Herefordshire Council

Agenda

Health and Wellbeing Board

Date:	**Monday 4 December 2023**
Time:	**2.00 pm**
Place:	**Conference Room 1, Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Henry Merricks-Murgatroyd, Democratic Services** Tel: 01432 260239 Email: henry.merricks-murgatroyd@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format or language, please call Henry Merricks-Murgatroyd, Democratic Services on 01432 260239 or e-mail henry.merricks-murgatroyd@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health and Wellbeing Board

Membership

Chairperson	Councillor Carole Gandy	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Vice-Chairperson	Jane Ives	Managing Director, Wye Valley NHS Trust
	Stephen Brewster	VCS representative
	Jon Butlin	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
	Ross Cook	Corporate Director for Economy and Environment, Herefordshire Council
	Kevin Crompton	Herefordshire Safeguarding Adults Board
	Darryl Freeman	Corporate Director for Children and Young People, Herefordshire Council
	Hilary Hall	Corporate Director for Community Wellbeing, Herefordshire Council
	Susan Harris	Director of Strategy and Partnerships, Herefordshire and Worcestershire Health and Care NHS Trust (representative of the Trust)
	Dr Mike Hearne	Herefordshire General Practice (Managing Director, Taurus Healthcare)
	Councillor Jonathan Lester	Leader of the Council, Herefordshire Council
	David Mehaffey	Executive Director of Strategy and Integration, NHS Herefordshire and Worcestershire ICB
	Matt Pearce	Director of Public Health, Herefordshire Council
	Councillor Ivan Powell	Cabinet Member Children and Young People, Herefordshire Council
	Christine Price	Chief Officer, Healthwatch Herefordshire
	Simon Trickett	Chief Executive, NHS Herefordshire and Worcestershire ICB
	Superintendent Helen Wain	Superintendent, West Mercia Police

Agenda

Pages

THENOLANPRINCIPLES

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

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

3. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest in respect of table A and/or table B or other interests from members of the board in respect of items on the agenda.

4. MINUTES 7 - 12

To approve and sign the minutes of the meeting held on 25th September 2023.

5. 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 29th November 2023 at 5.00 pm.

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

6. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is 29th November 2023 at 5.00 pm, unless the question relates to an urgent matter.

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

7. JSNA REVIEW 13 - 56

To ask the Health and Wellbeing Board to approve and endorse the recommendation in the report.

8. UPDATE ON THE PROGRESS OF THE HEALTH AND WELLBEING STRATEGY DRAFT IMPLEMENTATION PLANS FOR THE TWO KEY PRIORITIES 'BEST START IN LIFE' (BSIL) AND 'GOOD MENTAL HEALTH' (GM) 57 - 88

To provide the Board with an update on the progress of the draft implementation plans for 'Best Start in Life' (BSiL) and 'Good Mental Health' (GMH) and to receive feedback and approval from the Board for the aforementioned plans.

9. COMMUNITY PARADIGM UPDATE 89 - 100

To update the Health and Wellbeing Board on the progress being made to develop the community paradigm approach in Herefordshire.

10. HEALTH PROTECTION ASSURANCE FORUM ANNUAL REPORT 101 - 160

The purpose of this report is to update the Health and Wellbeing Board on health protection system performance, achievements, and risks for 2023, as well as areas of focus for 2024.

11. DATE OF NEXT MEETING

The next scheduled meeting is 11th March 2024, 14:00-17:00.

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 Room 1, Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE on Monday 25 September 2023 at 2.00 pm

Board members present in person, voting:

Kevin Crompton	Independent Chair, Herefordshire Safeguarding Adults Board
Darryl Freeman	Corporate Director for Children and Young People, Herefordshire Council
Councillor Carole Gandy (Chairperson)	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Hilary Hall	Corporate Director for Community Wellbeing, Herefordshire Council
Dr Mike Hearne	Managing Director, Taurus Healthcare
Jane Ives (Vice-Chairperson)	Managing Director, Wye Valley NHS Trust
Councillor Jonathan Lester	Leader of the Council, Herefordshire Council
Matt Pearce	Director of Public Health, Herefordshire Council
Christine Price	Chief Officer, Healthwatch Herefordshire
Simon Trickett	Chief Executive, NHS Herefordshire and Worcestershire ICB

Board members in attendance remotely, non-voting:

Superintendent Helen Wain	Superintendent, West Mercia Police

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

Others present in person:

Harpal Aujla	Consultant in Public Health	Herefordshire Council
Gareth Boulton	Chief Executive, West Mercia Police	West Mercia Police
John Campion	Police and Crime Commissioner, West Mercia	

Others in attendance remotely:

Lorraine Baker	Service Lead, Urgent Care	Herefordshire and Worcestershire Health and Care NHS Trust
Stephen Brewster	VCS representative	VCS
Marie Gallagher	Integrated Systems Lead	Herefordshire Council
Joanne Lilley	Community Wellbeing Communications Officer	

27. APOLOGIES FOR ABSENCE

Apologies were received from: Jon Butlin, Councillor Ivan Powell, and Mark Yates.

28. NAMED SUBSTITUTES (IF ANY)

Lorraine Baker acted as a substitute for Susan Harris to represent Herefordshire and Worcestershire NHS Trust.

29. DECLARATIONS OF INTEREST

There were no declarations of interest.

30. MINUTES

The board approved the minutes of the meeting 26 June 2023.

31. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received.

32. QUESTIONS FROM COUNCILLORS

No questions were received.

33. APPOINTMENT OF VICE-CHAIRPERSON

Resolved: That Jane Ives (Managing Director, Wye Valley NHS Trust) be re-appointed vice-chairperson of the board for the remainder of the municipal year.

34. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

Matt Pearce (Director of Public Health) gave a brief overview of the proposed Terms of Reference which includes some changes to the membership of the committee.

The recommendation was proposed, seconded, and approved unanimously.

Resolved that:

a) **The Health and Wellbeing Board considers the revised terms of reference at appendix 1 and provides comments before being ratified by Full Council.**

35. HEREFORDSHIRE'S BETTER CARE FUND (BCF) INTEGRATION PLAN 2023-25

Hilary Hall (Corporate Director for Community Wellbeing) provided an overview of the Better Care Fund (BCF) Integration plan 2023-25.

Simon Trickett (Chief Executive, NHS Herefordshire and Worcestershire ICB) thanked the Corporate Director and officers for the work in providing the plan. It was noted that approval has been received from NHS England which represents a national approval process. It was raised that work still needs to be done regarding local arrangements and specifically, over the next twelve months, it was noted that there is an overreliance on spot-purchasing placements and instead clarity needs to be established about longer-term arrangements which are better for patients and service users.

The Corporate Director for Community Wellbeing agreed that there should not be an overreliance on spot-purchasing. It was also raised that enabling more people to come home and be supported in their own homes rather than moving into residential and nursing care is appropriate.

Jane Ives added that through the resources that exist, efficiency and effectiveness can be driven by having a much more local ownership of the problem. More work needs to be done but this is an exciting first step in the right direction.

The report recommendations were proposed, seconded, and approved unanimously.

Resolved that:

a) **The Herefordshire Better Care Fund 2023-25 narrative plan (Appendix 1), planning template (Appendix 2) and the ICB Discharge template (Appendix 3) be approved; and**
b) **the ongoing work to support integrated health and care provision that is funded via the BCF is noted by the board.**

36. MOST APPROPRIATE AGENCY

John Campion (West Mercia Police Crime Commissioner) provided an overview of the Most Appropriate Agency (MAA) report produced by West Mercia Police. The points under item 24 of the MAA report were referred to in asking for feedback from board members.

Kevin Crompton asked what the mechanism is for multiagency decision making and where is the conversation for agencies to decide whose remit it is to respond to a certain situation.

The Police Crime Commissioner responded that there is no multiagency function in West Mercia, however, part of the solution may include the development of a new forum which makes it easier for the right response to be made to a person in need.

The Chair asked if there will be confusion as to who people should contact in certain situations.

The Police Crime Commissioner responded that while the police are very accessible, not all emergency services are in that position. It is for the partners to sort out how demand is re-routed not necessarily the person in need.

Lorraine Baker (Service Lead) noted that there is an escalation policy in place with the police to request the police deployment to assist with certain situations, particularly with relation to mental health.

Superintendent Helen Wain (West Mercia Police) added that the escalation policy is available should agencies feel that the decision taken by the police is not correct. There are monthly meetings with A+E and mental health services at which these issues are discussed.

Simon Trickett noted the success of the pilot in Humberside and is confident in the strength of local partnerships to make a success of this policy.

The Police Crime Commissioner added that going forward how the different processes, budget cycles, and commissioning of services are aligned and how gaps are addressed where they exist.

Jane Ives noted that Herefordshire, as a small county with small public services, needs to be more flexible with how public services work together.

The Police Crime Commissioner agreed that Herefordshire is unique, however, this provides opportunities where partners can collaborate and work closely together. At present, the route map does not exist to make that happen enough of the time on such particular issues.

Jane Ives responded that in relation to the first bullet point under item 24 of the report, partners do not fully understand the implications of the policy for themselves from both a strategic and an operational perspective. Broad conversations do need to take place with the partners.

The Chair asked regarding Humberside, what are they doing differently to what Herefordshire is doing now and what can be learned from Humberside.

The Police Crime Commissioner responded that the Humberside partnership was set up as a partnership around the shared problem of demand not being met in the right place. The way they set up their project is very different to how it started in West Mercia.

Simon Trickett added that working with the community is important to ensure that there is a self-sufficiency and people can help look out for others.

Councillor Jonathan Lester (Leader of the Council) thanked the Police and Crime Commissioner for the document and noted that unless there is a policy response for people to know who to approach then this policy will not have the traction it needs to have an impact. A policy therefore needs to be in place to cope with the requirements of this document.

Stephen Brewster (VCS) added that the VCS has a role to help support what comes next in the development of the policy.

The Director of Public Health noted that there is a consensus around some sort of partnership, and it is worth considering how existing groups/partnerships are utilised to oversee this policy or whether a short task and finish group can be created.

The Police Crime Commissioner added that there was enough governance to go forward. A number of partners are not happy with what is happening and therefore it is important to reassure those partners that everything that could be being done is being done. Therefore within existing organisations, it would be useful to focus on the areas where concerns remain.

In addition to the report recommendations, the Director of Public Health recommended that a meeting to work through solutions be delegated to the One Herefordshire Partnership and then an item be brought to the meeting in December for the Health and Wellbeing Board.

Resolved that:

a) **Members are invited to note the report.**
b) **Members are invited to consider implications of the West Mercia Police policy as part of both their own organisations and the wider system.**
c) **Members are invited to consider potential options relating to joint / co-ordinated governance activity.**
d) **A meeting be delegated through to the One Herefordshire Partnership before an item is brought to the Health and Wellbeing Board in December.**

37. UPDATE ON THE WORK OF THE ORAL HEALTH IMPROVEMENT PARTNERSHIP BOARD

Harpal Aujla (Consultant in Public Health) presented the update on the work of the oral health improvement partnership board. The key points included:

1. The Oral Health Improvement Partnership Board aims to deliver on the recommendations made in the Health Needs Assessment published in 2019.
2. The board was restarted in 2021 and meets quarterly and is chaired by the Public Health consultants.
3. Key areas of development are good activity at system level including new dental service called the ‘golden hello’. For children and young people, the ‘Time to Shine’ programme continues to improve children’s oral health and a ‘Brush, Book, Bed’ pack has been made available via libraries and aims to give every child aged 3 a pack including a toothbrush and book.
4. However, decay in children aged 5 has risen from 33.6% in 2012 to 38.7% in 2022.

5. There are areas which could be focused on for further improvement including fluoride varnishing and fluoridation of the water supply.

Simon Trickett added that the golden hello initiative will provide two new dental services in Herefordshire. It was asked whether water fluoridation could be discussed further.

The Director of Public Health noted that water fluoridation would be beneficial to improving children's oral health but that there was not enough clarity on how this can be achieved.

The Chair commented that rural areas of Herefordshire whereby public transport is limited, getting to a dental practice is very difficult. The use of a mobile dental unit could be used to help those who find it difficult to travel to dental practices.

Stephen Brewster asked if there was a correlation to the childhood obesity data in terms of whether the hotspots are the same.

The Director of Public Health responded that there was not enough evidence to suggest there was a direct correlation. This is an area that can be followed up going forward.

The Leader of the Council asked if there was any focus on drinks other than water that may be harming oral health and what advice is being given to families.

The Director of Public Health answered that some work is being done regarding the development of the healthy setting standards for early years and the wider promotion of healthy drinking.

The Chair asked whether it was still the case that fluoride varnishing is offered in dental practices and whether that is sufficiently publicised as available.

Harpal Aujla responded that it fluoride varnishing is still being offered and carried out by dental practices.

The Director of Public Health added that, in terms of publicising fluoride varnishing, this would need to be taken away and looked at by the Oral Improvement Partnership Board.

Christine Price (Healthwatch) asked Simon Trickett of the ICB whether there are opportunities for commissioning different ways of providing services which aren't traditionally seen by dentists.

Simon Trickett commented that dentistry was commissioned nationally until 1st April 2023 when it was devolved down to local level. The incentive to help with set up cost was part of creative thinking associated with the 'golden hello' scheme. Dental access can be improved but the other elements of the plan such as fluoridation of the water supply is vital.

In addition to the report recommendations which were proposed, seconded, and approved unanimously, it was resolved that fluoride varnishing be brought to the oral health improvement board and to look into the correlation between childhood obesity data and oral health.

Resolved that:

That members of the Health and Well-being Board:

a) **Note the progress of the Oral Health Improvement Partnership Board;**

b) **Continue to support and deliver Herefordshire oral health action plan. (Appendix 1)**

c) **Support work to explore fluoridation of the water supply in Herefordshire.**

d) **That fluoride varnishing be brought to the oral health improvement board.**

e) **To look into the correlation between childhood obesity data and oral health.**

38. LAUNCH OF HEREFORDSHIRE'S JOINT LOCAL HEALTH AND WELLBEING STRATEGY

The Director of Public Health gave a summary of the launch event which was held in July. Participants helped contribute to the delivery of the strategy's two key priorities and these are currently being written up in delivery plans that are due to come to the Board in December.

The Chair noted that she received positive feedback from councillors about the event and this underlines the need to do more to reflect the positive work that is ongoing in Herefordshire. It was recommended that an annual event is held.

Resolved that:

a) **The Health and Wellbeing Board is invited to reflect on the conference and any lessons that can be learned to inform future events.**
b) **An annual Health and Wellbeing event is held.**

39. WORK PROGRAMME

The Chair asked the board if members wanted to hold a private development session in November. No requests were received to do so.

40. DATE OF NEXT MEETING

The next scheduled meeting is 4 December 2023, 14:00-17:00.

The meeting ended at 15:31 pm **Chairperson**

Herefordshire Council

Title of report: JSNA Review

Meeting: Health and Wellbeing Board

Meeting date: Monday 4 December 2023

Report by: Robert Davies, Consultant in Public Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

To approve and endorse the recommendation in the report.

Recommendation(s)

a. Establish a JSNA steering group to respond to the findings of this review;

b. Maintain a JSNA steering group to make on-going partnership decisions on the form, function, administration and governance of the JSNA;

c. Incorporate the function of a JSNA steering group into One Herefordshire Partnership, with the ability to involve additional partners as needed.

Alternative options

1. Do nothing (Not recommended)

    a. Weaknesses highlighted in the JSNA review would remain

2. Decide on form, function and administration unilaterally (Not recommended)

    a. Single stakeholder group e.g. NHS, local authority intelligence unit or public health, could take a view on what's needed and implement change.

    b. A single stakeholder view is not representative of diverse primary user needs.

    c. This option runs counter to the "Joint" nature of the JSNA process and perpetuates an existing limitation identified in the review.

Further information on the subject of this report is available from
Rachel Watkins, email: Rachel.Watkins@herefordshire.gov.ukl

d. A fundamental partnership governance gap would remain.

Key considerations

What is a JSNA?

3. The Joint Strategic Needs Assessment (JSNA) is a process by which local authorities and NHS integrated care boards (ICBs) assess the current and future health, care and wellbeing needs of the local community to inform local decision making[1].

4. This includes, but is not limited to:

- Providing a shared view of current and future health and care needs for the local community.
- Looking at the health of the population, with a focus on behaviours that affect health such as smoking, diet and exercise.
- Being concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment.
- Identifying specific health inequalities affecting our residents
- Identifying gaps in health and care services and documenting unmet needs

5. The JSNA process is made up of two elements. The data and information collected, sometimes called the "evidence base", and the process of making sense of that information in terms of joint strategic planning and decision making.

Rationale and purpose of the JSNA rapid review

6. Our current JSNA form and function reflects the preferences of the Health and Wellbeing Board around 2018. Since then, there have been significant organisational changes in the local authority and NHS; for example, in the formation of primary care networks in 2019, integrated care systems in 2022, and a resource shift to respond to the COVID-19 pandemic from 2020 to 2022. No stable group has been in place to guide the JSNA process through these changes.

7. As a result, it is not clear how well the current JSNA is meeting its goal of informing local decision making, from the perspective of those decision makers.

8. The purpose of the JSNA review is to uncover the strengths and weaknesses of our current JSNA in meeting its goal. The review outputs aim to provide a clear critique of the strengths and weaknesses of our current JSNA approach, and outline options for improvement, to be agreed by the Health and Wellbeing Board.

Method

9. We drew on four sources to understand our current JSNA strengths and weaknesses:

a. The number of Understanding Herefordshire newsfeed subscribers (n=478)

[1] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, 2022

b. Usage patterns of those navigating the Understanding Herefordshire website (2,000 views per month)

c. Subjective feedback submitted via an online feedback form embedded on the Understanding Herefordshire website (n=59 over 5-years)

d. Direct engagement with JSNA user groups via individual or group meetings, using feedback prompts (n=60 from Aug to October 2023)

10. Group feedback provided the richest data. Around 60 people generated over 300 unique lines of feedback that were reviewed and summarised.

11. With a better understanding of what's working well and less well with our current approach, we moved to assess options to improve. This included:

a. A search of best practice examples and frameworks from national sources

b. A review of JSNAs from other areas (n=7)

Results

12. The full report detailing our JSNA strengths weaknesses opportunities and threats can be found in the Appendix 1. The report is 34 pages long with 7-page Executive Summary.

13. It found there are many opportunities to improve our JSNA, much appetite across our user groups to do so, and clear options on how to do it.

14. A fundamental rejuvenation of our JSNA processes would require:

a. Adopting the 10 top tips and recommendations for JSNAs published in, "Best practice and opportunities for innovation in Joint Strategic Needs Assessments (2020)".

b. Applying first principles thinking guided by the 7-step process from Joint Strategic Needs Assessment: a springboard for action, Local Government Association (2011)

c. Reviewing options documented in the "local authorities similar to our own" section and deciding which, if any, to adopt.

15. The sources above provide a clear path to address our weaknesses, and a clear path to better shape our JSNA to the needs of our users, so it has more impact.

16. But this leaves the question of who decides which of the top 10 tips to adopt, how much first principles thinking is needed, or what options from other local authorities we wish to emulate and which we do not, or cannot?

17. In this report we have resisted the temptation to make recommendations unilaterally, as we think this perpetuates one of the main weaknesses of the JSNA process as is. Instead the main opportunity is to define a partnership group that can work through the best practice options above, and make those decisions on behalf of the JSNA primary users.

18. These judgements have not been made explicitly for years, so may take time and challenging conversations to work through fully, document and implement. But in our

favour; the options are already well-framed, distilled and decision frameworks ready to use.

Community impact

19. An improved JSNA process could have a positive community impact by improving our understanding of reality, leading to higher-quality health and social care commissioning decisions, leading to improved health and wellbeing outcomes for residents.

Environmental Impact

20. This is a decision on back office functions and will have minimal environmental impacts. Consideration has been made to minimise waste and resource use in line with the Council's Environmental Policy.

Equality duty

21. One of the goals of a JSNA is to highlight and minimise health inequalities, which includes groups with protected characteristics listed in the equality duty (specific duty). As this is a decision on back office functions, the impact will be indirect.

Resource implications

22. The recommendation to form a Steering Group to decide on next steps is cost neutral. However the Steering Group in its attempts to decide on the best ways of improve the JSNA may wish to discuss whether the JSNA process is adequately resourced and make recommendations as a result. These recommendations, if they have resource implications, will need to be considered and agreed by the relevant organisations on a case by case basis.

Legal implications

23. JSNAs were introduced by the Department of Health in April 2008 to strengthen joint working between the NHS (National Health Service) and local authorities.

24. The Health and Social Care Act 2012 awarded the responsibility for the JSNA and developing a Joint Health and Wellbeing Strategy to Health and Wellbeing Boards, with the purpose of reducing inequalities and improving the health and wellbeing of the whole community.

25. The constitution at paragraph 3.5.24(e) provides that one function of the Health and Wellbeing Board is to prepare a Joint Strategic Needs Assessment for the county

26. Recommendations in the report ensure that the board complies with its legal duties and acts in accordance with the constitution and Terms of Reference for the Board.

Risk management

27. No financial, legal, or reputation risks identified.

28. In reinvigorating our JSNA process we see the project risks. Their opposites are the mitigation or counterbalance. These risks will be managed at partnership steering group level with delegation to relevant partner officers.

    a. An overemphasis on JSNA form (the most visible part of the JSNA, like the website) without collaboratively defining JSNA functions (the invisible missing part). Form should follow function.

    b. Taking unilateral decisions on JSNA processes and outputs for speed, rather partnership decisions for long-term value.

    c. A focus on data and information generation or pooling, rather than insights generation from that information, which will require analyst and commissioner collaboration. For example, to interpret and provide a narrative around what we know now, irrespective of any new or different data sources in future.

    d. A focus on analytical capacity and outputs that underplays the vital role that commissioners and other decision makers play in generating shared insights. This includes the capacity and capability of decision makers to provide professional input and insights in a timely way.

    e. Over-emphasis on putting information on a website vs providing personalised analytical capability to probe question-driven insights and decision making

    f. Sunk-cost bias: a reluctance to strip back what is low value but familiar, in favour of the higher value, but less familiar.

    g. Expecting data to point to a decision, rather than providing the best available information to inform a partnership judgement. The threat is not having a decision making process or prioritisation process that uses information routinely and well.

    h. Focus on demand not need. So unmet needs remain hidden or not clear enough to act on.

    i. Capacity and capability of local Intelligence system to collaborate and deliver JSNA in partnership

    j. Capacity to define a JSNA programme lead with time and skills to drive change.

Consultees

29. The rapid review sought feedback from 10 primary stakeholder groups and obtained feedback from 8. This accounted for around 60 people, generating around 300 unique lines of feedback that were reviewed and summarised below.

30. Stakeholder groups included:

    a. Health and Wellbeing Board

    b. Health Watch

    c. Ward Councillors

    d. Communities directorate leadership team (includes adult social care)

    e. Children and Young People’s directorate leadership team

f. Clinical practitioners forum

g. All age commissioning team

h. Public Health Team

31. Stakeholders we hoped to include but could not within the time available included:

a. Integrated Care Board Executive Leadership Team

b. Intelligence Cell (analysts from different health partner organisations)

Appendices

32. Appendix 1: JSNA Review_Main Report_08Nov23

Background papers

33. 'None identified'

Report Reviewers Used for appraising this report:

Please note this section must be completed before the report can be published		
Governance	Matt Evans	Date 20/11/2023
Finance	Wendy Pickering	Date 20/11/2023
Legal	Sam Evans	Date 16/11/2023
Communications	Luenne featherstone	Date 14/11/2023
Equality Duty	Harriet Yellin	Date 20/11/2023
Procurement	Lee Robertson	Date 14/11/2023
Risk	Jo Needs	Date 14/11/2023

Approved by	Hillary Hal	Date 22/11/2023

Herefordshire's Joint Strategic Needs Assessment

A rapid review 2023

Herefordshire Council

Contents

Herefordshire Council

Executive Summary

Background

Rationale and purpose of the JSNA rapid review

Our current JSNA form and function reflects the preferences of the Health and Wellbeing Board around 2018. Since then, there have been significant organisational changes in the local authority and NHS; for example, in the formation of primary care networks in 2019, integrated care systems in 2022, and a resource shift to respond to the COVID-19 pandemic from 2020 to 2022. No stable group has been in place to guide the JSNA process through these changes.

As a result, it is not clear how well the current JSNA is meeting its goal of informing local decision making, from the perspective of those decision makers.

The purpose of the JSNA review is to uncover the strengths and weaknesses of our current JSNA in meeting its goal. The review outputs aim to provide a clear critique of the strengths and weaknesses of our current JSNA approach, and outline options for improvement, to be agreed by the Health and Wellbeing Board.

What is a JSNA?

The Joint Strategic Needs Assessment (JSNA) is a process by which local authorities and NHS integrated care boards (ICBs) assess the current and future health, care and wellbeing needs of the local community to inform local decision making[1].

This includes, but is not limited to:

- Providing a shared view of current and future health and care needs for the local community.
- Looking at the health of the population, with a focus on behaviours that affect health such as smoking, diet and exercise.
- Being concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment.
- Identifying specific health inequalities affecting our residents
- Identifying gaps in health and care services and documenting unmet needs

The JSNA process is made up of two elements. The data and information collected, sometimes called the "evidence base", and the process of making sense of that information in terms of joint strategic planning and decision making.

Who is the JSNA for?

The main audience for the JSNA is health and social care commissioners who use it to plan health and social care services.

[1] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, 2022

It can also be used as an evidence base for preparing bids and business cases; by the voluntary and community sectors to ensure that community needs and views are represented; by service providers to assist in the future development of their services, by local councillors to provide insights into their area of democratic accountability, and by the public to scrutinise local health and wellbeing information and plans.

Our current JSNA process

The live evidence base of Herefordshire's JSNA is displayed on a website called "Understanding Herefordshire". The information is arranged into programme and place-based topics, such as population, health, economy and place. Outputs include Herefordshire specific reports, presentations and infographics as well as "useful links" to external national or regional information sources.

A JSNA summary is currently agreed on a 3-yearly cycle and was last produced in December 2021 as a 61 slide PowerPoint presentation. This is the attempt to bring the many parts of the evidence-base jigsaw together into a shared narrative of current and future needs.

Method

We aimed to assess our current JSNA approach through objective and subjective feedback, looking specifically at four elements: form, function, administration and governance:

- **Form**: the content, look, ease of use, lucidity, and timeliness of JSNA outputs.
- **Function**: how the JSNA is, or isn't, used by different audiences to inform strategic planning and decision-making
- **Administration**: capacity and time to produce and maintain JSNA process and outputs.
- **Governance**: how the JSNA process is controlled and directed. Who makes decisions about its scope, content, and how do we go from data to insights to priorities across diverse stakeholders.

Current reality

We drew on four sources to understand our current JSNA strengths and weaknesses:

- The number of Understanding Herefordshire newsfeed subscribers (n=478)
- Usage patterns of those navigating the Understanding Herefordshire website (2,000 views per month)
- Subjective feedback submitted via an online feedback form embedded on the Understanding Herefordshire website (n=59 over 5-years)
- Direct engagement with JSNA user groups via individual or group meetings, using feedback prompts (n=60 from Aug to October 2023)

Group feedback provided the richest data. Around 60 people generated over 300 unique lines of feedback that were reviewed and summarised.

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Future opportunity

With a better understanding of what's working well and less well with our current approach, we moved to assess options to improve. This included:

- A search of best practice examples and frameworks from national sources
- A review of JSNAs from other areas (n=7)

Results

Strengths

1. The JSNA is clearly *informing* some work in a light-touch manner, although it is *driving* far less.
2. Bespoke needs assessments, driven by a multi-agency group, seemed the most effective way of linking data to decisions and driving change e.g. 0-19s needs assessment linked to recommissioning of that service.
3. Consistent "Understanding Herefordshire" website branding acting as a one stop shop for information in line with best practice guidance.
4. Some find the website a useful source of light-touch reference material/facts when writing funding bids, reports, and strategies, or to orientate themselves to local issues when new in post.

Weaknesses

1. **The "Joint" in JSNA.**
    a. Unbalanced "Joint" element. Local authority driven rather than balanced with NHS: both in setting scope and direction, but also in administration and use.
    b. Limited or inefficient collaboration between analytical teams on important shared approaches to using data to help health and care systems improve population health and wellbeing, for example, the JSNA process or population health management approach.

2. **Collaboration**.
    a. There is a governance gap. We are missing a partnership group of primary users who can decide the JSNA scope, main audiences, products, and alignment with important strategic and contractual commissioning cycles. At present this falls to a single analytical stakeholder.

3. **Future focus.**
    a. Limited future focus: painting a clear picture of future need and implications for services.

4. **Adding meaning and impact.**
    a. Limited emphasis on uncovering unmet need and inequalities
    b. More demand for adding meaning and impact to data and information, spelling out the answer to the question, "what does this mean for now and the future?"

5. **Failing to plan, planning to fail.**

a. Limited project planning, development of ongoing stakeholder engagement plan, use of agile project management methodologies etc. to be more responsive.

6. **Data: giving them what they need.**
    a. Core datasets for different JSNA products not defined, unclear process to keep the JSNA up-to-date and relevant, limited incorporation of local consultation findings.
    b. Limited innovative for more efficient analysis e.g. automation, scenario/impact modelling, use of application programming interfaces.

7. **Making evidence the norm**
    a. Using evidence does not seem the norm. Low use and perceived value for some primary commissioner and decision-making audiences
    b. Most users struggle to make sense of the information available and draw meaningful insights from it to uncover unmet need, drive quality improvement or inform commissioning intentions.

8. **Communication**
    a. JSNA awareness and impact was limited. Limited use of awareness enhancing methods such as: a clear communications plan, continued & consistent awareness raising by JSNA 'champion', blogs, newsletters, training, press releases, social media, etc.

9. **Asset based approach**
    a. Limited development of asset indicators, voluntary and community sector involvement

Opportunities

There are many opportunities to improve our JSNA, much appetite across our user groups to do so, and clear options on how to do it.

A fundamental rejuvenation of our JSNA processes would require:

- Discussing and documenting answers to the 7 quality themes outlined in Joint Strategic Needs Assessment: a springboard for action, Local Government Association (2011). Summary questions listed in Appendix: "Local Government Association Toolkit Questions"
- Adopting the 10 top tips and recommendations for JSNAs published in, "Best practice and opportunities for innovation in Joint Strategic Needs Assessments (2020)".
- Reviewing options documented in the local authorities similar to our own review and deciding which to adopt.

The sources above provide a clear path to address our weaknesses, and a clear path to better shape our JSNA to the needs of our users, so it has more impact.

But this leaves the question of who decides which of the top 10 tips to adopt, how much first principles thinking is needed, or what options from other local authorities we wish to emulate and which we do not, or cannot?

In this report we have resisted the temptation to make recommendations unilaterally, as we think this perpetuates one of the main weaknesses of the JSNA process as is. Instead the main opportunity is to define a partnership group that can work through the best practice options above, and make those decisions on behalf of the JSNA primary users.

These judgements have not been made explicitly for years, so may take time and challenging conversations to work through fully, document and implement. But in our favour; the options are already well-framed, distilled and decision frameworks ready to use.

Threats

In reinvigorating our JSNA process in future we see the following threats:

1. An overemphasis on JSNA *form* (the most visible part of the JSNA, like the website) without collaboratively defining JSNA *functions* (the invisible missing part). Form should follow function.
2. Taking unilateral decisions on JSNA processes and outputs for speed, rather partnership decisions for long-term value.
3. A focus on data and information generation or pooling, rather than insights generation from that information, which will require analyst and commissioner collaboration. For example, to interpret and provide a narrative around what we know now, irrespective of any new or different data sources in future.
4. A focus on analytical capacity and outputs that underplays the vital role that commissioners and other decision makers play in generating shared insights. This includes the capacity and capability of decision makers to provide professional input and insights in a timely way.
5. Over-emphasis on putting information on a website vs providing personalised analytical capability to probe question-driven insights and decision making
6. Sunk-cost bias: a reluctance to strip back what is low value but familiar, in favour of the higher value, but less familiar.
7. Expecting data to point to a decision, rather than providing the best available information to inform a partnership judgement. The threat is not having a decision making process or prioritisation process that uses information routinely and well.
8. Focus on demand not need. So unmet needs remain hidden or not clear enough to act on.
9. Capacity and capability of local Intelligence system to collaborate and deliver JSNA in partnership
10. Capacity to define a JSNA programme lead with time and skills to drive change.

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Options and recommendation

Option	Recommended?	Recommendation rationale	Resource implications
Do nothing	No	Weaknesses would remain unaddressed	None
Decide on form, function and administration unilaterally. Single stakeholder group e.g. local authority intelligence unit and public health, take a view on what's needed and implement change.	No	Single stakeholder view is not representative of primary user needs. Runs counter to the "Joint" nature of the JSNA process and perpetuates an existing limitation. Partnership governance gap remains.	Likely met within current capacity
Establish a JSNA steering group that makes decisions on form, function, administration and governance. 1) To decide which actions to take forward in response to this review 2) As a business as usual steering group	Yes Recommend incorporating into role of One Herefordshire Partnership (1HP) Recommend 1HP consider the best method of including wider partners as needed.	Steering group is good practice and in place in most areas. Addresses governance gap and gives a forum to make decisions on all aspects of the JSNA Resources are available on what issues the steering group should consider, agree and document. 1HP has core health and social care primary users, and could include wider partners as needed for specific JSNA decisions.	Demands senior leadership time to attend and manage steering group. Likely more time upfront in establishing a new group and working through list of tasks in response to this review. Steady state likely to be less labour intensive – developing an annual JSNA work plan linked to strategic planning and commissioning. The steering group can make JSNA decisions with knowledge of the capacity and capability of intelligence unit and NHS analytical resources.

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Background

Rationale and purpose of the JSNA rapid review

Our current JSNA form and function reflects the preferences of the Health and Wellbeing Board around 2018. Since then, there have been significant organisational changes in the local authority and NHS; for example, in the formation of primary care networks in 2019, integrated care systems in 2022, and a resource shift to respond to the COVID-19 pandemic from 2020 to 2022. No stable group has been in place to guide the JSNA process through these changes.

As a result, it is not clear how well the current JSNA is meeting its goal of informing local decision making, from the perspective of those decision makers.

The purpose of the JSNA review is to uncover the strengths and weaknesses of our current JSNA in meeting its goal. The review outputs aim to provide a clear critique of the strengths and weaknesses of our current JSNA approach, and outline options for improvement, to be agreed by the Health and Wellbeing Board.

What is a JSNA?

The Joint Strategic Needs Assessment (JSNA) is a process by which local authorities and NHS integrated care boards (ICBs) assess the current and future health, care and wellbeing needs of the local community to inform local decision making[2].

This includes, but is not limited to:

- Providing a shared view of current and future health and care needs for the local community.
- Looking at the health of the population, with a focus on behaviours that affect health such as smoking, diet and exercise.
- Being concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment.
- Identifying specific health inequalities affecting our residents
- Identifying gaps in health and care services and documenting unmet needs

The JSNA process is made up of two elements. The data and information collected, sometimes called the "evidence base", and the process of making sense of that information in terms of joint strategic planning and decision making.

Who is it for?

The main audience for the JSNA is health and social care commissioners who use it to plan health and social care services.

It can also be used as an evidence base for preparing bids and business cases; by the voluntary and community sectors to ensure that community needs and views are represented; by service providers to assist in the future development of their services, by local councillors to provide insights into their area of democratic accountability, and by the public to scrutinise local health and wellbeing information, plans and commissioning

[2] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, 2022

recommendations.

Our current JSNA process

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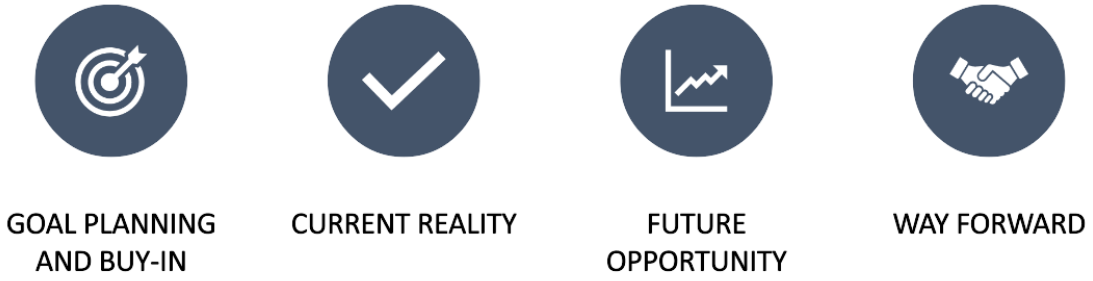
Figure 1 Understanding Herefordshire Website Landing Page

The website content is managed by Herefordshire Council's intelligence unit; a team of 4.8 full time equivalent analytical staff servicing the diverse information needs of the whole Council. They undertake most analysis and reporting, publish outputs on the website and co-ordinate summary findings in collaboration with others.

