London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 23 March 2015
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care (Chair)
Dr Tim Spicer, Chair of H&F CCG (Vice-chair)
Councillor Sue Macmillan, Cabinet Member for Children and Education
Liz Bruce, Tri-borough Executive Director of Adult Social Care
Andrew Christie, Tri-borough Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Dr Susan McGoldrick, Vice-Chair, H&F CCG
Trish Pashley, Local Healthwatch representative
Stuart Lines, Deputy Director of Public Health

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Date Issued: 13 March 2015

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

23 March 2015

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 7
	(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 19 January 2015.	
	(b) To note the outstanding actions.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST**	

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4.	**NORTH WEST LONDON WHOLE SYSTEMS MENTAL HEALTH & WELLBEING STRATEGIC PLAN: BRIEFING PAPER**	8 - 46

This report provides a briefing on the programme to develop a North West London wide Whole System Mental Health & Wellbeing Strategic Plan, which will build on the previous NWL Mental Health Strategy (Shaping Healthier Lives) and the Whole Systems approach to involving health and social partners in developing the plan.

5. PHARMACEUTICAL NEEDS ASSESSMENT 47 - 166

This report provides the 2015-18 Pharmaceutical Needs Assessment for the London Borough of Hammersmith and Fulham.

6. HAMMERSMITH & FULHAM CLINICAL COMMISSIONING GROUP: LOCAL PRIORITY 2015/16: UPDATE AND NEXT STEPS 167 - 171

This report is for information.

7. WORK PROGRAMME 172 - 175

The Board's proposed work programme for the municipal year 2015/2016 is set out as Appendix 1 to this report.

The Board is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future.

8. DATES OF NEXT MEETINGS

This is the last meeting of the municipal year.

Agenda Item 1

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 19 January 2015

PRESENT

Councillor Vivienne Lukey (Cabinet Member for Health and Adult Social Care) (Chair)
Councillor Sue MacMillan (Cabinet Member for Children and Education)
Liz Bruce, Tri-Borough Executive Director of Adult Social Care
Andrew Christie, Tri—Borough Executive Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Stuart Lines, Deputy Director of Public Health
Dr Susan McGoldrick, H&F CCG

Other Councillors: Rory Vaughan

Adult Safeguarding Executive Board: Mike Howard

St. Mungo's Broadway: Rod Cullen

Officers: Sue Perrin (Committee Co-ordinator)

41. MINUTES AND ACTIONS

The minutes of the meeting held on 10 November 2014 were approved as an accurate record of the meeting and signed by the Chair.

42. APOLOGIES FOR ABSENCE

Apologies were received from Dr Tim Spicer and Trish Pashley.

43. DECLARATIONS OF INTEREST

There were no declarations of interest.

44. ST. MUNGO'S BROADWAY: CHARTER FOR HOMELESS HEALTH

Rod Cullen, Area Manager for Hammersmith & Fulham explained that the St. Mungo's Broadway campaign 'A Future Now – Homeless Health Matters' aimed to raise awareness of the impact that homelessness had on health, and the difficulties that homeless people faced in accessing healthcare.

The campaign asked HWBs to sign the 'Charter for Homeless Health', committing to:

- Identify need: include single homelessness in their Joint Strategic Needs Assessment (JSNA)
- Provide leadership to improve homeless health
- Commission for inclusion to ensure that people who are homeless can easily access the health related services they need.

Dr McGoldrick stated that there had been a number of projects towards homeless health, including community provision. It was more difficult to access acute services, if for example homeless people had nowhere to pick up an appointment letter.

Councillor Lukey queried whether homeless people tended to go A&E. Mrs Bruce responded that there were dedicated GP practices and multi-agency teams. H&F had looked at other models across the country and aimed to do better. The discharge of people with mental health problems back on to the street was a particular problem.

Councillor Lukey offered to share with St. Mungo's the JSNA on rough sleepers, written in February 2013.

RESOLVED THAT:

The HWB agreed to sign the St. Mungo's charter.

45. CHILD POVERTY

Mr Christie introduced the report, which provided an update, following the JSNA on Child Poverty, published in July 2014, and recommended further activity.

The JSNA report had suggested six priority areas:

- Supporting families to engage with services
- Promoting parental employment
- Access to quality/affordable early years childcare, for all families
- Supporting the role of the school community
- Appropriate healthcare, at the right time
- All families have access to housing of a reasonable standard

The report recommended that the Lead Member for Children should be identified as the portfolio holder for child poverty policy and strategy

development, delegating to the Director for Children's Services, on behalf of the Board, working with statutory and voluntary partners.

There was recognition that poverty now also included working families. Whilst there were some national issues, there was also a lot which could be achieved locally. Addressing the causes and consequences of child poverty required attention from a range of services, both statutory and voluntary.

Children's Services were the main contributor to Priority 3 of the Joint Health and Wellbeing Strategy (every child has the best start in life). It was recommended that the Board commissioned a standalone child poverty strategy.

Councillor Macmillan added that a child poverty strategy could be led by Children's Services, but would have to be delivered by a cross Council commitment and working with external partners.

Dr McGoldrick commented that 'Appropriate healthcare, at the right time' should include dental care. Health could support the needs identified via the JSNA through, for example, the move of midwives into the community. It was important to look at the early years of childhood in a more joined up way. Preventative work was also important.

Councillor Lukey noted the importance of joined up working and the key role of Public Health in developing the JSNA.

The draft strategy would add to the Board's work programme for the June/July meeting. Child Poverty was likely to feature in the Public Health Strategy as a local priority.

Councillor Vaughan noted that it was essential to measure outcomes, including housing.

RESOLVED THAT:

The committee supported the recommendations that:

(i) The Lead member for Children should be identified as the portfolio holder for child poverty policy and strategy development, delegating to the Director for Children's Services on behalf of the Board, working with statutory and voluntary partners.

(ii) The Health and Wellbeing Board commissions a child poverty strategy, led by Children's services and working across statutory and voluntary partners and with parents locally. It is also recommended that each partner on the Health and Wellbeing Board commits relevant resources

46. CARE ACT IMPLEMENTATION

Mrs Bruce introduced the report, which updated on progress in relation to the implementation of the Care Act in Hammersmith & Fulham. The report set out the phase 1 key deliverables for compliance by 31 March 2015. There were a number of work streams and these were on track to implement the deliverables. The report set out what had been involved in the work.

Mrs Bruce highlighted 'Eligibility and the new National Minimum Threshold' as an issue for both Hammersmith & Fulham and Kensington & Chelsea. The current national minimum eligibility criteria were based on the existing FACS criteria for 'Critical' and 'Substantial' needs. Hammersmith & Fulham currently provided a service to those with 'Upper Moderate' needs and Kensington & Chelsea to those with 'Moderate Needs'. Legal advice would be sought in respect of local discretion.

A number of duties within the Care Act were likely to have financial impacts for the Council. Initial financial modelling indicated an increase in the cost of care; increased demand for needs assessments; and rising demand for deferred payments.

Mr Christie noted that the transition from children and young people services to adult services could also have implications for NHS commissioners. However, the duties in the Act to integrate with health services were not distinctly different from current practice.

Councillor Vaughan noted that transition from children and young people services to adult services was on the work programme for the Health, Adult Social Care & Social Inclusion PAC, and that it was hoped to set up a task group.

Mrs Bruce noted that, in addition to the Care Act, Better Care Fund work would be taken into account in determining how many staff were required and at what point in the Customer Journey.

The Board noted the report.

47. BETTER CARE FUND AND WHOLE SYSTEMS INTEGRATION

The Board received an update on progress with development of the Better Care Fund (BCF).

Councillor Vaughan asked for clarification in respect of hospital discharges and how they could impact on A&E waiting times. Mrs Bruce responded that work was in progress locally to develop a new integrated Community Independence Service (CIS), which would help people with good care at home when they might otherwise need to be in hospital. CIP would reach into hospitals to pro-actively discharge people. CIP had been developed in the BCF and was integral to the aims of Whole Systems Integrated Care (WSIC). It would be rolled out in the three boroughs.

There had been an upsurge in winter pressures over the previous six weeks, and additional money there had been additional money to support delayed

discharges. Work was also in hand to standardise discharge protocols and policies across the three boroughs.

Dr McGoldrick added that it might be necessary to use interim residential care or intermediate beds to prevent delayed discharges. Funding had been allocated at the beginning of the year and CIP was also contributing.

Ms Jones stated that NW London had invested significantly in intermediate beds. Many patients were in their late 90s and 100s and likely to have complex health and social care needs. Whilst A&E attendances were fairly stable, the length of stay had increased for non-elective patients. The CCG had been expanding transitional care facilities for these patients for sometime. Intermediate beds were provided at CLCH sites and Imperial, and also out of borough if necessary. Hammersmith beds could be offered to other boroughs, if there was spare capacity.

Mrs Bruce stated that there was a correlation between GP availability and elderly patients going to A&E. Providers were struggling with the complexity of needs and a lack of nursing bed provision. For example, there people in their 100s with dementia, who social workers had only met for the first time when admitted to hospital. Increasing demand and complexity had reduced beds and increased the need for joined up health and social care.

Dr McGoldrick noted that A&E was the place of choice for some people. H&F CCG had invested in GP practices evening and Saturday opening, out of hour's services and the 111 service. There was good access to GPs and hospital appointments could be booked on the same day.

Dr McGoldrick suggested that the CCG and Council could work together to, for example, advertise seven day services. There tended to be an increase in A&E services between 4pm and 7pm by younger parents with children.

Ms Jones stated that A&E attendances were being analysed, but there was not one answer for the surge in attendance.

Mr Lines suggested that community pharmacies should be used as a point of access and signposting.

Mr Christie stated that there was a high churn of 25-35 year olds in the borough and information could be provided to estate agents, and also to schools and the voluntary sector housing.

RESOLVED THAT:

The Board noted the report.

48. ADULT SAFEGUARDING BOARD

Mike Howard, Chair of the Safeguarding Adults Executive Board (SAEB) presented the report on a joint-working relationship between the HWB and the

SAEB, including agreeing a protocol to describe this relationship and identifying any areas where joint-working might be beneficial to improve health and wellbeing outcomes for residents.

The report set out some themes that the SAEB considered required a joint response: safer recruitment; commissioning care for older people with complex care needs; and understanding and resourcing shared responsibilities for the Deprivation of Liberty Safeguards.

The report appended a protocol setting out governance arrangements between the HWB and SAEB.

Mrs Bruce considered that the change of the SAEB to a statutory board from 1 April 2015 was welcome and overdue.

Mr Christie suggested an annual report in respect of SAEB's work, work programme for future years and issues.

Councillor Vaughan queried how it was intended to ensure that safeguarding was 'everyone's business' and suggested the inclusion of examples of how safeguarding works, together with success stories.

A SAEB sub-group could focus on community engagement and making safeguarding accessible to the public and making sure that the message was understood and spread widely. Other bodies needed to be aware of their responsibilities.

RESOLVED THAT:

The HWB endorsed the draft protocol for working with the SAEB and the three proposed areas for joint working.

49. WORK PROGRAMME

The work programme was received.

50. DATE OF NEXT MEETING

23 March 2015

Meeting started: 5.00 pm
Meeting ended: 7.00 pm

Chairman .....

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	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **23 March 2015**
NWL WHOLE SYSTEMS MENTAL HEALTH & WELLBEING STRATEGIC PLAN: BRIEFING PAPER	
REPORT BY NHS NORTH WEST LONDON (STRATEGY & TRANSFORMATION TEAM)	
Open Report	
Classification - For Decision and Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Thirza Sawtell, Director of Strategy & Transformation Team, NHS NWL	
Report Author: Eleanor Wyllie, Programme Director, NW London Whole System Mental Health & Wellbeing Strategic Plan	**Contact Details:** Tel: 020 3350 4164 E-mail: eleanor.wyllie@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1. The Collaboration Board of NWL CCGs and the NWL Mental Health Programme Board have approved the commencement of a programme to develop a NWL-wide Whole System Mental Health & Wellbeing Strategic Plan. It will build on the previous NWL Mental Health Strategy (Shaping Healthier Lives) and the Whole Systems approach to involving health and social partners in developing the plan. A launch event for the programme 'Like Minded: Working together for mental health and wellbeing in NW London' was held on 6 February 2015.

1.2. The programme is being mobilised, and the programme plan is to:

- develop a case for change and agree priority strategic areas (c.4 months)
- develop care models for those areas (c. 7 months)
- hold a joint health & social care public consultation (if required) (c. 3 months)
- revise the care models further to consultation feedback (c.4-5 months).

1.3. Local authorities play an essential role in commissioning mental health and wellbeing services, and therefore their commitment will be crucial to the success of this programme. We request Health and Wellbeing Board

members to actively seek the commitment and involvement of council members in the programme.

2. RECOMMENDATIONS

2.1. The Board is requested to review the briefing paper below, and the draft Programme Initiation Document (Appendix 1).

2.2. The Board is requested to use their influence to secure Council commitment and involvement in the programme.

3. REASONS FOR DECISION

3.1. Local authorities play an essential role in commissioning mental health and wellbeing services, and therefore their commitment will be crucial to the success of this programme.

4. INTRODUCTION AND BACKGROUND

4.1. The NWL Mental Health Programme Board developed a refreshed vision for mental health services:

'**Excellent, integrated** mental health services to **improve mental and physical health**, secured through collaboration and determination to **do the best** for the population of North West London. Services that:

- Are responsive, focussed on the person, easy to access and navigate.
- Provide care as close to home as possible, with service users at the heart; where and when it is needed.
- Improve the lives of users and carers, promoting recovery and delivering excellent health and social care outcomes, including employment, housing and education.'

4.2. The people and the organisations of North West London have a commitment to, and a passion for, ensuring that mental health has an equal priority with physical health and that everyone who needs mental health care should get the right support at the right time.

4.3. Wellbeing covers both physical and mental wellbeing, and is impacted by many factors, including those within the influence of local authorities, such as public health services, housing and education.

5. PROPOSAL AND ISSUES

Need

5.1. Poor wellbeing leads to low educational attainment and employment levels, anti-social and criminal behaviour. It also leads to worse mental and physical health, often resulting in increased mortality.

5.2. Mental health problems are common and expensive:

- At least one in four of us will experience a mental health condition at some point in our lives and one in six adults has a mental health condition at any given time.
- One in ten children (aged 5-15) has a mental health condition and half of all people with lifelong mental health conditions have developed them by the age of 14. Therefore schools have a key role.
- Sickness absence due to mental health problems costs the UK economy £8.4bn a year and also results in £15.1bn in reduced productivity.
- The cost of mental health in England is estimated to be £105bn and the cost of health services to treat mental illness could double over the next 20yrs.
- Mental illness accounts for 23% of the total burden of disease in the UK; more than cardiovascular disease or cancer.
- One in three people over 65 will develop dementia; two-thirds of whom will be women.

5.3. Changing demographics, including an ageing population, mean the demand for services is increasing, creating pressure on service quality and outcomes, as well as on the sustainability of the current system over time.

Proposal

5.4. Through development of the NWL Whole System Mental Health and Wellbeing Strategic Plan we hope to transform both the mental health and wellbeing services in North West London, delivering real change for our population. Taking a whole system approach and working in partnership with all local stakeholders will ensure that we explore a wide range of factors affecting people's mental health and wellbeing and how it can be improved.

6. OPTIONS AND ANALYSIS OF OPTIONS

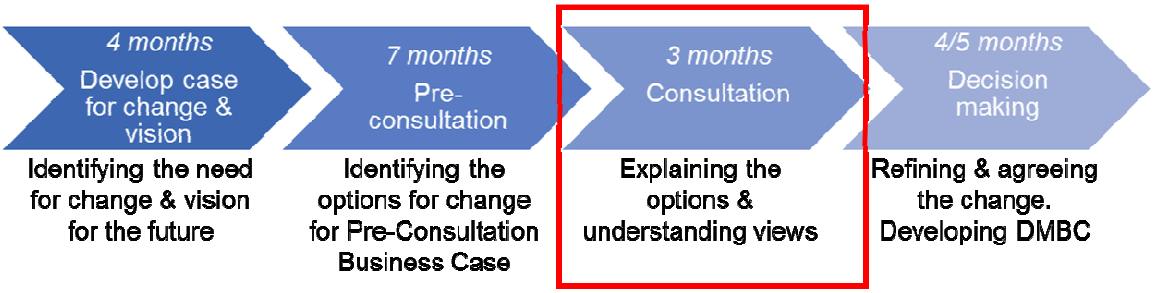
6.1. The programme is taking a 'Whole System' approach (ie looking across health and social care services) to transforming the way that mental health and wellbeing services are delivered in NWL.

6.2. Within our proposed governance structure we have included representation from local authorities (Directors of Adult Services, Directors of Children's Services and Public Health). We will need Local Authority representation in order to have an informed debate about the services they commission that impact on mental health and wellbeing.

6.3. Each Local Authority will need to sign-off any proposals to make changes to mental health and wellbeing services they commission, and in order to do so they will need to input into developing those proposals.

7. CONSULTATION

7.1. The programme plan for the next 18 months is below:



7.2. If the models of care developed through the Pre-Consultation Business Case result in significant changes to the way that health and social care services are delivered, there will need to be a joint public consultation (highlighted in the figure above). This will take 3 months.

8. EQUALITY IMPLICATIONS

8.1. An Equality and Engagement lead will be appointed as part of the programme management office, to ensure these issues are considered and addressed throughout the programme. In addition, we propose to commission an external Integrated Impact Assessment as part of the programme.

9. LEGAL IMPLICATIONS

9.1. As programme is in mobilisation phase, and there are not yet any proposals that impact on services, there has not been the need to seek legal advice.

9.2. Implications verified/completed by: N/A

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. The NHS NWL Collaboration Board recommended that significant additional resource would be required to develop the Whole Systems Mental Health & Wellbeing Strategy, which has been taken into account in developing the 2015/16 budgets across NHS NWL.

10.2. Within the proposed programme governance arrangements there is a Financial and Technical Reference Group, whose role will be to scrutinise financial and activity models, and provide assurance on them to the programme Transformation Board. Representation from Local Authority Finance Departments will be required to enable sign-off of plans that might have a financial or activity impact on services they commission.

10.3. Implications verified/completed by: N/A

11. RISK MANAGEMENT

11.1. *Risk:* Lack of engagement from all partner organisations may undermine the success of this project.
Action taken to minimise risk: Governance arrangements include all partner organisations. Communications with Health and Wellbeing Boards, joint commissioners and directly with Councils to increase engagement and ownership of this programme.

11.2. *Risk:* If the Strategic Plan is not co-designed with patients, carers, clinicians and staff, it will not have the intended impact in transforming mental health and wellbeing services for the NWL population.
Action taken to minimise risk: 'Embedding partnerships' approach to ensure programme is co-designed with lay partners (patients and carers), who sit on all Boards and working groups within the governance arrangements.

11.3. Implications verified/completed by: Eleanor Wyllie, Programme Director for Like Minded

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. *N/A*

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.			

LIST OF APPENDICES:

Appendix 1: Draft Programme Initiation Document

North West London Mental Health and Wellbeing Programme

Draft Programme Initiation Document

[Please note: this PID will be updated during programme mobilisation]

DOCUMENT CONTROL

VERSION	AUTHOR & DATE	COMMENTS
0.1	*Eleanor Wyllie 090914*	*Initial draft*
0.2	*Thirza Sawtell 150914*	*Review and amends*
0.3	*Eleanor Wyllie 160914*	*Update to reflect TS comments*
0.4	*Eleanor Wyllie 071014*	*Update to reflect Collab Board, Robyn Doran, Abbas Mirza, Caroline Leveux comments*
0.5	*Eleanor Wyllie 141014*	*Further updates following stakeholder meetings*
0.6	*Eleanor Wyllie 251114*	*Update to reflect feedback from all stakeholder meetings*
0.7	*Eleanor Wyllie 301214*	*Includes economic impact of MH, and demographic info in section 1*

DOCUMENT APPROVAL

SRO *Signed:* *Date:*
Thirza Sawtell
Director, Strategy & Transformation Team, NHS NW London

CRO *Signed:* *Date:*
Fiona Butler
Clinical Lead for Mental Health, NHS NW London

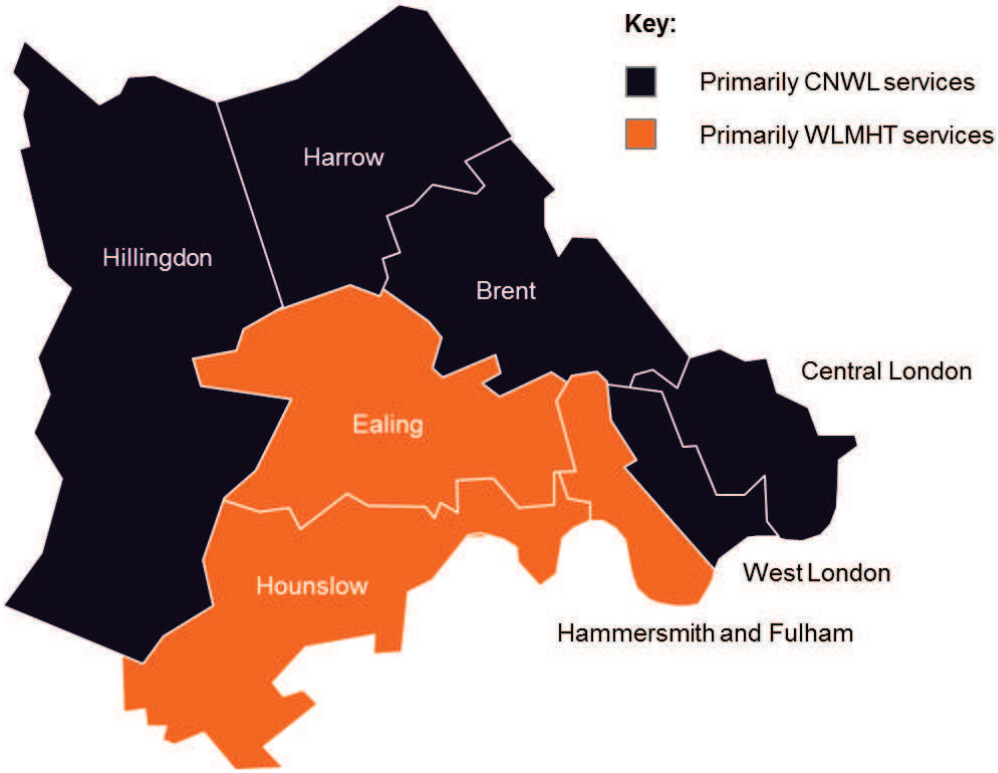
*Please send comments on this document to: Eleanor.Wyllie@nw.london.nhs.uk

Contents

1. Background / context

North West London comprises eight boroughs. The NHS in North West London (NWL) serves a population of 1.9m and has two mental health providers, 10 acute and specialist hospital trusts and two community trusts. NWL covers 8 boroughs, and has 8 Clinical Commissioning Groups (CCGs), which are broadly co-terminus, with the exception of Central London CCG (which comprises the majority of Westminster) and West London CCG (which comprises Kensington and Chelsea and part of Westminster).

The two mental health trusts are Central and North West London NHS Foundation Trust (CNWL) and West London Mental Health NHS Trust (WLMH), and the primary areas they serve are shown in the figure below.



- In 2012/13 mental health accounted for almost 12.5% or £460 million of the total NHS spend across NW London, with spend on learning disability costing £56 million; together they account for 14% of NHS NWL spend (although this varies from 9.4% in Hillingdon to 19.7% in Westminster)[1].
- The estimated prevalence of common mental health disorders such as depression, anxiety, and obsessive–compulsive disorder (OCD) in the CCG population ranges from under 14% in Harrow to over 21% in Central London.[2]
- Rates of serious mental illness (SMI) are estimated to be 1.08% across NWL (compared with 0.84% in England). Inner boroughs do have higher rates, with West London having the 4th highest rate of SMI in the country (1.46%)[3].
- Within NWL Local Authorities, there is variation in the effectiveness of spend and outcomes on public health and other services, which can impact on NHS services.

[1] **Source: Programme Budgets, 2012/13**
[2] **Common Mental Health Disorders, Public Health England, 2014.**
[3] **QOF 2012/13, Public Health England**

1.1 Impact of poor mental health and wellbeing

- Poor wellbeing leads to low educational attainment and employment levels, anti-social and criminal behaviour. It also leads to worse mental and physical health, often resulting in increased mortality.
- Mental health problems are common and expensive:
  - At least one in four of us will experience a mental health condition at some point in our lives and one in six adults has a mental health condition at any given time.
  - One in ten children (aged 5-15) has a mental health condition and half of all people with lifelong mental health conditions have developed them by the age of 14.
  - Mental illness accounts for 23% of the total burden of disease in the UK; more than cardiovascular disease or cancer.
  - One in three people over 65 will develop dementia; two-thirds of whom will be women.
  - Sickness absence due to mental health problems costs the UK economy £8.4bn a year and also results in £15.1bn in reduced productivity.
  - The cost of mental health in England is estimated to be £105bn and the cost of health services to treat mental illness could double over the next 20yrs.
- Changing demographics, including an ageing population, mean the demand for services is increasing, creating pressure on service quality and outcomes, as well as on the sustainability of the current system over time.

1.2 Strategic context

In 2012, NW London agreed a three year strategy for mental health services 'Shaping Healthier Lives'. The strategy was innovative and ahead of its time in its approach and provided the coalescing factor bringing together, through the NW London Mental Health Programme Board led by Dr Fiona Butler, clinical leaders (both commissioners and providers), strategic leaders from across health and care (both commissioners and providers), key partner organisations such as the Metropolitan Police Service and lay people.

'Shaping Healthier Lives' focused on three priority themes, each targeting a different part of the mental health care system:

- **Shifting settings of care**, which aimed to move patients to less intensive settings of care, as appropriate to their needs;
- **Acute psychiatric liaison**, which improved access to mental health care for patients in general acute hospitals and support acute hospitals to identify and treat mental health patients; and
- **Improving physical and mental health integration**, which provides tailored support to improve patient outcomes.

The 'Shaping Healthier Lives' strategy concludes in 2015. An interim, high level review of the implementation of the strategy confirms good progress has been made against many of its key strategic deliverables:

- **Shifting settings of care:** Primary Care Plus has been designed, developed and implemented across CWHHE, to provide enhanced primary mental health services for patients who no longer need to be treated in acute settings. Improving Access to Psychological Therapies (IAPT) has been rolled out across all 8 CCGs. [DN some data available for this – awaiting it] Urgent care pathways are being redesigned to deliver shifts in settings of care, and business cases for the redesign are currently with CCGs (as at November 2014).
- **Acute psychiatric liaison:** standardised services are in place in all 10 acute sites across North West London, delivering a more efficient model of care. By applying standard costs across all 8 CCgs, savings were made for BHH of c£1m (25% of contract price), although Hammersmith and

Fulham had additional costs of £6-700k due to not having a service in place. Data is starting to be reported (from Nov 14).

- **Improving physical and mental health integration:** this strand of the strategy is being taken forwards by the Whole Systems Integrated Care Early Adopter pilots, which are in early stages of development. There are two pilots focussing on long term mental health conditions, in Hounslow and West London.

Implementation of these changes has however exposed the need for future areas for change across the system and the requirement to ensure that all these changes are undertaken through a coordinated, whole system approach to ensure that the best outcomes are achieved for service users and carers, in a way that demonstrates the best value for money.

Looking forward it is important that any North West London Whole System Mental Health and Wellbeing Strategic Plan should be developed within the wider London and national context for mental health improvements, so that we value mental health equally with physical health (parity of esteem). Most obviously, the NW London plan needs to build from the six unambiguous objectives set put in the mental health strategy 'No health without mental health' published by the government in 2011; the mental health strategy implementation framework and suicide prevention strategy published in 2012, the work undertaken through the 'Time to Change' campaign and the first mandates to NHS England and Health Education England.

The NW London plan also needs to take on the challenge set out in the DH document 'Closing the Gap: Priorities for essential change in mental health' published in February 2014. It needs to acknowledge and bridge the gap between long-term ambition and short term action. In doing so the plan will need to capture the shared long-term ambitions of people and pioneer partners across NW London and also address areas where partners need to work together to achieve the twenty-five areas set out in 'Closing the Gap' where people can expect to see, and experience, the fastest changes over the next one to two years.

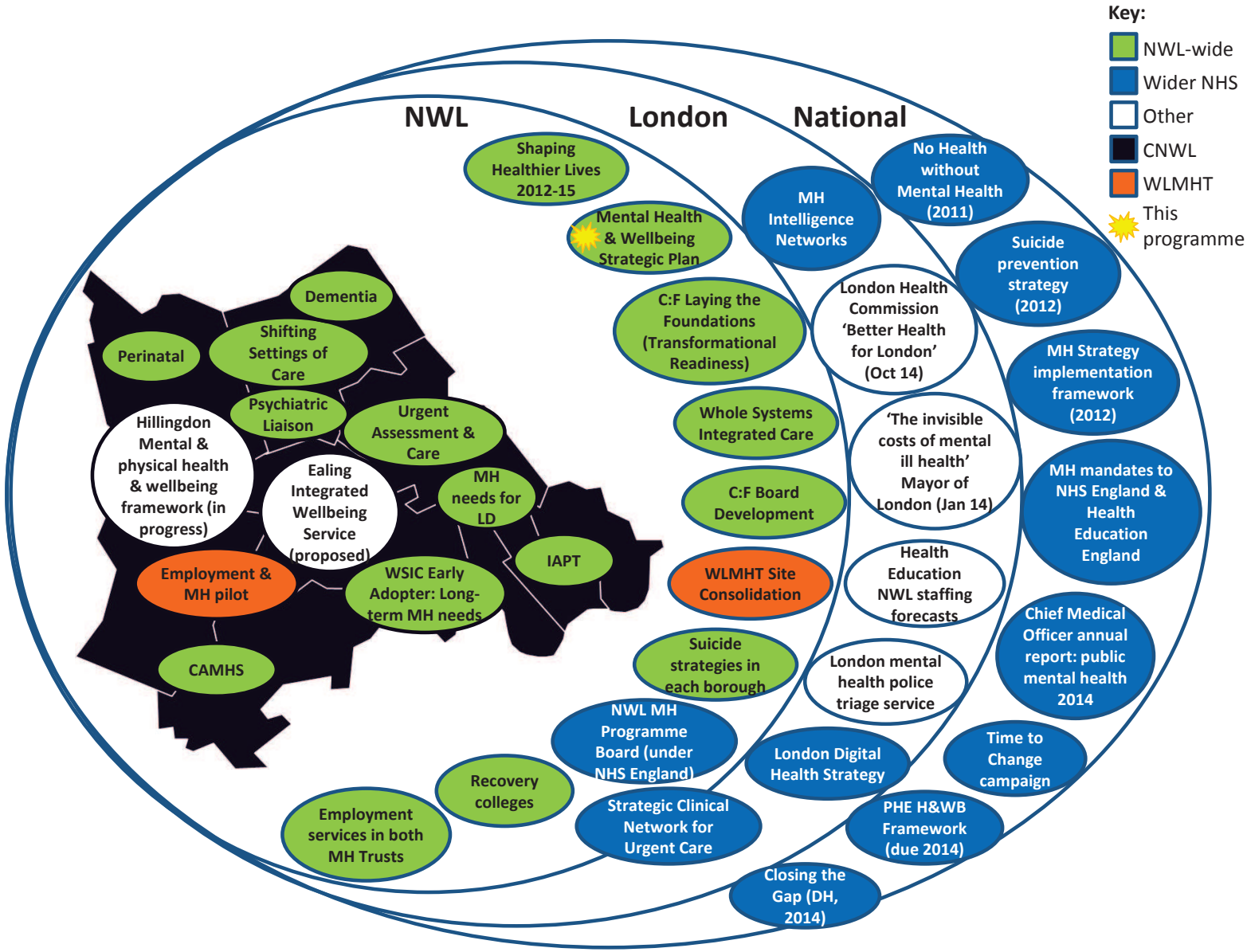
The plan should build on the evidence set out in the 2013 Annual Report of the Chief Medical Officer: Public Mental Health Priorities: Investing in the Evidence, take note of the 14 recommendations outlined therein, and act on them where appropriate (particularly recommendations 1-4, 12 and 13).

Within its report 'Better Health for London' (Oct 14), the London Health Commission used as one of its organising constructs segmentation of the population which closely aligns to the NW London population segmentation approach. It is therefore entirely aligned to continue to use this approach in the development of the NW London plan. The London Health Commission report focussed on both health and wellbeing and set ambitious aspirational goals for London. All mental health trusts in London have committed to a set of shared ambitions for mental health care:

- they have set the goal to reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 10% within 10 years.
- they will lead an all-London, all-agency pledge to identify and treat psychosis in half of cases within two weeks and all cases within eight weeks of the first signs and symptoms.
- they pledge to work with commissioners to proactively offer access to smoking cessation, blood pressure monitoring and treatment, cancer screening and treatment, and effective weight management programmes for people under their care.

It is anticipated that NW London localities will both adopt any aspirational goals agreed and will also want to enhance these goals, using a similar approach, with NW London 'ambitions' developed as part of the programme through co-design with the people of NW London. In addition, the NW London plan will build upon the work being led across London by Dr Geraldine Strathdee on developing mental health intelligence networks.

It is clear that mental health is a complex area; the figure below outlines local, regional and national initiatives, programmes and guidance that the development of this strategic plan will need to take into account of (some of which have been described above).



1.3 Vision for Mental Health and Wellbeing in North West London

Earlier this year, the NW London Mental Health Programme Board suggested a refreshed vision for mental health services:

> '**Excellent, integrated** mental health services to **improve mental and physical health**, secured through collaboration and determination to **do the best** for the population of North West London. Services that:
>
> - Are responsive, focussed on the person, easy to access and navigate.
> - Provide care as close to home as possible, with service users at the heart; where and when it is needed.
> - Improve the lives of users and carers, promoting recovery and delivering excellent health and social care outcomes, including employment, housing and education.'

In addition, in June 2013, thirty-one partner organisations across North West London entered together into the North West London Whole System Pioneer Integration Programme[4]. The programme was built upon a shared vision:

> 'We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community'

Since that time NW London pioneer partners have worked together to develop a co-designed framework for how integrated care in NW London could look. This framework is captured in the NW London Whole Systems Toolkit[5] which was launched in May 2014. The co-design phase developed ideas and solutions based on the best intentions, knowledge and experience of all involved.

Both visions are clearly closely aligned and completely interdependent. Both also take a whole systems approach to mental and physical health and wellbeing.

A North West London Whole System Mental Health and Wellbeing Strategic Plan will be developed within the context of the NW London Whole Systems programme. This strategic plan will encompass all population groups, including children and young adults, with a focus upon both mental health and wellbeing for all population groups. It will provide a foundation for further work being planned across the whole systems programme, most notably in relation to children and young people. The strategic plan will acknowledge and celebrate the diverse communities of NW London and will have a commitment to delivering outcomes that will have meaning for local communities.

To fully achieve this, the pioneer programme will widen its scope to include not just the health and social care community in relation to the transformation of the support and care available to people with mental health problems but also more actively involve the public health community, with local government in the lead, to ensure mental health and wellbeing promotion and prevention is given the attention required to deliver the outcomes agreed.

Following the ethos of the NWL Whole System Pioneer Programme, the development of the plan will be undertaken using a genuine co-design and co-production approach (see section 2.5 below). It will also recognise the sovereignty of each locality (borough and CCG) and will seek to bring partners together to support the delivery of local ambitions and plans, agree plans that can only be achieved at pace across a wider geography, seek to share learning and agree outcomes or ambitions that resonate across NW London to complement local outcomes and ambitions. It will be a significant piece of work, and will require a proportion of the Shaping a Healthier Future budget to be delivered.

[4] http://www.healthiernorthwestlondon.nhs.uk/news/north-west-london-selected-national-pioneer-joined-care
[5] http://integration.healthiernorthwestlondon.nhs.uk/chapters

2. Objectives and expected benefits

2.1 Programme objectives

The overarching objective of the NWL Whole System Mental Health and Wellbeing Strategic Plan is to bring together local commissioners, providers, users and carers and other local stakeholders to identify, test and refine the optimal approach to delivering mental health and wellbeing services across NWL and to transition to implementation of this solution.

