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NHS West Yorkshire
Integrated Care Board

Kirklees Scrutiny Committee

9th October 2024

Communities Accessing Care

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Questions raised and addressed

NHS West Yorkshire Integrated Care Board

To continue to review the work of health services in the community to include:

- Assessing progress of the integration of services and workforce.
- Considering the work that is being done locally to action the national delivery plan for recovering access to primary care.
- Access to GP services and hospital referrals
- An update to the work being done by the local authority and Locala on providing reablement support, including the actions and initiatives to support hospital avoidance and provide the appropriate level of care and support at or closer to home.
- An update on the work of community pharmacy and the proposals from Government and NHS on price concessions reform and relief measures to ease pressure on pharmacies.
- The impact and uptake of pharmacy service to prescribe.
- The uptake of vaccination programmes

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Integration of Services and Workforce

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National Context - Integration

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Fuller Stocktake - 2022

Following the Fuller Stocktake in 2022, the focus was directed towards

- Building integrated teams in every neighbourhood
- Improving same-day access for urgent care
- the delivery of proactive care and preventative care
- Creating the national environment to support locally driven change – key enablers, workforce, estates and data

Darzi Review – September 2024

- Aftermath of the pandemic - People are struggling to see their GP, impact on waiting list, focus of budget spend – historically acute rather than community, capital investment shortfall
- Lock in the shift of care closer to home
- Simplify and innovate care delivery for a neighbourhood NHS “The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services”.

Kirklees Picture

NHS West Yorkshire Integrated Care Board

- 9 PCNs have neighbourhood footprints with aligned key services across Community, Local Authority, Voluntary and Pharmacy sectors.
- Embedded roles in PCNs dedicated to a more joined up holistic approach – Social Prescribing Link Workers, Health and Wellbeing Coaches, Care Co-ordinators
- Mental Health Social Prescribing Link Workers “Social prescribing has really helped more than any other service I have accessed over the years. You’re so full of ideas and just ‘get me’. I was so scared at first when you spoke about creative opportunities available for me but you fully supported me through the whole process and I've now turned that corner. Thank you.”
- .Regular Multidisciplinary Team Meetings – membership wider than just General Practice
- Focus on proactive care – go beyond national ask to identify patients at risk of frailty and put pre-emptive care and support in place
- Anticipatory Care Plans for certain conditions – piloted new approach in 4 PCNs
- Joint approach to managing patients with Long Term Conditions between General Practice and Locala

Kirklees Picture

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April – June 2024 (Quarter 1) – Personalised Care Summary

- 1552 referrals into the service, 5795 appointments delivered
- 38% reduction in GP appointments for patients referred to social prescribing
- 27% reduction in GP appointments for patients referred to care coordination
- 57% reduction in A&E attendances for patients referred to social prescribing
- 36% reduction in A&E attendances for patients referred to care coordination
- 30% of patients referred have 2 or more long term health conditions

Patients who have actively worked with the service have shown an overall 38% reduction in GP attendances 3 months after being referred. This data is based on patients referred in January, February and March who have had 3 or more GP attendances in the 3months prior to their referral.

Patient Feedback – 3 Centres PCN

“This support is the first time I have been given tools to help me manage my bi-polar. Up until this it has always been about more tablets. On a daily basis I have started using the handout “What I can control and what I can’t” It helps me to organise my mind. It’s helping me untangle things in my head.”

Workforce

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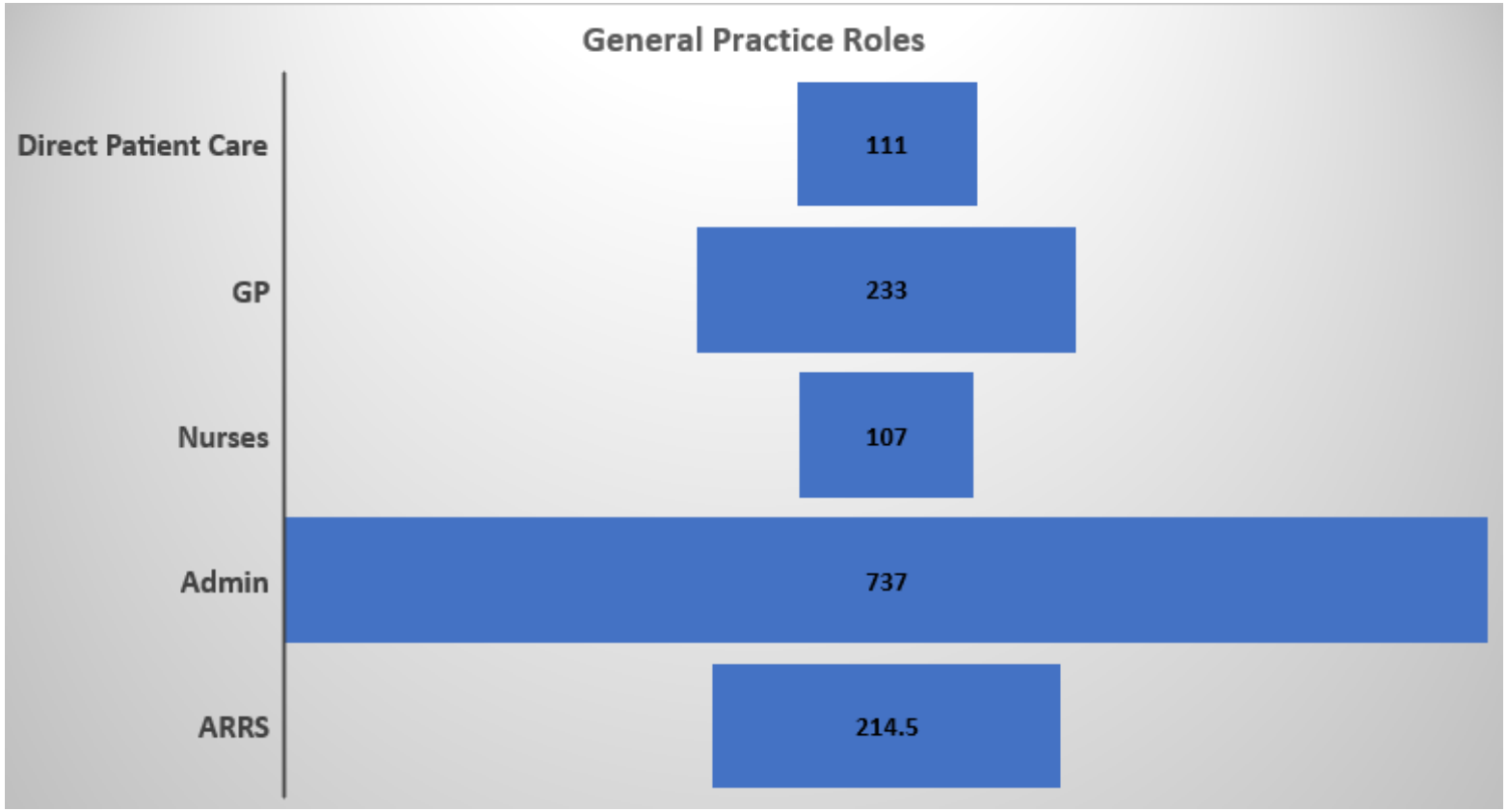
Overview of General Practice Employees



Workforce – Placement Capacity Expansion

NHS West Yorkshire Integrated Care Board

Kirklees Approach

- Maximise the use of existing placement capacity by better matching students with placements

- Increasing placement capacity:
  - Increasing the number/range of placements in non-traditional settings
  - Increasing the number/range of non-traditional placements in traditional settings

- Increasing the number/range of innovative placement approaches:
  - Rotational placements
  - Hub and spoke placements
  - Student lead clinics

- Improving system co-ordination, planning, and support infrastructure.

Workforce – Placement Capacity Expansion

NHS West Yorkshire Integrated Care Board

The Paramedics in Social Care Environments (PISCEs) project

This project was developed in partnership with KirCA, University of Huddersfield and the University of Bradford. Funding provided from National Health Service Education (NHSE).

AIM:

- To help integrate social care into the fundamentals of paramedic training (30 undergraduate paramedic students)
- To complete the practical experience element of the Care Certificate

CHALLENGES:

- Students coming straight from secondary education with a lack of practical exposure to essential competencies such as caregiving and effective communication

KirCA's ROLE:

- Involvement in initial discussions with University of Huddersfield - tailoring the scheme for Social Care Providers in Kirklees
- Communication and Engagement of the sector to understand the benefits and encourage participation

Workforce – Placement Capacity Expansion

NHS West Yorkshire Integrated Care Board

The Paramedics in Social Care Environments (PISCEs) project

Project Overview

- A 2-week placement block in care homes for paramedic students (across 15 care homes in Kirklees)
- Students are supernumerary and work normal shift patterns to experience the different challenges that working in social care can bring
- Each care home take two students at the same time
- Long arm supervision from the University
- Care Certificate 'practical aspects' completed whilst on the placement

Opportunities/Outcomes

- Care Homes consider hiring students part time
- Confirm if the project is feasible to run annually
- Students become more confident in caregiving and improve their communication skills
- Students understand the pressures in social care when they take up their role as a paramedic
- The possibility to role this out to other allied health professionals (Physio, OT, Dieticians)

Workforce – Placement Capacity Expansion

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Pharmacy placements – Designated Prescribing Professional (DPP)

- A Designated Prescribing Professional (DPP) is a healthcare professional in Great Britain or Northern Ireland with legal independent prescribing rights who supervises a health care professional during their independent prescribing (IP) course and provides ‘sign-off’ on their competency to prescribe.
- A DPP does not now have to be a doctor to supervise an IP learner. The role of DPP can be performed by any independent prescriber including doctors, nurses and Allied Health Professionals (AHPs).
- It is a requirement that a pharmacist undertaking independent prescribing training must have a named DPP who takes overall responsibility for supervision and will determine that the IP learner is suitable for IP annotation on their professional register.
- Within the area 15 out of 30 placements have been provided by general practice settings

Workforce – Placement Capacity Expansion

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Placements in Independent Social Care

Supported KirCA to employ a placement co-ordinator role to :

- Support local universities with the sourcing, securing and monitoring of suitable, vocational social care work placements for students on related courses.
- To organise effective marketing materials to promote and communicate the placement opportunities available within social care.
- Build and support a network of social care providers willing to provide placement opportunities aligned with students' learning objectives.
- Evaluate the effectiveness of placements and identify areas for improvement to enhance the overall experience for students and social care providers.

Workforce – Placement Capacity Expansion

NHS West Yorkshire Integrated Care Board

Community Led Student Clinics

Locala are working in several areas:

- Student Led Clinics
- Clinical fellow looking into physiotherapy Student Led Clinics to plan for these properly so that they are a long-term success
- Leadership Placements:
- Students work in pairs to explore specific projects
- Explore student led clinics in fatigue management – increased capacity, better student learning opportunities, wider team/organisation benefits
- Specialist Nursing Spoke Placements:
- Working with University of Huddersfield to encourage increased allocations to specialist nursing placements to take up under-utilised capacity

Workforce Collaboration

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Additional Roles Reimbursement Scheme (ARRS) – Roles

Roles employed through this scheme has enabled the development of new ways of working, such as multidisciplinary working.

Roles employed through the 9 PCNs in Kirklees are

- Clinical
  - Advanced Practitioners (Pharmacists, Paramedics, First Contact Physios and Nurses)
  - Pharmacy Technicians
  - Physician Associates
  - Paramedics
- Nursing (Mental Health Nurses, Nurse Associates and Trainees)
- Allied Health Professionals (First Contact Physio, Dietitian)
- Personalised Care (Care Coordinators, Health and Wellbeing Coaches, Social Prescribing Link Workers)
- Admin (Digital and Transformation Leads, General Practice Assistants)

Workforce Collaboration

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Additional Roles Reimbursement Scheme (ARRS) – Social Prescribing Link Workers (SPLW) and Mental Health SPLWs

- Kirklees Personalised Care (Kirklees Council) employees and trains SPLW and Mental Health SPLWs who provide support to patients from practices/PCNs in Kirklees

- The team enables individuals to focus on “what matters to them” and make positive changes for an improved quality of life. The vision is to promote more choice and control in people’s lives by providing an inclusive, person-centred approach to people’s health & wellbeing. Enabling holistic conversations to encourage lasting change as what matters to you matters to us.

- In Quarter 1 of 2024/2025 the below referrals were made from practices in Kirklees to the Personalised Care team.
  - **1189** Social Prescribing Link Worker referrals
  - **209** MH Social Prescribing Link Worker referrals

Workforce Collaboration

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Additional Roles Reimbursement Scheme (ARRS) – Social Prescribing Link Workers (SPLW) and Mental Health SPLWs

Reducing Demand and Improving Access

- Patients who have actively worked with the service have shown an overall reduction in GP attendances and A&E attendances. This data is based on patients referred in January, February and March
  - 3 or more GP attendances in the 3months prior to their referral.
  - 1 or more A&E attendances in the 3months prior to their referral.

Reducing Demand on	No of patients	3 months prior	3 months during	Increase/ Decrease	%
Practices	211	999	623	-376	-38%
A&E	119	204	88	-116	-57%

The activity will continue to be measured over a 6-month period to identify if there has been a sustained change in accessing appointments.

Workforce Collaboration

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Additional Roles Reimbursement Scheme (ARRS) – Mental Health Pharmacy Team

Blended Mental Health Pharmacists Model Covering all 9 Kirklees PCNs

Implementation		
Role	Whole time equivalent (wte)	Start date
Lead Pharmacist	0.5	January 2023
Advanced Clinical Pharmacist	2.00	January 2023
Foundation Pharmacist	1.00	January 2023
Medicines Optimisation Technician	2.00	January 2023

General details of service to be offered:

- Medication reviews for complex mental health regimens
- Patient consultations and medication counselling
- Empowering patients to make informed decisions on their care plan
- Medication reconciliation post mental health discharge
- Rationalising and optimising medication, mental health medications (for people with severe mental health problems, particularly those with complex co-morbid physical health problems)
- Answering queries from other practitioners
- Prescribing medications for mental health related conditions
- Switching medications
- Signposting
- Discharge follow up
- Providing mental health support for those with long term physical health conditions
- Writing policy
- Education and training
- Deprescribing
- Assessing overuse and suitability of PRN medications
- Medication advice – including use of herbal and OTC remedies

- Addressing adherence issues, poor communication, drug errors

Workforce Collaboration

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Additional Roles Reimbursement Scheme (ARRS) – Mental Health Pharmacy Team

Outcomes and Networking

Our work outcomes

Since March 2023:

- We have contacted 462 number of patients.
- We have conducted a 1139 review of medication for patients (e.g. antidepressant, STOMP, promethazine, as part of SPA MDT, etc.)
- We have followed up 427 patients after discharge from MH inpatient services and made 182 interventions.
- We have updated 268 GP patient records so that it now includes specialist secondary care mental health medications.
- We have received 53 queries from our colleagues in primary care

Our networking

- Attend meetings across PCNs /WYICB
- Develop links with social prescribers, physical health practitioners, NHS talking therapies staff, MH ACP's, GP based pharmacy teams.
- Linkin with our inpatient colleagues
- Provide educational sessions for our primary care colleagues.
- Attend national level STOMP meetings and training around antidepressant deprescribing.