A JSNA summary is currently agreed on a 3-yearly cycle and was last produced in December 2021 as a 61 slide PowerPoint presentation. This is the attempt to bring the many parts of the evidence-base jigsaw together into a shared narrative of current and future needs.

Method

The JSNA rapid review is following a 4-step approach between August and December 2023.



Goal, planning and buy-in

Step 1 aimed to:

- Define the goal of the JSNA review, seek key stakeholder group buy-in and get their steer on the scope of the review and engagement approach
- Develop a project plan for the review including identifying risks, mitigations and opportunities, for example, the opportunity link to “Thrive”, the Council’s Transformation Programme.

A project plan for the review was agreed by One Herefordshire Partnership 22 Aug 2023.

Current Reality

Step 2 step aimed to assess our current JSNA approach through objective and subjective feedback, looking specifically at four elements: form, function, administration and governance:

- **Form**: the content, look, ease of use, lucidity, and timeliness of JSNA outputs.
- **Function**: how the JSNA is, or isn’t, used by different audiences to inform strategic planning and decision-making
- **Administration**: capacity and time to produce and maintain JSNA process and outputs.
- **Governance**: how the JSNA process is controlled and directed. Who makes decisions about its scope, content, and how do we go from data to insights to priorities across diverse stakeholders.

We drew on four sources to understand current JSNA strengths and weaknesses:

- Number of Understanding Herefordshire newsfeed subscribers
- Usage patterns of those navigating the Understanding Herefordshire website

- Subjective feedback submitted via an online feedback form embedded on the Understanding Herefordshire website
- Direct engagement with JSNA user groups via individual or group meetings, using feedback prompts.

Future Opportunity

With a better understanding of what's working well and less well with our current approach, we moved to assess options to improve. This included:

- A search of best practice examples and frameworks from national sources
- A review of JSNAs from other areas

Way forward

The JSNA rapid review has a defined start and end date. It is envisaged it will be followed by an implementation phase once options for improvement have been considered and a collective way forward agreed.

- JSNA review phase Aug to Dec 2023
    - Present JSNA review findings and recommendation for improvement to Health and Wellbeing Board (Dec 2023)
- JSNA rejuvenation phase Jan to Dec 2024:
    - Agree and implement JSNA improvements (Jan to Mar 2024)
    - Agree scope of next JSNA summary due Dec 2024 (Apr to Dec 2024)
    - Deliver next JSNA summary Dec 2024

Results

Current Reality

Newsfeed subscribers

As of June 2023, 478 people had signed up to receive Understanding Herefordshire news updates via email. Subscriber numbers have accumulated gradually over time and include Herefordshire Council employees, a wide range of voluntary and community organisations, faith groups, schools, NHS organisations and others.

The newsfeed publicises recent data updates and publications across the wide range of topics covered by Understanding Herefordshire. In 2023 this was focused on monthly updates about the impacts of the rising cost of living, new analysis of data emerging from the 2021 Census, and updated Ward Profiles.

Website data

In the year from September 2022 to August 2023 inclusive, the Understanding Herefordshire Website attracted around 2,000 views per month.

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Table 1 shows the top 10 most viewed pages within the micro-site, with population, inequalities and “economy and place” taking the top 6 spots. Average time spent on these pages ranged from 1 to 3 minutes. Some pages outside of the top 10 had longer visits, for example; Census 2021 population information, ward profiles, and water quality all averaged over 5 minutes per visit.

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Table 1 Most viewed pages of the Understanding Herefordshire Website (Oct 2022 to August 2023)

Section of Understanding Herefordshire Website	% of total views
1. Population	7.8
2. Inequalities/index of multiple deprivation	4.7
3. Population/population around the county	3.8
4. Economy and place	3.7
5. Economy and place/facts and figures about local areas	3.0
6. Inequalities	2.8
7. Joint Strategic Needs Assessment	2.8
8. Health	2.6
9. Community	2.3
10. Economy and place/topics-relating-to-the-economy/the-cost-of-living-crisis/	1.7

Source: Google Analytics

Online feedback form

The Understanding Herefordshire Website has an online feedback option that prompts users to rate the content, appearance and ease of use of the site, along with, “what do you particularly like” and “what do you dislike” free-text options.

Not many people use this option. In the 5 years from 2019 to 2023, 59 people submitted comments, averaging between 7 and 18 a year.

Figure 2 Ratings on content, appearance and ease of use from online feedback forms submitted over a 5-year period (2019 to 2023)

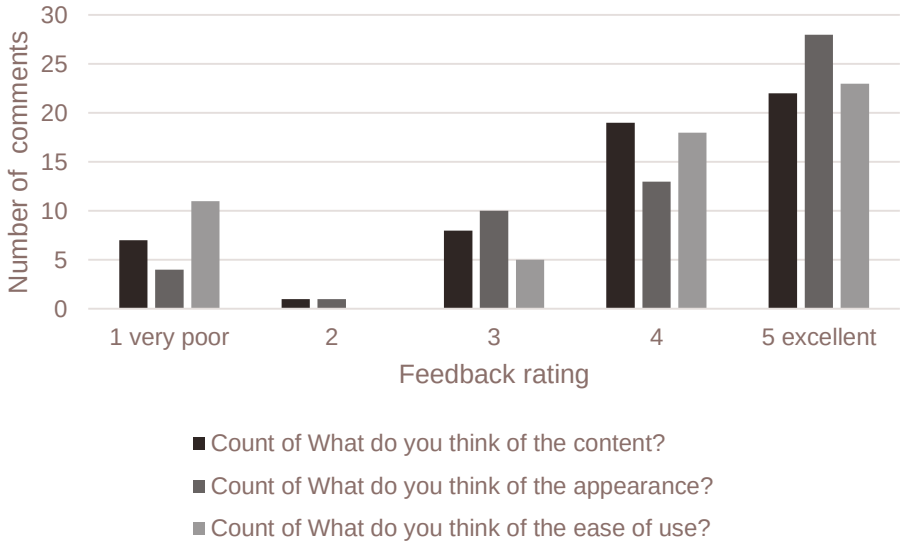

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Figure 2 shows that generally, feedback was submitted to provide positive feedback on “content” and “appearance” dimensions. The dimension of “ease of use” attracted the highest number of "very poor" ratings (n=11).

In the free-text feedback section, things people particularly liked were:

- level and clarity of information (16)
- ease of use / navigation (9)
- range of topics covered (4)

Things people disliked were:

- Not enough information / detail, reasons or actions (8)
- Out-of-date information (7)
- Insufficient explanation of technical terms or sources (3)
- Missing information or broken links (3)

Workshops and individuals giving feedback

The rapid review sought feedback from 10 primary stakeholder groups and obtained feedback from 8. This accounted for around 60 people, generating around 300 unique lines of feedback that were reviewed and summarised below.

Stakeholder groups included:

1. Health and Wellbeing Board
2. Health Watch
3. Ward Councillors
4. Communities directorate leadership team (includes adult social care)
5. Children and Young People’s directorate leadership team
6. Clinical practitioners forum
7. All age commissioning team
8. Public Health Team

Stakeholders we hoped to include but could not within the time available included:

1. Integrated Care Board Executive Leadership Team
2. Intelligence Cell (analysts from different health partner organisations)

Stakeholder feedback

Form

Form: the content, look, ease of use, lucidity, and timeliness of JSNA outputs.

Most comments were directed at the Understanding Herefordshire website as the live JSNA evidence base. Few commented on specific outputs, like the 3-yearly summary slide deck, or specific needs assessments, potentially out of lack of awareness or direct experience of using them.

The majority of users agreed that the website was broadly easy to use once they were familiar with it and knew which part of the website to go to access the information they

needed.

For stakeholders who did not regularly use the website, some had been put off. Many commented that there was a huge body of information, and they didn't know where to start to find what they needed, or what sort of information was on there to begin with. Some users found it difficult to find information specifically about Herefordshire. Others did not know what the Understanding Herefordshire website was, or had ever heard of it.

Lack of timeliness came up a lot. When users came to use different parts of the website it is often stated that, 'this could be out of date' so it was difficult to establish what was current and useable. Others said it was unclear what information was still relevant and accurate despite being a few years old, compared with what was out of date, potentially misleading, inaccurate or no longer relevant.

Users commented that aspects of the JSNA don't seem joined up to some of the biggest areas of work being completed within the local authority, for example, should Children's Service Improvement plans, which are key to the current Children's services, be included or referenced in the JSNA? There are multiple users for the website, not just commissioners, and some felt the data is tailored towards the latter only.

To improve the website, it was regularly suggested to have a type of executive summary of information at the top of key pages and links to the more in depth detailed data elsewhere.

Users would like to see more insights (what does this mean) included alongside information and data. For example, services said they were keen to do more strategic planning and be more future focused, but required help to understand and articulate what the predicted impact on service areas could be, such as where we would end up in 5 years if existing trends continued.

The value of looking forward was frequently highlighted, and so too was the value of looking backwards, as a learning and evaluation tool. For example, could we show trends from 4-5 years ago, alongside different projects and programmes, and see whether they look to have made an impact by making a dent in those trends?

Function

Function: how the JSNA is, or isn't, used by different audiences to inform strategic planning and decision-making

The JSNA website was most often referred to as a 'starting point', or a "reference point" to pick out some quick facts and figures for a report, funding bid, or writing a Strategy, for example, Herefordshire's joint Health and Wellbeing Strategy 2022-23 and the Integrated Care System's Integrated Care Strategy 2022-23.

Most people are using the JSNA as a light touch reference point of facts to inform what they are already planning to do, or are restricted to do via grant conditions or national policies. Few are identifying service gaps or making significant service changes *driven* by information or insights generated within the JSNA.

Some stated that the content of the website is too light touch and therefore they are not able to find the information needed to make informed decisions. As a result, users found

themselves going to the intelligence team directly to find the specific, timely information they required.

A common theme was the perception that the JSNA is not used often enough to understand local need, or unmet need. In some cases this was justified, for example, because of the way some funding or grants restrict activity to specific areas or groups. But there was a general feeling from many that the JSNA was underused.

Users recognised there were multiple audiences for the JSNA and so it needed to be accessible and comprehensible for different readers and decision makers. A key findings report was suggested to be circulated quarterly to keep a broad range of users informed, with more detail available on the website for those who wanted it.

The commissioning teams said they would like to do more strategic planning, which ideally would tie into the JSNA work priorities for the year, so that the right information could drive their decision making at the right time.

There was widespread appetite for more joined-up working across teams and organisations to build a shared understanding of the truth. This was driven by a perception among many JSNA users that there were lots of information sources out there (the JSNA, other websites, dashboards, performance monitoring intelligence, reports etc.) and a huge amount of work going on. But that it was difficult to piece it together. So it was hoped it was possible to work more collectively across JSNA stakeholders to make the JSNA more of a central point of information and shared understanding.

Administration

Administration: capacity and time to produce and maintain JSNA process and outputs.

The Council Intelligence Unit (4.8 FTE) do most of the JSNA related analysis and report writing, publish outputs on the website, and co-ordinate the 3-yearly summary of findings report. They are a small team with competing demands from across the Council and wider partners.

The last JSNA summary report was completed in December 2021 in a 61 slide format. It included engagement with wide range of stakeholders and contributors. However, the team often struggled to get relevant timely information from partners and so the process of coordinating it was perceived as being less efficient and engaged than it could be.

All of the primary JSNA users we met with perceived there to be a huge amount of data that could potentially be useful to them, but recognised that this needs to be matched with resources available to gather, organise and make sense of it. And that this is a commissioner and leadership responsibility as it is an analyst one.

Often users couldn’t answer a question from the website alone. So said it was useful going directly to the Intelligence Unit Team to request information, as they liked having someone to talk with to understand what information is available, what might be relevant to the question they have, and get help understanding what the answer means. However, these tailored conversations weren’t often possible due to the capacity of the intelligence team, or timelines of response. Users perceived there to be little in the way of process to prioritise multiple requests to the intelligence team, so it was unclear to them how different

requests were ordered in terms of relative importance, urgency, strategic fit, or impact value across people, teams, departments and organisations.

Most JSNA users were conscious of potential duplication of effort and output. They are aware of similar types of data being produced at different organisational levels (GP, PCN, Ward, Local Authority, ICB, Hospital Trust etc.). They recognised each organisation holds a different piece of the overall jigsaw and use them for different purposes. This is appropriate. But users felt more of this could be joined up, and if the JSNA was created with the LA and health together in more of a balance, there could be more buy-in from partners and less duplication.

Groups commented that it's not just about having more data, it's about how we best use data we already generate, especially how we work together to interpret it. Users recognised that this needs subject matter experts inputting into the JSNA, not just analysts.

Governance

Governance: how the JSNA process is controlled and directed.

It was implicit in the conversations that there is little governance or documentation around the current JSNA processes. There is no agreed process, for example, of bringing together the differing needs of the user groups into a prioritised and agreed JSNA work programme or product cycle. Without which it's possible to have a disconnect between the needs of decision makers and the outputs and timelines of JSNA outputs.

Most groups stated that coproduction between partners was vital, and implicitly, could be improved. They perceived that the JSNA was the first point of call for understanding and if all partners were using the same data, this could eliminate duplication and join up working more than is currently the case.

Multiple users talked about wanting more system-wide awareness of the programmes and commissioning intentions of partners such as social care, NHS, and public health. Some suggested partner commissioning intentions could be collated and aligned to the JSNA process to form a JSNA topics work programme, managed through the Health and Wellbeing Board or subgroup.

Contributors suggested there needs to be a lead for the JSNA, but it should be mandated that there is a collective responsibility to shape and contribute to the JSNA, which the subgroup could manage. The subgroup could be made up of partners who would then have oversight of the JSNA, agree the JSNA work programme each year, look at what is next and what they are going to do with the information from the JSNA.

Some wanted to increase the visibility of what's available through the JSNA. For example, that the JSNA needs to come to boards more regularly to maintain awareness and relevance of it, rather than coming occasionally for specific reasons. If there was more visibility across more boards then it could be more routinely used by officers. Users were keen that the JSNA was considered as a source of information whenever there were relevant commissioning or strategic planning activities or decision making processes.

Future Opportunity

Herefordshire Council

To identify opportunities for improvement we looked at national best practice recommendations, approaches, the JSNAs of 5 local authorities most similar to our own; and 2 local authorities with significantly larger resources.

10 top tips for JSNAs

In 2020, Public Health England published, "Best practice and opportunities for innovation in Joint Strategic Needs Assessments (2020)". The aim was to raise awareness of the role JSNAs can play by:

- Reinforcing the JSNA as a fundamental decision support tool.
- Reinvigorating JSNAs by aligning with the emerging population health management/integrated agenda.

To support this they developed a set of the top 10 tips and recommendations. The tips are a set of ideas intended to revitalise local JSNA process and products. They are based on recommendations from Public Health England Local Knowledge and Intelligence Service teams, national award winners and online research/appraisal. Each have examples of good practice from a local area, explain, "Why is this important?" and provide a recommendation.

The 2020 report recognises there is no "one size fits all" for JSNAs and the tips should be adapted accordingly to the local area.

The 10 Tip Areas and Recommendations are summarised below.

1. **Communicate, communicate, communicate**
    a. Develop a detailed communications plan, continued & consistent awareness raising by JSNA 'champion', apply branding, utilise range of communications methods e.g. blogs, newsletters, training, press releases, social media, etc.

2. **Make evidence the norm**
    a. Actively promote use of evidence, showcase local research.

3. **Future focussed**

a. Develop skills/capacity amongst analytical colleagues, being innovative in data use e.g. automation, impact/scenario modelling, use of application programming interface programmes for more efficient analysis.

4. **Fail to plan – plan to fail!**
    a. Consider having a dedicated programme manager to oversee your JSNA, establish a detailed project & implementation plan, develop an ongoing stakeholder engagement plan, use of agile project management methodologies to be more responsive.

5. **Data: Give them what they need**
    a. Define core datasets for different JSNA products, adopt a continuous cyclical process to keep the JSNA up-to-date and relevant, incorporate local consultation findings. Identifying health inequalities and unmet need should be the main driver for selection of data sources

6. **Add meaning and impact**
    a. Consider adopting some consistent branding for all your JSNA activity, look to produce a suite of documents that complement each other, make accessible on local website, stakeholder analysis to identify need, regular review of effectiveness

7. **Don't forget the asset based approach**
    a. Development of asset indicators, voluntary and community sector involvement

8. **Identify priorities**
    a. Timing JSNA process to fit with local strategic planning and commissioning cycles, facilitated discussion with Health and Wellbeing Board, direct link to Joint Health and Wellbeing Strategy, consider use of prioritisation tools (e.g. Multiple-criteria Decision Analysis (MCDA), Programme Budgeting Marginal Analysis (PBMA), STAR, PHE's prioritisation framework

9. **Collaboration**
    a. Adopt a clear governance structure, form a local JSNA steering group, agree terms of reference, requirement to demonstrate use of JSNA before sign off of commissioning plans/decisions

10. **Evaluate and adapt**
    a. Success indicators, feedback from stakeholders, regular review of use in local decisions.

First principles thinking

The Joint Strategic Needs Assessment: a springboard for action, Local Government Association (2011) publication provides a systematic approach for members of health and wellbeing boards to reflect on their ambition for the JSNA and how they will ensure it contributes to improved outcomes. This was used when JSNA's were first mandated, but can also be used to rejuvenate them.

Whilst the potential value of a JSNA is clear to most, each JSNA process requires local

design beyond the basic essentials.

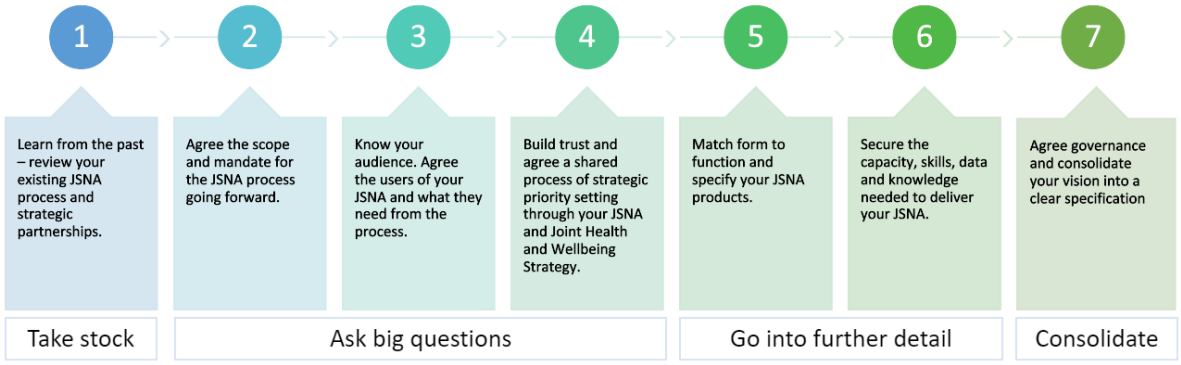
The document argues that health and wellbeing boards need to take ownership of the JSNA process and lead a review from first principles.

Experience shows that the most effective JSNAs have, in partnership, considered and resolved a number of big questions around what their JSNA should be, and do.

The document aims to guide health and wellbeing boards through a 7-step process to reach clarity on their unique JSNA needs and processes. Figure 3 shows the top-level 7-step process and prompts, but there is considerable depth under each in the full document.

Each theme provides a different angle on the same question, 'What should our JSNA process set out to achieve?' A question that needs to be considered, agreed, articulated and documented in partnership.

Figure 3 Seven step process for rejuvenating a JSNA



Source: adapted from Joint Strategic Needs Assessment: a springboard for action, Local Government Association (2011)

Local authorities similar to our own

The JSNA's of five local authorities most similar to Herefordshire were reviewed rapidly online for opportunities to improve (CIPFA Nearest Neighbours). The rationale for this was that they would have roughly the same resources. However, as the JSNA is an equal responsibility of local authorities and the NHS, this excludes the NHS contribution.

2023/24 Public Health Ring Fenced Grant Allocations are also included as an additional proxy for equivalence of team size and resource. Herefordshire's for comparison is £9.9 million.

The 5 local authorities reviewed were:

1. Shropshire (£13.2 million)
2. Cheshire East (£17.9 million)

3. North Somerset (£10.2 million)
4. Cheshire West and Chester (£17.7 million)
5. Wiltshire (£18.6 million)

- Birmingham (£99.1 million)
- Worcestershire (£32.2 million)

In addition we reviewed our ICS Neighbour Worcestershire and the largest Council in the Country, Birmingham. They aren't directly comparable to Herefordshire but represent what's hypothetically possible with significantly larger teams and budgets.

Table 2 in the Appendix documents the variety of approaches to the JSNA process and outputs. For ease, they are grouped into form, function, administration and governance below, focussing on areas of weakness in our current approach, guided by stakeholder feedback and best practice principles.

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Options - form

Considerations for JSNA content, website navigation, timeliness, outputs and future focussed insights.

- Clean, well-thought-through, uncluttered information outputs are more important than the format (PowerPoint Slides, Word Document, Power BI display). Overcrowding of information blocks comprehension. Clarity is king.
- Some are using short Power BI interactive reports, others, simple impactful slide decks. Good outputs are simple to understand and clean looking. Added bonus of Power BI is interactivity. Users can create custom geographies, ages, parameters of interest etc. to answer the questions they may have. However, it is unclear how much added value that is to primary users wanting fully formed insights, or whether it is more useful for analysts doing exploratory analysis to try to generate those insights.
- Display long-term trends so users can understand the history up to now at a glance. Where appropriate, state, model or chart what is likely to happen in the future. Particularly relevant for long-term stable trends.
- Integrate data and information with a clear narrative about its probable implications, explaining the "so what" consequences for now and the years ahead.
- Consider providing an "all reports list" with publication date and "current/archived" tag, to leave no doubt what is useable and what is not.
- Relevant examples of community profiles from Birmingham, disabled, LGBT, Veteran, Carers, specific faith groups etc. including evidence of inequalities. Groups that services are often trying understand better e.g. 20% most deprived
- Few have integrated NHS data well in their standard website output. JSNA summaries are also NHS data light, unless through OHID Public Health Profiles.
- Bring the different elements of "public voice" together in one place on the website. Multiple JSNA users want to know what the public has said on different topics and take that into account.

Options – function

- Define a primary audience, for example, "The JSNA is for everyone but will primarily be used by health and social care commissioners and service providers". Defining the audience and their need helps define the most useful product for the user in terms of data, format and footprints e.g. PCNs, neighbourhoods, wards, videos, reports, dashboards etc. Form should follow function.
- More awareness and efficient integration of existing national and regional data and platforms so we're not replicating things locally that exist elsewhere e.g. Instant Atlas, OHID Fingertips.
- Main achievement of "joint strategic" part of the JSNA is in the production of Health and Wellbeing and or ICB Strategies. Ideally this facilitates a local authority and NHS shared view of the truth and priorities. Be clear on the process by which strategy development could be *driven* by the JSNA, rather than using the JSNA as a post-hoc reference source.
- JSNA programme explicitly orientated towards commissioning and provider cycles with an annual cycle of work programme planning
- Joint outcomes framework tracking Health and Wellbeing Strategy progress.
- No one has brought LA and NHS data into one place for self-serve/exploration. It's nested within topic specific reports, so that it points toward a "so what" for that topic area.

- Some are not doing regular JSNA summaries, some do this annually, some 3-yearly.
- Some have embedded key performance dashboards into their websites to display progress towards JSNA priority areas or display measures for monitoring and awareness (North Somerset, although mainly OHID Fingertips).

Options - administration

- Some have very minimalist websites that clearly take little maintenance
- Others taking a display everything approach
- Some have dedicated JSNA manager/lead, a role, not necessarily a post.
- Cheshire East have a useful guide helping to provide role clarity and balance of analyst and commissioner input
- Looks to be largely local authority business intelligence team driven rather than LA/ICS balance. Widespread opportunity to be more balanced.

Options - governance

- Most places have a Health and Wellbeing Board sub-group or steering group to direct and decide the most useful JSNA process and outputs. Including a forward plan of information needs 1-5 years ahead
- Useful to clearly define, JSNA roles in programme documentation, for example, health and wellbeing board, steering group, JSNA programme lead, analysts, commissioners and other users.
- Cheshire East have examples of documents and process for JSNA governance

Way forward

Strengths

1. The JSNA is clearly *informing* some work in a light-touch manner, although it is *driving* far less.
2. Bespoke needs assessments, driven by a multi-agency group, seemed the most effective way of linking data to decisions and driving change e.g. 0-19s needs assessment linked to recommissioning of that service.
3. Consistent “Understanding Herefordshire” website branding acting as a one stop shop for information in line with best practice guidance.
4. Some find the website a useful source of light-touch reference material/facts when

writing funding bids, reports, and strategies, or to orientate themselves to local issues when new in post.

Weaknesses

Weaknesses relative to best practice principles:

1. **Collaboration**.
    a. There is a governance gap. We are missing a partnership group of primary users who can decide the JSNA scope, key audiences, products, and alignment with important strategic and contractual commissioning cycles etc. At present this falls to a single analytical stakeholder.
    b. There are lots of data jigsaw pieces out there, and a perception that we could do more to join them up, but we have no process for how to do this.

2. **Adding meaning and impact.**
    a. Limited emphasis on uncovering unmet need and inequalities
    b. More demand for adding meaning and impact to data and information, spelling out the answer to the question, “what does this mean for now and the future?”

3. **Future focus.**
    a. Limited future focus on painting a clear picture of future need and implications for services. Also limited skill/capacity development to deliver the JSNA in terms of being innovative in data use (e.g. automation, scenario/impact modelling, use of application programming interfaces for more efficient analysis)

4. **Failing to plan, planning to fail.**
    a. Limited project planning, development of ongoing stakeholder engagement plan, use of agile project management methodologies etc. to be more responsive.

5. **Data: Giving them what they need.**
    a. Core datasets for different JSNA products not defined, unclear process to keep the JSNA up-to-date and relevant, limited incorporation of local consultation findings. Identifying health inequalities and unmet need should be the main driver for selection of data sources, but not currently the case

6. **The “Joint” in JSNA**
    a. Unbalanced “Joint” element. Local authority driven rather than balanced with NHS - both in setting scope and direction, but also in administration.
    b. Limited or inefficient collaboration between analytical teams on important shared approaches to using data to help health and care systems improve population health and wellbeing, for example, the JSNA process or population health management approach.

7. **Making evidence the norm**
    a. Using evidence does not seem the norm. Low use and perceived value for some primary commissioner and decision-making audiences
    b. Most users struggle to make sense of the information available and draw

meaningful insights from it to uncover unmet need, drive quality improvement or commissioning intentions.

8. **Communication**
    a. JSNA awareness and impact was limited.
    b. Limited use of awareness enhancing methods such as: a clear communications plan, continued & consistent awareness raising by JSNA 'champion', using a range of communications methods e.g. blogs, newsletters, training, press releases, social media, etc.

9. **Asset based approach**
    a. Limited development of asset indicators, voluntary and community sector involvement

Opportunities

There are many opportunities to improve our JSNA, much appetite across our user groups to do so, and clear options on how to do it.

A fundamental rejuvenation of our JSNA processes would require:

- Discussing and documenting answers to the 7 quality themes outlined in Joint Strategic Needs Assessment: a springboard for action, Local Government Association (2011). Summary questions listed in Appendix: "Local Government Association Toolkit Questions"
- Adopting the 10 top tips and recommendations for JSNAs published in, "Best practice and opportunities for innovation in Joint Strategic Needs Assessments (2020)".
- Reviewing options documented in the local authorities similar to our own review and deciding which to adopt.

The sources above provide a clear path to address our weaknesses, and a clear path to better shape our JSNA to the needs of our users, so it has more impact.

But this leaves the question of who decides which of the top 10 tips to adopt, how much first principles thinking is needed, or what options from other local authorities we wish to emulate and which we do not, or cannot?

In this report we have resisted the temptation to make recommendations unilaterally, as we think this perpetuates many of the weaknesses of the JSNA process as is. Instead the main opportunity is to define a partnership group that can work through the best practice options above, and make those decisions on behalf of the JSNA primary users.

These judgements have not been made for years, so may take time and challenging conversations to work through fully, document and implement. But in our favour; the options are already well-framed, distilled and decision frameworks ready to use.

Threats

In reinvigorating our JSNA process in future we see the following threats:

1. An overemphasis on JSNA *form* (the most visible part of the JSNA, like the website)

without collaboratively defining JSNA *functions* (the invisible missing part). Form should follow function.

2. Taking unilateral decisions on JSNA processes and outputs for speed, rather partnership decisions for long-term value.
3. A focus on data and information generation or pooling, rather than insights generation from that information, which will require analyst and commissioner collaboration. For example, to interpret and provide a narrative around what we know now, irrespective of any new or different data sources in future.
4. A focus on analytical capacity and outputs that underplays the vital role commissioners and other decision makers play in generating shared insights. This includes the capacity and capability of decision makers to provide professional input and insights in a timely way.
5. Over-emphasis on putting information on a website vs providing personalised analytical capability to probe question-driven insights and decision making
6. Sunk-cost bias: a reluctance to strip back what is low value but familiar, in favour of the higher value but less familiar.
7. Expecting data to point to a decision, rather than providing the best available information to inform a partnership judgement. The threat is not having a decision making process or prioritisation process that uses information routinely and well.
8. Focus on demand not need. So unmet needs remain hidden or not clear enough to act on.
9. Capacity and capability of local Intelligence system to collaborate and deliver JSNA in partnership
10. Capacity to define a JSNA lead with time and resources to drive change.

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Options and recommendation

Option	Recommended?	Recommendation rationale	Resource implications
Do nothing	No	Weaknesses would remain unaddressed	None
Decide on form, function and administration unilaterally. Single stakeholder group e.g. local authority intelligence unit and public health, take a view on what's needed and implement change.	No	Single stakeholder view is not representative of primary user needs. Runs counter to the "Joint" nature of the JSNA process and perpetuates an existing limitation. Partnership governance gap remains.	Likely met within current capacity
Establish a JSNA steering group that makes decisions on form, function, administration and governance. 3) To decide which actions to take forward in response to this review 4) As a business as usual steering group	Yes Recommend incorporating into role of One Herefordshire Partnership (1HP) Recommend 1HP consider the best method of including wider partners as needed.	Steering group is good practice and in place in most areas. Addresses governance gap and gives a forum to make decisions on all aspects of the JSNA Resources are available on what issues the steering group should consider, agree and document. 1HP has core health and social care primary users, and could include wider partners as needed for specific JSNA decisions.	Demands senior leadership time to attend and manage steering group. Likely more time upfront in establishing a new group and working through list of tasks in response to this review. Steady state likely to be less labour intensive – developing an annual JSNA work plan linked to strategic planning and commissioning. The steering group can make JSNA decisions with knowledge of the capacity and capability of intelligence unit and NHS analytical resources.

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JSNA steering group initial tasks

1. Discuss and document answers to the 7 quality themes outlined in the Joint Strategic Needs Assessment: a springboard for action, Local Government Association (2011) publication (Summary Questions in Appendix: Local Government Association Toolkit Questions)
    a. Each theme provides a different angle on the same fundamental question, 'What should our JSNA process set out to achieve?' A question that needs to be considered carefully, agreed and articulated in partnership
    b. Why? It provides a systematic approach for members of health and wellbeing boards (or steering group) to reflect on their ambition for the JSNA and how they will ensure it contributes to improved outcomes. This is fundamental to address the governance gap.
2. Agree which of the 10 recommendations in "Best practice and opportunities for innovation in Joint Strategic Needs Assessments (2020)" to take forward locally.
3. Review options outlined in the "Local authorities similar to our own" section" and decide what to take forward for 2024/25
4. Business as usual
    a. Maintain JSNA documentation outlining key decisions and processes
    b. Develop an annual JSNA work plan linked to the most important strategic planning and commissioning cycles.
    c. Consider even longer forward plan timescales if relevant to key contracts or decision making points (2-5 years).

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Appendix

JSNAs from similar areas

- **Form**: content, look, ease of use, comprehension, timeliness etc.
- **Function**: How are people using the information, are they? Who, what, where, why, how, when and for whom? Key users/non-users. Balance of current vs future focus.
- **Administration**: capacity and time to produce, maintain, who is doing the leg work, analysts, commissioners? Opportunity cost of measurement.
- **Governance**: who is directing the JSNA process and decision making, who owns it?

Table 2 JSNA form, function, administration and governance, from local authorities most similar to ours (accessed Oct 2023)

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Local authority most similar to Herefordshire*	Form	Function	Administration	Governance
Shropshire £13.2 million	• 7 themed Power BI reports (around 6 pages each) e.g. demographics and life expectancy trends, includes brief narrative • Some top level static reports • No obvious summary or priorities, strategies • Main hyperlinked products are JSNA, Annual Report, and Pharmaceutical Needs Assessment.	• Defined primary audience. The JSNA is for everyone but will primarily be used by health and social care commissioners and service providers. • Seems data driven and self service via Power BI charts and tables. • Many sections "Thematic/Specialist needs assessment" and "other profiles and intelligence" say "content to follow" and are blank.	• Business Intelligence produced Power BI platforms and update • Minimal content on website	• Not stated

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Cheshire East £17.9 million	• Products by theme but also "a complete list of JSNA products" as table.
	• Clear evidence-review titles with publication date
	• "Can we improve this page" prompt options for immediate feedback
	• Status tag "current or archived" to signal what's most up-to-date
	• Most outputs are documents, presentations – no significant Power BI, dashboards, or other style outputs.
		• JSNA programme explicitly orientated towards commissioning and provider cycles
		• Annual cycle of work programme planning Joint outcomes framework tracking Health and Wellbeing Strategy progress.
			• Have a defined JSNA manager role
			• Roles of others clearly defined in programme document
				• HWBB approved JSNA work programme
				• Programme has written principles and aims to align to commissioning cycles.
				• Includes developing the JSNA documentation:
				  • JSNA work programme
				  • JSNA governance to resolve issues
				  • Written process of content production

North Somerset £10.2 million	• 2022 115 page PowerPoint slide deck • A 12 page data dashboard giving detail (Power BI), ward profiles, topic reports, bespoke needs assessments (spotlight reports) • Dashboard KPI summary grouped by life-course, benchmarked vs England or Region. • Bullet summary analysis of "What is going well" (green) and "things to consider" for each JSNA section. • Single page "spotlight reports" produced for different topics and make up the JSNA.	• Defined primary audience. The main audience for the JSNA are health and social care commissioners who use it to plan their services. • Informs HWB Strategy with clear priorities	• Business Intelligence • Dashboard running off OHID fingertips (mostly) but also education statistics, and other public sources, links them together.	• Health and Wellbeing Board responsible for producing JSNA, requested JSNA advisory group overseas development (LA, NHS and voluntary)
Cheshire West and Chester £17.7 million	• JSNA webpage is minimal. A few lines and current published JSNA products list • Separate Data and Intelligence Tab has census, ward profiles, population, health (COVID, Mortality, Ward profiles), economy and inequalities tabs • Reports are busy slides • ACORN ward profiles • Resident and user views section • Power BI Interactive Council Performance	• One line "The JSNA is a useful resource base for a wide range of partners and the public."	• Unclear. Minimal content on website	• Unclear. Minimal content on website

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	Report. • Minimal content on website.			

