Health and Wellbeing Board

TUESDAY, 24TH MARCH, 2015 at 18.30HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: SEE ATTACHED

AGENDA

1. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

The Chair will welcome those present to the meetings and introductions will then be made.

2. APOLOGIES

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 13).

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. QUESTIONS, DEPUTATIONS, PETITIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

6. MINUTES (PAGES 3 - 20)

To consider and agree the minutes of the meeting of the Board held on 13th January 2015.

7. TRANSFORMING HEALTH & WELLBEING IN HARINGEY (PAGES 21 - 86)

8. PRIMARY CARE TASK & FINISH REPORT (PAGES 87 - 88)

9. PHARMACEUTICAL NEEDS ASSESSMENT (PAGES 89 - 278)

10. HEALTH & HOMELESSNESS REPORT (PAGES 279 - 296)

11. HEALTH AND CARE INTEGRATION PROGRAMME (PAGES 297 - 314)

12. CQC REPORT / COMPLAINTS (PAGES 315 - 362)

13. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at item 3 above.

14. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

Members of the Board are invited to suggest future agenda items.

The dates of future meetings will be advised at the meeting on 24 March 2015.

Bernie Ryan
Assistant Director – Corporate Governance and Monitoring Officer
Level 5
River Park House
225 High Road
Wood Green
London N22 8HQ

Philip Slawther
Principal Committee Coordinator
Level 5
River Park House
225 High Road
Wood Green
London N22 8HQ

Tel: 0208 4892957
Email:
philip.slawther2@haringey.gov.uk

Monday, 16 March 2015

This page is intentionally left blank

Agenda Item 1

Membership of the Health and Wellbeing Board – March 2015

*** denotes voting member of the Board**

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	*Leader of the Council (Chair of the HWB)	Cllr Claire Kober
			*Cabinet Member for Children and Young People	Cllr Ann Waters
			*Cabinet Member for Health and Wellbeing	Cllr Peter Morton
	Officers' Representatives	3	Director of Adult Social Services	Beverly Tarka
			Interim Director of Children and Young People's Services	Jon Abbey
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	*Chair (Vice -Chair of the HWB)	Dr Sherry Tang
			GP Board Member	Dr Helen Pelendrides
			Chief Officer	Sarah Price
			*Lay Member (Confirmed as voting member by Full Council 23/02/15)	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	*Chair	Sharon Grant
Voluntary Sector Representative	HAVCO	1	Interim Representative	Gill Hawken
Haringey Local Safeguarding Children Board		1	Chair	Sir Paul Ennals

This page is intentionally left blank

Agenda Item 6

Haringey Council

healthwatch Haringey

HAVCO HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

NHS Haringey Clinical Commissioning Group

MINUTES OF THE HEALTH AND WELLBEING BOARD
13 JANUARY 2015

Board Members Present: Councillor Claire Kober (Chair), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Zina Etheridge (Deputy Chief Executive LBOH), Sir Paul Ennals (Chair of Haringey LSCB), Sharon Grant (Chair, Healthwatch Haringey) , Cathy Herman (Lay Member, Haringey CCG), Dr Helen Pelendrides (Vice-Chair Haringey CCG), Sarah Price (Chief Operating Officer, Haringey CCG), Jon Abbey (Interim Director of Children's Services), Dr Sherry Tang (Chair, Haringey CCG), Beverley Tarka (Interim Director Adult Social Care) and Cllr Ann Waters (Cabinet Member for Children, LBOH).

Officers Present: Philip Slawther (Principal Committee Coordinator LBOH), Clifford Hart (Democratic Services Manager), Stephen Lawrence-Orumwense (Assistant Head of Legal Services), Cassie Williams (Assistant Director of Primary Care Quality and Development – Haringey CCG), Sarah Barron (Interim Manager, Primary Care – NHS England),

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL101.	**WELCOME AND INTRODUCTIONS** In the absence of the Chair the Vice–Chair (Dr Sherry Tang) took the Chair. The Chair welcomed those present to the meeting.	
CNCL102.	**APOLOGIES** The following apologies were noted: • Gill Hawken (HAVCO) • Councillor Peter Morton (Cabinet Member for Health and Wellbeing) In addition, Cllr Kober sent apologies for late arrival.	
CNCL103.	**URGENT BUSINESS** None.	
CNCL104.	**DECLARATIONS OF INTEREST** Sharon Grant noted the following two amendments to the register of interests:	

	• Was recently confirmed as Chair of Healthwatch Haringey, as opposed to Interim Chair. • Confirmed as Director of Public Voice CIC, and that it was envisaged that this community interest company would manage Healthwatch Haringey from April 2015.	
CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** There were no declarations of interest made.	
CNCL106.	**Minutes** It was noted that there were two main actions contained in the previous minutes: • Set up a Task and Finish Group around Primary Care. This will be discussed later as part of item 8. • Report back to the Health and Wellbeing Board on how the Board will be included in the Health and Care Integration Programme. This will be discussed later as part of Item 10. **RESOLVED:** That the minutes of the meeting held on 30 September 2014 be confirmed as a correct record.	
CNCL107.	**STRATEGIC COMMISSIONING FRAMEWORK FOR PRIMARY CARE TRANSFORMATION IN LONDON** Cllr Kober arrived at the meeting and assumed the role of Chair. The Board received a presentation, from Ms Cassie Williams, Assistant Director of Primary Care Quality and Development for Haringey CCG giving an overview of primary care. Following the presentation the Board discussed the findings. It was noted that NHS England had put out an offer for Co-Commissioning of Primary Care with local Clinical Commissioning Groups (CCG's). The aim of which was to create a joined-up clinically led commissioning system delivering integrated routine and unplanned primary care services based on the needs of local people. There were three types of co-commissioning offered: Greater involvement; joint commissioning or delegated responsibility. North Central London opted for a joint commissioning approach. Ms Williams noted that this process was still ongoing and that Haringey CCG was submitting a further bid to provide joint commissioning at the end of January. The three main elements of the strategic commissioning framework were:	

- Proactive Care: Promoting self-care, health literacy and helping people to stay healthy.
- Accessible Care: Providing a personalised, responsive, timely and accessible service.
- Co-ordinated Care: Patient centred, co-ordinated care with GP-patient continuity.

Ms Williams outlined NHS England's 5 year forward view. The three main areas were noted as:

- Prevention
- Restructure how care is provided
- Invest into Primary Care

In response to this the Government had agreed to give an additional £1.95 billion to the NHS for 2015/16.

Haringey CCG's Primary Care Strategy was currently being redrafted. The key objectives of which were noted as:

- Make primary care more accessible
- Coordinate care around the needs of our patients
- Make care more proactive
- Support practices to work at scale
- Develop our workforce, recruit & retain the best staff
- Ensure our premises are of the highest possible quality
- Improve our technology and information systems

Ms Williams advised that one of the most significant technological improvements was the development of interoperable IT databases so that GP's etc would be able to see each other's records. The acute care and community providers would shortly have the capacity to do this as well.

Dr Helen Pelendrides commented that as a GP, the ability to access a patient's records across different surgeries and IT systems was "revolutionary". Every GP in Haringey had agreed to the data sharing protocols, not just among themselves but with other partners externally. This would have a significant impact on health and care integration. The next stage was to complete the join up with synthesis in A&E and Out of Hours services.

The Chair asked Dr Pelendrides what the impact of this change would be on her as a GP in 5 years time. Dr Pelendrides responded that this would positively impact on both the quality of patient care as well as deliver financial savings as the number of duplicate referrals and wasted appointments should dramatically decrease, with patients being able to access services with fewer delays. It was noted that, by way of an information safeguard, patient consent to share these records was required every time a clinician accessed their personal records. Dr Pelendrides also commented that this process would be likely to

encourage greater prioritisation of work flow and in the longer term it should be possible to hold “virtual” clinics.

Ms Price commented that the provision should have a particular impact on being able to see people that a GP may not have been able to see previously as it would open up access to more specialised clinics, especially where patients were assigned to smaller practices. Dr Pelendrides commented that although the Prime Minister had stated that access to services would be opened up and patients would not necessarily have to wait to see their own GP, there may be a significant amount of education involved in this as many people may prefer to wait to see their own GP.

Ms Herman asked whether the new service would really enable the NHS to offer more flexibility in its primary care services as, she noted, the current service offer was very much one size fits all. Dr Sherry Tang commented that bringing secondary care up to the same standard of digitalisation and information sharing would be a key challenge, though overall the process of bringing about greater interoperability should further increase flexibility and give people greater choice. For example, choice in terms of what types of consultations they would like to receive i.e. virtual or non-virtual.

The Deputy Chief Executive, Zina Etheridge commented that the co-commissioning proposal presented some significant opportunities, but also some significant challenges. For instance, co-commissioning brings about some issues around conflicts of interest particularly in terms of public perception. Ms Etheridge also asked colleagues from Haringey CCG what support they would require from those around the table to assist in the implementation process and that sharing access to the system with partners around the table might help tackle some of those concerns early on. Ms Etheridge also sought clarification with regard to governance arrangements for the project and whether progress would continue to be monitored by the HWB.

Ms Etheridge further enquired what the project would mean for the system as a whole, particularly around the points raised on specialisation. In particular how were colleagues from Haringey CCG going to ensure that those benefits were realised across the system and used to drive further reforms, as well as implications for the integration of primary care and the acute care sector and whether these services would remain separate.

Ms Williams responded to a number of points of clarification by advising that part of the governance arrangements for co-commissioning would involve the creation of a joint commissioning board at the North Central London level, including representations from; all of the CCGs, GPs, lay member representation, NHS England and Healthwatch organisations. Final arrangements about the specific make up and voting rights were still to be determined as were whether there

would be representation from all 5 Health and Wellbeing Boards at the joint commissioning board.

In terms of specialisation, Ms Williams agreed that the CCG could be more intentional about how we share the specialisms and the different services available. Ms Price added that in terms of federations developing in the borough and groups of GPs working together, the CCG as commissioners could commission services to work better at a local level across primary, acute and community services. This would encourage and foster the creation of specialist services as groups of GPs look to take advantage of those development opportunities.

Sharon Grant, from Healthwatch Haringey, commented that increasing access to primary care on its own would not engender the required outcomes; the challenge was to do it strategically, looking at prevention and looking at different models of care. Otherwise the danger was that the Strategic Commissioning Framework would just create a lot of new appointments across different formats and media but no real change to the delivery services would be realised. The key was to focus on the enablers for this change. Dr Tang responded that the ability to review other records and the wider drive towards interoperability would hopefully mitigate any potential capacity for duplication and limit any negative consequences of expansion of access.

In terms of any potential support required from the wider HWB, it was noted that there would be a number of discussions with partners required about what kind of models would be required. For example, as Tottenham developed discussion was needed about the services offered to residents and the local demand needing to be met. Dr Tang commented that one of the key challenges faced was around workforce, as it was difficult to find and retain local staff and to keep the skill set of the workforce up. It was noted that if there was anything partners can do to help retain a specialised workforce, then that would have a significant impact on the efficacy of these proposals.

The Chair commented that the physical regeneration of the borough and the desire of the CCG to play its part in this would create something that could be quite exciting. Particularly in terms of creating a compelling offer to Haringey's workforce and ensuring that residents had access to the highest quality well motivated staff. The Board should keep this in mind as a key challenge going forward.

Ms Grant noted three main issues for patients:

- Communication – a lot of work would be needed to be invested in this to explain the changes and explain what they meant to people.
- Impact on the continuity of care – would someone still retain responsibility for a particular person's care and would patients still be able to make appointments to see the same GP

regularly?

- Confidentiality – Clearly this was going to open up people's health records to a far wider array of staff working across an array of health and social wellbeing groups. There was a risk that just a few cases where confidentiality was breached could seriously undermine the proposals.

The Chair asked Ms Grant whether she had any sense of what residents had to say about continuity of care versus a demand for greater flexibility. Ms Grant responded that this may be something that Healthwatch could undertake as a piece of work.

Ms Williams responded, noting that she shared concerns around the need for communications and engaging far and wide with residents. Similarly, it was agreed that confidentiality was a risk and a challenge but that the GP's would not have signed up to this agreement if they did not feel that the protections etc were not in place. It was also noted that people could choose to opt of the new system in the first instance and nobody would be able to share their confidential records. In addition, as mentioned earlier, the clinician would be required to ask the patient for permission to access their records each time. There were therefore a number of checks in place to guard confidentiality issues but no system was 100% foolproof.

Dr Pelendrides responded that in terms of continuity of care, her perception was that younger people and those who worked full time or worked unsociable hours would prefer additional flexibility to speak to or see a clinician when they wanted. However people with complicated conditions would be far more inclined to utilise the same services and the information sharing process should help reduce patients needing to explain the details of their case to numerous health care workers. Dr Pelendrides also added that there were no proposals to prevent people seeing the same GP if that was their wish. The example of the over 75's project was noted and the use of care coordinators to supervise the care of the top 2% most vulnerable patients.

The Director of Public Health – Dr Jeanelle de Gruchy asked for further clarification on the model of primary care development and integration with secondary care that Haringey was exploring. Dr Jeanelle de Gruchy also asked for more detail on plans to improve the physical infrastructure, developing new premises, built to a high standard. Ms Williams responded that in terms of primary and secondary care specific details of the Haringey model were to be developed.

Ms Price noted that NHS England were going to begin work on the range of models acceptable for integration. The challenge for the CCG is to be ambitious and to be ready to act when integration options were released.

	Ms Price also noted that in the Claire Gerrarda work that was undertaken, the conclusions were that it would be very difficult to bring the standard of primary care up to the level of acute care as the cost of investing in facilities would be prohibitive. Money (c. £1billion) was made available by the Government in the Autumn Statement for improving the standards of facilities. NHS England would be communicating with GPs on how to potentially access some of these additional funds. The Interim Director of Children's Services – Mr Abbey noted that the rationale and link to Early Help was really reassuring. Despite concerns around confidentiality, information sharing protocols did already exist with child protection agencies etc. In addition, the flexibility of offering a universal standard whilst also being able to tailor access to services to suit different needs would be a real positive. Ms Grant noted that in terms of confidentiality, what people would be concerned about was how much their personal details would be accessed by Local Authority services and this would require a significant programme of communications and one that might raise a number of questions. The Chair then summarised and it was: **RESOLVED:** That the information outlined in the presentation relating to the future of primary care be noted.	
CNCL108.	**LSCB ANNUAL REPORT 2013-14** The Chair advised that Sir Paul Ennals had to leave the meeting at around 14:50 and so proposed that Item 11 was brought forward, after which the Board would return to the agenda. The Board agreed to the variation. The Board received a copy of the annual report, previously circulated within the agenda pack, from Sir Paul Ennals, Chair of Haringey's LSCB. Sir Paul Ennals summarised some of the key aspects of the report. It was commented that the LSCB had two roles; one to promote partnership and the other was to bring together all of the relevant agencies within Haringey, in order to facilitate each agency being able to hold one another to account. There was a legal requirement that an annual report was published. It was noted that in summary, for last year, there were no serious concerns highlighted in the report. Sir Paul Ennals commented that hopefully this year's report would show an improvement.	

Cathy Herman from the Haringey Clinical Commissioning Group commented that when the board last looked at attendance there were a couple of organisations that stood out as having low attendance. Ms Herman asked what happened when organisations do not attend these meetings regularly. Sir Paul Ennals responded that if this became a serious issue then contact would be made with the head of the relevant agency and regular attendance would be requested. Sir Paul Ennals advised that attendance at the meeting was not the most accurate way of measuring engagement with the LCSB process. It was also commented that one of the issues raised by Ofsted and referred to in the tabled report was difficulties with getting schools engaged in this process (now that schools are fully independent). Significant progress had been made in the last period and engagement was much improved.

Ms Herman asked Sir Paul Ennals what happened if, despite contacting the head of the partner agency and reiterating expectations around levels of engagement, this did not improve. In response, Sir Paul highlighted that there was a process of biennial formal reviews of safeguarding practices in all partner agencies which every LSCB undertakes. This involved each agency doing a self evaluation of safeguarding practice and then this would be challenged and scrutinised by each of the constituent agencies.

Ms Herman further commented that a key challenge going forward for the Board was how to make consultations more joined up with partners, particularly around young people. Sir Paul Ennals responded that this was indeed one of the priorities identified in the report.

The Chair commented that she was pleased to see the link between gangs and Child Sexual Exploitation highlighted as a priority for this year in the annual report and asked Sir Paul to comment on how he thought this work was progressing. In response, he commented that one of the actions arising from previous LSCB discussion was the need to update and expand our CSE strategy. Ms Etheridge was leading a task and finish group bringing together all of the agencies on behalf of the LSCB which was due to be reported back to the LSCB Board on the 27th January. Ms Etheridge noted that the third Task & Finish group was taking place on the 14th January and that engagement from partners to this group so far has been very good. Ms Etheridge also commented that she believed that we are getting to a much better place on CSE than we had been previously and that the task would be to ensure that this work was fully embedded in practice.

The Chair then summarised and it was:

RESOLVED:

i. That the Annual Report of the Haringey LCSB (2013-2014) be noted; and

CNCL109.	ii. That the Priorities for 2014-16 also be noted. **PRIMARY CARE TASK AND FINISH REPORT** The Board received a presentation, previously circulated within the agenda pack, from Sarah Barron, Interim Manager, Primary Care at NHS England on behalf of the Task & Finish Group Following the presentation the Board discussed the group's findings. Ms Barron noted that she had asked Ms Williams to help present this item in order to show that NHS England and the CCGs had been working closely on this to allay the perception that the two organisations tend to work in isolation. It was also noted that Nicky Hopkins of North London Estate Partnerships had also been asked to help present part of this item. Ms Hopkins would be presenting what North London Estate Partnerships would be doing as part of the strategic plan that was being developed. Ms Barron commented that although she was on a short term interim posting, she was fully aware of the level of concern around primary care access around east Haringey and Tottenham Hale in particularly. At the last meeting in September 2014 a mapping of need was called for and proposals were requested from NHS England on how that need for primary care would be met. As part of this process a Task and Finish group was established and it was noted that it had now had three meetings. In addition an officer sub-group and an access taskforce was also set up as a sub group to look at the immediate issues that were arising. The idea was that the Task &Finish group would look at the strategic concerns that have been raised. Ms Barron noted that since that last meeting of the HWB a PID document was submitted to the NHS Finance Investment Committee to get funding to undertake a full strategic plan. This included what needs to happen around primary care as part of the regeneration of east Haringey, but also what quick wins could be achieved to tackle immediate concerns around primary care. It was commented that the process of commissioning primary care was a statutory process and that it required clear evidence of strategic need; this was what the strategic plan was intended to give. Ms Barron noted that the plan would hopefully provide evidence of the strategic case for investment. The plan was envisaged to be completed by April but a draft would be brought to the next meeting of this Board. Ms Barron advised there seemed to be some disconnection between known capacity and what patients were experiencing. The presentation tabled in the agenda pack contained a graph showing the GP Full Time Equivalent rate (FTE) across London of which Haringey sat in the middle. When the figures were broken down to show individual	

practices that were experiencing problems with access, these practices did not necessarily have the fewest doctors. In addition, it was noted that one particular practice that concerns were raised with in the past regarding access was actually towards the upper end of GP FTE rate scores.MS Barron commented that this showed that GP access was a multi faceted problem that was not just about capacity. However, it was commented that, the strategic plan would examine the capacity problems and attempt to fill those gaps.

In addition, Ms Barron commented that one of the key things she wanted to highlight was what they could do in the short term to address some of the issues identified. Some of the key access issues in this respect were; the management of appointment systems, utilisation of nurse capacity, using alternative methods of consultation and a poor level of patient experience of access in areas of east Haringey.

The GPs Survey had recently been released and it was noted that a number of improvements had come about in supporting some of the practices that were at the bottom end of the curve on the aforementioned GP FTE rate graph. Including one example where patient satisfaction levels with being able to see or speak to a GP went from 41% to 76 %. Showing that a commitment from those practices where improvements were needed was taking place. NHS England was working with those practices to bring about these improvements to accessibility and the ability to see or speak to a GP.

Ms Barron noted that in cases where GP practices were not engaging with current processes to improve performance levels around accessibility NHS England were able to take contractual compliance measures where necessary, including serving breach and/or remedial notices. It was commented that some of the practices were in the process of being taken through the contractual compliance route.

Ms Barron noted that work has been undertaken with the CCG to understand if there were any short term fixes in the Tottenham / east Haringey area that can be undertaken to tackle these accessibility problems. There were no solutions that NHS England could get funding for through their Finances & Investment Committee without demonstrating clear evidence as part of the strategic plan. Initial conversations had taken place with the developer at Tottenham Hale around finding an on-site solution but again this funding would have to be fully evidenced and again would have to go through the Finances & Investment Committee. Ms Hopkins would continue to explore this as part of the process of bringing together the strategic plan.

Ms Hopkins spoke to the Board and outlined that her organisation was a public-private partnership that was established to address premises needs in Health and Social Care in the Barnet, Haringey and Enfield area. They have developed two health centres in the area at Hornsey and Lordship Lane. They were tasked by NHS England to develop a

Primary Care Premises Plan or a Strategic Premises Development Plan for east Haringey and to support the decision making processes. In order to do this the short, medium and long term primary care needs were to be determined and a clear picture of existing capacity to deliver services developed. As part of this process Ms Hopkins commented that they hoped to identify some quick wins such as a potential temporary solution at Tottenham Hale. The timescales for completion of this project were noted as usually taking 3-4 months; however it was hoped that it would be done sooner in this instance. An update on the project will be brought back to this Board at its next meeting.

Beverly Tarka, Interim Director for Adult Social Care, asked for a little further clarification about the short term routes that were available to tackle poor performance from individual practices. Ms Barron noted that the routes available ranged from the more severe contractual processes that were outlined above, to the CCG providing support to ensure that a practice was able to provide everything that they should provide. Examples of this included liaising with them to determine whether their operating system is operating as smoothly as it can or working to see if a practice provided access through other forms of consultations.

Ms Tarka noted that these routes would take some time before a resolution was found and questioned whether the integrated collaborative GP system provided any opportunities for residents to access appointments quicker. Ms Williams responded that this was currently being looked at by the CCG. In addition to actively going in and supporting a particular practice, the working at scale project was highlighted as having enabled some practices to open up their appointment processes. However it was commented that in the north east the pilot project focused on enabling telephone appointments with doctors, as opposed to making more appointments available. Any future roll-out of the working at scale pilot would also need to be funded.

Ms Barron noted that the current pilots could not provide an immediate solution as the federation of practices was at a very embryonic stage and asking them to undertake any additional tasks could destabilise them. It was further commented that, any additional funding for primary care capacity had to be agreed through the NHS Finances and Investment Committee and this required evidence of strategic need.

The Chair noted that she still did not have a clear sense of where the problem was in Haringey following the last session when a number of residents and Councillors recounted their difficulties of getting an appointment. Ms Barron responded that the charts were provided to illustrate that there was not necessarily a correlation between a lack of capacity and an inability of residents to access services. Ms Price commented that this was not necessarily an issue of just GP numbers. Instead the issue was less straightforward and was more about; how these services were run, the quality of individual GPs or how practices

organised themselves. Ms Herman commented that instead of this being a capacity issue it seemed that this was more about the capability of particular primary care providers.

Cllr Waters, the Cabinet Member for Children and Families asked Ms Hopkins to give the board an estimation of how long this process would take. Ms Hopkins responded that for some of the issues around organisational practices and the re-development alterations, the next step would be to go back to the NHS England governing bodies to see how the projects could be taken forward. It was commented that a key consideration in taking any projects forward would be how they fitted into the strategic plan. It was commented that it would take at least 12 months to build a new building and 6 months to secure planning permission. A range of options would likely be required and that was why a short, medium and long term plan was being developed.

The Chair asked for clarification on what the timescales were for resolution if there were contractual issues. Ms Barron responded that a remedial route involved serving a notice and giving a timescale for improvement; a timescale of two months was suggested. In the case of a breach notice the practice would be informed that they were in breach of contract and NHS England would continue to monitor the practice to ensure that this did not happen again. Both of these courses of action would ordinarily happen at the same time.

Ms Grant expressed concern that the representatives from NHS England and the CCG were unable to give any assurances of remedying the situation in the short term. Ms Grant commented that Healthwatch had previously demonstrated that a severe lack of access to primary care existed around Tottenham Hale. It was also commented that the graph showing the GP FTE was based on averages and did not necessarily do much to help those people who were struggling to access GP services. Ms Barron commented that a key practice in the area was within the top quartile of GP FTE and the correlation wasn't necessarily about lack of capacity and an inability of residents to access services. Health inequalities existed in a number of areas of the borough not just around Tottenham Hale. In the short term NHS England's role was around contract management.

Ms Herman commented that consideration should be given to providing solutions to the primary care shortage that do not necessarily involve providing new facilities i.e. ones that looked into other models of primary care provision.

Ms Etheridge thanked colleagues from NHS England, the CCG and North London Estate Partnerships for their levels of engagement in this process.

It was:

RESOLVED:

i. That progress of the Primary Care Task And Finish Group, be noted;

ii. That the next steps given as part of the presentation be noted; and

iii. That an update on the progress of the Primary Care Task And Finish Group be brought back to the Health and Wellbeing Board on 24th March 2015.

CNCL109. HEALTH AND WELLBEING STRATEGY 2015-18

The Board received a report, previously circulated within the agenda pack, from Dr de Gruchy. A draft copy of the Health and Wellbeing strategy and an accompanying presentation was also tabled. Ms De Gruchy talked through the presentation and both reports and then summarised the key points.

Dr de Gruchy outlined the wider context of the strategy and the HWB Strategy refresh programme. It was noted that the refresh programme was agreed by the HWB in May 2014 and included reviewing the Joint Strategic Needs assessment (JSNA). The program also included setting up a range of key stakeholder group meetings and setting up workshop survey focus groups of voluntary sector stakeholders set up by HAVCO and Healthwatch and some of this work was included in the wider Council budget consultation for the Council's Corporate Plan. These measures were then integrated to facilitate an understanding of areas where we need to take a strong strategic lead.

Dr de Gruchy then gave a brief overview of the outcomes identified in the strategy and a summary of the highs and lows. It was noted that:

- Outcome 1 was to give every child the best start in life and that the key points were: A reduction in teenage pregnancy (but was still high compared to London and nationally); a reduction in infant mortality (but was still high compared to London and nationally); one in three children lived in poverty; childhood obesity was high and tooth decay in children has worsened.

- Outcome 2 was to increase healthy life expectancy. The key points were: Life expectancy was improving generally, especially for men. But men died younger than women primarily due to early death from heart disease and stroke); the inequality gap for men (8 years) and women (about three years) has remained constant over the last 10 years; on average, women lived the last 20 years of their lives in poor health which was worse than London and national average and the number of people with dementia and long term conditions was increasing.

Dr de Gruchy outlined that analysis of demographics around life expectancy was increasingly focused on 'healthy life expectancy'. A graph included in the presentation slides showed the average life expectancy and average healthy life expectancy against an index of deprivation levels. It was commented that in the most deprived areas long term poor health started to develop around age 53 and this was increased to around age 70 for the most affluent areas.

- Outcome 3 was improving mental health and emotional wellbeing and the key points were: Recorded crime was down 40%, partially due to a downward trend in drug use; there was an increased national focus on mental health; there were high numbers of children with behavioural problems; a high level of people suffering from anxiety and depression who were not receiving help and a high level of people with severe mental illness across the borough.

Dr de Gruchy commented that this showed that there are still a number of ongoing challenges in these major areas as these were long term major issues and that these issues had by no means been resolved in the three year lifespan of the previous strategy. The same issues remained key for the borough going forward. Dr de Gruchy also commented that the context for the strategy going forward is that the Health and Wellbeing Board has grown in strength and now benefits from some much stronger partnership working. In terms of the future role of the Health and Wellbeing Board, Dr de Gruchy noted that the potential for Haringey is huge and that the Board should be considering how to capitalise on regeneration and other opportunities in the borough to deliver the biggest health improvements for residents. Dr de Gruchy advocated that the new strategy needed to be ambitious and to find synergies with some of the other key corporate priorities.

It was noted that the three month consultation on the draft strategy was being launched that day and an easy read version was to be developed. The consultation process would involve a consultation on the overall priorities as well as consultation activity on each of the three individual priorities. Delivery plans would also be developed throughout the consultation period. Dr Jeanelle de Gruchy noted that the Health and Wellbeing Strategy and high level delivery plans would be brought back for approval to the Health and Wellbeing Board in June.

Dr de Gruchy asked the Board to give their opinions on the strategy and in particular sought their input on the purpose of the strategy and the role of the Health and Wellbeing Board. Opinions were also sought on

	what the role of partners was and finally, how ambitious did the HWB want to be – should there have been some headline ambitions stated at the end of the strategy? The Chair asked that a discussion on the above points and on the strategy as a whole was delayed until the next meeting of the Board in order to do it justice given that the meeting was due to finish very shortly. It was: **RESOLVED:** i. That the start of a three month public consultation on the draft Health and Wellbeing Strategy be noted. ii. The Health and Wellbeing Strategy and high level delivery plans be presented to the Health and Wellbeing Board in June 2015 for approval; and. iii. That a discussion topic on the Health and Wellbeing Strategy be a scheduled for consideration at the Health and Wellbeing Board on 24 March 2015.	Director of Public Health Director of Public Health
CNCL110.	**HEALTH AND CARE INTEGRATION UPDATE** Ms Etheridge asked the Board to note that progress was being made with Health and Care integration. It was commented that there was a renewed strategic governance structure in Appendix A, on page 35 of the agenda pack, and Ms Etheridge asked the Board to note and approve the revised governance structure. It was: **RESOLVED:** i. That the progress made to date around Health and Care integration be noted; and ii. That the proposed governance structure in Appendix A of the report be noted and approved.	Deputy Chief Executive
CNCL111.	**MENTAL HEALTH CRISIS CONCORDAT** Ms Price, from the Haringey CCG, outlined that the Mental Health Crisis Concordat is something that ties-in very closely with the work of the Board. The Mental Health Crisis Concordat was published in February 2014 by the Department of Health and the Home Office and it set out	

	how organisations would work together to ensure that people receive the required help when suffering mental health crisis. As part of the concordat, there was a requirement to achieve local sign-up and to develop an action plan to deliver the aims of the concordat. Following a London workshop in October local organisations signed the concordat before the 31st December deadline. The task was now to develop a multi-agency action plan by March 2015; some resources had been secured to assist with the development of the action plan. It was: **RESOLVED:** i. that the Mental Health Crisis Concordat be noted and endorsed; and ii. That an action plan be brought for consideration and approval to the Health and Wellbeing Board on 24 March 2015.	Chief Operating Officer Haringey CCG
CNCL112.	**HWB GOVERNANCE: BOARD MEMBERSHIP APPOINTMENT AND CHANGE TO VOTING RIGHTS** The Board considered a report, previously circulated, which recommended a change to the HWB membership to change the Lay Member to a full voting member and also confirmed the appointment of the Chair of the LSCB as a non-voting member of the Board. It was suggested that the reason for this change was that that following the appointment of an additional elected member to the Board, there had been an imbalance in the voting rights between Council and non-Council members of the Board. Ms Grant noted that she had no objection to the proposal but asked whether the composition of the Board could be altered further to strengthen patient/user representation levels. It was: **RESOLVED:** i. That the Chair of the Haringey LSCB be appointed to the Health and Wellbeing Board as a non-voting member of the Board. ii. That it be recommended to Full Council that voting composition on the Health and Well Being Board be amended to allow voting	Assistant Head of Legal Services / Committe e Clerk Assistant Head of

	rights to the Lay Board Member of the Clinical Commissioning Group; and	Legal Services / Committe e Clerk
	iii. That the detail of the the report be accepted and agreed as a consultation by Full Counci, for the purpose of altering the voting rights of the Board member.	
	iv. That the voting rights issue be progressed without further delay due to the immediate need to resolve the imbalance in voting rights.	Assistant Head of Legal Services
	v. That the makeup of the Board be kept under review	
	vi. That future business be brought back for consideration at the Health and Wellbeing Board on the 24th March.	
CNCL113.	**NEW ITEMS OF URGENT BUSINESS** No new items of urgent business were tabled.	
CNCL114.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the date of the next meeting was 24th March at 18:30.	

The meeting closed at 15.30pm.

COUNCILLOR CLAIRE KOBER

.....

Chair

This page is intentionally left blank

Haringey Council healthwatch Haringey HAVCO Haringey Association of Voluntary and Community Organisations NHS Haringey Clinical Commissioning Group

`

Report for:	**Health and Wellbeing Board – March 24th 2015**

Title:	**Transforming health and wellbeing in Haringey**

Report Authorised by:	**Zina Etheridge, Deputy Chief Executive, LBH** **Sarah Price, Chief Officer, CCG**

Lead Officer:	**Jeanelle de Gruchy, Director of Public Health, LBH** **Beverley Tarka, Director of Adult Services, LBH** **Jon Abbey, Director of Children Services, LBH**

1. Describe the issue under consideration

1.1 This paper draws together a number of key developments – legislative, strategic and commissioning – relating to health and wellbeing in Haringey, and draws out the common outcomes and underlying principles emerging from these key developments – legislative, strategic and commissioning.

1.2 Delivering the outcomes requires new ways of working – within the public sector; with the voluntary and community sector; with users, patients and communities. The draft Health and wellbeing strategy (currently out for consultation) seeks to capture the key priorities to deliver these outcomes. Agreed principles will need to be embedded in the strategy's delivery plans; and bold system leadership will be needed to ensure their effective implementation. This paper presents for discussion the strategic leadership role of the Health and Wellbeing Board in this transformation.

2. Cabinet Member introduction

2.1 Haringey faces considerable challenges with areas of high health need and rising demand for services, particularly in social care; this at a time of shrinking budgets. At the same time, regeneration in the borough provides considerable potential to improve health and wellbeing and reduce inequalities.

2.2 The key developments covered in this paper present an opportunity to transform the way in which we seek to improve the health and wellbeing of our residents. Working with our partners and residents, we must ensure that we are ambitious and bold in our approach to delivering our vision.

3.Recommendations

3.1 Note the impact of the Care Act 2014 and the Children and Families Act 2015;
3.2 Note the Council, NHS England and Haringey CCG Strategic Plans and Priorities referred to in the report
3.3 Note the progress on the consultation for the Health and wellbeing strategy
3.4 Agree the Mental Health and Wellbeing Framework in Haringey attached as Appendix 2.

4.Alternative options considered

N/a

5.Background information

5.1 The Care Act and the Children and families Act are new legislation that will have considerable impact on public sector services and the experience of residents in Haringey.

5.2 **The Care Act (2015)**

The Care Act requires the provision of care and support that:

- is clearer and fairer
- promotes people's wellbeing
- enables people to prevent and delay the need for care and support, and carers to maintain their caring role
- puts people in control of their lives so they can pursue opportunities to realise their potential.

The Council will have a 'wellbeing duty', ie a general duty that applies to all residents and requires the Council to promote the individual's wellbeing in all decisions taken or activities performed in relation to the. Wellbeing is defined as:

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

The Health and Wellbeing Board is asked to note that whilst the Care Act comes into force on 1st April 2015 a transitional period will be allowed to help local authorities comply with the new statutory requirements. This, when combined with

the robust approach Haringey is taking to implementation, allows confidence to be invested Council's state of readiness.

Appendix 1 provides further information on the implications of the Care Act for Haringey.

5.3 The Children and Families Act

The Children & Families Act 2014 will give greater protection to vulnerable children and is wide ranging, including a new system to help children with special educational needs and disabilities, help for parents to balance work and family life and perhaps more fundamentally, changes to adoption and major reforms to improve the lives of looked after children.

The key elements of the Children and Families Act related to children's health and wellbeing are:

- The integration between educational and training provision with health care and social care provision in the context of promoting wellbeing.
- Joint commissioning arrangements between The Council and CCGs in the context of special educational, health and social needs.
- A holistic approach to planning and supporting children and young people through the Education, Health and Care (EHC) plan.
- A strengthened duty of care placed upon partners (i.e. schools to support children at school with medical conditions, provision of free school meals)
- Reforms for looked after children, specifically around adoption and the promotion of LAC educational achievement.
- Increased choice for children and young people (i.e. changes to the law to give children in care the choice to stay with their foster families until they turn 21)
- Strengthening the role of the Children's Commissioner with the primary function of the Commissioner changing *from* representing the views and interests of children and young people *to* promoting and protecting children's rights.

5.4 LBH Corporate Plan

The Council's Corporate Plan sets out its 5 major priorities for the next 3 years:

1) Enable every child and young person to have the best start in life, with high quality education
2) Empower all adults to live healthy, long and fulfilling lives
3) A clean and safe borough where people are proud to live
4) Drive growth and employment from which everyone can benefit
5) Create homes and communities where people choose to live and are able to thrive

The Plan also sets out how the Council needs to change as an organisation to deliver improved outcomes in these priority areas on a reduced budget, shifting the focus to:

- Prevention and early intervention - preventing poor outcomes for children, young people and adults and intervening early when help and support is needed
- A fair and equal borough - tackling underlying factors of poverty and discrimination with a scale and intensity proportionate to the level of disadvantage
- Working together with communities - building resilient communities where people are able to help themselves and support each other
- Value for Money - achieving the best outcome from the investment made
- Customer Focus - placing our customers at the heart of what we do
- Working in Partnership - delivering with and through others.

5.5 NHS Five Year Forward View (5YFV)

The NHS Five Year Forward View (5YFV) was published in October 2014 and sets out a vision for the future of the NHS. It was developed and endorsed by a number of organisations, led by NHS England, and gives a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The 5YFV covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs (including primary care); integration between services; and consistent leadership across the health and care system. The 5YFV can be found on NHS England's website: http://www.england.nhs.uk/ourwork/futurenhs/

5.6 NHS Haringey Clinical Commissioning Group five year plan

Haringey CCG has developed a five year plan to achieve its vision of enabling the people of Haringey to live long and healthy lives. The CCG wants to make primary care and care closer to home really work for all Haringey's residents by:

- Supporting and empowering people to self-care, where appropriate
- Supporting people to live independently for as long as possible
- Strengthening and extending partnership working across the whole Haringey community
- Changing the way we commission to focus on paying for outcomes defined by patients, as opposed to activity
- Ensuring young people get the best start in life and are equipped to make healthy decisions which will positively impact their lives as adults
- Ensuring that high quality, easily accessible services are available near where people live and are joined up so that people cannot notice differences between providers or when one takes over from another.

Haringey CCG is also working in partnership with the other 4 CCGs in North Central London - Barnet, Enfield, Camden and Islington - to develop a five year plan for this

wider area, recognising that there are some areas where transformation would be more effective and efficient for on a larger scale.

5.7 Better health for London – report of the London Health Commission

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

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

The recommendations set out actions for all levels of administration. To be effective they need borough, London and national actions to be aligned; this may mean putting pressure up the system to take actions that support our local strategies and to keep engaged with actions taken at London and national levels to ensure the best local impact. The London CCGs are committed to working together to address the recommendations.

5.8 Health and wellbeing strategy (2015-2018)

The Board's draft Health and wellbeing strategy (2015-2018) is out for consultation (until March 30th). This draft strategy was developed following a review of the current Health and wellbeing strategy (2012-2015).

The draft Health and wellbeing strategy (2015-2018) proposes a focus on three areas where we need to make the most significant and sustainable improvements:

Priority 1: Reducing obesity
Priority 2: Increasing healthy life expectancy
Priority 3: Improving mental health and wellbeing

The strategy is underpinned by three principles:

1) Tackling inequalities
   Inequalities due to residents' different social circumstances are, quite simply, unfair. Our actions to tackle underlying factors of poverty and discrimination

must be universal, but with a scale and intensity that is proportionate to the level of need in a certain area

2) Prevention and early intervention
Prevention means shifting our focus from treating symptoms to reducing underlying causes. We have to prevent problems starting in the first place by creating environments where the healthy choice is the easier choice.
3) Working with communities
Existing approaches to the delivery of public traditionally focus on the deficits and vulnerabilities in a population. However, increasingly there is a desire to shift the focus of these services so that they build on residents' and communities' strengths, especially in areas facing many challenges. This requires a radical transformation in how the public sector works, and how its relationship with communities is considered. Services will need to be designed with residents to ensure that every contact promotes independence, self-sufficiency, and a greater sense of self-worth and self-efficacy.

The Mental health and wellbeing Framework (see 5.8 below) will support delivery of Priority 3.

5.9 Haringey's Mental health and wellbeing framework

Under the current Health and wellbeing strategy (2012-2015), the HWB initiated the development of a joint council and CCG Mental Health and Wellbeing Framework in July 2015. The Framework was developed by a mental health expert reference group consisting of various stakeholders including providers, the voluntary sector, housing associations, commissioners from the CCG and LBH and service users. The process was overseen by Outcome 3 Delivery Group. This process for development of the Framework was approved by the HWB board in September 2014. Consultation on the Framework took place in February and consultation feedback has been included in the Framework and its underpinning delivery plan.

The Framework incorporated recommendations from Children and Young People (CYP) and Adults Health (AH) Overview and Scrutiny Panels; it was taken to the joint CYP and AH Overview and Scrutiny Panel on 18th March prior to its publication by the HWB.

The Framework (appendix 2) aims to transform mental health and wellbeing services locally. This will require a cross-partnership response which seeks to address the causes of poor mental health, promote positive mental health and resilience, tackle stigma and discrimination, offer early help and engage fully with those affected by mental ill-health, their families and communities.

The four priorities for the Framework are:

1) Promoting mental health and wellbeing and preventing mental ill health across all ages;

2) Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood;
3) Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa;
4) Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives.

These four priorities are underpinned by a delivery plan (Appendix II) that will be regularly reviewed and refined following further detailed work by task and finish groups to drive the transformation. Reporting will be to the Health and Wellbeing Board.

A key recommended focus for the HWB to support the transformation is to mobilise system leadership and cross-partnership working to ensure that the design, commissioning and delivery of an innovative enablement model based on community assets. This approach will improve outcomes for people who live with mental illness such as having good housing, employment (where appropriate) and fulfilling social relationships.

5.10 Common outcomes and principles

The common outcomes and underlying principles emerging from these key developments – legislative, strategic and commissioning – are:

Outcomes:
- Promoting wellbeing
- Improving health and reducing health inequalities
- Enabling people to be in control of their lives
- Resilient communities
- Safety (protection from abuse and neglect)

Principles:
- A whole population approach
- Tackling stigma and discrimination
- Ensuring young people get the best start in life
- Prevention
- Early intervention
- Strong partnerships
- Working with communities
- Supporting self-care and independence
- Flexible models of service delivery and promoting diversity and quality in the market of providers
- High quality, easily accessible services

- Considering the impact on health and wellbeing of determinants such as the environment, housing, environment and education

5.11 The role of the Health and Wellbeing Board

This paper has presented new key legislation which herald major changes to roles and responsibilities for the public sector and citizens. It describes plans for the NHS and the council which are ambitious and transformational. Strong leadership by the Board is necessary to manage the considerable challenge and change in the system over the next three years.

Our draft Health and wellbeing strategy should capture the key priorities we need to focus on to deliver these outcomes. Delivering the outcomes requires new ways of working – within the public sector; with the voluntary and community sector; with users, patients and communities. We will need to ensure that our agreed principles are embedded into our strategy's delivery plans – and we will need to provide bold system leadership to ensure their effective implementation.

Key questions for the Board to consider are:

- Do we have a sufficiently strong shared strategic vision transform the health and social care system?
- Do we agree on the outcomes and principles that will drive forward this change?
- Do we have the appropriate governance and structures in place locally to ensure collaboration for cost-effective integration of health and other services?
- Are we confident about our ability to transform our approach to deliver 'enablement' (enabling people to be in control of their lives).

6.Comments of the Chief Finance Officer and financial implications

6.1 This report provides a summary of a number of significant developments relating to Health and Wellbeing in Haringey; as such there are no financial implications directly arising from this report. However the Board should be aware of the financial context in which these developments are arising. As set out in the Council's medium term financial strategy the authority is facing the requirement to deliver around £69m of savings by 2018-19. The Medium Term Financial Strategy and the Corporate Plan have been developed together to meet this challenge. In order to ensure that the Council remains clearly focused on its objectives, the MTFS has been drawn up in terms of its investment in each of the five priorities. Priority one and two are most closely linked to the Health and Wellbeing Strategy but given the general duty of promoting wellbeing, all priorities must be seen as contributing to it.

6.2 The new responsibilities introduced by the Care Act do have financial implications for the Council. Under the new burdens principle, Central Government will provide some additional funding to meet these new responsibilities. In 15-16 this is in the form of three specific grants to meet the early implementation costs and more funding is

expected in 16-17 but full details have yet to be announced. However there remains a real risk that this funding has been underestimated and so will not be sufficient. There are also very real pressures for both Social Care and Health arising from demographic changes.

6.3 In this challenging context the successful implementation of the transformative work and the embedding of the principles outlined above will be key to sustaining the financial position of the Borough and the local NHS.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 The Board has a strategic leadership role in the health and wellbeing of the local population in the context of the Board's statutory and constitutional functions which are: a) to promote and coordinate joint commissioning and integrated provision between health, social care (adult and children) and public health services in Haringey; b) to develop, update and publish the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy (HWB); and c) to ensure that commissioning plans are in place to address local need and priorities, in line with the HWB Strategy, and to deliver an integrated approach to the planning and delivery of services and d) to oversee the delivery of the Council's strategic outcomes for local health and wellbeing targets, holding those responsible to account.

7.2 The Care Act 2014 sets out the new legal framework for the provision of adult social care (as set out above and in Appendix 1 attached). The Children and Families Act 2014 makes provision about children, families, and people with special educational needs or disabilities. Part 3 of the Act provides for the new legal framework for identifying children and young people with special educational needs (SEN), assessing their needs and making provision for them. They require local authorities to co-operate with their partners to plan and commission provision for those children and young people and publish clear information on services they expect to be available. There are aspects of these legislative provisions that directly impacts on the Board's functions. The most important are the provisions that require the Council and the CCG to further develop joint working arrangement across services to improve outcomes for children and young people and adults.

7.3 Section 3 of the Care Act 2014 places a duty on the Council to carry out its care and support responsibilities with the aim of joining-up services with those provided by the NHS and other health-related services (for example, housing or leisure services). The duty will apply where the Council considers that integration of services would promote the wellbeing of adults with care and support needs (including carers), contribute to the prevention or delay of developing care needs, or improve the quality of care in the Council's area. This duty reflects the similar duties placed on the NHS England and Clinical Commissioning Groups by sections 13N and 14Z1 of the National Health Service Act 2006. This duty to 'join-up services' apply to all Council care and support functions for adults with needs for care and support and for carers, including in relation to preventing needs, providing information and advice, shaping and facilitating

the market of service providers, safeguarding and transition to adult care and support. The Care Act 2014 Statutory Guidance makes clear that local authorities are not solely responsible for promoting integration with the NHS, and this responsibility reflects similar duties placed on NHS England and Clinical Commissioning Groups (CCGs) where this would improve the quality of health and/or reduce inequalities in access or outcomes.

7.4 The Care Act Statutory Guidance at Paragraphs 15.7 to 15.14 provides advice on strategic planning for integration with health and through the JSNA and JHWS. At Paragraph 15.8 *"Local authorities and clinical commissioning groups already have an equal and joint duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) through health and wellbeing boards. JSNAs are local assessments of current and future health and care needs that could be met by the local authority, CCGs or the NHS Commissioning Board, or other partners. JHWSs are shared strategies for meeting those needs, which set out the actions that each partner will take individually and collectively."* At Paragraph 15.9 "*Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are therefore key means by which local authorities work with CCGs to identify and plan to meet the care and support needs of the local population, including carers. JHWSs can help health and care and support services to be joined up with each other and with health related services. Local Authorities and CCGs can include in their JHWSs a statement of how arrangements for the provision of health, social care and health-related services might be better integrated."*

7.5 For children and young people with special educational needs or disability, Section 25 of the Children and Families Act 2014, requires the Council to carry out its functions under Part 3 of the Act in a way that promotes integration between educational and training provision with health care provision and social care provision where the Council considers that this would promote the well-being of children or young people who have special educational needs or a disability or where it would improve the quality of special educational provision for children and young people with special educational needs. This section also reflects the duty placed on CCGs by section 14Z1 of the National Health Service Act 2006 and the local authority duty under Section 3 of the Care Act 2014 above.

7.6 Section 26 requires the Council and the Clinical Commissioning Group (or NHS England) to make joint commissioning arrangements for the education, health and care provision for children and young people with special educational needs SEN or with disabilities. The joint commissioning arrangements must include arrangements for the Council and CCG to consider and agree the special educational, health and social care provision required locally, and to determine what provision is to be secured and by whom, in order to meet that need. The arrangements must also cover what information and advice is to be provided about education, health and care provision, how it is to be provided, and how complaints about education, health and care provision may be made and handled. In addition, the arrangements will also include procedures for resolving disputes between the partners.

7.7 The Statutory Guidance issued under the Act - Special Educational Needs and Disability Code of Practice: 0 to 25 years (January 2015) provides that *" 3.4 Joint commissioning should be informed by a clear assessment of local needs. Health and Wellbeing Boards are required to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, to support prevention, identification, assessment and early intervention and a joined-up approach." 3.7 Joint commissioning arrangements should enable partners to make best use of all the resources available in an area to improve outcomes for children and young people in the most efficient, effective, equitable and sustainable way (Good commissioning: principles and practice, Commissioning Support Programme, (Rev) September 2010). Partners* ***must*** *agree how they will work together. They should aim to provide personalised, integrated support that delivers positive outcomes for children and young people, bringing together support across education, health and social care from early childhood through to adult life, and improves planning for transition points such as between early years, school and college, between children's and adult social care services, or between paediatric and adult health services.* Under the heading "Local Accountability" at Paragraph 3.70 the Guidance clearly indentifies individual and collective roles for the Council, Children Services, Adult Social Care, NHS England, the CCG, Healthwatch and the Health and Wellbeing Board in the joint commissioning arrangement.

7.8 The Board has the power to approve the Mental Health and Wellbeing Framework as part of the delivery framework for its proposed Health and Wellbeing Strategy for its area.

8. Equalities and Community Cohesion Comments

8.1 The main areas of the board's work relating to the Public Sector Equality Duty under the Equality Act 2010 are the JSNA and the development of our Health and Wellbeing Strategy which will be subject to an Equalities Impact Assessment.

8.3 In the leadership of the 'transforming health and wellbeing' agenda in Haringey, the HWB needs to consider all individuals in shaping policy and have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people.

8.4 To help the HWB do this, mechanisms to ensure the capture of qualitative and quantitative data on different communities is needed.

9. Head of Procurement Comments

The CARE Act 2014 will require the Council to manage and develop the market for care in the borough. Part of this market development may be directly generated by the Council itself, and enable it to delegate social care functions to organisations in the borough and this could create new market opportunities for local providers. The Council's commissioning services with other London Councils are developing a market position statement which will be ready in due course.

The CARE Act 2014 will require transparency about social care costs to the Council. The government guidance on this provision confirms that this is intended to allow individuals to benefit from lower prices that should come from Council Framework contracts. This raises the potential of an end to the split markets for the Council and self-funded care. For the Council negotiating social care contracts this could have a significant impact on local authority commissioning and spending in which the demands made on the Cojcil are significantly increased.

In these times of austerity and the reductions in Council funding to be managed against the Medium Term Financial Strategy, the Council's resources for commissioning and procurement may be severely stretched to manage demand generated through the CARE act 2014.

10. Policy Implication

10.1 The Care Act 2014 is a major reform of adult social care law which imposes a range of new duties for the Council that will have implications for its current policies, procedures and practices.

10.2 The Children & Families Act will give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life. The act also ensures changes to the adoption system can be put into practice, meaning more children who need loving homes are placed faster.

10.3 The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health and Wellbeing Strategy. The Health and wellbeing strategy aims to improve the health and wellbeing of children and adults in our borough and reduce health inequalities between the east and west of the borough.

11. Reasons for Decision

The Framework was developed on behalf of the Health and Wellbeing Board and will feed into the refreshed Health and Wellbeing Strategy.

12. Use of Appendices

Appendix 1: The implications of the Care Act for Haringey
Appendix 2: The Haringey Mental health and wellbeing Framework

13. Local Government (Access to Information) Act 1985

Appendix 1: The implications of the Care Act for Haringey

The Care Act

The Act came onto the statute books on 14th May 2014 and is a bold and historic piece of legislation. It is the most wide-ranging reform to adult social care in nearly 70 years. It modernises and consolidates, for the first time, adult care and support law in a single clear statute.

The Act is divided into five parts with eight schedules. Part 1 of the Act deals with the reform of adult social care and support legislation and is the part most relevant to Local Authorities. It is structured around an individual's journey through the reformed system (be they someone in need of care, or their carer). The Act will put a limit on the amount those receiving care will have to pay towards the costs of their care, with a cap on care costs beginning in April 2016. The remainder of Part 1 of the Act, such as national eligibility criteria and universal deferred payments, will come into force in April 2015.

Sections 1 to 7 of the Act place a number of general duties on local authorities. These are:

1. Promoting individual well-being
2. Preventing needs for care and support
3. Promoting integration of care and support with health services etc.
4. Providing information and advice
5. Promoting diversity and quality in provision of services
6. Co-operating generally
7. Co-operating in specific cases

Unless otherwise indicated all references made to the Act in this appendix will be made to Part 1 of the Act as this covers the statute's care and support provisions and financial reforms. However, the different provisions in Part 1 will not be considered in detail. Should members of the Health and Wellbeing Board wish to read a detailed summary of these key provisions, please consult the guidance produced by the Local Government Association, *'Get in on the Act: The Care Act 2014'*

(http://www.local.gov.uk/documents/10180/11309/L14-284+Getting+in+on+the+Act_web.pdf/edfb186d-166f-4058-a20d-5ba5e2646e6e)

The Wellbeing Duty and Principle

The Care Act imposes a *duty* on local authorities to promote *individual wellbeing* when carrying out *any* of their care and support functions in respect of a person. This duty is sometimes referred to as the *"wellbeing principle"* because it is the guiding principle of the Act. It puts individual wellbeing at the heart of care and support system.

The paramountcy of the wellbeing principle means it provides the *acid test* of the actions local authorities take when carrying out their care and support functions. The principle means that whenever a local authority makes a decision about an adult it *must* promote or seek to promote individual wellbeing.

The Act's definition of wellbeing covers:

1. personal dignity (including treatment of the individual with respect);
2. physical and mental health and emotional well-being;
3. protection from abuse and neglect;
4. control by the individual over day-to-day life (including over care and support, or support provided to the individual and the way in which it is provided);
5. participation in work, education, training or recreation;
6. social and economic well-being;
7. domestic, family and personal relationships;
8. suitability of living accommodation;
9. the individual's opportunities to contribute to society.

The expansive nature of the definition of wellbeing means that the Care Act has *whole Council* implications. It *cannot* be regarded as being *'just'* an Adult Social Care Act. The Act also establishes a *duty* of co-operation that requires an authority to ensure that all its departments co-operate in meeting the wellbeing duty. In short, the Act makes 'wellbeing' *'everybody's business'*.

A duty to promote integration

This duty imposes on local authorities a responsibility to promote the integration of care and support with health and other services and is the logical corollary of the Care Act's wellbeing principle. Statutory Guidance makes clear that the duty must be looked at in the round as it encompasses closer working between the services (i.e. departments of local authorities) and between the local authority and all it external partners, especially Health, who have a contribution to make to wellbeing.

As a result when the integration and cooperation provisions of the Care Act we can see that it is, not only, a *whole Council Act*, it is also, a *whole health and social care economy* Act.

Highlights of the Act

Table 1 lists some of the highlights of the Act which, unless stated, come into force on 1st April 2015. The listing is not all inclusive but, summarises how the statute will determine the Council's statutory duties for Adult Social Care and its delivery of this important service. This will have important implications across the whole economy.

Table 1. Highlights of the Act

Requirements
Prevention **(New in law but not new in practice/policy)** A new *general duty* requiring local authorities to ensure the provision of preventative services. That is, services which help prevent or delay the development of care and support needs, or reduce care and support needs (including carers' support needs).
Integration **(New in law but not new in practice/policy)** A new local authority *duty* to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services. The duty's emphasis on *"other health related services"*, whose definition encompasses housing, leisure services, education etc, means that the Council's services have to work more closely together.
Information and advice (**Modernises existing law)** A new *general duty* to provide information and advice on social care, including independent generic and regulated financial advice, to all residents regardless of whether, or not, they have eligible care needs.
Diversity and quality of provision and market shaping **(New in law but not new in practice/policy)** A new *general duty* to promote diversity and quality in care and support provider market. Local authorities must act to ensure that there is a range of different providers of services available. These must offer a range of services shaped by the demands of individuals, families and carers, and be of a high quality, in order to meet the needs and preferences of people wanting to access services. Commissioners in Haringey have a track record of working with providers to ensure a vibrant and sustainable provider market. The publication of the Market Position Statement will help providers shape their businesses to meet future commissioning intentions.
Cooperation (generally) (**Modernises existing law)** A new *general duty* of mutual cooperation between local authorities and their relevant partners (see Appendix 2) in the exercise of their respective functions relating to; a) an adults with needs for care and support, and; b) carers. This duty provides a new ability to require cooperation from a relevant partner, in relation to an individual case. The duty makes clear that compliance with the Act requires excellent partnership working.
Cooperation (specific cases) **(New in law but not new in practice/policy)** ***Assessments:*** A new *duty* for a local authority to carry out an assessment, which is referred to as a *'needs assessment',* where it appears that an adult may have needs for care or support. Assessments must be person centered with the person being assessed empowered to take a leading role in the assessment process.
Carers' Assessments **(New in law but not new in practice/policy)** A *new duty* for local authorities to undertake a 'carer's assessment', on the basis of the appearance of a need for support. This is a lower threshold for assessment than under the current law. It removes the existing requirement that the carer must be providing *"a substantial amount of care on a regular basis".* Work is being undertaken to identify the

financial impact of this while Adult Social Care and Health Watch are collaborating to ensure that the voice of carers is heard with respect to carers' rights under the Act.
Eligibility **(New in law and new in practice/policy)** A new *duty* to introduce a separate national minimum eligibility threshold (see Appendix 3) in place of the current Fair Access to Care Services (FACS) eligibility criteria where, until now, the level for accessing services, e.g. substantial and critical in Haringey, is set by the Council..
Personal Budgets: **(New in law but not new in practice/policy)** A new *duty* to offer everyone who is eligible for a service a personal budget with the expectation that the default form of provision will be a direct payment.
Deferred Payments **(New in law but not new in practice/policy)** The Care Act 2014 establishes a universal Deferred Payment Scheme, which means that from April 2015 people may not need to sell their home in their lifetime to pay for the costs of care. A Deferred Payment is a way of deferring the costs of care against a property which is the person's main home. It is a loan against the value of the property. The loan is paid back at the time of the person's death by the sale of their property. Haringey is unusual in so far as it, currently, has no Deferred Payments scheme or policy.
Independent advocacy **(New in law and new in practice/policy)** A *new duty* to arrange independent advocacy for people who need help to be involved in assessment, care planning, appeals or safeguarding and have no appropriate person who can represent their views. This duty reflects best practice and to ensure compliance with the Act Haringey let, in January 2015, a contract for independent advocacy to Voiceability.
Adult safeguarding **(New in law and new in practice/policy)** The Act sets out the local authority's responsibility for adult safeguarding for the first time in primary legislation. Local authorities *must* make enquiries if they believe an adult is, or is at risk of, being abused or neglected. They *must* also host and lead multi-agency *Safeguarding Adults Boards* (SABs) to maintain strategic oversight of safeguarding and carry out *Safeguarding Adults Reviews* when people die as a result of neglect or abuse and there's a concern that the local authority, or its partners, could have done more. Haringey already has robust, mature safeguarding arrangement in place; including a SAB There is a high degree of confidence that these arrangements are compliant with the requirements of the Act.
Self-funders **(New in law and new in practice/policy)** The Act introduces a range of *new duties* for people who fund their own care. This includes the provision of assessments, care plans and care accounts, service finding and providing self-funders with alternative provision in the case of provider failure. Local authorities will also become liable for the care costs of self-funders once they hit the *'cap'* on care costs.

On 1st April 2016 a tranche of funding reforms (known as the Dilnot reforms) will come into force. These reforms, which will be the subjects of a later report, will put a

limit on the amount those receiving care will have to pay towards the costs of their care, with a cap on care costs beginning in April 2016.

Assessing the Impact of the Care Act

When assessing the likely impact of the Act in Haringey it is useful to consider if its various sections are:

1. new in law and practice/policy, or;
2. new in law but not new in practice/policy, or;
3. simply modernise existing law.

It has been suggested that as many sections of the Act are new in law but not in practice/policy the impact may be limited. – see Table 1 and LGA clause analysis at:

http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/5761381/ARTICLE

However, this conclusion is misleading as it applies only in so far as existing practice standards meet those demanded by the Act and its statutory guidance. In assessing the Act's impact for the Haringey it is essential to understand the extent to which local practice, procedures and policies meet the new statutory requirements. Therefore, all relevant practice, procedures and policies are currently being reviewed to ensure that they are compliant with the Act.

Consideration must also be given to how the Care Act will impact on the demand for adult social care and to identifying any accompanying financial implications. It is accepted that the Act will increase demand and, as a consequence, costs. Increased demand for assessment for carers services and support for self-funders are likely to be those areas where increases in demand will be the greatest.

However, identifying the precise level of increase is extremely difficult. It is something the Government and all local authorities are struggling with and work on this matter is being taken forward locally, on a pan-London basis and at national level.

Haringey's approach to implementing the Care Act

Much work has taken place to ensure that Haringey will be compliant with those aspects of the Care Act which come into force on 1st April 2015. This is a large and complex undertaking that is being delivered through a programme management approach consisting of the following workstreams:

1. Commissioning
2. Workforce planning
3. Assessment, eligibility and care planning
4. Advice and information
5. Deferred payments
6. Safeguarding

7. Financial reform

The workstreams reflect those identified by the Local Government Association as being critical to implementation and each is managed by a senior officer, with a relevant professional background, with the support of a dedicated programme team. The Interim Director of Adult Social Services acts as the sponsor of the implementation programme with governance provided through an Implementation Board and the Adult Social Services Departmental Management Team.