Integrated Workforce Offers

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Staff Development: Health and Care Apprenticeship Programme

- 2 Programmes:
  - Senior Leader Higher Apprenticeship [Level 7]
  - Professional Manager Apprenticeship [Level 5]
- Started 2023, second cohorts for 2024 just commenced
- Around 40 learners per programme
- Benefits:
  - Individual learning and development
  - Team/organisation benefits
  - Health and care system benefits
  - Helps to utilise apprenticeship levy
  - Joint working with University of Huddersfield

Kirklees Health & Care Partnership

Integrated Workforce Offers

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Health and Wellbeing Offers

Range of Health and Wellbeing Offers to support staff, including:

- Community Schwartz rounds
- Compassionate Leadership Programme
- Compassionate Leadership Communities of Practice Network
- Social Care Innovation Programme
- Bite size virtual sessions

We are kind and treat people with compassion, courtesy and respect

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Recovery of Access to Primary Care

Primary Care Access Recovery Plan

1		**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy
2		**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity • Rapid assessment and response
3		**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs • Priority of primary care in new housing developments
4		**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Streamlining IIF indicators and freeing up resources

Primary Care Access Recovery Plan

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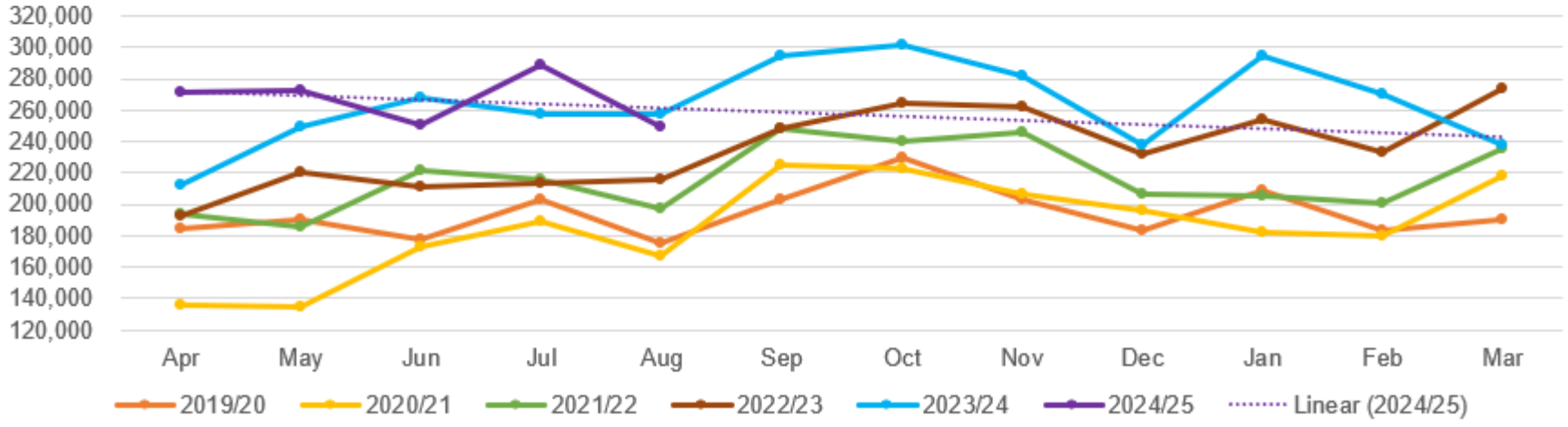
- In May 2023, NHS England published a two-year delivery plan for recovering access to primary care and to aim to take some off the pressure off General Practice
- Since the plan's publication, record numbers of general practice (GP) appointments were delivered alongside the expansion of pharmacy services.
- There has been sustained significant demand on primary care and rates of consultations remain much higher than pre-covid pandemic levels.
- The focus in the second year of the plan has been to support practices to make full use of digital telephony capabilities and enabling practices to have a single view of all requests whether these are online, phone or walk in.
- The interface between primary and secondary care also remains an area of focus
- NHS England will begin to share data on the number of calls to 111 in core hours with primary care networks (PCN) clinical directors, to support quality improvement, so practices only divert to 111 in exceptional circumstances

Access to Primary Care

Appointments in General Practice – Aug 24

NHS West Yorkshire Integrated Care Board

Overall Appointments	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Change from Previous year
2019/20	184,775	189,886	177,708	202,778	175,365	202,500	230,103	202,861	183,201	208,311	183,393	190,232	
2020/21	136,055	135,133	172,804	189,224	167,229	224,921	222,640	206,507	196,470	182,062	180,256	218,089	-99,723
2021/22	193,598	185,958	221,775	215,559	197,822	248,298	240,275	245,642	207,038	204,806	200,581	235,416	365,378
2022/23	192,989	220,835	211,517	212,949	216,146	247,779	264,532	261,652	232,310	254,116	232,706	273,645	224,408
2023/24	212,830	249,392	267,312	257,789	257,380	294,588	301,139	281,796	238,157	294,641	269,876	237,904	341,628
2024/25	**270,921**	**272,498**	**250,367**	**288,880**	**249,792**								**Monthly Change**
Change from the same point last year 2023/24	58,091	23,106	-16,945	31,091	-7,588								-13.5%
Change from previous month	33,017	1,577	-22,131	38,513	-39,088								



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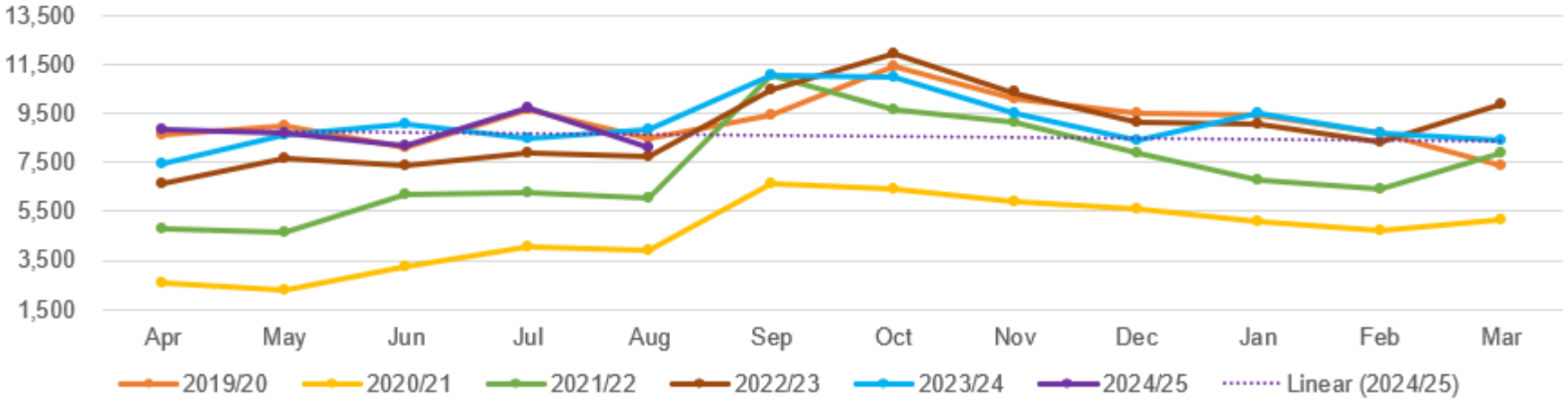
Access to Primary Care

Appointments in General Practice - DNA

NHS West Yorkshire Integrated Care Board

DNA Tracking	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Change from Previous year
2019/20	8,626	9,026	8,149	9,685	8,475	9,440	11,438	10,095	9,494	9,439	8,710	7,378	
2020/21	2,576	2,323	3,265	4,069	3,930	6,667	6,409	5,879	5,573	5,067	4,709	5,132	-54,356
2021/22	4,817	4,631	6,190	6,274	6,021	11,030	9,654	9,125	7,902	6,821	6,385	7,859	31,110
2022/23	6,675	7,649	7,411	7,902	7,753	10,464	11,950	10,362	9,168	9,079	8,300	9,916	19,920
2023/24	7,437	8,630	9,062	8,468	8,834	11,070	11,023	9,538	8,431	9,505	8,713	8,378	2,460
2024/25	**8,819**	**8,669**	**8,189**	**9,768**	**8,092**								**Monthly Change**
Change from the same point last year 2023/24	1,382	39	-873	1,300	-742								↓ 17.2%
Change from previous month	441	-150	-480	1,579	-1,676								



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Access to Primary Care

Appointments in General Practice – Phone and Video

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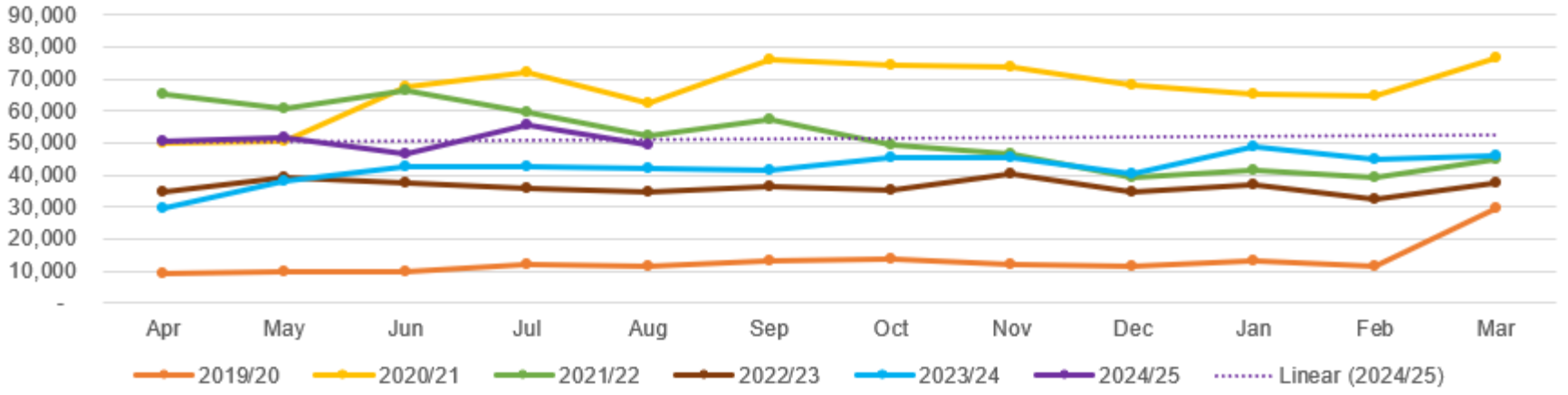
Phone and video appointments tracking	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Change from Previous year
2019/20	9,522	9,722	9,700	11,960	11,310	13,168	13,571	12,123	11,799	13,155	11,330	29,731	
2020/21	49,830	50,786	67,597	71,994	62,418	76,026	74,594	73,853	68,018	65,442	65,007	76,580	645,054
2021/22	65,162	60,763	66,566	59,862	52,130	57,471	49,499	46,401	39,520	41,583	39,270	44,745	-179,173
2022/23	34,974	39,517	37,543	35,903	35,035	36,630	35,434	40,581	34,851	36,780	32,319	37,772	-185,633
2023/24	29,788	38,364	42,612	42,570	42,285	41,533	45,580	45,677	40,602	49,158	45,093	46,236	72,159
2024/25	**50,503**	**51,689**	**46,865**	**55,432**	**49,487**								**Monthly Change**
Change from the same point last year 2023/24	20,715	13,325	4,253	12,862	7,202								-10.7%
Change from previous month	4,267	1,186	-4,824	8,567	-5,945								



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Access to Primary Care

Appointments in General Practice – Face to Face

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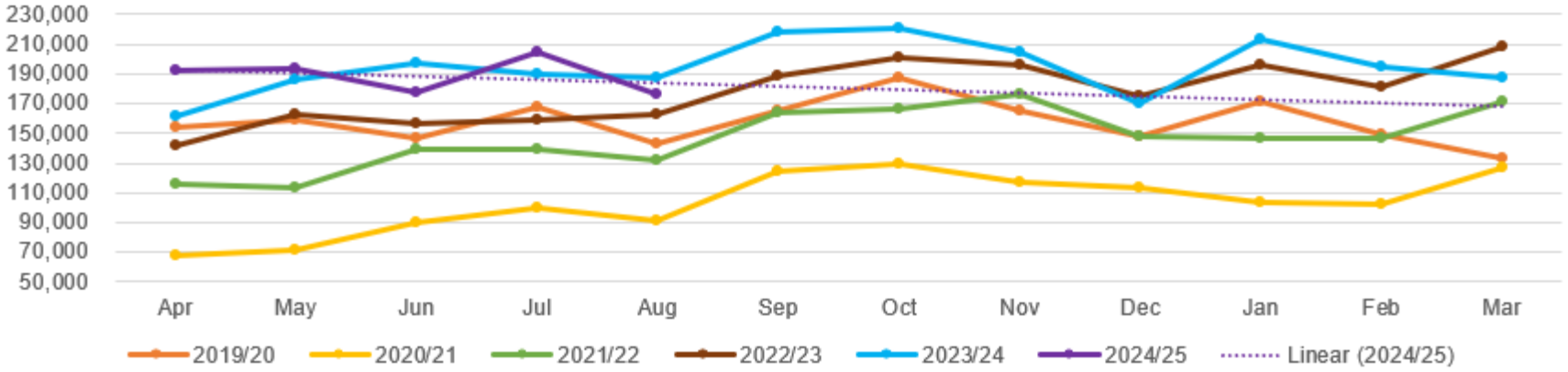
Face-to-face (inc home visit) appointments tracking	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Change from Previous year
2019/20	154,428	158,519	146,478	167,815	143,052	165,597	186,876	164,660	148,274	171,046	149,277	133,406	
2020/21	68,399	71,505	90,019	100,141	90,969	125,128	129,730	116,901	112,965	103,090	102,271	127,353	-650,957
2021/22	115,630	112,889	139,294	139,584	131,459	163,845	166,041	175,986	148,306	146,673	146,219	171,820	519,275
2022/23	142,040	163,102	156,309	158,816	163,335	188,352	200,946	196,192	175,333	196,629	181,445	208,947	373,700
2023/24	161,054	186,576	197,270	189,561	187,931	218,466	220,233	204,983	169,862	213,556	194,796	187,794	200,636
2024/25	**192,452**	**193,043**	**177,833**	**204,093**	**175,877**								**Monthly Change**
Change from the same point last year 2023/24	31,398	6,467	-19,437	14,532	-12,054								↓ -13.8%
Change from previous month	4,658	591	-15,210	26,260	-28,216								



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Access to Primary Care

Appointments in General Practice – within 14 days

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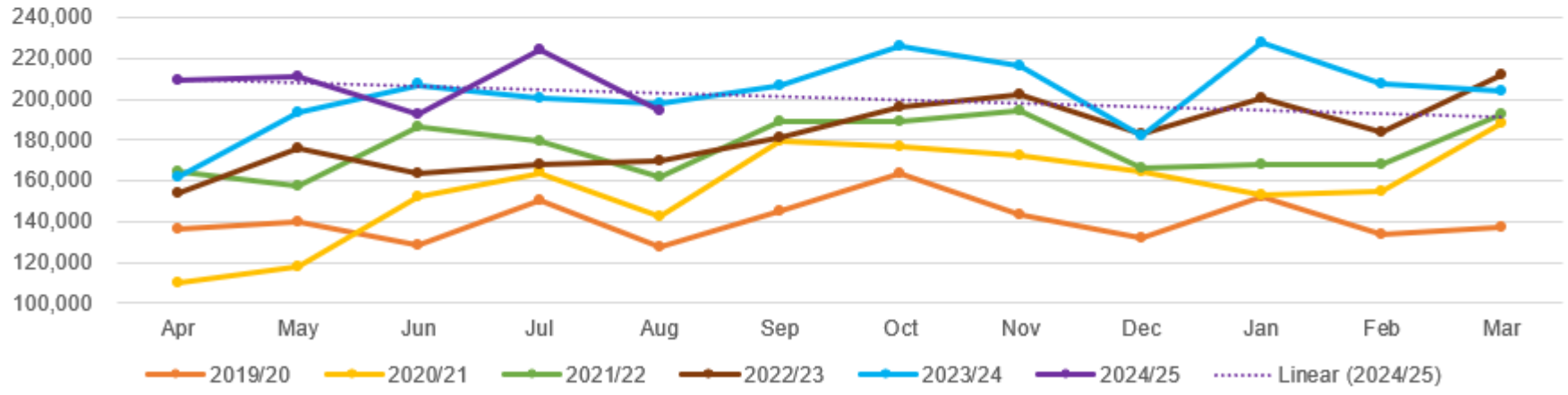
Appointments took place within 14 days tracking	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Change from Previous year
2019/20	136,320	140,142	128,878	150,357	127,488	145,591	163,884	143,830	132,435	152,580	133,438	137,548	
2020/21	110,155	117,677	152,524	164,060	142,946	179,327	177,066	172,042	164,120	153,479	155,226	188,287	184,418
2021/22	164,109	157,523	186,297	179,714	162,287	189,192	188,746	194,122	166,042	167,765	167,751	192,548	239,187
2022/23	154,006	175,509	164,028	167,835	169,658	181,235	196,507	202,531	182,577	200,079	183,901	211,535	73,305
2023/24	162,065	193,057	207,060	200,423	197,553	206,683	225,606	216,426	181,646	227,895	207,558	204,126	240,697
2024/25	**209,424**	**210,769**	**192,929**	**224,294**	**194,360**								**Monthly Change**
Change from the same point last year 2023/24	47,359	17,712	-14,131	23,871	-3,193								↓ - 13.3%
Change from previous month	5,298	1,345	-17,840	31,365	-29,934								



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Modern General Practice Access

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43 Kirklees GP practices have been financially supported to move to a Modern General Practice Access (MGPA) model.

