EAST SUSSEX HEALTH AND WELLBEING BOARD

THURSDAY, 29 SEPTEMBER 2022

2.30 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -	Councillor Keith Glazier, East Sussex County Council (Chair) Councillor Carl Maynard, East Sussex County Council Councillor John Ungar, East Sussex County Council Councillor Trevor Webb, East Sussex County Council Councillor Andy Batsford, Hastings Borough Council Councillor Mrs Pam Doodes, Wealden District Council Jessica Britton, NHS Sussex Vacancy, NHS Sussex Vacancy, NHS Sussex Mark Stainton, Director of Adult Social Care Darrell Gale, Director of Public Health Alison Jeffery, Director of Children's Services John Routledge, Healthwatch East Sussex Sarah MacDonald, NHS England South (South East) Joanne Chadwick-Bell, East Sussex Healthcare NHS Trust Dr Jane Padmore, Sussex Partnership Foundation Trust Vacancy, Sussex Community Foundation NHS Trust
INVITED OBSERVERS WITH SPEAKING RIGHTS	Councillor Emily O'Brien, Lewes District Council Councillor Rebecca Whippy, Eastbourne Borough Council Councillor John Barnes MBE, Rother District Council Becky Shaw, Chief Executive, ESCC John Willett, Sussex Police and Crime Commissioner Mark Matthews, East Sussex Fire and Rescue Service Geraldine Des Moulins, Voluntary and Community Sector representative

A G E N D A

1. Minutes of meeting of Health and Wellbeing Board held on 19 July 2022 *(Pages 3 - 8)*

2. Apologies for absence

3. Disclosure by all members present of personal interests in matters on the agenda

4. Urgent items

   Notification of items which the Chair considers to be urgent and proposes to take at the end of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgently

5. Pharmaceutical Needs Assessment *(Pages 9 - 266)*

6. Better Care Fund Plans 2022/23 *(Pages 267 - 322)*

7. East Sussex Health and Social Care Programme - update report *(Pages 323 - 332)*

8. East Sussex Safeguarding Adults Board (SAB) Annual Report 2021-2022 *(Pages 333 - 380)*

9. Residents at Kendal Court, Newhaven and homeless people accommodated by Brighton and Hove City Council in temporary accommodation in East Sussex *(Pages 381 - 382)*

10. Work programme *(Pages 383 - 384)*

11. Any other items previously notified under agenda item 4

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21 September 2022

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EAST SUSSEX HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the East Sussex Health and Wellbeing Board held at Council Chamber, County Hall, Lewes on 19 July 2022.

MEMBERS PRESENT	Councillor Keith Glazier (Chair) Councillor Carl Maynard, Councillor John Ungar, Councillor Rebecca Whippy, Councillor Mrs Pam Doodes, Ashley Scarff, Mark Stainton, Darrell Gale, Alison Jeffery, John Routledge and Dr Jane Padmore
INVITED OBSERVERS PRESENT	Councillor Emily O'Brien, Councillor Andy Batsford, Councillor John Barnes MBE, Becky Shaw and Geraldine Des Moulins

1. MINUTES OF MEETING OF HEALTH AND WELLBEING BOARD HELD ON 1ST MARCH 2022

1.1 The minutes of the meeting held on 1st March 2022 were agreed as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 The Chair welcomed the following new invited observers:

- Councillor Emily O'Brien, Lewes District Council
- Councillor Andy Batsford, Hastings Borough Council

2.2 The following apologies for absence were received from members of the Board:

- Councillor Trevor Webb
- Councillor Pam Doodes, Wealden District Council
- Alison Jeffrey, Director of Children's Services
- Sarah MacDonald, NHS England South
- Siobhan Melia, Sussex Community Trust
- Joe Chadwick-Bell, East Sussex Healthcare Trust

2.3 It was also noted that two NHS Sussex representatives had not yet been appointed.

2.4 The following substitutions were made from members of the Board:

- Becky Shaw substituted for Mark Stainton
- Ashley Scarff substituted for Jessica Britton

2.5 The following apologies for absence were received from invited observers with speaking rights:

- Mark Matthews, East Sussex Fire and Rescue Service

3. DISCLOSURE BY ALL MEMBERS PRESENT OF PERSONAL INTERESTS IN MATTERS ON THE AGENDA

3.1 Cllr Rebecca Whippy declared a personal interest in items 5 and 7 as the provider of services supporting children with special educational needs.

4. URGENT ITEMS

4.1 There were no urgent items.

5. EAST SUSSEX HEALTH AND SOCIAL CARE PROGRAMME - UPDATE REPORT

5.1 The Board considered a report providing an update on progress with the East Sussex system integration and related areas of collaboration. This included the arrangements for the new Sussex Integrated Care System (ICS) and statutory bodies that came into force on 1 July and subsequent amendments to the HWB terms of reference agreed by the Council on 12 July, and a refresh of the Board's Strategy 'Healthy Lives, Healthy People', which provides the overarching strategic framework for the work of health, social care and the wider system for the population of East Sussex.

5.2 The Board asked why the cardiology service may not be provided from the Eastbourne District General Hospital (EDGH) in future, subject to the outcome of the review process, when a new hospital is planned for the site.

5.3 Mark Stainton, Director of Adult Social Care, advised the timeline for the Building for our Future hospital programme to deliver new hospital buildings is several years, whilst the HWB Strategy is for 3+2 years. This means the NHS will have needed to make clinical decisions around the provision of cardiology and ophthalmology services before any new hospital will have been built. He advised the cardiology and ophthalmology reconfigurations are being reviewed by the Health Overview and Scrutiny Committee (HOSC).

5.4 The Board asked whether the new Special Educational Needs and Disability (SEND) strategy will ensure children's neuro-diversity is recognised with their Education, Health and Care Plans (EHCPs).

5.5 Alison Jeffrey, Director of Children's Services, said East Sussex County Council (ESCC) and the NHS organisations in East Sussex are committed to improving their joint working around Children's Services. There are proposals that NHS Sussex is assisting ESCC to resource that are designed to improve the response to children who are neuro diverse and try and ensure they receive more help sooner. It is important SEND needs are captured in EHCPs and schools are supported to assist children who are neuro diverse, even those without an EHCP.

5.6 The Board asked whether discharge to assess will continue to be provided.

5.7 Mark Stainton confirmed that discharge to assess will remain as a core element of the range of services offered to assist patients who are medically fit to leave hospital and require ongoing social care.

5.8 The Board asked what the reasons are for the performance in Emergency Departments (ED).

5.9 Mark Stainton said that there are several reasons including that demand for ED is higher than it was two years ago; there are staff recruitment and retention issues exacerbated by COVID-19 outbreaks that compromise staff availability; and the flow of patients who are medically ready for discharge is also not as swift as it could be at times given the exceptional challenges with the independent sector care market, particularly home care. Discharge to Assess has helped alleviate many of these issues around patients who are medically ready for discharge, as they can be moved to home care or block purchased care homes where the necessary assessments can be carried out. The outbreak of hot weather is also likely to increase demand through greater cardiac and respiratory issues.

5.10 The Board asked whether future iterations of the Strategy should factor in adaptations to extreme weather under the challenges section.

5.11 Vicky Smith, Programme Director - East Sussex Health and Social Care Transformation, agreed it would be helpful to add extreme weather events to the challenges section in future versions of the strategy. Cllr Keith Glazier, Chair of the Board, also agreed that it could be useful to include in the future and provided assurance that such plans were already in place. ESCC, for example, has activated its service plans for helping the most vulnerable residents through the level 3 weather warning. This includes making contact with those at highest risk, advising carers to contact GPs with health concerns and sharing the latest public health advice. Other public organisations such as Sussex Police, East Sussex Fire and Rescue Service and the district and borough councils have released similar information. Darrell Gale, Director of Public Health (DPH), added that people most at risk of overheating in hot weather are those in single aspect flats, new builds, and on converted properties. Future Public Health strategies would include adaptations to buildings as a way of mitigating against climate change. He added Public Health has a small team supporting the Town Deal in Hastings to look at health inequalities and help get green jobs into Hastings to help deliver the Borough Council's own building adaptations.

5.12 The Board RESOLVED to:

1) note the contents of this update and the work that has taken place to respond to recent national and local developments, including the updated Health and Wellbeing Board terms of reference (Appendix 1); and

2) endorse the refreshed HWB Strategy 'Health Lives, Healthy People 2022 – 2027' (Appendix 2)

6. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2021/22

6.1 The Board considered a report on this year's Director of Public Health (DPH) report on Work, Skills, and Health ahead of wider dissemination and an update on previous and future DPH reports.

6.2 The Board asked whether the increasing number of older people working beyond retirement age is a cause for concern due to the increased likelihood of it impacting their health.

6.3 Darrell Gale said that one of the great health inequalities in the county is that some people in poorer communities do not reach retirement age without suffering serious health

problems and die before they receive a pension, whilst some in wealthier areas of the county enjoy 10 or more years of healthy retirement. Given the number of old people in East Sussex, valuing their experience and integrating them into plans to develop a vibrant economy is very important. Utilising and encouraging older people's entrepreneurship is particularly beneficial, as the economy is based on small and medium-sized enterprises.

6.4 The Board asked whether public sector organisations should be encouraged to report their response to the DPH report.

6.5 Darrell Gale agreed it was a good idea and would follow it up with larger organisations such as those in the NHS. He added the report contains a brief summary of actions against recommendations in the last two reports, so responses from other organisations could be included in this section too.

6.6 The Board asked how the importance of volunteering to a person's mental health could be promoted, particularly in rural areas where Voluntary, Community and Social Enterprise (VCSE) are declining due to the aging population and the lack of replacement volunteers.

6.7 Darrell Gale agreed VCSE suffer from a lack of volunteers. Employers should look at the work life balance of their staff to make sure they have time to volunteer at a younger age and use their workplace skills in a voluntary setting. He agreed volunteering had a lot of health benefits and can help people looking for better or new employment by developing a wider set of skills.

6.8 The Board asked whether the term Black, Asian and Minority Ethnic (BAME) should be replaced with more granular details of particular ethnic groups.

6.9 Darrell Gale said he knew the label is problematic and far more inclusive terms are needed. There is a need to work with all groups to describe the similarities and difference between people of different social, ethnic and religious groups, as their backgrounds can affect their health outcomes, without it appearing tokenistic.

6.10 The Board asked whether East Sussex Wellbeing at Work Award is being rolled out to district and borough councils.

6.11 Becky Shaw, Chief Executive of ESCC, confirmed that ESCC has been promoting the Award with the boroughs and districts and other employers.

6.12 The Board RESOLVED to thank the Public Health team and note this year's annual DPH report.

7. HEALTHWATCH ANNUAL REPORT 2021/22

7.1 The Board considered a report providing an overview of Healthwatch East Sussex's Annual Report 2021-22 – Championing what matters to you.

7.2 The Board RESOLVED to:

1) thank Healthwatch and Healthwatch volunteers for the variety and quality of their work; and
2) note the report.

8. RESIDENTS AT KENDAL COURT, NEWHAVEN AND HOMELESS PEOPLE ACCOMMODATED BY BRIGHTON AND HOVE CITY COUNCIL IN TEMPORARY ACCOMMODATION IN EAST SUSSEX

8.1 The Board considered a report providing an update on the ongoing welfare concerns for unsupported homeless people placed in Kendal Court and other temporary accommodation in the Lewes and Eastbourne areas by Brighton and Hove City Council.

8.2 The Board RESOLVED to:

1) Note the additional information, ongoing concerns and actions set out in this report in respect of Brighton and Hove residents temporarily accommodated in East Sussex; and

2) agree to receive a further update report on the situation at its next meeting on 29 September 2022.

9. SUSSEX LEARNING FROM LIVES AND DEATHS (LEDER) ANNUAL REPORT

9.1 The Board considered a report on provide an overview of the Learning Disabilities Mortality Review (LeDeR) Sussex CCGs Annual Report 2021-22.

9.2 The Board asked how Public Health and the NHS can work together to ensure there is a fuller picture of the reasons for higher suicides amongst people with autism spectrum disorder.

9.3 Alison Cannon, Chief Nursing Officer at NHS Sussex, agreed this was an important area to understand fully. The Chief Nursing Officer suggested it be looked at via the LeDeR Steering Group and further details included in the next annual report.

9.4 The Board RESOLVED to note the report.

10. EAST SUSSEX OUTBREAK CONTROL PLAN

10.1 The Board considered a report providing an update on the latest version of the East Sussex Outbreak Control Plan (OCP)

10.2 The Board asked whether the Plan can support the work around other communicable diseases such as monkey pox or seasonal flu.

10.3 Darrell Gale explained this is the OCP for COVID-19, however, there are other diseases like avian flu or monkey pox – along with seasonal outbreaks of measles, norovirus and flu – that could be dealt with through advice from the UK Health Security Agency, knowledge obtained through developing the OCP, and the skills and resources of local Public Health teams.

10.4 The Board asked whether, with such high infection rates of COVID-19, guidance for the public on what to consider would be worthwhile.

10.5 Darrell Gale said Public Health has adopted a ‘Covid Calm’ approach over the spring and summer which involves not responding to every rise in cases with action, simply because it is recognised greater harm will happen in the autumn when other diseases and colder weather are present. Some nudging messages have been put out, however, around recognising small

changes people can make to reflect the situation and think about others. the DPH said if these are not reaching people, then further consideration could be given how best to promote them.

10.6 The Board asked why more council meetings could not be held online, particularly for more vulnerable members, given the continued infection rates of COVID-19.

10.7 Cllr Keith Glazier explained that, following the expiration of temporary regulations that allowed remote meetings, the law prevents meetings from taking place remotely, so committee members must meet in person in order to take decisions. ESCC responded to a Government consultation on the matter – requesting the power to determine which meetings should be in person, remote or hybrid – however, the Government has not responded to the consultation feedback to date. ESCC, through the Local Government Association and County Council Network, continues to lobby the Government for a response.

10.8 The Board RESOLVED to:

1) approve the update of the East Sussex Outbreak Control Plan contained in Appendix 1; and

2) agree to stop receiving updates of the East Sussex Outbreak Control Plan

11. WORK PROGRAMME

11.1 The Board considered its work programme.

11.2 The Board RESOLVED to:

1) agree its work programme;
2) request a future report on the Building for our Future hospital programme at the 13th December meeting; and
3) agree to refer the issue of access to NHS Dentistry to the HOSC for consideration.

The meeting ended at 4.05 pm.

Councillor Keith Glazier (Chair)

Report to:	**East Sussex Health and Wellbeing Board**
Date:	**29th September 2022**
By:	**Director of Public Health**
Title of report:	**East Sussex Pharmaceutical Needs Assessment 2022**
Purpose of report:	**To present the 2022 East Sussex Pharmaceutical Needs Assessment to the Health and Wellbeing Board for approval, and agreement for it to be published, as required by the NHS (Pharmaceutical and Pharmaceutical Services) 2013 Regulations.**

RECOMMENDATION

East Sussex Health and Wellbeing Board is recommended to:

1) **approve the 2022 East Sussex Pharmaceutical Needs Assessment attached as Appendix 1; and**

2) **agree to the publication of the Pharmaceutical Needs Assessment.**

1 Background

1.1 As from 1 April 2013 every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up to date a statement of the need for pharmaceutical services in its area, otherwise referred to as a pharmaceutical needs assessment (PNA). HWBs had to publish their first PNA by April 1st 2015.

1.2 The PNA is a key document used in the development and improvement of pharmaceutical services in East Sussex. NHS England is expected to make reference to the PNA when making decisions about Market Entry for new service providers, as well as in the commissioning of pharmaceutical services, which include advanced and enhanced services from pharmacies.

1.3 Normally a PNA is required every three years, but this was extended due to the COVID-19 pandemic, with a PNA expected to be in place by October 2022.

1.4 HWBs are required to publish a revised PNA report sooner if significant changes are identified in the meantime about the availability of pharmaceutical services since the publication of the last PNA. This is unless the Board is satisfied that making a whole revised assessment would be a disproportionate response to these changes.

1.5 Pending the publication of a revised PNA, Supplementary Statements may be added. Supplementary Statements are a way of updating what the PNA says about which services are provided and where. They explain changes to the availability of pharmaceutical services since the publication of the existing PNA and then become part of the PNA (Regulation 3D (3)).

1.6 A Supplementary Statement is issued where:

a) the changes are relevant to the granting of Market Entry applications but a revised assessment would be a disproportionate response to those changes, or,

b) in the course of producing a revised PNA, immediate modification of the current PNA is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.

1.7 The Public Health Department leads the process and produces the PNA on behalf of the HWB. The first PNA was agreed by the Board in July 2014 and subsequently published on the East Sussex Joint Strategic Needs and Assets Assessment website.

1.8 The process for developing the revised PNA has been completed, after complying with all the Regulations associated with the production. The PNA is now brought to the HWB for approval.

2 Supporting information

2.1 The main aim of the East Sussex PNA 2022 (**Appendix 1**) is to describe the current pharmaceutical services in East Sussex, systematically identify any gaps/unmet needs and, in consultation with stakeholders, make recommendations on future development.

2.2 The 2022 East Sussex PNA process began in July 2021 and has involved reviewing and analysing East Sussex's demographic details, health needs, current pharmaceutical service provision, as well as consulting the public and other stakeholders through surveys.

2.3 A public consultation of the PNA document was undertaken between June and July 2022 as required by the NHS 2013, Regulation 8. Views from the public, community pharmacy contractors, dispensing GP practices, neighbouring Health and Wellbeing Boards and other stakeholders were sought and used in drafting the final report.

Content of the Report

2.4 The document has 12 sections, an executive summary, and includes six Appendices and a glossary.

Section 1 is an introduction to what is meant by Pharmaceutical Needs Assessment [PNA].

Section 2 describes the processes followed in developing the Pharmaceutical Needs Assessment.

Section 3 explains the strategic context of health and social care integration, with changes in primary care and changing roles of community pharmacy.

Section 4 describes the population [demography] of East Sussex and expected changes in the size of the population between 2022-25.

Section 5 covers the health and social care needs of the population and in each locality [local authority] and identifies population subgroups with additional needs.

Section 6 describes current pharmacy and GP dispensing service provision in East Sussex.

Section 7 describes the findings from the East Sussex residents' survey in January 2022.

Sections 8 and 9 describe the community pharmacy and GP dispensary surveys in

January 2022.

Section 10 describes the gap analysis for each district/borough council area: Eastbourne; Hastings; Lewes; Rother and Wealden.

S**ection 11** describes the stakeholder consultation from June to July 2022 and ESCC response to the issues raised.

Section 12 has overall conclusions about current services and future roles of pharmacies in East Sussex.

Key PNA Findings

2.5 As at January 2022, the East Sussex rate of pharmacy provision was 17.6 per 100,000 in East Sussex [excluding the GP dispensaries]. This crude, unadjusted rate is lower than the England rate of provision 19.0 per 100,000, although similar to neighbouring local authorities.

2.6 There are 99 community pharmacies and 16 GP dispensaries in East Sussex. Of the 99 community pharmacies, 91 have contracts for 40 hours of opening, while eight have 100-hour contracts. In addition, there are also three distance selling [internet] pharmacies located in East Sussex.

2.7 Trends in the number of pharmacies have shown a gradual reduction at national and regional level since the last PNA in 2017.

2.8 The provision of essential pharmaceutical services in East Sussex, based on the above rate per 100,000 in East Sussex, and in each local authority, appears to be satisfactory. Detailed travel times analyses (distance to nearest pharmacy/dispensing practice) and local surveys of pharmacy providers and dispensaries were undertaken.

2.9 The public consultation on the 2022 PNA report indicates that the purpose of the PNA report is well understood among stakeholders. It is a good reflection of the current health needs and pharmaceutical services to meet those needs in East Sussex, and is sufficient in informing future NHS market entry decisions and commissioning future service provision.

Summary of PNA Recommendations

- The PNA has not identified gaps in essential services in East Sussex
- Improving current choice of essential dispensing services in the evenings and weekends could be achieved by consideration of commissioning an extended hours service from existing providers on a rota basis, particularly in Lewes, Rother and Wealden council areas
- The Discharge Medicines Service needs to be promoted within NHS Trusts and closely monitored by commissioners
- If there were to be an increase in contracted GP surgery hours to 8pm on weekdays and to Saturday afternoons following the publication of the PNA, then there may be a need for commissioners to consider commissioning an extended hours service from existing providers
- Better access to necessary services in evenings and at weekends could also be enabled by improvements in public transport in rural East Sussex
- Current plans for housing developments locally would not require a new pharmacy
- We recommend that Districts and Boroughs clearly communicate to residents the location of existing disabled parking

3 Conclusion and Reason for Recommendation

3.1 The Health and Wellbeing Board is required by the NHS (Pharmaceutical and Pharmaceutical Services) 2013 Regulations to publish and keep up to date a statement of the need for pharmaceutical services in its area.

3.2 The due process for developing the revised PNA has been completed and all the regulations associated with its production have been followed.

3.3 The Health and Wellbeing Board is recommended to approve the 2022 East Sussex PNA and to agree to its publication.

Darrell Gale
Director of Public Health

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East Sussex
County Council

EAST SUSSEX

Pharmaceutical Needs Assessment

October 2022

Document summary

This document is an analysis of the health needs of the population of East Sussex regarding the need for and use of community pharmacy services for the period 2022-2025.

The document has 12 sections, an executive summary, six Appendices and a glossary.

Section 1 is an introduction to what is meant by Pharmaceutical Needs Assessment [PNA].
Section 2 describes the processes followed in developing the Pharmaceutical Needs Assessment.
Section 3 explains the strategic context of health and social care integration, with changes in primary care and changing roles of community pharmacy.
Section 4 describes the population [demography] of East Sussex and expected changes in the size of the population between 2022-25.
Section 5 covers the health and social care needs of the population and in each locality [local authority] and identifies population subgroups with additional needs.
Section 6 describes current pharmacy and GP dispensing service provision in East Sussex.
Section 7 describes the findings from the East Sussex residents' survey in January 2022.
Sections 8 and 9 describe the community pharmacy and GP dispensary surveys in January 2022.
Section 10 describes the gap analysis for each district/borough council area: Eastbourne; Hastings; Lewes; Rother and Wealden.
Section 11 describes the stakeholder consultation from mid-May to mid-July 2022 and ESCC response to the issues raised.
Section 12 has overall conclusions about current services and future roles of pharmacies in East Sussex.
Appendices
Glossary

Document Control

Version	Date	Revision made	Author(s)	Comments
Draft 1	14-04-22	Pre-steering group review	N.Kendall	
Draft 2	25-05-22	After Steering Group meeting	N.Kendall	
Draft 3	08-06-22	After Steering Group review	N.Kendall	Full version for public consultation
Draft 4	5-8-22	After Consultation comments	V.Spencer-Hughes, G.Evans	Amended after public consultation

				comments and reviewed by steering groups
Final draft	19-08-22	After review by steering group on 17-08-22	V.Spencer-Hughes N.Kendall	Further review of public consultation

Distribution of PNA Draft for Consultation

Name	Role	Organisation	Date
Nicola Rosenberg	Consultant in PH	Brighton & Hove Health and Wellbeing Board	01/06/22
Clair Bell	Chairman	Kent Health and Wellbeing Board	01/06/22
Tim Oliver	Chairman	Surrey Health and Wellbeing Board	01/06/22
Jacqueline Clay	Head of PH intelligence	West Sussex Health and Wellbeing Board	01/06/22
Julia Powell	Chief Executive	East Sussex Local Pharmaceutical Committee	01/06/22
Dr.Julie Sharman Dr.Sangeetha Sornalingam	Medical Director	Surrey and Sussex Local Medical Committee	01/06/22

Approval

This document has been approved by:

Signature:

Designation: Date:

About this document

Version number: V5

Related information

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Acknowledgements

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Elizabeth Mackie	Healthwatch, East Sussex
Stewart Marquis	Community Pharmacy Support Officer, ESCC
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Ciara O'Kane	Principal Pharmacist, Sussex HNS Commissioners
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ESCC – East Sussex County Council

LPC- Local Pharmaceutical Committee

LMC- Local Medical Committee

The East Sussex Health and Wellbeing Board would like to acknowledge the contribution of staff from: ESCC departments (Adult Social Care, Marketing and Communications, Public Health); NHS England– South-East Region; Community Pharmacies; GP Practices; the Local Pharmaceutical Committee; the Local Medical Committee; and all other stakeholders and members of the public towards the development of the 2022 Pharmaceutical Needs Assessment (PNA).

Executive summary

Introduction

Since 1st April 2013 every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish every three years and keep up to date a statement of the need for pharmaceutical services in its area, otherwise referred to as a pharmaceutical needs assessment (PNA).

From July 2022, the NHS Sussex Integrated Care Board is responsible for managing the Community Pharmacy Contractual Framework and is expected to refer to the PNA when making decisions about market entry for new service providers, as well as in the commissioning of enhanced services from pharmacies.

The required content for PNAs is set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.[1,2,3]

The aim of the East Sussex PNA is to describe the underlying need for and current provision of pharmaceutical services in East Sussex, to ensure that the minimum statutory requirements for PNAs are met, to identify systematically any gaps in services and, in consultation with stakeholders, make recommendations on future development.

Process

To oversee the process, a PNA Steering Group was formed consisting of key professionals drawn from the Public Health department at East Sussex County Council (ESCC), the Inclusion and Advisory team at ESCC, the Local Pharmaceutical Committee (LPC), Healthwatch, NHS England-South (South-East) and the Local Medical Committee (LMC).

The PNA has reviewed and analysed East Sussex's demographic changes, health needs, mapped current pharmaceutical service provision and consulted the public and other stakeholders through surveys.

To comply with the Regulations a public consultation of the PNA document was undertaken from 1st June to 30th July 2022. Views from the public and other stakeholders were sought and responded to in drafting the final document.

Key findings

Population Change 2022-2025

The East Sussex population was estimated to be 563,167 in 2022. East Sussex has a much older age profile compared to England and the South-East. Twenty-seven per cent [27%] of the county's population is aged 65 or over, compared to [19%] in England and 20% regionally. The median age of the county is 48.4, compared to the national average of 40.2.

By 2025, it is estimated that that the population will increase by 12,376 persons [a 2.2% increase]. Most of the increase is predicted to be in people aged over 65, who are more likely to need pharmaceutical services. There is also some net migration into the county.

Wealden District Council is the largest lower tier local authority with an estimated 164,760 residents and Hastings Borough Council the smallest with 92,709 residents in 2022. The majority of the population increase is expected to occur in Wealden.

These demographic changes present a challenge for commissioners and providers of all health and social care services, including providers of community pharmacy services.

Long-term conditions and frailty

Notably, the increase in the number of older people in the population means not only will people be living for longer but also living with one or more long-term health conditions [also known as multi-morbidity] as well as increasing frailty.[4,5]

Pharmaceutical service providers [community pharmacies] are contracted to participate in the identification and management of people with long-term conditions [LTCs], as well as in their prevention. Pharmacists' involvement with the management of LTCs is expected to increase substantially in the future.

Pharmacies are an increasingly recognised resource for health advice and their expertise will help reduce the increasing burden on other urgent care services.[6,7] This is recognised in the NHS Long Term Plan,[8] and in the GP Forward View.[9]

Optimising care pathways for all people with long-term conditions can have substantial benefits for the health and social care system. Pharmacies play an important role in this.

Health needs and health inequalities

The health needs and profiles of the population in the five lower tier local authorities in East Sussex: Eastbourne Borough Council; Hastings Borough Council; Lewes District Council; Rother District Council and Wealden District Council are summarised in Section 5 of this document.

The Index of Multiple Deprivation [IMD] 2019 describes relative deprivation nationally. The existing pharmacies in East Sussex have been mapped according to this. Please see Section 5 for more detail. Nationally, health inequality effects have been made considerably worse by the effects of the pandemic.[10]

People living in deprived communities have a lower uptake of screening programmes, and vaccinations.[11,12] When very unwell, people in deprived areas may delay seeking medical attention where necessary. Deprived areas are noted to have high A&E attendance and emergency admission rates.[13] There has been a relative reduction in access to elective hospital care in deprived communities during the pandemic and substantial, unmet clinical need exists.[14,15]

Pharmaceutical service providers [community pharmacies] have the potential to play an even greater role in identifying and helping to address local health inequalities. Pharmacies

are very accessible as they are based at the heart of communities, including those located in rural and deprived areas.

Changes in commissioning of pharmaceutical services

East Sussex Clinical Commissioning Group was the healthcare commissioning organisation for patients registered with an East Sussex GP. However, from the 1st of July 2022, it has been merged into the NHS Sussex Integrated Care Board.

The NHS Sussex Integrated Care Board (a new NHS Body) has statutory responsibility for commissioning healthcare services across the whole of Sussex (East Sussex, Brighton and Hove and West Sussex).

From July 2022, the NHS Sussex Integrated Care Board is responsible for managing the Community Pharmacy Contractual Framework and is expected to refer to the PNA when making decisions about market entry for new service providers, as well as in the commissioning of enhanced services from pharmacies.

As with any organisational change, it will be important to ensure that roles and responsibilities are clear to all concerned as new arrangements bed in.

Potential changes to standard GP practice opening hours

There are ongoing national negotiations between the NHS and the British Medical Association regarding the possibility of extending the opening hours of general practices. If these are introduced into the standard GP contract this could mean greater number of appointments available in the evenings and Saturday afternoons. There could need to be a corresponding increase in the opening hours and availability of pharmacies for dispensing prescriptions through commissioning an extended hours service from the existing pharmacies.

Current provision of community pharmacies

There are currently 102 pharmacies in East Sussex [including the three distance selling pharmacies located within the borders of East Sussex].

As at January 2022, the East Sussex rate of pharmacy provision was 17.6 per 100,000 [excluding the GP dispensaries]. There are 99 community pharmacies and 16 GP dispensaries in East Sussex. Of the 99 community pharmacies, 91 have contracts for 40 hours of opening, while eight have 100-hour contracts. In addition, there are also three distance selling [internet] pharmacies located in East Sussex.

Looking at the rates of community pharmacy provision per 100,000 resident population by districts and boroughs in East Sussex, there would appear to be relatively lower provision in Wealden and Rother districts [if the GP dispensaries in those localities are not included]. Please see Section 6.

Changes since the last PNA

There are ten fewer pharmacies in East Sussex than when the last PNA was published in 2017, when there were 112.

There are two fewer pharmacies in Eastbourne Borough, both 40-hour pharmacies.

There are two fewer 40-hour pharmacies in Hastings Borough.

Lewes District has two fewer pharmacies, both 40-hours.

Rother District has two fewer pharmacies [one 40 hour and one 100-hour] but has gained one distance selling pharmacy.

Wealden District has two fewer distance selling pharmacies and has lost one 40-hour pharmacy.

Please see Table 12, on page 91, summarising the changes since 2017.

Trends in the number of pharmacies have shown a gradual reduction at national and regional level since the last PNA in 2017. As at end of 2021/22, the number of pharmacies 17.6 per 100,000 in East Sussex [crude, unadjusted rate] is lower than the England rate of provision 19.0 per 100,000, and similar to neighbouring local authorities.

Future provision

The majority of providers who responded to the community pharmacy survey [30/46] stated that they had sufficient capacity to manage a potential increase in demand now, whilst a further nine [9/46] could make adjustments in future.

GP practices with their own dispensaries

Thirteen General Practices [with a total of 16 GP dispensaries] provide medicines dispensing services to some of their registered local populations, mainly on weekdays. These GP dispensaries serve the rural parts of Hastings, Rother and Wealden. Please see section 3.4 Dispensing GP practices

When the GP practices with dispensaries are included in the total number of dispensaries in the county [and including the community pharmacies in the total] the rate of dispensary provision is 20.4 per 100,000 for East Sussex. The rate is relatively higher in Rother [24.9 per 100,000] than Hastings [22.6 per 100,000] and Wealden [20.0 per 100,000] local authorities. The lowest rate of provision overall is in Lewes [16.3 per 100,000].

Internet Access to Pharmacy

There has been an increase in the use of dispensing services accessed via the internet [both from a local pharmacy and distance selling premises] due to COVID pandemic restrictions and since. Nationally, there are now over 300 distance selling premises that must deliver to anyone in England. All pharmacies [even local ones] are now required to facilitate remote access to services where that is appropriate.

Distance Selling Pharmacies

The proportion of items dispensed by a distance selling pharmacy has been steadily increasing. At East Sussex level this is now 6.2% overall [at the end of 2021/22]. Notably this is even greater in Lewes [7.6%] and Wealden [6.8%] local authorities.

Travel access to pharmacies

In order to assess whether residents are able to access a pharmacy, travel times were analysed using TRACC software to model travel times to a pharmacy at different times of the week, using different modes of transport (car, public transport, and walking).

This model considers traffic flow and volume at different times of the week, as well as distance. A 30-minute journey one way by any means of transport was considered reasonable by the Steering Group. Further analyses have been undertaken to look at access in those wards where more than 15% of residents do not have access to a car. [It's not possible to say how many individuals do not actually have access to a car, just that these wards overall have lower car accessibility than most of East Sussex].

Overall, car owners can reach a pharmacy within 30 mins one way travel time at any time of the week, although around 2,300 people (0.4% of the population) would have to drive more than 30 mins on a Sunday.

Weekdays

Around 42,800 residents of East Sussex (7.7%) cannot physically attend any pharmacy (including dispensing GP surgeries) during the day on a weekday within half an hour using public transport, and 29,300 of these people (5% of the county's population) cannot access any pharmaceutical provision at all [within two hours] using this mode of transport.

Access to pharmacies during the day, using public transport, has declined marginally since 2019, when 41,500 residents (7.5%) were unable to access a pharmacy within 30 minutes, and 28,200 (5%) had no access. This may be because of changes to public transport provision or because of a decline in the number of pharmacies. This has reduced from 240 in 2019, to 223 in 2022. (The total includes dispensing pharmacies in GP surgeries and pharmacies in neighbouring local authority areas within a five-mile buffer zone).

Weekday evenings

Evening access has been defined in this report as premises open on at least three or more weekday evenings. The number (126,700) and proportion (23%) of people unable to access a pharmacy within 30 minutes using public transport rise considerably in the evenings (up from 88,000 in 2019). An estimated (81,600) people (15%) have no access at all using public transport within two hours (up from 52,300 in 2019).

This calculation includes the GP surgeries which have their own dispensaries. In 21 wards, more than three quarters of the population cannot access a pharmacy within two hours using public transport in the evening. The number of pharmacies open in the evening has declined from 97 in 2019 to 84 in 2022. (The total open includes the nine GP surgeries that do provide a dispensing service on some weekday evenings).

Weekends

On Saturdays, more pharmacies are open in the morning (184) than are open all day (95), and this is reflected in accessibility using public transport. While 50,300 people (9.0%) cannot access a pharmacy in the morning within 30 minutes, this rises to 63,000 (11.3%) in the afternoon, with 37,900 (6.8%) having no access at all [within two hours] at any time on a Saturday.

Access on a Sunday is more of a challenge, with nearly a third of people in the county (174,300 or 31%) unable to get to a pharmacy within half an hour using public transport, and 76,800 (14%) with no access at all [within two hours]. Access in Wealden and Rother on a Sunday is worst where more than half of residents live more than 30 minutes from a pharmacy, (57% in Rother and 56% in Wealden). In Rother, a third of people (32%) cannot access a pharmacy at all [within two hours using public transport] on a Sunday, and in Wealden (20%). Note that the number of pharmacies open on a Sunday has declined from 48 in 2019 to 37 in 2022.

In the Residents' Survey most respondents (81%) most commonly use pharmacies between the hours of 9am and 6pm during the week. This pattern is reflected across all five county districts, and over 90% say their needs are met by those opening hours, East Sussex Residents' Survey 2022 findings.

A total of 2,002 telephone interviews were conducted with a representative, random sample from each of the five lower tier local authorities of East Sussex residents in January and February 2022.

Visiting pharmacy

- More than three-quarters (77%) of our county-wide sample are most likely to use a pharmacy or chemist's shop to pick up their prescription.
- Eight per cent are most likely to use a GP's practice dispensary, and this is highest in Rother (20%), whilst 7% have a delivery from their usual pharmacy and 8% use other methods, such as online.
- 16% of residents visit a pharmacy several times monthly, with 4 out of 10 typically visiting once a month. Almost one-in-ten (8%) have not visited a pharmacy in the last 12 months.
- More than 80% of all respondents collect their medicines, with (8%) having them delivered free, and the balance (7%) paying for their delivery. [The delivery of prescriptions is not part of NHS commissioned services].

Service received and opening hours

- 60% of all respondents who attend a chemist rate the advice they receive from pharmacies/chemists as 'good', with another 33% rating this advice as 'fair'.
- More than 8 of out 10 of our respondents agreed that their pharmacist provides a good service, with just 2% disagreeing.

- Of those using a GP's practice dispensary, 95% rated the advice they receive as 'good'.
- Respondents generally find it easy to find an open pharmacy during the day (89% rate this as 'good').
- Only half (52%) rate finding an open pharmacy at the weekend as 'good'.
- However just 4 out of 10 give a 'good' rating for being able to access a pharmacy on Bank Holidays, with more than 1-in-4 rating this as 'poor'.
- Even fewer (just 30%) rated finding an open pharmacy in the evenings as 'good' with 1-in-5 rating being able to do this as 'poor'.
- 1% of respondents had stopped using a specific pharmacy due to service provision issues.

Services for people with additional needs

- 2% of respondents had looked after a terminally ill relative or friend living in East Sussex in the last 12 months.
- 61% agreed that if they wanted to, they could speak to their pharmacist without being overheard.
- 4% of respondents reported having accessibility needs relating to a disability, whilst 3% reported having a communication need.
- 6% said they helped either a friend or adult family member to use pharmacy services.

Qualitative findings from the Residents' Survey

There were many positive comments received from residents about care and service received.

There were some comments about 'poor service' in pharmacies - having medicines delivered was a way of avoiding receiving a poor service. The closure of pharmacies was mentioned as a reason, but this was mainly from Hastings Borough residents.

The most common themes why opening hours were not meeting needs were the lack of evening openings or weekend availability. Many who were working full-time found it difficult to use the daytime, weekday pharmacies. There were specific mentions from those in Hastings about the recent closures of pharmacies in their own area.

Respondents who said that their pharmacy never meets their communication needs wanted staff to be 'more patient and understanding', or to 'listen more to their needs'. This was especially where English may not be their first language.

The new Community Pharmacy Contract 2019 to 2024

A new contractual framework was introduced for community pharmacies on 1st October 2019.[16] Key elements are:

- Phasing out of the Medicines Use Review [MUR] service by 2020/2021

- Expansion of the New Medicines Service to include a new range of medicines
- Introduction of the Community Pharmacy Consultation Service [CPCS], with a referral service, initially from NHS111 to pharmacies, and subsequently referrals from GPs
- Pharmacies and GP practices to collaborate with each other in Primary Care Networks [PCNs]

Essential services within the contract include dispensing medicines, disposing of unwanted medicines, the Discharge Medicines Service from hospitals, and health promotion campaigns.

People may run out of medicines and for some this may potentially cause an issue. This is therefore one benefit of the new Community Pharmacy Consultation Service for providing replacement medicines where appropriate, following referral from NHS 111. The hospital pharmacy can dispense to patients seen in A&E [as can the out of hours service from its own limited formulary].

Public transport

Better access to necessary services in evenings and at weekends could also be made available by improvements in public transport in rural East Sussex.

Future need for necessary services in the next three years

Should there be substantial housebuilding completion [of the order of 2,000 houses or more] focused in a given parish or town in East Sussex in the lifetime of this PNA [between 2022 to 2025], then there could be a need for a new pharmacy. From current planning estimates this seems unlikely to be the case.

Any new pharmacy would be expected to provide the following: all essential services, as well as the Community Pharmacist Consultation Service; the New Medicine Service, 'flu vaccination and hypertension case finding advanced services. These services would be expected to be provided Monday to Saturdays.

Conclusions

Overall, there is good pharmaceutical service provision across East Sussex. In rural areas there are enough dispensing practices to provide essential dispensing services to the rural population on weekdays.

No gap in pharmaceutical provision has been identified in any of the five local authorities and the planned housing will create no gap in the lifetime of this PNA.

In the context of their new contractual framework pharmaceutical service providers will play an important future role in:

- providing a range of clinical and public health services
- the management of long-term health conditions, as well as their prevention[17]
- facilitating new approaches to urgent and emergency care[18,19]

- supporting safe and effective medicines management in general practice

The potential increase in opening hours of GP practices to 8 p.m. on weekdays and on Saturdays until 5 p.m. from October 2022 could need to be addressed in terms of making pharmacy services more accessible in future by aligning pharmacy hours through the commissioning of an extended hours service from existing pharmacies.

If there are changes in provision of services, the Health and Wellbeing Board will publish a supplementary statement setting out whether it considers that the change has created a gap in the provision of pharmaceutical services.

PCN pharmacists working alongside GP practices should ease some of the burden on GPs by dealing with routine medicines enquiries, as well as undertaking structured medicines reviews. PCN pharmacists are not dispensing pharmacists, so this will not offset any further loss of community pharmacies from a dispensing point of view.

COVID-19 has meant many people have adapted the way they access dispensing services and the ways in which medicines support services are provided.

The Director of Public Health has a statutory obligation to keep under review the pharmacy capacity in each locality in East Sussex in terms of meeting the needs of the population. Should pharmacies have to, or choose to, close in future we will publish supplementary statements and keep the Health and Wellbeing Board duly informed.

Recommendations

Current Position and Provision

The following evidence-based statements are required, following the national PNA guidance. These are summarised in Table 1[current position] and Table 2 [future position] below.

Table 1 Required statements in the Regulations-Current position

East Sussex Required Statement	Evidence Reviewed
Necessary Services-that are currently provided **All the essential and the following advanced services New Medicines Service, 'flu immunisation, and Community Pharmacy Consultation Service currently provided within East Sussex community pharmacies are necessary.**	The PNA report shows the number, and distribution of pharmacy premises covering each of the five lower tier local authorities in East Sussex, providing essential and advanced services. The matching of their location according to relative deprivation in each area is shown. The PNA also includes a description of the GP dispensaries serving rural areas in East Sussex. Necessary, essential and advanced pharmacy services are also provided from pharmacies in the neighbouring local authorities of Brighton & Hove, West Sussex and Kent. We have used a five-mile buffer zone around East Sussex to identify these pharmacies.
Necessary services: that are not provided but need to be provided to meet current or future need-gaps in current provision **There is no gap in providers of essential services.** **The Steering Group has noted the travel analysis for each district and borough and recommends that consideration is given to**	Evidence: responses to residents' surveys and travel time analyses . Around 20% of residents across all districts and boroughs felt ease of access to essential dispensing services on weekday evenings was poor [Evidence Residents' Survey 2022]. However, over 90% say their needs are

East Sussex Required Statement	Evidence Reviewed
improving current choice of essential dispensing services in the evenings and weekends through commissioning an extended hours service on a rota basis from existing providers, particularly in Lewes District, Rother District and Wealden District.	met by existing opening hours (range: 88% Hastings – 94% Wealden) Please see section 10.5, Table 36 for overall summary comparison and for each individual district and borough.
Better access to necessary services in evenings and at weekends could also be enabled by improvements in public transport in rural East Sussex	Travel analyses sections 6.7 to 6.10
There is good provision of advanced services by community pharmacies in East Sussex **A pharmacy palliative care locally commissioned service is commissioned and supports end of life care**	Majority of pharmacies are offering NMS, CPCS, 'flu immunisations. See section 10 for further details.
Uptake of PH locally commissioned services **There is appropriately distributed provision of supervised consumption, needle exchange, Emergency Hormonal Contraception and smoking cessation.**	Location of Public Health commissioned services were reviewed in section 6.
Consideration of other NHS services serving East Sussex which affect pharmaceutical need **Other NHS services include Urgent Treatment Centres, Minor Injury Units, GP out-of-hours services, acute and community trusts, and hospices.** **These have all been taken into consideration in determining whether needs for pharmaceutical services are being met.**	Relevant NHS services are provided to East Sussex residents by: Sussex Community NHS Foundation Trust; East Sussex Healthcare NHS Trust, Sussex Partnership NHS Foundation Trust and IC24. Services are also accessed from neighbouring trusts University Hospitals Sussex NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust.

East Sussex Required Statement	Evidence Reviewed
	Please see Section 6 for more details.
Consideration of other relevant services, that are, or could be, provided and that would secure improved access. **None were identified.**	Hepatitis C virus antibody testing to cease in March 2023. Assurance from sexual health commissioner that there is an alternative route for diagnosis, in addition to drug and alcohol services. Please see section 6 for more details.

The following recommendations are based on statements required in the PNA guidance. These are summarised in Table 2, Future Provision

Table 2: Required statements in the Regulations-Future position

East Sussex Required Statement	Evidence reviewed
Services that would secure improvements or provide better access in future	
If there were to be an increase in contracted GP surgery hours to 20:00 on weekdays and Saturday afternoons from October 2022 then there will be a need to consider the commisioning of an extended hours service from existing providers.	NHSE are proposing to extend GP opening hours by requiring Primary Care Networks to implement this. If new arrangements are implemented then this will increase demand for pharmacy services in the evenings and at weekends which could be met from existing providers.
Future need for necessary services in the next three years **Current plans for housing developments locally would not require a new pharmacy**	Should there be substantial housebuilding completion [of the order of 2,000 houses or more] focused in a given parish or town in East Sussex in the lifetime of this PNA [between 2022 to 2025], then there could be a need for a new pharmacy. From current planning estimates this seems unlikely to be the case.
Any new pharmacy would be expected to provide the following: all essential	

East Sussex Required Statement	Evidence reviewed
services, as well as the advanced services: Community Pharmacist Consultation Service; the New Medicine Service; 'flu vaccinations advanced services; and hypertension case-finding in future. These services would be expected to be provided Monday to Saturday.	
We recommend that Ds and Bs clearly communicate to residents the location of existing disabled parking.	From public consultation [Section 11]

1. Introduction

1.1 What is a Pharmaceutical Needs Assessment [PNA]

Since April 2013 every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish every three years, and keep up to date, a statement of the need for pharmaceutical services in its area, otherwise referred to as a pharmaceutical needs assessment (PNA).

The role of the PNA in the provision of services

If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to NHS England to be included in the pharmaceutical list for the Health & Wellbeing Board's area in which they wish to have premises.

In general, their application must offer to meet a need that is set out in the Health & Wellbeing Board's PNA, or to secure improvements or better access similarly identified in the PNA. However, there are some exceptions to this, such as applications offering benefits that were not foreseen when the PNA was published ('unforeseen benefits applications').

In April 2016, NHS England published (updated in April 2019) the Pharmacy Manual which outlines the procedures to be followed which are relevant to pharmacy contractors, including market entry, applications to join the pharmaceutical list, change of ownership and no significant change relocation.

As well as identifying whether there is a need for additional premises, the PNA will also identify whether there is a need for an additional service or services, or whether improvements or better access to existing services are required. Identified needs, improvements or better access could either be current or will arise within the three-year lifetime of the pharmaceutical needs assessment.

Commissioning of Community Pharmacy

Whilst the PNA is primarily a document for commissioners of pharmaceutical services to use to make commissioning decisions, it may also be used by local authorities.

Following advent of the new Health and Care Bill 2022, from 1st July 2022 Clinical Commissioning Groups have been abolished and Integrated Care Systems with Integrated Care Boards (ICBs) and Integrated Care Partnerships have been established across England. Commissioning responsibilities for community pharmacies have been delegated to ICBs and Integrated Care Systems for early adopters from 1st July 2022.

A robust PNA will ensure those who commission services from community pharmacies and dispensing appliance contractors target services to areas of health need and reduce the risk of overprovision in areas of less need.

In summary the Regulations require a series of statements of:

- the pharmaceutical services that the Health and Wellbeing Board has identified as services that are necessary to meet the need for pharmaceutical services
- the pharmaceutical services that have been identified as services that are not provided but which the Health and Wellbeing Board is satisfied need to be provided to meet a current or future need for a range of pharmaceutical services or a specific pharmaceutical service
- the pharmaceutical services that the Health and Wellbeing Board has identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access
- the pharmaceutical services that have been identified as services that would secure improvements or better access to a range of pharmaceutical services or a specific pharmaceutical service, either now or in the future and
- other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service.

Other information that is to be included or considered is described in the methods Section 3.

PNAs are key reference documents as regards the development and improvement of local pharmaceutical services. NHS England must consider local PNAs while dealing with applications from potential new pharmaceutical service providers to join the pharmacy list.

Applicants may challenge NHSE decisions not to add new pharmacies and PNAs need to provide a robust summary of evidence which may subsequently be contested when legal challenges to NHSE decisions are made. The NHS Litigation Authority will refer to the PNA when hearing appeals on NHSE decisions.

Local commissioning bodies may also use the PNA in making decisions on which other NHS and local authority funded local services need to be provided by local community pharmacies, although this is not a statutory function of a PNA.

1.2 NHS pharmaceutical services provision

Pharmaceutical services are defined within the National Health Service Act 2006. NHS England commissions pharmaceutical services for the population.

Pharmaceutical services may be provided by:

- A pharmacy contractor who is included in the pharmaceutical list for the area of the Health & Wellbeing Board
- A pharmacy contractor who is included in the Local Pharmaceutical Services list for the area of the Health & Wellbeing Board
- A dispensing appliance contractor who is included in the pharmaceutical list held for the area of the Health & Wellbeing Board and

- A doctor or GP practice that is included in the dispensing doctor list held for the area of the Health & Wellbeing Board

NHS England is responsible for preparing, maintaining and publishing these lists.

To provide pharmaceutical services in England a person and the premises from which they will provide services must be included in the relevant pharmaceutical list.

Pharmaceutical services Section 126 of the 2006 Act places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons.

Pharmaceutical services is a collective term for a range of services commissioned by NHS England. In relation to pharmaceutical needs assessments it includes:

- essential, advanced and enhanced services provided by pharmacies
- essential and advanced services provided by dispensing appliance contractors
- the dispensing service provided by some GP practices and
- services provided under a local pharmaceutical services contract that are the equivalent of essential, advanced and enhanced services

The following areas were assessed in determining the adequacy of the pharmaceutical services provided for the needs of the East Sussex population:

1.3 Essential pharmaceutical services

Essential services and clinical governance [provided by all pharmacy contractors] are commissioned by NHS England.[1]

All pharmacies, including distance selling premises, are required to provide the essential services. As of October 2021, there are eight essential services.

1. dispensing of prescriptions [providing timely supply of medicines and advice to patients]
2. dispensing of repeat prescriptions i.e. prescriptions which contain more than one month's supply of drugs on them. For example, an electronic repeatable prescription may say that the prescription interval is every 28 days, and it can be repeated six times. This would give a patient approximately six months' supply of medication, dispensed every 28 days with the prescriber only needing to authorise them once [of particular benefit to patients on lifelong medicines such as blood pressure medication]
3. disposal of unwanted medicines returned to the pharmacy by someone living at home, in a children's home, or in a residential care home [reduces the risk of hoarding medicines at home and decrease the risk of errors in taking inappropriate or expired medicines]

[1] Clinical governance is a framework which underpins the provision of all pharmaceutical services. Schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 set out the 'Terms of Service' of NHS pharmacists in four parts. Part 4 sets out the Terms of Service, including Clinical Governance.

4. promotion of healthy lifestyles, which includes providing advice to people who appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), or smoke, or are overweight, and participating in up to six health campaigns where requested to do so by NHS England[2]
5. signposting people who require advice, treatment or support that the pharmacy cannot provide to another provider of health or social care services, where the pharmacy has that information
6. support for self-care which may include advising on over-the-counter medicines or changes to the person's lifestyle
7. discharge medicines service. This service was introduced in 2021 and aims to reduce the risk of medication problems when a person is discharged from hospital. It is estimated that 60 percent of patients have three or more changes made to their medicines during a hospital stay. A lack of robust communication about these changes may result in errors being made once the person has left hospital. Under this service a pharmacist will review a person's medicines on discharge and ensure that any changes are actioned accordingly
8. Healthy Living Pharmacy

Essential services provided by Dispensing Appliance Contractors (DACs)[20]

Dispensing appliance contractors have a narrower range of services that they must provide:

- dispensing of prescriptions and repeat prescriptions
- for certain appliances, offer to deliver them to the patient (delivering in unbranded packaging), provide a supply of wipes and bags, and provide access to expert clinical advice
- where the contractor cannot provide a particular appliance, signposting or referring a patient to another provider of appliances who can

1.4 Advanced Services

These can be provided by all contractors, and are commissioned by NHS England

[2] Undertaking public health campaigns

Improve awareness of the signs and symptoms of conditions, e.g. the F.A.S.T. campaign to identify strokes

Promote validated information resources for patients and carers

Collect information from the local population on their awareness and understanding of diseases and their associated risk factors

Targeting "at risk" groups to reduce inequalities within the local population and to promote understanding and access e.g. for men in their 40s for NHS Health Checks; and to immunisation e.g. uptake of COVID vaccine.

- New Medicine Service (pharmacies only) to help improve medicine adherence among people with long-term health conditions who have been prescribed new medication
- Flu vaccination (pharmacies only) pharmacists offer a seasonal flu vaccination service for patients in eligible groups
- Appliance Use Review (pharmacies and DACs) to support patients in the use, safe storage and disposal of appliances
- Stoma Customisation Service (pharmacies and DACs) to ensure the proper use and comfortable fitting of the stoma appliance
- Community Pharmacist Consultation Service [CPCS] for minor illnesses and urgent medicines supply
- Community pharmacy hepatitis C antibody testing service (currently due to end on 31 March 2023)
- Hypertension case finding
- Smoking cessation

1.5 Necessary services

For the purposes of this PNA, the broad term 'necessary services' includes all essential services plus the following advanced services: New Medicines Service, Community Pharmacy Consultation Service, 'flu immunisation and hypertension case finding in future.

The community pharmacy role in improving the public's health

The PHE and LGA publication: The Community Pharmacy Offer for Improving the Public's Health gives case studies illustrating the potential of community pharmacy teams to improve the health of the population and to reduce inequalities in health within and between communities.[21]

Community pharmacists and their teams work at the heart of communities and are trusted professionals in supporting individual, family and community health. They are uniquely placed to deliver public health services due to their access, location and informal environment. They are an important social asset, as they are often the only healthcare facility located in an area of deprivation.

Pharmacy staff reflect the social and ethnic backgrounds of the community they serve and are accessible to individuals living in deprived areas who may not access conventional NHS services. A wide range of public health services are already provided by pharmacy teams and there is the potential for further development. The Local Government Association (LGA) and Public Health England (PHE) recommend that community pharmacy teams should be fully integrated into local primary care networks (PCNs).

Community pharmacy is a key strategic partner in local public health programmes and in prevention and early detection of disease. Pharmacy has an important role in medicines optimisation, ensuring that people get the best out of their medicines and providing health promoting advice for people living with long-term health conditions.

2. The Pharmaceutical Needs Assessment Process

2.1 Aim

The aim of the East Sussex PNA is to describe the current pharmaceutical services in East Sussex, systematically identify any gaps in provision in relation to population need and, in consultation with stakeholders, make recommendations on future development, and meet or exceed the minimum statutory requirements for PNAs and enable the HWB to have regard to all relevant matters.

2.2 Objectives

- To state on behalf of the HWB which pharmaceutical services are
    - necessary to meet the need for pharmaceutical services
    - not provided but need to be to meet a current or future need for a range of or specific pharmaceutical service
    - not necessary to meet the need for pharmaceutical services but have secured improvements or better access
    - which would secure improvements or better access either now or in the future
    - other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service
- Examine the current and future demographics of the local population and their health needs in relation to pharmaceutical service provision
- State how localities have been determined and how their different needs have been identified, included the different needs of those who shared a protected characteristic
- Compile a comprehensive list of pharmacies and review the services currently provided
- Define choice and identify whether there is sufficient choice about obtaining pharmaceutical services
- Compile a comprehensive list of GP dispensaries
- List other services including community pharmacies, and services available in neighbouring Health and Wellbeing Board (HWB) areas that might affect the need for services in East Sussex
- Identify service gaps that could be met by providing additional or new pharmacy services [including hours of opening], or potentially by opening one or more new pharmacies

- Produce maps relating to East Sussex pharmaceutical services, location of pharmacies in relation to population deprivation indices, estimate travel/walking times
- Consult and engage with stakeholders and the public throughout the process so that their opinions inform the PNA document
- Collate the findings from the two-month statutory public consultation period, after completion of the draft PNA assessment, before consideration by the Health and Wellbeing Board and publication in October 2022

2.3 Methodology

The PNA 2017 report has been used in developing the current 2022 PNA. A Supplementary Statement was issued in February 2021. We reviewed the recommendations from 2017 and these can be found in Appendix F.

A key reference document has been the DHSC Guidelines for PNA development October 2021. See also bibliography Refs 34-39.

2.4 Key Steps

The assessment has involved the following key steps:

1. Review the East Sussex Health and Wellbeing Strategy 2016-19, Director of Public Health Annual Reports[3] and other relevant local plans
2. Reviewing current and predicted population
3. Looking at health and social care needs
4. Collation of community pharmacy and GP dispensary information about current service provision. Collation and summary of routine pharmacy contracting and activity data
5. Summarise patient experience: a telephone questionnaire to a stratified sample of the population. Patients who were called by the market research organisation in 2022 were given the opportunity to complete an online version on ESCC website if they preferred
6. Summarise professional experience: on-line questionnaires
7. Synthesise identified health needs and priorities, map these against service provision (Gap Analysis)
8. Undertake professional and public consultation

2.5 Necessary services

The 2013 regulations require the Health and Wellbeing Board to include a statement of those pharmaceutical services that it has identified as being necessary to meet the need for

[3] The Director of Public Health's Annual Reports

The DPH Reports expand on areas addressed in the JSNAA, although with a sharper focus on issues that the Director believes to be especially salient

pharmaceutical services within the Pharmaceutical Needs Assessment. There is no definition of necessary services within the regulations and the Health and Wellbeing Board therefore has complete freedom in this matter.

Necessary services: current provision within East Sussex

Necessary services are defined within the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended, as those services that are provided:

- Within the Health and Wellbeing Board's area and which are necessary to meet the need for pharmaceutical services in its area and
- Outside the Health and Wellbeing Board's area but which nevertheless contribute towards meeting the need for pharmaceutical services within its area

For the purposes of this pharmaceutical needs assessment, the Steering Group has agreed that necessary services are:

- Essential services provided at all premises included in the pharmaceutical lists
- The New Medicine Service, Community Pharmacist Consultation Service and 'flu vaccination advanced services and the hypertension case-finding service in future
- The dispensing service provided by some GP practices

3. Strategic Context

Part of the NHS Long Term Plan in England includes the development of **Integrated Care Systems** (**ICS**).

Integrated Care Systems [ICS] bring together the organisations planning, buying and providing publicly funded healthcare, including mental health and community care services, to the population of a geographical area. As well as the NHS, other organisations include local authorities and independent care providers.

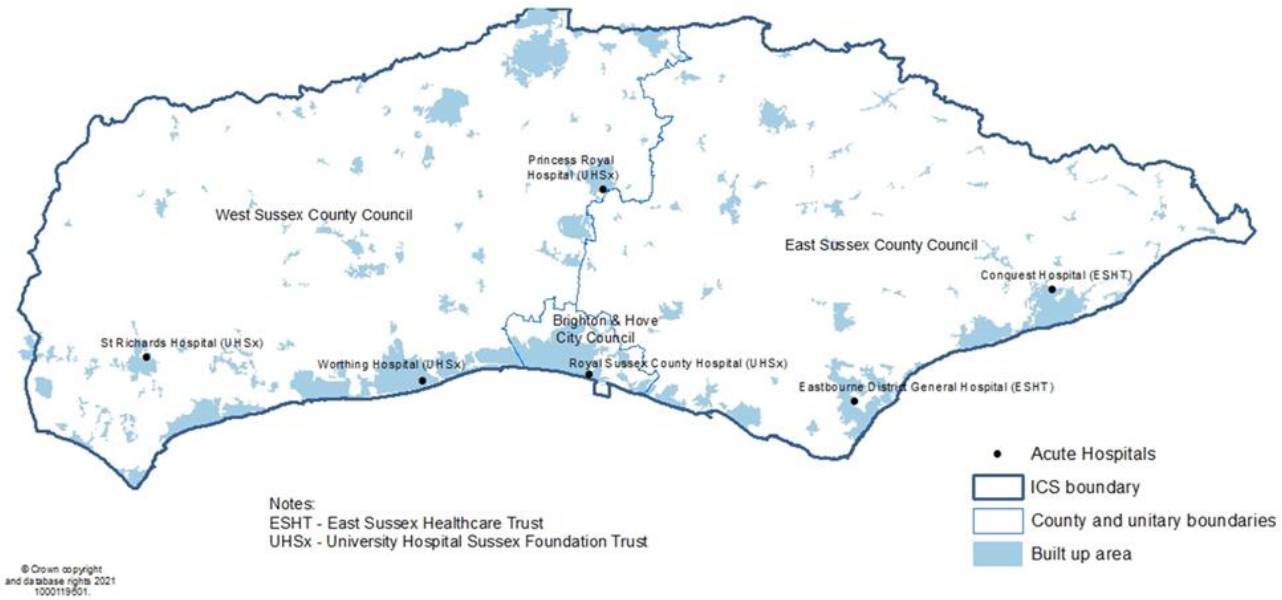
The Sussex Integrated Care System consists of the NHS Sussex Integrated Care Board and Sussex Health and Care Assembly.

In line with this, the three NHS Clinical Commissioning Groups (CCGs) in Sussex closed on 30th June 2022, and a new statutory NHS Integrated Care Board (ICB) known as NHS Sussex was formally established on 1st July. NHS Sussex is responsible for agreeing the strategic priorities and resource allocation for all NHS organisations in Sussex, taking on the healthcare commissioning functions previously carried out by CCGs. It has also taken on responsibility for wider primary care services including dental, pharmacy and opticians.

NHS Sussex held its inaugural Board meeting on 6th July, with East Sussex County Council, West Sussex County Council and Brighton & Hove City Council as partner members.

The Sussex Health and Care Assembly will also be established, as a statutory joint committee between the NHS and local government, to come together with wider partners to agree formally the strategic direction for our system to meet the broader health, public health and social care needs of the population in the ICS footprint. It will do this primarily through agreeing an Integrated Care Strategy for Sussex, building on local Joint Strategic Needs Assessments and the Health and Wellbeing Strategies in each of the three 'Places' in Sussex (East Sussex, West Sussex and Brighton & Hove). Figure 1 shows the ICS boundary, local authority boundaries and acute trusts.

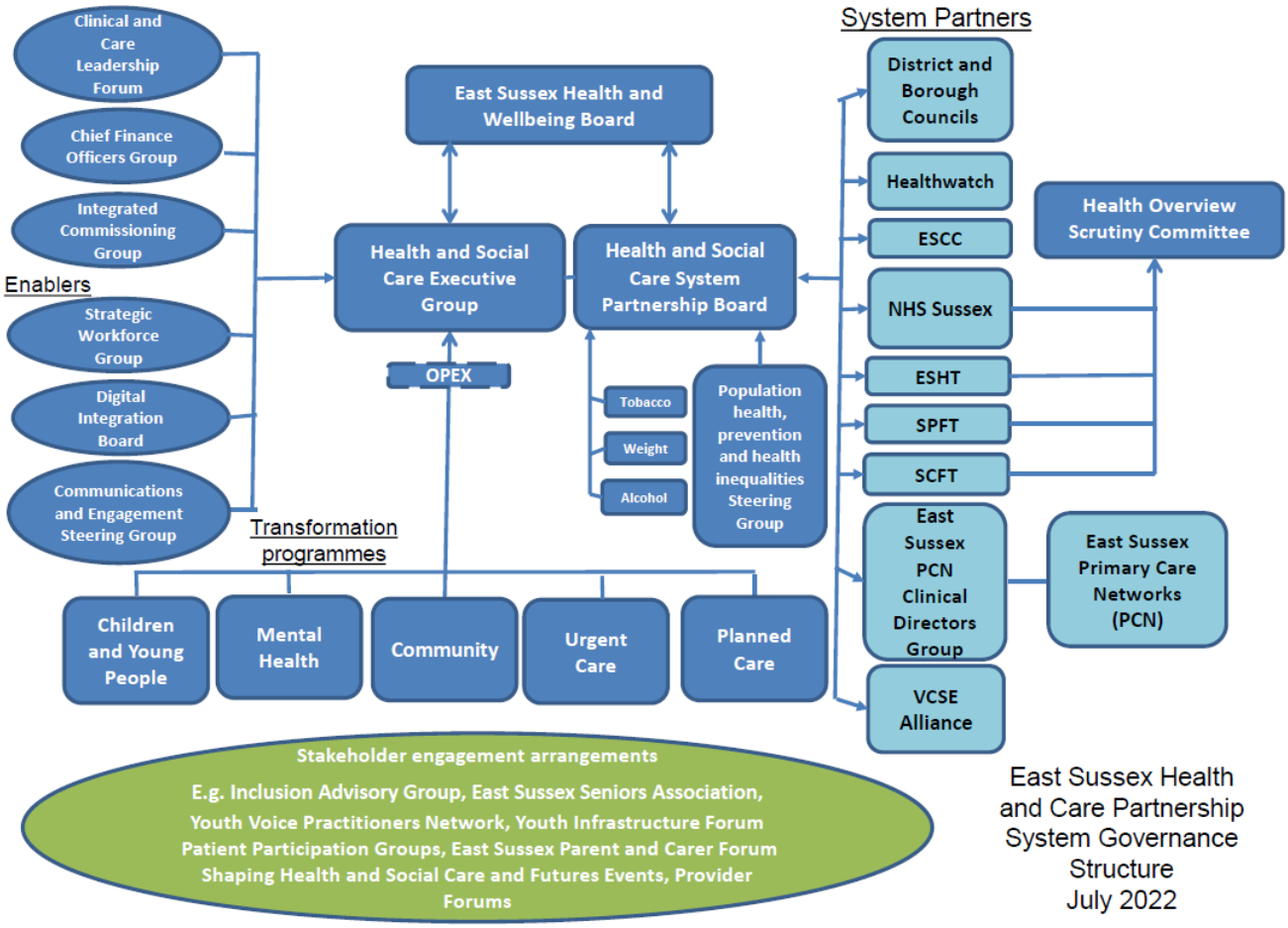
Figure 1 Sussex Integrated Care System boundary, local authority boundaries and acute trusts.



3.1 East Sussex Health and Care Partnership

At the local level, integration is managed through the longstanding East Sussex Health and Care Partnership. This brings together East Sussex County Council, NHS Sussex, East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, and our wider system partners including primary care networks, district and borough councils, Healthwatch, the Voluntary, Community and Social Enterprise (VCSE) sector. There is shared leadership through: joint system responsible officers; partnership governance; a Health and Care Partnership Plan and transformation programmes; and a shared strategic Outcomes Framework. The East Sussex Health and Care Partnership is accountable to the East Sussex Health and Wellbeing Board. Figure 2 below summarises these system changes and relationships.

Figure 2 East Sussex Health and Care Partnership System partnership governance:



Place [geographical] role of local authorities

Upper tier local authorities are known as "place" within the ICS. They have a leadership role at place [geographical] level covering a range of economic, environmental and infrastructure services and issues. This is wider than the NHS role.

Upper tier local authorities have responsibility for:

- Children's Services
- Adult Social Care
- Public Health Services
- Wider local government services that support wellbeing

The Health and Wellbeing Board oversees the way local organisations work together to improve health and deliver joined up care to local populations. It is chaired by the Leader of ESCC.Membership includes District and Borough Councils, the NHS, VCSE, Healthwatch, and representation from NHS SE Region.

The Health Overview Scrutiny Committee has democratic oversight of local health services, with membership drawn from ESCC and District and Borough Councils.

Community pharmacy has a role in helping people to navigate the health and social care system. Community pharmacy is a part of primary care, along with optometry, dentistry and General Practice.

A range of different organisations and types of service provide health care in Sussex.

Depending on the service, they may either meet the needs of people at a neighbourhood, county, Sussex-wide, or South-East regional level.

In East Sussex we have an integrated acute and community health provider, East Sussex Healthcare Trust [ESHT], which provides services that only operate within our county.

People living in the High Weald, Lewes, & Havens part of the county could have their community health care provided by either ESHT or Sussex Community Foundation Trust, depending on what support is required.

Social Care Provision in East Sussex

Social care provision is made up of the independent sector (the private sector), the Voluntary Community and Social Enterprise (VCSE) sector, and those services directly provided by ESCC.

ESCC commissions a wide range of social care support across the county, but there is also a significant proportion of services financed by people funding their own care, also known as 'self-funders'. ESCC leadership role is in purchasing and shaping the care market rather than directing it.

Unpaid carers also make a significant contribution to supporting people with social care needs in East Sussex.

Care homes play an important role in enabling people to maintain their independence in the community and facilitate discharge from hospitals. Care home settings are just one example of where health and social care services intersect and work together to keep people safe and well.

In summary, East Sussex has a wide range of organisations and service types in place to meet the health and care needs of its population.

The structure and areas of operation for some services are evolving in line with national policy developments and local priorities.

3.2 Place (East Sussex) Next steps

In East Sussex, the place programme will develop integrated, preventative care focussed on our elderly, frail and vulnerable populations, aimed at strengthening our target operating model for community health and social care services.

This will involve working with different strengths and needs in our localities and embedding anticipatory Population Health Management (PHM) as an approach, focused on improving health, prevention and health inequalities.

3.3 Changes in Primary Care

Primary Care Networks

Primary care networks [PCNs] are a key vehicle for delivering many of the commitments in the NHS Long-Term Plan and providing a wider range of services to patients.[22] PCNs build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care.

Primary Care Networks consist of a group of collaborating GP practices which, in many instances nationally, serve a population of between 30,000 and 50,000 people [although in East Sussex the Hastings PCN covers 100,000 people].

Primary Care Networks (PCNs) work to deliver primary care at scale in a local area. They have no defined boundaries. Figure 5 divides the County up into the PCN that most residents are registered with. In some cases these are practices/PCNs that operate outside of the county.

The 52 GP practices in East Sussex are working together as part of 12 Primary Care Networks (PCNs). As GP practices do not operate within fixed boundaries, two patients living in close proximity could be registered with differing practices.

Whilst District and Borough areas are not coterminous with the areas PCNs operate within, having multiple practices collaborating as networks should make partnership working with primary care easier for both upper and lower tier local authorities.

Figure 3 The footprints of the PCNs and local authorities in East Sussex

Figure 3 The footprints of the PCNs and local authorities in East Sussex

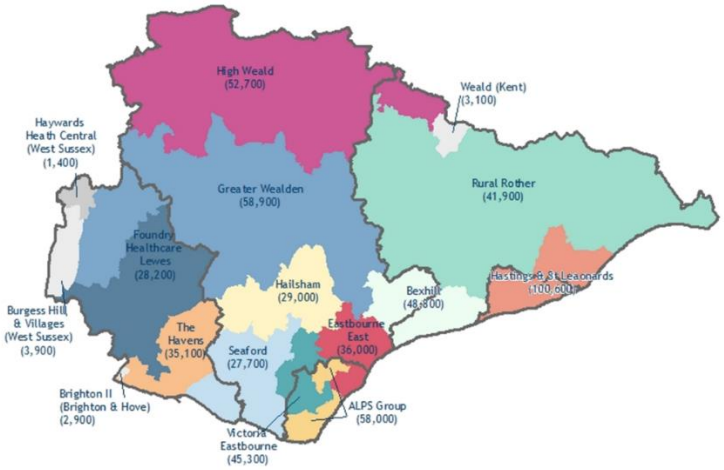


Figure 4 compares the populations served by each of the PCNs. Hastings & St Leonards PCN is the largest (100,000 people) and Seaford PCN is the smallest (28,000 people).

Figure 4 The populations served by each of the PCNs in East Sussex.

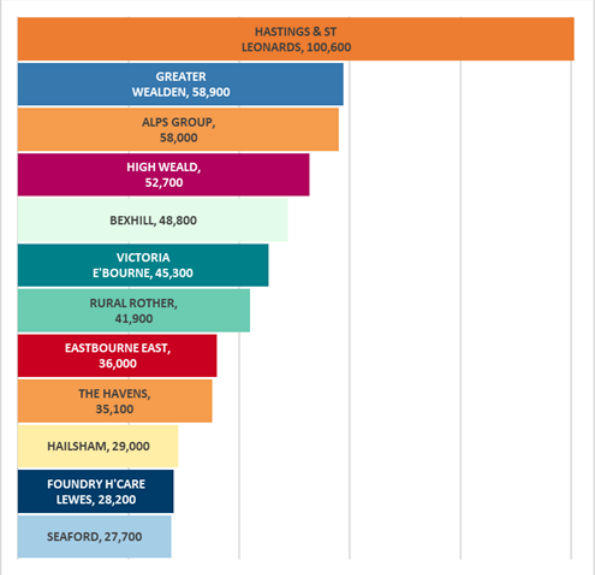
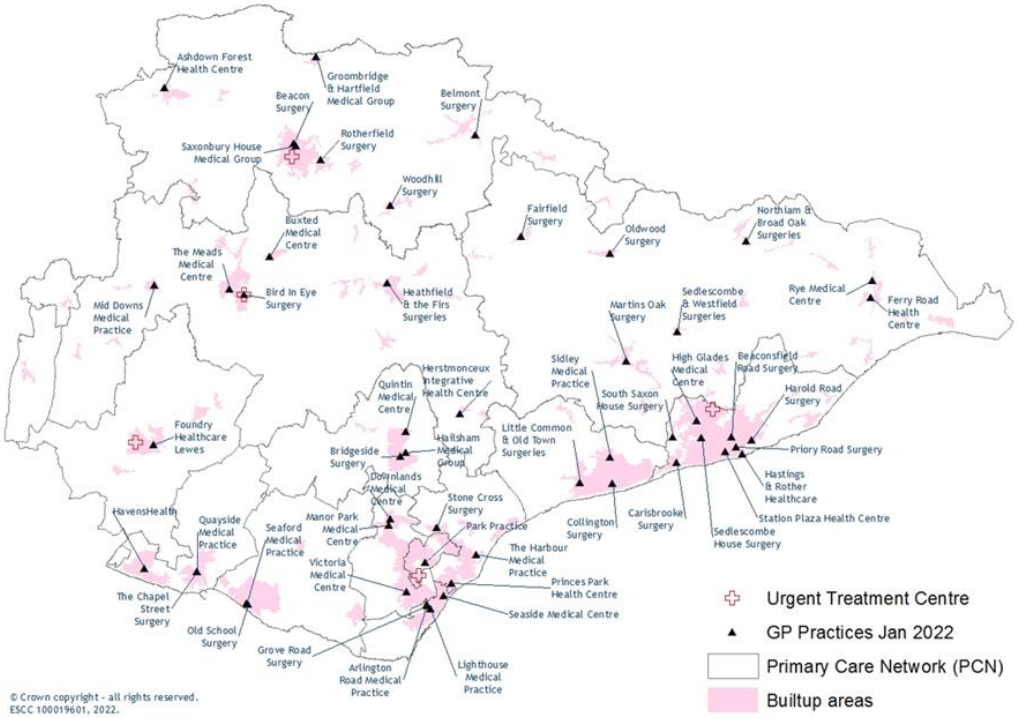


Figure 5 shows the names of the GP practices in each PCN.

Figure 5 Names of GP practices in PCNs in East Sussex



PCNs deliver a set of national service specifications under the terms of the Network Contract Directed Enhanced Service [DES], Table 3. This requires extensive consultation with stakeholder groups for its implementation, including collaboration and consultation with community pharmacies.[23]

Table 3 Service specifications to be implemented in PCNs in 2021/22

Service specification	Introduced from	Examples
Structured medicines review and optimisation	2021/22	Directly tackling over-medication, including inappropriate use of antibiotics, drugs of dependency. Focus on priority groups including the frail elderly
Enhanced health in care homes	2021/22	Aligned care homes in PCN with a lead GP. Multi-disciplinary team and weekly care home round [24]
Social prescribing service	2021/22	Access to social prescribing via link workers
Supporting early cancer diagnosis	2021/22	Ensuring high and prompt uptake of cancer screening. Peer review
Cardiovascular disease prevention and diagnosis	2021/22	PCN to work in collaboration with community pharmacies From October 2021, every NHS pharmacy in England will be able to provide blood pressure checks to people aged 40 and over according to the service criteria. The deal is part of the Community Pharmacy Contractual Framework
Tackling neighbourhood inequalities	2021/22	People with learning disability checks People with Serious Mental Illness reviews Recording ethnicity Improving vaccine uptake is in the Pharmacy Quality Scheme for 2021/22
Extended hours access to clinical appointments	2021/22	As specified. Further extension from October 2022 to be decided

Primary Care Networks [PCNs] receive specific funding for pharmacists, social prescribing link workers, physiotherapists, physician associates and paramedics.[25] PCNs are the footprint around which integrated community-based teams are developing.

Community and mental health services are expected to configure their services around Primary Care Networks.[26] These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

3.4 The Community Pharmacy Contractual Framework

The community pharmacy contract [revised from 2019-2024]:

- confirms community pharmacy's future as an integral part of the NHS, delivering clinical services as a full partner in local primary care networks (PCNs)
- underlines the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community
- continues to prioritise quality in community pharmacy and to promote medicines safety and optimisation
- underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme

There will be a new contract during the lifetime of this PNA.

The NHS Community Pharmacist Consultation Service [CPCS][27]

The NHS Long Term Plan and the five-year framework for the GP contract have set out an ambition to develop the role of community pharmacy in managing demand for urgent and primary medical services. Up to 6% of all GP consultations could be safely transferred to this service.

The NHS Community Pharmacist Consultation Service (CPCS) takes referrals to community pharmacies from NHS 111 for urgent medication requests and minor illnesses. 94% of pharmacies have signed up to this advanced service.

As NHS 111 tend to refer more patients during evenings and weekends it tends to be those pharmacies which have long opening hours which have the greatest number of referrals. The pharmacies cannot initiate referrals with patients.

CPCS numbers will change and increase with the implementation of the GP CPCS service which is starting roll-out across East Sussex. CPCS referrals through A and E and Urgent Care Centres are starting as a pilot.

National evidence supports the success of this scheme with patients getting same day appointments for urgent medication requests for conditions such as diabetes or asthma and people with a minor illness given clinical advice, such as for a sore throat or earache.[28]

The consultation service is supported by the NHS 'Help Us Help You' Pharmacy Advice campaign.

Drug Dispensing Reforms

Dispensing for people with long term conditions on stable medication can be delivered in different ways. The new pharmacy contract commits to exploring whether changes to fee structures could support more efficient dispensing, such as for 90-day dispensing of medicines for people with long term conditions, linked to changes to GP prescribing and medication review services. This can potentially reduce footfall in pharmacies.

Electronic Prescription Service (EPS)[29]

The Electronic Prescription Service (EPS) sends electronic prescriptions from GPs to pharmacies. It is a three-way system with information flowing from GPs to a central database (the Spine) where it is collected by community pharmacies. The dispensing information then flows to this database from the pharmacy to show whether the prescription has been dispensed or not.

A paper prescription will still be used when a patient explicitly asks their GP for one. EPS has mostly benefited patients who receive regular medications and who tend to get their prescriptions dispensed at the same pharmacy most of the time. EPS moved on during COVID and the majority of acute prescriptions are all EPS as well and can be sent to the spine to be pulled down by any pharmacy.

Electronic Repeat Dispensing (eRD)

Repeat dispensing is an essential service within the Community Pharmacy Contractual Framework (CPCF). This enables pharmacy teams to dispense repeat prescriptions issued by a GP. The pharmacy can ensure that each repeat supply is needed and can check whether the patient should be referred to their GP. Most repeat dispensing is carried out via EPS and is termed Electronic Repeat Dispensing (eRD).

NHS Summary Care Record [SCR]

Every patient now has access to their health record [the Summary Care Record (SCR)] via the NHS App. All pharmacies in East Sussex have access to the SCR. The Summary Care Record in community pharmacy supports clinical decision-making, reduces the risk of prescribing errors and improves urgent care. By March 2023, all systems within a Shared Care Record collaborative will be expected to be able to exchange information across the whole collaborative, with a view to national exchange by March 2024.

Pharmacists and pharmacy technicians can have access to key clinical information in the SCR with a patient's consent (about medicines, allergies and adverse reactions).

The SCR is especially useful for people with complex or long-term conditions, and patients reaching the end of life. The NHS Long Term Plan sets out ambitions for digitally enabled care across the NHS. However, there remain considerable challenges for people who are digitally excluded.

NHS England [NHSE]

Since 2013, NHSE has worked alongside CCGs and has undertaken functions relating to primary care contracts, as well as some other activities previously performed by the Department of Health, such as screening and immunisation. NHSE also liaises with partners to oversee the quality and safety of the NHS and promote patient and public engagement. NHS England South-East is one of the regional arms of NHSE and East Sussex is covered by the South-East Regional Team.

Pharmacies provide services under their terms of service set out in regulations and in the contractual framework. The regional arms of NHSE have a special role regarding pharmaceutical services. This includes the assessment and assuring of performance of pharmaceutical contractors and ensuring the quality and safety of pharmaceutical services in line with the NHS Pharmacy Contractual Framework.

3.5 The Impact of the COVID-19 Pandemic on Pharmaceutical Services

On account of the national emergency posed by the COVID-19 pandemic, the implementation of some of the initiatives and innovations outlined above has been slowed down. The multiple impacts of the pandemic on pharmacies have been summarised in a House of Commons briefing.[30]

Community pharmacies have remained open to customers throughout the periods of national lockdown and restrictions, employing preventive measures, such as mask wearing, social distancing, use of hand gel and protective Perspex screens. To some extent the effects of these measures are reflected in the findings of customer surveys.

There have also been challenges to pharmacies in maintaining staff-levels due to illness, in keeping the physical environment secure and in an increase in abusive behaviour from customers. Pharmacies have been more involved in providing remote consultations (by telephone or sometimes video link) and in supplying repeat prescriptions.

All pharmacy contractors were asked by NHSE to support the delivery of medicines to vulnerable patients shielding at home, but this was a temporary measure commissioned during COVID and no longer operational after March 2022.

The voluntary sector also played a very important role in maintaining delivery of medicines to vulnerable groups of people which was also the case in East Sussex.

Community pharmacies have been involved during the pandemic in supporting victims of domestic abuse. The ‘Ask for ANI’ (Action Needed Immediately) scheme was launched in January 2021. By asking for ANI, a trained pharmacy worker can be alerted to offer a private space where they can understand if the victim needs to speak to the police or would like help to access support services such as national or local domestic abuse helplines.

Throughout 2021 a certain proportion of pharmacies have been able to carry out vaccination against COVID-19 based on need in a locality. All pharmacies that are NHS

contractors were asked to supply lateral flow test kits. As COVID-19 becomes an endemic disease (that is, a disease like influenza, present in the population with an expected winter peak each year) the role of vaccinating against COVID-19 will, in all probability, continue in many pharmacies.

Suitably qualified pharmacists could be permitted to prescribe oral anti-viral drugs to those in greatest need in future.[31] They will continue to ensure the safe use of the new anti-viral drugs by checking for interactions with other medicines.

3.6 Joint Strategic Needs and Assets Assessment [JSNAA]

The Joint Strategic Needs and Assets Assessment (JSNAA) is an ongoing process, overseen by the Health and Wellbeing Board. The JSNAA looks at the current and future health and care needs of the local population to inform and guide the planning and commissioning of services in East Sussex.

The JSNAA encompasses a wide variety of themes and summaries of knowledge such as social and demographic descriptions of the population, economic analyses, population projections, analyses of mortality, the prevalence of different diseases, usage of hospital and other health services, survey data on lifestyle factors and well-being. The findings of the JSNAA process are often published in separate reports and profiles dealing with certain topics. A comprehensive refresh of the JSNAA findings is in preparation.

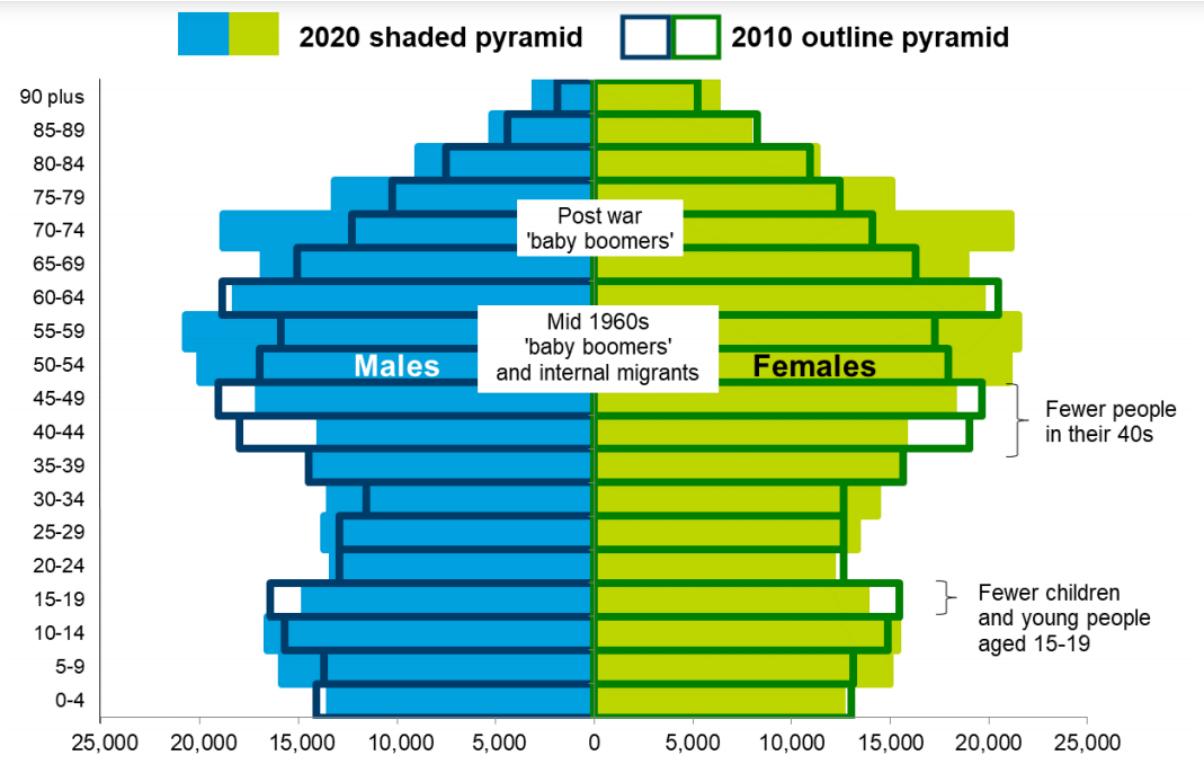
4. Demography

4.1 Age and sex

The population of East Sussex was estimated to be 558,852 in mid-2020 (ONS mid-year estimates, 2020).[4] East Sussex has a much older age profile compared to England and the South East, the changes since 2010 are shown in Figure 6. Twenty-six per cent [26%] of the county's population is aged 65 or over, compared to 19% in England and 20% regionally.

