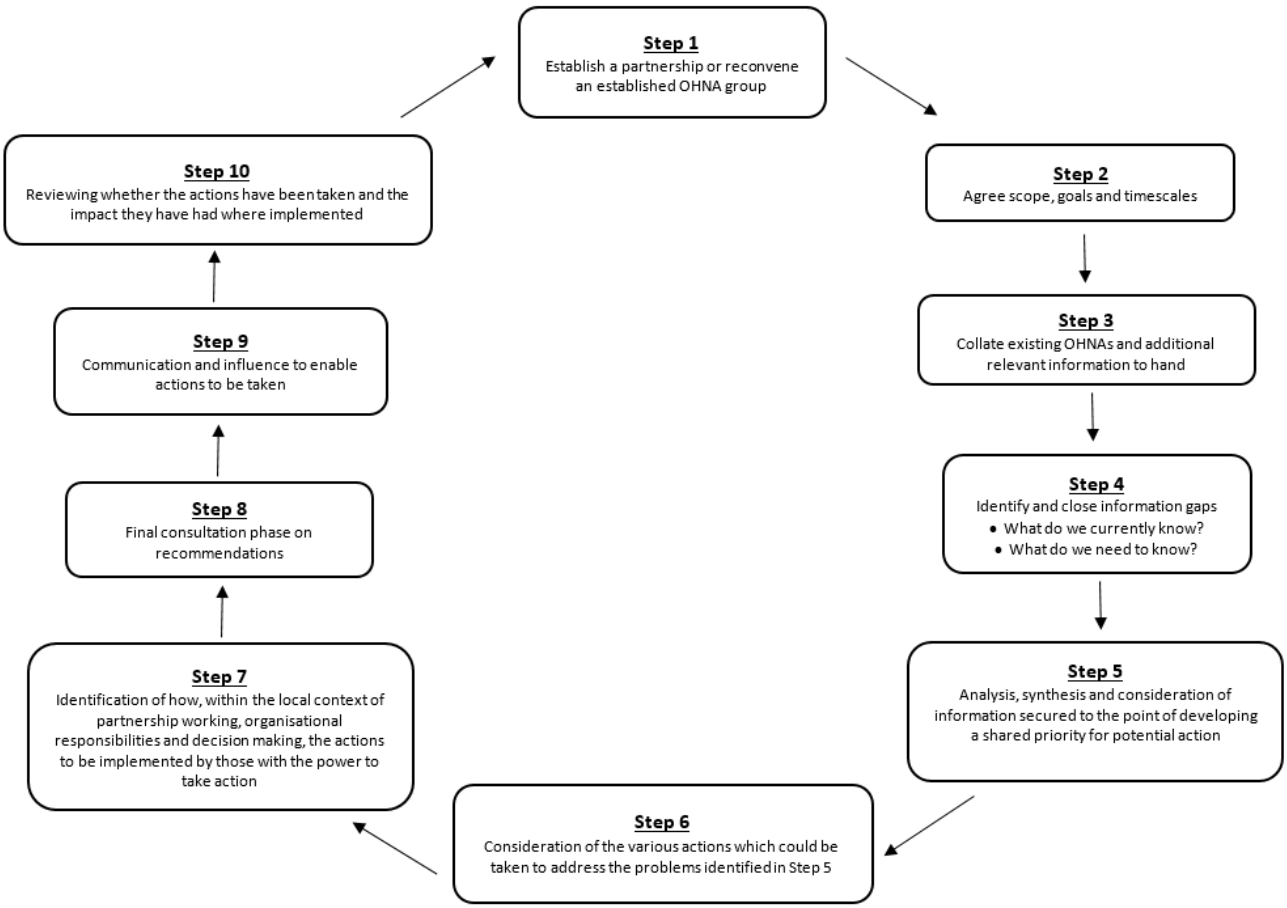


Figure 2 - 10 steps of conducting an OHNA

As part of this guidance and to ensure the methods for conducting an OHNA are comprehensive and robust, NICE recommended local authorities adopt the 10 step approach presented in figure 2.

This approach and the example OHNA template included in this guidance, has informed the final Herefordshire OHNA report.

HEREFORDSHIRE OHNA – AIMS, OBJECTIVES AND SCOPE

The specific aim and objectives of this OHNA were -

Aim

In order to inform the local strategic approach to oral health improvement and the reduction of health inequalities in Herefordshire, comprehensively describe the oral health of children and adults and the provision of oral health services across the county.

Objectives

The following objectives were developed to achieve the overarching project aim. In relation to the geographical footprint of Herefordshire –

- Describe the oral health needs of both children and adults, reporting on variation according to key socio-demographic and geographic variables
- Describe the provision and access of oral health services and identify any gaps in service
- Describe the provision of oral health improvement programmes, interventions and activities
- Identify opportunities to strengthen the access to and collection of data relevant to oral health
- Make recommendations for the future development of high quality, evidence based and outcome focused oral health care and oral health improvement services

POPULATION OF INTEREST

The OHNA covered the geographical footprint of the County of Herefordshire (within the West Midlands region). As presented in later chapters, the data included within the OHNA reflects both the resident population of Herefordshire (inclusive of both children and adults) and those accessing oral healthcare services in the county (who may or may not be residing in Herefordshire).

Where possible (based on data availability), the OHNA also considered and described the oral health needs of vulnerable groups within Herefordshire i.e. *"those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access oral health services*" [5 - pg 93/94]. A description of the vulnerable groups of interest are described in more detail in the following chapter.

METHODS AND SOURCES OF DATA

The NICE 10 step approach informed the overall methodology employed for conducting Herefordshire's OHNA. The OHNA was conducted as a desk-based exercise and no primary research was undertaken.

To meet the aim and objectives of the OHNA, an extensive range of existing data sources were collected, analysed and reviewed. This included data from –

- Dental Epidemiology Programme (PHE)
- Public Health Outcomes Framework (PHOF)
- NHS Dental Statistics (NHS Digital)
- Office for National Statistics
- Hospital Episode Statistics (NHS Digital)
- GP Patient Survey Dental Statistics (NHSE)

- Understanding Herefordshire (Herefordshire Council and Herefordshire CCG)
- Healthwatch Herefordshire

Furthermore, an extensive range of national policies and guidance underpinned the resultant OHNA findings and recommendations (see Appendix A).

GOVERNANCE AND ACCOUNTABILITY

The process of completing the OHNA was governed by and accountable to the OHNA Task and Finish Group. Membership of this group included –

- Emma Booth – Specialty Registrar in Public Health, Herefordshire Council (Project lead and main author)
- Chris Nikitik - Intelligence Analyst, Herefordshire Council (Co-author)
- Caryn Cox – Consultant in Public Health, Herefordshire Council (Project supervisor)
- Sophie Hay – Health Improvement Practitioner, Herefordshire Council
- Anna Hunt – Consultant in Dental Public Health, PHE

In addition to the OHNA task and finish group, engagement with the following key stakeholders was crucial in guiding the structure and content of the OHNA –

- NHSE and NHS Improvement (Midlands)
- PHE (West Midlands Centre)
- Herefordshire Local Dental Committee (LDC)
- Wye Valley NHS Trust (Community Dental Services)

Final approval and sign-off for the OHNA was obtained from the Director of Public Health for Herefordshire Council in September 2019.

REPORT DISSEMINATION

The final local OHNA report will be published on the 'Understanding Herefordshire' website and cascaded to the following key groups and organisations during September 2019 –

- Cabinet of the Herefordshire Council
- Children and Young People Scrutiny Committee – Herefordshire Council
- Herefordshire Council services and teams
- Herefordshire LDC
- Herefordshire CCG
- PHE
- NHSE
- Healthwatch Herefordshire
- Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP)

ORAL HEALTH AND DISEASE – AN OVERVIEW

Oral health is integral to a person's overall health, well-being and quality of life. The World Health Organization defines oral health as –

"a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum disease), tooth decay, tooth loss and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking and psychosocial wellbeing" [23]

ORAL DISEASES AND CONDITIONS

This OHNA therefore reports the standard of oral health for both children and adults, in relation to the following oral conditions – tooth decay, gum diseases and oral cancer. Each have been chosen for inclusion within this OHNA, given significant concerns about their prevalence, associated health impacts and the fact they are largely preventable [5,6,15].

Furthermore, national guidance explicitly references the action required by local authorities and key partners to prevent tooth decay, gum diseases and oral cancer [3,4,8,15,24]. Therefore, the OHNA Task and Finish Group agreed that these conditions would be the focus of the OHNA and other aspects of oral health e.g. orthodontics and dental trauma, would not be included within the scope of this OHNA.

For reference, NHSE published a West Midlands Orthodontic Needs Assessment in 2018, which included the population of Herefordshire [25].

Tooth decay

- Tooth decay (dental caries) occurs when tooth tissue is demineralised in response to the acids produced when dental plaque bacteria respond to dietary sugars.
- Continued high intake of dietary sugars, inadequate exposure to fluoride and a lack of regular plaque removal, lead to the tooth structures being destroyed.
- Over time this results in cavities and pain, and in the advanced stage, tooth loss and systemic infection.

Gum diseases

- Gum (periodontal) diseases comprise a range of oral conditions characterised by inflammation of the gums and loss of the tissues supporting the teeth.
- Caused by an interaction between plaque bacteria and the body's immune system, gum diseases present as bleeding or swollen gums (gingivitis) and pain. As gum diseases progress, chronic inflammation leads to a loss of gum attachment to the tooth and a loosening/loss of teeth (periodontitis).

Oral cancer

- Oral cancers include cancers of the lip and all sub-sites of the oral cavity and oropharynx. Oral cancers (especially in their advanced stage) and their associated treatments may cause difficulty in eating, drinking, communicating and affect their facial appearance.

WHAT CAUSES POOR ORAL HEALTH?

Wider determinants of oral disease

Individual behaviours related to oral hygiene and lifestyle are important in determining the risk of poor oral health and oral diseases. For example, inadequate exposure to fluoride and high consumption of sugar increases a person's risk of developing tooth decay and gum disease [4,12].

However, it is widely accepted that individual behaviours are profoundly shaped by the circumstances in which people are born, grow, live, work, and age [26]. The causes of poor oral health are therefore understood to be driven by a complex range of interacting biological, behavioural, psychosocial, environmental and socioeconomic factors [7,26–28] – see figure 3.

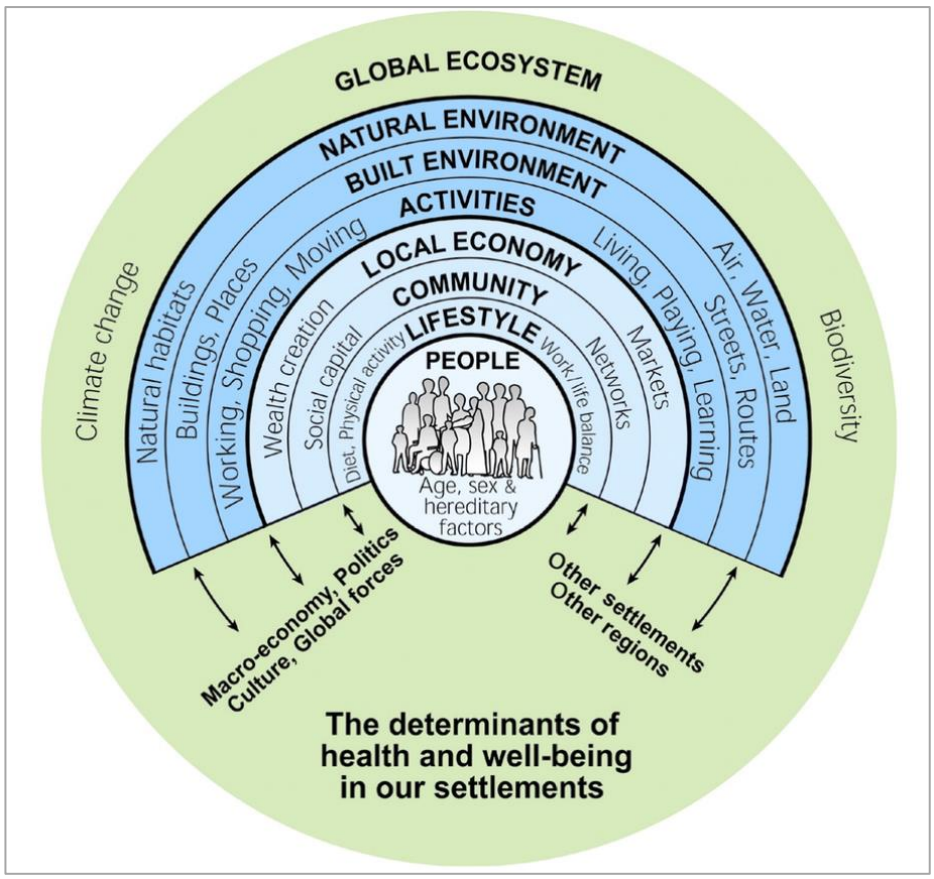


Figure 3 - The health map [25]

National policy and guidance on improving oral health [3,8,14,15,24,29], explicitly recognises the relationship between a person's risk of oral diseases and the 'wider determinants' of oral health. The wider determinants represent the background factors or characteristics that may increase someone's likelihood of adopting a particular behaviour or experiencing a specific health outcome.

For example, a person experiencing poverty is more likely to use tobacco, an important and modifiable risk factor for oral cancer [10,30,31].

Common risk factor approach

In order to achieve sustainable improvements in oral health, it remains crucial to address both the wider determinants and the modifiable risk factors for oral disease.

Significantly, most oral diseases share risk factors common to the four leading non-communicable diseases in the UK – Cardiovascular disease, cancer, respiratory diseases and diabetes [9]. These common risk factors include unhealthy dietary habits, tobacco use, excess alcohol consumption, poor oral hygiene and stress (see figure 4).

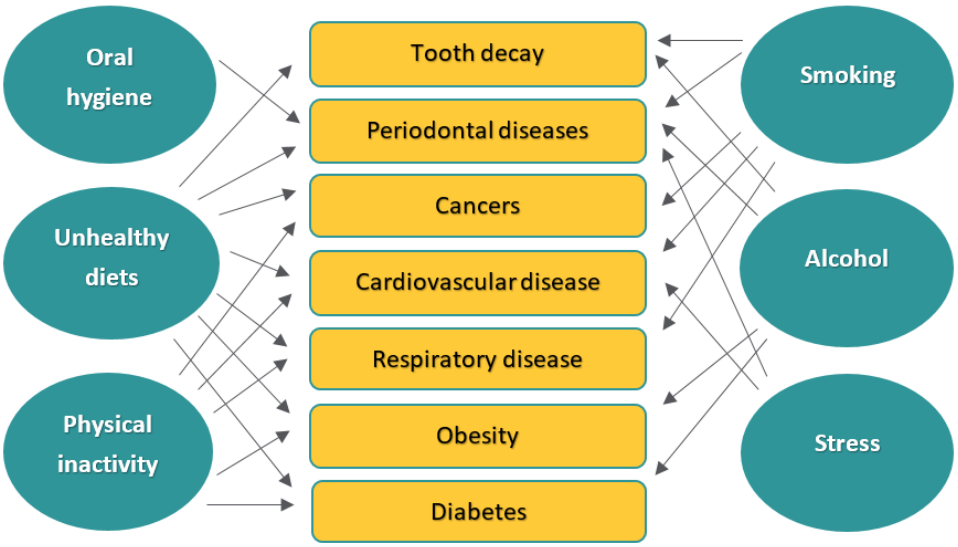


Figure 4 - Common risk factor approach for oral health (adapted from Watt, 2007[9])

By adopting a 'common risk factor approach' [10] both the wider determinants and risk factors common to chronic diseases are targeted and modified. This approach is deemed to be more effective and efficient than disease-specific approaches for improving oral health and population health more broadly because –

- Most chronic diseases have multiple risk factors e.g. cancer or cardiovascular disease
- A single risk factor can impact upon multiple diseases e.g. unhealthy dietary habits
- Some risk factors cluster in specific groups of people e.g. those from lower socio-economic backgrounds or particular minority ethnic groups

- Risk factors can interact e.g. relationship between tobacco use and excessive alcohol consumption

Intelligence regarding the incidence and prevalence of common risk factors, helps to understand future oral health needs. Therefore, in addition to the epidemiology of oral diseases, this OHNA also reports the local picture of common risk factors known to impact upon poor oral health i.e. smoking, alcohol use and dietary behaviours.

WHO IS MOST AT RISK OF POOR ORAL HEALTH?

Despite substantial improvements in oral health in England, marked inequalities remain [7,27,32,33]. Crucially as oral diseases are largely preventable, the existence of inequalities in oral health are considered to avoidable, unfair and unjust [7,34].

Poor oral health and oral diseases disproportionally affect individuals in society who are disadvantaged, vulnerable or socially excluded. For these groups, *"their economic, social or environmental circumstances means they are at greater risk of experiencing poorer oral health or may find it more difficult to access appropriate dental care"* [5 - pg 93/94]. This is inclusive of people who –

1) Are from a lower socioeconomic group or live in a more deprived area

Variations in outcomes related to oral health and health more broadly follow a continuum between different socioeconomic groups in society [26]. Those from higher socioeconomic groups experience better oral health than those from the lowest socioeconomic groups who typically experience poorer oral health [7,8].

For instance, a 20.1% difference exists in the prevalence of dental decay between 5 year olds in the most deprived and least deprived communities in England (33.7% and 13.6% respectively) [33].

Deprivation is also a significant driver for the lifestyle behaviours linked to poor oral health, with those in the lowest socioeconomic groups, more likely to smoke, have a diet higher in sugar and less likely to adopt good oral hygiene practices [7,13,30,32].

2) Are from a Black, Asian and Minority Ethnic group (BAME)

Within England, the standard of oral health varies according to ethnicity. Those from particular ethnic groups experience a markedly different burden of oral diseases such as tooth decay and oral cancer [6,7].

For example, in 2017, an almost 30% difference in the prevalence of dental decay was identified between Black/Black British children (19.6%) and children from an Eastern Europe background (49.4%) aged 5 [33].

3) Are older and frail

Maintaining good oral health can be difficult for those who are older or frail, especially those experiencing multiple long-term conditions and those living in residential care settings [24].

Those who are older or frail may face specific challenges, such as functional or mobility limitations and transport difficulties, which impact on their oral hygiene routine and their ability to access dental care. Both of which leave older people at higher risk of oral diseases and requiring increasingly complex oral healthcare [35,36].

4) Have learning disabilities

Children and adults with learning disabilities are likely to have a greater prevalence and severity of oral diseases [6,7]. Furthermore, compared to the general population, individuals with learning disabilities may have greater unmet dental care needs. PHE, recently published guidance [37] detailing the barriers someone with learning disabilities may face in achieving good oral health and accessing quality dental care.

5) *Are, or who have been in care i.e. Looked after children*

Looked after children (LAC) refer to those children under the age of 18 years, being looked after by a local authority. Due to issues associated with poverty, abuse and neglect, LAC tend to have poorer health and well-being than their peers and this is reflected in their standard of oral health [6,38].

LAC typically experience a greater burden of oral disease and are more likely to have unmet dental care needs. As part of the statutory health assessments for LAC, local authorities have a duty of care to identify and address their oral health needs [38].

6) *Are homeless*

People who are homeless are a diverse group comprising of the roofless and those living in temporary accommodation [39]. Limited research exists, which comprehensively evidences the oral health or oral health needs of people who are homeless. Recent studies however have identified that those who are homeless have significantly higher levels of tooth decay, gum disease and tooth loss than the rest of the population.

Furthermore, despite significant challenges in accessing appropriate care, people who are homeless often require more complex dental treatment [3,6,8].

7) Experience mental health problems

In 2014, around one in six adults in England met the criteria for having a common mental disorder [40]. Furthermore, 11% of children and young people aged between five and fifteen have a clinically diagnosable a mental health issue [41].

Those experiencing severe or enduring mental health problems are at particular increased risk of poorer oral health compared to the general population. In addition, accessing necessary dental treatment poses specific challenges for both children and adults experiencing mental health problems [42].

8) Experience issues with substance misuse

People who misuse drugs or alcohol tend to have poorer oral health. Use of illicit substances and excessive consumption of alcohol, negatively affects oral health by increasing a person's risk of tooth decay, gum disease and oral cancer [6,12,43].

9) Are from other vulnerable groups

This is inclusive of Gypsies and Travellers, refugees and asylum seekers, the medically compromised, as well as those with dental anxiety and dental phobia [6,44].

WHAT ARE THE IMPACTS OF POOR ORAL HEALTH?

As will be detailed later within the OHNA, the prevalence of oral diseases nationally and within Herefordshire, presents a significant public health issue. Poor oral health negatively affects a person's physical, emotional and social well-being and overall quality of life [45].

Oral diseases can cause pain and infection, which may impact upon a child or adults ability to eat, sleep, socialise, learn and work [11,23,34,44] – see figure 5.

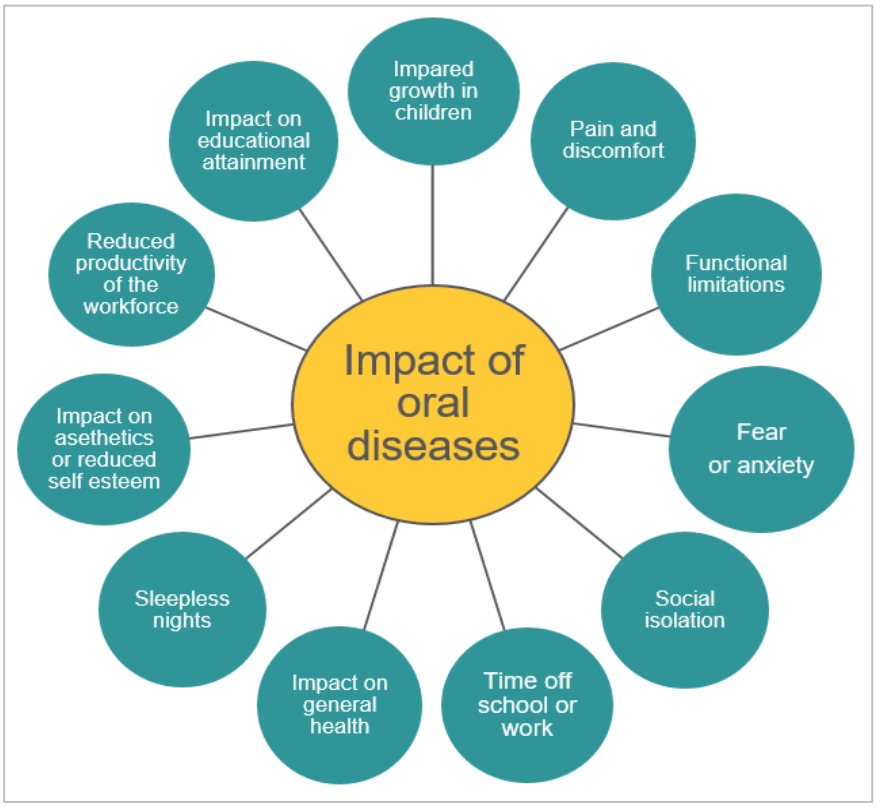


Figure 5 - Impact of oral diseases [29, 39]

A substantial negative impact of poor oral health relates to the level of disability in childhood resulting from oral diseases. For children aged 5-9 years in the UK, poor oral health was associated with a greater level of disability, than vision and hearing loss and diabetes mellutis [11,45].

