

University of Wales Trinity Saint David

Introduction to Health and Social Care

Course Code: LCHS4003

**Mini Report for Residential Care Home and Pharmacy Service to
Birmingham City Council**

Component 1: Task 1 and 2

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Task 1.

Residential care home

1. Introduction

The sustained escalation in demand for residential adult social care provision reflects acute demographic pressures characterized by population ageing, complex multi-morbidity, and advanced cognitive impairment (The King's Fund, 2023). Projections confirm substantial expansion within cohorts aged 85 and older, imposing severe structural strain on institutional social care capacity (Skills for Care, 2023). Adults requiring institutional accommodation necessitate continuous multidisciplinary oversight alongside health-promoting environments designed to sustain physiological stability, personal identity, and dignity (Haugan and Eriksen, 2021). Nevertheless, historic structural fragmentation and distinct funding streams separating the National Health Service (NHS) from means-tested social care undermine integrated provision (Glasby et al., 2023).

Statutory duties Part One of the Care Act 2014 mandates local administrations to conduct needs assessments whenever an individual displays an appearance of need under Section 9 (DHSC, 2023). Pursuant section 18, local administrations are legally required to meet eligible needs requiring full-time accommodation when national eligibility criteria are satisfied (DHSC, 2023). Local authorities also retain a duty under Section 5 to shape and sustain a high-quality care market (DHSC, 2023). Compounding financial constraints and provider exits have generated an acute shortage of residential beds, compromising statutory compliance (CQC, 2023).

2. Impact of the Issue on the Community

Insufficient residential care capacity directly impedes the overarching duty to promote individual well-being established under Section 1 of the Care Act 2014 (DHSC, 2023). In the absence of accessible residential placements, vulnerable adults with acute dependencies remain situated in unsuitable domestic environments where safety, psychological health, and physical dignity deteriorate rapidly (CQC, 2023; Haugan and Eriksen, 2021). Resulting domestic crises, falls, and self-neglect episodes correlate directly with escalations in statutory safeguarding enquiries initiated under Section 42 of the Care Act 2014 (DHSC, 2023). Simultaneously, unpaid family carers absorb unsustainable physical and psychological strain without institutional respite,

compromising carer health and infringing statutory rights established Section 10 of the Care Act 2014 (DHSC, 2023).

Systemic undervaluation of adult social care further entrenches community vulnerability (Glasby et al., 2023). Within the acute healthcare interface, capacity deficits precipitate prolonged delayed transfers of care (The King's Fund, 2023). Extended hospital stays induce physical deconditioning, vulnerability to infections, and loss of functional independence (British Geriatrics Society, 2023). Bed shortages also drive avoidable emergency readmissions (NHS England, 2023). Severe workforce attrition across independent providers further destabilizes local service continuity (Skills for Care, 2023).

3. Recommended Response to Address the Issue

To resolve local capacity deficits, commissioning strategies must realign baseline fee structures with independent Fair Cost of Care calculations, fulfilling market-shaping duties under Section 5 of the Care Act 2014 (Department of Health and Social Care, 2023). Transitioning away from transaction spot-purchasing towards multi-year block contracts for high-dependency placements provides independent providers with vital financial certainty (The King's Fund, 2023). Section 3 of the Care Act 2014 mandates the integration of social care with NHS provision to improve population outcomes (DHSC, 2023). Dismantling institutional boundaries requires treating adult social care as foundational infrastructure rather than a secondary expenditure (Glasby et al., 2023). Integrated pathways foster relational environments that advance functional preservation and holistic person-centred wellbeing (Haugan and Eriksen, 2021).

Operationally, local authorities and Integrated Care Boards must implement the national Enhanced Health in Care Homes framework across all registered residential facilities (NHS England, 2023). This clinical model delivers proactive primary care ward rounds, collaborative multidisciplinary team reviews, and structured medication reviews, demonstrably curtailing avoidable emergency department attendances and ambulance conveyances (British Geriatrics Society, 2023; NHS England, 2023). Concurrently, local adoption of the national Care Workforce Pathway establishes standardized competency progression and retention incentives to stabilize the care labor market (Skills for Care, 2023). Finally, investment in shared electronic records accelerates clinical communication across organizational boundaries (CQC, 2023).

4. Conclusion

Deficits in residential care capacity directly undermine statutory compliance under the Care Act 2014 (DHSC, 2023). Addressing this growing crisis requires structured market shaping under Section 5 and deeper clinical integration under Section 3 (The King's Fund, 2023). Fostering collaborative care environments reinforces proactive health promotion, mitigates systemic health inequalities, and protects vulnerable populations across local communities (Haugan and Eriksen, 2021). Establishing social care as foundational civic infrastructure ensures long-term sector viability and equitable service provision (Glasby et al., 2023). Furthermore, fully deploying the Enhanced Health in Care Homes framework safeguards clinical safety, optimizes resource distribution, and reduces unnecessary hospital admissions (NHS England, 2023). Executing these strategic, interconnected recommendations ultimately ensures resilient, person-centered, and lawful adult social care delivery across the region (CQC, 2023).

5. References

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Task 2.