Wiltshire £18.6 million	• Land on "Wiltshire Intelligence"
	• 2022 JSNA 6 topics areas 100 indicators, each topic has an embedded pdf slide deck to scroll through and "key focus areas"
	• Example topic report LE and causes of death(slides)
	• Library of reports and surveys
	• Data catalogue 67 items, searchable
	• Needs assessments as reports and embedded summary slides.
	• Additional JSNAs
	  ○ Recovery JSNA
	  ○ Community Area JSNA
		• Wiltshire evidence as a 'one-stop shop' for key local datasets and reports, presented in a consistent format that is easy to navigate and understand.
		• JSNA as summary current and future health needs
		• Directly informs HWB Strategy
			• Unclear. Minimal content on website	• Unclear. Minimal content on website

Birmingham £99.1 million	• Birmingham's JSNA consists of the following work programmes:
	  ○ JSNA dashboard
	  ○ a series of deep dive analyses
	  ○ a series of profiles
	• Integrated Power BI reports acting as briefings. Data and insight combined.
	• Health and Wellbeing Strategy is Power BI
	• JSNA key facts reports e.g. Older Adults
	• Wider intelligence offer is vast although lots of areas with no content
	• Embraced the Power BI dashboard <20 slide summary for topics and briefings e.g. census
	• Good examples of community profiles, LGBT, Veteran, Carers etc. including evidence of inequalities
		• Purpose is to inform local organisations enabling them to plan services for the future, including informing the Health and Wellbeing Strategy.
		• Very wide range of products
		• Includes attempt at others to "add their data set"
			• cityobservatory@birmingham.gov.uk	• Unclear. No specific mention on website

Worcestershire £32.2 million	• Annual summaries 57 slide deck. • Focussed on areas of most change, draws out key themes nicely, good projections, trends • 10+ Topic sections (to pdf hyperlinks)	• Used to determine what actions local authorities, the NHS, and other partners need to take to meet people's health and social	• Public Health Team write JSNA annual summaries, with others.	• Unclear. No specific mention on website

		care needs and to address the wider determinants that impact on their health and well-being.		
Summary considerations	• Cleaner outputs no matter the format, overcrowding of information blocks comprehension. Clarity is king. • More trends and forward looking narrative • All reports listed with date and current/archived tag to signal what is useable and what is not. • Integrate data with narrative and implications "so what" • Some using Power BI interactive reports, others simple impactful slide decks. Good outputs are universally simple to understand and clean looking. • Added bonus of Power BI is interactivity, but unclear how much of a value add that is to consumers wanting ready-made insights vs analysts doing exploratory analysis to get to those insights. • Examples of community profiles from Birmingham: LGBT, Veteran, Carers etc. including evidence of inequalities. Groups that services are often trying understand better. • Few have integrated NHS data well on their standard website output, JSNA summaries are also NHS data light. • Bring "public voice" together in one place on website	• Defined primary audience e.g. "The JSNA is for everyone but will primarily be used by health and social care commissioners and service providers" • Main achievement of "joint strategic" is in the production of Health and Wellbeing Strategy/ICB Strategies • JSNA programme explicitly orientated towards commissioning and provider cycles • Annual cycle of work programme planning • Joint outcomes framework tracking Health and Wellbeing Strategy progress. • No one has brought LA and NHS data into one place for self-serve/exploration. It's nested within topic specific reports, so that it points toward a "so what" for that topic area. • Some not doing regular summaries at all, some annual, some 3 yearly. • Some have website embedded dashboard monitoring into their JSNA to track progress or give key KPIs publically (North Somerset, although mainly OHID Fingertips).	• Cheshire East have a useful guide on role clarity and balance of analyst and commissioner input • Some have very minimalist websites that clearly take little maintenance • Others taking a display everything approach • Looks to be largely LA business intelligence team driven rather than LA/ICS balance. • Some have dedicated JSNA manager, a role, not necessarily a post.	• Most places have a Health and Wellbeing Board sub group or steering group to direct and decide the most useful JSNA process and outputs. Including a forward plan of information needs 1-5 years ahead • Useful to clearly define, JSNA roles in programme documentation, for example, health and wellbeing board, steering group, JSNA programme lead, analysts, commissioners and other users. • Cheshire East have examples of documents and process for JSNA governance

**23/24 Public Health Grant Allocation shown as a proxy for team size and resource. Herefordshire Council Public Health Ring Fenced Grant £9.9 million 2023/24 allocation*

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Communications plan considerations

Embed simple behavioural insights into the JSNA communications plan and processes to maximise its use. Consider EAST behaviour change principles to guide JSNA content and output considerations (Figure 5).

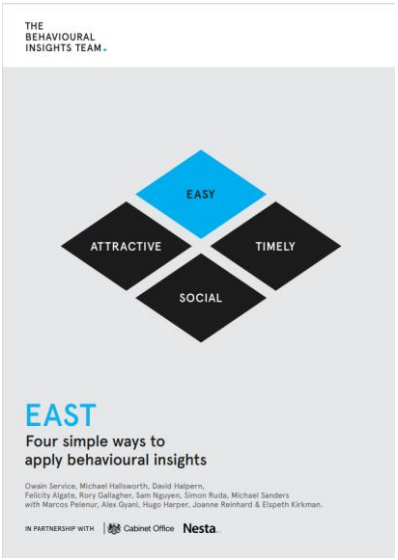
- Make it easy – defaults, reduce hassle, simplify messages
- Make it attractive – attract attention, images, colour personalisation
- Make it social – show most people use it, networks of advocates/users, make a public commitment with others
- Make it timely – prompt users when information is most likely to be timely, emphasise immediate costs and benefits, identify barriers to use and plan to address them

Seek ongoing feedback, for example, what's most useful and should continue, what's not and could stop?

- Pull factors
    - The simplest way to ensure the JSNA is impactful is to ensure it closely meets the needs of its primary users. If it's useful, it will be sought out.
    - The JSNA needs to be help people do their jobs better
    - The most important stakeholders have co-produced it from outset
    - The outputs and processes are: easy to use, attractive, timely and it's socially expected and normalised to use JSNA information and strategically plan

- Push factors
    - Develop a detailed communications plan, continued & consistent awareness raising by JSNA 'champion', apply branding, utilise range of communications methods e.g. blogs, newsletters, training, press releases, social media, etc.

Figure 4 EAST Behavioural Insights Framework (2014)



Source: Four simple ways to apply behavioural insights (2014)

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Local Government Association Toolkit Questions

Quality theme 1: Learn from the past. Review your JSNA and strategic partnerships to date.

- Was it clear what partners wanted from the JSNA process last time? Was a clear vision agreed?
- Did our JSNA impact on commissioning and decision-making? What worked and what didn't?
- What is our local experience of strategic partnership working? How far have we come? (For example since five, ten, or 15 years ago?)

Quality theme 2: Agree the scope and mandate for the JSNA

- To what extent do we want our JSNA to drive all health and wellbeing decisions? What influence and levers will it have to support this?
- To what extent will a health and wellbeing rationale drive all strategies across our locality? (For example, economic, regeneration, housing, etc.)?
- Will the JSNA process drive our strategic collaboration with the non-statutory sector? (For example, business, voluntary sector, housing associations)?

Quality theme 3: Know your audience. Agree the users of your JSNA and what they need from the process

- Who will our JSNA primarily speak to – elected members, commissioners, service providers, the voluntary sector, other non-statutory organisation, the public, or all of these?
- How do the needs of the JSNA differ? Are the needs of decision-makers on the Health and Wellbeing Board similar to the day-to-day needs of commissioners?
- To what extent is our JSNA expected to cater equally to these users? Are some more important than others?

Quality theme 4: Build trust and agree a shared process of strategic priority setting through your JSNA and Joint Health and Wellbeing Strategy

- How ready are we for a debate about shared, priority-setting processes that scrutinise value and redirect money?
- How will we handle the needs-assessment process moving from hard data, through analysis and interpretation, to priority setting?
- How do we bridge the gap between the different needs, perspectives and languages of partners?

Quality theme 5: Match form to function and specify your JSNA products

- What products will best meet our intentions so far for JSNA?
- Is our JSNA there to simply facilitate access to quality data or is it also to provide intelligence and drive priority-setting?
- How responsive will our JSNA be to the needs of audiences as and when they arise?

Quality theme 6: Secure the capacity, skills, data and knowledge needed to deliver your JSNA

- Where is data on health and wellbeing found? What is needed from outside of health, social care, public health and children's services, for example schools, planning, economic regeneration, housing, the voluntary and private sector?
- Are existing JSNA analytical skills sufficient? Who is needed to complement the

existing JSNA skill set?
- What is the capacity of wider partners to participate in the JSNA process? What could be done to encourage and facilitate this?

Quality theme 7: Agree governance and consolidate your vision into a clear specification

- Roles and responsibilities – who will need to do what, and when, to make this work?
- How will actions and priorities be set and recorded?
- How will we know if our JSNA and Joint Health and Wellbeing Strategy are working?
- Who will evaluate and review the process, and when?

Herefordshire Council

Title of report: Best Start in Life and Good Mental Health Implementation Plans

Meeting: Health and Wellbeing Board

Meeting date: 4 December 2023

Report by: Public Health Principal

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose:

1.4 To provide the Board with an update on the progress of the draft implementation plans for 'Best Start in Life' (BSiL) and 'Good Mental Health' (GMH)

1.5 To receive feedback and approval from the Board for the aforementioned plans

Recommendation(s)

1.6 That the Board consider the reports and note their progress.

1.7 That the Board consider its response to the draft plans and suggest modifications for consideration as appropriate.

Alternative options

The Board could choose not to adopt these implementation plans, but the plans set out the intention to deliver on the key strands of activity of the Joint Local Health and Wellbeing Strategy (JLHWBS) 2023-2033 and are therefore crucial components in taking forward the ambitions of the JLWBS.

Key considerations

1.8 The JLHWBS 2023-2033 was approved by Board in April 2023: its central focus at the beginning of this ten year period is on 'Best start in life' for children under 5 (BSiL) and 'Good mental wellbeing throughout life' (GMH).

Further information on the subject of this report is available from
Matt Pearce email: Matthew.Pearce@herefordshire.gov.uk

- In July 2023 all partners came together for the launch of the strategy and to consider what outcomes and activity would help meet our commitment to BSiL and GMH. Since then there has been ongoing work with relevant groups and service leads to identify and discuss the specific actions that will go into the implementation plans.

- There has been an enormous amount of enthusiasm for both priorities and a huge amount of input has been received over what is effectively a 2 month period; this has been very encouraging, but ensuring that all relevant voices and possible commitments for action have been captured has consequently been an immense undertaking.

- The process for developing actions, capabilities and identifying measures needs to be seen as part of ongoing engagement and as an iterative process and therefore cannot be definitive at this point. We also need to make sure that any commitments are relevant to/consistent with the ICS and ICB developments.

- A Community Paradigm workshop took place for both priorities on the 29 September and the contribution that this approach can make towards successful delivery of both plans has been acknowledged as crucially important. To support the community paradigm approach, Public Health have committed £150,000 non-recurrent funds to support the two delivery plans.

- In formulating the plans we were mindful of the need to follow the principles laid down in the JLHWBS for its fulfilment

    - That there should be a prevention first approach
    - That the focus should be on reducing health inequalities
    - That we should work with communities at every stage (co-production, 'community paradigm')
    - That an integrated way of working should be developed
    - That we should recognise and value our workforce
    - That activity should be evidence informed
    - That we should be outcomes focused and strive for continuous improvement

1.9 Whilst the Health and Wellbeing Strategy is a 10-year strategy, it is recognised that community needs may change and that through delivery of actions against the core priorities, the board may wish to shift its priorities. Therefore the proposed implementation plans are set over a period of 2 years

Community Impact

The purpose of the BSiL implementation plan is to specify the actions and activity that will improve the lives of the 0-5s and their families in Herefordshire. Similarly the GMH plan details the actions that will help to improve the mental health and wellbeing of Herefordshire residents. One of the key principles upon which the JLHWBS was developed was that of community empowerment ('community paradigm') and commitment to this principle will be demonstrated by involving our communities in any actions that are proposed. The BSiL and GMH plans therefore incorporate actions that follow through on this commitment.

Environmental Impact

There are no general implications for the environment arising from this report; however both plans include a commitment to promote healthier eating and increase levels of physical activity through active travel, which in due course could have a positive environmental benefit.

Equality duty

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

1.11 The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

1.12 The principles of equality and the reversal of health inequalities are key strands of the strategy

1.13 To be effective in delivering good population outcomes and helping those most in need, the strategy calls for intervention by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Resource implications

1.14 There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWBB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

1.15 Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.

1.16 Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.

1.17 The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.

1.18 The production of a Joint Local Health and Wellbeing strategy is a statutory requirement and therefore its endorsement and support is required.

Risk management

There are no risk implications identified emerging from the recommendations in this report. However, the delivery of these plans require system and collaborative working across all partners. Where possible, we have identified where activity is funded, but given the fiscal position across partners these will need to be kept under review.

Consultees

Matt Pearce (Director of Public Health), Hilary Hall (Corporate Director Community Wellbeing), Henry Merricks-Murgatroyd (Democratic Services Manager)

Appendices

Appendix 1 – Best Start in Life Implementation plan

Appendix 2 – Good Mental Health Implementation plan

Appendix 3 – Provisional Outcomes Dashboard

Appendix 4 - BSiL & GMH Main Report

Background papers

None identified

Best Start in Life
Implementation Plan 2023-2025

This draft implementation plan has been developed through engagement with the Early Years Group and Children and Young People Partnership, Health & wellbeing board partners, and the voluntary sector. The plan will continue to evolve and develop throughout its life course

Cross-cutting, collaborative actions, required to underpin all transformational developments:

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
A. Work to establish an integrated approach across teams that include practice nurses and staff from the new 0-19 service	December 2024	WVT/ICB/Taurus/PCNs	Progress report from ICB/ICP Impact on families	Existing resource	The national Fuller Review & recommendations on primary care neighbourhood teams
B. Ensure cross partner communications plans to promote healthy living messages	April 2024	Hfds/WVT/ICB/PCNs/CP & CVS/One Herefordshire Communications Group	Immunisation data; A&E admissions for 0-5s; Increased role of pharmacies	Existing resource	Consistent and effective communications process across and within partner agencies
C. Develop a cross-sector dashboard covering health services, social care, CVS and early years data	March 2024	Hfds council/WVT/ICB/CVS	Dashboard with health and social care data	Existing resources	Key data to reflect priority outcomes
D. Ensure that the 'Voice of the Child' approach is being implemented across all activity	June 2024	CVS/all partners	Measure activity against the HSCP Voice of the Child Participation Toolkit	Community paradigm through PHRFG	Inclusion on Risk Registers

AMBITION 1: CHILDREN ENJOY GOOD HEALTH AND WELLBEING				
Outcomes	Reduction in tooth decay	Reduction in obesity of all children	Increased mental wellbeing and resilience of parents & children	Improvement in health outcomes for all children and seek parity in health for the most disadvantaged children

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
1.1 Continue roll-out of tooth brushing programme to include: SEND/MOD pre-schools and reception classes Establish brush packs in Health Visitor 2 year review & new pre-school review	June 2024	Hfds Council Public Health/Early Years Coordinators/WVT Health Visiting	Oral health data % of 5 year olds with dental decay, missing or filled teeth; Link with Oral Health Improvement Board data; Increase in children who at receiving oral health pack 2 year review.	PHRFG	
1.2 Roll-out of new oral health & healthy weaning contact of the 0-19 contract.	October 2024	Wye Valley Trust Health Visiting/Hfds Council/	Reach and accessibility measures	Existing resources	Alternative models to be explored eg face to face, digital, group offer
1.3 Work to secure more NHS dentists, so that pre-school children can have regular dental check-ups	December 2024	ICB/Public Health	Increased access to dental services/qualitative report from ICB/PH	ICB	Inadequate numbers of NHS dentists On-going work with NHS dental providers to increase provision & prioritise children
1.4 Establish Healthy Tots programme & toolkits, including healthy eating and physical activity policy in Early Years settings, including SEND/MOD children	December 2024	Hfds Council Community Hubs/Public Health	Excess weight at reception age (National Child Measurement Programme data) Number of schools & early years providers signed up to Healthy Tots;	PHRFG	Potential pilot settings identified

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
			Impact data on targeted, vulnerable groups		
1.5 Expand B/F friendly accreditation: In the community eg children's centre services and Community Hubs Maternity: Complete process for Baby Friendly status/accreditation Progress the Infant Feeding Strategy towards implementation	December 2024 June 2024 March 2024	Hfds Council/Public Health Wye Valley Trust/Midwifery ICB/WVT/PH	Breast feeding rates at 6-8 weeks County-wide implementation	PHRFG WVT Existing resources	Currently 55% of babies are still breast fed at 6-8 weeks
1.6 Future development of TC community hubs that can offer comprehensive information and have staff trained in healthy living coaching Launch virtual offer providing information & support for families through Talk Community	December 2024 June 2024	Hfds Talk Community/CP	Number of parents accessing support; monitoring data Number of families using TC hubs	Talk Community	TC review in progress 2023-24 Risk of postponement of launch
1.7 Expand collaborative work with commercial sector around healthy eating e.g. supermarkets, cafes	May 2025	Hfds Public Health	Increase in provision	Existing resources	
1.8 Develop training for all 0-5s workers to identify oral health, healthy weight	2024/25	Hfds council/PCNs/WVT/CVS	Numbers/type of staff trained Health & wellbeing surveys	Children's Services / PHRFG	

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
issues, MH issues & ACEs including PCNs/social prescribers, family support workers, Homestart, community development workers and early years settings			Numbers using CHAT line Link with GMH Implementation Plan and CYP Emotional Health & Wellbeing Delivery Plan		
1.9 Strengthen reach to families that do not engage with statutory services/who do not seek support eg Gypsy/Roma families	December 2024	Hfds council/CVS	Qualitative report Link with Health Inequalities Strategy 2023-2026		Joint working with CVS must be progressed
1.10 Sustain support for the poorest families across the county, including holiday activities fund	December 2024	Hfds council – County Plan, Big Economic Plan/CVS	Data on benefit claims, free school meals; Numbers of children living in poverty	Government Funding	Lack of funding, economic plan failure

AMBITION 2 : CHILDREN ARE PROTECTED FROM HARM AT HOME AND IN THE COMMUNITY				
Outcomes	Reduction in number of children experiencing neglect & unintentional injuries	Reduction in number of children with experience of trauma / ACEs	Reduction in number of children taken into care	Greater numbers of parents are successfully supported to develop healthy parenting routines & behaviours

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
2.1 Pilot the PH Wales Adverse Childhood Events(ACEs) Enquiry Questionnaire	June 2024	WVT- HV service	Qualitative report	Existing resources	Funding/capacity to progress the pilot
2.2 Develop training programme/effective signposting/Healthy Tots/Solihull approach for ACEs to include: Family Support Workers, EY and primary school staff, foster carers, Talk Community volunteers Establish West Mercia Women's Aid & Turning Point involvement in training package	December 2024 June 2024	Hfds council	Link with 'Early Help & Prevention' Plan Number of staff trained Numbers of staff accessing Solihull training Impact on practice	Existing resource PHRFG	Training commissioned for assessment & emotional coaching for ACEs in early years
2.3 Broaden 'First Steps' programme to include domestic violence, previous child removal & incorporate the PAUSE approach.	January 2025	Hfds council	Number of staff trained and impact measures	Expansion of existing programme	PAUSE is a licensed programme but a bespoke, local approach could be developed
2.4 Roll out 'Dingley's Promise' (SEND) training to primary school staff	June 2024	Hfds council	Numbers of staff trained		

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
2.5 Signpost parents to Dingley's Promise support package	March 2024	Hfds council	Numbers of families that access the programme	Existing resource	
2.6 'Broaden' the early help/Start for Life offer within the community to involve more community hubs, community groups, CVS etc – so that early help is everyone's responsibility	September 2024	Hfds council & CVS partners/community stakeholders	Data from hub staff numbers/training Link with 'Early Help & Prevention' Plan	Talk Community	Dependent on the development of TC/community hubs Availability of volunteer workforce
2.7 Monitor/note progress/link with Children's Services improvement plan	Ongoing	Hfds council & stakeholders	Progress reports Data from A & E re NAIs Performance data from Children & families service eg numbers for those in care Qualitative measures – the voice of children and families Link with Corporate Parenting Strategy 2022-2024	CYPP Board/PH	Improvement plan in progress

AMBITION 3: CHILDREN ARE ABLE TO ACHIEVE THEIR EARLY DEVELOPMENTAL MILESTONES				
Outcomes	Increase in number of children achieving the appropriate level of development at 2-2½ yrs.	Identification of those children that don't achieve their milestones and the offer of support	Children who are experiencing disadvantage have a clear pathway of support	All children are ready for school/ schools are ready for children of all abilities

Actions	Target/review date	Responsible services	Indicators/measurements	Resource	Risk/Comment
3.1 Establish specialist HV for SEND children, so families can be supported better	June 2024	WVT HV service	Link with SEND Strategic Assurance Board	WVT	Recruitment to post in progress
3.2 Expand joint HV clinic with physio/speech therapy for early discussions on potential signs of delay	June 2024	WVT/PH/ICB	0-19 service performance data – developmental assessments	WVT	
3.3 Work towards a consistent universal offer that incorporates joint working between HV & Early Years. Eg expand the integrated development reviews	December 2024	Hfds council/WVT	0-19 performance data	WVT	Some joint reviews happen, but are inconsistent
3.4 Work towards fulfilling the statutory duty for providing early years education as set out by DfE, supported by: Workforce plan to expand training/career pathways for Early Years education posts Work with estates/capital projects to identify possible physical buildings for EY groups	December 2024	Hfds Council/CVS partners/education/ community stakeholders	Number of children taking up EY places across the county. Information from Childcare Sufficiency Strategy (annual assessment) Number of those taking up training Number of settings/venues available across the county	Existing resource	Currently sufficient places exist but there is a need to understand the impact of the national offer of increased hours from April 2024 Dependent on recruitment and retention of Early Years staff in future

Actions	Target/review date	Responsible services	Indicators/measurements	Resource	Risk/Comment
Scoping with Parish Councils to identify potential physical assets					
3.5 Work to ensure that all reception-age children are in their chronological age group	July 2025	Hfds Council	School access data; qualitative reporting		
3.6 Expansion of community approach and co-production so that communities & parents together support children's communication & social experiences Expand work with CVS to reach marginal groups eg Roma/Gypsy/other minority ethnic groups	December 2024	Hfds/TC council/CVS/health partners	Number of children requiring specialist speech and language therapy. Qualitative reporting		Lack of interest and cultural change is a risk

AMBITION 4: PARENTS ARE WELL SUPPORTED DURING PREGNANCY AND POST BIRTH				
Outcomes	Increase in numbers of women experiencing a healthy pregnancy	Reduction in infant mortality rate	Improvement in antenatal and post-natal mental wellbeing	Parents are able to make a confident transition to parenthood

	Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
	4.1 Establish pre-conceptual care education within 'Healthy Schools' programme/Women's health Hubs/PCNs	September 2024	Hfds PH/Educ/health partners	Infant mortality data Low birth weight data Smoking in pregnancy data	PHRFG	Access to pre-conceptual advice
	4.2 Continue roll-out of 'challenging conversations' training for midwives around healthy lifestyles and expand to health visiting services	December 2024	WVT	Number of staff trained Qualitative feedback and impact	Existing resource	
	4.3 Identify opportunities to continue healthy lifestyle trainers for Healthy Mums programme weight management & MH and family coaching approach Continue with stop smoking specialist service for pregnant smokers	March 2024 December 2024	Hfds PH/WVT	Healthy lifestyles data eg maternal obesity; postnatal smoking data; Healthy Start vitamins and food vouchers uptake Smoking in pregnancy and smoking at time of delivery rates	Options being explored to extend existing resource Options being explored with ICB	Funding a risk: additional funding being sought by ICB Midwifery leads for smoking currently on fixed term basis – March 2025
	4.4 Monitor progress of perinatal MH worker programme – severe MH	June 2024	H & W MH collaborative	Number of women accessing the service; partner support	ICB	
	4.5 Expand the 'First Steps' programme (currently for under 21s) to include all 1st time parents	December 2024	Hfds council/ WVT/CVS	Under-21s data: Women returning to education, training or work;	Existing resource currently	There are potential capacity issues that could limit expansion

Actions		Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
	who are vulnerable see Ambition 2)			breastfeeding at 6-8 weeks; smoking cessation uptake; Postnatal contraception		
	4.6 Develop community & peer support programmes within the Community Hubs (see outcomes 1,2 & 3)	December 2024	Hfds PH/CVS			Future of Hub development
	4.7 Expand promotion and uptake of Solihull approach online courses for parents (see ambitions 1,2 & 3) and training for 0-5s workers	June 2024	Hfds/PH	Numbers of parents/carers accessing programme; Number of schools, foster carers trained Impact on professional practice	PHRFG	

Good Mental Health Throughout Lifetime
Implementation Plan 2023-2025

This draft implementation plan has been developed through engagement with the Adult Better Mental Health Partnership, Health & wellbeing board partners, and the voluntary sector. In addition, the plan considers the Best Start in Life (BSiL) delivery plan, the Herefordshire children and young people's emotional health and wellbeing plan, and H&W mental health collaborative plans. The plan will continue to evolve and develop throughout its life course.

Cross-cutting, collaborative actions, required to underpin all transformational developments:

Actions	Target/review date	Responsible Service(s)	Indicators/measurements	Resource	Risk/Comment
A. Sign up to the National 'Prevention Concordat for Better Mental Health' initiative	Dec 2024	Herefordshire Council	Listed as signatory of the Concordat	Existing resource	
B. Deliver a Mental Health needs assessment	Q2/Q3 2024	Public health	Completed needs assessment	Existing resource	Monthly working group meetings
C. Create a collaborative 12 month localised comms plan to include Better Health-Every Mind Matters,	Dec 2024	Herefordshire Council	Completed comms plan/ No. of delivered comms	Existing resource	May need consolidation of comms plans

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AMBITION 1: PEOPLE FEEL SATISFIED WITH LIFE AND HAVE A POSITIVE SENSE OF PERSONAL WELLBEING			
Outcomes	Improve individual good mental health and resilience	Reduce the rates of self-harm amongst young people	Reduce the rates of suicide

	Actions	Target / review date	Responsible service(s)	Indicators / measurement	Resource	Potential risks / Comments
	1.1 Increase uptake of Mental Health First Aid training in the community	Dec 2024	Talk Community	No. completing MHFA training	BCF Talk community	May require comms
	1.2 Increase uptake of Making Every Contact Count (MECC) training and Solihull offer	Dec2024	Talk Community / Public Health	No. completing MECC training/ taking up Solihull offer	Talk community Public Health	May require comms
	1.3 Increase completion rate of Making Every Contact Count e-learning among MH services staff	Dec 2024	All	No. MH services staff completing MECC e-learning		Need to engage MH services leadership
	1.4 Distribute Mental wellbeing PSHE resource toolkits to schools	Dec 2024	CLD	No. schools receiving/ accessing resource toolkits	Talk community PHRFG	
	1.5 Deliver targeted physical activity interventions to improvement the mental wellbeing of children and young people	Dec 2025	Stride Active	No. interventions delivered/ No. CYP participating CYP physical activity levels Qualitative feedback and impact	PHRFG	Future sustainability of interventions
	1.6 Ensure 5 ways to wellbeing is integrated primary care networks and associated care pathways	Dec 2024	Taurus	Comms to PCNs % residents in contact with family, friends, neighbours % patients signposted to community support % people volunteering	Existing resource	Hard to measure promotion by PCN staff to patients

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Actions	Target / review date	Responsible service(s)	Indicators / measurement	Resource	Potential risks / Comments
1.7 Support the activity of the Physical activity strategy steering group to enhance wellbeing offer	Dec 2024	Public Health	Attendance at Physical activity strategy steering group meetings % physically active adults % physically active children	Existing resource	
1.8 Refresh the local suicide strategy	Dec 2024	Public Health	Completed strategy	Existing resource	New staff member in place
1.9 Implement and roll-out a local Real time suicide surveillance system	June 2024	Commissioning/Public Health	Completed dashboard	Existing resource	New staff member in place
1.10 Raise awareness of the issue of suicide, its causes and sources of help to those affected by either feeling suicidal or bereaved as a result of suicide.	Dec 2024	H&W suicide prevention team	No. distributed resources Rate of Suicides (PHOF)	PHRFG	New staff member in place
1.11 Increase uptake of bereaved by suicide support	Dec 2025	All partners	No. people bereaved by suicide accessing support	Existing resource	May require new data collection
1.12 Support employers to develop a workplace mental wellbeing support offer	Dec 2025	Public health	No. employers/ workplaces supported No. employees taking up support offers/engaging with resources	PHRFG / E&E?	May need to review support offer for employers
1.13 Implement and roll-out a local Real time suicide surveillance system	June 2024	Commissioning/Public Health	Completed dashboard	Existing resource	New staff member in place

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AMBITION 2: INDIVIDUALS AND FAMILIES ARE ABLE TO ACCESS APPROPRIATE MENTAL HEALTH INFORMATION AND SERVICES			
Outcomes	Improvement in access to Mental Health advice and information	Increase access to Mental Health services	Improve the physical health of individuals with mental illness

	Actions	Target / review date	Responsible service(s)	Indicators/measurement	Resource	Potential risks / Comments
	2.1 Undertake a Children & Young People survey	Spring 2024	Herefordshire Council / Business Intelligence	Survey results	PHRFG	
	2.2 Undertake a Community Wellbeing survey	Spring 2025	Public health	Survey results	PHRFG	Date of next survey TBD, 2023 results not yet published
	2.3 Scope prevalence of Neurodivergent CYP in H&W to understand current and future needs	Dec 2024		Scoping results	Existing resource	May require new data collection
	2.4 Increase provision and uptake of a countywide peer support offer in collaboration with partners	Dec 2025	All	No. of peer support offers No. of peer support pairs	TBC	Availability of resource, capacity
	2.5 Complete the recommissioning of the Talk Community Directory and ensure inclusion of dedicated mental health advice and information	April 2024	All	Updated Talk Community Directory Dedicated mental health advice and information section	Talk Community	
	2.6 Ensure all schools are aware of and consider applying for the MH lead training grant	Dec 2024	All	No. applications for the MH lead training grant No. people who have completed MH lead training	Education services/D of E	School capacity to submit an application/change in staff
	2.7 Increase uptake of physical health checks among those living with serious mental	Dec 2026	Public Health/Health check provider	% adults with SMI with completed physical health checks	ICB	Resource required to reach target

Actions		Target / review date	Responsible service(s)	Indicators/measurement	Resource	Potential risks / Comments
	illness (and reduce variation) ensuring appropriate signposting and provision of support to access services					groups to improve uptake
	2.8 Decrease smoking among people with a mental health condition by working with providers of MH services and smoking cessation services to ensure effective support	Dec 2026	Public Health	% people with a MH condition who smoke/engage services/quit attempt and successfully quit	PHRFG	Resource required to reach target groups to decrease prevalence
	2.9 Pilot physical activity interventions for people living with dementia to enable them to get physically active and socialise	Dec 2026	Public Health/Halo	No. pilot physical activity interventions No. people living with dementia participating in pilots	PHRFG	Long-term sustainability of interventions
	2.10 Ensure effective sign-posting to perinatal MH services	June 2024	Public Health/Service provider	No. referrals to perinatal MH services	Existing resources	Need more/new service data collected
	2.11 Implement relevant actions from C&YP emotional health and wellbeing transformation plan	Dec 2024	BSiL/Public Health link	Review implementation progress of transformation plan actions	ICB	
	2.12 Review referral management between teams to reduce gap in eligibility and ensure smooth transitions	June 2025	Public Health/Service providers	Referral management review	TBC	Team(s) may require additional resource to expand eligibility to reduce/ eliminate gap
	2.13 Raise awareness of interventions that address rural isolation and loneliness	Dec 2023	Talk Community	% residents (18+) who say they feel lonely often or always; % of residents in contact with family, friends or neighbours	Existing resources	

AMBITION 3: PEOPLE FEEL SAFE FROM HARM IN THEIR COMMUNITY			
Outcome	Increase Community Mental Health Support	Improve Partnership Working	Improvements to surroundings

Actions	Target / review date	Responsible service(s)	Indicators / measurement	Resource	Potential risks / Comments
3.1 Produce and implement a comms plan aimed at reducing Mental Health stigma	Dec 2024	All comms	Completed comms plan No. of delivered comms	Existing resources / PHRFG	May need consolidation of comms plans
3.2 Undertake a review of Talk Community	April 2024	Herefordshire Council	Completed Talk Community review	Existing resources	
3.3 Deliver a range of initiatives through the Safer Communities Fund to support early help and tackle the root causes of crime	March 2023	Herefordshire Council Police and Crime Commissioner	Increase in level 2 early help support How safe or unsafe do people feel when outside in their local area after dark? (Community Wellbeing survey)	Herefordshire Council / PCC	
3.4 Support implementation of the 'most appropriate agency' policy across organisations to deal with problems or concerns	Dec 2025	BMHPB	Review and implementation of 'most appropriate agency' policy	PCC / H&W NHS Trust	Outcome of this may influence resource need
3.5 Pilot Mental Health support in different settings when out of hours	Dec 2025	Community organisations	Implement and review pilot of out of hours mental health support provision	TBC	Resource to support extended support
3.6 Create a tool which allows policymakers to examine	Dec 2025	Public Health / planning	Engagement with planning teams	Existing resources	

	impact of their proposals decision making on mental health			Creation of new tool		
	3.7 Implement relevant actions from C&YP emotional health and wellbeing transformation plan	Dec 2024	BSiL / Public Health link	Review implementation progress of transformation plan actions	Existing resources	
	3.8 Deliver the priorities of the community safety partnership to keep people safe from harm e.g. violence against women, domestic abuse	Jan 2025	Community Safety Partnership	Community Safety Strategic Assessments	Existing resources / PCC Grant	

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AMBITION 4: PEOPLE FEEL CONNECTED IN THEIR COMMUNITY			
Outcomes	Increase access and knowledge of community support	Reduce loneliness & social isolation	Increase community activity offer

Actions	Target / review date	Responsible service(s)	Indicators / measurement	Resource	Potential risks / Comments
4.1 Invest £75,000 into a community solutions initiatives to create meaningful connections for people to improve their emotional wellbeing	January 2025	Better Mental Health Partnership Children and Young People Partnership	To be determined	PHRFG	
4.2 Support the youth officer pilot support within diabetes/ epilepsy WVT service	June 2024	WVT	No. patients engaged	TBC	Long-term sustainability post-pilot
4.3 Continue to invest in the children and young people's community eating disorder team	June 2024	ICB	No. patients engaged Healthy eating and drinking data (CYP QoL survey)	TBC	Long-term sustainability of team
4.4 Improve signposting and awareness of local community groups (e.g. support groups, activity groups, clubs) via different channels (e.g. social prescribers, town notice boards	December 2025	All	No. people participating in local community groups No. comms % residents who give unpaid help to any group(s), club(s) % CYP who took part in some form of volunteering outside school/college	Talk Community	Barriers to participation for the most deprived

Actions	Target / review date	Responsible service(s)	Indicators / measurement	Resource	Potential risks / Comments
4.5 Promote volunteering opportunities available via Herefordshire Wellbeing Ambassadors and Strong Young Minds Champions	December 2024	Community organisations	% residents who give unpaid help to any group(s), club(s) % CYP who took part in some form of volunteering outside school/college	TBC	Barriers to participation for the most deprived
4.6 Continue to support the health trainer model to develop community activity and link people into activities	December 2025	Healthy Lifestyle trainer service	No. health trainers No. people referred into activities Health trainer feedback	Existing resource	Barriers to participation for the most deprived
4.7 Support the Sustainable Food Places approach and the opportunities created by 'food'	December 2025	Public Health	Review implementation of plans	PHRFG	
4.8 Increase volunteering opportunities	December 2025	All	No. of volunteering opportunities	Existing resource	
4.9 Support the creation of activities and initiatives that enable people to connect with nature and greenspace to improve their wellbeing	December 2025	All	No. comms promoting local designated wildlife sites/ visits/foot traffic to wildlife sites CYP wellbeing scores on the Stirling Children's wellbeing scale (CYP QoL survey)	TBC	May require new data collection
4.10 Promote and develop existing activities around arts and culture as part of the national creative health initiative	December 2025	Public Health	Leisure and physical activity data (CYP QoL survey)	TBC	
4.11 Support local befriending schemes to reduce loneliness & social isolation	December 2025	Public Health/Community organisations	No. people participating Proportion of residents who say they feel lonely often or always; Percentage residents in contact	Existing resource	Availability of resource, capacity

Actions	Target / review date	Responsible service(s)	Indicators / measurement	Resource	Potential risks / Comments
			with family, friends or neighbours most days		

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Herefordshire Council

Appendix 3 Provisional Outcomes Dashboard, Best Start in Life

Table 1 Impact Area 1: Children enjoy good health and wellbeing

Outcome Indicator (s)	Data Source (Hyperlinked)	Time Period	Next release	Herefordshire Baseline*	Worcestershire Baseline*	Region	England	Nearest Neighbour High	Nearest Neighbour Low	Target year 1 (2024)	Target year 5 (2028)	Target year 10 (2033)
Percentage of 5 year olds with dental decay	PHOF	2021/22	2025	38.7	17.6	23.8	23.7	38.7	14.6	TBC	TBC	TBC
Reception prevalence of overweight (including obesity)	PHOF	2022/23	2024	19.4	21.8	22.2	21.3	25.6	17.0	TBC	TBC	TBC
Year 6 prevalence of overweight (including obesity)	PHOF	2022/23	2024	35.4	36.3	39.3	36.6	38.3	28.1	TBC	TBC	TBC

Outcomes requiring further indicator(s) development:

- Increased mental wellbeing and resilience of parents & children
- Improvement in health outcomes for all children and seek parity in health for the most disadvantaged children

*Red, amber green ratings. Where available, baseline figures for Herefordshire and Worcestershire are colour coded Green, Amber or Red, representing significantly better, the same, or worse performance than the England average respectively.