Significantly, the impacts of poor oral health are not limited to the individual or their family, but present consequences to society more broadly. Despite being largely preventable, treating oral disease is costly, given the requirement for highly trained professionals, expensive technology and materials.

The NHS spent approximately £3.4 billion per annum on dental treatment in England during 2014, with an estimated additional £2.3 billion spent in the private sector [45]. Of considerable concern are the costs associated with tooth extractions. During 2015/2016, the NHS spent £50.5 million on tooth extractions for those under 19 years of age, the majority of which were due to preventable tooth decay.

In England, among children under five years of age, there were 9,306 admissions to hospital for tooth extractions in 2015/2016 (with 7,926 specifically identified as being due to tooth decay), at a cost of approximately £7.8 million.

HEREFORDSHIRE – PLACE AND POPULATION

PLACE

The County of Herefordshire is located in the West Midlands of England bordering Wales to the west, Shropshire to the north, Worcestershire to the east and Gloucestershire to the south-east (Figure 6). The city of Hereford lies in the middle of the county and other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

The county has extensive countryside with remote valleys and rivers and a distinctive heritage. The River Wye divides the county, flowing east from the Welsh border through Hereford city before turning south through the Wye Valley 'Area of Outstanding Natural Beauty'. The Malvern Hills rising to 400m border the east of county, while the south-west is dominated by the western reaches of the Black Mountains with altitudes of more than 600m.

Herefordshire covers 2,180 square kilometres (842 square miles) with 95% of the land area classified as 'rural' and 53% of the population live in these rural areas. Being a predominantly rural county presents opportunities in, for example, tourism and agriculture, but also presents challenges, for example in geographical barriers to services.

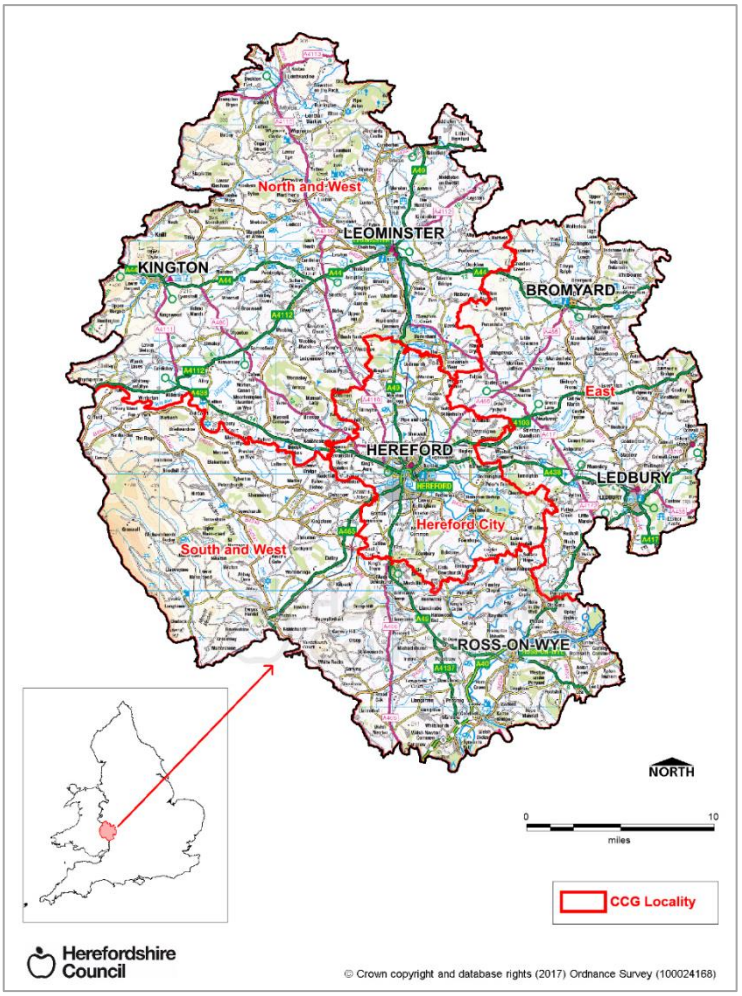


Figure 6 - Map of the County of Herefordshire

POPULATION

This section provides an overview of the total population of Herefordshire using figures produced by the Office for National Statistics (ONS), including information about recent and predicted total population growth and age structure.

Herefordshire is a predominantly rural county and has the fourth lowest population density in England. Between 2001 and 2017 the Herefordshire population increased from 174,900 to 191,000, which represents a 10.9% increase compared to population growth of 12% observed across England and Wales over the same period.

Although Herefordshire has a similar proportion of under-16s (17%) to that across England and Wales (19%), the county has an older age structure with 24% of the population aged 65+ (45,800 people) compared to 18 % nationally. This includes 6,100 people aged 85+.

Herefordshire is resident to a lower proportion of younger working age adults (from the age of 16 to mid-forties) compared with England & Wales, but has a higher proportion of older working age adults (mid-forties to the age of 64).

If recent (last five years) demographic trends were to continue and nationally determined assumptions about future fertility, mortality and migration were to be realised, the total population of Herefordshire is predicted to increase by 1% from the 2017 figure of 191,000 to 193,000 in 2020, and to 218,800 people by 2030, an increase of 9.2% from 2017 (Table 1).

Between 2017 and 2030 the majority of age groups show predicted increases in numbers, the exceptions being between 45 and 59 where numbers are predicted to fall by 3,000, a proportional decrease of 7.3%.

The greatest increase in numbers are predicted for those aged 75 and over where numbers will increase by 10,500, a proportional rise of over 50%. For those aged under 15 numbers will increase by 12.3% from 30,000 to 33,700.

These changes are reflected in the predicted change in population structure between 2017 and 2030 with there being an evident decrease in the overall proportion represented by those age 45 to 59 falling from 21.6 to 17.5%, a pattern reflected in both males and females (Figure 7).

Conversely, the proportion of the whole population accounted for by those aged 75 and over increases from 10.8 to 14.2%.

Table 1 - Estimated headline population figures for Herefordshire, mid-2017 to mid-2030

Age group	2017	2020		2025		2030	
		N	% change	N	% change	N	% change
0-4	9,500	9,600	1.1	10,300	8.4	10,800	13.7
5-9	10,600	10,800	1.9	10,800	1.9	11,400	7.5
10-14	9,900	10,600	7.1	11,500	16.2	11,500	16.2
15-19	9,700	9,100	-6.2	10,200	5.2	11,000	13.4
20-24	8,900	9,100	2.2	9,200	3.4	10,200	14.6
25-29	11,000	10,900	-0.9	11,100	0.9	11,000	0
30-34	10,800	11,500	6.5	12,300	13.9	12,400	14.8
35-39	10,600	11,100	4.7	12,600	18.9	13,300	25.5
40-44	10,200	10,600	3.9	12,100	18.6	13,400	31.4
45-49	13,000	11,800	-9.2	11,400	-12.3	12,800	-1.5
50-54	14,500	14,100	-2.8	12,600	-13.1	12,100	-16.6
55-59	13,700	14,800	8.0	14,900	8.8	13,300	-2.9
60-64	13,000	13,500	3.8	15,500	19.2	15,500	19.2
65-69	13,100	12,700	-3.1	13,800	5.3	15,600	19.1
70-74	12,000	13,000	8.3	12,500	4.2	13,400	11.7
75-79	8,200	9,600	17.1	12,000	46.3	11,500	40.2
80-84	6,300	6,700	6.3	8,200	30.2	10,300	63.5
85-89	3,900	4,200	7.7	4,900	25.6	6,000	53.8
90+	2,200	2,300	4.5	2,700	22.7	3,300	50.0
All ages	191,100	196,000	2.6	208,600	9.2	218,800	14.5

(Data source: ONS 2017 mid-year estimates © Crown copyright)

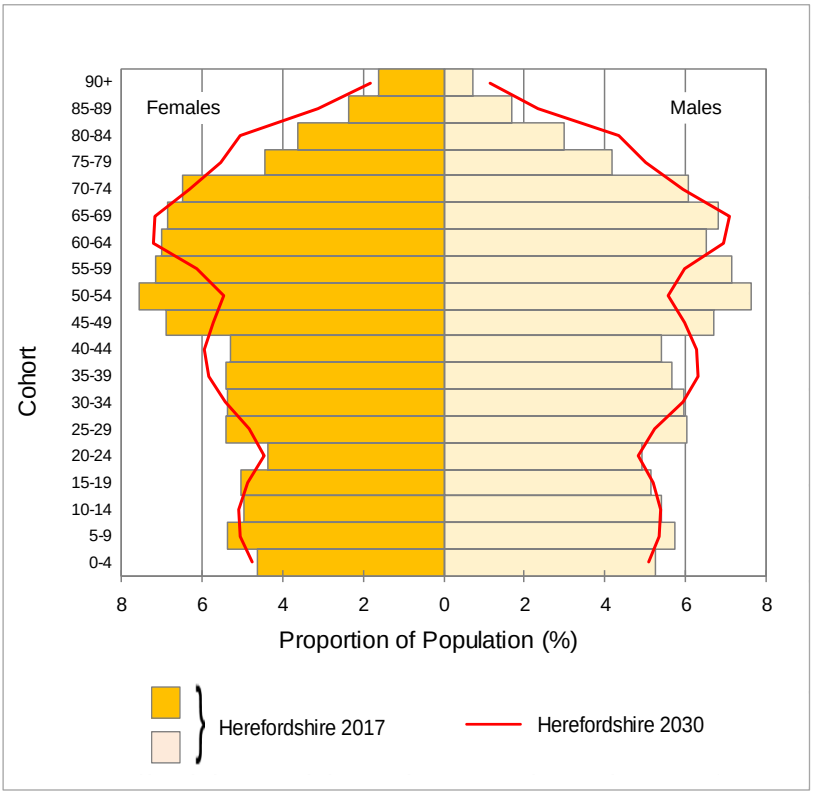


Figure 7- Estimated resident population of Herefordshire in 2017 and 2013

(Data source: ONS 2017 mid-year estimates © Crown copyright**)**

The predominantly rural nature of Herefordshire is reflected in the population density across the county with densities of over 5,000 individuals per km^2 recorded in some areas of Hereford, while densities of between 1,000 and 5,000 individuals per km^2 also evident in the market towns and parts of Hereford; much of the west of the county is resident to low population densities of less than 50 individuals per km^2 (Figure 8).

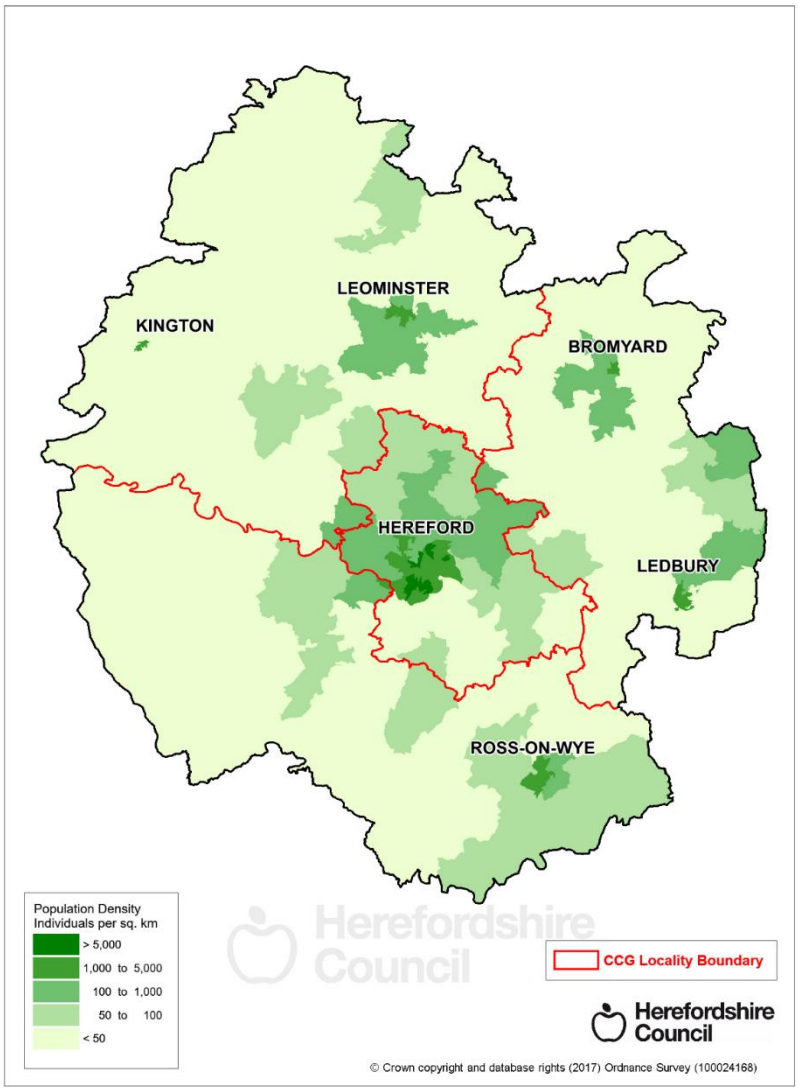


Figure 8 - Population density across Herefordshire, 2017

(Data source: ONS 2017 mid-year estimates © Crown copyright)

ETHNICITY

The 2011 census was the first opportunity to accurately quantify the impact that the expansion of the European Union in 2004 had had on Herefordshire's population, and it remains the only accurate source of information about the characteristics of the population. Estonia, Czech Republic, Hungary, Lithuania, Latvia, Poland, Slovakia and Slovenia joined in 2004; Romania and Bulgaria in 2007.

Experimental estimates in the years between censuses in 2001 and 2011 had indicated that the population of an ethnic origin other than 'white English, Welsh, Scottish, Northern Irish, British' –

known as the ‘Black, Asian and minority ethnic’ (BAME) population – had increased from 2.5 to 5.9%.

However, the 2011 census revealed that migration from Eastern Europe had been significantly under-counted in these estimates (mostly people of ‘white: other’ origin), and that they had also over-estimated the growth in the non-white population. In fact, the non-‘white British’ population in 2011 was 11,600 – more than two-and-a-half times bigger than in 2001 (4,300).

The proportion had increased from 2.5 to 6.3%, although this was still very low in national terms (19.5% across England and Wales as a whole). The ethnicity of the Herefordshire population is summarised in Table 2.

Table 2 - Ethnicity of Herefordshire population

Ethnic Group	Herefordshire		England
	No.	%	%
White: English/Welsh/Scottish/Northern Irish/British	171,900	92.0	80.5
White: Irish	700	0.4	0.9
White: Gypsy or Irish Traveller	350	0.2	0.1
White: Other White	7,200	5.1	4.4
Mixed/multiple ethnic groups	1,250	0.8	2.2
Asian/Asian British	1,450	1.1	7.5
Black/African/Caribbean/Black British	350	0.2	3.4
Other ethnic group	250	0.2	1
Total not 'White'	3,300	2.3	14.1

(Data Source: 2011 Census, table KS201. © Crown copyright)

DEPRIVATION

Based on the Index of Multiple Deprivation, out of 152 upper tier (county or shire council) authorities Herefordshire is the 92nd most deprived and is more deprived than its geographical neighbours – Shropshire (ranked 115th), Worcestershire (ranked 111th) and Gloucestershire (ranked 123th).

Of the 116 ‘Lower Layer Super Output Areas’ (LSOAs) in Herefordshire, Golden Post-Newton Farm is amongst the 10% most deprived across England; a further eight are included within the most deprived 20% in the Country, four of which are in south Hereford and three are in Leominster town.

When considering deprivation in Herefordshire across the county it is evident that a division exists between the east and the west of the county, with the latter comprising a relatively larger number of areas in the 50% most deprived in the county (Figure 9). Hereford city and the surrounding

rural area also have some of the least deprived areas in Herefordshire. Other less deprived areas include LSOAs located within the towns of Bromyard, Ledbury, Leominster and Ross-on-Wye, as well as rural areas between Hereford and Leominster and around Ledbury.

The income deprivation affecting children index is a supplementary index to the overall income domain. It gives the actual proportion of children aged 0-15 living in income deprived families. There are around 4,300 children living in income deprivation across Herefordshire (14% of all children), with the ten most deprived LSOAs in the county each have at least 28% of their under 16s living in income deprivation.

Ridgemoor in Leominster and Golden Post - Newton Farm in south Hereford have the highest proportions of children living in income deprivation with 38 and 34% respectively.

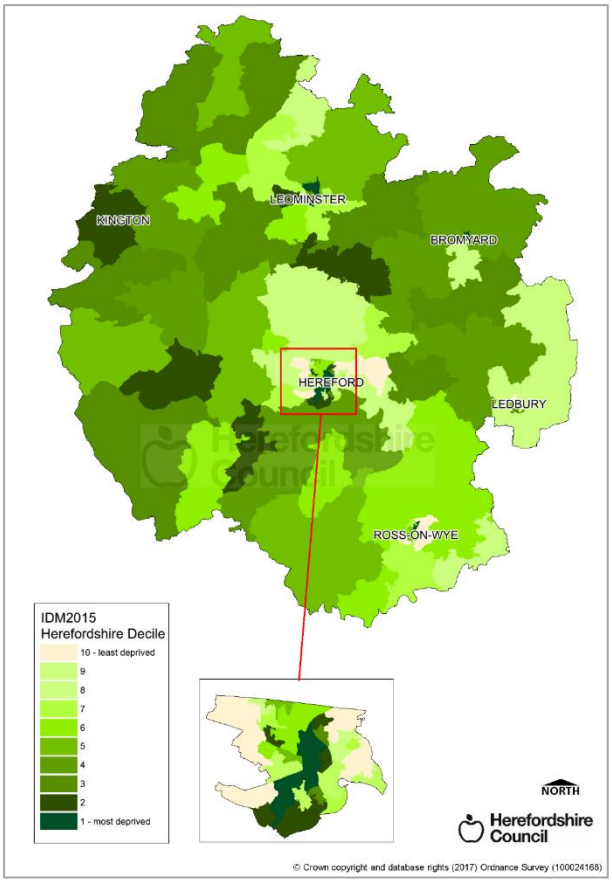


Figure 9 - Distribution of the IMD 2015 for Herefordshire LSOAs

(Data Source: ONS, 2015 © Crown copyright).

LIFE EXPECTANCY

Between 2001-03 and 2015-17 the life expectancy in males and females in Herefordshire have shown a steady increase, although small falls have been evident in subsequent years (Figure 10). For those born in Herefordshire in 2015-17 the average life expectancy is 79.8 years for males and 83.6 years for females. Similar patterns were also evident for England, although throughout

this period both the Herefordshire male and female figures have been higher than those recorded nationally, although in recent years the differences have not been significant.

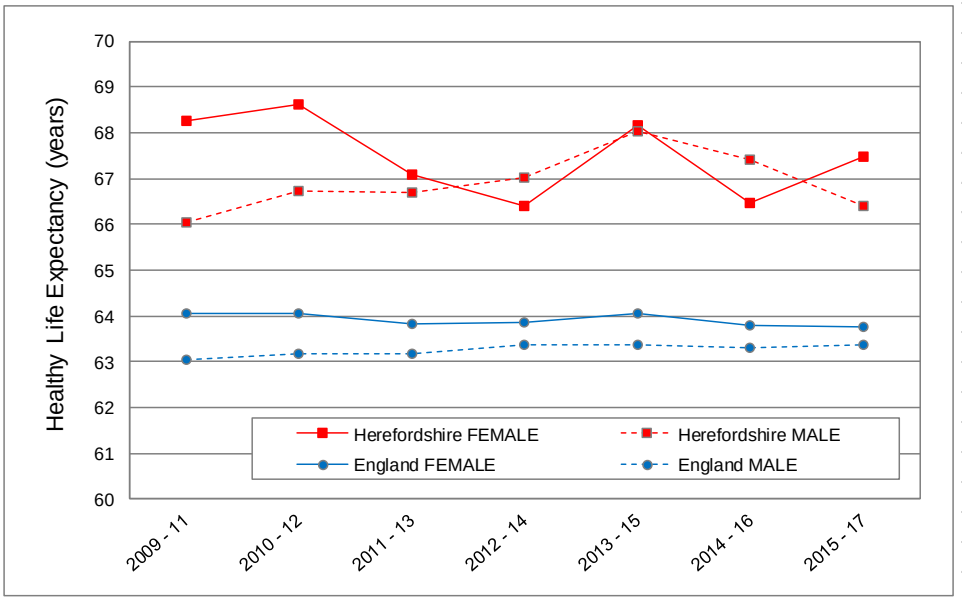


Figure 10 - Male and female life expectancy at birth in Herefordshire and England.

(Data source: Public Health Profiles, PHE)

Between 2009-11 and 2015-17 the healthy life expectancy in males and females in Herefordshire have shown some variability, although throughout this period the local figures have been significantly higher than those reported nationally (Figure 11). For those born in Herefordshire in 2015-17 the healthy life expectancy is 66.4 years for males and 67.5 years for females.

