Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 17 March 2015 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 9 March 2015

Chris Naylor
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Laila Butt	(LBBD) Cabinet Member for Crime and Enforcement
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Education and Schools
Cllr Bill Turner	(LBBD) Cabinet Member for Children's Services and Social Care
Anne Bristow	(LBBD) Corporate Director of Adult and Community
Helen Jenner	(LBBD) Corporate Director of Children's Services
Matthew Cole	(LBBD) Divisional Director of Public Health
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Jacqui Van Rossum	(North East London NHS Foundation Trust)
Dr Nadeem Moghal	(Barking Havering & Redbridge University NHS Hospitals Trust)
Sultan Taylor	(Metropolitan Police, Borough Commander)
John Atherton (Non-voting member)	(NHS England)

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting on 10 February 2015 (Pages 3 - 15)**

CARE ACT ISSUES

4. **Carers Strategy and Commissioning of Carers Services (Pages 17 - 56)**

5. **Arrangements for Advocacy Provision in 2015/16 and Future Years (Pages 57 - 64)**

6. **Information and Advice Plan for Adult Social Care and Support (Pages 65 - 96)**

7. **Care Act 2016 - Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support (Pages 97 - 113)**

PUBLIC HEALTH ISSUES

8. **Director of Public Health Annual Report (Pages 115 - 176)**

9. **Pharmaceutical Needs Assessment for Barking and Dagenham 2015 (Pages 177 - 437)**

SECTION 75 AGREEMENTS AND COMMISSIONING INTENTIONS

10. **The provision of a Section 75 Agreement for the Better Care Fund between the Council and Barking and Dagenham's Clinical Commissioning Group (Pages 439 - 447)**

11. **Section 75 Arrangements for the Provision of Learning Disability Services (Pages 449 - 454)**

12. **Procurement Plan 2015/16 - To follow**

13. **Barking and Dagenham Clinical Commissioning Group (CCG) Commissioning Plan 2015/16 (Pages 455 - 461)**

INFORMATION AND STANDING ITEMS

14. Update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme from NHS England to London Borough of Barking and Dagenham. (Pages 463 - 469)

15. Systems Resilience Group - Update (Pages 471 - 475)

16. Sub-Group Reports (Pages 477 - 481)

17. Chair's Report (Pages 483 - 488)

18. Forward Plan (Pages 489 - 499)

19. Any other public items which the Chair decides are urgent

20. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

21. Any other confidential or exempt items which the Chair decides are urgent

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London Borough of Barking & Dagenham
lbbd.gov.uk

Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

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MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 10 February 2015
(6:00 - 8:14 pm)

Present: Cllr Maureen Worby (Chair), Anne Bristow, Conor Burke, Cllr Laila Butt, Cllr Evelyn Carpenter, Frances Carroll, Matthew Cole, Helen Jenner, Nadeem Moghal, Cllr Bill Turner, Jacqui Van Rossum and Sean Wilson

Also Present: Sarah Baker and Cllr Eileen Keller Paul Roach, Joanne Murfitt

Apologies: Dr Waseem Mohi, John Atherton and Dr John

88. Declaration of Members' Interests

Jacqui Van Rossum, NELFT, declared a pecuniary interest in Agenda Item 6, 'NHS England London Commissioning Intentions for 2015/16' and took no part in the discussion or decision.

There were no other declarations of interest.

89. Appointments

The Board noted a change in representatives to the Board:

(i) BHR Hospitals
Nadeem Moghal, Medical Director, BHR Hospitals had replaced Steven Burgess

(ii) Metropolitan Police
Chief Superintendant Sultan Taylor, Borough Commander LBBD would be replacing Chief Superintendant Andy Ewing.

90. Minutes - 9 December 2014

The minutes of the meeting held on 9 December 2014 were confirmed as a correct.

91. Strategic Commissioning Framework for Primary Care Transformation in London

Paul Roach, Programme Director of Primary Care Transformation, NHS England, introduced the report and gave a presentation which explained how the NHS England was working towards a five year view for London, including the 'new deal' for GPs and the importance of the CCG in setting specifications and commissioning of services that will provide GP services in the future. The Board's attention was drawn to the 'Call to Action' and the challenges that GP practices in London would be facing and how the framework would bring all 32 CCGs and NHS England / London together and were advised that around 2,000 people had been involved in testing the framework and its aims. The Board noted that NHS England felt the framework would:

- Provide better joined up care and the right investment in better premises

- Improve accountability as it set out clearer expectations and people could raise concerns with NHS England.

Councillor Carpenter, Cabinet Member for Education and Schools, asked what would be the most significant difference she would find in five years time. Paul Roach advised that GPs would be able to understand and support medical conditions and access facilities for individualised care, including social and health care pathways, possibly through local access through a group of practices.

Councillor Turner raised the issue of accountability of GP practices, particularly in regards to ease of access and delivering public health aims. Paul Roach responded that the new contractual forms would within the next five years ensure that funding is available for the correct level of health professionals across the range of conditions and needs.

Councillor Turner commented that any member of the public could complain but it was essential that expectation levels were set and new modern ways of working and different media methods were utilised for the modern world in which we now live.

Anne Bristow, Corporate Dierector of Adult and Community Services, indicated that there were at least 6.8m people in the NHS London area but it is not clear where problems are reported, to whom and when, within the NHS / GP structures. Anne Bristow also commented that local people would like an appointment within a reasonable time and it was not all about major investments and solutions at a London level may in reality not improve local problems on the ground. Paul Roach responded that the answer lay with co-commissioning and work would need to be undertaken at a much more local CCG level with the knowledge and understanding of what the needs were locally.

Councillor Worby commented that whilst the principle of the framework and objectives were fine, she was concerned that the co-commissioning was cross London and this could be a retrograde step and move us back to where we were two years ago. Connor Burke agreed that all public organisations delivery of services needed to be at a local level and meet local needs and understood why there were some concerns as London was a large area with diverse needs and inherent differences between the 32 boroughs. Conor Burke added that they had put in an application for co-commissioning and this had just been approved. As a result from the 1 April the CCG will be the performance manager with NHS England as a key partner and that shadow governance arrangements had been put into place.

Councillor Worby commented that the specifications in the framework must make a difference to patients turning up at the GPs surgery and there must be a better front line experience.

Matthew Cole raise the issue of the Royal College report on the need for more GPs over the coming years and how that had indicated that 56 more GPs would be needed for Barking and Dagenham and over a 100 for Redbridge and asked how the NHS were going to get close to 200 new GPs in this sub area. Paul

Roach advised that there is a national commitment to increase the number of GPs and this would include long-term training and recruitment. However, 70% of the workforce we had now would still be in place in 10 years time and training would be needed to update their skill sets to deal with health needs in the future.

The Board:

(i) Reminded NHS England of the need to ensure that local provision meets the Borough's needs and that it does not grow to become a recreation of Outer North East London (ONEL) and raised and noted NHS England's assurances in regard to new co-commissioning being shared between NHS England, CCG and the Council.

(ii) Raised its concerns in regards to the accountability of GPs / GP practices and their delivery of services.

(ii) Raised concern about the number of health professionals, particularly GPs that would be required by LBBD and surrounding boroughs in the next five to ten years and noted the reassurance given by NHS England to their activity to meet demand.

92. Health and Wellbeing Outcomes Framework Performance Report - Quarter 3 (2014/15)

Mathew Cole, Director of Public Health, presented the report and drew the Board's attention to issues set out within the report and appendix and the significant issues that remain in A&E, referral to treatment time, the cancer pathway and unplanned admissions for ambulatory care sensitive conditions. The discussions included:

Councillor Carpenter drew the Boards attention to page 45 of the agenda and raised concern around the Chlamydia screening targets and achievement rates, which appeared to show both a reduction in target levels and a worsening performance. Matthew Cole explained that that tests undertaken at GUM clinics are not included in the figures and how the target had changed from the number of positive results to the number of people screened: on that basis we were achieving higher identification rates. Matthew Cole also reminded the Board that currently the contract is out for procurement. Testing facilities will also be at all LBBD 50th Anniversary public events during 2015.

Councillor Worby raised the issue of how the awareness of the young could be increased in regards to the risks of Chlamydia and other sexually transmitted infections (STIs).

Frances Carroll, Healthwatch, drew the Boards attention to page 41 of the agenda and commented that there still appeared to be a considerable level of unprotected sexual activity in under 25s and there were clearly links to this behaviour and the under 18 conception rates and asked what the plans were to target this issue. Matthew Cole responded significant work had been undertaken on this issue in previous years and that under 18 conception rates, whilst still of concern, had been reducing over the years.

The Chair, Councillor Worby, Cabinet Member for Adult Social Care and Health, raised the issue of the A&E performance. Dr Nadeem Moghal, Medical Director,

BHR Hospitals, recognised that there has been a problem around A&E over the winter pressures and why the targets were important to the treatment and subsequent discharge of patients. Dr Moghal explained that the Elderly Receiving Unit had now been established and also gave an update on the progress that was being made in regards to ambulatory care team(s). Consultants were also looking at redesigning the A&E and other systems to improve workflow and patient transitions. Work was also being undertaken to ensure that the workforce was skills based and not just profession based.

Conor Burke added that the figures had improved since the report was completed in January. There have been a number of occasions where 97% or 98% of patients had been seen within four hours at King George's Hospital and 90% to 95% at Queens Hospital and work was continuing to achieve those rates every day. Discharge rates had also improved and they were now amongst the higher quartile.

Councillor Turner raised the issue of the London Ambulance Service (LAS) and their input to the process and the lack of LAS engagement with this Board. Conor Burke advised that the LAS do attend the Urgent Care Board. The LAS was also experiencing recruitment and retention issues, as are many other ambulance services across the country.

The Chair agreed that the LAS should be formerly invited to attend the next meeting of the Board.

The Chair pointed out that health check target was 20%, but currently only 5% is being achieved and asked what was being done to improve on this. Anne Bristow explained to the Board the actions that were being taken to increase the rate and would gladly receive any suggestions from partners on how the rates could be improved further. Matthew Cole advised the challenge had been issued to GPs to improve their rate but it should be noted that LBBD are currently achieving higher rates in some areas than many across London and are performing much better than Havering or Redbridge. Conor Burke agreed to add this issue to the HA improvement Programme.

Jacqui Van Rossum pointed out that the child mental health treatment rates had improved considerably.

Having received the report, reviewed the overarching dashboard. discussed the performance report for Quarter 3, noted the further detail provided on specific indicators and the new data available, specifically the A&E survey, smoking quitters, Chlamydia screening and NHS Health Check and the actions being taken to sustain or achieve good performance, the Board:

(i) Noted in particular the:

- 'Green shoot' improvement in A&E performance on a number of days during January and early February 2015.

- The new Joint Assessment and Discharge Service (JAD) had the resulted in the lowest levels of delayed transfer of care in London.

- Improvement achieved by the CAHMS service.

(ii) Agreed to invite the London Ambulance Service (LAS) to attend the next Board meeting to discuss issues affecting their service.

(iii) Requested Partners to pass any suggestion they had for improving the NHS Health Check rates and Chlamydia awareness and screening to the Director of Public Health.

93. NHS England London Commissioning Intentions for 2015/16

Matthew Cole, Director of Public Health, LBBD and Joanne Murfitt, Head of Public Health in The Justice System and Military Health, NHS England London, jointly presented report on the progress on the implementation of the 2015/16 NHS England London commissioning plan, the full details of which were set out in report.

The Board were reminded that the 0 to 5 transfer is due to occur on the 1 October but LBBD had not yet accepted the service as there were still issues in regards to staff numbers and funding. There was also improvement needed to the immunisation records and improving links with maternity services and a further report on immunisation would be presented in due course.

The Board were assured that the flu vaccination was still effective against some antigens even though another had mutated. Vaccination should be encouraged, especially for high risk groups such as pregnant women.

As part of the cancer screening programme a new administrative centre had been established at King George's Hospital for bowel cancer screening. The breast screening service was currently being scoped to go out to tender and discussions were also being held with local women to identify their barriers to attending screening. It was noted that cervical screening rates had also dropped across London and Europe generally.

The new diabetic eye screening service would be in place by October 2015 and consideration would be given to making it more locally accessible.

The Audit of the Custody Suite in Freshwharf had been undertaken and it had been assessed as one of the best in London. Continuity of care for offenders was also being reviewed.

Councillor Turner raised the issue of women being encouraged to undertake testing for sickle cell anaemia and getting them booked in for the necessary care. Councillor Turner raised the issue of service co-ordination between NHS, who commission the tests, and the CCG who commission maternity provision. Anne Bristow commented that a large amount of resources had gone into sickle cell over recent years and this had been one of the success stories of the Health and Wellbeing Strategy.

The Board:

(i) Noted progress on the implementation of the 2015/16 NHS England London commissioning plans and in particular the current position for the following programmes of care:
- Antenatal and new born screening

- Early years and Child Health Information Systems
- Immunisations
- Cancer Screening Programmes
- Adult Screening Programmes
- Health in the Justice System services
- Veterans Health
- Sickle Cell and Maternal identification

(ii) Noted as part of the retender of the Diabetic Eye Screening service, it was intended to provide a more local service and for the service to be in place by end October 2015.

(iii) Requested NHS England to provide further information to the Board on the arrangements being put in place to improve performance in achieving the optimum uptake of immunisation programmes by the eligible population of Barking and Dagenham.

94. Health and Young Offenders

Matthew Cole, Director of Public Health, presented the report which had been provided to enable partners to jointly consider how to deal with the health issues of young offenders. Young offenders' health issues were often complex, and included risky sexual and health behaviours, language, communication difficulties, learning difficulties, autistic spectrum disorders and mental health issues.

The Chair drew the Board's attentions to paragraph 2.9 of the report and details of the family situations, living circumstances and homelessness of many young offenders. The Chair was concerned about wording in reports and said that care needed to be taken to ensure that it was not inflammatory. Councillor Turner pointed out that the accepted phraseology now was 'learning difficulties' not 'learning disabilities'.

Councillor Turner advised that a report had been published three years before about the neurological disorders in young offenders and how offending may in some instances not be a learned behaviour. It was noted, however, that early intervention, especially with troubled families, can significantly reduce offending behaviour.

As part of the discussion it was suggested that at the next refresh of the Health and Wellbeing Strategy that Young Offenders should be considered for inclusion as a vulnerable groups.

Chief Superintendent, Sean Wilson, Deputy Borough Commander, advised that young people were given a lot of attention when in custody. For the first time all custody suites were now under one command across London and as the command matures some of the concerns of the past would be allayed. Sean Wilson said that he had personally visited custody suites and had been impressed but accepted that there was still work to be done, especial where mental health issues were involved. Helen Jenner, said that one of the things that we do know is that many of the needs of young people in custody could be met by use of therapies and counselling support.

Sara Barker, Independent Chair of Safeguarding Children Board, commented on the work that needed to be done to ensure that whether or not a young person is being looked after under the Children's Act does not impact disproportionally and how safeguarding issues, such as sexual exploitation are recognised and appropriate action taken.

The Chair said the Children and Maternity Sub Group would clearly be picking up some of the work needed and reporting back to the Board in due course.

Anne Bristow said that following Havering pulling out of the Joint Service it was necessary and opportune to look again at the needs of young offenders and the services provided collectively by partners.

The Board received the report and the information contained within it, and noted the involvement of partners in delivering health and prevention services to young offenders.

The Board agreed:

(i) The Divisional Director Community Safety and Public Protection should liaise with the Chief Operating Officer LBBD CCG in regards to a 'task and finish' group and to report back to the Board in six months on the support needed and available for young offenders, particularly for those that fall in between troubles families and offending.

(ii) NHS Barking and Dagenham Clinical Commissioning Group (CCG) needed to have regard for the adequate provision of health services to support Youth Offending Services with a clear set of outcomes and activity expectations across the breadth of the youth justice system.

(iii) All young offenders should have an annual health check encompassing physical, mental health, emotional health and health risk behaviours. The findings and the agreed health outcomes plan agreed with the client should form part of the overall YOS care and support planning records.

(iv) YOS Health Services need to be commissioned with adequate resource and a clear set of outcomes and activity expectations across the breadth of the youth justice system.

(v) Significant work was needed to educate the wider health community about the needs of young offenders and develop a clear coherent pathway and transition plans for youth offenders; this work could be led by a GP clinical champion who has a special interest in adolescent medicine and the criminal justice system.

(vi) Workforce development planning and training programmes for both health and social care staff should include explicit education on youth justice for all front line professionals. There should also be specific training additional training support on health risk assessment and understanding of the NHS for YOS professionals.

(vii) Consideration should be given to adding Young Offenders to the list of vulnerable groups in the Health and Wellbeing Strategy.

(viii) Noted that the Metropolitan Police Custody Suites were now under a dedicated London-wide command to bring consistency to the service provided and NHS England had indicated that they were re-thinking their health provision in prisons and custody suites.

95. New Psychoactive Substances

Anne Bristow, Corporate Director of Adult and Community Services, and Sonia Drozd, Drug Strategy Manager jointly presented the report and explained that new psychoactive substances (NPS), often referred to as 'legal highs', were unregulated substances being openly sold to the public and why there were problems in making them banned substances under legislation. NPS were untested and there were no quality controls during production and NPS certainly could not be considered safe just because they were not banned substances. NPS could also have a significant detrimental impact on the user's mental and physical health.

The Board's attention was drawn to the pilot survey of young people undertaken by the Substance Misuse Strategy team to understand the use of NPS and in view of those results the survey was now going to be expanded in order to obtain a much more accurate insight into NPS locally. The Chair said that she was concerned about the percentage of young people in the pilot who had used or knew somebody who had used NPS.

Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group, advised that she would be meeting with clinical directors and would see if the survey could be raised with GPs and other health professionals to increase awareness and improve evidence capture.

Councillor Carpenter raised misuse of over-the-counter and prescribed medications. Anne Bristow said that this issue was coming more to the fore and it was intended to produce a scoping report for the Board for consideration in the autumn.

In response to a question Sonia Drozd confirmed that there had not been any increase in individuals accessing drug treatment services for advice and support since 'Khat' had been banned.

Councillor Turner said that he felt that legal highs and medication misuse should form part of our overall substance misuse strategy. Discussion was then held on the mobility of the supply of NPS and the benefit for cross-borough working with adjoining boroughs.

Sarah Barker questioned if schools and teachers were aware of NPS and stressed the need to ensure that that work would be undertaken in conjunction with the schools, young people's safety group, BAD Youth Forum and young people to raise awareness amongst young people to the dangers associated with NPS. Helen Jenner confirmed that PHSE in schools now included NPS to make sure that teachers and students are being informed.

The Board received the report and:

(i) Noted the work to date and discussed GPs, pharmacies and other health partners and schools actions in response to this problem.

(ii) Agreed this issue should be part of the Substance Misuse Strategy and requested Partners to disseminate information to their staff and that cross borough working may be beneficial, especially in regards to spreading information and awareness to the public and professionals.

(iii) Requested a report on over the counter medication abuse at a future Board meeting.

96. The Care Act 2014: Preparedness of NHS organisations

Baker Anne Bristow, Corporate Director of Adult and Community Services, presented the report which contained the responses from the partners on their preparedness to meet the requirements of service provision and support that would be required by the Care Act 2014 and assurances that resources would be in place.

Councillor Carpenter asked for clarification on the comment on Page 101 of the agenda about the expected price differential and possible disruption of the local market for residential care and the price discrimination between local authority procured and self-funded provision. Anne Bristow explained that due to their buying power, local authorities can often achieve very keen charges and could also give a level of assurance of the quality being provided. The Council could also be approached to arrange care, and gave the example of beds being bought to support the winter crisis points.

Councillor Carpenter commented that the BHRUT answers seem rather brief and needed more specific detail and Sara Baker commented that there was not explicit information about transition care. Anne Bristow advised that we are clear about what the Act requires and how it should operate but at the moment there was still a concern that health partners may not be 100% ready and conversations would be continuing with the health partners to obtain more details and assurances.

The Chair said that she could not stress strongly enough the implications of this Act and the resource needed and that she still had concerns about individuals deciding what care they wish to buy and from whom, which then turned out to not be the best choice for their need.

Having received the report and presentation, the Board:

(i) Noted the submissions at Appendix 1 of the report, from NHS organisations, which gave assurance of their Care Act awareness and preparedness.

(ii) Noted the duties and requirements highlighted at Appendix 2 of the report.

97. The Care Act 2014: National and Local Communications

Anne Bristow, Corporate Director of Adult and Community Services introduced the report and gave a presentation which explained that Public Heath England had devised tool kit and communication campaign that would be on radio, media, internet information, poster advertisements and leaflet drops. Work would need to

be undertaken to ensure that all local GPs are aware and are advertising the changes. This national campaign was launched on 2 February. The Council had decided to go with the national materials, adjusted to reflect local needs, and would not be advertising on buses. The BBC was also running a series of programmes / items that would focus on care.

Councillor Worby said that it seemed strange to her that Public Health England had chosen Chadwell Heath ward for the every household leaflet drop, rather than some of the more deprived areas of the Borough.

Dr Nadeem Moghal commented that as the services need to become increasingly integrated work was progressing on those relationships.

Anne Bristow concluded by advising it was expected that as the public, clients, and relatives pick up on these changes the call levels seeking advice and reassurance would increase considerably and plans were already in place to deal with that pressure.

Having received the report and presentation, the Board:

(i) Noted the approach to communications and the activities planned throughout the public awareness campaign to reach residents on the changes to care and support that arise from the Care Act.

(ii) Discussed ways in which partner organisations can support communications activities and also ensure that their staff were aware of the impending changes.

98. Section 75 Agreement for the Joint Assessment and Discharge Service

Bruce Morris presented the report and advised that the Board had received a report previously on the establishment of a Joint Assessment and Discharge Service (JAD) that was intended to provide an integrated approach to the discharge of patients and the contributing partners were BHRUT, NELFT, LBBD and Havering: with LBBD leading the implementation and being the host for the service.

The service was now fully operational and a Section 75 agreement was now needed to formalise the arrangements. The CCG Governing Bodies had already signed off the Section 75 agreement and Havering were also going through the sign off process at the moment.

Bruce Morris said that the service had only been operational since June but had worked well through the winter. Across the partnership it had been seen as positive in supporting the acute services, especially in the reduction of pressures on hospital A&E departments over the winter months, and partners were keen to use the service and felt it had a key role in supporting hospitals to facilitate safe discharge. Brue Morris also drew the Boards attention to the Highly Commended Quality Award that JAD had recently received under the category of ‘Collaboration and Partnership Education’.

Bruce Morrison stressed that the service had not cost any extra money but had simply been the pooling of services that were already there.

Dr Nadeem Moghal commented that the Chief Operating officers were also saying this new JAD was having a positive effect.

Councillor Turner asked about the awareness of adult safeguarding. Bruce Morris advised that all JAD staff would be fully qualified social workers, occupational therapist, nurses or other health professionals that would have safeguarding training and this would ensure that safeguarding issues can be recognised and dealt with effectively and quickly.

The Board wished to place on record its appreciation to the staff and services who had risen to the challenge in finding and working in new and novel ways.

Having received and discussed the report, the Board:

(i) Agreed the proposed S75 agreement, as set out in Appendix 2 of the report, and noted the successful implementation of the Joint Assessment and Discharge Service.

(ii) Noted the positive performance of the Joint Assessment and Discharge Service and its contribution to winter planning and operational resilience across health and social care, the details of which were set out in Appendix 1 to the report.

(iii) Noted the Service had won an award for training under the category of 'Collaborative and Partnership Education'

(iv) Noted the Service had been provided from utilising existing resources in novel and different ways and as a result had not required additional financial support.

99. Sub-Group Reports

Noted update reports from

(i) Integrated Care Sub-Group

(ii) Mental Health Sub-Group

(iii) Learning Disability Partnership Board

(iv) Children and Maternity Sub-Group

(v) Public Health Programme Board

100. Systems Resilience Group - Update

The Board:

(i) Received the update from the Systems Resilience Group, and noted that briefing given to the Group's meetings held on the 19 December 2014.

(ii) Noted that efforts were starting to improve performance and patient

experience but there was still concern about Accident and Emergency targets not being met.

101. Chair's Report

The Board noted the Chair's report, which provided information on a number of events / issues:

- **Make a Change** – Healthier Lifestyle campaign.
  The Chair also encouraged the Board members to make their own pledge about what they would do or change to make their own life healthier.

- **50th Anniversary Celebrations**.

- **News from NHS England**
  - Increase in patients accessing medical records online
  - Patients able to book appointments and request repeat prescriptions has jumped to 91 per cent and 88 per cent respectively

- **Cancer Drug Fund**

- **Have your say on health and services**
  Feedback from the public event held January 2015.

- **New Medical Director**
  Appointment of Dr Nadeem Moghal has been appointed as the new executive Medical Director at Barking, Having and Redbridge University Hospitals NHS Trust.

- **Better Care Fund**

- **0 – 5 Transfer of Health Visitors**
  Update on the transfer, funding implications, supervision and management, contract performance and MASH allocations, including a letter sent by the Council on 16 January 2015 to Department of Health in regards to inadequate baseline allocations.

- **Ebola – The National Situation**
  UK public health risk from Ebola continues to be very low.

- **Adult Social Care Survey for 2014/2015**
  658 service users would be sent a questionnaire.

- **Dates for Diaries**
  Health and Wellbeing Board Development Afternoon will be on17 April 2015

102. Timing of Meetings

The Board noted the Council would be changing its meeting default start time to 7.00 p.m., however, having considered the preferred start time of the partners the Board:

(i) Agreed that it would continue to start its meetings at 6.00 p.m, and aim to concluding business within two hours.

103. Forward Plan

The Board

(i) Noted the draft Forward Plan for the Health and Wellbeing Board and there had been some changes and items added since the publication of the agenda; and,

(ii) Noted any new items / changes must be provided to Democratic Services by no later than 6.00p.m, on 11 February 2015 for them to be considered at the 17 March 2015 meeting or later.

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HEALTH AND WELLBEING BOARD

17 March 2015

Title: Carers Strategy 2015-2018	
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Author: Mark Tyson Group Manager, Integration & Commissioning	**Contact Details:** Tel: 020 8227 2875 Email: mark.tyson@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult and Community Services	

Summary:

In October 2014, the Health & Wellbeing Board received a draft set of outcomes for improving support to carers in Barking and Dagenham and the critical role that they play in supporting people to remain healthy and independent for as long as possible.

Following further work, including consultation events with carers and service providers, the Board is now presented with a Strategy for approval covering the period 2015 to 2018. The broad outcomes are as agreed by the Health & Wellbeing Board in October, with an action plan for the first year of the Strategy demonstrating how the outcomes will be improved over that period.

Recommendation(s)

Members of the Board are recommended to:

- Approve the attached Strategy as the basis for future joint work on the development of carers' services in Barking & Dagenham;
- Delegate authority to the Corporate Director of Adult & Community Services to work with partners including carers, carer service providers and health partners in the development of proposals of a specification for future carers' services; and
- Delegate authority to the Corporate Director of Adult & Community Services in consultation with:
    - the Cabinet Member for Adult Social Care & Health,
    - Divisional Director of Legal Services,
    - Chief Finance Officer, and
    - partners through the Carers Strategy Group and Joint Executive Management Group for the Better Care Fund,

  to proceed to tender for carers' support services for April 2016 onwards, in line with

the intentions set out in the Carers' Strategy.
Reason(s) Carers' support is a major plank of social care reform as set out in the Care Act 2014. It is also one of the 11 schemes in the Better Care Fund plan agreed by the Board through recent meetings. The Council's priority around **enabling social responsibility** frames the Council's intentions around supporting residents to take greater responsibility for their own wellbeing; protecting the most vulnerable and ensuring that everyone can access good quality healthcare when they need it. The proposed Carers' Strategy will be core to the delivery of these aims within a challenging financial climate.

1. Introduction

1.1 At its meeting on 28 October 2014, the Health & Wellbeing Board received an outline of a strategy to improve support for carers, based on extensive consultation and analysis undertaken by CarersUK, commissioned on behalf of all borough partners by the Council and Clinical Commissioning Group. That report set out the background for the development of carers' support services, including the new duties placed on the Council by the Care Act 2014 and the commitments made by the Council and Clinical Commissioning Group in agreeing their plans under the Better Care Fund.

1.2 The discussion at the Board broadly welcomed the seven-outcome structure for the proposed strategy, and the emphasis on better identification of carers, on preventive support, and on ensuring that support is targeted at key points in a carer's journey, such as crisis or when caring comes to an end. The Board further observed that it was currently difficult to predict demand for formal assessment and packages of services as envisaged by the Care Act reforms.

1.3 The Board further agreed the general approach to the recommissioning of carers' services that was set out. This report provides further detail on how the recommissioning of carers' support services will proceed over the coming year.

2. Carers in Barking & Dagenham

2.1 The October report contained background on the contribution carers make to the health and social care system in Barking & Dagenham. From the wealth of information collated by CarersUK, a further summary is included in the body of the Strategy that is now presented for approval.

2.2 Key points from this analysis include that:

- Carers' support services need to be available at a wider range of times, and need to make more use of peer-led approaches which have proved successful;
- There need to be more services available for working carers and for those who wish to return to the workforce either during or after their period of caring;

- Support needs to respond effectively to crises and changes of circumstances in carers' lives;

- Statutory services need to be more proactive at identifying carers, including in general practice, and more knowledgable about the support options that are available for them;

- There needs to be greater diversity in the targeting of carers' services at different types of carer, different demographic demands and different locations and times of service delivery.

2.3 The work provided by CarersUK will continue to inform further development of the Strategy over its first year, and be a source of analysis to support the work of commissioners and the Carers' Strategy Group.

3. The structure of the strategy

3.1 The Strategy includes a number of components:

i) An overview of the Care Act and Better Care Fund and what they are seeking to achieve in respect of carers' services;

ii) An overview of the data and demography around carers in Barking & Dagenham;

iii) A clear statement of the outcomes that we want to see delivered for carers, including expression of these outcomes in 'I' statements in the spirit of *Think Local Act Personal*;

iv) A set of messages to the market about the carers services we want to see delivered, which will be expanded and developed into a new Carers section in the Market Position Statement, to be refreshed for late summer 2015;

v) Two pictorial representations of the new carers' system, one focusing on service provision, the other seeing the world with the carer at the centre – and both of which will need continued development as the action plan is implemented and the Carers' Strategy Group gets underway;

vi) An action plan for 2015/16 setting out particular milestones to see the outcomes delivered; and

vii) Governance arrangements, including how we are encouraging comments and contributions from carers, service providers and other stakeholders at any point in order to continue to strengthen the Strategy.

3.2 It is important to note that the focus for the first year, 2015/16, is very much on ensuring that the core changes to the way that services are provided, including arrangements for carers' assessments under the Care Act are in place. The Carers' Strategy Group, established in February 2015 to provide final input to the Strategy, will have a task in 2015/16 to develop the longer term, and perhaps more ambitious, action plans to deliver the Strategy's aims.

3.3 In October 2015, the Health & Wellbeing Board discussed the relationship between this Strategy, focusing primarily on adult carers, and work with young carers. A further document is under development which will describe this relationship, led by Children's Services with participation from adult services and third sector partners. Commissioning intentions with respect to carers' services have been worked on jointly to ensure that consistency of approach, where appropriate, is being achieved. Completion of this work will be reported to the Board.

4. Commissioning of future carers services

4.1 As outlined in the October report, an extension of the contract with Carers of Barking & Dagenham to March 2016 for the provision of support services to carers has been implemented. As part of this extension, Carers of Barking & Dagenham will no longer be required to undertake the formal assessment of carers (as it is set out in the Care Act), but will continue to provide a screening and referral services, with a range of support services provided. As part of the contract extension, the Council has committed to continue to work with Carers of Barking & Dagenham to support the organisation's development to meet the requirements of the changed social care system described in the Care Act, and areas for that joint work will be set out in the contract terms.

4.2 Working with the Carers' Strategy Group as appropriate, the intended timeline for commissioning new carers' services is now as follows:

Task Timescales	
Review of market, opportunities and Care Act impact	To July 2015
Completion of tender documents	September 2015
Issuing of tender docs	September 2015
Completion of ITTs returned	November 2015
Panel evaluation completed	December 2015
Notice of award of contracts	January 2016
Contract 'go live'	April 2016

4.3 The Board may also wish to note that there are discussions taking place about pan London commissioning for information and advice services for carers, including a carers' telephone advice line.

5. Mandatory Implications

Joint Strategic Needs Assessment

5.1 The implications of this Strategy for the JSNA were identified in the October report to the Health & Wellbeing Board, in summary:

- the impact of migration into the borough and their particular needs, reflected in the recognition that a greater diversity of services would be required;
- the impact of welfare reform and austerity, reflected in the emphasis on working carers and supporting skills development for return to the workplace;

- the health inequalities associated with ethnicity, reflected again in the needs for diversity in the services provided, as well as the proactive emphasis on identification of carers;

- the requirement for more information and advice services to support service access and choice for carers, which is central to the Strategy.

Health and Wellbeing Strategy

5.2 The October report noted that the Health and Wellbeing strategy identifies a number of key principles which include to enable increased choice and control by residents who use services with independence, prevention and integration at the heart of how choices can be made and to seek to reduce health inequalities with themes early recognition and intervention and upon the promotion of positive health and wellbeing.

5.3 The new Joint Carers Strategy and commissioning proposals reflect these principles.

Integration

5.4 As noted in October, integration is supported through our steps to improve support to family carers which is a key scheme within our Better Care Fund supported by both our pooled funds and through the joint commissioning of services, review of their effectiveness in delivering required outcomes and oversight by the H&WBB.

5.5 **Financial Implications**

Implications completed by: Roger Hampson, Group Manager, Finance (Adults and Community Services)

The Better Care Fund plan for Barking and Dagenham provides resources of £925,000 for support for family carers provided by the local authority and the CCG.

There are a number of areas as a result of the implementation of the Care Act where additional resources are needed. These are currently being evaluated in order to prepare proposals for the Health and Wellbeing Board to consider on how these are to be funded within the limited resources available. In the first instance, it is the intention to use the New Burdens Grant in 2015/16 of £773k to fund additional carers services as the need for these services is likely to be on-going. If this is not possible, a request will be made for a further call on the departmental reserve (on top of the £500k previously agreed for Care Act implementation costs).

5.6 **Legal Implications**

Implications completed by: Dawn Pelle, Adult Care Lawyer

There are no legal implications for the following reasons:

- Duties to Carers under Care Act 2014 has been recognised;

- The Strategy aims to be carer centred;

- The relevant statutes have been referred to e.g. Care Act 2014 & Children and Families Act 2014.

6. Consultation

6.1 During the development of our new joint strategy we worked with Carers UK to undertake engagement with the local community. They combined this with an extensive analysis of the data around caring in Barking & Dagenham to produce a set of recommendations on which this strategy is based.

6.2 The engagement involved:

- 48 individual carers, providing care to people with a range of different care needs;
- Social workers;
- GPs;
- Hospital staff;
- Voluntary sector and local support groups including Carers of Barking and Dagenham;
- Commissioners;
- North East London Foundation Trust;
- Health and Wellbeing Board.

6.3 On 23 February, a workshop was convened with service providers and carers to review the strategy aims and to provide comment.

7. Public Background Papers Used in the Preparation of the Report:

Report to the Health & Wellbeing Board, 28 October 2014
Joint Carers' Strategy and Commissioning Priorities For Future Contract(s)

8. List of Appendices:

Appendix 1: Carers Strategy 2015-2018

“A carer-conscious community, working together to create innovative and sustainable support for carers, where carers are viewed as ‘everybody’s business’ and feel valued.”

CARING TOGETHER

A Carers’ Strategy for Barking and Dagenham

2015 - 2018

Logos to be added following approval

Contents

Foreword 1

Carers play a vital role in Barking and Dagenham. We want to put better support in place to help them in their caring role.

The health and social care system simply couldn't function without carers. Through their commitment to their loved one, and the work that they do, they contribute an enormous amount to the safe and sustainable delivery of care. They are our partners in the delivery of health and social care services.

Around 16,000 people reported in the Census that they provide some level of informal care. Nationally, it is estimated that 1 in 9 people in the workforce are also caring for someone who is ill, frail or has a disability. It is therefore not just the right thing to do to ensure carers get the support that they need, it has an important impact on our local economy.

Everyone has a role to play in ensuring that carers are given support to keep on caring. This is why the London Borough of Barking and Dagenham and Barking and Dagenham Clinical Commissioning Group have worked with nationally-recognised charity Carers UK to develop a set of plans for improving the support offered to carers locally. We have worked with carers themselves, managers and frontline practitioners from across social care, health, and the voluntary sector to set out the things we think need to improve, and how we will get there.

The Care Act comes into effect on 1 April, recognising carers' right to support with new rights to good provision of information and advice, an assessment of their needs, and the services required to meet those needs. With our partners in the health service, we agreed a set of plans, called the Better Care Fund, that aim to keep people well and at home and avoid them going into hospital. Our work with carers is a crucial part of those plans.

Fundamentally, however, providing informal care for a loved one is a challenging – as well as rewarding – activity. The people that do it deserve all the support we are able to give them, and I am pleased to set out here how we think this should operate in the years ahead. I want to continue to hear your views on how things could get better, and there are details at the back on how you can feed back on your experience.

Our Vision: **"A carer-conscious community, working together to create innovative and sustainable support for carers, where carers are viewed as 'everybody's business' and feel valued."**

Introduction 2

Across the UK today, 6.5 million people are unpaid carers; around 16,200 in Barking & Dagenham.

This means that 1 in 8 adults spend a 'significant proportion' of their lives providing unpaid support to family or friends, for example those who are ill, frail, disabled, with mental health or substance misuse problems.[1] These carers play a hugely important role in our society. Research has shown that carers save the state billions of pounds each year by providing much-needed care to help sustain people in their own homes.[2] In a ward audit of our local hospitals it was identified that 75% of patients lived alone with no informal support and were not known to health or social care service. 76% of these had a chronic condition which could have been managed in an alternative and more cost-effective way.

It is vital that carers are supported as individuals to ensure that their caring responsibilities do not impact negatively on their own quality of life, for example, leading to the high levels of social isolation that carers report.

The specific needs of carers vary enormously. For example, 62% of all female and 73% of all male carers undertake their caring responsibilities alongside paid employment[3], and may require support to ensure that they can continue to do so effectively. Some carers have care needs themselves; 51% of elderly carers (aged 85+) care for more than 50 hours per week, often despite illness or frailty.[4] 2013 figures from the Office for National statistics suggest 244,000 people under 19 are carers, with about 23,000 under nine years old. Among 15-to-19-year-olds, about 5% of girls are carers and about 4% of boys.[5]

This is one of the reasons why the government passed the **Care Act** in 2014, which introduces significant changes to health and social care, with enhanced rights for carers. This strategy sets out how we will implement these new changes, as well as other improvements that we have identified through our discussions with local carers and those who work with them, such as social workers, GPs and voluntary sector organisations. This is our current assessment of how we will meet the new Care Act requirements, but we will need to keep it under review in the first year to be sure that we are adequately responding to local carers and their need for support.

This Strategy has been led by the Clinical Commissioning Group and the council working together under the Better Care Fund. However, it is intended to be a partnership strategy that drives activity across a wider set of partners: service providers, the voluntary sector, the private sector and other statutory agencies. We will work to continue to build the consensus around the actions and aspirations it identifies.

[1] Dept of Health (2008), *Carers at Heart of 21st Century Families & Communities*

[2] Carers UK (2011), *Valuing Carers*

[3] Carers UK and the University of Leeds (2007), *CES Report*

[4] Office for National Statistics (2006)

[5] Office for National Statistics (2013), *2011 Census*

Definitions and terminology

There are various definitions of 'carer' which apply through this document. In general, we use the term 'informal carer', to refer to people who provide care for relatives, friends and loved ones, and to distinguish them from the formal service provision that may be arranged through care agencies, either by the service user or the Council.

In our Better Care Fund we referred to 'family carers', which identified that the emphasis was on supporting hospital discharge and keeping people well at home, and that this may be more disproportionately a family role. However, it was not intended to be exclusive, and the term informal carers could often be taken to include family carers, and family carers should not necessarily be taken to exclude other caring arrangements, such as for friends or neighbours.

A note on Young Carers

The Care Act gives clear guidance on how the transition of young carers to adulthood should be approached. A separate document setting out the partnership's approach to support for young carers is in development, although the vision remains the same. Overall changes to assessment systems and information and advice must take account of the specific needs of young carers as they are developed.

The Care Act 3

Major changes are being introduced in how social care is delivered, and what support carers can expect

The Care Act introduces significant and welcome measures to improve the rights of adult carers. These measures include:

- A duty on local authorities to promote the physical, mental and emotional wellbeing of carers and their participation in work, education and training;
- Clearer information, advice and access to a range of preventative services which reduce carers' need for direct support;
- New assessments which put carers on an equal footing with the person they care for;
- Giving carers, for the first time, a clear right to receive services, via a direct payment if they choose;
- A national eligibility threshold, bringing greater clarity around entitlement for carers and those they care for;
- Processes in place to ease the transition between child and adult services.

Improving the lives of carers runs beyond the health and social care system. The emphasis on preventing need for direct support means that employers, schools, faith groups, local communities and service providers all have a role to play.

Whilst there has been a strong emphasis on the new rights to assessment and services to meet the needs that are identified, we believe that there is just as much importance in the duties around the provision of good information, advice and preventive support. Currently, we know that around £4m of Carer's Allowance goes unclaimed in the borough, and help to claim the financial support that carers are entitled to is just one of the ways in which the caring role can be made more manageable. We want to see more peer support available so that carers can help each other, based on the expertise that they have built up through their own caring role and experiences of our local health and social care system.

Where assessment and a formal package of support is appropriate, we want this process to be as supportive as possible. The Care Act is clear on the eligibility for services, but again our emphasis would be on ensuring that preventive support is in place alongside anything more structured to assist a carer in balancing their responsibilities and their wider aspirations and life choices.

The Better Care Fund 4

Health and social care services have agreed ambitious plans to prevent people going into hospital unnecessarily. Support to carers is an important element of our plans.

It is crucial that everyone works together to improve the lives of carers in Barking and Dagenham. The partnership between health and social care is of particular importance. Because of this, the government has announced the £3.6bn Better Care Fund (BCF), which locally will bring together £21m of investment to get services working together more closely, particularly to help prevent people having unnecessary stays in hospital. Some of this will be through work to better support carers.

One of the key aims of the local plan is to improve support for family carers, and this strategy captures the approach we are taking. In particular, the BCF plan sets out that we will:

- Improve the support available to carers and recognising their key role in helping people to remain in their own homes, which will in turn support planned reductions in rates of avoidable admissions to hospitals and care homes;
- Identifying additional services required for carers and supporting commissioning activities to develop these services;
- Targeting carers at risk of breakdown and positively increasing the number of carers supporting people in their own homes for as long as possible;
- Meeting the requirements of the Care Act – specifically to improve information and advice available to carers, and to improve the market to support the delivery of individual purchasing decisions through personal budgets;
- Improving the experience of carers and service users by ensuring that their needs and priorities are reflected in provision. This will also align with our improvements to end of life care, dementia and mental health support outside of hospital, with an increased number of people able to have their choices and wishes supported.

Barking and Dagenham's Health and Wellbeing Strategy (HWBS) also brings together health and social care services (alongside other partners) to improve overall health outcomes through better integrated services. A key action within the HWBS is to improve the quality of life of carers of highly dependent people through a range of measures, such as annual carer health checks.

The development of the new Carers' Strategy will therefore contribute towards the wider improvements required within health and social care services across Barking and Dagenham.

How we developed the Carers' Strategy 5

It was critical that we heard from carers themselves, as well as frontline professionals, in the development of this strategy. Carers UK conducted the research exercise for us.

During the development of our new joint strategy we worked with Carers UK to undertake engagement with the local community. They combined this with an extensive analysis of the data around caring in Barking & Dagenham to produce a set of recommendations on which this strategy is based.

The engagement involved:

- 48 individual carers, providing care to people with a range of different care needs;
- Social workers;
- GPs;
- Hospital staff;
- Voluntary sector and local support groups including Carers of Barking and Dagenham;
- Commissioners;
- North East London Foundation Trust;
- Health and Wellbeing Board.

The engagement approach combined individual interviews, participation in focus groups and presentations. Key areas of discussion were:

- How current services impact upon carers – what is working well and what would benefit from improvement;
- Challenges and barriers to improvement;
- Implications of the Better Care Fund and increased integrated working between health and social care;
- Views on the Care Act and its implications for organisations;
- Solutions to improve support for carers in the future.

What we found out through our research

Together with the demographic data, we heard that particular at-risk groups of carers (where there is a risk that their ability to care will break down, or they are experiencing significant detriment to their personal wellbeing) will include:

- High intensity carers;
- Older carers;
- Carers of people with dementia, mental health problems or at the end of their life;

It will also be necessary for us to think about service provision for carers living in wards in the borough with high levels of income deprivation and poorer health outcomes, as well as groups based around gender, ethnicity, religious belief etc. who appear not to be currently accessing support.

Through speaking to carers, we found that many of the support services available to carers work well. For example, Carers of Barking and Dagenham run very popular and respected services such as Memory Lane, which has helped people to live independently away from nursing care and supports carers through a range of services from advocacy to employment issues. In addition, the work of the Integrated Care Team and DABD was praised by many.

However, we also found some significant areas for improvement. For example, carers' assessments can be disjointed and carers do not always have support plans. Even where support plans are in place, they are often not specific enough.

What works well

The following were identified as elements of effective support for carers in our borough:

- **Carers of Barking and Dagenham:** supports a large number of carers, including young carers, with a varied service offer, and deliver flexible services that any carer can access regardless of eligibility;
- The carers section on **council website**;
- Work being conducted in conjunction with East London Solutions to help **micro-providers** (new small businesses) get a place in the market;
- **Carers Networking Group** for statutory and voluntary sector providers;
- Health systems like Care Applications and Health Analytics which **support integrated care**.

Areas for improvement

A summary of some key areas identified for improvement includes:

- **Current services:** support groups are often held during the day meaning that working carers cannot attend; these also rely upon professionals and may not sufficiently draw upon and utilise 'experts through experience' and address the social isolation which many carers feel.
- **Care-planning:** service users and carers are often not involved enough in care-planning sessions; Planning also needs to take into account emergencies or when things might go wrong
- **Information provision:** there is a lack of clarity regarding how personal budgets work for carers and how they can access them, with one carer commenting 'you don't know what you don't know'. It is also difficult to access specific information about mental health;
- **Health:** GPs don't always understand the benefits of carers' assessments and the potential clinical benefits of referring carers to community support, despite often being the first point of contact for carers; carers are also people who often put their own needs last when talking with GPs
- **Future opportunities to support carers:** there should be more ways to support carers without face-to-face groups. Carers should also be more involved in integrated care meetings.
- **Identifying young carers:** there are challenges in identifying young carers, particularly those under 9 years of age.

Links to other strategies and plans

We have already set out how the Better Care Fund and the Care Act will change the way we support carers. A number of other key national and local policies will have an impact on the development of carers' support in the London Borough of Barking and Dagenham. They are set out below:

- **The Council's Corporate Plan:** this sets out the Council's overall aspirations for the borough under the heading '*One borough; One community; London's growth opportunity*'; one of the three key priorities is enabling social responsibility through which the Council aims to protect the most vulnerable while supporting residents to take responsibility for themselves and their families, a key driver for improved support to carers. In addition, the priority around 'growing the borough', will be facilitated by better support for working carers.
- **The Clinical Commissioning Group's 5 Year Plan:** this sets out how the CCG will achieve its vision of "improving health and health outcomes for local people through clinically led commissioning of sustainable, safe, high quality local services" with a range of improvements to primary care, urgent care, planned care, and mental health services. Improvements in support for carers are threaded through all of those areas of activity, and are expressed through this strategy.
- **Integrated Care Case for Change in Barking & Dagenham, Havering & Redbridge: (2012)** developed by the Integrated Care Coalition which works to 'join up' care across the three boroughs, including ours, this sets out how partners will shift the emphasis towards early intervention, improved focus on outcomes and upon the promotion of self care and greater integration of services. It doesn't reference carers specifically, but this strategy should be taken as part of the delivery of those wider aims.
- **Children & Families Act 2014:** this Act seeks to improve services for vulnerable children and support strong families, by introducing greater protection to vulnerable children, and better support for children with special educational needs and disabilities.. A Local Authority must assess whether a young carer in their area has needs for support, and if so, what those needs are.
- **Joint Strategic Needs Assessment:** this local assessment of health and social care need gives a direction in terms of numbers of carers and their need for support; it is being updated and will reflect the work that Carers UK has undertaken to inform this strategy;
- **The Health & Wellbeing Strategy:** currently being refreshed, this strategy sets out the high-level aspirations of the Health & Wellbeing Board to improve health across the life cycle and to improve access to health and social care services; it is grouped under headings of Prevention, Protection & Safeguarding, Improvement & Integration, and Care & Support.
- **The Adult Social Care Market Position Statement:** in July 2014, the Council set out its first 'Market Position Statement' in which it described how it thinks the market of available social care services should develop. There was no separate section for carers, which this strategy seeks to correct in time for the refreshed MPS in the summer of 2015.
- **Think Local Act Personal:** the Council has signed up to implement 'Making it Real' under the 'Think Local Act Personal' banner, which seeks to move away from service-driven responses to carers to a greater emphasis on personalisation, with services more proactively tailored to individual needs and an emphasis good quality information and advice being available.

Caring in Barking and Dagenham 5

What we know about carers, their needs and aspirations in Barking and Dagenham.

During the development of the strategy we gathered a lot of information to ensure that we understand local need, local experience of caring and priorities. We have done this by analysing demographic data, undertaking consultation with residents, and building on our previous strategies.

There were around 186,000 people living in Barking and Dagenham according to the 2012 population projections, but we know that the borough population continues to grow. Just under one in ten residents (16,200) are estimated to be unpaid carers, supporting relatives, friends or neighbours. Our partner voluntary organisations currently have approximately 2,600 local carers registered for support and advice, suggesting that an extremely large number of carers are not receiving any support services. By 2021, the overall population of Barking and Dagenham is projected to grow by 22.7%, suggesting that there will be an even greater number of unpaid carers in the future.

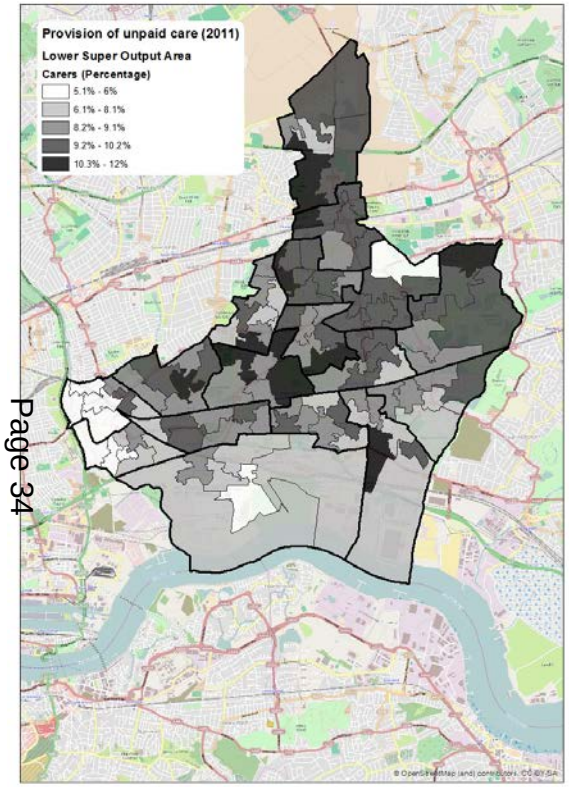
We know that identifying carers can be difficult for a variety of reasons. For example, people may be struggling to cope but unwilling to ask for support because they do not understand what support is available or they are concerned that it may affect their relationship with the person they care for. A key aim of the new Carers' Strategy is to improve the information available to carers and to support carers in local communities to help one another and 'spread the message', to ensure that all residents know where to turn if they are struggling to care for someone.

The needs of carers are many and varied, and we know that it is vital to focus on carers as individuals in order to meet these needs. Many factors can influence outcomes, such as age, ethnicity, gender and health and income inequalities. In many cases, a combination of these can place individuals at risk of higher breakdown.

For example, older carers are more likely to be in a high-intensity caring role, with two-thirds providing more than 20 hours of care per week.

There are 69,681 households in Barking and Dagenham. Of these, 60% are families, with a further 27% being one-person households. 4 in 10 people aged 65 and over are living alone. This ranges from 31% of older people in River ward living alone, to 46% in Gascoigne ward.

Carers make up 8.7% of the total population in Barking and Dagenham, compared to 8.4% of the population in London and 10.2% across England[6]. Nearly 500 young people in the borough have been identified as having caring responsibilities for a sibling or parent. However, this is estimated to be under-representative of the true picture.

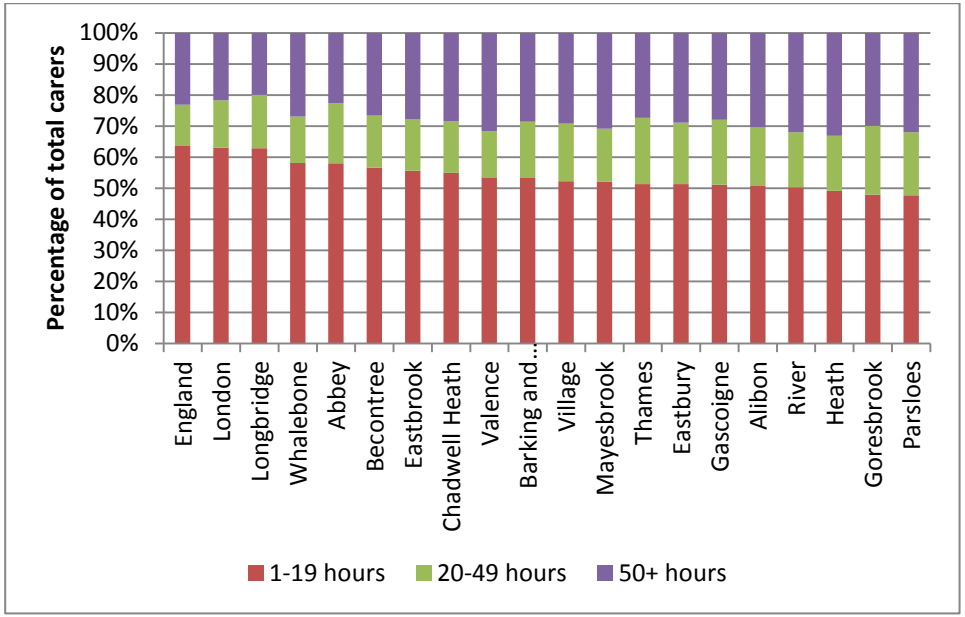


Intensity of care

The map on the left highlights the provision of unpaid care provided by Barking and Dagenham residents by area.

Parsloes ward has the highest proportion of carers in a high-intensity caring role, with 52% of carers providing more than 20 hours of care per week and 32% providing more than 50 hours of care per week.

The graph on the right shows the balance of hours of care provided per week by carers in each of the wards in Barking and Dagenham; London and England are also included for comparison purposes.



Hours of care provided per week by unpaid carers in Barking and Dagenham; Source: Census (2011)

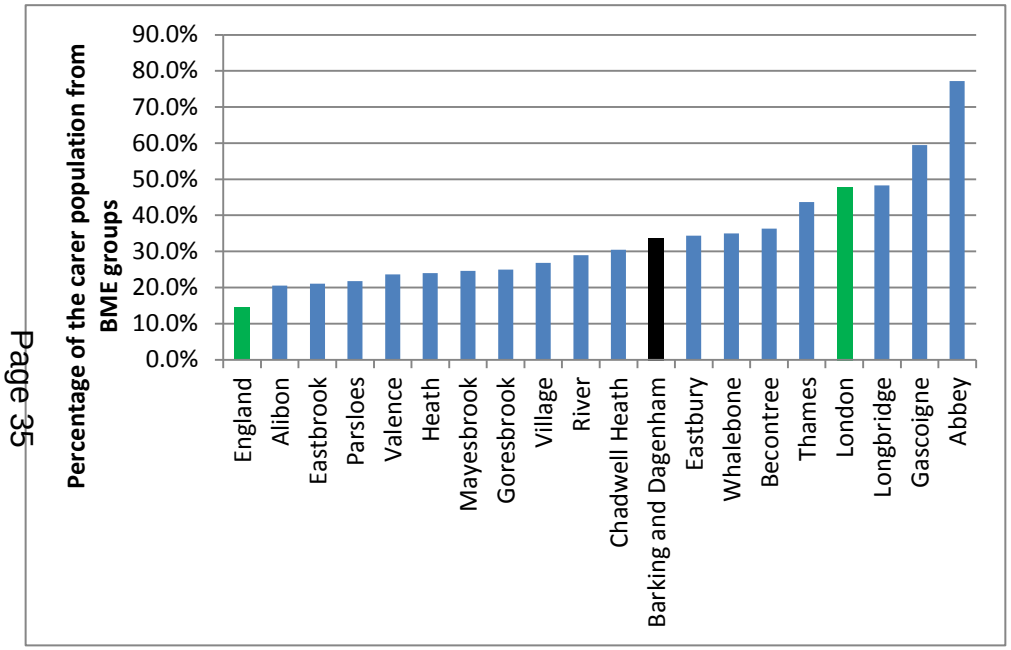
Ethnicity

Research[7] has shown that nationally, BME carers provide proportionately more high-intensity unpaid care than White British carers, putting them at greater risk of ill-health, isolation, loss of paid employment and social exclusion. There are also likely to be higher numbers of hidden carers in BME communities. This may be due to language and literacy barriers, stigma attached to certain conditions, cultural barriers that hinder access to services (e.g. notions of duty to care), or misconceptions about extended family support.

[6] Carers UK (2014), *Development of a Joint Carers' Strategy – Support to Family Carers: Evidence Report*

[7] Carers UK (2011), *Half a Million Voices: Improving Support for BAME Carers*

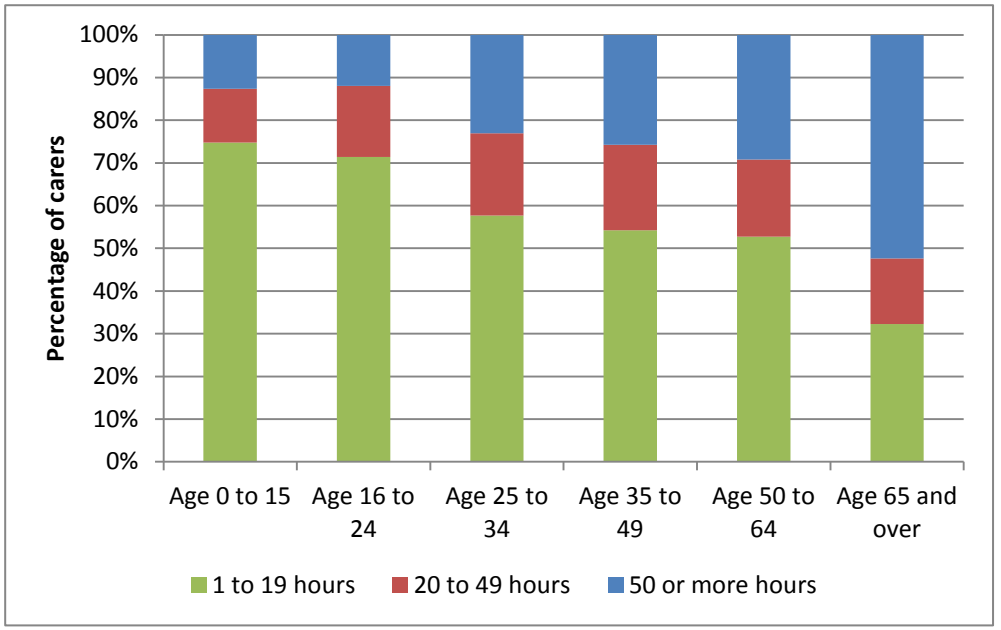
In Barking and Dagenham, 34% of the carer population who identified as such in the 2011 Census comes from BME groups. The graph below shows that this ranges from 20% of the carer population in Alibon ward to 77% of the carer population in Abbey ward. Across London, 47.8% of the carer population are from BME groups and across England, 14.4%.



Proportion of Barking and Dagenham carer population who are from BME groups; Source: Census (2011)

Age

The graph above, right, shows how the intensity of the caring role changes in Barking and Dagenham as carers get older. More than half of carers aged under 65 (57%) are providing 1 to 19 hours of care per week; for carers aged 65 and over, two thirds are providing 20 or more hours of care per week (67%).



Intensity of the caring role by age in Barking and Dagenham; Source: Census (2011)

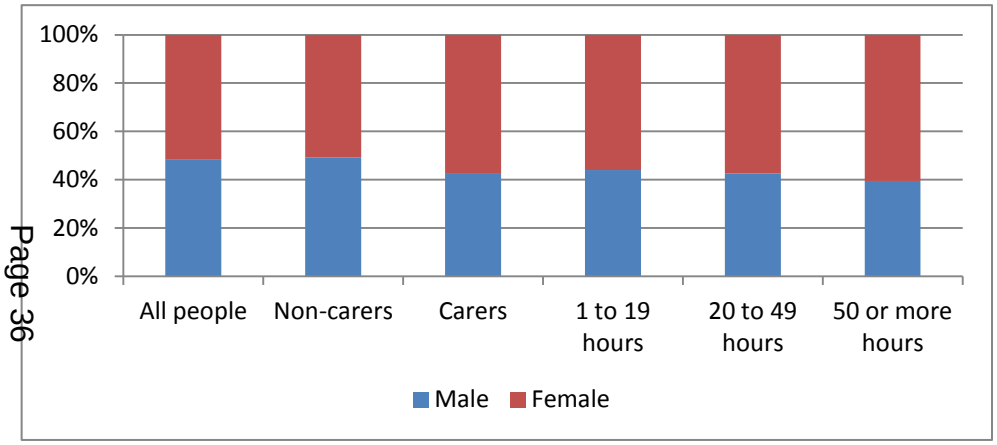
The 2011 Census identified 1,651 people aged 65 and over providing 20 or more hours of unpaid care per week in Barking and Dagenham, including 1,276 who are providing 50 or more hours. It is also often the case that as the cared-for person gets older and their level of support need gets higher, so the carer is in a similar age bracket and may develop their own greater need for support.

Gender

Caring is often viewed as a female role, but that perception is not borne out in the data. We also have evidence that male carers are generally less likely to seek support. The Census shows that more

than 4 in 10 carers in England and in Barking and Dagenham are male. The graph below shows the distribution of carers and non-carers in Barking and Dagenham by gender, breaking down the overall figures that 42% of carers are male and 57% are female.

6 in 10 carers who are providing unpaid care for more than 50 hours per week are female. This evens out for older carers; 50% of carers aged 65 and over and providing care for 50 or more hours per week are male.



Distribution of Barking and Dagenham population and carer population by gender; Source: Census (2011)

Education, employment and training

Nationally, nearly two thirds (65%) of carers in work have used annual leave to fulfil their caring responsibilities and nearly half (47%) have worked overtime to make up for taking time off to care. One in seven carers (15%) have taken a less qualified job or turned down promotion because of caring responsibilities.

In Barking and Dagenham, the proportion of carers aged 16 and over in full-time employment is 32%, lower than the 39% of non-carers in the same age group. Carers are more likely to be in part-time employment; 15% against 13% of non-carers.

758 residents in Barking and Dagenham provide unpaid care for more than 50 hours per week alongside being in full-time employment.

LGBT carers

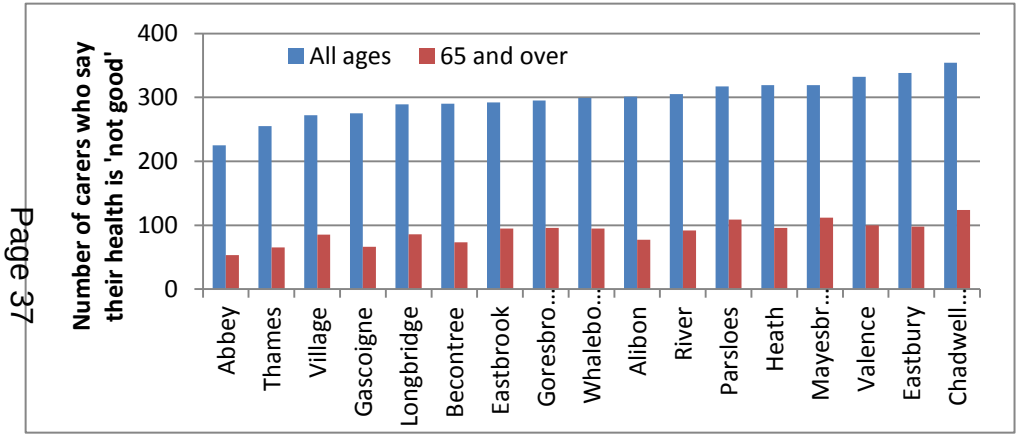
For lesbian, gay, bisexual or transgender (LGBT) carers, feelings of isolation or worry about services not being LGBT-friendly may lead to them staying hidden and not accessing support. There can also be issues with partners not being recognised, or discrimination from other family members, cultural or religious groups.

LGBT carers and people who require care may feel out of place in traditional support groups or be anxious about accessing services due to fears of homophobia or not having their specific needs met. Older LGBT people are more likely to be single, live alone and have less of a family support group. We have relatively little data about LGBT carers in Barking and Dagenham, further suggesting that they are likely to be 'hidden' carers.

Health

3 in 10 carers report being in poor health compared to 2 in 10 non-carers. Carers are more likely to suffer from high blood pressure, arthritis and long-term joint problems, and anxiety or depression. 61% of carers report a long-standing health condition compared to 46% of non-carers; this rises to 73% of carers who are providing over 50 hours of unpaid care per week.

More than 5,000 carers in Barking and Dagenham (including more than 1,500 aged 65 and over) declare their health to be 'not good'. This includes more than 1,400 carers (almost 500 aged 65 and over) who declare their health to be 'bad or very bad'. The graph below shows the numbers of carers and older carers in 'not good' health in each ward. This shows that those with the poorest self-reported health outcomes are resident in Chadwell Heath. Almost two-thirds of carers say that they are missing out on social contact or feel isolated, and almost 1,400 carers are missing out on over £4m Carers' Allowance.[8]



Number of carers who say their health is 'not good' by ward; Source: Census (2011)

Key messages from the demographic data analysis

The analysis of data has suggested the following key actions:

- to improve **identification of carers** – particularly those at higher risk of breakdown and in order to reduce numbers of 'hidden' carers; and carers at critical points in the care journey such as at hospital admission and discharge.
- to improve services for carers from **diverse groups**, particularly different **ethnic groups, cultural and religious groups**;
- to improve the availability of services at times that **people who are working ,or would like to return to employment,** can access them;
- to improve support for **carers to remain in work**;
- to improve **identification of health problems** and preventative screening and checks in carers;
- to consider what services might be needed for **male carers**;
- to consider what **geographic and condition specific-targeting** might be needed.

[8] All statistics from Carers UK (2014), *Development of a Joint Carers' Strategy Support to Family Carers, Evidence Report*

What carers can expect in future 7

This is our vision of how carers can expect to be supported in the future, starting with a proactive and comprehensive information and advice 'offer', with a more diverse range of support services available.

The values and aims that underpin this strategy

As we implement this strategy, we want some clear values to be evident to carers and cared-for people. They are:

- Carers will feel valued and respected for the massive contribution they make to the communities of Barking and Dagenham;
- Carers will feel that they are treated with dignity and respect by professionals, and as equal partners in care;
- Our staff will demonstrate the behaviours that make carers feel this way.

The *Think Local Act Personal* programme has tried to capture the essence of good health and social care services in a series of statements that express what service users would like to see, and begin "I…" We have adopted this principle for this Carers' Strategy, and will expect to see services developing to deliver the following experience for carers:

- I want friendly staff who understand my role as a carer and listen to me;
- I want to have the information I need, when I need it;
- I want the space to be someone other than a carer and to engage in activities in my community;
- I want to receive support in ways that help me to live my life whilst still caring for my loved-one;
- I want to know that there is help available if things go wrong and that I can access the support I need to get on with my life without worrying;
- If I receive a direct payment, I want a clear understanding about how to use the money well, and support to help me to make it work for me.

The world is increasingly 'digital', and we will seek to make good use of all the opportunities that this presents for getting timely information out to carers, and for supporting them to remain 'connected' to their communities. Community Checkpoints will be sites in various accessible locations which will allow people to get online and connected to sources of help and support. We need to ensure that these deliver for carers, alongside the more general information and advice offer.

Changing how we assess carers' needs

Currently, Carers of Barking and Dagenham undertake carers' assessments on behalf of the Council, as well as some assessment activity forming part of the professional social work assessment of the cared-for person, where they both agree that this is acceptable. This position was agreed by respondents to the consultation to be disjointed,

with difficulty in using and analysing the information about carers' needs, so that we are less able to plan for future carers' services.

The requirements of the Care Act, not least the new eligibility criteria and the requirement to ensure information and advice provision is clearly documented, mean that the decision has been taken to bring carers' assessments back into the Council. In future, assessments will be undertaken by social workers and recorded on the Council's social care information system so that they are more consistently documented, better able to inform individual support planning with carers, and better able to inform future carers' service development. .

The Care Act sets out clear eligibility criteria which will determine access to services, which can include a personal budget. Outside of this, there will be a strong emphasis on ensuring wider support for carer wellbeing, information and advice, so ineligibility for services as described in the Care Act will not mean that no support is provided. Under the Care Act, eligibility for services is determined by confirming that the carer's needs for support:

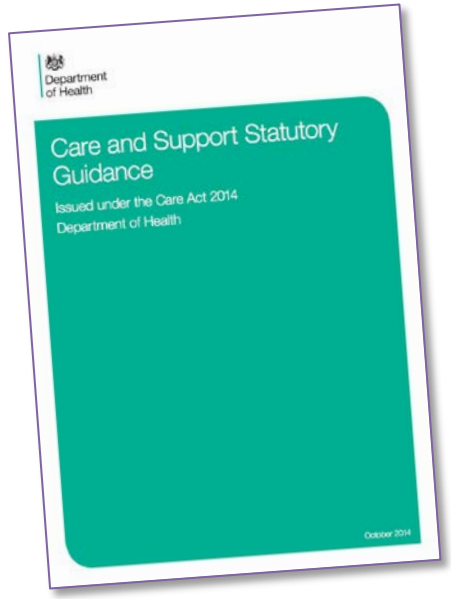
(1) arise as a result of providing necessary care;
(2) that the carer's mental or physical wellbeing is at risk of deteriorating and/or they are unable to achieve any particular list of 'outcomes'; and
(3) that as a consequence, there is likely to be a significant impact on their wellbeing.

You can find out more about the determination of eligibility in the Care Act statutory guidance, the details are at the end of this strategy. As part of delivering this strategy, we will be reviewing the published information on how carers' assessments work, so everyone can be clear on the new system.

Changing the way we commission services

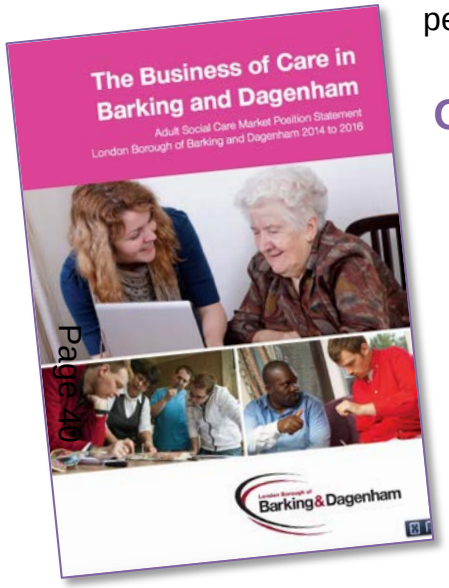
We took two clear messages out of the consultation with carers and frontline professionals. Firstly, that there needed to be greater diversity of support services provided to carers, not just across different 'care groups', but availability at different times of the day and tailored for different demographic groups. Secondly, that information and advice provision was disjointed and needed more focused planning.

We are therefore proposing to review the approach to commissioning carers' services, recognising that the starting point is good, comprehensive information and advice, and that this requires management across the range of statutory and voluntary sector providers of services. The contract we intend to develop for carers' services in future will focus heavily on the successful organisation being the first point of contact for carers, with strong and clear signposting and support to understand the system, as well as a key role in managing the information and advice offer across local partners so that it is consistent and clear. We want to harness the range of opportunities for communicating with and connecting carers that the modern, digital world presents, with social media and other options fully utilised.



In addition, personal budgets should increasingly mean that the block contracting of a central carers' agency gives way to a diverse market of services providing support, including short breaks, 'sitting' services,

personal assistants, as well as a more traditional offer based around support groups for those that continue to find that support valuable. Recognising the role of the expert-by-experience, however, we will be looking to stimulate more peer-led approaches to those groups, freeing up professionals to focus on more complex and tailored support. In addition, provision for young carers is to be distinct to ensure greater focus and clearer accountability around services for young people.



Our 'messages to the market'

In July 2015 we will refresh our Market Position Statement, and include a dedicated section describing the services we think need to be available to support local carers' needs. Starting with this strategy, we are seeking views on the information that we give to the providers of support to carers. These 'messages to the market' are intended to support the development of local care businesses as they look for opportunities to support carers in the future.

Currently, we think that the following is the basis of our message to providers of support to carers:

- All carers' support services should be designed to provide **maximum flexibility** so that they can fit in with the complex demands of caring and other responsibilities;
- We need more services to provide support to carers in the maintenance and **development of their careers**, alongside their caring responsibilities, with focused support to build skills and get into employment – and, in order to cater for **carers who currently work**, or who would seek to do so, there needs to be more evening and weekend provision;
- The **range of different care groups** provided with support options needs to be expanded, particularly (but not limited to) carers of those with mental health problems, whilst recognising the fact that there will always be a significant proportion of service provision which carers for older people, many of whom are in varying stages of dementia;
- **Information and advice provision** has to have regard to the wider borough offer, and be consistent and clear with innovative use of online communications - we would welcome working in partnership to refine the offer;
- As a particular subset of information advice, we need provision of good quality, **independent financial advice** to carers;
- More support for **young carers** reaching adulthood should be available, and any agency working with a young carer should be clear on the pathway to assessment of needs and provision of support for transition; support for young carers must focus on outcomes and move beyond respite, ensuring that young carers are enabled to reach their full potential;
- A clear message from carers was that more services are needed that **provide practical support**, such as short breaks or 'sitting' with the cared-for person for a period, which may be provided to the carer or through the care plan of the cared-for person;
- Services need to be able to **work positively in times of crisis**, planning with carers and strong communication will be required with others involved in the carer or cared-for person's care plan – in particular, good collaborative work with the Joint Assessment & Discharge Service, General Practice and the wider Integrated Care cluster teams will be important for those coming out of hospital or managing long-term conditions.

Our vision for support for carers, supported by seven outcomes

A carer-conscious community, working together to create innovative and sustainable support for carers, where carers are viewed as 'everybody's business' and feel valued.

1. **Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of their cared for;**
2. **Carers are provided with personalised, integrated support that is tailored to their assessed needs and aspirations, gives them choice and control and allows them to take a break and supports improved resilience;**
3. **Carers are involved and consulted in the care and support provided to their loved ones, treated with respect and dignity and have their skills and knowledge recognised;**
4. **Carers are supported to improve and maintain good physical and mental health and wellbeing;**
5. **Carers are supported to improve their individual social and economic wellbeing, reduce social isolation and fulfil their potential in life;**
6. **Carers are supported to cope with changes and emergencies and to plan for the future;**
7. **Carers are supported when their caring role is coming to an end and to have a life after caring.**

"I want friendly staff who understand my role as a carer and listen to me."

"I want the space to be someone other than a carer and to engage in activities in my community."

"I want to have the information I need, when I need it."

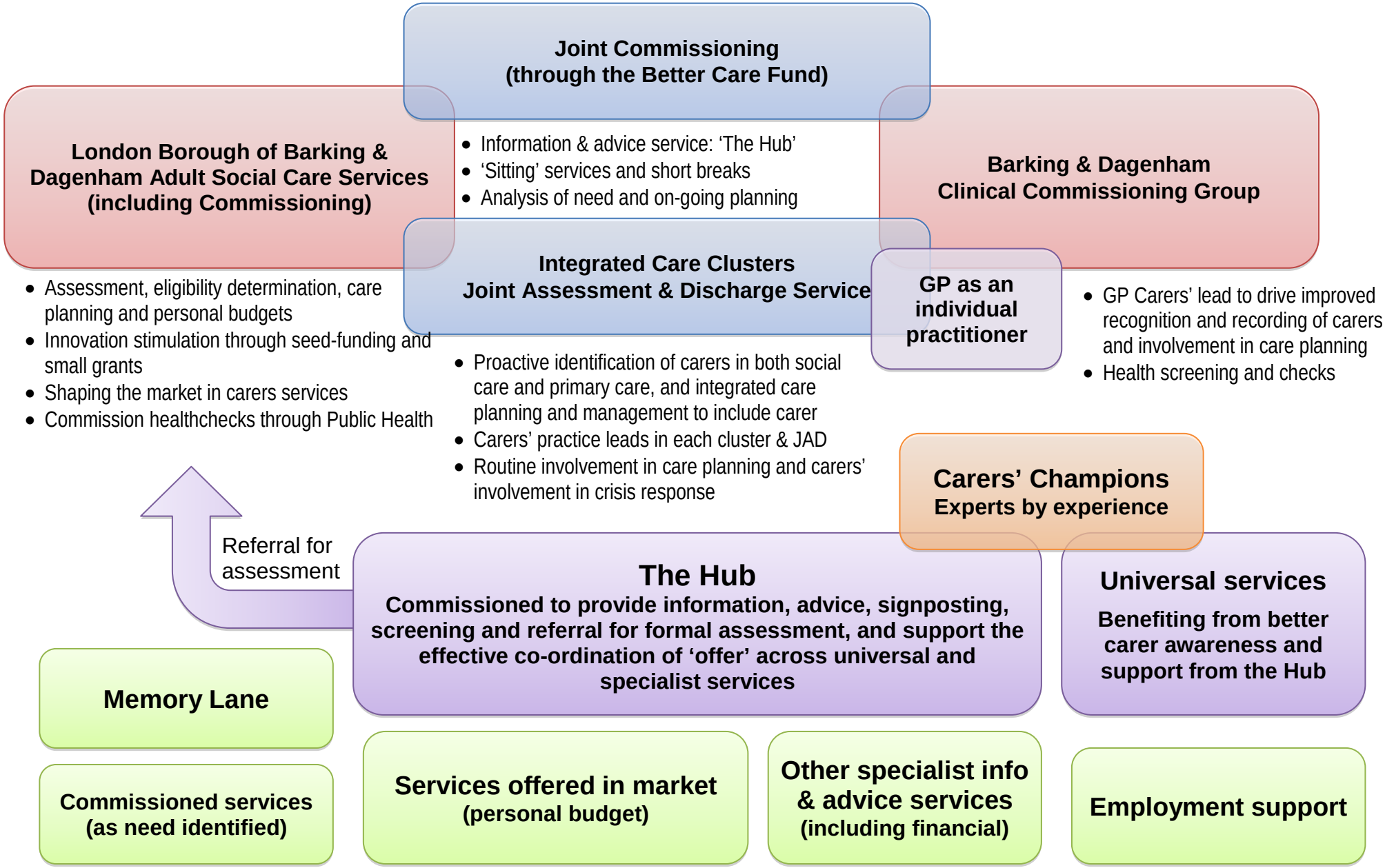
"I want to receive support in ways that help me to live my life whilst still caring for my loved-one."

"If I receive a direct payment, I want a clear understanding about how to use the money well, and support to help me to make it work for me."

"I want to know that there is help available if things go wrong and that I can access the support I need to get on with my life without worrying."

Overleaf, we set out how the overall 'system' for supporting carers will look as we develop the approach described in this strategy.

The action plan is set out in the next section, and describes what we will develop and by when, in order to see these aspirations delivered.

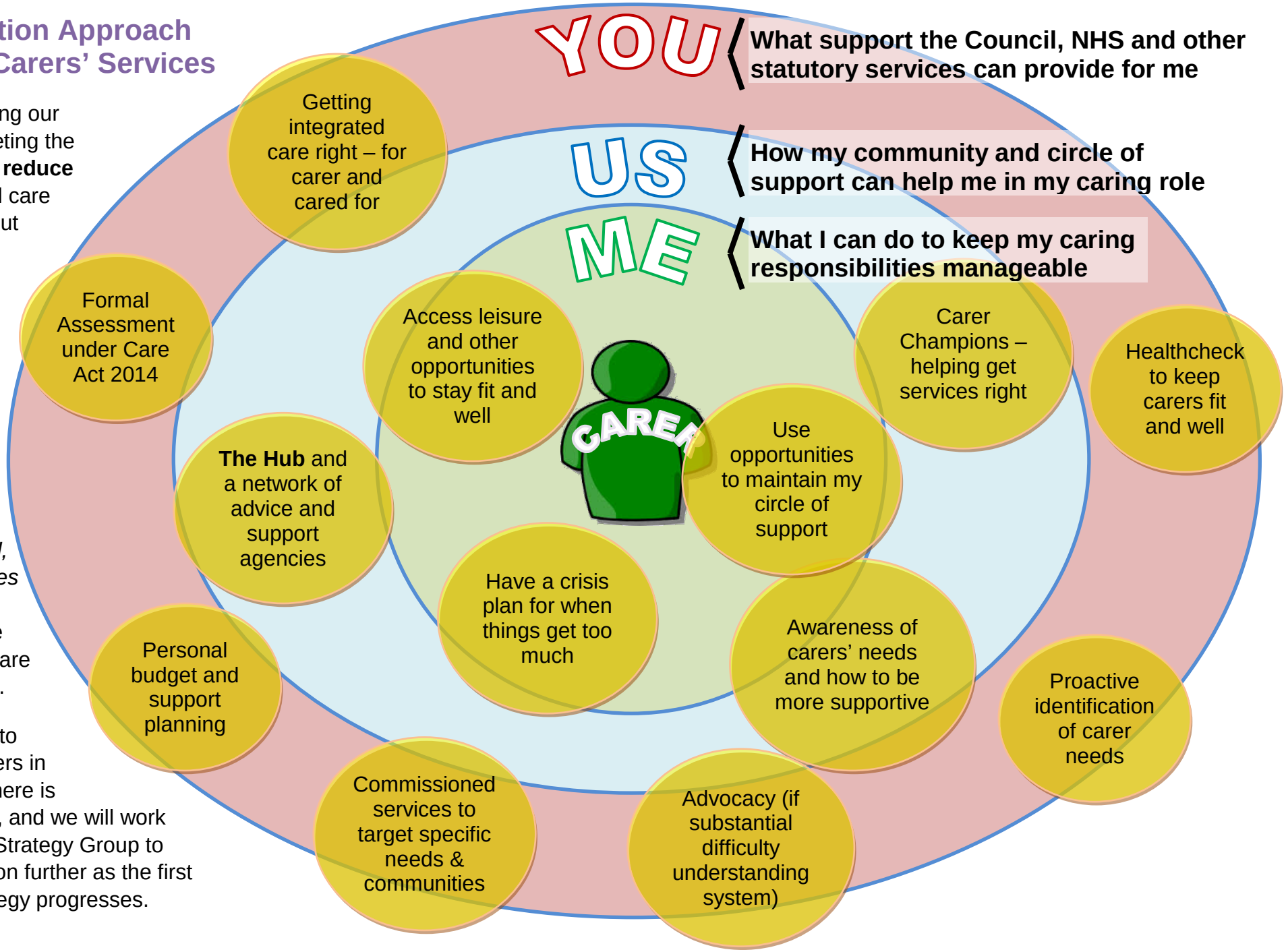


SERVICE MAP FROM APRIL 2016
And informing service development through 2015/16

Our Prevention Approach Applied to Carers' Services

We are developing our approach to meeting the duty to **prevent, reduce and delay** social care needs – as set out in the Care Act 2014. We are basing this on an approach that looks at *what people can do to support themselves, what they can do with their community*, and *what the Council, and other services can do for them* that prevents the need for social care becoming worse.

We have begun to apply this to carers in this diagram. There is more work to do, and we will work with the Carers Strategy Group to develop this vision further as the first year of the Strategy progresses.



How we will get there in 2015/16 8

We are setting out clear actions to improve services in line with the vision we have set out. In the 2015/16 action plan that follows we are focusing on getting the essentials of our model in place. We will review it as the year progresses to shape future years' activity.

The Care Act will bring unprecedented change to adult social care in the year ahead, and much of the first year is adapting to this change. Reforming our assessment systems, communicating the changes and ensuring that they 'bed in' effectively is crucial. In addition, we will focus on improving early identification of carers and their involvement in care planning, introducing carer champions and leads within organisations to push this work forward.

There are a number of links across the action plan that is set out below, around such issues as the development of the assessment system, workforce development and information and advice provision. We will continue to refine the actions set out to ensure that they capture the priorities that we have to deliver. The first action of the Carers' Strategy Group will be to review and strengthen this plan, and they will lead its implementation working together with the Health & Wellbeing Board subgroups and the Joint Executive Management Committee for the Better Care Fund.

Developments for the longer term

The first year's actions, set out over the next few pages, describe the priorities for 2015/16. Delivery of this plan will see address many of the areas for development identified through our work with CarersUK. During 2015/16 the Carers Strategy Group will be charged with considering the actions that will be necessary in 2016/17 and 2017/18 to continue to improve services and to deliver the longer-term aspirations we set out in the strategy and that have been scoped for us by CarersUK. In doing so, they will support further decisions taken by the Joint Executive Management Group for the Better Care Fund, and the Health & Wellbeing Board itself.

1

Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of their cared for

Activity	Milestones	Dates	Lead agency/officer
Develop more focused information and advice offer to support carers	Publish information on assessment, eligibility, services available, personal budgets, through Care & Support Hub	April 2015	LBBD GM Integration & Commissioning
	Refresh Care & Support Hub to have clearer 'one-stop' carers' information	May 2015	
	Scope information available through Community Checkpoints/Community Hubs and develop options	June 2015	
Commission new 'Hub' to provide focal point for revised information and advice offer	Extend current contract, agree development plan with current contractor	April 2015	LBBD GM Integration & Commissioning
	Agree specification of new service, and consult where relevant; current 'Hub' begins to take on these functions	July 2015	
	Initiate tender process	Sept 2015	
	New service operational	April 2016	
Public promotion campaign of the importance of recognising carers in all walks of life, and where to signpost	Campaign planned	May 2015	LBBD GM Integration & Commissioning with Public health and CCG
	Campaign launch/run time	July-Dec 2015	
Identify CCG Clinical Director lead on carers to work with practices	Clinical Director identified for role, and define scope and role	April 2015	CCG Chief Operating Officer
Implement mechanisms to promote visibility of carers' issues through General Practice	Agreed through CCG Governing Body	April 2015	CCG Chief Operating Officer, GPs
	Communicated to practices and partners	May 2015	
Promote early identification in general practice (other activities to be identified CCG Clinical Director lead, e.g. double appointment slots, prompts in proactive care incentive scheme)	Confirmed set of improvement priorities agreed by Clinical Director lead	May 2015	CCG Chief Operating Officer, GP clinical lead and identified Carers'Champions
	Protected Time Initiative: development	June 2015	
	Campaign materials for GP surgeries	July 2015	

2

Carers are provided with personalised, integrated support that is tailored to their assessed needs and aspirations, gives them choice and control and allows them to take a break

Activity	Milestones	Dates	Lead agency/officer
Revised arrangements for carers' assessments in place	Develop and publish care pathway for assessment to staff, third sector with Carers referral protocol	April 2015	LBBD DD Adult Social Care
	Complete IT systems redesign to ensure recording is established	May 2015	
	Develop and publish referral materials for info and advice providers	May 2015	
	Training/workforce development	April-June 2015	
Activities to develop the market in support for carers, including diverse carer groups, widened access and different models of support	Consultation activity to develop carers section of revised Market Position Statement	June-July 2015	LBBD GM Integration & Commissioning
	MPS revision published	Sept 2015	
	Develop innovation grant programme and invite bids, based on emerging gaps in provision	Sept 2015	
Specific service commissioning initially carers' breaks and respite	Make available personalised breaks through Direct Payments; simplify information and access	May 2015	LBBD GM Integration & Commissioning
	Review access to respite to follow up on issues identified in consultation process	July 2015	
Develop commissioning plans for a more diverse carer base looking for opportunities to integrate improved carer support as part of the contracting of all commissioned services	Review of need as new systems develop; joint commissioning intentions agreed through BCF Joint Executive Management Group (JEMG)	Oct 2015	LBBD GM Integration & Commissioning CCG Chief Operating Officer

3

Carers are involved and consulted in the care and support provided to their loved ones, treated with respect and dignity and have their skills and knowledge recognised

Activity	Milestones	Dates	Lead agency/officer
New assessment and eligibility systems for service users promote involvement of their carer and are recording such involvement *(linked to new carers' assessment systems, referred to above)*	New assessment and eligibility training underway, including carer assessment Complete IT developments in order that recording system supports improved practice	April 2015 May 2015	LBBD DD Adult Social Care
Develop 'Carers Champions' programme and ensure influence on commissioning and service development	Scheme scoped and links to commissioning systems agreed Invitation to participate issued Appoint Carers Champions Initial meeting to 'kick off' programme and shape work programme	June 2015 July 2015 Sept 2015 Oct 2015	LBBD GM Integration & Commissioning with CCG Chief Operating Officer
Develop arrangements across services commissioned by CCG to support carers identification and review needs – for example through integrated case management meetings and networked links across borough where carer not at same practice as cared for	Review detail of current position and system blocks Proposals for change agreed (JEMC) New systems in place	July 2015 Sept 2015 Jan 16	CCG Chief Operating Officer
Workforce development programme to include working with carers as part of on-going delivery *(will provide an opportunity for a number of the issues raised throughout this action plan to be addressed)*	On-going programme beyond the Care Act implementation – scoped based on early months of Care Act Roll out across health and social care workforce	Aug 2015 Sept 2015 on	LBBD GM Integration & Commissioning CCG Chief Operatiing Officer and Clinical Director lead *[link to Health Education North Central London]*

4

Carers are supported to improve and maintain good physical and mental health and wellbeing

Activity	Milestones	Dates	Lead agency/officer
Improve take up and provision of preventative health checks and screening through revision to the health offer and active promotion	Public Health to review current uptake and contracting of healthchecks for this group Promotional campaign developed and launched with support from Carers of Barking & Dagenham Targeted work with particular practices where uptake needs to be improved	May 2015 June 2015 Sept 2015	LBBD Public Health CCG Chief Operating Officer, Clinical Director lead
IAPT referral pathway for carers experiencing mental health problems	Mental Health subgroup to review uptake of IAPT by carers and develop actions to address any shortfall	Sept 2015	Chair, Mental Health Subgroup of HWBB
Promotion of Big White Wall resources (or similar as London-wide retender goes ahead) to carers	Develop information offer in partnership with Carers of Barking & Dagenham Publish, targeting groups at most risk	June 2015 July 2015	LBBD Public Health
Promotion of Mental Health First Aid training to organisations working with carers	Plan specific courses for carer organisations, publicise and deliver	July 2015	LBBD Community Safety & Integrated Offender Management

5

Carers are supported to improve their individual social and economic wellbeing, reduce isolation and fulfil their potential in life

Activity	Milestones	Dates	Lead agency/officer
Clear information and advice on employment support options, and links to JobCentre Plus	*Linked to information and advice review, set out in priority 1.*	*As above*	LBBD GM Integration & Commissioning LBBD GM Employment & Skills JobCentre Plus
Develop improved range of employment support options, and work with local major employers to improve workplace support	Task and finish group to review options for improvement in services To include review of steps to paid employment through the provision of 'Carers' Champions'	May 2015	LBBD GM Employment & Skills JobCentre Plus
Monitor assessments received by carers of working age to ensure they take account of right to work, training (including vocational) and education	First review undertaken by service managers	Sept 2015	LBBD GM Integrated Care LBBD GM Integration & Commissioning

6

Carers are supported to cope with changes and emergencies and to plan for the future

Activity	Milestones	Dates	Lead agency/officer
Maintain shared information on carers 'at risk'	Develop approach to risk assessment, plan risk mitigation and agree approach through Integrated Care Subgroup, scope information governance and ensure 'fit' to integrated care management 'cluster' arrangements	Oct 2015	LBBD GM Integration & Commissioning CCG Chief Operating Officer
Widen options for carer support in crisis	Review service availability and priorities	July 2015	LBBD GM Integration & Commissioning CCG Chief Operating Officer
	Develop commissioning intentions including the development of an Emergency Planning Scheme with existing out-of-hours and emergency providers	Sept 2015	
	Revised commissioning steps finalised through governance	Dec 2015	
	Implement	Jan 2016	

7

Carers are supported when their caring role is coming to an end and to have a life after caring

Activity	Milestones	Dates	Lead agency/officer
Through development of more focused 'peer support' offer, provide opportunity to maintain engagement in social care system	Convene group to develop proposals, including LBBD, Carers of B&D Develop proposals and plan for delivering, including commissioning intentions if necessary	June 2015 Sept 2015	LBBD GM Integration & Commissioning
Develop volunteer opportunities	Volunteer programme to be established for those moving on from a caring role – scope involvement of 'Hub' service and existing volunteer support arrangements	June 2015	LBBD GM Integration & Commissioning
Develop materials to support the transition into residential care	Materials agreed and published	Nov 2015	LBBD GM Integration & Commissioning, working with Carers' Champions

How we will know we have had an impact 9

The measures that we will use to track our progress and to understand whether our strategy is improving the experience of carers in the borough.

We will use three types of information to track our progress. One will be to ensure that we have done the things that we set out to do, described in the plan, as well as our commitments to convene, enhance and run the Carers' Strategy Group. We will also keep our investment in carers' services under review to ensure that BCF commitments have been delivered.

We will also ensure that we have regular contact with carers and hear from them how the support and services that they receive are helping them. Drawing on the 'I' statements in Section 7, in particular we will:

- Ensure that we keep track of information and advice being requested, so that we can be sure that we have the right information available to people;
- Review care plans to understand the choices being made and to ensure that services are in place in sufficient quantity to meet those needs;
- Use our 'spot check' system (in the Commissioning team) to ensure that we ask carers about their experience of services, drawing on the 'I' statements that we set out earlier;
- Use surveys and our engagement with peer support groups periodically to hear direct about the experience of carers.

We will also use data that we gather along the way. In particular, we will look to measure:

- Information and advice 'hits' on the Care & Support Hub;
- Information and advice, signposting and support throughput in the services that are commissioned to provide this support;
- Carers' assessments undertaken;
- Support plans agreed with carers;
- Data on the diversity of carers and of the provision that they access to get their support;
- Carers identified through general practice and other universal services;
- Numbers of health checks undertaken for carers;
- Numbers of carers accessing the mental health support that we have identified as available;
- Number of carers identified as such on GP surgery lists
- Number of carer and ex-carer volunteers engaging with our volunteering programmes;
- Numbers of carers identified as 'at risk' and, despite complexities, some assessment of admissions to hospital and residential care that have been avoided through support to carers.

How we will oversee this work 10

Working together has developed this strategy, and will underpin the approach we take to improving it and seeing it delivered in 2015/16 and beyond.

The Health & Wellbeing Board is primarily responsible for promoting the health and wellbeing of residents, and promoting integration amongst local health, health-related and social care services. It is ultimately responsible for the delivery of the commitments in this strategy.

It is supported by five subgroups, working on Children & Maternity Services, Integrated Care, Mental Health, Learning Disability and Public Health Programmes. They will all be expected to contribute to the delivery of this strategy and its on-going development through shaping the understanding of needs and putting in place plans to deliver the needs of the respective care groups for which they are responsible.

The Better Care Fund is 'overseen' by the Integrated Care subgroup, but at a more detailed operational level, both finance and performance are managed by the Joint Executive Management Group. They will be responsible for ensuring that the commitments are delivered and that the resources are made available from within the overall 'pot' that was agreed in the BCF submission to NHS England.

Finally, we will ensure that the Carers' Strategy Group is refreshed, strengthened and becomes the place where this strategy is taken forward in practice. Their deliberations will shape the future of carers' services, providing the source of advice for these other groups, and ultimately the Health & Wellbeing Board, to act upon.

How you can tell us what you think 11

The publication of this strategy is not the end of the process. It needs to be delivered and, as the work rolls out, there will be opportunity to further develop our understanding of what is needed.

It's important we hear from as many people as possible when planning work of this nature. If you have views that you would like to contribute to the future development of carer services, please contact us.

You can email us at adultcommissioning@lbbd.gov.uk

You can write to us at

Carers' Strategy
Integration & Commissioning
Adult & Community Services
Barking Town Hall
1 Town Square
Barking
Essex IG11 7LU

There will be a number of public events, as well as provider and service user forums, during the first year of the strategy – keep an eye out for details and come and talk to us there.

Produced by the Adult & Community Services Directorate of
the London Borough of Barking & Dagenham, following consultation

March 2015

www.careandsupport.lbbd.gov.uk

HEALTH AND WELLBEING BOARD

17 March 2015

Title: Arrangements for advocacy provision in 2015/16 and future years	
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Louise Hider, Health and Social Care Integration Manager	**Contact Details:** Tel: 020 8227 2861 Email: louise.hider@lbbd.gov.uk

Sponsor:
Anne Bristow, Corporate Director of Adult and Community Services

Summary:

Local authorities are required to involve people in decisions made about them and their care and support. The Care Act states that an independent advocate must be appointed to support and represent a person for the purpose of assisting their involvement in the care and support process where a person has substantial difficulty in being involved and that they have no appropriate individual to support them. The Care Act is clear that local authorities have a duty to ensure that there is sufficient provision of independent advocacy to meet their obligations under the Care Act and that it will be unlawful not to provide someone who meets the criteria with an advocate.

The Council already commissions a generic advocacy framework which provides an advocacy service that is independent from the Council and provides issue-based one-to-one advocacy support during a major life change or decision. This report sets out that the current advocacy service will be extended for one year and brought up to 'Care Act compliance' from 1 April 2015. This will enable the Council to achieve an interim position to comply with the requirements of the Care Act over the next 12 months, whilst allowing redesign of services, further consultation and discussions to ensure a longer term approach which will meet local need as required and ensure full Care Act compliance.

Recommendation(s)

Members of the Board are recommended to:

- Discuss and comment upon the report attached.
- Receive a report at the November Health and Wellbeing Board meeting which will

provide an overview of the use of individual advocacy covering the first six months of the extended service, and sets out the options for a revised service approach from 1 April 2016.

Reason(s)

The Care Act is clear that local authorities have a duty to ensure that there is sufficient provision of independent advocacy to meet their obligations under the Care Act. In order to meet the requirements, the current advocacy service will be extended for one year and brought up to 'Care Act compliance' from 1 April 2015.

The Council has committed to the vision of 'One borough; one community; London's growth opportunity' and advocacy services deliver this vision and in particular, the priority of 'enabling social responsibility'. Independent advocacy supports individuals to be meaningfully involved throughout the care and support process, enabling individuals to direct their care and support and have choice and control.

1. Introduction

1.1 The Health and Wellbeing Board has received a number of reports over the last 18 months regarding the Care Act 2014 and the significant changes from 1 April 2015.

1.2 At the heart of the Care Act are the concepts of wellbeing and prevention. All actions taken by local authorities under the Act will be driven by their duty to consider the impact of care needs on an individual's wellbeing, as well as its duty to prevent, reduce and delay needs arising and consequently having an impact on wellbeing.

1.3 Consequentially, local authorities will need to focus on people's strengths, aspirations and connections with the local community and ensure that they are meaningfully involved throughout the care and support process.

1.4 Some people have substantial difficulty in understanding the care and support process and may not have anyone appropriate to support them. In these cases, the Care Act requires the local authority to arrange independent advocacy to ensure the service user's involvement in their care and support process. This includes assessment, care and support planning, reviews, as well as any safeguarding concerns or investigations.

1.5 Barking and Dagenham has a long history of supporting individuals to exercise choice and control over their care and support, particularly through the use of personal budgets. The Borough has an established advocacy service in place to support people's involvement in the social care process who would otherwise have difficulty in participating and directing the process. This report sets out the requirements of the Care Act in relation to independent advocacy, the Borough's current service and the developments that will be required to ensure the service is Care Act compliant. This represents a timely and important opportunity to set out plans for redesigning our advocacy provision from 1 April 2016.

2. Requirements of the Care Act 2014

2.1 Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions. An independent advocate can help someone to do this.

2.2 The Care Act is clear that all local authorities must ensure that there is sufficient provision of independent advocacy to meet their obligations under the Care Act. There should be sufficient independent advocates available for all people who qualify, and it will be unlawful not to provide someone who qualifies with an advocate (paragraph 7.59 of the statutory guidance).

When will the requirement for individual advocacy apply?

2.3 Individual advocacy must be considered from the very first point of contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding adult review.

2.4 The criteria for the provision of independent advocacy is if the individual has substantial difficulty in:

- Understanding relevant information
- Retaining information
- Using or weighing the information as part of engaging
- Communicating their views, wishes and feelings.

2.5 An individual advocate will need to be provided if there is no other appropriate individual available to support and represent the person's wishes and their involvement in the care and support process. It should be noted that an individual advocate cannot be paid or professionally engaged in providing care or treatment to the person or their carer.

2.6 The Care Act sets out the key areas of activity for which an independent advocate could be used, namely:

- a needs assessment
- a carer's assessment
- the preparation of a care and support or support plan
- a review of a care and support or support plan
- a child's needs assessment
- a child's carer's assessment
- a young carer's assessment

- a safeguarding enquiry
- a safeguarding adult review
- an appeal against a local authority decision under Part 1 of the Care Act (subject to further consultation as this will come into effect from 1 April 2016).

2.7 However advocacy is provided the authority will retain responsibility for determining whether independent advocacy is appropriate.

Continuing Health Care

2.8 Board Members are asked to note that the advocacy duty in the Care Act applies equally to those people whose needs are being jointly assessed by the NHS and the local authority, or where a package of support is planned, commissioned or funded by both a local authority and a clinical commissioning group (CCG), known as a 'joint package' of care.

Advocacy under the Mental Health Act and Mental Capacity Act

2.9 Where someone already requires an Independent Mental Capacity Advocate (IMCA) or an Independent Mental Health Advocate (IMHA) the same advocate may be used in the context of providing individual advocacy.

Requirements of independent advocates

2.10 The Care Act sets out the qualities, experience and training that should be held by an independent advocate and by advocacy organisations. These are in two main areas:

- **Independence** - providers of advocacy must be independent of the local authority, with their own constitution, code of practice and complaints procedure. Advocates under the Care Act should be managed by, and primarily accountable to, the advocacy organisation that recruits and employs them, thereby maintaining their independence from the local authority.
- **Training** - Once appointed, all independent advocates under the Act should work towards the National Qualification in Independent Advocacy (City & Guilds, level 3) within a year of being appointed, or achieve it in a reasonable amount of time thereafter.

3. Current contractual arrangements for advocacy

3.1 The Council currently commissions a generic advocacy framework which provides an advocacy service that is independent from the Council and provides issue-based one-to-one advocacy support during a major life change or decision.

3.2 The contract is currently delivered through a framework of three advocacy providers (VoiceAbility, DABD and Royal Mencap), with a Gateway Service provider (Independent Living Agency) managing the access and referrals into the service.

3.3 The current contract has a budget allocation of up to £40,000 (split between the three advocacy providers) plus £5,000 per annum for the gateway keeper. The contract is due to expire on 31st March 2015 but has an option to extend.

3.4 Alongside this 'generic' advocacy services, the Council also commissions an Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA) and advocacy for those undergoing the Deprivation of Liberty Safeguards (DoLS) process. This is provided by Voiceability and the contract ends on 31 March 2016. The Council also contributes to a Pan-London NHS complaints service provided by Voiceability. This is commissioned on behalf of London boroughs by the London Borough of Hounslow and the contract will end on 31 March 2016.

3.5 As the IMCA, IMHA and DoLS contract expires in March 2016, this will allow us to have the opportunity to remodel all of the advocacy contracts at once.

4. Care Act compliance

4.1 Inevitably it is difficult to predict the demand for individual advocacy under the Care Act. On the one hand, there are clear, well-publicised expectations about when statutory advocacy can be required. On the other, the guidance is specific about the points in the social care assessment, care planning and safeguarding system when the statutory advocacy arrangements should be called upon. It is proposed, therefore, that a measured approach is taken to ensure that the Council is Care Act compliant for 1 April 2015, allowing full opportunity to consult, develop and redesign services from 1 April 2016. To do this, we propose to:

- Take up the extension option in the current contracts for one year until 31 March 2016. This ensures continuity of service while allowing development;
- Increase the budget available to fund advocacy 'called off' under those contracts; and
- Institute a careful monitoring approach for the first six months to understand how these services are accessed, and the emerging demand.

4.2 The extension of the current (non-statutory) advocacy framework will run until 31 March 2016. As part of this, the Council will vary the contracts to ensure that they are compliant with the requirements of the Care Act as set out in Section 2 above. Discussions have been held with all advocacy providers and the Gateway service about the requirements of the Care Act and documentation is currently being finalised with the providers and Legal Services.

4.3 To ensure Care Act compliance, a number of system and workforce changes are required by both the advocacy providers and the Council's own social care teams. These are set out in more detail below.

Prioritisation of independent advocacy

4.4 We will be issuing draft interim practice guidance to front line staff to ensure Care Act compliance in the use of individual advocacy.

4.5 A significant change around independent advocacy under the Care Act will be that the determination of eligibility for advocacy will be undertaken by local authority social care staff. The Gateway will provide the process for allocating, tracking and monitoring functions for the advocacy contract.

Training

4.6 It is clear that the advocacy duties place training requirements on social care teams and the advocacy provider workforce. In terms of social care, teams are attending a number of training sessions on the Care Act and a specific development session will be held with staff on advocacy, in which the advocacy duty and the referrals system will be clearly worked through. Additionally, providers will be expected to promote their services with social care staff and other organisations and do this regularly throughout the next financial year.

4.7 Independent advocates are required to work towards the National Qualification in Independent Advocacy (City & Guilds, level 3) within a year of being appointed, or achieve it in a reasonable amount of time thereafter. Each of the providers have already taken their staff through basic Care Act training, but as part of the extended contract, providers will be expected to provide the Council with a training plan for each of their members of staff by May, detailing when they will be completing the City & Guilds training. This will be monitored at regular contract monitoring meetings thereafter to ensure that enrolments for training are made and adhered to.

4.8 There is currently no local training centre for the City & Guilds training, however there are a number of training providers who will travel to independent advocacy organisations to conduct the training with them. Local organisations, including our colleges, do not currently offer the advocacy training. However, the Council has written to the local colleges asking them about their intention to run future advocacy courses and whether they intend to become an accredited City & Guilds training centre.

4.9 In addition, other providers of advocacy, notably IMCA/IMHA and DoLS advocacy services will be expected to work towards the independent advocacy training requirements. This is particularly important as it is stated within the Care Act that the same advocate can provide support as an advocate under the Care Act and under the Mental Capacity/Mental Health Act.

Monitoring of numbers of referrals

4.10 Although it is difficult to model the future demand for advocacy under the Care Act, the Department of Health estimates that by 2017/18 as many as 150,000 people every year will receive advocacy support to help them make decisions about their care and support. Some initial work undertaken at a national level by VoiceAbility, an advocacy organisation, has indicated that the estimated cost of ensuring that the advocacy duty is met nationally will rise from £14m in 2015/16 to £67m in 2018/19, a 378% increase.

4.11 It has is proposed that the Council will put additional funding into the advocacy contract, both for the Gateway service and the advocacy providers, in order to meet the expected increase. An increase of £6,700 will be given to the Gateway provider for more support hours to co-ordinate the referral and allocation system. A maximum of £55,000 will be budgeted across the three providers to meet additional

advocacy referrals on top of the £40,000 already available. Potential funding for these proposals is set out in the financial implications below.

4.12 The Council will be regularly monitoring the referrals and contract volumes and will ask the providers to submit regular monitoring information from May to monitor numbers, the budget and ensure that the 'system' is robust and working well. Regular feedback will also be sought from social care teams to see whether improvements to the service can be made.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment

The Advocacy Report responds to the JSNA, with more detailed work to follow to ensure recommendations in the refreshed JSNA are mapped into commissioning plans.

5.2 Health and Wellbeing Strategy

The commitments set out in the Health & Wellbeing Strategy are consistent with the report as to the future development of social care services: towards more integrated delivery and greater personalisation. The refresh of the Strategy will complement the reports broad thrust for the future of social care.

5.3 Integration

We will ensure that we liaise with our partners over the coming months in our discussions and consultation on the redesign of advocacy services from 1 April 2016. This will be particularly important as the IMCA, IMHA and DoLS contract expires in March 2016 and health colleagues, particularly North East London NHS Foundation Trust, will have views on the ways in which advocacy services will be developed in the future.

5.4 Financial Implications

Implications completed by: Roger Hampson, Group Manager Finance (Adult and Community Services)

The current budget for advocacy services is £45,000 including £5,000 for the gateway keeper. It is proposed to increase these resources by £61,700 in 2015/16 on a temporary basis in order to provide time to prepare longer term proposals.

There are a number of areas as a result of the implementation of the Care Act where additional resources are needed. These are currently being evaluated in order to prepare proposals for the Health and Wellbeing Board to consider on how these are to be funded within the limited resources available. In the first instance, it is the intention to use the New Burdens Grant in 2015/16 of £773k to fund additional advocacy services as the need for these services is likely to be on-going. If this is not possible, a request will be made for a further call on the departmental reserve (on top of the £500k previously agreed for Care Act implementation costs).

5.5 Legal Implications

Implications completed by: Dawn Pelle, Adult Care Lawyer

There are no legal implications for the following reasons:

- Duties around independent advocacy under the Care Act 2014 have been recognised.

6. Public Background Papers Used in the Preparation of the Report:

None

7. List of Appendices:

None

HEALTH AND WELLBEING BOARD

17 March 2015

Title:	**Information and Advice Plan for Adult Social Care and Support**
Report of the Corporate Director of Adult and Community Services	
Open Report Yes	**For Decision**
Wards Affected: All	**Key Decision: Yes**
Report Authors: Mark Tyson, Head of Integration and Commissioning; Karen West- Whylie Group Manager - Learning Disabilities, Adult and Community Services	**Contact Details:** Tel: 020 8227 2875 E-mail: mark.tyson@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services	

Summary:
The purpose of this report is to brief the Health and Wellbeing Board the development of a local Information and Advice Plan. The plan sets out proposals for Barking and Dagenham's strategic approach to meeting the requirements of the Care Act 2014 in relation to providing information and advice locally. The plan covers council provided and commissioned information and advice services, and other national and local sources of information and advice. The proposed vision is: ***Delivering high quality[1], impartial information and advice supporting health and wellbeing***

The proposed priorities are:

- there is a **comprehensive range information and advice about care and support** available locally
- Ensure all digital and face to face information and advice is **accurate, up to date, easy to understand, and consistent with other sources of information**
- Offer **tailored information and advice about care and support (in a variety of formats) whenever possible** to help individuals understand their range of options
- Work with key information and advice providers from all sectors to improve the **co-ordination of information and advice locally**
- Develop and promote the **Care and Support Hub** as the borough's web based local directory
- **Transform information and advice provision** in line with the council's 'digital by design' approach to ensure quick, efficient and localised signposting

In developing this plan we:

- Analysed which residents are most likely to need information and advice about their care and support
- Undertook an initial mapping of local information and advice and evaluated it against the requirements and recommendations of the Care Act
- Collected the views of service users, providers, partners and staff
- Adopted the *Think Local Act Personal* principles for delivering information and

[1] By quality information and advice we mean it should be: accurate, valid, reliable, timely, relevant and complete.

advice services

An action plan for 2015-16 showing the key activities to deliver these priorities is included as Appendix 4. As a living document the action plan will evolve during the year and a new action plan for 2016-18 will be developed.

Recommendation(s)

The Health and Wellbeing Board is asked to comment on the draft Plan and in particular on the proposed priorities.

Reason(s)

The provision of high quality reliable information and advice to residents will help the council deliver its vision of '*One borough; one community; London's growth opportunity'* and key priority of:

Enabling social responsibility*, which* aims to *'support residents to take responsibility for themselves, their homes and their community'* and *'protect the most vulnerable, keeping adults and children healthy and safe*'.

The council is committed to delivering more public services online and making online options easier and more accessible for residents to use, recognising the need for reasonable adjustments under the Equality Act 2010. This is based on the belief that to be sustainable in the long term, digital self-service options need to be the first point of call for residents accessing public services. The council's Digital by Design programme will develop means to switch users from face-to-face contact and encourage uptake of online services. This approach will be integral to delivering information and advice in line with the Care Act.

1 Introduction and Background

1.1 From April 2015 the Care Act places a statutory duty on councils to provide information and advice to the whole population that is both accessible and proportionate. Providing accurate and timely information and advice is '*fundamental to enabling people, carers and families to take control of, and make well-informed choices about their care and support and how they fund it…. It is also vital in preventing or delaying people's need for care and support*.'

1.2 The aim of the Care Act is to enable people to understand how the care and support system works, what services are available locally, and how to access those services including those aimed at preventing need and improving wellbeing. The Act provides for a universal information and advice service, which is available to all people who request it, and not just limited to those people with assessed care and support needs and their carers.

1.3 The Care Act requires local authorities to adopt a 'co-production' approach to their information and advice provision, involving individuals, user groups and, appropriate statutory, commercial and voluntary sector service providers.

2 Proposal and Issues

2.1 The Health and Wellbeing Board is asked comment on the draft Plan.

2.2 Work is under way to:

- Develop a service offer/charter
- Develop information and advice around finance in more detail
- Further refine the mapping of current information and advice provision

2.3 The Plan will continue to be updated and refined in the light of the above work and with feedback from the Board.

2.4 As a living document the action plan will evolve during the year and a new action plan for 2016-18 will be developed.

3 Consultation

3.1 Views from the consultation undertaken with the voluntary sector information and advice providers' forum (18 February), the Care providers' forum (19 February) and service users (2 March) have been fed into the draft plan and accompanying action plan.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

While there is a duty under the Care Act to signpost to general information and advice, local evidence shows that there is higher demand than the rest of London on local adult social care services and a corresponding need for information and advice (see Appendix 3). The key factors are listed below.

- Barking and Dagenham scores highly against the deprivation index making the borough one of the most deprived in London.
- There is a large number of people under 65 living with long term conditions needing care and support.
- In the next 20 years the number of older people 85+ is likely to grow increasing the need to enable this group to plan for their care and support.
- There is a large number of people under 65 living with long term conditions needing care and support.
- There is a high proportion of young people with learning disabilities whose transition needs must be planned for.
- The ethnic mix of local residents is significantly changing becoming more diverse, some of whom may need information and advice in languages other than English.
- From 2016 the council will need to raise awareness of what the cap on care means for self-funders.

4.2 Health and Wellbeing Strategy

The provision of information and advice as set out in this plan will play a key role in contributing to improving health and well being locally. The Care Act states that if a person is provided with care and support or support as a carer by the local authority, 'the authority must provide them with information and advice about what can be done to prevent, delay, or reduce their needs as part of their care and support plan or support plan.'

The term 'prevent' covers many different types of support, services, facilities or other resources, ranging from wide-scale whole-population support aimed at promoting health, to more targeted, individual interventions aimed at improving someone's skills, health and wellbeing or reducing the impact of caring on a carer's health and wellbeing.

This approach will contribute to the delivery of the joint Health and Wellbeing Strategy outcomes of:

- Increasing the life expectancy of people living in Barking and Dagenham
- Closing the gap between the life expectancy in Barking and Dagenham with the London average
- Improving health and social care outcomes through integrated services

To ensure that quality information and advice is available locally it is suggested that a link to this plan is made in the refreshed Health and Wellbeing strategy.

4.3 Integration

The Care Act promotes integration, co-operation and partnership working. Whilst this is not new, the Act aims to clarify expectations and boundaries and enshrine the principle of joint working in statute. It recognises that this way of working can improve service user/patient experience, eliminate duplication, streamline care pathways, promote prevention and earlier intervention and improve safeguarding.

The Act recognises that the council does not have to provide all the information and advice needed, locally a wide range of people and organisations such as the NHS, voluntary and community organisations as well as private providers are involved in the provision of information and advice locally. Some are paid and others are volunteers who work together to provide a coherent offer.

4.4 Financial Implications

Financial implications completed by: Roger Hampson Group Manager Finance (Adults and Community Services)

The report presents a draft Information and Advice Plan, and the resource implications have yet to be finalised in a number of areas. However an indicative figure for the resources required is around £100k on top of any existing revenue budgets that can be applied.

There are a number of areas as a result of the implementation of the Care Act where additional resources are needed. These are currently being evaluated in order to prepare proposals for the Health and Wellbeing Board to consider on how these are to be funded within the limited resources available. In the first instance, it is the intention to use the New Burdens Grant in 2015/16 of £773k to fund additional information and advice services as the need for these services is likely to be on-going. If this is not possible, a request will be made for a further call on the departmental reserve (on top of the £500k previously agreed for Care Act implementation costs).

4.5 Legal Implications

Legal implications completed by: Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services.

There are no legal implications for the following reason: the authority's duties as set out in the Care Act 2014 and associated guidance are clearly recognised and incorporated into the report and appendices.

4.6 Risk Management

An action plan for 2015-16 showing the key activities to deliver these priorities is included as Appendix 4. As a living document it will evolve during the year and a new action plan for 2016-18 will be developed. It will be monitored through additional questions to the annual adult social care user survey as well as through the regular contract monitoring of services commissioned by the council. The priorities will be monitored by the council's Information and Advice workstream and reported to Care Act Programme Board.

4.7 Patient/Service User Impact

An equality impact assessment is being carried out; no negative impact has been identified as the plan will ensure the provision of a comprehensive range information and advice about care and support, tailored to suit individuals needs. This will have a positive impact on all those with characteristics protected under the Equality Act 2010.

5 Non-mandatory Implications

5.1 Safeguarding

This plan includes activities to help the council implement the Care Act in relation the provision of information and advice about safeguarding issues. Specifically local authorities have a duty to provide information and advice on how to raise concerns about the safety or wellbeing of an adult who has needs for care and support. They must also support public knowledge and awareness of different types of abuse and neglect, how to keep yourself physically, sexually, financially and emotionally safe, and how to support people to keep safe. Council's must also provide information and advice provided covering who to tell when there are concerns about abuse or neglect and what will happen when such concerns are raised, including information on how the local Safeguarding Board works.

Public Background Papers Used in the Preparation of the Report:
None

List of Appendices:

Appendix 1: Draft Information and Advice Plan

Appendix 2: Information and advice must dos

Appendix 3: Demographic facts and social care need

Appendix 4: Draft Information and Advice Action Plan

DRAFT

Information and Advice Plan

2015-18

Contents

Document details	Information and Advice Plan 2015-18	
Author(s)	Eve Pelekanos, Helena Pugh, Liz Marnham	
Lead officer	Mark Tyson, Group Manager Integration and Commissioning, Adult and Community Services Karen West-Whylie, Group Manager - Learning Disabilities	
Version history		
Version	**Change/reasons for change**	**Date**
Draft v1	To include comments from: • Corporate Director • Information and Advice workstream	 25/2/15 4/3/15
Approval history		
Version	**Approving body**	**Date**

Executive summary

The plan sets out Barking and Dagenham's strategic approach to meeting the requirements of the Care Act 2014 in relation to providing information and advice locally. It recognises that the need for accurate and timely information and advice is applicable to all residents aged 18 and over. This covers those needing care and support, unpaid carers including young carers, and people planning future care and their families, regardless of their ability to pay for care and support.

The plan covers all council provided and commissioned information and advice services, and other national and local sources of information and advice.