Table 2 Impact Area 2: Children are protected from harm at home and in the community

Outcome Indicator (s)	Data Source (Hyperlinked)	Time Period	Next release	Herefordshire Baseline	Worcestershire Baseline	Region	England	Nearest Neighbour High	Nearest Neighbour Low	Target year 1 (2024)	Target year 5 (2028)	Target year 10 (2033)
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years) crude rate per 10,000	PHOF	2021/22	2024/25	83.6	90.2	100.1	103.6	179.5	81.7	TBC	TBC	TBC
Children in care crude rate per 10,000	PHOF	2022	2024	112	76.0	88.0	70.0	175.0	69.0	TBC	TBC	TBC

Outcomes requiring further indicator(s) development:

- Reduction in number of children experiencing neglect & unintentional injuries
- Reduction in number of children with experience of trauma / ACEs
- Greater numbers of parents are successfully supported to develop healthy parenting routines & behaviours

Table 3 Impact Area 3: Children are able to achieve their early developmental milestones

Outcome Indicator (s)	Data Source (Hyperlinked)	Time Period	Next release	Herefordshire Baseline	Worcestershire Baseline	Region	England	Nearest Neighbour High	Nearest Neighbour Low	Target year 1 (2024)	Target year 5 (2028)	Target year 10 (2033)
Children achieving a good level of development at 2 to 2 and a half years	PHOF	2022/23	2024	79.6	Not available	76.3	79.3	87.6	53.8	TBC	TBC	TBC
School readiness: percentage of children achieving a good level of development at the end of Reception	PHOF	2021/22	2024	71.8	65.0	63.7	65.2	71.8	58.5	TBC	TBC	TBC

Outcomes requiring further indicator(s) development:

- Identification of those children that don't achieve their milestones and the offer of support
- Children who are experiencing disadvantage have a clear pathway of support

Table 4 Impact Area 4: Parents are well supported during pregnancy & post birth

Outcome Indicator (s)	Data Source (Hyperlinked)	Time Period	Next release	Herefordshire Baseline	Worcestershire Baseline	Region	England	Nearest Neighbour High	Nearest Neighbour Low	Target year 1 (2024)	Target year 5 (2028)	Target year 10 (2033)
Low birth weight of term babies (%)	PHOF	2021	2024	1.7	2.3	3.0	2.8	2.9	1.5	TBC	TBC	TBC
Infant mortality rate crude rate per 1,000	PHOF	2019-21	2024	6.1	5.5	5.6	3.9	7.5	3.8	TBC	TBC	TBC
Outcomes requiring further indicator(s) development: • Improvement in antenatal and post-natal mental wellbeing • Parents are able to make a confident transition to parenthood												

Herefordshire Council

Main reports

1.0 Best start in Life

1.1 Ambitions

The JLHWBS 2023-2033 identified 'Best Start in Life' as one of two core priorities and has committed to the achievement of four main ambitions for children:

1. Children enjoy good health and wellbeing
2. Children are protected from harm at home and in their community
3. Children are able to achieve their early development milestones
4. Parents are well-supported during pregnancy and post-birth and are able to access appropriate information, resources and services

1.2 Developing the plan

There were several steps involved in this process which included extensive consultation with both internal and external links across services:

- The launch of the JLHWBS took place in July of 2023, which included an initial workshop where attendees from across the services were invited to begin the process of formulating action plans for the two core priorities
- Following the JLHWBS launch information was gathered and collated from members of the Early Years (EY) Partnership Board, many of whom are relevant 'experts in practice', asking them how they thought their respective services should be developed
- A review of the Children and Young People health needs assessment to identify key needs and opportunities
- Two workshops were held with the EY partnership to scope out detailed outcomes
- Information and comments were collected from service users through the Maternity Voices Partnership
- Four 'Think Tank' sessions, one for each ambition were held to discuss the detail and feasibility of actions. Representatives from health, 'Early Years' the Community Partnership and the Integrated Care Board(ICB) were included
- Cross reference has been made and will continue with Worcestershire and its 'Best Start' activity and also the ICB as it develops its strategy and indicators for 'Best Start'

There are several other strategies and plans which will dove-tail with the BSiL plan and which are referenced within the BSiL plan and the supporting document.

It was intended that the BSiL plan would achieve some 'quick wins' and address what needs to happen soon, but also that it should aspire to some longer term goals which will be more complex but are also greatly needed. Variable timelines therefore reflect this and given that the JLHWBS is a 10 year strategy it is consistent with this ethos.

1.3 Common Themes

From the consultations and discussions some recurring themes emerged that consultees thought should be acknowledged and acted upon; these were:

- The need for future asset mapping in order to understand the numerous and variable projects/groups that exist to help families with children
- In connection with the above the need to tap into the community resource much more, including the CVS, but also community at its most 'grass roots' – to establish a pattern of engagement that's in keeping with the community paradigm approach
- The need for co-production and better integration between ALL services
- The need for much better communications plans that span ALL partner services if we are to get relevant and meaningful messages out to our populations

The BSiL implementation plan can be viewed in detail at Appendix 1

2.0 Good Mental Health

2.1 Ambitions

The JLHWBS 2023-2033 identified 'Good Mental' as the second of the two core priorities and has committed to the achievement of four main ambitions for this:

1. People feel satisfied with life and have a positive sense of personal wellbeing
2. Individuals and families are able to access appropriate mental health information and services
3. People feel safe from harm in their community
4. People feel connected to their community

2.2 Developing the plan

As with the BSiL plan it has involved a series of steps:

- The launch of the JLHWBS took place in July of 2023, which included an initial workshop where attendees from across the services were invited to begin the process of formulating action plans for the two core priorities
- Information was gathered from relevant 'experts in practice' – about how should services be developed
- A workshop was held with the Adult Mental Health Partnership Board, which included representatives from CVS organisations, the Health and Care Trust, Wye Valley Trust, Talk Community/Community hubs, Taurus and the ICB.
- There has been feedback through the Community Partnership and a stakeholder engagement process
- Service user comments have been collected through the Health Participation Project and the Community Survey
- Work has begun on a mental health needs assessment
- Feedback from representatives from the community and voluntary sector
- A new 'better mental health partnership' established and terms of reference reviewed
-

Consideration has been given to and cross-referencing has been made to the work of relevant groups across the Integrated Care System (ICS) i.e the Emotional Health and Wellbeing Partnership Board (children), the Adult Mental Health Partnership Board (adults), Dementia Partnership Board and the ICS Mental Health Collaborative

3.0 Delivering the plans and Governance

In developing the BSiL and GMH implementation plans a Public Sector Scorecard (PSS) approach has been taken. The PSS is a useful tool which emphasises that risks, challenges and barriers that can prevent plans and strategies from being implemented; it suggests that all these factors need to be brought into the discussions so that the realities of implementation are given due consideration. The process starts with the outcomes that are desirable and then considers the processes that are required to fulfil them and whether these exist in sufficient measure to make any changes feasible. Decision on measurable indicators are only decided once the decisions above have been decided on.

The Early Years Partnership group has produced the BSiL implementation plan. The group reports to the Children and Young People Partnership Board, which will monitor the progress of the plan. The below diagram shows the governance involved and the relationships between the relevant groups.

A new Adult Better Mental Health Partnership has been established to replace the existing Adult Mental Health Partnership and will report into One Herefordshire Partnership. The intention of the new group is to provide more effective strategic oversight for mental health activity across Herefordshire and closer alignment with the ICS mental health collaborative.

The GMH implementation plan can be viewed in detail at Appendix 2

4.0 Outcomes Framework

A draft outcomes dashboard is being developed which the board will use to monitor overall progress of the delivery plans against the high level ambitions of the health and wellbeing strategy. An early iteration of the dashboard can be found in appendix 3 for BSiL

5.0 Next Steps

The Health and Wellbeing Board will receive a bi-annual update on progress against each implementation plan

Herefordshire Council

Title of report: Community paradigm update

Meeting: Health and Wellbeing Board

Meeting date: Monday 4 December 2023

Report by: Corporate Director Community Wellbeing and Chief Officer Healthwatch Herefordshire

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

To update on the progress being made to develop the community paradigm approach in Herefordshire

Recommendation(s)

That:

a) **Health and Wellbeing Board note the progress made to date; and**
b) **Organisations represented on the Board commit to supporting the further development of the community paradigm in Herefordshire, building on the principles identified at paragraph 9.**

Alternative options

None identified

Key considerations

1. As public services face increasing pressures to meet demand and many people face inequalities in their outcomes, investing in prevention to provide better outcomes for the population and address the long-term sustainability challenge is essential.

2. The community paradigm shift is a pivot in approach from one of a market paradigm where the state commissions the provision largely through the public sector, to a way of working where communities have the power to design the solutions they need and have the resources to deliver as many solutions addressing the root causes as possible, with the state playing an enabling role. This requires a shift in current public service culture, commissioning, and delivery.

3. There are many places in the UK and across the world where community power is beginning to flourish. People are taking responsibility, often working in partnership with public services and local government to build better services and places to live. Herefordshire is well placed to join them.

Background

4. In March 2023, leaders from across the council, NHS, police, fire & rescue, education, businesses, funders, community voluntary and faith sectors came together to explore a collaborative approach to enabling people of Herefordshire to have greater control of their lives, shifting the balance of power and resources to communities to address prevention. The aim of doing so is to improve health, wellbeing and safety outcomes for residents, whilst addressing rising and unsustainable demand on public services.

5. A number of keynote speakers described what it would mean for Herefordshire to start the journey of a paradigm shift in how we work together with communities to create community power and action in Herefordshire. All partners agreed to move to a different way of working, committed to developing Herefordshire's approach to a community paradigm shift.

6. Since the inaugural event, a range of different workshops and discussions with public sector leaders, and with community organisations have taken place. In addition, learning from elsewhere in the country has been sought to shape an approach that will work for Herefordshire.

7. The visual strategy, see appendix 1, is an output of this work, establishing that the community paradigm would be a 10-year long-term way of working with communities, giving the community power and resources to achieve community led approaches which deliver prevention and develop resilient communities. This vision aligns to the Herefordshire Joint Health & Wellbeing Strategy 2023 ambitions

What do we want Herefordshire to be like in 10-years?

Thriving Communities

Our communities will foster wellbeing and resilience, where children and young people feel safe, loved, valued, and grow up with the confidence and skills to be the best that they can be.

Opportunity for all

There will be improved access to quality education and fair employment opportunities, with those who come from disadvantaged groups able to get jobs that pay a living wage, which enables them to improve the standard of living for themselves, their families and their community.

Healthy and Sustainable Places

People will grow, learn, live and work in environments that prioritise health and wellbeing where the healthy choice is the easy choice.

Healthy People

People will be empowered to take control of their health to lead healthy lives by reducing risky behaviours. Everyone will have equitable access to the information, services and preventative support they need, enabling them to access the right service at the right time.

Source: Herefordshire Joint Health & Wellbeing Strategy 2023

Issues and principles

8. Whilst there was overwhelming support for moving forward with the community paradigm, there were a number of 'big issues' that emerged as key obstacles to overcome, or where a radical change in approach would be required, for a community paradigm approach to be successful, which are:

   - Cultural change across the partnerships between sectors.
   - Need to involve communities and the wider workforce.
   - Engagement at a very local level of neighbourhoods.
   - A shared 'community chest' with proportionate governance and some high-level outcomes attached, to deliver community-led prevention.
   - An alternative to traditional commissioning and procurement processes that stimulates community solutions, innovation, and grass roots capacity building.
   - A shared approach to training and learning to embed paradigm vision and principles.
   - A co-produced prevention plan for Herefordshire.
   - Proportionate way to measure impact and outcomes of a community paradigm to demonstrate the 'invest to save' principle of prevention and community led solutions.

9. Reflecting on these issues led to the development of the following principles of the paradigm:

   - Invest to save has to be the fundamental basis of the approach.
   - Brave, bold leadership is needed.

- Focus should be on changing culture and thinking, not developing just another initiative.
- A matrix approach to solutions will need to evolve; small, medium, large, short, medium long-term, innovative, high-risk vs tried and tested evidence-based approaches.
- Community paradigm has to form part of all organisations' long term financial planning.
- The processes for managing the community chest need to be suitably flexible to match the differing levels of financial investment required within the model.
- Dependency on the state is not part of the future, neither is doing **TO** people. We need to be working **WITH** people and have a different relationship with communities.
- There are no ready-made answers – we are developing a pioneering approach together.

Reflections on the journey so far

10. There is no doubt that the statutory organisations and the community sector are genuinely committed to prevention as a concept. What is proving problematic is moving from concept to implementation. It is even more difficult when the focus is on the reality of a current challenging financial climate.

11. The move from concept to implementation is not helped by the wording of "community paradigm". Essentially, we are working towards a vision of **Herefordshire 2033**. That is the working title and the Board's views on alternative titles are welcomed.

12. More importantly, there is a need to take people through various steps towards understanding that vision and their role in it. This is very important, and vital to securing long term outcomes and long-term financial sustainability.

13. Having discussed and explored the paradigm shift extensively over the last eight months as a partnership, achieving widespread system support and enthusiasm, this work is now at the point of requiring more dedicated programme support and coordination to drive it forward.

14. Funding has been agreed jointly by the partners of One Herefordshire, which includes, Wye Valley Trust, Herefordshire Council Community Wellbeing, Public Health, Healthwatch, *General Practice* and *Herefordshire & Worcestershire Health & Care Trust*. This will fund a programme management role, hosted by Healthwatch, for a 12 month period.

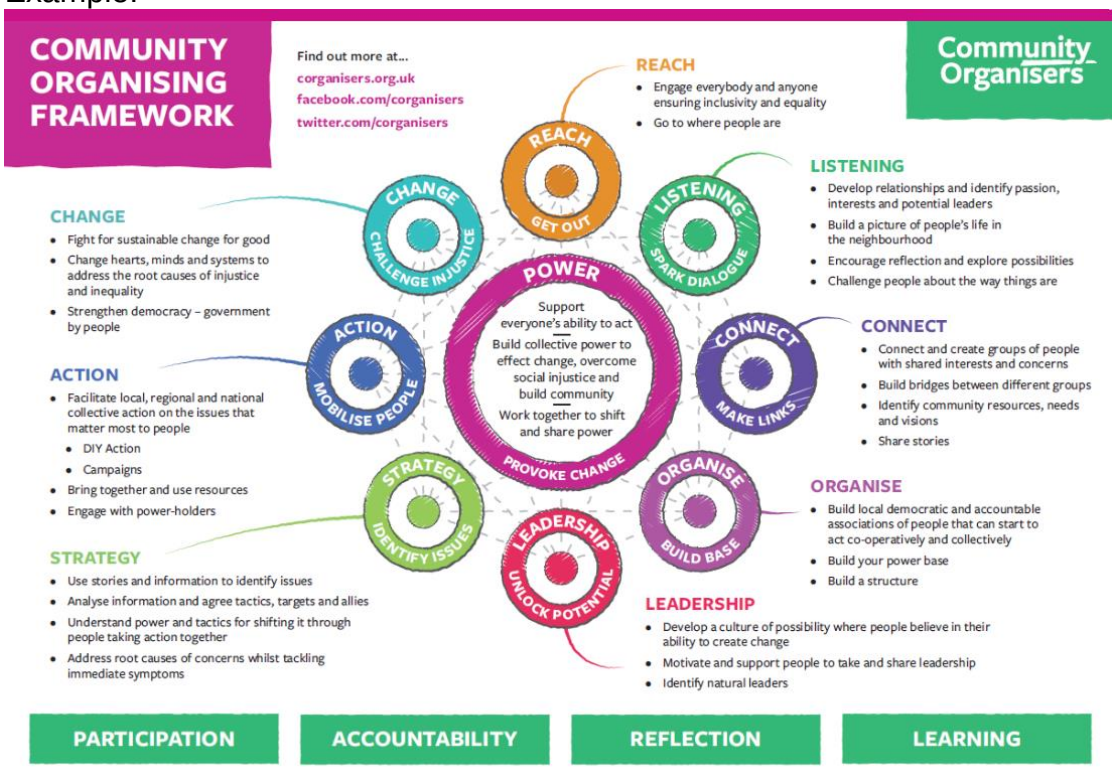
15. The role will work across local partnerships in the community sector and with public sector leaders, to coordinate the implementation of the community paradigm approach for Herefordshire across the following six workstreams. It is intended to create a sustainable community approach beyond the 12-month period.

Workstreams

Workstream 1: An immersive walk-through training experience

Source resources and coproduce an experiential space open over the long term where staff across Herefordshire can spend a half day training to understand the community paradigm vision, including: • What is community power. • Examples of an integrated approach to understanding and supporting populations. • The key components of successful community led solutions. • Developing alternatives to “doing to people”.
Aim: Understanding the power of a community paradigm and communicating the shared vision for Herefordshire 2033.
Workstream 2: Community led decision making and action, different voices in different places.
Source resources and coproduce a programme of community showcase conversations in each ward to: • Bring together and connect local people. • Maximise existing community assets. • Hear what local people want to offer. • Hear what local people want to address together. • Gather story telling examples of community co-design and action.
Aim: Community building, grassroots asset-based development
Workstream 3: Developing the Community Chest
• Work with Herefordshire Community Foundation, businesses, philanthropy, charities, public sector, and crowd sourcing to have a long-term plan to grow investment. • Develop governance and proportionate processes to manage the chest. • Further develop the guiding principles we all must share to have effective governance and implementation of our approach to paradigm.
Aim: A thriving community chest to fund and develop community led solutions.
Workstream 4: Creating the enabling conditions for thriving communities
• Develop processes to gather thematic intelligence from communities and community organisations, as a systematic regular process. • Sharing the needs gaps with communities, to address them collectively. • Supporting a range of networks and communities of practice • Connecting the dots so people know what is available and how to get it. • Supporting people to connect with one another. • Coproduction frameworks & Charter etc. • Infrastructure support.
Aim: Community resilience for individuals, and a robust stronger VCSE sector.
Workstream 5: Build a strong Community Alliance that can sustain and drive this.
• Using a community organizing approach

Example:



Aim: A sustainable vehicle and movement with a community powerbase

Workstream 6: Pilots and initiatives

- Trial the initial community chest investment of £150k for two health & wellbeing priorities through the Herefordshire Community Foundation governance.
- Invite expressions from community groups and organisations that demonstrate that meaningful connections will be made in communities for individuals to improve their wellbeing, e.g., reducing isolation, loneliness, increasing support for children & families through connections.
- Use the learning from this process to inform the principles of our prevention paradigm, shaping future pilots and initiatives with a range of outcomes built into the use of the community chest.

Aim: Increased connections for people to improve individual resilience and wellbeing

16. In relation to workstream 6, the intention is to launch the initial community chest investment by Christmas 2023 through Herefordshire Community Foundation. The Foundation has significant experience in managing grant schemes and has been heavily involved with the community paradigm development work from the outset. This is the proposed flyer advertising the opportunity:

Implications for public sector organisations

17. There are implications of adopting the community paradigm approach for public sector organisations. Whilst there will always remain a need for intensive, sometimes crisis,

support for individuals, driving a more proactive approach of communities supporting themselves through prevention and early intervention is desirable. However, at the moment, much of the funding and focus is on the high end, expensive provision/support and the success of the community paradigm will depend on public sector organisations being able to 'pivot' financial resource into prevention and early intervention.

18. There are also implications for the public sector around commissioning practices. Market commissioning drives a focus on commissioning at scale, with detailed service specifications and a schedule of performance indicators in order to demonstrate value for money and secure efficiencies. Shifting the focus towards more locally developed, relatively small scale initiatives will be challenging. Often described as "glorious messiness", there is more likely to be a wider range of providers, operating in local areas, focused on local needs. Operating on a 'community chest' principle will require a more flexible approach to agreeing outcomes from the financial investment. The role of the public sector will inevitably change to one of facilitation and enabling, seeking to share best practice and learning across the county rather than directly controlling what is done.

19. Moving to a community paradigm approach does not, of itself, preclude large scale commissioning where that makes sense to do so. For example, replicating sexual health services many times at a local level is unlikely to make sense, financially or economically, but the nature of ongoing support for individuals receiving such services may well look different and be delivered differently based on local need.

20. The culture change for all sectors endemic in this approach is significant and should not be understated. Herefordshire is pioneering this approach across all sectors, a real opportunity to build on the richness of the voluntary, community and faith provision in the county, as well as the embedded partnerships across agencies.

Community impact

21. The development of the community paradigm approach will have a significant, positive impact on communities, building on the strong community foundations in the county.

Environmental impact

22. This report is considered to have minimal environmental impact.

Equality duty

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

24. 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 Equality Act 2010 established a positive obligation on local authorities to promote equality and to reduce discrimination in relation to any of the nine 'protected

characteristics' (age; disability; gender reassignment; pregnancy and maternity; marriage and civil partnership; race; religion or belief; sex; and sexual orientation). In particular, the council must have 'due regard' to the public sector equality duty when taking any decisions on service changes.

26. The development of the community paradigm approach will take full account of the equality duty.

Resource implications

27. There are no resource implications arising from the recommendations of this report.

Legal implications

28. This report is for noting the progress of the work on the community paradigm and supporting the ongoing developments. There are no specific legal implications arising out of this report.

Risk management

29. Accepting the recommendations of this report carries no risk for the constituent organisations of the Health and Wellbeing Board.

Consultees

30. There has been no direct consultation on the contents of this report. However, there has been ongoing involvement of the Community Partnership and the constituent organisations of the One Herefordshire Partnership in the development of the community paradigm approach.

31. Consultation and engagement will be integral to the roll out of the six workstreams.

Appendices

Appendix 1: Community Paradigm visual

Background Papers

None identified

Appendix 1: Community Paradigm Vision

Herefordshire Council

Title of report: Health Protection Assurance Forum Annual Report 2023

Meeting: Health and Wellbeing Board

Meeting date: Monday 4 December 2023

Report by: Sophie Hay | Health improvement practitioner

Classification
Open

Decision type

This is not an executive decision

Wards affected
(All Wards);

Purpose
The purpose of this report is to update the Health and Wellbeing Board on health protection system performance, achievements, and risks for 2023, as well as areas of focus for 2024.

In Herefordshire, the Health Protection Assurance Forum (HPAF) is a partnership group that helps enable the Director of Public Health to fulfil their statutory role in seeking assurance that satisfactory arrangements are in place to protect the health of the local population.

Recommendation(s)
That:

a) **Health and Wellbeing Board to note the content of the report and are aware of the key findings, performance, risks, achievements and future priorities of the Health Protection Assurance Forum;**

b) **Identify and feedback to Health Protection Assurance Forum whether the Health and Wellbeing Board require any further follow up reports, or updates, on key health protection activities.**

Alternative options

1. The Board could choose not to consider this report

Key considerations

Introduction

The purpose of this report is to update the Health and Wellbeing Board on our health protection system performance, achievements, and risks for 2023, as well as areas of focus for 2024.

In Herefordshire, the Health Protection Assurance Forum (HPAF) is a partnership group that helps enable the Director of Public Health to fulfil their statutory role in seeking assurance that satisfactory arrangements are in place to protect the health of the local population. It also reports into the Health and Wellbeing Board to identify key issues and challenges facing our local population and where partnership working might help address those challenges.

Due to the COVID-19 pandemic the HPAF was temporarily stood down and replaced by a range of COVID specific groups. In April 2022, the group was re-established to fulfil the statutory role of the Director of Public Health in seeking assurance that arrangements are in place to protect the health of the local population.

Health protection functions expected of a local health systems as a whole, include:

- Emergency preparedness,
- Resilience and response
- Communicable disease control
- Risk assessment and risk management
- Risk communication
- Incident and outbreak investigation and management
- Monitoring and surveillance of communicable diseases
- Infection prevention and control in health and care settings
- Delivery and monitoring of immunisation and vaccination programmes
- Environmental public health and control of chemical, biological and radiological hazards

The local authority has a specific statutory duties around:

- Prevention
- Planning and preparedness
- Environmental health
- System assurance

An outline of key messages for each of the eight topics covered in this report are given below.

<u>Antimicrobial Resistance (AMR)</u>

- Internationally, antimicrobial resistance is one of the top 10 global public health threats. Local action is important to maintain the effectiveness of common antimicrobial drugs over the long term, including in Herefordshire.
- In Herefordshire and Worcestershire combined, the number of cases of antimicrobial resistant infection has remained relatively static between 2021/22 and 2022/23. However, 5 of the 6 infectious agents monitored are higher than agreed thresholds.
- The focus for 2024 will be reducing AMR case numbers below these agreed thresholds.
- This will be done by implementing the Herefordshire and Worcestershire Integrated Care System (ICS) AMR reduction strategy.

<u>Immunisation programmes</u>

- In general, Herefordshire's pre-school and school-aged routine vaccination programmes achieve performance in line with England averages, and local authorities similar to our own.

- Both pre-school and school-aged programmes were affected by COVID but have bounced back to pre-pandemic levels. However, uptake in the pre-school routine programme has been declining slowly over many years, while uptake in the school-aged programmes has relatively static. There are notable exceptions within those trends.
- For example, the school HPV vaccination programme was severely affected by the pandemic in Herefordshire but has recovered back to be one of the highest performing in the country. HPV vaccination coverage achieved the recommended ≥90% target for girls although coverage in boys was lower (85 to 89%). Both were a lot higher than the England average of 62% for boys and 67% for girls.
- Flu vaccine coverage among those aged 65 and over in 2022/23 has also remained high at 83.8%, the highest in the region and comfortably over the 75% nationally set target.
- Priorities for 2024 include increasing MMR dose 1 and 2 coverage above 95%, with particularly emphasis on dose 1 (currently 93% in 2022/23), which provides the majority of protection. Measles is making a resurgence nationally in unvaccinated groups and in response, Herefordshire and Worcestershire ICS are developing a measles elimination plan.

Population screening programmes

- Herefordshire typically performs similarly to the national average across most national screening programmes, and tracks their long-term upward or downward trends.
- The programmes were differentially affected by the pandemic. For example, antenatal and new-born screening (ANNB) screening, cervical screening and bowel screening were minimally impacted.
- By contrast, Abdominal Aortic Aneurism (AAA) screening, diabetic eye screening programme (DESP) and Breast screening were more impacted, building up significant backlogs.
- The breast cancer screening programme in particular went from stably achieving over 75% coverage before 2019, to less than 60% in 2021 and 2022.
- Cervical cancer screening coverage is also on a downward trend, reducing about 5% over a decade both in Herefordshire and nationally.
- In 2024 the focus is on improving backlogs from the pandemic and maintaining focus on known inequalities in screening update during that recovery. This will take local and national action, including implementation of the National Screening Strategy, due shortly.

COVID-19

- COVID-19 vaccination remains the most important tool in reducing the risk of ill health as a result of COVID infection, particularly in those at higher risk of worse outcomes from infection due to age, existing illness or other vulnerability.
- As of 23 September 2023; 437,165 COVID-19 vaccinations have been taken up in Herefordshire.
- A total of 19,211 (75%) of eligible people have received a spring 2023 booster, higher than the England average of 70%.
- Our future focus will be to continue to promote COVID-19 vaccination to those who are eligible, where season boosters are recommended and available.

Sexual health

- Overall, the rate of sexually transmitted infections diagnosed among residents of Herefordshire in 2023 (322 per 100,000) was less than half the England average (694 per 100,000).
- Specific areas where Herefordshire does less well than England include HIV testing, the number of people with a late HIV diagnosis, and the proportion of 15 – 24 year olds screened for chlamydia.
- Risks include recruitment and retention of sexual health staff due to Herefordshire's rural location and patient access to sexual health services
- The focus for 2024 includes further promotion of sexual health screening in schools, and investigating the reasons behind the HIV testing and late diagnosis figures. New services are planned, including a new virtual clinic, as well as a review our young person's walk in clinic, to ensure it's meeting the needs of users.

Drugs and alcohol

- Alcohol use accounts for the highest proportion of individuals seeking treatment locally
- There has been a rise in the number of drug and / or alcohol related deaths in Herefordshire. As a result, the Herefordshire Recovery Service is establishing a new Drug Related Death (DRD) panel
- Future focus includes building better links with GP practices and offering drop-in alcohol clinics and assessments from their premises to aid further referrals and promote the availability of support.
- Exploring and identifying ways to provide earlier intervention to alcohol users before they become dependent, to reduce the risk of them developing liver disease in the future.
- Continuing to provide training for other professionals regarding Brief Interventions, which can support early discussions about motivation to change.

Tuberculous (TB)

- Herefordshire continues to be a low incidence area for TB, averaging between zero and six cases per year since 2000.
- This poses resilience and efficiency challenges for the specialist TB service locally in prevention and response
- Nationally and locally TB vaccine is not routinely offered, but continues to be provided on the NHS when a child, or adult, is thought to have an increased risk of coming into contact with TB. This was the case locally for 63 individuals in 2021/22, down from 144 a year earlier.

Environmental hazards to health, safety and pollution control

- COVID had a significant impact on the delivery of Environmental Health services. As a result a COVID-19 recovery plan was successfully implemented.
- There has been a small reduction in the number of reportable accidents and incidents and in year health and safety visits conducted by Environmental Health in 2022/23.
- Food premises with a food hygiene rating score at 3 (satisfactory) or above have remained consistently high (2022/23, 98.2%)
- Herefordshire has a high number of poultry farms and processing facilities, increasing its risk of avian flu outbreaks. There were four such avian flu outbreaks requiring environmental health visits in 2021/22, including to ensure biosecurity measures were in place.

Community impact

In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review

Environmental Impact

This report helps to contribute to the following environmental policy commitments and aligns to the following success measures in the County Plan.

- Reduce the council's carbon emissions
- Work in partnership with others to reduce county carbon emissions
- Improve the air quality within Herefordshire

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.

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. As this is a decision on back office functions, we do not believe that it will have an impact on our equality duty.

Resource implications

There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

The Health and Wellbeing Board carries out statutory functions as required by the Health and Social Care Act 2012. The Boards functions are set out in Part 3.5.22 of the Council's constitution. Risk management

There are no risk implications identified emerging from the recommendations in this report.

Any specific system risk/s identified within the body report are included within the Health Protection Assurance Forum's risk log and will be monitored and reviewed by Health Protection Assurance Forum partners on a quarterly basis.

Consultees

- Members of the Health Protection Assurance Forum
- Contributors to the Health Protection Annual Report
- Public Health Leadership Team
- Matt Pearce (Director of Public Health)

Appendices

Appendix 1 – Health Protection Assurance Forum Annual Report 2023

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	Henry Merricks-Murgatroyd	Date 24/11/2023
Finance	Karen Morris	Date 24/11/2023
Legal	Sam Evans	Date 22/11/2023
Communications	Luenne featherstone	Date 21/11/2023
Equality Duty	Click or tap here to enter text.	Date Click or tap to enter a date.
Procurement	Lee Robertson	Date 21/11/2023
Risk	Jo Needs	Date 24/11/2023

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

Health Protection Assurance Forum Annual Report 2023

Contents

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Executive Summary

Introduction

The purpose of this report is to update the Health and Wellbeing Board on health protection system performance, achievements, and risks for 2023, as well as areas of focus for 2024.

In Herefordshire, the Health Protection Assurance Forum (HPAF) is a partnership group that helps enable the Director of Public Health to fulfil their statutory role in seeking assurance that satisfactory arrangements are in place to protect the health of the local population.

Summary messages for each of the 8 topics covered in this report are given below.

Antimicrobial Resistance (AMR)

- Internationally, antimicrobial resistance is one of the top 10 global public health threats facing humanity. Local action is also important to maintain the effectiveness of common antimicrobial drugs over the long term, including in Herefordshire.
- In Herefordshire and Worcestershire combined, the number of cases of antimicrobial resistant infection has remained relatively static between 2021/22 and 2022/23. However, 5 of the 6 infectious agents monitored are higher than agreed thresholds.
- The focus for 2024 will be reducing AMR case numbers below these agreed thresholds.
- This will be done by implementing the Herefordshire and Worcestershire ICS AMR reduction strategy.

Immunisation programmes

- In general, Herefordshire's pre-school and school-aged routine vaccination programmes achieve performance in line with England averages, and local authorities similar to our own.
- Both pre-school and school-aged programmes were affected by COVID but have bounced back to pre-pandemic levels. However, uptake in the pre-school routine programme has been declining slowly over many years, while uptake in the school-aged programmes has relatively static. There are notable exceptions within those trends.
- For example, the school HPV vaccination programme was severely affected by the pandemic in Herefordshire but has recovered back to be one of the highest performing in the country. HPV vaccination coverage achieved the recommended ≥90% target for girls although coverage in boys was lower (85 to 89%). Both were a lot higher than the England average of 62% for boys and 67% for girls.
- Flu vaccine coverage among those aged 65 and over in 2022/23 has also remained high at 83.8%, the highest in region and comfortably over the 75% nationally set target.
- Priorities for 2024 include increasing MMR dose 1 and 2 coverage above 95%, with particularly emphasis on dose 1 (currently 93% in 2022/23), which provides the majority of protection. Measles is making a resurgence nationally in unvaccinated groups and in response, Herefordshire and Worcestershire ICS are developing a measles elimination plan.

Population screening programmes

- Herefordshire typically performs similarly to the national average across most national screening programmes, and tracks their long-term upward or downward trends.
- The programmes were differentially affected by the pandemic. For example, antenatal and new-born screening (ANNB) screening, cervical screening and bowel screening were minimally impacted.

- By contrast, Abdominal Aortic Aneurism (AAA) screening, diabetic eye screening programme (DESP) and Breast screening were more impacted, building up significant backlogs.
- The breast cancer screening programme in particular went from stably achieving over 75% coverage before 2019, to less than 60% in 2021 and 2022.
- Cervical cancer screening coverage is also on a downward trend, reducing about 5% over a decade both in Herefordshire and nationally.
- In 2024 the focus is on improving backlogs from the pandemic and maintaining focus on known inequalities in screening update during that recovery. This will take local and national action, including implementation of the National Screening Strategy, due shortly.

COVID-19

- COVID-19 vaccination remains the most important tool in reducing the risk of ill health as a result of COVID infection, particularly in those at higher risk of worse outcomes from infection due to age, existing illness or other vulnerability.
- As of 23 September 2023; 437,165 COVID-19 vaccinations have been taken up in Herefordshire.
- A total of 19,211 (75%) of eligible people have received a spring 2023 booster, higher than the England average of 70%.
- Our future focus will be to continue to promote COVID-19 vaccination to those who are eligible, where season boosters are recommended and available.

Sexual health

- Overall, the rate of sexually transmitted infections diagnosed among residents of Herefordshire in 2023 (322 per 100,000) was less than half the England average (694 per 100,000).
- Specific areas where Herefordshire does less well than England include HIV testing, the number of people with a late HIV diagnosis, and the proportion of 15 – 24 year olds screened for chlamydia.
- Risks include recruitment and retention of sexual health staff due to Herefordshire's rural location and patient access to sexual health services
- The focus for 2024 includes further promotion of sexual health screening in schools, and investigating the reasons behind the HIV testing and late diagnosis figures. New services are planned, including a new virtual clinic, as well as a review our young person's walk in clinic, to ensure it's meeting the needs of users.

Drugs and alcohol

- Alcohol use accounts for the highest proportion of individuals seeking treatment locally
- There has been a rise in the number of drug and / or alcohol related deaths in Herefordshire. As a result, the Herefordshire Recovery Service is establishing a new Drug Related Death (DRD) panel
- Future focus includes building better links with GP practices and offering drop-in alcohol clinics and assessments from their premises to aid further referrals and promote the availability of support.
- Exploring and identifying ways to provide earlier intervention to alcohol users before they become dependent, to reduce the risk of them developing liver disease in the future.
- Continuing to provide training for other professionals regarding Brief Interventions, which can support early discussions about motivation to change.

Tuberculous (TB)

- Herefordshire continues to be a low incidence area for TB, averaging between zero and six cases per year since 2000.
- This poses resilience and efficiency challenges for the specialist TB service locally in prevention and response
- Nationally and locally TB vaccine is not routinely offered, but continues to be provided on the NHS when a child, or adult, is thought to have an increased risk of coming into contact with TB. This was the case for 63 individuals in 2021-22, down from 144 a year earlier.

Environmental hazards to health, safety and pollution control

- COVID had a significant impact on the delivery of Environmental Health services. As a result a COVID-19 recovery plan was successfully implemented.
- There has been a small reduction in the number of reportable accidents and incidents and in year health and safety visits conducted by Environmental Health in 2022/23.
- Food premises with a food hygiene rating score at 3 (satisfactory) or above have remained consistently high (2022/23, 98.2%)
- Herefordshire has a high number of poultry farms and processing facilities, increasing its risk of avian flu outbreaks. There were four such avian flu outbreaks requiring environmental health visits in 2021/22, including to ensure biosecurity measures were in place.