Modern general practice is the foundation of a transformation journey to better align capacity with need, improve patient experience and improve the working environment for general practice staff by:

- optimising contact channels; offering patient choice of access channel (telephone, online and in person) via highly usable and accessible practice websites, online consultation tools and improved telephone systems.
- structured information gathering at the point of patient contact (regardless of contact channel) to understand what is being asked of the service.
- using one care navigation (and workflow) process across all access channels to assess and prioritise need safely and fairly, and to efficiently get patients to the right healthcare professional or service, in the appropriate time frame (including consideration of continuity of care) moving away from a 'first come first served approach'.
- better allocating existing capacity to need, making full use of a multi-professional primary care team, community services and 'self access' options where appropriate, and helping GPs and practice staff to optimise use of their time to where it's needed most.
- building capability in general practice teams to work together and to access, understand and use data, digital tools and shared knowledge to lead, plan, implement, improve and sustain change.

Improving Access - Ambition to support Self-directed care

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- For some conditions general practice involvement is not necessary if it is clear to patients where to get care and it is clinically safe to do so directly. This is more convenient for patients and frees up valuable practice time. This is already a reality for some conditions, but we will increase the number of self-refer options, guided by clinical advice.
- We also want to help patients care for themselves. We want to make it easier for them to monitor certain long-term conditions at home, such as high blood pressure, where it is clinically safe, and make it easier for practices to review their patients' self-monitoring. 20% of patients consult their GPs for problems that are non-clinical or social in nature and NHS England will continue to support social prescribing link workers who improve patient outcomes and reduce pressure on primary care.
- These include selected community musculoskeletal services, audiology for older people including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services

Improving Access - Self referral pathways

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1. Weight Management services - **Kirklees Council, Kirklees Wellness Service**
2. Community Podiatry - **Locala**
3. Wheelchair Services **- Ross Care, self referral for follow up's, initial referral required of confirmation of nee**d
4. Community equipment services - **Can order against catalogue - if more specialist needs a referral from HCP.**
5. Falls service - **Kirklees Counts & Locala**.
6. Physiotherapy - Service has been reviewed and in a procurement process. Self-referrals will be considered as part of any new model from providers **(Mobilisation: April 2025)**
7. Audiology - Service currently under review, working with Leeds, plan to deliver same specification across West Yorkshire. (**Mobilisation: September 2025)**
   - Wax removal
   - Hearing aid provision
   - ENT community pathway

Improving Access – Pharmacy First

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- Pharmacy First was introduced in January 2024 with the ambition of freeing up GP appointments for patients who need them most.
- Pharmacy will supply appropriate medicines for 7 common conditions including earache, sore throat, and urinary tract infections, aiming to address health issues before they get worse.
- Community pharmacies offer a more convenient way to access healthcare that includes support with healthy eating, exercise, stopping smoking, monitoring your blood pressure, contraception, flu and covid vaccinations.
- A survey found that 90% of patients who sought guidance from a community pharmacy within the past year reported receiving good advice.
- We are beginning to gather data on the use of these new pathways.

Improving Access – Pharmacy First

NHS West Yorkshire Integrated Care Board

Accessing Pharmacy First Services

The following table shows the 7 conditions pharmacists can manage across various age ranges.

Clinical pathway	Age range
Acute otitis media*	1 to 17 years
Impetigo	1 year and over
Infected insect bites	1 year and over
Shingles	18 years and over
Sinusitis	12 years and over
Sore throat	5 years and over
Uncomplicated urinary tract infections	Women 16-64 years

* Distance selling pharmacies will not complete consultations for acute otitis media.

Access to Primary Care

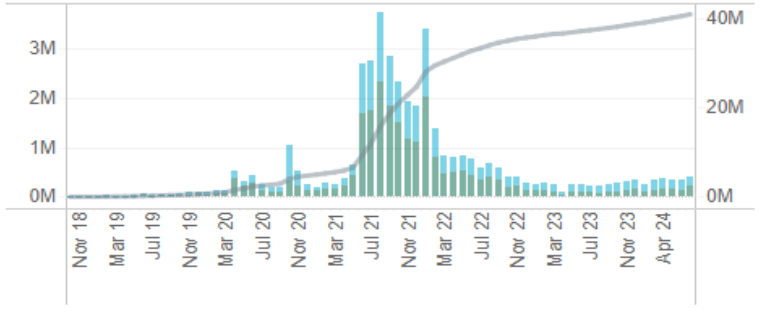
Improving Access – NHS App Uptake

NHS West Yorkshire Integrated Care Board

Monthly National Downloads - Apple, Android

420,343
▲21.7%

Running Total
40,939,009

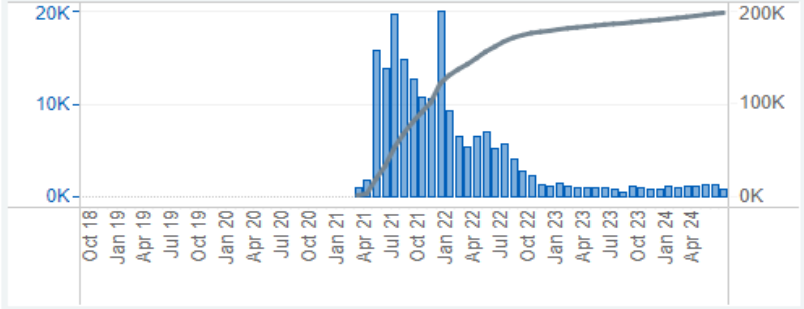


Monthly Registrations

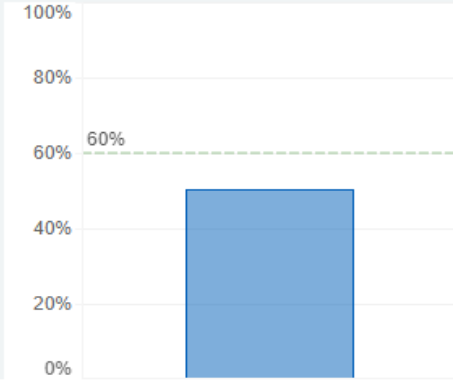
P9 Registrations

810.0
▼ 34%

Running Total
197,240

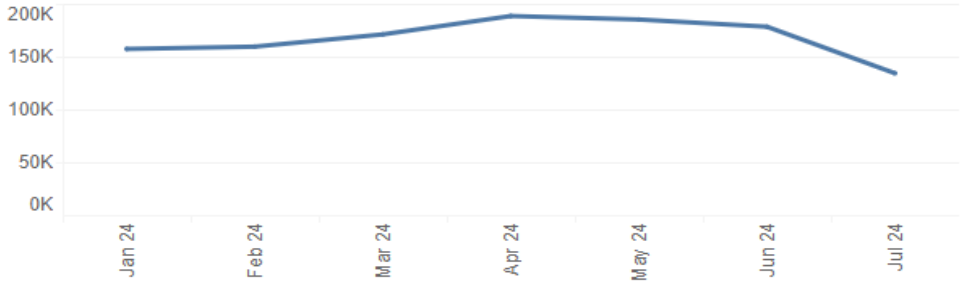


50% of GP Patients 13+ Registered for NHS App



Monthly NHS App Logins

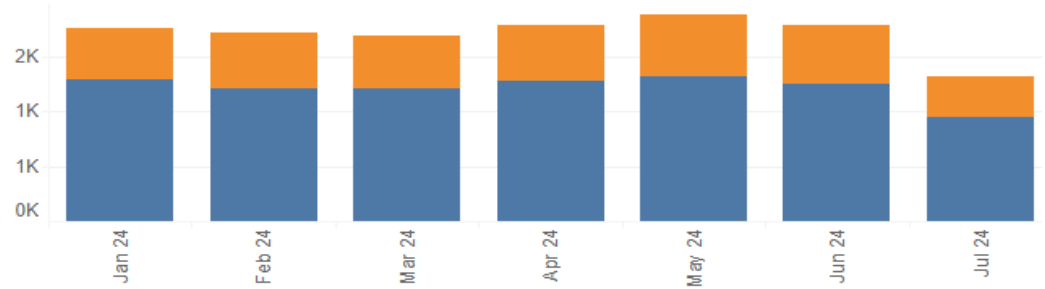
134,567
▼-24.7%



Monthly Appointments Managed

Cancelled Booked

1,312
▼-26.3%



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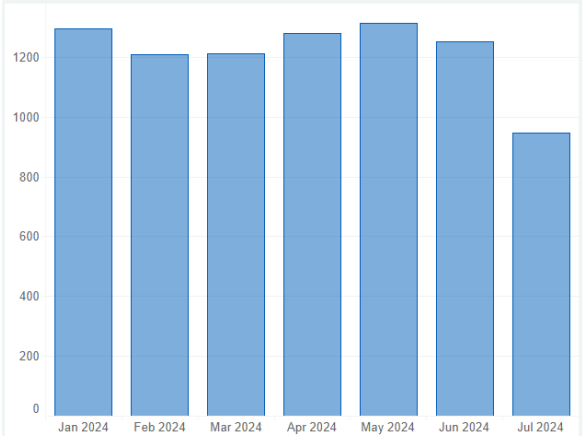
Improving Access – NHS App Usage

NHS West Yorkshire Integrated Care Board

Decreasing usage figures

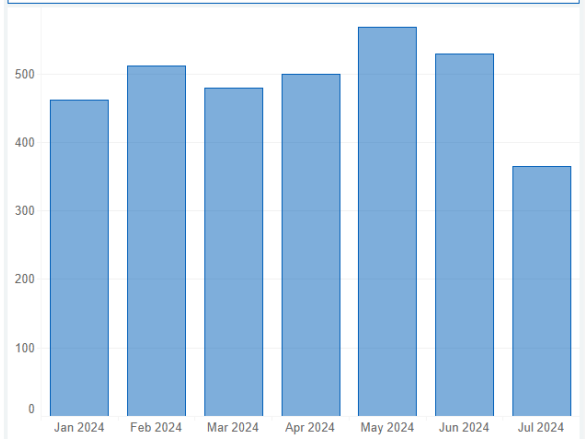
Primary Care Appointment Booked

947.0
▼ -24%



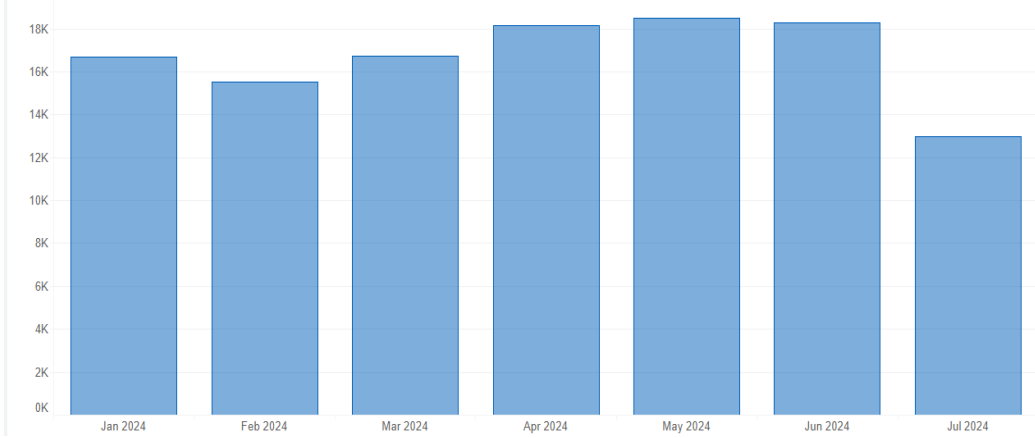
Primary Care Appointment Cancelled

365.0
▼-31%



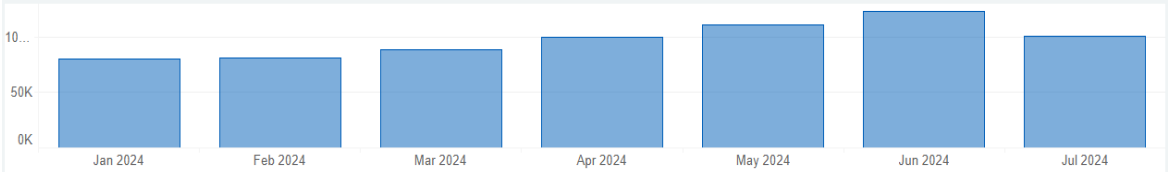
Repeat Prescriptions Ordered

12,996
▼-29%



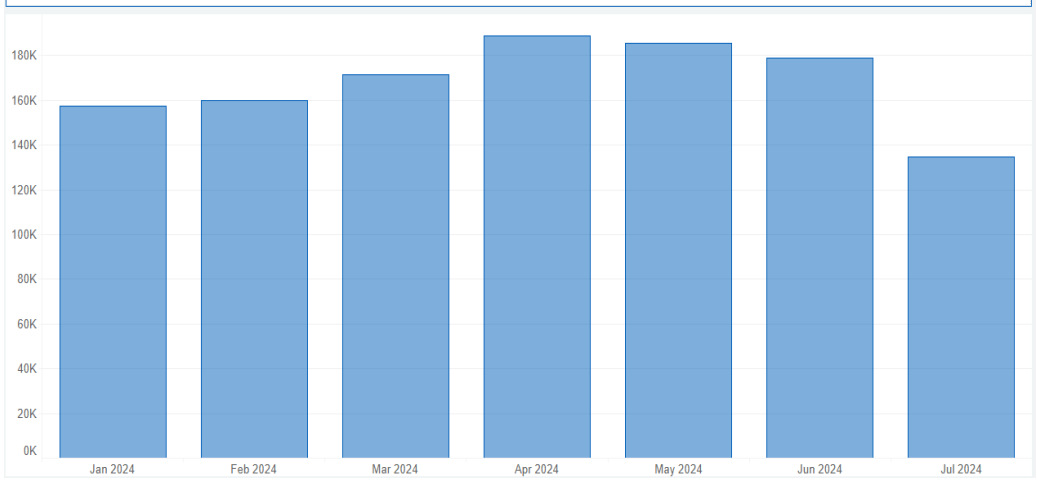
Record Views

100,145
▼-19%



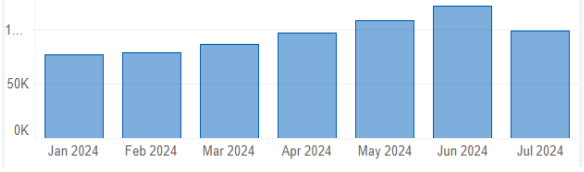
Monthly Logins

134,567
▼ -25%



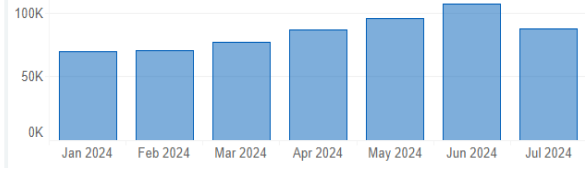
Detail Coded Record Views

98,555
▼-19%



Summary Coded Record Views

87,784
▼ -18%



Improving Access – GP Practice Total Appointments (West Yorkshire)

NHS West Yorkshire Integrated Care Board

2022	On average 1,324,030 appointments per month	On average 70.1% of appointments are Face to Face	On average 45.3% of appointments are Same Day	On average 83.8% of appointments are within 14 Days	On average 42.4% of appointments are with a GP
2023	On average 1,402,203 appointments per month	On average 74.0% of appointments are Face to Face	On average 44.0% of appointments are Same Day	On average 81.6% of appointments are within 14 Days	On average 40.9% of appointments are with a GP

Improving Access – GP Practice Total Appointments (West Yorkshire)

NHS West Yorkshire Integrated Care Board

	On average 1,402,203 appointments per month	On average 74.0% of appointments are Face to Face	On average 44.0% of appointments are Same Day	On average 81.6% of appointments are within 14 Days	On average 40.9% of appointments are with a GP
2023					
2024 YTD Jun	On average 1,447,500 appointments per month	On average 72.0% of appointments are Face to Face	On average 43.4% of appointments are Same Day	On average 81.1% of appointments are within 14 Days	On average 39.8% of appointments are with a GP
					