Achieving this will require other objectives to be met, namely:

- Ensure the strategic plan addresses the mental health and wellbeing all population groups, including children and young people
- Review and refresh 'Shaping Healthier Lives', with a focus on wellbeing and prevention of poor mental health
- Modernise our approach to wellbeing and maximise local authority impact on public mental health
- Co-production approach with service users and carers ('Lay Partners'), clinicians and staff.
- Effective engagement of clinical and non-clinical stakeholders, driven by improvements to quality of clinical care and non-clinical outcomes.
- Share learning and agree outcomes that resonate across NWL to complement local outcomes and ambitions across health and social care
- Alignment of local delivery plans and strategies with wider NWL transformation programmes, including for NHS NWL:
  - the overarching Whole System Strategic Plan,
  - SaHF hospital reconfiguration programme,
  - Primary Care transformation programme (including the Better Care Fund and Prime Minister's Challenge Fund)

  and across the councils:
  - regeneration
  - place shaping
  - employment and skills agendas.
- Alignment of strategic plan with NWL financial strategies within each Council (medium term financial strategies), CCG (including Better Care Fund recovery plans) and mental health trust (long term financial models).
- Greater ownership; how individuals, families and communities can help themselves look after themselves
- A transparent and rigorous process for moving from a long-list of options to a short-list
- Transparent and well-informed decision-making
- An open and compliant statutory consultation (if applicable)
- A well-planned hand-over to providers for effective and timely implementation

2.2 Programme outcomes

By the end of the programme we should have:

- Addressed the case for continuity and change in a way that best delivers the desired clinical standards and broader benefits, within the constraints affecting the sector (e.g. financial) and that provides a blueprint for sustainable future mental health and wellbeing services across health and social care
- Co-developed a mental health and wellbeing strategic plan that is in line with the wider Whole System programme and other transformational programmes across NWL.
- Developed a vision and case for continuity and change based on a population needs assessment and best practice evidence
- Achieved a greater understanding of wellbeing and what we as the public sector can do to improve this.
- Delivered this activity in a way that will stand-up to external scrutiny and challenge
- Delivered within agreed timescales, effectively managing the transition of programme ownership during the course of its lifetime
- Successfully created the necessary impetus and structure for implementation and to have handed this over to the team that will lead that implementation.

2.3 Long term programme benefits (post-implementation)

The programme is being established to ensure that the ambitions for mental health and wellbeing in NWL are covered by the NWL Whole System Pioneer programme, to ensure 'parity of esteem' between mental health and physical health conditions. It will be important to define, track and realise the benefits the programme seeks to deliver.

Specific benefits will also be dependent upon the agreement of the scope of the programme; in particular, identification of the specific services in which changes will take place. However, this type of programme typically aims for the following benefits for the services in which changes are made:

- More integrated whole system approach to delivering mental health and wellbeing services
- Improved experience and outcomes for patients accessing mental health and wellbeing services;
- Greater ownership; how individuals, families and communities can help themselves look after themselves (eg dementia friends)
- More people being treated in primary and community settings where this leads to improved quality of care;
- More effective integration of care across different settings and providers;
- Early intervention to reduce crisis attendance in acute settings for certain conditions;
- Greater opportunities for clinicians to enhance their skills, where applicable;
- Improved utilisation of buildings; and
- Improved deployment of clinical staff, supporting them to provide better care to patients and carers.

These benefits should collectively deliver better outcomes for the NWL health and social care economy, such as:

- Increased patient satisfaction;
- Increased social capital or wellbeing measures about people's lives, eg patients reporting they have 'had a meaningful day'
- Increased patient resilience – i.e. a greater ability to deal with life's problems and a reduced risk of developing mental illness or committing suicide;
- Improved relevant public health outcomes[6]
- Reduction in crisis non-elective admissions through better management of conditions;
- Reduction in delayed transfers of care – particularly for acute mental health admissions.
- Reduction the variation in life expectancy for people affected by serious mental illness (such as psychosis);
- Reduction in the high percentage of years of life people spend with a disability due to a mental health cause;
- Reduced criminal behaviour, anti-social behaviour, risk-taking behaviour (e.g. smoking), and sickness absence;
- Reductions in readmission of patients;
- Improved patient educational attainment and outcomes, greater productivity and remaining in employment, improved cognitive ability and quality of life, and improved social connectedness;
- Improvement in self-reported happiness index of NWL population
- Support mental health indicators within the Better Care Fund recovery plans.
- Increased staff satisfaction; and
- Improved financial sustainability of the local health economy.

Development and agreement of a benefits framework for NWL will form part of the programme, and will be shaped by both the case for continuity and change and the clinical vision. A mechanism for tracking and managing benefits realisation will need to be defined and established during the later stages of the programme.

[6] For example:
1.02i - School Readiness: The % of children achieving a good level of development at the end of reception
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate
1.05 - 16-18 year olds not in education employment or training
1.18i and ii - Social Isolation: % of adult social care users (or their carers) who have as much social contact as they would like
2.13i - Percentage of physically active and inactive adults - active adults
2.23i-iv - Self-reported well-being indicators – low satisfaction, low worthwhile, low happiness and high anxiety

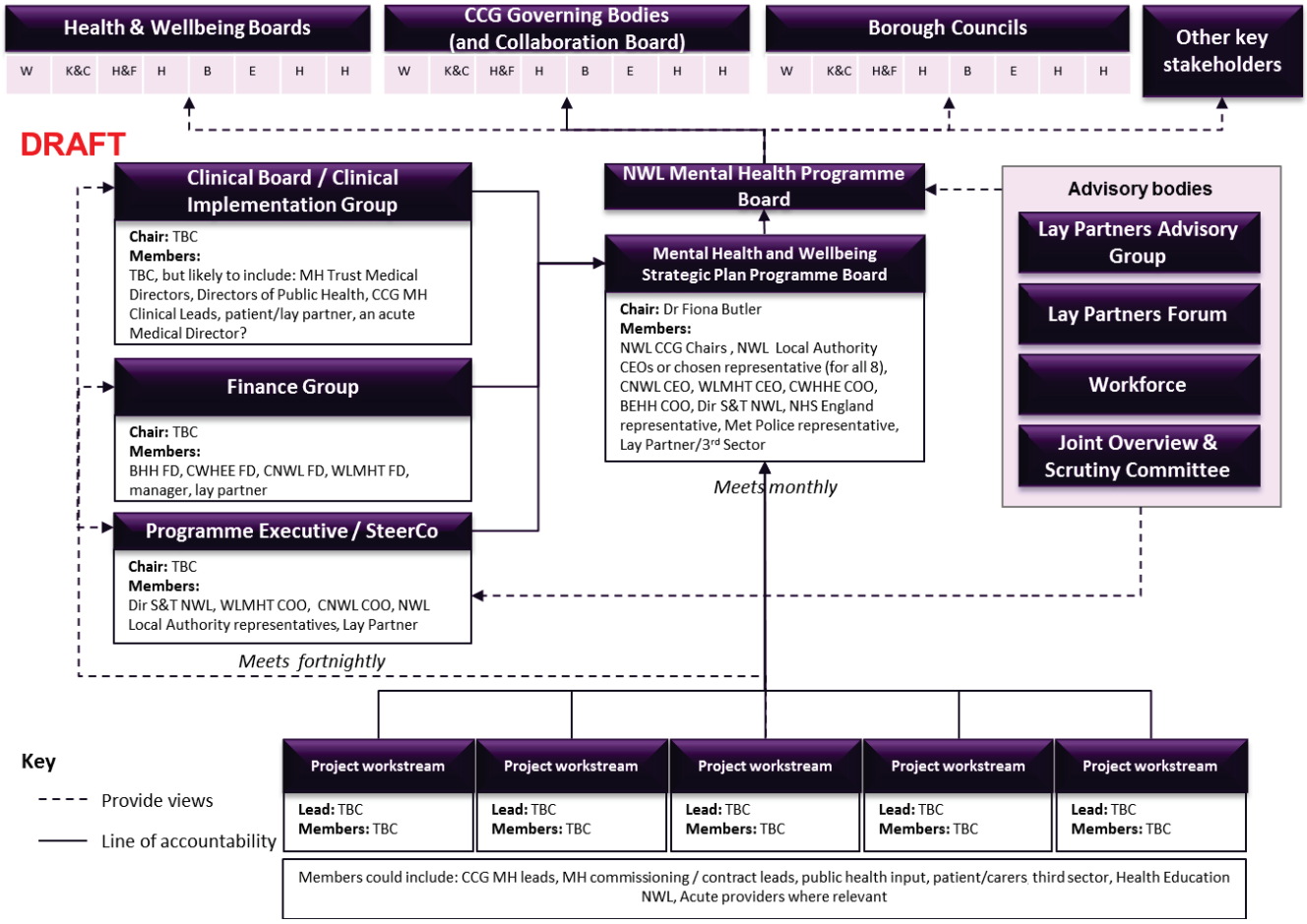
2.4 Governance

[DN: The below assumptions could change depending on the outputs of the Board Development work carried out by Carnall:Farrar, and following programme mobilisation once the external resource is in place]

Key principles underpinning Programme governance arrangements:

- Ultimate commissioning decisions will be made by CCG Governing Bodies, local authorities and NHS England (for specialist mental health services) as appropriate and in conjunction with local Health and Wellbeing Boards
- Although providers have no legal role in the decision-making process, it is very important that they are engaged with and supportive of the process. Local providers must have the opportunity to influence decision-making and involve their staff in the development of informed solutions that reflect actual provider circumstances. In the development of a whole system strategic plan for NWL, all partners have to own it, and it has to deliver the changes required to ensure a financially sustainable solution to mental health and wellbeing services in NWL. Providers will therefore be active partners in the development of the plan. Care will be taken to ensure there is no conflict of interest post as the strategy nears commissioning/contracting stage.
- It is proposed that the Mental Health Programme Board (MHPB) is amended such that a Strategic Mental Health Programme Board is established, dedicated to developing the Strategic Plan. This strategic board will align closely with the Delivery MHPB [DN: subject to change following C:F review]. As a minimum the Clinical Responsible Officer for the programme will chair both components of the board and the clinical leads from each CCG will be members of both components (strategic and delivery) of the board.
- The MHPB Strategic Board will act in an advisory role to the CCGs.
- Clinical leadership of the programme will be facilitated and senior local clinicians (CCG mental health leads, Medical Directors and equivalent) given the opportunity to influence the development of solutions; ensuring that they are clinically sound.
- Service users, carers, clinicians and staff will co-design and co-create the strategic plan and the solutions within it.
- Lay partners will be present on the MHPB Strategic Board, the Clinical Board and all working groups below that. This is in line with the Embedding Partnerships approach taken by the NWL Whole System Integration programme.
- The public health community, local government and the police will be actively involved, and will be members of the MHPB Strategic Board.
- Where possible, existing forums and meetings will be used when setting up the governance arrangements, to reduce the burden on busy people's time.

The proposed Governance structure is set out below [DN subject to change following C:F review].



The **CCG Governing Bodies** will have formal decision-making responsibility. [DN suggestion to include timescales and clearly articulate process for decision making] This will include responsibility for:

- Setting out the overall scope, aims and timescales for the programme
- Signing-off key programme deliverables
- Taking the final decision on whether to proceed to consultation (based on PCBC)
- Ultimately, taking the final decision on whether to proceed with proposed service changes

However, if the proposed service model(s) require changes to services that are commissioned by Councils and NHS England, then sign-off will be required by these organisations also.

Whilst this governance structure makes use of existing arrangements where possible, it is necessary to establish additional groups to manage, support and scrutinise programme delivery:

The **MHPB Strategic Board** (part of MHPB) will:

- Set the strategic direction of the plan
- Oversee delivery of the programme in line with the scope, aims and timescales set out by the Collaboration Board; in particular managing cross-organisational issues, risks and dependencies

- Oversee development of programme deliverables
- Ensure that decisions/proposals are consistent with changes and transformation that are occurring across NW London and within individual organisations, such as the WLMH site consolidation project
- Bring together partner organisations to jointly oversee the strategy development
- Ensure appropriate links are made with other strategic programmes and groups within NHS NWL; in particular the London Health Commission analysis and the Imperial College Health Partners analysis.
- Act as a forum for managing the most serious risks and issues and handling issues that relate to inter-organisation and inter-programme dependencies
- Provide final approval of key outputs and deliverables.

The **Clinical Board (or Clinical Implementation Group)** will ensure the programme develops robust clinical proposals and make clinical recommendations. [DN due to the distributed leadership arrangements for clinicians within MHPB, there may not be a need for a separate clinical board – instead clinicians could sit on all groups and report back to the programme board and agree next steps.][DN: Subject to change following C:F review] Specifically they will:

- Review and agree the vision and case for continuity and change
- Develop the evidence base for good quality care, and agree a definition of what good care looks like (in terms of outcomes and quality care)
- Agree the NWL ambitions for mental health and wellbeing
- Develop options for how mental health services should be provided to achieve the agreed ambitions and outcomes
- Develop options for the future configuration of mental health and wellbeing services (if applicable)
- Develop and recommend criteria for the assessment of options for the future configuration of services to the MHPB
- In addition the Clinical Board / Clinical Implementation Group will:
    - Provide expert clinical advice on other programme deliverables; including expected clinical benefits
    - Ensure there are clinical advocates for proposals in each relevant service area

The **Programme Executive** will:

- Manage programme delivery in line with the scope, aims and timescales set out by the Collaboration Board.
- Utilise wider stakeholder engagement, expert advice and act as a ‘critical friend’ to:
    - Assist risk mitigation and issue resolution
    - Work through barriers that surface during development of the Strategic Plan
    - Provide quality assurance during development of the Strategic Plan
- Facilitate the flow of information and feedback across the programme, to support the development of outputs
- Provide direction and challenge to any workstreams

The **Workstreams** will:

- *Workstreams to be confirmed during programme mobilisation.*
- *XXX*

2.5 Advisory and/or collaborative bodies

[DN: To be confirmed during programme mobilisation phase – possibly including HWB / Healthwatch / 3rd sector / Acute Trusts etc?? . JOSC, Lay Partners, Finance & modelling, workforce]

- 'Critical Friend' role – an external advisory and/or collaborative body that reviews key programme outputs [to be elaborated on after discussion with CM/SS/FB].

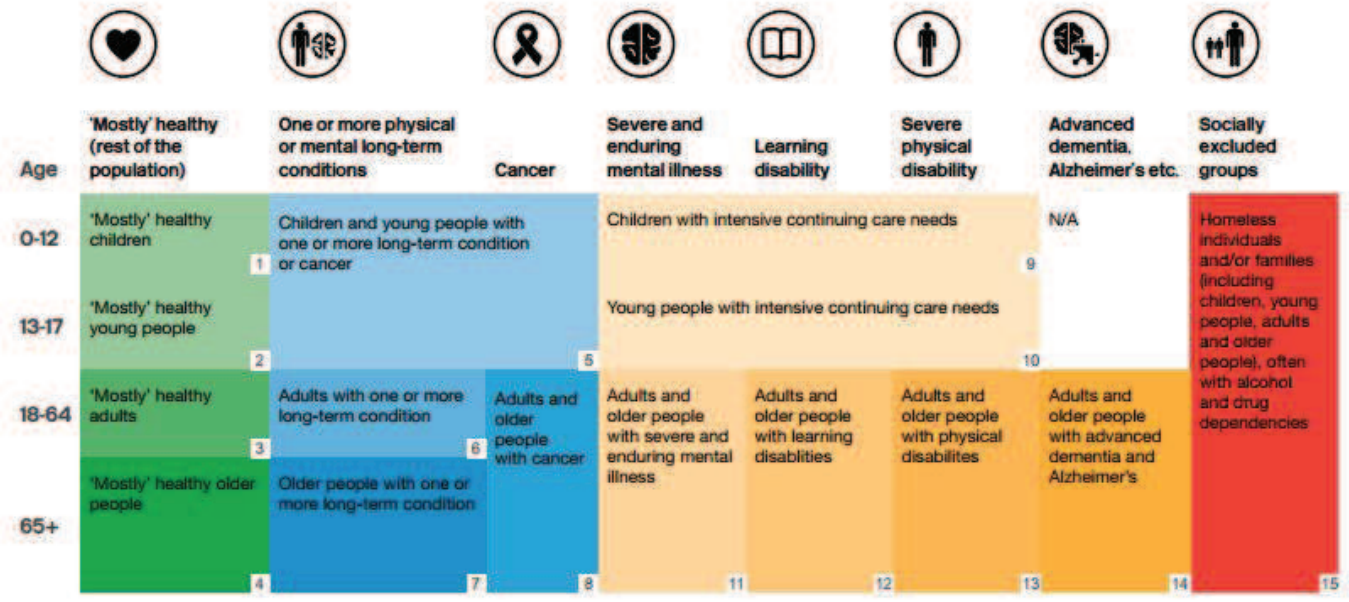
2.6 Embedding Partnerships

The NWL Whole System Mental Health and Wellbeing Strategic Plan will use the embedding partnerships approach taken by the Whole System Integrated Care Programme. Embedding partnerships is founded in principles of co-design of solutions with partner organisations, patients, carers, clinicians, staff and a wide range of stakeholders at every stage.

Through Embedding Partnerships we will:

- Co-produce the programme with patients, people who use services and carers as partners, as well as with clinicians and staff
- Represent the voice of patients, people who use services and carers and educating other stakeholders
- Consider specifically the role of self-management in delivering Whole System Mental Health and Wellbeing services
- Hold the programme to account and ensure that Whole System Mental Health and Wellbeing services deliver improved outcomes and experience for patients, people who use services, and carers

We intend to recruit additional patients with a mental health condition, and their carers, to the existing Lay Partners Forum. We will then draw members from this to sit on all groups within the governance arrangements. We will recruit members from existing patient groups, such as CCG PPGs, Mental Health Trust Groups, HealthWatch groups, Council groups, police groups and third sector groups. We will try and ensure that the lay partners we recruit are representative of the NWL population (referring to the population segments below), but where this isn't possible (ie for hard to reach groups, or children and young people), we will attend existing forums (for example, through the mental health trusts or third sector groups) to ensure that all views are heard.
Population segments set out in the London Health Commission report 'Better Health for London' (Oct 14):



3. Scope

3.1 Programme scope and context

The initial scope of the programme is broad, encompassing mental health and wellbeing services for all population and age groups within North West London. It is intended that through development of the case for change and vision, the programme board will identify priority areas to focus on, and these will probably become the programme workstreams and the focus of new service models.

The NWL Whole System Mental Health and Wellbeing Strategic Plan will be developed within the context of North West London – in particular within the financial context. The short, medium and long-financial strategies of each CCG, Council and mental health trust will be considered when developing the plan, so that it is deliverable within the financial constraints, and will therefore be realistic and financially sustainable.

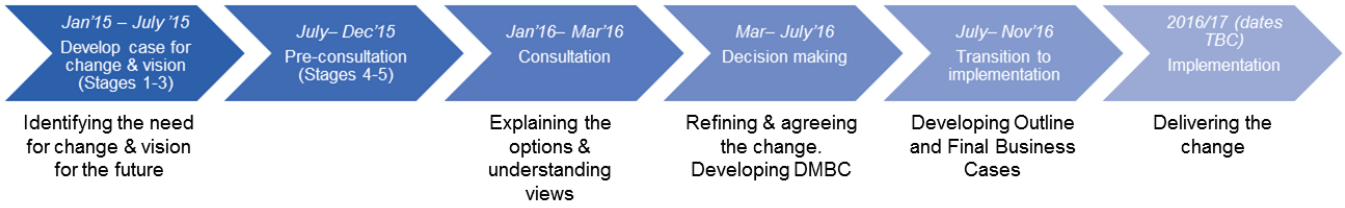
The Plan will also be developed within the context of the other transformational programmes currently underway in NW London – including Reconfiguration, Primary Care, and in particular the Whole System programme:

- Encompassing all population groups, including children and young adults with a focus upon both mental health and wellbeing for all population groups.
- Providing a foundation for further work being planned across the Whole System programme, most notably in relation to children and young people.
- Acknowledging and celebrating the diverse communities of NW London
- Committing to delivering outcomes that will have meaning for local communities.

To fully achieve this the pioneer programme will widen its scope to include not just the health and social care community in relation to the transformation of the support and care available to people with mental health problems, but also more actively involve the public health community, with local government in the lead, to ensure mental health and wellbeing promotion and prevention is given the attention required to deliver the outcomes agreed. It will also embrace the Embedding Partnerships approach taken within the wider Whole System programme, and involve Lay Partners, clinicians and staff in the co-design and co-production of the Strategic Plan.

3.2 Programme

The overall timeline for the programme is broken down into six phases as follows:



During this period there will be a general election (7 May 2015). If there is a change in government as a result, then there may be changes to local and national organisations, across health and social care. The programme will need to plan for and respond to such changes as they take place; ensuring an appropriate fit with new arrangements as part of the overall NWL response to the changes. Most critically we will work with emerging stakeholders at an early stage to build understanding of and buy-in to the programme.

The Programme will be considered complete and can be closed down when:

- The CCGs (and Councils and NHS England, if appropriate) have approved a final proposal for service change (if applicable)
- Any review process has been concluded (if applicable)
- It has been identified who will lead implementation
- Hand-over to the implementation phase is confirmed, including:
    - Development of implementation plans by providers
    - Establishment of provider governance structures to own and drive forward these implementation plans
    - Oversight of implementation (including benefits realisation tracking) built into commissioning arrangements (governance, contracts, KPIs / performance reporting, etc.)

Alternatively, the NWL CCGs may take the decision to close down the Programme before it is complete if, for example, the NWL commissioning strategy alters significantly.

3.3 Inclusions

The programme will be commissioner-led and will manage the process for commissioners to design and agree proposals for service change across NWL to improve mental health and wellbeing services for patients through increased clinical quality and financial sustainability.

3.4 Exclusions

The programme will exclude any programmes being specifically developed and delivered within single CCGs / boroughs, although if they are directly relevant then we will ensure alignment between the programmes.

3.5 Dependencies

The following dependencies for the development of the NWL Whole System Mental Health and Wellbeing Strategic Plan have been identified:

- NWL Whole System Pioneer Programme
- WSIC Early Adopter project for Long Term Mental Health needs
- 'Shaping Healthier Lives' projects and workstreams
- WLMHT Site Consolidation
- Carnall:Farrar (Laying the Foundations) work in WLMHT and CNWL
- Carnall:Farrar Board Development work for MHPB
- Imperial College Health Partners analysis into Psychosis, and actions arising from that.
- London Health Commission report 'Better Health for London' (Oct 14).
- 2015/16 Contracting round
- Public Health England's Health and Wellbeing Framework for England (was due August 2014)
- Health Education NWL re-procurement of five year Mental Health Nurse training contract over the next 6 months.

- Reduction in MH Nurses planned by providers (compiled by Health Education) NWL will be submitted to Health Education England.

In addition, the interaction between the NWL Whole System Mental Health and Wellbeing Strategic Plan and the local strategies of organisations within NWL will need to be considered, for example:

- Direction and priorities
- Communication and co-ordination
- Resource and support
- Decision-making and assurance

3.6 Assumptions

Assumptions made in the development of the PID include:

- That the programme will be able to secure sufficient resources to deliver the Strategic Plan to the agreed timetable.
- That the partnership organisations will lead and work together to drive development of the Strategic Plan, sharing experiences and learning lessons together.
- That the two MH providers, and possibly some of the acute providers, the CCGs and the Councils will contribute data and resources to inform the case for continuity and change, and any options appraisal in a timely manner.
- That the partnership organisations will actively participate in developing the Strategic Plan, taking responsibility for content development, risk mitigation, issue resolution and shared leadership.
- That the approvals process can be flexed to fit tight programme timescales in order to expedite key decisions and / or approval of key deliverables, e.g. by running extraordinary meetings of the Collaboration Board and Programme Board
- That there are no major changes in national or local policy during the planned lifetime of the programme.
- That issues arising during consultation (if required) can be resolved in a timely manner.

4. Programme resources

4.1 Programme design

The programme will need to interact with, and take account of, the other NWL-wide programmes, such as SaHF reconfiguration, primary care (including the Prime Ministers Challenge Fund), Whole Systems Integrated Care and the Better Care Fund within health. In addition, within social services some of the big programmes focus on regeneration, place shaping ,and employment and skills.

The workstreams to deliver the Strategic Plan are yet to be determined (see governance structure in section 2.4). These will be agreed during programme mobilisation, and resources agreed accordingly.

4.2 Programme team

The Programme will have a Programme Management Office (PMO) consisting of primarily internal staff, including:

- Programme Director
- Programme Manager
- Programme Administrative Support
- Public Health Consultant and registrar input
- User Engagement & Equalities leads
- Communications and engagement lead

There will also be external support within the PMO – likely to be in the form of a Programme Manager and a Programme Officer.

In addition, the Programme will include the following Leadership roles:

Role	Who	Responsibilities
Senior responsible officer (SRO)	Thirza Sawtell, Director, NWL Strategy and Transformation Team	• Set strategic direction & ensure programme prioritised & issues resolved • Champion proposals locally, influencing key stakeholders where required
Programme Director	Internal post – yet to be appointed	• Oversee programme delivery*; chairing and coordinating programme executive [DN – or would this be the role of CRO/SRO?]* • Champion proposals locally, influencing key stakeholders where required
Programme Manager	Internal post – yet to be appointed	• Lead Programme Delivery activities and ensure products meet acceptance criteria • If required, ensure programme fully supports NHS London assurance process, delivering all requirements of NHS England Guide 'Planning and delivering service changes for patients', including PCBC and consultation document

Role	Who	Responsibilities
Clinical Responsible Officer (CRO)	Fiona Butler Mental Health Lead for NWL [DN: any additional clinical leads?]	• Chairing Mental Health Programme Board, and Strategic Board • Ensure expert clinical advice provided on programme deliverables • Ensure proposals are clinically sound and will deliver improved service quality, building clinical consensus & support • Explain and champion proposals to other local clinicians building their support for change • Explain and champion proposals to local and national stakeholders, the media, patients and the public; working closely with the NHS NWL Communications lead [DN will this be required?] • Ensure there are clinical advocates for proposals in each service area
Communications & Engagement Lead	Internal post – yet to be appointed	• Lead Communications and Engagement activities and ensuring delivery of products to meet acceptance criteria • Ensure the programme adopts the Whole Systems Embedding Partnerships approach; ie co-design and co-production of programme materials and decisions. • Recruit lay partners as required, to ensure that a broad spectrum of mental health users and carers are represented within the programme. • Ensure that the programme plans and undertakes appropriate engagement with relevant stakeholders at each stage • Ensure that statutory requirements to engage stakeholders in the programme are met so that a compliant consultation process is delivered • Ensure consistency of communications between stakeholders as part of managing the internal communications of the Programme
Finance & Business Planning Lead [DN may not be a specific role within the programme]	To be confirmed	• Ensure the programme works with local leads for financial, capital, estates, productivity and workforce • Ensure programme proposals and deliverables in particular the options development and appraisal, are based upon robust modelling and assumptions • Ensure the financial, capital, estates, activities and workforce implications of proposals are fully understood, for the sector as a whole and at site level and that provider CEOs are fully sighted on these implications • Ensure programme deliverables have appropriate input from provider leads for finance, capacity / estates planning and workforce

These programme leaders will be supported by appropriate resources which are expected to vary to meet the needs of each stage of the programme and to consist of a variety of internal resources and specialist external resources. Resources to support the programme through to consultation are being procured.

4.3 Programme costs

This is a significant piece of work with considerable costs attached, and will commit a large proportion of the SaHF budget – programme benefits and deliverables and prioritisation of money needs to be fully considered. The 2015/16 SaHF budget needs to ensure that there is sufficient funding for this mental health programme.

In addition to the resources described above, other programme costs might include:

- Legal advice - the programme will require access to legal advice to help it to ensure statutory requirements are met
- Communications activities and materials - such as programme branding, public events costs, printing, consultation materials, and wider communications beyond legal consultation to underpin wider change across mental health services.
- Clinical time – organisations participating in the programme are expected to bear the cost of clinicians participating except in exceptional circumstances.
- Expenses for lay partner involvement, in line with embedding partnerships expense reimbursement policy.

5. Approach

5.1 Principles underpinning our approach

The approach to develop a robust Whole System Mental Health and Wellbeing Strategic Plan for North West London, will be based on the following principles:

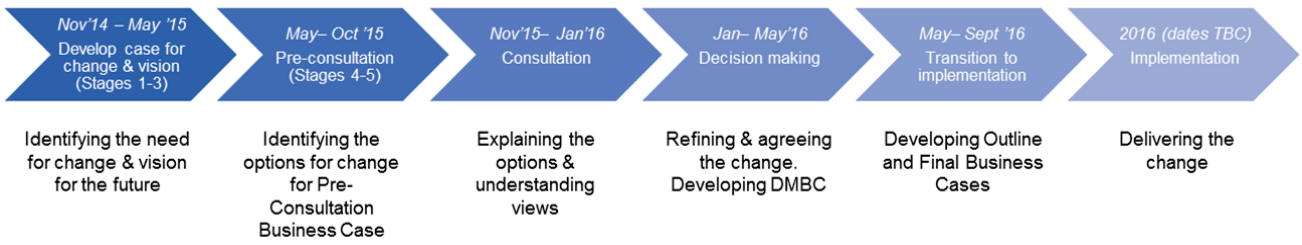
- **Whole Systems** – the Strategic Plan will cover the 'whole system' of care for mental health and wellbeing in North West London, and so will be developed with a wide range of stakeholders, including health, social care, public health, voluntary sector and the police. We will modernise our approach to wellbeing, and maximise local authority impact on public mental health. Co-production with local authorities will be essential in the development of this plan.

- **Co-design and co-production** – the plan will be designed and created with service users,carers, clinicians and staff. Lay partners will not be merely consulted on the proposals, they will help develop solutions. We will adopt the Embedding Partnerships approach used within the Whole Systems Integrated Care programme, and will utilise existing forums and groups where possible. We will undertake a formal public consultation (if required), for at least 12 weeks, during which we will explain our proposals to the wider public and listen to their views on the implications of those proposals. This will include specific work to understand the implication of proposals on different equalities groups, in particular traditionally under-represented groups.

- **Robust and transparent process underpinned by a sound clinical evidence base** – the vision and case for continuity and change will be based on a sound evidence base for good quality care. We will develop a robust, evidence-based process for developing and appraising options for continuity and change that we will share with stakeholders at each stage of its development; working in particular with senior local clinicians [DN – through the Clinical Board / CIG] to ensure any options are clinically sound. This will also include testing the impact of proposals on patients and the public – for example, for residents of each borough, for inequalities, for patients with specific mental health and wellbeing needs etc – assisted by the embedding partnerships approach.

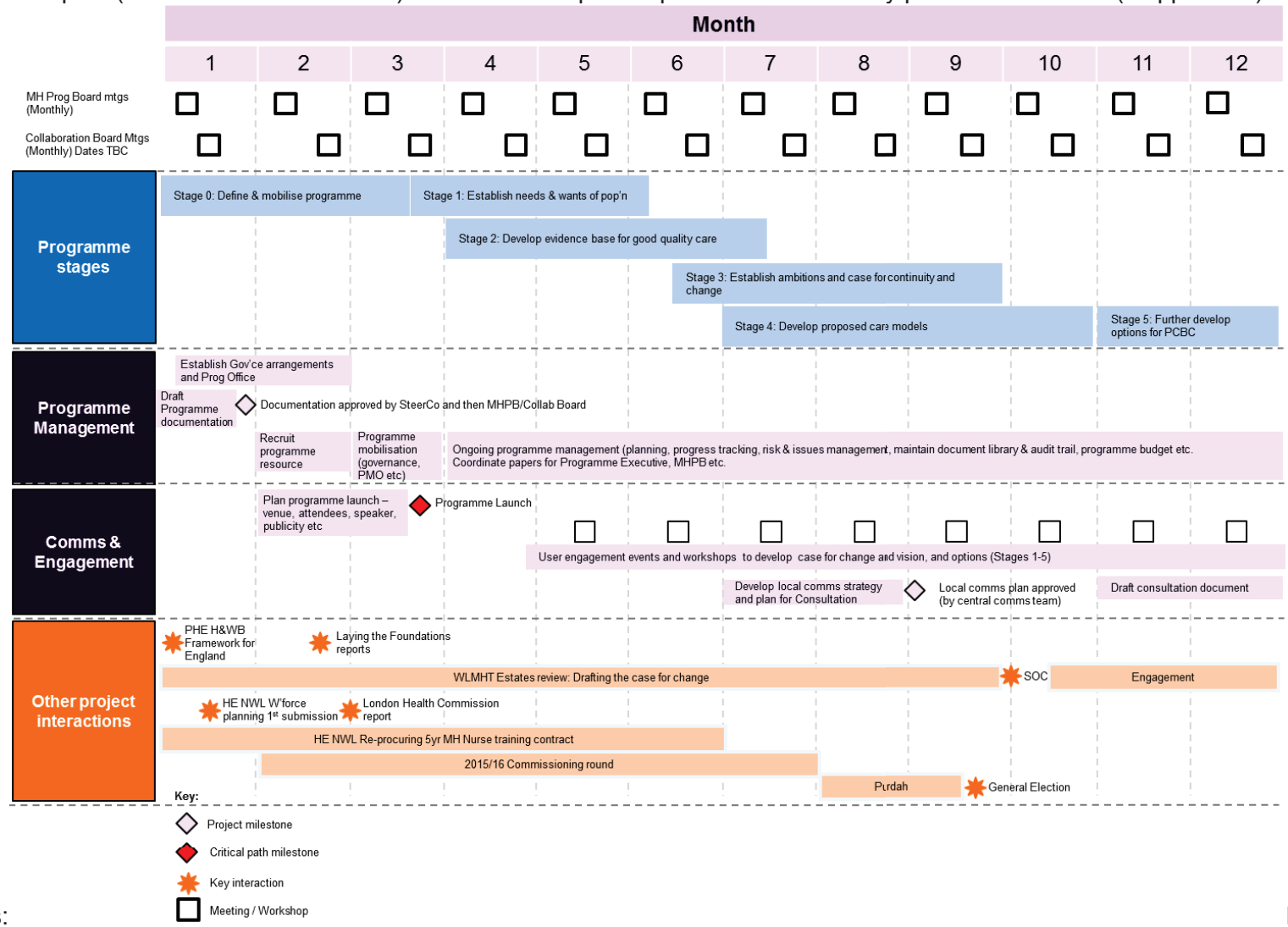
5.2 Programme plan

The overall timeline for the programme is broken down into six phases as follows:



Detailed plans will be developed and maintained for each phase in the lead up to and during that phase. This will be the responsibility of the Programme Manager.

A high level plan (as at 25 November 2014) for the work required up to the launch of any public consultation (if applicable) is as follows:



Draft plans for stages 0-5 are provided in the appendix to this document. The stages are outlined below.

5.3 Stages within the programme

Stage 0: Define and mobilise programme
Support the mobilisation of the programme including:

- Establishing appropriate governance, resourcing and workstream arrangements
- Establish detailed programme plan, interdependencies and deliverables
- Establish ways of working including with wider team
- Agree and submit data requests (to providers, CCGs, Local Authorities etc, for both financial and activity data).

Stage 1: Establish the needs and wants of the population in NW London
Taking a population health based approach:

- Establishing the disease burden and how this varies across the population of NW London
- Understanding the wants of different parts of the population
- Understanding the experience of service users, their families and carers
- Understanding the experience of people with mental health needs within the justice system
- Understanding what outcomes are achieved today and how they vary (for both health and social care mental health and wellbeing service provision)

Stage 2: Developing the evidence base for good quality care
Using the population health based approach:

- Agreeing a definition of what good care looks like
- Identifying through literature review, interviews etc examples of evidence-based practice
- Understanding and quantifying the potential for improvement across NW London

Stage 3: Establishing the ambitions and the case for continuity and change
Across the NW London geography:

- Agreeing the NW London ambitions for mental health and wellbeing
- Establishing the potential for improvement across NWL – how NWL compares to best practice and meeting needs
- Establishing the need for change to meet the identified improvement gap and achieve the agreed ambitions
- Establishing what works well today and should be retained in the future
- Establishing what does not work well and needs to change
- Defining principles of care and benefits framework
- Drafting case for change

Stage 4 (in parallel with stage 3): Developing the proposed care models
Using the agreed population segmentation approach:

- Agreeing how the mental health and wellbeing needs of each segment should be addressed – including the role of the mental health services
- Identifying how mental health services should be provided to achieve the ambitions and outcomes, including in-depth understanding of the resources required across the settings of care

Stage 5: Establishing the required infrastructure to deliver and identifying options for change (Options Development for Pre-Consultation Business Case (PCBC))

- Confirming scope of pathways to be reviewed
- Defining and agreeing quality standards and proposed care models

- Agreeing evaluation criteria for proposed options, conducting modelling and other assessments and testing and developing any short listed options
- Agreeing plans to address the key enablers to change including workforce, capital, information and payments
- Identifying the estates solutions required to deliver the improvements
- Development of consultation materials (if required)
- Drafting PCBC
- Carry out equalities impact assessment

The stages below are dependent on the outcome of stages 1-5.

Consultation (if required)

- Ongoing programme of activities to consult with the public and other stakeholders.

Decision making

- Report on consultation findings.
- Development of Decision Making Business Case (DMBC) to include response to consultation findings.

Transition to implementation

- Agreeing the required implementation plans, including timescales and alignment and ensuring alignment with whole system programme timeline
- Identifying for all aspects of the implementation the geography and the interdependencies
- Taken account of any external factors likely to impact upon implementation
- Integrating implementation into business-as-usual commissioning
- Establishing provider implementation plans and governance arrangements

5.4 Programme deliverables

The production of the North West London Mental Health and Wellbeing Strategic Plan and other key documents as outlined in the stages above and the table below. The case for continuity and change will need to identify solutions that best deliver the desired ambitions, benefits and outcomes within the constraints of NWL (eg financial) and that provides a blueprint for sustainable future service provision.