In developing this plan we:

- Analysed which residents are most likely to need information and advice about their care and support
- Undertook an initial mapping of local information and advice and evaluated it against the requirements and recommendations of the Care Act
- Collected the views of service users, providers, partners and staff
- Consult service users to help develop and monitor the plan
- Adopted the Think Local Act Personal principles for delivering information and advice services

Proposed vision

Delivering high quality[1], impartial information and advice supporting health and wellbeing

Proposed priorities

- Ensure there is a **comprehensive range of information and advice about care and support** available locally
- Ensure all digital and face to face information and advice is **accurate, up to date, easy to understand, and consistent with other sources of information**
- Offer **tailored information and advice about care and support (in a variety of formats) whenever possible** to help individuals understand their range of options
- Work with key information and advice providers from all sectors to improve the **co-ordination of information and advice locally**
- Develop and promote the **Care and Support Hub** as the borough's web based local directory
- **Transform information and advice provision** in line with the council's 'digital by design' approach to ensure quick, efficient and localised signposting

An action plan for 2015-16 showing the key activities to deliver these priorities is included as Appendix 3. As a living document the action plan will evolve during the year and a new action plan for 2016-18 will be developed.

[1] By quality information and advice we mean it should be: accurate, valid, reliable, timely, relevant and complete.

1. Introduction

From April 2015 the Care Act places a statutory duty on councils to provide information and advice (for details see section 1.1) to the whole population that is both accessible and proportionate.

Providing accurate and timely information and advice is '*fundamental to enabling people, carers and families to take control of, and make well-informed choices about their care and support and how they fund it…. It is also vital in preventing or delaying people's need for care and support*.'

1.1 The Care Act 2014

The aim of the Care Act is to enable people to understand how the care and support system works, what services are available locally, and how to access those services including those aimed at preventing need and improving wellbeing.

The Act provides for a universal information and advice service, which is available to all people who request it, and not just limited to those people with assessed care and support needs and their carers.

Specifically the Act requires local authorities to:

'*empower people to be involved in decisions about their care by providing information and advice, and access to independent advice to support their choices*'.

Section 4 of the Act sets out the areas where local authorities must provide information and advice, specifically:

- What types of care and support are available e.g. specialised dementia care, befriending services, reablement personal assistance, residential care
- The range of care and support services available to local people, i.e. what local providers offer certain types of services
- What processes local people need to use to get the care and support that is available
- Where local people can find independent financial advice about care and support and help them to access it
- How people can raise concerns about the safety or wellbeing of someone who has care and support needs

1.2 What local authorities must do to provide information and advice

The Care Act requires local authorities to adopt a 'co-production' approach to their information and advice provision, involving individuals, user groups and, appropriate statutory, commercial and voluntary sector service providers.

The guidance states that there should be a plan covering the areas listed below (full details are shown in Appendix 1).

- Duty to establish and maintain a service
- Audiences for the information and advice service
- Access to and quality of information and advice
- What should be provided – information and advice content
- When information should be provided
- Accessibility of information and advice
- Proportionality of information and advice
- Financial information and advice
- Understanding care charges
- Money management
- Making informed financial decisions
- Facilitating access to independent financial information and advice
- Information and advice on adult safeguarding

1.3 Links with borough wide priorities

The provision of high quality reliable information and advice to residents will help the council deliver its vision of '*One borough; one community; London's growth opportunity'* and key priority of:

> ***Enabling social responsibility*** which aims to *'support residents to take responsibility for themselves, their homes and their community'* and *'protect the most vulnerable, keeping adults and children healthy and safe*'.

The council is committed to delivering more public services online and making online options easier and more accessible for residents to use, recognising the need for reasonable adjustments under the Equality Act 2010. This is based on the belief that to be sustainable in the long term, digital self-service options need to be the first point of call for residents accessing public services. The council's *Digital by Design* programme will develop means to switch users from face-to-face contact and encourage uptake of online services. This approach will be integral to delivering information and advice in line with the Care Act.

1.4 Definitions of information and advice

The council has adopted the Care Act 2014 guidance description of information which includes self help information, assisted information, advice and, specialist advice and advocacy[2]. This plan focuses on information and advice and uses the Care Act definitions below.

'Information' means *the communication of knowledge and facts regarding care and support.* This can either be passively available or actively distributed.

'**Advice**' means *helping a person to identify choices and/or providing an opinion or recommendation regarding a course of action in relation to care and support*.

[2] This plan does not cover advocacy services which are currently delivered through Voiceability, CAB, DABD and Royal Mencap.

1.5 Purpose of this plan

This plan sets out Barking and Dagenham's strategic approach to meeting the requirements of the Care Act in relation to information and advice described above. The plan:

- Reviews the information and advice needs of residents and where they currently access care and support information and advice
- Identifies improvements needed
- Sets out the principles and priorities for the provision of information and advice
- Provides the basis for a service specification for future services
- Incorporates an action plan

1.6 Scope of this plan

The document covers local care and support information and advice services aimed at all residents aged 18 and over, unpaid carers including young carers, people planning their future care and their families, regardless of their ability to pay for care and support.

1.7 How this plan was developed

This plan was developed by:

- mapping the range of existing information and advice services, including independent financial advice providers
- working with key stakeholders to understand how their needs can best be met. Workshops were held with service users, statutory and voluntary sector providers and their views fed into this plan
- discussing it with key statutory bodies with an interest in care and support, e.g. Health and Wellbeing Board members including the Clinical Commissioning Group and Healthwatch

2. Who is likely to need information and advice?

While there is a duty to signpost residents to general information and advice, local evidence shows that there is higher demand than the rest of London on local adult social care services and a corresponding need for information and advice about care and support services (see Appendix 2).

The key factors are listed below:

- Barking and Dagenham scores highly against the deprivation index making the borough one of the most deprived in London.
- There is a large number of people under 65 living with long term conditions needing care and support.
- In the next 20 years the number of older people 85+ is likely to grow increasing the need to enable this group to plan for their care and support.
- There is a high proportion of young adults with learning disabilities whose transition needs must be planned for.
- The ethnic mix of local residents is significantly changing becoming more diverse, some of whom may need information and advice in languages other than English. The top ten languages other than English are subject to constant change.
- From 2016 the council will need to raise awareness of what the cap on care means for self-funders.

3. The current position locally

3.1 Current information and advice provision

A wide range of people and organisations are involved in the provision of information and advice locally. Some are paid and others are volunteers. Local people get information and advice in many ways.

Information and advice is available online on the council's website and on the Care and Support Hub for adults, which includes information about care and support options, provides details of personal assistants and information about activities to keep people active and improve their wellbeing. Children and young people and their families can access information on the council's website through the Local Offer.

National websites such as NHS Choices, Age UK, Money Advice (MA) and the BBC provide web links to quality information and advice.

Face to face information and advice is available through the one stop shops, the libraries, leisure centres, council contact centres, GPs as well as from local voluntary and community organisations. In addition, social workers and other care and support staff provide information and advice on care and support services. The council's Intake and Access Team provides information and advice over the telephone, by email and, from time to time, face to face.

Information and advice services commissioned by the council are shown below.

Provider	Information and Advice provided
Barking & Dagenham CAB	CAB Barking office, Heathway Centre in Dagenham) and children's centres deliver generic advice to 5,000 residents
	Hate Crime reporting and case work
	Targeted debt advice service to families
DABD UK	Enhanced Welfare Rights advice delivering to 1,000 residents (sub-contractual arrangement from Barking & Dagenham CAB)
Carers of Barking and Dagenham	A targeted benefits and welfare advice to portage families (families of children with disabilities aged under 3)
	Parents in partnership (PIP) service - independent advice to children with statements
SEN- Pre-school learning alliance	Inclusion advice service for nurseries, advice to practitioners and settings about children

3.2 Mapping local information and advice provision

An initial mapping of local information and advice provision against the requirements and recommendations of the Care Act was undertaken. It shows:

- There are a variety of organisations providing information across most of the areas identified in the Act.
- No single organisation provides the full range of information advice.
- Some providers have client group specific services, whilst others do not.
- Information is available online, through leaflets and face to face from both universal and targeted services.
- The Care and Support Hub is the most comprehensive source.
- Generally the area in most need of development is independent financial advice on matters relating to care and support.

A detailed mapping of local information and advice provision is underway and will be used to inform future service developments.

4. Key findings and implications

The key findings from the mapping and stakeholders' views show that:

i) The Care and Support Hub fulfils many of the information and advice requirements set out in the Care Act including safeguarding, advocacy and the Mental Capacity Act. However, further development of it is needed to make it the definitive source of information for service users, residents, partners and council staff and to enable it to support self-service and possibly self-assessment.

Development areas include:

- Financial advice i.e. capping, self-funders, independent financial advisers, access to befriending services
- Additional information about sheltered, supported and extra care housing
- Accessible information on how to raise safeguarding concerns
- Information on getting power of attorney, the court of protection, and becoming a deputy[3]
- Information on transition from children's to adult services and employment support for disabled adults
- More links to the information on Health and Wellbeing on the main website e.g. Culture and Leisure sections to the Care and Support Hub
- Information in a standardised format and ability to print directly from the Care and Support Hub

ii) The council and partner organisations need to be aware of the information and advice each provide. A system needs to be put in place through which partners' information is signposted, linked and kept up to update.

iii) Alongside digital provision, that there will be requests for face to face information and advice giving. Within the council, the Intake and Access Team and other services such as Libraries and Housing currently fulfil this role along with third sector providers such as CAB, DABD UK, Carers of Barking and Dagenham and others. It is important that these services provide accurate and relevant information and advice derived from one source.

iv) As there are many providers of local information and advice, it is crucial that this is quality assured and accessible.

[3] Deputies manage the personal welfare or the property and affairs of another person, who lacks the mental capacity to manage them themselves.

5. Ensuring good quality local information and advice

5.1 Vision and aim

Our **proposed vision** is:

Delivering high quality, impartial information and advice supporting health and wellbeing

The **aim** of our approach is '*to ensure that people who need help get the right help at the right time in a style that suits their needs*'.

Service users need to be able to access information and advice at crucial points in their care pathway. As part our approach to prevention we need to provide residents with information and advice to prevent, reduce and delay any care and support needs.

Key to this is ensuring that people get the 'right' information and advice at the 'right time'.

5.2 The future of Information and Advice locally

Information and advice will continue be available online as set out in section 3.1 above. The council is developing the Care and Support Hub as the borough's local directory alongside its Community Network Strategy which builds on the 'digital by design' approach providing local access points where it is intended that residents can find a wide range of information. The community network should include:

Community hubs: using buildings where the community comes together to deliver localised services and advice, with the support of the council. Each developing hub will be responsible for meeting the specific needs of their local geographical area and promoting community self-help. Services may include: a children's centre, library, sports facilities, job centre plus, benefits and housing advice. As part of this strategy options may include:

Community checkpoints: linked through community hubs, so that all residents are within walking distance (one mile) of community support. A checkpoint is any building or organisation that is willing to help local people to access information and services.

Community champions – at least one in each checkpoint – helping local people to access digital information and guidance from the checkpoint. Champions will be able to help meet the needs of different communities by signposting to relevant services.

CommunityConnect which aims to provide relevant and accurate signposting to appropriate services including benefits, local agencies and other support organisations.

Care and Support staff will continue to provide tailored information and advice as part of the assessment and review process.

5.3 Financial advice

A key requirement of the Care Act 2014 is that each council must make sure that people are able to access financial information and advice which help them to plan and pay for their care.

To do this the council will ensure that its staff can actively describe the general benefits of getting independent financial information and advice and will direct people to sources of information and advice with appropriate expertise to deal with complex cases and issues such as debt, benefits, employment and housing.

Sources of independent financial information and advice will be signposted on the Care and Support Hub. Web links to approved national websites and regulated advisors will be listed.

5.4 Ensuring quality standards

As part of our approach to quality assurance, the Care and Support Hub will include information about the standard each individual information and advice provider meets. It is proposed that each provider listing will include reference to the following classifications:

- Care Quality Commission rating
- East London Solutions quality mark
- Subject to London Borough of Barking and Dagenham contract monitoring
- Council service
- Not rated

5.5 Principles

In developing our plan and any new information and advice service, Barking and Dagenham will apply the following principles[4] taken from the *Think Local, Act Personal (TLAP)*[5] programme.

Principles

- Involve people who use services and carers in determining what is needed and how it is provided
- Be available at the right time for people who need it, in a range of formats and through a range of channels
- Meet the needs of all groups
- Be clear, comprehensive and impartial
- Be consistent, accurate and up-to-date
- Meet quality standards
- Be based on a detailed analysis of the needs of the local population served by the council
- Be commissioned in tandem with advice, support and advocacy services.
- Avoid reinventing the wheel
- Signpost people to sources of further information
- Be used to inform future planning

[4] http://www.thinklocalactpersonal.org.uk/_library/AIPrincipalsFINAL.pdf

[5] TLAP is a national partnership transforming health and care through personalisation and community-based support and is working to help councils prepare for the introduction of the Care Act.

5.6 Priorities

Following an analysis of local need and a review of current information and advice provision the local priorities below have been identified.

Proposed priorities

- Ensure there is a **comprehensive range of information and advice about care and support** available locally
- Ensure all digital and face to face information and advice is **accurate, up to date, easy to understand, and consistent with other sources of information**
- Offer **tailored information and advice about care and support (in a variety of formats) whenever possible** to help individuals understand their range of options
- Work with key information and advice providers from all sectors to improve the **co-ordination of information and advice locally**
- Develop and promote the **Care and Support Hub** as the borough's web based local directory
- **Transform information and advice provision** in line with the council's 'digital by design' approach to ensure quick, efficient and localised signposting

An action plan for 2015-16 showing the key activities to deliver these priorities is included as Appendix 3. As a living document the action plan will evolve during the year and a new action plan for 2016-18 will be developed.

6. Monitoring the plan

The Care Act says that:
"Information and advice should only be judged as clear if it is understood and able to be acted upon by the individual receiving it."

This information and advice plan covers the period 2015-18. It will be monitored through additional questions to the annual adult social care user survey. Information will be collected as part of regular contract monitoring of services commissioned by the council.

Appendices

Appendix 1: Information and advice must dos
Appendix 2: Demographic facts and social care need
Appendix 3: Information and advice action plan 2015-2018

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Appendix 1: Information and Advice must dos

#	Category	Duty	Paragraph #
1.	Core duty	Local authorities **must**: "establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers".	3.2
2.	Core duty	The local authority has an active and critical role in the provision of information and advice and **must** take an active role.	3.3
3.	Range of information	The local authority **must** ensure that information and advice services established cover more than just basic information about care and support and cover the wide range of care and support related areas set out in paragraph 3.22 below.	3.5
4.	Identifying people who may benefit from financial information and advice	Local authorities **must** also have regard to identifying people that contact them who may benefit from financial information and advice independent of the local authority and actively facilitate those people to access to it (see paragraph 3.49)	3.6
5.	Involving the person Providing advocacy	Separately to the duty to establish and maintain an information and advice service, local authorities **must** provide independent advocacy to facilitate the person's involvement in the care and support assessment, planning and review processes where an individual would experience substantial difficulty in understanding, retaining or using information given, or in communicating their views, wishes or feelings and where there is nobody else appropriate (see chapter 7).	3.6
6.	Core duty	Local authorities **must** establish and maintain a service for providing people in their areas with information and advice relating to care and support for adults and support for carers.	3.11
7.	Universal provision	The information and advice service **must** cover the needs of all its population, not just those who are in receipt of local authority funded care or support.	3.11
8.	Role of LA as provider	It is important to recognise that while local authorities **must** establish and maintain a service, the duty does not require they provide all elements of this service.	3.14
9.	Tailoring offer	In providing information and advice, local authorities **must** recognise and respond	3.17

#	Category	Duty	Paragraph #
		to the specific requirements that carers have for both general and personal information and advice.	
10.	Accessibility	The local authority **must** ensure that there is an accessible information and advice service that meets the needs of its population. Information and advice **must** be open to everyone who would benefit from it.	3.18
11.	Timeliness	All reasonable efforts should be taken to ensure that information and advice provided meets the individual's requirements, is comprehensive and is given at an early stage. Local authorities **must** seek to ensure that all relevant information is available to people for them to make the best informed decision in their particular circumstances, and omission or the withholding of information would be at odds with the duty as set out in the Act	3.21
12.	What should be provided – information and advice content	In discharging this duty, local authorities **must** ensure that information and advice is provided on: • the care and support system locally –about how the system works. An outline of what the 'process' may entail and the judgements that may need to be made. Including specific information on what the assessment process, eligibility, and review stage is, • how to complain or make a formal appeal to the authority, what they involve and when independent advocacy should be provided and be widely available. This also includes wider information and advice to support individual wellbeing (see paragraph 3.25); the charging arrangements for care and support costs (utilising current and developing national resources (see paragraphs 3.66-3.67); how a person might plan for their future care and support needs and how to pay for them, including provision for the possibility that they may not have capacity to make decisions for themselves in the future; • how to access the care and support available locally – where, how and with whom to make contact, including information on how and where to request an assessment of needs, a review or to complain or appeal against a decision; • the choice of types of care and support, and the choice of care providers available in the local authority's area – including prevention and reablement services and wider services that support wellbeing. Where possible this should include the likely costs to the person of the care and support services	3.23

#	Category	Duty	Paragraph #
		available to them. This should also include information on different types of service or support that allow people personal control over their care and support for example, details of Independent Service Funds, and direct payments (see chapter 4 on market shaping and commissioning); • how to access independent financial advice on matters relating to care and support – about the extent of their personal responsibilities to pay for care and support, their rights to statutory financial and other support, locally and nationally, so that they understand what care and support they are entitled to from the local authority or other statutory providers. Including what information and advice people may wish to consider when making financial decisions about care so that they can make best use of their financial resources and are able to plan for their personal costs of care whether immediately or in the future. (See paragraphs 3.34-3.45.); • how to raise concerns about the safety or wellbeing of an adult with care and support needs (and also consider how to do the same for a carer with support needs) (see paragraphs 3.49-3.50).	
13.	Range of info and advice	The breadth of the circumstances under which information and advice **must** be provided, and the overall duty to promote individual wellbeing, means that local authorities **must** ensure that the subject matters covered by their information and advice available to people in their areas go much further than a narrow definition of care and support and cover all those subject matters listed in paragraph 3.22 above.	3.24
14.	Working in partnership	Local authorities, working with their partners **must** use the wider opportunities to provide targeted information and advice at key points in people's contact with the care and support, health and other local services.	3.26
15.	Client groups	Local authorities **must** ensure that their information and advice service has due regard to the needs of these people. These include, but are not limited to: • people with sensory impairments, such as visual impairment, deafblind and hearing impaired; • people who do not have English as a first language; • people who are socially isolated; • people whose disabilities limit their physical mobility; • people with learning disabilities; • people with mental health problems.	3.30

#	Category	Duty	Paragraph #
16.	Formats/channels	In providing an information and advice service, local authorities **must** be providing more than just leaflets and web-based materials. The focus should be on enabling people to access what they need through a tailored range of services that assists people to navigate all points and aspects of their journey through care and support.	3.35
17.	Financial info and advice	The service that local authorities are required to establish and maintain **must** include financial information and advice on matters relevant to care and support.	3.38
18.	Signposting to independent financial advice.	However, where it would not be appropriate for a local authority to provide it directly, the local authority **must** ensure that people are helped to understand how to access independent financial advice.	3.38
19.	Identifying those who would benefit from financial info and advice.	The local authority **must** have regard to the importance of identifying those who may benefit from financial advice or information as early as possible.	3.39
20.	Understanding of charging arrangements	The local authority **must** provide information to help people understand what they may have to pay, when and why and how it relates to people's individual circumstances. This **must** include the charging framework for care and support, how contributions are calculated (from both assets and income) and the means tested support available; top-ups (see chapter 8 on charging); and how care and support choices may affect costs.	3.43
21.	Ways to pay	The local authority **must** provide people with information on the availability of different ways to pay for care including through income and assets (e.g. pension or housing wealth), a deferred payment agreement (see chapter 9 on deferred payment agreements), a financial product or a combination of these things.	3.44
22.	Supporting financial decision-making	The local authority **must** support people to make informed, affordable and sustainable financial decisions about their care throughout all stages of their life. In many situations the role of the local authority will be to understand the circumstances of the person, understand their preferences and help them to access the tailored information and advice that they need to make well-informed decisions. Where a person lacks capacity, the authority **must** establish whether a person has a deputy of the Court of Protection or a person with Lasting Power of Attorney acting on their behalf.	3.46

#	Category	Duty	Paragraph #
23.	Ways to pay	The local authority **must** offer to consider a person's specific circumstances and provide them with information about the methods of paying for their care and support that may be available to them.	3.47
24.	Safeguarding	The local authority **must** provide information and advice on how to raise concerns about the safety or wellbeing of an adult who has needs for care and support and should support public knowledge and awareness of different types of abuse and neglect, how to keep yourself physically, sexually, financially and emotionally safe, and how to support people to keep safe. The information and advice provided **must** also cover who to tell when there are concerns about abuse or neglect and what will happen when such concerns are raised, including information on how the local Safeguarding Board works.	3.53
25.	Complaints	The local authority **must** make its own arrangements for dealing with complaints in accordance with the 2009 regulations. As an essential part of how the whole system operates, under the 2009 Regulations the local authority's arrangements **must** ensure that those who make complaints receive, as far as reasonably practicable, assistance to enable them to understand the complaints procedure or advice on where to obtain such assistance.	3.54
26.	Integration and co-operation	The local authority **must** exercise its functions under the Care Act, including the duty to provide an information and advice service, with a view to integrating care and support provision with health and health-related issues (including housing). It **must** also co-operate more generally with each of its relevant partners taking account of their respective functions (see chapter 15). The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012), provides that local authorities are under a duty to work with their local CCGs, and other partners through the Health and Wellbeing Board to undertake Joint Strategic Needs Assessments for their areas and to develop Joint Health and Wellbeing Strategies.	3.57

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Appendix 2: Demographic facts and social care need

In planning our approach the council needs to understand who the residents and service users are in order to meet their information and advice needs. The following sections identify those who are most likely to need information and advice about their care and support.

1. Key demographic facts[1]

- The 2011 Census shows that the population has increased by 22,000 to 185,900 between 2001 and 2011. It is expected to grow by a further 20% over the next 20 years.
- The proportion of white British residents decreased from over 80% to 49%; there was a increase in residents from black and minority ethnic groups (black African - 293%; Bangladeshi - 1000%). This will result in an increase of BME residents aged 65+.
- In the last two years there has been an increase in the number of requests made for translating and interpreting services from 1688 in 2012-13 to 2789 in 2013-14. The first quarter of 2014-15 shows that the number of requests has continued to increase.
- There has been little change in the top ten languages requested for translation during 2012-13 and 2013-14 with Lithuanian, Portuguese and Romanian in the top three. In 2013-14 4% of the requests for interpreting were for British Sign Language.
- There has been a slight decrease in the number of people aged 65+ to approximately 19,700 older people; however there is predicted to be an increase in people aged 85+.
- In 2010, 7,534 people aged 18 to 64 years were living with a moderate physical disability and 2,100 with a serious physical disability in the borough. By 2015, there will be an additional 272 people of working age with moderate physical disability and 60 with serious physical disability.
- More people of working age in Barking and Dagenham (6.61%) than in London (4.89%) or England (5.6%) reported in the 2011 Census that their ‘day-to-day activities are limited a lot’.
- The local population has significant health problems, at rates higher than other areas of London for conditions such as heart disease, diabetes and respiratory disease.

[1] This is information from the Joint Strategic Needs Assessment and updates prepared for the Local Account and *Adult Social Care: Understanding Demand in the (Older) Population of Barking and Dagenham* Final Report, London Metropolitan University 2014

- Barking and Dagenham remains England's 22nd most deprived local authority area. With the high levels of deprivation and the potential impact of welfare reform it is expected that:
  - The prevalence of drug misuse and related harms may increase
  - The risk of mental health problems is likely to be high
  - People will have less money to contribute to their care

- Approximately 85% of our residents are internet users[2]. Over 93% of non internet users are over 65. Of those who are not internet users the Office of National Statistics (ONS) reports that:
  - 60% of them are not users because they do not want to be - not that they can not.
  - About a third of those who do not cite cost and skills as the barrier.

2. Key facts about adults with care and support needs

Whilst the Care Act is applicable to all residents not just those currently receiving care and support, knowing who is currently receiving care will help us to plan for future needs[3].

The high levels of local deprivation are reflected in the comparatively high number of adult social care contacts. In 2013/14 there were 5,119 adult social care contacts per 100,000 of the population. This is substantially above the London average of 2,320 and the England average of 2,765.

Carers

The 2011 Census showed that in Barking and Dagenham there were 16,201 carers, making up 8.7% of the local population, compared to 8.4% of the population in London. The number of carers' assessments or reviews carried out in 2013/14 rose to 741 from 551 in the previous year, across both the council's social care teams and *Carers of Barking & Dagenham*. In addition *Carers of Barking & Dagenham* report having contact with around 3,000 carers via their regular newsletter.

In January 2015, there were 400 young carers in Barking and Dagenham who are known to voluntary sector group Carers of Barking and Dagenham; in addition there are likely to be more young people contributing to the care of others such as parents, grandparents, siblings or friends. Over 50% of identified young carers in Barking and Dagenham care for a parent.

[2] Source: ONS, verified by two annual Labour Force Surveys 2011, 2012

[3] Detailed information about the health and social needs of the population is available in our Joint Strategic Needs Assessment on the council's website.

Older people

Older people represent the largest group of people receiving social care support from the council: 70.6% of the service users. In 2013-14 there was a monthly average of around 330 in residential care; 136 were admitted into permanent placements in the year (125 residential, 11 nursing placements). 2,248 received community-based services, including 763 people who were in receipt of aids and adaptations for their home, and 522 people at the end of the year were receiving a direct payment.

People with learning disabilities

The JSNA identified that there are approximately 9,300 residents who have some form of a learning disability, though not all will require social care support. 620 people with learning disabilities are currently known to the Community Learning Disability Team, 339 who are eligible to receive services. 673 people with learning disabilities are identified on GP registers: 62 with profound or complex needs. 128 are aged under 17 years, 506 are 18-64 and 39 are aged 65+.

The number of residents with a learning disability is expected to increase by 20% adults with learning disabilities living longer; and children with learning disabilities become adults. Their transition to adult services needs to be planned, ensuring that they and their carers can access the information and advice for their future.

People with mental health problems

According to the latest data for 2013/14 231 people aged 18 – 64 were accessing mental health services provided by North East London Foundation Trust (NELFT). 310 people aged 65+ were accessing mental health services, including people with dementia.

People with physical disabilities and sensory impairments

In 2013/14 561 people with physical and sensory disabilities received services. An estimated 4.5% (7650) of the local population has significant sight impairment; the proportion rises to over 20% of those aged over 75, however not all of these people will be eligible to receive services.

Residents who pay for their own care and support – self funders

The Care Act changes the way that individuals fund the cost of their social care. A minimal estimate based on 2014 figures shows that there were 52 self-funders using home care agencies (17.7% of the total) and 54 self-funders in residential care (11.3% of the total).

With greater number of people with long term health issues than other areas, the new cap on care costs will mean it will be in the interests of self-funders to approach Barking and Dagenham Council for an assessment of their needs, so they can start to accrue towards the cap.

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Appendix 3: High Level Information and Advice Action Plan 2015-16

As a living document the action plan will evolve during the year and a new action plan for 2016-18 will be developed.

Priorities	Key Activities	Resources	Who	By when
1. Ensure there is a comprehensive range of quality information and advice about care and support available locally	1.1 Identify gaps in provision	Within existing resources	Mark Tyson	31.03.15
	1.2 Review existing contracts	Within existing resources	Mark Tyson	30.06.15
	1.3 Identify/commission means of co-producing information and advice to fill identified gaps	Within existing resources	Mark Tyson	30.09.15
2. Ensure all digital and face to face information and advice is accurate, up to date, easy to understand, and consistent with other sources of information	2.1 Ensure that the council's website includes up to date clearly signposted information on health and wellbeing	Within existing resources	Council Web Team	Ongoing
	2.2 Develop a suite of factsheets which can be printed as required from the Care and Support Hub including on: • information on the care and support system locally • how to access the care and support system locally • costs of care and deferred payment scheme • access to independent financial advice • people with no recourse to public funds • how to make a complaint • how to raise safeguarding concerns • information for self funders • information for carers • employment support • housing options • befriending services • meeting translation and interpreting needs • transition from children's to adults' services • Court of Protection • Power of Attorney • becoming a deputy[1] • online self assessment	Temporary resource	Care Act Team	31.03.15
	2.3 Develop a service charter and easy read version	Temporary resource	Care Act Team	31.03.15
	2.4 Ensure that information and advice is available in accessible formats • Community languages in with our translation and	Within existing resources		

[1] Deputies manage the personal welfare or the property and affairs of another person who lacks the mental capacity to manage them themselves.

Priorities	Key Activities	Resources	Who	By when
	interpreting provision • Large print, audio • Easy read		J Davis Jane Norris	31.03.15 30.06.15
3. Offer tailored information and advice about care and support (in a variety of formats) whenever possible to help individuals understand their range of options	3.1 Consider the role of the Intake and Access Team in providing information and advice in relation to the one stop shops, call centre and clusters	To be agreed	Care Act Team with operational managers	31.03.15
	3.2 Develop a range of materials to support the assessment process e.g. letters, personalised information	Within existing resources	Bruce Morris	30.04.15
	3.3 Ensure IT systems (AIS and FACE) are developed to meet Care Act requirements (eligibility, assessment, care planning and review) there is the facility to electronically provide information and advice at every stage of the customer journey	To be agreed	Bruce Morris with IT Sub Group	31.03.15
	3.4 Ensure that staff are informed about all local information and advice services available to residents	Within existing resources	Bruce Morris Glynis Rogers	31.03.15
4. Work with key information and advice providers from all sectors to improve the co-ordination of information and advice locally	4.1 Set up regular sessions with providers to discuss information and advice	Within existing resources	Mark Tyson	First meeting: 19.02.15
	4.2 Encourage providers to use the Care and Support Hub as the most up-to-date source of local information and advice and include a link to the Hub on their websites	Within existing resources	J Davis	Ongoing
	4.3 For all voluntary sector providers commissioned by the council, include a requirement to: • Provide information and advice which is Care Act compliant in terms of content, accessibility and proportionality • Use the Care and Support Hub as the source of the most up to date information • Provide performance information to enable the council to monitor the quality of information and advice provided	Within existing resources	Mark Tyson	From 31.03.15 (in the next commissioning cycle)
	4.4 Investigate developing arrangements with SOLLA[2] registered advisors to provide financial advice locally	Within existing resources	Mark Tyson	30.04.15

[2] Society of Later Life Advisors (SOLLA)

Priorities	Key Activities	Resources	Who	By when
5. Develop and promote the Care and Support Hub as the borough's web based local directory	5.1 Work with Open Objects to identify additional functionality to enable, for example, self assessment and care cost calculations	Within existing resources	Mark Tyson	28.02.15
	5.2 Promote the Care and Support Hub as the source of information to staff and face to face information providers	Within existing resources	Operational managers	Ongoing
	5.3 Develop a professional zone on the Care and Support Hub	Within existing resources	J Davis	31.03.15
	5.4 Develop i-learn induction module on the Care and Support Hub for staff and partners and include it in induction for new staff	To be agreed	Training Manager	30.06.15
	5.5 Undertake an initial content review and improve the search facility of the Care and Support Hub	Within existing resources	Mark Tyson	31.03.15
	5.6 Develop a rolling programme for ongoing content review and updates including identifying content owners	Within existing resources	J Davis and services	31.03.15
	5.7 National and local contacts: create a page that can be accessed from the Care and Support Hub home page including links for information and advice	Within existing resources	J Davis	31.03.15
	5.8 Encourage care and support providers not currently listed on the hub to register their details	Within existing resources	J Davis	Ongoing
	5.9 Include quality mark for each provider listed on the Care and Support Hub	Within existing resources	Monica Needs with J Davis	Ongoing
	5.10 Produce a short step-by-step guide for providers on how to register in order to create a profile on the Care and Support Hub	Within existing resources	J Davis	28.02.15
	5.11 Consider links between the Care and Support Hub and the Community Network Strategy including: • Ensure there are clear links signposting to and from CommunityConnect and the Care and Support Hub • Offer training on Care and Support Hub to Community Champions	Within existing resources	Mark Tyson	31.03.16 28.02.15 31.03.16

Operational Priorities	Key Activities	Resources	Who	By when
6. Liaise with partners to ensure information and advice is kept up to date	6.1 Identify an extra resource to develop and maintain web content including the care and support hub (This might be a shared partner resource.)	To be agreed	Mark Tyson	30.04.15
7. Develop Action Plan for 2015-18	7.1 Review progress on 2015-16 priorities • Include questions on information and advice in the annual adult social care user survey • Review information collected as part of regular contract monitoring • Carry out a mystery shopping exercise	Within existing resources	Karen West Whylie & Mark Tyson	31.03.16
	7.2 Identify new priorities	Within existing resources	Karen West Whylie & Mark Tyson	31.03.16
8. Develop a 2015-16 communication plan for residents, partners and staff	8.1 Inform staff and partners of funding reforms to begin in 2016	Within existing resources	Ellen Doran with Care Act Team	30.04.15
9. Prepare for the introduction of new financial arrangements	9.1 Develop a suite of factsheets which can be printed as required from the Care and Support Hub including: • Individual personal budgets • Cap on care • Appeals system • Extended means tests • Care Accounts • Top up payments	Within existing resources	Mark Tyson Bruce Morris	31.12.15
	9.2 Train staff on new financial arrangements	To be agreed	Care Act Programme Board Financial and Workforce sub groups	31.3.16

HEALTH AND WELLBEING BOARD

17 MARCH 2015

Title:	**Care Act 2016 - Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support**

Report of the Cabinet Member for Adult Social Care and Health

Open Report	**For Information**
Wards Affected: None	**Key Decision: NO**
Report Author: Ian Winter CBE, Care Act Programme Lead Glen Oldfield, Care Act Project Officer	**Contact Details:** Tel: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk

Sponsor:

Anne Bristow, Corporate Director, Adult and Community Services

Summary:

On 4 February 2015 the Department of Health launched the consultation on the changes of the Care Act that come into effect from April 2016.

The consultation is in two parts:

— Part 1 seeks stakeholders' views on funding reform, focusing on draft regulations and guidance that will introduce the cap on care costs

— Part 2 seeks stakeholders' views on appeals policy proposals for a new system of appeals for care and support

The consultation closes on 30 March 2015. This report summarises the areas local authorities are being consulted on and sets out at Appendix 1 the response of the Council to the consultation questions.

The consultation document, draft regulations for the cap on care costs, and the funding reform impact assessment can be found at the link below.

https://www.gov.uk/government/consultations/care-act-2014-cap-on-care-costs-and-appeals

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Cabinet Member for Adult Social Care and Health, to finalise the consultation response (Appendix 1) following the comments of the Health and Wellbeing Board.

1. Areas under consultation

1.1. Cap on care costs

The cap will place a limit on the costs of care that people will face to meet their eligible care and support needs. The cost per week used to calculate whether someone has reached the cap is the amount that it would cost the person's local authority to meet their needs if they were eligible for local authority support and is not intended to cover the costs of daily living or any additional costs relating to the accommodation elements of their care, for example to have a bigger room.

1.2. Extended means test

Under the current system people with assets between £14,250 and £23,250 pay an amount towards their care. Above £23,250 individuals are required to fund the whole cost of their care.

Under the new system people with assets of more than £118k (the new upper capital limit) will pay the full costs of their care and support. People with assets below £118k right down to £17k will get financial support from the local authority to meet their care costs. The level of contribution for the individual will be calculated by applying what is known as tariff income[1]. People below the £17k lower capital limit will pay only what they can afford from their income.

How will this work

a) For all clients the lower capital limit will be £17,000. This is an increase by £2,750. This places £11 notional tariff income back in the pockets of a service user.

b) For those in receipt of **community based services** the upper capital threshold limit will be **£27k**. At this point the client will become a self-funder, however the Act has allows a Council to commission the services on the individuals' behalf applying a brokerage fee if applicable.

c) For those in **residential homes**:

a. Where the home has been **taken into** account as part of the financial assessment (Deferred Payment Agreement), the individual upper capital limit is **£118K**

b. Where the home is **disregarded** for the purposes of the financial assessment (dependent /spouse in the property) the individual upper capital limit is **£27k.** This reflects the fact that the capital asset is not being depleted

d) Tariff income will still apply between the lower capital limit and upper capital limit- still £1 in every £250.

   a. Upper capital limit of £27k: the maximum notional tariff income will be £40 per week, reviewed annually.
   b. Upper capital limit of £118k : the maximum notional tariff income will be £404 per week.

[1] Tariff income requires that individuals contribute £1 towards their care and support costs for every £250 they have in assets that falls between the relevant upper and lower limits.

1.3. **Working age adults**

Under the new system people who develop eligible care and support needs below the age of 25 will have a zero cap for life. For those who develop a care and support need from the age of 25, the cap will be set at £72,000.

Alongside this there are proposals to make a change to the means test to increase the amount of income someone of working age receiving care outside a care home is left with after charges so that it is in line with the amount pensioners are left with. This will need to be phased in, but when complete it is anticipated that working age people will be over £50 a week better off.

1.4. **Care Accounts**

Under the Care Act local authorities will be responsible for maintaining this record for anyone ordinarily resident in their area with eligible needs for care and support. This will be known as a care account and will allow local authorities to keep track of when people are approaching the cap and to work with them to ensure a smooth transition to local authority support when the cap is reached. It will also ensure that a person's progress towards the cap is maintained should they move between local authorities.

The local authority will also be required to provide regular care account statements (at least annually) to keep people informed of their own progress towards the cap.

1.5. **Daily living costs**

The consultation confirms the intention to set daily living costs at £230 per week, in line with the recommendations of the Dilnot Commission, and recognising the concerns that have previously been raised about affordability, particularly for those on lower incomes.

1.6. **First party top-up payments**

The draft regulations will lift the restrictions on first party top-up arrangements that apply currently and under the 2015 reforms and require that arrangements are subject to the person being willing and able to meet the payments and a written agreement with the local authority. The scope of the statutory guidance will be expanded to cover first party top-ups under the new arrangements

1.7. **Independent personal budgets**

A self-funder will receive a record that sets out what the cost would be to the local authority of care to meet the person's eligible needs. It will be this cost, less daily living costs where applicable, that counts towards the cap. The record will be called the independent personal budget (IPB).

1.8. **Appeals**

As the Care Act 2014 progressed through Parliament, there was support for introducing a means of challenging local authority decisions made under the part 1 of the Care Act. Section 72 of The Care Act provides the power to make regulations to implement a system of appeals to challenge decisions taken by local authorities in respect of a person when exercising certain functions under Part 1 of the Act.

The purpose of the consultation in relation to appeals is to seek views on the appeals policy proposals for the new system that will inform the development of statutory

guidance. The proposals aim to set out a cost effective system for people to have their appeals heard in comparison to other legal means of redress, except where the courts are the most appropriate route for determining an appeal. They focus on achieving an early resolution between the person and local authority wherever possible. Where this is not possible, there is a review stage which is independent of the local authority, in which the appeal is considered by a third party with powers to make recommendations to which the local authority must have regard. The person would be able to take the matter to the Local Government Ombudsman (LGO) if they remain dissatisfied.

Scope of appeals system:

Section	**Area of Appeal**
Assessment	The local authority's decision as to the format of the needs or carer assessment eg. should it be face-to-face compared with a phone assessment
Eligibility	A decision by the local authority as to whether the person's needs are eligible for care and support or whether a carer's needs are eligible for support.
Care planning	The needs that the local authority is going to meet and how it is going to meet them
Direct payments	Decisions by the local authority for direct payments to the person or nominated/authorised person
Personal budgets	The amount that the local authority deems is appropriate to meet eligible needs Independent personal budgets The costs which count towards the cap for a person and care accounts meeting their own needs (Section 28)
Deferred payment agreements	Decisions about how much local authorities allow people to defer
Transition for children to adult	The local authority's decision to refuse a transition care and support assessment to a child, young carer, or child's carer
Independent advocacy support	Decisions by the local authority as to whether a person should have an independent advocate

2. Developing a consultation response

2.1. Included at Appendix 1 is the draft response to the consultation. It has been developed by the Care Act Programme Board and the Cabinet Member for Adult Social Care and Health.

2.2. On 24 February 2015 there was a regional event organised by the London Social Care Partnership (LSCP) to discuss and explore the consultation document and draft

statutory guidance and regulations. Issues arising from the facilitated workshops about care accounts and appeals have informed our local response.

2.3. Questions 1 - 10 relate to funding reforms and questions 11-22 seek stakeholder views on a set of policy proposals for the appeals system. In our response we have given answers to all 22 questions. Following comments and discussion by the Health and Wellbeing Board the response will be updated and then submitted to the Department of Health before 30 March 2015.

2.4. The timetable below outlines when we can likely expect final regulations and guidance from which we can implement the changes using.

Consultation timetable	
04 February 2015	Consultation on draft regulations and guidance for the cap on care
30 March 2015	Consultation closes
April 2015	2015 package of regulations and guidance come into force
7 May 2015	General Election
October 2015	Final regulations and guidance that will come into force on 1 April 2016 published
April 2016	Funding Reform comes into force

2.5. A regional response is being organised by the LSCP. Officers have worked at a sub-regional level to compile the response working on consultation questions 1-3 on behalf of the region. We await the draft of the complete London response to give comments and feed local perspectives into. Similarly London Councils is drafting a response to highlight London specific issues. Again, we wait to receive the draft to comment on.

3. Implementation issues/challenges

3.1. Arising from the April 2016 changes we will need to have in place:

- New charging arrangements to reflect the extended means test and the introduction of the cap on care costs
- Care accounts and independent personal budgets for all clients who contribute towards the costs for their care (which now includes self-funders)
- Local processes and procedures for responding to appeals.

3.2. Throughout 2015/16 the Care Act Programme Board will be working towards delivering the above changes. There are several challenges in doing so:

- **Short timescales**

  As with the 2015 changes local authorities will have little time in which to implement considerable changes. Final regulations and guidance will be issued

in October 2015 leaving a short period to work with the final detailed implementation instructions.

- **IT development**

  The introduction of the cap on care costs and care accounts requires significant development of IT systems and solutions. IT suppliers will be working under similarly tight timescales to develop products and this will have an impact on the speed at which we can introduce new or upgraded systems locally.

- **Scope and scale of appeals system**

  The policy proposals for the appeals system, as it is currently set out in the consultation document, suggests that it will be challenging for local authorities to implement as it will require significant administration. Also the system described does not seem to take account of existing complaints procedures and has the potential to cause duplication and overlap by adding another means of redress which is seemingly separate and can run in parallel to the adult social care complaints function in terms of process.

3.3. The Care Act Programme Board is still analysing the implications of the 2016 Care Act changes and developing the approach to implementation. Further Care Act related reports to the Health & Wellbeing Board in 2015/16 will be necessary to explore the implications for the local health and social care system.

4. Financial implications

(Comments prepared by Roger Hampson Group Manager Finance, Adults and Community Services)

A report on the Care Act was presented to Cabinet at its February meeting; the report explained the rationale behind the reforms, gave an overview of the thrust of the Act and its main provisions, highlighted the impact of the Care Act for the Council and our partners, and outlined our approach to implementation. The report also spelled out implications for areas of corporate policy and the latest financial position.

The major financial impact for local authorities as a result of the Care Act 2014 is from 2016/17 with the raising of ceilings where individuals will pay less towards their care costs, and the local authority will pay more. Draft guidance on the cap on care costs and the appeals process has now been published and the Council's response is set out in this report. Further financial modelling work will be undertaken to estimate the likely impact on the Council. Provisionally, this is calculated at £4.5m; details of additional funding from central government may not be announced until after the General Election, possibly in December 2015.

5. Legal implications

(Comments prepared by Dawn Pelle, Adult Social Care Lawyer)

There are no legal implications. Legal Services has contributed directly to the answers to the consultation questions set out in Appendix 1.

6. Background Papers Used in Preparation of the Report:

— The Care Act 2014: Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support (Department of Health, February 2015)

7. List of appendices

— Appendix 1: London Borough of Barking and Dagenham response to the consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support (DRAFT)

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Appendix 1: London Borough of Barking and Dagenham response to the consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support

#	Question	Response
	Funding reforms	
1	Do you agree that the draft regulations and guidance will provide a robust framework that will protect the 1 in 8 of us that will face catastrophic care costs? Please state yes or no along with any rationale.	The cap is a positive move in preventing people facing catastrophic care costs. However, we estimate that very few people are likely to reach the cap, particularly with daily living expenses excluded from the calculation. Furthermore, the proposals do not address the key issue of severe underfunding of social care services. The question focuses on the 1:8 that are affected facing catastrophic costs and which in terms will be the outliers for Barking and Dagenham. It is 7 in 8 who will still be affected by the change and may find the issue of a care cap misleading as it may not lead to them spending significantly less of their expected savings/capital in care costs.
2	Do you agree that independent personal budgets should generally be set according to an average of personal budgets allocated to people with similar levels of need? Please state yes or no along with any rationale.	No. The London Borough of Barking and Dagenham does not agree because people have needs that vary and it may be difficult to calculate an average that would be equitable for those persons with similar levels of needs. There will invariably be differences. There is also the spectre of legal challenge if there is insufficient flexibility in provision, this could put local authorities in a difficult position. Applying averages does not take account of the variances between local authorities' market rates, different approaches to commissioning, and availability of care and support in the market.
3	Is the guidance sufficiently clear as to the principles for calculating independent personal budgets? Please state yes or no along with any rationale.	The guidance is clear as regarding the principles for calculating independent personal budgets. However it only gives limited suggestions as to how practically difficulties are to be dealt with. Please note 11.38-11.41 about appeals and disputes. No matter what steps are taken, even if wholly reasonable, many service users may not be happy with provision especially if it involves finance and the potential loss of funds.
4	Does the draft guidance provide sufficient clarity about the operation of care accounts to ensure	The questions have to be covered in two ways. If the general principle of how the account is operated will ensure consistency in its application the answer is yes as guidance advises what should be included

#	Question	Response
	consistency between local authorities and reduce the risk of challenge? Please state yes or no along with any rationale.	within the care account and information that should be made available to an individual. There should be no departure from this without good reason where the person is entitled to receive a care account. However it ignores the variations between local authorities such as the application of their RAS and market rates of the borough; social care and health integration will also shape the services offered to individuals, how they are offered and what will count towards their care cap costs. These regional differences may result in challenges from individuals and family members.
5	Can more be done to ensure that the care account is a useful tool to support people in planning for care costs?	The original discussions assumed that central government was to lead on introducing a consistent care account tool. This does not appear to be mentioned in recent consultation documents provided. This would have provided a structured and consistent framework which all local authorities could work from. If this is to be considered as a future tool for care planning costs there has to be the ability to: • consolidate information across the country which enables individuals to understand the market of the borough in which they live; • develop account for the care and support planning process specific to that borough; • be clear about the choices that are available in that area; • consider future inflationary effects of care costs; • allow flexibility for change in circumstances/care support (long-term stay vs community based care); • be easily updated to account for changes in government policy, local decisions and changing demographic needs of individual authorities.

#	Question	Response
6	Do you agree that the preferred option best meets the principles and priorities identified? Please state yes or no along with any rationale.	Yes, the preferred option is simpler to understand and easier to administer. The option meets the principles and priorities identified, but does this include those persons who have received compensation payments for personal injury? The guidance does not make it clear that it only applies to individuals who apply and who are assessed for services under the Care Act 2014 from April 2016 only. This needs to be made explicit to current service users and family members, namely clients with a learning disability and those coming through transition in 2015/16. The equalisation of minimum income does not deal with the following: i. Insufficient work has been completed at this time to understand the financial implications of those whose income will be equalised between 2016 and 2019; how is it intended that the local authority picks up any loss in income? The loss of income will be dependent on the demographics of the borough and the proportion of income generated by younger adults with disabilities. ii. The shift to the minimum income level ignores risk. There are a number of clients due to their vulnerability are flagged through the financial assessment process (e.g. non payment of bills, difficulty obtaining financial info) enables the Council to pick up the issue of financial abuse/ inability to effectively manage their financial affairs. As an individual moves towards the minimum income guarantee, these clients will be lost in the system with no immediate way of indentifying financial risk issues until possibly the abuse has happened. If there is to be an age cut-off for the cap on care costs then the age of 25 is the best point at which to set that cut-off. By this point the person would have been through transition. Also benefit entitlements change at the age of 25 which adds further logic to this cut-off.

#	Question	Response
7	What are your views on how people of working age can be supported further to enable them to save and plan?	The Care Act 2014 implies that it will be dependent on the younger generation to build up their finances to support the future generation however if the younger generation do not take a savings approach, they will still need to be supported. It is not clear there are sufficient incentives to support the younger generation(s) to think about future care needs. In the current climate: • The ability for the younger generation is limited; more young adults are renting properties rather than investing in the purchase of homes. Also young people who have completed higher education will do so with a high level of debt due to rises in tuition fees; • The market has removed the retirement age of individuals resulting in fewer young adults going into roles which once would have been made available when individual's retired; • Zero costs for the rest of one's life does not account for those younger adults who do build up savings over their life time i.e. learning disability/mental service users clients. What happens if they meet the £27k capital limit? For example where a young person with learning disabilities inherits wealth or builds up resources and can afford to be charged for care and support they will not because the cap for them is set at zero regardless of their wealth. This is not necessarily fair. • This is also dependent on the structure/ investment in health and younger generations approach to future care and how future needs are met?
8	Is there evidence to support further consideration of the level and/or approach to daily living costs? Please state yes or no along with any rationale and provide any evidence you may have to support the rationale.	Yes, the current approach simplifies the process and places the responsibility of defining the daily living costs on central government removing the possibility of Councils being challenged. However, the daily living costs will have regional differences and the central government may need to consider a daily living rate for London Boroughs vs. out of London in the same way that demographic and regional differences are considered when allocating funding.

#	Question	Response
9	Do you agree that the extension of the existing requirements for third party top-ups to cover first party top-ups will provide both the local authority and the person with the necessary clarity and protection? Please state yes or no along with any rationale.	Yes, it make it easier for family members and individuals who may want to enter a third party top-up; thus removing the need to pursue family members when the default on the agreement with the home. Although the Deferred Payments Agreements will set equity limits it needs to be clear in the guidance so that family members and parties that a Council has the discretion to limit the 'top-up' to an agreed level as would be expected in the current local market for that borough.
10	Do you agree that the guidance is clear on how the extensions to the means test will work and that the draft regulations achieve their intended purpose? Please state yes or no along with any rationale.	The guidance may be clear to local authorities but probably not to individuals who may find the means test extension misleading. Yes there may be the care cap limit of £72k and the increase of the capital limit to £118k for those where the property is taken into account however some individuals depending on their available income, capital and the Council's market rate may still find they meet the full care costs. Individuals may see it more advantageous to ensure their property is disregarded and pay their care costs. Example below assumes a property with an equity limit of £270k and weekly residential care costs of £550: Service user with eligible needs with £60k in savings and net available income of £114 per week after applying the personal expenses allowance whose property has been **taken into account** will be required to pay: a) £114 per week net available income b) £132 per week from their savings (tariff income) c) Local authority would defer £304 per week against the property. d) Amount towards the cap would be £320 per week which the individual would meet their cap after spending **£72k** towards their care costs. Service user with eligible needs with £60k in savings and net available income of £114 per week after applying the personal expenses allowance whose property is **disregarded**: a) £114 per week net available income

#	Question	Response
		b) The service user will pay £436 per week from their capital until they fall below £27k. c) Between £17k and £27k will be tariff income. d) Maximum contribution towards the cap will be approx **£25k**
	Appeals	
11	Do you think there is a need to introduce a new appeals system to allow people to challenge care and support decisions? Please state yes or no along with any rationale.	Yes, but the delineation between roles and purpose of complaints and appeals must be clearly set out to avoid confusion and extra work. Areas for appeal should only cover clear and defined 'decision' areas. It is not clear where the boundary lies between what is a complaint and what is an appeal. This may confuse a service user who will not know which path to follow. This will likely result in duplication of complaints, or result in appeals which are in fact by nature complaints. Furthermore, people may gravitate towards launching an appeal rather than a complaint as ultimately an appeal, if successful, has the ability to overturn the decision whereas the outcome of a complaint cannot alter the decision. Conversely people may choose a complaint in the belief that it might be the quickest route to the LGO. This lack of clarity between appeals and complaints (both in definition and process) will undermine both systems.
12	Do you think that the appeals reforms are a priority for reforming care and support redress? Please state yes or no along with any rationale.	Appeals reforms are important, though they do not have the highest priority as the new requirements of the Care Act (information/advice; advocacy; good assessment; care planning) will all lead to better outcomes for individuals across the board from the outset and throughout the process. A priority for the appeals reforms should be building on current complaints systems/procedures and building on good practice that exists in handling complaints and resolving disputes. It is essential that complaints and appeals are part of the same pathway of redress and we do not end up with two systems. The model for appeals relating to children's social care is a single process and works well. The Care Act appeals policy proposals appear to result in two separate processes, one for complaints and another for appeals. It does not seem that there has been much regard for existing complaints procedures and

#	Question	Response
		how these can be developed to include an appeals mechanism.
13	Do you agree the areas identified should be within the scope of the appeals system? Are there any other areas under Part 1 of the Care Act 2014 that should be included?	No. The scope of the appeals system needs to be reduced and focussed only on key decisions that have an impact on the individual and are definable and have consistent comparisons. Appeals should only be launched against measurable decisions where there are clear criteria or processes that should have been applied/adhered to. For example appealing against the format of the assessment is complaining about a process not an outcome of a decision. Likewise, with care planning a local authority is limited to how it can meet a person's needs because of local service provision; this does not mean that the process and decision-making is in flawed and should therefore be able to be challenged. Because of care cap it is in the interest of self-funders to appeal to start the meter running towards the cap. Tight criteria/scope will therefore be needed.
14	Do you think that charging should be part of the adult social care appeals system? Please state yes or no along with any rationale.	No. The charging policy of any authority will have been tested through public consultation and the democratic decision-making of the Council. As with any policy there will have been ample opportunity for individuals or groups to challenge or make representations. Where an individual believes that the policy on charging (or indeed any other policy) has been wrongly or inappropriately applied this should properly be a matter of complaint. It is not at all clear from the guidance what it is that the individual can appeal about.
15	Do you have suggestions as to the expertise, knowledge and person specification for the role of an Independent Reviewer?	Similar to requirements for individual advocates the Department of Health should be very specific about the role of Independent Reviewers and the expectations people and local authorities should have about the skills, knowledge, and calibre of the independent reviewer. Chapter 7 of the Care and Support Guidance (p7.43 – 7.50) describes the role of an independent advocate. A similar description in the Statutory Guidance for appeals about the role of the Independent Reviewer would be welcome, as a starter. As set out in our response to question 22, any Independent Reviewer will need to have wide and

#	Question	Response
		varied experience of case work but also possess senior policy experience and strong local authority credentials to be able to analyse the political, organisational, and practice implications to properly adjudicate appeals.
16	Do you think the local authority or another body should be appointing the Independent Reviewer? If another body, please specify.	The local authority. There is no conflict of interest and local authorities have many years of experience of appointing and funding individuals who also may have the functions of holding the authority to account.
17	Do you think a 3 year gap in the Independent Reviewer's employment from the local authority concerned is sufficient to provide independence, or should this period be longer, or should they never have been previously employed by the local authority concerned?	Two years is sufficient. Three years is not required of Civil Servants.
18	Do you agree that the Independent Reviewer's role should be to review decisions with reference to relevant regulations, guidance, facts and local policy to ensure the local authority's decision was reasonable?	Yes.
19	How do you think we can promote consistency in decision making for care and support appeals?	By focussing on those areas of the Act that have national criteria (e.g eligibility). Please see also response to question 14. Consistency will be achieved by making it clear that appeals have no bearing on policy itself and no locus on application of policy as these are either a matter of public consultation and political decision-making; or if wrongly applied a matter of complaint which provides a clear and accessible route to redress.
20	Do you think the timescales proposed to process appeals are right?	Yes, generally.

#	Question	Response
	If not, which timescales would be more appropriate?	
21	Do you feel that the Appeals system, as set out, will aid the early resolution of disputes and thus help avoid costs and delays associated with challenging decisions in the courts? Please state yes or no and any rationale.	No. The difference between complaints and appeals is fundamentally unclear and confusing. The scale of appeals is a mish-mash of decision(s) and professional assessment or local policy (e.g. charging) that has already been subject to formal consultation and public debate. There is no evidence that costs will be saved. Are local authorities expected to decide if a person is complaining or appealing? If local authority officers cannot understand the difference how can we expect the public? To an outsider the system will appear complex and bureaucratic. This presents a challenge for information and advice in simply explaining the appropriate path. There is no evidence of fewer court challenges.
22	In the accompanying Impact Assessment we have set out the costs to administer the Appeals system. We would welcome your comments on this and any evidence that you are able to provide	See previous comments on confusion and lack of clarity. The Independent reviewer will need to have wide, varied and senior experience and be able to deliver to tight deadlines. The costs quoted are unlikely to cover this. The proposals are not clear where appeals fit with Judicial Reviews and whether an appeals system will result in fewer legal proceedings as intended. There is concern that the appeals system becomes another layer of bureaucracy that inevitably leads to a Judicial Review. More detail is needed about how the appeals system fits into the Judicial Review process. There is concern that local authority lawyers will spend a lot of time dealing with appeals and giving legal advice to appeal responses. This will cancel out savings from fewer legal challenges, if indeed that comes to pass. There are relatively few Judicial Review cases but the appeals system has the potential to be considerable.

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HEALTH AND WELLBEING BOARD

17 March 2015

Title: Director of Public Health Annual Report	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected:	**Key Decision:** Yes
Report Author: **Matthew Cole, Director Public Health**	**Contact Details:** Tel: 0208 227 3657 Email: matthew.cole@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

The Director of Public Health Annual Report is a statutory requirement under the provisions of the Health and Social Care Act 2012. It provides an opportunity for me to give an independent assessment of the health of the population and focus on some priority areas where I consider that the council and its partners need to consider individually and collectively where more needs to be done to realise health gain.

My report has been informed by and supports the achievement of the Council's and wider communities' vision that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing." This year the report explores five areas where there is a case for change, highlights the issues and challenges, and considers some change opportunities where partnership between residents, funders and care givers can evolve new models that improve health and wellbeing, deliver the public health agenda and ensure appropriate access to and uptake of high quality health and social care. My aim is not to make recommendations but to pose questions for the reader to investigate and find solutions.

In Chapter 1, I examine the evidence and analysis on how we have funded interventions using the Public Health Grant to improve population health. Chapter 2 building on last year's report that explored the opportunities presented by Transforming Primary Care in London: A Call to Action. In looking at new models of delivery that contain cost and manage the increasing demand on the health and social care system, the role of early detection of disease is critical. I continue this theme in Chapter 3 where I examine what prevention means in the context of the Care Act 2014 and the Children's and Families Act 2014 and how we can both transform care for our most vulnerable residents and deliver the necessary services on tightening budgets. This is against a backdrop of many councils raising concerns on how a modern, stable and predictable adult social care

system can be properly resourced. In Chapter 4, I examine my concerns about sexual health in the borough through the lens of technology and internet services for sexual healthcare. In my final chapter, I revisit my great concern that for too many of our residents their lifestyle choices are adversely affecting their health and wellbeing. This year I focus on the harms from drinking alcohol.

I hope my observations act as a starting point for sharing local experience and helping ourselves, our partners and our residents, to reflect on the need to commission services that are flexible, reflect need and are delivered closer to people's homes.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note and comment on the observations of the Director of Public Health in his Annual Report.

(ii) Note that the Director of Public Health Annual report will be used to inform future iterations of the Joint Health and Wellbeing Strategy and joint Strategic Needs Assessment.

Reason(s)

A number of the Director of Public Health's specific responsibilities and duties arise directly from Acts of Parliament – mainly the NHS Act 2006 and the Health and Social Care Act 2012 – and related regulations.

The Director of Public Health has a duty to write a report, whereas the authority's duty is to publish it (section 73B(5) & (6) of the 2006 Act[1], inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

APPENDIX 1

Barking and Dagenham Annual Report of the Director of Public Health 2014

Growing the borough to improve health

Director of Public Health
Annual Report 2014

Growing the borough to improve health

London Borough of Barking & Dagenham
lbbd.gov.uk

One borough; one community; London's growth opportunity

The Council's vision recognises that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing.

The borough's corporate priorities that support the vision are:

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

Cover picture: young people of Barking and Dagenham at their inaugural Youth Parade, 2014.

Contents

Foreword

Matthew Cole

Director of Public Health

Matthew Cole pictured with Dr Jagan John (local GP and a Clinical Director on the Board of Barking and Dagenham's Clinical Commissioning Group), at the 2014 'Walk a mile in her shoes' event; as part of the '16 Days of Activism' campaign against domestic violence.

In 2015 Barking and Dagenham commemorates its 50th anniversary of becoming one borough. It will be another defining point in our borough's history and brings with it a once in a generation opportunity to radically transform the relationship between our residents and the Council as well as between patients and the NHS.

Becontree Heath Leisure Centre in Dagenham – the country's busiest pool

A perfect storm of financial austerity, demographic change, legal change and policy proposals are fundamentally altering the way in which resources are deployed and the way in which we and our partners deliver services that better meet our health and wellbeing outcomes in priority areas. Implementation of the Care Act 2014, the Children and Families Act 2014 and the Welfare Reform Act 2013 impact on every individuals rights, responsibilities and support. *Better Health for London*[1], the report of the London Health Commission published in October 2014, and *The NHS Five Year Forward View*[2] published in October 2014 by NHS England, will shape the future organisation and delivery of London's health and public health policies and services for the foreseeable future.

In response, the Council has set out our new vision and priorities for the borough as our predecessors did in the 1920's and 30's, based on growing the borough as a key asset for London and on regeneration of the community. Four key themes of transformation underpin this:

- **Thrive through austerity**
- **Realise potential**
- **Modernisation of the Council**
- **New models of delivery**

The Health and Wellbeing Board is currently refreshing our joint Health and Wellbeing Strategy to protect and improve the health of residents, and engagement with partners across all agencies to achieve this goal continues. The Board's key public health task is to deliver an innovative approach tailored to local needs that tackles the diseases and consequences of modern living, as well as strives to raise standards of care and address health inequalities. Growth and regeneration provide an opportunity by developing and using our community assets, strengthening partnership between those who deliver and those who benefit from our services, and looking beyond needs and treatments to a healthy and prosperous community where residents and businesses contribute as well as gain.

In supporting the concept of wellness the Board has continued to advocate shifting care away from traditional paternalistic approaches to the redesign of patient pathways focusing on prevention, on keeping people out of hospital and encouraging residents to take personal responsibility for managing their own and their family's health, and social responsibility for the health of their neighbours and communities. To achieve this, we want to see innovations that fundamentally change the shape and

1 http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
2 http://www.england.nhs.uk/ourwork/futurenhs/

The Healthy Schools programme includes the 'Seed to Plate' project, encouraging school children to grow their own food

scope of health and caring services and meet local needs in new ways within a tighter financial framework. However, translating innovative models into practical delivery of care on the ground is fraught with challenge and requires a transformation in the way we listen, engage and communicate with residents. Social media can play a huge role in realising this opportunity and we need to fully realise the benefits that it can bring.

This year my annual report explores five areas where there is a case for change, highlights the issues and challenges, and considers some change opportunities where partnership between residents, funders and care givers can evolve new models that improve health and wellbeing, deliver the public health agenda and ensure appropriate access to and uptake of high quality health and social care. The report gives a professional perspective based on sound epidemiological evidence and objective interpretation taken from our Joint Strategic Needs Assessment and other published data. My aim is not to make recommendations but to pose questions for the reader to investigate and find solutions.

Chapter 1

Chapter 1 examines the evidence and analysis on how we have funded interventions using the Public Health Grant to improve population health outcomes. The National Audit Office has recently reviewed the early evidence about the funding of the new public health arrangements and the work of Public Health England. They conclude that, while it is too early to say whether the new arrangements will lead to improvements in outcomes, there is increased transparency of public health spending and improved understanding of the services provided in each locality, while further work is needed to align resources with need[3]. Within this context I consider both how we have a spent the Public Health Grant in Barking and Dagenham and what return we got for our money.

Chapter 2

In Chapter 2 I build on last year's report that explored the opportunities presented by *Transforming Primary Care in London: General Practice – A Call to Action*[4]. In looking at new models of delivery that contain cost and manage demand on the health and social care system, the role of early detection of disease is critical. *The NHS Five Year Forward View* promises a radical upgrade in prevention and public health that acts to address the rising burden of avoidable illnesses that are the consequence of lifestyles and behaviours. Locally we know that almost one in four adults smoke, one in six drink enough alcohol to risk damaging their health, two in three are overweight or obese and one in three men and one in two women are not getting enough exercise. The transformation question for us to consider is: "Can we deliver proactive primary care on a scale that halts or slows the progress of conditions or diseases in their earliest stages?"

3 http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england%E2%80%99s-grant-to-local-authorities.pdf

4 http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf

New housing in Dagenham that reflects the needs of older people

Older People's Week – a range of signposting, including this 'Get Walking' booklet

Chapter 3

Chapter 3 examines what prevention means in the context of the Care Act 2014 and the Children and Families Act 2014 and how we can both transform care for our most vulnerable residents and deliver the necessary services on tightening budgets. This will depend on influencing both social and environmental issues, as well as health and social care services, and the continued commitment of residents, councillors, and officers is essential in making this happen.

For the new prevention agenda to deliver we need to grow and strengthen our communities, building on the energy and compassion that exists within them. The proposals in the *NHS Five Year Forward View* outlining better support for carers, creating new options for health-related volunteering, and designing easier ways for voluntary organisations to work alongside the NHS mirror the Council's vision and the responsibilities that result from the new legislation.

Chapter 4

Chapter 4 examines my concerns about sexual health in the borough through the lens of technology and internet services for sexual healthcare. The emergence of the self care market opens our minds to what we can and should be doing for ourselves; increasing our own confidence and skills to self-manage our own and our family's wellbeing. In five years time we can expect that a new civic culture will recalibrate our perspective on how we live supported by affordable public services that both enhance the quality of our lives and improve our neighbourhoods.

Chapter 5

In the final chapter, I revisit my great concern that for too many of our residents their lifestyle choices are adversely affecting their health and wellbeing. This year I focus on the harms from drinking alcohol. A lot of good work is already happening and the Community Safety Partnership has agreed an outstanding strategy which now needs to be translated into effectively executed delivery.

I hope you enjoy reading this report as well as finding it of interest and value.

Matthew Cole

Director of Public Health

1

Investing in Public Health

Barking and Dagenham
is investing in supporting people to improve their health and wellbeing

Health Roadshow 2014 – a 'have a go' healthy food workshop for children and parents, run by the Adult College Barking and Dagenham - http://adultcollege.lbbd.gov.uk/

Investing in Public Health – value for money from public health interventions

Responsibility for promoting and protecting the public's health was returned to local authorities as part of the changes included in the Health and Social Care Act 2012[5], thus reinstating many of the responsibilities that local government had held until 1974. These changes recognised the perspective and opportunities for local government in respect of their:

- Population focus as democratically accountable stewards of their local population's wellbeing
- Ability to shape services to meet local needs, including the environment within which people live, work and play, the housing they live in, the green spaces around them, and their opportunities for work and leisure, which are all critical to health and wellbeing
- Ability to influence the wider social determinants of health; the conditions in which people are born, grow, live, work and age
- Ability to tackle health inequalities, taking strategic actions to prevent inequalities across a number of functions such as housing, economic and environmental regeneration, strategic planning, education, children and young people's services, fire and road safety[6].

Investing in '16 Days of Activism'; raising awareness of the impact of domestic violence on individuals, families, communities and services. Supporters included Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health, and Chair of the borough's Health and Wellbeing Board.

The local authority responsibility to promote the health of the their population is expected to be delivered through translation of local knowledge and experience about local needs, set out in the Joint Health and Wellbeing Strategy[7], into policies and services that improve population health and wellbeing, resulting in measurable improvement in outcomes as demonstrated in the Public Health Outcomes Framework[8]. A small number of services were mandated – sexual health services (sexually transmitted infections and contraception), NHS Health Check Programme, National Child Measurement Programme, providing public health advice to NHS commissioners and ensuring plans are in place to protect the health of the public. The Healthy Child Programme for children aged 0-5 years will be added to the mandated services from October 2015.

To support local authorities in carrying out their new public health functions, a ring-fenced public health grant is allocated by the Department of Health. The amount of the grant is based on the estimated spend on public health by primary care trusts prior to the transfer of responsibilities. The estimated spend per head varied widely across the country, with the average for England at £47, and the range from £18 to £186. Barking and Dagenham

5 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216709/dh_131898.pdf
7 http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx
8 http://www.phoutcomes.info/

Engaging with older people at Harmony House

was reasonably well placed with an inherited spend per head of £60, which was increased to £66 per head in the actual 2013/14 allocation and £71 per head in 2014/15. Nevertheless the borough is still below the calculated target and well short of the grant level in some other London Boroughs such as Tower Hamlets and Islington. Over time there is an intention to move to a needs based grant taking account of factors that influence need such as deaths under the age of 75, population age distribution and unavoidable cost differences in delivering services.
The ring fenced grant for the London Borough of Barking and Dagenham in 2013/14, was £12.921m, rising to £14.213m for 2014/15 and 2015/16. Monitoring of spend is undertaken by the Department for Communities and Local Government and by Public Health England on behalf of the Department of Health, and the Council's Chief Executive (or Section 151 Officer) and the Director of Public Health are required to return a statement confirming that the grant has been used in line with the conditions set[9].

The National Audit Office has recently reviewed the early evidence about the funding of the new public health arrangements and the work of Public Health England. They conclude that, while it is too early to say whether the new arrangements will lead to improvements in outcomes, there is increased transparency of public health spending and improved understanding of the services provided in each locality, while further work is need to align resources with need[10].

The Public Health Grant in Barking and Dagenham – how has it been spent?

At the time of writing we are coming to the close of the second year of the Council's responsibilities for Public Health and therefore detailed data on spend is only available for the first year (2013/14), with budget estimates for the second year (2014/15). In the first year the Council inherited many of the programmes and contracts put in place by the former Barking and Dagenham NHS Primary Care Trust and therefore had limited opportunity for change. Nevertheless, the integration of public health functions within the totality of the Council's responsibilities has enabled us to strengthen the Council's role and purchasing power for services such as those aimed at children and young people and services to promote and enable increasing physical activity amongst children and adults.

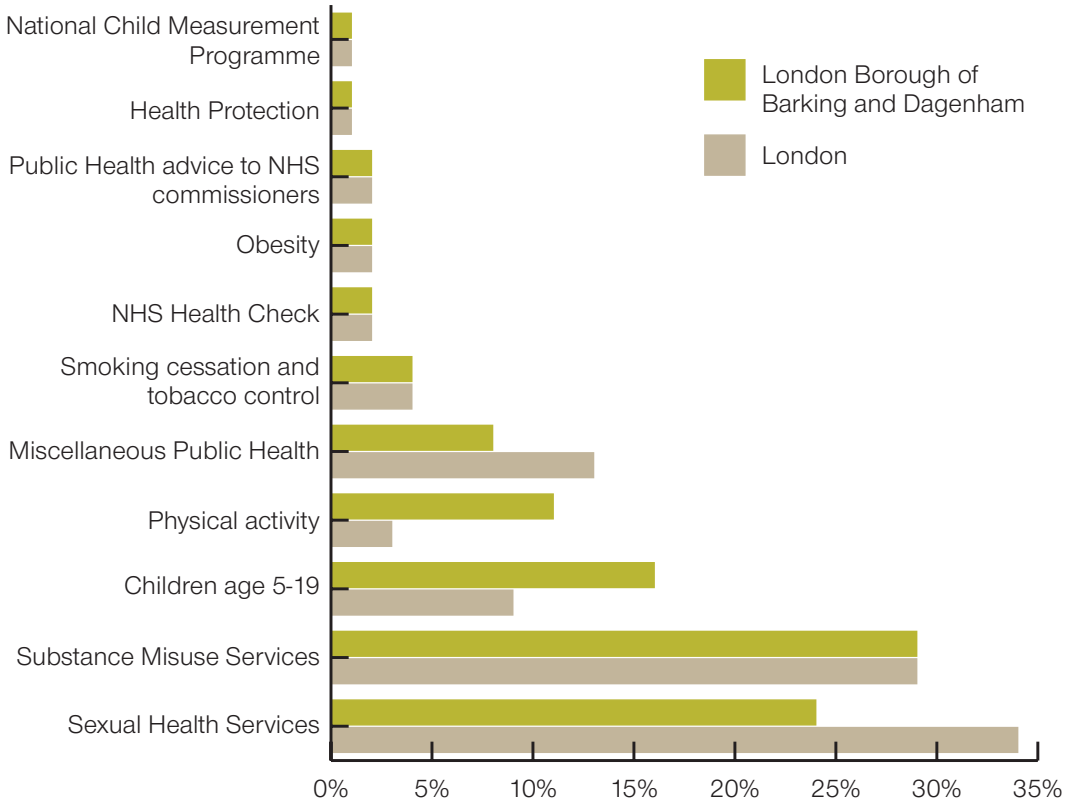
The Government requires expenditure returns based on defined categories of public health spend, and these enable comparison across geographies between the proportion of the budget spent on various categories. In 2013/14 94% of the budget was spent, with the remainder carried forward and added to the 2014/15 budget. Figure 1 shows the distribution of spend between programme areas for Barking and Dagenham compared with London as a whole. It shows that Barking and Dagenham spends a greater proportion of the Grant on Children aged 5-19 years and on Physical Activity and less on Sexual Health Services than the London average, reflecting the high proportion of children in the borough and our concerns about the low levels of physical activity amongst children and adults.

9 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf
10 http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england%E2%80%99s-grant-to-local-authorities.pdf

Inclusive cycling with Cycle4All (c) Cycle4All www.cycle4all.com

Figure 1:

Distribution of spend by programme areas, % of Public Health Grant, London Borough of Barking and Dagenham and London, 2013/14



Source: https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2013-to-2014-individual-local-authority-data-outturn

The Public Health Grant in Barking and Dagenham – what do we get for our money?

The Public Health Grant (PHG) funds a wide range of services as well as the technical expertise for analysis of health and wellbeing needs and evaluation of the evidence to maximise the impact of what we commission. Figure 2 gives a general description of the service areas that are resourced through the PHG and details some of the programmes commissioned to meet local needs.

Figure 2:

Public Health Programmes resourced through the Public Health Grant (mandated programmes in bold)

Programme name	Summary of programme
Sexual Health Services	Mandated requirement to commission open access sexual health services for everyone present in the area, covering free sexually transmitted infections testing and treatment, notification of sexual partners of infected persons, free contraception and reasonable access to all methods of contraception
Substance Misuse Services	Prevention and treatment programmes for children, young people and adults who misuse drugs and alcohol or are affected by the misuse by others
Children's services for age 5-19	School health assessments, promotion of health and wellbeing, immunisation programme for school age children, safeguarding
Physical activity	Enabling and encouraging children and adults to increase their levels of physical activity
Obesity	Promoting healthy eating and commissioning weight management services
Smoking Cessation and Tobacco Control	Smoking cessation services, tobacco control initiative and work to prevent people taking up smoking
NHS Health Check	Programme to invite all adults aged 40-74 years without pre-existing conditions to check circulatory and vascular health and risk of certain diseases
Public Health Advice to NHS Commissioners	Mandated support to NHS Barking and Dagenham Clinical Commissioning Group to provide specialist public health expertise and advice to support them in delivering their objectives to improve the health of their population
Health Protection	Ensure plans are in place to protect the health of the population and respond to health incidents and emergencies
National Child Measurement Programme	Measure the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obese levels for children within primary schools.

The Public Health Grant in Barking and Dagenham – is our spending in line with our priorities?

While we are required by Government to provide detailed information about how we spend our PHG by defined programme areas, we also need to know whether we are directing our resources at the things that we have agreed locally through our Health and Wellbeing Board to be our priorities. Our commissioning priorities were agreed in November 2013 and are detailed in Figure 3.

Figure 3:
Public Health Commissioning Priorities 2014/15

Commissioning Priority	Areas to address	Examples of investment	Budgeted spend % of Public Health Grant 2014/15
Transformation of Health and Social Care	Early disease identification; Prevention including immunisation, breast feeding, dementia; Reducing the impact of isolation and other support for vulnerable people; Effective care for chronic conditions and end of life	Contribution to the Better Care Fund, including support to Active Age Centres, Leisure offer for people aged 60 years and over, Tenancy Support Scheme and Winter Warmth Programme	7%
Improving premature mortality	Cancer prevention and early diagnosis; Smoking cessation	Smoking cessation services, Pulmonary Rehabilitation Programme, Health Promotion Campaigns	6%
Tackling obesity and increasing physical activity	Promotion of breast feeding, healthy child nutrition and physical activity programmes for children; Effective treatment pathways and weight management programmes; Availability and uptake of sports and physical activity programmes	Weight management and activity programmes for children and adults	11%
Improving sexual and reproductive health	Halting the spread of sexually transmitted infections and reducing teenage pregnancies; Improving access to services that are non-judgemental and widely promoted; Increasing the focus on prevention and knowledge to reduce the risk of infection and unintended pregnancy	Clinic and support services to diagnose, prevent and treat sexually transmitted diseases, contraceptive services, prevention of unintended pregnancy and HIV infection	22%
Improving child health and early years	Safe transfer of effective health visiting services to Council responsibility; Increasing school nursing services; Caring for Looked After Children; Provision of alcohol advice where needed for children and young people; Increasing support to vulnerable families	Early Years Prevention Programme, Breast Feeding and Early Years Nutrition, Healthy Child Programme	14%

Commissioning Priority	Areas to address	Examples of investment	Budgeted spend % of Public Health Grant 2014/15
Improving community safety	Working with young people to reduce young offenders re-offending rates; Addressing sexual exploitation and domestic and sexual violence	Domestic Violence Programme	3%
Alcohol and substance misuse	Early identification and brief intervention to reduce alcohol misuse; Increasing access to community detoxification; Availability of high strength lagers and beers; Reducing alcohol related crime through preventive policing of alcohol hotspots; Continuing to deliver successful drug treatment services	Drug and alcohol prevention and treatment services	19%
Improving mental health	Develop a mental wellbeing strategy to address the economic and social determinants of poor mental health, prevention and accessible support and treatment; Improve access to psychological therapies and school based programmes	Mental Health and Wellbeing Services for children and adults	1%
Reducing injuries and accidents	Safety measures to support safe walking and cycling; Reducing falls and accidents among older people	Accident Prevention Programme	<1%
Mandated public health programmes and wider Council priorities	Health protection; Public health advice to NHS commissioners; Mandated Public Health Programmes	Emergency Planning, National Child Measurement Programme, NHS Health Check	5%
Staff and corporate costs	Public Health staff team and corporate support	Public Health qualified staff, public health commissioning	12%

Note: For the purposes of the Government return detailing spend by Public Health Programme area, staff and corporate costs are distributed across programme areas depending on staff resource needed to support delivery of the programme. The proportion of spend on each programme will therefore vary from that shown in this table, where staff and corporate costs are shown separately.

Investing to make a difference – the evidence base

There is a substantial body of research on where to intervene to address the social determinants of health and consequent health inequalities, and the transfer of public health functions to local authorities has stimulated the publication of useful reports gathering together information about effective interventions, such as *Improving the Public's Health* published by The King's Fund[11]. In addition, the National Institute of Health and Care Excellence (NICE) publish both economic analysis and cost effectiveness tools which enable councils to calculate the return on investment for a number of public health interventions. NICE analysed 200 cost-effectiveness estimates of various interventions that informed public health guidance they published between 2006 and 2010 and found that 15% were costs saving and 70% were good value for money, as determined by the cost per QALY[12] being less than £20,000, the level which NICE apply to treatments deemed to be cost effective[13]. The most extensively studied interventions are those that support smoking cessation, with brief advice programmes using self-help material and nicotine replacement therapy being cost saving, and a wide range of programmes that identify smokers as people at risk of dying prematurely and offering advice and incentives are highly cost-effective. Other cost effective interventions include information about exercise and exercise on prescription to increase levels of physical activity amongst adults and brief advice to prevent harmful levels of alcohol consumption, especially when given by the GP when new patients are registered or during a consultation.

The 2014 Healthy Schools awards event

Value for money depends on knowing where to direct attention, investing in the right interventions and delivering those interventions effectively. The commissioning priorities agreed by the Health and Wellbeing Board identify those areas where action is agreed to be needed and where the majority of the Public Health Grant resource is invested.

11 http://www.kingsfund.org.uk/publications/improving-publics-health

12 QALY or Quality-adjusted Life Year is a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a zero to 1 scale). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance. https://www.nice.org.uk/glossary?letter=q

13 http://jpubhealth.oxfordjournals.org/content/early/2011/09/20/pubmed.fdr070.full.pdf+html

Walk4Days volunteers

Public Health Outcomes Framework – measuring health and wellbeing

The Public Health Outcomes Framework (PHOF) sets out the key measures which demonstrate the health status of local people, and how our population compares with other parts of London and England. There are over 60 indicators, many of which are broken down into sub-indicators based on age or gender, and they demonstrate the many and varied influences on people's health, and the extent to which health is affected by a wide range of actions and policies implemented by the Council and by NHS Barking and Dagenham Clinical Commissioning Group. While the Public Health Grant can contribute resources, the impact of spending plans and reductions on people's health needs to be considered across the totality of Council and NHS spend. The responsibility to protect health and prevent and treat disease ranges from ensuring that the air we breathe is monitored for pollution, our parks and leisure services are safe and welcoming and places that people want to visit, that people have the information they need to be healthy and to know when they have a health problem that needs investigating, to rapid access and effective treatment for those who are ill, and compassionate care in a place of their choosing for those who are dying.

There are two overarching indicators included in the PHOF; firstly to increase healthy life expectancy and secondly to reduce differences in life expectancy and healthy life expectancy between communities. Healthy life expectancy is a measure that summarises both morbidity and mortality, reflecting as it does both the extent to which people report that they are in good health as well as the age at which people die. In Barking and Dagenham Healthy Life Expectancy is 59.4 years for men and 57.3 years for women. These figures are significantly below those for London (63.2 years for men, 63.6 years for women), which are similar to those for England (63.4 years for men, 64.1 years for women). Of particular note is that for women in Barking and Dagenham Healthy Life Expectancy is two years less than it is for men, even though life expectancy is longer for women than for men (82 years for women, 77.6 years for men), meaning that women can expect to live for more years in poor health than men. Tower Hamlets is the only other London borough where all the measures of Healthy Life Expectancy and Life Expectancy are significantly worse than the England average, and both Barking and Dagenham and Tower Hamlets experience life expectancy levels that are much more similar to those in the north of England than the south.

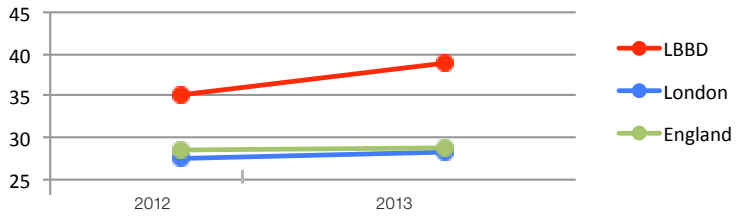
The contributing factors that result in our lower life expectancy levels can be identified through indicators that set out our position on the wider determinants of health, such as children in poverty and people who are homeless, health improvement indicators such as excess weight in children, percentage of adults that are physically inactive, and smoking prevalence, health protection indicators such as low uptake of some immunisations and high levels of late diagnosis of HIV infection, and healthcare and premature mortality indicators such as the mortality rates from conditions considered to be preventable. The detailed data, including trend data, is published on the Public Health England Outcomes Framework website and updated quarterly with new data as it is published[14]. While trend data is limited for some of our most important indicators, Figure 4 highlights a selection of indicators where trends suggest greater effort is needed to achieve improvement in local people's health.

14 http://www.phoutcomes.info/

Figure 4:

Public Health Outcomes Framework – selected indicators where action is needed to address adverse trends

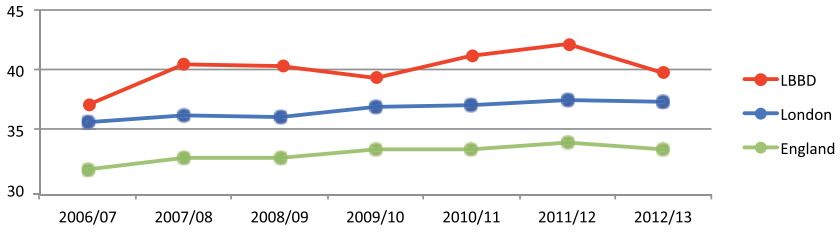
Percentage of inactive adults



Period	Sig	LBBD	London	England
2012	●	35.1	27.5	28.5
2013	●	38.8	28.4	28.9

Proportion %

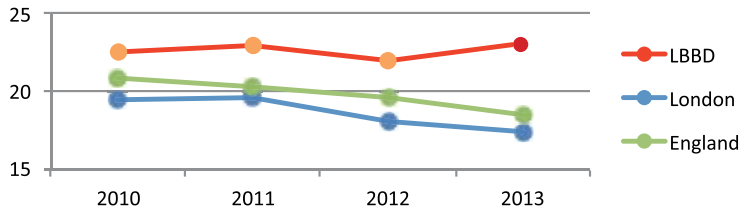
Excess weight in 10-11 year olds



Period	Sig	LBBD	London	England
2006/07	●	37.1	35.6	31.7
2007/08	●	40.5	36.2	32.6
2008/09	●	40.3	36	32.6
2009/10	●	39.3	36.9	33.4
2010/11	●	41.2	37	33.4
2011/12	●	42.2	37.5	33.9
2012/13	●	39.8	37.4	33.3

Proportion %

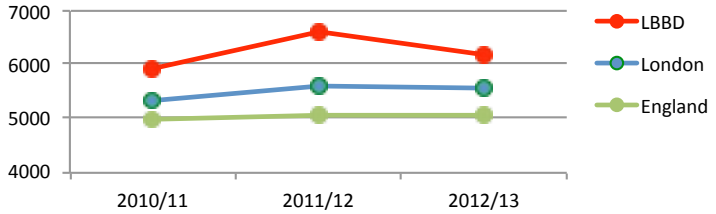
Smoking prevalence



Period	Sig	LBBD	London	England
2010	●	22.5	19.4	20.8
2011	●	22.9	19.5	20.2
2012	●	21.9	18	19.5
2013	●	23.1	17.3	18.4

Proportion %

Injuries due to falls in people aged 80 and over



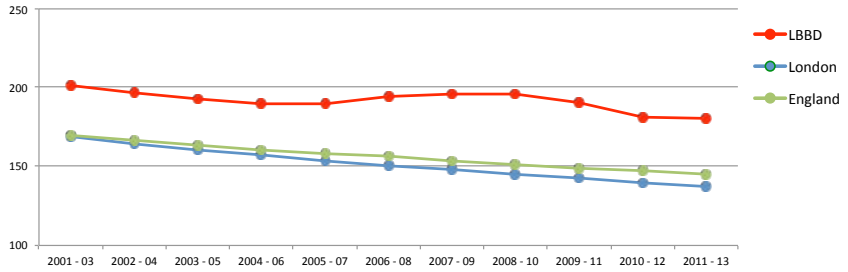
Period	Sig	LBBD	London	England
2010/11	●	5,909	5,297	4,953
2011/12	●	6,595	5,596	5,034
2012/13	●	6,188	5,528	5,015

Directly standardised rate per 100,000

Figure 4 continued:

Public Health Outcomes Framework – selected indicators where action is needed to address adverse trends

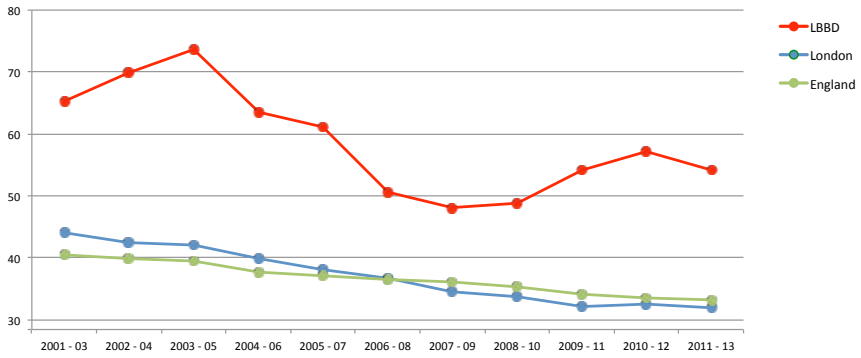
Under 75 mortality rate from cancer (persons)



Period	Sig	LBBD	London	England
2001 - 03	●	200.9	168.3	169.4
2002 - 04	●	196.7	164	166.2
2003 - 05	●	192.6	159.6	162.7
2004 - 06	●	189.4	156.6	160
2005 - 07	●	189.5	152.7	157.8
2006 - 08	●	193.9	149.5	155.7
2007 - 09	●	195.6	147.1	153.2
2008 - 10	●	195.7	144	150.6
2009 - 11	●	189.8	142.2	148.5
2010 - 12	●	180.5	139.1	146.5
2011 - 13	●	179.7	136.5	144.4

Directly standardised rate per 100,000

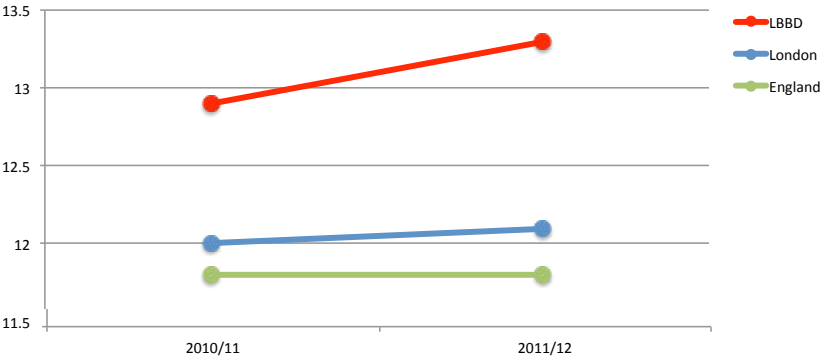
Under 75 mortality rate from respiratory disease (persons)



Period	Sig	LBBD	London	England
2001 - 03	●	65.3	44	40.5
2002 - 04	●	69.8	42.4	39.8
2003 - 05	●	73.6	42	39.4
2004 - 06	●	63.5	39.8	37.6
2005 - 07	●	61.1	38	37.1
2006 - 08	●	50.5	36.6	36.5
2007 - 09	●	48.1	34.6	36
2008 - 10	●	48.9	33.7	35.3
2009 - 11	●	54.1	32.1	34.2
2010 - 12	●	57.2	32.6	33.5
2011 - 13	●	54.1	31.9	33.2

Directly standardised rate per 100,000

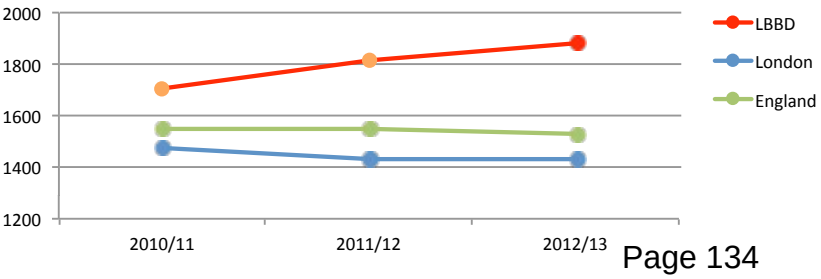
Emergency readmissions within 30 days of discharge from hospital (persons)



Period	Sig	LBBD	London	England
2010/11	●	12.9	12	11.8
2011/12	●	13.3	12.1	11.8

Indirectly standardised proportion %

Hip fractures in people aged 80 and over



Period	Sig	LBBD	London	England
2010/11	●	1,705	1,474	1,551
2011/12	●	1,812	1,430	1,545
2012/13	●	1,884	1,430	1,528

Directly standardised rate per 100,000

Moving forward – local and national policies

Improving people's health does not happen in a vacuum, and the Public Health Grant is a tiny proportion of the resource that influences people's health, albeit one which we can use specifically to address issues of concern, and stimulate, pilot or pump prime initiatives which, if they are effective, will be mainstreamed in future. In order to be most effective we need to influence and work with local and national policies to maximise the positive and minimise the negative impacts on people's health.

One borough; one community; London's growth opportunity

The vision that the Council has for the borough is summarised as: One borough; one community; London's growth opportunity. This recognises that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing.

The borough's corporate priorities that support the vision are:

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

There is a strong relationship between many of these priorities and the measures of health and improvement included in the PHOF, either directly or indirectly, and focusing and delivering on these priorities will make a real contribution to the health and wellbeing of people in the borough.

NHS Barking and Dagenham Clinical Commissioning Group

Our local Clinical Commissioning Group (CCG) commissions prevention, care and treatment services for local people. Member practices also provide primary care services and the CCG are developing a new way of working that will bring GP practices together in groups, based on where they are located. This means they will be able to provide more joined up, or 'integrated', care along with social services to make more of a difference to local people.

To deliver the strategic objectives and vision developed in their Commissioning Strategic Plan, the following areas have been prioritised for action:

1. **Properly design, contract and manage (commission) safe, sustainable, high quality services for the local population**

Improving quality and ensuring the safety of acute hospital services, primary care, community services, mental health and specialist services is of the highest priority.

2. **Working together to integrate care**

Improvements in joining up health care services across general practice, community services and hospitals, result in a better experience, improved results and better value for money for our residents.

3. **Redesign urgent and emergency care services**

Ensuring patients and the public have access to convenient, high quality,

timely and cost effective urgent and emergency care services and patients know where to get help at the right place and at the right time.

4. Staying healthy

Taking action to reduce the need for healthcare and to improve the health of the local population.

5. Increasing productivity

Increase productivity; understand that high quality services are also productive services; and know that productivity measures can improve results and patient experiences[15].

The London Health Commission

Better Health for London[16], the report of the London Health Commission, an independent inquiry established by the Mayor of London and chaired by Professor the Lord Darzi of Denham, drew on the views of many Londoners to propose the biggest public health drive in the world. The report makes 64 recommendations which are intended to support the Commission's aspirations for London:

- Give all London's children a healthy, happy start to life
- Get London fitter with better food, more exercise and healthier living
- Make work a healthy place to be in London
- Help Londoners to kick unhealthy habits
- Care for the most mentally ill in London so they live longer, healthier lives
- Enable Londoners to do more to look after themselves
- Ensure that every Londoner is able to see a GP when they need to and at a time that suits them
- Create the best health and care services of any world city, throughout London and on every day
- Fully engage and involve Londoners in the future health of their city
- Put London at the centre of the global revolution in digital health

The recommendations set out actions for all levels of administration, and to be effective we need borough, London and national actions to be aligned. This may mean putting pressure up the system to take actions that support our local strategies, and to keep engaged with actions taken at London and national levels to ensure the best local impact.

The NHS Five Year Forward View

The *NHS 5 Year Forward View*[17] was published in October 2014 by NHS England, promising a radical upgrade in prevention and public health, greater control for patients and new support for carers, breaking down of the barriers in how care is provided and radical new care delivery options. It reminds us of the need to act to address the rising burden of avoidable illnesses which are the consequence of the lifestyles and behaviours of people across England, with one in five adults smoking, one in three drinking too much alcohol, two in three being overweight or obese and one in three men and one in two women not getting enough exercise.

The *Forward View* commits the health service to supporting the public health priorities and working to deliver them both nationally and locally. Proactive primary care is recognised as central to secondary prevention – actions to halt or slow the progress of conditions or diseases in their earliest stages. More broadly, the *Forward View* demonstrates the contribution of the NHS as a partner to support people to get and stay in employment, to empower patients to manage their own health, and to engage communities in their role as carers and volunteers. A range of examples of new models of care including urgent care networks and better care at home are intended to benefit patients through more flexible care and reduce the need for hospital care.

The factors that are seen as most important in keeping people well at home or in employment are widely recognised by partners across the system:

- Self-management – to stay healthy and to manage disease
- Information for early diagnosis – so people check out symptoms sooner and health professionals identify disease promptly
- Social connectedness – strong communities supporting people and reducing isolation
- Children getting a good start in life – to lay the foundations for a healthy and fulfilling life
- Information on prevention and support to change lifestyle behaviours – stopping smoking, reducing alcohol consumption, eating healthily and being physically active

The *NHS England Five Year Forward View* and the CCG strategy demonstrate that the priorities for people's health and wellbeing are very similar regardless of whether you come from the NHS perspective or the Council perspective. We need to take advantage of these shared values and aspirations to work together for local people.

15 http://www.barkingdagenhamccg.nhs.uk/About-us/Our-plans/strategy-csp.htm
16 http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
17 http://www.england.nhs.uk/ourwork/futurenhs/

Regular outreach and events to help people make a change

The 2014 World Mental Health Day event

Moving Forward – Investing to improve health in Barking and Dagenham

As we move into the third year since the Council regained responsibility for Public Health, and what may be the final year that the Public Health Grant is ring-fenced to defined public health investment, it is timely to remember that Public Health is not just an isolated issue, with only specific spending from the Public Health Grant being used to improve people's health.

Public health is about supporting people to stay healthy, and protecting them from threats to their health. While helping people to make healthier choices is an important part of public health, it is not the whole, nor is it just about what people as individuals do. There is a health impact of all policies – economic decisions result in people becoming wealthier or poorer, planning decisions may make it easier for people to be active or for them to access green spaces or even hospitals, but may also blight the lives of people whose community is split by a new road or whose lives are affected by noise or air pollution. Health in all policies[18] is not just a catch phrase but needs to be recognised as the reality, both by those of us who are public health specialists and those with whom we work. Our role in the Council gives us the opportunity to work from within to articulate how the policies and actions taken by the Council impact on health and to demonstrate to the Council the leadership role that it carries, not just through the Director of Public Health, but through the Leader, every Councillor, and every Officer.

As the Public Health function becomes more fully integrated into the Council, we need both to focus the Public Health Grant to get the most impact, and strengthen the recognition across the wider Council of the impact on people's health of the totality of the Council's spend. Public health is everyone's responsibility and relies on everyone's contribution, it is not just the responsibility of public health specialists nor is it addressed simply through the Public Health Grant. In recognising this and working together, both within the Council and with our partners, we create the momentum to realise potential through an increased sense of personal and social responsibility, the establishment of a thriving community and economy and the implementation of new models of delivery that are fit for the 21st Century environment and realise the health and wellbeing outcomes that we seek.

18 http://en.wikipedia.org/wiki/Health_in_All_Policies

2

Diagnosing early and managing well

Outreach sessions around the borough, like this Hearty Lives event, help raise awareness and signpost residents to a range of health interventions

‘Prevention is better than cure’ is a saying that most of us will have heard from our earliest years, and remains true in almost all circumstances. While modern medicine can reduce the impact and improve the outcome of many diseases and conditions, not developing the condition is surely preferable. Nevertheless, even an active life with a good diet eaten in moderation, and not smoking, can only reduce risk of disease and not eliminate our chances of developing conditions which will reduce the years of life that we live in good health.

Hearty Lives outreach – heart healthy cookies

If we develop a disease, diagnosing the condition early in its course will generally enable us to get advice and treatment which will either reduce it’s impact or enable us to plan for the future. Some conditions have few symptoms, but if diagnosed early and managed well can have less serious outcomes than if left undiagnosed. High blood pressure is a good example of where treatment can prevent much more serious circulatory diseases. Cancer detected at an early stage can result in less invasive treatment and a much greater chance of cure. Detecting diseases earlier or case-finding of conditions that, if left untreated, will lead to much more serious diseases, may avoid the consequences of poorer quality of life, early death, and substantial costs to the health and social care system and the wider economy.

Early diagnosis depends firstly on the individual; taking up opportunities offered for early diagnosis, such as cancer screening, taking advantage of access to good information about signs and symptoms that should be discussed with a health professional, and actually accessing advice and diagnostic tests. Secondly the systems for early diagnosis have to be accessible and effective; appointments easy to make and change, symptoms recognised and appropriate testing undertaken, results interpreted accurately and further care provided in a timely and acceptable way.

For the individual, knowledge is power, and encouraging and supporting people to access the huge range of high quality information available through the internet helps people to take control. In Britain 83% of households have access to the internet with 73% of adults accessing the internet every day and 72% of adults buying goods or services online[19]. As people become better able to access information about prevention, symptoms and treatments which was formerly only available to professionals we need to find ways of using this access to stimulate the behaviour changes that would address the shortfall in demand from individuals for screening and early diagnosis and their demand for effective treatment with no unnecessary variation in care or outcomes.

19 http://www.ons.gov.uk/ons/rel/rdit2/internet-access--households-and-individuals/2013/stb-ia-2013.html

Cancer screening uptake in Barking and Dagenham

Cancer screening programmes are provided for cervical cancer (for women aged 25-64 years), breast cancer (for women aged 50-70 years, and being extended to 47-73 years) and lower bowel cancer (for men and women aged 60-69 years and being extended to age 75 years). These programmes were established because there is good evidence that screening can detect cancer earlier than without screening, and because treatment at an early stage is more effective than at late stages when symptoms are more evident.

Cervical cancer screening

Screening for cervical cancer involves taking a sample of cells from the cervix. The cells obtained are looked at under the microscope for abnormalities which may develop into cancer. Women are invited when they reach 25 years, then every 3 years until the age of 49 years, and every 5 years until the age of 64 years. Cervical cancer screening was first introduced in the late 1980's, when a threefold increase in deaths from cervical cancer had been seen over the previous 20 years, and it is estimated that if that increase had continued there would now be about 4,500 deaths each year which are avoided through the screening programme[20].

The incidence of cervical cancer in the UK has almost halved since the introduction of the screening programme in the late 1980's, but there are still around 2,700 cases of invasive cancer per year. Not enough women in Barking and Dagenham take advantage of the opportunity to have cervical cancer screening. At 31 March 2014, 72.4% of eligible women had been screened within the appropriate time period. In comparison, 77.8% of women in Havering had been screened[21]. Although screening levels in Barking and Dagenham are above those for London as a whole (70.3%), they are significantly below the level for England (74.2%). On average 3 women a year in Barking and Dagenham die from cervical cancer, (incidence of cervical cancer 7.8 per 100,000 female population) while in Havering on average one woman a year dies from this disease (incidence of cervical cancer 5.3 per 100,000 female population)[22].

Data for England shows that the lowest uptake for cervical screening is amongst women aged 25-29 (63%), while this age group also has the highest percentage of high grade abnormalities found in the samples (3.34%), twice the incidence of abnormalities in samples from women aged 30-34 years (1.7%), the group with the next highest level of abnormalities[23]. Although in the longer term the introduction of HPV immunisation for girls aged 12-13 years in 2008 will result in a lower incidence of cervical cancer (certain types of Human Papilloma Virus are associated with an increased risk of cervical cancer), the benefit will not be seen for at least another five years and it remains very important to take up the opportunity for cervical screening when it is first offered at the age of 25 years.

Breast cancer screening

Breast cancer is the most common cancer in the UK, comprising 15% of all cancer cases, with nearly 50,000 cases of invasive breast cancer diagnosed in women every year. Breast cancer also occurs in men, but less than 1% of breast cancer cases are men. Around 11,600 women and 75 men die each year from breast cancer, which is 7% of all cancer deaths. The risk of breast cancer is increased when a close family member has been diagnosed with the disease, but eight out of every nine cases occur in women with no family history. Around 9% of cases are linked to obesity, 6% to excess alcohol consumption and 3% to being physically inactive. Around 85% of women with breast cancer survive five or more years, and death rates have fallen by around one-fifth in the last ten years, although breast cancer is remains the second most common cause of cancer death in women after lung cancer[24].

Breast cancer screening was introduced in England in the late 1980's and means having mammography (an x-ray) of the breasts. It is estimated that breast cancer screening in the UK diagnoses

20 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)16674-9/abstract
21 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/3/par/E12000007/are/E09000002
22 http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0
23 http://www.hscic.gov.uk/article/2021/Website-Search?productid=16474&q=cervical+cancer+screening&sort=Relevance&size=10&page=1&area=both#top
24 http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/breast-cancer/

15,500 cancers, of which 4,000 are over-diagnosed (a breast cancer that would not have caused any harm to the individual) and 1,300 lives are saved. Breast cancer screening is one of the best ways of detecting breast cancer at an early stage when treatment is more likely to be effective.

In Barking and Dagenham at 31 March 2014, 71.2% of eligible women had been screened in the previous three years, significantly less than the 75.9% level for England and well below the 79% level achieved by Havering, although above the very poor London level of 68.9%[25]. Nearly 100 new cases of breast cancer are diagnosed every year in Barking and Dagenham women, and around 27 women die each year from the disease[26]. While incidence is significantly lower than the UK average, and mortality rates similar to the UK average, higher levels of screening could increase early diagnosis and reduce the death rate in women under the age of 75 years, which is above the national average[27].

Bowel cancer screening

Screening for bowel cancer was first introduced in 2006 and has been fully implemented since 2010. It involves looking for hidden traces of blood in the faeces, using a testing kit that is sent to people at home. Bowel cancer is the third most common cancer in men after prostate and lung cancer, and also in women after breast and lung cancer. In the UK there are around 41,000 cases and 16,000 deaths every year, and only 55% of people with bowel cancer survive more than five years[28]. Incidence in Barking and Dagenham is similar to the UK average, with around 78 new cases each year (44.9 per 100,000 population) and 33 deaths (15.5 per 100,000 population)[29].

Bowel screening uptake is generally low, and is particularly low in Barking and Dagenham. Uptake locally was 38.6% in 2012/13 (unpublished data), below the average uptake for North East London of 45.4% and for London of 48%[30]. The highest uptake in England is in Dorset, with 66% of people being screened, but uptake varies widely across the country and there are many parts of the north of England with high uptake. Local uptake is worrying, and action needs to be taken to improve the rate and reduce the impact of bowel cancer. Research evidence about reasons for not taking up screening demonstrate that many people find the need to collect a sample of faeces to be distasteful and potentially risk spreading infection, and do not like the need to take the sample personally. In addition, people find the sending of kit tests through the post to be something that comes out of the blue and that the detachment of the test from clinical surroundings meant they were less likely to see it as relevant to themselves[31]. With only just over one in three people locally returning the test there is an urgent need to understand barriers locally and particularly for GPs and their teams to discuss the test when they see people in the screening age group.

25 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/3/par/E12000007/are/E09000002
26 http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0
27 http://www.england.nhs.uk/wp-content/uploads/2014/11/cfv-bark-dagenhm.pdf
28 http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/bowel-cancer/
29 http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0
30 http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140401/text/140401w0001.htm#1404026000191
31 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3974074/

Be Clear on Cancer national campaigning supported locally

Early diagnosis of cancer

Only around two in every five cases of cancer are diagnosed at an early stage (stage one or two) before the cancer has spread to other parts of the body. Increasing the number of cases diagnosed early is a high priority for Public Health England and NHS England. In January 2015 NHS England launched an early diagnosis programme to test seven new approaches to identifying cancer more quickly. Public Health England have launched a national 'Be Clear on Cancer' campaign urging people to visit their doctor if they have heartburn most days for 3 weeks or more, as this can be a sign of oesophageal or stomach cancer. We can expect to see further national actions to encourage people to become more aware of symptoms that may be caused by cancer and to act on them by seeing their doctor or taking other advice.

The likelihood of a symptom being due to a cancer and getting the threshold right for which patients need to be referred for further investigation is another issue under the spotlight. NICE recently consulted on new guidelines about when to refer for suspected cancer[32] and the revised guidelines are due to be published in May 2015. Although these guidelines are designed for health professionals, they will be accessible to the public via the internet, as is another tool that is becoming increasingly used by GPs to consider whether investigation for cancer is appropriate. This tool, QCancer[33], primarily intended for doctors and nurses, works out the risk of a patient having a current but yet undiagnosed cancer, in a similar way to the much more familiar tool, QRISK[34], that can work out the risk of having a heart attack or stroke.

Alongside the advances in information technology that aid prediction and earlier diagnosis of cancer, there is an urgent need to increase awareness of the improving effectiveness of treatment, especially with earlier diagnosis. It is estimated that more than 8,000 lives a year could be saved in England if more cancers were diagnosed earlier. The diagnosis of cancer is still one of the most feared diagnoses in people's lives, leading to reluctance to undertake screening or discuss symptoms with a health professional for fear of a cancer diagnosis, even though late diagnosis is a significant contributor to poor outcomes. Early diagnosis of cancer depends not just on recognition of symptoms but addressing the psychological aspects that concern people, and we need to explore how best we can understand and support local people with their natural anxieties about these diseases.

Identifying risk factors – NHS Health Check

Taking advantage of screening programmes to detect cancers is one aspect of early diagnosis. What other opportunities can be taken to identify precursor conditions or the early stages of disease? The NHS Health Check is commissioned by the Council and available to people aged 40-74 years, and aims to assess their risk of heart disease, stroke, kidney disease, diabetes and certain types of dementia. The programme is based on inviting people who are not known to be suffering from these diseases for a range of checks, once every five years. The programme is now in it's second round; in the first round between

32 https://www.nice.org.uk/guidance/gid-cgwave0618/resources/suspected-cancer-update-draft-nice-guideline2
33 http://www.qcancer.org/
34 http://www.qrisk.org/

2009 and 2013 around 23,500 people received a Health Check, out of around 42,000 people who were eligible. In the first year of the new five year period (2013/14 – 2017/18), 45% of those people who were invited for the check received it, meaning that 4,800 people were checked.

Across England, around half of people offered the NHS Health Check take advantage of this simple opportunity to have key checks on their health and advice given about how to address any risk factors. In Barking and Dagenham the proportion of those invited who take up the check is a little lower, at 45%. In a borough ranking 128th out of 150 local authorities for premature mortality and with high levels of risk factors that could be addressed (see Figure 5), advantage is not being taken of an important opportunity to improve health.

Figure 5:

Risk factors and health outcomes which could be detected and addressed by the NHS Health Check, London Borough of Barking and Dagenham

Risk Factor or Health Outcome	London Borough of Barking and Dagenham	London	England
Overweight and obese	63.5%	57.3%	63.8%
Physically inactive	38.8%	28.4%	28.9%
Smoking prevalence	23.1%	17.3%	18.4%
Alcohol related admissions to hospital (persons per 100,000)	552	554	637
Estimated proportion of detected hypertension prevalence	58.4%	Not available	54.3%
Diabetes prevalence recorded in Quality and Outcome Framework	7.25%	6.00%	6.21%
Dementia prevalence recorded in Quality and Outcomes Framework	0.37%	0.39%	0.62%
Under 75 mortality rate from cardiovascular diseases considered preventable (persons per 100,000)	64.0	50.2	50.9
Under 75 mortality rate from cancers considered preventable (persons per 100,000)	107	79.6	83.8
Under 75 mortality rate from liver disease considered preventable (persons per 100,000)	18.7	15.7	15.7
Under 75 mortality rate from respiratory disease considered preventable (persons per 100,000)	29.9	17.1	17.9

Significance levels where available:
Red = worse than England, Yellow = similar to England, Green = better than England
Sources: Public Health Outcomes Framework: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000007/are/E09000002
Except –Estimated proportion of detected hypertension prevalence: http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,pat,19,par,E38000004,are,-,sid1,2000010,ind1,727-4,sid2,-,ind2,-
Diabetes and Dementia Prevalence : 2013/14 QOF http://www.hscic.gov.uk/article/2021/Website-Search?productid=16273&q=Quality+Outcomes+Framework&sort=Relevance&size=10&page=1&area=both#top

Preventing Lung Disease in Barking and Dagenham – the impact of smoking

In the 'league tables' for premature deaths in England, Barking and Dagenham ranks at 141st out of 149 local authorities for lung disease[35] with a premature mortality rate of 54.1 per 100,000 population. In the group of local authorities with similar socioeconomic deprivation only Nottingham and Salford have a higher mortality rate[36].

Smoking is the main cause of chronic obstructive pulmonary disease and nine out of every ten deaths from lung cancer can be attributed to smoking. To address smoking related mortality locally we estimate that around 7,000 people each year need to quit smoking, far more than the number reported as quitting using NHS Stop Smoking Services (around 1150 per year)[37].

In general practice information is recorded for the Quality and Outcomes Framework (QOF) about the smoking status of people with chronic conditions including chronic obstructive pulmonary disease (COPD). The data shows that for nearly 96% of people who are on the practice registers with these conditions, smoking status is recorded, and across the borough 94% of these people have been offered smoking cessation support and treatment[38]. Nevertheless, with an estimated 3,405 people with COPD in the borough (QOF prevalence 2013/14), there are certain to be many people with COPD who continue to smoke.

Figure 6:

Premature mortality for lung disease and smoking prevalence in areas with similar socioeconomic deprivation to London Borough of Barking and Dagenham

Rank	Local Authority	Premature deaths from lung disease per 100,000 population	Smoking Prevalence
1	Brent	26.5	16.9
2	Walsall	34.4	20.5
3	Lewisham	38.6	20.6
4	Greenwich	41.6	16.6
5	Leicester	45.4	23.6
6	Lambeth	45.7	19.9
7	Wolverhampton	47.1	22.0
8	Bradford	48.9	22.6
9	Rochdale	49.4	22.7
10	Blackburn with Darwen	49.6	22.5
11	Hartlepool	50.1	24.0
12	Halton	53.0	18.4
13	Barking and Dagenham	54.1	23.1
14	Nottingham	54.9	24.4
15	Salford	58.4	22.9

Colours denote significance:
Premature deaths: Red = worst, Orange = worse than average, Yellow = better than average, Green = best
Smoking prevalence: Red = worse, Yellow = similar, Green = better. Benchmark = England
Source: Premature Mortality 2011-13: Public Health England Healthier Lives http://healthierlives.phe.org.uk/topic/mortality/comparisons#are/E09000002/par/cat-2-2/ati/102/pat/
Smoking Prevalence 2013: Public Health England Local Tobacco Control Profiles
http://www.tobaccoprofiles.info/profile/tobacco-control/data

35 http://healthierlives.phe.org.uk/topic/mortality/area-details#are/E09000002/par/E92000001/ati/102/pat/
36 http://healthierlives.phe.org.uk/topic/mortality/comparisons#are/E09000002/par/cat-2-2/ati/102/pat/
37 http://www.hscic.gov.uk/article/2021/Website-Search?productid=15174&q=stop+smoking+services&sort=Relevance&size=10&page=1&area=both#top
38 http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,par,E38000004,are,-,sid1,2000006,ind1,90616-4,sid2,-,ind2,-

Around 123 Barking and Dagenham residents develop lung cancer every year and nearly 100 die each year from this disease[39]. Lung cancer is no longer a disease primarily in men – in Barking and Dagenham on average 66 men and 58 women develop the disease every year. While breast cancer is a more common disease, with nearly 100 women developing it every year in Barking and Dagenham, more women die each year from lung cancer (around 40 women dying from lung cancer compared with 27 dying from breast cancer) because survival is so poor; 95% of women with breast cancer survive at least one year, while only 30% of people with lung cancer survive for a year.

Smoking affects health in many ways and contributes to many diseases as well as lung disease. Smoking levels are a major challenge for Barking and Dagenham, and, regardless of any other actions to improve health taken by the Council, the CCG, and our partners, reducing smoking remains the single most important disease risk factor that we need to address on an industrial scale. Evidence for effectiveness of smoking cessation methods still points to the superiority of the structured smoking cessation programmes formerly commissioned by the NHS and now commissioned by councils from the Public Health Grant. In Barking and Dagenham around £1m per year is invested by the Council in smoking prevention and smoking cessation programmes, with particular emphasis on the role of pharmacies and general practice in supporting smoking cessation and we need to promote widely the support available.

Improving care for long term conditions

In my 2013 Report I wrote in detail about the variation in care for people in Barking and Dagenham with diabetes, and showed that general practices vary substantially in the extent to which they provide high standards of care by carrying out all of the care processes that are necessary to reduce the risk of complications from diabetes and admissions to hospital. These variations continue to exist, and apply not just to diabetes, but to a range of other conditions. Further examples of variation in care are considered here for cardiovascular disease.

Preventing and managing cardiovascular disease

Cardiovascular diseases include a range of conditions that affect the heart and circulation, including myocardial infarction (heart attack), stroke and atrial fibrillation (a disorder of the heart rhythm which can cause a stroke), peripheral arterial disease and heart failure. Lifestyle factors such as poor diet, lack of exercise, smoking and excess alcohol consumption influence the risk of developing these conditions and the course of the disease.

High blood pressure (hypertension) is an important indicator that cardiovascular disease is developing, and diagnosing high blood pressure may provide an early opportunity to both reduce the risk of serious cardiovascular disease by reducing blood pressure, and to provide lifestyle advice. While the NHS Health Check provides a systematised opportunity to do this, with less than half of people invited to the Health Check taking up the opportunity, opportunistic checking that a blood pressure measurement has been taken in the last five years should be a routine part of primary care – available both at the general practitioner and the pharmacy. The importance of blood pressure checks has also been taken up by a charity, Blood Pressure UK, who hold a Know your Numbers! week[40] every year to highlight the importance of blood pressure testing and provide opportunities for checks to be done.

Data from the 2013/14 QOF[41] gives insight into how many people registered with a GP have a record of their blood pressure being checked in the previous five years and whether lifestyle advice has been given to those with high blood pressure. For people aged 40 and older, 92% of people have had a blood pressure check, although at practice level the proportion varies from 84% to 98% (denominator includes those stated as exceptions).

Having diagnosed hypertension, NICE Guidance states that Blood Pressure should be maintained at 140/90mm Hg or less, that people should be assessed for their level of physical activity using the General Practice Physical Activity Questionnaire[42 43], and that those found to be 'less than active' should receive a brief intervention, that is advice about how active they should ideally be and how best to achieve this. The percentage of patients on the practice Hypertension Register varies from 5% to 18%; some of this variation will be due to the difference in age structure and other demographics, and some due to difference in case-finding. Variation in the percentage of patients with tightly managed blood pressure extends from 47% to 86% (Figure 7), for the

39 http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0
40 http://www.bloodpressureuk.org/microsites/kyn/Home
41 http://www.hscic.gov.uk/catalogue/PUB15751
42 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192450/GPPAQ_-_pdf_version.pdf
43 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192453/GPPAQ_-_guidance.pdf

questionnaire assessment from 49% to 95% and giving brief advice on physical activity from 31% to 100%. Other lifestyle advice on smoking cessation, safe alcohol consumption and a healthy diet is also recommended. Practices report on having given this lifestyle advice in the previous 12 months, the variation between practices is from 18% to 97%.

Similar variation is also seen in the management of established cardiovascular disease. As an example, people who have had a myocardial infarction are advised to take aspirin, or alternative anti-coagulation treatment, for life. The percentage of patients who actually receive this intervention varies from 72% to 100% (Figure 8). The percentage of patients recorded as an exception, which is patients for whom this intervention is not considered appropriate varies from none to 23%.