Access to Primary Care

Improving Access – Digital Highlights

NHS West Yorkshire Integrated Care Board

Telephony:-

Since May 2023 **34** practices have been supported to transfer to new cloud-based telephone systems or have their systems upgraded in line with the Delivery Plan for Recovering Access to Primary Care

Prospective Records Access:-

All Kirklees practices now offer prospective records access to patients, allowing patients to view their GP record via the NHS APP

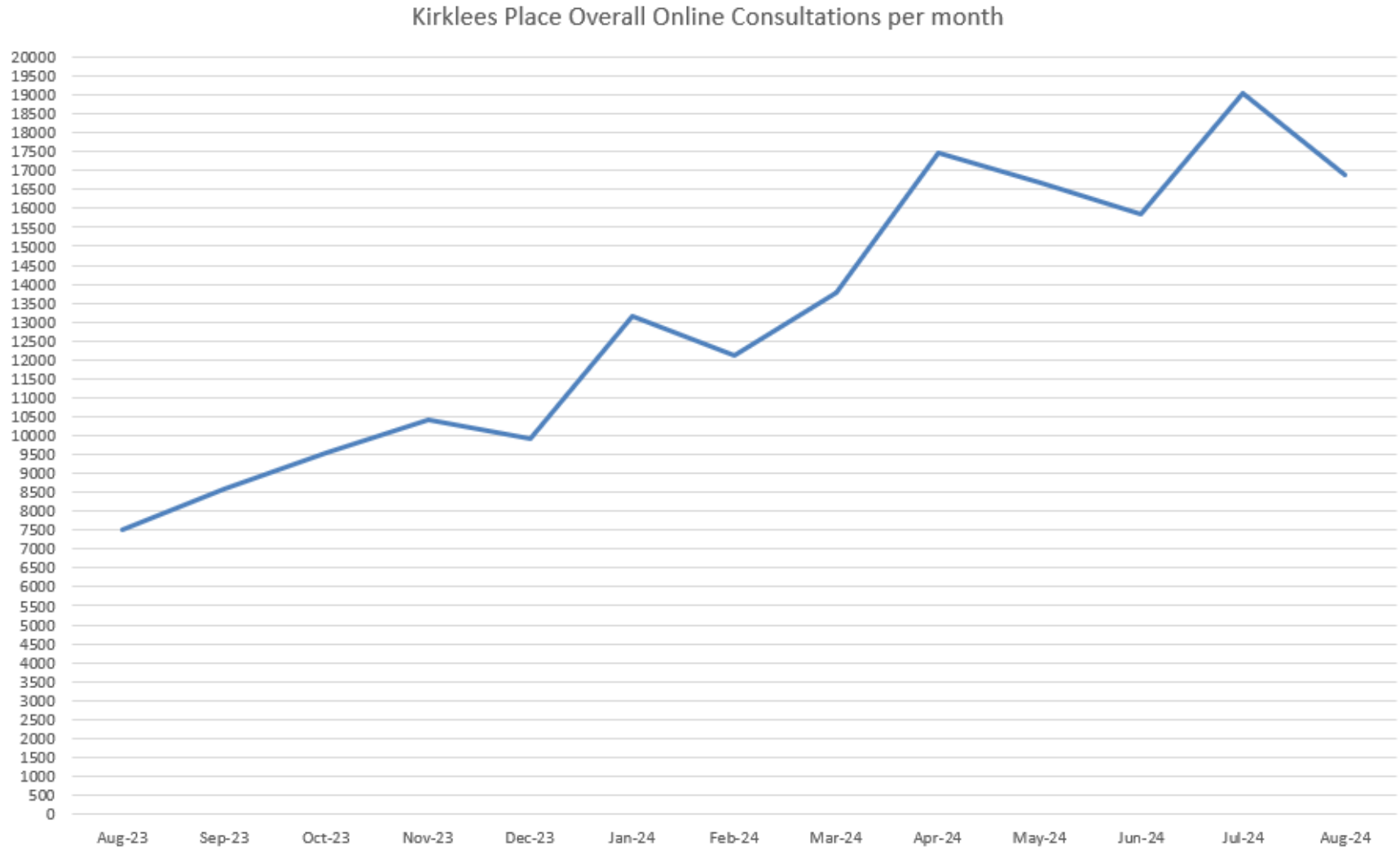
Register with GP Surgery Service:-

As of 16/9/24 **44/64** practices offering registration service on-line, remaining 20 practices due to go live by end October 2024

Access to Primary Care

Improving Access – Online Consultations

NHS West Yorkshire Integrated Care Board



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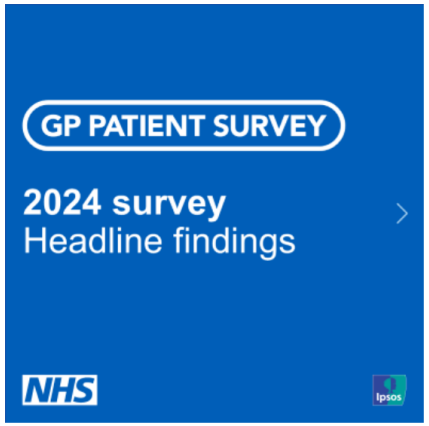
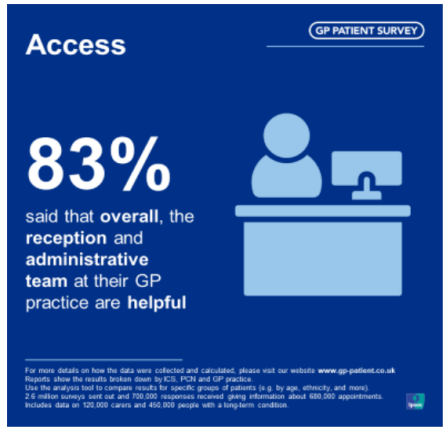
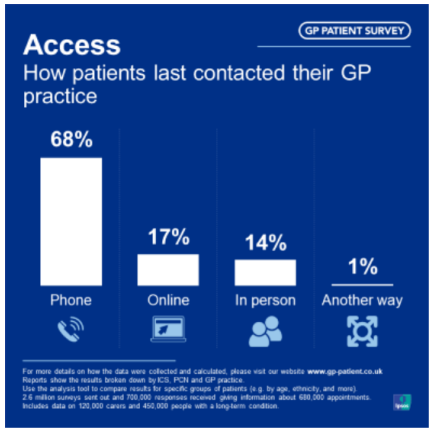
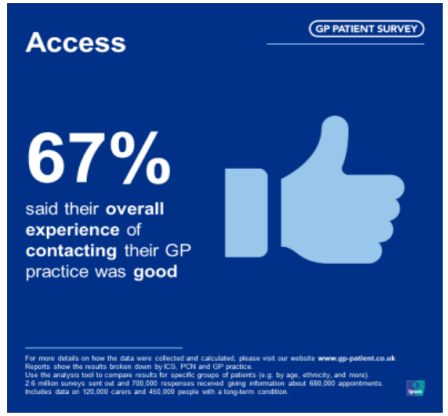
GP Patient Survey - 2024

NHS West Yorkshire
Integrated Care Board









GP Patient Survey – Kirklees

NHS West Yorkshire Integrated Care Board

- The GP Patient Survey National Report https://gp-patient.co.uk/surveysandreports provides an extensive analysis of all questions.
- Results are presented for West Yorkshire by PCN.
- The questions changed this year which makes year on year comparison difficult.
- The Valleys PCN ranks as the highest performing across West Yorkshire for the third consecutive year.
- Practices and PCNs are asked to review their results, discuss them with their Patient Reference Groups, within their PCN and these are also picked up as part of an annual practice visit with the ICB Primary Care Team

Shared Referral Pathways (ShaRP)

NHS West Yorkshire Integrated Care Board

ShaRP encourages the use of Advice and Guidance and e-consultation processes.

Advice and Guidance (A&G) services are a clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity . Advice and Guidance (A&G) services are a key part of the National Elective Care Recovery and Transformation Programme's work. A&G provides primary care with continued access to specialist clinical advice, enabling a Patients care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity.

What is Advice and Guidance?

A&G is defined as non-face-to-face activity delivered by consultant-led services which can be:

- Synchronous (for example, a telephone call)
- Asynchronous (enabled electronically through the NHS e-Referral Service, or through other agreed IT platforms or email addresses)

By providing a digital communication channel, A&G allows a clinician (often in primary care) to seek advice from another (usually a specialist) prior to or instead of referral. Reasons why a clinician may wish to seek advice and guidance include:

- Asking another clinician or specialist for their advice on a treatment plan.
- Asking for clarification regarding a patient's test results.
- Seeking advice on the appropriateness of a referral.
- Identifying the most clinically appropriate service to refer a patient into.

Shared Referral Pathways (ShaRP)

NHS West Yorkshire Integrated Care Board

Why use Advice and Guidance?

A&G services help transform the way referrals are managed by improving the interface and facilitating shared decision making between primary and secondary care. Through better enabled communication, A&G provides GPs with access to consultant advice on investigations, interventions and potential referrals. This helps manage non-urgent (elective) patients in the most appropriate setting, helping reduce unnecessary referrals into secondary care.

To note, Advice and Guidance is the national service available to all General Practice. A&G is accessed via the ~ Electronic Referral Service platform when referrals are made to Calderdale and Huddersfield Foundation Trust specialties. For referrals to The Mid Yorkshire Teaching NHS Trust the platform and process is referred to as e-consultation.

In 2023/2024 there were ~29,000 A&G/consultation messages recorded between primary and secondary care.

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Reablement Support, Hospital Avoidance and Support at or Closer to Home

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Kirklees Home First Discharge Pathway

NHS West Yorkshire
Integrated Care Board

The following section describes the Kirklees Home First Discharge pathway and the services which support each level.

The new model is based on 'home' being the preferred destination and moves away from the previous D2A bed model. The D2A beds have been replaced with Recovery beds.

The home first discharge pathway should be described to patients as:

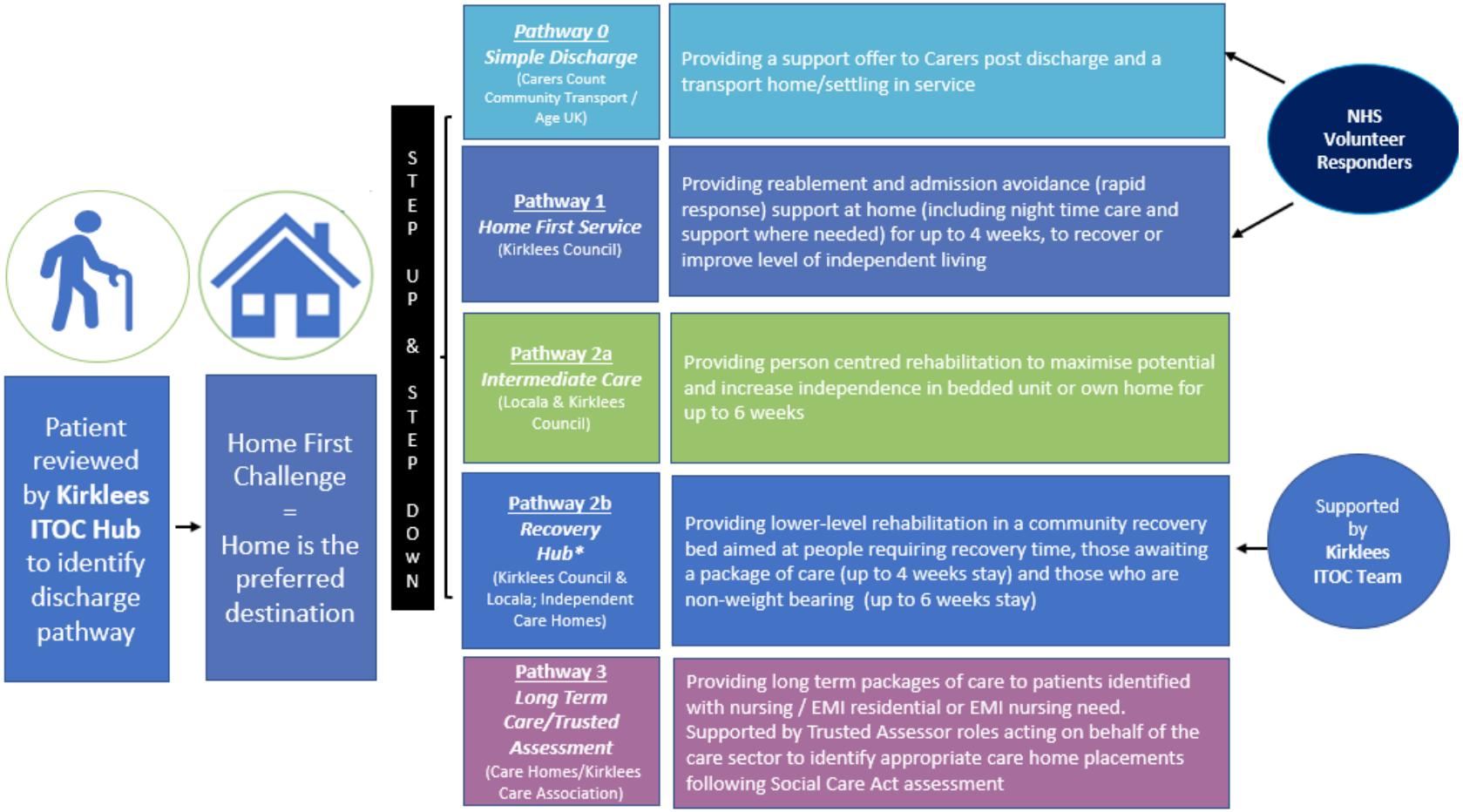
'When you are ready for discharge, we will try to get you home, with some support if you need it. If you need some extra support for your recovery, you may be transferred from hospital to a 'Recovery bed' for a period of up to 4 weeks,. During this time, the Recovery bed team will do all they can to support you to get ready to go home. If you need to stay in the Recovery bed setting for longer than 4 weeks, you may be charged depending on your financial assessment.

The Recovery beds are based at Netherton, Huddersfield.

Community

Kirklees Home First Discharge Pathway

NHS West Yorkshire
Integrated Care Board



* In-reach Rehabilitation support to dementia patients in care home settings

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Kirklees Health & Care Partnership

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Kirklees Home First Discharge pathway	
Home without any new support	The patient is ready to be discharged home without any new support. **Community Transport** and **Age UK** can take patients home from hospital and settle them back in. **Carer Support** can call carers to see how we are doing. **NHS Volunteers Responders** can also provide check-in and chat calls and support with some activities.
Home with new support	The patient is ready to be discharged home, but needs some support at home to help him/her be as independent as they can be. The **Home First Reablement Team** will help the patient be as independent as they can be by supporting them with things like meal preparation and self-care.
Intermediate Care	The patient is ready to be discharged from hospital, but not ready to go home yet. He/she needs extra support to regain their independence and will be cared for in an **Intermediate bed** setting until they are safe to go home. The **Intermediate Care Team** will support patient needs in the Intermediate Care bed setting. The patient will receive support from a range of people, including nurses, therapists and carers. Together, a plan will be agreed with the patient based on their abilities, needs and wishes to help them regain their independence.
Recovery Bed	The patient is ready to be discharged from hospital, but not ready to go home yet. He/she needs extra support and recovery time and will be cared for in a **Recovery bed** setting until they are safe to go home. The patient will receive support from a range of people, including therapists and carers. Together, a plan will be agreed with the patient based on their abilities, needs and wishes to help them recover and maintain their independence.
Long Term Care	The patient is no longer able to be looked after safely at home. It is in their best interest to move into a care home. The **Care Home** staff will support the patients' needs. Together, a plan will be agreed based on the patient's abilities, needs and wishes to keep him/her at their best.

Community

Kirklees Home First Discharge Pathway

NHS West Yorkshire Integrated Care Board

Achievements:

- Carers Count providing support for up to 35 carers a week for each Acute Trust
- 382 North Kirklees patients supported home with Age UK
- Increased Reablement offer > 385 people supported each week from October 2024 (average 3 days from referral to receipt of service)
- Achieved the additional 14 people going home first rather than to a temporary bed setting
- Improvement work with Discharge ITOC team and processes
- Recovery Bed Hub at Moorlands Grange now fully staffed (40 beds)/reduction in the need for spot purchased recovery beds
- Night Sitting service fully established
- Trusted Assessors working with 60 care homes in Kirklees
- Creation of a Kirklees Discharge Dashboard which closely monitors activity

Community

Kirklees Home First Discharge Pathway

NHS West Yorkshire Integrated Care Board

Pathway 1 – Home First Service (including Nights Service)

- The Home First Service helps people to regain the skills and confidence needed to live independently at home, particularly after an illness or a stay in hospital.
- The Home First Service is a short-term service, provided in the home which is offered to people who have the potential to recover or improve their level of independence. This could include:
  - Support to practice daily activities such as cooking and bathing to help regain skills and get confidence back
  - Finding new ways to do some things to make people feel safer and more confident
  - Looking at other options which may help to support independence at home. For example, use of assistive
  - technology, equipment or alterations to the home
  - Supporting with therapy plans, if prescribed by an physiotherapist or occupational therapist
  - Night-time care and support, providing a full wrap around offer through night visits or night sits
  - 0–2-hour admission avoidance where required.