In producing the documents, the PMO will need to ensure buy-in from key stakeholders – the plan needs to be realistic and owned by each of the organisations that are to deliver it and achieved in a way that will stand up to any external scrutiny and challenge. Genuine co-design and working in partnership with all stakeholders is therefore crucial.

The key deliverables within each of these stages are as follows:

Stage	Milestone	Planned Date
0: Mobilisation	Established governance, resourcing and workstreams for programme	Jan 15
	Programme plan signed off	Jan 15
	Programme launch	Feb 15
	Programme mobilisation	Nov 14-Jan 15
1-3: Case for change & vision	Clinical & public engagement events	
	Vision and Case for change	July 15
	Proposed Clinical service models	Nov 15
4-5: Pre-consultation	Benefits framework	
	Options development & appraisal process	
	Long list options (if applicable)	
	Evaluation criteria & weightings	
	Shortlist of options	
	NCAT, OGC and initial four test reviews (if required)	*Nov 15*
	Pre-consultation Business Case (PCBC)	Dec 15
	Four tests evidence	*Dec 15*
	Integrated impact assessment	Dec 15
	Consultation documents (if required)	Dec 15
Consultation (if required)	Ongoing programme of activities to consult with the public and other stakeholders	Jan 16-Mar 16
Decision making	Report on consultation findings	Apr 16
	Decision making business case (DMBC) including response to consultation findings	July 16
Transition to implementation	Outline and Final Business Cases drafted	Aug-Dec 16
	Integrate implementation into business-as-usual commissioning	Aug-Dec 16
	Provider implementation governance established	Aug-Dec 16
	Provider implementation plans	Jan 17 16

5.5 Progress management and reporting

Each workstream will provide a fortnightly report on workstream progress, risks and issues to the Programme Executive. [DN – or should the PMO just compile one progress report and send it to the Programme Exec?]

The Programme Management Office will also provide a fortnightly report on progress against key programme deliverables to the Programme Executive.

The Programme Management Office will produce a summary programme progress report (drawing on workstream reports) as part of the papers for the monthly MHPB Strategic Board.

5.6 Equalities

We will ensure that work undertaken in developing the Mental Health and Wellbeing Strategic Plan adheres to and follows the principles of the Equalities Act of 2010. The Equality Duty has three aims and the Act requires public bodies to have *due regard* to these aims. Which are to:

1. Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it
3. Foster good relations between people who share a protected characteristic and people who do not share it.

This will mean that our future approach to service transformation will include the following:

1. We will continue to seek the views from patients, their representatives and from protected groups to ensure that they are involved in helping to design future service change
2. We will ensure that all workstreams should consider equalities and engagement issues and these are imbedded in the work and plans they develop. All decisions on future service change should show how equalities issues have helped to determine service change.
3. Each workstream should have a robust process for engaging with and responding to the needs of patients, carers and the public, this will include specific work with protected groups particularly those affected by the changes.

We will utilise the existing Whole System approach to embedding partnerships, such as the Lay Partners Forum, to ensure that those likely to be impacted by any changes brought about by the Strategic Plan are considered from the outset of the programme. We will appoint recruit additional mental health representatives to the Lay Partners Forum, and then appoint lay partners from this to sit on all forums and groups within the programme governance. There will be an equalities lead appointed as part of the Programme Management Office.

An Integrated Impact Assessment will be carried out by an external company.

6. Risks

The Programme Manager will ensure that programme and workstream level risks are regularly identified and that appropriate mitigation strategies are in place; escalating risks and issues through the programme governance structure where appropriate to ensure timely resolution. The workstreams will maintain risk logs, which will inform the programme risk log. The Programme Executive will receive a copy of the programme risk log on a fortnightly basis, and high level risks will be submitted to MHPB Strategic Board meetings. However, it is vital that all organisations participating in developing the Whole System Mental Health and Wellbeing Strategic Plan are collectively responsible for managing risks and resolving issues.
[DN: how to escalate risks that might lie within individual organisations or localities?]

Key programme level risks identified at the start of the programme were identified as follows.

	Risk	Mitigation
1	Unable to access data required to develop case for change	- Programme mobilisation phase of c.3 weeks to assess data requirements and submit data requests - Utilise alternative sources of data (such as that used by ICHP or other S&T programmes)
2	Insufficient stakeholder engagement results in insufficient buy-in / support of the Strategic Plan.	- Embedding Partnerships approach; co-design of programme - Detailed stakeholder engagement plans to be developed and delivered.
3	Insufficient clinical support for proposals.	Establish Clinical Board / CIG, active clinical input to case for change, clinical service models; actively engage clinicians in options development and appraisal
4	If the Strategic Plan is not co-designed with users and carers and Lay Partners, it will not have the intended impact in transforming mental health and wellbeing services for the NWL population.	Embedding partnerships approach; co-design of programme. Lay partner membership on all key groups.
5	If potential service changes include services commissioned by Councils (such as public health and wellbeing services), then the affected Council(s) will need to sign off the proposals	- Identify early-on in the programme which mental health and wellbeing services the Councils commission - Incorporate sign-off by Councils into Governance structure if required
6	Time allocated to the Strategic part of MHPB may be insufficient to discuss all programme outputs and make recommendations	Review with MHPB
7	Setting-up Clinical Board / CIG may delay the programme	- Review programme timelines during programme mobilisation phase - Utilise existing clinical forums if appropriate, or continue with distributed leadership model, and not have a Clinical Board/CIG.

7. Stakeholder engagement and communications

The programme management office and the communications and engagement lead will work together to maintain a view of key stakeholders and to deliver proactive and reactive engagement with these stakeholders.

7.1 Stakeholder engagement map

The approach to stakeholder engagement and communications needs detailed planning and consideration. Initial thinking is set out below.
[DN: DRAFT – work in progress]

Group	Subgroup	Approach
CCGs	Chair / AO CFO MD/COO Executive Governing Body	Membership of MHPB Strategic Board Briefing to Collaboration Board + MD/COOs
CCG Collaborative / Federation / Collaboration Board	CWHHE Chairs Forum CWHHE SMT BHH Chairs Forum BHH SMT Collaboration Board	As above, and offer to attend forums / SMT meetings for key programme updates
WLMHT CNWL	CEO / Chair Executive Trust Board Clinical leads	Membership of MHPB Strategic Board and Programme Executive CEOs disseminate to Executives Clinical leads input to Clinical Board / provide clinical input to programme groups.
Local Authorities	CEO DPH DASS / DCS Executive structure H&WBB	Membership of MHPB Strategic Board (CEO, DPH, DASS, DCS) and other groups as required Public Health consultant as part of internal programme resource. Possible DPH membership on Programme Executive Provide key programme updates to Health & Wellbeing Boards
NHSE / PHE	Specialist commissioning Public health commissioning PHE	NHS England membership of MHPB Strategic Board, due to commissioning role for specialist MH services
Other health partners	ICHP	Briefing to Chief Executive Possible membership of MHPB Strategic Board
	Other NHS providers	Raise at SAHF Implementation Board
Other providers	TBC	
Lay people	Healthwatch (PPRG) WSIC Lay Partners Other user groups	Membership of MHPB, Programme Executive, Clinical Board / CIG and any workstream groups Attend existing forums for under-represented / hard-to-reach groups
Justice System	Police	Membership of MHPB Membership of sub-groups as required
Wider Pioneer community	Pioneer partners	Regular briefings and updates provided
Third/voluntary sector	Mind/ Rethink/ Depression Alliance etc.	Possible membership of some groups within governance structure. Co-production of programme outputs Regular briefings/updates provided
External leaders / supporters	TBC	

8. Quality assurance

The programme may deliver changes to NHS and social services and as such will be subject to rigorous quality assurance, both internally and externally.

Internal quality assurance will include:

- Programme Manager / Director reviewing key deliverables as they develop and prior to submission through formal approval routes
- Discussion of major programme deliverables with a wide range of stakeholders through programme governance – as set out in section 2.4 (Governance).

External quality assurance will include:

- External clinical peer review of the clinical proposals (via the Clinical Board/ CIG)
- 'Critical Friend' role – an external advisory and/or collaborative body that reviews key programme outputs.

If required:

- An Integrated Impact Assessment to test the impact of proposals on equalities groups, the environment etc [exact requirement TBC]
- Scrutiny by a Joint Overview and Scrutiny Committee (representing Health Overview and Scrutiny Committees for boroughs covered by the Strategic Plan).

9. Programme documentation

The programme will need to establish systems to:

- Maintain well-structured records of papers and minutes of key programme / decision making meetings including clear record of decisions made and who took those decisions
- Maintain records of other programme events (e.g. clinical or public engagement events), including who was invited, who attended, what was discussed, what concerns or issues were raised and the programme's response
- Document programme attendance at external meetings and events, including obtaining records of those meetings and keeping records of any information presented by the programme
- Maintain an audit trail showing the development and approval of key documents and deliverables (from the PID to final decision making business case) – including documenting how the views of clinicians and the public have been considered at each stage
- Manage any requests for information under the Freedom of Information Act.

[DN need to develop a document and version control process and store on the shared drive.]

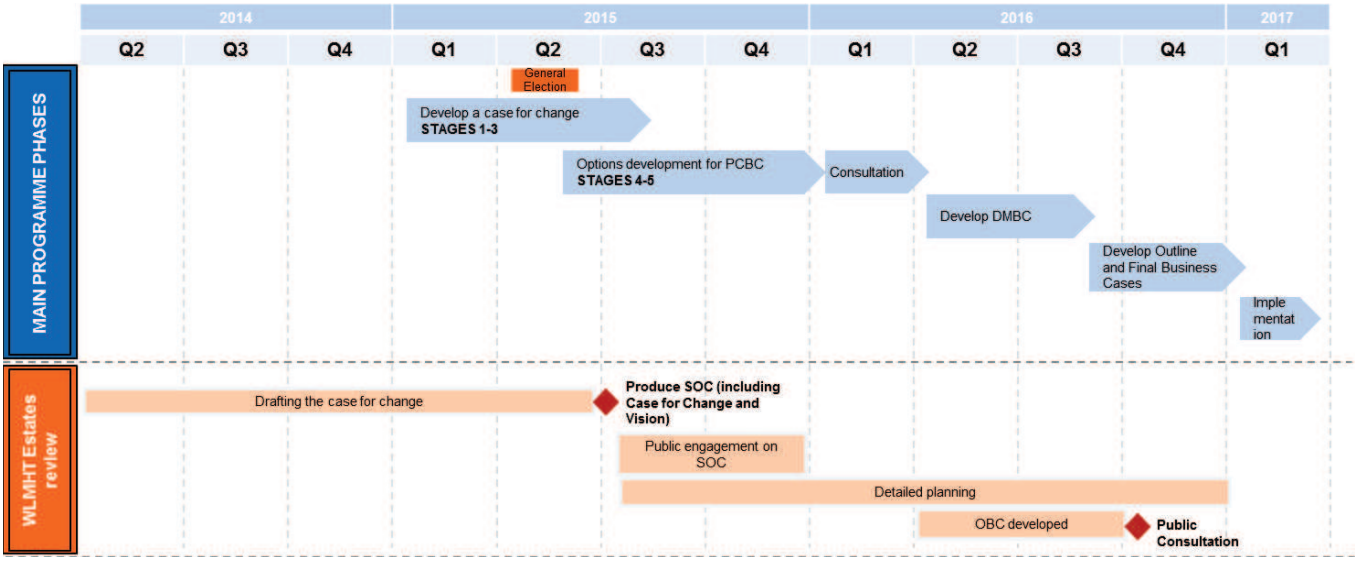
Programme management tracking (including project plans, risk and issues logs) will be through PM3 software.

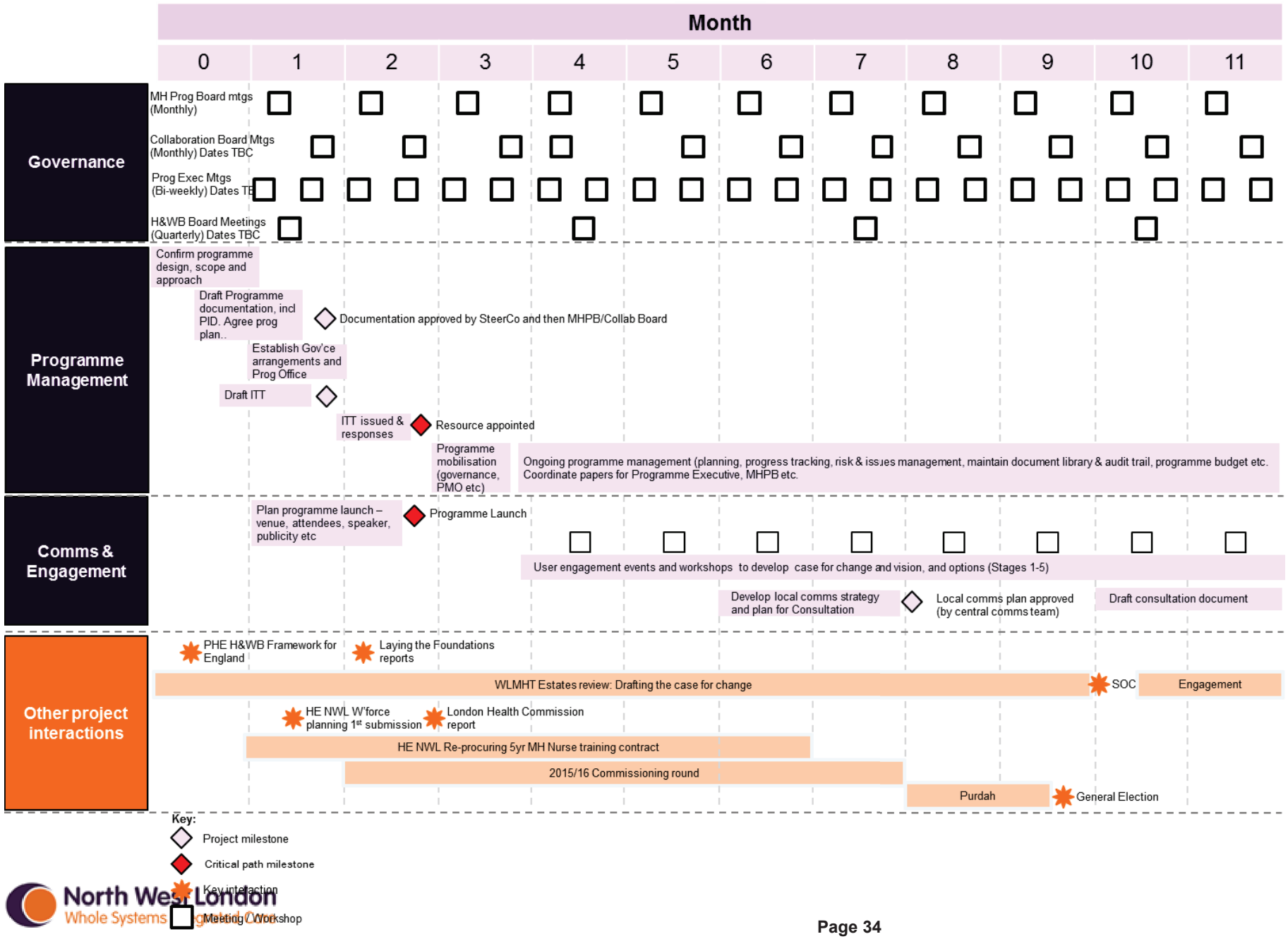
APPENDIX: Programme plans

Initial plans are set out below for:

- The overall Programme, showing interaction with the WLMHT site consolidation review
- The Governance, Programme Management, Communications & Engagement and key project interactions for the first year
- More detailed programme plans will be developed during programme mobilisation.

These are the plans as at December 2014. Latest versions of plans are held on the shared drive at \\Wpct.local\CCG\CWHHE\Strategy & Service Transformation\4. Mental Health\004. (e) MH & WB strategic plan\7. Project Plans:




Month
0
1
2
3
4
5
6
7
8
9
10
11
Governance
MH Prog Board mtgs (Monthly)
Collaboration Board Mtgs (Monthly) Dates TBC
Prog Exec Mtgs (Bi-weekly) Dates TB
H&WB Board Meetings (Quarterly) Dates TBC
Programme Management
Confirm programme design, scope and approach
Draft Programme documentation, incl PID. Agree prog plan..
Documentation approved by SteerCo and then MHPB/Collab Board
Establish Gov'ce arrangements and Prog Office
Draft ITT
ITT issued & responses
Resource appointed
Programme mobilisation (governance, PMO etc)
Ongoing programme management (planning, progress tracking, risk & issues management, maintain document library & audit trail, programme budget etc. Coordinate papers for Programme Executive, MHPB etc.
Comms & Engagement
Plan programme launch – venue, attendees, speaker, publicity etc
Programme Launch
User engagement events and workshops to develop case for change and vision, and options (Stages 1-5)
Develop local comms strategy and plan for Consultation
Local comms plan approved (by central comms team)
Draft consultation document
Other project interactions
PHE H&WB Framework for England
Laying the Foundations reports
WLMHT Estates review: Drafting the case for change
SOC
Engagement
HE NWL W'force planning 1st submission
London Health Commission report
HE NWL Re-procuring 5yr MH Nurse training contract
2015/16 Commissioning round
Purdah
General Election
Key:
Project milestone
Critical path milestone
Key interaction
Meeting / Workshop

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **23 March 2015**
TITLE OF REPORT Pharmaceutical Needs Assessment	
Report of the Director of Public Health	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Director of Adult Social Care	
Report Author: Colin Brodie Public Health Knowledge Manager	**Contact Details:** Tel: 020 7641 4632 E-mail: cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. The Health and Wellbeing Board is requested to approve the 2015-18 Pharmaceutical Needs Assessment (PNA) report for the London Borough of Hammersmith and Fulham in order to meet their statutory requirement to publish a PNA by 1 April 2015

1.2. PNAs are a statement of the need for pharmaceutical services of the population in a defined geographical area.

1.3. Responses from the 60 day consultation on the PNA held between October to December 2014 have been considered in the development of the final report.

1.4. The PNA Task and Finish Group consider that the final report meets the statutory requirements of the Health and Wellbeing Board as set out in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

2. RECOMMENDATIONS

2.1. It is recommended that the Health and Wellbeing Board approve the PNA for the London Borough of Hammersmith and Fulham.

3. REASONS FOR DECISION

3.1. The PNA Task and Finish Group consider that the PNA includes all the information required from the PNA as set out in Schedule 1 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and allows the Health and Wellbeing Board to meet its legal requirements.

4. INTRODUCTION AND BACKGROUND

4.1. PNAs are a statement of the need for pharmaceutical services of the population in a defined geographical area.

4.2. PNAs are an important tool, used by NHS England, in market entry decisions (in response to applications from business, including independent owners and large pharmacy company). The assessments are also used by commissioners to make decisions on which funded services need to be provided by local community pharmacies.

4.3. Across the three Boroughs the PNA has been incorporated as part of the JSNA work programme. The project has been managed by the PNA Task and Finish Group and a PNA has been produced for each Borough

4.4. The responsibility for producing, and managing the update of PNAs transferred from Primary Care Trusts to Health and Wellbeing Boards on 1 April 2013. All Health and Wellbeing Boards are required to publish a fully revised PNA by 1 April 2015.

5. CONSULTATION

5.1. When producing a PNA, Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once during the process of developing the Pharmaceutical Needs Assessment.

5.2. There is a minimum duration of 60 days for the consultation. The consultation for the London Borough of Hammersmith and Fulham PNA ran alongside the consultation for the other two boroughs from 21 October to 19 December.

5.3. Prior to the consultation the draft PNA was circulated to the Health and Wellbeing Board in October 2014.

5.4. In total 10 responders submitted comments as part of the consultation on the London Borough of Hammersmith and Fulham PNA. These comments have been collated and summarised in Appendix 1, which also describes how the consultation responses have informed the final PNA.

5.5. NHS England submitted a detailed response with feedback to ensure the PNA would meet statutory requirements and allow NHS England to complete its statutory function with regard to market entry decision

making. The proposed changes in Appendix 1 have taken this feedback into account and have been approved by NHS England.

6. EQUALITY IMPLICATIONS

6.1. The PNA considers the health needs of people with Protected Characteristics and vulnerable groups in Chapter 2 of the report, and where these may have implications for pharmacy services.

7. LEGAL IMPLICATIONS

7.1. Health and Wellbeing Boards are legally required to publish and maintain a PNA for their local area by virtue of Section 128A of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) as amended by d the Health and Social Care Act 2012.

7.2. PNAs must be developed in accordance with the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

7.3. The Health and Wellbeing Board is required to publish its first PNA by 1 April 2015

7.4. Implications verified/completed by: (LeVerne Parker Chief Solicitor and Head of Regeneration Law Bi-Borough Legal Services 020 7361 2180)

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Hammersmith and Fulham PNA draft (v4thMarch 2015)	Colin Brodie, Public Health Knowledge Manager	Public Health 3rd Floor, Westminster City Hall

Appendix 1

Hammersmith & Fulham Pharmaceutical Needs Assessment 2015-2018

Report from the Public Consultation (October 2014 – December 2014)

Table of Contents

INTRODUCTION

1.1 The Pharmaceutical Needs Assessment (PNA) identifies the key health needs of the local population and how those needs are being fulfilled, or could be fulfilled, by pharmaceutical services in different parts of the borough. The role of the PNA is twofold: to inform local plans for the commissioning of pharmaceutical services; and to support the 'market entry' decision making process (undertaken by NHS England) in relation to applications for new pharmacies or changes of pharmacy premises.

1.2 As outlined in the 2013 regulations, the PNA describes pharmaceutical services in terms of the following summary categories:

A. **Necessary Services – Current Provision:** services currently being provided which are regarded to be "necessary to meet the need for pharmaceutical services in the area". This includes services provided in the Borough as well as those in neighbouring Boroughs

B. **Necessary Services – Gaps in Provision:** services *not* currently being provided which are regarded by the HWB to be necessary "in order to meet a current need for pharmaceutical services".

C. **Other Relevant Services – Current Provision:** services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have "secured improvements or better access to pharmaceutical services". This includes services provided in the Borough as well as those in neighbouring Boroughs.

D. **Improvements and Better Access – Gaps in Provision:** services *not* currently provided, but which the HWB is satisfied would "secure improvements, or better access to pharmaceutical services" if provided.

E. **Other NHS Services**: any services provided or arranged by a local authority, NHS England, the CCG, an NHS trust or an NHS foundation trust which affects the need for pharmaceutical services in its area or where future provision would secure improvement, or better access to pharmaceutical services specified type, in its area.

1.3 Section 128A of the NHS Act 2006 required each NHS Primary Care Trust (PCT) to assess the pharmaceutical needs for its area and to publish a statement of its assessment and of any revised assessment.

Subsequently, the Health Act 2009 contained the powers needed to require PCTs to develop and publish PNAs and use them as the basis for determining market entry to NHS pharmaceutical services provision subject to further regulations.

1.4 With the introduction of the Health and Social Care Act 2012 and the abolition of PCTs, this responsibility transferred to the newly established HWBs from 1 April 2013. It is a statutory responsibility for Health & Wellbeing Boards (HWBs) to develop and update a PNA for its area. HWBs are required to publish their first PNA by 1 April 2015.

Consultation Methodology

1.5 The methodology of the PNA is detailed in the draft document and will be published in the Final Document. No changes have been made and have therefore not been documented in this report.

1.6 Regulation 8 sets out the requirements for consultation on PNAs. The local authority duty to involve was first introduced in the Local Government and Public Involvement in Health Act 2007 and was updated and extended in the Local Democracy, Economic Development and Construction Act 2008.

The Regulations set out that:

- HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA. Any neighbouring HWBs who are consulted should ensure any LRC in the area which is different from the LRC for the original HWB's area is consulted;
- there is a minimum period of 60 days for consultation responses; and
- those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

1.7 The Hammersmith & Fulham PNA was consulted with the following bodies from October 2014 to December 2014 for a total of 60 days:

a. A
b. B
c. C

The PNA was made available at http://www.jsna.info/pharmaceutical-needs-assessment-2015 and the above mentioned bodies were directed to the website via email, with the option of requesting an electronic or hard copy version.

SUMMARY OF RESPONSES

A total of 10 responders contacted the HWB during the consultation process

Hammersmith & Fulham	***Commenter Code***
Comments made	
NHS England	*HF-NHSE*
LPC	*HF-LPC*
CCG (Offline)	*HF-CCG*
Boots	*HF-Boots*
Chelsea & Westminster Hospital Trust	*HF-CWHft*
London North West Healthcare NHS Foundation Trust	*HF-LNWHft*
Oza Chemist	*HF-Oza*
Richmond HWB	*HF-RichHWB*
West London Mental Health Trust	*HF-WLMHT*
Accepted without Comments	
Imperial College Healthcare NHS Trust	

FINDINGS

The key changes to the PNA resulting from the Public Consultation have been listed underneath the original chapter headings of the draft document.
The key suggestions from stakeholders have been listed in the Indices and referenced to the changes made in the document. If multiple comments affect the same change, they have been referenced to the first change that affects

APPENDIX A – KEY SUGGESTIONS FROM NHS ENGLAND

HF-NHSE1	Information in the PNA in relation to the area borough demographics is clear and well described. However the information conveyed lacks feedback and input from other service providers, CCGs, mental health etc.	CCG, Public health, HWB and Adult Social Care represented in the Task & Finish Group. Other service providers were consulted as part of the Consultation process. The above will be noted in Chapter 1.
HF-NHSE2	There is no link between the demographics of the borough and service provision. PNA does not consider the population characteristics or the health needs of the population at the HWB are level or locality level when determining the pharmaceutical needs of the residents of H&F	Demographic data in Chapter 2 will be rearranged according to a list of services that are/can be provided by pharmacies whcih will be listed in Chapter 8 and referenced appropriately. A statement will be made regarding each of the services, current provision, adequacy (at a ward level, when possible) and potential for future improvement.
HF-NHSE3	Information in the PNA has not been clearly/consistently presented at electoral ward level for example not every locality appears to have a pharmacy (figure 5.1)? For localities with pharmacies the number and the services they provide have not been considered at a locality level. The PNA map appears to show that not all localities have a pharmacy but as there is no discussion of the impact of this on pharmaceutical service provision at a locality level.	Demographic data will be presented at electoral ward level, if available. A summary of Appendix A, sorted by Ward, with a statement describing the adequate coverage of pharmaceutical service provision at a locality level will be made in Chapter 5.
HF-NHSE4	Immunisation services have not been considered in the analysis of services. These services are enhanced services commissioned by NHS England therefore a pharmaceutical service	Awaiting data from PHE - statement stating this if not provided by end of January

HF-NHSE5	Advanced service provision at a locality level has not been considered	As per HF-NHSE2
HF-NHSE6	Lack of clarity on what information was used to determine pharmaceutical need. A list of the information used in drawing conclusions would make it clear to the reader. The rationale used to determine a necessary service and a relevant service is unclear. This is not considered on a locality or HWB area level.	A list will be provided in Appendix D
HF-NHSE7	The only enhanced service cited is H.P breath tests with no discussion of activity or whether the service is meeting the needs of the population. If this data was not available the PNA should state so as opposed to stating nothing. The same point applies to all the locally commissioned services no attempt is made to consider whether or not they are meeting a health need e.g. relating the service to chapter 2. Once again emphasising the disconnect between chapter 2 and the rest of the document.	As per HF-NHSE2
HF-NHSE8	When considering necessary services this is only done on a HWB area level and not on a locality level. Why have opening times not been presented on a locality basis? This undermines the PNA decision making process as localities seem to have been totally disregarded in chapter 5..	Information will be presented at ward level

HF-NHSE9	In chapter 5 when considering necessary services the only factors taken into account are the number of pharmacies and their location. Other factors such as population density, health needs or modes of access to pharmacies e.g public transport links are disregarded. No rationale is presented for taking this approach. An example of this is in 5.4.	Statement will be expanded, taking in to account information that would be rearranged in Chapter 2 as per Comment code - KC-NHS3, with explanation for rationale.
HF-NHSE10	The estimated number of pharmacy contractors per 100,000 population is only considered at HWB area level, this should have been considered at locality level as well. This emphasise the lack of analysis at a locality level and a lack of clarity on what information was used to determine pharmaceutical need.	As per HF-NHSE9
HF-NHSE11	The PNA has used a contractor survey as opposed to official NHSE data to establish who is providing advanced services. Is this acceptable as it is categorised as a necessary service, surely the PNA should cite NHSE data e.g. HSCIC website. MUR and NMS are only considered on a HWB area level and not on a locality level. There is no analysis of whether these services are available in every locality or a discussion as to how they could be accessed if not available. The same point applies to all the locally commissioned services no attempt is made	Data made available to us post-consultation. Will be presented at ward level

	to consider whether or not they are meeting a health need at a locality level or a HWB area level e.g. relating the service to chapter 2. Once again emphasising the disconnect between chapter 2 and the rest of the document. The two have been explored very separately however the provision of pharmaceutical needs should be interlinked with the local health needs; not solely in the borough as a whole but in terms of the differing needs of people within the borough.	
HF-NHSE12	Appendix C is particularly confusing…what is the purpose ? At present it adds virtually nothing to the PNA e.g. which pharmacies provide EHC or stop smoking? Even though these are not pharmaceutical services they have been identified as providing improvement and better access so should the reader not be aware who provides the service?	Appendix to be expanded to include all the pharmacies that provide commisioned services including those commissioned by the LA. The appendix will also include a list of pharmacies who would be willing to provide these services if commissioned.
HF-NHSE13	It is recommended that clear and explicit linkage is made between locality health needs and pharmaceutical service provision. If the HWB has decided to divide the area up into localities the PNA must be based upon these localities as the needs assessment should inform/determine service provision at a locality	As per HF-NHSE2

HF-NHSE14	The PNA makes no reference to the need for pharmaceutical services, if in future circumstances there is a change configuration of primary care settings following a move to extended hours for GPs. This needs to be made explicit as it could be an instance where the PNA specifies a need to secure improvements or better access to pharmaceutical services in the circumstances where GP Surgeries move to 7 day opening or provision of extended hours.	Statement to be made in Chapter 5 and under a new subtitle "Service provision in relation to changing service providers and needs of community" in Chapter 8 which will include a statement regarding provision if there are to be future changes as referenced to in Chapter 3.
HF-NHSE15	Are there known firm plans in and arising from local joint strategic needs assessments or joint health and wellbeing strategies? None found	Statement from the HWB in Chapter 1
HF-NHSE16	Are there known firm plans for changes in the number and/or sources of prescriptions i.e. changes in providers of primary medical services, or the appointment of additional providers of primary medical services in the area? None found	Statement to be made in Chapter 3 "Location of Current Services"
HF-NHSE17	Are there known firm plans for developments which would change the pattern of local social traffic and therefore access to services, i.e. shopping centres or significant shopping developments whether these are in town, on the edge of town or out of town developments? None found	Statement to be made at the end of Chapter 2 "Changing Patterns of Need"
HF-NHSE18	Are there plans for the development of NHS services? None found	As per HF-NHS16

HF-NHSE19	Are there plans for changing the commissioning of public health services by community pharmacists, for example, weight management clinics, and life checks? None found	Statement from Public health & Adult Social Care in Chapter 1. Pharmacy services to be a part of a wider review of Services that is currently being scoped.
HF-NHSE20	Are there plans for introduction of special services commissioned by clinical? None found commissioning groups?	Statement from CCG in Chapter 1.
HF-NHSE21	Are there plans for new strategies by social care/occupational health to provide aids/equipment through pharmacies or dispensing appliance contractors? None found	Statement from Public health & Adult Social Care in Chapter 1. Pharmacy services to be a part of a wider review of Services that is currently being scoped.

APPENDIX B – KEY SUGGESTIONS FROM THE CCG REPRESENTATIVE (ASHFAQ KHAN)

HF-CCG1	section 1.16 it states "sexual health is a particular challenge within the borough. Hammersmith & Fulham has the 5th highest reported acute sexually transmitted infections (STI) rate in England". Pharmacies in other parts of England are commissioned to provide a range of sexual health services including: condom distribution; pregnancy testing and advice; Chlamydia screening ; Chlamydia treatment; Screening for syphilis, HIV and gonorrhoea; Contraception advice and supply; Sexual health advice. With the high rates of STIs there may be an unmet need and consideration could be given to how the community pharmacy sector could contribute towards meeting any unmet needs.	To be noted
HF-CCG2	Flu vaccinations - reference should be made to the flu targets in Hammersmith & Fulham and whether these were being met with vaccinations offered almost exclusively through GP Practices. Is there an unmet need and is this need being addressed with the addition of pharmacies vaccinating. Additionally are pharmacies attracting	As per HF-NHSE4

	patients in particular risk groups that have not normally attended GP Practices to be vaccinated.	
HF-CCG3	Hammersmith & Fulham Local Authority (through their Public Health Department) commissions a further 5 services from community pharmacies: Stop smoking service; Needle and syringe exchange ; Supervised consumption (methadone, buprenorphine); NHS Health Checks; Emergency hormonal contraception. Maps showing the location of provision of these services could be included in the PNA to demonstrate that these services are available in the areas with the greatest need.	Maps to be produced

APPENDIX C – KEY SUGGESTIONS FROM THE LPC

HF-LPC1	The LPC recognises 40 pharmacies in the Borough of Hammersmith and Fulham. The pharmacy that is listed as MyPharmacy in North Pole Road W10 used to be in Hammersmith and Fulham but moved to Kensington and Chelsea following a boundary change. The LPC would also point out that the pharmacy listed as Forrest Pharmacy changed hands in April 2014 and is now trading as Sophia Chemists Ltd	To be verified and amended
HF-LPC2	The LPC considers Medicines Use Reviews (MURs) to be a "Relevant Service" and not a "Necessary Service". Unlike Essential Services, it is not mandatory for pharmacies to provide MURs/NMS. They are voluntary, requiring both personal and premises accreditation. MURs require prior usage of that pharmacy by a patient for a period of three months. As a result, a patient cannot be referred by a non-provider to a providing pharmacy. Provision of NMS cannot be undertaken in the absence of personal accreditation for provision of MUR. Other healthcare practitioners cannot provide MURs but can support patients in the use of their medicines e.g. practice nurses advising on	To be considered by HWB after completion of draft

	the use of inhalers in respiratory disease. We would suggest that they are classified as “relevant” services	
HF-LPC3	The LPC considers the Advanced Service of New Medicines Service (NMS) to be a “Relevant Service” and not a “Necessary Service” for the reasons outlined above	To be considered by HWB after completion of draft
HF-LPC4	As a consequence of the changes suggested by the LPC the section under **8.11** may need to be reworded**.** **“**Having assessed the local needs and the current provision of necessary services, the Hammersmith & Fulham HWB have not identified any necessary pharmaceutical services that are not provided in the area of the HWB.	To be considered by HWB after completion of draft
HF-LPC5	Some services such as Emergency Hormonal Contraception (EHC) and the Minor or Common Ailments Service (which is not commissioned yet in Hammersmith and Fulham) are relevant services at some times of the day and on some days of the week but at other times e.g. on a Sunday afternoon when other service providers are	To be considered by HWB after completion of draft

	not available, these become ‘necessary’ services.	