Reducing variations in patient care in general practice

Variation in the quality of patient care in general practice has been recognised for years, and publication of data is one way of identifying variation and working with practices to address the consistency of care delivered. NHS England is now driving forward action to address what it describes as 'the care and quality gap' by reshaping models of care and care pathways and developing co-commissioning models with CCGs to increase the flexibility in use of

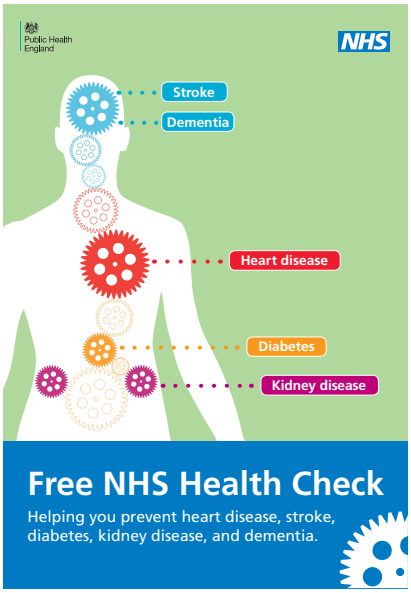
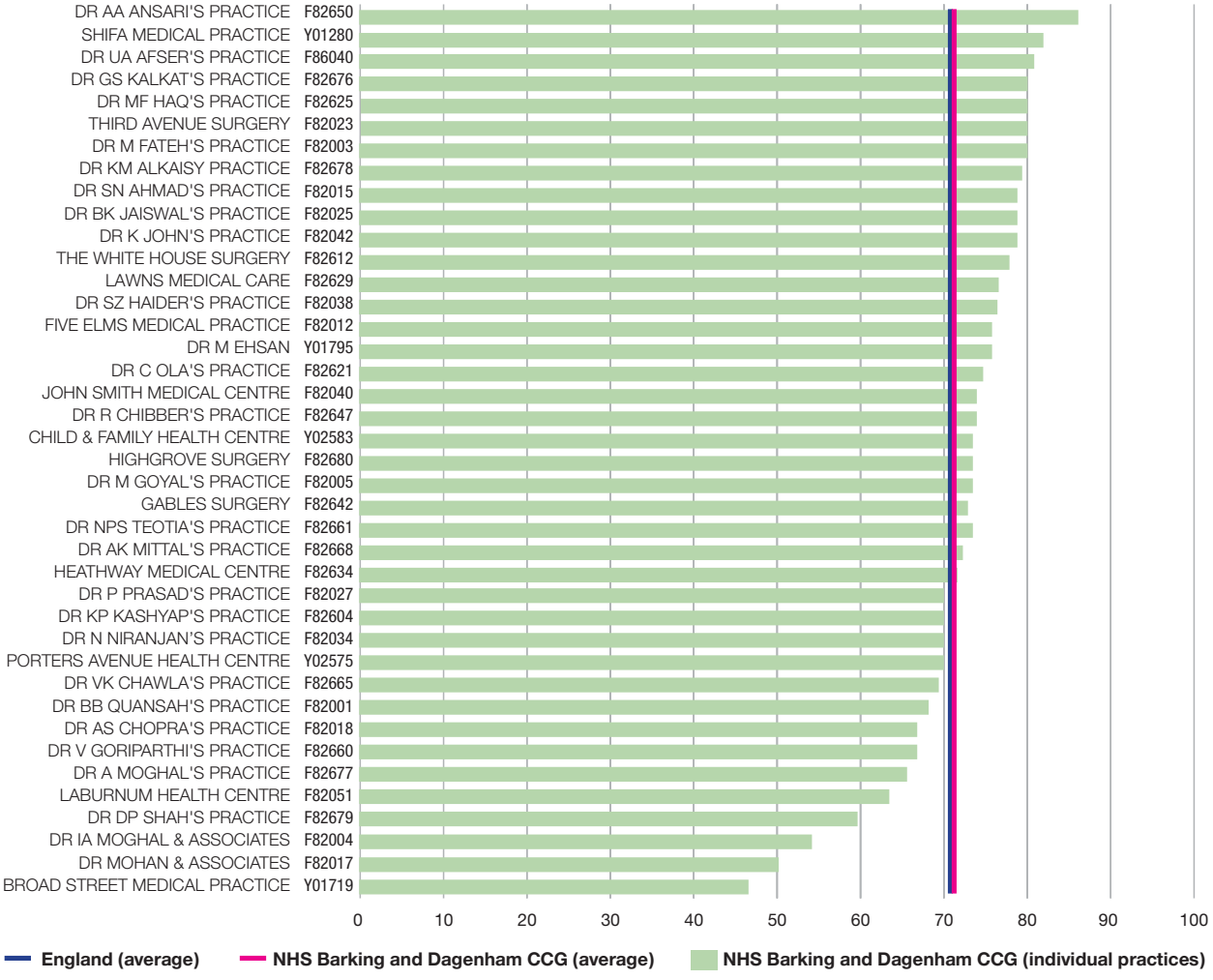


Figure 7:

Blood Pressure measured in last 9 months at or below 140/90

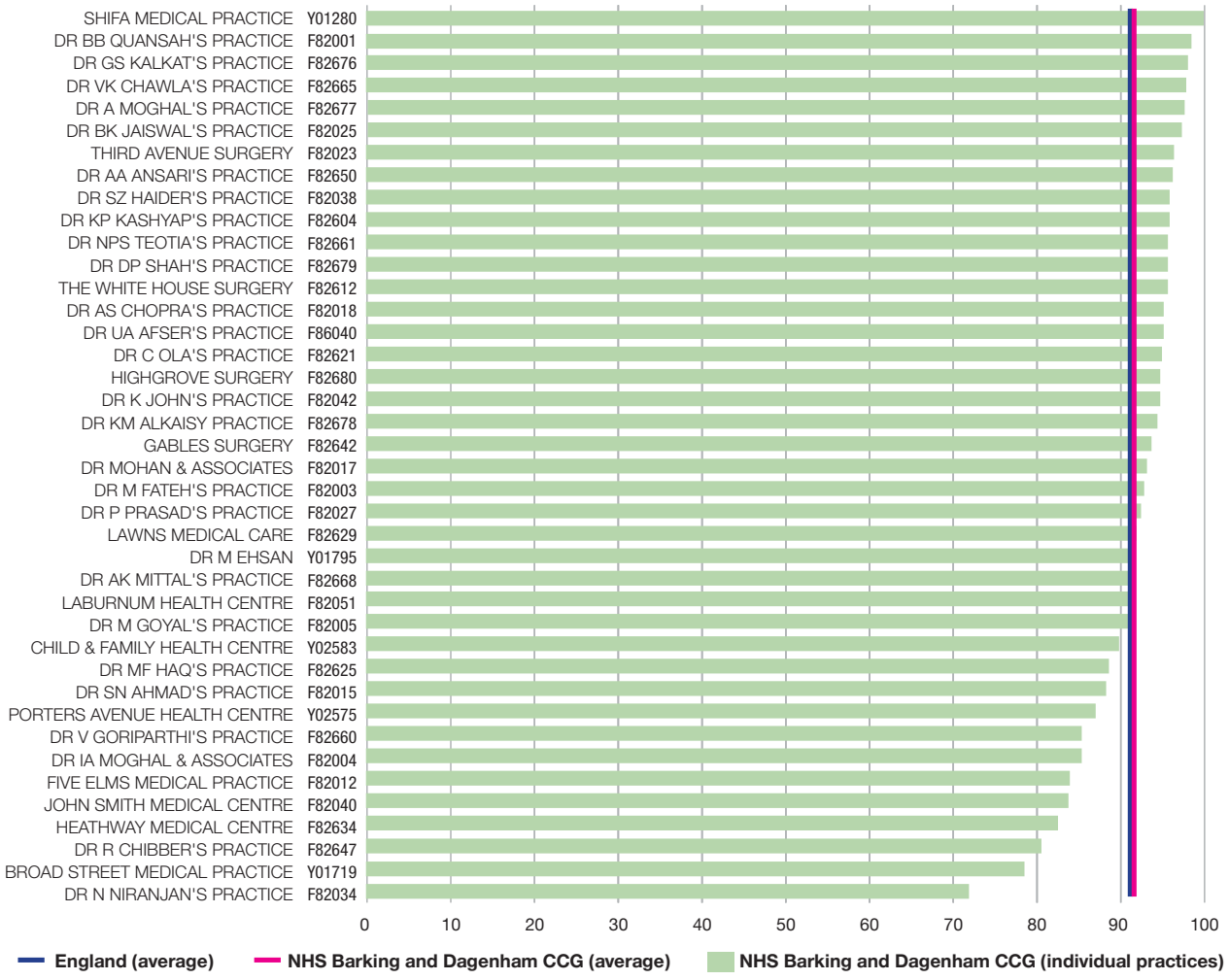


Source: Indicator HYP003 Blood Pressure measured in last 9 months at or below 140/90 at http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,pat,19,par,E38000004,are,-,sid1,3000010,ind1,91234-4,sid2,-,ind2,-

44 http://www.england.nhs.uk/ourwork/futurenhs/

Figure 8:

Percentage of patients with coronary heart disease with a record that aspirin or an appropriate alternative is being taken



Source: CHD 005 at http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,pat,19,par,E38000004,are,-,sid1,3000008,ind1,90999-4,sid2,-,ind2,-

resources and the local insight into how services can be organised to maximise clinical effectiveness[44].

Primary care co-commissioning is intended to harness the clinical insight that CCGs have about local services and local providers and give them greater power and influence over the commissioning of primary medical care. The benefits of co-commissioning are intended to be improved access to primary care and wider out-of-hospital services, with more services available closer to home, high quality out-of-hospitals care, improved health outcomes, equity of access, reduced inequalities and better patient experience through more joined up services[45]. NHS Barking and Dagenham CCG have welcomed this opportunity and have recently been approved for full delegated powers to commission general medical services[46]. Actions to address variations in patient care are key to optimising the benefits that the greater freedoms and more local decision making that co-commissioning is intended to achieve.

Living longer, living healthier

While no one can be guaranteed a long and healthy life, there is good evidence that too many people in Barking and Dagenham die at an earlier age than they need to. While unhealthy lifestyles make a major contribution to the causes of diseases, and addressing lifestyle issues reduces risk of illness and early death, early diagnosis and effective treatment make a real difference to the course of the condition and the likelihood of early death. Preventing disease, diagnosing early and having the best possible treatment is a partnership between individual and care giver, and addressing the many opportunities to intervene effectively in this pathway is a challenge on which we all need to work together.

45 http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf
46 http://www.england.nhs.uk/2015/02/18/commissioning-of-gp/

3 Care and prevention

Carers of Barking and Dagenham, based in Dagenham, celebrate Carers' Week in June 2014
www.carerscentre.org.uk/

Introduction

With increasing life expectancy and advances in treatment and technology for people of all ages, the number of people who need care and support inevitably also increases. For older people, smaller family size and greater geographic mobility means that there may be no family members living nearby to provide help and support – an estimated 2.9 million people aged 65 years and over feel they have no-one to go to for help and support[47]. In addition, one in eight adults, or 6.5 million people, in the UK are carers, many of whom have had to give up work to care, and both struggle financially and become depressed because of their caring role[48].

Recognition of the increasing needs of people and their carers has resulted in new responsibilities set out in the Care Act 2014 and the Children and Families Act 2014. Together these Acts of Parliament describe how individuals and their carers should have their needs assessed and met, the approach to prevention which is intended to maintain independence and reduce the need for care and support and the financial framework for charging depending on assets and savings.

For public health professionals the term 'prevention' focuses primarily on the prevention of disease. We think about primary prevention – reducing the risk of people getting a disease by healthy eating, being physically active, not smoking and not drinking alcohol to excess, and many of our actions and programmes are aimed at addressing these lifestyle actions. We also address secondary prevention – halting or slowing the progress of a disease or preventing a recurrence, for example daily low dose aspirin to prevent a stroke, and tertiary prevention - managing long term health problems to prevent further deterioration and maximise quality of life. This is a disease based interpretation, and a narrow reflection of 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society', the accepted definition of modern public health in England included in the 1998 report by Sir Donald Acheson about the future development of the public health function[49].

Times, society and needs have moved on, and with the public health function now delivered at local level by local authorities, we need to expand our public health thinking with a much broader and more flexible approach to prevention, in the context of the Council's wellbeing role and the many facets of prevention that are implicit and explicit within Care Act responsibilities, focusing on independence and wellbeing and the care and support needs that enable people to live independently. As we look across the lifespan, we need to rebalance our efforts and interests so that we engage as enthusiastically with how people are helped to remain in their own homes as with smoking cessation or preventing the spread of sexually transmitted diseases.

Care Act 2014

The Care Act 2014 places a series of new duties and responsibilities on local authorities about the care and support of adults and improving their independence and wellbeing. Local authorities have to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- Can get the information and advice they need to make good decisions about care and support;
- Have a range of providers offering a choice of high quality, appropriate services.

The Care Act makes clear that councils must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. They have to consider the services, facilities and resources available in the area and identify the people, and the carers, who have care and support needs that are not being met. Key to their role is the provision of comprehensive information on the care and support available, the process to get it, and financial advice to help plan and prepare for the costs of care[50].

Under the Care Act, councils have a duty to carry out an assessment to determine whether an adult has needs for care and support. This assessment must be provided to all

47 http://www.ageuk.org.uk/latest-news/1-in-4-older-people-feel-they-have-no-one/
48 http://www.carersuk.org/
49 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Features/FeaturesArchive/Browsable/DH_5017805
50 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366803/Factsheet_1_-_General_responsibilities.pdf

those who appear to have needs for care and support, regardless of finance and whether the individual will be eligible to have those needs met, and the assessment must be of the person's needs and how they impact on their wellbeing. This means that the assessment is based on needs and wants, and the outcomes that the individual aims to achieve, rather than the services that exist or their eligibility to receive funded care[51]. Carers should also have their needs assessed, taking into consideration what they want to achieve in their own day-to-day life[52].

Care and support needs that people may have can include the very basics of everyday life – getting out of bed, washing and dressing, eating and drinking, going to the toilet or managing incontinence, as well as the next level of function such as cooking, shopping, and seeing family, friends and neighbours. The guiding principle is that at the heart of care and support is the promotion of a person's wellbeing, defined in the statutory guidance as a broad concept relating to:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

Promoting wellbeing means actively seeking improvements in these aspects of wellbeing and supporting an individual to achieve their desired wellbeing outcomes, based on their own beliefs and wishes and the importance of preventing or delaying the need for care or reducing needs that already exist[53].

Prevention and the Care Act 2014

The Care Act Statutory Guidance essentially defines prevention as any population or individual level intervention or action that helps people to maintain their independence and reduces the risk of needing care or support or delays the need for increased care and support. Preventative activity includes population based health promotion measures as well as individual interventions to improve skills or functioning. Rather than give a precise definition the Guidance gives examples of the kinds of activities that may be preventative, using the primary, secondary and tertiary approach familiar to public health[54] (See Figure 9).

51 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366083/Factsheet_3_-_Assessments_and_eligibility.pdf
52 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366089/Factsheet_8_-_Carers.pdf
53 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf Pages 1-3
54 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf Pages 8-9

Figure 9:

Prevention as described by The Care Act 2014

Prevention Level	Definition	Example of service or activity
Prevent: primary prevention/ promoting wellbeing	Services, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing. Generally universal.	• Provide universal access to good quality information • Support safer neighbourhoods • Promote healthy and active lifestyles (e.g. exercise classes) • Reduce loneliness or isolation (e.g. befriending schemes) • encourage early discussions in families or groups about potential changes in the future (e.g. conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled)
Reduce: secondary prevention/early intervention	More targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing.	• Falls prevention clinic • Adaptions to housing to improve accessibility or provide greater assistance, • Handyman services • Short term provision of wheelchairs • Telecare services
Delay: tertiary prevention	Interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, (including progressive conditions, such as dementia), supporting people to regain skills and manage or reduce need where possible.	• Services, resources or facilities that maximise independence for those already with needs, e.g. interventions such as rehabilitation/reablement services, community equipment services and adaptations and the use of joint case-management for people with complex needs. • Improving the lives of carers by enabling them to continue to have a life of their own alongside caring, e.g. respite care, peer support groups like dementia cafés, or emotional support or stress management classes

Children and Families Act 2014

The Children and Families Act 2014[55] has made changes to the law to give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life. It includes responsibilities for assessment of the need for care and support for children that mirror those in the Care Act 2014, and complementary requirements that are intended to ensure that the transition from children to adult services are seamless and safe.

A similar approach to wellbeing is taken in the Children and Families Act to that in the Care Act. Wellbeing for children and young people is described as:

- physical and mental health and emotional well-being
- protection from abuse and neglect
- control by them over their day-to-day lives
- participation in education, training or recreation
- social and economic well-being
- domestic, family and personal relationships
- the contribution made by them to society.

The main focus of the Act is on vulnerable children – those with special educational needs or with a disability, as well as those who are in the care of the local authority or are vulnerable due to family circumstances including parental separation and adoption.

While there is not the same emphasis on prevention in the Children and Families Act as there is in the Care Act, the need to take a preventative approach is implicit in the requirement to put the needs and desired outcomes of the individual child or young person at the heart of planning and for them to realise their ambitions such as those for education, employment, independent living and participation in society. The Act also requires a duty of collaboration and of joint commissioning, thus ensuring that education, children's social care and health work together to provide personalised, integrated care that delivers positive outcomes for children and young people.

Better Care Fund

The Better Care Fund (BCF) was announced by the Government in the June 2013 Spending Round, to support transformation and integration of health and social care services to ensure local people receive better care. The BCF is a mechanism to pool relevant health and social care budgets and use them to develop interventions and services that strengthen care and support for individuals whose needs encompass clinical and social care. The Fund is a reallocation from existing budgets intended to improve patient experience and outcomes by better integrating health and social care, thus enabling a combined approach that focuses on needs and reduces duplication. The Fund requires local bodies to:

- bring health and social care planning together
- support people's health and independence in the community
- meet the challenges of increasing demand for care and constraints on public funding.

The overarching principle behind the BCF is integration, with the content of the programme designed to move resources across the system towards prevention and short term care interventions and away from high cost packages in acute or care home settings. There is a particular focus on the requirement to reduce the rate of emergency admissions to hospital, thus directing attention towards care programmes that maintain independence and identify potential deterioration in long term conditions, ensuring timely support at home rather than emergency hospital admission. The BCF should therefore stimulate investment in services that are necessary to meet the implications of the Care Act, and creates a practical, programme based approach for the Council and NHS Barking and Dagenham Clinical Commissioning Group to work together to deliver the interventions that prevent, reduce and delay the need for care and support and enable people to retain their independence in their own homes for as long as possible.

In Barking and Dagenham the vision for the BCF is a plan that is intended to put residents at the heart of the health and social care system, and aims to:

- Improve how people experience care and ensure the best possible quality that delivers the right care, in the right place, at the right time
- Ensure the health and social care system is 'future proof' and able to effectively manage increasing demand and need, not only today, but in years to come
- Reduce reliance upon bed based services and ensure improved support closer to home
- Ensure that services are efficient, sustainable and deliver value for money.

The BCF in Barking and Dagenham is invested in 11 schemes (Figure 10) which are intended to address a wide spectrum of opportunities to refocus and integrate services around the needs of individuals. These fit well with the key

55 http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

areas for intervention and the examples of schemes recommended by The Kings Fund[56].

Around £1m of the Public Health Grant is invested in schemes that contribute to this programme of transformation of health and social care delivered through the BCF. Just under half of this investment is in programmes that support older people to be more physically active, and the remainder is invested in a range of schemes that support people's wellbeing and ability to remain independent. These schemes fall more within the spectrum of services that may be referred to as 'social prescribing'[57], services often provided by volunteers and third sector organisations that are specifically focused on peer support and reducing social isolation, including community health champions and befriending schemes.

The effectiveness of the BCF as a pathway to improving integration across health and social care, reducing emergency admissions and making savings overall to support people's care and support at home remains to be proven. The National Audit Office, in their November 2014 report *Planning for the Better Care Fund,* question the ability of local areas to achieve the required reduction to emergency admissions and criticise the impact of changes in the planning requirements on the time available to a local area to move forward with workforce planning and training to deliver the service changes necessary to achieve the goals of the BCF[58].

Figure 10:
Barking and Dagenham Better Care Fund

Scheme		Intervention
1	Integrated Health and Social Care Teams	Integration of services for Case Management, community nursing, therapies, integration of mental health social worker support and long term conditions services
2	Admissions avoidance and improved hospital discharge	Joint Assessment and Discharge service and seven day working
3	New model of intermediate care	Introduction of Community Treatment Team and an Intensive Rehabilitation Service
4	Mental health support outside hospital	Bringing together health and social care commissioned services that work to support people with mental health problems through talking therapies, primary care, social care, accommodation and employment and recovery services
5	Integrated commissioning	Integrated Programme Management to ensure delivery of the programme
6	Support for family carers	Supporting carers and taking into account the requirements of the Care Act
7	Care Act implementation	Contributing to the additional costs of the services required by the Care Act
8	Prevention	Evaluating current prevention work that is already in place e.g. physical activity and falls prevention and co-ordinating disparate activity which contributes towards improved prevention and well being
9	End of life care	Focusing on supporting training and service improvements across agencies and services, and integrating this into cluster teams
10	Equipment and adaptations	Bringing together commissioning and provision of equipment and adaptations that are required to support people in their homes. The scope also includes commissioning and provision of Assistive Technology and Tele-health
11	Dementia support	Improving early diagnosis and support to people with dementia.

56 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf
57 http://www.nesta.org.uk/sites/default/files/more_than_medicine.pdf
58 http://www.nao.org.uk/report/planning-better-care-fund-2/

Council Leader Councillor Darren Rodwell joined residents for a line dancing session at Park Active Age Centre

Rising demand, insufficient resources

The winter of 2014/15 has seen unprecedented pressure on the NHS, as evidenced by an increase in the percentage of people waiting more than 4 hours in accident and emergency departments, an increase in the number of operations cancelled at the last minute, a reduction in the percentage of patients with cancer receiving their first treatment within the target of 85% starting treatment within two months of GP referral and the number of hospital beds still occupied by patients who are well enough to leave being at a six year high[59]. The implementation of many of the responsibilities of the Care Act in April 2015 will add to the pressures on Social Care and the need for health and social care and support to help people stay in their own homes will continue to increase. It is estimated that there will be a £30bn funding gap between NHS demand and available resources by 2020/21[60] and a £65bn gap by 2030[61], with differences of opinion about the extent to which efficiency savings can mitigate these funding pressures. In addition, Government funding for local authorities has fallen by 28% in real terms over the 2010 Spending Review period[62], with substantial cuts in the spending and volume of social care services for older adults across England[63]. Some commentators question whether the current funding models for health and social care can survive, and whether a single ring-fenced budget for health and social care with a single local commissioner in conjunction with a simpler graduated pathway of support would make better use of resources and provide more equal support for equal need[64].

These pressures on health and social care may in part be the outcome of people's lifestyle – smoking, drinking alcohol, being overweight and not taking enough exercise, but they largely represent the impact of current and existing disease. People who are ill today need care and support which we cannot ignore while we are investing to prevent the illnesses of tomorrow.

Approaches to wellbeing and prevention

The NHS Five Year Forward View proposes a radical upgrade in prevention and public health, taking a traditional perspective about 'this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences' and the need to address this burden, highlighting Public Health England's new strategy which 'sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals'[66]. The *Forward View* sets out an exciting approach which takes forward the principles previously described by Sir Derek Wanless[67] and Professor Sir Michael Marmot[68] and

59 http://qmr.kingsfund.org.uk/2015/14/
60 http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
61 http://www.health.org.uk/public/cms/75/76/313/5297/Briefing_NHS%20finances.pdf?realName=rtHrtG.pdf
62 http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england%E2%80%99s-grant-to-local-authorities-summary.pdf
63 http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140326_qualitywatch_focus_on_social_care_older_people_0.pdf
64 http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care
66 http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf Page 10
67 http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/consult_wanless04_final.htm
68 http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Residents, Council staff and health partners took up the Dementia Friends challenge, as part of the Alzheimer's Society national campaign

describes how the NHS can work with local government on targeted prevention, helping people to get and stay in employment, workplace health, empowered patients with a better understanding about their condition and ability to manage their care and engaged communities supporting carers, volunteers and voluntary organisations.

For councils, the lifestyle approach to prevention and public health is reinforced by the requirement to submit data on how the Public Health Grant is spent according to a defined list of programme areas based on the lifestyle approach (see Figure 1, Page 9). This adds weight to the expectation that the primary focus of public health spend will be on lifestyle programmes that are expected to prevent future ill health, such as those addressing smoking, substance misuse, obesity, and physical activity. The best of these investments will be in programmes that can demonstrate cost effectiveness over the lifespan, and many compare very favourably with other investments approved by the National Institute for Health and Care Excellence (NICE) because of their long term benefits. Much of the investment in schemes that are part of the Better Care Fund fall within the category of 'Miscellaneous Public Health' making it difficult to identify across the country how the Public Health Grant is supporting innovative approaches to promoting independence and reducing the need for care and support, including social prescribing.

How then do the expectations for prevention and public health described by the NHS and Public Health England sit alongside the descriptions of wellbeing and prevention set out by the Care Act 2014? The contradiction between the long term, and hopefully cost effective, lifestyle programmes intended to increase wellbeing and prevent disease in ten, twenty and thirty years and the responsibility for wellbeing and prevention as described by the Care Act and the pressure on health and care services today is stark. Is it possible to reconcile these approaches and the demands and pressures on today's services? What is clear is that the partnership between the NHS and the Council is crucial and mutually reinforcing when considering how best to support people to live healthy lives and remain independent. The role of the GP and primary care team in advising on diet and exercise is reinforced by the Council's approach to fast food outlets and provision of parks and leisure services. Education about self-management for people with long term conditions interlinks with programmes for carer support. Whatever the lifestyle concern or care issue, input from both the NHS and the Council, supported where possible by the voluntary sector, are essential to maximise impact.

Wellbeing

Wellbeing has come to prominence over the last twenty years and has increasingly been associated with the 'happiness' lobby. An accepted broad definition of wellbeing used by the OECD is of 'good mental states, including all of the various evaluations, positive and negative, that people make of their lives and the affective reactions of people to their experiences'[69]. The Public Health Outcomes Framework includes indicators of wellbeing based on four questions from the Annual Population Survey carried out by the Office for National Statistics:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?

69 http://www.oecd.org/statistics/Guidelines%20on%20Measuring%20Subjective%20Well-being.pdf

4. Overall, to what extent do you feel the things you do in your life are worthwhile?

Wellbeing as described in the Care Act Guidance[70] is much more specific and practical, and while one could describe a path from the specifics such as personal dignity and control over one's life, to an outcome around feeling happy and not anxious, it is hard to see that effectively addressing the wellbeing requirements of the Care Act will contribute to improvement in the measures of wellbeing included in the Public Health Outcomes Framework. Nevertheless, the wellbeing principles described in the Care Act Guidance do provide meaningful questions for individuals, their carers, and their care assessors to ask, for example: Will this intervention help me to maintain or recover my personal dignity? There is therefore some conflict between the different improvements that councils are expected to address.

Prevention

Prevention is the action that stops something from happening or arising[71]. Prevention of disease is fundamental to public health responsibilities, and the public health system prioritises actions that address the causes or underlying causes of disease, primarily through actions that seek to influence people's lifestyle choices. These actions are generally termed primary prevention, but prevention also encompasses those actions that reduce or delay the impact of diseases and conditions that have developed, both to avoid deterioration and to enable better management of the impact of the condition. Collectively such actions aggregate to influence the overarching indicators for public health outcomes, those of life expectancy and healthy life expectancy.

Within the Council's broad responsibilities for prevention, those years during which people describe themselves as not in good health have a big impact on care and support needs and therefore the demand for resources. In Barking and Dagenham healthy life expectancy data suggests that men may live for 18 years, and women for 25 years, in less than good health, and we know that the need for healthcare and home care and support increases with increasing age. In considering therefore the Council's prevention responsibilities, now enshrined in legislation within the Care Act 2014, we have to take account not only of the need to influence lifestyles amongst children, young people and adults, but also what actions could prevent the breakdown of people's ability to live independently and precipitate the need for some form of institutionalised care, whether in hospital or a nursing home.

This takes us into a much more comprehensive approach to prevention, perhaps based on the life course approach but with more emphasis on the needs of old age and those who are in the later stages of long term conditions. This suggests the need for the public health system to move beyond it's comfort zone of smoking cessation and obesity, important though these things are, and work to better understand the actions that are necessary to reduce and delay the deterioration of those who are already ill, particularly with long term conditions. Some of this will be territory that we well understand, for example the importance of the annual review for people with diabetes, and some will be territory where we need to work more closely with our social care colleagues, for example to address social isolation and loneliness.

The opportunity within our grasp is a truly comprehensive prevention strategy, that includes not just prevention as public health people know it, or prevention as understood by children's or adults services, or by the NHS, or as defined by the Care Act, but a truly joined up approach which our residents, as well as all our departments and services, recognise as including them. This does not mean being all things to all people, but an overarching strategy that is inclusive and recognises that there are immediate pressure points and short term preventative actions as well as long term investments, that prevention is not only about the birth of a healthy baby but also about the dignity and independence of someone who is dying, that some actions are cost effective and some are cost containing, and that prevention is a collective responsibility to which we can all contribute.

70 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf
71 http://www.oxforddictionaries.com/definition/english/prevention

4

21st century healthcare opportunities

Daynight Pharmacy in Barking and Dagenham opens till 12 midnight, offering a full pharmacy service

Modern technology is transforming the potential for self-diagnosis and self-care.

An increasingly wide range of testing kits can be purchased via the internet, and a number of prescription only treatments can also be purchased using online doctor services associated with pharmacies. While this approach has been available from other countries for some years, the introduction of UK based services that comply with UK quality standards including Care Quality Commission registration, opens up new opportunities for people to take charge of their own care, and while these services have to be paid for, costs are relatively low and the benefits of convenience and confidentiality, as well as taking control of one's own care, will outweigh the costs for some people.

World AIDS Day 2014 - a cupcake treat for everyone taking up an HIV test on the day

Self-care includes all health decisions people make for themselves and their families in order to manage their health needs and stay well. It includes the actions people take to eat well, exercise and avoid unhealthy habits such as smoking and drinking excess alcohol, as well as taking care of oneself in respect of minor ailments, long term conditions or after discharge from hospital. Taking advantage of opportunities to identify the early stages of disease such as through screening programmes, recognising that one has symptoms that need investigating are decisions that we make when caring for ourselves and becoming well-informed about our conditions in order to ensure that we, and our health and care professionals, are taking advantage of the most effective treatment and management are issues that are considered in Chapter 2 of this report. In this Chapter I review the potential impact of technology and internet services on sexual healthcare.

Sexual healthcare is readily available online. Testing kits for chlamydia, gonorrhoea and HIV are available as well as treatment for chlamydia, herpes and genital warts. Contraceptive pills, patches and vaginal contraceptive rings are all available for purchase following online assessment by a doctor. From around £30 per year the oral contraceptive pill can be prescribed following an online consultation with a doctor and purchased online. Emergency hormonal contraception, the 'morning after pill' is available without prescription and can be purchased over the counter at pharmacies.

The availability of such services challenges our preconceptions not only about the safety of making prescriptions only drugs available to an individual who has not physically met a healthcare professional, but also our longstanding belief in the importance of that interaction and the balance of control between individual and healthcare professional. In recent years patient autonomy has come to the fore, with the 'doctor knows best' approach of benevolent paternalism out of fashion[72]. However that autonomy is controlled; while information availability has been revolutionised by the internet,

72 http://www.medscape.com/viewarticle/827006#vp_1

Posters and viral videos were produced by young people for young people, throughout the year, with commissioned organisation Chain Reaction Theatre Company

treatment availability can still be a matter of interpretation, with one healthcare professional recommending a treatment that another refuses.

The availability of sexual healthcare services online, supported in some cases by High Street pharmacies, provides a relatively safe area to consider our approach to patient autonomy and the extent to which we are prepared to support a patient's right to choose and to take advantage of services that they can access from their armchair. Are self-care services a way of reducing the stigma of accessing tests and treatments, as well as increasing access? Do they normalise care and contribute to a more comprehensive public health approach to health and wellbeing services? Are we encouraged or threatened by the opportunities our patients and population have to receive care without our involvement? This section considers some of the services available in the context of local needs and health status and explores how we might respond to these advances in care.

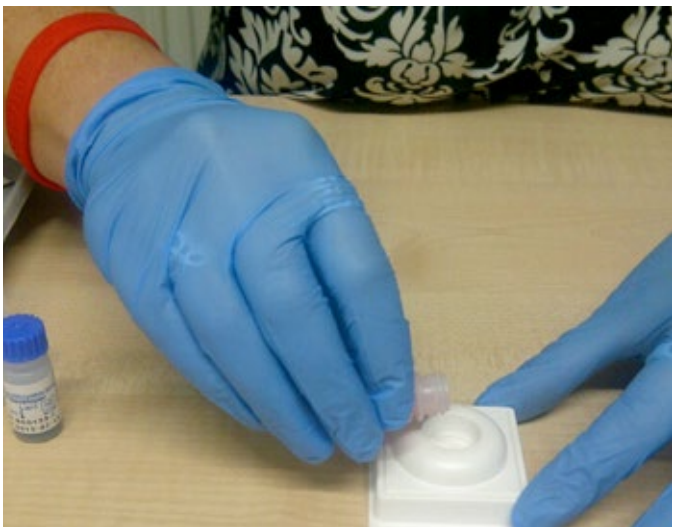
HIV infection

In 2013, the prevalence of diagnosed HIV infection in Barking and Dagenham was 6.07 per 1000 persons aged 15-59 years. This prevalence is higher than that in London as a whole (5.69) and a lot higher than the overall prevalence in England (2.14)[73].

The pattern of HIV infection in Barking and Dagenham is very different to that seen across the UK. Locally, Men who have Sex with Men (MSM) are 10% of those infected, whereas nationwide 44% of those diagnosed with HIV are MSM. 83% of those people known to be living with HIV in Barking and Dagenham are heterosexual, compared with 50% nationally. Both nationally and locally the main ethnic group affected is Black African; around two-thirds of those infected are Black African, and around two thirds of Black Africans known to have HIV are women. Overall 59% of those known to be living with HIV locally are women. Prevalence is highest in those aged 35-49 years. In 2013, 764 people who live in Barking and Dagenham were receiving treatment and care for HIV[74].

The local pattern of HIV infection is important as an indicator of need for HIV testing and where to target testing. It is a real concern locally that many people with HIV are diagnosed late. In Barking and Dagenham, 54.2% of adults aged 15 and over newly diagnosed with HIV infection had CD4 counts of less than 350 cells per mm^3 as a percentage of the number of adults newly diagnosed with HIV infection. Barking and Dagenham has a higher proportion of people diagnosed late than London (40.5%) and England (45%) (2011–2013, three year moving averages). Only 6 London boroughs have higher rates of late diagnosis than we do in Barking and Dagenham, and all of those boroughs have diagnosed prevalence rates below that of Barking and Dagenham. Late diagnosis means that treatment is started too late to be most effective, and can result in poor outcomes for patients, as well as being more costly. People living with HIV can expect to have a near normal lifespan if diagnosed promptly. Those diagnosed late have a ten-fold increased risk of death in the year following diagnosis compared with those diagnosed promptly[75].

73 http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/0/par/E12000007/are/E09000002
74 Public Health England HIV Surveillance Data (unpublished)
75 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377104/2013_PHE_HIV_annual_report_19_11_2014.pdf



HIV testing at the Barking Learning Centre

Testing for HIV infection

HIV testing is integral to the treatment and management of HIV and knowledge of HIV status means that treatment can be offered appropriately and the risk of transmission can be reduced. HIV testing should be offered to all those who attend Sexual Health Services unless they are known to be HIV positive or testing is otherwise inappropriate.

In Barking and Dagenham, 89% of MSM attending a sexual health clinic at least once during the year accepted an HIV test. However for men overall acceptance was lower at 79%, and for women even lower at 72%. The majority of people who are offered the test accept, 93.5% of MSM, 84.6% of all men, and 80.9% of women. Given our local circumstances with a high proportion of HIV being in heterosexual women, ensuring that women attending our sexual health clinics are both offered and accept HIV testing is crucial – in 2013 only 7 out of every 10 women did so.

As well as testing for HIV infection in sexual health clinics, women are tested as part of antenatal screening, and men and women have access to outreach services. Testing of new patient registrations in primary care is being introduced, and this is an important step to normalising HIV testing as a routine part of every person's care. The recent introduction of self-sampling arranged and paid for online has offered another way of testing and we need to consider whether we should acknowledge and encourage the use of these services.

Self-testing and self-sampling for HIV infection

One approach to address late HIV diagnosis is to encourage people to test themselves at home. Information can be confusing, but whether called home-testing or self-sampling the currently available method is to request a self-sampling kit, which is readily available through online pharmacies, and costs around £30-£40. Kits are also available free on the NHS, through the Dean Street Clinic, part of Chelsea and Westminster NHS Trust. Blood and saliva tests are both available, and involve obtaining a test kit and returning the relevant sample, taken according to instructions sent with the kit. Blood tests are more reliable, and can detect infection around 4 weeks after exposure, compared with the saliva test which is not positive until around 14 weeks after exposure. Results are generally given by text message or logging on to the website if negative, or by phone call if positive.

Self-testing is a new approach, which was legalised in the UK in advance of any tests being approved for use in the UK (CE marked)[76], although tests are available in other countries that can be shipped to the UK. It is likely that UK approved tests will become available in 2015. Full self-testing means purchasing a kit that can be used at home and gives the results within a few minutes, without any need to send the sample away for testing. Although it will always be recommended that a positive test should be repeated by a health professional, self-testing will give an individual complete control over the test and finding out the result without intervention from a health professional.

Concern remains about the psychological impact of receiving a provisional diagnosis of HIV infection in a context unsupported by a healthcare professional. Finding out that you have HIV can be an emotionally devastating experience, and an individual who

76 http://www.bbc.com/news/health-26888272

does a test at home that turns out to be positive may still be reluctant to access care, and to admit to the home test when they do visit a sexual health clinic or their GP. Nevertheless, if the individual would otherwise have been delaying testing, treatment may be started earlier as a result of them finding out their diagnosis through self-testing and then approaching the health system for care. With prompt treatment being critical to life expectancy, widening access to testing should not only mean managed testing through physical healthcare services, and we should recognise that self-testing will have a role to play in our approach to reducing late diagnosis.

Sexually Transmitted Infections

Barking and Dagenham has moderately high rates of the common sexually transmitted infections, especially compared with our neighbours in Redbridge and Havering, although rates in inner London and therefore London as a whole are generally much higher (Figure 11). In addition, rates for chlamydia diagnosis, an infection which is frequently asymptomatic in women but can result in infertility, are related to the proportion of the population screened, so the local diagnosis rate is a positive result reflecting higher levels of testing.

Figure 11:
Rates of Sexually Transmitted Infections, outer north east London, London and England, 2013

Sexually Transmitted Infection	Barking and Dagenham	Havering	Redbridge	London	England
Syphilis (Diagnosis rate per 100,000 population)	6.8	2.1	3.5	19.8	5.9
Gonorrhoea (Diagnosis rate per 100,000 population)	80.8	43.8	56.2	155.4	52.9
Chlamydia (Diagnosis rate per 100,000 people aged 15-24)	2087	1589	1176	2179	2016
Chlamydia (Proportion of 15-24 population screened)	30.0%	22.2%	22.1%	27.7%	24.9%
Genital warts (Rate of 1st episode diagnosis per 100,000 population)	144.8	170.2	106.8	163.9	133.4
Genital Herpes (Rate of 1st episode diagnosis per 100,000 population)	76.6	70.5	48.8	89.9	58.8

Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Self-sampling kits for chlamydia, gonorrhoea and vaginal infections are readily available online, as are antibiotic treatments when the tests for chlamydia prove positive. Gonorrhoea treatment is usually given by injection and so treatment at a sexual health clinic is advised. Self-sampling and treatment for chlamydia means that tracing and notification of sexual partners is totally dependent on the individual, whereas those cases diagnosed and treated as part of the National Chlamydia Screening Programme will discuss partner notification with a health professional and have support for advising partners of the need for treatment.

Data on sexually transmitted infections that present to NHS services and those identified as a result of council or NHS commissioned tests are collected by Public Health England and published annually. This data collection helps us understand the epidemiology and need for services for diagnosis and treatment. Data about infections diagnosed through private healthcare need not be collected, and in the past the number of infections identified in this way would

be very small. In the future, with online testing services, the numbers may be more significant, affecting not only our knowledge of the frequency of infection but also the targets for testing that we work to meet.

Contraception and fertility control

The use of the oral contraceptive pill, and the newer associated hormonal methods such as the contraceptive ring and patches have become widespread since 'the pill' was first introduced in the 1960's. Over the last 50 years the pill has revolutionised women's health and separated sex from the risk of pregnancy, although it was only in 1974 with the introduction of NHS Family Planning clinics that it became widely available to single women. It is estimated that 3.75 million women in the UK use oral contraception[77] and that over 70% of women in Britain use the pill at some time in their lives[78].

Data on use of contraception is limited. Around 1.2million women in England attend community clinics of whom around 47% use oral contraception. In Barking and Dagenham in 2013 there were 6175 attendances at the community contraception service run by Barking, Havering and Redbridge University Hospitals NHS Trust made by around 4400 people. 44% of these attendances were related to long acting methods of contraception such as intrauterine devices and injections, while 31% were for oral contraception. Nearly 60% of attendances are made by women aged 25 and over and 54% of these attendances are for long acting methods, 26% for oral contraception and 19% for condoms. Over 97% of those attending community clinics are women, although male condoms are available to men who attend. In 44% of attendances the current method of contraception was maintained, in 20% a new method of contraception was provided and in 13% the method was changed[79].

In Barking and Dagenham around 9 per 100 females aged 13-44 years use community contraception services, below the average rate for London of 12.5 and for England of 10.6 per 100 females aged 13-44 years. Contraception prescribed in general practice is complicated by the data being based on numbers of prescriptions rather than the number of individuals receiving contraception. In Barking and Dagenham in 2013 there were over 23,000 prescriptions for oral contraception. Based on two prescriptions per year of a six month pill supply this would equate to around 11,000 women getting the pill from their GP. Data on the provision of long acting methods by GPs, estimates a rate of 45 per 1,000 women aged 15-44 years, the second highest rate in London (the London average is 25 per 1,000 women) and fairly close to the England rate of 52.7. This equates to around 2,000 women. Prescribing data shows that about half of these women use injectable contraception, 20% use implants and the remainder an intrauterine contraceptive.

Modelling the likely use of contraception by women in Barking and Dagenham and comparing with what we know nationally, we can draw on the survey that the Office for National Statistics used to carry out on contraceptive methods used, although the last of these was done in 2008/09[80], covering women aged 16-49 years. This survey found that there had been little change in the use of methods of contraception over the previous 9 years, with 25% of women under 50 using oral contraception (34% of those using contraception) and 25% not using any contraceptive method. In Barking and Dagenham there are nearly 50,000 women aged 16-49 years[81], so if national patterns were followed locally around 12,000 women could be using oral contraception. An approximate estimate of those using community clinics for oral contraception is around 1,500, and of those getting the pill from their GP around 11,000, which suggest that contraceptive use locally is in line with what would be expected.

Another way of looking at contraceptive need is to look at fertility and abortion statistics. In 2012 there were an estimated 5,237 conceptions to women living in Barking and Dagenham, with 27% leading to abortion. The conception rate of 119 per 1,000 women aged 15-44 years compares with a rate of 86.7 for London as a whole and 78.8 for England. This conception rate is the highest in England, with the next highest being Newham, where the rate is 103.3[82]. There is also a high birth rate in Barking and Dagenham as measured by the General Fertility Rate (GFR, the number of live births per 1,000 women aged 15-44 years) and Total Fertility Rate (TFR, average number of live children a woman would bear). The GFR is 85.5 compared with 64.0 for London and 62.4 for England, and the TFR is 2.45 compared with 1.74 for London and 1.85 for England. Both of

77 http://www.theguardian.com/society/2010/jun/06/rachel-cooke-fifty-years-the-pill-oral-contraceptive
78 http://www.bbc.co.uk/news/uk-15984258
79 http://www.hscic.gov.uk/article/2021/Website-Search?productid=16268&q=srhad&sort=Relevance&size=10&page=1&area=both#top
80 http://www.ons.gov.uk/ons/rel/lifestyles/contraception-and-sexual-health/2008-09/index.html
81 http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population#tab-data-tables
82 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-322652

www.selfcareforum.org

these rates are the highest for any local authority in England[83]. The abortion rate is also the highest in England, 31.4 per 1,000 women aged 15-44 years, compared with 21.7 for London and 16.1 for England[84].

Research about pregnancy planning suggests that around half of pregnancies are planned, and of those that are not planned around one-third are 'unplanned' and two-thirds are 'ambivalent'. While the highest proportion of unplanned pregnancies occurs in women in aged 16 -19 years, the most unplanned pregnancies are in women aged 20-34[85]. While it is not possible to know how many conceptions locally are intended, taken as a whole the fertility and abortion rates suggest that a high proportion of pregnancies are unintended, resulting in both a high rate of pregnancy continuation and a high abortion rate, with 72% of abortions in 2013 in women aged 20-34 years. While it can be argued that the demography and ethnic make-up of our population contributes to our conception rates, with a high proportion of women of child bearing age from cultures that are more likely to have larger families, the substantial difference between Barking and Dagenham conception rates and those in every other part of the country suggests that this cannot be the whole story, and we should be looking hard at increasing the use of contraception overall as well as increasing the use of the more reliable long acting methods.

The cost effectiveness of contraception services is well established, with a figure of £1 spent on provision of contraception saving £11 in NHS costs being widely used as an overall figure since the work of McGuire and Hughes was first published in 1995[86]. More recent work has shown the increased cost effectiveness of long acting methods of contraception compared with oral contraception[87 88]. While long acting contraception is the ideal from the perspective of effectiveness – with the lowest risk of failure and the highest cost effectiveness of reversible methods of contraception, we should take every opportunity to maximise the use of all reliable methods of contraception and the availability of hormonal methods online is another source that can be considered.

Of the numerous online providers of oral contraception in the UK, some will supply them after an online Doctor's assessment to new pill users, and others will only supply to women who have already been using the pill for 3 or more months. The American Society of Obstetricians and Gynaecologists have recommended that oral contraception should be available without prescription[89 90], although commentators have described wider support for this change as a politically motivated attempt to reduce healthcare costs by taking contraceptive care outside of the American insurance system.

There has been very little discussion about removing the prescription only status from oral contraception in the UK, although emergency hormonal contraception has been available over the counter since 2001 to women over the age of 16. It is interesting that the limitation of oral contraception to prescription only status is a feature of Western Europe, USA, Canada and Australia, with most of the rest of the world allowing it to be sold either with a pharmacy consultation or no formal approval process at all[91]. There have been a small number of pilot studies assessing the benefits of making oral contraception available through pharmacies in England[92], and it is unclear why there is not more interest in this approach using the system of Patient Group Directions, whereby prescription only drugs can be supplied within a legal framework.

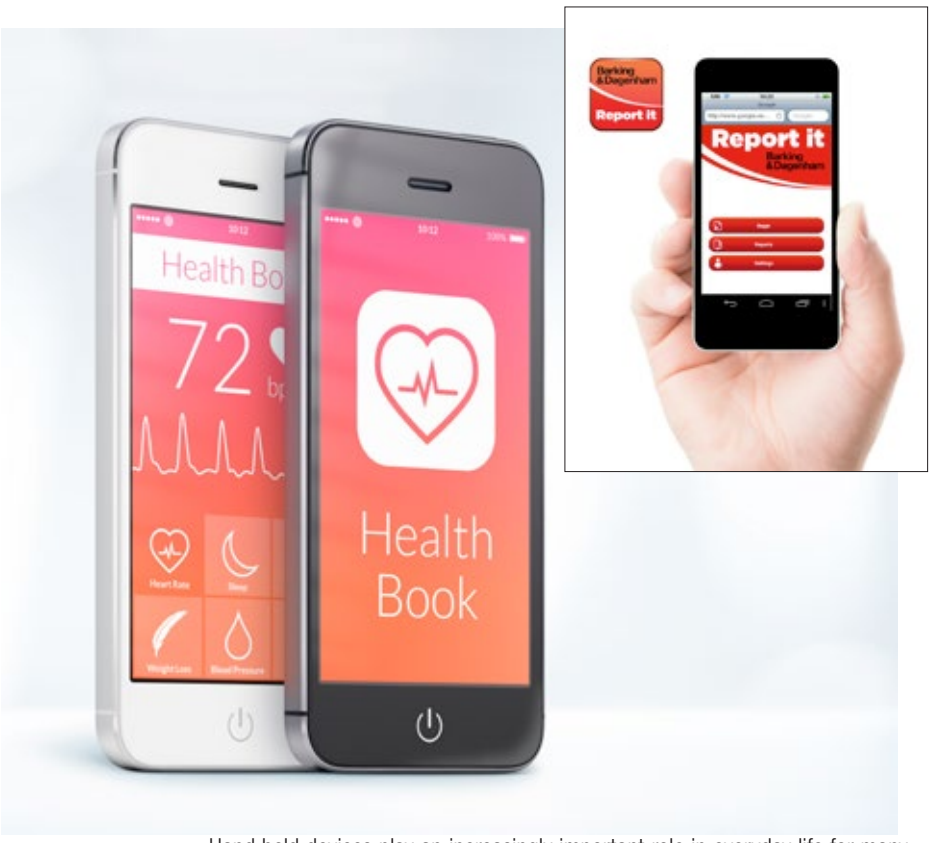
Recommended standards for oral contraception are published by the Faculty of Sexual and Reproductive Healthcare[93] and include the need

83 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-317529
84 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics__England_and_Wales_2013.pdf
85 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3898922/
86 Published in 1995 by the Family Planning Association, subsequently published in 1996 and available at http://jpubhealth.oxfordjournals.org/content/18/2/189.full.pdf.
87 http://humrep.oxfordjournals.org/content/23/6/1338.full.pdf
88 http://www.nice.org.uk/guidance/cg30/resources/longacting-reversible-contraception-cost-impact-report2
89 http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Over-the-Counter-Access-to-Oral-Contraceptives
90 http://www.acog.org/About-ACOG/News-Room/Statements-and-Advisories/2014/ACOG-Statement-on-OTC-Access-to-Contraception
91 http://cdn3.vox-cdn.com/assets/4662559/Screen_Shot_2014-06-24_at_1.45.04_PM.png
92 http://www.theguardian.com/society/2012/apr/25/the-pill-13-girls-nhs?guni=Article:in%20body%20link
93 http://www.fsrh.org/pdfs/CEUGuidanceCombinedHormonalContraception.pdf

for a detailed history for medical conditions such as migraine, family history of medical conditions and use of prescription and non-prescription drugs. Such a requirement is readily amenable to self-assessment and studies have found greater than 90% agreement between clinicians and clients when assessing medical history using a self-completed questionnaire[94]. A blood pressure recording is necessary prior to first use of oral contraception as raised blood pressure carries well documented risk, and this is easily available at pharmacies or by the purchase and use of home blood pressure monitors[95]. Similarly, BMI or body mass index is also recommended, and can be easily measured at home or elsewhere with a set of scales. Information on risks and use is readily available, and even with a conservative approach to a Patient Group Direction many thousands of women could easily be supplied with oral contraception through their local pharmacy.

Self-care – a public health opportunity?

The increasing availability of internet services, including access to diagnostic kits and treatments collected from local pharmacies or delivered by post, for sexual healthcare adds to the range of opportunities that individuals have to manage and control their own health and disease. While commercial ventures are driving many of these opportunities, with their basis being that individuals buy the services, some localities are using similar approaches to improve access for residents by commissioning charities and business providers to provide similar services so that the individual's ability or choice to pay is not the deciding factor. Remote access to service provision also challenges professional belief that health care and support is best given as part of a face to face interaction, which may be outmoded as the use of the internet and social media brings access to information and services to our smartphones wherever we are.



Hand held devices play an increasingly important role in everyday life for many

The interface between personal health choices and behaviours and personal responsibility for the health consequences is a complex ethical debate and a high proportion of public health and healthcare investment is directed at addressing the consequences of lifestyle choices that have costly health implications, as well as promoting and supporting healthy choices. We tread a path where there is conflict between holding individuals responsible for their own health related choices, attempting to retain and control access to diagnostic and treatment services which may be safe for people to manage for themselves, and fulfilling our societal obligations to treat the consequences of poor lifestyle choices or difficult access to care. Perhaps self-care for sexual health offers an opportunity to challenge our thinking and reconsider individual freedom to access diagnosis and treatment and our assessment of the risks and benefits to both individuals and society as a whole.

94 http://jfprhc.bmj.com/content/34/1/51.long
95 http://www.bhsoc.org//index.php?clD=246

5 Lifestyle challenges

Recovery Café – healthy food and good company in a drug and alcohol free environment

Addressing harm from alcohol consumption

Challenges and disincentives to adopting healthy lifestyles operate at individual, community and population level. The conditions in which people are born, grow, live, work and age, the so-called social and economic determinants of health which are largely responsible for health inequalities, can be influenced by national and local action to create healthier environments and to make healthier choices the easier choices, although we also make personal choices that have a big impact on our health. While it can be argued that our choices about what food to eat are affected by affordability and access – foods with high sugar and fat content are generally cheaper and easier to buy than fresh fruit and vegetables, neither tobacco nor alcohol are necessary for life and both are expensive and damaging to health.

Smoking is the biggest single cause of preventable mortality; around 250 people die each year in Barking and Dagenham because they smoke and the smoking attributable mortality rate is 384 per 100,000 population aged 35 years and over. This compares with a rate for London of 275.9 and for England of 288.7. Smoking prevalence locally is 23% of those aged 18 years and over, rising to nearly 30% in those from routine and manual groups. Every £1 spent on smoking cessation is estimated to save £10 in future health care costs and health gains, and a 20-a-day smoker saves around £3,000 a year by quitting[96]. Supporting more people to quit smoking, and discouraging more people from starting to smoke, is the most important thing we can do to improve people's health and reduce health inequalities, given that smoking is a greater source of health inequality than social position[97].

Problems resulting from drinking alcohol are also widespread. In England, 9 million adults drink at levels that increase the risk of harm to their health, 1.6 million adults show some signs of alcohol dependence and alcohol is the third biggest risk factor for illness and death[98]. Public Health England estimate that the NHS incurs £3.5bn a year in costs related to alcohol. Deaths from alcohol related liver disease have doubled since 1980, and one quarter of all deaths in 16-24 year old men are attributable to alcohol. Alcohol misuse contributes to a wide range of conditions and diseases, including high blood pressure, heart conditions and stroke, a number of cancers (liver, mouth, tongue, larynx, oesophagus and breast), pancreatitis, depression and anxiety, and infertility, as well as harming the unborn child.

Alcohol misuse not only harms the individual, but also has a big impact on families, communities and society. Misuse of alcohol contributes to almost half of all violent assaults, is instrumental in many cases of domestic violence and marital breakdown and in the psychological and behavioural problems of children of parents with alcohol

Alcohol Concern
Making Sense of Alcohol

Alcohol Concern leads on national campaigns with Public Health England: Alcohol Awareness Week and Dry January

problems. To control the impact of alcohol misuse and improve the safety of public places and public transport, alcohol is often banned from public events and drinking in public places may be prevented by local bye laws.

Data from the Health Survey for England (2012) found that, among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts[99].

In Barking and Dagenham, 16% of people, around 20,000, are estimated to be drinking alcohol at levels that may be damaging their health, and about 8,000 of them are already likely to have damaged their health. Around 30,000 accident and emergency attendances every year are related to alcohol, and nearly 3,000 hospital admissions. Alcohol related healthcare costs are estimated to be £10m per year, and around 50 people die every year from

96 http://www.nta.nhs.uk/uploads/why-invest-tobacco-final.pdf
97 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645845/
98 http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf
99 http://www.hscic.gov.uk/catalogue/PUB13218

Alternatives to alcohol offered by 'Company' – a community led enterprise

alcohol-related causes[100].

Alcohol drinking guidelines

Lower risk drinking guidelines advise that women should not drink more than 2-3 units a day (a large glass of wine is about 3 units, depending on the strength of the wine) and no more than 14 units a week. For men the lower risk level is 3-4 units a day (about a pint of strong beer or lager) and no more than 21 units a week. While no level of alcohol is completely safe, these levels are thought to carry a low risk of harm[101]. Above these levels, harm to the body from alcohol becomes increasingly likely – at 22 units a week for women and 35 units for men, harm is likely and at 35 units for women and 50 for men, harm is almost certain, although it may not be obvious for some time[102]. The difference in the number of units that lead to risk between women and men, and also between people of different body weight, is to do with the amount and proportion of fat in the body – fat helps to slow down the absorption of alcohol and therefore slows the rate at which blood alcohol levels increase and ultimately the highest blood levels achieved.

Alcoholic drinks also contribute to obesity as they tend to have high numbers of calories. A pint of beer or lager has about the same number of calories as a sugar doughnut or a large slice of pizza. A large glass of wine has about the same number of calories as a small burger or a piece of cake. As alcohol tends to be drunk in addition to food, and the calories are mostly sugar and bring no nutritional benefit to the body, it can make a significant contribution to overweight and obesity.

Binge drinking

Binge drinking is defined as drinking double the recommended amount of alcohol in one session[103]. It is often also considered to be about drinking a lot of alcohol quickly with the intention of getting drunk. Because the alcohol is drunk quickly, faster than it can be metabolised by the body, it can make you drunk quickly and also do physical harm, such as directly on the brain cells damaging mood and memory as well as affecting balance so leading to accidents and falls. Serious over dosing on alcohol can lead to death through stopping the heart or breathing, or through choking on vomit. Binge drinking can lead to aggressive, anti-social and violent behaviour.

Many people will not be aware how little alcohol needs to be drunk to cause harm to oneself by binge drinking. Double the recommended alcohol level means drinking about 3 pints of strong beer for a man, or just less than 3 large (250ml) glasses of wine. For a woman, drinking about 2 pints of strong beer or 2 large glasses of wine is enough alcohol to be a binge, especially if drunk in an hour or two. Binge drinking accounts for about half of the alcohol drunk in the UK[104].

Even if this quantity of alcohol is drunk once a week, and therefore weekly consumption of alcohol is within the recommended limits, drinking this amount of alcohol quickly is enough to cause harm to the body. The body metabolises alcohol at the rate of about one unit per hour. This means that, after a heavy bout of drinking, blood alcohol

100 https://www.alcoholconcern.org.uk/for-professionals/alcohol-harm-map/
101 http://www.nhs.uk/change4life/Pages/alcohol-lower-risk-guidelines-units.aspx
102 http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx
103 https://www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking
104 https://www.gov.uk/government/policies/reducing-harmful-drinking

Public Health England's national campaign, Change 4 Life, includes advice on safe use of alcohol

levels will still be high the next day, not only leaving you with a 'hangover' but meaning that you are still above the legal alcohol limit for driving.

Young drinkers

Children who begin drinking at a young age drink more frequently and in greater quantities than those who delay drinking, and are more likely to drink and to get drunk, particularly if they start to drink before the age of 13[105]. Drinking at a young age is frequently associated with other risky behaviours, and changes in brain function associated with heavy drinking may affect brain function in the short and longer term. Parents and carers own drinking behaviours influence children's drinking behaviours, as does the drinking habits of their peers.

Since 2003 there has been a downward trend in the number of children aged 11-15 years who said they had drunk alcohol at least once, from 61% in 2003 to 43% in 2012[106]. However, of those underage drinkers who do drink, the number of units drunk in the week is high at 12.5 on average, and the majority had drunk over the recommended levels for adults on each drinking day[107]. Although in adults males are more likely to be admitted to hospital with alcohol related problems (65%), amongst children (under 16 years) the reverse is true, with females more likely to be admitted (55%) than males. In 2012/13, 2,400 children under the age of 16 and 20,670 people aged 16-24 years were admitted to hospital in England with conditions wholly attributable to alcohol consumption, mainly acute intoxication or toxic effects.

Young people's drinking habits differ from older people as they drink less often during the week and are more likely to drink heavily when they do drink. Average weekly consumption of alcohol by people aged 16-24 years was 11.1 units in 2010, having reduced from 16.9 units in 2005. 54% of people aged 16-24 reported drinking alcohol in the previous week in 2011[108]. Young people now drink less than the national average, and drink fewer times a week than most age groups, but when they do drink a significant proportion binge drink.

A review commissioned by Drinkaware to investigate 'drunken nights out' by young people found that such nights out are entirely normal, at least from the perspective of those who participate in them[109]. Participants in the study reported that drunken nights out were beneficial in terms of escaping from everyday life, bonding and belonging, providing the opportunity for more extreme social interactions such as sexual encounters or fighting, and providing shared experiences for storytelling. Underage drinking was described as a learning phase, testing the effects of alcohol, and increasing age, with changing personal circumstances and priorities, generally signifies reduced participation in such nights out.

Older drinkers

Alcohol related problems are increasing in people over the age of 60, especially women. A recent survey[110] found that 15% of people aged 60 and over drank alcohol daily, compared with 1% of people aged 16-30 years, and that 25% of people aged 16-30 years stated that

105 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110256.pdf
106 http://www.hscic.gov.uk/catalogue/PUB14184
107 http://www.ias.org.uk/Alcohol-knowledge-centre/Underage-drinking/Factsheets/Prevalence-of-underage-drinking.aspx
108 http://www.ias.org.uk/Alcohol-knowledge-centre/Young-people-and-alcohol/Factsheets/Changing-trends-in-young-peoples-drinking.aspx
109 https://www.drinkaware.co.uk/media/264229/drinkaware_exec_summary_vfinal_individualpages.pdf
110 http://comres.co.uk/polls/Channel_4_Drinking_habits_survey_26_September_2014.pdf

Figure 12:
AUDIT-C questionnaire guidance

they never drank alcohol, compared with 14% of the over 60's. Although regular drinking in older people is associated with a 'drink to mark the end of the day' or drinking with their evening meal, alcohol related problems are rising fast in the over 60's, particularly amongst women, with the number of women over the age of 65 years treated for alcoholism in the last 5 years more than doubling[111].

In 2013/14, 9,000 people aged 60 and over were in treatment programmes for alcohol use, 63% of whom were male. Trend data shows a continuing increase in alcohol related hospital admissions in the over 65's, as well as in the number of deaths from alcohol related causes. Of nearly 400,000 admissions wholly or partly attributable to alcohol in people aged 65 and over, 12.5% were wholly attributable to alcohol[112].

Middle age drinkers

40% of those admitted to hospital with conditions wholly or partly attributed to alcohol are aged 45-64 years. Hospital admissions peak in those aged 40-49. A history of problem drinking in middle age more than doubles the risk of developing severe memory problems and dementia in later life[113]. Men aged 55-64 years consume the highest average number of units per week (21 units), but for women the highest average number of units consumed is at a much younger age, 35-44 years (12 units per week)[114].

Addressing alcohol consumption by individuals - identification and brief intervention

At the individual level, every opportunity should be taken to identify those with drinking habits that put them at risk of current and future health and social problems and to use effective brief intervention techniques to help reduce or stop alcohol consumption.

The Alcohol Use Disorders Identification Test or AUDIT[115] is the gold standard screening test and is used internationally. Locally the AUDIT-C test is used (see Figure 13), which has three initial questions about frequency and quantity of drinking, followed by further detailed questions if necessary.

111 http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-report-2013-14.pdf
112 http://www.hscic.gov.uk/catalogue/PUB14184
113 http://www.bmj.com/content/349/bmj.g4908?sso
114 http://www.ias.org.uk/Alcohol-knowledge-centre/Consumption/Factsheets/Drinking-patterns-and-trends.aspx
115 http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896
http://www.alcohollearningcentre.org.uk/_library/WHO_-_AUDIT.pdf

Figure 13:

Audit-C questionnaire

Questions	Scoring System					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Scoring: A total of 5+ indicates increasing or higher risk drinking An overall total score of 5 or above is AUDIT-C positive.						
					TOTAL	

Remaining AUDIT questions

Questions	0	1	2	3	4	Your score
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence						
TOTAL Score equals AUDIT C Score (above) + Score of remaining questions						

Substance misuse display at 2014 health event: left to right, Sonia Drozd, Cllr Saima Ashraf, Margaret Hodge MP

Brief interventions

Brief interventions can be effectively used by a wide range of trained staff including those in primary care including pharmacies, A&E and a range of other hospital departments, criminal justice, social services, drug services and youth services.

The recommended intervention is an evidence-based approach using the FRAMES[116] principles:

Feedback on the client's risk of having alcohol problems

Responsibility – change is the client's responsibility

Advice – provision of clear advice when requested

Menu – what are the options for change?

Empathy – an approach that is warm, reflective and understanding

Self-efficacy – optimism about the behaviour change

It should cover the potential harm caused by the client's level of drinking and reasons for changing their behaviour, including the health and wellbeing benefits and the barriers to change. Practical strategies to help reduce alcohol consumption should be outlined and a set of goals should be arrived at. Where possible, monitoring of progress should be undertaken[117].

There is good evidence for the effectiveness and cost effectiveness of this type of approach. For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels[118]. This compares favourably with smoking where only one in twenty will act on the advice given, improving to one in ten with nicotine replacement therapy[119].

Treatment services for problem drinkers

Treatment services are provided in primary care for those needing simple or extended brief interventions, and commissioned from community and hospital services for those requiring more complex care. Treatment is organised in tiers depending on the extent of the alcohol problem and the scale of the intervention needed:

Tier 1: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence.

Tier 2: alcohol specific advice; information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.

Tier 3: provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

Tier 4: provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare[120].

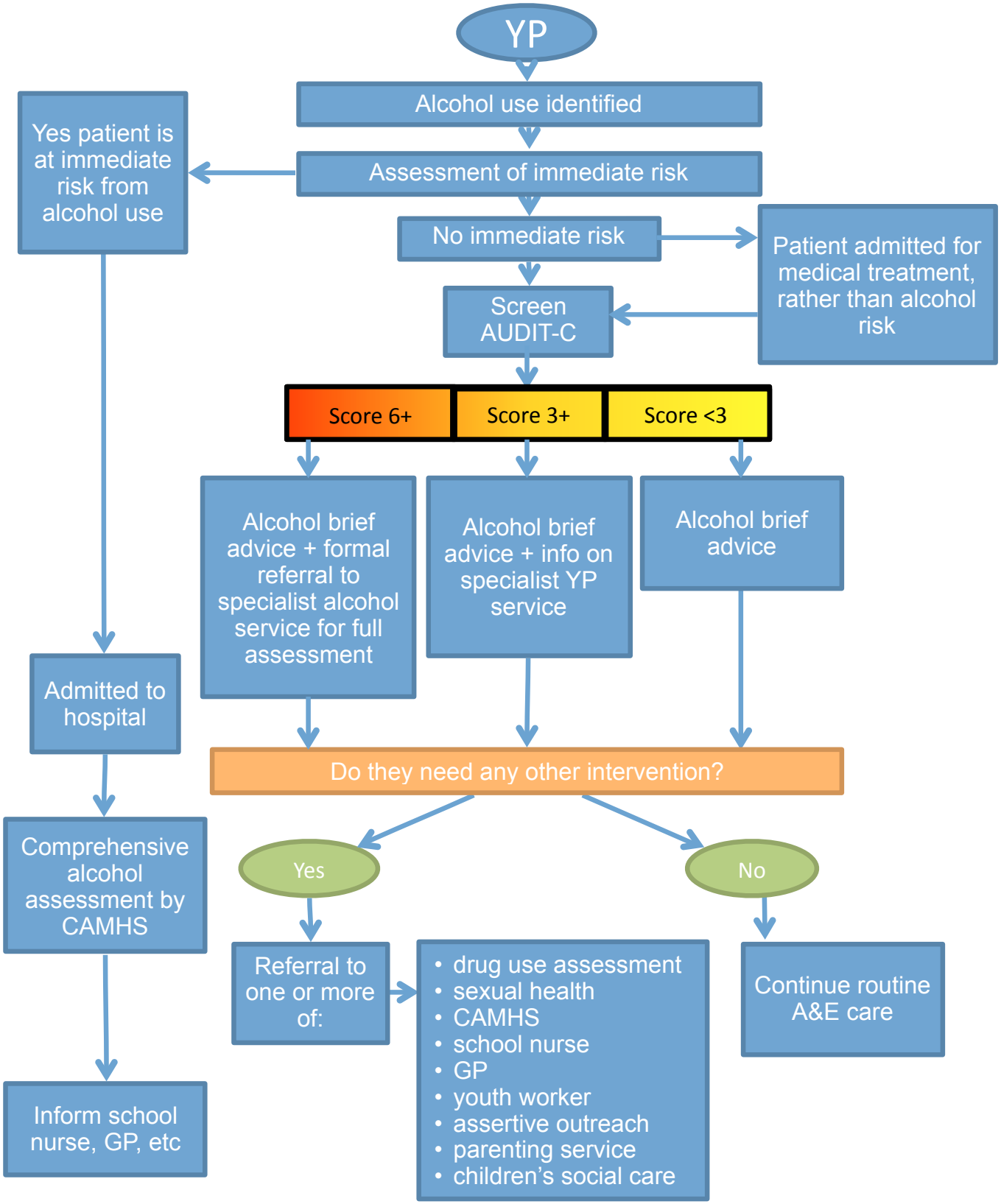
Helpful guidance has been published by Public Health England to show the necessary approach for young people attending A&E departments (Figure 14)[121].

Localising such guidance with contact details relevant to Barking and Dagenham, and producing a similarly localised pathway for adults attending primary care as well as A&E and appropriate training and promotion for a wide range of staff could help to ensure a more consistently implemented approach to identification and appropriate interventions for higher risk drinkers.

116 http://www.alcohollearningcentre.org.uk/alcoholeLearning/learning/IBA/Module4_v2/D/ALC_Session/300/tab_909.html
117 http://pathways.nice.org.uk/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders#path=view%3A/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders.xml&content=view-index
118 http://www.ncbi.nlm.nih.gov/pubmed/11964101
119 http://www.thecochranelibrary.com/userfiles/ccoch/file/World%20No%20Tobacco%20Day/CD000165.pdf
120 http://www.alcohollearningcentre.org.uk/_library/care_pathways1_Bexley.pdf
121 http://www.nta.nhs.uk/uploads/young-peoples-hospital-alcohol-pathways-support-pack-for-ed-departments.pdf

Figure 14:

Model care pathway for alcohol misusing adolescents in A&E



Policy approaches to reducing harm from alcohol

Policies that regulate the economic and physical availability of alcohol are effective in reducing alcohol related harm and interventions directed at those already drinking and at risk of harm are also effective. Information and education programmes do not reduce alcohol-related harm, but have a role in increasing knowledge and attracting attention towards the political and public opportunities to regulate alcohol availability, interventions which are highly cost-effective. The most cost-effective policy options to reduce alcohol-related harm are increasing and enforcing tax, reducing access, banning advertising and brief advice to drinkers[122].

In 2009 the Department of Health published suggested commissioning interventions to reduce alcohol related harm in their community. Included in this guidance are seven high impact changes that guide our approach to addressing alcohol-related harm (Figure 15).

Figure 15:
High impact changes to reduce alcohol-related harm

High Impact Change		What this means	What we do in Barking and Dagenham
1	Work in partnership	Co-ordinated action at local level through multi-agency groups	The Alcohol Alliance, a committee of the Substance Misuse Strategy Board, brings together partners to progress actions from the Alcohol Strategy[123]
2	Develop activities to control the impact of alcohol misuse in the community	Make use of all the existing laws, regulations and controls available to all the local partners to minimise alcohol related harm	The whole of the borough is a designated No Drinking Zone, no alcohol consumption in public places is permitted. There is a test purchasing programme to check licensed premises comply with alcohol purchasing age requirements and alcohol misuse screening of people arrested
3	Influence change through advocacy	Find high-profile champions to provide leadership within partner organisations and a focus for action to reduce alcohol harm	Council support for Alcohol Awareness Week, in 2014 there were 26 events in 20 locations, support also from business
4	Improve the effectiveness and capacity of specialist treatment	Providing evidenced based, effective treatment as well as increasing treatment opportunities for dependent drinkers may offer the most immediate opportunity to reduce alcohol-related admissions	Community detoxification programme and panel of providers for Tier 4 residential services

122 http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf
123 http://moderngov.barking-dagenham.gov.uk/documents/s66622/Alcohol%20Strategy%20Report%20-%20App.%201%20Strategy.pdf

5	Appoint an Alcohol Health Worker	Appointment of a dedicated alcohol liaison Nurse in each major acute hospital, to provide a focus for: • Medical management of patients with alcohol problems within the hospital • Liaison with community alcohol and other specialist services • Education and support for other healthcare workers in the hospital • Implementation of case-finding strategy and delivery of brief advice within the hospital	Established alcohol liaison workers in BHRUT with good links between A&E and other departments, carrying out Identification and Brief Advice and highlighting the pathway to the Community Alcohol Service (CAS)
6	Identification and Brief Advice (IBA) – Provide more help to encourage people to drink less	Opportunistic case-finding followed by the delivery of simple alcohol advice in primary care, A&E, specialist settings (such as fracture clinics and sexual health clinics) and criminal justice settings	In place, but opportunity to review consistency of delivery and use of AUDIT-C approach to identification and ensure brief advice widely available, with an IBA trained professional in every GP practice and a comprehensive plan for widespread delivery of IBA across the borough
7	Amplify national social marketing priorities	Social marketing is the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, for a social good. For alcohol, the goal is to reduce alcohol-related hospital admissions by influencing those drinking at higher risk to reduce their use of alcohol to within lower risk levels	Promotion of Alcohol Awareness week on annual basis, increasing use of social media including Apps that help to keep track of drinking and associated events (eg http://www.drinkcoach.org.uk/download-alcohol-app-for-ios-and-android.html). Targeting of regular drinkers to increase recognition of how quickly units add up to harmful levels.

Source: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104854.pdf and London Borough of Barking and Dagenham Community Safety Partnership

Addressing alcohol in Barking and Dagenham – our alcohol strategy

In 2013 the Community Safety Partnership agreed a local strategy[124] that takes a comprehensive approach to the personal, community and environmental aspects of alcohol consumption. The focus areas for the strategy are:

- Advice and information
- Alcohol related crime, domestic violence and anti-social behaviour
- Children, young people and families
- Adults
- Alcohol related hospital admissions, treatment and health
- Licensing and alcohol retail
- Economic impact

This comprehensive approach continues to drive our work, and in particular we have made good progress with the collection of anonymised A&E data to identify alcohol hotspots, reduce violent crime and address A&E attendance and admission.

Addressing harmful drinking – a partnership approach

Reducing the impact of alcohol on our community and the numbers of people who drink at higher risk and harmful levels will only be achieved through a partnership between national and local government, and between health and care services and individuals. The recently published manifesto from the All Party Parliamentary Group (APPG) on Alcohol Misuse[125] sets out a clear ten point plan which is a useful approach to the necessary actions.

Most of the actions proposed by the APPG are aimed at central government – making reducing alcohol harm the responsibility of a single government minister, introducing a minimum price for alcoholic drinks, introducing public health as a fifth licensing objective, strengthening regulation of alcohol marketing to protect children and young people, including a health warning on all alcohol labels, and reducing the blood alcohol level for driving. Their proposal to introduce the widespread use of sobriety orders, which require an offender to abstain from alcohol for a fixed period of time following a conviction, with alcohol levels monitored either through regular breath tests or electronic tags, is being trialled around the country and offers an approach to breaking the cycle of violent crime and domestic violence.

The remaining actions proposed by the APPG are aimed at local commissioners and providers, and these are within the remit of our health and care services. There is good evidence that identification and brief advice from GPs and other health professionals are effective in enabling people to understand and address harmful levels of drinking and that good treatment services help to reduce alcohol-related hospital admissions. We need to work together to prioritise training for professionals in a wide range of health and care settings, so that identification of people drinking at hazardous and harmful levels is a routine part of care, and every opportunity is taken to reduce the overall burden of alcohol related disease. Training for social workers, midwives and healthcare professionals on parental substance misuse, foetal alcohol syndrome and alcohol-related domestic violence is within our strategy and we need to ensure that it is effective in identifying those at risk. The final action in the strategy is a proposal to increase funding and improve access to treatment services to the target of 15% of problem drinkers having treatment locally from the current national level of 6%. We will be reviewing access and care pathways as we refresh our alcohol strategy and commissioning to assess our current treatment programme.

While central and local government builds an environment which makes problem drinking more of a challenge and supports people to reduce harmful drinking habits, and local government and the NHS continue to invest in treatment services, individuals themselves share responsibility to be aware of the risks associated with their drinking levels and seek to control harm, accessing support if this is the most effective approach for themselves. Partnership for health and wellbeing is as much about individuals as it is about organisations, and regardless of the extent of legislation and support, behaviour change depends on each individual understanding their own drinking habits and taking the necessary steps to change their behaviour to protect their own health and wellbeing.

124 http://moderngov.barking-dagenham.gov.uk/documents/s66622/Alcohol%20Strategy%20Report%20-%20App.%201%20Strategy.pdf
125 http://www.alcoholconcern.org.uk/wp-content/uploads/2014/10/APPG_Manifesto.pdf

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HEALTH AND WELLBEING BOARD

17 March 2015

Title:	Pharmaceutical Needs Assessment for Barking and Dagenham, 2015

Report of the Director of Public Health

Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: Yes**
Report Authors: Remi Omotoye, Head of Health Intelligence Sue Lloyd, Consultant in Public Health	**Contact Details:** Tel: 0208 227 5907 E-mail: remi.omotoye@lbbd.gov.uk

Sponsor: Matthew Cole, Director of Public Health

Summary:

This paper is to seek Board approval for the Pharmaceutical Needs Assessment 2015.

The Barking and Dagenham Health and Wellbeing Board received a paper about it's responsibilities in respect of the production of a Pharmaceutical Needs Assessment (PNA) in September 2013. The Health and Wellbeing Board, as an Executive Committee within the Council, is statutorily required to produce an assessment of pharmaceutical services in its area by 1 April 2015. This paper provides an update on progress with the work undertaken to complete the new Barking and Dagenham PNA, and outlines the next steps that are planned to complete the work by 1 April 2015.

The PNA provides an assessment of the local need for pharmaceutical services. This is different from identifying general need and there are specific requirements for it's content, set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

NHS England will rely on the PNA when making decisions on applications to open new pharmacy and dispensing appliance contractor premises, so called 'market entry' decisions. A person or organisation wishing to provide NHS pharmaceutical services has to demonstrate how they will be able to meet a need as set out in the PNA. Such decisions can have significant commercial implications, can be appealed against and decisions made on appeal can be legally contested.

The draft PNA issued on 19 December 2014 for public consultation was extended past the statutory 60 day to close on 1 March 2015. The report was widely publicised on the Council website[1] and via other popular media channels so as to sensitise the public of its availability. Electronic copies of questionnaire for completion was provided by a link on the Council website, and paper versions were also disseminated to key places across the borough for residents.

The key finding of the draft Pharmaceutical Needs Assessment did not find any gap in

[1] https://www.lbbd.gov.uk/residents/health-and-social-care/health-and-wellbeing/have-your-say-on-health/pharmaceutical-needs-assessment-2014/

provision or access to services provided from community pharmacies in Barking and Dagenham either now or in the next three years. A summary of the report findings and consultation is detailed in **Appendices 1 and 2**. The PNA itself is attached at **Appendix 3**.

The Public Health team and the Steering Group are assured that it will be delivered by the 1st of April 2015 deadline.

The following is the timeline for the process of completion of the PNA:

- Consultation closes Sunday 1 March, with paper and electronic copies uploaded onto the Survey Monkey website by the following day, 2 March 2015.
- Completed consultation analysis and drafting of final PNA sent to Steering Group members on Monday, 2 March 2015 for review. The tight timeline means the report will not be proof read or formatted.
- 5 March – PNA Steering Group Meeting at a proposed time of 12.30pm for 2 hours.
- 6 March – Amendments made to PNA from Steering group meeting (providing the volume permit the amendments to be done in a day).
- **9 March – Final PNA sent to the Director of Public Health and the Health and Wellbeing Board for *approval* on Monday 9 March - again, this will not be proof read or formatted at this stage, as time will not allow.**
- 17 March – Action notes to be taken at the HWB meeting on any amendments to be made - Soar Beyond will guide the Health Intelligence team on what is needed nearer to the time.
- 18 March – Notes to be sent to Soar Beyond after the HWB on 17 March 2015.
- 19 March – Soar Beyond to work in any changes to the final document (if any), proof read and format to return a final PNA for publication, by 31 March 2015.

Recommendation(s)

The Health and Wellbeing Board is recommended to note that:

1. Barking and Dagenham HWB has 38 community pharmacies.

2. This equates to about 19.6 community pharmacies per 100,000 population - which is lower than the average for London (22.3/100,000) and England (21.7/100,000).

3. Of these community pharmacies, 79% are open weekday evenings, 97% are open on Saturdays, and 18% are open on Sundays.

4. Half of the pharmacies in Barking and Dagenham are owned by independents, compared to 39% nationally.

5. From a pharmacy user survey taken in the autumn last year (480 responses) 91% rated the service received from pharmacies in Barking and Dagenham as good or excellent; 82% indicated that they do not have a preferred pharmacy they use; 85% said the ease of obtaining medicines was good or excellent; 71% said their journey time to a pharmacy was no more than 10 minutes.

6. Pharmacies in Barking and Dagenham are commissioned to provide services on behalf of NHS England, Barking and Dagenham CCG, and Barking and Dagenham Council.

The Pharmaceutical Needs Assessment did not find any gap in provision or access to services provided from community pharmacies in Barking and Dagenham, either now or in the next 3 years.

Reason(s):

The PNA provides key evidence, which informs commissioning and strategic decisions for pharmaceutical services to residents and workers within the borough.

It is also intended to support a broad range of strategies to improve health and wellbeing including the Better Care Fund work programme, Children and Young People's Plan, Community Strategy 2013-2016**,** NHS Barking and Dagenham Clinical Commissioning Group's 5 year Strategic Plan and Care Act 2014 implementation**.** The PNA makes reference to developments in the borough that deliver the Council's strategy *One borough; one community; London's growth opportunity.*

It is a statutory duty of the Health and Wellbeing Board to publish a PNA for the health system across the London Borough of Barking and Dagenham health system by 1 April 2015.

1. Introduction and Background

One of the significant reforms to the NHS following the enactment of the Health and Social Care Act 2012 was the inception of Health and Wellbeing Boards (HWB). HWBs were set up to oversee joined up work across the health and social care system, made up of the NHS, public health, adult social care and children's services as well as elected representatives and Local Healthwatch. One of the many responsibilities of the Barking and Dagenham HWB is to develop and produce a Pharmaceutical Needs Assessment (PNA).

The PNA looks specifically at the current provision of pharmaceutical services in Barking and Dagenham and determines whether these pharmaceutical services meet the needs of the population currently and over the lifetime of this PNA (2015-18) and determines if there are or are likely to be any potential gaps within the service provision. The primary purposes of the Barking and Dagenham Pharmaceutical Needs Assessment are summarised below:

1.1. The PNA will be used by the NHS when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements.

1.2. The PNA will help the HWB to work with providers to target services to the area where they are needed.

1.3. The PNA will inform interested parties of the PNA and enable collaborative work to plan, develop and deliver pharmaceutical services for the population.

1.4. The PNA will help inform commissioning decisions by local commissioning bodies.

1.5. NHS Pharmaceutical Services comprises the following:

i. essential services which all community pharmacies must provide – dispensing of medicines and appliances, promotion of health lifestyles, disposal of unwanted medicines, support for self-care;

ii. advanced services which community pharmacies can choose to provide and require extra accreditation, including medicines use review, appliance use review, new medicines service, stoma appliance customisation;

iii. enhanced services which are commissioned by NHS England area teams to meet local need. These include flu vaccination, minor ailments services, support to residents and staff in care homes, and out of hours services.

Pharmacies also make a significant contribution to front line health and care services, being a source of advice to customers about health and wellbeing selling a range of products that do not require prescription. The siting of pharmacies and skills available is therefore of interest to the Council and the CCG, which may commission additional services.

1.6 Public Health services may be commissioned by local authorities from pharmacies, including smoking cessation services, sexual and reproductive health services such as emergency contraception and chlamydia screening, and drug misuse services, such as supervised consumption of methadone and needle exchange services.

1.7 CCGs may also commission pharmacies to support local delivery of services, including monitoring of long term conditions to reduce the need for attendance at a general medical practitioner.

1.8 Currently there are 39 pharmacies distributed across the borough providing a range of services.

2. Statutory Requirements in respect of the PNA

2.1 The Pharmaceutical Needs Assessment is a report on the local need for pharmaceutical services. It is used to identify any gaps in current services or improvements that could be made to current or future pharmaceutical service provision. The specific content required is set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The PNA must contain:

i. A statement of the pharmaceutical services provided that are necessary to meet needs in the area

ii. A statement of the pharmaceutical services that have been identified by the HWB that are needed in the area, and are nor provided (gaps provision)

iii. A statement of the other services which are provided, which are not needed, but which have secured improvements or better access to pharmaceutical services in the area

iv. A statement of the services that the Health and Wellbeing Board has identified as not being provided , but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area

v. A statement of other NHS services provided by the Council, NHS England, the CCG, and the local NHS Trusts, which affects the needs for pharmaceutical services

vi. An explanation of how the assessment has been carried out (including how the consultation was carried out), and

vii. A map of providers of pharmaceutical services

2.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 requires a minimum 60 day consultation period on a draft assessment. The consultation on the Barking and Dagenham draft PNA is planned to be undertaken between 19 December 2014 and 1st March 2015.

2.3 The Regulations specify the organisations and individuals that must be consulted by the Health and Wellbeing Board. These are:

- Any Local Pharmaceutical Committee covering the area
- Any Local Medical Committee covering the area
- Any persons on the pharmaceutical lists and any dispensing doctors lists for the area
- Any Pharmacy in the area with whom NHS England has made arrangements for the provision of local pharmaceutical services
- Any local Healthwatch for the area, and any other patient, consumer or community group in the area which in the opinion of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in the area
- Any NHS Trust of NHS Foundation Trust in the area
- NHS England
- Any neighbouring Health and Wellbeing Board

2.4 The Regulations also require the PNA to be kept under review. This includes:

- Assessing whether the current PNA needs revisions on the basis of substantial changes occurring to pharmaceutical services.
- Producing a supplementary statement to capture changes in pharmaceutical provision occurring since the last PNA was published, which are not substantial.
- Keeping a map of pharmaceutical services in the area as up to date as possible.

2.5 Regardless of any changes, a revised assessment must be published within three years of the publication of the PNA.

3. Local arrangements for preparation, consultation and publication of the PNA

3.1 A steering group was formed to provide governance and expertise to facilitate the production of the PNA. The steering group is chaired by the Head of Health Intelligence and other officers from the Council, CCG, NHS England, Healthwatch, and the Local Pharmaceutical Committee.

3.2 The Council tendered for specialist input from an external agency to guide the development and publication of the PNA. The successful agency, Soar Beyond Ltd, is currently assisting in the production of a number of Pharmaceutical Needs Assessments throughout north east London.

3.3 To help inform the draft assessment and consultation, a pharmacy user questionnaire was developed to seek feedback from the following groups:

- Members of the public – resident or working in the borough
- Providers of pharmaceutical Services - Community pharmacies, GP Practices, and Hospital pharmacies
- Commissioners of services – CCGs, NHS England, Local Authorities

3.4 Questionnaires were distributed through community pharmacies, GP practices in Barking and Dagenham, as well as to various statutory consultees and community groups.

3.5 The draft PNA will be presented to the steering group on 8 December 2014, and issued for consultation on 19 December 2014.

3.6 Following closure of consultation on 1st March 2015, comments will be considered and the final document will be prepared for publication by the statutory deadline of 1 April 2015.

3.7 A summary of the report findings and consultation is detailed in Appendix 1.

4 Mandatory Implications

4.1. Pharmaceutical Services Needs Assessment

Publication of the PNA by 1 April 2015 is mandatory under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

4.2 Other Strategic Documents

The completed report is supported and aligned with the following strategic documents:

- The Joint Strategic Needs Assessment 2014
- The Joint Health and Wellbeing Strategy 2012-2015
- Joint Better Care Fund work programme
- Children & Young People's Plan
- Community Strategy 2013 -2016
- NHS Barking and Dagenham Clinical Commissioning Group's 5 year strategic plan
- The Council's Housing Strategy for the next 5 years[2]
- Implications of the Care Act 2014

[2] http://www.lbbd.gov.uk/Environment/PlanningPolicy/Pages/Monitoring.aspx

4.3 Integration

The report will make recommendations related to the need for effective integration of services and partnership working.

4.4 Financial Implications

- The Pharmaceutical Needs Assessment has been completed at a cost of £34,900.00, and this has been funded from the Public Health grant. There are no other financial implications directly arising from this report.
  (Implications completed by: Roger Hampson, Group Manager Finance (Adults and Community Services)

4.5 Legal Implications

There are no legal implications for the following reasons:

- The reports identifies the content that is required to be incorporated into the PNA by the 2013 Regulations;
- You have adhered to the consultation period within the said regulations;
- There are no gaps in service provision in LBBD currently or any anticipated in the next 3 years

  (Implications completed by: Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services)

4.6 Risk Management

The recommendations of this paper are a product of the evidence based PNA process, with an aim to improve health and wellbeing across the population. There are no risks anticipated, provided the commissioning and strategic decisions take into consideration equality and equity of access and provision.

5. Non-mandatory Implications

The PNA seeks to review the evidence of need for local residents across the breadth of health and wellbeing. Therefore the recommendations presented here and the full PNA document will be of relevance to stakeholders across the health and social care system

List of appendices

Appendix 1: Data Collection, Report Preparation and Consultation

Appendix 2: Summary of the Barking and Dagenham Pharmaceutical Needs Assessment 2015

Appendix 3: Pharmaceutical Needs Assessment 2015

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Appendix 1 – Data Collection, Report Preparation and Consultation

6.1. Data collection:

6.1.1 COMPLETED: Pharmacy Contractor questionnaires: An online pharmacy contractor questionnaire was finalised and agreed by the Steering Group. It was sent to all pharmacies in Barking and Dagenham for completion. The LPC supported this work, encouraging pharmacists to complete the survey.

6.1.2 COMPLETED: Pharmacy user/ resident survey: A survey was agreed and finalised by the Steering Group. Paper copies (approved by LBBD) were sent out for distribution through all pharmacies, GP Practices, libraries and Leisure Centres in Barking and Dagenham. The online survey has also been distributed through Barking and Dagenham HealthWatch.

6.1.3 COMPLETED: Commissioner Survey: Sent to Barking and Dagenham CCG, LBBD, and NHSE.

6.1.4 COMPLETED: Background report collection: Background reports and copies of plans for the work have been submitted by the Barking and Dagenham CCG, LBBD Housing team and other departments as were requested.

6.2 Report Preparation

6.2.1 COMPLETED: New draft Barking and Dagenham PNA Report: The new draft Barking and Dagenham Pharmaceutical Needs Assessment was completed in December 2014. The full report and also summary report were available to view/ download via the LBBD website.

6.3 Consultation

6.3.1 COMPLETED: The mandatory consultation is a minimum 60 days long. It started on 19 December 2014 and closed on 1 March 2015.

The Consultation has included the following elements:

- E-mailed PNA and online survey questionnaire to all mandatory consultees (including pharmacists and neighbouring Health and Wellbeing Boards) (December 2014)
- Consultation documents and questionnaire available through the London Borough of Barking and Dagenham website consultation page (December 2014)
- Paper summary report and survey questionnaires sent to all Barking and Dagenham pharmacies (December 2014)
- Paper summary report and survey questionnaires sent to all Barking and Dagenham GP practices (December 2014)

A timeline for the delivery of the PNA was agreed by the Board; it was agreed that due to the necessary consultation period and the need to

complete the PNA by 31 March 2015 the Board would complete the sign off of the new Barking and Dagenham Pharmaceutical Needs Assessment at its 17th March 2015 meeting.

Appendix 2 Summary of the Barking and Dagenham Pharmaceutical Needs Assessment 2015

7.1 The London Borough of Barking and Dagenham current has 38 community pharmacies

- This equates to an average of 19.6 pharmacies per 100,000 population
- This is lower than the London (22.3) and England (21.7) averages
- Pharmacies in LBBD, on average, dispense fewer prescriptions than the England average (LBBD-6328 per month, England-6784 per month) but more than the London region average (5393 per month)
- 79% of pharmacies in the borough are open weekdays after 6pm
- 97% are open on Saturdays
- 18% are open on Sundays

7.2 A short pharmacy-user survey conducted in the borough last autumn received 480 responses:

- 91% rated the pharmacy service in the borough as ‘excellent’ or ‘good’
- 85% rated the ease of obtaining medicines from pharmacies in the borough as ‘excellent’ or ‘good’
- 71% had a journey time of no more than 10 minutes to a pharmacy

7.3 Pharmacies in Barking and Dagenham are commissioned (by NHS England, Barking and Dagenham CCG, or Barking and Dagenham Council) to provide a range of additional services:

- Vaccinations
- Urgent access to emergency medicines
- Minor ailments service
- Emergency hormonal contraception
- Chlamydia screening and treatment
- Condom distribution
- Community equipment (disability aids)
- Drug addiction services (supervised consumption of opiates, and needle exchange)
- Anticoagulation services
- Support to stop smoking

7.4 An analysis of travel to pharmacies shows:

- 100% of the Barking and Dagenham population have no more than a 10 minute drive to their nearest pharmacy
- 88% of the Barking and Dagenham population have no more than an average 10 minute public transport journey to their nearest pharmacy
- 89% of the Barking and Dagenham population have no more than a 15 minute walk to their nearest pharmacy

7.5 Access to services provided through pharmacies was considered in the Pharmaceutical Needs Assessment (PNA) across the six localities in the borough

- The PNA Steering Group concluded within the assessment that there were no gaps across the whole of the borough in accessing any service provided by pharmacies.

7.6 Following a consultation on the draft Pharmaceutical Needs Assessment, 43 responses were received (from the public, community pharmacists, NHS England, Barking and Dagenham Clinical Commissioning Group, and Barking and Dagenham LPC):

- 59% agreed (19% neither agreed nor disagreed, 8% didn't know) with the conclusion that there are no gaps in pharmacy provision anywhere in the borough
- 60% agreed (21% neither agreed nor disagreed, 11% didn't know) with the other conclusions of the PNA
- None felt that the PNA did not reflect the current provision of pharmacy services in the borough
- 3% felt that the PNA did not reflect the current needs of pharmacy services in the borough
- 5% felt that the PNA did not reflect the future needs of pharmacy services in the borough

Pharmaceutical Needs Assessment 2015

Barking and Dagenham Health and Wellbeing Board

Contents

This Pharmaceutical Needs Assessment (PNA) has been produced through the PNA Steering Group for Barking and Dagenham Health and Wellbeing Board by the London Borough of Barking and Dagenham with authoring support from Soar Beyond Ltd.

Executive summary

Every Health and Wellbeing Board (HWB) is now required to produce a Pharmaceutical Needs Assessment (PNA).

This mapping of pharmaceutical services against local health needs provides Barking and Dagenham HWB with a framework for the strategic development and commissioning of services. It will enable the local pharmacy service providers and commissioners to:

- understand the pharmaceutical needs of the population
- gain a clearer picture of pharmaceutical services currently provided
- make appropriate decisions on applications for NHS pharmacy contracts
- commission appropriate and accessible services from community pharmacies
- clearly identify and address any local gaps in pharmaceutical services
- target services to reduce health inequalities within local health communities

This draft PNA has been produced through the PNA Steering Group for Barking and Dagenham HWB by the London Borough of Barking and Dagenham (LBBD), with authoring support from Soar Beyond Ltd. The consultation on the draft PNA took place between 19th December 2014 and 27th February 2015.

NHS pharmaceutical services in England

NHS pharmaceutical services are provided by contractors on the pharmaceutical list held by NHS England. Types of providers are:

- community pharmacy contractors, including distance-selling pharmacies
- dispensing appliance contractors
- local pharmaceutical service providers
- dispensing doctors

Community pharmacies operate under a contractual framework agreed in 2005 which sets out three levels of service:

Essential services:	Negotiated nationally. Provided from all pharmacies
Advanced services:	Negotiated nationally. Provided from some pharmacies, specifically accredited
Enhanced services:	Negotiated locally to address local health needs. Provided from selected pharmacies, specifically commissioned

This contract enables NHS England area teams to commission services to address local needs, whilst still retaining the traditional dispensing of medicines and access to support for self-care from pharmacies.

Health in Barking and Dagenham

The area

Barking and Dagenham is a borough on the north east of London. It has borders with the other London boroughs of Newham, Havering, Redbridge, Greenwich and Bexley. Main urban areas in the borough include the towns of Barking and Dagenham and the area between the towns of Ilford and Romford. Covering an area of just under 14 square miles, Barking and Dagenham is bordered in the east partly by the River Rom and in the south fully by the River Thames.

The population

The population has grown by almost 20% over the last 15 years and by almost 25% over the last 25 years. The current estimated population is 194,352(2013). This number is projected to rise to:

- 210,300 by 2017 (8.2%)
- 218,100 by 2019 (12.2%)

These rates are similar to the England average (7.1% and 13.1% respectively).

LBBD plans to develop 6,000 homes during 2014-2019 which will help support the growing population and demand for housing.

Barking and Dagenham has a similar proportion of non-white ethnic population (42%) to the London average of 40%, and significantly greater than the England average of 15%.

The increasing population and its diversity will require significant planning for the delivery of services, in particular to meet its varied health and social care needs.

Health inequalities

The borough, on the whole, is relatively more deprived than other parts of London. The most deprived areas are concentrated largely in the West, and the least deprived in the North locality.

Health and illness

Life expectancy at birth for men in Barking and Dagenham (77.6 years) is lower than in both England (79.2 years) and London (79.7 years). Life expectancy in women (82.0 years) is also lower than both the London (83.8 years) and England (83.0 years) average values. There is a variation in life expectancy between wards, with River having the lowest life expectancy for both men and women. Abbey has the highest for men and Longbridge the highest for women.

Lifestyle

Lifestyle issues are of a concern in some areas, particularly smoking prevalence as overall, the borough, has a significantly higher rate than London and England. 10% of mothers are smokers when they have their baby, compared with 5% for London as a whole.

The impact of this is that Barking and Dagenham has worse rates than London and England for many of the indicators of ill health and mortality associated with smoking.

Pharmacies in Barking and Dagenham

Barking and Dagenham has 38 community pharmacies (as at 30th January 2015) for a population of about 194,352. Provision of current pharmaceutical services and locally-commissioned services are well distributed serving all the main population centres. There is excellent access to a range of services commissioned, and privately provided from, pharmaceutical service providers.

Using current population estimates, the number of community pharmacies per 100,000 population for Barking and Dagenham is currently 19.6. Barking and Dagenham is well-served with community pharmacies, although the rate of provision is currently less than London and England average. Table 1 shows the change in the numbers of community pharmacies compared with regional and national averages over the previous few years.

Table 1 - Number of community pharmacies per 100,000 population

	Community pharmacies per 100,000 population		
	England	**London SHA**	**Barking and Dagenham**
2013/14	21.7	22.3	19.6
2012/13	21.6	22.5	20.3*
2011/12	21.2	22.2	19.2*
2010/11	21.1	23.3	20.5*

**This figure is an estimate and includes DAC and DSP therefore the figure may differ for estimates based solely on community pharmacy contractors.*

The majority of community pharmacies in Barking and Dagenham are open weekday evenings (79%) and Saturdays (97%).

A number are open on Sundays (18%), mainly in shopping areas. There is also a much higher than national ratio of independent providers to multiples offering a good choice of providers to local residents (national average is 39% independent providers versus 50% in Barking and Dagenham).

Feedback on pharmaceutical services

Views of pharmacy service users were gained from a questionnaire circulated for comments from the general public.

From the 480 responses received from the public questionnaire:

- **91%** rated their overall satisfaction on the service received from their local pharmacy as **'Excellent'** or **'Good'**
- **32%** indicated that they used pharmacies **up to every month for the purchase of over the counter medicines**, with **82%** having a **regular or preferred pharmacy** they use

- **85%** rated the ease of obtaining medication as **'Excellent'** or **'Good'**
- **42%** rated as important that the pharmacy is **close to their GP surgery; 73%** that the pharmacy is **close to their home**; **20%** that the pharmacy is **close to where they work** and **31%** that the pharmacy has **friendly staff**
- **61%** walk to their community pharmacy; **32%** use a **car / taxi**; **6%** use **public transport; 2%** use **other forms** (wheelchair, mobility scooter)
- **80%** had **no difficulties travelling** to their pharmacy; **15%** had **parking difficulties**; **4%** had **problems with the location** of the pharmacy; and **1%** had **problems of public transport availability**
- a significant number of respondents had no **most convenient day (58%)** or **time (49%)** to **visit their pharmacy**
- **71%** of respondents report having a **journey time of no more than 10 minutes**
- **91%** rated their **confidence in the pharmacists knowledge and advice** as **'Excellent'** or **'Good'**

Conclusions

Current provision – necessary and other relevant services

Barking and Dagenham HWB has identified necessary services as essential services and advanced services as required by Paragraphs 1 and 3 of Schedule 1 to the Regulations

Barking and Dagenham HWB has identified enhanced services as pharmaceutical services which secure improvements or better access to, or have contributed towards meeting the need for, pharmaceutical services in the area of the HWB.

Barking and Dagenham HWB has identified locally commissioned services as those which secure improvements or better access to, or have contributed towards meeting the need for, pharmaceutical services in the area of the HWB.

Necessary services – gaps in provision

As required by Paragraph 2 of Schedule 1 to the Regulations:

Access to essential services

In order to assess the provision of essential services against the needs of the residents of Barking and Dagenham, the HWB consider access (travelling times by car, public transport and walking) and opening hours as the most important factors in determining the extent to which the current provision of essential services meets the needs of the population.

Access to essential services normal working hours

Barking and Dagenham HWB has determined that the travelling times by car, public transport and walking and opening hours of pharmacies in all six localities, and across the whole HWB area, are reasonable in all the circumstances.

There is no gap in the provision of essential services during normal working hours across the whole HWB area.

Access to essential services outside normal working hours

Supplementary opening hours are offered by all pharmacies in each locality. There are also three 100 hour contract pharmacies and four "late night" pharmacies open until at least 8pm on week days or weekends. Almost one in five or 18% of pharmacies within the HWB area are either 100 hour or late night opening pharmacies. These are geographically spread across the HWB area and present in four localities. This is a significant proportion of pharmacies. There is no pharmacy open on Sunday in the East locality. Based upon the results of the patient survey, population density and access to pharmacies across the HWB area there is no gap in services which would equate to the need for access to essential services outside normal hours in this locality. The HWB will monitor the uptake and need for necessary services. It will also consider the impact of any changes in this locality in the future which may provide evidence that a need exists.

There are no gaps in the provision of essential services outside of normal working hours across the whole HWB area.

Access to advanced services

There is no identified gap in the provision of advanced services as medicines use reviews (MURs) are accessible in 89-100% of pharmacies across all six localities and new medicines service (NMS) is available in 83-100% of pharmacies across all six localities.

There are no gaps in the provision of advanced services across the whole HWB area.

Access to enhanced services

There is no identified gap in the provision of enhanced services as minor ailments services are accessible in 62-100% of pharmacies across all six localities and immunisation services are accessible in 78-100% of pharmacies across all six localities.

There are no gaps in the provision of enhanced services across the whole HWB area.

Future provision of necessary services

Barking and Dagenham HWB has not identified any pharmaceutical services that are not currently provided but that will, in specified future circumstances, need to be provided in order to meet a need for pharmaceutical services in any of the six localities.

No gaps in the need for pharmaceutical services in specified future circumstances have been identified across the whole HWB area.

Improvements and better access – gaps in provision

As required by Paragraph 4 of Schedule 1 to the 2013 Regulations:

Current and future access to essential services

Barking and Dagenham HWB has not identified services that would, if provided either now or in future specified circumstances, secure improvements, or better access, to essential services in any of the six localities.

No gaps have been identified in essential services that if provided either now or in the future would secure improvements, or better access, to essential services across the whole HWB area.

Current and future access to advanced services

In 2013/14 MURs are available in 89-100% of pharmacies across all localities and NMS is available in 83-100% of pharmacies across all localities. Where applicable, NHS England should encourage all pharmacies and pharmacists to become eligible to deliver the service in all pharmacies so that more suitable patients are able to access and benefit from this service.

Demand for the appliance advanced services, stoma appliance customisation (SAC) and appliance use review (AUR), is lower than for the other two advanced services due to the much smaller proportion of the population that may require the services. Pharmacies and dispensing appliance contractors (DACs) may choose which appliances they provide and may also choose whether or not to provide the two related advanced services.

NHS England may wish to encourage those contractors in the area that do provide appliances to become eligible to deliver these advanced services where appropriate.

There are no gaps in the provision of advanced services at present or in the future that would secure improvement, or better access, to advanced services across the whole HWB area.

Current and future access to enhanced services

NHS England commissions the immunisation service and minor ailments service from pharmacies. NHS England currently commissions the Pharmacy Urgent Repeat Medication (PURM) service. This is being run as a pilot, and will be reviewed in April 2015. Should this service be fully commissioned beyond this time, Barking and Dagenham HWB will consider provision and access to this service.

Some of the enhanced services listed in the 2013 Directions are now commissioned by Barking and Dagenham Clinical Commissioning Group (CCG) (anti-coagulation) or LBBD (NHS health checks, emergency hormonal contraception, chlamydia screening, condom supply, stop smoking, supervised consumption, needle exchange and transforming community equipment services) and therefore fall outside of the definition of both enhanced services and pharmaceutical services.

There are no gaps identified in respect of securing improvements, or better access, to enhanced services provision on a locality basis as identified in Section 6 either now or in specified future circumstances. The HWB will monitor the uptake and need for enhanced services within the HWB area to establish if these services are meeting the needs of the local population.

No gaps have been identified that if provided either now or in the future would secure improvements, or better access, to enhanced services across the whole HWB area.

Other NHS services

As required by Paragraph 5 of Schedule 1 to the 2013 Regulations, Barking and Dagenham HWB has had regard for any other NHS services that may affect the need for pharmaceutical services in the area of the HWB.

Based on current information no gaps have been identified in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances across the whole HWB area.

Locally commissioned services

With regard to enhanced services and locally commissioned services, the HWB has acknowledged that only those commissioned by NHS England are regarded as pharmaceutical services. The absence of a particular service being commissioned by NHS England is in some cases addressed by a service being commissioned through Barking and Dagenham Clinical Commissioning Group (CCG) (anti-coagulation) or LBBD (NHS health checks, emergency hormonal contraception (EHC), chlamydia screening, condom supply, stop smoking, supervised consumption, needle exchange and transforming community equipment services (TCES)). This PNA identifies those as locally commissioned services (LCS).

The HWB has noted, with the exception of TCES in North locality, all LCS are accessible to the population in all PNA localities.

With the exception of anti-coagulation service, the HWB has not been presented with any evidence to date which concludes that any of these LCS should be decommissioned or that any of them should be expanded. Based on current information, the HWB has not identified a need to commission any LCS not currently commissioned.

Section 1: Introduction

1.1 Background

The PNA provides key evidence which informs commissioning and strategic decisions for pharmaceutical services to residents and workers within the borough.

It is also intended to support a broad range of strategies to improve health and wellbeing including the Joint Health and Wellbeing Strategy 2012-2015[1], Better Care Fund work programme[2],Children & Young People's Plan[3], Community Strategy 2013 -2016[4], NHS Barking and Dagenham Clinical Commissioning Group's 5 year strategic plan[5], and Care Act 2014[6] implementation. The PNA makes reference to developments in the borough that deliver on the Council's vision for one borough; one community; London's growth opportunity.

It is a statutory duty of the Health and Wellbeing Board to publish a PNA for the London Borough of Barking and Dagenham (LBBD) by 1 April 2015.

The Health Act 2009, 128A[7], made amendments to the NHS Act 2006 requiring Primary Care Trusts (PCTs) to assess the needs for pharmaceutical services in its area and publish a statement of its assessment and any revised assessment. The regulations required the Pharmaceutical Needs Assessment (PNA) to be published by the 1st February 2011. There was also a requirement to re-write the PNA every three years or earlier if there were significant changes to the pharmaceutical needs of the area. Barking and Dagenham PCT produced their first PNA in February 2011.

The responsibility for the development, publishing and updating of PNAs became the responsibility of Health and Wellbeing Boards (HWBs) as a result of the Health and Social Care Act 2012[8]. The Act reformed the NHS from 1st April 2013 - PCTs were abolished and Health and Wellbeing Boards (HWBs), Clinical Commissioning Groups (CCGs) and NHS England were formed:

[1] Barking and Dagenham Partnership, Joint Health and Wellbeing Strategy 2012 to 2015:http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf

[2] Barking and Dagenham Better Care Fund Plan Summary http://www.lbbd.gov.uk/AdultSocialCare/Documents/BD%20BCF%20summaryV2.pdf

[3] London Borough of Barking and Dagenham. (2011) Summary Needs Assessment Barking and Dagenham's Children and Young People's Plan 2011-2016. (Online) Available from:http://www.lbbd.gov.uk/ChildrenAndYoungPeople/CYPP/Documents/CYPP-Needs-Analysis.pdf (Accessed 10 December 2014).

[4]http://www.lbbd.gov.uk/CouncilandDemocracy/MeetingsAndPlans/Documents/CommunityStrategy2013-16.pdf

[5] NHS England. (2013) Everyone Counts: Planning for patients 2014/15 to 2018/19. (Online) Available from: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (accessed 16 November 2014)

[6] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[7] Health Act 2009 - http://www.legislation.gov.uk/ukpga/2009/21/part/3/crossheading/pharmaceutical-services-in-england?view=plain

[8] Health and Social Care Act 2012 - http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

- HWBs, a statutory Executive body, have their membership drawn from local leaders (including NHS England, CCGs and local government) and are responsible for the continual improvement of the health and wellbeing of the local population
- CCGs are GP - led NHS bodies responsible for planning, purchasing and monitoring the majority of local health services including hospital, community, emergency and mental health care
- NHS England oversees the operations of the CCGs as well as commissioning primary and specialist services (such as cancer care). Along with CCGs, it has the responsibility of improving health outcomes and reducing health inequalities

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (SI 2013/349)[9], hereafter referred to as the Pharmaceutical Regulations 2013, came into force on 1st April 2013. Unless required to be produced earlier, these regulations permitted HWBs to a temporary extension of the PNAs previously produced by the PCT; HWBs are now required to publish their first PNA by 1st April 2015 at the latest.

The 2013 Regulations were updated to The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations 2014 on 1st April 2014. This PNA has considered these amendments but the 2013 Regulations have been referenced throughout.

1.2 Purpose of the PNA

NHS England is required to publish and maintain pharmaceutical lists for each HWB area. Any person wishing to provide NHS pharmaceutical services is required to be listed on the pharmaceutical list. NHS England must consider any applications for entry onto the pharmaceutical list. The Pharmaceutical Regulations 2013 requires NHS England to consider applications to fulfil unmet needs determined within the PNA of that area, or applications for benefits unforeseen within the PNA. Such applications could be for the provision of NHS pharmaceutical services from new premises or to extend the range or duration of current NHS pharmaceutical services offered from existing premises.

As the PNA will become the basis for NHS England to make determinations on such applications, it is therefore prudent that the PNA is compiled in line with the regulations, and with due process, and that the PNA is accurately maintained and up-to-date. Although decisions made by NHS England regarding applications to the pharmaceutical list may be appealed to the NHS Family Health Services Appeals Unit, the final published PNA cannot be appealed. It is likely the only challenge to a published PNA will be through application for a judicial review of the process undertaken to conclude the PNA.

[9] Pharmaceutical Regulations 2013 - http://www.legislation.gov.uk/uksi/2013/349/contents/made

The PNA should also be considered alongside the local authority's Joint Strategic Needs Assessment (JSNA)[10]. The PNA will identify where pharmaceutical services address public health needs identified in the JSNA as a current or future need. Through decisions made by the local authority, NHS England and the CCGs, these documents will jointly aim to improve the health and wellbeing of the local population and reduce inequalities.

1.3 Scope of the PNA

The Pharmaceutical Regulations 2013[9] gives details of the information required to be contained within a PNA. A PNA is required to measure the adequacy of pharmaceutical services in the HWB area under five key themes:

- necessary services: current provision
- necessary services: gaps in provision
- other relevant services: current provision
- improvements and better access: gaps in provision
- other services

In addition, the PNA details how the assessment was carried out. This includes:

- how the localities were determined
- the different needs of the different localities
- the different needs of people who share a particular characteristic
- a report on the PNA consultation

As already mentioned, the PNA is aligned with the Barking and Dagenham JSNA[10].

To appreciate the definition of pharmaceutical services as used in this PNA, it is firstly important to understand the types of NHS pharmaceutical providers comprised in the pharmaceutical list maintained by NHS England. They are:

1. pharmacy contractors
2. dispensing appliance contractors
3. local pharmaceutical service providers
4. dispensing doctors

For the purposes of this PNA, pharmaceutical services have been defined as those which are / may be commissioned under the provider's contract with NHS England. A detailed description of each provider type, and the pharmaceutical services as defined in their contract with NHS England, are detailed below.

1.3.1 Pharmacy contractors

Pharmacy contractors operate under the Community Pharmacy Contractual Framework initially agreed in 2005. This sets three levels of service under which they operate.

[10] Barking and Dagenham Joint Strategic Needs Assessment: http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

Essential services - these can be found in Schedule 4 of the Pharmaceutical Regulations 2013[9]. They are nationally negotiated and must be provided from all pharmacies:

- dispensing of medicines
- repeat dispensing
- safe disposal of unwanted medicines
- promotion of healthy lifestyles
- signposting
- support for self-care
- clinical governance

Advanced services - these can be found in Parts 2 and 3 of The NHS Act 2006, the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013, the 2013 Directions[11].

They are negotiated nationally and any contractor may provide:

- medicines use reviews (MURs)
- new medicines services (NMS)
- appliance use reviews (AURs)
- stoma appliance customisation (SAC)

A full list of provision of advanced services provided by pharmacies in Barking and Dagenham HWB area (correct as of 4th November 2014) can be found in Appendix A.

Enhanced services - these can be found in Part 4 of the 2013 Directions[11]. They are negotiated locally by NHS England Area Teams and may only be provided by contractors directly commissioned by NHS England:

- anticoagulant monitoring service
- antiviral collection service
- care home service
- disease specific management service
- emergency supply service*
- gluten free supply service
- independent prescribing service
- home delivery service
- language access service
- medication review service
- minor ailment service

[11] The 2013 Directions - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193012/2013-03-12_-_Advanced_and_Enhanced_Directions_2013_e-sig.pdf
and amendment
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266023/pharmaceutical_services_directions_amendment_2013.pdf

- needle and syringe exchange service*
- on-demand availability of specialist drugs service
- out of hours service
- patient group direction service*
- prescriber support service
- schools service
- screening service*
- stop smoking service*
- supervised administration service*
- supplementary prescriber service

The responsibility for public health services transferred from PCTs to local authorities with effect from 1st April 2013. A number of these services* are sometimes commissioned by local authorities, and are therefore not considered enhanced or pharmaceutical services. The 2013 Directions[11], however, permit NHS England to commission them from pharmacy contractors if asked to do so by a local authority.

In this case, if commissioned by NHS England, they are enhanced services and fall within the definition of pharmaceutical services. In Barking and Dagenham HWB area, NHS England currently commission one public health service from pharmacies: the immunisation service.

The enhanced services listed above are commissioned by NHS England were a need has been identified. Section 3.4 details the enhanced services commissioned by NHS England from pharmacies in Barking and Dagenham HWB area. Appendix A lists all providers of these services.

Pharmacy contractors comprise both those located within the Barking and Dagenham HWB area as listed in Appendix A, those in neighbouring HWB areas and remote suppliers - such as distance-selling pharmacies. Although distance-selling pharmacies may provide services from all three levels as described above, and must provide all 'essential' services, they may not do so 'face-to-face'.

Additionally, they must provide services to the whole population of England. There are no distance-selling pharmacies located within Barking and Dagenham HWB area. It should also be noted that distance-selling pharmacies throughout England (there were 211 in 2013/14[12]) are capable of providing services to Barking and Dagenham HWB area.

1.3.2 Dispensing appliance contractors

Dispensing appliance contractors (DACs) operate under the Terms of Service for Appliance Contractors as set out in Schedule 5 of the 2013 Regulations[12]. They can

[12] General Pharmaceutical Services in England - 2003-04 to 2013-14**:** http://www.hscic.gov.uk/article/2021/Website-Search?productid=16440&q=general+pharmaceutical+2014&sort=Relevance&size=10&page=1&area=both#top

supply appliances from an NHS prescription such as stoma and incontinence aids, dressings, bandages etc. DACs must provide a range of essential services such as dispensing of appliances, advice on appliances, signposting, clinical governance and home delivery of appliances. In addition, DACs may provide the advanced services of appliance use reviews (AURs) and stoma appliance customisation (SAC).

Pharmacy contractors, dispensing doctors and local pharmaceutical service (LPS) providers may supply appliances but DACs are unable to supply medicines.

There is one DAC in the Barking and Dagenham HWB area:

- Fittleworth Medical, 7 The Midas Business Centre, Wantz Road, Dagenham RM10 8PS

Residents can also access DACs from elsewhere in the UK if required. There were 112 DACs in England 2013/14[12].

1.3.3 Local pharmaceutical service providers

A pharmacy provider may be contracted to perform specified services to their local population or a specific population group. This contract is locally commissioned by NHS England and provision for such contracts is made in the 2013 Regulations[12] in Part 13 and Schedule 7. Such contracts are agreed outside the national framework although may be over and above what is required from the national contract. Payment for service delivery is locally agreed and funded.

There are no local pharmaceutical service provider (LPS) pharmacies in the Barking and Dagenham HWB area.

1.3.4 Dispensing GP practices

The 2013 Regulations[12], as set out in Part 8 and Schedule 6, permit GPs in certain areas to dispense NHS prescriptions for defined populations. These provisions are to allow patients in rural communities, who do not have reasonable access to a community pharmacy, to have access to dispensing services from their GP practice. Dispensing GP practices therefore make a valuable contribution to dispensing services although they do not offer the full range of pharmaceutical services offered at community pharmacies. Dispensing GP practices can provide such services to communities within areas known as 'controlled localities'.

GP premises for dispensing must be listed within the pharmaceutical list held by NHS England and patients retain the right of choice to have their prescription dispensed from a community pharmacy, if they wish.

There are no dispensing GP practices in the Barking and Dagenham HWB area.

1.3.5 Other providers of pharmaceutical services in neighbouring HWB areas

There are five other HWB areas which border the Barking and Dagenham HWB area:

- Havering HWB
- Redbridge HWB

- Newham HWB
- Greenwich HWB
- Bexley HWB

In determining the needs of, and pharmaceutical services provision to, the population of the Barking and Dagenham HWB area, consideration has been made to the pharmaceutical service provision from the neighbouring HWB areas. It should be noted that the HWBs to the south (Greenwich and Bexley) are fully divided from Barking and Dagenham by the River Thames and therefore provision within these HWB areas may not be readily accessible to residents of Barking and Dagenham.

Map A provides a detailed analysis of pharmacy contractors which lie across the Barking and Dagenham HWB border but are within easy reach of the Barking and Dagenham area. All maps have been generated using post codes therefore location is only an approximation on the maps generated for the PNA. As a result certain pharmacy locations may appear to be on the border with localities or the outside the HWB area. All pharmacies illustrated in Map A and subsequent Maps D, E and F are located within the HWB area.

1.3.6 Other services and providers in Barking and Dagenham HWB area

As mentioned earlier, for the purpose of this PNA, pharmaceutical services have been defined as those which are, or may be, commissioned under the provider's contract with NHS England.

The following are providers of pharmacy services in Barking and Dagenham HWB area but not defined pharmaceutical services.

Hospitals – in Barking and Dagenham there are two hospitals sites. Pharmacies services on both sites are provided in-house to all patients by the hospital trust:

- Barking Hospital, Upney Lane, Barking, Essex. IG11 9LX
- Fenshawe Centre (out patients only), 57 Halbutt Street, Dagenham, Essex. RM9 5AR.

In addition, residents of Barking and Dagenham may receive hospital services from NHS trusts outside the HWB area. The following are some of the hospitals in surrounding HWB areas (all providing in-house pharmacy services to patients):

- King George Hospital, Barley Lane, Goodmayes, Essex. IG3 8YB
- Queen's Hospital, Rom Valley Way, Romford, RM7 0AG
- Brentwood Community Hospital (outpatients only), Cresent Drive, Brentwood, Essex. CM15 8DR
- Victoria Centre, Pettits Lane, Romford, Essex. RM1 4HP

Prisons - in Barking and Dagenham HWB area there are no prisons.

Minor injury units and walk-in centres - Barking Community Hospital, Upney Lane, Barking, IG11 9LX provides a GP led walk-in centre and operates as a minor injury unit too.

The following are services provided by NHS pharmaceutical providers in Barking and Dagenham HWB area, commissioned by organisations other than NHS England or provided privately, and therefore out of scope of the PNA.

CCG commissioned services – Barking and Dagenham commission an anticoagulation service from one pharmacy in the HWB area. The CCG have however served notice to terminate this service from 1st April 2015 from this pharmacy.