- The service is available free of charge for up to 4 weeks. After 4 weeks a person led needs assessment will be done, and the amount paid based on a financial assessment. To get this service a Care Act Assessment is required for eligibility (Determination of eligibility under the Care Act) and the person needs to be willing and able to relearn how to carry out everyday skills and tasks.

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Key Contact: Julie Bacon (Kirklees Council) Julie.Bacon@kirklees.gov.uk

Kirklees Health & Care Partnership

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Kirklees Home First Discharge Pathway

NHS West Yorkshire
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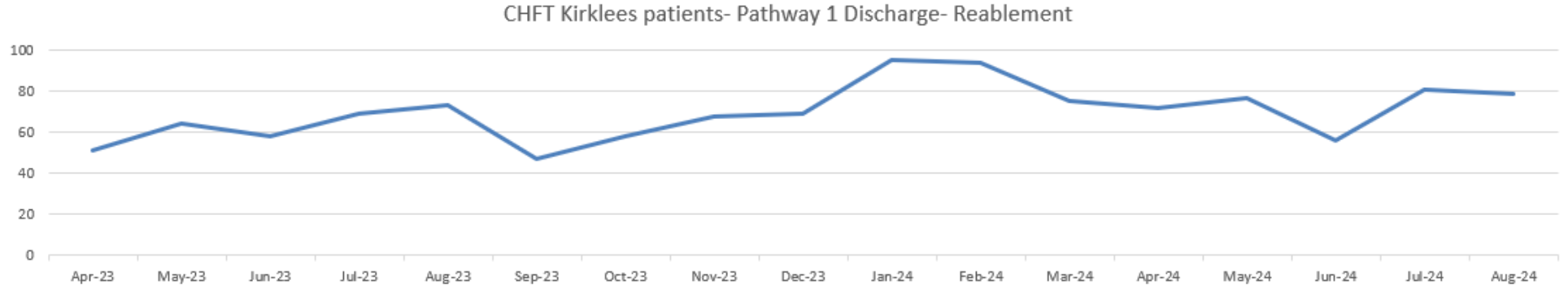
CHFT Discharges into Reablement

CHFT Kirklees Discharges	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change from month	Direction
Pathway 1 Discharge- Reablement	51	64	58	69	73	47	58	68	69	95	94	75	72	77	56	81	79	-2	↓
Discharged to:																			
Usual place of residence	51	63	57	68	72	45	56	67	68	93	91	74	69	74	54	79	79	0	↔
Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment)		1				1	1		1		1	1		1	1	1			
Care Home With Nursing				1						2			1			1			
Patient died								1			2		2	2	1				
Other (Inc. NHS other hospital provider - ward for general PATIENTS or the younger physically disabled, Non-NHS (other than Local Authority) run Care Home, An Organisation responsible for forced repatriation)			1		1	1	1												



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Kirklees Home First Discharge Pathway

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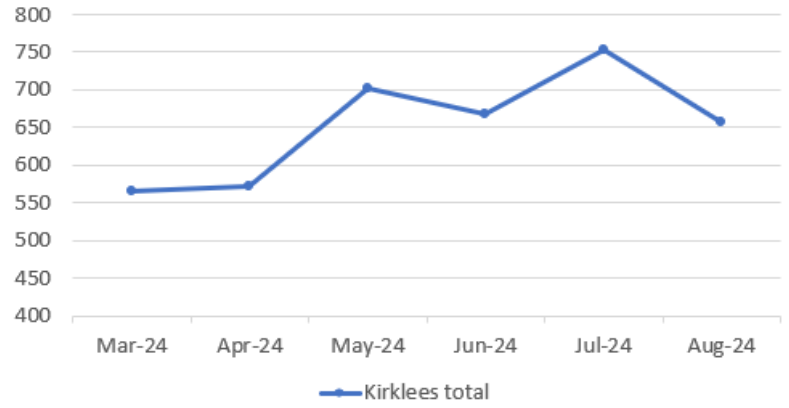
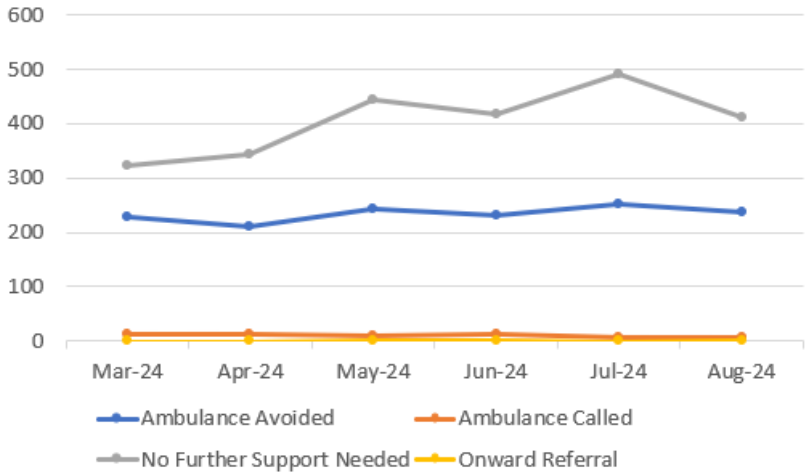
Night Service

Number of patients referred into Night Service	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change from month	Direction
Kirklees total	566	571	701	668	752	656	-96	↓



Outcome Kirklees total - Mobile response	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change from month	Direction
Ambulance Avoided	229	210	242	230	251	236	-15	↓
Ambulance Called	12	13	9	12	8	7	-1	↓
No Further Support Needed	324	342	445	417	492	412	-80	↓
Onward Referral	0	0	1	1	0	1	1	↑



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Kirklees Home First Discharge Pathway

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Pathway 2a – Intermediate Care

The Intermediate care service will provide support to people for up to 6 weeks in a community Intermediate Care Bed setting or in the person's own home. The team will help people to recover from an episode of acute illness, a fall or operation to maximise their independence and enable them to resume living at home.

The bedded unit is provided at **Ings Grove, Mirfield** where the **Intermediate Care beds** are hosted. The unit is supported by a joint team from both Health and Social Care. Personal care is provided by the Social Care staff with health care and rehabilitation provided by Locala clinical Intermediate Care team.

To access Intermediate Care the person needs to be medically stable and in the need of extra rehabilitation to cope at home. People not coping at home due to recent illness but who want to remain independent may also access the service.

The Intermediate Care team provide 24-hour support and care at Ings Grove. Therapists and care staff work with residents to ensure that they become more independent and can carry out day to day activities. Residents are encouraged to participate in daily rehabilitation. Discussions with residents and families are put in place to plan the person's return home and identify any support needs.

This service may provide home-based intermediate care within the 6-week period to continue rehabilitation, provided that the home is a suitable and safe environment. The Kirklees ITOC Hub may identify some people as suitable for Intermediate Care Support at home, directly on discharge. These patients will have the option to step up into the Intermediate Care Bed setting if required.

N.B. The Intermediate Care acceptance criteria is currently under review

Community

Kirklees Home First Discharge Pathway

NHS West Yorkshire Integrated Care Board

KPI outcomes for IMC for Q1

- 90% of patient overall experience reported good or higher – **95.45%**
- 80% of patients will be discharged within 6 weeks – **86.96%**

Community

Kirklees Home First Discharge Pathway

NHS West Yorkshire
Integrated Care Board

Pathway 2b – Recovery beds

The Kirklees Council Recovery beds are based at **Moorlands Grange (Netherton, Huddersfield)** and provides a single, consolidated bed base of up to 40 beds to aid post-discharge recovery and allow recuperation time alongside providing a low-level rehabilitation for people not quite ready follow the home first pathway home. The bed base will also accommodate people who are awaiting a package of care to go home and those who are non-weight bearing (NWB).

Length of stay in a Recovery bed is expected to be up to 4 weeks (6 weeks for NWB) with an aim to support people to go home earlier if possible, with appropriate support to meet the person's assessed social care and ongoing medical needs in the community.

Patients diagnosed with advanced dementia will be supported in a Recovery bed within a care home setting in the community.

People in Recovery beds are supported by the **Kirklees ITOC Discharge Team**.

Any Recovery bed stay beyond 4 weeks (6 weeks for NWB) would require a care act assessment to be undertaken by the social work team.

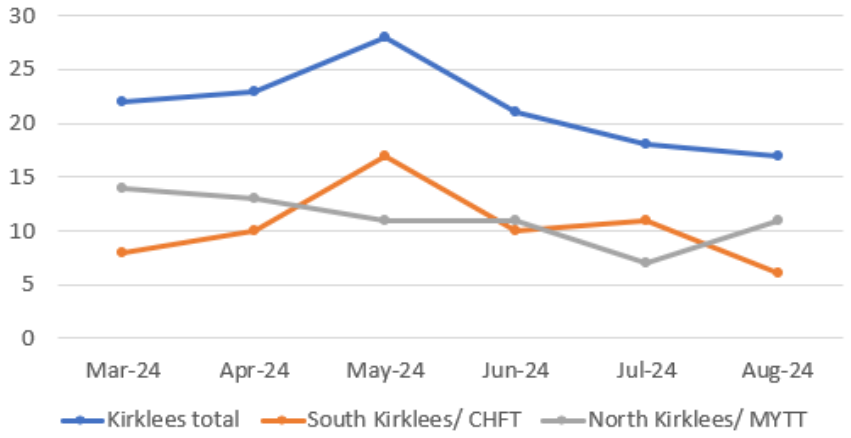
Community

Kirklees Home First Discharge Pathway

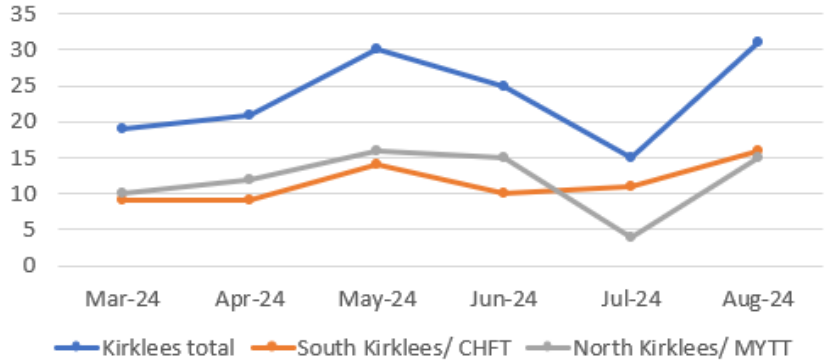
NHS West Yorkshire
Integrated Care Board

Recovery Beds Data

Referred in month Recovery bed	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change from month	Direction
Kirklees total	22	23	28	21	18	17	-1	↓
South Kirklees/ CHFT	8	10	17	10	11	6	-5	↓
North Kirklees/ MYTT	14	13	11	11	7	11	4	↑



Discharged in month recovery bed numbers	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change from month	Direction
Kirklees total	19	21	30	25	15	31	16	↑
South Kirklees/ CHFT	9	9	14	10	11	16	5	↑
North Kirklees/ MYTT	10	12	16	15	4	15	11	↑



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Kirklees Home First Discharge Pathway

NHS West Yorkshire Integrated Care Board

Pathway 2b – Kirklees ITOC Discharge Team

- The Kirklees ITOC Discharge Team provide initial holistic assessment within 48 hours of admission into Recovery bed which helps inform development of an individualised rehabilitation plan and clearly stages any therapy or ongoing health/social care needs.
- The team will have a daily presence (during the hours of 8am to 5pm) within the Recovery Hub unit supporting staff and patients to implement personalised care and support plans which encourage reablement.
- The team will also provide in-reach to dementia patients staying in care home recovery beds.
- Length of stay in the recovery beds is up to 4 weeks, with earlier discharge and support by the team at home where appropriate.
- The team will also support discharge from the Recovery bed setting by arranging any equipment and referrals onto other services for post discharge support.

Kirklees ITOC Discharge Team – Tel: 0303 330 8999

Community

Kirklees Adult Social Care Change Programme Scope

NHS West Yorkshire
Integrated Care Board

PROGRAMME VISION

To ensure that our residents experience good adult social care outcomes that maximise independence in line with the Vision for Adult Social Care, within the resources available and the ability to mitigate external pressures such as the impact of reform and increases in demand.

Forecasted savings 24/25 £9.8m

Programme Delivery Budget £938,119

FRONT DOOR

Supporting our residents with a robust universal offer that prevents need for Adult Social Care or reduces formal need.
Note: this does not include wider contact centre integration activity.

Increasing referrals into Community based support by 25%

ADULTS

Driving ownership across our teams and enabling them to deliver strength-based support through a simple, streamlined process.

450 more of our adults every year to have a better journey through social care and live more independently

REABLEMENT – SHORT TERM SERVICES

Delivering preventative services that are therapy led whilst still linking into intermediate care.

1200 people per year to live more independently and have smaller formal packages of care

LEARNING DISABILITIES AND MENTAL HEALTH

Challenging our mindset and model around progression, enabling creative and strengths-focussed decision making, utilising enabling services and ensuring we have an effective transitions pathway.

500 of our residents with a learning disability or mental health conditions to live more independently

FINANCIAL ASSESSMENT AND DEBT RECOVERY

To maximise the collection of adult social care client income and reduce client debt.
Note: Workstream scope in development whilst discovery activity is underway.

Community

Kirklees Adult Social Care Change Programme

NHS West Yorkshire Integrated Care Board

Kirklees Reablement Vision

Working collaboratively to support people to live as independently as they can, through a belief in partnership, trust and a belief in people's capacity to live a good life

We will do this by embedding an optimised Kirklees reablement model which seamlessly integrates, connects, and transitions between locations (Home/Hospital), across different sectors (acute/primary care/social care/housing) and between different states (illness/recovery):

- ✓enabling individuals to live independent lives with meaning and purpose,
- ✓empowering individuals to be self-determined, and
- ✓avoiding dependency on health and social care.

The New Reablement Offer

- A timely response utilising a reablement ethos which identifies the least restrictive support possible.
- Period of up to seven days support from reablement/STUST for an initial assessment of need.
- Initial joint assessment of need with a therapy-focused approach to identify the onward pathway i.e. further reablement, transfer to long-term package of care, signpost and onward referrals, identify independence and exit.
- Early support with a financial assessment to identify charges for longer term support. Care Act compliant assessment at the onset of service which mitigates the risk of demand failure.
- Flexible and responsive night support which supports hospital discharge and bed-base avoidance.
- Maximise independence with the least restrictive support utilising digital and assistive technology and equipment
- Support timely discharge, facilitating an increase of up to three additional hospital discharges per day across seven days.
- Recovery bed step-up referral to be made within 72 hours if the discharge home plan is at risk of failing.

adult social care

Kirklees COUNCIL

Kirklees Health & Care Partnership

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Community

Kirklees Adult Social Care Change Programme

NHS West Yorkshire Integrated Care Board

Workstream Impact

We want to increase the **volume** of referrals into reablement per week and ensure those referrals are accepted.