In addition, adult social care staff are being provided with a rolling programme of briefings about the Care Act and specialised legal training. As of 20th February 2015, 626 staff, carers, service users, Health colleagues, third sector partners and providers had attended meetings to find out more about the Act. Information about the Act has also been placed on the intranet and internet.

The Health and Wellbeing Board is asked to note that whilst the Care Act comes into force on 1st April 2015 a transitional period will be allowed to help local authorities comply with the new statutory requirements. This, when combined with the robust approach Haringey is taking to implementation, allows confidence to be invested Council's state of readiness.

The Risks of Care Act Implementation

Although, good progress has been made in preparation for 1st April there are areas of risk. The most significant risks are referenced in Table 2, below.

Table 2. The Risks of Implementation

Risks	Treatment
Government funding may not be sufficient to cover the actual costs of implementation	Lobby Government through national and regional forums e.g. LGA, ADASS, London Councils etc.
The Care Act will create additional demand side pressures from carers and people who self-fund their care and support. These pressures will have unknown cost implications.	Continue support local and regional work to produce impact assessments.
Uncertainty about how the introduction of the national minimum eligibility threshold will impact on the number of people who will qualify for publically funded adult social care.	• Monitor impact of national minimum eligibility. • Use information and advice services to redirect people to alternative community based provision. • Develop low cost preventative services.
The Care Act places a prevention duty on	Implement draft Corporate Plan

the Council but it is not clear how this duty is to be funded.	

Appendix 2: The Haringey Mental health and wellbeing Framework and delivery plan

Mental Health and Wellbeing Framework in Haringey

NHS
Haringey Clinical Commissioning Group

Haringey Council

This framework was developed by Tamara Djuretic, Assistant Director of Public Health, Haringey Council and Tim Deeprose, Assistant Director, Mental Health Commissioning, Haringey Clinical Commissioning Group (CCG) on behalf of Haringey's Mental Health Expert Reference Group.

March 2015

CONTENT

1 EXECUTIVE SUMMARY

Joint Mental Health and Wellbeing Framework – Plan on a page

Our vision:	All residents in Haringey are able to fulfil their mental health and wellbeing potential
Context:	Haringey's Health and Wellbeing Strategy focuses on improving the mental health and wellbeing of our residents. Over recent years, there has been a greater emphasis on improving services, tackling stigma and discrimination, and a focus on prevention to improve the overall mental health state of the people living in the borough. We now need to scale up our ambition and work together to transform mental health and wellbeing services locally. This will require a cross-partnership response which seeks to address the causes of poor mental health, promote positive mental health and resilience, tackle stigma and discrimination, offer early help and engage fully with those affected by mental ill-health, their families and communities.
Our priorities:	1. Promoting mental health and wellbeing and preventing mental ill health across all ages; 2. Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood; 3. Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa; 4. Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives.
What would success look like?	➔ More people will have good mental health ➔ More people with mental health problems will recover ➔ More people with mental health problems will have good physical health ➔ More people will have a positive experience of care and support ➔ Fewer people will suffer avoidable harm and die by suicide ➔ Fewer people will experience stigma and discrimination
Principles:	➔ Working together in partnership to co-design services with residents ➔ Offer person-centred services based on individual choice that is reflected in commissioning ➔ Promote asset based approach that builds individual, family and community strengths ➔ Strive for quality and ensure timely access to appropriate services ➔ Commission and deliver efficient and effective services based on robust evidence ➔ Integrate commissioning and delivery of services, whenever possible, where those with mental ill health, their families and carers feel supported
Enablers:	Health and social care integration, Value Based Commissioning, Working with communities National and local policies, Effective monitoring and evaluation

2 INTRODUCTION

Our mental health and wellbeing has a great impact on our ability to live happy and fulfilling lives, to achieve our goals, have good social relationships and to contribute positively to society. However 1 in 4 people will experience some form of mental health problems during their lives ranging from mild anxiety and depression to severe mental illness. Those who experience poverty, unemployment, social isolation, poor quality housing and lower levels of education, are exposed to crime, violence or substance misuse, are at greater risk of developing mental illness.

What is mental health?

Good mental health is not just the absence of a mental health condition but the foundation for the wellbeing and effective functioning of individuals and communities. It is defined as 'a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'. (World Health Organisation).

What is wellbeing?

The Care Act 2014 defines the wellbeing of an individual in relation to all of the following:

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

What is mental ill health?

Mental illness is generally categorised in Common Mental Disorders (CMD) and Severe Mental Illness (SMI).

Common mental disorders are those which tend to occur most often. People with CMD have more severe reactions to emotional experiences than the average person. For example, this may mean developing depression rather than feeling low, or having panic attacks rather than experiencing feelings of mild anxiety.

CMD includes conditions such as depression, anxiety disorders, obsessive compulsive disorders and post traumatic stress disorder.

Severe mental illness is less common. It disrupts person's perception of reality, their thoughts and judgement, and affects their ability to think clearly. People affected may see, hear, smell or feel things that nobody else can. This includes conditions such as schizophrenia and bipolar disorder. Severe mental health illness may be referred to as psychotic conditions.

Haringey's Health and Wellbeing Board, Haringey CCG and the London Borough of Haringey (LBH) identified mental health and wellbeing as one of three priorities for the next three years. This Framework sets out our vision, ambition and joint commitment for improving the outcomes for residents starting from early years, through adulthood and into older age. The Framework articulates commissioning intentions and calls on effective partnership working to transform mental health services, tackle stigma and discrimination, promote mental health, offer early help and engage fully with those affected by mental ill health, their families and communities.

As we are developing the Framework, it is important to reflect on the current Health and Wellbeing Strategy, evaluate its progress and identify further challenges. The success achieved in these areas should encourage us to achieve our greater ambitions through this Mental Health Framework. Here are just a few main achievements of the 2012 – 2015 HWB Strategy, Outcome 3: Improving mental health and wellbeing:

- **Reduced risk factors** for mental ill health such as the number of young people not in education, employment or training (NEET), crime by 40% and helped 320 adults and 100 young people to find jobs (third of them maintained job after six months);
- Commissioned a range of interventions on mental health awareness raising, **mental health promotion and mental ill health prevention** in a range of settings including schools, voluntary sector, Tottenham Hotspur Foundation etc.;
- The Clarendon Recovery College has been established as a **community based initiative** which, working with a range of partners, assist people with mental ill health to find employment, pursue education and training and improve social life;
- **Service improvements:** commissioned Recovery House run by Rethink, developed value based commissioning approach to mental ill health, re-commissioned 185 mental health units by Housing Related Support, re-commissioned drugs and alcohol services informed by the needs of the local population;

- Four **Overview and Scrutiny** reviews, recently completed, focused on mental health and physical health, mental health and accommodation, Children's and Young People Mental Health Services in transition, and mental health and community safety. Recommendations of these reviews can be found at http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=128&MId=6266

Further challenges are ahead of us as we seek to transform mental health care to person-centred and seamless provision of integrated services based in and within the communities. Over the last couple of years we have seen real improvements locally in how we support people with mental ill health to access adequate interventions and treatments. We now need to reach more people and scale up our offer for recovery and enablement. By recovery and enablement we mean supporting people to meet their potential to live independently, to have meaningful social relationships, maintain good quality housing, find and/or maintain employment and live a satisfying life.

The scope of the Framework will include: the importance of promoting wellbeing and developing community assets; a life course approach to mental health from early years to older age; a cohort of people with dual diagnoses needs such us those with mental health problems who also have dementia, substance misuse, learning disabilities or autism.

Due to their specific and complex needs the following groups of people and the services they require will be excluded from the Framework:

- People with dementia and frailty;
- People with learning disabilities;
- Adults with autism

Separate strategic and commissioning approaches are taken for these services.

To inform the development of the Framework, we have set up an Expert Reference Group with a range of stakeholders that met in a series of workshops over the last six months. Details on the process of the Framework development are set out in Appendix I. We conducted informal consultation with a range of stakeholders and service users. Comments received during consultation were incorporated into the Framework and will feed into delivery plan.

3 VISION AND OUTCOMES

Haringey's Mental Health and Wellbeing Framework Expert Reference Group proposed the following vision:

All residents in Haringey are able to fulfil their mental health and wellbeing potential

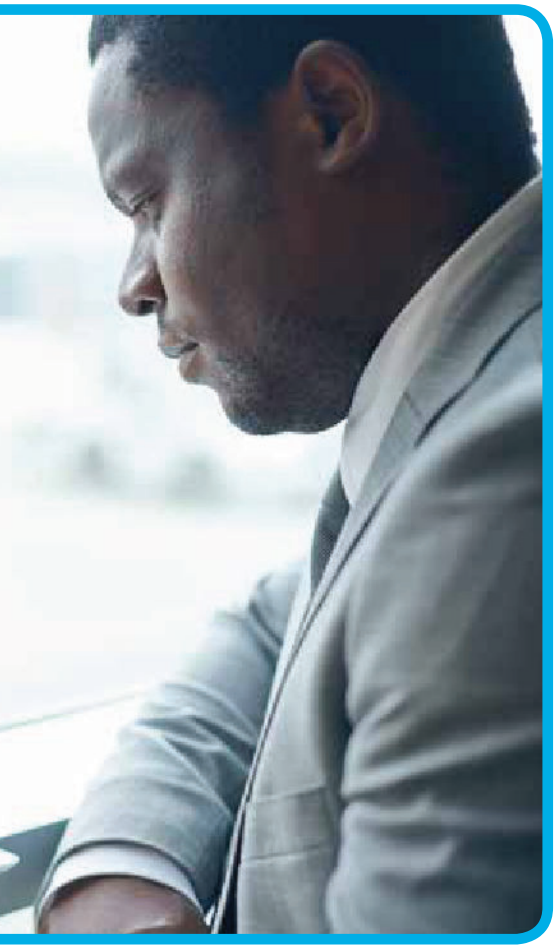
This articulates the need to focus on prevention and mental health promotion. It also recognises that there is a wide range of mental health and wellbeing experiences within Haringey's communities, and encompasses principles of services being flexible and tailored for a range of individual needs.

In Haringey, by 2018, we would like good mental health and wellbeing to be a main focus of all frontline services. Certainly, there will be a group of people that would need extensive multi-disciplinary service support and for those, we would work towards commissioning and providing care that will be wrapped up around their individual, their family and their carer's needs. We will strive to ensure that people access appropriate services timely and based on their needs. There will be equal partnership between services and individuals and intervention models will be designed together.

Emphasis on the importance of good mental health will start from early years. Families will be supported, whenever needed, to access a range of community interventions to help and support when there is an emotional or behavioural concern for any member of the family. There will be greater focus on improving maternal mental health. Schools will aspire to mainstream emotional literacy and emphasis on resilience in curricula, fully and consistently. They will also be able either to offer or signpost to appropriate support, those pupils who may be at risk of developing mental or emotional problems.

Focus on mental health promotion will be integrated and delivered from a range of community settings: libraries, schools, GPs, pharmacies, third sector. A large proportion of frontline staff will be trained to raise awareness, offer prevention advice and advocacy and spot early signs of mental and emotional problems, where appropriate. The model of prevention will be based on building community capacity and strengths and focusing on asset based community development to enable residents to actively improve their mental wellbeing and learn essential coping skills.

Case study: John: 45 year old male



John suffered with depression and anxiety along with a history of alcohol misuse. He also had financial issues with mounting debts. He was seen and assessed by the community mental health team who discovered John walking around at night, sometimes shouting and causing disturbances resulting in unhappiness within the local community.

At first John reluctantly engaged with the services. Joint visits held by the Community Mental Health team and a Community Psychiatric Nurse were helpful and treatment with medication proved successful. John was also assessed by the Dual Diagnosis team who referred him onwards to the Primary Care Alcohol Mental Health Counsellor based at his local surgery. On completion of this programme, he engaged with the Substance Misuse recovery service run by St Mungos. Regular support from his key worker has seen him getting back into employment starting with voluntary work. His debt has now cleared and he is currently in receipt of disability living allowance. As John's life became stable, he had a support and recovery plan that set out the support he needed over 18 months. Currently John continues to receive peer support from BUBIC (Bringing Unity Back into the Community – community organisation).

NB This case study is describing how services could look like in the future

We would like to see a whole system approach in enabling people to be supported in the community to live independently. This will be achieved by designing innovative models for enablement in the community (including support for obtaining and maintaining employment, appropriate housing with care wrapped around individual needs, a focus on assets and individual resilience, and promoting social connections). Also, by partnership working with a range of stakeholders including residents, primary care, NHS, local authority, housing associations, police and the third sector.

Given the current financial climate, it is really important to reduce inefficiencies and duplication, and provide services based on robust evidence. We will strive to integrate at both levels, commissioning and provision of services, whenever possible. We will modernise current models of care to be delivered in line with the national and regional guidelines. We recognise that successful examples of mental health service modernisation did not happen overnight and we will reflect this in a phased approach over the next three years in the Framework Delivery Plan. This Plan will be aligned to the North Central London (NCL) 5-year strategy, the CCG's 5-year strategy, Haringey's Health and Wellbeing Strategy 2015-2018 and Haringey's Corporate Plan.

In achieving the proposed vision, we commit to improve mental health and wellbeing outcomes for all residents and, in particular, those with mental ill health. Below is a set of locally defined outcomes aligned to the national mental health strategy. Further details of on how we will measure these outcomes are included in Appendix II.

Haringey's Mental Health and Wellbeing Outcomes

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support, including carers
- Fewer people will suffer avoidable harm or die by suicide
- Fewer people will experience stigma and discrimination

4 NATIONAL AND LOCAL POLICY CONTEXT

4.1 National policy context

The national mental health strategy: **'No Health Without Mental Health**[1]' was published in 2011. It sets out six main objectives and emphasises the role of the individual and that of the community, in strengthening and managing their own mental health, with appropriate support provided by statutory services. The strategy also describes a life course, outcomes based preventative approach to responding to mental illness and notes the importance of significantly increasing the involvement of primary care, education, employment and housing in the prevention of and recovery from mental health problems.

In January 2014 the Department of Health (DoH) published **'Closing the GAP**[2]' which aims to bridge the gap between long-term ambition and shorter term action in mental health. The strategy sets out four priority areas focused on increasing access to mental health services, integrating physical and mental health care, starting early to promote mental wellbeing and prevent mental health problems, and on improving the quality of life of people with mental health problems.

Launched in February 2014, the '**Mental Health Crisis Care Concordat**[3]' seeks to improve outcomes for people experiencing mental health crises by ensuring services are working with a shared commitment to provide the proper level of care in the right environment. Haringey CCG and LBH will be working with partners from Barnet, Enfield and Haringey Mental Health Trust (BEH MHT), the Police, the London Ambulance Service and the Voluntary and Community Sector (VCS) to ensure there is a local action plan to support this national policy.

National policy context also sets out links between mental health and wellbeing and particular risk groups such as gangs, women and young girls. **The Strategic Framework for Responding to Gang-Associated Women and Girls** highlights the fact that this group of people often experience domestic and sexual violence and sexual exploitation and have complex mental health problems such as depression, anxiety, post-traumatic stress disorder, suicide and attempted suicide, self-harm, substance misuse and physical harm. This particular group at risk is therefore highlighted as one of the focus areas for our local action.

Suicide Prevention Strategy for England published in 2012 sets out plans for preventing suicide rates and supporting people affected by suicide. It suggests a range of measures that can be integrated into the overall local plans for improving the overall mental health and wellbeing; the approach that is adopted locally.

The Care Act, which received Royal assent on 14 May 2014, places a range of new duties on local authorities. The aim of the Care Act is to put people and their carers in control of their care and support, and to change the way in which people are cared for with the concept of 'wellbeing' being central to the act. This means local authorities have a duty to consider the physical, mental and emotional wellbeing of the individual needing care.

The new **'National Tariff Payment System'** has been implemented from April 2014. This new way of commissioning mental health services based on 'tariff payments' rather than activities and processes will assist in commissioning services across the whole pathway and focusing on the outcomes. In preparation for the implementation of Mental Health Tariffs, each Trust has been clustering patients under 21 groupings. Patient clusters are determined through the use of specified clinical tools and protocols and are based on specific diagnostic, severity and risk characteristics, which will inform the basis of treatment and payment mechanisms.

The Mental Health Promotion, Mental Health Prevention: Economic Case[4] and the **Chief Medical Officer's Annual Report on Public Mental Health**[5] clearly describe a range of low-cost, evidence-based prevention services that could be implemented across life course pathways to promote mental health, prevent mental ill-health, detect mental health problems early, improve outcomes and subsequently reduce high care costs further along the pathway[6].

Plans from NHS England such as the 'Five Year Forward View' and the CCGs Operating Plan propose additional funding for mental health. Additionally, the Autumn Statement announced national investment in eating disorder services for children and adolescents of £150 million.

1 Department of Health 2011: No Health Without Mental Health https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
2 Department of Health 2014: Closing the Gap
3 HM Government 2014: Crisis Care Concordat http://www.crisiscareconcordat.org.uk/
4 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case
5 Department of Health 2014: Chief Medical Officer Report on Public Mental Health
6 Department of Health 2011: Mental health promotion and mental illness prevention: The economic case https://www.gov.uk/government/publications/mental-health-promotion-and-mental-illness-prevention-the-economic-case

Work is being undertaken locally to look at how these national policies will be implemented in Haringey to better achieve balanced investment across the whole pathway and implementation of this Framework.

Children and Young People's Mental Health Services are starting to attract significant national attention. **The Health Select Committee Report** published in November 2014 on Children and Adolescent Mental Health Services (CAMHS) articulates concerns about commissioning and provision of CAMHS across the country. A DoH and NHS England Taskforce will be developing plans on how to support local commissioning and provision over the coming months.

4.2 Local policy context

The draft **Haringey Council Corporate Plan 2015-2018** and the draft **Health and Wellbeing Strategy 2015-2018** are currently out for consultation. The importance of mental health and emotional wellbeing has been articulated throughout the Corporate Plan with a specific focus in Priorities 1 and 2 and it is defined as one of the three priorities in the Health and Wellbeing Strategy. Additionally, one of the proposed cross-cutting themes for the Corporate Plan is 'Working with Communities' – an approach to strengthen communities and support them to lead positive change and be more involved in service re-design and delivery.

The vision of **Haringey's Community Safety Partnership (CSP) Strategy 2013-17** is to make Haringey one of the safest boroughs in London. The CSP works closely with health and safeguarding partners to address alcohol, drugs and mental disabilities as critical drivers of offending, disorder and ill health across all crime types.

Tottenham is the most deprived area in the borough and has a high prevalence of mental ill health. **Tottenham's Strategic Regeneration Framework** – a landmark 20-year vision for the future of Tottenham – sets out how local people's priorities could be achieved through long-term regeneration including creating more opportunities for employment, affordable housing and making the place safe and pleasant to walk, cycle and play.

The Haringey Clinical Commissioning Group Five-Year Plan focuses on partnership working to deliver a major shift from provision of services from hospitals to primary and community care, whenever possible. Better management of people with mental ill health is dependent on strong primary care that takes an active part in early detection of cases but also management of those living with severe mental illness in the community. Haringey CCG, with their role in improving the quality of primary care, has been supporting practices to work together 'at scale' to run services more effectively, and organise themselves in a federation model. This might include seeing each other's patients, running call centres or sharing back office functions. These models encourage a mixing of skills and professionals to work together in one place or as part of one network e.g. welfare advice, nurses, health care assistants. This model could, in the future, include hubs with multidisciplinary primary care mental health teams in areas of greatest need.

The NHS North Central London (NCL) five-year strategic plan aligns the plans across Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups and proposes stronger partnership with local authorities. The vision is to develop an integrated care network between organisations focused on outcomes with patients taking greater responsibility for their own health and accessing care appropriately. One of the focuses in the plan is supporting people with mental health needs.

Across North Central London, there are areas of excellent practice and some trusts (including BEH) are piloting these approaches. However, pathways and indicators used to monitor how 'good' services are delivered, need to be strengthened. There is a significant investment imbalance between preventative services and services for those in crisis, with the majority of resource directed at inpatient acute services and more generally at the higher end of need. Furthermore, the pattern of provision is not best equipped to respond to service user and carer wishes to ensure that their care is co-produced, personalised and responds to individual preferences and needs. As tariff, choice and personal budgets are being introduced locally; we need a reshaping of pathways to ensure these policies have positive and meaningful outcomes for people with mental health needs in Haringey.

NHS England and Clinical Commissioning Groups have a statutory duty[7] to work with local authorities to promote integrated health and social care, making person-centred coordinated health and social care the norm for people with multiple health problems, including mental ill-health. The London Borough of Haringey and Haringey CCG are progressing a structured approach to development and provision of integrated services. This work is led by the newly-established **Health and Social Care Integration Programme Board**. It will enable Haringey to achieve better outcomes for local people, improve the experience of service users and deliver efficiencies and value for money. Mental health and wellbeing is one of the main priorities identified for the integration, especially with a focus on commissioning and providing integrated enablement model and the integration of mental health and wellbeing services for children and young people.

Under the **Public Services (Social Value) Act**, all public bodies in England and Wales are required to consider how the services they commission and procure can improve the economic, social and environmental wellbeing of the area. 'Social value' is a way of adding further benefit to contracts where resources are being directed towards improving people's lives, opportunities and the environment. Commissioning and procuring for social value can help join up all the strategic aims of public services. Haringey Council, in partnership with the CCG is part of the national programme that aims to use the implementation of the Public Services (Social Value) Act 2012 as a catalyst for maximising social value through a cross sector partnership approach to health and care commissioning and delivery. We will pilot this approach on future commissioning and procurement of mental health and wellbeing services.

7 http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf, para 14Zi

5 LOCAL NEEDS AND SERVICE LANDSCAPE

This section summarises the mental health needs of Haringey's residents from various sources such as local Joint Strategic Needs Assessment on mental health in children, young people, adults and older people; Mental Health HaringeyStat; Public Health England's mental health profiles; NHS Benchmarking tools; Healthcare Information System (HCIS); local adult social care; Community Mental Health Profile 2014 and the CCG's and the Council's financial information. Full details are enclosed in Appendix III.

5.1 Local needs

Children and young people

Some children and young people in Haringey may be at greater risk of developing mental health problems than those living elsewhere in London and nationally. This is attributed to the number of factors impacting on mental health such as lack of education, rates of offending, levels of deprivation, unemployment and children living in lone parent households. Mental health needs of children and young people are greater in the east part of the borough. The pyramid diagram below summarises the estimated prevalence and current service utilisation by children and young people in Haringey with mental ill health.

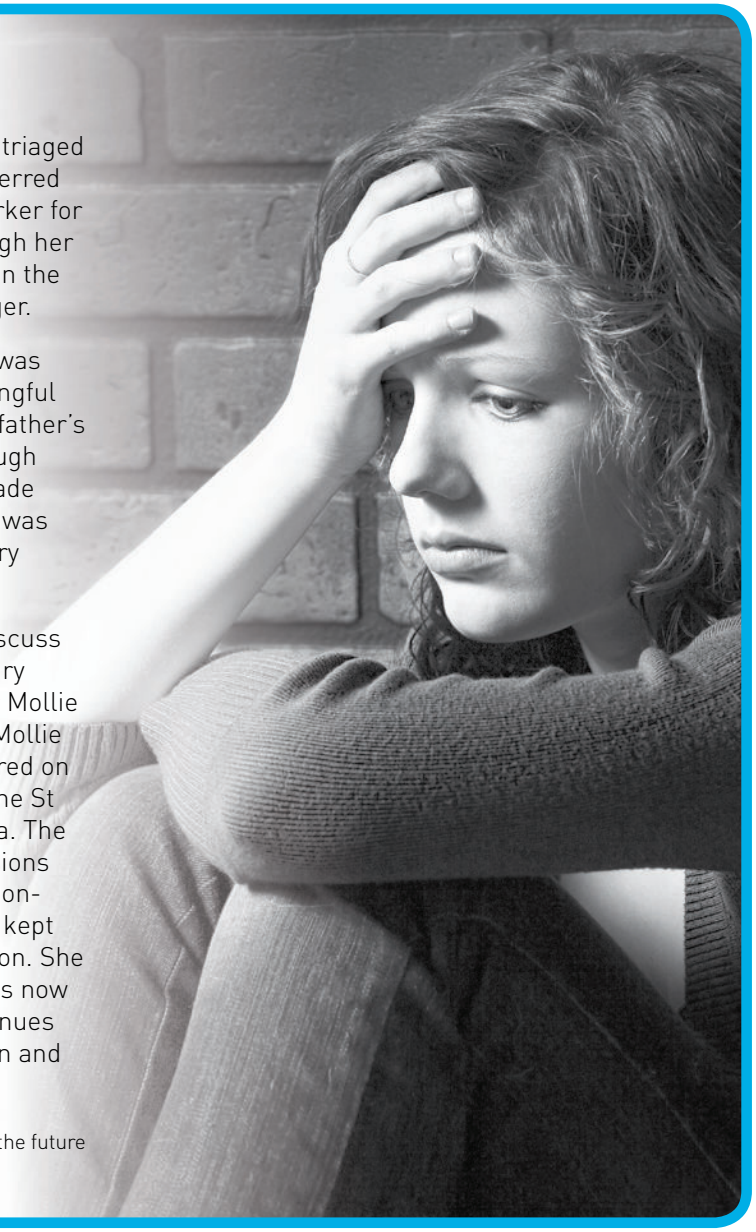
Case study: Mollie, 15 year old girl

Mollie was arrested for common assault. She was triaged under Youth Crime Action Plan (YCAP) and was referred to a Youth Justice Liaison and Diversion (YJLD) worker for her mental health and emotional wellbeing. Through her interviews it was revealed Mollie had self harmed in the past and was having difficulty in managing her anger.

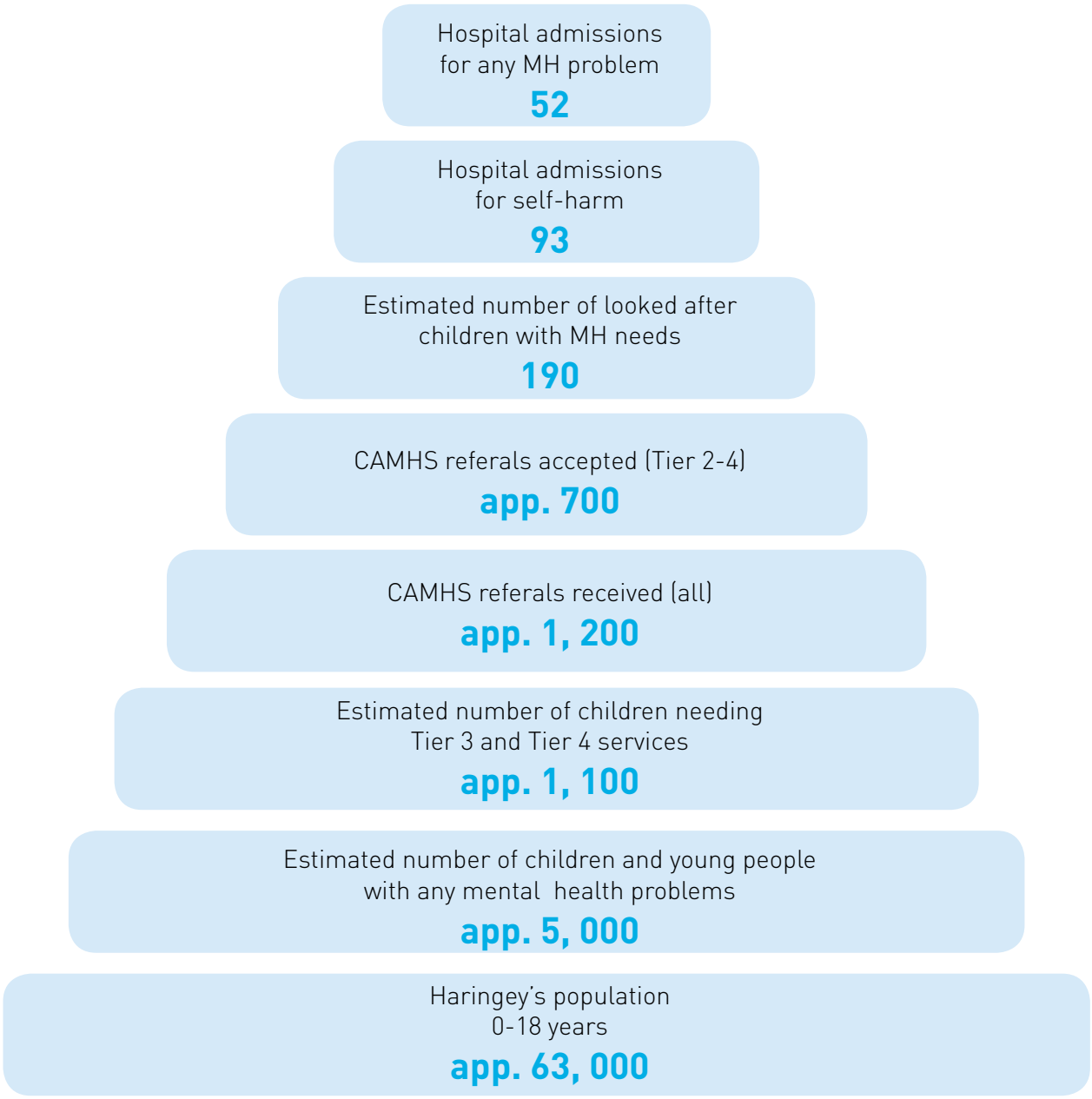
Mollie's grandfather passed away a year ago. She was very close to him, as she has never had any meaningful contact with her father. Quite soon after her grandfather's death Mollie was raped by her boyfriend. Even though police were involved at the time, a decision was made not to pursue the matter further and the assailant was subsequently only given a caution. Mollie is still very angry about the outcome.

The YJLD worker offered a series of sessions to discuss her issues and offer a way forward. An initial enquiry questionnaire was completed to establish whether Mollie was suffering with posttraumatic stress disorder. Mollie scored very high in this and has agreed to be referred on further for specialist help within Tier 2 service at the St Ann's Hospital to help her recover from her trauma. The YLJD worker also organised brief therapeutic sessions to explore her mood and feelings. She has learnt non-violent strategies to manage her anger. Mollie has kept herself out of trouble following the YJLD intervention. She completed her work experience last summer and is now back in full time education. The YJLD worker continues to meet with her fortnightly to monitor the situation and provide mental support when she needs.

NB This case study is describing how services could look like in the future



Children and young people in Haringey with any mental health problems, 2013/14*



2013/14 data used from different sources including Public Health England, CHiMAT, Haringey's JSNA and children's social care. Population figures were obtained from Census 2011.

Local data suggests that we have a higher number of referrals to CAMHS but a lower number of those seen by Tier 3 and Tier 4 services it is estimated by Public Health England (PHE).

PHE also estimated a higher prevalence of mental ill health in children and young people compared to England, in particular conduct disorders. Almost 50% of children with conduct disorders engage in crime activities by the age of 20 and are at higher risk of suicide and substance misuse[8].

Our local information on self-harm referrals in children and young people seems much lower than that reported anecdotally by schools, general practitioners and accident and emergency departments. It is therefore important to understand real need in local communities and focus on prevention, particularly in school settings.

Adults and older people

The risks to mental ill health in adults and older people vary by age, sex and ethnicity. The borough has high levels of factors impacting on mental ill health such as large proportion of ethnic minorities, deprivation, low levels of education, unemployment, substance misuse, violence and crime, social isolation and homelessness. These risk factors and mental health needs are greater in the east part of the borough.

The pyramid diagram below provides details of the estimated prevalence of mental ill health in adults and

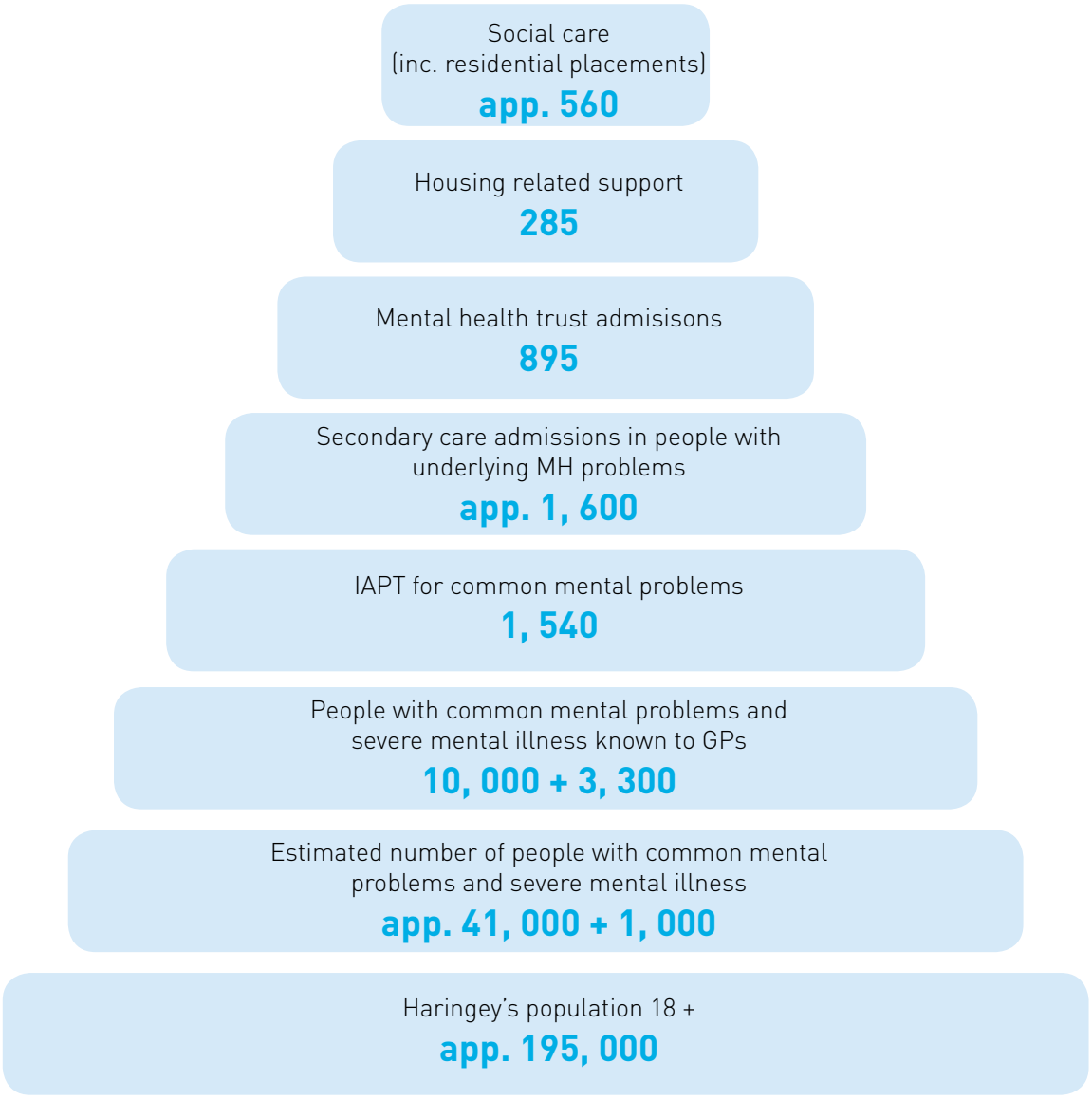
8 Friedli L and Parsonage M (2007): Mental health promotion: building an economic case

older people and their utilisation of services. Only one third of people living with mental ill health are known to health services. This is possibly due to the stigma and discrimination surrounding mental illness coupled with a lack of trust and understanding of how statutory health services work.

Undiagnosed depression is one of the main risk factors for suicide; these people are more likely to live in the east and central part of the borough. Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age. About 26 Haringey residents commit suicide each year. The highest numbers of deaths by suicide are in men aged 25-44, living in east part of the borough.

Public Health England estimated that common mental disorders will be increasing over the next ten years by 25-30%. This is probably due to people living longer and in a more challenging economic climate.

Adults and older people with mental ill health in Haringey, 2013/14*



2013/14 data used from different sources including Public Health England, Haringey's JSNA, adult social care and supported living activity data. Population figures were obtained from Census 2011.

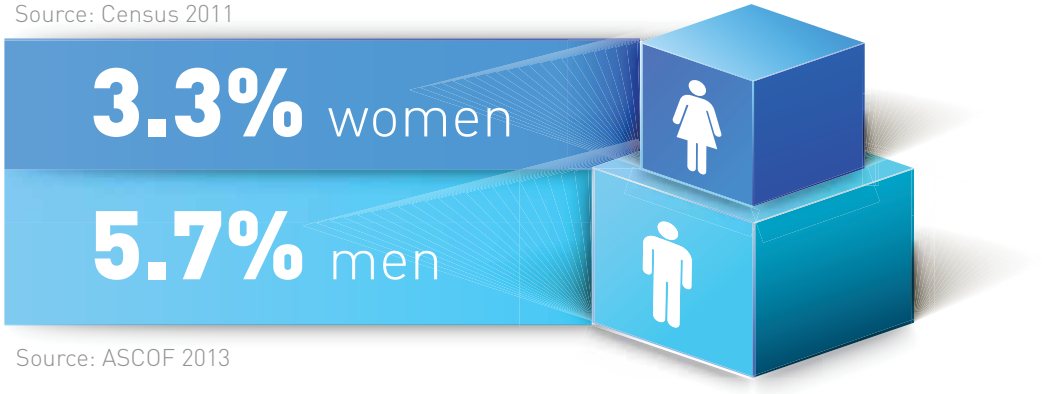
Local data from GP registers suggest that there are three times more people living with SMI than estimated; the 6th highest prevalence of SMI in London. People with SMI have complex care needs often requiring a number of different services at some point on their care pathway. They are at higher risk of dying earlier and are affected by lifestyle risk factors that often cause long term physical conditions. Local primary care information suggests that over 20% of people with SMI have diabetes, 44% are smokers and 34% are obese. This is coupled to a high number of admissions to the acute trusts for people with underlying mental ill health seeking care for their physical conditions.

In terms of understanding how people known to mental health services live in the community, it is important to note that only 65 per cent of people with care programme approaches were in settled accommodation and overall 3.9 per cent in employment in 2012/13.

People with severe mental illness known to mental health services and in employment

Haringey overall employment rate **69.1%**

Source: Census 2011



Source: ASCOF 2013

HaringeyStat on mental health identified a number of unmet mental health needs in high risk groups such as offenders, those of Black Caribbean and Black African origin, those with mental ill health and substance misuse, and young men.

Mental health and substance misuse problems are major public health and social issues. Studies suggest that dual diagnosis may affect between 30 and 70 per cent of those presenting to health and social care settings.

In Haringey, 28% of people who access mental health services also access drug misuse services, compared to 17% for England. This suggests higher prevalence of dual diagnosis locally.

It is important to note that one in three offenders on probation have either mental ill health, substance misuse or both. These cohorts of people are more likely to have late diagnosis of mental illness that often comes to light after the offence.

Local needs assessment on community safety suggests that 67% of those committing domestic violence have mental ill health.

Case study: Esther, 27 year old woman

Esther was diagnosed with schizoaffective disorder following referral and assessment by the Community Forensic Mental Health Team. She had been under forensics due to offences pertaining to a series of assaults mostly on her mother and on some occasions, involving members of the public.

Due to her illness, her physical health was also affected and was monitored by her GP. Over the course of treatment, she put on 5 stones in weight and her thyroid and asthma started to become affected. It was very difficult for her to find the right medication that worked for her.

Working with a Community Psychiatric Nurse, Esther has now found the right medication and is slowly reducing it. In consultation with her GP, Esther developed weight management programme, she is now looking after her physical health and has lost 2 stones. Esther has gone through cognitive behavioural therapy (CBT) which was very positive. It enabled her to go back to university, where she is now in her final year. Currently Esther has a support plan along with wellness and recovery action plans that help her identify the early warning signs of poor mental health as well the plans and advise she can implement to prevent any deterioration or worsening of her condition.

NB This case study is describing how services could look like in the future

5.2 Current service landscape

Our current local offer of services for people with mental ill health is based upon highly specialised hospitalised services, a few beds for recovery and rehabilitation, a large number of outpatient attendances in the Community Mental Health Teams, and high cost care packages and residential care. This offer does not always result in long-term improvement of health outcomes and it creates a community that is highly dependent on the services. Individuals are seldom supported to move on and have a fulfilling, independent life.

Furthermore, the current emphasis on the treatment at the severe end of illness rather than prevention and early help results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes.

Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and the independent sector.

Specialist services commissioned by NHS England include eating disorders services and a range of forensic services and liaison and diversion services. Some of these services often don't link seamlessly into locally commissioned services and there is a need for the commissioning arrangements to be better integrated to reduce duplication and improve efficiency.

The main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contract making it challenging to support the shift of resources to prevention and early help, or to develop further community based services.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet, Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and the voluntary and community sector.

BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework (Appendix I) and there is a single point of referral[9] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council. However, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by schools, the Council, the CCG, the Public Health Department and a number of external agencies (Appendix I). Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide a more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people age 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

BEHMHT is the main provider of nearly all specialist adults and older people mental health services in Haringey, including forensic services. The Trust services operate from over 30 locations across Barnet, Enfield and Haringey, some of them large hospital sites but most are small units in the community. Haringey's main site is at St. Ann's Hospital. The services available from the Trust in Haringey are described in more details in Appendix III. There were over 6,000 outpatient contacts and over 90,000 community contacts last year. Only a small proportion of these contacts are new patients suggesting that the Trust has a significant demand from patients with severe and enduring mental health problems that need a lot of support, coupled with a lack of capacity to discharge these patients safely into a variety of community settings, including adequate supported housing.

Anegdotal evidence suggests that community triage services conducted by the Trust sees over 5,000 referrals annually. Of those, only a small proportion are referred to the Trust suggesting a large demand and service users being managed by primary care and community services.

The Trust also provides substance misuse services and dual diagnosis services for Haringey residents.

Improving Access to Psychological Therapy (IAPT) service provides a range of interventions including 1:1 therapy, counselling and group therapies for those experiencing mild to moderate anxiety, depression and stress. This service is provided in collaboration between BEH MHT and Whittington Health http://www.lets-talk.co/. This service receives between 3, 000 – 3, 500 referrals a year.

The second largest provider of mental health services in the borough is Haringey Council which provides social worker input to Community Mental Health Services and day services. It also provides social care to people with severe mental illness such as domiciliary care, supported living, day care centres, home care, direct payments, personal budgets and adaptation equipment.

The Council also provides Clarendon Recovery College (CRC) aimed at assisting the recovery process for people with severe mental illness. There are currently 230

9 Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

enrolled students who are seen by secondary mental health services. This service has been recently evaluated by Middlesex University and has been shown to be very effective in assisting people to move on, find appropriate employment and pursue further education.

Residential accommodation and supported housing is provided by a range of independent providers and some VCS, the majority of which are in east of the borough. A large proportion of residential care placements (40%) are being utilised by people living outside the borough although this figure has been decreasing recently. The independent sector and VCS also provide supported accommodation, floating support and domiciliary care.

Haringey has a number of supported living providers (mostly independent providers and some VCS), working with people with mental ill health that do not reach a threshold for social care support. The Council funded Housing Related Support (supporting people) Programme delivers forensic, 24 hour and step down accomodation based support, and floating support MH services linked to the Community Mental Health teams in a pathway of services designed to meet a wide range of service users needs.There are 13 main providers of supported housing schemes, offering around 285 places.

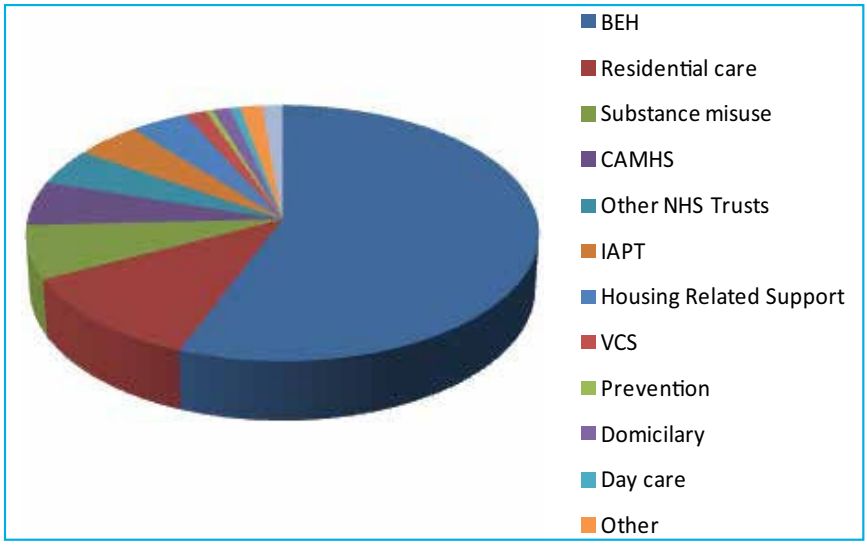
Mental Health and Wellbeing prevention and promotion interventions are largely commissioned by Council's Public Health team. These include awareness raising and training in schools, tackling stigma and discrimination in the community (such as interventions targeting specific risk groups such as Turkish and Kurdish men) and digital peer support for mild to moderate anxiety and depression.

Information and advocacy services are provided by a range of VCS in the borough. These arrangements will be reviewed in the near future to align this offer with Care Act 2014 requirements.

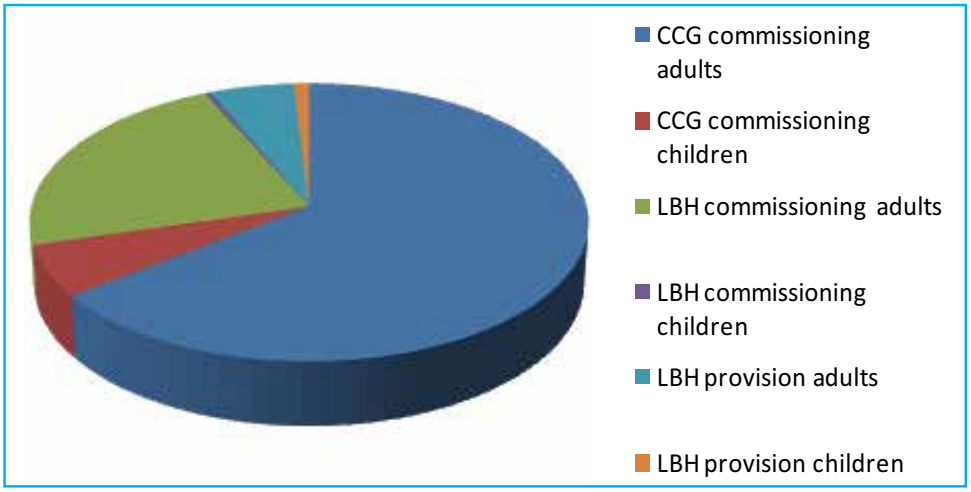
5.3 Total spend on mental health services

Total spend on mental health in Haringey (including substance misuse) for 2013-14 was over £51m. This equates to 11% of the total CCG budget and 6% of the Council's budget. Below is a chart describing total spend by services and total budgets by commissioners.

Total spend on mental health in Haringey in 2013/14 by services



Total spend on mental health in Haringey 2013/14 for the CCG and L



Benchmarking data from various sources suggests that spend on residential care, housing related support, children's and young people mental health, specialist adult mental health services (forensic services), prescribing on psychosis in primary care and the overall spend on secondary mental health per head of population is higher in Haringey compared to England.

Expenditure on community mental health teams and outreach services per head of the population is lower than England's average. This information should be treated with caution as the quality of data depends on accurate and complete returns. However, the overall trend analyses suggest that local spend is highest at the severe top end of the pathway (secondary care, residential placement and supported housing) while there is underinvestment in outreach and community services. Furthermore, lower spend in secondary care for people with psychosis coupled with high spend in primary care for the same cohort of patients suggest that, probably due to high demand, these people are more likely to be cared for in the community.

Considering that the Council's and other partners investments' are indirectly related to tackling root causes of mental ill health (such as employment, affordable housing, community safety and clean and safe environment), it is likely that the overall spend on tackling mental ill health in Haringey is much higher than could be easily quantified.

6 WHAT GOOD LOOKS LIKE?

National evidence suggests that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and that standards of care across the country vary greatly[10]. Even though 50% of all mental illness starts before age of 14, investment in prevention and early identification and in children and young people's services is limited .

Effective mental health services should represent a continuum from prevention, promotion and early help through primary care, secondary care and highly specialised services. It should ideally be delivered through an enablement model in collaboration with a range of partners and service users. The model should be based on individual, family and community assets and designed to promote social connectivity and reduce isolation. However, currently the pathways, often being very complex, are delivered disjointedly, resulting in fragmentation of care for patients and carers. Patients, GPs and other professionals have found access to services difficult and management across interfaces and boundaries unachievable.

Over the last few years, there has been a focus on building a body of evidence on what integrated and modern mental health and wellbeing services should look like. The Joint Commissioning Panel for Mental Health, the London Strategic Mental Health Network and the National Institute of Clinical Excellence have published a series of commissioning guides, quality standards and guidelines to assist commissioners and providers at the local level in transforming mental health services across the life course. Brief summary of wealth of national evidence is enclosed in Appendix IV.

In Haringey, we are committed to using robust evidence to transform services to be more effective, to improving quality and outcomes and to offer best value for money.

The aim is to shift from medical model to community based services where primary care will play pivotal role in the clinical system. Based on the evidence, it is proposed that Haringey's whole system mental health and wellbeing model contains the following components:

- **A better start in life** – ensuring that services for 0-5 year olds support lifelong mental health and wellbeing, by promoting emotional and social resilience and strong and positive parental attachment;
- **Promotion of mental health and wellbeing for all children and young people**, working with schools and other parts of the community to ensure there is early intervention as well as support for ongoing emotional and social development;
- **A prevention and early help offer based on working with communities** to build emotional resilience, to tackle root causes of mental illness such as unemployment, low levels of education and reduce social isolation, stigma and discrimination;
- **Integration of mental health and wellbeing aims** into the delivery of major regeneration and development in the borough – particularly through ensuring that more residents are able to live in good quality accommodation, access stable employment and to have attractive places for walking, cycling and children's play;
- **Effective, evidence based primary care mental health services** - models focusing on multidisciplinary teams based in communities and arranged as 'hubs'. The aim of these teams would be to manage people with stable and ongoing mental ill health holistically as a part of their social system and network to support enablement and independent life. One of the leading roles of primary care mental health is to support people with long-term conditions to manage their mental ill health and also for those with mental ill health to manage their physical health effectively.

10 Joint Commissioning Panel for Mental Health: Practical Mental Health Commissioning (2011)

- **Secondary and specialist services** that are commissioned based on the outcomes, with co-ordinated single point of entry with information about services, waiting times and support to access services readily available to service users, carers and professionals. Referral and treatment pathways should be clear and transparent and arranged around nationally defined clustered funded by Mental Health Tariff.
- **A whole system approach to integration and enablement** that include:
  - Integrated commissioning and service provision of Child and Adolescent Mental Health Services across all tiers;
  - Integrated pathways between specialist services commissioned by NHS England and locally commissioned services.
  - Integrated commissioning which supports integrated delivery, through value based commissioning and by exploring whole system approaches to creating a more joined up system;
  - Integrated service provision between the mental health trust, social care, residential care, housing related support and primary care, including through multi-disciplinary hubs, to support a more seamless service for users;
  - Effective pathways into employment and housing for those with mental ill health, based on the evidence;

7 PRINCIPLES AND PRIORITIES FOR ACTION

The aim of the Framework is to mobilise effective, whole system partnership working to deliver integrated pathways for mental health and wellbeing that will improve the outcomes of our residents. We recognise that such an ambitious task is complex and will take time. We therefore set principles that we would embed in our work while we are approaching major transformation of services:

Principles

- Working together in partnership to co-design services with residents;
- Offer person-centred services based on individual choice that is reflected in commissioning
- Promote assets based approach and interventions that build on individual, families and community strengths at every level
- Strive for quality and ensure timely access to appropriate services
- Commission and deliver efficient and effective services based on robust evidence on what works
- Integrate commissioning and delivery of services, whenever possible, where those with mental ill health, their families and carers feel supported

This set of principles will underpin our approach to the delivery of the four main priorities that we are focusing on over the next three years. These priorities are informed by the national and local policy context, evidence review, needs of our population and local expertise. Below is a brief rationale for these priorities. Detailed recommendations for actions are enclosed in Appendix V.

Priority 1: Promoting mental health and wellbeing and preventing mental ill health across all ages

Why is this priority?

Current resources are locally directed towards the higher end severe mental health needs. This model of care is not sustainable and it does not improve outcomes. There is a strong financial case for shifting some of the resources towards prevention and tackling root causes of mental ill health on a universal basis. This would include access to good housing, work and leisure facilities, and for children and young people, particularly through schools. Additionally, there is a significant number of children, young people and adults living with mental ill health in the community who are not accessing services. We need to tackle stigma, provide better information on the existing interventions and promote benefits of early access to services.

What are we going to do about it?

We will establish a baseline on mental health and wellbeing in Haringey by commissioning a community based survey. This would give us a good basis for monitoring the effectiveness of any interventions over the life of the Framework. We will also work on raising awareness, by providing better information on existing services and tackling stigma through working together with community leaders. This priority will focus on developing resilience at the individual, family and community level. This priority will also include interventions aimed to prevent suicide in Haringey.

Priority 2: Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments, by focusing on transition into adulthood

Why is this priority?

Good mental health and wellbeing starts from conception and continues into early years. Given that Haringey is a borough with stark inequalities and many risk factors for developing mental ill health, it is important to focus on giving children the best start in life and then support those who have emotional or mental health concerns as early as possible. It is estimated that we have a higher number of children with mental ill health and a high number of children at risk, including children in care. Our services are fragmented and not necessarily co-ordinated in best possible way.

What are we going to do about it?

We will use evidence from the recent Overview and Scrutiny review to inform planning on the transition pathways between adolescent and adult services. By working in partnership with other family services in the community, we will develop quality standards based on the evidence to support commissioning of children and young people mental and emotional wellbeing interventions by schools and other organisations and develop clear pathways across Tier 1 to Tier 4.

Priority 3: Improving mental health outcomes of adults and older people by focusing on the three main areas:

- ➔ meeting the needs of those most at risk;
- ➔ improving care for people in mental health crisis;
- ➔ improving the physical health of those with mental-ill health and vice versa;

Why is this priority?

Haringey has a large number of those at highest risk of developing mental ill health such as offenders, children in care, young people and adults with substance misuse, a large proportion of BMEs, homeless, older people and those who are socially isolated. Other groups at risk identified locally are women and girls exposed to violence and lesbian, gay, bisexual and transgender population (LGBT). These groups of people are often accessing services late when they are acutely ill and have worse outcomes.

It is a national priority to strengthen services for those who are in crisis and work has started to implement Crisis Care Concordat locally. Both LBH and the CCG have signed the local concordat.

Finally, people with serious mental illness are more likely to die early and have poor physical health. We are committed to tackle those inequalities and work on parity of esteem.

What are we going to do about it?

We will make links between those groups identified to be at high risk locally and mental health services to enable access to a range of preventative services and we will also strive to include fast-tracking assessments for those with early signs and symptoms of mental ill health.

We will explore how to improve access to people who are at high risk of mental ill health by strengthening pathways between primary care and mental health services and establish fast-track for those most at risk, including people in crisis.

We will develop a Crisis Concordat action plan in partnership with a wide range of stakeholders and also develop suicide post-vention interventions to help individuals, communities and families to deal with aftermath of suicides/attempted suicides.

We will strive to further improve relationships between mental health service users, primary care (especially GPs) and secondary care services and ensure that people with mental ill health are followed up more regularly in primary care. Care co-ordinators can play important role in promoting physical health in those with mental ill health.

Priority 4: Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives

Why is this priority?

At present, the mental health care model focuses on high cost secondary and residential care with under-investment in community mental health teams and outreach services. People stay longer in hospital even if they are clinically fit to be discharged due to complex pathways for securing accommodation and care support. We need to radically change the way we care for people with mental ill health in the community, help individuals to be able to achieve their goals and provide opportunities for adequate employment, affordable housing and timely care packages. We also need to reconnect people into communities to better achieve their potential.

What are we going to do about it?

We will integrate at both levels, commissioning and provision of services to develop an enablement model where people will receive seamless holistic care that focuses on their social problems at the same time as providing ongoing and stable clinical treatment. GPs and care co-ordinators will be at the centre of this model supported by a range of providers such as housing associations, jobcentre plus, VCS and independent sector. We will link this work with Tottenham regeneration to create safer environments in the community as part of wellbeing and work on reducing stigma and discrimination.

8 RECOMMENDATIONS FOR ACTIONS AND NEXT STEPS

Detailed recommendations for actions supporting each of four priorities is enclosed in Appendix V. This is iterative document including suggestions from MH Expert Reference Group and comments received during consultation. It is envisaged to further shape and prioritise recommendations and actions over the comming months as we set up Task and Finish groups underpinnig priorities. These groups will feed into the Health and Wellbeing Board Delivery Group on Mental Health and Wellbeing and will also work closely together with MH reference group under Adult Partnership Board and Children's Partnership Board. Regular updates on Delivery Plan will be taken to the Health and Wellbeing Board.

The impact of the proposed outcomes and priorities will be monitored regularly. National Mental Health Services Dashboard illustrating a set of indicators aimed at monitoring six outcomes is enclosed in Appendix II.

Appendices

Appendix I: Development process and governance framework

This Appendix sets out the process for developing the Mental Health and Wellbeing Framework and how the process will be governed. The final framework will be approved by the Health and Wellbeing (HWB) Board which has senior representation from the council, Clinical Commissioning Group (CCG), Healthwatch and the voluntary sector. Before the final framework is sent to the Health and Wellbeing Board, we are planning the following process:

1. A draft framework will be co-produced by an expert reference group. The expert group will consist of one or two representatives from the following groups:

- Users of mental health service and carers of people with mental health needs (representatives drawn from the Adult Partnership Board and its sub-groups).
- Local voluntary sector organisations that specialise in mental health care
- Local providers from independent sector
- Clinicians from the Barnet, Enfield and Haringey Mental Health Trust
- GPs or other primary care practitioners as providers of primary care and GPs as commissioners
- Public health
- Senior council officers managing social workers in the Mental Health Teams
- Commissioning managers from the council
- Commissioning managers from the CCG

The expert group is expected to meet 2-3 times to develop the draft framework.

2. The draft framework will then be consulted on more widely in the following ways:

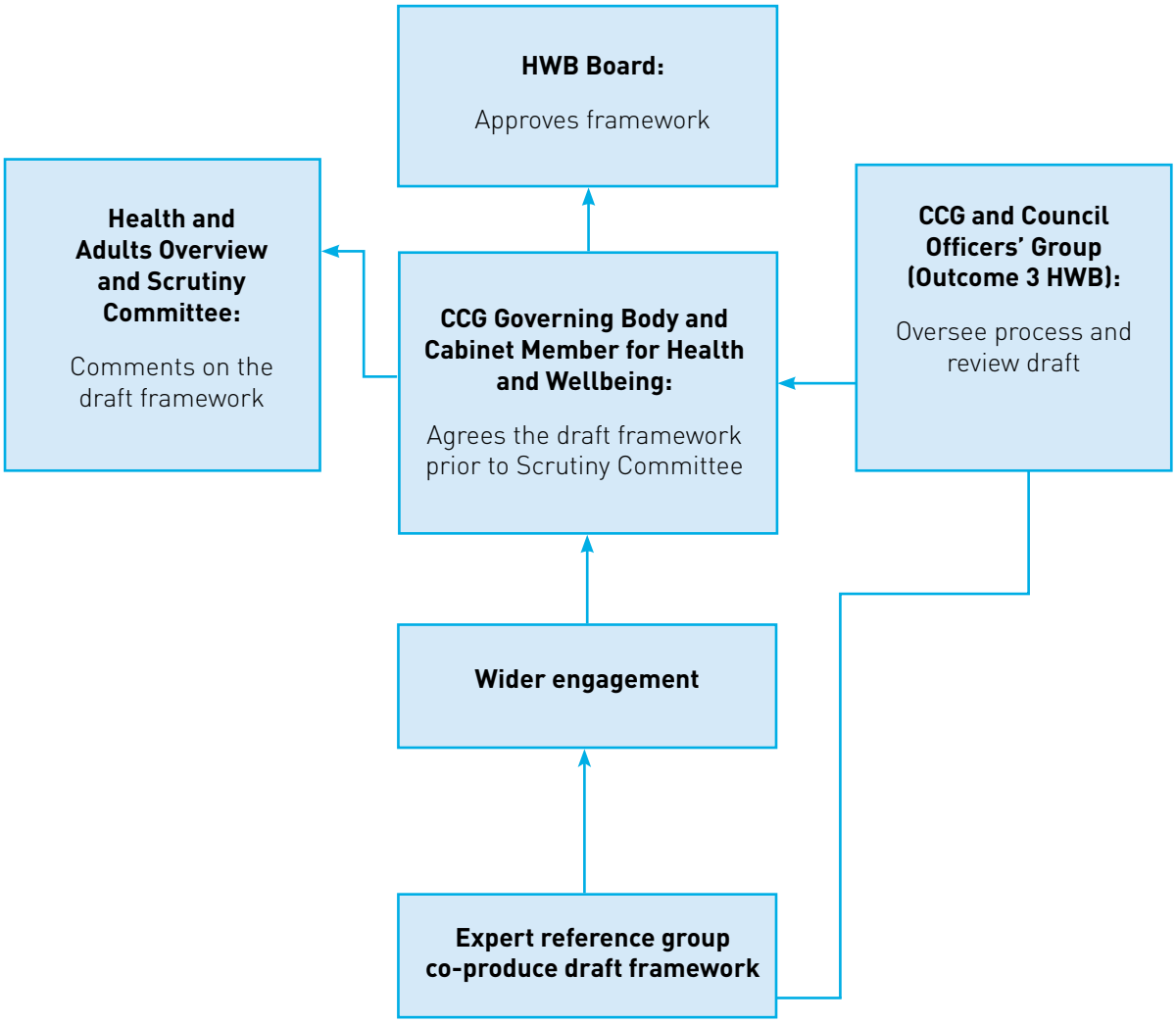
- Commissioners will write to all local providers of mental health services and other services commonly used by people with mental health needs and ask them to comment on the framework;
- Commissioners will meet with wider groups of carers and service users to get their comments;
- The draft framework will be taken to the CCG's Governing Body, GP Collaboratives and Cabinet Member for Health and Adult Services for agreement that the document can be taken to Adults and Health Overview and Scrutiny Committee;
- The draft framework will then be discussed at Scrutiny before being sent to the HWB Board for final approval.