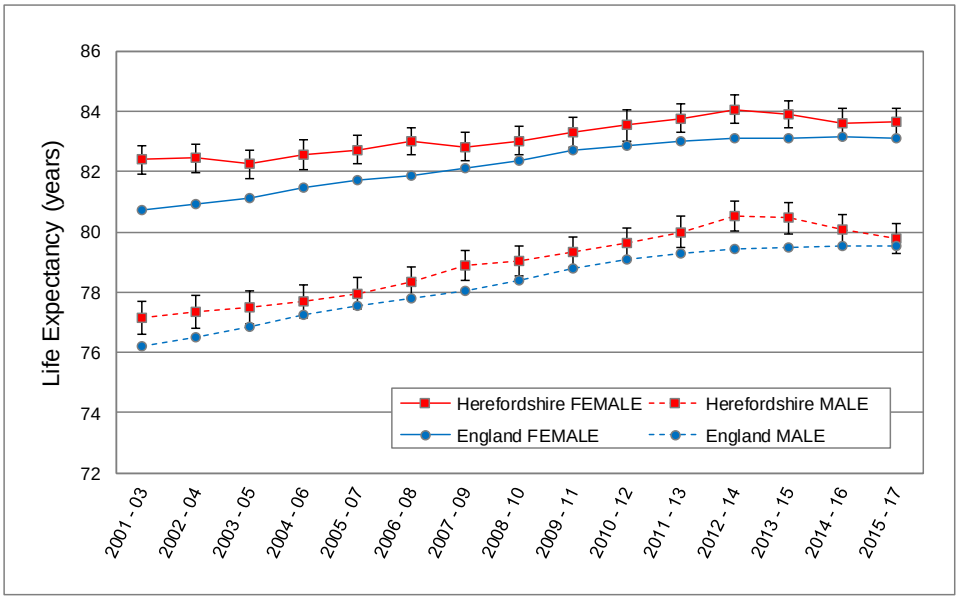


Figure 11 - Male and female healthy life expectancy in Herefordshire and England.

(Data source: Public Health Profiles, PHE)

OVERWEIGHT AND OBESITY - CHILDREN

Between 2007/08 and 2017/18 the proportion of children in reception (4-5 years) who were overweight varied between 20.7% and 24.0% locally, while levels of obesity ranged between 8.0% and 9.8%. In both cases no temporal trends were evident and the local figures were broadly similar to that observed nationally (Figure 12).

Over the same period the proportion of children in year 6 (10-11 years) who were overweight varied between 29.1 and 34.8% locally, while levels of obesity ranged between 15.5 and 19.8%. As with the reception data no temporal trends were evident and the Herefordshire figures were broadly similar to those recorded across England.

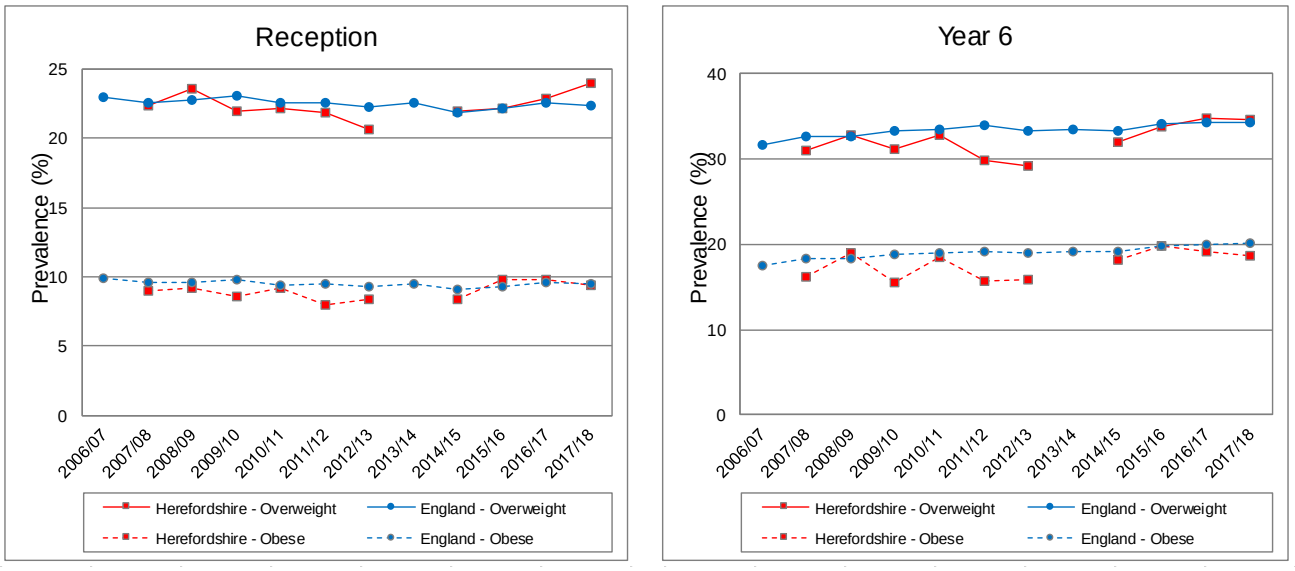


Figure 12 - Prevalence of overweight and obesity in reception and year 6 children in Herefordshire and England
(Data source: Public Health Profiles. PHE)

In 2017/18, of 1,841 Herefordshire reception age children measured, 441 (24.0%) were overweight; of this overweight cohort 172 (9.3%) were obese. In 2016/17 a total of 1,757 year 6 children were measured of which 6082 (34.6%) were overweight, 329 (18.7%) were obese. The local overweight and obese prevalence figures for both age groups were similar to those reported for England.

In reception and year 6 the highest prevalence of obesity was evident in the most deprived areas of Herefordshire with prevalence falling with decreasing deprivation, although in both cohorts this pattern is reversed in the least deprived quintile where both figures being higher than the second quintile (Figure 13). However, there are no areas of the county where fewer than 10% of children are obese when they leave primary school.

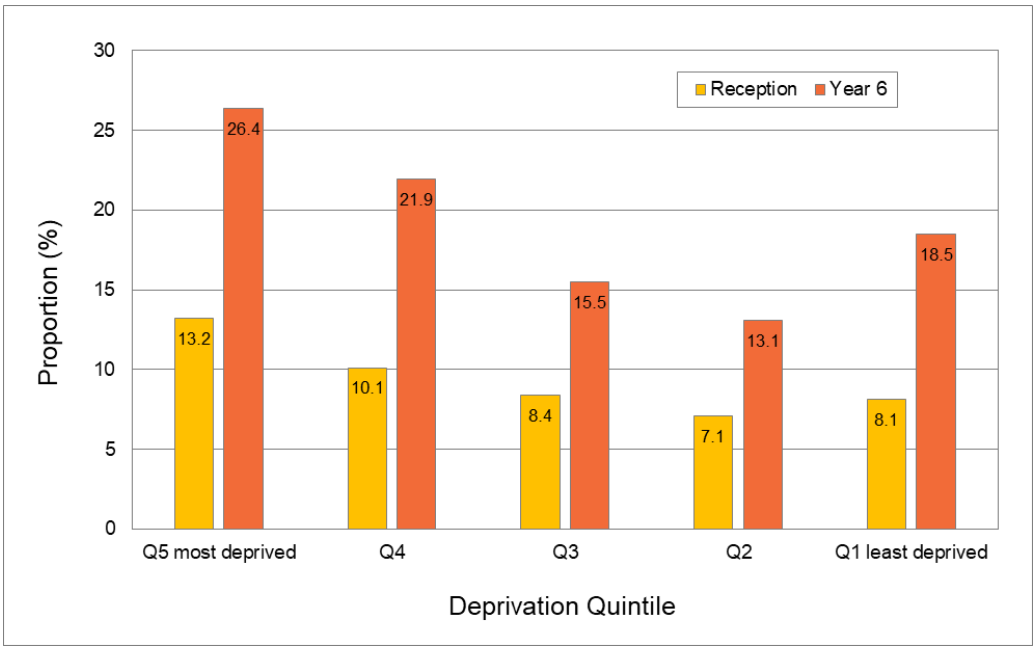


Figure 13 - Proportion of obese children in reception and year 6 by deprivation in Herefordshire.
(Data source: National Child Measurement Programme 2017/2018 and IMD 2015)

OVERWEIGHT AND OBESITY - ADULTS

Since 2015/16 there has been little variability in the prevalence of excess weight or obesity in adults in Herefordshire (Figure 14). In 2017/18 the local prevalence of excess weight was 64.5% which was similar to that recorded for England as a whole (62.0%). The prevalence of obesity in adults in Herefordshire in 2017/18 of 10.2%, was statistically higher than that recorded for England (9.8%).

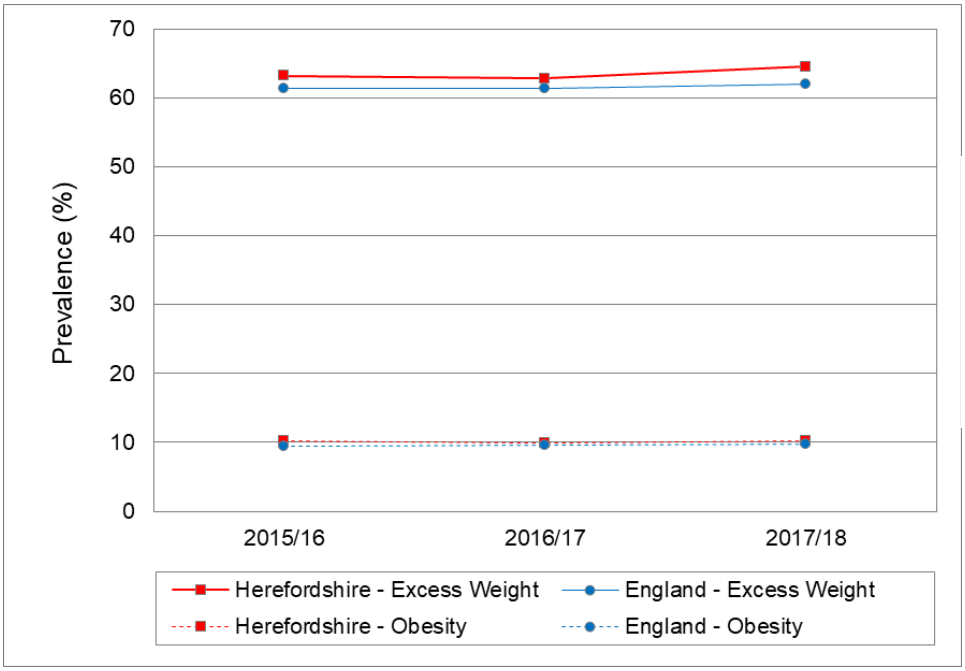


Figure 14 – Local and national trends in adult overweight and obesity prevalence

(Data source: Public Health Profiles, PHE)

HEALTHY EATING - CHILDREN

The government encourages healthy eating through campaigns such as '5 A DAY', which encourages everyone to eat at least five portions of a variety of fruit and vegetables every day. In 2014/15 the What About YOUth (WAY) survey [46] found that 58.3% of 15 year olds in Herefordshire reported eating at least five portions of fruit and vegetables on a daily basis, a figure significantly higher than that for England as a whole.

The Every Child Matters study conducted in 2009 reported that 62% of school children ate "a lot" of fresh fruit and 50% ate "a lot" of vegetables, although 10% reported "never" eating vegetables [47].

HEALTHY EATING – ADULTS

Between 2015/16 and 2017/18 the proportion of the adult population in Herefordshire reported as consuming at least five portions of a variety of fruit and vegetables every day has varied between 64.8% and 68.5% with this local figure being consistently higher than that reported for England as a whole (Figure 15).

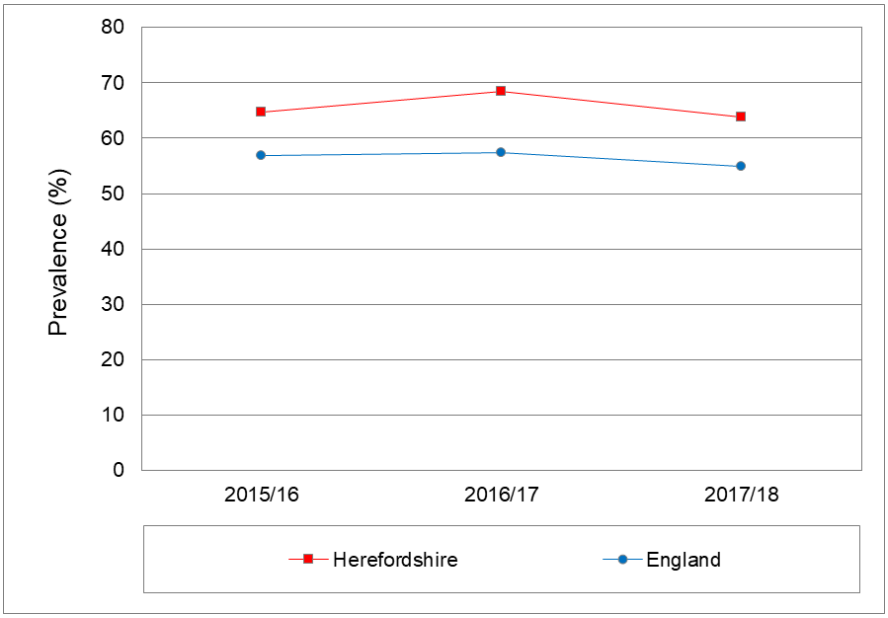


Figure 15 - Proportion of adults meeting the recommended '5-a-day' on a 'usual day'
(Data Source: Public Health Profiles, PHE)

SMOKING – ADULTS

Information on the prevalence of adult smoking has been collected as part of the Integrated Household Survey (IHS) up until 2014 and since 2012 as part of the Annual Population Survey (APS) [31]. Therefore the ONS announced it would no longer produce the IHS. Instead the questions formerly regarded as the IHS core will continue to be asked in the APS.

Between 2010 and 2017 the proportion of adults (aged 18 years and over) in Herefordshire who self-reported as smokers showed a general fall from 19.8 to 12.2%, while over the same period the figures for both England and the West Midlands also fell (Figure 16). With the exception of 2015 the local prevalence was below those recorded nationally and regionally; in 2015 the local figure was higher than both of these figures, although not significantly so.

When considering estimated smoking prevalence and average level of deprivation at each GP practice across Herefordshire it is evident that smoking is more prevalent in the most deprived quartile compared to less deprived quartiles and the lowest smoking prevalence was evident in the least deprived quartile.

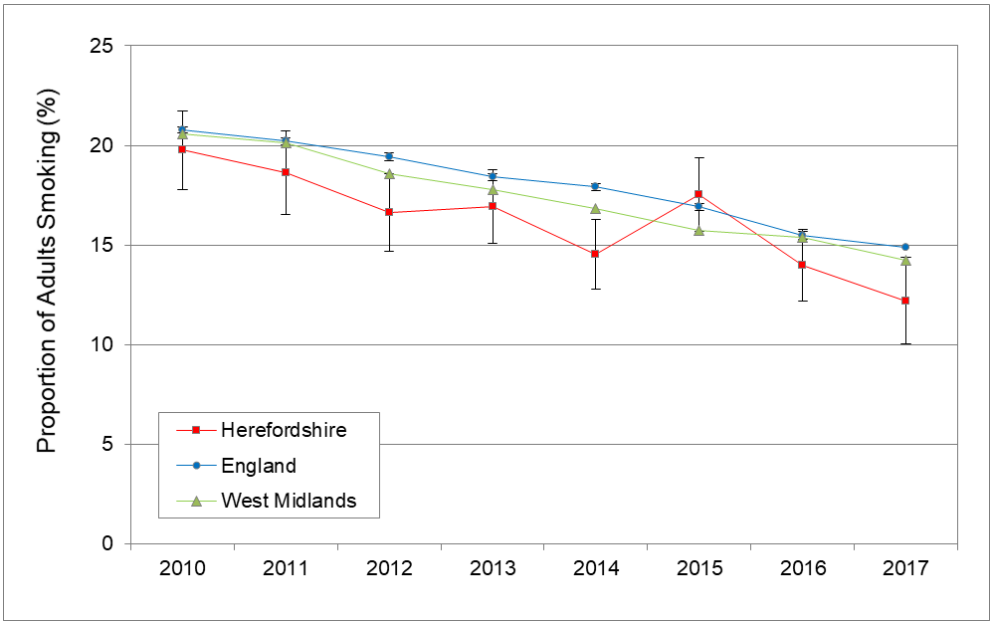


Figure 16 - Local, regional and national trends in prevalence of self-reported smoking in adults.
(Data source: PHE Local Tobacco Control Profiles for England)

ALCOHOL CONSUMPTION– ADULTS

The Herefordshire Health and Well-Being Survey [48] undertaken in 2011 included a section on drinking habits over the previous 12 months and on alcohol intake based on the previous week's consumption.

The findings indicated that 56% of adults reported consuming alcohol on a weekly basis, ranging in frequency from 26% who drank alcohol on average once or twice a week to 11% drinking almost every day (Figure 17). The proportion of males drinking on a weekly basis was 65%, which was significantly higher than the female figure of 46%. Similarly, the proportion of males who drank almost every day (14%) was significantly higher than the female rate of consumption (8%).

Approximately 10% of adults reported that they had not consumed any alcohol over the previous 12 months, while 35% drank less than once a week on average. This data indicates that on average males tend to drink more often than females, a pattern which is evident at all ages,

although for both genders the average frequency of drinking increases with age until 65 years of age after which frequency falls (Figure 18).

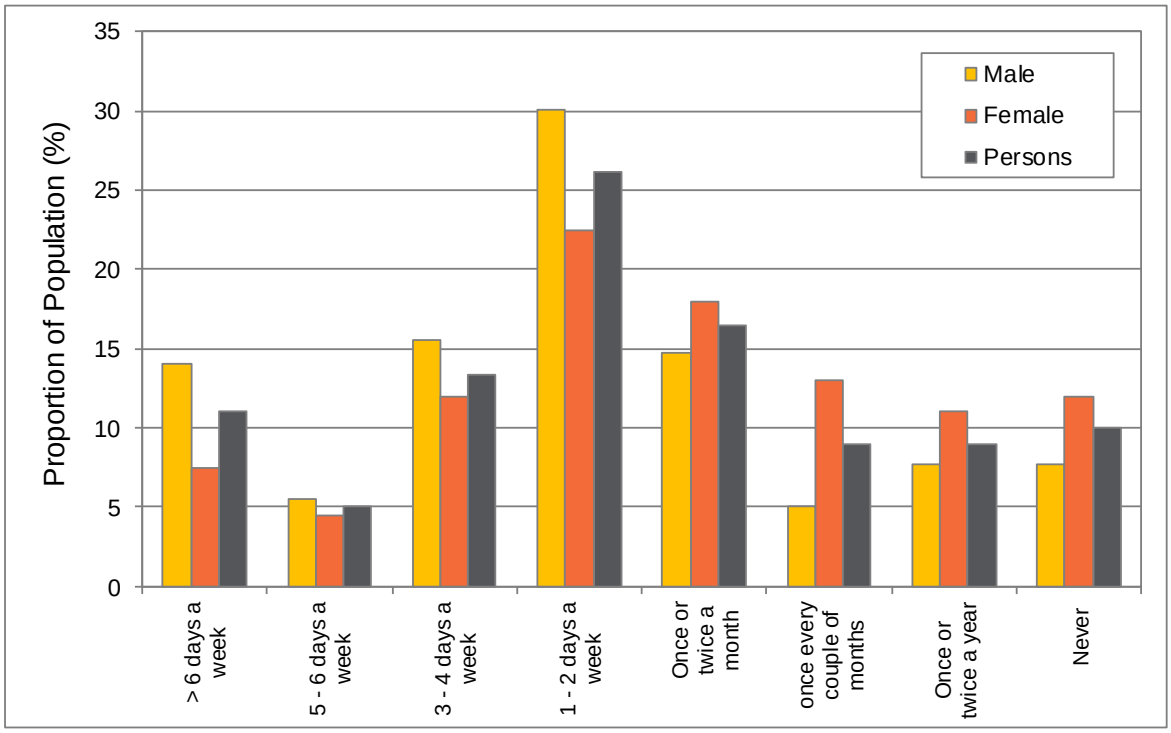


Figure 17 - Average frequency of alcohol consumption in Herefordshire, 2011.

(Data source: Herefordshire Health and Well-Being Survey, 2011)

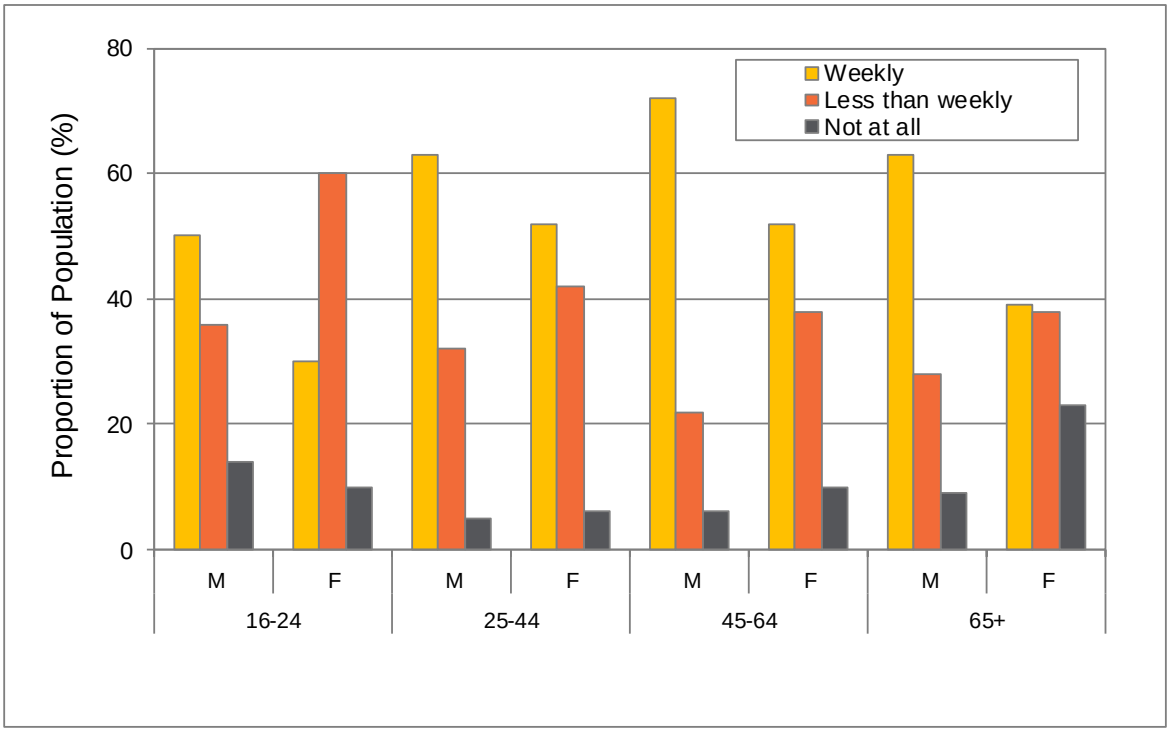


Figure 18 - Average frequency of alcohol consumption by gender and age in Herefordshire, 2011.

(Data Source: Herefordshire Health and Well-Being Survey, 2011)

Recommendations from the four Chief Medical Officers in the UK state that in order to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis [49].

Data for 2001 – 2014 indicate that in Herefordshire 25.9% of adults consumed more than 14 units per week and 21.0% of adults in Herefordshire reported binge drinking on their heaviest drinking day while 14.4% abstained from alcohol.