APPENDIX D – KEY SUGGESTIONS FROM BOOTS UK

HF-Boots1	Map of the Borough (page 5) - We feel it would be good to show all the transport links (stations, main transport hubs) across Hammersmith & Fulham, which showcase the excellent links and ease of travel across the borough for access to pharmaceutical services.	The road network and all the underground tube stations will be added to the map. Further, an online tool will be created to visualise the data.
HF-Boots2	Local Health & Wellbeing Priorities (page 9) - It would be good to understand from the Health and Wellbeing board how they see pharmacy, and access to pharmaceutical services fitting into the 8 priorities for 2013-16. Community pharmacy has a role to play in all 8 priority areas, in particular supporting immunisation and sexual health.	Statement from the HWB in Chapter 1
HF-Boots3	Enabling better care in tri-borough (page 10) - The NW London 5-year plan sets out health promotion, early diagnosis and early intervention through local health and wellbeing strategies and through collaborative work with partners to improve screening, immunisations and cardiovascular disease prevention, as one of the programmes. The recent pan London pharmacy vaccination service across all London boroughs has shown success in delivery of Public health programmes, through immunisation, and due to the access and use of Community Pharmacy as a provider. This took into consideration the issue raised on page 14 of the draft PNA, regarding population churn which can create challenges around effective delivery of PH programmes.	To be noted in Chapter 2 and 8 as relevant

HF-Boots4	Lifestyles (page 24) - The PNA states that smoking is the 4th highest in London . The current service is Hammersmith & Fulham is restrictive, whereby if a resident works in another borough, and it is more convenient for them to access the service in another borough, the stop smoking service may not support this. This would be a good example of a service which is likely to be a priority to most health and wellbeing boards across London, where some more effective pan London commissioning would support patients better by giving better access.	As per HF-Boots3
HF-Boots5	The PNA states that hospital admissions for alcohol related and alcohol specific harm are significantly higher in Hammersmith & Fulham. Pharmacy can have a proactive and positive role to play here, whether that be via a commissioned alcohol intervention service, or a commissioned public health promotion intervention. Community pharmacies in London were successful with a health promotion campaign in London around alcohol in 2012/13 whereby they reached out to 24,000 people in London.	As per HF-Boots3
HF-Boots6	The PNA states that Hammersmith & Fulham has the 3rd highest rate of acute sexually transmitted diseases in the country. This could be supported with more widespread commissioning of sexual health services such as Chlamydia screening and treatment and C-card. The number, opening hours and location of pharmacies in H&F, make this an accessible service, whilst providing anonymity for patients who view this as important.	As per HF-Boots3
HF-Boots7	The PNA states that the premature death rate from COPD is higher than London and England. Pharmacy can play a role in medicines reviews, commissioned services to support patients with COPD. Reference to such services can be found	As per HF-Boots3

	on http://www.communitypharmacyfuture.org.uk/pages/copd_229724.cfm.	
HF-Boots8	Location of current health services (page 42) -The PNA makes no assessment of need for pharmaceutical services in secondary care, however there is interest in managing the transfer of patients across care settings with particular regard to medicines review and reconciliation processes between hospital and community pharmacies. This could be supported by community pharmacy with collaborative working using the MUR (discharge MURs) and NMS services. Given that a significant number of pharmacies already provide these advanced services, this is something that could be developed further with the existing pharmacy network, whilst also contributing to the 8 local health and wellbeing priorities.	To be noted in Chapter 8
HF-Boots9	MAS is currently only commissioned in seven pharmacies across the borough. This is a valued service to patients, and reduces pressure on GPs. Given the access of pharmacies in Hammersmith & Fulham, this should be a necessary service that is commissioned more widely. The majority of pharmacies would be willing to provide this service. The draft PNA document does not highlight the responses from pharmacy contractors on the number of contractors that would be willing to provide the service, which would be useful to state	To be included in Chapter 8 and Appendix C
HF-Boots10	It would be important to note that the level of AURs is low across England, and this could be partly explained due to the support that patients receive in secondary care, or other clinics when establishing their ongoing care.	To be noted

HF-Boots11	It would be important to note that the level of SACs is low across England, and this could be partly explained by the advice and support patients receive from other care providers.	To be noted
HF-Boots12	Stop smoking services We agree with the draft PNA that the provision of stop smoking service is a necessary service with no gaps. As there are no gaps in provision, it would be useful to consider how to increase provision within the borough- which could include options to open up the service to any resident (due to the transient population) as Hammersmith & Fulham residents could benefit from access to the service in boroughs that they may work in if not in Hammersmith & Fulham. It may also be useful to look at other harm reduction services e.g. supply of Champix, cutting down, and/or the role of e-cigarettes in smoking cessation.	To be considered by HWB after completion of draft
HF-Boots13	H. pylori service -We agree that this is a relevant service, and would welcome increased commissioning of this service.	To be considered by HWB after completion of draft
HF-Boots14	Needle & syringe and supervised consumption services -We agree that there should be no need for any new pharmacies to provide these services, however, it may be beneficial to have this service commissioned more widely to offer patients a greater choice.	To be considered by HWB after completion of draft
HF-Boots15	Emergency hormonal contraception service - We agree that this is a relevant service, and would welcome increased commissioning of this service.	To be considered by HWB after completion of draft
HF-Boots16	Improvements and better access: gaps in provision (page 61) - It is important to note the number of current contractors that would be willing to provide copd, alcohol misuse services, weight management services, and immunisation and vaccination services to secure access to these services. We would hope that should this gap need fulfilling, the HWB would consult with existing	To be considered by HWB after completion of draft

	contractors to provide these services if commissioned.	

APPENDIX E – OTHER RESPONDERS

HF-CWHft1	Reference to NHS England 2013 "Improving care through community pharmacies - a call to action" & Royal Pharmaceutical Society May 2014 "Good Practice guidance for healthcare professional in England"	Reference to be made
HF-LNWHft1	3.14 - The Trust is pleased that the document refers to the transfer of care of patients across care settings. This is a major area of concern and opportunity to improve services for patients1. We would welcome the opportunity to share our Medicines Optimisation Strategy which includes improving transfer of care. We would suggest that you obtain the Medicines Optimisation strategies from your local secondary care providers in order to obtain their input.	To be noted
HF-LNWHft2	6.10 - To improve transfer of care and communication, we would suggest all pharmacies should have access to “nhs.net”. We need to work together to use the electronic discharge summaries from the acute trusts in their localities as a method of referring patients to their local community pharmacist for post discharge follow up, including discharge medicines use review and the new medicines service.	

HF-LNWHft3	8.5- As mentioned above in 6.10, we would suggest the document refers to the discharge medicines use reviews as a method of facilitating safe discharge of care. The new medicines service may also be relevant for post discharge follow up especially for housebound patients as it is nationally commissioned for both face to face and telephone support.	
HF-LNWHft4	8.30 We note that there is no mention of a common ailment service and recognize that the professional body for pharmacy are strongly supportive of this being commissioned by NHS England in support of the urgent and emergency care challenge. http://www.rpharms.com/what-s-happening-/news_show.asp?id=2342	To be noted in Chapter 8
HF-Oza1	PNA survey completed (old survey)	
HF-RichHWB1	Richmond connected via Hammersmith Bridge to the area of Barnes - relative disadvantage and deprivation. One pharmacy in Richmond within 500m of H&F. With regard to the section on Acute Care and Mental Health Care (3.13-4) we advise that, as there is no acute hospital in Richmond, a significant proportion of Richmond residents accessing urgent and planned care will be treated at Hammersmith Hospital or	

	Charing Cross Hospital. Transfer of these patients across care (with particular regard to medicines review and reconciliation processes between hospital pharmacists and community pharmacists) is equally important. Bearing in mind these points, the Richmond HWB agrees with the cotent of the draft PNA, insofar as it relates to Richmond.	
HF-WLMHT1	The report highlights the importance of improvimg mental health and wellbeing in the boroughs, as well as a high number of patients on the SMI registers, however I was unclear how the needs of this vulnerable patient group is being addressed.	Protected groups will be listed and described in Chapter 2 under "Protected Characteristics and Local Vulnerable Groups" . They will also be discussed in Chapter 8 linking the demand to need.
HF-WLMHT2	There does not appear to be any pharmacists with a specialist interest in mental health in either Hammersmith and Fulham nor in Kensington and Chelsea, and this is an area that should be improved.	To be noted
HF-WLMHT3	Considering the shifting settings of care agenda there are no enhanced services for patients with long term mental health conditions, these are not included in the MUR nor in the new medicines service.	To be noted
HF-WLMHT4	Medicines adherence is a challenging area in mental health and can ensure patients remain well in the community. Services to support patients with long term mental health conditions to remain	To be noted

	compliant will enhance quality of life and improve the health and wellbeing of individuals as well as having a positive effect on the local health economy.	
HF-WLMHT5	Pharmacists are in an ideal position to monitor compliance by means of collection of prescriptions, as well as ensuring patients know what medicines are for and how to take them.	To be noted
HF-WLMHT6	If delivering medicines to patients with mental health conditions there is also a role for 'assessing medicines at home' to identify if patients are storing medicines safely or if they are hoarding medicines.	To be noted
HF-WLMHT7	Pharmacists should be trained to assess mental health to identify patients who may be deteriorating.	To be noted
HF-WLMHT8	There is also potential for pharmacists to be trained to administer long acting injections.	To be noted

Hammersmith & Fulham Pharmaceutical Needs Assessment

2015 - 2018

DRAFT : 4th March 2015

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Acknowledgements

The Hammersmith & Fulham Health & Wellbeing Board would like to thank all the community pharmacies who supported the development of the 2015-18 Pharmaceutical Needs Assessment (PNA).

Pharmacies in the borough were invited to complete a questionnaire in July and August 2014 as part of the process; the results of these questionnaires inform this needs assessment. Responses from the 60 day consultation period on the draft document (October-December 2014) were also be incorporated.

As the questionnaires were sent in July 2014, views in this document are a reflection of stated provision, intentions and attitudes of pharmacists at that point in time. Data from other sources was the most up to date provided at the time of the production of the report in September 2014 and included information from pharmacies in neighbouring Boroughs.

This document has been compiled in accordance with The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 in order to inform commissioning decisions and managing Control of Entry, rather than as a Strategic Plan.

The preparation of this PNA relies on information submitted by others. The contents of the PNA accurately reflects the information received by 3rd October 2014

Chapter 1 – Introduction

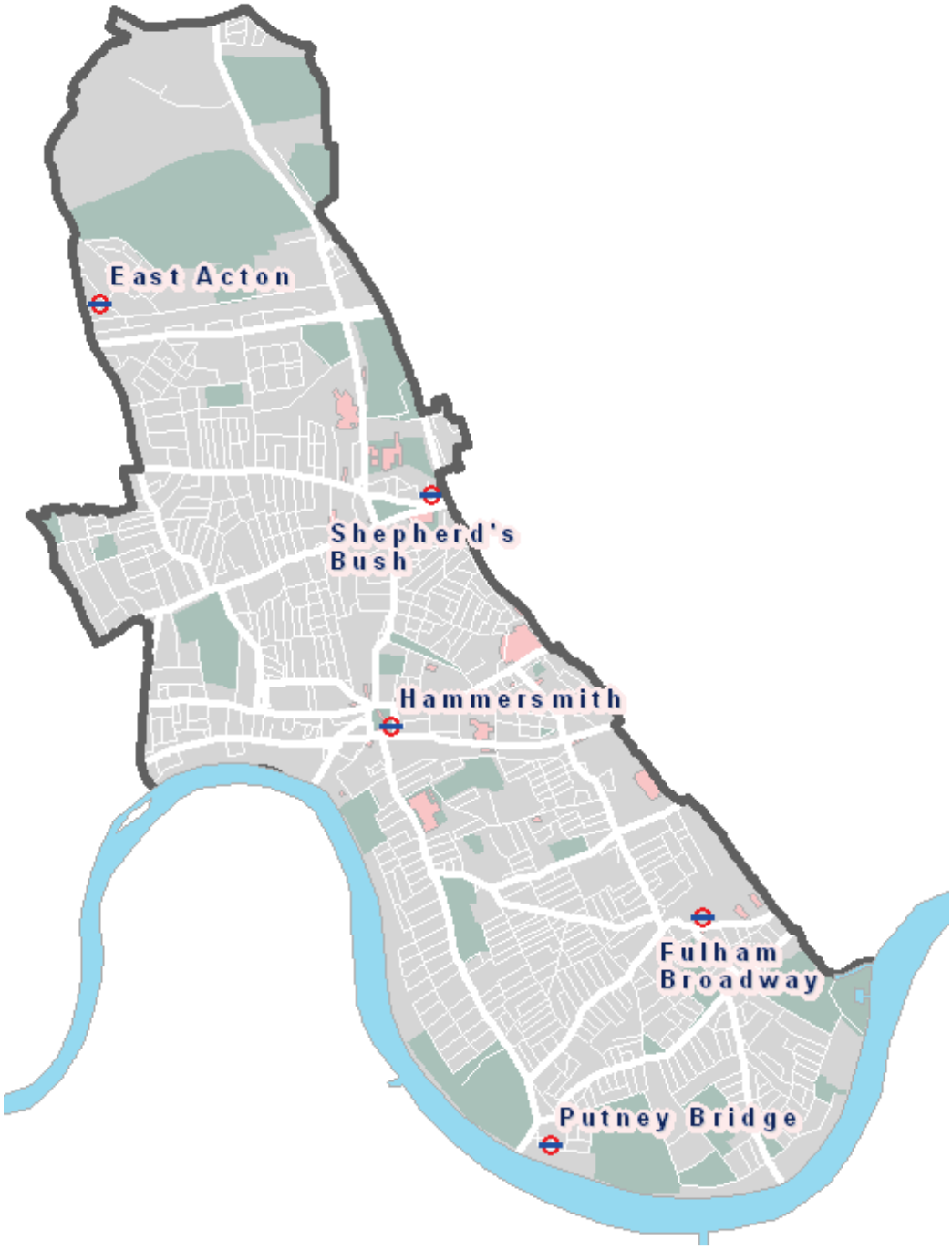


Figure 1.1: Map of Hammersmith & Fulham

Role of Pharmacies

1.1 Community pharmacists and their teams work at the heart of communities and are trusted professionals in supporting individual, family and community health. Community pharmacies are often patients' and the public's first point of contact and, for some, their only contact with a healthcare professional. Community

pharmacies are not only a valuable health asset, but also an important social asset because often they are the only healthcare facility located in an area of deprivation.

Purpose of the Pharmaceutical Needs Assessment

1.2 The Pharmaceutical Needs Assessment (PNA) identifies the key health needs of the local population and how those needs are being fulfilled, or could be fulfilled, by pharmaceutical services in different parts of the borough. The role of the PNA is twofold:

- to inform local plans for the commissioning of pharmaceutical services; and
- to support the 'market entry' decision making process (undertaken by NHS England) in relation to applications for new pharmacies or changes of pharmacy premises.

1.3 As outlined in the 2013 regulations, this PNA describes pharmaceutical services in terms of the following summary categories:

A. **Necessary Services – Current Provision:** services currently being provided which are regarded to be "necessary to meet the need for pharmaceutical services in the area". This includes services provided in the Borough as well as those in neighbouring Boroughs

B. **Necessary Services – Gaps in Provision:** services *not* currently being provided which are regarded by the HWB to be necessary "in order to meet a current need for pharmaceutical services".

C. **Other Relevant Services – Current Provision:** services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have "secured improvements or better access to pharmaceutical services". This includes services provided in the Borough as well as those in neighbouring Boroughs.

D. **Improvements and Better Access – Gaps in Provision:** services *not* currently provided, but which the HWB is satisfied would "secure improvements, or better access to pharmaceutical services" if provided.

E. **Other NHS Services**: any services provided or arranged by a local authority, NHS England, the CCG, an NHS trust or an NHS foundation trust which affects the need for pharmaceutical services in its area or where future provision would secure improvement, or better access to pharmaceutical services specified type, in its area.

Policy Background Relating to the PNA

1.4 It is a statutory responsibility for Health & Wellbeing Boards (HWBs) to develop and update a PNA for its area.

1.5 Section 128A of the NHS Act 2006 required each NHS Primary Care Trust (PCT) to assess the pharmaceutical needs for its area and to publish a statement of its assessment and of any revised assessment. Subsequently, the Health Act 2009 contained the powers needed to require PCTs to develop and publish PNAs and use them as the basis for determining market entry to NHS pharmaceutical services provision subject to further regulations.

1.6 With the introduction of the Health and Social Care Act 2012 and the abolition of PCTs, this responsibility transferred to the newly established HWBs from 1 April 2013. HWBs are required to publish their first PNA by 1 April 2015.

1.7 The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 provided HWBs with the minimum information that must be contained within their PNA and also the process to be followed in their development and publication. The development and publication of this PNA has been carried out in accordance with these Regulations.

1.8 Since 1 April 2008, Local Authorities and the NHS have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) by virtue of the Local Government and Public Involvement in Health Act 2007. The Health and Social Care Act 2012 introduced duties and powers for HWBs in relation to the JSNA. The JSNA is a strategic assessment of the health and wellbeing needs of the local population, and this PNA builds on the findings of the JSNA by supporting the commissioning and the development of appropriate, sustainable and effective pharmacy services. For further information on the JSNA please refer to http://www.jsna.info

Local health and wellbeing needs

1.9 Hammersmith & Fulham is a small, but densely populated borough in West London. The population is unusual in that it has a large proportion of young working age residents, high levels of migration in and out of the borough, and much ethnic and cultural diversity. Whilst many residents are affluence, there are significant areas of poorer health in the more deprived parts of the borough and therefore there are large health inequalities between rich and poor. While most people in Hammersmith & Fulham consider their health to be good, those living in areas of high density social housing are twice as likely to report bad or very bad health compared to those in areas with low density housing.

1.10 Studies have shown that the earliest years of life lay the foundations for physical, intellectual and emotional development that impacts on later life. There are some specific challenges in Hammersmith & Fulham that particularly impact on children. More than a third of children of school age within the borough are either overweight or obese and child immunisation uptake, while it has recently

improved, is still below national levels. Around a third (29%) of children under 17 in the borough are classified as living in poverty.

1.11 Sexual health is a particular challenge within the borough. Hammersmith & Fulham has the 5th highest reported acute Sexually Transmitted Infections (STI) rate, and the 11th highest HIV prevalence rate, in England. Teenage conception has also been higher in the borough than the London average, although this is now dropping.

1.12 More people smoke in Hammersmith & Fulham (21%) than the average for London and England, and the borough has the 9th highest rate of problem drug users in London. Hammersmith & Fulham also has the 8th highest population with sever and enduring mental illness known to GPs in the country. Coverage of breast screening in the borough is the 5th lowest in the country, while cervical screening is the lowest in the country for younger women.

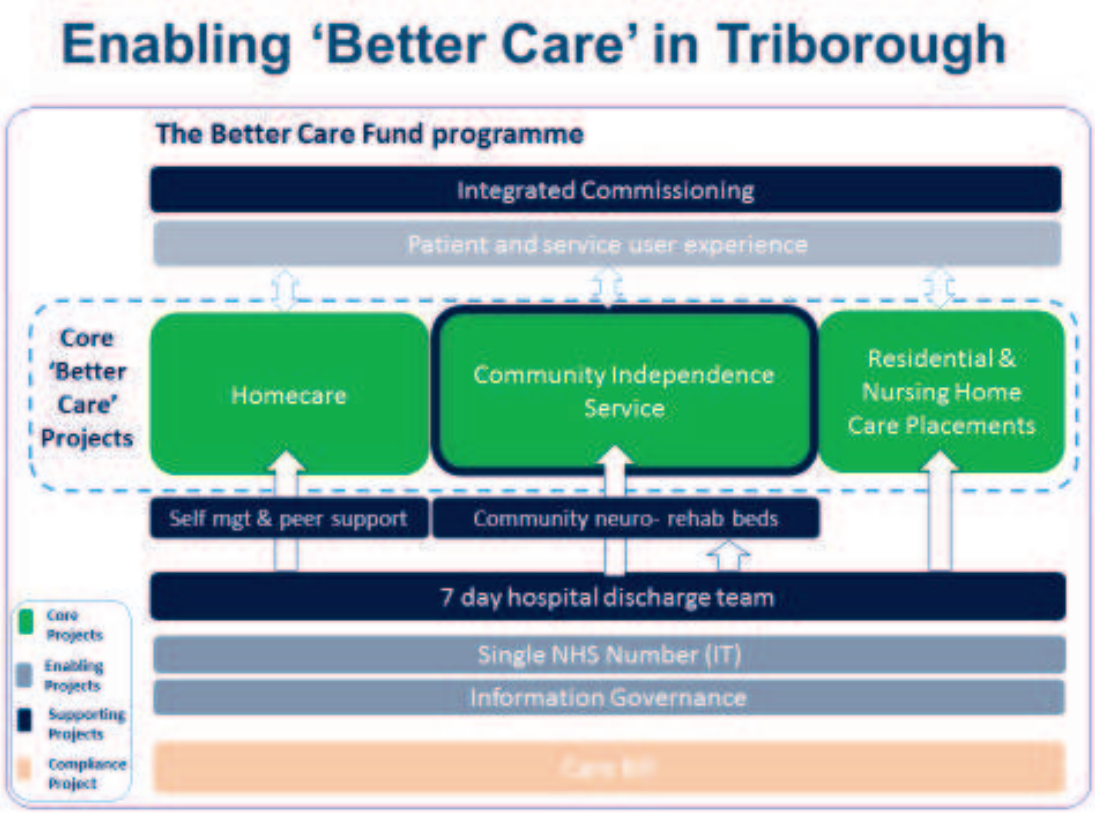
1.13 Finally, like most areas of the country, Hammersmith & Fulham is expecting an increase in the number of older people who live in the borough. Over the next decade, the number of older people is expected to rise by 12%. This change in the population profile will have a knock on impact on the key health needs of the population. For example, the number of people living with dementia is expected to rise by 24% over the same period.

Local health and wellbeing priorities

1.14 As part of their new responsibilities, HWBs are required to produce a Health and Wellbeing Strategy which sets out how partners will meet local health needs, improve outcomes and reduce health inequalities within the borough. The Hammersmith & Fulham Joint Health and Wellbeing Strategy 2013 - 2016 identifies 8 priorities for the local area:

- Integrated health and social care services which support prevention, early intervention and reduce hospital admissions;
- Delivering Park View Centre for Health & Wellbeing to improve care for residents and regenerate the White City Estate
- Integrated services across all relevant agencies which support prevention and early intervention to reduce illness, neglect and abuse for children
- Tackling childhood obesity
- Integrated services across all relevant agencies which support prevention and early intervention to reduce avoidable demand for services by adolescents
- Improving mental health services for service users and carers to promote independence and develop effective preventative services
- Better access for vulnerable people to Sheltered Housing
- Better sexual health across Tri-borough with a focus on those communities most at risk of poor sexual health.

1.15 The Hammersmith & Fulham HWB has also been focussing on the development of the Better Care Fund Plan. The Better Care Fund is a "single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". The BCF will support the aim of providing people with the right care, in the right place, at the right time, including expansion of care in community setting. The Better Care Fund Plan has been developed with our neighbouring boroughs of the Royal Borough of Kensington and Chelsea and Westminster.



1.16 Alongside local priorities, the eight Clinical Commissioning Groups (CCGs) in North West London have published a five year strategic plan, which sets out the collective plans and priorities of these CCGs, working in partnership with NHS England. Hammersmith & Fulham Clinical Commissioning Group (CCG) is one of these CCGs. The North West London five year strategic plan sets out five jointly developed transformation programmes:

- Health promotion, early diagnosis and early intervention through local Health and Wellbeing Strategies and through collaborative work with partners to improve screening, immunisations and Cardiovascular disease prevention
- Out of Hospital strategies including Primary Care Transformation through the creation of GP networks. Hammersmith & Fulham Clinical Commissioning Group's Out of Hospital strategy 2012-15, Better Care, Closer to Home aims to reduce unscheduled care and improve planned care through the organisation of GP

practices and providers into new multi-disciplinary groups who can support effective care planning for their most at-risk patients.

- Whole Systems Integrated Care which aims to ensure that people are empowered to direct their care and support and to receive care in their homes or local community; that GPs are at the centre of organising and coordinating people's care and that systems enable and do not hinder the provision of integrated care
- Transforming Mental Health Services which aims to ensure that services are responsive, focused on the person and are easy to access and navigate; care is provided as close to homes as possible where and when it is needed; the lives of users and carers are improved by promoting recovery and delivering excellent health and social care outcomes (including employment, housing and education).
- Shaping a Healthier Future (SaHF) which aims to achieve better clinical outcomes and safer services for patients by centralising most emergency specialist services (such as A&E, Maternity, Paediatrics, Emergency and Non-elective care) into 5 major hospitals. The Seven Day Services programme is part of the Shaping a healthier future reconfiguration to ensure that people are treated at the right place at the right time and includes an intention to extend pharmacy weekend services.

Defining Localities

1.17 For the purposes of the PNA it is necessary to divide the geographical area of Hammersmith & Fulham into distinct localities.

1.18 The HWB has used 2 approaches to define localities in this PNA:

- **Electoral wards** are used to summarise demographic and health need.
- Provision and choice of pharmacies is determined by using a **500 metres radius** from the centre of the postcode of a pharmacy. This is considered to be approximately a 10 minute walk from the outer perimeter of the buffer zone created.

1.19 It is important to note that the local population are not bound by electoral ward or borough boundaries when accessing essential pharmaceutical services. The excellent travel infrastructure available within Central London places many more pharmacies, both inside and outside the borough, within convenient access to our local population. Pharmacies also provide delivery services which further improve access.

1.20 The rationale for using the more detailed "500m radius" approach was to identify the range of access and service provision in a far more precise fashion than ward averages would allow. For example, where boundaries of wards are main roads, pharmacies on the opposite side of the road would not be counted towards the ward's provision, thereby giving an inaccurate picture of provision; use of the more detailed 500m radius approach avoids this. It also allows the PNA to assess the impact of pharmacies in surrounding boroughs that are within 500m of the borough border.

1.21 The 500m radius approach illustrates where there is at least one pharmacy within 500m and where there is no pharmacy within 500m. The distance of 500m was chosen by the Steering Group as being a reasonable measure to identify variation and choice. However, whilst highlighting variation, it is not always used to determine gaps in services; in some instances, wider measures are more appropriate (e.g. where there is lower patient demand for services, such as needle exchange and dispensing outside normal working hours). These instances have all been stated in the relevant sections of the report.

Hammersmith & Fulham Wards

1.22 Hammersmith & Fulham consists of 16 electoral wards.

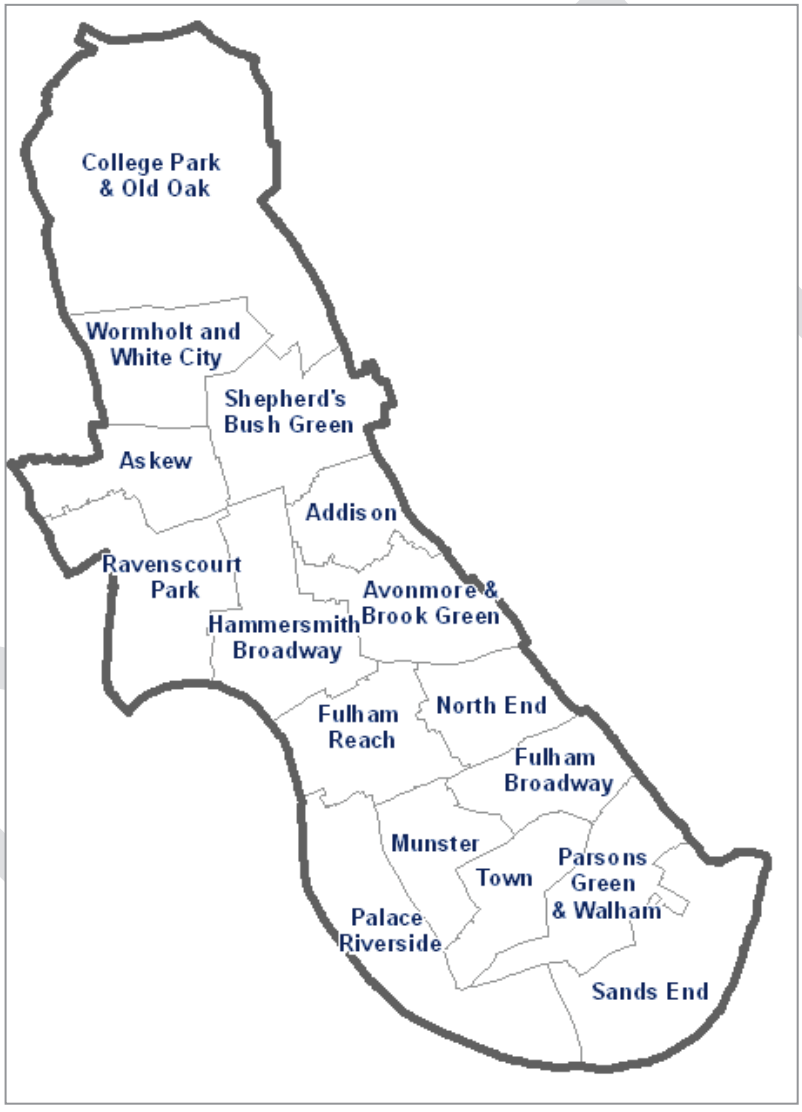


Figure 1.2: Hammersmith & Fulham Electoral Wards

Pharmacy Contractor Survey

1.23 The pharmaceutical needs assessment survey was sent to the pharmacies within Hammersmith & Fulham and those from the Tri-borough listed in Appendix A. The response rate was 83% (34/41) for Hammersmith & Fulham. The results from this survey are referred to throughout this document.

Chapter 2 - Demographics & Health Need

The Joint Strategic Needs Assessment

2.1 The demographic and health information included here is covered in graphical detail in this chapter as well as in the Joint Strategic Needs Assessment (JSNA) for the Hammersmith & Fulham. The JSNA identifies current and future health and social care needs of the borough's population and analyses whether these needs are being met locally. (For JSNA highlights report, please see http://www.jsna.info/document/highlight-reports-2012)

2.2 All the maps that follow indicate the size of something, e.g. patient list size, rate of dementia among patients etc, are shown by quintiles. The lowest 20% have the lightest colour or smallest marker, and the highest 20% have the darkest colour or largest marker. The boundaries between the quintile are shown in the legend.

Summary of Population Characteristics

2.3 Characteristics of the local population have been summarised below. Further detail is provided later in this chapter.

The borough at a glance…			
80,600	Households	8	Live births each day
£464,000	Median house price	2-3	Deaths each day
182,500	Residents	11,900	Local businesses
32%	From BAME groups	£33,000	Annual pay
43%	Born abroad (2011 Census)	3.1%	Unemployment rate (JSA) (London 3.1%)
23%	Main language not English	22%	Local jobs in Public Sector
46%	State school pupils whose main language not English	Ranked 55th	Most deprived borough in England (out of 326) (13th in London)
17k/19k	Annual flows in and out of the borough	29%	Children <16 in poverty, 2011 (HMRC)
198,900	Registered with local GPs	Ranked 6th	Highest carbon emissions in London (not including City of London)
260,000	Daytime population in an average weekday		

Table 2.1: Overview of characteristics of the local population

Overall population

2.4 Hammersmith & Fulham is a small and very densely populated borough situated in the centre west of London, bordered by the River Thames on the south and south west side. The borough has three main town centre areas: Shepherd's Bush, Hammersmith, and Fulham. Population density is highest in Addison, North End and Munster wards (Figure 2.1)

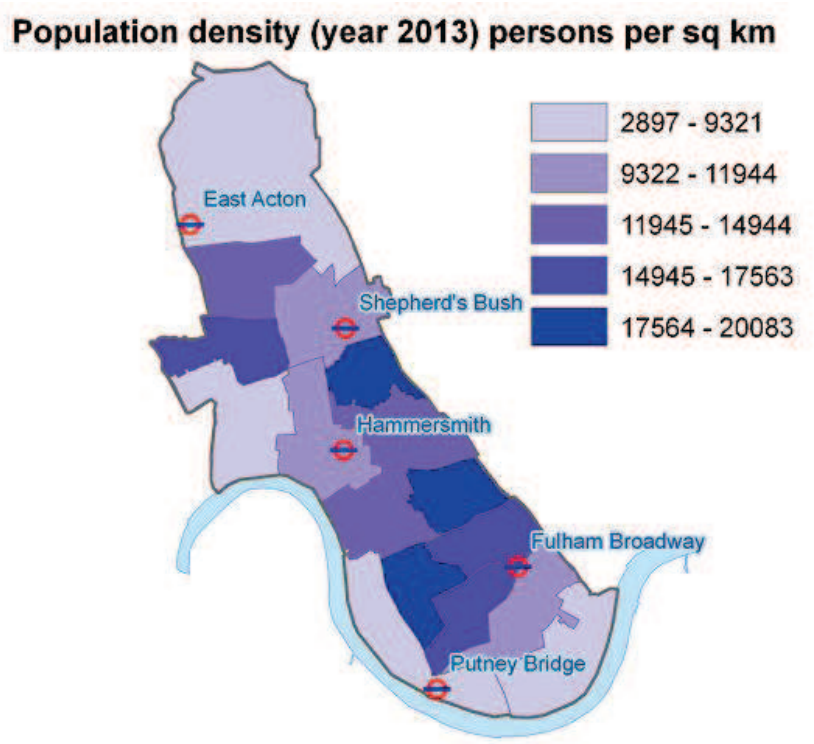


Figure 2.1: Population density in Hammersmith & Fulham

2.5 The Office for National Statistics estimates the resident population in 2011 census to be 182,493 people, and some of these will be registered with GPs outside of the borough. There are 198,900 patients registered with Hammersmith & Fulham GPs but not all of these patients will live within the borough. The population is expected to increase in the medium to long term, particularly in areas such as White City in the north of the borough where number of births are highest.

Ward	Population - 2013
Addison	11,450
Askew	14,050
Avonmore and Brook Green	12,350
College Park and Old Oak	9,850
Fulham Broadway	11,200
Fulham Reach	11,500
Hammersmith Broadway	12,050
Munster	10,950
North End	12,050
Palace Riverside	7,500
Parsons Green and Walham	10,750
Ravenscourt Park	10,800
Sands End	13,050
Shepherd's Bush Green	12,450

Town	11,150
Wormholt and White City	13,450

Table 2.2: Population breakdown by Ward (GLA SHLAA Trend based Population Projection data, and Mid year estimates 2013)

2.6 The population is characterised by a large proportion of young working age residents, high levels of migration in and out the borough, and ethnic and cultural diversity. Although residents have a higher life expectancy than nationally, there are significant areas of poorer health in the more deprived parts of the borough and therefore large health inequalities.

2.7 There are around 80,600 households in Hammersmith & Fulham, with an average household size of 2.2 persons. Around four out of ten households are single households, one fifth are occupied by families, and one in ten by lone parents. Single elderly households account for 13% of all households. The proportion of social and private rented housing is high compared to London and England.

2.8 Hammersmith & Fulham had the fifth highest population mobility rate in England and Wales in 2011, with one in five residents moving address in the previous year. Population 'churn' can create challenges around effective delivery of public health programmes such as screening and immunisation.

The large non-resident population must be taken into account when assessing the sufficiency of pharmacy provision in the borough; extended opening hours during weekdays is important for this demographic. The population is not limited by electoral boundaries and thus the availability of pharmacies near the border in surrounding boroughs must be concurrently assessed. This is discussed on page 49.

Age Structure

2.9 The age profile in Hammersmith & Fulham is typical of inner city areas, with a very high proportion of young working age adults, and a smaller proportion of older people and children. The 123,000 residents aged 16 to 64 represent 72.5% of the total population. This population structure impacts on the types and range of service required in the borough ().

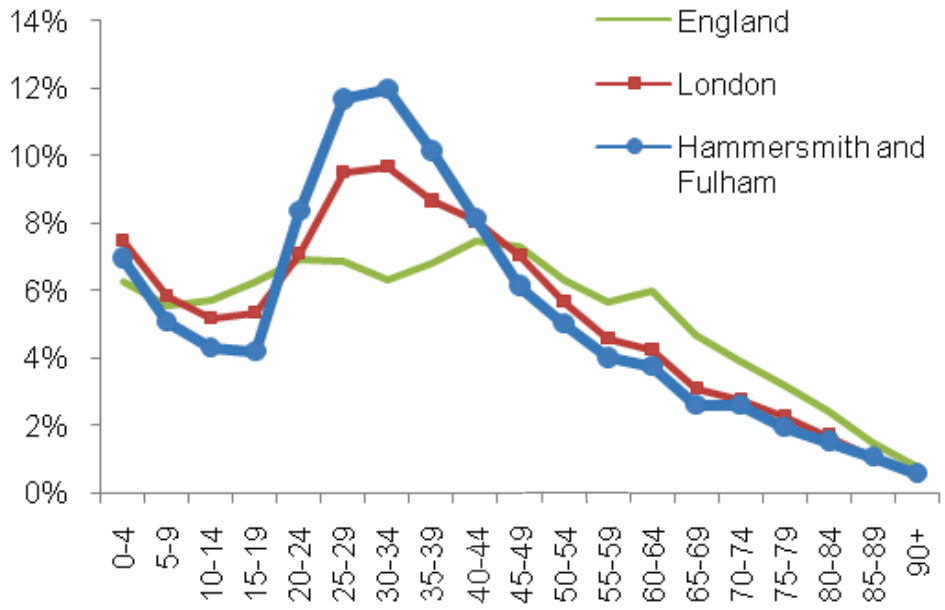


Figure 2.2: Population structure, 2011

2.10 Most of the 0- 15 population live in northern deprived wards, while a high proportion of older people live in affluent southern parts of Hammersmith & Fulham (Figure 2.3)

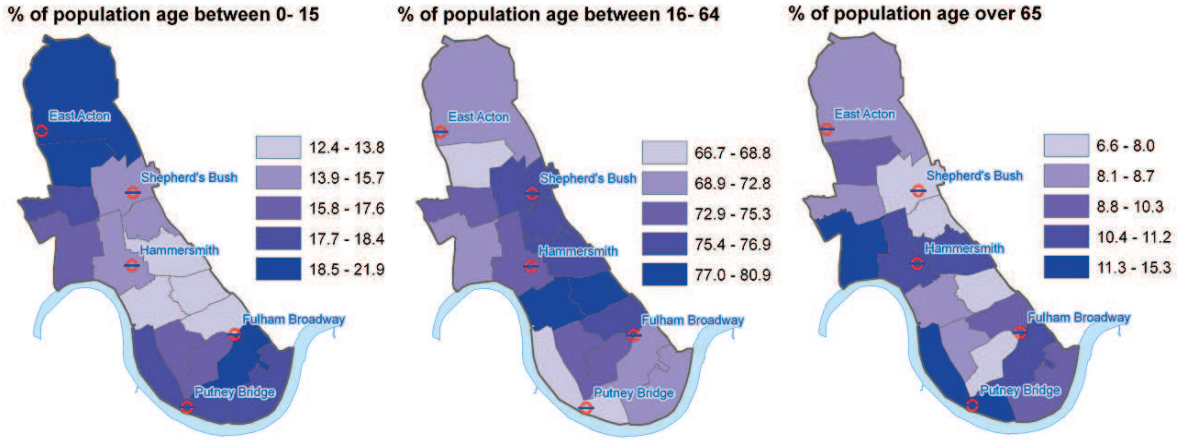


Figure 2.3: Maps showing location of population groups in Borough

Ward	Children aged 0-15 - 2013	Working-age (16-64) - 2013	Older people aged 65+ - 2013
Addison	1,800	8,750	900
Askew	2,500	10,400	1,150
Avonmore and Brook Green	1,550	9,500	1,300
College Park and Old Oak	1,950	7,100	850
Fulham Broadway	1,550	8,550	1,150
Fulham Reach	1,450	9,050	1,000
Hammersmith Broadway	1,850	8,900	1,250

Munster	1,750	8,250	950
North End	1,500	9,750	800
Palace Riverside	1,350	5,000	1,150
Parsons Green and Walham	2,000	7,550	1,200
Ravenscourt Park	1,900	7,650	1,250
Sands End	2,400	9,500	1,150
Shepherd's Bush Green	1,950	9,500	1,000
Town	1,950	8,350	850
Wormholt and White City	2,950	9,250	1,250

Table 2.3: Population structure of individual wards (GLA SHLAA Trend based Population Projection data, and Mid year estimates 2013)

The younger working population are usually considered to be low users of the healthcare system. However, pharmacies may provide enhanced services such as immunisations, minor ailment services and sexual health services which may be more accessible than GPs and secondary care and also reduce the demand on these services. As the population ages, the demand on health care and dispensing services increases. Accessibility is an important factor for the elderly population. This is discussed on 59.