3. The process will be overseen by a Council and CCG officers' group (called the Health and Wellbeing Outcome Three Group) chaired by the Director of Commissioning at the CCG. The role of this group is to:

- Ensure that the process described above is followed;
- Review the draft framework to ensure that it is aligned with existing council and CCG strategic priorities and deliverable within available resources.

The process and governance is shown as a diagram below:

Governance of the development of the Haringey Mental Health and Wellbeing Framework



Appendix II: National Mental Health Dashboard

Table below describes a list of indicators that will be regularly monitored to demonstrate the impact of MH Framework and Delivery Plan implementation.

PHOF-Public Health Outcomes Framework; MHMDS-Mental Health Minimum Data Set; NHSOF – NHS Outcomes Framework; ASCOF-Adult Social Care Outcomes Framework

More people have better mental health	More people with mental health problems will recover	Better physical health
WHOLE POPULATION Self-reported wellbeing (PHOF) Self-reported of children and young people Prevalence of MH problems Possible mental health problems (HSE) Long-term mental health problems (HSE) Days lost due to common mental illness (LFS) WIDER DETERMINANT Homelessness (PHOF) Absolute low income (HBAI) Illicit drug use Social isolation Child development at 2, 2.5 years (PHOF, Placeholder)	CARE AND TREATMENT Improving access to psychological therapies (IAPT, NHS OF) Access to IAPT Recovery rates Patient outcomes following Children and Adolescent Mental Health Services (CAMHS) Treatment outcomes for people with severe mental illness RECOVERY AND QUALITY OF LIFE Employment of people with mental Illness (NHS OF) People with mental illness or disability in settled accommodation (PHOF). The proportion of people who use services who have control over their daily life (ASCOF) IAPT Recovery Rate (IAPT Programme)	Excess under 75 mortality rate in adults with severe mental illness (NHS QF & PHOF, Placeholder).
More people have positive experience of care and support	**Fewer people will suffer avoidable harm**	**Fewer people will experience stigma and discrimination**
Patient experience of community mental health service (NHS OF). Overall satisfaction of people who use services with their care and support (ASCOF). The proportion of people who use series who say that those services have made them feel safe and secure (ASCOF) Proportion of people feeling supported to manage their condition (NHS OF). Indicator to be derived from Children's Patient Experience questionnaire.	Safety incidents reported. (NHS OF) Safety incidents involving severe harm or death (NHS OF) Hospital admissions are a result of self harm (PHOF). Suicide (PHOF) Absence without leave of detained patients (MHMDS)	National Attitudes to Mental Health survey (Time to Change) Press cutting and broadcast media analysis of stigma (Time To Change) National Viewpoint Survey – discrimination experienced by people with MH problems (Time To Change)

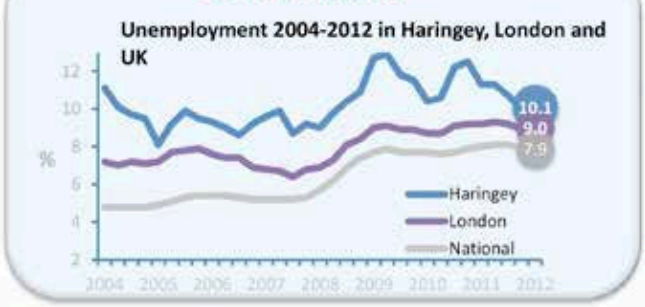
Appendix III – Mental Health Needs and Service Landscape

This section summarises the mental health needs of Haringey's residents from various sources such as local Joint Strategic Needs Assessment on mental ill health in children, young people, adults and older people; Mental Health HaringeyStat; Public Health England's mental health profiles; NHS Benchmarking tools; Healthcare Information System (HCIS); local adult social care; Community Mental Health Profile 2014 and the CCG's and the Council's financial information.

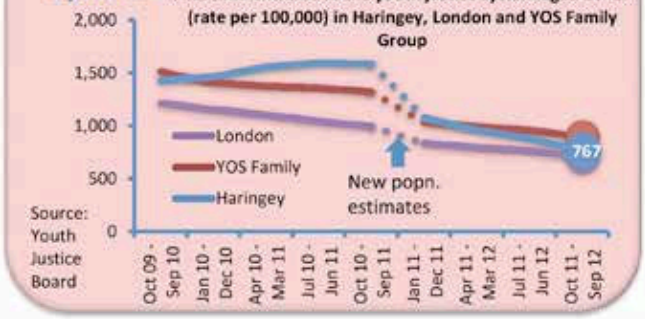
Children and Young People

Factors influencing mental health and wellbeing

Unemployment



Involvement in the criminal justice system



Family environment

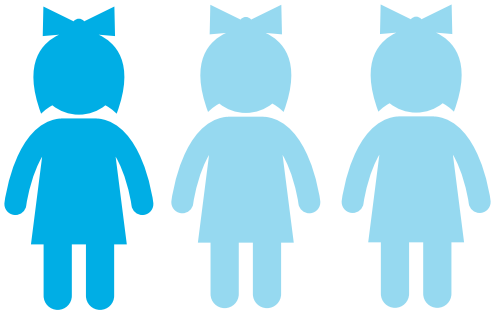
10,647 lone parent households with dependent children. Higher proportion of households with dependant children are lone parent households (34% compared to 28% in London)

7,338 households with dependant children with no adults in employment. Higher proportion of households with dependant children have no adults in employment (23% compared to 18% in London)

Source: 2011 Census

Disability

11,258 0-19 year olds have a long-standing disability (6,155 boys and 5,103 girls)



One child in **three** live in poverty

Mental ill health

It is estimated that approximately 4, 600 children and young people 5-16 years of age have mental health concerns locally. Below is table that summarises various conditions.

Estimated prevalence of any mental health concerns in children and young people 5-16 years of age

Condition	Prevalence	Estimate
Emotional disorder	3.9%	1463
Conduct disorder	6.6%	2288
Hyperkinetic disorder (ADHD)	1.6%	600
Less common disorder	0.7%	262

Source: Public Health England CYP Profile and 2011 Census

Children in the care of local authorities are at particular risk of mental ill health. At the end of March 2014, there were 511 looked after children. Of those 50% were without any concerns, 13% had borderline mental health concerns and 37% had mental health concerns, as identified by the Strengths and Difficulties Questionnaire (SDQ) screening tool.

Young offenders are at high risk of suffering mental ill health. It is estimated that up to 40 per cent of young people in the youth justice system have mental ill health. The rate for first time entrants to the youth justice system in Haringey (417 per 100,000) was similar to London and England.

Adults and older people

Factors influencing mental health and wellbeing

Marital status

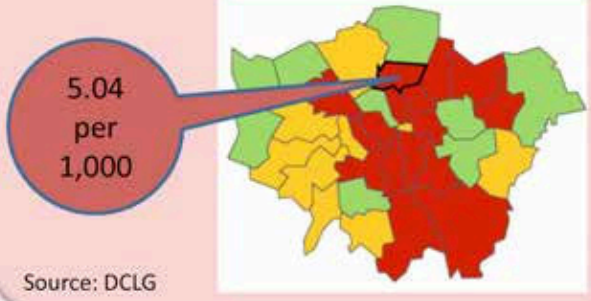
33% of people are married compared to 39% in London and 46% in England and Wales.

Living alone

A lower proportion of people over 65 live alone (7.8% compared to 9.6% in London)

However, a higher proportion of all people live alone in (24% compared to 22% in London and 18% in England and Wales)

Statutory homelessness



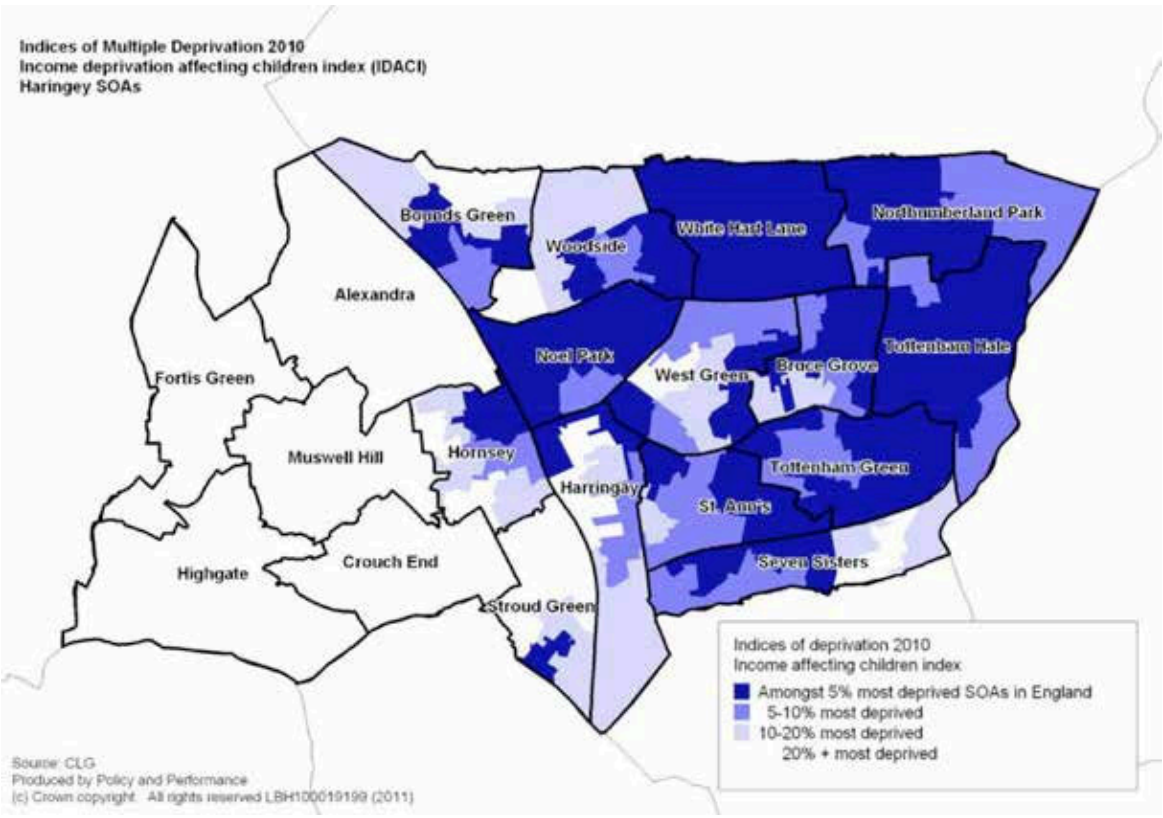
Source: DCLG

Unemployment

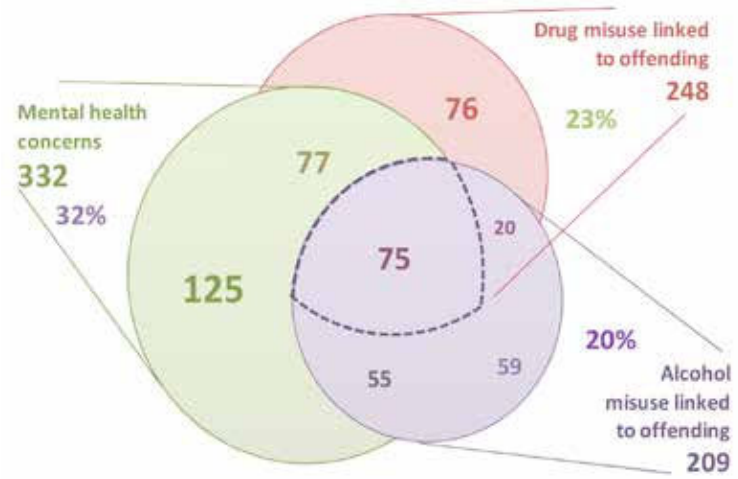
85 out of 1,000 people of working age in Haringey are unemployed compared to 59 per 1,000 in England.

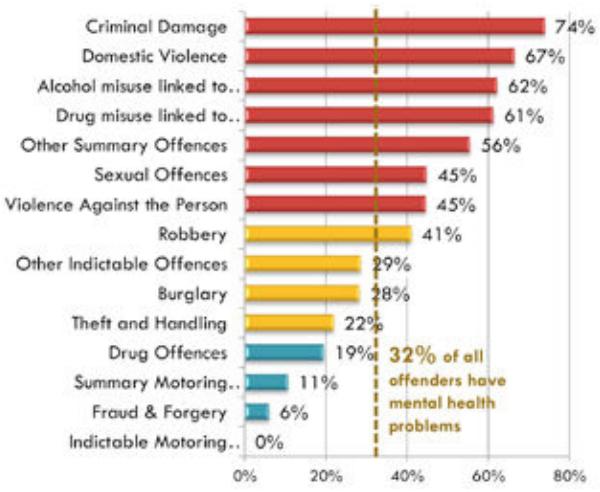
Haringey is 4th most deprived borough in London and unemployment rates are still high, especially in younger age groups. Almost 2,000 adults are claiming job seekers allowance and 48% of those have mental health behavioural disorders. Estimated 27 per cent adults have no qualification or level one qualifications and a high proportion of those under 65 years of age live alone. On the other hand, borough has significantly higher household crowding (16.3%) and households living in rented accommodation (58.2%) compared to London and national figures. Five in every 1,000 residents are homeless and statutory homelessness (5.8%) is significantly higher than London (3.9%) and nationally (2.3%).

Employment and support allowance claimants in Haringey whose condition in mental and behavioural disorders



Key issues linked to offending (Of the 1062 statutory offenders commencing probation Sept - Aug 2011/12)





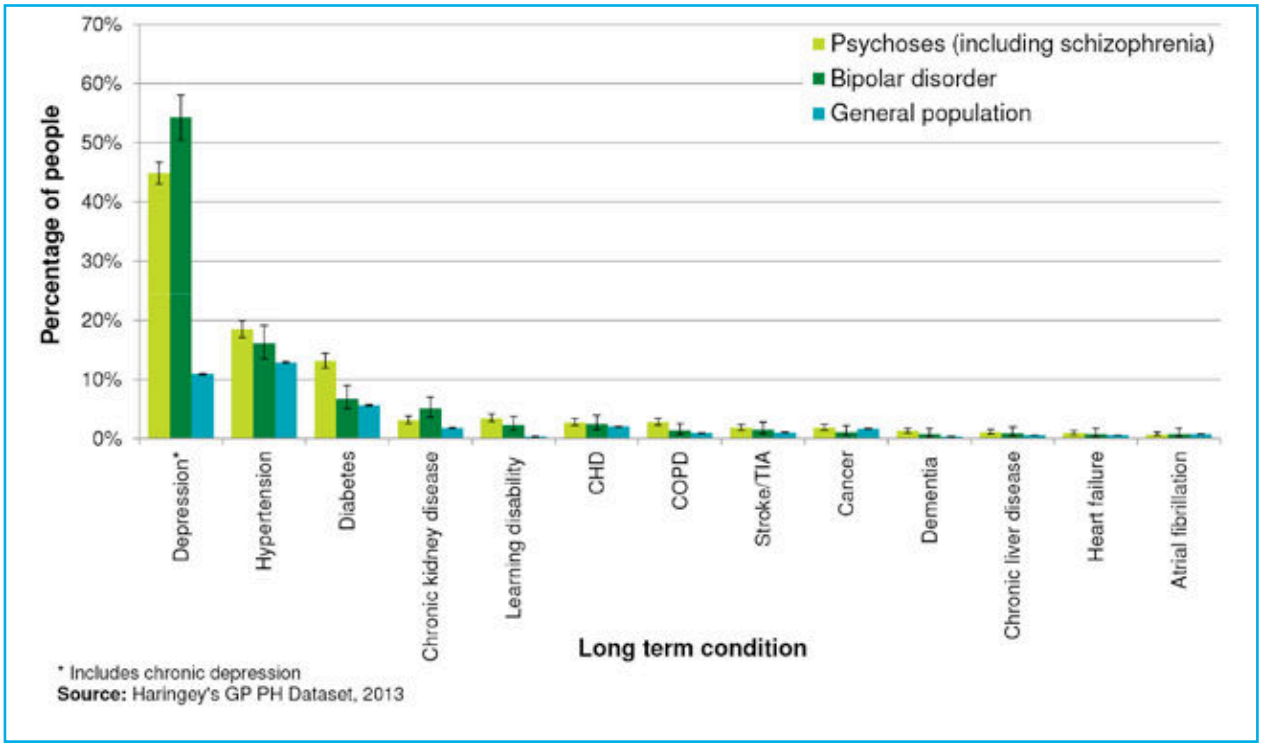
207 offenders (19.5%) had mental health problems and substance misuse problems

Local needs assessment on community safety suggests that 671 of those committing domestic violence have mental ill health.

In Haringey, 28% of people who access mental health services also access drug misuse services compared to 17% in England. This suggests higher prevalence of dual diagnosis locally.

Mental health problems are associated with long term physical conditions. Graph below suggests that a large proportion of people with SMI have one or more long-term conditions.

Prevalence of long term conditions among people diagnosed with serious mental illness compared to Haringey's registered population

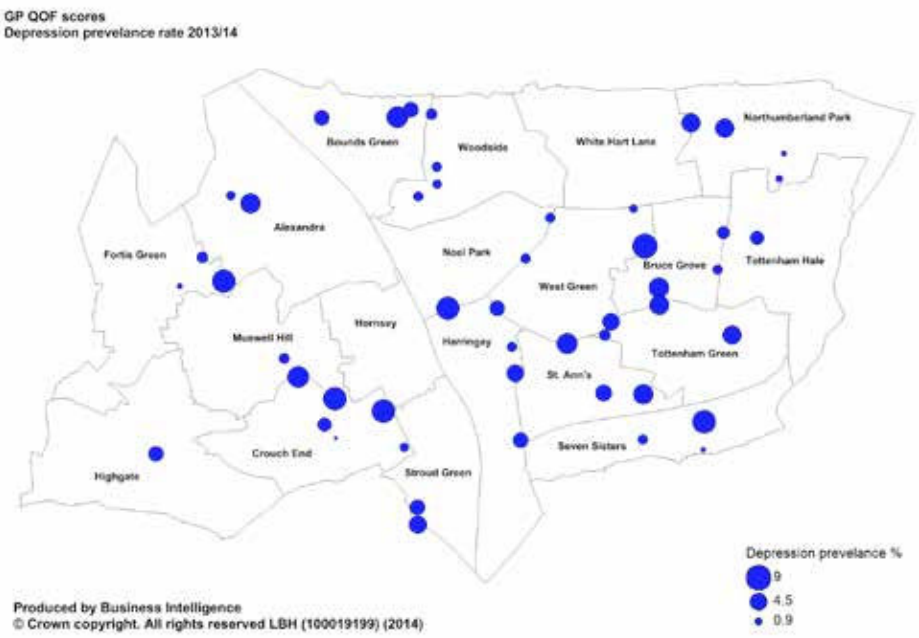


Source: Camden and Islington Public Health Intelligence

Mental ill health

Locally there are over 41, 000 adults (16-74 year olds) who are estimated to have a common mental health disorder. Of those, only 9,452 adults with depression known to Haringey GPs and 1,184 adults have a new diagnosis of depression (QOF 2013-14) . It is estimated that this will rise by 26% in 2021.

Diagnosis of depression by Haringey GPs



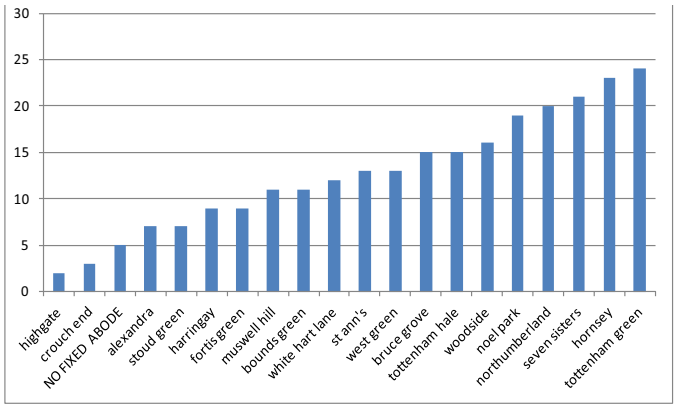
Source: Haringey JSNA

In March 2014, 10.4 per cent (300) people entered Improved Access to Psychological Therapies (IAPT) services as a proportion of those estimated to have anxiety and/or depression and 39.4 per cent (65) have completed IAPT treatment and 'moving to recovery[11]' . This figure is lower than expected national standard and particularly low for people over 64 years of age.

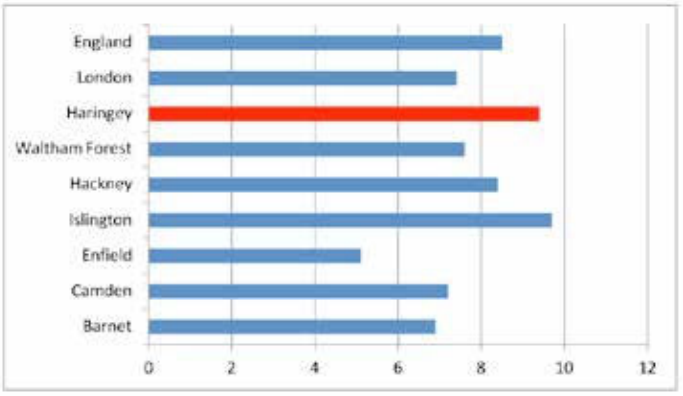
Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age. About 26 Haringey residents commit suicide each year. The highest numbers of deaths by suicide are in men aged 25-44. In the last 10 years, 62% of suicides were people born in the UK compared to 34% born abroad (Haringey's Suicide Audit).

11 Health and Social Care Information Centre: Quality and Outcomes Framework, October 2014

Suicides by ward 2002-2012



Suicide rates by 100, 000 population, by borough



Clustering Outcome - Haringey Ccg (Based On Current Caseload As At 2 Dec 2014)

		Number of Registered Service Users			Proportion of Registered Service Users	
		Services Users on CPA	Services Users Not on CPA	Total Service Users	% Services Users with CPA	% Services Users Without CPA
CCG - HARINGEY						
1	Common mental health problems (low severity)		5	5	0%	100%
2	Common mental health problems		10	10	0%	100%
3	Non-psychotic (moderate severity)	12	57	69	17%	83%
4	Non-psychotic (severe)	13	68	81	16%	84%
5	Non-psychotic (very severe)	34	113	147	23%	77%
6	Non-psychotic disorders of overvalued Ideas	9	50	59	15%	85%
7	Enduring non-psychotic disorders (high disability)	72	275	347	21%	79%
8	Non-psychotic chaotic and challenging disorders	22	68	90	24%	76%
10	First episode in psychosis	131	15	146	90%	10%
11	Ongoing recurrent psychosis (low symptoms)	378	179	557	68%	32%
12	Ongoing or recurrent psychosis (high disability)	318	48	366	87%	13%
13	Ongoing or recurrent psychosis (high symptom and disability)	258	127	385	67%	33%
14	Psychotic crisis	14	10	24	58%	42%
15	Severe psychotic depression	1	3	4	25%	75%
16	Dual diagnosis (substance abuse and mental illness)	5	6	11	45%	55%
17	Psychosis and affective disorder difficult to engage	24	8	32	75%	25%
18	Cognitive impairment (low need)	7	329	336	2%	98%
19	Cognitive impairment or dementia (moderate need)	18	135	153	12%	88%
20	Cognitive impairment or dementia (high need)	14	44	58	24%	76%
21	Cognitive impairment or dementia (high physical or engagement)	6	9	15	40%	60%
Sub Total		**1336**	**1559**	**2895**	**46%**	**54%**

Haringey has high levels of severe and enduring mental illness, the 6th highest prevalence (1.3%) of serious mental illness (SMI) in London; 82 per cent (2,900) are diagnosed with psychoses and 18 per cent (650) with bipolar disorders[12] . Men have higher prevalence than women and men from Black and Ethnic Minority Groups (BME) have the higher prevalence of SMI. The borough has estimated 1,000 living with severe mental health problems against actual 3,381 patients registered with GPs who have a diagnosis of a psychotic disorder; 917 in the west and 2,462 in the east. Of those with SMI, 2,959 people had a comprehensive care plan in primary care[13] . In 2014, nine GP practices administer antipsychotic injections for their patients and those practices are scattered around the borough.

There were 65 new cases of psychosis serviced by Early Intervention teams and it is significantly higher in Haringey compared to national figures suggesting higher demand and good access to services[14] . The rate of people

12 Camden and Islington Public Health Intelligence: Serious mental illness in Haringey: The facts

13 Serious Mental Illness profiles, Public Health England, 2014
14 Severe Mental Illness profiles: Public Health England, 2014

receiving assertive outreach services in Haringey (12%) was significantly lower than London (40.9%) and England (25.7%). Given such a high need locally, this information would suggest concerns with access to outreach teams.

Below is table with details on people seen by BEH MHT (as of December 2014) and their conditions split by Clusters. In total, BEH MHT have seen 2, 895 patients compared to 2, 972 in Enfield and 3, 033 in Barnet. Majority of Haringey's patients had severe psychosis followed by those with cognitive impairment and non-psychotic severe illness.

The rate of social care mental health clients receiving services was significantly low in Haringey (189) compared to London (419) and England (404) per 100,000 population. This may be a result of service reduction over the recent years where social care is only accessible to those at the highest end of needs. Also significantly low was the rate of social care mental health clients aged 18-64 receiving home care (28.2 per 100, 000 population) in comparison to London (46.6) and England (47.6).

Current service landscape

Our current local offer of services for people with mental ill health focuses on highly specialised hospitalised services, few beds for recovery and rehabilitation, and high cost care packages and residential care. This offer does not always result in long-term improvement of health outcomes and it creates a community that is highly dependent on the services and individuals that are seldom supported to move on and have fulfilling, independent life.

Furthermore, the current emphasis on the treatment at the severe end of illness rather than prevention and early help results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes.

Mental health services in Haringey are commissioned by Haringey CCG, NHS England (specialist services) and Haringey Council. Services are provided by a range of providers including Haringey Council, NHS Trusts, primary care, VCS and independent sector.

Main provider of mental health services for Haringey is Barnet, Enfield and Haringey Mental Health Trust. Most of the current activity is commissioned in a block contracts making it challenging to support shift of resources to prevention and early help and develop further community based services.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) provides a range of mental health services principally to the London Boroughs of Barnet, Enfield and Haringey. They provide a comprehensive range of services for children and young people working closely with the local authority (public health, education, youth justice and social care departments) and voluntary and community sector.

Children and young people services

BEH MHT Children and Adolescent Mental Health Services (CAMHS) are provided in the four-tier framework and there is a single point of referral[15] for all children. Most referrals to CAMHS are from GPs, followed by schools and social services.

15 Emotional wellbeing and mental health for children and young people in Haringey Needs Assessment 2011

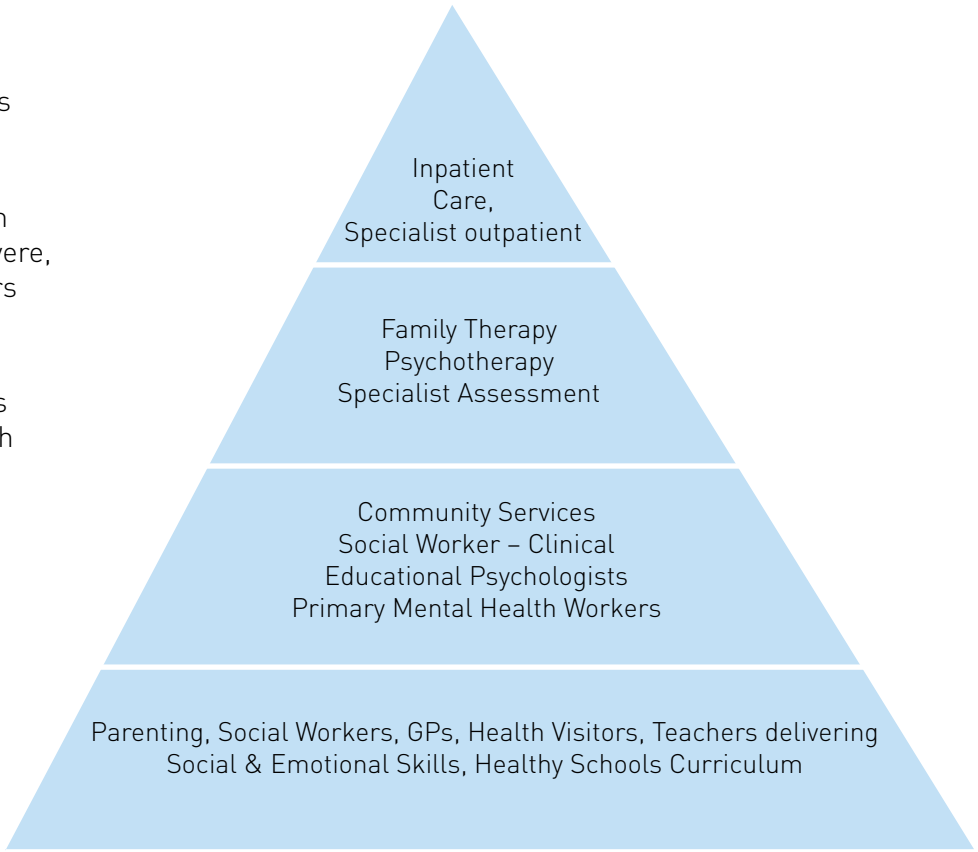
Mental health services for Haringey's Children and Young People

Tier 4 - Inpatient and highly specialist mental health services

Tier 3 – Specialist mental health services for those with more severe, complex and persistent disorders

Tier 2 – consultation for families and other practitioners, outreach to identify complex needs, and assessments and training to practitioners at Tier 1

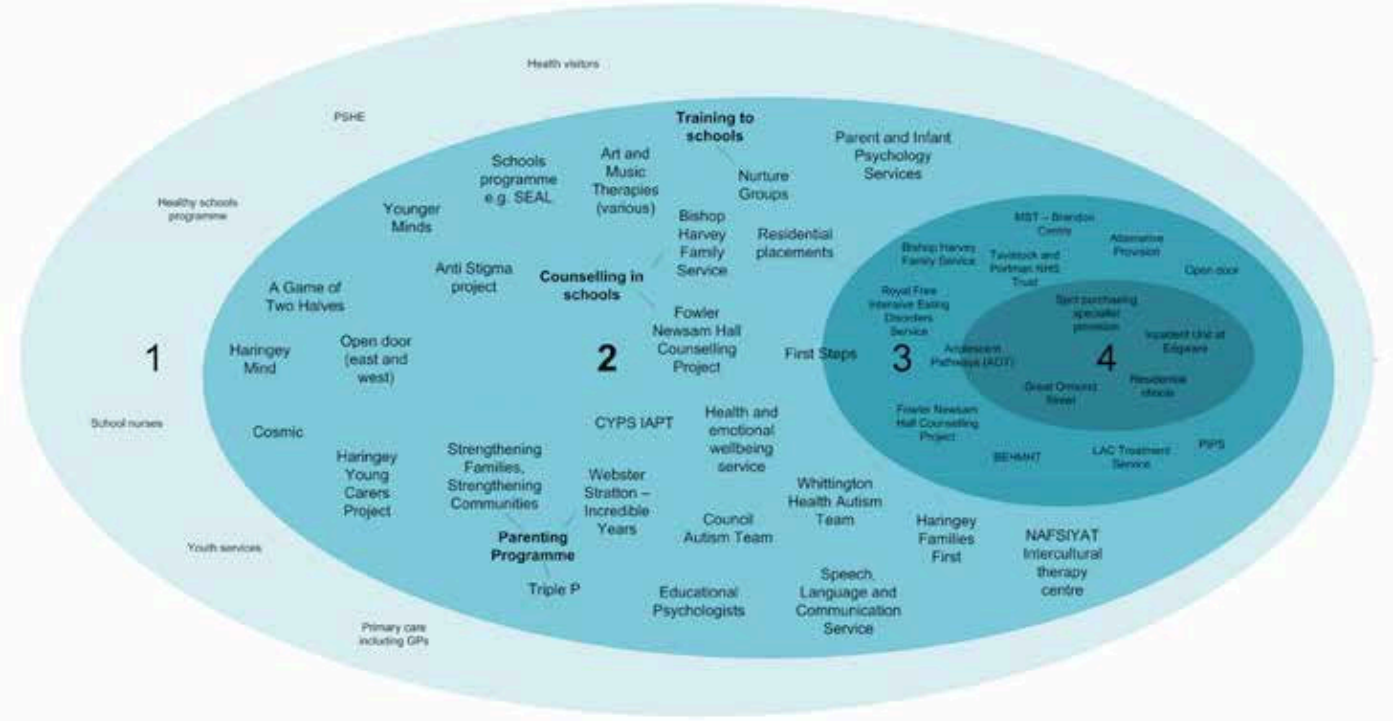
Tier 1- promote mental health, early identification of problems and refer to more specialist services



Source: National Service Framework for Children, Young People and Maternity Services, 2004

There is a variety of services provided in Tier 1 and Tier 2 ranging from interventions in the community, schools, and primary care and parenting initiatives provided by the Council however, at present, there is no system in place to monitor comprehensively the referrals to Tier 1 and 2 and follow children and young people along the whole pathway. Appropriateness of referrals depends on the information being disseminated to all stakeholders and the communities. Commissioning arrangements for Tier 1 and Tier 2 services could also be better integrated to reduce duplication and improve efficiency. At present, over 40 services and interventions are being commissioned by the schools, Council, CCG, Public Health Department and a number of external agencies. Some of these services are general and include a component of mental health and wellbeing such as health visiting and school nursing. Other services provide more targeted approach such as Open Door, a charity that provides counselling and psychotherapy to young people age 12-24. At present, there is no single directory of Tier 1 and Tier 2 services in Haringey that would enable full utilisation of this diverse offer. Also, fragmented provision arrangements make it challenging to consistently apply quality standards for commissioned services across the whole borough and in line with the national evidence and best practice.

Children and young people services currently commissioned in Haringey



Specialist Children and Adolescent Mental Health Services (CAMHS) are NHS services offering assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. In 2012, there were 1,080 children in Haringey who required Tier 3 and 45 for Tier 4 CAMHS services (Public Health England 2014. Current data (March 2014) from CAMHS shows 40% of children referred into CAMHS tier 3 were 10-14 years old. About one in five referrals were made for children age 5-9 years and nearly a third (31%) were referred into CAMHS among the 15-18 year age range. The greatest numbers of referrals were from General Practitioners, equating to 45%. Local Authority referrals were mainly from Education (24%) and Social Services (14%).

In 2012-13, inpatient admission rate (89 per 100,000) for mental health disorders for 0-17 year olds was similar to London and England. Young people's hospital admission rate for self harm (191.7 per 100,000 directly standardised) was lower than London and England figures (Public Health England 2014).

Adults And Older People Services

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) is the main provider of nearly all specialist adults and older people mental health services in Haringey including forensic services. The Trust services operate from over 30 locations across Barnet, Enfield and Haringey, some of them large hospital sites but most are small units in the community. Haringey's main site is at St. Ann's Hospital. The services available from the Trust in Haringey are described in more details in Appendix I. There were over 6,000 outpatient contacts and over 90,000 community contacts last year. Only a small proportion of these contacts are new patients suggesting that the Trust has a significant demand from patients with severe and enduring mental health problems that need a lot of support, coupled with a lack of capacity to discharge these patients safely into a variety of community settings, including adequate supported housing.

The NHS Benchmarking assessment suggests that BEH MHT has the overall slightly lower number of adult beds (22 vs. 23[16] national average), with significant variation across the Boroughs - lowest in Barnet (14), followed by Enfield (21.5) and Haringey (32.5). There has been an overall 25% reduction in adult beds over the last five years.

The overall availability of inpatient beds in the Trust is aggravated by a slow throughput, especially in Enfield and Haringey. Evidence suggests that service users in these two boroughs tend to stay longer than clinically required (Delayed Transfers of Care or DTOC) mostly due to their more complex social needs (e.g. unemployed, homeless, history of offending). Organising adequate support in the community for this cohort of people is a very challenging process due to a lack of integration and communication between the Trust and other key stakeholders locally. This issue was also highlighted in the service users' survey[17] where concerns were raised with the level of advice and support given to carers and service users on getting back to employment, accessing benefits and securing suitable accommodation.

NHS Benchmarking data also suggests that BEH MHT has relatively lower reference cost which, at 87, are the lowest

16 Number of beds are per 100, 000 population so it would equate to app. 3.2x for Barnet, 3x for Enfield and 2.6x for Haringey to get the total number

17 Care Quality Commission: Patient Survey on BEH Mental Health Trust, April 2014

of any London NHS mental health inpatient provider and are considerably lower than those of neighbouring Camden and Islington NHS Foundation Trust (at 107) and Central and North West London NHS Foundation Trust (at 112).

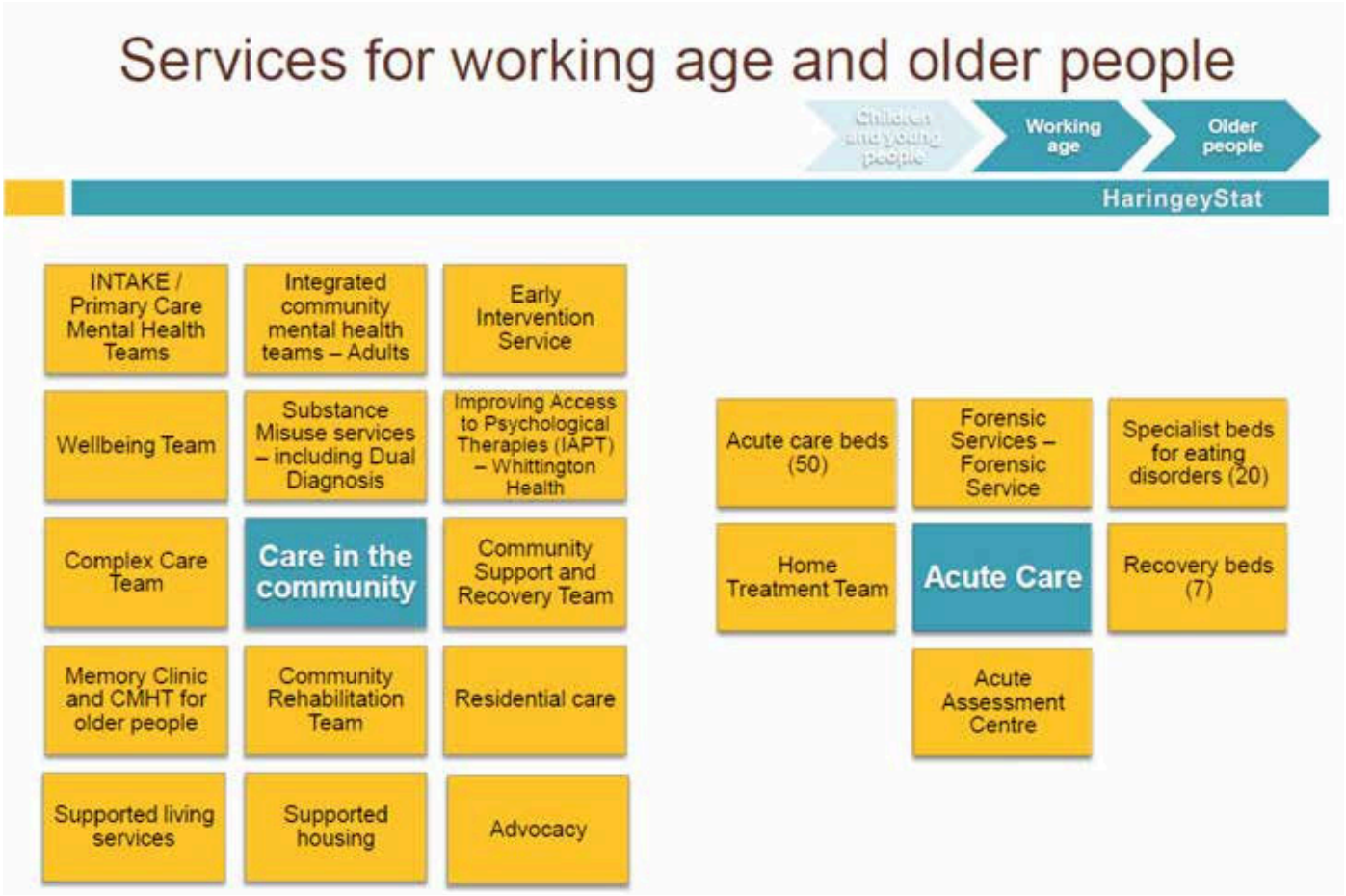
The Trust also provides substance misuse services and dual diagnosis services for Haringey residents.

Improving Access to Psychological Therapy (IAPT) service provides a range of interventions including 1:1 therapy, counselling and group therapies for those experiencing mild to moderate anxiety, depression and stress. This service is provided in collaboration between BEH MHT and Whittington Health http://www.lets-talk.co/. This service receives between 3, 000 – 3, 500 referrals a year.

The Grove Drug Treatment Service provides a wide range of treatment services to people experiencing problems with drugs misuse in Haringey. Dual diagnosis network provides treatment and support to people who are 18 years old and above with both a severe and enduring mental illness and problematic substance misuse, living in Haringey.

BEH MHT also provides inpatient and community forensic services across five London boroughs. This consists of nearly two hundred medium and low secure inpatient beds including a female ward and Learning Disabilities wards. BEH MHT also have community forensic teams in each borough, which act as the step down for patients leaving secure inpatient care who are on section 37/41 MHA 1983 (2007 amended) restriction orders.

Consultation feedback highlighted a gap in provision of MH services for people who have both autism or learning difficulties and mental health illness.



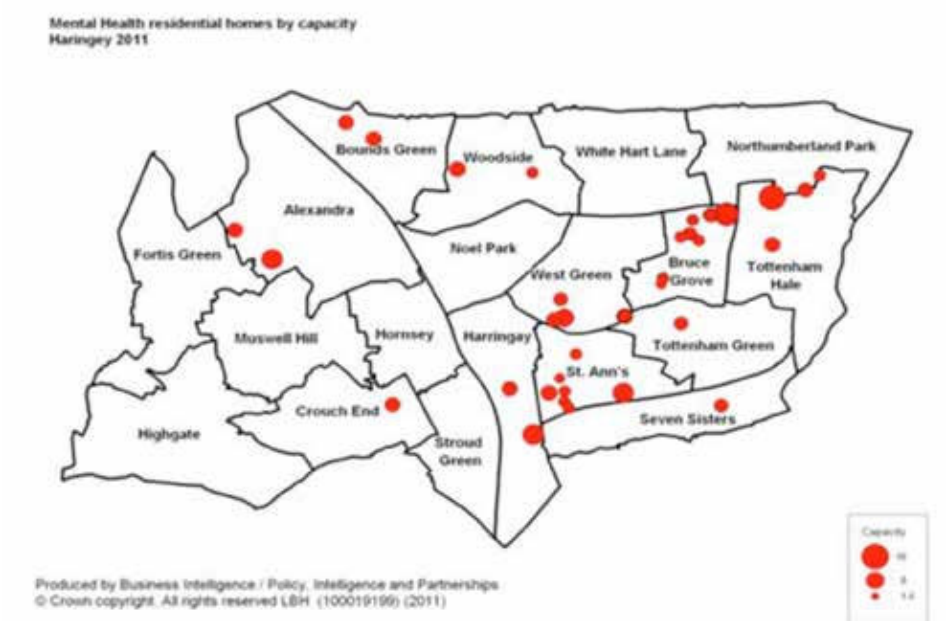
Second largest provider of mental health services in the borough is Haringey Council that provides social worker input to Community Mental Health Services and day services. It also provides social care to people with severe mental illness such as domiciliary care, supported living, day care centres, home care, direct payments, personal budgets and adaptation equipment.

The rate of social care mental health clients receiving services was significantly low in Haringey (189) compared to London (419) and England (404) per 100,000. Also significantly low was the rate of social care mental health clients aged 18-64 receiving home care (28.2) in comparison to London (46.6) and England (47.6) per 100,000 population. In 2012-13 there were 389 people with mental health condition who were provided a care package from the Council. In total 529 adults (18-64 year olds) had a service brought to them through a mental health budget code. Between April 1, 2013 and January 2014 566 people 65 per cent patients aged 18-69 years of age on CPA were in settled accommodation and 3.9 per cent in employment[18].

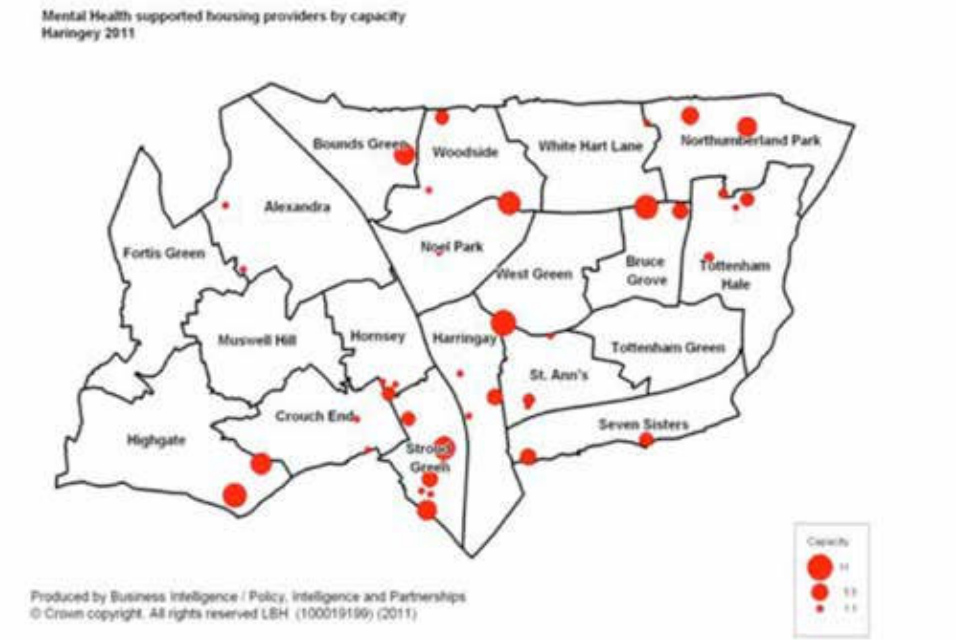
18 Mental Health Minimum Dataset 2014

The Council also provides Clarendon Recovery College (CRC) aimed at assisting recovery process for people with severe mental illness. There are currently 230 enrolled students who are seen by secondary mental health services. This service has been recently evaluated by Middlesex University and it is showing to be very effective in assisting people to move on, find appropriate employment and pursue further education.

Residential accommodation and supported housing is provided by a range of independent providers and some VCS, the majority of which are in east of the borough. A large proportion of residential care placements (40%) are being utilised by people living outside the borough although this figure has been decreasing recently. Independent sector and VCS also provide supported accommodation, floating support and domiciliary care.



Haringey has a number of supported living providers (mostly independent providers and some VCS), working with people with mental ill health that do not reach a threshold for social care support, including those funded through the Council's Housing Related Support. It typically provides the service user with a flat or shared housing within a warden controlled scheme. Schemes vary in terms of the level of support provided to cater for a wide ranging level of user need. Including Supporting People funded schemes; there are 13 main providers of supported living, offering around 285 places.



Mental Health and Wellbeing prevention and promotion interventions are largely commissioned by Council's Public Health team ranging from awareness raising and training in schools, tackling stigma and discrimination in the community ranging from interventions targeting specific risk groups such as Turkish and Kurdish men to digital peer support for mild to moderate anxiety and depression.

Information and advocacy services are provided by a range of VCS in the borough. These arrangements will be reviewed in the near future to align this offer with Care Act 2014 requirements.

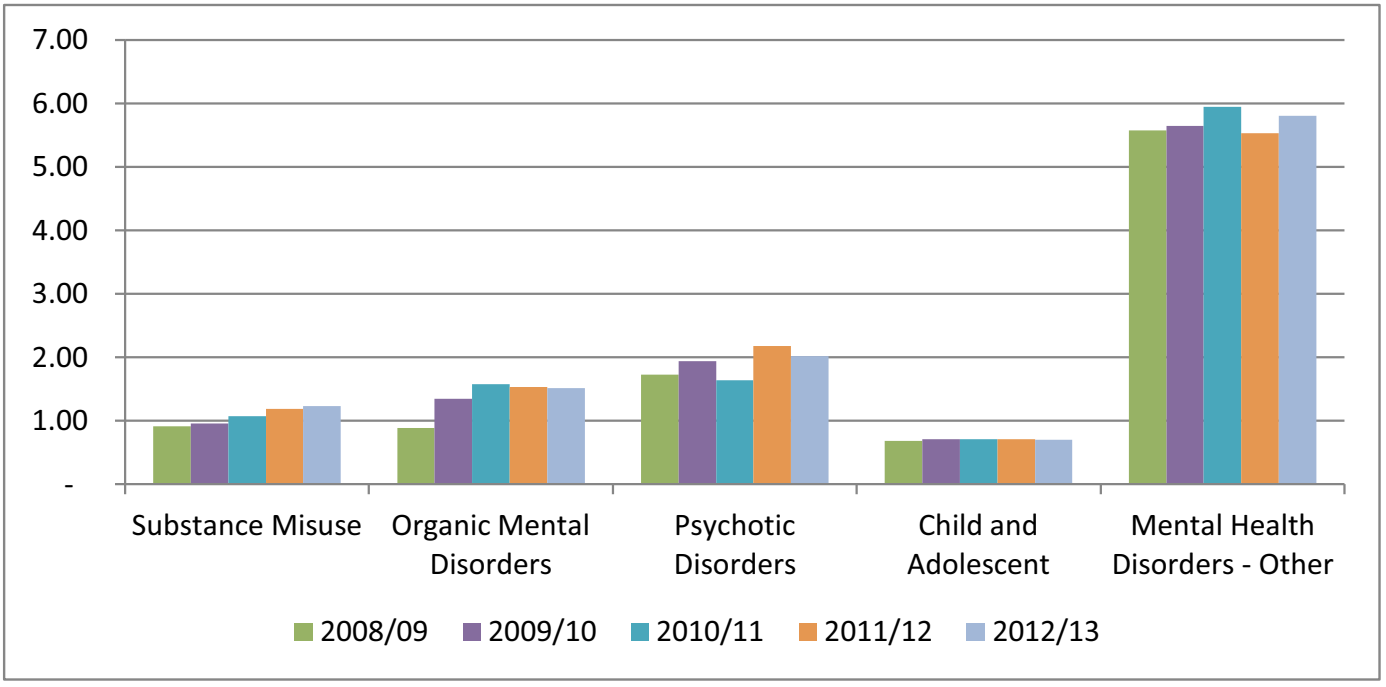
Total spend on mental health services

Total spend on mental health in Haringey (including substance misuse) for 2013-14 was over £51m. This equates to 11% of the total CCG budget and 6% of the Council's budget. Table below provides breakdown, by main commissioners.

Total spend on mental health in Haringey in 2013/14 by services

	LA	CCG
BEH MHT	1m (Section 75)	28.3m
Other NHS Trusts		2.9m
CAMHS		2m
IAPT		2.36m
VCS	600k	188k
Adult social care (including residential homes)	11m	
DAAT	3.5m	
Prevention and promotion	260k	
Other services		260k

Mental Health Gross Expenditure in last 5 years



Source: 2012-13 Benchmarking tool

Benchmarking data from various sources suggest that spend on residential care, housing related support, children's and young people mental health, specialist adult mental health services (phorensic services), prescribing on psychosis in primary care and the overall spend on secondary mental health per head of population is higher in Haringey compared to England.

Secondary care spend on psychosis, community care and outreach services care spend on mental health per head of the population is lower than England's average (Table below). These information should e treated with caution as the quality of data depends on accurate and complete returns. However the overall trend analyses suggest that local spend is highest at the severe top end of the pathway (secondary care, residential placement and supported housing) while there is underinvestment in outreach and community services. Furthermore, lower spend in secondary care for people with psychosis coupled with high spend in primary care for the same cohort of patients suggest that, probably due to high demand, these people are more likely to be cared for in primary care settings. Considering that the Council's and other partners investments are indirectly related to tackling root causes of mental ill health such as employment, affordable housing, community safety and clean and safe environment (open spaces etc.), it is likely that the overall spend on tackling mental ill health in Haringey is much higher than what could be easily quantified.

Haringey's expenditure on adults mental health for 2012-13, compared to England and based on the population size

High Low

Indicator	Haringey	England
Specialist mental health services spend (per 100,000 population) (rates are calculated for PCT and then mapped to CCG)	£33,167	£26,756
Primary care prescribing spend on mental health (rate (£000s) per 100,000 18+ population)	£1,791	£2,021
Primary care prescribing spend on psychosis (rate (£000s) per 100,000 18+ population)	£934	£541
Cost of GP prescribing for psychoses and related disorders (net ingredient cost per 1,000 population)	£713 (quarter 4)	£657
Secondary care spend on mental health (rate (£000s) per 100,000 18+ population)	£18,8480	£12,518
Secondary care spend on psychosis (rate (£000s) per 100,000 18+ population)	£1,356	£3,051
Community care spend on mental health (rate (£000s) per 100,000 18+ population)	£1,974	£5,094
Spend on psychosis services (rate (£000s) per 100,000 18+ population) (rates are calculated for PCT and then mapped to CCG)	£3,712	£4,789
Spend on psychological therapy services (IAPT and non IAPT) (rate (£000s) per 100,000 18+ population) (rates are calculated for PCT and then mapped to CCG)	£1,069	£1,021

Source: Mental Health Dementia and Neurology Intelligence Network, Public Health England, 2014

Appendix IV – Summary of evidence on best practice for mental health services

National evidence suggests that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and standards of care across the country vary greatly[19]. Even though 50% of all mental illness starts before age of 14, investment in prevention and early identification and children and young people's services is limited[20].

Effective mental health services should be integrated and include the whole pathway from prevention and early help through primary care, secondary care, highly specialised services and enablement model delivered in collaboration with a range of partners and service users.

Recent years have seen an increase in the body of evidence for investment in prevention of mental ill health and promotion of mental and emotional wellbeing that result in long-term cost savings and improve the outcomes. Some of the interventions cited having most impact across life course are parenting interventions for preventing conduct disorders, school-based emotional wellbeing learning programmes to prevent conduct problems, workplace initiatives for improving wellbeing and screening for anxiety and depression, befriending for older adults etc[21].

The effectiveness of current services for children and young people or Children and Adolescent Mental Health Services (CAMHS) has been debated nationally and the evidence is emerging that focus on four tier services actually lead to service fragmentation. Tavistock is proposing to replace the tiered model with a conceptualisation that is aligned to emerging thinking on payment systems, quality improvement and performance management, observed for adult mental health services. The THRIVE[22] model below conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of preven¬tion and promotion initiatives in the community.

Current commissioning arrangements for adults and older people services are based usually on block contracts with mental health trusts and do not allow for an approach where multiple providers are supported and encouraged to provide integrated services based on the outcomes[23]. Value Based Commissioning has become a recent focus in health care as commissioners seek to ensure more innovation and integration in services and across providers in order to improve patient outcomes and quality of services. The Joint Commissioning Panel for Mental Health (JCPMH), published a guidance for implementing values based commissioning in mental health noting that the approach will achieve higher levels of patient and carer engagement than in traditional managerial or medical approaches.

19 Joint Commissioning Panel for Mental Health: Practical Mental Health Commissioning (2011)
20 NHS England, 2014, A Call to Action
21 Department of Health 2011: The Mental Health Promotion, Mental Health Prevention: Economic Case

22 The Tavistock and Portman NHS Foundation Trust and Ana Freud Centre, 2014: Thrive: The AFC-Tavistock Model for CAMHS
23 Joint Commissioning Panel for Mental Health 2014, Guidance for implementing values-based commissioning in mental health

JCPMH has published a series of commissioning guides to assist commissioners at CCGs and Local Authorities in transforming the overall mental health services[24]. Their website provide a wealth of information on different services aimed to support local commissioners in the CCG and Local Authorities. Furthermore, recent Kings Fund publication[25] identified some underpinning principles for the overall effective mental health provision:

- A collaborative or integration strategy to the delivery of mental health care,
- Equality and equity, ensuring a parity of esteem between physical and mental health,
- Involvement and engagement of patients and clinicians is central to all aspects of mental health service design, delivery and monitoring,
- Patient centred in order to improve patient experience and enable staff deliver high quality care,
- Embedded within the community taking account of the holistic needs of the individual and the interaction between health and other areas of people's lives,
- Holistic with a shift of focus from ill health to one that offers support to enable people maintain their health and wellbeing,
- Prevention focussed,
- Recovery/enablement oriented care supporting people to take an active role in determining their needs and goals and supporting them to achieve this.

One of the main pillars in transforming mental health services is effective primary care mental health. One in four of the population will need treatment for mental health problems at some time in their lifetime and the majority of these will be managed in primary care. There are pockets of good practice in primary care regionally, nationally and internationally however the level of mental health support and training in primary care in general does not often reflect the level of need and responsibility. London Strategic Clinical Network[26] produced guide for commissioners based on a summary of over 60 case studies collated across the country and internationally. Primary care mental health models proposed are focusing on multidisciplinary teams based in communities and often arranged as 'hubs'. Those teams aim is to manage people with stable and ongoing mental ill health holistically as a part of their social system and network to support enablement and independent life. One of the leading roles of primary care mental health is to support people with long-term conditions to manage their mental ill health and also those with mental ill health to manage their physical health effectively.

The ultimate outcome of any effective system is to enable people to recover and to help them better manage their own health and care needs. This is best supported by timely evidence based interventions using an integrated care model that assist people to regain hope and motivation, control over their own life while providing opportunities to participate in a wider society by having adequate employment, decent housing and socially fulfilling life. 'Recovery is For All'[27] publication describes integrated models of care and challenges current mental health services to radically change the way people with mental illness are perceived and treated. Their proposed model is based on enablement and 'social recovery'. The benefits of the proposed model include improving employment outcomes based on the best evidence of Individual Placement and Support (IPS) model[28]; users involvement in decision making about their treatment and management; peer support by those with lived experience helping others with similar problems; and self management that aims to enable people to develop practical tools of everyday living.

Evidence suggests that housing issues are more common in people with mental illness in terms of maintaining adequate tenancy and the overall satisfaction with housing conditions[29]. Housing support is therefore an essential part of a good enablement model. National and international reviews that looked at the best model of housing support for people with mental illness are however inconclusive but do suggest that best outcomes are achieved where housing solution is secured first followed by adequate care wrapped around a person that is flexible and changing with needs over time[30].

Holistic enablement model in current commissioning landscape can only be achieved by integrated commissioning and provision of a range of services that are working across organisational boundaries. This could be achieved effectively by focusing on the Value Based Commissioning.