Introduction

The purpose of this report is to update the Health and Wellbeing Board on health protection system performance, achievements, and risks for 2022/23, and areas of focus for 2023/24.

Health protection assurance arrangements

Due to the COVID-19 pandemic a partnership meeting called the Herefordshire Health Protection Assurance Forum (HPAF) was stood down. In April 2022, the group was re-established to fulfil the statutory role of the Director of Public Health in seeking assurance that satisfactory arrangements are in place to protect the health of the local population.

Health protection seeks to prevent, or reduce, the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

The Director of Public Health (DPH) seeks assurance from the following organisations to fulfil a range of statutory functions. These organisations collectively work to protect the health of the local population that no single agency can address on its own.

Successful health protection requires strong working relationships at a local level. To underpin and support good working relationships, there are a number of legal and other levers to ensure that the relevant organisations do what is required of them to protect the public and take public health advice.

In Herefordshire, the Health Protection Assurance Forum (HPAF) aims to enable the Director of Public Health to fulfil the statutory role in seeking assurance that satisfactory arrangements are in place to protect the health of the local population.

Herefordshire Council arrangements

Under the Health and Social Care Act 2012 local authorities, through their Director of Public Health, have an assurance role to ensure that appropriate arrangements are in place to protect the health of their local populations.

Herefordshire Council has statutory health protection functions and powers, mainly in the area of environmental health, social care and supported by emergency planning, resilience and response. This includes the enforcement of safe standards for food; clean air; safe levels of noise; disposal of waste and safe housing conditions.

In addition to these existing responsibilities Herefordshire Council has a statutory duty to commission open access sexual health services and substance misuse services.

Herefordshire and Worcestershire Integrated Care Board

Since 2016, all local NHS organisations, local authority and other organisations have been working together as a sustainability and transformation partnership. Locally, our ICS is made up of two key bodies – an Integrated Care Board (ICB) and Integrated Care Partnership Assembly.

NHS Herefordshire and Worcestershire Integrated Care Board (ICB) took over from NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) on 1 July 2022. It is part of the Herefordshire and Worcestershire Integrated Care System (ICS) and is responsible for improving health outcomes for our local population, reducing health inequalities, and supporting broader social and economic development.

The ICB does this through ensuring more effective joined up working with local partners across health, social care, voluntary and community sectors.

Wye Valley NHS Trust
Secondary care providers are responsible for treatment services, responding to emergencies, communicable disease notification and their subsequent control. NHS organisations are expected to deliver functions that support health protection in accordance with the NHS England Standard Contract. This includes areas such as emergency planning and tuberculosis specialist services.

NHS England
NHS England has a specific roles and responsibilities as set out within the NHS public health functions agreement 2018-19. They are currently responsible for commissioning a range of services such as immunisations programmes; screening programmes and cancer screening programmes however this responsibility is shortly due to transfer to ICB's. They also have a responsibility to improve public health outcomes and reduce health inequalities.

UK Health Security Agency (UKHSA)
UKHSA respond to all local health related incidents, locally this is provided by UKHSA's West Midlands Health Protection Team. They provide specialist support to prevent and reduce the impact of infectious diseases; chemical and radiation hazards and major emergencies.

Their role is to support and provide local disease surveillance; maintain alert systems; investigate and manage health protection incidents and outbreaks; and implement and monitor national action plans for infectious diseases at local level.

Antimicrobial Resistance (AMR)

Summary

- Internationally, antimicrobial resistance is one of the top 10 global public health threats facing humanity. Local action is also important to maintain the effectiveness of common antimicrobial drugs over the long term, including in Herefordshire.
- In Herefordshire and Worcestershire combined, the number of cases of antimicrobial resistant infection has remained relatively static between 2021/22 and 2022/23. However, 5 of the 6 infectious agents monitored are higher than agreed case thresholds (Figure 1).
- The focus for 2023/24 will be reducing AMR case numbers below these agreed thresholds.
- This will be done by implementing the Herefordshire and Worcestershire ICS AMR reduction strategy.

Background

The World Health Organisation (WHO) have declared antimicrobial resistance (AMR) as one of the top 10 global public health threats facing humanity. In 2019 there were 4.95 million deaths associated with bacterial AMR across 204 countries, and 1.27 million of those were directly attributed, leading the WHO to declare it a top global public health threat.

Antimicrobials, including antibiotics, antivirals, antifungals and antiparasitics, are medicines used to prevent and treat infections in humans, animals and plants. Antimicrobial Resistance (AMR) occurs when bacteria, viruses, fungi and parasites change over time and no longer respond to medicines making infections harder to treat and increasing the risk of disease spread, severe illness and death.

We rely on antibiotics, antifungals, and antiparisites to treat the microorganisms that cause many common diseases, such as tuberculosis (TB), HIV / AIDS, malaria, sexually transmitted infections, urinary tract infections, chest infections, bloodstream infections and food poisoning. These microorganisms, however, can already resist a wide range of antimicrobial medicines. This isn't just a problem in treating illness; routine surgical procedures and cancer treatment – such as caesarean sections, hip and knee replacements, cardiac surgery and chemotherapy – also rely on these antimicrobial medicines prior to carrying out surgical procedures to prevent infections.

There are few replacement antibiotics or alternative products in development, and even fewer which target specific super resistant bacterium, virus, or other microorganisms.

Misuse and overuse of antimicrobials are the main drivers in the development of drug-resistant pathogens.

Performance

Figure 1 show the number of AMR infections reported across the Herefordshire and Worcestershire Integrated Care System combined. Information is not currently available at a Local Authority level.

Figure 1 Number of AMR reported cases in Herefordshire and Worcestershire ICS during 2021-22 and 2022-23

		Reported cases by period		
Infection	**Threshold**	**2021-22**	**2022-23**	**No. breaches for 2022-23**
Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections	0	9 cases	10 cases*	<5 cases
Clostridioides difficile *(C. diff)*	248	284 cases	281 cases	+38 cases
Gram Negative *E. coli* bloodstream infections	459	507 cases	497 cases	+38 cases

Klebsiella sp. bloodstream infections	121	117 cases	127 cases	+6 cases
Pseudomonas bloodstream infections	72	67 cases	58 cases	-14 cases
Methicillin-resistant Staphylococcus aureus (MSSA) bloodstream infections	NA	153 cases	161 cases	NA

** Figure also includes patient/s who have been recorded on more than on occasion*

Source: Herefordshire & Worcestershire ICS

Achievements

- Strengthened system working
- The ICS Health Care Associated Infection (HCAI) Forum maintains the collaborative working of IPC services throughout Herefordshire and Worcestershire, with a focus on AMS across the ICS,
- Development of an AMR reduction strategy alongside a dedicated *C. diff* group and Herefordshire & Worcestershire TB Network progressing a gap analysis against the National TB Action Plan.
- All practices to undertake a retrospective review of individual clinician antimicrobial prescribing over the period April-June 2023. Results will be shared as anonymised data across the Primary Care Network (PCN) or with at least 3 practices, with each clinician being told which their results are. Members of the ICB Medicines and Pharmacy Team attend PCN meetings so will be part of any discussions. This review is based on one already undertaken by a group of practices
- IPC Teams are participating in the NHS England IPC regional collaborative around *C. diff* infection , and gram-negative infections.
- IPC services across the ICS have continued to support a system wide response for situations such as the Mpox outbreak, Group A Streptococcal infections, seasonal Influenza, avian influenza, measles and other infections.
- IPC services have supported wider public health, specifically around contingency and bridging hotels and responding to Infectious disease incidents and outbreaks

Risks

- Low incidence integrated care system
- Challenges in undertaking new entrance latent TB infection testing (LTBI)
- Current TB service specification under review

Future focus

- Antimicrobial Stewardship being planned as one of the regular lunchtime educational session for Herefordshire and Worcestershire.
- Implementation of ICS AMR reduction strategy

Immunisation programmes

Summary

- In general, Herefordshire's pre-school and school-aged routine vaccination programmes achieve performance in line with England averages, and local authorities similar to our own.
- Both pre-school and school-aged programmes were affected by COVID but have bounced back to pre-pandemic levels. However, uptake in the pre-school routine programme has been declining slowly over many years, while uptake in the school-aged programmes has relatively static. There are notable exceptions within those trends.
- For example, the school HPV vaccination programme was severely affected by the pandemic in Herefordshire but has recovered back to be one of the highest performing in the country. HPV vaccination coverage achieved the recommended ≥90% target for girls

although coverage in boys was lower (85 to 89%). Both were a lot higher than the England average of 62% for boys and 67% for girls.

- Flu vaccine coverage among those aged 65 and over in 2022/23 has also remained high at 83.8%, the highest in region and comfortably over the 75% nationally set target.
- Priorities for 2024 include increasing MMR dose 1 and 2 coverage above 95%, with particularly emphasis on dose 1 (currently 93% in 2022/23), which provides the majority of protection. Measles is making a resurgence nationally in unvaccinated groups and in response, Herefordshire and Worcestershire ICS are developing a measles elimination plan.

Background

"The two public health interventions that have had the greatest impact on the world's health are clean water and vaccines" - World Health Organisation

Vaccines work by teaching your immune system how to create antibodies that protect you from diseases. It's much safer for your immune system to learn this through vaccination than by catching the diseases and treating them. Some diseases that are caused by viruses can't be cured with antibiotics so the only way to control them is through immunisations.

Immunisation is therefore the most important thing we can do to safely protect ourselves; our children and our community against ill health. It is estimated that immunisation alone prevents up to 3 million deaths worldwide every year.[1]

Vaccines have been deemed one of the one of the biggest health successes of the last century. Since vaccines were introduced in the UK, diseases like smallpox, polio and tetanus that used to kill or disable millions of people are either gone or seen very rarely. Other diseases like measles and diphtheria have been reduced by up to 99.9% since their vaccines were introduced.

Having a vaccine also benefits the whole community through 'herd immunity'. If enough people are vaccinated, it's harder for the disease to spread which is especially important for those people who cannot have vaccines. For example, people who are ill; are allergic or have a weakened immune system.

However, if people stop having vaccines, it's possible for infectious diseases to quickly spread again. The World Health Organization (WHO) has listed vaccine hesitancy as one of the biggest threats to global health.

Emerging issues – vaccine preventable diseases

Measles

Data published by UKHSA shows that there has been a rise in measles cases in England. Between 1 January and 20 April 2023, there have been 49 cases of measles compared to 54 cases in the whole of 2022. Most of the cases have been in London, although there have been cases picked up across the country and some are linked to travel abroad. Since 2022, measles activity has also been slowly ramping up globally with large outbreaks currently underway in multiple countries in South Asia and Africa.

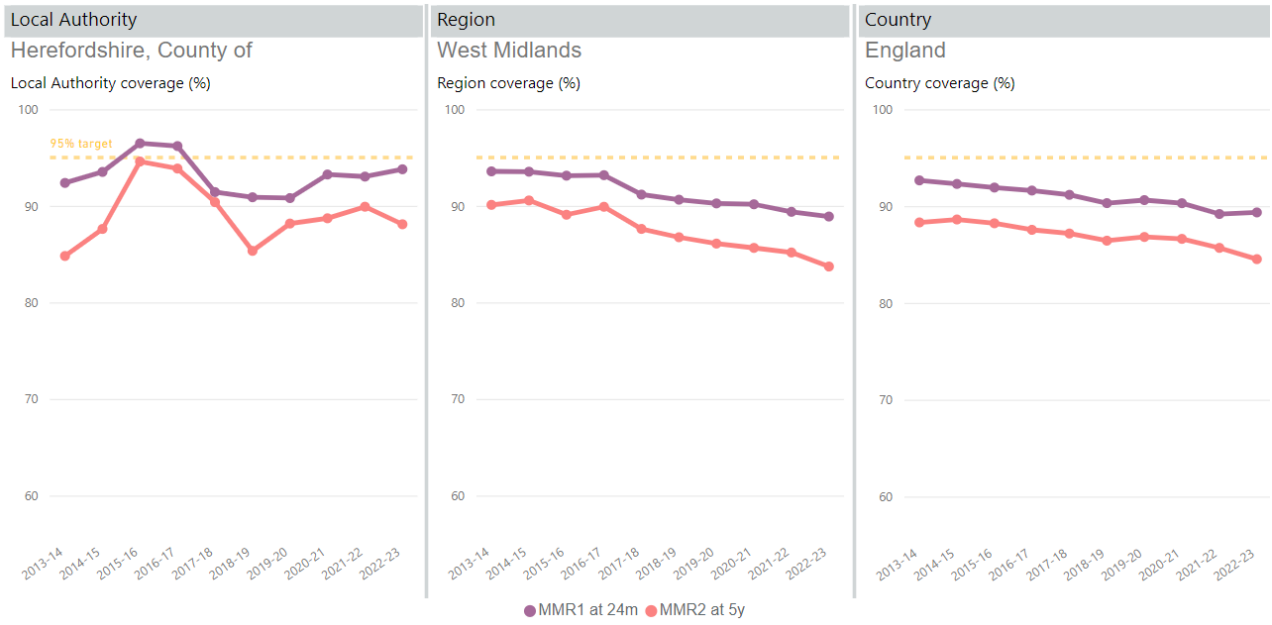
[1] https://www.nhs.uk/conditions/vaccinations/why-vaccination-is-safe-and-important/

Over a 10 year period (2013 – 2023) Herefordshire has had a total of 90 confirmed, probable and possible measles cases. Of this 15 were confirmed, 12 probable and 63 possible. During this period 3 reported measles situations were reported (outbreaks connected to a particular setting). Since 2020 the number of cases have dropped to <5 cases per year. COVID-19 measures such as social distancing and national lockdowns will have played a key role in the reduction of cases.

In Herefordshire, the 0-9 age group accounted for the highest number of cases. Since 2013 there have been 68/90 case involving this age group. This mirrors the age profile of recent national cases with 41% of cases being in children under the age of 5 years and 27% in 15 to 34 year olds.

Figure 2 shows the number of children vaccinated against measles has fallen in recent years across Herefordshire, the West Midlands and England. In 2022-23 uptake for the first dose of the MMR vaccine, which protects against measles, mumps and rubella, in children aged 24 months in Herefordshire was 93.0%, this marked slight increase (0.8%) in coverage compared to the previous year. However, uptake of 2 doses of MMR in children at 5 years decreased to 88.1%. Both uptake indicators are below the 95% target set by the World Health Organization (WHO), which is necessary to achieve and maintain elimination.

Figure 2 First and second dose MMR vaccination coverage 2013-14 to 2022-23, Herefordshire compared with West Midlands and England



Source: Childhood Vaccination Coverage Statistics, NHS England (2022/23)

Measles is a highly infectious disease that can lead to serious problems such as pneumonia, meningitis, and on rare occasions, long-term disability or death. In order to have maximum protection people need to have 2 doses of the MMR vaccine which protects against measles, mumps and rubella.

A single dose of MMR vaccine[2]:

- 90% of people will develop measles, mumps and rubella antibodies
- Is at least 95% effective in preventing clinical measles
- provides close to 100% protection against laboratory confirmed rubella
- provides between 61 and 91% protection against mumps

[2] *Green book, Chapter 21: Measles, 2019*

A second dose of MMR vaccine:[3]

- protects those who do not respond to the first dose
- increases protection against measles to well above 95%
- increases protection against mumps
- provides a much lower likelihood of suffering complications from mumps

The UK briefly achieved measles elimination in 2016 and 2017, but by 2018 measles virus transmission had re-established in the UK, at a time when the whole of Europe was experiencing large epidemics. Due to the COVID-19 pandemic cases of measles reduced significantly from early 2020.

As part of the UK's commitment to achieve measles and rubella elimination the Herefordshire public health team is therefore working with colleagues across Herefordshire and Worcestershire Integrated System to develop a comprehensive measles elimination action plan. This plan will outline key actions in order to address measles immunity gaps, reduce inequalities and meet local population needs.

Focus / priorities

As a system the focus and priorities for 2023/24 onwards includes:

- Increasing MMR uptake in the county through:
    - Developing and implementing a joint measles elimination plan across Herefordshire and Worcestershire
    - Taking a data driven approach to identifying inequalities and exploring interventions to tackle and address MMR uptake in the county.
    - Review and implement findings from NHS England's national call / recall MMR initiative

- Working with system partners to ensure that the delegation of immunisation commissioning from 2025/26 is established and integrated locally.

- Reviewing and implementing findings from the national immunisations strategy at a local system level

Routine childhood immunisations

Summary

- Locally, only 4 out of 14 routine childhood immunisations achieved the World Health Organisation's (WHO) 95% coverage target.
- In 2021-22 vaccination coverage was lowest in diphtheria; tetanus; whooping cough and polio vaccination and MMR second dose in 5 year olds
- The school HPV programme was severely affected by the pandemic in Herefordshire but has recovered well in the last few years. HPV achieved the recommended ≥90% target for females however coverage in males is lower.
- From September 2023, the HPV vaccination programme will move from two doses to a single dose following updated advice.
- Although Herefordshire mirrors the national trend for flu vaccination coverage in 2-3 year olds Herefordshire did not achieve the recommended >65% coverage target in 2021-22.

[3] *Green book*

- With the exception of secondary school aged children Herefordshire achieved and exceeded the >65% coverage target for school aged flu vaccination in 2022-23.

Background

As children develop they're exposed to many risks, one of these risks being infections. Most of these will cause mild illnesses. However, despite great medical advances, infection can still cause severe illness, disability and, at times, death.

In the UK, the NHS vaccination schedule sets out a list of routine vaccinations which are recommended across a person's life course. The majority of these vaccinations take place when you are a child aged between 8 weeks – 14 years. An overview of the recommended routine vaccinations for children and how they are delivered can be seen in Table 1

Locally, the majority of childhood vaccinations are provided through Primary Care (where they are registered at a GP Practice) which is commissioned by NHS England. However, for school aged children NHS England have commissioned a schools based immunisations provider. In Herefordshire, Vaccination UK are currently commissioned to deliver this service.

In 2025 it is expected that NHS England will transfer and delegate their vaccine commissioning responsibility to local Integrated Care Boards (ICB's). This marks an important transformational change.

Most immunisations such as the 6-in-1 vaccine and MenB vaccine need to be given several times to build long-lasting protection. Until they receive all the doses they need, they are still at risk of getting sick if they come into contact with these diseases. It's therefore extremely important that children are vaccinated at the recommended age when they are invited to receive them.

Table 1 NHS vaccination schedule for children up to 14 years of age

Age offered	Vaccination	Helps protect against	Provided by
8 weeks	6-in-1 vaccine .	Diphtheria; hepatitis B; Hib (Haemophilus influenzae type b); polio; tetanus; whooping cough (pertussis)	GP Practice
	Rotavirus vaccine	Highly infectious gastrointestinal (GI) infection	GP Practice
	MenB vaccine	Meningococcal group B bacteria (meningitis and sepsis)	GP Practice
12 weeks	6-in-1 vaccine (2nd dose)	Diphtheria; hepatitis B; Hib (Haemophilus influenzae type b); polio; tetanus; whooping cough (pertussis)	GP Practice
	Pneumococcal vaccine	Pneumococcal infections caused by the bacteria Streptococcus pneumonia	GP Practice
	Rotavirus vaccine (2nd dose)	Highly infectious gastrointestinal (GI) infection	GP Practice
16 weeks	6-in-1 vaccine (3rd dose)	Diphtheria; hepatitis B; Hib (Haemophilus influenzae type b);	GP Practice

		polio; tetanus; whooping cough (pertussis)	
	MenB vaccine (2nd dose)	Meningococcal group B bacteria (meningitis and sepsis)	GP Practice
1 Year	Hib/MenC vaccine (1st dose)	Haemophilus influenzae type b (Hib) and meningitis C.	GP Practice
	MMR vaccine (1st dose)	Measles, mumps and rubella	GP Practice
	Pneumococcal vaccine (2nd dose)	Pneumococcal infections caused by the bacteria Streptococcus pneumonia	GP Practice
	MenB vaccine (3rd dose)	Meningococcal group B bacteria (meningitis and sepsis)	GP Practice
2 to 10 or 11 years	Children's flu vaccine (every year until children finish primary school	Influenza (flu)	School based immunisations provider
3 years and 4 months	MMR vaccine (2nd dose)	Measles, mumps and rubella	GP Practice
	4-in-1 pre-school booster vaccine	Diphtheria; tetanus; whooping cough and polio	GP Practice
12 to 13 years	HPV vaccine	Helps protect against cancers and genital warts caused by the human papillomavirus (HPV).	School based immunisations provider
14 years	3-in-1 teenage booster vaccine	Diphtheria; tetanus and polio	School based immunisations provider
	MenACWY vaccine	4 strains of the meningococcal bacteria – A, C, W and Y – which cause meningitis and blood poisoning (septicaemia).	School based immunisations provider

Source: NHS

Performance

A snapshot of current performance on annual coverage childhood immunisations is summarised in Table 2 below. The immunisation listed within table two are specific to those which have a coverage target of ≥95%.

Vaccination rates that are ≥95% provide immunity and protection for wider society. High vaccination rates provide increased probability of immunity throughout the population (herd immunity), which is particularly important for protecting individuals who cannot be vaccinated, and can also lead to the elimination of some diseases. Even when a disease is no longer common in the UK, without sustained high rates of vaccination it is possible for these diseases to return as demonstrated by recent the increase in national measles cases.

Table 2 Herefordshire routine childhood immunisations coverage summary – latest annual data

Below 90% coverage					
Immunisation	**Period**	**Local coverage**	**Recent trend**	**Comparator average**	
				CIPFA neighbours	**England**
Dtap & IPV booster (5 yrs.)	2021/22	88.2%	No significant change	90.1%	84.2%
MMR 2 doses (5 yrs.)	2021/22	89.9%	No significant change	91.1%	85.7%
Between 90% - 95% coverage					
Immunisation	**Period**	**Local coverage**		**Comparator average**	
			Recent trend	**CIPFA neighbours**	**England**
Men B (1 year)	2021/22	94.8%	Increasing	94.8%	91.5%
Dtap IPV Hib (2 yrs.)	2021/22	94.9%	No significant change	95.7%	93.0%
MenB booster (2 yrs.)	2021/22	92.1%	Not available	92.8%	88.0%
Rotavirus (1 yrs.)	2021/22	93.1%	Increasing	93.6%	89.9%
MMR 1 dose (2 yrs.)	2021/22	93.0%	No significant change	93.7%	89.2%
PCV booster	2021/22	92.5%	Not available	93.7%	89.3%
Hib & MenC booster (2 yrs.)	2021/22	92.9%	Increasing	Not available	89.0%
Above 95% coverage					
Immunisation	**Period**	**Local coverage**	**Recent trend**	**Comparator average**	
				CIPFA neighbours	**England**
Dtap IPV Hib (1 yrs.)	2021/22	95.0%	Increasing	95.1%	91.8%
PCV	2019/20	95.0%		95.1%	93.2%
Hepatitis B (2 yrs.)	2021/22	100%	Not available	88.0%	N/A
MMR 1 dose (5 yrs.)	2021/22	95.3%	No significant change	96.3%	93.4%

Sources: NHS Digital; Public Health Outcomes Framework (PHOF)

Based on data from Table 2, two childhood immunisation performance indicators are below 90% coverage. For example, two doses of Measles, Mumps and Rubella (MMR) vaccine before the age of 5 provides the best protection against those diseases. Herefordshire's coverage (88.2%) is higher than the England average (84.2%) but is below the average seen in local authorities similar to our own (90.1%).

Human papillomavirus (HPV) vaccination uptake

Human papillomavirus (HPV) is very common, more than 70% of unvaccinated people will get it. There are more than 100 different types of HPV, and around 40 that affect the genital area. HPV can be caught through any kind of sexual contact with another person who already has it.

Most people will get an HPV infection at some point in their lives and their bodies will get rid of it naturally without treatment. However, some people infected with a high-risk type of HPV will not be able to clear it. Over time, this can cause abnormal tissue growth as well as other changes, which can lead to cancer if not treated. High risk types of HPV can be found in more than 99% of cervical cancers.

More than 280 million doses of the HPV vaccine have been given worldwide, including 120 million doses in the US and over 10 million in the UK. The HPV vaccine has been offered to all girls in

school year 8 since September 2008. From September 2019 the vaccine has also been offered to year 8 boys.

For operational purposes a 12 month gap between the two doses is currently recommended, that is, the first HPV vaccine dose should be offered in year 8 (aged 12 to 13) and the second dose should be offered in year 9 (aged 13 to 14), as this reduces the number of HPV vaccination sessions required in school.

However, children who become eligible for the HPV vaccine from the academic year 2023 to 2024 (date of birth between 1 September 2010 to 31 August 2011) onwards will only require one dose. This is because the Joint Committee on Vaccination and Immunisation (JCVI) has advised that a one dose HPV vaccine schedule has shown to be just as effective as 2 doses at providing protection from HPV infection.

It is expected that the vaccine will save hundreds of lives every year in the UK. A recent Scottish study has already shown a 71% reduction on pre-cancerous cervical disease in young women[4].

Table 3 HPV population vaccination coverage in 2021/22 in Herefordshire

Indicator	Coverage %	
	Herefordshire	England
HPV vaccination coverage, one dose, 12-13yrs, males	85.5%	62.4%
HPV vaccination coverage, one dose, 12-13yrs, females	90.4%	69.6%
HPV vaccination coverage, one dose, 13-14yrs, male	89.2%	62.4%
HPV vaccination coverage, one dose, 13-14yrs, females	91.4%	67.3%

Source: Public Health Outcomes Framework (PHOF)

As Table 3 indicates, coverage is lower in males than females. It is important to note that the male HPV programme was only introduced in September 2019 just before the start of the COVID-19 pandemic and has had less time to embed. In 2019/20 one dose of HPV vaccine in 12-13 year old males in the county was 23.0%. Since then coverage has increased significantly. In 2020/21, coverage increased to 90.7% and achieved the recommended ≥90% target. However, in 2021/22 coverage reduced by 5.2% to 85.5%.

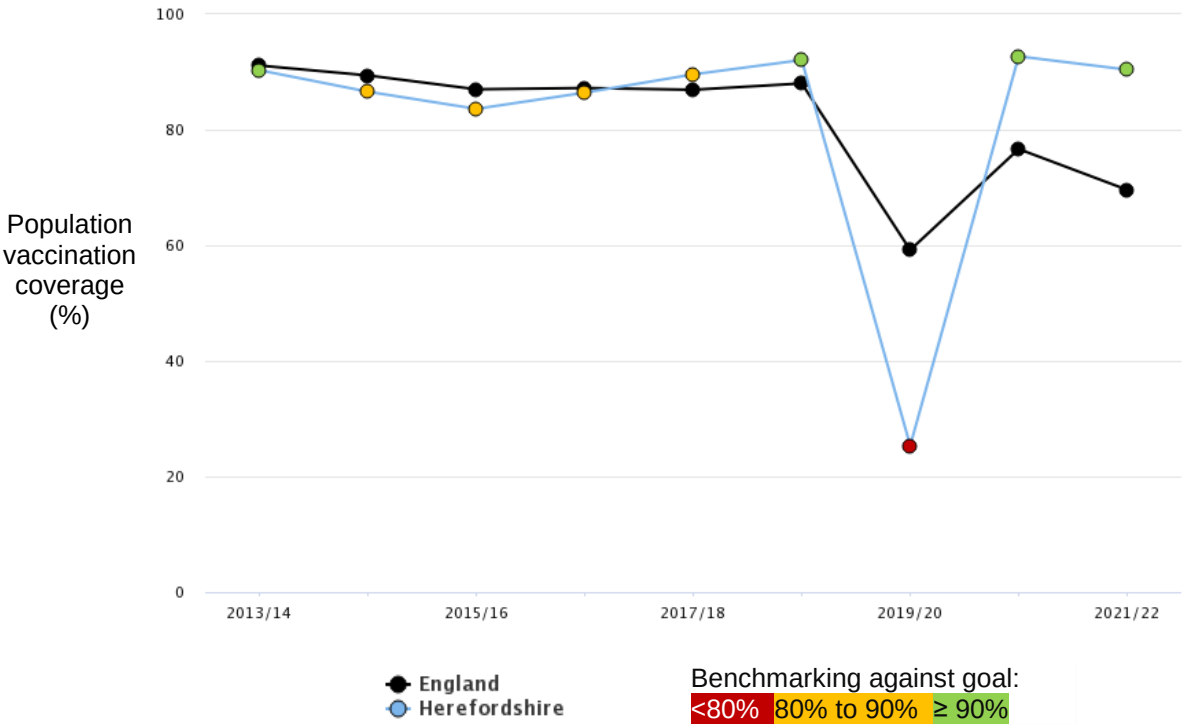
When compared to other areas Herefordshire was one of highest performers in England for HPV coverage in 2021/22. Out of a total of 153 areas Herefordshire had the:

- third highest vaccination coverage uptake for one dose in 12-13 year old females
- seventh highest vaccination coverage uptake for one dose in 12-13 year old males
- second highest vaccination coverage uptake for two doses in 13-14 year olds females
- second highest vaccination coverage uptake for two doses in 13-14 year olds males

Figure 3 show's that the school HPV programme was severely affected by the pandemic in Herefordshire but has recovered well in the last few years. Vaccination coverage for this cohort is within the ≥90% recommended target range.

[4] Information on the HPV vaccination - GOV.UK (www.gov.uk)

Figure 3 Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 years olds, female)



Source: Public Health Outcomes Framework (PHOF)

Flu vaccination

Flu can be an extremely unpleasant illness in children, with those under the age of 5 being more likely to be hospitalised due to flu than any other age group. A vital part of protecting the whole population from flu is to vaccinate children, who we know are 'super-spreaders', passing the virus more easily to those around them who are vulnerable and can suffer from the complications of flu.

Each year the childhood flu vaccine helps to prevent thousands of hospitalisations and deaths from flu and helps protect the NHS every winter. In 2022/23 the national NHS flu vaccination programme was available to:

- Priority cohort:
  - all children aged 2 or 3 years – these children are vaccinated via their GP Practice
  - primary school aged children (from reception to year 6) – through an NHS England commissioned school based immunisations provider

- Secondary cohort:
  - secondary school-aged children focusing on Years 7, 8 and 9 and
  - any remaining vaccine offered to years 10 and 11, subject to vaccine availability.

The flu vaccination benchmark coverage goal is significantly lower than that of other routine childhood vaccinations and therefore is excluded from Table 2. Currently, the recommended benchmark for flu vaccination coverage is >65%.

Herefordshire did not achieve the >65% for coverage in 2 – 3 year olds as referenced in Table 4.

Table 4 Flu vaccination coverage in 2 – 3 year olds (%)

Between 40-65% coverage				
Immunisation	**Period**	**Local coverage**	**Comparator average**	
			CIPFA neighbours	**England**
Flu (2-3 years)	2021/22	57.1%	Not available	50.1%

Only one out of sixteen CIPFA nearest neighbours to Herefordshire achieved ≥65% for vaccinating children aged 2-3 years against flu. All remaining areas including Herefordshire achieved between 48.4% and 64.4% coverage.

As Figure 4 shows, Herefordshire has continued to mirror the national trend for flu vaccination coverage in 2-3 year olds. Although we saw increase in uptake in this cohort during 2020-21, mainly due to the impacts from the COVID-19 pandemic, coverage reduced locally by 4.5% when compared to the previous year.

Figure 4 Flu population vaccination coverage for 2 to 3 years olds in Herefordshire

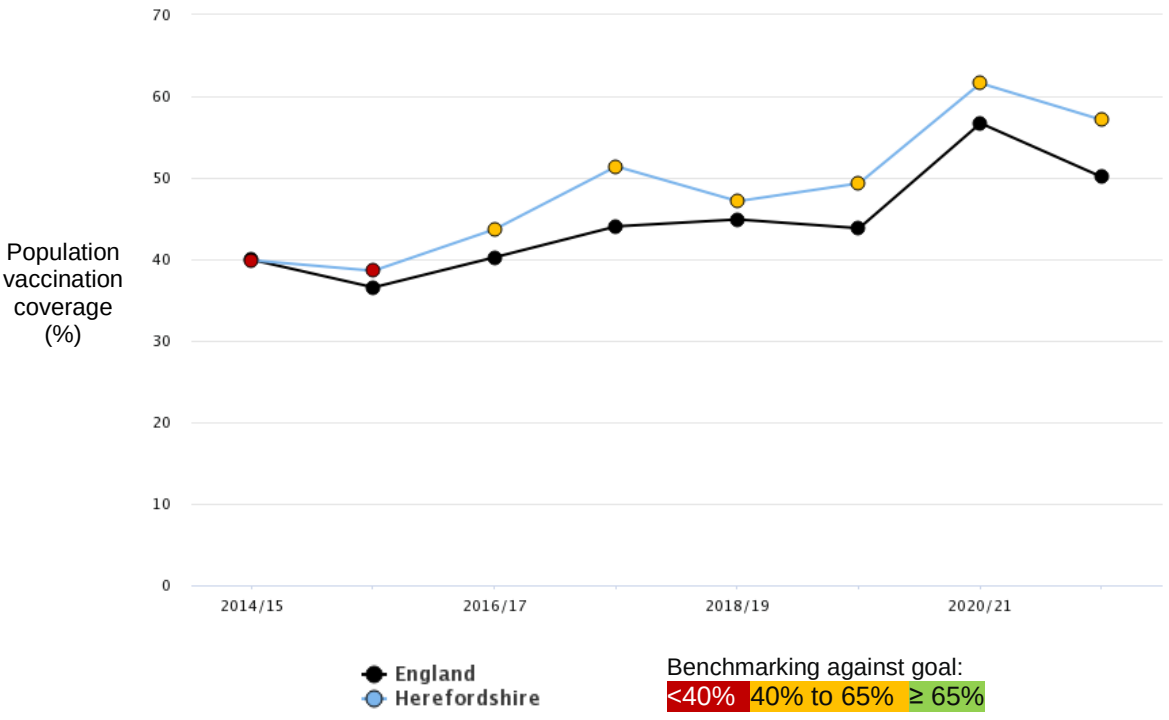


Table 5 shows that we have achieved and exceeded the >65% coverage target in the majority of school aged children who were within the initial priority cohort.

Table 5 Seasonal influenza vaccine uptake in children of school age from 1 September 2022 – January 2023

Above 65% coverage target				
Flu immunisation cohort	**Period**	**Local coverage**	**Comparator average**	
			Midlands	**England**
All eligible primary school aged children 4-11 years	2022-23	70.5%	53.4%	55.9%
All eligible secondary school aged children 11-14 yrs	2022-23	67.1%	40.8%	40.2%
Year Reception (4-5 years)	2022-23	70.2%	53.5%	56.3%
Year 1 (5-6 years)	2022-23	68.8%	53.6%	56.%
Year 2 (6-7 years)	2022-23	70.0%	54.7%	57.2%
Year 3 (7-8 years)	2022-23	71.4%	54.5%	56.9%
Year 4 (8-9 years)	2022-23	73.4%	53.0%	55.9%
Year 5 (9-10 years)	2022-23	71.0%	53.0%	55.3%
Year 6 (10-11 years)	2022-23	68.6%	51.8%	53.8%
Year 7 (11-12 years)	2022-23	68.0%	44.4%	43.5%
Year 8 (12-13 years)	2022-23	67.7%	39.5%	39.4%
Year 9 (13-14 years)	2022-23	65.4%	38.6%	37.5%

Below 65% coverage				
Immunisation	**Period**	**Local coverage**	**Comparator average**	
			Midlands	**England**
All secondary school children aged 11-16 years	2022-23	42.8%	27.9%	26.8%
All school aged children 4- 16 years	2022-23	59.0%	43.4%	44.4%
Year 10 (14-15 years)	2022-23	1.1%	1.3%	1.1%
Year 11 (15-16 years)	2022-23	1.5%	1.2%	1.0%

Source: UKHSA

Although coverage was low for both Year 10 and Year 11 cohorts it was still above the England and Midlands average. These cohorts were not listed as a priority group within the National Flu Immunisation Letter for 2022/23 and were therefore only eligible for vaccination if there was any remaining vaccine, subject to availability.

As Year 10 and Year 11 students were included within the data it therefore reduced local coverage figures giving a false representation of accurate coverage for the following two indicators:

- All secondary school children aged 11 – 16 years
- All school aged children 4 –16 years

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Routine adult immunisations

Summary

- Shingles vaccination (71 years) and pneumococcal polysaccharide vaccination (PPV) coverage are below the England average and benchmark target for 2021/22.
- Flu vaccination in those aged 65 years and over exceeded the England average and national benchmark target in 2021/22.

- As of 1 September 2023, more people will be eligible to receive the shingles vaccine. Further work is therefore required to increase awareness and coverage in both new and existing cohorts.

Background

Many of the vaccines we receive as children can create immunity and last a long time. However, as we age immunity may fade or we may become more susceptible to diseases and therefore require a vaccination to provide protection.