Local authority services - LBBD commission the following 'locally commissioned services' from community pharmacies in Barking and Dagenham HWB area:

- emergency hormonal contraception services
- condom supply service
- chlamydia screening
- stop smoking services
- NHS health checks
- supervised consumption service
- needle exchange service
- transforming community equipment services (TCES) programme

Privately provided services - most pharmacy contractors and DACs will provide services by private arrangement between the pharmacy / DAC and the customer / patient. The following are examples of services and may fall within the definition of an enhanced service. However as these services have not been commissioned by the NHS, and are funded and provided privately, they are not a pharmaceutical service:

- care home service e.g. direct supply of medicines / appliances and support medicines management services to privately run care homes
- home delivery service e.g. direct supply of medicines / appliances to the home
- patient group direction service e.g. hair loss therapy, travel clinics
- screening service e.g. skin cancer

Services will vary between provider and are occasionally provided free of charge e.g. home delivery.

1.3.7 Other services which may affect the need for pharmaceutical services

Care homes – care home providers will often make arrangements with individual community pharmacies to provide services for the entire resident population of the care home. This may not necessarily be a nearby community pharmacy. Changes in care home provision may therefore have a change on the needs for pharmaceutical service provision.

Dental services – dentists may prescribe medicines for patients, and therefore changing dental provision may have a change on the need for pharmaceutical service provision.

Non-medical prescribers in the community – legislation now permits a number of non-medical professions to be permitted to prescribe medicines e.g. nurses,

pharmacists, physiotherapists, chiropodists. Some of these professionals work within community-based teams e.g. community matrons. Changing service provision may therefore lead to a changing need for pharmaceutical service provision.

GP 'out of hours' providers – In early 2015, Barking and Dagenham CCG announced the trial opening of GP services in the evening between 6.30pm and 10pm. This may directly impact upon the need for pharmaceutical services. There are three 100 hour contract pharmacies and four "late night" pharmacies open until at least 8pm on week days or weekends. Almost one in five or 18% of pharmacies within the HWB area are either 100 hour or late night opening pharmacies.

Commissioning and provision changes – Commissioners in Barking and Dagenham have signalled their intentions to consider changes to how health and social care services are provided throughout the borough. Such changes include the planned move to 7-day GP services, the integration of primary and secondary care services, the provision of more 'out of hospital' care, and the 'centralising' of some services. As plans become more detailed, the impact on pharmaceutical service provision will need to be continually reflected in the PNA.

This PNA has considered known planned changes in all of the above. Where definite plans and timescales are known, this has been reflected within this document.

1.4 Process for developing the PNA

As a direct result of the Health and Social Care Act[8], a paper was presented to Barking and Dagenham HWB on 17th September 2013.

The purpose of the paper was to inform the HWB of its statutory responsibilities under the Health and Social Care Act[8] to produce and publicise a PNA for its area by 1st April 2015.

The HWB accepted the content of the paper at the meeting and the recommendation to delegate responsibility of the PNA to a steering group. It also agreed to the funding necessary to research and produce the PNA.

The responsibility to oversee the production of the document on behalf of the HWB was assigned to the Public health department of the Council. The department subsequently commissioned Soar Beyond Limited to undertake the PNA. Soar Beyond was chosen from a selection of potential candidates due to their significant experience in providing services to assist pharmaceutical commissioning, including the production and publication of PNAs. They also have a dedicated PNA project management team.

Step 1: Steering group

On 30th September 2014 Barking and Dagenham's PNA Steering Group was established. The terms of reference and membership of the PNA Steering Group can be found in Appendix B.

Step 2: Project management

At its first meeting, Soar Beyond and the steering group presented and agreed the project plan and ongoing maintenance of the project plan. Appendix F shows an approved time line for the project.

Step 3: Review of existing PNA and JSNA

Through the project manager, the PNA Steering Group reviewed the existing PNA and subsequent supplementary statements[13] and JSNA[10]. It was agreed that the existing PNA and subsequent supplementary statements were accurate and up-to-date and the Head of Health Intelligence would be responsible for the ongoing maintenance of the current PNA until this PNA is published.

Step 4a: Public survey on pharmacy provision

A public survey to establish views about pharmacy services was produced by the steering group which was circulated to:

- all pharmacy contractors in Barking and Dagenham to distribute to the public
- all GP practices in Barking and Dagenham to distribute to the public
- Healthwatch Barking and Dagenham
- leisure centres and libraries within Barking and Dagenham
- local authority website
- social media

A total of 480 responses were received. A copy of the public survey can be found in Appendix C and the detailed responses can be found in Appendix I.

Step 4b: Pharmacy survey

The steering group agreed a survey to be distributed to the local community pharmacists to collate information for the PNA. The local LPC supported this survey to gain responses.

A copy of the pharmacy survey can be found in Appendix D.

Step 4c: Commissioner survey

The steering group agreed a survey to be distributed to all relevant commissioners in Barking and Dagenham to inform the PNA.

A copy of the commissioner survey can be found in Appendix E.

Step 5: Preparing the draft PNA for consultation

The steering group, facilitated by the Director of Public Health with support from Soar Beyond, reviewed and revised the content and detail of the existing PNA.

[13] Barking and Dagenham PNA and subsequent supplementary statements, accessed on 11/9/14 – http://www.Barking and Dagenham.gov.uk/downloads/download/3050/pharmaceutical_needs_assessment

The process took into account the JSNA[10] and other relevant strategies in order to ensure the priorities were identified correctly. A draft PNA was approved for consultation by the PNA Steering Group at its meeting on 8th December 2014.

Step 6: Consultation

In line with the 2013 Regulations[12], a consultation on the draft PNA was undertaken between 19th December 2014 and 27th February 2015. The draft PNA and consultation response form were issued to all identified stakeholders. These are listed in the final PNA. The draft PNA was also be posted on the LBBD's website.

Step 7: Collation and analysis of consultation responses

The consultation responses were collated and analysed by the Council's Engagement Manager and Soar Beyond. A summary of the responses received and analysis is noted in Appendix I.

Step 8: Production of final PNA

The collation and analysis of consultation responses was used by the project manager to revise the draft PNA and a final PNA will be presented to the PNA Steering Group. The final PNA was presented to the Barking and Dagenham HWB for approval and publication before 1st April 2015.

1.5 Localities for the purpose of the PNA

The PNA Steering Group, at its second meeting, considered how the localities within Barking and Dagenham would be defined.

Whilst it is recognised that the CCG localities are defined by the GP Practices, the local authority ward boundaries provides reasonable statistical rigor, and residents will more likely use pharmacies close to where they live rather than where their GPs are located.

It was therefore agreed that localities coterminous with the council wards would be used to define the localities of the borough. .

The localities used for the PNA for Barking and Dagenham was based on that used in the description of the summary needs assessment for the Council's Children and Young People's Plan[3]. The localities listed below are made up of the following wards:

- East – Alibon, Eastbrook and Heath wards
- West – Abbey and Gascoigne wards
- North – Chadwell Heath and Whalebone wards
- Central – Becontree, Mayesbrook, Parsloes and Valence wards
- South East – Goresbrook, River and Village wards
- South West – Longbridge, Eastbury and Thames wards.

A list of providers of pharmaceutical services in each locality is found in Appendix A.

The information contained in Appendix A has been provided by NHS England (who are legally responsible for maintaining the pharmaceutical list of providers of pharmaceutical services in each HWB area), LBBD, Barking and Dagenham CCG and

North East London LPC. Providers who were previously listed in the 2011 PNA for Barking and Dagenham continued to be considered within this PNA. Information was provided from NHS England on community pharmacies' opening hours. In some cases this differed from that provided by contractors through the pharmacy contractor survey. In these cases, opening hours information in the PNA reflects the information provided from the contractor, as the opinion of the PNA Steering Group was that this reflects current provision, upon which this assessment has been made.

Section 2: Context for the PNA

2.1 Joint strategic needs assessment

The PNA is undertaken in the context of the health, care and wellbeing needs of the local population, as defined in the Barking and Dagenham Joint Strategic Needs Assessment (JSNA)[10] which is currently being refreshed. The JSNA, as well as defining the needs of the local population, also identifies a strategic direction of service delivery to meet those needs, and commissioning priorities to improve the public's health and reduce inequalities. The PNA should therefore be read alongside the JSNA.

2.2 Barking and Dagenham Health and Wellbeing Strategy

The current Barking and Dagenham Health and Wellbeing Board Strategy (2012/14)[1] is guided by the JSNA and other relevant sources of information. The following are the four priority areas that have been identified as key to the improvement of the health of the local population and in reducing health inequalities:

- supporting local people to make lifestyle choices at an individual level which will positively improve the quality and length of their life and overall increase the health of the population
- protecting local people from threats to their health and wellbeing
- improving treatment and care by benchmarking against best practice and where we identify that care has failed
- ensuring that patients, service users and carers have control and choice over the shape of the care and support that they receive in all care settings

The Health and Wellbeing Strategy (HWBS) highlights the need for a multiagency approach (including local pharmaceutical service providers) in addressing the above priorities in order to realise a more coherent and effective response and to accomplish set outcomes.

Regulation 9 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations[11] requires that HWBS, when carrying out assessments for the purpose of publishing PNAs, have regard to:

- the number of people in its area who require pharmaceutical services
- the demography of its area
- the risks to the health or wellbeing of people in its area

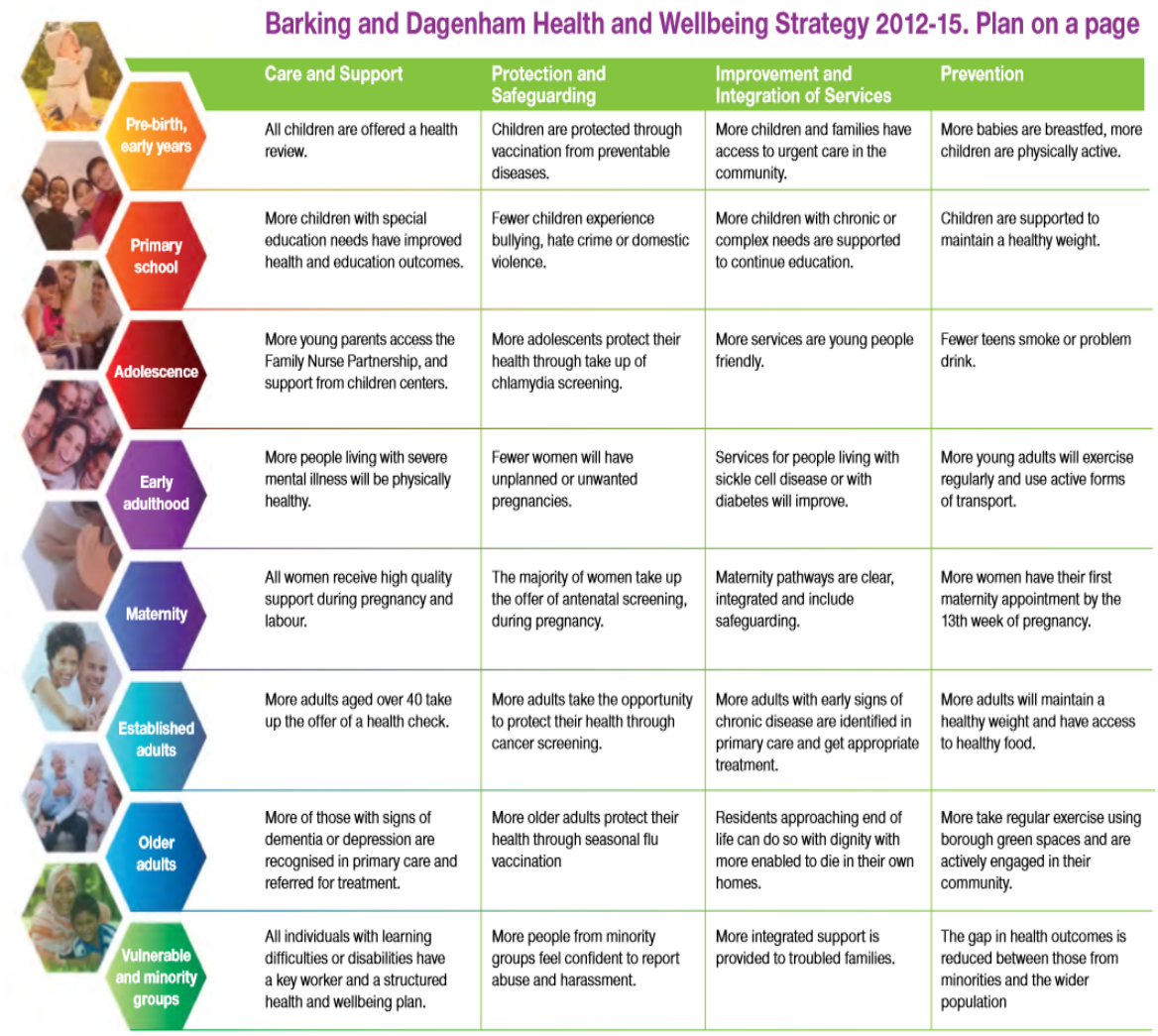
Pharmaceutical service providers have the potential to play a greater role in identifying and helping address priority health needs as they are strategically placed in the community and have daily interactions with the local population.

Evidence from the Healthy Living Pharmacy Initiative[14] implemented since 2010 shows that community pharmacies can make a significant impact in the improvement of health and wellbeing of local populations.

In consideration of the three areas highlighted above, the sections below further examine Barking and Dagenham's population characteristics and major causes of ill health as a pre-requisite to understanding local health needs and how pharmaceutical service providers can be involved in various interventions

The Health and Wellbeing Strategy for 2012-2015 is being refreshed; the new strategy will be published in spring 2015. Figure 1 sets out on a 'plan on a page' the ambitions for the current strategy which are not expected to change significantly, although the programmes and deliverables to support the strategy will have evolved during the last three years.

Figure 1 - Health and Wellbeing Strategy 2012-2015 plan on a page



[14] National Pharmaceutical Association, (2012) Health Living Pharmacy: overview (online) Available from: http://www.npa.co.uk/Documents/HLP/HLP_overview_12.11.pdf (Accessed: 10th December 2014)

The outcomes contained within the strategy are to:

- increase the life expectancy of people living in Barking and Dagenham
- close the gap between the life expectancy in Barking and Dagenham with the London average
- improve health and social care outcomes through integrated services

2.3 Commissioning priorities to improve health and wellbeing

The HWB have agreed the following priority areas where action is necessary to improve health and wellbeing.

2.3.1 Transformation of health and social care

This aims to address health and social care outcomes through shared priorities and indicators particularly around those geared to reducing hospital admissions, supporting care outside of the hospital and reducing A and E attendances. Some of the more common reasons for acute care are time-limited children's conditions like gastrointestinal and chest conditions. In adults and older people it is chronic lung disease, dementia related issues, falls and terminal illness. Actions that expand and reinforce interventions that decrease illness and disease progression to support the delivery of health and social care outcomes are prioritised, these include:

- immunisation of adults and children – whilst the responsibility for commissioning lies with NHS England, local support is still needed to improve immunisation rates
- early disease identification and effective early interventions especially for diabetes, high blood pressure, irregular heart beat (atrial fibrillation), chronic lung disease and certain cancers
- breast feeding which is proven to decrease gastrointestinal conditions and infectious diseases
- fall prevention and bone fracture prevention in those defined as high risk
- dementia prevention through addressing hypertension, diabetes and cardiovascular disease control and treatment
- sustaining and expanding current programmes to reduce the health and social care impact of isolation on vulnerable people and families
- maintaining vulnerable people, especially older people, enabling them to live in their own homes safely, without fuel poverty (winter warmth) while minimising their risk of hospital admission from hypothermia and respiratory infection
- chronic obstructive pulmonary disease (COPD) – ensuring effective treatments including pulmonary rehabilitation
- improving availability and access to relevant services that support reduction in alcohol intake
- end of life care – pathway analysis and improvement

2.3.2 Reducing premature mortality

The top three priorities that would impact on premature mortality are:

- reducing smoking prevalence
- reducing obesity and increasing physical activity
- diagnosing disease early and treating effectively

Priorities for intervention:

- there is substantial scope for public health programmes and initiatives to promote cancer prevention as well as increase screening coverage and early diagnosis as outlined in the recommendations from the JSNA[10]. Enhancing the promotion of the breast, bowel and cervical screening programmes in Barking and Dagenham both through public awareness campaigns as well as through primary care staff (general practice and pharmacy) would be expected to result in greater uptake of each of the three programmes. Subsequently, this would contribute to improving cancer outcomes through earlier diagnosis. Currently, other than invitational letters from the screening programme, there is little promotion of the services locally
- supporting national campaigns to raise awareness of the signs and symptoms of common cancers, including innovative outreach campaigns. Such campaigns would increase public awareness of symptoms and subsequently earlier diagnosis and improved patient outcomes
- increasing the availability of smoking cessation services, with easy local access at times and venues that make it easy for the smoker to attend

2.3.3 Tackling obesity and increasing physical activity

Obesity accounts for a great deal of disability, illness and premature death in Barking and Dagenham and is a contributory factor in arthritis, diabetes, and cardiovascular disease. Childhood and adult overweight and obesity levels and inactivity levels are very high in the borough, with 40% of 10-11 year olds and 64% of adults overweight or obese and 39% of adults classified as inactive. To lengthen life in the borough and to narrow the gap with the rest of London, we must reduce obesity. Our two main evidence-based ways focus on helping residents to reduce the amount they routinely eat and drink, improve their diets and increase the length of time each week they are physically active. While obesity prevention is complex, there is good evidence to support the use of reducing barriers to healthier eating and regular activity, particularly where this is tailored to different groups' needs.

Priorities for intervention include:

- local partners working together to ensure public health interventions to promote breastfeeding, child nutrition and physical activity are embedded and easy to access
- supporting weight management interventions through advice and information about weight loss and how to build higher levels of physical activity into daily life

- improving the uptake of sport and physical activity and building on the legacy of the 2012 Olympics games

2.3.4 Improving sexual and reproductive health

Barking and Dagenham faces a challenge in terms of sexual and reproductive health with rising levels of sexually transmitted infections (STIs), terminations of pregnancy and human immunodeficiency virus infections (HIV). Numbers and rates may be low in comparison with some of the inner London boroughs, but they are higher than in the neighbouring boroughs of Redbridge and Havering. There is a comparatively young population compared with the England average and a high rate of teenage pregnancies although this has declined from the peaks seen in 2002/03. HIV prevalence is high at 6.07 per 1,000 persons aged 15-59 years. Late diagnosis levels are of particular concern, with 54.2% of adults aged 15 and over newly diagnosed with HIV infection having CD4 counts of less than 350 cells per mm^3 (as a percentage of the number of adults newly diagnosed with HIV infection). Of the 764 people known to have HIV infection in the borough, 83% were infected heterosexually, 59% are female, the main ethnic group affected is black African and the highest age group infected is 35–49 years. This means that the local pattern of HIV infection is very different to the common belief that this is an infection in men who have sex with men.

Priorities for intervention:

- more needs to be done to halt the spread of STIs and HIV infection. Targeted work such as community outreach and near-patient testing is needed to encourage more people to be tested and be advised about prevention
- there is a need to increase access (in terms of geography, timing and timeliness), to services that support better sexual health and address the challenges of teenage pregnancy
- services must be non-judgmental and 'young person friendly'. Available services and screening should be promoted widely, to increase awareness of the need for better sexual health and to encourage people of all ages to attend for treatment and care

2.3.5 Improving child health and early years

The evidence and analysis set out in 'Fair Society, Healthy Lives' has been developed and strengthened by the report of the 'Independent Review on Poverty and Life Chances'. The reports draw attention to the impact of family background, parental education, good parenting, primary education and the opportunities for learning and development in the crucial first five years of life.

They identified what matters most in preventing poor children becoming poor adults as:

- healthy pregnancy
- good maternal mental health
- secure bonding with the child

- love and responsiveness of parents with clear boundaries
- primary education
- opportunities for a child's cognitive, language and social and emotional development
- good services including health services, children's centres and high quality childcare
- priorities for intervention:
- the transition of the health visitor service, currently commissioned by NHS England, to council commissioning from October 2015 must be seamless so that children are not disadvantaged by changes in commissioning arrangements
- the school nursing service currently has 11 nurses working with 60 schools which creates a high caseload. In addition, the increasing numbers of children on the school role means that the service will continue to be under pressure. Support for children and young people should be creatively explored to assess additional ways of supporting their health and wellbeing development
- there are around 450 looked after children in Barking and Dagenham the majority of whom have been removed from their families due to domestic violence. This puts Barking and Dagenham in the top quartile for numbers of children in this situation and considering their psychological and physical needs, as well as those of other vulnerable groups such as young offenders and disabled young people, needs joint action across the borough to improve outcomes
- there has been a reported increase in the numbers of alcohol affected children and young people attending A&E although the under 18 alcohol admission rate is low compared with the national average. Availability of accessible brief intervention advice on alcohol and structured care programmes are needed to support young people and their families.

2.3.6 Improving community safety

In partnership with the Community Safety Partnership there are a number of areas from a health and wellbeing perspective that need consideration:

- youth offending is increasing with the increase in the numbers of young people living in the borough and the impact of gang activity. In 2012/13 348 young people under the age of 18 years were arrested. Effective work by the Youth Offending Service has seen a reduction in first time entrants to the service from 2,205 in 2005/6 to 472 in 2012/13
- the increase in young re-offenders is being linked to emerging gang activity. Gang members are more prolific offenders and have different profiles to the major youth offending population and transfer in from other boroughs due to cheaper accommodation

- the Serious Youth Violence Partnership is considering the public health needs of this group in particular in the context of sexual exploitation and violence where females associated with gang members have been subject to assaults and abuse
- there are a number of sex workers working across a tri-borough patch of Barking and Dagenham, Redbridge and Newham and a cross-borough strategic approach to responding to the needs of the population is being planned. However, there is a gap in outreach provision for this group and an outreach service is needed so that their health needs can be addressed more effectively.

2.3.7 Alcohol and substance misuse

Barking and Dagenham has a high rate of alcohol related hospital admissions with a rate of 2,276 per 100,000 of the population in 2012/13 compared with the London average of 2,035. Although the rate is down 1% from the previous year, alcohol misuse still presents a significant challenge to the borough. The impact of alcohol misuse is experienced across the spectrum: primary care, acute trust, police, licensing and environment all have a significant strategic role to play in achieving improved outcomes.

The Department of Health estimates that interventions for dependent drinkers (a range of interventions to suit a variety of users – those based on cognitive behavioural approaches have the best chance of success) that with the average local population of 350,000 for every £583,464 invested there would be a saving of £1,808,737 in return on the investment. For every additional £1m invested in appropriate levels of intervention, up to 1,200 alcohol related hospital admissions could be avoided

Priorities for intervention:

- early identification and intervention in cases of alcohol misuse is key to reducing alcohol-related hospital admissions and reducing alcohol-related anti-social behaviour in the long-term. Alcohol identification and brief advice (IBA) is the evidence based approach that should be embedded in a local health system to achieve this aim. The coverage of alcohol IBA in Barking and Dagenham is limited and consideration should be made of the impact investment in this could have on alcohol misuse
- Barking and Dagenham's alcohol treatment outcomes have a high success rate with around 70% of individuals being discharged from treatment with a successful outcome. However, there is still significant potential in the system to treat more individuals and improve pathways into community based treatment such as community detox, preventing attendance at A&E. There is a strong evidence base for providing pharmacological detox with psychosocial interventions in the community that are highly cost-effective compared with emergency admission and residential detox and rehabilitation

- the consumption of high strength ciders and lagers and street drinking is a significant problem for retailers, licensing and the police. The adoption of the Ipswich Model could have a positive impact on alcohol related disorder in the major centres in the borough. This model involves the voluntary participation of retailers in banning the sale of high strength ciders and lagers and this has been proven to be effective in Ipswich.
  However, the utility of this approach in an urban environment such as Barking and Dagenham has yet to be investigated and will require significant buy-in from retailers to be a success
- in relation to alcohol related violence, identification of alcohol hot spots analysis is contributing to an improved intelligence led response to reducing alcohol related violent crime. This is a data sharing initiative based on the Cardiff Model that uses anonymous information collected at A&E. This is shared with the Community Safety Partnership so that preventative policing approaches can be used where there has been an instance of alcohol related violence
- Barking and Dagenham's success rate in drug treatment completions has been recognised as high by Public Health England. There is a strong evidence base for investing in drug treatment with research suggesting that every £1 invested in drug treatment saves society two and a half times that in the crime and health costs of drug addiction. National Institute for Health and Care Excellence (NICE) estimates the costs generated by each injecting drug-user adds up to £480,000 over their lifetimes. While people are in treatment they use fewer illegal drugs and commit less crime to fund the purchase of drugs from street dealers. There is also less risk to the public's health from drug litter.
  Additionally, individual users are better able to cope, so can attend education and training, hold down jobs and look after their families.

2.3.8 Improving mental health

The Health and Wellbeing Strategy recognises that poor mental health is a massive 'burden of disease' affecting our residents and that poverty, disadvantage, disability, chronic illness, exclusion and debt are major factors that drive it, while trauma, domestic violence, hate crime and bullying at school and work also create much stress, depression and anxiety.

The economic downturn together with changes to the benefits system and cuts in public services were expected to lead to a great deal of stress for disadvantaged adults and families. These changes have already resulted in many residents having severe housing problems and a substantial increase in homelessness.

People with existing mental health problems are particularly vulnerable to changing circumstance and need support and advice.

Many residents with less severe (but nevertheless misery-creating) mental health problems will go undetected or untreated and will encounter barriers to getting help and getting better.

The Health and Wellbeing Strategy aims to increase the number of troubled families getting integrated help and increase access to mental health services for people from ethnic minorities.

Priorities for intervention:

- the need for a mental wellbeing strategy to address the economic and social determinants of poor mental health, prevention and detection of problems and good access to help, support and treatment
- there is a great deal of evidence to support the use of interventions such as psychological therapies and school-based programmes. However there is also evidence to support programmes addressing the social determinants of mental health, such as interventions to reduce the impact of debt

2.3.9 Reducing injuries and accidents

The Health and Wellbeing Strategy aims to reduce falls and accidents in the home among older people which adds to pressures on local hospitals as well as increasing risks of earlier death. The borough has a higher than average rate of older people admitted to hospital due to falls and injuries.

Priorities for intervention:

- the need to reduce the risk of traffic accidents in order to make big increases in the numbers of children and adults walking and cycling
- the need to reduce the risk of vulnerable older people being admitted to hospital for falls and injuries through falls prevention and bone fracture prevention programmes

2.4 NHS Barking and Dagenham Clinical Commissioning Group Strategy

The clinical commissioning group (CCG) strategy follows the principles of *Everyone Counts: Planning for Patients 2014/15 – 2018/19*[5], working towards achievement of seven outcomes objectives:

1. securing additional years of life for the people of England with treatable mental and physical health conditions.
2. improving the health related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions.
3. reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. increasing the proportion of older people living independently at home following discharge from hospital.
5. increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6. increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

7. making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

2.5 Population characteristics

2.5.1 Overview

The population of Barking and Dagenham has grown by 19.7% over the past 15 years and 24.3% over the past 25 years. The 2013 mid-year population estimates is 194,352, although this is now around 198,410 based on projections for 2014.

The population changes in recent years were graphically demonstrated by the 2011 census. The population size increased by 13% between the 2001 and 2011 census. The number of people living in Barking and Dagenham that were born outside of the UK had increased from one in ten people to nearly one in three people (31%). Even so, Barking and Dagenham still had one of the highest proportions in London of people born in England, ranking ninth of the 33 boroughs, and nearly three-quarters of those born outside of the UK had been resident in the UK for five or more years.

Table 2 below shows the number of people living in each of the defined localities.

Table 2 - Population size, Barking and Dagenham localities, 2013

Locality	Persons	Men	Women
East	32,816	15,805	17,011
West	26,055	13,545	12,510
North	21,587	10,419	11,168
Central	44,177	21,238	22,939
South East	33,864	16,265	17,599
South West	35,853	17,668	18,185
TOTAL	194,352	94,940	99,412

Source: Office for National Statistics (ONS)

Currently all of the Barking and Dagenham population live in areas classified as urban by ONS

2.5.2 Age distribution of the population

Table 3 shows the number of men, women and persons living in Barking and Dagenham split by five year age group.

Table 3 - Barking and Dagenham population by age group, men, women and persons, 2013

	Men		Women		Persons	
Age band (years)	N	%	N	%	N	%
Under 1	2,159	2.27%	1,853	1.86%	4,012	2.06%
1-4	7,979	8.40%	7,621	7.67%	15,600	8.03%
5-9	8,781	9.25%	8,123	8.17%	16,904	8.70%
10-14	6,665	7.02%	6,334	6.37%	12,999	6.69%
15-19	6,861	7.23%	6,189	6.23%	13,050	6.71%
20-24	6,312	6.65%	6,401	6.44%	12,713	6.54%
25-29	7,240	7.63%	8,145	8.19%	15,385	7.92%
30-34	7,435	7.83%	8,531	8.58%	15,966	8.21%
35-39	7,263	7.65%	7,969	8.02%	15,232	7.84%
40-44	6,894	7.26%	7,179	7.22%	14,073	7.24%
45-49	6,147	6.47%	6,690	6.73%	12,837	6.61%
50-54	5,501	5.79%	5,518	5.55%	11,019	5.67%
55-59	4,202	4.43%	4,101	4.13%	8,303	4.27%
60-64	3,254	3.43%	3,466	3.49%	6,720	3.46%
65-69	2,687	2.83%	2,858	2.87%	5,545	2.85%
70-74	1,826	1.92%	2,305	2.32%	4,131	2.13%
75-79	1,593	1.68%	2,167	2.18%	3,760	1.93%
80-84	1,174	1.24%	1,867	1.88%	3,041	1.56%
85+	967	1.02%	2,095	2.11%	3,062	1.58%
TOTAL	94,940	100.00%	99,412	100.00%	194,352	100.00%

Source: ONS

Barking and Dagenham has a very different population age distribution to other parts of England. It has the highest proportion of children aged 0-4 years and 0-14 years in England. One in four of the population is under the age of 15, and one in ten is under the age of five years. The number of young and very young has increased rapidly, putting pressure on schools and children's services. The number of children under the age of five increased by almost 50% between the 2001 and 2011 censuses (18,676 in 2011 compared with 12,542 in 2001) and the number of children under the age of 15 increased by one quarter (45,674 in 2011 compared with 36,112 in 2001).

The high proportion of children is balanced by a smaller proportion of the working age population than that in London and a smaller proportion of older people than in England as a whole. The proportion of people over the age of 40 is similar in Barking and Dagenham to that in London (37.5% Barking and Dagenham, 39.7% London), but very different to England as a whole where 49% of people are aged 40 or over. For people aged 20-39, Barking and Dagenham has a smaller proportion than London (31% compared with 36% for London) but a higher proportion than England (27%).

Table 4 shows the population proportions in five year age bands for Barking and Dagenham and England and Figure 2 shows the population age distribution for Barking and Dagenham, London and England as a population tree.

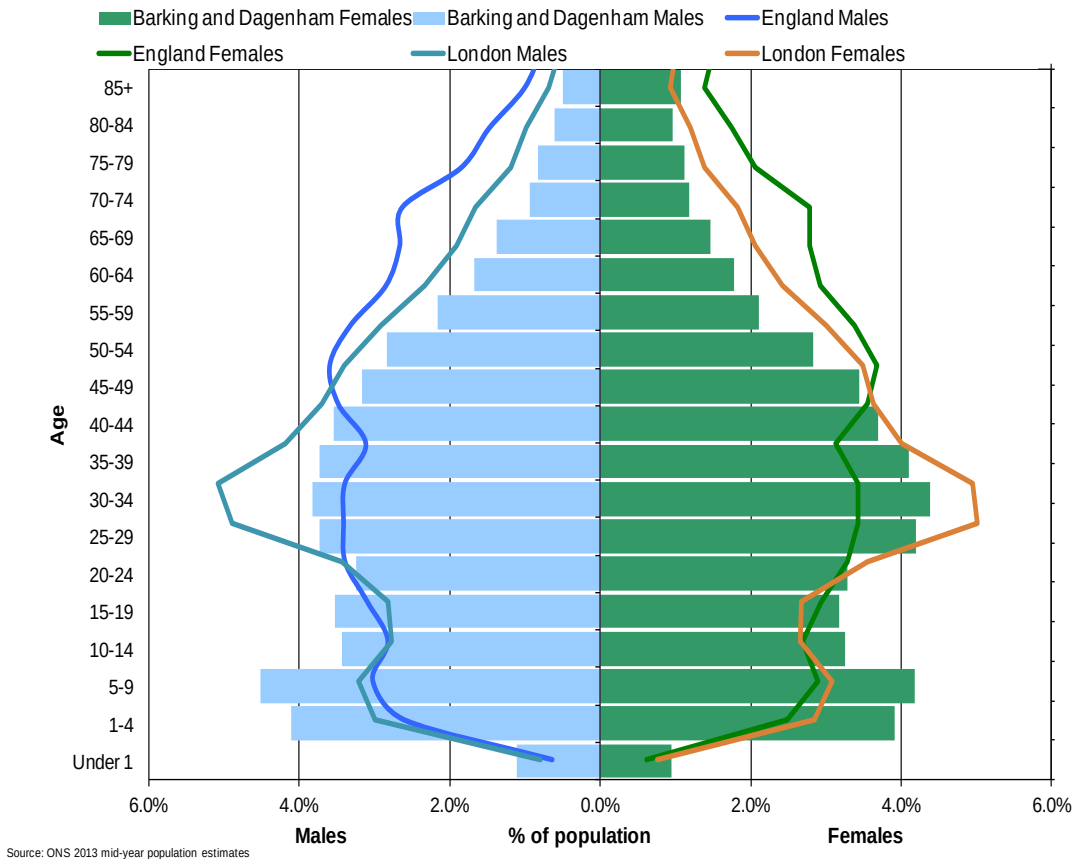
This visibly demonstrates the high proportion of children and low proportion of older people in Barking and Dagenham.

Table 4 - Proportion of population by age group, Barking and Dagenham and England, 2013

Age band (years)	Barking and Dagenham	England
Under 1	2.06%	1.26%
1-4	8.03%	5.08%
5-9	8.70%	5.92%
10-14	6.69%	5.53%
15-19	6.71%	6.04%
20-24	6.54%	6.69%
25-29	7.92%	6.84%
30-34	8.21%	6.84%
35-39	7.84%	6.25%
40-44	7.24%	7.04%
45-49	6.61%	7.29%
50-54	5.67%	6.72%
55-59	4.27%	5.78%
60-64	3.46%	5.46%
65-69	2.85%	5.42%
70-74	2.13%	3.91%
75-79	1.93%	3.24%
80-84	1.56%	2.41%
85+	1.58%	2.30%
TOTAL	100.00%	100.00%

Source: ONS

Figure 2 - Population size by age band, Barking and Dagenham, London and England, 2013



Source: ONS 2013 mid-year population estimates

2.5.3 Population distribution and density

The population of Barking and Dagenham is spread across 17 wards. The average population per ward is 11,450, with the lowest numbers in Parsloes (9,900) and the highest numbers in Thames (14,750), Gascoigne (14,050) and Abbey (13,650). Table 5 shows the age distribution for each ward, based on school age, working age and retirement age, demonstrating how the age distribution varies between wards. Gascoigne and Thames having a high proportion of children and a low proportion of people aged 65 years and over. Eastbrook and Chadwell Heath have relatively high proportions of people aged 65 and over, balanced out in EastBrook by a smaller proportion of children and in Chadwell Heath by a slightly smaller proportion of people of working age.

Table 5 - Ward level population age distribution, Barking and Dagenham, 2013

Ward name	Population - 2013	Children aged 0-15 - 2013	Working-age (16-64) - 2013	Older people aged 65+ - 2013	% All Children aged 0-15 - 2013	% All Working-age (16-64) - 2013	% All Older people aged 65+ - 2013	Mean Age - 2013	Median Age - 2013
Abbey	13,650	3,450	9,550	700	25.3	70.0	5.1	29.5	29.0
Alibon	10,400	2,700	6,600	1,100	26.0	63.5	10.6	33.8	33.0
Becontree	12,050	3,000	8,000	1,100	24.9	66.4	9.1	33.0	32.0
Chadwell He	10,150	2,450	6,150	1,550	24.1	60.6	15.3	36.2	34.0
Eastbrook	10,600	2,150	6,900	1,550	20.3	65.1	14.6	37.7	36.0
Eastbury	11,700	3,000	7,550	1,150	25.6	64.5	9.8	33.4	32.0
Gascoigne	14,050	4,450	8,800	800	31.7	62.6	5.7	29.0	29.0
Goresbrook	11,300	2,900	7,150	1,200	25.7	63.3	10.6	34.1	33.0
Heath	10,950	2,800	6,850	1,300	25.6	62.6	11.9	34.4	32.0
Longbridge	11,650	2,550	7,650	1,400	21.9	65.7	12.0	35.2	32.0
Mayesbrook	10,400	2,750	6,500	1,150	26.4	62.5	11.1	33.9	33.0
Parsloes	9,900	2,550	6,250	1,100	25.8	63.1	11.1	34.3	33.0
River	11,400	3,000	7,250	1,150	26.3	63.6	10.1	33.4	32.0
Thames	14,750	4,650	9,250	850	31.5	62.7	5.8	28.7	28.0
Valence	10,000	2,500	6,300	1,200	25.0	63.0	12.0	34.8	34.0
Village	10,850	2,650	6,950	1,250	24.4	64.1	11.5	34.5	33.0
Whalebone	10,850	2,500	7,000	1,300	23.0	64.5	12.0	35.3	34.0

Source: GLA (SHLAA)

Population density is affected by the different geographical sizes of the wards, and the population focus along the East-West axis of the A13. The wards with the highest population density are Gascoigne and Abbey, reflecting the concentration of people around Barking town centre. The wards with the lowest population density are Thames in the south, where substantial development is planned, and Chadwell Heath in the north (Map G). Thames ward therefore stands out as having the highest population number and the lowest population density, although the density will increase as the developments on former industrial land take place.

2.5.4 Population deprivation levels

Barking and Dagenham is a borough with high levels of deprivation. The borough is ranked as the seventh most deprived in London and nationally it is ranked as the 22nd most deprived local authority. Of the 109 lower super output areas (LSOAs) in the borough, 11 of these are ranked in the top 10% of the most deprived wards in England (Map C).

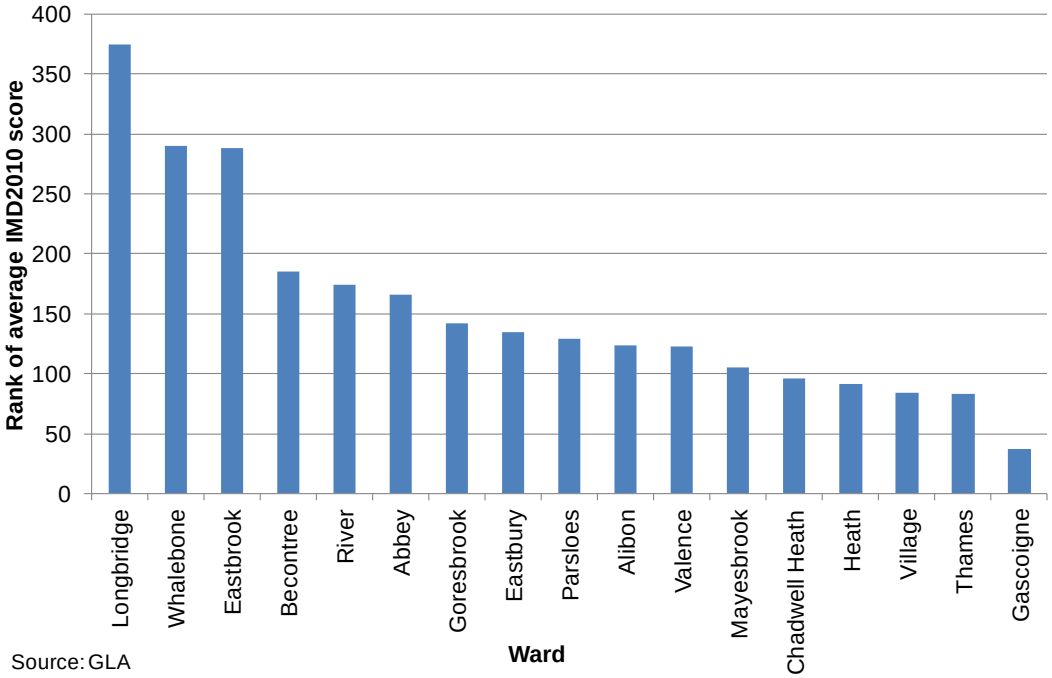
Apart from Abbey and Longbridge, all the LSOAs within the remaining wards are ranked in the top half of the most deprived categories nationally (Table 6 and Figure 3).

Table 6 - Deprivation at ward level, rank of average deprivation score and %age LSOAs in worst 50% for England

Ward	(ID2010) - Rank of average score (within London) - 2010	(ID2010) % of LSOAs in worst 50% nationally - 2010
Longbridge	375	66.7%
Whalebone	290	100.0%
Eastbrook	288	100.0%
Becontree	185	100.0%
River	174	100.0%
Abbey	166	85.7%
Goresbrook	142	100.0%
Eastbury	135	100.0%
Parsloes	129	100.0%
Alibon	124	100.0%
Valence	123	100.0%
Mayesbrook	105	100.0%
Chadwell Heath	96	100.0%
Heath	91	100.0%
Village	84	100.0%
Thames	83	100.0%
Gascoigne	37	100.0%

Source: GLA

Figure 3 - Rank of average score for Index of Deprivation 2010 (within London), Barking and Dagenham wards, 2010



Five of the six defined localities[3] for the needs assessment fall within either the eighth or ninth most deprived categories within London. At national level, the West is ranked in the top 10% most deprived category (Table 7).

Table 7 - Index of Multiple Deprivation (IMD) 2010 score, Barking and Dagenham decile and London decile, Barking and Dagenham localities

Locality	IMD*	Barking and Dagenham IMD decile**	London IMD decile**
West	38.1	8	9
South east	35.2	5	8
Central	35.0	5	8
East	33.5	4	8
South West	32.5	3	8
North	31.6	2	8

*IMD = Index of multiple deprivation 2010[15]

** The Barking and Dagenham and London IMD deciles are calculated using IMD scores for individual wards within those areas[16]

Source: PHE

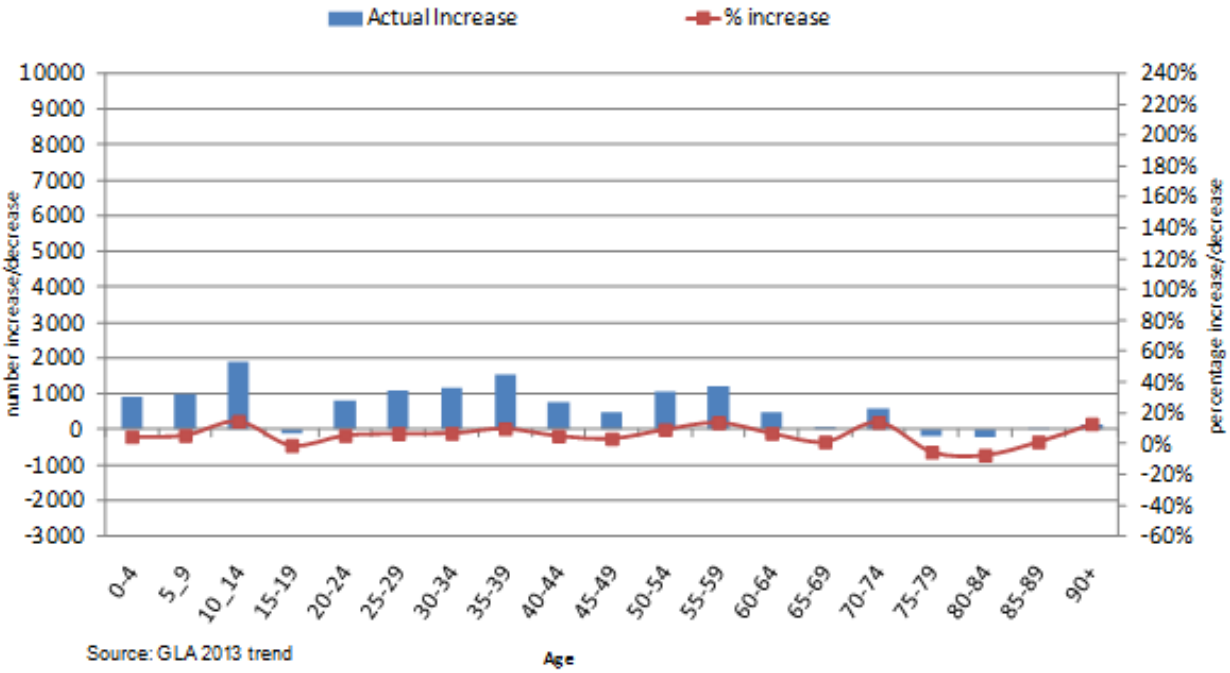
[15]Public Health England. (2011) Summary IMD 2010 scores for non-LSOA geographies. (Online) Available from: http://www.apho.org.uk/resource/item.aspx?RID=111280 (Accessed 3 November 2014)

[16] Department for Communities and Local Government (2011) The English Indices of Deprivation 2010. (Online) Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6320/1870718.pdf (Accessed 3 November 2014)

2.5.5 Predicted population growth

The Greater London Authority (GLA) forecasts suggest that the borough population will go up 6% to an estimated 213,000 by 2017, and a further 9% increase to an estimated 227,000 by 2021. Figures 4 and 5[17] show significant increases in the ages 10-14, 55-59, 70-74 and 90+ compared to the rest of the age groups

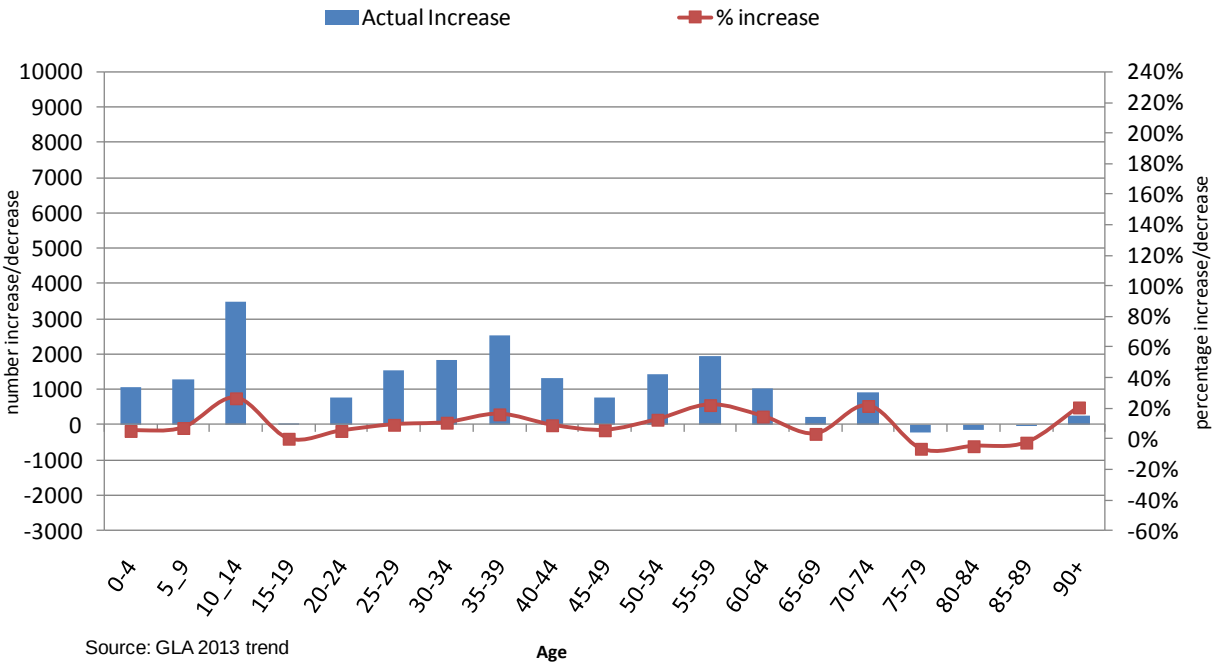
Figure 4 - Increase / decrease in population by 5 year age band between years chosen 2014-2017



Source: GLA 2013 trend

[17] GREATER LONDON AUTHORITY (2014) Ward Profiles and Atlas. (Online) Available from: http://data.london.gov.uk/dataset/ward-profiles-and-atlas (Accessed 10 December 2014)

Figure 5 - Increase / decrease in population by five year age band between years chosen 2014-2021



Source: GLA 2013 trend

2.5.6 Local development plan

In the next 20 years, Barking and Dagenham will undergo its biggest transformation since the borough was first industrialised and urbanised. The Thames Gateway, of which it forms the heart, is the largest regeneration area in Europe. It is crucial to the government's plans to develop sustainable communities in the south-east and to the London Mayor's ambition to ensure prosperity is more evenly shared between east and west in London.

The borough contains the UK's biggest brownfield regeneration site at Barking Riverside and the future home of London's environmental technologies at Dagenham Dock. A major sustainable community will be developed on land released by Ford Co Ltd in South Dagenham and Barking town centre will be revitalised to become the town centre of choice for the new communities.

The Council has adopted a growth strategy setting out how the regeneration of the borough will be achieved. The strategy objectives are:

- attracting Investment
- creating a Higher Skilled Workforce
- building Businesses
- widening the Housing Choice[18]

The key development opportunities in the borough are shown in Figures 6a and 6b.

[18] London Borough of Barking and Dagenham (2014) Regeneration. (Online) Available from: http://www.lbbd.gov.uk/Regeneration/Pages/home.aspx (Accessed 19 November 2014)

Figure 6a - Key development opportunities, Barking and Dagenham Growth Strategy

Source: http://www.lbbd.gov.uk/Regeneration/Regenerationvision/Documents/GrowthStrategy36pp2013_v3_print.pdf

Figure 6b - Key development opportunities, Barking and Dagenham Growth Strategy

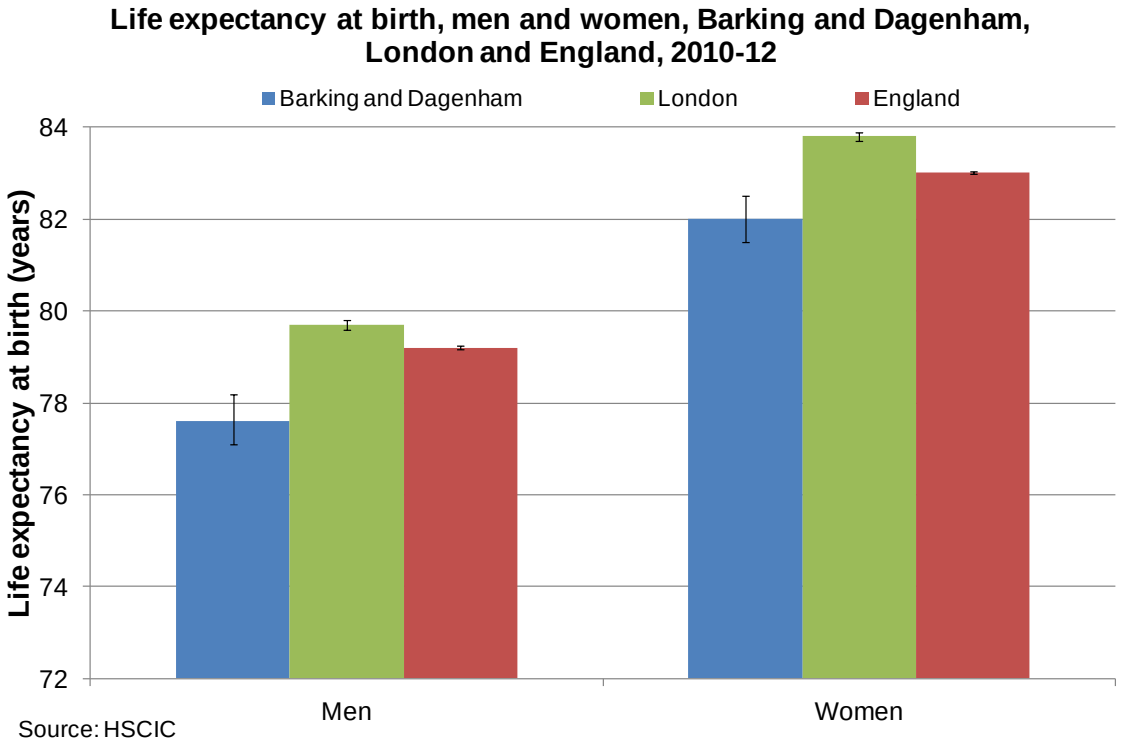
Source: http://www.lbbd.gov.uk/Regeneration/Regenerationvision/Documents/GrowthStrategy36pp2013_v3_print.pdf

2.5.7 Life expectancy

Life expectancy is higher in women than in men in Barking and Dagenham (82.0 years and 77.6 years respectively), as it is in London and England. Life expectancy at birth for men in Barking and Dagenham (77.6 years) is lower than in both England (79.2 years) and London (79.7 years). Life expectancy in women (82.0 years) is also lower than both the London (83.8 years) and England (83.0 years) average values[19]. Figure 7 demonstrates these life expectancy differences.

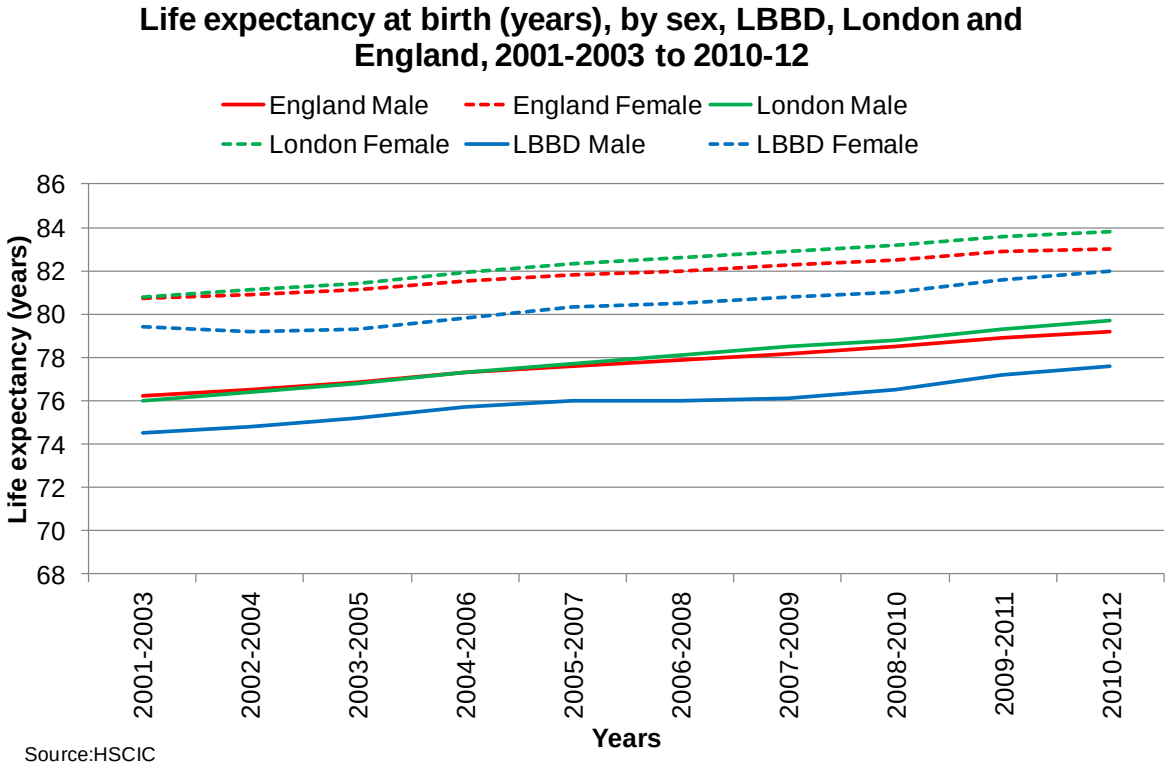
[19] Health and Social Care Information Centre (2014) Indicator portal. (Online) Available from: https://indicators.ic.nhs.uk/webview/ (Accessed 10 October 2014)

Figure 7 - Life expectancy at birth, men and women, 2010-2012



Life expectancy in the borough, as in other parts of the country, has increased in recent years however without reducing the gap between Barking and Dagenham and London and England since 2001 (Figure 8).

Figure 8 - Life expectancy at birth (years), 2010-2012



At ward level, there is a variation in life expectancy between wards, with River having the lowest life expectancy for both men and women. Abbey has the highest for men, and Longbridge the highest for women (Figures 9 and Table 8).

Figure 9 - Life expectancy at birth, Barking and Dagenham wards, 2008-2012

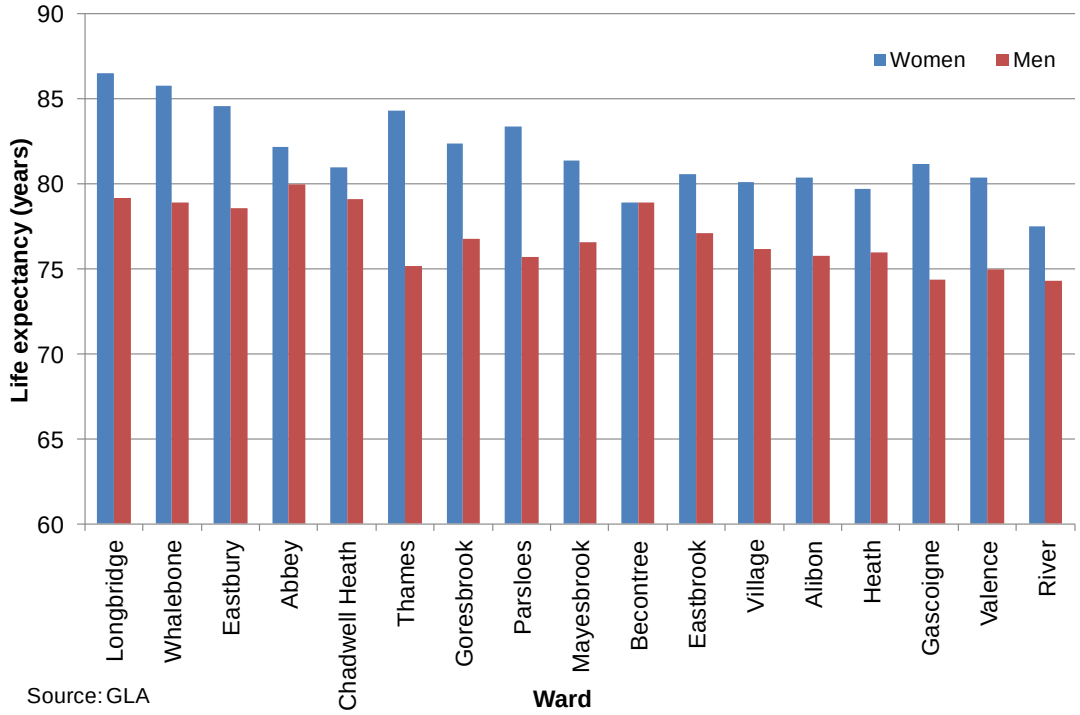


Table 8 - Life expectancy by ward, 2008-2012

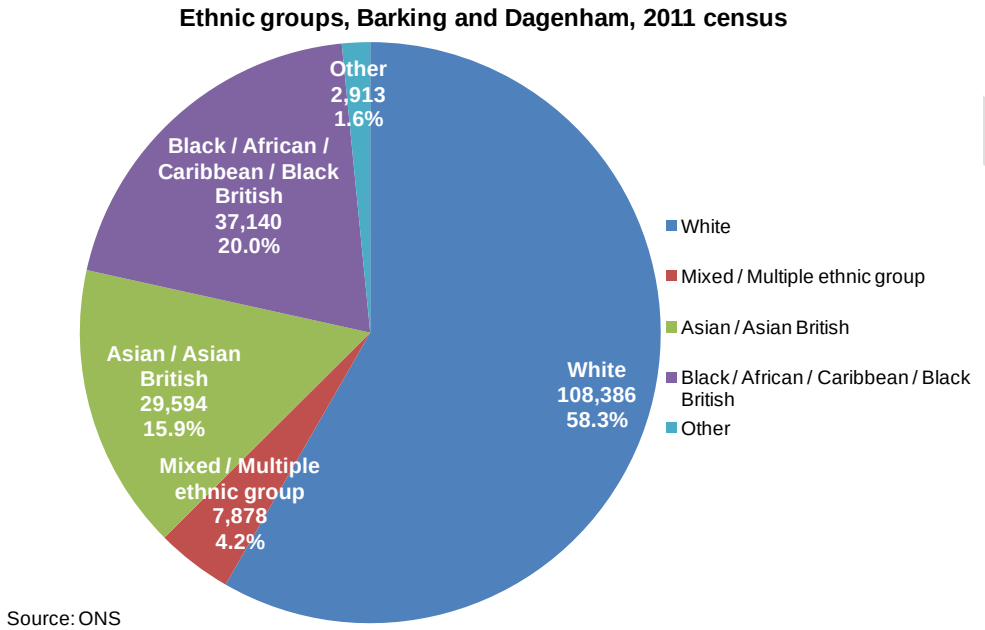
Ward	Female life expectancy - 2008-2012	Male life expectancy - 2008-2012
Longbridge	86.5	79.2
Whalebone	85.8	78.9
Eastbury	84.6	78.6
Abbey	82.2	80.0
Chadwell Heath	81.0	79.1
Thames	84.3	75.2
Goresbrook	82.4	76.8
Parsloes	83.4	75.7
Mayesbrook	81.4	76.6
Becontree	78.9	78.9
Eastbrook	80.6	77.1
Village	80.1	76.2
Alibon	80.4	75.8
Heath	79.7	76.0
Gascoigne	81.2	74.4
Valence	80.4	75.0
River	77.5	74.3

2.5.8 Specific populations

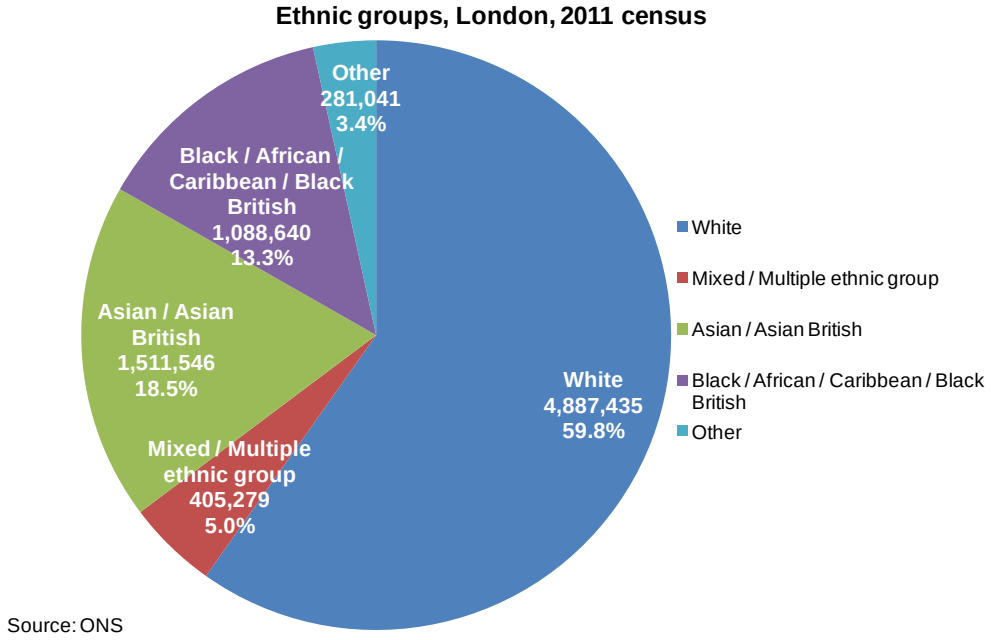
2.5.8.1 Ethnicity

Barking and Dagenham has a very ethnically diverse population. The proportion of people from black, Asian, minority ethnic (BAME) groups is much higher than in the general England population. Compared with London, Barking and Dagenham has a higher proportion of people from black ethnic groups and a lower proportion from Asian ethnic groups (Figure 10).

Figure 10 - Distribution of population by ethnicity, Barking and Dagenham, London and England, 2011 census



Source: ONS



Source: ONS

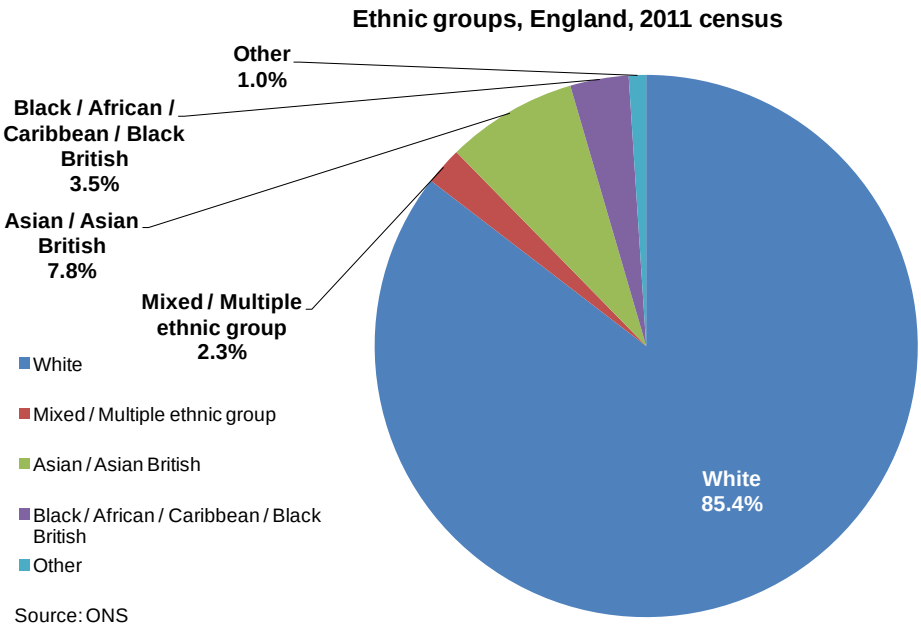


Figure 10 provides further detail on the ethnic breakdown of the Barking and Dagenham population. The population of white Europeans born outside the UK are mainly from the new European countries of Lithuania, Poland and Romania. Of those born in Africa, 40% are from Nigeria, three-quarters of those born in the Middle East and Asia were born in India, Pakistan and Bangladesh with an almost equal division between those three countries.

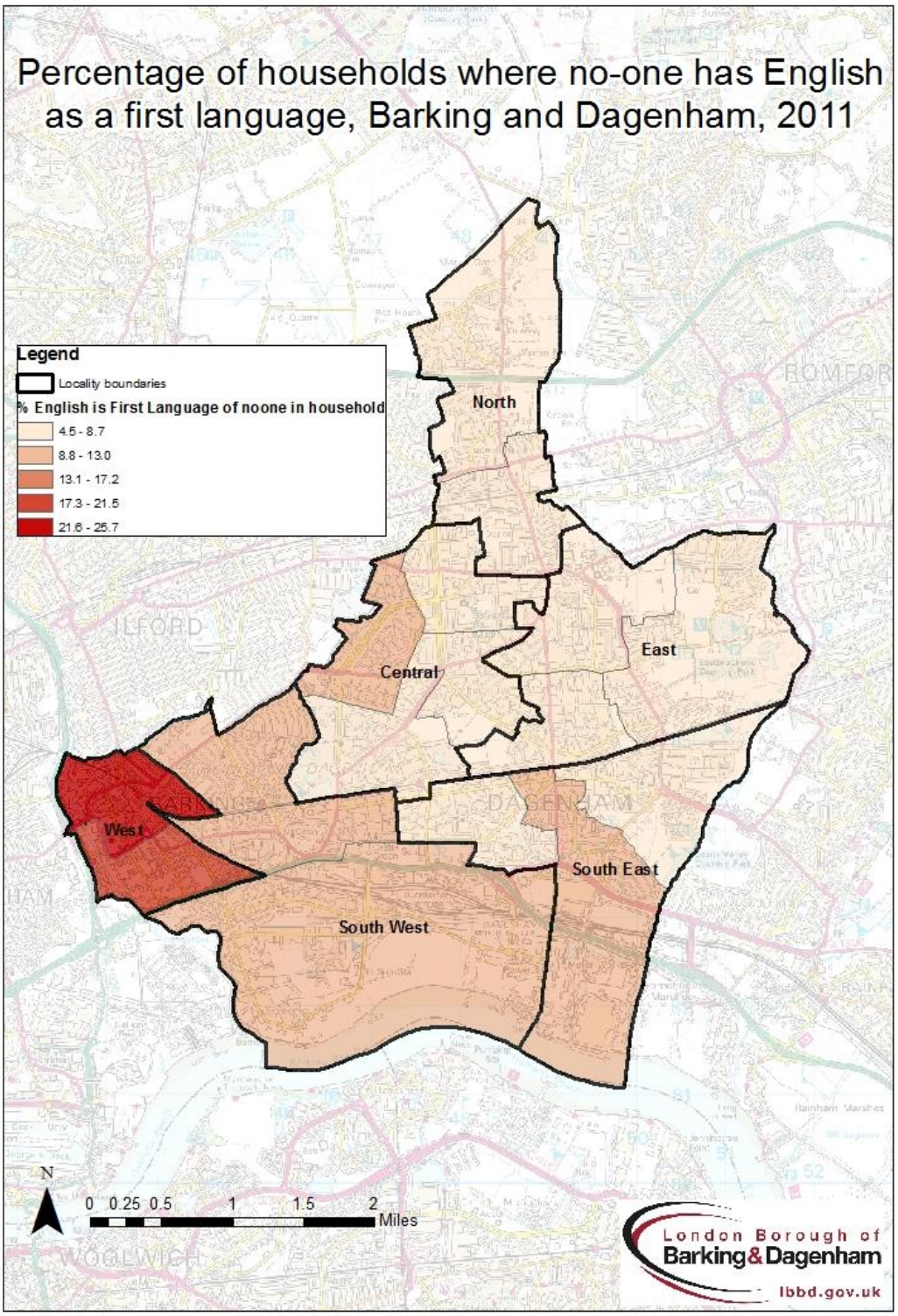
Table 9 - Detailed ethnic group breakdown, Barking and Dagenham, 2011 census

Ethinic group	Number of people
White: English/Welsh/Scottish/Northern Irish/British	91,949
White: Irish	1,730
White: Gypsy or Irish Traveller	182
White: Other White	14,525
Mixed/multiple ethnic group: White and Black Caribbean	2,669
Mixed/multiple ethnic group: White and Black African	2,128
Mixed/multiple ethnic group: White and Asian	1,246
Mixed/multiple ethnic group: Other Mixed	1,835
Asian/Asian British: Indian	7,436
Asian/Asian British: Pakistani	8,007
Asian/Asian British: Bangladeshi	7,701
Asian/Asian British: Chinese	1,315
Asian/Asian British: Other Asian	5,135
Black/African/Caribbean/Black British: African	28,685
Black/African/Caribbean/Black British: Caribbean	5,227
Black/African/Caribbean/Black British: Other Black	3,228
Other ethnic group: Arab	973
Other ethnic group: Any other ethnic group	1,940

Source: ONS

Four out of every five households in Barking and Dagenham, all people have English as their main language, although one in ten households has no one in the household for whom English is their main language. For the remainder, at least one person in the household speaks English as their main language, although in about one in 30 households this person is a child under the age of 16 years (Figure 11).

Figure 11 - Percentage of households where no-one has English as a first language, Barking and Dagenham wards, 2011



This detailed information about country of birth and language spoken helps understanding about the needs for service availability. At ward level, Abbey, Gascoigne, Thames, Longbridge and Eastbury have the highest proportions of people not born in the UK and the greatest likelihood of needing health and wellbeing advice in a language other than English (Tables 10 and Figure 12).

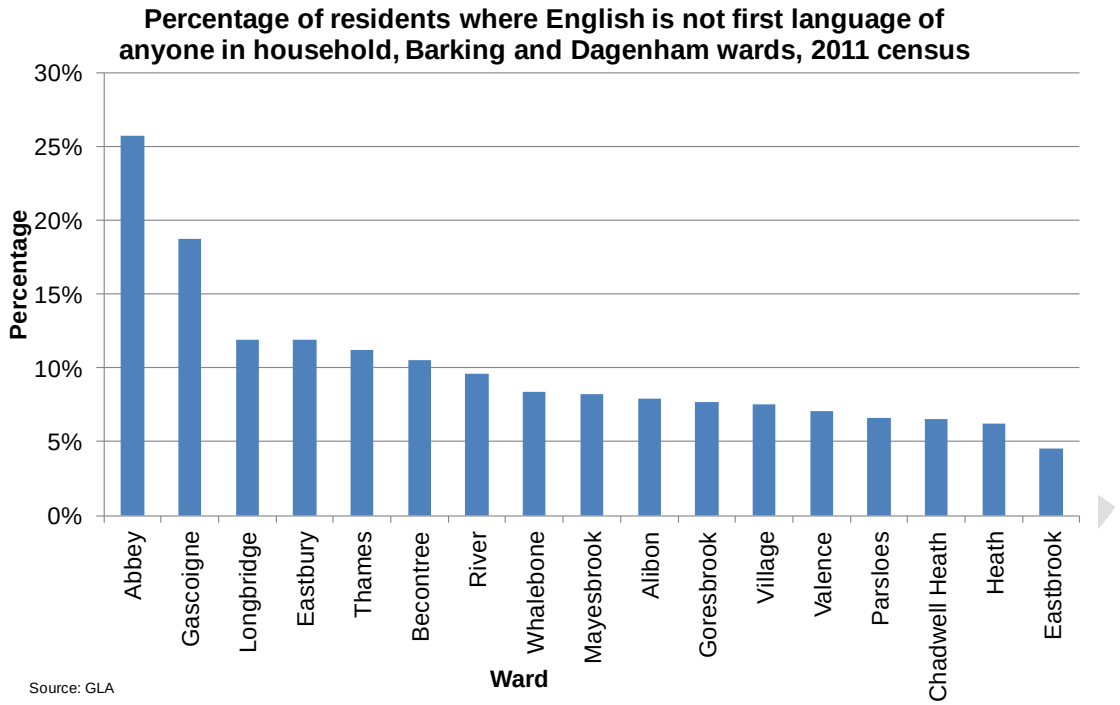
Table 10 - BAME groups, country of birth and first language, Barking and Dagenham wards, 2011 census

Ward	% BAME - 2011	% Not Born in UK - 2011	% English is First Language of no one in household - 2011
Abbey	71.9	57.3	25.7
Gascoigne	60.4	48.2	18.7
Longbridge	57.4	33.3	11.9
Thames	54.9	37.2	11.2
Whalebone	44.0	29.2	8.4
Eastbury	41.7	32.2	11.9
Becontree	41.2	30.1	10.5
River	38.4	30.9	9.6
Chadwell Heath	37.9	24.8	6.5
Village	34.8	26.0	7.5
Goresbrook	33.3	26.8	7.7
Heath	32.3	24.1	6.2
Valence	31.5	23.3	7.1
Mayesbrook	31.2	25.0	8.2
Parsloes	30.9	23.3	6.6
Alibon	29.9	24.7	7.9
Eastbrook	24.8	19.0	4.5

Source: GLA[20]

[20] GLA uses White or not white. It does not separate out the White: Other group. This is important to note due to White: Other originating predominantly from EU accession countries

Figure 12 - Percentage of residents where English is not first language of anyone in the household



Detailed information is also available from the 2011 census about the percentage of residents in each ward from BAME groups and those not born in the UK. Abbey, Gascoigne, Longbridge and Thames wards consistently make the top four wards with over a third of their populations in these categories (Figure 13 and 14).

Figure 13 - Percentage of residents from BAME groups

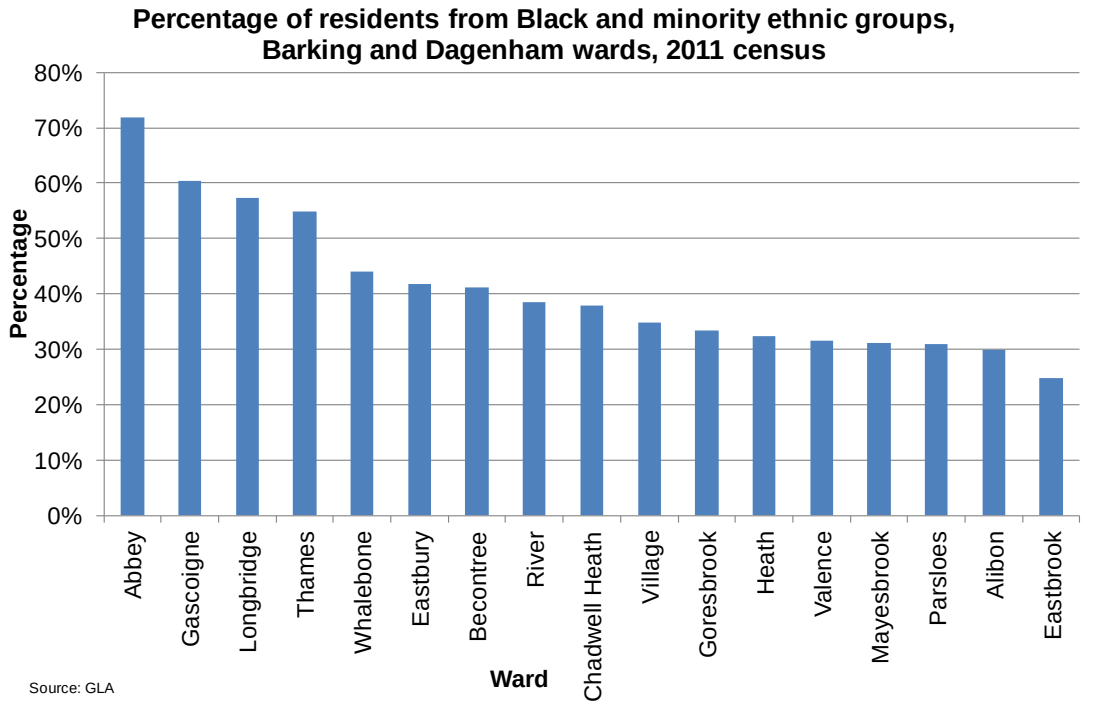
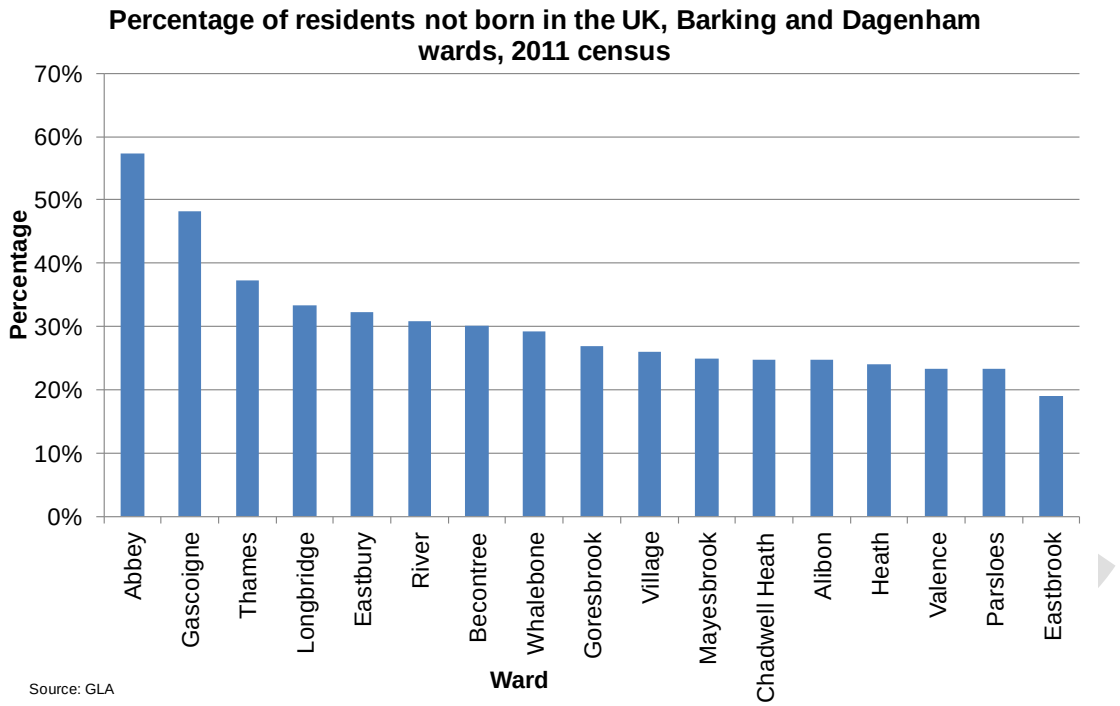
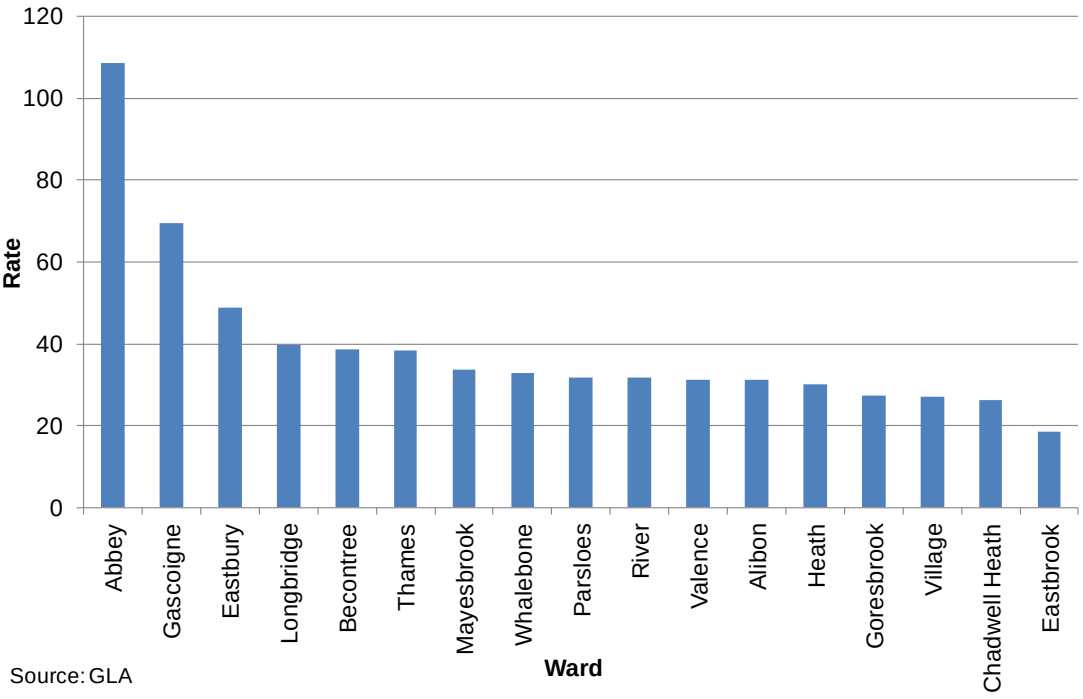


Figure 14 - Percentage of residents not born in the UK



Data on new National Insurance registrations of migrant workers shows where new migrants are most likely to live in Barking and Dagenham (Figure 15), with Abbey having the highest rate, 109 per 1,000 aged 16-64, followed by Gascoigne (70/1,000) and Eastbury (49/1000).

Figure 15 - New registrations of a national insurance number (NINO) from overseas national per 1,000 aged 16-64 years old (migrant workers)



2.5.8.2 Children

Some of the relevant key findings from the JSNA Chapters on children are summarised below:

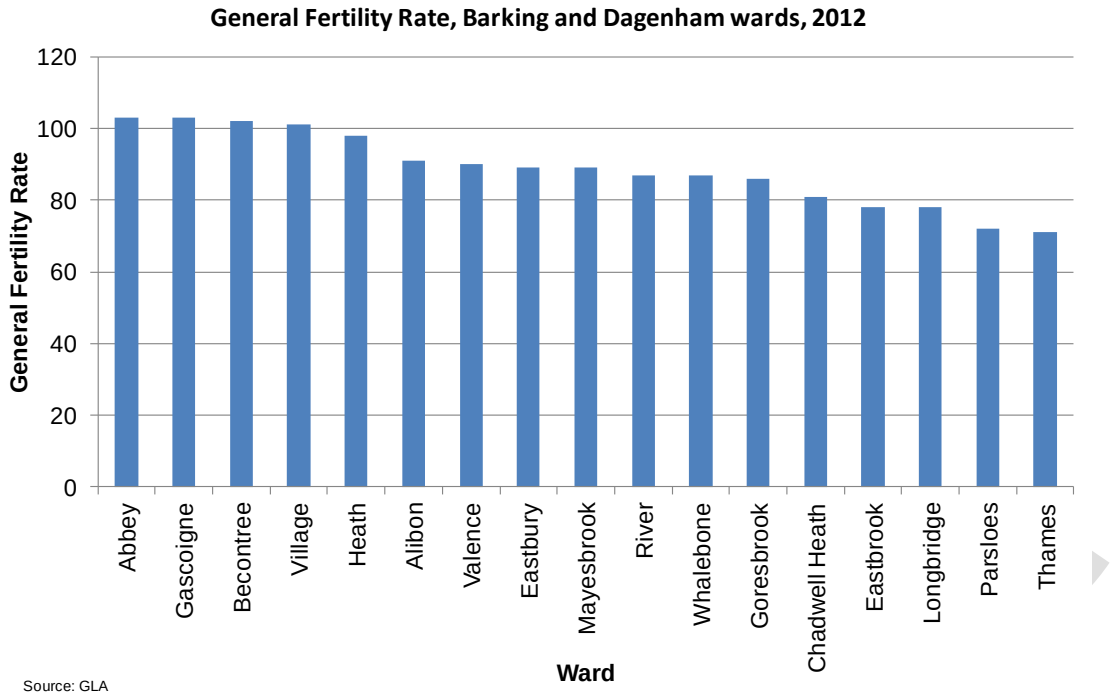
2.5.8.2.1 Population

- the 2011 Census found that the population of children aged 0-4 years had grown by 49% in the previous ten years: this was the highest growth for this age group of any local authority in England and Wales
- the most recent midyear population estimates from the Office for National Statistics (ONS) state that in 2013 there were 19,612 children under five years of age in the borough, 10% of the total borough population of 194,352 and 62,565 (32%) children and young people aged 0-19 years
- ONS population projections (2012) predict the number of 0-19 year olds in the borough is to rise to 72,117 (32.5%) by 2020 which will lead to a potential strain on children's services

2.5.8.2.2 Births and early years

- in 2013, there were 3,796 live births to residents in the borough, with 63% of these births being to mothers born outside of the UK and of these, 70% were to mothers born outside Europe
- the number of births to Barking and Dagenham residents increased by 45% between 2004 and 2012 (2,751 births in 2004, 3,984 in 2012). Fertility rates vary across the different wards with the highest rates in Abbey, Gascoigne, Becontree, Village and Heath and the lowest in Parsloes and Thames (Figure 16)
- there is continuing evidence of an increase in health risk behaviours, such as smoking. Around 10% of women are smokers at the time they deliver their baby and although the percentage is reducing, it remains the highest level in London, where the average is 4.6%
- there have been reductions in the proportion of births to younger mothers: the number of conceptions in women under the age of 18 years decreased from 46.3 per 1,000 women aged 15-17 years in 2011 to 35.4 in 2012. However this is significantly worse than the London and England averages (25.9 and 27.7 per 1,000 women aged 15-17 years)
- immunisation uptake has improved significantly and moved substantially closer to the local target of 90% uptake but still remains below the national target of 95% across all childhood immunisations
- breastfeeding reporting has improved but only around three-quarters of mothers initiate breastfeeding and by the time of the 6-8 week check only half of mothers are wholly or partially breastfeeding . This compares with the average for London of 85% of mothers initiating breastfeeding and 60% continuing to breastfeed at 6-8 weeks

Figure 16 - General fertility rate, Barking and Dagenham wards, 2012



Source: GLA

2.5.8.2.3 Child poverty

- in 2011 33.9% of children under 16 in the borough were living in poverty, compared to 26.5% in London and 20.6% in England. This can have a huge impact on a child's start to life, and to future educational achievement and employment prospects
- as a result of the increase in child population there has also been an increase in the number of households with dependent children, especially in the number of lone parent households, which increased by over 40% from 2001 to 2011. There was an increase in the proportion of lone parents in employment, although much of this is part-time employment and over 50% of lone parents are not in employment
- the 2011 Census showed that although the proportion of adults over 16 years in the borough with no qualifications had fallen from 42.3% in 2001 to 27.9% in 2011, this remains higher than the London and England averages (17.6% and 22.5% respectively). There is a strong correlation between parental education levels and early child outcomes. Positive parenting with an active home learning environment contributes significantly to a child's educational and vocational achievements

2.5.8.2.4 School aged population

- there has been a year on year increase in the number of school age children in Barking and Dagenham since 2008. In January 2014 there were 38,954 pupils in all primary and secondary schools, a rise of 1,774 (5.9%) on the previous year

- the number of pupils in secondary schools in Barking and Dagenham grew by 2.6% from 2013 to 2014. In January 2014 there were 13,618 pupils singly enrolled in secondary schools. In the same timescale, the numbers of pupils in our statistical neighbours on average have not changed. Nationally, the figure has increased by 0.3% while London has increased by 2.1%. (Note: data for 2011 nationally, London and statistical neighbours includes dually registered pupils)
- the number of pupils who are entitled to free school meals (FSM) can be used as a proxy for the level of deprivation, as it is linked to parental income. The percentage of school children eligible for FSM dropped to 24% in the January 2014 Census compared to 27% in the previous census. Barking and Dagenham FSM proportion still remains above the national and London averages
- in May 2014 there were 526 young people (16-18 years) not in employment, education or training (NEET) in the borough, which is 6.6% of the 16–18 year olds in the borough. In the same period, 11.2% of the 16-18 population were recorded as 'situation unknown'. As of Quarter 4 2013/14, 6.9% of the 16-18 population were NEET.

Table 11 shows the number of school age children resident in Barking and Dagenham by single year age group.

Table 11 - Population size, school aged children, Barking and Dagenham, London and England, mid 2013 estimates

	Barking and Dagenham		London	England
Age (years)	N	% of total population (all ages)	% of total population (all ages)	% of total population (all ages)
4	3,837	1.97%	1.38%	1.24%
5	3,872	1.99%	1.38%	1.26%
6	3,793	1.95%	1.32%	1.21%
7	3,371	1.73%	1.26%	1.19%
8	3,084	1.59%	1.20%	1.14%
9	2,784	1.43%	1.14%	1.12%
10	2,689	1.38%	1.11%	1.09%
11	2,645	1.36%	1.07%	1.07%
12	2,686	1.38%	1.08%	1.09%
13	2,518	1.30%	1.08%	1.12%
14	2,461	1.27%	1.09%	1.16%
15	2,827	1.45%	1.09%	1.17%
16	2,753	1.42%	1.11%	1.20%
TOTAL	39,320			

Source: ONS

2.5.8.3 Looked after children

There were 441 children (ages 0-18) in care in Barking and Dagenham as of 27 October 2014[21]. Looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers in part due to the impact of poverty, abuse and neglect.

2.5.8.4 Adults in residential and nursing care

Table 12 shows the number of adults (ages 18+) that received residential or nursing care during the period 1st April 2013 to 31st March 2014. It should be noted that individuals may be counted more than once if they had more than one period and / or type of care.

Table 12 - Adults in nursing or residential care in Barking and Dagenham, 2013/14

Reason for needing care	Number in residential care	Number in nursing care
Physical disability	319	232
Mental Health	128	48
Learning disability	73	<5
Substance misuse	<5	0
Other vulnerable people	8	5

Source: LBBD (unpublished)

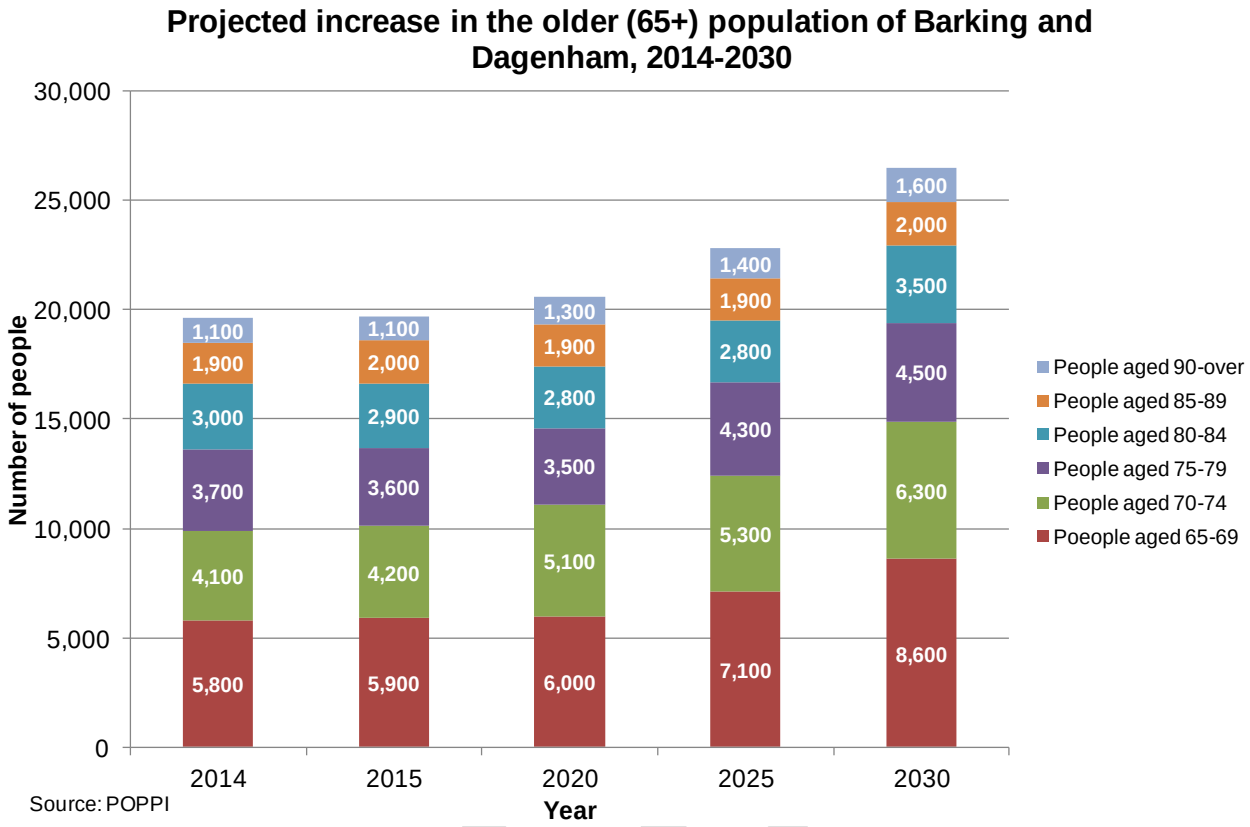
2.5.8.5 Older people

The need for publicly funded care and social support is related to age, gender, dependency, household type and household tenure. Physical or mental frailty, lack of informal care, unsuitable housing and lack of money to pay for their own support will all impact on the extent to which older people are able to manage without social support. The likelihood of people needing care rises sharply as they move into their eighties.

While the proportion of the population aged 65 and over is relatively small in Barking and Dagenham compared with England as a whole, the absolute numbers are predicted to increase as overall population size increases. Figure 17 shows the predicted increases, and also demonstrates that an increase in the number of people over the age of 80 years, the age at which care needs increase, is not anticipated until after 2025.

[21] Internal council data source

Figure 17 - Projected increase in the older population (age (65+), 2014-2030, Barking and Dagenham



2.5.8.6 Less able populations

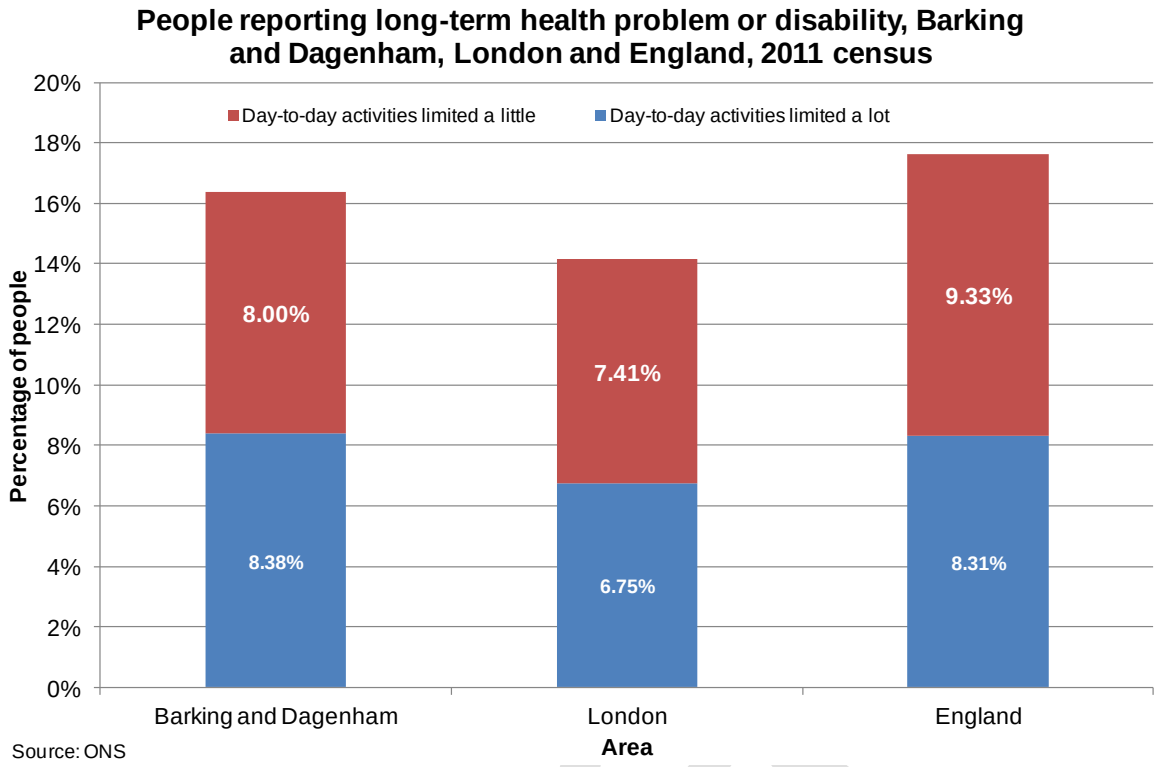
People with disabilities or long term problems may need additional support and easy access to services may make a real difference to their ability to live independently. Data on limitation of activities was collected in the 2011 census, and shows that nearly 16,000 people living in Barking and Dagenham have a lot of limitation to their day to day activities because of poor health or disabilities (Table 13 and Figure 18).

Table 13 - Long-term health problem or disability, Barking and Dagenham, London and England, 2011 census

	Day-to-day activities limited a lot		Day-to-day activities limited a little		Day-to-day activities not limited	
	N	%	N	%	N	%
Barking and Dagenham	15,584	8.38%	14,876	8.00%	155,451	83.62%
London	551,664	6.75%	605,501	7.41%	7,016,776	85.84%
England	4,405,394	8.31%	4,947,192	9.33%	43,659,870	82.36%

Source: ONS

Figure 18 - Long-term disability, Barking and Dagenham, London and England, 2011



Source: ONS

2.5.8.7 Visual and hearing impairment

2.5.8.7.1 Children

Data about children with visual and hearing impairments is collected by school nurses and collated into the school census. Figure 30 shows data from the Schools Census 2014 conducted in January 2014. At 5th November 2014 the special educational needs (SEN) database records show that 55 children have an SEN statement with their main category listed as hearing impairment and 28 children have an SEN statement with their main category listed as visual impairment.

Table 14 - Children with special educational needs (hearing and visual impairment) attending schools in Barking and Dagenham

	Main category of need	Secondary category of need	Total
Visual impairment	32	16	48
Hearing impairment	72	28	100

Source: Schools Census 2014

2.5.8.7.2 Adults

The predicted number of adults (aged 18-64 years) with serious visual impairment in 2014 is 78 (Figure 15). The estimated rate of 40 per 100,000 adults is the same as the England rate and below the London rate of 44 per 100,000.

Figure 15 - Predicted numbers of people with visual impairment, adults, Barking and Dagenham

Age group and category of impairment	2014	2015	2020	2025	2030
18-24 Serious visual impairment	12	12	12	14	15
25-33 Serious visual impairment	21	21	23	24	24
35-44 Serious visual impairment	19	20	22	24	25
45-54 Serious visual impairment	16	16	17	19	21
55-64 Serious visual impairment	10	10	12	14	15
65-74 Moderate or severe visual impairment	554	566	622	694	834
75+ Predicted to have a moderate or severe visual impairment	1,203	1,190	1,178	1,209	1,438
75+ Predicted to have registerable eye condition	621	614	608	666	742

Source: PANSI

Visual impairment is much more common in older adults, as can be seen from the large number of people with moderate or severe visual impairment over the age of 65 years. Such impairments include degenerative eye disorders such as cataracts and macular degeneration, as well as the impact of long term diseases such as diabetes.

The total population aged 18 and over predicted to have a profound hearing impairment in Barking and Dagenham in 2014 is 269 people (Table 16). The rate for Barking and Dagenham of 16 per 100,000 people is below the London and England rates (17 and 21 per 100,000 respectively).

Table 16 - Predicted numbers of people with hearing impairment, adults, Barking and Dagenham

Age group and category of impairment	2014	2015	2020	2025	2030
18-24 Predicted to have a profound hearing impairment	0	0	0	0	0
25-34 Predicted to have a profound hearing impairment	0	0	0	0	0
35-44 Predicted to have a profound hearing impairment	0	0	0	0	0
45-54 Predicted to have a profound hearing impairment	11	12	12	13	15
55-64 Predicted to have a profound hearing impairment	19	20	24	27	29
65-74 Predicted to have a profound hearing impairment	62	62	68	76	91
75-84 Predicted to have a profound hearing impairment	43	41	40	45	51
85+ Predicted to have a profound hearing impairment	134	134	137	144	152

Source: PANSI

Moderate or severe hearing loss is much more common, with the rate for Barking and Dagenham being 1,928 per 100,000 population, lower than the London (2,069) and England (2,351) rates. Hearing deteriorates with age and a much larger number of older people will have mild or moderate hearing loss that can be managed with the use of a hearing aid.

2.5.8.8 People with learning disabilities

Estimates of GP registered patients[22] known to have learning disabilities can be compared with the projections predicted number and forecast future numbers from PANSI. The estimated rate per 100,000 for people aged 18-64 years is 348, slightly above the England rate of 342 but below the London rate of 375 (Table 17).

Table 17 - Prevalence of learning disabilities, Aged 18+, QOF 2013-14

	Number	Prevalence (%)*
Barking and Dagenham	725	0.50%
London	25,302	0.36%
England	214,352	0.48%

*Prevalence using age 18+ list size for denominator

Source: HSCIC

Table 18 - Predicted numbers of people with learning disability, adults aged 18-24, Barking and Dagenham

Age group	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a learning disability	504	512	519	560	634
People aged 25-34 predicted to have a learning disability	807	822	886	906	901
People aged 35-44 predicted to have a learning disability	727	739	833	917	959
People aged 45-54 predicted to have a learning disability	568	581	626	672	756
People aged 55-64 predicted to have a learning disability	350	359	433	492	524
Total population aged 18-64 predicted to have a learning disability	2,955	3,013	3,296	3,546	3,774

Source: PANSI

2.5.8.9 Homelessness

Homelessness has increased sharply in recent years as the impact of the economic recession and changes in benefits entitlements have affected people.

[22] Health and Social Care Information Centre (2014) Quality and Outcomes Framework (QOF)- 2013-14. (Online) Available from: http://www.hscic.gov.uk/article/2021/Website-Search?productid=16273andq=qof&sort=Relevance&size=10&page=1&area=both#top (Accessed 10 December 2014)

As of 19th October 2014 the number of cases in temporary accommodation was 1,392[23]. Each case can comprise of more than one person, for example it could mean one family. The published number for 2013/14 was 1,386, giving a crude rate of 19 per 1,000 estimated total households, ranking 7th in London, where the average rate is 12.8[24].

The ONS estimates that there were no people rough sleeping in Barking and Dagenham in autumn 2013[25].

2.5.8.10 Asylum seekers and refugees

Data about asylum seekers and refugees is collected by the Home Office. The numbers are shown in Table 19.

Table 19 - Asylum seekers in receipt of Section 95 support, as at end of quarter 2 2014

	Total supported under Section 95	In receipt of subsistence only	In dispersed accommodation
Barking and Dagenham	140	40	100
London	2,708	1,776	932
England	26,720	3,090	23,630

Source: Home Office

2.5.8.11 Daytime population

The population present in Barking and Dagenham during the normal working day is mainly influenced by the numbers who commute out of the borough to work and those that commute from outside the borough to work within it (Table 20)[26]. Barking and Dagenham has good transport links which enable people to travel into and out of the borough with relative ease.

[23] Department for Communities and Local Government (2014) Rough Sleeping in England: Autumn 2013. (Online) Available from: https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2013: (accessed 10 November 2014)
[24] Public Health England (2014) Public Health Outcomes Framework. (Online) Available from: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/pat/6/ati/102/page/3/par/E12000007/are/E09000002 (Accessed 17 November 2014)
[25] Department for Communities and Local Government (2014) Rough sleeping in England: Autumn 2013. (online) Available from: https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2013 (Accessed 10 November 2014)
[26] Greater London Authority (2013) Daytime population, borough (Online) Available from: http://data.london.gov.uk/datastore/package/daytime-population-borough (Accessed 21 October 2014)

The GLA estimates that the workday population in Barking and Dagenham (excluding tourists) is 169,853 people[27]. Of these, 31% are estimated to be in employment, compared to 46% across London. Nearly 36% are not in work, compared to 26% nationally, whereas the rest, are children under five and of school age.

Table 20 - Daytime population, Barking and Dagenham, London and England, 2012

Components	Barking and Dagenham		London	
Total Daytime Population (includes tourists)	190,382		10,783,949	
Workday Population (excludes tourists)	**169,853**	% of workday population	**9,405,092**	% of workday population
In work (employee)	46,983	27.7%	4,340,344	46.1%
In work (self-employed)	6,264	3.7%	733,235	7.8%
Not in work	61,473	36.2%	2,424,497	25.8%
Population aged 0-4	18,643	11.0%	602,918	6.4%
School children aged 5 or over	36,490	21.5%	1,304,098	13.9%
Overseas Staying visitors	1,499		265,148	
Domestic Staying Visitors	236		19,600	
Day Trip Visitors	18,795		1,094,110	

Source: GLA

2.5.8.12 Traveller population

The 2011 census identified 182 people living in Barking and Dagenham who stated "White: Gypsy or Irish Traveller" as their ethnicity[28].

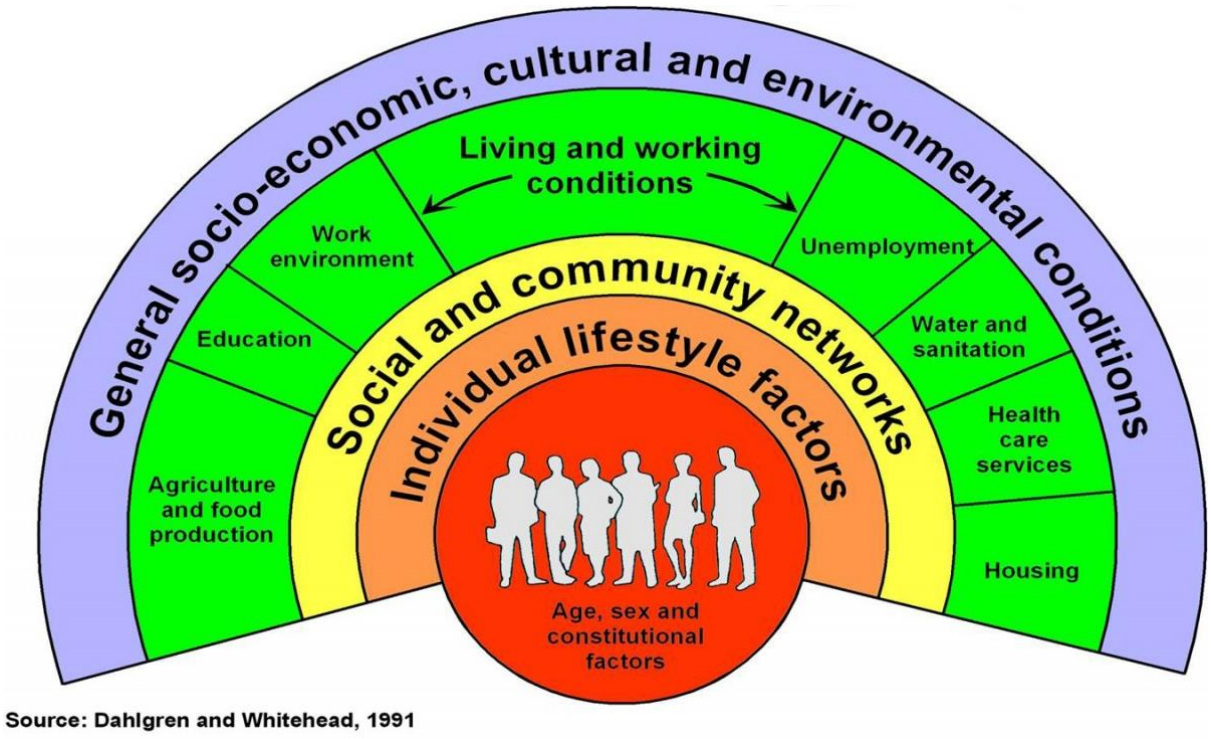
This group makes up approximately 0.10% of the Barking and Dagenham population – the same proportion as in London and England.

2.6 Health and lifestyles

People's health is influenced by a range of wider determinants, which are popularly illustrated in a diagram first drawn up by Dahlgren and Whitehead in 1991 (Figure 19).

[27] Greater London Authority (2013) Daytime population, borough. (Online) Available from: http://data.london.gov.uk/datastore/package/daytime-population-borough (Accessed 21 October 2014)
[28] Office For National Statistics (2012) 2011 Census Key Statistics for Local Authorities in England and Wales. (Online) Available from: http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/index.html (Accessed 1 November 2014)

Figure 19 - The wider determinants of health



Source: Dahlgren and Whitehead, 1991

There are four main lifestyle factors that impact on health: smoking, diet, physical activity and drinking alcohol.

2.6.1 Smoking

The prevalence of smoking in people aged 18 and over is significantly higher in Barking and Dagenham than in London and England[29] as shown in Table 21.

The impact of this is that Barking and Dagenham has worse rates than London and England for many of the indicators of ill health and mortality associated with smoking (Table 22).

Table 21 - Prevalence of smoking, persons aged 18+, 2013

	Smoking prevalence (18+)	95% lower CI	95% upper CI
Barking and Dagenham	1.23%	0.96%	1.49%
London	1.23%	1.19%	1.27%
England	0.94%	0.93%	0.96%

Source: PHOF

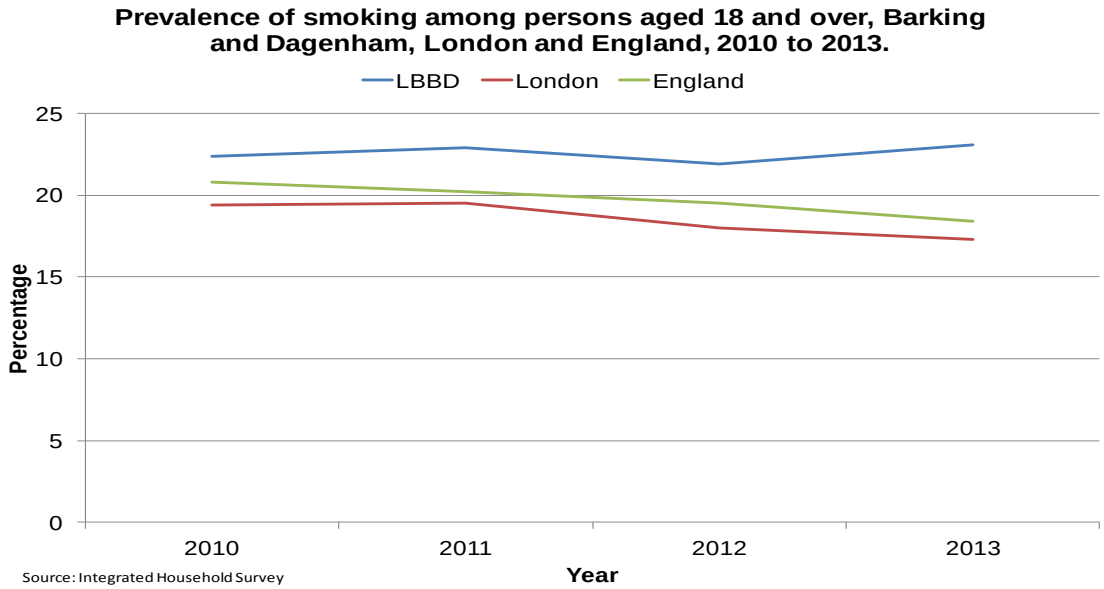
[29] PUBLIC HEALTH ENGLAND (2014) Public Health Outcomes Framework. (Online) Available from: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000002 (Accessed 6 November 2014)

Table 22 - Comparison of smoking indicators, Barking and Dagenham against London and England

Indicator	LBBD compared to:	
	London	England
Smoking attributable mortality	LBBD has a worse rate	LBBD has a worse rate
Smoking attributable deaths from heart disease	LBBD has a similar rate	LBBD has a similar rate
Smoking attributable deaths from stroke	LBBD has a similar rate	LBBD has a similar rate
Deaths from lung cancer	LBBD has a worse rate	LBBD has a worse rate
Deaths from chronic obstructive pulmonary disease	LBBD has a worse rate	LBBD has a worse rate
Lung cancer registrations	LBBD has a worse rate	LBBD has a worse rate
Oral cancer registrations	LBBD has a similar rate	LBBD has a similar rate
Smoking attributable hospital admissions	LBBD has a similar rate	LBBD has a worse rate
Smoking prevalence - routine and manual	LBBD has a similar rate	LBBD has a similar rate
Smoking status at time of delivery	LBBD has a worse rate	LBBD has a better rate

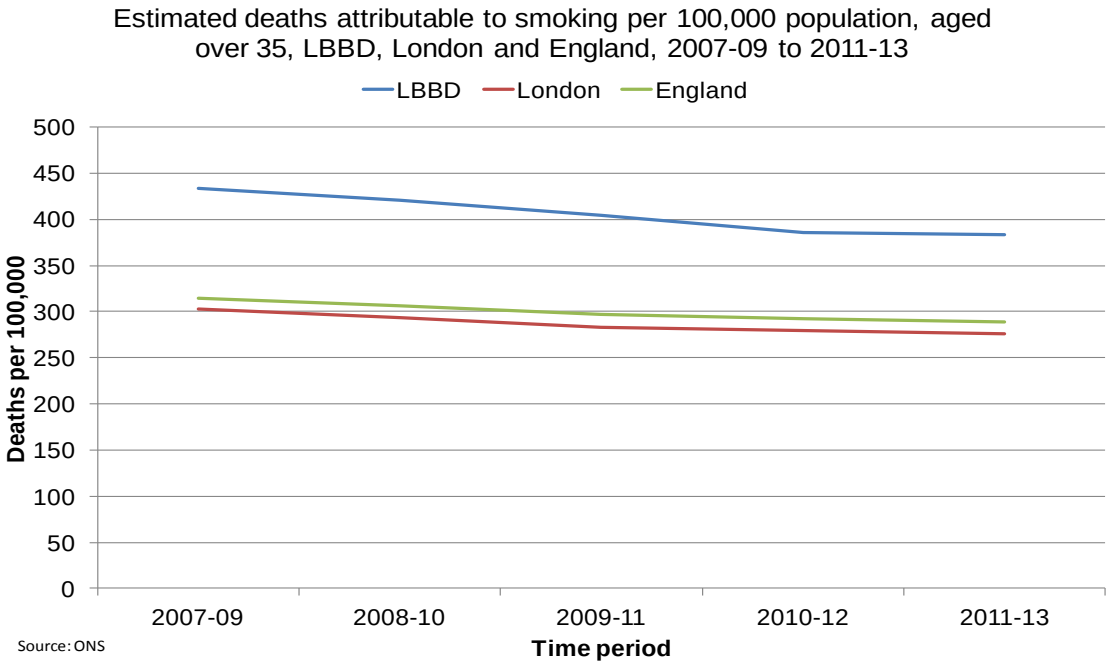
The prevalence of smoking is not reducing in Barking and Dagenham as it is in London and England and much more effort is needed to increase access to smoking cessation support and to encourage people to want to give up smoking.

Figure 20 - Smoking prevalence time trend, Barking and Dagenham, London and England, 2010-2013



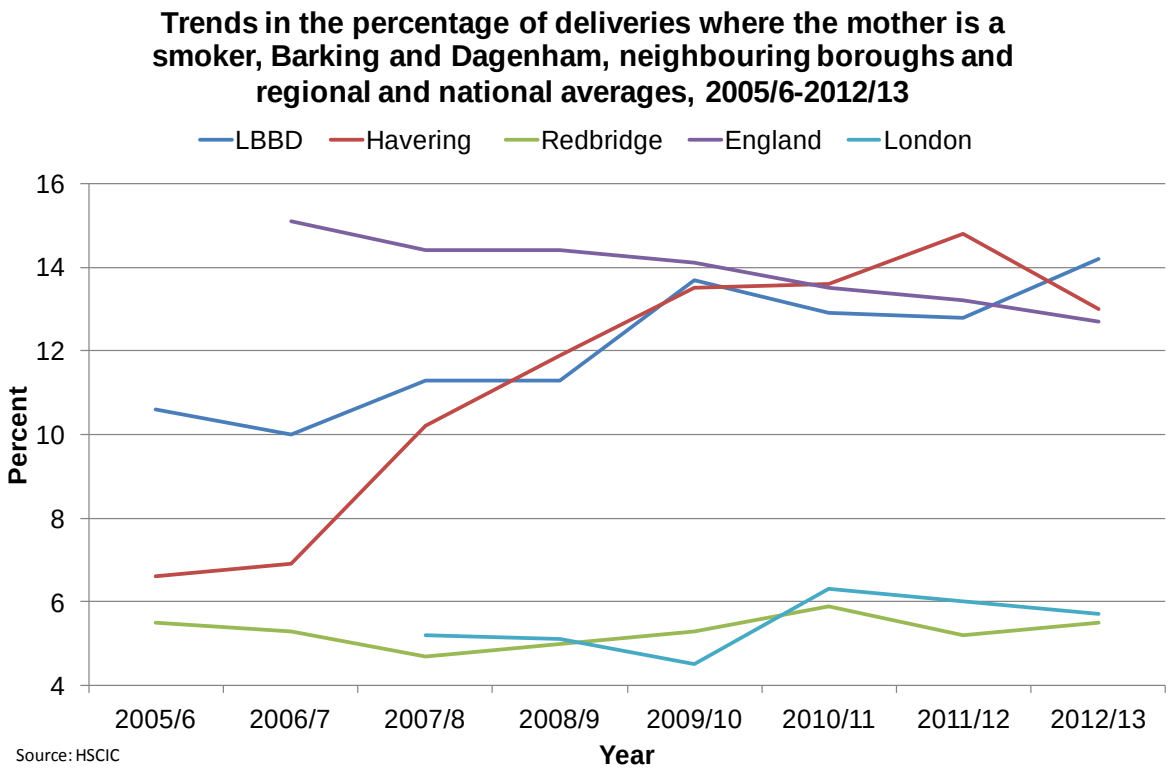
However smoking attributable deaths are reducing slightly, this may be due to earlier diagnosis and more effective management of diseases caused by smoking (Figure 21)

Figure 21 – Estimated deaths attributable to smoking per 100,000 population, aged over 35, LBBD, London and England 2008-2009 to 201-2013



Smoking during pregnancy and with children is harmful to the health of the unborn baby and increases the risk of sudden unexplained death in infancy (SUDI). In Barking and Dagenham, 10% of mothers are smokers when they have their baby, compared with 5% for London as a whole (Figure 22)

Figure 22 – Trends in %age of deliveries where the mother is a smoker, Barking and Dagenham, neighbouring boroughs and regional / national averages 2005/6 to 2012/13



2.6.2 Diet and obesity

There were 18,757 people on the 2013/14 QOF register for obesity in Barking and Dagenham[30]. This gives a disease prevalence of 12.36% in Barking and Dagenham (list size age 16+ denominator).