24 Joint Commissioning Panel for Mental Health access @ http://www.jcpmh.info/
25 Kings Fund 2014, Transforming Mental Health- A Plan of Action for London
26 London Strategic Clinical Network: A commissioner's guide to primary care mental health. July 2014

27 South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists. London: SLAM/SWLSTG.
28 Sainsbury Centre for Mental Health (2009c) commissioning what Works: The economic and financial case for supported employment. Briefing paper 41. London: The Sainsbury Centre for Mental Health
29 Johnson R, Griffiths C, Nottingham T (2006). At home? Mental health issues arising in social housing. London: NIMHE. www.socialinclusion.org.uk/publications/GNHFullReport.doc
30 Crisis UK and University of York: Staircases, elevators and cycles of change, 2010

Appendix V – Delivery Plan - working document

	2015/16	2016/17	2017/18
Priority 1: Promoting mental health and wellbeing			
Conduct mental health and wellbeing survey to establish the baseline locally	✓		
Work with schools to include/commission emotional and mental wellbeing training as part of their standard curriculum	✓		
With Health Visiting services being commissioned from the Council from 2015, explore opportunities to deliver specific programmes for early years on promoting positive attachment and good parenting		✓	
Capitalise on the opportunities with Tottenham regeneration re. employment, affordable housing, built environment			✓
Integrate, whenever possible, prevention and awareness raising within a wide range of frontline services;		✓	
Re-commission mental health awareness raising for frontline staff	✓		
Review information, advice and advocacy services to provide single web-base information portal and to integrate commissioning and delivery of the eservices in line with Care Act 2014		✓	
Prevention of mental ill health and promotion of good mental health to be delivered in and by the communities – retender prevention and promotion contracts to focus on community development;	✓		
Tackling social isolation – some services existing for older people, important to broaden out to all people who are at risk of mental illness (e.g. people with LTCs). Innovative models e.g. Family Mosaic projects;	✓		
Commission prevention of self harm training and education for schools;	✓		
Suicide prevention – training on suicide prevention for primary care professionals and provision of bereavement services and lessons learnt from incidents (recent suicides);	✓		
Tackling mental ill health amongst offenders and gang members (e.g. integrating MAC-UK model into streamline services across the borough)		✓	
Develop joint pathways for women and their families affected by perinatal mental ill health;		✓	
Include prevention element in contracts with all service providers		✓	
Evidence-based prevention interventions for families with children at risk of conduct disorders;			✓

	2015/16	2016/17	2017/18
Commission interventions based on assets in the community (e.g. time bank)	✓		
Priority 2: Improving mental health outcomes of children and young people			
Review all CYP mental health services in order to focus on prevention and early help and strengthen referral pathways, avoid duplication and commission care model based on the evidence;	✓		
Strengthen Tier 2 services with targeted youth offending teams and provide targeted interventions at schools for those children at risk in line with quality standards and best evidence;		✓	
Implement NICE guidelines for severe mental illness in CYP, in particular review Early Intervention in Psychosis (14-35 years of age);		✓	
Review transition from CAMHS to adults, subject to Children's O&S Panel;	✓		
Review of mental health services offer for Looked After Children (LAC). Also, pilot jointly with Enfield and Haringey swifter completion of care proceedings where LBH applied for care order. Work towards 26 weeks against average of 56 weeks. Mental and emotional wellbeing assessment is a crucial part of this process.	✓		
Priority 3: Improve mental health outcomes for adults and older people			
Improving care for people in mental health crisis			
Develop Crisis Concordat Action Plan and implement London Mental Health Strategic Clinical Network commissioning standards;	✓		
S136 – Implement London MH Partnership Board guidelines and refresh local joint protocols in line with the new standards.	✓		
Including crisis plan in CPA on discharge with specific guidelines on how to recognise early signs of worsening conditions and mechanisms to prevent crisis occurring		✓	
Provision of crisis houses with psychiatric care and support		✓	
Dedicated areas for mental health assessment in A&E and 24 hours psychiatric liaison service	✓		
Mental health crisis care training for GPs, practice nurses and community care staff	✓		
Improving physical health of those with mental-ill health and vice versa			
Implement the NHS Five Year Forward View standards in relation to access to mental health services (Actions included in the 5-year NCL plan);			✓

	2015/16	2016/17	2017/18
There should be greater focus on smoking cessation, weight management and physical activities interventions and referrals to these pathways for people with mental ill health;		✓	
Increase awareness of services offering behavioural change support such as Health Trainers and Health Champions amongst people with mental ill health;		✓	
Review current pathways between primary and secondary care referrals and update to strengthen management of physical and mental health;	✓		
Agree and establish role of pharmacies in relation to mental and physical health;	✓		
Review current model of liaison psychiatric service (Rapid Assessment and Interface Discharge scheme) in order to improve the outcomes and impact on the wider system and agree a standardised performance framework based on the outcomes;	✓		
Primary care is currently performing well on recording physical illness in people with severe mental illness, review if this is the case for people with long term conditions (LTCs);	✓		
Audit a random sample or Trust-wide of care plans to understand if those with co-morbidity have clear plans on how to manage their physical illness;	✓		
Develop strong relationships between those working with people with mental illness and primary care staff	✓		
Meeting the needs of those most at risk (including young adults)			
Improve waiting times for referrals in people in contact with Criminal Justice who have mental health problems.	✓		
Establish more effective liaison between mental health services in the criminal justice sector to achieve a seamless treatment pathways		✓	
Ensure that all mental health services are culturally appropriate for Haringey's diverse communities by developing minimum standards for training frontline services	✓		
Focus on mental health and wellbeing in 'Violence against women and girls' Council's workstream	✓		
Improve information sharing between Integrated Offender Management Unit, primary care, accident and emergency department and primary care		✓	
Link mental health prevention with antisocial behaviour initiatives based on the best practice		✓	
Forge links with Serious Gangs and Youth Violence Strategy	✓		

	2015/16	2016/17	2017/18
Develop strong relationships with Forensic Integrated Community Services mental health liaison and diversion pilot to ensure seamless transfer from secure estate to community based services		✓	
Promote mental health and wellbeing for homeless people within 'Homeless Health and Wellbeing Charter		✓	
Priority 4: Commission and deliver integrated enablement model			
Explore possibilities of further integration between adult social care, housing related support and prevention public health programmes;	✓		
Develop service specification for enablement model that improves the outcomes such as good housing, employment, social relationships) and tailored to individual needs;	✓		
Strengthening role of primary care in management of mental illness (implement Joint Commissioning Panel for Mental Health guidelines: Commissioning primary care mental health services);	✓		
Strengthen pathways between Community Mental Health Teams, Home Treatment teams and primary care;	✓		
Provide local evidence on needs and service effectiveness to support BEH MH Trust to develop enablement model;	✓		
Support third sector to deliver enablement model in collaboration with mental health trust, LBH and other stakeholders;	✓		
Commission and implement housing based solution for people with mental ill health;	✓		
Develop flexible pathways for accommodation that promote choice;	✓		
Develop jointly between the CCG, MHT and LBH care packages in line with the mental health tariff care clusters;	✓		
For those who are known to have experienced crisis, include crisis management plan in their CPAs;	✓		
Enable people with mental ill health to enter employment market and maintain their job;			✓
Promote 'Time to Change' model for all local employers		✓	
Develop asset based community approach that promotes independence, self-reliance and resilience in partnership with voluntary and community sector;	✓		
Review care-coordination against minimum standards in terms of capacity and competencies; offer training on welfare benefits, housing pathways and the importance of physical and mental health (Manchester model).	✓		
Undertake financial modeling on how future demand on services can be managed through changing the current model of care	✓		

This page is intentionally left blank

HARINGEY PRIMARY CARE TASK AND FINISH GROUP
REPORT TO HEALTH AND WELLBEING BOARD MARCH 2015

1. INTRODUCTION

Following the setting up of a Primary Care Task and Finish Group in late 2014, a Strategic Plan and Options Appraisal for East Haringey has been commissioned, which is due to be completed in April 2015. The key aims of the Strategic Plan are to address primary care provision in specific regeneration areas of Haringey and to explore increasing the capacity of primary care services across the east of the borough in the short-term, particularly in the Tottenham Hale area. The Task and Finish Group was asked to report its interim findings at this March Board. The attached paper sets out progress to date but further progress will provided in a verbal report at the Health and Wellbeing Board on 24th March.

2. PROGRESS TO DATE

As discussed at the Health and Wellbeing Board in January 2015, East Haringey is facing the dual challenge of large regeneration schemes and housing developments, together with significant concerns about the capacity and quality of primary care in East Haringey, particularly in the Tottenham Hale area, which has already seen considerable housing development in recent years.

At the Health and Wellbeing Board in January 2015, NHS England reported that they had commissioned North London Estate Partnerships (NLEP) to undertake a Strategic Plan and Options Appraisal for East Haringey. This addresses two key areas:

a. The first is the long-term need for increased primary care, having regard to the regeneration in the area. This Plan will involve an Options Appraisal and recommendations on where new primary care locations should be sited and how many new GPs (and other primary care staff) will be required. It will draw up timelines for when new primary care services will be required and involve the Council in identifying existing and new sites that will be suitable for new services identified.

b. The second key area is the identification of short-term need. It is recognised that there are significant concerns about access to primary care in East Haringey. As presented to the January Board, whilst the Healthwatch report provided information that there was a

shortage of appointments in the east of the borough this does not always equate to a shortage of GPs. Therefore, in order to provide a complete, evidenced-based picture, making the case for investment specifically in Tottenham Hale, expertise from NLEP was required. Their role was to undertake a full needs assessment and capacity audit, to understand the gaps and to make the case for commissioning further primary care capacity in the area. The result will be a case for investment presented to NHS England's Finance, Investment, Procurement and Audit Committee (FIPA) in April 2015.

The Strategic Plan is being drawn up under very short timescales, having only commenced in January. Therefore, the interim conclusions are not available at the time of writing but will be available by 24th March and a full verbal report on NHS England's short-term commissioning plans will be provided at the Board meeting.

As part of the Strategic plan development a stakeholder engagement event occurred on 17th February 2015. During this meeting it was confirmed that three geographic areas required further in depth investigation in the second stage of NLEP's work. These areas were Tottenham Hale, High Road West and the Wood Green / Turnpike Lane area.

The next part of the process will involve:

a. Confirming the levels of additional demand in each of these priority areas
b. To what degree this demand can be met through current service provision
c. Identifying potential new or existing sites which could house Primary Care in future and their feasibility to deliver what is required
d. Recommending options for consideration by NHS England in collaboration with the CCG as part of co-commissioning arrangements.

At the January Board NHS England also committed to carry out compliance measures under the GP contract. Whilst not breaching the confidentiality of individual contract holders, NHS England can confirm that contractual action is currently being taken where concerns have been identified about practices in relation to primary care access.

3. STEPS AFTER HEALTH AND WELLBEING BOARD

a. To work with North London Estate Partnerships, to complete the Strategic Plan and Options Appraisal by April 2015
b. A further report will be provided to the Health and Wellbeing Board after April 2015. This will report on progress and recommendations as a result of the Strategic Plan and Options Appraisal and progress through FIPA.

Haringey Council

healthwatch Haringey

HAVCO HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

NHS Haringey Clinical Commissioning Group

Report for:	**Health and Wellbeing Board – 24 March 2015**

Title:	**Pharmaceutical Needs Assessment**

Report Authorised by:	**Jeanelle De Gruchy, Director of Public Health**

Lead Officer:	**Tamara Djuretic, Assistant Director of Public Health**

1. Describe the issue under consideration

1.1 From 1st April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep an up to date statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). The PNA must be published every three years.

1.2 The PNA is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require each HWB to publish its first PNA by 1st April 2015.

2. Cabinet Member introduction

2.1 The PNA is a useful document that comprehensively encapsulates the needs of the local population and describes pharmaceutical services offered to meet that need. Pharmacies are universal points of contact for the public and as such, trusted public health resource with the potential to provide services outside of a hospital or practice environment and to reduce health inequalities.

2.2 I am delighted to present this comprehensive Pharmaceutical Needs Assessment produced on behalf of the Health and Wellbeing Board for final approval.

3. Recommendations

3.1 The HWB is asked to approve Haringey's Pharmaceutical Needs Assessment 2015.

4. Alternative options considered

4.1 None

5. Background information

5.1 The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

5.2 The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417) set out the system for market entry.

5.3 From 1st April 2013, Health and Wellbeing Boards (HWBs) assumed responsibility for publishing and keeping an up to date a statement of the needs for pharmaceutical services of the population in their area, referred to as a Pharmaceutical Needs Assessment (PNA). Under the same Regulations, the PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or when commissioning services.

5.4 A PNA is a document that includes a count of local pharmacies and the services they already provide including dispensing, medicines, reviews and local public health services, such as stop smoking, and sexual health and support for drug users services. A PNA often includes other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area. A PNA also describes the demographics of its local population, across the area and in different localities, and their needs. It should look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs. The PNA should contain relevant maps relating to the area and its pharmacies. A PNA normally takes at least 9 months to develop because of the complexity of the process and the statutory requirement to undertake a formal consultation which must run for a minimum of 60 days.

5.5 The development of this document has been overseen by a PNA Steering Group, which is accountable to the HWB. In making the assessment, six key steps were undertaken:

Step 1: Establishment of project governance and project management arrangements

Step 2: Gathering and validating data, including undertaking a community pharmacy questionnaire
Step 3: Documentation of health needs and strategic priorities
Step 4: Building the pharmacy profile, on a service by service basis
Step 5: Drawing together emerging themes and documenting the assessment based on the analysis
Step 6: Formal consultation, with local stakeholders as required by the Regulations

5.6 Stakeholder consultation was undertaken by Haringey Council on its draft Pharmaceutical Needs Assessment (PNA), in accordance with the requirements as set out in the *National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417).* The consultation was initiated on the 9 December 2014 and ended at 5pm on the 10 February 2015. This period is complied with the minimum 60 days consultation required by the Regulations. All comments and feedback was consolidated in the final PNA document. Feedback, comments and responses are detailed in Appendix G of the main document.

5.7 Pharmaceutical Services within Haringey are provided by 59 pharmacies, including five pharmacies which open for 100 hours a week; and a distance selling pharmacy. There are no dispensing appliance contractors (DAC), dispensing doctors or local pharmaceutical services providers. We have demonstrated that Haringey is well resourced with respect to pharmaceutical services and that there are no current needs for either essential, enhanced or advanced services identified. There is good alignment with GP surgeries and areas with high population density are well served. There is a reasonable correlation with deprivation across the borough apart from North East Tottenham (White Hart Lane and Tottenham Hale) which has a below average number of pharmacies per 100,000 (Appendix I). However, assessing 'capacity' of the pharmacies to dispense medicines was not found to be an issue in these wards because pharmacies on the boundaries of neighbouring wards are accessible to residents in these two wards. Mapping tools utilised across Haringey estimated that all residents are within one mile of a pharmacy.

5.8 In light of the Tottenham regeneration that will result in a significant population increase over the next ten years, there may be a need for additional pharmaceutical services in this area in the future. It is therefore essential to review the PNA annually to reflect these changes.

5.9 Future maintenance of the PNA will be undertaken by Public Health Directorate on behalf of the Health and Wellbeing Board.

6. Comments of the Chief Finance Officer and financial implications

6.1 The Pharmaceutical Needs Assessment was funded from the 2014/15 Public Health Grant. The maintenance of the PNA will be carried out within existing resources in the Public Health Team on behalf of the HWB.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 Under Section 128A of the NHS Act 2006, amended by the Health and Social Care Act 2012, the Health and Well-being Board (HWB) must in accordance with regulations assess needs for pharmaceutical services in its area and publish a statement of its first assessment and of any revised assessment.

7.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements relating to the production of pharmaceutical needs assessments ("PNAs"). The HWB must publish its first PNA by 1st April 2015 and the revised assessment within 3 years of publication of their first assessment. The PNA must contain the prescribed information set out in Schedule 1 of the Regulations. This include

a) a statement of the pharmaceutical services that are provided in the area and which are necessary to meet the need for pharmaceutical services (i.e. necessary services: current provision);

b) a statement of the pharmaceutical services that are not provided in the area but which the HWB is satisfied need to be provided (i.e. necessary services: gaps in provision);

c) a statement of the pharmaceutical services that are provided in the area and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area (i.e. other relevant services: current provision);

d) a statement of the pharmaceutical services that are not provided in the area but which the HWB is satisfied need to be provided in order to meet a current and/or future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; (i.e. improvements and better access: gaps in provision);

e) a statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment (i.e. other NHS services)

f) an explanation of how the assessment has been carried out: a) how it has determined what are the localities in its area; b) how it has taken into account (where applicable) the different needs of different localities in its area, and the different needs of people in its area who share a protected characteristic; and c) a report on the consultation that it has undertaken. (i.e. how the assessment was carried out); and

g) a map that identifies the premises at which pharmaceutical services are provided in the area (i.e. map of provision).

7.3 There is a consultation requirement that must be complied with before a PNA is completed and published. Regulation 8 "Consultation on pharmaceutical needs assessment" provides a list of bodies that HWB must consult about the contents of the assessment it is making. This include any Local Pharmaceutical Committee, any Local Medical Committee, any persons on the pharmaceutical lists and any dispensing doctors list for its area, any Local Healthwatch organisation for its area, and any neighbouring HWB. They must together be consulted at least once during the process of developing the PNA. The bodies consulted must be given a minimum period of 60 days for making their response to the consultation. 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.

7.4 Regulation 9 sets out the matters HWB must consider when developing their PNA. This include: a) the demography of its area; b) whether in its area there is sufficient choice with regard to obtaining pharmaceutical services; c) any different needs of different localities within its area; d) the pharmaceutical services provided in the area of any neighbouring HWB which affect the need for pharmaceutical services in its area; e) any other NHS services provided in or outside its area which affect the need for pharmaceutical services in its area. The HWB must also take account of likely future needs. This is intended to address and compliments the prescribed information in Schedule 1 at Paragraph 7.2 above.

8. Equalities and Community Cohesion Comments

8.1 In the course of development of PNA, we have looked at protected characteristics that informed recommendations for reducing inequalities in access and health outcomes, whenever possible.

9. Head of Procurement Comments

N/A

10. Policy Implication

10.1 The Pharmaceutical Needs Assessment is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.

10.2 The Pharmaceutical Needs Assessment can be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.

10.3 As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities[1]. In addition, community pharmacies are an important investor in

[1] "*Healthy lives, healthy people*", the public health strategy for England (2010)

local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

11. Reasons for Decision

11.1 HWB Board's statutory duty is to produce a PNA every three years. The Public Health Directorate conducted PNA on the HWB Board behalf and the process was overseen by the PNA Steering Group.

11.2 The Board is asked to approve final PNA 2015.

12. Use of Appendices

Appendix A: Final Haringey's PNA 2015 with appendices (A-F)

13. Local Government (Access to Information) Act 1985

Not applicable.

Haringey Council

Pharmaceutical Needs Assessment

FFINAL FOR HWB APPROVAL
FEBRUARY 2015

Made in accordance with the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417)

Contents

1. Executive Summary

1.1. Introduction

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only) who wishes to provide NHS Pharmaceutical Services must apply to be on the Pharmaceutical List.

The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417) set out the system for market entry. Under the Regulations, Health and Wellbeing Boards are responsible for publishing a Pharmaceutical Needs Assessment (PNA); and NHS England is responsible for considering applications and maintaining the pharmaceutical list.

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The PNA is subsequently used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or commission additional services. The document will be used by local commissioners to inform commissioning strategy and to support the future commissioning of pharmacy services. It may also act as a reference source for existing NHS pharmaceutical services contractors who may wish to change the services they provide and/or by potential new entrants to the market.

The development of this document has been overseen by a PNA Steering Group, which has accountability through to London Borough of Haringey's Health and Wellbeing Board (HWB). In making the assessment, six key steps were undertaken:

Step 1: Establishment of project governance and project management arrangements
Step 2: Gathering and validating data, including undertaking a community pharmacy questionnaire
Step 3: Documentation of health needs and strategic priorities
Step 4: Building the pharmacy profile, on a service by service basis
Step 5: Drawing together emerging themes and documenting the assessment based on the analysis
Step 6: Formal consultation, with local stakeholders as required by the Regulations

This PNA replaces the PNA published by the former Haringey PCT.

1.2. Summary of the Assessment of Pharmaceutical Services

Pharmaceutical Services within Haringey are provided by 59 pharmacies, including five pharmacies which open for 100 hours a week; and a distance selling pharmacy.

There are no dispensing appliance contractors (DAC), dispensing doctors or local pharmaceutical services providers.

We have demonstrated that Haringey is well resourced with respect to pharmaceutical services. There is good alignment with GP surgeries and areas with high population density are well served. There is a reasonable correlation with deprivation, although this is not the case in NE Tottenham which has a below average number of pharmacies per 100,000.

The table on the next page provides a summary of our findings for pharmaceutical services, and other locally commissioned services, currently provided within Haringey.

Essential Services *Must be provided by all pharmacies*	
Community Pharmacies: ▪ Dispensing, including electronic prescription services, and actions associated with dispensing (e.g. keeping records) ▪ Repeat dispensing ▪ Disposal of waste medicines ▪ Public health campaigns, which includes promotion of health lifestyles and prescription linked interventions ▪ Signposting ▪ Support for self-care **Refer to section 5.4 for full details of the assessment**	Essential services are fundamental pharmacy services, which ensure that patients can access medicines through the dispensing of NHS prescriptions. Pharmacy also plays a valuable role in addressing health needs and inequalities through the provision of health promotion and signposting advice. We have determined that essential services are **necessary to meet the pharmaceutical needs of the population.** Our assessment has demonstrated that in most localities, there is good access and a choice of pharmacy on weekdays (9:30am - 6pm), Saturdays (from 10am through to 5pm). All residents can access a pharmacy within a mile and that the majority are within 20 minutes reach of their nearest pharmacy at these times. We have identified the following potential gaps: ▪ More limited access and choice in the NE Tottenham locality; this is particularly the case in the early mornings and on Sundays when only one pharmacy is open ▪ Insufficient alignment between pharmacy and GP practice opening hours; this is most apparent in the mornings in the Central locality With respect to dispensing we have demonstrated that there is sufficient capacity within the existing network of pharmacies to meet the future dispensing needs of the population. Our conclusions may be summarised as follows: **Current Need** ▪ None identified **Future Need** ▪ If GPs move to a 7 day a week service, pharmacy opening hours *may* need to be reviewed to ensure timely access to dispensing following a GP consultation. *At the time of publication the arrangements for operational delivery, and timescales, of such changes are not known* ▪ NE Tottenham has higher levels of deprivation, poorer health outcomes and is set to see significant population growth as a result of housing developments and a local programme of regeneration. We have identified that this locality, which has below average provision, may benefit from additional access to pharmaceutical services, once housing developments have been completed **Current Improvements or Better Access** ▪ Extending pharmacy opening hours, particularly in the mornings in the Central locality, would improve alignment with GP opening hours and ensure residents have timely access to dispensing following a GP consultation ▪ In terms of supporting the needs of people with disabilities, we have identified opportunities to provide support to improve effective communication with people who have hearing impairment **Future Improvements or Better Access** ▪ None identified

Advanced Services *Provision of these services is optional*	
Medicines Use Reviews (MURs) & Prescription Interventions (PIs) *This service allows accredited pharmacists to undertake medicines reviews with patients to help them understand their medicines. This helps to improve adherence and reduce waste. A maximum of 400 MURs may be provided each year. An MUR may only be offered if a patient has been using a pharmacy for 3 months* **Refer to section 5.11.1 for full details of the assessment**	92% (54/59) pharmacies offer the MUR and PI Service. We have determined that the service is **necessary** to meet the pharmaceutical needs of our population. Access is good on weekdays (9:30am - 6pm) and Saturdays (up until 5pm), but is more limited at all other times. We have identified the following gaps: ▪ 5 pharmacies don't offer MUR & PI services ▪ Some pharmacies are not actively providing the service; and the average number of MURs undertaken is significant below the maximum number permitted in any given year ▪ The 3 month rule means that MURs may not be accessed from a pharmacy, other than a patient's regular pharmacy. This means that some of our residents are not able to access the service at all We have identified there is sufficient capacity within our existing network of pharmacies to meet an anticipated increase in demand. Our conclusions may be summarised as follows: **Current Need** ▪ The gap, whereby some residents cannot access the service because it is not offered by their regular pharmacy, cannot be addressed through granting of new applications because of the 3 month rule for MURs. We wish to see all Haringey pharmacies to offer the MUR service. Another option is for a resident to be signposted to a pharmacy which does offer MURs (noting that prescriptions will need to be dispensed by the alternative pharmacy) **Future Need** ▪ We would like to see the national cap, limiting the number of MURs to 400 a year lifted. This would ensure that the capacity of individual pharmacies to provide reviews is not exceeded **Current and Future Improvements or Better Access** ▪ We wish to see pharmacies proactively targeting the MUR service at the patients who will derive the most benefit ▪ We would like to see more pharmacies opening earlier in the morning, or staying open later in the evening, where there is demand for service provision at these times; alternatively, there is an option for pharmacies to offer 'out of hours' appointments to facilitate access for people who work full time ▪ Providing the service in the domiciliary setting would improve access for the house bound or for those who find it difficult to get to a pharmacy without assistance
New Medicine Service (NMS) *This service supports patients with long term conditions, who are newly prescribed a medicine, to help improve adherence.* **Refer to section 5.11.2 for full details of the assessment**	76% (46/59) pharmacies offer the NMS service. We have determined that at this point in time, the NMS is not necessary to meet the pharmaceutical needs of our population but is relevant in that it **improves access to medicines reviews** We have identified the following potential gaps: ▪ 13 pharmacies do not offer the service; and a further 13 pharmacies are inactive ▪ There is variation between localities in the number of reviews undertaken; this is of concern in the NE Locality which has a high number of people with a limiting long term illness

Essential Services *Must be provided by all pharmacies*	
	▪ Access the service is limited, in all localities, on weekday mornings (up until and including 8am) and on Sundays We have identified there is sufficient capacity within our existing network of pharmacies to meet an anticipated increase in demand. Our conclusions may be summarised as follows: **Current and Future Need** ▪ None identified **Current Improvements or Better Access** ▪ We would like all our pharmacies to offer the NMS for as long as the service is commissioned ▪ We would like to understand why some pharmacies are not active and why others only undertake limited numbers of reviews, so that we can improve service uptake ▪ Adopting an integrated approach to service delivery, whereby pharmacies and prescribers in primary and secondary work closely together, may increase the number of people referred into the service and secure improvements for patients. ▪ We would, like to see more pharmacies opening earlier in the morning, or staying open later in the evening, where there is a demand for service provision at these times **Future Improvements or Better Access** ▪ None identified.
Stoma Appliance Customisation Service (SACs) *This service involves the customisation of one or more stoma appliances based on a patient's measurements or template in order to ensure proper use and comfortable fitting. SACs may be carried out in the patient's home.* **Refer to section 5.11.3 for full details of the assessment**	10% (6/59) pharmacies offer the SAC service We have determined that the service is not necessary to meet the pharmaceutical needs of our population but is **relevant in that it potentially offers a choice of provider for people who wish to use pharmacy-based services.** Whilst there is very little SACS activity undertaken within Haringey, we have not identified any current or future gaps. This is because our analysis indicates a high out of area dispensing rate for stoma appliances and it follows that SACs may also be accessed outside of the area. In addition, many people receive support from the hospital or clinical responsible for their ongoing care.
Appliance Use Reviews (AURs) *AURs may be carried out by a pharmacist or a specialist nurse and aim to improve patient adherence, to resolve issues due to ineffective use of the appliance and to reduce waste. AURs may be carried out in the patient's home.* **Refer to section 5.11.4 for full details of the assessment**	8% (5/59) pharmacies offer AURs. We have determined that the service is not necessary to meet the pharmaceutical needs of our population but is **relevant in that it potentially offers a choice of provider for people who wish to use pharmacy-based services** No AURs were undertaken in Haringey (2012/13 data. However, we have not identified any current or future gaps. This is because our analysis indicates a high out of area dispensing rate for appliances and it follows that AURs may also be accessed outside of the area. In addition, many people receive support from the hospital or clinical responsible for their ongoing care.

Enhanced Services *Services commissioned by NHS England in line with the local Pharmaceutical Needs Assessment*	
Minor Ailments Service (MAS) *Advice, support and provision of medicines, at no cost, to patients who would otherwise have gone to their GP, and referral on to other health and social care professionals where this is appropriate.* **Refer to section 5.12.1 for full details of the assessment**	88% (52/59) pharmacies have been commissioned to provide the service; of these 41% (24/59) are accredited to supply prescription only medicines via a patient group direction. We have determined that the MAS is **necessary to meet the pharmaceutical needs of our population**. We have identified the following potential gaps: ▪ Reduced access to the service on weekday mornings (including no pharmacies open in the Central Locality before 9am) and on Saturday evenings and Sundays. This means that residents may have to travel further to access this service at these times. This may be more of an issue at the weekend as most GP surgeries are closed and our residents may be more reliant on the pharmacy-based minor ailments service ▪ A number of pharmacies in some localities are not active Our conclusions may be summarised as follows: **Current and future need** ▪ None identified **Current & Future Improvements or Better Access** ▪ We would like to see improved access to the service, in the early mornings and at weekends, particularly in areas with higher deprivation (e.g. NE Tottenham) where there may be a greater demand for the service ▪ Better advertising of the service, would raise awareness and may increase uptake (where this is clinically appropriate)
London Pharmacy Vaccination Service *Pharmacist administration of immunisations, within the pharmacy setting. The scope of the service currently includes the following portfolio from September 2014 - March 2015* ▪ *Pneumococcal polysaccharide vaccination* ▪ *Seasonal Influenza vaccination* **Refer to section 5.12.2 for full details of the assessment**	61% (36/59) have been commissioned to provide the service We have determined that this service is not necessary to meet the pharmaceutical needs of our population, but is **relevant because it secures improves access and a choice of provider** for people requiring seasonal influenza vaccination and/or pneumococcal vaccination. Whilst there is a choice of provider in all 4 localities, we have identified that service provision does not necessarily align with need in the West locality. Our conclusions may be summarised as: **Current and Future Need** ▪ None identified **Current and Future Improvements or Better Access** ▪ Commissioning the service from additional pharmacies, particularly in the West Locality, would improve access to the service and may address historically low uptake of seasonal influenza vaccination within Haringey

Enhanced Services *Services commissioned by NHS England in line with the local Pharmaceutical Needs Assessment*	
On Demand Access to End of Life Care and other Specialised Medicines *This pharmacy-based service is intended to improve timely access, during extended hours to palliative care and specialist medicines that are not commonly stocked by pharmacies; or where there are anticipated delays in supplies* **Refer to section 5.12.3 for full details of the assessment**	4 pharmacies, one in each locality, have been commissioned to provide the service We have concluded that the service is not necessary to meet the pharmaceutical needs of our population **but is relevant in that it improves timely access to palliative care medicines**. In terms of gaps, two of the pharmacies are not open on a Sunday, which means that residents may have to travel further if they need to access the service. Alternatively, Barndoc, the GP Out of Hours Provider, provides access to key these medicines in the out of hours' period. **Current and Future Need** ▪ None identified **Current & future Improvements or better access** ▪ Improvements in access could be secured if the service was commissioned from other pharmacies which are open for extended hours on 7 days each week.

Locally Commissioned Services	
Services commissioned locally, by another NHS organisation or the Local Authority, and which may affect the need for pharmaceutical services or which are commissioned in response to a need for pharmaceutical services. ***Applications must relate to pharmaceutical services*** *(i.e. essential, advanced and/or enhanced services) and should not be submitted on the basis of the gaps identified for locally commissioned services.*	
Stop Smoking in Healthy Living Pharmacies *The pharmacy-based service, is a pilot which includes offering very brief advice; providing one to one support (and supply of medication if required) as part of an 8 week programme to residents who wish to quit smoking; health promotion advice; and referring on to specialist services where appropriate. To provide the service pharmacies must achieve Healthy Living Pharmacy status* **Refer to section 6.2.1 for full details of the assessment**	41% (24/59) pharmacies have been commissioned to provide the pharmacy-based smoking cessation service. We have concluded that the service is **necessary to meet the pharmaceutical needs of our population.** Access to the service on weekdays (9:30am - 6pm) and Saturdays (10am - 1pm) is generally reasonable in all localities. We have identified the following potential gaps: ▪ Reduced access to the service on weekday mornings, Saturday afternoons and evenings and Sundays ▪ No access to the service at all in NE Tottenham on a Sunday; this locality has high rates of deprivation and a population that stands to benefit from stop smoking services **Current and Future Needs** ▪ No needs identified **Current & Future Improvements or better access** ▪ We would like to see the service commissioned from a wider range of pharmacies in order to improve access, in the early mornings and at weekends; this may encourage the working population to seek support and would improve access in those localities where there is a higher smoking prevalence rate and/or demand for the service i.e. the Central Locality, NE Tottenham and SE Tottenham

Locally Commissioned Services	
Sexual Health Services *The community pharmacy based sexual health service has recently been re-commissioned in Haringey and is comprised of two bundles:* ▪ ***Services for young people aged under 25 years**; the scope of service includes supply of EHC, chlamydia and gonorrhoea screening, supply of chlamydia treatment and condom distribution, health promotion advice and signposting* ▪ ***Services for people aged 25 years and over**; the scope of the service is as above; plus HIV point of care testing (for those aged 18 years and over). Pharmacies providing this service must achieve Healthy Living Pharmacy status* **Refer to section 6.2.2 for full details of the assessment**	**Under 25s bundle** 42% (25/59) pharmacies have been commissioned to provide the under 25s bundle **25 years and over bundle** 47% (28/59) pharmacies have been commissioned to provide the 25 years and over bundle. *It should be noted, that at the time of publication, the training and accreditation of pharmacies is ongoing but it is anticipated all pharmacies listed in Appendix E will be live by the end of June 2015.* We have concluded that the service is **necessary to meet the pharmaceutical needs of our population.** There is good access to the service during the daytime on weekdays and on Saturday mornings and we have demonstrated good alignment with need. We have identified the following potential gaps: ▪ More limited access on weekday mornings up until and including 8am, Saturday evenings at 7pm or later; and on Sundays ▪ For the under 25s service, the impact of this is that the service is not necessarily correlated with need at these times, particularly in the wards with historically high teenage pregnancy rates (Harringay, Bruce Grove and Tottenham Green) **Current Need** ▪ There is a need to ensure that the residents of NE and SE Tottenham can access sexual health services, within their own localities, on every day of the week. This is particularly important for EHC where treatment has to be taken as soon as possible, and within a maximum of 72 hours, after unprotected sexual intercourse **Future Need** ▪ No needs identified **Current Improvements or better access** ▪ We would like to see the service commissioned from more pharmacies, particularly those which open for extended hours on 7 days a week. This would improve access and provide a greater choice, in the areas of highest need; and would ensure service availability on the days, and at times, where there is potentially an increased demand for the service **Future Improvements or better access** ▪ None identified

Locally Commissioned Services	
Supervised Consumption of methadone and buprenorphine *The service requires the pharmacist to supervise the consumption of either methadone or buprenorphine (Subutex®) at the point of dispensing in the pharmacy, ensuring that the dose has been administered to, and consumed by, the patient.* *The service aims to improve patients' outcomes and to reduce the diversion of illicit drugs into the community.* **Refer to section 6.2.3 for full details of the assessment**	46% (27/59) pharmacies are commissioned to provide the supervised consumption service. We have concluded that the service **is necessary to meet the pharmaceutical needs** of our population. There is good accessibility during day time hours, in all areas on Mondays through to Saturdays. Access outside of these hours is more limited, particularly on Sundays. High risk service users are referred to pharmacies which open on 7 days each week. This helps to address the potential gap associated with Sunday opening. **Current and Future Need** ▪ None identified **Current Improvements or better access** ▪ Commissioning the service from additional pharmacies which open during extended hours and at weekends would improve access and enhance the level of supervision for all service users **Future Improvements or better access** ▪ None identified
Needle and Syringe Programme *Pharmacies provide access to sterile needles and syringes, and sharps containers for the return of used equipment. They offer a user-friendly, non-judgmental, client-centred and confidential service including referral to other health and social care professionals and specialist drug and alcohol treatment services where appropriate. The service is open to adults aged 18 years and over.* *The programme is an important public health service which reduces risks to injecting drug users and the general public* **Refer to section 6.2.4 for full details of the assessment**	17% (10/59) of pharmacies are commissioned to provide the needle and syringe exchange programme. We have determined that pharmacy-based substance misuse services are **necessary** to meet the pharmaceutical needs of our population. We have identified that there is reasonable access on weekdays between 9:30am - 6pm. We have identified a potential gap in that access is more limited in the early mornings on weekdays, Saturdays and Sundays which means that service provision doesn't necessarily align with need, particularly in local "hot spots" including Wood Green (Noel Park ward) and N15 postcodes (Tottenham Green, Seven Sisters and St Ann's). **Current Need** ▪ There is a need to ensure access to the needle and syringe programme, on 7 days a week particularly in the areas of high pharmaceutical need **Future Need** ▪ None identified **Current & Future Improvements or better access** ▪ Commissioning the service from a wider range of pharmacies, including those which open for extended hours and/or at weekends would improve access to the service across Haringey

Locally Commissioned Services	
Healthy Start Vitamins *Pharmacy based supply of Healthy Start Vitamins, free of charge to those falling into the following groups:* ▪ *Pregnant women* ▪ *Women who have had a baby in the last year* ▪ *Children under four years old (e.g. up to their fourth birthday)* **Refer to section 6.2.5 for full details of the assessment**	The service currently commissioned from 17% (10/59) pharmacies; Healthy Start Vitamins may also be accessed from 17 Children's centres across Haringey We have determined that the service is not necessary to meet the pharmaceutical needs of our population, but **is relevant** in that the pharmacy based service provides a choice of provider and improves access to the vitamins, and the benefits associated with these The map shows that there is a reasonable correlation with need, although there are opportunities to improve access in the NE Locality (particularly Northumberland Park); and in parts of the West Locality (particularly Fortis Green). We have not identified any specific gaps, although access is limited on certain days of the week **Current and Future Need** ▪ None identified at this point in time **Current & Future Improvements or better access** ▪ None identified at this point in time, however, there are plans to evaluate the service with a view to determining whether or not current provision requires revision
Anti-coagulant and Stroke Prevention Service *Community providers of the anti-coagulant and stroke prevention service are responsible for sampling, testing and dosing patients according to locally agreed protocols approved by NHS Haringey. Providers are also responsible for communicating dosing recommendations to patients and their GPs.* **Refer to section 6.3.1 for full details of the assessment**	NHS Haringey CCG currently commissions an anti-coagulant and stroke prevention service from one community pharmacy and five GPs. We have concluded that the service is not necessary to meet the pharmaceutical needs of our population, but is **relevant** because the service improves access to community based anti-coagulant monitoring. The existing network of providers has capacity to manage additional patients now, and in the future. However, should the need arise to commission more pharmacies our community pharmacy questionnaire indicated that 48 pharmacies are willing to provide this service. We have not identified any specific gaps, needs or areas for improvement at this point in time.

1.3. Pharmaceutical Services in the Future

Our vision for future of community pharmaceutical services is to embed the nationally recognised approach on the Healthy Living Pharmacy (HLP).

In Haringey, we've already started the implementation of HLP (refer to section 6.1) and our vision is to extend this offer equally across the borough and establish pharmacies as healthy living community hubs.

We have identified, that in Tottenham, an area which has high levels of deprivation and health challenges, coupled with poor access to GPs and low GP registration, there is an opportunity for pharmacy to drive improvements in public health through the HLP.

1.4. Aspirations for Future Pharmacy Premises and Services

In reflecting upon the gaps, areas for improvement and our vision (as set out in section 7.1 above), we have identified aspirations for pharmacy services and premises throughout our PNA; and would like to see these prioritised for future applications.

2. Introduction

The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417)[1] set out the system for market entry. Under the Regulations, Health and Wellbeing Boards are responsible for publishing a Pharmaceutical Needs Assessment (PNA); and NHS England is responsible for considering applications and maintaining the pharmaceutical list.

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor (DAC) or dispensing doctor (rural areas only) who wishes to provide NHS Pharmaceutical services must apply to be on the Pharmaceutical List.

The PNA is subsequently used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or commission additional services. The document will be used by local commissioners to inform commissioning strategy and to support the future commissioning of pharmacy services. It may also act as a reference source for existing NHS pharmaceutical services contractors who may wish to change the services they provide and/or by potential new entrants to the market.

Haringey's Health and Wellbeing Board (HWB), in accordance with the Regulations, have prepared this document. It replaces the PNA published by the former Haringey PCT.

2.1. Duty of the Health and Wellbeing Board

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis and the full HWB responsibilities for developing and updating PNAs, which may be summarised as follows:

- **Publish and maintain the PNA**
  The first PNA, for the HWB area, must be published by 1 April 2015.

- **Maintain and keep the PNA up to date**
  In response to changes in the availability of pharmaceutical services, there is a requirement for the HWB to determine whether or not it needs to revise the PNA or, where this is thought to be a disproportionate response, to issue a supplementary statement setting out the change(s). As a minimum, a new PNA must be published every 3 years.

  In addition, the HWB is required to keep up to date a map of provision of NHS Pharmaceutical Services within its area.

  The HWB must make the PNA, and any supplementary statements, available to NHS England and neighbouring HWBs.

- **Respond to a consultation by a neighbouring HWB**
  The Regulations require that, when consulted by a neighbouring HWB on a draft of their PNA, the HWB must consult with the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) for its area (unless the areas are served by the same LPC and/or LMC) and have regard for the representations from these committee(s) before making its own response to the consultation.

2.2. Minimum Requirements for the PNA

2.2.1. Minimum Information which should be contained within the PNA

Schedule 1 of the Regulations state that the PNA must include, as a minimum, a statement of the following:

- **Necessary services** i.e. pharmaceutical services which have been assessed as **required to meet a pharmaceutical need**. This should include their current provision (within the HWB area and outside of the area) and any current or likely future gaps in provision (if any).

- Services which have been determined to be **relevant** because they have **secured improvements, or better access, to pharmaceutical services**. This should include their current provision (within the HWB area and outside of the area) and any current or future gaps in provision (if any).

- **Other NHS services**, either provided or arranged by a Local Authority, NHS England, a CCG, an NHS Trust or Foundation Trust which either impact upon the need for pharmaceutical services, or which would secure improvements, or better access to, pharmaceutical services within the area.

- A map showing the premises where pharmaceutical services are provided.

- An explanation of how the assessment was made, including setting out:

    - How the Localities were determined;
    - How different needs of different Localities have been taken into account;
    - How the needs of different groups who share a protected characteristic (as defined within the Equality Act 2010[2]) e.g. disability, race, age etc, have been taken into account.

- A report on the consultation.

2.2.2. Matters for Consideration when Making Assessments

In making an assessment, the HWB is expected to take into account the following matters, explaining how it has reached its conclusions:

- The demography and health needs of the population

- Whether or not there is reasonable choice within the area

- Any different needs of different Localities within the HWB area

- The needs of those who share a protected characteristic

- Whether further provision of pharmaceutical services would secure improvements or better access (taking into account both pharmaceutical and other NHS services inside & outside of the area)

- Likely future pharmaceutical needs taking into account the number of people who require pharmaceutical services; demography and the risks to the health and wellbeing of people within the HWB area

2.2.3. Consultation requirements

HWBs must consult on a draft of the PNA, for a minimum of 60 days (and good practice dictates that a minimum of 2 days should be allowed to serve the draft).

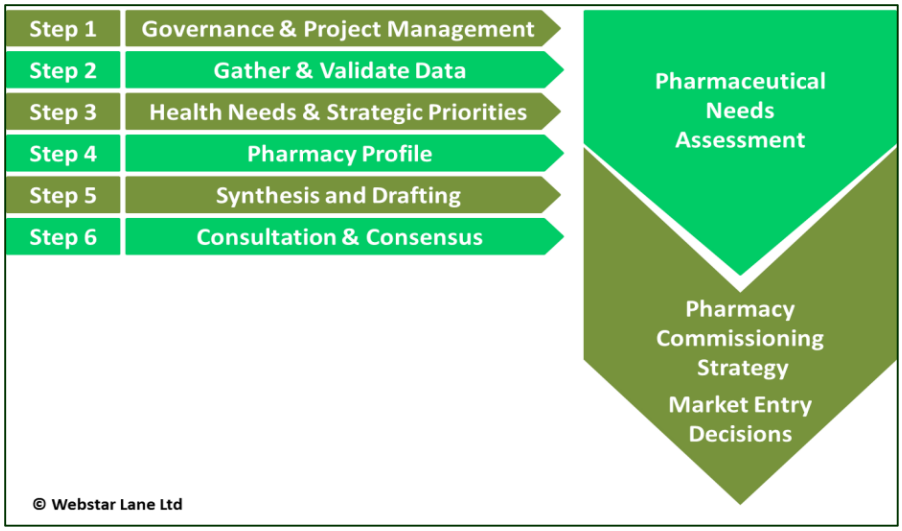
This consultation must include specified stakeholders including:

- The Local Pharmaceutical Committee
- The Local Medical Committee
- All persons on the pharmaceutical list and any Local Pharmaceutical Service (LPS) contract pharmacies.
- The local Health Watch and any other relevant local patient or consumer groups within the HWB area
- Any NHS Trusts and Foundation Trusts within the area
- NHS England
- Any neighbouring HWBs

The HWB may choose to consult more widely than this, should it wish to.

2.3. Process & methodology followed in developing the PNA

Our PNA has been developed using a mixture of methods and reinforced through consultation with stakeholders and pharmaceutical service providers. The diagram below provides a high level overview of the process adopted:



The table below summarises the key activities, together with the data and information sources, which were carried out at each stage:

	Activity	Data and Information Source(s)
Step 1 **Governance and Project Management**	▪ A PNA Steering Group was established to oversee and drive the development of the PNA, ensuring compliance with the Regulations. Refer to Appendix A for the Terms of Reference ▪ A specialist consultancy, Webstar Lane Ltd, was appointed to provide subject matter expertise and project management support	▪ Not applicable
Step 2 **Gather and Validate Data**	▪ Information and data was requested from: ○ Managers & Commissioners within LBH ○ NHS England ○ NHS Haringey CCG ▪ A questionnaire was designed and disseminated to community pharmacists, in July 2014, to verify current service provision, and to provide insights into other aspects of service delivery, e.g. characteristics of the consultation area(s); languages other than English spoken by staff; how the pharmacy meets the needs of those with a disability; enhancements made to patient care; future aspirations for service provision; the provision of non-NHS services. This is attached in Appendix B ▪ The data from the community pharmacy questionnaire was triangulated with the data supplied by service commissioners and NHS England, and any anomalies addressed, to produce an accurate dataset	▪ NHS Pharmaceutical List ▪ Pharmacies accredited to provide advanced services and activity data for such services ▪ GP opening hours (including extended hours) ▪ Service level agreements, provider information and activity data for enhanced service and locally commissioned services ▪ HSCIC: General Pharmaceutical Services in England (2012/13) ▪ Epact prescribing data for Haringey (2013/14) ▪ Joint Strategic Needs Assessment (JSNA) ▪ Relevant healthcare and other relevant strategies

	Activity	Data and Information Source(s)
Step 3 **Health Needs and Strategic Priorities**	▪ A desktop review of the JSNA and key strategies was undertaken. ▪ This review was supplemented by meetings with Public Health Managers, service commissioners and managers and other key personnel in order to inform current and future priorities.	▪ JSNA (http://www.haringey.gov.uk/JSNA) ▪ Haringey Health Profile (2014) ▪ Public Health Outcomes framework (http://www.phoutcomes.info/) ▪ NHS England "Everyone Counts - Planning for Patients 2014/15 – 2018/19" ▪ NHS England "Call to Action" ▪ Joint Health & Wellbeing Strategy (2012-15) ▪ NHS Haringey CCG 5 year plan (2014/15 - 2018-19) ▪ Haringey CCG Prospectus ▪ Better Care Fund: Local Health and Social Care Integration Plan ▪ North Central London Strategic Planning Group 2014 - 19 ▪ Local Development plan and spatial strategy
Step 4 **Pharmacy Profile**	▪ The current pharmacy profile was documented, on a service by service basis, building this up from ward through to locality level.	▪ Validated dataset from step 2 above
Step 5 **Synthesis and Drafting**	▪ Emerging themes were drawn together and presented to the PNA Steering Group. ▪ The PNA Steering Group made appropriate recommendations and formulated conclusions for the PNA.	▪ Information and analysis from steps 3 and 4 above
Step 6 **Formal Consultation and Consensus**	▪ A formal consultation was undertaken, between 9 December 2014 and 5pm on 10 February 2015 in accordance with the Regulations. ▪ Comments were collated, analysed and presented to the PNA Steering Group for discussion. ▪ The draft PNA was updated to reflect decisions of the PNA Steering Group, following review of the consultation responses, in order to produce the final PNA for approval by the HWB. ▪ The consultation report is set out in section 8 [*Final PNA only*].	▪ Responses from formal stakeholder consultation

3. Scope of the Pharmaceutical Needs Assessment

3.1. Pharmaceutical Services

A Pharmaceutical Needs Assessment is defined in the regulations as: *"The statement of the needs for pharmaceutical services [in its area] which each HWB is required to publish".* Pharmaceutical Services are defined as *"all pharmaceutical services that may be provided under arrangements made by the NHS Commissioning Board (NHS England)"* and encompass services provided by contractors included on the Pharmaceutical List.

The table summarises the range of pharmaceutical services, provided by each contractor type within Haringey, which have been included within the scope of the PNA.

Contractor Type	Pharmaceutical Services Provided
Pharmacy Contractors *Community pharmacies that provide services under the national 'contract'.* *All pharmacies must provide the full range of essential services.* *Advanced and enhanced services are defined in the "Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013".* *A contractor has discretion as to whether or not they provide advanced services. There are requirements which need to be met in relation to premises, training or notification to NHS England.* *Enhanced services may be commissioned by NHS England in response to the needs of the local population. The Regulations define the range of services which may be commissioned.*	**Essential services** ▪ Dispensing (including Electronic prescription services) and actions associated with dispensing ▪ Repeatable dispensing ▪ Disposal of unwanted medicines ▪ Promotion of healthy lifestyles (Prescription-linked interventions, Public health campaigns) ▪ Signposting ▪ Support for self-care **Advanced services** ▪ Medicines Use Review and Prescription Interventions (MURs) ▪ New Medicines Service (NMS) ▪ Appliance Use Reviews (AUR) ▪ Stoma Appliance Customisation Service (SAC) **Enhanced Services** ▪ Minor ailments Service ▪ London Pharmacy Vaccination Service ▪ On Demand Access to Palliative Care & Specialist Medicines
Local Pharmaceutical Services (LPS) Contractors *Pharmacies that are commissioned to provide 'local pharmaceutical' services (LPS), by NHS England, under a locally defined contract.* *As a minimum the LPS contract must include dispensing in addition to the specific LP service(s).* *It is permissible to 'bolt' an LPS contract onto the national contract.*	Not applicable in Haringey
Dispensing Appliance Contractors *Contracted to provide a range of appliances including dressings, stoma and incontinence appliances.* *Advanced and enhanced services are defined in the "Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013".* *A contractor has discretion as to whether or not they provide advanced services. There are requirements that need to be met in relation to premises, training or notification to NHS England.*	Not applicable in Haringey
Dispensing Doctors	Not applicable in Haringey

3.2. Other Services

When making its assessment, the Regulations require the HWB to consider how other services affect the need for pharmaceutical services. For the PNA, we looked at this from two perspectives:

- Firstly, an assessment of the services that have been directly commissioned from pharmacies by other organisations, e.g. the Local Authority, the Clinical Commissioning Group, NHS Foundation Trusts etc.
- Secondly, how other NHS services may impact upon the need for pharmaceutical services

a. Locally Commissioned Services Delivered by Haringey Pharmacies

The table below summarises the locally services which have been commissioned from pharmacies by Haringey Council and other NHS Organisations.

Commissioner	Services Commissioned from Pharmacy
London Borough Haringey	**Public Health Services** ▪ Healthy Living Pharmacies ▪ Stop Smoking ▪ Sexual Health ▪ Healthy Start Vitamins
NHS Haringey CCG	▪ Anti-Coagulant and Stroke Prevention Service
NHS Trusts / Foundation Trusts	Barnet, Enfield & Haringey Mental Health NHS Trust Drug Advisory Service for Haringey (DASH): ▪ Needle and Syringe Exchange Programme ▪ Supervised Consumption *BEHMHT has been commissioned as the prime contractor for the above services and sub-contracts with Haringey pharmacies*

b. Services which Affect the Need for Pharmaceutical Services

The table below provides an overview of NHS services which have been included within the scope of the PNA because they may influence the need for Pharmaceutical Services within Haringey.

Organisation	Relevance to pharmaceutical services
Whittington Hospital NHS Trust (part of Whittington Health)	▪ NHS Haringey CCG commissions hospital and community services for patients registered with GPs within Haringey ▪ FP10 prescriptions are sometimes issued for dispensing in the community; we have not been made aware of any plans to out-source outpatient dispensing
North Middlesex University Hospital NHS Trust	▪ NHS Haringey CCG commissions services for patients registered with GPs within Haringey ▪ FP10 prescriptions are sometimes issued for dispensing in the community; we have not been made aware of any plans to out-source outpatient dispensing
Barnet, Enfield and Haringey Mental Health Trust	▪ NHS Haringey CCG commissions mental health services for patients registered with GPs within Haringey. ▪ The Drug Advisory Service for Haringey (DASH) uses FP10 prescriptions and refers service users into the community pharmacy based needle & syringe programme and supervised consumption service
Barndoc	▪ NHS Haringey CCG commissions a GP out of hours service from Barndoc which are based in two locations: o The Laurels Healthy Living Centre (St Ann's Ward) o Finchley Memorial Hospital (Woodhouse ward, Barnet) ▪ The service uses FP10 prescriptions for a minority of patients

Organisation	Relevance to pharmaceutical services
Walk-in Centres	▪ Haringey residents may access the walk-in centre based at Finchley Memorial Hospital.
"Care closer to home pathways"	▪ NHS Haringey has redesigned the following pathways of care all of which use NHS FP10 prescriptions: o Community ophthalmology o Musculoskeletal services o Community Urology o Community ENT ▪ The dermatology pathway is to be redesigned across North Central London

In addition, all of the above services may signpost to community pharmacy services for advice on self-management that may include accessing the Minor Ailments service.

3.3. Excluded from the PNA scope

There are a range of other services associated with pharmacy and/or medicines management, other than those described in section 3.1 and 3.2 above, which have not been included within the scope of this PNA, because they do not fall within the 2013 Regulations. Examples are provided below:

3.3.1. Non-NHS Services Provided by Community Pharmacists

Community pharmacy contractors may provide a range of non-NHS services directly to patients, which are not commissioned by NHSE, the LA, the CCG or other NHS Services. These include:

- Prescription collection and home delivery services
- Supply of prescription only medicines on a private basis under patient group directions. Includes medicines for erectile dysfunction, hair loss, weight management
- Chiropody services
- Screening or 'Wellness checks' which may include blood pressure measurement, cholesterol testing, blood glucose monitoring, body mass index measurement
- Flu vaccination for people who are not eligible for vaccination under the NHS

Non-NHS services are potentially valuable to residents of Haringey; however, they have not been evaluated in any depth because they cannot be taken into account, by NHS England, when considering market entry applications.

3.3.2. Pharmacy Services within NHS Trusts

NHS Haringey CCG commissions care from a range of NHS Trusts and Foundation Trusts, which provide community healthcare services, mental healthcare services and hospital services to the residents of Haringey.

The pharmaceutical services provided by these Trusts to the patients utilising their services have not been assessed as part of the PNA.

However, we are concerned to ensure that patients moving in and out of hospital have an integrated pharmaceutical service which ensures continuity of support around medicines.

3.3.3. Medicines Management Team

NHS Haringey CCG has a medicines management team which provides advice and support to the CCG and prescribers on matters relating to the safe, effective and cost effective use of medicines.

4. Context for the PNA in Haringey

In this section, we summarise the local context with respect to the demography and health needs of our population, together with a high level overview of our strategic priorities. Further information can be found on the following websites:

- http://www.haringey.gov.uk
- Haringey's Joint Strategic Needs Assessment (accessed via http://www.haringey.gov.uk/JSNA)
- Haringey's Health and Wellbeing Strategy 2012-2015
- http://www.haringeyccg.nhs.uk

4.1. Overview of Haringey

Haringey is an exceptionally diverse and fast-changing borough. We have a population of 263,386 according the 2013 Office for National Statistics Mid-Year Estimates. Almost two-thirds of our population, and over 70% of our young people, are from ethnic minority backgrounds, and over 100 languages are spoken in the borough. Our population is the fifth most ethnically diverse in the country.

The borough ranks as one of the most deprived in the country with pockets of extreme deprivation in the east. Haringey is the 13th most deprived borough in England and the 4th most deprived in London.

Death rates in Haringey are decreasing year on year but are still remaining to be higher than London and England's average. Over half of deaths in Haringey are due to cardiovascular disease and cancer. Mortality rates for males are higher than females and remain higher than the rates for London and England overall.

Haringey has seen a significant improvements in the overall male life expectancy however inequalities within the borough remain stark. Men in most deprived areas of the borough live, on average, 7.7 years less than their counterparts in west. Female life expectancy in Haringey is similar to London's female life expectancy and higher than England's average although there are some variations between the wards.

Haringey shares a border with the following HWB areas, and our assessment will take into account pharmaceutical and other services within these areas:

- Barnet
- Camden
- Enfield
- Hackney
- Islington
- Waltham Forest

Haringey has similar characteristics to a number of other London Boroughs including City and Hackney, Lambeth, Lewisham and Southwark. *These Boroughs will be used for the purposes of comparison within our PNA and are referred to throughout this document as "ONS comparators".* They are located within inner London. Southwark is the most typical Local Authority District (LAD) and Haringey the least typical in this subgroup.

The PNA regulations require that the HWB divide its area into Localities that are then used as a basis for structuring the assessment. For our PNA, we have adopted a structure which is comprised of four localities. The table below summarises the Localities and the 19 wards from which they are built up.

West	Central	NE Tottenham	SE Tottenham
Alexandra	Bounds Green	Bruce Grove	St Ann's
Crouch End	Harringay	Northumberland Park	Seven Sisters
Fortis Green	Noel Park	Tottenham Hale	Tottenham Green
Highgate	Woodside	West Green	
Hornsey		White Hart Lane	
Muswell Hill			
Stroud Green			

Whilst the localities will form the basis of our PNA, we will also make reference to wards as a means of pin pointing specific issues within the localities; or where locality level information is not available.

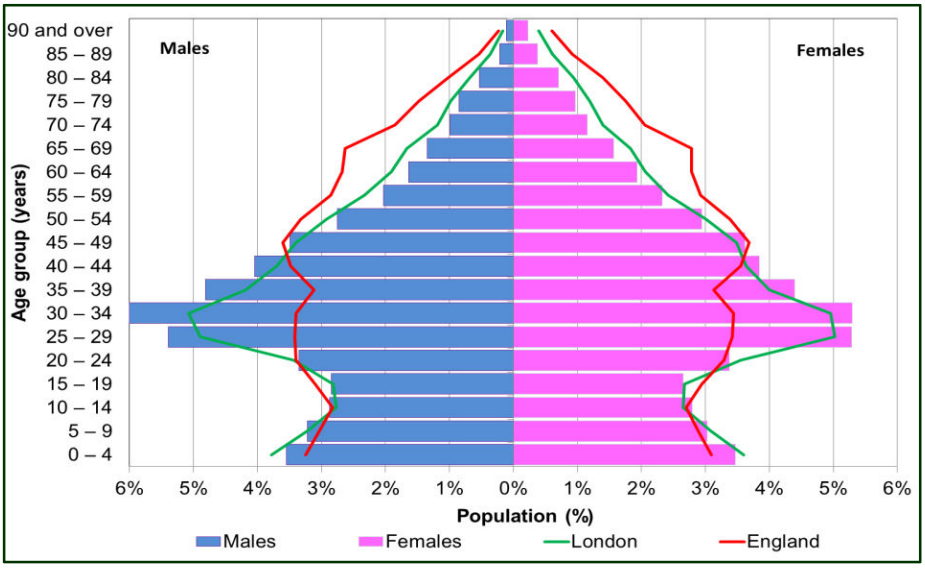
The choice of localities for the PNA has been influenced by the historical development of different areas in Haringey. The reasons underpinning the use of these localities may be summarised as follows:

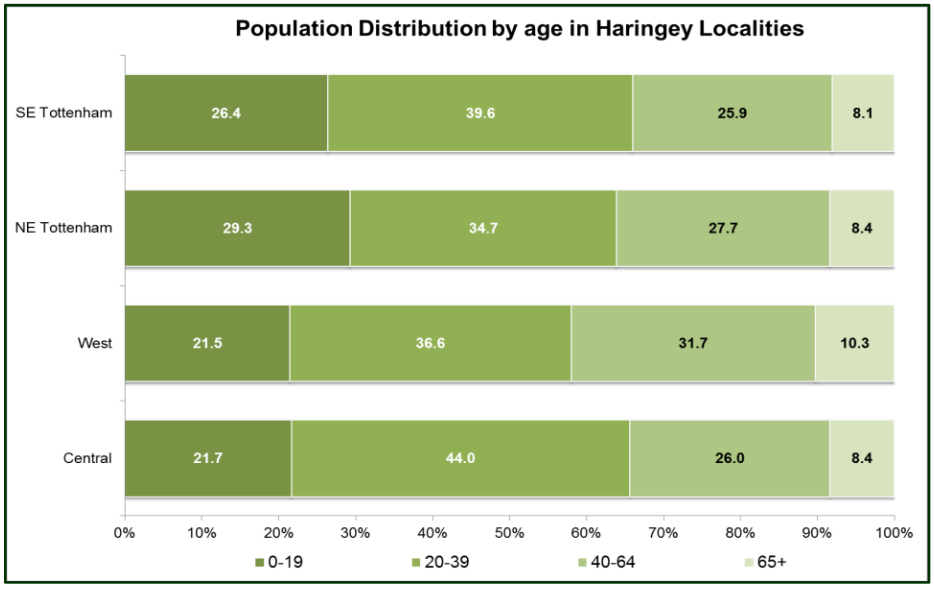
- They are used by the London Borough Haringey, NHS Haringey CCG and also by other agencies in Haringey
- They are four very distinctive geographical regions with differing health needs and demographics
- A railway line forms a physical barrier between the East and the West of the borough
- The west is very different from the east in terms of demography and health outcomes. The west therefore makes up the first of the four localities
- The central locality is concentrated around the Green Lanes area, which is predominantly Greek / Turkish
- The third and fourth localities make up the eastern borders of Haringey, which are more ethnically diverse. Tottenham has a concentration of Black population from both Africa and the Caribbean. In order to make them a manageable size Tottenham is split into two: North East Tottenham and South East Tottenham

4.2. Demography

4.2.1. Population and Population Projections

The graphs below provide an overview of the sex and age breakdown of local population and how age varies between the localities.



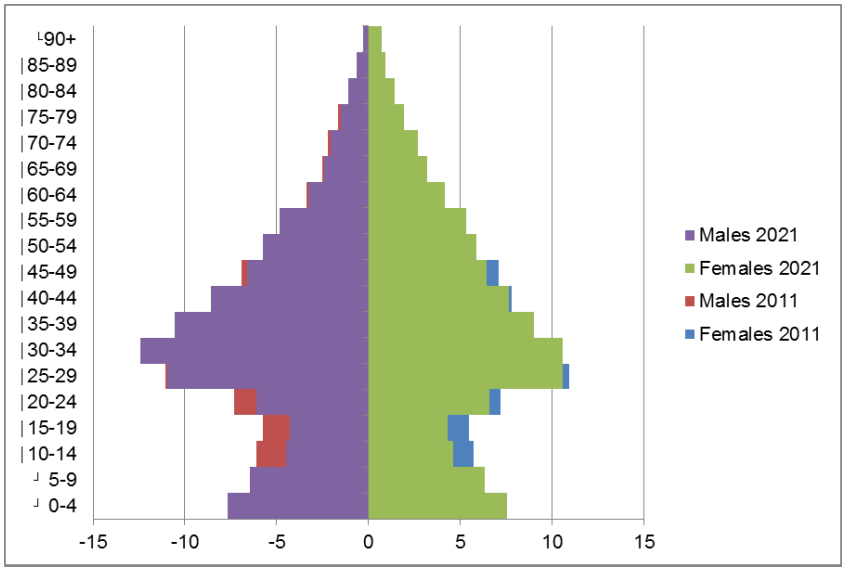


The population of Haringey is growing. Population growth locally is mostly due to the increase in birth rates and net gain from international migration. Birth rates locally and nationally are increasing while death rates are decreasing. In 2011/12, there were 3,120 more births than deaths in Haringey. The additional net increase in the population due to international migration was from top three countries: Italy, Spain and Poland.