Older people have a much greater need for pharmaceutical services. The median age of the county is 48.4 years, compared to the national average of 40.2. More than 60% of the prescriptions made in the community are for people aged over 60.

Figure 6 Population structure of East Sussex 2020, compared to 2010



In mid-2020, 52% of the county's population was estimated to be female and 48% male, similar to the national split. However, for those aged 65 and over, it was estimated that 55% of the population was female and 45% male.

4.2 Ethnicity

The 2021 Census data were not available for inclusion in the production of this report. The East Sussex population is predominantly white (96.1%), with 3.9% recorded as non-white at the last Census in 2011. There is a low proportion of persons who cannot speak English or

[4] Early data from the 2021 Census show that the East Sussex population was 545,800 and has been overestimated.

not speak English well (0.5%). The largest proportion of non-white minority residents is in Hastings Local Authority, Table 4.

The total populations shown here in Table 4 refer to the 2011 Census figures. Ethnicity and language influence health seeking behaviours, the adherence to the use of medicines, and the use of non-prescribed medicines.

Table 4 Ethnic Groups within East Sussex Source: Census 2011

	Total Population	% White	% Non-white
Eastbourne	99,412	94.1	5.9
Hastings	90,254	93.8	6.2
Lewes	97,502	96.6	3.4
Rother	90,588	97.0	3.0
Wealden	148,915	97.4	2.6
East Sussex	526,671	96.1	3.9
England	53,012,456	85.5	14.5

Eight per cent of the population belong to ethnic groups other than White British or Northern Irish. A large proportion of people who define themselves as 'White Other' are Polish, but there are also other European groups and other white migrants. 'Other White Background' and 'Other Mixed Background' population groups are the two most common BME groups in East Sussex, followed by 'White and Asian', 'Any Other Asian Background' then 'White and Black Caribbean'.

This differs from the national picture where Pakistani, African and Indian groups are more prevalent, although the most predominant BME subgroup nationally is 'Other White Background'. The profile of the 'Mixed Heritage' group is made up of White and Asian, White and Black Caribbean.

East Sussex is becoming increasingly ethnically diverse. Locally the proportion of school age children from minority ethnic backgrounds is increasing from 10.4% in 2013 to 15.9% (10,485 pupils) in 2022 (January 2022 School Census) but is still significantly lower than the latest national figure of 35.1%. (DfE, Academic Year 2020/21). In East Sussex, 61 per 1,000 pupils have English as an additional language. Eastbourne Borough has the highest rate, twice that of the county average, whereas Wealden District has the lowest.

4.3 Population Change 2022-2025

Since the last PNA in 2017 there are 10,900 more people in East Sussex.

From estimates for the East Sussex population in 2022 of 563,167 there will be an estimated population of 575,544 by 2025, an increase of 12,376 persons [a 2.2% increase].

In 2025 we expect that just over half of our population will be aged 18-64, with over a quarter aged 65 and over.

These demographic changes present a challenge for commissioners and providers of all health and social care, including providers of community pharmacy services. The increase in numbers of older people is expected to result in an increase in the prevalence of people living with one or more long-term health conditions. The associated multi-morbidity and frailty will place substantial additional demands on health and social care services.

This section includes population projections for East Sussex County and for the five lower tier local authorities.

For the purposes of the PNA 2022, lower tier local authorities have been used as the main unit of analysis for defining localities. This is because of the readily available, robust information from which to make comparisons in terms of underlying need within their respective populations and the pharmacy services provided to them.

A more detailed look at ward level has been used in the general travel access analysis in Section 6.

A summary of changes in the East Sussex population by 2025 is shown in Figure 7 and Table 5

Figure 7 Summary of changes in the East Sussex population by 2025

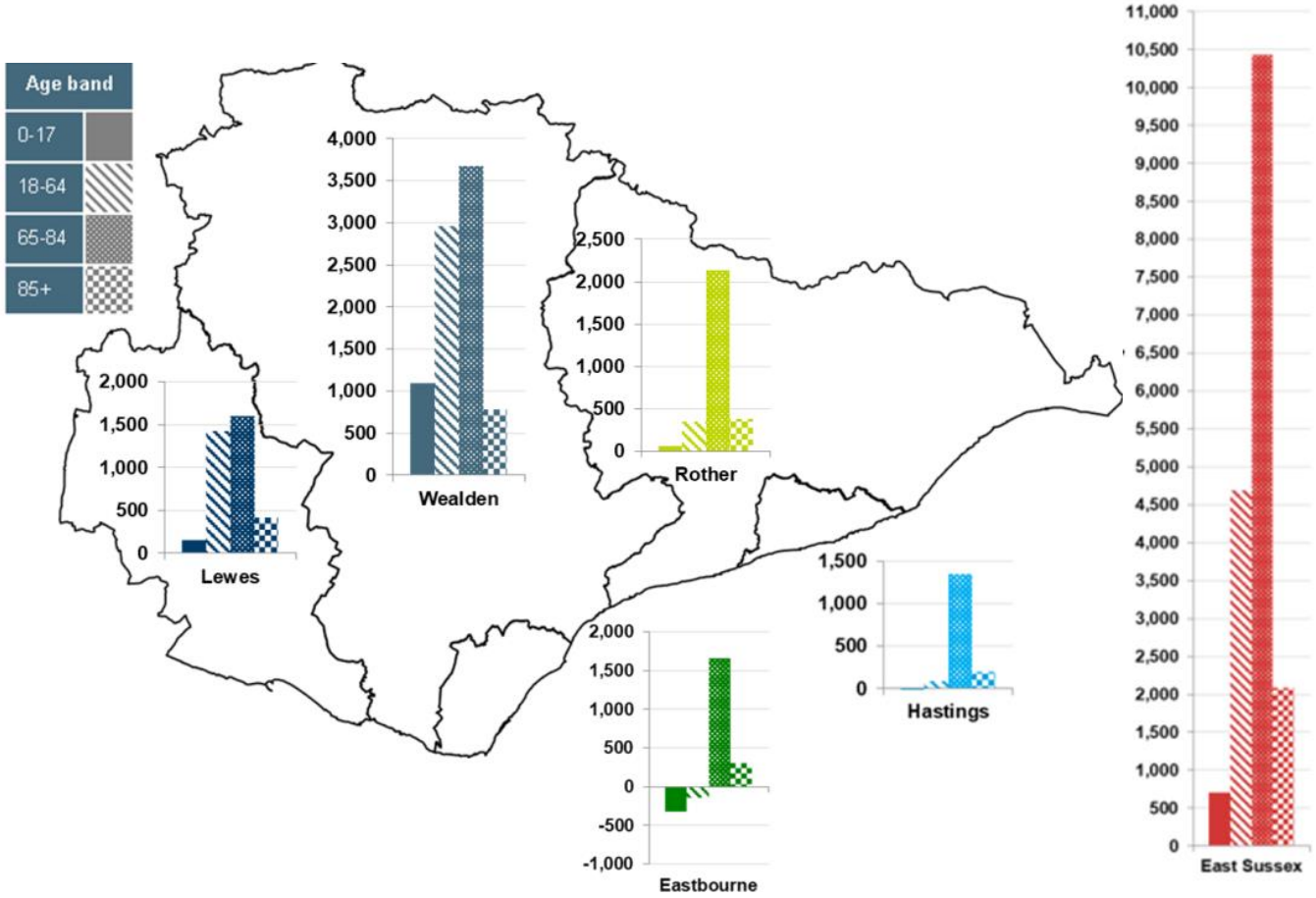


Table 5 Changes in subgroups in the East Sussex population between 2022-25

Age group	2022	2025	Change
Aged 0-17	106,821	107,008	186
Aged 18-64	305,468	308,323	2,856
Aged 65-84	127,948	135,668	7,720
Aged 85+	22,930	24,544	1,614
East Sussex Total	563,167	575,544	12,376

Source: EsiF, ESCC population projections (dwelling led) March 2022

4.4 How will the East Sussex population structure compare to England in 2025?

In 2025 we expect that just over half of our population will be aged 18-64, with over a quarter aged 65 and over. Comparisons of the relative proportions of age groups in the East Sussex population in future compared to England in 2025 are shown in Table 6.

East Sussex is ranked first in England for the highest proportion of population aged 85+. The elderly [65 to 84-year-olds] and very elderly [those aged 85+] have the greatest need for pharmaceutical services.

Table 6 Comparison of population proportions East Sussex and England, 2025

Age range	East Sussex	England
0-17	18.6%	21.1%
18-64	53.6%	59.2%
65-84	23.6%	17.0%
85+	4.3%	2.7%

Source: East Sussex State of the County Report, July 2021

4.5 District and Borough population changes between 2022 and 2025

Table 7 shows the projected change in the district and borough populations 2022-25.

Table 7 Projected change in the district and borough populations 2022-25

		2022	2025	Change	% Change
Eastbourne	All ages	103,928	104,834	906	0.9
	0-17	19,875	19,554	-321	-1.6
	18-64	57,082	56,792	-290	-0.5
	65-74	12,571	12,716	145	1.2
	75-84	9,676	10,849	1,173	12.1
	85+	4,725	4,923	198	4.2
Hastings	All ages	92,709	93,992	1,283	1.4
	0-17	19,022	18,788	-234	-1.2
	18-64	53,958	54,313	355	0.7
	65-74	10,509	10,625	116	1.1
	75-84	6,491	7,390	899	13.8
	85+	2,729	2,878	149	5.5
Lewes	All ages	104,694	106,405	1,711	1.6
	0-17	20,013	19,954	-59	-0.3
	18-64	56,937	57,205	268	0.5
	65-74	13,411	13,417	6	0.0
	75-84	9,976	11,126	1,150	11.5

	85+	4,357	4,703	346	7.9
Rother	All ages	97,076	99,338	2,262	2.3
	0-17	16,374	16,475	101	0.6
	18-64	48,594	48,968	374	0.8
	65-74	15,332	15,339	7	0.0
	75-84	11,951	13,417	1,466	12.3
	85+	4,826	5,139	313	6.5
Wealden	All ages	164,760	170,973	6,213	3.8
	0-17	31,538	32,237	699	2.2
	18-64	88,896	91,045	2,149	2.4
	65-74	21,866	22,543	677	3.1
	75-84	16,166	18,247	2,081	12.9
	85+	6,294	6,901	607	9.6

By 2025 there will be:

- 600 more people aged 85+ in Wealden, an increase of [10%]
- 200 more people aged 85+ in Eastbourne, the smallest increase of [4%]
- 2,760 more people aged 65-84 in Wealden, a [7%] increase in that age band, and 1,010 more people [6%] in Hastings. Lewes will see (1,160) more, a [5%] increase

This demographic changes will increase the workload of primary care services.

- Wealden will also see the largest increase of (2,150) in the working age population (18-64) a [2%] increase. Eastbourne will see a 1% (290) fall in the working age population

Source: ESiF ESCC population projections March 2022

4.6 Where do people live in East Sussex?

Almost three quarters of the population in East Sussex live in an urban area, with the remaining quarter living in a rural area, Table 8 and Figure 8 Population Density.

Most pharmacy services provision is in urban areas. Please see Figs 17,18 and 19 [later in the document].

Table 8 Where the population of East Sussex live

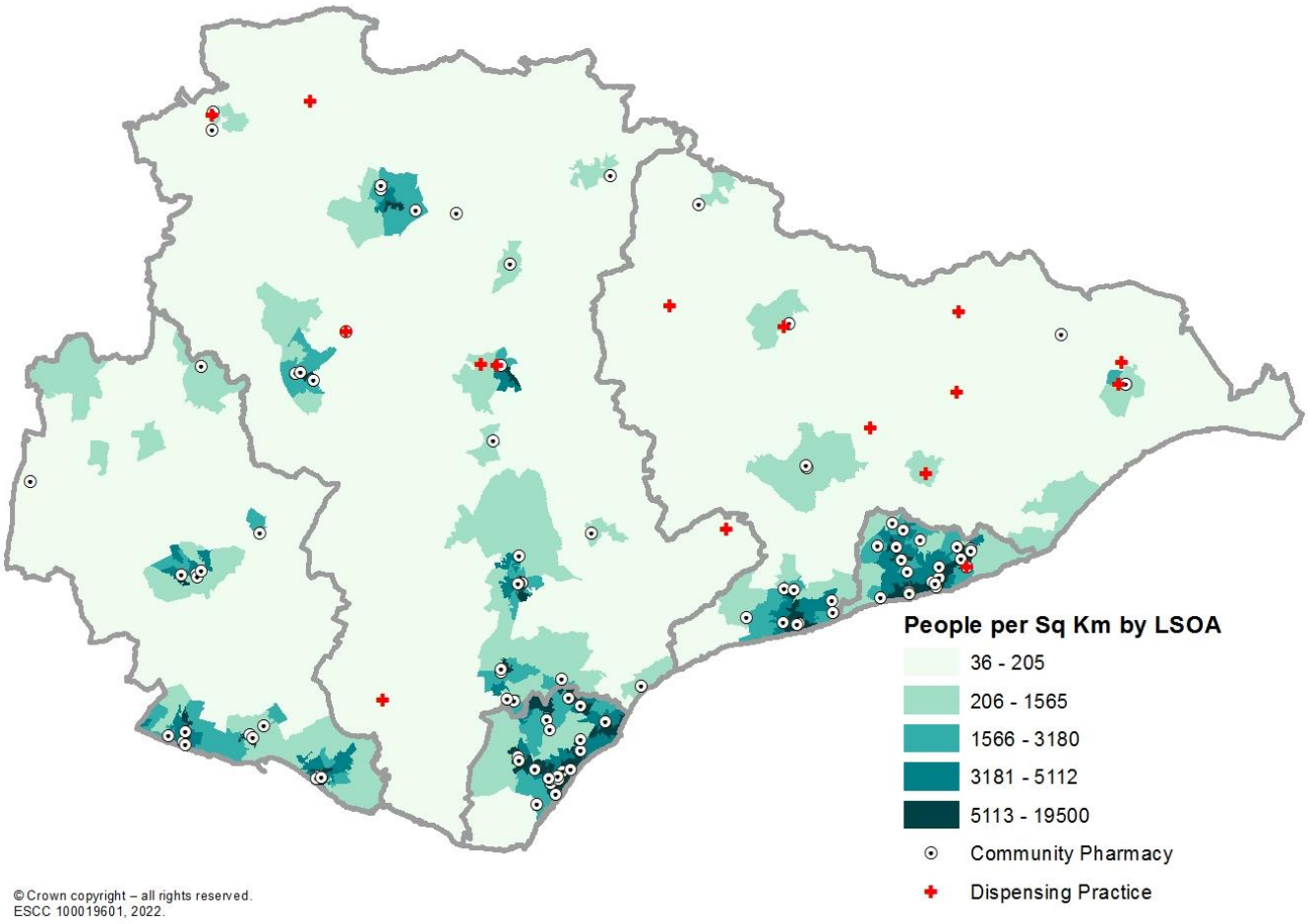
Classification	Number	% of population
Rural town and fringe	42,406	9.5%
Rural village and dispersed	74,830	16.8%
Urban city and town	307,575	68.9%
Urban major conurbation	17,281	3.9%
Urban minor conurbation	4,122	0.9%

Source: ESiF

Changes in local employers

We are not aware of any firm plans by any major local employers to close, or to relocate which would result in major changes to the demand for pharmaceutical services in consequence.

Figure 8 Population Density



4.7 Index of Multiple Deprivation (IMD 2019)[32]

The Index of Multiple Deprivation 2019 [IMD] measures relative deprivation for small areas (or neighbourhoods) in England. The small areas used are called Lower-layer Super Output Areas (LSOAs), of which there are 32,844 in England.

LSOAs are designed to be of a similar population size with an average of 1,500 residents each (in 2011) and are a standard way of dividing up the country. The Index of Multiple Deprivation ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). Figure 9 shows the IMD profile by local authority in East Sussex.

Please note when viewing maps that LSOAs in rural areas cover a much larger footprint due to lower population density but they do not necessarily represent more people than smaller urban LSOAs.

Figure 9 Index of Multiple Deprivation 2019 by decile by district

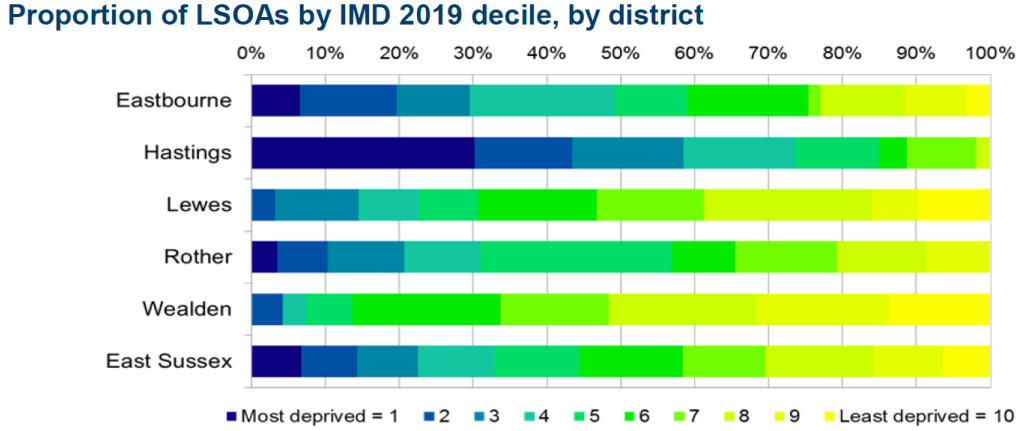


Figure 10 shows the distribution of community pharmacies and GP dispensaries in East Sussex by IMD score.

Figure 11 shows Income Deprivation Affecting Children Index (IDACI 2019)

Figure 12 shows Income Deprivation Affecting Older People Index (IDAOPI 2019)

Figure 10 Distribution of community pharmacies and GP dispensaries in East Sussex in 2022 [by IMD score 2019]

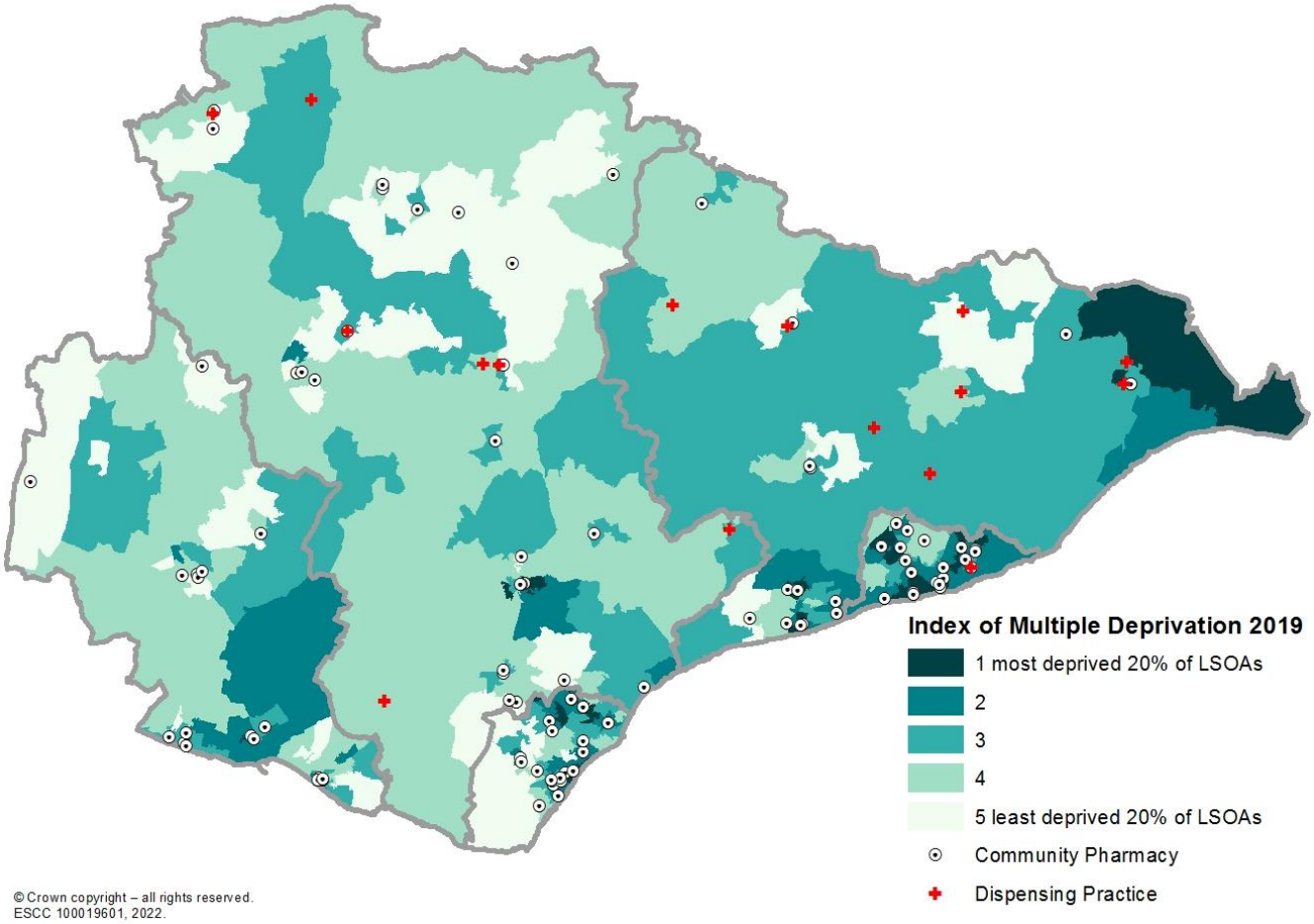
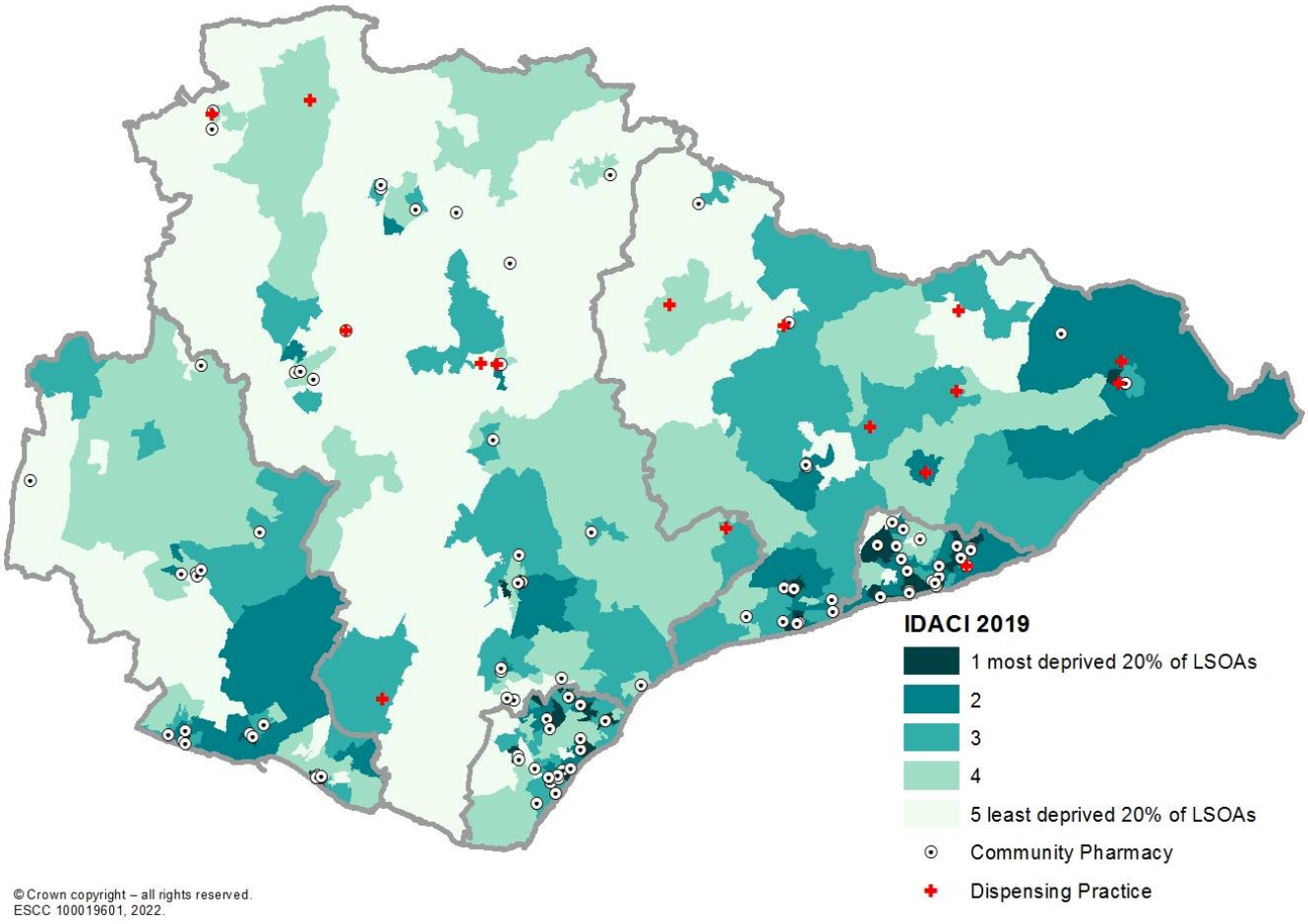


Figure 11 Income Deprivation Affecting Children Index (IDACI 2019)



Nineteen of the LSOAs in East Sussex fall into the most deprived 10% nationally for the Index of Deprivation Affecting Children Index, with 13 in Hastings, four in Eastbourne and one each in Lewes and Rother, Figure 11. This is a relatively more deprived picture than in 2015 when there were 17 LSOAs in the county which were in the most deprived decile nationally.

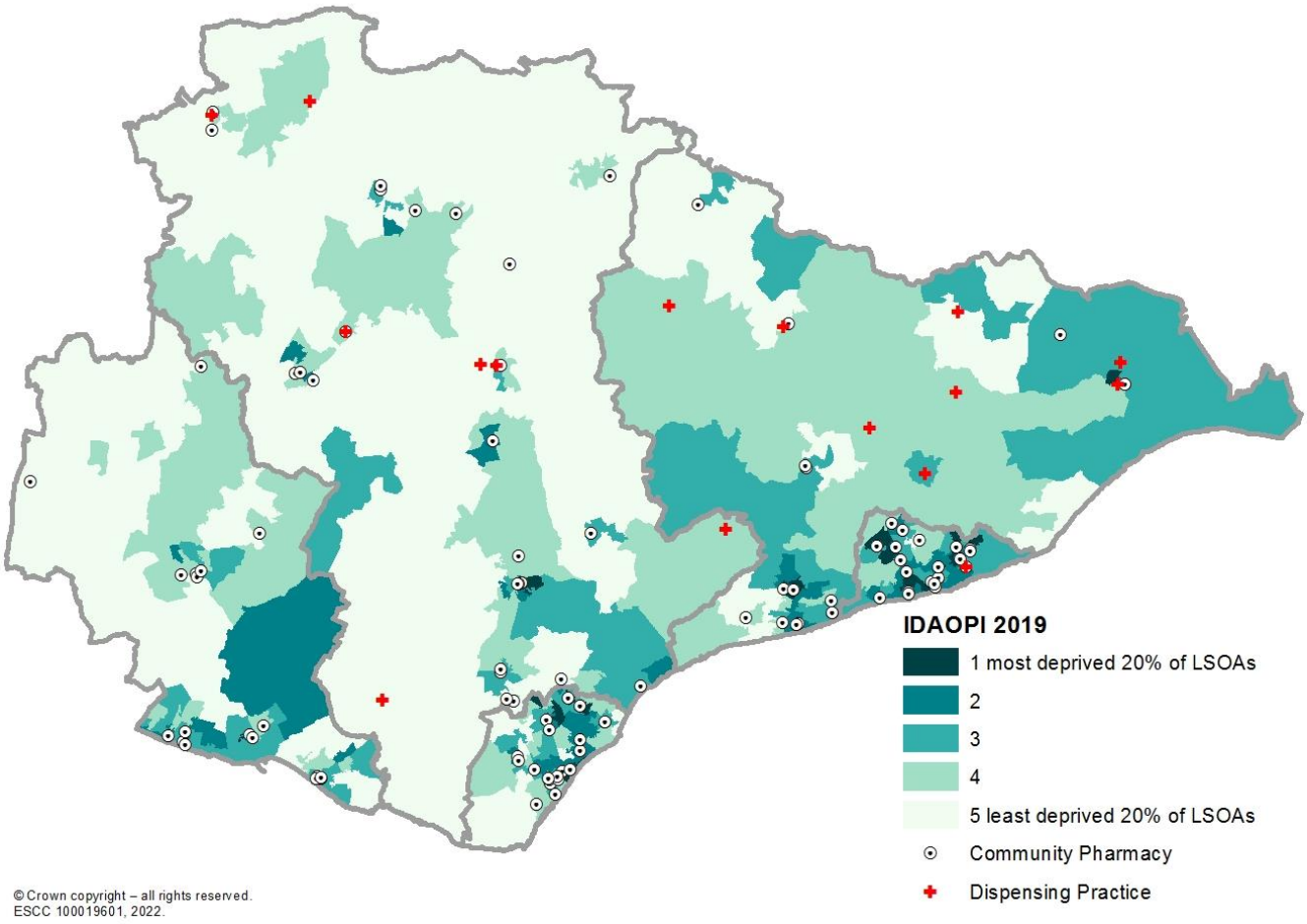
15,000 or 16% children are affected by income deprivation in the county. This is higher than the regional average of 12%, but lower than the average for England as a whole (20%).

There is a much variation within the county. More than a quarter (27%) of children in Hastings BC are living in families affected by income deprivation compared to 1 in 10 in Wealden DC.

Figure 12 Income Deprivation Affecting Older People Index (IDAOPI 2019)

About 19,500 or 11% of older people in the county are affected by income deprivation. This is higher than the regional average of 10%, but lower than the average for England as a whole (14%), Figure 12.

There is much variation within the county. 1 in 5 older people in Hastings BC are affected by income deprivation compared to less than 1 in 10 in Wealden DC.



Health inequalities: pharmacy services for people living in deprived areas

People living in relatively more deprived areas have a higher demand for public services. Deprived communities are characterised by poorer health and greater disability, lower skills, educational disadvantage, higher crime and drug misuse.[33]

A recent Chief Medical Officer [CMO] report has highlighted the issues of deprivation in coastal communities relative to their corresponding neighbouring communities inland. Hastings featured in this report.

5. Health care needs[34]

It should be borne in mind that, when assessing the need for pharmaceutical services, it is not possible for these services to meet all the health needs of the population. The Public Health Outcomes Framework [PHOF] systematically summarises indicators of health and care needs of the population.[35]

Outcomes for each D&B in East Sussex are shown on Table 9. Figure 13 and Figure 14 are maps showing where people with long term conditions or disability live, and where those who were deemed clinically extremely vulnerable during the COVID-19 pandemic live.

There follows an accessible commentary section for each district and borough which highlights where health needs are significantly higher or lower than England:

- Eastbourne 5.1
- Hastings 5.2
- Lewes 5.3
- Rother 5.4
- Wealden 5.5

Health Inequalities are avoidable and unfair systematic differences in health between different groups of people. These are summarised in each district and borough section as well as some additional information in section 5.6.

The PHOF groups health and care needs into the following categories:

- Overarching indicators – life expectancy
- Wider determinants of health
- Health Improvement – behavioural risk factors and their impacts e.g. alcohol related admissions
- Health Protection – including environment, vaccination and infectious diseases
- Healthcare and premature mortality

Green is significantly better, orange the same and red significantly worse than England.

Table 9 Summary of Public Health Outcome Indicators December 2021

	Unit	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
A01b - Life expectancy at birth, Female, All ages, 2020	Years	82.6	84.0	84.0	81.8	84.5	84.1	84.9
A01b - Life expectancy at birth, Male, All ages, 2020	Years	78.7	80.1	79.1	77.6	80.9	79.9	81.9
A01b - Life expectancy at 65, Female, 65, 2020	Years	20.7	21.9	22.0	20.8	22.2	21.7	22.3
A01b - Life expectancy at 65, Male, 65, 2020	Years	18.1	19.3	19.6	18.1	19.5	19.1	19.9

	Unit	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
B01b - Children in absolute low income families (under 16s), Persons, <16 yrs, 2019/20	%	16	14	15	19	11	15	11
B01b - Children in relative low income families (under 16s), Persons, <16 yrs, 2019/20	%	19	17	18	23	14	18	14
B08a - Gap in the employment rate between those with a long-term health condition and the overall employment rate, Persons, 16-64 yrs, 2019/20	Percentage points Gap	11	10	10	7	10	15	8
B08d - Percentage of people in employment, Persons, 50-64 yrs, 2020/21	%	72	74	53	81	68	84	77
B15a - Homelessness - households owed a duty under the Homelessness Reduction Act, Persons, Not applicable, 2020/21	per 1,000 Crude rate	11	12		21			7
B15c - Homelessness - households in temporary accommodation, Persons, Not applicable, 2020/21	per 1,000 Crude rate	4.0	2.7		6.3			0.5

	Unit	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
C02a - Under 18s conception rate / 1,000, Female, <18 yrs, 2019	per 1,000 Crude rate	15.7	13.2	16.7	19.0	11.0	11.2	10.3
C04 - Low birth weight of term babies, Persons, >=37 weeks gestational age at birth, 2020	%	2.9	2.4	1.6	3.0	3.8	1.8	2.0
C05a - Baby's first feed breastmilk, Persons, Newborn, 2018/19	%	67.4	65.5					
C06 - Smoking status at time of delivery, Female, All ages, 2020/21	%	9.6	10.4	10.4	10.4	10.4	10.4	10.4
C09a - Reception: Prevalence of overweight (including obesity), Persons, 4-5 yrs, 2019/20	%	23	23	24	23	23	24	22
C09b - Year 6: Prevalence of overweight (including obesity), Persons, 10-11 yrs, 2019/20	%	35	32		35	31	31	30
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years), Persons, 0-4 yrs, 2020/21	per 10,000 Crude rate	109	150	140	232	120	185	109
C14b - Emergency Hospital Admissions for Intentional Self-Harm, Female, All ages, 2020/21	per 100,000 DSR	238	339	292	550	249	372	284
C14b - Emergency Hospital Admissions for Intentional Self-Harm, Male, All ages, 2020/21	per 100,000 DSR	126	187	257	350	146	152	82
C14b - Emergency Hospital Admissions for Intentional Self-Harm, Persons, All ages, 2020/21	per 100,000 DSR	181	261	272	447	196	262	182
C15 - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults), Persons, 16+ yrs, 2019/20	%	55	61	65	46	61	63	65
C16 - Percentage of adults (aged 18+) classified as overweight or obese, Persons, 18+ yrs, 2019/20	%	63	63	63	67	60	67	58
C17b - Percentage of physically inactive adults, Persons, 19+ yrs, 2019/20	%	23	20	26	20	16	21	17
C18 - Smoking Prevalence in adults (18+) - current smokers (APS), Female, 18+ yrs, 2019	%	12	11	12	16	8	12	8
C18 - Smoking Prevalence in adults (18+) - current smokers (APS), Male, 18+ yrs, 2019	%	16	14	22	17	12	13	10
C18 - Smoking Prevalence in adults (18+) - current smokers (APS), Persons, 18+ yrs, 2019	%	14	13	17	17	10	12	9
C19d - Deaths from drug misuse, Female, All ages, 2018 - 20	per 100,000 DSR	3	3					
C19d - Deaths from drug misuse, Male, All ages, 2018 - 20	per 100,000 DSR	7	8	14	9	13		
C19d - Deaths from drug misuse, Persons, All ages, 2018 - 20	per 100,000 DSR	5	5	8	6	9		2
C22 - Estimated diabetes diagnosis rate, Persons, 17+ yrs, 2018	%	78	69	69	74	69	69	68
C23 - Percentage of cancers diagnosed at stages 1 and 2, Persons, All ages, 2019	%	55			50			
C27 - Percentage reporting a long term Musculoskeletal (MSK) problem, Persons, 16+ yrs, 2020	%	19	21	20	22	21	24	20
C29 - Emergency hospital admissions due to falls in people aged 65 and over, Female, 65+ yrs, 2020/21	per 100,000 DSR	2285	2656	2755	2737	2480	2665	2675
C29 - Emergency hospital admissions due to falls in people aged 65 and over, Male, 65+ yrs, 2020/21	per 100,000 DSR	1667	1859	1812	2151	1823	1861	1791
C29 - Emergency hospital admissions due to falls in people aged 65 and over, Persons, 65+ yrs, 2020/21	per 100,000 DSR	2023	2314	2351	2487	2193	2327	2295

	Unit	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
D07 - HIV late diagnosis (all CD4 less than 350) (%), Persons, 15+ yrs, 2018 - 20	%	42.4	42.1	36.4	54.6	28.6	25.0	60.0
D10 - Adjusted antibiotic prescribing in primary care by the NHS, Persons, All ages, 2020	per STAR-PU Indirectly	0.75	0.69	0.70	0.73	0.59	0.71	0.70

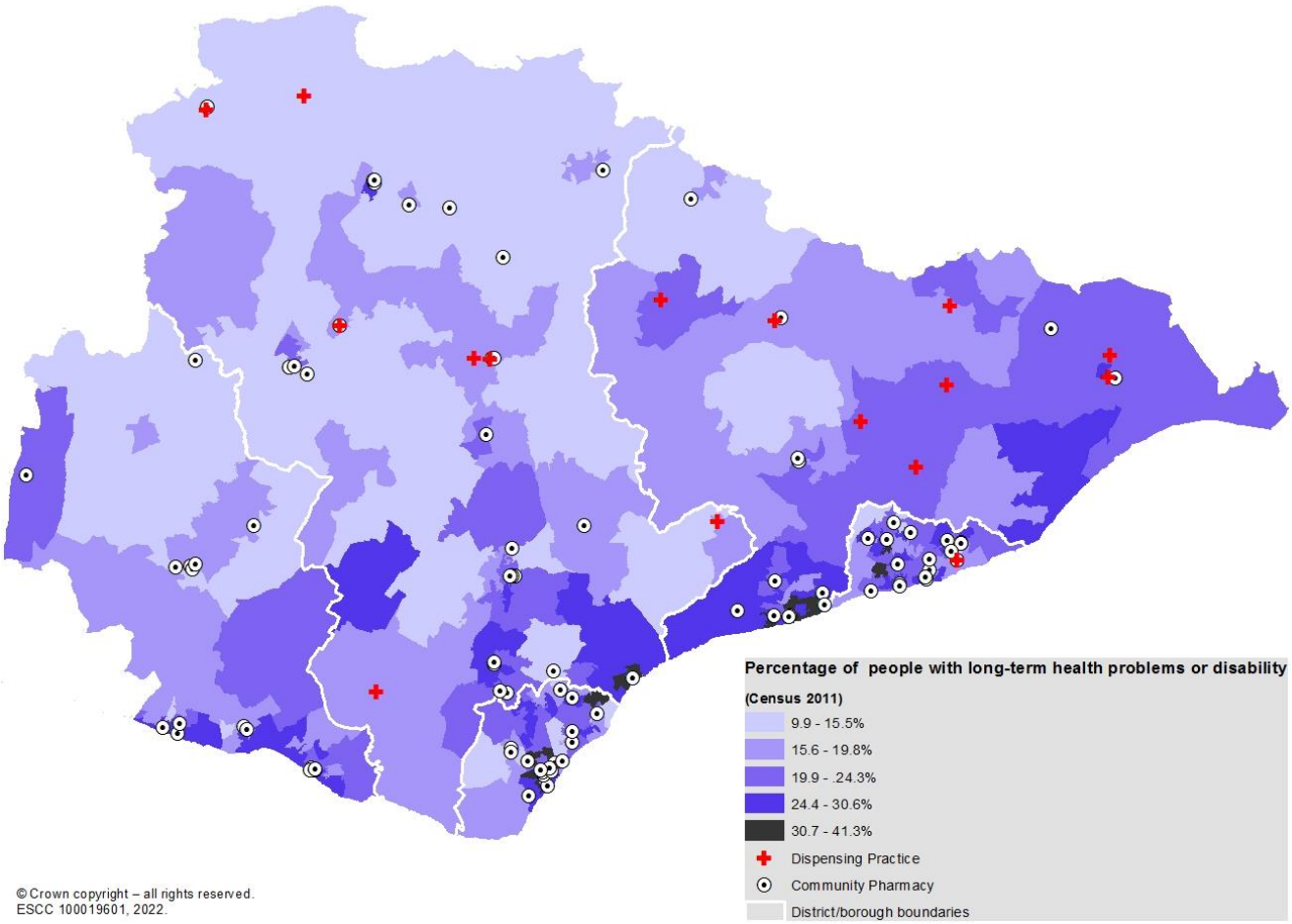
	Unit	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
E01 - Infant mortality rate, Persons, <1 yr, 2018 - 20	per 1,000 Crude rate	4	4	6	3	4	3	2
E02 - Percentage of 5 year olds with experience of visually obvious dental decay, Persons, 5 yrs, 2018/19	%	23	9	21	1	8	11	8
E04a - Under 75 mortality rate from all cardiovascular diseases, Female, <75 yrs, 2017 - 19	per 100,000 DSR		34	33	61	29	32	27
E04a - Under 75 mortality rate from all cardiovascular diseases, Male, <75 yrs, 2017 - 19	per 100,000 DSR		86	87	135	78	73	74
E04a - Under 75 mortality rate from all cardiovascular diseases, Persons, <75 yrs, 2017 - 19	per 100,000 DSR		59	59	96	52	52	49
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition), Female, <75 yrs, 2020	per 100,000 DSR	16	12		22		17	
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition), Male, <75 yrs, 2020	per 100,000 DSR	43	34	31	60	33	22	30
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition), Persons, <75 yrs, 2020	per 100,000 DSR	29	23	22	40	20	19	18
E05a - Under 75 mortality rate from cancer, Female, <75 yrs, 2017 - 19	per 100,000 DSR		108	115	146	102	108	91
E05a - Under 75 mortality rate from cancer, Male, <75 yrs, 2017 - 19	per 100,000 DSR		133	162	169	129	117	113
E05a - Under 75 mortality rate from cancer, Persons, <75 yrs, 2017 - 19	per 100,000 DSR		120	137	157	115	112	101
E05b - Under 75 mortality rate from cancer considered preventable (2019 definition), Female, <75 yrs, 2020	per 100,000 DSR	39	32	26	51	32	26	29
E05b - Under 75 mortality rate from cancer considered preventable (2019 definition), Male, <75 yrs, 2020	per 100,000 DSR	65	56	58	87	49	58	41
E05b - Under 75 mortality rate from cancer considered preventable (2019 definition), Persons, <75 yrs, 2020	per 100,000 DSR	51	43	41	69	40	41	35
E06a - Under 75 mortality rate from liver disease, Female, <75 yrs, 2017 - 19	per 100,000 DSR		11	11	16	11	6	10
E06a - Under 75 mortality rate from liver disease, Male, <75 yrs, 2017 - 19	per 100,000 DSR		24	34	39	21	18	16
E06a - Under 75 mortality rate from liver disease, Persons, <75 yrs, 2017 - 19	per 100,000 DSR		17	22	27	16	12	13
E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition), Female, <75 yrs, 2020	per 100,000 DSR	13	6					
E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition), Male, <75 yrs, 2020	per 100,000 DSR	24	18	30	28			12
E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition), Persons, <75 yrs, 2020	per 100,000 DSR	18	12	18	17	13		8
E07a - Under 75 mortality rate from respiratory disease, Female, <75 yrs, 2017 - 19	per 100,000 DSR		27	39	43	18	28	18
E07a - Under 75 mortality rate from respiratory disease, Male, <75 yrs, 2017 - 19	per 100,000 DSR		38	54	58	27	40	23
E07a - Under 75 mortality rate from respiratory disease, Persons, <75 yrs, 2017 - 19	per 100,000 DSR		32	46	50	22	34	20
E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition), Female, <75 yrs, 2020	per 100,000 DSR	15	9					
E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition), Male, <75 yrs, 2020	per 100,000 DSR	19	17	25	36			
E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition), Persons, <75 yrs, 2020	per 100,000 DSR	17	13	17	23	13	10	6
E11 - Emergency readmissions within 30 days of discharge from hospital, Persons, All ages, 2019/20	% Indirectly standardised	14.4		14.6	15.4	13.6	13.4	14.2
E13 - Hip fractures in people aged 65 and over, Female, 65+ yrs, 2020/21	per 100,000 DSR	638	592	602	588	516	611	631
E13 - Hip fractures in people aged 65 and over, Male, 65+ yrs, 2020/21	per 100,000 DSR	379	353	336	384	298	339	389
E13 - Hip fractures in people aged 65 and over, Persons, 65+ yrs, 2020/21	per 100,000 DSR	529	491	490	498	417	495	535
E15 - Estimated dementia diagnosis rate (aged 65 and over), Persons, 65+ yrs, 2021	%	62	62	68	63	70	54	58

A detailed description of each data item can be found at this link.

Cancer screening programmes' coverage data can be found at this link.

Figure 13 shows the distribution of people reporting long-term health problems or disability [Census 2011].

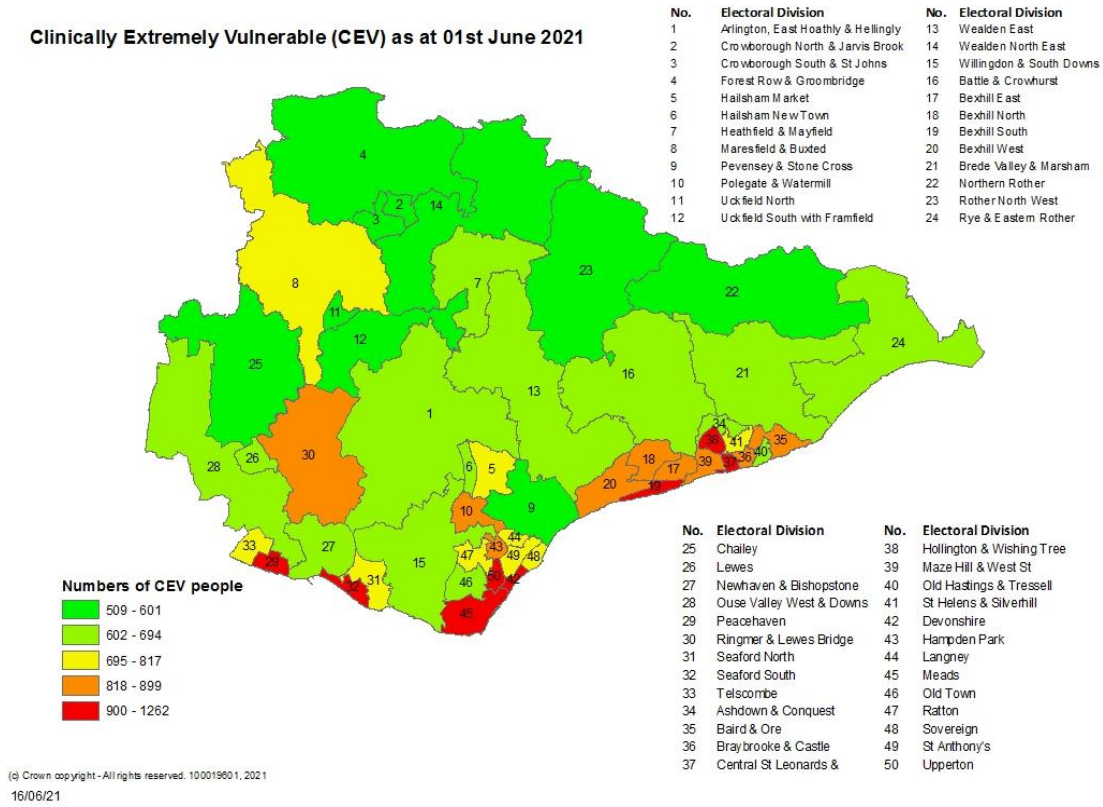
Figure 13 Long-Term Health Problems or Disability



Clinically Extremely Vulnerable

Figure 14 shows the number of Clinically Extremely Vulnerable persons as at 1st June 2021 by electoral division.

Figure 14 Numbers of Clinically Extremely Vulnerable [CEV] people June 2021



No.	Electoral Division	No.	Electoral Division
1	Arlington, East Hoathly & Hellingly	13	Wealden East
2	Crowborough North & Jarvis Brook	14	Wealden North East
3	Crowborough South & St Johns	15	Willingdon & South Downs
4	Forest Row & Groombridge	16	Battle & Crowhurst
5	Hailsham Market	17	Bexhill East
6	Hailsham New Town	18	Bexhill North
7	Heathfield & Mayfield	19	Bexhill South
8	Maresfield & Buxted	20	Bexhill West
9	Pevensey & Stone Cross	21	Brede Valley & Marsham
10	Polegate & Watermill	22	Northern Rother
11	Uckfield North	23	Rother North West
12	Uckfield South with Framfield	24	Rye & Eastern Rother

No.	Electoral Division	No.	Electoral Division
25	Chailey	38	Hollington & Wishing Tree
26	Lewes	39	Maze Hill & West St
27	Newhaven & Bishopstone	40	Old Hastings & Tressell
28	Ouse Valley West & Downs	41	St Helens & Silverhill
29	Peacehaven	42	Devonshire
30	Ringmer & Lewes Bridge	43	Hampden Park
31	Seaford North	44	Langney
32	Seaford South	45	Meads
33	Telscombe	46	Old Town
34	Ashdown & Conquest	47	Ratton
35	Baird & Ore	48	Sovereign
36	Braybrooke & Castle	49	St Anthony's
37	Central St Leonards &	50	Upperton

5.1 Eastbourne Borough Council

Health in summary

The health of people in Eastbourne is varied compared with England. [Please see the charts in the Public Health Outcome Framework indicators in Table 9 above].

Eastbourne had a significantly higher percentage than the national average of the population who reported general health as bad, or very bad, and who report having a long-term limiting illness or disability.

Wider determinants of health

The proportion of children living in absolute low-income families [14.7%] is significantly lower than England [15.6%] in 2019/20. The proportion of children in relatively low-income families [18%] is lower than in England [19.1%] but is increasing [2019/20].

Pupil absence in 5 to15 year olds in 2018/19 was higher [5.15%] than in England [4.73%].

The rate of households owed a duty under the Homelessness Reduction Act [15.3 per 1,000] was significantly higher than England [12.3 per 1,000] in 2019/20.

Eastbourne has a higher percentage of the population who live in the most deprived areas than England, based on the [IMD 2019].

In 2020/21, the proportion of people in employment aged 50 to 64 [53%] is significantly worse than England [72%].

The proportion of adults reporting that they feel lonely often or always [15.3%] was significantly better than England [22.3%] in 2019/20.

Health inequalities

In 2020, life expectancy at birth for men [79.1] was similar to the England average [78.7] years, and better for women [84.0] compared to England [82.6].

In 2020, life expectancy at 65 was significantly better than England for males [19.6] years [18.1] and better for females at 22 years than England [20.7].

Health Improvement

The proportion of the population meeting the recommended 5 fruit and vegetables a day [64.9%] on a usual day was significantly higher than England in 2019/20 [55.4%].

Child health

Infant mortality of 6.1 per 1,000 [between 2018 to 2020] is higher than in England [3.9] but not significantly so.

The rate of hospital admissions caused by unintentional and deliberate injuries aged 0-4 years [140 per 10,000] is higher than in England [109] in 2020/21 but not significant.

The proportion of low birth-weight babies at term [1.6%] in 2020 was significantly lower than England [2.9%].

Adult health

Emergency hospital admissions rate for intentional self-harm in females all ages [292] was significantly worse than England [238] in 2020/21. Similarly for males all ages significantly worse [257] compared to England [126] in 2020/21.

The rate of emergency admissions due to falls in persons aged 65+ [2351] was higher than England [2023] though not significantly so for males.

The suicide rate for the period 2018-20 is significantly higher [18.1 per 100,000] compared to [10.4 per 100,000] in England.

Out of the estimated number of people with diabetes aged 17 and over in the population [69.1%], the proportion with a recorded diagnosis of diabetes was significantly lower than England [78.0%] in 2018.

Out of the estimated number of people with dementia, there is a higher proportion of people with a recorded diagnosis of dementia [68.0%] than were diagnosed in England [61.6%] in 2021.

The coverage of breast cancer screening was significantly lower in 2020 [65.2%] than in England [74.1%].

Cervical cancer screening was significantly higher for 25- to 49-year-olds [72.0%] compared to [70.2%], but significantly lower for 50- to 64-year-olds [74.0%] compared to 76.1% in England.

Bowel cancer screening proportions were similar to England in 2020, whereas Abdominal Aortic Aneurysm screening had significantly better coverage [81.2 %] compared to England [76.1%] in 2019/20.

5.2 Hastings Borough Council

Health in summary

The health of people in Hastings is generally worse than the England average, particularly under 75 mortality for cardiovascular disease, respiratory disease, liver disease and cancers, as well as hospital admissions for self-harm and falls. Please see the charts in Public Health Outcome Framework indicators, Table 9 above.

Wider determinants of health

Hastings is one of the 20% most deprived districts/unitary authorities in England [IMD 2019].

The proportion of children in absolute low-income families [19.0%] is higher than in England [15.6%] in 2019/20. The proportion of children in relative low-income families [23.0%] is higher than in England [19.1%] in 2019/20. The trend is for these to be getting worse.

Pupil absence in 5 to15 year-olds in 2018/19 was higher [5.35%] than in England [4.73%].

The rate of households owed a duty under the Homelessness Reduction Act [21 per 1,000] is significantly higher than England [11 per 1,000] in 2020/21.

The rate of homeless households in temporary accommodation [6.3] is significantly higher than England [4.0] in 2020/21.

Health inequalities

In 2020, life expectancy at birth for men [79.1] was similar to the England average [78.7] years, and better for women [84.0] compared to England [82.6].

The inequality in life expectancy at birth was 7.6 years for males and 5.5 years for females for the period 2017-19.

Health Improvement

The proportion of the population meeting the recommended 5 a day [45.7%] on a usual day was significantly lower than England in 2019/20 [55.4%].

The proportions of the population overweight [67.3%] was significantly higher than England [62.8%].

Child health

There are significantly higher rates of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years [2020/21] at 232 per 10,000 residents in that age group, compared to England [109]. Similarly, there is a higher rate for young people aged 15 to 24, at 242 per 10,000 compared to 112 [England].

Adult health

There is a significantly higher rate of admissions for intentional self-harm [persons all ages] at 447 per 100,000 compared to England [181] in 2020/21. Both male and female rates are significantly higher.

The rate of emergency re-admissions within 30 days [all ages] is significantly higher 15.4 compared to England [14.4] in 2019/20.

The rate of admissions for alcohol-related conditions [638 per 100,000] for persons of all ages is significantly higher than England [456 per 100,000] in 2020/21.

In 2020/21, the rate of emergency hospital admissions due to falls in people aged 65 and over [2,487 per 100,000] is significantly higher than England [2,023 per 100,000]. Both male and female rates are significantly higher.

Coverage for breast cancer screening is significantly lower [56% compared to 74%] in 2020. Cervical cancer screening coverage in women aged 50-64 is significantly lower [72% compared to 76%]. Bowel cancer screening coverage is significantly lower [60% compared to 63%].

The under 75 mortality rates per 100,000 for all cardiovascular diseases between 2017-19 was significantly higher than England for males [134 compared to 98] and females [60.5 compared to 43].

The under 75 mortality rates per 100,000 for cancers in females [146 compared to 116] and males [168 compared to 143] in 2017-19 were both significantly different. For cancers considered preventable under 75, the mortality rates in 2020 were not significantly different from England in males and females separately but the combined rate is significantly higher for persons [68.6 compared to 51.4].

The under 75 mortality rate per 100,000 for liver disease 2017-19 is significantly higher for males [39 compared to 26] and for persons [27 compared to 18] but not for females [16 compared to 13].

The under 75 mortality rate per 100,000 from respiratory disease 2017-19 in females [42.5 compared to 28], males [58.3 compared to 38] and persons [50 compared to 33] are all significantly higher than England. In 2020, the under 75 mortality rate from respiratory disease considered preventable is significantly higher in males [36 compared to 19] and persons [23 compared to 17].

The proportion with a recorded diagnosis of diabetes out of the estimated number of people with diabetes [73.8%] was significantly lower than England [78%] in 2018.

5.3 Lewes District Council

Health in summary

The health of people in Lewes is varied compared with the England average. Please see the charts in Public Health Outcome Framework indicators Table 9 above.

Lewes has a significantly higher percentage of its population who report having a limiting long-term illness or disability compared to England.

Wider determinants

The district is significantly better than the England average for indicators around deprivation, child poverty, and long-term unemployment.

The proportions of children under 16 living in absolute low-income families and in relative low-income families are both significantly lower than England [2019/20].

The proportion of households in fuel poverty is lower than England [2019].

The rates of homeless households owed a duty under the Homeless Reduction Act and of homeless households in temporary accommodation were significantly better than England in 2019/20.

Health inequalities

Life expectancy at birth for both men 80.9 [78.7] and women 84.5 [82.6] are higher than the England average. Life expectancy at birth is 4.8 years lower for men in the most deprived areas of Lewes than in the least deprived areas [in 2017-19].

Life expectancy at 65 is significantly better than England for males and females [2018-20]. The inequality in life expectancy at 65 [in 2017-19] is less than in England for males and females.

Child health

The proportion of pupil absence in 2018/19 was significantly higher than England.

In Year 6, the proportion of children classified as overweight is significantly lower than the average for England [2019/20].

Adult health

The rate of deaths from drug misuse are significantly higher than England in 2018-20.

The rate of admissions for alcohol related conditions is significantly lower [2019/20].

The rate of killed and seriously injured on roads was worse than the England average [2016-18].

The proportion of cancers diagnosed at stages 1 and 2 was significantly better in 2018.

The coverage of breast cancer screening was significantly lower than England in 2020.

Cervical cancer screening was significantly better than England in the younger age band [25 to 49 years old].

Screening for bowel cancer was significantly better than England 2020.

Abdominal aortic aneurysm screening coverage in men was significantly better in 2020.

Rates of hip fractures in females and all persons aged 65 and over are significantly lower than England [2020/21].

There is a significantly lower proportion of readmissions within 30 days of discharge from hospital [2019/20] compared to England.

The proportion with a recorded diagnosis of diabetes out of the estimated number of people with diabetes aged 17 or over [68.7%] is significantly lower than England [78.0%] in 2018.

There is a significantly higher proportion of the estimated number of people [aged 65 and over] diagnosed with dementia than in England in 2021.

5.4 Rother District Council

Health in summary

The health of people in Rother is varied compared with the England average. Please see the charts in Public Health Outcome Framework indicators, Table 9 above.

Wider determinants of health

A significantly lower proportion of children live in relative low-income families [2019/20].

Rother is better than the England average for indicators around overall deprivation [IMD 2019].

Rother had a significantly higher proportion of people aged 50-64 in employment [84%] than England [72%] in 2020/21.

Rother has significantly lower rates of households owed a duty under the Homelessness Reduction Act [10.4 per 1,000] compared to England [12.3 per 1,000] and of households in temporary accommodation [1.18 per 1,000] compared to England [3.76 per 1,000] in 2019/20.

Rother had a lower proportion of households living in fuel poverty compared to England in 2019.

The rate of people killed and seriously injured [88.4 per 100,000] was significantly higher than England between [42.6 per 100,000] in 2016-18.

Health inequalities

Life expectancy at birth [2020] is significantly higher than the England average for females 84.1 years [82.6].

Life expectancy was 8.2 years lower for men and 7.2 years lower for women in the most deprived areas of Rother than in the least deprived areas in 2017-19.

Child health

The proportion of low birth-weight babies at term in Rother in 2020 [1.8%] was lower than England [2.90%].

In Year 6, the proportion of children overweight [31.1%] was significantly better [lower] than the average for England [35.2%] in 2019/20.

The rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 [185 per 10,000] is significantly higher than England [109 per 10,000] in 2020/21.

Adult health

The proportion of persons aged 16+ reporting a long-term, musculoskeletal problem is significantly higher [24.1% compared to compared to 18.6%] in 2020.

The rate of emergency admissions due to falls in people aged 65 and over is significantly higher than England [2,327 compared to 2,023 per 100,000] in 2020/21. The rate for females is significantly higher than England.

The excess winter deaths index [August 2019 – July 2020] for persons is lower than England but not significant.

The cancer screening uptake rates in 2020 are all significantly better than England [except cervical screening in the 50-64 age group which is similar.]

Under 75 mortality rate per 100,000 from Cardio Vascular Disease [CVD] considered preventable was significantly lower than England in 2020.

Under 75 mortality rates per 100,000 from cancers considered preventable is lower than England but not significantly so in 2020.

Under 75 mortality rate per 100,000 from liver disease [11.3] is significantly lower than England [20.6] in 2020.

The proportion of readmissions within 30 days of discharge from hospital [13.4%] was significantly lower than England [14.4%] in 2019/20.

The proportion with a recorded diagnosis of diabetes out of the estimated number of people with diabetes [69.3%] was significantly lower than England [78%] in 2018.

There is a significantly lower proportion of the estimated number of people with dementia who have been diagnosed [53.9%] than in England [61.6%] in 2021.

5.5 Wealden District Council

Health in summary

The health of people in Wealden is generally better than the England average. Please see the charts in Public Health Outcome Framework indicators, Table 9 above.

Wider determinants

Wealden is one of the 20% least deprived districts/unitary authorities in England [IMD 2019].

The proportion of children living in absolute low-income families [11.3%] compared to England [15.6%] and in relative low-income families [13.5%] compared to England [19.1%] are significantly lower in 2019/20.

Wealden has a higher proportion of people aged 50-64 in employment than England in 2020/2021. There is a smaller gap in the employment rate for persons with long-term conditions and the overall employment rate compared to England.

The district is significantly better than the England rates for indicators around statutory homelessness [households owed a duty under the Homelessness Reduction Act] and [households in temporary accommodation] in 2020/21.

There is a lower proportion of households in fuel poverty.

There was a significantly lower proportion of adults saying they feel lonely in 2019/20.

Health inequalities

In 2020, life expectancy at birth was significantly higher than England for both males [81.9] years compared to [78.7] and females [84.9] compared to [82.6].

Life expectancy was 4.9 years lower for men and 2.9 years lower for women in the most deprived areas of Wealden than in the least deprived areas [2017-19].

Life expectancy at 65 was significantly better than England for males 19.9 years [18.1] and females 22.3 years [20.7] in 2020.

Child health

The under 18s conception rate per 1,000 was significantly lower than England [2019].

In 2020, the proportion of low birthweight babies at term [2%] was lower than England [2.9%].

In year 6 the proportion classified as overweight was significantly lower than the average for England [2019/20].

Adult health

The rate per 100,000 of people killed and seriously injured on roads was significantly worse than the England average [2016-18].

The proportion of the population meeting the recommended 5 a day on a usual day was significantly better than England in 2019/20.

The proportion of physically inactive adults was significantly lower in 2019/20.

There was a significantly lower rate of deaths from drug misuse than England [in 2018-20].

The uptake of all cancer screening programmes is significantly better than in England in 2020 and for Abdominal Aortic Aneurysm screening in 2019/20.

The emergency hospital admissions due to falls for people aged 65 and over was significantly higher than England in 2020/21.

The under 75 mortality rate per 100,000 from cardiovascular diseases considered preventable and under 75 mortality rate from cancers considered preventable are significantly better than the England average in 2020.

The under 75 mortality rate from liver and respiratory disease considered preventable are significantly better than England in 2020.

The proportion with a recorded diagnosis of diabetes as a proportion of the estimated number of people with diabetes [68.1%] is significantly lower than England [78.0%] in 2018.

There is a lower proportion of the estimated number of people with dementia [58.3%] who have been diagnosed than in England [61.6%] in 2021.

5.6 National evidence on health Inequalities

COVID-19 and inequalities in mortality

Mortality from COVID-19 has had an unequal impact on different population sub-groups and exacerbated inequalities. Between 2019 and 2020 life expectancy in males fell by almost 2 years in the most-deprived decile of areas (from 74.3 to 72.4 years) compared with 1 year in the least-deprived decile (from 83.6 to 82.6).

For females in the most-deprived areas life expectancy fell by 1.6 years (from 78.9 to 77.3) compared with 1 year in the least-deprived (86.8 to 85.8). As a result, the gaps in life expectancy between the richest and the poorest areas have widened in 2020 to 10.2 years for males and 8.5 years for females, compared with 9.3 and 7.9 years respectively in 2019.

Mortality data for some other groups also show inequalities, which will have an impact on life expectancy. For example:

- learning disabilities [LD]: mortality from COVID-19 is about 1.5 times higher among people with a learning disability, or self-reported disability, compared with those without a disability
- ethnicity: although most ethnic minority groups had lower overall mortality than the white population in the decade before the pandemic, that differential was reversed between January 2020 and March 2021 in some groups (Pakistani and Bangladeshi

men and women, and Black Caribbean men) because of their higher mortality from COVID-19

Public Health England provisional estimates of life expectancy at birth for 2020 show the impact of the COVID-19 pandemic in England and its regions.[5] The leading cause of death in England & Wales 2020 was COVID-19, responsible for nearly 70,000 deaths. Despite the introduction of COVID-19 in 2020, the relative ranking of other causes of death was unchanged.

The scale of excess mortality associated with COVID-19 in 2020 and 2021 is unprecedented in recent decades. The pandemic isn't over and the magnitude of its continuing impact on life expectancy in England will depend on associated mortality (caused directly by COVID-19 and indirectly by fewer people seeking or receiving care for other conditions) in the years ahead. These, and the wider socio-economic effects of the COVID-19 pandemic on population health and mortality, could last well beyond 2021, and widen health inequalities further.[36]

Inequalities in Healthy Life Expectancy

Healthy life expectancy has increased over time, but not as much as life expectancy, so more years are spent in poor health. Although an English male could expect to live 79.8 years in 2017–19, his average healthy life expectancy was only 63.2 years – in other words he would have spent 16.6 of those years (21 per cent) in 'not good' health. In 2017–19 an English female could expect to live 83.4 years, of which 19.9 years (24 per cent) would have been spent in 'not good' health. Although females live an average of 3.6 years longer than males, most of that time (3.3 years) is spent in poor health. Similarly, disability-free life expectancy is almost two decades shorter than life expectancy, and is higher among males (62.7 years) than females (61.2 years).[37]

There is now a national focus on the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD), as well as five clinical areas of focus: maternity; severe mental illness; chronic respiratory disease; early cancer diagnosis and hypertension case finding.[38]

5.7 COVID-19 and the Health of the Population

Nationally we have moved to a position of "living with COVID".[39] Below is a summary of some of the health behaviours and outcomes which may have changed during the pandemic and may have an impact on the demand for pharmacy services.

- Mental Health: the effects on mental health and well-being could be persistent and long-term in both adults and children. The people most likely to suffer a continuing

[5] The life expectancy estimates for 2020 are the average number of years a newborn baby would live if they experienced the national (or regional) age-specific mortality rates for 2020 throughout their life. As mortality rates will change in the future, the figures are not a forecast of future life expectancy but provide instead a snapshot of current mortality rates. Life expectancy estimates are an alternative way of presenting mortality rates in order to show the impact of COVID-19 on levels of mortality, and inequality in mortality, in 2020

impact are people who already had existing, long term mental health vulnerabilities at the start of the pandemic

- Health Service Activity: many non-COVID-19 health problems have not received due attention and waiting times for non-urgent outpatient appointments and less pressing treatments have become longer
- Physical Health: health-related behaviours during the pandemic do not suggest that higher levels of poor physical health will inevitably result, but health inequalities have widened
- Evidence of an increase incidence of some long-term conditions [40]
- Physical Activity: there is a mixed picture for physical activity as people's life routines change
- Alcohol: alcohol consumption increased nationally in the pandemic
- Smoking: concern about alcohol might be balanced by increased smoking cessation in adults overall, but more young adults are now smoking
- 'Long-COVID': crudely estimated about 2% of people may be suffering with ongoing, persistent symptoms attributable to COVID in East Sussex [41]

The NHS Confederation has published research into the impact of COVID-19 on people with protected characteristics with recommendations for health and care systems.

The King's Fund explains the different types of health inequality and the effect the pandemic is having in increasing these.

COVID-19 in East Sussex

A separate JSNAA report describes the overall effects of COVID in East Sussex [the COVID-Overview Report].

5.8 Population sub-groups with additional health needs

This section systematically describes the health needs of people from each of the group from the Equality Act 2010 and additional groups who are not covered under the Equality Act but who are known to have further health needs.

Whilst some of these groups are referred to and quantified in other parts of this pharmaceutical needs assessment, this section focusses in general terms on their particular health issues and expected requirements for pharmaceutical services.

Pharmacists follow their code of professional practice when dealing with patients with additional health needs and have undergone equality and diversity training.

Older people[42]

Age is the single biggest factor associated with having a long-term condition and 60% of people aged 65 and over have a long-term condition. Lifestyle factors such as smoking, excessive alcohol consumption, unhealthy diets and physical inactivity are estimated to

contribute to developing long term conditions at an earlier age and to ongoing complications of these.

People are living longer, with more co-morbidities and living more years in a state of frailty. Frailty is a significant factor affecting the physical and mental health of older people in East Sussex. Inequalities in levels of frailty are widening and levels of frailty are increasing for the poorest in our population. Frail, older people living in deprived areas are more prone to acquiring COVID infection, despite having been vaccinated.[43]

Well established issues affecting the health of older people include:

Cigarette smoking is implicated in eight of the top fourteen causes of death for people 65 years of age or older. Smoking causes disabling and fatal disease, including lung and other cancers, heart and circulatory diseases, and respiratory diseases. It also accelerates the rate of decline of bone density during ageing. At age 70, smokers have less dense bones and a higher risk of fractures than non-smokers. Female smokers are at greater risk for post-menopausal osteoporosis. Half of long-term smokers die of tobacco related illnesses, most prematurely, and many suffer from a variety of long-term conditions related to smoking.

Even modest alcohol use in old age may be potentially harmful as a contributor to falls, compromised memory, medicine mismanagement, inadequate diet and limitations on independent living.

Loneliness can have a significant and lasting effect on health. It is associated with higher blood pressure, depression and leads to higher rates of mortality. The risks are comparable to those associated with smoking and alcohol consumption. It is also linked to a higher incidence of dementia. Lonely people tend to make more use of health and social care services and are more likely to have early admission to residential or nursing care.

The prevalence of common mental health disorders is generally lower in people aged 65 and over [10.4%] compared to the overall population [16%].[44]

Depression is the most common mental health need for older people and prevalence rises with age.[45] Women are more often diagnosed with depression than men. At any one time, around 10-15% of the over 65s population nationally will have depression and 25% will show symptoms of depression.[46] The prevalence of depression among older people in acute hospitals is estimated at 29% and among those living in care homes is 40%. More severe depression is less common, affecting 3-5% of older people.

People with mental health needs can seek advice and support from their GP. However, two-thirds of older people with depression never discuss it with their GP, and of the third that do, only half are diagnosed and treated.[47] Of those with depression only 15 per cent, or one in seven, are diagnosed and receiving any kind of treatment. Even when they are diagnosed, older people are less likely to be offered treatment than those aged 16 to 64.

Dementia affects about 900,000 people in the UK and is the second most common mental health problem in older people. The risk of developing dementia increases with age, although it is not a feature of normal ageing. The condition usually occurs in people over the age of 65. One in 14 people aged over 65 has dementia. This rises to 1 in 6 for people

aged over 80.[48] The number of cases of dementia is increasing in the population [and in East Sussex].

Around a third of people aged 65 years and over will experience at least one fall a year, increasing to 50% of those aged 80 years and over.[49]

Summaries of the health needs associated with physical disability, vision loss and hearing loss in East Sussex can be found in the JSNA website.

The average number of GP consultations per person, per year increased across all age groups pre-pandemic and this trend was particularly marked among older people.

During the pandemic, concerns about the care of non-COVID patients and the consequences of delayed referrals and diagnoses have been raised.[50]

Consultation rates fell in the first lockdown for all age groups. From September 2020 onwards consultation rates were back to their long-run average.[51]

5.9 Medicines management risks in the elderly[52]

In England, more than one in 10 people aged over 65 take at least eight different prescribed medications each week. This increases to nearly one in four people aged over 85. Up to 50 per cent of all medicines for long term health conditions are not taken as intended and around one in five prescriptions for older people living at home may be inappropriate.

The many benefits of medicines and treatments are reduced if they are: prescribed in excessive numbers (where this is not clinically justified or safe); in unsafe combinations; without the consent and involvement of the older person themselves; and without support to use them properly. One study showed only 59% of patients identified with 'severe frailty' received an annual medicines review at their GP surgery in 2018/2019.[53]

Older people continue to be admitted to hospital as an emergency from avoidable health problems including falls and confusion. These can follow adverse reactions to medications, or be caused by prescribing of multiple medications having serious cumulative effects. Ageing affects how the body absorbs medicines and how the physiological systems respond to medicines.

The burden of taking multiple medications can also lead to an older person not taking any at all. Practical barriers include the ability to open medicine packs and deal with large volumes of different pills. Information on existing medicines being taken is not always complete, or accessible. NICE clinical guidance is available to assist in treating multiple conditions.[54] Older people are more likely to be living with frailty, dementia, and to be malnourished, all of which create significant additional challenges. Living in a care home also has its challenges from a medicines management point of view.

An estimated 16% of households in East Sussex are occupied by an older person living alone, higher than the England average (13%). More older people living alone means there will be more who have greater needs for assistance with taking their medicines. The number of

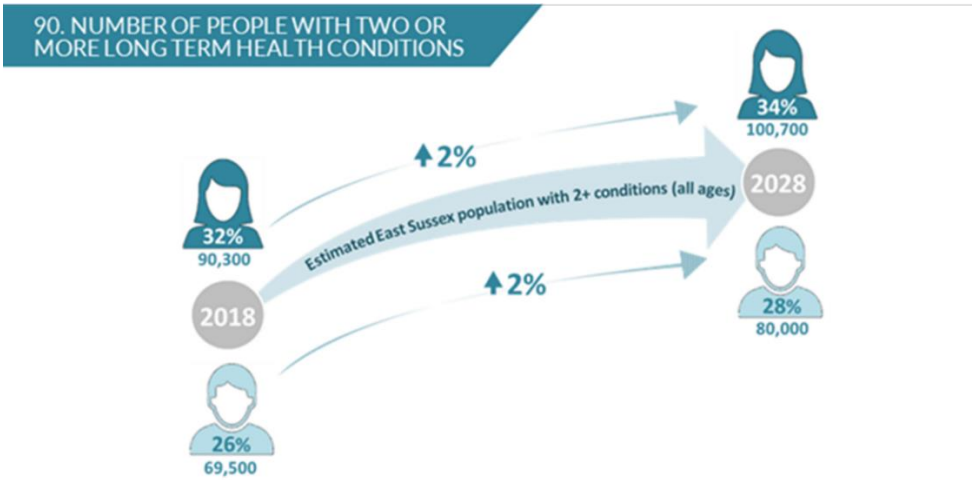
carers is increasing as well and they too will benefit from a greater understanding of the medicines being taken by the person they are caring for.

People living with Long-Term Conditions

Living with multiple long term health conditions poses a challenge for individuals, their unpaid carers, and the health and social care system, their need for medication and to manage the risks of polypharmacy as described above.

By 2028, around 20,000 more people in East Sussex will be living with two or more of these long-term conditions, when compared with the needs of our population in 2018, Figure 15.

Figure 15 Increasing number of people with two or more long term conditions by 2028.



Children and young people[55]

There is evidence of unmet need and different patterns of use of healthcare services in children living in socio-economically deprived areas.[56] In the year prior to the pandemic, nearly half (49%) of children in lone-parent families were in relative poverty – defined as having an income of less than 60% of median incomes adjusted for household size. This is almost double the rate among children living in two-parent families (25%).[57]

Nationally, the pandemic has reduced access to local systems designed to protect children. Pharmacists are expected to have undertaken safeguarding training.[58]

Mental health issues in children and young people have become even more evident during the pandemic.[59,60,61,62]. Examples of the most serious and urgent cases where a child or young person is referred to Child and Adolescent Mental Health Services [CAMHS] include an immediate risk from an eating disorder, self-harm or suicidal thoughts.

The total number of referrals to CAMHS was highest in Hastings and St. Leonard's PCN [the largest PCN] and lowest in Seaford PCN [the smallest PCN] for the period February 2020 to 2021. Referrals to CAMHs for Attention Deficit Hyperactivity Disorder [ADHD] are prominent in Hastings and St. Leonard's.

There were 628 children looked after by East Sussex County Council as at the end of March 2022.This is similar to the end of year figures for 2020 (602), 2019 (607), and in 2018 (606).

Lifestyle behaviours impact on longer term health and social care outcomes in adults and are closely linked to lifestyle in the teenage years. Influencing positive lifestyle choices in teenagers will impact on health outcomes for young people and on future demand for a wide range of services.

Breast feeding provides health benefits for both mother and baby and promotes attachment, however young mothers are among the groups least likely to breast feed. Pharmacists have a role in encouraging breast feeding and safe use of formula feeding where appropriate.

More than eight out of ten adults who have ever smoked regularly started before the age of 19.

Eight out of ten obese teenagers go on to become obese adults.

Nationally, the diagnosis of sexually transmitted infections in young people, such as Chlamydia, has increased by 25% over the past ten years. Untreated sexually transmitted infections can have a longer-term health impact including reduced fertility. Young people's sexual behaviour may also lead to unplanned pregnancy. [Please see EHC section]

Alcohol misuse amongst family members contributes to increased pressure on a wide range of agencies including health, housing, social care, police and the voluntary sector.

Medicines management risks in children and young people

Prescribing and administering medicines to children has its own risks and is prone to error.

Six per cent of households are lone parent households. Hastings Borough (8%) has the highest percentage and Rother and Wealden districts (both 5%) the lowest.

Lone parent households may particularly benefit from having readily available, local access to professional advice from a pharmacist.

Disability[63]

A person is considered to have a disability if they have a physical or mental impairment that has 'substantial' and 'long term' negative effects on their ability to do normal daily activities.

It is difficult to estimate the number of people with disability in a population. One source is the Family Resources Survey.[64] The Census gives people the opportunity to report any limitations to their daily activities, whether or not they have a formally recognised disability or diagnosed condition.

NHS recording codes list eleven categories of impairment type.[65]

People with physical or mental impairments may experience poorer health outcomes than the general population and may face greater exposure to risk factors that drive inequalities in health, such as unemployment (around 50% of disabled people are in employment in the UK, compared to over 80% of non-disabled people)[66], deprivation, isolation and loneliness, and reduced access to services, including health services.

Access to services may vary depending on the type of disability. Common barriers may include inaccessible physical environments, including low space, lack of ramps and support equipment/fittings etc. Physical disability has been shown to be associated with greater 'unmet healthcare need'.[67]

Transport, long waiting lists and costs have also been identified as key barriers to accessing healthcare for disabled people, with female disabled people reporting worse outcomes than male disabled people.

It is estimated that in 2022 there are 2,000 young people aged 10-17, 36,400 people of working age 18-64 and 60,800 aged 65 and over with a disability in East Sussex. Further details will come from the 2021 Census. Physical Disability is discussed in more detail in the JSNA.

People with hearing impairment[68]

Depending on their level of need, people with hearing loss of all ages may need a range of types of support to contact services and to communicate well whenever they do.[69]

Where people have a hearing impairment, this makes the communication of confidential information even more difficult. Explaining complex drug regimes in a noisy shop environment is less than ideal and can contribute to misunderstandings. Pharmacies do have access to a private consultation room to support this.

The number of older people with hearing loss is predicted to increase substantially over the next decade. A separate JSNA report about hearing loss discusses the issues in more detail. Hearing loss will continue to be a major public health issue for all organisations in East Sussex including pharmacies.

People with visual loss

There is specialist advice available for improving access in pharmacies for people with a visual impairment.[70] Visual loss will continue to be a major public health issue in East Sussex. A separate JSNA report about visual loss discusses the issues in more detail.

Social care

The percentage of the population receiving Long Term Support in ESCC has remained steady at 2.1%. Table 10 below shows a breakdown by gender of people who received long-term support (LTS) in the financial year 2020/21 from ESCC. A significantly greater proportion of older women receive long term support.

Table 10 Adults with care and support needs receiving long-term support, by gender

2020/21	Number of people receiving LTS	Percentage of total receiving LTS	Percentage of population of that gender receiving LTS
Female	5,436	58.5%	2.3%

Male	3,850	41.5%	1.8%
Total	9,286	100%	2.1%

Source: ASC ESCC

In 2020/21, 6,474 carers received support including information, advice and other universal services or signposting from Adult Social Care ESCC. East Sussex County Council has commissioned the organisation Imago to support 976 people aged under 16 years as young carers.

Learning disability

In 2021/22 a total of 1,422 working age adults and 183 older people with a Primary Support Reason (PSR) of Learning Disability Support were supported through Long Term Support by Adult Social Care, ESCC.

A prevalence rate often used in the context of the British population for any degree of learning disability is approximately 2% of the population.[71]

In East Sussex in 2019/20, there were 3,382 people with learning disabilities recorded on GP registers, representing 0.6% of all people registered with GPs in the county.[72]

People with learning disabilities are at particular risk of poor health outcomes and have shorter life expectancies than the general population.[73] These differences in health status are, to an extent, avoidable.[74] Health inequalities faced by people with a learning disability begin in childhood and may be made worse because of lack of access to timely, appropriate and effective healthcare.

Reasonable adjustments by services are those modifications that should be made to ensure that a disabled person can access the service in the same way as the general population.[75]

People with LD may have difficulties with reading forms, explaining symptoms, understanding new information, remembering basic information, and understanding and telling the time. They may need longer consultation times in pharmacy to understand their medicines.

Some people with LD may have epilepsy or diabetes, and many have multiple conditions for which they receive multiple medications.[76] Annual health checks are available for all people with learning disabilities aged 14 or over on their GP's learning disability registers but not every eligible adult receives one.

Proactive ongoing support for people with learning disability and related conditions has been identified by the Royal Pharmaceutical Society as a training need for pharmacy staff generally.[77]

Community pharmacists have regular interactions with people with LD and their carers over a long period of time. Pharmacists can assist with the choice of the most appropriate medicines, identify medication interactions and help to assess their side effects.

Pharmacists can advise on taking medicines effectively, their correct storage and especially how to overcome swallowing difficulties.

Stopping over-medication of people with a learning disability, autism or both (STOMP) [78] is a national project aimed at stopping the over-use of psychotropic medicines in people with a learning disability, autism or both. STOMP aims to encourage regular medicines check-ups, ensuring that health professionals involve people, families and support workers in decisions about medicines. The project raises awareness of other interventions and support to reduce the need for medicines.

The number of older people with a learning disability is increasing. Older people with a learning disability need more support to age well, and to remain active and healthy for as long as possible.

People with physical disabilities, learning disabilities or mental health problems tend to have lower uptake of screening services than the general population. This may be because of difficulties with physical access to services, fear about what screening involves or low awareness of services.[79]

Promotion of existing national screening programmes by pharmacists can help improve uptake in under-served groups. Increasing the uptake of screening for cancers and non-cancer screening [for diabetes and Abdominal Aortic Aneurysms] has the potential to reduce health inequalities.

Pregnancy and maternity

There are many common health problems that are associated with pregnancy and after delivery. Community pharmacists provide a regular, trusted source of professional advice about these and advice about immunisation during pregnancy. Notably, pregnant women are at a greater risk of being admitted to hospital and of developing severe disease if they acquire Covid infection.[80]

Race

Although ethnic minority groups broadly experience the same range of illnesses and diseases as others, some people within ethnic minority groups report worse health than the general population and poorer experiences of using health services compared to the white population.[81] Racial discrimination may play a part in this, with a recent review finding poorer mental and physical health in adults of minority ethnicities who perceive racial discrimination than in those who do not.[82]

Minority ethnic groups do not uniformly fare worse in health outcomes; risk factors and disease prevalence vary across ethnic groups. Ethnic differences in health are marked in the areas of mental wellbeing, the diagnosis of some cancers, early onset of heart disease and diabetes, infection with Human Immunodeficiency Virus, and tuberculosis.

Examples of ethnic groups experiencing different burdens of diseases are shown below for blood disorders, infant and maternal mortality and severe mental illness.

Blood disorders

Specific life-threatening illnesses such as sickle cell anaemia/disease and thalassemia are more prevalent in some ethnic groups. Sickle cell disease is particularly common in people with an African or Caribbean family background.[83] Thalassemia mainly affects people of Mediterranean, south Asian, southeast Asian and Middle Eastern origin.[84] Pharmacists can encourage the uptake of the national screening programme for these blood disorders.

Infant and maternal mortality

Maternal mortality has been found to be four times higher in Black ethnic groups, three times higher in mixed ethnicity groups and twice as high in Asian ethnic groups compared in White groups (in the period 2017-19).[85] Pharmacists can help with professional advice in the antenatal and postnatal period.

Although stillbirth and infant mortality rates have overall decreased for all ethnic groups in recent years, there are ethnic differences, with the highest rates in Black ethnicity babies, followed by Asian ethnicity babies.[86] Racism contributes to poor maternity outcomes.[87]

Severe Mental Illness

There are significant inequalities in access, experience and outcomes between different ethnic groups, with a greater number of people of Black African and Caribbean ethnicities coming into contact with mental health services via the criminal justice system, rather than via their GP or referral to talking therapies, than people of white ethnicities.[88] Black Caribbean people are also more likely to be referred to specialist mental health services by their GP, rather than be treated in primary care, and are more likely to be detained under the Mental Health Act.[89]

An increase in the number of older black and minority ethnic people in the population is likely to lead to a greater need for provision of culturally sensitive social care, primary and palliative care.

People from Black and Minority Ethnic Groups [BAME groups] may not speak English as their first language and may have lower levels of health literacy.[90] Non-English language speakers may struggle with information or applications on digital platforms not being made available in other languages.[91]

BAME groups may have different belief systems about their health, and may show different help-seeking behaviours, including the use of non-prescribed medicines.

Whilst the proportions of persons from BAME groups are relatively low in East Sussex compared to England these are expected to have increased. Further information will become available when the results of the 2021 Census are published in late 2022.

Gypsy/Traveller/Roma communities[92]

Gypsy, Roma and Traveller communities have the worst health outcomes of any ethnic group. They face some of the highest levels of health deprivation, with significantly lower life expectancy, higher infant mortality, and higher maternal mortality alongside mental

health issues, substance misuse and diabetes. These issues are representative of various lifestyle factors, alongside issues of poor education, lack of integration with mainstream support services and a lack of trust in such institutions.

