

**Certificate of Higher Education Skills for the
Workplace
Health & Social Care.**

LCHS4003 – Introduction to Health and Social Care

Task 1: Guided Scenario Response

**Strengthening Domiciliary Care Services in Coventry:
A Care Act 2014-Based Response**

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To: Councilor Linda Bigham, Cabinet Member for Adult Services. Coventry City Council

1. Introduction

This report considers the need to strengthen domiciliary care, also referred to as home support, for adults with care and support needs in Coventry. Domiciliary care enables individuals to receive personal and practical assistance in their own homes rather than moving unnecessarily into residential settings. When appropriately designed, it can support independence, dignity, choice and participation in community life. This is particularly important as Coventry experiences an ageing population and increasing complexity of care needs. Coventry City Council's current commissioning strategy places prevention, independence, community-based alternatives and outcome-focused home support at the centre of its approach to adult social care (Coventry City Council, 2025a).

2. Evidence of Need and Impact on the Community

The scale of adult social care demand demonstrates why accessible community-based support is important. Nationally, 2.02 million requests for support were made by people new to social care during 2024/25. Of these, 1.30 million were from people aged 65 and over and 665,000 from adults aged 18–64 (DHSC, 2025). These figures demonstrate substantial demand, although the Department of Health and Social Care cautions that the data should not be directly compared with earlier datasets because of changes in methodology.

The issue is particularly relevant to Coventry. The Council reports that the number of residents aged 50–64 increased by more than 18% between the 2011 and 2021 censuses and anticipates increasing demand for home care and other social care services as people live longer with disabilities and more complex conditions (Coventry City Council, 2025a).

Local evidence also shows that home support is already a significant component of Coventry's adult social care system. Approximately 40% of people receiving long-term support received a home-support package in March 2024. Coventry identifies concerns relating to the consistency of care staff, timing of visits, language barriers and whether staff consistently use reablement approaches that promote independence (Coventry City Council, 2024).

These issues can affect more than service satisfaction. Delayed or inconsistent visits may interfere with medication routines, nutrition, personal care and daily activities, while frequent changes of care worker can make it more difficult to develop trusting relationships. For unpaid carers, insufficient or unreliable formal support may increase the practical and emotional demands of caring. Consequently, the challenge for Coventry is not simply to increase the number of care

packages but to ensure that support is reliable, person-centred and capable of producing meaningful outcomes.

3. Applying the Care Act 2014

The Care Act 2014 provides a clear statutory framework for responding to these challenges. Section 1 places individual wellbeing at the centre of local authority responsibilities. Wellbeing includes personal dignity, physical and mental health, protection from abuse and neglect, control over day-to-day life, participation in community life and maintaining relationships (Care Act 2014, s.1). Therefore, domiciliary care should not be reduced to completing prescribed tasks. Its purpose should be to help people achieve outcomes that matter to them and maintain as much independence and control as possible.

Section 2 establishes the local authority's responsibility to take steps to prevent, reduce or delay the development of care and support needs (Care Act 2014, s.2). This provides a strong legal foundation for investment in reablement and preventative home support. Coventry's evidence demonstrates the potential value of this approach: in 2023/24, 76.7% of people receiving short-term home support subsequently required no or reduced long-term services (Coventry City Council, 2025a). This suggests that effective short-term intervention can support independence while potentially reducing longer-term dependency.

Section 3 is also relevant because it requires local authorities to promote integration between care and support and health services where this would promote wellbeing, prevent or delay needs, or improve care quality (Care Act 2014, s.3). Home support should therefore connect effectively with GPs, community health services, hospitals, occupational therapists and voluntary-sector organisations. Better information sharing and coordinated planning can help identify deterioration earlier and reduce avoidable crises.

Finally, section 5 requires local authorities to promote an efficient and effective care market, including a variety of high-quality services and sufficient information for people to make informed choices. The legislation requires consideration of current and future demand, market sustainability, continuous improvement, innovation and a workforce with the skills and working conditions necessary to provide high-quality services (Care Act 2014, s.5).