Gender Structure

2.11 In terms of gender, according to the ONS Census 2011, there are 95 males for every 100 females (Figure 2.4).

2.12 Hammersmith & Fulham has a similar gender split to the rest of London and elsewhere in Great Britain, with the percentage of women being 1% greater and the percentage of men 1% lower. Because women live longer than men and due to the health inequalities between men and women, there are a much greater proportion of older women than older men among the H&F CCG population.

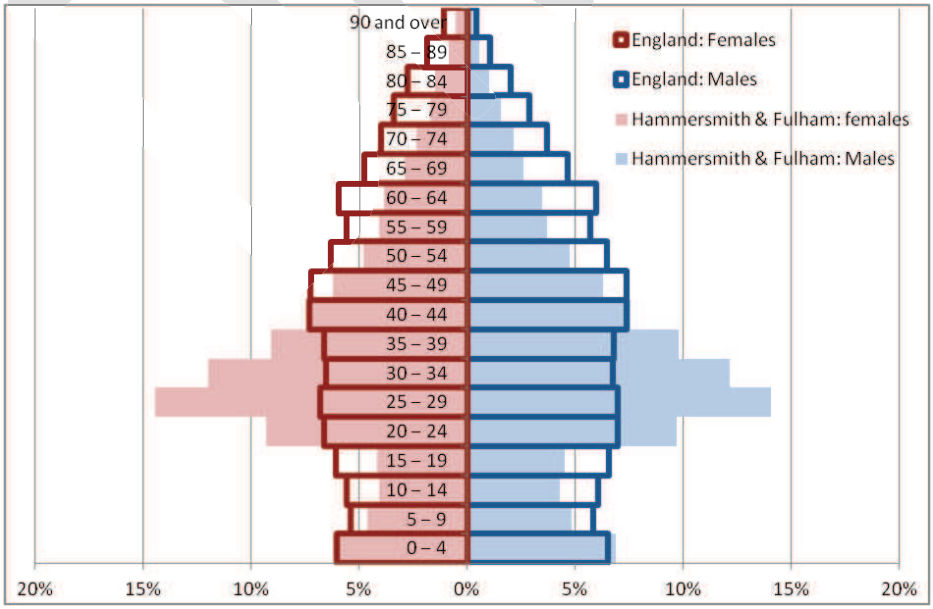


Figure 2.4: Proportion of resident population by age-band, 2011, Hammersmith & Fulham (Data source, ONS census 2011)

Ethnicity and diversity

2.13 The borough has a similar proportion of residents from 'White British', 'Black' and 'Other/mixed' ethnic groups in comparison to London. There are far more from the 'White other' category, and far fewer from the 'Asian' category, in comparison to London. The White other category includes those from Europe, Ireland, the Americas and Australia. 76% of the borough's state school children are from ethnic groups other than White British.

2.14 Nearly half of the resident population in Shepherd's Bush Green, Avonmore & Brook Green and North End wards were born outside UK.

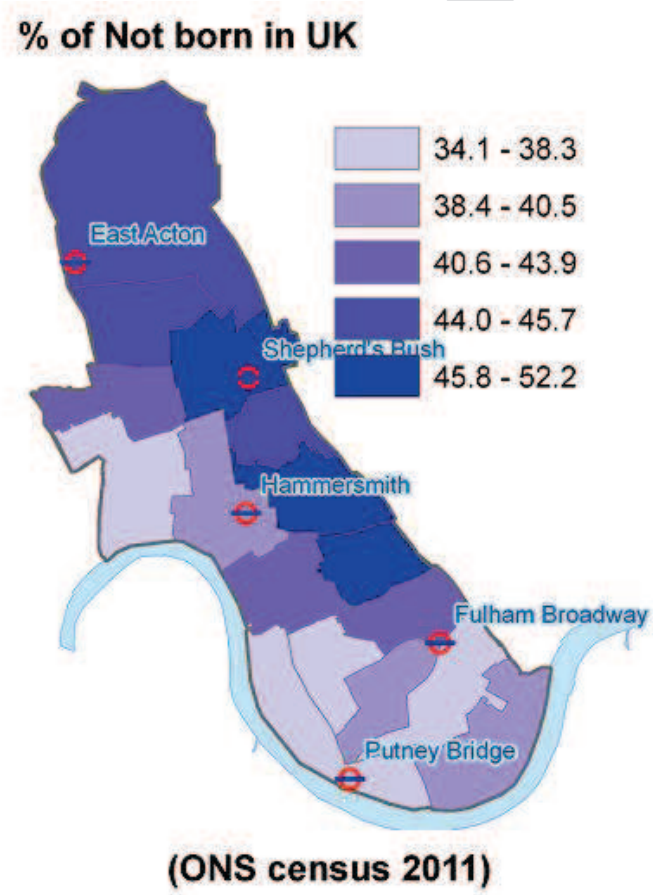


Figure 2.5: Percentage of residents not born in UK (Data source: ONS census 2011)

Ward	% Not Born in UK - 2011
Addison	44.1
Askew	42.5
Avonmore and Brook Green	52.2
College Park and Old Oak	45.7
Fulham Broadway	43.9
Fulham Reach	43.6
Hammersmith Broadway	40.5

Munster	38.3
North End	47.9
Palace Riverside	34.1
Parsons Green and Walham	38.2
Ravenscourt Park	37.3
Sands End	39.0
Shepherd's Bush Green	47.2
Town	40.5
Wormholt and White City	45.0

Table 2.4: Percentage of residents not born in UK (Data source: ONS census 2011)

2.15 The percentage of White British population during 2011 is lower than 2001 in Hammersmith & Fulham and significantly lower than England. On the other hand, there is an increase in white other population groups in Hammersmith & Fulham from 2001 to 2011 and is higher than England. There is also an increase in Asian and other/ mixed groups from 2001 to 2011 (Table 2.5).

2.16 Most of the minority ethnic groups in Hammersmith & Fulham reside in the northern deprived wards (Figure 2.6)

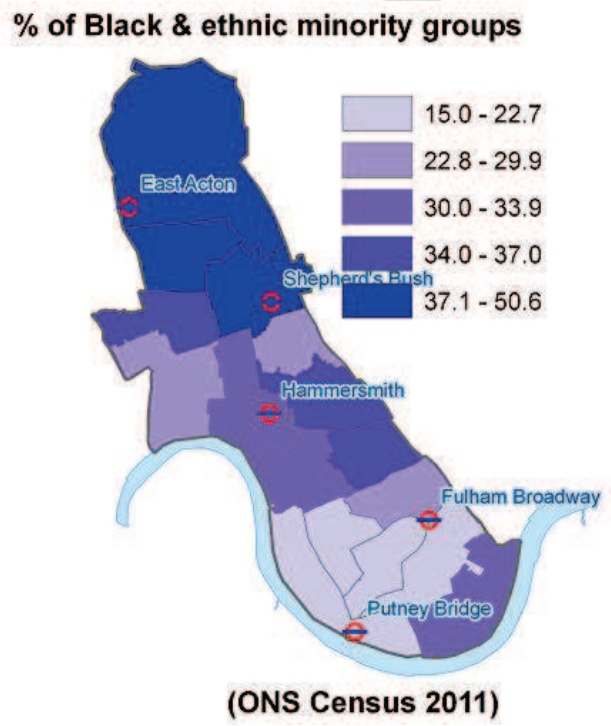


Figure 2.6: Distribution of black and ethnic minority groups in Hammersmith & Fulham

Figure 2.7:	Hammersmith & Fulham		London		England	
	2001	2011	2001	2011	2001	2011
White British	58%	45%	60%	45%	87%	80%
White Other	20%	23%	11%	15%	4%	6%
Black	11%	12%	11%	13%	5%	3%

Asian	4%	9%	12%	18%	2%	8%
Other/ Mixed	7%	11%	6%	8%	2%	3%
White	78%	68%	71%	60%	91%	86%
BME	22%	32%	29%	40%	9%	15%

Table 2.5: Population by ethnicity 2001 and 2011 census, all ages (Data source: ONS census 2001 and 2011)

Ward	% BAME - 2011
Addison	27.9
Askew	37.0
Avonmore and Brook Green	35.5
College Park and Old Oak	50.0
Fulham Broadway	29.9
Fulham Reach	30.5
Hammersmith Broadway	33.9
Munster	19.3
North End	34.2
Palace Riverside	15.0
Parsons Green and Walham	17.8
Ravenscourt Park	26.7
Sands End	30.6
Shepherd's Bush Green	40.1
Town	22.7
Wormholt and White City	50.6

Table 2.6: Percentage of black and ethnic minority groups (Census 2011)

2.17 Analysis of data on patients registered with GPs suggests there are significant populations from Australia, New Zealand, Western and Eastern Europe, Somalia, Caribbean countries, the Philippines, Iraq and Iran. By far the most common minority language spoken is Arabic (). English is spoken as an additional language by 47% of the borough's state school children.

Language	%	Country	%
English	**77%**	UK	**61%**
French	**3.1%**	Australia	**3.7 %**
Arabic	**1.9%**	France	**2.4 %**
Spanish	**1.9%**	Poland	**1.7 %**
Polish	**1.6%**	New Zealand	**1.6 %**
Italian	**1.4%**	Ireland	**1.5 %**

Somali	1.3%	Somalia	1.5 %
Portuguese	1.3%	Italy	1.5 %
Persian/ Farsi	0.8%	USA	1.3 %
Tagalog/ Filipino	0.8%	Caribbean countries	1.2 %

Table 2.7: Most common languages spoken (2011 Census) and countries of birth (GP registrations)

2.18 Wards including College Park & Old Oak, Addison and Avonmore & Brook Green have a high percentage of households where their first language is not English among any of the households (Figure 2.7).

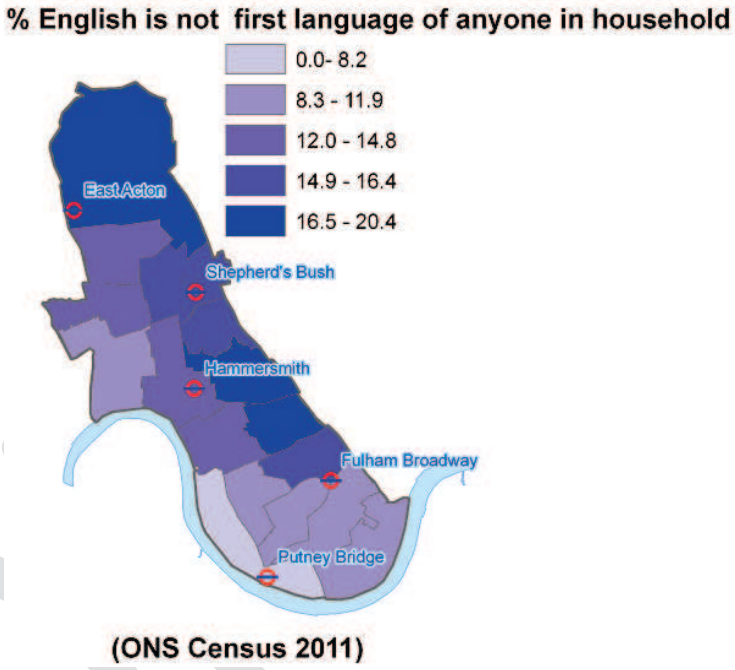


Figure 2.7: Percentage of population whom English is not first language for anyone in the household

Ward	% English is First Language of no one in household - 2011
Addison	15.8
Askew	14.8
Avonmore and Brook Green	20.4
College Park and Old Oak	19.5
Fulham Broadway	15.6
Fulham Reach	14.0
Hammersmith Broadway	13.4
Munster	10.7
North End	19.4

Palace Riverside	8.2
Parsons Green and Walham	10.8
Ravenscourt Park	11.6
Sands End	11.8
Shepherd's Bush Green	16.4
Town	11.9
Wormholt and White City	14.3

Areas where diversity is higher correlate with areas of higher levels of deprivation and poorer health. Engagement with healthcare may be hampered by language and cultural barriers widening the health inequality gap. Pharmacies employ staff from diverse backgrounds who may be able to speak multiple languages.

Health and well-being

2.19 There is significant variation in **life expectancy** across the social gradient in Hammersmith & Fulham. The Slope Index of Inequality, which measures the absolute difference in life expectancy between the most and least deprived areas, shows a 7.9 year life expectancy gap for men and a 5.4 year gap for women. These are similar to the median figures for England (8.9 and 6.0 respectively). Both males and females in Addison ward have life expectancy while College Park & Old Oak men and women both have low life expectancy (Figure 2.8).

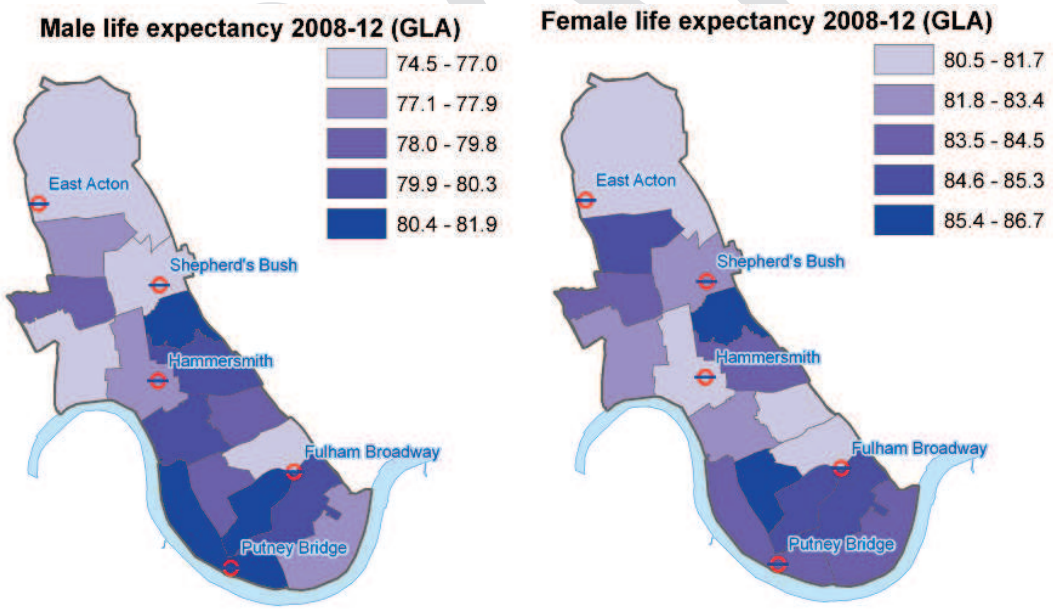


Figure 2.8: Life expectancy among males and females in Hammersmith & Fulham

Ward	Male life expectancy - 2008-2012	Female life expectancy - 2008-2012
Addison	81.0	86.7
Askew	79.8	84.5
Avonmore and Brook Green	80.2	84.3
College Park and Old Oak	74.5	81.2

Fulham Broadway	77.0	80.5
Fulham Reach	80.3	82.0
Hammersmith Broadway	77.4	81.4
Munster	79.4	85.4
North End	79.4	81.7
Palace Riverside	81.8	84.5
Parsons Green and Walham	79.9	85.1
Ravenscourt Park	76.2	82.5
Sands End	77.8	84.4
Shepherd's Bush Green	76.2	83.4
Town	81.9	85.3
Wormholt and White City	77.9	85.1

Table 2.8: Life expectancy among males and females in Hammersmith & Fulham

2.20 However, the gap appears to have widened over the last five years in Hammersmith & Fulham, for both men and women. Overall increases in life expectancy have been driven primary by improvements in the more affluent areas, with life expectancy in the more deprived areas remaining almost the same.

2.21 Prioritising action to reduce early death is important because work focused in particular areas or with particular groups has the power to reduce the variation in life expectancy that currently exists in the borough, thereby narrowing health inequalities.

2.22 High rates of mortality are observed among the most deprived parts of Hammersmith & Fulham (Figure 2.9).

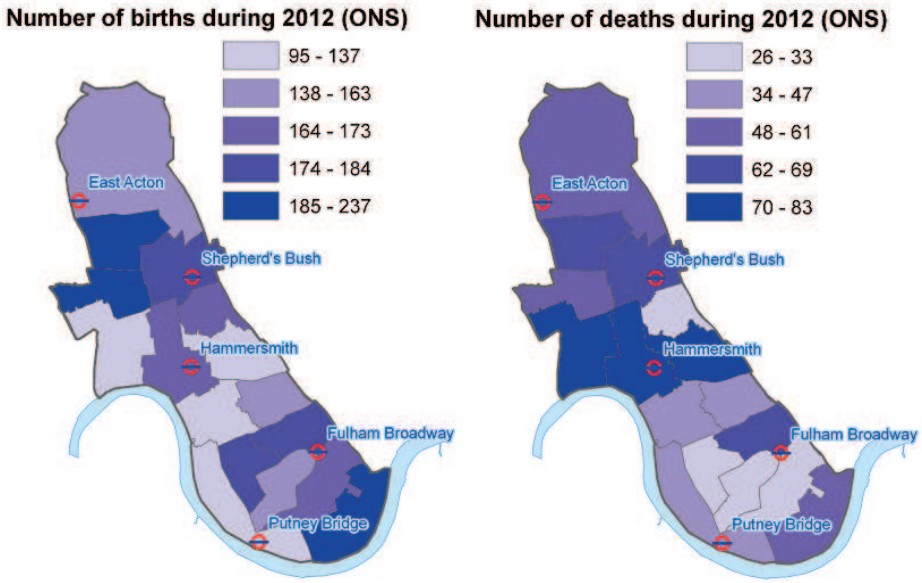


Figure 2.9: Number of births and deaths in Hammersmith & Fulham (Data source: Office for National statistics, mortality files 2012)

2.23 People living in northern deprived wards and Hammersmith Broadway ward stated their day to day activities are limited due to their ill health.

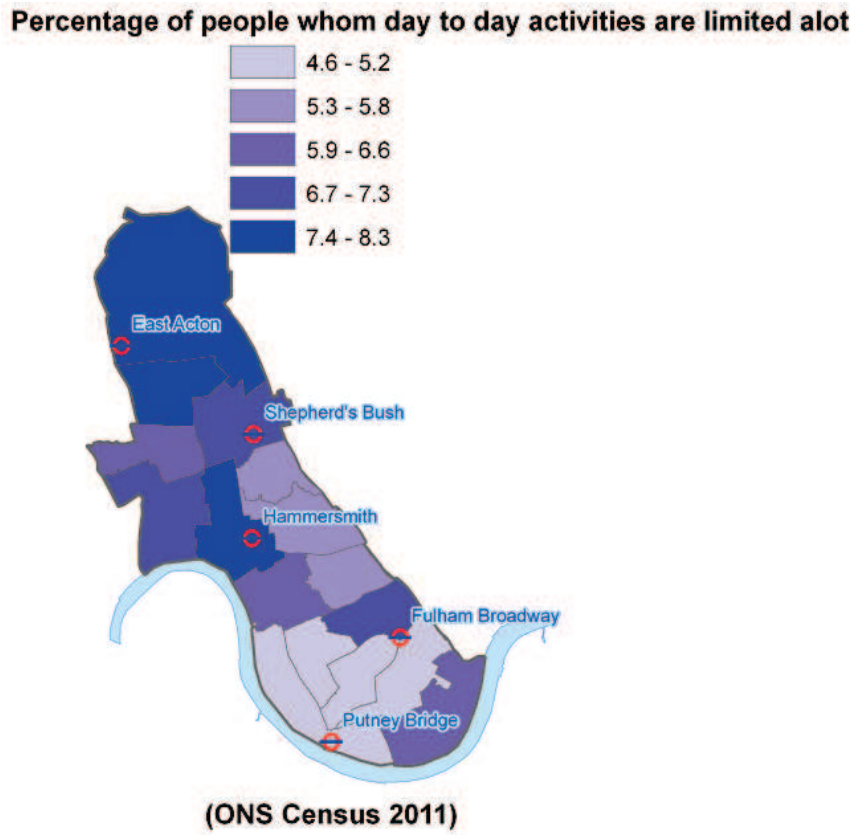


Figure 2.10: Percentage of people whom day to day activities are limited a lot due to ill health

2.24 This rise is caused by improvements in life expectancy and greater numbers of people born in the post war 'baby boom' who are approaching old age. The latter explains the predicted acceleration in numbers of 80+ year olds from around 2025 onwards. Those people living Palace Riverside, Sands End and Town wards have better subjective well-being score compared with rest of the wards in Hammersmith & Fulham (figure 2.25)

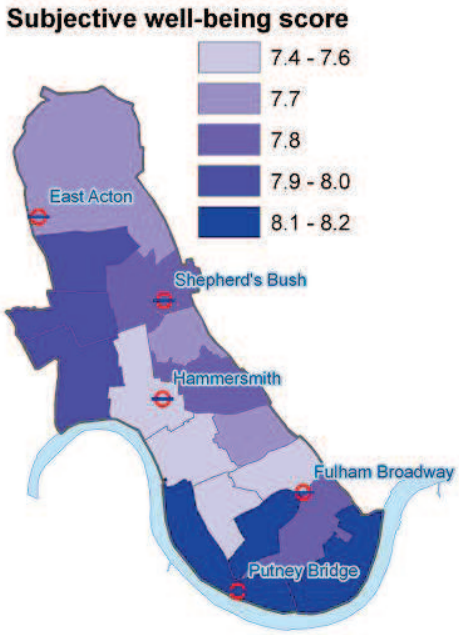


Figure 2.11: Subjective well-being of Hammersmith & Fulham population

2.25 Residents in Shepherd's Bush Green, Askew, and Hammersmith Broadway wards have stated that their health is either bad or very bad in the last census.

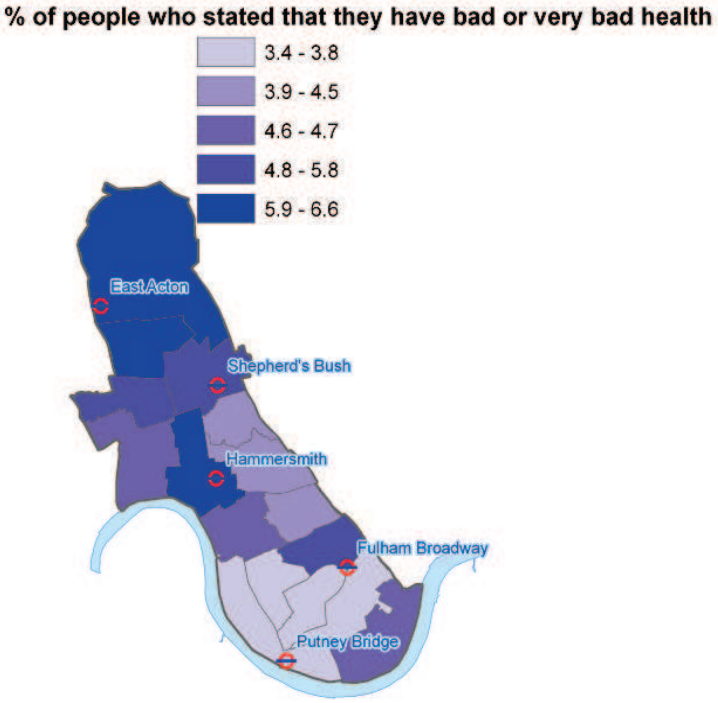


Figure 2.12: Percentage of people who stated their health is either bad or very bad

2.26 Incapacity benefit claimant rates due to mental health and other medical reasons are high in Shepherd's Bush, Wormholt & White City and Hammersmith Broadway (Figure 2.13)

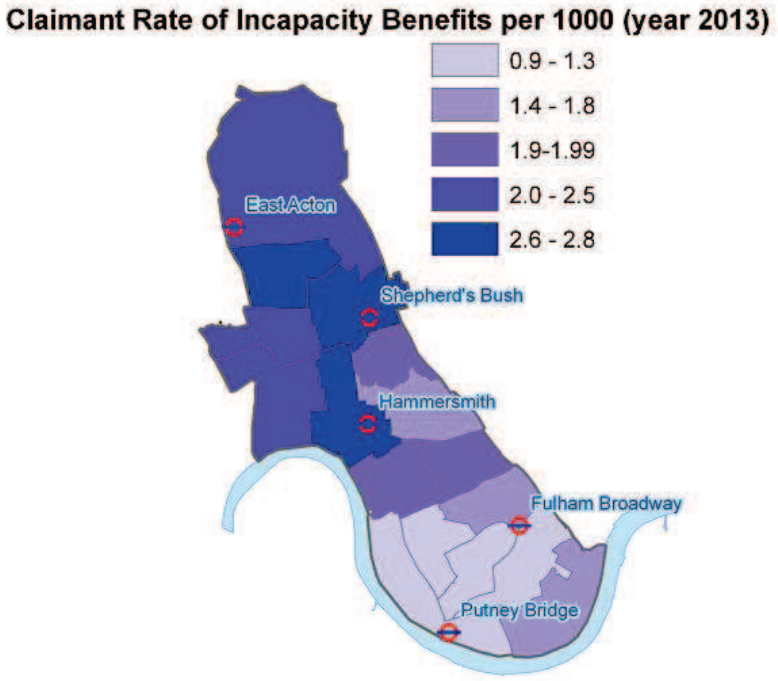


Figure 2.13: Incapacity benefit rates per 1000 in Hammersmith & Fulham

Patterns of ill health

2.27 The **overall premature (under 75) death rate** is higher than London and England, and Shepherd's Bush Green, Askew, and Hammersmith Broadway wards fall within the 20% worst wards in London, with around 7-11 more early deaths a year than is typical for London.

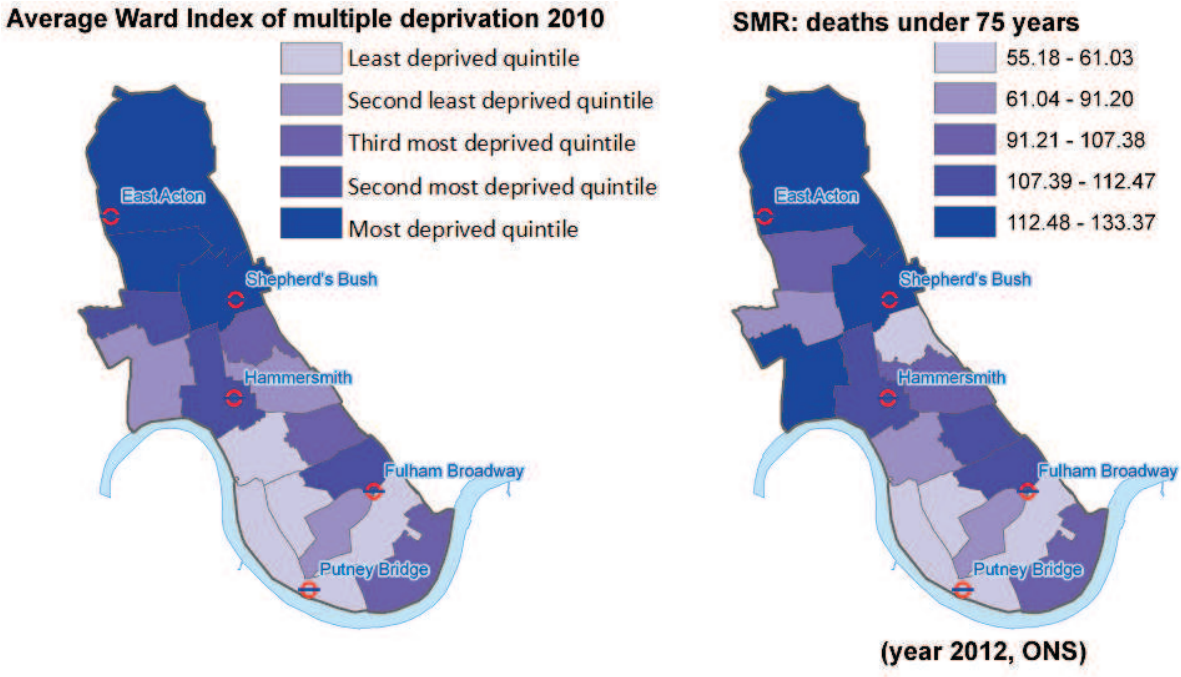


Figure 2.14: Map showing deprivation and premature mortality (under 75) in Hammersmith & Fulham

2.28 The principle cause of premature death in Hammersmith & Fulham is cancer, followed by cardiovascular disease (CVD) (which includes heart disease and stroke). A significant number of people also die from respiratory diseases (Figure 2.15). Accidents and injuries are most common among younger residents. This is pattern is broadly similar to the rest of the country.

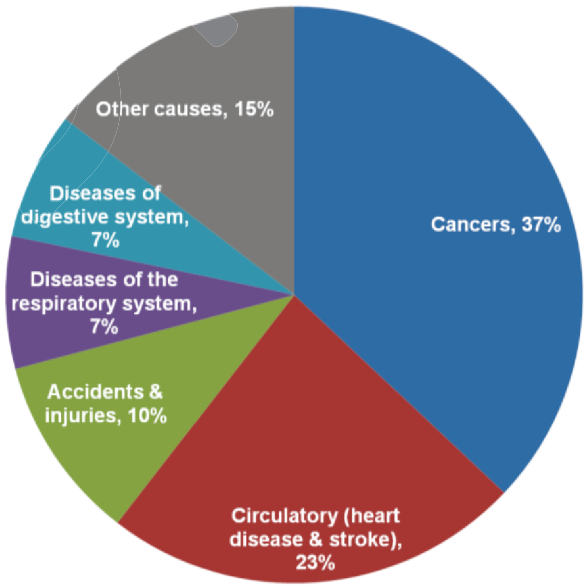


Figure 2.15: Premature deaths by cause, 2011

2.29 The premature death rate from **cancer** is higher than London and England. Five electoral wards (Askew, Fulham Broadway, Fulham Reach, Hammersmith Broadway, and Munster) have among the 20% worst rates in London, with around 2-3 more early deaths a year in each than London (Figure 2.16)

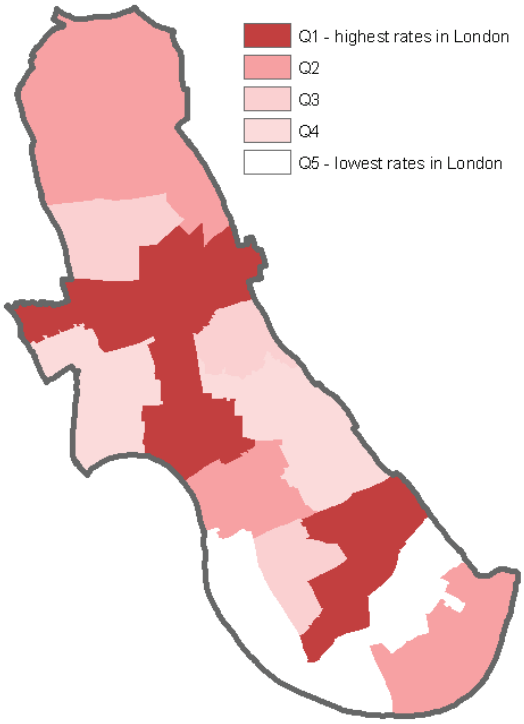


Figure 2.16: Cancer - Premature Mortality 2006-10 : Mortality rates by London quintile

2.30 Breast and cervical screening coverage rates continue to be among the lowest in the country, with local evidence population diversity, migration and high use of private services create a constant challenge to improvement. Survival from breast and lung cancer is higher in the borough than the London average. There are 1-3 deaths a year from cervical cancer in the borough.

2.31 Improvements in lifestyles, as well as more accessible and high quality care, have resulted in a modest decline in the early death rate for cancer. However, the change has been small compared to London and England (5% locally in the last decade, compared to 20% in London and 17% nationally). Nationally, issues still exist around early diagnosis of cancer, with chances of survival much poorer in areas of deprivation.

2.32 Currently 150 residents of the borough die prematurely each year from cancer, which is around 15 more than a typical London borough. Lung, breast and bowel cancer account for the greatest number of early deaths in the borough.

Pharmacists can play in an important role in the early detection and diagnosis of cancer. Raising awareness and talking to patients about signs and symptoms of different cancers really can save lives because it can result in earlier diagnosis and

better treatment options for patients.

2.33 The premature death rate from **cardio-vascular disease** is broadly similar to London but higher than nationally. Within the borough, Shepherd's Bush Green ward has among the 20% worst rates in London, with around 3 more early deaths a year, compared to London (Figure 2.17).

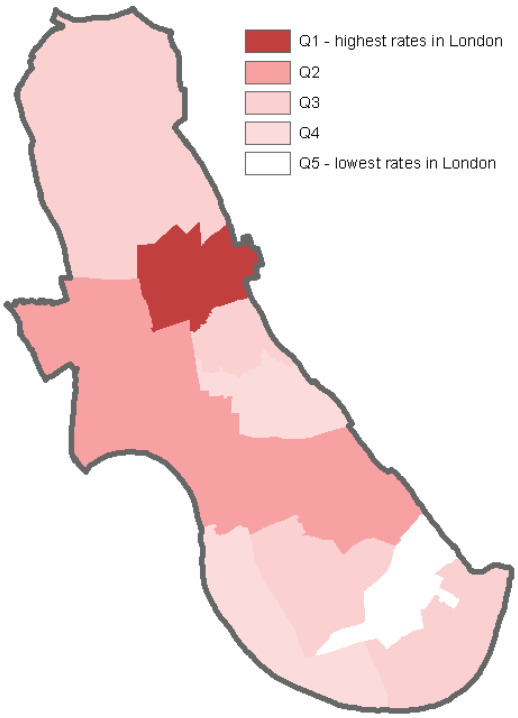


Figure 2.17: CVD - Premature Mortality 2006-10: Mortality rates by London quintile

2.34 There have been marked reductions locally in premature mortality from CVD in the past decade (by 46%), the result of factors such as more timely high quality treatment, effective prescribing, and a reduction in the number of smokers. Ten years ago, CVD was the primary cause of early death; it is now the second most common.

2.35 Currently 75 residents of the borough die prematurely each year from heart disease and 20 from stroke.

2.36 The premature death rate from **COPD** is higher than London and England. Five more people in the borough die before 75 from COPD than is typical for London. Hospital admissions are also much higher.

Pharmacies may provide **NHS Health Checks** (page 71) for people aged 40-74 years: carrying out a full vascular risk assessment and providing advice and support to help reduce the risk of heart disease, strokes, diabetes and obesity.

2.37 In the past, the hospital admission rate for accidents and injuries among 0-17 year olds has been high compared to London (and similar to England), although it appears

to be dropping. There are around 370 hospital admissions a year, and considerably more people are seen in A&E. There are much greater numbers in areas of deprivation, due to larger child populations in these areas, but also a greater likelihood of occurrence among these residents.