Children are weighed by the National Child Measurement Programme (NCMP) in reception class and year 6. There is a dramatic difference in child obesity between the two age groups, with children in reception (aged 4-5 years) being around half as likely to be overweight or obese as children in year 6 (aged 10-11 years).

Table 23 shows that Thames, River and Abbey have the highest percentage of overweight and obese children in the younger age group and Village and River in the higher age group. Adding both percentages together shows River and Village have the highest percentages for both ages combined.

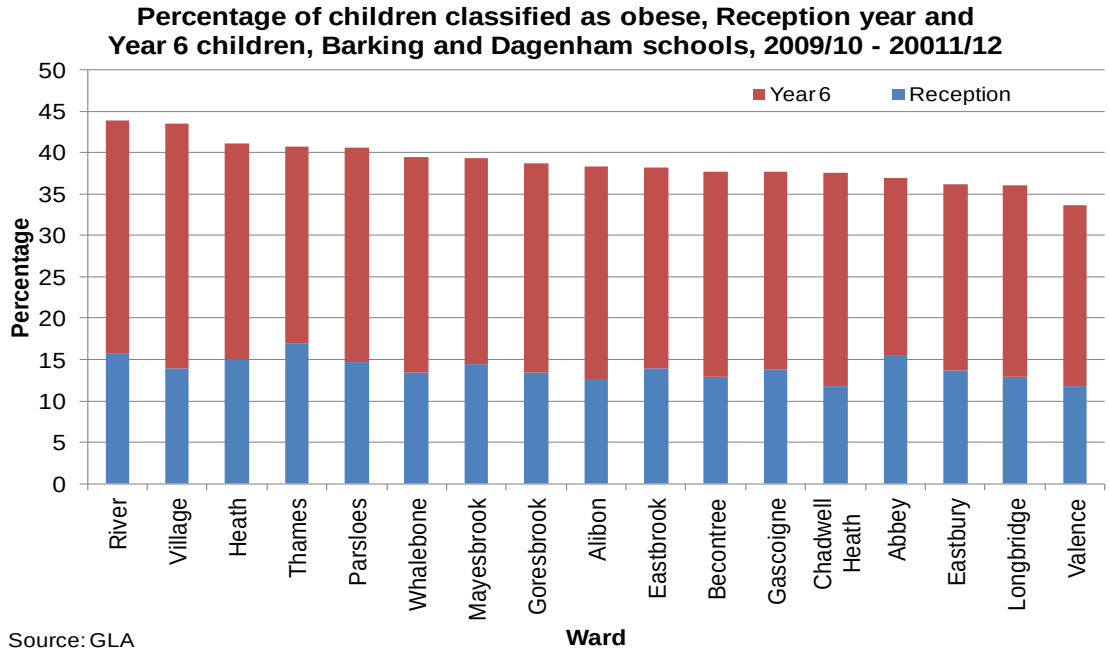
[30] Health and Social Care Information Centre (2014) Quality and Outcomes Framework (QOF) -2013-14. (online) Available from: http://www.hscic.gov.uk/searchcatalogue?productid=16273&q=qof&sort=Relevance&size=10&page=1#top (Accessed 10 November 2014)

Table 23 - Percentage of children classified as obese, reception and year 6 children, Barking and Dagenham wards, 2009/10-2011/12

Ward	% children in reception year who are obese - 2009/10-2011/12	% children in year 6 who are obese - 2009/10-2011/12
River	15.64	28.26
Village	13.97	29.54
Heath	14.94	26.21
Thames	16.96	23.74
Parsloes	14.62	26.00
Whalebone	13.38	26.15
Mayesbrook	14.47	24.94
Goresbrook	13.46	25.24
Alibon	12.50	25.85
Eastbrook	13.94	24.32
Becontree	12.86	24.87
Gascoigne	13.84	23.89
Chadwell Heath	11.75	25.82
Abbey	15.42	21.47
Eastbury	13.62	22.61
Longbridge	12.95	23.10
Valence	11.75	21.88

Source: GLA

Figure 23 - Percentage of children classified as obese, reception and rear 6 children, Barking and Dagenham wards, 2009/10-2011/12



Source: GLA

2.6.3 Breastfeeding

Breastfeeding is recommended for the first six months of life and helps to protect the baby from infections and, in the longer term from weight, problems. The majority of mothers do breastfeed their baby immediately after birth but by 6-8 weeks less than half of mothers are fully or partially breastfeeding (Table 24)

Table 24 - Breastfeeding at 6-8 weeks, 2013/14, Barking and Dagenham, London and England

Area	Number of maternities	Number breastfeeding at 6 to 8 weeks	Prevalence of breastfeeding at 6 to 8 weeks*
Barking and Dagenham	4,350	2,022	46.5%
London	113284	68685	60.6%
England	628,445	287,999	45.8%

Source: NHS England

*It is important to note that Barking and Dagenham CCGs data did not meet validation criteria. London and England also include data from areas that did not meet validation criteria so numbers should be interpreted with extreme caution.

2.6.4 Physical activity

Adults in Barking and Dagenham need to increase their levels of physical activity. Only 44.5% of adults achieve the 150 minutes of physical activity a week that is the recommendation of the Chief Medical Officers, and 38.8% are classified as inactive[31]. These levels are below the London (55.5% and 28.4%) and England averages (55.6% and 28.9%)

2.6.5 Alcohol and drug misuse

Although excessive drinking of alcohol and alcohol related hospital admissions are comparable with London levels, they are of concern and taking action to reduce alcohol consumption is a local priority.

[31] Public Health England (2014) Public Health Outcomes Framework. (Online) Available from: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000007/are/E09000002 (Accessed 19 November 2014)

Table 25 - Alcohol drinking prevalence in Barking and Dagenham, mid 2009 (synthetic estimates32)

Type of drinking	Percentage	Lower 95% CI	Upper 95% CI
Lower risk	76.5%	53.5%	90.7%
Increasing risk	16.8%	8.9%	35.0%
Higher risk	6.6%	2.2%	23.9%
Binge drinking	14.2%	12.4%	16.2%

Source: LAPE

2.6.5.1 Alcohol and related disease

Table 26 shows the number and rate of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised) for 2012/13. The rate for Barking and Dagenham is significantly lower than the rate for England but not significantly different to the rate for London[33].

Table 26 - Alcohol-related hospital admissions, 2012/13

	N	DSR*	95% lower CI	95% upper CI
Barking and Dagenham	843	552	513	593
London	38,568	554	548	560
England	325,866	637	635	639

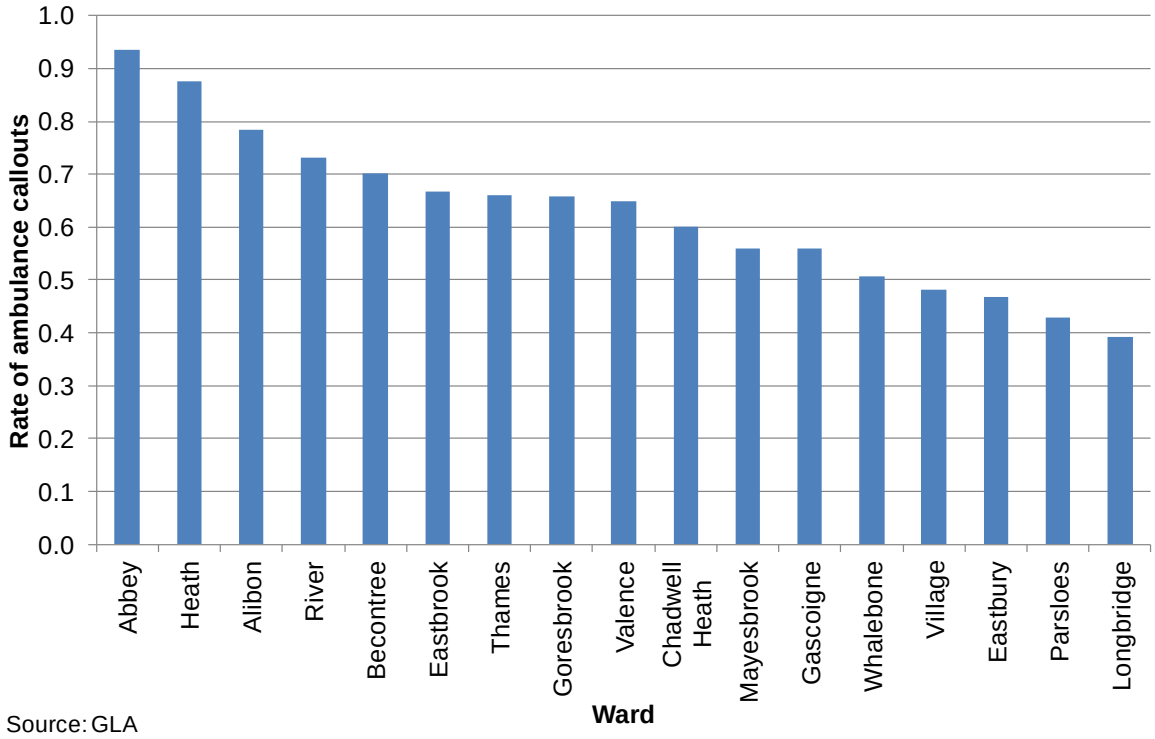
Source: PHOF

*Directly standardised rate per 100,000 population

Data on ambulance call outs for alcohol related illness gives some indication of where in the borough excess alcohol consumption is of greatest concern (Figures 24)

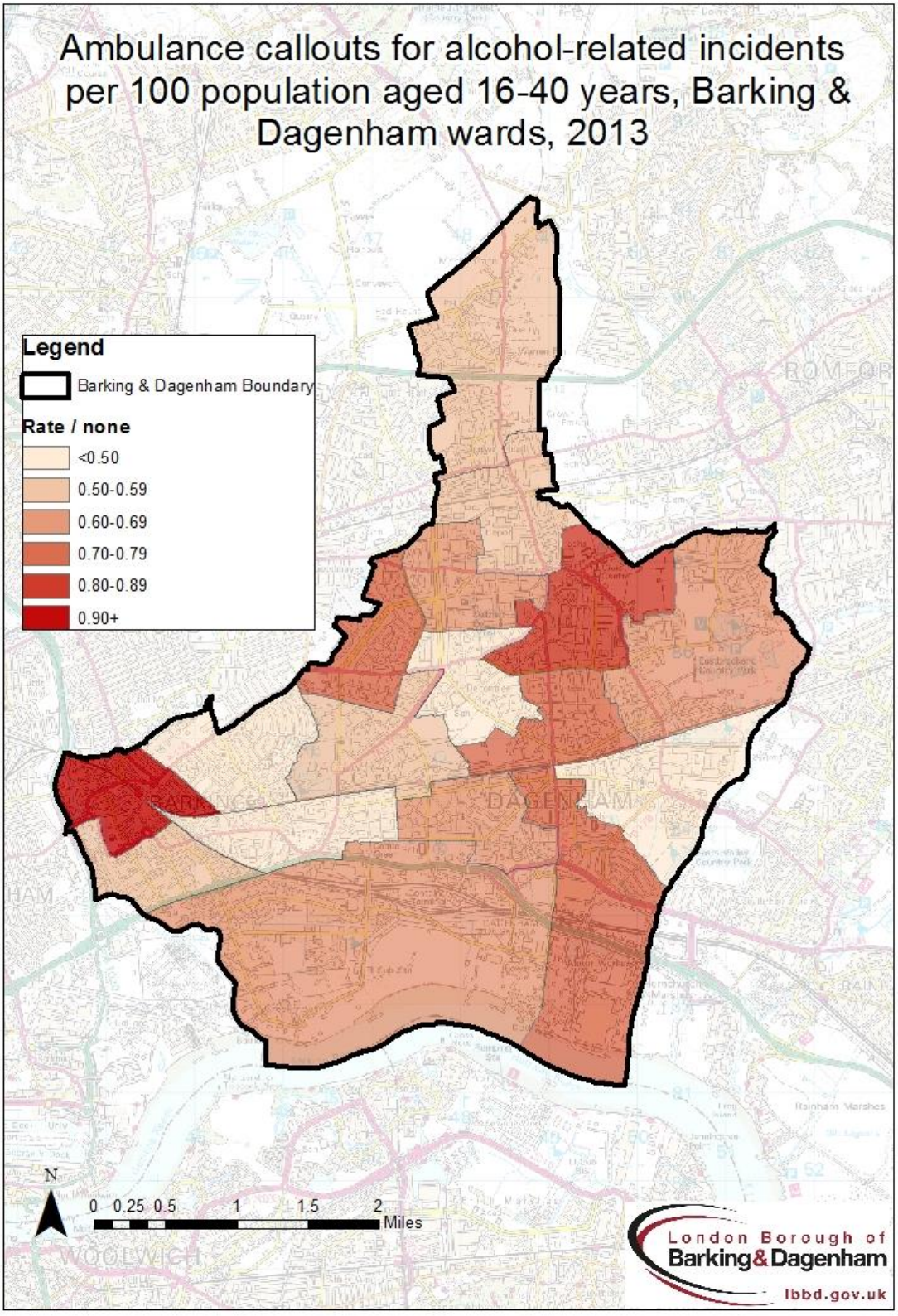
[32] Public Health England (2014) Local Alcohol Profiles for England. (Online) Available from: http://www.lape.org.uk/data.html (Accessed 6 November 2014)
[33] Public Health England (2014) Public Health Outcomes Framework. (Online) Available from http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/3/par/E12000007/are/E09000002 (Accessed 6 November 2014)

Figure 24 - Ambulance call-outs by ward for alcohol related incidents, 2013



Source: GLA

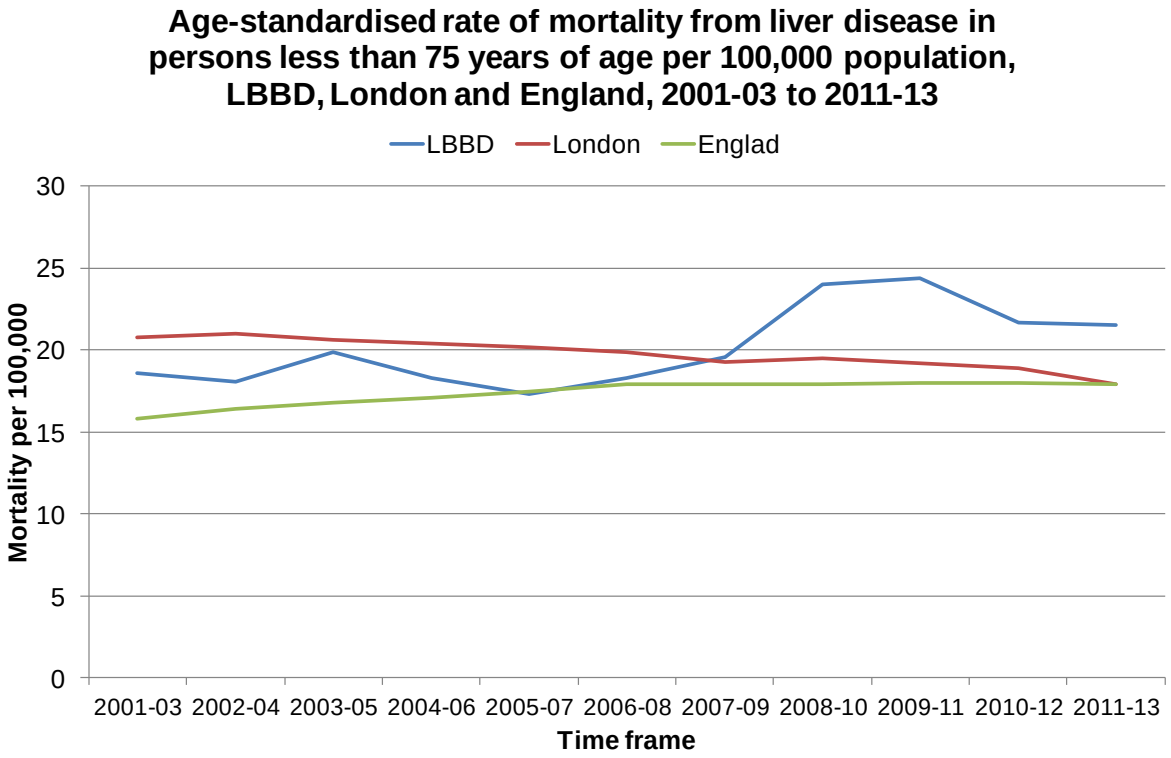
Figure 25 - Ambulance call outs for alcohol related incidents, Barking and Dagenham wards, 2013



Source: GLA

Deaths from liver disease, the majority of which will be related to excess alcohol consumption, are increasing in Barking and Dagenham while in London as a whole they have decreased (Figure 26).

Figure 26 – Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population LBBD, London and England 2001-2003 to 2011-2013



2.6.5.2 Drug misuse

In 2012/13 there were 436 opiate users in treatment out of an estimated 696 (Glasgow prevalence estimates), meaning that 63% of the estimated opiate users in Barking and Dagenham received treatment during that period[34].

2.6.6 Sexual health and teenage pregnancy

2.6.6.1 Chlamydia

The National Chlamydia Screening Programme operates in Barking and Dagenham with intention of diagnosing and treating chlamydia infection and preventing future illness and infertility which can result from not treating this infection. In women this is often symptomless. 30% of people under the age of 25 years were screened in 2013 and positivity rates were similar to the national average (Table 27).

[34] Barking and Dagenham Substance Misuse Strategy Team Substance 2014/15 Needs Assessment Executive Summary Report

Table 27 - Chlamydia detection rate, 2013

	N	Crude rate*	95% lower CI	95% upper CI
Barking and Dagenham	539	2,087	1,915	2,271
London	23,421	2,179	2,151	2,207
England	139,237	2,016	2,005	2,026

*Crude rate per 1,000 population aged 15-24

Source: PHOF

It is important to note that increasing diagnostic rates indicates increased control activity: it is not a measure of morbidity[35].

2.6.6.2 Teenage pregnancy

Although teenage pregnancy has reduced in Barking and Dagenham, it remains high compared with the rate in London and England (Table 28).

Table 28 - Conceptions in females aged under 18, 2012

	N	Conception rate*	95% lower CI	95% upper CI
Barking and Dagenham	133	35.4	29.6	41.9
London	3,504	25.9	25.0	26.7
England	26,157	27.7	27.4	28.1

Source: PHOF[36].

2.6.7 Oral Health

Children in Barking and Dagenham have poor dental health. The recently published survey of three year olds[37] showed that 18% of three year old children in Barking and Dagenham have decayed, missing or filled teeth (DMF) compared with 13.6% for London and 12% for England. The average number of teeth affected in the population as a whole was 0.45 in Barking and Dagenham, 0.42 in London and 0.36 in England.

[35] Public Health England (2014) Public Health Outcomes Framework. (Online) Available from http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000007/are/E09000002 (Accessed 6 November 2014)

[36] Public Health England (2014) Public Health Outcomes Framework. (Online) Available from http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000002 (Accessed 6 November 2014)

37 Public Health England (2014) Dental public health epidemiology programme: Oral health survey of three-year-old children 2013: A report on the prevalence and severity of dental decay. (Online) Available from: http://www.nwph.net/dentalhealth/reports/DPHEP%20for%20England%20OH%20Survey%203yr%202013%20Report.pdf (Accessed 18 November 2014)

Of those with tooth decay, the average number of teeth affected was 2.49 in Barking and Dagenham, 3.11 in London and 3.08 in England, so although there is a higher percentage of children affected in Barking and Dagenham they have less teeth affected.

The estimated percentage of children with early childhood caries is 6.2% in Barking and Dagenham, 5.3% in London and 3.9% in England. DMF levels are known to correlate with deprivation so the higher levels locally are unsurprising.

Data from 2011/12 on tooth decay in five year old children showed a borderline significantly higher average of DMF teeth in children aged five in Barking and Dagenham than in England overall[38]. The average for London was the same as the average for Barking and Dagenham (Table 29).

Table 29 - Tooth decay in children aged 5, 2011/12

	Mean DMFT* per child	95% lower CI	95% upper CI
Barking and Dagenham	1.23	0.96	1.49
London	1.23	1.19	1.27
England	0.94	0.93	0.96

*DMFT = Decayed, missing or filled teeth

Source: PHOF

2.7 Mortality and ill health

This section describes mortality and the leading causes of ill health in Barking and Dagenham.

2.7.1 Premature mortality

Although life expectancy, even in Barking and Dagenham, is around 80 years, premature mortality is conventionally defined as death before the age of 75 years.

Figure 27 details the premature (all-cause) mortality rate for Barking and Dagenham as a whole and for each of the localities. The rate for Barking and Dagenham is 439 people per 100,000 population. Table 30 shows the most recently available England rate, for 2010-2012, is 350 per 100,000 population and for London the rate is 341 per 100,000 population, demonstrating how high the rate for Barking and Dagenham is by comparison.

[38] Public Health England (2014) Public Health Outcomes Framework. (Online) Available from http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/3/par/E12000007/are/E09000002 (Accessed 6 November 2014)

Barking and Dagenham ranks 128th out of 150 local authorities for premature deaths, with ranking for the main causes at 142nd for lung disease, 137th for cancer, 118th for heart disease and stroke and 95th for liver disease[39].

Figure 27 – Directly standardised all-cause premature mortality rate (<75 years), Barking and Dagenham 2009-2013

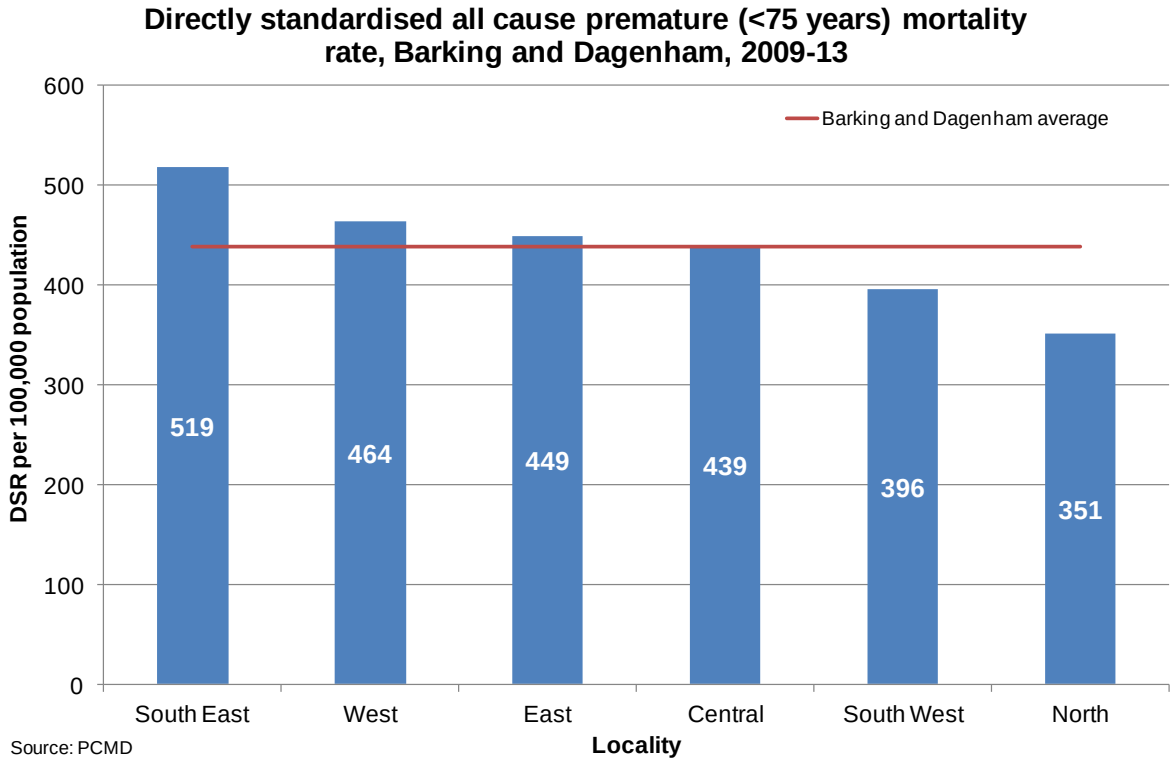


Table 30 - Directly standardised premature (<75 years) mortality rate, Barking and Dagenham, London and England, 2010-12 pooled

Area	Directly standardised mortailty rate in men	Lower confidence limit	Upper confidence limit	Directly standardised mortality rate in women	Lower confidence limit	Upper confidence limit	Directly standardised mortailty rate in persons	Lower confidence limit	Upper confidence limit
Barking and Dagenham	530.91	492.50	571.38	349.52	320.27	380.64	435.41	411.52	460.28
London	427.45	422.55	432.38	261.42	257.77	265.10	340.83	337.81	343.86
England	427.30	425.67	428.94	276.56	275.28	277.83	349.84	348.81	350.87

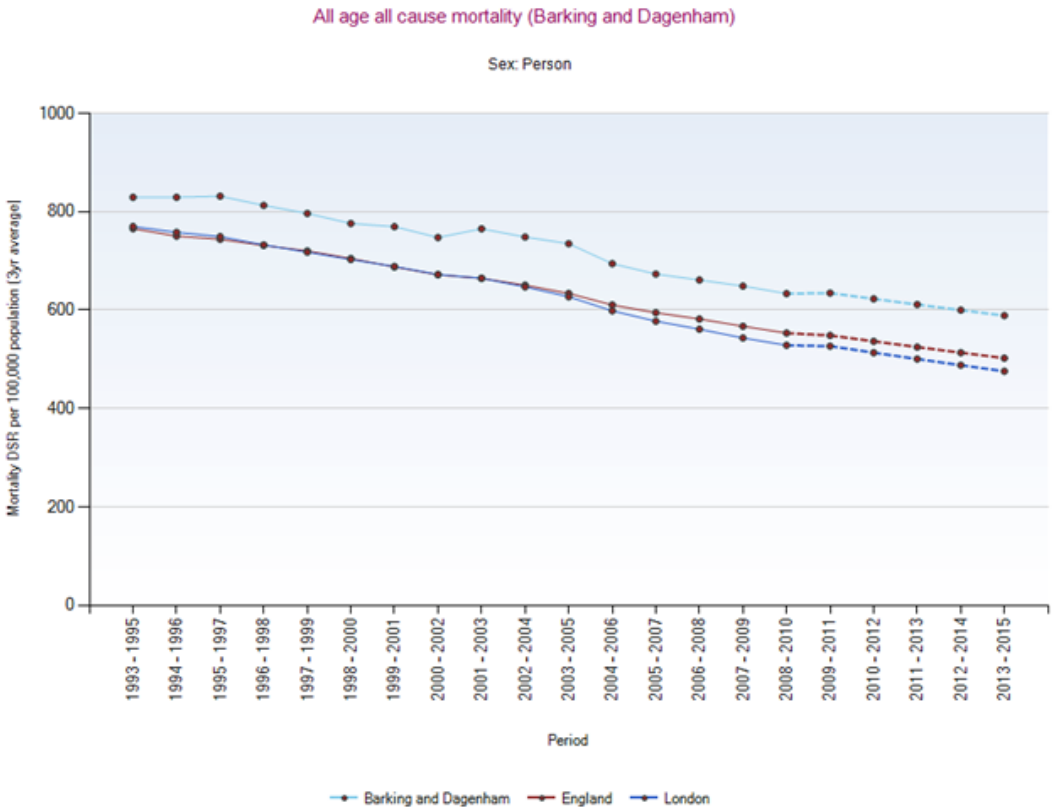
Source: HSCIC

2.7.2 All age all-cause mortality

All age all-cause mortality is a measure of the rate at which people die. The rate is higher in Barking and Dagenham than in London and England as a whole (Figure 28) and although the rate is decreasing, as is the rate for London and England, the gap between the local rate and the rates for London and England are not narrowing (Table 31).

[39] Public Health England (2014) Healthier Lives, Mortality Rankings. (Online) Available from: http://healthierlives.phe.org.uk/topic/mortality/area-details#are/E09000002/par/E92000001/ati/102/pat/ (Accessed 17 November 2014)

Figure 28 - All age all-cause mortality trend, Barking and Dagenham, London and England, 1993-2015



Source: PHE Health Needs assessment Toolkit

Table 31- Directly standardised all age all-cause mortality rate, 2010-2-12 pooled

Area	Directly standardised mortailty rate in men	Lower confidence limit	Upper confidence limit	Directly standardised mortality rate in women	Lower confidence limit	Upper confidence limit	Directly standardised mortailty rate in persons	Lower confidence limit	Upper confidence limit
Barking and Dagenham	1308.85	1245.18	1374.79	937.81	895.55	981.51	1092.16	1056.52	1128.67
London	1111.82	1103.23	1120.47	795.01	789.13	800.92	932.58	927.66	937.51
England	1165.69	1162.79	1168.60	853.41	851.41	855.41	988.25	986.60	989.91

Source: HSCIC

Although all age all-cause mortality is reducing, there are big differences between localities (Figures 29 and 30). The highest and above borough death rates are in South East (1122/100,000). The lower and below borough death rates are in the North (928/100,000) and South West localities.

Figure 29 – Directly standardised all age all-cause mortality rate, Barking and Dagenham 2009-2013

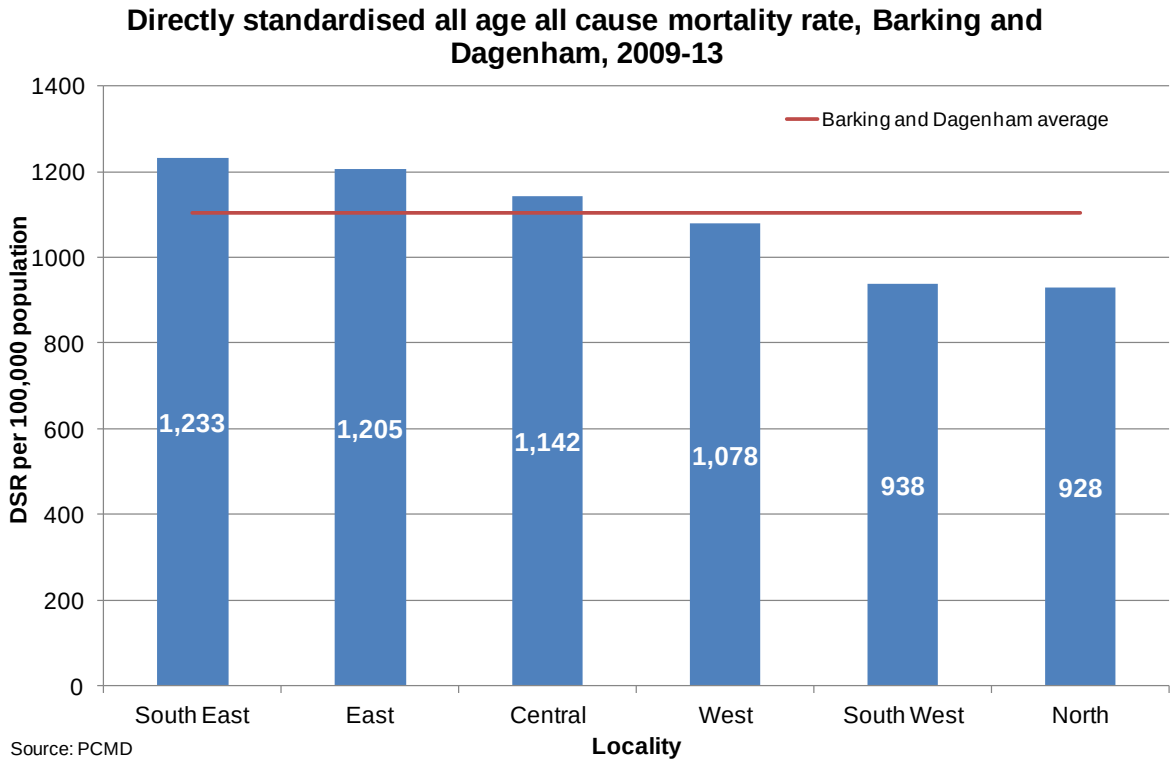
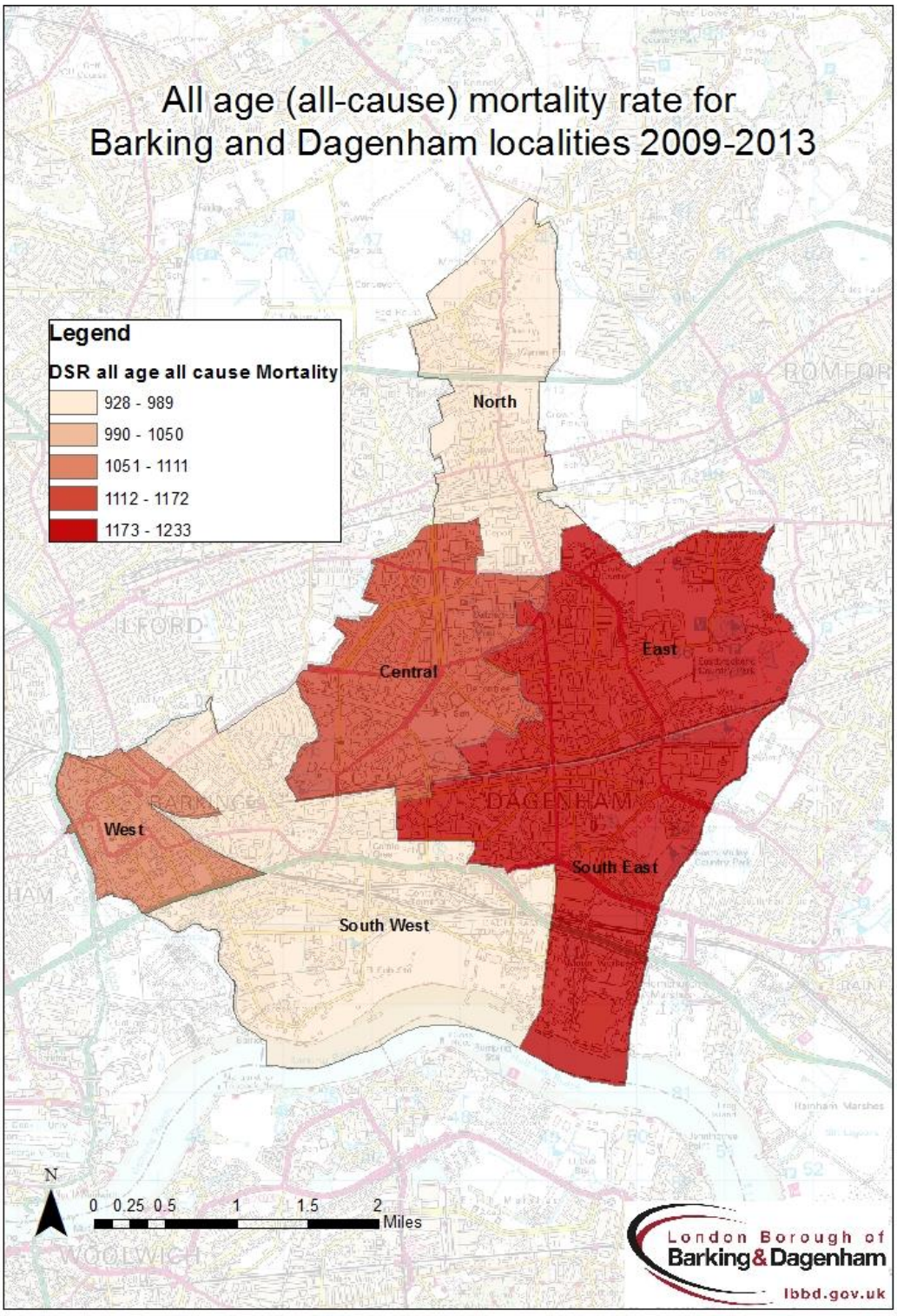


Figure 30 - All age all-cause mortality, Barking and Dagenham localities, 2009-2013



Source: Public Health England

2.7.3 Deaths from cardiovascular disease and cancers

Cardiovascular disease (CVD) and cancers are the leading causes of death in Barking and Dagenham. Although there are small differences in the ranking between localities, North and South West localities are below the Barking and Dagenham average for deaths from both conditions (Figures 31 and 32).

Figure 31 – Directly standardised mortality rate from CVD, Barking and Dagenham 2009-2013

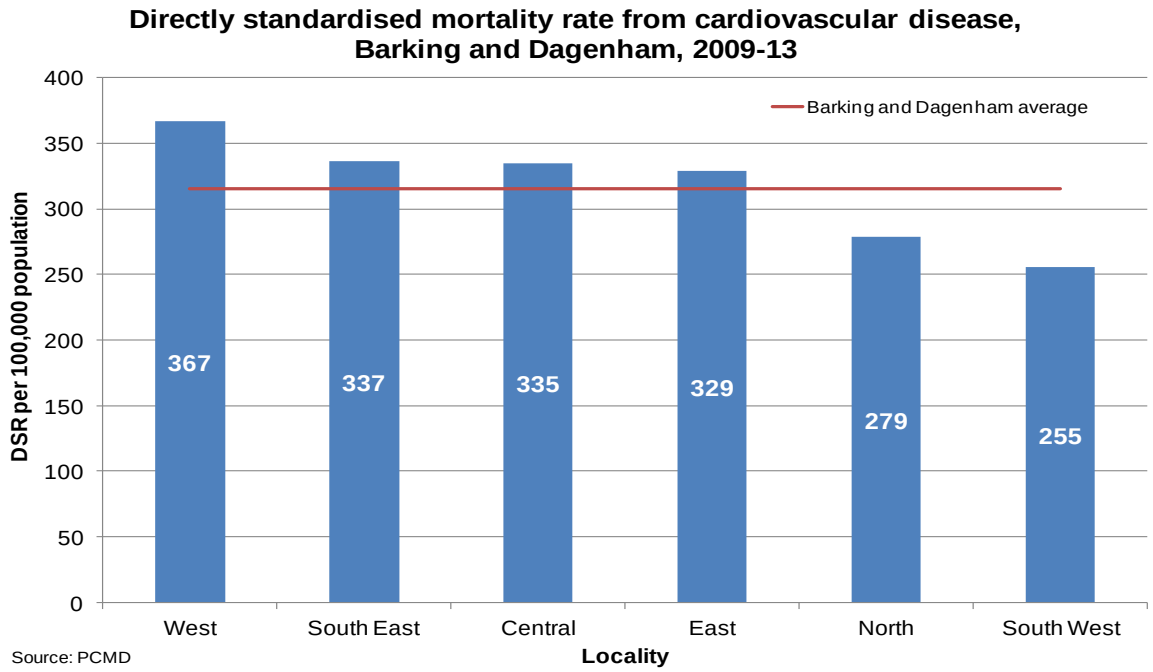
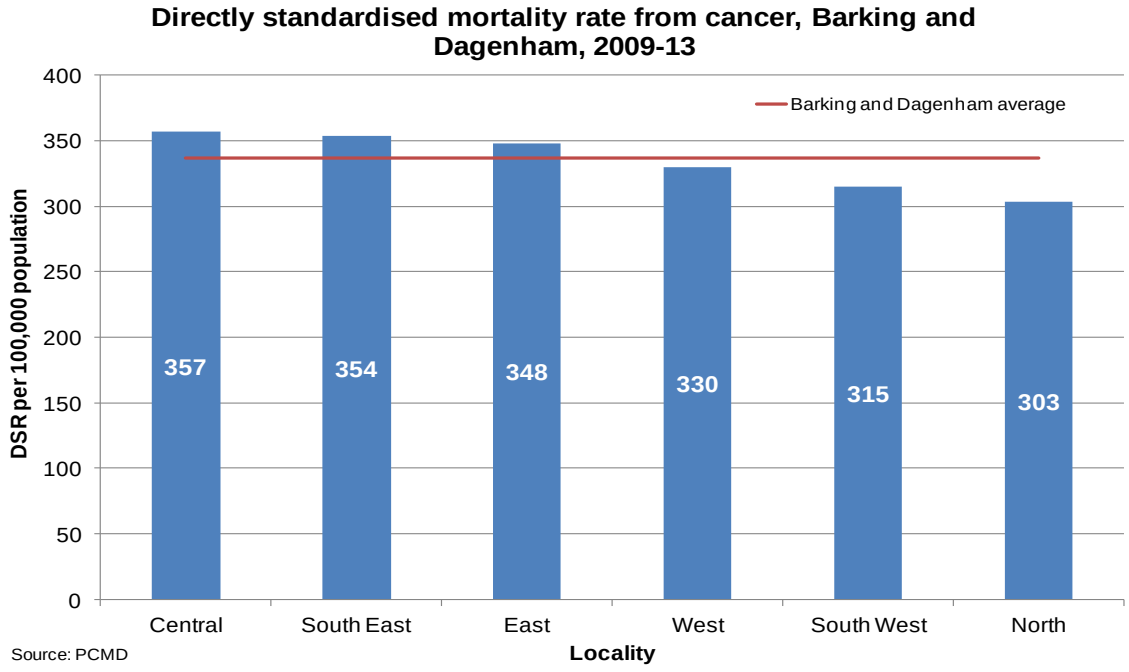


Figure 32 – Directly standardised mortality rate from cancer, Barking and Dagenham 2009-2013



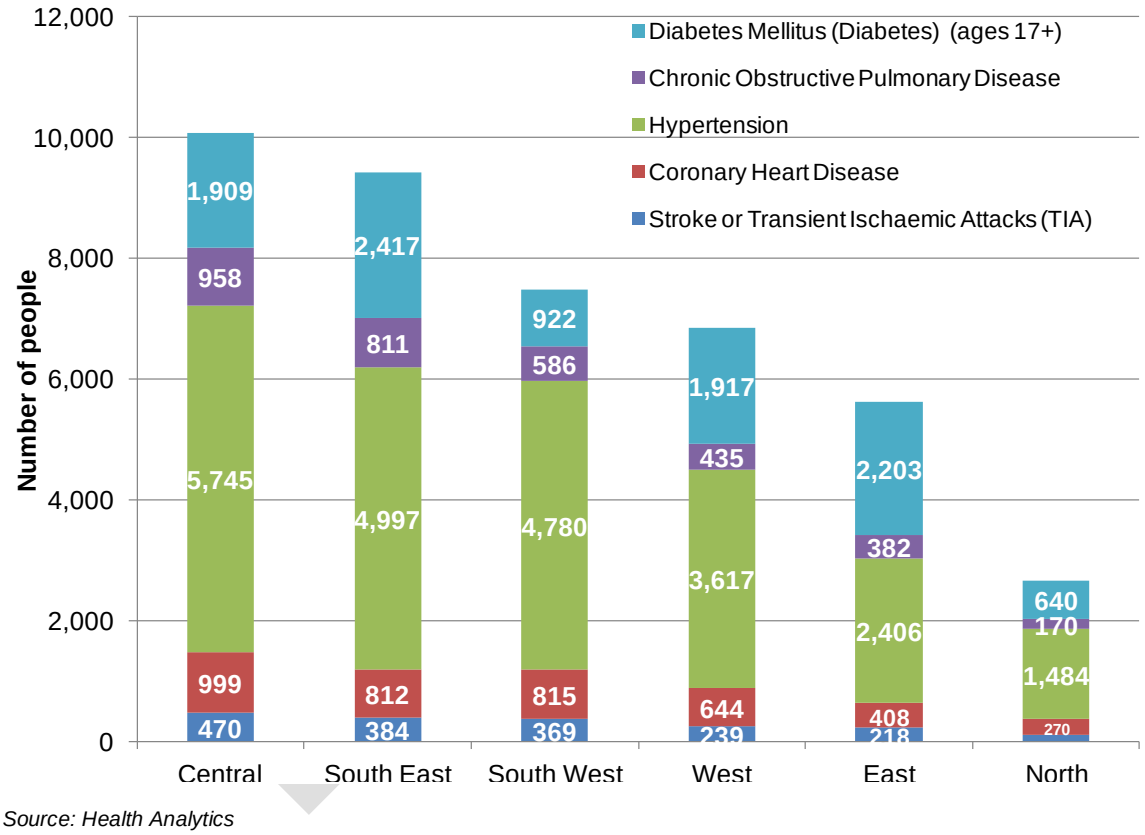
2.7.4 Prevalence of long term conditions

The numbers of people with the common long term diseases in each locality is shown in Table 32.

Table 32 - Prevalence of diseases by locality

Condition	West		North		Central		East		South West		South East	
	N	%	N	%	N	%	N	%	N	%	N	%
Stroke or Transient Ischaemic Attacks (TIA)	239	13.4%	101	5.7%	470	26.4%	218	12.2%	369	20.7%	384	21.6%
Coronary Heart Disease	644	16.3%	270	6.8%	999	25.3%	408	10.3%	815	20.6%	812	20.6%
Hypertension	3,617	15.7%	1,484	6.4%	5,745	24.9%	2,406	10.4%	4,780	20.8%	4,997	21.7%
Chronic Obstructive Pulmonary Disease	435	13.0%	170	5.1%	958	28.7%	382	11.4%	586	17.5%	811	24.3%
Diabetes Mellitus (Diabetes) (ages 17+)	1,917	19.2%	640	6.4%	1,909	19.1%	2,203	22.0%	922	9.2%	2,417	24.2%

Figure 33 - Prevalence of disease by locality



Source: Health Analytics

2.7.4.1 Diabetes

The prevalence of diabetes is increasing with increasing obesity in the population. Type 1 diabetes, which normally develops in childhood, is much less common than Type 2 diabetes.

Table 33 - Number of people recorded as having diabetes, Barking and Dagenham, 2014

Type of diabetes	Number of people	Prevalence*
Type 1	570	0.37%
Type 2	9,784	6.31%
Type Unpecified	1,678	1.08%
Total	12,032	7.76%

*Prevalence in age 17+ population

Source: Health Analytics

Figure 34 – Registered GP patients with a diabetic condition, rate per 1,000 population, by practice Barking and Dagenham as at 19th November 2014

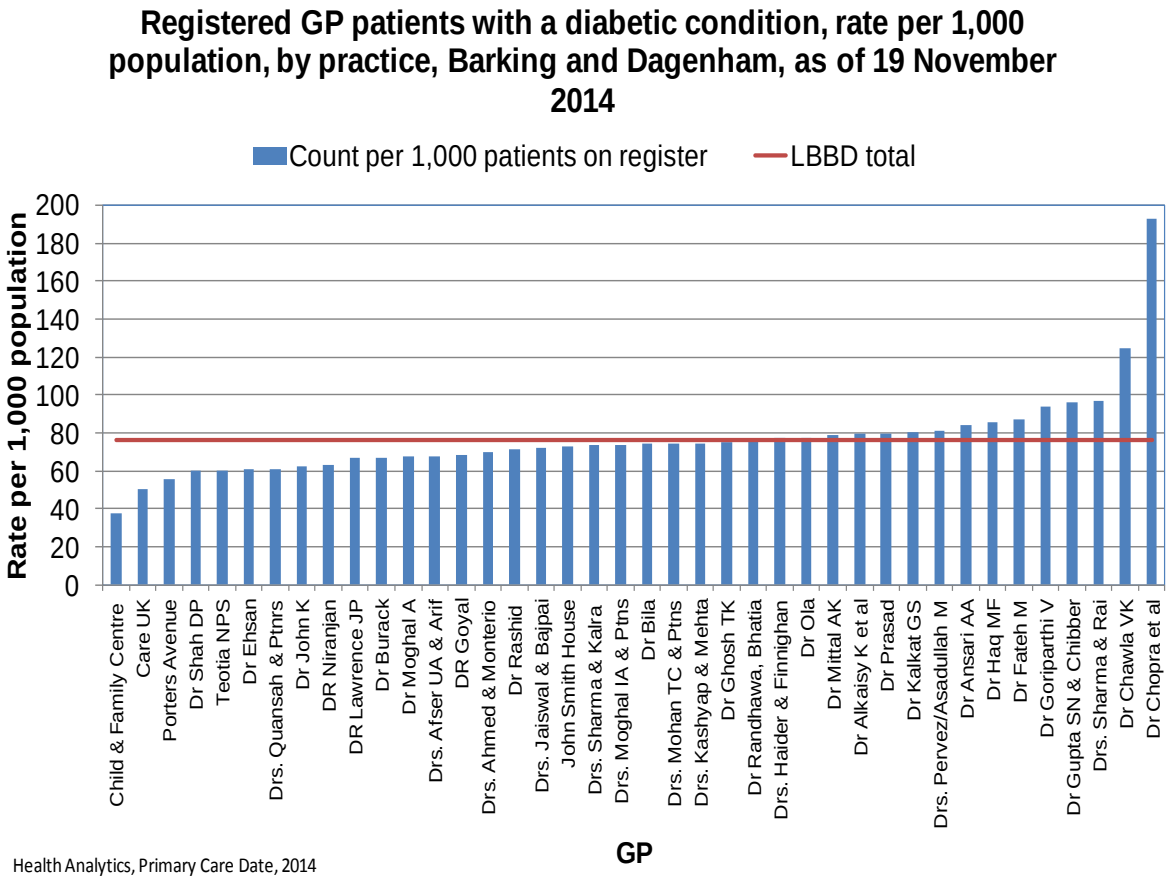
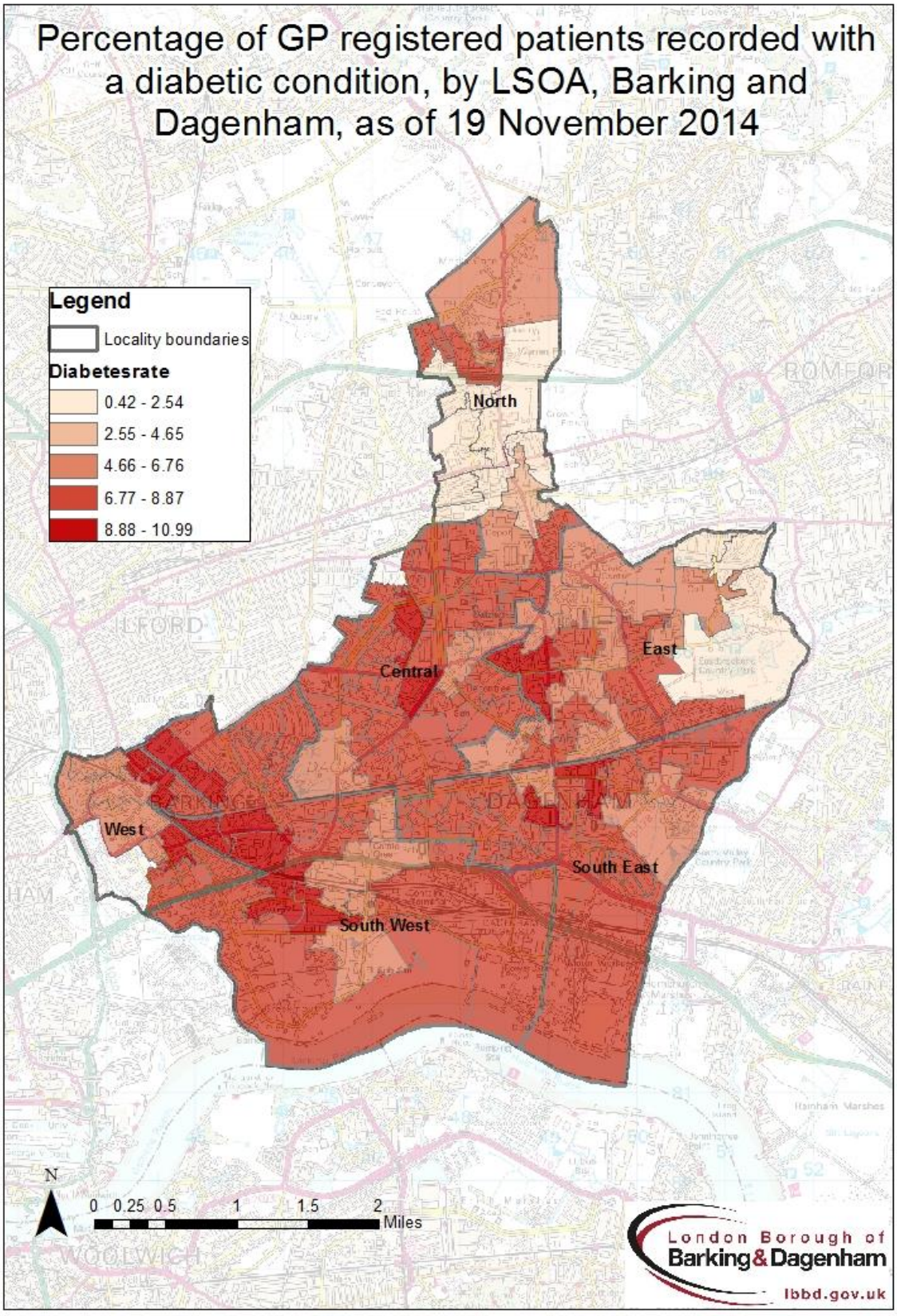


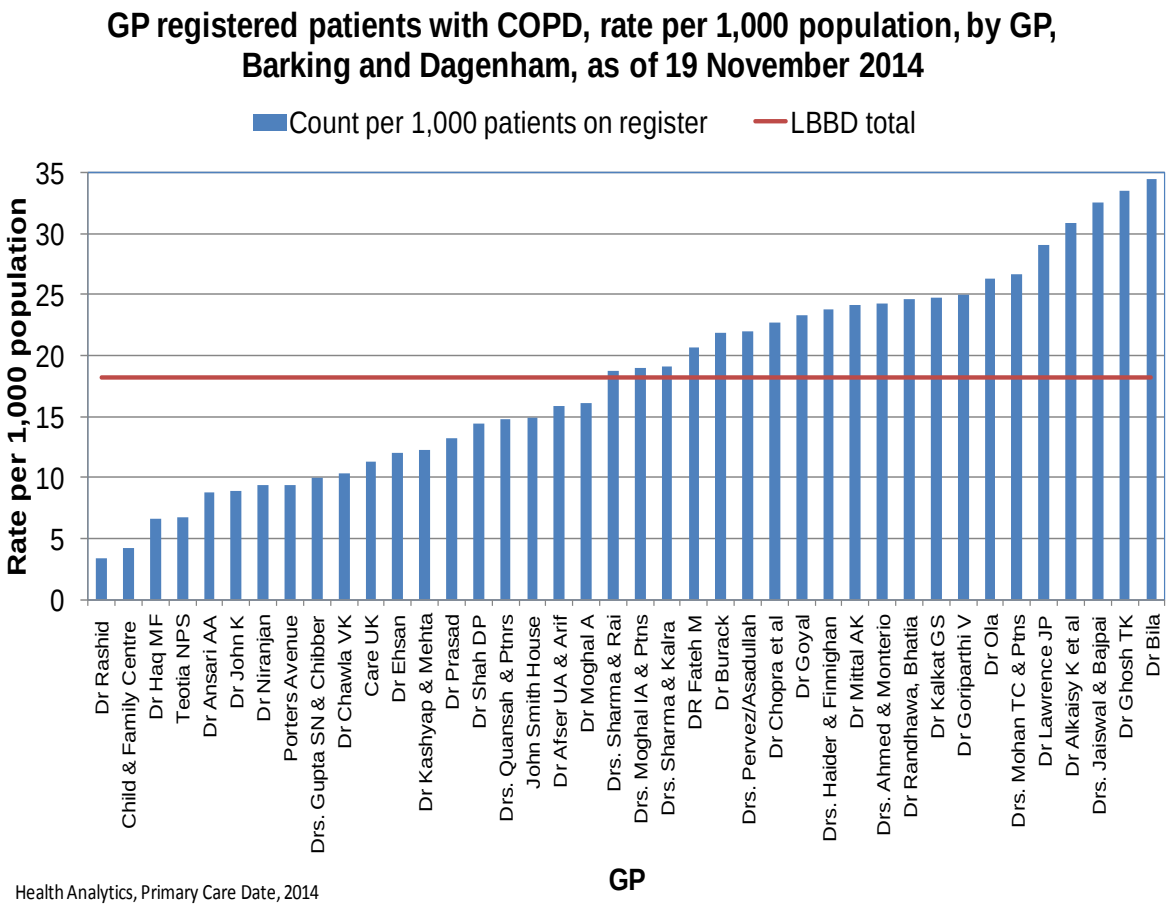
Figure 35 - Percentage of GP registered patients with a diabetic condition



2.7.4.2 Chronic obstructive pulmonary disease

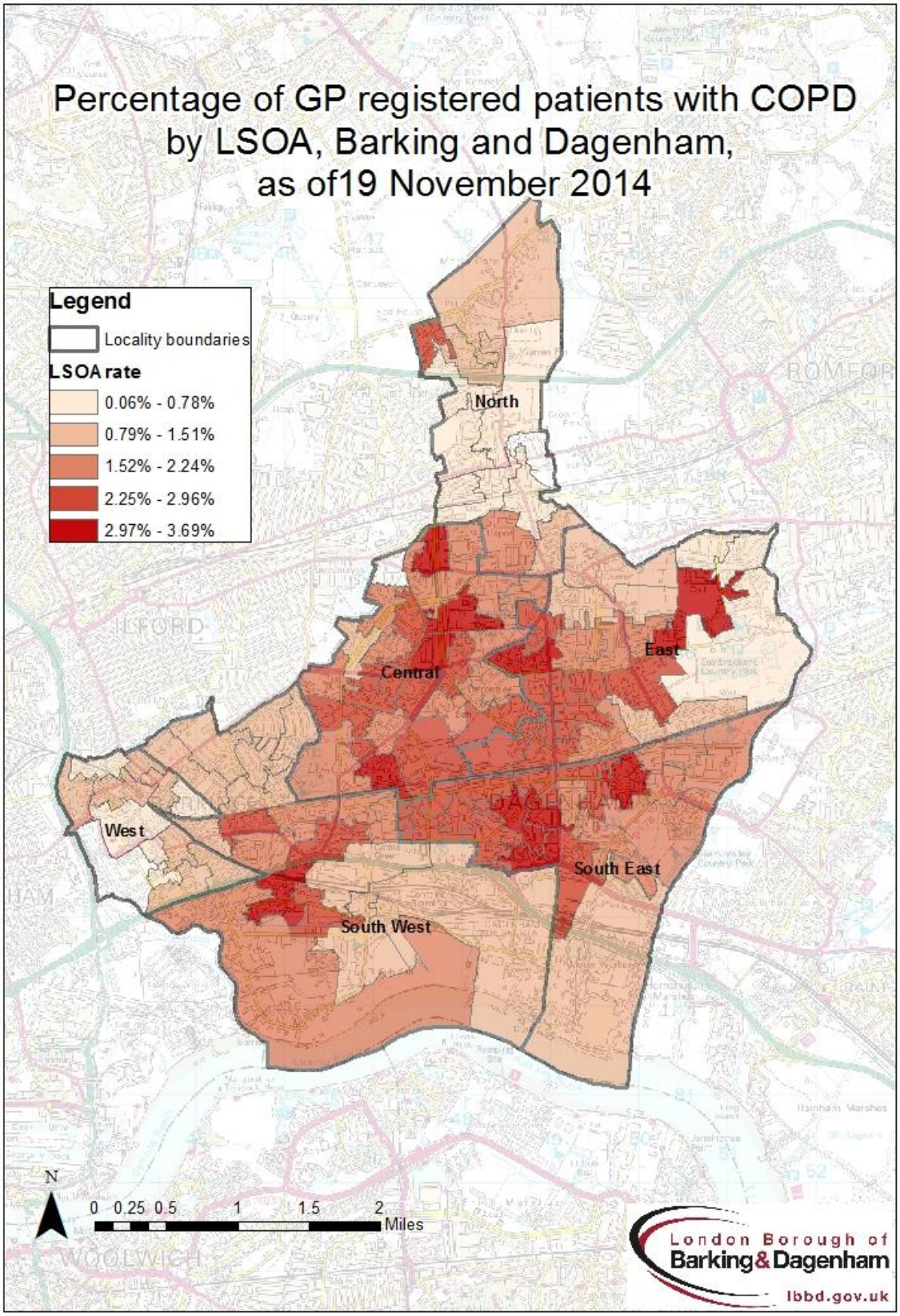
There are 3,688 people diagnosed with chronic obstructive pulmonary disease (COPD) in Barking and Dagenham[40], with a disease prevalence of 1.74%. Figure 36 shows the practice variation across the borough.

Figure 36 – GP registered patients with COPD, rate per 1,000 population by GP, Barking and Dagenham as at 19th November 2014



[40] Health Analytics

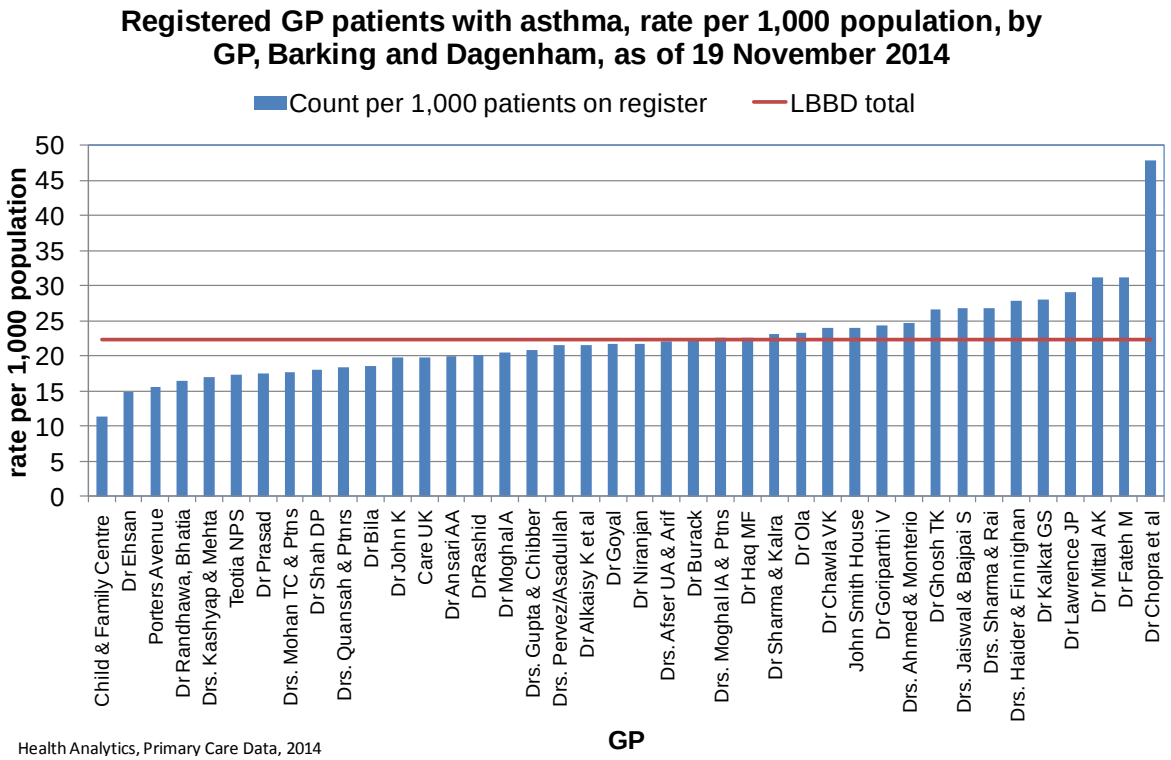
Figure 37 - Percentage of GP registered patients with COPD



2.7.4.3 Asthma

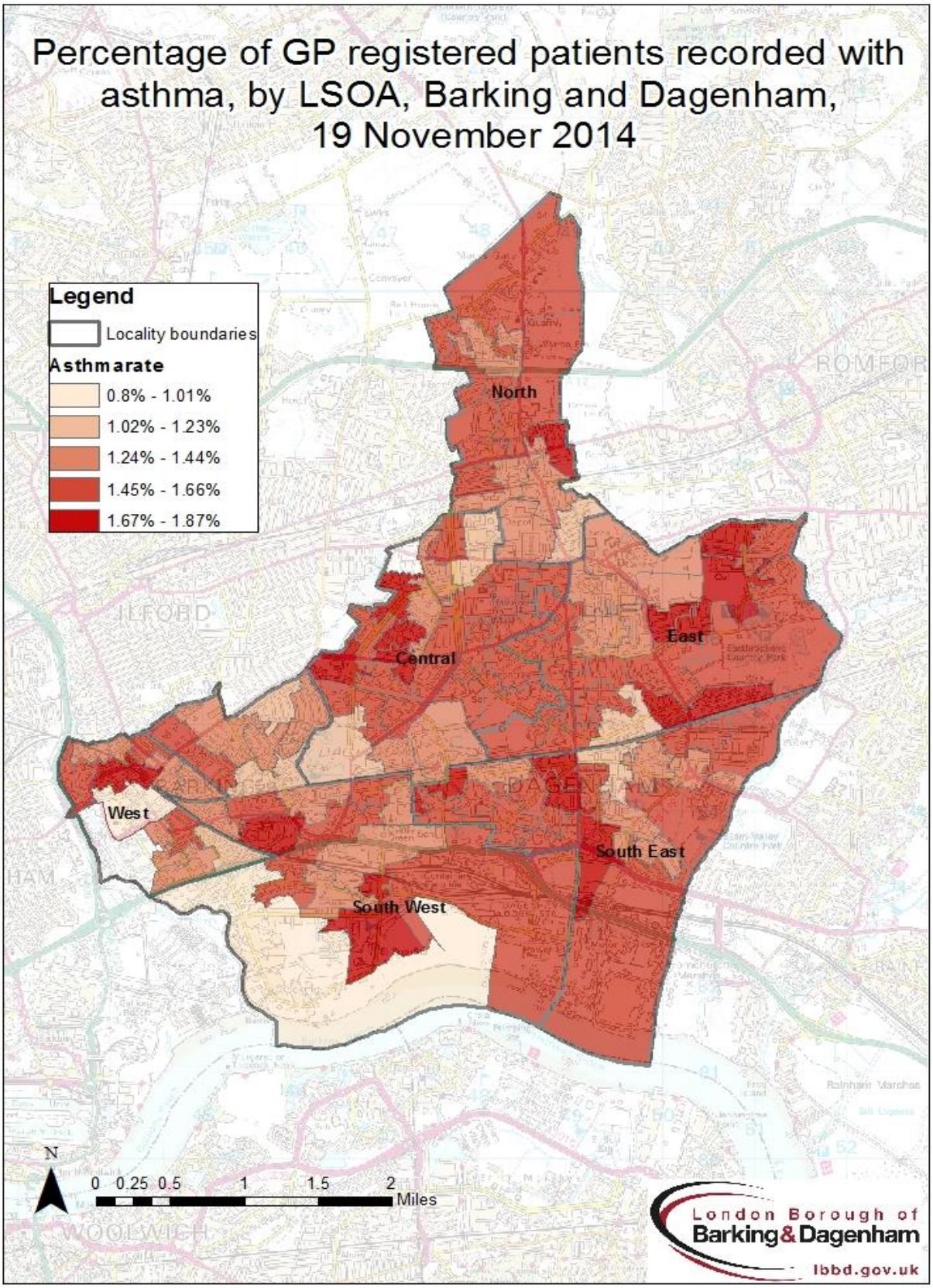
There are 10,720 people in Barking and Dagenham who have a diagnosis of asthma (excluding patients with asthma who have been prescribed no asthma-related drugs in the previous 12 months)[41]. Figure 38 shows the variation at practice levels given a disease prevalence of 5.05% in Barking and Dagenham

Figure 38 - Prevalence of asthma by postcode district



[41] Health Analytics, 28/10/14

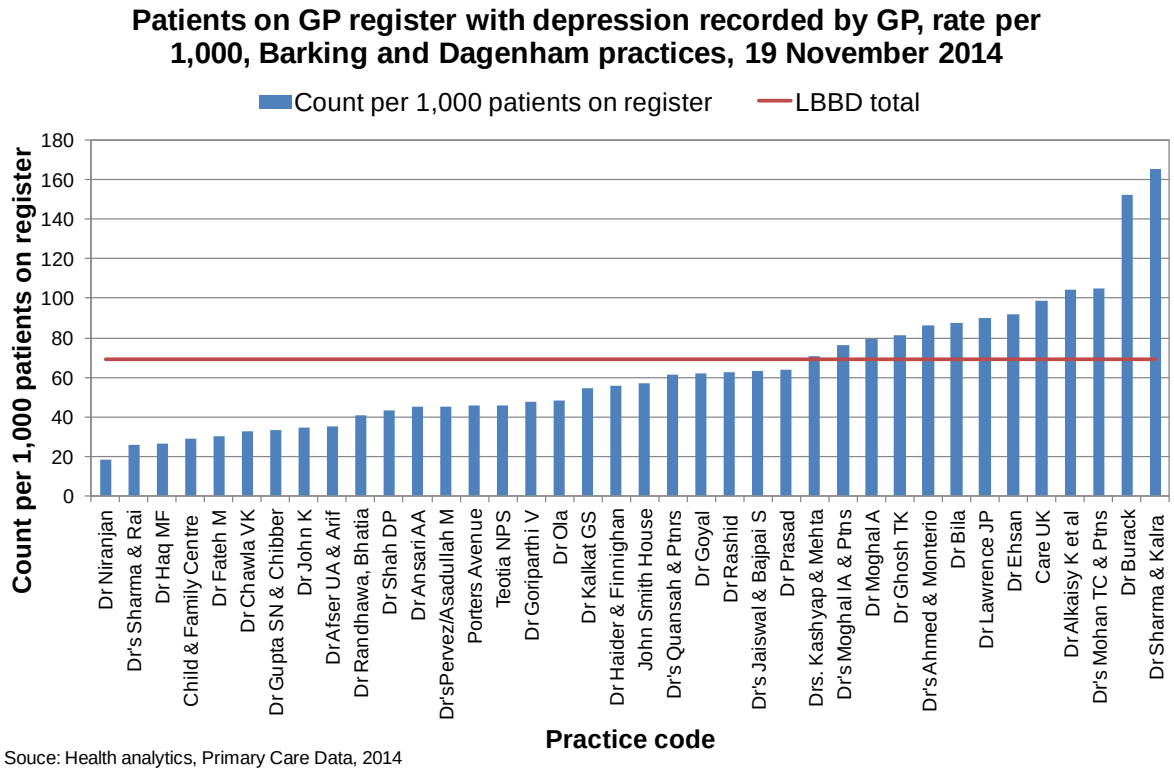
Figure 39 - Percentage of GP registered patients with asthma



2.7.4.4 Depression

There are 10,724 people diagnosed with depression in Barking and Dagenham[42]. This gives a disease prevalence of 6.82% in Barking and Dagenham (Figure 40).

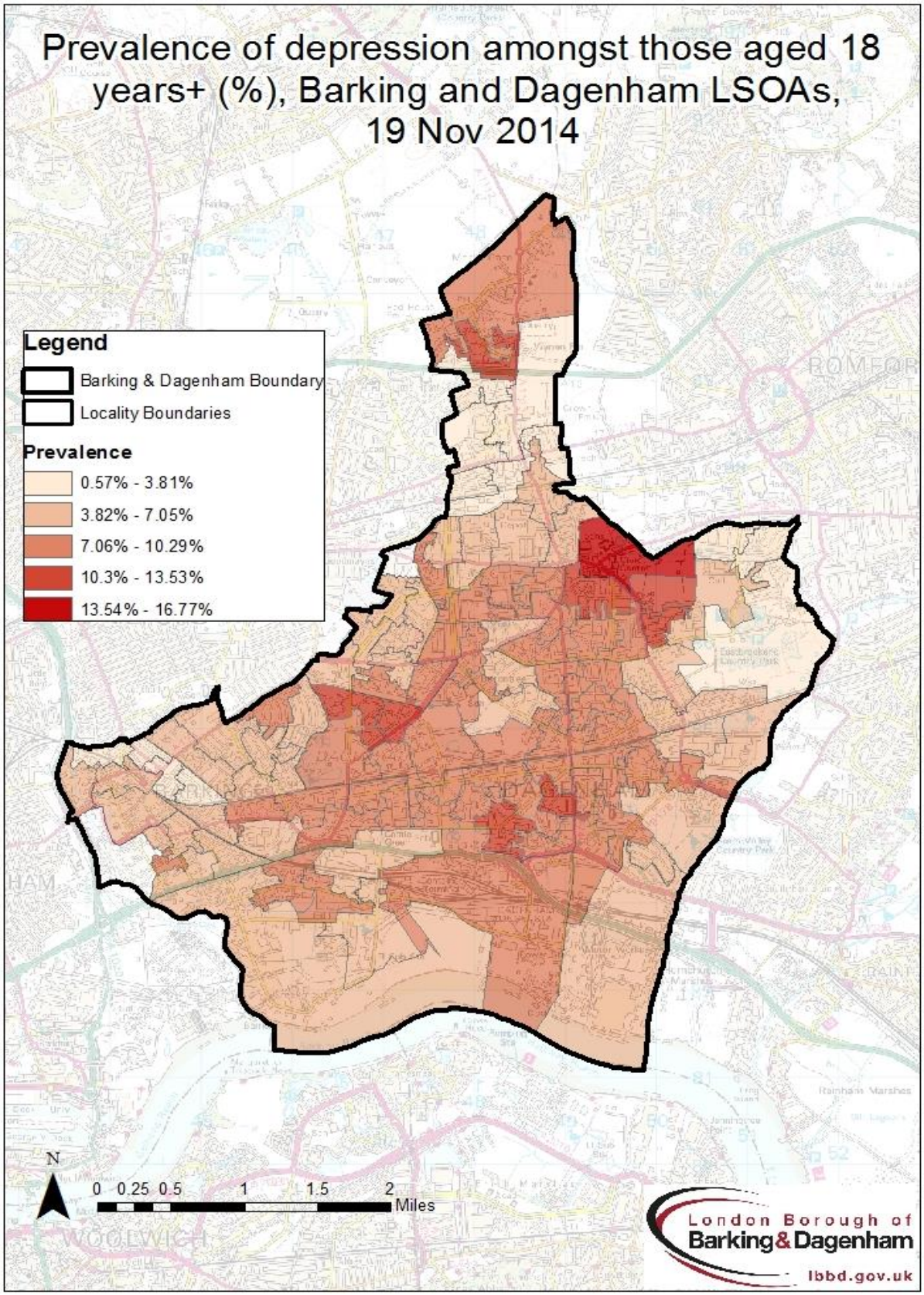
Figure 40 – Patients on GP register with depression recorded by GP, rate per 1,000 Barking and Dagenham practices, 19th November 2014



Souce: Health analytics, Primary Care Data, 2014

[42] Health Analytics

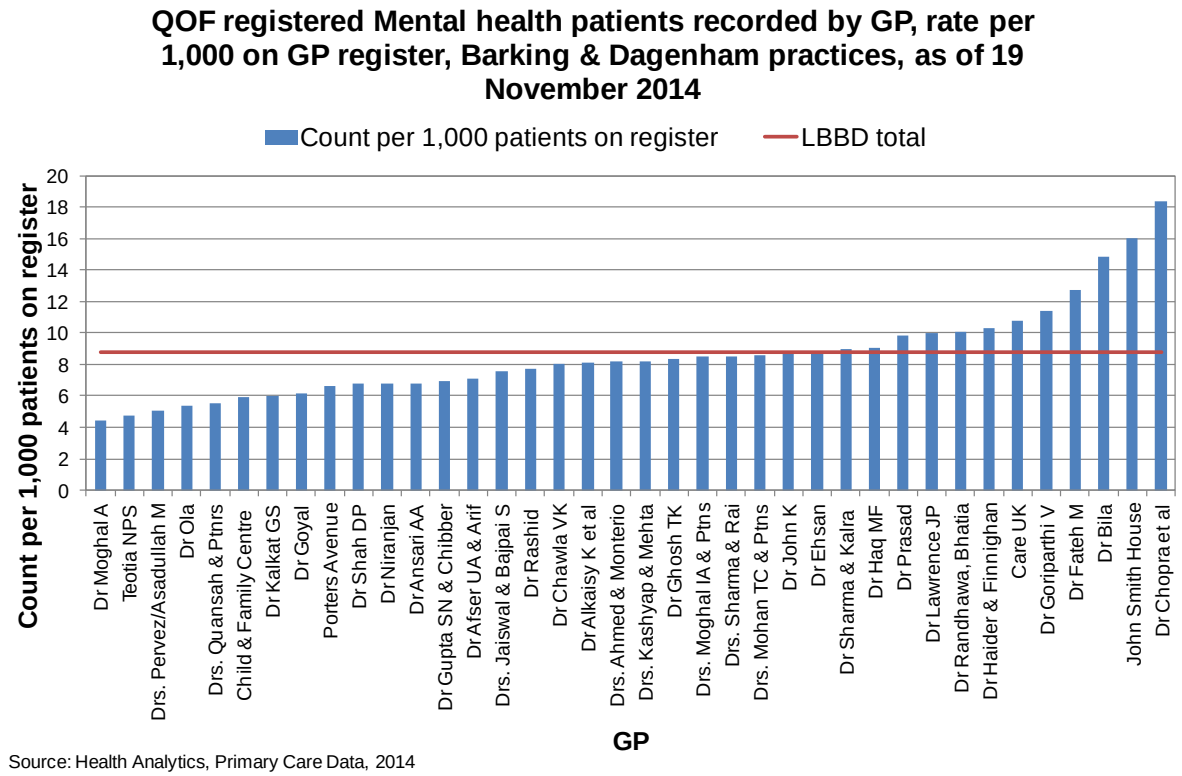
Figure 41 - Prevalence of depression by LSOA



2.7.4.5 Mental health

There were 1,562 people on the 2013/14 QOF register for mental health conditions in Barking and Dagenham (Figure 42). This gives a disease prevalence of 0.76%[43] in Barking and Dagenham.

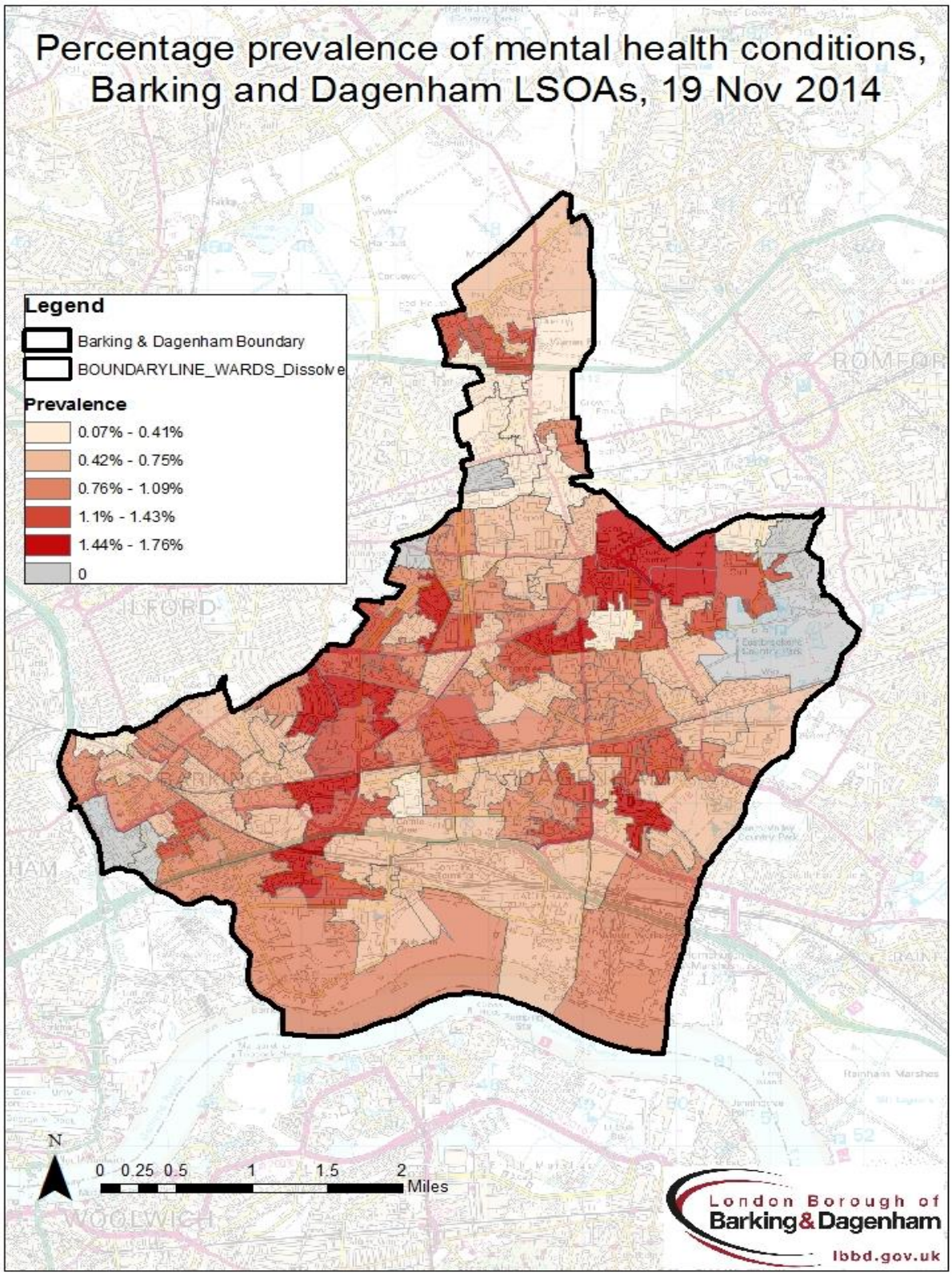
Figure 42 – QOF registered mental health patients, Barking and Dagenham at 19th November 2014



Source: Health Analytics, Primary Care Data, 2014

[43] Health and Social Care Information Centre (2014) Quality and Outcomes Framework (QOF) -2013-14. (Online) Available from: http://www.hscic.gov.uk/searchcatalogue?productid=16273&q=qof&sort=Relevance&size=10&page=1#top (Accessed 29 October 2014)

Figure 43 - Prevalence of QOF mental health register conditions

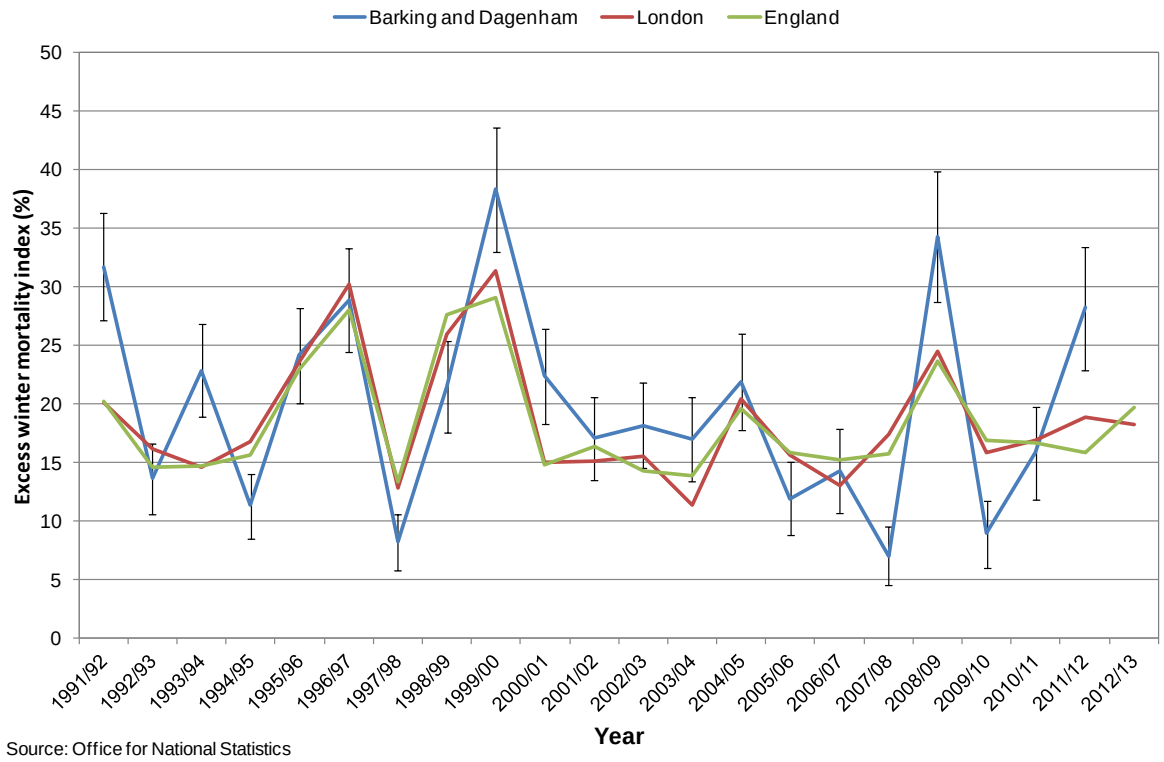


2.7.5 Excess winter deaths

People are more likely to die in conditions of extreme temperature. In England, there are usually more deaths in winter than in summer. Cold weather and being cold through living in a home with persistently low temperatures impacts on physical health and causes death from circulatory and lung diseases that would not have occurred in warmer temperatures and warmer homes. There are also excess deaths that result from extreme weather events including from freezing conditions (snow and ice causing falls, fractures and road traffic accidents.

Figure 44 shows the trend in excess winter deaths over time. The level fluctuates between years in Barking and Dagenham, London and England. This is as would be expected because excess winter deaths are affected by weather and particularly associated with periods of very low temperature. Generally the trend over time seen in Barking and Dagenham closely follows the trend in London and England. Barking and Dagenham does however show a greater degree of variation and in many years the index is significantly higher or lower than that for London and England.

Figure 44 - Excess winter mortality index, %, annual trend for Barking and Dagenham, London and England, 1991/92 – 2012/13



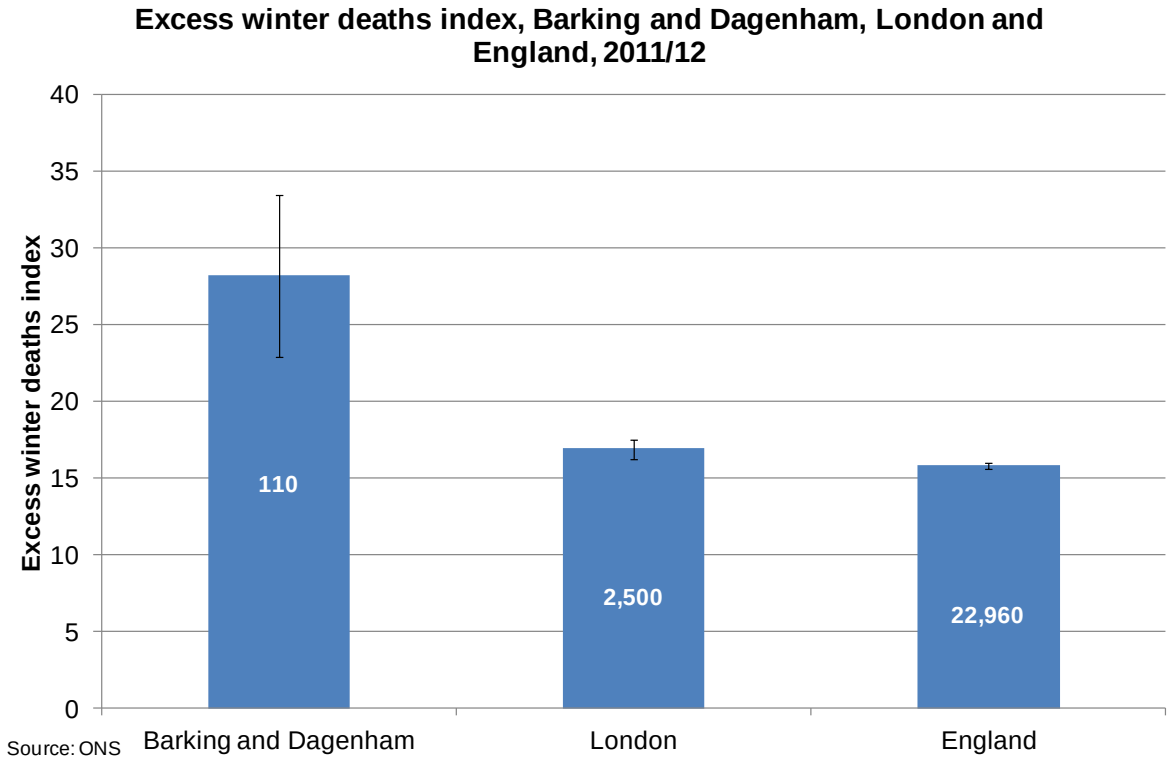
Source: Office for National Statistics

Table 34 and Figure 45 show that in 2011/12 the excess winter deaths (EWD) index was significantly higher than that for both London and England; with the index being almost twice as high for Barking and Dagenham (28.2%) than for England (15.8%).

Table 34 - Excess winter deaths, index (%) and number, 2011/12

	Excess winter deaths		95% CI	
	N	Index	LCL	UCL
Barking and Dagenham	110	28.2	22.9	33.4
London	2,500	16.9	16.2	17.5
England	22,960	15.8	15.6	16.0

Figure 45 - Excess winter deaths index, 2011/12



Section 3: NHS pharmaceutical services provision; currently commissioned

3.1 Community pharmacies

There are 38 community pharmacies in Barking and Dagenham HWB area (as of 30th January 2015) for a population of 194,352. This equates to an average of 19.6 pharmacies per 100,000 population. Latest data shows the England average is 21.7 community pharmacies per 100,000 population and London average is 22.3 community pharmacies per 100,000 population. London has a transient population with generally good transport links. Populations may therefore find community pharmacies in neighbouring HWB areas more accessible and / or more convenient. There is a varying rate of community pharmacies per 100,000 population in neighbouring HWB areas to Barking and Dagenham: Havering (18.9), Redbridge (19.9), Newham (21.9), Greenwich (23.9) and Bexley (19.3). There were 480 responses received to the pharmacy user questionnaire undertaken in the autumn of 2014. Over 82% of respondents use the same pharmacy (have a regular pharmacy they go to). When asked what factors they considered when choosing their pharmacy, over 73% indicated 'Close to home' and over 42% 'Close to GP surgery' as important reasons. 61% respondents walk to their community pharmacy, whilst 32% use a car or taxi. The full results of the pharmacy user survey is detailed in Section 5.

Table 35 provides a breakdown, by locality, of the average number of community pharmacies per 100,000 population. Populations in all localities have access to extensive public transport links and road networks and for some populations the nearest community pharmacy provision from their home may be in a neighbouring locality or HWB area. Maps D to F show the travel times to nearest community pharmacy for residents of Barking and Dagenham HWB area.

Table 35 - Breakdown of average community pharmacies per 100,000 population[12]

Area	Number of community pharmacies (as of 30/1/15)	Total population (mid 2013 estimates)	Average number of community pharmacies per 100,000 population (as of 30/1/15)
East locality	4	32,816	15.2
West locality	8	26,055	30.7
North locality	5	21,587	23.2
Central locality	9	44,177	20.4
South East locality	6	33,864	17.7
South West locality	6	35,853	16.7
Barking and Dagenham Health and Wellbeing Board area (2013/14 data)	38	194,352	19.6
London region (2013/14 data)	1,851*	8,308,000	22.3*
England (2013/14 data)	11,647*	-	21.7*

**Data includes distance-selling (internet) pharmacies, which do not provide face-to-face services*

Section 1.3 lists the essential services of the pharmacy contract. It is assumed that provision of all of these services is available from all contractors. Further analysis of the pharmaceutical service provision and health needs for each locality is explored in Section 6.

3.1.1 Choice of community pharmacies

Table 36 shows the breakdown of community pharmacy ownership in Barking and Dagenham. The data shows that pharmacy ownership is at levels between those seen regionally and higher than those seen nationally, with no one provider having a monopoly in any locality. People in Barking and Dagenham therefore have a good choice of pharmacy providers.

Table 36 - Community pharmacy ownership, 2013/14[12]

Area	Multiples (%)	Independent (%)
England	61.2	38.8
London	38.9	61.1
Barking and Dagenham (2014 data)	50	50

3.1.2 Intensity of current community pharmacy providers

For most community pharmacy providers, dispensing provides the majority of their activity. Table 37 shows the average monthly dispensing activity from community pharmacies. The data shows that average activity in Barking and Dagenham is higher than the London region, but lower than the England average.

Table 37 - Average dispensed items per community pharmacy, 2013/14[12]

Area	Average number of monthly dispensed item per community pharmacy
England	6,784
London region	5,393
Barking and Dagenham (2012/13 data)	6,328

3.1.3 Weekend and evening provision

It is estimated that collectively, community pharmacies in England are open approximately 150,000 hours per week more than 10 years ago[44]. This has been mainly driven through the opening of 100 hour pharmacies. There are over 700 community pharmacies in England open for 100 hours or more per week.

Table 38 shows that Barking and Dagenham has a higher percentage of its pharmacies open for 100 hours or more compared with regionally and nationally. All 100 hour pharmacies are open late and at the weekends.

Table 38 - Numbers of 100 hour pharmacies (and percentage of total)

Area	Number hour pharmacies	Percentage of 100 hour pharmacies
England (2012/13 data)[12]	773	6.7%
London region	71	3.8%
Barking and Dagenham	3	7.7%
East locality	0	0.0%
West locality	2	25.0%
North locality	1	20.0%
Central locality	0	0.0%
South East locality	0	0.0%
South West locality	0	0.0%

[44] 'Who do you think we are? Community Pharmacy: dispensers of health', Pharmacy Voice: http://www.dispensinghealth.org/wp-content/uploads/2014/01/DH-Launch-FINA1.pdf

3.2 Dispensing appliance contractor

There is one dispensing appliance contractor (DAC) in Barking and Dagenham HWB area:

- Fittleworth Medical, 7 The Midas Business Centre, Wantz Road, Dagenham RM108PS

DAC services are available to the population from elsewhere in the UK. Appliances may also be dispensed from community pharmacies. 36 responses (95%) were received from the community pharmacy contractor questionnaire. 97% of respondents reported that they provide stoma and / or incontinence appliances.

As part of the essential services of appliance contractors, a free delivery service is available to all patients. It is therefore likely that some patients will obtain appliances delivered from DACs outside the HWB area. There were 112 DACs in England in 2013/14[12].

3.3 Distance-selling pharmacies

A distance-selling pharmacy provides services as per the Pharmaceutical Regulations, 2013[9]. It may not provide essential services face-to-face at the pharmacy premises, and therefore provision is by mail order and / or wholly internet. As part of the terms of service for distance-selling pharmacies, provision of all services offered must be offered throughout England. It is therefore likely that some patients within Barking and Dagenham HWB area will be receiving pharmaceutical services from a distance-selling pharmacy outside Barking and Dagenham HWB area. There are no distance-selling pharmacies in Barking and Dagenham HWB area. Figures in 2013/14[12] show that in England there were 211 distance-selling pharmacies, accounting for 1.8% of the total number of pharmacies (London: 14 (0.8%)).

3.4 Access to community pharmacies

The majority of community pharmacy providers in Barking and Dagenham HWB area are sited in areas co-located with shops, GP practices or other routine destinations; many also provide extended opening hours. As such they attract a high level of convenience.

The white paper, 'Pharmacy in England: Building on strengths – delivering the future[45] noted that 99% of the population – even those living in the most deprived areas – can get to a community pharmacy within 20 minutes by car and 96% by walking or using public transport. Maps D to F provide a travel analysis of the population of Barking and Dagenham to their nearest community pharmacy.

A list of community pharmacies in Barking and Dagenham HWB area and their opening hours can be found in Appendix A.

[45] 'Pharmacy in England: Building on strengths – delivering the future', Department of Health (2008) - http://www.official-documents.gov.uk/document/cm73/7341/7341.pdf

3.4.1 Routine daytime access to community pharmacies

Percentages of the Barking and Dagenham HWB area and average daytime drive time, walking and public transport travel times to their nearest community pharmacy can be found in Table 39.

Average drive time to community pharmacies in Barking and Dagenham is shown in Map D. Average public transport time to community pharmacies is shown in Map E. Average walking time to community pharmacies is shown in Map F. A recently published article[46] suggests that over 89% of the population of England has a maximum 20 minute walk to a community pharmacy, however this figure falls to as low as 14% in rural areas. The same study found that access is greater in areas of high deprivation. Higher levels of deprivation are linked with increased premature mortality rates and high burden of disease.

Map D illustrates that, 98.2% of residents within the HWB area have an average drive time not exceeding five minutes to their nearest community pharmacy. Map E illustrates that, 100% of the residents within the HWB area have an average public transport time not exceeding 15 minutes to their nearest pharmacy. Map F illustrates that 95% of the residents of HWB area have an average walking time not exceeding 20 minutes to their nearest pharmacy. There are also many localities in Barking and Dagenham with populations amongst the most deprived in England.

Table 39 - Percentage of population of Barking and Dagenham HWB and average daytime travel times to nearest community pharmacy

	Average peak drive	Average public transport	Average walking
0-5 mins	98.2%	29.5%	20.1%
0-10 mins	100.0%	88.2%	64.6%
0-15 mins	100.0%	100.0%	89.3%
0-20 mins	100.0%	100.0%	95.0%
0-25 mins	100.0%	100.0%	97.3%
0-30 mins	100.0%	100.0%	100.0%

[46] 'The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England', BMJ Open 2014, Vol. 4, Issue 8 - http://bmjopen.bmj.com/content/4/8/e005764.full.pdf%20html

3.4.2 Routine weekday evening access to community pharmacies

The number, location and opening hours of community pharmacy providers open beyond 6pm, Monday to Friday (excluding bank holidays) varies within each locality; they are listed in the table below. 'Average' access is difficult given the variety of opening hours and locations. Access is therefore considered at locality level and, as can be found from Table 40, the population of Barking and Dagenham have reasonable access to community pharmacies in the evening as the majority of providers in Barking and Dagenham HWB area are open after 6pm. A further analysis of provision in each locality is detailed in Section 6.

Table 40 - Community pharmacy providers open Mon-Fri (excl. bank holidays (BHs)) beyond 6pm

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl. BHs)
East locality	Britannia Pharmacy 5 Althorne Way, Dagenham, Essex. RM10 7AY	09:00-19:00
	Oxlow Chemist 217 Oxlow Lane, Dagenham, Essex. RM10 7YA	09:00-19:00
	Talati Chemists 282 The Heathway, Dagenham, Essex. RM10 8QS	09:00-18:30
	Waller Pharmacy 279 Heathway, Dagenham, Essex. RM9 5AQ	09:00-18:30
West locality	Boots The Chemists Ltd 68 East Street, Barking, Essex. IG11 8EQ	09:00-19:00
	Daynight Pharmacy 17 Station Parade, Barking, Essex. IG11 8ED	08:00-23:59
	Lords Chemist 35 Station Parade, Barking, Essex. IG11 8EB	09:00-19:30
	Mayors Chemist 214 Ripple Road, Barking, Essex. IG11 7PR	09:00-19:30 (Thurs 09:00-16:00)
	S S Kalsi 125 St.Marys Parade, Gascoigne Road, Barking, Essex. IG11 7TF	09:00-18:30 (Thurs 09:00-17:30)

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl. BHs)
	Tesco Instore Pharmacy Highbridge Road, Barking, Essex. IG11 7BS	Mon 08:00-22:00, Tue-Fri 06:00-22:00
	Thomas Chemist 19 Ripple Road, Barking, Essex. IG11 7NN	09:00-18:30
North locality	Lloyds Pharmacy 167- 169 High Road, Chadwell Heath, Romford, Essex. RM6 6NL	09:00-18:30
	Mastaa-Care Pharmacy 26 Whalebone Lane South, Dagenham, Essex. RM8 1BJ	09:00-19:00 (Thurs 09:00-17:30)
	Sainsburys Pharmacy 97-131 High Road, Chadwell Heath, Essex. RM6 6PA	08:00-20:00
	Super.Care Pharmacy+ 198-200 High Road, Chadwell Heath, Romford, Essex. RM6 6LU	08:00-23:59
Central locality	Alvin Rose Chemist 606 Longbridge Road, Dagenham, Essex. RM8 2AJ	09:00- 19:00
	David Lewis Chemist 16 Porters Avenue, Dagenham, Essex. RM8 2AQ	09:00-20:00
	Hannigan Pharmacy 240 Bennetts Castle Lane, Beacontree, Dagenham. RM8 3UU	09:00-18:30
	Lloyds Pharmacy 281 Wood Lane, Dagenham, Essex. RM8 3NL	09:00-19:00
	Nuchem Pharmacy 778 Green Lane Dagenham Essex, RM8 1YT	09:00-18:30
	Sandbern Pharmacy 703-705 Green Lane, Dagenham, Essex. RM8 1UU	Mon- Fri 09:00-19:30
	Valence Pharmacy 453 Becontree Avenue, Dagenham, Essex. RM8 3UL	09:00-18:30

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl. BHs)
South East locality	Day Lewis Pharmacy 149 Broad Street, Dagenham, Essex. RM10 9HX	09:00-19:00
	Hedgemans Pharmacy 428 Hedgemans Road, Dagenham, Essex. RM9 6BU	09:00-19:00
	Kry-Ba Pharmacy 21 Goresbrook Road, Dagenham, Essex. RM9 6XA	09:00-18:30
South West locality	Asda Pharmacy Merrielands Crescent, Dagenham, Essex. RM9 6SJ	08:00-22:00
	Boots Pharmacy 454 Lodge Avenue, Dagenham, Essex. RM9 4QS	09:00-18:30
	Britannia Pharmacy 19 Faircross Parade, Upney Lane, Barking, Essex. IG11 8UW	09:00-19:00 (Thurs: 09:00-18:00)
	Britannia Pharmacy Thames Valley Health Centre, Bastable Avenue, Barking, Essex. IG11 0LG	09:00-19:00
	Newlands Pharmacy 359 Ripple Road, Barking, Essex. IG11 9PN	09:00-19:00

3.4.3 Routine Saturday daytime access to community pharmacies

The number, location and opening hours of community pharmacy providers open on a Saturday vary within each locality. Over 97% of pharmacies in Barking and Dagenham HWB area are open on Saturdays, the majority of which are open into the late afternoon. 'Average' access is difficult given the variety of opening hours and locations. Access is therefore considered at locality level. Table 41 shows that almost all of the pharmacies in Barking and Dagenham HWB area are open on Saturdays. A further analysis of provision is detailed in Section 6.

Table 41 - Community pharmacy providers open on Saturdays

Locality	Pharmacy name and address	Saturday opening hours
East locality	Britannia Pharmacy 5 Althorne Way, Dagenham, Essex. RM10 7AY	09:00-13:00
	Oxlow Chemist 217 Oxlow Lane, Dagenham, Essex. RM10 7YA	09:00-13:00
	Talati Chemists 282 The Heathway, Dagenham, Essex. RM10 8QS	09:00-14:00
	Waller Pharmacy 279 Heathway, Dagenham, Essex. RM9 5AQ	09:00-17:30
West locality	Boots The Chemists Ltd 68 East Street, Barking, Essex. IG11 8EQ	09:00-19:00
	Daynight Pharmacy 17 Station Parade, Barking, Essex. IG11 8ED	10:00-23:59
	Lords Chemist 35 Station Parade, Barking, Essex. IG11 8EB	09:00-17:00
	Mayors Chemist 214 Ripple Road, Barking, Essex. IG11 7PR	09:00-16:00
	S S Kalsi 125 St.Marys Parade, Gascoigne Road, Barking, Essex. IG11 7TF	09:00-13:00
	Superdrug Chemist 12-13 Station Parade, Barking, Essex. IG11 8DN	08:30-18:00
	Tesco Instore Pharmacy Highbridge Road, Barking, Essex. IG11 7BS	06:00-22:00
	Thomas Chemist 19 Ripple Road, Barking, Essex. IG11 7NN	09:00-17:30
North locality	Lloyds Pharmacy 167- 169 High Road, Chadwell Heath, Romford, Essex. RM6 6NL	09:00-13:00
	Mastaa-Care Pharmacy 26 Whalebone Lane South, Dagenham, Essex. RM8 1BJ	09:00-14:00

Locality	Pharmacy name and address	Saturday opening hours
	Sainsburys Pharmacy 97-131 High Road, Chadwell Heath, Essex. RM6 6PA	08:00-20:00
	Super.Care Pharmacy+ 198-200 High Road, Chadwell Heath, Romford, Essex. RM6 6LU	08:00-23:59
	The Co-Operative Pharmacy 107 Rose Lane, Chadwell Heath, Romford, Essex. RM6 5NR	09:00-17:00
Central locality	Alvin Rose Chemist 606 Longbridge Road, Dagenham, Essex. RM8 2AJ	09:00-17:30
	Andrew Bass Pharmacy 1148 Green Lane, Becontree Heath, Dagenham, Essex. RM8 1BP	09:00-13:00
	Britannia Pharmacy 453 Porters Avenue, Dagenham, Essex. RM9 4ND	09:00-13:00
	David Lewis Chemist 16 Porters Avenue, Dagenham, Essex. RM8 2AQ	09:00-17:30
	Hannigan Pharmacy 240 Bennetts Castle Lane, Beacontree, Dagenham. RM8 3UU	09:00-13:00
	Lloyds Pharmacy 281 Wood Lane, Dagenham, Essex. RM8 3NL	09:00-17:30
	Nuchem Pharmacy 778 Green Lane Dagenham Essex, RM8 1YT	09:00-19:00
	Sandbern Pharmacy 703-705 Green Lane, Dagenham, Essex. RM8 1UU	09:00-14:00
	Valence Pharmacy 453 Becontree Avenue, Dagenham, Essex. RM8 3UL	09:00-14:00
South East locality	Boots The Chemist 17 The Mall, Heathway, Dagenham, Essex. RM10 8RD	08:30-17:30

Locality	Pharmacy name and address	Saturday opening hours
	Day Lewis Pharmacy 2 Royal Parade, Church Street, Dagenham, Essex. RM10 9XB	09:00-13:00
	Day Lewis Pharmacy 149 Broad Street, Dagenham, Essex. RM10 9HX	09:00-14:00
	Hedgemans Pharmacy 428 Hedgemans Road, Dagenham, Essex. RM9 6BU	09:00-17:30
	Kry-Ba Pharmacy 21 Goresbrook Road, Dagenham, Essex. RM9 6XA	09:00-14:00
South West locality	Asda Pharmacy Merrielands Crescent, Dagenham, Essex. RM9 6SJ	09:00-20:00
	Boots Pharmacy 454 Lodge Avenue, Dagenham, Essex. RM9 4QS	09:00-13:00
	Britannia Pharmacy 11 Faircross Parade, Longbridge Road, Braking, Essex. IG11 8UN	09:00-18:00
	Britannia Pharmacy 19 Faircross Parade, Upney Lane, Barking, Essex. IG11 8UW	09:00-13:00
	Britannia Pharmacy Thames Valley Health Centre, Bastable Avenue, Barking, Essex. IG11 0LG	09:00-14:00
	Newlands Pharmacy 359 Ripple Road, Barking, Essex. IG11 9PN	09:00-14:00

3.4.4 Routine Sunday daytime access to community pharmacies

The number, location, and opening hours of community pharmacy providers open on a Sunday vary within each locality. Fewer pharmacies are open on Sundays than any other day in Barking and Dagenham HWB area, however each of the main shopping areas has a pharmacy open on Sundays. A further analysis of provision is detailed in Section 6.

Table 42 - Community pharmacy providers open on Sundays

Locality	Pharmacy name and address	Openings hours (Sundays)
East locality	No pharmacies open	
West locality	Boots the Chemists Ltd 68 East Street, Barking, Essex. IG11 8EQ	11:00-17:00
	Daynight Pharmacy 17 Station Parade, Barking, Essex. IG11 8ED	11:00-17:00
	Tesco Instore Pharmacy Highbridge Road, Barking, Essex. IG11 7BS	10:00-16:00
North locality	Sainsburys Pharmacy 97-131 High Road, Chadwell Heath, Essex. RM6 6PA	10:00-16:00
	SuperCare+ Pharmacy 198-200 High Road, Chadwell Heath, Romford, Essex. RM6 6LU	11:00-16:00
Central locality	Sandbern Pharmacy 703-705 Green Lane, Dagenham, Essex. RM8 1UU	10:00-16:00
South East locality	Boots The Chemist 17 The Mall, Heathway, Dagenham, Essex. RM10 8RD	10:00-16:00
South West locality	Asda Pharmacy Merrielands Crescent, Dagenham, Essex. RM9 6SJ	10:00-16:00

3.4.5 Routine bank holiday access to community pharmacies

Community pharmacies are not obliged to open on nominated bank holidays. Whilst many opt to close, a number of pharmacies (often those in regional shopping centres, retail parks, supermarkets and major high streets) opt to open - often for limited hours.

The number, location and opening hours of community pharmacy providers open on a bank holiday vary within each locality and on different bank holidays. Annually, NHS England requests feedback from community pharmacies on their bank holiday intentions. For most bank holidays, a number of providers have planned to open and NHS England has deemed provision as satisfactory and not commissioned any further provision.

However, on occasion, NHS England may need to commission a bank holiday rota service from a small number of pharmacies, particularly in some areas for Easter Sunday and Christmas Day.

3.5 Advanced service provision from community pharmacies

Section 1.3 lists all advanced services which may be provided under the pharmacy contract. As these services are discretionary, not all providers will provide them all of the time. Data supplied from NHS England has been used to demonstrate in Appendix A which pharmacies have previously claimed (and therefore provided) MURs and NMSs until 31st March 2014. Table 43 lists a summary of the latest available data (2012/13) on provision of advanced services.

Table 43 - Advanced service provision

Advanced Service	Percentage of providers currently providing (Average number per provider, 2012/13)					
	England		London		Barking and Dagenham	
	Average number	%	Average number	%	Average number	%
Medicines use reviews (MURs)	267	92.0%	263	89.9%	340	97.4%
New medicines service (NMS)	68	82.3%	74	78.7%	100	94.7%
Appliance use review (AUR)*	197	1.2%	242	0.5%	22	1.3%
Stoma appliance customisation (SAC)*	635	15.2%	921	4.1%	3,520	7.5%

**AUR and SAC data includes provision from Dispensing Appliance Contractors*

The average number per provider and percentage of providers of both the MUR and NMS services in Barking and Dagenham HWB area are higher than the regional and national levels. Appendix A lists those community pharmacies that have provided these services (up until 31st March 2014).

Only three community pharmacies in Barking and Dagenham HWB area (2.6% of providers) had not provided the NMS service and one community pharmacy in Barking and Dagenham HWB area (7.9% of providers) had not provided the MUR service.

100% of respondents to the community pharmacy contractor questionnaire indicated that they have a consultation room which complies with the requirements to perform NMS / MUR services. The percentage of pharmacies providing the SAC service is low compared with nationally, but greater than rates seen regionally.

The percentage of providers of the AUR is very similar to that seen nationally: there were only 143 community pharmacy or DAC providers nationally (1.2%), and 9 community pharmacy or DAC providers (0.5%) in the whole of London in 2012/13.

3.6 Enhanced service provision

Under the Regulations[9], enhanced services are those directly commissioned by NHS England. Therefore any 'locally commissioned services' commissioned by CCGs or the local authority are not considered here. They are outside the scope of the PNA, but are considered in Chapter 4.

There are currently three enhanced services commissioned by NHS England from pharmacies in Barking and Dagenham HWB area:

- Immunisation services
- Minor Ailments Service
- Pharmacy Urgent Repeat Medication (PURM) service

A list of pharmacies contracted to provide the Immunisation service is detailed in Appendix A. In December 2014 NHS England launched the Pharmacy Urgent Repeat Medication (PURM) service, which is to run to April 2015. NHS England has indicated that this service will be evaluated, and if successful consideration will be given to future commissioning of it.

3.7 Pharmaceutical service provision provided from outside Barking and Dagenham HWB area

Barking and Dagenham HWB area is bordered by five other HWB areas:

- Havering
- Redbridge
- Newham
- Greenwich
- Bexley

As previously mentioned, like most London boroughs, Barking and Dagenham has a comprehensive transport system. As a result, it is anticipated that many residents in Barking and Dagenham HWB area will have reasonable access to pharmaceutical service providers in neighbouring HWB areas and beyond. It is not practical to list here all those pharmacies outside the HWB area by which Barking and Dagenham residents will access pharmaceutical services. A number of providers lie within close proximity to the borders of Barking and Dagenham HWB area boundaries, and are demonstrated on Maps D to F. Further analysis of cross-border provision is undertaken in Section 6. 82% of respondents to the pharmacy user questionnaire noted that they choose a pharmacy provider close to their home, whilst 42% chose a provider close to their GP. Over 80% had no difficulties in accessing their community pharmacy, whilst 15% had difficulties with parking. 85% rated ease of obtaining medication as excellent or good.

3.8 SelfCare Pharmacy

Self-care is a means of improving patient experience and outcomes and reducing pressure on acute as well as other primary care and community services.

3.8.1 The SelfCare Pharmacy model

The SelfCare Pharmacy is a way of supporting the health of local populations and co-morbidities of patients who have stable long-term conditions.

The North East London Local Pharmaceutical Committee along with local CCG, the Local Authority and Department of Health are supporting the SelfCare Pharmacy model in Barking and Dagenham.

Pharmacists in SelfCare pharmacies undergo training in health coaching in at least four clinical conditions. These are currently cardiovascular disease, diabetes, respiratory disease and mental health. In addition, the pharmacist would undertake training in the SelfCare Pharmacy and the SelfCare Plan.

- innovative pharmacy practice that involves managing co-morbidities and stable long term conditions, using therapeutic and psychological tools.
- brings together public health, social care, and self-care and goes beyond the concept of self-management of single disease.
- it focuses on empowering the patient to take control of their own health condition and live independently in their communities. Reduces unplanned hospitalisation as well as A and E admissions.

3.8.2 Health coaching skills

Pharmacists are trained in health coaching to transfer responsibility for care to patients from the pharmacist. They are present to facilitate a prioritised behaviour change to manage long term conditions and living independently.

Offering guidance for setting realistic, manageable milestones to achieve their personal goals. With subsequent sessions of coaching, an improvement in health outcomes will be expected.

3.8.3 Philosophy of SelfCare Pharmacy Practice

- socially responsible pharmacy practice
- part of an integrated primary care for patients
- understanding the wider determinants of health
- fairness and Human rights

3.8.4 Entry of patients into the SelfCare Pharmacy

- self-referral patient
- newly diagnosed long term condition patient at GP surgery: GPs will prescribe a Pharmacy Care Plan that will be completed in community pharmacies.
- long term condition patient (repeat prescriptions) regularly presenting at pharmacy

- hospital discharge patient: Discussions are ongoing about electronic discharge summaries from North East London Foundation Trust (NELFT) being sent to a community pharmacy in North East London.

3.8.5 Pharmacy SelfCare Plan

- this is a written process – the result is a written record
- it puts the person, their needs and choices at the centre of the process. It focuses on goal setting and outcomes that support the person to achieve optimal health and wellbeing
- it encourages prevention of disease and future complications
- plans of how to get the best out of medicines (medicines optimisation)
- it encourages independent living – need for daily living aids and mobility aids
- it might include contingency plans to manage 'crisis' episodes e.g. early identification of signs of a 'crisis' episode

Section 4: Other services which may impact on pharmaceutical services provision

Community pharmacies and GP practices provide a range of other services. These are not considered pharmaceutical services under the 2013 Pharmaceutical Regulations[9] and may be either free of charge, privately funded or commissioned by NHS England, the local authority or the CCG.

Examples of such services include delivery services, allergy testing, care homes services, and sexual health services; this is not an exhaustive list.

4.1 Local authority commissioned services provided by community pharmacies in Barking and Dagenham

LBBD commissions the following services from community pharmacies:

- NHS health checks
- support to stop smoking service
- sexual health service:
    - emergency contraception service
    - chlamydia screening
    - condom distribution
- substance misuse service
    - supervised consumption of methadone and buprenorphine service
    - needle exchange service
- transforming community equipment services (TCES) programme

All services may also be provided from other providers e.g. GP practices. A full list of services and community pharmacy providers can be found in Appendix A.

4.2 Clinical commissioning group commissioned services

Barking and Dagenham CCG currently commissions an anti-coagulation service in one community pharmacy:

- Britannia Pharmacy, 11 Faircross Parade, Longbridge Road, Barking, Essex, IG11 8UU

This service has been given notice of withdrawal from 1st April 2015. Local authority and CCG commissioners were asked for their views on which services they would consider commissioning from community pharmacy providers. Many services are already commissioned by the CCG or local authority from other providers. For the majority of services, the CCG or local authority would be willing to commission from community pharmacies. A copy of the survey can be found in Appendix E and the full results of the survey in Appendix K.

4.3 Other services provided from community pharmacies

As part of the community pharmacy contractor survey, found in Appendix D, community pharmacies were asked to indicate against a range of other services which they currently provide, would be willing to provide or would not be willing to provide. A number of pharmacies indicated that they currently provide a number of these services. Apart from those services commissioned by the local authority, these services are not currently commissioned.

Therefore any services are privately provided and funded. A summary of the community pharmacy contractor survey is detailed in Appendix J.

4.4 Collection and delivery services

From the pharmacy contractor survey, 84% of pharmacies offer a free delivery service of dispensed medicines, upon request and 7% offer a chargeable delivery service. Over three out of four pharmacies offer this service only to selected patient groups. Almost all pharmacies who responded offer a repeat prescription service, to order repeat prescriptions on the patient's behalf, collect the prescription from their surgery and dispense it ready for the patient to collect / be delivered.

4.5 Language services

All pharmacies that responded to the community pharmacy contractor questionnaire reported that they offer at least one additional language in addition to English. A total of 23 languages, other than English, were reported as spoken in pharmacies in Barking and Dagenham. Most common spoken additional languages were Urdu and Hindi (15% of respondents), Gujarati (14% of respondents) and Punjabi (13%).

4.6 Services for less-abled people

As a requirement of the Equalities Act 2012, community pharmacies are required to make 'reasonable adjustments' to their services to ensure they are accessible by all equalities groups, including less-abled persons

4.7 Electronic prescription service

Many GP practices are now able to transmit prescriptions electronically to a pharmaceutical service provider (community pharmacy or dispensing appliance contractor). This system is known as EPS Release 2 and means that the patient no longer needs to obtain a paper prescription and present it at their pharmacy for dispensing. Electronic prescriptions are sent directly to the pharmacy nominated by the patient. GP practices which are enabled to provide this service may transmit electronic prescriptions to a pharmacy who has a dispensing system enabled to receive electronic ('Release 2') prescriptions. 100% of respondents to the community pharmacy contractor questionnaire report that they have a system which is compliant to receive electronic prescriptions.

Data available on which pharmacies in England are enabled to offer the EPS is available from NHS Choices[47]. Appendix A contains information (correct as 4th November 2014) from the NHS Choices website showing that 100% of pharmacies in Barking and Dagenham HWB area are enabled to provide the EPS.

[47] NHS Choices website: http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10

Section 5: Findings from the public survey

A public survey about pharmacy provision was developed (Appendix C) and compiled by Barking and Dagenham PNA Steering Group. This was circulated to a range of stakeholders listed below:

- all pharmacy contractors in the borough to distribute to the public
- all GP practices in the borough to distribute to the public
- the local Healthwatch
- leisure centres and libraries within the borough
- the Council website and,
- social media

A total of 480 surveys were received. A summary of the results can be found in Appendix I.

Table 44 provides the demographic analysis of respondents.