For some adults, such as those not in an at-risk group or who have not been pregnant, this may be their first vaccination that they have been invited to attend since childhood. In the UK, adults are routinely offered three vaccinations as part of the NHS vaccination schedule, these are outlined in Table 6.

Table 6 NHS vaccination schedule for adults

Age offered	Vaccination	Helps protect against	Provided by
65 years old	Pneumococcal polysaccharide vaccine (PPV)	Pneumonia and meningitis	GP Practice
65 years and every year after	Flu vaccine	Influenza (flu)	GP Practice or Community Pharmacy
70 to 79 years	Shingles vaccine	Shingles (varicella-zoster virus)	GP Practice

Performance

Table 7 shows adult vaccination coverage from the most recent year where information is available. Each immunisation has different coverage goals so cannot be compared like for like.

Table 7 Adult vaccination coverage summary

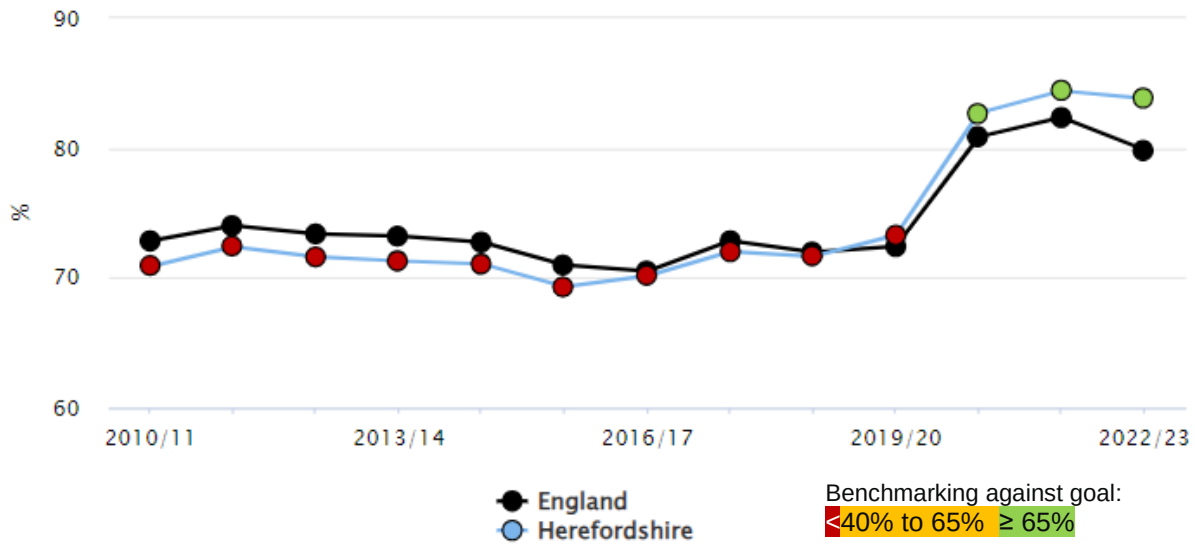
Indicator	Period	Coverage %			National benchmark coverage goal %		
		Herefordshire	CIPFA	England			
PPV coverage	2021/22	68.4%	NA	70.6%	<65%	65-75%	>75%
Flu aged 65 and over vaccination coverage	2022/23	83.8%	NA	79.9%	<75%		>75%
Shingles vaccination coverage (71 years)	2021/22	37.8%	45.7%	44.0%	<50%	50-60%	≥60%

Source: Public Health Outcomes Framework (PHOF)

Coverage across the three vaccinations is mixed with only one vaccination exceeding the set benchmark coverage goal.

Figure 5 shows, flu vaccination coverage in those aged 65 years has varied between 82% and 84% over the last 3 years (2020-2023) and exceeded the national coverage goal of over 75% each year. Although coverage was in-line with the national trend, the increase in uptake coincides with the COVID-19 pandemic. Research showed that some people, coinfection of COVID-19 and flu increases the risk of complications and death.

Figure 5 population vaccination coverage for flu vaccination in 65 years and over in Herefordshire

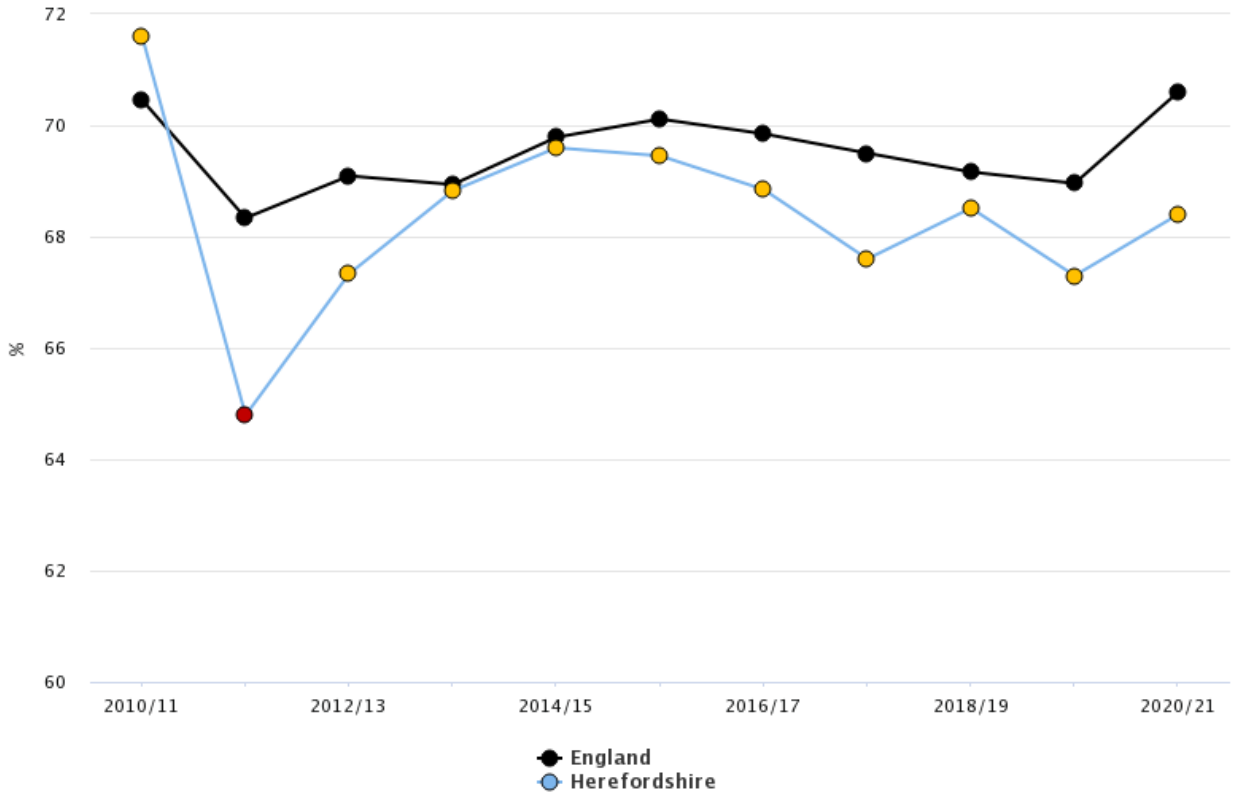


Source: Public Health Outcomes Framework (PHOF)

As indicated within Figure 6, there has been no significant change in PPV coverage in Herefordshire in recent years. Since 2012-13, coverage has constantly been within the 65% to 75% benchmark goal.

Out of sixteen CIPFA areas, Herefordshire is one of thirteen which are within the 65% to 75% coverage. Only three out of the sixteen Local Authority areas achieved ≥75% in 2020-21.

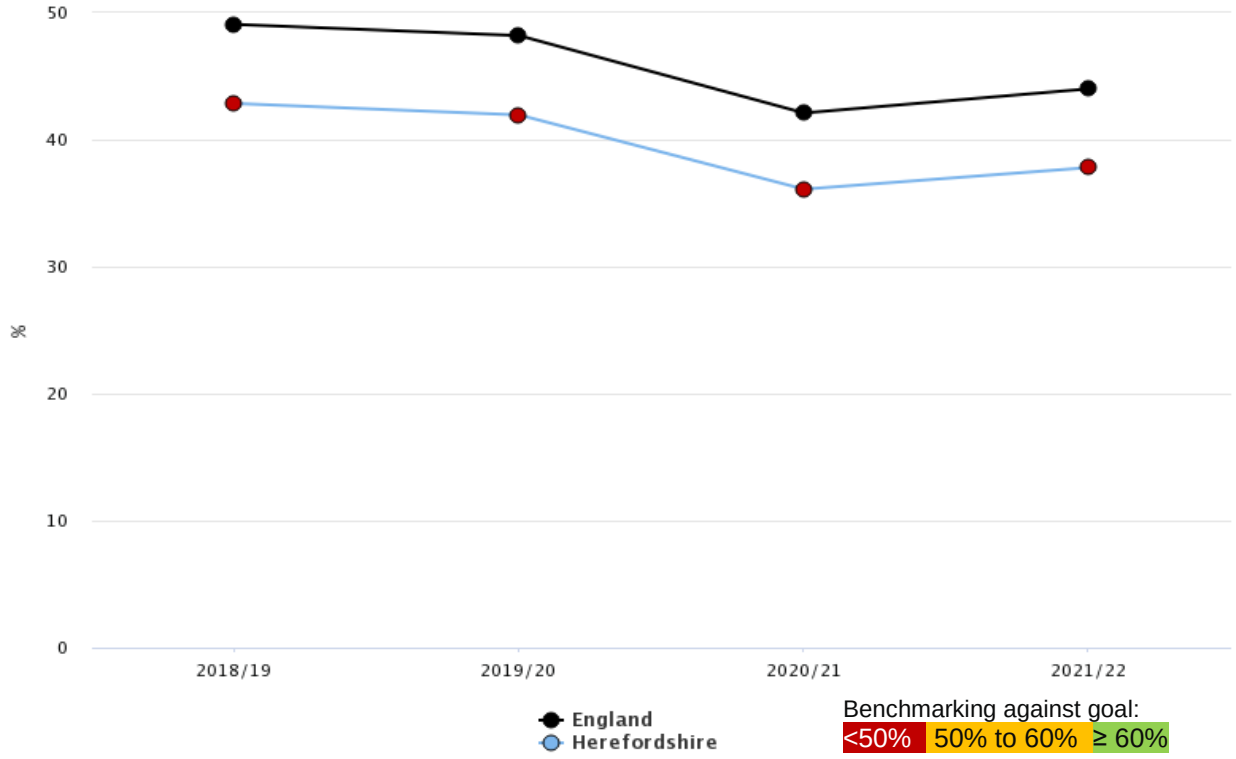
Figure 6 PPV population vaccination coverage in Herefordshire



Source: Public Health Outcome Framework (PHOF)

As Figure 7 shows, shingles vaccination coverage in Herefordshire has been slowly declining since 2018-19. Herefordshire are one of thirteen CIPFA nearest neighbours which are within 50% coverage. Only four out of the sixteen Local Authority areas achieved ≥60% in 2020-21.

Figure 7 Shingles vaccination overage in Herefordshire (71 years) by financial year



Source: Public Health Outcomes Framework (PHOF)

From 1 September 2023, more people will be eligible to receive the shingles vaccine. As well as people aged 70 to 79 the following individuals will also be eligible:

- Those aged 65 years (turned 65 before 1 September 2023)
- Those aged 50 or over and have a severely weakened immune system

In order to address and increase vaccination awareness in newly eligible, and existing cohorts, further work across the ICS is required in order to address low uptake.

Selective immunisation programmes

Summary

- Flu vaccination uptake remains low in pregnant women

Background

There are a number of selective immunisation programmes that target children and adults who are at particular risk of serious complications from certain infections, such as hepatitis B, influenza, meningococcal and pneumococcal infection.

Other vaccines, including BCG, HPV, hepatitis B and hepatitis A, are also recommended for individuals at higher risk of exposure to infection, due to lifestyle factors, close contact or recent outbreaks in their community

Individuals at risk of exposure through their work should be advised about any required vaccinations by their employer or their occupational health service and are therefore excluded from this report.

A summary of selective immunisation programmes are outlined in Figure 8.

Figure 8 Individuals eligible for NHS selective immunisation programme

Target group	Age and schedule	Disease	Vaccine
Babies born to hepatitis B infected mothers	At birth, 4 weeks and 12 months	Hepatitis B	Hepatitis B (Engerix B/HBvaxPRO)
Infants in areas of the country with tuberculosis (TB) incidence >= 40/100,000	Around 28 days old	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country	Around 28 days old	Tuberculosis	BCG
Children in a clinical risk group	From 6 months to 17 years of age	Influenza	Live Attenuated Influenza Vaccine (LAIV) or inactivated flu vaccine if contraindicated to LAIV or under 2 years of age
Pregnant women	At any stage of pregnancy during flu season	Influenza	Inactivated flu vaccine
	From 16 weeks gestation	Pertussis	dTaP/IPV (Boostrix-IPV)

Performance

Nationally, pregnant women remains one of the lowest cohorts for flu vaccination uptake. From 1 September 2022 – 28 February 2023 only 35.0% of pregnant women in England obtained the flu vaccine. Herefordshire mirrored this with an uptake of 35.1%.

Population screening programmes

Summary

- H Herefordshire typically performs similarly to the national average across most national screening programmes, and tracks their long-term upward or downward trends.
- The programmes were differentially affected by the pandemic. For example, antenatal and new-born screening (ANNB) screening, cervical screening and bowel screening were minimally impacted.
- By contrast, Abdominal Aortic Aneurism (AAA) screening, diabetic eye screening programme (DESP) and Breast screening were more impacted, building up significant backlogs.

- The breast cancer screening programme in particular went from stably achieving over 75% coverage before 2019, to less than 60% in 2021 and 2022.
- Cervical cancer screening coverage is also on a downward trend, reducing about 5% over a decade both in Herefordshire and nationally.
- In 2024 the focus is on improving backlogs from the pandemic and maintaining focus on known inequalities in screening update during that recovery. This will take local and national action, including implementation of the National Screening Strategy, due shortly.

Background

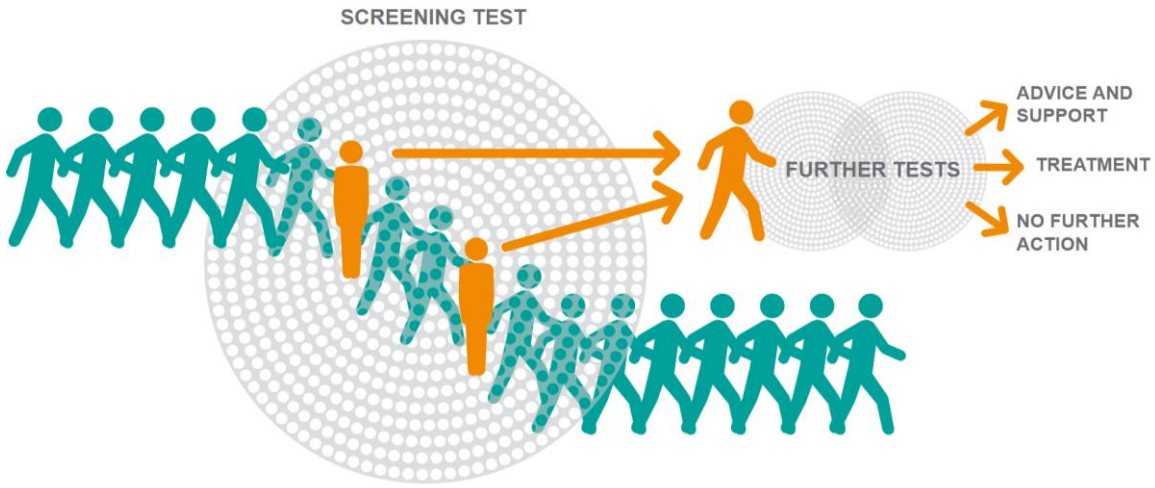
Screening is the process of identifying apparently healthy people who may have an increased chance of a disease or condition. The NHS offers a range of screening tests to different sections of the population who are most likely to benefit from it. It is an individual's choice whether or not to have screening, people can opt out if they do not want to receive screening invitations.

Screening can:

- save lives or improve quality of life through early identification of a condition;
- reduce the chance of developing a serious condition or its complications;
- give pregnant women informed reproductive choice.

Figure 9 illustrates the current screening process. Most people will pass through the screening test and get a normal result (a screen negative result) and therefore are at low risk of having the condition that they are being screened for. However, some people may receive a higher-risk result (a screen positive result) which means that they may have the condition which they have been screened for. At this point individuals will be offered further diagnostic tests to confirm if they have condition. They will then be offered treatment, advice and support.

Figure 9 Illustration of the screening process



Screening is a way of finding out if people have a higher chance of having a health problem, so that early treatment can be offered or information given to help them make informed decisions. NHS England commissions 6 national screening programmes as summarised in Table 1.

The UK National Screening Committee (UK NSC) advises the NHS, in all 4 UK countries, on which screening programmes to offer. In England, 6 national screening programmes are commissioned by NHS England. These programmes and providers are listed in *Table 8*.

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Table 8 NHS Screening Programmes commissioned by NHS England

Screening programme	Programme details	Provider
Breast cancer screening	Offered to women aged 50 – 70 years, every 3 years to detect early signs of breast cancer. Women over 70 can self-refer.	Worcestershire Acute Hospitals NHS Trust (WAHT)*
Bowel cancer screening	Currently offered to everyone aged 60 to 74 every 2 years. Men over 75 years can self-request a screening kit every 2 years. Since 2021, the programme has been gradually expanded over a 4 year period to include all those aged 50 to 59 years.	WAHT*
Cervical cancer screening	Offered to all women and people with a cervix aged 25 to 64 years to check the health of cells within the cervix. It is offered every 3 years for those aged 25 to 49 and every 5 years for those aged 50 to 64 years.	GP practices
Diabetic Eye screening (DESP)	Diabetics from the age of 12 are offered an annual diabetic eye test to check for early signs of diabetic retinopathy.	NEC Care **
Abdominal Aortic Aneurism (AAA) screening	Offered to men during the screening year (1 April to 31 March) that they turn 65 to detect abdominal aortic aneurysms (a dangerous swelling in the aorta). Men over 65 can self-refer.	WAHT*
Antenatal and New-born screening (ANNB)	Screening in pregnancy: • Infectious diseases • Down's syndrome, Patau's syndrome and Edwards syndrome • Sickle cell disease and thalassaemia • 20-week scan for physical development of the baby New-born screening: • Physical examination • Hearing test • Blood spot (9 rare conditions)	Wye Valley NHS Trust – maternity service

**joint Herefordshire and Worcestershire programme*
*** Recently completed a procurement exercise, this Provider will cease as of 30th September 2023 with a new DESP Provider (In Health Intelligence Ltd) commencing as of 1st October 2023- Mobilisation of the new Contract Award is currently under way.*

Performance

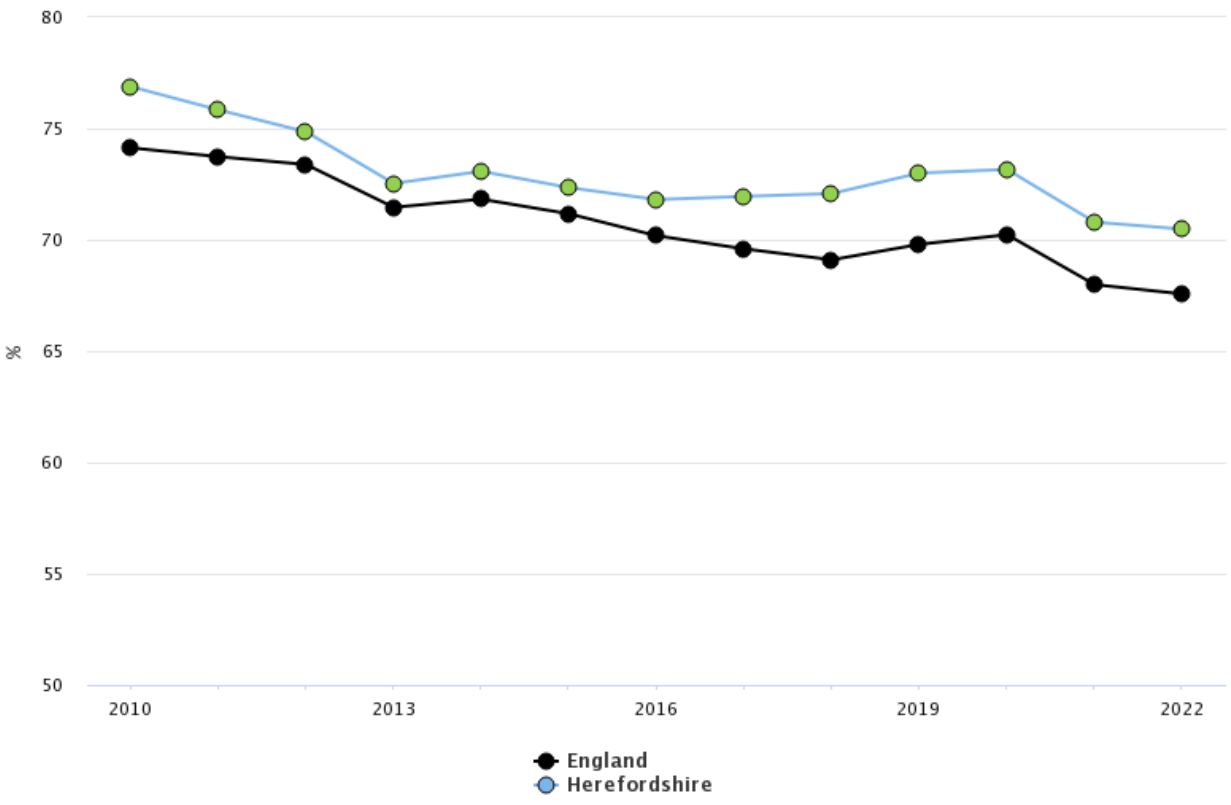
This report presents a selection of published performance data. It concentrates on uptake/coverage (proportion of those eligible or invited that attend screening) rather than service performance (eg: timeliness of results letters being sent out). Most data relates to Herefordshire only but only up to 2022. DESP data relates to the whole programme covering Arden, Herefordshire and Worcestershire.

Cervical cancer (aged 25 – 49 years old)

Cervical screening checks the health of your cervix and helps find any abnormal changes before they can turn into cancer. All women aged 25 to 64 are invited by letter to cervical screening (a smear test) to check the health of their cervix. During the screening appointment, a small sample of cells are taken from the cervix. The sample is checked for certain types of human papillomavirus (HPV) that can cause changes to the cells in the cervix. These are called "high risk" types of human papillomavirus (HPV).

Figure 10 Cancer screening coverage: cervical cancer (aged 25 – 49 years old) in HerefordshireFigure 10 outlines cervical cancer screening coverage for those aged 25-49 years old in Herefordshire. In 2022, 70.5% of those who were eligible were screened. Although this is significantly better than the England average (67.6%) it below the acceptable performance coverage level of 80% or greater. Herefordshire coverage is following a similar decreasing trend to England. Statistical neighbour comparison data is not available for this indicator.

Figure 10 Cancer screening coverage: cervical cancer (aged 25 – 49 years old) in Herefordshire

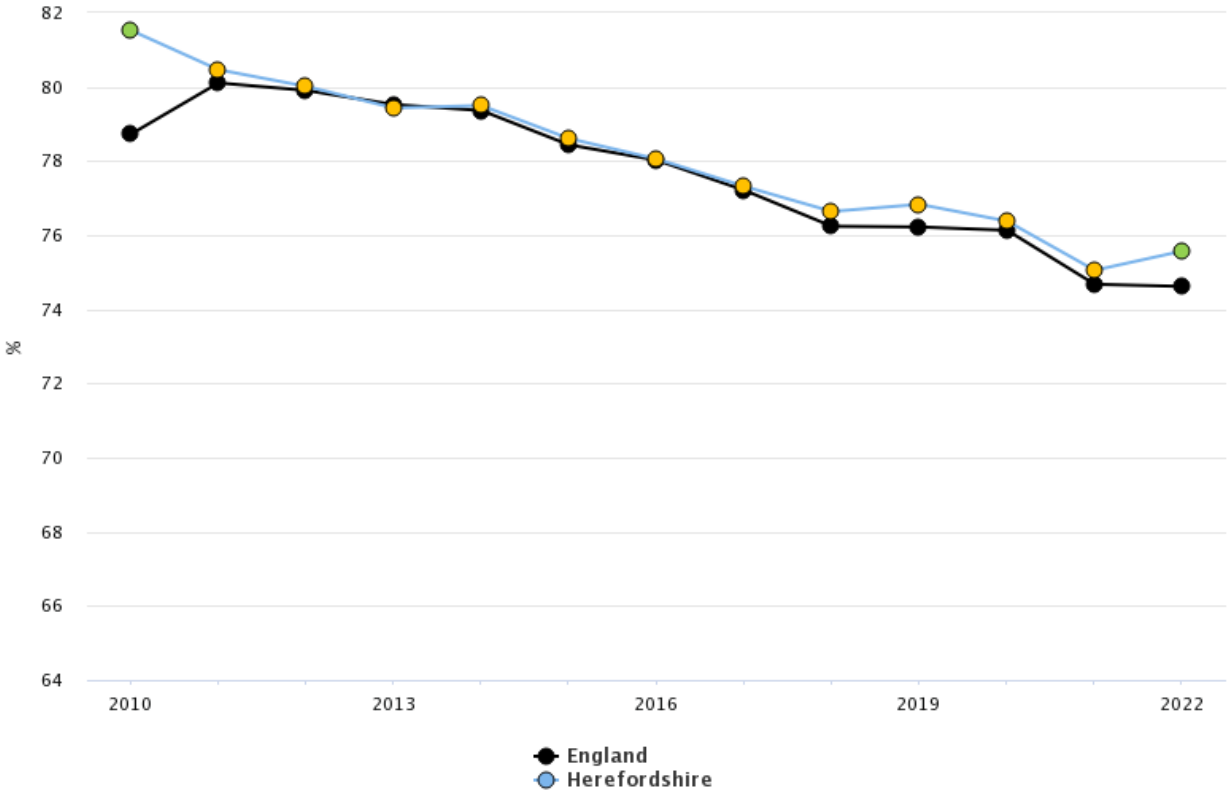


Source: [Public Health Outcomes Profile (PHOF)]

Cervical cancer (aged 50 – 64 years old)

As Figure 11 indicates, local coverage (75.6%) in the 50 – 64 year population is higher than that of England (74.6%) but still below the acceptable coverage target of 80%. Up until 2022, Herefordshire had been mirroring England with a slow decline in screening coverage. Statistical coverage data shows that Herefordshire is within range of its neighbours, their coverage for 2022 ranges between 74.6% - 77.8%.

Figure 11 Cancer screening coverage: cervical cancer (aged 50 to 64 years old) for Herefordshire



Source: Public Health Outcomes Profile (PHOF)

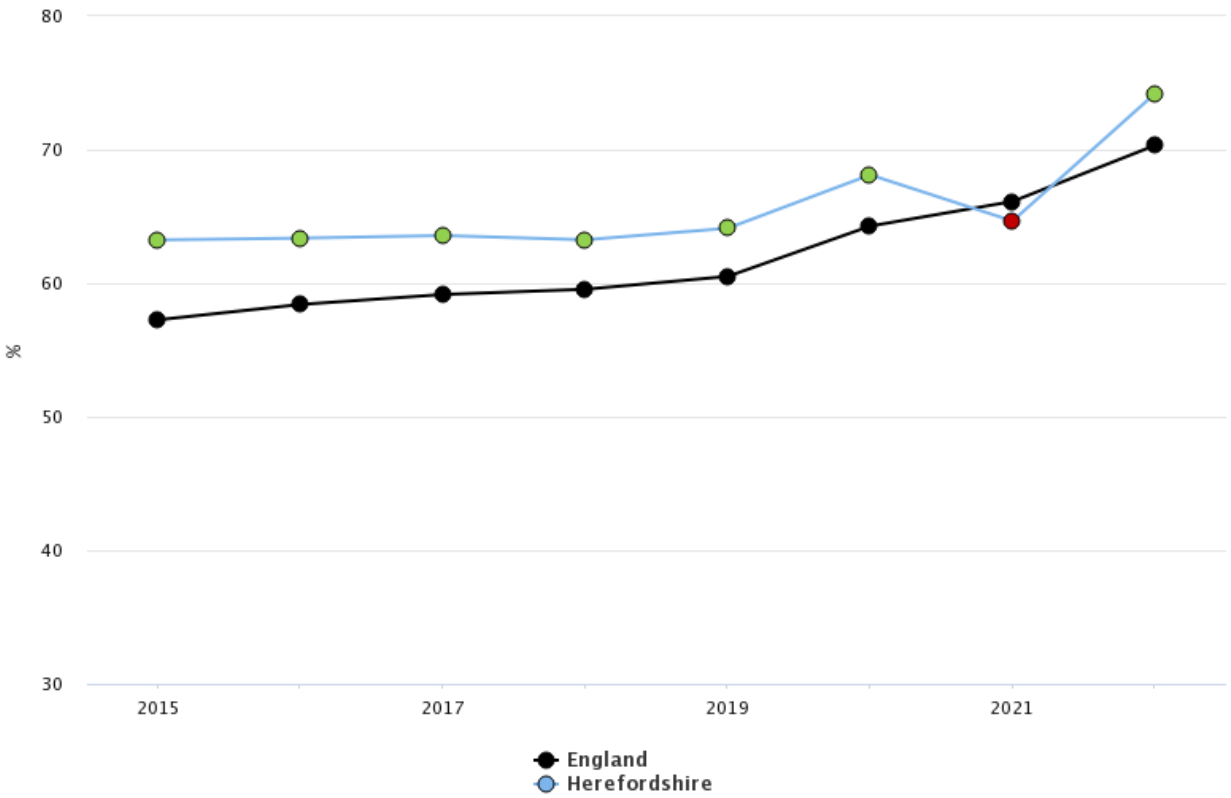
Bowel cancer

Bowel cancer is the 4th most common type of cancer. Screening can help prevent bowel cancer or find it at an early stage, when it's easier to treat. Those eligible are automatically sent a home test kit, called a faecal immunochemical test (FIT), every 2 years to collect a small sample of faeces and send it to a lab. This is checked for tiny amounts of blood. Blood can be a sign of polyps or bowel cancer. Polyps are growths in the bowel. They are not cancer, but may turn into cancer over time. Regular NHS bowel cancer screening reduces the risk of dying from bowel cancer.

Figure 10 Cancer screening coverage: cervical cancer (aged 25 – 49 years old) in HerefordshireFigure 12 outlines bowel cancer screening coverage in Herefordshire. In 2022, 74.2% of those eligible were screened. Local uptake is not only better than the England average (70.3%) but it also met both the acceptable uptake target of 52% and achievable target of 60%.

In line with England trends, bowel screening coverage is increasing locally. Statistical coverage data shows that Herefordshire is within range of its five comparable neighbours, coverage for 2022 ranged between 73.3% - 77.6%.

Figure 12 Bowel cancer screening coverage for Herefordshire



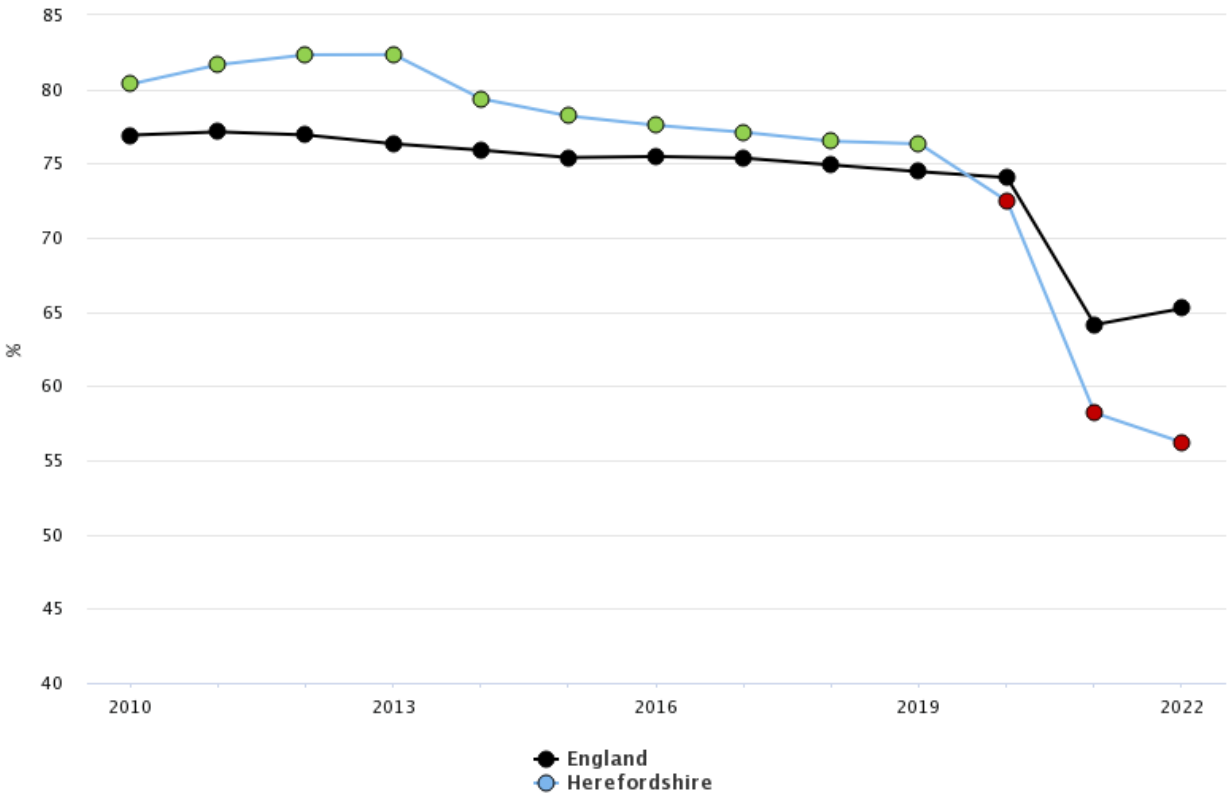
Source: Public Health Outcomes Framework (PHOF)

Breast cancer

Breast cancer is the most common type of cancer in the UK. The chance of getting breast cancer increases as you get older. Most breast cancers are diagnosed in women over 50 years old. NHS breast screening checks use X-rays (mammograms) to look for cancers that are too small to see or feel. Regular breast screening can find breast cancer before people notice any signs or symptoms.

As Figure 13 indicates, coverage in Herefordshire has slowly been declining since 2020. In 2022, local coverage was lower than that of England (65.2%) by 9%. Locally, screening uptake is also below the acceptable uptake target of 70% and achievable uptake target of 80%. When compared with its five statistical neighbours it is one of two counties which are below the England average.