Nationally, poor conditions and sanitation on Traveller sites are contributing to the poor health of Gypsy and Traveller families, including many children. Living accommodation is often damp which leads to respiratory problems in the Gypsy, Roma and Traveller community.

East Sussex County Council Managed Traveller sites have access to electricity, hot water, toilet, bath/shower and cooking facilities that is their own to use. Locally, the East Sussex County Council Gypsy and Traveller Team supports the community to access health care and support. The Team does this by connecting people to services, and by providing advocacy and advice to people who are struggling to access the support they are entitled to. There is still a high proportion of adults with poor literacy which also leads to an increased difficulty in accessing mainstream services.

Gypsy, Roma and Traveller communities spend less years of their lives in good health. Roadside Gypsy, Roma and Traveller communities have less ability to access mainstream health services. Sustained health and social care support is not possible if a person is transient. This puts roadside Gypsy, Roma and Traveller communities at greater risk of poor health.

One of the most frequently cited healthcare problems facing Gypsy, Roma and Traveller people is in accessing primary and secondary health services. Problems with registering and accessing GP services, immunisation services, maternity care and mental health provision have been reported. The reasons for this have been variously attributed to discrimination, difficulties navigating the NHS, and a reluctance by Gypsy, Roma and Traveller people to seek medical attention until their condition has become very serious.

Gypsy, Roma and Traveller people, especially travelling families, tend to use emergency services such as A&E departments, rather than any structured approach to healthcare, due to previous poor experiences. This leads to disrupted health provision and makes preventative care very difficult to administer.

Maternity and antenatal care provide an opportunity for healthcare staff to support Gypsy, Roma and Traveller women. NHS England may wish to train maternity staff and pre-natal staff [including pharmacists] to enquire about, signpost and refer to services that may also be beneficial to Gypsy, Roma and Traveller women, including immunisation, dental services, mental health services and sexual health checks.

Religion and belief

Religious views and beliefs may influence health.

There is a possible link with ‘honour-based violence’, a type of domestic violence motivated by the notion of honour, in those communities where the honour concept is linked to expected behaviours of families and individuals. Pharmacies have a role in helping

victims of all religions and beliefs to report abuse and access help urgently [the ask ANI scheme].[93]

Some Roman Catholics oppose the use of Emergency Hormonal Contraception which is available in pharmacy.

Religious beliefs may affect uptake of vaccines and some medicines depending on beliefs about their constituents. Pharmacists have a role in explaining misunderstandings about vaccine constituents.[94]

Fasting influences the management of some long-term conditions-diabetes for example.

Sex

Sex plays a significant role in health and disease outcomes, with differences observed in life expectancy, the causes of mortality and the prevalence of lifestyle risk factors.

Some of the differences between men and women are attributable to biological/genetic factors. These affect the prevalence of various diseases, their clinical presentation and different responses to treatment.

Other differences may be due to the influence of the social environment, with behavioural/lifestyle differences affecting exposure to risks and the response to illness.[95]

Mortality from coronary heart disease is much higher in men. Women's risk of cardiovascular disease may go unrecognised and increases later in life.

Men have different health care seeking behaviours than women.[96] In one study, men aged 16 to 55 tended to be 'avoiders', actively not going to pharmacies.[97] They may feel uncomfortable in a pharmacy environment thinking that the environment is feminised, meant for older people, lacking privacy and of customer service being indiscreet.

The proportion of men and women who are obese is roughly the same, although men are markedly more likely to be overweight than women, and present trends suggest that weight-related health problems will increase among men. Women are more likely than men to become morbidly obese.

Women are more likely to report, consult for and be diagnosed with depression and anxiety.

Women and girls are more likely than men to experience common mental health disorders[98] and eating disorders.[99] The prevalence of these is increasing. Mental ill health is a particular issue in younger women. In the Millennium Cohort Study 22% of females were found to have higher levels of psychological distress at age 17 compared with 10% of males.[100]

Depression and anxiety may be under-diagnosed in men. Suicide is more common in men, as are all forms of substance abuse.

Alcohol disorders are twice as common in men, although binge drinking is increasing at a faster rate among young women. Among older people, the gap regarding alcohol disorders between men and women is less marked.

Morbidity and mortality are consistently higher in men for virtually all cancers that are not sex specific. However, cancer morbidity and mortality rates are reducing more quickly for men than women.

Sexual orientation

A separate ESCC JSNA report describes LGBTQ+ health related needs.

Robust estimates of the number of LGBTQ+ people locally are lacking. There may be between 17,000 and 39,000 LGB+ people living in East Sussex (between 3.1% and 7% of the population) and 5,600 Trans and Gender Diverse (TGD) people (1% of the population). There is some overlap between these groups. Census 2021 data on sexual orientation (SO) and gender identity (GI) with estimates of the number of LGBTQ+ people living in East Sussex are awaited.

Estimates of the number of people who have an intersex variation range between 0.05%-1.7% of the global population.

Problematic alcohol use appears to be high in young LGBTQ+ people, with almost one quarter (23%) of young people who responded to our community survey reported drinking five or more alcoholic drinks in a typical drinking session, increasing to 67% in gay men.

The prevalence of mental health conditions and the need to access mental health support is disproportionately high in young LGBTQ+ people, especially in TGD people.

Drug use appears to be substantially higher in LGBTQ+ people compared to non-LGBTQ+ people, especially in gay/bi (GB) men. Sexualised drug use may be higher in LGBTQ+ people.

Smoking prevalence is disproportionately high in LGBTQ+ people. Alcohol use appears higher in LGBTQ+ people compared to non-LGBTQ+ people.

In adults, the GP patient survey found that mental health condition prevalence was significantly higher in LGB+ people (41%), compared to heterosexual people (11%), especially in bi people (56%). Additionally, TGD people were much more likely to report a mental health condition than cis people (27% compared to 12%).

There is an increased risk of self-harm and suicide in LGBTQ+ people, especially TGD groups.

Up to 20% of activity in key LGBTQ+ organisations based in Brighton is from East Sussex residents. This suggests there may be significant unmet need locally.

Older LGBTQ+ people may be more likely to be single, live alone and may be less likely to have traditional family structures to rely on for support than non-LGBTQ+ people.

Almost one in five (18%) of older respondents to the community survey reported accessing health and care services outside of East Sussex, especially with regards to HIV services.

There has been a significant, continued fall in the numbers of new diagnoses of HIV in men who have sex with men [as a self- defined group]. The small decline in testing and the continuing availability of Pre-Exposure Prophylaxis [PrEP] for HIV prevention have

contributed to the year-on-year reduction in HIV transmission in this group. There has been a fall in HIV testing during the pandemic, most notably among heterosexuals.[101]

Pharmacists continue to have a role in encouraging the uptake of blood borne virus testing. The big drive now is to test opportunistically, population-wide, in high prevalence areas to eradicate HIV, (along with the previous medical preventative strategies). East Sussex is no longer a high prevalence area.

Gender re-assignment

Many drugs and alcohol are metabolised by the liver, as are the steroid sex hormones. Heavy use of alcohol and/or drugs whilst taking supplementary sex hormones may increase the risk of interactions.

Alcohol, drugs and tobacco and the use of hormone therapy can all increase cardiovascular risk. Taken together, they can also increase the risk already posed by sex hormone therapy.

Smoking can affect oestrogen levels, increasing the risk of osteoporosis and reducing the feminising effects of oestrogen medication.

Transgender people face several barriers that can prevent them from engaging in regular exercise. Many transgender people struggle with body image and as a result can be reluctant to engage in physical activity.

Transgender people are likely to suffer from mental ill health as a reaction to the discomfort they feel. This is primarily driven by a sense of difference and not being accepted by society. If a transgender person wishes to transition and live in the gender role they identify with, they may also worry about damaging their relationships, losing their job, being a victim of hate crime and being discriminated against. The fear of prejudice and discrimination, which can be real or imagined, can cause significant psychological distress.

University students

The Eastbourne campus of the University of Brighton is in the Meads area, a mile from Eastbourne town centre. The halls of residence are home to more than 350 students. This campus may close in 2024.

Plumpton College accommodates over 200 students on campus. Other universities are just over the county border in Brighton and Hove.

Students are often a transient population. They may spend more time living at their university address during the academic year so are encouraged to register with a local GP. This is particularly important for students who have an ongoing health condition-for example those with diabetes, epilepsy or asthma.[102]

Students are noted to have the following health needs/risks:

- Mumps outbreaks [having missed MMR vaccine in childhood]; meningitis outbreaks
- Screening for sexually transmitted diseases; access to contraception, including emergency hormonal contraception provision

- Smoking cessation
- Mental health problems are more common among students than in the general population. This is increasingly recognised as an issue[103,104]

Term times impact on needs for primary care services and dispensing from pharmacies.

Offenders[105]

The term 'offenders' refers to an individual who is convicted in a court of law as having committed a crime, violated a law, or transgressed a code of conduct. It includes community offenders and those accommodated in prison.

Offenders are much more likely than average to be subject to factors affecting mental wellbeing, personality disorders, learning disabilities, substance misuse, homelessness, and below average academic achievement. Offenders may also have had issues with accessing the medical care and support they need to address and manage these issues. A common factor is alcohol abuse.

Offenders represent a distinct population with high mental and drug related issues:

- Drug and alcohol misuse fuels offending behaviour
- Nationally, more than 70% of the prison population have two or more mental health disorders. 72% of those identified as having a mental illness were also found to have a substance misuse problem
- Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners are 35 times more likely than women in general
- Mental disorders are significantly over-represented in the prison population. As many as 12% to 15% of all prisoners have four concurrent mental disorders. 30% of all prisoners have a history of self-harm and the incidence of mental health disorder is higher for women, older people and those from ethnic minority groups
- The suicide rate in prisons is almost 15 times higher than in the general population. Boys aged 15-17 are 18 times more likely to kill themselves in prison than in the community.

A separate section of this report considers services in Lewes Prison.

Homeless persons and rough sleepers

Sleeping rough is seriously detrimental to a person's physical and mental health. Multi-faceted interventions in primary and secondary care are needed.[106,107] During the COVID pandemic many people sleeping rough were accommodated in the Everyone In programme.

Groups already experiencing inequalities and difficult conditions are more at risk of homelessness, including young people leaving care, offenders, and people at risk of domestic violence.[108]

Children experiencing homelessness are at particular risk of long-lasting harm, with an increasing risk to health and wellbeing the longer a person is homeless.

Young people are particularly vulnerable to harm and poor health, with increased risk of numerous issues, including mental health issues, self-harm, drug and alcohol use, sexually transmitted infections, and unwanted pregnancies. This group may face exploitation, abuse and other harms.

Almost all long-term physical health problems are more prevalent in the homeless population than in the general public.

Compared to the general population, the prevalence of infectious diseases (such as TB, HIV and hepatitis C) is greater in rough sleepers, as is the risk of certain conditions, such as musculoskeletal disorders, skin and foot problems, dental problems and respiratory illnesses.[109]

The mean age at death for someone who is homeless in England and Wales is 44 years for men and 42 for women compared to the mean age at death for the general population of England and Wales for males [76] and females [81] respectively (in 2017). Even those people who sleep rough for only a few months are likely to die younger.

In 2020, nearly 40% of deaths were related to drug poisoning, around 12% to alcohol-specific causes and nearly 11% to suicide.[110] An analysis of deaths of homeless people in England found nearly a third of deaths were due to conditions that are amenable to timely healthcare, such as TB and gastric ulcers.[111]

People sleeping on the street are almost 17 times more likely to have been victims of violence. More than one in three people sleeping rough have been deliberately hit or kicked or experienced some other form of violence whilst homeless. Homeless people are over nine times more likely to take their own life than the general population.

A report by Homeless Link highlighted the extent to which homeless people experience some of the worst health problems in society.[112]

Widespread ill health:

- 73% of homeless people reported physical health problems. 41% said this was a long-term problem, 80% of respondents reported some form of mental health issue, 45% had been diagnosed with a mental health issue
- 39% said they take drugs or are recovering from a drug problem, while 27% have or are recovering from an alcohol problem
- 35% had been to A&E and 26% had been admitted to hospital over the past six months

Worse health than the general public:

- 41% of homeless people reported a long-term physical health problem (compared to 28% of the general population)
- 45% had been diagnosed with a mental health problem (25% for the general population)
- When short term health problems reported by homeless people are included [minor ailments] the prevalence of physical health problems is even greater

Health related behaviours:

- 36% had taken drugs in the past six months (5% for the general population)
- 35% do not eat at least two meals a day
- Two-thirds consume more than the recommended amount of alcohol each time they drink
- 77% smoke

Access to primary care is significantly lower in homeless people.[113] Homeless Link found that a third of rough sleepers are not registered with a GP.

Refugees, asylum seekers and migrants

ESCC is welcoming refugees from around the world, notably in recent times from Syria and Ukraine, as the crisis unfolds.

The council is making provision for an allocated number of migrants.

Refugees and asylum seekers are among the most vulnerable groups within society, often with complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill health.[114] UKHSA guidance for primary care is now available to inform the management of clinical and public health risks in people coming from Ukraine.[115]

Many asylum seekers arrive in relatively good physical health. Some asylum seekers can have increased health needs relative to other migrants owing to the situation they have left behind them, their journey to the UK and the impact of arriving in a new country without a support network.

Common physical health problems affecting asylum seekers include:

- Communicable diseases – immunisations may be incomplete, or non-existent,[116] for asylum seekers from countries where healthcare facilities are lacking, or where the prevalence of diseases such as TB are higher than in the UK
- Sexual health needs – UK surveillance programmes of sexually transmitted diseases (except Human Immunodeficiency Virus) do not routinely collect data on country of origin. Uptake of family planning services is low, which may reflect some of the barriers to accessing these services by women
- Long-term conditions may not have been diagnosed in the country of origin, perhaps due to a lack of healthcare services
- Dental disorders – dental problems are commonly reported amongst refugees and asylum seeker and
- Consequences of injury and torture

With regards to women's health:

- Poor antenatal care and pregnancy outcomes[117]

- Asylum seeking, pregnant women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population
- Uptake rates for cervical and breast cancer screening are typically very poor
- Other concerns include female genital mutilation and domestic violence

Irregular or undocumented migrants such as those who have failed to leave the UK once their asylum claim has been refused, or those who have been illegally trafficked, also have significant health needs and are largely hidden from health services. Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country, with consequences for their mental health.

Culturally, mental illness may not be expressed or may manifest as physical complaints. Stigma may also be attached to mental ill-health. Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common. Post-traumatic stress disorder is underestimated and underdiagnosed and may be contested by some healthcare professionals. Children are particularly neglected in this area.

Pharmacists could have a role in supervised treatment for TB. There is the opportunity to commission a service from pharmacies for Directly Observed Therapy [DOT] and Visually Observed Therapy [VOT] for TB treatment [currently not commissioned in Eat Sussex]. This is highly relevant given the increasing numbers of asylum seekers and refugees arriving in East Sussex.

Military veterans

East Sussex is not home to any military installations [other than a territorial unit] and therefore does not house a substantial community of armed forces personnel.

Whilst there is often an emphasis on veterans with post-traumatic stress disorder (PTSD), the actual rates are not high, around 6.2% which is broadly equivalent to the incidence amongst civilians. More common issues include other mental health difficulties, such as anxiety and depression, as well as problems related to alcohol.

For those veterans who deployed when serving, rates of PTSD are higher at 9% and up to 17% for those who were deployed in a front-line, infantry combat role.

There is growing evidence that a range of mental health conditions may appear some years after individuals have left the armed forces. These conditions may relate to combat, training or other military experiences, transition out of service, or pre-service vulnerabilities.

Stigma associated with mental health and a traditional culture of reluctance to admitting to a perceived weakness or being in a position of having to ask for help, means that a substantial number of unwell veterans are unlikely to access the appropriate support and services. This is further compounded by a lack of awareness amongst veterans of what

services are available to them, as well as varying levels of awareness across the NHS on the health needs of this patient group.

Visitors to East Sussex

East Sussex coastal towns and villages are popular tourist destinations. Visitors' health needs are unlikely to be very different to those of the resident population. Their health needs are likely to be treatment of an acute condition which requires the dispensing of a prescription; the need for repeat medication; support for self-care; or signposting to other health services such as a GP or a dentist.

Promoting safe travel

Pharmacies can be proactive in encouraging safer foreign travel for East Sussex residents by recommending reliable sources of advice such as Fit for Travel. They can also reinforce advice about COVID immunisations and boosters before travel abroad.

People taking dependency forming medicines

Public Health England Prescribed Medicines Review assessed the prescribing of a group of medicines in the population and which people are likely to become dependent on [known as dependency forming medicines]. The review covered adults (aged eighteen and over) and five classes of medicines:

- benzodiazepines (mostly prescribed for anxiety)
- z-drugs (sleeping tablets with effects similar to benzodiazepines)
- gabapentin and pregabalin (together called gaba-pentinoids and used to treat epilepsy, neuropathic pain and, in the case of pregabalin, anxiety)[118]
- opioids for chronic non-cancer pain
- antidepressants

In 2017 to 2018, 11.5 million adults in England (26% of the adult population) received, and had dispensed, one or more prescriptions for any of the medicines within the scope of the above review. The proportions of the adult population receiving each medicine were: antidepressants (17%); opioid pain medicines (13%); gaba-pentinoids (3%); benzodiazepines (3%); and z-drugs (2%). NICE has issued new guidelines for the management of patients receiving these drugs.[119]

Inequalities in prescribing of drugs liable to dependency

Pharmacies have a role in advising/supporting people who take dependency forming medicines including opiates. Prescribing rates for opioid pain medicines and gaba-pentinoids have a strong association with deprivation and are higher in areas of greater deprivation. This is also the case locally in Hastings, and in a part of Eastbourne.

A commissioned service in East Sussex helps patients with their dependency and aims to raise awareness among prescribers.[120] Appropriate and effective treatment pathways are available to patients who experience drug dependency and challenges when withdrawing from prescription medication.

Areas of relatively high social deprivation also have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in treatment.[121,122]

A separate section of this report discusses the needle exchange and supervised consumption service in pharmacy.

Are current pharmaceutical services in East Sussex adequately responding to the changing needs of local communities?

East Sussex's population profile shows a significantly higher percentage of older people and fewer younger adults compared to the national average. This will be even more evident over the next three years and in the future.

Pharmaceutical service providers will be increasingly expected to participate in the prevention, identification and treatment of long-term conditions [LTCs].[123] More frail elderly people will be living in the community either in their own home, a care home, or in extra care living accommodation and with one or more long-term conditions [LTCs].[124]

A proportion of older people will be expected already to have, or to be developing, mild cognitive impairment and dementia. This will affect adherence to complex medicine regimes and create additional challenges for carers.

For example, East Sussex has over 32,800 people aged 17 and over diagnosed with diabetes [7.1%, a similar proportion to England]. There is an increasing trend in the number of people with diabetes in the population which is associated with increasing levels of obesity. Pharmacies can help to identify more people who have undiagnosed diabetes.

There is a strong link between the prevalence of long-term conditions [LTCs] and social inequalities. People in the lowest socio-economic groups not only have a higher prevalence of LTCs but also these tend to be more severe, and with an earlier onset in life.[125] People, in East Sussex, particularly those at lower levels of household income, will therefore continue to need prescribed medicines for these conditions, as well as benefitting from expert pharmaceutical advice to help manage them.[126]

Carers

Estimates of the numbers of unpaid or informal carers in the population vary. Using 11% of the population from the 2011 Census gives an estimated 62,000 people are unpaid carers in East Sussex. The majority of carers in East Sussex are of working age, although 26 per cent are aged over 65. Of all carers in East Sussex, 58 per cent are women.[127]

Approximately a fifth of carers do 50 or more hours of unpaid care a week. As the population ages, the number of older people who are informal carers is growing, particularly in those aged 85 and over. This group may not recognise themselves as carers, and may be at increased risk of isolation, loneliness and mental health issues.[128]

Carers UK identified the significant negative impacts on mental health due to caring, with around 70% of carers experiencing mental health issues, such as stress or depression, due to caring and around 80% of carers reporting feeling lonely or socially isolated due to their caring role.[129]

Palliative and End of Life Care

There should be adequate provision of a defined group of drugs to support end of life care in the community, both in-hours and out-of-hours. National guidance recommends that palliative care formularies should be part of End-of-Life Care pathways. This issue is being taken forward in the Sussex-wide, End of Life Care Strategy Group and a palliative care service is commissioned in community pharmacies by Sussex ICB.

6. Current pharmaceutical services provision

6.1 Tiers and providers of pharmaceutical services

Pharmaceutical Services as defined in the Regulations cover:

- Essential Services – services **all** pharmacies are required to provide (see also 1.3)
- Advanced Services – additional services which pharmacies can provide (see also 1.4)
- Locally Commissioned Services (LCS) (see also 6.6)

Pharmaceutical services can be provided by:

- Community pharmacies
- Distance selling / online pharmacies
- GP dispensaries
- Dispensing Appliance Contractors

As at January 2022, there were 99 community pharmacies included in the pharmaceutical list for East Sussex, operated by 33 different contractors, and additionally three distance selling pharmacies located within the borders of East Sussex. There are 16 GP Dispensaries in East Sussex (1 fewer than in 2017), and no Dispensing Appliance Contractors providing services within the Health and Wellbeing Board's area.

GP dispensaries

Whilst it is recognised that dispensing doctors' practices provide valuable services to their registered dispensing patients, these GP dispensary services are limited by statute to the dispensing of prescriptions only, not the full range of essential or advanced services.

Not all patients registered with a dispensing practice will meet the criteria for receiving dispensing services. In East Sussex, those eligible amount to 42% [49,007/115,695] of all patients registered with GP dispensing practices. This ranges from 16% to 100% of all patients registered in the dispensing practices.

Distance selling or online pharmacies

operate over the Internet and send orders to customers through the mail or shipping companies. They must provide the full range of essential services during opening hours to all persons in England presenting prescriptions but cannot provide essential services face to face.

Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice. Patients therefore can access any of the many internet pharmacies available nationwide in addition to community pharmacies.

See Appendix C for further information on the roles and regulations relating to GP Dispensaries, Dispensing Appliance Contractors and Distance Selling Pharmacies.

Owing to the effect the COVID-19 pandemic on the provision of services from the end of 2019/20, to 2021/22 this pharmaceutical needs assessment has considered the years 2018/19, 2019/20, 2020/21 and 2021/22 to gain a more accurate picture overall.

6.2 Necessary services

This section describes the pharmaceutical services that the Health and Wellbeing Board has identified **as necessary to meet the need for pharmaceutical services (1.5)**.

This includes all essential services plus the following advanced services: New Medicines Service, Community Pharmacy Consultation Service and 'flu immunisation service.

This section also provides further details on the provision of NHS Pharmaceutical Services as defined in the Community Pharmacy Contractual Framework.

Section 10 of this document covers a gap analysis identifying services that are **not provided** but which the Health and Wellbeing Board is satisfied **need to be provided** to meet a current or future need for pharmaceutical service or services.

The pharmaceutical services that the Health and Wellbeing Board has identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access are also discussed in Section 10.

6.3 Pharmacy provision in East Sussex

Provision compared to neighbouring local authorities

There has been a gradual reduction in provision of pharmacies at regional and national level since the last PNA in 2017. The number of pharmacies per head of population in East Sussex [17.6 per 100,000 - crude rate, unadjusted for age/sex] is lower than the England rate, although similar to neighbouring local authorities, Table 11.

Table 11 Comparison of Rates of provision of community pharmacy per 100,000

Year	Brighton and Hove	East Sussex	Kent	Surrey	West Sussex	England
2018/2019	18.0	19.3	17.4	17.0	18.6	19.5
2019/2020	16.9	19.8	17.3	17.7	18.0	19.3
2020/2021	16.9	18.8	17.0	16.5	17.3	18.8
2021/2022	17.8	17.6	17.0	16.1	17.6	18.5

Source: NHS BSA NHS BSA copyright 2022 [6]

[6] The data comparing East Sussex with neighbouring local authorities and England are adapted from the NHS BSA in May 2022. The rates do not include DSPs. Rates shown for Kent, Surrey, and England are calculated based on any pharmacy open during the year [including some pharmacies that have since closed] and using ePACT populations as denominators. The England rate is therefore an inflated value.

The East Sussex, Brighton and Hove rates use actual counts of pharmacies at a point in time in May 2022. The West Sussex rate is based on the number of pharmacies as at end of March 2022.

The rates for East and West Sussex, and Brighton and Hove have been calculated using resident population denominators.

The reduction in the number of pharmacies since the last PNA has been shown in the supplementary statements and published on the County Council website, alongside the main PNA document. Table 12 below summarises the net changes between June 2017 and January 2022 by district and borough.

Table 12 Community pharmacy net changes by LA in East Sussex, June 2017- January 2022

	Jun 2017	Jan 2022	Net changes
Eastbourne BC	22	20	-2
Community pharmacy 40 hrs	18	16	-2
Community pharmacy (100 core hours)	4	4	0
Internet/Mail order	0	0	0
Hastings BC	22	20	-2
Community pharmacy 40 hrs	19	17	-2
Community pharmacy (100 core hours)	3	3	0
Internet/Mail order	0	0	0
Lewes DC	20	18	-2
Community pharmacy 40 hrs	18	16	-2
Community pharmacy (100 core hours)	1	1	0
Internet/Mail order	1	1	0
Rother DC	18	17	-1
Community pharmacy 40 hrs	17	16	-1
Community pharmacy (100 core hours)	1	0	-1
Internet/Mail order	0	1	1
Wealden DC	30	27	-3
Community pharmacy 40 hrs	27	26	-1
Community pharmacy (100 core hours)	0	0	0
Internet/Mail order	3	1	-2
	112	102	-10

Source: NHS England supplementary statement, September 2017, Regional list NHSE January 2022

Comparing the rates of provision by local authority in East Sussex, as at the end of Q3 in 2021, there is relatively lower provision of community pharmacies in Rother, Lewes and Wealden local authorities, with Hastings having the highest provision of community pharmacies per 100,000 population. This reflects the greater health needs in Hastings compared to other Districts and Boroughs described in chapter 5, Table 13.

When the GP dispensaries are included the rate of pharmacy provision overall is relatively higher in Rother [24.9 per 100,000] than Hastings [22.6 per 100,000] and Wealden [20.0 per

100,000] local authorities. The lowest rate of provision overall is in Lewes [16.3 per 100,000]. Please note in the following Table 13 rates per 100,000 exclude the Distance Selling Pharmacies physically located in these local authorities.

Table 13 Rates of community pharmacy and GP dispensary provision in East Sussex local authorities

District & Borough	Population	Community Pharmacies CP	Rate per 100,000	GP dispensaries [including branches]	GP + CP Dispensing sites	Overall rate per 100,000
East Sussex	562,748	99	17.6	16	115	20.4
Eastbourne	104,324	20	19.2	0	20	19.2
Hastings	92,861	20	21.5	1	21	22.6
Lewes	104,308	17	16.3	0	17	16.3
Rother	96,569	16	16.6	8	24	24.9
Wealden	164,686	26	15.8	7	33	20.0

Source: ESiF April 2021; NHSE January 2022

Geographical location of pharmacies and GP dispensaries

Figure 16 shows the distribution of community pharmacies and GP dispensaries across the county, including the location of 100-hour pharmacies. Pharmacy premises are generally located in areas of relatively greater population density (those areas shaded in a darker pink colour), whereas the GP dispensaries serve rural East Sussex.

Figure 16 Community pharmacies and dispensing GP practices by Local Authority in East Sussex, 2022

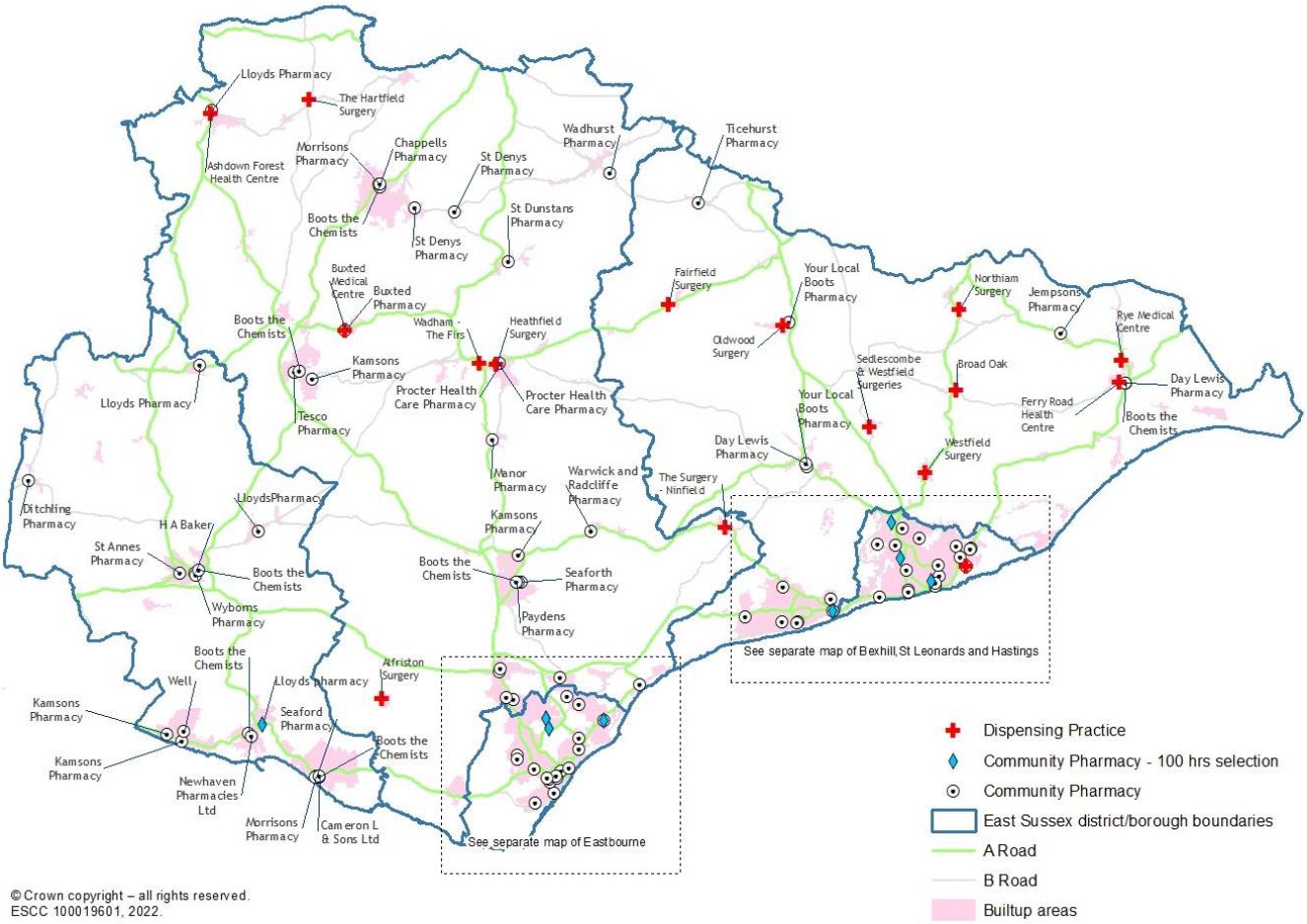


Figure 17 focusses on Eastbourne and Figure 18 on Hastings.

Figure 17 Community pharmacies and GP practices in Eastbourne

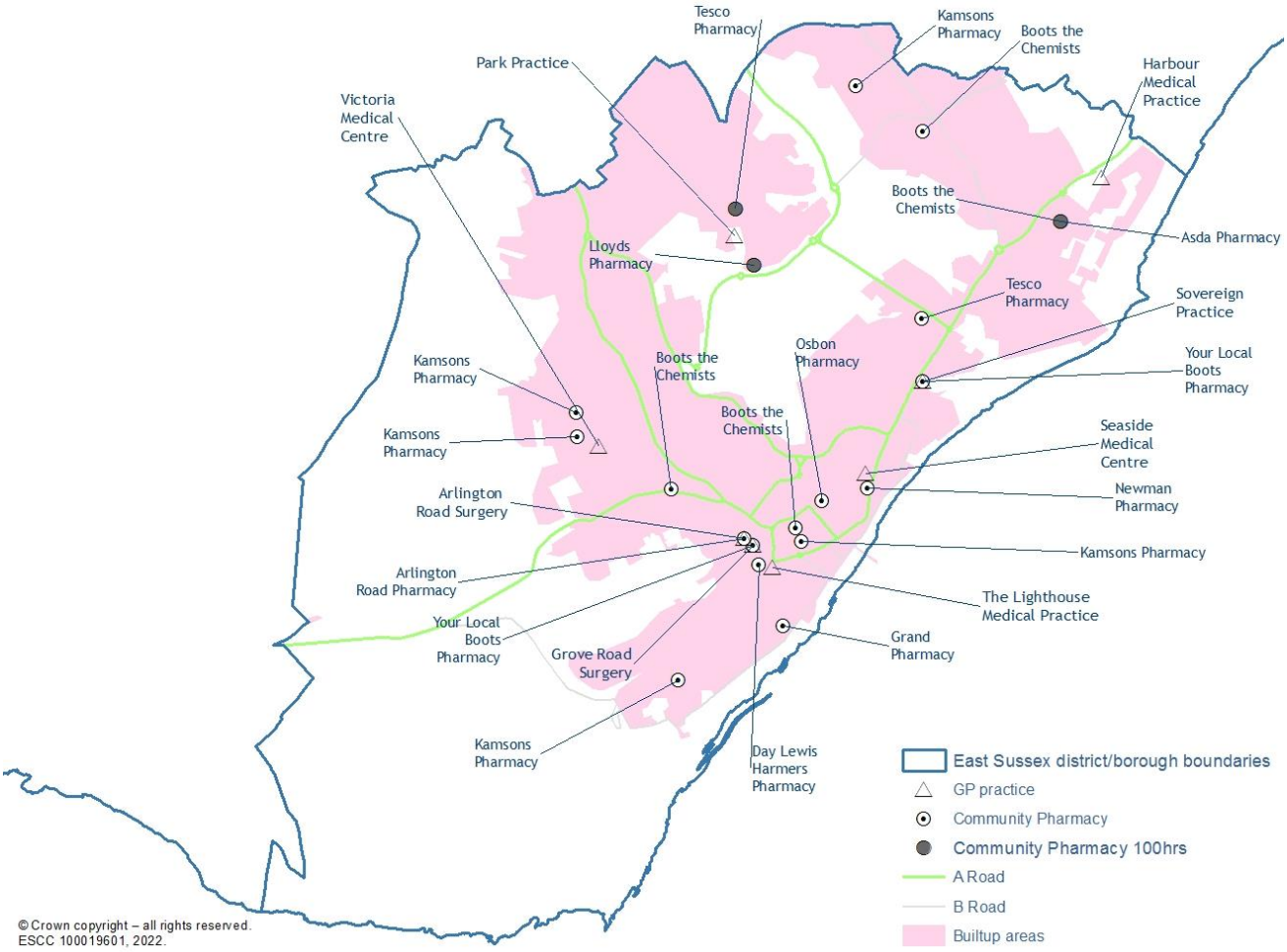
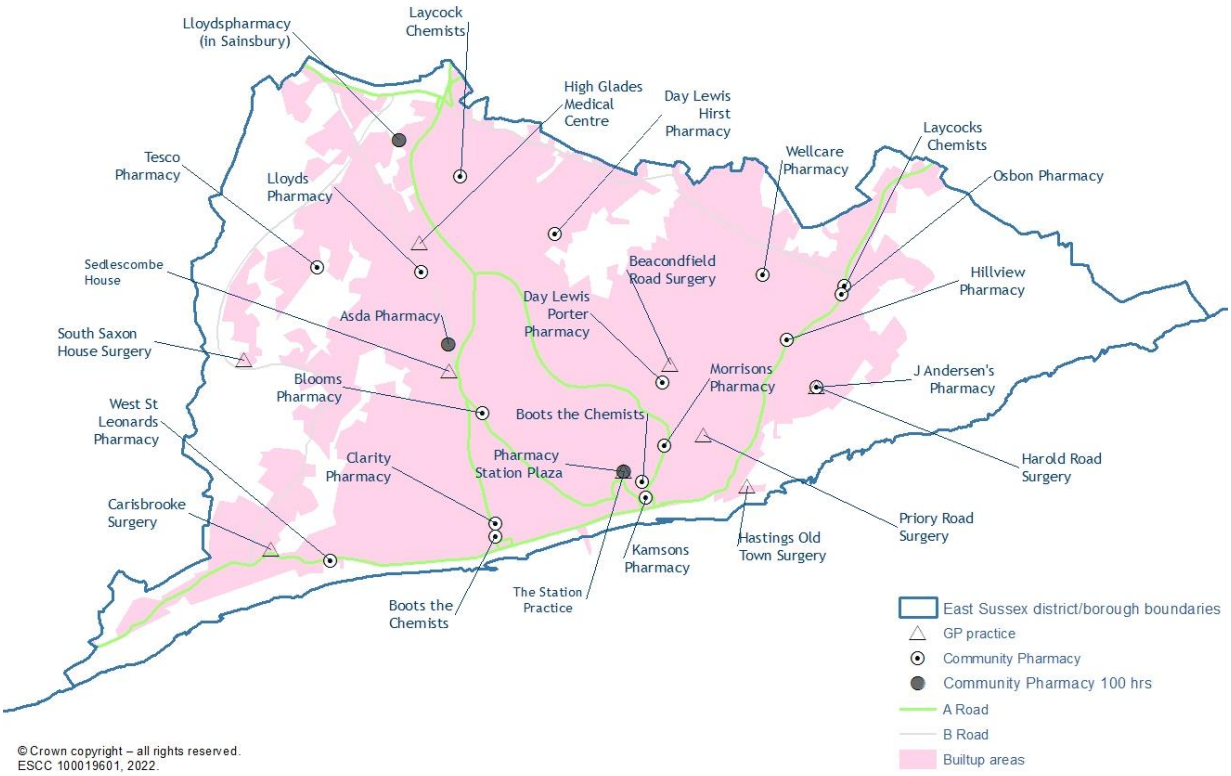


Figure 18 Community pharmacies and GP practices in Hastings



6.4 NHS pharmaceutical service provision

Essential services: Routine prescribing and dispensing of medicines

Prescription items

Prescriptions are either on a paper prescription form or sent via an Electronic Prescribing System [EPS] message. Each single item is counted as a prescription item.

The total number of items prescribed over a four-year period by LA in East Sussex are shown in Tables 14-20. This includes the pandemic period from Q2 2020 to the end of March 2022.

Prescribing by East Sussex GP practices, by local authority

Table 14 shows all items prescribed in East Sussex district or borough coming from where the prescribing organisation sits geographically.

Compared with 2018/19, there was an increase in total items prescribed in 2019/20 in East Sussex, followed by a decrease in 2020/21. The trends in the total items prescribed over the last three years show a small increase in Eastbourne and Hastings, and a slight decrease in Lewes, Rother, and Wealden.

As more Electronic Prescribing System [EPS] prescribing has been implemented there has been a corresponding decrease in the amount of non-EPS prescribing, Table 14 total items and percentage EPS by local authority 2018/19 to 2021/22.

Table 14 Total items and percentage EPS by local authority 2018/19-2021/22

	Eastbourne		Hastings		Lewes		Rother		Wealden		East Sussex	
Year	Items	% EPS	Items	% EPS	Items	% EPS	Items	% EPS	Items	% EPS	Items	% EPS
2018/2019	2,110,056	74%	2,181,380	66%	1,823,145	73%	2,192,418	44%	3,278,328	58%	11,585,327	62%
2019/2020	2,146,287	81%	2,239,943	77%	1,848,561	79%	2,203,539	47%	3,343,949	62%	11,782,279	68%
2020/2021	2,128,911	96%	2,194,978	95%	1,804,937	92%	2,174,697	58%	3,254,091	71%	11,557,614	81%
2021/2022	2,148,770	97%	2,163,961	96%	1,815,429	93%	2,196,979	57%	3,321,419	71%	11,646,558	81%

Source: NHS BSA copyright 2022

The proportion of items prescribed using the Electronic Prescribing System [EPS] in East Sussex CCG [81%] is consistently lower than found in the average across England [90%], and particularly lower in Rother and Wealden.

Dispensing

Patients have a choice of where they access pharmaceutical services. This may be close to their GP practice, their home, their place of work or where they go shopping.

The total number of items dispensed by all pharmacies in East Sussex has decreased slightly overall in the past three years, Table 15. The local authority here refers to the location of the dispensing pharmacy regardless of where the patient lives.

Table 15 Total items dispensed by all pharmacies located in East Sussex [regardless of where the patient lived]

Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/2019	2,057,634	2,116,882	1,685,079	1,490,636	2,761,833	10,112,064
2019/2020	2,077,753	2,189,193	1,717,061	1,471,789	2,726,090	10,181,886
2020/2021	2,012,271	2,133,163	1,626,870	1,444,027	2,612,244	9,828,575
2021/2022	1,993,271	2,097,607	1,616,481	1,406,268	2,684,368	9,797,995

Source: NHS BSA copyright 2022

Not all the prescriptions written for residents of East Sussex will be dispensed by the pharmacies within its county boundary.

Table 16 below shows the total items prescribed in East Sussex and dispensed by any community pharmacy in England for the residents of each local authority. [This excludes DACs, GP dispensary activity and GP personally administered items.]

Table 16 Items prescribed in East Sussex and dispensed in any community pharmacy in England

Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/2019	2,051,150	2,029,516	1,703,949	1,534,876	2,736,779	10,056,270
2019/2020	2,083,585	2,090,474	1,726,355	1,534,474	2,797,901	10,232,789
2020/2021	2,067,619	2,090,691	1,693,498	1,502,756	2,723,893	10,078,457
2021/2022	2,088,976	2,066,629	1,716,442	1,488,132	2,775,916	10,136,095

Distance Selling Pharmacy dispensing

The number of items dispensed by any distance selling pharmacy 2018/19 to 2021/22, by [residents'] local authority, are shown in Table 17. The proportion of items dispensed in this way has been steadily increasing. At East Sussex level this is now 6.2% overall. Notably this is even greater in Lewes district [7.6%] and in Wealden [6.8%].

Table 17 Total items dispensed by a distance selling pharmacy

	Eastbourne		Hastings		Lewes		Rother		Wealden		East Sussex	
Year	Items	%DSP	Items	%DSP	Items	%DSP	Items	%DSP	Items	%DSP	Items	%DSP
2018/2019	87,197	4.3%	31,412	1.5%	60,345	3.5%	45,420	3.0%	177,720	6.5%	402,094	4.0%
2019/2020	86,882	4.2%	39,383	1.9%	64,437	3.7%	32,860	2.1%	194,928	7.0%	418,490	4.1%
2020/2021	99,453	4.8%	77,567	3.7%	103,782	6.1%	65,642	4.4%	162,487	6.0%	508,931	5.0%
2021/2022	123,249	5.9%	96,455	4.7%	130,696	7.6%	93,847	6.3%	187,615	6.8%	631,862	6.2%

Proportion of items dispensed by a distance selling pharmacy by Local Authority

The number of items dispensed by distance selling pharmacies [DSP] excluding those in East Sussex, are shown by local authority in Table 18, together with the proportion of total items that were dispensed in this way. For East Sussex overall, the figure has now increased to 4.5%, with the largest proportion from Lewes district [5.9%].

Table 18 Total items and proportion dispensed by a Distance Selling Pharmacy not in East Sussex

	Eastbourne		Hastings		Lewes		Rother		Wealden		East Sussex	
Year	Items	%DSP	Items	%DSP	Items	%DSP	Items	%DSP	Items	%DSP	Items	%DSP
2018/2019	24,493	1.2%	20,597	1.0%	20,447	1.2%	17,506	1.1%	21,291	0.8%	104,334	1.0%
2019/2020	30,797	1.5%	31,549	1.5%	26,686	1.5%	21,315	1.4%	40,075	1.4%	150,422	1.5%
2020/2021	73,713	3.6%	67,089	3.2%	70,611	4.2%	45,318	3.0%	81,374	3.0%	338,105	3.4%
2021/2022	97,951	4.7%	90,140	4.4%	101,410	5.9%	64,997	4.4%	98,589	3.6%	453,087	4.5%

Discharge Medicine Service

This new, essential service was introduced in 2020/21 to improve communication from hospitals to community pharmacy and therefore reduce the medicines risks of patients being newly discharged from hospitals on complex drug regimes.

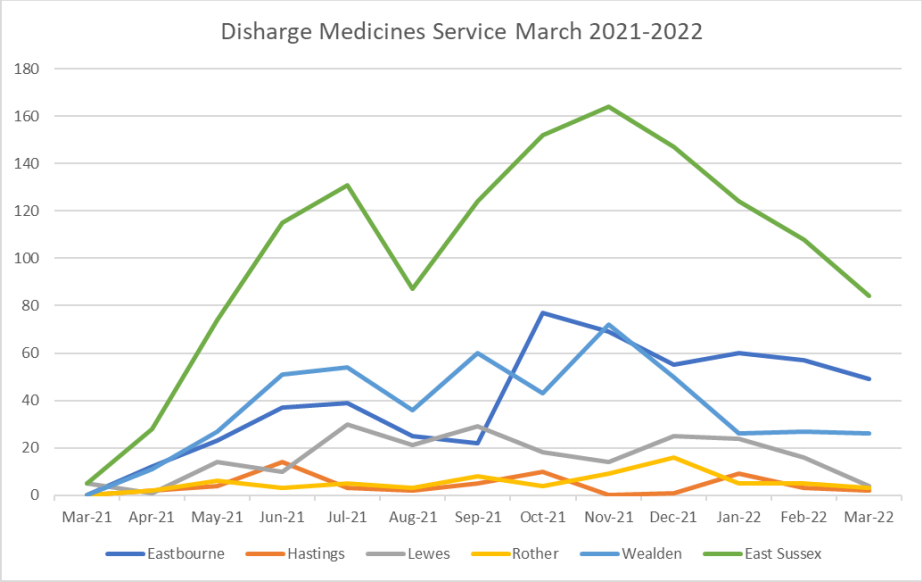
When a patient is discharged from hospital, the hospital can choose to send an electronic referral from the trust to the patient's chosen community pharmacy. The service is reliant on the hospital sending through the referral to community pharmacy. The pharmacy may choose to accept this referral [within 72 hours of receipt]. Once accepted the pharmacist will carry out a medicines reconciliation with the GP repeat prescription and contact the patient to discuss their medicine regime.

If clinical issues are found these are either addressed with the GP or attached practice clinical pharmacist who may do a Structured Medicines Review. There has been a decline in referrals from hospitals into this service and there is very little activity noted in Hastings and Rother. Most referrals come from East Sussex Healthcare NHS Trust.

The CQC reported on reducing risks with the use of medicines in health and social care settings.[130] There are opportunities to reduce avoidable hospital admissions, readmissions, and patient morbidity through further proactive medicines management in the community.[131] Follow up after discharge from hospital is now a core element of the community pharmacy contract. This is now covered in the Discharge Medicines Service.

Figure 19 shows the recent activity within this new discharge medicines service.

Figure 19 Discharge Medicines Service by Local Authority



NHS England has funded Community Pharmacy Leads within ICBs. The roll-out of DMS is going to be one of the key priorities for the post holder in NHS Sussex, and Trusts are being heavily pushed by NHSE to implement the service.

Advanced services

The following are advanced services in the community pharmacy contract:

1. New Medicine Service (pharmacies only) to help improve medicine adherence among people with certain long-term health conditions who have been prescribed new medication.
2. Community Pharmacist Consultation Service [CPCS] for minor illnesses and urgent medicines supply.
3. Flu vaccination (pharmacies only) service for patients in eligible groups.
4. Appliance Use Review (pharmacies and DACs) to support patients in the use, safe storage and disposal of appliances.
5. Stoma Customisation Service (pharmacies and DACs) to ensure the proper use and comfortable fitting of the stoma appliance.
6. Community pharmacy hepatitis C antibody testing service (currently due to end on 31 March 2023).
7. Hypertension case-finding service
8. Smoking cessation service

Please see Appendix C for more detailed descriptions of these advanced services.

Community pharmacies can opt to provide any of these services if they meet the requirements set out in the Secretary of State Directions. Pharmacies are required to seek approval from NHS England before providing these services, are required to have an appropriate consultation area, and have a pharmacist who has been accredited to provide the service.

Those advanced services which the Health and Wellbeing Board views as necessary services are the New Medicines Service, the Community Pharmacy Consultation Service, and the 'flu immunisation service and hypertension case-finding service.

The number of claims in the period 2018/19 to Q2 2020/21 for these advanced services are shown by Local Authority in Table 19 to Table 23 . Source: NHS BSA

New Medicines Service

The New Medicine Service (NMS) provides support for people with long-term conditions who have been newly prescribed a medicine to help improve their understanding and use of their medicine, Table 19.

Table 19 New Medicines Service (NMS) activity by Local Authority

Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	1,752	1,829	1,496	1,364	4,258	10,699
2019/20	1,813	1,972	1,354	1,634	5,006	11,779
2020/21	1,409	1,902	863	1,650	3,017	8,841
2021/22	2,102	2,712	1,854	1,724	5,155	13,547
Grand Total	7,076	8,415	5,567	6,372	17,436	44,866

Community Pharmacy Consultation Service

Activity within this newly established service has been gradually increasing, although not all pharmacies are showing claims for any activity yet in this service as the GP CPCS only started to rollout gradually across East Sussex in December 2020, Table 20.

Table 20 Community Pharmacist Consultation Service (CPCS) Activity

Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	0	0	0	0	0	0
2019/20	205	316	202	150	194	1,067
2020/21	987	983	634	498	549	3,651
2021/22	1,272	1,261	852	535	782	4,702
Grand Total	2,464	2,560	1,688	1,183	1,525	9,420

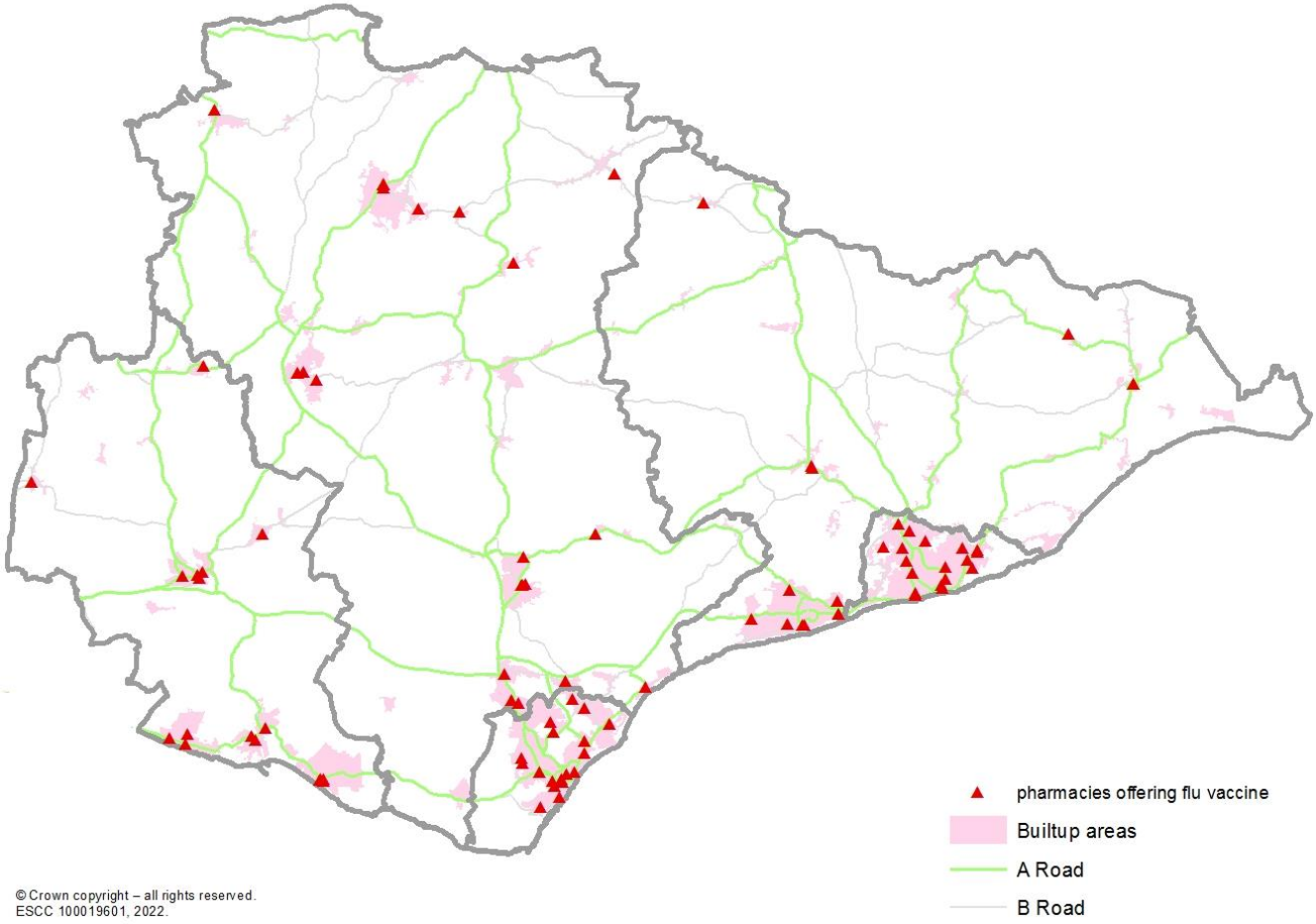
Flu vaccination service

There have been steadily increasing numbers of people immunised with 'flu vaccine in community pharmacy. Table 21 shows the income from the 'flu vaccination advanced service. The number of immunisations is not available. Each uses a different vaccine and charges a different fee. Broadly, finance corresponds to activity. The location of pharmacies offering the 'flu vaccination service in 2021/2022 can be seen in

. Table 21 Seasonal 'flu Advanced Service Income by Local Authority

Seasonal Influenza Vaccination Advances Service (FLU) Income						
Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	£ 44,830.92	£ 33,644.52	£ 25,833.00	£ 19,178.04	£ 36,014.52	£ 159,501.00
2019/20	£ 44,891.20	£ 40,341.38	£ 27,015.60	£ 27,092.24	£ 43,502.78	£ 182,843.20
2020/21	£ 58,932.26	£ 65,247.84	£ 45,884.16	£ 44,614.08	£ 69,660.12	£ 284,338.46
2021/22	£ 99,028.46	£ 105,912.66	£ 73,890.54	£ 52,929.50	£ 129,330.00	£ 461,091.16
Grand Total	£ 247,682.84	£ 245,146.40	£ 172,623.30	£ 143,813.86	£ 278,507.42	£ 1,087,773.82

Figure 20 Pharmacies offering 'flu vaccination



Appliance Use Reviews (AURs)

Appliance Use Reviews aim to improve the patient's knowledge and use of a 'specified appliance'. There has been very little activity in this service within East Sussex in the past three years as the majority of the service is provided by appliance contractors outside of East Sussex, Table 22.

Table 22: Appliance Use review Activity by Local Authority

Appliance Use Reviews (AUR) Activity						
Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	0	0	0	0	0	0
2019/20	0	16	0	30	0	46
2020/21	0	0	0	0	0	0
2021/22	0	0	0	0	0	0
Grand Total	0	16	0	30	0	46

Stoma Appliance Customisation (SAC) Service

A stoma is an outlet in the abdominal wall where faecal matter (or urine) can be safely collected following surgery on the bowel (or bladder). A stoma appliance is a bag placed

over the outlet. The Stoma Appliance Customisation (SAC) service involves the customisation of a stoma appliance, based on the patient's measurements or a template.

The SAC service can be provided by pharmacies in the normal course of their business, if they meet the conditions of service.[132] There has been very little activity in this service within East Sussex as the majority of the service is provided by appliance contractors outside of East Sussex, Table 23.

Table 23 Stoma Customisation Activity by Local Authority

Stoma Customisation (STOMA) Activity						
Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	0	31	16	19	91	157
2019/20	2	32	19	23	49	125
2020/21	0	13	8	6	39	66
2021/22	0	9	9	3	19	40
Grand Total	2	85	52	51	198	388

Hepatitis C antibody testing service

There has been no activity in this service since it commenced two years ago in any of the local authorities. There are no pharmacies delivering the service in East Sussex. According to pharmacy colleagues it was a difficult service specification to deliver, and roll out of the service occurred during COVID, so take-up was low. This service is continuing in 2022-23 until 31st March 2023.

Hypertension case-finding service[133]

This new advanced service aims to:

- Identify people with high blood pressure aged 40 years or older (who have previously not had a confirmed diagnosis of hypertension), and to refer them to general practice to confirm diagnosis and for appropriate management
- At the request of a general practice, undertake ad hoc clinic and ambulatory blood pressure measurements and
- Provide another opportunity to promote healthy behaviours to patients

Smoking Cessation Service [SCS][134]

The new SCS has been designed to enable NHS trusts to undertake a transfer of care on patient discharge, referring patients (where they consent) to a community pharmacy of their choice to continue their smoking cessation treatment, including providing NRT and support as required.

The ambition is for referral from NHS trusts to community pharmacy to create additional capacity in the smoking cessation pathway. The NHS LTP commitment also included the follow up of patients from maternity and mental health services, therefore referrals into community pharmacy for the SCS may also start to include these patients when they are being discharged from an acute NHS trust. Direct referrals from mental health and maternity NHS trusts are not part of this service.

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

NHS trusts will be expected to make referrals to the SCS as this is a new contractual requirement in the 2022/23 NHS Standard Contract. While the rollout of the service is expected to be gradual, it is expected that more NHS trusts will start to engage with the service and the wider tobacco support responsibilities they have in relation to inpatients over the rest of 2022.

Contractors outside East Sussex

East Sussex residents can access advanced services from contractors outside the borders of East Sussex. Information on the use of advanced services provided by pharmacies outside the HWB's area to East Sussex residents is not available to ESCC but is available to their respective local authority.

When claiming for advanced services, contractors claim for the total number provided for each service.

Enhanced Services

COVID Vaccination Service

For operational reasons, pharmacies are commissioned to offer this service only where there is a need in a locality. In Eastbourne COVID vaccinations were being provided elsewhere in the PCN. Activity in pharmacies has increased in the other local authorities during the pandemic. Table 24 shows COVID vaccination service activity by local authority.

Table 24 COVID vaccination service activity by local authority

Year	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	0	0	0	0	0	0
2019/20	0	0	0	0	0	0
2020/21	0	8,290	0	15,128	0	23,418
2021/22	0	84,279	7,789	79,886	1,207	173,161
Grand Total	0	92,569	7,789	95,014	1,207	196,579

Medicines Use Reviews (MURs) and Prescription Intervention Service

The Medicines Use Review (MUR) and Prescription Intervention Service consisted of accredited pharmacists undertaking structured adherence (compliance) centred reviews with patients taking multiple medicines, particularly those receiving medicines for long term conditions.[135] This service was decommissioned on the 31st of March 2021, Table 25.

Table 25 Medicines Use Review and Prescription Intervention Service [MUR] activity

	Eastbourne	Hastings	Lewes	Rother	Wealden	East Sussex
2018/19	7,647	7,000	5,638	5,939	8,130	34,354
2019/20	4,482	4,173	3,778	3,503	5,350	21,286
2020/21	1,915	1,676	1,742	1,480	1,860	8,673
2021/22	28	0	0	0	0	28
Grand Total	14,072	12,849	11,158	10,922	15,340	64,341

Enhancing Medicines Management in the community

Patients will continue to be supported to take their own medicines appropriately, safely and to maintain their independence by community pharmacists.[136,137] Medicines reviews by suitably qualified pharmacists in GP practices will especially benefit those with complex drug regimes.

Local pharmacies continue to have regular opportunities to explain the appropriate use of antimicrobials to the public and the rationale behind reducing the risk of acquiring MRSA and Clostridium difficile infections. Antibiotic stewardship appears in the 2021/2022 pharmacy quality scheme.

The introduction of additional clinical roles which include: clinical pharmacists,[138] physician associates, first contact physiotherapists, first contact community paramedics in Primary Care Networks [PCNs], may change the number of prescriptions. Any prescribing would be attributed to the practices where patients are registered.

Increasing prescribing and dispensing workload

The routine dispensing workload and need for medicines advice for patients and carers is likely to increase in the next three years on account of the ageing population.

Medicines management teams are actively working on improving the repeat prescribing process. Reducing inappropriate polypharmacy (people taking multiple medicines) helps to mitigate the growth in prescribing volume. Pharmacists working in general practices will reduce prescribing risks. NHS England's comprehensive model for personalised care has committed to expanding social prescribing as an alternative to prescribing medicines.

6.4 Other NHS services affecting demand and which supply pharmaceutical services

Other NHS services are those services that are provided as part of the health service. They include services that are provided or arranged by a local authority (for example the public health services commissioned from pharmacies), NHS England, a clinical commissioning group, an NHS trust or an NHS foundation trust.

NHS services that **reduce** the need for pharmaceutical services, in particular the dispensing service, include:

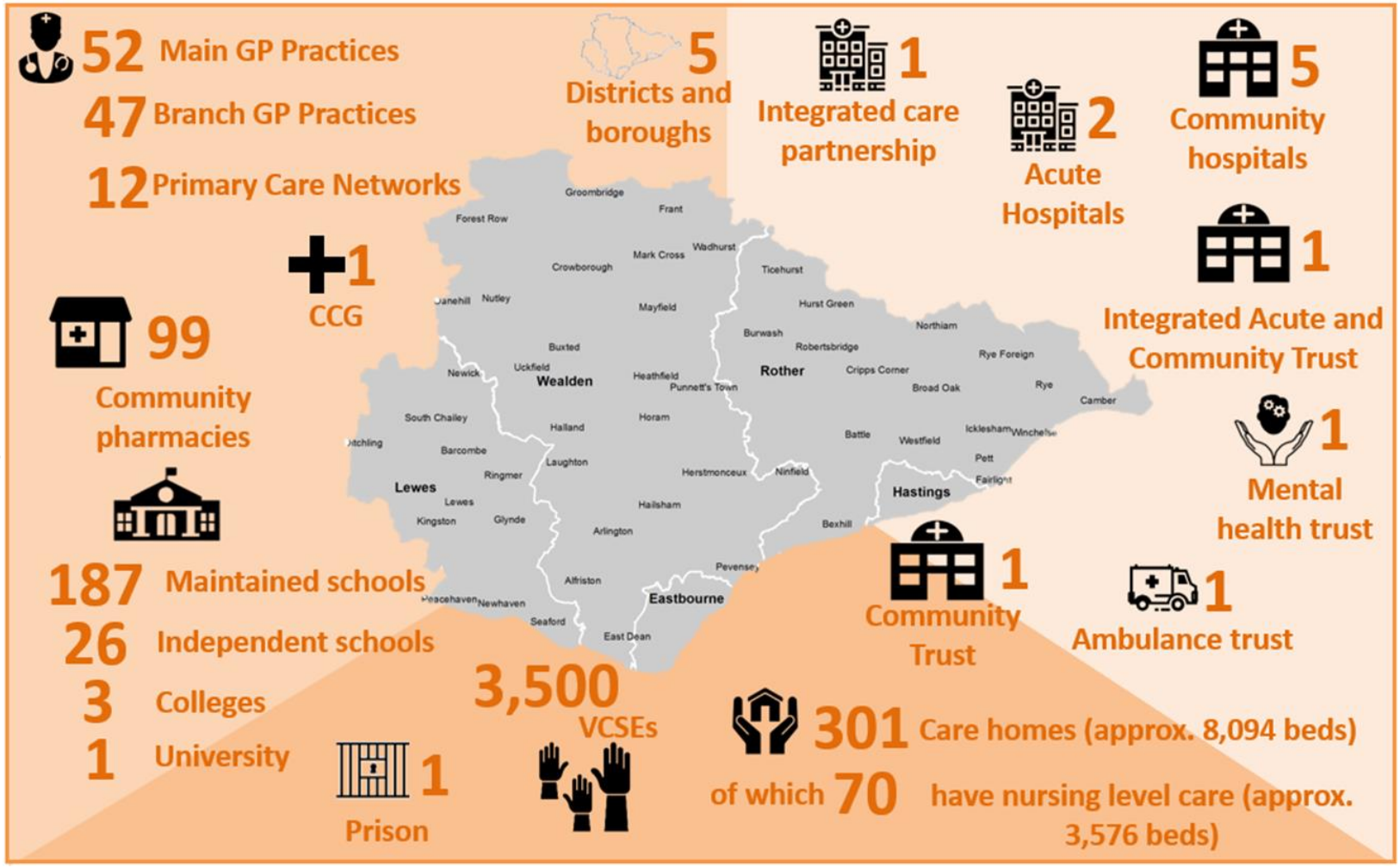
- hospital pharmacies- prescriptions written in hospitals that are dispensed by the hospital pharmacy service
- personal administration of items by GP practices
- GP out of hours service (as it may give patients a course of treatment rather than a prescription)
- public health services commissioned by the local authority (as this reduces the need for these services to be commissioned as enhanced services by NHSE)
- prison pharmacy services (where relevant)
- substance misuse services and
- flu vaccination by GP practices

NHS services that **increase** the demand for pharmaceutical services include:

- GP out of hours services (where a prescription is issued)
- walk-in centres and minor injury units (where a prescription is issued)
- GP extended access hubs
- community nursing prescribing
- dental services
- end of life services and
- services that have been moved into the primary care setting

Figure 21summarises the overall picture of health and care organisations in East Sussex.

Figure 21 Overall picture of health and care organisations in East Sussex.



NHS Acute Trust Hospitals

East Sussex NHS Trust [ESHT] is the main trust providing both acute hospital and outpatient services to East Sussex residents in the East of the county. Acute hospital services are provided over two sites at Eastbourne District General Hospital, and The Conquest Hospital in Hastings. The hospital pharmacy service operates from both acute sites with a single Chief Pharmacist overseeing both.

Pharmacy services are provided for inpatients in the form of a ward top up system and medicines to be taken home. Outpatient appointments may result in a recommendation being sent to the patient's GP for prescribing medicines. These are subsequently dispensed in community pharmacies, or practice dispensaries, as appropriate. The exceptions are where there is an immediate need for treatment, for unusual medicines, and for those medicines only available in hospital. The hospital pharmacy also provides specialist medicinal supplies within the hospital itself (e.g. anaesthetics to surgical theatres).

University Hospitals Sussex and Maidstone and Tunbridge Wells Hospital also provide extensive acute inpatient and outpatient services to many East Sussex residents.

NHS Community Hospitals

Sussex Community NHS Foundation Trust (SCFT) runs three community hospitals across the county in Crowborough, Lewes, and Uckfield. Rye and Bexhill Hospitals are run by ESHT. Community hospital services in East Sussex are summarised below, Table 26

Table 26 Community Hospital Services in East Sussex

Community Hospital	Services provided (Trust)
Crowborough War Memorial	18 intermediate care beds; MIU; community nursing; therapies; community nursing; diagnostic imaging. (SCFT) Crowborough birthing centre. (MTW)
Lewes Victoria	26 intermediate care beds; Urgent Treatment Centre (UTC); community nursing; therapies; diagnostic imaging. (SCFT)
Uckfield Community	14 intermediate care beds; MIU; community nursing; therapies; Diagnostic imaging. (SCFT)
Rye, Winchelsea and District Memorial	15 bed intermediate care unit. Patients are under the care of the two Rye doctors' surgeries. Palliative and end of life of care from multidisciplinary team. (ESHT)
Bexhill	Ophthalmic Day Surgery, Outpatient clinics, Physiotherapy, Radiology, Wet Age-related Macular Degeneration (AMD) follow-up; Diabetic Retinal

Community Hospital	Services provided (Trust)
	Screening. The Irvine Unit is an intermediate care service offers both stroke rehabilitation and generic inpatient facilities. The capacity is 42 beds (18 stroke, 24 generic). (ESHT)

Source: SCFT; ESHT; MTW

Sussex Partnership NHS Foundation Trust (SPFT)

Sussex Partnership NHS Foundation Trust provides mental health services across Sussex, covering East and West Sussex and Brighton & Hove. This includes services for child and adolescent mental health, learning disabilities, working age adult mental health, older peoples' mental health and secure and forensic mental health. There is a medium secure mental health facility in East Sussex for adults. The Trust also provides child & adolescent mental health services in Hampshire.

The Trust has an extensive, specialist pharmacy team that provides prescribing advice, education and supports medicines optimisation both to inpatient services, to community mental health teams and limited support to people with learning disabilities in the community.

Medicines are provided to inpatient psychiatric units by University Hospitals Sussex West under contract and most outpatient dispensing is done by community pharmacies.

Patients prescribed medication in SPFT community services settings are usually given an FP10 prescription (written by a prescriber in SPFT) when they start a new medicine to take to their community pharmacy of choice. Prescribing is then transferred to the patient's GP once stable and provided it is approved under the Sussex Health & Care Partnership Joint Formulary. This may be within a shared care agreement between GP and SPFT, so the GP can prescribe, while the patient is still under the care of an SPFT community team for monitoring and assessment (for example). Some specialist medications, such as clozapine, are prescribed on hospital prescriptions and dispensed through a hospital pharmacy and will continue to be prescribed by community services in SPFT.

Notably, there is a plan to build a new in-patient mental health hospital in Bexhill in 2024.

Other relevant services:

The Lansdowne Unit

The Lansdowne unit is a secure children's home in Hailsham, East Sussex, commissioned by ESCC.

Residential, nursing and care homes, and hospices

In East Sussex there were 231 residential care homes [with approximately 4,518 beds] and 70 nursing homes [with approximately 3576 beds] as at January 2022. There are three hospices [one in Hastings, Eastbourne and Chailey respectively] registered in East Sussex.

Many people living in care homes will have complex needs, including severe frailty, higher fall rates than in older people living in their own homes and dementia (around 70% of people living in care home have dementia).[139]

All care homes and hospices are scrutinised by Care Quality Commission inspectors. Clinical services are provided by General Practitioners who write NHS prescriptions (FP10s) for their registered patients. These are then dispensed by local community pharmacies.

A Medicines Optimisation in Care Homes service has been commissioned from Sussex Community NHS Foundation Trust. A team of pharmacists and technicians carry out clinical medication reviews and support staff with the safe storage and handling of medicines.

Care Homes

Apart from Lewes District, the District and Boroughs in East Sussex have more care home beds per 100 people aged 75 and over than the England average, Table 27.

The number of nursing home beds per 100 people aged 75 and over is lower than the England average for Lewes and Rother DCs and higher for Eastbourne BC, Hastings BC and Wealden DC.

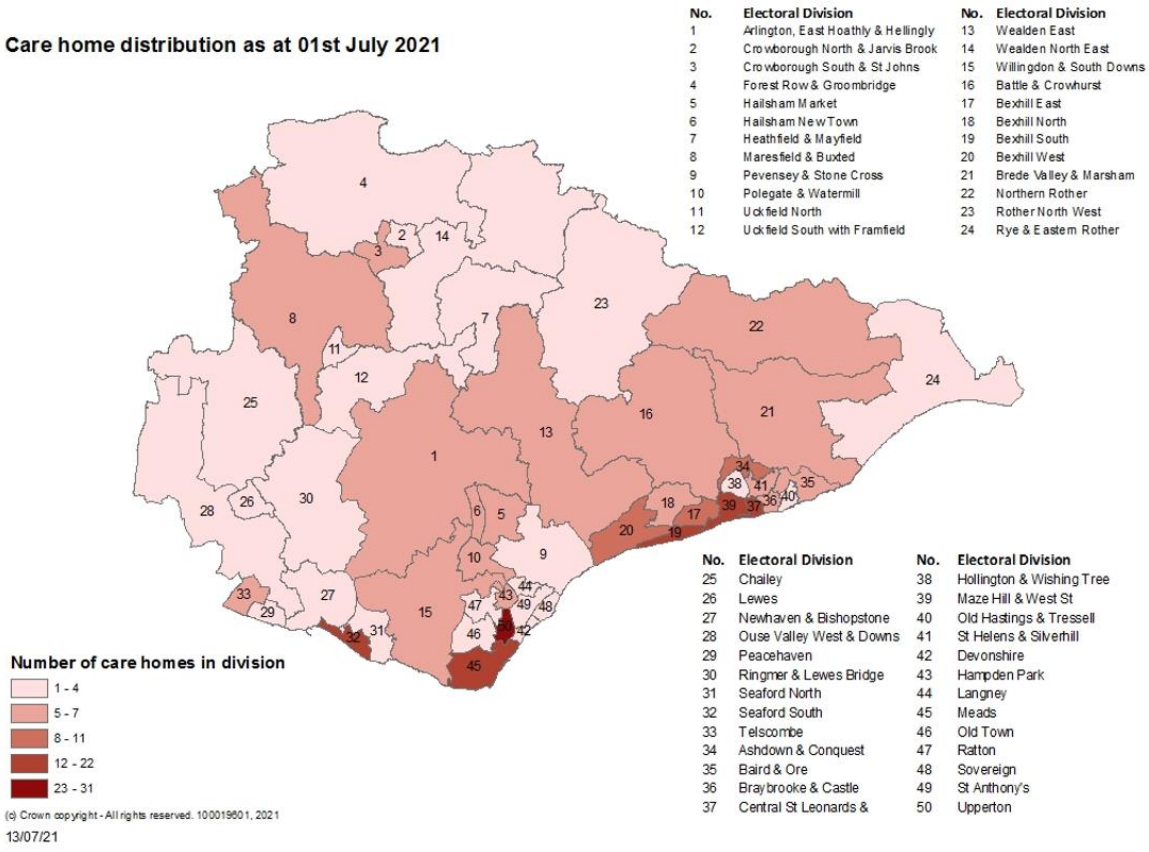
Table 27 Rates of care home bed provision

	England	Eastbourne BC	Hastings BC	Lewes DC	Rother DC	Wealden DC
Care home beds per 100 people 75 and over	9.4	13.9	17.2	8.2	12.2	9.8
Nursing home beds per 100 people 75+	4.6	6.3	7.0	3.5	3.9	5.4

Source: Fingertips, 2021

Figure 22 shows the number of care homes in each electoral division in East Sussex. A more detailed geographical representation can be found in SHAPE place atlas.

Figure 22 Care Home distribution by electoral division July 2021



Dentists

Dentists will issue NHS prescriptions which are dispensed as part of pharmaceutical services. However the level of activity is unknown.

Cross border NHS services

East Sussex is bounded to the west by Brighton & Hove City and West Sussex, to the north by West Kent and Surrey and to the east by East Kent.

Patients who live toward the borders of the county may choose to access pharmaceutical services from pharmacies located in the major towns close to these borders, namely Brighton & Hove, Burgess Hill, Haywards Heath, East Grinstead and Royal Tunbridge Wells, all of which are found within five miles of the East Sussex border.

Prison services

HM Prison Lewes is situated within East Sussex with a capacity of 742 male offenders (convicted and remand adult, and local young remand offenders).[140]

Many prisoners will have low levels of health literacy, have long-term health conditions and need access to ongoing healthcare.

Health care services at HMP Lewes are commissioned by NHS England. CareUK is the sole provider for healthcare.

There is a 19-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics. Substance misuse services are contracted by NHSE to Forward Trust. The nearest prison for female offenders is located at East Sutton Park, Maidstone (NHS West Kent).

Prisoners must be registered with a general practitioner before their release. "…release from custody can be a crisis situation for some and can result in the reversal of previous health improvements. … [pre-registration] is vital in helping to support better health outcomes and maintain continuity of care for these individuals."[141]

The arrangements on discharge from prison are subject to inspection by the CQC and HMIP. There are risks when prisoners are transferred between prisons in arranging medicines for those with long term conditions [for example if taking drugs for epilepsy].[142,143]

Private hospitals

There are three private healthcare sites within East Sussex: the Esperance (BMI Healthcare) in Eastbourne, the Horder Centre (Horder Healthcare) in Crowborough, and the Spire Hospital Sussex (Spire Healthcare) in Hastings. These provide several specialties, including surgical and non-surgical services. All have in-house pharmacy departments.

Will there be changes in providers of primary medical services, or the appointment of additional providers of primary medical services in the area?

The core requirements for extended access to GP appointments are:

- weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) to provide an additional 1.5 hours a day
- weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs
- appointments can be provided on a hub basis with practices working at scale

The ICB plans do not indicate any major changes in providers of primary medical services in the next three years. The number of practices may reduce over the coming years as more practices merge contracts.

6.5 Community pharmacy: definitions of opening hours

Core hours: Those hours a pharmacy is formally contracted to provide NHS pharmaceutical services.

Pharmacies – usually either 40 or 100 hours per week but could be different if there is an identified need. Mostly Monday to Friday.

Can only be changed on application to NHS England and the change must be based on patient need.

Supplementary hours: Additional hours a pharmacy opens beyond their core hours. These can be modified with 90 days' notice to NHS England.

Opening hours of pharmacies include a pharmacy's core hours, 40 hours per week, and supplementary hours. Supplementary hours may be varied by giving three months' notice whereas core hours can only be varied on application to NHS England.

One-hundred-hour pharmacies are obliged to fulfil this minimum requirement per week unless prevented from doing so by legislation.

NHS England has a duty to ensure that residents of the HWB area can access pharmaceutical services every day. Pharmacies are not required to open on bank holidays, or Easter Sunday, although some choose to do so. NHS England asks each contractor to confirm their intentions regarding these days and where necessary will direct a contractor (or contractors) to open on one or more of these days to ensure adequate access.

Bank holiday opening hours are largely serviced by voluntary opening arrangements covered by supplementary hours. High Bank Holidays (Christmas Day, and Easter Sunday) are covered by an Enhanced Service and a Directed Service from NHS England, for which an additional payment is made to the contractor/pharmacy for opening.

There are 102 pharmacies in total in East Sussex. Of these there are ninety-one with 40-hour contracts, while eight have 100-hour contracts. Included in the overall total are three distance selling pharmacies physically located in East Sussex.

Pharmacies with 40-hour contracts can choose to open for longer under supplementary hours arrangements.

There are three 100-hour pharmacies located within Hastings LA, three in Eastbourne LA, one in Rother LA, and one in Lewes LA, Table 28 .Please see

Figure 16,

Figure 17 and Figure 18.

Pharmacies located within five miles of the East Sussex HWB border are also shown in Figure 23.

Whilst there are pharmacies outside of the HWB's area providing pharmaceutical services during hours that may be regarded as providing improvement or better access, it is a choice of individuals whether to access these as part of their normal lives. None are specifically commissioned to provide services to the population of East Sussex.

Table 28 summarises the numbers of pharmacies, according to whether they have 40- or 100-hour contracts, and by local authority.

The opening hours for any given pharmacy can be found at: https://www.nhs.uk/service-search/find-a-pharmacy

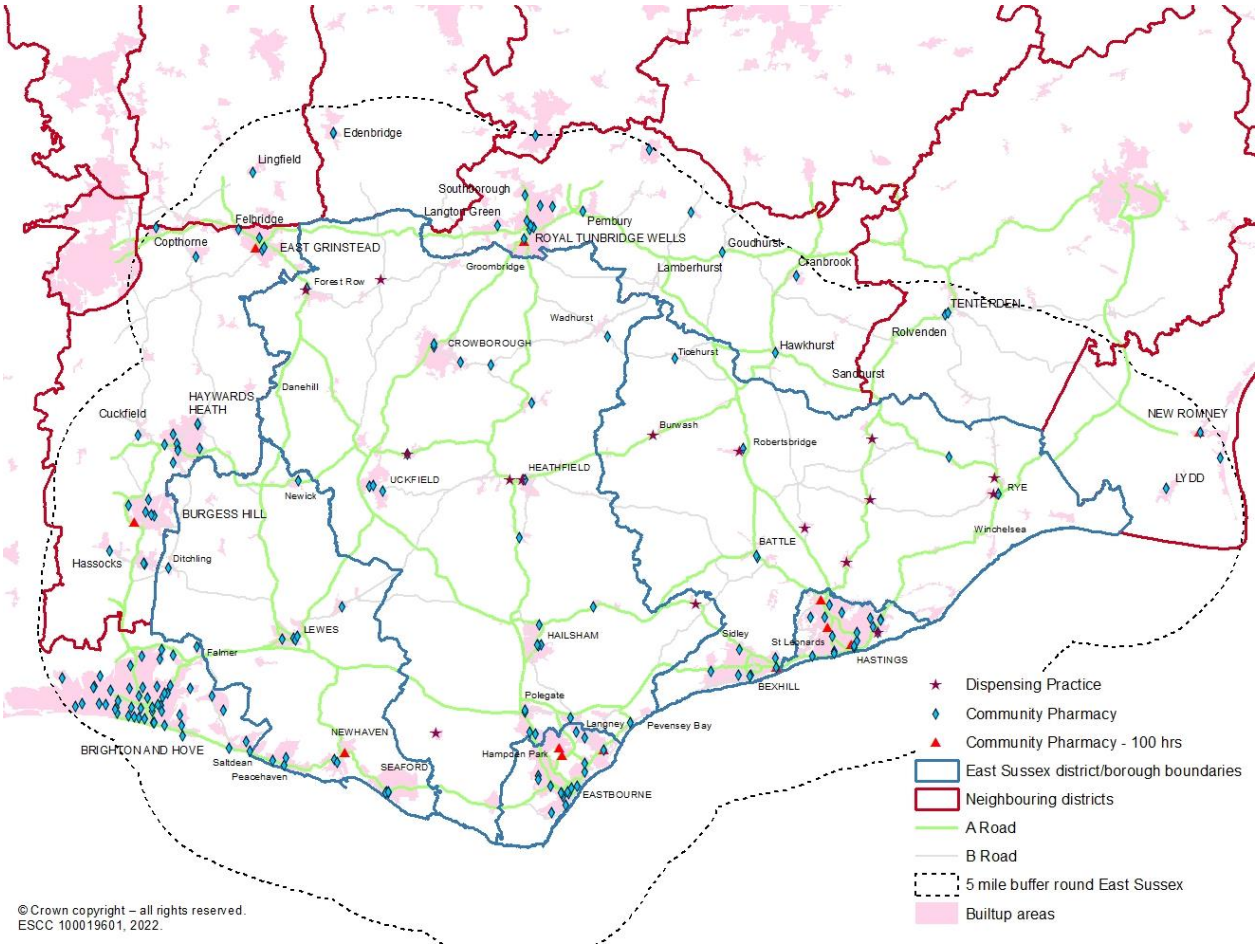
Table 28 Community pharmacies in Local Authorities in East Sussex by core hour contract type, January 2022:

District and Boroughs	Grand Total
Eastbourne BC	20
Community pharmacy [40 hours]	16
Community pharmacy (100 core hours)	4
Internet / Mail order	0
Hastings BC	20
Community pharmacy [40 hours]	17
Community pharmacy (100 core hours)	3
Internet / Mail order	0
Lewes DC	18
Community pharmacy [40 hours]	16
Community pharmacy (100 core hours)	1
Internet / Mail order	1
Rother DC	17
Community pharmacy [40 hours]	16

Community pharmacy (100 core hours)	0
Internet / Mail order	1
Wealden DC	27
Community pharmacy [40 hours]	26
Community pharmacy (100 core hours)	0
Internet / Mail order	1
Grand Total	102

Source: NHSE January 2022

Figure 23 Location of East Sussex community pharmacies by core-hour contract type (40 and 100 hours)



Evening and weekend community pharmacy opening

For this needs assessment, and as agreed by the Steering Group, evening opening has been classified as a community pharmacy with any opening after 18:00 hours.

For the purposes of the mapping, evening opening has been shown where a pharmacy is open for the majority of evenings in the week [in other words for three or more evenings after 18:00]. The mapping includes a five-mile buffer zone around East Sussex borders.

On weekday evenings, 32 pharmacies located in East Sussex are open for at least part of the evening after 6 pm. Ninety-two pharmacies are open on a Saturday morning and 45 are open all day on a Saturday. Twenty are open on a Sunday,

Table 29. Late opening and weekend opening in the one hundred and four pharmacies in the buffer zone are summarised in Table 30. Source: NHSE January 2022.

Table 29 Community pharmacy in East Sussex late opening hours and weekend opening

Core hours contract	Number	Weekday evenings	Saturday morning	All day Saturday	Sunday
40 hours	91	24	84	37	12
100 hours	8	8	8	8	8
All pharmacies*	99	32	92	45	20

*This denominator excludes the three distance selling [internet] pharmacies

Table 30 Community pharmacies in East Sussex buffer zone late opening hours and weekend opening

Core hours contract	Number	Weekday evenings	Saturday morning	All day Saturday	Sunday
40 hours	100	39	88	46	13
100 hours	4	4	4	4	4
All pharmacies*	104	43	92	50	17

*This denominator excludes the one distance selling [internet] pharmacy in B&H

Out of hours GP services

Out of hours medical services are defined as those hours not routinely covered by GP practices (in other words between 18:30 and 08:00 hours Monday to Friday, and all day on Saturdays, Sundays and Public Holidays). During these times general medical services are largely channelled through the Out of Hours provider, IC24, which provides general medical services to all patients in need of immediate medical treatment.

When no pharmacy is open, the Out of Hours providers have access to medicines under the National Out of Hours Formulary. Only if they do not have appropriate stock is there a need to issue a patient with a prescription.

Extended access hubs operate across the Health and Wellbeing Board's area offering bookable routine appointments with GPs and other health care professionals making it easier for patients to get an appointment at a time that suits them, including evenings and weekends.

Figure 24 shows pharmacies in East Sussex and neighbouring LAs open on weekdays during the day.

Figure 25 shows locations of pharmacies open in the evening on three or more weekdays (after 18:00 hours).

Figure 26 shows pharmacies in East Sussex and neighbouring LAs open on Saturday mornings.

Figure 27 shows pharmacies open any time on a Saturday.

Figure 28 shows pharmacies open on Sundays.