We want to optimise the **efficiency** of the service offer by maximising contact time

We want to reduce the 'time to re-able' average to enhance the **effectiveness** and throughput of the service model

We want to maximise peoples reablement potential to improve their **outcomes**, to ensure they go on to need a reduced or no package of care

We want to extend the **duration**/time a person's independence is maximised, following a period of reablement

adult social care

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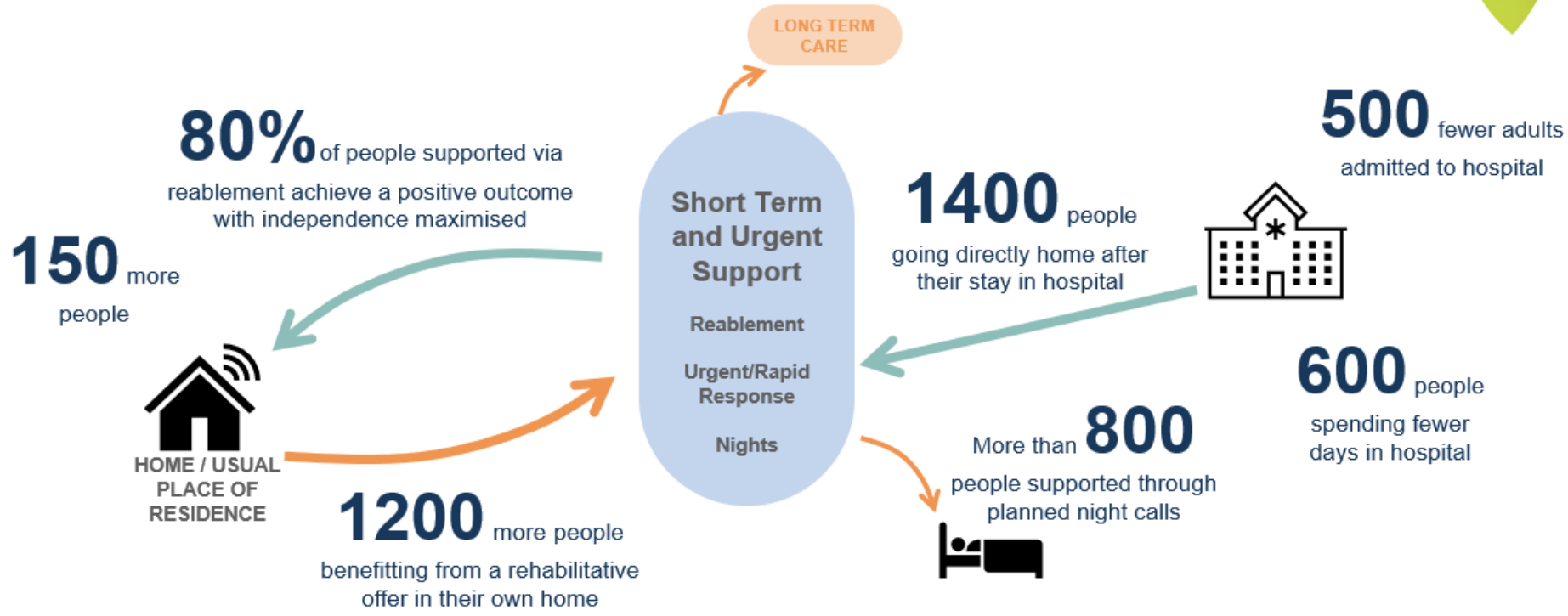
Kirklees Adult Social Care Change Programme

NHS West Yorkshire Integrated Care Board

Achieving our vision will provide a full wrap around (day and night) support offer in people's homes and enable more than 4000* people each year to have a better outcome



adult social care

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Admissions Avoidance

NHS West Yorkshire
Integrated Care Board

Achievements:

- Revised service specifications for all KCS services
- Falls Response and Assessment tool launched
- MY STAR patients > process agreed

Initiatives:

- **UCR** - Joint review of workforce to maximise efficiencies
- **Virtual Ward -** Developing Step Up pathway and LA/Locala working to look at integration
- **LCD** - linked with High Intensity User Groups
- **Discharge ITOC Team -** Supporting STAR patients and patients in A&E at DDH to avoid admission
- **Reablement** - Locala and the Local Authority working jointly as an IHSC team on the Home First Pathway

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Integrated Care Board

Community Pharmacy

Community Pharmacy

Primary Care Access Recovery and Community Pharmacy

Pharmacy's role has been increasing in recent years. Working to embed and integrate community pharmacy into the NHS, delivering more clinical services and making them the first port of call for many minor illnesses.

- January 2024 saw the launch of the Pharmacy First Service to enable community pharmacists to complete episodes of care for patients without the need for the patient to visit their general practice.
- This, alongside expansions to the pharmacy blood pressure checking and contraception services, will save up to 10 million general practice team appointments a year and help patients access quicker and more convenient care, including the supply of appropriate medicines for minor illness.

Kirklees has **98** community pharmacy contractors.

Community Pharmacy

NHS West Yorkshire
Integrated Care Board

Kirklees Ambition for Primary Care Access Recovery and Community Pharmacy

- The importance of the role of community pharmacy is prominent within the Primary Care Access Recovery Plan.
- Within Kirklees – since their inception, encouraging PCNs to work collaboratively with CP and PCNs have a link pharmacist to support discussion.
- Some practices have already embraced the use of Pharmacy First and are seeing the benefits to workload.
- Kirklees has agreed to an ambitious stretch in terms of Pharmacy First referrals which when it is broken down means there would be enough referrals for the Pharmacies to achieve their threshold for payment. This would support the sustainability of the service for the future.
- Key to releasing these ambitions is integration and collaborative working between GP practices and community pharmacies.

Community Pharmacy

Community Pharmacy – Pharmacy First

NHS West Yorkshire Integrated Care Board

Pharmacy First offers patients who contact either;

- NHS 111 (by telephone or online)
- 999
- Their own practice
- Primary care out of hours service
- UEC setting (ED, UTC, UCC)

The opportunity to access appropriate urgent care services in a convenient and easily accessible community pharmacy setting.

There are three elements to the service

1. Electronic referrals for minor illness consultation with a pharmacist
2. Electronic referrals for the urgent supply of repeat medicines and appliances (not available for GP referrals)
3. Clinical pathway consultations (electronic referral or self referral)

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Community Pharmacy

Community Pharmacy – Pharmacy First

NHS West Yorkshire Integrated Care Board

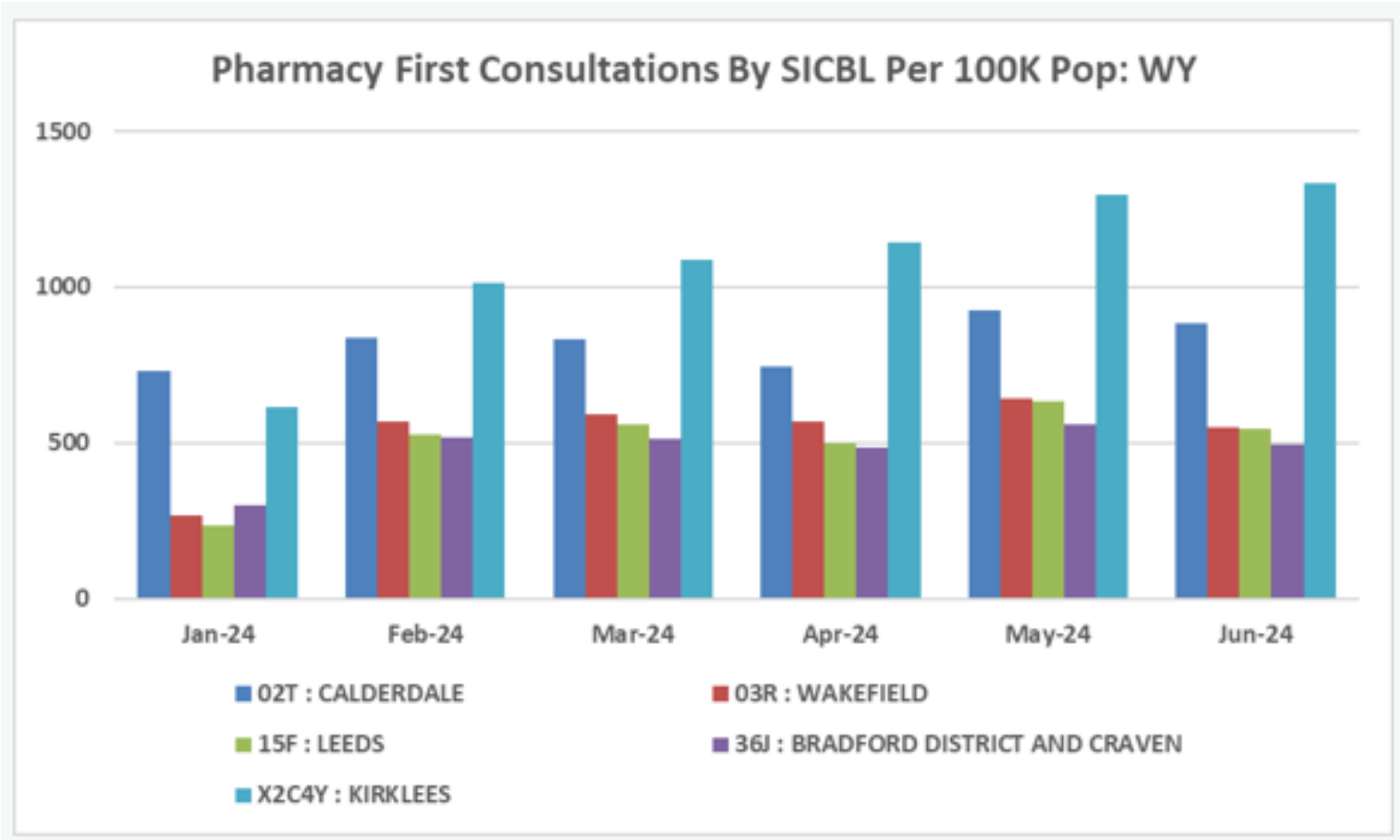
The clinical pathway consultation element enables pharmacists to provide advice and where appropriate NHS-funded treatment for 7 common conditions:

- Sinusitus (12 years and over)
- Sore Throat (5 years and over)
- Acute Otitis Media (1 to 7 years old) – Distance-selling pharmacies not able to provide
- Infected insect bite (1 year and over)
- Impetigo (1 year and over)
- Shingles (18 years and over)
- Uncomplicated UTI (women 16 to 64 years)
- The patients GP practice is notified after every Pharmacy First Service.

95.9% of Kirklees pharmacies signed up to provide the service.

Community Pharmacy – Pharmacy First

NHS West Yorkshire Integrated Care Board



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Kirklees Health & Care Partnership

Community Pharmacy

Community Pharmacy – Hypertension Case Finding through the BP Check Service

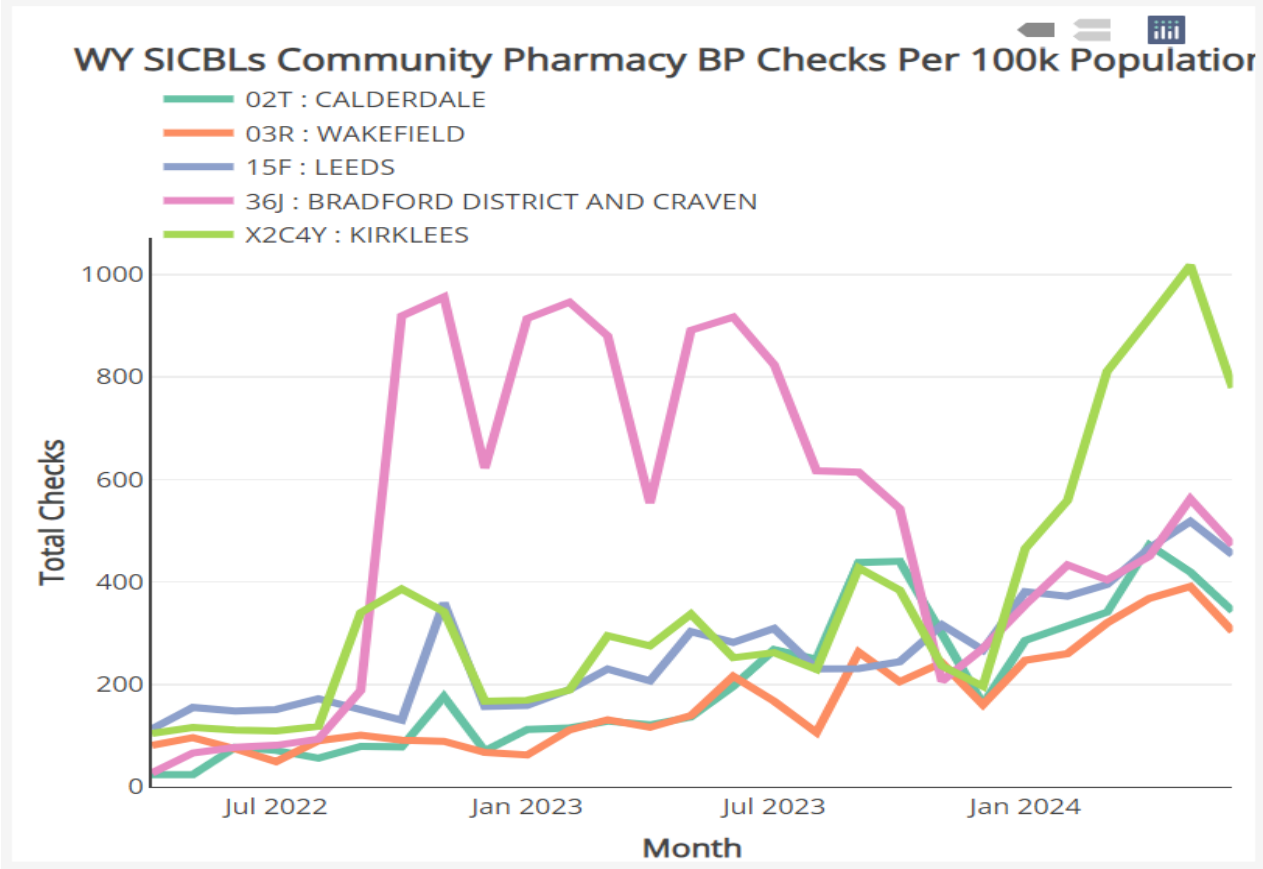
NHS West Yorkshire Integrated Care Board

- NHS England ambition for hypertension is that 80% of the expected number of people with high BP are detected by 2029, and that 80% of the population diagnosed with hypertension are treated to target. Estimated less than 60% of people with hypertension have been diagnosed.
- Current hypertension prevalence in West Yorkshire is 14.82% of adults and the ICS has a target to increase this to an expected 30%.
- NHS Hypertension Case-Finding Service aka BP Check is an Advanced Service provided by 89% of community pharmacies in WY and has two stages:
  - Stage 1 – Identifying people at risk of hypertension and offering them the opportunity to have their blood pressure measured.
  - Stage 2 – This is offered if a person's blood pressure reading is high at Stage 1. A person will be offered waking hours ambulatory blood pressure monitoring (ABPM).
  - At the request of a general practice, undertake ad hoc normal and ambulatory blood pressure measurements.

Community Pharmacy

Community Pharmacy – Hypertension Case Finding through the BP Check Service

NHS West Yorkshire Integrated Care Board



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Community Pharmacy

Community Pharmacy – Hypertension Case Finding through the BP Check Service

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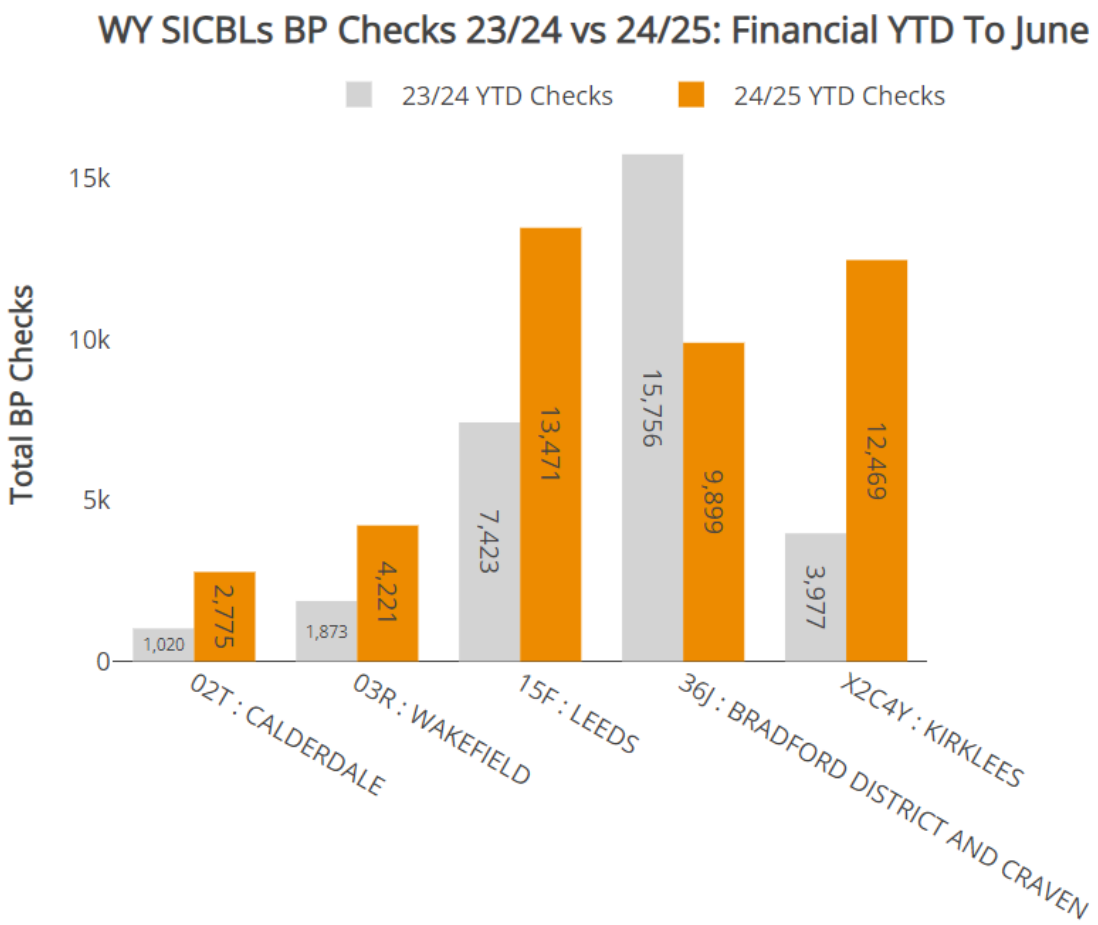

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Community Pharmacy

Community Pharmacy – Contraception Service

NHS West Yorkshire Integrated Care Board

The aim of the Pharmacy Contraception Service (PCS) is to offer people greater choice and access when considering starting or continuing their current form of oral contraception.