Figure 13 Breast cancer screening coverage for Herefordshire



Source: [Public Health Outcomes Framework]

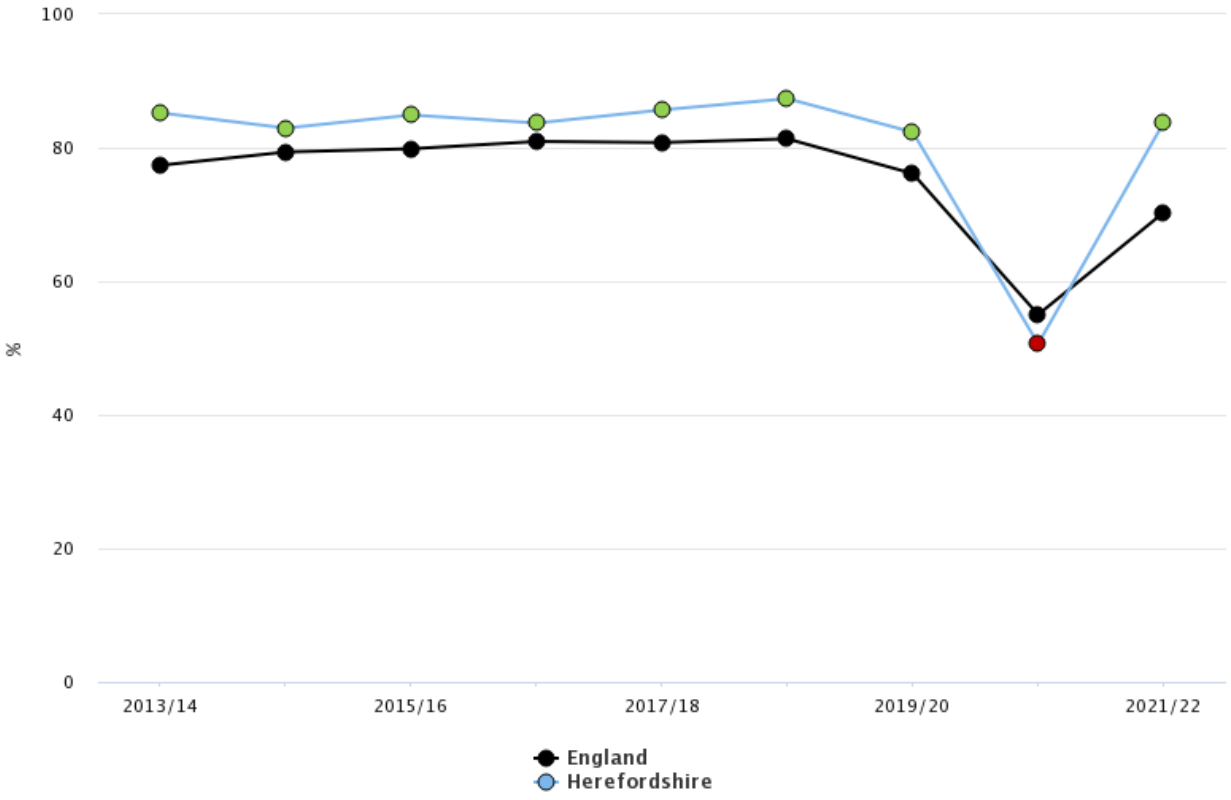
Abnormal Aortic Aneurysm Screening Coverage

Abdominal aortic aneurysm (AAA) screening is a way of checking if there's a bulge or swelling in the aorta, the main blood vessel that runs from your heart down through your abdomen. This bulge or swelling is called an abdominal aortic aneurysm, or AAA. Screening for AAA involves a quick and painless ultrasound scan of the abdomen

Men aged 65 or over are most at risk of getting AAAs. An AAA will often cause few or no obvious symptoms, but if it's left to get bigger, it could rupture and cause life-threatening bleeding inside your abdomen. About 8 in every 10 people who have a burst AAA die before they get to hospital or do not survive emergency surgery to repair it. Screening can pick up an AAA before it bursts. If an AAA is found, individuals can choose to have regular scans to monitor it or surgery to stop it bursting. Research suggests it can halve the risk of dying from an AAA.

Figure 14 show AAA screening locally (83.7%) is significantly higher than the England average (70.3%) and following a similar trend. Uptake in Herefordshire has exceed the acceptable coverage target of 75% but narrowly missed the achievable target of 85%. Statistical coverage data shows that Herefordshire is within range of its five comparable neighbours, coverage for 2022 ranged between 79.7% - 88.8%.

Figure 14 Abdominal Aortic Aneurysm (AAA) screening coverage for Herefordshire



Source: Public Health Outcomes Framework

Diabetic eye screening programme (DESP)

Diabetic eye screening is offered annually to anyone with diabetes who is 12 years old or over. A range of eye problems can affect people with diabetes one of these conditions is diabetic retinopathy. This is a complication of diabetes, which is caused by high blood sugar levels damaging the back of the eye (retina). Diabetic retinopathy can cause blindness if it is left undiagnosed and untreated.

DESP data relates to the whole programme coverage covering Arden, Herefordshire and Worcestershire. Herefordshire specific data is not available.

The proportion of those offered routine digital screening (RDS) who attended a RDS event where images were captured is captured is shown in Table 9. Although Arden, Herefordshire & Worcestershire is higher than the Midlands it is still below the England average by 2.7%.

Whilst Arden, Herefordshire & Worcestershire have achieved the acceptable uptake target of 75% they have not met the achievable uptake target of 85%.

Table 9 DESP performance by screening service, Q3 October 2022 to December 2022

Programme	Numerator	Denominator	Performance (%)
Arden, Herefordshire & Worcestershire	70,036	92,490	75.7%
Midlands	455,867	628,603	72.5%
England	2,356,894	3,009,511	78.3%

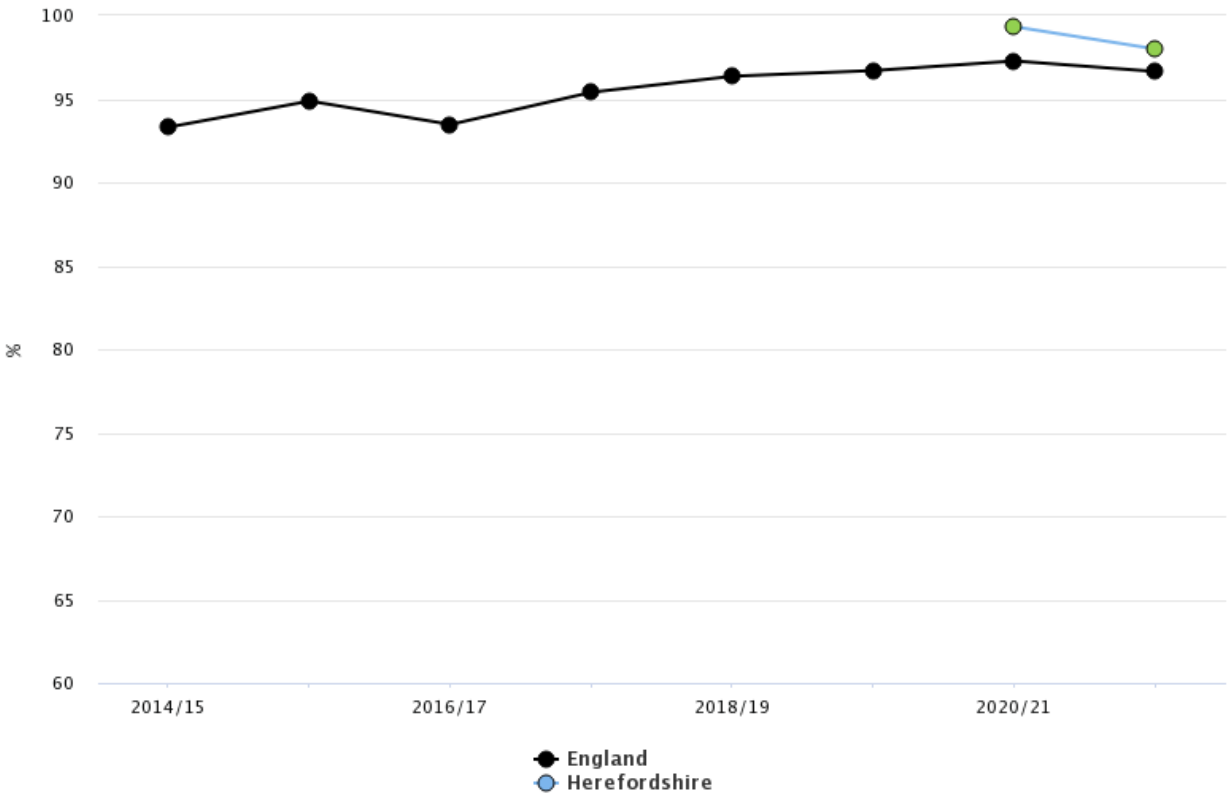
Source: NHS England

New-born Screening Coverage

All parents are offered a thorough physical examination for their baby within 72 hours of giving birth. The examination includes screening tests to find out if the baby has any problems with their eyes, heart, hips and, in boys, testicles (testes).

As Figure 15 indicates, data prior to 2020/21 is limited due to the implication of new data platforms. In 2021/22, 98.0% new-borns and infants were screened, this is above the national average of 96.6%. Statistical neighbour comparison data is not available for this indicator.

Figure 15 new-born and infant physical examination screening coverage for Herefordshire



Source: Public Health Outcomes Framework (PHOF)

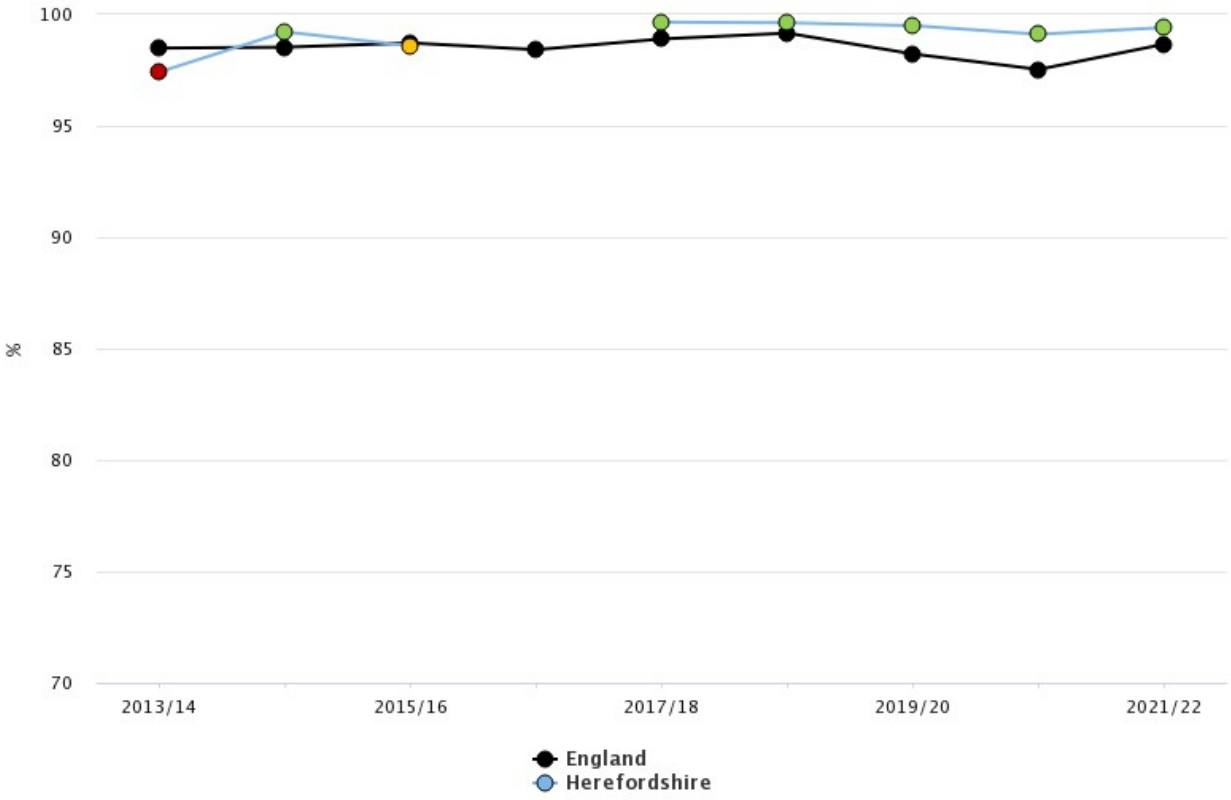
1 to 2 babies in every 1,000 are born with permanent hearing loss in 1 or both ears. This increases to about 1 in every 100 babies who have spent more than 48 hours in intensive care. Most of these babies are born into families with no history of permanent hearing loss. Permanent hearing loss can significantly affect babies' development. Finding out early can give these babies a better chance of developing language, speech and communication skills. Babies born in hospital maybe offered a new-born hearing best before discharge otherwise it is done by a health care professional

or health visitor within the first few weeks (ideally in the first 4 to 5 weeks, but it can be done up to 3 months of age).

As Figure 16 indicates Herefordshire has a high rate of new born hearing screening coverage. There has been no significant change in screening coverage. Since 2017/18 Herefordshire has been consistently above the England average. In 2021/22, screening coverage was 99.4%, although this above both the acceptable coverage target of 98% it is slightly below the achievable coverage target of 99.5%.

When compared to its nearest CSSNBT neighbours Herefordshire has the second highest coverage out of five areas (range 93.3% - 99.8%).

Figure 16 Newborn hearing screening coverage for Herefordshire



Source: Public Health Outcomes Framework

Every baby is offered new-born blood spot screening, also known as the heel prick test, ideally when they're 5 days old. New-born blood spot screening involves taking a blood sample to find out babies have 1 of 9 rare but serious health conditions such as sickle cell disease, cystic fibrosis, congenital hypothyroidism and inherited metabolic diseases. Most babies won't have any of these conditions but, for the few who do, the benefits of screening are enormous. Early treatment can improve their health, and prevent severe disability or even death.

Achievements

Screening services have worked well to clear backlogs from the pandemic and to implement expansion of some programme such as age extension in bowel screening.

Risks

The key risks tend to be around workforce especially in some specialist fields. NHS England is working closely with ICBs, Cancer Boards and the national team to mitigate these risks.

Programmes are regularly reviewed through Programme Boards and also receive NHS England SQAS (Screening Quality Assurance Service) quality visits where the whole pathway is reviewed and recommendations are made with implementation monitored by SQAS and commissioners.

Future focus

In 2023/24 the key focus/priorities are to:

- emphasise on health inequalities and coverage/uptake now that backlogs from the pandemic are reduced
- working more closely with Integrated Care Systems and Cancer Boards to leverage change
- implementation of the National Screening Strategy when it is published
- implement 2023/24 programme changes

COVID-19

Summary

- COVID-19 vaccination remains the most important tool in reducing the risk of ill health as a result of COVID infection, particularly in those at higher risk of worse outcomes from infection due to age, existing illness or other vulnerability.
- As of 23 September 2023; 437,165 COVID-19 vaccinations have been taken up in Herefordshire.
- A total of 19,211 (75%) of eligible people have received a spring 2023 booster, higher than the England average of 70%.
- Our future focus will be to continue to promote COVID-19 vaccination to those who are eligible, where season boosters are recommended and available.

Background

Coronaviruses are a large family of viruses that usually cause mild to moderate upper-respiratory tract illnesses in humans. However, to date the following three coronaviruses have caused more serious and fatal disease in people:

- SARS coronavirus (SARS-CoV) which emerged in November 2002 and causes severe acute respiratory syndrome (SARS);
- MERS coronavirus (MERS-CoV) which emerged in 2012 and causes Middle East respiratory syndrome (MERS);
- SARS-CoV-2, which emerged in 2019 and causes coronavirus disease 2019 (COVID-19).

SARS-CoV-2, also known as COVID-19, was identified Chinese city of Wuhan in December 2019. Despite attempts to contain it spread to other countries and on the 30 January 2023 the World Health Organsiation (WHO) declared the outbreak as a public health emergency of international concern (PHEIC).

Anyone can get sick with COVID-19 and become seriously ill or die, but most people will recover without treatment. However, people over the age of 60 and those who have pre-existing health problems are at higher risk of getting seriously ill and developing complications from COVID-19.

Over 760 million cases and 6.9 million deaths have been recorded worldwide since December 2019, but the actual number is thought to be higher.

In Herefordshire, Herefordshire Council, the Clinical Commissioning Group (now known as integrated Care Boards) and Public Health England (now known as UK Health Security Agency)

worked in partnership to support settings with high risk cases, or outbreaks of COVID-19, in their settings. Common settings where an outbreak response was required included care homes (residential and nursing); domiciliary care settings; supported living settings; early years and education settings; healthcare settings and workplaces.

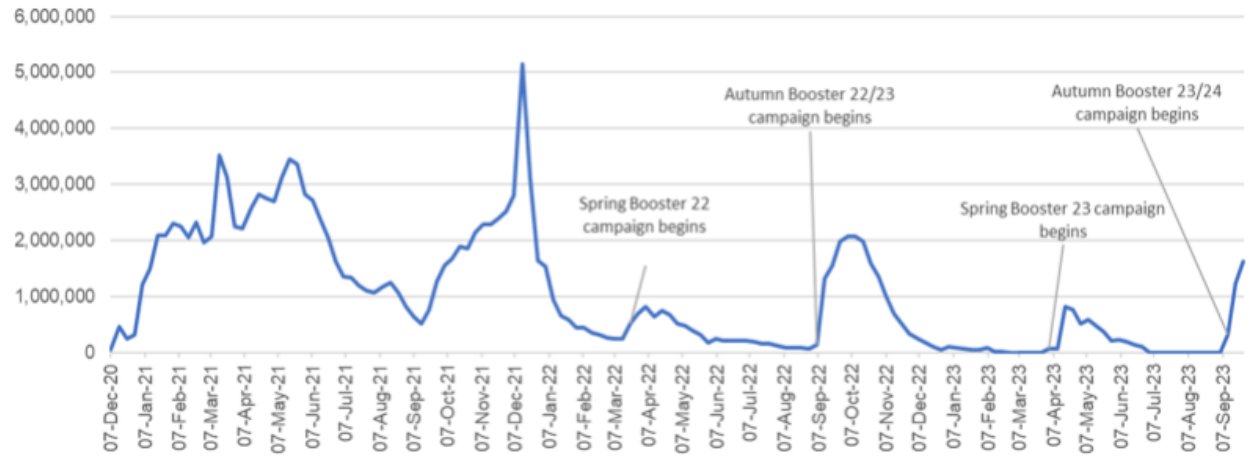
Surveillance and performance

COVID-19 vaccination

Figure 17 details the roll out of the COVID-19 vaccination programme in the UK to date. In Herefordshire:

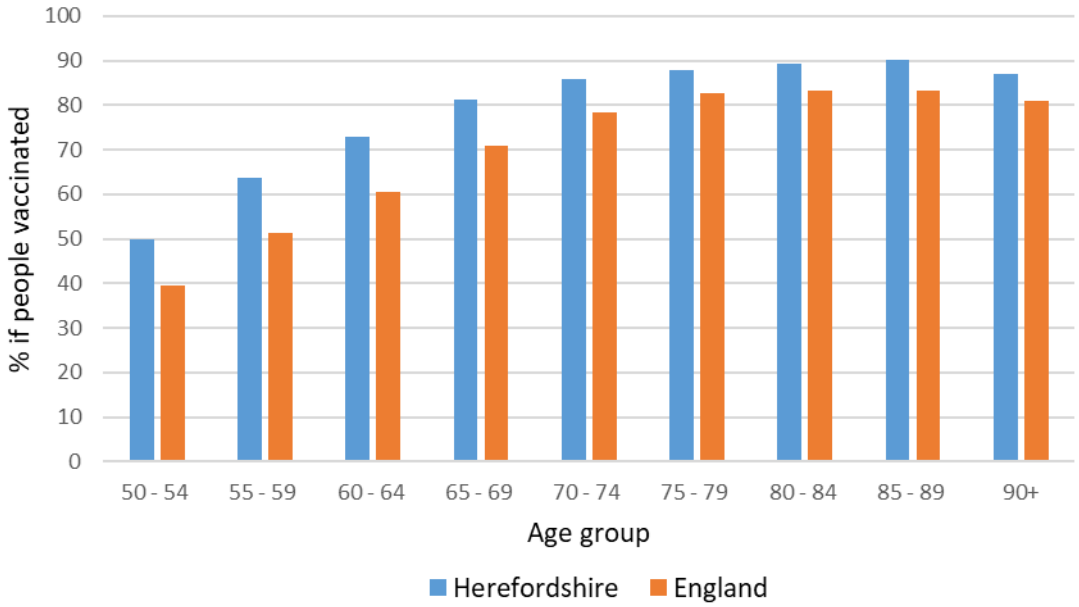
- A total of 437,165 vaccinations have been given as of the 23 September 2023.
- A total of 19,211 (75%) people received a spring 2023 booster by the end of 27 September 2023. This is higher than the England average of 70%. Of this:
    - 69.5% of people aged 75 years and over received a spring booster COVID-19 vaccination. Uptake of the spring booster was highest in 85-89 year group (77.8%). This was closely followed by the 80-84 year group (77.4%) and 90 year plus age group (75.1%).
- Nationally, rates for unvaccinated adults were higher for Black Caribbean, Black African and White Other ethnic groups. Rates were also higher for those living in deprived areas, who have never worked or are long-term unemployed, who are limited a lot by a disability, who identify as Muslim or as having an “Other Religion”, or who are male

Figure 17 Number of COVID-19 vaccinations by week of vaccination in England, 8 December 2020 to 1 October 2023



Source NHS England

Figure 18 Percentage of people in Herefordshire who have received an autumn 2022 booster COVID-19 vaccination by age group up until 27 September 2023



Risks

- Possible future pandemic threats

Future priorities

- Herefordshire Council to develop and implement a pandemic threat plan
- To continue to promote COVID-19 vaccination to those who are eligible, where season boosters are recommended and available.

Sexual health

Summary

- Overall, the rate of sexually transmitted infections diagnosed among residents of Herefordshire in 2023 (322 per 100,000) was less than half the England average (694 per 100,000).
- Specific areas where Herefordshire does less well than England include HIV testing, the number of people with a late HIV diagnosis, and the proportion of 15 – 24 year olds screened for chlamydia.
- Risks include recruitment and retention of sexual health staff due to Herefordshire's rural location and patient access to sexual health services
- The focus for 2024 includes further promotion of sexual health screening in schools, and investigating the reasons behind the HIV testing and late diagnosis figures. New services are planned, including a new virtual clinic, as well as a review our young person's walk in clinic, to ensure it's meeting the needs of users.

Background

> Sexual health is fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries.
>
> - *World Health Organisation*

Certain population groups are particularly affected by poor sexual and reproductive health, this include young people; men who have sex with men; black and minority ethnic populations and women of reproductive age.

Sexual health services are commissioned at a local level to meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy.

Since 1 April 2023, Local authorities have been responsible for commissioning comprehensive open access sexual health services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Some specialised services are directly commissioned by integrated care systems (ICSs), and at the national level by NHS England, these commissioning responsibilities are outlined below.

Commissioning responsibilities		
Local Authorities	**ICS's**	**NHS England**
• comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception • STI testing and treatment, chlamydia screening and HIV testing • specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies	• most abortion services • sterilisation • vasectomy • non-sexual-health elements of psychosexual health services • gynaecology including any use of contraception for non-contraceptive purposes	• contraception provided as an additional service under the GP contract • HIV treatment and care (including drug costs for post-exposure prophylaxis following sexual exposure (PEPSE)) • promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs • sexual health elements of prison health services • sexual assault referral centres • cervical screening • specialist fetal medicine services

In Herefordshire, the Local Authority has commissioned Solutions 4 Health to deliver an integrated sexual health service until March 2024. Currently services are delivered under a single contract with a lead provider who the works in partnership, or subcontracts services to other organisations.

Following an extensive recommissioning process the new service for April 2024 onwards has been awarded to Solutions 4 Health. The contract is awarded on a new 5 year plus 2 year term contract.

Performance
Genitourinary Medicine Clinic Activity Dataset (GUMCAD) is the mandatory surveillance system for STIs and collects data on STI tests, diagnoses and services from all commissioned sexual health services in England.

UK Health Security Agency (UKHSA) are responsible for coordinating and managing data collection, processing, storage, analysis, and reporting of GUMCAD data on behalf of the Department of Health and Social Care (DHSC). All Local Authority commissioned specialist (level 3) and non-specialist (level 2) sexual health services are required to complete and return GUMCAD data to UKHSA.

All STI's

Overall, the number of new sexually transmitted infections (STIs) diagnosed among residents of Herefordshire in 2023 was 603. The rate was 322 per 100,000 residents, lower than the rate of 694 per 100,000 in England.

Herefordshire ranked 143rd highest out of 156 unitary authorities (UAs) for new STI diagnoses excluding chlamydia in those aged under 25 in 2022, with a rate of 184 per 100,000 residents, better than the rate of 322 per 100,000 for England.

In March 2020, in response to the Coronavirus Disease 2019 (COVID-19) pandemic, the UK Government implemented strict non-pharmaceutical interventions (NPIs) in the form of national and regional lockdowns, as well as social and physical distancing measures including an emphasis on staying at home. Sexual health services (SHS) in England had substantially reduced capacity to deliver face-to-face consultations but underwent rapid reconfiguration to increase access to STI testing via telephone or internet consultations. STI testing and diagnoses decreased across all infections during 2020. Testing levels largely recovered during 2021, while diagnoses overall remained lower. Larger decreases in diagnoses were observed for STIs that are usually diagnosed clinically at a face-to-face consultation, such as genital warts or genital herpes, when compared to those that could be diagnosed using remote self-sampling kits such as chlamydia and gonorrhoea.3 STIs continue to disproportionately impact gay, bisexual and other men who have sex with men (MSM), young people aged 15 to 24 years, and people of Black Caribbean ethnicity.

Chlamydia

Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group.

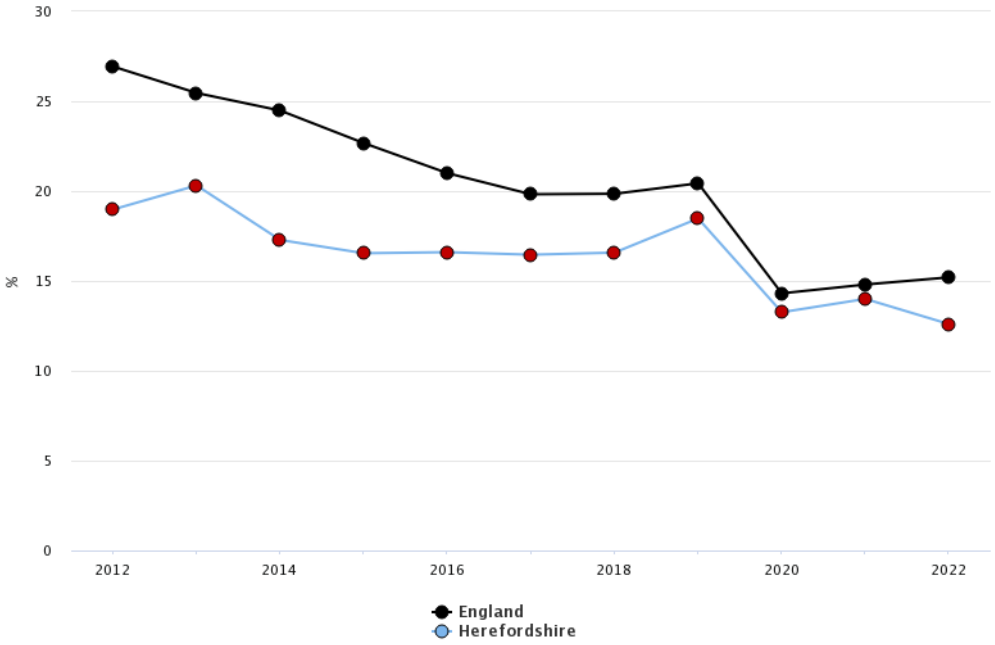
By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing chlamydia associated complications, and also reduce the amount of time someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. In June 2021, the NCSP changed to focus on reducing the harms from untreated chlamydia infection. These harms occur predominantly in young women and other people with a womb or ovaries - this includes transgender men, non-binary people assigned female at birth, and intersex people with a womb or ovaries.

As chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences.

As Figure 19 depicts, the proportion of 15 – 24 year olds screened for chlamydia both locally and nationally is decreasing. In 2022, 12.6% were screened locally compared to 15.2% in England. When comparing to its nearest CIPFA neighbours Herefordshire are one of thirteen counties and unitary authorities who are below the England average (range 9.1% - 14.7%). Only three counties and unitary authorities were above the England average (range 17.1% - 18.1%).

Figure 19 Chlamydia proportion (%) aged 15 – 24 screened in Herefordshire



Source: Public Health Outcomes Framework (PHOF)

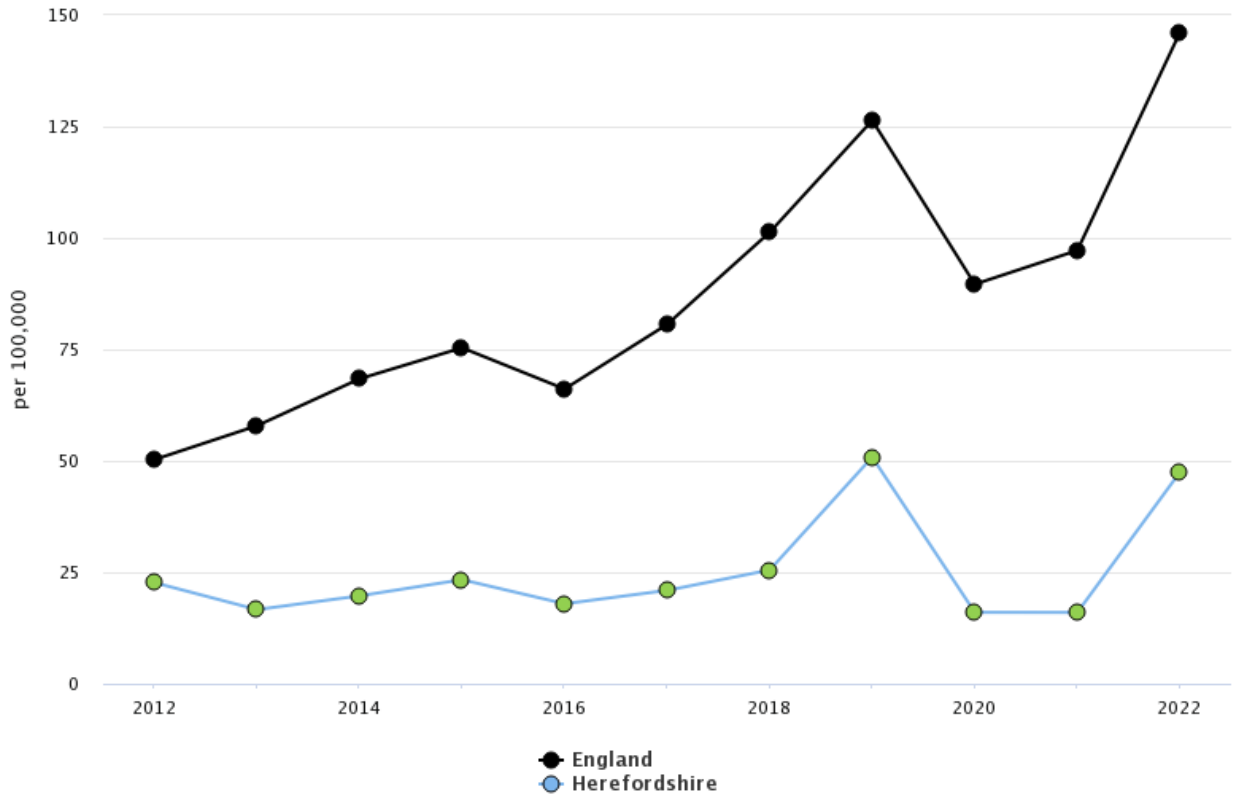
The chlamydia detection rate in 15 to 24 year olds in 2023 in Herefordshire was 1,107 per 100,000 population, this is lower than that of the England average (1,680 per 100,000) and the 2,300 NCSP target. When broken down by sex, the chlamydia detection rate is higher in females (1,554 per 100,000) than males (694 per 100,000 population) locally.

Gonorrhoea

The rank for gonorrhoea diagnoses (which can be used as an indicator of local burden of STIs in general) in Herefordshire was 145th highest (out of 150 UTLAs/UAs) in 2021.

As figure 7 depicts, Herefordshire has consistently mirrored the national trend for gonorrhoea diagnoses. In 2022, the rate per 100,000 was 47 which was better than the rate of 146 in England. A notable decrease was seen locally and nationally in 2021, this coincides with the COVID-19 pandemic and national restrictions.

Figure 20 Gonorrhoea diagnostic rate per 100,000 in Herefordshire



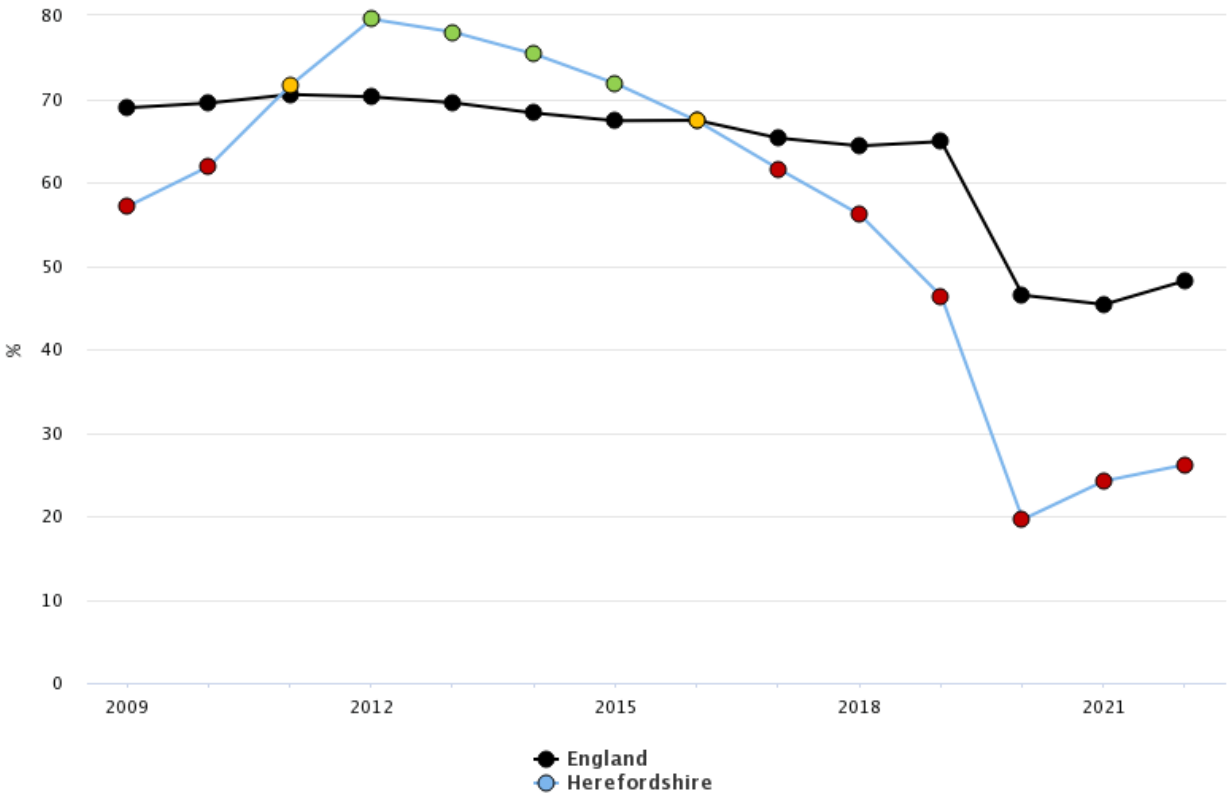
Source: Public Health Outcomes Framework (PHOF)

HIV

HIV testing is integral to the treatment and management of HIV infection. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of onward transmission.

As Figure 21 depicts, Herefordshire HIV testing coverage between 2012 – 2019 had been decreasing and getting worse. In 2022, 26.2% of eligible patients in Herefordshire were tested for HIV, this is worse than the England average of 48.2%. When compared to CIPFA nearest 16 neighbours, Herefordshire is the lowest for HIV testing coverage. There is also a notable drop in testing coverage in 2020, this coincides with the COVID-19 pandemic and national restrictions.

Figure 21 HIV testing coverage for Herefordshire sexual health service (SHS) patients, 2009 – 2022.

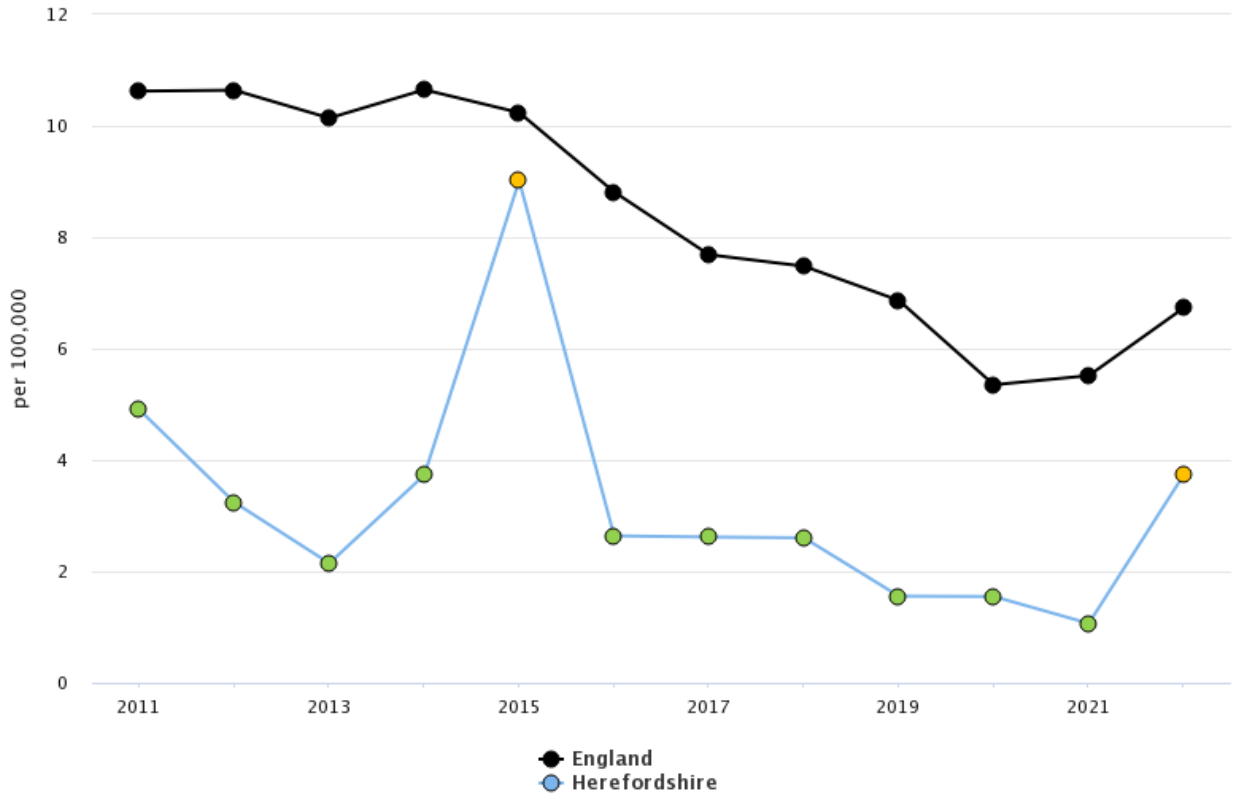


Source: ***Public Health Outcome Framework (PHOF)***

Between 2012 – 2019, HIV testing coverage in women had been slowly decreasing in Herefordshire (76.9%, 2012 – 11.3%). Although, testing coverage increased by 3.7% between 2020 – 2022 (11.3%, 2022 – 15.0%, 2022) it is still significantly lower than the 2022 England average of 38.5%. Coverage has been consistently higher in both men (55.4%, 2022) and gay, bisexual and other men who have sex with men (80.5%, 2022).