Figure 24 Pharmacies in East Sussex and neighbouring LAs open during weekdays [daytime]

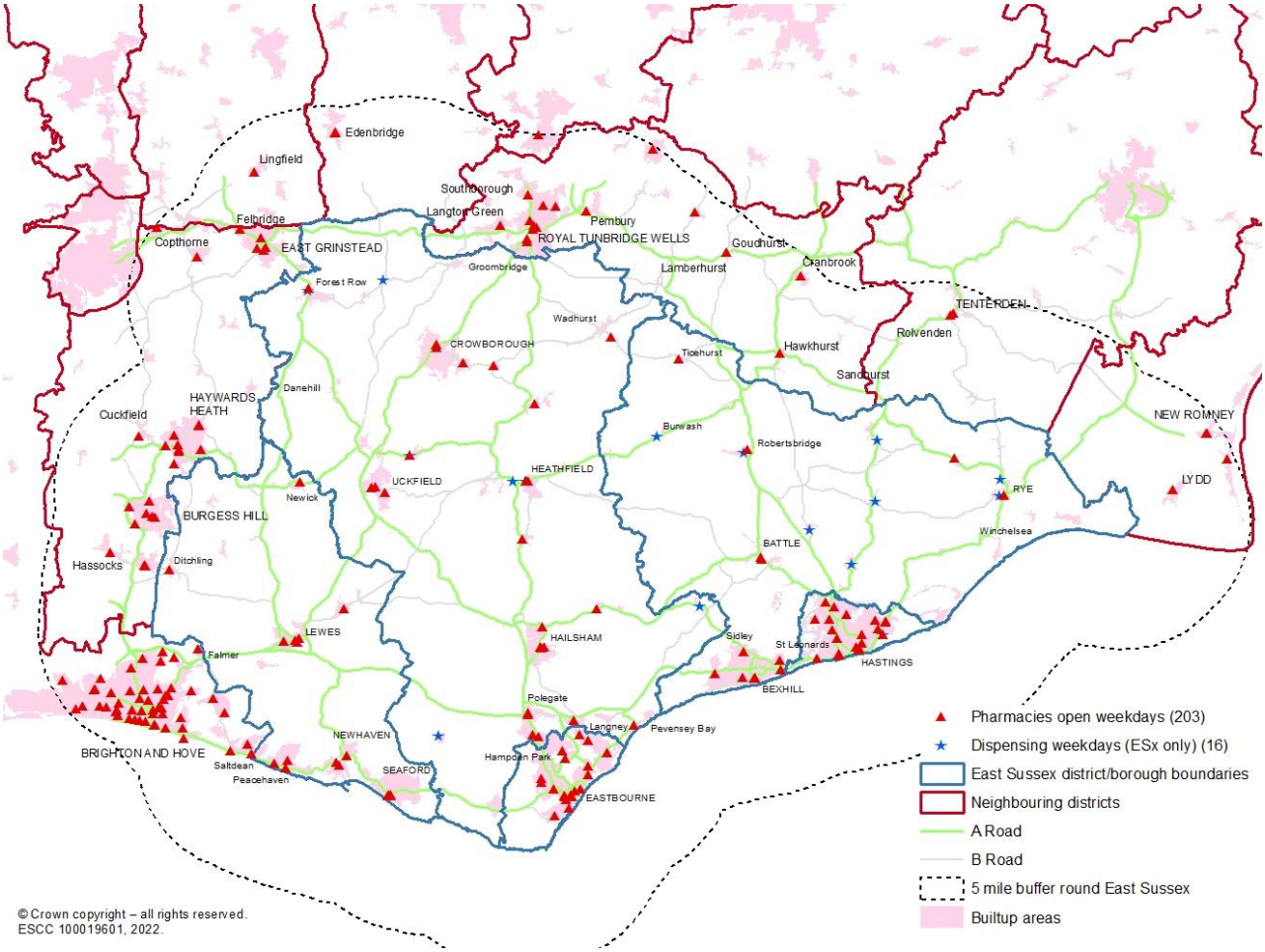


Figure 25 Pharmacies in East Sussex and neighbouring LAs open during weekday evenings (after 6 p.m.)

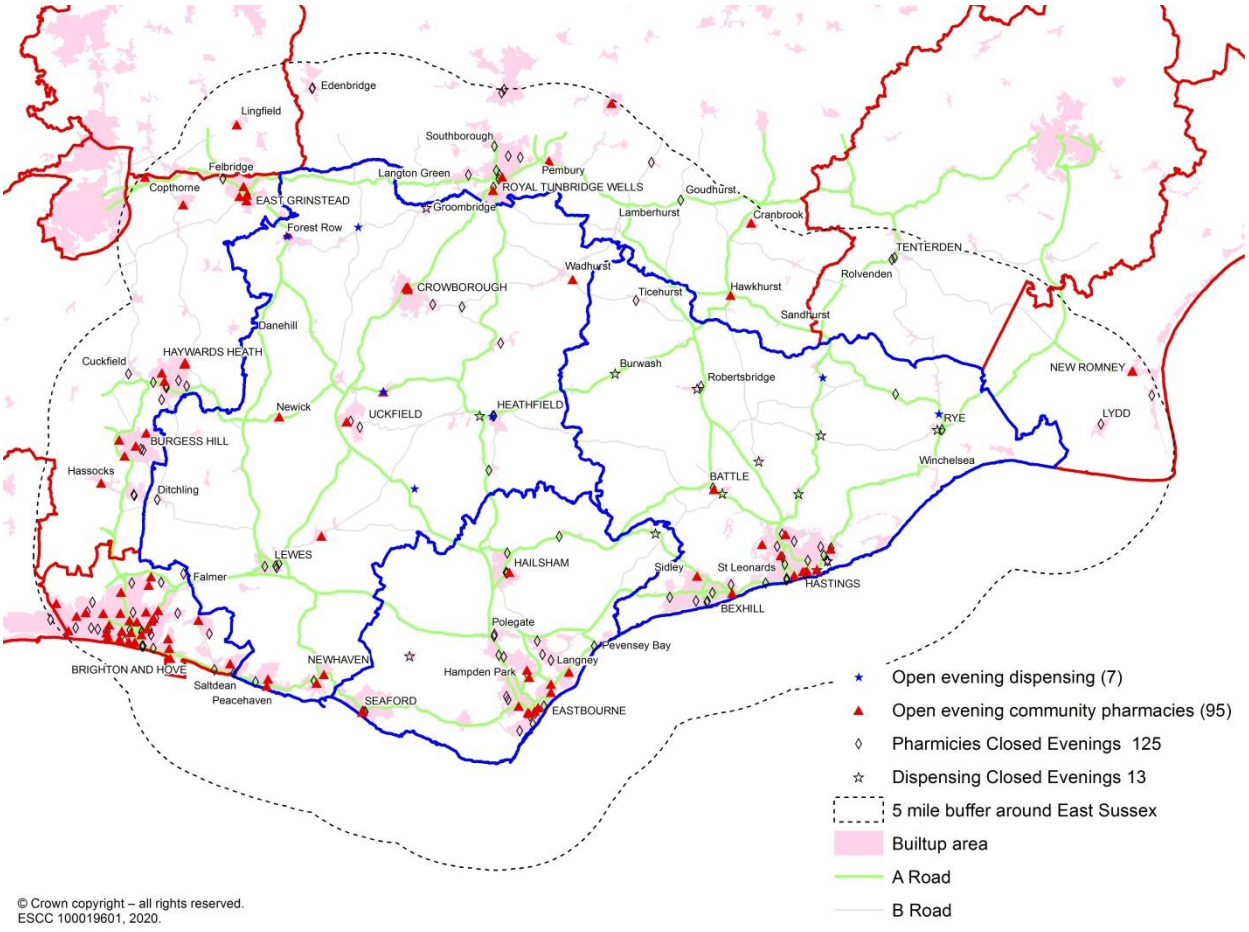


Figure 26 Pharmacies in East Sussex and neighbouring LAs open on Saturday mornings

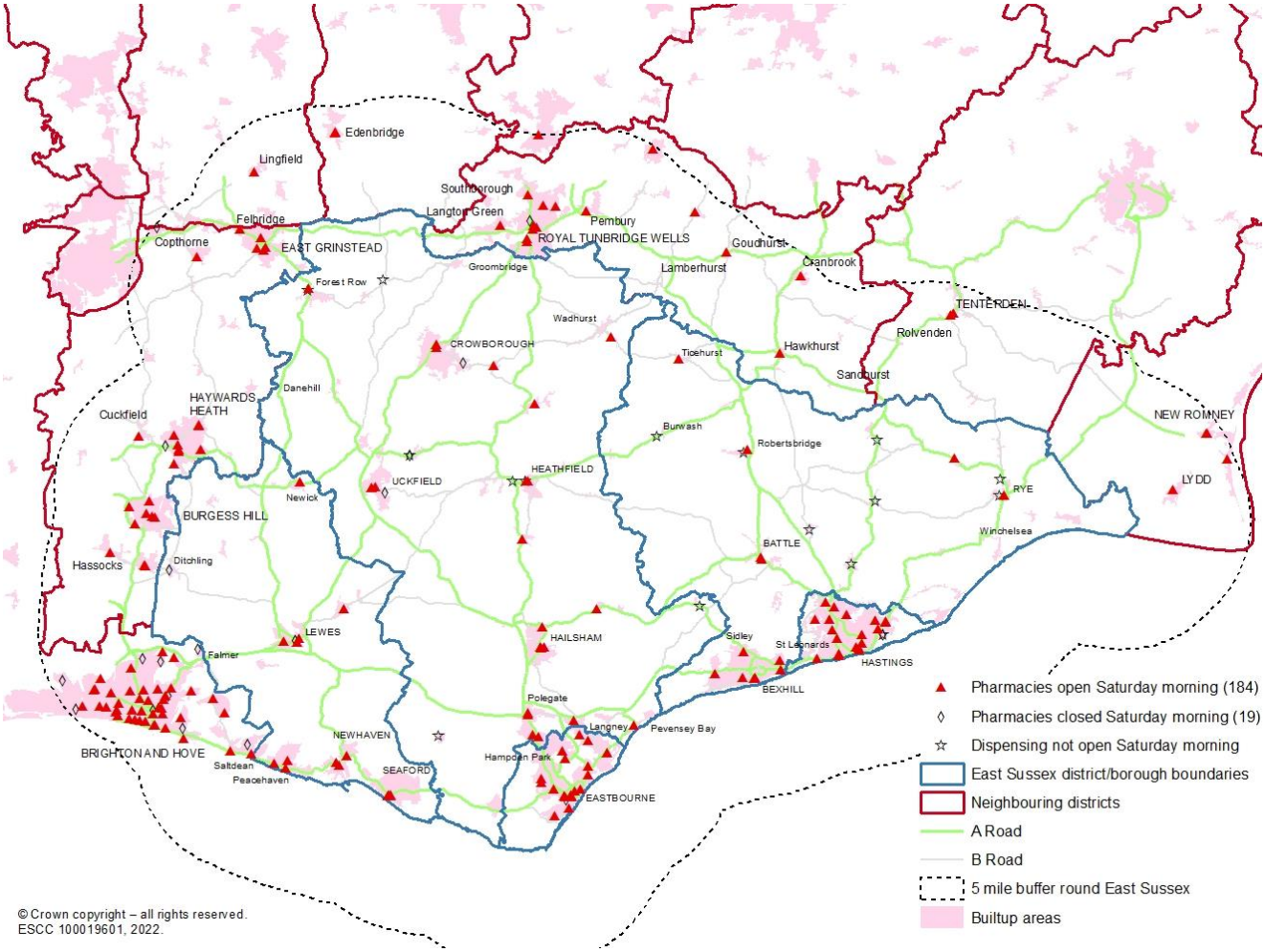


Figure 27 Pharmacies in East Sussex and neighbouring LAs open on Saturday all day

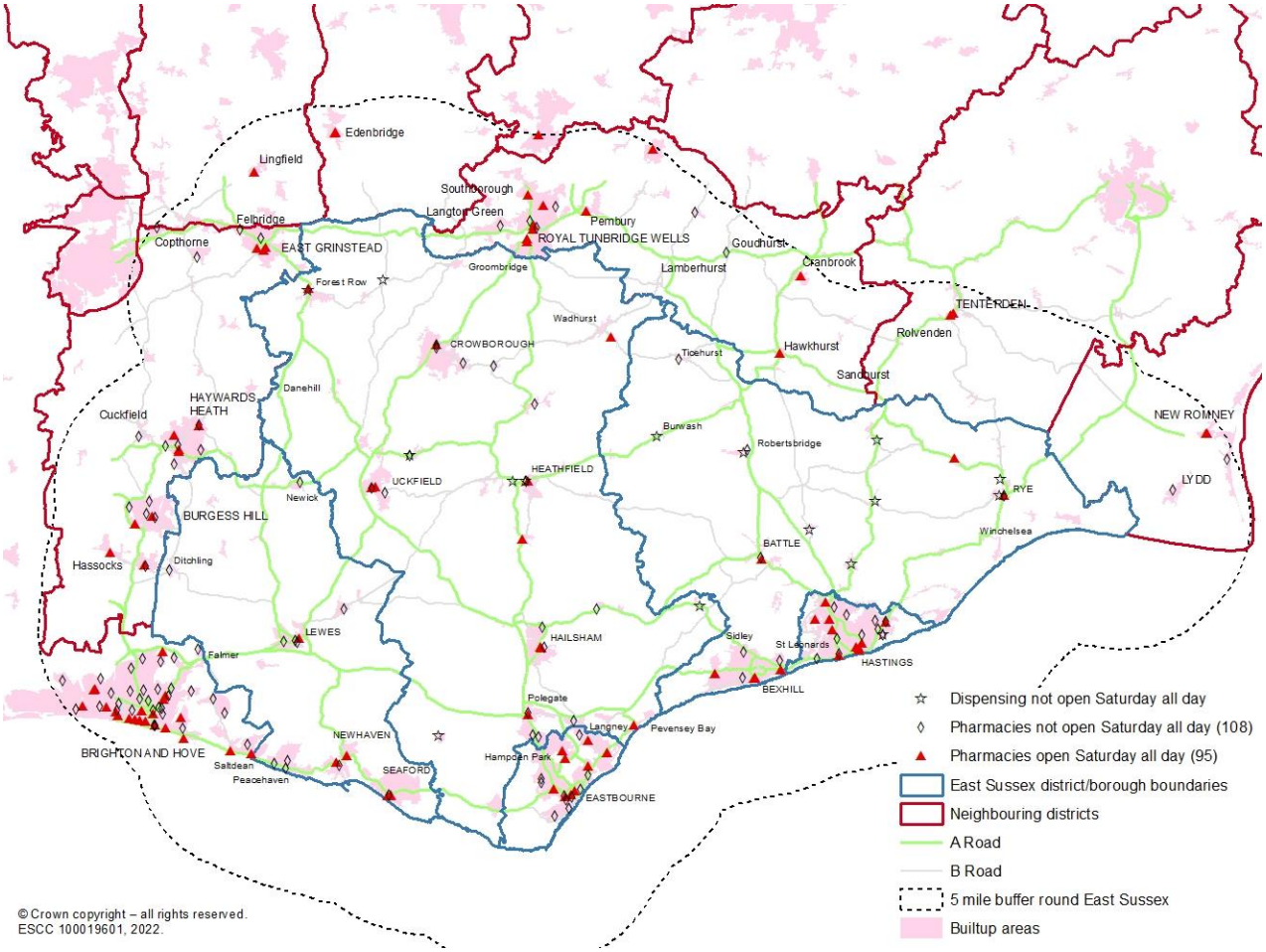
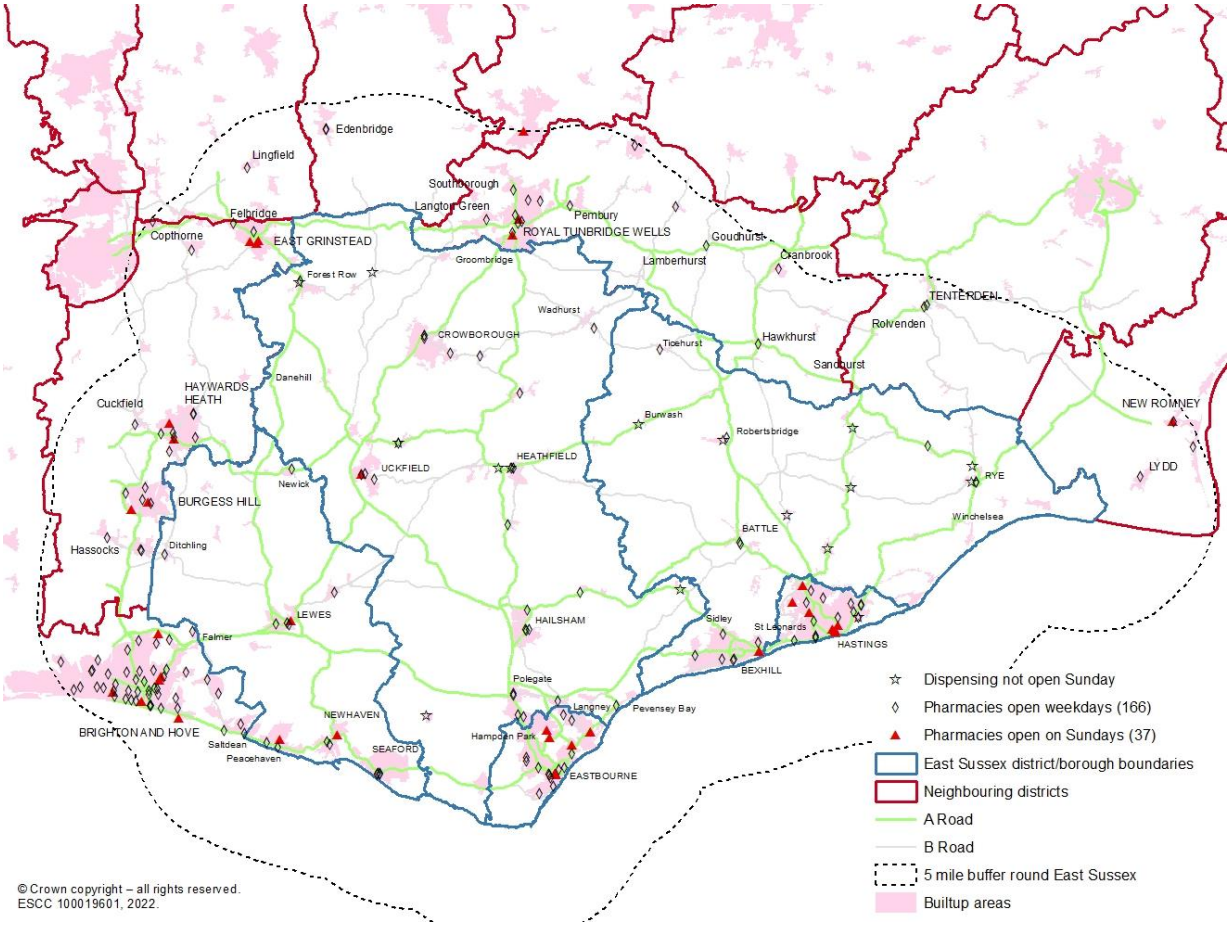


Figure 28 Pharmacies in East Sussex and neighbouring LAs open on Sundays



Pharmacy Access Scheme (PhAS)[144]

The Pharmacy Access Scheme is intended to support access where pharmacies are sparsely spread and patients depend on their services. The scheme will protect access in areas where there are fewer pharmacies with higher health needs so that no area need be left without access to NHS community pharmaceutical services. Please see Figure 29

A pharmacy is eligible for the PhAS payment if it meets all the following criteria:

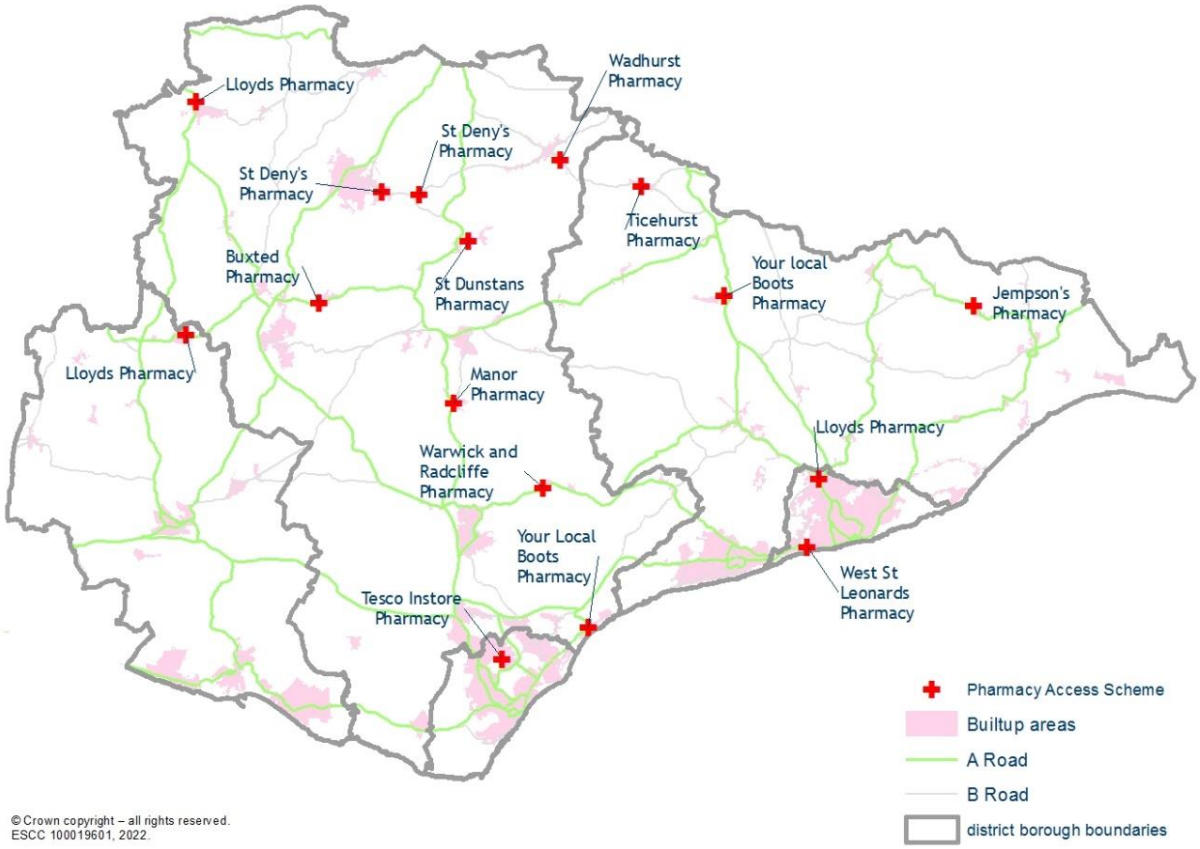
- the pharmacy is on the pharmaceutical list of 31 March 2021. Distance-selling pharmacies (DSPs), dispensing appliance contractors, local pharmaceutical services (LPS) contractors, and dispensing doctors are not eligible for PhAS
- the pharmacy is more than one mile from the next nearest pharmacy, based on pharmacy-to-pharmacy distance calculations using Ordnance Survey
- where a pharmacy is in a deprived area (the premises are in the area assigned to IMD decile 1 to 2), the distance to the next nearest pharmacy is reduced to more than 0.8 miles

- the pharmacy had a dispensing volume between 1,200 and 104,789 in 2019 to 2020. For pharmacies that opened after March 2019, a mixture of scaling and data from the following months will be used to get a full 12 months' volume
- the pharmacy premises are directly accessible to the public, that is, not in an area with restricted access (for example, beyond airport security)

For further details please visit [2022 Pharmacy Access Scheme | NHSBSA]

Grounds for Appeals are described in Appendix D.

Figure 29 Community pharmacies Eligible for the Pharmacy Access Scheme



6.6 Public Health Locally Commissioned Services

Locally commissioned public health and NHS services are an important part of the contribution community pharmacy makes to the health and wellbeing of the population. Although not part of the Community Pharmacy Contractual Framework, these are also presented in this section.

East Sussex County Council commissions pharmacies to provide a range of public health services. These include: Emergency Hormonal Contraception [EHC], C- Card and Chlamydia Screening, Stop Smoking Service, Needle and Syringe Exchange, Take Home Naloxone and Supervised Administration of Medicines. One You East Sussex, which provides services on behalf of East Sussex County Council, also subcontract NHS Health Check activity to community pharmacies in East Sussex.

Emergency Hormonal Contraception [EHC]

There is a very strong evidence base for the use of EHC in reducing unplanned or unwanted pregnancies, especially within teenage years. Its use forms part of an overall national strategy to reduce the rate of teenage pregnancy in England. Through this service, treatment is supplied under a patient group direction (PGD) to women. They must meet the criteria for inclusion stated in the PGD and the service specification.

EHC provided through community pharmacy is one of four access points along with primary care, online provision and specialist sexual health services. Whilst access via a community pharmacy may not be evident in all areas of East Sussex, this does not suggest access to EHC in general is an issue. Online provision introduced during covid has tended to replace lost access to face to face services during this period and the online option will remain. Teenage pregnancy and abortion rates in East Sussex are low, indicating a good use of contraception where people are sexually active and potentially less unintended and unwanted pregnancies in general.

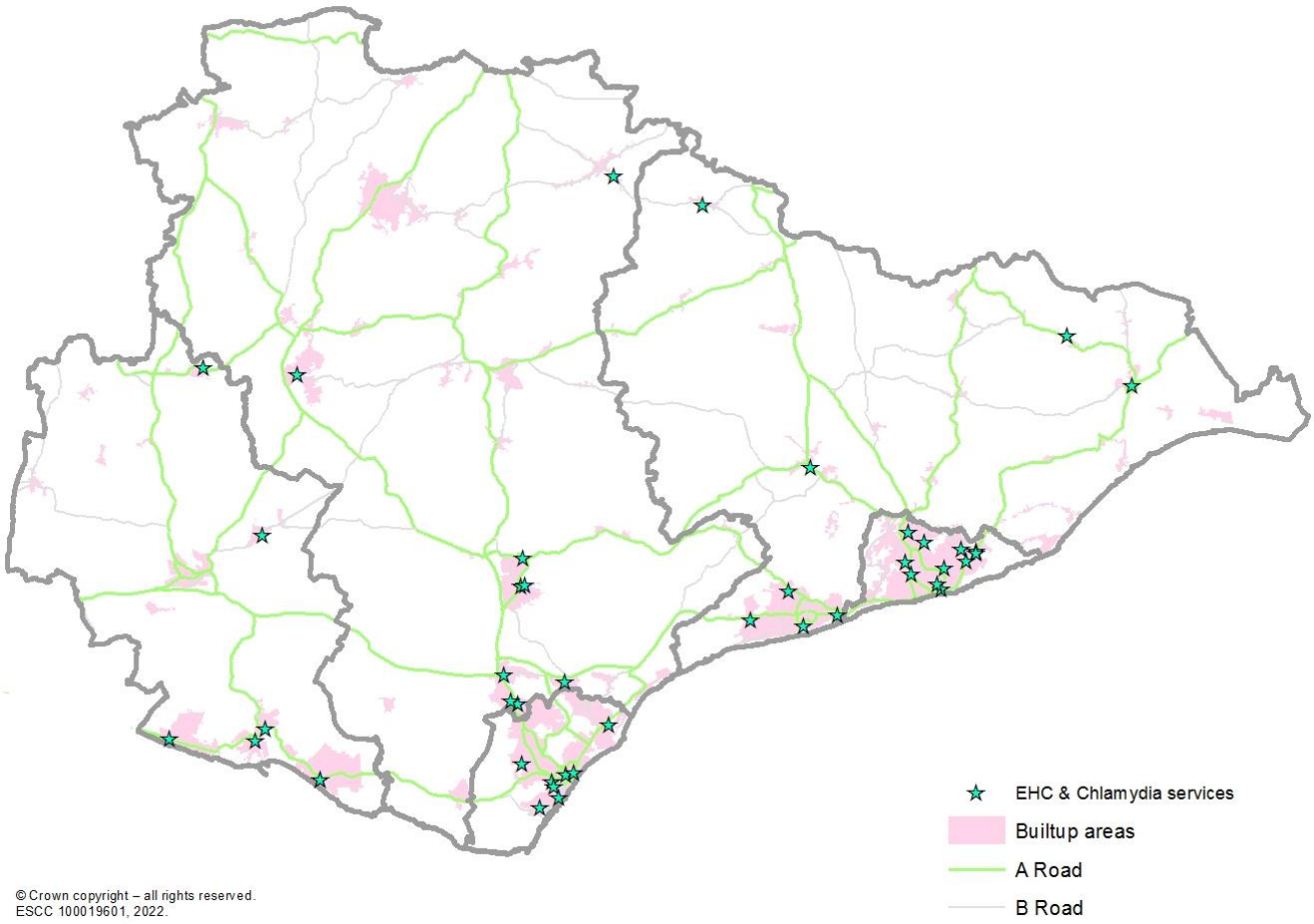
Sexual Health JSNA

A detailed account of the provision of sexual health services in community pharmacies can be found on pages 156 to 161 of the sexual health JSNA. Recommendations arising from the sexual health JSNA of relevance to community pharmacy development are:

- More effective awareness raising of sexual health services available in pharmacies and consideration of expanding provision to deliver health promotion messages better and to include oral contraceptive prescribing.
- In the market research in 2019, nearly three in five [59%] of women aged 16 to 44 said they would be interested in using a pharmacy to start or change their contraception.
- The promotion of self-sampling for HPV virus could be promoted in pharmacies if this were to be introduced in future, as it has been in the Netherlands and Australia.[145]

Pharmacies commissioned to provide emergency hormonal contraception [EHC] are shown in Figure 30.

Figure 30 Pharmacies commissioned to provide Emergency Hormonal Contraception [EHC]



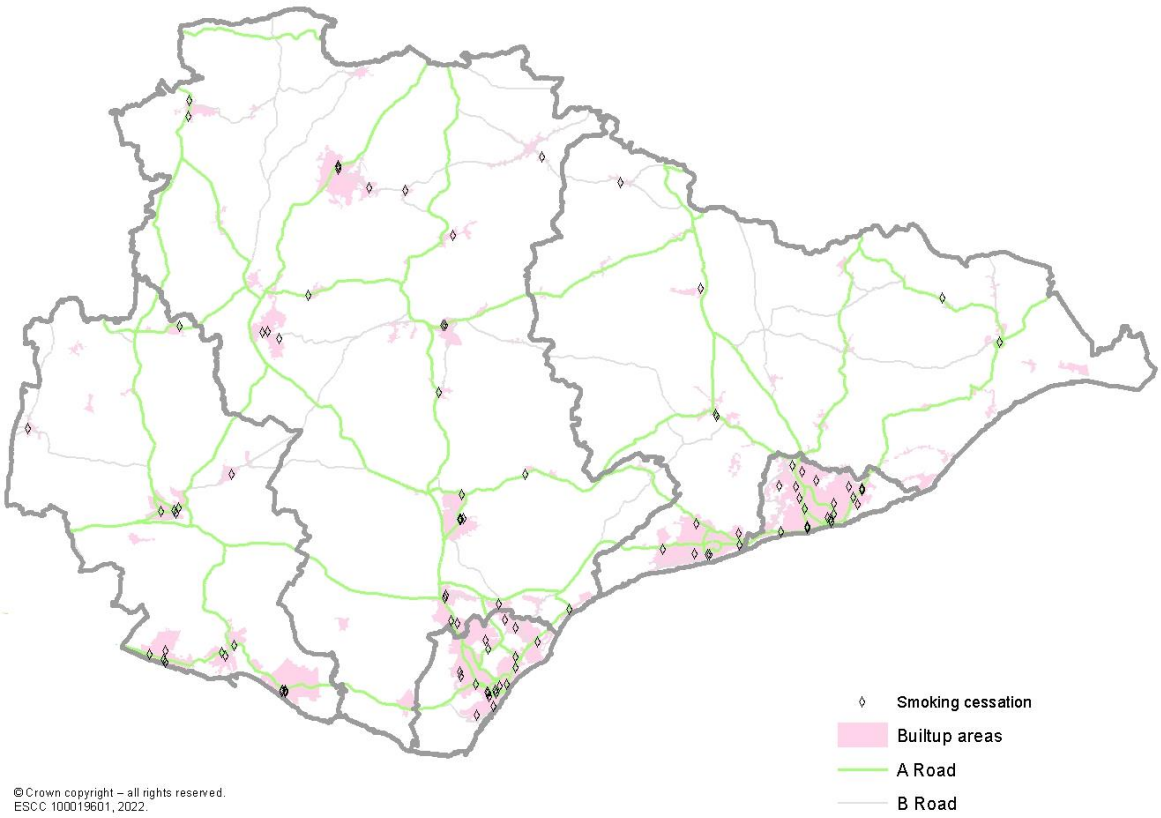
Smoking cessation

Pharmacies are commissioned to help patients continue with their efforts to stop smoking and are contributing to East Sussex becoming a smoke-free county by 2030 [aiming for a population smoking prevalence of less than 5%].[146,147,148]

NHS trusts can refer patients to a community pharmacy smoking cessation service when they are discharged from hospital.

Community pharmacists offering the stop smoking service can supply Champix [Varenicline] under a Patient Group Directive (PGD) to clients registered on stop smoking courses with One You East Sussex (OYES). The pharmacies commissioned to provide this service are shown in Figure 31.

Figure 31 Pharmacies commissioned to provide a smoking cessation service



Substance misuse: needle and syringe exchange and supervised consumption

An integral part of the harm reduction strategy for drug users are the needle and syringe exchange (NEX) service and the supervised administration of medicines. This involves the client consuming methadone or buprenorphine under the direct supervision of a pharmacist in a community pharmacy and at a given time interval.

Pharmacies are being encouraged to take up providing the opiate antidote naloxone. This first aid overdose treatment can be administered via an injection. There is also a formulation of naloxone which can be given via the nose in an emergency community setting.

Needle and syringe exchange aims to:

- Reduce the spread of blood borne pathogens e.g. Hepatitis B, Hepatitis C and HIV [149]
- Be a referral point for service users to other health and social care services

Direct supervision is a medicines adherence service which aims to:

- Reduce the risk of harm to the client by over or under usage of drug treatment
- Reduce the risk of harm to the local community by the inappropriate use of prescribed medicines via the illicit drug market
- Reduce the risk of harm to the community by accidental exposure to prescribed medicines

There is compelling evidence to support the effectiveness of supervised administration with long term health benefits to drug users and the whole population.

Needle exchange, the supply of Take-Home Naloxone and the supervised consumption of methadone/buprenorphine are commissioned by public health, East Sussex City Council.

The drug and alcohol service in community pharmacy is managed and delivered by CGL (Care, Grow, Live).

Substance misuse

People living in the most socio-economically deprived areas are more likely to be prescribed opioids.[150] A systematic review found that 4.7% of people prescribed opioids for pain went on to develop formally diagnosed misuse or addiction.[151] There could be between 1,400 and 2,500 people who are dependent on opiates in East Sussex.[152]

A new service for young people up to the age of 25 has recently been commissioned by ESCC. Pharmacists can signpost to this new service.[153]

The pharmacies commissioned to provide the needle exchange service are shown in Figure 32

Figure 33 shows pharmacies providing supervised medicine consumption and naloxone.

Figure 32 Pharmacies providing Needle Exchange service

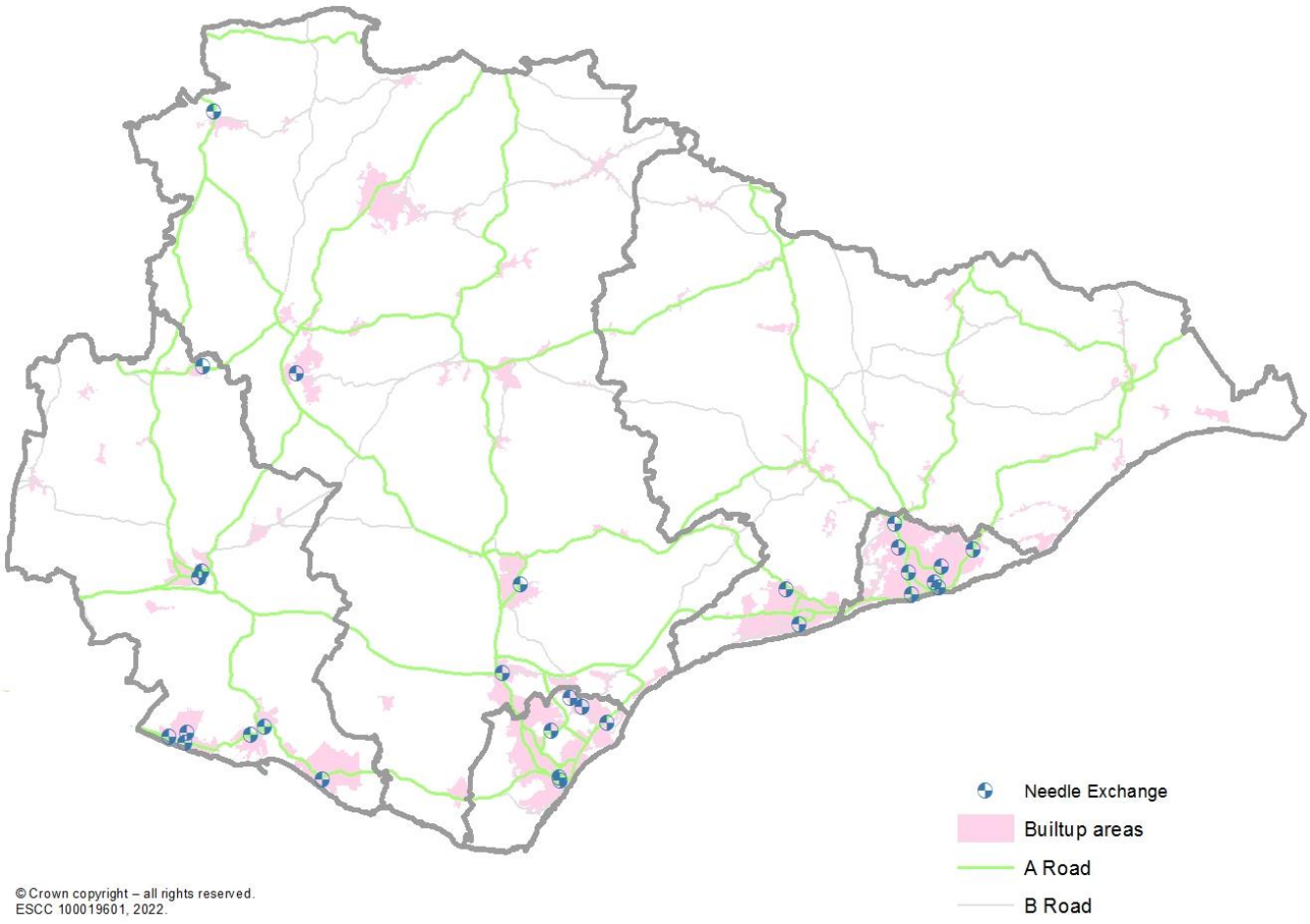
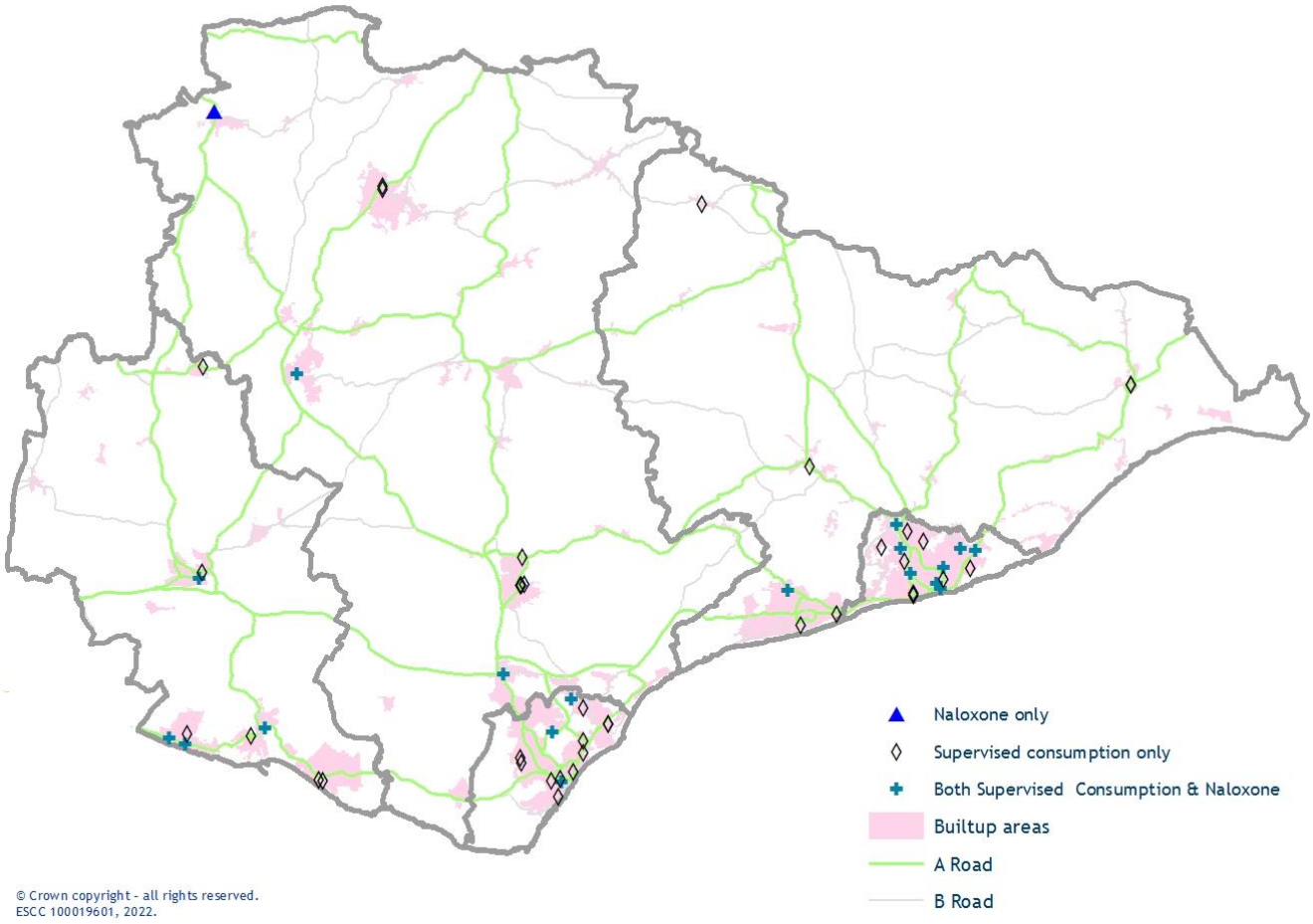


Figure 33 Pharmacies providing supervised consumption and naloxone services



The East Sussex Healthy Living Pharmacy [HLP] programme

Service availability across community pharmacy in East Sussex

HLP training provision

The programme remains committed to providing regular training and development opportunities for pharmacists and Health Champions.

Service specific training has covered the introduction of Patient Group Directives [PGDs] under the Emergency Hormonal Contraception [EHC] and Smoking Cessation Public Health Local Service Agreements.

The programme continues to work closely with partners and contractors to improve and enhance our training offers to meet the changing needs within community pharmacy.

Community Pharmacy Contractual Framework [CPCF]

With prevention now central to the NHS Long Term Plan, the CPCF recognises the value of community pharmacies in delivering a wide range of health interventions under the Healthy Living Pharmacy framework.

The HLP programme is supported by the NICE guideline, Community Pharmacies: promoting Health & Wellbeing. This quality standard covers how community pharmacies can support the Health & Wellbeing of the local population. It describes the overarching principles of good practice for community pharmacy teams.

The HLP programme also aims to support actions defined in the Joint National Plan for Inclusive Pharmacy Practice. The joint initiative aims to provide training and resources to develop and embed inclusive pharmacy professional practice into the ongoing care of patients and communities, to support the prevention of ill-health and address inequalities.

Plans and commitments for the East Sussex HLP programme

The Public Health supported Healthy Living Pharmacy programme came to an end in March 2021. It was agreed by partners that, rather than continuing to have a specific programme for supporting and undertaking work within community pharmacies, we would instead move to a business-as-usual approach to supporting the setting and ensure that it is considered a key setting when planning health improvement services and programmes.

6.7 Choice about obtaining pharmaceutical services

The 2013 Regulations require the Health and Wellbeing Board to have regard to whether there is sufficient choice regarding obtaining pharmaceutical services.

Key Questions:

What is the current level of access within East Sussex to pharmaceutical services?

A summary of the detailed travel time analysis follows.

What is the extent to which services already offer people a choice, and which may be improved by the provision of additional facilities?

This is discussed further regarding the responses in the Residents' Survey in early 2022 in Section Seven.

As of 30th June 2021, each resident has had the choice of using any of the 379 distance selling premises [DSPs] in England, all of which are required to provide all the essential services remotely to anyone, anywhere in England who may request them.

All pharmacies are now required to facilitate remote access to the pharmaceutical services they provide, to a reasonable extent, where people wish to access them remotely. This change was brought into the Terms of Service in 2021 and will take time to become embedded.

It is likely that this will be an attractive option for certain residents, but not all, as there will be those who do not have access to the internet or who prefer to access services on a face-to-face basis.

6.8 General Access to Pharmacy Premises

Key Questions:

How good is general access to pharmaceutical services within East Sussex localities? How does access vary by time of day and weekday vs weekend?

A summary of the travel time analyses follows.

When considering travel times to pharmacies the Steering Group considered a journey time of 30 mins one way, by car, public transport or walking to be acceptable.

The latest information relating to car ownership from the 2021 Census was not available at the time of compiling this report so data from the 2011 Census have been included.

6.9 Travel Times to Access Pharmacies

To assess whether residents can access a pharmacy in line with this travel standard, travel times were analysed using TRACC software to model travel times to a pharmacy at different times of the week, using different modes of transport (car, public transport, and walking). This model considers traffic flow and volume at different times of the week, as well as distance.[154]

Table 31 shows the percentage and number of people without access to a pharmacy within 30 minutes using different modes of transport.

Table 31 People without access to a pharmacy using each mode of transport.

	Opening	Hours	of pharmacy			East Sussex residents
	All day	Evening	Saturday morning	Saturday all day	Sunday	
BUS: No access within 30 mins	7.7% 42,800	22.7% 126,700	9.0% 50,300	11.3% 63,000	31.2% 174,300	% with no access Number with no access
Walking: No access within 30 mins	16.4% 91,900	39.9% 222,900	19.6% 109,300	29.5% 164,900	55.5% 310,200	Number of residents in 2020: 558,852
CAR: No access within 30 mins	0.01% 31	0.05% 256	0.01% 31	0.01% 40	0.41% 2,281	

Public Transport

Data for public transport were calculated both inbound and outbound and the two results were then compared to identify the maximum journey time in either one or the other direction.

Around 42,800 residents of East Sussex (7.7%) cannot physically attend any pharmacy (including dispensing GP surgeries) during the day on a weekday within half an hour using public transport, and 29,300 of these people (5% of the county's population) cannot access any pharmaceutical provision at all [within two hours] using this mode of transport.

Access to pharmacies during the day, using public transport, is similar to 2019, when 41,500 residents (7.5%) were unable to access a pharmacy within 30 minutes, and 28,200 (5%) had no access. This may be because of changes to public transport provision or because of a decline in the number of pharmacies. This has reduced from 240 in 2019, to 223 in 2022. (The total includes dispensing pharmacies in GP surgeries and pharmacies in neighbouring local authority areas within a five-mile buffer zone).

Evening access has been defined in this report as premises open on at least three or more weekday evenings after 6 p.m.. The number (126,700) and proportion (23%) of people unable to access a pharmacy within 30 minutes using public transport rise considerably in the evenings (up from 88,000 in 2019). An estimated (81,600) people (15%) have no access at all using public transport within two hours (up from 52,300 in 2019). This calculation includes the GP surgeries which have their own dispensaries. In 21 wards, more than three quarters of the population cannot access a pharmacy within two hours using public transport in the evening. The number of pharmacies open in the evening has declined from 97 in 2019 to 84 in 2022. (The total open includes the nine GP surgeries that do provide a dispensing service on some weekday evenings).

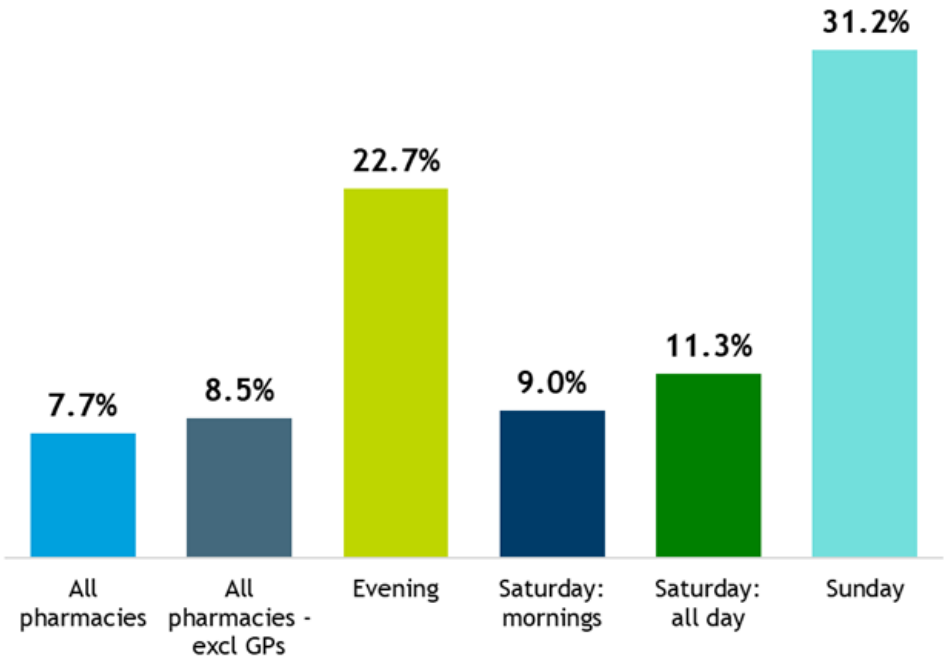
On Saturdays, more pharmacies are open in the morning (184) than are open all day (95), and this is reflected in accessibility using public transport. While 50,300 people (9.0%) cannot access a pharmacy in the morning within 30 minutes, this rises to 63,000 (11.3%) in the afternoon, with 37,900 (6.8%) having no access at all [within two hours] at any time on a Saturday.

Access on a Sunday is more of a challenge, with nearly a third of people in the county (174,300 or 31%) unable to get to pharmacy within half an hour using public transport, and 76,800 (14%) with no access at all [within two hours]. Access in Wealden and Rother on a Sunday is worst where more than half of residents live more than 30 minutes from a pharmacy, (57% in Rother and 56% in Wealden). In Rother, a third of people (32%) cannot access a pharmacy at all [within two hours] using public transport on a Sunday, and in Wealden (20%). Note that the number of pharmacies open on a Sunday has declined from 48 in 2019 to 37 in 2022.

People may run out of medicines and for some this may potentially cause an issue. This is therefore one benefit of the new Community Pharmacy Consultation Service for providing replacement medicines when referral is made via 111. The hospital pharmacy can dispense to patients seen in A&E [as can the out of hours service from its own limited formulary].

The percentage of people who cannot access a pharmacy within 30 minutes using public transport is shown in Figure 34.

Figure 34 People who cannot access a pharmacy within 30 minutes using public transport]



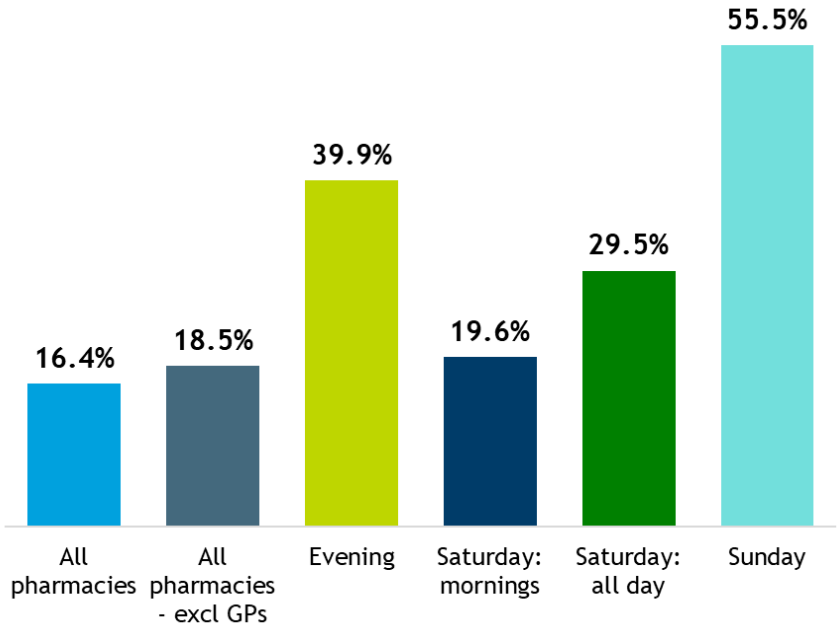
Walking

84% of East Sussex residents live within a half-hour walk of a pharmacy which is open on a weekday (including dispensing pharmacies in GP surgeries) during the day. However, this means that 91,900 people (16%) cannot access any pharmaceutical provision by walking for 30 minutes. These proportions are similar to 2019, when 95,700 (17%) were further than half an hour's walk from a pharmacy. If we exclude dispensing pharmacies at GPs surgeries, 103,600 people (19%) cannot access a pharmacy on a weekday within half an hour's walk.

In the evenings, 40% of residents (222,900) live more than 30 minutes' walk from a pharmacy (including dispensing GPs surgeries). While 20% (109,300) cannot access provision on a Saturday morning, this rises to 30% (164,900) all day on a Saturday.

Access on a Sunday is poorest, with more than half of the population (56%, or 310,200 people) unable to walk to a pharmacy within half an hour, up from 53% (294,900 people) in 2019. The percentage of people who cannot access a pharmacy within 30 minutes' walk is shown in Figure 35.

Figure 35 People who cannot access a pharmacy within 30 minutes' walk



Car

When looking at car journeys, we have added 5 minutes to each trip to account for the time taken to find a parking space, park and secure a car, in line with Department for Transport (DfT) journey time data.

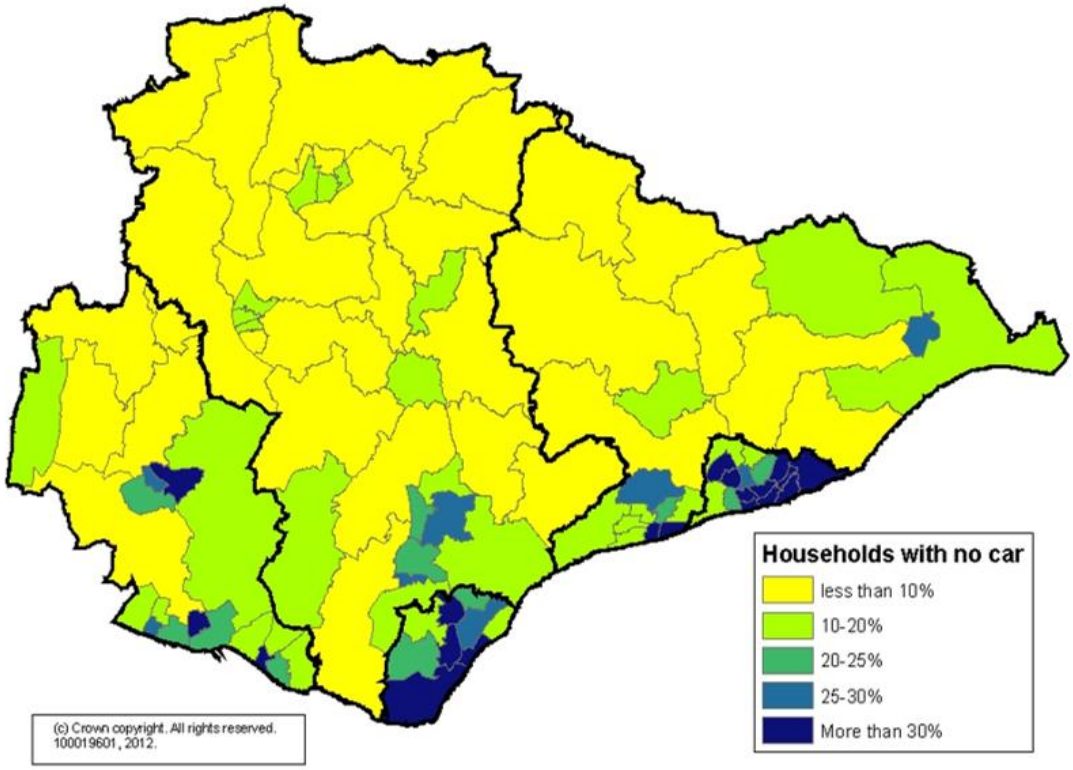
On a weekday, 0.01% of East Sussex residents (31 people) cannot drive to a pharmacy (including dispensing pharmacies in GP surgeries) within 30 minutes and it makes no difference if we exclude dispensing GPs surgeries. 256 (0.05%) are further than 30 minutes' drive from a pharmacy (including dispensing GPs surgeries) in the evening.

At weekends there are 31 persons (0.01%) unable to access a pharmacy by means of a car within 30 minutes on a Saturday morning, and this is similar in the afternoon with 40 persons (0.01%).

0.41% of East Sussex residents cannot access a pharmacy within 30 minutes on a Sunday, 2,281 people. Most of these residents are in Rother district with 1,914 (1.98%) of residents unable to access a pharmacy on a Sunday within 30 minutes' drive.

The percentage of households without a car in East Sussex in 2011 by ward is shown in Figure 36.

Figure 36 Percentage of households without a car in East Sussex in 2011 by ward



Source 2011 Census

The proportion of households without a car by local authority in 2011 is shown in Table 32.

Table 32 Households without a car in 2011

	All households		Households without a car		% of households without a car	
	All households	Pensioner households	All households	Pensioner households	All households	Pensioner households
Eastbourne	45,012	12,468	12,911	5,670	28.7%	45.5%
Hastings	41,159	8,249	13,693	3,961	33.3%	48.0%
Lewes	42,181	11,948	8,488	4,223	20.1%	35.3%
Rother	40,877	13,939	7,781	4,577	19.0%	32.8%
Wealden	62,676	17,767	7,801	4,926	12.4%	27.7%
East Sussex	**231,905**	**64,371**	**50,674**	**23,357**	**21.9%**	**36.3%**

Source: 2011 Census, ONS

6.10 Travel times summary

Car

Overall, car owners can reach a pharmacy within 30 mins one way travel time at any time of the week, although around 2,300 people (0.4% of the population) would have to drive more than 30 mins on a Sunday.

However, not everyone owns a car, so how does access change if you have to access a pharmacy by public transport or walking?

We looked at **wards where more than 15% of people don't have access to a car** and then considered travel times to pharmacy by public transport and walking at each time period.

Public transport

In terms of public transport, the picture differs between the rural and urban areas of the county. There is not an issue for most people regarding access to a pharmacy using public transport during weekdays or at weekends in the urban areas of Eastbourne or Hastings.

In Lewes District: looking at those wards where more than 15% of people don't have access to a car,

- Weekdays, 352/27,812 (1.3%) of people resident in those wards don't have access to a pharmacy within 30 minutes.
- Weekday evenings, 5,222/40,476 (12.9%) of people don't have access to a pharmacy within 30 minutes.
- Saturday mornings, 435/27,812 (1.6%) of people don't have access to a pharmacy within 30 minutes.
- Saturday afternoons, 491/35,520 (1.4%) people don't have access to a pharmacy within 30 minutes.
- Sundays, 7,599/53,713 (14.1%) people don't have access to a pharmacy within 30 minutes.

In Rother District: looking at those wards with low car ownership,

- Weekdays, 2,203/27,062 (8.1%) of people don't have access to a pharmacy within 30 minutes.
- Weekday evenings, 21,699/41,545 (52.2%) of people don't have access to a pharmacy within 30 minutes.
- Saturday mornings, 2,263/27,062 (8.4%) of people don't have access to a pharmacy within 30 minutes.
- Saturday afternoons, 2,867/27,062 (10.6%) of people don't have access to a pharmacy within 30 minutes.
- Sundays, 21,040/41,471 (50.7%) of people don't have access to a pharmacy within 30 minutes.

In Wealden District: looking at wards with low car ownership:

- Weekdays, 786/29,302 (2.7%) of people don't have access to a pharmacy within 30 minutes.
- Weekday evenings, 1,753/38,201 (4.6%) of people don't have access to a pharmacy within 30 minutes.
- Saturday mornings, 527/29,302 (1.8%) of people don't have access to a pharmacy within 30 minutes.
- Saturday afternoons, 880/29,302 (3.0%) of people don't have access to a pharmacy within 30 minutes.
- Sundays, 16,971/38,201 (44.4%) of people don't have access to a pharmacy within 30 minutes.

Walking

However, we acknowledge not everyone can [or will be able to] afford public transport, so we also looked at walking time in those wards with low car ownership, during the daytime in the week.

Eastbourne Borough: a total of 587 people living in a ward with low car ownership could not access a pharmacy by walking for 30 minutes or more one way [Meads, Old Town and Ratton wards].

Hastings Borough: a total of 242 people living in a ward with low car ownership could not access a pharmacy by walking for 30 minutes or more one way [in Ore and West St.Leonard's wards].

Lewes District: a total of 3,368 people living in a ward with low car ownership could not access a pharmacy by walking 30 minutes or more one way [in East Saltdean and Telscombe, Lewes Bridge, Lewes Priory, Newhaven Denton, Peacehaven East, Seaford East , Seaford North and Seaford South].

Rother District: a total of 6,370 people living in a ward with low car ownership could not access a pharmacy by walking 30 minutes or more one way [in Battle Town, East Rother, Rye, Sidley and St.Michael's wards].

Wealden District: a total of 1,285 people living in a ward with low car ownership could not access a pharmacy by walking 30 minutes or more one way [in Hailsham Central, Hailsham East, Hailsham South, Polegate North, Uckfield New, Uckfield North and Willingdon].

7. East Sussex Residents' Survey 2022

7.1 Background and sample

The Residents' Survey report consists of two parts. The first part examines responses for the whole county and examines variances across the five districts/boroughs. Whilst the second examined the differences between those who use GP located pharmacies, those who collect their prescriptions from pharmacies elsewhere, and those using online services.

A total of 2,002 telephone interviews were conducted with East Sussex residents between early January and mid-February 2022.

Quotas were set for age, gender, and working status to match the population across the five district councils or boroughs of Eastbourne, Hastings, Lewes, Rother, and Wealden. In total, the number of interviews achieved by council district/borough were: Eastbourne 400, Hastings 401, Lewes 400, Rother 400 and Wealden 401. The demographic make-up of the sample is shown below, compared with East Sussex estimates, Table 33.

Table 33 : Demographics of respondents and representativeness of residents' sample

Gender	No. respondents	% in sample	E. Sx % ONS	E % in sample	H % in sample	L % in sample	R % in sample	W % in sample
Male	952	47.6	48.5	45.2	49.4	48.0	44.5	50.6
Female	1,050	52.4	51.5	54.8	50.6	52.0	55.5	49.4
Total respondents	2,002	100	100	100	100	100	100	100
Age group								
16-17 years	19	0.9	2.6	0.8	1.2	0.8	0.5	1.5
18-24 years	192	9.6	7.7	10	12	8.5	7.3	10.2
25-44 years	524	26.2	24.6	27.8	32.4	24.5	21.0	25.2
45-59 years	512	25.6	25.5	24.5	22.9	28.0	26.8	25.7
60 years+	755	37.7	39.6	37.0	31.4	38.3	44.5	37.4
Total respondents	2,002	100	100					
Working status								
Working full time	563	28.1						
Working part	537	26.8						

Gender	No. respondents	% in sample	E. Sx % ONS	E % in sample	H % in sample	L % in sample	R % in sample	W % in sample
time								
Not working	902	45.1						
Total respondents	2,002	100.0						
Ethnic group								
White	1,832	91.5	91.7%					
Non-white	170	8.4	8.3%					
Prefer not to say	0	0.0	0					
Total respondents	2,002	100.0	100.0%					
Additional needs								
Carer		6%	11%					
Physical disability		4%	11%					
Communication needs		3%	Sight loss 4.5% Severe hearing loss 3%					

The proportions of gay men [3.5%] and gay women [3.6%] in the sample are within the expected range for the population. [Ref LGBT JSNA 2022].

Whilst the survey included 3% of the population with communication needs we recognise that the figure could be higher because people may have communication difficulties other than sight loss and severe hearing loss.

7.2 Summary findings

Where people go for prescriptions

- More than three-quarters (77%) of our county-wide sample are most likely to use a pharmacy or chemist's shop to pick up their prescription. This clear dominance of pharmacies and chemists is apparent in all areas but is highest in Hastings (84%) and is lowest in Rother (68%).
- Overall 8% are most likely to use a GP's practice dispensary, but this is predominately in in the rural districts of Rother (20%) and Wealden (15%) with 0-2% using in Eastbourne, Hastings and Lewes.

How people get their prescriptions

- 7% have a delivery from their usual pharmacy and 8% use other methods, such as online. Delivery from their usual pharmacy peaks at 15% in Eastbourne, and lowest in Wealden (4%).
- More than 80% of all respondents collect their medicines, with 8% having them delivered free, and the balance (7%) paying for their delivery. Delivery is not an NHS funded service.

Frequency of visit to a pharmacy

- 16% of residents visit a pharmacy several times monthly, with 4 out of 10 typically visiting once a month. At the other end of the scale, almost one-in-ten (8%) have not visited a pharmacy in the last 12 months. There is little variance of these behaviours across the five district council areas.

Access to pharmacies

- A significant majority of respondents (81%) most commonly use pharmacies between 9am and 6pm Monday to Friday (range: 77% Wealden – 86% Hastings)
- The remaining 19% are split between 9% using pharmacies after 6pm (range: 5% Rother – 12% Eastbourne) and 10% at the weekend (range: 5% Hastings -16% Wealden)
- Over 90% say their needs are met by those opening hours (range: 88% Hastings – 94% Wealden)
- Respondents generally find it easy to find an open pharmacy during the day (89% rate this as 'good' (range: 87% Eastbourne – 92% Hastings)
- Only half (52%) rate finding an open pharmacy at the weekend as 'good' (range: 45% Rother - 62% Eastbourne)
- Access to a pharmacy on Bank Holidays is more challenging with 41% overall rating as good (range: 38% Rother – 44% Wealden), with 28% rating this as 'poor'.(range 26% Hastings – 30% Rother)
- Even fewer (just 30%) rated finding an open pharmacy in the evenings as 'good' (range 25% Wealden – 35% Lewes) with 1-in-5 rating being able to do this as 'poor'
- 6% said they helped either a friend or adult family member to use pharmacy services

Quality of advice and service

- 60% of all respondents who attend a chemist rate the advice they receive from pharmacies/chemists as 'good', with another 33% rating this advice as 'fair'
- Those using a GP's practice dispensary, 95% rated the advice they receive as 'good'
- Two-thirds (67%) agreed their pharmacist gives them clear advice on how their medicines should be taken
- More than 8 of out 10 of our respondents (82%) agreed that their pharmacist provides a good service, with just 2% disagreeing

Awareness of other pharmacy services

- Almost 4 out of 5 (78%) of all respondents were aware of Flu vaccines being available from their local pharmacy, and this was quite consistent across all areas
- Well over a half (58%) of all respondents were aware that they could obtain Urgent supplies of their medicines if they run out, there were only minor variances in this figure across our five districts
- A little under half (47%) were aware of stop smoking advice being available from their local pharmacy. Once again, the level of awareness did not vary significantly across the county
- (61%) agreed that if they wanted to, they could speak to their pharmacist without being overheard
- Around a half (51%) agreed they prefer to see their regular pharmacist than someone they don't know

Just 1% of respondents had stopped using a pharmacy due to service provision issues.

7.3 Qualitative findings

The 15% of people who had their medicines delivered were asked why.

- The most common reasons were related to 'convenience', 'ease of ordering', 'saving time', and the fact that if they were using an online pharmacy it was 'part of the service'. There were some comments about 'poor service' in pharmacies and so delivery was something that avoided receiving that poor service. The closure of pharmacies was mentioned as factor for moving to delivery by Hastings residents (9 times) and Lewes residents (2 times).

The 6-12% of people in each district and borough who said that opening hours did not meet their needs were asked why they said this.

- The highest number of comments on opening hours came from Hastings (47) and Eastbourne (39) with fewer from Lewes (27), Rother (28) and Wealden (25)
- The most common themes for each district and borough were around the lack of evening openings or weekend availability
- Many who were working full-time found it difficult to use the daytime weekday pharmacies, particularly during the pandemic when restrictions allowed pharmacies

to shut for two hours at lunchtime. (Note the opportunity to change opening hours during the COVID-19 pandemic to allow for infection control cleaning etc.is no longer in place)

- Again, there were specific mentions about the recent closures of pharmacies from Hastings

We asked those people who were looking after someone who was terminally ill what difficulties they had experienced with accessing specialist medicines to manage their lives.

- 27 out of 39 responses had no issues to raise, there were however some concerns about the availability of medicines (9) and levels of customer care and customer service (2) and one comment on finding an open pharmacist from Hastings

The 1-2% of people who had stopped using pharmacies were asked why they either avoided using them or had stopping using them: the key themes here were again around general poor attitudes of some staff, stock control problems, and issues with queuing during COVID-19.

We asked respondents for suggestions as to how their local pharmacy could improve their medicine and health services

- It should be noted that in each of the five districts more than 75% of respondents had no suggestions to make
- Whilst there were a number of positive comments made in all five locations, often suggestions for improvement related to the 'quality of the staff' or the 'level of service' i.e. waiting times or phone answering'
- There were more critical comments around things such as 'poor service', 'unfriendly staff', 'queuing', and lack of advice from the pharmacist
- 'Lack of privacy' (3/27)
- Some of these issues were attributed to how busy the staff were, due to the pandemic, but others were less forgiving suggesting a more general lack of care or interest from staff members

We went on to ask those respondents who said that they had access needs relating to a physical disability [4% of the sample] to outline why their pharmacy does not meet their needs.

- The most common theme related to car parking availability, size of signage, and no seating to wait on

We then went on to ask those respondents who said that their pharmacy never meets their communication needs [3% of the sample] why they say that.

- The more common responses were around wanting staff to be 'more patient and understanding', or to 'listen more to their needs'. In one respondent this was where English was not their first language and in one where they also had a hearing impairment as well

- Mask wearing, along with screens, as part of the NHS COVID-19 infection control procedures, has also impacted some interpersonal communication between some members of pharmacy staff and customers

Those who said their pharmacy sometimes or never met their needs as a carer, were asked to give some more details [6% of the sample].

- Queuing' seemed to be perhaps the most common issue, and the need for the pharmacist to see the patient in person was mentioned several times

Finally, we asked all respondents for any suggestions they might have for how their local pharmacy could improve the way they meet their needs and provide them with support

- The majority of respondents had no comments to make, 341 comments were received in total from all districts with most coming from Hastings (80), followed by Lewes (72), Eastbourne (69), Wealden (66) and fewest from Rother (44)

In additional to the [107] compliments, comments covered a wide range of topics. The most often mentioned themes were 'opening hours', especially 'evening hours', general levels of 'customer service' or staff 'attitudes', along with some 'privacy issues'.

Summary of responses from East Sussex residents online

East Sussex residents were also given the opportunity to comment on an online version of the same survey. They were directed by the market research organisation to this online version which appeared on the ESCC consultation page.

There were 30 responses present of which 22 were from Hastings residents, five from Rother and one each from Eastbourne, Lewes, and Wealden local authorities.

The strength of feeling about the loss of the community pharmacy in St.Leonard's was very clearly expressed, as was the strong support for the professional, high-quality service received from the pharmacist.

There remains the possibility of some degree of response bias. Some of these people may have been directed to the ESCC website survey link by other local residents and not contacted directly by the market research company.

7.4 Discussion and conclusions

Variation in place of getting prescription was clearly influenced by the rural or urban nature of districts. Use of online pharmacies is still relatively low but delivery is seen as a convenient option for most, although some in Hastings and fewer in Lewes saw it as necessary due to closure of pharmacies near them. Please see section 10 for number of pharmacies per head of population.

Overall most respondents were happy with weekday opening hours, and felt their needs were met (90%). This satisfaction was slightly lower (88%) in Hastings, despite also being the district with the highest proportion of people saying it was easy to find a pharmacist during the day (92%).

Satisfaction with opening times for different periods is significantly lower than weekdays: weekends (52%); bank holidays (41%) and evenings (30%).

The qualitative findings also identified evening opening as a key issue, particularly amongst the employed.

Thirty-nine percent of respondents felt that they could not speak to their pharmacist in private if they wanted to. This is a clear area for improvement, particularly in raising patient awareness of the availability of the pharmacy consultation room area for private conversations.

7.5 ESCC reference group for adults with a learning disability.

Adults with a learning disability were given the opportunity to complete the Residents survey with the assistance of an advocate.

There were nine completed responses to the survey.

E[1]; L [1]; H[4]; R [1]; W[2]. Two of the respondents also had physical disabilities.

- Each person states that information about medicines should be in an accessible format

From the replies we all agree that information about medicines should be accessible. Medicines information is outside of scope of PNA, however.

We will produce any future surveys in an accessible format.

8. Community pharmacy provider survey January 2022

8.1 Background and response rate

The purpose of the community pharmacy survey was to find out about areas that would not be covered in the routine national survey undertaken by pharmacies annually, for example implementation of the NHS accessible information standard, and the provision of facilities for people with additional needs.

To give insight into meeting future needs and demand, pharmacies were also asked about capacity to take on more workload, and two priorities for future services.

46/99 community pharmacies in East Sussex responded to the online survey in January 2022, a response rate of 46%. The response rate is slightly lower than the previous survey when 50% responded.

8.2 Summary findings

We asked about the facilities and services pharmacies provide:

Access for disabled customers at the pharmacy premises

- Most pharmacies reported that there was easy access for disabled customers at the pharmacy premises, including wheelchairs [43/46]. No further clarification was given
- None of these pharmacies in Q3 reported difficulties with meeting the NHS accessible information standard in Q4

Home delivery of dispensed medicines – Note that this is not an NHS commissioned service.

Nine stated they are not planning to do this. One may have to start charging because the demand is large

Implementation of the NHS Accessible Information Standard

- Most responding pharmacies [43/46] stated that they did not have any difficulty with implementing the NHS Accessible Information Standard
- Of the three that reported difficulty, one mentioned that large print was fine but Braille and interpreter services were more difficult. Another mentioned [the need for] ongoing training

Current and future service provision:

- The majority of respondents [30/46] stated that they had sufficient capacity to manage an increase in demand. This is discussed further in the Gap Analysis in Section 10
- A smaller proportion [9/46] stated they could adjust to an increase in demand
- A minority [7/46] said they would have difficulty currently managing an increase in demand

Vision for future services (Responses have been grouped into themes). Please see Appendix E

- Meeting Population needs
- Promoting health and wellbeing
- Access
- GP Community Pharmacy Consultation Service [referrals]
- Pharmacy immunisations / Developing vaccination services
- Developing advanced services
- Improving services
- Supporting and improving primary care locally
- Managing COVID
- Staff training
- General store staff management and stock control
- Funding and commissioning being improved

8.3 Discussion and conclusions

With a response rate of less than 50% there may be an element of response bias and potentially not being representative of all community pharmacies.

The majority of pharmacies felt they could deal with additional demand, which may seem at odds with responses in the residents' surveys which identified waiting times to be served as an issue. However, the residents' survey was carried out when COVID infection control procedures were in place which did cause temporary increases in queuing.

Similarly, 43/46 (93%) of the pharmacies said that they provided easy access for disabled customers but of the 89 people with a physical access need in the total sample of 2,002 only [57/89] 64% of residents with physical accessibility needs said their access needs were met.

There is an interest from many community pharmacies in expanding their role although staff training and funding are also themes mentioned as needing addressing.

The supply of medicines

NHS regulations require all NHS prescriptions to a pharmacy to be dispensed but the law does not oblige manufacturers and wholesalers to meet these orders.

There are national guidelines for managing medicines supply and shortages.[155]

As an example of manufacturer supply issues there have been recent concerns regarding the availability of Hormone Replacement Therapy.

In a recent survey by the PSNC there were supply chain and medicine delivery issues for two thirds of pharmacies on a daily basis, and almost all pharmacies reported additional workload and stress for these reasons. Three-quarters of pharmacies reported experiencing aggression from patients related to supply issues.[156]

9. GP Dispensaries Survey January 2022

9.1 Background and response rate

This survey was made available to the GP dispensaries via the ESCC online portal in January 2022, and practices were encouraged to respond to the 2022 Survey by the LMC. Survey questions were different to the community pharmacy survey, focussing on dispensaries' business continuity plans and dispensary opening hours as this information was not apparent from all practice websites.

Five responses were received from GP dispensaries [out of 13 dispensing practices]. This is a much lower response rate than in 2017 when all but one responded. In the previous PNA 'phone calls were made to dispensary managers to complete a semi-structured interview.

Does your GP dispensary have a business continuity plan in the event of urgent closure?

- All of the responding dispensaries have a business continuity plan and gave details of the organisations that they would inform if their plan were to be implemented.

When is your dispensary open?

- All the GP dispensaries are open during weekdays. None are open at weekends.
- In Rother and Wealden districts the majority (9/15) of practices with GP dispensaries are open in the evening after 6pm, and the dispensaries have the same hours.

What would be your top two priorities for developing the service in the dispensary you work in?

Chasing to follow items

More space (x2)

Ensuring availability of medicines through various wholesalers

Turnaround

Service to the customers. Improve serving area

Minimizing significant events

Continue CPD to enhance service provided

Opening times

Is there a particular need for a locally commissioned pharmacy service in your area?

None were mentioned

9.2 Discussion and conclusions

There are no plans to change the arrangements for GP dispensing in the foreseeable future. Patients using GP dispensaries report receiving a good service in the residents' survey. GP dispensaries are not open at weekends.GP dispensaries may wish to review their opening hours if surgery hours are extended.

10. Gap analysis

10.1 Approach

The Regulations do not specify how the Health and Wellbeing Board identifies any gaps. National guidelines have informed the East Sussex PNA 'Gap Analysis'.

There are three ways in which gaps may be defined:

1. **geographical gaps in the location of premises- are premises in the right locations? Are there any current gaps in the spread of premises?**
2. **geographical gaps in the provision of services- are necessary services in the right places?**
3. **gaps in the times at which, or days on which, services are provided**

The following criteria were agreed by the Steering Group with regard to identifying gaps:

- All parts of the population should have access to a **physical** community pharmacy. (Internet pharmacies and Dispensing Appliance Contractors (DACs) will be recorded but will not be part of the gap analysis)
- Pharmacies located outside the borders of East Sussex and dispensing GP practices within East Sussex will also be regarded as potential providers of access for the purpose of the gap analysis
- The majority of the population should be within 30 minutes travel time of the above providers, so driving, walking and public transport time will be considered
- Areas of low car ownership (where 15% or more of households are without cars) should be identified and examined for acceptable walking and / or public transport access
- Reasonable access to palliative care drug services across East Sussex should be assessed by CCG colleagues
- Locations where the construction of 2,000 or more dwellings is planned in the period April 2022 to October 2025 should be identified and the prospective needs of these new build areas considered
- This projection of gaps in general access for new build areas in each locality should, as far as possible, apply the same criteria in the attempt to predict the emergence of gaps in pharmaceutical services in the future (by October 2025)

These criteria are broad and practical, to be viewed as aids in assessment, rather than as rigid tools, for all information collated about pharmacies and to be interpreted in the context of the socio-demographic and health profile of the population.

In the travel analyses we have taken into account that there may be some residents of East Sussex, both now and within the lifetime of the document, who may not:

- have access to private transport at times when they need to access pharmaceutical services

- be able to use public transport, or be able to walk to a pharmacy, or have access to the internet

The COVID-19 pandemic has substantially increased the use and acceptance of remote consultations within primary care.

For the above residents, some but not all, will be able to access pharmaceutical services remotely either via:

- the delivery service that Distance Selling Premises (in East Sussex and those in the rest of England) must provide or
- the private delivery service offered by some pharmacies and
- remote access (via the telephone or online) to pharmaceutical services that all pharmacies are now required to provide

Necessary services- current provision outside the East Sussex area

Some residents choose to access contractors outside East Sussex Health and Wellbeing Board's area to access services:

- Offered by Dispensing Appliance Contractors
- Offered by Distance Selling Premises
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Patient choice about obtaining pharmaceutical services

We have looked at travel analyses, use of online pharmacies and the Residents' survey to inform our consideration of patient choice.

10.2 Geographical distribution of pharmacies

Table 34 shows the number of pharmacies per 100,000 population by district within East Sussex, and the number of people over 30 minutes away by car on weekdays.

Table 34 Comparison of provision of premises offering services [geographical]

District	Per head of population Rate per 100,000	Weekday access by car Number of people over 30 minutes away- one way journey
Eastbourne	19.2	3
Hastings	22.6	0
Lewes	16.3	25
Rother	23.8	3
Wealden	20.6	0

Please note the crude rates per 100,000 of providers shown above include all community pharmacies and GP dispensaries but not the distance selling pharmacies located in each local authority.

10.3 Distribution of services

Table 35 summarises number of pharmacies providing advanced services and PH commissioned services by district and borough.

- **Advanced services** (Number providing)
    - NMS | CPCS | Flu Immunisations
- **PH Advanced Services** (Number providing)
    - Needle exchange, Supervised Consumption, EHC.

Table 35 Range of services provided by pharmacies by District and Borough

District	Community pharmacies (Number)	NMS	CPCS	Flu imms	Needle Exchange	Supervised consumption (and naloxone)	EHC
Eastbourne	20	20	20	19	5	11+(3)	8
Hastings	20	19	19	18	8	8+(8)	11

Lewes	17	17	17	17	9	6+(4)	7
Rother	15	15	12	14	2	6+(1)	8
Wealden	27	26	26	22	4	6+(2)	9

Glossary:

NMS: New Medicines Service

CPCS: Community Pharmacy Consultation Service

Flu imms: Flu immunisation service

PH Advanced Services: Public health commissioned advanced services

EHC: Emergency Hormonal Contraception

10.4 Gaps in the hours / times

Pharmacy contracts are either for 40 hours per week (most pharmacies) with a few having contracts to be open 100 hours per week. Please see Table 12.

Provision of 100-hour pharmacies is highest in Eastbourne and Hastings with three each, although Eastbourne had four in 2017.

Hastings now has 17, 40-hour pharmacies, having two fewer compared to 2017 and still has its three 100-hour pharmacies.

Lewes and Rother both have one 100-hour pharmacy, which is no change from 2017.

Wealden has no 100-hour pharmacy.

10.5 Additional gap analyses using agreed criteria and with Residents' ratings:

Table 36 summarises general access to pharmacy by public transport and Residents' survey access ratings by local authority.

Table 36 Access to pharmacy by public transport and Residents' access ratings

Percentage (no.) of residents who need to travel over 30 mins by Public Transport to nearest pharmacy (including GP dispensaries)

	Daytime	**Evening**	**Weekend**		
Area			Sat morning	Sunday	Residents' Survey comments and [ratings]

	Daytime	Evening	Weekend		
Eastbourne	0.4% 400	1% 946	0.4% 406	1% 906	More access in evenings wanted Weekday evenings 22% [poor] Bank holidays 28% [poor]
Hastings	0.18% 164	0.3% 314	0.18% 164	1% 495	More access in evenings wanted Weekday evenings 22% [poor] Bank holidays 26% [poor]
Lewes	6.4% 6,662	23% 23,521	7% 7,581	25% 25,659	More access in evenings wanted Weekday evenings 18% [poor] Bank holidays 29% [poor]
Rother	13.1% 12,683	53% 51,288	18% 17,695	57% 55,458	More access in evenings wanted Weekday evenings 21% [poor] Bank holidays 30% [poor]
Wealden	14.0% 22,847	31% 50,733	15% 24,477	56% 91,807	More access in evenings

	Daytime	Evening	Weekend	
				wanted Weekday evenings 20% [poor] Bank holidays 28% [poor]

The following sections 10.6 to 10.10 discuss the individual Boroughs and Districts in East Sussex.

10.6 Eastbourne Borough

Are pharmacy services meeting the needs of the population in Eastbourne

There are 20 pharmacies in Eastbourne, of which 3 are 100-hour pharmacies please see

Figure 17.

Population

Eastbourne has a significantly older age profile compared to England.

The Borough has a significantly lower percentage of its population who are non-White, British [2016] and who have English as a second language compared to England.

The percentage of adults whose current marital status is separated or divorced is significantly higher compared to England. Lone parent households are significantly lower.

Pensioners who live alone and the percentage of the population who provide 50 or more hours per week unpaid care are significantly higher compared to the national average.

Population Growth

The expected changes in the population of Eastbourne between 2022 and 2025 are shown in Table 37 .

Table 37 Expected population changes in Eastbourne 2022-25

		2022	2025	Difference	% Change
Eastbourne	All ages	103,928	104,834	906	0.9
	0-17	19,875	19,554	-321	-1.6
	18-64	57,082	56,792	-290	-0.5
	65-74	12,571	12,716	145	1.2
	75-84	9,676	10,849	1,173	12.1
	85+	4,725	4,923	198	4.2

Source: ESiF

Distribution of pharmacies within Eastbourne

Figure 37 shows the distribution of pharmacies by ward and built up areas in Eastbourne.

Figure 37 Community pharmacies in Eastbourne by ward

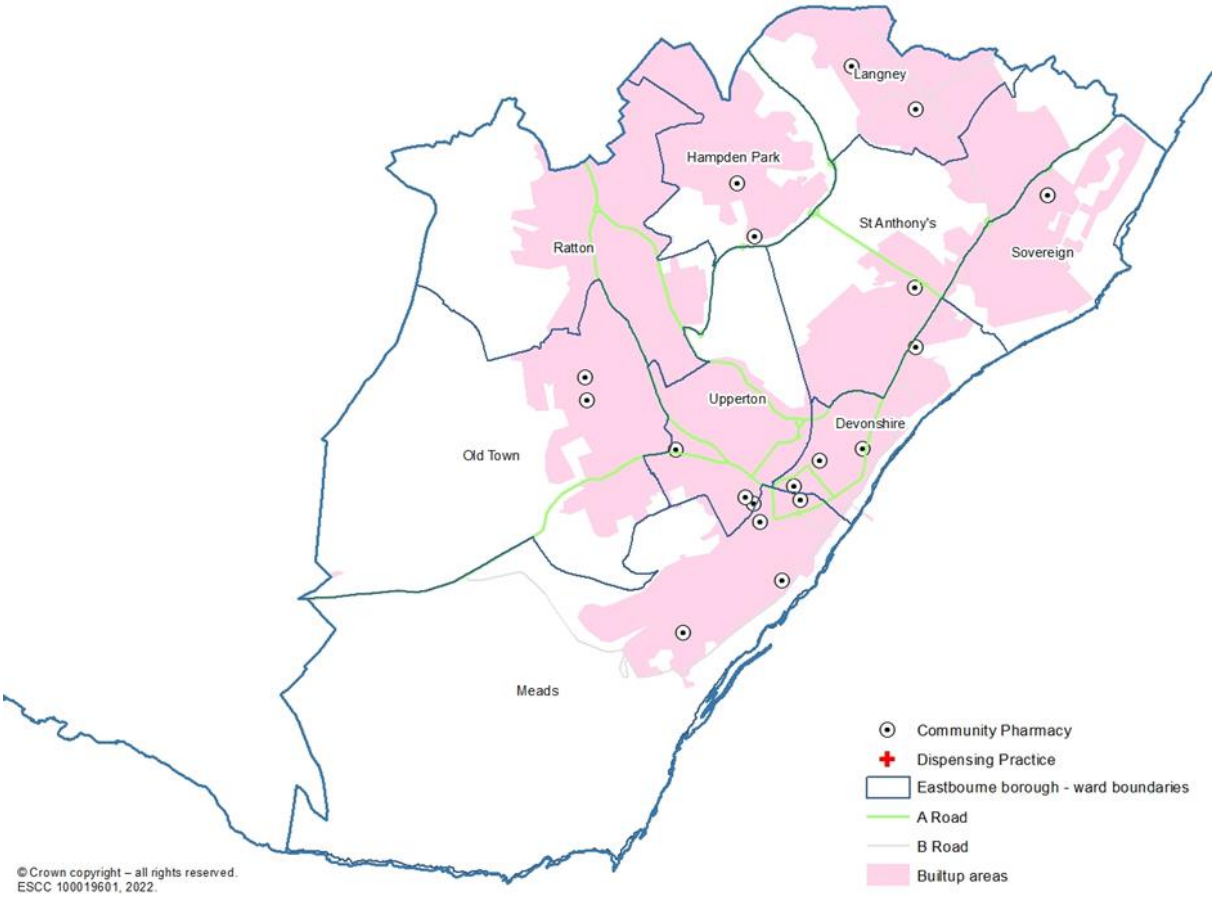


Figure 38 shows community pharmacies mapped onto the Index of Multiple Deprivation (IMD) 2019.