The fastest growing population locally is in age groups 30-34 and 45-49 and the number of people aged 65-69 and over 85 decreased since 2001. In 2012, there were 4,209 births in Haringey. Total births have been steadily increasing since 2002 but have taken a dip since 2008. The birth rate (births per 1000 of the population) in Haringey was consistently higher than London during the period up to 2008 and is now level with London.

Under the Sub National Population Projections method, the previous 2011 ONS census population estimate of 255,540 is projected to reach 286,700 by 2021. This is an increase of just over 31,000 (and almost 23,500 against our current population). The population pyramid demonstrates that the greatest growth is anticipated in:

- Males and females falling into the 10 - 14, 15 - 19 and 20 - 24 age groups
- Females in the 25 - 29 and 45 - 49 age groups
- Males in the 45 - 49 age group (but to a lesser extent than females)



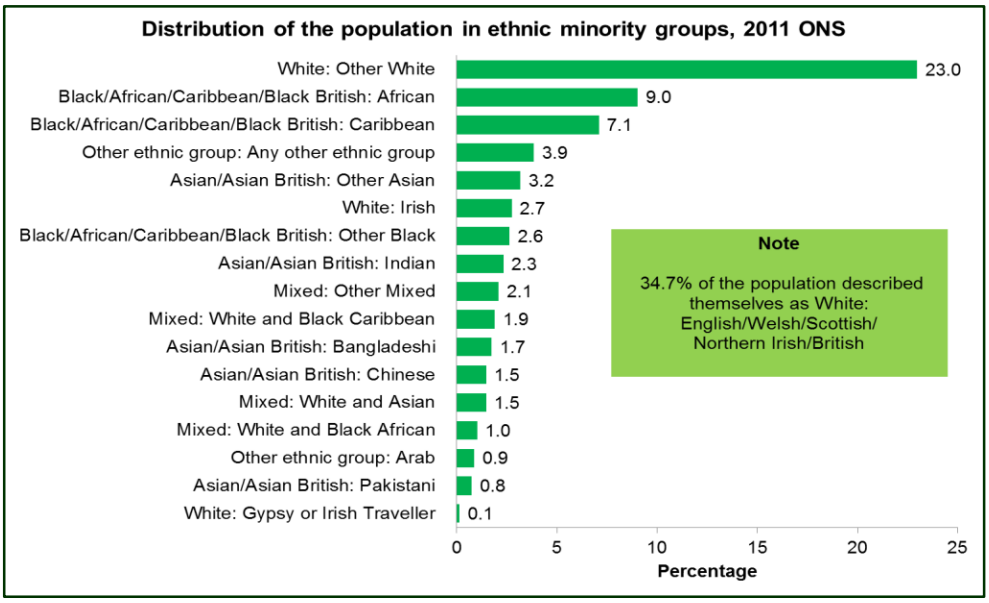
In addition to estimated population projections, Haringey has one of the largest regeneration areas within the east of the borough. Regeneration in Tottenham is focused on four areas: High Road West; Northumberland Park; Tottenham High Road/Seven Sisters; and Tottenham Hale.

Our Council estimates for population growth are approximate based on 2.4 people per unit (and 2.0 for High Road West).

Cumulative population growth from additional housing	By 2020	By 2025	By 2035
High Road West & surrounding	3,700	3,700	5,400
Northumberland Park	-	-	7,500
Bruce Grove, Seven Sisters and Tottenham Green	1,900	5,200	6,500
Tottenham Hale	5,100	5,100	10,200
5 Wards Total	**10,700**	**14,000**	**29,600**
St Ann's	-	1,100	4,300
7 Wards Total	**10,700**	**15,100**	**33,900**

4.2.2. Ethnicity

Haringey has an ethnically diverse population. 60.5% of the Haringey population are White. This is higher than the London figure of 59.8%. The graph provides an overview of the ethnic breakdown of the Haringey population.



4.2.3. Religion or Belief

A wide range of religions are practiced including Christianity, Islam, Judaism, Hinduism and Buddhism. A proportion of the population also describe themselves as being without any religion.

4.2.4. Deprivation

Haringey is a Borough of contrasts with respect to deprivation and this has a major effect on the health and wellbeing of the population of Haringey. People in the west have better health outcomes and access health services more than those that are in greatest need living in the east of the borough. These differences have created inequalities in health between the east and the west of the borough.

What this means for the PNA

Age

The age of a person has a material impact upon how and when they may need to use pharmacy services. Appendix C provides an overview of potential pharmaceutical needs across the lifecourse. It provides an illustration of services which may be accessed by people irrespective of age and services which may be more relevant at different times in an individual's life. Therefore, it is important that community pharmacy services are tailored to meet the pharmaceutical needs of the population which they service.

A survey of the population in England[3] showed that the people more likely to visit a pharmacy once a month or more are: older people, children, women aged 55 years and over and those with a long term condition. Conversely men, younger adults and people in employment are less likely to visit a pharmacy once a month or more. The findings of this study are of relevance for all Haringey localities given the younger population. It is essential that pharmacies maximise opportunities to target health promotion and public health interventions in order to improve health and prevent or delay the onset of disease and long term conditions.

Whilst the proportion of older people aged 65+ is below 10%, it is important that pharmaceutical services meet the pharmaceutical needs of this segment of the population.

Population Growth

The growing population of Haringey has implications for the future demand for services, including those provided by community pharmacies. Our assessment will consider the capacity of our existing network of pharmacies in meeting this increased demand.

Ethnicity

There is a correlation between health inequalities and the levels of diversity within the population. BAME communities are exposed to a range of health challenges from low birth weight and infant mortality through to higher incidence of long term conditions such as diabetes and cardiovascular disease. Pharmaceutical services need to reflect the specific needs of the BAME populations as well as providing a broad range of services to the entire population.

The diversity of spoken languages potentially presents challenges for the delivery of pharmaceutical services, particularly with respect to the effective communication of health promotion messages and lifestyle advice. In our questionnaire, we asked pharmacies which languages, other than English, that their staff speak. The results are summarised in the table:

Language	No. of Pharmacies	Percentage of Pharmacies	Other languages spoken (<5% pharmacies)
Gujarati	46	78%	Farsi Arabic Punjabi Lithuanian Slovakian Kurdish Greek South African Chinese Cantonese
Hindi	43	73%	
Urdu	17	29%	
Turkish	15	25%	
Swahili	13	22%	
Polish	10	17%	
French	9	15%	
Spanish	9	15%	
Bengali	9	15%	
Italian	7	12%	
Romanian	6	10%	

There is a relatively good correlation between languages spoken in pharmacies and those spoken by the general population. This may assist in overcoming communication barriers within the community they serve. However, the diversity of languages spoken also highlights a potential need for services such as telephone translation.

Religion

Pharmaceutical services need to ensure advice on medicines and medicines-related issues are tailored to meet the needs of specific religions or beliefs. For example, residents may seek advice on taking medicines during Ramadan; or whether or not a particular medicinal product includes ingredients, which are derived from an animal.

Deprivation

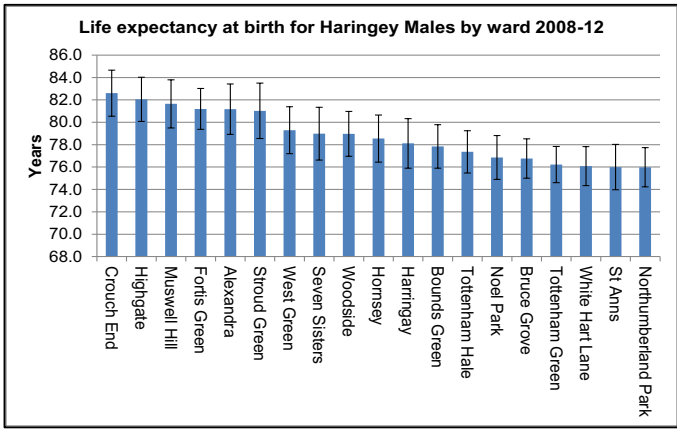
There is a correlation between deprivation and higher incidence of long term conditions, earlier onset of disease and lifestyle-related health inequalities. This has a negative impact upon health outcomes and will contribute towards the health inequalities within Haringey. Access to community pharmacy within deprived communities is important in supporting the population to address their health needs. The PNA will need to take into account whether the services provided by pharmacies are available to the most deprived communities and whether there is sufficient capacity to meet their pharmaceutical needs.

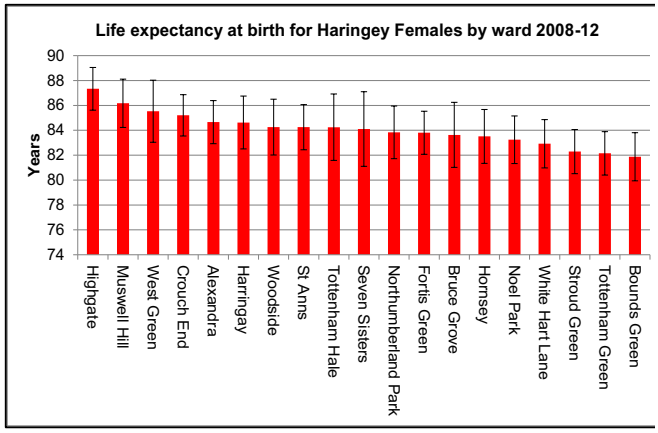
4.2.5. Health Inequalities

Life expectancy is often used as a key indicator of health inequalities within a geographical region. It identifies areas where people are dying younger than in other areas. The key issues that affect differentials in life expectancy are adults that die young from diseases such as cancer and circulatory diseases and infants that die in the first year of life (Infant Mortality).

Life expectancy for men living in Haringey at 79.4 years is now slightly higher (though not significantly) than the life expectancy in England (79.2 years). London overall is (79.7 years) and Haringey has the 17th highest out of 32 boroughs in London (public health outcomes framework life expectancy data 2010-12). Life expectancy in females in Haringey (83.8 years) is the same as London and significantly higher than the current life expectancy for England (83.0 years). Haringey's female life expectancy is ranked 16th in London (public health outcomes framework life expectancy data 2010-12).

Life expectancy varies significantly between wards in Haringey with stark differences in life expectancy in males and females between the east and the west of the borough. This is summarised in the graphs below.





The number of deaths in Haringey residents has been falling in recent years with 1,107 occurring in 2011. The age standardised mortality rate (which enables populations with different age profiles to be compared) suggests that the death rate in Haringey is lower than those of both London and England.

Over half of deaths in Haringey are due to cardiovascular disease and cancer. Mortality rates for males are higher than females and remain higher than the rates for London and England overall. Lifestyle choices, in relation to smoking, poor diet and nutrition, physical inactivity, substance misuse (alcohol and drug misuse) and risky sexual behaviour contribute towards health inequalities.

The table provides an overview of areas where improvements have been made and areas which remain a concern (based on the JSNA 2013):

	Improvements	Areas which remain a concern
Children & Young People	▪ Infant mortality rates are now lower than the London and England overall (3.9 per 1,000) ▪ Teenage pregnancy rates have decreased significantly but at 33 per 1,000 are still higher than London and England.	▪ High levels of estimated behavioural problems in children and young people, only a proportion referred to the services ▪ It is estimated that over 11, 000 children in Haringey live with some form of long-standing disability ▪ Over 9,000 have Special Educational Needs (SEN) in primary and secondary schools. Approximately 1, 200 children have statement; of those, 35% had autism followed by moderate learning difficulties (21%) and emotional, behavioural and social difficulties (12%) ▪ We are seeing an annual increase of 33% in a number of children and young people in treatment for alcohol and cannabis misuse; over 80% are non-white British. Use of 'legal highs' over the Internet is on increase

	Improvements	Areas which remain a concern
Adults & Older People	▪ Crime rates are going down ▪ Overall life expectancy for both, males and females is improving and a gap in life expectancy appears to be decreasing ▪ Mortality from CVD and cancer in men is going down ▪ Tuberculosis rates have almost halved over the last four years	▪ Physical activity overall is higher than the average in London but some parts of the borough have physical activity levels amongst lowest in the country. More likely that girls and women not to engage in physical activity ▪ Number of falls overall is decreasing however, for people over 85 years of age, fall accidents and hip fractures are increasing ▪ Cancer mortality in women is increasing unlike anywhere in London or England; the most common cancers are breast and colorectal ▪ Women living longer but in poor health after they reach the age of 60 (mostly due to long-term conditions and mental illness) ▪ Depression is under-detected in primary care but over-represented in the acute settings ▪ Three times higher than expected levels of severe mental illness and disproportionately based in east of the borough ▪ High number of people with mental illness who have poor physical health & long-term conditions ▪ Number of people with dementia and long-term conditions is increasing (due to people living longer).

What this means for the PNA

Community pharmacies are well placed to deliver a range of services which collectively contribute to tackling health inequalities, through addressing lifestyle behaviours and the wider health and social care challenges within Haringey. For example:

Essential services

- Dispensing services ensure that people can obtain the medicines which they need in a timely manner
- Pharmacies receive a payment as contribution towards providing auxiliary aids, for people eligible under the Equality Act 2010, who require support with taking their medicines (refer to Section 5.7)
- Health promotion advice is provided as an essential service by all community pharmacies, with up to 6 tailored campaigns being provided each year. Whilst NHS England set the campaigns, there is no reason as to why additional campaigns, tailored to the needs of the Haringey population may not be undertaken. Pharmacy patient medication records (PMRs) provide a valuable tool to help identify people who may benefit from health promotion advice or other lifestyle modification services
- Signposting to other services is another important essential service. Community pharmacies need to be equipped to ensure that residents are signposted on other services e.g. drug and alcohol, specialist stop smoking services, sexual health services, where this will be beneficial or is appropriate for the clinical or social circumstances

Advanced Services

Community pharmacies also provide a range of services which potentially support improved identification and/or management of long term conditions. For example:

- Many pharmacies offer medicines use reviews (MURs) and the new medicine service (NMS). These services play a pivotal role in the helping patients to take their medicines as prescribed and in identifying adverse effects. This potentially improves outcomes and may reduce unplanned admissions and re-admissions to hospital. In older people, reviews may help reduce falls associated with medication
- For mental health disorders, there is a vast array of medicines available and medicines optimisation is critical to ensure that treatment is tailored to the needs of patients; and to improve adherence which is often poor as a result of both the condition itself as well as a reflection of the unpleasant side effects of many of these medicines

Enhanced and Locally Commissioned Services

- In Haringey, pharmacies already provide a range of services which make a valuable contribution towards tackling the health needs of the population i.e. pharmacy based vaccination services, stop smoking services, sexual health services, needle and syringe programme, supervised consumption of methadone and buprenorphine; supply of healthy start vitamins and there are opportunities to expand the range of services e.g. alcohol IBA

- The accessibility and high number of people using pharmacies (whether this is for health related or other reasons) provides a real opportunity to proactively target people for health promotion advice and brief interventions and to "Make every Contact Count". The roll out of healthy living pharmacies and a move towards integrating more services will also help to maximise the contribution which may be made by pharmacies.

In undertaking our assessment we will reflect on how the current contribution made by community pharmacies in Haringey may be strengthened. We will consider whether or not commissioning a broader range of services which will assist us with identifying unmet need and/or delivery of local strategy priorities with respect to the management of long term conditions.

4.3. Long Term Local Health & Care Strategy

4.3.1. Overview

As a result of the changes arising from the Health and Social Care Act 2012, Healthcare Strategy is now set by a range of health and care organisations working in an integrated way:

- Public Health England (PHE) is an executive agency of the Department of Health. They play a strategic role to protect and improve the nation's health and wellbeing; and reduce health inequalities. They do this by informing health protection, health improvement and health & social care commissioning. Locally, Directors of Public Health are statutory Chief Officers and principal advisers on all health matters advising local authorities on the best ways to improve the health of the population.

- Local Authorities (LAs) have responsibility for public health and improving the health of the population.

- Health and Wellbeing Boards (HWBs) which must be established by each LA. The HWB is responsible for overseeing the health and wellbeing needs of its local community and for developing a Joint Health and Wellbeing Strategy, which provides a framework to inform the commissioning of integrated and/or co-ordinated health, social care and public health services based on local need. Membership of the HWB includes local commissioners of health and social care, elected members of the LA and representatives from Healthwatch.

- NHS England (NHSE) is the national body responsible for commissioning 'primary care services' from GPs, pharmacies, dentists and optometrists. In addition, it is responsible for commissioning healthcare services for prisons (and other custodial organisations), the armed forces and a range of specialised and highly specialised services.

- Clinical Commissioning Groups (CCGs) commission the majority of NHS healthcare for their area. Core responsibilities include securing continuous improvements in the quality of services commissioned, reducing health inequalities, enabling choice, promoting patient involvement, securing integration and promoting innovation and research.

Healthcare strategy influences both the need for pharmaceutical services and how pharmaceutical services are delivered. Therefore, in this section we set out high level strategic priorities together with the implications for the PNA. Much of this strategy is evolving. Our assessment reflects emerging themes and priorities at the time the PNA was written.

4.3.2. NHS England

NHS England's ambition, to ensure "high quality health care for all, now and in the future", is set out within *"Everyone Counts: Planning for Patients 2014/15 to 2018/19"*.
The document describes a five-year transformation programme. A nationwide consultation exercise, "*A Call to Action"*, has been undertaken to secure commitment to this transformation programme.

Some of the key changes, which are relevant to the provision of pharmaceutical services, include:

- Providing a broader range of services, from the wider primary care providers (including pharmacy), in order to improve access and support for patients with a moderate mental health or physical long term condition

A more integrated system of community-based care focused on improving health outcomes including:

- Developing new models of primary care which provide holistic services, particularly for frail older people and those with complex health needs;
- A greater focus on preventing ill health;
- Involving patients and carers, more fully, in managing their health
- The establishment of urgent and emergency care networks with a view to improving access to the highest quality services in the most appropriate care setting;
- A move towards providing responsive and patient-centred services on seven days a week. Initially the focus will be on urgent and emergency care coupled with up to 9 pilots to improve access to GP services in the evenings and at weekends.

4.3.3. Acute Services & Reconfiguration

There is not an acute hospital with fully resourced A&E function within the geographical boundaries of Haringey, although interestingly, Haringey residents make greater use of A&E services than some other boroughs. North Middlesex University Hospital and Whittington Health are located close to the Borough's boundaries and provide the majority of hospital care for patients in Haringey. Other hospital used by Haringey residents are the Royal Free Hospital and University College London Hospital.

St Ann's Hospital lies within the administrative boundaries of Haringey and its site is used to provide the following range of services to the local population:

Provider	Service
Barnet, Enfield and Haringey Mental Health Trust	▪ Outpatient services ▪ Adult inpatient services ▪ Community mental health services ▪ Eating disorder services ▪ Drug and alcohol advisory services ▪ Dementia services
Whittington Health	▪ Audiology ▪ Foot Health ▪ Sexual Health ▪ Child development ▪ Community dentistry ▪ Community physiotherapy ▪ Seating and mobility service (wheelchair clinic) ▪ Psychological therapies (Talking Therapies)
North Middlesex Hospital	▪ X-ray services ▪ Sickle cell services
Moorfields Eye Hospital	▪ Day surgery hospital services ▪ Outpatient services
North London Breast Screening Service	▪ Screening services
London Ambulance Service	▪ Tottenham base

4.3.4. North Central London Strategic Planning Group 2014/19

A Five Year Plan has been developed to align plans across all five NCL CCGs (Barnet, Enfield, Haringey, Islington & Camden).

This acknowledges that fundamental change is needed in the delivery of healthcare to reflect patient need, expectation, and to use medical and technology advances to maximise the "value". The plan proposes that the commissioning of healthcare will be increasingly outcome based.

The vision is to develop an integrated care network between organisations focused on outcomes with patients taking greater responsibility for their own health and accessing care appropriately. The aim is to deliver financially sustainable services within five years. The initial focus is on support for older people with frailty, people with mental health needs and people with diabetes and will be expanded to cover more areas in future.

4.3.5. Haringey Joint Health and Wellbeing Strategy (2012-2015)

Haringey's Joint Health and Wellbeing Strategy aims to reduce health inequalities, illness and disability and improve the quality of its residents' lives through:

- Partnership working between public services and residents
- A focus on prevention, early diagnosis and treatment of long term conditions, as close to home as possible
- Empowering people to do things for themselves and lead independent lives.

The strategy identifies three outcomes and includes the following health-related priorities:

	Outcome Description	Health Related Priority
Outcome 1	Every Child has the best start in life	▪ Reduce infant mortality ▪ Reduce teenage pregnancy ▪ Reduce childhood obesity
Outcome 2	A reduced gap in life expectancy	▪ Reduce smoking ▪ Increase physical activity ▪ Reduce alcohol misuse ▪ Reduce early death from cardiovascular disease and cancer ▪ Support people with long term conditions to live a healthier life
Outcome 3	Improved mental health and wellbeing	▪ Promote the emotional wellbeing of children and young people ▪ Support independent living ▪ Address common mental health problems among adults ▪ Support people with severe and enduring mental health problems ▪ Increase the number of problematic drug users in treatment

4.3.6. NHS Haringey Clinical Commissioning Group Outline Strategy 2014/15 - 2018-19

Haringey CCGs Five Year Strategic Plan is focusing on a major shift from provision of services mainly in hospitals to community care, whenever possible. The CCG will work with primary and community care which contributes to the regeneration of Haringey and is better aligned with other plans and initiatives to improve health outcomes for ALL residents.

The key objectives and delivery mechanisms of the CCGs strategy are described below:

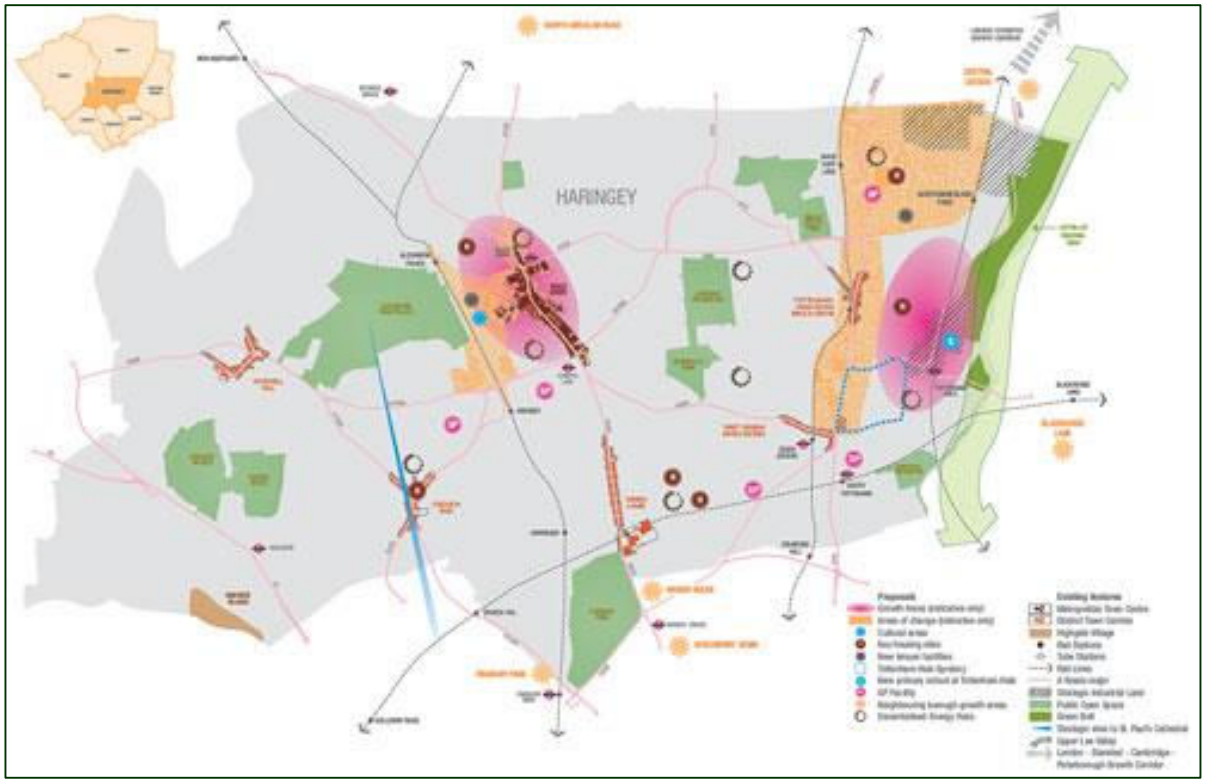
Objective	Aim
Global transformation of services and providers	▪ Maximise the quality of care experienced for every pound spent; move away from commissioning units of activity from fragmented service providers and towards commissioning the outcomes delivered by providers working together. Key aspects of this objective are: ○ Ensuring people are supported in the most appropriate setting, as close to their homes as possible ○ GP Networks supporting the management of patients with long-term conditions more effectively by providing educational and self-management support; and ○ Empowering people to enhance their own health and wellbeing by providing them with information, practical tools, skills and signposting to relevant support or activities in the wider community
A greater range and integration of providers	▪ Haringey's population will be able to plan their care with people who work together to understand them, give them control and enable them to achieve the outcomes that are important to them ▪ The vision is of services that are focused on early identification and pro-active, coordinated care that prevents crises. ▪ Models of care will be focused on enabling independence, maximising time spent free from symptoms and avoiding unnecessary hospital admissions
Engaging communities in new and more innovative ways	▪ Haringey CCG is committed to giving local people the opportunity to help shape the services we commission and contribute to how they are run and monitored with greater clarity about when information is being offered compared to when the public is being consulted ▪ Effort will continue to be expended on engaging and communicating with a more diverse group of patients and public, reflective of Haringey's demography and health profile using different approaches and technology.
A re-defined model for primary care	▪ The development of primary care in Haringey is a priority for the CCG and better access to GPs and primary care services is a key theme. The development of primary care services is fundamental to the improvements required, for example: ○ Supporting primary care to plan and coordinate older people's care and prevent or delay hospital admission and facilitate early discharge. ○ Developing and supporting primary care to improve early diagnosis and management of common mental health disorders as a means to effectively transforming local mental health services ▪ It is envisaged that networks of practices will provide more services locally to more patients reducing the need for patients to go to hospital for planned care and to reduce the demand for urgent and emergency care.

4.3.7. Local Development Plan & Haringey's Spatial Strategy

The Council's overall strategy for managing future population growth as described in section 4.2.1, is to promote the provision of homes, jobs and other facilities in the areas with significant redevelopment opportunities at, or near, transportation hubs, and support appropriate development at other accessible locations, with more limited change elsewhere as shown in the diagram (next page).

The Borough has a capacity to deliver approximately 13,000 homes between 2011 and 2026.

Development in Tottenham is a major priority in Haringey and this regeneration programme will have an impact on the population growth, as described in population projection section above.



The Council will maximise the supply of additional housing to meet and exceed 8,200 homes from 2011-2021 (820 per annum), promoting development in the following areas:

- Haringey Heartlands (Central Locality) and Tottenham Hale (NE Locality) will be the key locations for the largest amount of Haringey's future growth

- Regeneration of the wider Northumberland Park area (including the redevelopment of Tottenham Hotspur Football Club) and Seven Sisters Corridor will provide a substantial number of jobs and new homes, as well as other community uses, facilities and estate regeneration.

Beyond the above growth areas there are a number of other parts of the borough which are considered suitable locations for significant development as they are highly accessible by a range of means of transport.

Efficient use of land and buildings will be made by encouraging higher density development in the most accessible parts of the borough (generally Tottenham Hale, Haringey Heartlands and Wood Green Metropolitan Town Centre) as well as other appropriate locations.

What this means for the PNA

It is clear from our review of the local long term health and care strategy, that there will be fundamental changes arising as a result of the transformation work. This has implications for community pharmacy and how it integrates with the full range of health and social care providers in the future.

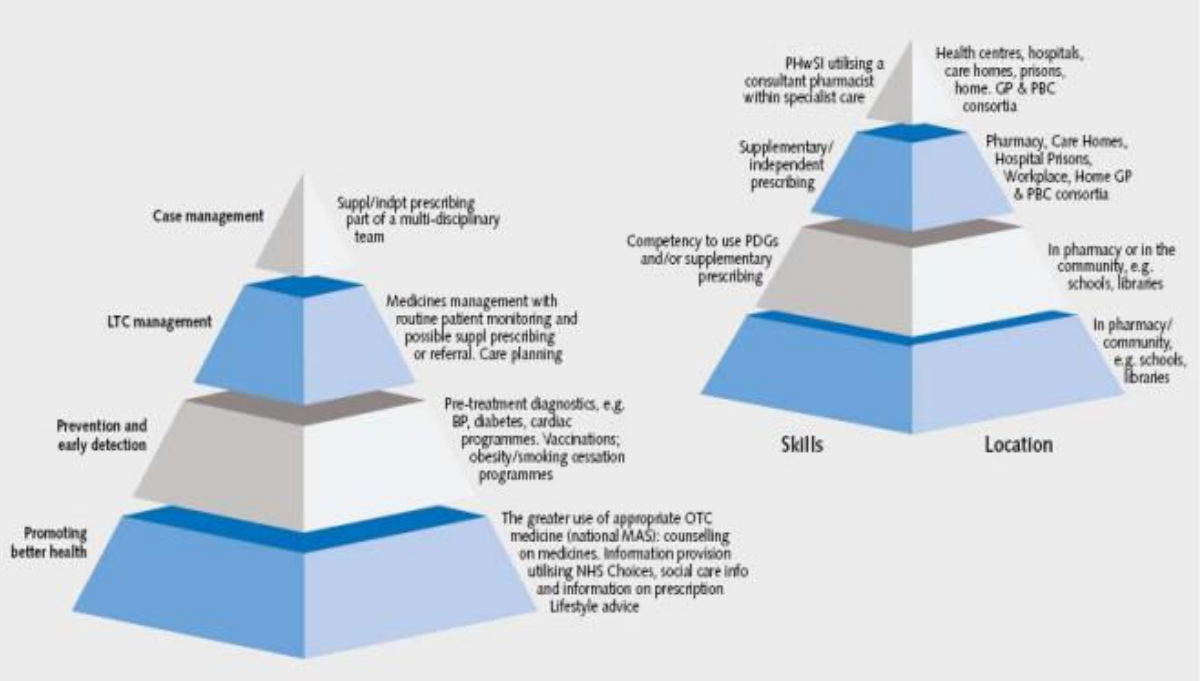
There will also be opportunities for community pharmacy to broaden its role. In order to explore this, we have stepped back and reviewed the white paper, "Pharmacy in England[4], published in 2008, which set out the Government's vision for a 21st century pharmaceutical service.

The paper identified a number of strengths within the healthcare system at the time:

- A network of pharmacies in the heart of communities which are easily accessible and with a broad window of opening times, noting that:
  - 1.6m people a day visit a pharmacy
  - 84% of adults visit a pharmacy each year; of these 78% of visits are for health-related reasons
  - 99% of the population are within 20 minutes of a community pharmacy by car, and 96% by walking or public transport

- A highly trained workforce
- Premises which provide an informal 'everyday' environment and which reach all parts of the population
- A contractual framework which supports a range of clinical services

It reinforced that the role of pharmacy in ensuring the safe use of medicines will always be important and went on to emphasise the role of community pharmacies' with respect to health improvement, as summarised in the diagram below:



This model of care proposed clearly fits with the current direction of travel within Haringey and effectively illustrates the contribution which is already made and which we have described throughout this local context section.

In section 7, which looks at the pharmaceutical services in the future, we will reflect upon this model in setting out our vision for pharmacy.

We will also examine, in section 5.9.2, the impact of the Council's ambitious local development and regeneration plans on NHS Pharmaceutical services.

5. The Assessment

5.1. Introduction and approach

This section sets out the current provision of pharmaceutical services and other locally commissioned services within Haringey.

In making its assessment, the HWB has taken into account a variety of data sources and has determined broad principles which have informed its decisions. These may be summarised as follows:

A. Data Sources

- Benchmarking data from the Health and Social Care Information Centre. The latest published data set relates to 2012/13 and was published in November 2013.
- Data collected or held by NHS England, LB Haringey and NHS Haringey CCG in relation to the planning, commissioning and delivery of pharmaceutical and other NHS services.
- The findings from the Community Pharmacy Questionnaire. A 100% response rate was achieved
- Our review of the local demography, health needs and health services strategy as set out in section 4 of this document

B. Determining Services which are Necessary to meet a Pharmaceutical Need

In determining whether or not a service is **necessary to meet a pharmaceutical need** (i.e. required) or if it is **relevant** in that it has **secured improvements or better access to pharmaceutical services**) we have considered the following factors and principles:

Factor	Principle(s)
Who provides a service?	Where a given service may only be delivered by a person on the pharmaceutical list (e.g. dispensing) it is more likely to be determined as necessary.
Health needs and benefits	Where there is a clear local health need for a given service, it is more likely to be determined as necessary.
Published evidence	Where there is strong evidence to support delivery of a service (including improved outcomes) through pharmacy it is more likely to be determined as necessary.
Performance	Where a service is delivered by a range of providers, if pharmacy performs well compared with other provider types, the service is more likely to be determined as necessary. *However factors which influence demand were also considered.*
Accessibility	Where a service is provided by a range of providers, but pharmacy offers benefits in terms of accessibility (e.g. extended opening hours, access at weekends, etc.), it is more likely to be determined as necessary.

C. Choice

For patients, choice is a mechanism to drive up the quality of services and to improve patient satisfaction. For the overall health system, choice is a mechanism to encourage more appropriate and cost-effective use of resources.

In determining whether or not there is reasonable choice, we have taken a range of factors and principles into account, including:

- The current level of access to NHS pharmaceutical services within the area, taking into account, for each locality:
  - The number of pharmacies per 100,000 population
  - The number of pharmacies per square mile
  - The nationally established statistic that “99% of people live within 20 minutes’ drive of a pharmacy and 96% within 20 minutes by foot”

- The extent to which existing services already offer a choice and the extent to which this may be improved by the availability of either additional providers or facilities

- The extent to which current service provision adequately responds to the changing needs of the community it serves

- The need for specialist or other services which would improve the provision of, or access to, services for vulnerable people or specific populations e.g. those with a protected characteristic as described by the Equality Act 2010.

D. Other Factors

We have also considered the impact of a range of other factors, on the need for pharmaceutical services, including:

- Considering the different needs of different populations
- Services provided outside of the Haringey HWB area
- NHS Services provided by NHS Trusts
- Specific circumstances which influence future needs including projected changes in population size, demography, health needs, future plans for commissioning or service delivery and other local plans

5.2. High Level Overview of Pharmaceutical Services within Haringey

Haringey has 59 community pharmacies including:

- Five pharmacies which open for 100 hours or more a week

- One distance selling pharmacy (also referred to as "wholly mail order" or internet pharmacies"). *This pharmacy is not permitted to provide face to face services for essential services; however, they may invite people who live locally to attend for advanced, enhanced or locally commissioned services providing they ensure that no essential services are provided as part of this interaction.*

There are no local pharmaceutical services contractors, dispensing appliance contractors or dispensing doctors.

5.3. Essential Services

All Pharmaceutical Services Contractors are required to provide essential services, as set out in the 2013 Regulations, although the scope of services varies between the different contractor types.

As previously stated, Haringey only has community pharmacies and these will be the primary focus of this section. However, we will make reference to other contractor types e.g. dispensing appliance contractors where relevant.

Essential services are fundamental to enable patients to obtain prescribed medicines in a safe and reliable manner. Whilst dispensing NHS (FP10) prescriptions forms the primary basis of this evaluation, we also assess other elements including health promotion, sign-posting and support for self-care. The table below provides a brief overview of the full range of essential services provided by community pharmacies:

Service Element	Description
Dispensing and actions associated with dispensing	▪ Supply of medicines or appliances ▪ Advice given to the patient about the medicines being dispensed and possible interactions with other medicines ▪ Recording of all medicines dispensed, advice provided, referrals and interventions made using a Patient Medication Record (PMR) ▪ Electronic prescription services (EPS) allow the prescriber to electronically transmit a prescription to a patient's chosen pharmacy for dispensing. The system is more efficient than the paper based system and potentially reduces errors

Repeat dispensing	▪ Allows patients, who have been issued with a repeatable prescription, to collect repeat medication, for up to a year, from their pharmacy without having to request a new prescription from their GP ▪ The pharmacist must ascertain the patient's need for a repeat supply of a particular medicine before each dispensing and communicate significant issues to the prescriber with suggestions on medication changes as appropriate
Disposal of unwanted medicines	▪ Pharmacies act as collection points for unwanted medicines returned from patients and Residential Homes. *NB. They cannot accept returns from Nursing Homes who have to organise their own disposal contract.*
Signposting, Healthy Lifestyles & Public Health Campaigns	▪ Opportunistic advice, information and signposting around lifestyle and public health issues ▪ NHS England sets the health promotion campaigns although HWBs have discretion to run alternative campaigns
Support for self-care	▪ Provision of advice and support to enable patients to derive maximum benefit from caring for themselves or their families ▪ This may include self-limiting conditions as well as long term conditions

In addition, the pharmacies must comply with clinical governance requirements. Specifically:

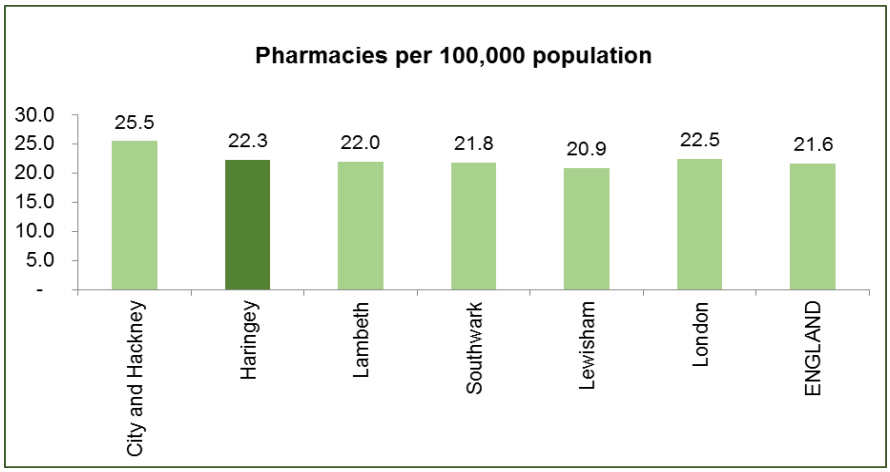
- Use of standard operating procedures
- Demonstrate evidence of pharmacist Continuing Professional Development
- Operate a complaints procedure
- Patient safety & incident reporting
- Clinical audit
- Commitment to staff training, management and appraisals
- Compliance with Health and Safety and the Equality Act 2010
- Significant event analysis
- Patient satisfaction surveys

As essential services are a mandatory requirement for all community pharmacies, they will be used to explore key service fundamentals including:

- The distribution of pharmacies
- Access
- Future capacity

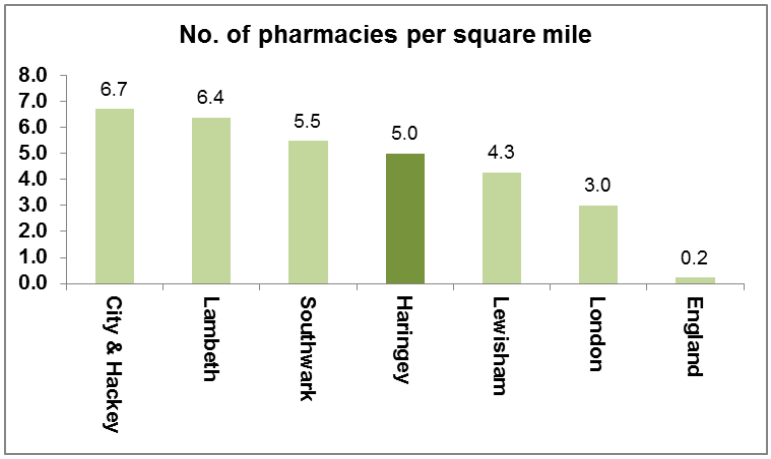
5.4. Distribution

The graph, which uses our ONS comparators together with the London and England average, sets the provision of pharmacy services within Haringey into context.



Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13)

In considering the distribution of pharmacies, we have also looked at the number of pharmacies per square mile as shown by the graph below:



Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13); Ordnance Survey Boundary Line OpenData

Whilst Haringey has a lower number of pharmacies per square mile than many of our ONS comparators, it is significantly higher than the London and England average.

Overall, the benchmarking analysis demonstrates that Haringey is well resourced in terms of the number of pharmacies it has and this serves to afford a reasonable choice, compared with other areas, to our residents.

The table (next page) and maps 1 and 2 (subsequent pages) provide an overview of the distribution of pharmacies by locality and ward, taking into account deprivation and population density and demonstrates:

- All wards have one or more pharmacies with the exception of West Green, which has no pharmacy. However, residents have access to a wide choice of pharmacies on the borders with adjacent wards

- There is a reasonable correlation with deprivation. In terms of the five wards which rank highest in terms of deprivation, three of these (Northumberland Park, Noel Park and Tottenham Green) are above the London, England and benchmarked average in terms of the number of pharmacies per 100,000 population; one ward (White Hart Lane) is below the London and benchmarked average but is similar to the England average; only Tottenham Hale is significantly below all benchmarked averages

- In terms of population density those areas with a higher population per hectare are relatively well served

- There is good alignment with GP surgeries, with all surgeries being within one quarter of a mile to the nearest pharmacy.

- There is also a reasonable spread of pharmacies within all localities with all residents being within 1 mile of a pharmacy. There are a number of pharmacies, outside of the area, which are accessible for Haringey residents who live close to the borders

- A useful proxy measure of the appropriateness of the distribution of pharmacies and accessibility is travel time. It is generally recognised that 99% of the population are within 20 minutes of a community pharmacy by car, and 96% by walking or public transport[4] Taking into account the average walking speed for an adult is 3.1 miles an hour (which equates to 1 mile every 20 minutes) and the average driving speed is 19.33 miles per hour on major London road between the hours of 7am and 7pm[1]), then it follows that the vast majority of Haringey residents can access a pharmacy 20 minutes.

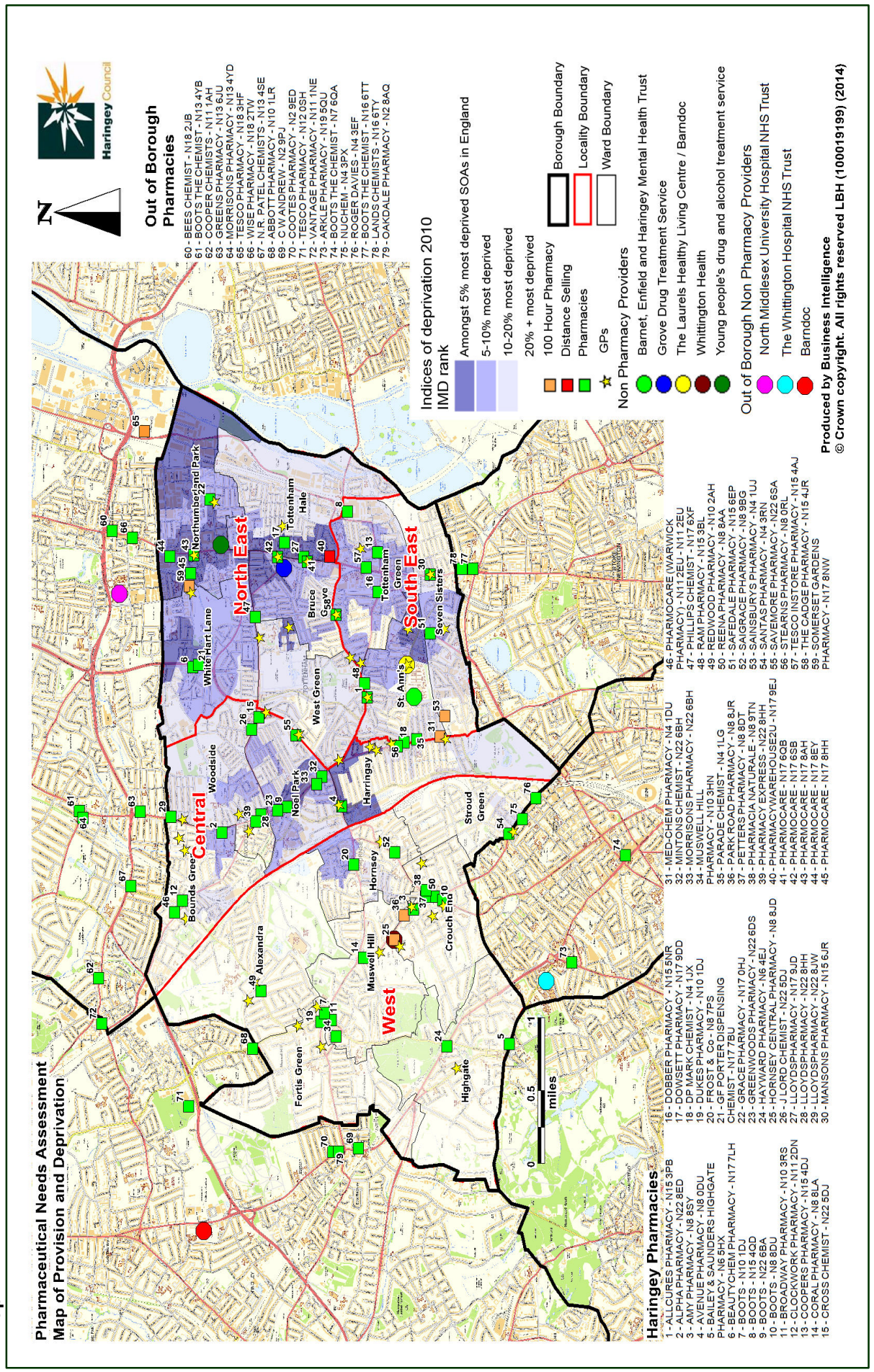
- Map 3 summaries the public transport accessibility level (PTAL) in relation to pharmacy services. It demonstrates good access to public transport in the West Locality. However, there are areas within the other localities, notably large areas of both the Central and SE Localities where public transport accessibility is poor. This may reduce access to pharmacy services for people who are dependent upon public transport.

[1] Statistical Release - National Travel Survey 2012

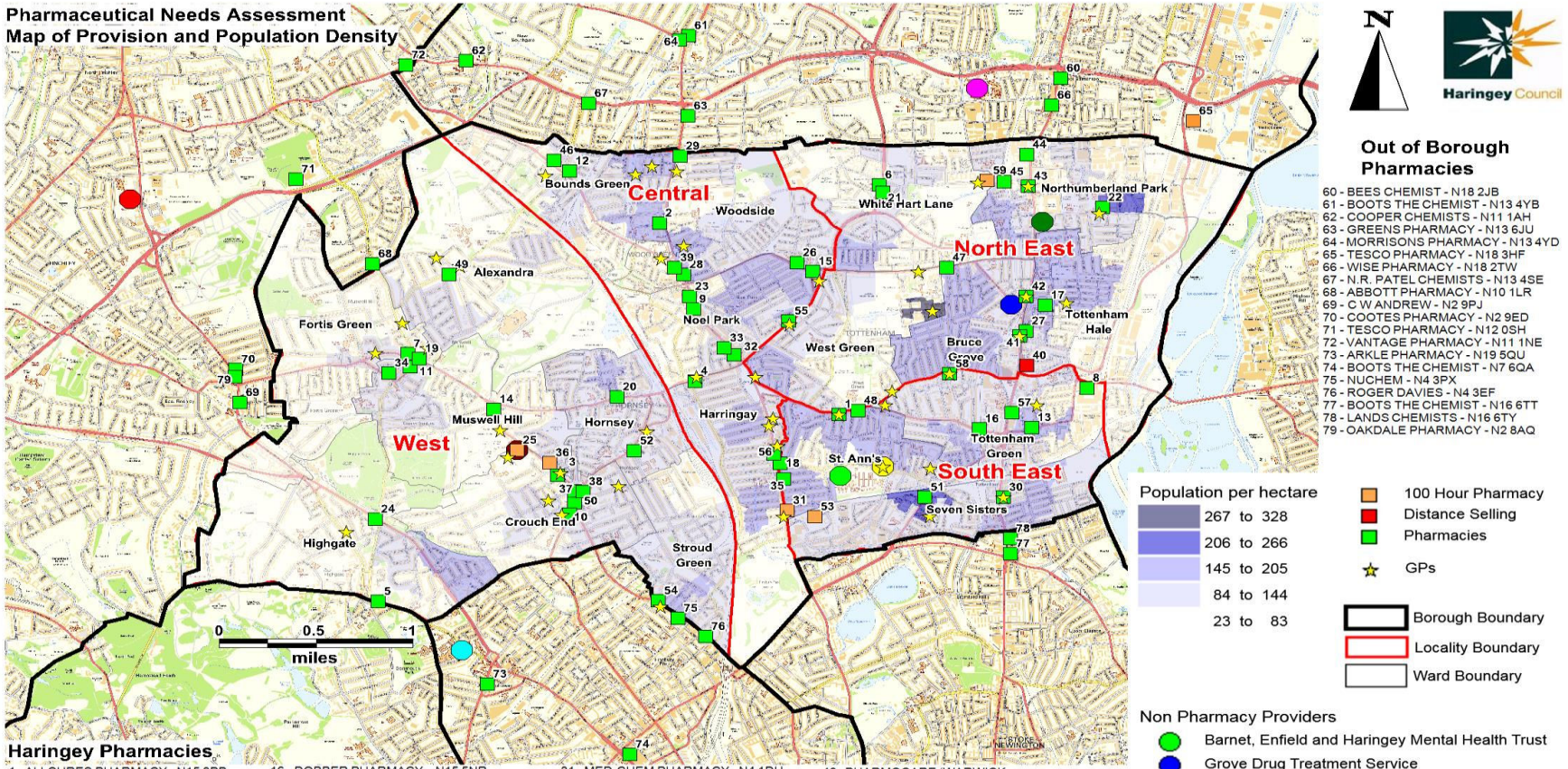
Locality	Ward	IMD Rank*	Pharmacies	Pop	Pharmacies per 100,000 population	Pharmacies / Locality	Locality Pharmacies / 100,000 population
Central	Bounds Green	13	3	14,311	21.0	15	25.8
	Harringay	11	2	13,952	14.3		
	Noel Park	4	7	14,574	48.0		
	Woodside	9	3	15,232	19.7		
NE Tottenham	Bruce Grove	6	3	14,935	20.1	13	17.4
	Northumberland Park	1	4	15,011	26.6		
	Tottenham Hale	5	3	16,828	17.8		
	West Green	8	0	13,919	0.0		
	White Hart Lane	2	3	13,863	21.6		
SE Tottenham	Seven Sisters	10	3	16,508	18.2	13	27.1
	St Ann's	7	5	15,820	31.6		
	Tottenham Green	3	5	15,636	32.0		
West	Alexandra	17	1	12,009	8.3	18	21.0
	Crouch End	15	5	12,719	39.3		
	Fortis Green	18	2	12,918	15.5		
	Highgate	19	2	12,034	16.6		
	Hornsey	12	2	13,025	15.4		
	Muswell Hill	16	5	11,030	45.3		
	Stroud Green	14	1	12,150	8.2		
Grand Total			**59**	**266,474**		**59**	**22.1**

* IMD = Index of Multiple Deprivation (2010) where 1 is the highest rank and 19 is the lowest within Haringey
* The 5 wards ranked highest in terms of deprivation are highlighted

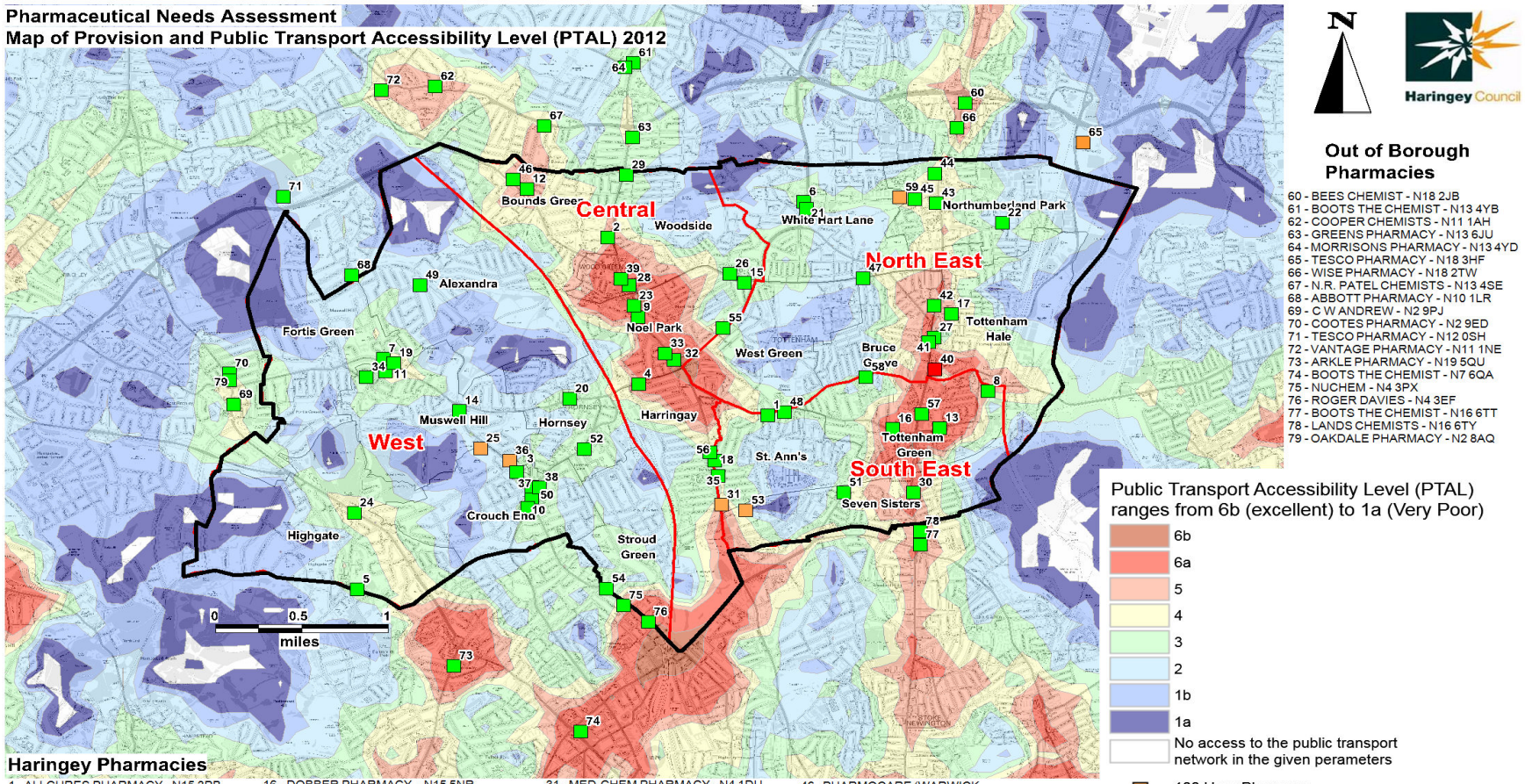
Map 1


Pharmaceutical Needs Assessment
Map of Provision and Deprivation
Haringey Council
N
Out of Borough Pharmacies
60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
62 - COOPER CHEMISTS - N11 1AH
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
72 - VANTAGE PHARMACY - N11 1NE
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
79 - OAKDALE PHARMACY - N2 8AQ
Indices of deprivation 2010
IMD rank
Amongst 5% most deprived SOAs in England
5-10% most deprived
10-20% most deprived
20% + most deprived
100 Hour Pharmacy
Distance Selling
Pharmacies
GPs
Borough Boundary
Locality Boundary
Ward Boundary
Non Pharmacy Providers
Barnet, Enfield and Haringey Mental Health Trust
Grove Drug Treatment Service
The Laurels Healthy Living Centre / Barndoc
Whittington Health
Young people's drug and alcohol treatment service
Out of Borough Non Pharmacy Providers
North Middlesex University Hospital NHS Trust
The Whittington Hospital NHS Trust
Barndoc
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)
North East
Central
West
South East
Northumberland Park
White Hart Lane
Woodside
Bounds Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Tottenham Green
Seven Sisters
St. Ann's
Harringay
Stroud Green
Hornsey
Muswell Hill
Crouch End
Alexandra
Fortis Green
Highgate
0
0.5
1
miles
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW

Map 2


Pharmaceutical Needs Assessment
Map of Provision and Population Density
Central
North East
West
South East
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Alexandra
Noel Park
West Green
Tottenham Hale
Bruce Grove
Fortis Green
Muswell Hill
Hornsey
Harringay
Tottenham Green
St. Ann's
Seven Sisters
Crouch End
Highgate
Stroud Green
0 0.5 1 miles
N
Haringey Council
Out of Borough Pharmacies
60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
62 - COOPER CHEMISTS - N11 1AH
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
72 - VANTAGE PHARMACY - N11 1NE
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
79 - OAKDALE PHARMACY - N2 8AQ
Population per hectare
267 to 328
206 to 266
145 to 205
84 to 144
23 to 83
100 Hour Pharmacy
Distance Selling
Pharmacies
GPs
Borough Boundary
Locality Boundary
Ward Boundary
Non Pharmacy Providers
Barnet, Enfield and Haringey Mental Health Trust
Grove Drug Treatment Service
The Laurels Healthy Living Centre / Barndoc
Whittington Health
Young people's drug and alcohol treatment service
Out of Borough Non Pharmacy Providers
North Middlesex University Hospital NHS Trust
The Whittington Hospital NHS Trust
Barndoc
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)

Map 3


Pharmaceutical Needs Assessment
Map of Provision and Public Transport Accessibility Level (PTAL) 2012
N
Haringey Council
Central
North East
West
South East
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Alexandra
Fortis Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Muswell Hill
Hornsey
Harringay
Tottenham Green
St. Ann's
Seven Sisters
Crouch End
Highgate
Stroud Green
0 0.5 1 miles
Out of Borough Pharmacies
60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
62 - COOPER CHEMISTS - N11 1AH
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
72 - VANTAGE PHARMACY - N11 1NE
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
79 - OAKDALE PHARMACY - N2 8AQ
Public Transport Accessibility Level (PTAL) ranges from 6b (excellent) to 1a (Very Poor)
6b
6a
5
4
3
2
1b
1a
No access to the public transport network in the given perameters
100 Hour Pharmacy
Distance Selling
Pharmacies
Borough Boundary
Locality Boundary
Ward Boundary
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)

5.4.1. Dispensing

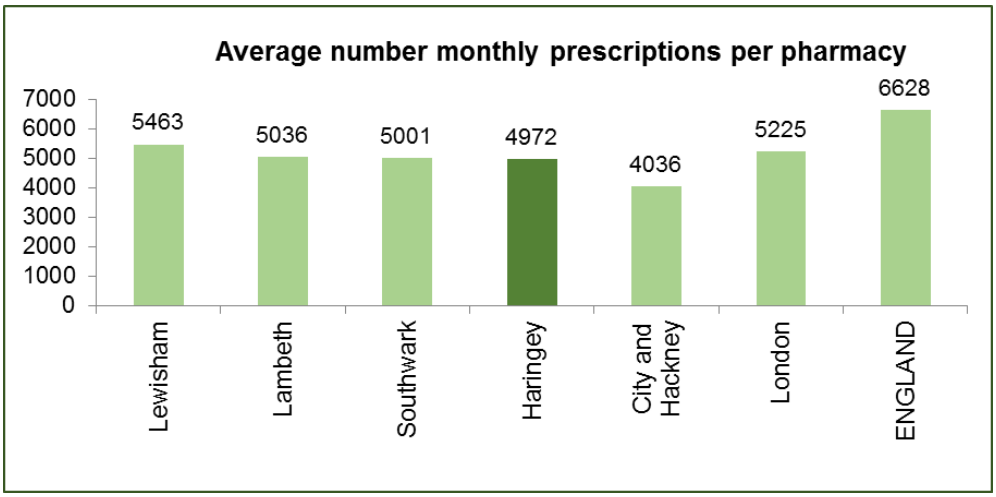
It is essential for Haringey residents to access the medicines they need in a timely manner.

Our review of dispensing has evaluated a range of factors including:

- The pattern of dispensing. This includes a high level comparison with our ONS comparators together with a more detailed look at Haringey
- The extent to which the dispensing needs of our residents are met by pharmacies in neighbouring areas
- The role of repeat dispensing and electronic prescription services
- The future capacity of our pharmacies to continue to meet pharmaceutical need

A. Dispensing within Haringey

The graph compares the average dispensing rate in Haringey compared with our ONS comparators and the London and England average. The data (which includes all prescriptions dispensed by Haringey pharmacies, not just those issued by Haringey GPs) demonstrate that the dispensing rate for Haringey pharmacies is lower than the averages for all Comparators other than City and Hackney.



Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13)

A detailed review of the total number of items dispensed against prescriptions written by Haringey GPs (using epact data from April 2013 – March 2014) has been undertaken in order to identify where these were dispensed.

The total number of items prescribed was 3,737,406. 84% of these items were dispensed by a Haringey pharmacy. The table below summarises dispensing by Locality.