As Figure 22 shows, the new HIV diagnosis rate per 100,000 (all ages) in Herefordshire saw a marked increase in 2022. Despite the recent local increase Herefordshire rates is still lower than that of England (6.7 per 100,000, 2022).

Figure 22 new HIV diagnosis rate per 100,000 (all ages) in Herefordshire, 2011 - 2022



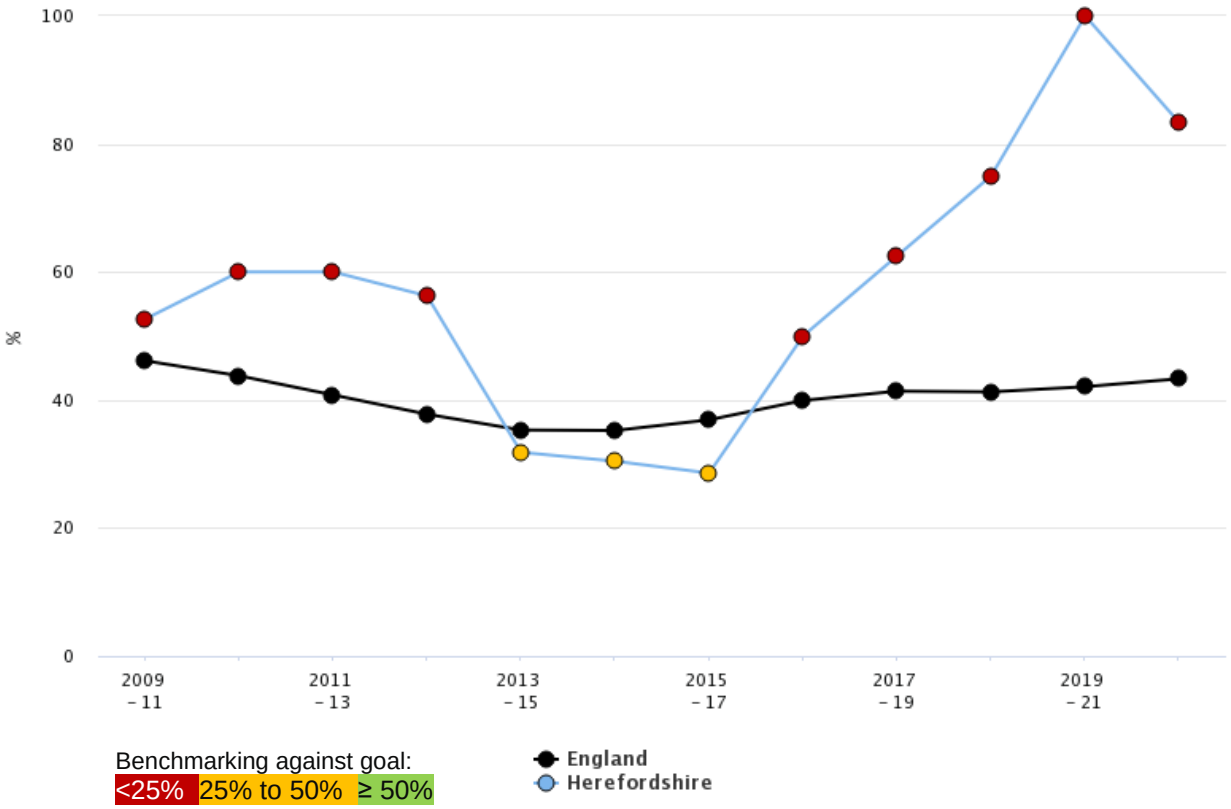
Source: [Public Health Outcomes Framework (PHOF)]

In Herefordshire, in the three year period between 2019 - 21, the percentage of HIV diagnoses made at a late stage of infection amongst those first diagnosed in the UK (all individuals with CD4 count ≤350 cells/mm3 within 3 months of diagnosis) was 100%, similar to 43.4% in England.

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Among those diagnosed in England, those diagnosed late in 2019 had more than a 7-fold increased risk of death within a year of diagnosis compared to those diagnosed promptly, and this indicator is essential to evaluate the success of expanded HIV testing.

As Figure 24 indicates, Herefordshire is above the threshold benchmark of ≥50% for the percentage of adults (aged 15 years +) with a late HIV diagnosis (newly diagnosed with HIV with a CD4 count less than 350 cells mm3 within 91 days of diagnosis, excluding those with evidence of recent seroconversion).

Figure 23 HIV late diagnosis in people first diagnosed with HIV in the UK for Herefordshire and England, 2009-11 to 2019-21



Source: Public Health Outcomes Framework (PHOF)

Risks

- Recruitment and retention of staff due to Herefordshire's rural location.
- Patient access to sexual health services

Future focus

- Continue to work in partnership with school nursing teams, colleges and Turning Point, in order to raise awareness and promote the sexual health service and its screening offer
- Explore reason for high HIV testing refusal rate
- Explore recent increase in late diagnosis in people first diagnosed with HIV in Herefordshire
- Roll out of a new virtual clinic with a remote working nurse in order to extend patient offer.
- Review of young person's walk in clinic to ensure that service is meeting their needs.

Drugs and alcohol

Summary

- Alcohol use accounts for the highest proportion of individuals seeking treatment locally
- There has been a rise in the number of drug and / or alcohol related deaths in Herefordshire. As a result, the Herefordshire Recovery Service is establishing a new Drug Related Death (DRD) panel
- Future focus includes building better links with GP practices and offering drop-in alcohol clinics and assessments from their premises to aid further referrals and promote the availability of support.

- Exploring and identifying ways to provide earlier intervention to alcohol users before they become dependent, to reduce the risk of them developing liver disease in the future.
- Continuing to provide training for other professionals regarding Brief Interventions, which can support early discussions about motivation to change.

Background

Drug misuse is a significant cause of premature mortality in the UK. Analysis of the Global Burden of Disease Survey 2013 shows that drug use disorders are now the third ranked cause of death in the 15 to 49 age group in England. Nearly one in nine deaths registered among people in their 20s and 30s in England and Wales in 2014 were related to drug misuse. Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase over these two years.

The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation. The reasons for this are not fully understood. People on a low income do not tend to consume more alcohol than people from higher socioeconomic groups. The increased risk is likely to relate to the effects of other issues affecting people in lower socioeconomic groups.

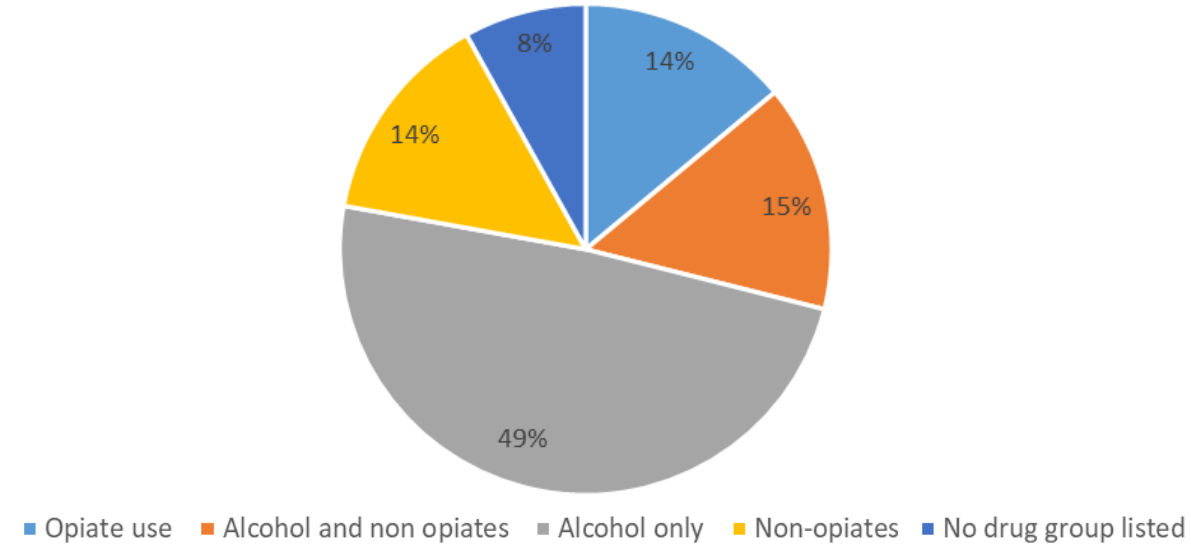
In order to reduce harms, and support people to rebuild their lives from drug and alcohol misuse, Turning Point have been commissioned by Herefordshire Council to provide the Herefordshire Recovery Service. This service provides an integrated drug and alcohol treatment service to people aged 11 years plus. In order to reduce inequalities the service offers support and interventions in community settings across the county.

Performance

During 2022-23 Turning Point had 695 services users referred to them for treatment. Of this:

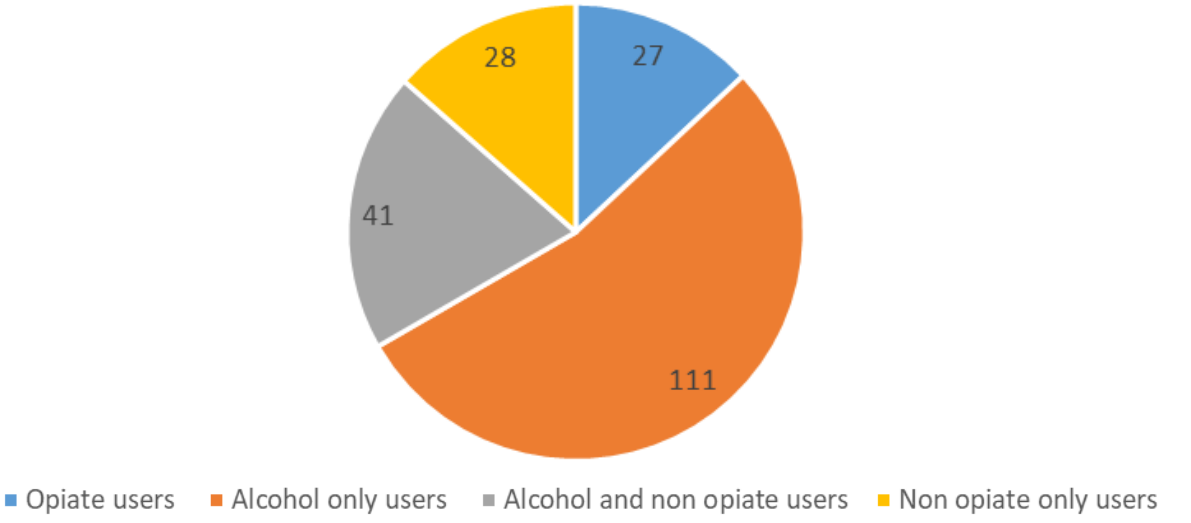
- The majority of these referrals were self-referrals, other referral sources included GP practices, hospitals and mental health services.
- As Figure 24 indicates, the majority of referrals (45%) were related to solely alcohol use.
- The majority of referrals received were for men (64%).
- 65% of those entering structured treatment successfully completed their treatment programme. As Figure 25 indicates, the highest number of completions were seen in alcohol only users.
- Turning point distributed over 200 naloxone kits
- Dispensed over 15,500 barrels, needles, and syringes through their needle exchange programme.
- Completed 365 dry blood spot tests to check for Hepatitis B, C and HIV status.

Figure 24 Percentage of referrals to Turning Point by drug type, 2022-23



Source: Turning Point

Figure 25 Number of Turning Point service users successfully completing drug treatment, by drug type, 2022-23

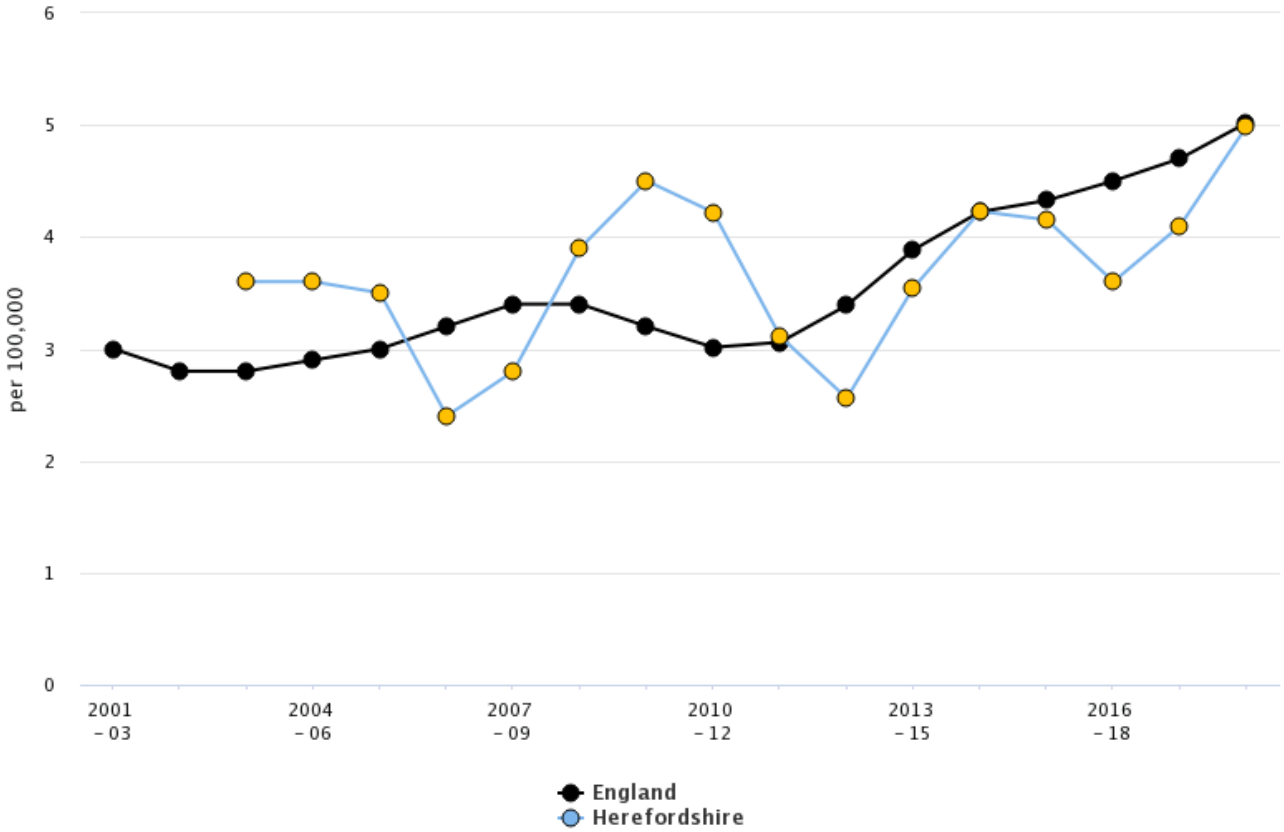


Source: Turning Point

As

Figure 26 indicates, latest data shows that drug related deaths in Herefordshire were the same rate as England (5.0 per 100,000 population) for the period 2018 - 20. 2018-20 marked the highest rate of deaths in Herefordshire since records began in 2003.

Figure 26 Deaths from drug misuse in Herefordshire (per 100,000 population), 2001-03 to 2018-20



Source: Public Health Outcomes Framework (PHOF)

During 2022-23 Turning Point service data identified 11 deaths which could be linked to drug or alcohol use. The majority of these deaths were linked to liver disease.

Locally, reducing drug and alcohol related deaths remains a priority. Turning Point are currently in the process of establishing a Drug Related Death (DRD) Panel, which will draw various agencies together to review drug related deaths in the county and ensure that learning is shared, which changes to local procedure where necessary. The panel will also support the roll out of additional harm reduction messages to key agencies, this includes naloxone training to prevent avoidable

opiate overdose, and champion for improvements in health inequality. The process will also include a 72-hour investigation period for all service user deaths, followed by a 60-day report where appropriate. So that any learning and service improvement actions can be shared and implemented.

The service also utilises a risk assessment process in line with their national governance framework, which supports staff to review static and dynamic risks, including overdose risk, suicide risk and deterioration of health. The service has several Multi-Disciplinary Team (MDT) pathways to review risk and discuss clinical treatment plans for dependent drinkers, injecting heroin users, those currently pregnant, and people with severe or enduring mental health issues.

Achievements

- Robust pathway in place with Hepatology where positive service users can be referred for hepatitis C treatment.
- Delivered a recent event in partnership with the Hepatitis C Trust to offer rapid-result testing for people at risk of infection
- Working towards micro-elimination of Hepatitis C within the county by providing hard to reach groups with regular testing events, incentivised testing, peer to peer support, targeted testing activity and opportunistic in service and at other services.

Future focus

- To build links with GP practices and offer drop-in alcohol clinics and assessments from their premises to aid further referrals and promote the availability of support.
- Explore and identify ways to provide earlier intervention to alcohol users before they become dependent to reduce the risk of them developing liver disease in the future.
- Explore and scope the offer of wider harm reduction advice to prevent other impacts of alcohol use, including societal risks i.e. domestic violence and offending behaviour).
- Continue to provide training for other professionals regarding Brief Interventions, which can support early discussions about motivation to change.
- Continue to work towards micro-elimination of Hepatitis C within the county.
- Preparing to deliver a pilot of Buvidal (prolonged-release Buprenorphine injection), which will initially include 10 service users, including those who we struggle to engage, those who are classed as ‘stable’ (i.e. working full-time), and those who live in more remote areas and are unable to access pharmacies daily. Previous pilots of this scheme in other areas have shown positive results, with people who may otherwise not have successfully engaged with Opiate Substitute Treatment (OST) being able to maintain engagement and stabilise their substance use.
- Identify and explore opportunity to provide service users with seasonal flu vaccination.

Tuberculous (TB)

Summary

- Herefordshire continues to be a low incidence area for TB, averaging between zero and six cases per year since 2000.
- This poses resilience and efficiency challenges for the specialist TB service locally in prevention and response
- Nationally and locally TB vaccine is not routinely offered, but continues to be provided on the NHS when a child, or adult, is thought to have an increased risk of coming into contact with TB. This was the case for 63 individuals in 2021-22, down from 144 a year earlier.

Background

Tuberculosis, also known as TB, is an infectious illness caused by the airborne bacteria Mycobacterium Tuberculosis. It is spread through inhaling tiny droplets from the coughs or sneezes of an infection. TB mainly affects the lungs however it can affect any part of the body, including the glands, bones and nervous system.

Pulmonary TB, in which TB which affects the lungs, is the most contagious type. However, it usually only spreads after prolonged exposure to someone with the illness, for example within family members who live in the same household.

Although it is a serious condition it can usually be cured with prompt and proper treatment.

- A person with TB can infect up to 10-15 other people per year but once diagnosed and started on treatment the majority of persons are considered no longer infectious after just two weeks of taking medication.
- If left untreated it can be life threating – about 1 in 20 patients with TB die each year in England.

In Herefordshire, TB services are provided by Wye Valley NHS Trust based at the County Hospital. They provide a specialist service to manage and support patients with active and latent TB infections, their services include:

- contact tracing and screening for close contacts of both human and Bovine Infection
- early detection and treatment of active and latent TB through contact, immigrant and diagnostic screening
- diagnostic investigations inclusive of assessment, chest x-ray, Mantoux (skin test), sputum and T-spot blood test
- telephone advice for health professionals and the public
- treatment initiation, monitoring and supervision for adherence and adverse drug reactions
- a comprehensive, tailor made daily video observed treatment programme
- pre-treatment assessment, testing and counselling
- BCG vaccinations to selected pre-school and adult high risk groups
- health promotion and education in order to raise awareness of TB

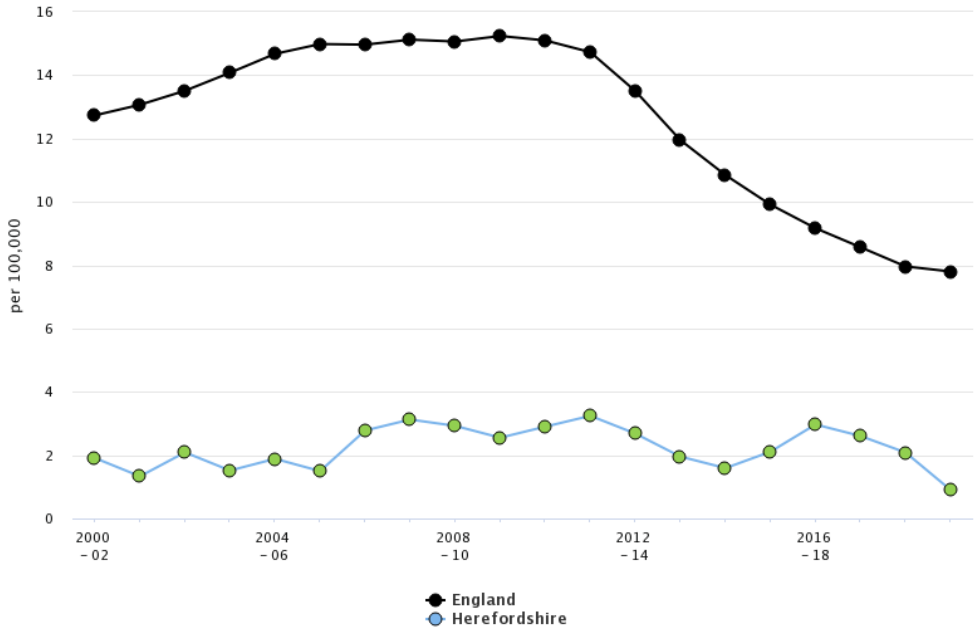
Surveillance

TB continues to be a major cause of disease and death worldwide, being the second leading infectious killer after COVID-19. It is estimated that 10.6 million people became ill with TB and an estimated 1.6 million TB related deaths in 2021 (according to the WHO Global tuberculosis report 2022).

The UK Is considered a low incidence country (country with an estimated incidence rate less than 40 per 100,000). In England, the highest rates of TB remain concentrated in large urban areas. For example London alone accounted for 35.5% of cases in 2021.

As outlined in Table 10, Herefordshire continues to have a low incidence rate of TB. Herefordshire has seen a steady decline in cases since 2016-18 and had the lowest incidence rate recorded at 0.9 per 100,000 population in 2019-2021.

Table 10 TB incidence (three year average) for Herefordshire



Source: Public Health Outcomes Framework

Although Herefordshire is a low TB incidence rate area this creates several challenges, this includes:

- small TB workforce which is therefore impacted by leave, sickness and patient capacity
- limited cross over / surge capacity
- lack of resources due to small number of cases
- resources for incident management are less available as it's a rare event
- difficulties in commissioning an appropriate specialist service due to very small numbers
- little support for complex case management or management of TB outbreaks
- succession planning

Health inequalities

TB is also strongly associated with deprivation. Certain groups are disproportionately affected by TB and this under-served population includes:

- ethnic minority groups
- refugees and asylum seekers
- migrants
- those with a history of or current homelessness
- those with a history of or current imprisonment
- those with a history of or current drug or alcohol misuse
- people who are immunocompromised

TB patients with social risk factors have a greater potential for infecting others, have poorer treatment completion as well as a greater risk of having drug resistance. There is significant regional and local variation in rates of TB in England, depending on population characteristics, socioeconomic factors and level of local risk.

People living with HIV are PLHIV are 18 (15–21) times more likely to develop active TB disease than people without HIV. TB remains the leading cause of death among people living with HIV (PLHIV). In 2019, TB accounted for an estimated 30% of the 690 000 AIDS-related deaths in the world. These 208 000 deaths represented approximately 15% of the 1.4 million TB deaths that year.

As Table 11 indicates, due to Herefordshire being a low incidence area data is routinely supressed for the proportion of TB cases who are routinely offered a HIV test. 2018 is the only period in which data is publically available. In 2018, 87.5% of TB cases were offered a HIV test, although this is lower than England by 9.2% it is not significantly different to the England average.

Table 11 Proportion of TB cases offered an HIV test in Herefordshire

Period	Benchmark	Herefordshire		England
		Count	Value %	Value %
2012		7	Supressed <5	93.2%
2013		Supressed <5	Supressed <5	93.6%
2014		Supressed <5	Supressed <5	95.4%
2015		Supressed <5	Supressed <5	96.3%
2016		Supressed <5	Supressed <5	97.0%
2017		Supressed <5	Supressed <5	96.5%
2018	●	7	87.5%	96.7%
2019		Supressed <5	Supressed <5	97.6%
2020		Supressed <5	Supressed <5	97.4%

Benchmark = ● Better 95% | ● Similar | ● Worse 95%

Source: Public Health Outcomes Framework (PHOF)

Bacillus Calmette-Guérin (BCG) immunisation

The Bacillus Calmette-Guérin vaccine, or BCG as it is more commonly known, is a vaccine which helps provide protection against the most severe forms of TB, such as TB meningitis in children.

The BCG vaccine is no longer given as part of the routine NHS vaccination schedule. Since 2005 the BCG vaccine is only provided on the NHS when a child, or adult, is thought to have an increased risk of coming into contact with TB. Examples of increased risk include:

i. children who have a parent or grandparent who was born in a country where there's a high rate of TB
ii. children who have recently arrived from countries with high levels of TB, including those in Africa, the Indian subcontinent, parts of southeast Asia, parts of South and Central America, and parts of the Middle East
iii. children who will be living with local people for 3 months or longer in countries with high rates of TB
iv. children who live with, or are close contacts of, someone with infectious TB

In addition to this selective approach all infants (0 to 12 months old) living in an area where the incidence of TB is greater than 40 per 100,000 should be offered BCG vaccine. Due to large cross boundary movements a universal vaccination offer is in place across all London boroughs, regardless of TB incidence.

As Herefordshire is a low TB incidence area it provides a risk based BCG programme. As Table 12 indicates, 63 children received the BCG vaccine in 2021-22. This demonstrates a marked reduction in when compared to previous years for which there is available data.

Table 12 Number of children in Herefordshire who were vaccinated for BCG by their first birthday by year

Year	Number of children vaccinated
2019 – 2020	127
2020 – 2021	144
2021 – 2022	63

Source: Public Health Outcomes Framework (PHOF)

Environmental hazards to health, safety and pollution control

Summary

- COVID had a significant impact on the delivery of Environmental Health services. As a result a COVID-19 recovery plan was successfully implemented.
- There has been a small reduction in the number of reportable accidents and incidents and in year health and safety visits conducted by Environmental Health in 2022/23.
- Food premises with a food hygiene rating score at 3 (satisfactory) or above have remained consistently high (2022/23, 98.2%)
- Herefordshire has a high number of poultry farms and processing facilities, increasing its risk of avian flu outbreaks. There were four such avian flu outbreaks requiring environmental health visits in 2021/22, including to ensure biosecurity measures were in place.

Background

One of Herefordshire Council's most important roles is helping to protect the people of Herefordshire from threats to their safety and health.

Environmental Health and Trading Standards regulation fulfils a number of key public policy objectives, including public protection, fair business competition and environmental stewardship. The environmental health contribution to public health and health improvement span:

- community support and community development,
- economic, social and environmental regeneration,
- housing and planning,
- availability of wholesome drinking water supplies,
- quality and availability of safe and nutritious food supplies and support for local food production,
- prevention of accidents and injuries,
- control of infectious diseases,
- noise, pollution and the management of air quality and nuisances,
- control on the use of contaminated land, and occupational health and safety, and the achievement of workplace standards

Surveillance

Food safety:

Food inspections, in hotels and cafes as well as hospitals and schools, have as their primary purpose the protection of the public. Public information schemes such as “Scores on the Doors” are managed by Environmental Health, to provide information about food hygiene that enables all consumers to make informed choices. Officers from environmental health carry out food hygiene interventions either six monthly, annually, every 18 months, every two years, or every three years depending upon the risk assessment.

Last year’s COVID-19 recovery plan was successful in targeting the highest risk food premises, and maintaining public safety. In 2022/23, 282 high risk food inspection (A-C) were undertaken together with 374 lower risk inspections (Ds) and 291 interventions through the alternative enforcement strategy. The percentage of food premises with a food hygiene rating score at 3 (satisfactory) or above remained consistently high at 98.2% by end of year.

In 2022/23 Herefordshire Council were involved in the School Food Standards compliance pilot project. The project delivered by Environmental Health food inspectors and Public Health has given

insight into what's happening nutritionally in schools today and identified additional support needed to drive positive change in the school food system.

Occupational health and safety:
People are entitled to assurance that employers are complying with proportionate and risk-based safeguards to prevent deaths, serious injuries and industrial diseases in the workplace. It is through regulation of occupational health and safety legislation that Environmental Health intervene to reduce the number of personal tragedies, accidents and ill health as far as reasonably practicable. Promoting healthier lifestyles and safer workplaces is a key strand of improving public and environmental health. Providing advice for the safe operation of sports and leisure activities are at the forefront of protecting people from possible harm, particularly in the summer months.

In 2022/23, Environmental Health reviewed and investigated 74 reportable accidents and incidents (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) in accordance with the HSE enforcement management model. There were also 24 in year health and safety visits (in accordance with LAC 67/2 (rev6)). When compared to the previous year there was a small reduction in both the number of reportable accidents and incidents which were reviewed (n=82 in 2021/22) and the number of health and safety visits (n=34, 2021/22).

Private water supplies
Clean water is fundamental to human health and well-being. Whether it is used for drinking, cooking, washing or recreation, we all expect our water to be safe. If it is not, micro-organisms can cause health problems, ranging from a mild stomach upset, to a serious illness such as cryptosporidiosis and chemicals can additionally cause poisoning.

Environmental Health protect water quality with a particular focus on private water supplies. Where quality standards fall below those required, the service works with the water providers to minimise risks to health. Herefordshire has one of the largest number of private water supplies in the UK. It is estimated that between 5 and 10 percent of Herefordshire's population use a private water supply for domestic purposes. Key activity and interventions undertaken include:

Activity / intervention	2021/22	2022/23
Number of private water supply samples taken	325	388
% of resampled supplies passed chemical and / or bacteriological parameters, demonstrating an improvement in the supply	76.7%	81.8%
DWI private water supply risk assessment reports completed	29	45

Environmental protection
There is growing public awareness of the science linking our physical environment and human health. The air we breathe, the water essential for so much of our daily routine, the noise we are exposed to, the land we build on and cultivate - all can affect our health.

Air pollution is associated with a number of adverse health impacts. It is recognised as a contributing factor in the onset of heart disease and cancer. Additionally, air pollution particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions. The annual health cost to society of the impacts of particulate matter alone in the UK is estimated to be around £16 billion.

In Herefordshire, there are two Air Quality Management Areas (AQMA's) declared due to levels of NO_2 exceeding national standards (40µg/m^3). The AQMAs cover parts of the A49 Road through Hereford and the Bargates Road junction in Leominster.

In 2022, the ratified continuous monitored NO_2 annual mean concentration was 31.0 µg/m^3 in the Hereford AQMA. From 2021 to 2022 the nitrogen dioxide levels at this site decreased by 2 µg/m^3.

NO_2 is also measured at 15 locations in the AQMA using passive diffusion tubes. This is an indicative method which is less accurate than the continuous monitor. The maximum concentration measured using diffusion tubes in the Hereford AQMA was 33.3 µg/m^3.

NO_2 concentrations in the Bargates AQMA are monitored at five locations. The highest annual mean concentration in 2022 was 36.4µg/m^3 (site 61b, 35 Bargates, Leominster). From 2021 to 2022, the nitrogen dioxide levels at this site decreased by 1.4µg/m^3.

During the summer months of 2022, Environmental Health again successfully ran an out of hours noise nuisance service providing late night community support at weekends, up to and including the August Bank holiday.

Key activity and interventions undertaken include:

Activity / intervention	2021/22	2022/23
Air quality monitoring systems (AQMS) in the Leominster and Hereford AQMA	Funding allocated to commission system	Systems introduced
Number of environmental protection service requests received and actioned	2576	2634
Number of environmental protection planning consultations received and actioned	763	593

Housing

Environmental health practitioners, working with social landlords, social care providers and housing action trusts are responsible for the regulation of housing standards, e.g. in relation to fitness for human habitation and standards for houses of multiple occupation (HMO).

Key activity and interventions undertaken for 2022/23 include:

- 611 housing standards enquires received and actioned
- 76 HMO inspections completed
- 77 HMO self-certifications completed
- 78 single family dwelling inspections completed
- 75 housing notices served
- 16 houses in multiple occupation licenced

Regulatory response to COVID-19

During 2021/22 officers across Environment Health and Trading Standards (EHTS) continued joint patrols with West Mercia Police to deliver reassurance patrols, which operate in the daytime and on Friday and Saturday nights for the licensed trade.

This continued until restrictions were lifted in the summer of 2022. The Trading Standards intelligence officer was embedded with the police at Hereford police station, assisting joint working and coordination between the council and police to provide a shared and unified regulatory response.

Working with the police, EHTS officers patrolled known hotspot areas in the city and market towns that were reported or known to be areas of social gatherings or non-compliant retail, including restaurants and hospitality businesses disregarding the government's legislative controls in relation to the pandemic.

Key activity and interventions undertaken for 2021/22 were:

- responding to 158 requests for CV19 advice,

- responding to 103 CV19 complaints,
- undertaking 226 patrol visits where the target was deemed to be compliant, and
- undertaking 30 patrol visits where the target was deemed to be non-compliant and taking appropriate enforcement action.

Trading standards interventions

Trading Standards continue to support and promote strategies and practices to address passive smoking targets by contributing to the enforcement of no smoking policies in workplaces and public spaces, and the use of proof-of-age cards.

Data for 2022/23 is currently unavailable however key activity / interventions undertaken in 2021/22 includes:

- Enforcement activity saw over 135,000 illegal cigarettes and 32kg of hand rolling tobacco seized from premises in Herefordshire which were being sold on the black market. The value of these products combined were circa £94,000.
- All of the individuals involved in the supply and sale of the illegal tobacco products were charged with multiple offences at both Magistrates' and Crown court. Due to the delays in the court system due to Covid, these cases were pushed back well beyond 2021/22
- A number of multi-agency operations saw problem premises closed under the Anti-social Behaviour, Crime and Policing Act 2014. Cash seizures of over £5000 were made for concealed cash linked to illegal tobacco supply
- Impacts from COVID as above

Animal health

Animal health is important because major outbreaks of diseases, particularly on livestock farms can have the following implications:

- Serious welfare problems for affected animals
- A huge effect on business and the economy
- Certain diseases can be passed on to the human population e.g. avian influenza, foot and mouth, swine fever, rabies.

Preparedness and responses for emergency outbreak control work for potentially zoonotic animal health diseases are therefore extremely important.

Data for 2022/23 is currently unavailable however key activity / interventions undertaken in 2021/22 includes:

- 225 Animal welfare complaints were responded to
- 285 Animal health compliance checks were carried out over and above the welfare complaints
- 4 Avian flu outbreaks were responded to with all premises within a 3 kilometre radius of the infected premise were visited to determine if any birds were kept at the property, advise any bird keepers of the outbreak and to ensure biosecurity measures were in place and the birds were kept inside as per the legislation to prevent further spread of the disease.
- 2 farmers were banned from keeping livestock for life due to not providing suitable environment and unnecessary suffering.