Pharmacy premises are generally located in areas of higher relative deprivation and greater health need (those areas shaded in a darker green colour).

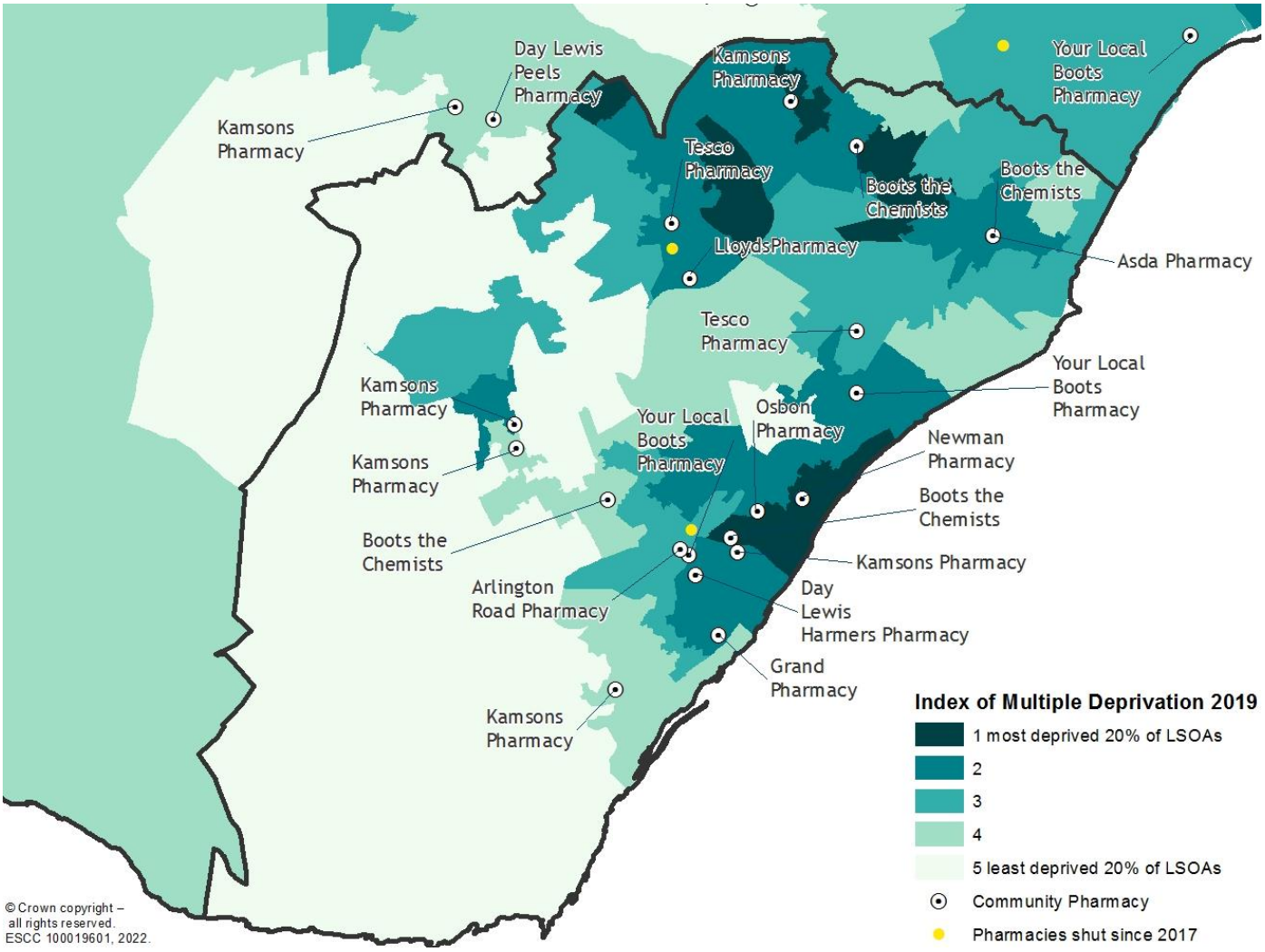
Looking at the distribution, the majority of people will have sufficient choice of a pharmacy.

Travel analysis

Walking

Eastbourne Borough: a total of 587/32,953 (1.8%) of people living in a ward with low car ownership could not access a pharmacy by walking in a 30 minutes or more one way journey during the day [Meads (321), Old Town (188) and Ratton (78) wards].

Figure 38 Distribution of community pharmacies in Eastbourne in 2022 [by IMD score in 2019]



Necessary services current provision in Eastbourne

Discharge [from hospital] Medicines Service. There has been a consistent level of activity within this service in 2021/22. In 2020/21 all except one pharmacy received income for providing this service. This service is not within the control of community pharmacies and needs to be promoted by NHS commissioners to improve activity further through to community pharmacies.

Other NHS services in Eastbourne

These are all NHS services which may generate prescriptions:

- ESHT – Urgent Treatment Centre at Eastbourne District General Hospital
- East Sussex Outpatients Services
- St Wilfrid's Hospice
- STAR – East Sussex Drug & Alcohol Service
- Sussex Downs And Weald Special Allocation Scheme

Gaps in necessary services

There are no gaps in the provision of necessary services in Eastbourne.

There are net **two** fewer pharmacies in Eastbourne [one fewer 40-hour pharmacy, one fewer 100-hour pharmacy]. Figure 38 shows that the pharmacies which have closed were very close to other pharmacies which remain open.

Based upon the information contained in the preceding sections:

The steering group has noted the opening hours of the existing pharmacies in Eastbourne and is of the opinion that they are able to meet the likely needs of residents in the locality.

Out of 20 pharmacies all current needs are fully met in relation to the provision of those **advanced services which fall within the definition of necessary services,** namely:

- New Medicine Service: all provided in 2021/22; two did not record activity in 2020/21
- Community Pharmacist Consultation Service: all pharmacies provided this in 2021/22
- Flu vaccination: one shows no activity in 2021/22. All provided this in 2020/21

The needs for these advanced services are therefore being fully met at present.

Choice in obtaining pharmaceutical services in Eastbourne

Eastbourne: 22% of respondents felt ease of access to essential dispensing services on weekday evenings was poor [Evidence Residents' Survey 2022].

The Steering Group has noted the travel analysis for Eastbourne and is of the opinion that the current opening hours of existing pharmacies are able to meet the likely current needs

of residents for essential services in the locality in the evenings. [Evidence: public transport travel analysis evening - less than 0.5% cannot reach a pharmacy in 30 mins]

Improvements or better access: gaps in provision

There are no gaps in the provision of essential and advanced services in Eastbourne.

There is no pharmacy activity in either the Appliance Use Review [AUR] or Stoma Appliance Customisation [SAC] services.

Prescriptions for appliances are dispensed by a Dispensing Appliance Contractor outside of East Sussex, and patients will therefore be able to access this service via those contractors. Patients requiring a SAC service will have their needs met at the patient's home or by stoma nurses employed by dispensing appliance contractors. In addition, East Sussex Healthcare Trust has a stoma care service.

A palliative care enhanced service is commissioned in Eastbourne to improve end of life care.

Future needs for pharmacy services in Eastbourne

Nine pharmacies of the 20 pharmacies in Eastbourne responded to the community pharmacy survey in 2022:

- Two don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand
- One doesn't have sufficient premises and staffing capacity but could adjust manage an increase in demand in their area
- Six have sufficient capacity within our existing premises and staffing levels to manage an increase in demand in their area

Eastbourne Borough Council planned housing developments by ward for the period 2020-25. Table 38 shows planned housing development by ward 2020-25. The highest concentration of new dwellings will be in Devonshire, Upperton, and Meads wards.

No single area has close to a further 2,000 planned developments and therefore there is no need for additional pharmacy locations.

Table 38 Planned housing development by ward in Eastbourne BC, 2020-25 Source: EBC Planning department 29/12/2021

Ward name	Net completions 2020-21	2021-22	2022-23	2023-24	2024-25	
Devonshire	29	87	80	40	66	302
Hampden Park	1	0	29	0	1	31
Langney	20	19	16	16	17	88

Meads	57	60	37	82	18	254
Old Town	0	2	6	6	11	25
Ratton	0	45	8	0	0	53
Sovereign	17	21	18	0	1	57
St.Anthony's	6	2	9	7	79	103
Upperton	100	13	41	111	137	402
Eastbourne total	230	249	244	262	330	1,315

10.7 Hastings Borough

Are pharmacy services meeting the needs of people in Hastings?

There are 20 pharmacies in Hastings, of which 3 are 100-hour pharmacies (please see **Figure 39**).

Population

Hastings has a slightly older age profile compared to England.

The borough has significantly lower percentages of its population who are non-White British and who have English as a second language.

The percentage of adults whose current marital status is separated or divorced, and lone parent households are significantly higher compared to England.

Pensioners who live alone and the percentage of the population who provide 50 or more hours per week unpaid care are significantly higher compared to the national average.

Hastings has the greatest underlying health needs and level of relative deprivation in any district or borough in East Sussex. The Indices of Multiple Deprivation [IMD 2019] are summarised in a separate JSNA document.[157]

Population growth

The expected changes in the population of Hastings between 2022 and 2025 are shown in Table 39.

Table 39 Expected population changes in Hastings 2022-25

		2022	2025	Difference	% Change
Hastings	All ages	92,709	93,992	1,283	1.4
	0-17	19,022	18,788	-234	-1.2
	18-64	53,958	54,313	355	0.7
	65-74	10,509	10,625	116	1.1
	75-84	6,491	7,390	899	13.8
	85+	2,729	2,878	149	5.5

Source: ESiF

Distribution of pharmacies within Hastings

Figure 39 shows the distribution of pharmacies and GP dispensary by ward and built up areas in Hastings.

Figure 40 shows community pharmacies mapped onto the Index of Multiple Deprivation (IMD) 2019.

Pharmacy premises are generally located in areas of higher relative deprivation and greater health need (those areas shaded in a darker green colour).

Looking at the distribution the majority of people will have sufficient choice of a pharmacy.

Figure 39 Location of community pharmacies in Hastings by ward

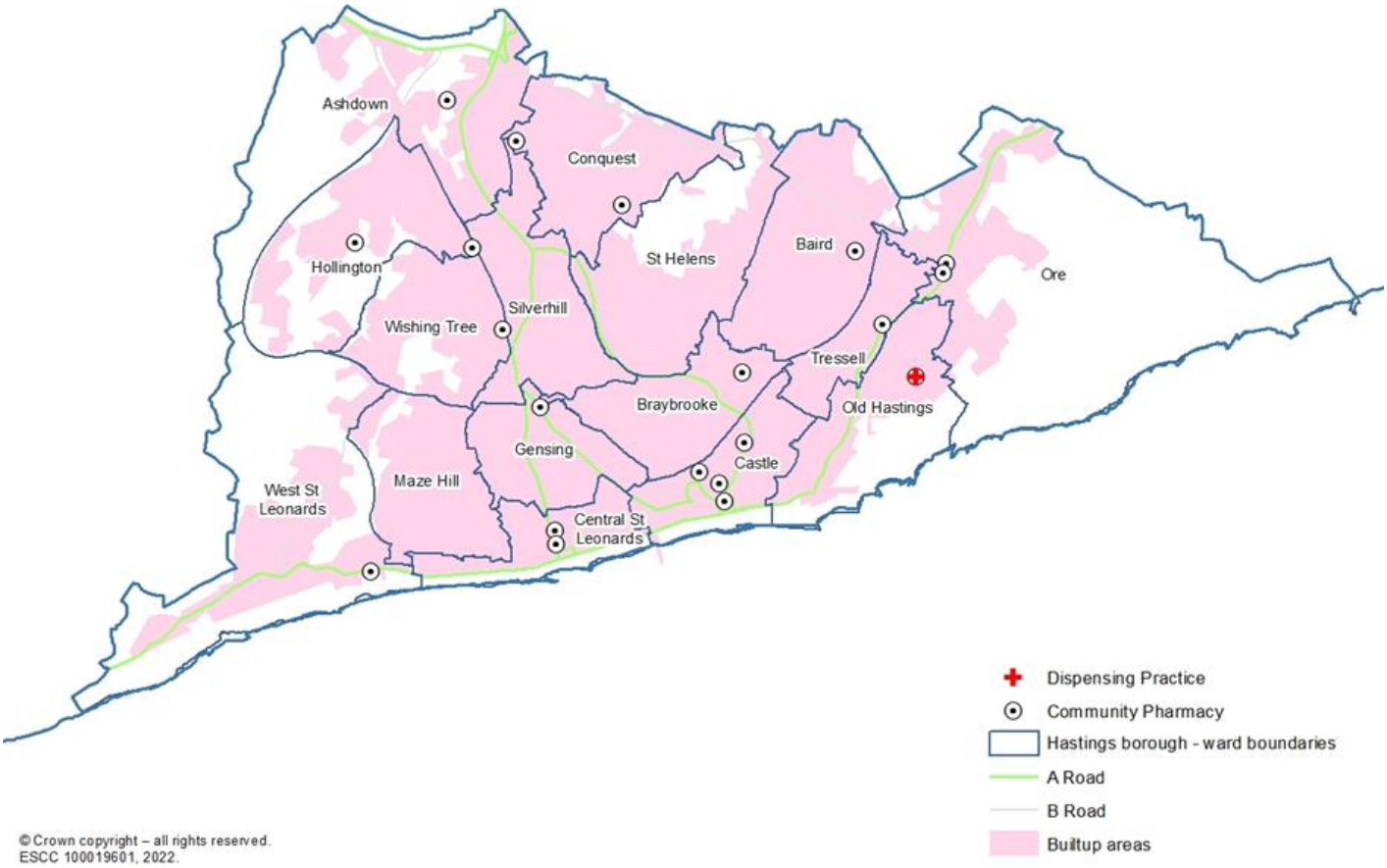
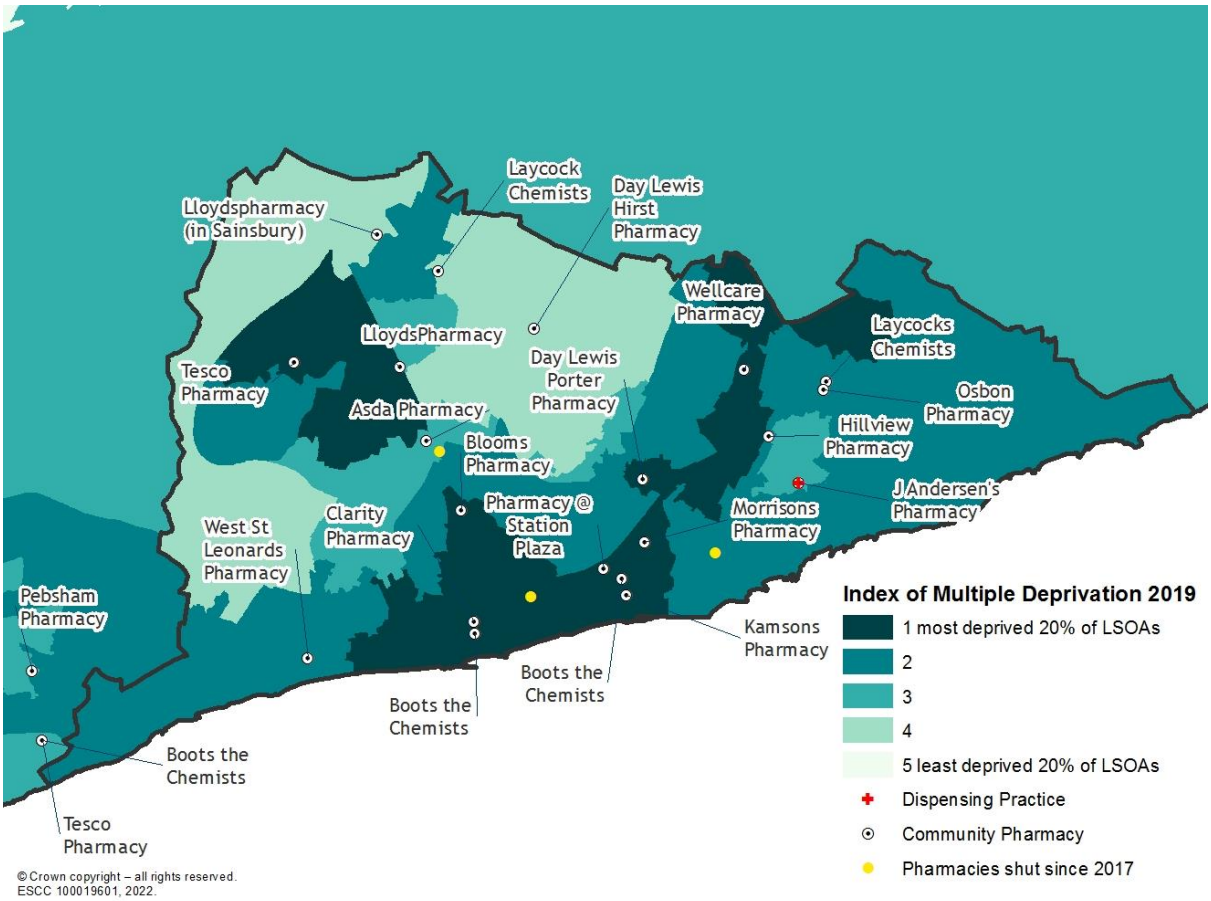


Figure 40 Distribution of community pharmacies in Hastings in 2022 [by IMD 2019]



Travel analysis

Walking

Hastings Borough: an estimated 242/10,552 (2.3%) of people living in a ward with low car ownership could not access a pharmacy by walking in a 30 minute journey or more during the day [in Ore (102) and West St. Leonard's (140) wards].

Necessary services current provision in Hastings

Discharge [from hospital] Medicines Service.There was very little activity within this service in 2021/22. In 2020/21 all except two pharmacies received income from this service. This service is not within the control of community pharmacies and needs to be promoted by NHS commissioners to improve activity through to community pharmacies.

Other NHS services

- East Sussex Healthcare Trust - Urgent Treatment Centre at the Conquest Hospital
- Hastings Primary Care Hub is open 08:00 to 18:30 weekdays. 08:00 to 20:00 weekends and provides appointments for residents and visitors to the town. The hub doesn't hold a registered list of patients
- Hastings Homeless Service
- St Michaels Hospice
- Hastings & Rother P C Special Scheme

Other relevant services- current provision

Spire Sussex Hospital

Gaps in necessary services

There are no gaps in the provision of necessary services in Hastings.

The steering group has noted the opening hours of the existing pharmacies in Hastings and is of the opinion that they are able to meet the likely needs of residents in the locality.

Figure 40 shows the location of current pharmacies and those which have closed. Overall, there are [net] two fewer 40-hour pharmacies in Hastings since the last PNA in 2017, with closures close to remaining pharmacies. The number of pharmacies per 100,000 is slightly higher than neighbouring districts and boroughs.

Of the 20 pharmacies in Hastings, with regard to current or future needs in relation to the provision of those advanced services which fall within the definition of necessary services, namely:

- New Medicine Service-two recorded no activity in 2021/22; five recoded no activity in 2020/21

- Community Pharmacist Consultation Service-one has not recorded any activity in 2021/22; four have recorded no activity in 2020/21
- Flu vaccination-two have not recorded any activity in 2021/22. Two recorded no activity in 2020/21

The needs for these advanced services are therefore being fully met at present.

These services should be promoted by providers in the wider system that can initiate this activity.

Choice about obtaining necessary pharmaceutical services in Hastings

Hastings: 22% of respondents felt ease of access to essential dispensing services on weekday evenings was poor [Evidence Residents' Survey 2022].

The Steering Group has noted the travel analysis for Hastings and is of the opinion that the current opening hours of existing pharmacies are able to meet the likely current needs of residents for essential services in the locality in the evenings. [Evidence public transport travel analysis evening - less than 0.5% cannot reach a pharmacy in 30 minutes.]

Improvements or better access: gaps in provision

There are no gaps in the provision of essential and advanced services in Hastings.

Appliance Use Review [AUR] no activity was recorded and Stoma Appliance Customisation [SAC], one pharmacy provided the service in 2020/21 and in 2021/22.

Prescriptions for appliances are dispensed outside of the locality as they are sent to a Dispensing Appliance Contractor. Patients will therefore be able to access this service via those contractors. In addition, stoma nurses employed by dispensing appliance contractors will provide the services at the patient's home and also the stoma care department at East Sussex Healthcare NHS Trust.

A palliative care enhanced service is commissioned in Hastings to improve end of life care.

Future needs:

Nine of the 20 Hastings community pharmacies responded to the Community Pharmacy survey:

- Two don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand
- One doesn't have sufficient premises and staffing capacity but could make adjustments to manage an increase in demand in our area
- Six have sufficient capacity within the existing premises and staffing levels to manage an increase in demand in the area

Planned housing development by ward Hastings Borough Council 2020-25

Table 40 shows planned housing development by ward 2020-25 in Hastings Borough. The highest concentration of new dwellings will be in Ashdown, Baird, Conquest, Maze Hill, and Central St. Leonards wards.

No single area has close to a further 2,000 planned developments and therefore there is no need for additional pharmacy locations on this basis.

Table 40 Planned housing development by ward Hastings Borough Council 2020-25

Ward name	Net completions 2020-21	2021-22	2022-23	2023-24	2024-25	Total 2020-25
Ashdown	4	7	3	67	67	148
Baird	10	48	46	2	15	121
Braybrooke	1	-1	7	3	22	32
Castle	14	11	15	25	13	78
Central St.Leonard's	10	12	14	8	91	135
Conquest	1	3	44	44	45	137
Gensing	-3	13	2	2	22	36
Hollington	2	1	7	40	3	53
Maze Hill	54	44	48	2	10	158
Old Hastings	2	7	2	2	2	15
Ore	14	1	3	2	2	22
Silverhill	3	4	2	2	10	21
St.Helens	0	3	2	2	2	9
Tressel	0	14	2	35	9	60
West St.Leonard's	0	8	2	42	42	94
Wishing Tree	-1	1	15	2	30	47
Hastings Total	111	176	214	280	385	1,166

Source: Planning policy team, HBC February 2022

10.8 Lewes District

Are pharmacy services meeting the needs of people in Lewes?

There are 18 pharmacies in Lewes, of which 1 is a 100-hour pharmacy (Please see Table 12).

Population

This locality contains the county town of Lewes and coastal towns of Seaford and Newhaven.

Lewes District has an older population profile compared to England.

The district has significantly lower percentages of its population who are non-White British and who have English as a second language.

The percentage of adults whose current marital status is separated or divorced is significantly higher compared to England. However, lone parent households are significantly lower.

Population growth

The expected changes in the population of Lewes District between 2022 and 2025 are shown in Table 41.

Table 41 Expected population changes in Lewes District 2022-25

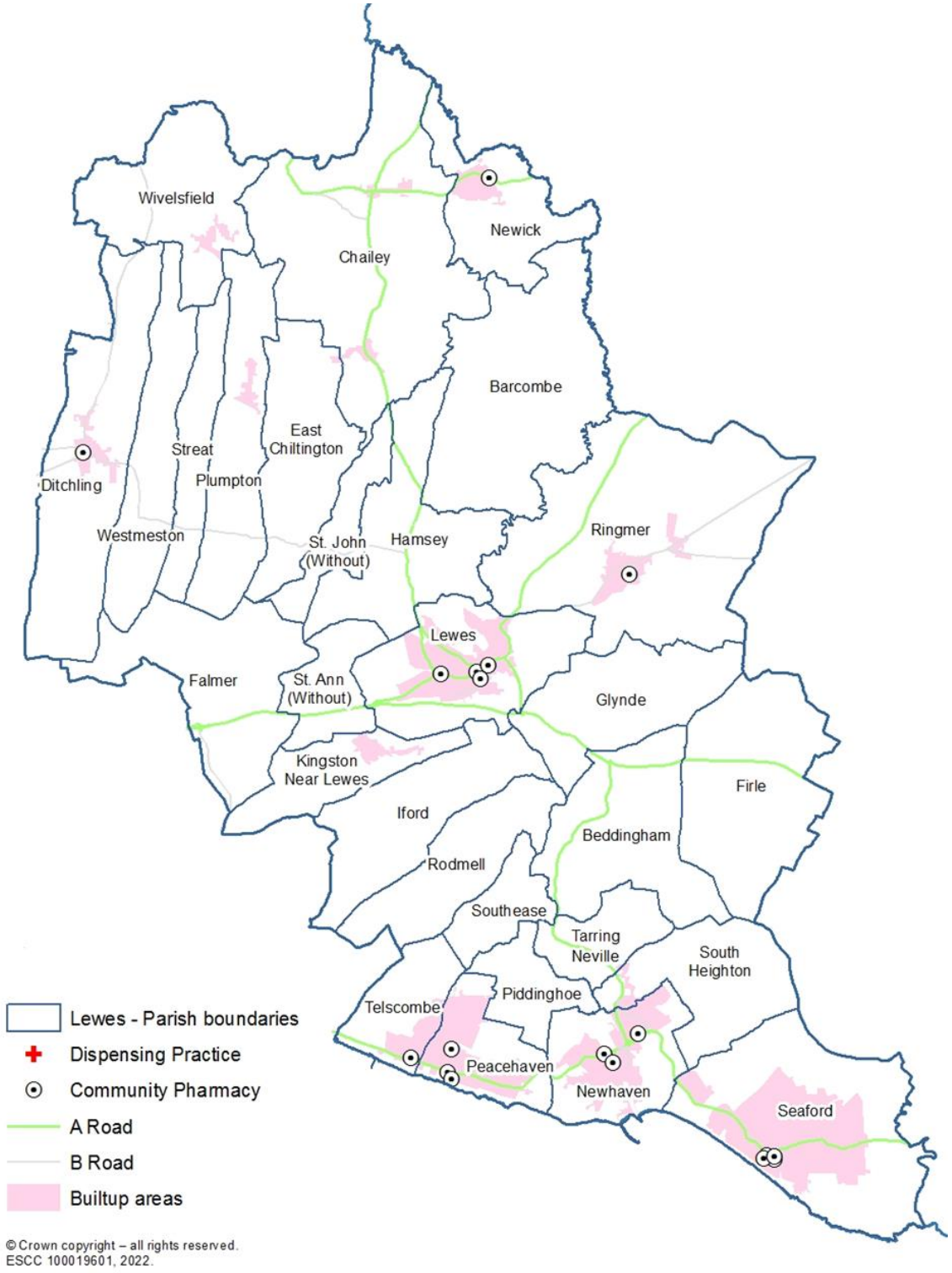
		2022	2025	Difference	% Change
Lewes	All ages	104,694	106,405	1,711	1.6
	0-17	20,013	19,954	-59	-0.3
	18-64	56,937	57,205	268	0.5
	65-74	13,411	13,417	6	0.0
	75-84	9,976	11,126	1,150	11.5
	85+	4,357	4,703	346	7.9

Source: ESiF

Distribution of pharmacies within Lewes District

Figure 41 shows the distribution of pharmacies by parish in Lewes District.

Figure 41 Community pharmacies in Lewes by parish



Looking at the distribution the majority of people will have sufficient choice of a pharmacy in the most populated built-up areas.

The most deprived areas in Lewes district are in Lewes town and around Newhaven. Please see Figure 11.

Travel analysis

Walking

Lewes District: an estimated 3,368/50,836 (6.6%) of people living in a ward with low car ownership could not access a pharmacy by walking 30 minutes or more in East Saltdean and Telscombe (154), Lewes Bridge (134), Lewes Priory (50), Newhaven Denton (46), Peacehaven East (377), Seaford East (1,372), Seaford North (1,093) and Seaford South (142).

Public transport [in wards with low car ownership]

During the daytime in the week, an estimated 152 people do not have access [more than 60 minutes for a journey, one way], and a further 200 people are without access [more than 30 minutes] in East Saltdean and Telscombe [33], Lewes Bridge, Seaford East [62], Seaford North [48] and Seaford South [57] wards.

This figure rises to 227 people in those same wards on a weekday evening with no access and a further 4,995 people with no access within 30 minutes to a pharmacy. This also includes some residents of Lewes Priory, Lewes Castle and Seaford South wards.

On a Saturday morning, there are an estimated 152 people with no access, and a further 283 with no access within 30 minutes, increasing to 339 people with no access within 30 minutes on a Saturday pm.

On a Sunday there are an estimated 252 people with no access [more than 60 minutes] and a further 7,347 people in total with no access within 30 minutes in East Saltdean and Telscombe, Lewes Bridge, Lewes Castle, Lewes Priory, Seaford East, Seaford North, Seaford South, Newhaven Denton and Newhaven Valley wards.]

Necessary services current provision in Lewes

Discharge Medicines Service-there has been some activity within this service although this has reduced in the past two quarters of 2021/22. All except two pharmacies received income for the DMS service in 2020/21. This service is not within the control of community pharmacies and needs to be promoted by NHS commissioners to improve activity through to community pharmacies.

Other NHS services

- Lewes Urgent Treatment Centre Open 08:00 to 20:00 seven days per week. No dispensing activity out of hours.
- East Sussex Dermatology Service
- High Weald Lewes Havens/Sussex Partnership NHS Foundation Trust Memory Assessment Service

Other relevant services- current provision

- St Peter & St James Hospice
- Her Majesty's Prison Lewes

Gaps in necessary services

There are no gaps in the provision of necessary services in Lewes.

Lewes district has **two** fewer pharmacies since the last PNA in 2017.

Regarding current needs in relation to the provision of those advanced services which fall within the definition of necessary services, namely:

- New Medicine Service-all were providing this service in 2021/22; two pharmacies were not providing this in 2020/21
- Community Pharmacist Consultation Service- one recorded no activity in 2021/22; two recorded no activity in 2020/21
- Flu vaccination-all provided in 2021/22; two did not record any activity in 2020/21

The needs for these advanced services are therefore being fully met at present.

Choice about obtaining necessary pharmaceutical services in Lewes

Lewes: 18% of respondents felt ease of access to essential dispensing services on weekday evenings was poor [Evidence Residents' Survey 2022].

The Steering Group has noted the travel analysis for Lewes and recommends that improving current choice of essential dispensing services in the evenings and weekends could be achieved by consideration of commissioning an extended hours service on a rota basis from existing pharmacies.

Improvements or better access: gaps in provision

There are no gaps in the provision of essential or advanced service in Lewes.

Appliance Use Review [AUR] and Stoma Appliance Customisation [SAC]. No AUR activity is shown in 2021/22, or 2020/21. Two pharmacies provided the SAC service in 2021/22, and in 2020/21.

Prescriptions are dispensed outside of the locality as they are sent to a Dispensing Appliance Contractor. Patients will therefore be able to access this service via those contractors. In addition, stoma nurses employed by dispensing appliance contractors will provide the services at the patient's home and the stoma care department at ESHT and/or University Hospitals Sussex.

A palliative care enhanced service is commissioned in Lewes district to improve end of life care.

Future Need:

Future needs in relation to the provision of essential services by pharmacies in the locality could be improved by commissioning an extended hours rota service from existing providers.

10 of the pharmacies that responded to the survey in 2022

- Two don't have sufficient premises and staffing capacity but could make adjustments to manage an increase in demand in our area
- Eight have sufficient capacity within the existing premises and staffing levels to manage an increase in demand in the area

There is very small amount of new housing envisaged both within the South Downs National Park Area, likewise outside the SDNPA.

The highest number of new dwellings in the overall plan will be in Newhaven, Lewes Town, Peacehaven & Telscombe, Seaford, Ringmer & Broyle Side.

Table 42 shows the housing trajectory for 2020-25 for areas **inside** the South Downs National Park Authority [SDNPA]. No single area has close to a further 2,000 planned developments and therefore there is no need for additional pharmacy locations on this basis

Table 42 Housing trajectory for parishes inside the SDNPA [Lewes District] 2020-25

Town/Parish	2020-21	2021-22	2022-23	2023-24	2024-25
Beddingham	0	0	0	0	0
Ditchling	0		4	0	6
East Chiltington	0	0	0	0	0
Kingston	0	0	11	0	0
Lewes Town	48	79	95	103	99
Piddinghoe	0	0	0	0	0
Ringmer	0	5	0	0	0
Rodmell	0	0	0	0	0
Streat	0	0	0	0	0

Table 43 shows the housing trajectory 2022-25 for parishes **outside** the SDNPA in Lewes District. **Source:** Lewes DC 24/01/22

Table 43 Housing trajectory for areas outside the SDNPA [Lewes District] 2020-25

Town/parish	Total net completions 2010-11 to 2019-20	Net completions 2020-21	2021-22	2022-23	2023-24	2024-25
Barcombe Parish	10	0	5	6	7	1
Beddingham Parish	0					
Chailey Parish	54	9	30	32	27	6
Ditchling Parish	122	0	0	1	0	0
East Chiltington Parish	1	0	0	0	0	0
Falmer Parish	1	0				
Firle Parish	0	0				
Glynde Parish	1	0				
Hamsey Parish	38	28	10	12	6	6
Iford Parish	0					
Kingston Parish	5					
Lewes Town	267					
Newhaven Town	261	27	91	122	130	46
Newick Parish	61	3	4	13	2	15
Peacehaven Town	642	78	102	79	93	59
Piddinghoe Parish	2					
Plumpton Parish	26	3	21	21	1	
Ringmer Parish	79	47	91	61	60	30

Town/parish	Total net completions 2010-11 to 2019-20	Net completions 2020-21	2021-22	2022-23	2023-24	2024-25
Rodmell Parish	1					
Seaford Town	382	13	42	56	68	75
Southease Parish	0					
South Heighton Parish	1	0	0	0	0	0
St Ann Without Parish	0					
St John Without Parish	0	0	0	0	0	0
Streat Parish	1	0	0	1	0	0
Tarring Neville Parish	0	0	0	0	0	0
Telscombe Parish	91	7	7	7	3	0
Westmeston Parish	2	1	1	0	2	0
Wivelsfield Parish	370	56	14	20	10	15
Lewes District Total	2418	272	418	431	409	253

No single area has close to a further 2,000 planned developments and therefore there is no need for additional pharmacy locations on this basis.

10.9 Rother District

Are pharmacy services meeting the needs of people in Rother?

There are 17 community pharmacies in Rother, of which none are 100-hour pharmacies. (Please see Table 12).

Population

This locality contains the town of Bexhill as well as Battle, Winchelsea, and Rye.

Rother has a significantly older age profile compared to England. The district has significantly lower percentages of its population who are non-White British and who have English as a second language.

In Rother the percentage of adults whose current marital status is separated or divorced is significantly higher compared to England. However, lone parent households are significantly lower. The percentage of the population who provide 50 or more hours per week unpaid care is significantly higher compared to the national average.

Population growth

The expected changes in the population of Rother District between 2022 and 2025 are shown in Table 44.

Table 44 Expected population changes in Rother District 2022-25

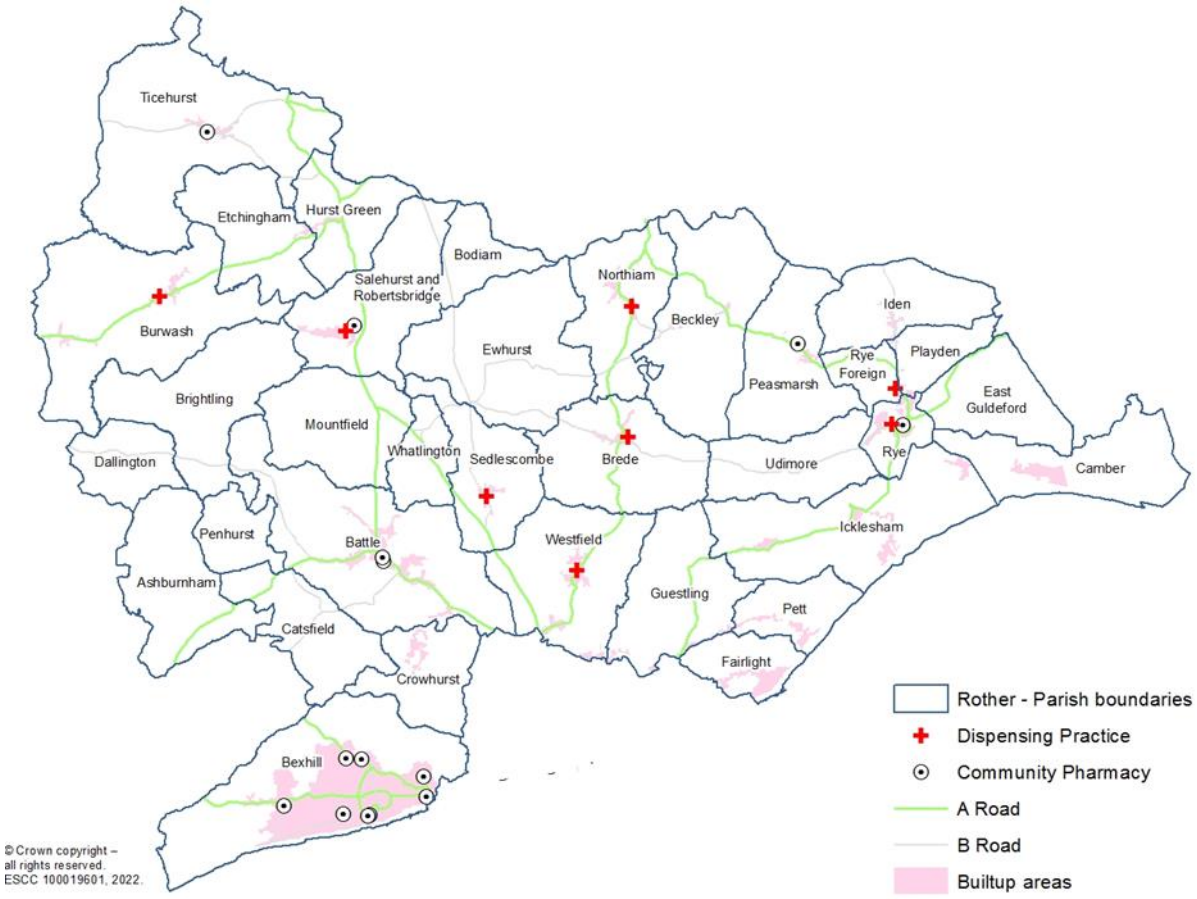
		2022	2025	Difference	% Change
Rother	All ages	97,076	99,338	2,262	2.3
	0-17	16,374	16,475	101	0.6
	18-64	48,594	48,968	374	0.8
	65-74	15,332	15,339	7	0.0
	75-84	11,951	13,417	1,466	12.3
	85+	4,826	5,139	313	6.5

Source: ESiF

Distribution of pharmacies within Rother District

Figure 42 shows the distribution of pharmacies and GP dispensaries in Rother by parish.

Figure 42 Community pharmacies in Rother District by parish



Travel analysis

Walking

Rother District: a total of 6,370/27,062 (23.5%) of people living in a ward with low car ownership could not access a pharmacy by walking 30 minutes one way [in Battle Town (1,238), East Rother (4,722), Rye (20), Sidley (329) and St. Michael's (61) wards].

Public transport, looking at wards with low car ownership

On a weekday daytime there are 1,219 people in total with no access [more than 60 minutes one way], and a further 984 people without access within 30 minutes in Battle Town, East Rother, Rye, Sidley and St. Michael's wards.

This rises quite considerably on weekday evenings to 21,699 people in the above wards, as well as some residents of Kewhurst, Old Town Bexhill and St. Stephens wards.

On a Saturday morning there are 1,260 people with no access [more than 60 minutes one way], and a further 1,003 with no access within 30 minutes for some residents of Battle Town, East Rother, Rye, Sidley and St. Michael's wards.

On a Saturday pm there are 1,260 people with no access, and a further 1,607 with no access within 30 minutes for some residents of Battle Town, East Rother, Rye, Sidley and St. Michael's wards.

On Sundays 4,373 people in total have no access, and a further 16,667 without access within 30 minutes for residents in Battle Town, East Rother, Rye, Sidley, St. Michael's, as well as some residents of Collington, Kewhurst and St.Stephen's wards.

Necessary services current provision in Rother

Discharge [from hospital] Medicines Service.There is very little activity in this service. All except one received income for the service in 2020/21. This service is not within the control of community pharmacies and needs to be promoted by NHS commissioners to improve activity through to community pharmacies.

Other NHS services

- Community Dermatology Service NHS H&R
- Bexhill Hospital
- Urgent Care

Gaps in necessary services

There are no gaps in the provision of necessary services in Rother.

Three community 40-hour pharmacies have closed and one distance selling pharmacy has opened in Rother since the last PNA in 2017.

Regarding current needs, in relation to the provision of those advanced services which fall within the definition of necessary services, namely:

- New Medicine Service-one pharmacy did not provide the service in 2021/22; two did not provide this in 2020/21
- Community Pharmacist Consultation Service-three have not recorded any activity in 2021/22; one recorded no activity in 2020/21
- Flu vaccination-two recorded no activity in 2021/22; two recorded no activity in 2020/21

The needs for these advanced services are therefore being fully met at present.

These services should be promoted by providers in the wider system that can initiate this activity.

Choice about obtaining necessary pharmaceutical services in Rother

Rother: 21% of respondents felt ease of access to essential dispensing services on weekday evenings was poor [Evidence Residents' Survey 2022].

The Steering Group has noted the travel analysis for Rother and recommends that improving current choice of essential dispensing services in the evenings and weekends could be achieved by consideration of commissioning an extended hours service on a rota basis from existing providers.

Improvements or better access: gaps in provision

There are no gaps in the provision of essential or advanced services in Rother.

Appliance Use Review [AUR] and Stoma Appliance Customisation [SAC]. AUR no activity was recorded in 2021/22, or in 2020/21. One pharmacy provided the SAC service in 2021/22, whilst two pharmacies provided this SAC service in 2020/21.

Prescriptions are dispensed outside of the locality and are sent to a Dispensing Appliance Contractor. Patients will therefore be able to access this service via those contractors. In addition, stoma nurses employed by dispensing appliance contractors will provide the services at the patient's home and the stoma care department at ESHT.

A palliative care enhanced service is commissioned in Rother to improve end of life care.

Future need

Of the four pharmacies that responded to the survey all four have sufficient capacity within their existing premises and staffing levels to manage an increase in demand in the area.

There is some new housing envisaged in Bexhill but not so great an extent as to justify a new pharmacy across the district. Other small housing developments are spread across the district.

Developments to the north-east of Bexhill are the focus for housing growth in the district and are now under construction, Table 45.

Table 45 Housing development by town/parish in Rother District 2020-25

Town/Parish	Total Net Completions 2011-12 to 2019-20	Net Completions 2020-21	2021-22	2022-23	2023-24	2024-25
Ashburnham	3	0	0	0	0	0
Battle	47	7	7	114	145	83

Town/Parish	Total Net Completions 2011-12 to 2019-20	Net Completions 2020-21	2021-22	2022-23	2023-24	2024-25
Beckley	18	1	1	1	1	1
Bexhill Town	851	95	236	264	247	280
Bodiam	16	11	0	0	0	0
Brede	34	0	9	1	1	2
Brightling	2	0	0	0	0	0
Burwash	22	0	1	1	1	1
Camber	70	1	1	1	1	1
Catsfield	8	10	2	2	2	1
Crowhurst	10	1	2	2	2	2
Dallington	3	0	0	0	0	0
East Guldeford	1	0	0	0	0	1
Etchingham	36	0	1	1	1	1
Ewhurst	39	0	2	2	2	2
Fairlight	10	1	1	1	1	1
Guestling	39	0	1	11	1	1
Hurst Green	26	0	1	1	21	0
Icklesham	18	1	2	17	2	2
Iden	6	0	0	0	0	1
Mountfield	3	0	0	0	0	0

Town/Parish	Total Net Completions 2011-12 to 2019-20	Net Completions 2020-21	2021-22	2022-23	2023-24	2024-25
Northiam	84	3	2	2	36	2
Peasmarsh	27	0	1	0	0	0
Penhurst	-1	0	0	0	0	0
Pett	10	0	0	1	0	0
Playden	0	0	0	0	1	0
Rye Foreign	32	0	0	0	0	1
Rye Town	201	1	3	15	37	43
Salehurst and Robertsbridge	15	0	1	1	33	48
Sedlescombe	34	0	1	1	1	9
Ticehurst	60	41	1	1	16	26
Udimore	3	1	0	0	0	0
Westfield	95	1	22	21	2	21
Whatlington	4	0	0	0	0	1
Rother District Total	1826	175	298	461	554	531

Source: Planning Department Rother DC 17/01/22

10.10 Wealden District

Are pharmacy services meeting the needs of people in Wealden?

There are 26 community pharmacies in Wealden, none of which are 100-hour pharmacies. (Please see Table 12).

Population

This locality contains the towns of Polegate, Hailsham, Heathfield, Uckfield, and Crowborough.

Wealden has an older age profile compared to England. The district has significantly lower percentages of its population who are non-White British and who have English as a second language.

Lone parent households, pensioners living alone and the percentage of the population who provide 50 or more hours per week unpaid care are significantly lower compared to the national average.

Population growth

The expected changes in the population of Wealden district between 2022 and 2025 are shown in Table 46.

Table 46 Expected population changes in Wealden District 2022-25

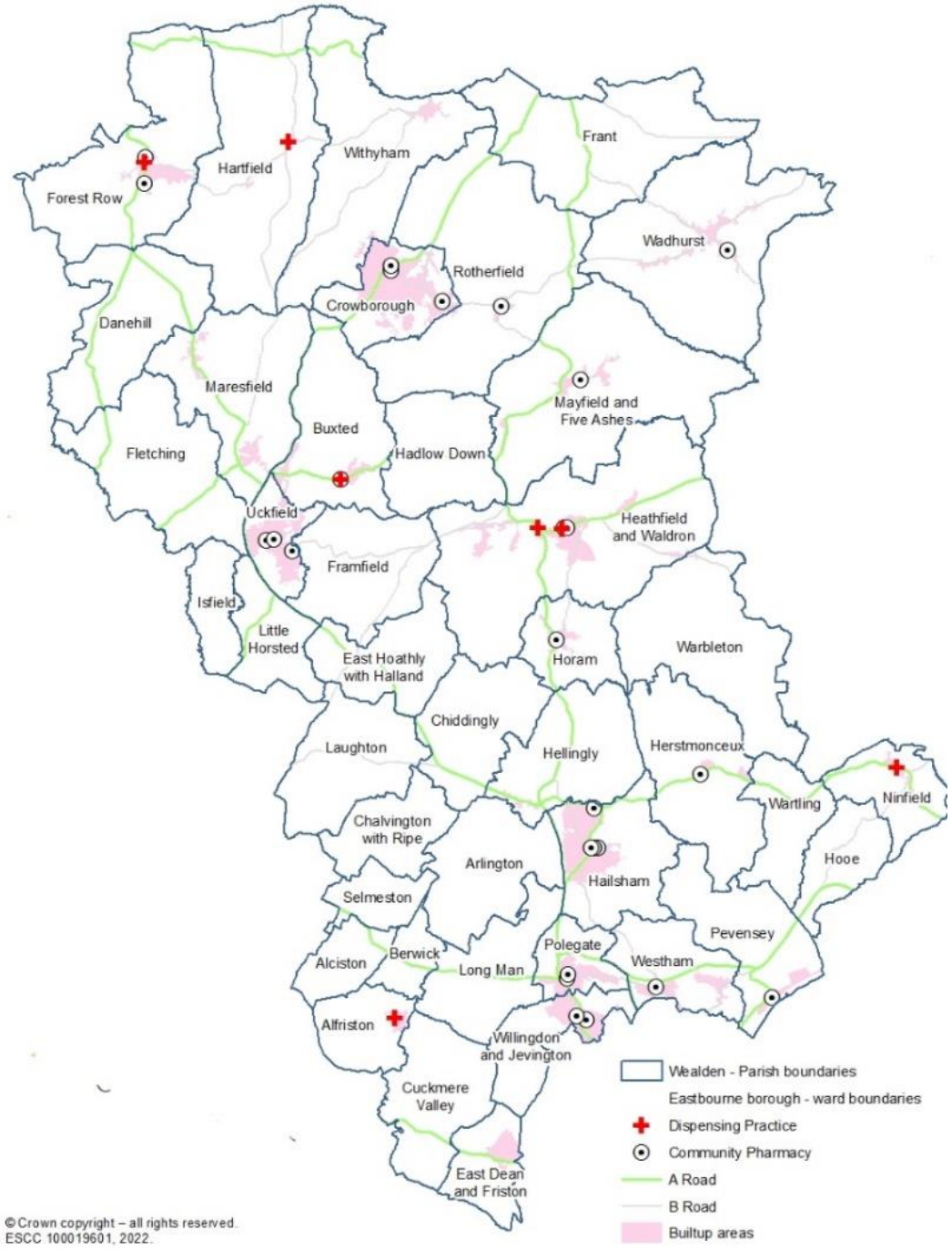
		2022	2025	Difference	% Change
Wealden	All ages	164,760	170,973	6,213	3.8
	0-17	31,538	32,237	699	2.2
	18-64	88,896	91,045	2,149	2.4
	65-74	21,866	22,543	677	3.1
	75-84	16,166	18,247	2,081	12.9
	85+	6,294	6,901	607	9.6

Source: EsiF

Distribution of pharmacies within Wealden District

Figure 43 shows the distribution of pharmacies and dispensaries by parish in Wealden.

Figure 43 Community pharmacies in Wealden by parish



Travel analysis

Walking

Wealden District: a total of 1,285/41,033 (3.1%) of people living in a ward with low car ownership could not access a pharmacy by walking more than 30 minutes one way in Hailsham Central (104), Hailsham East (448), Hailsham South (300), Polegate North (79), Uckfield New (44), Uckfield North (128) and Willingdon (182) wards.

Public transport: looking at those wards with low car ownership

On a weekday, there are 355 people who are more than 60 minutes away [one way], and a further 431 without access within 30 minutes [one way], in Hailsham Central, Hailsham East, Polegate North, Uckfield North and Willingdon wards.

On a weekday evening there are 483 with no access, and a further 1,270 without access within 30 minutes in the above wards, including some residents of Hailsham South.

On a Saturday morning there are 355 people with no access, and a further 172 without access within 30 minutes in Hailsham Central, Hailsham East, Polegate North, Uckfield North and Willingdon wards.

On a Saturday afternoon there are 359 with no access, and a further 521 without access within 30 minutes in Hailsham Central, Hailsham East, Polegate North, Uckfield North, and Willingdon wards.

On Sundays there are 964 people in total with no access, and a further 16,007 without access within 30 minutes in the above wards. [This total includes the residents of Hailsham South and West ward].

Necessary services current provision in Wealden

Discharge [from hospital] Medicines Service.-There was limited activity in this service in 2021/22. All pharmacies except one received income for the service in 2020/21. This service is not within the control of community pharmacies and needs to be promoted by NHS commissioners to improve activity through to community pharmacies.

Other relevant services- current provision

Horder Healthcare

Other NHS services

- Uckfield Hospital Minor Injuries Unit: 08:00 to 20:00 seven days per week. No dispensing activity
- Crowborough Minor Injuries Unit: 08:00 to 20:00 seven days per week. No dispensing activity.
- HWLH Dermatology Service
- Lansdowne Specialist Children’s Home

Gaps in necessary services

There are no gaps in provision of necessary services in Wealden

Wealden has two fewer distance selling pharmacies since the last PNA in 2017 and no change in the number of pharmacies.

Regarding current or future needs, in relation to the provision of those advanced services which fall within the definition of necessary services, namely:

- New Medicine Service-two have recorded no activity in 2021/22; three have recorded no activity in 2020/21
- Community Pharmacist Consultation Service-one recorded no activity in 2021/22; two had no activity in 2020/21
- Flu vaccination-six have recorded no activity in 2021/22; eight recorded no activity in 2020/21

These services should be promoted by providers in the wider system that can initiate this activity.

Choice about obtaining pharmaceutical services in Wealden

Wealden: 20% of respondents felt ease of access to essential dispensing services on weekday evenings was poor [Evidence Residents' Survey 2022].

The Steering Group has noted the travel analysis for Wealden and recommends that improving current choice of essential dispensing services in the evenings and weekends could be achieved by consideration of commissioning an extended hours service on a rota basis from existing providers.

Improvements or better access: gaps in provision

There are no gaps in the provision of essential or advanced services in Wealden.

Appliance Use Review [AUR] and Stoma Appliance Customisation [SAC]. No activity was recorded for AUR in 2021/22, or in 2020/21. One pharmacy provided the SAC service in 2021/22, whilst two pharmacies provided this in 2020/21.

Prescriptions are dispensed outside of the locality because are sent to a Dispensing Appliance Contractor. Patients will therefore be able to access this service via those contractors. In addition, stoma nurses employed by dispensing appliance contractors will provide the services at the patient's home and the stoma care departments at University Hospitals Sussex NHS Foundation Trust and Maidstone and Tunbridge Wells hospitals.

A palliative care enhanced service is commissioned in Eastbourne to improve end of life care.

Future need:

Of the six pharmacies responding to the survey in Wealden: all six have sufficient capacity within the existing premises and staffing levels to manage an increase in demand in the area

There is increased housing envisaged in Crowborough Town, Hailsham Town, Hellingly, Uckfield Town, and Westham but not to a degree to justify a new pharmacy in any one parish.

Expected housing development is shown in Table 47.

Table 47 Housing development by town/parish in Wealden District 2020-25

Town/Parish	Net Completions 2019-2020	Net Completions 2020-21	2021-22	2022-23	2023-24	2024-25
Alciston	0	0	0	0	1	0
Alfriston*	-	-				
Arlington	1	1	3	6	18	15
Berwick	2	0	2	2	2	2
Buxted	4	2	10	8	2	2
Chalvington with Ripe	1	0	2	15	15	3
Chiddingly	4	0	2	2	6	12
Crowborough Town	129	169	67	53	120	208
Cuckmere Valley*	-	-				
Danehill	0	1	1	2	2	2
East Dean & Friston*	-	-				
East Hoathly with Halland	7	3	1	6	26	51
Fletching	2	2	4	4	4	4

Town/Parish	Net Completions 2019-2020	Net Completions 2020-21	2021-22	2022-23	2023-24	2024-25
Forest Row	0	4	2	2	2	2
Framfield	5	5	13	13	5	33
Frant	39	11	2	9	9	51
Hadlow Down	1	7	3	2	2	2
Hailsham Town	133	99	95	79	197	332
Hartfield	2	2	1	1	2	1
Heathfield and Waldron	38	59	7	33	24	7
Hellingly	217	118	85	118	118	129
Herstmonceux	18	10	11	24	42	57
Hooe	0	0	0	0	1	0
Horam	97	29	43	42	29	38
Isfield	1	3	1	1	6	6
Laughton	0	3	1	2	2	1
Little Horsted	0	6	0	0	0	0
Long Man	0	0	0	1	1	0
Maresfield	5	3	5	21	20	15
Mayfield and Five Ashes	5	7	4	4	3	3
Ninfield	3	1	1	37	54	42
Pevensey	0	1	1	5	5	0

Town/Parish	Net Completions 2019-2020	Net Completions 2020-21	2021-22	2022-23	2023-24	2024-25
Polegate Town	68	34	45	42	39	34
Rotherfield	12	3	4	3	7	8
Selmeston	1	0	0	0	0	0
Uckfield Town	125	57	60	59	88	133
Wadhurst	35	0	7	8	17	18
Warbleton	6	3	2	2	2	2
Wartling	2	2	2	3	3	2
Westham	72	15	52	77	132	171
Willingdon and Jevington	0	60	76	75	75	75
Withyham	0	2	3	3	3	2
	1035	722	618	764	1084	1463

*These parishes are contained within the South Downs National Park and WDC therefore no longer keep records of completions or commitments within the National Park.

Additional mapping further to public consultation

In order to address comments made during the public consultation we have added the detailed contour maps from the Access Study showing travel times by walking, public transport and by car.

There is no evidence of a geographical gap in Hastings or Eastbourne Boroughs.

Figure 44 shows contours with access to all pharmacies by walking. Areas with access within 15 minutes are shown as yellow, the lightest green represents areas within 15 and 30 minutes, with increasingly darker greens moving to blues (60+minutes) to represent increasingly longer walking journeys, up to a maximum of 120 minutes.

Areas where a pharmacy cannot be accessed within 2 hours walk are coloured white. The map shows residents in many areas cannot access a pharmacy within a half hour walk, with many in rural areas having no access at all or only access within more than an hour's walk.

Access to pharmacies (including dispensing GP surgeries) on weekdays

Figure 44 Daytime access to pharmacies by walking

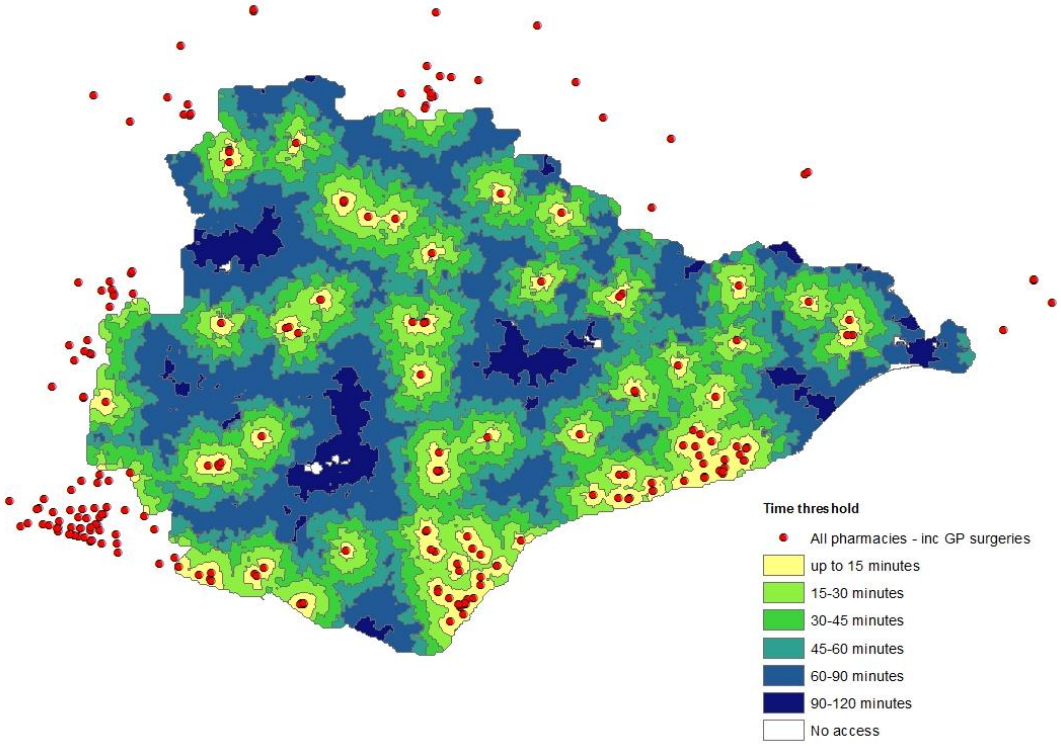


Figure 45 shows contours with access to all pharmacies using public transport, where people can make a journey both to and from a pharmacy with the longest journey shown.

Areas with access within 15 minutes are shown as yellow, the lightest green represents areas within 15 and 30 minutes, with increasingly darker greens moving to blues (60+minutes) to represent increasingly longer public transport journeys, up to a maximum of 120 minutes.

Areas where a pharmacy cannot be accessed within 2 hours using public transport are coloured white. The map shows residents in many areas cannot access a pharmacy within a half hour public transport journey with many in rural areas having no access at all.

Figure 45 Daytime access to pharmacies by Public Transport – two way journey

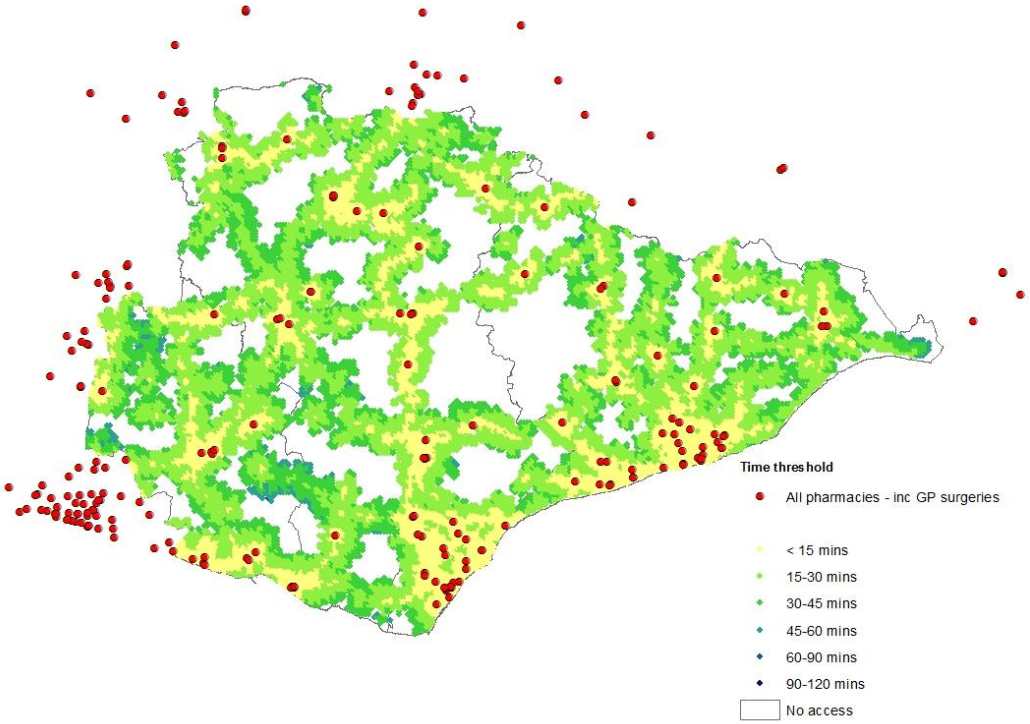


Figure 46 shows contours with access to all pharmacies using public transport, where people can make a one-way journey to a pharmacy.

Areas with access within 15 minutes are shown as yellow, the lightest green represents areas within 15 and 30 minutes, with increasingly darker greens moving to blues (60+minutes) to represent increasingly longer public transport journeys, up to a maximum of 120 minutes.

Areas where a pharmacy cannot be accessed within 2 hours using public transport are coloured white. The map shows residents in many areas cannot access a pharmacy within a half hour public transport journey with many in rural areas having no access at all.

Figure 46 Daytime access to pharmacies by Public Transport - outbound

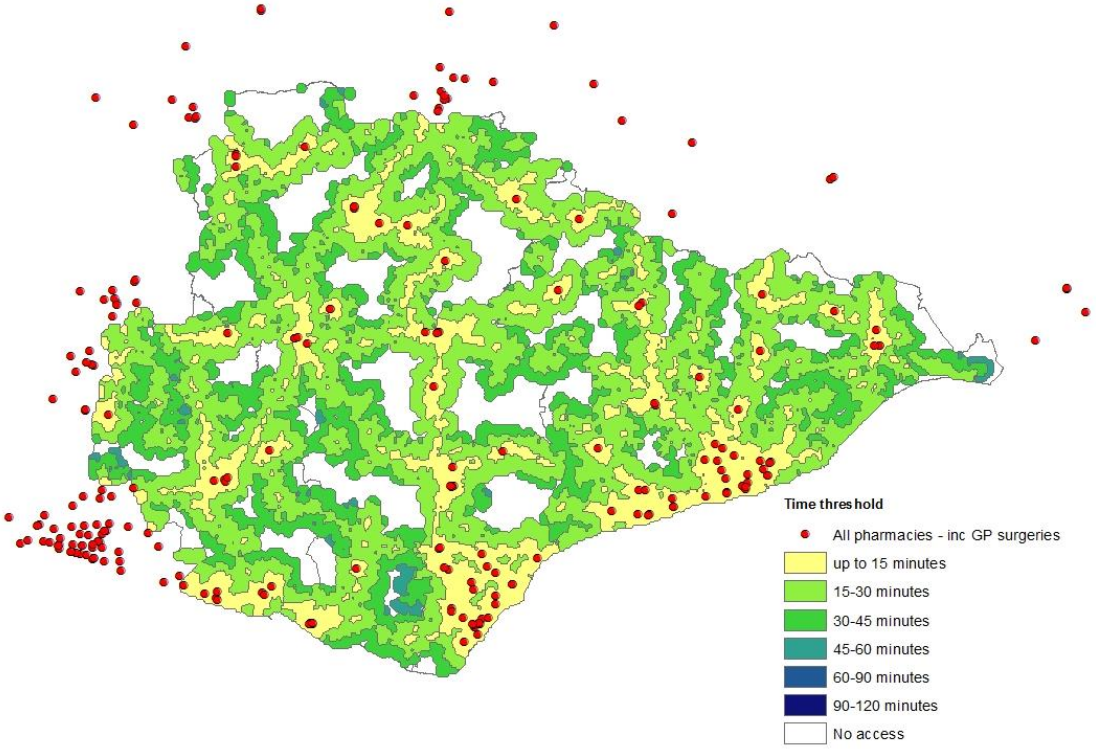


Figure 47 shows contours with return journeys from all pharmacies using public transport, where people can make the one-way journey returning from a pharmacy to their home.

Areas with access within 15 minutes are shown as yellow, the lightest green represents areas within 15 and 30 minutes, with increasingly darker greens moving to blues (60+minutes) to represent increasingly longer public transport journeys, up to a maximum of 120 minutes.

Areas where return journey from a pharmacy cannot be made within 2 hours using public transport are coloured white. The map shows residents in many areas cannot access a pharmacy within a half hour public transport journey with many in rural areas having no access at all.

Figure 47 Daytime access to pharmacies by Public Transport – inbound

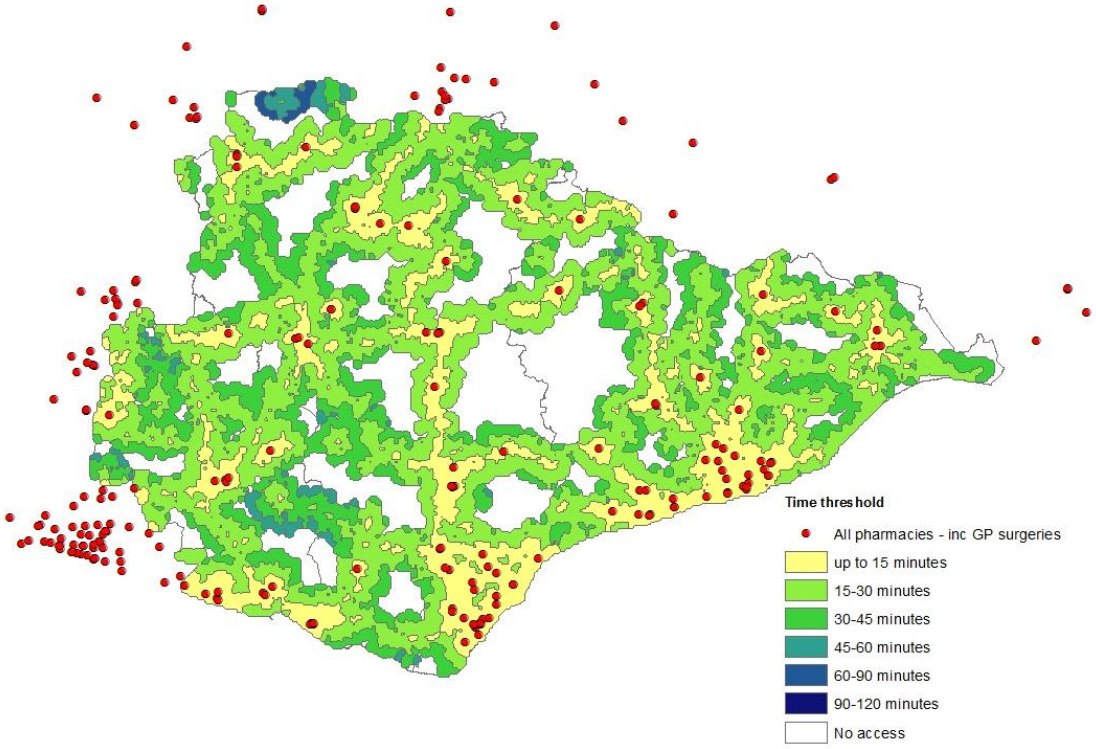
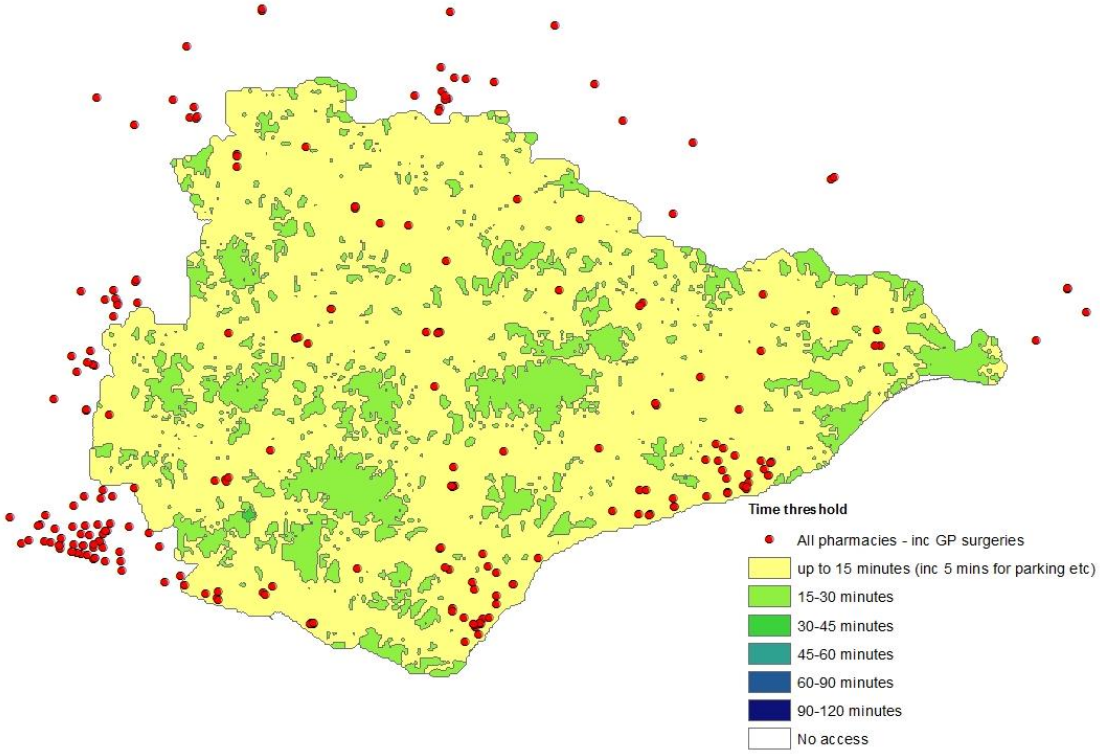


Figure 48 shows contours with access to all pharmacies by car.

Areas with access within 15 minutes are shown as yellow, the lightest green represents areas within 15 and 30 minutes, and journeys of 30-45 minutes are shown as darker green. There are no areas where a pharmacy cannot be accessed within 45 minutes' drive.

The map shows residents in many rural areas cannot drive to a pharmacy within 15 minutes, but only a tiny number cannot drive within 30 minutes. Note that 5 minutes has been added to journey times to account for time spent searching for a parking space, parking and securing the vehicle.

Figure 48 Daytime access to pharmacies by car



Equality Act Compliance

Accessibility of pharmacy premises and parking was raised by some residents during the public consultation.

Some pharmacy premises in East Sussex are less accessible, for example, because they are in a listed building, or are on a hill. In these circumstances the pharmacy would make reasonable adjustments such as having a ramp available.

Blue badge holders can park on double yellow lines for a limited period outside a pharmacy so would have no less access than if they were coming from a disabled parking area.

Residents are advised to check the facilities of their pharmacy as they are recorded on the NHS website.

Pharmacies are required to report annually to NHSE about the accessibility of their premises. Any new premises, or changes to existing premises, must meet accessibility standards.

ESCC is working with Districts and Boroughs to address parking issues for disabled people.

We recommend that Ds and Bs clearly communicate to residents the location of existing disabled parking.

11. Stakeholders' consultation

Each Health and Wellbeing Board has a duty to consult with key stakeholders as defined in Regulation 8 of The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (legislation.gov.uk).[158] A minimum of 60 days were given to respond to the PNA report between 1st June and 30th July 2022.

The following groups/organisations were consulted by means of an on-line web page, hosted by ESCC.

(a) The Local Pharmaceutical Committee (including any Local Pharmaceutical Committee for part of its area, or for its area and that of all or part of the area of one or more other HWBs);

(b) The Local Medical Committee (including any Local Medical Committee for part of its area, or for its area and that of all or part of the area of one or more other HWBs);

(c) Persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) Any LPS chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;

(e)The Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB has an interest in the provision of pharmaceutical services in its area; and

(f) Any NHS trust or NHS foundation trust in its area;

(g) NHS England

(h) Any neighbouring HWB: Brighton & Hove; West Sussex; Kent; Surrey.

The PNA has a specific function which is to describe the underlying need for and provision of pharmaceutical services for the population within the geographical area covered. This includes looking at the overall distribution of premises and services but does not have a role in quality assuring those services or commenting on the location of individual premises. There are separate NHS England processes for both of those functions.

Complaints or issues with a specific pharmacy or dispensing practice should be dealt with using the pharmacy's or GP practice complaints procedure, and if the matter is not satisfactorily resolved it can be escalated to NHS England.

Challenges relating to the location of specific pharmacy premises are dealt with through the Market Entry process, with rights to appeal on the outcome.

The PNA sits at a high level to show whether or not there is appropriate pharmacy provision across the county as a whole. Its purpose is not to comment on, or interfere with, commercial and NHS England processes and decisions.

In the period since the last PNA, there has been a change to pharmacy provision within St Leonard's, which has resulted in the NHS appeals process being fully used, with a decision from NHS Resolution. The Health and Wellbeing Board are aware of the strength of feeling of local residents. [Evidence: ESCC consultation website and from the petition from local residents] however it is outside of the scope of the PNA for the reasons set out above.

Summary of stakeholders' consultation

Fifty-five responses were received during the stakeholder consultation: 12 on the full PNA document and 43 on the summary document. 3 responses were from organisations, one from a pharmacy and two from neighbouring local authorities on behalf of their Health and Wellbeing Board.

Tables 48 – 50 summarise the non-free text responses received

Table 48: Do you think the summary explains the following things well?

Question	Yes	No	Not sure
Do you think the summary explains the following things well:			
What a PNA is?	40	4	2
How we created our PNA?	37	1	4
The gaps we identified	29	6	7

Table 49: Do you agree or disagree with the final recommendations made in the PNA?

Question	Strongly agree	Agree	Neither	Disagree	Strongly disagree
Do you agree or disagree with the final recommendations made in the PNA summary	2	23	8	7	2
Do you agree or disagree with the final recommendations made in the PNA	2	2	4	1	1

Table 50: The following questions were only asked of people responding to the full PNA (n=12)

Question	Yes	No	Comments
Do you think the PNA shows a good understanding of the health and wellbeing needs of the people of East Sussex	6	5	Blister packs, [point 1. below] Closure of specific pharmacy [point 10. Below] No indication of disabled access [point 2. Below]
Do you think the PNA accurately describes the pharmaceutical services on offer in East Sussex?	7	4	Holding a pharmacist's licence doesn't mean good service; Closure of pharmacy in St. Leonards; [Point 10. Below]

			Inaccurate/inconsistent maps of GP dispensaries in north of County [Point 17. below]
Do you think the PNA accurately describes any gaps that exist now or might in the future	5	6	Doesn't address quality of services, doesn't have qualitative data [Point 11. below] Closure in St Leonards [Point 10. below]
Do you think the PNA properly highlights the challenges people in East Sussex might face in using a pharmacy?	8	3	St Leonards issue not mentioned [Point 10. below] Needs to show disabled access [Point 2. and point 16. Below] Doesn't include cost benefit of one-month medication rule [Point 7. below]
Do you think the PNA gives NHS England the information it needs to make "market entry" decisions about new pharmacies for East Sussex?	8	3	St Leonards not highlighted. [Point 10. below] Doesn't cover quality of services [Point 13 below]

Table 51

Table 51 summarises the comments received during the consultation process, with similar comments grouped together, along with the Steering Group's response on behalf of the Health and Wellbeing Board.

Table 51 Summary of stakeholders' consultation comments and Steering Group replies

	Source(s)	Comment	Steering Group response
1.	General practitioner, Member of the public	Please address inadequate pharmacy services to deliver drugs in blister packs for an increasingly frail population which is increasing. There are no local pharmacies	The delivery and the provision of blister packs [boxes containing medicines to be taken at certain times of the day/week] is not part of the Community Pharmacy

		with capacity to take on new elderly / confused patients and the situation has remained the same throughout the time of the pandemic and, in spite of relaxation of restrictions, no increase of provision has been made Currently this poses a safeguarding concern in the wider community Please address this as a priority safeguarding need	Contractual Framework nor is it a locally commissioned service. The pharmacist will complete an assessment under the Equality Act to see what reasonable adjustment could be made to enable a patient to take their medication. This could include large print labels, easy to open tops, tick charts, blister packs etc. The pharmacist would assess the patient and decide what adjustment would be suitable. With the ever-increasing volume of requests for blister packs for patients from carers, family members and other healthcare professionals, this can lead to governance and safety issues for a pharmacy for example, due to the size of the dispensary, storage space, staffing etc. When safety could be compromised by increasing the volume of blister packs a pharmacy could decide to limit that number. This is one of the reasons that some pharmacies are assessing their current blister pack patients to determine if they are providing them for the most vulnerable patients who would fall under the Equality Act and require the adjustment of a blister pack, or whether there are patients currently being provided them who would be able to self-manage, or with whom another adjustment would improve patient outcomes such as reminder alarms. In a statement published on the 22nd of June, the Royal Pharmaceutical Society (RPS) said that while blister packs are "often viewed as a solution" to people experiencing obstacles when taking their medicines,

			"the limited evidence base suggests a lack of patient benefit regarding outcomes and sometimes they can cause harm". The RPS pointed to other solutions to help with medicine use.
2.	3 members of the public	Disabled access "The PNA needs to include an analysis that shows disabled access and parking, not just where pharmacies are." The plan of pharmacies should show which buildings do not have disabled access. The nearest one with disabled access is the supermarket approximately 2 miles away. "As a disabled Wealden resident, I am not sure that your figures really take rural wheelchair living into account. I cannot get to a town with a pharmacy that I can park close to. Pharmacies are by nature in towns, but Wealden is predominantly hilly, and therefore towns are often out of reach of the disabled."	The guidelines for PNA development do not specifically require the mapping of disabled parking near pharmacies, or wheelchair access. A new section has been added to Section 10 of the report explaining Equality Act Compliance. We have not included a map of premises with disabled access. Some premises are in listed buildings where they are unable to create permanent disabled access. However all pharmacies are required by law to make reasonable adjustments which might include temporary ramps. Disabled people with blue badges can park on single or double yellow lines for up to three hours, which should help facilitate access to pharmacies and other facilities. Patients are advised to check the NHS website for accessibility at their respective pharmacy and contact them directly to discuss their individual needs. We acknowledge people who use wheelchairs and those with other physical access needs find moving around the County more difficult. Most community pharmacies [43/46] replying to the pharmacy survey stated they have easy access for disabled customers at the pharmacy premises (including wheelchairs).

			About a quarter of people with an unmet physical access need in the Residents' survey specifically mentioned a problem with parking. Parking is controlled by district and borough councils. We recommend that Ds and Bs clearly communicate to residents the location of existing disabled parking.
3.	4 members of the public	Opening hours People made some comments about out of hours and weekends. There were comments about opening before 09:00 "due to timing of publication, you may not have taken recent changes to opening hours of a number of branches of … into consideration"	The travel analysis section considers both public transport and walking, as well as travel by car. The analysis covers this for weekdays and weekends. There is provision outside of normal office hours. The majority of this provision is in the evenings. There is a recommendation to consider commissioning additional evening hours from existing providers on a rota basis to improve access in evenings. The out-of-hours doctor can give urgent medicines. Where it is safe and appropriate, other prescriptions written out of hours can wait to be dispensed the next day. The PNA report and the associated mapping were undertaken at a given point in time in January 2022. There may be changes to the opening hours of pharmacies after January 2022. Any substantive change to service provision after publication of the PNA will require the production of Supplementary Statements.
4.	2 members of the public	Staff shortages "telephone lines are constantly engaged" "The gaps you have identified are mostly due to lack of pharmacy	The majority of pharmacies in the survey have stated that they would be able to manage an increase in demand.

	Pharmacy staff member	staff. These are trained to a high level and in short supply. They are extremely poorly paid, mostly Dispensers earn less than a living wage at under £10 an hour. Very difficult to recruit new staff at that level of pay. "Whilst the PNA as written serves a useful service and highlights perceived provision shortcomings it doesn't seem to highlight the fact that the existing pharmacies are overwhelmed, mainly due to being under resourced with staff and management systems, probably due to them being the end of the chain in a business." "The pharmacy I use (2 mile walk) has become significantly busier due to many new homes having been built. Staff are constantly under pressure and there is always a queue."	There is a national shortage of pharmacists across all healthcare areas. Locally this was reflected with some qualitative evidence from the pharmacy survey. There are workforce plans being put into place both nationally and at ICS level. There is an ICS workforce group. Each individual business has its own business continuity plan and workforce plan to address staff shortages. As part of the pharmacy assurance framework, pharmacies are checked that they have a standard operating procedure for business continuity and for dispensing.
5.	3 members of the public, 1 GP	Medication shortages "There are occasions when there is no supply of vital medication. They do not seem to be able to order sufficient supplies to fulfil repeat prescriptions" "it is taking over 7 days to get medication in some pharmacies." "why doesn't your gap analysis cover the issue of models to address low supply…in a few places 8.3 and 7.4 you mention stock shortages..,inability to fulfil contractual obligation…but you don't address this as a gap? Why not?" "Inability to fulfil contractual obligation to dispense prescription appears to me to be a major gap….what can pharmacies do to work together to address this problem locally…and in severe shortage cases how do pharmacies act to get the shortage recognised and dealt with nationally quickly."	There are significant and ongoing national supply issues of stock from pharmaceutical manufacturers. This issue has been raised at a national level by the PSNC [Pharmaceutical Services Negotiating Committee]. This is outside of the control of the community pharmacy and outside the scope of the PNA.

		A prescriber expressed frustration on the occasions where there were shortages of drugs resulting in delays and inefficiencies.	The levels of stock at the wholesalers of any given medicine can change throughout the working day.
6.	3 members of the public	Impact of new housing. "The existing pharmacy in .. struggles to cope with the increasing demand caused by additional housing." "New housing estates don't seem to provide the society driven infrastructure that is required.."	This PNA considered planned housing developments for the period 2020-25 in the gap analysis for each district and borough (Tables 38, 40, 42, 43, 45 and 47). No area has sufficient planned housing to justify a new pharmacy in any one parish. And therefore we do not anticipate additional pressure from future housing developments
7.	5 members of the public	Challenges with repeat prescriptions "An increase in either hours or capacity is urgently needed as the 5-day requirement for repeat prescriptions is never able to be fulfilled." Two questions about why repeat prescriptions can't be for a longer period?	There is no contractual requirement for the timeframe for repeats. One week [five working days] is normal practice for routine repeat prescriptions from point of ordering at the GP practice to allow them to generate and sign the prescription, followed by time for the pharmacy to dispense the prescription. The GP decides prescribing duration according to their clinical assessment and safety considerations.
8.		I cannot understand why I had to travel on a crowded bus from […] to [named hospital] to collect .. [specific medication before an examination] . Surely it could be either posted to me, or stocked in my local chemist, or even sent to the pharmacy in my doctor's surgery. It caused me a great amount of stress having to ride on a packed-out bus where I was likely to be exposed to all sorts of germs.	When the hospital issues prescriptions for 'hospital only medicines' there should be the means for patients to collect these easily. PALS at […] informed and have forwarded to endoscopy suite staff.
9.	Members of the public	Complaints about specific local pharmacies "As a resident of Rye, the current situation at our local [...] is lamentable - but I don't know whether this comes under the	This is outside the scope of the PNA. Each pharmacy has its own complaints procedure.

		auspices of […] or a more general body." "I only have a very slow and understocked supermarket pharmacy within a short walking distance. Why is there not an independent one nearer in Hampden Park, Eastbourne? […] is so busy and they ask stupid questions before they hand over your prescription. […]is a bit too far to walk for me and they are always busy". Complaint about pricing in independent pharmacists being significantly more expensive the supermarkets or chains.	If need be, a complaint can be escalated to the NHS England complaints resolution service. The pricing of items is a commercial decision of the pharmacy taking into account their business costs.
10.	5 members of the public 1 GP	Closure of pharmacy, St.Leonards. "No apparent consideration given to the reduction in the number of pharmacies in St Leonards due to the withdrawal of licensing." "Pharmacy attached to St Leonards Medical Centre must be reinstated in order to provide accessible services and support the two surgeries." "We need the .. pharmacy in St Leonards medical centre."	There has been a change in service provision in the area, as has also occurred in other areas within East Sussex. As explained at the beginning of this chapter, there is a separate statutory process for decisions on individual premises. The NHS licensing processes were followed. The travel access analyses show that most people in St.Leonards can access a pharmacy during the working day and have sufficient choice.
11.	Member of public + other	There are existing gaps - this PNA seems to be based on quantitative data and not qualitative. Not enough qualitative research on how service is delivered.	Qualitative data have been included in the PNA: Chapter 7 – East Sussex Residents Survey, Chapter 8 – Community pharmacy provider survey, Chapter 9 – Dispensing Practices Survey
12.	Member of public	Ordering medication online has been very helpful to me and I wish it had been available 10 years ago when I was a carer for my father….I didn't notice any reference to this as standard practice, but perhaps it is	The use of online dispensing is referred to on page 14 of the Executive Summary.
13.	Individual (other)	Proximity to a pharmacy is only part of the equation. What about	The PNA report is not looking at quality of service.

		the total convenience offered by an integrated healthcare system? Parking, ease of access, appropriate opening hours linked to the opening hours of a surgery - what about weekend access for out-of-town centre services?	The purpose of PNA is to assess overall provision of pharmacies and in doing so will contribute to the overall ICB development processes for the integrated care system. This is covered in the travel access section and mapping.
14.	NHS employee	Terminology confusing and direct comparative analysis is impossible. (summary document)	A glossary appears in the main document. We will include a link to the glossary in the short version as well.
15.	NHS employee	Rather than looking at distance from walking or driving you need to look at [the] population within a certain radius of a pharmacy.	If a radius from a pharmacy is used for access analyses it only reflects how the crow flies and not the real journeys undertaken by people.
16.	Member of public	I think you have focussed on the number and access to pharmacies in a very numerical model….not on access to meeting needs….I read a lot of general description of categories of people who may have needs…not about their needs and how better to meet them….	The PNA section 5, health-related needs, focusses in general terms on groups of people with additional needs and where health inequality is greatest. The implementation of the new pharmacy contract and services being provided in pharmacy will improve access. These will help in meeting some of the needs for the most disadvantaged. Pharmacies endeavour wherever possible to meet patient needs by making suitable adjustments. Pharmacies will continue to give appropriate signposting to other sources of support in their communities.
17.	B&H CC	Pharmacies and dispensing GP locations don't seem consistent. The map shows that there is less provision of community pharmacies in more densely populated areas. Is this correct?	We have checked maps of dispensaries and pharmacies in north of County. Older/draft versions of maps included in the consultation draft have been corrected and replaced.
18.	B&H CC	It would be helpful to add more narrative to describe what the maps in the report show.	There are detailed maps of Eastbourne and Hastings with a commentary showing distribution of pharmacies by IMD score in Section 10.