2.38 Road casualties are high among Shepherd's Bush green and College Park & Old Oak wards (Figure 2.18).

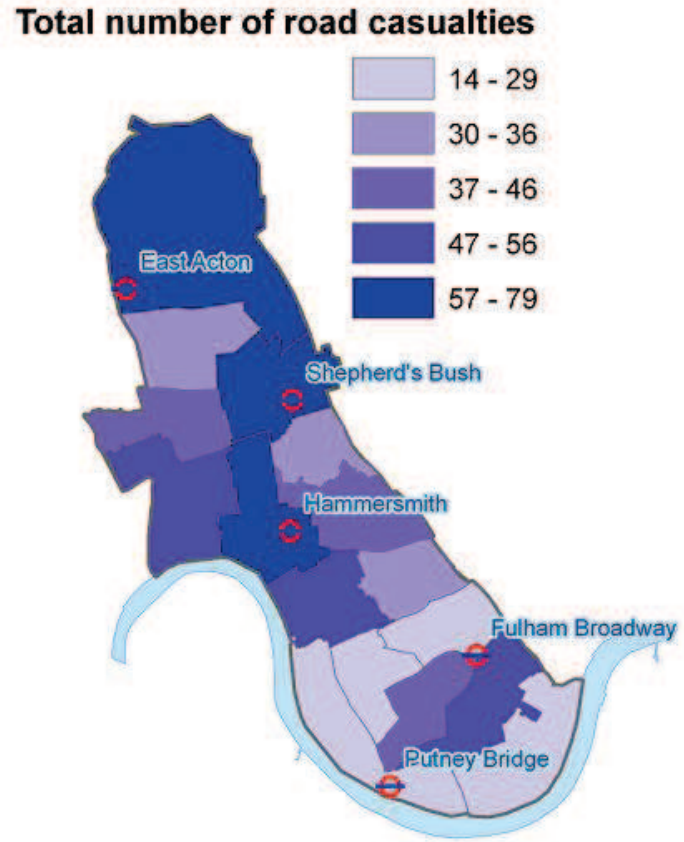


Figure 2.18: Total number of road casualties in Hammersmith & Fulham (Dep of Transport 2012)

2.39 There are currently 1,051 residents in Hammersmith & Fulham diagnosed with HIV, the 7th highest rate aged 15-59 in the country, with a higher proportion of cases contracted via sex between men. In 2010, 19% of cases were diagnosed late, compared to the London average of 27%. Late diagnosis carries with it increased risk of poor health and death and increases chances of onward transmission. High rates of HIV/ AIDs patients known to services are residing in North End ward.

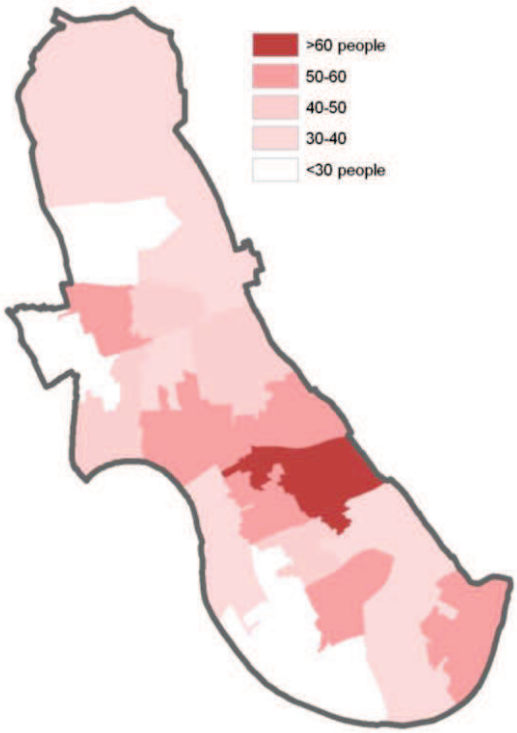


Figure 2.19: HIV/AIDS – People known to services, 2009

2.40 Hammersmith & Fulham have the 3rd highest rate of acute sexually transmitted infections in the country. Rates of Chlamydia among 15-24 year olds are less high but still above the national average.

2.41 There were 89 under 18 conceptions in the borough in 2010 - around 11 more than typical for a London borough - and 24 associated births. Deprived northern parts of the borough have high rates of teenage conception (figure 2.20). Teenage mothers nationally are three times as likely to suffer from post-natal depression, are less likely to breastfeed and more likely to smoke.

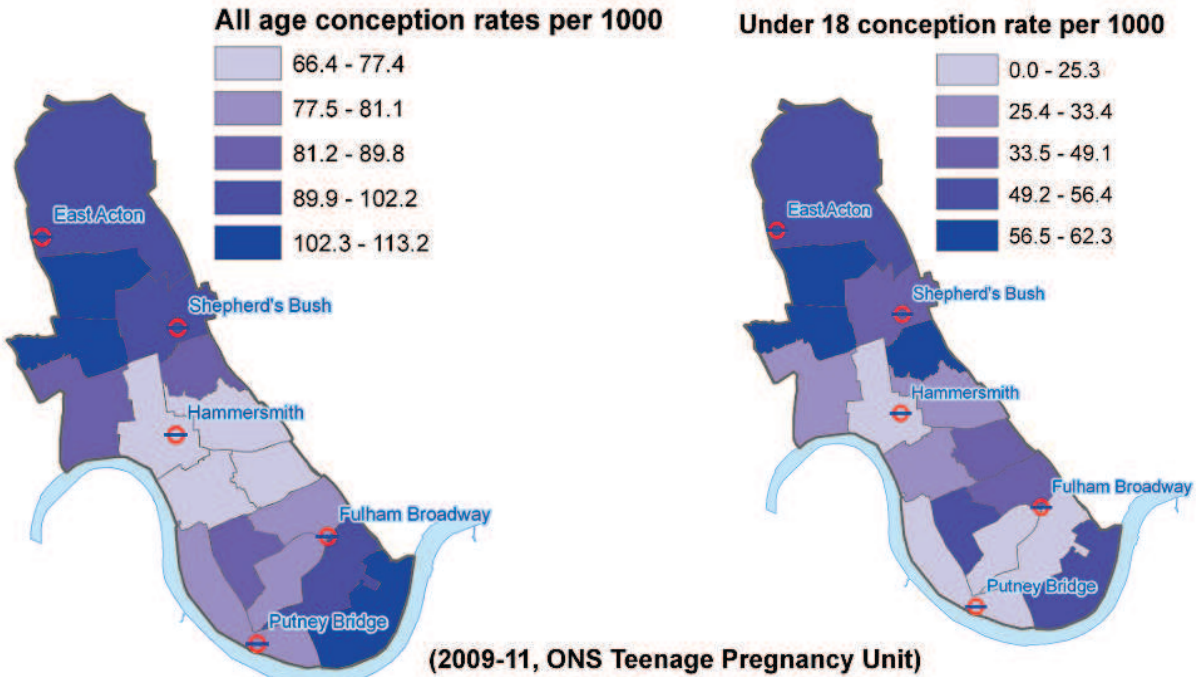


Figure 2.20: Teenage and all age conception rates

Pharmacies may provide **Sexual health services** such as emergency hormonal contraception services (page 75); condom distribution; pregnancy testing and advice; Chlamydia screening and treatment; other sexual health screening, including syphilis, HIV and gonorrhoea.

2.42 There are currently 2,395 patients in the borough on a GP register for severe and enduring mental illness (e.g. schizophrenia), the 8th highest in the country in 2010/11. These patients are spread relatively uniformly throughout the borough.

Medicines are a key component of mental health care and pharmacists have the expertise required to improve adherence to medication and bridge the gaps between services in different healthcare settings. Services such as **Medication Use Reviews** (page 63) and **New Medicine Services** (page 65) are examples of services that improve access to this group. Pharmacists also have the expertise to make a vital contribution to the reduction in the inappropriate use of medicines.

Lifestyles

2.43 The prevalence of smoking in Hammersmith & Fulham is, at 24%, the 4th highest in London (Figure 2.21). It is estimated that one in two long-term smokers dies prematurely and that around 6 hospital admissions per day in Hammersmith & Fulham are attributable to smoking.

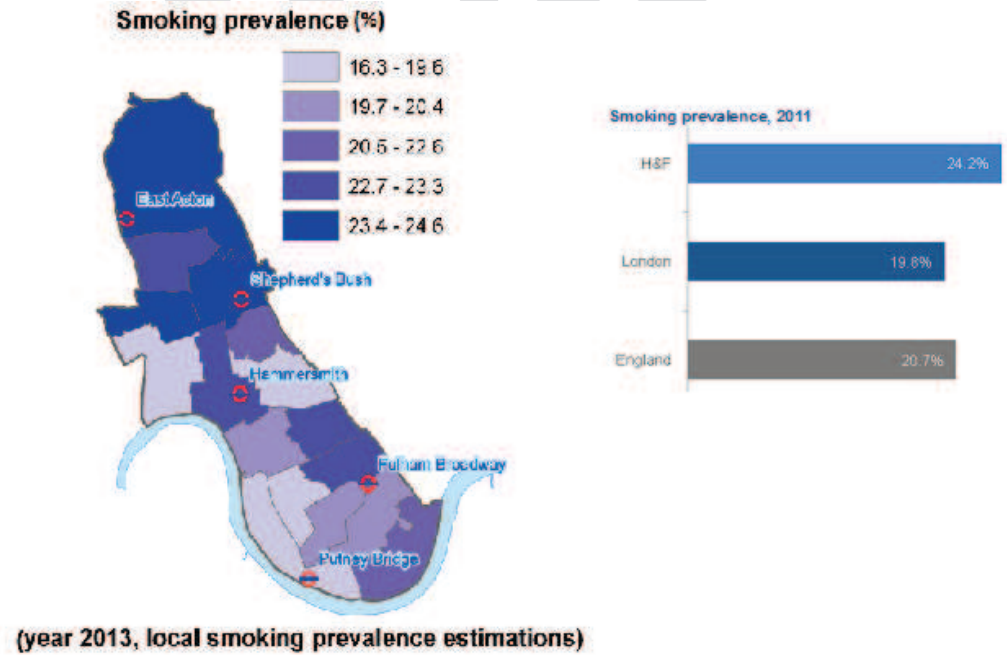


Figure 2.21: Map showing ward level smoking prevalence estimations (year 2013) and comparison of smoking prevalence with London and England (2011 British Household survey)

Pharmacies may provide **Stop smoking services** (page 73): proactive promotion of smoking cessation through to provision of full NHS stop smoking programme

2.44 Obesity can lead to a greater risk of heart disease, stroke, some cancers, high blood pressure, mental ill-health, and is likely to have contributed to 31% rise over 5 years in GP-recorded numbers with diabetes locally.

2.45 There are estimated to be 22,000 obese adults in the borough, 15% of the total. Levels of adult obesity have been rising nationally. Adult obesity rates are in deprived wards in the north (Figure 2.22). The cost to the local NHS from obesity is around £10-20 million a year.

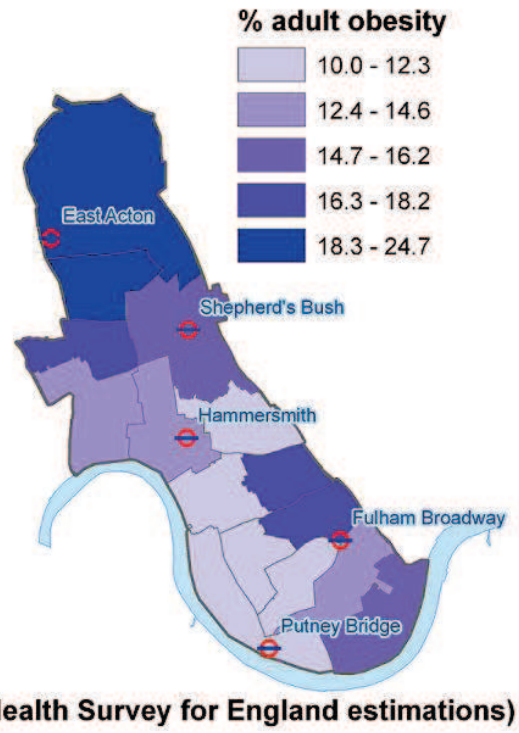


Figure 2.22: Adult obesity rates in Hammersmith & Fulham

2.46 Child obesity in Hammersmith & Fulham state primary schools has been consistently higher than **nationally** for Year 6 pupils (aged 10-11) over a period of time. These higher rates may in part be a result of physical inactivity and poor diet, which is also reflected in poorer than average levels of tooth decay locally. In 2010/11, 158 children in reception and 275 children in year 6 were found to be at risk of obesity (BMI 95th percentile) and 99 and 188 were classified as clinically obese (BMI 98th percentile). 10% of the borough's primary school children live outside the borough. Highest rates of childhood obesity rates were observed in Wormholt & White City in the north and Sands End, parsons Green & Walham and Town in the south.

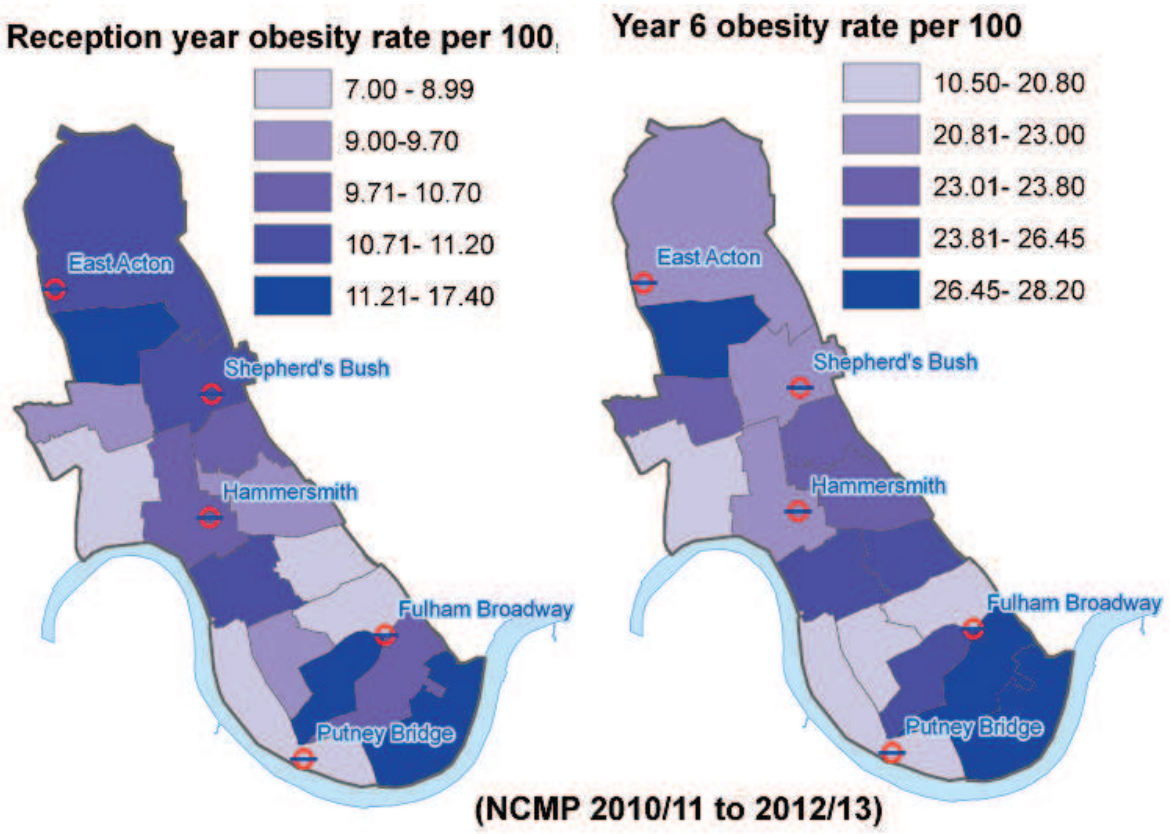


Figure 2.23: Level of childhood obesity in Hammersmith & Fulham

Pharmacies may provide **Weight management services**: promoting healthy eating and physical activity through to provision of weight management services for adults who are overweight or obese. They may also be involved in providing brief interventions to sign post patients towards increasing their physical activity and improving their diet.

2.47 Hospital admissions for alcohol-related and alcohol-specific harm (e.g. liver disease) are significantly higher in Hammersmith & Fulham than in London and England, as are alcohol-related crimes. Around 19 people every year in Hammersmith & Fulham die before 75 from chronic liver disease, 7 more than is typical for London. 'Hotspots' for alcohol-related admissions include the White City and Shepherd's Bush areas. Ambulance call outs for alcohol related illnesses during 2013 highest in Shepherd's Bush Green, Hammersmith Broadway and Parsons Green and Walham ()

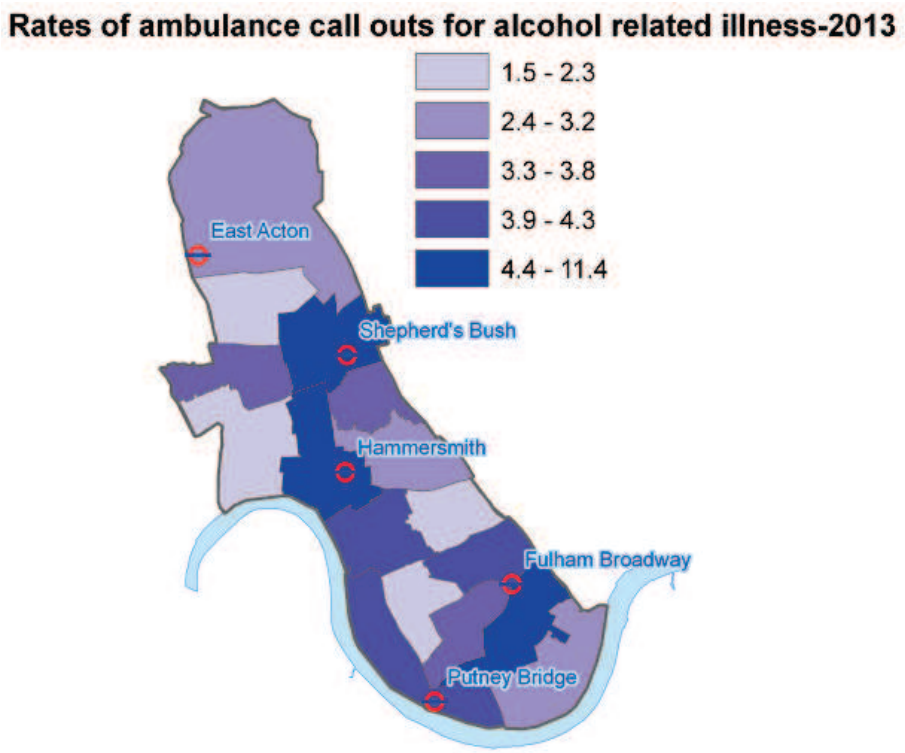


Figure 2.24: Ambulance call outs for alcohol related illnesses during 2013

Pharmacies may provide **Alcohol misuse services**: providing proactive brief interventions and advice on alcohol with referral to specialist services for problem drinkers

2.48 Hammersmith & Fulham is home to a significant prison population: HMP Wormwood Scrubs is a closed category B prison of around 1,200 male inmates. Most inmates are either on remand or serving shorter sentences.

2.49 Between one-third and one-half of the prison population nationally is drug-dependent, one-third is alcohol-dependent and up to three-quarters have a personality disorder. Local data identifies a smoking prevalence of 80-85%, and there are 50-70 referrals a month to mental health services.

2.50 There are likely to be in the region of 338 families financially affected by welfare reform by £20 a week or more, resulting from changes in legislation around housing benefit. There will also be further families affected from the introduction of Universal Credit, which may result in a changing population composition and need for services over the next few years. Local services are in the process of ensuring those at risk are supported through the process.

2.51 The estimated number of problem drug users in Hammersmith & Fulham was 1,450 in 2009/10, a rate of 11.5 per 1,000 population aged 15-64, the 9th highest rate in London. The cost to society of crimes associated with problem drug use in the borough may be as much as £60 million, (based on national estimates from the Home

Office).Drugs offence rate per 1000 is high among Shepherd's Bush, Hammersmith Broadway and North End wards (figure 2.23)

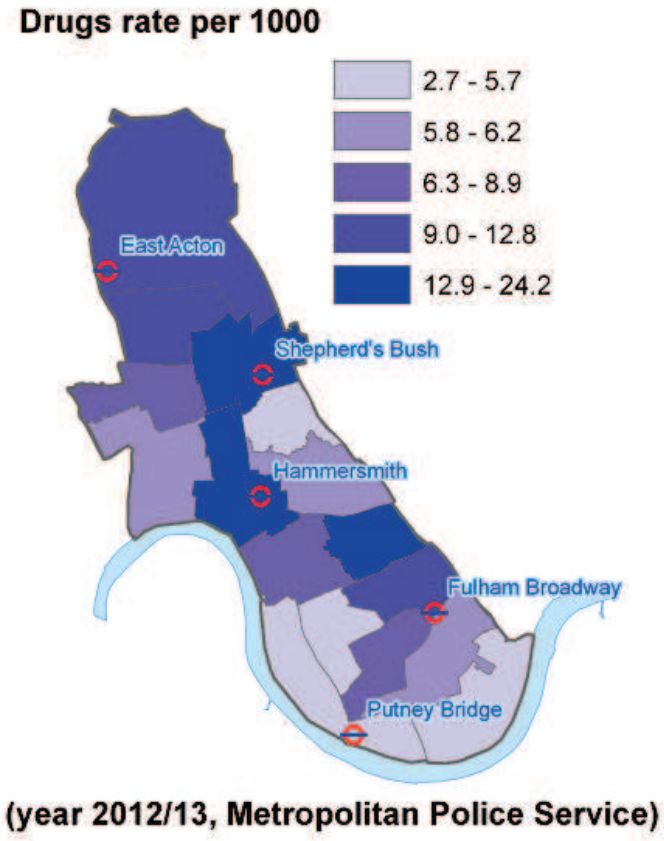


Figure 2.25: Drugs offence rate in Hammersmith & Fulham

Pharmacies may provide **Substance misuse services** (page 72): needle and syringe services; supervised consumption of medicines to treat addiction, e.g. methadone; Hepatitis testing and Hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situations

Protected Characteristics and Vulnerable Groups

2.52 A "protected characteristic" means a characteristic listed in section 149(7) of the Equality Act 2010. There are also certain vulnerable groups that experience a higher risk of poverty and social exclusion than the general population. These groups often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment.

2.53 As a part of the PNA process, we have examined the health needs of these different groups and the implications they may have on the PNA. The provision of services is discussed in Chapter 5.

Age

2.54 The current age profile of the borough is discussed earlier in this chapter and the future age projections are discussed later in this chapter.

2.55 Pharmacies provide essential services to all age groups such as dispensing, promotion of healthy lifestyles and signposting patients to other healthcare providers.

2.56 Staff who provide pharmaceutical services to children and vulnerable adults are required to be aware of the safeguarding guidance and the local safeguarding arrangements. This includes the reporting of concerns and so are alert to and act on indications that a child or vulnerable adult may be being abused, or at risk of abuse or neglect.

2.57 The younger population benefits specifically from enhanced services such as Minor Ailment Services and Sexual Health Services offered by certain pharmacies.

2.58 The elderly population in the borough is increasing which will increase the demand on dispensing. They are supported further by services such as the provision of the flu immunisation service, medicine use reviews (MURs) and new medicine services (NMS). There is potential to improve access to care home services. The increasing care home population may benefit from Care Home Services.

2.59 The HWB has not identified any gaps in access to the provision of pharmaceutical services based on age.

Disability

2.60 350 people are registered deaf or hard of hearing. 840 people are registered blind or partially sighted (NHS statistics 2011). 385 people are on the GP learning disability register (0.19% of the H&F GP population). An estimated 6,000 people are economically inactive due to long-term sickness or disability (3.9% of working age population (London 3.7%).

2.61 Those of working age with a disability are more likely to be living in areas of social housing. Disability among older people is likely to rise due to improved life expectancy and ageing of post war baby boom. Improved life expectancy at birth and better hospital care means increase in numbers with complex needs living in adulthood. Limited information is collected on patient disability.

2.62 All pharmacies must comply with the Disability Discrimination Act 1995 (now superseded by the Equality Act 2010). Pharmacy contractors may have assessed the extent to which it would be appropriate to install hearing loops, or provide access ramps wide aisles to allow wheelchair access. 30 of the pharmacies with a consultation room indicated that they were accessible to wheelchair users.

2.63 Accessible information formats are alternatives to printed information, used by blind and partially sighted people, or others with a print impairment. Nearly two thirds of the pharmacies that responded to the survey provide large prints (22/34). 18

pharmacies provide Easy read material. 3 pharmacies within the borough provide information in Braille.

2.64 The HWB has not identified any gaps in access to the provision of pharmaceutical services to the disabled population.

Sex

2.65 The current gender split is discussed earlier in this chapter. All essential services are provided equitably to both sexes. Pharmacies may provide relevant enhanced services specifically for women such as Emergency Hormonal Contraception through patient group directives.

2.66 The HWB has not identified any gaps in access to the provision of pharmaceutical services to the different genders.

Gender reassignment

2.67 Numbers for transgender and gender reassignment are not known locally. Nationally, around 1500 people aged over 15 years old are presently undergoing treatment for gender dysphoria per year. There is also a rapid growth (15% per year) in the number of people, of all ages, who are seeking medical treatment for profound and persistent gender dysphoria.

2.68 Pharmacies are involved in the pathway of gender reassignment in their role of dispensing medication. Almost all of the pharmacies who responded to the survey (33/36) have a clearly signposted private consultation room. Pharmacists who provide sexual health services have undergone extra training.

2.69 The HWB has not identified any gaps in access to the provision of pharmaceutical services to the population who have or are currently undergoing gender reassignment.

Sexual orientation

2.70 Little data is gathered around sexual orientation in the area. According to Stonewall, the size of the lesbian and gay population in the country may be in the region of 5-7% of the population.

2.71 As above, pharmacists provide their professional services irrespective of sexuality or sexual orientation.

2.72 The HWB has not identified any gaps in access to the provision of pharmaceutical services based on sexual orientation.

Marriage and civil partnership

2.73 Little data is gathered around the number of family breakdowns and adoptions in the area. The 2011 Census identifies 10.3% of the local adult population as separated or divorced, which is lower than the London and national averages.

2.74 The HWB has not identified any gaps in access to the provision of pharmaceutical services relating to this group.

Pregnancy and maternity

2.75 Pharmacies provide a range of services for women during the entire process of pregnancy and maternity, from provision of pregnancy testing to advice during the pregnancy such as medication reviews and stop smoking services and, in the postnatal period, provision of supplements and signposting to other medical professionals for both mother and baby.

2.76 The HWB has not identified any gaps in access to the provision of pharmaceutical services in pregnancy and maternity.

Race

2.77 The ethnic diversity and the impact on provision of pharmaceutical services is discussed earlier in this chapter.

2.78 The HWB has not identified any gaps in access to the provision of pharmaceutical services to the different ethnic groups.

Religion and belief

2.79 According to the 2011 Census data, 54% of the population in Hammersmith & Fulham were Christian, higher than London (48%) but lower than England. A far smaller proportion of the Hammersmith & Fulham population were Hindu, Jewish or Sikh compared to the London average

2.80 Hammersmith & Fulham has a diverse population as noted above and multiple religions are practiced within the borough.

2.81 The HWB has not identified any gaps in access to the provision of pharmaceutical services based on religion and belief.

Those struggling with substance abuse

2.82 The current need is discussed on page 36. Public Health Services are commissioned from Hammersmith & Fulham, and surrounding borough pharmacies, such as Supervised Consumption, Needle Exchange Services and Stop Smoking Services. These services improve access for this vulnerable group.

2.83 HWB has not identified any gaps in access to the provision of pharmaceutical services to those struggling with substance abuse.

The Homeless

2.84 Those sleeping rough in the borough have been found to have very high levels of emergency health care use and poor levels of health which could be avoided with better coordination and support. A recent JSNA (available at www.jsna.info) has highlighted gaps in service provision for rough sleepers in primary care resulting in excessive use of secondary care. A significant proportion of the homeless population tend to have multiple issues such as alcohol and drug dependence and mental health issues.

2.85 Pharmacies are ideally situated to target services for hard-to-reach populations such as homeless sleepers who are usually not registered with a GP.

2.86 The availability of pharmacies throughout the borough with extended opening hours and the provision of services such as Supervised Administration Services, Needle Exchange Services and Stop Smoking Services improve access for this vulnerable group.

2.87 HWB has not identified any gaps in access to the provision of pharmaceutical services to the Homeless Population.

Changing Patterns of Need

2.88 Obesity can lead to a greater risk of heart disease, stroke, some cancers, high blood pressure, mental ill-health, and is likely to have contributed to the 31% rise over 5 years in GP-recorded numbers of diabetes diagnoses locally.

2.89 Child obesity in Hammersmith & Fulham state primary schools has been consistently higher than nationally for Year 6 pupils (aged 10-11) over a period of time. These higher rates may in part be a result of physical inactivity and poor diet, which is also reflected in poorer than average levels of tooth decay locally. In 2010/11, 158 children in reception and 275 children in year 6 were found to be at risk of obesity (BMI 95th percentile) and 99 and 188 were classified as clinically obese (BMI 98th percentile). 10% of the borough's primary school children live outside the borough.

2.90 Alcohol-related harm is an increasing public health issue and Hammersmith & Fulham is an 'outlier': it has more hospital admissions for alcohol-related and specific harm (e.g. liver disease) and alcohol-related crimes than the national average. Over the last decade, alcohol-related admissions have more than doubled, faster than nationally. 'Hotspots' for alcohol-related admissions include the White City and Shepherd's Bush area.

2.91 The number of older people is expected to rise considerably over the next two decades. Although the rise experienced locally may not be as substantial as the rise nationally, it will nevertheless have a dramatic impact on demand for services. At the same time, the number of those providing unpaid care in Hammersmith & Fulham was the 4th lowest in the country in 2001.

2.92 Illnesses such as dementia, primarily prevalent among very old populations, will become increasingly commonplace. Currently, there are likely to be around 1,250 patients in Hammersmith & Fulham with dementia. By 2025, there are likely to be in the region of 1,500 patients. Earlier diagnosis of dementia is associated with delayed admission to nursing care.

Changing Population

2.93 The number of older people is expected to rise considerably over the next two decades. Although the rise experienced locally may not be as substantial as the rise nationally, it will nevertheless have a dramatic impact on demand for services. At the same time, the number of those providing unpaid care in Hammersmith & Fulham was the 4th lowest in the country in 2001.

2.94 Unless behaviour and services change, people will experience longer periods of time living with disability, resulting from improved survival rates from major diseases such as stroke, heart disease and cancer.

2.95 Illnesses such as dementia, primarily prevalent among very old populations, will become increasingly commonplace. Currently, there are likely to be around 1,250 patients in Hammersmith & Fulham with dementia. By 2025, there are likely to be in the region of 1,500 patients. Earlier diagnosis of dementia is associated with delayed admission to nursing care.

2.96 The proportion of the 80+ population is estimated to increase up to 20% by year 2030 (Figure 2.26). Public health issues for the older population, such as social isolation, physical inactivity, and falls, may become more commonplace, as will levels of disability and mobility issues.

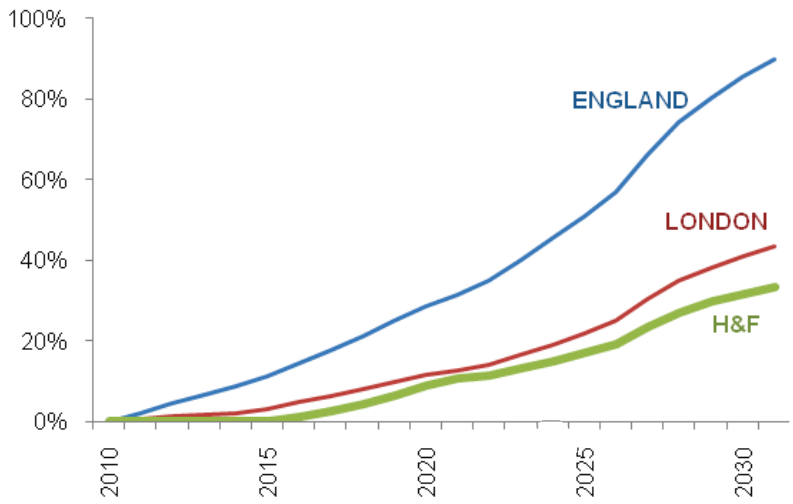


Figure 2.26: Projected growth population age 80+

2.97 Medical and social care advances have been leading to significant increases in the life expectancy of children with complex needs. This vulnerable population group may therefore need support over longer periods.

2.98 There are several proposed large scale development sites in the borough which may result in significant and concentrated increases in population if completed. All of these are likely to require reconsideration of pharmaceutical requirements if progressed. At present, timescales for development are likely to be longer than the timescale of the 2015-2018 PNA. According to the Greater London authority, there are 44 development schemes proposing 10 or more units either not started or under construction as at 29th September 2014 (Figure 2.27).

Figure 2.27: Potential new developments in Hammersmith & Fulham

2.99 As at 29th September 2014, 22 construction sites have started construction while another 22 have obtained planning permission. These new developments sites will increase the Hammersmith & Fulham population by over 14,000.

Ward	Construction not started	Construction started	All developments
Askew	32 (2)	40 (1)	72 (3)
Avonmore &Brook Green	63 (3)	38 (1)	101 (4)
College Park & Old Oak	0 (0)	223 (2)	223 (2)
Fulham Broadway	15 (1)	1006 (4)	1021 (5)
Fulham Reach	0 (0)	744 (1)	744 (1)
Hammersmith Broadway	413 (3)	540 (4)	953 (7)
North End	5919 (3)	0 (0)	5919 (3)
Palace Riverside	58 (1)	26 (1)	84 (2)
Parason'a Green & Walham	11 (1)	0 (0)	11 (1)
Ravenscourt Park	0 (0)	98 (2)	98 (2)
Sands End	241 (3)	1406 (4)	1647 (7)
Shepherd's Bush Green	3078 (5)	30 (1)	3108 (6)

Town	0 (0)	24 (1)	24 (1)
Total	22	22	14,005 (44)

Table 2.9: Expected increase in number of residents (number of developments) by ward of the location

The HWB believes that the current provision of pharmaceutical services (discussed in Chapter 5) is sufficient to meet the needs of the changing health and demographics of the population over the lifetime of this PNA (2015-2018).

Chapter 3 – Location of Health Services

Primary Care

3.1 NHS Hammersmith & Fulham Clinical Commissioning Group is the new organisation responsible for buying health services from Hospital Trusts, Mental Health Trusts and community organisations. Hammersmith & Fulham CCG is a membership organisation, made up of all 31 GP practices (Figure 3.1), and manage an annual budget of £256 million[1].

Figure 3.1: Map of GP practices in Hammersmith & Fulham

[1] Hammersmith and Fulham CCG Prospectus 2013–2014

Dentists

3.2 There are 28 dental practices in Hammersmith & Fulham

Figure 3.2: Map of dental practices in Hammersmith & Fulham

Acute Care and Mental Health Care

3.3 The main secondary care provider for Hammersmith & Fulham population is Imperial College hospitals (Hammersmith Hospital and Charing Cross Hospital). Mental health services are provided by West London Mental Health NHS trust.

Figure 3.3: Map showing location of Acute Trust sites and Urgent Care Centres

3.4 The PNA makes no assessment of the need for pharmaceutical services in secondary care. However there is interest in managing the transfer of patients across care settings, with particular regard to medicines review and reconciliation processes between hospital pharmacists and community pharmacists.

Community Services

3.5 Central London Community Healthcare (CLCH) is a NHS community healthcare provider in four London boroughs. Providing healthcare in the boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, and Westminster. They employ more than 3,000 health professionals and support staff to provide community and in-patient services to almost 1 million people across London.

3.6 Central London Community Healthcare NHS Trust provides range of services including a tuberculosis (TB) nursing service from Hammersmith Hospital, stroke services across Kensington & Chelsea, Hammersmith & Fulham and Westminster, Hammersmith NHS Urgent Care Centre provides a range of walk-in health services to the general public 7 days a week.

3.7 Hammersmith NHS Urgent Care Centre provides a range of walk-in health services to the general public from 7 days a week. Central London Community Healthcare NHS

Trust provides a range of services from Hammersmith Bridge Road including district nursing, school nursing, and speech and language therapy for adults.[2]

Taking into account the location, opening times and proposed changes to the above sources of prescriptions, the HWB believes that the current provision of pharmaceutical services (described in Chapter 4) is sufficient to meet the demands of the population during the lifetime of this PNA.

[2] http://www.clch.nhs.uk/about-us.aspx

Chapter 4 –Access to pharmaceutical Services

Pharmacy Distribution and Choice

4.1 There are currently 40 pharmacies on the NHS England pharmaceutical list for Hammersmith& Fulham as of the 7th of July 2014. These have been marked on Figure 4.1 and listed in Appendix A.

4.2 There are 22 community pharmacies per 100,000 resident population within Hammersmith & Fulham. This is similar to the London and England average (London 23; England 22)[3].

4.3 The PNA examines the geographical accessibility of pharmaceutical services and has hence used the postcode of the pharmacy to consider which borough the pharmacy belongs to. *My Pharmacy* (HF35) which is on NHS England's Kensington & Chelsea pharmaceutical list has been considered a Hammersmith & Fulham pharmacy as it lies geographically within Hammersmith & Fulham and was surveyed as a part of the Tri-borough.

3.8 There are 17 pharmacies that are located within 500m outside of the Hammersmith & Fulham borough border. These have been marked on figure 3.1 and listed in Appendix A. Geographically, Marcus Jones Pharmacy, Ealing (EA03) is within the Hammersmith & Fulham boundary but has not been included in the survey as it has its services commissioned by the Ealing Borough and will be included in their PNA.