4. Recommended Response

First, Coventry should strengthen outcome-focused reablement and home support. Care plans should identify individual goals, such as preparing meals independently, managing personal routines or safely accessing the community, rather than measuring performance primarily through completed tasks. This directly reflects Coventry's existing commitment to outcome-based home support.

Second, workforce development and continuity should be strengthened. Providers should prioritise training in person-centred care, communication, cultural awareness, safeguarding and reablement. Where possible, service users should receive support from a consistent group of care workers. This would respond directly to concerns identified in Coventry's Market Position Statement concerning staff consistency, communication and independence-focused practice.

Third, quality monitoring should become more outcome-focused. Coventry should monitor missed and delayed visits, continuity of care, safeguarding concerns, complaints, service-user and carer feedback, hospital admissions and changes in people's levels of independence. This is consistent with Coventry's commissioning framework, which identifies performance measures, quality assurance and monitoring of service-user outcomes and experiences as important elements of commissioning.

Fourth, partnership working should be strengthened. Adult Social Care, NHS services, domiciliary-care providers, housing services and voluntary/community organisations should share appropriate information and coordinate interventions. Coventry already identifies partnership working and community-based delivery as important elements of its commissioning model.

Finally, people who use services and unpaid carers should be involved in commissioning and evaluation. Co-production can help the Council understand whether services are actually improving people's lives rather than simply meeting contractual outputs. This is particularly relevant in Coventry's diverse population, where culturally and linguistically appropriate support may be necessary. The Council itself identifies co-production, cultural sensitivity and user involvement as important commissioning principles.

5. Conclusion

Domiciliary care is an important mechanism through which Coventry can support adults to remain safe, independent and connected to their communities. The evidence indicates that Coventry has an established home-support market, but continuing challenges concerning workforce consistency, visit reliability, communication and reablement demonstrate the need for further improvement. The Care Act 2014 provides a strong framework through its duties concerning wellbeing, prevention, integration and market shaping.

Coventry should therefore focus not simply on expanding the volume of home support, but on improving its quality, reliability and outcomes. Strengthening reablement, workforce capability, integrated working, co-production and outcome-based monitoring would provide a practical response to local needs while supporting the Council's existing strategic direction. Ultimately, successful domiciliary care should be judged by whether adults are able to exercise greater choice and control, maintain independence and achieve outcomes that are meaningful to them.

**LCHS4003 – INTRODUCTION TO HEALTH AND
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TASK 2: 750-WORD ESSAY

**Certificate of Higher Education Skills for the
Workplace (Health & Social Care)**

**Assignment: Written Assignment – Coursework
Portfolio**

**Selected Health Care Service: Community Pharmacy
Services**

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1.0 Introduction

Community pharmacy is an important part of primary healthcare in England, providing accessible medicines and healthcare support within local communities. Historically, pharmacy practice concentrated largely on preparing and supplying medicines; however, its role has progressively developed towards patient-centred clinical care, prevention and medicines optimisation. More recently, initiatives such as Pharmacy First and independent prescribing have further expanded pharmacists' contribution to NHS primary care. This essay examines the historical development of community pharmacy, critically evaluates how the service functions today and considers its significance in improving service users' quality of life.

1.1 Origins and Historical Development

The development of modern British pharmacy can be linked to the establishment of the Pharmaceutical Society of Great Britain in 1841, which contributed to the professionalisation, education and regulation of pharmacists. During the nineteenth and early twentieth centuries, pharmacists supplied medicines while also providing accessible advice within their communities. The creation of the National Health Service (NHS) in 1948 transformed this role because increasing prescription volumes made dispensing an increasingly significant part of community pharmacy practice. However, from the 1980s onwards, policy and professional developments gradually encouraged pharmacists to regain a broader role in health promotion and public health (Anderson, 2007).