19.	B&H CC	It would be helpful in Table 9 pages 53 to 55 to indicate whether the figures represent number, % or rates (units not always specified).	A link to a detailed description of the public health data has been included. Units added to the table.
20.	B&H CC	Comments requesting further clarification about recommendations regarding the professional roles of pharmacists and customer service.	These appeared in the shortened version of the online consultation only and have now been removed.

12. Overall conclusions

In the context of their new contractual framework pharmaceutical service providers will play an important future role in:

- providing a range of clinical and public health services[158]
- the management of long-term health conditions, as well as their prevention
- facilitating new approaches to urgent and emergency care[159]
- supporting safe and effective medicines management in general practice

Overall, there is good pharmaceutical service provision across East Sussex. In rural areas there are enough dispensing practices to provide essential dispensing services to the rural population on weekdays.

The potential increase in opening hours of GP practices to 8 p.m. on weekdays and on Saturdays until 5 p.m. from October 2022 could need to be addressed in terms of making pharmacy services more accessible in future by aligning pharmacy hours through the commissioning of an extended hours service from existing providers.

If there are changes in provision of services, the Health and Wellbeing Board will publish a supplementary statement setting out whether it considers that the change has created a gap in the provision of pharmaceutical services.

PCN pharmacists working alongside GP practices should ease some of the burden on GPs by dealing with routine medicines enquiries, as well as undertaking structured medicines reviews. PCN pharmacists are not involved in dispensing, so this will not offset any further loss of community pharmacies from a dispensing point of view.

COVID-19 has meant many people have adapted the way they access dispensing services and the ways in which medicines support services are provided.

The Director of Public Health has a statutory obligation to keep under review the pharmacy capacity in each locality in East Sussex in terms of meeting the needs of the population. Should pharmacies have to, or choose to, close in future we will publish supplementary statements and keep the Health and Wellbeing Board duly informed.

Appendix A: Policy context and background

Health and Care Reforms

Health and care reforms are summarised in:

- The Health and Care Bill NHS planning and commissioning
- The White Paper (integration): Joining up care for people, places and populations NHS and Local Government Integration
- The White Paper: People at the heart of care 10-year vision for adult social care
- The Independent Review of Children's Social Care

The NHS Health and Care Bill

The NHS Health and Care Bill aims to remove some of the barriers to integration within the NHS, and those between the NHS, Local Government and wider partners.

It puts Integrated Care Systems (ICSs) on a legislative footing from July 2022 to commission healthcare services and absorbs the current functions of Clinical Commissioning Groups.

It introduces a new duty for the NHS and Local Authorities to collaborate but is not a comprehensive package of reforms. The NHS Health and Care Bill should be seen alongside broader national reforms to:

- Public Health
- Mental Health Act
- Social Care: Building Back Better

The Integration White Paper

This builds on the Health and Care Bill and introduces the **role of place** within ICSs as the "engine" for delivering integration.[160] There are shared outcomes and a resourced plan. There is an identified lead role accountable for delivery to the Local Authority and NHS ICB Chief Executive.

Local agreements

There is a Pan-Sussex ICS – Sussex Health and Care Partnership. Primacy of place is built around three place-based partnerships and populations:

- East Sussex
- West Sussex
- Brighton and Hove

Each place is to develop provider partnerships over time. There are opportunities to act at scale for specialist provision e.g. aspects of children's services, learning disability and autism services.

Work together at scale will occur where this brings clear benefits: through three collaboratives for acute, community and primary care; mental health; networked delivery for cancer; Local Maternity Services and other specialist service commissioning; as well as approaches to workforce and digital.

Place focus within the Sussex ICS

There will continue to be population health management using public health principles which include addressing health inequalities.

There will be transformation of clinical pathways and health and social care service models, and a focus on primary care.

Priorities for social care and housing, and other services related to delivering outcomes for the community are included, while operational issues and pressures will be addressed.

Political context

The national and local picture for NHS and social care services is very challenging. Councils and NHS organisations are facing unprecedented financial challenges. People are living longer, many with complex health conditions, whilst the demand for NHS and social care services is increasing. People are expecting more from their NHS and social care services, want to be able to choose what services they have, and how they are delivered.

Pharmacists in GP practices have an excellent opportunity to promote health and wellbeing messages when they are optimising the use of medicines, especially for people with long term health conditions.[161]

The Department of Health (DH) has imposed a reduction in the funding for community pharmacy while suggesting that further services could be commissioned. This presents a potential risk of community pharmacies being forced to cut services which are currently not commissioned by the NHS and provided for free, such as free delivery service with consequences for patients and for the local health and social care economy.

Community pharmacy funding background

NHS England has held responsibility for commissioning community pharmacy services. Other local commissioning bodies such as Clinical Commissioning Groups (CCGs) and Local Authorities can commission additional local services from community pharmacies. The system is governed by statutory arrangements, known as the Community Pharmacy Contractual Framework.

The English NHS currently spends £2.6 billion a year on a network of 11,569 community pharmacies - principally to supply and dispense NHS medicines.[162] The bulk of their total income, between 68-85%, comes from the NHS. Around 60% of pharmacies are part of multiple chains, with the remaining 40% being independent pharmacies or small chains of less than six outlets. Following Government liberalisation of market entry, there are nearly 2,000 more pharmacies than 15 years ago. Notably 40% of pharmacies are located within a 10-minute walk of two of more other pharmacies.

The opportunity for reform

Considerable scope exists to:

make better use of the skills and expertise of pharmacists in different settings, including pharmacists as an integral part of the core GP team;
utilise the network better, through introducing new services for the benefit of patients and the wider NHS; and
unlock major efficiency savings through the transformation and reform of dispensing using automation, online ordering, and supervision.

Changes in the funding for pharmacies

- Establishment payments (a basic payment for being open as a pharmacy) have been phased out and a range of dispensing-related fees have been amalgamated into a single activity fee.
- A Pharmacy Access Scheme remains in place to support services in isolated areas.
- A £75 million Pharmacy Quality Scheme continues to provide the opportunity for community pharmacies to earn back some of the funding that has been cut, based on how well they perform against criteria set out by the Government.

Appendix B: Consolidation of pharmacies: Regulations

Where one pharmacy gives up its premises and the functions are taken over by another in the area [otherwise known as consolidation], the HWB must take note of the proposed change and respond accordingly.

When NHS England receives an application, the relevant interested parties are notified. This includes the Health and Wellbeing Board [HWB]. The HWB must indicate whether, in the opinion of the Board, the proposed *removal* of the premises would create a gap in pharmaceutical services provision which could result in another subsequent application to open a pharmacy in that area. Once consulted, the HWB will issue a supplementary statement which is valid until the next PNA.

The regulations facilitate pharmacies in consolidating from two or more sites onto an existing site without allowing a new pharmacy to open in the 'perceived gap'.[163] There will be further proposed reform in the new Community Pharmacy Contractual Framework [CPCF].

"…. the funding delivered through the CPCF is still supporting more pharmacies in some places than may be necessary to ensure good access to NHS pharmaceutical services. It is recognised that some pharmacy contractors, particularly those with other branches of their own or a competitor's pharmacy closely located, could consider it commercially beneficial to consolidate. To support contractors who may be considering this option, we want to strengthen the protections offered to pharmacies wishing to consolidate under Regulation 26A of the NHS (Pharmaceutical and Local Pharmaceutical) Regulations 2013 whilst maintaining fair and open competition and access to NHS pharmaceutical services. As part of this exercise, we will look to remove any unnecessary administrative requirements to reduce the regulatory burden on service providers." [164]

Community Pharmacy Forward View

The 'Community Pharmacy Forward View,[165] sets out the sector's ambitions radically to enhance and expand the personalised care, support and wellbeing services that community pharmacies provide. Pharmacy teams will be fully integrated with other local health and care services to improve quality and access for patients, increase NHS efficiency and produce better health outcomes for all.[166] The three key roles for the community pharmacy of the future are:

- As the facilitator of personalised care for people with long-term health conditions
- As the trusted, convenient, first port of call for episodic healthcare advice and treatment
- As the neighbourhood health and wellbeing hub

The NHS Five Year Forward View[167] looks to develop practical examples for new models of care. Community pharmacy needs to be fully integrated into these new care models. The care models particularly relevant for community pharmacy are:

- Enhanced health in care homes offering older people better, joined up health, care and rehabilitation services
- New approaches to improve the coordination of urgent and emergency care services and reduce the pressure on A&E departments

The General Practice Forward View described how pharmacists were still 'one of the most underutilised professional resources in the system' and there was a need to 'bring their considerable skills into play more fully'.

The Pharmacy Quality Scheme

The Pharmacy Quality Scheme [PQS][168] forms part of the Community Pharmacy Contractual Framework (CPCF).

It supports delivery of the NHS Long Term Plan and rewards community pharmacy contractors that achieve quality criteria in the three domains of healthcare quality: **clinical effectiveness, patient safety and patient experience.**

The Pharmacy Quality Scheme is negotiated on an annual basis and the elements of the scheme change in each financial year.

Results from the previous 2020/2021 Pharmacy Quality Scheme declaration showed that all eligible pharmacies in East Sussex and Brighton and Hove LPC completed Part 2 of the PQS in February 2021.Two pharmacies did not take part in Part 1 of the PQS.

Prevention

Through the Healthy Living Pharmacy (HLP) framework, the majority of community pharmacies are already proactively delivering a wide range of interventions to support people's health and wellbeing.

From 1st January 2021 HLP status became an *essential* requirement for community pharmacy contractors. This requires all community pharmacies to have trained health champions in place to deliver interventions on key issues such as smoking and weight management, providing wellbeing and self-care advice, and signposting people to other relevant services.

The Department of Health and Social Care [DHSC], NHS England and the PSNC agree the reach of the mandated annual health promotion campaigns that community pharmacies already take part in. As far as possible these will be aligned to the equivalent campaigns in general practice as part of effective integration across Primary Care Networks. They will seek to make better use of digital technology to deliver and evaluate the impact of these campaigns.

In late 2020, the introduction of Hepatitis C testing in community pharmacies for people using needle and syringe exchange programmes was funded to support the national Hepatitis C elimination programme. There are now medicines offering a potential cure for hepatitis C infection if diagnosed.

All patient facing staff are expected to be trained as dementia friends. A dementia friendly environment checklist is recommended for pharmacies.

Safeguarding training: [80% of all registered pharmacy professionals working at the pharmacy have achieved level 2 safeguarding status for children and vulnerable adults in the last two years prior to the date of their declaration. Part of the 2020/2021 PQS.]

NHS 111 and Directory of Service [DoS] Profile updating

Having accurate information about the community pharmacy [maintaining accurate information in their online NHS profile] supports communication with other NHS providers. This will enable effective communication and referrals (importantly to the Community Pharmacist Consultation Service, CPCS). The contractor must update its NHS website profile in respect of its opening hours.

NHS mail

It is now a contractual requirement for all pharmacies to have access to NHS mail. Pharmacy staff at the pharmacy must be able to send and receive NHS mail from their shared premises specific NHS mail account, which must have at least two live linked accounts.

Governance in pharmacies

Which organisation(s) is/(are) held accountable for customer service in community pharmacy?

The owner or Superintendent Pharmacist of the pharmacy, or both, depending on the customer service it relates to. The superintendent pharmacist is responsible for the professional and clinical management of a pharmacy and the administration of the sale and supply of medicines.

Which organisation is responsible for quality of services within pharmacies?

Quality of service under the Pharmacy Contractual Framework would be under the responsibility of the Superintendent Pharmacist for the pharmacy. The superintendent pharmacist is responsible for the professional and clinical management of a pharmacy and the administration of the sale and supply of medicines.

The General Pharmaceutical Council regulates and inspects pharmacies. They also set standards for registered pharmacy professionals and pharmacy premises

For commissioned services the commissioner of the service would set the quality standards required for the service e.g. NHSE&I for national advanced services, the local authority for locally commissioned Public Health services.

What is the role of the CQC (if any) in regulating the activities of pharmacies?

Community pharmacy is regulated and inspected by the General Pharmaceutical Council and not CQC.

Regulations update

Changes were made in December 2021 to the Regulations.[7] The National Enhanced Service (NES) was introduced where NHS England commissions an Enhanced Service with a service specification that sets standard conditions nationally.

The Pharmaceutical Services Negotiating Committee [PSNC] becomes the body consulted on the service and its funding, rather than one or more Local Pharmaceutical Committees (LPCs).

NHS (Charges, Primary Medicinal Services and Pharmaceutical and Local Pharmaceutical Services (Coronavirus) (Further Amendments) Regulations 2021 (SI 2021 No. 1346) and make amendments to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Regulations).

The Contractors' Terms of Service have been revised to allow NHSE to introduce a pandemic response programme.

A Listed Prescription Item Voucher (LPIV) scheme has been introduced, as a further option for the community pharmacy supply of treatments or medicines during, or in anticipation of, pandemic disease. This may be used for the supply of medicines without charge to the patient.

Contractors may supply a Patient Only Medicine (POM) to a person in accordance with a Pandemic Treatment Protocol (PTP) or Pandemic Treatment Patient Group Direction (PT PGD), if and when one is issued by NHSE.

What has been the overall impact of the Community Pharmacy Contractual Framework [CPFC]?

New services specified in the CPFC, working with Primary Care Networks, will help address some of the needs of vulnerable groups. This includes myth busting regarding COVID immunisations and early identification and management of people who have increased cardiovascular disease risk.

[7] NHS (Charges, Primary Medicinal Services and Pharmaceutical and Local Pharmaceutical Services (Coronavirus) (Further Amendments) Regulations 2021 (SI 2021 No. 1346) make amendments to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Regulations).

Appendix C: Definitions of pharmaceutical services

Essential services

All pharmacies, including distance selling premises, are required to provide the essential services. As of October 2021, there are eight essential services.

1. Dispensing of prescriptions,
2. Dispensing of repeat prescriptions i.e. prescriptions which contain more than one months' supply of drugs on them. For example, an electronic repeatable prescription may say that the prescription interval is every 28 days and it can be repeated six times. This would give a patient approximately six months' supply of medication, dispensed every 28 days with the prescriber only needing to authorise them once.
3. Disposal of unwanted medicines returned to the pharmacy by someone living at home, in a children's home, or in a residential care home.
4. Promotion of healthy lifestyles, which includes providing advice to people who appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), or smoke, or are overweight, and participating in six health campaigns where requested to do so by NHS England.
5. Signposting people who require advice, treatment or support that the pharmacy cannot provide to another provider of health or social care services, where the pharmacy has that information.
6. Support for self-care which may include advising on over the counter medicines or changes to the person's lifestyle.
7. Discharge medicines service. This service was introduced in 2021 and aims to reduce the risk of medication problems when a person is discharged from hospital. It is estimated that 60 percent of patients have three or more changes made to their medicines during a hospital stay. However, a lack of robust communication about these changes may result in errors being made once the person has left hospital. In summary, under this service a pharmacist will review a person's medicines on discharge and ensure that any changes are actioned accordingly.
8. Healthy Living Pharmacy

Advanced and Enhanced Services

Advanced services

These can be provided by all contractors, and are commissioned by NHS England

- New Medicine Service (pharmacies only) to help improve medicine adherence among people with long-term health conditions who have been prescribed new medication
- Flu vaccination (pharmacies only) pharmacists offer a seasonal flu vaccination service for patients in eligible groups
- Appliance Use Review (pharmacies and DACs) to support patients in the use, safe storage and disposal of appliances

- Stoma Customisation Service (pharmacies and DACs) to ensure the proper use and comfortable fitting of the stoma appliance
- Community Pharmacist Consultation Service [CPCS] for minor illnesses and urgent medicines supply
- Community pharmacy hepatitis C antibody testing service (currently due to end on 31 March 2023)
- Hypertension case-finding
- Smoking cessation service

Enhanced services

Enhanced services are the third tier of services that pharmacies may provide and they can only be commissioned by NHS England. The services that may be commissioned are listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (as amended) which can be found in the Drug Tariff. Whilst the local authority may commission public health services from pharmacies these do not fall within the legal definition of enhanced services. See 'locally commissioned services' below.

These services can be commissioned by NHSE

- Anticoagulant monitoring
- Care homes
- Disease specific medicines management
- Gluten free food supply
- Home delivery
- Language access
- Medication review
- Medicines assessment and compliance support service
- Minor ailment
- Needle and syringe exchange
- On demand availability of specialist drugs
- Out of hours
- Patient Group Direction
- Prescriber support
- Schools service
- Screening
- Stop smoking
- Supervised administration

- Supplementary prescribing
- Emergency supply service
- Antiviral collection points

Locally commissioned services [other NHS services]

Locally commissioned services is not a term that can be found within the 2013 Regulations but is used to describe those services commissioned from pharmacies by local authorities and clinical commissioning groups. They are not enhanced services because they are not commissioned by NHS England.

Local authority [ESCC] commissioned services

These are commissioned by East Sussex County Council Public Health department

- Smoking cessation
- Emergency Hormonal Contraception [EHC]
- Chlamydia screening
- Supervised consumption
- Needle exchange
- NHS Health Checks
- Take Home Naloxone

Local pharmaceutical services

NHS England does not hold signed contracts with the majority of pharmacies. Instead, pharmacies provide services under a contractual framework and the terms of service are set out in the 2013 Regulations. The one exception to this rule is *local pharmaceutical services*.

A local pharmaceutical services contract allows NHS England to commission services that are tailored to meet specific local requirements. It provides flexibility to include within a locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. The contract must, however, include an element of dispensing.

Appliances

A smaller proportion of the population will require access to appliances. Those that are available on the NHS are set out in Part IX of the Drug Tariff and include:

• catheters, • dressings, • elastic hosiery, • hernia support garments, • trusses, • colostomy bags, and • urostomy bags.

Whilst pharmacies are required to dispense valid NHS prescriptions for all drugs, both they and dispensing appliance contractors may choose which appliances they provide in their normal course of business. They may choose to provide a certain type of appliance, or types of appliance, or they may choose to provide all appliances. Some pharmacies may choose not to provide any appliances.

A large proportion of patients who are regular users of appliances will have them delivered, often by dispensing appliance contractors based in other parts of the country.

Dispensing appliance contractors

Dispensing appliance contractors are different to pharmacy contractors because they: • only dispense prescriptions for appliances. They cannot dispense prescriptions for drugs • are not required to have a pharmacist • do not have a regulatory body • their premises do not have to be registered with the General Pharmaceutical Council.

Dispensing appliance contractors tend to operate remotely, receiving prescriptions either via the post or the electronic prescription service, and arranging for dispensed items to be delivered to the patient. There are far fewer of them compared to pharmacies (there were 111 dispensing appliance contractors as at 30 June 2021 compared to 11,201 pharmacies). Consequently, not every health and wellbeing board will have a dispensing appliance contractor operating in their area, however residents will be accessing their services elsewhere in the country.

New Medicine Service

Service description

The New Medicine Service is provided to patients who have been prescribed for the first time, a medicine for a specified long-term condition, to improve adherence.

The New Medicine Service involves three stages, recruitment into the service, an intervention about one or two weeks later, and a follow up after two or three weeks.

Aims and intended outcomes

The purpose of the service is to promote the health and wellbeing of patients who are prescribed a new medicine or medicines for certain long-term conditions, to help reduce symptoms and long-term complications. By intervening post dispensing, to help identify problems with management of the condition and the need for further information or support and to help patients:

- Make informed choices about their care
- Self-manage their long-term conditions
- Adhere to agreed treatment programmes and
- Make appropriate lifestyle changes

Stoma Appliance Customisation

Service description

Stoma appliance customisation is the customisation of a quantity of more than one stoma appliance, where:

- The stoma appliance to be customised is listed in Part IXC of the Drug Tariff
- The customisation involves modification to the same specification of multiple identical parts for use with an appliance and
- Modification is based on the patient's measurement or record of those measurements and if applicable, a template

Aims and intended outcomes

The purpose of the service is to:

- Ensure the proper use and comfortable fitting of the stoma appliance by a patient and
- Improve the duration of usage of the appliance, thereby reducing wastage of such appliances

Appliance Use Review

Service description

An Appliance Use Review is about helping patients use their appliances more effectively. Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

Aims and intended outcomes

The purpose of the service is, with the patient's agreement, to improve the patient's knowledge and use of any specified appliance by:

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

National influenza adult vaccination service

Service description

Pharmacy staff will identify people eligible for flu vaccination and encourage them to be vaccinated. This service covers eligible patients aged 18 years and older who fall in one of the national at-risk groups. The vaccination is to be administered to eligible patients, who do not have any contraindications to vaccination, under the NHS England patient group direction.

Aims and intended outcomes

The aims of this service are to:

Sustain uptake of flu vaccination by building the capacity of community pharmacies as an alternative to general practice

Provide more opportunities and improve convenience for eligible patients to access flu vaccinations and

Reduce variation and provide consistent levels of population coverage of community pharmacy flu vaccination across England by providing a national framework

NHS Community Pharmacist Consultation Service

Service description

Under the NHS community pharmacist consultation service patients who urgently need medicines, or who have symptoms of a minor illness and contact either NHS 111, or an Integrated Urgent Care Clinical Assessment Service, or contact surgery for minor illness are referred to a community pharmacist for a consultation, thereby releasing capacity in other areas of the urgent care system such as accident and emergency (A&E) and general practices and improving access for patients.

Aims and intended outcomes

The aims of this service are to:

- Support the integration of community pharmacy into the urgent care system, and to refer patients appropriately with lower acuity conditions or who require urgent prescriptions, releasing capacity in other areas of the urgent care system
- Offer patients who contact NHS 111 the opportunity to access appropriate urgent care services in a convenient and easily accessible community pharmacy setting on referral from an NHS 111 call advisor and via the NHS 111 Online service
- Reduce demand on integrated urgent care services, urgent treatment centres, Emergency Departments, walk in centres, other primary care urgent care services and GP Out of Hours (OOH) services, and free up capacity for the treatment of patients with higher acuity conditions within these settings
- Appropriately manage patient requests for urgent supply of medicines and appliances

- Enable convenient and easy access for patients and for NHS 111 call advisor referral
- Reduce the use of primary medical services for the referral of low acuity conditions (i.e. minor illnesses) from NHS 111 and the need to generate urgent prescriptions
- Identify ways that individual patients can self-manage their health more effectively with the support of community pharmacists and to recommend solutions that could prevent use of Urgent and Emergency Care services in the future
- Ensure equity of access to the emergency supply provision, regardless of the patient's ability to pay for the cost of the medicine or appliance requested
- Increase patient awareness of the role of community pharmacy as the 'first port of call' for low acuity conditions and for medicines access and advice
- Be cost effective for the NHS when supporting patients with low acuity conditions

Community pharmacy hepatitis C antibody testing services

Service description

People who inject drugs who are not engaged in community drug and alcohol treatment services will be offered the opportunity to receive a Hepatitis C virus test from a community pharmacy of their choice (subject to the pharmacy being registered to provide the service). Where the test produces a positive result, the person will be referred for appropriate further testing and treatment via the relevant Operational Delivery Network. This is currently only commissioned until 31st March 2023.

Aims and intended outcomes

The aim of this service is to increase levels of testing for Hepatitis C virus amongst people who inject drugs who are not engaged in community drug and alcohol treatment services to:

- Increase the number of diagnoses of Hepatitis C virus infection
- Permit effective interventions to lessen the burden of illness to the individual
- Decrease long-term costs of treatment and
- Decrease onward transmission of Hepatitis C virus

Dispensing GP practices

Dispensing GP practices are permitted to deliver dispensing services to patients in certain circumstances. These are summarised in the NHS Regulations.[169]

The term pharmaceutical services, used in the context of the provision of services by a medical practitioner, means the dispensing of drugs and appliances, but not the other pharmaceutical services that contractors on a pharmaceutical list could provide.

Dispensing from the GP practice dispensary is permitted where:

- A patient would have serious difficulty in obtaining any necessary drugs or appliances from a chemist by reason of distance, or inadequacy of means of communication (colloquially known as the serious difficulty test which can apply anywhere in the country), **or**
- A patient is resident in an area which is rural in character, **known as a controlled locality,** and **lives at more than one mile (1.6km) from a community pharmacy's premises**. The pharmacy's premises do not have to be in a controlled locality.

GP Dispensaries

There are 13 GP practices that are permitted to dispense medicines in East Sussex. Since the last PNA, the Guestling branch in Hastings has closed. There are 16 GP dispensaries in East Sussex including all the branch dispensaries.

Not all patients registered with a dispensing practice will meet the criteria for receiving dispensing services. In East Sussex, those eligible amount to 42% [49,007/115,695] of all patients registered with GP dispensing practices. This ranges from 16% to 100% of all patients registered in the dispensing practices.

Table 52 shows the number of GP dispensaries by local authority in East Sussex and the name and local authority of their associated branch dispensary. The total registered list for each practice is available on request.

Table 52 Number of GP dispensaries by local authority

Local authority	GP practice	Dispensing list size	Branch dispensary
Hastings	Harold Road Surgery	1,934	
Lewes	Old School Surgery [main not dispensing]	1,733	Alfriston, in Wealden LA
Rother	Rye Medical Centre	4,226	
Rother	Fairfield Surgery	4,037	
Rother	Sedlescombe & Westfield surgeries	5,273	Westfield
Rother	Collington Surgery [main not dispensary]	1,860	Ninfield, in Wealden LA
Rother	Oldwood Surgery	1,436	

Rother	Ferry Road Health Centre	1,395	
Rother	Northiam Surgery	6,661	Broad Oak
Wealden	Ashdown Forest Health Centre	3,808	
Wealden	Heathfield Surgery	3,728	Firs
Wealden	Buxted Medical Centre	8,162	
Wealden	Groombridge and Hartfield med group	4,738	Hartfield dispensary

Source: Dispensing Practices in England from NHS Business Authority

Controlled localities

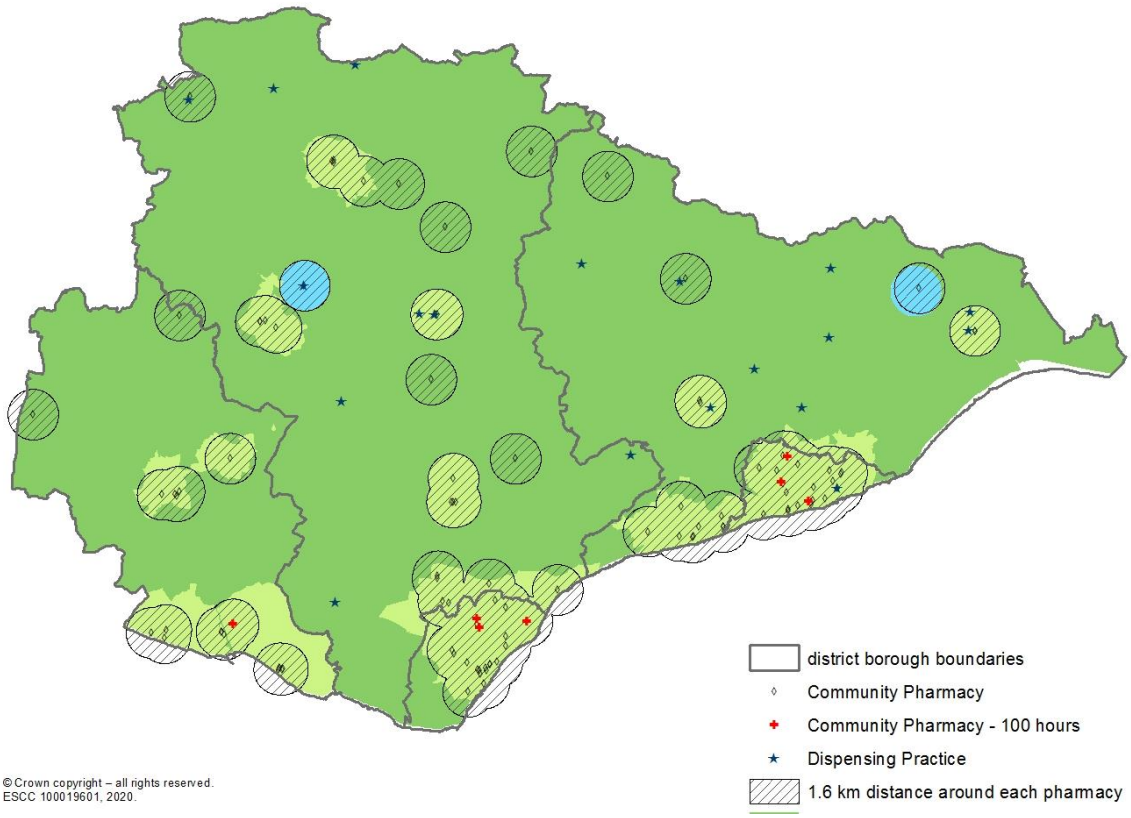
Controlled localities are areas that have been determined to be 'rural in character' by NHS England (or a preceding organisation), or on appeal by NHS Resolution. There is no single factor that determines whether an area is rural in character. NHS England will consider a range of factors which may include population density, the presence or absence of facilities, employment patterns, community size and distance between settlements, and the availability of public transport.

Their importance comes into play in relation to the ability for a GP practice to dispense to its registered patients. To be dispensed to, as a starting point, the patient must live in a controlled locality, and more than 1.6km (measured in a straight line) from a pharmacy.

GP practices may have premises within a town and still be able to dispense because some of their patients live in a controlled locality and meet the other requirements of the Regulations. Dispensing practices are not required to have a pharmacist in their dispensary and their premises do not have to be registered with the General Pharmaceutical Council.

Figure 49 Shows the controlled [rural] localities in East Sussex.

Figure 49 Controlled [rural] localities in East Sussex



Internet/distance selling pharmacies

Online pharmacies operate over the Internet and send orders to customers through the mail or shipping companies. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 detail a number of conditions for distance selling pharmacies:

- must provide the full range of essential services during opening hours to all persons in England presenting prescriptions
- cannot provide essential services face to face
- must have a responsible pharmacist in charge of the business at the premises throughout core and supplementary opening hours
- must be registered with the General Pharmaceutical Council[170]

Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice. Patients therefore can access any of the many internet pharmacies available nationwide.

Currently there are three internet pharmacies based in East Sussex.

They will receive prescriptions either via the electronic prescription service or through the post, dispense them at the pharmacy and then either deliver them to the patient or arrange for them to be delivered using a courier, for example. They must provide essential services to anyone, anywhere in England, where requested to do so.

They may choose to provide advanced services, but when doing so must ensure that they do not provide any element of the essential services whilst the patient is at the pharmacy premises. As of 30 June 2021, there were 379 distance selling premises in England, based in 115 health and wellbeing boards. Some East Sussex residents will choose to use one located outside their area.

Dispensing Appliance Contractors

Dispensing Appliance Contractors (DACs) hold an NHS contract to dispense dressings and appliances, as defined in the Drug Tariff, at the request of a patient (or their representative).

These contractors who may only dispense appliances such as catheters and stoma bags. They do not dispense drugs.

- There are approximately 111 nationally, 18 in the south-east
- Not pharmacies
- Not regulated by the General Pharmaceutical Council and the premises are not registered with that body
- Not required to have a pharmacist on site
- Tend to provide services remotely

Appendix C

There are **no** Dispensing Appliance Contractors within East Sussex. Patients residing within East Sussex may wish to exercise their right to have an appropriate prescription dispensed by a Dispensing Appliance Contractor from outside this area under the patient choice scheme.

Appendix D: Pharmacy Access Scheme Appeals

Pharmacies that are not on the Pharmacy Access Scheme [PhAS] payment list can apply to NHS England to have their case reviewed if they believe they are eligible for PhAS payments.

Pharmacies can qualify for a review on the following grounds:

- Inaccuracy: the contractor's pharmacy site address, used for the distance calculation, is incorrect and the correct location would mean the contractor was eligible for PhAS.
- Inaccuracy: the address of the contractors next nearest pharmacy, used for the distance calculation, is incorrect and the correct location would mean the contractor was eligible for PhAS.
- Physical feature anomaly: For example, a semi-permanent roadblock means the nearest pharmacy is more than 1 mile away by the most practicable route means the contractor was eligible for PhAS.

This had to be submitted by the 4th of February 2022.

Appendix E: Community pharmacy provider survey 2022 replies

Priority 1

Meeting Population needs

- Ensuring we meet the needs of the local population (8)
- Making sure it meets the demand of the area (2)
- To provide a range of services developed for the local demographic
- To provide services that are most relevant and beneficial to our patient demographic

Support patients in our local area with services they require

- More access for disadvantaged groups, reaching those who avoid GP services and similar formal healthcare
- More local pharmaceutical services. Online and telephonic pharmacy consultation.

GP Community Pharmacy Consultation Service [referrals]

- GP CPCS (2)
- GP CPCS to take the pressure off GP and better access for patients

Community pharmacy funding

- Financially beneficial services to benefit the local population
- Better funding model from NHS to support the delivery of new services and to still support existing services

Adaptability and versatility to accommodate e.g. the tourists and travellers

Promoting health and wellbeing

- Promoting health and wellbeing
- Smoking cessation (2)
- To continue to promote the awareness of the weight management programme, and support staff to be confident in having these conversations.
- To continue to promote Care for the Carers which is an excellent organisation that provides information & help to carers.

Staff training

- Staff training
- Continued colleague training
- Additional training and enough staff
- Stable staffing levels
- Appointing a store-based pharmacist

Pharmacy immunisations

- Increased flu next season
- Flu vaccinations
- Looking into providing a travel vaccine clinic
- Travel Vaccines

Developing advanced services

- Continued growth of New Medicines Service. Including new condition criteria groups.
- New Medicines Service (2)
- Developing services for prevention of long-term health problems e.g. hypertension
- Starting the Hypertension Service

Stock control and store management

- Computer in consultation room would help with speed/customer care
- Space to complete a new service
- Improving stock availability for walk in patients
- Reduction of Owings

Accessible parking and disabled access to pharmacy premises

Most community pharmacies stated they already have accessible parking and disabled access. Parking facilities are not within the direct control of a community pharmacy.

Implementing the NHS England Accessible Information Standard

The NHS, social care and other local services must meet requirements under the Equality Act 2010 to make reasonable adjustments if people face substantial difficulties accessing their services due to their hearing, or vision loss or other issues regarding communication. There is guidance for meeting NHS England's Accessible Information Standard for NHS and adult social care providers in meeting the requirements of the Equality Act.[171]

The 2022 community pharmacy survey asked whether pharmacies were having difficulty implementing this NHS standard. The majority of those pharmacies that responded to the pharmacy provider survey weren't having any difficulty.

Digital Exclusion

The ability to use computer-based technology is now becoming ever more essential for everyday life including interaction with pharmacy-based services. Being unable to access digitally focused services remains an ongoing issue, particularly among the elderly and for all people with a low level of general literacy.[172,173]

Personal privacy and respect for personal information

In the 2022 Survey, 61% agreed that if they wanted to, they could speak to their pharmacist without being overheard. Around a half (51%) agreed they prefer to see their regular pharmacist than someone they don't know.

There is a message that failure to respect people's personal information is influencing perceptions of the whole service. Most pharmacies stated they have consultation rooms which comply with the service specification. However, from the residents' surveys it seems that these are not being consistently used for consultations about personally sensitive information and there is a lack of awareness about them.

Customer service and high staff turnover

Many people mentioned that customer service skills need to be improved. The lack of continuity of staff made it difficult to trust the advice given in some pharmacies [2022 Residents' Surveys].

Pharmacy-based vaccinations

Pharmacy based vaccinations for adult and childhood vaccines were strongly supported by community pharmacies as possible developments of the existing vaccination service. This may be especially beneficial where vaccine uptake in the local GP-based service has been consistently low and in under-served groups.[174]

Commissioners may wish to consider how community pharmacies offering the NHS flu vaccination service can support an increase in the uptake of flu vaccination in social care workers and care home residents – due to high satisfaction with pharmacy vaccination services.

Commissioners [NHSE] and future ICS] may wish to consider commissioning PPV and Shingles vaccinations via community pharmacy to support increasing uptake. This could be delivered alongside the flu vaccination programme in pharmacies as similar cohorts are eligible.

Commissioners may wish to increase the number and geographical spread of community pharmacy delivering COVID19 vaccinations. This is to increase access and uptake of COVID19 vaccinations and due to high satisfaction of pharmacy services.

Reducing cardio-vascular disease [CVD] risk in the population

Identifying cardiovascular risk in the population by measuring blood pressure in pharmacies is now commissioned as an advanced service.[175,176] There is scope for undertaking targeted NHS Health Checks in pharmacies in areas where uptake is poor from the GP-led service, and in under-served population groups.

Pharmacies continue to support the annual "know your numbers campaign" and participate in the CVD prevention, optimal value pathway.[177]

There is the opportunity to deliver a communications and engagement campaign to increase use of the newly commissioned hypertension case-finding service to increase the detection of hypertension and to support the prevention of cardiovascular disease in East Sussex.

Developing new locally commissioned services in pharmacy

Many pharmacies appear willing to provide any locally commissioned service with appropriate training.

Public health commissioned services which have secured better access to pharmaceutical services in East Sussex include supervised consumption of prescribed medicines by pharmacists, provision of emergency hormonal contraception, condoms and access to chlamydia testing in pharmacy.

Local authority commissioners will wish to explore ways of ensuring more pharmacies sign up to the existing services, that staff are adequately trained and supported to provide high performing, locally commissioned services, and that the public are aware of these services.

Appendix F: Update on 2017 PNA Recommendations

Table 53 shows an update of the PNA 2017 recommendations. The responsible lead/organisation (s) for implementing these recommendations are:

NHSE: NHS England
HEE: Health Education England
CCGs: Clinical Commissioning Groups
HWLH CCG: High Weald Lewes Havens CCG
EHS CCG: Eastbourne, Hailsham and Seaford CCG
H&R CCG: Hastings and Rother CCG
ESCC PH: East Sussex County Council Public Health

Table 53: Update on PNA recommendations from 2017

1.	**Service Quality Improvement**	**Progress to date**
	Actively support all community pharmacies to achieve the standards in the national contract Quality Payments Scheme NHSE, and ESCC PH	NHSE completed New NHSE commissioned contract in place since October 2019
	Consider the training needs of community pharmacists to address issues identified in the stakeholder surveys and the national training needs analysis e.g. Implementation of the Accessible Information Standard, Customer Service skills, Dementia friendly services etc. HEE, NHSE	NHSE completed As part of Healthy Living Pharmacy sessions training was provided. Dementia Friends training was provided. You're Welcome training for pharmacies providing young-people-friendly services. Health inequalities training. [postgrad education]. Consultation skills [postgrad]. Ongoing CPD re Learning Disability. Mental health training is available [CPPE].
2.	Access to Pharmaceutical Services	
	Review the extended hours rota scheme for community pharmacy in light of the PNA findings. NHSE	NHSE reviewed provision of services over bank holidays. There is no commissioned

		service for a rota out of hours scheme in place.
	Use different forms of media to improve availability of information for the general public about alternative services when pharmacy is not open. NHSE	NHSE ongoing.
	Support implementation of the NHS Urgent Medicine Supply Advanced Service (NUMSAS) through integration with other local urgent care services. NHSE and all CCGs	Replaced by the commissioning of the advanced Community Pharmacy Consultation Service
	Include referral to community pharmacy for self-care and treatment of minor ailments in local pathways, where appropriate. NHSE and all CCGs	Included in the service specification for Community Pharmacy Consultation Service (CPCS) via NHS 111. Referrals into Community Pharmacy Consultation Service from GPs now commissioned.
	Recognise and monitor the risk in the system if the pharmacy contract funding cuts result in community pharmacies ceasing to deliver some of their unfunded activities such as home delivery of medicines which are outside the community pharmacy contractual framework. ESCC PH, NHSE, and all CCGs	Ongoing risk of pharmacy closures exists. 10 pharmacies have closed since 2017. Now 102 pharmacies in East Sussex [99, plus 3 Distance Selling Pharmacies]
3.	Improving outcomes: Public Health Services provided by community pharmacies	
	Encourage all community pharmacies to implement Level 1 of the Healthy Living Pharmacy through the quality payments scheme. NHSE	NHSE completed
	Commission the roll out of Level 2 Healthy Living Pharmacy to areas of highest need.	HLP is now included as part of

	CCGs and ESCC PH	core pharmacy contract
	Encourage all community pharmacies to signpost patients and carers to other appropriate local services through the HLP scheme. ESCC PH and all CCGs	HLP is an essential requirement for all pharmacies under the Community pharmacy contractual framework. October 2019 was launch of the new Community Pharmacy Consultation Service (CPCS). Almost all pharmacies will need to have a confidential consultation room.
	Review the locally commissioned services particularly sexual health and the smoking cessation service. ESCC PH	The Sexual Health NA has been completed. Ongoing smoking cessation service commissioned in pharmacy. Hospitals can refer in from March 2022.
	Improve signposting *to pharmacy public health* commissioned services *from other health care access points* e.g. 111 & GP practices. ESCC PH and all CCGs.	Public health services commissioned from community pharmacy have been advertised in the PH monthly bulletin which has been widely shared across the health and social care sector.
	Look to develop additional public health services where a local need is identified. ESCC PH and all CCGs	No new PH locally commissioned services are envisaged at present. Commissioning pharmacy to undertake missing immunisations in addition to 'flu is strongly supported and was raised with the Public Health England immunisation lead consultant.
4.	Medicines Optimisation Service	

	Encourage community pharmacies to undertake Medicines Use Reviews (MURs) in localities with low uptake. NHSE	The new community pharmacy contract is phasing out MURs.
	Consider implementing services that support community pharmacy to expedite hospital discharge e.g. Refer to Pharmacy. All CCGs	Now included as an essential service, the Discharge Medicines Service.
	Include local education sessions about medicines from community pharmacists in the Level 2 HLP service specification ESCC PH and all CCGs	Not in the HLP specification
	Consider how joint working with general practice could improve medicines optimisation. All CCGs and NHSE	NHSE completed. Clinical pharmacists are attached to GP practices in PCNs.
5.	IMT improvements	
	Improve connectivity between community pharmacy and other services NHSE	NHSE completed. All community pharmacies have nhs.net email addresses, these are available to all health care professionals through the local service finder. GP Community Pharmacy Consultation Service has been launched across Sussex, which should improve communications. LPC is doing the training for practice staff and linking them in with their local pharmacies
	Explore how community pharmacy could support the implementation of electronic repeat dispensing [eRD] so that it becomes the norm for patients on long term medication. All CCGs	Most repeat dispensing is electronic. Practices are encouraged to use the. Electronic Prescribing Service [EPS].

Glossary

Advanced Services: a group of services specified within the NHS Community Pharmacy Contractual Framework (CPCF). Pharmacies can choose to provide these with additional training.

A&E: Accident and Emergency.

AUR: Appliance Use Review. Checking how someone uses an inhaler for example.

BBV: Blood borne viruses: HIV, Hepatitis B and C (HBV, HCV)

BNF: The British National Formulary-the pharmaceutical reference manual in the UK which provides information and advice to pharmacists, doctors and other prescribing professionals on prescribing, in addition to specific details about medicines available on the National Health Service (NHS).

Carer: Someone who looks after a friend or family member (in an unpaid role).

Care worker: Someone who is paid by the patient, his or her relatives, or public bodies such as local authorities to look after a patient.

C-Card: Free condom distribution service from pharmacy

CCG: Clinical Commissioning Groups are responsible for commissioning healthcare services for the local areas that they cover. These have merged to form one East Sussex CCG.

COPD: Chronic Obstructive Pulmonary Disease

CPCF: The Community Pharmacy Contractual Framework- the overarching national agreement between NHS England and community pharmacies governing provision of NHS services.

DfT: Department for Transport.

DHSC: Department of Health and Social Care.

DMS: Discharge Medicines Service. The hospital informs a chosen pharmacy of a patient's drugs on discharge from hospital.

EHC: Emergency Hormonal Contraception, sometimes referred to as the 'morning after pill'.

EPS: Electronic Prescription Service. This NHS service enables prescribers, such as GPs and practice nurses, to send prescriptions electronically to a pharmacy of the patient's choice.

ESCC: East Sussex County Council

ESHT: East Sussex Healthcare NHS Trust

Essential Services: Services that all pharmacy contractors must provide under the Community Pharmacy Contractual Framework. This includes dispensing medicines from prescriptions and the Discharge Medicines Service.

GIS: A Geographic Information System: to assist with mapping and geographical analysis.

GMC: The General Medical Council

GP OOH: the GP out-of-hours service, part of the urgent care system. It provides services between 18:30 and 08:00 (including weekends) when GPs are not contractually obliged to see patients.

HWB: Health and Wellbeing Board

IC 24: Integrated Care 24 out-of-hours service.

IDACI: Income Deprivation Affecting Children Index

IDAOPI: Income Deprivation Affecting Older People Index

IMD 2019: Index of Multiple Deprivation 2019

JSNAA: Joint Strategic Needs and Assets Assessment

LA: Local authorities (councils) are the administrative bodies within local government. East Sussex County Council is an upper tier local authority. There are five lower tier councils in East Sussex: Eastbourne BC, Hastings BC, Lewes DC, Rother DC and Wealden DC.

Locally Commissioned Services: Services contracted on a local basis by different Commissioners. Commissioners include local authorities, Clinical Commissioning Groups (CCGs) and local NHS teams. They are not mandatory and are not provided universally within England.

LMC: Local Medical Committee

LPC: Local Pharmaceutical Committee: the local organisation which represents community pharmacies.

LSOA: Lower Super Output Areas are statistical areas (within England) with roughly 1,500 residents and approximately 650 households.

MMR: Measles, mumps, and rubella vaccine

MOCH: Medicines Optimisation in Care Homes (MOCH). The MOCH service actively contacts nursing home staff. They have a generic email address they can send queries and requests through to that is checked during working hours.

MURs: Medicines Use Reviews (MURs) have been replaced for patients by enhanced, Structured Medication Reviews carried out by clinical pharmacists working within GP practices.

NHS 111: This is part of the urgent care system. It is a phone service that provides patients with medical advice and is also the gateway to other points of delivery in the urgent care system.

NHS England: The organisation that leads the National Health Service (NHS) in England, setting priorities, providing direction and commissioning services on behalf of the NHS.

NICE: The National Institute for Health and Care Excellence

NMS: The New Medicine Service provides support to patients with long-term conditions who are newly prescribed a medicine.

NSP: Needle and Syringe Programmes provide injecting drug users with access to clean injecting equipment and effective disposal of used equipment, referred to as a needle exchange service.

ONS: The Office for National Statistics

OTC: Over-The-Counter drugs are medicines sold directly to a consumer without a prescription from a healthcare professional. Prescription medicines may be sold only to customers possessing a valid prescription.

PhAS: Pharmacy Access Scheme-a payment to pharmacies which is intended to support access where pharmacies are sparsely spread, and patients depend on their services.

PGD: Patient Group Direction is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs allow specified health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD.

Pharmaceutical list in order to provide pharmaceutical services in England a person and the premises from which they will provide services must be included in the relevant pharmaceutical list. NHS England is responsible for preparing, maintaining and publishing pharmaceutical lists in respect of each health and wellbeing board's area.

PharmOutcomes: a web-based system allowing pharmacy teams to record their locally commissioned services and payment claims.

PIP: A pharmacist independent prescriber [PIP] is a pharmacist who has completed the relevant approved education and training as approved by the General Pharmaceutical Council.

POD: Patients can access repeat prescriptions through the Prescription Ordering Direct (POD) telephone system, electronic repeat dispensing (eRD) between GP Practice and chosen pharmacy, or by writing or visiting their GP Practice. The POD reduces waste by discussing the repeat medications order and alerting patients to the need for medication reviews.

POM: Prescription Only Medicines are those which must be prescribed by a doctor and are not licensed for sale to the general public.

Prescription item: A single item prescribed on a prescription form. A prescription form may have more than one item on it.

Prescribing error: A clinical error on a prescription script, for example the wrong drug or quantity. Look-Alike, Sound-Alike [LASA] medicines are another source of error when dispensing.

PSNC: The Pharmaceutical Services Negotiating Committee-recognised by the UK Secretary for Health as representing community pharmacy on NHS matters in England.

QALY: A Quality-Adjusted Life Year is a generic measure of disease burden, including both the quality and quantity of life lived.

SC: Supervised Consumption is the controlled, supervised self-administration of prescribed methadone or buprenorphine by an addict in daily instalment doses at a community pharmacy.

STI: Sexually Transmitted Infections.

TIA: Transient Ischaemic Attack: a period during which the brain is deprived of oxygen, arbitrarily defined as an episode lasting for less than 24 hours.

TRACC: specialist software used by ESCC for calculating travel times between locations.

Urgent care: Urgent care is the provision of care where patients require prompt attention but where their condition is not considered life-threatening: provided by various organisations including GP out of hours services, Accident and Emergency departments, Walk-in centres, ambulance services, community pharmacies and other Urgent Care centres.

List of Pharmacies included in PNA 2022

	Code	Name	Location	Postcode	LA
1	FAF25	Lloyds Pharmacy	Ringmer	BN8 5QN	Lewes
2	FAN63	Blooms Pharmacy	St Leonards on Sea	TN37 6RE	Hastings
3	FC177	Procter Health Care Pharmacy	Heathfield	TN21 8HU	Wealden
4	FC448	Grand Pharmacy	Eastbourne	BN21 4EJ	Eastbourne
5	FCM48	Kamsons Pharmacy	Eastbourne	BN20 8QJ	Eastbourne
6	FCM81	Little Common Pharmacy	Bexhill on Sea	TN39 4SL	Rother
7	FCQ39	Chappells Pharmacy	Crowborough	TN6 1DL	Wealden
8	FCV62	Ashdown Pharmacy	Forest Row	RH18 5AT	Wealden
9	FD341	Seaforth Pharmacy	Hailsham	BN27 1BH	Wealden
10	FD420	Day Lewis Harmers Pharmacy	Eastbourne	BN21 4EY	Eastbourne
11	FDL07	Day Lewis Pharmacy	Rye	TN31 7JF	Rother
12	FWM16	Clarity Pharmacy	St Leonards on Sea	TN37 6DU	Hastings
13	FDN08	J Andersen's Pharmacy	Hastings	TN35 5NH	Hastings
14	FDR00	H A Baker	Lewes	BN7 2DD	Lewes

	Code	Name	Location	Postcode	LA
15	FDR15	Wellcare Pharmacy	Hastings	TN34 3PX	Hastings
16	FE086	Lloyds Pharmacy	Forest Row	RH18 5ES	Wealden
17	FE574	Jempsons Pharmacy	Peasmarsh	TN31 6YD	Rother
18	FE587	St Dunstans Pharmacy	Mayfield	TN20 6AB	Wealden
19	FEC49	St Denys Pharmacy	Rotherfield	TN6 3LJ	Wealden
20	FEH23	Boots the Chemists	Hailsham	BN27 1BG	Wealden
21	FEJ06	Wyborns Pharmacy	Lewes	BN7 2JU	Lewes
22	FEJ10	Manor Pharmacy	Horam	TN21 0EH	Wealden
23	FEM25	Boots the Chemists	Rye	TN31 7JF	Rother
24	FEM37	Kamsons Pharmacy	Eastbourne	BN20 7RG	Eastbourne
25	FEX32	Your Local Boots Pharmacy	Eastbourne	BN22 7PG	Eastbourne
26	FF114	Osbon Pharmacy	Eastbourne	BN21 3TZ	Eastbourne
27	FF388	Lloyds pharmacy (in Sainsbury)	St Leonards on Sea	TN37 7SQ	Hastings
28	FFC93	Boots the Chemists	Bexhill on Sea	TN40 2JS	Rother

	Code	Name	Location	Postcode	LA
29	FFE25	Newman Pharmacy	Eastbourne	BN22 7QP	Eastbourne
30	FG055	Lloyds Pharmacy	Newick	BN8 4LA	Lewes
31	FG057	Tesco Pharmacy	Eastbourne	BN23 6QD	Eastbourne
32	FG630	Your Local Boots Pharmacy	Eastbourne	BN21 4TX	Eastbourne
33	FGA19	Kamsons Pharmacy	Uckfield	TN22 1BA	Wealden
34	FGW00	Lloyds pharmacy (in Sainsburys)	Newhaven	BN9 0AG	Lewes
35	FH358	Morrisons Pharmacy	Crowborough	TN6 2QB	Wealden
36	FH594	Pharmacy @ Station Plaza	Hastings	TN34 1BA	Hastings
37	FH723	Tesco Pharmacy	Uckfield	TN22 1BA	Wealden
38	FH752	Tesco Pharmacy	St Leonards on Sea	TN38 9RB	Hastings
39	FHJ23	Paydens Pharmacy	Hailsham	BN27 1AN	Wealden
40	FJ416	Kamsons Pharmacy	Hailsham	BN27 1UL	Wealden
41	FJA86	Kamsons Pharmacy	Eastbourne	BN20 8NH	Eastbourne
42	FJG00	Seaford Pharmacy	Seaford	BN25 1LL	Lewes
43	FJJ23	St Denys Pharmacy	Crowborough	TN6 2EG	Wealden
44	FJK61	Asda Pharmacy	Eastbourne	BN23 6JH	Eastbourne

	Code	Name	Location	Postcode	LA
45	FJL76	Your Local Boots Pharmacy	Robertsbridge	TN32 5AE	Rother
46	FJQ76	Lloyds Pharmacy	Bexhill on Sea	TN39 5HE	Rother
47	FKV77	Laycocks Chemists	Hastings	TN35 5BL	Hastings
48	FLA61	Kamsons Pharmacy	Eastbourne	BN21 3JU	Eastbourne
49	FLE70	Osbon Pharmacy	Hastings	TN35 5BG	Hastings
50	FLG35	Day Lewis Peels Pharmacy	Eastbourne	BN22 0PS	Wealden
51	FLQ27	St Annes Pharmacy	Lewes	BN7 1RP	Lewes
52	FMG75	Morrisons Pharmacy	Hastings	TN34 1RN	Hastings
53	FMJ50	Pebsham Pharmacy	Bexhill on Sea	TN40 2SW	Rother
54	FMJ93	West St Leonards Pharmacy	St Leonards on Sea	TN38 0AH	Hastings
55	FMW80	Pharmacy Requirements	Bexhill on Sea	TN39 5BG	Rother
56	FMX79	Boots the Chemists	Eastbourne	BN23 7RT	Eastbourne
57	FN068	Lloyds Pharmacy	St Leonards on Sea	TN37 7AN	Hastings
58	FN280	Day Lewis Hirst Pharmacy	Hastings	TN34 2PS	Hastings
59	FNJ90	Buxted Pharmacy	Buxted	TN22 5FD	Wealden

	Code	Name	Location	Postcode	LA
60	FL244	Kamsons Pharmacy	Polegate	BN26 5AB	Wealden
61	FP421	Procter Health Care Pharmacy	Heathfield	TN21 8LD	Wealden
62	FP954	Boots the Chemists	Crowborough	TN6 2QA	Wealden
63	FPA95	Boots the Chemists	Eastbourne	BN23 6JH	Eastbourne
64	FPC61	Wadhurst Pharmacy	Wadhurst	TN5 6AP	Wealden
65	FPD84	Boots the Chemists	Newhaven	BN9 9PD	Lewes
66	FPM78	Kamsons Pharmacy	Hastings	TN34 1NN	Hastings
67	FPV58	Your Local Boots Pharmacy	Battle	TN33 0AE	Rother
68	FQ395	Boots the Chemists	Eastbourne	BN21 1HR	Eastbourne
69	FQ577	Kamsons Pharmacy	Peacehaven	BN10 8LD	Lewes
70	FQC51	Boots the Chemists	Lewes	BN7 2LP	Lewes
71	FQG85	Warwick and Radcliffe Pharmacy	Herstmonceux	BN27 4JX	Wealden
72	FQH11	Hillview Pharmacy	Hastings	TN35 5LT	Hastings

	Code	Name	Location	Postcode	LA
73	FQP33	Boots the Chemists	Uckfield	TN22 1AG	Wealden
74	FQV53	Kamsons Pharmacy	Uckfield	TN22 5AW	Wealden
75	FQV61	Tesco Pharmacy	Eastbourne	BN22 9NG	Eastbourne
76	FQY87	Boots the Chemists	Seaford	BN25 1LS	Lewes
77	FRA20	L J Collis & Co	Bexhill on Sea	TN40 1HJ	Rother
78	FRH13	Boots the Chemists	St Leonards on Sea	TN37 6AJ	Hastings
79	FRN35	Procter Health Care Pharmacy	Polegate	BN26 6AH	Wealden
80	FRV64	Boots the Chemists	Bexhill on Sea	TN40 1AU	Rother
81	FRV87	Your Local Boots Pharmacy	Pevensey Bay	BN24 6ET	Wealden
82	FTG15	Your Local Boots Pharmacy	Bexhill on Sea	TN39 3PU	Rother
83	FTQ44	Boots the Chemists	Eastbourne	BN21 3NL	Eastbourne
84	FV050	Asda Pharmacy	St Leonards on Sea	TN37 7AA	Hastings
85	FVH64	Lloyds Pharmacy	Eastbourne	BN22 9PW	Eastbourne
86	FVM25	Arlington Road Pharmacy	Eastbourne	BN21 1DH	Eastbourne
87	FVY65	Boots the Chemists	Hastings	TN34 1PH	Hastings

	Code	Name	Location	Postcode	LA
88	FW734	Kamsons Pharmacy	Telscombe Cliffs	BN10 7LX	Lewes
89	FWD95	Day Lewis Pharmacy	Battle	TN33 0EN	Rother
90	FWD96	Kamsons Pharmacy	Eastbourne	BN23 8ED	Eastbourne
91	FWL19	Ticehurst Pharmacy	Ticehurst	TN5 7AA	Rother
92	FX478	Morrisons Pharmacy	Seaford	BN25 1DL	Lewes
93	FX679	Cameron L & Sons Ltd	Seaford	BN25 1ND	Lewes
94	FX749	Kamsons Pharmacy	Pevensey	BN24 5DZ	Wealden
95	FXA84	Medication Delivery Services Ltd	Peacehaven	BN10 8LN	Lewes
96	FXM83	Kamsons Pharmacy	Eastbourne	BN20 9PL	Wealden
97	FY677	Tesco Pharmacy	Bexhill on Sea	TN40 2JS	Rother
98	FYE94	Well	Peacehaven	BN10 8NF	Lewes
99	FYN83	Laycock Chemists	St Leonards on Sea	TN37 7LS	Hastings
100	FYN91	Day Lewis Porter Pharmacy	Hastings	TN34 3SB	Hastings
101	FYX43	Newhaven Pharmacies Ltd	Newhaven	BN9 9QD	Lewes

	Code	Name	Location	Postcode	LA
102	FKW32	Ditchling Pharmacy	Ditchling	BN6 8UQ	Lewes

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Report to: **East Sussex Health and Wellbeing Board**

Date: **29th September 2022**

By: **Director of Adult Social Care and Health**

Title: **Better Care Fund Plans 2022/23**

Purpose of Report: **To provide a summary of the Better Care Fund (BCF) requirements for 2022/23 and to seek approval of the East Sussex BCF plans.**

Recommendations:

East Sussex Health and Wellbeing Board is recommended to:

1. **Note the requirements for 2022/23 Better Care Fund**

2. **Approve the East Sussex Better Care Fund Plans for 2022/23**

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1 Background

1.1 Since 2014, the Better Care Fund (BCF) has provided a mechanism for joint health, housing and social care planning and commissioning, focusing on personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to Local Government, including the Disabled Facilities Grant (DFG) and the improved Better Care Fund (iBCF).

1.2 The continuation of national conditions and requirements of the BCF in recent years has provided opportunities for health and care partners to build on their plans to embed joint working and integrated care further. This includes working collaboratively to bring together funding streams and maximise the impact on outcomes for communities whilst sustaining vital community provision.

2 National BCF Planning Guidance and Requirements for 2022/23

2.1 The 2022/23 Planning Guidance was published on 19th July with local plans to be submitted by 26th September.

2.2 The BCF Policy Framework and Planning Requirements were published on 19th July 2022 with plans due for submission on 26th September.

2.3 The Better Care Fund plans for 2022/23 include:

- A completed planning template which confirms the expenditure plan meets the national conditions and the East Sussex ambitions to progress performance against the identified metrics.

- A narrative plan outlining how the Better Care Fund is used in East Sussex to support local priorities including integration, hospital discharge, support for unpaid carers, collaboration with housing and addressing health inequalities.

- A Capacity and demand template outlining the available capacity and predicted demand for intermediate care services for the remainder of 22/23 and the associated spend both from the BCF and from other funding streams. Whilst submission of a completed template is required, it will not be part of the BCF assurance for 2022/23.

BCF National Conditions

2.4 National conditions 1-3 for the fund are broadly similar to 2021-22 and continue to require a minimum spend level on social care from the NHS Sussex (formerly CCG) minimum.

2.5 National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:

I. Enable people to stay well,
II. Provide the right care in the right place at the right time.

2.6 This is outlined in the narrative plans and includes:

- Our approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.

- How BCF funded services support delivery of the objectives.

- Local implementation of the High Impact Change Model with identified actions.

BCF Metrics

2.7 The length of stay metric is not part of requirements in 2022-23. However, it will remain a priority and the data will continue to be provided and monitored regionally and nationally.

2.8 The metrics included in the planning template for this year are:

Metric	Detail
Avoidable admissions	Unplanned Admissions for chronic ambulatory care sensitive conditions (NHS OF 2.3i)
Residential care admissions	Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. (ASCOF 2A part 2)
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement (ASCOF 2B part 1)
Discharge destination	Percentage of discharges to a person's usual place of residence (SUS data)

3 East Sussex Better Care Plans 22/23

3.1 Unlike previous years, the NHS minimum has risen by 5.66% uniformly across all Health and Wellbeing Boards (HWBs) and has been set out in the published allocations

3.2 Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) conditions remain broadly the same and have been issued to local authorities – iBCF has increased by 3% in all LAs.

3.3 Adult Social Care (ASC) contribution and NHS commissioned Out of Hours (OOH) ringfences to increase in line with the overall increase i.e., 5.66%.

3.4 Contributions to the Better Care Fund have been confirmed and agreed as:

Resources	Funding	Lead Org	Contribution (000)
East Sussex CCG	CCG Minimum Contribution	CCG	£46,960
ESCC- Carers	ESCC	ESCC	£694
ESCC - DFG	Disabled Facilities Grant	ESCC	£8,124
ESCC - IBCF	Improved Better Care Fund	ESCC	£21,777
Total Resources			£77,555

3.5 Whilst many of the schemes remain the same as previous years, some amendments are proposed for this year:

- **Healthy Hastings and Rother:** whilst some HH&R schemes have been funded from BCF in previous years, it was recommended and agreed for all the remaining schemes to be funded via BCF in 22/23 whilst subject to review. This amounted to an additional commitment from BCF of £205k and the detailed breakdown of these schemes can be found on relevant tab of the schedule.

- **Integrated Community Equipment Services (ICES):** in addition to an annual uplift of £150k NHS contribution to the pooled fund, £250k has also been identified to ensure the service is resourced to fully support the system this year. ESCC contributions are funded outside of the BCF and the pooled budget functions on a 50/50 basis.

- **Hospital Discharge Programme:** £576k unallocated funds have been aligned to support the Hospital Discharge Programme.

3.6 As with previous years the East Sussex BCF Plans for 2022/23 align with and support the delivery of wider transformation of the health and care system and the key priorities within the East Sussex Health and Social Care Plans

3.7 The previous Section 75 agreement which facilitates the pooling of the Better Care Fund in East Sussex will be updated for 2022/23 once these plans have been approved.

3.8 Due to the Health & Wellbeing Board meeting after the submission date the plans were submitted with delegated authority, however, they will not receive final assurance until approval by the Health & Wellbeing Board has been confirmed.

4 Conclusion and reasons for recommendations

4.1 This paper summarises the Better Care Fund requirements for this year and sets out the East Sussex plans confirming their alignment with national requirements and delivery of the wider transformation of the health and care system locally.

4.2 The Health and Wellbeing Board is recommended to:

1) Note the requirements for 2022/23 Better Care Fund

2) Approve the East Sussex Better Care Fund Plans for 2022/23

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Appendix 1: East Sussex HWB Better Care Fund Narrative Plan 2022-23

Appendix 2: East Sussex HWB BCF 2022-23 Planning Template

Appendix 3: East Sussex HWB Capacity and Demand Template

East Sussex

Better Care Fund Plan

2022/23

September 2022

1. Health and Wellbeing Board: East Sussex

1.1 Bodies involved in preparing our plan

An integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in supporting people to manage their own health and wellbeing effectively. At the local level that integration is managed through the East Sussex Health and Care Partnership. This brings together East Sussex County Council, our new NHS Sussex Integrated Care Board, East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, and our wider system partners including primary care networks, district and borough councils, Healthwatch, the Voluntary, Community and Social Enterprise (VCSE) organisations, East Sussex Fire and Rescue Service, South East Coast Ambulance Service and education providers, registered landlords and a wide range of other public and private organisations.

In addition to the above, there are a wide range of forums where plans are discussed such as the East Sussex Housing Officers Group and Independent Providers forums.

1.2 How we involved these stakeholders?

The overall purpose of the East Sussex Health and Care Partnership is to support delivery of our locally agreed plans and programmes of transformation for the recovery, stabilisation and future sustainability of our health and care system. Our aim is to work together as a system to ensure a focus on prevention and deliver high quality, effective care, and improved health outcomes, and the operational models that enable this, for the population in East Sussex.

Through a partnership approach the East Sussex Health and Care Partnership has the following key roles:

1. Supporting the ongoing development and implementation of a longer-term integrated local East Sussex Plan which will form part of our Sussex and Surrey Sustainable Transformation Partnership plan and respond to the NHS Long Term Plan. This will cover physical and mental health services across acute, community and primary care settings, social care, housing, and prevention.
2. Supporting the delivery of initial agreed priority programmes of transformation in three core areas of urgent care, planned care and community services, and
3. Ensuring engagement with the delivery of the plans we agree, and collectively tackling the issues and challenges we face as a system.

2. Executive summary

Our draft high level East Sussex Health and Wellbeing Strategy 2022 – 2026 provides the overarching framework for our joint plans and programmes of work, based on the strengths and needs of the East Sussex population. For 2022/23 we have identified a small number of priority areas where we are collectively working together to improve and transform services.

Shared priorities are where we feel we can make a real difference through working together at place (East Sussex) level within our wider Sussex Integrated Care System (ICS). They complement and align with the existing range of work our organisations will deliver locally through their annual business and operating plans and strategies, including supporting our Sussex ICS and NHS commitments.

We have reviewed our work last year to support people during the Covid-19 pandemic, as well as our progress with our programmes of work to integrate and transform care models and pathways, to ensure we can take account of our learning for 2022/23. Our priorities fall into the following the areas:

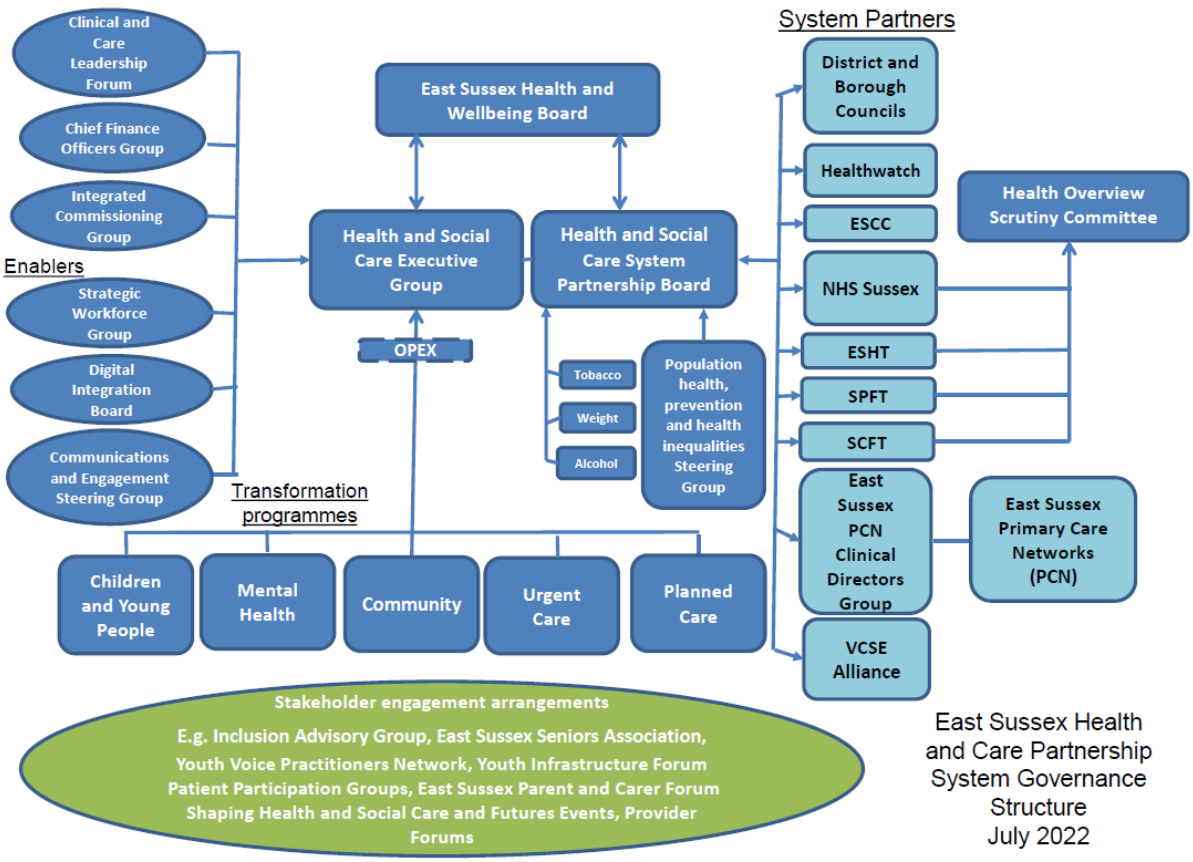
- The strategic and long-term steps we need to take to further develop our capability overall as a place-based health and care partnership within our Sussex ICS. This is aimed at increasing our ability to improve health, reduce health inequalities and deliver integrated care.
- Our shared work to integrate and transform care models and pathways in specific services and pathways. This is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services for children and young people, mental health, community, urgent care and planned care, to improve the quality, experience and sustainability of care.
- Our shared work to to empower people to stay healthy and well for as long as possible, reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county in our population.

3. Governance

Supporting delivery of our shared priorities - our governance for the BCF plan and its implementation in East Sussex

Our organisations work together to deliver these shared priorities through our system partnership governance. Our East Sussex Health and Care Partnership reports to the East Sussex Health and Wellbeing Board, and works in the context of our Sussex Integrated Care System to strengthen how we plan, organise, commission, and deliver services together and better deliver our shared priorities for our population across the county,

Overall, in the context of our Sussex Integrated Care System, our East Sussex Health and Care Partnership is working to strengthen the way we join forces to improve the health and wellbeing of our population, the quality and experience of health and care services, and do this within the collective resources we have available.



East Sussex Health and Care Partnership System Governance Structure July 2022

4. Overall BCF plan and approach to integration

4.1 Our approach to embedding integrated, person-centred health, social care and housing services

The East Sussex Health and Well-being strategy highlights our plans for health and care services in our county. Health and wellbeing for all, however, is not just about services. It is improved by access to good jobs, transport, housing and green space as well as opportunities for lifelong learning, exercise, good nutrition and supportive networks and relationships between people and within communities. The strategy signposts to other key strategies and plans relating to these crucial 'wider determinants of health' which are led by various members of the Health and Wellbeing Board and encourages us all play our part in ensuring that everyone in the county can lead a healthy, happy, fulfilled life.

An integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in supporting people to manage their own health and wellbeing effectively. At the local level that integration is managed through the East Sussex Health and Care Partnership.

Our organisations are each responsible for making decisions about their resources and delivering improvements to services. The Health and Wellbeing Board's role is to oversee how well we work together to make the most of opportunities where a more joined up approach will help to improve outcomes, reduce inequalities and deliver efficiency savings that can be reinvested in service improvements.

This includes supporting the strengths and capabilities that exist in our diverse communities and neighbourhoods to make the best use of our collective resources. The strategy will also inform our shared work across Sussex, and we would expect everyone to use it when making decisions about spending money and planning services, and our joint working and collective action over the next few years in East Sussex.

4.2 Our joint priorities for 2022-23

To ensure we take account of our learning for 2022/23, our priorities fall into the following the areas:

- The strategic and long-term steps we need to take to further develop our capability overall as a place-based health and care partnership within our Sussex ICS. This is aimed at increasing our ability to improve health, reduce health inequalities and deliver integrated care.
- Our shared work to integrate and transform care models and pathways in specific services and pathways. This is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services for children and young people, mental health, community, urgent care and planned care, to improve the quality, experience and sustainability of care.
- Our shared work to to empower people to stay healthy and well for as long as possible, reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county in our population.

Priorities for integrated health and care services

Organisations across the public, private and voluntary sector are responsible for delivering a wide range of health and care plans and services. Through our partnership work we will focus on a small number of shared priorities where we can achieve better results if we work together to offer more integrated care:

- Children and young people
- Mental health
- Community
- Urgent care
- Planned care

We work with our citizens in our number of ways to ensure the way these priorities are delivered fits with what people have told us is important about their health and care, including Healthwatch and Young Healthwatch, Youth Infrastructure Forum, Mental Health Action Group, East Sussex Seniors Association and Patient Participation Groups.

4.3 Our Approaches to joint/collaborative commissioning

Delivering the vision: Working with everyone

Our East Sussex Health and Care Partnership brings together the contributions of a range of partners to deliver this strategy, including the NHS, county, borough and district councils, the voluntary, community and social enterprise sector, and Healthwatch East Sussex.

Together, we will explore the new opportunities in the White Paper and as part of our ICS to further strengthen the way we work together on our priorities. These include more formal arrangements to plan services and share resources, aimed at increasing integrated care and better responding to the needs of our population.

In delivering the vision and our joint commissioning priorities we recognise:

- Working with people, carers, families, and communities themselves is crucial to designing services and support that works. We will continue to build on the strengths of our communities and involve people in ways that suit them through the wide range of existing arrangements and new approaches
- Healthwatch will continue to play a role at both a local and national level, ensuring that the views of the public and people of all ages who use health, care and other related public services are taken into account
- Health and care services can offer joined up high quality care that anticipates needs and intervenes as soon as possible to have a positive impact on people's day-to-day life and deliver better outcomes
- Borough and district council actions have a positive effect on public health, and an enabling role in the health of their populations and communities through innovation in service delivery

- Voluntary, community and social enterprise (VCSE) organisations in East Sussex play a key role in mobilising local social action that can bring communities together, both in times of need and more generally, as well as being a part of health and care delivery that supports people's health and wellbeing
- Family Hubs, early years settings, schools and colleges play a vital role
- Working together at a local and neighbourhood level with these and other partners will give a strong platform for the delivery of initiatives which improve health and wellbeing and services

4.4 How BCF funded services are supporting our approach to integration/ changes to the services we are commissioning through the BCF from 2022-23.

The services funded from the BCF in 21/22 will continue to be funded in 22/23 as they remain critical components of the system, by way of prevention or supporting system flow. Alongside this, additional BCF funding has been identified to support the local Hospital Discharge Programme.

All jointly funded and jointly commissioned BCF funded services contribute to delivery of the East Sussex plans for integration outlined above and support avoidance of admission to and reduced length of stay in bedded care, either directly or indirectly.

5. Implementing the BCF Policy Objectives (national condition four)

5.1 Our approach to integrating care to deliver better outcomes, how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home or return home following an episode of inpatient hospital care.

The vision of the East Sussex Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone can have a life that is as safe, healthy, happy and fulfilling as possible.

Services are one part of the picture, and they need to be high quality and effective in empowering people to support their health and wellbeing. For health and care services, our aim is to work towards a fully integrated health and care system by 2026. By doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives. The Health and Wellbeing Strategy is designed to support the progress of the East Sussex health and care transformation programme to ensure it achieves health benefits for the people of East Sussex.

Through our work together we want to promote health and wellbeing for everyone, and make sure those who need it benefit from care and support that intervenes early, works with their strengths and supports their resilience as much as possible.

What will this look like?

- Health and wellbeing will be improved, and health inequalities reduced
- Personal and community resilience will be supported, and prevention and early intervention will be at the heart of everything we do
- The quality of care and people's experience of using services will be outstanding. Our staff will be working in a way that really makes the most of their dedication, skills and professionalism
- The cost of care will be affordable and sustainable, and secured for the next generation

Delivering the vision: Our approach

For most people their day-to-day health, care and support needs will be expressed and met locally in the place where they live. Therefore, our role as a place within our Sussex ICS is an important building block for health and care integration, and an offer to our local population to ensure that everyone can access:

- Clear advice on staying well
- A range of preventative services
- Simple, joined up care and treatment when this is needed
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care
- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk

In addition, our joint work will also support:

- Approaches to employment, training, procurement and volunteering activities and use of estates to allow all organisations to play a full a part in social and economic wellbeing and environmental sustainability, and

- Strong links across the full range of public and voluntary services that have an impact on people's day to day health, for example through improving local skills and employment or ensuring high quality housing and accommodation. This means working better collectively to support creating better opportunities for everyone in our community, including for example people recovering from mental ill-health or homelessness, and young people leaving care.

In delivering the vision and our priorities we will:

- Take a whole life approach from conception to death and enable links to be made throughout life, especially at key stages
- Value and build on the strengths, skills, knowledge and networks that individuals, families and communities have and can use, to overcome challenges and build positive and healthy futures
- Promote strong awareness of the impact of the wider determinants of health and wellbeing and seek to engage everyone in playing their part to ensure those determinants are as positive as possible in our county
- Increase prevention and early intervention to improve people's chances of a healthy life and to help us to manage demand for health and care services in the future
- Develop an integrated system of empowering health and care services so that people get the right care, at the right time and in the best place, whether that is in the community, primary care, secondary care or specialist care
- Reduce the inequalities that exist within and between different parts of the county and different groups of people in terms of access to services and information, advice and support. Ensuring we better record and understand the characteristics of people using our services, and tailor support

5.2 How East Sussex BCF funded services will support delivery of the objective

The East Sussex Better Care Fund Plans support the delivery of the East Sussex Health and Social care plans which address the local needs identified, the vision for integrating health and social care and to enable people to stay well, safe, and independent at home for longer whilst providing the right care in the right place at the right time.
The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2022/23 seek to support the key priorities outlined above.

To achieve these, the range of schemes listed in the planning template cover key areas of focus including:

1. Enhance prevention, personalisation and reduce health inequalities
    - Falls and Fracture Programme
    - A range of services provided by the Voluntary and community sector including support for people with sensory impairment.

2. Support for people with mental health needs by ensuring access to a full range of services including
    - Improved access to psychological therapies
    - Dementia services
3. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Health and Social Care Connect (Single point of Access)
    - Housing support and adaptations
    - Maintaining social care services
    - Community Equipment services
4. Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:
    - Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
    - Crisis response
    - Hospital Intervention team based in A&E
    - Discharge to Assess - bed-based capacity
    - Domiciliary Care capacity
    - Hospital discharge support
    - 24/7 Health and Social Care Connect (Single point of Access)
5. Improve services that deliver planned care for local people
    - Diabetes self-management and pharmacy support
    - Medicines Optimisation in Care Homes
    - Dietician support to medicines management

These schemes support the delivery of all of the national BCF metrics; many of these schemes are jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.
In addition, focus has been given to developing preventative services which adopt a proactive approach to supporting people at earlier stages of care pathways.

Many of the services funded partially or wholly through the BCF in 21/22 have been continued into this year as they remain critical components of the system, either by way of prevention or supporting system flow.
In addition to these, further investment has been made into supporting the local Hospital Discharge Programme.

5.3 Our plans for supporting people to remain independent at home for longer

Our Steps to personalise care and deliver asset-based approaches

Personalised care is a key focus in East Sussex in line with the Sussex ICB priorities for 2022/23 which include:

Personalised care and support planning

- Continue to spread and scale the implementation of personalised care and support plans ensuring adherence to the quality standard criteria
- Identify a minimum of two clinical cohorts to implement PCSPs – identified priority areas for Sussex include Maternity, post covid service, digital PSCPs in EHCHs, children and young people and mental health
- Ensure workforce have access to e-learning via the personalised care institute and whole teams training where possible
- Audit quality of the personalised care and support plans including patient experience

Personal Health Budgets (PHB)

- Ensure that all Sussex residents legally entitled to a PHB are offered one. To include the right to have groups: CHCs, PWBs and S117s.
- To capture patient demographic data in relation to PHB users to ensure equity and demonstrate where efforts are being made to reduce health inequalities.
- Encourage staff groups that require additional training/support regarding Personalised Care to undertake PCI modules, eLFH module and make use of NHS Collaborative platform.
- To collect case studies from a variety of cohorts to gain feedback from service users to use as a learning tool for workforce and new PHB users.

Social Prescribing link workers

- To undertake a 'stock-take' of current place & local networks and forums to understand function/input/output to inform alignment to overall Personalised Care strategy and clear information channels.
- to ensure appropriate data process and collections are in place to support the capture of assurance and improvement metrics.
- To understand the needs of the workforce and identify opportunities to support with ongoing training and development.

In the Eastbourne, Hailsham, Seaford, Hastings and Rother areas, Southdown is jointly commissioned to provide a social prescribing service, funded via BCF called 'Community Connectors'. Southdown also provides a SMI (severe mental illness) social prescribing service called "Health & Wellbeing Coordinators" and is aimed at residents on the SMI register. In addition to the ICB/LA commissioned services, there are other services that adopt a social prescribing approach for example, Care for the Carers who are jointly commissioned via the BCF to provide a carers social prescription service specifically aimed at people with additional caring responsibilities

Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care

East Sussex is the nominated place from Sussex Health and Care Partnership to participate in the population health programme.
Some of the key achievements:

- The strategy and road map are informed by national best practice, benchmarking within the programme & system assessment against a maturity matrix that includes population health management's core capabilities 4 I's
- Governance-A system level PHM steering group established with reporting to the Population Health and Prevention Board
- A linked dataset was created and analysts from across the system have been brought together to learn PHM approaches and support PCNs when possible.
- PCNs and Place have developed MTDs, identified population groups and designed PHM interventions
- Finance professionals from across the system have come together to develop understanding of PHM approaches and support Place and PCN workstreams.

The schemes commissioned through the BCF will support these approaches through ensuring that everyone is able to access:

- Clear advice on staying well
- A range of preventative services
- Simple, joined up care and treatment when this is needed
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care
- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk

Multidisciplinary teams at place or neighbourhood level.

Working with our Primary Care Networks we will continue to enhance community services and strengthen our overall model for integrated community health and social care services. This is aimed at better supporting people with long term complex care needs and their carers in their own homes, care homes and other community settings, through embedding proactive and seamless wrap around care, including where people are approaching the end of their lives. Specific joint work includes:

Working with our Primary Care Networks and local VCSE organisations to design and develop our model for jointly planning and delivering services in our localities and neighbourhoods will help us to:

- ensure strong links between primary care, community health and social care, mental health, housing and key VCSE teams and services that support individuals with long term and complex care needs
- use more integrated data, improve and better manage the health of local populations and enable longer lives that are healthy and independent by affecting the wider determinants of health and wellbeing

5.4 Our plans for improving discharge and ensuring that people get the right care in the right place

Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

East Sussex system partners as part of the Sussex wide approach to the future of hospital discharge have agreed an emerging discharge model incorporating a range of discharge routes: from simple discharge, discharge with settling in support, discharge with Home First, discharge to a bedded setting for long term needs assessment and discharge to a bedded setting for rehabilitation.

Plans to transition the East Sussex system towards the new model of care have been developed collaboratively across partners including Opex members. They include:

- A recognition of reduced levels of system funding to hospital discharge
- Prioritisation and agreement of how reduced funding will be applied
- Improving processes and building on our existing integrated approaches across East Sussex
- Understanding of the impact on system performance of reductions in capacity
- Highlighting risks and where possible mitigations to reduce the impact.

The following principles have been developed:

- Focus on building our Home First/Crisis Response approach and reducing our existing levels DTA (former P3) bedded approach to fit within financial envelope.
- Reduction of DTA (former P3) capacity should aim to support patients across East Sussex
- Ensuring the development of our model has oversight of East Sussex Health and Care Partnership's Integrated Community Oversight Board (and other relevant strategic integration programmes in particular urgent care and planned care).