All three local measures were similar to the majority of figures reported for the ten nearest neighbour authorities. In relation to the level of deprivation across Herefordshire, 45% of adults in the most deprived areas abstain from alcohol, a figure appreciably higher than in less deprived quintiles where the proportions varied between 29 and 32% (Figure 19).

It is interesting to note that the highest proportion of adult binge drinking (22%) was also reported in the most deprived areas. However, a significantly lower proportion of residents in the most deprived areas also reported drinking within guidelines (18%) compared to 26% across the county as a whole. The lowest level of binge drinking in Herefordshire (17%) was recorded in the least deprived areas.

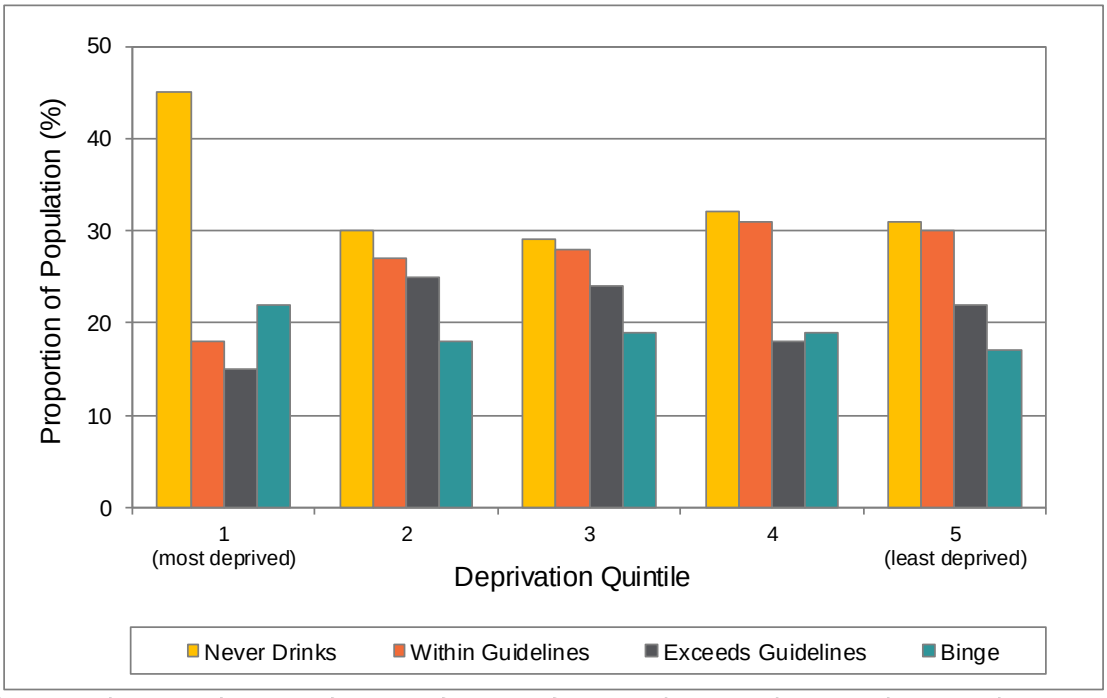


Figure 19 - Drinking behaviour in relation to consumption guidelines by level of deprivation in Herefordshire, 2011
(Data Source: Herefordshire Health and Well-Being Survey, 2011)

POPULATIONS AT RISK

As detailed previously, specific groups in the population are at greater risk of experiencing poorer oral health and some may find it more difficult to access appropriate oral health care. Despite this, there remains a paucity of data related to the oral health experience and overall oral health needs of at risk groups.

Local intelligence does however provide an indication of the numbers and proportion of Herefordshire's population, who belong to specific groups of interest. This information is crucial as it can be used by health and social care professionals to inform the future commissioning and delivery of oral health care services locally.

Looked after children

As of the 31st March 2018, there were 313 LAC in Herefordshire [50]. Table 3, presents the rates of children (aged under 18 years), who were looked after by a local authority at a local, regional and national level. Since 2015, the local rate of LAC has increased year on year and remains higher than both the regional and national values.

Table 3 – Local, regional and national rates of children (aged under 18 years) looked after (per 100,000) as of 31st March 2018 [50]

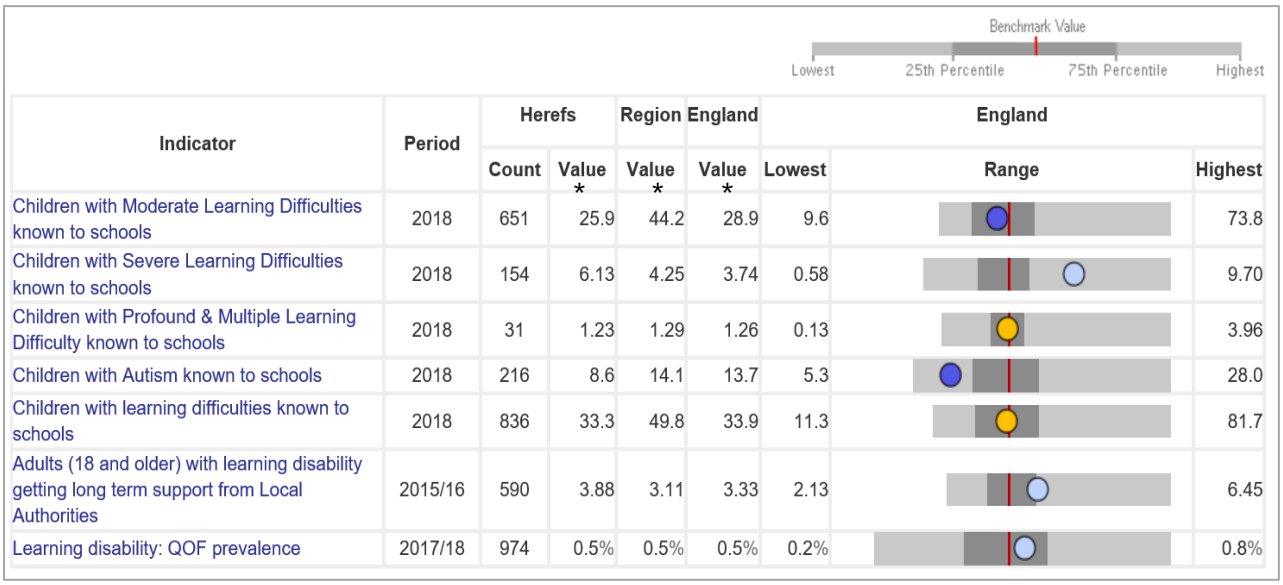
	2014	2015	2016	2017	2018
Herefordshire	67	75	79	84	87
West Midlands	73	74	73	75	78
England	60	60	60	62	64

Learning disabilities

The Public Health Outcomes Framework [17], publishes 'learning disability' profiles for local authorities in England. Each profile includes local data related to children and adults who are known to have a learning difficulty or learning disability and Figure 20 presents the data for Herefordshire.

It is important to note that there are no reliable statistics, which accurately report how many people there are with learning disabilities across the UK. Modelled estimates suggest that GP registers (i.e. QOF prevalence in figure 20), are likely to be an underestimation of the prevalence of learning disabilities.

For example, the true number of people (aged over 14 years) in Herefordshire with a learning disability is estimated to be over 3500 – 2.3% of the population [51,52]. As detailed in Herefordshire's Adult Learning Disabilities Needs Assessment (2018) [52], Herefordshire Council currently provides long-term social care support to around 600 adults with a learning disability.



Indicator	Period	Herefs		Region England	England	England		
		Count	Value *	Value *	Value *	Lowest	Range	Highest
Children with Moderate Learning Difficulties known to schools	2018	651	25.9	44.2	28.9	9.6		73.8
Children with Severe Learning Difficulties known to schools	2018	154	6.13	4.25	3.74	0.58		9.70
Children with Profound & Multiple Learning Difficulty known to schools	2018	31	1.23	1.29	1.26	0.13		3.96
Children with Autism known to schools	2018	216	8.6	14.1	13.7	5.3		28.0
Children with learning difficulties known to schools	2018	836	33.3	49.8	33.9	11.3		81.7
Adults (18 and older) with learning disability getting long term support from Local Authorities	2015/16	590	3.88	3.11	3.33	2.13		6.45
Learning disability: QOF prevalence	2017/18	974	0.5%	0.5%	0.5%	0.2%		0.8%

Figure 20 - Learning disability population data for Herefordshire (Data source: PHE Learning Disability Profiles)

***** Unless % is provided, the term 'value' refers to a rate and reflects a value 'per 1000 pupils' (for indicators related to children) and 'per 1000 population' (for the indicator related to adults).

People who experience mental health problems

PHE publish intelligence related to mental health at a national, regional and local level [(53)]. This includes data about the prevalence of common mental disorders i.e. depression and severe mental illness i.e. schizophrenia [(54)].

Based on data from GP registers in Herefordshire (2017/2018), PHE reported that for adults (over 18 years), the prevalence of depression was 9.1% (9.9% nationally) and the prevalence of severe mental illness was 0.83% (0.94% nationally). This equates to 13,856 and 1,557 people respectively.

In addition and based on modelled estimates, the local prevalance of mental health disorders in children (aged 5-16 years) during 2015 was 8.9% (2,139 children), lower than both regionally (9.7%) and nationally (9.2%).

As mental health data is obtained from registers of those diagnosed or treated, or from self-reported surveys, it is likely that the true burden of mental health problems is underestimated both locally and nationally.

People who need adult social care

There are currently around 1,500 people aged 65 years and over in Herefordshire living in either a local authority or privately funded care home [(55)]. Based on modelling commissioned by Herefordshire Council, the demand for care home places is expected to increase by 3% by 2021

and 5% by 2036 (to 2900). The proportion of people living with dementia in a Herefordshire care home is also expected to rise, from 1200 in 2016 to 2,300 in 2036.

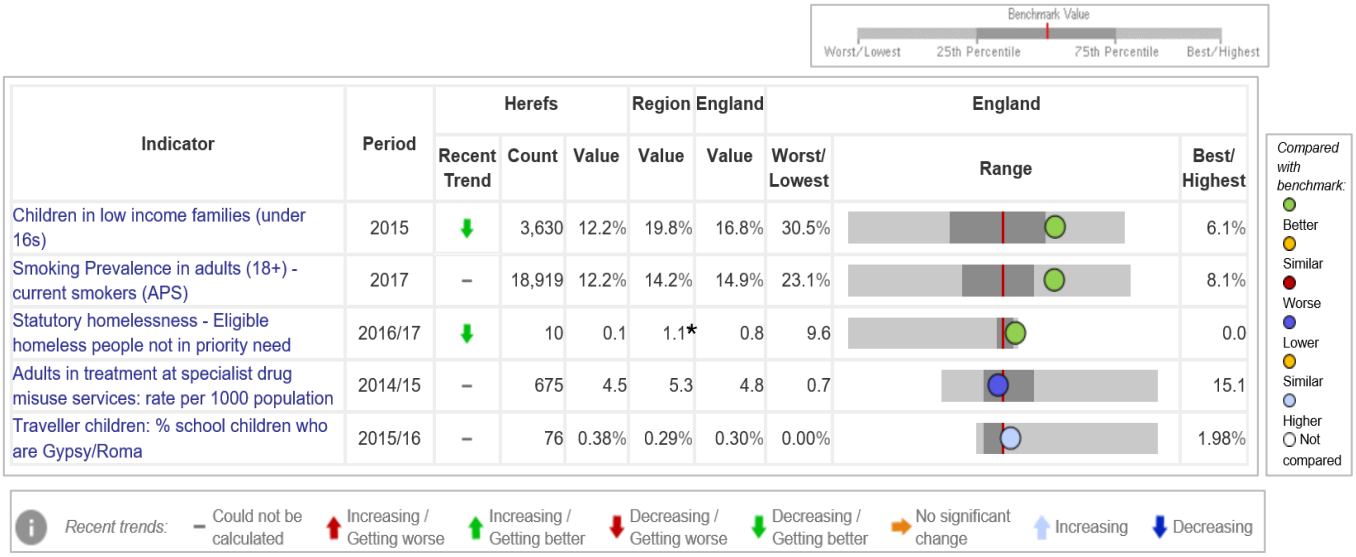
Asylum seekers and refugees

Herefordshire has supported the 'Syrian Vulnerable Person's Resettlement Scheme' (SVPRS), with 60 refugees (14 households) being resettled locally between 2016 and 2017 [56]. In addition up to 25 children and young people who are 'unaccompanied asylum seekers' are 'looked after' and supported by Herefordshire Council.

Herefordshire has agreed in principle to re-settle a further 35 refugees through SVPRS and the Vulnerable Children Resettlement Scheme (VCRS) and up to 40 asylum seekers under the General Asylum Dispersal Scheme (GADS).

Other vulnerable groups

The Public Health Outcomes Framework, publishes oral health profiles for local authorities in England [17]. Each profile includes local data set related to particular socio-demographic and lifestyle factors that are known to increase a person's risk of poor oral health (see figure 21).



Indicator	Period	Herefs			Region Value	England Value	England			Compared with benchmark:
		Recent Trend	Count	Value			Worst/ Lowest	Range	Best/ Highest	
Children in low income families (under 16s)	2015	↓	3,630	12.2%	19.8%	16.8%	30.5%		6.1%	Better
Smoking Prevalence in adults (18+) - current smokers (APS)	2017	–	18,919	12.2%	14.2%	14.9%	23.1%		8.1%	Similar
Statutory homelessness - Eligible homeless people not in priority need	2016/17	↓	10	0.1	1.1*	0.8	9.6		0.0	Worse
Adults in treatment at specialist drug misuse services: rate per 1000 population	2014/15	–	675	4.5	5.3	4.8	0.7		15.1	Lower
Traveller children: % school children who are Gypsy/Roma	2015/16	–	76	0.38%	0.29%	0.30%	0.00%		1.98%	Similar

Higher
Not compared

Recent trends: – Could not be calculated; ↑ Increasing / Getting worse; ↑ Increasing / Getting better; ↓ Decreasing / Getting worse; ↓ Decreasing / Getting better; → No significant change; ↑ Increasing; ↓ Decreasing

***** Aggregated from all known lower geography values as a crude rate per 1000 estimated total households.

Figure 21 - Factors impacting on oral health - Oral health profile for Herefordshire (Data source: PHE Oral Health Profiles)

The data above indicates that aside from adults in treatment for substance misuse services, Herefordshire is broadly better or similar to the regional and national values for the remaining risk factors listed. Despite this, there clearly remains a considerable number of children and adults residing in the county, who may have additional oral health needs compared to the general population.

HEREFORDSHIRE - EPIDEMIOLOGY OF ORAL DISEASES

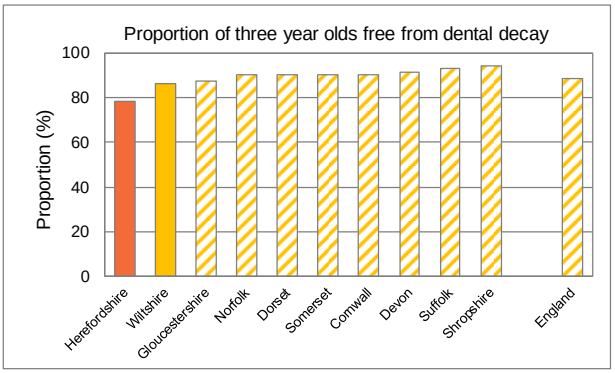
CHILDREN

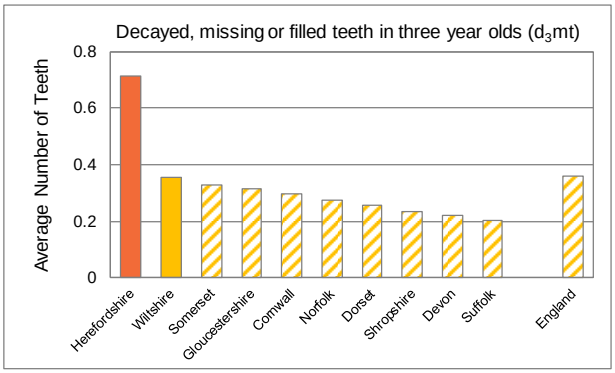
ORAL HEALTH OF THREE YEAR OLDS

A survey of the oral health of three year olds was undertaken in 2013 as part of the Public Health England (PHE) 'National Dental Epidemiology Programme' (NDEP) [57]. Of the 179 children in Herefordshire who participated, 78.3% were found to be free from dental decay, a figure significantly lower than that reported for England as a whole and for the majority of nearest statistical neighbours (Figure 22).

In Herefordshire there were an average of 0.71 teeth per child affected by decay (decayed, missing or filled teeth – d_3mt), a figure twice that recorded nationally and over two and a half times the average for the nearest neighbours (Figure 22). Locally, the number of teeth with obvious, untreated dental decay made up 87% of this figure compared to 89% nationally.

Among those three year olds in Herefordshire with decay experience, the average number of decayed, missing (due to decay) or filled teeth was 3.18, which corresponds to almost one sixth of teeth expected to be present at this age (most children have all 20 primary teeth present by age three). The local figure is similar to that recorded for England (3.08) and is broadly similar to the nearest statistical neighbours (Figure 22).





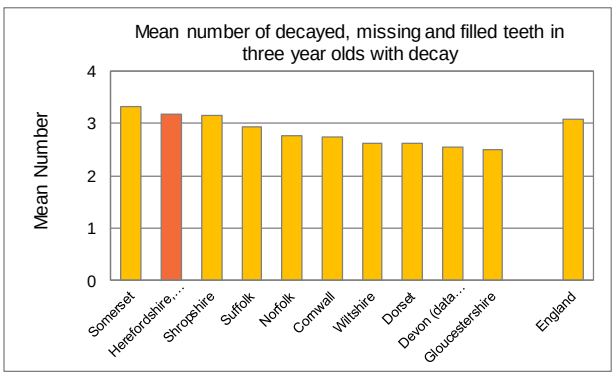


Figure 22 - Oral health of three year olds, 2013 (shaded bars indicate significantly different from Herefordshire figure).

(Data Source: NDEP – PHE)

ORAL HEALTH OF FIVE YEAR OLDS

The proportion of five year olds free from dental decay in Herefordshire has shown some variability with time and the local figure has been consistently lower than that reported for England [33]. The 2016/17 Herefordshire figure of 69.5% was significantly lower than that for England and was lower than the majority of nearest Upper Tier Local Authorities (UTLA) comparators (Figure 23).

The Herefordshire figure was 35th lowest out of 144 UTLAs across England for which data was available.

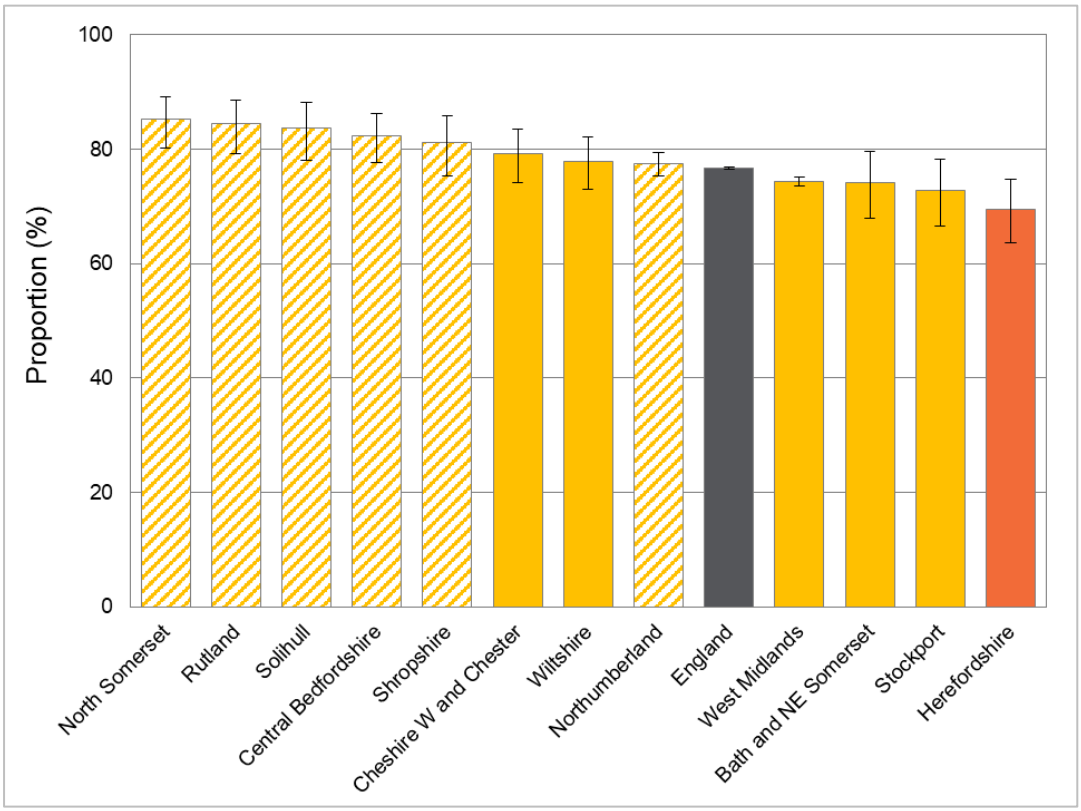


Figure 23 - Proportion of five year old children free from dental decay, 2016/17 (shaded bars indicate significantly different from Herefordshire figure). (Data source: NDEP – PHE)

The mean number of decayed, missing or filled teeth in five-year-olds in Herefordshire 2016/17 was 1.08, much higher than nationally (0.78) and regionally (0.82). Herefordshire was also the worst performing authority of its comparator group for this indicator.

The local figure was ranked the 35th highest out of 144 UTLAs across England for which data was available (Figure 24).