This historical transition is important because it demonstrates that community pharmacy has not remained a static medicines-supply service. Instead, its development reflects changing population needs and NHS priorities, particularly the growing emphasis on prevention, self-care and delivering treatment closer to patients' homes.

2.0 Community Pharmacy in Contemporary Healthcare

Today, community pharmacies combine their traditional responsibility for the safe supply of medicines with increasingly clinical functions. Services include dispensing prescriptions, medicines advice, medicines optimisation, contraception and support for common health conditions. A significant development was the introduction of Pharmacy First in England on 31 January 2024, enabling participating pharmacies to manage defined common conditions through clinical pathways (Community Pharmacy England, 2026).

This development potentially improves access to treatment while allowing other parts of primary care to concentrate on patients requiring more complex assessment. The direction of policy has progressed further in 2026. The Community Pharmacy Contractual Framework provides for independent prescribing to be introduced into national community-pharmacy services from autumn

2026, including prescribing within existing Pharmacy First pathways and additional prescribing pathways (Department of Health and Social Care, 2026).

Nevertheless, expanding pharmacists' clinical responsibilities does not automatically guarantee high-quality care. Hindi et al. (2024), reviewing 81 international studies, identified six important dimensions of community-pharmacy quality: person-centred care, access, environment, safety, professional competence and integration with local healthcare systems. This suggests that successful expansion requires more than increasing the number of services. Pharmacists require appropriate competence, consultation facilities, adequate staffing and effective communication with GPs and other professionals. For example, a pharmacist assessing a patient through Pharmacy First must recognise when symptoms fall outside their scope and require referral. Partnership working and accurate communication are therefore fundamental to continuity and patient safety.

There are also concerns regarding the sustainability of the service. House of Commons Library data show that England had 10,526 pharmacies in February 2026 compared with 11,609 in February 2016, a decline of 1,083 pharmacies or approximately 9%. Funding pressures, operating costs and difficulties recruiting and retaining pharmacists have been identified among factors associated with closures (Balogun and Harker, 2026). This creates a significant tension: the NHS is asking community pharmacy to assume greater clinical responsibility while parts of the pharmacy network are experiencing workforce and financial pressures.

3.0 Contribution to Quality of Life

Community pharmacy can improve quality of life because it provides accessible professional support for medicines use, self-care and management of health conditions. This is particularly valuable for older people and individuals living with long-term conditions who may use several medicines. Pharmacists can identify medicine-related problems, improve understanding and encourage adherence, potentially reducing avoidable deterioration.

Evidence nevertheless requires careful interpretation. Fares et al. (2025), in an overview of 29 systematic reviews, found that pharmacist-led community interventions produced positive clinical and behavioural outcomes, including improvements associated with medication adherence and patients' understanding of their conditions. However, evidence concerning economic outcomes, quality of life and patient satisfaction was less consistent. Consequently, it would be inappropriate to assume that every pharmacy intervention automatically improves quality of life.

Furthermore, physical proximity does not necessarily mean equal access. Service users may experience barriers related to opening hours, staffing capacity, disability, language, digital exclusion, health literacy or lack of private consultation space. Person-centred pharmacy services must therefore consider individual circumstances rather than simply increasing service availability.

This reflects Hindi et al.'s (2024) argument that access should be considered alongside safety, competence, environment and integration when evaluating quality.

4.0 Conclusion

Community pharmacy has evolved considerably from its traditional medicines-supply role into an increasingly clinical and preventive component of primary healthcare. Pharmacy First and the expansion of independent prescribing illustrate this continuing transformation. Community pharmacists can enhance quality of life through accessible advice, safer medicines use, prevention and timely treatment. However, evidence also demonstrates important limitations relating to workforce pressures, pharmacy closures, service capacity and inequalities in access. Therefore, the future effectiveness of community pharmacy depends not simply on expanding pharmacists' responsibilities, but on ensuring sustainable funding, sufficient staffing, professional competence, effective partnership working and genuinely person-centred care.

5.0 References

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