The service supports the important role community pharmacy teams can play to help address health inequalities by providing wider healthcare access in their communities and signposting service users to local sexual health services. It also aims to create additional capacity in primary care and sexual health clinics (or equivalent) to support meeting the demand for more complex assessments.

To be eligible to access this service a person must be an individual seeking to be initiated on an oral contraception (OC), or seeking to obtain a further supply of their ongoing OC:

- Combined Oral Contraceptive (COC) – from menarche up to and including 49 years of age; or
- Progestogen Only Pill (POP) – from menarche up to and including 54 years of age.

People who wish to consult another healthcare provider for contraception support are still free to do so.

70.4% of Kirklees pharmacies provide the Pharmacy Contraception Service.

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Community Pharmacy

Community Pharmacy – Contraception Service

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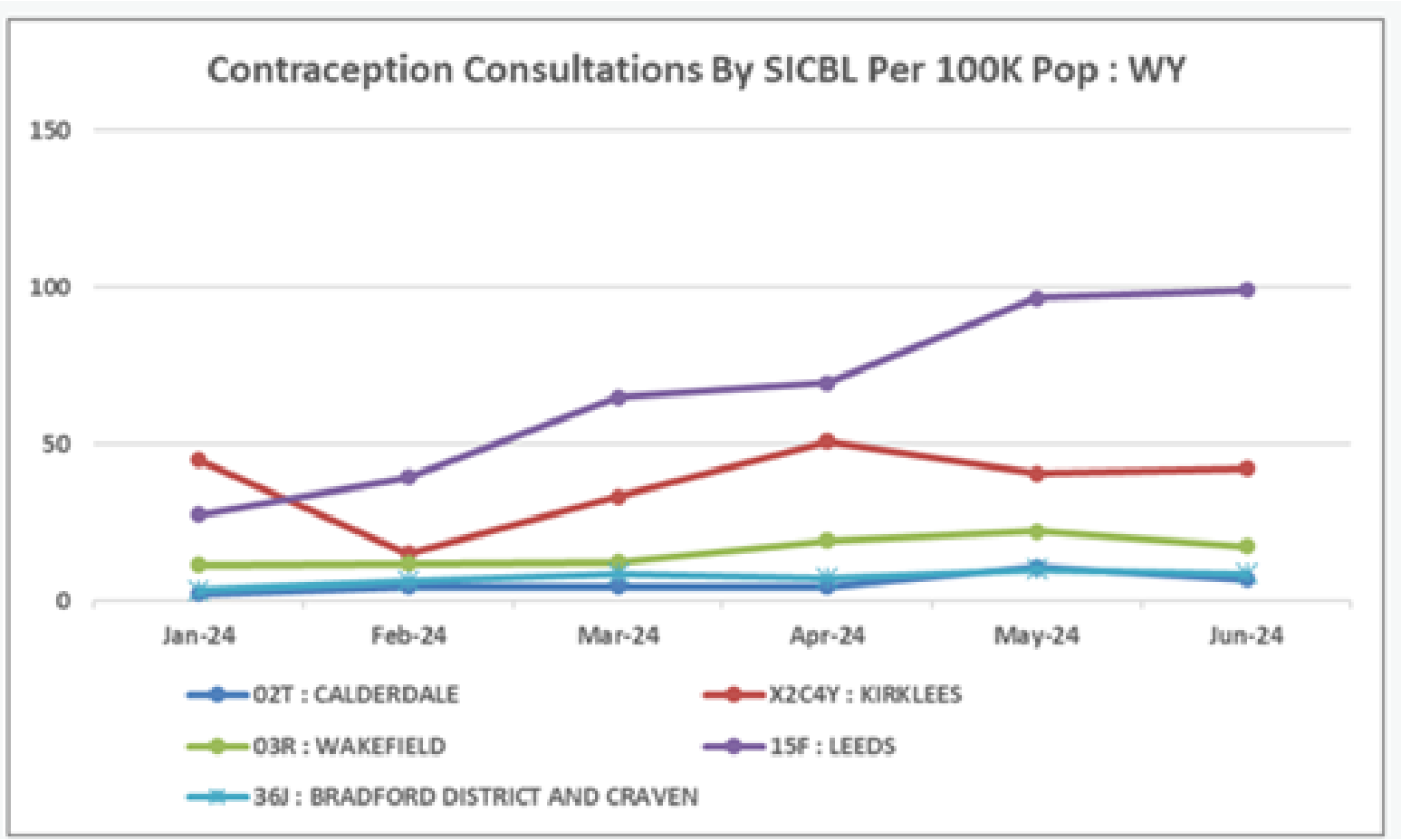

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Kirklees Health & Care Partnership

Community Pharmacy

Community Pharmacy – Workforce

NHS West Yorkshire Integrated Care Board

What is happening from 25/26

- Trainee Pharmacists (previously Pre-Reg Pharmacists) who pass their GPHC exam will be independent prescribers
- Trainees will need to have access to an appropriate prescribing setting
- Trainees need to complete 90 hours of learning in practice
- An e-portfolio will be submitted containing prescribing assessment activities

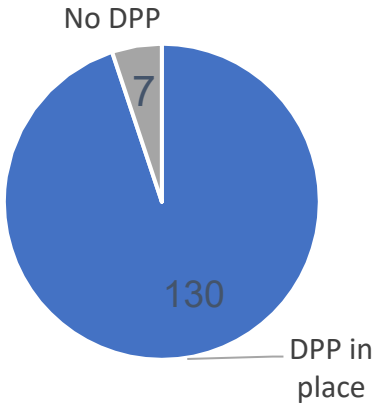
Community Pharmacy

Community Pharmacy – Workforce

NHS West Yorkshire Integrated Care Board

What is happening from 25/26

- Approximately 260 trainees in West Yorkshire (Based off postcode given to GPHC some may not work within their postcode constituent)
- Huge cross sector match making activity has taken place to identify suitable DPP provision for the trainee's across both primary and secondary care.
- From those we have engaged in the process and we are aware of their DPP status by August 2024



Community Pharmacy – Challenges

NHS West Yorkshire Integrated Care Board

https://cpe.org.uk/wp-content/uploads/2024/08/Pharmacy-Pressures-Survey-2024-Funding-and-Profitability-Report_compressed.pdf

Summary

Community pharmacies are facing critical financial pressures. As privately owned businesses providing NHS services, pharmacies are run by skilled business people who combine an entrepreneurial approach with a real desire to improve health outcomes.

The average pharmacy relies on NHS funding for around 90% of its income. But that core NHS funding **has decreased in real terms by 30% since 2015,** while costs and activity have spiralled. The number of NHS services they are expected to deliver has grown over that period so they are working harder and harder for significantly less money.

The reality is now that too many pharmacies are struggling to stay afloat, with less than half barely breaking even, and **countless pharmacies are at risk of closure with an indication that nearly 1-in-6 may close within the next year.**

Community pharmacies urgently need more funding to cover the costs of delivering their core contractual services for the NHS and their patients. Over half (52%) of pharmacies have revealed that **the pressures are having a negative impact on patients.**

Community Pharmacy England is seeking increased funding for the sector so pharmacies can continue their frontline role supporting the NHS and the long-term health needs of local communities.

Pharmacy teams are being burdened with unnecessary administrative tasks, diverting their attention from crucial services such as Pharmacy First, Blood Pressure Service, Contraceptive Service, and ensuring patients receive their regular medications.

Pharmacy owner

Community Pharmacy

Community Pharmacy – Workforce

NHS West Yorkshire Integrated Care Board

Stock shortages

- This year has been particularly challenging. Multiple factors have impacted on drug availability causing drug prices to fluctuate which has affected the ability to obtain drugs.
- The shortages of drugs has made the process of dispensing and supply much more labor intensive.
- Serious Shortage Protocols (SSPs) have been issued for a limited number of drugs.
- There have been several high-volume lines this year where pharmacy contractors have made a significant loss on a specific drug line due to the price concession granted at the end of the month not meeting the purchase price.
- Community Pharmacy England is fully aware of the difficult challenges faced by community pharmacy owners when the final prices granted or imposed by DHSC fall below the purchase prices they have paid. This can have a disproportionate effect particularly on those pharmacies dispensing large volumes of any affected lines. Concerns about the process for setting price concessions have been raised to senior Government officials responsible for medicines supply.

Update from Community Pharmacy West Yorkshire

Community Pharmacy – Overview

NHS West Yorkshire Integrated Care Board

- Despite the current pressures that our community pharmacy teams are reporting the network continue to support the people they serve through engagement with and delivery of NHS services.

- Community pharmacy teams continue to support self-care, healthy lifestyle choices and behaviour change and for many are the first port of call for our local population with non-acute illness and health concerns.

- This includes the shift to better using the clinical skills within community pharmacy. Community pharmacies are currently supporting development of the ten West Yorkshire community pharmacy independent prescribing pathfinder sites.

NHS West Yorkshire
Integrated Care Board

Vaccination Programme

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Uptake to Vaccination Programme

Covid Vaccination Programme

NHS West Yorkshire Integrated Care Board

COVID-19: JCVI advice for Autumn 2024

- The government has accepted final advice from the Joint Committee on Vaccination and Immunisation (JCVI) regarding a COVID-19 autumn/winter 2024/25 vaccination programme.

- The groups to be offered a COVID-19 vaccine in autumn/winter 2024/25 are:
  - residents in a care home for older adults
  - all adults aged 65 years and over
  - persons aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the UK Health Security Agency (UKHSA) Green Book on immunisation against infectious disease

- **The JCVI also advises that health and social care service providers may wish to consider whether vaccination provided as an occupational health programme to frontline health and social care workers is appropriate in future years;**

Uptake to Vaccination Programme

Covid Vaccination Programme

NHS West Yorkshire Integrated Care Board

Outreach

- It is vital that the autumn/winter 2024/25 vaccination delivery network includes outreach services to meet the needs of communities that are currently disadvantaged, particularly those who are more deprived. For example, providers may want to consider how to design services for people who struggle to make appointments during working hours.
- It is expected that any provider would make reasonable efforts to reach the whole eligible population.
- Where possible, these outreach services should be aligned across all vaccinations – and with wider prevention efforts – to ensure that we are taking all opportunities to improve the health of unvaccinated and under-vaccinated communities.
- Access and Inequalities Funding has been made available to support outreach activities.
- PCNs are invited to plan family vaccination events to offer all available vaccines to those eligible including missed early years vaccination
- An application has been submitted to financially support PCNs additional outreach activities

Uptake to Vaccination Programme

Covid Vaccination Programme

NHS West Yorkshire Integrated Care Board

Covid uptake (Autumn 2023)

West Yorkshire

SEASONAL BOOSTER UPTAKE WITHIN SELECTED POPULATION

Total Population	Booster Eligible Population	Booster Doses	Booster Doses (of eligible population)	Received a Booster Dose (of eligible population)
2,621,550	842,478	449,706	426,893	50.7%

Kirklees

SEASONAL BOOSTER UPTAKE WITHIN SELECTED POPULATION

Total Population	Booster Eligible Population	Booster Doses	Booster Doses (of eligible population)	Received a Booster Dose (of eligible population)
450,262	148,949	74,604	71,426	48.0%

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Uptake to Vaccination Programme

Covid Vaccination Programme

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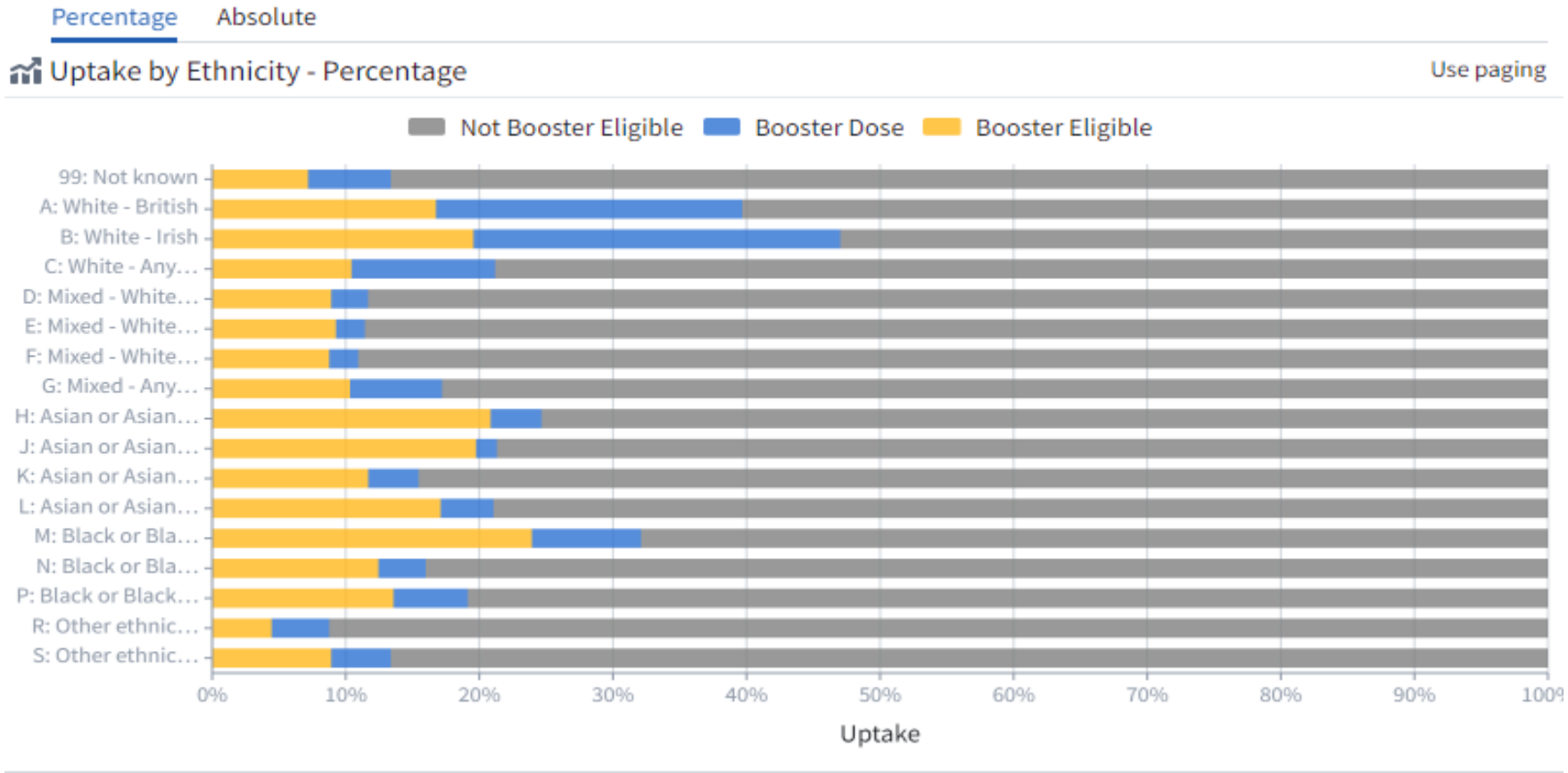
Covid uptake by Ethnicity (Autumn 2023)