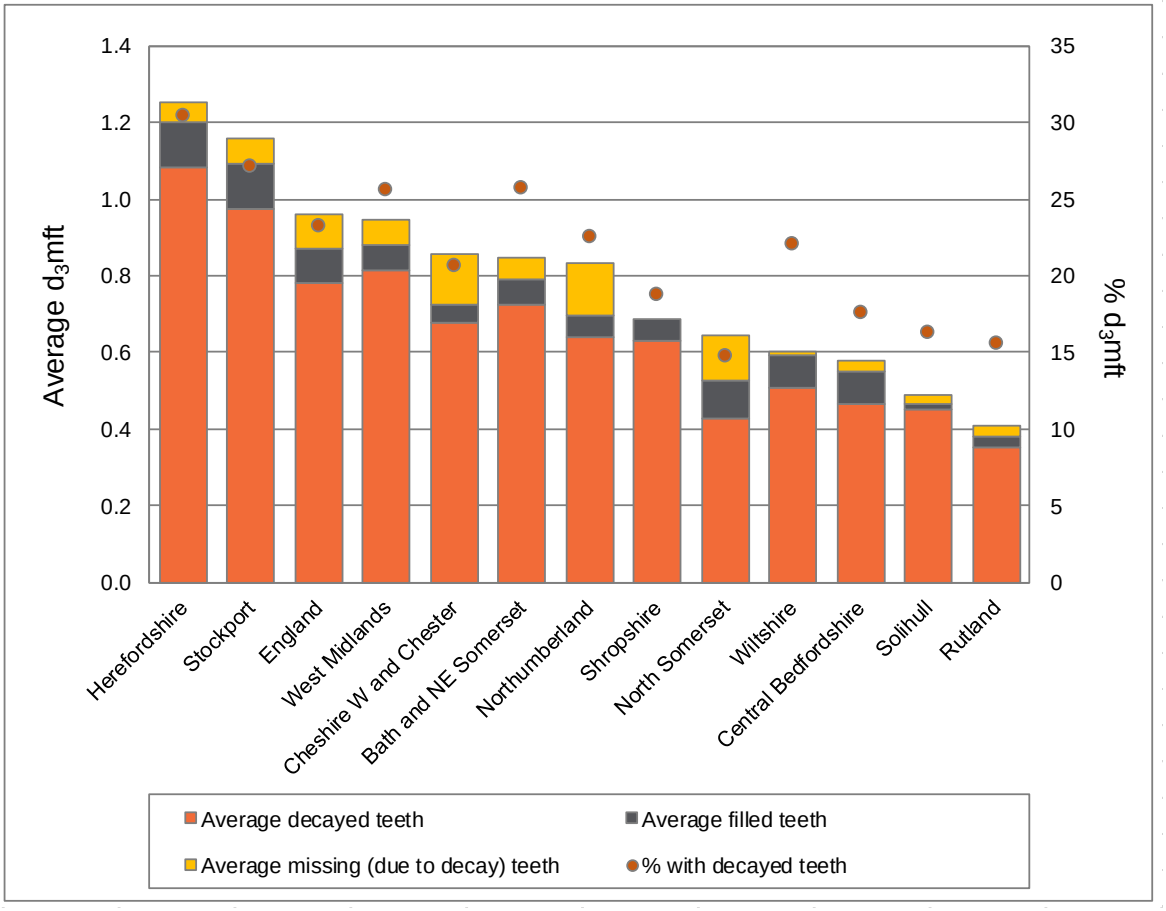


Figure 24 - The average number of decayed, extracted or filled teeth (d3mft) and the proportion of children affected by dental decay (% d3mft>0) among five-year-old children (Herefordshire, comparator local authorities and England).
(Data source: NDEP - PHE)

Data from 2017, would indicate at first glance that there has been a considerable local improvement (see figure 25); in 2017, 30% of children in Herefordshire experienced tooth decay compared to 41% in 2015.

However, it is important to note that the differences between the latest local figures and those reported previously are not statistically significant. What can be concluded from the data is:

- There has been no significant change in the local proportion of 5 year old children with experience of tooth decay over the last 10 years.

- 5 year old children in Herefordshire generally have poorer dental health than that reported nationally.

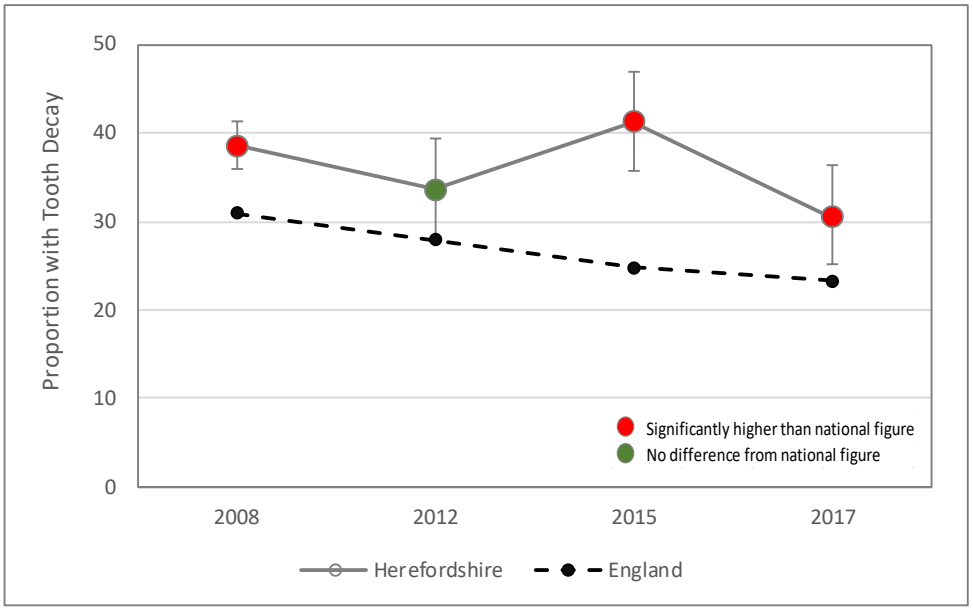


Figure 25 - Proportion of 5 year old children with tooth decay, 2016/17.

(Data source: NDEP – PHE)

Deprivation

Every child who has teeth is at risk of tooth decay, but the risk increases for those living in the more deprived areas where a range of socioeconomic factors influence children's development. However, in 2016/17, while the lowest level of tooth decay in 5 year old was evident in the least deprived population quintile, there was no strong association between levels of decay and deprivation across the county as a whole (Figure 26).

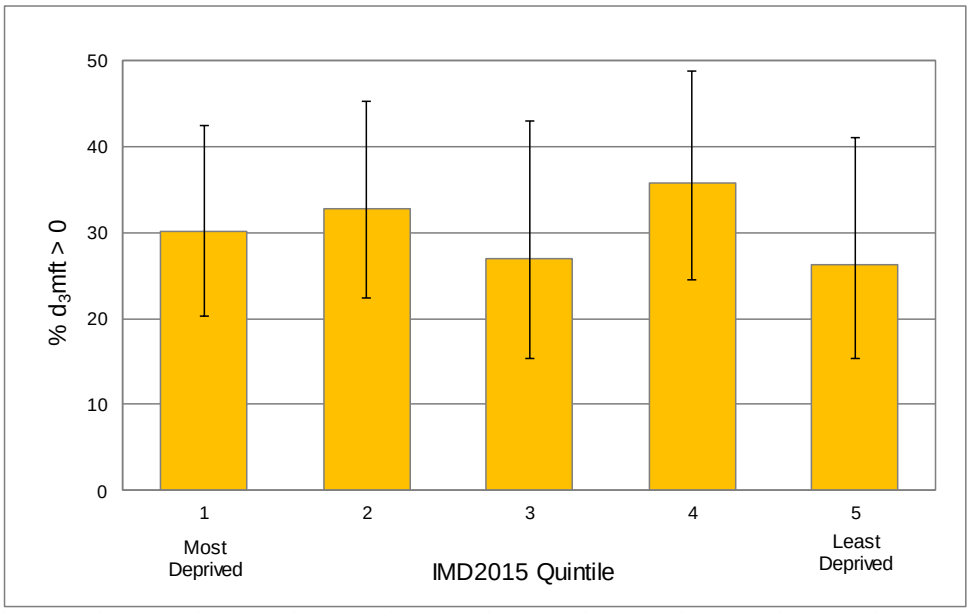


Figure 26 - Prevalence of decay in 5 year olds in Herefordshire by Index of Multiple Deprivation 2015 quintiles

(Data source: NDEP – PHE/IMD 2015)

There were however, spatial patterns evident in the levels of tooth decay in Herefordshire, with high levels observed in Hereford (particularly in South West Wye) and also in Leominster (Table 4).

Table 4 – Tooth decay severity and prevalence in 5 year olds in Herefordshire

Area	Average $d_3$mft	% with decay experience	Average $d_3$mft in those with decay experience
South Wye West	1.70	40.0	4.25
Leominster	1.20	43.9	2.72

Ethnicity

As previously described, at a national level there are known associations between oral health and ethnicity, with children from Chinese and Eastern European backgrounds experiencing greater levels of oral disease [33]. Despite this, at a local level, it is currently not possible to determine the standard of oral health in children according to ethnicity.

ORAL HEALTH OF TWELVE YEAR OLDS

A survey of the oral health of twelve year olds was undertaken in the school year 2008/09 as part of the PHE NDEP [58].

Of the 267 Herefordshire children which participated 55.9% were found to be free from dental decay, a figure significantly lower than that reported for England as a whole and for the majority of nearest statistical neighbours (Figure 27).

In Herefordshire there were an average of 1.05 teeth per child affected by decay (decayed, missing or filled teeth – D_3MFT), a figure significantly higher than that recorded nationally and in the majority of nearest neighbours (Figure 27). Locally, the number of teeth with obvious, untreated dentinal decay made up 38% of this figure compared to 44% nationally.

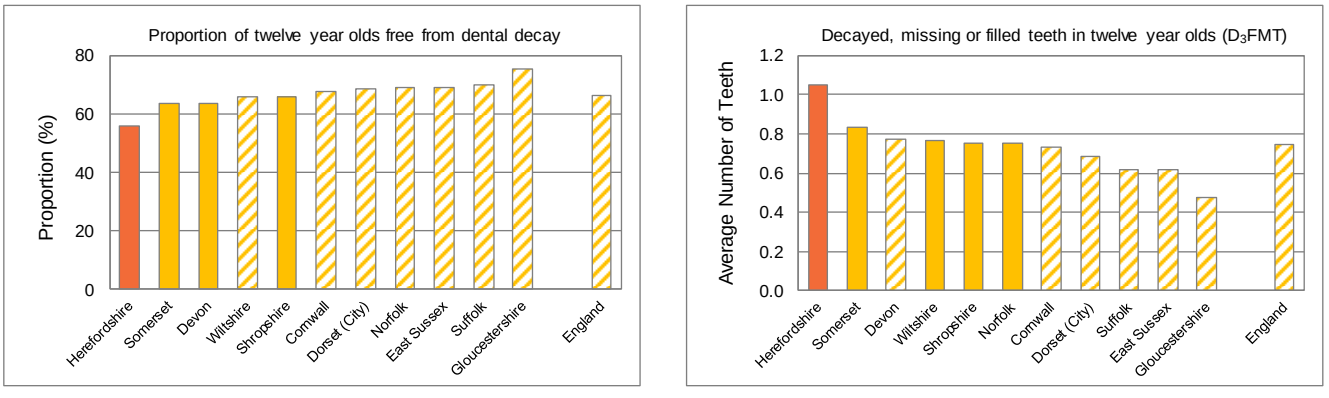


Figure 27 - Oral health of twelve year olds, 2008/09 (shaded bars indicate significantly different from Herefordshire figure).
(Data Source: NDEP – PHE)

LOOKED AFTER CHILDREN

Limited data exists that indicates the current oral health experience of LAC nationally or locally. Data previously published by the Department for Education [59] does however report the number and proportion of LAC who had their teeth checked by a dentist (see table 5). This figure is lower than both the national and regional figure.

Table 5 - Number and proportion of LAC who had their teeth checked by a dentist (as of 31 March 2016) [59]

	Number of LAC (looked after for at least 12 months)	Number of LAC who had their teeth checked by a dentist	Proportion of LAC who had their teeth checked by a dentist (%)
Herefordshire	205	145	70.7
West Midlands	6,860	5,620	81.9
England	48,490	40,770	84.1

HOSPITAL ADMISSIONS

In Herefordshire (during 2017/18) there was a total of 104 hospital admissions in individuals aged under 19 for which diseases of the oral cavity, salivary glands and jaws (ICD10 K00-K14) were the primary diagnosis [60].

Of the 104 hospital admissions recorded, 97 were for elective admissions, of which 44 were for impacted teeth i.e. a tooth has been blocked from breaking through the gum. Dentofacial anomalies and dental caries accounted for 14 and 10 admissions respectively. Overall, 60 out of the 104 admissions resulted in the extraction of one or more teeth, with all but seven being in individuals aged 10 or over.

Currently robust data is not available to ascertain whether the numbers of children undergoing dental extractions under general anaesthesia in Herefordshire is higher than regional or national rates.

ADULTS

ADULT DENTAL HEALTH SURVEY

The Adult Dental Health Survey is completed every 10 years with data available at a regional level [61]. The results of the last survey, which was undertaken in 2009, are discussed below.

Across the West Midlands, 91% of adults were dentate (i.e. had teeth), compared to 94% in England as a whole. The average number of natural teeth of dentate adults in the West Midlands was 25.1 while the figure nationally was 25.7; a functional amount of teeth is assessed as being 21.

Across the West Midlands 9% of adults were classed as periodontally (i.e. gum) healthy compared to a figure of 17% reported for England. Regionally, a further 32% of adults were periodontally healthy but had calculus, while 59% had loss of attachment and/or bleeding; the corresponding figures for England were 33% and 50%. Only 4% of adults in the West Midlands were classed as having excellent oral health compared to 10% nationally.

In the West Midlands, 39% of dentate adults had carious teeth (crowns and roots) compared to the national figure of 30% across England.

Around one in seven dentate adults in the West Midlands reported never or hardly ever feeling dental pain in the last 12 months, a figure similar to that reported nationally. Similarly, the proportion of dentate adults regionally reporting feeling pain fairly or very often (7%) was broadly similar to that reported across England (8%).

ORAL HEALTH SURVEY OF MILDLY DEPENDENT OLDER PEOPLE

As part of PHE's NDEP, standard examinations and questionnaires of a random sample of older people (aged 65 and above) living in supported housing were undertaken in the year September 2015 to August 2016 [35].

Of those assessed in Herefordshire 14.5% were endentulous (i.e. had none of their own teeth), a figure appreciably lower than those report for England (27.0%) or the West Midlands (54.8%). While 17% of those assessed in Herefordshire had not seen a dentist within the last two years, the figure for England was twice this (34.0%); the proportion for the West Midlands was 41.4%.

Of those dentate individuals in Herefordshire 5.1% reported feeling oral pain on the day of examination compared to 9.5% and 8.5% reported across England and the West Midlands respectively.

While 3.2% across England and 2.8% in the West Midlands were considered to be in urgent need of dental care none of those assessed in Herefordshire were in such need.

The proportion of dentate individuals in Herefordshire with an open pulp, ulceration, fistula or an abscess was 1.7 compared to 7.8 per cent nationally and 4.2% regionally. Locally, 80% of dentate individuals had visible plaque and 63% had visible calculus, with both figures being higher than those reported nationally and regionally.

Of those individuals in Herefordshire with partial dentures 6.9% were in need of replacement compared to 13.0% across England and 8.8% in the West Midlands. The local figure for individuals in need of replacement of full dentures was 15.8%, while the national and regional proportions with a similar need were 14.8% and 11.8% respectively.

Overall, the study found that nationally poorer oral health tended to be recorded in the more deprived areas.

ORAL CANCER

Between 2001-03 and 2014-16 the incidence of oral cancer in Herefordshire has shown a general rise which is mirrored in the incidence rate (Figure 28); a similar pattern is evident across England as a whole. In 2014-16 the local incidence rate was 14.0 per 100,000, a figure similar to that observed nationally and in nearest statistical neighbours (Figure 29)

Over this period the number of deaths Herefordshire related to oral cancer over any given three years showed some variability ranging between 10 and 23. Similarly, the local oral cancer mortality rate has shown some variability with no consistent pattern evident, although since 2009-11 the rate has shown a general increase (Figure 28). In 2015-17 the local mortality rate was 14.0 per 100,000, a figure similar to that observed nationally and in nearest statistical neighbours (Figure 29).

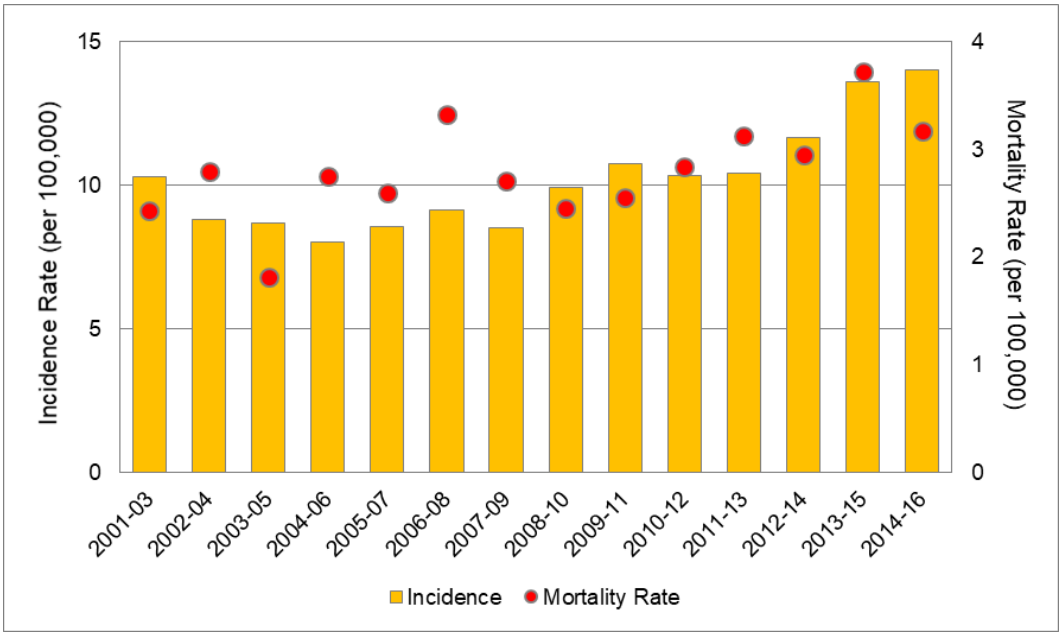
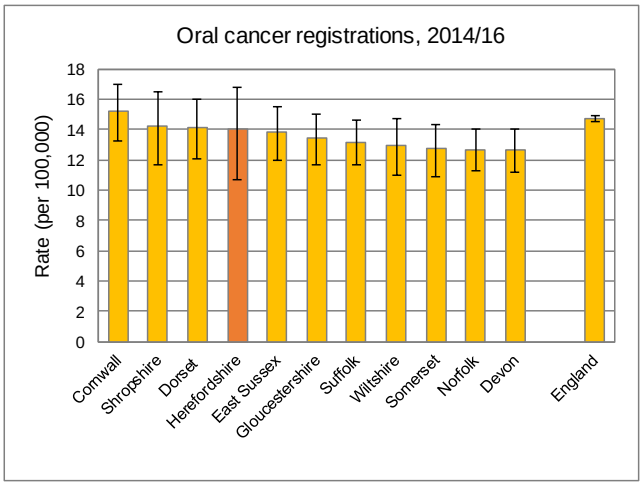


Figure 28 - Oral cancer incidence and mortality rates in Herefordshire. (Data Source: NCRAS)



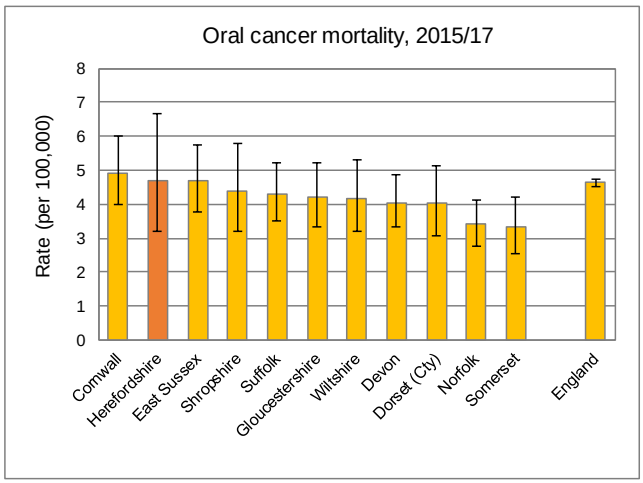


Figure 29 - Oral cancer incidence and mortality rates in Herefordshire. (Data Source: NCRAS)

HOSPITAL ADMISSIONS

The most common primary diagnosis associate with the 557 elective admissions in adults was dental caries which accounted for 175 cases, while 91 admissions were related to “other” disorders of teeth and supporting structures and 83 were associated with “other” diseases of lip and oral mucosa [60].

More specialist dental services can be provided in Primary and/or Secondary care and are accessed by referral from a primary care general dental practitioner. They are not discussed in this needs assessment as they fall outside the agreed scope.

HEREFORDSHIRE - ORAL HEALTHCARE SERVICES

PROVISION OF ORAL HEALTHCARE SERVICES

In England, a range of key organisations commission, deliver and support the provision of oral healthcare services (see figure 30). The specific roles and responsibilities of each of these organisations listed in figure 30, were defined by Public Health England in 2014 (see Appendix B).

In relation to NHS dental services, NHS England has the statutory responsibility for securing provision, which meet the needs of a local population. NHS dental services in Herefordshire, comprises primary care, which is inclusive of general dental services, together with unplanned (urgent) dental care and services provided by the Community Dental Service.

Furthermore, and as displayed in figure 30, NHS England also commission secondary dental services for delivery within hospital settings i.e. specialist orthodontic services.