- **91%** rated their overall satisfaction on the service received from their local pharmacy as **'Excellent'** or **'Good'**
- **32%** indicated that they used pharmacies **up to every month for the purchase of over the counter medicines**, with **82%** having a regular or preferred pharmacy they use
- **85%** rated the ease of obtaining medication as **'Excellent'** or **'Good'**
- **42%** rated as important that the pharmacy is **close to their GP surgery; 73%** that the pharmacy is **close to their home**; **20%** that the pharmacy is **close to where they work** and **31%** that the pharmacy has **friendly staff**
- **61%** walk to their community pharmacy; **32%** use a **car / taxi**; **6%** use **public transport; 2%** use **other forms** (wheelchair, mobility scooter)
- **80%** had **no difficulties travelling** to their pharmacy; **15%** had **parking difficulties**; **4%** had **problems with the location** of the pharmacy; and **1%** had **problems of public transport availability**
- A significant number of respondents had no **most convenient day (58%)** or **time (49%)** to **visit their pharmacy**
- **71%** of respondents report having a **journey time of no more than ten minutes**
- **91%** rated their **confidence in the pharmacists knowledge and advice** as **'Excellent'** or **'Good'**

Table 44 - Demographic analysis of the community pharmacy user questionnaire respondents

Sex (%)					
Male			**Female**		
34.13%			65.87%		
Age (%)					
U18	**18-24**	**25-34**	**35-44**	**45-59**	**60+**
0.25%	6.84%	13.92%	19.75%	32.15%	27.09%
Illness or disability (%)?					
Yes			**No**		
14.38%			85.62%		

Ethnic origin (%)	**Survey**	**2011 census**
Arab	0	0.5%
Asian / Asian British - Bangladeshi	1.58%	4.1%
Asian / Asian British - Indian	4.22%	4%
Asian / Asian British - Pakistani	2.11%	4.3%
Asian / Asian British - Chinese	0.26%	0.7%
Asian / Asian British - Other (please state)	0.53%	2.8%
Black / African / Caribbean / Black British - African	3.43%	15.4%
Black / African / Caribbean / Black British - Caribbean	2.64%	2.8%
Black / African / Caribbean / Black British - Other (please state)	1.32%	1.7%
Gypsy or Traveller of Irish Heritage	0	0.1%
Dual Heritage - White and Asian	0.79%	0.7%
Dual Heritage - White and Black African	0.79%	1.1%
Dual Heritage - White and Black Caribbean	1.85%	1.4%
Dual Heritage – Other (please state)	0	1%
White - British	73.61%	49.5%
White - Irish	3.17%	0.9%
White - Other	3.43%	7.8%
Other ethnic group (please state)	0.26%	1%

Section 6: Analysis of health needs and pharmaceutical service provision

6.1 Pharmaceutical services and health needs

Section 2 and Barking and Dagenham Health and Wellbeing Board Strategy (2012/14)[1] show the four priorities that can be supported by the provision of pharmaceutical services within the HWB area which in broad terms are

- prevention
- protection
- improvement
- personalisation

Medicines management is vital in the successful control of many long-term conditions e.g. circulatory diseases, mental health, diabetes, therefore having a positive impact on morbidity and mortality. Disease-specific guidance e.g. National Institute for Health and Care Excellence (NICE) regularly emphasises the importance of medicines optimisation and adherence in control of conditions such as hypertension, asthma and stroke.

6.2 Essential services

The essential services (ES) of the community pharmacy contract must be provided by all contractors:

- ES 1: Dispensing of medicines
- ES 2: Repeat dispensing
- ES 3: Disposal of unwanted medicines
- ES 4: Promotion of healthy lifestyles
- ES 5: Signposting patients to other healthcare providers
- ES 6: Support for self-care
- ES 7: Clinical governance

ES1 and ES2 support patients living with long-term conditions by providing timely supply of medicines and advice to patients. ES2 may be of particular benefit to patients on lifelong medicines as part of their treatment e.g. statins or insulin.

Using ES3, pharmacies can direct patients in the safe disposal of medicines and reduce the risk of hoarding medicines at home, which may increase the risk of errors in taking medicines or in taking out-of-date medicines.

ES4 can support local and national campaigns informing people of managing risk factors associated with many long-term conditions such as smoking, healthy diet, physical activity and alcohol consumption.

ES4 provides the ability to:

- improve awareness of the signs and symptoms of conditions such as stroke e.g. FAST campaign
- promote validated information resources for patients and carers
- collect data from the local population on their awareness and understanding of different types of disease and their associated risk factors
- target “at risk” groups within the local population to promote understanding and access to screening programmes e.g. men in their 40s for NHS Health Checks

Community pharmacy also plays a vital role in the management of minor ailments and self-care. Evidence shows that community pharmacists are potentially the most accessed healthcare professionals in any health economy[44] and are an important resource in supporting people in managing their own self-care and in directing people to the most appropriate points of care for their symptoms[44]. Although the evidence base is currently very small in measuring the effectiveness and cost effectiveness of community pharmacies’ contribution to urgent care, emergency care and unplanned care, there is a growing recognition of the importance of this role and for further research. This has been highlighted as a key area for improving health outcomes in the Joint Health and Wellbeing Strategy and supports all four priority areas.

Using ES5, pharmacies can signpost patients and carers to local and national sources of information and reinforce those sources already promoted. Appropriate signposting has a significant role in the supporting all eight priorities and could have a supportive role in all four priority areas.

Through ES6, pharmacy staff can advise patients and carers on the most appropriate choices for self-care and also direct queries to the pharmacist for further advice when purchasing over-the-counter medicines or general sales lists products. Some over-the-counter medicines are contraindicated e.g. decongestant use in circulatory disease and inappropriate use could increase the risk of an unplanned hospital admission. Equally, some symptoms can be much more significant in certain long-term conditions e.g. foot conditions in diabetes and the attempted purchase of an over-the-counter medicine by a patient or carer could alert a pharmacist leading to an appropriate referral.

ES7 provides the governance structure for the delivery of pharmacy services. This structure is set out within the 2013 regulations and includes:

- a patient and public involvement programme
- a clinical audit programme
- a risk management programme
- a clinical effectiveness programme
- a staffing and staff programme
- an information governance programme

It provides an opportunity to audit pharmacy services and influence to the evidence base for the best practice and contribution of pharmacy services especially to meeting local health priorities within Barking and Dagenham HWB area.

Many of the Barking and Dagenham CCG commissioning intentions[48] are in partnership with neighbouring Havering CCG and Redbridge CCG and therefore may incorporate pharmacies in all three corresponding HWB areas and are outlined in the Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan June 2014[48].

This strategic plan highlights the "Primary Care Transformational Programme" Barking and Dagenham, Havering and Redbridge CCGs are committed to playing its part in ensuring that primary care services in the borough meet the needs of local people. The CCGs want to empower and support patients and carers to maintain independence, and work in partnership in an integrated, co-ordinated health and social care system to achieve this.

Fundamental to achieving this vision will be the role of general practice and the wider primary care 'family' (i.e. community pharmacy, dentistry and high street opticians), however, primary care needs to transform in three main ways to deliver:

- improvement in the quality and performance of primary care
- general practice working more effectively with others to deliver co-ordinated and integrated care
- where appropriate, smaller general practice units working together as a single unit to realise better outcome and benefits for patients and the local health economy

The Primary Care Transformation Programme aims to allow local GPs to lead a system that empowers patients to feel more supported to manage long term conditions, increase positive patient experience and reduce unplanned attendances and admissions to hospital.

The programme has three key areas of focus:

- the development of the primary care provider market to ensure that it is fit for purpose and ready to respond to commissioning intentions
- quality improvement: identifying local needs and working with partners to set standards
- the co-commissioning of primary care services by NHSE, public health and the CCGs to provide a whole-system approach to meet our population needs

6.3 Advanced services

Evidence shows that up to half of medicines may not be taken as prescribed, or simply not taken at all.

[48] Barking and Dagenham Commissioning Strategy Plan: www.barkingdagenhamccg.nhs.uk/.../PT-presentation-6-11-2012.pdf

Advanced services have a role in highlighting issues with medicines or appliance adherence issues and also in reducing waste through inappropriate or unnecessary use of medicines or appliances. Polypharmacy is highly prevalent in long-term conditions management. Advanced services provide an opportunity to identify issues with side effects, changes in dosage, confirmation that the patient understands the role of the medicine or appliance in their care and opportunities for medicine optimisation. Appropriate referrals can be made to GPs or other care settings resulting in patients receiving a better outcome from their medicines, and in some cases, cost saving for the CCG. Advanced services may also identify other issues such as general mental health and well-being, providing an opportunity to signpost to other local services or service within the pharmacy e.g. seasonal flu immunisation or repeat dispensing.

Promotion of self-care is an important aspect to the management of many long-term conditions and a key element to support priority three. Advanced services are accessible in six localities (Section 6) and provide a key opportunity for the pharmacist to do so e.g. promoting the importance of dry weight monitoring in heart failure management. Other opportunities involving medicines management are highlighted in the Case for Change – Integrated Care across Barking and Dagenham CCG, Havering CCG and Redbridge CCG[48].

6.4 Enhanced services

In Barking and Dagenham there are three pharmaceutical enhanced services commissioned by NHS England (Section 3.6) which are a minor ailments service, immunisation services, and the Pharmacy Urgent Repeat Medication (PURM) service. Enhanced services are included within this assessment where they affect the need for pharmaceutical services, or where the further provision of these services would secure improvements or better access to pharmaceutical services. Appendix A provides details of the pharmacies providing enhanced services.

The Pharmacy Urgent Repeat Medication (PURM) service was launched on 1st December 2014. The service allows pharmacies to provide emergency repeat medications at NHS expense, without the need for a prescription or GP appointment. The service recognises that on occasions patients may mistakenly run out of urgent repeat medication when their GP surgery is closed, and prevents the need to access urgent care to obtain a prescription for the medication. The service is currently being run as a pilot until 1st April 2015, when it will be evaluated. For the purpose of this PNA, provision of this service has not been analysed. Should a full service be commissioned beyond 1st April 2015, the HWB will consider the provision of this service.

Commissioning, delivery and regulation of immunisation services are now shared at national level between NHS England, Public Health England (PHE) and the Department of Health (DH); the local operating model divides responsibilities between NHS England, PHE and Barking and Dagenham Local Authority.

6.4.1 Immunisation services

In Barking and Dagenham, a total of 38,143 vaccines were administered of which 3,120, or 8.18%, were provided in community pharmacies.

The number of pharmacies per CCG area ranged from 14 to 49 – a rate of 6.85 pharmacies per 100,000 people to 18.47 per 100,000. The mean was 13 per 100,000.

In Barking and Dagenham 31 pharmacies, or 82%, provided immunisation services in 2013/14, this equates to 15.9 per 100,000. These are geographically spread across the borough and the service is accessible in six localities.

Immunisation is a key intervention to protect at-risk groups such as older people, people living with diabetes, COPD, CVD or carers against diseases such as seasonal flu or shingles which can cause additional health complications that can be associated with unplanned hospital admissions. Therefore, there is a vital need for this service which supports all priority areas but in particular one and two.

There is a strong evidence base for the role of immunisation in reducing morbidity and mortality in the adult and child population. For example, seasonal flu immunisation is established as an effective and cost effective intervention in reducing unplanned hospital admissions in many long-term conditions e.g. respiratory disease, circulatory disease.

In 2014/15, an additional immunisation service will be commissioned from pharmacies by NHS England in line with national immunisation programmes. This service is the pneumococcal immunisation programme.

6.4.2 Minor ailments service

The aims of a minor ailment scheme or service are to improve access to treatment for people with minor ailments by encouraging them to utilise a pharmacist, and thereby decrease attendances at GP practices and other care settings e.g. urgent care for the treatment of minor ailments. In doing so, this can increase capacity within GP practices and other care settings. There is a growing evidence base for the effectiveness of such schemes.

The Barking and Dagenham JSNA[10] does not specifically consider minor ailments schemes provided by pharmacies however this service also supports the self-care agenda which features strongly in the Joint Health and Wellbeing Strategy[1].

Minor ailments schemes are commissioned by NHS England on a borough basis and not on a pan-London model. It should be noted there is heterogeneity in service description across London.

At September 2014, 33 pharmacies, or 87%, are commissioned to provide a minor ailment scheme in the HWB area. These pharmacies are geographically spread across the borough and the service is accessible in all six localities. Activity levels were not available for this service from NHS England.

Appendix A shows details of pharmacies providing this enhanced service.

6.5 Locally commissioned services

Appendix A provides a summary of locally commissioned services (LCS) within Barking and Dagenham pharmacies described in Section 4.1 and 4.2. It is important to note the commissioning status of each service as this defines whether or not it is a locally commissioned service.

Locally commissioned services are included within this assessment where they affect the need for pharmaceutical services, or where the further provision of these services would secure improvements or better access to pharmaceutical services. Some of these services are considered.

6.5.1 Locally commissioned services by Barking and Dagenham CCG

Barking and Dagenham CCG commission one locally commissioned service from only one pharmacy (Britannia Pharmacy, map reference 7); this is an Anti-coagulation Service. This service will be decommissioned on 31st March 2015 therefore has not been considered in the PNA.

Anti-coagulation services are referred to as an enhanced service within the Pharmaceutical Directions[11]. In theory they may be commissioned by NHS England as a pharmaceutical enhanced service but currently they are commissioned by LBBD. If NHS England chooses to commission this service from pharmacies in the future, this should be based upon a defined need within the population.

6.5.2 Locally commissioned services by LBBD

6.5.2.1 Stop smoking services

Smoking is the UK's single greatest cause of preventable illness and early death. Adults who smoke lose on average 13 to 14 years of their lives and more than 86,000 people in the UK die from smoking each year. It is a major issue highlighted in the Barking and Dagenham JSNA[10] and Joint Health and Wellbeing Strategy[1]. The prevalence of smoking in people aged 18 and over is significantly higher in Barking and Dagenham than in London and England[49] and is discussed in Section 2 in detail.

Thirty pharmacies, or 79%, of the pharmacies in the borough, 30 (or 79%), are commissioned to provide stop smoking services. These are spread across the HWB area and the service is available in the six localities. Nationally pharmacies have been an established provider of stop smoking services for a number of years.

Stop smoking services are referred to as an enhanced service within the Directions[11.] In theory they may be commissioned by NHS England as a pharmaceutical enhanced service, but currently they are not in Barking and Dagenham. If NHS England chooses to commission this service from pharmacies in Barking and Dagenham in the future, the capacity, quit rates and accessibility of all providers of stop smoking services within

[49] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000002 accessed 6/11/14

localities and within the whole HWB area should be considered along with the commissioning intentions for pharmacies.

6.5.2.2 Emergency hormonal contraception

Sexual health has a major focus in the Barking and Dagenham JSNA[10] and Joint Health and Wellbeing Strategy[1], with pharmacies role highlighted in service provision.

Teenage conception includes all conceptions before the mother's 20th birthday, but the national focus is on conception under 18. The conception rate is the number of pregnancies that start before the mother's 18th birthday (per 1,000 young women aged 15 to 17) and includes pregnancies that end either in birth or in termination.

There is a comparatively young population compared with the England average and a high rate of teenage pregnancies although this has declined from the peaks seen in 2002/03. In 2012, teenage pregnancy rates are higher than the London and national average in England and are discussed in Section 2.

Emergency hormonal contraception (EHC) is provided as a free service to females aged 13 to 24 years of age presenting at a commissioned pharmacy in the HWB area. 21 pharmacies, or 55% are commissioned to provide this service. These are geographically spread across the HWB area and the service is accessible in six localities. Nationally, pharmacies have been an established provider of EHC for a number of years.

Activity data for this service was not available however 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 within England as recommended by NICE.

The drug, Levonorgestrel is used for emergency hormonal contraception. Through this service it is supplied under a patient group direction (PGD) service to women who meet the criteria for inclusion of the PGD and service specification. Note the drug can also be prescribed using an NHS prescription. It may also be bought as an over-the-counter medication from pharmacies, however the user must be 16 years or over hence the need for a PGD service within pharmacies, which provides access from 13 years of age.

PGD services are referred to as an enhanced service within the Pharmaceutical Directions. In theory they may be commissioned by NHS England as a pharmaceutical enhanced service but currently they are commissioned by LBBD.

If NHS England chooses to commission this service from pharmacies in the future, this should be based upon a defined need within the population. When establishing service need and the commissioning intentions for pharmacies,

It should also consider the capacity, activity and accessibility of all providers who have the potential to supply Levonorgestrel under PGD on an NHS prescription or as an over-the-counter medication in Barking and Dagenham.

6.5.2.3 Chlamydia screening

The National Chlamydia Screening Programme (NCSP), which started locally in Barking and Dagenham in 2008, specifically targets 15-24 year olds. 30% of people under the age of 25 years were screened in 2013. Positivity rates were similar to the national average and are discussed in Section 2. In 2012/13, there was a coverage of 25% nationally and 27% for London, with an 8% positivity rate for London and England alike (Chlamydia Testing Activity Dataset 2013). Activity data specifically for the pharmacy based service was not available. There is a strong evidence base for the effectiveness of chlamydia screening programmes in reducing the prevalence of chlamydia within the population.

There is no treatment element to this service and therefore this is not currently a PGD service.

Twenty one pharmacies (55%), are commissioned to provide this service. These are geographically spread across the HWB area and the service is accessible in six localities. Nationally, pharmacies have been an established provider of chlamydia screening for a number of years.

Screening services are referred to as an enhanced service within the Pharmaceutical Directions[11]. In theory, they may be commissioned by NHS England as a pharmaceutical enhanced service but currently they are commissioned by LBBD. If NHS England chooses to commission this service from pharmacies in the future, this should be based upon a defined need within the population. It should also consider the capacity, activity and accessibility of all providers of chlamydia screening services in Barking and Dagenham when establishing service need and the commissioning intentions for pharmacies.

6.5.2.4 Condom supply service

The service is commonly known as the C-card scheme and is a free condom distribution service. The C-card scheme operates in tandem with the EHC and chlamydia service.

Activity data for this service was not available however there is a very strong evidence base for the use of free condom services in reducing unplanned or unwanted pregnancies and reducing the transmission of STI. Their use forms part of an overall national strategy to reduce the rate of teenage pregnancy within England as recommended by NICE.

Twenty one pharmacies (55%), are commissioned to provide this service. These are geographically spread across the HWB area and the service is accessible in six localities. Nationally, pharmacies have been an established provider of the C-card scheme.

Condom supply, or this type of supply service, are not referred to as an enhanced service within the Pharmaceutical Directions[11].

Therefore they may not be commissioned by NHS England as a pharmaceutical enhanced service. This service can only be commissioned as a LCS.

6.5.2.5 NHS Health Checks

The NHS Health Check is a vascular risk assessment aimed at calculating the risk of a cardiovascular event within ten years of the day of the check. They are aimed at adults in England aged 40 to 74, and form part of the Putting Prevention First, NHS programme[50]. Crucially, a NHS Health Check can detect potential problems before they do real damage.

Everyone is at risk of developing heart disease, stroke, diabetes, kidney disease and some forms of dementia. The NHS Health Check can help to detect risk factors such as obesity and high blood pressure associated with these health problems and gives an opportunity to give personalized advice on how to reduce these risks. It is a free service to the public including any follow-up tests or appointments. Many of the risk factors associated with CVD are also associated risk factors for cancer e.g. smoking.

Ten pharmacies, or 26%, are commissioned to provide this service. These are geographically spread across the HWB area and the service is accessible in six localities. Nationally, pharmacies have been an established provider of NHS Health Checks for a number of years.

Screening services are referred to as an enhanced service within the Pharmaceutical Directions[11]. In theory they may be commissioned by NHS England as a pharmaceutical enhanced service but currently they are commissioned by LBBD. If NHS England chooses to commission this service in from pharmacies the future, this should be based upon a defined need within the population. It should also consider the capacity, activity and accessibility of all providers of NHS Health Checks in Barking and Dagenham when establishing service need and the commissioning intentions for pharmacies.

6.5.2.6 Other screening services

Increasingly, community pharmacies have been commissioned to provide screening services therefore providing additional choice and access to local populations. Currently chlamydia and NHS Health Checks are the only screening services commissioned from pharmacies within the HWB area.

Some examples of others are HIV screening, alcohol screening and weight management. The commissioners survey (Appendix E) highlighted the potential for utilising pharmacies for some of these screening services. The Joint Health and Wellbeing Strategy highlights the importance of screening programmes with access to screening services have a significant role in the supporting numerous outcomes highlighted but in particular priorities one and two.

[50] Putting Prevention First: Vascular Checks: risk assessment and management, DH, 2008. www.healthcheck.nhs.uk/document.php?o=227

6.5.2.7 Substance misuse services

Community pharmacies have been utilised for a number of years by Drug and Alcohol Action Team (DAAT) service providers in the provision of supervised consumption services and needle exchange services.

Access to DAAT services have a significant role in supporting several outcomes highlighted in the Joint Health and Wellbeing Strategy and are discussed in Section 2.

6.5.2.7.1 Supervised consumption

Supervised consumption involves the client consuming opioid substitution products under the direct supervision of a pharmacist in a community pharmacy. It 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

30 pharmacies, or 79%, in Barking and Dagenham are commissioned to provide this service. These are geographically spread across the borough and the service is accessible in six localities.

Alcohol and drug use, especially in the younger population, is a health priority for Barking and Dagenham.

Supervised administration services are referred to as an enhanced service within the Pharmaceutical Directions[11]. In theory, they may be commissioned by NHS England as a pharmaceutical enhanced service but currently they are commissioned by LBBD. If NHS England chooses to commission this service from pharmacies in the future, this should be based upon a defined need within the population.

When establishing service need and the commissioning intentions for pharmacies, it should also consider the capacity, activity and accessibility of all providers of supervised administration substance misuse services within Barking and Dagenham.

6.5.2.7.2 Needle exchange service

This service is an integral part of the harm reduction strategy for drug users. It aims to reduce the spread of blood borne pathogens e.g. Hepatitis B, Hepatitis C, HIV and to act as a referral point for service users to other health and social care services.

There is established evidence to support the effectiveness of needle exchange services with long-term health benefits to drug users and the whole population.

12 pharmacies, or 32%, in Barking and Dagenham are commissioned to provide this service.

Needle and syringe exchange services are referred to as an enhanced service within the Pharmaceutical Directions[11].

In theory they may be commissioned by NHS England as a pharmaceutical enhanced service but currently they are commissioned by LBBD. If NHS England chooses to commission this service from pharmacies in the future, this should be based upon a defined need within the population. It should also consider the capacity, activity and accessibility of all providers of needle and syringe exchange services within Barking and Dagenham when establishing service need and the commissioning intentions for pharmacies.

6.5.2.8 Transforming community equipment services

Transforming community equipment services (TCES) project is a London region wide programme to accelerate the implementation of a retail solution for simple aids to daily living (SADLs) across London. Simple aids are those items such as eating and drinking utensils, grab rails, bathing aids, furniture, sensory aids and raised toilet seats which help people to be independent.

Currently if a person qualifies for local authority social care support, an assessment by an occupational therapist, physiotherapist or community nurse will take place and the assessor orders the equipment which is loaned to the user. The user has no choice in the equipment given to them, which is also usually second hand. Local authorities across England are free to adopt this model as part of Transforming Adult Social Care Services. London however, is the first region to gain commitment to a regional approach.

Under the TCES programme, accredited retailers, including community pharmacies, are reimbursed for supplying ability aids and equipment against 'prescriptions' (N.B. not NHS FP10 forms). Pharmacies register as accredited retailers under TECS with the Community Equipment Dispenser Accreditation Body (CEDAB)

By utilising pharmacies as distribution hubs. TECS is located right in the heart of local communities.

17 pharmacies, or 45%, in the HWB area are commissioned to provide this service. These are geographically spread across the borough, the service is available in every locality with the exception of North.

TCES or this type of supply service is not referred to as an enhanced service within the Pharmaceutical Directions[11]. Therefore they may not be commissioned by NHS England as a pharmaceutical enhanced service. This service can only be commissioned as a LCS.

6.6 PNA localities

There are 38 pharmacies within the HWB area, these are illustrated in Map A. Pharmacy opening times are listed in Sections 3.4.2, 3.4.3, 3.4.4, Map A and Appendix A.

As described within Section 1.5, the PNA Steering Group decided that the Barking and Dagenham HWB should be divided into six localities for the PNA:

- Central
- East
- North
- South East
- South West
- West

Substantial health data are available at this level, and populations and their health needs vary widely between wards. This is illustrated to varying degrees per locality and subsequently discussed in detail in Section 2.

Taking the health needs highlighted in each locality into consideration including Map B and Map C, this chapter considers the pharmaceutical service provision within each locality. The location of pharmacies by locality is illustrated in Map A.

6.6.1 Central locality

There are nine community pharmacies in this locality and the estimated average number of community pharmacies per 100,000 population is 20.4. This is slightly greater than the Barking and Dagenham average (19.6), less than the London average of 22.5 and less than the England average of 21.6 (Table 31, Section 3.1). This locality has the highest number of pharmacies and an IMD score of 35 (Figure 10, Section 2). This is the most populated locality. All nine pharmacies hold a standard 40 core hour contract. There are no 100 hour contract pharmacies however there is one “late night” pharmacy open until 8pm on weekdays (David Lewis Pharmacy, map reference 12)

Based upon the nine pharmacies:

- seven pharmacies (78%) are open after 6pm weekdays
- nine pharmacies (100%) are open on Saturdays
- one pharmacy (11%) is open on Sunday
- eight pharmacies (89%) provide MURs
- eight pharmacies (89%) provide NMS

Regarding access to enhanced services within the locality:

- nine pharmacies (100%) provide MAS
- seven pharmacies (78%) provide immunisation services

Regarding access to locally commissioned services within the locality:

- two pharmacies (22%) provides NHS Health Checks
- eight pharmacies (89%) provide stop smoking services
- five pharmacies (56%) provide EHC, chlamydia screening and condoms supply
- seven pharmacies (78%) provide supervised consumption
- one pharmacy (11%) provides needle exchange
- seven pharmacies (78%) provide TCES

Appendix A contains details of pharmacy opening times, contractual status and the provision of advanced services, enhanced services and locally commissioned services. Although specific data are not available, it is anticipated that some residents may rely upon the delivery services provided by distance-selling pharmacies and DACs. Although specific data are not available, the locality population could access essential, advanced, enhanced and locally commissioned services from pharmacies in other HWB localities.

6.6.2 East locality

There are four community pharmacies and one DAC in this locality and the estimated average number of community pharmacies per 100,000 population is 15.2, which is the lowest estimate for any locality. This estimate is less than the Barking and Dagenham average (19.6), less than the London average (22.5) and less than the England average of 21.6 (Table 2, Section 3.1). This locality (and North locality) have the lowest number of pharmacies and an IMD score of 33.5 (Figure 10, Section 2). All four pharmacies hold a standard 40 core hour contract. The DAC is opening for 12 hours on weekdays until 8pm and for four hours on a Saturday. There are no 100 hour contract or "late night" pharmacies in the locality.

Based upon the four pharmacies:

- four pharmacies (100%) are open after 6pm weekdays
- four pharmacies (100%) are open on Saturdays
- zero pharmacies (0%) are open on Sunday
- four pharmacies (100%) provide MURs
- four pharmacies (100%) provide NMS

Regarding access to enhanced services within the locality:

- four pharmacies (100%) provide MAS
- four pharmacies (100%) provide immunisation services

Regarding access to locally commissioned services within the locality:

- two pharmacies (50%) provide NHS Health Checks
- four pharmacies (100%) provide stop smoking services
- four pharmacies (100%) provide EHC, chlamydia screening and condoms supply
- two pharmacies (50%) provide supervised consumption
- three pharmacies (75%) provide needle exchange
- four pharmacies (100%) provide TCES

Appendix A contains details of pharmacy opening times, contractual status and the provision of advanced services, enhanced services and locally commissioned services.

Although specific data are not available, it is anticipated that some residents may rely upon the delivery services provided by distance-selling pharmacies and DACs. Although specific data are not available, the locality population could access essential, advanced, enhanced and locally commissioned services from pharmacies in other HWB localities.

6.6.3 North locality

There are five community pharmacies in this locality and the estimated average number of community pharmacies per 100,000 population is 22.4, which is greater than the Barking and Dagenham average (19.6), almost equals the London average (22.5) and is greater than the England (21.6) (Table 2, Section 3.1). This locality is the less populated, the least number of pharmacies (with East locality) and an IMD score of 31.6 which is the lowest of any locality (figure 10, Section 2). Four pharmacies hold a standard 40 core hour contract. There is one 100 hour contract pharmacy (Super.Care Pharmacy+, map reference 32) and one of the other four pharmacies is a “late night” pharmacy open until 8pm on Monday to Saturday and for six hours on Sunday weekdays (Sainsburys Pharmacy, map reference 30)

Based upon the five pharmacies:

- four pharmacies (80%) are open after 6pm weekdays
- five pharmacies (100%) are open on Saturday
- two pharmacies (40%) are open on Sunday
- five pharmacies (100%) provide MURs
- five pharmacies (100%) provide NMS

Regarding access to enhanced services within the locality:

- five pharmacies (100%) provide MAS
- four pharmacies (80%) provide immunisation services

Regarding access to locally commissioned services within the locality

- one pharmacy (20%) provides NHS Health Checks
- four pharmacies (80%) provide stop smoking services
- one pharmacy (20%) provides EHC, chlamydia screening and condoms supply
- one pharmacy (20%) provides supervised consumption
- two pharmacies (40%) provide needle exchange
- zero pharmacies (0%) provide TCES

Appendix A contains details of pharmacy opening times, contractual status and the provision of advanced services, enhanced services and locally commissioned services. Although specific data are not available, it is anticipated that some residents may rely upon the delivery services provided by distance-selling pharmacies and DACs. Although specific data are not available, the locality population could access essential, advanced, enhanced and locally commissioned services from pharmacies in other HWB localities.

6.6.4 South East locality

There are six community pharmacies in this locality and the estimated average number of community pharmacies per 100,000 population is 17.7, which is less than the Barking and Dagenham average (19.6), less than the London average (22.5) and less than the England average of 21.6 (Table 2, Section 3.1). This locality has an IMD score of 35.2 (Figure 10, Section 2). All six pharmacies hold a standard 40 core hour contract. There are no 100 hour contract pharmacies and none of the six pharmacies could be regarded as a "late night" pharmacy.

Based upon the six pharmacies:

- three pharmacies (50%) are open after 6pm weekdays
- five pharmacies (83%) are open on Saturdays
- one pharmacy (17%) is open on Sunday
- six pharmacies (100%) provide MURs
- six pharmacies (100%) provide NMS

Regarding access to enhanced services within the locality:

- six pharmacies (100%) provide MAS
- five pharmacies (83%) provide immunisation services

Regarding access to locally commissioned services within the locality:

- three pharmacies (50%) provide NHS Health Checks
- four pharmacies (67%) provide stop smoking services
- three pharmacies (50%) provide EHC, chlamydia screening and condoms supply
- six pharmacies (100%) provide supervised consumption
- one pharmacy (17%) provides needle exchange
- one pharmacy (17%) provides TCES

Appendix A contains details of pharmacy opening times, contractual status and the provision of advanced services, enhanced services and locally commissioned services. Although specific data are not available, it is anticipated that some residents may rely upon the delivery services provided by distance-selling pharmacies and DACs. Although specific data are not available, the locality population could access essential, advanced, enhanced and locally commissioned services from pharmacies in other HWB localities.

6.6.5 South West locality

There are six community pharmacies in this locality and the estimated average number of community pharmacies per 100,000 population is 16.7, which is less than the Barking and Dagenham average (19.6), less than the London average (22.5) and less than the England average of 21.6 (Table 2, Section 3.1). This locality has an IMD score of 32.2 (Figure 10, Section 2). All six pharmacies hold a standard 40 core hour contract.

There are no 100 hour contract pharmacies however two of the six pharmacies could be regarded as a “late night” pharmacy, (Asda Pharmacy - map reference 3, and Britannia Pharmacy – map reference 11)

Based upon the six pharmacies:

- five pharmacies (83%) are open after 6pm weekdays
- six pharmacies (100%) are open on Saturdays
- one pharmacy (17%) is open on Sunday
- six pharmacies (100%) provide MURs
- five pharmacies (83%) provide NMS

Regarding access to enhanced services within the locality:

- six pharmacies (100%) provide MAS
- five pharmacies (83%) provide immunisation services

Regarding access to locally commissioned services within the locality:

- one pharmacy (17%) provides anti-coagulation service
- two pharmacies (33%) provide NHS Health Checks
- five pharmacies (83%) provide stop smoking services
- four pharmacies (67%) provide EHC, chlamydia screening and condoms supply
- six pharmacies (100%) provide supervised consumption
- one pharmacy (17%) provides needle exchange
- one pharmacy (17%) provides TCES

Appendix A contains details of pharmacy opening times, contractual status and the provision of advanced services, enhanced services and locally commissioned services. Although specific data are not available, it is anticipated that some residents may rely upon the delivery services provided by distance-selling pharmacies and DACs.

Although specific data are not available, the locality population could access essential, advanced, enhanced and locally commissioned services from pharmacies in other HWB localities.

Barking Riverside is a new neighbourhood being developed along a 2km shore of the Thames. Outline planning consent has been granted for a total of 10,800 new homes. It is anticipated that by March 2015 there will be in the region of 700 homes occupied. Planning consent has been agreed for around a further 700 dwellings for the period 2015-2017. Planning currently restricts the development to up to 1,500 homes until further significant transport infrastructure is built. During 2014 and 2015, public consultations are being held regarding the extension of existing rail lines to cover the Riverside development. Eventually it is anticipated the 10,800 homes will provide housing for a population in the region of 29,000 new residents, which require significant new community infrastructure including healthcare services. Until further detailed development plans are known, the HWB will continue to work with NHS England and

the local council to understand the community infrastructure plans and healthcare provision needs of this growing community. It is anticipated that the pharmaceutical service of the predicted population of Barking Riverside through the time horizon of this PNA will be met by existing nearby providers.

6.6.6 West locality

There are eight community pharmacies in this locality and the estimated average number of community pharmacies per 100,000 population is 30.7, which is the highest estimate for any locality. This estimate is also much higher than the Barking and Dagenham average (19.6), the London average (22.5) and the England average of 21.6 (Table 2, Section 3.1). This locality has an IMD score of 38.1 which is the highest for any locality (Figure 10, Section 2). Six pharmacies hold a standard 40 core hour contract. There are two 100 hour contract pharmacies which is the highest proportion for any locality. None of the other six pharmacies could be regarded as a "late night" pharmacy.

Based upon the eight pharmacies:

- seven pharmacies (88%) are open after 6pm weekdays
- eight pharmacies (100%) are open on Saturdays
- three pharmacies (38%) are open on Sunday
- eight pharmacies (100%) provide MURs
- eight pharmacies (100%) provide NMS

Regarding access to enhanced services within the locality

- five pharmacies (62%) provide MAS
- eight pharmacies (100%) provide immunisation services

Regarding access to locally commissioned services within the locality

- one pharmacy (12%) provides NHS Health Checks
- six pharmacies (75%) provide stop smoking services
- four pharmacies (50%) provide EHC, chlamydia screening and condoms supply
- eight pharmacies (100%) provide supervised consumption
- three pharmacies (38%) provide needle exchange
- four pharmacies (50%) provide TCES

Appendix A contains details of pharmacy opening times, contractual status and the provision of advanced services, enhanced services and locally commissioned services.

Although specific data are not available, it is anticipated that some residents may rely upon the delivery services provided by distance-selling pharmacies and DACs.

Although specific data are not available, the locality population could access essential, advanced, enhanced and locally commissioned services from pharmacies in other HWB localities.

6.7 Necessary services – gaps in service provision

For the purposes of this PNA, necessary services are defined as:

- essential services provided at all premises on the pharmaceutical list during all the opening hours of the pharmacy in line with their terms of service as set out in the 2013 Regulations
- advanced services in line with their terms of service as set out in the 2013 Regulations

The HWB have considered the White Paper Pharmacy in England: Building on strengths – delivering the future (2008)[45] which states that it is strength of the current system that community pharmacies are easily accessible. The HWB consider that the population of Barking and Dagenham currently experience this situation in all six PNA localities.

The HWB has considered the following when assessing the provision of necessary services in the HWB area and each of the six PNA localities:

- the location of pharmacies within each of the six PNA localities and across the whole Barking and Dagenham HWB area (Map A)
- the BAME levels by electoral ward compared to the relative location of pharmacy premises (Map B)
- the IMD and deprivation ranges compared to the relative location of pharmacy premises (Map C)
- percentage of population of the HWB area and the average daytime travel times to nearest community pharmacy (Section 3)
- using average drive time, 98.2% residents can access their nearest pharmacy by car within five minutes, increasing to 100% within ten minutes (Map D)
- using average public transport times, 88.2% of residents can access their nearest pharmacy within ten minutes, increasing to 100% within 15 minutes (Map E)
- using average walking times, 95% of residents can access their nearest pharmacy within 20 minutes, increasing to 100% within 30 minutes (Map F)
- the number, distribution and opening times of pharmacies within each of the six PNA localities and across the whole Barking and Dagenham HWB area (Appendix A and Map A)
- the choice of pharmacies covering the each of the six PNA localities and the whole HWB area (Appendix A)
- results of the patient survey (Section 5 and Appendix I)
- estimate of the average number of community pharmacies per 100,000 population (Section 3)
- average dispensed item per community pharmacy (Section 2)
- key housing developments sites within Barking and Dagenham HWB area (Section 2)

- population density compared to the relative location of pharmacy premises (Map G)
- projected population growth (Section 2)

The HWB has concluded there are no gaps in the provision of necessary services across the HWB area

In each locality, there are pharmacies open beyond what may be regarded as normal hours in that they provide pharmaceutical services during supplementary hours in the evening, on Saturday and on Sunday. There are three 100 hour pharmacies spread across two localities (Table 5, Section 3).

The HWB has concluded that there is no gap in necessary service provision.

The HWB will consider the change in health needs of each of the six localities as the housing developments listed in Section 2 progress through the three year time horizon of the PNA. The HWB will consider the responses from the public, pharmacy contractors and other stakeholders involved in these developments when considering the changing health needs of the residents of the HWB area.

The Barking and Dagenham CCG Commissioning Strategy Plan[48] and Joint Health and Wellbeing Strategic Plan[1] both refer to initiatives that could have an impact on the provision of pharmaceutical services in Barking and Dagenham in the next three years e.g. relocation of secondary care-based services into primary care settings and Primary Care Transformation Programme. These could see an increase in demand for pharmaceutical services in primary care settings within the HWB area. These will be considered by the HWB as the CCG progresses with its commissioning intentions.

Changes in the provision of GP practice based services are occurring e.g. extension in opening hours. Future development of the primary care estate and resultant changes in service provision e.g. introduction of primary care hubs could see an increase in demand for pharmaceutical services in primary care settings within the HWB area. It is unclear if these will occur during the time horizon of this PNA. Any changes will be considered by the HWB as the CCG progresses with its commissioning intentions.

6.8 Improvements and better access – gaps in service provision

The HWB consider it is those services provided in addition to those considered necessary for the purpose of this PNA that should reasonably be regarded as providing either an improvement or better access to pharmaceutical provision.

The HWB recognises that any addition of pharmaceutical services by location, provider, hours or services should be considered however a principle of proportionate consideration should apply.

The patient survey did not record any specific themes relating to pharmacy opening times (Section 5). The HWB therefore concludes there is no significant information to indicate there is a gap in the current provision of pharmacy opening times. The same conclusion is reached in considering whether there is any future specified circumstance that would result in creating a gap in pharmaceutical provision at certain times based upon the current information and evidence available. The HWB will consider the response by pharmacy contractors to the changing expectations of the public towards pharmacy opening times during the time horizon of this PNA.

With regard to enhanced services, the HWB is mindful that only those commissioned by NHS England are regarded as pharmaceutical services. However, since 1st April 2013, there has been a shift in commissioning arrangements for some services that would otherwise be defined as enhanced services (Section 1.3.1). Therefore, the absence of a particular service being commissioned by NHS England is in some cases addressed by a service being commissioned through the Barking and Dagenham CCG and through LBBD (Section 4.1 and 4.2). This PNA identifies those as LCS.

The HWB notes, with the single exception of TCES in North locality, all enhanced services and LCS are accessible to the population in all PNA localities. The HWB also notes that it is unclear in some cases if these services are meeting the needs of the local population due to a lack of activity data and service review. Nevertheless, the HWB has not been presented with any evidence to date which concludes that any of these enhanced services or LCS should be decommissioned or expanded. Based on current information, the HWB has not identified a need to commission any enhanced pharmaceutical services not currently commissioned.

Accessing all information used to construct this PNA, the HWB consider the location, number, distribution and choice of pharmacies covering each of the six localities and the whole HWB area providing enhanced services and LCS, to provide an improvement and better access for population. Based on the current information and evidence available, this conclusion also applied when considering any future circumstances within the time horizon of the PNA.

Section 7: Conclusions

7.1 Current provision – necessary and other relevant services

Barking and Dagenham HWB has identified necessary services in Section 6 as essential services and advanced services as required by Paragraphs 1 and 3 of Schedule 1 to the Regulations

Barking and Dagenham HWB has identified enhanced services in Section 3.6 as pharmaceutical services which secure improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

Barking and Dagenham HWB has identified locally commissioned services in Sections 4.1 and 4.2 which secure improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

7.2 Necessary services – gaps in provision

In reference to Section 6 and required by Paragraph 2 of Schedule 1 to the Regulations:

7.2.1 Access to essential services

In order to assess the provision of essential services against the needs of the residents of Barking and Dagenham, the HWB consider access (travelling times by car, public transport and walking) and opening hours as the most important factors in determining the extent to which the current provision of essential services meets the needs of the population.

7.2.1.1 Access to essential services normal working hours

Barking and Dagenham HWB has determined that the travelling times by car, public transport and walking and opening hours of pharmacies in all six localities and across the whole HWB area are reasonable in all the circumstances.

There is no gap in the provision of essential services during normal working hours across the whole HWB area.

7.2.1.2 Access to essential services outside normal working hours

Supplementary opening hours are offered by all pharmacies in each locality. There are also three 100 hour contract pharmacies and four “late night” pharmacies open until at least 8pm on week days or weekends.

Almost one in five (18%), of pharmacies within the HWB area are either 100 hour or late night opening pharmacies (open until at least 8pm on weekdays).

These are geographically spread across the HWB area and present in four localities out of six (West, North, Central and South West). This is a substantial proportion of pharmacies. There is no pharmacy open on Sunday in the East locality. Based upon the results of the patient survey, population density (Section 2) and access to pharmacies across the HWB area there is no gap in service which would equate to the need for access to essential services outside normal hours in this locality. The HWB will monitor the uptake and need for necessary services and will consider the impact of any changes in these localities in the future which may provide evidence that a need exists.

There are no gaps in the provision of essential services outside of normal working hours across the whole HWB area.

7.2.2 Access to advanced services

Section 6 defines the level of access to advanced services. There is no identified gap in the provision of advanced services as medicines use reviews (MURs) are accessible in 89-100% of pharmacies across all six localities and new medicines services (NMS) are available in 83-100% of pharmacies across all six localities.

There are no gaps in the provision of advanced services across the whole HWB area.

7.2.3 Access to enhanced services

Section 6 defines the level of access to enhanced services. The PURM service is currently being run as a pilot until April 2015. There is no identified gap in the provision of enhanced services as minor ailments services are accessible in 62-100% of pharmacies across all six localities and immunisation services are accessible in 78-100% of pharmacies across all six localities.

There are no gaps in the provision of enhanced services across the whole HWB area.

7.2.4 Future provision of necessary services

Barking and Dagenham HWB has not identified any pharmaceutical services that are not currently provided but that will, in specified future circumstances, need to be provided in order to meet a need for pharmaceutical services in any of the six localities.

The population growth, coupled with the growing ageing population, will be key drivers for the need for continued growth of pharmaceutical service provision. For each new planned housing development, listed in section 2.5.6, the location and accessibility of existing pharmaceutical service provision has been reviewed by the HWB to ensure there is adequate provision for the new community. Considering the new developments planned for the borough, the HWB is satisfied that in all cases, adequate provision exists for all services in all areas of new developments for the time horizon of this PNA.

No gaps in the need for pharmaceutical services in specified future circumstances have been identified across the whole HWB area.

7.3 Improvements and better access – gaps in provision

As described in Section 6 and required by Paragraph 4 of Schedule 1 to the 2013 Regulations:

7.3.1 Current and future access to essential services

Barking and Dagenham HWB has not identified services that would, if provided either now or in future specified circumstances, secure improvements to or better access to essential services in any of the six localities.

It is recognised that commissioners have expressed strategies on varying how health and social care may be provided in the borough in the future. The HWB are not aware of any firm plans affecting the need for pharmaceutical service provision.

A trial extension of GP practice appointments (between 6.30pm and 10pm weekdays) is currently underway, with a potential to extend to Saturday and Sundays. The HWB considers that there are no gaps for pharmaceutical service provision as a result of the extended GP practice services on weekday evenings and weekends throughout the whole HWB area. Should a need for additional pharmaceutical service provision be proposed within any particular area, existing providers should be encouraged to meet this need, and therefore not be translated into a gap in service provision.

No gaps have been identified in essential services that if provided either now or in the future would secure improvements, or better access, to essential services across the whole HWB area.

7.3.2 Current and future access to advanced services

In 2013/14 MURs are available in 89-100% of pharmacies across all localities and NMS is available in 83-100% of pharmacies across all localities. Where applicable, NHS England should encourage all pharmacies and pharmacists to become eligible to deliver the service in all pharmacies so that more suitable patients are able to access and benefit from this service.

Demand for the appliance advanced services stoma appliance customisation (SAC) and appliance use reviews (AUR) is lower than for the other two advanced services due to the much smaller proportion of the population that may require the services. Pharmacies and DACs may choose which appliances they provide and may also choose whether or not to provide the two related advanced services. NHS England should encourage those contractors in the area that do provide appliances to become eligible to deliver these advanced services where appropriate.

There are no gaps in the provision of advanced services at present or in the future that would secure improvement or better access to advanced services across the whole HWB area.

7.3.3 Current and future access to enhanced services

NHS England commissions two enhanced services from pharmacies. It also commissions immunisation services from other non-pharmacy providers, principally GP practices.

Some of the enhanced services listed in the 2013 Directions (Section 1.3.1) are now commissioned by Barking and Dagenham CCG (anti-coagulation) or LBBD (NHS Health Checks, Emergency Hormonal Contraception (EHC), chlamydia screening, condom supply, stop smoking, supervised consumption, needle exchange and Transforming Community Equipment Services (TCES) and therefore fall outside of the definition of both enhanced services and pharmaceutical services.

There are no gaps identified in respect of securing improvements, or better access, to enhanced services provision on a locality basis as identified in Section 6 either now or in specified future circumstances. The HWB will monitor the uptake and need for

enhanced services within the HWB area to establish if these services are meeting the needs of the local population.

No gaps have been identified that if provided either now or in the future would secure improvements, or better access to enhanced services across the whole HWB area.

Comprehensive service reviews are required in order to establish if currently and in future scenarios enhanced services secure improvement or better access as an enhanced services across the whole HWB area.

7.4 Other NHS services

As required by Paragraph 5 of Schedule 1 to the 2013 Regulations, Barking and Dagenham HWB has considered the implications of any other NHS services that may affect the need for pharmaceutical services in the area of the HWB.

Based on current information no gaps have been identified in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances across the whole HWB area.

7.5 Locally commissioned services

With regard to enhanced services and locally commissioned services, the HWB is mindful that only those commissioned by NHS England are regarded as pharmaceutical services. The absence of a particular service being commissioned by NHS England is in some cases addressed by a service being commissioned through Barking and Dagenham CCG (anti-coagulation) or LBBD (NHS Health Checks, EHC, chlamydia screening, condom supply, stop smoking, supervised consumption, needle exchange and TCES). This PNA identifies those as locally commissioned services (LCS).

The HWB notes that, with the single exception of TCES in North locality, all LCS are accessible to the population in all PNA localities. The HWB also notes that it is unclear if these services are meeting the needs of the local population due to a lack of activity data and a lack of service review. With the exception of anti-coagulation service, the HBW has not been presented with any evidence to date which concludes that any of these LCS should be decommissioned or expanded. Based on current information, the HWB has not identified a need to commission any LCS not currently commissioned.

Regular service reviews are recommended in order to establish if currently and in future scenarios locally commissioned services secure improvement or better access across the whole HWB area.

Appendix A: List of pharmaceutical service providers in Barking and Dagenham HWB area

East locality

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
8	Britannia Pharmacy	5 Althorne Way, Dagenham, RM10 7AY	40hr	09:00-19:00	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y
22	Fittleworth Medical	7 The Midas Business Centre, Wantz Road, Dagenham RM10 8PS	DAC	08:00-20:00	09:00-13:00	Closed	Y	N	N	N	N	N	N	N	N	N	N	N
28	Oxlow Chemist	217 Oxlow Lane, Dagenham, RM10 7YA	40hr	09:00-19:00	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	Y
34	Talati Chemists	282 The Heathway, Dagenham, RM10 8QS	40hr	09:00-18:30	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y
39	Waller Pharmacy	279 Heathway, Dagenham, Essex. RM9 5AQ	40hr	09:00-18:30	09:00-17:30	Closed	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y

West locality

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
Page 331	Boots The Chemists Ltd.	68 East Street, Barking, Essex. IG11 8EQ	40hr	09:00-19:00	09:00-19:00	11:00-17:00	Y	Y	Y	Y	Y	N	N	N	Y	N	N	N
16	Daynight Pharmacy	17 Station Parade, Barking, Essex. IG11 8ED	100hr	08:00-23:59	10:00-23:59	11:00-17:00	Y	Y	N	N	Y	N	N	N	Y	Y	Y	N
23	Lords Chemist	35 Station Parade, Barking, Essex. IG11 8EB	40hr	09:00-19:30	09:00-17:00	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y
25	Mayors Chemist	214 Ripple Road, Barking, Essex. IG11 7PR	40hr	09:00-19:30 (Thurs 09:00-16:00)	09:00-16:00	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	N	N	N

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
2	S S Kalsi	125 St.Marys Parade, Gascoigne Road, Barking, Essex. IG11 7TF	40hr	09:00-18:30 (Thur 09:00-17:30)	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
33	Superdrug Chemist	12-13 Station Parade, Barking, Essex. IG11 8DN	40hr	08:30-18:00	08:30-18:00	Closed	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y
35	Tesco Instore Pharmacy	Highbridge Road, Barking, Essex. IG11 7BS	100hr	Mon 08:00-22:00, Tue-Fri 06:00-22:00	06:00-22:00	10:00-16:00	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y
37	Thomas Chemist	19 Ripple Road, Barking, Essex. IG11 7NN	40hr	09:00-18:30	09:00-17:30	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y

North locality

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
20	Lloyds Pharmacy	167- 169 High Road, Chadwell Heath, Romford, Essex. RM6 6NL	40hr	09:00-18:30	09:00-13:00	Closed	Y	Y	Y	N	N	N	Y	N	Y	N	Y	N
24	Mastaa-Care Pharmacy	26 Whalebone Lane South, Dagenham, Essex. RM8 1BJ	40hr	09:00-19:00 (Thur 09:00-17:30)	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	N
30	Sainsburys Pharmacy	97-131 High Road, Chadwell Heath, Essex. RM6 6PA	40hr	08:00-20:00	08:00-20:00	10:00-16:00	Y	Y	Y	Y	N	N	N	N	N	N	N	N

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
35	Super.Care Pharmacy+	198-200 High Road, Chadwell Heath, Romford, Essex. RM6 6LU	100hr	08:00-23:59	08:00-23:59	11:00-16:00	Y	Y	Y	Y	Y	N	N	N	Y	N	Y	N
36	The Co-Operative Pharmacy	107 Rose Lane, Chadwell Heath, Romford, Essex. RM6 5NR	40hr	09:00-18:00	09:00-17:00	Closed	Y	Y	Y	Y	N	N	N	N	N	Y	Y	Y

Central locality

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
1	Alvin Rose Chemist	606 Longbridge Road, Dagenham, Essex. RM8 2AJ	40hr	09:00-19:00	09:00-17:30	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y
2	Andrew Bass Pharmacy	1148 Green Lane, Becontree Heath, Dagenham, Essex. RM8 1BP	40hr	09:00-18:00	09:00-13:00	Closed	Y	N	N	Y	Y	N	N	Y	N	N	N	N
8	Britannia Pharmacy	453 Porters Ave, Dagenham, Essex. RM9 4ND	40hr	09:00-18:00	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
12	David Lewis Chemist	16 Porters Ave, Dagenham, Essex. RM8 2AQ	40hr	09:00-20:00	09:00-17:30	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y
17	Hannigan Pharmacy	240 Bennetts Castle Lane, Beacontree, Dagenham. RM8 3UU	40hr	09:00-18:30	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	N
21	Lloyds Pharmacy	281 Wood Lane, Dagenham, Essex. RM8 3NL	40hr	09:00-19:00	09:00-17:30	Closed	Y	Y	Y	Y	N	N	Y	N	Y	Y	Y	N
27	Nuchem Pharmacy	778 Green Lane Dagenham Essex, RM8 1YT	40hr	09:00-18:30	09:00-19:00	Closed	Y	Y	Y	Y	N	N	N	Y	Y	N	Y	Y

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
37	Sandbern Pharmacy	703-705 Green Lane, Dagenham, Essex. RM8 1UU	40hr	Mon- Fri 09:00-19:30	09:00-14:00	10:00-16:00	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y
38	Valence Pharmacy	453 Becontree Avenue, Dagenham, Essex. RM8 3UL	40hr	09:00-18:30	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	N	N	N	N	Y	N

South East locality

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
5	Boots the Chemist	17 The Mall, Heathway, Dagenham, Essex. RM10 8RD	40hr	08:30-17:30	08:30-17:30	10:00-16:00	Y	Y	Y	Y	N	N	Y	N	Y	N	N	Y
13	Day Lewis Pharmacy	2 Royal Parade, Church Street, Dagenham, Essex. RM10 9XB	40hr	09:00-18:00	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	N	N	Y	N	Y	N
14	Day Lewis Pharmacy	149 Broad Street, Dagenham, Essex. RM10 9HX	40hr	09:00-19:00	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	N

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
17	Day Lewis Pharmacy	7 Beadles Parade, Rainham Road South, Dagenham, Essex. RM10 8YL	40hr	09:00-18:00	Closed	Closed	Y	Y	Y	Y	Y	N	N	N	Y	N	N	N
18	Hedgemans Pharmacy	428 Hedgemans Road, Dagenham, Essex. RM9 6BU	40hr	09:00-19:00	09:00-17:30	Closed	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y
19	Kry-Ba Pharmacy	21 Goresbrook Road, Dagenham, Essex. RM9 6XA	40hr	09:00-18:30	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y	Y

South West locality

Marker	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
3	Asda Pharmacy	Merrielands Crescent, Dagenham, Essex. RM9 6SJ	40hr	08:00-22:00	09:00-20:00	10:00-16:00	Y	Y	N	Y	Y	N	Y	N	N	N	Y	N
4	Boots Pharmacy	454 Lodge Avenue, Dagenham, Essex. RM9 4QS	40hr	09:00-18:30	09:00-13:00	Closed	Y	Y	Y	Y	N	N	N	N	Y	Y	N	N
7	Britannia Pharmacy	11 Faircross Parade, Longbridge Road, Braking, Essex. IG11 8UN	40hr	09:00-18:00 (Thur 09:00-13:00)	09:00-18:00	Closed	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y

Map ref	Name of Pharmacy	Address	Type of contract	Mon-Fri Opening Hours	Sat Opening Hours	Sun Opening Hours	Electronic Prescription Service, as per NHS Choices (Y/N)	NHS England Advanced service providers		NHS England Enhanced Services- providers in 2013/14 (Y/N)		CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15					
								MURs	NMS	Minor Ailments Service	Immunisation Service	Anti-coagulation service	NHS Health Checks	TCES	Supervised consumption	Needle exchange	Tier 2 Smoking cessation service	Sexual Health (Inc. EHC, Chlamydia Screening and Condom Distribution)
1	Britannia Pharmacy	19 Faircross Parade, Upney Lane, Barking, Essex. IG11 8UW	40hr	09:00-19:00 (Thurs: 09:00-18:00)	09:00-13:00	Closed	Y	Y	Y	Y	Y	N	N	N	Y	N	Y	Y
11	Britannia Pharmacy	Thames Valley Health Centre, Bastable Avenue, Barking, Essex. IG11 0LG	40hr	09:00-19:00	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y
26	Newlands Pharmacy	359 Ripple Road, Barking, Essex. IG11 9PN	40hr	09:00-19:00	09:00-14:00	Closed	Y	Y	Y	Y	Y	N	N	N	Y	N	Y	Y

Appendix B: PNA Steering Group Terms of Reference

1. Objective / purpose

To support the production of a Pharmaceutical Needs Assessment on behalf of the Barking and Dagenham Health and Wellbeing Board, to ensure that it satisfies the relevant regulations including consultation requirements.

2. Accountability

The steering group is to report to the Barking and Dagenham Health and Wellbeing Board.

3. Membership

The steering group is to consist of:

- Health and Wellbeing Board lead member for the PNA (Chair)
- NHS England Area Team representative
- Local Medical Committee representative
- Local Pharmaceutical Committee representative
- Dispensing Doctors representative (if applicable)
- Clinical Commissioning Group (CCG) representative
- Council – Consultation Lead
- CCG Head of Patient and Public Involvement
- Healthwatch representative (lay member)

Additional members may be co-opted on to the group for particular roles.

4. Frequency of meetings

Meetings in 2014/15 will be arranged at key stages of the project plan. The steering group will meet in December 2014 to sign off the PNA for submission to the Health and Wellbeing Board.

5. Responsibilities

- Soar Beyond to provide a clear and concise PNA process
- Soar Beyond to collate and analyse information to inform the PNA
- steering group to review and validate information and data on population, demographics, pharmaceutical provision, and health needs
- Soar Beyond to facilitate the process of consultation to ensure the steering group consult with the bodies stated in Regulation 8 of The NHS Regulations 2013:

    - any Local Pharmaceutical Committee for its area
    - any Local Medical Committee for its area
    - any persons on the pharmaceutical lists and any dispensing doctors list for its area
    - any LPS chemist in its area
    - any Local Healthwatch organisation for its area
    - any NHS trust or NHS foundation trust in its area
    - the NHSCB
    - any neighbouring HWB
- ensure that due process is followed
- report to Health and Wellbeing Board on both a draft and final PNA.
- publish a final PNA by end 1st April 2015.

Appendix C: Patient survey

Tell us what you think of pharmacy services

We want to hear what you think of pharmacy services in Barking and Dagenham to help us develop services in the future. Your views will help us to develop our Pharmacy Needs Assessment (PNA), which will look at health needs in Barking and Dagenham, the level and accessibility of pharmacy services and how these will be maintained and developed in the future.

We would be grateful if you would take a few minutes to answer the questions below about your own experience and views. The information you provide is confidential. Please be honest with your answers so we can accurately assess areas where pharmacies are already performing well and areas that need improvement. Information returned about you will be recorded separately from your questionnaire response.

Closing date for this questionnaire is 3rd November 2014

Please return the questionnaire to your GP practice or Pharmacist or by post to:

Ellen Doran

London Borough of Barking and Dagenham, Room 218, Barking Town Hall, 1 Town Square, Barking, IG11 7LU

Should you require this questionnaire in any other format or language, please contact Name

E-mail: Ellen.doran@lbbd.gov.uk
Tel. no: 02082273861

N.B. All information supplied will be kept strictly confidential, held securely, and used for the purpose of planning appropriate services for all communities, it will not be passed on to any third party.

1) How often have you visited the pharmacy in the last 6 months?

For yourself:

- More than once a week
- Once a week
- Once every couple of weeks
- Once a month
- Once every few months
- Once in 6 months

For someone else:

- More than once a week
- Once a week
- Once every couple of weeks
- Once a month
- Once every few months
- Once in 6 months

2) Do you have a regular or preferred pharmacy that you visit?

- Yes
- No

3) When considering choice of pharmacy, which of the following helps you choose? (Please select all that apply)

- Close to home
- Close to GP surgery
- Close to work
- They offer a specific service
- Friendly staff
- Prefer not to say
- Other, please specify

4) Who would you normally visit the pharmacy for? (Please select all that apply)

- Yourself
- A family member
- Neighbour / friend
- Someone you are a carer for
- Other, please specify

5) If you visit your pharmacy on behalf of someone else, please give a reason why (you may select more than one answer).

- Opening hours of the pharmacy not suitable for patient
- Access (for example disability / transport)
- Most convenient
- Other, please specify

6) How would you usually travel to the pharmacy? (Please select one answer)

- Car / taxi
- Public transport
- Walk
- Bicycle
- Other, please specify

7) On average, how long does it take you to travel to a pharmacy? (Please select one answer)

- 0 to 10 minutes
- 10 to 20 minutes
- 20 to 30 minutes
- Over 30 minutes
- Don't know / not sure / varies

8) Do you have any difficulties when travelling to your pharmacy due to the following reasons? (Please select one answer)

- Location of pharmacy
- Parking difficulties
- Public transport availability
- No difficulties

9) What is the most convenient day for you to visit your pharmacy? (Select one answer)

- Monday to Friday
- Saturday
- Sunday
- Don’t mind / varies

10) What is the most convenient time for you to visit your pharmacy? (Please select one answer)

- Morning
- Lunchtime
- Afternoon
- Early evening
- Late evening
- Don’t mind / varies

11) How regularly do you buy an over the counter medicine from a pharmacy? (Please select one answer)

- More than once a week
- Weekly
- More than once a month
- Monthly
- More than once a year but less than monthly
- Yearly
- Less than once a year
- Never
- Prefer not to say

12) Do you buy an over the counter medicine from anywhere else? (Please select all that apply)

- Nowhere else
- Supermarket
- The internet
- Garage / petrol station
- Local / community shop
- Other shop
- Vending machine
- Prefer not to say

13) How do you rate the ease of obtaining medication (for example - waiting time or stock availability)?

- Excellent
- Good
- Fair
- Poor

14) Are you provided with sufficient information about your medication (such as dosage and side effects)?

- Yes
- No

15) Would you ask your pharmacist for advice about medication prescribed by your GP?

- Yes
- No

16) Which of the following pharmacy services are you aware that your pharmacy provides? (Please select all that apply)

- Dispensing of prescriptions
- Repeat prescriptions
- Home delivery and prescription collection services
- Buying over the counter medicines
- Advice from your pharmacist (e.g. healthy lifestyle, medicines advice, signposting)
- Disposing of unwanted medicines
- Sitting down with your pharmacist and talking about how to use your medicines
- Stopping smoking / nicotine replacement therapy
- Sexual health services (pregnancy testing, Chlamydia testing / treating, condom distribution, emergency contraception
- Palliative care
- Getting medicines for free without a prescription for minor ailments
- Supervised consumption of methadone and buprenorphine
- Needle exchange

17) How often have you used any of the following services at your pharmacy?

	At least once a month	Every 1 – 3 months	Occasionally	Never
Dispensing of prescriptions	☐	☐	☐	☐
Repeat dispensing	☐	☐	☐	☐
Home delivery and prescription collection services	☐	☐	☐	☐
Buying over the counter medicines	☐	☐	☐	☐
Advice from your pharmacist (e.g. healthy lifestyle, medicines advice, signposting)	☐	☐	☐	☐
Disposing of unwanted medicines	☐	☐	☐	☐
Sitting down with your pharmacist and talking about how you use your medicines	☐	☐	☐	☐
Stop smoking/nicotine replacement therapy	☐	☐	☐	☐
Sexual health services (pregnancy testing, Chlamydia testing/treating, condom distribution, emergency contraception)	☐	☐	☐	☐
Palliative care	☐	☐	☐	☐
Getting medicines for free without a prescription for minor ailments	☐	☐	☐	☐
Supervised consumption of methadone and buprenorphine	☐	☐	☐	☐
Needle exchange	☐	☐	☐	☐

18) How would you rate your confidence in the pharmacist's knowledge and advice?

- Excellent
- Good
- Fair
- Poor

19) Did you know the pharmacists can give private consultations?

- Yes
- No

20) Is there a private consultation room available in the pharmacy you normally visit?

- Yes
- No
- Don't know

21) Would you like to see any other services provide by pharmacists?

	Yes	No
Annual review of medication		
Cholesterol/lipid measurement and advice		
Head lice management		
Pregnancy testing		
Prescription home delivery service		
Smoking cessation		
Other (please specify)		

22) Please could we have the name of the pharmacy you use the most?

23) How do you rate your overall satisfaction with this pharmacy?

- Excellent
- Good
- Fair
- Poor

Any other comments you would like to make about your pharmacy?

Thank you for your time completing this questionnaire

If you wish to be kept informed about the Pharmaceutical Needs Assessment and the consultation we will be running, you can give us your contact details here

Name

Address

Telephone

Email

Preferred method of communication

Your answers to this survey are private and will be kept in line with the Data Protection Act.

Please return the questionnaire to your GP practice or Pharmacist or by post to:

Ellen Doran

London Borough of Barking and Dagenham, Room 218, Barking Town Hall, 1 Town Square, Barking, IG11 7LU

Thank you for completing this survey

A bit about you

This information is being collected anonymously and will only be used for the purpose of improving Barking and Dagenham's consultation service.

1) Are you male or female? (Please tick one box) □ Male □ Female

2) What is your age?

□ 17 or under □ 18 – 24 □ 25 – 34 □ 35 – 44 □ 45 – 59

□ Over 60 years

3) How would you describe your ethnic origin?

White - □ British White □ Irish White □ Any other White background (Please specify)

Dual Heritage - □ White and Black Caribbean □ White and Black African □ White and Asian

□ Any other dual heritage background (Please specify)

Asian/Asian British - □ Indian □ Pakistani □ Chinese □ Bangladeshi

□ Any other Asian background (Please specify)

Black/Black British - □ Caribbean □ African □ any other Black background (Please specify)

Other ethnic group - □ Arab □ Gypsy/Romany/Irish Traveller □ Any other ethnic group (Please specify)

4) If you are disabled, would you describe your impairment as (tick all that apply)

□ Visual □ Speech □ Hearing □ Mobility (a wheelchair user)

□ Mobility (not a wheelchair user) □ Learning disability □ Mental Health

□ Hidden Impairment □ Other (Please specify)

5) Are you:

□ Heterosexual □ Gay man/Lesbian □ Bisexual □ Prefer not to say

6) What is your religion, faith or belief?

□ Baha'i □ Buddhist □ Christian (inc. Church of England, Hindu Catholic, Protestant and any other Christian denomination □ Hindu □ Judaism □ Muslim □ Sikh □ Taoism

Appendix D: Pharmacy contractor survey

Barking & Dagenham PNA Pharmacy Contractor Survey

We would be grateful if you would take a few minutes to answer the questions below about your pharmacy and the services you currently offer or plan to offer in the future. Your views will help us to develop our Pharmacy Needs Assessment (PNA) which will look at health needs in Barking & Dagenham.

Closing date for this questionnaire is 3rd November 2014

This survey is based upon the PSNC Pharmacy Questionnaire v4 (December 2013) as approved by Barking & Dagenham LPC

Barking & Dagenham PNA Pharmacy Contractor Survey

Premises Details

*1. Contractor Code (ODS Code)

*2. Name of contractor (i.e. name of individual, partnership or company owning the pharmacy business)

*3. Trading Name

*4. Address of Contractor

*5. Is this pharmacy a Distance Selling Pharmacy? (i.e. it cannot provide Essential Services to persons present at the pharmacy)

- ◯ Yes
- ◯ No

*6. Pharmacy email address

*7. Pharmacy telephone

8. Pharmacy fax

9. Pharmacy website address

10. Can we store the above information and use this to contact you?

- ◯ Yes
- ◯ No

Barking & Dagenham PNA Pharmacy Contractor Survey

Opening time and accessibility

*** 11. Core hours of opening**

	From	To	Lunchtime start	Lunchtime end
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

*** 12. Total hours of opening**

	From	To	Lunchtime start	Lunchtime end
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Barking & Dagenham PNA Pharmacy Contractor Survey

Consultation Facilities

*** 13. On the premises, is there a consultation area (meeting the criteria for the Medicines Use Review service)?**

- ◯ None
- ◯ Available (including wheelchair access)
- ◯ Available (without wheelchair access)
- ◯ Planned within the next 12 months
- ◯ Other (please specify)

14. Where there is a consultation area, is it a closed room?

- ◯ Yes
- ◯ No

*** 15. Does the pharmacy have access to an off-site consultation area (i.e. one which the former PCT or Area Team has given consent for use)**

- ◯ Yes
- ◯ No

*** 16. Is the pharmacy willing to undertake consultations in patient's home/ other suitable site?**

- ◯ Yes
- ◯ No

*** 17. During consultations, are there hand-washing facilities?**

- ◯ In the consultation area
- ◯ Close to the consultation area
- ◯ None

*** 18. Do patients attending consultations have access to toilet facilities?**

- ◯ Yes
- ◯ No

19. Languages spoken (in addition to English)

Barking & Dagenham PNA Pharmacy Contractor Survey

IT Facilities

*** 20. Electronic Prescription Service (select any that apply)**

- [ ] Release 1 enabled
- [ ] Release 2 enabled
- [ ] Intending to become Release 1 enabled within next 12 months
- [ ] Intending to become Release 2 enabled within next 12 months
- [ ] No plans for EPS at present

Barking & Dagenham PNA Pharmacy Contractor Survey

Services

***21. Essential services**

Does the pharmacy dispense appliances?

- ◯ Yes, all types
- ◯ Yes, excluding stoma appliances
- ◯ Yes, excluding incontinence appliances
- ◯ Yes, excluding stoma and incontinence appliances
- ◯ Yes, just dressings
- ◯ None
- ◯ Other (please specify)

***22. Advanced services**

Does the pharmacy provide the following services?

	Yes	Intending to begin within the next 12 months	No, and not intending to provide
Medicines Use Review service	◯	◯	◯
New Medicine service	◯	◯	◯
Appliance Use Review service	◯	◯	◯
Stoma Appliance Customisation service	◯	◯	◯

Barking & Dagenham PNA Pharmacy Contractor Survey

*** 23. Enhanced and Other locally Commissioned Services**
Which of the following services does the pharmacy provide, or would be willing to provide?

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Anticoagulant Monitoring Service	◯	◯	◯	◯	◯
Anti-viral Distribution Service	◯	◯	◯	◯	◯
Care Home Service	◯	◯	◯	◯	◯
Chlamydia Testing Service	◯	◯	◯	◯	◯
Chlamydia Treatment Service	◯	◯	◯	◯	◯
Contraceptive Service (not EHC)	◯	◯	◯	◯	◯

*** 24. Other than dispensing services, does your pharmacy offer any of the following disease specific services?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Allergies	◯	◯	◯	◯	◯
Alzheimer's/dementia	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯
CHD	◯	◯	◯	◯	◯
COPD	◯	◯	◯	◯	◯
Depression	◯	◯	◯	◯	◯
Diabetes Type I	◯	◯	◯	◯	◯
Diabetes Type II	◯	◯	◯	◯	◯
Epilepsy	◯	◯	◯	◯	◯
Heart Failure	◯	◯	◯	◯	◯
Hypertension	◯	◯	◯	◯	◯
Parkinson's Disease	◯	◯	◯	◯	◯
Other (please specify below)	◯	◯	◯	◯	◯

Barking & Dagenham PNA Pharmacy Contractor Survey

*** 25. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Emergency Hormonal Contraception Service	◯	◯	◯	◯	◯
Gluten Free Food Supply Service(i.e. not via FP10)	◯	◯	◯	◯	◯
Home Delivery Service (not appliances)	◯	◯	◯	◯	◯
Independent Prescribing Service	◯	◯	◯	◯	◯

If currently providing an Independent Prescribing Service, what therapeutic areas are covered?

*** 26. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Language Access Service	◯	◯	◯	◯	◯
Medication Review Service	◯	◯	◯	◯	◯
Medicines Assessment and Compliance Support Service	◯	◯	◯	◯	◯
Minor Ailment Scheme	◯	◯	◯	◯	◯
MUR plus/ Medicines Optimisation Service	◯	◯	◯	◯	◯

If currently providing MUR plus/ Medicines Optimisation Service, what therapeutic areas are covered?

Barking & Dagenham PNA Pharmacy Contractor Survey

*** 27. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Needle and Syringe Exchange Service	◯	◯	◯	◯	◯
Obesity management (adults and children)	◯	◯	◯	◯	◯
On Demand Availability of Specialist Drugs Service	◯	◯	◯	◯	◯
Out of Hours Services	◯	◯	◯	◯	◯
Patient Group Direction Service (name the medicines covered by the Patient Group direction below)	◯	◯	◯	◯	◯
Phlebotomy Service	◯	◯	◯	◯	◯
Prescriber Support Service	◯	◯	◯	◯	◯
Schools Service	◯	◯	◯	◯	◯

Insert medicines covered by the Patient Group direction below

Barking & Dagenham PNA Pharmacy Contractor Survey

*** 28. Are the following screening and monitoring services offered?**

	Currently provide via NHS	Currently provide privately	Currently provide via LA	Would be willing to provide if commissioned	Not willing or able to provide
Alcohol	◯	◯	◯	◯	◯
Cholesterol	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯
Gonorrhoea	◯	◯	◯	◯	◯
H. Pylori	◯	◯	◯	◯	◯
HbA1C	◯	◯	◯	◯	◯
Hepatitis	◯	◯	◯	◯	◯
HIV	◯	◯	◯	◯	◯
Seasonal Influenza Vaccination Service	◯	◯	◯	◯	◯
Other (please specify below)	◯	◯	◯	◯	◯

*** 29. Which of the following other vaccination services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Childhood vaccinations	◯	◯	◯	◯	◯
Hepatitis (at risk workers or patients)	◯	◯	◯	◯	◯
HPV	◯	◯	◯	◯	◯
Travel vaccines	◯	◯	◯	◯	◯

Other (please specify)

Barking & Dagenham PNA Pharmacy Contractor Survey

*** 30. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Sharps Disposal Service	◯	◯	◯	◯	◯
Stop Smoking Service	◯	◯	◯	◯	◯
Supervised Administration Service	◯	◯	◯	◯	◯
Vascular Risk Assessment Service (NHS Health Check)	◯	◯	◯	◯	◯

Supplementary Prescribing Service (what therapeutic areas are covered?)

Barking & Dagenham PNA Pharmacy Contractor Survey

Non-commissioned services

*** 31. Does the pharmacy provide any of the following?**

	Yes	No
Collection of prescriptions from GP practices	◯	◯
Delivery of dispensed medicines - free of charge on request	◯	◯
Delivery of dispensed medicines - selected patient groups	◯	◯
Delivery of dispensed medicines – selected areas	◯	◯
Delivery of dispensed medicines - chargeable	◯	◯

Barking & Dagenham PNA Pharmacy Contractor Survey

Details of the person completing this form

* **32. Contact name of person completing questionnaire, if questions arise**

* **33. Contact telephone number**

Barking & Dagenham PNA Pharmacy Contractor Survey

Thank you for completing this survey.

Your answers to this survey are private and will be kept in line with the Data Protection Act.

Appendix E: Commissioner Survey

Barking & Dagenham PNA - Commissioner Questionnaire

We would be grateful if you would take a few minutes to answer the questions below about pharmacy services that are, or may be, commissioned from pharmacies in Barking & Dagenham. Your views will help us to develop our Pharmacy Needs Assessment (PNA) which will look at health needs in Barking & Dagenham.

Closing date for this questionnaire is 3rd November 2014.

N.B. All information supplied will be kept strictly confidential, held securely, and used for the purpose of planning appropriate services for all communities, it will not be passed on to any third party.

Barking & Dagenham PNA - Commissioner Questionnaire

1. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Anticoagulant Monitoring Service	◯	◯	◯	◯	◯
Anti-viral Distribution Service	◯	◯	◯	◯	◯
Care Home Service	◯	◯	◯	◯	◯
Chlamydia Testing Service	◯	◯	◯	◯	◯
Chlamydia Treatment Service	◯	◯	◯	◯	◯
Contraceptive service (not EHC)	◯	◯	◯	◯	◯

Barking & Dagenham PNA - Commissioner Questionnaire

Disease Specific Medicines Management Service

2. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Allergy management service	◯	◯	◯	◯	◯
Alzheimers/dementia management service	◯	◯	◯	◯	◯
Asthma management service	◯	◯	◯	◯	◯
CHD management service	◯	◯	◯	◯	◯
COPD management service	◯	◯	◯	◯	◯
Depression management service	◯	◯	◯	◯	◯
Diabetes type I management service	◯	◯	◯	◯	◯
Diabetes type II management service	◯	◯	◯	◯	◯
Epilepsy management service	◯	◯	◯	◯	◯
Heart Failure management service	◯	◯	◯	◯	◯
Hypertension management service	◯	◯	◯	◯	◯
Parkinson's disease	◯	◯	◯	◯	◯
Emergency Hormonal Contraception Service	◯	◯	◯	◯	◯
Gluten Free Food Supply Service (i.e. not via FP10)	◯	◯	◯	◯	◯
Home Delivery Service (not appliances)	◯	◯	◯	◯	◯
Independent Prescribing Service	◯	◯	◯	◯	◯
If currently providing an Independent	◯	◯	◯	◯	◯

Barking & Dagenham PNA - Commissioner Questionnaire

Prescribing Service, what therapeutic areas are covered?					
Language Access Service	◯	◯	◯	◯	◯
Medication Review Service	◯	◯	◯	◯	◯
Medicines Assessment and Compliance Support Service	◯	◯	◯	◯	◯
Minor Ailment Scheme	◯	◯	◯	◯	◯
MUR Plus/Medicines Optimisation Service	◯	◯	◯	◯	◯
If currently providing an MUR Plus/ Medicines Optimisation Service, what therapeutic areas are covered?	◯	◯	◯	◯	◯
Needle and Syringe Exchange Service	◯	◯	◯	◯	◯
Obesity management (adults and children)	◯	◯	◯	◯	◯
On Demand Availability of Specialist Drugs Service	◯	◯	◯	◯	◯
Out of Hours Services	◯	◯	◯	◯	◯
Patient Group Direction Service (name the medicines covered by the Patient Group Direction)	◯	◯	◯	◯	◯
Phlebotomy Service	◯	◯	◯	◯	◯
Prescriber Support Service	◯	◯	◯	◯	◯
Schools Service	◯	◯	◯	◯	◯
Other (please state)	◯	◯	◯	◯	◯

Barking & Dagenham PNA - Commissioner Questionnaire

Screening Service

3. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Alcohol screening service	◯	◯	◯	◯	◯
Cholesterol screening service	◯	◯	◯	◯	◯
Diabetes screening service	◯	◯	◯	◯	◯
Gonorrhoea screening service	◯	◯	◯	◯	◯
H. pylori screening service	◯	◯	◯	◯	◯
HbA1C screening service	◯	◯	◯	◯	◯
Hepatitis screening service	◯	◯	◯	◯	◯
HIV screening service	◯	◯	◯	◯	◯
Seasonal Influenza Vaccination Service (2)	◯	◯	◯	◯	◯
Other (please state below)	◯	◯	◯	◯	◯

Barking & Dagenham PNA - Commissioner Questionnaire

Other vaccinations

4. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Childhood vaccinations	◯	◯	◯	◯	◯
Hepatitis (at risk workers or patients)	◯	◯	◯	◯	◯
HPV	◯	◯	◯	◯	◯
Travel vaccines	◯	◯	◯	◯	◯

Barking & Dagenham PNA - Commissioner Questionnaire

Other miscellaneous

5. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Sharps Disposal Service	◯	◯	◯	◯	◯
Stop Smoking Service	◯	◯	◯	◯	◯
Supervised Administration Service	◯	◯	◯	◯	◯
Supplementary Prescribing Service (what therapeutic areas are covered?)	◯	◯	◯	◯	◯
Vascular Risk Assessment Service (NHS Health Check)	◯	◯	◯	◯	◯
Other (please state below)	◯	◯	◯	◯	◯

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Barking & Dagenham PNA - Commissioner Questionnaire

Thank you for completing this survey.

Your answers to this survey are private and will be kept in line with the Data Protection Act.

Appendix F: PNA timeline

Stage	Dates	Key Actions	Outcomes
Set up	August-September 2014	• HWB paper to outline PNA responsibilities • Produce project plan and secure resources. • Agree work stream plans and timelines.	• Delegated authority to PNA Steering Group for PNA production. • Isolation of necessary funding and resource for PNA production. • Formation of PNA Steering Group and PNA Project Group. Roles and responsibilities defined. Terms of Reference and meeting dates agreed.
Information finding	September-November 2014	• First steering group meeting • Receive information from local authority, LPC, CCG, NHS England, contractors and public.	• Work streams and timeline agreed. • Public and pharmacy questionnaires agreed. • Consultation plan drafted. • Localities agreed. • Maps agreed. • Public Health and Pharmaceutical provision information presented. • Results from public and pharmacy questionnaires presented. • Pharmaceutical provision and access maps presented.
Analysis	November 2014	• Further, focussed public engagement	• Analysis of information finding. Collation of findings to inform draft PNA. Consideration of need for further public qualitative feedback. • Identification and agreement to any potential gaps in provision of services • Agreement of consultation plan.
Draft PNA Production	November-December 2014	• Electronic circulation of various draft PNA documents to steering group members • HWB Board paper.	• Agreement of final draft PNA for consultation • Presentation to HWB on progress and draft PNA

Stage	Dates	Key Actions	Outcomes
		• Second steering group meeting.	
Consultation	19th December 2014 to 27th February 2015		• Distribution and consultation on draft PNA. • Feedback obtained on draft PNA • Collation of responses to consultation.
Final considerations	February-March 2015	• Third steering group meeting	• Analysis of consultation responses. • Agreement on Final PNA
HWB approval	March 2015	• Health and Wellbeing Board report	• Approval and sign-off by HWB Board of Final PNA. • Obtain HWB approval and resource allocation for ongoing review / update PNA
Publish Final PNA	March 2015	• Circulate final PNA and host on HWB / Council website	• HWB PNA now 'live' and used by NHS England to consider 'Control of Entry' applications

Appendix G: Consultation plan and list of stakeholders

PNA Engagement and Consultation Plan								
Stakeholder		**Engagement during PNA production**			**Draft PNA consultation**			
	Role	**PNA Briefing letter sent (Y/N)**	**Steering group representation (Y/N)**	**Questionnaire (Contractor/ Service User/ Commissioner)**	**Briefing letter sent (Y/N)**	**Draft PNA link sent (Y/N)**	**Meeting/ workshop attendance**	**Other**
Consultee as required by Pharmaceutical Regulations, 2103, Part 2 (8)	HWB Area LPC	Y	Y	None	Y	Y	No further activity undertaken	
	HWB Area LMC	Y	Y	None	Y	Y		
	Pharmacy contractor	Y	N	Contractor	Y	Y		
	Dispensing appliance contractor	Y	N	Contractor	Y	Y		
	Local Healthwatch	Y	Y	Service User	Y	Y		
	Various relevant patient groups	N	N	Service User	Y	Y		
	Various relevant community group	N	N	Service User	Y	Y		
	Barking, Havering and Redbridge University Hospital Trust	N	N	None	Y	Y		
	Barts Health	N	N	None	Y	Y		
	NHS England Area Team	Y	Y	Commissioner	Y	Y		
	Havering HWB	N	N	None	Y	Y		
	Redbridge HWB	N	N	None	Y	Y		
	Newham HWB	N	N	None	Y	Y		
	Greenwich HWB	N	N	None	Y	Y		
	Bexley HWB	N	N	None	Y	Y		

PNA Engagement and Consultation Plan								
Stakeholder		**Engagement during PNA production**			**Draft PNA consultation**			
	Role	**PNA Briefing letter sent (Y/N)**	**Steering group representation (Y/N)**	**Questionnaire (Contractor/ Service User/ Commissioner)**	**Briefing letter sent (Y/N)**	**Draft PNA link sent (Y/N)**	**Meeting/ workshop attendance**	**Other**
Other consultee	Havering LPC	Y	N	None	Y	Y	No further activity undertaken	
	Redbridge LPC	N	N	None	Y	Y		
	Newham LPC	N	N	None	Y	Y		
	Greenwich LPC	N	N	None	Y	Y		
	Bexley LPC	N	N	None	Y	Y		
	Havering LMC	N	N	None	Y	Y		
	Redbridge LMC	N	N	None	Y	Y		
	Newham LMC	N	N	None	Y	Y		
	Greenwich LMC	N	N	None	Y	Y		
	Bexley LMC	N	N	None	Y	Y		
	B+D CCG	Y	Y	Commissioner	Y	Y		
	LA Health Intelligence	Y	Y	Commissioner	Y	Y		
	LA Substance Misuse Team	Y	Y	Commissioner	Y	Y		

Appendix H: Summary of consultation responses and comments

As required by the Pharmaceutical Regulations 2013[9], Barking and Dagenham HWB held a consultation on the draft PNA from 20th December 2014 to 27h February 2015.

The draft PNA was hosted on the Barking and Dagenham Council website and invitations to review the assessment, and comment, were sent to a wide range of stakeholders including all community pharmacies in Barking and Dagenham. A number of members of the public had expressed an interest in the PNA and were invited to participate in the consultation as well as a range of public engagement groups in Barking and Dagenham as identified by Barking and Dagenham Council and Barking and Dagenham Healthwatch. Responses to the consultation were possible via an online survey, paper or email.

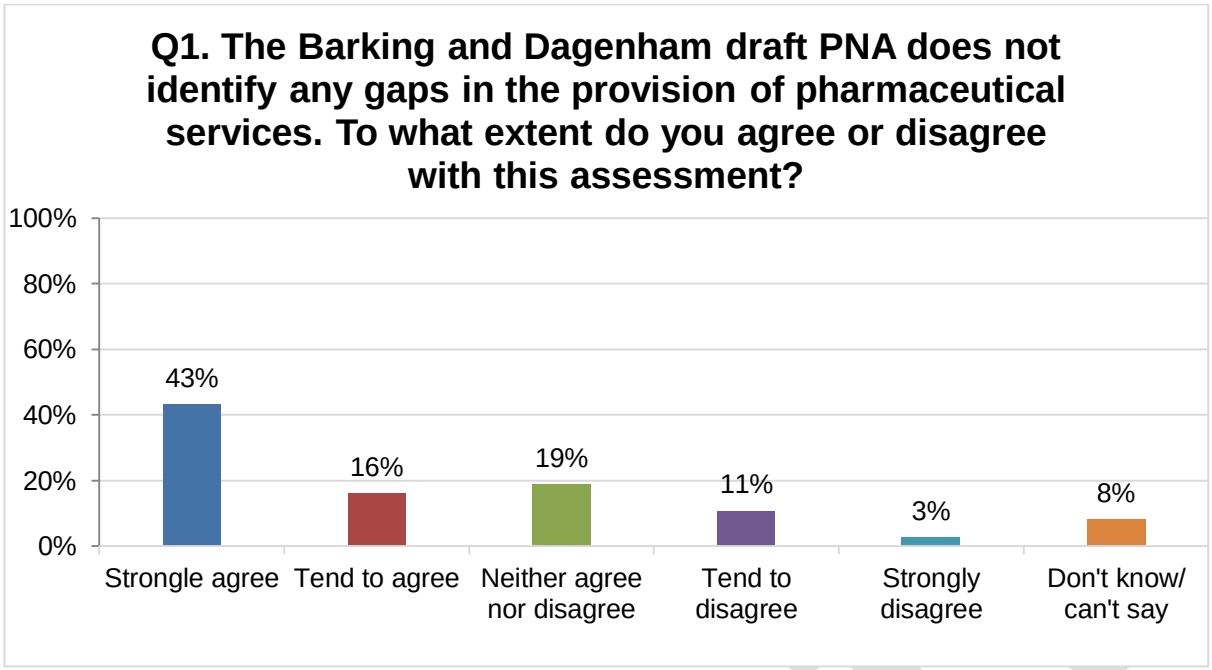
There were in total 43 responses of which 39 were to the internet survey, one was to the paper survey, and three were email comments. 13 responses were received from the public, 18 from community pharmacies, two from Barking and Dagenham Council employees, two businesses and six from 'other' (including NHS England, Barking and Dagenham Clinical Commissioning Group and Barking and Dagenham LPC).

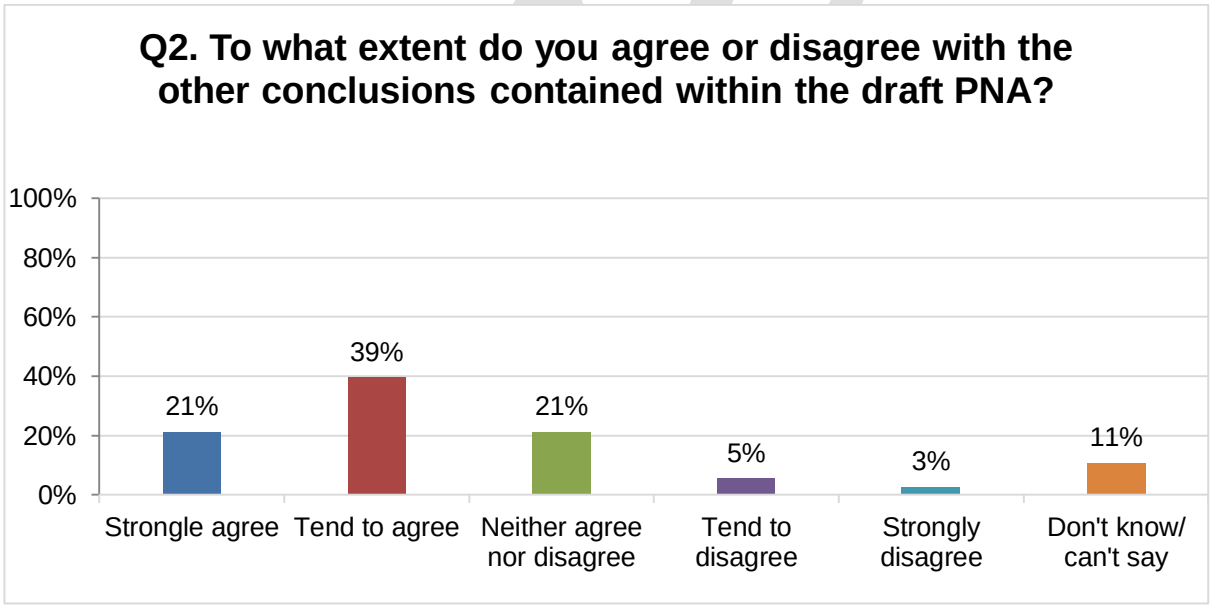
The following are the main themes, and PNA Steering Group's response, to feedback received during the consultation on the draft PNA. All responses were considered by the PNA Steering Group at its meeting on 5th March 2015 for the final report.

- Information provided in the PNA
- Issues over access to services
- Availability of services currently, and not currently, provided by pharmacies
- Correction of data in the PNA
- Population changes with Barking and Dagenham and future service provision

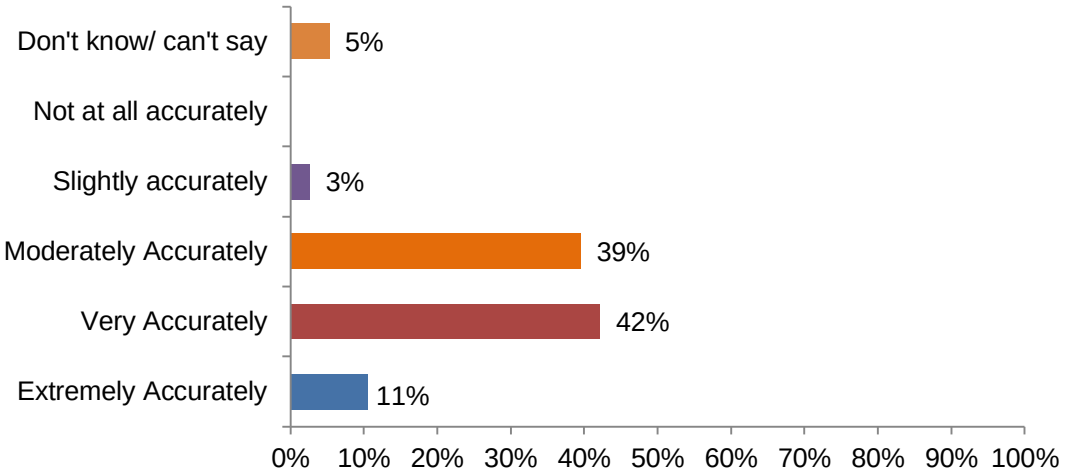
A number of additional comments were received that were considered by the steering group in the production of the final PNA. Should you wish to view these comments please contact Ellen Doran, London Borough of Barking and Dagenham, Room 218, Barking Town Hall, 1 Town Square, Barking, IG11 7LU.

Below is a summary of responses to the specific questions, asked during the consultation.

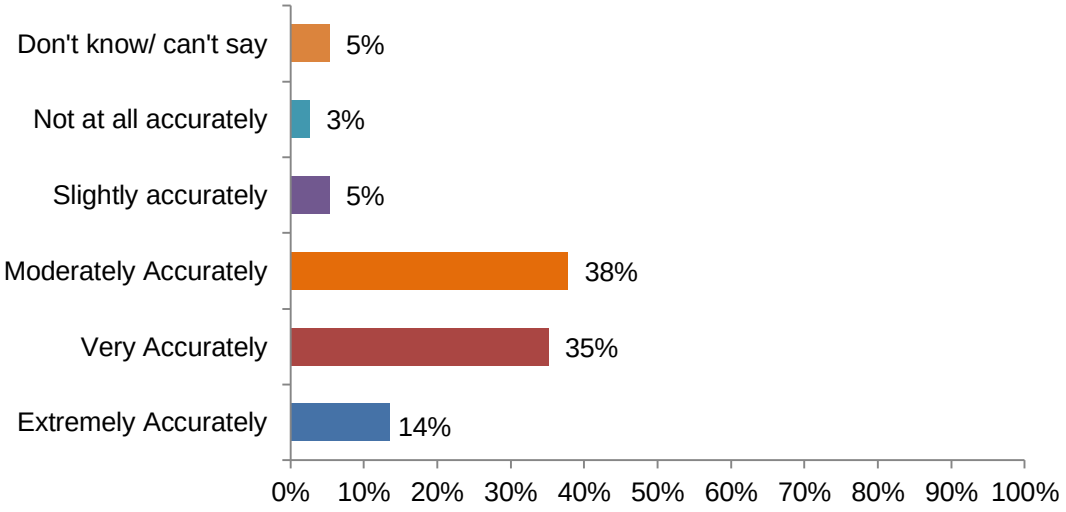

Q1. The Barking and Dagenham draft PNA does not identify any gaps in the provision of pharmaceutical services. To what extent do you agree or disagree with this assessment?
100%
80%
60%
40%
20%
0%
43%
16%
19%
11%
3%
8%
Strongle agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree
Don't know/ can't say

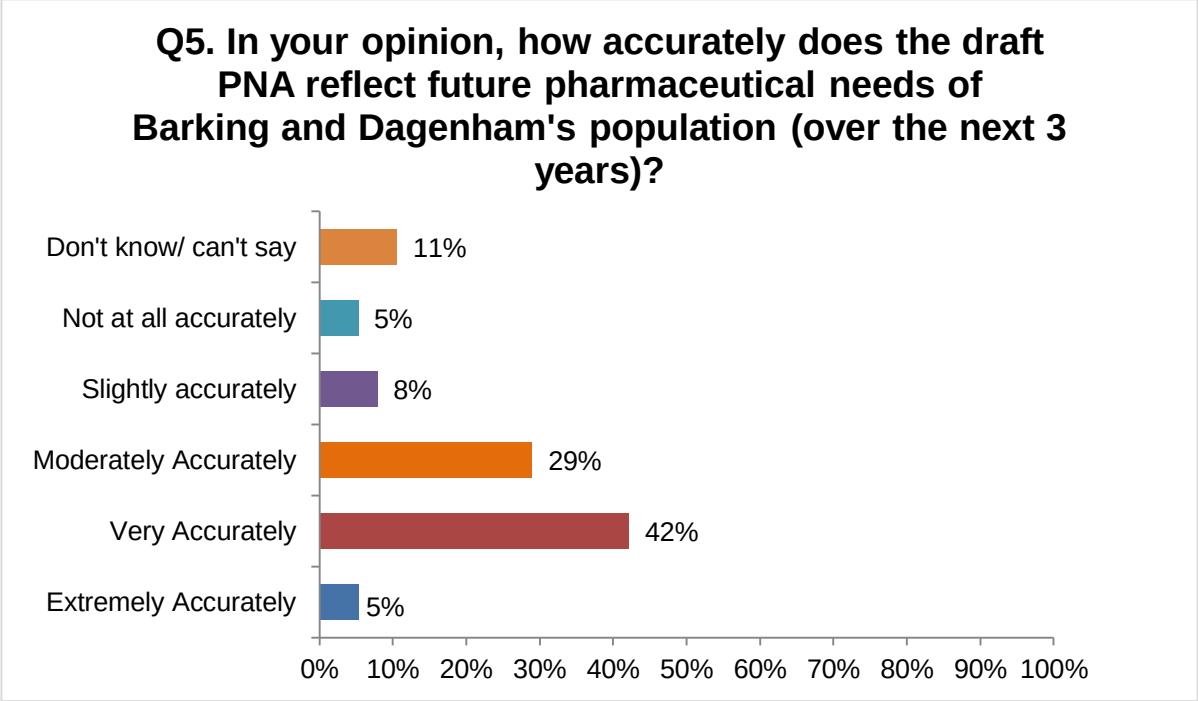

Q2. To what extent do you agree or disagree with the other conclusions contained within the draft PNA?
100%
80%
60%
40%
20%
0%
21%
39%
21%
5%
3%
11%
Strongle agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree
Don't know/ can't say

Q3. In your opinion, how accurately does the draft PNA reflect current provision of pharmaceutical services in Barking and Dagenham?

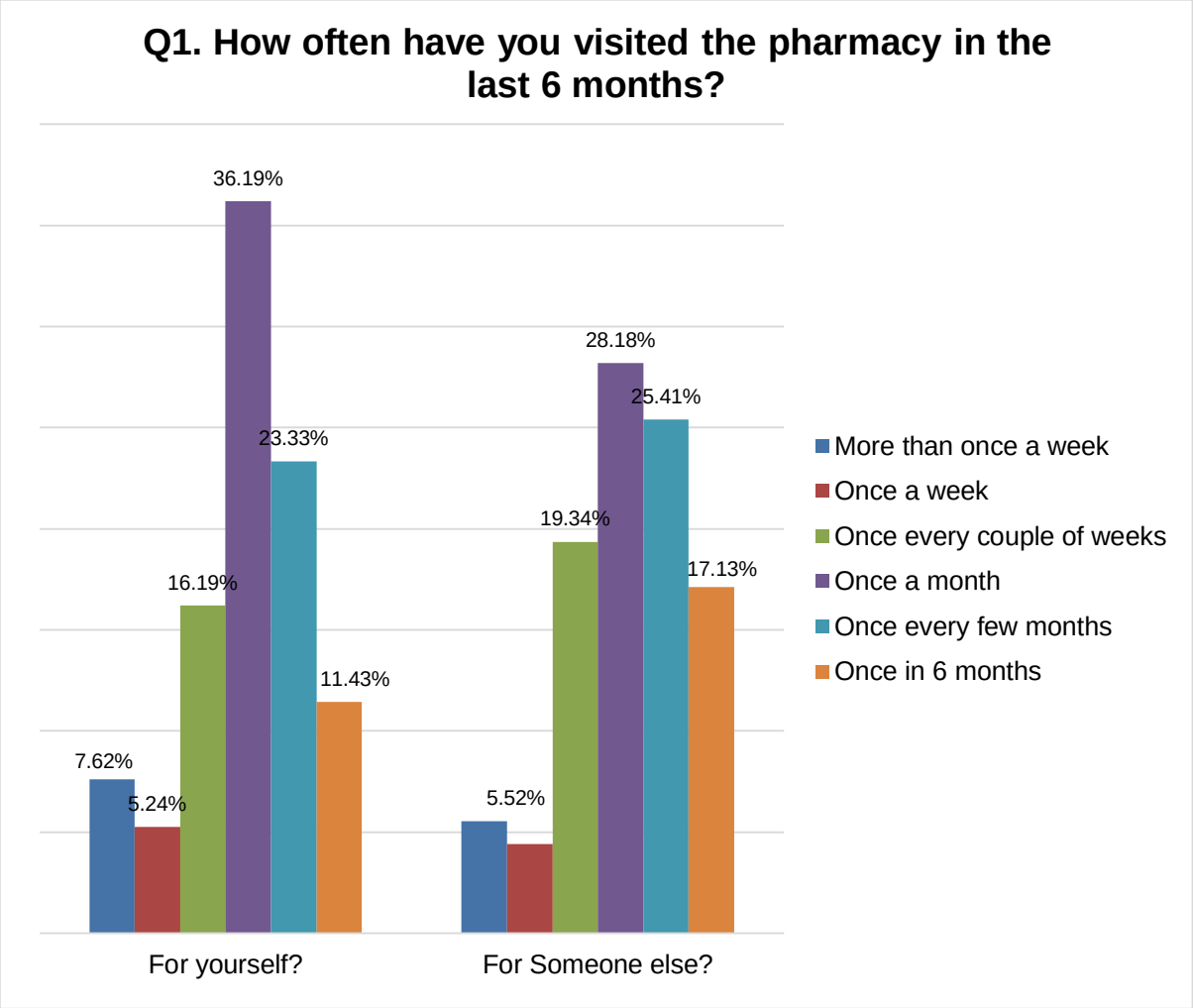


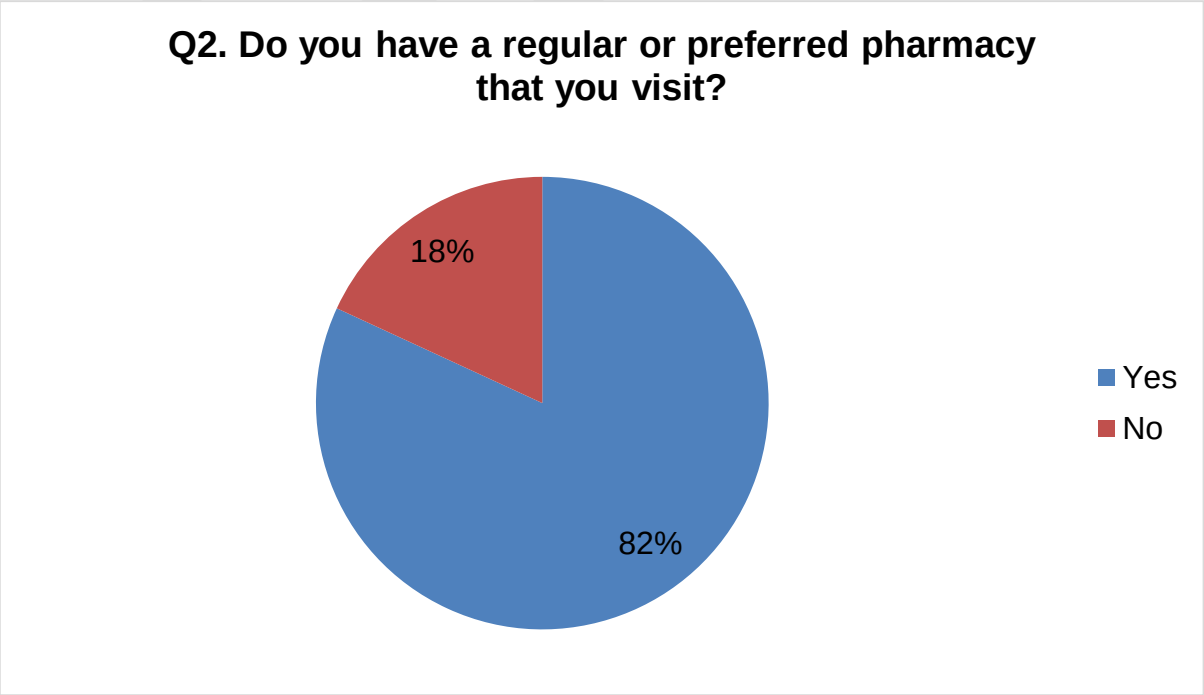
Q4. In your opinion, how accurately does the draft PNA reflect the current pharmaceutical needs of Barking and Dagenham's population?



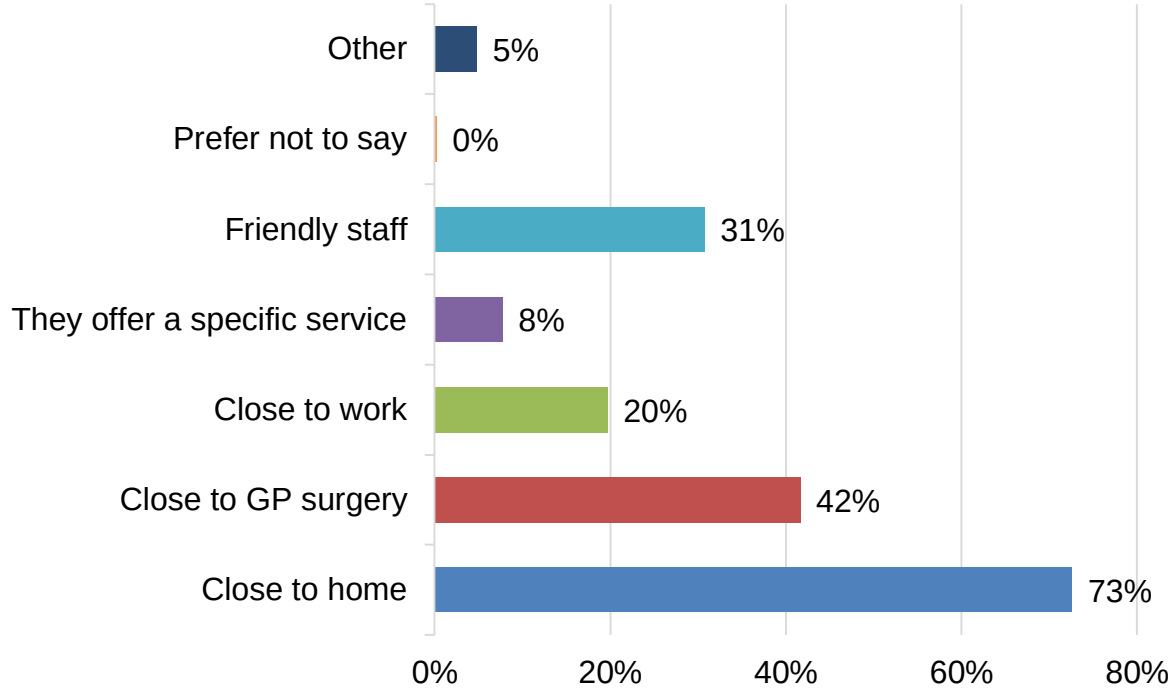

Q5. In your opinion, how accurately does the draft PNA reflect future pharmaceutical needs of Barking and Dagenham's population (over the next 3 years)?
Don't know/ can't say
11%
Not at all accurately
5%
Slightly accurately
8%
Moderately Accurately
29%
Very Accurately
42%
Extremely Accurately
5%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Appendix I: Results of the patient survey

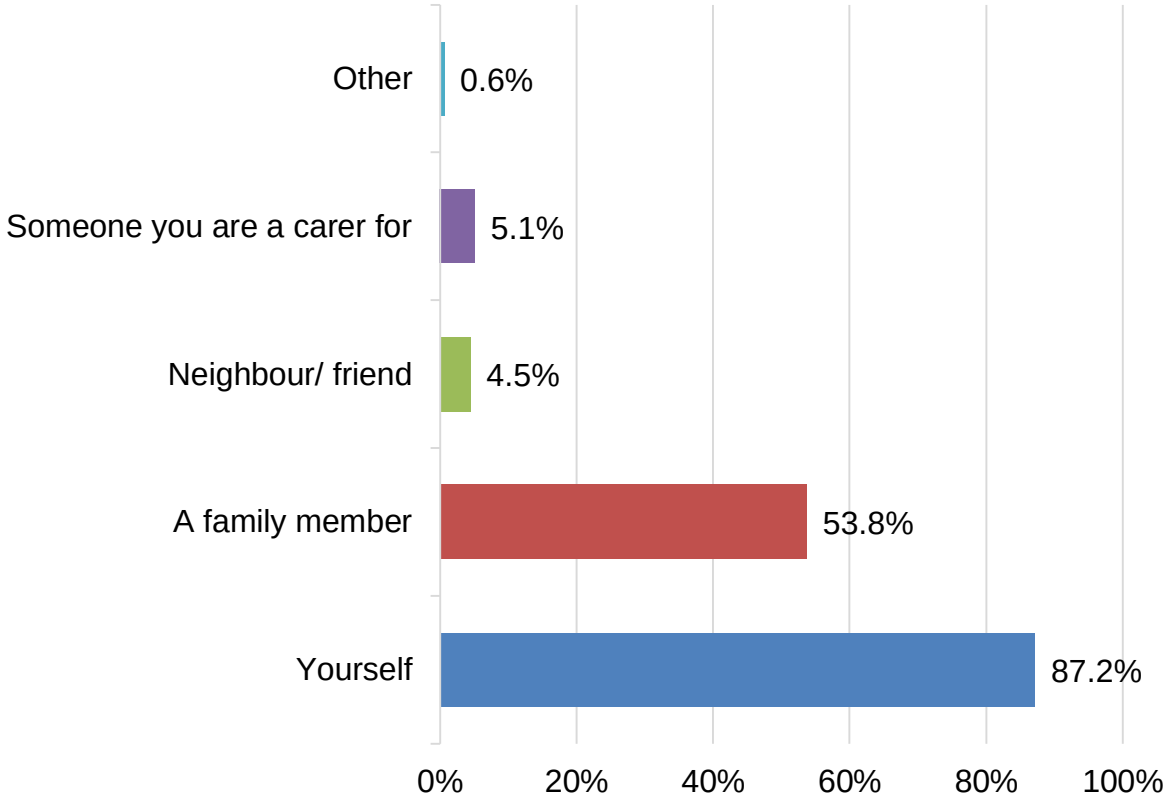


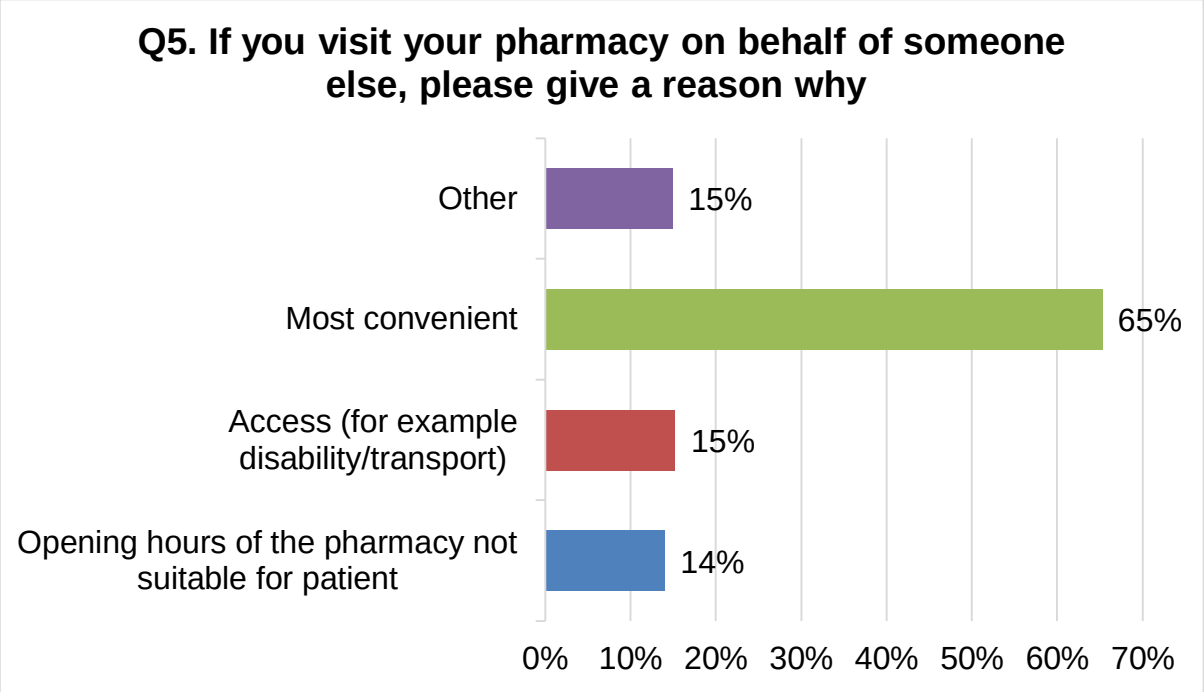


Q3. When considering choice of pharmacy, which of the following helps you choose?



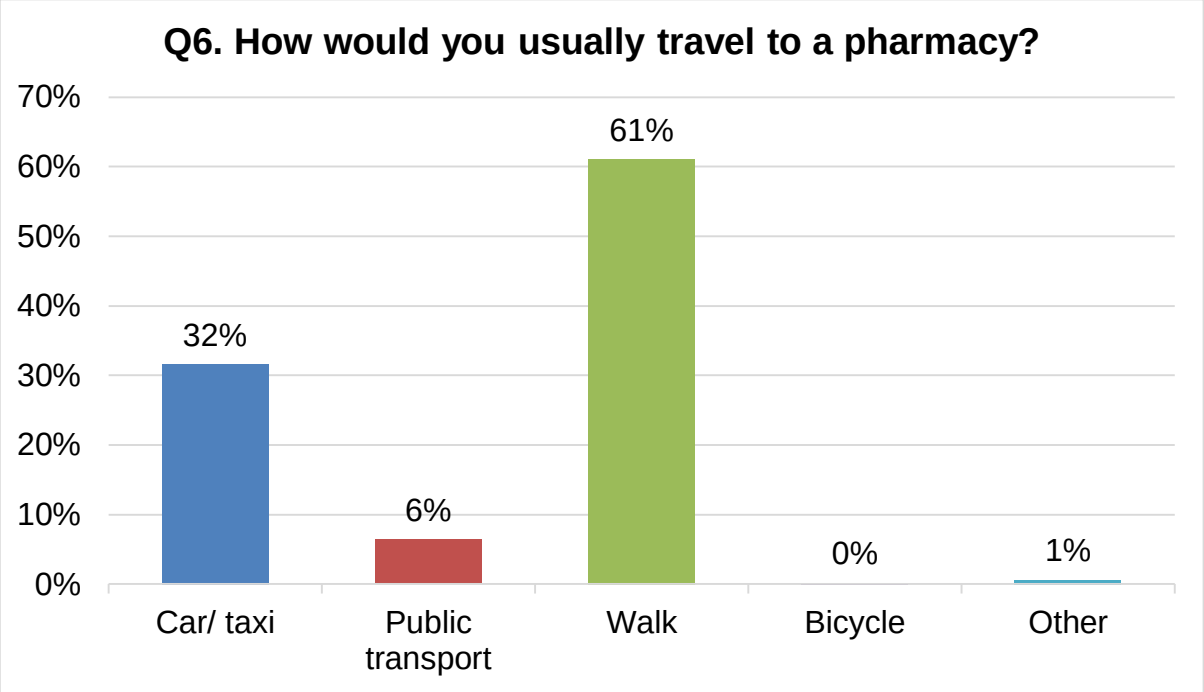
Q4. Who would you normally visit the pharmacy for?