Locality	No. of Pharmacies	Total Items Dispensed	% Total Items	Annual Items / Pharmacy	Items / Pharmacy / Month
Central	15	890,734	28%	59,382	4,949
NE Tottenham	13	796,621	25%	61,279	5,107
SE Tottenham	13	640,454	20%	49,266	4,105
West	18	818,920	26%	45,496	3,791

The data shows significant variation, between localities, with respect to the average number of items dispensed per pharmacy. The lowest proportion of items was dispensed in SE Tottenham (20% of the total) and the highest proportion in the Central Locality (28%).

All localities are below the London and England average, implying there are no issues with dispensing capacity (although it should be noted that this comparison is based entirely on prescriptions written by Haringey prescribers and excludes dispensing attributable to prescriptions written by other prescribers within and outside of Haringey).

B. Cross border Dispensing

Cross border dispensing is important in that it serves to improve access to pharmaceutical services, particularly for those residents who live close to the borders with other Health & Wellbeing Board areas, or for those who choose to get their prescription dispensed closer to their place of work or via an internet pharmacy.

16% of items written by Haringey GPs were either dispensed by pharmacies outside of the area or attributable to medicines which had been personally administered by GP surgeries (e.g. injections). The table provides an overview of cross-border dispensing and includes the pharmacy contractors that have dispensed the most items against prescriptions written by Haringey prescribers (the cut off was set at 4,000 items or more per annum).

HWB Area	Pharmacy Name	Postcode	No of Items	% of Total
Enfield	Bees Chemist	N18 2JB	145,030	3.9%
	Boots the Chemist	N13 4YB		
	Boots the Chemist	N9 0HW		
	Cooper Chemists	N11 1AH		
	Greens Pharmacy	N13 6JU		
	Morrisons Pharmacy	N13 4YD		
	Sainsburys Pharmacy	N21 3RS		
	Simmons Pharmacy	EN4 0DA		
	Tesco Pharmacy	N18 3HF		
	Wise Pharmacy	N18 2TW		
	N.R. Patel Chemists	N13 4SE		
Barnet	Abbot Pharmacy	N10 1LR	61,221	1.6%
	C W Andrew	N2 9PJ		
	Cootes Pharmacy	N2 9ED		
	Hampden Square Pharmacy	N14 5JR		
	Tesco Pharmacy	N12 0SH		
	Vantage Pharmacy	N11 1NE		
Islington	Arkle Pharmacy	N19 5QU	67,261	1.8%
	Boots the Chemist	N7 6QA		
	Nuchem	N4 3PX		
	Roger Davies	N4 3EF		
Hackney	Boots the Chemist	N16 6TT	38,082	1.0%
	Lands Chemists	N16 6TY		
Grand Total			**311,594**	**8.3%**

These 23 pharmacies, all of which are located in neighbouring HWB areas accounted for just 8.3% of the items. The remaining 7.7% of items were either attributable to GP personally administered items or were dispensed by other pharmacies and dispensing appliance contractors out of the area (dispensing or administration can be traced back to a total of 3,072 organisations).

C. Repeat Dispensing

Repeat dispensing allows patients who have been issued with a repeatable prescription to collect their repeat medication from a pharmacy without having to request a new prescription from their GP.

Benefits of repeat dispensing include:

- Reduced GP practice workload, potentially freeing up time for clinical activities
- Greater predictability in workload for pharmacies
- Reduced waste, because pharmacies are required to only dispense the medicines the patients need
- Greater convenience for patients

Repeat dispensing rates have been increasing steadily and have increased from 5% in April 2009 to 20% in 2014.

The CCG has recognised the benefits of repeatable prescribing and dispensing and is committed to continuing to maximise its use where this is appropriate (noting that it is not recommended for some medicines and certain clinical circumstances).

D. Electronic Prescription Services

The Electronic Prescription Service (EPS) allows a GP or practice nurse prescriber to electronically transmit a prescription to a patient's chosen pharmacy for dispensing. The system is more efficient than the traditional paper-based prescription and potentially reduces dispensing and labelling errors.

The former Haringey PCT was listed in the "Primary Medical Services (Electronic Prescription Service Authorisation) Directions 2008" and was permitted to authorise their primary medical services contractors or any other practice to use Release 2 of the Electronic Prescription Service.

Currently, all but five GP practices have 'gone live' with electronic prescription services, although the extent to which this facility is used varies from practice to practice.

5.5. Access and Opening Hours

A pharmacy must open for a minimum of 40 "core" contractual hours unless it was granted a contract under the "100 hour exemption"[2] or NHS England has granted a new application on the basis of more than 40 core hours under the market entry system. Additional hours, over and above core hours, are termed "supplementary" hours.

A pharmacy may not amend its core hours without permission from NHS England; but it is entitled to provide NHS England with 90 days' notice if it wishes to change its supplementary hours.

The table on the next page and maps 4-7 (appended in a separate document) provide an overview of opening hours and geographical coverage throughout the week. A visual representation of opening hours for each community pharmacy is provided in Appendix D.

A. Current Picture

A. Weekdays

On weekdays, all 59 pharmacies are open between the hours of 9:30am - 6pm, with the majority (58/59) pharmacies opening by 9am.

7 pharmacies close early on a Thursday afternoon. Three of these pharmacies (2 in the Central Locality and one in SE Tottenham Locality) close by 1pm and the remainder close throughout the afternoon. Two pharmacies close for lunch on weekdays (one for an hour and the other for half an hour); these are located in different wards and localities. Overall, access remains good in all localities.

A high proportion of Haringey's population are of working age and those people who work full time may wish to access pharmacies during the 'extended hour' period on weekdays (i.e. either on their way to work or on their way home). We have, therefore, looked at extended hour opening:

- On weekday mornings:
    - 3 pharmacies, open by 7am with one pharmacy located in each of the NE Tottenham, SE Tottenham and West Localities
    - 8% (5/59) pharmacies open by 8am in the morning; only the Central Locality has no pharmacies open at this time of day

[2] The 2005 control of entry regulations had 4 exemptions, which included pharmacies that were contracted to open for 100 hours per week.

Locality	Ward		No. of Pharmacies Offering Essential Services							
		Open on Weekdays					Open on Saturday			Open on Sunday
		8am or earlier	9:30am to 6pm	7pm or later	Early closing on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	
Central	Bounds Green	0	3	2	0	0	2	1	0	0
	Harringay	0	2	0	0	0	2	0	0	0
	Noel Park	0	7	3	2	0	5	4	2	3
	Woodside	0	3	2	0	0	3	3	1	0
NE Tottenham	Bruce Grove	0	3	2	0	1	3	3	0	0
	Northumberland Park	0	4	4	0	0	3	3	0	0
	Tottenham Hale	0	3	1	0	0	1	1	1	0
	White Hart Lane	1	3	1	2	0	3	1	1	1
SE Tottenham	Seven Sisters	1	3	2	2	0	2	1	1	1
	St Ann's	0	5	3	1	1	4	4	1	1
	Tottenham Green	1	5	4	0	0	5	2	2	2
West	Alexandra	0	1	1	0	0	1	0	0	0
	Crouch End	0	5	3	0	0	5	5	1	2
	Fortis Green	0	2	2	0	0	2	1	1	1
	Highgate	0	2	0	0	0	2	2	0	1
	Hornsey	0	2	1	0	0	2	1	1	0
	Muswell Hill	2	5	2	0	0	5	5	2	2
	Stroud Green	0	1	0	0	0	1	1	0	0
Total - Haringey		**5**	**59**	**33**	**7**	**2**	**51**	**38**	**14**	**14**
Percentage		**8%**	**100%**	**56%**	**12%**	**3%**	**86%**	**64%**	**24%**	**24%**

- On weekday evenings:
    - 56% (33/59) pharmacies remain open until 7pm or later
    - The distribution of these is shown in the table below and shows that SE Tottenham is particularly well resourced in the evenings and there is a reasonable choice of pharmacy in all localities at this time
    - Map 4 shows that all residents, with the exception of a very small area of Highgate ward (West Locality) are within a mile of a pharmacy
    - 8% (5/59) pharmacies remain open until 10pm or later with midnight being the latest closing time

Open on Weekdays 7:00pm or later	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	7	8	9	9	33
Population*	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	12.1	10.7	18.8	10.5	12.4

On Mondays - Fridays, there is no access to pharmaceutical services overnight from midnight until 7am.

B. Saturdays

On Saturdays, 86% (51/59) pharmacies open at some point during the day. The period when all pharmacies are open falls between 10am - 1pm.

The table below, and map 5, provide an overview of the distribution of pharmacies which open on a Saturday. They demonstrate that there is good access and a choice of pharmacy in all localities, with the exception of North East Tottenham where the number of open pharmacies per 100,000 population is significantly lower than the Haringey average.

Open on Saturday	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	12	10	11	18	51
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	20.7	13.4	22.9	21.0	19.1

As the day progresses, pharmacies start to close although 64% (38/59) remaining open until 5pm. However, map 6, demonstrates that all residents are within 1 mile of a pharmacy demonstrating that access remains reasonable.

Some pharmacies also open for extended hours on Saturdays:

- Two pharmacies open at 7am (one in SE Tottenham and the other in the West locality)
- Two additional pharmacies open by 8am (one in NE Tottenham and the other in the West locality)
- 24% (14/59) of pharmacies remain open until 7pm or later, of these:
    - One remains open until 10pm (West Locality)
    - One remains open until 10:30pm (West Locality)
    - One remains open until midnight (SE Tottenham)

There is no access to pharmaceutical services between midnight on Saturday night and 9am on a Sunday morning.

C. Sundays

On Sundays, a total of 14 pharmacies open at some point during the day.

The table below, and map 7, summarises the distribution of these pharmacies. It demonstrates that there is a choice of pharmacy in all localities apart from NE Tottenham, where only one pharmacy opens.

Open on Sunday	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	3	1	4	6	14
Population*	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	5.2	1.3	8.3	7.0	5.3

Sunday trading regulations for shopping centres and supermarkets restrict the maximum number of hours which may be opened to 6 hours. However, there is a reasonable level of coverage, across Haringey, throughout the day, although residents may have to travel further than 1 mile to access a pharmacy:

- Only two of the 14 pharmacies open for less than 6 hours
- Three open for 6 hours
- Six are open for 8 or more hours, with the last pharmacy closing at midnight

There is no access to pharmaceutical services between midnight on a Sunday and 7am on a Monday.

D. Bank Holidays

On bank holidays, there is no obligation for pharmacies to open. NHS England is obliged to ensure that NHS pharmaceutical services are available and to commission pharmacies to open if deemed necessary.

Currently, there is an enhanced service to provide access to NHS Pharmaceutical Services on Easter Sunday and Christmas Day. We have determined that this service is **necessary to meet the pharmaceutical needs of our population**, to ensure that residents can access dispensing, and other pharmacy services if required.

Adequate cover is provided, from within the existing network of pharmacies, on other Bank Holidays.

5.5.1. Alignment with GP Opening Hours

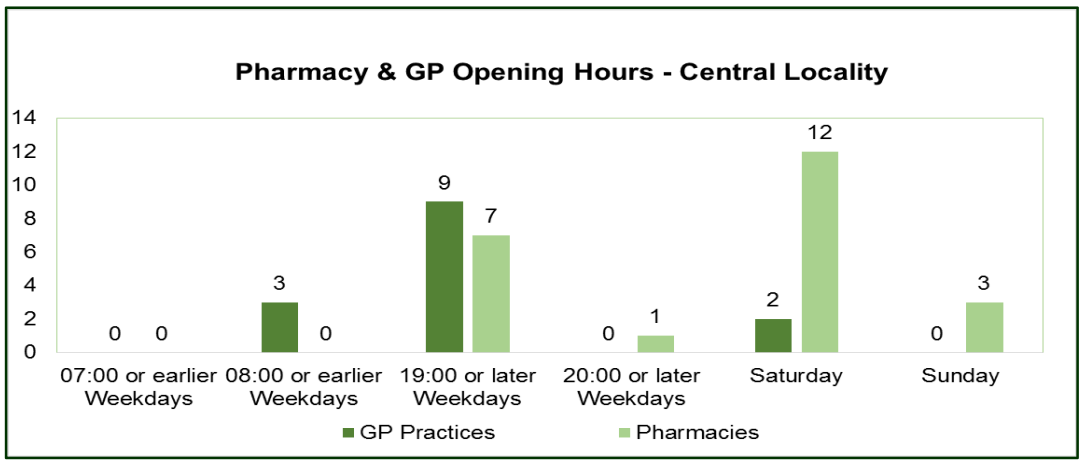
An important consideration is the alignment between pharmacy and other provider opening hours, i.e. GP practices, the GP out of hours service etc. This is because patients who receive a prescription will need to get this dispensed in a timely manner.

GP core hours are 8am - 6:30pm on weekdays (although historical arrangements mean that some practices do not open for the full core hours); In Haringey, some practices have been commissioned to provide extended hour opening.

The graphs below, which are based on information held by NHS England, provide a summary of GP practices which open for extended hours on *one or more days*. It should be noted that during extended hours there is at least one clinical member of staff on duty; this is usually a GP but sometimes a practice nurse.

Central Locality

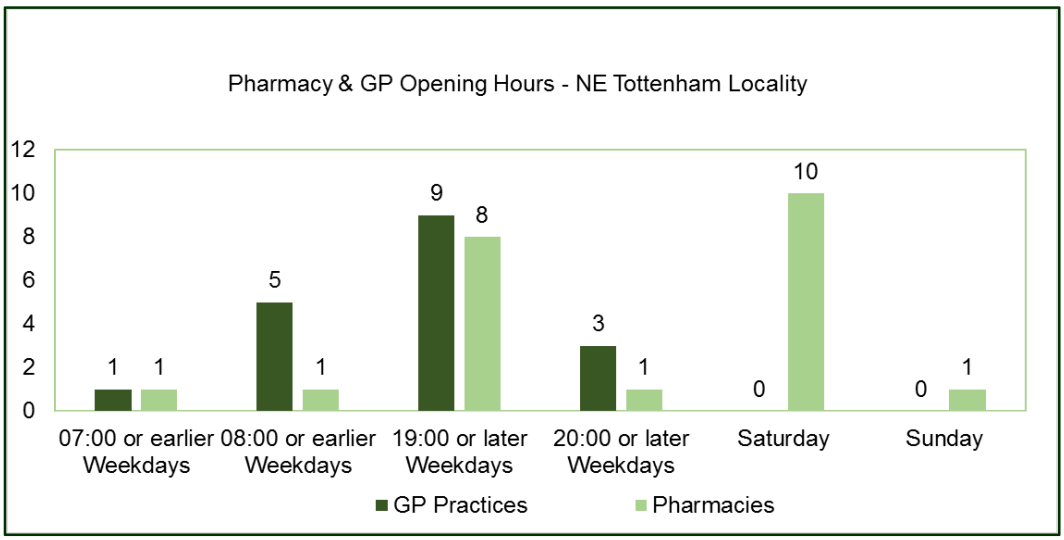
The graph shows that on weekday evenings, and on Saturdays, there is always a reasonable number of a pharmacy open when a GP surgery is open.



On one or more weekday mornings, up to 3 practices open by 8am (including access from 7:30am on 3 days a week). The earliest that a pharmacy opens in this locality is 9am. Following a GP consultation, residents either need to wait for a pharmacy within the locality to open; or would need to travel to another locality and specifically, White Hart Lane ward, Seven Sisters ward or Muswell Hill ward if they needed to get a prescription dispensed urgently.

NE Tottenham

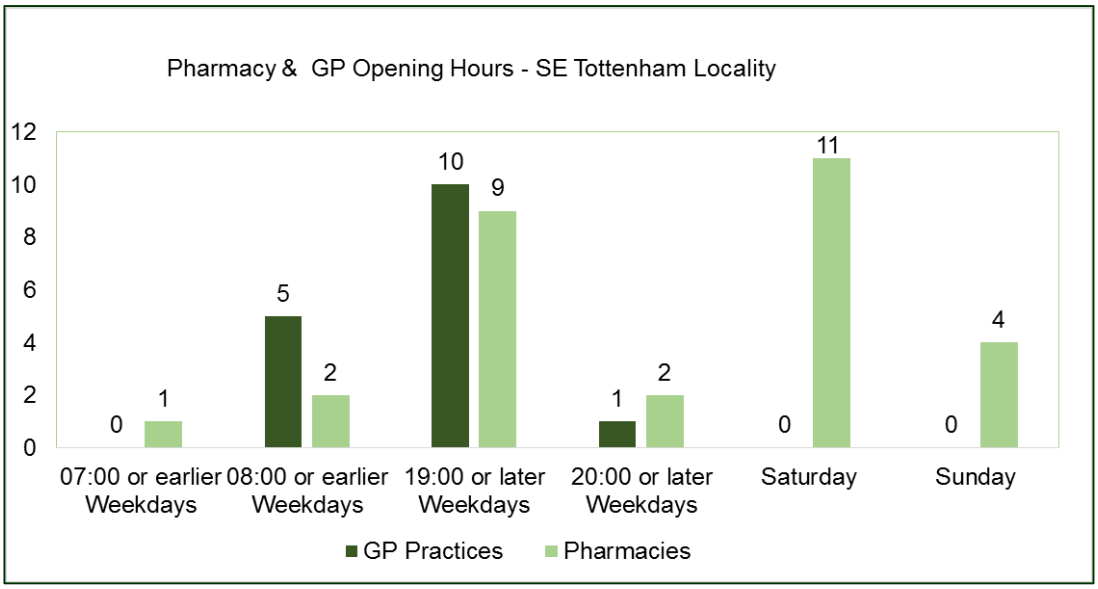
In this locality, there is a reasonable alignment of GP and pharmacy opening hours on weekdays, including in the evenings during the 'extended hour' period. There are no GP surgeries open on a Saturday or Sunday.



However, on weekday mornings 1 GP surgery opens at 7am on four days each week; and up to 5 surgeries are open by 8am. There is one pharmacy within the locality (White Hart Lane ward) which opens at 7am which residents may choose to access if following a GP consultation. The majority of GP surgeries, within the locality are within 1 mile of this pharmacy. The remaining pharmacies open at 9am.

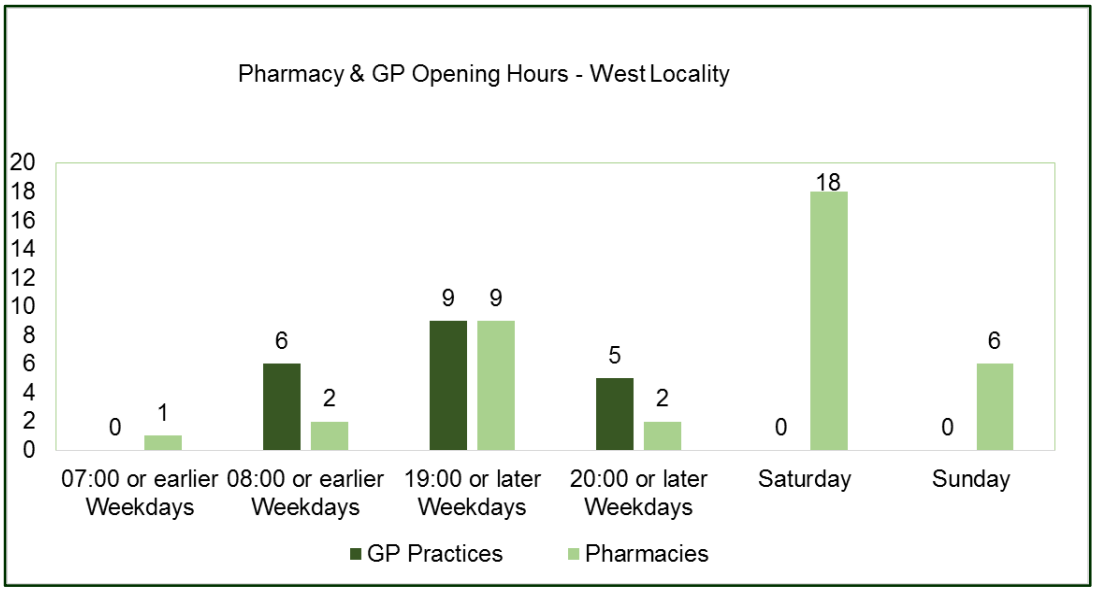
SE Tottenham

In this locality, there is a reasonable alignment of GP and pharmacy opening hours on weekdays, with two or more pharmacies open, whenever a GP surgery is open. No GP surgeries open on a Saturday or Sunday.



West Locality

In this locality, there is a reasonable alignment of GP and pharmacy opening hours on weekdays, with two or more pharmacies open, whenever a GP surgery is open. No GP surgeries open on a Saturday or Sunday.



In the future, if GPs move towards a 7 day a week service, the current pattern of pharmacy opening hours may need to be reviewed to ensure that the pharmaceutical needs of population, in terms of being able to access dispensing services in a timely fashion.

5.5.2. Pharmacy Urgent Repeat Medicine Service

In December 2014, NHS England launched the Pharmacy Urgent Repeat Medication service. This is a pilot scheme which will run until April 2015. Under the service, NHS 111 refers people directly to pharmacies when they are in need of an emergency supply of repeat medicines. The aim of the service is to reduce pressure on unscheduled care services and GP appointments at times of high demand.

It is our understanding, that NHS England plans to evaluate the PURM service and, if deemed to be successful, consideration will be given to commissioning this in the future.

We believe that this service potentially plays a valuable role in improving access to medicines. We would be supportive of a further roll out, providing the evaluation demonstrates both value for money and reduced pressure on GP and unscheduled care services.

5.5.3. Alignment with Other Services

In terms of unscheduled care providers there are no accident and emergency departments, urgent care centres, walk-in centres or minor ailments service provided from within the Borough of Haringey. Barndoc provides out of hours GP services from a base within Haringey, located at The Laurels Healthy Living Centre (St Ann's ward); and a second base located within Barnet at the Finchley Memorial Hospital.

Unscheduled care providers carry a stock of medicines, based on the national out of hours formulary and local historical experience, which they can issue to patients when there is an urgent need to start treatment in the out of hour's period. For Barndoc, this includes a range of palliative care medicines. However, there will be occasions when an FP10 prescription may be issued because a non-stock medicine is required. Residents of Haringey may choose to get such a prescription dispensed by a pharmacy which is close to the service they have used; or they have to option of attending their regular pharmacy, within Haringey, when it is open.

However, where a medicine needs to be started urgently, residents may face a challenge in getting a prescription dispensed from midnight through to 7am on weekdays and Saturdays and from midnight on Saturday night until 9am on a Sunday. We are not aware of any concerns or complaints with respect to access pharmacy services overnight, and our assumption is that this would only affect a very small number of residents on an occasional basis.

5.6. Other Essential Services

All community pharmacies are required to take part in up to six health promotion campaigns a year. This involves providing opportunistic advice, information and signposting around lifestyle and public health issues. NHS England sets the health promotion campaigns.

Community pharmacists and their staff are highly skilled at delivering health promotion advice and activities. In addition the medication records kept by pharmacies help to identify patients who may benefit from health promotion and healthy living advice.

Pharmacies provide a valuable service to dispose of waste medicines safely. This helps to reduce harm through inadvertent use of unwanted or expired medicines and also serves to protect the environment.

5.7. Access and support for those with a disability

A key consideration is the extent to which a pharmacy has taken action to meet the needs of people with a disability, noting that they are required to make reasonable adjustments to support the needs of those with protected characteristics under the Equality Act 2010. They receive a payment as a contribution towards providing auxiliary aids, for people who, under the Equality Act 2010, are eligible for support with taking their medicines. We explored this in our community pharmacy questionnaire and the results are summarised in the table on the next page:

- The majority of pharmacy premises (84.7%) are accessible to wheel chairs; where the pharmacy isn't fully accessible, pharmacies take action to provide support which includes providing home delivery services (most pharmacies) or consultations in patients' homes (14%)

- A small number of pharmacies have installed a hearing loop (17%) to assist communication with those who are hearing impaired; a further 29% said they had a staff member who is able to sign. Some pharmacies use written means of communication including email

- Almost 80% of pharmacies have the facilities to provide large print labels for people who have visual impairment or for those with learning disabilities/cognitive impairment; 12% of pharmacies are able to provide labels printed in braille (although it should be noted that most manufacturers also emboss original packs of medicines with braille)

- 88% of pharmacies provide monitored dosage systems (multi-compartment containers), 14% supply aide memoires and 39% provide easy to read information. Whilst there is no published evidence to demonstrate benefits of this support they may be beneficial for individual people who have complex medication regimens or those with cognitive impairment or learning disabilities

Locality	Ward	Wheel-chair Access	Hearing Impairment		Visual Impairment / Blindness		Support for those with cognitive impairment			
			Hearing Loop	Signing	Braille	Large print labels	'Aide memoire' for their medicines	Monitored Dosage Systems	Easy to read information	Large print labels
Central	Bounds Green	3	0	2	0	3	0	2	1	3
	Harringay	1	0	0	0	2	0	0	0	2
	Noel Park	5	2	2	1	5	2	7	2	5
	Woodside	3	2	0	0	2	0	3	2	2
NE Tottenham	Bruce Grove	2	0	0	0	1	0	2	1	1
	Northumberland Park	2	0	0	0	3	0	4	0	3
	Tottenham Hale	2	1	1	0	2	0	3	0	2
	White Hart Lane	3	1	2	0	3	1	3	3	3
SE Tottenham	Seven Sisters	3	1	1	1	3	0	3	1	3
	St Ann's	5	0	2	0	3	1	4	2	3
	Tottenham Green	4	1	2	1	4	1	4	2	4
West	Alexandra	1	0	0	0	1	0	1	1	1
	Crouch End	4	1	2	2	5	2	5	4	5
	Fortis Green	2	1	0	0	2	0	2	1	2
	Highgate	2	0	0	0	1	0	1	0	1
	Hornsey	2	0	0	0	1	1	2	1	1
	Muswell Hill	5	0	3	2	5	0	5	2	5
	Stroud Green	1	0	0	0	1	0	1	0	1
Total		**50**	**10**	**17**	**7**	**47**	**8**	**52**	**23**	**47**
Percentage of all pharmacies		**84.7%**	**16.9%**	**28.8%**	**11.9%**	**79.7%**	**13.6%**	**88.1%**	**39.0%**	**79.7%**

It should be noted that questionnaire results were inconsistent with respect to large print labels (fewer pharmacies said they were able to provide these for the visually sighted compared with cognitive impairment). Because the question was about the facility then the results for cognitive impairment have been used

5.8. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics, in relation to essential services, and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Advice and support needs to be tailored according to a patient's age e.g. o Older people often take multiple medications and are more susceptible to side effects o Parents may require advice on managing their child's medicines during school hours or advice on managing minor ailments ▪ People of working age, may wish to access services outside of normal working hours e.g. on weekdays before or after work; or at weekends and we have identified opportunities for improvements in this respect ▪ 42% of pharmacies told us that they offer consultations in the work place; this provides a mechanism to improve access to pharmacy services for people of working age
Disability	✓	▪ Many pharmacy users may be considered as disabled. This may include disability as a consequence of their disease as well as physical, sensory or cognitive impairment ▪ Pharmacies offer a range of support including: o The provision of large print labels for those who are visually impaired o Supply of original packs with braille or medicines labelled in braille for those who are blind o The use of hearing loops to aid communication for those with impaired hearing o Provision of aide memoirs and/or monitored dosage systems which may help to improve adherence in those who have memory impairment o 13.5% of pharmacies offer consultations in patients' homes or care homes respectively which helps improve access for people who are less able to get to a pharmacy without support ▪ People with a disability may have to exercise a choice and choose a pharmacy which better addresses their needs
Gender	✓	▪ We have identified that younger adults, particularly men, are less likely to visit pharmacies. We need to ensure that our pharmacies maximise opportunities to target health promotion and public health interventions (e.g. smoking cessation advice and stop smoking services) at this group
Race	✓	▪ Language may be a barrier to effectively delivering advice on taking medicines, health promotion advice and public health interventions. We have identified an opportunity to sign post patients to pharmacies where their first language is spoken ▪ BAME communities are exposed to a range of health challenges from low birth rate and infant mortality through to a higher incidence of long term conditions. People in this group are more likely to take medicines. This provides an opportunity to target health promotion advice and public health interventions in order to promote healthy lifestyles and improve outcomes
Religion or belief	✓	▪ Pharmacies are able to provide medicines related advice to specific religious groups. For example, advice on taking medicines during Ramadan; advice on whether or not a medicine contains ingredients derived from animals
Pregnancy and maternity	✓	▪ Pharmacies are ideally placed to provide health promotion advice to women who are pregnant or planning to become pregnant. They play a vital role in helping to promote breastfeeding and ensuring that pregnant and breast feeding mothers avoid medicines which may be harmful
Sexual orientation	✓	▪ No specific needs identified
Gender reassignment	✓	▪ Pharmacies may be part of the care pathway for people undergoing gender reassignment and play a role in ensuring that the medicines which form part of the treatment are available and provided without delay or impediment
Marriage & civil partnership	×	▪ No specific needs identified

5.9. Future Capacity

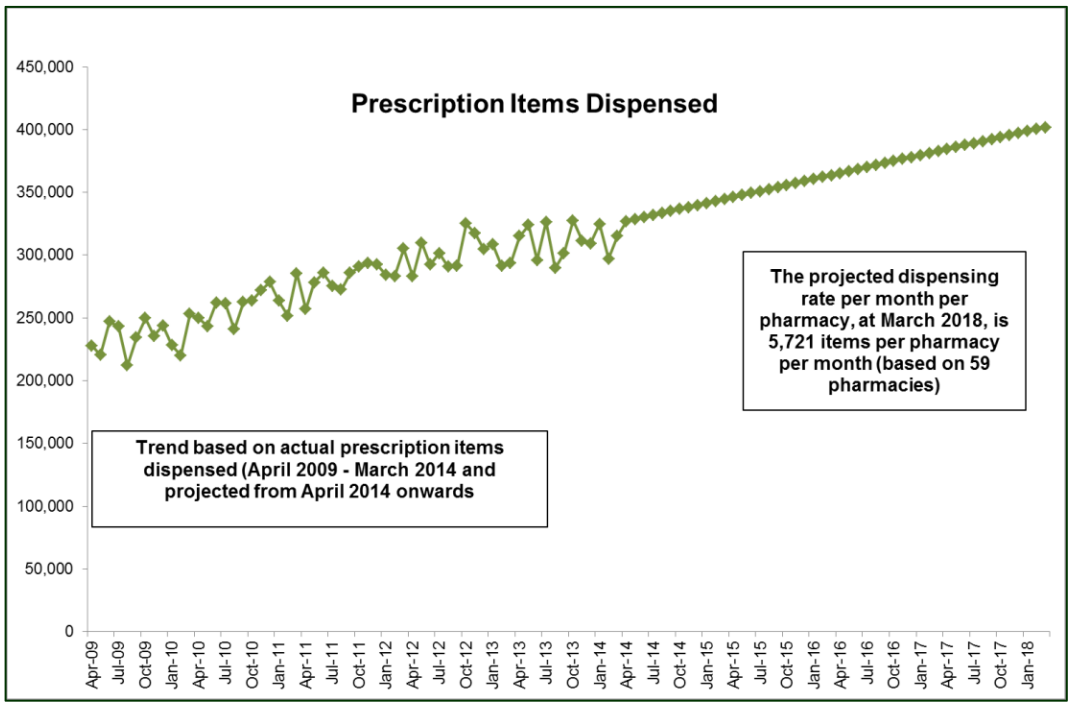
To consider the future capacity of Haringey pharmacies, we have looked at the following factors:

- The pattern and growth in prescribing as a proxy measure to assess the future dispensing capacity of pharmacies
- A review of significant housing developments within Haringey
- The projected population growth on the distribution of pharmacies per 100,000

5.9.1. Future Dispensing Capacity

The PNA regulations require the HWB to consider whether the pattern and growth in prescribing is of relevance to the future dispensing capacity of Haringey pharmacies.

The graph plots the number of items dispensed per month, between April 2009 and March 2014 and has been projected through to March 2018. It illustrates that the trend is for the volume of items to increase.



Assuming that the number of pharmacies and the cross border dispensing rate remains constant, the average number of items per pharmacy has been estimated to increase to 5,721. This projected dispensing rate is significantly lower than the current England average and suggests that there is sufficient capacity, within the existing network of pharmacies, to continue to meet the dispensing needs of Haringey residents.

However, it should be noted that whilst there are some limitations with the analysis, it is still a useful guide to the future dispensing capacity of our pharmacies:

- The items trend is based on prescriptions issued by Haringey prescribers and doesn't include prescription items issued in areas other than Haringey

- It doesn't allow for changes in prescribing patterns which may arise as a result of changes in evidence, guidelines, local demography etc

5.9.2. Impact of Projected Population Growth on Distribution of Pharmacies

In section 4.2.1 we set out the estimated population growth for Haringey and the areas of the Borough that are undergoing significant regeneration and/or housing developments. The table, within this section, estimates the population impact through to 2020, which goes beyond the maximum 3 year period for which our PNA will apply.

We have, therefore, projected the population growth through until 2018 using the Greater London Authority (GLA) Strategic Housing Land Availability Assessment (SHLAA) projections and have assessed the impact of this growth on the number of pharmacies per 100,000 population. The level of growth is constrained so that the resulting estimate of household numbers fits with the available dwellings. The SHLAA is an assessment of the land that is likely to be available to developers within the next 5 years, 10 years and 15 years i.e. trajectories are constructed based on these 3 time periods.

The table on the next page summarises our findings, noting the following:

- The Central and NE Tottenham localities are set to see the most significant increases in population (4,275 and 4,140 people respectively)

- In terms of the impact of population growth on the number of pharmacies per 100,000 population, the Central Locality will see the biggest change (-1.8) followed by NE Tottenham (-0.9) and SE Tottenham (-0.90 respectively

- NE Tottenham and the West Localities already have a lower than average number of pharmacies per head (compared with the current & future Haringey average; and the current London and England averages) and will be pushed further away from these (noting that it is not possible to compare with the future averages for London and England). This is potentially of concern for NE Tottenham given the health inequities and challenges within this locality

It should be noted that there is a commitment to improving healthcare facilities as part of the Tottenham regeneration programme, but there are no firm plans for a new healthcare centre, or for a pharmacy within this. There are also no firm plans to close or relocate any GP surgeries within this area or Haringey as a whole.

Locality	Ward	IMD Rank*	No. of Pharmacies		No. Pharmacies per 100,000 (2014)			No. Pharmacies per 100,000 (projected; 2018)			Difference	
			Ward	Locality	Population	Ward	Locality	Projected Population	Ward	Locality	Ward	Locality
Central	Bounds Green	13	3	15	14311	21.0	25.8	14341	20.9	24.1	-0.04	-1.8
	Harringay	11	2		13952	14.3		14553	13.7		-0.59	
	Noel Park	4	7		14574	48.0		17108	40.9		-7.11	
	Woodside	9	3		15232	19.7		16342	18.4		-1.34	
NE Tottenham	Bruce Grove	6	3	13	14935	20.1	17.4	15233	19.7	16.5	-0.39	-0.9
	Northumberland Park	1	4		15011	26.6		15960	25.1		-1.58	
	Tottenham Hale	5	3		16828	17.8		19181	15.6		-2.19	
	West Green	8	0		13919	0.0		14293	-		-	
	White Hart Lane	2	3		13863	21.6		14029	21.4		-0.26	
SE Tottenham	Seven Sisters	10	3	13	16508	18.2	27.1	16747	17.9	26.2	-0.26	-0.9
	St Ann's	7	5		15820	31.6		16232	30.8		-0.80	
	Tottenham Green	3	5		15636	32.0		16667	30.0		-1.98	
West	Alexandra	17	1	18	12009	8.3	21.0	12099	8.3	20.5	-0.06	-0.4
	Crouch End	15	5		12719	39.3		12889	38.8		-0.52	
	Fortis Green	18	2		12918	15.5		13092	15.3		-0.21	
	Highgate	19	2		12034	16.6		12389	16.1		-0.48	
	Hornsey	12	2		13025	15.4		13442	14.9		-0.48	
	Muswell Hill	16	5		11030	45.3		11500	43.5		-1.85	
	Stroud Green	14	1		12150	8.2		12181	8.2		-0.02	
Haringey Total			59		266474	22.1	22.1	278278	21.2	21.2	-0.94	-0.9

* The current number of pharmacies per 100,000 (2012/13) are 22.5 and 21.6 for London and England respectively

CONCLUSIONS ON ESSENTIAL SERVICES

Essential services are provided by all NHS Pharmaceutical Services contractors. We have, therefore, used provision of these services to explore a range of factors which are relevant to the pharmaceutical needs of our population. Many of the findings in this section e.g. access in relation to opening hours, support for people with disabilities etc are pertinent to other pharmacy based services and our conclusions should be borne in mind when reviewing other sections within the PNA

We have identified that essential services are **necessary to meet the pharmaceutical needs of our population** for the following reasons:

- Dispensing is a fundamental service which ensures that patients can access prescribed medicines in a safe, reliable and timely manner
- FP10 prescriptions may only be dispensed by providers of NHS Pharmaceutical Services
- Through supporting health promotion campaigns and a proactive approach to delivering health promotion and sign posting advice, community pharmacy plays a valuable role in addressing the health needs and tackling the health inequalities of Haringey's population

Distribution of Pharmacies

Haringey is well resourced in terms of the number of pharmacies it has and this serves to afford a reasonable choice to our residents. In addition, there are a number of pharmacies, located in neighbouring areas, which are easily accessible for Haringey residents should they choose to use these.

There is a reasonable correlation with deprivation, although this isn't the case within White Hart Lane and Tottenham Hale (NE Tottenham locality) which have a below average number of pharmacies per 100,000 population. However, addition capacity is available, within walking distance, from pharmacies in the neighbouring localities and borough. Areas with higher population density are relatively well served. There is good alignment with GP surgeries.

We have demonstrated that all residents can access a pharmacy, within a mile; and have estimated that the vast majority are within 20 minutes reach of their nearest pharmacy.

Opening Hours

In considering opening hours, we have taken into account the fact that Haringey has a high proportion of people who are of working age (and who may wish to access pharmacy services outside of 'working hours'); and have also looked at the alignment with other services.

We have demonstrated that, in most localities, there is good access to pharmacies on weekdays (9am - 6pm) and Saturdays (up until 5pm); and reasonable access on Sundays. In the extended hour period on weekdays, most residents can access a pharmacy, within 1 mile, up until 7pm.

There is no access to pharmacy services overnight. However, unscheduled care providers carry stock medicines which may be supplied to service users. Whilst, FP10 prescriptions may sometimes be issued, we are not aware of any concerns or complaints and have concluded that current arrangements are satisfactory.

We have identified the following potential gaps in relation to opening hours:

- Access and choice is more limited at all times in the NE locality; and this is particularly the case in the mornings (before and including 8am) and on Sundays when only one pharmacy is open

- In the Central Locality, no pharmacies open before 9am. This means that there is insufficient alignment with GP opening hours as a small number of GP practices provide clinical services from 7:30 - 8am (depending on the day of the week)

Dispensing

Haringey has a relatively low dispensing rate compared with our ONS comparators and the London and England averages. There is variation in dispensing rates between the localities and 16% of items are either dispensed by pharmacies outside of Haringey or are attributable to personally administered items by GPs.

We have not identified any issues with respect to the future dispensing capacity of pharmacies.

Access & Support for People with Disabilities

We have identified that our pharmacies have taken steps to ensure that they meet the needs of those with disabilities, particularly with respect to support for those who are wheelchair users and those with visual and cognitive impairment. However, we have identified that there is more to do to support the effective communication with people who are hearing impaired.

Current Need

- None identified

Future Need

- If GPs move to a 7 day a week service then current opening hours *may need to be reviewed*, to ensure timely access to dispensing following a GP consultation. At the time of publication, the arrangements for the operational delivery, and timescales, of such changes are not known

- NE Tottenham has high levels of deprivation, poorer health outcomes and is set to see significant population growth, in part as a result of housing and commercial developments. One of the pharmacies, within the locality, is potentially affected by the development. The impact will be to push this area even further away from the benchmarked average in terms of the number of pharmacies per 100,000. Taking this into account, and following completion of the developments, the locality may benefit from an additional access to pharmaceutical services. This may include existing pharmacies opening for extended hours; relocation of a pharmacy; and/or a new pharmacy (noting that we would wish to see such a pharmacy opening for extended hours on 7 days a week and being prepared to provide the full range of enhanced and locally commissioned services).

Improvements or Better Access

- GP and pharmacy opening hours do not necessarily align. We believe that extending pharmacy opening hours would improve timely access to dispensing , particularly in the mornings (before and including 8am) in the Central Locality; in the other localities this would improve choice for residents

- We anticipate that all pharmacies will take reasonable steps to meet the minimum requirements of the Equality Act 2010. We have identified opportunities for more pharmacies to support the needs of people with disabilities particularly those with a hearing impairment

Future improvements or Better Access

- None identified

5.10. Premises and Consultation Areas

There is interdependency between pharmacy premises and facilities and the ability of the pharmacy to deliver a broad range of advanced, enhanced and locally commissioned services.

A pre-requisite is a consultation area in which to hold private discussions with patients. For advanced services, the characteristics of a pharmacy consultation area have been defined within the regulations[5]:

- There must be a sign stating that there is a private consultation area available.
- The consultation area or room must be:
  - Clean and should not be used for storage of any stock
  - Laid out and organised so that any materials or equipment which are on display are healthcare related and
  - Laid out and organised so that once a consultation begins, the patient's confidentiality is respected.

We explored consultation area, and facilities within these, in our community pharmacy questionnaire. The table on the next page summarises the characteristics of the consultation areas and provides an overview as to why the feature(s) are important.

Consultation Areas & Facilities			
Feature	**Rationale**	**No. (n=59)**	**%**
On-site	Facilitates 'walk in' approach to service delivery	58	98%
Closed room	For confidentiality	51	86%
Space for a chaperone	Important for patients who wish to be accompanied during a consultation	39	66%
Wheel chair access	Improves access to a confidential area for those with a physical disability	38	64%
Hearing loop within the room	Improves quality of the consultation for those with a hearing impairment	8	14%
Computer	For contemporaneous patient records	36	61%
Internet access	Access to on-line resources	34	58%
Patient medication records	Access to patients' medication history during the consultation	29	49%
Telephone	Allows confidential calls to be made	21	36%
Sink with hot water	Required for services which include examination or taking samples	36	61%
Examination couch	Allows for a broader range of services to be provided	9	15%
CCTV	Affords protection and security	6	10%
Panic button	Affords protection and security	13	22%
Other Facilities on the Premises			
Patient toilet	Facilitates provision of samples	27	46%
N3 Connection	Secure connection for sharing confidential information and data	56	95%
Nhs.net email	Allows confidential correspondence	42	71%

98% (58/59) of Haringey pharmacies have one or more consultation areas. Of these, 3 pharmacies have two consultation areas; 1 pharmacy has three consultation areas and another pharmacy has 4 consultation areas. One pharmacy is currently installing a consultation area.

CONCLUSIONS ON PREMISES AND CONSULTATION AREAS

We have identified that the majority of Haringey pharmacies have one or more consultation areas.

These areas are generally well equipped and consistent with modern standards.

With respect to meeting the needs of those with a disability, almost two thirds of the consultation areas are fully accessible to a wheelchair and/or have space for a chaperone or carer which may be important for people with cognitive impairment. However, only 15% of pharmacies have a hearing loop in the consultation area which potentially disadvantages people with hearing impairment.

There are opportunities to improve both the use of technology within the consultation area and also security through the installation of CCTV and panic buttons.

5.11. Advanced Services

Advanced services are defined in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013[5]. A contractor has discretion as to whether or not they provide advanced services, providing that they meet the requirements in terms of premises and training and make a notification of intention to NHS England.

In this section, we explore the current provision of the four advanced services currently included within the community pharmacy contract.

5.11.1. Medicines Use Reviews (MURs) and Prescription Intervention (PIs) Service

A. Overview

Since 2005, community pharmacies have been able to provide Medicines Use Reviews (MURs). This service, together with the Prescription Intervention (PI) Service, consists of accredited pharmacists undertaking structured adherence-centred reviews of patients on multiple medicines.

The services are intended to improve patients' understanding of their medicines with the outcome of improving adherence and reducing waste. MURs tend to be more proactive and targeted at specific patient groups whereas PIs are more reactive and are usually undertaken following identification of a serious adherence issue. A pharmacy may undertake up to 400 MURs per annum. A pharmacy may only offer an MUR to a patient who has been using the pharmacy for 3 months (this is known as the 3 month rule).

In 2014/15, NHS England determined that from a specified implementation date the number of MURs, which must be directed at the national target groups, will be increased from 50% to 70%. From the same date, the target groups have been expanded. The table below summarises the historical and the additional target groups:

Historical Target Groups	Additional Target Groups
▪ People taking high risk medicines i.e. non-steroidal anti-inflammatory drugs (NSAIDs), anti-coagulants, anti-platelets and diuretics; ▪ Patients recently discharged from hospital; ▪ Patients prescribed certain respiratory medicines	▪ People who are taking a minimum of 4 regular medicines and who are at risk of, or who have, one or more of the following conditions: o Coronary heart disease o Diabetes o Atrial fibrillation o Peripheral arterial disease o Renal/chronic renal disease o Hypertension o Thyroid disorders o Heart failure o Stroke / Transient Ischaemic Attack o Lipid disorders

B. The Evidence Base

The effectiveness of MURs at improving adherence, improving outcomes and reducing medicines-related risks including adverse effects, has been demonstrated in studies[6]:

- 49% of patients reported receiving recommendations to change how they take their medicines, and of these 90% were likely to make the change(s).
- 77% had their medicines knowledge improved by the MUR.
- 97% of patients thought the place where the MUR was conducted was sufficiently confidential.
- 85% of patients scored the MUR 4 or 5 on a usefulness scale (1 = not useful; 5 = very useful).

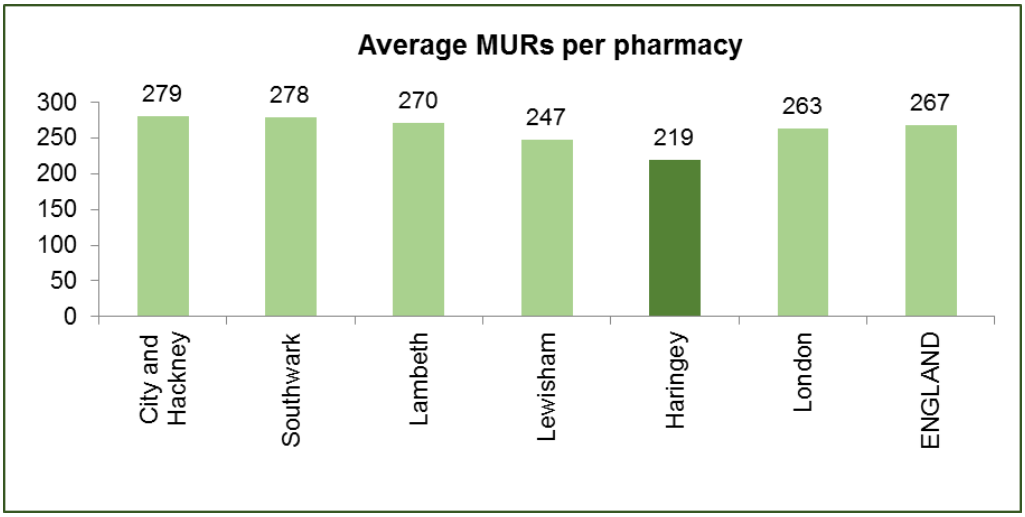
C. The Current Picture

In Haringey, 92% (54/59) of pharmacies told us in our community pharmacy questionnaire that they offer the MUR service. All 5 of the pharmacies which don't currently offer the service indicated that they would be willing to do so in the future.

Activity data for 2013/14 demonstrates that a total of 11,098 MUR reviews were undertaken by 50 of the pharmacies. This averages out at 222 reviews per pharmacy.

When compared to our ONS comparators (noting that the comparison is based on 2012/13 data which the most recent available), it is of note that this performance is lower than all the other ONS comparators, and London and England averages (as illustrated by the graph below).

It also falls significantly below the permitted maximum of 400 MURs per pharmacy per year.



Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13)

The table below provides a summary of MUR provision across each locality:

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	14	11	13	16	54
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	24.1	14.8	27.1	18.6	20.3
No. of active pharmacies (2013/14)	13	10	13	14	50
Range of MURs undertaken	2 - 436	24- 402	12 - 405	88 - 403	2 - 436
Total Activity	2875	1476	3534	3213	11098
MURs per 1,000 people	50	20	74	37	42

It demonstrates variation across the localities with pharmacies in NE Tottenham undertaking the lowest number of reviews and SE Tottenham the highest number per 1,000 population.

Map 8 (appended in a separate document) provides an overview of the distribution of pharmacies against a background of people who reported (2011 census) that they have a limiting long term illness (LLTI). This is a proxy for need on the basis that many people with a LLTI will be taking medicines and may benefit from an MUR. It demonstrates that there is a reasonable correlation with need in all localities.

The table (next page) provides an overview of MUR service provision on different days of the week.

The data demonstrate that there is good access to MURs in all 4 Localities, on weekdays between 9:30am and 6pm and on Saturdays between 10am and 1pm, which is when all pharmacies are open. During extended hours on weekdays, Saturday afternoons & evenings and Sundays, access is reduced in all localities.

The ‘3 month rule’ creates a difficulty with respect to accessing MURs in the extended hours period or at weekends, as patients cannot access this service from an alternative pharmacy. This means that patients may only access MURs when their regular pharmacy is open (rather than choosing to go elsewhere). This may reduce take-up by people of working age, who have a long term condition and who may not be able to attend their regular pharmacy during the day. It also means that patients who choose to have their prescriptions dispensed by the 5 pharmacies which do not offer the service, cannot access MURs at all.

Locality	Ward		No. of Pharmacies Offering Medicines Use Reviews								
			Open on Weekdays				Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	3	2	0	0	2	1	0	0	0
	Harringay	0	1	0	0	0	1	0	0	0	1
	Noel Park	0	7	3	2	0	5	4	2	3	0
	Woodside	0	3	2	0	0	3	3	1	0	0
NE Tottenham	Bruce Grove	0	3	2	0	1	3	3	0	0	0
	Northumberland Park	0	2	2	0	0	1	1	0	0	2
	Tottenham Hale	0	3	1	0	0	1	1	1	0	0
	White Hart Lane	1	3	1	2	0	3	1	1	1	0
SE Tottenham	Seven Sisters	1	3	2	2	0	2	1	1	1	0
	St Ann's	0	5	3	1	1	4	4	1	1	0
	Tottenham Green	1	5	4	0	0	5	2	2	2	0
West	Alexandra	0	1	1	0	0	1	0	0	0	0
	Crouch End	0	5	3	0	0	5	5	1	2	0
	Fortis Green	0	2	2	0	0	2	1	1	1	0
	Highgate	0	2	0	0	0	2	2	0	1	0
	Hornsey	0	1	0	0	0	1	0	0	0	1
	Muswell Hill	2	4	2	0	0	4	4	2	2	1
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**5**	**54**	**30**	**7**	**2**	**46**	**34**	**13**	**14**	**5**
Percentage of the Total		8%	92%	51%	12%	3%	78%	58%	22%	24%	8%

D. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Older people, on multiple medications for long term conditions are likely to require MURs. People of working age may wish to access this service during extended hours. Residents in care homes may have reduced access to MURs because this tends to be a pharmacy-based service (permission is needed to offer the service in patients' homes). However, 14% of pharmacies offer MURs in care homes which affords access to this group of our residents. A further 68% said they would be willing to do so in the future
Disability	✓	▪ MURs help to assess & provide support to patients to help improve adherence to medicines e.g. provision of large print labels for the visually impaired and/or for those with cognitive impairment. It is important for pharmacies to make sure that the service is accessible and tailored to meet the needs of those with learning disabilities
Gender	×	▪ No specific needs identified
Race	✓	▪ Language may be a barrier to delivering successful MURs
Religion or belief	×	▪ No specific needs identified (refer to essential services for specific support which may be required at the time of dispensing)
Pregnancy and maternity	✓	▪ MURs help women who are planning pregnancy or breast feeding women to avoid potentially harmful medicines
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	✓	▪ MURs may help to improve adherence to prescribed medicines
Marriage & civil partnership	×	▪ No specific needs identified

CONCLUSIONS ON MURs

Targeted MURs improve adherence with the prescribed regimen, help to manage medicines related risks and improve patient outcomes:

- People with long term conditions with multiple medicines benefit from regular reviews
- It is estimated that up to 20% of all hospital admissions are medicines related[9] and arise as a result of treatment failure or unintended consequence (e.g. a side effect or taking the wrong dose)

We have determined that this service is **necessary** to meet the pharmaceutical needs of our population:

- The service may only be provided by community pharmacists
- There is published evidence to demonstrate the benefits of MURs
- There is good alignment with the strategic aims set out within the Haringey JHWS and NHS Haringey CCG's commissioning strategy, particularly with respect to the focus on prevention, early diagnosis and treatment of long term conditions
- The service helps to ensure that our residents derive maximum benefit from the medicines which they need

54 pharmacies offer the MUR service. Access is good on weekdays (9:30am - 6pm) and Saturdays (10am - 1pm); but is reduced outside of these hours

We have identified the following potential gaps:

- Whilst a number of pharmacies offer the service, some are not currently actively undertaking MURs; there is also scope for some pharmacies to increase the number of MURs which are undertaken as only a quarter of pharmacies deliver the maximum number of permitted MURs per annum

- The 3 month rule means that MURs may not be accessed from a pharmacy other than the patient's regular pharmacy. The implications for:
  - The residents who use the 5 pharmacies which do not provide the service

- People who wish to use the service during extended hours, or at weekends, but cannot do so because their regular pharmacy is closed
- The 25% of pharmacies which deliver the maximum permitted number of MURs per annum and have no capacity to meet additional demand for the service

Taking the above into account, our overall conclusions for MURs may be summarised as follows:

Current Need

- The gap, whereby some residents cannot access the service because it is not offered by their regular pharmacy, cannot be addressed through granting of new applications because of the 3 month rule for MURs. We wish to see all Haringey pharmacies to offer the MUR service. Another option is for a resident to be signposted to a pharmacy which does offer MURs (noting that prescriptions will need to be dispensed by the alternative pharmacy)

Future Need

- We anticipate there will be an increase in the number of people requiring MURs as our population ages; as more patients are cared for closer to home; and as a result of the expected population increase due to regeneration and housing developments. The majority of our pharmacies have capacity to meet this increased need. However, we would like to see the national cap, limiting the number of MURs to 400 per annum, lifted

Current and Future Improvements or Better Access

- We wish to see all pharmacies proactively targeting the service at the patients who will benefit the most. This will help to ensure that pharmacies deliver the maximum number of MURs
- We would like to see more pharmacies opening earlier in the morning, or staying open later in the evening, where there is a demand for service provision at these times
- Providing the service in the domiciliary setting (subject to NHS England approval) would improve access to the service for people who are housebound and for those who are less able to get to a pharmacy unaided. Similarly, there is an option for pharmacies to offer appointments 'after hours' to facilitate access for people who work full time

5.11.2. New Medicine Service

A. Overview

The New Medicine Service (NMS) is the most recent advanced service to be added to the NHS community pharmacy contract; it commenced on 1st October 2011. The aim of this service is to support patients with long-term conditions, who are taking a newly prescribed medicine, to help improve medicines adherence.

At this point in time, the service is focused on the following patient groups and conditions:

- Asthma and COPD
- Diabetes (Type 2)
- Antiplatelet / anticoagulant therapy
- Hypertension

Patients are either referred to the NMS by a prescriber when a new medicine is started (this can be from primary or secondary care) or are identified opportunistically by the community pharmacist. The service differs from a MUR in that there is no 3 month rule. The number of NMS interventions which a pharmacy may undertake is linked to the volume of dispensing in any given month.

The NMS started as a time-limited service with the future continuation of the service being dependent upon the outcome of a formal evaluation. The results of this evaluation were published in August 2014 (see evidence base below) and NHS England has indicated its commitment to continuing the service throughout 2014/15. The future of the service beyond this is not known.

B. The Evidence Base

A recent randomised controlled trial[7],[8] demonstrated that the NMS intervention in community pharmacy may deliver health benefits by increasing adherence to medication and be cost effective:

- The NMS increased adherence by around 10% and increased identification in the numbers of medicine related problems and solutions
- Economic modelling showed that the NMS could increase the length and quality of life for patients, while costing the NHS less than the those in the comparator group
- Pharmacy ownership however, was likely to have affected effectiveness, with adherence seen to double, following an NMS if conducted by small multiple compared to an independent

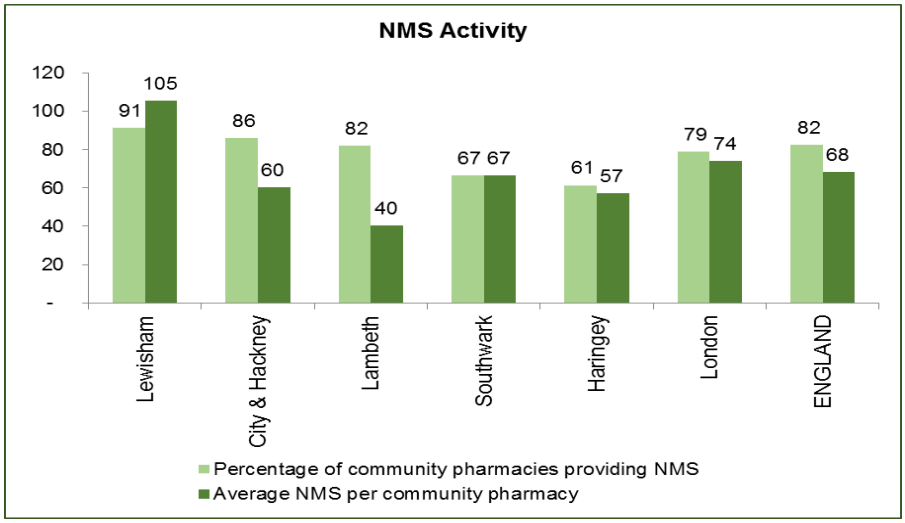
In a study evaluating a telephone based pharmacy advisory service[9], pharmacists met patients' needs for information and advice on medicines, when starting treatment.

C. The Current Picture

In Haringey, 76% (46/59) of pharmacies told us in our community pharmacy questionnaire that they offer the NMS service. Of the 14 pharmacies that don't provide the service, 10 told us they would be willing to do so in the future.

Activity data for 2013/14 demonstrates that a total of 1,798 NMS reviews were undertaken by 33 of the pharmacies. This averages out at 54 reviews per pharmacy.

Our benchmarking analysis demonstrates that this performance is lower than all the other ONS comparators except for Lambeth, and London and England averages (as illustrated by the graph below).



Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13)

The table below provides a summary of NMS provision across each locality, and Map 9 (appended in a separate document) provides an overview of the distribution of pharmacies offering the service against a background of the percentage of people who reported, in the 2011 census, that they have a limiting long-term illness (LLTI). As with MURs, this has been used as a proxy for need.

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	11	7	12	16	46
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	18.9	9.4	25.0	18.6	17.3
No. of active pharmacies (2013/14)	9	5	11	8	33
Range of reviews undertaken	3 - 109	6 - 174	6 - 167	14 - 300	3 - 300
Total Activity	398	245	492	663	1798
Activity per 1,000 people	6.9	3.3	10.3	7.7	6.7

The map demonstrates that there is a reasonable correlation between pharmacies offering the service and need in all localities.

In terms of activity, the table indicates that

- Only 33 (out of the 46 offering the service) are actively undertaking reviews; in the West Locality, only 50% of those offering the service are active. However, this may be a reflection of lower need within this locality.

- There is also variation between localities, with pharmacies in NE Tottenham undertaking the fewest reviews per 1,000 people and SE Tottenham undertaking the most. This is potentially of concern given that the map indicates that a high number of people in NE Totthenham have a LLTI.

The table on the next page provides an overview of the NMS provision on different days of the week. It demonstrates reasonable access to NMS, and a choice of pharmacy, in all 4 Localities on weekdays between 9:30am and 6pm and on Saturdays up until 5pm.

Access outside of these opening hours is reduced in localities, particularly on weekday mornings (up until and including 8am) and on Sundays.

D. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Older people, particularly those on multiple medications or those recently discharged from hospital, may benefit from the NMS. People of working age may wish to access this service during extended hours. Residents in care homes may have reduced access to the NMS
Disability	✓	▪ NMS help to assess & provide support e.g. provision of large print labels for the visually impaired and/or for those with cognitive impairment. It is important for pharmacies to make sure that the service is accessible and tailored to meet the needs of those with learning disabilities
Gender	×	▪ No specific needs identified
Race	✓	▪ Language may be a barrier to delivering successful NMS
Religion or belief	×	▪ No specific needs identified (refer to essential services for specific support which may be required at the time of dispensing)
Pregnancy and maternity	✓	▪ The NMS may help pregnant or breast feeding women to avoid harmful medicines
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	✓	▪ NMS may help to improve adherence to newly prescribed medicines
Marriage & civil partnership	×	▪ No specific needs identified

Locality	Ward	No. of Pharmacies Offering the New Medicine Service									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	3	2	0	0	2	1	0	0	0
	Harringay	0	1	0	0	0	1	0	0	0	1
	Noel Park	0	4	2	0	0	3	2	2	2	3
	Woodside	0	3	2	0	0	3	3	1	0	0
NE Tottenham	Bruce Grove	0	2	1	1	0	2	2	0	0	1
	Northumberland Park	0	0	0	0	0	0	0	0	0	4
	Tottenham Hale	0	3	1	0	0	1	1	1	0	0
	White Hart Lane	1	2	1	0	0	2	1	1	1	1
SE Tottenham	Seven Sisters	1	3	2	0	1	2	1	1	1	0
	St Ann's	0	5	3	1	1	4	4	1	1	0
	Tottenham Green	1	4	3	0	0	4	2	2	2	1
West	Alexandra	0	1	1	0	0	1	0	0	0	0
	Crouch End	0	5	3	0	0	5	5	1	2	0
	Fortis Green	0	2	2	0	0	2	1	1	1	0
	Highgate	0	2	0	0	0	2	2	0	1	0
	Hornsey	0	1	0	0	0	1	0	0	0	1
	Muswell Hill	2	4	2	0	0	4	4	2	2	1
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**5**	**46**	**25**	**2**	**2**	**40**	**30**	**13**	**13**	**13**
Percentage of the Total		**8%**	**78%**	**42%**	**3%**	**3%**	**68%**	**51%**	**22%**	**22%**	**22%**

CONCLUSIONS ON NMS

The NMS has been shown to improve adherence with a newly prescribed medicine, helps to manage medicines-related risks and improve patient outcomes by tackling the following problems[10]:

- Only 16% of patients take a new medicine as prescribed
- 10 days after starting a new medicine, almost one-third of patients are non-adherent
- It is estimated that up to 20% of all hospital admissions are medicines-related and arise as a result of failure or unintended consequence (e.g. a side effect or taking the wrong dose) of using a prescribed medicine.