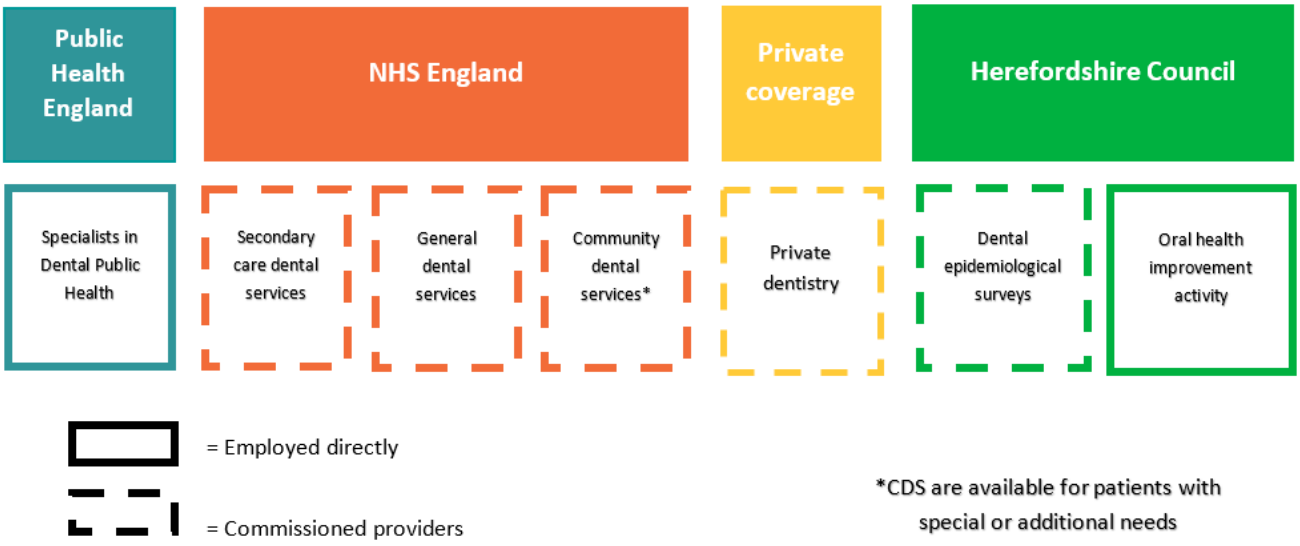


Figure 30 - Organisation of oral healthcare services

PRIMARY CARE DENTAL SERVICES

NHS dental services in England are provided predominantly within primary care. The majority of primary care dental services are non-specialist in nature and are provided by General Dental Practitioners (General Dental Services or GDS) or Community Dentists (Community Dental Services or CDS). Both types of service provision are described and discussed within this chapter of the OHNA. Primary care specialist services e.g. orthodontics fall outside of the scope of this OHNA.

GENERAL DENTAL SERVICES

Nationally and within Herefordshire, most NHS GDS are delivered by general dental practitioners (GDPs) – i.e. high street dentists [62–64]. Dentists providing GDS for the NHS, are not employed by the NHS, but are independent providers commissioned for their services.

Access to NHS primary care dentistry is commissioned for anyone who seeks it, regardless of where they live. In contrast to general practice registration, patients can choose any geographical area to access NHS dental services in England. For example, those in employment may choose to access an NHS dental provider close to where they work rather than where they live.

Since April 2006, patients are no longer registered to a dental practice and are only 'attached' to a dental practice when they are in active treatment [62,64]. Practices providing NHS GDS hold a notional list of patients who regularly attend their practice. Maintaining a patient list, enables dental practices to manage their capacity for providing dental care to both regular patients and new patients.

Whilst NHS dental services are recognised to be demand led, as part of the current NHS dental contract, NHS England are expected to target services towards those whose oral health is poor or who are at high risk of disease.

Current NHS dental contract

Since 2006, payments for NHS GDS are based on a contracted number of 'Units of Dental Activity' (UDAs) performed each year [63,65]. Each individual dental practice has a separate contract with NHS England, which outlines the number of UDAs they will be paid to deliver every year and the cost associated/contract value.

The number of UDAs contracted per area or per dental practice, is decided by NHS England based on their assessment of local population need. Practices are expected to deliver the contract value with a 4% tolerance for underperformance and over-performance is not remunerated [62,63].

The contract held between a dental practice and the NHS does not limit the amount of private practice it is able to perform.

In England, children under the age of 18 years of age are eligible for free dental care in any NHS environment. However, unless exempt from paying NHS dental charges [66], adults contribute towards the costs of NHS dental treatment in primary care. As displayed in table 6, the cost of the contribution is determined by the treatment band [67].

Table 6 - NHS patient dental charges (aged 18 years+)*

Course of treatment	Cost
Band 1	£22.70
Band 1 urgent	£22.70
Band 2	£62.10
Band 3	£269.30

* As of May 2019

National Contract Reform

In England, new NHS dental contract prototypes for GDS are being tested. This includes piloting a new remuneration system, which blends activity and capitation (i.e. patient registration) [65]. The pilot prototype scheme aims to increase the focus within GDS to preventive dental care by aligning both financial and clinical drivers. Two dental practices in Herefordshire are currently testing the new prototype dental contract (one within Hereford and one within Leominster).

AVAILABILITY OF SERVICES

Based on information from NHS England, as of May 2019, there are 17 contracts providing NHS GDS within Herefordshire (8 of which are based within Hereford City centre).

This number is subject to annual variation, given that existing dental general practices close and new ones open. Figure 31 overleaf, presents the geographical distribution of NHS GDS providers in Herefordshire.

During 2017/2018, there were 103 Dentists delivering NHS activity in Herefordshire. At 54 Dentists per 100,000 population, this was a 9.6% increase from 2016/2017 and higher than both the regional and national rates (43 and 44 per 100,000 respectively).

Dental access survey

The NHS website [64,68] provides information about general dental practices within a specific geographical area, including confirmation about whether a practice is taking on new patients. Whilst it is the responsibility of individual practices to keep the NHS website updated with this information, guidance from both NHS England and the Herefordshire Local Dental Committee, indicated this may not always the case.

Consequently, in May 2019, a local dental access survey was undertaken. Each of the 17 contracted providers delivering NHS GDS services in Herefordshire were contacted via telephone and asked if they were currently accepting new NHS patients.

Of the 17 practices, 6 reported they were currently accepting new child NHS patients, of which 3 were also accepting adults. Therefore as of May 2019, a total of 11 practices were not accepting new child NHS patients and 14 were not accepting either new child or adult NHS patients.

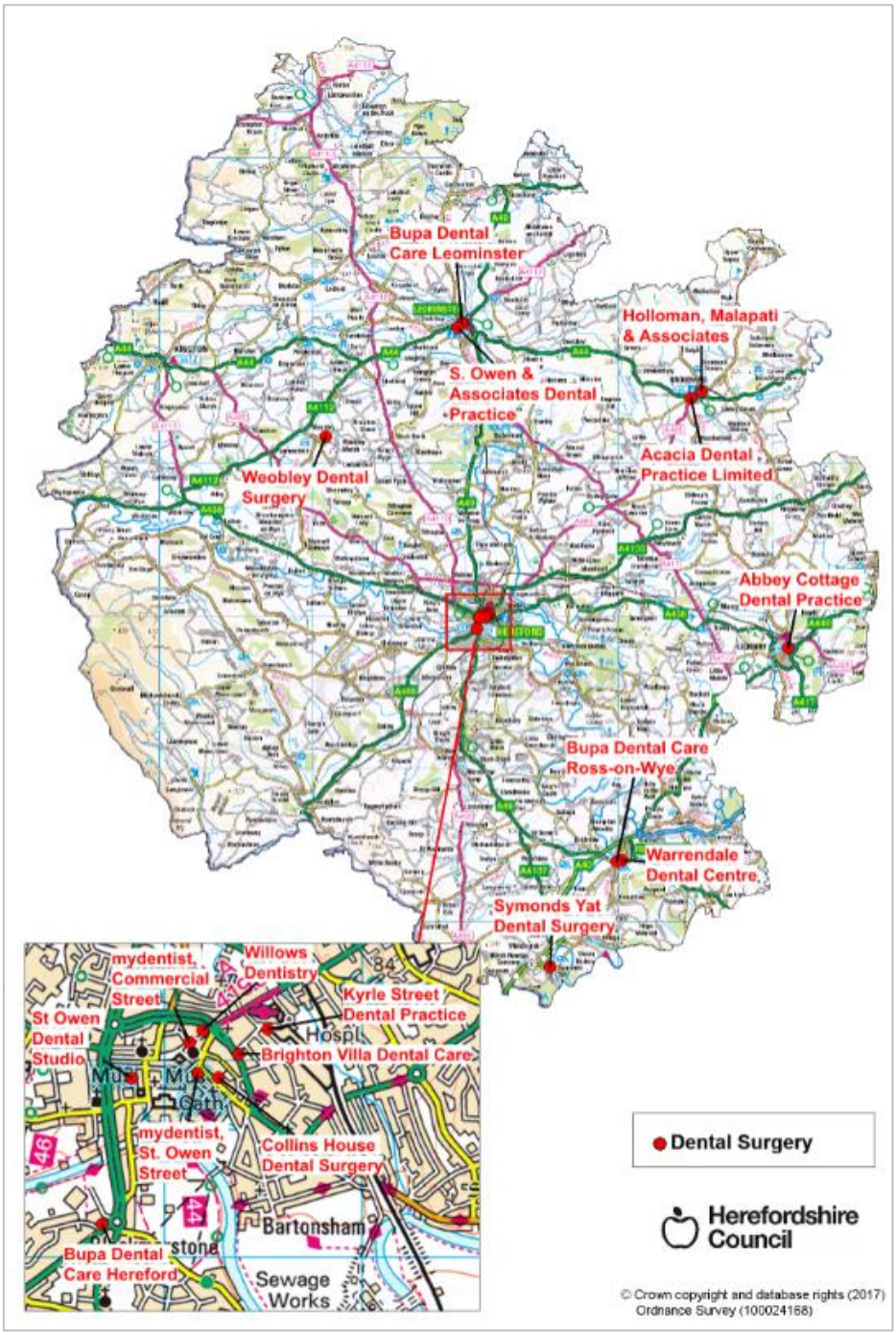


Figure 31 - Geographical distribution of NHS GDS providers in Herefordshire (as of May 2019)

ACCESS TO GENERAL DENTAL SERVICES

Access to GDS rates reflect the widespread availability of NHS dental care. Access rates are measured by the proportion of the resident population who were seen by an NHS dentist in the 12 months prior (for children) or 24 months prior (for adults).

This metric is based upon NICE guidance, which recommends specific interval lengths between dental examinations, based on a patient's oral health and other factors such as age and lifestyle risk factors i.e. smoking [(69)].

A total of 21,084 children (aged 0-17 years) were seen by an NHS dentist in Herefordshire, in the 12 months prior to the 31st of December 2018 (see figure 32). This is 58.7% of all children in Herefordshire (aged 0-17 years) and is approximately the same proportion as that identified nationally for the same age group over the same period (58.6%).

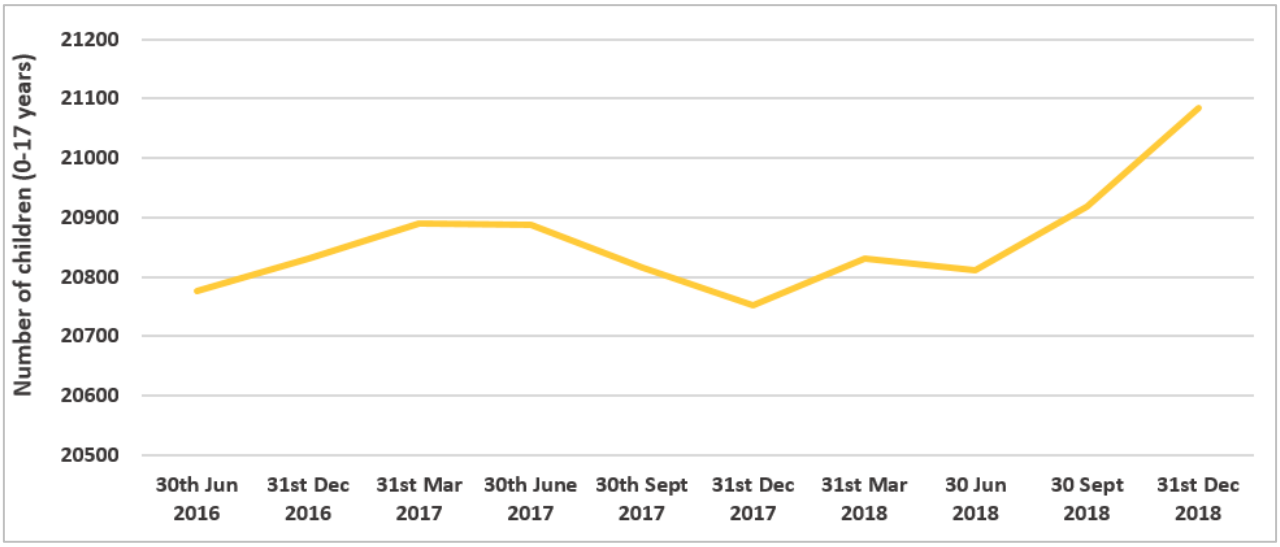


Figure 32 - Number of children in Herefordshire, seen by an NHS Dentist in the 12 months prior to 31st December 2018 (Data source: NHS Digital)

As of the 31st of December 2018, 43.1% of children aged 0-5 years in Herefordshire were seen by an NHS dentist (compared to 38.9% in England) – see figure 33.

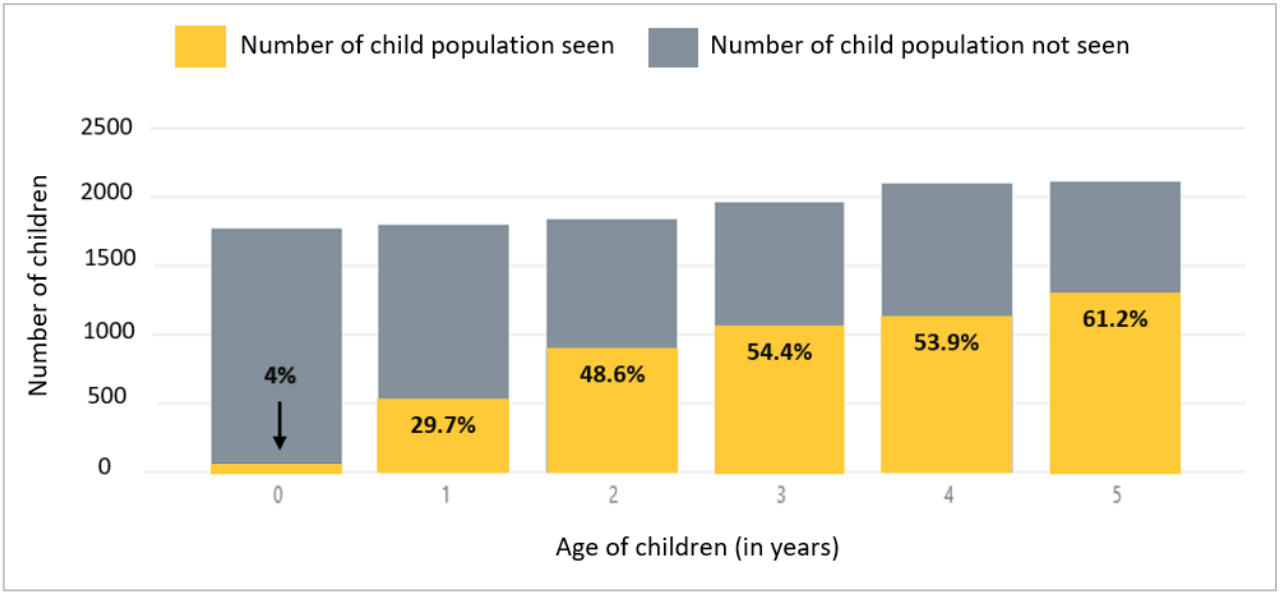


Figure 33 - Number and proportion of children (aged 0-5 years) in Herefordshire, seen by an NHS Dentist in the 12 months prior to 31st December 2018 (Data source: NHS Digital)

A total of 74,592 adults were seen by an NHS dentist in Herefordshire, in the 12 months prior to the 31st of December 2018 (see figure 34). This is 48.1% of all adults in Herefordshire and is marginally lower than the national proportion over the same period (50.4%).

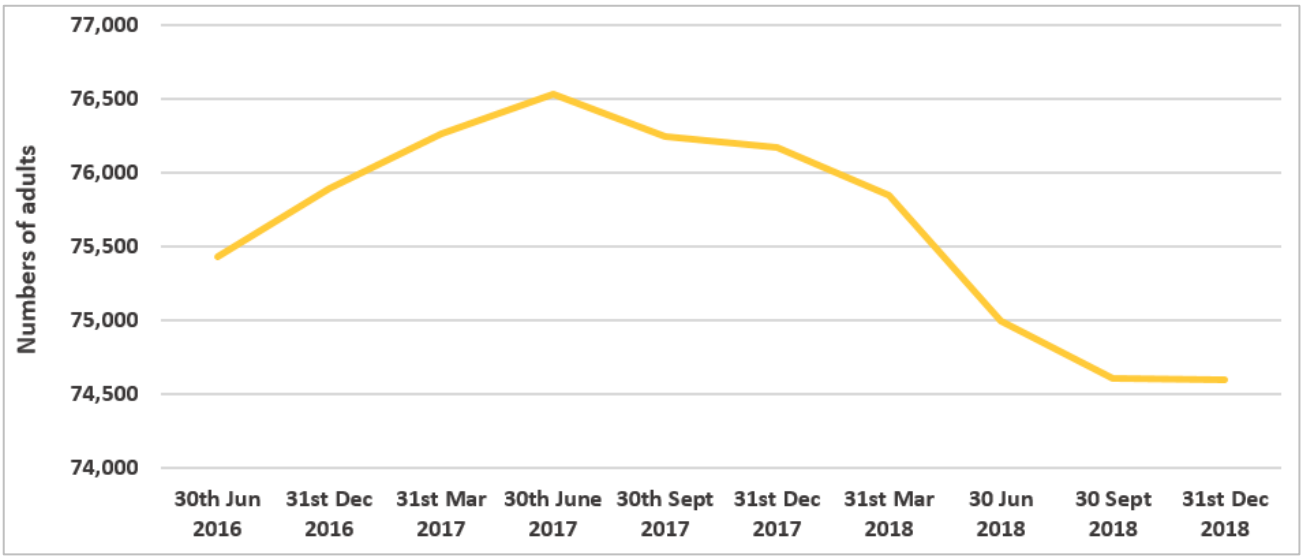


Figure 34 – Number of adults in Herefordshire, seen by an NHS Dentist in the 12 months prior to 31st December 2018
(Data source: NHS Digital)

It is important to note that NHS dental access data does not reflect the number of children and adults who were seen within private dental practice or who may have used hospital dental services exclusively.

This information is not included within NHS primary dental care data sets and therefore the reported dental access rates within Herefordshire may be higher than shown in figures 32, 33 and 34 above.

DENTAL SERVICE USAGE

Between 1st October 2017 and 30th September 2018, there were 127,755 Courses of Treatment (CoT) delivered within NHS GDS in Herefordshire. Dental care is provided to patients as CoT, and reflects -

- An examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment

- The provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient.

Each COT delivered within GDS is allocated a treatment banding and a fixed number of UDAs per band [62,63,65,70]:

- **Band 1**: includes an examination, diagnosis and advice. If necessary, it also includes x-rays, a scale and polish, application of fluoride varnish or fissure sealants, prevention advice and planning for further treatment (1 UDA)

- **Band 1 urgent**: includes urgent care such as removal of the tooth pulp, removal of up to two teeth, dressing of a tooth and one permanent tooth filling (1.2 UDAs)

- **Band 2**: includes all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatments and removal of teeth (3 UDAs)

- **Band 3**: includes all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges (12 UDAs)

For every CoT conducted, contracted providers submit a standard form i.e. 'FP17' to NHS Business Services Authority in order to receive payment. Each FP17 details the specific treatment the patient has received according to the relevant banding and therefore the associated UDAs [62,63,70].

Figure 35, presents the proportion of CoT delivered in Herefordshire during 2017/2018 according to each treatment band. As displayed in figure 35, band 1 treatments constitute the majority of COTs between 2017/2018.

Between 1st October 2017 and 30th September 2018, there were 228,180 UDAs delivered within GDS in Herefordshire. As described previously, UDAs are the currency in which GDS providers are remunerated for their NHS dental activity.

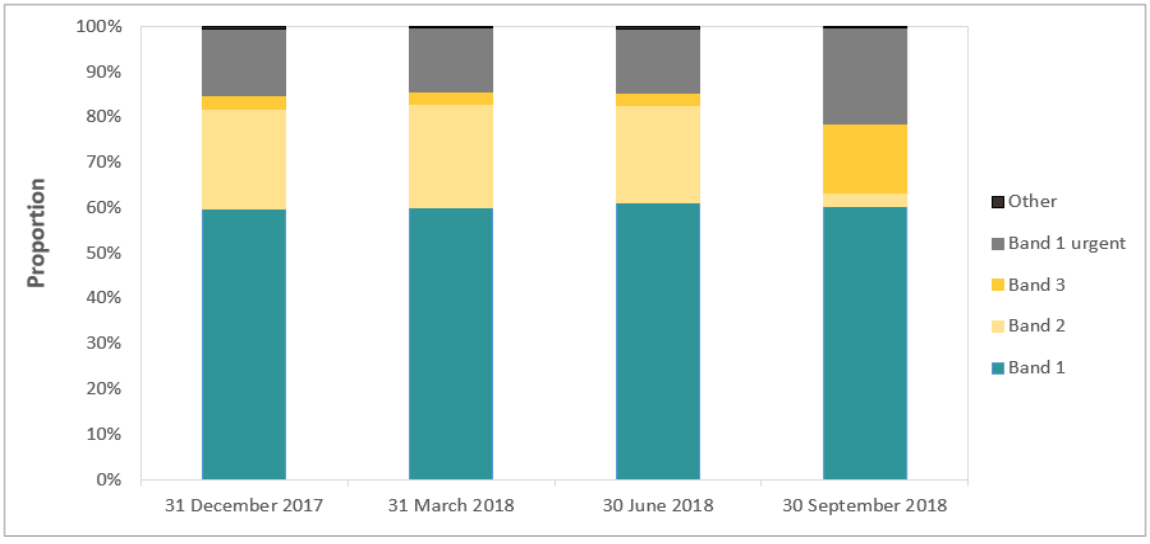


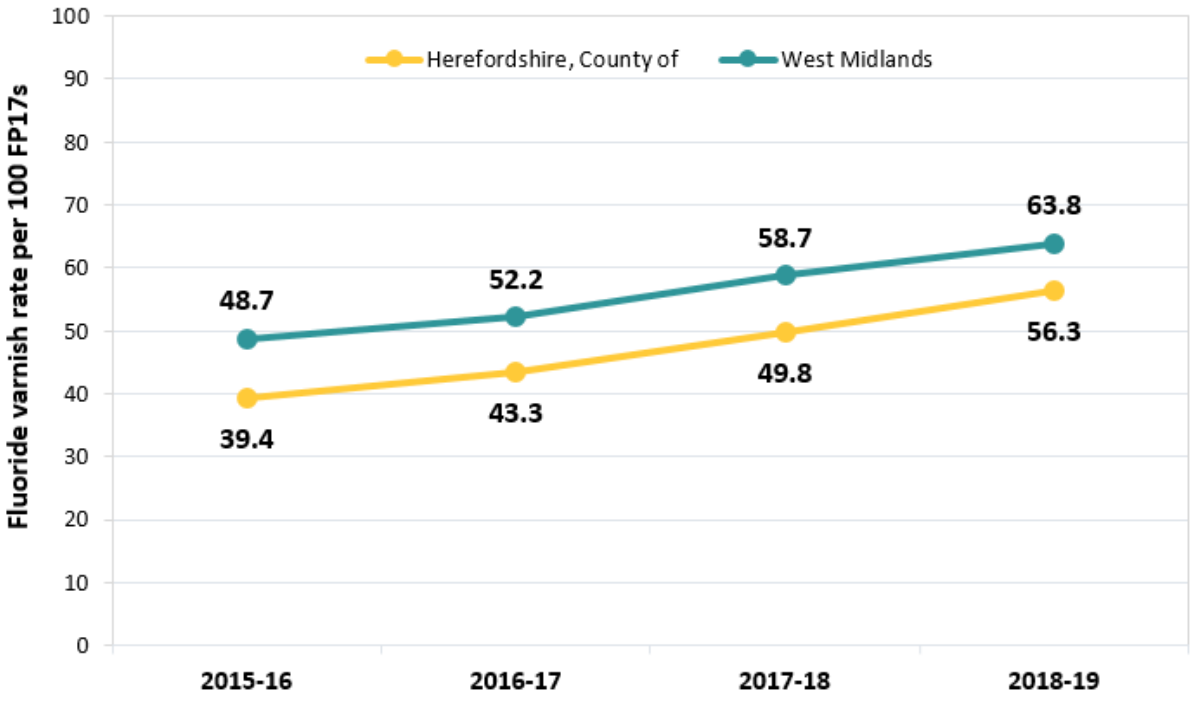
Figure 35 - Proportion of CoT delivered in Herefordshire according to each treatment band during 2017/2018.
(Data source: NHS Digital)

Fluoride varnish application

Evidence clearly demonstrates that application of fluoride varnish by a trained professional, reduces tooth decay in both children and adults (delivering better, 2017). Consequently, national guidance recommends the application of fluoride varnish every six months for all children between 3-16 years old and more frequently for all children (0-16 years) at higher risk of tooth decay i.e. those likely to develop caries or those with special needs [4]. For adults with a higher risk of tooth decay, it is recommended that fluoride varnish is applied twice a year.