Significance In Enhancing The Quality Of Life Of Service Users. Pharmacy Service In England

1. Historical Origins and Developmental Context

The professional evolution of pharmacy services in England demonstrates a prolonged transition from unregulated apothecary trade to an integrated clinical pillar of primary healthcare. Formal professionalization emerged in 1841 with the founding of the Pharmaceutical Society of Great Britain, established under Jacob Bell to counteract unregulated retail, introduce formal scientific curricula, and establish distinct professional demarcations separating pharmaceutical practice from medical surgery (Anderson, 2021). Statutory codification arrived via the landmark Pharmacy Act 1868, which restricted the compounding, dispensing, and retailing of scheduled poisons strictly to examined pharmaceutical chemists, introducing a mandatory statutory register and legal societal accountability (Anderson, 2021). Following the administrative bifurcation of prescribing and dispensing under the National Insurance Act 1911, the inception of the National Health Service (NHS) in 1948 structurally integrated independent pharmacy contractors into universal state-funded healthcare provision (Timmins, 2021).

Nonetheless, post-war NHS operations remained incentive by transaction dispensing volumes rather than patient-centered clinical care. The fundamental turning point occurred with the publication of the Nuffield Report (1986), formally titled Pharmacy: The Report of a Committee of Inquiry Appointed by the Nuffield Foundation. Chaired by Sir Kenneth Clucas, the inquiry identified community pharmacists as a profoundly under-utilized clinical asset within primary healthcare. Crucially, the Nuffield Report recommended that practitioners pivot away from routine dispensing towards structured patient counselling, professionalization collaboration with

general practitioners, and clinical medicine optimization, establishing the intellectual foundation for modern pharmaceutical cognitive services and clinical governance (Nuffield Foundation, 1986).

2. Contemporary Operational Architecture and Clinical Function

Contemporary community pharmacy in England operates within an evolving clinical delivery framework governed by NHS England, reallocating professional resources from manual prescription fulfillment toward accredited diagnostic services (DHSC, 2024). Today, community pharmacy acts as a vital frontline triage and urgent-care portal. A landmark structural progression occurred with the national commissioning of Pharmacy First in January 2024 (DHSC, 2024; NHS England, 2024). Operating under standardized clinical assessment protocols and statutory Patient Group Directions, pharmacists independently assess, diagnose, and supply Prescription Only Medicines for seven acute clinical conditions: uncomplicated urinary tract infections, shingles, impetigo, acute sore throat, sinusitis, infected insect bites, and acute otitis media (NHS England, 2024).

By delegating diagnostic and therapeutic authority to community clinicians, Pharmacy First alleviates severe primary care backlogs, successfully redirecting millions of consultations away from overwhelmed general practices and emergency departments (The King's Fund, 2024). Simultaneously, the integration of independent prescribing qualifications into initial educational standards equips modern pharmacists to manage complex chronic conditions directly, including hypertension monitoring and oral contraception prescribing (General Pharmaceutical Council, 2023). Nevertheless, contemporary clinical operations face critical systemic bottlenecks. Escalating drug acquisition costs, severe medicine supply shortages, real-terms funding reductions, and widespread workforce attrition toward primary care networks have triggered persistent commercial insolvency and localized pharmacy closures (Community Pharmacy England, 2024).

3. Significance in Enhancing Service User Quality of Life

Community pharmacy generates profound improvements in patient-reported quality of life by safeguarding equitable healthcare accessibility across diverse populations. Operating without appointment prerequisites, community pharmacies uniquely counter historical healthcare inequalities through the documented positive pharmacy care law, maintaining superior geographic availability within England's most socially deprived communities (Abozied et al.,

2025). This walk-in proximity ensures that vulnerable demographic groups access immediate diagnostic triage, health education, and preventative screenings that mitigate health deterioration.

Furthermore, structured cognitive pharmaceutical services enhance the wellbeing and independence of individuals living with complex multi-morbidity and poly-pharmacy. Advanced clinical pathways, such as the New Medicine Service and the Discharge Medicines Service, enable pharmacists to resolve discharge discrepancies, manage adverse medication reactions, and optimize therapeutic adherence (NHS England, 2023). Empirical evidence demonstrates that targeted pharmacist consultations significantly diminish avoidable emergency readmissions, resolve patient anxieties regarding pharmacotherapy, and preserve functional autonomy (Latif et al., 2022). Complementary public health services including cardiovascular blood pressure checks, seasonal vaccinations, and lifestyle cessation support empower individuals to maintain dignity, proactive self-management, and sustained quality of life within familiar neighborhood environments.

4. Conclusion

From its 1841 foundation under the Pharmaceutical Society and statutory recognition via the Pharmacy Act 1868, through integration into the National Health Service in 1948 and clinical reorientation under the Nuffield Report (1986), English community pharmacy has transformed into an indispensable clinical service. The contemporary Pharmacy First framework cements this clinical evolution by establishing community pharmacists as autonomous prescribers and diagnosticians. Despite intense operational and fiscal constraints, community pharmacy remains vital in protecting healthcare equity, optimizing complex pharmacotherapy, and elevating the quality of life for millions of diverse service users nationwide (The King's Fund, 2024).

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