On balance, at this point in time, we have determined that the service is not necessary to meet a pharmaceutical need but is **relevant in that it improves access to medicines reviews and clinical support**. The following factors have influenced this decision:

- The service may only be provided by community pharmacists but other healthcare professionals (e.g. practice nurses, hospital pharmacists) may offer comparable services
- There is published evidence to demonstrate the benefits of the NMS
- There is good alignment with the strategic aims set out within the Haringey Joint Health and Wellbeing Strategy and NHS Haringey CCG's commissioning strategy, particularly with respect to:
- The focus on prevention, early diagnosis and treatment of long term conditions;
- Helping to prevent medication-related falls
- Potentially reducing hospital admission or re-admissions due to non-adherence to a new medicine
- Whilst the service improves access to medication reviews, the number of NMS reviews undertaken is low compared with our ONS comparators and the London & England averages
- The long term future of the service is not known

With respect to service provision we have identified a number of potential gaps:

- 13 pharmacies do not offer the NMS. However, 10 of these pharmacies have indicated that they are willing to offer this service in the future.

- 13 of the pharmacies which offer the service are not actively undertaking NMS reviews.

- There is variation between localities, with respect to the number of reviews undertaken per 1,000 people. This is of potential concern in NE because a high number of people have a LLTI.

- Access the service is limited, in all localities, on weekday mornings (up until and including 8am) and on Sundays.

In the future, we anticipate there will be an increase in the number of people requiring the NMS as our population ages; as more patients are cared for closer to home; and as a result of the expected population increases due to regeneration and housing developments. Our analysis suggests there is sufficient capacity within the existing network of pharmacies to meet the growth in demand, particularly if more pharmacies come on board and start to offer the service.

Taking the above into account, our overall conclusions for the NMS may be summarised as follows:

Current and Future Need

- None identified.

Current Improvements or Better Access

- We would like all Haringey pharmacies to provide the NMS service for as long as it is commissioned by NHS England. Where a pharmacy does not offer the service, we would signposting to pharmacies who do offer the service

- We would like to understand why some pharmacies are not active and why others undertake low numbers of reviews (particularly in NE Tottenham). This will facilitate us providing support to pharmacies with a view to increasing uptake of the service

- Adopting an integrated approach to service delivery, whereby pharmacies and prescribers in primary and secondary care work closely together, may increase the number of people referred into the service and secure improvements for patients.

- We would, like to see more pharmacies opening earlier in the morning, or staying open later in the evening, where there is a demand for service provision at these times

5.11.3. Stoma Appliance Customisation Service

A. Overview

This service involves the customisation of stoma appliances, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the appliance and to improve the duration of usage, thereby reducing waste. There are no limits on the number of SACs which may be undertaken.

B. The Evidence Base

We have undertaken a literature review and have not identified any published studies to demonstrate the benefits of the SAC service. The benefits associated with the service, as stated above, remain theoretical.

C. Current Picture

In Haringey, 10% (6/59) pharmacies told us in our community pharmacy questionnaire that they offer the SAC service.

Of the 53 pharmacies which don't provide the service, 38 told us they would be willing to do so in the future. Barriers to delivering the service included the need for training and lack of demand.

The table below, based on 2012/13 data shows the number of Stoma Appliance Customisations undertaken within Haringey compared with the ONS comparators.

ONS Comparator Area	SACs Service 2012/13	
	Total SACs	Average No. per Pharmacy / DAC
Lewisham	42	14
Haringey	**25**	**8**
Lambeth	16	16
Southwark	9	5
City and Hackney	0	0
London	70,883	921
England	1,117,971	635

Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13)

This demonstrates that there is generally a low uptake of pharmacy-based SACs within both Haringey and our ONS comparator areas. Furthermore, this pattern tends to be replicated across most of England, although a small number of areas appear to undertake the vast majority of activity (e.g. Croydon undertook 27,395 SACS in the 2012/13).

The table below summarises the findings of a detailed review of stoma appliance dispensing (based on prescriptions issued by Haringey prescribers between April 2013 - March 2014) and demonstrates that 65% of items were dispensed outside of the Borough. It follows that SACS are likely to be undertaken outside the area.

Locality	Items	Percentage
Central	1,027	9.8%
NE Tottenham	906	8.6%
SE Tottenham	562	5.3%
West	1,185	11.3%
Total Haringey	**3,680**	**35.0%**
Out of area >100 items per pharmacy / DAC	5,790	**55.0%**
Out of area <100 items per pharmacy / DAC	1,055	**10.0%**
Total out of area	**6,845**	**65.0%**

D. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Older people are more likely to have stomas and therefore may be more likely to require access to the SAC service.
Disability	✓	▪ The SAC service may help to assess need and provide support to help people with disabilities to manage their stoma.
Gender	×	▪ No specific needs identified
Race	✓	▪ Language may be a barrier to delivering a successful service
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ The SAC service may be required by pregnant women to help to accommodate changes in body shape during pregnancy
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

CONCLUSIONS ON SACs

The SACS service aims to ensure the proper use and comfortable fitting of the appliance and to improve the duration of usage, thereby reducing waste.

6 pharmacies offer the service and a further 38 are willing to do so in the future. Whilst access and choice are limited, benchmarking data shows that this is similar to many other areas.

We have determined that whilst this service is not necessary to meet the pharmaceutical needs of our population, it is **relevant** for the following reasons:

- Our analysis of dispensing indicates that Haringey residents may choose to access stoma customisation both within and outside of the area. They may also opt to receive stoma customisation support from the hospital or clinic providing their ongoing care i.e. the pharmacy-based service offers improvements in relation to choice

- The SAC service provides theoretical benefits to the patients, however, there is insufficient published evidence to demonstrate improved patient outcomes or value for money

We are not aware of a demand for a pharmacy-based service nor have there been any complaints with respect to service provision of SACS and have concluded that there are not any current or future gaps.

5.11.4. Appliance Usage Reviews

A. Overview

Appliance Use Reviews (AURs) may be provided by community pharmacies and dispensing appliance contractors. They may be carried out by an appropriately trained pharmacist or specialist nurse either within the contractor's premises or in a patient's own home

The purpose of AURs is to improve a patient's knowledge and use of any 'specified appliance' that they have been prescribed i.e.:

- Catheter appliances, accessories & maintenance solutions
- Stoma appliances
- Incontinence appliances
- Laryngectomy or tracheostomy appliance
- Anal irrigation kits
- Vacuum pump or constrictor rings for erectile dysfunction

The pharmacist would normally dispense and undertake a review with a view to improving adherence and to minimise waste by resolving any issues related to poor or ineffective use of the appliance by the patient.

A contractor may undertake a limited number of AURs linked to the volume of appliances dispensed (i.e. 1/35 of specified appliances)

B. The Evidence Base

We have undertaken a literature review and have not identified any published studies to demonstrate the benefits of the AUR service. The benefits associated with the service, as stated above, remain theoretical.

C. Current Picture

In Haringey, 8% (5/59) pharmacies told us in our community pharmacy questionnaire that they offer the AUR service. However, 41 pharmacies told us they would be willing to do so in the future and they cited barriers to delivering the service as a need for training and a lack of demand.

The table below, based on 2012/13 data shows that no AURs were undertaken within Haringey or our ONS compactor areas.

ONS Comparator Area	No. of AURs provided (2012/13)			
	Home	Premises	Total	% at Home
City and Hackney	0	0	0	0%
Haringey	**0**	**0**	**0**	**0%**
Lambeth	0	0	0	0%
Lewisham	0	0	0	0%
Southwark	0	0	0	0%
London	1820	354	2174	84%
England	23,554	4593	28147	84%

Source: Health & Social Care Information Centre, General Pharmaceutical Services in England (2012/13)

We have used dispensing of incontinence appliances as a means of exploring provision of AURs.

The table summarises the findings of a detailed review of incontinence appliance dispensing (based on prescriptions issued by Haringey GPs; April 2013 - March 2014):

Incontinence Appliance Dispensing			
	Total Items	% Total Items	Max No. AURs
Central	313	9%	9
NE Tottenham	490	14%	14
SE Tottenham	293	8%	8
West	719	21%	21
Total - Haringey	**1815**	**53%**	**52**
Out of area >100 items per pharmacy / DAC	965	28%	28
Out of area <100 items per pharmacy / DAC	670	19%	19
Total - out of area	**1635**	**47%**	**47**

The data helps to explore the provision of the AUR service:

- The total number of incontinence appliances dispensed was 3,450
- 53% of these were dispensed by 53/59 pharmacies in Haringey
- The West locality dispensed the highest volume of items (21%) and SE Tottenham Locality the lowest volume of items (8%)
- 47% of the items were dispensed out of area, with just 3 pharmacies accounting for 28% of the items
- Based on this dispensing pattern, the maximum number of AURS which could theoretically have been offered to people using incontinence appliances within Haringey was 52; and 47 for those using pharmacies outside the area
- Similarly, for stoma appliances the maximum number would be 105 within Haringey and 196 outside the area

This pattern of dispensing demonstrates that even if residents had chosen to access the pharmacy-based AUR service, the number of reviews which pharmacies are permitted to undertake would be relatively low. This reinforces the views expressed in our community pharmacy questionnaire that demand for the service is low.

As with the SACs service, patients often receive the specialist support they require from the hospital or clinic responsible for their ongoing care.

D. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Older people are more likely to use appliances and, as such, are more likely to require an AUR
Disability	✓	▪ People with certain disabilities are more likely to use appliances and, as such, are more likely to require an AUR
Gender	✓	▪ Appliance advice can be specific to gender
Race	✓	▪ Language may be a barrier to delivering a successful AUR
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	×	▪ No specific needs identified
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

CONCLUSIONS ON AURs

The purpose of AURs is to improve a patient's knowledge and use of specified appliances that they have been prescribed

Currently, only 5 Haringey pharmacies offer this service and a further 41 have said that they would be willing to provide this in the future

Benchmarking data demonstrates that no AURs have been undertaken in Haringey or in our ONS comparator areas. We believe the reasons for this can be explained by:

- A relatively high out of area dispensing rate
- The fact that AURs are linked to dispensing activity
- The specialist nature of the service which means that patients often receive the support they need from the hospital or clinic responsible for their on-going care
- A high proportion of AURs are provided in peoples' homes. This improves access for people with a disability and overcomes any barriers introduced by the fact some localities don't have a pharmacy providing the service

We have concluded that within Haringey, the AUR service is not necessary to meet a pharmaceutical need but it is a **relevant** service for the following reasons:

- The service potentially provides a choice of provider for people who wish to use a pharmacy-based service rather than the hospital or clinic providing their ongoing care
- There is insufficient published evidence to demonstrate improved patient outcomes or value for money

We are not aware of a demand for a pharmacy-based service nor have there been any complaints with respect to service provision of AURs and have concluded that there are not any current or future gaps.

5.12. Enhanced Services

Enhanced services are defined in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013[5]. NHS England is responsible for commissioning enhanced services from community pharmacies. The requirements for each service are defined within a service level agreement provided by NHS England.

5.12.1. Minor Ailments Scheme

A. Overview

Pharmacies participating in the minor ailments scheme provide advice and support to people on the management of minor ailments, including where necessary, the supply of medicines for the treatment of the condition, for those people who would have otherwise gone to their GP for a prescription. Where the patient is exempt from prescription charges the medicine is supplied free of charge. The pharmacy operates a triage system, including referral to other health and social care professionals, where appropriate.

The aims and intended service outcomes are:

- To improve access and choice for people with minor ailments
- Promote self-care through the pharmacy, including provision of advice and where appropriate medicines, dressings and/or appliances without the need to see a GP
- Operate a referral system from local medical practices or other primary care providers
- Supplying appropriate medicines and devices (dressings etc) at NHS expense.
- To improve primary care capacity by reducing medical practice workload related to minor ailments

The table below provides a summary of the scope of the minor ailments service:

Conditions Included in the Scheme		
Athlete's foot	Diarrhoea	Insect bites and stings
Back pain	Dyspepsia / indigestion	Minor injuries
Cold sores	Earache	Nappy rash
Conjunctivitis*	Haemorrhoids	Sprains and strains
Constipation	Hay fever, allergic rhinitis & allergies	Teething
Contact dermatitis	Headache, fever	Threadworms
Cystitis*	Head lice	Vaginal Thrush

* Antibiotics may only be supplied under a Patient Group Direction (PGD) by accredited pharmacists

Haringey residents registered with a Haringey GP have direct access to the service and register with the pharmacy of their choice. However, Haringey residents, who are registered with a GP in a neighbouring borough, are entitled to access a minor ailments scheme within the borough of their registration.

A leaflet is available, to facilitate residents' understanding of the MAS; this provides key information on how the service may be accessed and the conditions which are included within the scheme.

B. Provider Criteria

Pharmacies must meet the following criteria in order to provide the minor ailments service:

- All pharmacists providing the service will have satisfactorily completed the following courses/training from the Centre for Pharmacy Postgraduate Education (CPPE):
  - "Responding to minor ailments (2008)"; or
  - "Minor ailments services: a starting point for pharmacists (2009)"; or
  - Have attended a workshop organised by NHS Haringey

- The pharmacist must ensure all pharmacy staff have been trained

- The pharmacist must keep up-to-date with their continued professional development

- The pharmacy should have:
  - The relevant policies in place including data protection, record keeping and audit
  - A standard operating procedure for the service
  - A sufficient level of privacy e.g. consultation area

C. The Evidence base

Evidence has demonstrated that pharmacy-based Minor Ailment services can improve health outcomes and be cost effective:

- One study demonstrated improved access to medicines and provided greater choice in primary care for patients with minor illness[11]

- A systematic review[12] including one randomised trial showed the following benefits:
  - Symptom resolution in 68-94% of patients
  - Less than a quarter of patients went to their GP after the index consultation
  - Between 47%- 92% of people would have seen their GP, if no pharmacy scheme had been available
  - Over 90% were satisfied with their experience and would re-use the pharmacy based service
  - Areas with high levels of deprivation, may benefit from the pharmacy-based service[13]

D. The Current picture

88% (52/59) pharmacies have been commissioned to provide the minor ailments service. Of these, 41% (24/59) are accredited to supply antibiotics under a patient group direction. All of the pharmacies which aren't commissioned to provide the service said that they would be willing to do so in the future.

The table below provides a summary of service provision by locality and map 10 (appended in a separate document) provides an overview of the distribution of pharmacies against a background of deprivation. This has been used as a proxy of pharmaceutical need.

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	14	12	12	14	52
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	24.1	16.1	25.0	16.3	19.5
No. of active pharmacies (2013/14)	12	11	10	11	44
Active pharmacies per 100,000 population	20.7	14.8	20.8	12.8	16.5

The map demonstrates that there is good access in all areas of deprivation, where this service is likely to be in more demand. The Central and SE Tottenham Locality are well resourced.

44 (out of the 52 pharmacies) were active in 2013/14. All localities had at least one inactive pharmacy. The pharmacies in the West are the least active, however, this locality tends to be more affluent than other areas of Haringey, and the lower activity is likely to be a reflection of lower demand.

The table (on the next page) provide an overview of the service availability and distribution on different days each week. It shows there is good access to the minor ailments services (and reasonable access to those which supply medicines under PGD) in all 4 Localities, on weekdays between 9:30am and 6pm and on Saturdays between 10am and 1pm.

Access, and choice, outside of these opening hours is more reduced particularly on weekday mornings up until and including 8am (with no pharmacies open in the Central Locality) and on Saturday evenings and Sundays.

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ The service is open to all Haringey residents, irrespective of age. However, in the case of those who are aged under 16, the pharmacy needs to assure itself that the child is capable of providing consent through application of Fraser Guidelines; alternatively, the service may be accessed via a parent or guardian
Disability	✓	▪ Services and advice need to be tailored to meet the needs of those with learning disabilities and cognitive impairment
Gender	×	▪ No specific needs identified
Race	✓	▪ Language may be a barrier to delivering the service successfully
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ The suitability of medication for use in pregnant and/or breast feeding women needs to be considered
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

Locality	Ward	No. of Pharmacies Offering the Minor Ailments Service*									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	3 (2)	2 (1)	0	0	2 (1)	1	0	0	0 (1)
	Harringay	0	1 (1)	0	0	0	1 (1)	0	0	0	1 (1)
	Noel Park	0	7 (5)	3 (3)	2	0	5 (4)	4 (4)	2 (2)	3 (3)	0 (2)
	Woodside	0	3 (1)	2	0	0	3 (1)	3 (1)	1	0	0 (2)
NE Tottenham	Bruce Grove	0	3 (1)	2	0	1 (1)	3 (1)	3 (1)	0	0	0 (2)
	Northumberland Park	0	4 (1)	4 (1)	0	0	3 (1)	3 (1)	0	0	0 (3)
	Tottenham Hale	0	2 (1)	1	0	0	1	1	1	0	1 (2)
	White Hart Lane	1 (1)	3 (2)	1 (1)	2 (1)	0	3 (2)	1 (1)	1 (1)	1 (1)	0 (1)
SE Tottenham	Seven Sisters	1	3 (2)	2 (1)	2 (2)	0	2 (1)	1	1	1	0 (1)
	St Ann's	0	4 (1)	3 (1)	1	1	3 (1)	3 (1)	1 (1)	1 (1)	1 (4)
	Tottenham Green	1 (1)	5 (3)	4 (2)	0	0	5 (3)	2 (1)	2 (1)	2 (1)	0 (2)
West	Alexandra	0	1	1	0	0	1	0	0	0	0 (1)
	Crouch End	0	4	3	0	0	4	4	1	2	1 (5)
	Fortis Green	0	2 (1)	2 (1)	0	0	2 (1)	1	1	1	0 (1)
	Highgate	0	0	0	0	0	0	0	0	0	2 (2)
	Hornsey	0	1	0	0	0	1	0	0	0	1 (2)
	Muswell Hill	2 (2)	5 (3)	2 (2)	0	0	5 (3)	5 (3)	2 (2)	2 (2)	0 (2)
	Stroud Green	0	1	0	0	0	1	1	0	0	0 (1)
Total - Haringey		**5 (4)**	**52 (24)**	**32 (13)**	**7 (3)**	**2 (1)**	**45 (20)**	**33 (13)**	**13 (7)**	**13 (8)**	**7 (35)**
Percentage of the Total		**8% (7%)**	**88% (41%)**	**54% (22%)**	**12% (5%)**	**3% (2%)**	**76% (34%)**	**56% (22%)**	**22% (12%)**	**22% (14%)**	**12% (59%)**

* The figure in (brackets) denotes the number of pharmacies which are accredited to supply medicines under PGDs

CONCLUSIONS ON MINOR AILMENTS SERVICE

The minor ailments service aims to encourage people who are registered with a Haringey GP to use pharmacy services as the 'first port of call' for the management of self-limiting conditions. As such it improves access to primary care and potentially reduces unnecessary visits to GP practices and unscheduled care providers

We have determined that the service **is necessary to meet the pharmaceutical needs** of our population for the following reasons:

- The service is only available from community pharmacies
- Published evidence demonstrates that minor ailments services are cost effective, can improve health outcomes as well as improving access to healthcare expertise
- It supports our local strategic priorities in that it reduces demand and frees up GP capacity and attendance at unscheduled care providers

52 pharmacies are commissioned to provide the service; of these 24 are accredited to supply prescription only medicines under a PGD.

There is good access to the service, and a choice of pharmacy, on weekdays (9:30 - 6pm) and on Saturday mornings (10am - 1pm).

We have identified the following gaps:

- Reduced access to the service on weekday mornings (including no pharmacies open in the Central Locality before 9am) and on Saturday evenings and Sundays. This means that residents may have to travel further to access this service at these times. This may be more of an issue at the weekend as GP surgeries are closed and our residents may be more reliant on the pharmacy-based minor ailments service

- A number of pharmacies in some localities are not active. This may be a reflection of local demand, but we need to understand the full reasons behind this to ensure that residents who need to access this valuable service are able to do so

Current Need and Future Need

- None identified

Current & Future Improvements or better access

- We would like to see improved access to the service, in the early mornings and at weekends, particularly in areas with higher deprivation where there may be a greater demand for the service

- Better advertising of the service, would raise awareness and may increase uptake (where this is clinically appropriate)

5.12.2. London Pharmacy Vaccination Service

A. Overview

The aim of immunisation programmes is to minimise the health impact of disease through effective prevention of cases.

The London Pharmacy Vaccination Service has been established with the aim of delivering population-wide, evidence based immunisation programmes with a view to:

- Ensuring timely delivery of immunisations to achieve optimum coverage for the target population
- Promote a choice of provider for patients and facilitate the "Every Contact Counts" approach by offering co-administration opportunities where an individual is eligible for two or more vaccinations under different immunisation programmes
- Improving access to vaccination services

- Addressing the historically low uptake of seasonal influenza vaccination by those aged under 65 who fall into an 'at risk' group and those aged 65+

The scope of the service currently includes the following portfolio from September 2014 - March 2015

- Pneumococcal polysaccharide vaccination
- Seasonal Influenza vaccination

Pharmacies participating in the service are expected to work in partnership with local GPs to identify and encourage those that have failed to attend previous vaccination appointments.

B. Provider Criteria

Pharmacies must demonstrate that they meet the following criteria in order to provide the service:

- The pharmacy must have a designated consultation area or alternative premises that meet specific criteria including workspace & infection control arrangements
- The service must be provided by an accredited pharmacist working under the NHS England Core PGD for Administration of 2014/15 Vaccinations, as well as individual PGDs for the pneumococcal and seasonal influenza vaccinations
- A Declaration of Competences for Vaccination Services (the London Service); including CPPE materials on Immunisations and basic life support training must be completed
- Pharmacists must attend relevant study days/courses, keeping up to date with clinical literature
- Pharmacists must be aware of the need to have hepatitis B vaccination
- Standard operating procedures must be available which cover all elements of the service
- All pharmacy staff must be trained on the operation of the scheme, with full details available for locum pharmacists

C. The Evidence Base

A literature review[14] of community pharmacy delivered immunisation services demonstrates:

- Immunisation can be safely delivered through community pharmacy
- Pharmacy patient medication records are effective at identifying 'at risk' clients to be invited for immunisation and this can increase uptake of vaccine
- User satisfaction with pharmacy based services is high
- Support for non-physician delivered immunisation is greater for adults than children

In 2011/12, pharmacies in one area used 'PharmOutcomes' to record seasonal influenza vaccinations and notify GP colleagues[15]:

- 4,192 people were vaccinated (approximately 15% of total vaccinated)
- 35% were under 65 and in 'at risk' groups (other providers vaccinated 17% in this category)
- 19% of patients stated vaccination was unlikely without pharmacy access
- 97% rated the service as 'excellent'
- 13% of patients cited difficulties in obtaining the vaccine from other providers

D. Current Picture

In Haringey, 61% (36/59) of pharmacies have been commissioned to provide the London Pharmacy Vaccination Service.

The table below provides a summary of service provision by locality. It shows that the SE Locality is particularly well resourced; and that the other localities are around the Haringey average in terms of the number of pharmacies per 100,000.

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	7	9	9	11	36
Population*	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	12.1	12.1	18.8	12.8	13.5

Map 11 (appended in a separate document) provides an overview of the distribution of pharmacies against a background of the number of people aged 65+. This has been used as a proxy of pharmaceutical need (although it is acknowledged that this does not represent pharmaceutical need for people aged 64 years and under and are 'at risk'. The map demonstrates that there is a reasonable correlation between pharmacies providing the service in all localities apart from Highgate (West Locality); this ward has a high number of people aged 65+ but residents within the ward may have to travel more than 2 miles to access the service.

The table (next page) provides an overview of service availability on different days each week.

There is very good access on weekdays (9.30am- 6pm) and on Saturday (up until 5pm) with at least one pharmacy providing this service in all wards, except for the wards of Harringay (Central locality) and Highgate (West locality).

Outside of these hours, access and choice is more limited, particularly:

- In the mornings (up until and before 8am), when there only two pharmacies offering the service are open (one in SE Tottenham and the other in the West Locality)
- On Sundays the service is very limited with no service at all in the NE Tottenham locality

Non-pharmacy providers include GPs and community nurses.

F. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Service available to those over 65 and under 65 in at risk groups. Haringey historically does not achieve the national target of 75% in either group and vaccination rates of below the London and England average. People of working age may wish to access the service outside of normal working hours on weekdays or at weekends.
Disability	✓	▪ Pharmacy-based services may be more accessible and convenient for people with a physical disability
Gender	×	▪ No specific needs identified
Race	✓	▪ BAME people are more likely to be in the "at risk" groups
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ The service is available to women who are pregnant; historically vaccination rates in this group are below the London and England average.
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

Locality	Ward	No. of Pharmacies Offering the London Pharmacy Vaccine Service									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	2	2	0	0	1	1	0	0	1
	Harringay	0	0	0	0	0	0	0	0	0	2
	Noel Park	0	3	2	1	0	3	2	2	2	4
	Woodside	0	2	1	0	0	2	2	1	0	1
NE Tottenham	Bruce Grove	0	2	2	0	0	2	2	0	0	1
	Northumberland Park	0	3	3	0	0	2	2	0	0	1
	Tottenham Hale	0	2	1	0	0	1	1	1	0	1
	White Hart Lane	0	2	0	2	0	2	0	0	0	1
SE Tottenham	Seven Sisters	0	2	1	2	0	1	0	0	0	1
	St Ann's	0	3	3	0	0	2	2	1	1	2
	Tottenham Green	1	4	3	0	0	4	1	1	1	1
West	Alexandra	0	1	1	0	0	1	0	0	0	0
	Crouch End	0	3	2	0	0	3	3	1	2	2
	Fortis Green	0	1	1	0	0	1	1	1	1	1
	Highgate	0	0	0	0	0	0	0	0	0	2
	Hornsey	0	1	0	0	0	1	0	0	0	1
	Muswell Hill	1	4	1	0	0	4	4	1	1	1
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**2**	**36**	**23**	**5**	**0**	**31**	**22**	**9**	**8**	**23**
Percentage of the Total		**3%**	**61%**	**39%**	**8%**	**0%**	**53%**	**37%**	**15%**	**14%**	**39%**

CONCLUSIONS ON LONDON VACCINATION SERVICE

The London Pharmacy Vaccination Service aims to improve timely access to key immunisations with a view to addressing historically low vaccination rates and protecting the health of the population.

We have determined that the service is not necessary to meet the pharmaceutical needs of our population but is relevant in that it **secures improvements in access and a choice of provider**:

- Community pharmacies are one of a range of providers which can offer vaccinations
- Published evidence has demonstrated that pharmacy based immunisation services are effective, safe and are associated with high user satisfaction
- It supports our local strategic priorities in that it reduces demand and frees up GP capacity and attendance at unscheduled care providers

36 pharmacies have been commissioned to provide the new vaccination service.

Access is very good on weekdays and Saturdays up to 5pm in all localities; and there is a choice in all four localities. Outside of these times, access more limited.

We have identified that service provision does not necessarily align with need in the West Locality.

Current and Future Need

- None identified

Current Improvements or better access

- Commissioning the service from additional pharmacies, particularly in the West Locality where current provision does not necessarily align with need. This would improve access to the service and may address historically low uptake of seasonal influenza vaccination in all at risk groups.

Future improvements or better access

- None identified

5.12.3. On Demand Access to End of Life Care and Specialised Medicines service

A. Overview

In Haringey, there is an aim to increase choice for people nearing the end of their life, with respect to where they are cared for and where they die.

This pharmacy-based service is intended to improve timely access, during extended hours to palliative care and specialist medicines that are not commonly stocked by pharmacies; or where there are anticipated delays in supplies.

During working hours, it is anticipated that prescriptions should be presented at any local community pharmacy and that the “on demand” pharmacies provide support in emergency situations and where a local community pharmacy cannot access a prescribed medicine(s) within an appropriate timescale.

In addition to supplying end of life care and specialist medicines, the pharmacies are required to provide information and advice as appropriate to users, carers and/or clinicians as required. Pharmacies may also refer on to specialist centres, support groups and other health or social care professions where necessary.

The service aims to facilitate the management of patients in a community setting and reduce the need for inappropriate admissions to hospital, particularly during the last few weeks of a patient’s life.

B. Provider Criteria

Pharmacies providing the service are required to meet the following criteria:

- The pharmacy needs to open for extended hours, have good accessibility and parking facilities
- The pharmacy must guarantee to stock the agreed formulary of commonly prescribed medicines, which is sufficient to meet the majority of "urgent" requests
- The pharmacist has a duty to ensure that all pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service; this includes locum pharmacists
- Standard operating procedures must be in place and regularly reviewed (minimum annually)
- The pharmacy must be able to demonstrate that pharmacists and staff have undertaken relevant CPD e.g. CPPE training on Palliative Care
- All participating Community Pharmacies must attend any local update events on request
- To liaise with the prescriber re patient needs
- The pharmacy agrees to hold the specified list of medicines required to deliver this service and will dispense these in response to NHS prescriptions presented

C. The Evidence base

Evidence exists to support the use of pharmacies to provide palliative care services (noting that the scope of studies potentially goes beyond that of this service):

- The introduction of a 24-hour community pharmacy scheme for palliative care was generally praised[16]

- An evaluation of effectiveness of UK community pharmacist interventions in community palliative care was undertaken. Most of the clinical interventions, made by the community pharmacists for palliative pharmaceutical care, were judged by the expert panel as being likely to be beneficial. The result supports the view that when community pharmacists are appropriately trained and included as integrated members of the team, they can intervene effectively to improve pharmaceutical care for palliative care patients[17]

- A review of palliative care pharmacists in a retail-based ambulatory care setting was undertaken. Initial results demonstrate the success of this pilot programme[18]

D. The Current Picture

Four pharmacies (4/59), one in each locality, have been commissioned to provide the service.

The table below provides an overview of service availability on different days of the week:

			Opening Hours		
Locality	**Pharmacy**	**Post code**	**Monday - Friday**	**Saturday**	**Sunday**
Central	Pharmacy Express	N22 8HH	09:00 - 18:30	09:00 - 17:00	Closed
NE Tottenham	Phillips Chemist	N17 6XF	09:00 - 18:30	09:00 - 17:00	Closed
SE Tottenham	Boots	N15 4QD	09:00 - 19:00	09:00 - 19:00	11:00 - 17:00
West	Hornsey Central Pharmacy	N8 8JD	07:00 - 22:00	07:00 - 22:00	09:00 - 19:00

The data demonstrates that residents can access the service from 7 am through to 10pm at night on Monday to Saturday; and for extended periods on Sundays. Given the service is intended as a back up to using the local pharmacy then this coverage may be considered reasonable, although opening hours on a Sunday in Central and NE Tottenham would be considered desirable.

Barndoc, the GP Out of Hours Provider, carries an identical formulary to the "on demand" pharmacies and is able to provide access to key medicines in the out of hours period.

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ People of all ages may need to access end of life and specialist medicines
Disability	×	▪ No specific needs identified. All the pharmacies providing the service are fully accessible to wheelchairs
Gender	×	▪ No specific needs are identified
Race	✓	▪ Language may be a barrier to providing advice on medicines
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ Pharmacies may be required to provide advice on the use of medicines in pregnancy and for women who are breast feeding
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

CONCLUSIONS - "ON DEMAND ACCESS TO END OF LIFE AND SPECIALIST MEDICINES"

The on-demand access to end of life and specialist medicines service provides a back-up service to ensure people can access the medicines they need, in a timely manner, when their local community pharmacy is unable to supply

We have concluded that the service is not necessary to meet the pharmaceutical needs of our population **but is relevant in that it improves timely access to palliative care medicines**:

- The service may only be accessed through community pharmacies during the 'in-hours' period and is intended as a 'back up' service (as opposed to a 'first port of call')
- There is some published evidence demonstrates that community pharmacies play a valuable role in delivering palliative care services and improving access to medicines
- It supports our local strategic priorities in that it potentially reduces attendance at unscheduled care providers and may reduce admission to hospital
- Such a service is essential to limit suffering and stress in very distressing circumstances

There is a pharmacy in each locality providing the service and this can be accessed for extended hours every day of the week. Whilst residents may have to travel further to access the service in the early morning or later in the evenings, the coverage provided is reasonable because this is a back-up service. In terms of gaps, two of the pharmacies are not open on a Sunday.

Barndoc, the GP Out of Hours Provider, provides access to key these medicines in the out of hour's period.

Current and Future Need

- None identified

Current & future Improvements or better access

- Improvements in access could be secured if the service commissioned from pharmacies which are open for extended hours on 7 days each week.

6. Locally Commissioned Services

In this section, the PNA considers those services commissioned from Haringey Pharmacies, by another NHS organisation or the Local Authority, and which may affect the need for pharmaceutical services.

- In undertaking our assessment, we have adopted a structure and approach similar to that used for pharmaceutical services. This includes setting out where we believe there are current and future gaps and identifying areas for further improvement

- We have also found it helpful to consider whether or not a locally commissioned service is necessary to meet a pharmaceutical need; or if we believe the service is relevant in that it delivers improvements in access or choice

- It should be noted that applications **must relate to pharmaceutical services** (i.e. essential, advanced and/or enhanced services) and should not be submitted on the basis of gaps or needs identified for locally commissioned services.

6.1. Healthy Living Pharmacy Programme

In Haringey, we have recognised the increasing potential for health improvement programmes to be delivered through community pharmacies.

We have made a strategic decision to roll out the Healthy Living Pharmacy (HLP) programme approach as a foundation upon which to commission the delivery of a range of public health services. In the first instance, the stop smoking service and the over 25s sexual health service are being commissioned through the HLP framework.

The HLP Programme aims to create an ethos which puts the local community's health and wellbeing at the heart of everything the pharmacy team does; it supports reducing health inequalities and preventing ill health by:

- Promoting healthy living
- Providing wellbeing advice and services
- Supporting people to self-care and manage long-term conditions

To achieve status as a Healthy Living Pharmacy, the pharmacy must demonstrate achievement of the following criteria:

- **Leadership:** At least one member of the management team must have completed a specific HLP leadership programme

- **Health Champion:** Appoint a least one non-pharmacist health champion, who must have successfully completed the Royal Society for Public Health "Understanding Health Improvement" Level 2 (UHI2) award; and be familiar with health promotion campaigns and literature

- **Premises:**
  - Must reflect a professional image and promote healthy living
  - Be welcoming, clean and in good state of repair; with positive signage in place
  - Posters & promotional material should be current
  - Health related promotion materials, products and services must be clearly differentiated from other activities
  - The consultation area should have space for a chaperone and a computer terminal

A number of community pharmacies are currently working towards HLP status.

6.2. Public Health Services

A range of public health services are currently commissioned from community pharmacies in Haringey:

- Stop Smoking in Healthy Living Pharmacies Service
- Sexual Health Services
- Needle & Syringe Programme

- Supervised Consumption of Subutex and Methadone
- Healthy Start Vitamins service

These services are either directly commissioned by the London Borough of Haringey or are sub-contracted via a Prime Contractor.

6.2.1. Stop Smoking in Healthy Living Pharmacies Service

A. Overview

In Haringey, smoking cessation is the most important lifestyle programme in reducing mortality, morbidity and health inequalities over the next 20 years. Within 15-20 years of stopping smoking, the risk of lung cancer is almost the same as the risk for people who have never smoked. The reduction in risk for cardio-vascular disease (CVD) is particularly rapid, with the risk falling within a year or so.

A new service, the “Stop Smoking in Healthy Living Pharmacies”, has been commissioned from Haringey pharmacies from the 1 October 2014.

The pharmacy-based service, which at the time of writing is being piloted, focuses on pharmacies:

- Offering very brief advice (VBA)
- Providing one to one support to local residents who want to give up smoking. This is part of an 8 week programme providing behaviour support and including the supply of nicotine replacement therapy (NRT) or varenicline via a patient group direction where required
- Undertaking appropriate promotion of the service locally
- Providing health promotion material/Smoke free resources relevant to patients’ needs.
- Referring on to specialist stop smoking services, currently provided by Solutions4Health. People who require specialist support include: pregnant women, people with COPD, those living with severe mental illness, those with co-morbidities, people using smokeless tobacco and those with higher levels of dependence
- Offering the service to those under the age of 16 if at least one advisor meets the requirements for providing a service to young people

The aim and intended outcomes of the service include:

- Improving access to and choice of stop smoking services
- Reducing smoking related illnesses and deaths by helping patients to give up smoking
- Improving the health of the population by reducing exposure to second hand smoke
- Supporting patient access to additional treatment by offering referral to specialist services
- Reducing health inequalities

B. Provider Criteria

To be eligible to provide the service pharmacies must meet the following criteria:

- The pharmacy must achieve status as a Healthy Living Pharmacy
- The pharmacy must have an area which provides a sufficient level of privacy and safety
- The pharmacy is responsible for the ownership, calibration, maintenance and, where necessary, replacement of all CO monitoring equipment and consumables
- All staff delivering the stop smoking service must have successfully completed the National Centre for Smoking Cessation and Training’s online training and assessment for level 1 advisors (www.ncsct.co.uk/).
- Refresher and follow up training must be attended annually by at least one Stop Smoking Advisor who will cascade the messages to other members of the pharmacy
- All staff involved in the provision of the Stop Smoking service must have relevant knowledge and are appropriately trained in the operation of the service in accordance with the local protocols and relevant NICE guidance
- Verify 4 week quits using a carbon monoxide monitor
- A standard operating procedure must be put in place and be updated, along with referral pathways, on a quarterly basis
- The pharmacy must maintain appropriate and accurate records to ensure effective ongoing service delivery and audit

C. The Evidence Base

There is good evidence to support the role of community pharmacists in stop smoking services[14, 19]:

- Studies have demonstrated the effectiveness and cost effectiveness of stop smoking services, provided by trained pharmacy staff, in improving quit rates
- Community pharmacists trained in behaviour-change methods are effective in helping clients stop smoking. Training increases knowledge, self-confidence and the positive attitude of pharmacists and their staff in relation to smoking cessation.
- Involving pharmacy support staff may increase the provision of brief advice and recording of smoking status in patient medication records
- Abstinence rates from one-to-one treatment services provided by community pharmacists versus primary care nurses are similar

D. The Current Picture

41% (24/59) pharmacies have been commissioned to provide the pharmacy-based smoking cessation service.

The table below provides a summary of service provision by locality and map 12 (appended in a separate document) provides an overview of the distribution of pharmacies. The MOSAIC Index Score of likelihood of being a heavy smoker has been used as the background, as a proxy of need.

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	5	6	6	7	24
Population*	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	8.6	8.0	12.5	8.2	9.0

The map shows a reasonable correlation of service provision and need.

The table (on the next page) and provides an overview of the service availability and distribution on different days each week and shows good access to the service on weekdays (9.30am – 6pm) and on Saturdays (10am – 1pm).

Outside of these hours, access and choice is more limited particularly on:

- Weekday mornings (up until and including 8am), when the service is only available from two pharmacies; one in SE Tottenham and the other in the West Locality
- Saturday afternoons and evenings
- Sundays, noting that the service is not available from any pharmacies in the NE Tottenham locality, which is an area with potentially high need

We have not reviewed activity data as the service is newly commissioned.

Non-pharmacy providers include General Practices and specialist stop smoking services via Solutions 4 Health, as part of the newly established integrated system for reducing smoking in Haringey. A mobile service is to be introduced to provide access in areas where gaps in service have been identified.

Locality	Ward	No. of Pharmacies Offering the Stop Smoking Service									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	1	0	0	0	1	0	0	0	2
	Harringay	0	0	0	0	0	0	0	0	0	2
	Noel Park	0	3	2	0	0	3	3	1	2	4
	Woodside	0	1	0	0	0	1	1	0	0	2
NE Tottenham	Bruce Grove	0	1	1	0	0	1	1	0	0	2
	Northumberland Park	0	2	2	0	0	1	1	0	0	2
	Tottenham Hale	0	1	0	0	0	0	0	0	0	2
	White Hart Lane	0	2	0	2	0	2	0	0	0	1
SE Tottenham	Seven Sisters	0	1	0	1	0	0	0	0	0	2
	St Ann's	0	1	1	0	0	1	1	0	0	4
	Tottenham Green	1	4	3	0	0	4	2	2	2	1
West	Alexandra	0	1	1	0	0	1	0	0	0	0
	Crouch End	0	2	1	0	0	2	2	1	2	3
	Fortis Green	0	1	1	0	0	1	1	1	1	1
	Highgate	0	0	0	0	0	0	0	0	0	2
	Hornsey	0	1	0	0	0	1	0	0	0	1
	Muswell Hill	1	1	1	0	0	1	1	1	1	4
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**2**	**24**	**13**	**3**	**0**	**21**	**14**	**6**	**8**	**35**
Percentage of the Total		**3%**	**41%**	**22%**	**5%**	**0%**	**36%**	**24%**	**10%**	**14%**	**59%**

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ In Haringey, there is a correlation between age (and gender) and the consequences of smoking suggesting that there are opportunities to proactively target services at specific segments of the population e.g. men aged 55 - 70 (who account for the largest proportion of smoking related hospital admissions) & women aged 35 - 64 years (who account for a high proportion of lung cancer. The JSNA notes the need to target stop smoking services at younger adults who do not tend to access services
Disability	✓	▪ Services and advice need to be tailored to meet the needs of those with learning disabilities and cognitive impairment and people within these groups may benefit from referral on to specialist services
Gender	×	▪ See age above.
Race	✓	▪ Language may be a barrier to delivering the service successfully. BAME communities are more susceptible to long term conditions e.g. CVD, diabetes which may be exacerbated by smoking. The JSNA notes the need to target stop smoking at BAME groups.
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ Pregnant women / mothers with children. Both themselves and family members would benefit. Referral to specialist services is required
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

CONCLUSIONS ON THE STOP SMOKING SERVICE

Stop smoking services are vital with respect to reducing the health consequences and inequalities associated with smoking. They are a priority for Haringey given the high prevalence of smoking, particularly in some of the more deprived areas and the health consequences in specific groups of the population (e.g. lung cancer, smoking related admissions and higher than average prevalence of COPD in those under 75 years).

We have concluded that the service is **necessary to meet the pharmaceutical needs of our population**:

- There is good evidence to support community pharmacy-based stop smoking services. Pharmacy services are beneficial in that medication to support a quit attempt may be supplied at the point of consultation
- Whilst pharmacy is one a range of providers for this service, the pharmacy-based service offers benefits over the other services in terms of access (including availability during extended hours and at weekends in some localities)
- The service also supports us with meeting our strategic priorities around CVD, cancer and COPD.

Access to and choice of services on weekdays (9:30am - 6pm) and Saturdays (10am - 1pm) is generally reasonable in all localities. However, we have identified the following potential gaps:

- Reduced access to the service on weekday mornings, Saturday afternoons and evenings and Sundays; noting that these are times when the working population within Haringey may wish to access the service

- No access to the service at all in NE Tottenham on a Sunday; this locality has high rates of deprivation and a population that stands to benefit from stop smoking services

Current and Future Needs

- None identified

Current & Future Improvements or better access

- We would like to see the service commissioned from a wider range of pharmacies in order to improve access, in the early mornings and at weekends; this may encourage the working population to seek support at a time which is convenient to them. In addition, this would improve access in those localities where there is a higher smoking prevalence rate and/or demand for the service i.e. the Central Locality, NE Tottenham and SE Tottenham. It should be noted that the GP based services and the mobile service will also help to improve access to stop smoking services for our residents.

6.2.2. Sexual Health Services

A. Overview

It is recognised nationally that in order to improve the sexual health of a population and to reduce teenage conceptions, a local area should commission a variety of interventions from a variety of providers to increase access to sexual health services. Community pharmacists are viewed as an effective provider for prevention and early intervention in improving sexual health.

The community pharmacy based sexual health service has recently been re-commissioned in Haringey and is comprised of two bundles:

- Services for young people aged 24 years and under
- Services for people aged 25 years and over

The table below summarises the service scope for each bundle, noting that pharmacies will adopt an "Every contact counts" approach so that service users are offered all relevant service elements irrespective of their original reason for accessing the sexual health service.

Service Element	Under 25s	25 years and Over
Emergency Hormonal Contraception (EHC)	Supply, and supervised administration on the pharmacy premises, of Levonorgestrel 1.5mg EHC, where appropriate, to female clients aged 13 - 24, in line with the requirements of the Patient Group Direction	Supply, and supervised administration on the pharmacy premises, of Levonorgestrel 1.5mg EHC, where appropriate, to female clients, in line with the requirements of the Patient Group Direction
Chlamydia and Gonorrhoea screening	Chlamydia & gonorrhoea testing, including supply of postal kits to young people aged 15 - 24 years as part of the national screening programme. Includes providing support with completing the form and labels; information on how test results will be communicated; and treatment options for the service user, and their partner(s), in the event of a positive test	Supply of chlamydia & gonorrhoea testing kits (includes encouraging those who have attended for EHC to participate). Includes providing support with completing the form and labels; information on how test results will be communicated; and treatment options for the service user, and their partner(s), in the event of a positive test
Chlamydia treatment	Supply of azithromycin, under a patient group direction, to service users who have screened positive for chlamydia. Service users will be encouraged to take the treatment in the pharmacy. In addition, details of all partners/sexual contacts will be recorded as part of the consultation	Supply of azithromycin where indicated, under a patient group direction, to service users who have screened positive for chlamydia. Service users will be encouraged to take the treatment in the pharmacy. In addition, details of all partners/sexual contacts will be recorded as part of the consultation
Condom distribution	Condom Distribution (Come Correct C-Card Scheme) including registration and repeat encounters for condom supply to young people aged 13 – 24	Free, open access provision of condoms for adults who are resident of London Borough of Haringey. Pharmacies are required to register and distribute condoms as part of the HLP

Service Element	Under 25s	25 years and Over
HIV point of care testing	***Not applicable***	HIV POCT will be promoted and offered to service users either through direct request by the service user or through opportunistic engagement when the service user requests a Chlamydia/Gonorrhoea test or EHC. It should be noted that people aged 18 years and above may access this service element.
Health Promotion advice	Provide health promotion advice (verbal & written) as relevant to service users and in accordance with the service specification e.g. the avoidance of pregnancy and STIs through safer sex and condom use, advice on the use of regular contraceptive methods	
Signposting	Pharmacies are required to signpost to other services as relevant to the service user e.g. to services which provide long-term contraceptive methods; diagnosis and management of STIs etc	

The key objectives and outcomes for the service include:

- Reduce teenage pregnancy
- Reduce unplanned pregnancy
- Reduce the prevalence of Chlamydia and Gonorrhoea
- Reduce the transmission of sexually transmitted infections (STIs) including HIV
- Promote good sexual health and healthy lifestyle choices
- Promote access to other contraception and sexual health services

B. Provider Criteria

To be eligible to provide the service pharmacies must meet the following criteria:

- Healthy Living Pharmacy status, must be achieved, to provide the over 25s sexual health bundle

- Pharmacists must have passed an advanced Disclosure & Barring screen (DBS)

- The pharmacist will have satisfactorily completed the following training courses:
  - Centre for Pharmacy Postgraduate Education (CPPE) workshop/distance learning course on EHC
  - Pharmacists must attend Child Protection training provided by Haringey Council and/or complete the CPPE course in child protection
  - Pharmacists must attend any locally arranged training/workshop organised by Haringey Council
  - Pharmacists must attend training on the use of Chlamydia and gonorrhoea testing kits and treatment of Chlamydia under a Patient Group Direction (PGD), as organised by Haringey Council
  - Pharmacists must attend any other relevant training provided by Haringey Council
  - **For pharmacies offering the over 25s bundle,** the HLP pharmacist and/or designated HIV POCT facilitator (i.e. HLP Healthy Champion) MUST have completed all relevant training for delivering the HIV POCT service; and be familiar with the care pathway procedure for supporting and referring patients for additional clinical and social/emotional support were necessary

- Any other pharmacy staff promoting or delivering any element of the service must be DBS checked and attend child protection and other Council provided training

- The pharmacy must designate window space for a window sticker and/or poster advertising the availability of the service from that pharmacy and is required to provide written information (supplied by Haringey Council) about Chlamydia, Gonorrhoea, and other STIs, plus details of local sexual health services

- The pharmacy must maintain written records and must use the PharmOutcomes proforma for EHC and chlamydia treatment consultations

- The pharmacy must ensure that it complies with Fraser guidance and Department of Health guidance on confidential sexual health and treatment for young people aged under 16

C. The Evidence Base

The effectiveness of Sexual Health Services at improving outcomes and reducing chlamydia infections and unwanted pregnancies has been demonstrated in studies:

- Over 14,000 Chlamydia tests were administered in one private pharmacy over 2 years; private and NHS services improve choice for patients[20]
- Community pharmacy-based chlamydia testing and treatment services increase client access[14]
- EHC services provide timely access, with most women are able to receive it within 24 hours of unprotected intercourse[19, 21]
- EHC services (including supply against prescription, under PGDs or over the counter sales) are highly rated by women who use them[19,21]
- There has been a steady decline in teenage pregnancy since the first EHC service was established in 1999, but it is not possible to separate out the contribution of the community pharmacy service[22]
- Evidence of EHC impact is generally lacking, although one randomised controlled trial noted fewer A&E visits[23]. A Scottish Government review concluded the service was useful, especially in rural areas, but it would benefit from better skill mix, referrals, links to contraception advice and pregnancy testing[24]
- 10% of women choose pharmacy supply of EHC to maintain anonymity. Some women prefer to use town centre pharmacies as these offer a greater sense of anonymity compared to more 'local' pharmacies[14]

Our literature review did not yield any specific evidence on the benefits of pharmacy-based condom distribution schemes.

D. The Current Picture

a. Under 25s bundle

42% (25/59) pharmacies have been commissioned to provide the under 25s bundle of sexual health services.

The table below provides a summary of service provision by locality. Maps 13 and 14 (appended in a separate document) provide an overview of the distribution of pharmacies providing the service taking into account relative need based on the number of people aged 15 - 25 years (i.e. the age range for the national chlamydia screening programme); and the number of females aged 13 - 24 (i.e. the segment of the population who are eligible to access EHC under the service). Both maps demonstrate a good correlation between need and service provision.

Under 25s	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	8	4	6	7	25
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	13.8	5.4	12.5	8.2	9.4

The table on the next page provides an overview of service availability and distribution on different days each week. It shows good access, and a choice of pharmacy, in all localities on weekdays (9:30am - 6pm) and Saturday (10am - 1pm). This includes areas with highest teenage pregnancy rates (2009-11) i.e. NE Tottenham locality (Bruce Grove), SE Tottenham Locality (Tottenham Green wards) and Central locality (Harringay ward), where residents of these wards have access to at least one pharmacy within their own ward and further choice in neighbouring wards.

However, outside of these hours, service availability is more limited particularly on:

- Weekday mornings, up until and including 8am, when only one pharmacy (located in Muswell Hill, West Locality) is open

- Sundays, when the service is only available from 3 pharmacies; and there is no provision in NE Tottenham

b. Over 25s bundle

47% (28/59) pharmacies have been commissioned to provide the over 25s bundle of sexual health services. *It should be noted, that at the time of publication, the training and accreditation of pharmacies is ongoing but it is anticipated all pharmacies listed in Appendix E will be live by the end of June 2015.*

The table below provides a summary of service provision by locality; and map 15 (appended in a separate document) plots service provision against a background of the number of people aged 25 years and over as a proxy of potential pharmaceutical need.

Over 25s	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	8	7	6	7	28
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	13.8	9.4	12.5	8.2	10.5

The map demonstrates a reasonable correlation between pharmacy service provision and need. However, there are areas within the West Locality, which have a number of people aged 25 years and over, where residents may have to travel more than a mile to access the service.

The table (next but one page) provides an overview of the service availability and distribution on different days each week. As with the under 25s bundle service, there is good access in all localities on weekdays (9:30am - 6pm) and Saturday (10am - 1pm), but more limited service availability at other times, particularly on:

- Weekday mornings, up until and including 8am, when only one pharmacy (located in Muswell Hill, West Locality) is open
- Saturday evenings up until 7pm or later when only 3 pharmacies offering the service are open across the borough; and no service within the NE and SE Tottenham Localities
- Sundays, when the service is only available from 5 pharmacies; and no provision within the NE and SE Tottenham Localities

There is a range of non-pharmacy providers. Full details, of pharmacy and non-pharmacy providers, are available via the following link http://www.haringey.gov.uk/sexualhealth

Locality	Ward	No. of Pharmacies Offering the Sexual Health Service - Under 25s Bundle									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	3	2	0	0	2	1	0	0	0
	Harringay	0	1	0	0	0	1	0	0	0	1
	Noel Park	0	3	1	1	0	3	2	1	1	4
	Woodside	0	1	0	0	0	1	1	0	0	2
NE Tottenham	Bruce Grove	0	2	2	0	0	2	2	0	0	1
	Northumberland Park	0	1	1	0	0	0	0	0	0	3
	Tottenham Hale	0	0	0	0	0	0	0	0	0	3
	White Hart Lane	0	1	0	1	0	1	0	0	0	2
SE Tottenham	Seven Sisters	0	1	1	1	0	1	0	0	0	2
	St Ann's	0	2	2	0	0	1	1	0	0	3
	Tottenham Green	0	3	2	0	0	3	1	1	1	2
West	Alexandra	0	1	1	0	0	1	0	0	0	0
	Crouch End	0	1	1	0	0	1	1	0	0	4
	Fortis Green	0	0	0	0	0	0	0	0	0	2
	Highgate	0	0	0	0	0	0	0	0	0	2
	Hornsey	0	2	1	0	0	2	1	1	0	0
	Muswell Hill	1	2	1	0	0	2	2	1	1	3
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**1**	**25**	**15**	**3**	**0**	**22**	**13**	**4**	**3**	**34**
Percentage of the Total		**2%**	**42%**	**25%**	**5%**	**0%**	**37%**	**22%**	**7%**	**5%**	**58%**

Locality	Ward	No. of Pharmacies Offering the Sexual Health Service - 25s & Over Bundle									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	3	2	0	0	2	1	0	0	0
	Harringay	0	0	0	0	0	0	0	0	0	2
	Noel Park	0	4	3	0	0	4	4	2	3	3
	Woodside	0	1	0	0	0	1	1	0	0	2
NE Tottenham	Bruce Grove	0	2	2	0	0	2	2	0	0	1
	Northumberland Park	0	2	2	0	0	1	1	0	0	2
	Tottenham Hale	0	1	0	0	0	0	0	0	0	2
	White Hart Lane	0	2	0	2	0	2	0	0	0	1
SE Tottenham	Seven Sisters	0	1	1	1	0	1	0	0	0	2
	St Ann's	0	2	2	0	0	1	1	0	0	3
	Tottenham Green	0	3	2	0	0	3	0	0	0	2
West	Alexandra	0	1	1	0	0	1	0	0	0	0
	Crouch End	0	2	1	0	0	2	2	0	1	3
	Fortis Green	0	1	1	0	0	1	0	0	0	1
	Highgate	0	0	0	0	0	0	0	0	0	2
	Hornsey	0	1	0	0	0	1	0	0	0	1
	Muswell Hill	1	1	1	0	0	1	1	1	1	4
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**1**	**28***	**18**	**3**	**0**	**24**	**14**	**3**	**5**	**31**
Percentage of the Total		**2%**	**47%**	**31%**	**5%**	**0%**	**41%**	**24%**	**5%**	**8%**	**53%**

* *It should be noted, that at the time of publication, the training and accreditation of pharmacies is ongoing. It is anticipated all pharmacies listed in Appendix E will be live by the end of June 2015. Full details, of pharmacy and non-pharmacy providers, are available via the following link*
http://www.haringey.gov.uk/sexualhealth

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ Young people are at higher risk of poor sexual health. Pharmacy-based sexual health services are age specific. In the case of those aged under 16 the pharmacy needs to assure itself that the child is capable of providing consent through the application of Fraser Guidelines
Disability	✓	▪ Services and advice need to be tailored to meet the needs of those with learning disabilities and cognitive impairment
Gender	✓	▪ Health promotion advice may need to be tailored according to gender
Race	✓	▪ Language may be a barrier to delivering the service successfully. People from African communities are at higher risk of poor sexual health
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ Chlamydia infection may have an adverse effect on fertility and the ability to become pregnant; pharmacies can sign post women who are pregnant on to relevant services depending on whether or the not the pregnancy is planned or unplanned
Sexual orientation	✓	▪ Men who have sex with men (MSM) are at higher risk of poor sexual health
Gender reassignment	✓	▪ Sexual health services need to be sensitive and tailored to people who are undergoing, or who have undergone, gender reassignment
Marriage & civil partnership	×	▪ No specific needs identified

CONCLUSIONS ON SEXUAL HEALTH SERVICES

Haringey has high rates of sexually transmitted infections, including chlamydia (1,603 per 100,000) compared with the London and England (1,332 and 834 per 100,000 respectively). The HIV prevalence rate, at 6.7 per 1,000 is higher than the London average (5.5) and significantly higher than the England average (2.1). Similarly teenage pregnancy rates, whilst declining, are higher than the London and the England & Wales averages (33.1 per 1,000 versus 25.9 and 27.9).

The pharmacy based service aims to improve access to a range of sexual health services with a view to helping to tackle these local sexual health issues. Services have been designed as two 'bundles' - one targeted at those aged under 25 years and the other for those aged 25 years and over.

We have concluded that the service is **necessary to meet the pharmaceutical needs of our population** for the following reasons:

- There is published evidence to demonstrate the benefits of pharmacy-based chlamydia screening and EHC supply, particularly for young people
- Whilst pharmacy is one a range of providers, the pharmacy-based service potentially improves access to a broad range of sexual health services; in many areas of Haringey, this includes at extended hours on weekdays and at weekends
- Improving sexual health is an important strategic priority for Haringey

There is good access to the service during the daytime on weekdays and on Saturday mornings. However, we have identified the following potential gaps:

- More limited access on weekday mornings up until and including 8am, Saturday evenings at 7pm or later; and on Sundays; This applies to both the under 25s and the 25 years and over service

- For the under 25s service, the impact of this is that the service is not necessarily correlated with need at these times, particularly in the wards with historically high teenage pregnancy rates (Harringay, Bruce Grove and Tottenham Green)

However, published evidence demonstrates that a proportion of people using sexual health services choose a pharmacy which offers anonymity and, as such, they may be prepared to travel further to do so

Current Need

- There is a need to ensure that the residents of NE and SE Tottenham can access sexual health services, within their own localities, on every day of the week. This is particularly important for EHC where treatment has to be taken as soon as possible, and within a maximum of 72 hours, after unprotected sexual intercourse

Future Need

- No needs identified

Current & Future Improvements or better access

- We would like to see the service commissioned from more pharmacies, particularly those which open for extended hours on 7 days a week. This would improve access, and improve choice, in the areas of highest need; and would ensure service availability on the days, and at times, where there is potentially an increased demand for the service. This would also be beneficial for people who work full time

6.2.3. Supervised Consumption of Methadone and Buprenorphine

A. Overview

The pharmacy based supervised consumption service is commissioned by the Barnet, Enfield and Haringey Mental Health Trust, Drugs and Alcohol in Haringey (DASH) Service.

The service requires the pharmacist to supervise the consumption of either methadone or buprenorphine (Subutex®), for DASH clients, at the point of dispensing in the pharmacy, ensuring that the dose has been administered to, and consumed by, the patient. Pharmacies offer a user-friendly, non-judgmental, client-centred and confidential service. The pharmacy provides support and advice to the patient, including referral to primary care or specialist centres where appropriate.

The services aims and outcomes include:

- Reducing service users' dependence upon illegal substances

- Ensuring compliance with the agreed treatment plan by:
  - Dispensing in specified instalments (doses may be dispensed for the patient to take away to cover days when the pharmacy is closed, unless the patient is high risk, in which case the DASH service will refer to a pharmacy which is open for 7 days a week)
  - Ensuring each supervised dose is correctly consumed by the patient for whom it was intended
  - Monitoring user stabilisation

- Reducing the risk to local communities of diversion of prescribed medicines onto the illicit market and preventing accidental exposure to supervised medicines

- Providing service users with regular contact with health care professionals and helping them to access further advice or assistance. Service users may be referred to specialist treatment centres or other health and social care professionals, to meet their wider health and social care needs, where appropriate.

B. Provider Criteria

To be eligible to provide the service, pharmacies must meet the following criteria:

- All pharmacists must have completed the relevant CPPE course on substance misuse and attend an annual DASH training session
- With the exception of Bank Holidays the service will normally operate on Monday to Saturday inclusive
- Where a locum pharmacist is employed for two or more weeks, then the DASH should be informed. The pharmacist will be expected to ensure that they understand the scheme guidelines and procedures
- There must be a private area e.g. a consultation area within which the supervision must be undertaken
- The pharmacy must have appropriate insurance in place

C. The Evidence Base

Studies have demonstrated the effectiveness of community pharmacy based supervised consumption services at improving adherence, improving outcomes and reducing medicine diversion[14,19]:

- There is moderate quality evidence that there is high attendance at community pharmacy based supervised methadone administration services and that this service is acceptable to users
- Recent evidence suggests inclusion of trained community pharmacists in the care of intravenous drug users, attending to obtain methadone substitution treatment, improved testing and subsequent uptake of hepatitis vaccination
- Most drug users value community pharmacy-based services highly

D. The Current Picture

46% (27/59) pharmacies are commissioned to provide the supervised consumption service.