4.4 The ward distribution of the pharmacies by electoral ward is shown in

Ward	Number of pharmacies
Addison	4
Askew	2
Avonmore and Brook Green	1
College Park and Old Oak	3
Fulham Broadway	2
Fulham Reach	3
Hammersmith Broadway	4
Munster	2
North End	2

3 General Pharmaceutical Services in England 2003-04 to 2012-13

Parsons Green and Walham	1
Sands End	1
Shepherd's Bush Green	9
Town	5
Wormholt and White City	2

4.5 Table 4.1. Palace Riverside and Ravenscourt do not geographically have a pharmacy located in them but - as seen on Figure 4.1 where a 500m radius buffer has been drawn from the centre of each Pharmacy postcode – the wards have good provision from pharmacies within a short distance near the border.

4.6 This map shows that most of the borough is within 500m of at least one pharmacy. The larger area in College Park & Old Oak that appears to not be covered consists of railway tracks. The other small areas not within a 500m radius of a pharmacy are only a short distance further from a pharmacy either within or outside the borough.

4.7 There are no dispensing doctors, mail order or internet based or distance selling pharmacies based in Hammersmith & Fulham.

4.8 There are no community pharmacies receiving payment under the Essential Small Pharmacies Local Pharmaceutical Services (ESPLPS) scheme and Local Pharmaceutical Service (LPS) schemes as of 1st October 2014 in Hammersmith & Fulham.

Figure 4.1: Pharmacies within Hammersmith & Fulham and surrounding Boroughs. Areas that are served by a pharmacy within 500m are coloured in red.

Ward	Number of pharmacies
Addison	4
Askew	2
Avonmore and Brook Green	1
College Park and Old Oak	3
Fulham Broadway	2
Fulham Reach	3
Hammersmith Broadway	4
Munster	2
North End	2
Parsons Green and Walham	1
Sands End	1
Shepherd's Bush Green	9
Town	5
Wormholt and White City	2

Table 4.1: Distribution of pharmacies by ward

The areas where there do not appear to be a pharmacy within 500m corresponds with areas with the lowest persons per hectare (Figure 2.1 on page 15). In particular, the area in the North of the borough in College Park and Old Oak has 10 persons per hectare when divided by LSOA (the lowest in the borough).

Transport Networks

4.9 The local population are not bound by electoral ward or borough boundaries when accessing pharmaceutical services. The excellent travel infrastructure available within Central London places many more pharmacies, both inside and outside the borough, within convenient access to our local population.

4.10 There are 15 London Overground and Underground stations in the borough (Figure 4.2)

4.11 There are is also a good bus transport links on the road network (Figure 4.3).

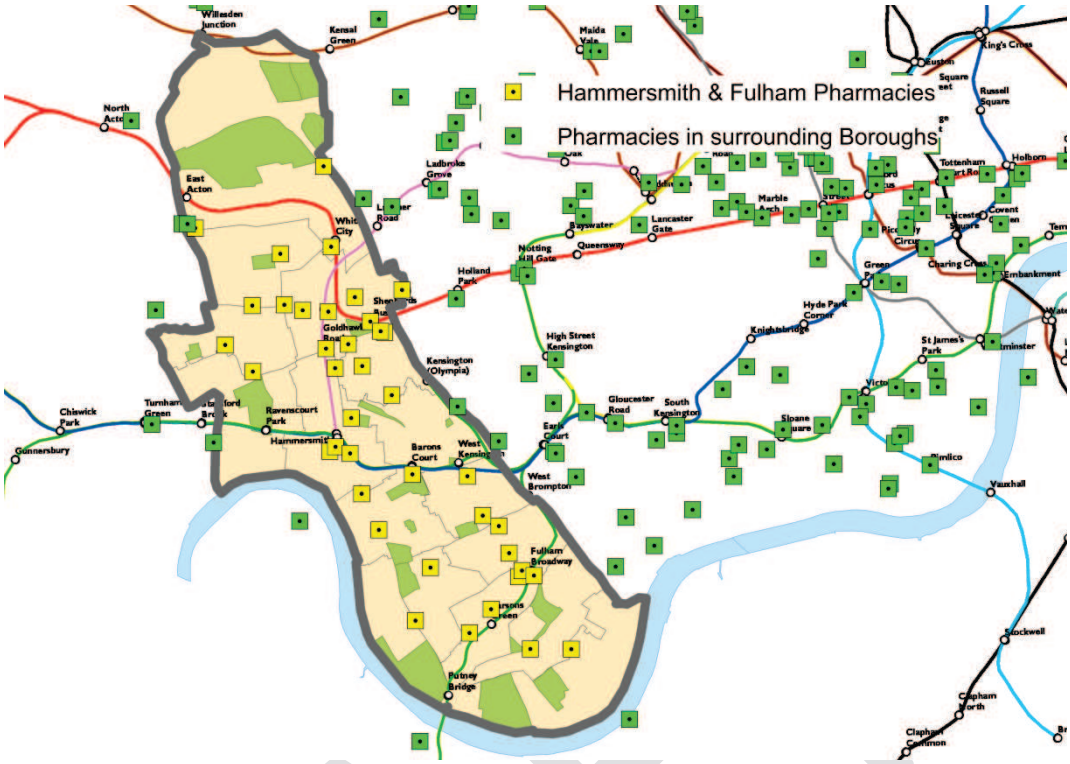


Figure 4.2: Tube networks

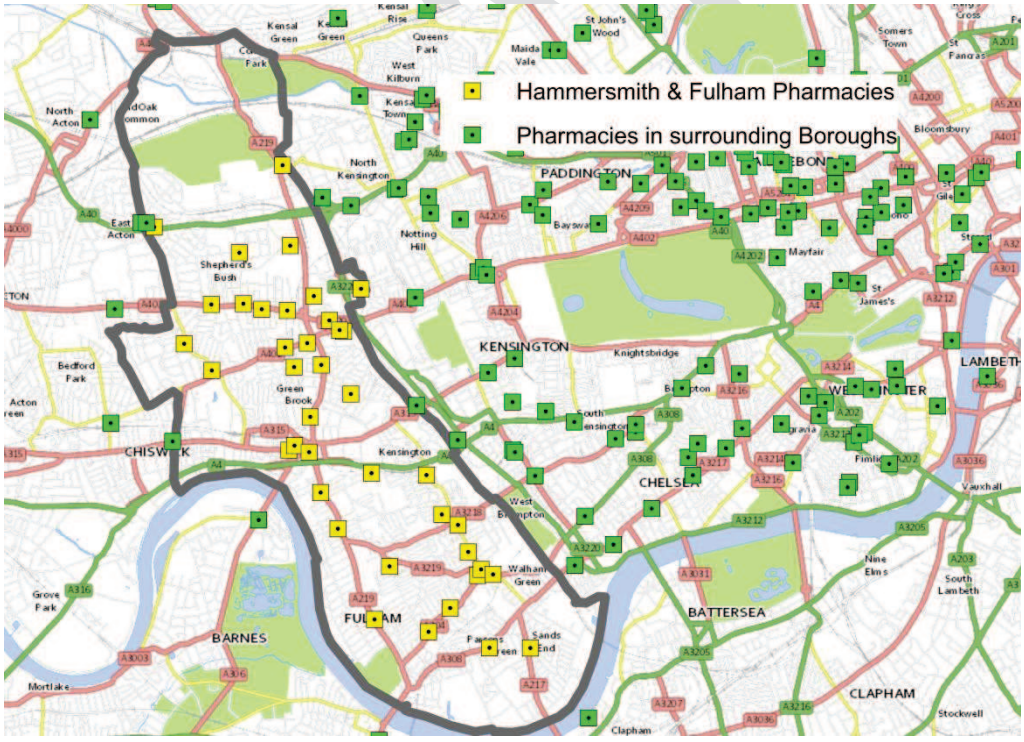


Figure 4.3: Road network

Opening times

4.12 Pharmacy contracts with NHS England stipulate the core hours during which the pharmacy must remain open. Further to these opening hours and if willing, a pharmacy may stay open longer as supplementary hours.

4.13 Opening times were obtained from NHS England in June 2014. They were also collected as a part of the pharmacy contractor survey. NHS England became aware that opening times reported by pharmacies in the contractor survey were different to those in their records. Any changes to core hours need to be agreed with NHS England but changes to supplementary hours as reported by the survey would be accepted as notice of change.

4.14 The PNA has used the core + supplementary hours reported by pharmacies from the contractor survey to produce the figures below. For pharmacies that did not respond and for pharmacies in surrounding boroughs, we have used the opening times as held by NHS England on June 2014. The PNA relies on the accuracy of data provided by NHS England who continue to retain the statutory responsibility to maintain the list of pharmacies. A supplementary statement will be made in the future if NHS England informs the HWB of any changes in opening times that impact the provision of services.

4.15 NHS England has one 100 hour pharmacy (core) on their list for Hammersmith & Fulham: Boots the Chemist on Fulham Road, SW6 1BH.

4.16 It should be noted that Kensington & Chelsea has a pharmacy that is open 24 hours a day, 7 days a week, Zafash Pharmacy (KC13), which is easily accessible by Hammersmith & Fulham residents.

4.17 9 pharmacies are open before 9am within the borough on weekdays with a further 5 open in boroughs around Hammersmith & Fulham within 500m outside the border.

Figure 4.4: Pharmacies open before 9am on weekdays

Ward	Number of pharmacies
Addison	2
Askew	0
Avonmore and Brook Green	1
College Park and Old Oak	0
Fulham Broadway	0
Fulham Reach	0
Hammersmith Broadway	4
Munster	1
North End	0
Parsons Green and Walham	0
Sands End	0
Shepherd's Bush Green	0
Town	1
Wormholt and White City	0

4.18 There are 8 pharmacies open after 7pm on weekdays with a further 4 open in boroughs around Hammersmith & Fulham within 500m outside the border.

Figure 4.5: Pharmacies that close after 7pm on weekdays

Ward	Number of pharmacies
Addison	2

Askew	0
Avonmore and Brook Green	1
College Park and Old Oak	0
Fulham Broadway	0
Fulham Reach	0
Hammersmith Broadway	2
Munster	1
North End	0
Parsons Green and Walham	0
Sands End	0
Shepherd's Bush Green	1
Town	1
Wormholt and White City	0

4.19 Most pharmacies are open on Saturdays (37/41) within the borough with a further 15 open in boroughs around Hammersmith & Fulham within 500m outside the border.

Figure 4.6: Pharmacies open on a Saturday

Ward	Number of pharmacies
Addison	4
Askew	1
Avonmore and Brook Green	1
College Park and Old Oak	2

Fulham Broadway	2
Fulham Reach	2
Hammersmith Broadway	4
Munster	2
North End	2
Parsons Green and Walham	1
Sands End	1
Shepherd's Bush Green	9
Town	5
Wormholt and White City	1

4.20 There are 11 pharmacies open on a Sunday within the borough with a further 4 open in boroughs around Hammersmith & Fulham within 500m outside the border

Figure 4.7: Pharmacies open on a Sunday

Ward	Number of pharmacies
Addison	2
Askew	0
Avonmore and Brook Green	1
College Park and Old Oak	0
Fulham Broadway	1
Fulham Reach	1
Hammersmith Broadway	2

Munster	1
North End	0
Parsons Green and Walham	0
Sands End	0
Shepherd's Bush Green	2
Town	1
Wormholt and White City	0

4.21 The HWB believes that early morning, late evening, Saturday and Sunday access to pharmacies is **sufficient for supplying a necessary service with no gaps** in order to meet the need for pharmaceutical services in the borough. This is based on the current opening hours, the close proximity of pharmacies to local residents, and the lower demand for pharmacy services outside of office hours compared to within office hours.

Appliance contractors

3.9 Appliance contractors provide services to people who need appliances such as stoma and incontinence care aids, trusses, hosiery, surgical stockings and dressings. They range from small sole-trader businesses to larger companies. They do not supply drugs. However, pharmacies and dispensing doctors can also supply appliances.

3.10 There are currently no appliance-*only* contractors in Hammersmith & Fulham.

3.11 20 of the pharmacies that responded to the survey supply stoma care aids with 4 intending to begin within the next 12 months.

3.12 21 of the pharmacies that responded to the survey supply incontinence aids with 4 intending to begin within the next 12 months.

3.13 20 of the pharmacies that responded to the survey supply dressings with 1 intending to begin within the next 12 months.

3.14 There are no dispensing doctors or appliance contractors in Hammersmith & Fulham.

Communication

4.22 Pharmacies hire staff from a variety of ethnic backgrounds.

4.23 The most common languages spoken other than English in Hammersmith & Fulham are French, Arabic, Spanish and Polish. All of the above languages are spoken in at least one of the pharmacies in the borough. Table 4.2 lists the most common languages spoken by a member of staff in the pharmacies that responded to the survey.

Language	Number of pharmacies
Gujarati	22

Hindi	13
Urdu	13
Arabic	11
Polish	8
Punjabi	7
French	6
Farsi	5
Spanish	4
Swahili	4

Table 4.2: 10 languages spoken by a member of staff at the pharmacies that responded to the survey in Hammersmith & Fulham

Consultation Rooms

4.24 Ideally, pharmacies should have consultation areas/ rooms, with wheelchair access, in order to be able to offer a broad range of services.

6.1 Almost all the pharmacies in Hammersmith & Fulham that responded to the survey currently report having a clearly signposted private consulting room (33 out of 34 pharmacies) with two having access to an off-site consultation room or area. The one pharmacy that does not have a consulting room at the time of the survey is planning a room/area in the future. All of the consulting rooms comply with MUR/NMS requirements.

Disability Access

4.25 30 of the pharmacies with a consultation room indicated that they were accessible to wheelchair users.

4.26 Almost all the pharmacies surveyed have hand washing facilities close to the consultation room. 18 of the them off offer patients access to toilet facilities.

4.27 Accessible formats are alternatives to printed information, used by blind and partially sighted people, or others with a print impairment. Nearly two thirds of the pharmacies that responded to the survey provide large prints (22/34). 18 pharmacies provide Easy read material. 3 pharmacies within the borough provide information in Braille.

Delivery of medication

Pharmacies in Hammersmith & Fulham further improve access by providing delivery services to the local population.

	Number of pharmacies
Collection of prescriptions from surgeries	34
Delivery of dispensed medicines - free of charge on request	20
Delivery of dispensed medicines - free of charge to selected patient groups only	20
Delivery of dispensed medicines - chargeable	3

Table 4.3: Collection of prescriptions and delivery of medication (contractor survey)

Parking

4.28 2 of the 34 pharmacies surveyed have free car parking. 30 have paid car parking nearby. 24 pharmacies have disabled parking close to the premises.

Information Technology

4.29 All pharmacies are Release 1 enabled for Electronic Transfer of Prescriptions. 30 of the surveyed pharmacies are currently Release 2 enabled, with all the remainder intending to be enabled in the next 12 months.

4.30 18 of the pharmacies surveyed have access to an IT system within the consultation room. 14 of these pharmacies have access to patient records from this IT system.

4.31 Almost all the pharmacies (30/34) have access to Microsoft Office applications.

4.32 23 pharmacies have access to NHS.net email.

Chapter 5 - Services Provided by Pharmacies

Pharmaceutical Services

5.1 Pharmaceutical services in relation to PNAs include:

- **Essential services** which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service;
- **Advanced services** - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary
- **Locally Enhanced Services** - services commissioned locally by NHS England's area teams
- **Other Locally Commissioned Services** - Public Health Services commissioned by the Local Authorities in order to meet the needs of the population.

5.2 All pharmacy contractors must provide Essential services, but they can choose whether they wish to provide Advanced, Enhanced or Locally Commissioned services.

5.3 The provision for those services must:

(a) only be performed by appropriately trained and qualified persons; and

(b) only be provided:

(i) in accordance with relevant national guidelines or standards,

(ii) from premises that are suitable for the purpose, and

(iii) using the appropriate or necessary equipment.

Summary of Categorisation of Services

5.4 The categorisation of these services into those stipulated by the PNA regulations (defined in Chapter 1) for Hammersmith & Fulham has been summarised in Table 5.1 below. As there has been no significant change in the description of the population or its needs between this and the last PNA, this table rolls forward the assessment made in the last PNA with adjustment to reflect changes in regulation.

Necessary services: current provision (Schedule 1, paragraph 1)	**Necessary services: gaps in provision (Schedule 1, paragraph 2)**
Essential Services	No gaps in provision of necessary services
Other relevant services: current provision (Schedule 1, paragraph 3)	
Medicine Use Review Service New Medicine Service Appliance Use Reviews Stoma Appliance Customisation Reviews H Pylori Breath Testing	

Other services (Schedule 1, paragraph 5)
Stop Smoking
Supervised Methadone Consumption
Needle Exchange Services
NHS Health Checks
Emergency Hormonal Contraception
Improvements and better access: gaps in provision (Schedule 1, paragraph 4)
Minor Ailment Service
Chlamydia Services
Chronic Obstructive Pulmonary Disease screening service
Alcohol misuse service
Weight management service

Table 5.1: Summary of Categorisation of services into those stipulated by PNA regulations

Essential Services

5.5 All pharmacies are required to deliver and comply with the specifications for all essential services. Compliance is assessed as part of the PCT contract monitoring process. Essential services are:

- Dispensing
- Repeat dispensing
- Disposal of waste medicines
- Support for self care
- Public health
- Signposting
- Clinical governance

5.6 The assessment of the adequacy of provision of essential services considers:

- Density of provision
- Geographical distribution of pharmacies, within and outside the borough
- Opening hours
- Accessibility

Essential Services - Necessary services: current provision (Schedule 1, paragraph 1)

The provision of Essential Services is a necessary service. The HWB believes that the current number, location and opening times of pharmacies in and outside the area of the HWB is sufficient for **supplying this necessary service with no gaps**.

Advanced Services

There are four Advanced Services within the NHS community pharmacy contractual framework. Community pharmacies can choose to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions.

Medicines Use Reviews (MURs)

5.7 The Medicines Use Review and Prescription Intervention Service (MUR) as part of the community pharmacy contractual framework was the first advanced service to be introduced. The purpose of the MUR service is, with the patient's agreement, to improve their knowledge and use of medicines, through a specific consultation between the pharmacist and the patient. In particular, by:

- establishing the patient's actual use, understanding and experience of taking medicines
- identifying, discussing and resolving poor or ineffective use of medicines
- identifying side effects and drug interactions that may affect the patient's compliance with the medicines prescribed for them
- improving clinical and cost effectiveness of medicines prescribed also helping to reduce medicines wastage

5.8 Currently 33 of the pharmacies that responded to the survey provide MURs with the remaining one intending to do so in the next 12 months.

5.9 NHS England provided, after the completion of the PNA consultation process, payment figures to pharmacies for this advanced service for the period April 2014 to August 2014. 35 pharmacies had activity during this period; a summary of activity during this period and a map showing the distribution of these pharmacies can be found below.

PNA Borough Code	Name	Ward
FE658	Boots the Chemist	Addison
FG861	Healthside Pharmacy	Addison
FTM33	Sophia Chemists	Addison
FXC05	Morrisons Pharmacy	Addison
FL905	Windwood Chemist	Askew
FT809	Tesco In-Store Pharmacy	Avonmore and Brook Green
FH822	Westway Pharmacy	College Park and Old Oak
FWH06	My Pharmacy	College Park and Old Oak
FPE14	Pestle & Mortar	College Park and Old Oak
FPV83	Superdrug	Fulham Broadway
FTP49	Boots the Chemist	Fulham Broadway
FRQ17	Rite-Chem	Fulham Reach
FY324	Boots the Chemist	Fulham Reach
FL310	Boots the Chemist	Hammersmith Broadway
FMF82	Superdrug	Hammersmith Broadway
FY620	Boots the Chemist	Hammersmith Broadway
FD872	Palace Pharmacy	Munster
FD905	Fontain Pharmacy	Munster

FK506	Parmay Pharmacy	North End
FE147	C. E. Harrod Chemist	Parsons Green and Walham
FCJ02	Day Lewis Pharmacy	Sands End
FAL39	Caregrange Pharmacy	Shepherd's Bush Green
FC883	Limegrove Pharmacy	Shepherd's Bush Green
FEE50	Bush Pharmacy	Shepherd's Bush Green
FFQ59	Superdrug	Shepherd's Bush Green
FPK47	Greenlight Pharmacy	Shepherd's Bush Green
FXM72	Faro Pharmacy	Shepherd's Bush Green
FYN39	Boots the Chemist	Shepherd's Bush Green
FHK46	Babylon Health Ltd	Shepherd's Bush Green
FM812	Pestle & Mortar	Shepherd's Bush Green
FD035	Chana Chemist	Town
FDQ50	Boots the Chemist	Town
FWC05	Fulham Pharmacy	Town
FRT73	Hamlins Chemist	Wormholt and White City
FV137	Jay's Pharmacy	Wormholt and White City

Table 5.2: Pharmacies that provided MURs in Hammersmith & Fulham during the period April 2014 – August 2014

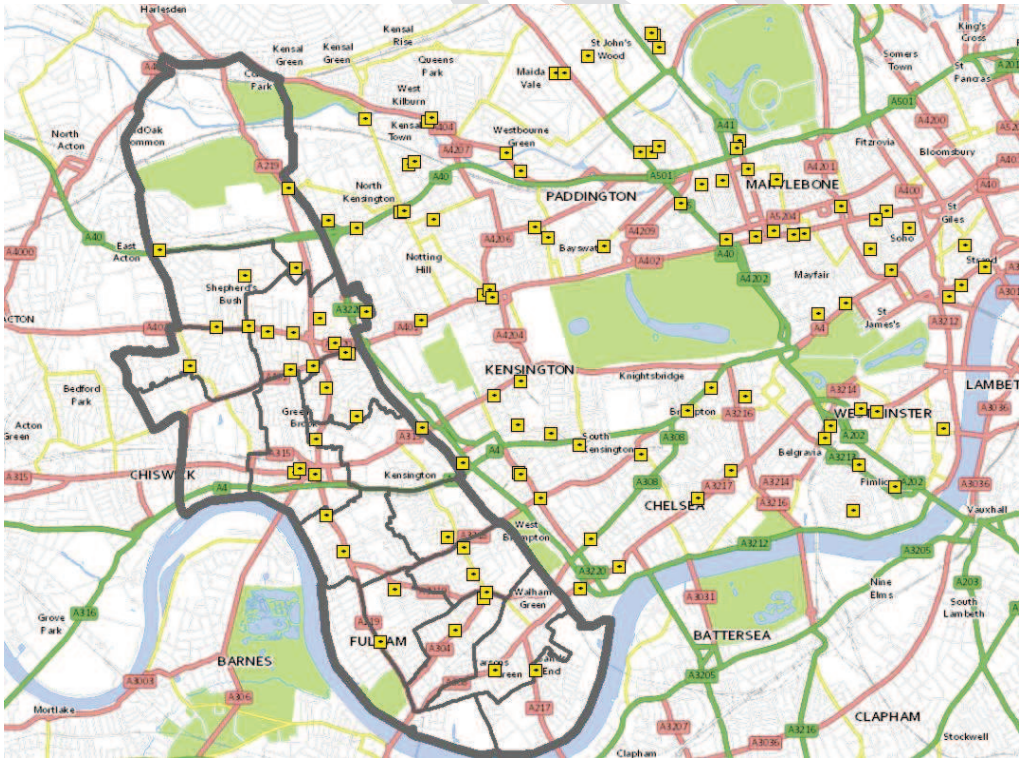


Figure 5.1: Pharmacies that provided MURs in the Tri-Borough during the period April 2014 – August 2014

MUR - Other relevant services: current provision (Schedule 1, paragraph 3)

The number and proximity of pharmacies locally means the vast majority of residents

in the borough live close to a pharmacy that provides MURs. Given the current low volume of use, this is a service that does not need to be provided within 500m. The HWB believes that the current provision of MURs is sufficient for **supplying a relevant service with no gaps.**

New Medicines Services (NMS)

5.10 The NMS is focused on the following patient groups and conditions:

- asthma and chronic obstructive pulmonary disease (COPD)
- type 2 diabetes
- antiplatelet/anticoagulant therapy
- hypertension.

5.11 The service aims to:

- help patients and carers manage newly prescribed medicines for a long-term condition (LTC) and make shared decisions about their LTC
- recognise the important and expanding role of pharmacists in optimising the use of medicines
- increase patient adherence to treatment and consequently reduce medicines wastage and contribute to the NHS Quality, Innovation, Productivity and Prevention agenda
- supplement and reinforce information provided by the GP and practice staff to help patients make informed choices about their care
- promote multidisciplinary working with the patient's GP practice
- link the use of newly-prescribed medicines to lifestyle changes or other non-drug interventions to promote well-being and promote health in people with LTCs
- promote and support self-management of LTCs, and increase access to advice to improve medicines adherence and knowledge of potential side effects
- support integration with LTC services from other healthcare providers and provide appropriate signposting and referral to these services
- improve pharmacovigilance, and
- through increased adherence to treatment, reduce medicines-related hospital admissions and improve quality of life for patients.

5.12 Currently 31 of the pharmacies that responded to the survey provide NMS with the remaining five intending to do so in the next 12 months.

5.13 NHS England provided, after the completion of the PNA consultation process, payment figures to pharmacies for this advanced service for the period April 2014 to August 2014. 27 pharmacies had activity during this period; a summary of activity during this period and a map showing the distribution of these pharmacies can be found below:

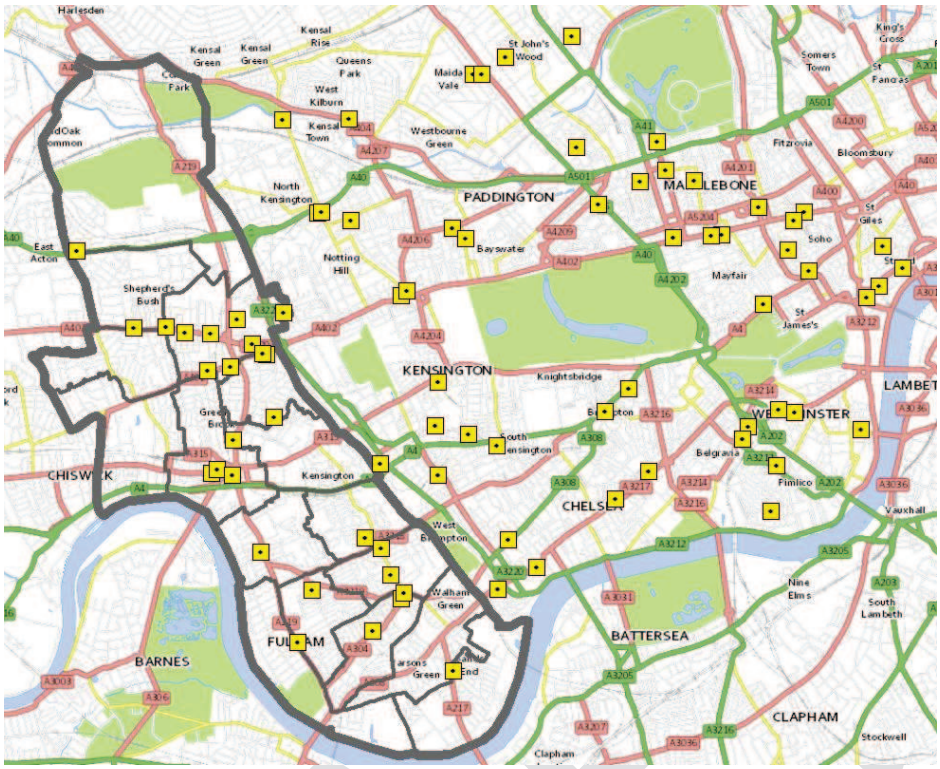


Figure 5.2:Pharmacies that provided NMS in the Tri-Borough during the period April 2014 – August 2014

PNA Borough Code	Name	Ward
HF09	Boots the Chemist	Addison
HF30	Sophia Chemists	Addison
HF36	Morrisons Pharmacy	Addison
HF29	Tesco In-Store Pharmacy	Avonmore and Brook Green
HF15	Westway Pharmacy	College Park and Old Oak
HF25	Superdrug	Fulham Broadway
HF31	Boots the Chemist	Fulham Broadway
HF39	Boots the Chemist	Fulham Reach
HF19	Boots the Chemist	Hammersmith Broadway
HF22	Superdrug	Hammersmith Broadway
HF40	Boots the Chemist	Hammersmith Broadway
HF05	Palace Pharmacy	Munster
HF06	Fontain Pharmacy	Munster
HF18	Parmay Pharmacy	North End
HF03	Day Lewis Pharmacy	Sands End
HF01	Caregrange Pharmacy	Shepherd's Bush Green
HF02	Limegrove Pharmacy	Shepherd's Bush Green
HF10	Bush Pharmacy	Shepherd's Bush Green
HF13	Superdrug	Shepherd's Bush Green
HF24	Greenlight Pharmacy	Shepherd's Bush Green

HF37	Faro Pharmacy	Shepherd's Bush Green
HF41	Boots the Chemist	Shepherd's Bush Green
HF17	Babylon Health Ltd	Shepherd's Bush Green
HF04	Chana Chemist	Town
HF07	Boots the Chemist	Town
HF34	Fulham Pharmacy	Town
HF32	Jay's Pharmacy	Wormholt and White City

Table 5.3: Pharmacies that provided NMS during April to August 2014

NMS - Other relevant services: current provision (Schedule 1, paragraph 3)

The number and proximity of pharmacies locally means the vast majority of residents in the borough live close to a pharmacy that provides NMS. Given the current low volume of use, this is a service that does not need to be provided within 500m. The HWB believes that the current provision of NMS is sufficient for **supplying a relevant service with no gaps.**

Appliance Use Reviews (AURs)

5.14 Appliance Use Review (AUR) is an advanced service that community pharmacy and appliance contractors can choose to provide so long as they fulfill certain criteria. AURs can be carried out by, a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home. AURs should improve the patient's knowledge and use of any specified appliance by:

- Establishing the way the patient uses the appliance and the patient's experience of such use
- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted

5.15 Currently 2 of the pharmacies that responded to the survey provide AURs with 9 intending to begin within the next 12 months. There are no appliance only contractors in Hammersmith & Fulham.

AUR - Other relevant services: current provision (Schedule 1, paragraph 3)

The HWB has identified the Appliance Use Review Service as a relevant service, as it secures improvements or better access to service provision.

Stoma Appliance Customisation Service (SAC)

The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure

proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

5.16 Currently 2 of the pharmacies that responded to the survey provide SACs with 8 intending to begin within the next 12 months. There are no appliance only contractors in Hammersmith & Fulham.

Locally Commissioned Services

5.17 Certain enhanced services may be commissioned by NHS England from 1 April 2013 in line with The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The responsibilities for commissioning some of the locally enhanced services under the previous regulations now sits within public health and are commissioned by Local Authorities. These are described later as "Other Services" later in this chapter reflecting Regulation 4 and Schedule 1 of the 2013 Regulations.

5.18 The trend nationally since 2005-06 shows that the number of locally commissioned and funded enhanced services increased significantly until 2011-12 when there was an overall decrease of commissioned services, a trend which continued into 2012-13. This may have been due to the uncertainty around the new structure of the NHS following the introduction of the Health and Social Care Act 2012 which came into force from 1 April 2013. PCTs, now abolished, may have been cautious about commissioning services with new contractors in light of these changes.

5.19 The following section defines the enhanced services currently commissioned and explores their relevance to the local population and their current and future commissioning.

Flu Vaccinations

5.20 Flu vaccination by injection, commonly known as the "flu jab" is available every year on the NHS to protect certain groups who are at risk of developing potentially serious complications, such as:

- anyone over the age of 65
- pregnant women
- children and adults with an underlying health condition (particularly long-term heart or respiratory disease)
- children and adults with weakened immune systems

5.21 Pharmacies have been commissioned to provide flu vaccination across the borough. These are shown and listed below. NHS England were unable to provide the volume of immunisations provided. However, GPs currently provide the bulk of these vaccinations. Pharmacies help improve access to this service given their convenient

locations, extended opening hours and walk-in service. As demonstrated in Figure 5.3, pharmacies across the borough provide easy access to all the wards to obtain flu vaccinations. The HWB believes that the current provision of flu vaccinations is sufficient for **supplying a relevant service with no gaps.**

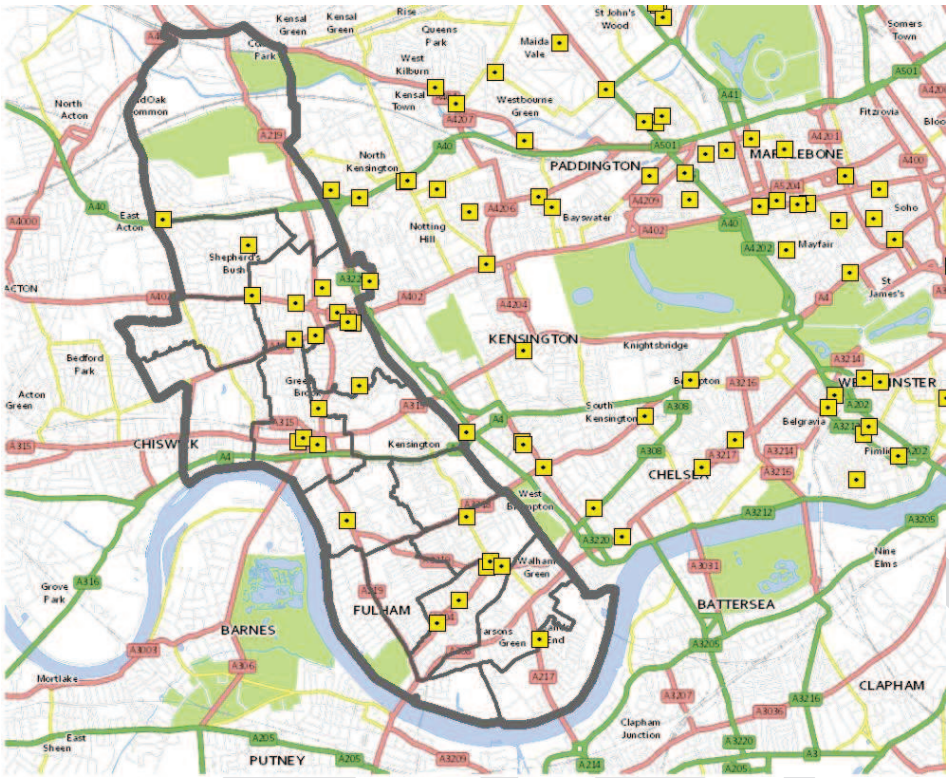


Figure 5.3: Pharmacies that provide flu vaccinations

PNA Borough Code	Name	Ward
HF09	Boots the Chemist	Addison
HF30	Sophia Chemists	Addison
HF36	Morrisons Pharmacy	Addison
HF29	Tesco In-Store Pharmacy	Avonmore and Brook Green
HF15	Westway Pharmacy	College Park and Old Oak
HF25	Superdrug	Fulham Broadway
HF39	Boots the Chemist	Fulham Reach
HF19	Boots the Chemist	Hammersmith Broadway
HF22	Superdrug	Hammersmith Broadway
HF40	Boots the Chemist	Hammersmith Broadway
HF03	Day Lewis Pharmacy	Sands End
HF01	Caregrange Pharmacy	Shepherd's Bush Green
HF02	Limegrove Pharmacy	Shepherd's Bush Green
HF10	Bush Pharmacy	Shepherd's Bush Green
HF13	Superdrug	Shepherd's Bush Green
HF24	Greenlight Pharmacy	Shepherd's Bush Green

HF37	Faro Pharmacy	Shepherd's Bush Green
HF41	Boots the Chemist	Shepherd's Bush Green
HF04	Chana Chemist	Town
HF07	Boots the Chemist	Town
HF34	Fulham Pharmacy	Town
HF38	Kanari Pharmacy	Town
HF12	Oza Chemist	Town
HF28	Hamlins Chemist	Wormholt and White City

Table 5.4: Pharmacies that provide flu vaccination

H. Pylori breath testing.

5.22 The H pylori breath test undertaken in a local pharmacy provides a simple and convenient alternative to hospital referral for GPs and patients. The test confirms the presence of gastro-duodenal infection which is linked to gastric and duodenal ulcer disease.

5.23 21 pharmacies in the borough provide the H. Pylori service according to the Medicines Management Team which handed over responsibility of commissioning this service to NHS England in April 2014 which will continue to do so until review. The HWB identifies this as a **relevant service, as it secures improvements or better access to service provision**.

Improvements and better access: gaps in provision

5.24 The Hammersmith & Fulham HWB has identified certain services below that are not currently commissioned in the area of the HWB but which the HWB is satisfied would, if they were provided, secure improvements, or better access to pharmaceutical services of a specific type. These have been summarised in the Table 5.1 above under **Improvements and better access: gaps in provision (Schedule 1, paragraph 4).**It should be noted that despite the HWB identifying these services, NHS England does not have to meet the need – this is because NHS England may have other factors to take into account, i.e. other commissioning decisions.

Minor Ailment Scheme

5.25 The Minor Ailment Scheme offers free advice and treatment for minor, self-limiting conditions. This service helps to relieve pressure from GPs and Secondary Care. 30 pharmacies would be willing to provide advice to care homes.