As displayed in figure 36, the rate of fluoride varnish applications in children (aged 3-16 years) accessing NHS GDS in Herefordshire has increased since 2015/2016. Despite this, there remains a significant proportion within this age group who appear to have not received this intervention within NHS GDS in Herefordshire (43.7%).

Furthermore, based on submitted FP17s the rates of fluoride varnish applications in Herefordshire for this age group, appear to be consistently lower than the regional* average rate as reported by NHS Business Services Authority [71].



* 'West Midlands' - Inclusive of Birmingham, Coventry, Solihull, Warwickshire, Worcestershire, Herefordshire, Sandwell, Dudley, Warwickshire, Walsall and Wolverhampton.

Figure 36 - Fluoride varnish applications for 3-16 year olds resident in Herefordshire and the West Midlands.
(Data source: NHS Digital)

COMMUNITY DENTAL SERVICES

Across England and Herefordshire, community dental services (CDS), form an integral role in the delivery of primary dental care provision. Commissioned CDS providers deliver specialist and additional services for those with special care needs and/or those experiencing difficulties in accessing GDS. This may include –

- Children and adults with learning disabilities
- Children with complex and extensive dental treatment needs
- Children and adults experiencing mental health issues
- Frail older people who cannot receive care in general dental practice
- Children and adults who are severely physically and/or medically compromised
- Children and adults with severe dental anxiety
- Looked after children or children with identified safeguarding concerns
- People who are homeless
- People who are currently experiencing issues with substance misuse

In Herefordshire, the Wye Valley NHS Trust is commissioned to deliver CDS across the county. As of May 2019, local CDS provision in Herefordshire included –

- Advanced mandatory services – Provided on referral due to high level of facilities, experience or expertise required i.e. minor oral surgery
- Domiciliary services – Provided 'outreach' e.g. within a patients home or a care setting
- Sedation services – Including inhalation and intravenous sedation and general anaesthetic
- Urgent (i.e. unplanned) primary dental care

CDS in Herefordshire are delivered from seven dental clinics (i.e. Dental Access Centres - DACs) and within the County Hospital (e.g. for oral surgical procedures). Figure 37 overleaf, presents the geographical distribution of DACs within Herefordshire.

URGENT DENTAL CARE SERVICES

Urgent dental care is provided for patients who do not or are unable to access treatment from GDS but have an urgent need for treatment either in or out of hours.

Patients who require treatment urgently do not have to be registered or listed with a specific general dental practice in order to access appropriate dental care.

In Herefordshire, some NHS GDS providers offer urgent dental care within hours. The commissioned CDS provider offers urgent dental care both within and out of hours.

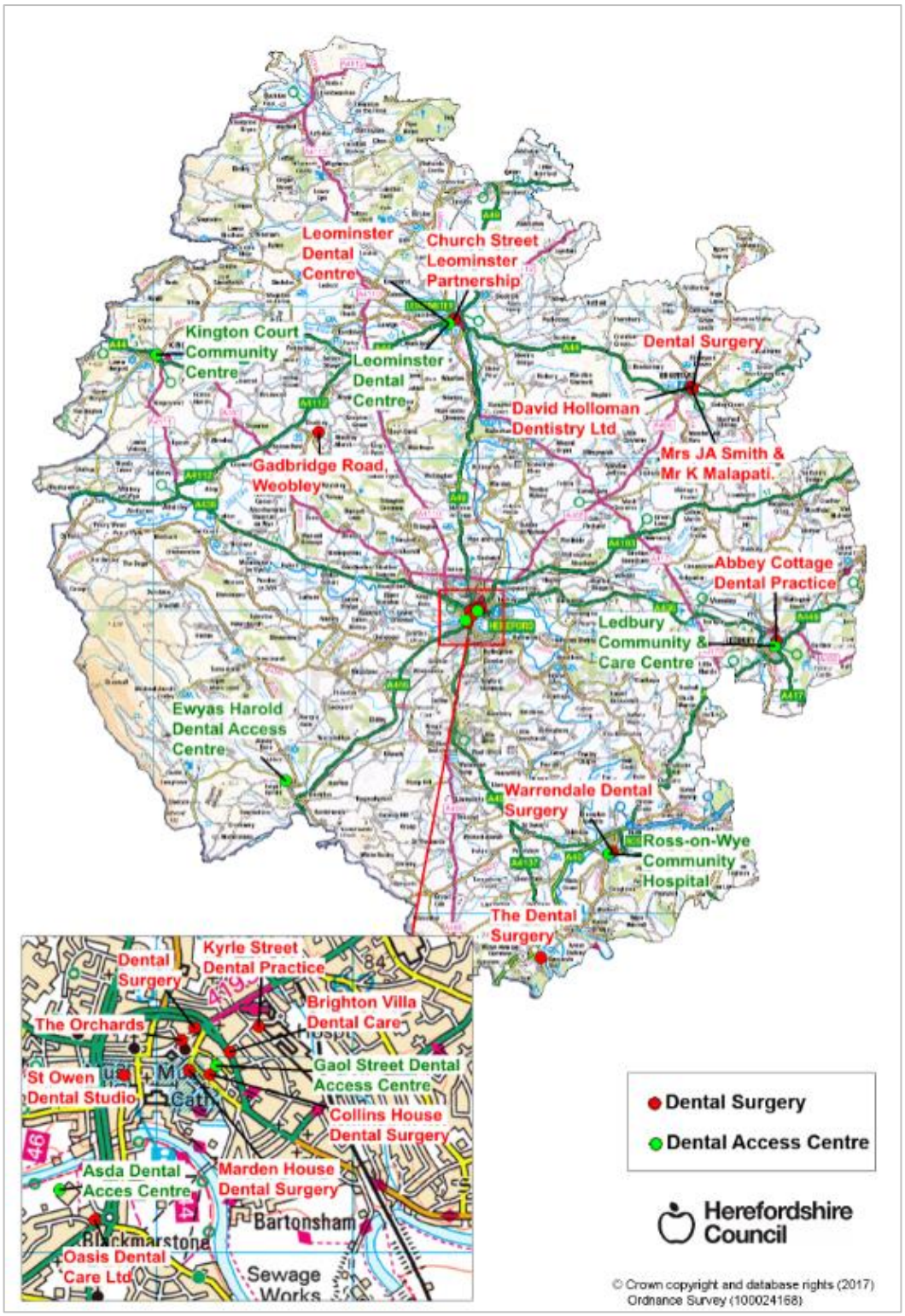


Figure 37 – Geographical distribution of NHS GDS providers and DACs in Herefordshire (as of May 2019)

SECONDARY CARE DENTAL SERVICES

Secondary care dental services are predominantly delivered within hospital settings and include oral surgery, orthodontics, oral medicine, oral and maxillofacial surgery and restorative dentistry. Secondary care dental services are primarily accessed via referrals from primary dental care (either NHS or private providers), with some referrals from primary medical care. Services delivered within secondary care are free from patient charges.

The following hospitals are commissioned to provide secondary care services for children and adults who are resident within Herefordshire. The type, nature and complexity of a patient's oral and general health needs will determine which services are accessed in each setting.

- County Hospital in Hereford (Wye Valley NHS Trust)
- Birmingham Dental Hospital (Birmingham Community Healthcare NHS Foundation Trust)
- Birmingham Children's Hospital (Birmingham Women's and Children's NHS Foundation Trust)
- Bristol Dental Hospital (University Hospitals Bristol NHS Foundation Trust)

PATIENT AND PUBLIC VIEWS

Healthwatch Herefordshire survey (April 2018)

Between 2017 and 2018, Healthwatch Herefordshire engaged with and consulted over 500 residents and professionals about their views and experiences of dental health in Herefordshire.

Findings from the published report in 2018 [72], indicated that that –

- Parents who were registered with a dentist tended to register their child at the same practice at about one years old.
- Parents who were not themselves registered with a dentist experienced no issues registering their child despite it being difficult to register themselves.
- Amongst parents of young children who had not as yet been registered with a dentist, approximately 50% were unsure as to what age their child should start to see a dentist
- A small number of parents thought that milk teeth were not that important.
- Approximately 5% of people did not know NHS dental care for children was free.
- Some parents from Eastern European countries, were unaware of how to find and register with a dentist.
- In rural areas, transport was identified as a barrier to accessing dental care as many parents reported not having access to a car. Furthermore, public transport was deemed to be expensive and commonly infrequent.

GP Patient Survey (August 2018)

The GP Patient Survey is an independent annual survey run by Ipsos MORI on behalf of NHS England [73]. The survey includes questions about a patient's experience of NHS dentistry.

Between January and March 2018, a total of 2,797 adults within Herefordshire completed the GP Patient Survey. Of the responses received, 94% people reported being successful in getting an NHS dental appointment within the last two years (compared to 93% nationally).

Of those reportedly not attempting to obtain an NHS dental appointment within the previous two years, 52% of respondents in Herefordshire (39% nationally), attributed this to either preferring private dental care (29%) or staying with a dentist when they moved from NHS provision to private practice (23%).

Finally, when asked about their overall experience of NHS dental services, respondents reported it was either very good (54%) or fairly good (33%). Both figures of which were comparable to the national picture (52% and 33% respectively).

IMPROVING POPULATION ORAL HEALTH

As previously described poor oral health and oral diseases, including those within the scope of this OHNA are largely preventable. Common risk factors exist, which affect a person's risk of developing oral diseases and a range of other non-communicable diseases. Furthermore, these common risk factors are understood to be driven by complex and interrelating economic, social and environmental determinants.

Addressing both the risk factors and wider determinants of poor oral health, is of fundamental importance for local authorities and key partners, who are tasked with improving oral health and reducing oral health inequalities at a population level [8,14,15,24].

NATIONAL GUIDANCE

To support local authorities to fulfil their specific role and responsibilities regarding oral health improvement, PHE, NICE and the LGA have published an extensive array of evidence-informed guidance and toolkits (see Appendix A).

Each of these national documents advocate for local authorities to –

- Identify, target and modify both the common risk factors and the wider determinants of oral diseases
- Adopt a population level needs based approach, whilst targeting action towards those groups at greater risk of poor oral health
- Prioritise the role of prevention, across the life course and within key settings i.e. families, schools, community and oral healthcare services
- Commission and/or deliver a range of evidence-informed oral health improvement programmes, that are co-created by professionals, families and wider-communities
- Ensure fair and equitable access to high quality dental care, which emphasises the importance of prevention
- Work in partnership with key partners for oral health improvement, including PHE, NHSE and CCGs

APPROACHES TO PREVENTION - UPSTREAM VERSUS DOWNSTREAM

A clear and consistent theme within national guidance is the requirement for local authorities and other key partners, to target interventions towards the prevention of poor oral health and oral diseases [3,4,8]. Whilst equitable access to high quality dental care forms an important part of improving a person's oral health, in isolation this will not achieve sustainable reductions in the burden of poor oral health and associated inequalities at a population level [7,13,32].

Approaches and options for preventing poor oral health and oral diseases can be understood as representing a continuum, from downstream interventions to upstream interventions [74].

Downstream interventions primarily aim to address the common risk factors or individual behaviours known to affect a person's risk of oral diseases. In contrast upstream interventions, aim to address the underlying causes of these common risk factors i.e. the wider determinants (see figure 38).

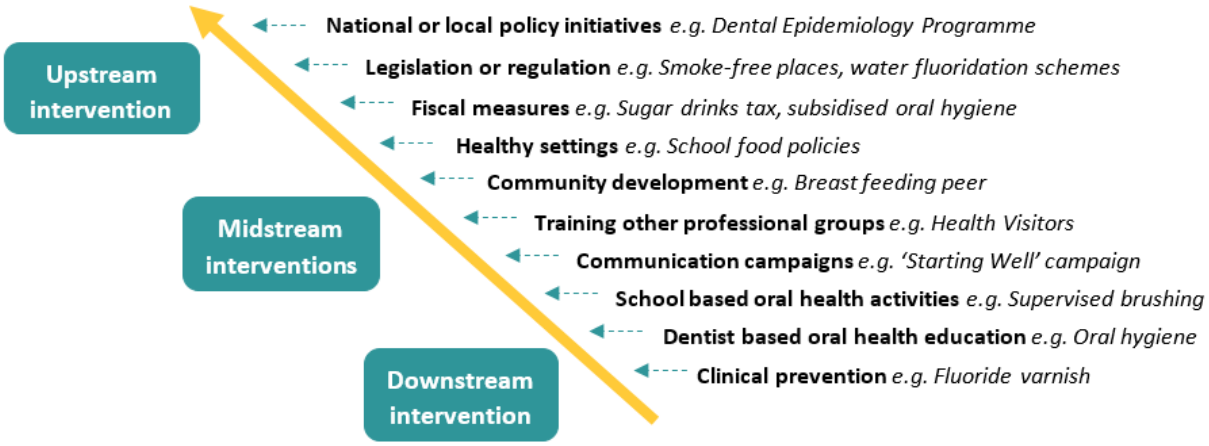


Figure 38 - Options for oral disease prevention (adapted from Watt, 2007 [67])

In fulfilling their statutory responsibilities, local authorities are expected to assess the local oral health needs of their population and then advocate for, influence and where relevant provide evidence-informed interventions across this continuum (presented in figure 38).

By ensuring upstream, midstream and downstream interventions are incorporated into a population level approach to prevention, the common risk factors and wider determinants for both oral diseases and other non-communicable conditions are simultaneously addressed. Evidence suggests the adoption of this approach reduces the overall burden of preventable ill-health and premature mortality within a population [5,23,45,75].

Proportional universalism

As discussed previously, there exists a social gradient in the experience of oral health and health outcomes more broadly [26,76]. With increasing disadvantage, vulnerability and social exclusion comes a greater prevalence and severity of oral diseases.

However, as everyone experiences some degree of inequality within a population, focusing solely on the most disadvantaged will not sufficiently reduce health inequalities across the social gradient [26,34].

Consequently, action to improve everyone's oral health needs to be universal, yet targeted with a scale and intensity that is proportionate to the level of inequality an individual, family or community faces. For example, whilst preventative dental care should be available for all children, 'Looked after children' and those experiencing poverty may require additional support i.e. through targeted fluoride varnish applications.

ORAL HEALTH IMPROVEMENT – WHAT WORKS?

A wealth of evidence now exists that proposes which interventions and action will improve the oral health of individuals and communities – See Appendix A. Since 2014, PHE have published a range of national toolkits, to reflect and summarise this evidence base [4,15,24,77].

Each toolkit makes evidence-informed recommendations regarding the local commissioning or provision of downstream, midstream and upstream interventions. The recommendations of 'what works' are relevant for primary care dental teams, local authorities and organisations who specifically engage with children, young people and older adults.

WHAT WORKS AT AN INDIVIDUAL LEVEL?

Primary care dental teams play an integral role in the prevention of oral diseases and the overall improvement of their patient's oral health. In recognition of this, in 2017, PHE published the 3rd edition of 'Delivering better oral health: an evidence-based toolkit for prevention' [4].

This provided dental professionals with clear guidance on which evidence-informed interventions should be delivered at an individual level. Key recommendations focused on providing patients with –

- Advice about oral hygiene practices across the life course e.g. twice daily exposure to appropriate levels of fluoride
- Tailored support and signposting in order to facilitate lifestyle behaviour changes e.g. reducing sugar consumption and stopping smoking
- Prevention focused dental care, including specific interventions known to prevent development or worsening of oral diseases i.e. application of fluoride varnish

Whilst NHS England (NHSE) are responsible for the commissioning of NHS primary care provision, local authorities can play a crucial role in advocating for dental professionals to adopt an preventive focus to individual care.

Furthermore, local authorities have a responsibility to seek assurance from NHSE and PHE that based on local need, their residents have equitable access to high quality and evidence-informed NHS dental services [3,14].

Outside of primary dental care, a number of downstream interventions i.e. delivered at an individual level, are promoted by PHE [15,24,77] as being effective for improving the oral health of children, young people and older vulnerable adults (e.g. those within care settings) –

Children and young people (0-19 years)

- The integration of oral health into targeted home visits by health and social care workers
- Targeted fluoride varnish programmes delivered outside of dental practices, for those who are deemed to be at greater risk of poor oral health
- Targeted provision of toothbrushes and tooth paste i.e. through health visiting services^

Vulnerable older people

- Appropriate oral hygiene promotion^, including daily exposure to higher fluoride toothpastes and powders (i.e. 2,800 to 5,000 ppm)
- Routine denture identification marking, to ensure lost dentures are returned to the correct person
- Targeted fluoride varnish applications in care homes and community settings

^ = *As of May 2019, a local mapping exercise has indicated that whilst not systematically adopted or delivered across Herefordshire, there is some evidence that the intervention is being provided locally*

WHAT WORKS AT A COMMUNITY LEVEL?

Individual interventions are an important component of local approaches to preventing poor oral health. However in order to achieve a sustainable improvement in population oral health and a reduction in inequalities, local authorities are required to commission or deliver interventions targeted at community settings and wider environments [3].

To inform this process, PHE published two evidence-informed toolkits for local authorities (one focusing on children and young people [15] and the other older vulnerable adults [24]. Each details the effectiveness of mid and upstream interventions for improving oral health in these specific groups.

Interventions deemed to be 'recommended' (R) or 'emerging' (E) and therefore of potential interest for local authorities included –

Children and young people (0-19 years) –

- Supervised tooth brushing in targeted childhood settings i.e. early years and schools (R)
- Healthy food and drink policies in childhood settings i.e. early years and schools^ (R)
- Targeted peer (lay) support groups and peer oral health workers (R)
- School or community food co-operatives (E)

- Fiscal policies to promote oral health (E)

Vulnerable older adults –

- Protocols for improving oral care in care settings (R)
- Outreach programmes & interventions to independently living older people (E)
- Assessment and multidisciplinary integrated preventive approach (including oral health) in primary care for independently living older people (E)

For children, young people and vulnerable older adults –

- Oral health training for the wider professional workforce e.g. health visitors, care home staff^ (R)
- Fluoridation of public water supplies* (R)
- Interventions and policies promoting breastfeeding, complementary feeding practices and wider dietary change across community settings for children and adults^ (E)

* Water fluoridation is the controlled adjustment of a fluoride compound to a public water supply in order to bring the fluoride concentration up to a level which effectively prevents tooth decay [77]. Deemed to be both safe and effective in improving oral health and reducing health inequalities, around 6 million people in England (approximately 10% of the population) currently receive water where fluoride has been artificially added [78].

RETURN ON INVESTMENT

In 2016, PHE published a rapid evidence review and return on investment (ROI) tool regarding the clinical and cost-effectiveness of the following evidence-based interventions for reducing tooth decay in 0-5 year olds [29] –

- Targeted supervised tooth brushing
- Targeted provision of fluoride varnish
- Targeted provision of toothbrushes and paste by post
- Targeted provision of toothbrushes and paste by post and by health visitors
- Community water fluoridation

The ROI tool was designed to support local authorities, who are making decisions about the commissioning and delivery of oral health improvement programmes for pre-school children in their area.

Based on a typical oral health profile and indicative costs, the infographic overleaf (figure 39) illustrates the 5 and 10 year ROI associated with each intervention included [29].

This includes monetised savings to the local authority and the NHS including the reduction in fillings provided in NHS primary care and tariff costs for dental extractions in NHS secondary care, the reduction in days missed at work for parents/carers accompanying children to the dentist and/or hospital. In addition the 'number of days saved at school' are generated although not monetised in the ROI.