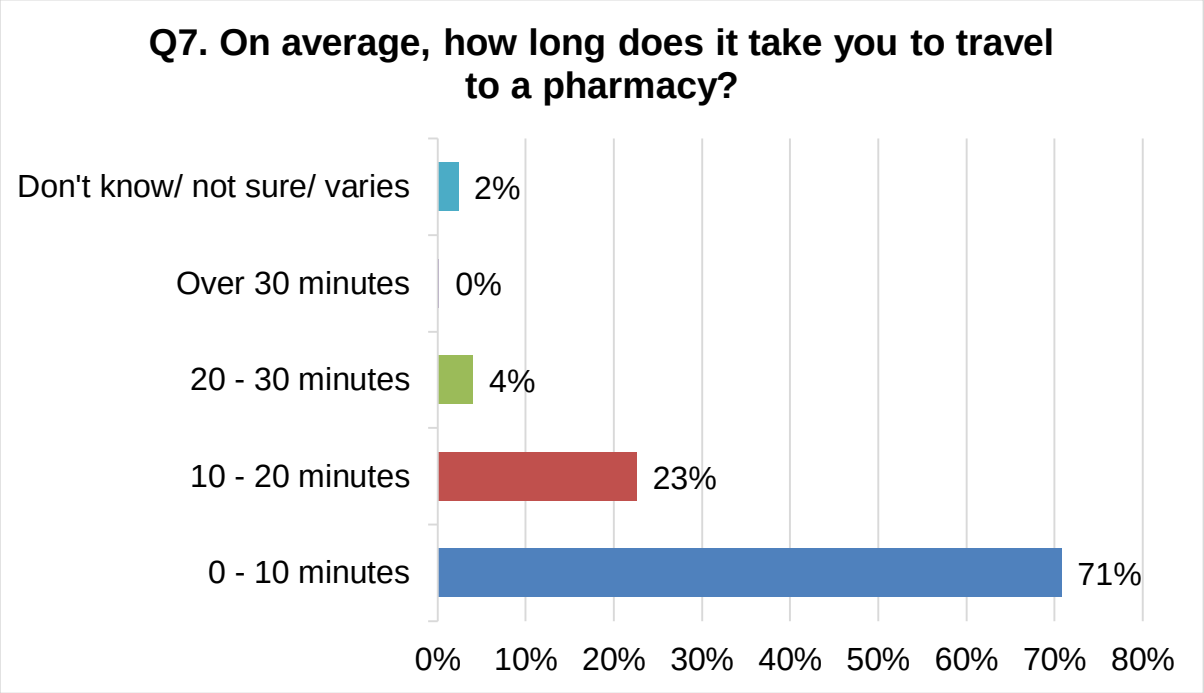


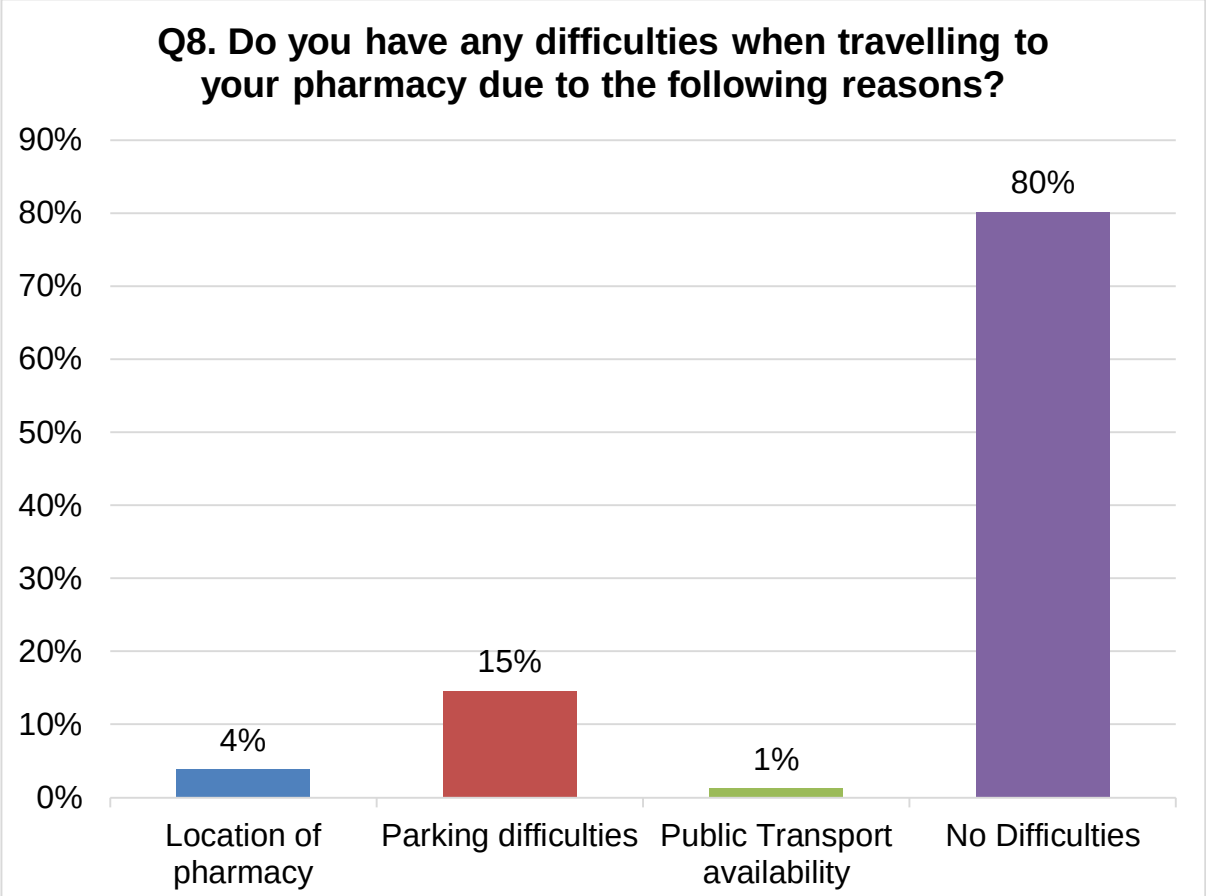
Reasons

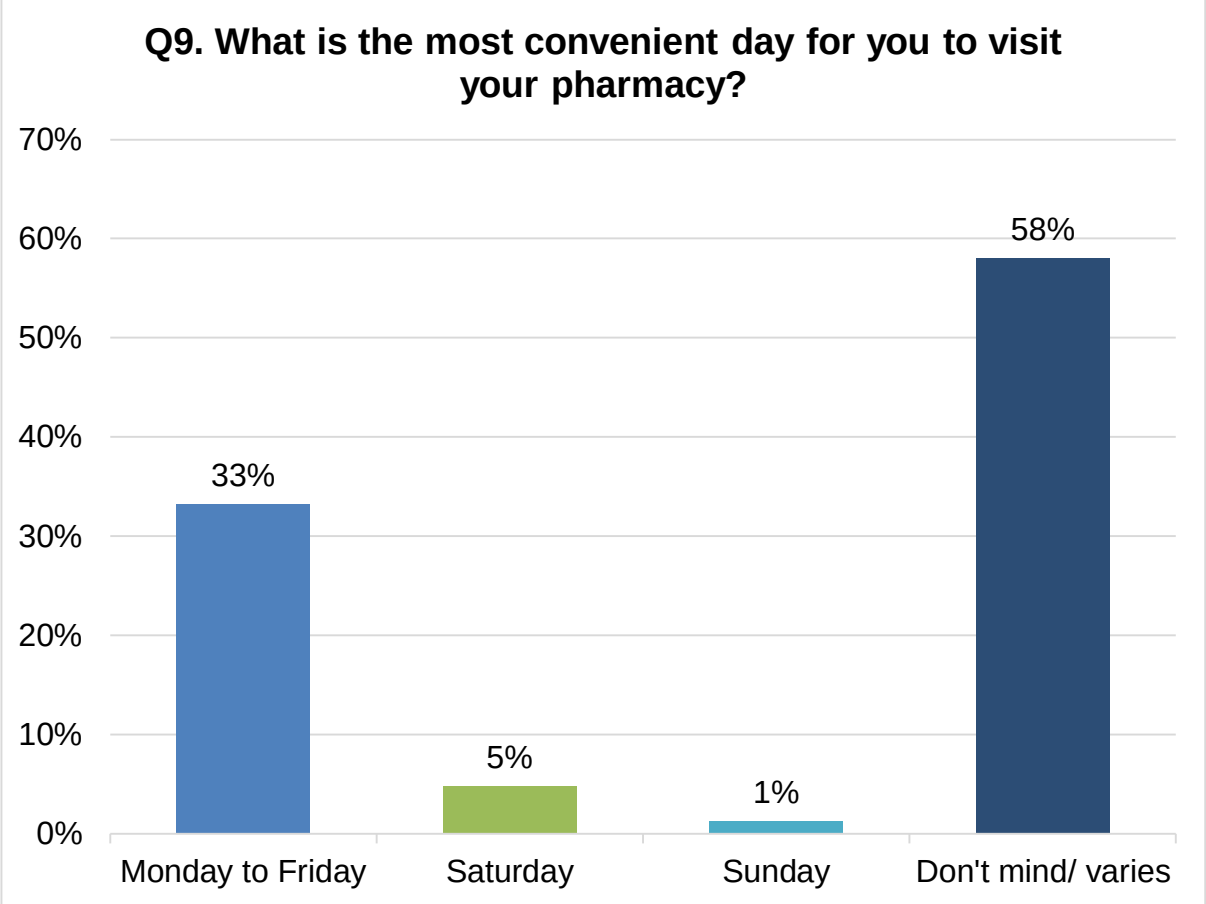
My child and husband are at college and work	Patient not always well enough to visit the pharmacy
I collect prescriptions for family members because I am home	Pharmacists good advice
Person is housebound	Collect mine and partners prescription
On behalf of my daughter who is still a child	Grandchild
My husband	Picking up over counter medicine
Partner	My husband's working hours
Mother has dementia	For my partner and children
Children (I visit pharmacy for them)	The person cannot go
Under 16	Husband is lorry driver so I pick up his repeat prescription sometimes
My wife has disability problems	I do not visit pharmacy on behalf of others

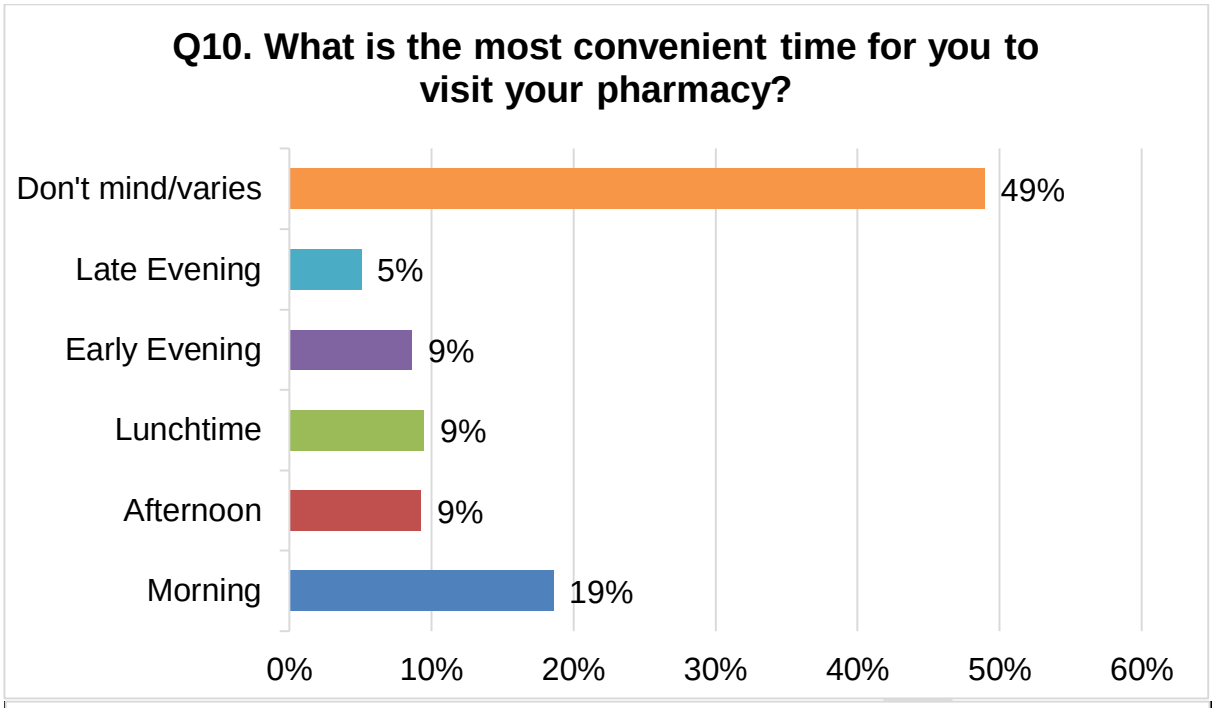


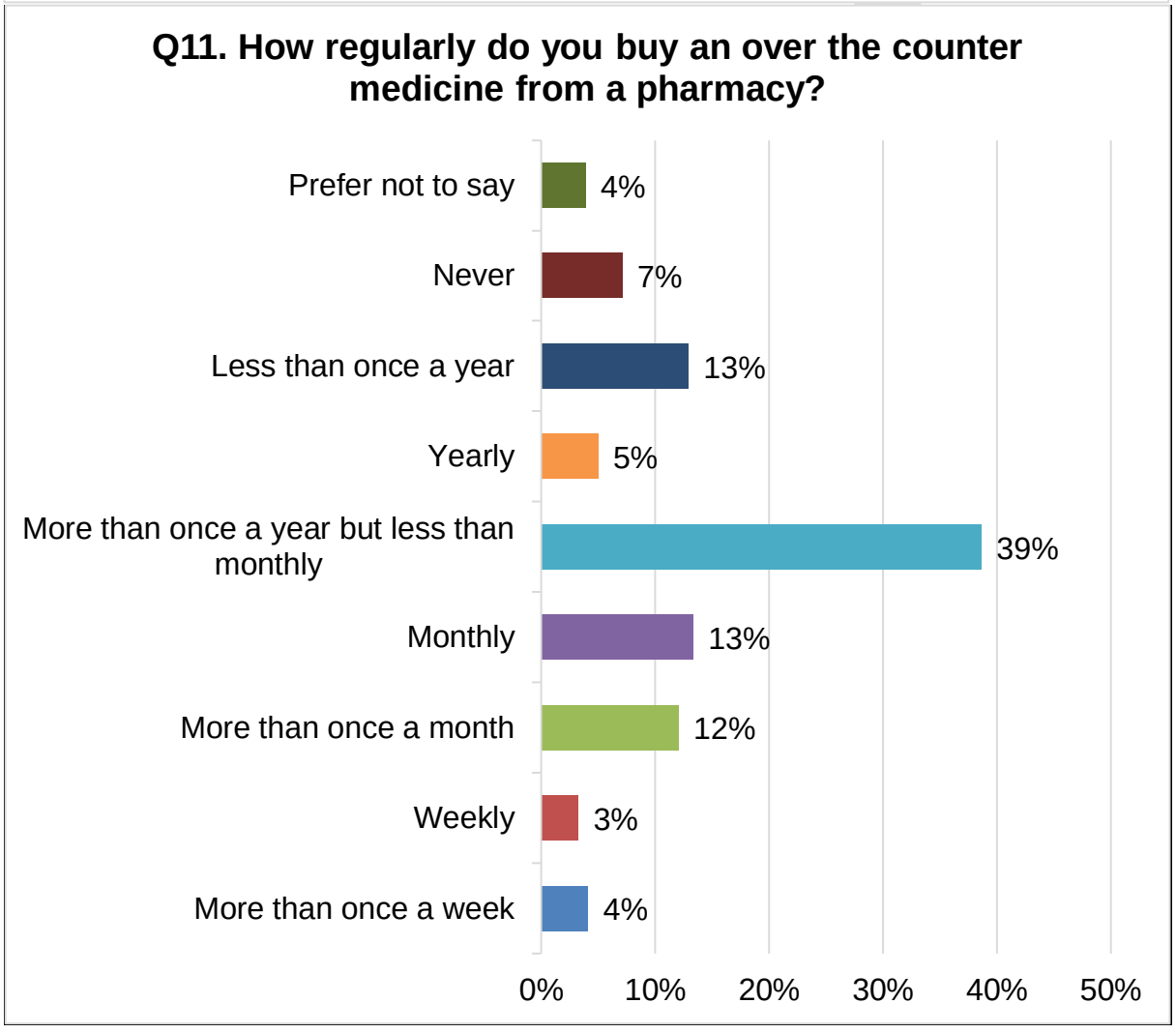
Other
Wheelchair
Mobility Scooter
Delivered to my home



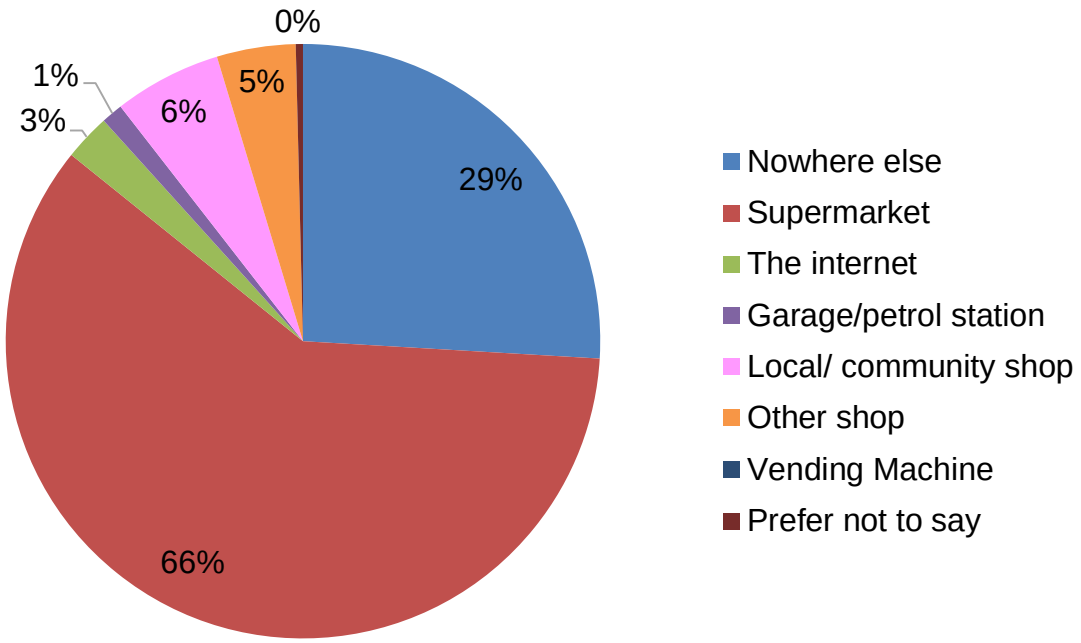

Q8. Do you have any difficulties when travelling to your pharmacy due to the following reasons?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
4%
15%
1%
80%
Location of pharmacy
Parking difficulties
Public Transport availability
No Difficulties


Q9. What is the most convenient day for you to visit your pharmacy?
70%
60%
50%
40%
30%
20%
10%
0%
33%
5%
1%
58%
Monday to Friday
Saturday
Sunday
Don't mind/ varies

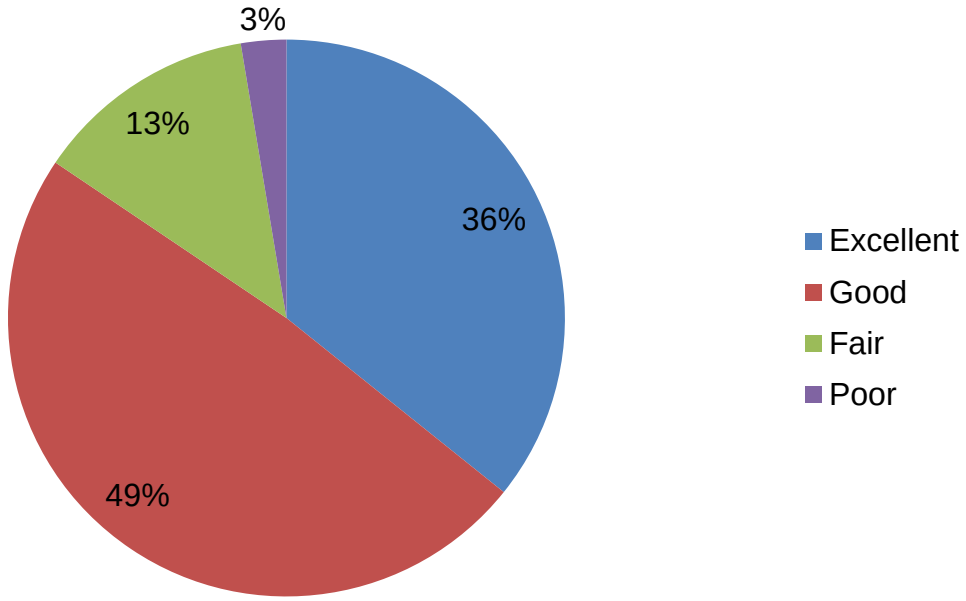

Q10. What is the most convenient time for you to visit your pharmacy?
Don't mind/varies
49%
Late Evening
5%
Early Evening
9%
Lunchtime
9%
Afternoon
9%
Morning
19%
0%
10%
20%
30%
40%
50%
60%

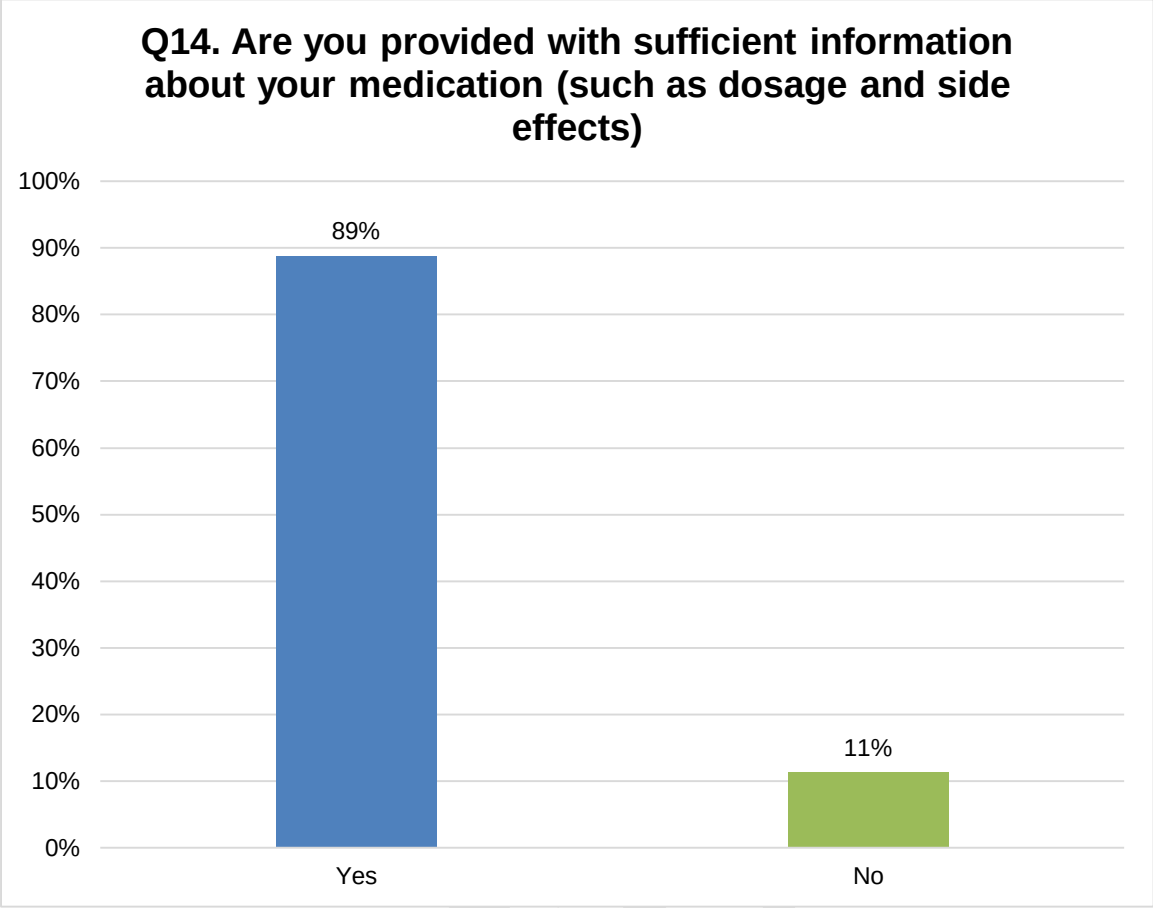

Q11. How regularly do you buy an over the counter medicine from a pharmacy?
Prefer not to say
4%
Never
7%
Less than once a year
13%
Yearly
5%
More than once a year but less than monthly
39%
Monthly
13%
More than once a month
12%
Weekly
3%
More than once a week
4%
0%
10%
20%
30%
40%
50%

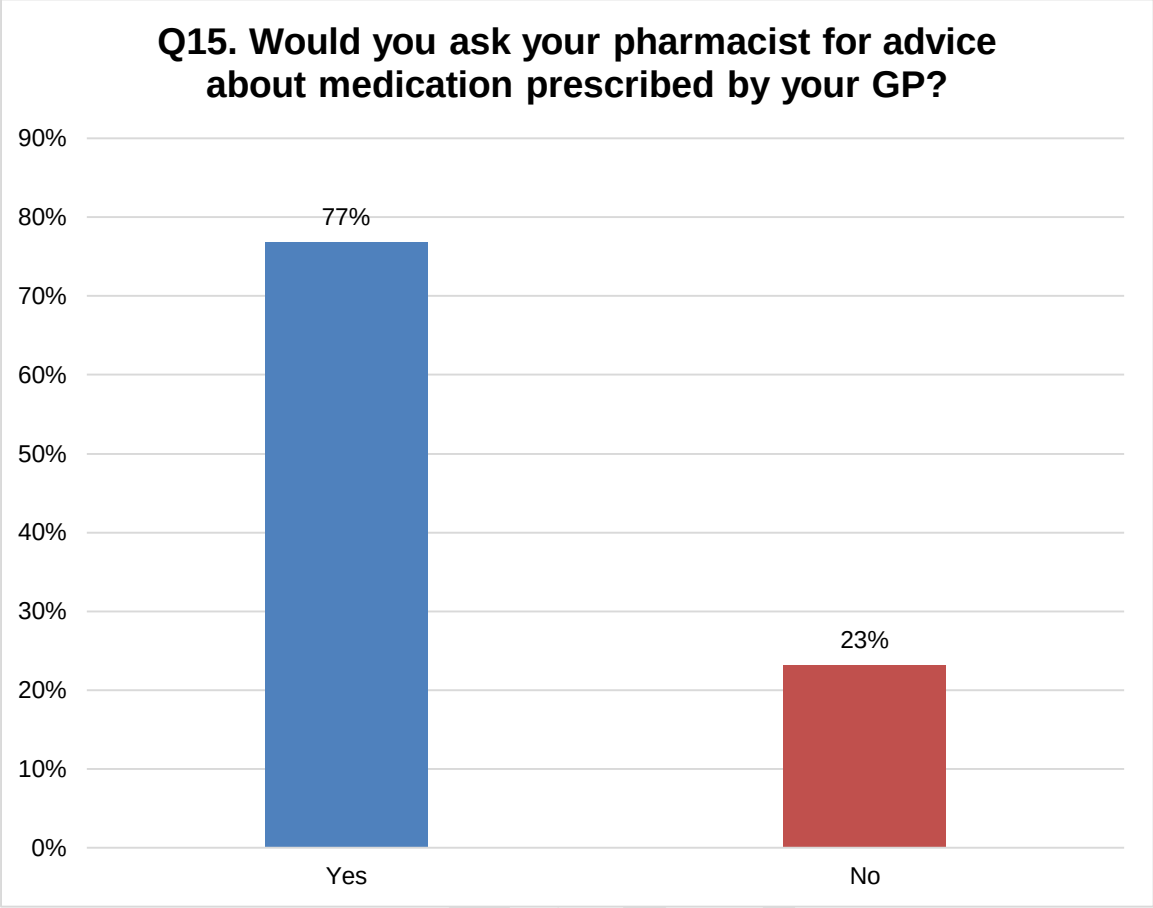
Q12. Do you buy over the counter medicines anywhere else?



Q13. How do you rate the ease of obtaining medication (For example - waiting time or stock availability)?




Q14. Are you provided with sufficient information about your medication (such as dosage and side effects)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
89%
11%
Yes
No

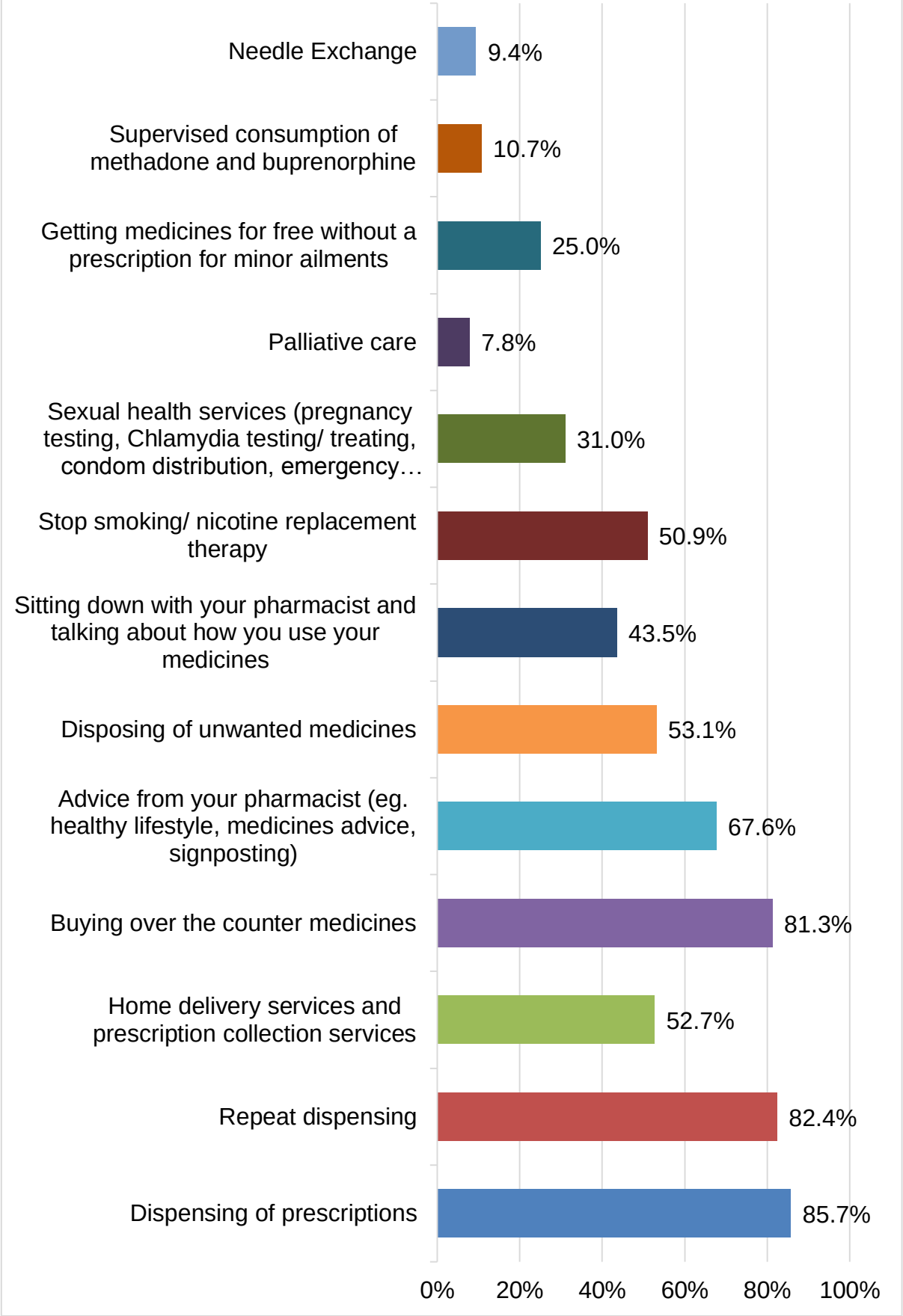


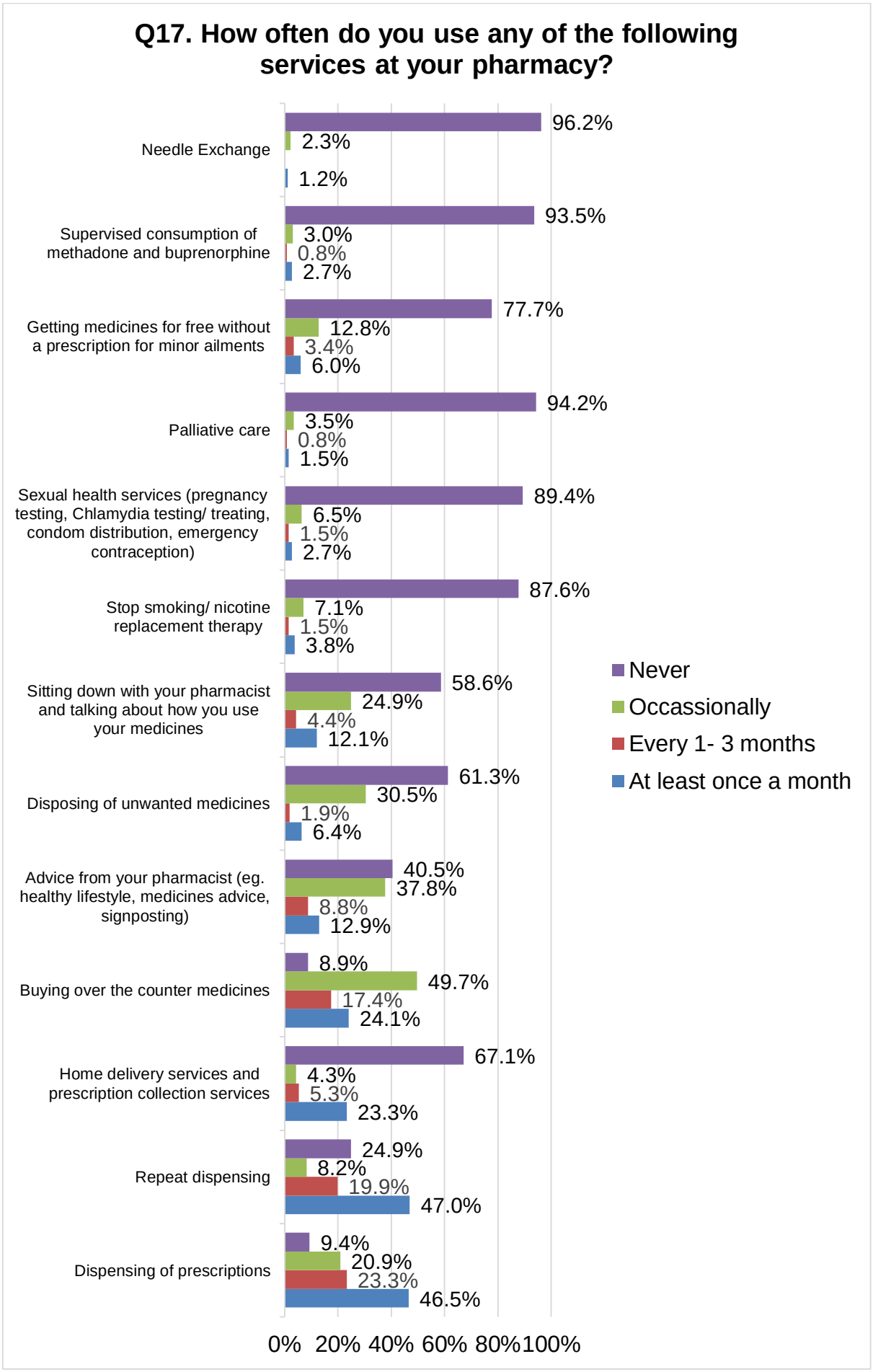
Reasons

If advice on label/prescription vary from each other	Side effects, form of medication
If tabs should be taken with food etc.	Time of day to take or with or without food
Just to clarify dosage to be taken	When to take the medication etc.
Doctors doesn't always have time to explain but I can ask my pharmacy about any medication	Dosage of medication and side effects if taken with other medication
If unsure as to when to take and if they conflict with the other medication I am taking. The pharmacist knows my history	I have had kidney stones twice; most medication warns about taking if you have had kidney problems
New inhalers	I think the pharmacist is just as knowledgeable as the GP
The pharmacist often asks me how I am getting on with my medication	Pharmacist often know more about medication, side effects and how they work with other medication
If I could buy cheaper over the counter	Whether there is an alternative

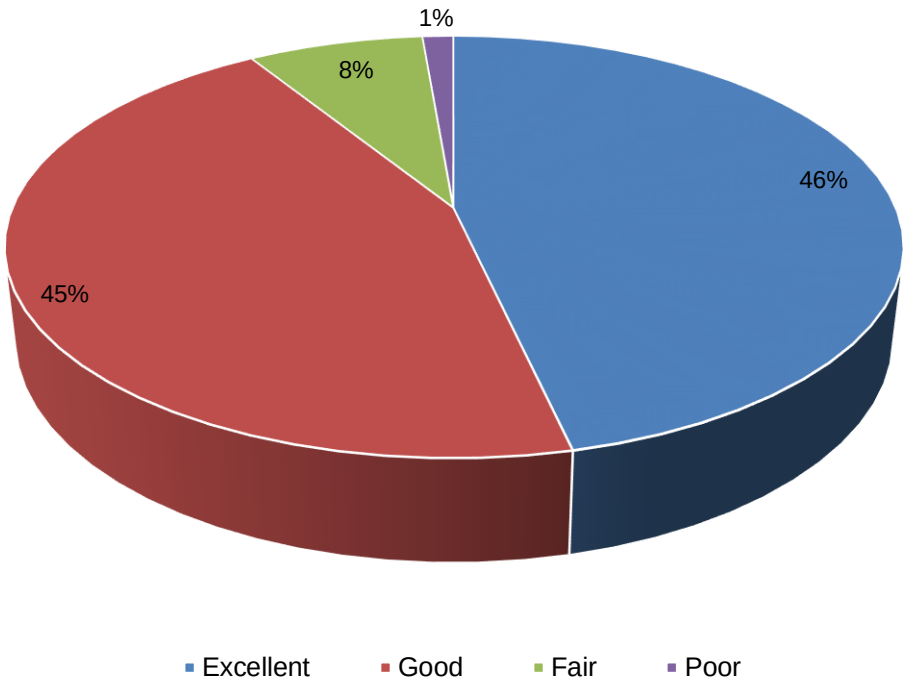
Side effects, advice	To make sure they are ok to use with current medication
If I got sank wrong with me	Clarification on whether it is OK to take with other medication
Asking advice about side effects or if a different type of tablet can be given because my Mum might not be able to swallow the make prescribed by the doctor	I would talk to a pharmacist if I had started taking a new medicine and was getting side-effects to check whether I should continue taking it or stop or see my GP. This would be helpful in the time waiting to see my GP - which can be a very long time!!
If I was not sure of the medication and needed more details	Diet to follow while on medication.
Not always given the correct product so I query it.	Side effects/availability/ generic substitutions
Side effects and if safe to take and drink alcohol	If it cheaper on prescription or over the counter, dosage, side effects etc.
Sometimes for clarification	Disposal of unused medicines, when to take with food etc.
Effect if using vitamins and other GP prescribed drugs	To ask if there are any other medication that could be taken
Side effects	To make sure I am not allergic to it as this has been prescribed for me in the past.
I take Warfarin / compatibility	

Q16. Which of the following pharmacy services are you aware that your pharmacy provides?

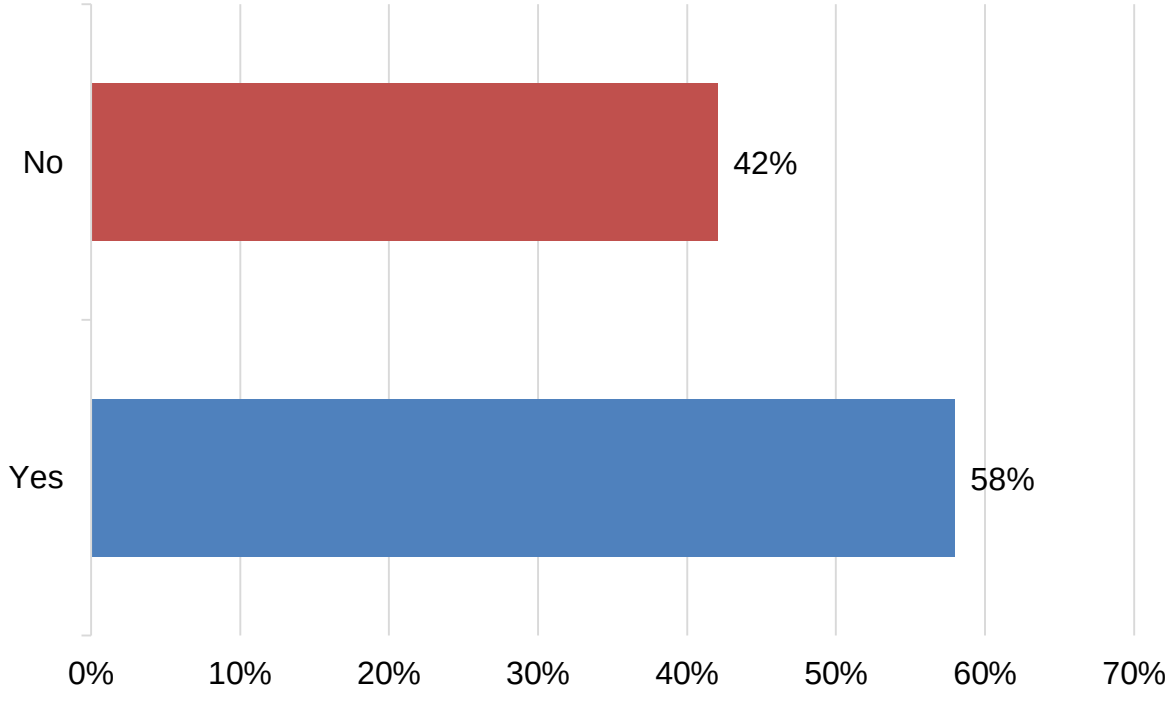


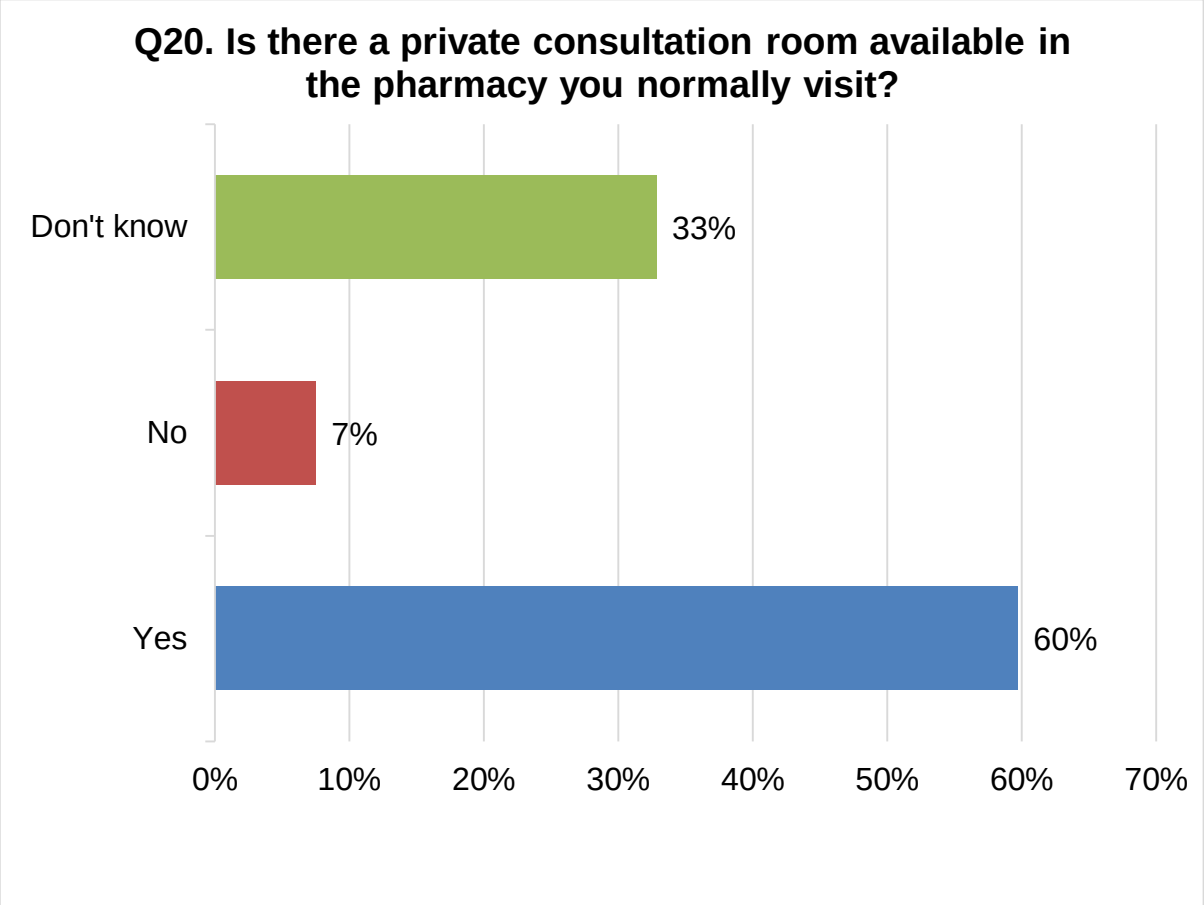

Q17. How often do you use any of the following services at your pharmacy?
Needle Exchange
96.2%
2.3%
1.2%
Supervised consumption of methadone and buprenorphine
93.5%
3.0%
0.8%
2.7%
Getting medicines for free without a prescription for minor ailments
77.7%
12.8%
3.4%
6.0%
Palliative care
94.2%
3.5%
0.8%
1.5%
Sexual health services (pregnancy testing, Chlamydia testing/ treating, condom distribution, emergency contraception)
89.4%
6.5%
1.5%
2.7%
Stop smoking/ nicotine replacement therapy
87.6%
7.1%
1.5%
3.8%
Sitting down with your pharmacist and talking about how you use your medicines
58.6%
24.9%
4.4%
12.1%
Disposing of unwanted medicines
61.3%
30.5%
1.9%
6.4%
Advice from your pharmacist (eg. healthy lifestyle, medicines advice, signposting)
40.5%
37.8%
8.8%
12.9%
Buying over the counter medicines
8.9%
49.7%
17.4%
24.1%
Home delivery services and prescription collection services
67.1%
4.3%
5.3%
23.3%
Repeat dispensing
24.9%
8.2%
19.9%
47.0%
Dispensing of prescriptions
9.4%
20.9%
23.3%
46.5%
Never
Occassionally
Every 1- 3 months
At least once a month
0%
20%
40%
60%
80%
100%

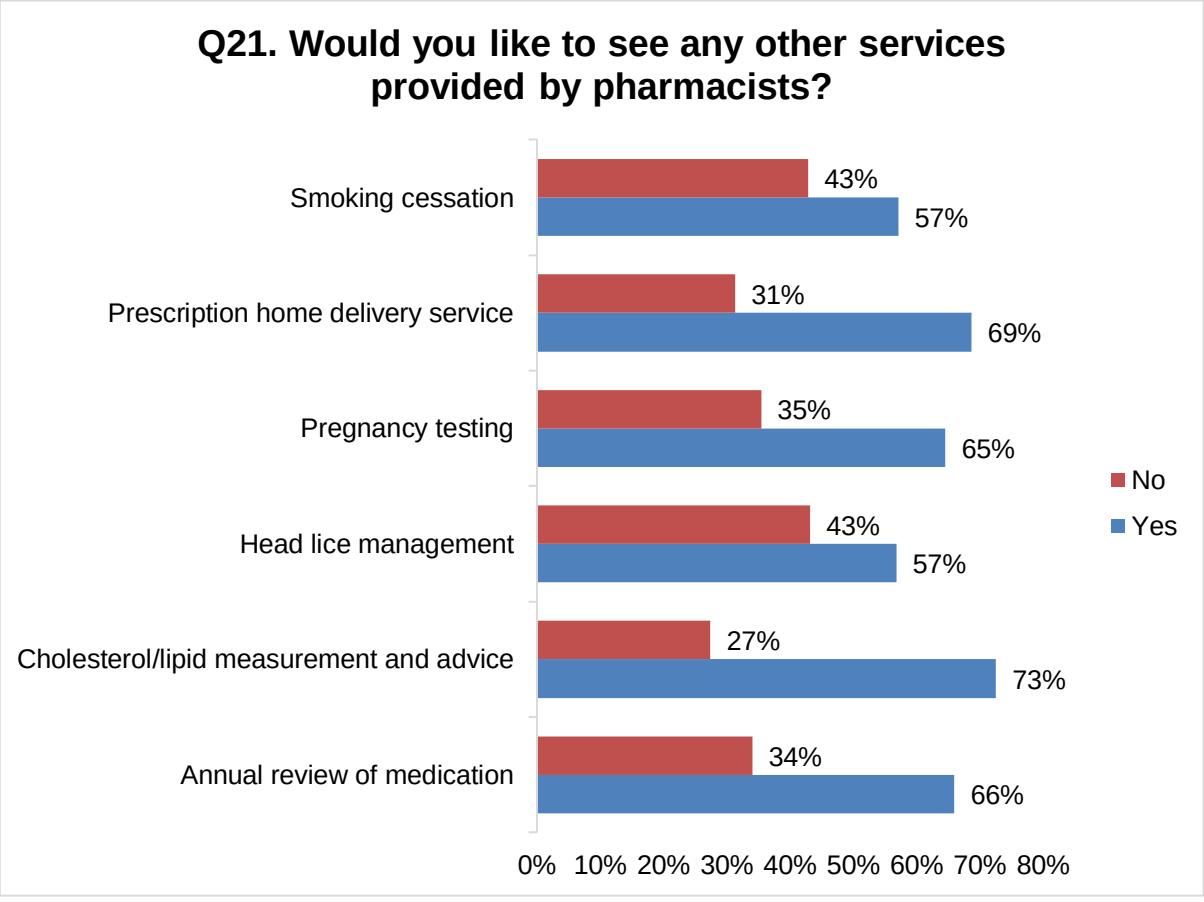
Q18. How would you rate your confidence in the pharmacist's knowledge and advice?



Q19. Did you know the pharmacists can give private consultations?

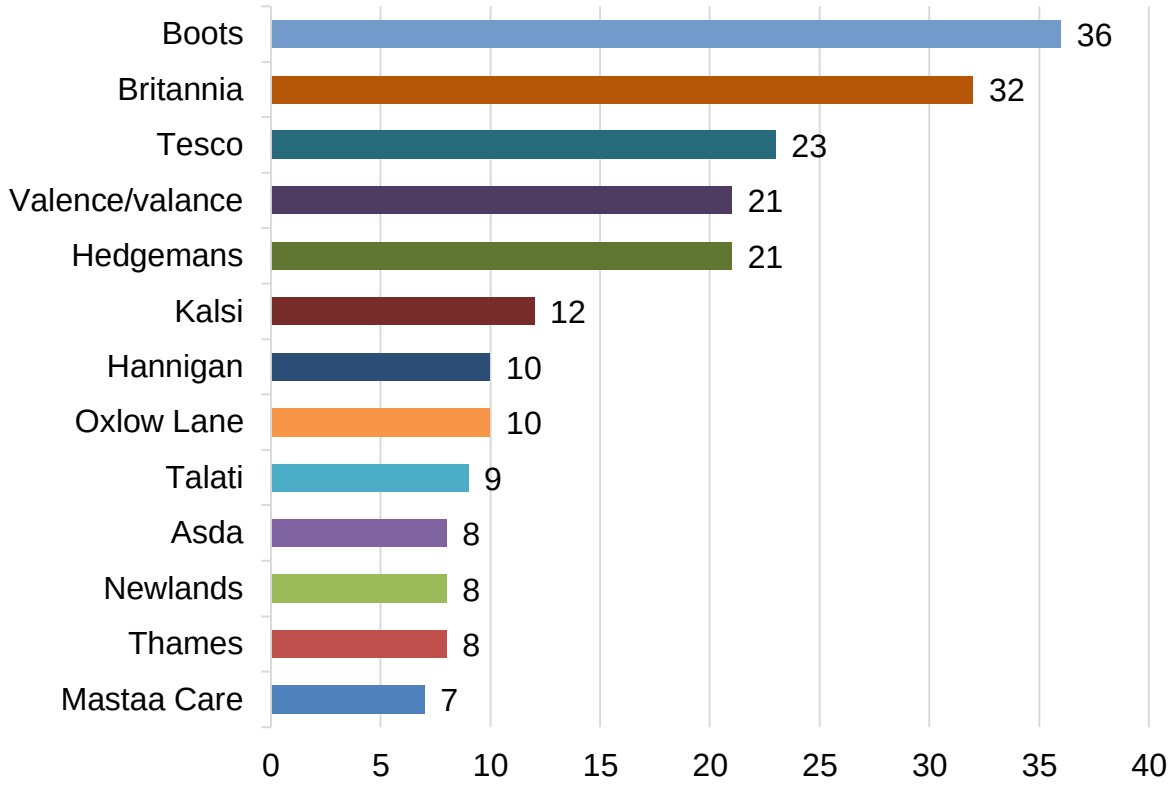



Q20. Is there a private consultation room available in the pharmacy you normally visit?
Don't know
33%
No
7%
Yes
60%
0%
10%
20%
30%
40%
50%
60%
70%

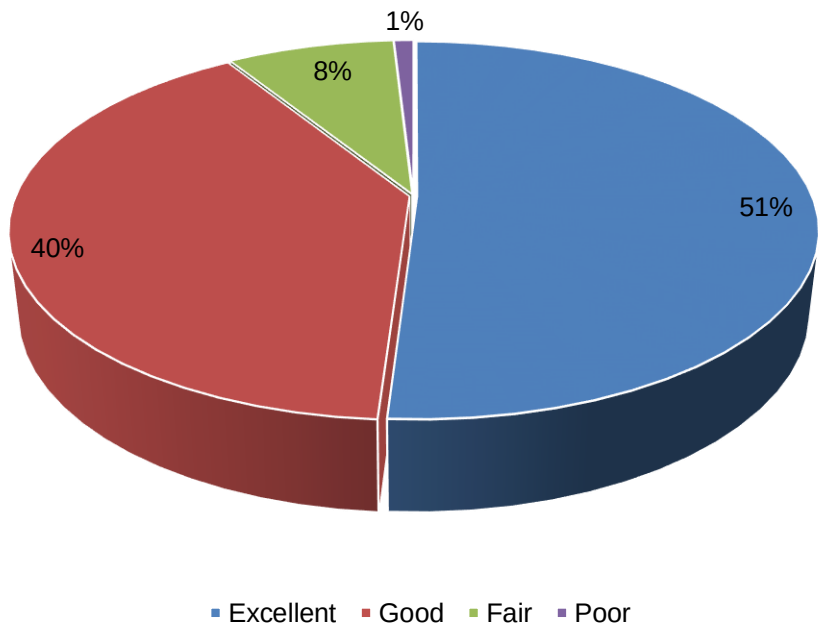

Q21. Would you like to see any other services provided by pharmacists?
Smoking cessation
43%
57%
Prescription home delivery service
31%
69%
Pregnancy testing
35%
65%
Head lice management
43%
57%
Cholesterol/lipid measurement and advice
27%
73%
Annual review of medication
34%
66%
No
Yes
0%
10%
20%
30%
40%
50%
60%
70%
80%

Other
B12 injection
Warfarin Service as they know what they are doing anywhere saves going to the clinic
Minor ailments - need to buy over-the-counter when, should be getting free
More sexual health services
Be able to prescribe medications mostly whatever is advised by the pharmacist is generally what the GP prescribe
Would like to see all the pharmacy open on a Sunday
Providing emergency prescriptions when people have run out of their usual medication. I know they can provide up to 7 days of medication if needed outside the opening hours of their GP surgery but they (Boots, Barking town centre) refuse to do it. This means a trip to the walk-in centre instead which is expensive to the NHS and completely unnecessary!
Longer opening hours on weekend
I do not use pharmacies frequently enough to comment
Anything to take the pressure off GP's
No - I am happy with the services my local pharmacy provides
Advice on continence for the elderly (signposting and stocking of appropriate pads)
Mole checking
Prescription for Coeliac to made available as it would be easier than visiting the doctor to obtain foods every month
I no longer smoke, can no longer get pregnant and rely on the doctor for repeat prescriptions and medicine review
General advice given more freely i.e. if medicines given, do you know what they may do
Blood pressure monitoring Diabetes testing Cholesterol monitoring
Where prescriptions not in stock, advice on where else to go
The ability to order larger occupational therapy and physiotherapy items and supplies
Being able to prescribe medication if it is repeats
Filling of assistive technology items such as medication reminders. Not just dosset boxes or blister packs
Asthma clinics and advice, food allergy testing, constipation advice
I guess all of the above would be useful for some, hence why I've ticked them all!
Diabetes checks doctors completely inefficient

Q22. Please could we have the name and address of your pharmacy you use the most



Q23. How would you rate your overall satisfaction with this pharmacy?



Q24. Any other comments you would like to make about your pharmacy

Sometimes waiting times are long	The service used to be excellent it has deteriorated over the last 4 months
Very very good and excellent service	The travel advice I have received from pharmacies has been good, beyond just the vaccinations required around how to stay healthy in foreign countries.
Always willing to help. The Pharmacist is very helpful	Again, they should provide up to 7 days of a patient's regular medication in an emergency. I'm sure they are legally allowed to do this and as it takes pressure off NHS services they should contractually obliged to do it.
All the staff are 100%, especially Maya and Lina	Nearest Pharmacy to Laburnum Health Centre
You get a personal service. Prakash knows about my prescription - the ladies too. I often spend 20-25 minutes talking. I like the chemist.	They are often short staffed and do not seem to care that people are on their lunch break and need their prescriptions dispensed within 15-20 minutes so they can get back to work on time - there have been many occasions where I've waited half an hour only to go back to the counter and find my prescription still hasn't been dispensed so I've had to get my prescription back so I can go elsewhere after work.
They are most helpful when I need to know what an item might be classed as or numbers to find out medication status	They rarely have everything in stock. They are only open Monday to Friday (No weekends at all). They close between 1 and 2 every day (Unbelievable)
Stock - even on other medication. I always have to return very inconvenient	Very friendly staff, Pharmacist always ensures follow up is offered for asthma etc., flu jabs offered.
The staff are always very friendly and the service is excellent	The staff here are wonderful. They are caring and compassionate, helpful and professional. The best pharmacy I've visited in the borough by far.
Sometimes they do not have stock the medication I need, So I have to wait for it	Newlands BARKING always have the correct prescription and good customer service.
They make an excellent team. I shall be very sorry to lose them	The home delivery service at this pharmacy is very good and responsive
I have been coming here and have always been treated well	I don't have a dedicated pharmacy i use what is most convenient at the time
Electronic repeat prescription takes time - 48 hours	Needs more awareness!

The staff are always very helpful. I commend them	As well as medication, the other items they sell are always competitively priced, thus encouraging me to spend "locally".
Efficient, all staff are friendly	Ok with customer service but not too much
Very friendly efficient staff. Giving me advice on any queries that I have. This chemist helped me to stop smoking. Using patches and inhaler...I quit smoking on 28th February with the help from this chemist.	The only criticism is usually long wait for the pharmacy service and sometimes I have to return later to collect the medicine.
Not good at all. They need help us. Worst ever	It can get very busy at times and sometimes there is a muddle with people waiting for their prescriptions for a long time (they get forgotten). Mr Patel the main pharmacist himself is very knowledgeable, but the helpers are less so. More knowledge about alternative medicines and treatments and also extended evening hours one or two days a week may be useful.
They are friendly and always very helpful	They are usually very helpful.
Withhold prescriptions when their IT equipment is not working	Staff are sometimes rude and you could be ignored for some time before being served.
Early morning opening hours especially after school run	Pleasant and helpful staff
They need help, Pharmacy is slow and not organised	There is sometimes mix up with repeat prescriptions very poor when it comes to products to buy
Often runs short of supplies	I have always found the staff friendly and helpful
Staff are always polite and helpful. Pharmacist is never too busy to see you.	Staff are always friendly and helpful
All the staff are friendly and helpful and give you confidence	Never enough places to sit whilst you wait. Long walk from the disabled parking bays to the pharmacy.
Always friendly and helpful	I wish they would stop selling toys, games and plastic crap like some pound shop tacky market stall. also over the counter drugs at near supermarket prices
Very good	Too slow
Very helpful and very personally and answers all my queries	Need to keep more quantity of items
Bigger Consultation room	Absolutely brilliant service faultless

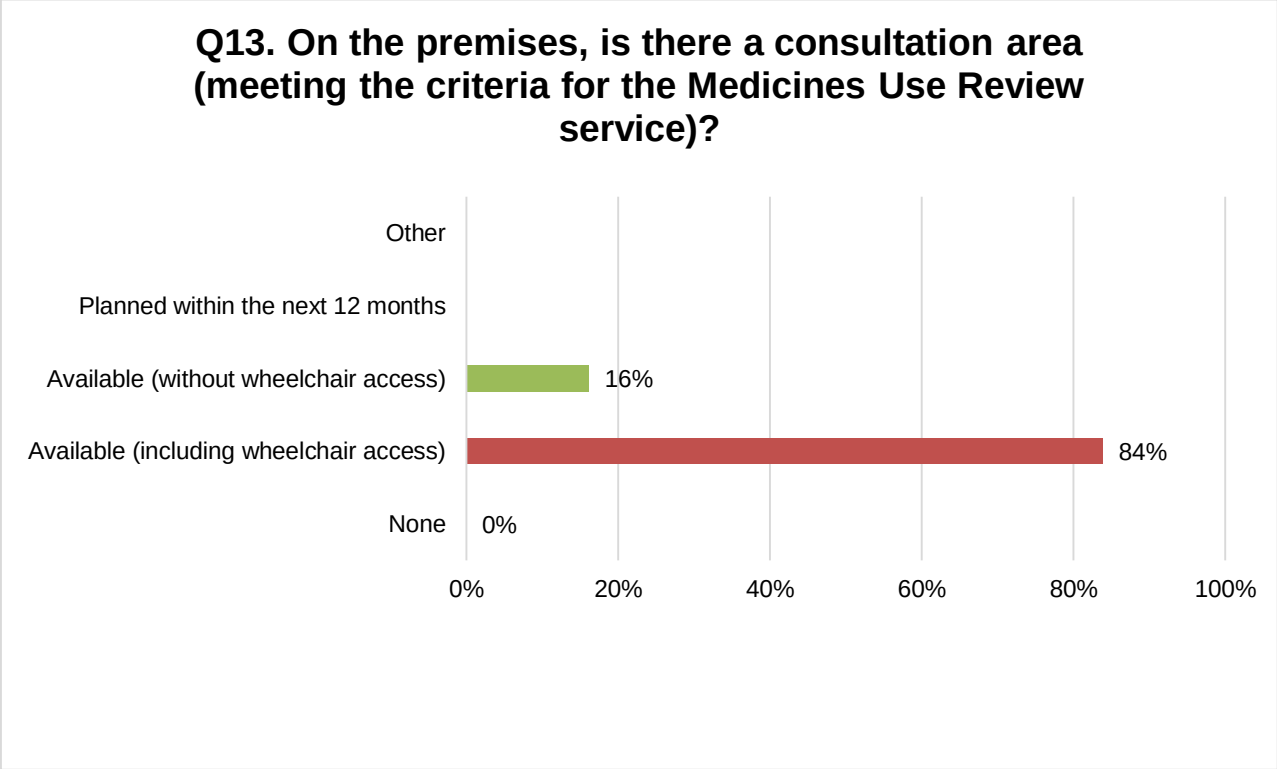
A very good service	I think it should open earlier in the morning and close later to cater for family's needs as it is always crowded after school
Friendly staffs, nice pharmacists and very helpful	They sometimes do not have the medication prescribed and I have to go elsewhere non repeat prescription medication.
Should be open till midnight	Always prepared to go the extra mile.
On 2 different occasions had to come back for owning item. Always shortage of stock, can be annoying but staff are friendly	Not enough staff and prescriptions never ready on time. And waiting while serving customers is dreadful
Should have the minor ailment scheme	Excellent pharmacy. Excellent delivery service, the lady driver is very helpful and patient. Bless her
More in stock items. So Don't need to come back for owing medications. But they do offer to deliver	Always friendly and I don't feel rushed
I have been visiting this pharmacy for over 20 years, The staff and pharmacist are always very friendly and helpful.	The staff are pleasant and helpful and the staff seem to stay for a long time so they get to know the customers and their needs and requirements
The waiting time to have the prescription is long sometimes it takes over 1/2 hour to get your prescription filled, they also don't call you when the medication is available or if you have a prescription to pick up, I would also like to see more under minor aliments being free for children.	The pharmacist always welcomes you and is happy to advise and his opinion is important - He doesn't give advice to order to sell you a product
They are very pleasant and never too busy	Helpful staff
Excellent service	Friendly bunch of people
My pharmacy are the best, give an excellent service	They keep changing the receptionist/pharmacist and they are too slow
They are very caring, helpful and always try to do what they can to help you	I would like to see the extended opening hours
They are very professional and give excellent service at all times. They are always friendly and helpful	Helpful and friendly, Nice people
The staff are all lovely	Always helpful
Very happy with the service	Sometimes they haven't got items in stock. Their stock control is poor. You have to wait. My repeat prescription is rarely made

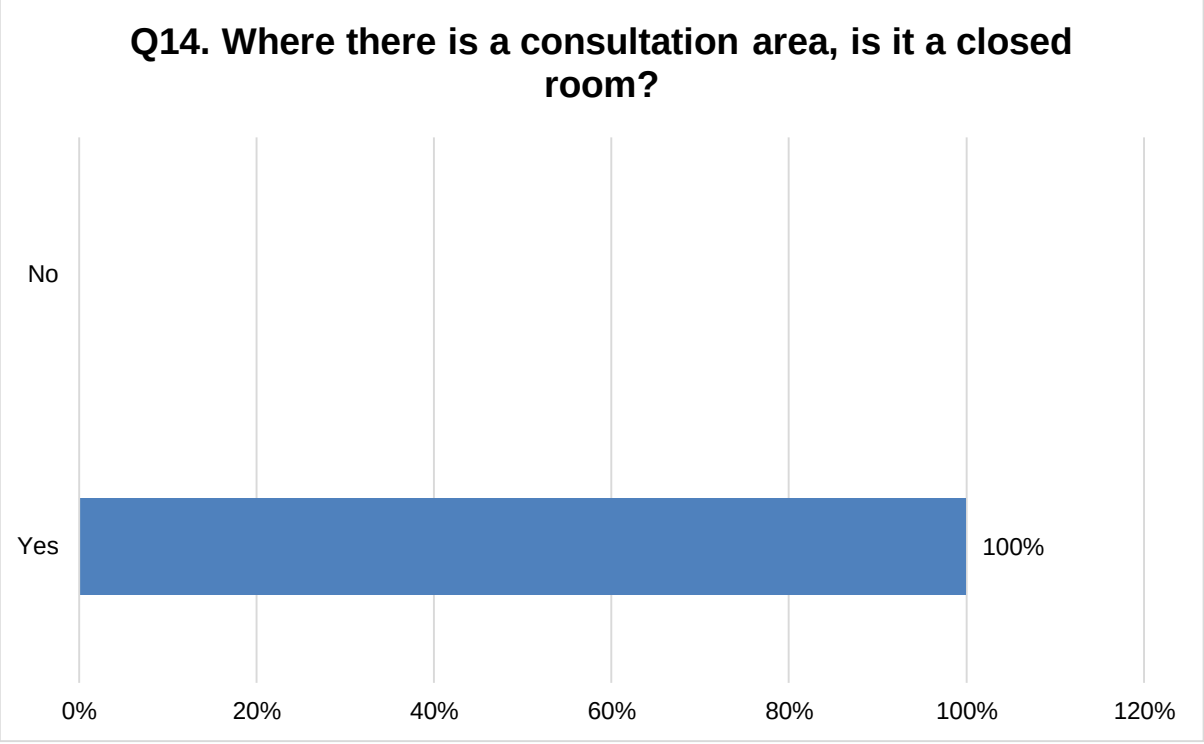
	up and bagged ready for me to collect. I have to wait around even though they have enough time!
Brian is the first pharmacist every in my life who explains about medication when to take and effects etc. He has private room to discuss this	I find the pharmacist and everyone who works very polite, knowledgeable and helpful
Good service with friendly helpful staff	Very good service, Very helpful and knowledgeable
Wouldn't like to use another pharmacy even thou I have at least two others near to where I live the service I get is the top The staff are great	Would be nice to have a late opening one day a week and even a few hours during the weekend as it is not open at all of a weekend.
Excellent service from the pharmacist and the staff in the shop. Friendly, helpful always a pleasure.	I have been given wrong dose of my tablets not told a new tablet I was taking could cause heart trouble and missing meds I find the way it is run is poor as they don't have a regular supply of medicine having had to wait over a week for part meds
Have been offered excellent service regarding flu jabs, testing and asthma control saves me having to take a day off to go to GP	They are always very helpful
The only thing I have to say it when it comes to getting medication delivered it takes so long and they is always a moan when we order because my dad is taking 8 tables a day and the amount they supply is only enough to last him the week then we have to re order and they always make some comment when we explain it they go quiet	Helpful and kid staff with good knowledge of all medicines they offer
Medication often not ready for collection and I have to come back - even though I have allowed 48 hours, as advised by the GP Surgery	All the staff are always friendly and very helpful. Very efficient too, highly recommended.

Appendix J: Results of the pharmacy contractor survey

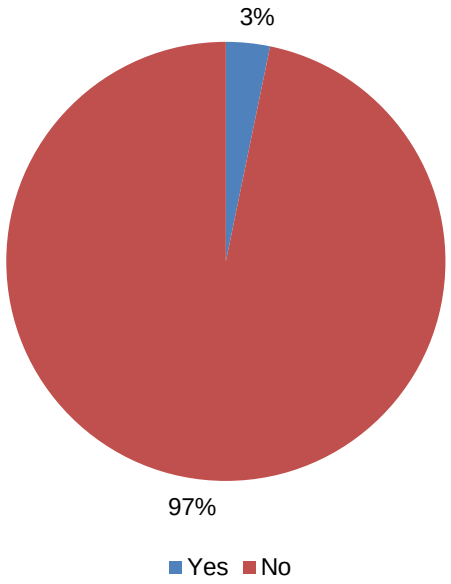
Q1 to Q10 are Pharmacy specific questions

Q11 and 12 related to the pharmacy opening hours; this information is provided in appendix A for each pharmacy

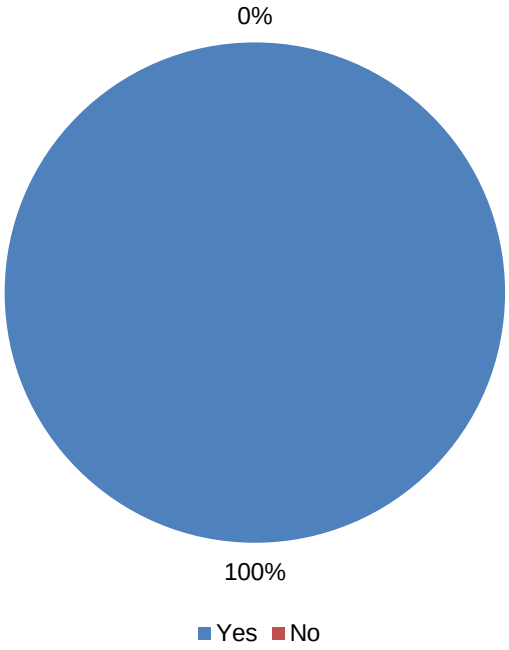


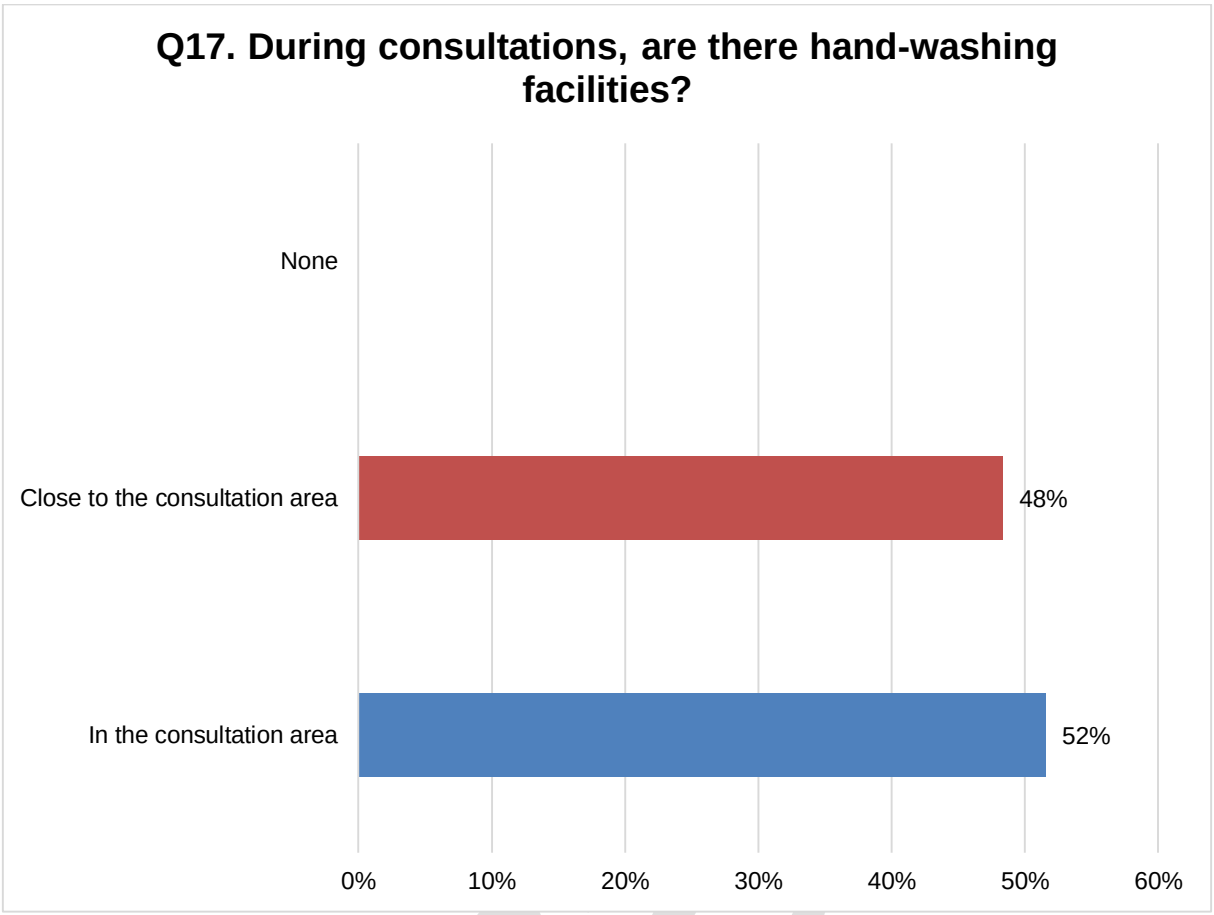


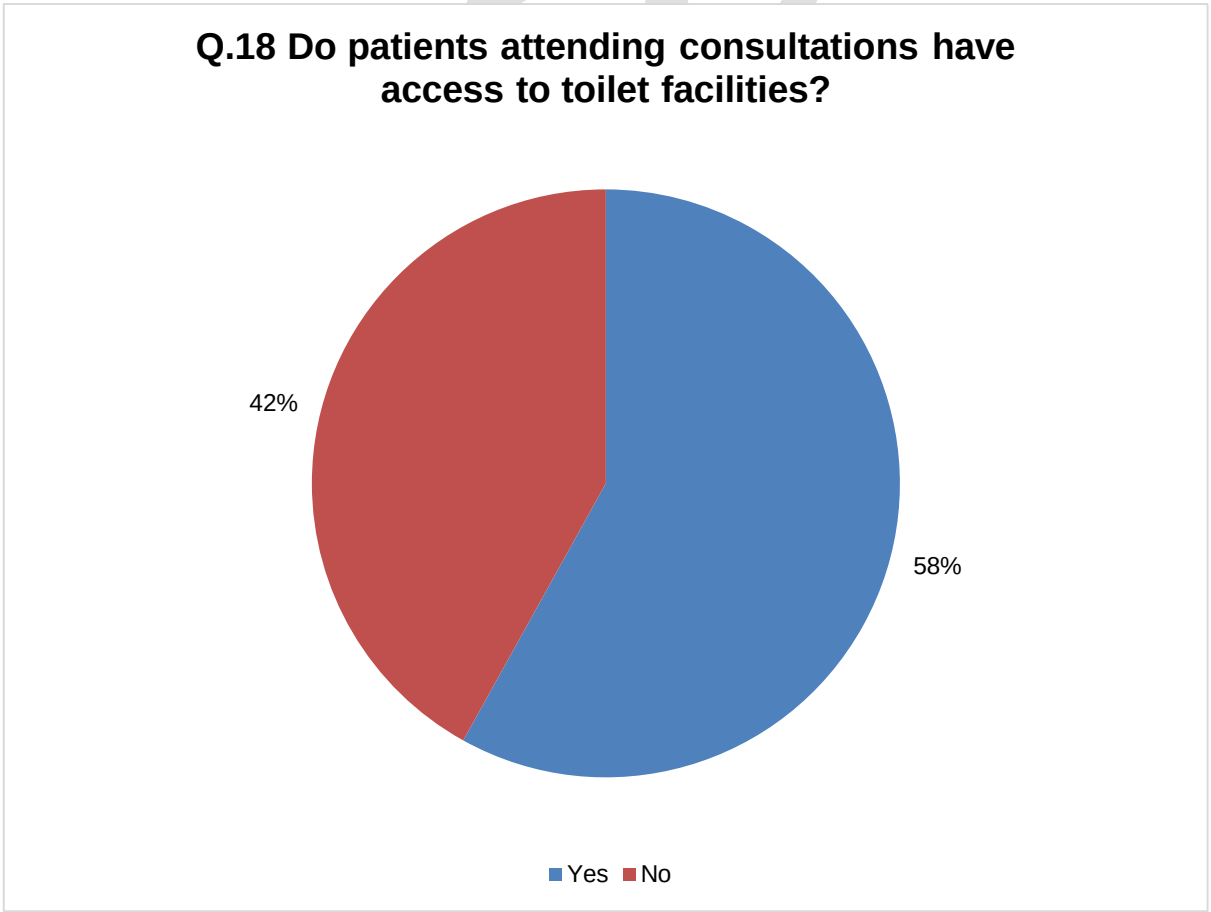
Q15. Does the pharmacy have access to an off-site consultation area (i.e. one which the former PCT or Area Team has given consent for use)



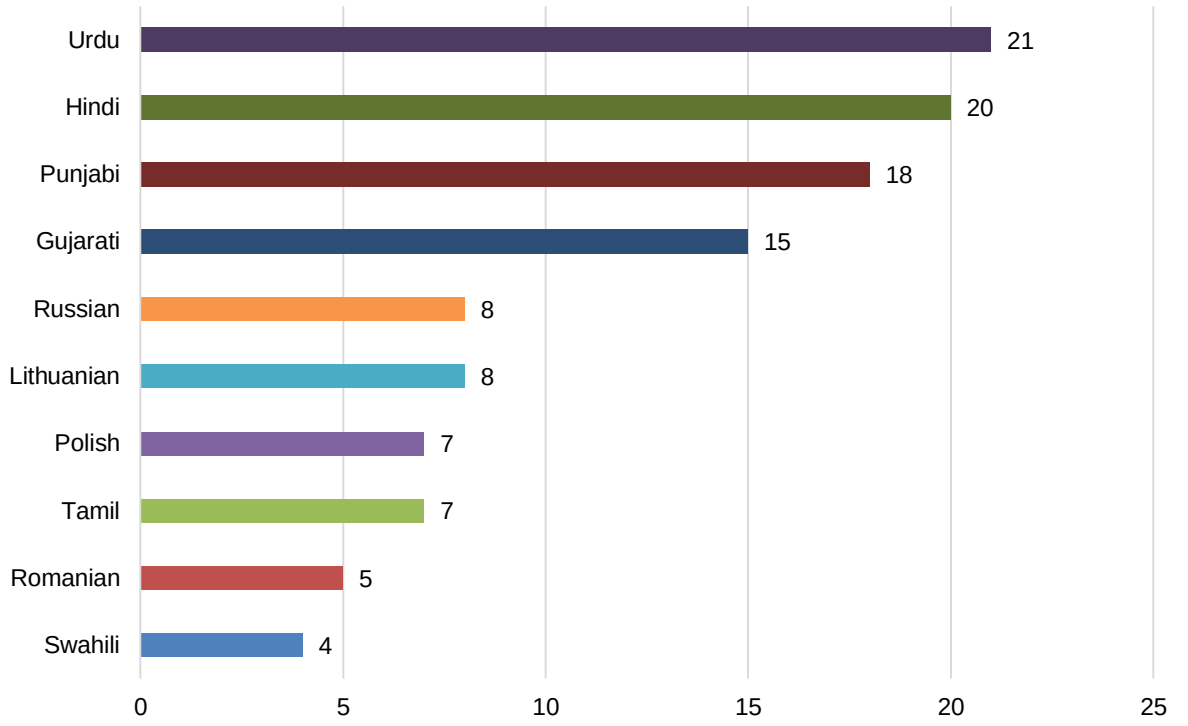
Q16. Is the pharmacy willing to undertake consultations in patient's home/ other suitable site?



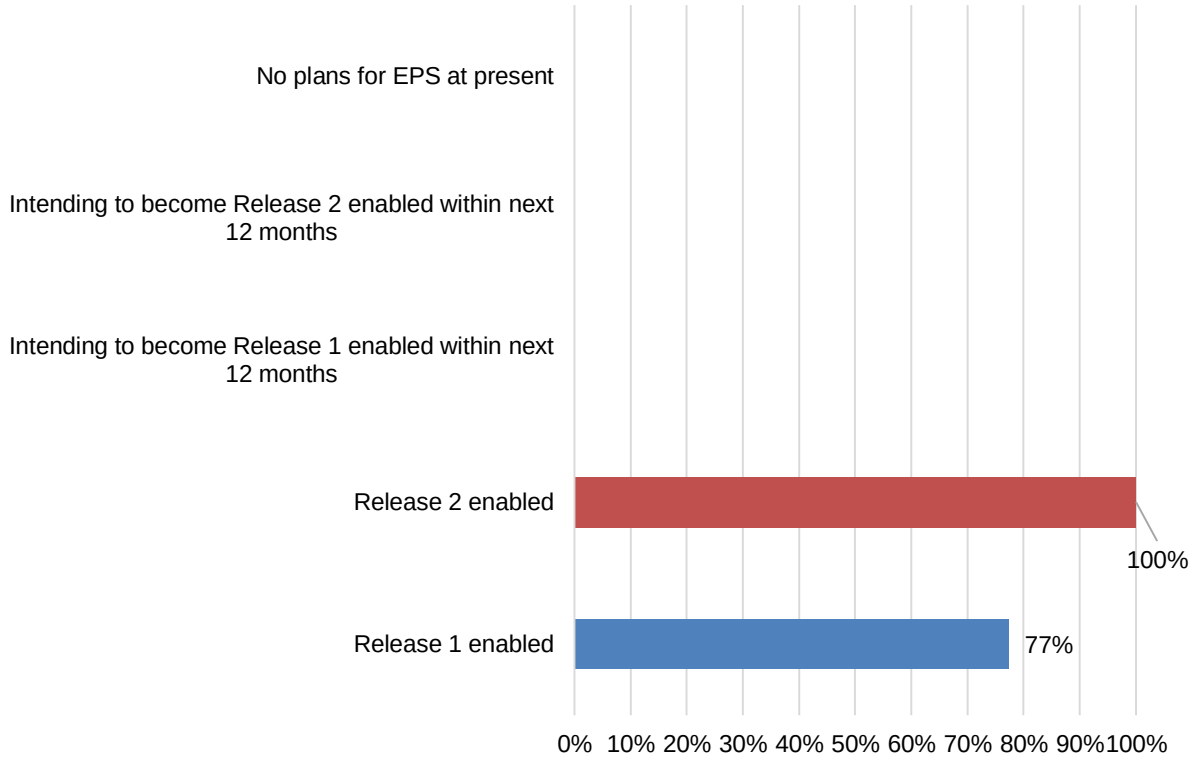

Q17. During consultations, are there hand-washing facilities?
None
Close to the consultation area
48%
In the consultation area
52%
0%
10%
20%
30%
40%
50%
60%


Q.18 Do patients attending consultations have access to toilet facilities?
42%
58%
Yes
No

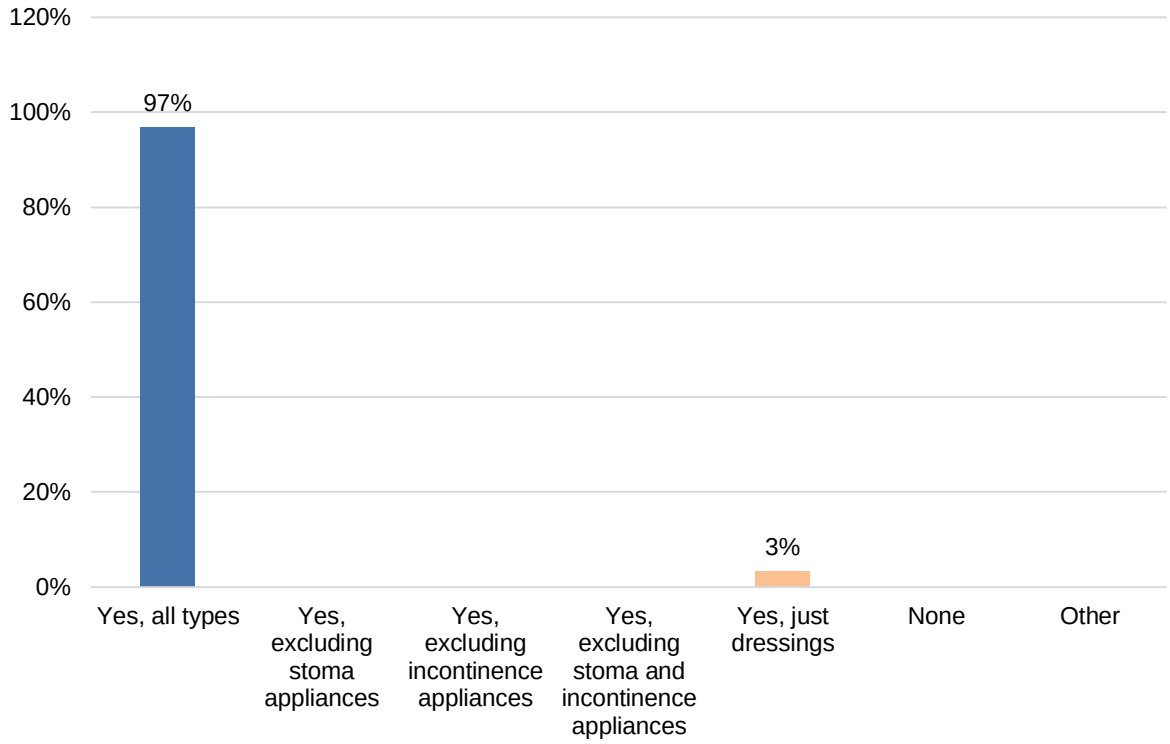
Q19. Top 10 Languages spoken (in addition to English)



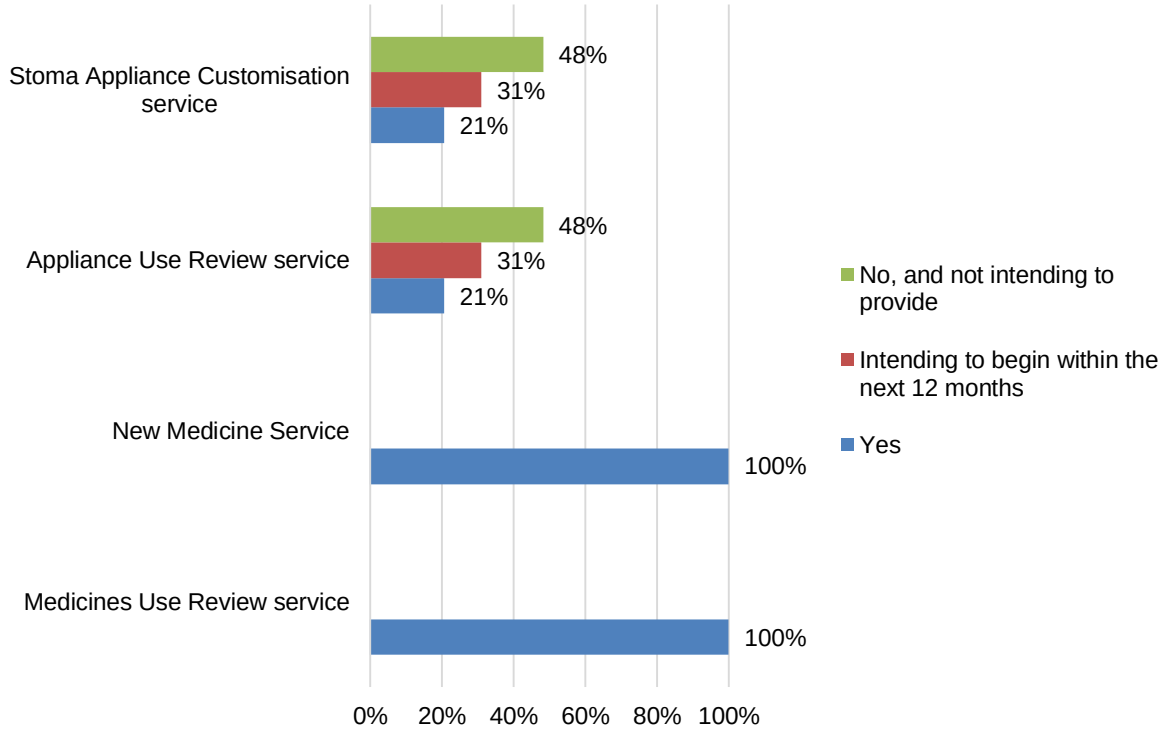
Q20. Electronic Prescription Service (select any that apply)



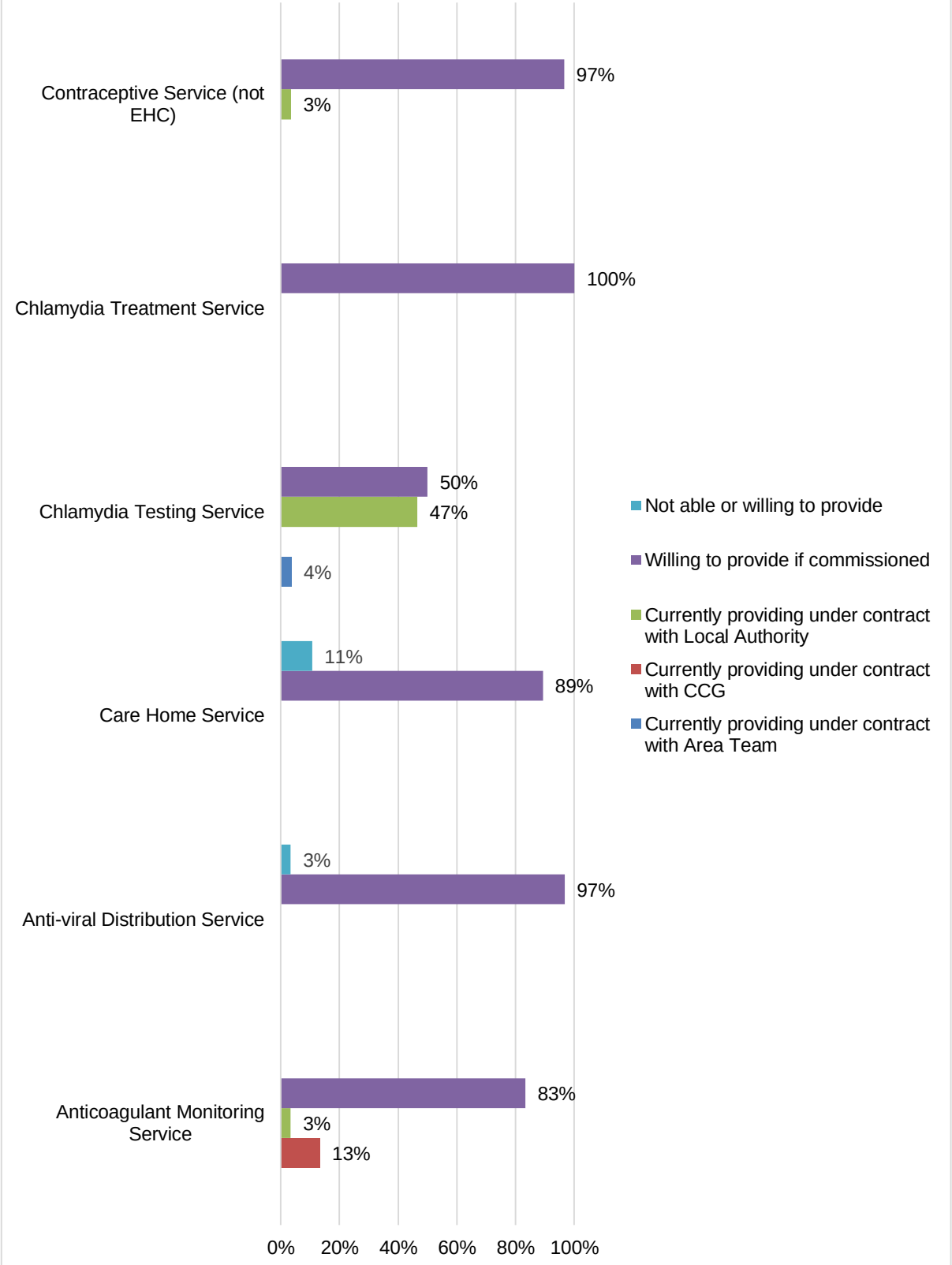
Q21. Essential Services: Does the pharmacy dispense appliances?

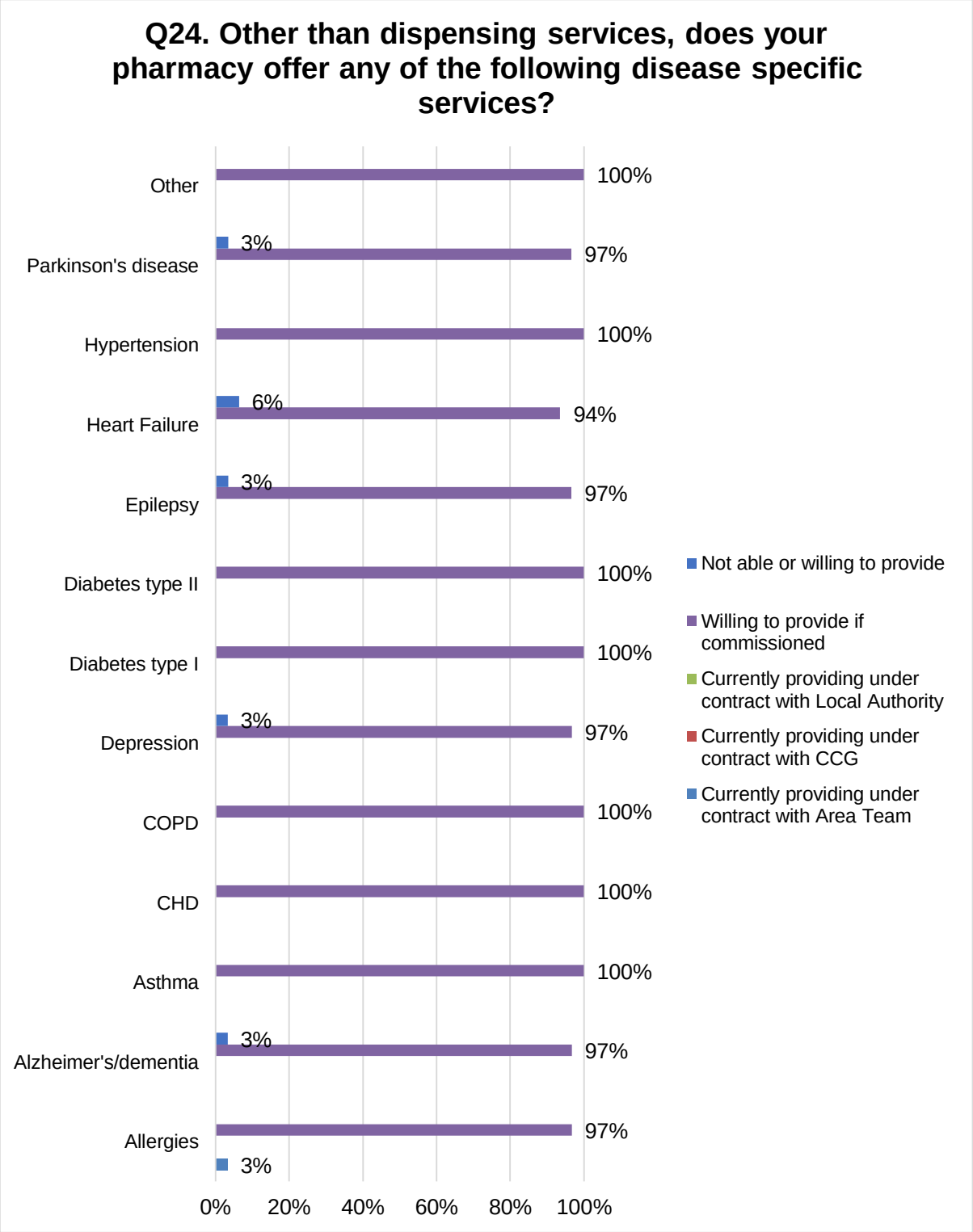


Q22. Advanced Services: Does the pharmacy provide the following services?



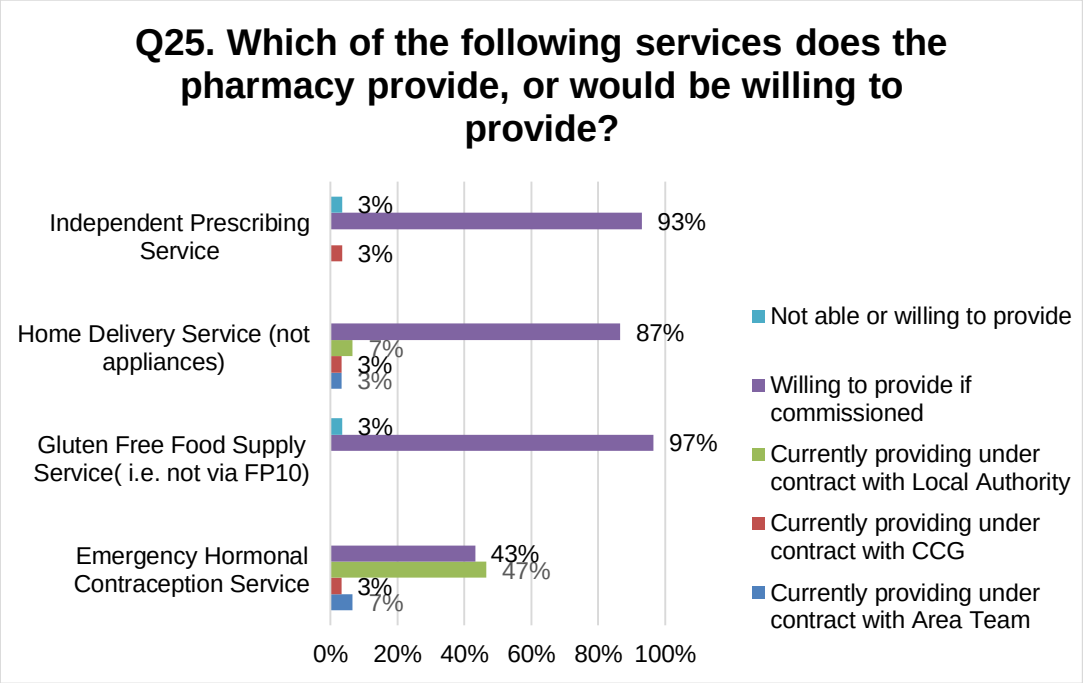
Q23. Enhanced and Other locally Commissioned Services: Which of the following services does the pharmacy provide, or would be willing to provide?



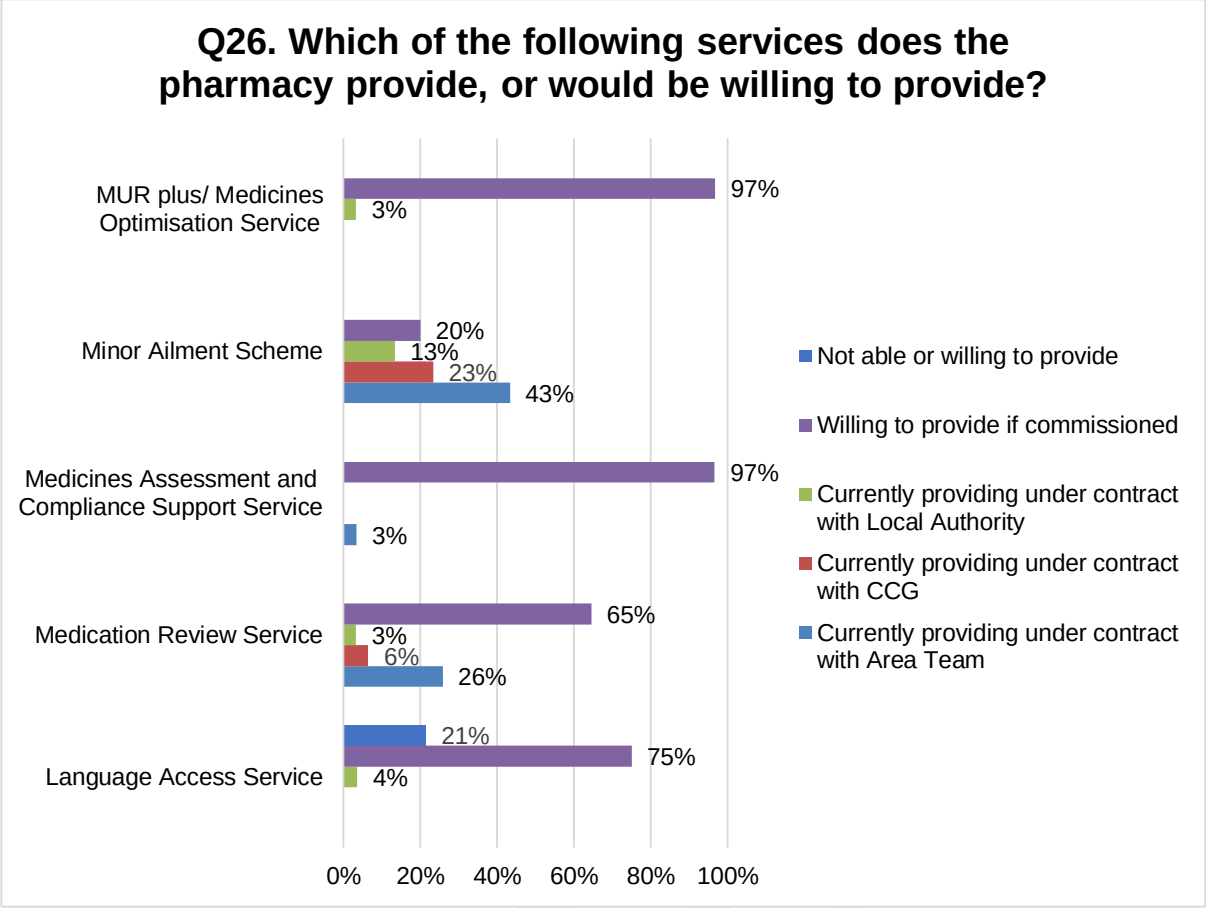


Other
Coaching for health, nutrition + diet clinic
We also provide TCES (Transforming Community Equipment Service) under contract with the Local Authority. This entails supplying (e.g. - disability equipment) against prescriptions issued by Occupational Therapists

We also provide TCES Transforming Community Equipment Service (provision of Equipment e.g. - disability products against requisitions from Occupational Therapists. This is commissioned by the Local Authority.

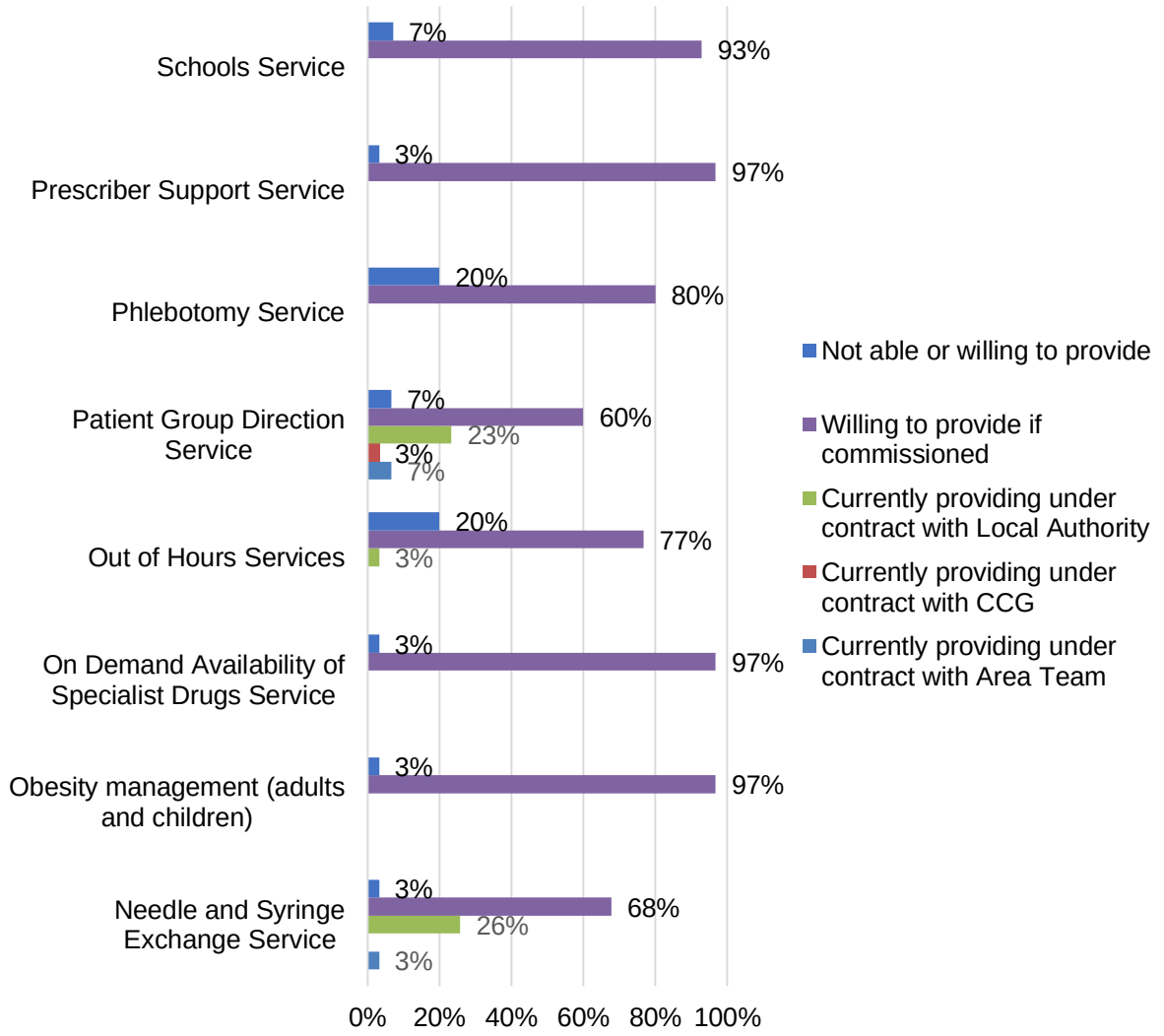


If currently providing an Independent Prescribing Service, what therapeutic areas are covered?
Free Home Delivery Service to patients currently provided as goodwill.
Anticoagulation, travel clinic
As commissioned

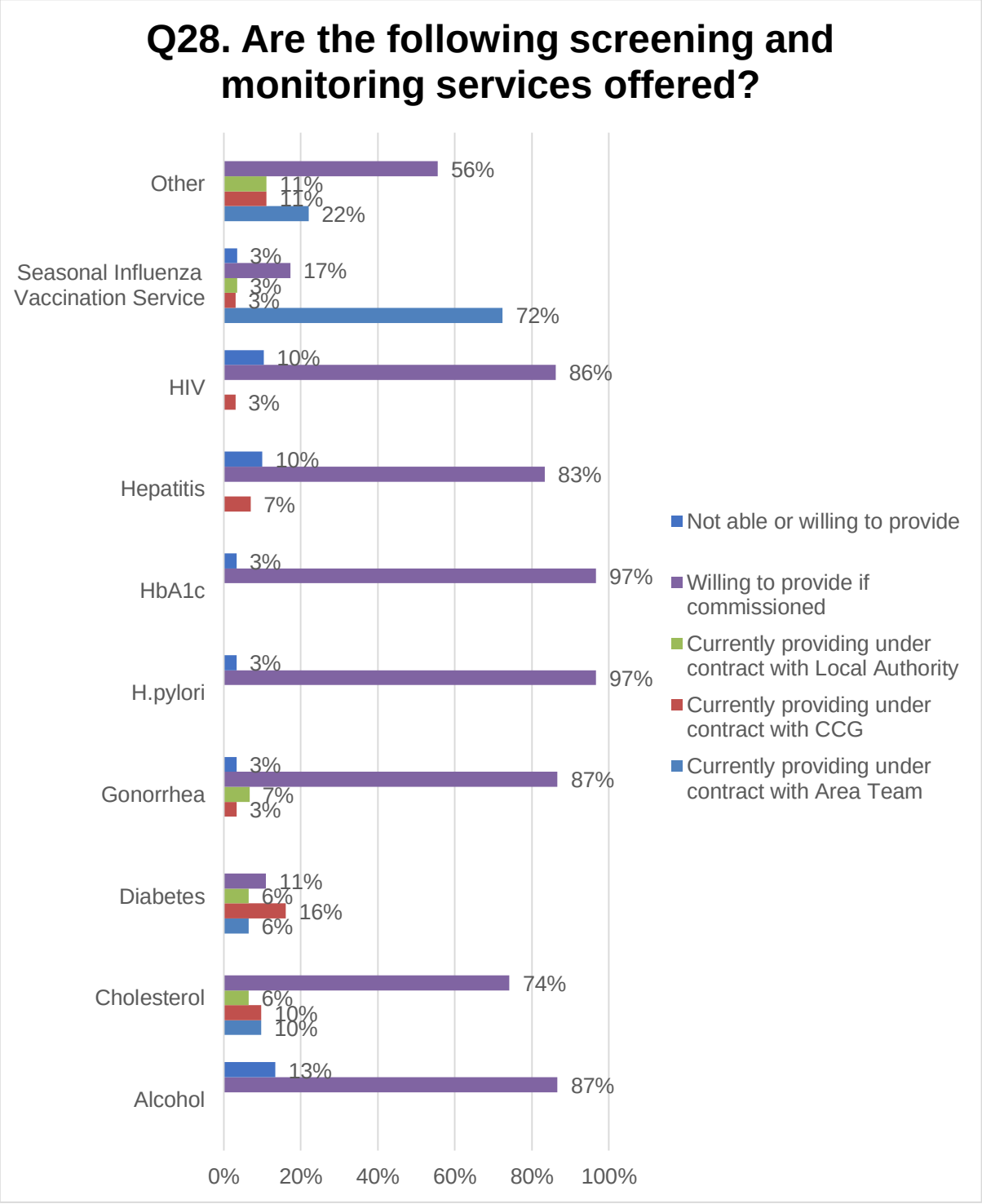


If currently providing MUR plus/ Medicines Optimisation Service, what therapeutic areas are covered?
Dermatitis

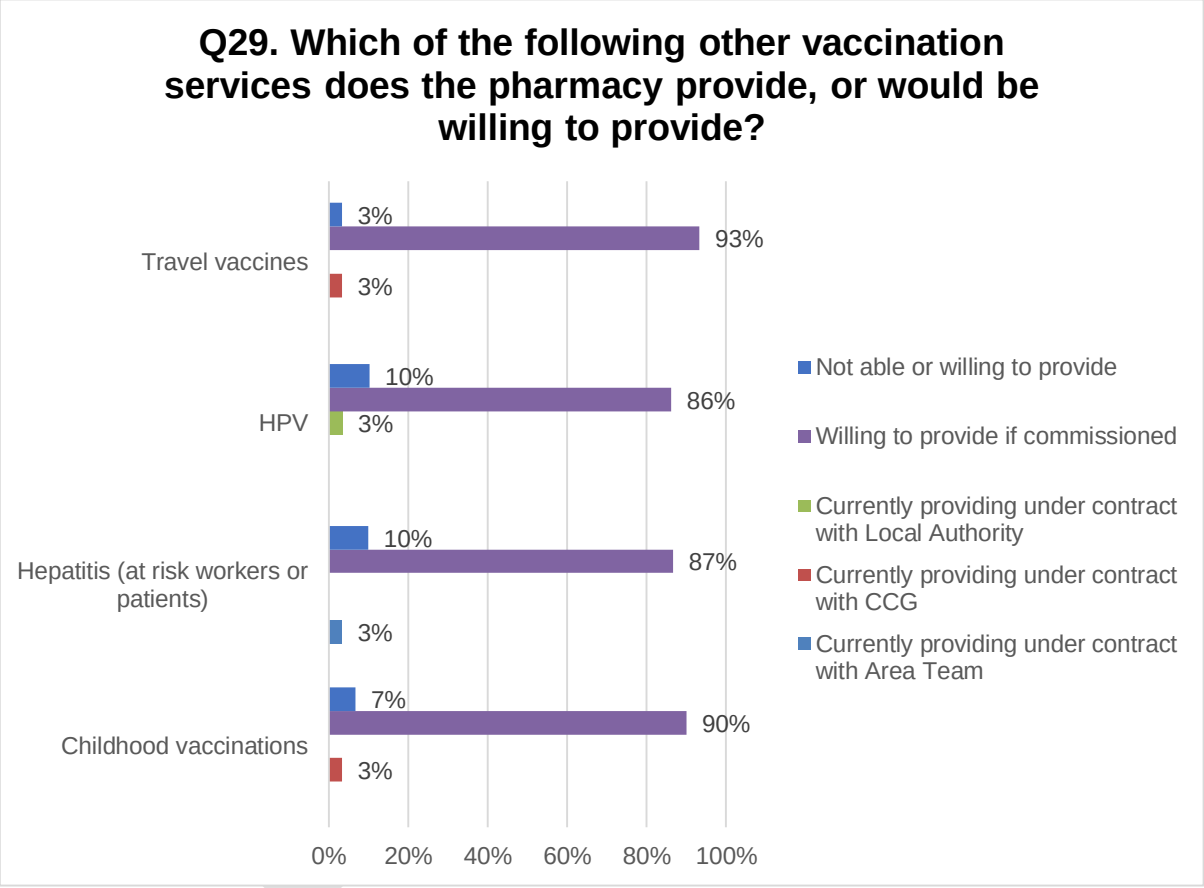
Q27. Which of the following services does the pharmacy provide, or would be willing to provide?



Patient Group Direction(medicines covered by the Patient Group Direction)
Malarone + sildenafil + Viagra Meningitis (Meaveu)
Levonorgestrel
Malarone, Ventolin, Sildenafil (Viagra)
Ventolin, Malarone, Sildenafil (Viagra)
Mefloquine, Doxycycline, Avotaquone/proguanil, sildenafil, tadenafil, vardenafil, salbutamol inhaler, champix, propecia, orlistat, contraceptive pills, emergency hormonal contraception, renicol, Xifaxanta, fluenz, Vaniqa
Levonell + ehl
Emergency Contraception Smoking Cessation
MAS meds
We are privately supplying under PGDs: Erectile Dysfunction (Sildenafil, Cialis, Levitra), Anti-Malarials (Malarone, Doxycycline, Lariam), Influenza and Hepatitis B Vaccine (all brands), Meningitis ACWY Vaccine (all brands), Hair Loss (Propecia), Emergency Contraception (Levonelle/ellaOne), Salbutamol Inhalers (asthma inhaler), Oral Contraceptive Pills (all brands) Travellers' Diarrhoea (Xifaxanta), Female Facial Hair (Vaniqa cream), Weight Loss (Orlistat 120mg), Period Delay (Norethisterone 5mg)
Levonelle – EHC via LA P Medicines – Minor Ailments via CCG

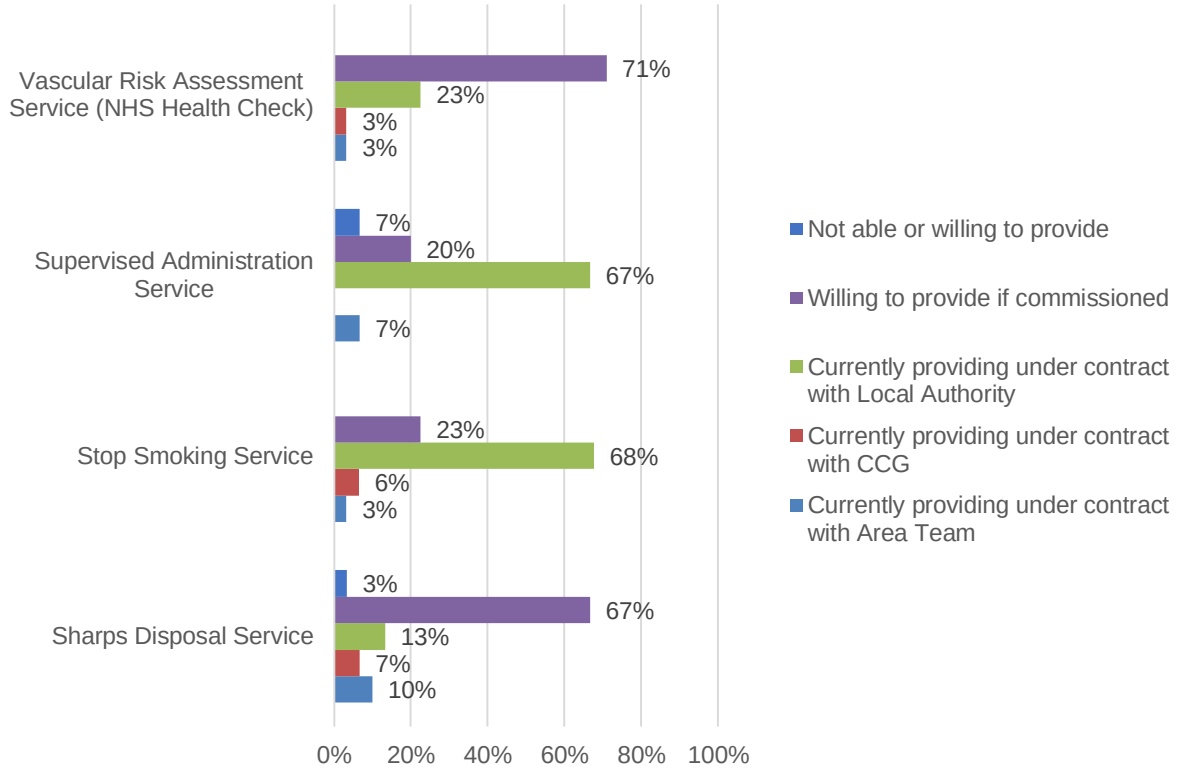

Q28. Are the following screening and monitoring services offered?
Other
56%
11%
11%
22%
Seasonal Influenza Vaccination Service
3%
17%
3%
3%
72%
HIV
10%
86%
3%
Hepatitis
10%
83%
7%
HbA1c
3%
97%
H.pylori
3%
97%
Gonorrhea
3%
87%
7%
3%
Diabetes
11%
6%
16%
6%
Cholesterol
74%
6%
10%
10%
Alcohol
13%
87%
0%
20%
40%
60%
80%
100%
Not able or willing to provide
Willing to provide if commissioned
Currently providing under contract with Local Authority
Currently providing under contract with CCG
Currently providing under contract with Area Team

Other
Pneumococcal vaccine
Full travel vaccination clinic + child immunisation service
Vascular risk assessment
We also offer seasonal Influenza Vaccination service privately under PGD. We also offer Pneumonia Vaccination under the NHS PGD
We also Offer Seasonal Influenza Vaccination Service Privately.
Private Flu

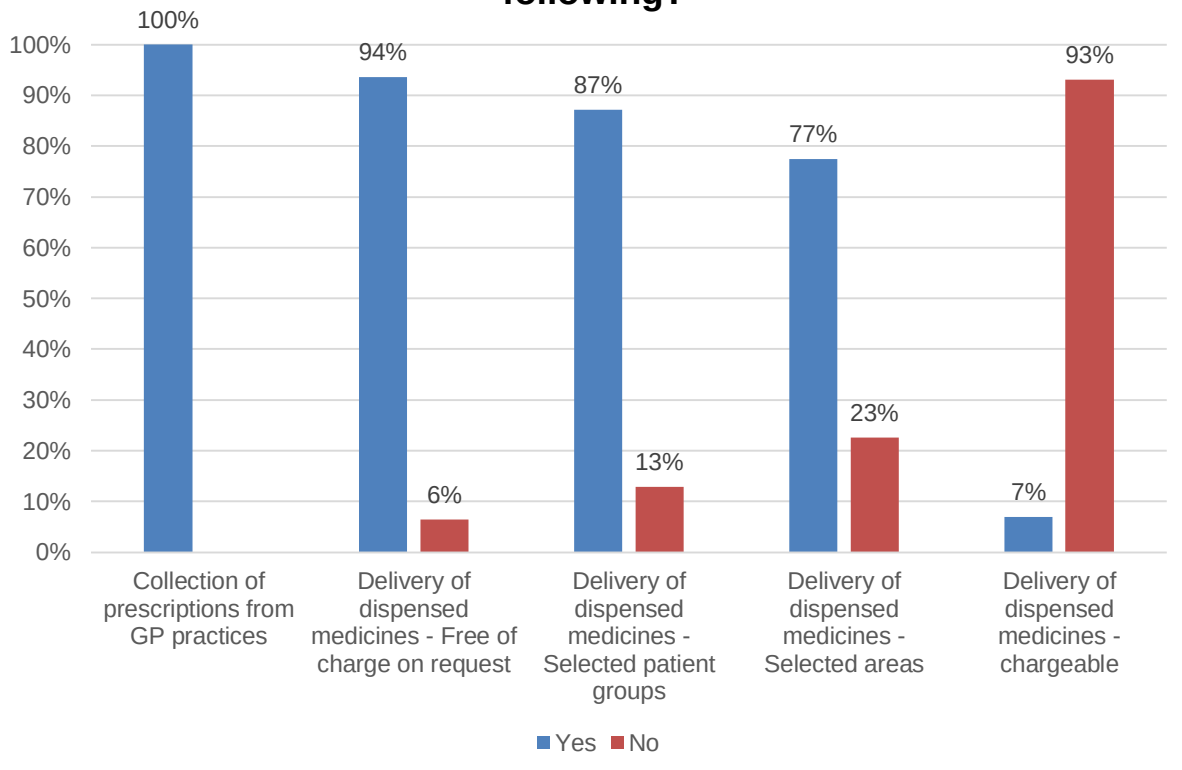


Other
Flu Vaccinations
We are also offering the Pneumonia Vaccination via the NHS.
We also offer seasonal Influenza Vaccination service privately under PGD. We also offer Pneumonia Vaccination under the NHS PGD

Q30. Which of the following services does the pharmacy provide, or would be willing to provide?