Collaborative commissioning of discharge services:

The development of the discharge model is based on an agreed set of Principles:

- Reduce DTA bedded capacitywhilst maintaining access across East Sussex, also considering service quality and opportunity to better support needs of local people
- Build Home First/Crisis Response domiciliary model alongside reduction in DTA bedded capacity
- Agreed Organisation Development across health and social care to improve consistency of approach to discharge with an emphasis on promoting independence supports implementation of future model
- Robust communications plan to be developed to support health and social care staff and patients and their families/carers
- East Sussex Strategic Workforce Group to support innovative approaches system-wide to workforce challenges that need addressing to ensure successful implementation of future discharge model.

Services funded from the BCF provide a significant contribution to these principles including D2A beds, domiciliary support for care and reablement, intermediate care provision and community equipment.

5.5 Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future

In September, the East Sussex Operational Executive (OPEX) reviewed the Hight Impact Change Model and the NHSE 100-day challenge requirement. OPEX agreed all requirements are broadly met or developing and work continues to improve discharge pathways following changes to the Hospital Discharge Programme (HDP).

The East Sussex priority remains the home first pathway to ensure people can return home with the support they need as soon as they are medically ready and key actions to progress this include:

- Establish future model and associated processes
- Further development of East Sussex Home First/Crisis Response Service
- Agree delivery trajectory alongside associated reduction in DTA beds (noting existing pressures in current P1 pathway).
- Identifying project resource and leadership across key organisations to deliver the project at the pace required
- Ensure programme plans with clear timeframes in place and monitored

A Capacity and Demand template has also been completed for Intermediate care services in East Sussex as part of the BCF submission for 22/23.

Actions to address key issues.

Addressing Workforce challenges

The East Sussex Strategic Workforce Group (SWG) is very aware of the current high level of vacancies across the health and care sector compounded by the national shortage in supply for many professional/registered roles that require years of training before having a positive impact on key vacancies. The current cost of living crisis is also likely to negatively affect recruitment and retaining current staff (our best source of supply), particularly for the lower paid roles with staff choosing to take other roles outside of the sector that are better paid.

SWG began to consider the impact of the rising cost of living on recruiting and retaining staff at its last meeting held on 20th July 2022 and agreed to await final confirmation of the NHS pay award before having a more detailed discussion and agreeing an approach to help support and attract staff.

In the meantime, SWG members, in consultation with independent, voluntary and hospice stakeholder organisations have agreed, through a collaborative approach, to focus on the following initiatives

- Creating an East Sussex Health and Care virtual careers hub
- Mobility – passporting across the system
- New to care apprenticeships - working as one system
- Maximising what we are already doing – recruitment pilots etc.

- Recruitment of 1.5 FTE Project Managers and 1 FTE trainer in Adult Social Care training team to promote the sector and maximise community opportunities
- Working in partnership with NHS Sussex and Armed Forces Network to establish on-going recruitment campaign for veterans, reservists, cadets
- Engaging with 6th form colleges to attract students to ASC through placements and training
- Pilot programme with DWP to offer 'try before you apply' placements for over 50s on Universal Credit
- Attending numerous careers/recruitment fairs across the County
- Working closely with partners to generate new ideas and undertake strategic planning
- Developing East Sussex Recruitment Hub to facilitate access to jobs across the County
- Funding to support independent sector home care agencies with overseas recruitment, resulting in 100 additional carers working in East Sussex by June 2022

Addressing cost of living crisis

Below outlines two initiatives which demonstrate how we are supporting vulnerable people and disadvantaged communities:

Free, confidential support and advice continues to be available through our BCF funded East Sussex Welfare Benefits Service for people who are facing financial difficulty, struggling to pay bills or concerned about growing debt. In Q1 22/23, the project realised £1,504,724 annualised benefit income for residents. Of those people:

- 4,747 household members benefitted from benefits and debt advice
- 511 people received face to face casework support
- 80% of respondents reported improved mental wellbeing
- 75% of callers and 59% of casework clients lived in the most deprived wards
- 84% of callers and 62% of casework clients had long term health conditions
- 490 older people received advice to support their independence
- 485 families with children received benefits and debt advice

Additionally in our most deprived communities, health and wellbeing community hubs have a vital role in providing advice and support to local people. For example, in North-East Hastings during Q1 22/23, 878 adults and children received an emergency food hamper with 5 new households receiving a hamper each week. Further analysis shows that 63% of those in receipt of a food hamper are on benefits, 12% considered themselves vulnerable and 9% were on low wages causing the need of additional support.

6. Supporting unpaid carers.

How our BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

6.1 Carers Centre provided by Care for the Carers to:

- Raise awareness with service providers & within communities to identify & reach carers
- Information & advice
- Targeted support both to assist with accessing appropriate support for carers & cared for and for carers' own emotional and physical wellbeing
- Act as "one stop shop" with referral pathways to a range of carers' services
- Provide a range of universal services provided directly by Care for the Carers and commissioned through small grants*
- Provide peer support, carer engagement, wellbeing support and training, Carers Card (contingency planning and discounts)
- Targeted services including one to one casework and emotional support, counselling, Health Care Appointments Respite Grant,
- Targeted support for carers of people with severe mental illness
- Working with Primary Care practices in the most deprived areas of Hastings to reach carers with the most complex needs/caring roles (funded separately through Health Inequalities monies)
- Undertaking carers' reviews on behalf of ASC

6.2 Outcomes

- Carers identified early in caring role
- Reduction in carers reaching crisis point
- Carers referred to Single Access Point
- Carers recognised as expert partners in care through the health and social care systems
- Increase in carer friendly communities
- Identification of carers from communities that are hard to engage, those who have additional vulnerabilities and those at key transition points
- Carers recognise themselves as carers and are enabled to access the information, advice and support that they need
- Carers have access to information and advice in a range of formats including by phone and online
- Carers are signposted/referred on and/or provided with appropriate support/services
- Carers are supported and enabled to find their own solutions without the need for ongoing support
- Single referral route for both carer and professional referrals
- Carers can access peer support e.g. through groups or online fora
- Carers have access to engagement opportunities such as consultation
- Carers have access to health and wellbeing opportunities
- Carers can access universal services which reduce the need for access to targeted services

- Carers can access emotional and practical support including face to face, counselling, short-term and crisis interventions that enable carers to look after their own health and wellbeing and sustain their caring role
- Carers can access training, e.g. condition specific, building resilience, stress management and digital inclusion that will inform their caring role and enable them to care without negatively impacting on their own health and wellbeing
- Services are inclusive of carers caring at end of life and experiencing bereavement; carers from communities that are hard to engage; those who have additional vulnerabilities and those at key transition points

6.3 Care Act services

- Carers Personal Budgets – direct payments to carers to meet Care Act eligible outcomes following a carers assessment or review
- Carers Reviews Pilot – carers' reviews allocated to Care for the Carer to undertake on behalf of ASC
- Funded Respite for ASC clients to give carers a break
- Volunteer Respite services - short home-based breaks (sitting service) where the cared for person is at risk if left alone
- Carers Break and Engagement Service – undertake carers assessments and reviews for carers of people living with dementia in addition to the NHS funded Dementia Support Service

6.4 Small Grants

A range of grant funded services including:

- Carer support at all 3 hospices
- Outreach to identify & support BAME carers in Hastings & Eastbourne
- Dementia training
- Digital inclusion
- Short breaks – lunch/supper clubs, creative & social activities, cookery
- Targeted support – Motor Neurone Disease, parent carers of young people with SEND (16-25)
- WRAP (Wellness Recovery Action Planning)

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Whilst the DFG funding is passed down in its entirety, deployment of the DFG funding within the BCF is overseen by the East Sussex Housing Officers group with representation from East Sussex County Council and the Housing departments within local District and Borough Councils as well as health commissioners and wider housing sector partners. This group provides a countywide strategic approach to housing and support issues and oversee to ensure effective use of the funding available, including use of adaptations to support independent living and the establishment of Occupational Therapy (OT) teams aligned to each of the Housing departments.

The Housing OT service enables an integrated approach to improved housing solutions and home adaptations to East Sussex residents. It is aligned to the District and Borough Councils' Housing departments to promote the prevention of ill health (falls), avoidable hospital admissions, improve hospital discharges, reduce residential / nursing home admissions and to promote quality of life and wellbeing through major and minor home adaptations.

This has enabled the D&Bs to provide home adaptations at the earliest point of contact, ensure that local needs are appropriately met, and a more seamless service is experienced by people with disabilities in respect of their housing and other social care needs.

In 21/22, 1.381 referrals were received by the Housing OT service. Referrals were for a mixture of adaptations and housing needs work, referred via ASC and also directly from the NHS to support complex hospital discharge.

The service has developed the use of 'standard recommendations' for level access showers and have piloted the use of this in Rother where it has worked well, this is for simple straightforward cases where the layout of the properties are known (ie some sheltered housing units), in some cases we have been able to use information from clinic along with a telephone assessment to complete recommendations. This has helped to speed up processes to enable adaptations to be installed more quickly.

With regards to housing needs, the Housing OTs service complete reports for Housing needs teams outlining where disability is significantly impacting on the current housing situation and providing information around features required within a property if being rehoused. The service will also consider properties that are being offered to a client to ensure they either have the required level of accessibility or are able to be adapted to make them accessible.

Recent feedback from Hospital OT team lead "*having the links with the housing OTs has been invaluable to support with complex discharges where housing issues are preventing discharge, the knowledge the housing OTs have and their ability to provide timely input has supported the hospital OTs*."

The service is also looking at ways to measure the impact of adaptations on individuals' quality of life, safety, independence and wellbeing through a pre and post adaptations survey.

Other examples of local innovation:

Wealden District Council:

The discretionary policy has been reviewed to provide additional assistance for Dementia, hardship and feasibility cases and support the continuation of our successful assistance in shared equity loans and top ups.

Wealden's shared equity loans, highlighted by Parity Trust in their recent newsletter and highlighted as best practice by Foundations, allows housing departments to offer an equity loan to individuals and families whose current home is unadaptable for their disability requirements, allowing them to purchase a home locally which is either adapted or adaptable to suit the needs of family members residing in it. This has provided help to help some of the most trapped vulnerable families.

Wealden are about to adapt 2 temporary accommodation units. One for ambulant disabled and one as a fully accessible wheelchair unit which will provide more much needed accessible temporary accommodation.

Following a disappointing take up of the new Dementia assistance Wealden are looking to review the scheme this year to adopt best practice coming out from national guidance and foundations best practice.

Hastings Borough Council:

Wider discretionary policies are currently being developed to address health inequalities and deprivation more effectively and to react to the realities of the current housing situation.

Where adaptable property is scare, particularly in terms of accessibility for wheelchairs etc, proposals include making adaptations to temporary accommodation so those waiting on the housing register for suitable properties are not left in unsuitable or insufficient housing until a more suitable property is found

The barriers to people getting adaptations they need are also being considered with a view to utilising DFG funding as far as is possible. Examples include widening the discretionary policy to cover circumstances such as:

- hospital discharge assistance – e.g., for cleaning, decluttering so they can come home
- alternative accommodation (in certain circumstances) – whilst DFG work is being carried out
- urgent home repairs to reduce risk of accidents
- incentives to bring empty homes into use to there is more availability of properties with adaptations provided
- adaptation of a second property where a child's parents are separated

8. Equality and health inequalities

Our priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services.

We have groups of people, communities and individuals living in East Sussex who experience worse health than other people. These inequalities are caused by a number of factors, including a person's income, their housing, education and employment status. These differences are avoidable and need more of a focus to tackle.

Some people find it hard to get the care they need due to physical, sensory and mental health issues, the language they speak, the attitudes of other people and difficulties in getting and understanding information. We want everyone to have the same opportunities to lead a healthy life, no matter where they live or who they are.

The Covid-19 pandemic also further highlighted how a combination of structural inequalities in our society (for example income and housing), and inequalities experienced due to ethnic background and other characteristics led to increased risks for some groups in our population.

We want to reduce health inequalities for our population. This will be measured by inequality in healthy life expectancy at birth and will require us to work differently at how resources are used, how we assess the impact of the decisions we make and look at new ways in which everyone can have equal access to appropriate services. This includes identifying where some groups may require more intensive support and additional help to access services. Health and care also needs to be delivered with an awareness of the differences between groups and within our population, and tailored to individual's strengths and potential vulnerabilities. Every opportunity will be explored to make sure we improve our ability to do this.

8.1 Changes from previous BCF plan

We will build on our existing progress to empower people to stay healthy and well for as long as possible, reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county. We will do this by working with all the services that influence health, like housing, employment and leisure as we believe that collectively our organisations can make a real difference to our population's economic and social wellbeing

8.2 How these inequalities are being addressed through the BCF plan and BCF funded services

We are monitoring our progress with delivery of our priorities across the four areas below to make sure we are having the most impact:

- Addressing the physiological causes of ill health to prevent premature death and the overall prevalence of disease including specific action on early cancer diagnosis, chronic respiratory disease, hypertension case finding to minimise risks of heart attacks and strokes, continuity of maternity care and annual health checks for people living with serious mental illness and learning disabilities

- Supporting individuals and populations to adopt healthy behaviours, including healthy weight, alcohol harm reduction and tobacco control
- Addressing 'psychosocial' factors and the wider determinants of health in our communities, including the social and economic wellbeing of our population
- Further developing our capability as a system, including through locality and neighbourhood working and a 'Population Health Management' approach. This is a way of working supported by data to help frontline teams understand current health and care needs, and what factors are driving poor outcomes in different population groups, resulting in more proactive models of care which will improve health and wellbeing today as well as in future years.

8.3 Any actions moving forward that can contribute to reducing these differences in outcomes

The Core20Plus5 approach is designed by NHS England to support Integrated Care Systems to drive targeted action in health inequalities improvement, particularly focussing in reducing healthcare inequalities.

Sussex ICS have asked each Place to identify two priority groups for their populations to focus on in 2022/23, and to set out high level plans for reducing the health inequalities (poorer health access, experience or outcomes) experienced by these groups.

Initial discussions about choice of "Plus" groups for East Sussex took place at the meetings of the East Sussex Population Health, Prevention and Inequalities Working Group and the following criteria were used to review potential plus groups for East Sussex:

1) Do we understand the unmet health access, experience and outcomes of the groups?

2) Is there already a programme in place to deliver improvements for this group?

3) Is there capacity to develop and deliver a plan of action for this group?

After consideration of several different protected characteristics and groups with poorer than expected outcomes, it was agreed East Sussex would focus on carers and LGBTQ+.

Outline plans to improve access, experience and/or outcomes to healthcare for LGBTQ+ groups were developed based on the recommendations of the recent needs assessment, and high level proposals for carers were developed following discussions between public health, the carers lead commissioner, children's equality lead and Care for the Carers. These were approved at the Population Health, Prevention and Health Inequalities Working Group in May 2022. The funding for carers services within the BCF plans will support this work.

One overarching recommendation is that the East Sussex Health and Care system prioritises the improvement recording and monitoring of protected characteristics. Although Carers are not a protected group under legislation, it is recommended that within the East Sussex health and care system that they are treated in this way. In terms of making change – there are two approaches – top down- SROs for Health inequalities champion the importance of data

recording and monitoring within their organisation; and practically - to link up with the ICS programme to improve ethnicity recording and include LGBTQ+ and carers at the same time when reviewing data systems and considering staff training.

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	East Sussex	
Completed by:	Sally Reed	
E-mail:	sally.reed@eastsussex.gov.uk	
Contact number:	01273 481912	
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 29/09/2022	<< Please enter using the format, DD/MM/YYYY
If using a delegated authority, please state who is signing off the BCF plan:	N/A	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Adult Social Care and Health
Name:	Mark Stainton

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Keith	Glazier	cllr.keith.glazier@eastsussex.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Adam	Doyle	adam.doyle5@nhs.net
	Additional ICB(s) contacts if relevant		Jessica	Britton	jessica.britton@nhs.net
	Local Authority Chief Executive		Becky	Shaw	becky.shaw@eastsussex.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Mark	Stainton	mark.stainton@eastsussex.gov.uk
	Better Care Fund Lead Official		Sally	Reed	sally.reed@eastsussex.gov.uk
	LA Section 151 Officer		Ian	Gutsell	ian.gutsell@eastsussex.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: East Sussex

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,123,612	£8,123,612	£0
Minimum NHS Contribution	£46,960,480	£46,960,480	£0
iBCF	£21,776,611	£21,776,611	£0
Additional LA Contribution	£694,000	£694,000	£0
Additional ICB Contribution	£0	£0	£0
Total	**£77,554,703**	**£77,554,703**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£13,344,837
Planned spend	£14,711,927

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£23,372,093
Planned spend	£23,470,545

Scheme Types

Assistive Technologies and Equipment	£2,900,000	(3.7%)
Care Act Implementation Related Duties	£1,540,000	(2.0%)
Carers Services	£4,284,833	(5.5%)
Community Based Schemes	£44,289,058	(57.1%)
DFG Related Schemes	£8,123,612	(10.5%)
Enablers for Integration	£1,604,315	(2.1%)
High Impact Change Model for Managing Transfer of	£195,000	(0.3%)
Home Care or Domiciliary Care	£1,289,000	(1.7%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£4,956,000	(6.4%)
Reablement in a persons own home	£1,664,400	(2.1%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£1,289,000	(1.7%)
Prevention / Early Intervention	£5,419,485	(7.0%)
Residential Placements	£0	(0.0%)
Other	£0	(0.0%)
Total	**£77,554,703**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)				

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.4%	88.6%	90.8%	91.4%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	501	490

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.5%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: East Sussex

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
East Sussex	£8,123,612
DFG breakdown for two-tier areas only (where applicable)	
Eastbourne	£1,755,225
Hastings	£2,056,655
Lewes	£1,225,885
Rother	£1,844,806
Wealden	£1,241,041
Total Minimum LA Contribution (exc iBCF)	**£8,123,612**

iBCF Contribution	Contribution
East Sussex	£21,776,611
Total iBCF Contribution	**£21,776,611**

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

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
East Sussex	£694,000	Carers services
Total Additional Local Authority Contribution	**£694,000**	

NHS Minimum Contribution	Contribution
NHS Sussex ICB	£46,960,480
Total NHS Minimum Contribution	**£46,960,480**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£46,960,480**	

	2021-22
Total BCF Pooled Budget	**£77,554,703**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: East Sussex

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£8,123,612	£8,123,612	£0
Minimum NHS Contribution	£46,960,480	£46,960,480	£0
iBCF	£21,776,611	£21,776,611	£0
Additional LA Contribution	£694,000	£694,000	£0
Additional NHS Contribution	£0	£0	£0
Total	**£77,554,703**	**£77,554,703**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£13,344,837	£14,711,927	£0
Adult Social Care services spend from the minimum ICB allocations	£23,372,093	£23,470,545	£0

>> Link to further guidance

Checklist

Column complete:

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

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Protecting ASC services which benefit health	A range of social care services which benefit health	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£6,565,000	Existing
2	Protecting ASC, with a focus on discharge support	A range of social care services to support hospital discharge	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£5,098,000	Existing
3	Protecting ASC - iBCF Funding including Winter	A range of social care services to meet iBCF criteria	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	iBCF	£21,776,611	Existing
4	Milton Grange - Community Bed Based	ESCC provision of Intermediate Care beds in Eastbourne	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,603,500	Existing
4	Milton Grange - Community Bed Based	ESCC provision of Intermediate Care beds in Eastbourne	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		LA			Local Authority	Minimum NHS Contribution	£1,603,500	Existing
5	Community Bed Based Intermediate Care	Funding towards Independent Sector Commissioned	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£81,000	Existing

5	Community Bed Based Intermediate Care	Funding towards Independent Sector Commissioned	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		LA			Private Sector	Minimum NHS Contribution	£81,000	Existing
6	Joint Community Rehabilitation Services	Funding to support provision of 7 day service	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£411,000	Existing
6	Joint Community Rehabilitation Services	Funding to support provision of 7 day service	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£411,000	Existing
7	Carers Servcies - CCG funded	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£3,066,726	Existing
7	Carers Services - CCG funded	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£524,107	Existing
8	Carers Services - ESCC funded	A range of carers support services commissioned by ESCC.	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£694,000	Existing
9	Disabled Facilities Grant	DFG and housing support services	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£8,123,612	Existing
10	Care Act Implementation	Care Act Duties, including info/advice, safeguarding, advocacy	Care Act Implementation Related Duties	Other	info/advice, safeguarding, advocacy and	Social Care		LA			Local Authority	Minimum NHS Contribution	£1,540,000	Existing
11	Frailty	Multi-discplinary frailty services in HWLH area	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£466,000	Existing
12	Diabetes	Diabetes Support in HWLH area	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,155,000	Existing
13	MIU - Lewes upgrade to UTC	Developing AA pathways	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£450,400	Existing
14	Intermediate Care Services	Joint Community Rehab servcies in HWLH area	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£842,400	Existing
15	IAPT	Access to Psycholgical Therapies in HWLH	Community Based Schemes	Other	Psychological therapies	Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£334,400	Existing
16	Enhanced Health in Care Homes	Enhanced Health in Care Homes	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,128,400	Existing
17	Enhanced HIT - scheme continuing	Addtional ASC capacity to cover extended hours	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			Local Authority	Minimum NHS Contribution	£195,000	Existing
18	SCT Medicines Optimisation in Care Homes	Medicines Optimisation in Care Homes	Community Based Schemes	Other	Medicines optimisation	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£502,400	Existing
19	ESHT Community Programme	Additional community services including crisis response, frailty	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£7,402,000	Existing
20	HSCC Overnight Service	Funding for HSCC cover 22.00-08.00hrs	Community Based Schemes	Other	Single point of access	Social Care		LA			Local Authority	Minimum NHS Contribution	£130,000	Existing

20	HSCC Overnight Service	Funding for HSCC cover 22.00-08.00hrs	Community Based Schemes	Other	Single point of access	Community Health		CCG			Local Authority	Minimum NHS Contribution	£130,000	Existing
21	Consultant pharmacist in diabetes	Consultant pharmacist in diabetes	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£72,347	Existing
22	Dieticians in Meds Management team (2)	Dieticians in Meds Management team (2)	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£90,250	Existing
23	Medicines Optimisation in LD Care Homes	Medicines Optimisation in Care Homes	Community Based Schemes	Other	Medicines optimisation	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£93,250	Existing
23	Home First Pathway 4	D2A beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£500,000	Existing
24	Home First Pathway 4	D2A beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		LA			Private Sector	Minimum NHS Contribution	£500,000	Existing
24	Staff - Programme and Project support	A range of joint posts	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£359,235	Existing
25	Staff - Programme and Project support	A range of joint posts	Enablers for Integration	Joint commissioning infrastructure		Other	Range of project and programmme	CCG			CCG	Minimum NHS Contribution	£645,080	Existing
26	Health and Social Care Connect	Funding for health hub within HSCC (Single Point of Access)	Enablers for Integration	Integrated models of provision		Community Health		CCG			Local Authority	Minimum NHS Contribution	£600,000	Existing
27	High Intensity User Service	High Intensity Users - case management	Personalised Care at Home	Other	Physical and mental health and wellbeing	Community Health		CCG			Local Authority	Minimum NHS Contribution	£134,000	Existing
28	Independent Domestic Violence Advice	Independent Domestic Violence Advice	Community Based Schemes	Other	Independent Domestic Violence Advice	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£50,000	Existing
29	ICES Pooled Budget	NHS contribution to Community Equipment Pooled budget	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Private Sector	Minimum NHS Contribution	£2,650,000	Existing
30	ICES Pooled Budget (contingency)	NHS contribution to Community Equipment Pooled budget	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Private Sector	Minimum NHS Contribution	£250,000	New
30	VCS (including HH&R)	NHS contibution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of community support services.	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£2,190,084	Existing
30	VCS (including HH&R)	NHS contribution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of community support services.	Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£2,555,098	Existing
31	VCS (including HH&R)	NHS contribution to VCS services commissioned by ESCC.	Prevention / Early Intervention	Other	A range of community support services.	Community Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£469,303	Existing
32	Healthy Hastings and Rother	VCS services commissioned by NHS.	Prevention / Early Intervention	Other	A range of community support services.	Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£205,000	New
33	Domiciallry care capacity	Additonal investment in home care provision to support hospital	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,289,000	Existing

34	Hosptial Discharge Programme	Additional investment in Home First	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£587,000	New

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: East Sussex

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	202.5	170.1	188.6	165.3	Quarterly Projections for 22/23 'observed' values have been initially based on the reductions identified in local data between Q1 21/22 and Q1 22/23 and phased based on 21/22 patterns (note: 21/22 local data	The pan Sussex ambition is to build on improvements seen through 21/22. This will be achieved through continued investment in D2A services (albeit at lower than 'pandemic' levels) with a focus on
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	169.9	143.5	152.9	134.7		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	91.1%	91.5%	90.4%	91.4%	Estimates based on Q1 performance - phased for remainder of year based on 21/22 pattern. Q2 has been further adjusted for increases in 'delayed discharges' in Q2 (becoming evident in local data) which has significantly impacted total hospital throughput. The lack of capacity in the 'Home Care Market' has also frustated intentions to discharge an	Revised pan Sussex model re Hospital Discharges to be implemented to enable activity levels and 'discharges to normal place of residence' to return to Q1 levels by Q4. All servcies will continue to be in place to optimise people's return to usual place of residence with some expanding further such as urgent response services. Many of these are fully or partially funded
	Numerator	10,943	10,938	10,448	9,710		
	Denominator	12,016	11,951	11,555	10,628		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	91.4%	88.6%	90.8%	91.4%		
	Numerator	9,920	9,534	9,395	9,920		
	Denominator	10,848	10,760	10,350	10,848		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	501.1	486.5	483.2	490.5	ASCOF measures currently use the 2020-21 population figures, making our outturn for 2021-22 a rate of 494.2. Target for 2022-23 using current population figure is 490.5. Our ambition is to continue to make a small reduction in	Continued investment in Joint Community Rehab and other community based services, maximising opportunitiy for people to remain living in their own homes. Maximising use of seven Extra Care Schemes across the East Sussex,
	Numerator	732	727	722	745		
	Denominator	146,088	149,426	149,426	151,889		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.2%	90.0%	89.7%	90.5%	Please note: figures are based on the ASCOF defintion, therefore relate to discharges between October and December only. As we are in the upper quartile (based on 2020/21 thresholds as 2021/22 national	Continued investment in Joint Community Rehabilitation Service and other community based services to maintain upper quartile performance.
	Numerator	330	576	288	344		
	Denominator	370	640	321	380		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: East Sussex

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Ref: Narrative Plan page 2		
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Ref: Narrative Plan pages 5 &8 Ref: Narrative Plan pages 6 & 8 Ref: Narrative Plan page 20 Ref: Narrative Plan page 20-21 Ref: Narrative Plan page 21		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Ref: Narrative Plan page 18 Ref: Narrative Plan pages 18-19		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	Ref: Narrative Plan pages 8-9 Ref: Narrative Plan pages 9-10 Ref: Narrative Plan page 14		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes	Ref: Narrative Plan pages 16-17		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

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Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in the guidance tab

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the england.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and
https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-dischar
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services at a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:
- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	East Sussex
Completed by:	Sally Reed
E-mail:	sally.reed@eastsussex.gov.uk
Contact number:	01273 481912
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off
If no, please indicate when the report is expected to be signed off:	Thu 29/09/2022 << Please enter using the format, DD/MM/YYYY

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Health and Social Care
Name:	Mark Stainton

How could this template be improved?	

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: East Sussex

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	2014.86411	1949.86849	2014.86411	2014.86411	1819.87726	2014.86411
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	1224.559452	1185.05753	1224.55945	1224.55945	1106.0537	1224.55945
2: Step down beds (D2A pathway 2)	379.8187945	367.566575	379.818795	379.818795	343.062137	379.818795
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	46.51415525	45.0136986	46.5141553	46.5141553	42.0127854	46.5141553

Any assumptions made:	
	1 Demand for service arising from hospital discharge v community based on best estimates as although we receive regular hospital discharge information there is insufficient up to date community data available to be more precise. 2 October to March demand most influenced by days in calendar month 3 Reablement services not routinely provided to new long term care home placements.

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
(Please select Trust/s.....)	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)						
EAST SUSSEX HEALTHCARE NHS TRUST		1953	1890	1953	1953	1764	1953
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUS		62	60	62	62	56	62
(Please select Trust/s.....)	1: Reablement in a persons own home to support discharge (D2A Pathway 1)						
EAST SUSSEX HEALTHCARE NHS TRUST		1225	1185	1225	1225	1106	1225
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUS		0	0	0	0	0	0
(Please select Trust/s.....)	2: Step down beds (D2A pathway 2)						
EAST SUSSEX HEALTHCARE NHS TRUST		278	269	278	278	251	278
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUS		102	99	102	102	92	102
(Please select Trust/s.....)	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)						
EAST SUSSEX HEALTHCARE NHS TRUST		42	41	42	42	38	42
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUS		5	5	5	5	4	5

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: East Sussex

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	1 Demand for service arising from hospital discharge v community based on best estimates as insufficient data to be more precise. 2 October to March demand most influenced by days in calendar month

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	618	598	618	618	558	618
Urgent community response	481	466	481	481	435	481
Reablement/support someone to remain at home	252	244	252	252	228	252
Bed based intermediate care (Step up)	18	18	18	18	16	18

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: East Sussex

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	1 October to March capacity influenced by days in calendar month 2 Shortfall in capacity (v demand) due to withdrawal of central funding specifically impacting D2A beds 3 Recent modeling of demand and capacity re Community beds indicates underprovision - based on LOS of 24 days and 100% occupancy 4 Capacity in long term care market, is variable and not routinely collected. ESCC Supply Management team

Capacity - Hospital Discharge							
Service Area	**Metric**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
VCS services to support discharge	Monthly capacity. Number of new clients.	975	943	975	975	880	975
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	1040	1007	1040	1040	939	1040
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	1225	1185	1225	1225	1106	1225
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	260	251	260	260	235	260
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.						

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: East Sussex

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	1 October to March capacity influenced by days in calendar month 2 Shortfall in capacity (v demand) due to withdrawal of central funding specifically impacting D2A beds 3 Recent modeling of demand and capacity re Community beds indicates underprovision - based on LOS of 24 days and 100% occupancy

Capacity - Community							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	618	598	618	618	558	618
Urgent Community Response	Monthly capacity. Number of new clients.	481	466	481	481	435	481
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	252	244	252	252	228	252
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	16	15	16	16	14	16

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: East Sussex

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	
BCF related spend	
Comments if applicable	

Report to:	**East Sussex Health and Wellbeing Board**
Date of meeting:	**29 September 2022**
By:	**Executive Managing Director, East Sussex, NHS Sussex and Director of Adult Social Care, East Sussex County Council**
Title:	**East Sussex Health and Social Care Programme – update report**
Purpose:	**To provide an update on progress with our system integration and related areas of collaboration**

RECOMMENDATIONS

The Board is recommended to note the contents of this update, including:

- **the further proposed updates to the Health and Wellbeing Board (HWB) membership, and;**
- **the draft Sussex Integrated Care Strategy will be brought to the December meeting of the Board for endorsement.**

1. Background

1.1 At the last meeting of the Health and Wellbeing Board (HWB), alongside information about our local health and social care programme, the HWB endorsed the updated Health and Wellbeing Board Strategy 'Healthy Lives, Healthy People 2022 – 2027', and received an update about progress with the new developments that are being put in place to support our joint working in the context of the new statutory arrangements for the NHS.

1.2 Within this, members of the Board also noted changes to the terms of reference for the HWB. This detailed the Board's relationship with the new statutory Sussex Health and Care Assembly and the development of an integrated care strategy for Sussex, which will build on the three joint local Health and Wellbeing Strategies and Joint Strategic Needs Assessments (JSNAs). The East Sussex population needs and outcomes in the strategy will be drawn from our JSNA and refreshed Health and Wellbeing Board Strategy.

1.3 This report sets out the progress made to further embed these new working arrangements, and the development of the Sussex integrated care strategy, along with an update about our place-based programme.

2. Supporting information

Integration programme

2.1 The monitoring supplement is attached at Appendix 1 for information. Alongside our ongoing progress with plans for integrated services across children and young people, mental health, community, urgent care and planned care we have collectively been finalising our assurance plans for winter. Due to a number of factors including; the current high levels of activity across the system, the continuing recovery of health and care services; potential new variants of COVID and Flu, and other challenges such as the cost of living and fuel crisis, we are anticipating that this will be a challenging season over and above what we would normally expect.

2.2 In light of this we are concentrating on access and supply of services for our population emphasising the support needed to help people to avoid needing hospital care unnecessarily, and supporting people to get back home quickly after an episode of ill health, including helping to

maintain and continue to enable access to social care. Current work is focussed on assuring ourselves as a system of the robustness of our plans in a number of areas including the following:

- Out of hospital services and urgent and emergency care pathways
- Discharge pathways
- Plans recognise the increasing need for mental health crisis response services, support for discharge, and the need to respond as a system to support good access to services
- Continued sustainable recovery of elective care.

2.3 The current assurance work is part of a new process introduced by NHS England, in preparation for the formal Winter planning cycle. As is the case every year planning processes are also in place to ensure we have a robust Sussex-wide System Winter Plan finalised. A separate report about this will be brought to the HWB about this as in previous years.

2.4 Progress has also been made by partners working on actions aimed at improving population health and wellbeing, increasing prevention and addressing health inequalities. In the last period this includes:

- Actions aimed at increasing the uptake of screening and health checks across circulatory disease and cancer are taking place.
- Annual Health Check trajectories for people with learning disabilities have been exceeded in all areas of Sussex for Q1 2022/23, and the new Locally Commissioned Service for Physical Health Checks for people with a serious mental illness was launched across Sussex in April 2022, with the first stage of the training programme delivered to clinicians and practice staff.
- Collaboration on licensing and age of sale legislation enforcement is continuing to contribute to reduced harm from alcohol. The annual review of the Healthy Weight Plan undertaken illustrating early achievements, and planning work is taking place to identify strengths and areas for development in reducing harm from tobacco.
- Reports from the engagement exercise to support a long term vision for community hubs and a systems approach to loneliness and isolation were reviewed, and partnership planning discussions have taken place to respond to the recommendations. An action plan has now been finalised for endorsement.
- 26,442 Holiday Activity and Food Programme sessions took place over the holiday period, and approximately 4,000-4,500 individual young people will have accessed provision during the summer.
- As part of the national Integrated Care System (ICS) Population Health and Place Development Programme, action learning sessions have taken place with representatives from health, social care and Voluntary, Community and Social Enterprise (VCSE) teams focussed on the population covered by the Foundry Primary Care Network (PCN) in Lewes, exploring the increased use of shared data to better understand risks of hospital admission for frail elderly people with dementia, and enable local proactive care interventions to be better targeted.
- Evaluation activity has been progressed to inform approaches based on supporting individual and community resilience and strengths, and targeted action to improve health in Hastings and Rother. The Community Connectors programme has focussed on drawing in learning, including from actions focussed on vaccination uptake and diabetes.
- Evidence has been reviewed to identify the health inequalities of LGBTQ+ communities and Carers as requiring enhanced focus.

Sussex Integrated Care System arrangements

2.5 The Sussex Health and Care Assembly has now been established as a statutory joint committee between health and care partners in Sussex including the NHS and East Sussex County Council (ESCC), West Sussex County Council (WSCC),Brighton & Hove City Council

(B&HCC) and VCSE partners to come together to formally agree the strategic direction for our system to meet the broader health, public health and social care needs of the population in the ICS footprint. It will hold its first meeting in public on 19th October. The Chair of the Health and Wellbeing Board represents ESCC at the meetings of the Assembly. More information about the Assembly, including the other representatives and meeting papers can be found here.

2.6 The NHS Sussex Integrated Care Board (ICB) held its second meeting in public on 7th September. ESCC, WSCC and B&HCC are each represented as partner members that still retain individually responsibility for their own services and budgets. Meeting papers and more details about the Board can be found here. As previously reported, the ICB covers a wider footprint than the previous CCGs and has also taken on primary care commissioning functions from NHS England, including General Practice, community ophthalmology, pharmacy and dentistry, which are planned to be commissioned at place level.

2.7 The Health and Wellbeing Board's role is unchanged and is to provide whole system leadership and strategic influence over commissioning in East Sussex, including ensuring commissioners have regard to and contribute to the delivery of the Joint Local Health and Wellbeing Strategy. Under the new NHS Sussex commissioning arrangements, HWBs in Sussex will focus their role on overseeing place-based commissioning through the work of the three place-based health and care partnerships.

2.8 Given the new NHS commissioning structure and transfer of wider primary care commissioning functions from NHS England to the ICB, NHS England is now unlikely to undertake significant commissioning activity at a 'place' level in the future. It is also the case that under the local ICS arrangements NHS providers will work more closely together and with commissioners through the local place-based partnerships.

2.9 In addition, in view of the creation of the ICB and the three underpinning 'place' based partnerships in East Sussex, Brighton & Hove and West Sussex bringing local commissioners and providers together as part of the wider ICS, it is proposed that one NHS provider trust Chief Executive represents all local providers on each of the three Health and Wellbeing Boards in Sussex. For East Sussex this is proposed to be the Chief Executive of ESHT.

2.10 As a result, further to the previously reported changes to the HWB Terms of Reference, and in order to more closely align the membership of the HWB with new commissioning arrangements within the Integrated Care System, the following additional changes are being proposed, subject to County Council approval:

- Removal of NHS England, Sussex Partnership NHS Foundation Trust and Sussex Community NHS Foundation Trust as members of the Board;
- Addition of a notification that NHS Sussex will represent NHS England on the Board;
- Addition of a notification that ESHT will provide representation on the Board for all NHS provider trusts delivering services in East Sussex; and
- Removal of Maidstone and Tunbridge Wells NHS Trust and University Hospitals Sussex NHS Foundation Trust as invited observers.

Sussex Integrated Care Strategy development

2.11 Our Sussex Health and Care Assembly's role will be to formally agree the strategic direction for our system to meet the broader health, public health and social care needs of the population in the ICS footprint. It will do this primarily through considering Sussex-wide matters and agreeing an integrated care strategy for Sussex, building on local Joint Strategic Needs

Assessments and Health and Wellbeing Strategies in each of the three 'places' in Sussex (East Sussex, West Sussex and Brighton & Hove).

2.12 The Department of Health and Social Care published guidance on 29th July on the preparation of integrated care strategies for the agreement by ICS Integrated Care Partnerships (the Sussex Health and Care Assembly) by December 2022. Some key points include:

- It is a joint NHS ICB and Local Authority responsibility to produce the strategy. The wide variation in how ICSs are structured in England and their differing maturities is acknowledged and there is flexibility for ICSs to translate the strategy into the local context, and in how developmental or ambitious it needs to be.
- An emphasis is placed on the principle of subsidiarity and place within the strategy which aligns well with Sussex ICS arrangements.
- Future Care Quality Commission (CQC) reviews will assess how the integrated care strategy is used to inform the commissioning and provision of quality and safe services across all partners, within the integrated care system, and that this is a credible strategy for the population.
- There will be a requirement to give due consideration to the NHS mandate within the strategy, and one of the detailed plans it will inform is the new '5-Year joint forward plan', which is to be published before the next financial year (2023/24). This is a joint plan shared by NHS Sussex ICB and NHS Trusts and Foundation Trusts within the ICS which will be produced January – March next year, and will be delivery focussed, taking in the issue of NHS Operational Planning Guidance for the following year. The joint 5-year forward plan will be updated annually.
- The strategy will be high level and relatively 'steady state', and for example could be updated when there are substantial changes in understanding population needs, for example through the JSNAs.

2.13 **Appendix 2** sets out the four principles that have been agreed to guide the strategy development process, and the suggested chapter framework that the strategy is built around. It is proposed that the strategy is built around six key chapters to arrive at a concise, publicly accessible document.

2.14 A co-production process is now underway involving organisations across the ICS to prepare the strategy in order that the Sussex Health and Care Assembly can agree it in December. This includes an engagement model for our citizens and workforce to ensure it is based on all the insight we have about health and care services. The draft strategy will be brought to the next meeting of the Health and Wellbeing Board for endorsement.

3. Conclusion

3.1 Our focus on improving population health and embedding prevention, early help and intervention is taking place in the context of continuing high levels of need for services in our population. Additional collective preparations for winter are in train to support the normal winter planning process to ensure we can best organise care and services for our population in response to what we anticipate will be challenging circumstances over the season.

3.2 The membership of our HWB has been updated to reflect our new NHS commissioning arrangements, and the role that the HWB continues to play in overseeing place-based commissioning and the work of our East Sussex Health and Care Partnership.

3.3 Our recently refreshed HWB Strategy 'Healthy Lives, Healthy People 2022 - 2027' will be used to inform and shape the content about our population's health and care needs in the Sussex Integrated Care Strategy as it is developed. This will set out how the three Health and Wellbeing Boards and the Sussex Health and Care Assembly can work together to improve health, reduce health inequalities and integrate care for their populations.

JESSICA BRITTON
Executive Managing Director, East Sussex, NHS Sussex

MARK STAINTON

Director of Adult Social Care, East Sussex County Council

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Background documents

None

Appendix 1 Monitoring information supplement

Appendix 2 Sussex integrated care strategy key principles and framework

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East Sussex Whole System Barometer indicators

Background

A small dashboard of indicators drawn from existing published performance reporting across each sector are chosen by the East Sussex Health and Social Care Executive Group, because they are each thought to give a useful guide as to how well we are functioning as a health and care system. This focusses on operational issues and pressures, and enables assurance of delivery. The dashboard also helps inform our priorities for changes to the way we deliver integrated services, which is managed through our Oversight Boards as it provides a picture of where we have relative strengths, weaknesses and opportunities, and the overall expected impact of any changes to care models and pathways that is in train.

Metric	Category	No	Indicator	Target	Target Currency	Data Definition	Latest Performance
Barometer	Primary Care	B9	GP Surgery Same Day Appointments	>45%	%age	Number of attended appointments where time between booking and appointment was 'Same day' as a percentage of total attended GP surgery appointments, includes GP and Non-GP	YTD as at June 22: 45% for all appointments June 22: 44% for all appointments 59% for GP appointments
		B13	GP surgery appointments held via video or telephone consultation	>16%	%age	Percentage of attended appointments where appointment mode was 'Video or 'Telephone' as a percentage of total attended GP surgery appointments, includes GP and Non-GP	YTD as at June 22: 40% for all appointments June 22: 40% for all appointments 57% for GP appointments
Barometer	Social Care	B26	People permanently admitted to Residential Care and Nursing Homes	<=60.5 per month	Number	Number of council-supported permanent admissions to residential and nursing care of older people.	YTD as at Feb 22: 54 Feb 22: 54
Barometer	Secondary Care	B14	A&E 4 Hour Target[i]	>=95%	%age	ESHT only: A&E Attendances for all A&E types, including Minor Injury Units and Walk-in Centres, and of these, the percentage admitted or transferred within four hours of arrival.	YTD as at August 22: 73% August 22: 70%
		B17	Cancer RTT 2 week	>=93%	%age	East Sussex CCG (any provider): Percentage of cancer referrals that meet the 2 weeks standard to start treatment, to see a specialist after urgent referral for suspected cancer.	YTD as at June 22: 88% June 22: 83%
		B18	Cancer RTT 62-day std	>=85%	%age	East Sussex CCG (any provider): Percentage of all cancer referrals that meet the 62-day standard, beginning first definitive treatment following urgent GP referral.	YTD as at June 22: 69% June 22: 65%
		B19	Diagnostic Access	<=1%	%age	East Sussex CCG (any provider): Percentage of patients waiting 6 weeks or more from referral for a diagnostic test.	YTD as at June 22: 14% June 22: 14%
Barometer	Mental Health	B3	Access to Improving Access to Psychological Therapies 18 weeks	95%	%age	The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period. SPFT only.	YTD as at June 22: 100% June 22: 100%
		B5	Number of Inappropriate Out of Area Mental Health Placements	0	Number	Number of Inappropriate Out of Area Mental Health Placements started in the reported period.	YTD as at June 22: Mean of 5 p/m June 22: 5

Source: East Sussex Integrated Transformation report 09/09/22

[i] ESHT figures

Sussex integrated care strategy key principles and framework

The Sussex integrated care strategy is required to be produced by the end of December 2022. It has been agreed by our ICS that the four following principles will guide the strategy development process:

- **Place and population first**: We have agreed that we will take an approach that considers the principles of place-based working that have been agreed across the system:

    a. The three place-based Health and Care Partnerships in Sussex are collaborative and non-statutory arrangements where all the organisations responsible for planning commissioning and delivering health and care services for the populations in that geographical area work together.
    b. In collaborating at place, individual statutory organisations are responsible for agreeing decisions relating to their budgets and services according to their existing practice and processes.
    c. The Joint Strategic Needs Assessments and the Health and Wellbeing Strategies agreed through the three Health and Wellbeing Boards set the evidence base and strategic framework within which priorities at place are identified.
    d. Place-based planning, commissioning and delivery will be focussed on a clear scope of services aimed at integrating care, improving health and reducing health inequalities. Wider partners in the voluntary, community, social enterprise (VCSE) and independent care sector, and Borough and District Councils where applicable, will be engaged to mobilise and support the best use of the resources collectively available.
    e. At a pan-ICS level, the Sussex Health and Care Assembly will be responsible for producing the Integrated Care Strategy for the system. This high level strategy will reflect the priorities in, and be built from, the three Health and Wellbeing Strategies.
    f. NHS Sussex is required to develop and implement a Delivery Plan that delivers the Assembly's Integrated Care Strategy. The principle of subsidiarity is paramount – NHS Sussex's Delivery Plan will be implemented through the three place-based Health and Care Partnerships, unless there is collective agreement that it makes more sense to deliver an element at the pan-Sussex level. NHS Sussex will align resources and management capacity to support the three place-based Health and Care Partnerships to implement the Delivery Plan
    g. Effective delivery at place therefore requires the full involvement of local authority partners in the development of NHS Sussex's Delivery Plan and other key related decisions before those decisions are taken by the NHS Sussex Board or its executive.

- **Data and evidence**: we will ensure that our approach is based on evidence, comparative data and responds to population need in line with the above principles.

- **Co-production**: Our communities will be central to the creation of the plan. To achieve this, we will ensure that every organisation is actively involved and leading the engagement with our communities.

- **NHS plan**: there will be a requirement for the yearly national mandate to be responded to but we will add national guidance to our strategy and ensure the guidance does not drive the framing of the document.

Based on this, and reflecting partnership conversations, it is proposed that the strategy is built around six key chapters, each framed concisely and in a publicly accessible way:

Chapter	Content
1	**Case for change** A brief, introductory analysis of the key challenges facing our population, and a shared vision and purpose for how the system wants to come together to address them
2,3, 4	**Place-based health and care strategies x3** A co-produced high-level strategy for each place, drawn from health and wellbeing strategies and based on an analysis of the population needs in each place; signed off by the respective Health and Wellbeing Board.
5	**Pan-Sussex priorities** An articulation of a small number of strategic priorities that all partners are committed to working on at a pan-system level and where the impact of action at this scale can be justified. Our collective roles as anchor institutions which can impact on the social and economic determinants of health will need to be considered in this chapter.
6	**NHS priorities** An articulation of the NHS priorities, driven by national policy imperatives (e.g. the NHS Long Term Plan) which the Health and Care System will be required to deliver across all places. This chapter of the strategy to be refreshed periodically as this priorities shift

Report to:	**East Sussex Health and Wellbeing Board**
Date:	**29th September 2022**
By:	**Independent Chair, East Sussex Safeguarding Adults Board**
Title of report:	**East Sussex Safeguarding Adults Board (SAB) Annual Report 2021 - 2022**
Purpose of report:	**To present the SAB Annual Report as required in the Care Act**

RECOMMENDATION

The East Sussex Health and Wellbeing Board is recommended to consider and comment on the report.

1 Background

1.1 The Care Act 2014 requires each Safeguarding Adults Board (SAB) to:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

1.2 The SAB Annual Report (Appendix 1) outlines safeguarding activity and performance in East Sussex between April 2021 and March 2022.

2 Supporting Information

2.1 The format of the report is structured against the SAB priorities as set out in the Strategic Plan 2021–24. The data section includes contributions from a number of partner agencies in addition to the core data from the local authority.

2.2 Deborah Stuart-Angus was appointed the new Independent Chair of the SAB following the resignation of Graham Bartlett in October 2021. Graham Bartlett had provided leadership, expertise and excellent support to the Board for six years. A number of staff changes have also taken place within the SAB business support area in 2021/22 including the addition of a safeguarding coordinator to support the increased safeguarding adult review (SAR) activity.

2.3 The coronavirus pandemic led to unprecedented challenges and put adult safeguarding in a position of greater importance than ever before. Over the past year the SAB has continued to seek assurance from our partner agencies about responses to COVID-19, and undertaken work to ensure services have been, and continue to be, supported to respond to emerging safeguarding themes.

2.4 Highlights in the report under the SAB five strategic themes are as follows:

Strategic Theme 1: Accountability and leadership

- The Multi-Agency Risk Management Protocol (MARM) was launched in January 2021 and is designed to provide guidance for practitioners on working adults with multiple complex needs and managing cases in which there is a high level of risk, but where the circumstances may sit outside the statutory safeguarding framework. The MARM group includes representation from East Sussex SAB partners and the voluntary and statutory sector. The group has the authority to use resources and make decisions to proactively support adults with multiple disadvantages and mitigate risks.

- To facilitate joint working across the partnerships a Partnership Protocol was developed and intended to support effective joint working between the following strategic partnership boards ('the partnerships') in East Sussex:
    - East Sussex Safeguarding Adults Board
    - East Sussex Safeguarding Children Partnership
    - East Sussex Safer Communities Partnership Board
    - East Sussex Children and Young Peoples Trust

  These partnerships are committed to ensuring that safeguarding is everyone's responsibility and to working together at every level to keep people in East Sussex safe from harm and abuse, and to improve health and wellbeing.

- The East Sussex SAB developed the Financial Abuse Multi-Agency guidance and accompanying documents to support practitioners in achieving co-ordinated multi-agency responses to financial abuse and to improve engagement and achieve positive outcomes for adults who experience financial abuse.

Strategic Theme 2: Performance, Quality and Audit, and Organisational Learning

- Further to an audit undertaken in 2019 in relation to young people at risk of exploitation, a working group was established in 2021 to review transitions between children's and adults' services. The project identified gaps in information sharing, provision and services for those young adults who may not have specific care and support needs, but who experience continuing risks and needs regarding child criminal and sexual exploitation.

- The SAB worked on a proposal to strengthen pathways across services and this was shared with ASCH Operational Teams in 2021. This work will be progressed in 2022/23 in conjunction with the East Sussex Safeguarding Children's Partnership.

- Following the recommendations outlined in the Adult C SAR published in December 2020 the action plan contained 16 recommendations with a number of associated actions and was completed in 2022 including developing and publishing Multi-agency domestic abuse guidance in December 2021. The guidance specifically covered a number of areas including responsibilities of reporting which may breach client confidentiality, effective information sharing, case coordination including the role of the lead professional and supporting agencies to effectively and routinely capture and record information that can support evidence-led prosecutions.

Strategic Theme 3: Policies and Procedures

- The three Sussex SABs produced the Sussex Safeguarding Adults Thresholds Guidance to assist practitioners and providers across all agencies in considering risk relating to potential safeguarding concerns involving adults with care and support needs. The new guidance enables safeguarding concerns to be reported when it is appropriate to do so and in a consistent way. It provides a framework for multi-agency partners to manage risk and to assist in identifying whether abuse and or neglect is taking place, and if a safeguarding concern needs to be referred to the local authority or whether alternative actions should be considered.

- In 2021-22 the Policies and Procedures review group agreed that some areas of the Sussex Safeguarding Adults Policy and Procedures needed review and revision following the last substantive update provided in 2019, when the self-neglect procedures were launched. It was agreed that different Local Authority areas would lead on completing certain updates and these would be added to the online procedures. This work continues into 2022/23.

Strategic Theme 4: Prevention, Engagement and Making Safeguarding Personal

- The SAB has continued to use social media to communicate to both professionals and the public, sharing posts, supporting partner and national campaigns and offering general guidance. We have significantly increased our Twitter followers over the past year and will strive to grow our followers in 22/23.

- The SAB produced quarterly e-newsletters during 2021– 22 to share news about the work of the Board, learning from SARs and audits, and adult safeguarding information. In 2022 we developed and now publish a SAB Monthly Digest which ensures information, consultations and events are promoted in a timelier manner to SAB members and their respective workforce.

Strategic Theme 5: Integration, and Training and workforce development

- With the outbreak of the coronavirus pandemic in March 2020 until 2022, all SAB multi-agency face-to-face training was put on hold. However, the Training and Workforce Development Subgroup has used creative ways to engage with the workforce to deliver training and reflective workshops, and over the past year set up several working groups to review the options for delivering our multi-agency training programme remotely via webinars or MS Teams.

- The SAB training programme is linked to our priorities, and over this last year has included the following workshops:
    - Modern slavery and human trafficking.
    - Adopting a Whole Family Approach to Domestic Abuse and Promoting Safety
    - Mental Capacity Act 2005: A multi-agency approach to complex cases.
    - Self-neglect.
    - Coercion and control.

3 Conclusions and recommendations

3.1 The key priority areas identified for the SAB in 2021 – 22 continue to be priority areas of development and require further embedding within safeguarding practice for 2022/23. Recommendations from recent reviews which concluded early in 2022: SAR Ben, SAR Anna and the Thematic SAR identified the same priority areas for further learning and assurance activity. These are:

- Embedding the Mental Capacity Act in practice
- Safeguarding transitions for young people at risk
- Supporting adults who face multiple disadvantage

3.2 The SAB will progress work in relation to the newly commissioned SARs in 2022/23 and seek assurance to ensure that the learning and recommendations from previous SARs continue to be embedded in practice. The People Scrutiny Committee is recommended to consider and comment on the report.

Deborah Stuart Angus
Independent Chair
East Sussex Safeguarding Adults Board

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Appendix 1: **East Sussex Safeguarding Adults Board Annual Report 2021/22**

East Sussex Safeguarding Adults Board Annual Report

April 2021 to March 2022

You can get all our publications in a format to suit you. If you would prefer this report in an alternative format or language, please ask us.

Please phone Health and Social Care Connect on 0345 60 80 191.

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Foreword by Deborah Stuart-Angus East Sussex SAB Independent Chair

I joined the East Sussex Safeguarding Adults Board in September last year, and it gave me great pleasure to be selected as the new Chair.

I applied for the role, for a very clear reason, which was to pick up from the good work and where our former Chair, Graham Bartlett, left off, and to be able to move things to the next natural point of development.

A strong foundation was and is, in place here, supported by a committed partnership with a firm desire to enhance a vibrant, local focus, symbiotic with a smart, pan-Sussex approach, and moreover, evident leadership, that warrants respect.

I have been given a very warm, true welcome and am proud to lead this Board, to continue to learn about what works well, and to discuss and develop what we can mutually build on, together. Already I am enormously proud of our industrious and diligent Safeguarding Adults Review Group; the real, fruitful outcomes from our Quality and Performance Group and the ease of working with our joint Policy and Procedures Group. Our work is set out in the Strategic Plan 2021 - 2024, which we have already added to, by introducing a quality assurance framework for our SARs; initiating the development of a protocol to share with our Coroner; jointly working with the Boards of West Sussex and Brighton and Hove, to improve the lives of vulnerable people and guests in this country, with accommodation and resettling issues; developing our policies and procedures to ensure independence in our review processes; and working to learn from our partners, how improvement is actually embedded into our safeguarding practices - to name but a few key areas of our focus.

I hope that going through this Report you learn more about the sheer scope and importance of our activity and thank you for taking the time do so. I think you will find, it is readable, comprehensive, and thorough, clearly reflecting the huge amount of work that takes place every day, by many people across our County, who safeguard others who have care and support needs.

I thank this partnership and I praise the teams who contribute, with their dedication, their resilience and moreover, their compassion.

I look forward to the year ahead, to continuing to take our Board forward, and to supporting our membership in the challenges they face when enabling others to live lives, free from abuse and neglect.

Deborah Stuart-Angus

Independent Chair, East Sussex Safeguarding Adults Board

Our Role and Purpose

The East Sussex Safeguarding Adults Board (SAB) is a multi-agency statutory partnership which provides leadership and strategic oversight of adult safeguarding work across East Sussex. The Board brings together partner agencies who have a responsibility for adult safeguarding and comprises of a core membership of statutory partners from East Sussex County Council (ESCC), NHS East Sussex Clinical Commissioning Group (CCG) and Sussex Police. Additional members from a range of organisations, including community and voluntary agencies and lay members, are represented on the Board to reflect that safeguarding activity and interventions can only be effective where there is collaboration and shared commitment. A full list of the partners of the East Sussex SAB is given at Appendix 1.

The work of the SAB is underpinned by the Care Act 2014, which sets out that we are required to:

- Develop and publish a Strategic Plan setting out how we will meet our objectives and how our partner agencies will contribute to this.
- Publish an annual report detailing how effective our work has been.
- Arrange for Safeguarding Adults Reviews (SARs) to be undertaken when the criteria under section 44 of the Care Act are considered to have been met.

The East Sussex SAB is led by our Independent Chair, Deborah Stuart-Angus, and supported by a SAB Development Manager, a shared Quality Assurance and Learning Development Officer post, a Safeguarding Coordinator and a part-time Administrator. The Board meets four times a year and is supported by a range of subgroups which are crucial in ensuring that the priorities set out in the Strategic Plan are delivered. Each subgroup has a work plan which details the areas of focus for the financial year and is regularly updated with specific actions and timescales. These subgroups ensure that the work of the Board really makes a difference to local safeguarding practice, and to the outcomes adults and their carers wish to achieve. A diagram outlining our Board structure can be found at Appendix 2.

Our Vision is for all agencies to work together and effectively build resilience and empower communities in responding to abuse, neglect and exploitation, and to widely promote the message that safeguarding is everybody's business in that:

- Abuse is not tolerated.
- People know what to do if abuse happens.
- People and organisations are proactive in working together to respond effectively to abuse.

Our Purpose

It is important to note that the SAB is not involved in operational practice. Our overarching purpose is to ensure that agencies work in partnership to deliver joined-up services that safeguard adults with care and support needs from abuse, neglect and exploitation. We do this by:

- Gaining assurance that local safeguarding arrangements are in place as defined by the Care Act and its statutory guidance.
- Working collaboratively to prevent abuse and neglect, where possible.
- Ensuring partner agencies are effective when abuse and neglect has occurred and give timely and proportionate responses.
- Gaining assurance that the principles of Making Safeguarding Personal (MSP) are central to safeguarding, and practice is person-centred and outcome focused.
- Striving for continuous improvement in safeguarding practice and supporting partner agencies to embed learning from local and national SARs, other learning reviews and multi-agency audits.

Partnership Working

The SAB has formal links with a number of other strategic partnerships in East Sussex, including the East Sussex Safeguarding Children Partnership, Safer Communities Partnership, Children and Young People's Trust, the East Sussex Domestic and Sexual Violence and Abuse Management Oversight Group and the Health and Wellbeing Board. In addition, the Board maintains links with Sussex-wide and national networks and forums including:

- National Network for Chairs of SABs.
- National SAB Managers Network.
- South-East Regional SAB Network.
- Sussex Anti-Slavery Network.

The Board works closely with the neighbouring Brighton & Hove and West Sussex SABs, and many of our policies and procedures are adopted on a pan-Sussex basis.

Our Strategic Priorities 2021-2024

Accountability and Leadership

Ensure the SAB provides strategic leadership to embed the principles of safeguarding, and contribute to the prevention of abuse and neglect

Performance, Quality and Audit, and Organisational Learning

To ensure learning from reviews is effectively embedded into practice and to facilitate organisational change across agencies.

Policies and Procedures

Have assurance that multi-agency safeguarding policies and procedures are regularly reviewed and reflect up to date legal frameworks, policy and guidance, and that these are easily accessible and used effectively by frontline staff.

Prevention, Engagement and Making Safeguarding Personal

To ensure adults, carers and the local community as well as professionals shape the work of the SAB and safeguarding responses.

Integration, and Training and workforce development

To ensure the workforce is equipped to support adults appropriately where abuse and neglect are suspected.

SAB Budget

Our statutory partners contribute annually to the SAB budget and running of the Board, for example by offering to chair meetings and co-deliver training.

Income for 2021 - 2022

East Sussex County Council	£69,300
NHS East Sussex Clinical Commissioning Group	£30,000
Sussex Police	£12,000
East Sussex Healthcare NHS Trust	£10,000
East Sussex Fire & Rescue Service	£5,500
20/21 Carry forward	£8,593
BHCC contributions	£14,546
WSCC contributions	£83
Total	**£150,022**

Expenditure for 2021 - 2022

SAB Independent Chair	£22,382
SAB Development Manager	£63,548
QA LD Officer and Admin Staff costs	£33,119
Mobile and Staff Training costs	£192
SAB Website Licence and Training	£1,236
Multi-Agency Training	£744
SARs/Multi-Agency Reviews	£8809
Total	**£130,030**

Safeguarding Adults during the COVID-19 Pandemic

The Social Care Institute for Excellence (SCIE) reported in February 2022 that COVID-19 will continue to be part of our lives for the foreseeable future and as infection rates remain high, disruption to people's lives will continue.

Adults who need care and support may be targeted at this time because of a number of factors. Generally speaking they may need assistance with some tasks, be less up to speed with technology, more welcoming of new contacts, more trusting and – for many older people – wealthier. There is evidence that social isolation increases the likelihood of abuse. Many older and disabled people spend long periods at home alone under normal circumstances and will continue to do so even as the restrictions lift. People who are more vulnerable to COVID-19 may not feel safe or ready to mix more freely.

Many people with care and support needs will be supported either in the family home or by residential and nursing care services. It could be argued that these people will be better shielded from abuse but national statistics show high incidence of abuse where the abuser is a family member or the paid care provider. Those living alone in the community, who continue to be isolated, may be a particular target for scammers and fraudsters.

The coronavirus pandemic led to unprecedented challenges and put adult safeguarding in a position of greater importance than ever before. Over the past year the SAB has continued to seek assurance from our partner agencies about responses to COVID-19, and undertaken work to ensure services have been, and continue to be, supported to respond to emerging safeguarding themes.

Over the past year, all SAB meetings and multi-agency training have been held remotely and we have seen an increase in engagement given the efficiencies that virtual meetings create.

East Sussex Adult Social Care and Health have and continue to provide COVID-19 updates for adult social care providers – these have included:

- Information on testing, test and trace, vaccinations, personal protective equipment (PPE) and infection control.
- Advice for personal assistants on COVID-19 and how to look after their clients safely.
- Resources to assist providers in supporting social care clients and carers affected by COVID-19.
- COVID-19 information specific to care homes.

- Training related to COVID-19 and national guidance.
- COVID-19 guidance for home care workers and providers.
- Recruitment and wellbeing resources for providers.
- COVID 19 adult social care provider email bulletin.

In May 2021, the SAB produced a Multi-Agency COVID-19 Safeguarding Assurance Interim Report which included a survey on the Impact of COVID-19 upon safeguarding practice with partner agencies.

Good practice was identified and shared through the SAB Performance and Quality Assurance subgroup. Some examples are listed below:

SPFT produced and widely circulated safeguarding briefing documents relevant to COVID-19 to staff and introduced domestic abuse training as mandatory for all clinical staff which supported the anticipated increase in levels of domestic abuse.

The ASCH Market Support Team worked closely with the CQC to identify and support care providers with prevention work. The aim of Market Support is to promote the efficient and effective operation of the local care and support market ensuring there is a sufficient supply of sustainable, good quality care and support services and resources.

Sussex CCG staff provided emergency cover to a care home severely affected by COVID-19, preventing closure and used their position in the Mass Vaccination Cell to highlight the needs of people rough sleeping, and those with learning disabilities and supported GPs in the consideration of how to prioritise these groups.

A number of local authority staff were re-deployed into various roles during the Pandemic for example: moving into direct caring roles within the Joint Community Rehabilitation Team which provided home support for adults who had been discharged early from Hospital , supporting the coordination of food box delivery to those who were clinically vulnerable or coordinating the distribution of PPE clothing.

Key Achievements 2021 – 22

Accountability and leadership:

- The SAB has continued to support the Modern Slavery agenda. Multi-Agency Modern Slavery guidance was published in January 2022 which raised awareness of modern slavery and human trafficking amongst partner agencies of the East Sussex Safeguarding Adults Board (SAB) and helped agencies to recognise modern slavery and have the confidence to report suspected cases.

  The SAB contributed to the East Sussex County Council Modern Slavery statement, outlining details of victim support and protection available locally. This annual statement outlines the steps an organisation has taken to address modern slavery in their operations and supply chains.

- A revised self-assessment tool was devised which was more proportionate and enabled partners to provide more qualitative responses to support rigorous peer challenge. The information collated will be used to inform the forthcoming ESSAB Learning Event in 2022.

- The Multi-Agency Risk Management Protocol (MARM) was launched in January 2021 and is designed to provide guidance for practitioners on working adults with multiple complex needs and managing cases in which there is a high level of risk, but where the circumstances may sit outside the statutory safeguarding framework. The MARM group includes representation from East Sussex SAB partners and the voluntary and statutory sector. The group has the authority to use resources and make decisions to proactively support adults with multiple disadvantages and mitigate risks.

- To facilitate joint working across the partnerships a Partnership Protocol was developed and intended to support effective joint working between the following strategic partnership boards ('the partnerships') in East Sussex:

  East Sussex Safeguarding Adults Board

  East Sussex Safeguarding Children Partnership

  East Sussex Safer Communities Partnership Board

  East Sussex Children and Young Peoples Trust

  These partnerships are committed to ensuring that safeguarding is everyone's responsibility and to working together at every level to keep people in East Sussex safe from harm and abuse, and to improve health and wellbeing.

- The East Sussex SAB developed the Financial Abuse Multi-Agency guidance and accompanying documents to support practitioners in achieving co-ordinated multi-agency responses to financial abuse and to improve engagement and achieve positive outcomes for adults who experience financial abuse.

- Learning from Safeguarding Adults Reviews: a multi-agency approach - a free interactive online conference chaired by Graham Bartlett took place on 26th May 2021. This was followed by interactive expert-led workshops on Trauma Informed Practice, Mental Capacity Act and Inherent Jurisdiction and Professional Curiosity. The event was attended by 250 professionals across both B&H and East Sussex.

- A bi-annual subgroup chairs' meeting now takes place with the aim of strengthening links and communication across the SAB's subgroups, and opportunities for peer support and reciprocal challenge.

Policies and procedures:

- The three Sussex SABs produced the Sussex Safeguarding Adults Thresholds Guidance to assist practitioners and providers across all agencies in considering risk relating to potential safeguarding concerns involving adults with care and support needs. The new guidance enables safeguarding concerns to be reported when it is appropriate to do so and in a consistent way. It provides a framework for multi-agency partners to manage risk and to assist in identifying whether abuse and or neglect is taking place, and if a safeguarding concern needs to be referred to the local authority or whether alternative actions should be considered.

- In 2021-22 the Policies and Procedures review group agreed that some areas of the policy and procedures needed review and revision following the last substantive update provided in 2019, when the self-neglect procedures were launched. It was agreed that different Local Authority areas would lead on completing certain updates and these would be added to the online procedures. This work will continue in 2022/23.

Performance, quality and audit, and organisational learning:

- Further to an audit undertaken in 2019 in relation to young people at risk of exploitation, a working group was established in 2021 to review transitions between children's and adults' services. The project identified gaps in information sharing, provision and services for those young adults who may not have specific care and support needs, but who experience continuing risks and needs regarding child criminal and sexual exploitation.

The ESSAB worked on a proposal to strengthen pathways across services and this was shared with ASCH Operational Teams in 2021. This work will be progressed in 2022/23 in conjunction with the East Sussex Safeguarding Children's Partnership.

- Following the recommendations outlined in the Adult C SAR published in December 2020 the action plan contained 16 recommendations with a number of associated actions. Actions completed in 2021 included:

    - The launch of the Multi-Agency Risk Management Protocol (MARM) and associated guidance on Assessing and Supporting People with Multiple Complex Needs in December - for practitioners working adults with multiple complex needs and managing cases in which there is a high level of risk.

    - Housing needs managers from each District and Borough Council provided assurance that their current processes have been updated to reflect their responsibilities in regard to the implementation of the Homelessness Reduction Act (HRA) in July 2021.

    - Reassurance was provided to the SAB in January 2021 in relation to trauma-informed support within refuge and supported accommodation services and updates on arrangements for women's accommodation across Sussex from the National Probation Service. The short sentence function design for women will result in staff placed both in prisons and the community working collaboratively with commissioned and voluntary services to offer wrap around accommodation support which can give women the best opportunities for successful resettlement from prison.

    - Multi-agency domestic abuse guidance was developed and published in December 2021. The guidance specifically covered a number of areas including responsibilities of reporting which may breach client confidentiality, effective information sharing, case coordination including the role of the lead professional and supporting agencies to effectively and routinely capture and record information that can support evidence-led prosecutions.

- An audit of cases to establish the extent to which a multi-agency approach is effective in supporting women with multiple complex needs who experience domestic violence and abuse will take place this summer and findings will be reported to the SAB in October. This will conclude the recommendations set out in the Adult C action plan.

Safeguarding Adults Reviews (SARs)

SABs have a statutory duty under the Care Act 2014 to undertake Safeguarding Adults Reviews (SARs). This is when:

- An adult dies as a result of abuse or neglect (including death by suicide), whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

- An adult is still alive but has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs can undertake reviews in any other circumstance where an adult has care and support needs.

The purpose of a SAR is set out in the Sussex SAR Protocol, namely to look at the ways professionals and agencies work together to determine what might have been done differently that could have prevented harm or death. It is not an enquiry into how a person died, nor is it to apportion blame; but to learn from such situations, and to ensure that any learning is applied to future cases to reduce the likelihood of similar harm occurring again.

- During 2021 – 22, the East Sussex SAB received six new referrals for SARs. Of these three have progressed to full SARs and are expected to be concluded by the end of 2022.

- SAR Anna was published in May 2022 and SAR Ben and the Thematic SAR are due to be published in the summer . All three Reviews have action plans which will be progressed over the forthcoming year.

Learning themes from these SARs include:

Absence of formal planning meetings involving front line staff and the need for the role of multi-disciplinary planning meetings to be promoted especially in complex and challenging cases

An understanding of how legal interventions can be used to better protect vulnerable adults and the need to raise awareness of the role of the Court of Protection.

The effectiveness of how each member agency has achieved organisational change and understanding from SARs, as well as implementing their recommendations.

Seeking assurance from agencies of the provision of training provided for staff and the need for multi-agency training.

Assurance that transitional safeguarding processes are meeting the needs of people who have had adverse childhood experiences but are struggling to engage with services, are met after they reach the age of 18 years old.

- The SAR Subgroup continued with its arrangements to share learning across review processes with its meetings receiving updates on Domestic Homicide Reviews (DHRs) and from the Learning Disabilities Mortality Review Programme and more recently an update on the Drug and Alcohol Related Deaths enquiry in 2022.

- There are some parallels and themes in terms of learning and in 2022/23 the DHR and SAR action plans will be analysed to identify opportunities to combine joint learning and reduce the potential of duplicating activity.

SAR Anna

- SAR Anna was published in May 2021. This review examined the circumstances leading up to the death of an 85-year-old woman who died in hospital of natural causes, but her condition on admission had raised concerns because it was noted that Anna had multiple bruises and skin tears over several parts of her body. Previously, safeguarding referrals were raised between 2016 and 2019, when she had been in residential care, but had later returned to live with her daughter – five months before Anna's death.

  A Review was commissioned to understand if lessons could be learnt by organisations who supported Anna, particularly in how the way agencies worked together: to evaluate and understand coercion and control and protect potential victims of domestic abuse. It was felt that the circumstances relating to Anna's death had some similarities with a previous SAR, (Adult B) published by the SAB in February 2020, and that this Review should also explore the extent to which previous learning had been embedded into practice. The SAB has accepted the findings in relation to SAR Anna, produced a formal response to the review and developed an action plan to address the learning and support improvements to services.

Integration, and training and workforce development:

- With the outbreak of the coronavirus pandemic in March 2020 until 2022, all SAB multi-agency face-to-face training was put on hold. However, the Training and Workforce Development Subgroup has used creative ways to engage with the workforce to deliver training and reflective workshops, and over the past year set up several working groups to review the options for delivering our multi-agency training programme remotely via webinars or MS Teams.

- As practitioners are dealing with increasingly complex and challenging safeguarding cases, the benefits of multi-agency training are significant, and create opportunities for increased collaboration and partnership, along with improved understanding of different roles and responsibilities.

  The SAB training programme is linked to our priorities, and over this last year has included the following workshops:

  - Modern slavery and human trafficking.
  - Adopting a Whole Family Approach to Domestic Abuse and Promoting Safety
  - Mental Capacity Act 2005: A multi-agency approach to complex cases.
  - Self-neglect.
  - Coercion and control.

- Adult Social Care and Health (ASCH) runs additional safeguarding training, including e-learning and virtual awareness and refresher courses. All our courses can be booked via the East Sussex Learning Portal and are available to SAB partner agencies and provider services in East Sussex.

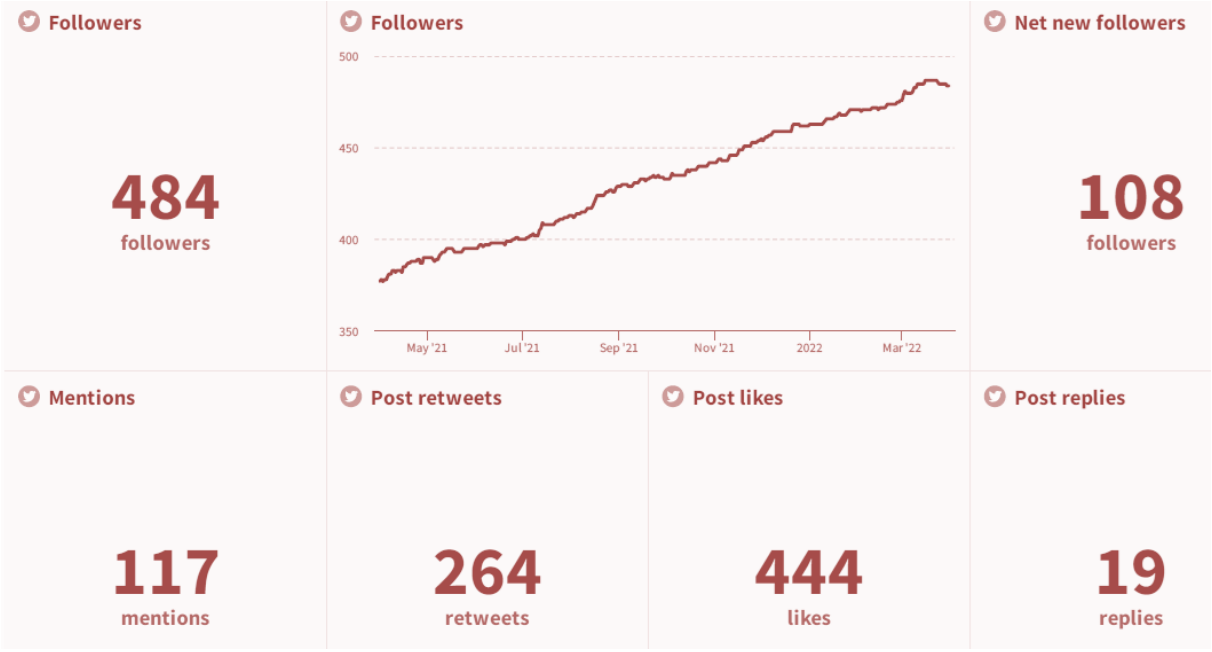
- The TWD Subgroup has produced an action plan to map progress against priorities in the Learning and Development Strategy, which will inform work to develop the new three-year strategy for 2022 - 2025.

- An action plan was completed to ensure the findings and learning from the University of Sussex project report ‘Organisational Learning from Research and SARs in Self-Neglect’ inform developments in practice.

- The TWD Subgroup have kept informed on developments with Liberty Protection Safeguards (LPS) and will ensure training programmes are developed ahead of future implementation which is due to take place in 2023.

Prevention, engagement and Making Safeguarding Personal

- The SAB has continued to use social media to communicate to both professionals and the public, sharing posts, supporting partner and national campaigns and offering general guidance. We have significantly increased our Twitter followers over the past year and will strive to grow our followers in 22/23.



- Our East Sussex SAB website received 17,375 visits between March 2021 and April 2022. The most popular page visited within the website was 'What is Safeguarding / How to raise a concern' receiving 1,880 views closely followed by 1,335 visits to the ESSAB SAR publications and 1,195 visits to the guidance and resource section. The average time a user spent on a page within the ESSAB website was 01:47 minutes and a total of 1,524 documents were downloaded from the website.

- The SAB produced quarterly e-newsletters during 2021 – 22 to share news about the work of the Board, learning from SARs and audits, and adult safeguarding information. In 2022 we developed and now publish a SAB Monthly Digest which ensures information, consultations and events are promoted in a timelier manner to SAB members and their respective workforce.

- The SAB has continued work towards increasing feedback from adults and carers on their experience of safeguarding interventions. The Safeguarding Development Team has updated questionnaire templates and is offering different options for adults to share their views to ensure the process is accessible to everyone.

A phased feedback proposal was developed during 2021 – 22 to explore the role that Healthwatch and other partner agencies can play in supporting mechanisms to increase feedback rates and offer creative ways for people to engage in this process.

Learning from complaints

The total number of new complaints received by Adult Social Care & Health (ASCH) in 2021 - 2022 was 342.

Of these, 15 directly related to safeguarding, this is 4.5% of the total complaints received and compares to 12 (5%) complaints received in relation to safeguarding in 2020 – 2021.

The outcome of the 15 complaints directly relating to safeguarding can be broken down as follows:

- Not upheld = 9
- Partially Upheld = 3
- No outcome recorded = 3

Learning and actions from the 15 complaints directly relating to safeguarding are:

- The provider continues to discuss policy with staff and has implemented further manual handling training.
- Apology given for staff member being late for an appointment.
- Apology given that it was not explained that some concerns were more appropriately dealt with through the care management process, rather than safeguarding.
- Support to be provided around the redaction of safeguarding reports and that the report has been redacted is explained to the recipient of the report.

A complex complaint that was directly related to safeguarding that was initially received in August 2020, went to the Local Government and Social Care Ombudsman (LGSCO) in June 2021. Following their investigation the LGSCO found fault with ASCH handling of the safeguarding enquiry, and this resulted in the following learning and actions:

- Provide an apology for the faults identified, the distress these have caused, and the time and trouble that had to be spent to pursue these matters subsequently with the Council.
- Pay £500.
- Discuss the lessons learned with those involved in investigating safeguarding concerns.
- To review its safeguarding procedures so as to ensure that the Council will always consider and record whether those involved in investigating a safeguarding issue will be independent enough.

Priorities 2022 – 23

In April 2021, the East Sussex SAB published its Strategic Plan for 2021 – 24.

The key priority areas identified for the SAB in 2021 – 22 continue to be priority areas of development and require further embedding within safeguarding practice for 2022/23. Recommendations from recent reviews: SAR Ben, SAR Anna and the Thematic SAR identified the same priority areas for further learning and assurance activity. They are:

Embedding the Mental Capacity Act in practice

Safeguarding transitions for young people at risk

Supporting adults who face multiple disadvantage

Some of our specific objectives for 2022/2023 include:

- Developing one SAR Action plan which contains common themes, shared learning and opportunities to collaborate with other similar processes for example Domestic Homicide Reviews (DHRs) and Drug and Alcohol Related Death (DARD) enquiries to avoid duplication of learning and improve cross communication between the different review processes.

- Develop and hold an ESSAB Learning Event with the purpose of:

1. Embedding and promoting a safeguarding culture throughout the organisation in line with the Care Act 2014 and Sussex Safeguarding Policy and Procedures.

2. Understanding how learning from SARs, other SAB reviews and multi-agency audits drive improvements internally and across the partnership.

3. Identifying what processes are used to ensure that learning from SAB activities is embedded across the workforce to improve practice and outcomes for adults.

- Work will be undertaken to evaluate whether policies, procedures and pathways for convening multi-agency risk management meetings are adequate and multi-agency meetings are used and are effective in coordinating responses in complex and challenging case when undertaking safeguarding work with vulnerable adults. SAR Ben and SAR Anna both identified this as an area for development.

- The Thematic Review identified the need to ensure transitional safeguarding processes are meeting the needs of people who have had adverse childhood experiences but are struggling to engage with services, are met after they reach the age of 18 years old. This work will be progressed in 2022/23 in conjunction with the East Sussex Safeguarding Children's Partnership.

- Explore how a strategic assessment of safeguarding activity and use of partnership data can inform future safeguarding priorities, learning and practice and compliment the learning identified within SAR reviews. A strategic assessment will support the development of a new Strategic Plan for 2024-2027.

- A review of the MARM process. The review will consider the themes from referrals, emerging issues and the chairing arrangements. Statutory agencies will be requested to seek feedback from individuals with lived experience of their support. This will help to identify outcomes as part of the review of the pilot.

- Developing more accessible and engaging learning materials such as podcasts/webinars for practitioners who may have reduced capacity to attend learning events. By developing alternative options for sharing information and learning means we are able to reach a large number of people at the same time, are cost effective and learners can take in the information at a more convenient time for themselves.

Our Data

The Care Act 2014 sets out our statutory duties and responsibilities for safeguarding adults including the requirement to undertake enquiries under section 42 of the Act. Below is a summary of key safeguarding activity during 2021 – 22 for both concerns raised and enquiries undertaken by Adult Social Care and Health (ASCH) in East Sussex County Council.

Summary of Data findings

The shift in patterns of social behaviour due to Covid Pandemic restrictions changing has had a significant impact on services and data recording. For example in line with further restrictions being removed data has reflected a decrease in the location of abuse within the home and an increase in community settings.

East Sussex has a population of 26.1% aged 65[1]. This means that there is a higher percentage of the population locally, compared to the national figure who will have, or will develop, care and support needs.

In 2021-2022 Safeguarding activity increased for some agencies:

- Adult Social Care and Health (ASCH) experienced a 15.6% increase in safeguarding contacts received which builds on the trend from last year when there was a 13.5% increase.

- Operation Signature had an increase in fraud related crimes reported. Reports show a total loss of £23.05 million to vulnerable victims of fraud in 2021-2022, with the average loss where recorded being £15,000 per victim. This is an increase on the previous year which totalled £6.87 million with an average loss per victim of £15,048 per victim.

- Sussex Community NHS Foundation Trust (SCFT) has had an increase of 40% in the total number of Safeguarding concerns raised when compared to last year. Neglect as a category of concern continues to increase with a 24% increase from last year.

- East Sussex Healthcare Trust (ESHT) has an increase of 47.1% in Safeguarding Concerns raised by in comparison to last year.

Safeguarding activity reduced overall for some agencies in 2021-22 compared to 2020-21:

There was a small .4% (47 less) reduction in the total number of Vulnerable Adult at Risk (VAAR) referrals raised by Sussex Police in comparison to the same data for the previous year.

[1] Data extracted from East Sussex in Figures, June 2020

The number of Home Safety Visit referrals received from Adult Social Care to East Sussex Fire and Rescue Service declined by 37% compared to the previous year.

Within ASCH data

- There has been an increase of enquiries with the Primary Category of Domestic Abuse which increases each year and this year is 18% higher than the previous financial year. This trend is noticeable significant as it is higher than the National Average which is 9%.

- Physical Abuse enquiries are lower this year by 4% than the previous year and lower than the National Average which is 27%.

- There is a marked increase of 4% in the reported risk source being Social Care staff.

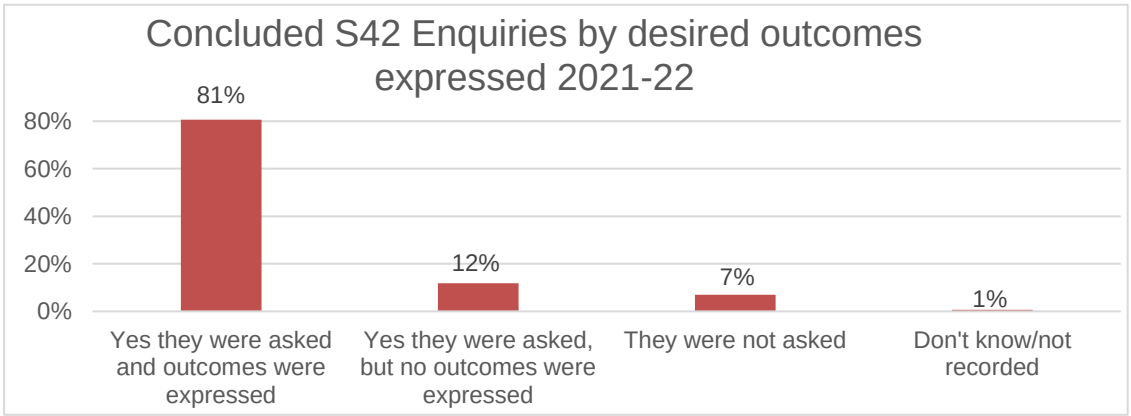
- Within East Sussex 1.7% of the population identify as Asian/Asian British. This ethnic group has the highest number of cases open for over 91 days (29%) and data also shows that this ethnic group has the lowest number of requests for Outcomes asked.

- 0.6% of the population within East Sussex identify as Black or Black British. This ethnic group is recorded as having the lowest percent (0%) of risk removed.

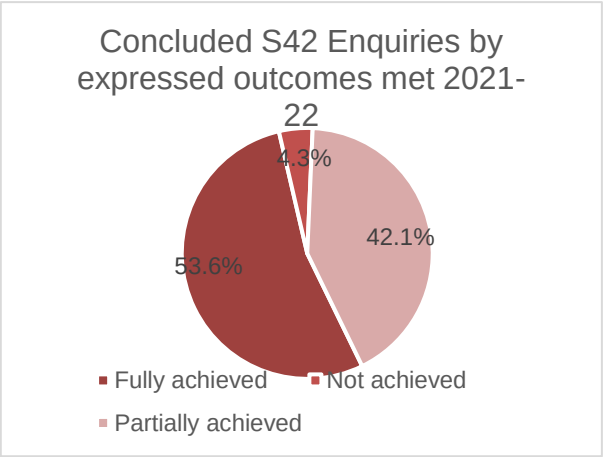
Analysing safeguarding data - Please note that as data sets are refreshed and cleansed on a regular basis through the year, noting for example when an enquiry is closed, then there will be minor variations in the figures depending upon the data a report is created.

Outcomes achieved through safeguarding

- **Expressed and achieved desired outcomes -**This past year saw an increase from last year of 87% to 93% of the proportion of adults who were asked for their desired outcomes. From this 81% of cases expressed an outcome which is a 5% increase from last year.