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Uptake to Vaccination Programme

Covid Vaccination Programme

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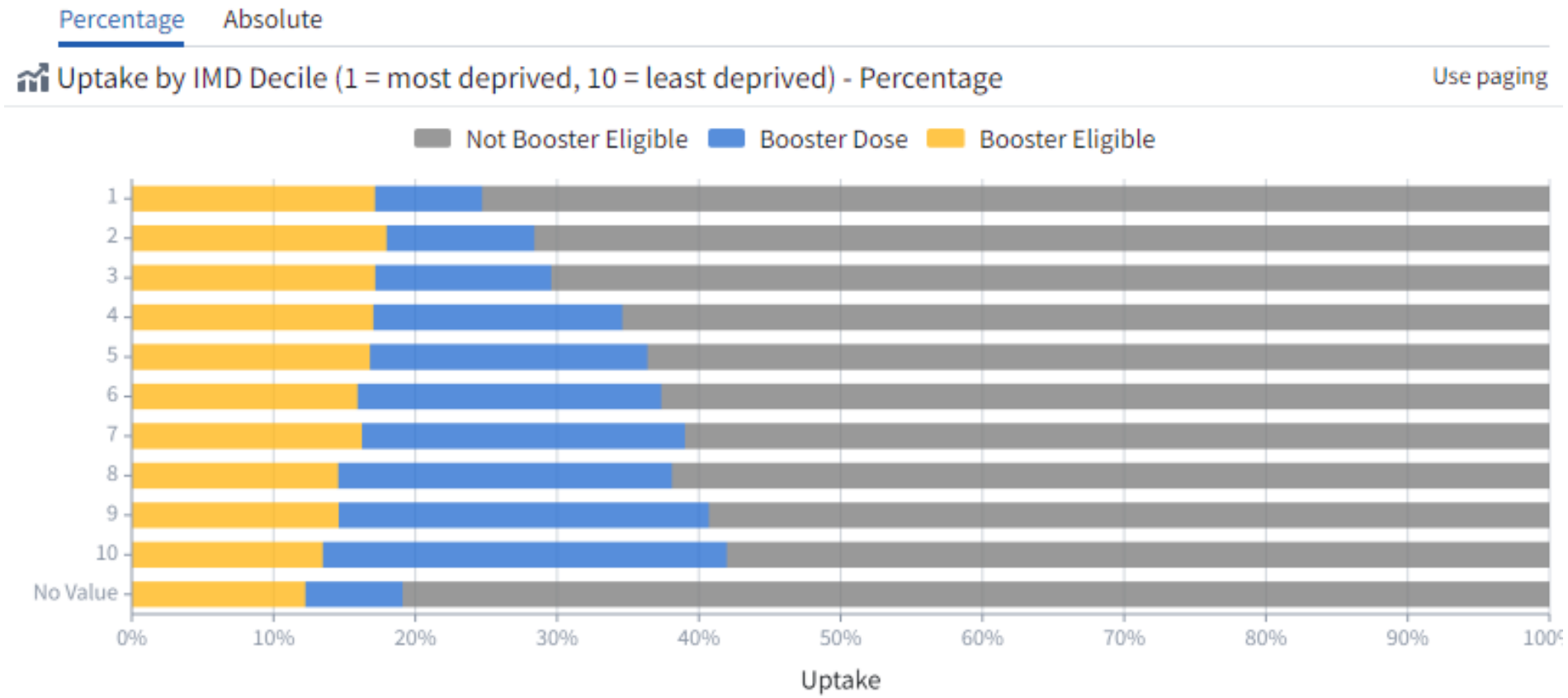
Covid uptake by Deprivation (Autumn 2023)



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Uptake to Vaccination Programme

Covid Vaccination Programme

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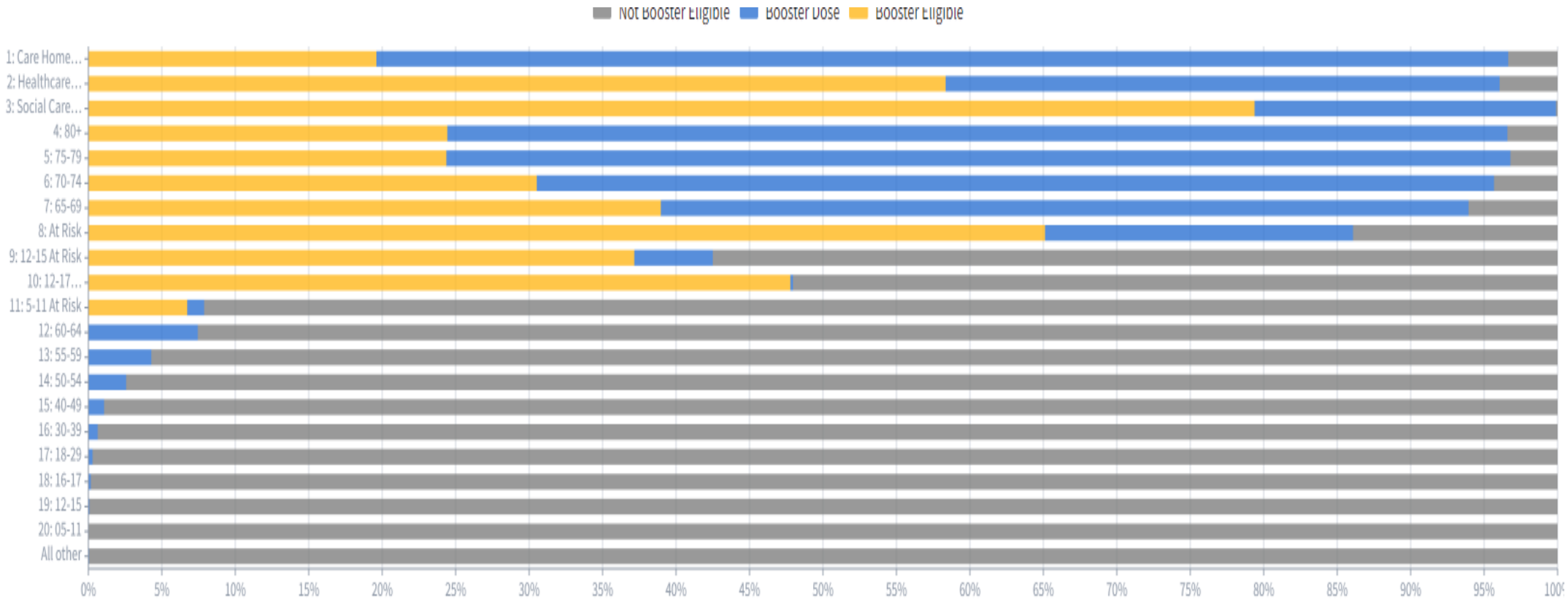
Covid uptake by JVCI Group (Autumn 2023)



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Uptake to Vaccination Programme

Covid Vaccination Programme

NHS West Yorkshire Integrated Care Board

Community Champions

During the Autumn/ Winter 2023 campaign Community Champions made a massive impact. As a result of having a conversation about Covid & Flu with a community champion:

- **1597** individuals have an improved awareness of Covid/Flu and immunisations available
- **283** were signposted to online resources or their health care provider to find out more
- The majority of people said they would think more about having the vaccines
- **85** people would now get the Covid jab
- **91** people would now get the flu jab

The majority of people said that they would use their new awareness to spread the message amongst family and friends

Uptake to Vaccination Programme

Covid Vaccination Programme

NHS West Yorkshire Integrated Care Board

Community Champions – Key Numbers

Winter Immunisations campaign

Aims

- Improving awareness of Covid and Flu vaccines & supporting informed decision making
- Increasing awareness and understanding of the increased risks associated with Covid and Flu
- Improved awareness of how to access vaccines including eligibility criteria
- Gaining important insights around barriers, key themes and learning
- Focus on all health inclusion groups

Proposed activity to achieve this:

- To hold community-based conversations to raise awareness and offer advice and signposting with individuals, groups, at events and in other community settings
- To organise and deliver pop up clinics within community settings

Key numbers:

1337 1-1 conversations took place
79 group visits
836 additional individuals reached as part of the group visits
16 pop up vaccine clinics organised and delivered by champions
9 smaller community voluntary groups awarded funding for wider reach

All within 3 months … wow!

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Uptake to Vaccination Programme

Covid Vaccination Programme

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Community Champions Pop Up Clinics

DATE	ORGANISATION	VENUE
Friday 6th October 2023	Outlookers	Brain Jackson House, Huddersfield
Wednesday 11th October 2023	Outlookers	Whitfield Centre, Batley
Thursday 12th October	Huddersfield Mission	Lord Street, Huddersfield
Monday 23rd October	Ravensthorpe Community Centre	Ravensthorpe community centre
Tuesday 24th October	Thornton Lodge Action Group	Thornton Lodge Action Group
Monday 6th November 2023	LS2Y	The Chestnut Centre, Deighton
Wednesday 8th November	Ravensthorpe Community Centre	Ravensthorpe community centre
Thursday 9th November 2023	Community Skills Centre	Community Skills Centre, 1 Hillhouse Lane, Huddersfield HD1 6EF
Saturday 18th November 2023	IMWS	Al Hikmah Track Road Batley
Tuesday 21st November 2023	Huddersfield Mission	Lord Street, Huddersfield
Wednesday 22nd November 2023	LS2Y	FOCAL,Oakes
Friday 1st December 2023	LS2Y	The Chestnut Centre, Deighton
Thursday 14th December 2023	S2R	Thornhill Lees Community Centre, Brewery Lane, Thornhill Lees
Friday 15th December 2023	The Branch	Jubilee Centre, Paddock
Thursday 21st December 2023	Huddersfield Mission	Lord Street, Huddersfield

Uptake to Vaccination Programme

Flu Programme 2024/25

NHS West Yorkshire Integrated Care Board

The National Flu Letter published 12 March 2024 set out guidance for the 2024 to 2025 season:

- The letter confirms that there are no changes to the eligible cohorts for the coming year June 2024)
- Providers are expected to deliver a 100% offer to eligible groups. They should ensure they make firm plans to equal or improve uptake rates in 2024 to 2025, particularly in those cohorts where uptake has traditionally been lower (clinical risk groups, children aged 2 and 3 years, and pregnant women). Providers should also ensure they have robust plans in place for tackling health inequalities for all underserved groups.
- Timing - JCVI have advised moving the start of the programme for most adults to the beginning of October. The committee agreed however that the children and maternal programme should commence in September

Uptake to Vaccination Programme

Flu Programme 2024/25

NHS West Yorkshire Integrated Care Board

Flu Eligibility

From 1 September 2024:

- pregnant women
- all children aged 2 or 3 years on 31 August 2024
- primary school aged children (from Reception to Year 6)
- secondary school aged children (from Year 7 to Year 11)
- all children in clinical risk groups aged from 6 months to less than 18 years

From October 2024, exact start date to be confirmed by NHS England in due course:

- those aged 65 years and over
- those aged 18 years to under 65 years in clinical risk groups (as defined by the Green Book, Influenza Chapter 19)
- those in long-stay residential care homes
- carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person
- close contacts of immunocompromised individuals
- frontline workers in a social care setting without an employer led occupational health scheme including those working for a registered residential care or nursing home, registered domiciliary care providers, voluntary managed hospice providers and those that are employed by those who receive direct payments (personal budgets) or Personal Health budgets, such as Personal Assistants

Uptake to Vaccination Programme

Flu Programme 2024/25

NHS West Yorkshire Integrated Care Board

Flu - Recommended Vaccines

- Every year JCVI reviews the latest evidence on flu vaccines and advises the type of vaccine to be offered to different age groups.
- No changes were recommended by JCVI for adult flu vaccines for 2024 to 2025.
- No changes were recommended by JCVI for children's flu vaccines for 2024 to 2025.The UK Health Security Agency (UKHSA) supplies all flu vaccines for the children's programme and these will be available to order through ImmForm and are not reimbursable.

Co-Administration

- Further guidance will follow on how the flu programme should be aligned to any autumn COVID-19 vaccination programme. Providers are encouraged to align delivery of the flu vaccination programme with other commissioned vaccination programmes for which the patient may be eligible.

Uptake to Vaccination Programme

Flu Programme 2024/25

NHS West Yorkshire Integrated Care Board

Flu report evaluation headlines

- Evaluation Report circulated for assurance/information
- Separate programme to Covid vaccination but co-administration where possible with close working between programmes
- Confused messaging regarding start date and not aligned with Covid
- Return pre-covid cohorts excluding 50–64-year-olds
- Change of Flu lead mid-season
- Established governance processes followed
- Eligible population 242,858 with 122,587 (50.4%) vaccinated

Uptake to Vaccination Programme

Flu Programme 2024/25

NHS West Yorkshire Integrated Care Board

Data Headlines

- Care Home residents 79.2% down 50% compared to last year (77.9%)
- Overs 65's 77.2% compared to last year 80.1%
- Pregnant women up by 0.2% compared to 7.9%
- 2–3-year-olds; significant increase from 24.2% last season to 32.3% this season
- Primary School age children 42.9%
- Secondary School age children 36.2%
- Significant increase (by 27.6%) to 30.3% for Household contacts of immunosuppressed

Uptake to Vaccination Programme

Flu Programme 2024/25

NHS West Yorkshire Integrated Care Board

Flu: Key Highlights

Challenges

- Limited national communications
- Reduction of PCN's providing Covid Vaccination
- Reported increased vaccine fatigue

Achievements

- Increased uptake 2–3-year-old cohort
- Community Champions engagement
- Local uptake in line with other areas

Recommendations

- Establish working group t conduct deep dive into uptake levels in three cohorts' pregnant women, household contacts of immunosuppressed and children aged 2-3
- Continue conversations about how Flu alongside Covid and Pertussis vaccinations are administered in Kirklees
- Explore working further with Community Champions and build on success of their support with the Covid programme
- Clarity required around role(s) of Kirklees Flu and Covid 19 Vaccination Lead(s) for forthcoming season

Uptake to Vaccination Programme

Respiratory syncytial virus (RSV) vaccination programme summary

NHS West Yorkshire Integrated Care Board

- RSV accounts for around 30,000 hospitalisations in children aged under 5 and is responsible for 20 to 30 infant deaths. It also causes around 9,000 hospital admissions in those aged over 75.
- RSV vaccine will be routinely offered for the first time this year from September to those turning 75 years of age.
- The RSV vaccine should also be offered to pregnant women from 28 weeks of pregnancy to protect infants. Where trust providers have commissioned maternity services to deliver the RSV vaccine, maternity providers should already be working to identify pregnant women in their care who will be eligible and inviting them for their vaccination from the beginning of September. General practice will be commissioned through the GP contract as a component of Essential Services, to offer and provide RSV vaccination in pregnancy on an opportunistic or on request basis from 28 weeks of pregnancy.
- For ICBs and general practice, the **RSV contractual guidance** sets out the programme requirements for practices and includes information on the eligible cohorts, clinical coding and payment processes.

Uptake to Vaccination Programme

RSV – GP Contract

NHS West Yorkshire Integrated Care Board

- Routine NHS-funded vaccinations and immunisations are delivered as essential services under the GP Contract from the 1 September 2024, the RSV vaccination programme will be included. There is no expectation that there will be any additional specifications or local commissioning requirements for this routine programme
- Practices will be responsible for proactively inviting individuals for their vaccine when they become eligible (i.e. from an individual's 75th birthday).
- Practices will also be responsible for proactively inviting individuals aged 75-79 years on 31 August 2024 as soon as possible. The expectation is that the catch-up activity (for adults aged 75-79 years old as of 31st August 2024) is undertaken at the earliest opportunity with the majority completed in the first 12 months of the programme.
- To offer the best protection, providers are asked to vaccinate as many people as possible during September and October 2024 prior to the expected RSV season.
- Under the terms of the Network Contract DES, practices will be able to collaborate within their Primary Care Networks to provide vaccination during core and enhanced hours to their collective registered population, including their collective registered population residing in care homes