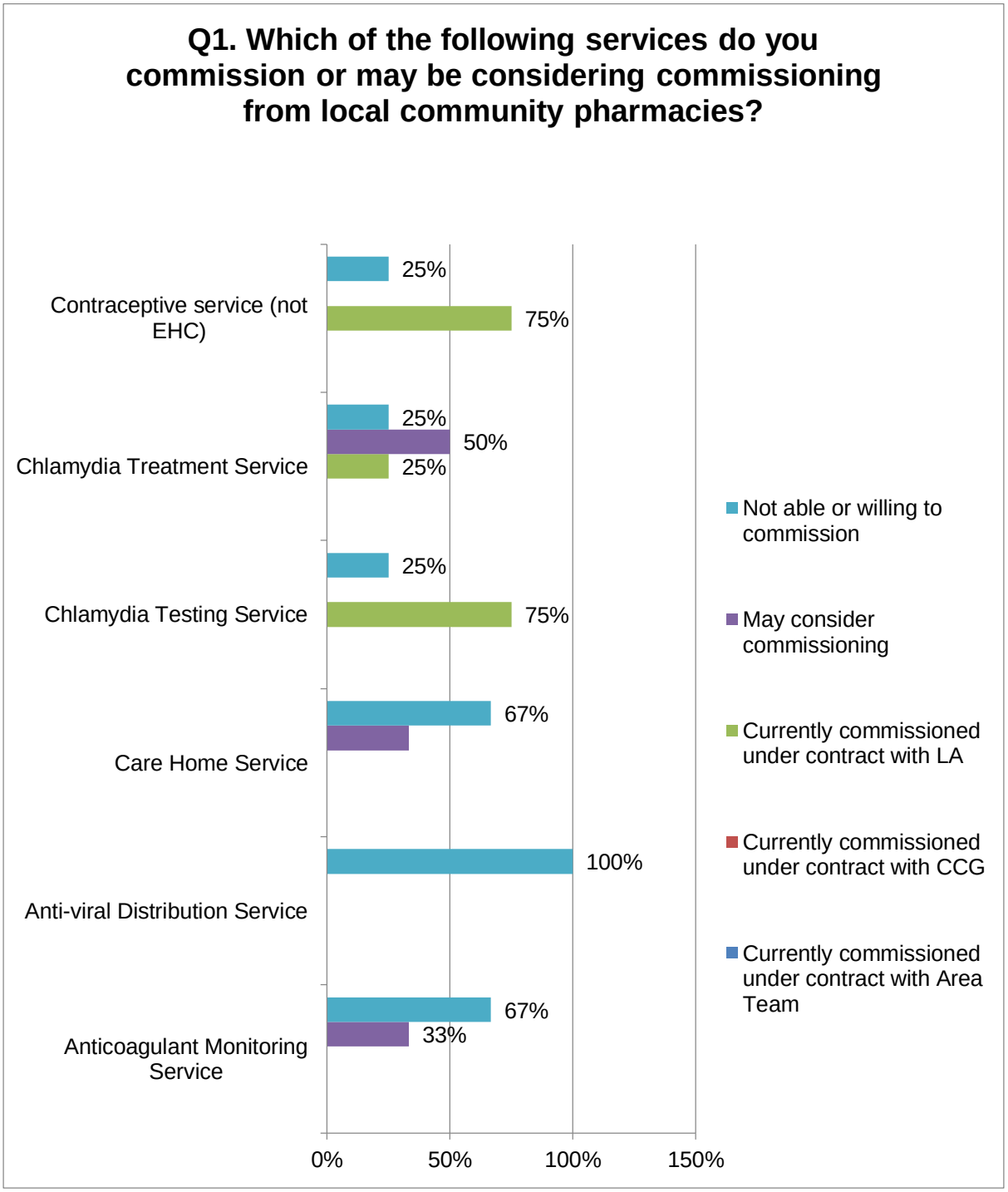


Q31. Does the pharmacy provide any of the following?



Appendix K: Results of the commissioner survey

NHS England, Local Authority and CCG commissioners were asked to respond to a series of questions regarding current and future service provision. The results of the survey are detailed below. It should be noted that no commissioner highlighted any intended current plans to commission new services through community pharmacies in Barking and Dagenham.



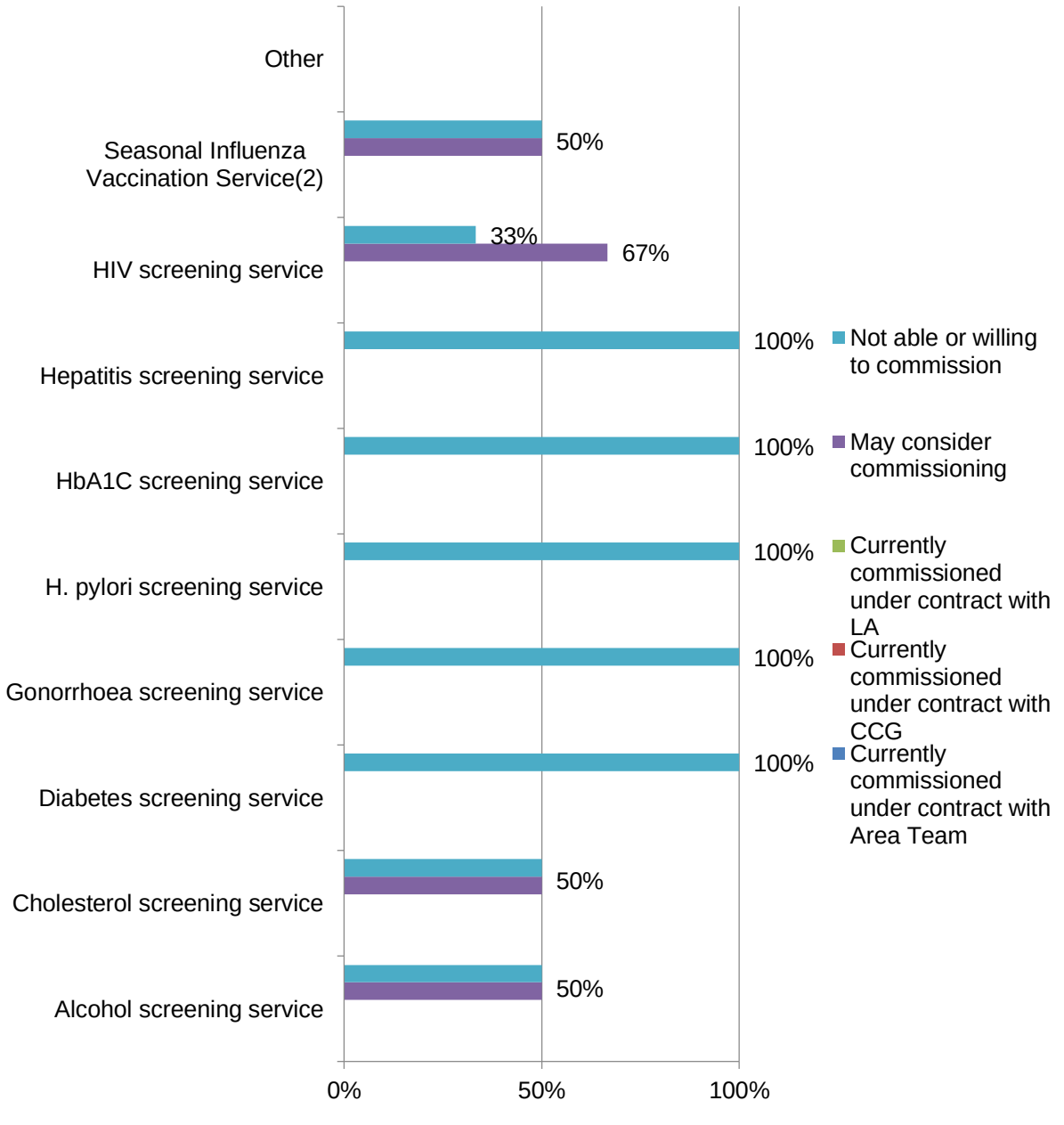
Q2. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Allergy management service	0%	0%	0%	0%	100%
Alzheimer's/ dementia management service	0%	0%	0%	100%	0%
Asthma management service	0%	0%	0%	50%	50%
CHD management service	0%	0%	0%	67%	33%
COPD management service	0%	0%	0%	67%	33%
Depression management service	0%	0%	0%	50%	50%
Diabetes type I management service	0%	0%	0%	50%	50%
Diabetes type II management service	0%	0%	0%	67%	33%
Epilepsy management service	0%	0%	0%	50%	50%
Heart Failure management service	0%	0%	0%	67%	33%
Hypertension management service	0%	0%	0%	67%	33%
Parkinson's disease	0%	0%	0%	50%	50%
Emergency Hormonal Contraception Service	0%	0%	50%	0%	50%
Gluten Free Food Supply Service (i.e. not via FP10)	0%	0%	0%	0%	100%

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Home Delivery Service (not appliances)	0%	0%	0%	0%	100%
Independent Prescribing Service	0%	0%	0%	0%	100%
If currently providing an Independent Prescribing Service, what therapeutic areas are covered?	0%	0%	0%	0%	100%
Language Access Service	0%	0%	0%	0%	100%
Medication Review Service	0%	0%	0%	50%	50%
Medicines Assessment and Compliance Support Service	0%	0%	0%	0%	100%
Minor Ailment Scheme	0%	0%	0%	0%	100%
MUR Plus/Medicines Optimisation Service	0%	0%	0%	0%	100%
If currently providing an MUR Plus/ Medicines Optimisation Service, what therapeutic areas are covered?	0%	0%	0%	0%	100%
Needle and Syringe Exchange Service	0%	0%	0%	50%	50%
Obesity management (adults and children)	0%	0%	0%	100%	0%
On Demand Availability of Specialist Drugs Service	0%	0%	0%	0%	100%
Out of Hours Services	0%	0%	0%	67%	33%

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Patient Group Direction Service (name the medicines covered by the Patient Group Direction)	0%	0%	67%	0%	33%
Phlebotomy Service	0%	0%	0%	0%	100%
Prescriber Support Service	0%	0%	0%	0%	100%
Schools Service	0%	0%	0%	0%	100%
Other (please state)	0%	0%	0%	0%	0%

Q3. Which of the following services do you commission or may be considering commissioning from local community pharmacies?



Q4. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Childhood vaccinations	0%	0%	0%	0%	100%
Hepatitis (at risk workers or patients)	0%	0%	0%	0%	100%
HPV	0%	0%	0%	0%	100%
Travel vaccines	0%	0%	0%	0%	100%

Q5. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Sharps Disposal Service	0%	0%	50%	0%	50%
Stop Smoking Service	0%	0%	67%	0%	33%
Supervised Administration Service	0%	0%	50%	0%	50%
Supplementary Prescribing Service (what therapeutic areas are covered?)	0%	0%	0%	0%	100%
Vascular Risk Assessment Service (NHS Health Check)	0%	0%	0%	0%	100%
Other (please state below)	0%	0%	100%	0%	0%

Abbreviations

AURs - Appliance Use Reviews

BAME - Black Asian Minority Ethnic

CCGs - Clinical Commissioning Groups

CEDAB - Community Equipment Dispenser Accreditation Body

COPD - Chronic obstructive pulmonary disease

CTAD - Chlamydia Testing Activity Dataset

CVD - Cardiovascular Disease

DACs - Dispensing Appliance Contractors

DH - Department of Health

EHC - Emergency Hormonal Contraception

HWB - Health and Wellbeing Board

HWBS - Health and Wellbeing Board Strategy

IMD - Index of Multiple Deprivation

JSNA - Joint Strategic Needs Assessment

LA - Local Authority

LB - London Borough

LPS - Local Pharmaceutical Service

LSOAs - Lower Super Output Areas

MAS - Minor Ailment Service

MIU - Minor Injuries Unit

MURs - Medicines Use Reviews

NCSP - National Chlamydia Screening Programme

NHS - National Health Service

NMS - New Medicines Service

ONS - Office for National Statistics

PCTs - Primary Care Trusts

PGD - Patient Group Direction

PNA - Pharmaceutical Needs Assessment

PSNC - Pharmaceutical Services Negotiating Committee

PURM – Pharmacy Urgent Repeat Medication service

SAC - Stoma Appliance Customisation

SADL - Simple Aids to Disability Living

SC - Supervised Consumption

SHA - Strategic Health Authority

STI - Sexually Transmitted Infection

TCES - Transforming Community Equipment Services

Equality Impact Assessment

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

About the service or policy development

Name of service or policy	Pharmaceutical Needs Assessment
Lead Officer Contact Details	Remi Omotoye remi.omotoye@lbbd.gov.uk

Why is this service or policy development/review needed?
As per the Pharmaceutical Services Regulations 2013[9], each Health and Wellbeing Board is required to produce a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. The PNA will assess the provision of pharmaceutical services within Barking and Dagenham HWB area and its neighbouring areas, for the people of Barking and Dagenham. The PNA will be used by NHS England to determine access to pharmaceutical services and by Barking and Dagenham HWB in conjunction with the JSNA and other strategic documents to plan services to address health inequalities in the Barking and Dagenham HWB area. Pharmaceutical services are the majority of services provided by community pharmacies, appliance contractors and some dispensing GP practices. Barking and Dagenham HWB area has community pharmacies and appliance contractors providing pharmaceutical services. A PNA was produced by Barking and Dagenham PCT in 2011. The Barking and Dagenham HWB PNA will revise this existing PNA and plan for the next three years. Future revisions of the Barking and Dagenham HWB PNA will occur at least every three years.

1. Community impact (this can be used to assess impact on staff although a cumulative impact should be considered).

What impacts will this service or policy development have on communities?
Look at what you know? What does your research tell you?

Consider:

- National and local data sets – for example, Knowing Our Community (link to be inserted
- Complaints
- Consultation and service monitoring information
- Voluntary and Community Organisations
- The Equality Act places a specific duty on people with 'protected characteristics'. The table below details these groups and helps you to consider the impact on these groups.

	Positive	Neutral	Negative	What are the positive and negative impacts?	How will benefits be enhanced and negative impacts minimised or eliminated?
Local communities in general		x		The PNA has assessed current health needs and access to pharmaceutical services. The assessment has made recommendations to fill any gaps in the provision of pharmaceutical services and also recommendations for improvements and / or better access to current provision. Prior to the production of the draft PNA a resident survey was undertaken to seek the public's views on access to pharmaceutical services in the Barking and Dagenham area. To ensure there is an equality of access for all people within Barking and Dagenham HWB area, the survey was distributed amongst a cross-section of Barking and Dagenham people. Residents within the protected characteristics groups were targeted to receive	The PNA has taken account of the health needs of all populations and consider how different populations' pharmaceutical needs vary and are currently met. The aim of the PNA is to address any health inequalities and / or variance to access pharmaceutical services. Recommendations to address these have been made where any variances were found.
Age		x			
Disability		x			
Gender reassignment		x			
Marriage and civil partnership		x			
Pregnancy and maternity		x			
Race (including Gypsies, Roma and Travellers)		x			
Religion or belief		x			
Gender		x			
Sexual orientation		x			
Any community issues identified for this location? *See above link to ward profiles.* If the project is based in a specific location please state where, or whether Borough wide. Please note any detail of relevance e.g. is it an area with high unemployment, or public transport limited?					

				feedback on any barriers to accessing pharmaceutical services by people from protected characteristics. Responses to the survey helped to inform the recommendations within the draft PNA and any potential gaps and / or improvements to pharmaceutical services in the Barking and Dagenham area. The draft PNA underwent an eight week consultation and views from the Barking and Dagenham public were sought. Populations from the protected characteristics populations were targeted within the consultation to seek their views upon the assessment and its recommendations.	

2. Consultation.

Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups? ***This is a vital step*** *– see* full guidance (PDF to be inserted).
A pharmacy user questionnaire was undertaken. Steering group members were asked to provide local expertise as to how best / whom to engage with for the completion of the questionnaires. Many steering group members had experience from previous council consultations, what the equalities and health inequalities are and which groups needed to be targeted. This helped to inform the engagement activities necessary to give a better understanding of how to address the equalities and health inequalities. Upon completion of the draft PNA, a public consultation exercise was undertaken to further seek the public's views on pharmaceutical services provision. A paper and electronic-based questionnaire was undertaken to receive feedback from the public on pharmaceutical services. Based on the feedback from the questionnaire, and steering group members' recommendations, specific consultation activities were planned.

Monitoring and Review

How will you review community and equality impact once the service or policy has been implemented?
These actions should be developed using the information gathered in ***Section1 and 2*** *and should be picked up in your departmental/service business plans.*

Action	**By when?**	**By who?**
Review EIA before the publication of the draft PNA, before the consultation	19th December 2014	

3. Next steps

It is important the information gathered is used to inform any Council reports that are presented to Cabinet or appropriate committees. This will allow Members to be furnished with all the facts in relation to the impact their decisions will have on different equality groups and the community as a whole.

Take some time to précis your findings below. This can then be added to your report template for sign off by the Strategy Team at the consultation stage of the report cycle.

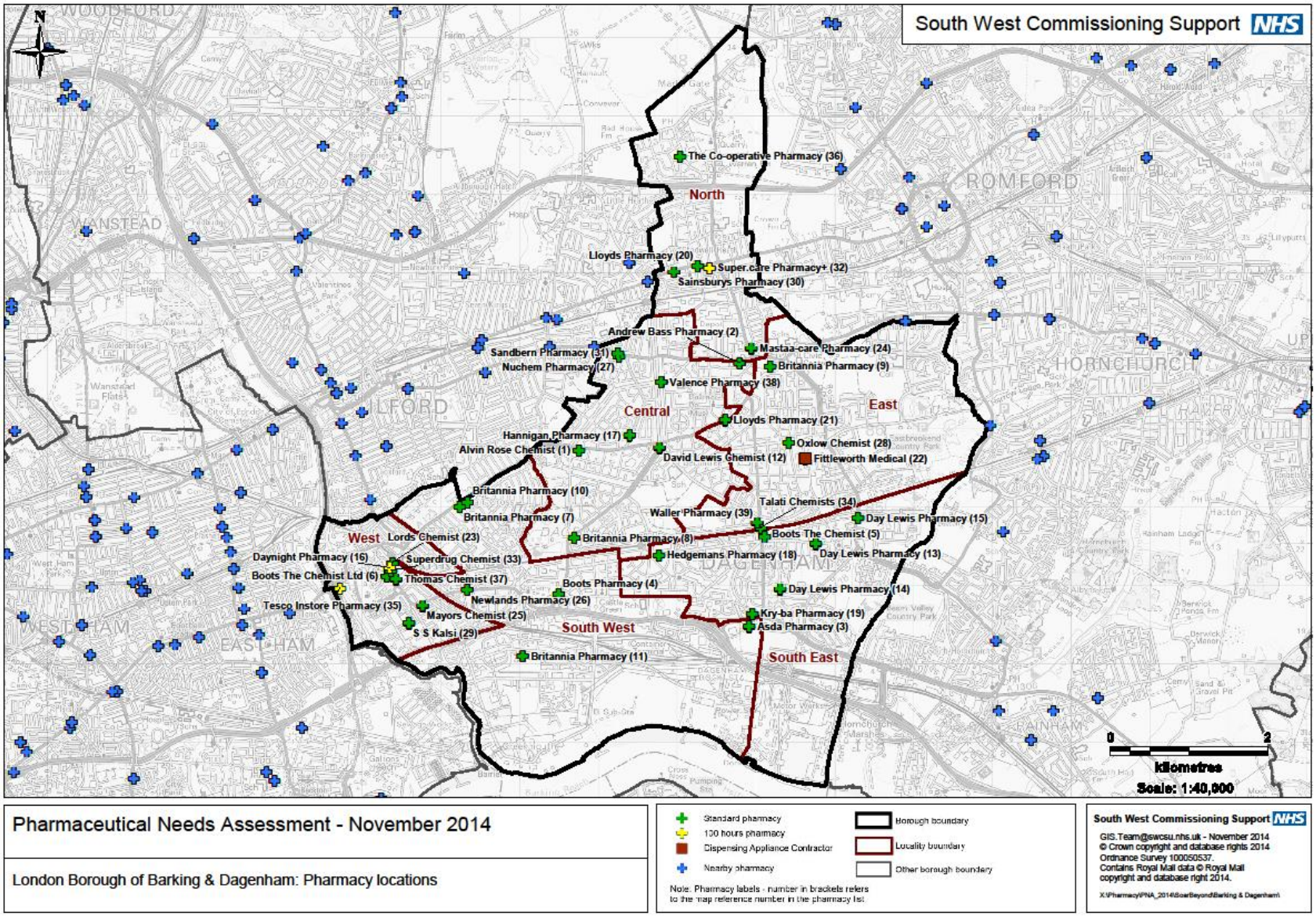
Implications/ Customer Impact

5. Sign off

The information contained in this template should be authorised by the relevant project sponsor or Divisional Director who will be responsible for the accuracy of the information now provided and delivery of actions detailed.

Name	Role (e.g. project sponsor, head of service)	Date

Map A: Contractor locations and ward boundaries



Pharmaceutical Needs Assessment - November 2014

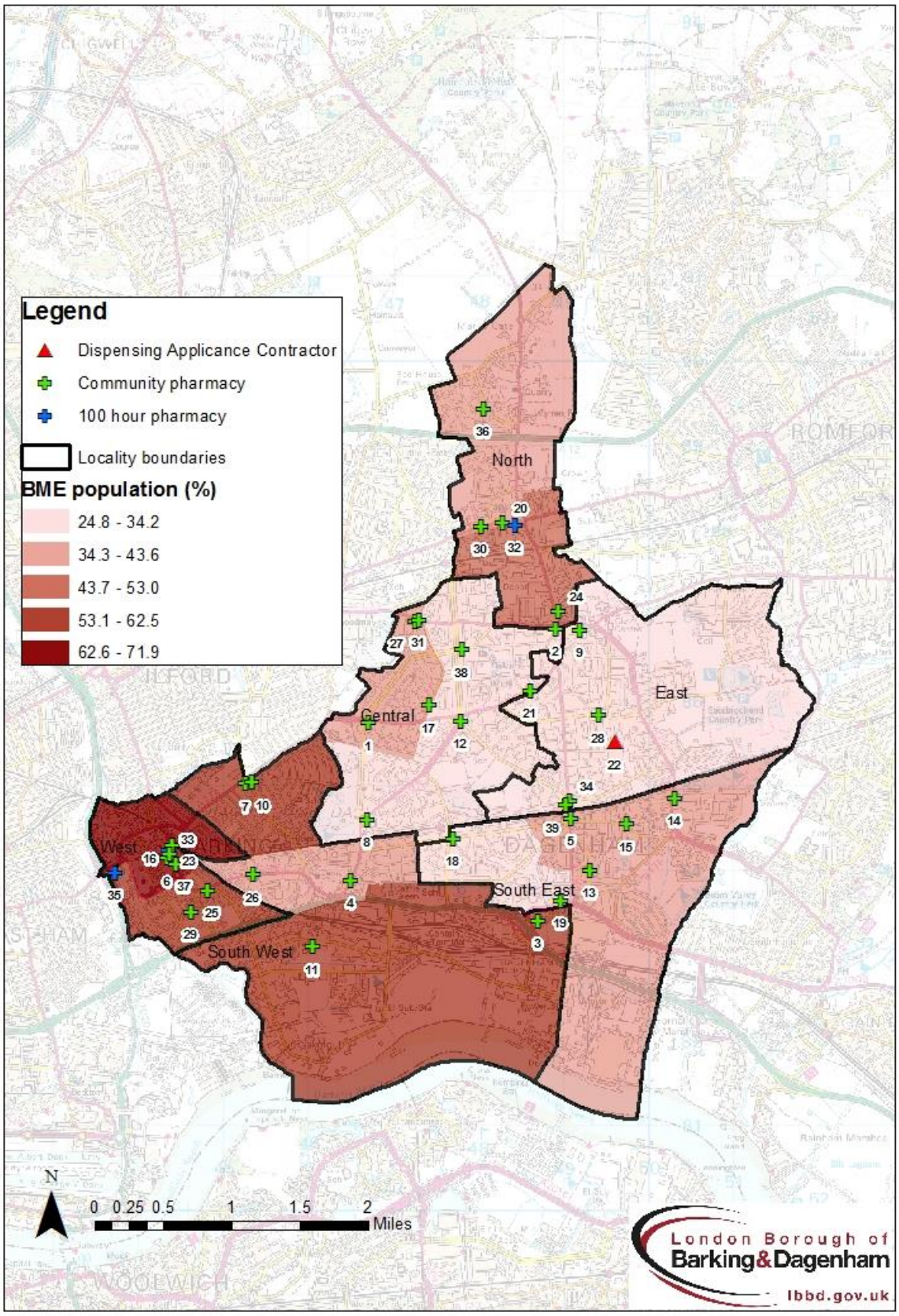
London Borough of Barking & Dagenham: Pharmacy locations

Standard pharmacy
100 hours pharmacy
Dispensing Appliance Contractor
Nearby pharmacy
Borough boundary
Locality boundary
Other borough boundary

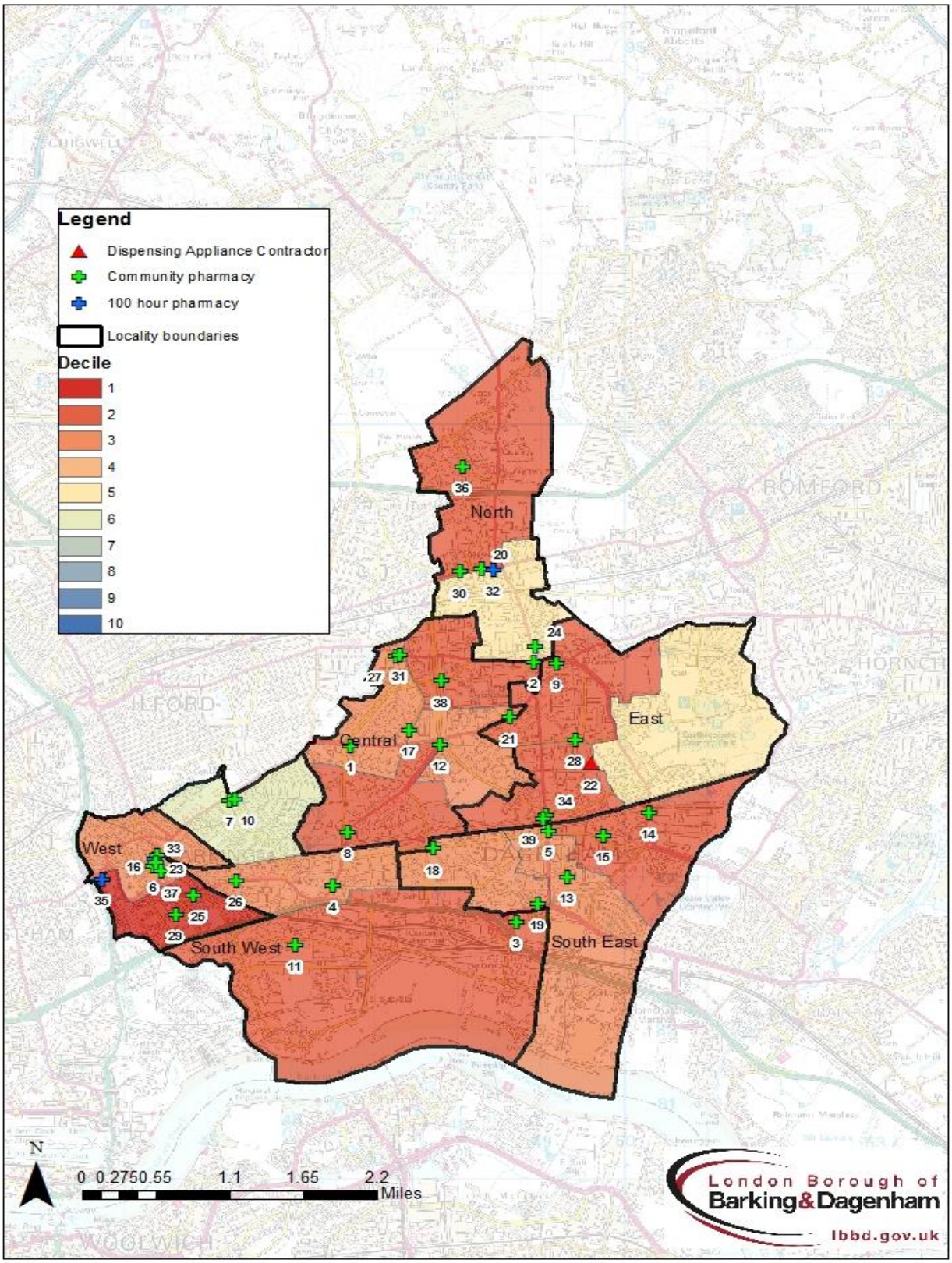
Note: Pharmacy labels - number in brackets refers to the map reference number in the pharmacy list

X:\Pharmacy\PNA_2014\BoarBeyond\Barking & Dagenham\

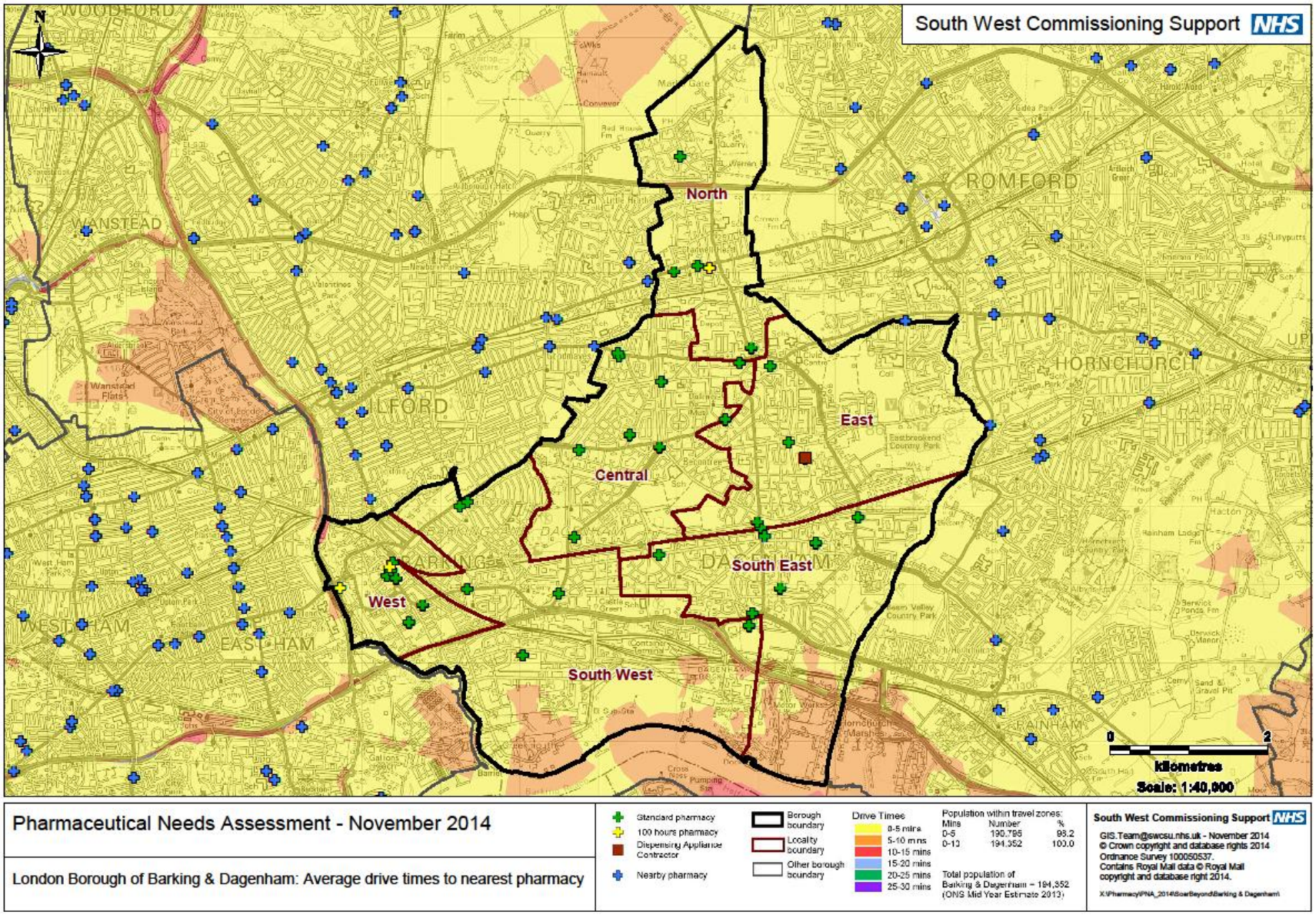
Map B: Contractor locations and percentage BAME populations



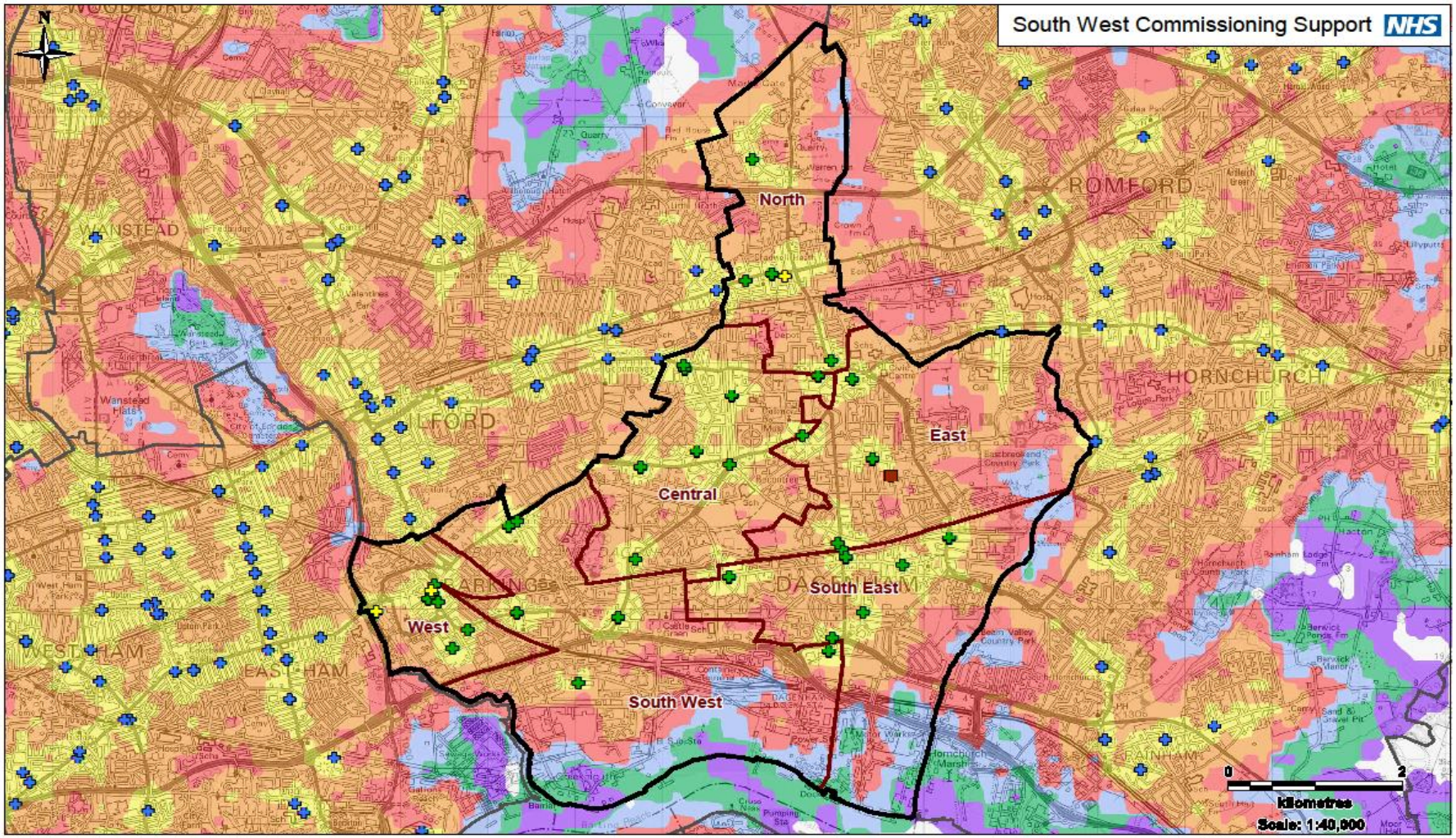
Map C: Contractor locations and Index of Multiple Deprivation 2010 by Output Area



Map D: Average drive times to nearest pharmacy



Map E: Average public transport times to nearest pharmacy, Tuesday, 9am to 5pm



Pharmaceutical Needs Assessment - November 2014

London Borough of Barking & Dagenham: Public Transport times to nearest pharmacy - Tuesday, 9am to 1pm

Standard pharmacy
100 hours pharmacy
Dispensing Appliance Contractor
Nearby pharmacy

Borough boundary
Locality boundary
Other borough boundary

Public Transport Times
0-5 mins
5-10 mins
10-15 mins
15-20 mins
20-25 mins
25-30 mins

Note: Times represent the best case scenario for journeys between the specified period

Population within travel zones:

Mins	Number	%
0-5	57,293	29.5
0-10	171,354	88.2
0-15	194,352	100.0

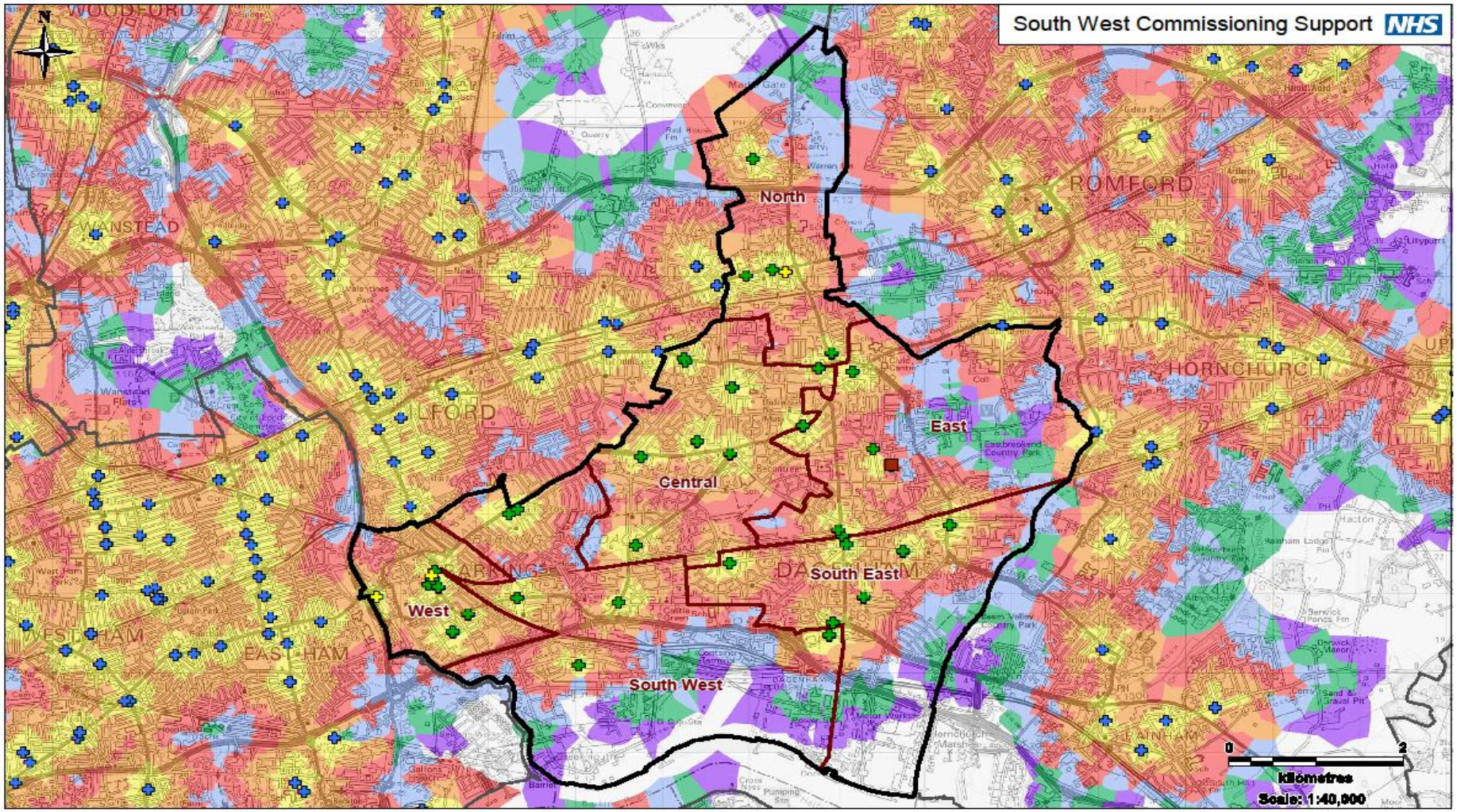
Total population of Barking & Dagenham = 194,352 (ONS Mid Year Estimate 2013)

South West Commissioning Support NHS

GIS.Team@swcsu.nhs.uk - November 2014

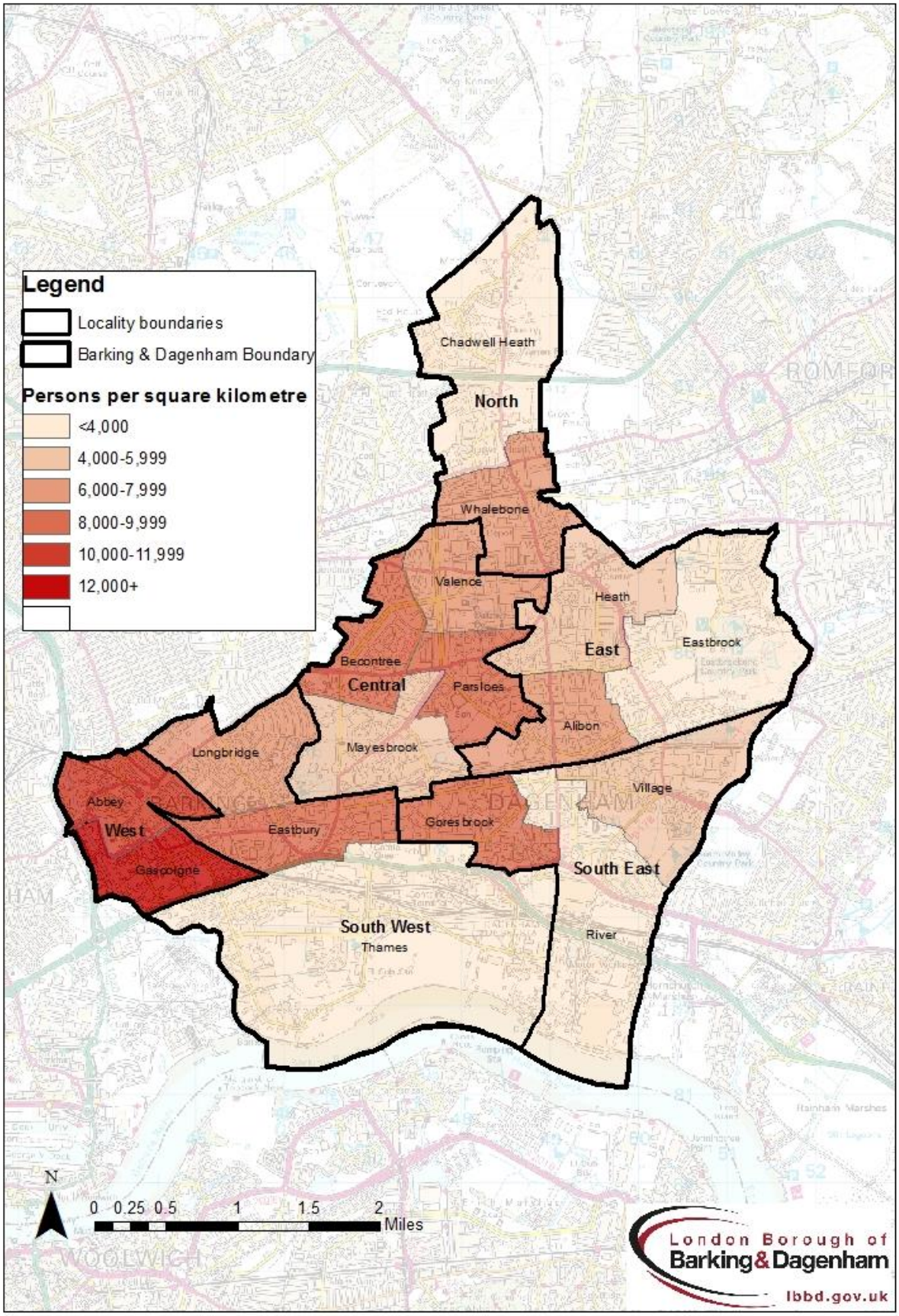
X:\Pharmacy\PNA_2014\BoarBeyond\Barking & Dagenham\

Map F: Average walking times to nearest pharmacy



Pharmaceutical Needs Assessment - November 2014	Standard pharmacy 100 hours pharmacy Dispensing Appliance Contractor Nearby pharmacy Borough boundary Locality boundary Other borough boundary Walking Times: 0-5 mins, 5-10 mins, 10-15 mins, 15-20 mins, 20-25 mins, 25-30 mins Population within travel zones: Mins / Number / % 0-5 / 39,130 / 20.1 0-10 / 125,537 / 64.6 0-15 / 173,524 / 89.3 0-20 / 184,079 / 93.6 0-25 / 189,113 / 97.3 0-30 / 194,362 / 100.0 Total population of Barking & Dagenham = 194,362 (ONS Mid Year Estimate 2013)
London Borough of Barking & Dagenham: Walking times to nearest pharmacy	South West Commissioning Support NHS GIS.Team@swcsu.nhs.uk - November 2014 © Crown copyright and database rights 2014 Ordnance Survey 100050537. Contains Royal Mail data © Royal Mail copyright and database right 2014. X:\Pharmacy\PNA_2014\SoarBeyond\Barking & Dagenham\

Map G: Population density by ward in Barking and Dagenham



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HEALTH AND WELLBEING BOARD

17 March 2015

Title: Section 75 Arrangements for the Better Care Fund	
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Authors: Mark Tyson, Group Manager, Integration & Commissioning Sharon Morrow, Chief Operating Officer Barking and Dagenham Clinical Commissioning Group.	**Contact Details:** Tel: 020 8227 2875 Email: mark.tyson@lbbd.gov.uk
Sponsors: Anne Bristow, Corporate Director of Adult & Community Services Conor Burke, Chief Accountable Officer, Barking and Dagenham, Clinical Commissioning Group.	

Summary:

The Better Care Fund between the Council and the Clinical Commissioning Group has now been fully assured by NHS England, recognising the positive joint work undertaken by the partners and the resolution of the remaining issues for implementation.

National directions for the Better Care Fund require the agreement of a Section 75 arrangement between local authorities and the Clinical Commissioning Group for Barking and Dagenham to be in place for year two of the fund, 2015/16. This will formalise arrangements for bringing together the financial contributions made by the Council and by the CCG into a single pool with a collective value of £21.299m, along with details of ,the 11 individual schemes that comprise our Better Care Fund plan. The agreement also formalises the management of the fund and the role of the Joint Executive Management Committee in monitoring and improving performance across the Better Care Fund plan.

The Board will be aware that a key policy objective is the pursuit of reduced unplanned admissions into emergency care. To this end we set a reduction in emergency admissions target of 2.5% which has been accepted as part of our plan submission and full approval by NHS England. A consequence of any failure to meet the reduction in emergency admissions for all areas is that a proportion of the fund may be withheld to pay for hospital services. We have therefore developed a risk share agreement as a schedule of the Section 75 through which such an event might be mitigated and, in the event that a financial shortfall remains, shared by the partners.

The Health and Wellbeing Board will be the key point of governance through which recommendations such as those to re-commission or de-commission services will be submitted and through which improvements in local services can be considered.

Whilst the Section 75 is established for one year it has been developed to include sufficient scope for flexibility to allow for further extension should there be a desire to do so. This flexibility also includes an option to bring in additional services into our shared pooled arrangements.

The work has now been successfully completed to ensure the legal and financial viability of the agreement for both partners. The agreement is attached to this report and the Board is invited to approve its signing on behalf of the Council. The CCG Governing Body is considering the same authorisation to enter into the agreement on 23rd March.

Recommendation(s)

It is recommended that Members of the Health and Wellbeing Board:

- Delegate authority to the Deputy Chief Executive & Corporate Director of Adult & Community Services, acting on advice from the Divisional Director of Legal & Democratic Services and the Chief Finance Officer, to enter into the Section 75 agreement for the Better Care Fund on behalf of the Council as set out in this report.

Reason(s)

It is a requirement of the Better Care Fund arrangements, that its schemes and services are governed by a formal S.75 agreement. Without such agreement, there is a risk that substantial funding would be withheld from the local health economy.

1. Introduction

1.1 The Better Care Fund (BCF) provides an opportunity to transform local commissioning and services so that people are provided with improved integrated care and support to achieve their health and social care outcomes. The Fund is intended to support the scale and pace of integration between health and social care and reduced reliance upon bed based services. In moving forward with the pooled fund arrangements through the S.75 agreement we have a positive opportunity to improve local outcomes.

1.2 As Board Members will remember from the previous reports and presentation to the Health and Wellbeing Board in February, March and December 2014, the Fund is made up of a number of existing funding streams to the Clinical Commissioning Group (CCG) and the local authority as well as recurrent capital allocations.

1.3 In addition to the overarching integration agenda, a number of conditions and indicators are attached to the Fund, designed to move resources across the system towards prevention and short term care interventions and away from high cost packages in acute or care home settings. The conditions, outcomes and metrics were outlined in the February 2014 report. A significant change over the summer was the requirement that local areas establish a target for the reduction in the

overall emergency (unplanned) admission rate for the local area, for which NHS England sought a minimum of 3% reduction. Barking & Dagenham has previously achieved an average annual reduction in such admissions of 3% over the previous four years whilst other areas have seen increases in admission numbers. This has had the effect of limiting opportunities to utilise quick or easy gains. We therefore agreed and submitted a target of 2.5% reduction, accompanied by a substantial supporting case, which was accepted by NHS England. However, failure to meet the agreed target could result in funds being withheld proportional to the level fo underperformance.

1.4 In the development of the Section 75 agreement we have utilised the template commissioned by NHS England for this purpose to ensure, as far as possible, that there is consistency in approach and format.

2. Overview of the Agreement

2.1 Barking and Dagenham Council and the Clinical Commissioning Group have been working together with shared intent and as trusted partners to ensure that the BCF Plan puts residents at the heart of the health and social care system. Against a backdrop of increased demand and reductions in resources, the BCF in Barking and Dagenham aims to:

- Improve how people experience care and ensure the best possible quality to deliver the right care, in the right place, at the right time;
- Ensure the health and social care system is 'future proof' and able to effectively manage increasing demand and need, not only today, but in years to come;
- Reduce reliance upon bed based services and ensure improved support closer to home.
- Ensure that services are efficient, sustainable and deliver value for money.

3. Key provisions of the Section 75 agreement are:

- It will run for the coming financial year and provides a mechanism through which the arrangements might be continued at the end of that year.
- The provision of a joint Executive Management Committee, comprising senior officers from the Council and the CCG to manage performance and financial matters relating to the Fund.
- Financial management reporting including actual spends and projections.
- A risk share agreement in relation to any shortfall in funding due to any failure to meet reductions in emergency admissions and the management of any overspends in respect of any of the schemes.
    - The primary focus is to continue to manage existing commissioning and contractual arrangements by each of the partners to mitigate any risks.
    - Ultimately, in the event that mitigating actions do not improve performance in relation to emergency admissions, the risk to be shared equally between the Council and the CCG.

- Management of the pooled fund between the Council and the CCG and the ability to recommend the re-deployment of monies to where these can deliver maximum benefit.
- Performance management provided by a dedicated BCF dashboard.
- Detailed specifications for each of our 11 Better Care Fund Schemes, setting out the purpose, contributions and required outcomes.

4. Governance

4.1 Governance arrangements were outlined in the report to the Board in September.

4.2 A joint executive management committee has been meeting in shadow form since October 2014 and will continue to oversee the development and management of the Section 75 Agreement, alongside reviewing performance outcomes currently achieved through the Better Care Fund.

5. Risk

5.1 Risk is managed through specific provisions provided within Schedule 3 of the Section 75 agreement and considers how financial and performance risks will be managed between the partners.

6. Finance

6.1 Through the development of the Section 75 agreement the management arrangements for the pooled funds have been developed by finance officers from both the CCG and the Council, receiving approval in turn by both organisations' Chief Finance Officers.

7. Mandatory Implications

Joint Strategic Needs Assessment

7.1 Integration is one of the themes of the JSNA 2013 and this paper is well aligned to address and support the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

7.2 The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and this paper identifies which areas can be addressed in more integrated way to shape future sustainable strategies for the borough.

7.3 Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular the sections that relate to:

- Supported living for older people and people with physical disabilities
- Dementia
- Adult Social Care

- Learning Disabilities
- Mental health- Accommodation for People with Mental Illness
- End of Life Care

7.4 The relevant sections of the JSNA can be found by visiting the following link: http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

Health & Wellbeing Strategy

7.5 The Better Care Fund reinforces the aims of the Health and Wellbeing Strategy and provides an excellent opportunity for alignment between the ambitious integration plans and the Strategy which are both as much about keeping people well and independent as about ensuring they receive the services they need if they become unwell. Our focus is on people's wants and needs rather than the organisations and structures that deliver care. We aim to prevent ill health and support people to stay well rather than only intervening in a crisis.

Integration

7.6 Integrated commissioning and provision is at the heart of the BCF. The integrated Care Coalition (ICC) with the relevant CCGs and local authorities for Barking & Dagenham, Redbridge and Havering came together to agree the strategic commissioning case for integration and commissioning work accordingly. Barking and Dagenham have a strong history of integrated work and the Fund provides opportunity to strengthen this. Alongside this work, the Integrated Care Coalition is leading the work on the required 5 year Strategic Plan. This will set out our shared vision for fully integrated commissioning by year 5 of the Plan.

7.7 There is an agreed vision for integration confirmed at the Integrated Care Coalition in November 2012. This includes supporting and caring for people in their own homes or closer to home, shifting activity from acute to community services and particularly to locality settings. It places individuals at the centre of delivery, driving improvements to the quality of experience and outcomes. Examples of local integrated services and approaches include:

7.8 Integrated multi-disciplinary teams across six clusters in Barking & Dagenham are well established aiming to achieve co-ordination of care across the health and social care economy with a focus on prevention and promotion of self management through Integrated Case Management.

7.9 Work has been successfully completed, establishing the Joint Assessment & Discharge Service based at Barking, Havering, Redbridge University Hospital Trust and working with North East London Foundation Trust and London Borough of Baking and Dagenham, and the CCG. The aim is to ensure timely co-ordinated discharge from hospital and admission avoidance of unnecessary admission to hospital. Seven day working is part of this service.

7.10 The promotion of physical activity through sports and leisure services using public health to improve health and well being.

7.11 Further integrated approaches will develop as part of the BCF Plan which will be overseen by the Integrated Care Subgroup of the H&WBB. Integration of funds and commissioning for people with learning disabilities is the subject of a separate piece of work between the Local Authority and the CCG.

Financial Implications

Implications completed by:

Roger Hampson, Group Manager (Finance) Adults and Community Services, Barking and Dagenham

8.1 The final Better Care Fund submission was discussed at the meeting of the Health and Wellbeing Board at its meeting in December 14, and the covering report set out broad financial implications for the Council and the CCG.

8.2 The Better Care Fund (BCF) is expected to lead to the transformation of health and social care services for people in the community; this is to be achieved through the integration of services between health and social care using pooled budget arrangements. These pooled budget arrangements are required to be in place from April 2015.

8.3 The delivery of integrated health and social care services at greater scale is expected to deliver improvements against national and local outcomes

8.4 The Better Care Fund is £21,299m in 2015/16 as set out in the table below. This is £311k lower than the December 2014 submission following the recent government decision to reduce Barking and Dagenham's allocation for the New Burdens Grants for implementation of the Care Act.

	£k	£k
Local authority funding:		
Social Care Capital Grant	508	
Disabled Facilities Grant	672	
LA minimum contribution		1,180
Public Health	1,191	
New Burdens Grant	773	
Base Budgets	5,100	
Additional LA contributions		7,064
Total LA funding		**8,244**
CCG funding:		
Reablement	1,120	
Carers	495	
Former Social Care Grant	4,185	
Care Act costs in BCF	513	
Existing services	6,742	
CCG minimum contribution		**13,055**
TOTAL BCF Pool		21.299

8.5 The Section 75 draft agreement sets out that the London Borough of Barking and Dagenham will act as host for the BCF Pool. In order to achieve this, the CCG will pay to the Council a total of £13.055m in equal monthly instalments to reflect their total contribution to the pool. Following these transfers, the Council will pay to the CCG a total of £7.707 in equal monthly instalments in respect of those services which the CCG will continue to directly commission, including the Community Treatment Team (£470k) and Carers Services (£495k).

8.6 Each partner is responsible for managing any overspend on those services they directly commission included in the BCF pool. In the event of an under spend, the options will be considered by the Joint Executive Committee.

8.7 Failure to meet the agreed target for reduced emergency admissions could result in funds being withheld by NHS England proportional to performance. A risk share agreement has been prepared and, if there is a financial shortfall, this will be shared equally by the partners. This is in recognition of the broadly equal financial contributions by each partner to the individual schemes in the BCF pool which are likely to impact on underachievement of the target. The total risk in the event of the very the worst performance is estimated to be £600k, i.e. £300k per partner. If the

BCF pooling arrangements were to continue beyond 2015/16, the Section 75 draft agreement envisages that the risk share agreement is reviewed on an annual basis.

Legal Implications

Implications completed by: Daniel Toohey, Principle Corporate Solicitor, Legal and Democratic Services.

9.1 Section 75 of the National Health Service Act 2006 gives powers to local authorities and clinical commission groups to make certain joint arrangements , including the establishing of pooled funds out of which payment can be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions. Such arrangements are often referred to in short hand as "s75 agreements".

9.2 It is a requirement of the Better Care Fund grant programme, as set down in national directions, that an agreement in the form of a Section 75 agreement be entered into between the Council and the Clinical Commissioning Group for Barking and Dagenham. This is required to be in place for year 2015/16. The agreement also formalises the management of the pooled funds and the role of the Joint Executive Management Committee in monitoring and improving performance across the Better Care Fund plan.

9.3 Under the s75 agreement, the Council has undertaken to host the fund, and in particular to manage and maintain the pooled funds, which entails ensuring that expenditure out of the pool occurs within strict parameters, and that specified actions regarding potential overspends are taken, including timely reporting back to the Joint Executive Management Committee.

10. Non-Mandatory Implications

Workforce Implications

10.1 The Better Care Fund and accompanying schemes will have various workforce implications and all relevant HR procedures will be followed to ensure that staff are consulted as these new services are developed. The BCF has included money for training and workforce development initiatives within the scheme plans. Each of the organisations will have their own change management processes and the Council and the CCG will need to ensure that the appropriate processes are followed. Members of the Board should note that the development and implementation of the Joint Assessment and Discharge service has shown the complexity of working across a number of organisations and this complexity should not be underestimated.

Customer Impact

10.2 Integrating health and social care services is expected to not only generate cash efficiencies but to improve the patient/service user experience in a number of ways. The benefits for patient/service user experience can be read in each of the schemes of work.

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HEALTH AND WELLBEING BOARD

17 March 2015

Title: Section 75 Arrangements for the Provision of Learning Disability Services	
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Authors: Mark Tyson, Group Manager, Integration & Commissioning	**Contact Details:** Tel: 020 8227 2875 Email: mark.tyson@lbbd.gov.uk

Sponsors:
Anne Bristow, Corporate Director of Adult & Community Services

Conor Burke, Chief Accountable Officer, Barking and Dagenham, Clinical Commissioning Group.

Summary:

One of the key recommendations from the Winterbourne View concordat was that local authorities and health partners put in place joint and collaborative commissioning arrangements.

Following an initial report in March 2014 which set out the intentions for the Borough's Section 75 agreements around learning disabilities, and a subsequent progress report at the September 2014 meeting, the attached report sets out the Section 75 arrangement for the provision of an integrated Community Learning Disability Team, bringing together the services provided by North East London NHS Foundation Trust and the Council.

Recommendation(s)

It is recommended that Members of the Health and Wellbeing Board:

- Delegate authority to the Deputy Chief Executive & Corporate Director of Adult & Community Services, in consultation with the Chief Finance Officer and the Director for Legal and Democratic Services, to finalise terms and enter into Section 75 agreements with North East London NHS Foundation Trust for the provision of the integrated learning disability service.

Reason(s)

There are national requirements to strengthen the arrangements for jointly commissioning and providing learning disability services in order to improve the quality of services provided to service users by health and social care. Furthermore, integration is a core

policy driver in health and social care, as evidenced by the introduction of the Better Care Fund, with the aim of improving both efficiency and service user experience. This arrangement provides a framework for taking that work forward locally.

The Council has committed to the vision of 'One borough; one community; London's growth opportunity'. To deliver this vision means that good quality support needs to be in place for those with a learning disability, to assist them to live independent lives. The Section 75 agreement will provide a better framework for considering the needs of service users and carers, and for meeting those needs. This will deliver, in particular, the Council's priority to 'enable social responsibility', and also supports the priority of 'growing the borough' by increasing household incomes through supporting those with a learning disability into employment.

1. Introduction

1.1 In December 2012 the Department of Health published its final report on the abuse that took place at the Winterbourne View Hospital. The report identified 63 actions to be completed by health and social care in relation to the findings of the investigation. One of the key recommendations was that local authorities and health partners put in place joint and collaborative commissioning arrangements, with pooled budgets where possible.

1.2 Back in March 2014, the Health and Wellbeing Board received a report on the overview of the arrangements that are being negotiated between the Clinical Commissioning Group and the Council for the creation of a Section 75 partnership agreement to cover both parties' commissioning budgets for learning disability services. The Board agreed to delegate authority to the Corporate Director for Adult & Community Services to conclude the negotiations of the commissioning Section 75 and enter into the agreement on behalf of the Council. Additionally, the March report also set out the intention to revise the Section 75 arrangements for the provision of an integrated Community Learning Disability Team (CLDT), comprising officers from NELFT and the Council.

1.3 Following this, a report in September 2014 set out the progress that had been made in negotiating the Section 75 agreement to cover the commissioning arrangements for the Council and the CCG, as well as the progress for the Section 75 to cover the integrated team.

1.4 This report gives an overview of the final stages of the Section 75 arrangement between the Council and NELFT for the provision of the integrated learning disability team. Delegated authority for the provision of the integrated service has not been previously sought at the Board, therefore the Health and Wellbeing Board are asked to delegate authority to the Corporate Director of Adult & Community Services to enter into Section 75 agreements with North East London NHS Foundation Trust for the provision of this integrated service.

Section 75 Agreement (Commissioning)

1.5 It should be noted that the Section 75 agreement for the commissioning of learning disability services is nearing its final stages. The CCG, through their Governing

Body, are seeking delegated authority for the Chief Operating Officer of the Clinical Commissioning Group to sign off the agreement on behalf of the CCG. The Health and Wellbeing Board has already delegated authority to the Corporate Director of Adult and Community Services to finalise and sign the agreement.

2. Section 75 Agreement for Integrated Service Provision

2.1 Powers to enable health and local authority partners to work together more effectively came into force on 1 April 2000. These were outlined in Section 31 of the Health Act 1999, which has since been repealed and replaced, for England, by Section 75 of the National Health Service Act 2006.

2.2 A Section 75 is a partnership agreement of equal control whereby one partner can act as a "host" to manage the delegated functions, including statutory functions of both partners who remain equally responsible and accountable for those functions being carried out in a suitable manner.

2.3 Over the last six months the Council and North East London NHS Foundation Trust (NELFT) have been working together to agree the terms of a Section 75 arrangement for the direct provision of an integrated Community Learning Disability Team (CLDT), between the Council and NELFT.

2.4 It is proposed that the Council will be the 'host' partner within the arrangement for the integrated team and the agreement will be effective for a term of three years, from its commencement date, with the option to extend for a further two years.

2.5 The purpose of the agreement it is to provide a robust framework within which the Council and NELFT will work to improve the health, social care and wellbeing outcomes of Barking and Dagenham residents who have a learning disability. It is intended that the agreement will:

- Jointly design and deliver services around the needs of service users and eliminate gaps in provision;
- Ensure effective management of community learning disability services in the Barking and Dagenham, thereby ensuring that delivery meets the requirements of the Care Act and the Personalisation agenda;
- Improve the provision and development of learning disability services for service users and carers through closer working between the Council and health partners, namely NELFT.

2.6 A group comprising of representatives from NELFT, the CCG and the Council have been regularly meeting in order to develop the Section 75 agreement and work is now nearing completion.

Workforce arrangements

2.7 NELFT and the Council have agreed a structure chart for the integrated service and have agreed to continue the employment of each of their respective members of staff on their existing terms and conditions. As is the current arrangement, posts in the integrated service will be managed by the Team Manager of the CLDT and

direct, day to day line management arrangements of the staff will be organised by the Council. The recruitment and appointment will be carried out by the employing organisation and training and development will also remain the responsibility of the respective employer, although it will be discharged jointly between the two organisations.

2.8 As part of the drafting of the Section 75 agreement, the operational procedure for the team, along with the specification for the CLDT, is being reviewed and agreed. These documents form the basis for the Section 75.

Arrangements to oversee the agreement

2.9 The Section 75 agreement details that an operational group will be set up to oversee the Section 75 arrangement for the integrated service. This group will maintain oversight of the running of the service and will discuss operational issues which require escalation to Senior Managers in the partner organisations for resolution. The Learning Disability Partnership Board will receive regular updates from this operational group and will be part of the escalation process for issues that cannot be resolved by the Partners.

2.10 It is proposed that the operational group will meet on a quarterly basis. Membership of the group will consist of:

- the Group Manager – Intensive Support (LBBD);
- the NELFT Integrated Care Director of the Barking and Dagenham Integrated Care Directorate or their nominee;
- the NELFT Assistant Director for Mental Health and Learning Disability;
- the CLDT Manager;
- the Learning Disability Joint Commissioner;
- the CLDT Consultant Psychiatrist;
- the Group Manager for ACS Finance (LBBD);
- the Senior Accountant for NELFT.

Outstanding issues

2.11 Negotiation of the Section 75 agreement for the provision of the integrated service is nearing completion. Aspects of this agreement, such as the operational procedure and the specification for the integrated service are now complete and agreed by representatives from the Council and NELFT. Additionally, the terms of the agreement itself are being finalised by legal advisors.

2.12 On the basis of the above, the Health and Wellbeing Board are asked to delegate authority to the Deputy Chief Executive & Corporate Director of Adult & Community Services, in consultation with the Council's legal and finance services, to enter into the Section 75 agreement with North East London NHS Foundation Trust for the provision of the integrated learning disability service.

3. Mandatory Implications

Joint Strategic Needs Assessment

3.1 The Joint Strategic Needs Assessment notes a number of areas for the improvement of services for people with a learning disability which will be, and are being, addressed through the development of these joint arrangements. These include:

- Improvement of the information needs of health and care professionals, and information sharing provisions, so that all staff use a single system based on person centred plans (included in the integrated service specification);
- Development of efficiency and performance measures as a basis for determining caseload and numbers of posts in the Community Learning Disabilities Team (both agreements contain performance metrics); and
- A focus in care pathways for those conditions which have a higher prevalence in people with learning disabilities (the agreement for integrated service provision sets out expectations with respect for health assessment and care management).

Health & Wellbeing Strategy

3.2 The integrated learning disability service is key to meeting the needs of people with a learning disability. In addition, the partnership arrangements that this agreement describes means that the mechanisms are in place to continue to deliver against the shared priorities for the improvement of services, as set out in broad terms in the Health & Wellbeing Strategy.

Integration

3.3 The Section 75 agreement is a mechanism by which the integration of services for people with a learning disability can be developed. The work that has been undertaken to agree the terms of the agreement will continue to improve the delivery of services to this client group.

3.4 Financial Implications

Implications completed by: Roger Hampson, Group Manager (Finance) Adults and Community Services, Barking and Dagenham

This report sets out progress in developing two separate s75 agreements in respect of the commissioining and provision of Learning Disability Services from April 2015 to March 2018. The first of these is in respect of the commissioning of services between the CCG and the Council; the second is in respect of the provision of an integrated Community Learning Disability Team between the Council and the North East London NHS Foundation Trust.

Details of the respective contributions to the two pooled budget arrangements by the partners are being finalised for 2015/16. However, based on 2014/15 budgets, the agreement for commissioned resources will bring together resources in the

region of £9.5m; the agreement for an integrated team will bring together resources in the region of £1.5m.

The s75 draft agreements include specific and robust arrangements to monitor the joint budgets. For example, in the event of an overspend the commissioning partner will be responsible for managing its own spend within its normal budget management arrangements, with no element of risk share. In the event of any underspends, discussions will take place between the partners during the year on how these should be applied.

Systems and processes need to be in place to manage the partnership's budgets over the life of the agreement up to March 2018. These will need to be within the context of significant financial challenges for both the local authority and the CCG over the next three to five years.

3.5 Legal Implications

Implications completed by: Bimpe Onafuwa, Contracts and Procurement Solicitor

3.6 This report details the arrangements between the Council and North East London Foundation Trust (NELFT) for the provision of an integrated Cumulative Learning Disability Team (CLDT).

3.7 Section 75 of the National Health Services Act 2006 permits a local authority and an NHS body in England to enter into such arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner, if this would lead to an improvement in the way these functions are exercised.

3.8 In negotiating the terms of CLDT S.75 agreement, both the Council and NELFT are considering and complying with the requirement of the NHS Act 2006, as well as other legislation and guidelines as relevant.

3.9 The recommendation of this report is that the Health and Wellbeing Board (HWB) delegate authority to the Corporate Director for Adult and Community Services to finalise the terms of, and enter into the S.75 Agreement. Paragraphs 1.1 and 7.1 of Chapter 1 of Part 3 to the Council Constitution confirm the delegation of authority to the Corporate Director for Adult and Community Services, to act on behalf of the Council in the area of strategic partnerships, while Paragraph 5.1 of Chapter 7 of Part 2 to the Constitution states that the HWB is has responsibility for authorising the signing of S.75 agreements on behalf of the Council, where the resources have already been allocated by Cabinet for the purposes described in the agreement.

3.10 The HWB is therefore able to authorise that the Corporate Director for Adult and Community Services finalise and enter into the S.75 CLDT agreement with NELFT.

4. List of appendices

None

HEALTH AND WELLBEING BOARD

17 March 2015

Title:	**Barking and Dagenham CCG Commissioning Plans 2015/16**
Report of the Clinical Commissioning Group (CCG)	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG	**Contact Details:** Tel: 020 3644 2370 E-mail: Sharon.morrow@barkingdagenhamccg.nhs.uk
Sponsor: Conor Burke, Chief Officer Barking and Dagenham CCG	

Summary:

The Board received a report on 9 December 2014 that outlined the CCG commissioning intentions for 2015/16. This subsequent report will:

- Update the Board on the development of the CCG commissioning plan for 2015/16;
- Provide information on the national NHS planning requirements set out in "The Forwards View into Action: Planning for 2015/16" and on the CCG operating plan submission;
- Provide information on the stakeholder engagement session held on 21 January 2015.

Recommendation(s):

The Board is asked to comment on the CCG commissioning plan update and alignment to the Health and Wellbeing Strategy.

1.0 Background and Introduction

1.1. NHS commissioners are required to refresh their Operating Plans annually to take into account changes in local needs, central planning guidance and annual financial allocations. The planning process develops year on year to reflect national policy.

1.2 In line with national requirements, Barking and Dagenham CCG has agreed a two year Operating Plan for 2014 – 2016 and a Better Care Fund Plan which has been approved by the Health and Wellbeing Board. Commissioning intentions for 2015/16 have been drafted based on the current Operating Plan, the output of service reviews, policy recommendations and stakeholder engagement.

1.3 National planning guidance for 2015/16 was issued on 23rd December 2014 by NHS England, the Trust Development Agency, Monitor, the Care Quality Commission, Health Education England and Public Health England. *"The Forward View into*

Action: Planning for 2015/16" describes the approach for local and national and local organisations to take in making a start in 2015/16 towards fulfilling the vision set out in the NHS Five Year Forward View. Guidance was also issued to CCGs in late December by NHS England setting out requirements for the refresh of the CCG operating plan in 2015/16.

1.4 This paper provides a summary of the key items from the guidance set within the wider context of local needs and the revised Health and Wellbeing strategy and priorities.

2.0 The Forward View into Action: Planning for 2015/16

2.1 The 2015/16 planning guidance re-confirms the Health Service's commitment to delivering the Five Year Forward View. Priorities for operational delivery remain, these being to improve service quality and outcomes, improve patient safety and meet the NHS constitution standards.

2.2 The guidance sets out a number of new requirements and initiatives that are to be taken forward in CCG commissioning plans for 2015/16. The full Planning Guidance and Five Year Forward View documents are available on the NHS England website: http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf. A summary of the key initiatives is set out below:

2.3 **Mental health** - CCG spending on mental health services in 2015/16 is to increase in real terms by at least as much as the CCGs allocation increase. Investment is linked to the delivery of new access and waiting time standards in mental health:

- By April 2016, people experiencing a first episode of psychosis to receive treatment within 2 weeks
- For IAPT, at least 75% of adults should have their first treatment session within 6 weeks of referral with a minimum of 95% treated within 18 weeks
- Commissioners will be required to draw up service delivery plans with acute providers to ensure adequate and effective liaison psychiatry services

CCGs and partners must to ensure that people experiencing a mental health crisis are properly supported.

2.4 **Learning disabilities** - CCGs, specialised commissioning and local authorities are expected to make demonstrable progress in improving the system of care for people with learning disabilities and reduce reliance on inpatient care.

2.5 **Quality incentives** – the introduction of new provider quality incentives for the treatment of sepsis and acute kidney injury and for improving urgent and emergency care; CCGs and providers are to work together to agree plans to improve antibiotic prescribing in secondary care. It is intended that a revitalised national quality board will review the current state of the quality of care and barriers to delivering high quality care working.

2.6 **Workforce** - a new workforce advisory board will be established, chaired by Health Education England, to develop the health and care workforce with the skills to support new models of care. Providers and commissioners are to agree plans to make further progress towards seven day working

2.7 **Transformation** - the planning guidance sets out four new care models with the goal of making rapid progress in developing new models for promoting health and wellbeing. These are:

- Multidisciplinary specialist providers (MCPs)
- Integrated primary and community providers (PACs)
- Viable smaller hospitals
- Enhanced care in care homes

The development of new models will be co-ordinated by a new Model of Care Board and successful sites will be able to draw on a £200m national transformation fund. Expressions of interest were invited from CCGs in January and the first support programmes are expected to be developed by the end of March.

2.8 **Challenged health economies** - the guidance flagged the introduction of a new "success regime" intended to create the conditions for success in the most challenged health economies. Further guidance is expected but this is likely to include a single aligned accountability mechanism for the national bodies to oversee the delivery of an improvement plan for the health economy.

2.9 **Prevention** - the importance of prevention programmes in ensuring the sustainability of the NHS is noted and CCGs are expected to work with local government partners to set local levels of ambition to reduce health inequalities and improve outcomes for health and wellbeing.

2.10 **Patient empowerment** - more focus is to be given on patient choice in mental health and maternity services and it is expected that CCGs will increase the offer personal health budgets to people who would benefit from them. The guidance refers to the introduction of the Care Act 2013 and the expectation that CCGs will work with local authorities to identify and support carers.

2.11 **Better Care Fund** - CCGs and the Local Authority are given the opportunity to review the ambition for the reduction in emergency admissions set out in the Better Care Fund Plan in light of actual performance over the winter period.

3.0 Implications for the CCG commissioning plans

3.1 The CCG operating plan for 2015/16 is being refreshed to take into consideration the new national guidance. The operating plan dataset requires the CCG to submit a greater level of information to NHSE than before, particularly in the reporting of NHS constitution measures for referral to treatment time (RTT), diagnostic test waiting times, cancer, A&E, ambulance performance. Other measures that are reported include the two new IAPT access standards, around 6 and 18 week waits for treatment; the patient experience of primary care is now measured through three measures based on the GP Patient survey.

3.2 The commissioner and provider operating plans will be required to demonstrate consistency of activity and financial trajectories that are being discussed through contract negotiations.

3.3 CCG commissioning intentions are being updated to reflect the new national requirements. The CCG has been working through the sub-groups of the Health and Wellbeing Board to undertake the detailed mapping and alignment of its commissioning plans against the JSNA recommendations and sub-group delivery plans and outcomes. This work is being fed into the Health and Wellbeing Board delivery plan which will be considered by the Board in May. An update against key priorities is set out below including reference to CCG led actions within current HWB delivery plan.

4.0 Update on commissioning intentions

4.1 Mental Health

CCG commissioning intentions were outlined in the paper presented to the Board on 9 December. These are currently being taken forward with providers in the context of contracting discussions with a particular focus on achieving IAPT and dementia standards. The delivery of dementia standards is aligned to the Better Care Fund (BCF) work streams on dementia and carers support.

Negotiations are also underway with providers around meeting the requirements outlined in Achieving Better Access to Mental Health Services by 2020, which aims to put mental health on a par with physical health services. This aligns with the current CCG Health and Wellbeing Strategy delivery plan actions to improve the care of people with depression and support access to IAPT and is being discussed as part of the revised delivery plan through the Mental Health subgroup.

The CCG is leading on pulling together the Borough Crisis Care Concordat plans – again developing this with partners through the Mental Health Sub Group and making the links with the wider improving mental health care, outcomes and wellbeing agenda. The draft plan will be considered by the group on 2nd March and the final plan due to come to the Health and Wellbeing Board in May.

In November ONEL CCGs working together were successful in accessing targeted one-off funding for 2014/15 to improve mental health crisis care and early intervention in psychosis. This funding covers improvements to NELFT Early Intervention in Psychosis (EIP) service, crisis single point of access pilot, Street triage pilot/Home Treatment Team capacity improvement, Access team increased capacity and support to evaluate the enhanced mental health liaison in acute hospital pilot. This work also forms a key element of the crisis concordat action plan.

4.2 Cancer

The work outlined in the December paper to address poorer under 75 mortality rates for cancer than the England average and the borough's position as outlier for early diagnosis of cancer continues. The Macmillan GPs – who are funded for two years – are working intensively with practices to undertake practice visits looking at their local cancer data and encouraging review of lung cancer patient care pathway through significant event analysis work.

4.3 Children and Maternity

The CMG has agreed 7 key themes for their work– sharing this with the Children's Trust and aligning this with the Children and Young People Plan as well as the HWB strategy and JSNA recommendations. These are:

- Improving Health outcomes for children with SEND
- Integrated Early years (to include Maternity, Breastfeeding, early years development, HV transition, Immunisations. Currently separate priorities' for children's health and Maternity board)
- Improving Health outcomes for Looked After Children, Care Leavers and Youth Offenders
- Childhood Obesity
- Children's Mental Health and Wellbeing
- Teenage pregnancy and Sexual Health
- Urgent care (with particular reference to reducing paediatric attendances at A&E)

A review of CCG commissioning of Children's Allied Health Professional's has just commenced.

One of the priority areas for the CCG in the current HWB delivery plan relates to the care particularly of children and young people with sickle cell. A specific sickle cell service was developed in 14/15.

The level of paediatric A&E attendances continues as a priority from the current HWB plan. The CCG is working with children's services to develop a pilot integrating primary and early years services to focus on providing greater support to parents in community settings as part of wider early intervention work and to help parents know the best place to get urgent care. This work is being seen in the context of the paediatric hot clinic arrangements available to primary care and a pilot Health Visitor in A&E project led by NELFT.

4.4 Primary care improvement

The CCG has recently applied for and been successful in being given delegated commissioning responsibility for primary care from 2015/16 onwards. Governance and capacity for supporting this work in earnest are currently being worked through. It is anticipated that this will provide a major element in working with primary care to effect real improvements linked to other developments in access and the care of frail older people under the Prime Ministers Challenge fund programmes and the wider focus on developing and making sustainable primary care as set out in the Five Year Forward Plan.

4.5 Learning disabilities

The S75 for Learning Disabilities appear is part of the S75 paper being considered by the Board as part of the agenda.

4.6 Integrated care

The Better Care Fund S75 arrangements are set out in the Board paper on S75 arrangements.

5.0 Engagement

A wider stakeholder session jointly with the Health and Wellbeing Board – hosted by Health Watch – took place on 21 January 2015. This follows on from regular sessions with stakeholders throughout the year devoted to specific commissioning areas. The session was designed as a market place event focusing on challenges to the system and individuals. The event had a video booth, information stalls,

featured on CCG and LBBD twitter feed and included a complementary survey monkey to gather views from wider audience than those attending event – in particular aimed at young people. The event was very well received and a full report is being finalised written by Healthwatch. A short film from the event will be shown at the Health and Wellbeing Board meeting.

6.0 Mandatory Implications

6.1 Joint Strategic Needs Assessment

The CCG commissioning intentions respond to the JSNA, with more detailed work ongoing to ensure recommendations in the refreshed JSNA are mapped into commissioning plans.

6.2 Health and Wellbeing Strategy

The Health and Wellbeing Strategy priority areas and revised delivery plan under development are reflected in the CCG commissioning plans. Public health priorities are set out in the BHR five year strategic plan, with deliverables for 2015/16 aligned to CCG operating plans.

6.3 Integration

Barking and Dagenham CCG and Local Authority have a strong history of integrated working and integrated commissioning is reflected throughout the CCG operating plan; the operating plan incorporates the Better Care Fund plan and joint commissioning arrangements for learning disabilities in 2015/16. The BHR Integrated Care Coalition has agreed a five year Strategic Plan, which sets out the delivery programmes that will improve system outcomes over this period.

6.4 Financial Implications

Implications completed by: Rob Adcock, Deputy Chief Finance Officer

The CCG will review and update its financial plans in line with the latest operating plan requirements. The financial plans will take into account a number of factors including; planning guideline assumptions, commissioning intentions, QIPP delivery and the baseline position. The 15/16 budget process will align to the plans and will be approved through CCG governance processes.

£1.98bn new monies have been allocated to the NHS in 2015/16. The funding comes with a number of requirements and includes; operational resilience funding, which has previously been allocated non-recurrently; £200m investment in new models of care and £250m investment in primary care. Growth monies have been directed to CCGs who are deemed to be below the funding target. BD CCG are deemed to be funded slightly over target.

6.5 Legal Implications

Implications completed by: Sharon Morrow, Chief Operating Officer

Joint commissioning for services in the Better care Fund Plan and for learning disabilities will be formalised through Section 75 agreements in 2015/16.

6.6 Risk Management

CCG risks are managed through the Governing Body Assurance Framework. A risk-share arrangement will form part of the s 75 agreement that will provide the governance for the Better Care Fund.

6.7 Patient/Service User Impact

The overall impact of the CCG's Operating Plan will be measured through nationally mandated and locally selected indicators.

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HEALTH AND WELLBEING BOARD

17 March 2015

Title: Update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme from NHS England to London Borough of Barking and Dagenham.	
Report of the Director of Public Health & Corporate Director of Children's Services	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Matthew Cole Director of Public Health Helen Jenner Director of Children's Services	**Contact Details:** Tel: 020 8227 3657 E-mail: matthew.cole@lbbd.gov.uk Tel: 0208 227 5800 Email: Helen.jenner@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

The purpose of this report is to give an update on the work underway to plan for the transfer in October 2015 of the commissioning of the Early Years Programme (Health Visiting and Family Nurse Partnership) services to the London Borough of Barking and Dagenham. These services are currently commissioned by NHS England and provided by North East London NHS Foundation Trust.

Recommendation

The Health and Wellbeing Board is asked to note the report the contract position in principal for the transition for the 0-5 commissioning arrangements.

Reasons

From 1 October 2015, the Government intends that local authorities (LAs) take over responsibility from NHS England for commissioning (i.e. planning and paying for) public health services for children aged 0-5. Elements of the programme will be mandated. In this context, mandation means a public health step prescribed in regulations as one that all LAs must take. The regulations are made under section 6C of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

The Government's aim is to enable local services to be shaped to meet local needs. Some services however need to be provided in the context of a national, standard format, to ensure universal coverage, and hence that the nation's health and wellbeing overall is

improved and protected. The smooth transfer of commissioning to the Council is the next step in providing high quality care for each and every child and their family.

1. Introduction and Background

1.1 On 28 January 2014 the Parliamentary under Secretary of State for Health, Dr Dan Poulter MP, confirmed the transfer of 0-5 public health commissioning. The transfer of commissioning responsibilities will now take place on 1 October 2015.

1.2 The scope of the transfer includes the 0 to 5 Healthy Child Programme (Universal/ Universal Plus), specifically:

- Health Visiting services (universal and targeted services)
- Family Nurse Partnership services (targeted services for teenage mothers).

1.3 The following commissioning responsibilities will remain with NHS England (NHSE):

- Child Health Information System (CHIS)
- The 6-8 week GP check (Child Health Surveillance (CHS).

1.4 Responsibility for commissioning the CHIS will remain with NHSE in order to improve system functionality nationally, although a commitment has been made by the Department of Health (DH) to review the responsibility for commissioning in 2020.

1.5 Responsibility for commissioning the 6-8 week GP check will remain with NHSE due to the nature and complexity of commissioning arrangements which suggest there is both risk and little or no return to be gained from transferring this responsibility.

1.6 The Government announced on 22 August 2014 that certain universal elements of the Healthy Child Programme will be mandated in regulations in the same way it has for sexual health and some other public health services. The universal elements which will be mandated are:

- antenatal health promotion review
- new baby review, which is the first check after the birth
- 6-8 week assessment
- 1 year assessment
- 2 to 2 and a half year review

The DH have published a factsheet on mandation to explain what this means for local authorities and to set out next steps.

2. Transfer of Health Visiting and Family Nurse Partnership – Contract Position agreed in principal with NHS England (London)

2.1 NHSE issued guidance in October to support local areas with contract transition. This guidance was tested with the DH, Local Government Association (LGA) and Public Health England (PHE) to ensure that it supports a smooth transition of responsibilities and sustainability of services, complies with legal requirements and enables local authorities and area teams to work effectively together in commissioning sustainable services for the whole of 2015/16 and beyond. The guidance can found on the following link http://www.england.nhs.uk/wp-content/uploads/2014/12/0-5-trans-guid-temp-let-stg2.pdf

2.2 The Council is afforded two options for consideration:-

- Option 1: Novation: The Area Team puts in place a single contract for 2015-16 with a Deed of Novation being approved by the Council at the same time the contract is signed to confirm the contract will transfer to the Council on 1 October 2015.

- Option 2: New contract from 1 October 2015. The Area Team puts in place a 6 month NHSE contract for the period between April and September 2015 and helps the Council to put in place a similar but separate contract with the provider for the period between October 2015 and March 2016. In this position it would be desirable for both contracts to be signed at the start of the 2015-16 year.

In all cases, NHS commissioners will lead negotiations, though there will be an opportunity for each borough to shape the service particulars to local needs. The London boroughs of Redbridge and Havering followed our position of opting for Option 2.

2.3 Under Option 2, it should be noted that the NHSE Standard Terms and Conditions will be used as the basis for negotiations with North East London NHS Foundation Trust (NELFT).

2.4 Under Option 2, there is also the potential for financial liability to arise which is important for the Council to be aware of, although the risk is hypothetical and considered unlikely to arise. Specifically, all provider contracts currently run until March 2016. Under the terms of those contracts, to apply Option 2, a 12 month notice period should have been given in October 2014. As transfer planning at that point had not reached agreement in respect of financial allocations, the decision was taken nationally to not issue notice of termination to any providers. Technically, because notice should have been given and wasn't, the terms of provider contracts do give rise for a financial liability of failing to meet notice terms. It is understood that such a liability would be equal to a 1/12th share of the 14/15 contract value for each month under the 12 required (e.g. if you provide 10 months notice, a technical liability arises equally to 2/12ths).

2.5 The provision of a new contract with the Council for the 6 month period between October 2015 and March 2016 should give NELFT assurance of stability and continuity; we therefore do not anticipate such liabilities arising. However, in the eventuality that such circumstances do arise it will be important for NHSE (London) and the Council to work together to mitigate such a risk. It is expected that the risk of such a liability arising will be known when negotiation with NELFT begins in January and February 2015. At this stage NELFT have indicated to NHSE (London) no wish to pursue this point.

2.6 The NHSE Standard Contract is still not available at the time of writing this report. The Council has agreed contract particulars with NHSE (London) NELFT will receive 5 NHSE Contracts. One Specialised and four Health Visiting/FNP for each of the outer north east London boroughs. Deadline for signatures is 21 March 2015.

2.7 NELFT will draft and sign a Deed of Novation for the Council and return to NHSE (London) by 2 March for onward transfer to the Council by 14 March 2015. Sunset

clause is 18 months, during which mandation outcomes must be achieved, as minimum.

2.8 The proposed procurement and contracting methodology falls under the previous Legislation (PCR 2006) and as such is viewed as a Part B service, which is not mandated to comply fully with the rules, but will still be bound to operate a fair and transparent process.

2.9 Under the Council's Contract Rules all procurements above £500k as defined in clause 28.8 shall be taken before the Health and Wellbeing Board for ratification.

2.10 The requirement for the service will need to be presented to both the Procurement Board and Corporate Management Team prior to issue to the Health and Wellbeing Board.

3. Baseline assessment

3.1 The baseline assessment of our 0-5 children's public health commissioning resource has now been completed as well as our position on the transfer of the Health Visiting and Family Nurse Partnership contracts in October 2015.

3.2 The transfer to LAs has been on a 'lift and shift' basis for 2015-16 with additional funding to ensure that LAs do not take on additional financial burden and also provide support for commissioning.

3.3 A funding floor has been provided on the amount of resource transferred such that no LA is funded below an adjusted spend per head (0-5) of £160, based on full year allocations. In addition, it is proposed that LAs are given £15k for 2015-16 (£30k on a full year basis) equivalent to the 0.5fte of commissioning resource.

3.4 For Barking and Dagenham, the proposed allocation for 2015-16 is £2.41m, made up of £2.395m of 'lift and shift' position by Area Teams and £15k commissioning support.

3.5 From 2016-17, allocations are expected to move to a formula distribution based on population needs. The Advisory Committee on Resource Allocation (ACRA) plan to consult LAs on the public health formula (including 0-5s) in the summer.

3.6 Estimates from NELFT suggest that direct non-salary costs and other overhead costs will result in additional pressures of circa £370,000. A breakdown of additional cost is shown in the table below:

Barking and Dagenham Health Visiting additional funding				
Pay	**Grade**	**WTE**		
Management post	Band 8A	0.5	59,400	29,700
Clinical admin support	Band 3	3	25,600	76,800
1.47 MASH post	Band 7	1.47	55,200	81,200
Total additional Pay costs				**187,700**

Non Pay				
Call to action Non pay for 41.5wte (Direct inc travel, equipment)		41.5	2,600	107,900
Mobile Devices for agile working		41.5	1,000	42,000
Mash post non pay		1.47	2,600	3,900
Total Non pay Direct				**153,800**
Management overheads				**28,200**
Total additional funding required				**369,700**

3.7 Funding at the proposed levels will not be adequate to commission the service at the level required without putting additional pressures on the Council's Public Health Grant. Other concerns include:

- Clarity is needed on what the arrangements for staff will be with regard to supervision and management. There is no funding to support this so current terms and conditions will not be able to be sustained.
- We also understand that it is likely that boroughs will be expected to demonstrate more rigorous performance management of the contracts, and yet there is no commissioner's management fee factored in.
- In addition not all boroughs have had their MASH staff taken from their health visitor allocations; we would like further information before we agree to this.

The Council responded in writing to the DH that it does not accept the baseline allocations as adequate to meet the financial demands of the of the 0-5 children's public health service on 16 January 2015.

3.8 DH has at the time of the report has not published the Council's baseline allocation following our challenge.

4. Mandatory implications

4.1 Joint Strategic Needs Assessment (JSNA)

The JSNA outlines the recent increases and changes in the 0-5 population which highlights the need for provision for this group. The complexity of provision of this age group is a reflection of several factors including ethnicity, poverty and parental life-style factors such as obesity, smoking and substance misuse. The current services plays a vital role in supporting our increasing and changing 0-5 population to become and remain healthy and preparing for a healthy adulthood.

4.2 Health and Wellbeing Strategy

Children having the best possible start in life from conception, so breaking the link between early disadvantage and poor outcomes throughout life is integral to the delivery of our joint Health and Wellbeing Strategy.

4.3 Integration

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report's

recommendation is underpinned for the need for effective integration of services and partnership working.

4.4 **Financial implications**

Financial implications completed by: Roger Hampson Group Manager Finance (Adults and Community Services)

Barking and Dagenham is one of a small number of local authorities which have raised specific issues in respect of whether the amounts transferring are an accurate reflection of lift and shift principles. After examination, the Department of Health considers these concerns merit further analysis and understanding prior to concluding final allocations, specifically as part of the contracting process which NHS England aims to conclude by the end of February. A further report will be presented when funding allocations are confirmed.

4.5 **Legal implications**

Legal implications completed by: Allan Donovan Interim Senior Projects Lawyer

4.5.1 Revised EU procurement regulations were introduced into UK law by the Public Contract Regulations 2015 (PCR 2015). These are effective from 26 February 2015.

4.5.2 However, BDT Legal consider that the subject matter of this report comes within an exemption by virtue of s.120 (PCR 2015) as a contract award procedure that relates to the procurement of health care services for the purposes of the NHS and will be executed before 18 April 2016.

4.5.3 The exemption cited above means that the procurement regulations governing the subject matter of this report are the previous PCR 2006 and that this would be considered a “part B service”.

4.5.4 PCR 2006 part B services are exempt from the rigours of a full EU procurement process but must still satisfy principles enshrined in the Treaty for the Functioning of Europe (TFEU). These state that any procurement must demonstrate equality, fairness, transparency, and openness.

4.5.5 Additionally, members are reminded of the need for strict adherence to the Council’s constitution and in particular the Contract Rules contained in Part 4 of that constitution.

4.5.6 BDT Legal understand that it is the intention of the report author to directly award the contract for continued provision of services to NELFT upon transfer from NHS (E) on 1 October 2015. BDT Legal are instructed that provision of the services in question are currently funded at some £4 million per annum and that it is intended to offer directly to NELFT a contract term of 2 years with an option to extend for a further period of 1 year. The total (lifetime) value of the contract therefore would be £12 million (3 years x £4 million)

4.5.7 Contract rule 28.5 states that contracts with an estimated value in excess of £500,000 MUST be let following publication of an appropriate advertisement and subsequent

competitive tendering process except where a formal waiver has been obtained in accordance with rule 6 of the rules.

4.5.8 Contract rule 6 states, so far as is relevant. 6.3 Where a contract value exceeds £500,000 approval to waive [the requirement of a formal tender exercise] MUST be obtained from Cabinet / HWBB except in an emergency in which case the Chief Executive can issue the waiver.

4.5.9 Rule 6.4 sets out the need for compliance with Chapter 16 of Part 2 of the Constitution in respect of Urgent Action procedure and exercise of the Chief Executive powers.

4.5.10 For a waiver to be granted in these circumstances a genuine emergency must exist. Reasons constituting a genuine emergency are set out at 6.6.1 to 6.6.8 of the rules.

4.5.11 In summary, a procurement strategy report will need to be completed. The procurement strategy report will need to be approved by Cabinet / HWBB as appropriate. Additionally, the procurement strategy report will need to include an application for a waiver from the contract rule requirement of a competitive tender procedure which must be approved by Cabinet / HWBB unless granted by the Chief Executive under emergency provisions.

4.6 **Risk management**

From 1 October 2015 the responsibility for commissioning public health services for 0-5 year olds will transfer from NHSE to LAs. The transfer marks the final part of the overall public health transfer. The DH intend to lay regulations on the mandatory aspects of the service (informal consultation on this is expected between September and December). The Council will wish to undertake a detailed risk assessment once the statutory responsibilities are confirmed.

Background Papers Used in the Preparation of the Report:

Department of Health (November 2014) Factsheet: Commissioning the National Healthy Child Programme**.** **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347047/Mandation_factsheet_final_22-8-14.pdf**

Department of Health (November 2014) Transfer of 0-5 children's public health commissioning to local authorities - Finance fact sheet https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377443/Second_Finance_Factsheet__0-5_Transfer_November_2014__2_.pdf

Department of Health (December 2014) Transfer of 0-5 children's public health commissioning to Local Authorities: Baseline Agreement Exercise. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389446/Baseline_Agreement_Exercise.pdf

London Borough of Barking and Dagenham Health and Wellbeing Board (September 2014). Update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service from NHS England to London Borough of Barking and Dagenham. http://moderngov.barking-dagenham.gov.uk/documents/g7564/Public%20reports%20pack%20Tuesday%2009-Sep-2014%2018.00%20Health%20and%20Wellbeing%20Board.pdf?T=10

NHS England (December 2014). Public health services for 0-5 year-olds. Transfer of commissioning responsibilities to local authorities. Additional contracting guidance for NHS commissioners. http://www.england.nhs.uk/wp-content/uploads/2014/12/0-5-trans-guid-temp-let-stg2.pdf

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HEALTH AND WELLBEING BOARD

17 MARCH 2015

Title:	**Systems Resilience Group Update**
Report of the Systems Resilience Group	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Louise Hider, Health and Social Care Integration Manager, LBBD	**Contact Details:** Tel: 020 8227 2861 E-mail: louise.hider@lbbd.gov.uk

Sponsor:

Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group

Summary:

This purpose of this report is to update the Health and Wellbeing Board on the work of the Systems Resilience Group. This report provides an update on the Systems Resilience Group meeting held on the 23 February 2015.

The Joint Assessment and Discharge (JAD) has played a key part in our operational resilience delivery over the winter period through its support to improve the usage of acute beds in both minimising delays when people are ready to leave hospital, through early planning and intervention and in the deployment of support worker staff at the front end of the hospital to support admission avoidance. Discharges supported by the JAD are averaging 100 people a week with positive use of services such as crisis response which are able to provide temporary support focused upon returning people home and optimising their independence and health, improving their experience of support, avoiding readmissions and where appropriate planning time for how on-going needs might be best met. We have consistently exceeded the target agreed for the JAD as part of a series of other programmes, for avoidable admissions into acute care. Funding provided through operational resilience planning has enabled a level of activity that would otherwise be unsustainable for Social Care Budgets.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the Systems Resilience Group.

Reason(s):

There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.

1 Mandatory Implications

1.1 Joint Strategic Needs Assessment

The priorities of the group is consistent with the Joint Strategic Needs Assessment.

1.2 Health and Wellbeing Strategy

The priorities of the group is consistent with the Health and Wellbeing Strategy.

1.3 Integration

The priorities of the group is consistent with the integration agenda.

1.4 Financial Implications

The Systems Resilience Group will make recommendations for the use of the A&E threshold and winter pressures monies.

1.5 Legal Implications

There are no legal implications arising directly from the Systems Resilience Group.

1.6 Risk Management

Urgent and emergency care risks are already reported in the risk register and group assurance framework.

2 Non-mandatory Implications

2.1 Customer Impact

There are no equalities implications arising from this report.

2.2 Contractual Issues

The Terms of Reference have been written to ensure that the work of the group does not impact on the integrity of the formal contracted arrangements in place for urgent care services.

2.3 Staffing issues

Any staffing implications arising will be taken back through the statutory organisations own processes for decision.

3 List of Appendices

System Resilience Group Briefings:

— Appendix 1: 23 February 2015

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System Resilience Group (SRG) Briefing	Meeting dated – 23 February 2015
	Venue – Havering Town Hall
Summary of paper	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Accountable Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
SRG dashboard:	Members were updated on the key areas from the dashboard report.
Trust improvement plan/CQC preparation:	Members received an update on the Trust Improvement Plan and were briefed on preparations taking place ahead of the CQC visit in March.
Workforce update:	Feedback was provided from the Workforce subgroup meeting that took place at the beginning of February.
Programme Board update/scheme review:	Members received an update on the progress of the S1 and S2 schemes.
Schemes requiring mainstreaming recommendation:	Members agreed a number of recommendations for 2015/16.
Discharge and flow update:	It was agreed to hold a discussion around the scope / preparation needed for the discharge workshop.
Feedback from the Frailty workshop:	Members were advised that the recommendations from the Frailty workshop would be turned into an action which will be reported back to the March meeting following review at the Integrated Care Steering group.
RTT Improvement Plan:	Members received a brief update on the progress of the RTT Improvement Plan.
Cancer Improvement Plan:	Members received a brief update on the progress of the Cancer Improvement Plan.
AOB:	None.
Next meeting:	Monday 23rd March 2015 2pm – 4pm, Barking Learning Centre 2 Town Square, Barking IG11 7NB.

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HEALTH AND WELLBEING BOARD

17 March 2015

Title:	**Sub-Group Reports**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: NONE	**Key Decision: NO**
Report Authors: Louise Hider, Health and Social Care Integration Manager, LBBD	**Contact Details:** Telephone: 020 8227 2861 E-mail: Louise.Hider@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board. It should be noted that the Integrated Care Sub-Group, Children and Maternity Sub-Group and Public Health Programmes Board have not met in this period due to the short timescales between Health and Wellbeing Board meetings, therefore there is no sub-group report attached for these groups.	
Recommendations: The Health and Wellbeing Board is asked to: • Note the contents of sub-group reports set out in Appendices 1 and 2 and comment on the items that have been escalated to the Board by the sub-groups.	

List of Appendices

- Appendix 1: Mental Health Sub-group
- Appendix 2: Learning Disability Partnership Board

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Mental Health sub-group

Chair: Gillian Mills, Integrated Care Director (Barking and Dagenham), NELFT

Items to be escalated to the Health & Wellbeing Board

(a) None to note.

Performance

Not applicable

Meeting Attendance

90%

Action(s) since last report to the Health and Wellbeing Board

(a) 2nd development session focused on further developing the sub group workplan for 2015/16 to take forward identified themed priorities within the synthesised' action plan (incorporating the Mental Health Needs Assessment, 'Closing the Gap', the Mental Health Crisis Concordat and the HASCC Welfare Reforms and Austerity Impact scrutiny review report).
(b) Reviewed B&D Mental Health Crisis Concordat draft action plan which has to be submitted by 31st March

Action and Priorities for the coming period

1. Mental Health Needs Assessment findings to be presented to Health and Wellbeing Board in May
2. MH sub group themed priorities and delivery plan to be presented to Health and Wellbeing Board in May

Contact:

Julie Allen, PA to Integrated Care Director (NELFT)

Tel: 0300 555 1201 ext 65067; **E-mail:** Julie.allen@nelft.nhs.uk

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Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Partnerships and Public Protection

Items to be escalated to the Health & Wellbeing Board

None

Performance

Not applicable

Meeting Attendance

Meeting attendance in February 2015 has been problematic in some areas and this is being actively followed up with individuals; last meeting attendance was 50%.

Action(s) since last report to the Health and Wellbeing Board

(a) The LDPB received an informative presentation on the assessment and eligibility process from the Care Act Programme Team.

(b) All sub groups have reviewed the Personal budget report completed by Health Watch.

(c) Supported the Care Act Programme Team with user involvement exercises on advice and information with some members of carers and service user forums attending.

(d) The LDPB were consulted and engaged about the Public Health strategy and the outcomes for people with a learning disability.

Action and Priorities for the coming period

(a) Develop the monitoring tool which will oversee the Autism Strategy actions.

(b) Recruit a new representative from the Provider forum to the Learning Disability Partnership board; three people have expressed an interest and elections from providers are under way.

(c) Review updates on the Winterbourne View Concordat

(d) Support the development of the Independent Living Strategy

(e) End of Life Care

Contact:Karen West-Whylie – GM Learning Disabilities

Tel: 020 8 724 2791; **Email:** karen.west-whylie@lbbd.gov.uk

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HEALTH AND WELLBEING BOARD

17 March 2015

Title:	**Chair's Report**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Louise Hider, Health and Social Care Integration Manager	**Contact Details:** Tel: 020 8227 2861 Email: louise.hider@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: Please see the Chair's Report attached at Appendix 1.	
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.	

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Chair's Report

17 March 2015

In this edition of my Chair's Report I talk about recent A&E performance, teenage pregnancy, the Care Act and the Learning Disability Self Assessment Framework.
I would welcome Board Members to comment on any item covered should they wish to do so.

Best wishes,
Cllr Maureen Worby, Chair of the Health and Wellbeing Board

A&E Performance

Efforts across the health and social care system are having a positive impact on A&E performance at BHRUT. The approach of strong commissioning, committed leadership at the Trust and wider system support from local authority and other colleagues is working well. Performance against the 4 hour target for A&E for week ending 22 February 2015 was 95% (the national standard is 95%). While this is good progress, all partners are still prioritising efforts to secure sustained performance and quality improvement.

BHRUT CQC Inspection

The Care Quality Commission inspectors visited King George and Queens Hospitals during the week 2 to 6 March to look at the work which has taken place to improve care and services for patients. Barking, Havering and Redbridge University Hospitals NHS Trust has been working to deliver its improvement plan: *Unlocking our potential*. At the time of printing, the results of the inspection had not been published but a verbal update will be brought to the Board meeting.

Changes at Barts

Barts Health NHS Trust has seen the size of its deficit grow from the £44m it forecast at the start of the financial year to £93m in its most recent board papers. The Trust's finance director Mark Ogden stepped down in February and Ian Miller has been appointed interim Finance Manager. After six years as Chief Executive, Peter Morris has announced his intention to step down. In addition the Chief Nurse, Professor Kay Riley has announced her retirement after 30 years service to the NHS, Janice Stevens has been Interim Chief Nurse on a six month secondment from Midlands and East Health Education England, where she is currently National Director. Barts is also awaiting the publication of two Care Quality Commission reports, one into Whipps Cross Hospital and the other into Newham and Royal London hospitals.

Tobacco Control Statement of Support

Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) has recently signed up to the Local Government Declaration on Tobacco Control. The declaration is a statement signed voluntarily by local partners, which publically affirms existing national and international commitments. It has been endorsed by the Minister for Public Health, Chief Medical Officer and Public Health England. We hope that local partners will follow BHRUT's lead through signing up and endorsing the declaration.

GP Hub

The Barking and Dagenham pilot surge scheme will end at the end of March 2015. The GP access hub at Barking Community Hospital opened in January 2015 and is working well, with increasing numbers of patients accessing the service and satisfaction ratings which are positive. The hub will also open on a Thursday afternoon from 2pm to 10pm from mid March, providing additional access to patients during working hours and at weekends from the end of March. Plans to open a second hub in Dagenham are in the pipeline and Together First will be working with Healthwatch to identify a second suitable hub site in Dagenham.

Chair's Report

17 March 2015

Teenage Pregnancy Rates

On 24 February the Office of National Statistics (ONS) published the latest teenage conception data for England. While the figures for Barking and Dagenham were not as good as we would have liked it's important to analyse the data and look at what's really happening in the borough.

- There has been a 26% drop in our figures since 1998, which is a strong downward trend.
- Over the last three years, despite small variations, the overall trend in teenage pregnancy is still going down.

Within our teenage pregnancies we see two distinct groups. Firstly, girls who become pregnant and are under 16. In 2013 there were 35 pregnancies in girls in this age group. As a result there were 11 babies born.

The second group are older young women aged over 16. Some of these women are in relationships and choosing to settle down and start a family. In 2013 there were 119 pregnancies in older young women, not all of which resulted in the mother giving birth.

Both groups need support, and for those who chose to become mothers at a young age we have excellent services provided by the family nurse partnership, the family intervention project and our Children's Centres. For those who did not intend to become pregnant, particularly those at a young age, we provide access to counselling services and support so that they can make an informed life choice.

All our young people across the borough deserve to be supported and we've been working with them through the Barking and Dagenham Youth Forum to provide effective sex and relationship education. This helps young people to deal with the very real pressure to have sex, as well as equipping them with the knowledge and skills to avoid unplanned pregnancies and sexually transmitted diseases (STIs).

The borough has excellent partnership working arrangements with health focussed organisations, through the Sexual Health Board. Our young people-centred contraceptive and sexual health services work includes:

- proactively offering easy to access to Chlamydia screening for young people
- the 'Young Inspectors' programme, which has seen 62 inspections of pharmacies, helping to improve young people's access to condoms
- the Healthy Schools programme has led the way on devising Personal, Social and Health Education (PSHE) learning that can be adapted as appropriate by each school
- regularly commissioning Chain Reaction Theatre Group to work with young people on devising social marketing campaigns (posters and viral videos) that target people of their own age
- the 'Beer Goggles' campaign which encourages young people to consider how they would use a condom correctly after having a drink
- The 'Come Correct C-card' key-fob scheme, with 8,000 condoms being distributed to sexually aware youngsters across London.

Response to UKHCA Report

Board members will no doubt have seen the press coverage that followed the publication of a report by the UK Homecare Association highlighting their view on the underfunding of home care services. The report was based on a freedom of information request which asked for data over a particular pre-Christmas week. Barking & Dagenham was cited as one of the lowest in London, and low by UK standards. In fact, the rates we typically call on are higher than this average for the particular week, so we have gone back to our data to check out our understanding.

However, it remains a concern and we are taking action as a result. Initially, the Council will be reaffirming with all providers that they are meeting national minimum wage legislation, including paying for travel time. We have recently launched a tendering exercise for providers to bid to provide homecare services, including crisis intervention, and through this competitive mechanism we anticipate a longer-term settling of the question about the price of homecare.

News from NHS England

NHS Staff Survey

NHS England has today published the **results of the 2014 NHS Staff Survey**. The survey collects the experiences and opinions of NHS staff on a range of matters such as job satisfaction, wellbeing and raising concerns. The annual survey saw over 255,000 responses from staff including doctors, nurses, healthcare assistants, ambulance workers and non-clinical employees. Nearly 290 NHS organisations from across the country took part. Organisations will use the results to review and improve staff experience, which in turn can bolster improvements to patient care. The results will also inform local and national assessments of the quality and safety of care, and how well organisations are delivering against the standards set out in the NHS Constitution.

Summary of key results:

- **Patient care -** In 2014 slightly more staff reported that the care of patients is their organisation's top priority (up from 66% in 2013 to 67% in 2014) and more felt that senior managers are committed to patient care (53%, up from 52% in 2013).
- **Raising concerns** – 93% of staff reported that they know how to raise any concerns they had about unsafe clinical practice.
- **Advocacy –** 64% of staff would be happy with the standard of care provided by their organisation if a friend or relative needed treatment, down from 65% in 2013.
- **Health and wellbeing at work** – 14% said that they experienced physical violence at work from patients, their relatives or the public in 2014 (15% percent in 2013). Fewer staff also said that they experienced harassment, bullying or abuse from patients, their relatives or the public, down from 29% in 2013 to 28% in 2014. Almost a quarter (24%) of staff said that they experienced harassment, bullying or abuse from their manager or other colleagues in 2014, a slight increase from 23% in 2013. From April 2014 the NHS is introducing a workforce race equality standard to track and reduce the differences on this and related issues between white and black minority ethnic (BME) staff at each NHS employer.

Guidance on New Mental Health Standards

NHS England has set out guidance for how new access and waiting time standards for mental health services are to be introduced. It explains the case for change in four areas and sets out the expectations of local commissioners for delivery during the year ahead working with providers and other partners. It sets out how commissioners and providers can begin to prepare for implementation of the new early intervention in psychosis and liaison mental health standards. It says that plans need to be submitted about how local commissioners will meet the new Improving Access to Psychological Therapies (IAPT) standard for people with depression and anxiety disorders. It also gives updates on funding for eating disorders services. In October, a wide range of measures were announced including a new standard whereby 50% of patients experiencing their first episode of psychosis will, from 1 April 2016, access NICE concordant care within two weeks of referral. Also from April 2016, 75% of patients with depression or anxiety disorders needing access to psychological therapies are to be treated within six weeks of referral, and 95% in 18 weeks. By 2020 all hospitals are to have effective liaison mental health services in place across acute settings.

London Calling for GPs – report launch

Around 16,000 more GPs will be needed nationally than are currently available by 2021. Almost 16 per cent of London GPs are over 60 years old, so if large numbers of GPs take early retirement, London could be desperately short of doctors. In order to meet the needs of a rapidly-growing population, London needs to attract new talent to the GP profession and retain the GPs it already has. You can ready the full report at the following link https://www.london.gov.uk/mayor-assembly/london-assembly/publications/access-to-gp-care

Chair's Report

17 March 2015

Care Act 2014 – 14 days to go!

Implementation activity is at full tilt as we approach the important milestone of 1st April 2015, by which date we must have delivered the majority of Part One of the Care Act. Since the last Health and Wellbeing Board meeting there have been the following developments:

- Cabinet has agreed its arrangements for deferred payment agreements and a revised Care and Support Charging Policy
- The HASSC has scrutinised the implementation programme
- The second wave of workforce development workshops have started focussing on developing procedures and practice guidelines
- There has been engagement with housing providers, care and support providers, service users, and voluntary sector issues generally on the Care Act and on specific issues
- The national public awareness campaign has become more visible
- The consultation on the cap on care costs and appeals has been launched

Implementation will carry over into 2015/16 as we embed changes and continue with developments to meet Care Act requirements. We are already looking ahead to April 2016 and the major changes of the cap on care costs and appeals. It's safe to say that the Care Act will continue to feature prominently in Health and Wellbeing Board business for the foreseeable future.

It is important that partners keep the Care Act at the forefront of their minds and build on the work that has taken place to ensure compliance with the Act from 1st April 2015. The Programme Team is on hand to provide support and help.

Learning Disability Self Assessment Framework

The Joint Health and Social Care Learning Disability Self-Assessment Framework (LDSAF) is currently overseen nationally by NHS England and National ADASS is a framework to provide a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met locally. This year's framework had a focus on the Winterbourne View Joint Improvement Plan. On the 31st January 2015 the authority submitted its self assessment which included Children, Adults, Heath and Social Care. The Borough saw an improvement in a number of key areas in comparison to the last LDSAF, including: more people in employment, more access to local amenities, greater awareness of learning disabilities within the criminal justice system, improved access and participation in Arts and Leisure services, improved preparation for adulthood (mainly through the work completed on Education, Health and Care Plans) and improved joint and effective working.

The authority will develop and implement an action plan to maintain and improve on its service delivery in supporting people with a learning disability and their carers and will bring the action plan to a future Health and Wellbeing Board for discussion.

Dates for your Diary

Health and Wellbeing Board Meeting Dates:

Tuesday 12 May 2015, Tuesday 7 July 2015, Tuesday 8 September 2015, Tuesday 20 October 2015, Tuesday 8 December 2015, Tuesday 26 January 2016, Tuesday 8 March 2016, Tuesday 26 April 2016, Tuesday 14 June 2016. All meetings start at 6pm and are held in the conference room of the Barking Learning Centre.

Health and Wellbeing Board Development Afternoon:

Thursday 16 April 2015, 2 – 6pm at Eastbury Manor House. Please contact Joanne Kitching on 020 8227 3216 or on joanne.kitching@lbbd.gov.uk for more information and to book a place.

HEALTH AND WELLBEING BOARD

17 March2015

Title:	**Forward Plan**
Report of the Chief Executive	
Open	**For Information**
Wards Affected: NONE	**Key Decision: NO**
Report Authors: Tina Robinson, Democratic Services	**Contact Details:** Telephone: 020 8227 3285 E-mail: tina.robinson@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

The Forward Plan lists all known business items for meetings scheduled for the 2015/16 municipal year and is an important document for not only planning the business of the Board, but also ensuring that we publish the key decisions to be taken at least 28 days notice of the meeting. This enables local people and partners to know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.

Attached at **Appendix A** is the Draft May 2015 issue of the Forward Plan for the Health and Wellbeing Board at the time of this agenda's publication.

Recommendation(s)

The Health and Wellbeing Board is asked to:

a) Note the draft forward plan and to advice Democratic Services of any issues of decisions that may be required so they can be listed publicly in the Board's Forward Plan, with at least 28 days notice of the meeting;

b) To consider whether the proposed report leads are appropriate;

c) To consider whether the Board requires some items (and if so which) to be considered in the first instance by a Sub-Group of the Board.

d) To note that the next issue of the Forward Plan will be published on 13 April 2015. Any changes or additions to the next issue should be provided before 6.00p.m, on 8 April.

Public Background Papers Used in the Preparation of the Report:
None

List of Appendices
Appendix A – Draft Forward Plan

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HEALTH and WELLBEING BOARD
FORWARD PLAN

DRAFT - May 2015 Issue

Publication Date: 13 April 2015

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).
In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk.

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2014 / 2015 Council year, in accordance with the statutory 28-day publication period:

Edition	Publication date
March 2015 edition	16 February 2015
May 2015 edition	13 April 2015
July 2015 edition	8 June 2015
September 2015 edition	11 August 2015
October 2015 edition	21 September 2015
December 2015 edition	10 November 2015
January 2016 edition	29 December 2015
March 2016 edition	9 February 2016
April 2016 edition	29 March 2016
June 2016 edition	17 May 2016

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk .

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 12.5.15	Quarter 4 Performance The Quarter 4 performance dashboard and Better Care Fund (BCF) update will be presented to Board for the Board to analyse and discuss. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 12.5.15	**Health and Wellbeing Board Strategy Refresh (Final)** : Community One of the key roles of the Health and Wellbeing Board is to oversee the development, authorisation and publication of the Health and Wellbeing Strategy. The Health and Wellbeing Strategy is the mechanism by which the Board addresses the needs identified in the Joint Strategic Needs Assessment (JSNA), setting out agreed priorities for collective action by the commissioners. The current Health and Wellbeing Board Strategy is due to be refreshed in 2015. The final refreshed version of the Health and Wellbeing Strategy will be presented for approval. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

Health and Wellbeing Board: 12.5.15	**Joint Health and Social Care Self Assessment Framework** : Community The Annual Joint Health and Social Care Self Assessment was carried out on how the Council meets the needs of People with a Learning Disability and their Carers. The assessment focussed on the period 1 April 2013 to 31 March 2014. The final submission was agreed by the Learning Disability Partnership Board. This report outlines the background, the findings and agreed actions for improvement. • Wards Directly Affected: All Wards	Open	Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)
Health and Wellbeing Board: 12.5.15	**Prevention Strategy** : Framework To meet Care Act duties relating to prevention the statutory guidance requires the Council to develop a prevention strategy on behalf of the borough. In keeping with the Council's corporate priority of encouraging social responsibility the Programme Board has agreed a framework which builds preventative support around the individual with an emphasis on self-help and access to universal service provision. This Strategy will be developed in the context of the refresh of the Health and Wellbeing Strategy and presented to the Board for agreement. • Wards Directly Affected: All Wards	Open	Ian Winter CBE, Care Act Programme Lead (Tel: 020 8227 5310) (ian.winter@lbbd.gov.uk)
Health and Wellbeing Board: 12.5.15	Review of Governance Arrangements Of The Sub Structure Of The Health And Wellbeing Board In Its Third Strategic Year. The report will outline and review the governance arrangements of the Health and Wellbeing Board. • Wards Directly Affected: Not Applicable	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)

Health and Wellbeing Board: 7.7.15	Annual Health Protection Profile *[Annual Item]* Representatives from Public Health England are invited to the Board to present and discuss Barking and Dagenham's Health Protection Profile which is compiled annually. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 7.7.15	**Children's Autism Strategic Plan** : Community The Children's Autism Strategy is being presented to the Board as the Children's Strategy has been reviewed and revised to reflect the Adult Autism Strategy. • Wards Directly Affected: All Wards	Open	Ann P Jones, Group Manager Education Inclusion, Children's Services (Ann.p.Jones@lbbd.gov.uk)
Health and Wellbeing Board: 7.7.15	**Primary Care Transformation Programme - Update** The Board will be presented with an update on the Primary Care Transformation Programme in Barking, Havering and Redbridge (BHRUT). • Wards Directly Affected: All Wards	Open	Conor Burke, Chief Officer (Tel: 020 8926 5238) (conor.burke@onel.nhs.uk)
Health and Wellbeing Board: 7.7.15	Barking and Dagenham Child Death Overview Panel (CDOP) Annual Report The CDOP Annual report will be presented to the H&WBB for information. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 7.7.15	Substance Misuse in Barking and Dagenham The Board will be provided with an information report to highlight the current situation regarding the misuse of illegal drugs, prescribed and over the counter medication. • Wards Directly Affected: All Wards	Open	Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)

Health and Wellbeing Board: 8.9.15	Complaints Report The Board will be presented with the health and wellbeing complaints report, including lessons learnt. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

Membership of Health and Wellbeing Board:

Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health (Chair)
Councillor Laila Butt, Cabinet Member for Crime and Enforcement
Councillor Evelyn Carpenter, Cabinet Member for Education and Schools
Councillor Bill Turner, Cabinet Member for Children's Social Care
Anne Bristow, Corporate Director for Adult and Community Services
Helen Jenner, Corporate Director for Children's Services
Matthew Cole, Director of Public Health
Frances Carroll, Chair of Healthwatch Barking and Dagenham
Dr Waseem Mohi, Chair of Barking and Dagenham Clinical Commissioning Group (Deputy Chair of the H&WBB)
Dr Jagan John, Clinical Director (Barking and Dagenham Clinical Commissioning Group)
Conor Burke, Accountable Officer (Barking and Dagenham Clinical Commissioning Group)
Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation (North East London NHS Foundation Trust)
Dr Nadeem Moghal, Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Chief Superintendant Sultan Taylor, Borough Commander (Metropolitan Police)
John Atherton, Head of Assurance (NHS England) (non-voting Board Member)

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