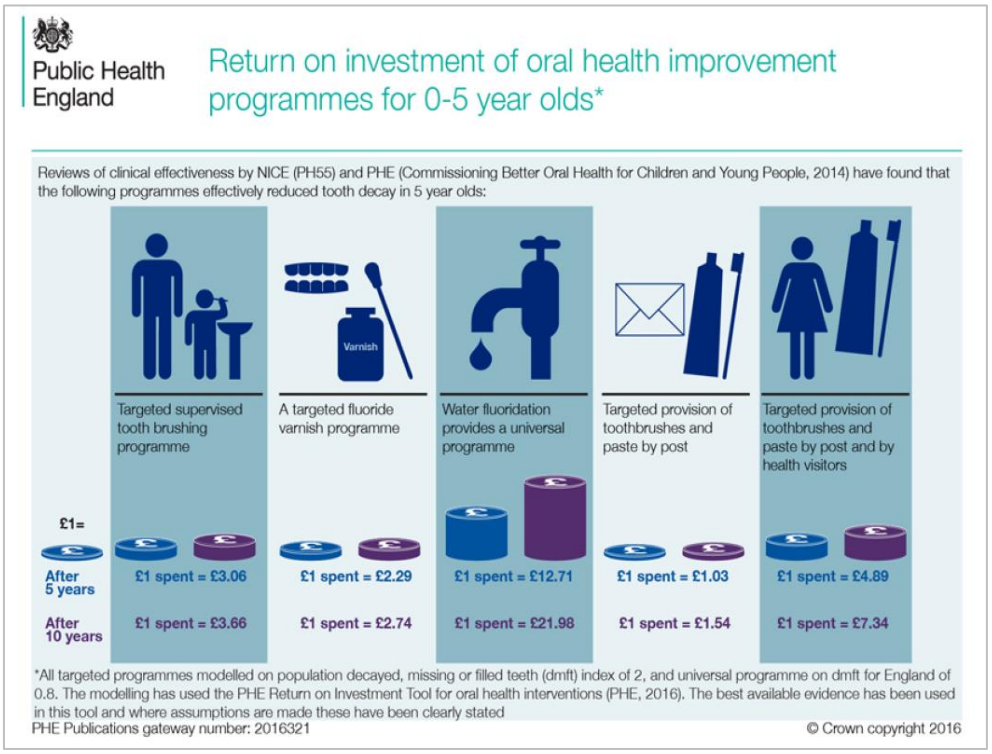


Figure 39 - Return on investment of oral health improvement programmes for 0-5 year olds

NICE GUIDANCE – LOCAL AUDIT AND MAPPING

As a unitary local authority, Herefordshire Council (HC) are the organisation statutorily required to commission or provide oral health improvement programmes for the population of Herefordshire. In addition to evidence reviews and toolkits available from PHE, NICE developed national guidance to inform the approach adopted by local authorities and key partners for improving oral health [8].

Table 7, details the 21 recommendations contained within this national guidance, and maps the current provision or activity in Herefordshire against each (as of May 2019). Recommendations to address any identified gaps are discussed in the next chapter.

Table 7 - Local audit against NICE guidance [8]

NICE recommendations	What's happening in Herefordshire?	Gaps against NICE recommendations
1. Ensure oral health is a key health and wellbeing priority	Oral health is a core component of Herefordshire's Joint Strategic Needs Assessment (JSNA) and Child Integrated Needs Assessment (CHINA). Improving the dental health of children and young people is a strategic priority for Herefordshire's Health and Well-being Board and identified in the Director of Public Health's annual report 2018.	The strategic responsibility for oral health improvement and reducing health inequalities is not led or overseen by a multi-agency group.
2. Carry out an oral health needs assessment (OHNA)	A final draft of the OHNA for Herefordshire was completed in June 2019 and the final report will be shared widely with partners throughout September 2019.	No formal plans exist for ensuring the OHNA forms part of a cyclical planning process.
3. Use a range of data sources to inform the oral health needs assessment	The recent OHNA, was informed by epidemiological and socio-demographic data, which was obtained at a national, regional and local level. PHE and NHS England supported the process of data collection and analysis.	N/A
4. Develop an oral health strategy	None identified	A local oral health strategy and/or action plan has not been developed, although is planned to be following the completion of the OHNA.
5. Ensure public service environments promote oral health	Areas and examples of good practice exist across Herefordshire i.e. promotion of breastfeeding; provision of healthy food and drink choices in some early years settings, schools and care settings.	A system-wide or consistent approach does not exist, which ensures all public service environments in Herefordshire promote oral health and healthier eating e.g. within leisure centres, nurseries, community centres, health and social care settings.

NICE recommendations	What's happening in Herefordshire?	Gaps against NICE recommendations
	HC Public Health Team are having initial discussions about engaging with public service environments to become 'health promoting'. Furthermore, 'levers' to influence planning decisions regarding fast food, are being reviewed.	
6. Include information and advice on oral health in all local health and wellbeing policies	Areas and examples of good practice exist across Herefordshire i.e. provision of information and advice in maternity and public health nursing services, schools and care settings. HC Public Health Team are having initial discussions with key services and settings about including oral health in local policies i.e. care homes.	A system-wide or consistent approach does not exist, which encourages all commissioners and providers of public services in Herefordshire to include information and advice on oral health.
7. Ensure frontline health and social care staff can give advice on the importance of oral health	Advice according to 'Delivering better oral health (PHE)', is delivered on an ad-hoc basis to various frontline services (by the HC Public Health Team). Making Every Contact Count (MECC), is delivered to some frontline staff within public services and includes topics on oral health and healthy eating.	A requirement for front line staff to receive oral health training is currently not detailed within all specifications of relevant public services in Herefordshire.
8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health	Oral health promotion is currently embedded within Public Health Nursing Services and Children's Centres. In addition, examples of good practice exist is some adult care settings i.e. provision of appropriate oral hygiene advice.	A requirement for oral health promotion to be incorporated into all existing services is currently not met. Variation in provision is evident across children's services and health and social care services.

NICE recommendations	What's happening in Herefordshire?	Gaps against NICE recommendations
9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health	None identified	Regular training (focused on oral or wider public health) is not routinely commissioned or provided for health and social care staff.
10. Promote oral health in the workplace	Limited ad-hoc oral health promotion advice may be offered in some public sector organisations in Herefordshire i.e. through occupational health and human resource services.	The promotion of oral health as per 'Delivering better oral health' (PHE)[4] is not delivered systematically and routinely across all public sector organisations in Herefordshire.
11. Commission tailored oral health promotion services for adults at high risk of poor oral health	None identified	Herefordshire Council do not commission or facilitate the provision of tailored oral health promotion services or interventions for specific at-risk groups i.e. outreach services for people who are homeless, Traveller communities, or those who have sought asylum locally.
12. Include oral health promotion in specifications for all early years services	Oral health promotion is included in the contract specification for the Herefordshire Public Health Nursing Service (contract commenced 2018) and is monitored by strategic targets.	A requirement for all contract specifications for early years services to promote oral health and train staff is currently not met within Herefordshire.
13. Ensure all early years services provide oral health information and advice	Areas and examples of good practice exist across Herefordshire i.e. provision of information about oral health and healthier eating within maternity and public health nursing services, Children's Centres, schools and care settings.	The provision of oral health information and advice as per 'Delivering better oral health' (PHE)[4] is not delivered systematically and routinely across all early years services.
14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health	Areas and examples of good practice exist across Herefordshire i.e. In 2019, Public Health Nursing Service provided free tooth brush packs to families in groups at high risk of poor oral health.	The provision of additional tailored information and advice is not delivered systematically and routinely across all early years services.

NICE recommendations	What's happening in Herefordshire?	Gaps against NICE recommendations
15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health	None identified	Currently Herefordshire Council do not commission or facilitate the provision of supervised tooth brushing schemes i.e. in early years settings or schools.
16. Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health	None identified	Currently Herefordshire Council do not commission or facilitate the provision of supervised tooth brushing schemes i.e. in early years settings or schools.
17. Raise awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools	Areas and examples of good practice exist across primary schools in Herefordshire i.e. implementation of the 'School Food Plan', availability of plain drinking water and provision of healthier food choices.	Local evidence is not available, which determines the proportion of primary schools in Herefordshire who adopt a 'whole school' approach to oral health or implement national guidance and policies for improving oral health of children.
18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health	None identified	Local evidence is not available, which determines the existence of specific schemes and interventions (i.e. staff training, adapted oral health advice, tooth brushing schemes being delivered in primary schools.
19. Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health	None identified	Currently Herefordshire Council do not commission or facilitate the provision of supervised tooth brushing schemes i.e. in early years settings or schools.

NICE recommendations	What's happening in Herefordshire?	Gaps against NICE recommendations
20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health	None identified	Currently Herefordshire Council do not commission or facilitate the provision of community-based fluoride varnish programmes i.e. in early years settings or schools.
21. Promote a 'whole school' approach to oral health in all secondary schools	Areas and examples of good practice exist across primary and secondary schools in Herefordshire i.e. implementation of the 'School Food Plan', availability of plain drinking water and provision of healthier food choices.	Local evidence is not available, to determine the proportion of secondary schools in Herefordshire who adopt a 'whole school' approach to oral health or implement national guidance and policies for improving oral health of children and young people.

CONCLUSIONS AND RECOMMENDATIONS

Based on the intelligence and information available, this OHNA has comprehensively described the standard of oral health of people living in Herefordshire. In addition, this OHNA has also presented a detailed overview of current oral health care services locally, in relation to their availability, accessibility and activity.

Where possible, the local picture in Herefordshire has been benchmarked against regional and national positions, in order to provide a comparative understanding of oral health needs and experiences locally.

CHALLENGES AND GAPS

Findings from this OHNA, indicate that a number of challenges and gaps exist in relation to the oral health of Herefordshire's population.

PLACE AND POPULATION

- Herefordshire has one of the highest proportions of people over the age of 65 years. As older adults are more likely to require complex oral health care, in the future this may increase the level of need and demand for appropriate dental services.

- Over half of all residents in Herefordshire live in rural communities. Although the local population-dentist ratio is higher than both nationally and regionally, approximately half of dental provision is in Hereford city. This may create challenges for rural communities, who require dental care but experience barriers to transport or access more broadly.

- A concerning proportion of children and adults in Herefordshire are overweight or obese. Furthermore, a significant number of people smoke and/or consume alcohol excessively. The prevalence and unequal distribution of these risk factors locally are an important consideration for addressing poor oral health in Herefordshire.

STANDARD OF ORAL HEALTH

- Children in Herefordshire have significantly poorer oral health than reported nationally and generally poorer oral health than reported by our geographical and statistical neighbours. This finding is consistent across all survey results for 3 year olds, 5 year olds and 12 year olds.

- For children aged 5 years, there has been no significant change in the standard of oral health locally over the last 10 years.

- In the last ten years the incidence and mortality rate of oral cancer in Herefordshire has generally increased (a trend reflected nationally).

Gaps in knowledge

- Small sample sizes and limited data, mean it is not possible to confirm the true prevalence and severity of oral diseases experienced in Herefordshire. In addition, reliable conclusions cannot be drawn about the extent of oral health inequalities locally e.g. related to deprivation or ethnicity.

- Whilst the numbers of people within particular at-risk groups can be estimated, local information is lacking about the burden of oral diseases experienced within these groups i.e. Looked after children, older adults in care, people who are homeless.

ORAL HEALTHCARE SERVICES

- A larger proportion of children in Herefordshire have been seen by an NHS dentist than reported nationally, however a significant number of children under 5 years have not accessed NHS dental services (especially those under 2 years).

- Results from the local dental access survey (May 2019) indicate that it may currently be difficult for both children and adults to obtain routine NHS dental care within Herefordshire.

- A large proportion of children and young people in Herefordshire appear to not be receiving fluoride varnish applications within NHS dental care.

- Approximately a third of 'Looked after children' in Herefordshire have not had their teeth checked by a dentist. Without more recent data, it is not known if this remains a current challenge.

Gaps in knowledge

- A lack of local data at a granular level, means it is not possible to determine the current equity of access to NHS dental care according to different demographics i.e. deprivation, age, sex, ethnicity or geography.

- It is not known whether there is reasonable and equitable access to local dental services that meet the needs of at-risk groups i.e. in relation to domiciliary care, outreach or specialist primary care services.

ORAL HEALTH IMPROVEMENT

As detailed in Table 7 (pg. 59), a number of gaps exist between NICE recommended practice for local authorities and the current approach to oral health improvement locally.

- Whilst improving oral health (particularly in children), is a local strategic priority, there remains a lack of strategic direction and designated resources to achieve positive outcomes at a population level

- There is limited co-ordination and consistency in the delivery of oral health improvement activities and messages across community settings (i.e. children's services, educational settings, care homes).

Gaps in knowledge

- Insufficient local data means it is not possible to evidence the extent of oral health inequalities in Herefordshire. Due to this, at the current time, the need for fluoridation of local public water supplies is not able to be determined.

- It is not known to what extent the dental workforce are engaged with Making Everyone Contact Count (MECC).

RECOMMENDATIONS

To address the challenges and gaps identified in this OHNA and improve the oral health of Herefordshire's population, 10 key recommendations are proposed (see table 8 below). Each recommendation is based on the findings from the OHNA and is extensively informed by national guidance (see Appendix A).

As per their statutory obligation, Herefordshire Council are expected to have overarching responsibility and accountability for the recommendations listed. However, ensuring the recommendations are actioned, will require engagement with and input from the following key multi-agency partners across the system –

- PHE
- NHS
- Herefordshire LDC
- Herefordshire and Worcestershire STP
- Healthwatch Herefordshire

Table 8 - Herefordshire OHNA - 10 key recommendations		
Recommendation Number	**Recommendation**	**By when? (Suggested owners)**
1	Establish a multi-agency steering group to lead the strategic direction for improving oral health and reducing oral health inequalities in Herefordshire. Ensure key partners are represented in the group's membership.	By October 2019 (Herefordshire Council – Public Health Team)
2	Based on the findings from the OHNA, develop a clear local vision and a high-level action plan for improving oral health and reducing oral health inequalities in Herefordshire.	By November 2019 (Herefordshire Council - in conjunction with multi-agency steering group)
3	Bridge the gaps in the current local approach to oral health improvement identified through the audit against the NICE guidance and the review of PHE guidance.	Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group)
4	In accordance with PHE evidence-informed toolkits, scope and investigate the commissioning and provision of programmes with a known return on investment – • Targeted community fluoride varnish (for children and older vulnerable adults) • Targeted supervised tooth brushing • Targeted provision of toothbrushes and toothpaste by post and/or health visitors	By December 2019 (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group)
5	In line with 'Delivering Better Oral Health' (PHE, 2017), promote the role and value of primary prevention within NHS primary dental care across Herefordshire. This is inclusive of – • Increasing the delivery of preventive interventions i.e. fluoride varnish applications • Encouraging parents/carers of infants (< 2 years) to access NHS dental care • Embedding Making Every Contact Count within dental care settings	Ongoing (NHS England and Public Health England in conjunction with the local dental committee and Herefordshire Council)

	• Ensuring dentists and oral health professionals are able to refer patients to community based health promotion activities i.e. for weight management, smoking cessation.	
6	Engage with and support key community settings (especially those commissioned or provided by the local authority) to develop local policies for improving oral health that reflect NICE guidance i.e. care settings, children and young people's settings, general practices and hospitals.	Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group)
7	Ensure continued local participation in the PHE Dental Public Health Epidemiology Programme and identify opportunities to increase both sample sizes and consent rates of local dental surveys	Ongoing (Public Health England in conjunction with Herefordshire Council)
8	Explore the feasibility of undertaking a health equity audit of access to dental services in Herefordshire, specifically related to 'at-risk groups' (e.g. Looked after children, vulnerable older adults, people who are homeless or refugees, those with a learning disability).	By December 2019 (Herefordshire Council - Public Health Team, in conjunction with NHS England)
9	Seek opportunities to influence the common risk factors and wider determinants for poor oral health, obesity and other key public health issues i.e. smoking, high-risk drinking. For example through encouraging public service settings to be 'health promoting' and influencing local relevant planning decisions.	Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group)
10	Based on a Cabinet approved recommendation (Jan 2019), investigate the case for commissioning a feasibility study into water fluoridation. This should be considered in the context of local needs and the range of oral health improvement programmes currently commissioned/provided.	By December 2019 (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group)

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Appendices

Appendix A – Key national guidance on oral health

Organisation	Guidance/toolkit title	Year of publication
Public Health England	• Local authorities improving oral health: commissioning better oral health for children and young people	2014
	• Improving the oral health of children: cost effective commissioning	2016
	• Delivering better oral health: an evidence-based toolkit for prevention	2017
	• Child oral health: applying All Our Health	2018
	• Oral health improvement programmes commissioned by local authorities	2018
	• Commissioning better oral health for vulnerable older people	2018
	• Oral care and people with learning disabilities	2019
	• Adult oral health: applying All Our Health	2019
National Institute of Health and Care Excellence	• Oral health: local authorities and partners, PH55	2014
	• Oral health promotion: general dental practice, NG30	2015
	• Oral health for adults in care homes, NG48	2016
	• Oral health promotion in the community, QS139	2016
	• Oral health in care homes and hospitals, QS151	2017
Local Government Association	• Tackling poor oral health in children	2016

Appendix B – Roles and responsibilities of the key organisations involved with improving oral health (15 - pg.15)

	Body	Key Responsibilities
National	NHS England	▪ planning, securing and monitoring primary care community and secondary dental services within a single operating model ▪ developing and negotiating contracts; policies, procedures, guidance and national care pathways ▪ commissioning public health services for children aged 0-5 years (including health visiting, family nurse partnerships within the healthy child programme (HCP) 0-5 years until 2015)
	Public Health England	▪ providing health improvement support for local authorities and NHS England ▪ informing and developing national oral health policies and clinical guidelines ▪ addressing oral health inequalities ▪ ensuring patient safety and governance systems
	Health Education England	▪ providing national leadership for planning and developing the whole healthcare and public health workforce
	National Institute for Health and Care Excellence (NICE)	▪ providing independent advice and guidance to the NHS and social care; developing dental public health guidance
	Health Watch England	▪ representing the rights and views of the public and health and social care users to inform commissioning ▪ identifying public concerns about health and social care services ▪ developing and leading local Health Watch
Regional	NHS England regional reams	▪ providing clinical and professional leadership at the regional level ▪ coordinating and planning dental services on the basis of regional needs ▪ direct commissioning functions and processes ▪ regional director of nursing responsible for supporting and providing assurance on safeguarding children
	PHE regional teams	▪ developing guidance for local authorities ▪ supporting collaborative commissioning of oral health improvement programmes
Local	NHS England area teams	▪ commissioning all NHS dental services - both primary and secondary care ▪ supporting CCGs to assess and assure performance ▪ direct and specialised commissioning ▪ managing and cultivating local partnerships and stakeholder relationships, including representation on local health and wellbeing boards ▪ local area team director of nursing responsible for supporting and providing assurance on safeguarding children
	PHE centres	▪ providing dental public health support to NHS England and local authorities ▪ contributing to joint strategic needs assessments (JSNA), strategy development, oral health needs assessment ▪ supporting local authorities to understand their role in relation to water fluoridation
	Local authorities – public health	▪ jointly statutorily responsible with CCGs for JSNAs assessing local health needs ▪ conducting and/or commissioning oral health surveys to assess and monitor oral health needs ▪ responsible for reducing health inequalities ▪ planning, commissioning and evaluating oral health improvement programmes ▪ leading scrutiny of delivery of NHS dental services to local populations ▪ commissioning surveys to facilitate PHE to monitor and report on the effect of water fluoridation programmes (if water fluoridation programmes affect the local authority area) ▪ lead responsibility for the healthy child programme 5-19 years (and HCP 0-5 years from 2015), the national child measurement programme and the care of vulnerable children and families (ie. looked after children, the troubled families programme) ▪ safeguarding children ▪ commissioning local healthy schools, school food and healthier lifestyle programmes
	Local health watch	▪ providing information and advice to the public about accessing health and social care services and power to enter and view service provision ▪ engaging and collecting public and users' views about access and the quality of services to inform commissioning
	Local dental networks (LDNs)	▪ providing local professional leadership and clinical engagement ▪ supporting the specialist dental public health workforce to plan and design local care pathways, dental services and oral health strategies
	Clinical commissioning groups (CCGs)	▪ GP-led commissioning groups accountable to NHS England for commissioning community health services, children's mental and physical health services, emergency care, maternity services
	Early year providers schools	▪ Department of Health and Department for Education integrated health and education reviews for children aged 2 to 2 ½ by 2015
	Schools	▪ Healthy schools programme ▪ delivering non-statutory personal, social, health and economic (PSHE) education in key stage 1 of the national curriculum

Health and Wellbeing Board Forward Plan 2022/23

2022-23	AGENDA ITEM	REPORT FROM	FREQUENCY	PURPOSE	ACTIONS
7 February	Private Workshop (HWB Strategy)	Amy Pitt	Quarterly	Information	
28 March	NHS Dental Provision in Herefordshire	Terrance Chikurunhe/ Nuala Woodman	Ad-hoc	Decision	~~E~~ndorsed - to be revisited
	Herefordshire's Physical Activity Strategy	Kay Higman/ Rachel Fowler	Ad-hoc	Decision	Endorsed
	Establishing the Integrated Care Partnership	David Mehaffey/Simon Trickett	Ad-hoc	Information	Ongoing
	Health and Wellbeing Work Plan 2022/23	Amy Pitt	Annual	Information	Ongoing
6 June	Private Workshop *Review of existing and new Health and Wellbeing Strategy*	Board Discussion	Quarterly	Information	
21 July	Better Care Fund (Year End 2021-22)	Marie Gallagher	Quarterly	Information	
	HWB Strategy Briefing	Matt Pearce/Public Health	Ad-hoc	Information	
	Integrated Care Partnership Assembly (ICPA) Terms of Reference and Integrated Care System (ICS) Updates	David Mehaffey/ICS	Ad-hoc	Information	
	Inequality Group Update/Briefing	Alan Dawson	Ad-hoc	Information	
26 September TBC	Private Workshop Session		Quarterly		
26 September TBC	Herefordshire Food Charter	Kristan Pritchard	Ad-hoc	Information	
	Khan Review Briefing/Needs Assessment Smoking	Luke Bennett/Frances Howie	Ad-hoc	Information	
	Better Care Fund	Marie Gallagher	Ad-hoc	Decision	
	Cost of Living Commission	Matt Pearce/Hilary Hall	Ad-hoc	Decision	
	Pharmaceutical Needs Assessment	Frances Howie/Public Health	Ad-hoc	Decision	
	Oral Health Improvement Board Update	Frances/Public Health	Ad-hoc	Information	
	Health and wellbeing Board Strategy Update	Lucy Beckett/Matt Pearce	Ad-hoc	Information	
17 October TBC	Private Workshop Session Health and Wellbeing Strategy Session		Quarterly		
12 December TBC	Joint Strategic Needs Annual Summary	ICS	Annually	Information	
	Mental Health and Suicide - Children and Young People's Partnership	Darryl Freeman	Ad-hoc	Information	
	Joint Health and Wellbeing Strategy Update	ICS	Ad-hoc	Information	

13 February TBC	Private Workshop Session		Quarterly		
20 March TBC	DPH Annual Report	Matt Pearce/Public Health	Annually	Information	
	Community Safety Partnership Update	TBC	Ad-hoc	Information	
	Mental Health Strategy/ Mental Health Collaborative	ICS	Annually	Decision	
	Carers Strategy	TBC	Ad-hoc	Information	
	Domestic Abuse Strategy 2021-24	Ewen Archibald/ Kayte Thompson-Dixon	Ad-hoc	Information	
	Children Improvement Plan	Bart Popelier/Lisa Arthey	Ad-hoc	Information	