Chronic Obstructive Pulmonary Disease (COPD)

5.26 A screening service to identify and refer clients with early stage COPD. 32 pharmacies would be willing to provide this service if commissioned.

Other Locally Commissioned Services (Schedule 1, paragraph 5)

5.27 The commissioning of public health services were transferred from PCTs to local authorities with effect from 1 April 2013. These services are not referred to as

Enhanced Services anymore as they are not commissioned by NHS England. The pharmacies providing these services have been listed in Appendix C.

Screening Service

5.28 The underlying purpose of which is for a registered pharmacist—

(i) to identify patients at risk of developing a specified disease or condition,

(ii) to offer advice regarding testing for a specified disease or condition,

(iii) to carry out such a test with the patient's consent, and

(iv) to offer advice following an test and refer to another health care professional as appropriate;

5.29 While some NHS Health Checks take place in general practice, pharmacies are also well placed to play a key role. The aim of the risk assessment and management programme is to identify the risk of vascular disease in the population early and then to help people reduce or avoid it. 8 pharmacies have been commissioned to provide NHS Health Checks (Figure 5.4). Most of the GPs in Hammersmith & Fulham are commissioned to provide NHS Health Checks and currently pharmacies perform a very small number of health checks. The HWB identifies the level of this service to be **sufficient, with no gaps**.

Figure 5.4: Provision of NHS Health Checks

Supervised Administration Service & Needle and Syringe Exchange Service

5.30 Supervised Administration Service - The underlying purpose of which is for a registered pharmacist to supervise the administration of prescribed medicines the pharmacy premises.

Figure 5.5: Pharmacies currently providing Supervised Administration Service

Needle and Syringe Exchange Service

5.31 The underlying purpose of which is for a registered pharmacist—

(i) to provide sterile needles, syringes and associated materials to drug misusers,

(ii) to receive from drug misusers used needles, syringes and associated materials, and

(iii) to offer advice to drug misusers and where appropriate refer them to another health care professional or a specialist drug treatment centre;

Figure 5.6: Pharmacies currently providing Needle Exchange Service

5.32 Good access to Needle & Syringe Exchange & Supervised Consumption Services is required to support safer use of drugs by injecting drug users and minimise the transmission of blood-borne diseases.

5.33 12 pharmacies provide needle exchange (Figure 5.6) and 17 provide supervised consumption (Figure 5.5), provision mapping well to areas of greatest need. These are spread throughout the borough. Given the specialist nature and low volumes of service use compared to normal dispensing, the HWB identifies the level of these services to be **sufficient, with no gaps**.

Stop Smoking Service

5.34 The underlying purpose of which is for pharmacies—

(i) to advise and support patients wishing to give up smoking, and

(ii) where appropriate, to supply appropriate drugs and aids;

5.35 Smoking is the single biggest preventable cause of death and inequalities. Securing good access to stop smoking services increases the opportunity for the population to benefit from improvements in health. With 35 pharmacies providing the service, the HWB identifies the Stop Smoking Service provided in local pharmacies as **sufficient for supplying a service with no gaps**. However, given the volume of smokers in the borough, an increase in provision in the borough may be desirable, given pharmacists' position of influence as health-promoting advocates.

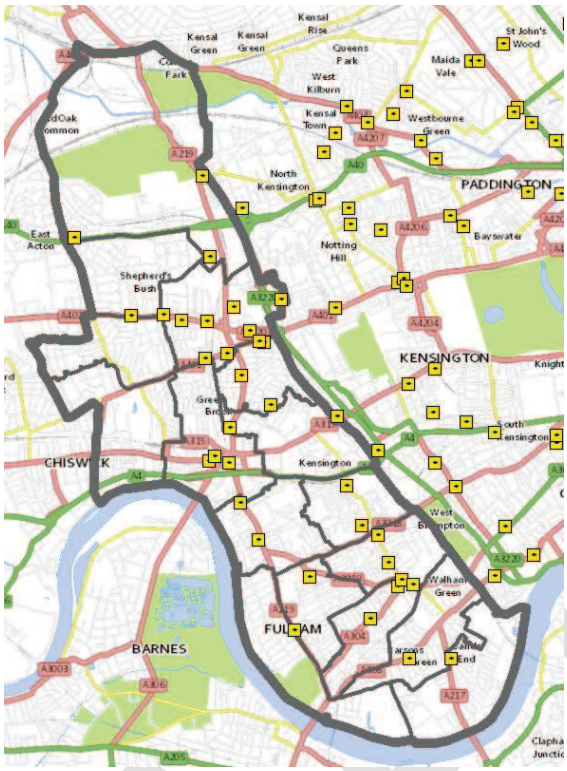


Figure 5.7: Provision of Stop Smoking Services

Emergency hormonal contraception services through patient group directions

5.36 22 pharmacies in the borough have been commissioned to provide Emergency Hormonal Contraception.

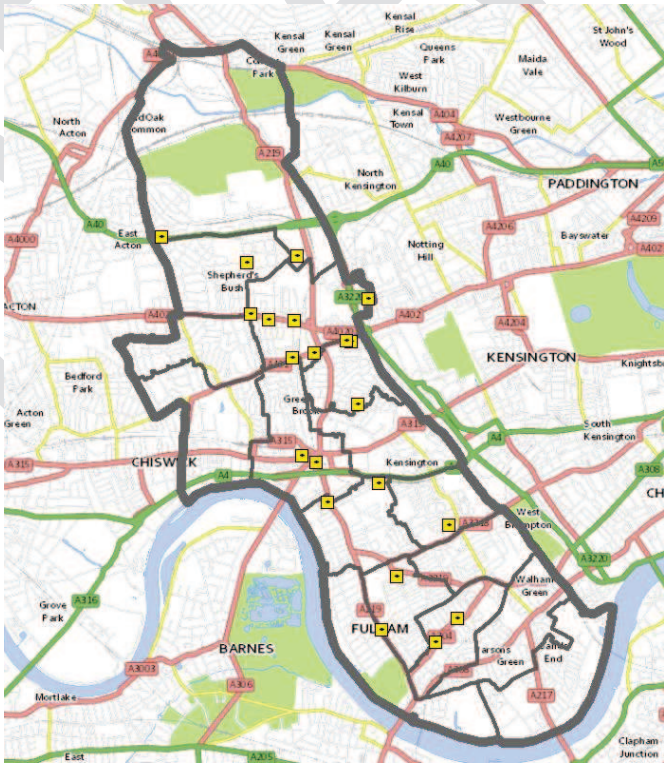


Figure 5.8: Provision of Emergency Hormonal Contraception

Improvements and gaps in access to Public Health Services

Sexual health services

5.37 Pharmacies can be commissioned to other services apart from emergency hormonal contraception services such as condom distribution; pregnancy testing and advice, Chlamydia screening and treatment and other sexual health screening, including syphilis, HIV and gonorrhoea. These services are currently; provided by GPs, GUM Clinics and Secondary Care Centres. However, the provision of these services from pharmacies may reduce the demand on the above mentioned services and improve access. Most pharmacies already provide these services privately and would be willing to provide them if commissioned.

Alcohol misuse service

5.38 This would identify higher-risk and increasing-risk drinking and provide brief interventions to motivate individuals to modify their drinking patterns.

Weight management service

5.39 Obesity is increasing in the general population and is likely to have significant impact on future health costs. This service would expand the health promotion role of pharmacies.

5.40 The future provision of these services will be considered in wider review of the use of pharmaceutical services in Westminster, Kensington & Chelsea and Hammersmith & Fulham to be conducted in the coming year.

Necessary services: gaps in provision (Schedule 1, paragraph 2)

5.41 Having assessed the local needs and the current provision of necessary services, the Hammersmith & Fulham HWB have not identified any necessary pharmaceutical services that are not provided in the area of the HWB.

Other skills and services

Utilisation of Clinical Skills in the Pharmacy

5.42 14 of the pharmacies reported that that the clinical skills in their pharmacies were ”totally utilised”. The rest indicated that they were “partly utilised”. None of the pharmacies reported that the clinical skills were not utilised.

Pharmacists with a Special Interest

5.43 2 of the pharmacies surveyed have pharmacists with special interests: IT and Travel health.

Health Champions

5.44 Health Champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform health and well-being in their communities.

5.45 3 pharmacies in Hammersmith & Fulham have health champions.

Health Trainers

5.46 Health trainers help people to develop healthier behaviour and lifestyles in their own local communities. They offer practical support to change their behaviour to achieve their own choices and goals.

5.47 1 pharmacy from those surveyed has a health trainer. This is in the Day Lewis Pharmacy in Sands End which has 1 health trainer.

Dementia Friends

5.48 A Dementia Friend learns a little bit more about what it's like to live with dementia and then turns that understanding into action.

5.49 8 pharmacies in Hammersmith & Fulham have dementia friends.

Appendix A – Index to pharmacies with opening time information

N.B.: Opening times obtained from the survey have been used for pharmacies that responded. Pharmacy opening times from those that did not respond and those that are not within the borough were obtained from NHS England (core + supplementary); 1 = open, 0 = closed, x = no data available

Code on map	Trading Name	Address	Postcode	Ward	Borough	Responded	Early opening	Late opening	Saturday	Sunday
HF01	Caregrange Pharmacy	9 Goldhawk Road	W12 8QQ	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	0	1	0
HF02	Limegrove Pharmacy	66 Goldhawk Road	W12 8HA	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	0	1	0
HF03	Day Lewis Pharmacy	117-121 Wandsworth Bridge Road	SW6 2TP	Sands End	Hammersmith & Fulham	YES	0	0	1	0
HF04	Chana Chemist	392-402 North End Road	SW6 1LU	Town	Hammersmith & Fulham	YES	0	0	1	0
HF05	Palace Pharmacy	331 Fulham Palace Road	SW6 6TE	Munster	Hammersmith & Fulham	YES	0	0	1	0
HF06	Fontain Pharmacy	290 Munster Road	SW6 6BQ	Munster	Hammersmith & Fulham	YES	1	1	1	1
HF07	Boots the Chemist	Unit 7 Fulham Broadway Retail Ctr.	SW6 1BH	Town	Hammersmith & Fulham	YES	1	1	1	1
HF08	C. E. Harrod Chemist	207 New Kings Road	SW6 4SR	Parsons Green and Walham	Hammersmith & Fulham	YES	0	0	1	0
HF09	Boots the Chemist	Unit 5-6 The West 12 Centre	W12 8PP	Addison	Hammersmith & Fulham	YES	1	1	1	1
HF10	Bush Pharmacy	334 Uxbridge Road	W12 7LL	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	0	1	0
HF11	Novapharma	100A North End Road	W14 9EX	North End	Hammersmith & Fulham	YES	0	0	1	0
HF12	Oza Chemist	9 Fulham Broadway	SW6 1AA	Town	Hammersmith & Fulham	NO	0	0	1	0
HF13	Superdrug	92-94 Uxbridge Road	W12 8LR	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	0	1	0
HF14	Healthside Pharmacy	90 Shepherds Bush Road	W6 7PH	Addison	Hammersmith & Fulham	YES	0	0	1	0
HF15	Westway Pharmacy	11 Westway	W12 0PT	College Park and Old Oak	Hammersmith & Fulham	YES	0	0	1	0
HF16	Globe Chemist	8 Kings Parade	W12 9BA	Askew	Hammersmith & Fulham	NO	0	0	0	0
HF17	Babylon Health Ltd	57 Uxbridge Road	W12 8NR	Shepherd's Bush Green	Hammersmith & Fulham	NO	0	0	1	0

HF18	Parmay Pharmacy	Unit 4, 160 North End Road	W14 9QR	North End	Hammersmith & Fulham	YES	0	0	1	0
HF19	Boots the Chemist	41-43 King Street	W6 9HW	Hammersmith Broadway	Hammersmith & Fulham	YES	1	1	1	1
HF20	Windwood Chemist	96 Askew Road	W12 9BL	Askew	Hammersmith & Fulham	NO	0	0	1	0
HF21	Pestle & Mortar	388 Uxbridge Road	W12 7LL	Shepherd's Bush Green	Hammersmith & Fulham	NO	0	0	1	1
HF22	Superdrug	43 Kings Mall	W6 0QB	Hammersmith Broadway	Hammersmith & Fulham	YES	1	0	1	0
HF23	Pestle & Mortar	59 South Africa Road	W12 7PA	College Park and Old Oak	Hammersmith & Fulham	NO	0	0	0	0
HF24	Greenlight Pharmacy	228-230A Uxbridge Road	W12 7JD	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	0	1	0
HF25	Superdrug	317 North End Road	SW6 1NN	Fulham Broadway	Hammersmith & Fulham	YES	0	0	1	0
HF26	Rite-Chem	84 Fulham Palace Road	W6 9PL	Fulham Reach	Hammersmith & Fulham	YES	0	0	1	0
HF27	Barons Pharmay	3 Margravine Gardens	W6 8RL	Fulham Reach	Hammersmith & Fulham	YES	0	0	0	0
HF28	Hamlins Chemist	73 Bloemfontein Road	W12 7DA	Wormholt and White City	Hammersmith & Fulham	YES	0	0	0	0
HF29	Tesco In-Store Pharmacy	180 Shepherds Bush road	W6 7NL	Avonmore and Brook Green	Hammersmith & Fulham	YES	1	1	1	1
HF30	Forrest & Co.	67 Blythe Road	W14 0HP	Addison	Hammersmith & Fulham	YES	0	0	1	0
HF31	Boots the Chemist	322 North End Road	SW6 1NF	Fulham Broadway	Hammersmith & Fulham	YES	0	0	1	1
HF32	Jay's Pharmacy	442 Uxbridge Road	W12 0NS	Wormholt and White City	Hammersmith & Fulham	YES	0	0	1	0
HF33	Lloydspharmacy	Richford Gate Primary Care Centre	W6 7HY	Hammersmith Broadway	Hammersmith & Fulham	NO	1	0	1	0
HF34	Fulham Pharmacy	608 Fulham Road	SW6 5RP	Town	Hammersmith & Fulham	YES	0	0	1	0
HF35	My Pharmacy	10 North Pole Road	W10 6QL	College Park and Old Oak	Hammersmith & Fulham	YES	0	0	1	0
HF36	Morrisons Pharmacy	Morrisons, 114-116 Concorde Centre	W12 8PH	Addison	Hammersmith & Fulham	YES	1	1	1	1
HF37	Faro Pharmacy	16 Swanscombe Road	W11 4SX	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	0	1	0
HF38	Kanari Pharmacy	682-684 Fulham Road	SW6 5SA	Town	Hammersmith & Fulham	YES	0	0	1	0
HF39	Boots the Chemist	198-200 Fulham Palace Road	W6 9PA	Fulham Reach	Hammersmith & Fulham	YES	0	0	1	1
HF40	Boots the Chemist	31-32 Hammersmith Broadway Ctr.	W6 9YD	Hammersmith Broadway	Hammersmith & Fulham	YES	1	1	1	1
HF41	Boots the Chemist	Unit 1109-1111 Westfield Shopping Ctr.	W12 7GD	Shepherd's Bush Green	Hammersmith & Fulham	YES	0	1	1	1

	Pharmacies within 500m outside of the borough									
BR01	Catto Chemist	79 High Street	NW10 4NS		Brent		0	0	1	0
BR07	Chana Chemist	96-98 High Street	NW10 4SL		Brent		0	0	1	0
EA01	Crossbells Chemist	131 The Vale	W3 7RQ		Ealing		0	0	1	0
EA02	Banks Chemist	59 Old Oak Common Lane	W3 7DD		Ealing		0	0	1	0
EA03	Marcus Jones Pharmacy	96 Old Oak Common Lane	W3 7DA		Ealing		0	0	1	0
EA04	Onsite Chemist	8E Europa Studios, Victoria Road	NW10 6ND		Ealing		0	0	0	0
HO01	Pestle and Mortar	10 High Road	W4 1TH		Hounslow		0	0	1	0
HO02	Bedford Park Pharmacy	5 Bedford Park Corner	W4 1LS		Hounslow		1	0	1	0
KC08	Tesco In-Store Pharmacy	West Cromwell Road	W14 8PB	Abingdon	Kensington and Chelsea	YES	1	1	1	1
KC13	Zafash Pharmacy	233-235 Old Brompton Road,	SW5 0EA	Redcliffe	Kensington and Chelsea	YES	1	1	1	1
KC14	Lloyds pharmacy	513 Kings Road	SW10 0TX	Cremorne	Kensington and Chelsea	YES	1	1	1	0
KC16	H Lloyd Chemist	382 Kensington High Street	W14 8NL	Holland	Kensington and Chelsea	YES	0	0	1	0
KC26	Borno Chemist	The Gatehouse	W10 6ND	Notting Barns	Kensington and Chelsea	YES	0	1	1	1
KC33	Bramley Pharmacy	Unit 1, 132 Bramley Road	W10 6TJ	Notting Barns	Kensington and Chelsea	YES	0	0	1	0
RI01	Prime Pharmacy	198 Castelnau	SW13 9DW		Richmond		0	0	1	0
WA01	The Olde Pharmacy	50 Chatfield Road	SW11 3UY		Wandsworth		0	0	0	0
WA02	Boots the Chemist	45-53 Putney High Street	SW15 1SP		Wandsworth		1	0	1	1

Appendix B – Index to pharmacy responses regarding Advanced Services

Code on map	Responded	MURs	AURs	SACs	NMS
HF01	YES	Yes	Don't know	Don't know	Yes
HF02	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF03	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF04	YES	Yes	Don't know	Don't know	Yes
HF05	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF06	YES	Yes	Yes	Yes	Yes
HF07	YES	Yes	Don't know	Don't know	Yes
HF08	YES	Yes	No, and not intending to provide	No, and not intending to provide	Intending to begin within the next 12 months
HF09	YES	Yes	Don't know	Don't know	Yes
HF10	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF11	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF12	NO	x	x	x	x
HF13	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF14	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF15	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes

HF16	NO	x	x	x	x
HF17	NO	x	x	x	x
HF18	YES	Yes	Don't know	No, and not intending to provide	Yes
HF19	YES	Yes	Don't know	Don't know	Yes
HF20	NO	x	x	x	x
HF21	NO	x	x	x	x
HF22	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF23	NO	x	x	x	x
HF24	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF25	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF26	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
HF27	YES	Intending to begin within the next 12 months	Intending to begin within the next 12 months	No, and not intending to provide	Intending to begin within the next 12 months
HF28	YES	Yes	Don't know	Don't know	Intending to begin within the next 12 months
HF29	YES	Yes	Don't know	Don't know	Yes
HF30	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF31	YES	Yes	Don't know	Don't know	Yes
HF32	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF33	NO	x	x	x	x
HF34	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF35	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Intending to begin within the next 12 months
HF36	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF37	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
HF38	YES	Yes	Yes	Yes	Yes
HF39	YES	Yes	Don't know	Don't know	Yes

HF40	YES	Yes	Don't know	Don't know	Yes
HF41	YES	Yes	Don't know	Don't know	Yes
BR01		x	x	x	x
BR07		x	x	x	x
EA01		x	x	x	x
EA02		x	x	x	x
EA03		x	x	x	x
EA04		x	x	x	x
HO01		x	x	x	x
HO02		x	x	x	x
KC08	YES	Yes	Don't know	Don't know	Yes
KC13	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
KC14	YES	Yes	No, and not intending to provide	No, and not intending to provide	Yes
KC16	YES	Yes	Don't know	Don't know	Yes
KC26	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
KC33	YES	Yes	Intending to begin within the next 12 months	Intending to begin within the next 12 months	Yes
RI01		x	x	x	x
WA01		x	x	x	x
WA02		x	x	x	x

Appendix C – Index to pharmacies providing Public Health Services

PNA Borough Code	Name	Ward	Supervised consumption	Needle exchange	Health Checks	Stop Smoking
KC01	Spivack Chemist	Colville	Yes	Yes	Yes	Yes
KC02	Sainsbury's Ladbroke Gr.	Golborne	No	No	No	No
KC03	Medicine Chest	Cremorne	Yes	No	No	Yes
KC04	Boots 205 Brompton Rd	Brompton	No	No	No	Yes
KC05	D.R. Evans Pharmacy	Colville	No	No	No	Yes
KC06	Boots 96 Nott. Hill Gate	Pembridge	Yes	No	No	Yes
KC07	Boots 148-150 Kings Rd	Stanley	Yes	No	No	Yes
KC08	Tesco In-Store Pharmacy	Abingdon	Yes	No	No	Yes
KC09	I T Lloyd Chemist	Cremorne	No	No	No	No
KC10	Earls Court Chemist	Earl's Court	No	No	Yes	No
KC12	Chana Pharmacy/Clifford Evans	Colville	No	No	No	Yes
KC13	Zafash Pharmacy	Redcliffe	No	No	Yes	Yes
KC33	Bramley Pharmacy	Notting Barns	Yes	No	No	No
KC14	Lloyds pharmacy	Cremorne	No	No	No	Yes
KC16	H Lloyd Chemist	Holland	No	No	No	Yes
KC17	Dillons Pharmacy	Golborne	No	No	Yes	Yes
KC18	World's End Pharmacy	Cremorne	Yes	Yes	Yes	Yes
KC19	Harleys Pharmacy	Brompton	No	No	No	Yes

KC20	Boots 30-31 Gloucester Arcade	Courtfield	No	No	No	Yes
KC21	Boots 228-230 Fulham Rd	Redcliffe	Yes	No	No	Yes
KC22	Boots 127A Ken High St	Queen's Gate	Yes	No	No	Yes
KC23	Astell Pharmacy	Hans Town	No	No	No	Yes
KC24	Baywood	Pembridge	Yes	Yes	Yes	Yes
KC25	Boots 254 Earls Court Rd	Earl's Court	Yes	Yes	No	Yes
KC26	Borno Chemist	Notting Barns	No	No	Yes	Yes
KC27	Sainsbury's Cromwell Rd	Queen's Gate	No	No	No	Yes
KC28	Stickland Chemist	Brompton	No	Yes	No	Yes
KC30	Hillcrest Pharmacy	Norland	No	No	No	Yes
KC32	Chana Chemist	Colville	Yes	Yes	Yes	Yes
KC35	Boots 60 Kings Road	Hans Town	No	No	No	Yes
KC36	Harrods Pharmacy	Brompton	No	No	No	No
KC37	Amoore & Co Ltd	Brompton	No	No	No	Yes
KC38	Stratford Pharmacy	Abingdon	Yes	No	No	Yes
KC39	Notting Hill Pharmacy (Go Go Chemist Ltd)	Pembridge	No	No	No	Yes
KC40	FJM Calder	Campden	No	No	No	Yes
KC41	Pestle And Mortar	Abingdon	No	Yes	No	Yes
KC11	Golborne Pharmacy	Golborne	Yes	No	No	Yes
KC15	Dajani Pharmacy	Brompton	No	No	No	No
KC29	Dr Care Pharmacy	Golborne	Yes	Yes	No	No
KC31	Andrews Pharmacy	Hans Town	No	No	No	No
KC34	Chelsea Pharmacy	Hans Town	No	No	No	Yes

Appendix E – Other Information

The PNA Task and Finish Group

- The Triborough PNA Task and Finish Group was created to be responsible for overseeing the development of the PNAs on behalf of the Health and Wellbeing Boards of Hammersmith and Fulham, Kensington and Chelsea, and Westminster. To ensure strong links with the JSNA the development of the PNA was included in the Triborough JSNA Work Programme for 2014/15. The Triborough PNA Task and Finish Group reported to the JSNA Steering Group, and provided regular updates to the Health and Wellbeing Board.

- The Terms of Reference and membership of this group are included below. Progress against the PNA Project Plan is monitored by the Triborough PNA Task and Finish Group.

Gathering Information for the PNA

- The Triborough PNA Task and Finish Group reviewed the NHS England assessment of previous Triborough PNAs and agreed to adopt the Royal Borough of Kensington and Chelsea PNA 2010-13 framework as the best model for the development of the needs assessment.

- A list of the data and information required for the development of the PNA was compiled. Data is held by a range of stakeholders (Triborough Public Health, NHS England, and North West London Commissioning Support Unit) and the appropriate member(s) of the group were tasked with providing the data. Pharmacy and GP lists for Hammersmith & Fulham, and neighbouring boroughs, were requested from NHS England.

- The Triborough PNA Task and Finish Group issued a PNA questionnaire to all community pharmacies to gather up to date information for the needs assessment. The questionnaire was adapted from the one developed by the Pharmaceutical Services Negotiating Committee (PSNC) and was 'signed off' by the Task and Finish Group, including LPC representatives. The questionnaire was sent to all Hammersmith & Fulham community pharmacy contractors in July 2014. The results were collated and analysed in August 2014. Information on bordering pharmacies outside of the Triborough was gathered from NHS England

- The PNA Task and Finish Group reviewed early drafts of the PNA in August and September 2014, providing an opportunity to comment prior to the official consultation period.

Consultation

- The responses and changes to the draft resulting from the public consultation between October and December 2014 can be found as a supplementary document on the JSNA website (www.jsna.info).

Next Steps

- In accordance with the 2013 Regulations, the Hammersmith & Fulham Health and Wellbeing Board will publish a statement of its revised assessment within three years of the publication of this document.

- In addition, the Hammersmith & Fulham Health and Wellbeing Board will make a new assessment of pharmaceutical need sooner than this, should it identify any changes to the availability of pharmaceutical services that have occurred since the publication of this PNA. This will be undertaken only where, in the HWBs view, the changes are so substantial that the publication of a new assessment is a proportionate response.

Terms of Reference for PNA Task and Finish Group

Purpose

- The purpose of the PNA Task & Finish Group is to ensure delivery of a quality assured and robust Pharmaceutical Needs Assessment (PNA) for the Health and Wellbeing Boards for Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

- The PNA is a commissioning tool and determines market entry for NHS pharmaceutical services provision

- The PNA Task & Finish Group will work to the agreed PNA Work Plan and develop a PNA that meets the requirements of NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

- The PNA Task & Finish Group will review and report on progress to the JSNA Steering Group, the Health and Wellbeing Boards and other stakeholders

Accountability & Governance

- The PNA is incorporated into the JSNA work programme as outlined in the JSNA Steering Group Terms of Reference. The JSNA Steering Group retains overall accountability to the three Health and Wellbeing Boards for the production of the PNA and will provide assurance to the Boards on progress and quality.
- The PNA Task & Finish Group is a subgroup of the JSNA Steering Group
- The PNA Task & Finish will provide regular progress reports to the JSNA Steering Group.
- The PNA Task & Finish Group will monitor and review progress against the timescales in the agreed PNA Work Plan and inform the JSNA Steering Group of risks to delivery
- The JSNA Manager will manage and coordinate the PNA Task & Finish Group.

Membership

- The Task & Finish Group will be chaired by Stuart Lines, Deputy Director of Public Health
- The group will be supported by the JSNA Programme Manager and Public Health Knowledge Manager.
- Membership of the Group:

Name	Representing/Role
Gerald Alexander/Michael Levitan	Local Pharmaceutical Committee (Hammersmith and Fulham)
Colin Brodie	Public Health Knowledge Manager
Annelise Johns	Interim Senior Public Health Officer
Ashfaq Khan	CCG Lead Pharmacist, North West London Commissioning Support Unit
Dan Lewer	JSNA Manager
Stuart Lines (Chair)	Deputy Director of Public Health
Holly Manktelow	Senior Policy Officer
Gayan Perera	Senior Public Health Analyst
Beneeta ShahLocal Pharmaceutical Committee (Boots)Rekha Shah	Local Pharmaceutical Committee (Kensington and Chelsea/Westminster)

- James Hebblethwaite, Tri-borough Adult Social Care, will provide input in an advisory capacity
- Additional expertise from other organisations will be drafted in as required.

Quorum

- The quorum shall be 4 members, to include representation from Public Health, LPC, Clinical Commissioning Groups, and the CSU.

Procedures

- The PNA Task & Finish Group will meet monthly in the first instance to be reviewed regularly dependent on need.

- The PNA Task & Finish Group may secure outside expert professional advice and/or the attendance of external advisers with relevant experience and expertise at meetings if this is considered necessary.

Reporting

- The PNA Task & Finish Group will report on progress to the JSNA Steering Group

- The Health and Wellbeing Boards will receive reports on an exception basis where appropriate. These will be included as part of the regular JSNA update to Health and Wellbeing Boards.

Review

- The terms of reference will be reviewed on 6 month basis

Data Sources

Population data

GLA 2013 Round SHLAA population projections

HSCIC, July 2014 (GP registrations)

Census 2011 (ethnic group analysis, population density)

Index of Multiple Deprivation (IMD2010)

Health needs

JSNA Borough Profiles

ONS (infant mortality, life expectancy)

Quality Outcomes Framework (disease prevalence comparators)

Health Survey for England (smoking prevalence)

Public Health England (local alcohol profiles for England, sexual and reproductive health profiles, TB incidence, sports participation)

National Child Measurement Programme (child obesity)

Essential, Advanced and Locally Commissioned Enhanced Services (including pharmaceutical lists and opening hours)

NHS England (pharmaceutical lists, opening hours)

Pharmacy Survey 2014

HSCIC (comparators)

Dispensing

CCG

Public health services

Tri-Borough Public Health Service

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Agenda Item 6

Local Priority 2015/16: update and next steps

March 2015

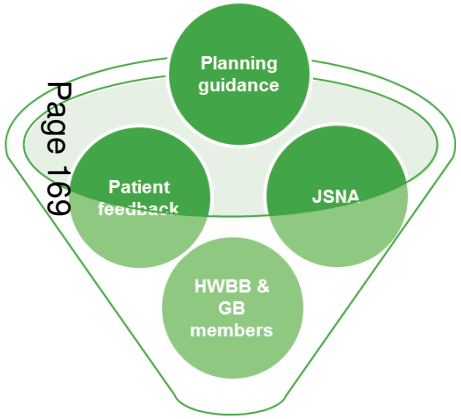
Background and process to date

Selection of CCG local priorities is an opportunity for us to focus on areas we all feel are relevant to our local population. We are currently in the process of developing local priorities for 15/16 as follows:

- **Stakeholders, including the HWBB, were asked for views on the local priority 'long list' in February 2015 – this formed our 'long list'**
- **We analysed the 'long list' to identify areas with good strategic fit, that are readily measurable, and where we believe we can make a difference in one year**
- **We created a 'short list' following this analysis and this is now out for consultation across stakeholder groups (due to close 20 March 2015)**
- **We await further guidance from NHS England on the number of local priorities to select, as well as timescales for submission**
- **Progress against our engagement plan is shown on the next slide**

Progress against our engagement plan

Step 1: compile a long-list from population information, public health, Governing Body and Health & Wellbeing Board members
Completed



Step 2: filter the long-list according to recurrent themes and where we can measure improvement to give a short-list
Completed

Step 3: Consultation on the short list through a survey for:

- CCG members
- HWBB members
- Members of the public

Consultation due to close 20 March 2015

Step 4: Analyse the response from the survey to give the final local priorities
Timescales pending further NHSE guidance

Step 5: Agree a sensible level of ambition for the improvement
Timescales pending further NHSE guidance

Step 6: Sign off through a virtual Health & Wellbeing Board and F&P prior to submission
Timescales pending further NHSE guidance

Healthy Future

Development of the local priority shortlist

The table below shows the areas on our 'long list', together with a rationale for why they did, or did not get included on the final shortlist

Area	Shortlisted?	Rationale
Childhood Imms - MMR2	Yes	In 13/14 we focussed on MMR1 vaccinations. Our performance is lower in MMR 2 and this should therefore be our next focus
Annual health checks for adult patients with learning disabilities	Yes	This remains an equality objective for the CCG until 2016. This has been a focus in 14/15 and we are on track to exceed our target; we therefore have the infrastructure and momentum to support continued delivery.
Diabetes	Yes	This is a significant development area in terms of implementing changes to care delivery, and making it a local priority would enable us to maintain the focus on benefits realisation
Childhood imms - flu for under 4s at risk	Yes	We are currently low performing in this area and this is an area of particular concern to local Councillors
Identification of young carers	Yes	This was a clear theme across stakeholders, and is also a CCG equality objective. With this as a local priority, we could also build on working across sectors, including the third sector
CAMHS	No	We were not able to identify clear measures that could be used from April 2015
Medicines related harm	No	We are relatively well performing on measures of antibiotic usage (as referenced in operating plan guidance)
Suicide	No	Advice from public health that numbers are small and therefore measurement within one year may not be meaningful. Suggest taking up as workstream within MH programme
Tackling social isolation	No	No currently available measure was identified, but we would like to develop work in this area in 15/16 to potentially inform a local priority in 16/17
Tackling childhood obesity – signposting to weight management services	Yes	Childhood obesity is high across Hammersmith & Fulham and a target in this areas would align well with existing public health projects; it is also a HWBB priority area

Next steps

- **We will analyse the results of the survey to rank the short list and identify the 'top' three**
- **Work with colleagues inside and outside the CCG to set a realistic but stretching level of ambition for each of these**
- **Await NHSE guidance in order to:**
  - Understand exactly how many priorities we should select
  - Understand when we should make our submission to NHSE
  - Communicate the final priorities to all stakeholders
  - Develop plans to support implementation and monitoring of the final priorities
- **We will also revisit the 'long list' to understand how we can improve areas such social isolation through other CCG plans**

Appendix 1

Hammersmith and Fulham Health & Wellbeing Board
Work Programme 2015/16

KEY
FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Meeting Date 23rd March 2015: END OF YEAR STRATEGIC PLANNING			
PRIVATE STRATEGIC PLANNING WORKSHOP – 1hr (Liz Bruce)			
STRATEGIC PLANNING DISCUSSION	A chance for the HWB to: • review progress against its priorities to date • reassess the challenges and prospects across the health and care economy • discuss and challenge itself on its role in providing system leadership.	Facilitated by the Exec Director of ASC	Planning
Business issues			
NHS Forward Plan	An update from CCGs on the **NHS Five Year Forward Plan**	CCGs and NHS England	For discussion
PHARMACEUTICAL NEEDS ASSESSMENT	Final LBHF Pharmaceutical Needs Assessment for publication	JSNA Steering Group Chair	For decision

Meeting Date June/July (tbc): SYSTEM IMPROVEMENT			
EARLY YEARS	Consider the preparations underway for the transfer of health visiting from NHS England to the local authority	Public Health	For discussion
PREVENTATIVE HEALTHCARE	Follow on from MMR discussion: Partnership strategy for improvement of preventative healthcare (particularly imms and screening)	Public Health & NHS England	For information and discussion
ADULTS AND HEALTH INTEGRATION	Update on Better Care Fund and Whole Systems Integration	Exec Director of ASC	For information
JSNA 2015/16	To agree recommendations from the JSNA Steering Group on JSNA Programme priorities for 2015/16	JSNA Steering Group Chair	For Decision
AVAILABLE SLOT			
Meeting Date September tbc): 2016/17 COMMISSIONING WORKSHOP			
HEALTH AND CARE COMMISSIONING	Key commissioning themes from CCG and local authority	Led by (tbc)	To steer 2016/17 commissioning across health and wellbeing system
	"Health of the health system" dashboard		
	Key messages from Adult and Children Safeguarding Boards, Children's Trust and other partnership groups		
	Key messages from Patients and Service Users		
PRIMARY CARE CO-COMMISSIONING	Discussion on NHSE/CCG co-commissioning and role of the Health and Wellbeing Board	H&FCCG and NHSE	For discussion
CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH	Discussion on new approach to commissioning children and young people's mental health (follow up from shared services task force)	Steve Buckerfield	For discussion and steer
AVAILABLE SLOT			
AVAILABLE SLOT			

Meeting Date November (TBC): SYSTEM IMPROVEMENT			
EARLY YEARS	Consider progress made in improving partnership and integration relating to child health and wellbeing	Children Services	For discussion
ADULTS AND HEALTH INTEGRATION	Update on Better Care Fund and Whole Systems Integration	Exec Director of ASC	For information
JSNA 2015/16	Review progress against JSNA Programme	JSNA Steering Group Chair	For information
AVAILABLE SLOT			
AVAILABLE SLOT			
Meeting Date: January (TBC): MISCELLANEOUS			
HEALTH AND WELLBEING STRATEGY	Update on progress against LBHF Health and Wellbeing Strategy and discussion on escalated issues	Board leads	For discussion
CHILD POVERTY	Provide steer on the developing approach to reducing child poverty in LBHF	Exec Director of Children's Services	For discussion and steer
HOUSING	Discussion on how to improve the independence and health outcomes of vulnerable people through housing	Housing lead	For discussion
AVAILABLE SLOT			
AVAILABLE SLOT			

Meeting Date: March(TBC): END OF YEAR STRATEGIC PLANNING MEETING			
<u>PRIVATE</u> TRATEGIC PLANNING WORKSHOP – 1hr (Liz Bruce)			
STRATEGIC PLANNING DISCUSSION	A chance for the HWB to: • review progress against its priorities to date • reassess the challenges and prospects across the health and care economy • discuss and challenge itself on its role in providing system leadership.	Facilitated by the Exec Director of ASC	Planning
Business issues			
LBHF Health and Wellbeing Board Annual Report	Draft LBHF Health and Wellbeing Board Annual Report	Chair of the HWB	For decision
AVAILABLE SLOT			
AVAILABLE SLOT			