Outcomes identified by the adult concerned were either ‘Fully’ or ‘Partially Achieved’ in 95.7% of cases; this is an increase from 2020-21 (95.5%).Adults whose outcomes were ‘Fully Achieved’ has increased slightly from 52.4% in 2020-21 to 53.6%.



There will be cases where outcomes will not have been achieved - where desired outcomes are beyond the remit and control of the enquiry, or where the situation has changed from the initial desired outcomes that were recorded.

Impact on risk

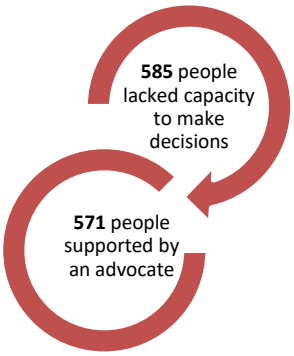
Effectiveness of S42 enquiries in reducing risk

88% of S42 enquiries identified a risk to the adult and action was taken. In 94% of these cases, the risk was either reduced or removed completely, this is an increase from last year (92%).
There has been a decrease from 8% to 7% in the proportion of cases where risk was identified and remained.

Support for adults at risk who lack capacity to make informed decisions

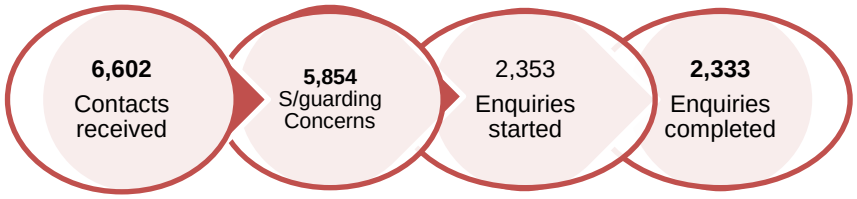
One of the key objectives for the SAB is to Make Safeguarding Personal. Adults should be able to inform wherever possible how safeguarding support can improve their outcomes. Appropriate support is needed therefore for those who may lack capacity to make safeguarding decisions for themselves.

In 2020-21, **97.6**% of all adults who lacked capacity received support, either by family or friends or via a referral to POhWER for advocacy support. This is an increase from 96.8% in 2020-21 and is higher than the national average of 80.6% as reported in the NHS digital for 2020-21.

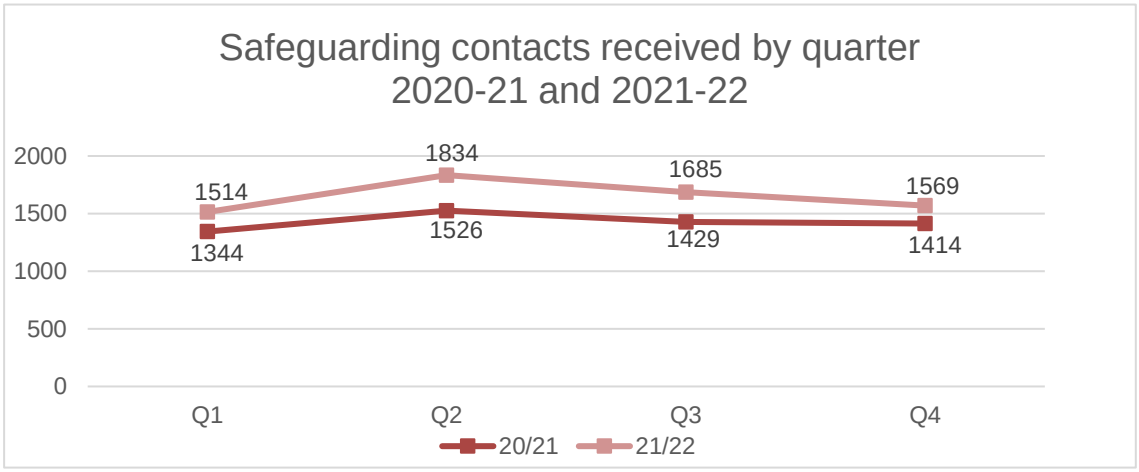


Safeguarding Contacts

During 2021-20 ASCH received 6,602 safeguarding contacts, a 15.6% increase from 5,713 in 2020 – 21. Both years follow very similar trends with increases in Q2**.**



Of the total contacts received in 2021 – 22, 5,854 (89%) were considered safeguarding concerns which is an increase of 3% from last year.

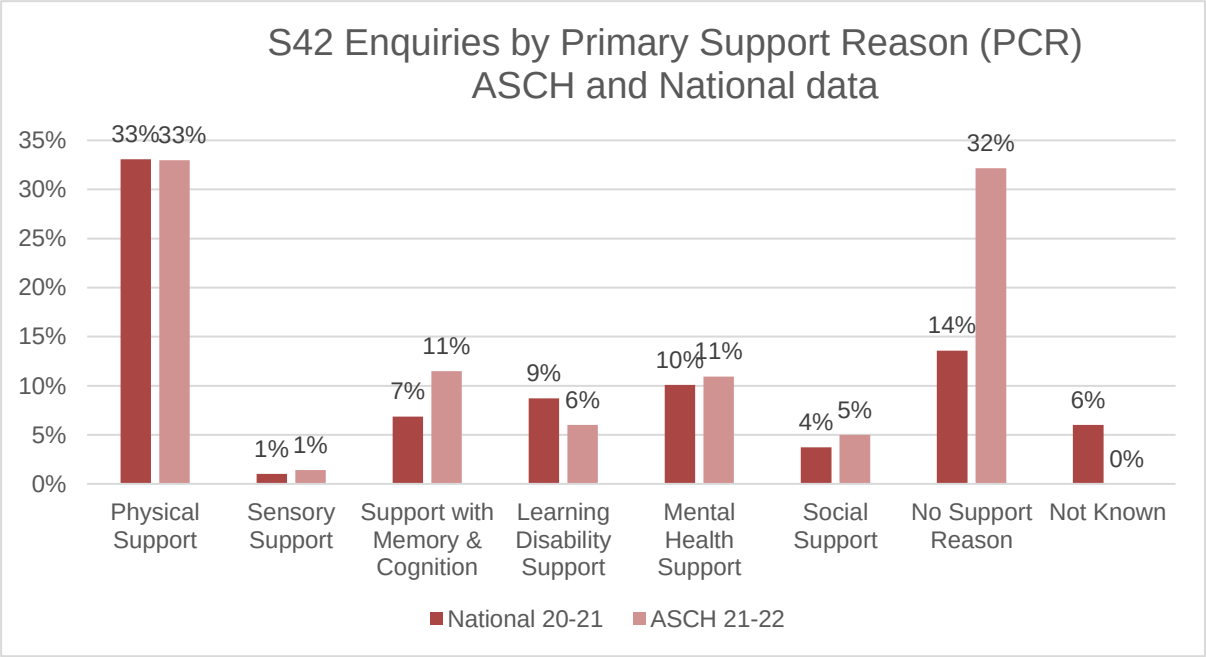


- 40% of Safeguarding Concerns are converted to Enquiries. This is higher than the national average of 34%[2] and the same as 2020-21. Initial analysis of the rate of conversion from safeguarding concerns to enquiries indicates that some safeguarding concerns are being dealt with but are not triggering a S42 process or the opening of a safeguarding episode; also some safeguarding enquiries are being undertaken but are being recorded in a different way.

- Some improvements in recording took place in 2019-20 but further analysis is being undertaken by the Safeguarding Development Team which may lead to additional work to improve the recording of safeguarding activity to ensure all enquiries are captured.

[2] NHS Digital, sourced from the Safeguarding Adults Collection (SAC) report,

Safeguarding enquiries by primary support reason



The above chart shows a breakdown of S42 safeguarding enquiries by Primary Support Reason (PSR) for 2021-22, with a comparison with the national data for 2020-21.

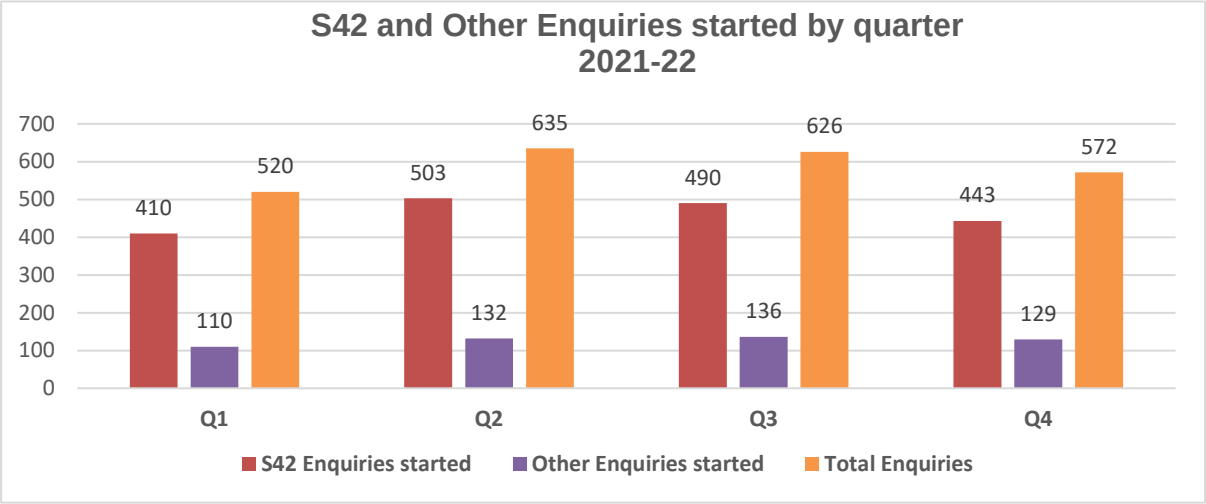
- The percentage of enquiries recording no PSR remains high in comparison with the national data. Guidance issued in relation to the 2018 Safeguarding Adults Collection (SAC) return clarified that authorities are expected to determine PSRs through a social care assessment or review and record this on the relevant local system.

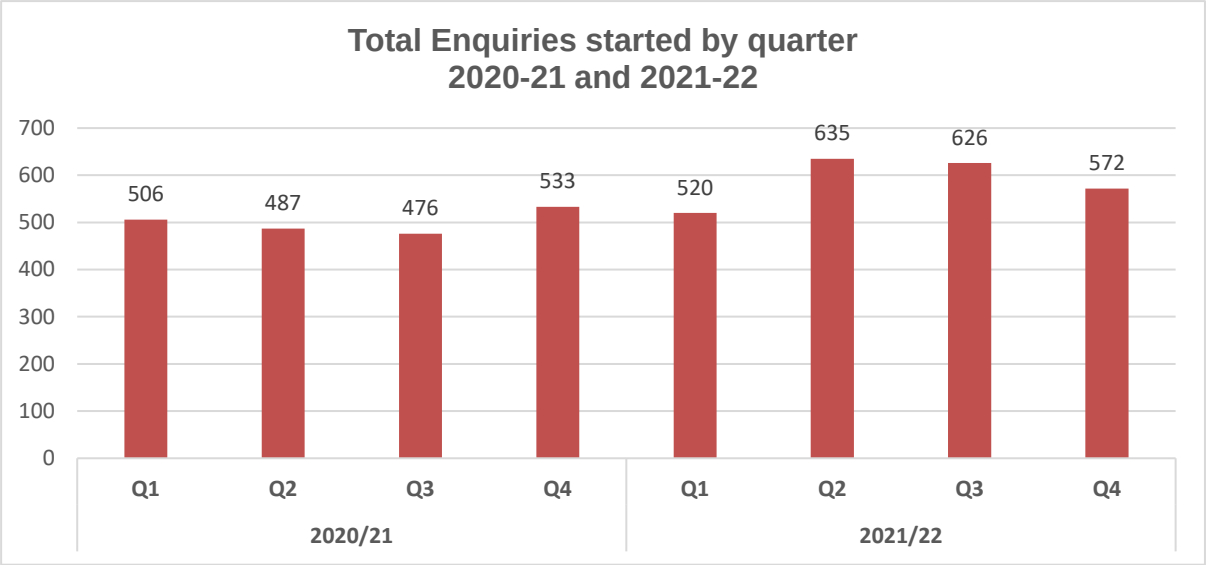
- It is not expected that authorities will assess PSRs as part of the safeguarding process. Therefore, safeguarding enquiries relating to adults who are not already recorded on the East Sussex Adult Social Care & Health system may not have a PSR recorded. As part of the end of year collation for the SAC return, previously determined PSRs are used for any cases with no current PSR.

Safeguarding Enquiries Opened

The next chart shows the number of safeguarding enquiries, including S42 and other enquiries, opened in each quarter, in 2021-22. There was a significant increase in the number of opened S42 and other enquiries in Q2 and Q3 with a slight dip in Q4. This reflects the 15.6% increase in safeguarding contacts received by ASCH.

The table below shows lower activity for enquiries started in 2020/21 compared to 2021/22.

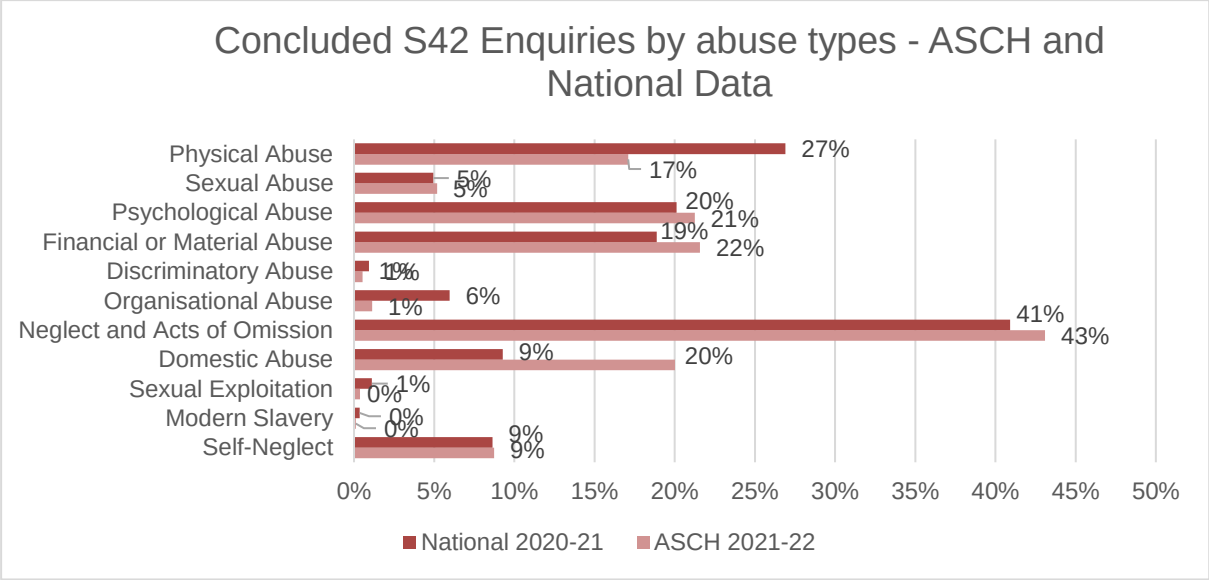




Types of abuse

Concluded Section 42 enquiries by type of abuse

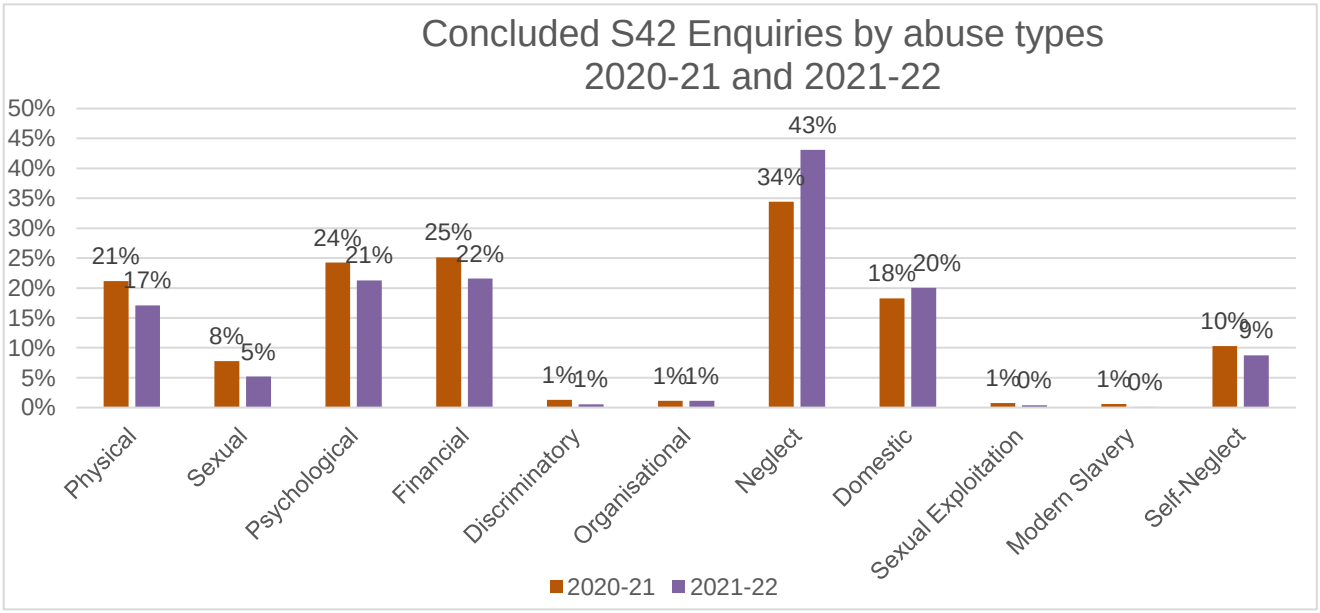
The following table below shows a breakdown of concluded S42 enquiries in the period 1st April 2021 – 31st March 2022, by type of abuse, including a comparison with the national data in the NHS Digital SAC report for 2020-21.



Source: NHS Digital: Safeguarding Adults Collection (SAC) England 2020-21 and ASCH.

Please note that the comparison with national data is the most recently available data which covers the 2020-21 period. National data for 2021-22 will be published later this year following the SAC submission in June 22.

This data represents a percentage and not a count; the figure is affected by the prevalence of other abuse types; an increase in the percentage does not necessarily mean an increase in occurrence.



- In 2021-22, 43.3% of all S42 enquiries undertaken included neglect. This is 8.9% higher than the previous year.

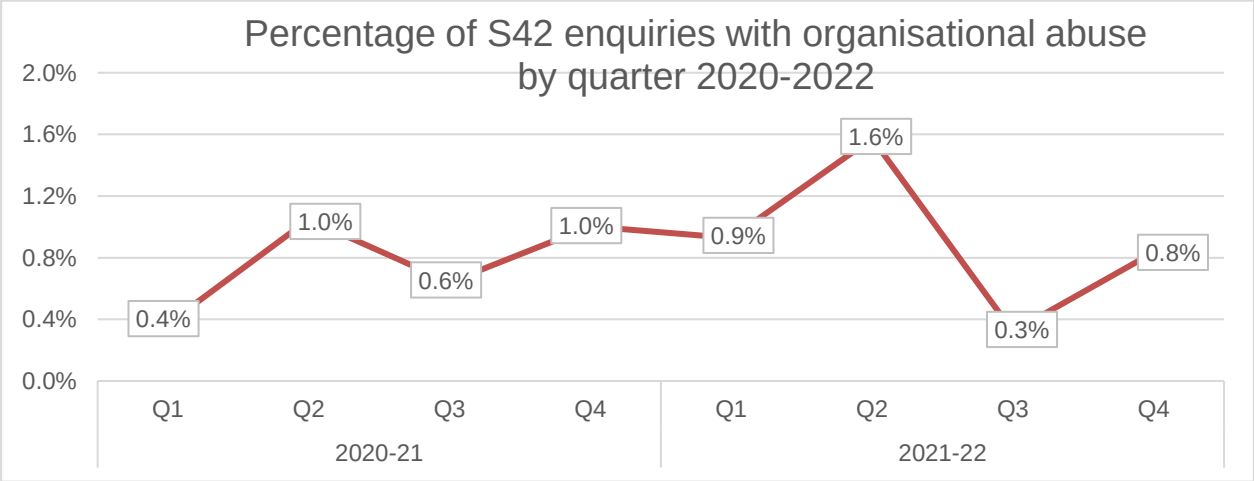
- Financial Abuse is still the second most common form of abuse reported; however, this has decreased slightly from 2020-21 (25% to 22%). Psychological Abuse is the second most common form reported but this has decreased from 24% to 21%.

- Domestic Abuse has increased from 18% in 2020-21 to 20% in 2021-22 and is significantly higher than the national average of 9%.
- There is a decrease of 4% of Physical Abuse type which is lower than the 2021-21 national average of 27%.

The total types of abuse will exceed the total completed enquiries as some enquiries involve multiple types of abuse. Percentages are rounded to the nearest whole number. The proportion of total enquiries relating to Organisational Abuse is an issue that has been highlighted in previous reports and it was agreed that the Performance Quality Assurance (PQA) subgroup would keep this under review.

The chart below shows the variation in the percentage of Organisational Abuse enquiries over the last two years. The proportion of enquiries locally relating to Organisational Abuse is again relatively low in comparison with national data, which is 6%. The data for the percentage of total S42 enquiries classified as Organisational Abuse varies significantly across different local authorities and an average does not indicate a normal rate that can be set as a target rate.

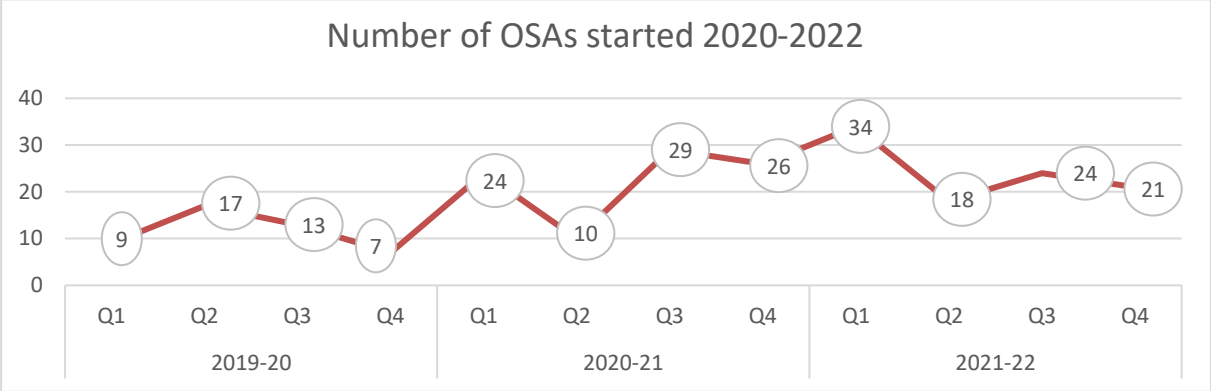
Please note that the table below depicts the number of S42 enquiries that relate to Organisational Abuse which is a different data set to the number of organisations that are subject to an Organisational Safeguarding Adults (OSA) enquiry**.**



The ASCH local reporting system has been updated to improve the mechanism to cross reference records to identify if an organisation involved in one safeguarding enquiry are, or have been, involved in other safeguarding enquiries relating to different adults and/or teams. This should increase identification, or instances, when there should be consideration of an OSA.

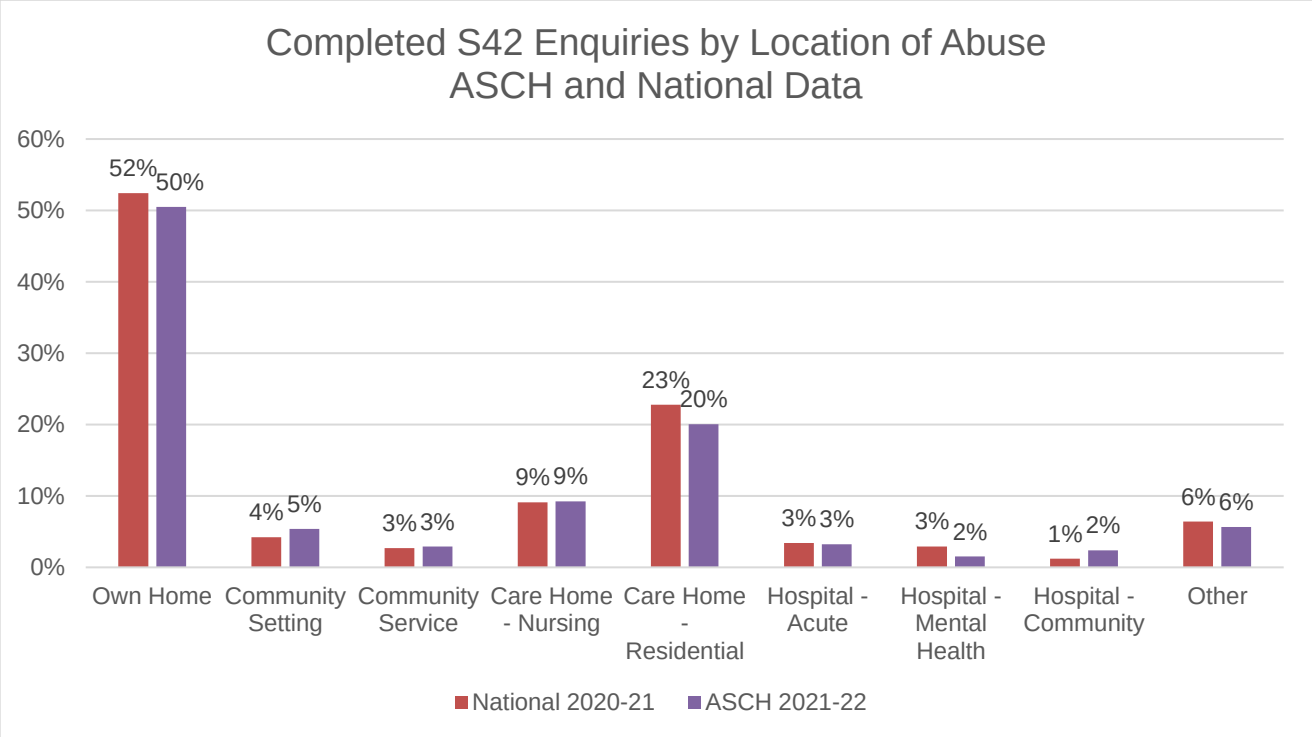
The table below shows the number of OSAs by quarter as a count. This shows that there has been a significant increase in the number of OSAs following the COVID outbreak which has begun to reduce slightly in the later quarters of 2021-22. While an increase in the number of OSAs could indicate that organisational issues are

being better identified, a reduction could mean effective and preventative market support.



Locations of abuse

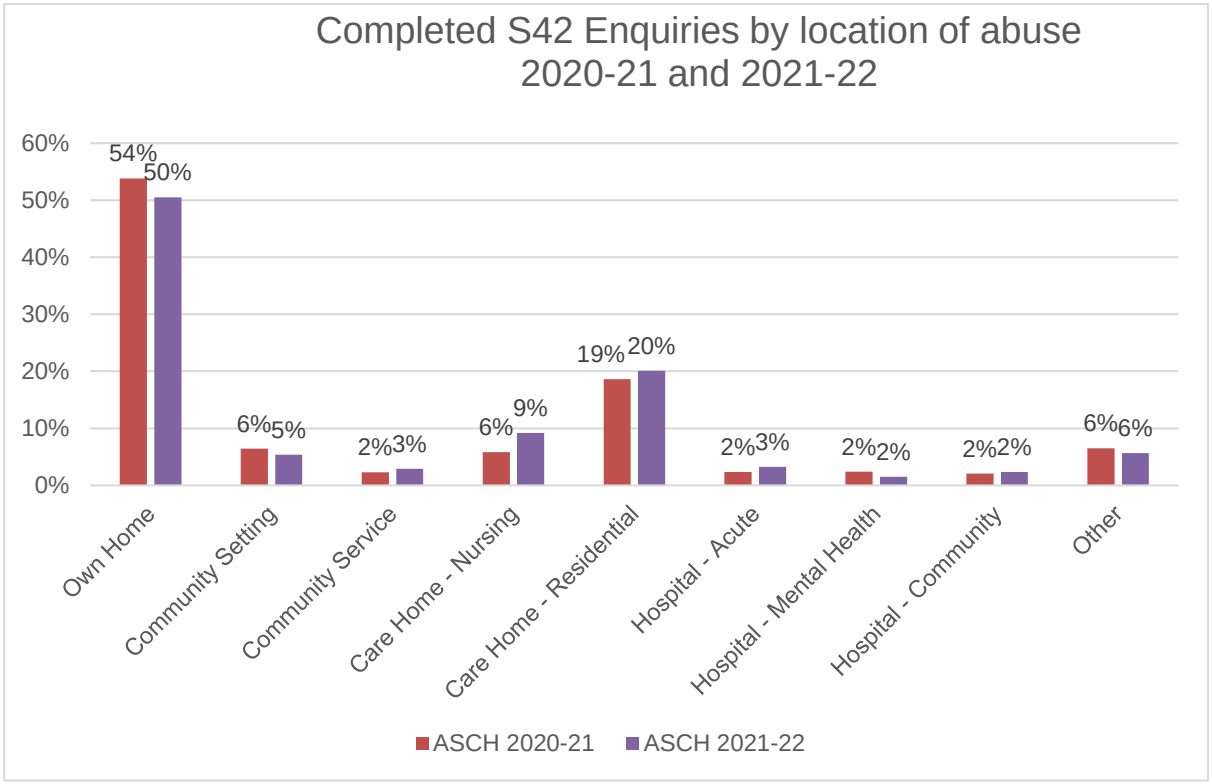
Concluded Section 42 enquiries by location of abuse / risk



The table above shows the percentages of completed S42 enquiries by Location of Abuse of Risk for 2021-22 with comparison to the national data for 2020-21.

- Locally, as in previous years, the most common reported location of abuse is in the adult at risk's own home, this year reported as 50% is a decrease of 2% from the previous year.
- The second most common location continues to be Care Homes. This has increase by 4% for this financial year. the figure was **29%** (including both residential and nursing).

This data suggests higher levels of identification of abuse as visiting was re-instated in care homes. Nursing care homes have increased BY 3% whilst Residential Care Homes have seen a slight decrease of 4% less.

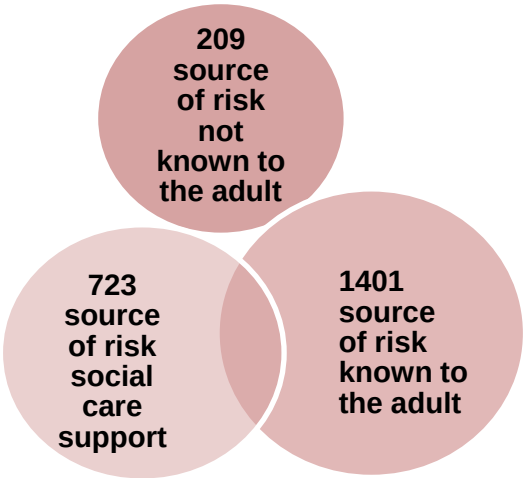


Source of risk

Concluded enquiries by source of risk

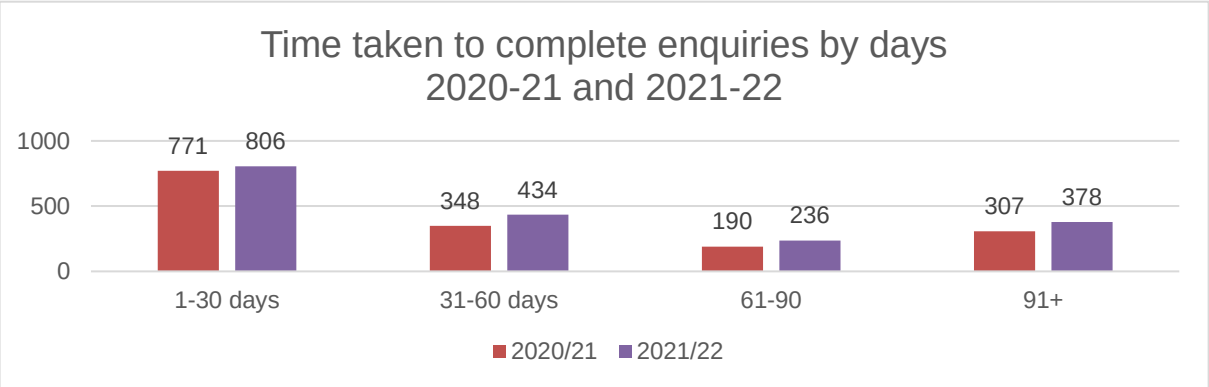
60% of the 2333 enquiries completed in 2021-22 the source of risk was known to the adult which is a 3% decrease from the previous year. In 61% of these cases the source of the risk was either the adult's partner or another family member. 9% of cases the source of risk was not known to the adult which remains the same as the previous year.31% of cases the source of risk was social care staff, an increase from 27% in the previous year.

This change is likely to have been influenced by the resuming in both face-to-face visits by professionals to adults with care and support needs and by professionals more broadly to social care settings and fits in with the decrease in 2021-22, compared to 2020-21, in S42 Enquiries where reported location of abuse is in the adult at risk's own home.



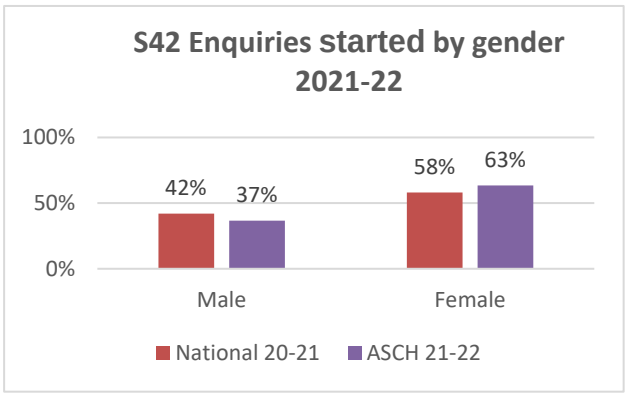
Adult Social Care Timescales and Demographics

Time taken to complete enquiries.



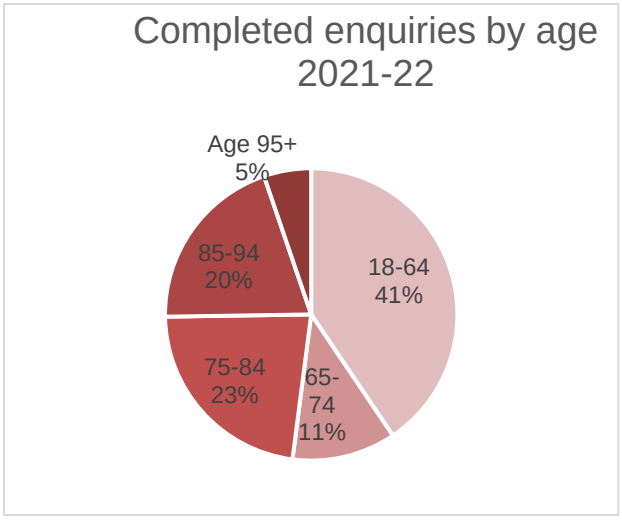
The chart shows the time taken (including weekends) to complete Section 42 enquiries in East Sussex in the periods 2020-21 & 2021-22. 20% of Section 42 enquiries took longer than 91 days to complete in 2021-22 which is a slight increase from 19% in 2020-21.

Safeguarding enquiries by gender



This chart shows the breakdown of completed S42 enquiries in East Sussex for 2021-22 by gender compared to the 2019-20 national data. The proportion of safeguarding enquiries relating to female adults continues to be a little higher in comparison with the national data, and lower for males.

Safeguarding enquiries by age

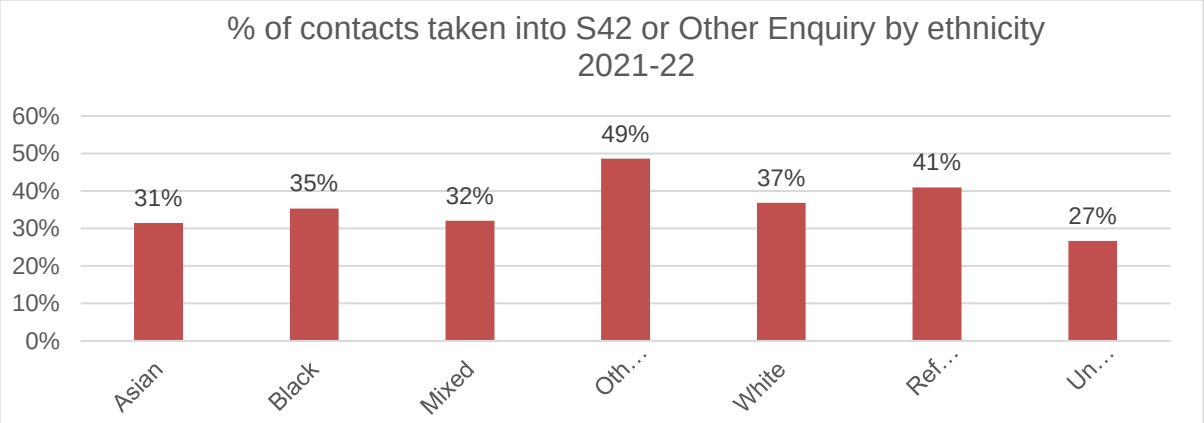


This chart shows the distribution of completed enquiries by age group for 2021-22. In East Sussex 41% of all safeguarding enquiries started involved adults over 65; this data is comparable with the national picture and the previous financial year. S42 enquiries are more likely to involve older people

Safeguarding enquiries by ethnicity.

- As with the previous annual data set report, for 2021-22, adults of white origin continue to be the largest group involved in S42 enquiries, accounting for 87.7% of individuals, which is consistent with East Sussex population data and in line with the previous year.
- The second largest recording (8.7%) is that of 'Unknown' ethnicity which represents 202 cases recorded as having no ethnicity.

Contacts into S42 or Other Enquiry:



The chart above indicates that contacts relating to people who are recorded as of an Other Ethnic Group (49%) have the highest conversion rate to S42 or Other Enquiry which is the same as 2020-21. This could indicate higher quality safeguarding concerns raised or that concerns are only raised when a situation, is more severe than on average for people with a different ethnicity.

The two ethnic categories with the lowest conversion rate are Mixed and where ethnicity is not known. It is difficult to extract a reason for this with the data available, but it could be where there the adult is not so well known, and information provided in the concern raised tended to be less detailed.

	2020/21			2021/22		
	Contacts received	**S42/Other Enquiry started**	**%**	**Contacts received**	**S42/Other Enquiry started**	**%**
Asian	19	42	45%	17	54	31%
Black	15	36	42%	12	34	35%
Mixed	25	68	37%	17	53	32%
Other Ethnic Group	11	19	58%	17	35	49%
White	1754	4797	37%	2064	5603	37%
Refused	12	42	29%	18	44	41%
Undeclared/not known	166	677	25%	208	779	27%

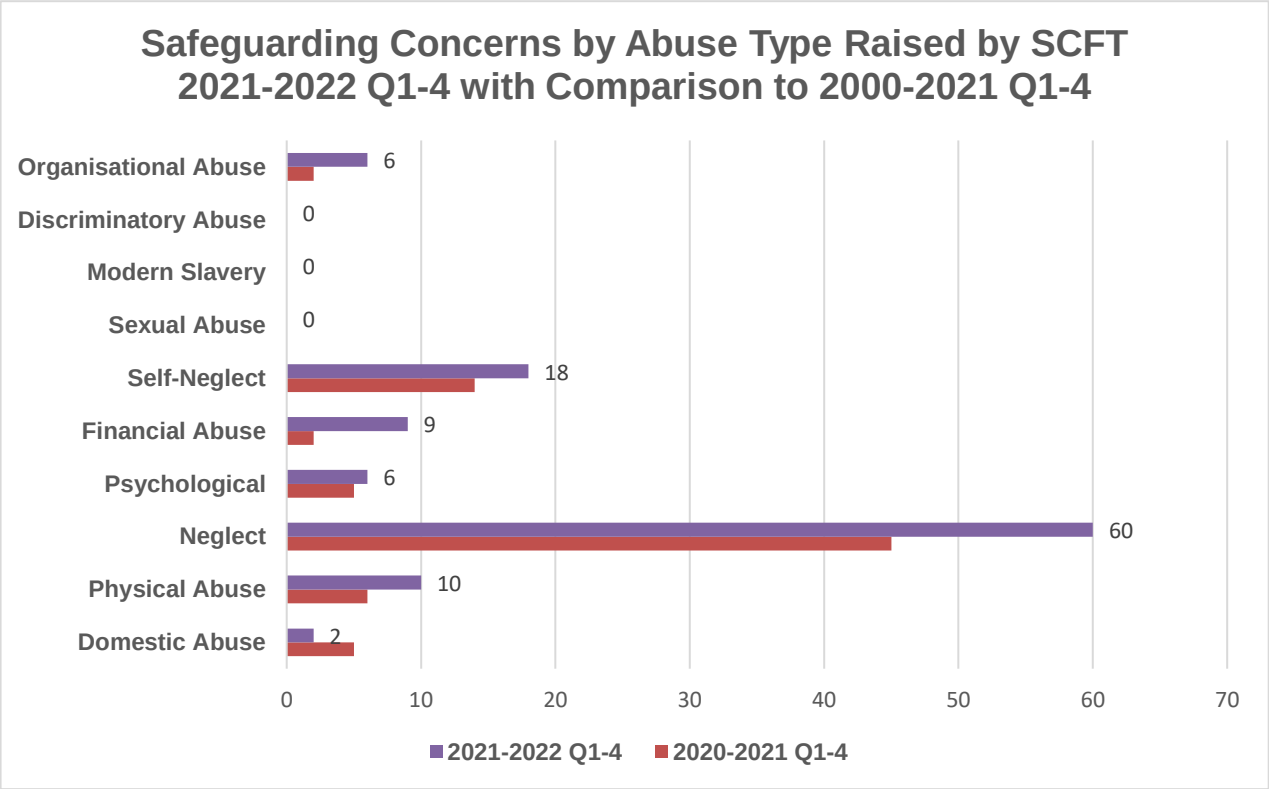
Sussex Community NHS Foundation Trust (SCFT)

The table below shows the number of Safeguarding Concerns by Abuse Type Raised by SCFT during 2021-2022 with a comparison to the previous year. In total there was a 40% increase in the total number of Safeguarding Concerns raised by SCFT this year in comparison to last year.

- The table shows a 25% increase in Neglect concerns raised in 2021-2022. This key theme of neglect/acts of omission is as expected given the wide range of health and social care delivery that can be captured with the Neglect domain. Qualitative SCFT advice line data indicates that this category of abuse captures discussions on issues that included wound care, pressure area care, and visiting regimes, and it is of note that the concerns raised may be in relation to SCFT care delivery, care delivery from another health or social care provider, or unpaid carers (including family and friends).

- The table also shows an increase in Organisational Abuse by 200% and Financial Abuse increased by 350%.

- The data shows us that Physical Abuse has increased from last year by 66.6% and Domestic Abuse has a decrease in concerns raised by 60%.



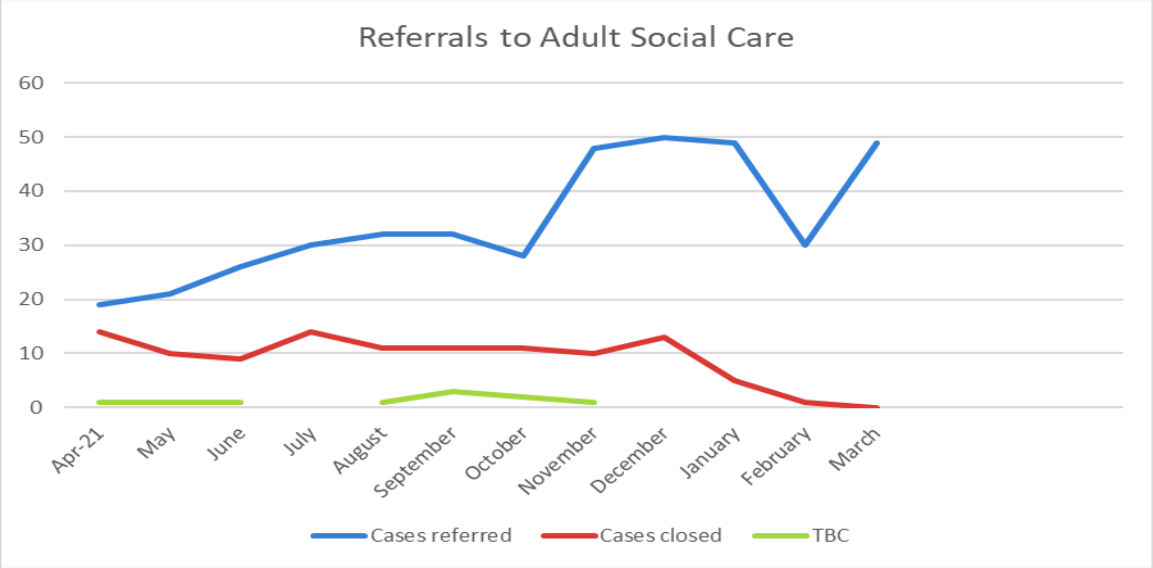
The data relates to the domains captured within within the safeguarding concerns raised, and as a safeguarding concern may capture more than one domain the total amount of adult safeguarding concerns may be lower.

Given the fluidity of numbers of adult concerns raised at any given time, it is not possible to provide a baseline of adult safeguarding concerns that may be raised at any given time. The reduction in face-to-face visits completed during the COVID-19 pandemic, and government led restrictions, is likely to been a contributing factor for a potential reduction in safeguarding concerns raised to Local Authority, especially for those types of abuse which are more easily identifiable through a face-to-face visit.

East Sussex Healthcare NHS Trust (ESHT)

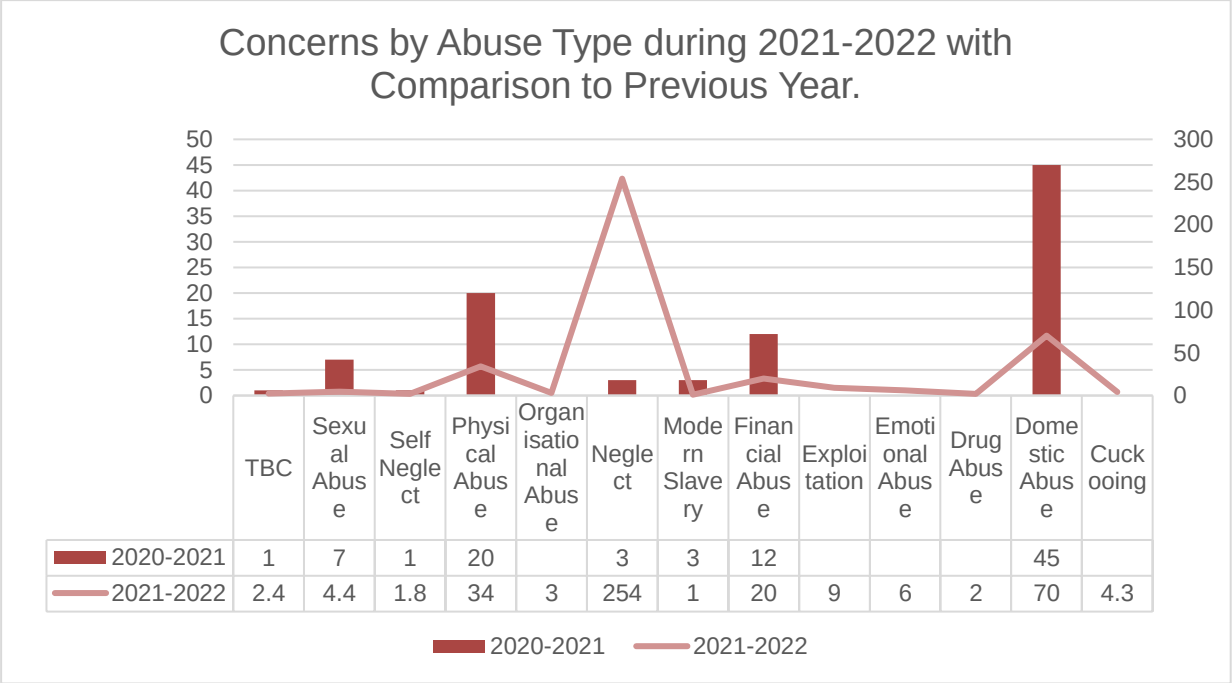
- Raised 365 safeguarding concerns in 2021-2022. This is an increase of 47.1% on referrals last year.
- ESHT staff raise concerns with ESCC ASCH directly and are also encouraged to discuss concerns with the ESHT safeguarding team if they have any queries or require support.

The table below shows Referrals to Adult Social Care during 2021-2022 Q1-4.



- Throughout 2021-2022 the ESHT Safeguarding team have facilitated a 'Think Family' programme of safeguarding training as a combined e-learning and virtual offer, this is mandatory for trained staff Band 5 and over.
- ESHT Safeguarding team have noted a gap in ESHT staff's knowledge of the process of raising a concern to the Local Authority and have produced a Webinar and flow chart resources on the referral process, we are awaiting IT support to finalise this and enable it to be available for all ESHT staff.

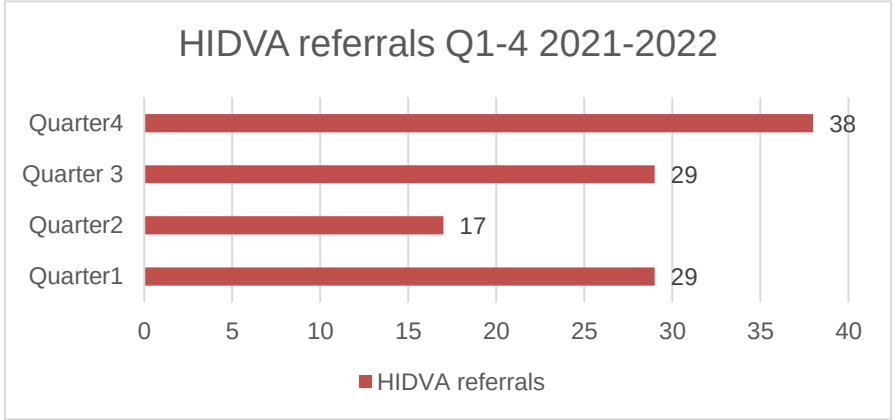
The table below shows the category of concerns raised by ESHT by Abuse Type during 2021-2022 with a comparison line to that of the previous year 2000-202.



- Neglect remains the most commonly reported abuse type, followed by Domestic Abuse and Self-Neglect. Complex cases are also reported which cover more than one type of abuse.

- The Multi Agency Risk Management (MARM) protocol and Threshold tools have been widely disseminated within the trust to inform colleagues and support work going forward. Concerns regarding Domestic Abuse may be reported to the Health Independent Domestic Violence Advocate (HIDVA) with possible need for a safeguarding referral to ASCH required alongside HIDVA input. A rapid assessment tool has been developed and uploaded to some of the trust recording systems to support staff to routinely enquire about Domestic Abuse

The table below shows the number of referrals made to the Health Independent Domestic Violence Advocate (HIDVA). The Safeguarding team have worked alongside the HIDVA to train a group of staff from all areas of the trust to be Domestic Abuse Champions. ESHT safeguarding continue to work on a robust database to accurately capture the picture of safeguarding within the trust.



Sussex Partnership NHS Foundation Trust (SPFT)

The level of safeguarding activity across the Sussex Partnership remains relatively constant although there has been an increase as pandemic lockdowns have ended. The likely reason for this increase is greater hospital ward activity. During the pandemic fewer people were admitted to hospital which meant that the potential for safeguarding situations was also less.

- Hospital admission levels have now increased and with this has come an increase in other work associated with busier wards and more people in contained environments. Incidents of patient-on-patient altercations have increased, reflecting this change in ward activity levels. During 2021 / 2022 there were at any one time between 4 to 8 open section 42 enquiries linked to the Sussex Partnership NHS Foundation Trust and East Sussex County Council.

- Like most NHS organisations, the Sussex Partnership Trust does not have the level of nursing staff with which it would like to operate. This has triggered some safeguarding concerns, a significant one being an organisational abuse enquiry at an inpatient unit in East Sussex. This safeguarding enquiry has closed but highlighted the issue of staffing level challenges and their impact on service delivery. The Trust mitigates the risks associated of operating below optimal staffing levels and acknowledges that it remains extremely challenging to recruit the required mix of professional staff to operate as it would wish.

- Recruitment challenges and increasing bed occupancy levels is also impacting on the ability to admit patients. This has led to safeguarding concerns being raised by East Sussex County Council when admission delays are considered to have placed patients at risk of harm, especially in relation to assessments under Section 136 of the Mental Health Act that led to psychiatric hospital admission. The issue is being discussed by both organisations and again reflects the pressures on the health and social care sector as a whole. For example, pressures on hospital admission are also affected by delays in discharge due to challenges securing other nursing and social care support in the community.

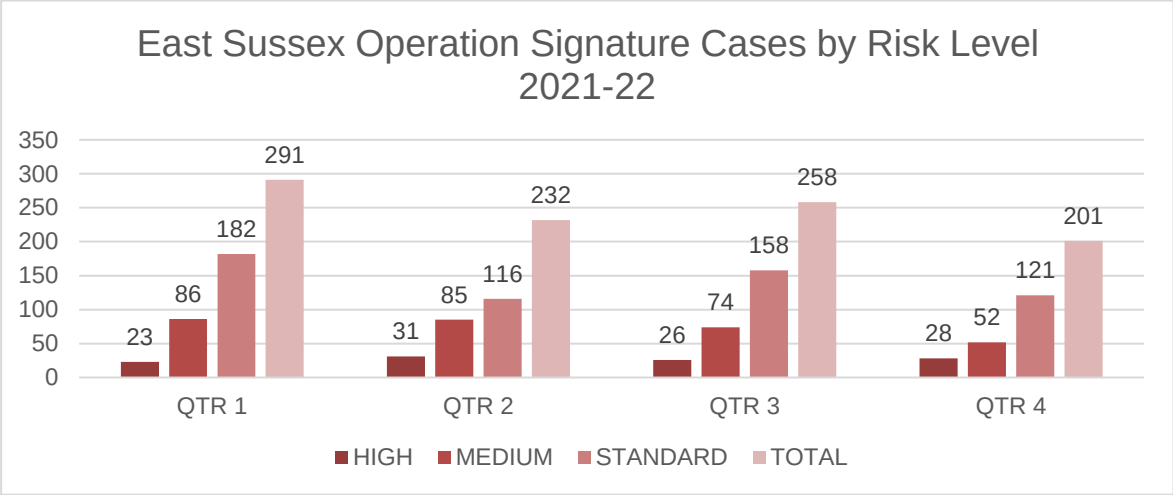
- During the pandemic, the safeguarding team within the Trust expanded and is now fully recruited. This is allowing better support to its frontline services to understand safeguarding, comply with Care Act requirements and protect adults at risk. The Trust's safeguarding service now also includes a Prevent Practitioner that attends the East Sussex Channel Panel and supports Prevent work across the Trust. The Director of Safeguarding represents the Trust on the East Sussex Safeguarding Adults Board and is the Vice Chair of the Board's Safeguarding Adults Review subgroup.

Sussex Police

- Operation Signature Fraud reporting continues to increase year on year, with recent data indication that fraud now accounts for 39% of all reported crime with much of it still going unreported.

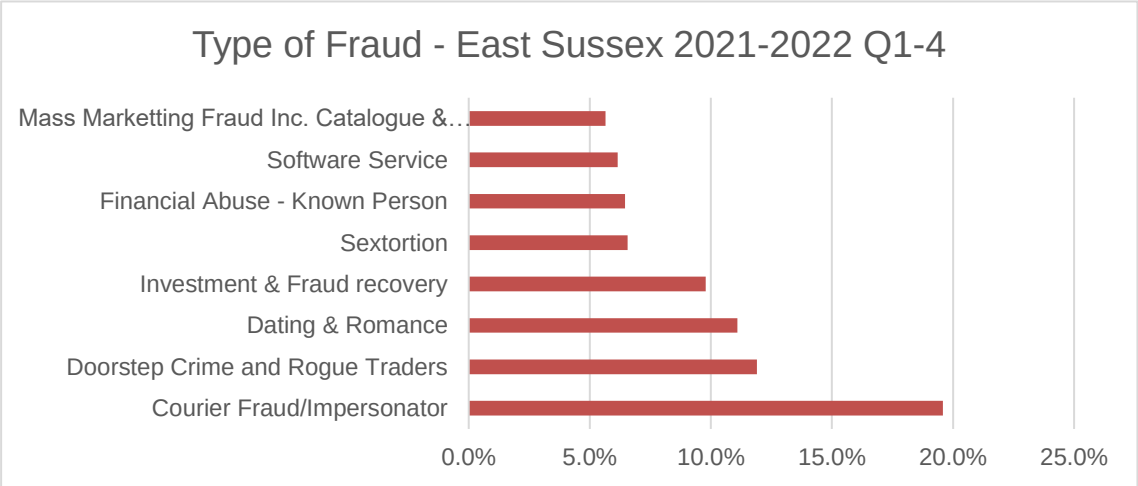
- Last year a disproportionate rise in Romance Fraud, false investment opportunities and doorstep criminals was attributed to the COVID-19 Pandemic and these trends have continued.

- Courier fraud has since emerged as one of the most prevalent fraud types affecting the vulnerable in Sussex.



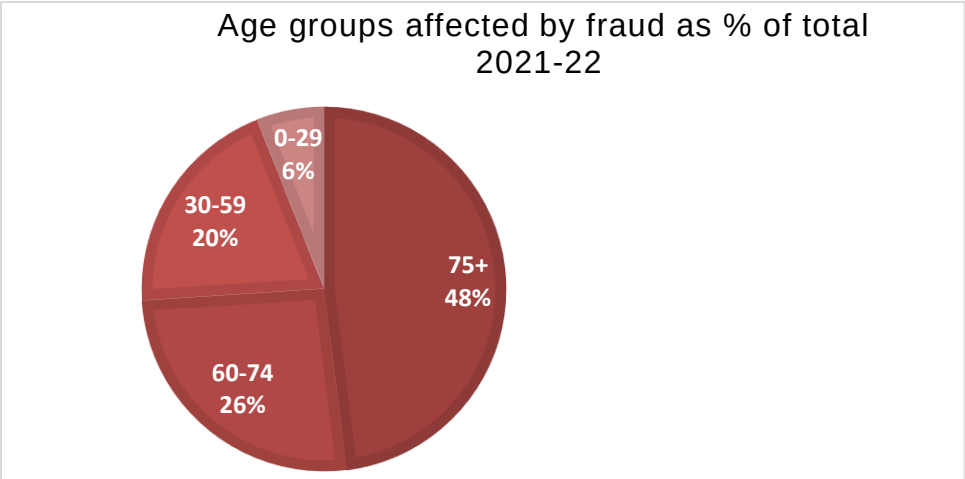
- Two specialist Operation Signature case workers have supported 1,165 victims of fraud in Sussex during 2021-2022. Whilst some support has been provided by over the telephone, face to face visits have now resumed where possible. The total loss to vulnerable victims of fraud in 2021-2022 is £23.05 million, with the average loss where recorded being £15,000 per victim which is an increase on the previous year.

The table below separates the type of fraud taking place in East Sussex during 2021-2022.



- Over the past 12 months Courier fraud, doorstep crime, dating and romance and investment fraud are the top four most common types of fraud affecting the vulnerable in East Sussex with people most commonly being contacted initially by telephone or in person on the doorstep.

The table below shows the total amount of people impacted by fraud separated into age group by percentage of total.



- In East Sussex 74% of cases were people over the age of 60.

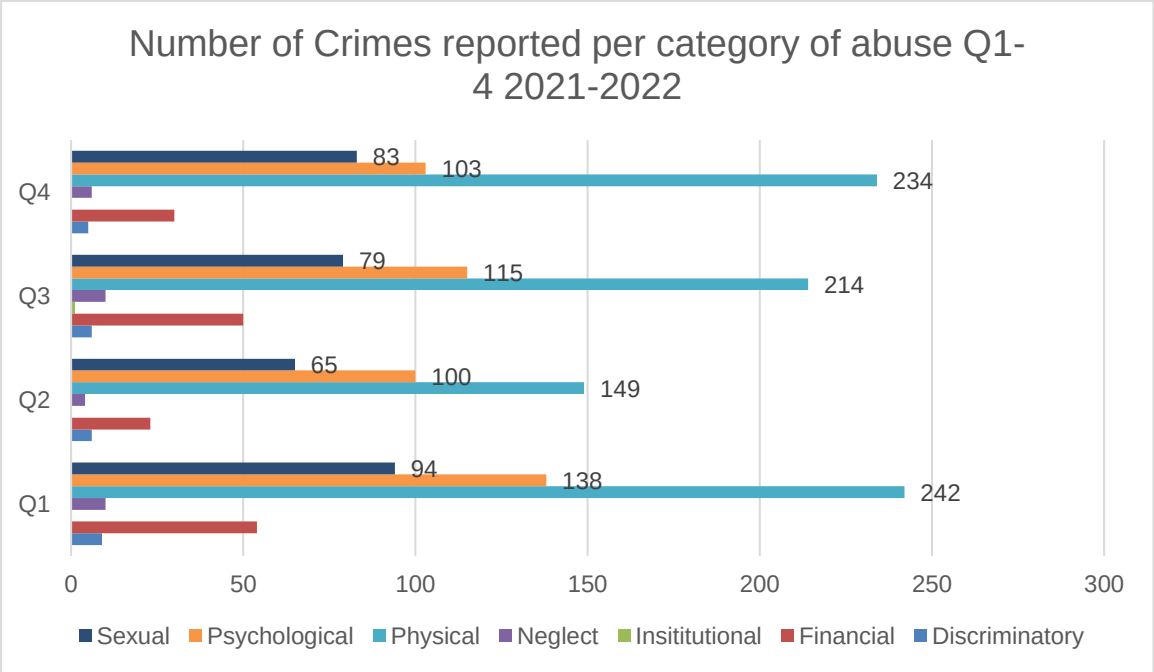
- The number of victims over 75 years old has dropped by 7% compared to the previous year, and the number of victims in the below 60 categories increased by 6%. This can in part be attributed to the rise in Romance fraud which affects a broader age range, due to the vulnerability of the victims and the impact of the crime.

- There has continued to be a wide range of scams exploiting the COVID-19 situation in 2021 – 22. The loneliness and isolation of victims, the financial worry, confusion and fear people have felt over the past year has been exploited. Vulnerable people have been targeted with fraudulent emails and text messages relating to NHS test and trace, with vaccine and testing related frauds prevalent at certain periods. Fraudsters targeted victims by impersonating the government to offer fake Covid-19 grants, setting up fake NHS websites to steal card details, and posing as delivery companies to target online shoppers stuck at home during national lockdowns and periods of self-isolation.

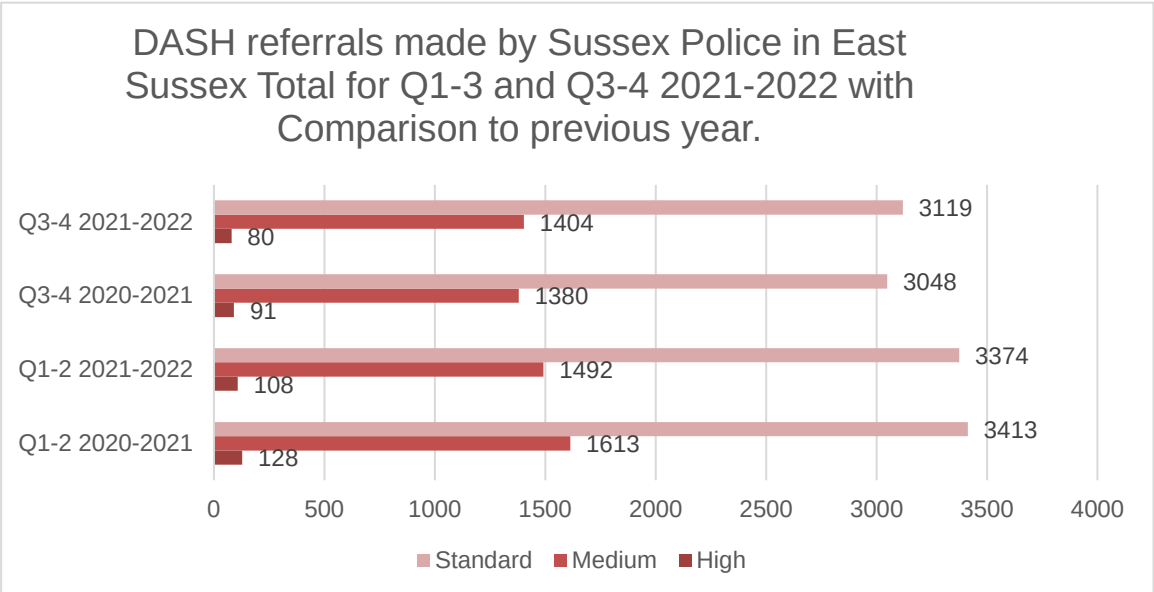
Crimes by Category of Abuse

The following table shows the number of reported crimes per category of abuse, but each quarter for the year 2021-2022. The data relates to recorded crimes, act which may result in harm or loss which is defined by parliamentary act as illegal.

Sussex Police receive information about incidents not all of which will be recordable crimes, All incidents are reviewed for possible crime and intelligence and those that meet the National Crime Recording Standard are recorded as crimes too.

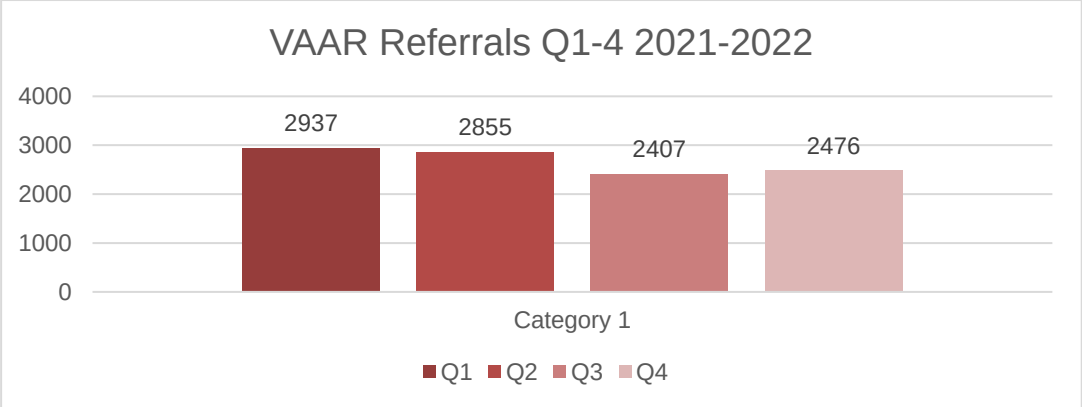


The table below shows the amount of Domestic Abuse, Stalking and Harassment (DASH) referrals-Incidents of Domestic Abuse are subject to a risk assessment using a DASH checklist. An officer, with the victim, assesses the level of risk using this checklist and will take initial steps to manage the risk identified.



The data shows that there are a total of 9577 DASH referrals made during 2021-2022 with 67% of these being classed as Standard Risk. This is similar to last year with a total of 9,673 referrals when there was 66.8% being classed as Standard Risk.

Vulnerable Adult at Risk (VAAR) referrals are made by Sussex Police to the Local Authority when safeguarding issues or concerns are identified. The table below shows the number of VAAR referrals made to East Sussex in 2021-2022.



The data shows us that there has been a total of 47 less referrals for 2021-2022 with 10,675 in comparison to 10,722 last year. Referrals are assessed and allocated as considered appropriate with East Sussex Adult Social Care. Not all VAAR referrals will involve recorded crimes.

NHS East Sussex Clinical Commissioning Group (CCG)

Sussex CCGs (including both NHS Brighton and Hove Clinical Commissioning Group and NHS East Sussex Clinical Commissioning Group) have undertaken a range of actions in relation to adult safeguarding during 2021/22.

- This has included the ongoing development of an adult safeguarding data dashboard and a statutory review tracker that enables enhanced oversight of health action plans in relation to Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHR's). This extends beyond the CCG itself and incorporates health providers in progressing identified actions from reviews undertaken. The available data shows a high number of open statutory case reviews across the system that include health actions and responsibilities, with 24 current reviews across SARs and DHRs in total.

- Across East Sussex in particular, there remains a high number of DHRs. Despite delays in reviews being published, assurance can be provided that key learning is continuing to be identified and shared with the health partnership.

- The CCG Safeguarding Team have been running Domestic Abuse half day training sessions for CCG and primary care staff which incorporate the lessons for health identified in the reviews, including awareness of the Homicide

Timeline, MARAC process, coding and flagging of primary care records, health indicators of domestic abuse and the need for routine screening. Each DHR has an overarching action plan and the CCG team maintain overall oversight and responsibility for all health actions

- During 2021/22, the CCGs have committed substantive funding to the MASH health team, which increases the health resource in both Brighton and Hove and East Sussex MASHs. From April 1st, 2022, this service will be provided by the CCG safeguarding team.

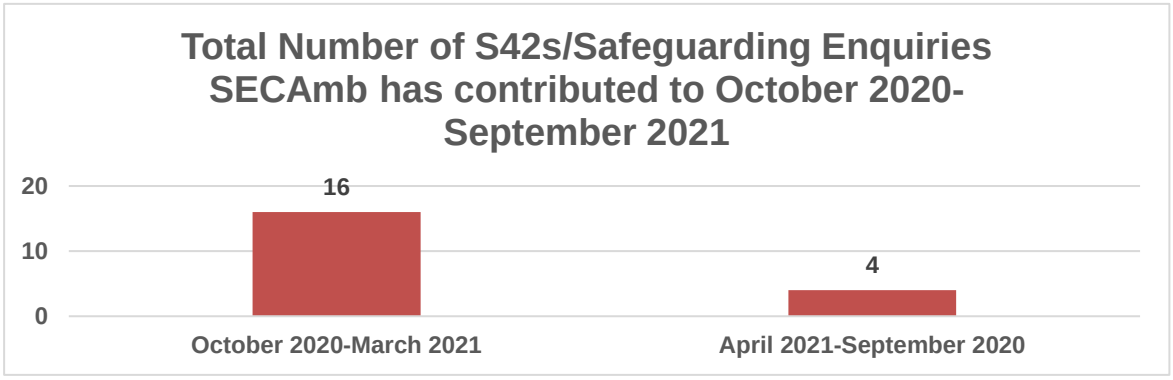
- A key part of this development has been the implementation of a pathway to increase awareness within primary care of both children and adults referred to Multi-Agency Risk Assessment Conferences (MARAC), particularly in relation to situations where domestic abuse is occurring. This supports the 'Think Family' approach to safeguarding that has been adopted by the CCGs and will support risk management and safety planning.

- From a staffing point of view all statutory safeguarding roles have been recruited to within the CCGs. Two further Specialist Safeguarding Nurse roles have been agreed for recruitment in April 2022, to help support partnership working functions of the team as the transition into an Integrated Care Board, under new statutory arrangements effecting all CCGs. These roles will play a crucial part in promoting the team's values of Think Family safeguarding and increased collaboration with provider health organisations in Sussex.

Southeast Coast Ambulance Service (SECamb)

- Data for Q3 and Q4 was not available at time of report issue. The table below shows the number of Safeguarding Enquiries SECamb has contributed to from October 2020-September 2021.

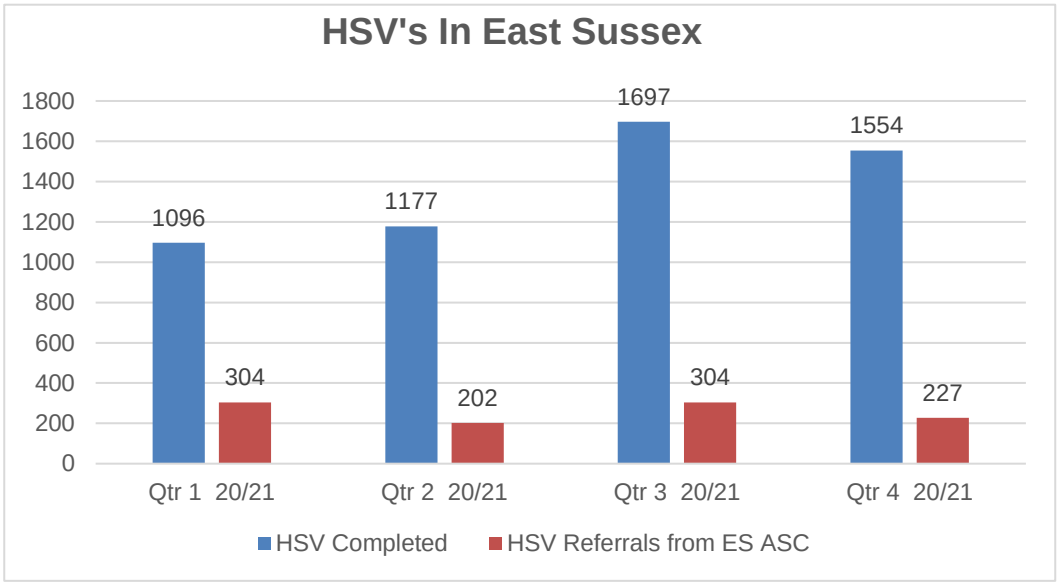
- SECamb are continuing to improve their safeguarding data and the next report issues will be able to contain a more accurate measure of current safeguarding arrangements.



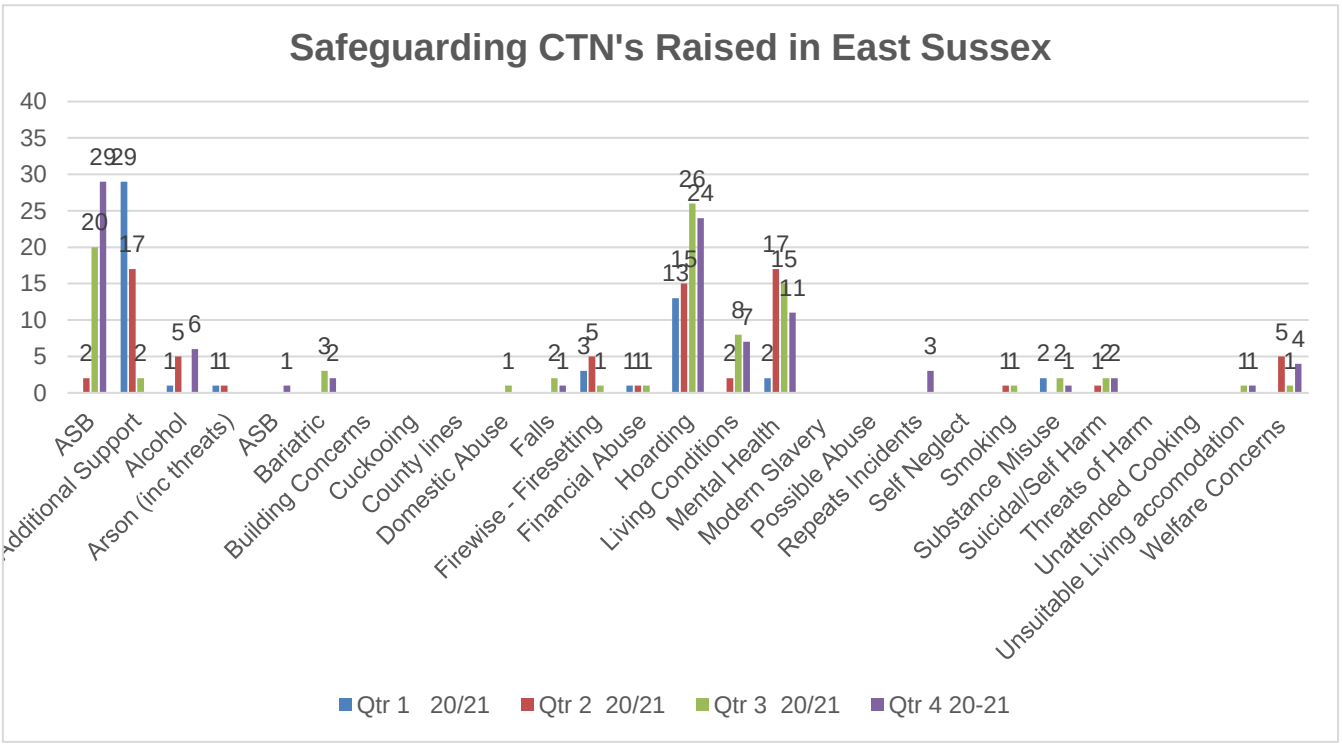
East Sussex Fire and Rescue Service (ESFRS).

The table below shows the number of Home Safety Visits (HSV) conducted by ESFRS in the last 4 Quarters, including the HSV referrals received from East Sussex Adult Social Care (ASC).

Referrals for HSVs from a wide range of sources significantly dropped during the Covid-19 pandemic. As the restrictions eased the number of referrals to ESFRS and completed HSVs increased. Home safety visits are one element of the ESFRS targeted prevention work providing support to the most vulnerable members of the community who may be more at risk of having a fire in their home.



The table below shows ESFRS safeguarding reports and highlights hoarding, mental health, anti-social behaviour and additional support as the key areas.



Raising a safeguarding concern

No one should have to live with abuse or neglect – it is always wrong, whatever the circumstances.

Anybody can raise a safeguarding concern for themselves or another person. Do not assume that someone else is doing something about the situation.

You can report a concern in the following ways:

Phone: 0345 60 80 191 (8am to 8pm 7 days a week, including bank holidays)

Email: Health and Social Care Connect

Online: Via the form on the East Sussex County Council website

Contact the police on 101 or in an emergency 999

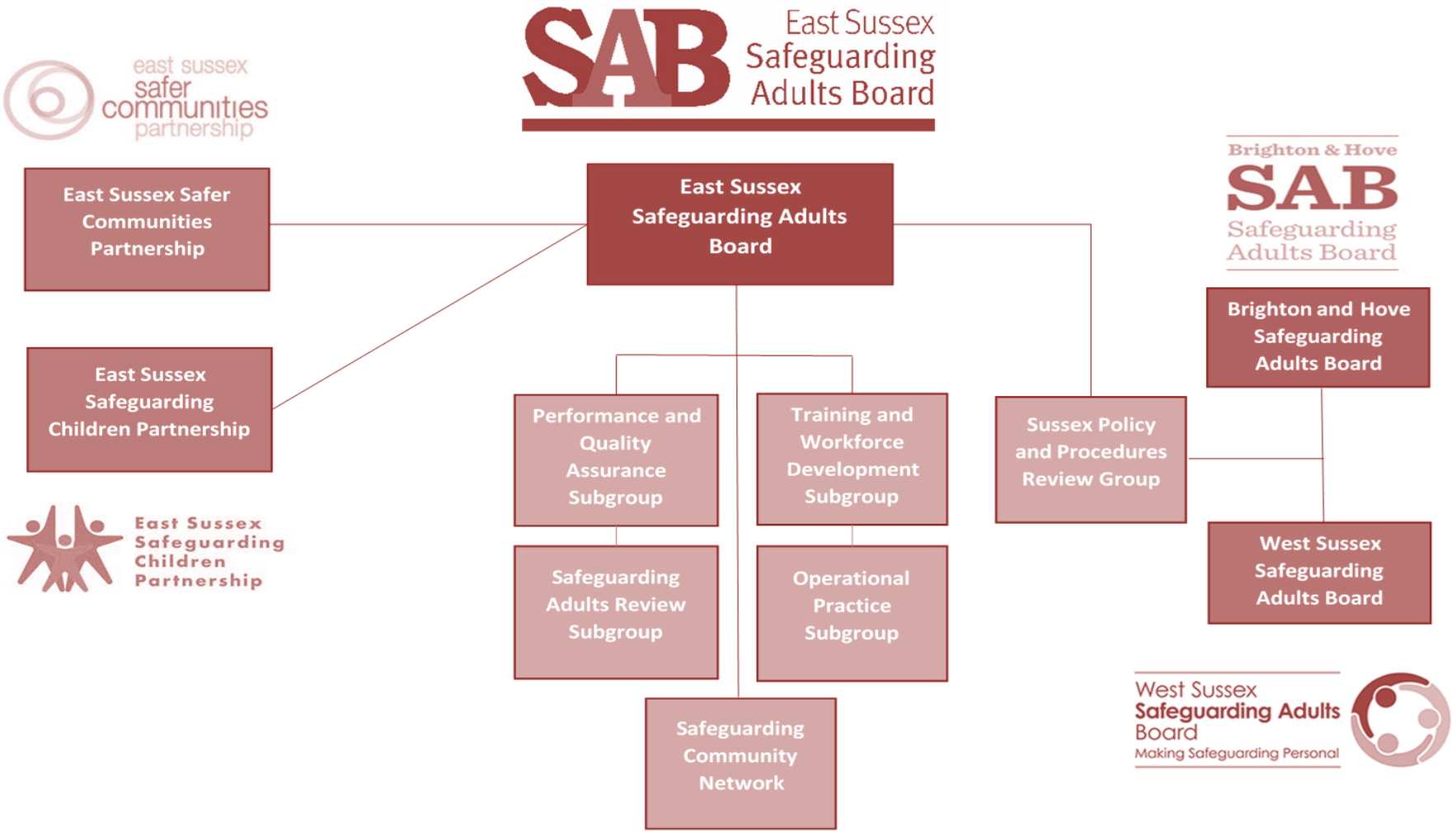
Find out more in our safeguarding leaflet and easy read version safeguarding leaflet.

Appendix 1 – Board membership

Partners of the East Sussex SAB are:

- East Sussex Adult Social Care & Health (ASCH)
- NHS East Sussex Clinical Commissioning Group (CCG)
- Sussex Police
- Care for the Carers
- Care Quality Commission (CQC)
- Change, Grow, Live (CGL)
- District and borough council representation
- East Sussex Fire and Rescue Service (ESFRS)
- East Sussex Healthcare NHS Trust (ESHT)
- East Sussex Safeguarding Children Partnership (ESSCP)
- Healthwatch
- HMP Lewes
- Homecare representatives
- Kent, Surrey, Sussex Community Rehabilitation Company (KSS CRC)
- Lay members
- National Probation Service (NPS)
- NHS England
- Registered Care Association (RCA)
- South East Coast Ambulance Service NHS Foundation Trust (SECamb)
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Trading Standards
- Voluntary and community sector representation

Appendix 2 – Board structure



Report to:	**East Sussex Health and Wellbeing Board**
Date of meeting:	**29 September 2022**
By:	**Director of Adult Social Care and Health**
Title:	**Health and wellbeing inequalities of residents at Kendal Court, Newhaven and homeless people accommodated by Brighton and Hove City Council in temporary accommodation in East Sussex**
Purpose:	**To update the Health and Wellbeing Board on the current situation in respect of homeless people placed in temporary accommodation in the Lewes and Eastbourne areas by Brighton and Hove City Council**

RECOMMENDATIONS:

The Health and Wellbeing Board is recommended to:

1) Note the latest information in respect of Brighton and Hove residents temporarily accommodated in East Sussex

1. Background

1.1 Reports concerning homeless people accommodated by Brighton and Hove City Council (BHCC) in temporary and emergency accommodation at Kendal Court in Newhaven have been presented to the last five meetings of East Sussex Health and Wellbeing Board (HWB).

1.2 The reports highlighted the health and wellbeing risks that individuals with multiple and complex health and social care needs may experience whilst accommodated by BHCC at Kendal Court seemingly without adequate support arrangements, as well as the steps taken by East Sussex County Council (ESCC) and partner agencies to ensure that BHCC minimises and mitigates those risks.

1.3 Despite some ongoing challenges, the last report presented to the HWB on 19 July 2022, included some positive steps taken and an improving situation in respect BHCC residents accommodated at Kendal Court and elsewhere in the County, as follows:

- The number of individuals accommodated by BHCC in East Sussex reducing to 118.
- A reduction in occupancy at Kendal Court from the 55 household maximum to 20.
- A continuation of the pause in new placements at Kendal Court since December 2021.
- Ongoing support to residents at Kendal Court through Welfare Officer drop-in sessions.
- A restatement of BHCC's strategic commitment to continuing the sustained reduction in its use of emergency accommodation.
- Progress towards this strategic aim through commissioning more accommodation within Brighton & Hove, including greater use of council owned emergency accommodation.

2. Supporting Information

2.1 Since the last meeting of the HWB on 19 July 2022, BHCC has confirmed the following:

- The last temporary resident at Kendal Court moving out at the end of July 2022.
- The termination of the contract for accommodation at Kendal Court with effect from 12th September 2022.
- A further reduction in the number of households accommodated by BHCC in East Sussex to 89 on 2nd September, compared to 118 on 27th May 2022.
- A restatement of BHCC's strategic commitment to continuing the sustained reduction in its use of emergency accommodation.

3.0 Conclusion and Reasons for Recommendations

3.1 The most recent communication from BHCC demonstrates an ongoing commitment to improve the quality of service and support to homeless people it places in temporary accommodation (including those it accommodates in East Sussex).

3.2 A trajectory towards meeting this commitment is supported by tangible actions including the termination of the contract for accommodation at Kendal Court, the sustained reduction in the number of people BHCC temporarily accommodates in East Sussex and the investment in additional welfare support for newly commissioned services.

3.3 The above actions currently provide adequate assurance that the situation has sufficiently improved to a point where ongoing monitoring and engagement can be embedded within core business activity and no longer requires the detailed oversight of the HWB.

3.4 As such, The HWB is asked to note the updates contained within this report with no further Board monitoring recommended at this stage.

Mark Stainton
Director of Adult Social Care and Health

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BACKGROUND DOCUMENTS:
None

East Sussex Health and Wellbeing Board Work Programme

Date of Meeting	Report
13 December 2022	East Sussex Health and Social Care Programme - update report
	Joint Strategic Needs and Assets Assessment (JSNAA) Annual Report
	Children's Safeguarding Annual report
	Children and Young Peoples Mental Health and Emotional Wellbeing Local Transformation Plan - October 2022 Refresh
	Draft Sussex Health and Care Assembly Strategy
7 March 2023	East Sussex Health and Social Care Programme - update report
	Building for our Future hospital programme
18 July 2023	East Sussex Health and Social Care Programme - update report
	Healthwatch Annual Report
	Director of Public Health Annual report
	Sussex learning from lives and deaths (LeDeR) Annual report
28 September 2023	East Sussex Health and Social Care Programme - update report
	Safeguarding Adults Board (SAB) Annual Report 2022-23
TBC	NHS Health and Care Act (item from Cabinet agreeing MOU and formal participation in ICB)
TBC	Workshop meeting - to look at and agree milestones and Key Performance Indicators (KPIs) for monitoring on integrated health and social care partnership

East Sussex Health and Wellbeing Board Work Programme