The table below provides a summary of service provision by locality and map 16 (appended in a separate document) provides an overview of the distribution of pharmacies against a background of deprivation (which is being used a proxy for need):

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	5	5	8	9	27
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	8.6	6.7	16.7	10.5	10.1

The map shows that there is a reasonable correlation between service provision and deprivation, noting that the pharmacies have been carefully selected to try and ensure that service users may access the supervised consumption service within walking distance of their home.

The table on the next page provides an overview of service availability on different days of the week. It demonstrates that there is good access on weekdays (9.30am – 6pm) and on Saturdays up until 5pm.

Access outside these hours is more limited, particularly in the mornings up until and including 8am; and on Sundays, where there is no provision in NE Tottenham and only 1 pharmacy that opens in the Central locality. However, it should be noted that the DASH service endeavours to refer 'high risk' patients into a pharmacy that opens 7 days a week to ensure an effective level of supervision.

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	×	▪ No specific needs identified
Disability	×	▪ No specific needs identified
Gender	×	▪ No specific needs identified
Race	✓	▪ Language may be a barrier to delivering the service successfully.
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	×	▪ No specific needs identified
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

Locality	Ward	No. of Pharmacies Offering the Supervised Consumption of Methadone & Buprenorphine Service									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	0	0	0	0	0	0	0	0	3
	Harringay	0	0	0	0	0	0	0	0	0	2
	Noel Park	0	3	1	1	0	3	2	1	1	4
	Woodside	0	2	1	0	0	2	2	0	0	1
NE Tottenham	Bruce Grove	0	0	0	0	0	0	0	0	0	3
	Northumberland Park	0	2	2	0	0	2	2	0	0	2
	Tottenham Hale	0	2	1	0	0	1	1	1	0	1
	White Hart Lane	0	1	0	1	0	1	0	0	0	2
SE Tottenham	Seven Sisters	0	1	1	1	0	1	0	0	0	2
	St Ann's	0	3	2	0	0	2	2	1	1	2
	Tottenham Green	0	4	3	0	0	4	1	1	1	1
West	Alexandra	0	0	0	0	0	0	0	0	0	1
	Crouch End	0	3	2	0	0	3	3	0	1	2
	Fortis Green	0	1	1	0	0	1	1	1	1	1
	Highgate	0	1	0	0	0	1	1	0	0	1
	Hornsey	0	0	0	0	0	0	0	0	0	2
	Muswell Hill	2	3	2	0	0	3	3	2	2	2
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**2**	**27**	**16**	**3**	**0**	**25**	**19**	**7**	**7**	**32**
Percentage of the Total		**3%**	**46%**	**27%**	**5%**	**0%**	**42%**	**32%**	**12%**	**12%**	**54%**

CONCLUSIONS ON SUPERVISED CONSUMPTION SERVICE
The supervised consumption service provides support to drug users with a view to helping them to manage their treatment programme. It aims to improve patients' outcomes and to reduce the diversion of drugs into the community We have concluded that the service **is necessary to meet the pharmaceutical needs** of our population for the following reasons: ▪ The service is primarily provided by community pharmacies ▪ Evidence suggests that a community pharmacy model of supervised consumption can improve health outcomes for service users including improved adherence to treatment and uptake of Hepatitis vaccinations. The service is also well accepted by users. ▪ The service aligns with local strategic priorities for substance misuse There is good accessibility during day time hours, in all areas on Mondays through to Saturdays. Whilst access outside of these hours is more limited, the DASH risks assesses service users and ensures that those who are high risk are referred to pharmacies which open on 7 days each week. This approach helps to address the potential gap associated with Sunday opening. **Current and Future Need** ▪ None identified **Current & Future Improvements or better access** ▪ Commissioning the service from additional pharmacies which open during extended hours and at weekends would improve access and enhance the level of supervision for all service users

6.2.4. Needle & Syringe Programme

A. Overview

The pharmacy based needle and syringe exchange programme, is commissioned by the Barnet, Enfield and Haringey Mental Health Trust, Drugs and Alcohol in Haringey (DASH) Service.

Pharmacies provide access to sterile needles and syringes, and sharps containers for the return of used equipment.

They offer a user-friendly, non-judgmental, client-centred and confidential service including referral to other health and social care professionals and specialist drug and alcohol treatment services where appropriate. The service is open to adults aged 18 years and over. Pharmacies are required to refer young people aged less than 18 years of age into the Young People's Drug and Alcohol Treatment Service.

The pharmacy promotes safe practice to the user, including advice on sexual health and STIs, HIV and Hepatitis C transmission and Hepatitis B immunisation. Used equipment is returned by the service user for safe disposal and the service user is provided with appropriate health promotion materials.

The service aims and outcomes include:

- Assisting service users to remain healthy until they are ready and willing to cease injecting; and ultimately achieve a drug-free life with appropriate support

- Protecting health and reducing the rate of blood-borne infections and drug related deaths among service users by:
  - Reducing the rate of sharing and other high risk injecting behaviours
  - Providing sterile injecting equipment and other support
  - Promoting safer injecting practices
  - Providing and reinforcing harm reduction messages including safe sex advice and advice on overdose prevention (e.g. risks of poly-drug use and alcohol use)

- Improving the health of local communities by preventing the spread of blood-borne infections by ensuring the safe disposal of used injecting equipment

- Helping service users to access treatment by offering referral to specialist drug and alcohol treatment centres and health and social care professionals where appropriate

- Maximising the access and retention of all injectors, especially the highly socially excluded

- Helping service users to access other health and social care and to act as a gateway to other services (e.g. key working, prescribing, hepatitis B immunisation, hepatitis and HIV screening, primary care services etc)

B. Provider Criteria

In order to provide the service, pharmacies must meet the following criteria:

- All pharmacists must have completed the relevant CPPE course on substance use and misuse;
- Pharmacists should attend mandatory training sessions organised by the Needle Exchange Co-ordinator or the DASH team as required
- Pharmacists should participate in appropriate continuing professional development
- A representative from each pharmacy must attend two yearly meetings with DASH as required
- With the exception of Bank Holidays the service will normally operate on Monday to Saturday inclusive
- There must be a private area e.g. a consultation room, where the service must be undertaken
- The pharmacy must ensure that it maintains adequate stocks of kits and that these are stored so that they are inaccessible to customers and in accordance with sterile medical equipment
- There must be a standard operating procedure in place which has been read and understood by all pharmacists and staff involved in service delivery
- Appropriate policies as required by the service level agreement, including a needle stick injury policy, must be in place
- The pharmacy must ensure that protective equipment to deal with spillages is readily available and kept close to the storage site
- The pharmacy must clearly display the national scheme or locally approved logo
- The pharmacy must have appropriate indemnity insurance in place

C. The Evidence Base

The effectiveness of Needle and Syringe Exchange services at improving outcomes and reducing injecting related risks e.g. Hepatitis B/C and HIV infections, has been demonstrated in studies[14,19]:

- Community pharmacy based needle exchange schemes were found to achieve high rates of returned injecting equipment and are cost effective. However, the evidence is based on descriptive studies only
- Most drug users value community pharmacy-based services highly

D. The Current Picture

17% (10/59) of pharmacies are commissioned to provide the needle and syringe exchange programme.

The table below provides a summary of service provision by locality, map 17 (appended in a separate document) provides an overview of the distribution of pharmacies against a background of deprivation (which is being used a proxy for need) and the table on the next page provides an overview of service availability on different days of the week.

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	4	1	2	3	10
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	6.9	1.3	4.2	3.5	3.8

The data demonstrates that, on weekdays (9:30am - 6pm), there is reasonable provision and access to pharmacies participating in the needle and syringe programme within the West, Central and SE Localities; but limited access in NE Tottenham (where only pharmacy has been commissioned to provide the service.

On all other days, access to the service is more limited:

- On weekday mornings, up until and including 8am, only one pharmacy (located in Muswell Hill) is open
- On Saturdays (10am – 1pm), there are no pharmacies open to provide the service in NE Tottenham; and on Saturday evenings only two pharmacies are open (one in the Central locality and the other in the West Locality)
- On Sundays, service users can only access the service from two pharmacies - one in the Central and West Localities

Therefore, at these times provision does not necessarily correlate with local "hot spots" including Wood Green (Noel Park ward) and N15 postcodes (Tottenham Green, Seven Sisters and St Ann's). The DASH has advised that service users tend to be willing to travel further to access a pharmacy implying that current provision may not be an issue.

The Grove Drug Treatment Service (based in Bruce Grove ward, NE Tottenham) provides support for young people aged less than 18 years and outreach services to high-risk groups e.g. sex workers.

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ The service is only open to those aged 18+ years; those aged under 18 years should be referred to the local Young People's service
Disability	×	▪ No specific needs identified
Gender	×	▪ No specific needs identified
Race	✓	▪ Language may be a barrier to delivering the service successfully
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	×	▪ No specific needs identified
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

Locality	Ward	No. of Pharmacies Offering the Needle and Syringe Programme									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	0	0	0	0	0	0	0	0	3
	Harringay	0	0	0	0	0	0	0	0	0	2
	Noel Park	0	3	1	1	0	3	2	1	1	4
	Woodside	0	1	0	0	0	1	1	0	0	2
NE Tottenham	Bruce Grove	0	0	0	0	0	0	0	0	0	3
	Northumberland Park	0	0	0	0	0	0	0	0	0	4
	Tottenham Hale	0	1	0	0	0	0	0	0	0	2
	White Hart Lane	0	0	0	0	0	0	0	0	0	3
SE Tottenham	Seven Sisters	0	1	1	1	0	1	0	0	0	2
	St Ann's	0	0	0	0	0	0	0	0	0	5
	Tottenham Green	0	1	1	0	0	1	0	0	0	4
West	Alexandra	0	0	0	0	0	0	0	0	0	1
	Crouch End	0	0	0	0	0	0	0	0	0	5
	Fortis Green	0	0	0	0	0	0	0	0	0	2
	Highgate	0	0	0	0	0	0	0	0	0	2
	Hornsey	0	0	0	0	0	0	0	0	0	2
	Muswell Hill	1	2	1	0	0	2	2	1	1	3
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**1**	**10**	**4**	**2**	**0**	**9**	**6**	**2**	**2**	**49**
Percentage of the Total		**2%**	**17%**	**7%**	**3%**	**0%**	**15%**	**10%**	**3%**	**3%**	**83%**

CONCLUSIONS ON THE NEEDLE & SYRINGE PROGRAMME

The community pharmacy-based needle and syringe exchange programme is an important public health service which reduces risks to injecting drug users and the general public

We have concluded that the service **is necessary to meet the pharmaceutical needs** of our population for the following reasons:

- The service is primarily provided by community pharmacies
- There is published evidence that needle and syringe programmes are cost effective and improve outcomes
- The aim of the service is to keep users as healthy as possible as well as reducing the transmission of blood-borne viruses. This aligns well with the local strategic priority to reduce harm associated with drug misuse, noting that Haringey is classed as "Band C" (a high band) by the Health Protection Agency for drug users infected with hepatitis C

We have identified that there is reasonable access on weekdays between 9:30am - 6pm. Outside of these hours we have identified a potential gap in that access is more limited in the early mornings on weekdays, Saturdays and Sundays which means that service provision doesn't necessarily align with need, particularly in local "hot spots" including Wood Green (Noel Park ward) and N15 postcodes (Tottenham Green, Seven Sisters and St Ann's).

Current Need

- There is a need to ensure access to the needle and syringe programme, on 7 days a week, in areas with high pharmaceutical need.

Future Need

- None identified

Current & Future Improvements or better access

- Commissioning the service from a wider range of pharmacies, including those which open for extended hours and/or at weekends would improve access to the service across Haringey.

6.2.5. Healthy Start Vitamins

A. Overview

Healthy Start is a nationwide government scheme which provides eligible families with vouchers to receive plain fruit and vegetables, milk and vitamins. It is an opportunity to provide encouragement, information and support about topics such as healthy eating, breastfeeding, vitamin supplements and nutrition for pregnant women, new mothers, babies and young children. The scheme exists to improve the health of low-income pregnant and breastfeeding women and their children. The Healthy Start vitamins in particular are tailored to suit the nutritional needs of both mother and child. The goal of Healthy Start is to ensure that every mother/child has access to the foods and nutrients they need to be as healthy as possible, irrespective of their income. This is important in Haringey as many families cannot afford to buy fruit, vegetables, milk and vitamins on a regular basis. Furthermore, by promoting nutrition and healthy eating practices early on in life, children are less likely to develop childhood obesity.

Historically, the pharmacy-based service was centred on the NHS eligibility criteria, however, Haringey has recently moved to a 'universal' scheme whereby anyone falling into the following groups may access the Healthy Start vitamins:

- Pregnant women
- Women who have had a baby in the last year
- Children under four years old (e.g. up to their fourth birthday). Breastfed babies are eligible from birth; babies fed on formula do not need supplementation until they are six months old.

B. Provider Criteria

To be eligible to provide the service, pharmacies must:

- Ensure that Pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service
- Ensure that Pharmacists attend / complete training on related public health issues including early booking for maternity care (by 12 weeks of pregnancy), breastfeeding and immunisation

C. The Evidence base

We are not aware of any published evidence demonstrating the benefits of pharmacy-based schemes to support the delivery of the healthy start vitamins scheme.

However, due to their general accessibility and often extended opening hours, pharmacies are well placed to provide supplies of vitamins to those eligible under this service.

D. The Current Picture

The service currently commissioned from 17% (10/59) pharmacies.

The table below provides a summary of service provision by locality and map 18 (appended in a separate document) plots the pharmacies providing the service against a background of children aged 0-4 who are living in poverty as a proxy for need.

	Central	North East Tottenham	South East Tottenham	West	Haringey
Number of Pharmacies	2	2	4	2	10
Population	58,069	74,556	47,964	85,885	266,474
Pharmacies per 100,000 population	3.4	2.7	8.3	2.3	3.8

The map shows that there is a reasonable correlation with need, although there are opportunities to improve access in the NE Locality (particularly Northumberland Park); and in parts of the West Locality (particularly Fortis Green).

The table (on the next page) provides an overview of the service availability and distribution on different days each week. There is one or more pharmacy commissioned to provide the service in all four localities on weekdays (9.30am – 6pm) and on a Saturday (10am – 5pm)

Access outside of these hours is much more limited, particularly up until and including 8am on weekdays, and on Sundays.

Non-pharmacy providers: 17 Children's Centres are involved in this service.

There are no formal arrangements for Haringey residents to access Healthy Start Vitamins in neighbouring areas.

Locality	Ward	No. of Pharmacies Offering Healthy Start Vitamins Programme									
		Open on Weekdays					Open on Saturday			Sunday	
		8am or earlier	9:30am - 6pm	7pm or later	Close early on Thurs	Closed for Lunch	10am - 1pm	5pm or later	7pm or later	Open at some point	Not offered at all
Central	Bounds Green	0	0	0	0	0	0	0	0	0	3
	Harringay	0	0	0	0	0	0	0	0	0	2
	Noel Park	0	1	1	0	0	1	1	1	1	6
	Woodside	0	1	0	0	0	1	1	0	0	2
NE Tottenham	Bruce Grove	0	1	0	0	1	1	1	0	0	2
	Northumberland Park	0	0	0	0	0	0	0	0	0	4
	Tottenham Hale	0	1	0	0	0	0	0	0	0	2
	White Hart Lane	0	0	0	0	0	0	0	0	0	3
SE Tottenham	Seven Sisters	0	1	1	1	0	1	0	0	0	2
	St Ann's	0	1	1	0	0	1	1	0	0	4
	Tottenham Green	1	2	1	0	0	2	1	1	1	3
West	Alexandra	0	0	0	0	0	0	0	0	0	1
	Crouch End	0	1	0	0	0	1	1	0	1	4
	Fortis Green	0	0	0	0	0	0	0	0	0	2
	Highgate	0	0	0	0	0	0	0	0	0	2
	Hornsey	0	0	0	0	0	0	0	0	0	2
	Muswell Hill	0	0	0	0	0	0	0	0	0	5
	Stroud Green	0	1	0	0	0	1	1	0	0	0
Total - Haringey		**1**	**10**	**4**	**1**	**1**	**9**	**7**	**2**	**3**	**49**
Percentage of the Total		**2%**	**17%**	**7%**	**2%**	**2%**	**15%**	**12%**	**3%**	**5%**	**83%**

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table below:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ The service is directed at women of child-bearing age and children under 4 years of age
Disability	×	▪ No specific needs identified
Gender	✓	▪ The service is focused on women who are pregnant or who have been pregnant in the last year; and children of either gender
Race	✓	▪ Language may be a barrier to delivering health promotion aspects of the service successfully
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ All pregnant women, and women who have had a baby within the last year are eligible to access the service
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

F. The Future

The service has recently been redesigned to allow universal access to Healthy Start vitamins for women and children who fall within the eligible groups

As part of the redesign process, a broader role for Children's Centres has been created. This includes identifying one centre, per locality, which will act as the main contact and venue for the service and be responsible for distributing the vitamins to families and other Children's Centres within their locality. A publicity campaign promoting the service is also planned.

There is an intention to review the pharmacy-based service with a view to ascertaining whether the current level of provision requires revision.

CONCLUSIONS ON THE HEALTHY START VITAMINS SERVICE

The JSNA highlights a number of local challenges with respect to both maternal and child health. What happens during these very early years, starting in pregnancy, has lifelong effects on many aspects of health and well-being. Poor nutrition is a major modifiable risk factor for a range of long term conditions. Nationally, there are marked differences in fruit and vegetable consumption between socio-economic groups, with higher consumption associated with higher income.

We have concluded that the service is not necessary to meet the pharmaceutical needs of our population, but **is relevant** for the following reasons:

- Healthy start vitamins may be access through Children's Centres as well as pharmacy. The pharmacy-based service therefore provides a **choice of provider and potentially improves access for residents**
- There is no published evidence base to support pharmacy-based supply of healthy start vitamins
- Many Haringey families cannot afford to buy fruit, vegetables, milk and vitamins on a regular basis and the service helps to ensure that pregnant women, new mothers and children aged under 4 years secure access to the vitamins which they require

There is one or more pharmacy commissioned to provide the service in all four localities on weekdays (9.30am – 6pm) and on a Saturday (10am – 5pm). Whilst access to the service outside of these hours is much more limited, particularly up until and including 8am on weekdays, and on Sundays it is not clear if this represents a gap because of recent changes in how the service has been commissioned.

Current and Future Need

- None identified at this point in time

Current & Future Improvements or better access

- None identified at this point in time, however, there are plans to evaluate the service with a view to determining whether or not current provision requires revision

6.3. Services Commissioned by NHS Haringey CCG

6.3.1. Anti-Coagulant and Stroke Prevention Service

NHS Haringey CCG currently commissioned an anti-coagulant and stroke prevention service from 5 GPs and a community pharmacy.

A. Overview

Providers of the anti-coagulant and stroke prevention service are responsible for sampling, testing and dosing patients according to locally agreed protocols approved by NHS Haringey. Providers are also responsible for communicating dosing recommendations to patients and their GPs.

Clinical support and advice is provided by the Haematology Department at the North Middlesex University Hospital and by the Anticoagulant team at the Whittington Hospital.

The service aims to:

- Provide an excellent integrated Anticoagulant and Stroke Prevention service across primary and secondary care in which therapy is usually initiated in secondary care and maintenance of appropriate patients is managed in a primary care setting.
- Provide more services that are near to patients and are easily accessible
- Increase capacity in the community to meet the rising demand for anticoagulant monitoring
- Shift the majority of the burden of anticoagulant monitoring from the Whittington and North Middlesex hospitals into the community allowing the hospitals to focus on new and problematic patients
- Ensure the same high quality of service to patients whether accessed in primary or secondary care
- Ensure that maintenance of patients is properly controlled and the need for continuation of therapy is reviewed regularly and discontinued where appropriate
- Support patients in understanding and managing their anti-coagulant treatment

B. Provider Criteria

To be eligible to provide the service, pharmacies must meet the following criteria:

- Have a private consultation area which is clinically appropriate, large enough for all necessary equipment and is maintained in a clean and tidy condition
- The premises should comply with the NHS Haringey infection control standards.
- There must be sufficient seating at the premises for patients whilst they are waiting to be seen
- The service provider must install and use computerised decision support software that provides guidance on dosing and follow up intervals
- Blood sampling and testing must only be undertaken by appropriately trained personnel.
- Dose adjustments of anticoagulant therapy can only be undertaken by qualified health care professionals that are currently registered with the GPhC **and** who fulfil the following criteria:
  - Have successfully completed a period of specialist training prior to the start of service delivery provided by the Whittington Hospital **and** demonstrate competence in a formal assessment
  - Are competent in managing the anti-coagulated patient

- Practitioners will be expected to maintain and develop their specialist skills and knowledge, by providing evidence relating to:
  - Relevant CPD
  - Quality improvements in response to audit/clinical governance information
  - Quality improvements in response to patient satisfaction surveys
  - Attendance at a refresher First Aid course every 2 years
  - Additionally, all practitioners will be expected to demonstrate satisfactory competence every 2 years

C. The Evidence base

The only published evidence to support pharmacy-based anti-coagulation services is from an Australian study[25]:

- The monitoring was well received by pharmacists, GPs and patients
- The results of the trial were very positive. The CoaguChek S monitor in pharmacy-based testing performed accurately compared with conventional laboratory testing
- The author's concluded that "Further research needs to be conducted on the impact of community pharmacy-conducted INR monitoring on patient care and outcomes."

There are examples of established models of community pharmacy managed services[26]: For example, a service provided within the area of the former Derwentside PCT has been established for several years. The service manages more than 900 patients with audits demonstrating that therapeutic control in a pharmacist led service is at least as good as that previously provided by the hospital

D. The Current Picture

The anti-coagulant and stroke prevention service is provided by 1 community and 5 General Practices in Haringey, with community access in each of the 4 localities, noting that the pharmacy provider is located in the Central Locality (Noel Park ward).

	Central	NE Tottenham	SE Tottenham	West	Haringey
No. of Primary Care Providers	1	2	1	2	6
Population	58,069	74,556	47,964	85,885	266,474
Providers per 100,000 population	1.7	2.7	2.1	2.3	2.3

E. Meeting the Needs of People with Protected Characteristics

In undertaking our assessment we have systematically considered the pharmaceutical needs of people with protected characteristics and have summarised this in the table:

Protected characteristic		Implications for Pharmaceutical Services
Age	✓	▪ The incidence of stroke, and potential need for the service increases with age
Disability	✓	▪ People who have had a stroke may have disabilities as a consequence of this and the service needs to be adapted to meet these
Gender	✓	▪ There are inequalities with respect to CVD and stroke with men being disproportionately affected and may have a greater need for the service
Race	✓	▪ Language may be a barrier to delivering the service successfully. BAME communities are more susceptible to circulatory disease and stroke
Religion or belief	×	▪ No specific needs identified
Pregnancy and maternity	✓	▪ Advice may be required on the use of anti-coagulants in pregnancy, in women planning pregnancy and for women who are breast feeding
Sexual orientation	×	▪ No specific needs identified
Gender reassignment	×	▪ No specific needs identified
Marriage & civil partnership	×	▪ No specific needs identified

F. The Future

48 pharmacies told us they would be willing to provide this service in the future.

Each service provider has additional capacity and could manage an increased number of patients being transferred from secondary care.

CONCLUSIONS - ANTI-COAGULANT AND STROKE PREVENTION SERVICE

The community pharmacy based anti-coagulant and stroke prevention service is part of an integrated service, across primary and secondary care. Therapy is usually initiated in secondary care and maintenance of appropriate patients is managed in a primary care setting.

We have concluded that the service is not necessary to meet the pharmaceutical needs of our population, but is **relevant** for the following reasons:

- The pharmacy providing the service is one of 6 community providers
- There is limited published evidence, together with 'real life' experience to support the provision of pharmacy based services
- It supports local strategic priorities to deliver 'care closer to home'

There is only one pharmacy providing this service; however, residents may also choose to attend one of the GP providers if this is more convenient for them.

The existing network of providers has capacity to manage additional patients now, and in the future. However, should the need arise to commission more pharmacies, our community pharmacy questionnaire indicated that 48 pharmacies are willing to provide this service.

We have not identified any specific gaps, needs or areas for improvement at this point in time.

7. Looking to the Future

Throughout the PNA, we have identified and documented the potential future pharmaceutical needs for our population, together with opportunities to secure improvements in services which have already been commissioned.

In this section, we describe our vision and ambition for how community pharmacy services may support the delivery of our local strategic priorities.

It should be noted that national and local strategy for health services is still evolving and we are also in the process of designing a number of pathways. Taking this into account, we have no firm plans at this point in time to commission new services from pharmacies.

We also set out our future aspirations for pharmacy services and premises.

7.1. Vision for future community pharmaceutical services in Haringey

Our vision for future of community pharmaceutical services is to embed the nationally recognised approach on the Healthy Living Pharmacy (HLP).

HLP is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.

The HLP concept provides a framework for commissioning public health services through three levels of increasing complexity and required expertise with pharmacies aspiring to go from one level to the next.

It is also an organisational development framework underpinned by three enablers of:

- Workforce development – a skilled team to pro-actively support and promote behavior change, improving health and wellbeing;
- Premises that are fit for purpose; and
- Engagement with the local community, other health professionals (especially GPs), social care and public health professionals and Local Authorities.

Community pharmacies wishing to become HLPs are required to consistently deliver a range of commissioned services based on local need and commit to and promote a healthy living ethos within a dedicated health-promoting environment.

In Haringey, we've already started the implementation of HLP (refer to section 6.1) and our vision is to extend this offer equally across the borough and establish pharmacies as healthy living community hubs.

We have identified, that in Tottenham, an area which has high levels of deprivation and health challenges, coupled with poor access to GPs and low GP registration, there is an opportunity for pharmacy to drive improvements in public health through the HLP.

7.2. Aspirations for Future Pharmacy Premises and Services

In reflecting upon the gaps, areas for improvement and our vision (as set out in section 7.1 above), we have identified aspirations for pharmacy services and premises throughout our PNA; and would like to see these prioritised for future applications.

8. Consultation Report

This report provides a summary of the stakeholder consultation, which was undertaken by Haringey Council on its draft Pharmaceutical Needs Assessment (PNA), in accordance with the requirements as set out in the *National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417).*

The consultation was initiated on the 9 December 2014 and ended at 5pm on the 10 February 2015. This period is complied with the minimum 60 days consultation required by the Regulations.

8.1. Consultation Process

The consultation was undertaken electronically. A dedicated web page was created on the Haringey Council website and the draft PNA and supporting documents were posted for the duration of the consultation. Consultees were advised that they may request hard copy of the PNA if they wished; all requests for hard copy were met within 14 days. Respondents had the option of completing an online survey or a consultation response form. Submissions not using the standard response form were also accepted providing that these were made in writing.

A list of stakeholders to be consulted was compiled. This reflected the minimum requirements of the Regulations with respect to the individuals and groups who must be consulted, as follows:

- All pharmacy contractors (59 in total)
- Barnet, Enfield & Haringey Local Pharmaceutical Committee (via Middlesex Pharmaceutical Group of LPCs)
- Haringey Local Medical Committee (via London wide LMCs)
- Healthwatch Haringey
- Barnet, Enfield & Haringey Mental Health Trust
- NHS England - London Area Team
- Neighbouring Health & Wellbeing Boards; specifically:
    - Barnet
    - Camden
    - Enfield
    - Hackney
    - Islington
    - Waltham Forest

In addition, the following wider stakeholder groups were included:

- The Whittington Hospital NHS Trust (Whittington Health)
- North Middlesex University Hospital NHS Trust
- NHS Haringey CCG
- Bridge Renewal Trust
- Positive Youth
- Haringey Association of Voluntary & Community Organisations (HAVCO)

An email providing notification that the consultation was being initiated was sent out to stakeholders electronically; a hard copy letter was also sent to pharmacies.

8.2. Consultation Outcome

In total, 15 responses were received. The table (on the next page) provides details of organisations which responded.

Organisation	Address
Dr M Lindsay (GP and member of the LMC)	Somerset Gardens, 4-6 Creighton Rd, N17 8NW
Redwood Pharmacy	116 Alexandra Park Road, N10 2AH
Mintons Chemist	5 High Road, Wood Green, N22 6BH
Savemore Pharmacy	67 Westbury Avenue, Wood Green, N22 6SA
Coopers Pharmacy (Ravalia Pharm Ltd)	59 Broad Lane, Tottenham, N15 4DJ
Parade Chemist (Conochem Management Ltd)	25 Grand Parade, Green Lanes, Haringey, N4 1LG
Pharmocare (Warwick Pharmacy)	48-50 Bounds Green Road, N11 2EU
Boots UK Limited	South Divisional Office, 14 Blacklands Terrace, Chelsea
Barnet, Enfield and Haringey NHS MH Trust	St Ann's Hospital, St.Ann's Road, N15 3TH
NHS Haringey Clinical Commissioning Group	4th Floor River Park House, 225 High Road, Wood Green, N22 8HQ
Grace Pharmacy	165 Park Lane, Tottenham, N17 0HJ
The Bridge Renewal Trust	Laurels Healthy Living Centre, 256 St Ann's Road, N15 5AZ
NHS England, London Area Team	2nd Floor, Southside, 105 Victoria Street, SW1E 6QT
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	1278 High Road, Whetstone, N20 9HH
Sexual Health Service Commissioner, Haringey Council	River Park House, 225 High Road, Wood Green, N22 8HQ

All comments and feedback was consolidated into a document for review by the PNA Steering Group on the 23 February 2015. A full overview of the comments, together with the PNA Steering Group response is attached in Appendix G.

Where applicable the draft PNA was updated to reflect the decisions of the PNA Steering Group.

9. References

1. The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and amended in 2014 (SI 2014 No. 417)
2. Equality Act 2010, Chapter 1, Part 11.
3. *"Use of community pharmacies: a population-based survey"*. Journal of Public Health 2005; 27 (3): 254-262. Boardman H, Lewis M, Trinder P, Rajaratnam G, Croft P.
4. *"Pharmacy in England: building on strengths – delivering the future"*. Department of Health. April 2008
5. The NHS Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013
6. *QI4PD Medicines Use Review audit reports.* London: RPS, *Annual report 2009/10*
7. *"A randomised controlled trial and economic evaluation with qualitative appraisal comparing the effectiveness and cost effectiveness of the New Medicines Service in community pharmacies in England ".* Rachel A Elliott, Matthew J Boyd et al. Trials 2013
8. *"Understanding and Appraising the New Medicines Service in the NHS in England".* PRP 029/0124
9. *The cost effectiveness of a telephone-based pharmacy advisory service to improve adherence to newly prescribed medicines".* Pharmacy World & Science 2008; 30(1), 17-23. Elliott RA, Barber N et al.
10. *"Medicines Optimisation: Helping Patients make the most of their Medicines".* Royal Pharmaceutical Society of Great Britain May 2013.
11. *"A multi-method evaluation of Pharmacy First Minor Ailment Scheme"*. International Journal of Clinical Pharmacy. June 2011. Vol 33 (3): 573 - 581. Somying P; Boardman HF; Anderson C
12. *"Are pharmacy-based minor ailment schemes a substitute for other service providers? A systematic review".* University of York, 2014. Paudyal V; Watson MC et al
13. *"Achieving and sustaining 24/48 hour access to primary care".* Department of Health Toolkit
14. *"The contribution of community pharmacy to improving the public's health: summary report of the literature review 1990–2007".* London: Pharmacy Health Link, 2009. Anderson, C., Blenkinsopp, A. Armstrong, M.
15. *"PharmOutcomes Data".* PSNC Website, October 2013.
16. *"Out-of-hours palliative care: a qualitative study of cancer patients, carers and professionals".* Worth, A., Boyd, K., Kendall, M., Heaney, D., Macleod, U., Cormie, P.et al. (2006). Br J of Gen Prac, 56(522), 6-13.
17. "Evaluation of the effectiveness of UK community pharmacists' interventions in community palliative care". Needham, D. S., Wong, I. C. K., & Campion, P. D. Palliative Medicine 2002; 16(3): 219-225.
18. *"Development of an ambulatory palliative care pharmacist practice".* Atayee, R. S., Best, B. M., & Daniels, C. E. Journal of Palliative Medicine 2008; 11(8): 1077-1082.
19. "*Consolidating and developing the evidence base and research for community pharmacy's contribution to public health: a progress report from Task Group 3 of the Pharmacy and Public Health Forum".* Public Health England, Jan 2014.
20. *"A pharmacy-based private chlamydia screening programme: results from the first 2 years of screening and treatment".* Anderson, C, Thornley T. International Journal of Clinical Pharmacy 2011; 33(1): 88-91.
21. *"Community pharmacy supply of emergency hormonal contraception: a structured literature review of international evidence".* Anderson C, Blenkinsopp A. Human Reproduction 2006; 21(1): 272-284.
22. ONS Contraception Statistics 2011, England and Wales, released April 2013
23. *"Emergency contraception. Has over the counter availability reduced attendances at emergency departments?"* Kerins M, Maguire E, Fahey DK, Glucksman E. Emerg Med J 2004; 21: 67–68.
24. *"Review Of The Community Pharmacy Public Health Service For Smoking Cessation And Emergency Hormonal Contraception".* Hametz I, et al. Edinburgh, Scottish Government Social Research: 2011.
25. *"Improving the outcomes of anticoagulation in rural Australia: an evaluation of pharmacist-assisted monitoring of warfarin therapy".* Jackson, S. L., Peterson, G. M.et al. Journal of Clinical Pharmacy and Therapeutics 2005; 30(4): 345-353.
26. *"Implementing care closer to home - providing convenient quality care for patients"* DH September 2006

This page is intentionally left blank

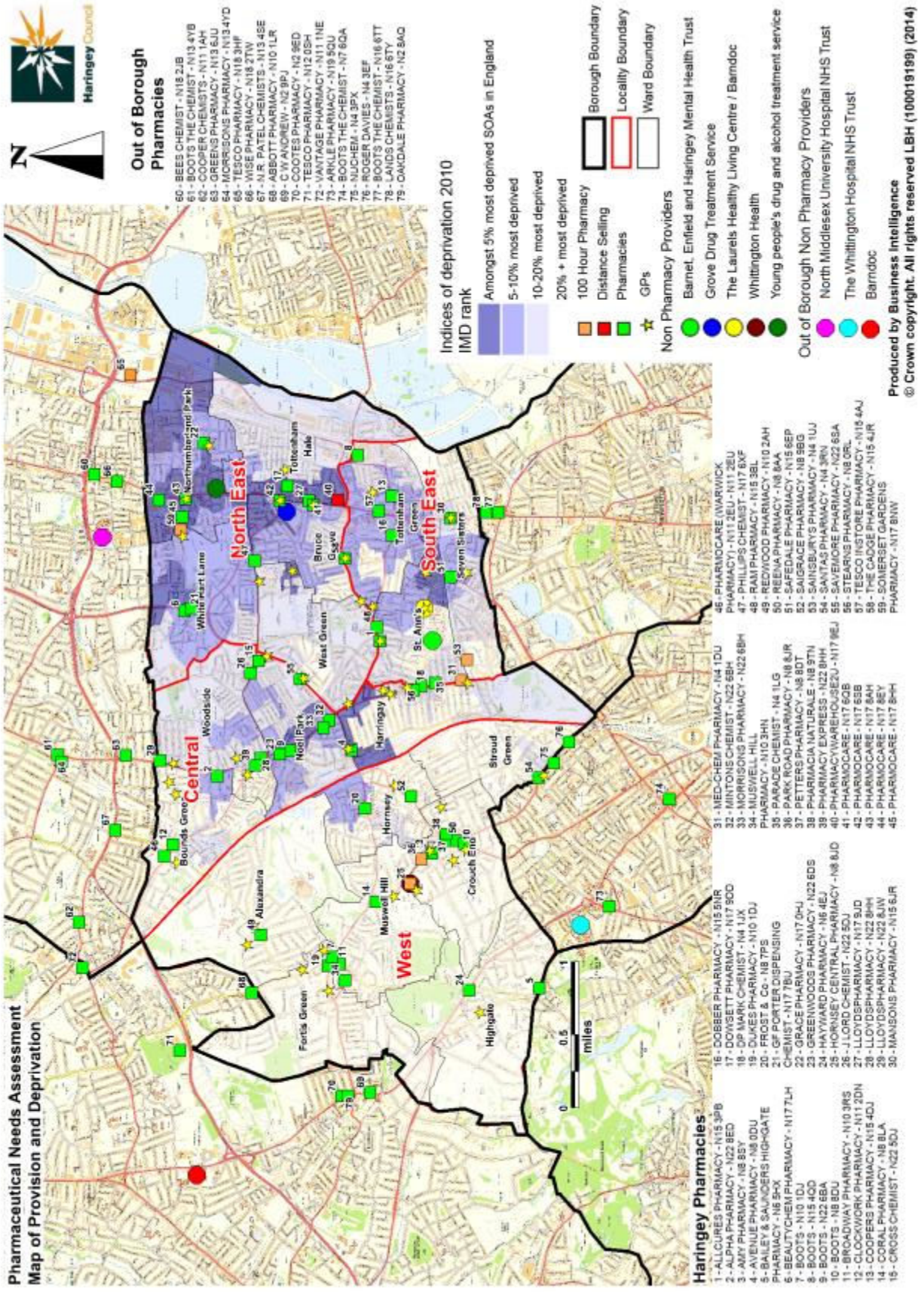
Haringey Council

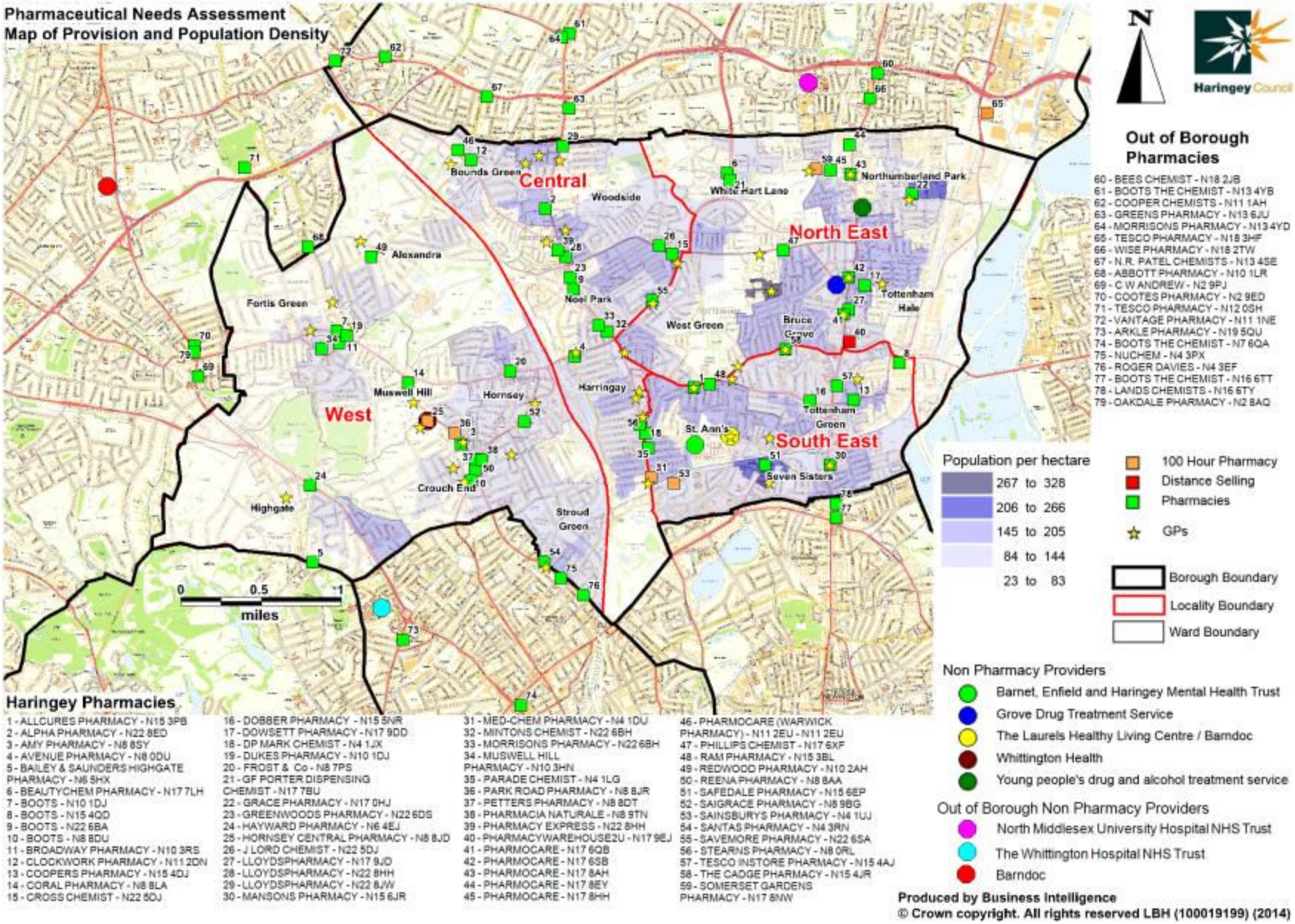
Pharmaceutical Needs Assessment

Maps

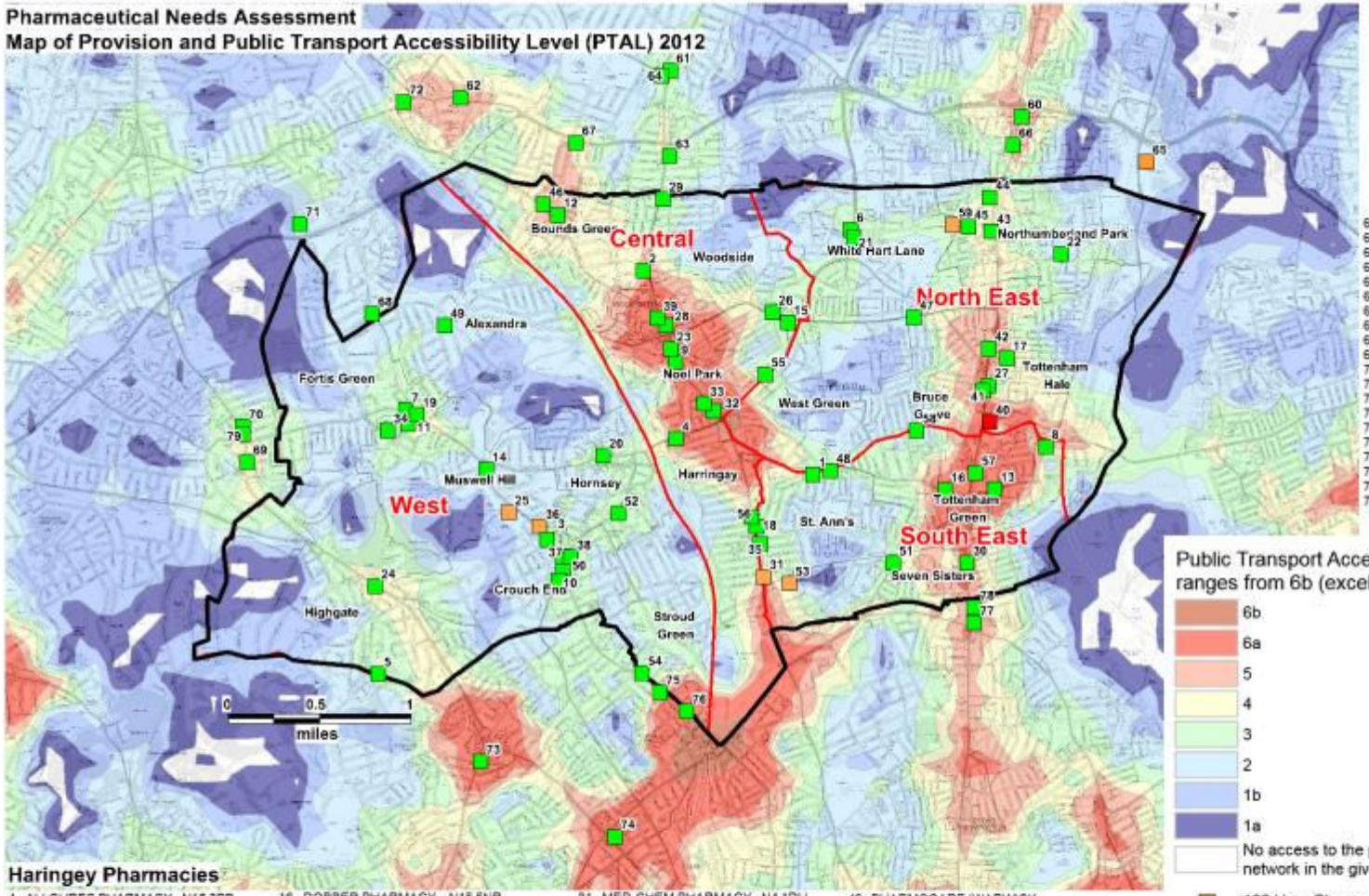
	Description
Map 1	Map of Provision plotted against deprivation
Map 2	Map of Provision plotted against population density
Map 3	Map of Provision plotted against Public Transport Accessibility Levels
Map 4	Pharmacies - Weekday Extended Hours
Map 5	Pharmacies - Open on Saturday
Map 6	Pharmacies - Open on Saturday until 5pm or later
Map 7	Pharmacies - Open on Sunday
Map 8	Pharmacies Providing Medicines Use Reviews
Map 9	Pharmacies Providing the New Medicine Service
Map 10	Pharmacies Providing the Minor Ailments Scheme
Map 11	Pharmacies Providing the London Pharmacy Vaccination Service
Map 12	Pharmacies Providing the Stop Smoking Service
Map 13	Pharmacies Providing Sexual Health Services - Under 25s plotted against young people aged 15-24
Map 14	Pharmacies Providing Sexual Health Services - Under 25s plotted against females age 13 - 24
Map 15	Pharmacies Providing Sexual Health Services - Over 25s
Map 16	Pharmacies Providing the Supervised Consumption Service
Map 17	Pharmacies Providing the Needle Exchange Service
Map 18	Pharmacies Providing the Healthy Start Vitamins Service

Map 1


Pharmaceutical Needs Assessment
Map of Provision and Deprivation
Haringey Council
N
Out of Borough Pharmacies
60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
62 - COOPER CHEMISTS - N11 1AH
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
72 - VANTAGE PHARMACY - N11 1NE
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
79 - OAKDALE PHARMACY - N2 8AQ
Indices of deprivation 2010
IMD rank
Amongst 5% most deprived SOAs in England
5-10% most deprived
10-20% most deprived
20% + most deprived
100 Hour Pharmacy
Distance Selling
Pharmacies
GPs
Non Pharmacy Providers
Barnet, Enfield and Haringey Mental Health Trust
Grove Drug Treatment Service
The Laurels Healthy Living Centre / Barndoc
Whittington Health
Young people's drug and alcohol treatment service
Out of Borough Non Pharmacy Providers
North Middlesex University Hospital NHS Trust
The Whittington Hospital NHS Trust
Barndoc
Borough Boundary
Locality Boundary
Ward Boundary
North East
South East
Central
West
Tottenham Hale
Northumberland Park
Bruce Grove
Tottenham Green
Seven Sisters
St. Ann's
West Green
Harringay
Noel Park
Woodside
Bounds Green
Alexandra
Muswell Hill
Fortis Green
Highgate
Hornsey
Crouch End
Stroud Green
0
0.5
1
miles
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3NR
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 3PB
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1LU
54 - SAVTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)


Pharmaceutical Needs Assessment
Map of Provision and Population Density
Central
North East
West
South East
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Alexandra
Noel Park
Tottenham Hale
Fortis Green
West Green
Bruce Grove
Muswell Hill
Hornsey
Harringay
Tottenham Green
St. Ann's
Seven Sisters
Crouch End
Highgate
Stroud Green
0 0.5 1 miles
N
Haringey Council
Out of Borough Pharmacies
60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
62 - COOPER CHEMISTS - N11 1AH
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
72 - VANTAGE PHARMACY - N11 1NE
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
79 - OAKDALE PHARMACY - N2 8AQ
Population per hectare
267 to 328
206 to 266
145 to 205
84 to 144
23 to 83
100 Hour Pharmacy
Distance Selling
Pharmacies
GPs
Borough Boundary
Locality Boundary
Ward Boundary
Non Pharmacy Providers
Barnet, Enfield and Haringey Mental Health Trust
Grove Drug Treatment Service
The Laurels Healthy Living Centre / Barndoc
Whittington Health
Young people's drug and alcohol treatment service
Out of Borough Non Pharmacy Providers
North Middlesex University Hospital NHS Trust
The Whittington Hospital NHS Trust
Barndoc
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)

Pharmaceutical Needs Assessment
Map of Provision and Public Transport Accessibility Level (PTAL) 2012



N

Haringey Council

Out of Borough Pharmacies

60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
62 - COOPER CHEMISTS - N11 1AH
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
72 - VANTAGE PHARMACY - N11 1NE
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
79 - OAKDALE PHARMACY - N2 8AQ

Public Transport Accessibility Level (PTAL) ranges from 6b (excellent) to 1a (Very Poor)

- 6b
- 6a
- 5
- 4
- 3
- 2
- 1b
- 1a
- No access to the public transport network in the given perameters

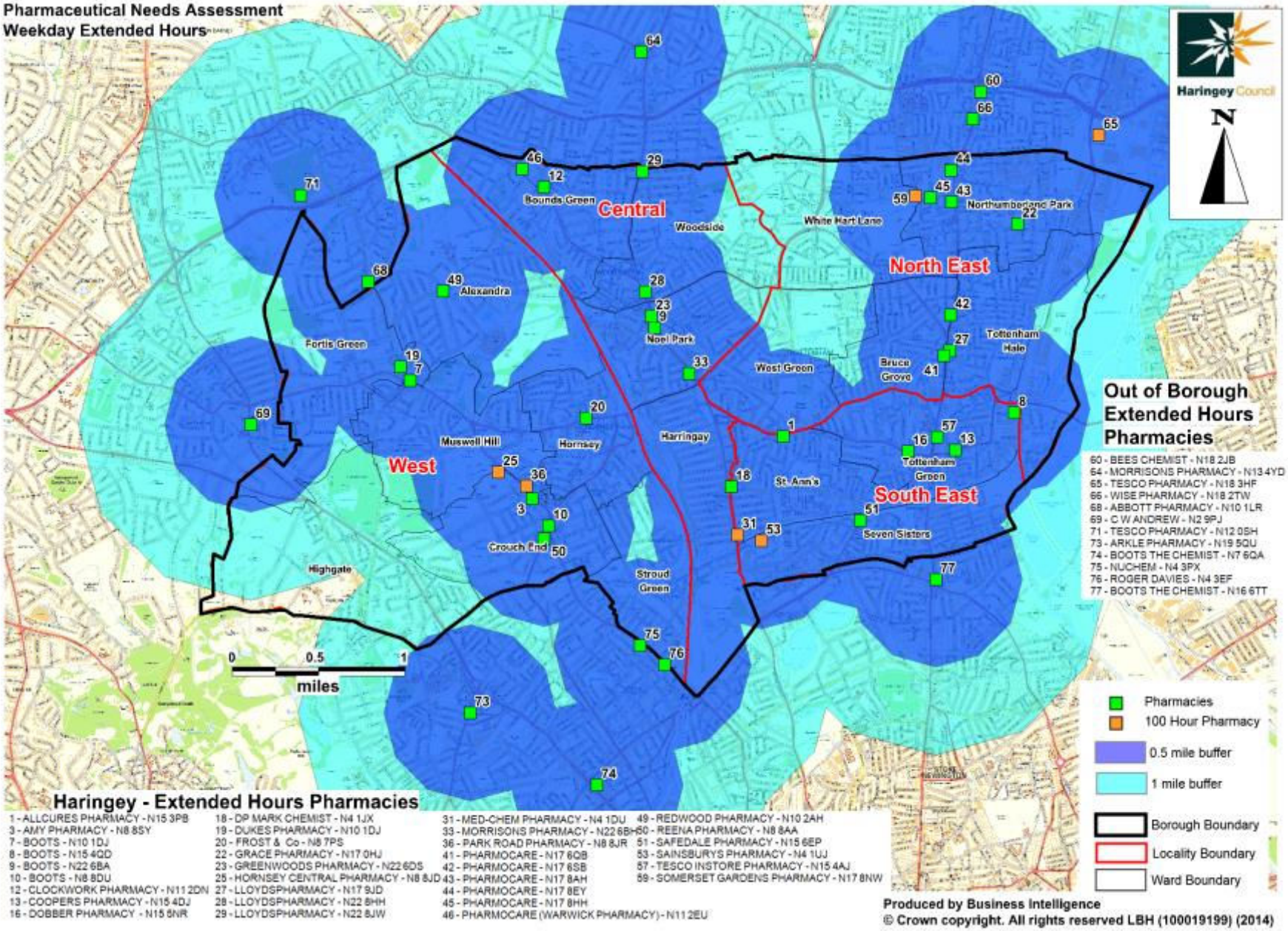
- 100 Hour Pharmacy
- Distance Selling
- Pharmacies

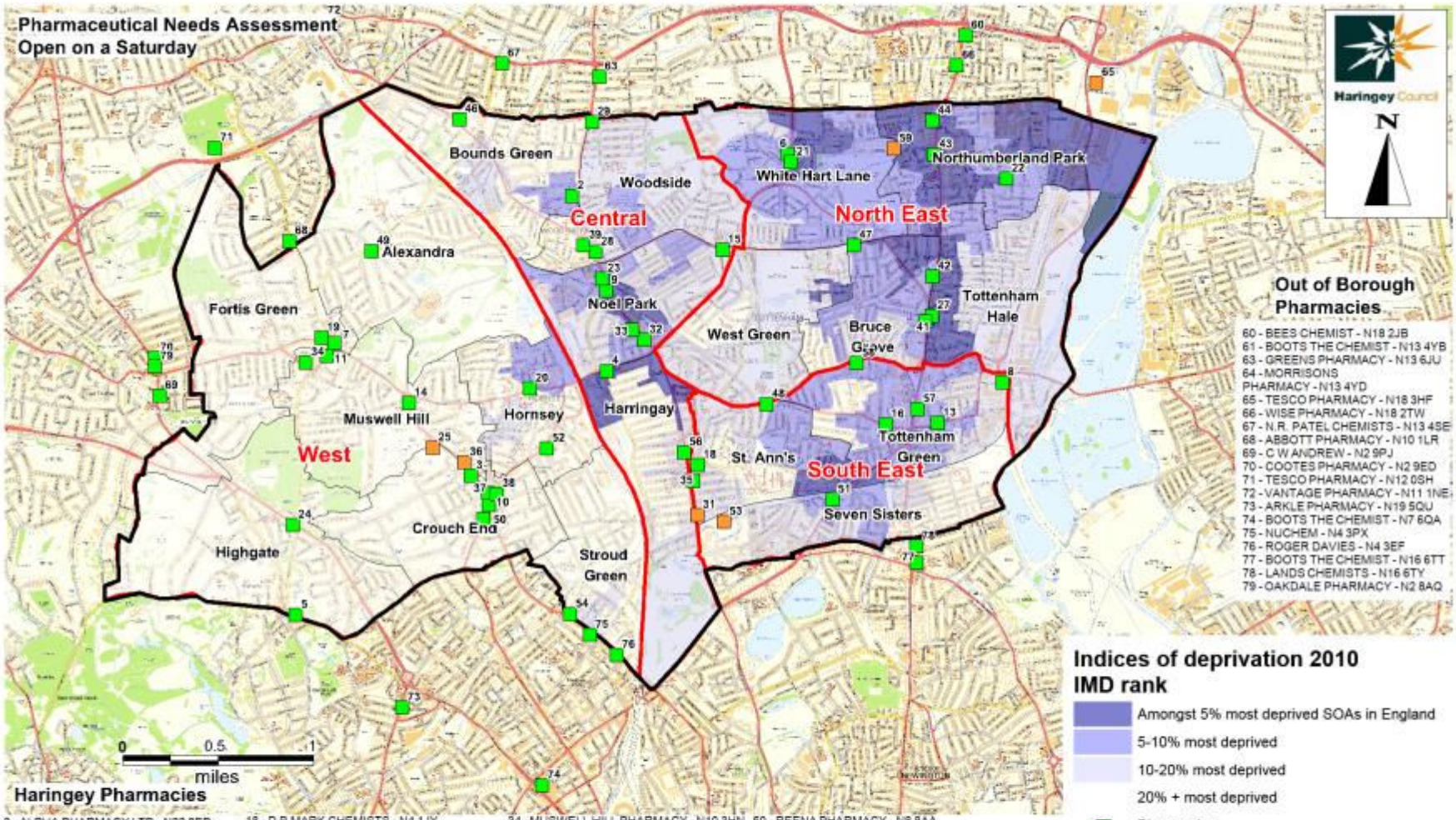
- Borough Boundary
- Locality Boundary
- Ward Boundary

Haringey Pharmacies

1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N8 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW

Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)

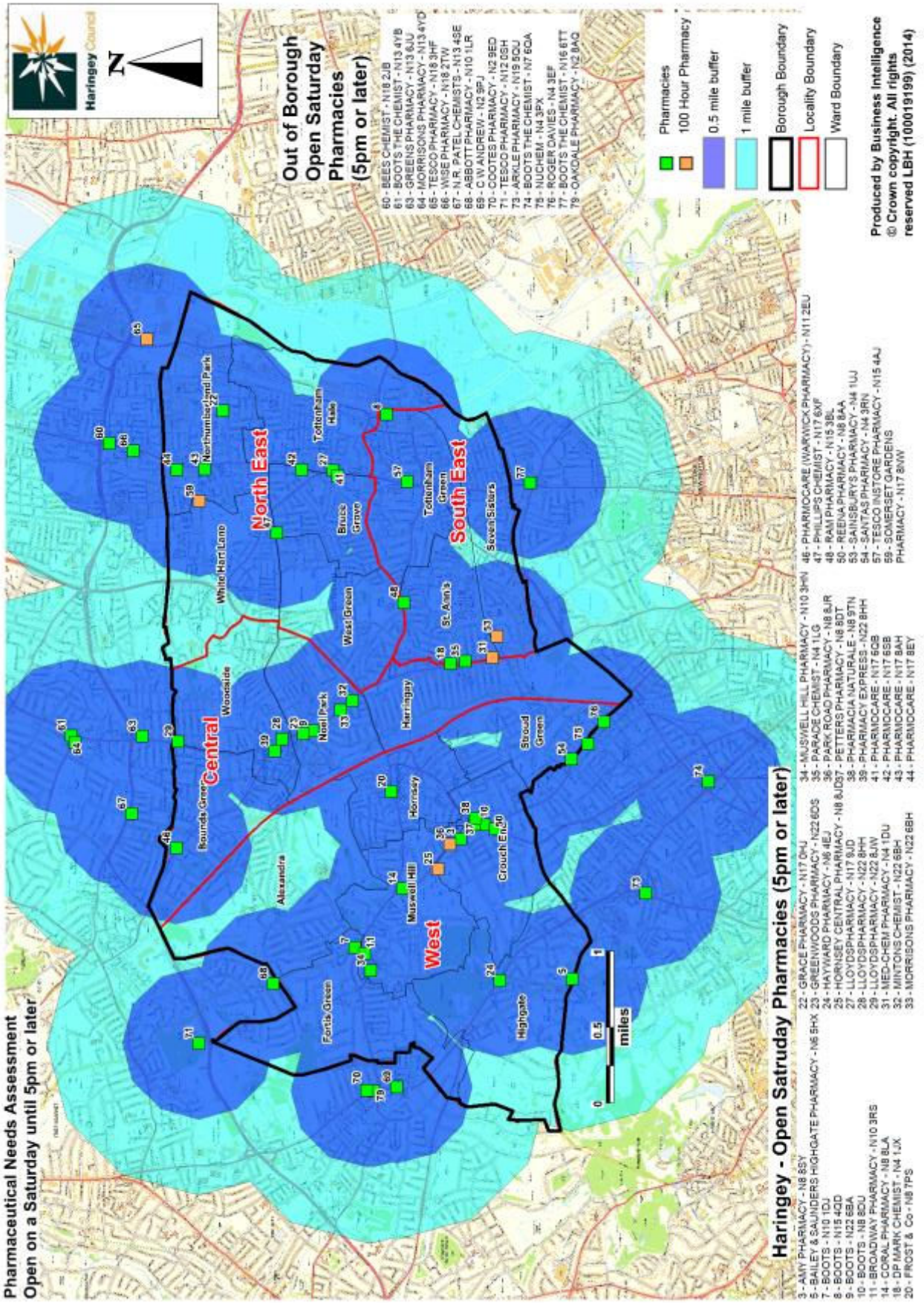

Pharmaceutical Needs Assessment
Weekday Extended Hours
Haringey Council
N
Central
North East
West
South East
Woodside
White Hart Lane
Northumberland Park
Bounds Green
Alexandra
Noel Park
Fortis Green
West Green
Bruce Grove
Tottenham Hale
Muswell Hill
Hornsey
Harringay
St Ann's
Tottenham Green
Seven Sisters
Crouch End
Highgate
Stroud Green
0 0.5 1
miles
Out of Borough Extended Hours Pharmacies
60 - BEES CHEMIST - N18 2JB
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
71 - TESCO PHARMACY - N12 0SH
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
Pharmacies
100 Hour Pharmacy
0.5 mile buffer
1 mile buffer
Borough Boundary
Locality Boundary
Ward Boundary
Haringey - Extended Hours Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
3 - AMY PHARMACY - N8 8SY
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
16 - DOBBER PHARMACY - N15 5NR
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & Co - N8 7PS
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
31 - MED-CHEM PHARMACY - N4 1DU
33 - MORRISONS PHARMACY - N22 6BH
36 - PARK ROAD PHARMACY - N8 8JR
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
53 - SAINSBURYS PHARMACY - N4 1UJ
57 - TESCO INSTORE PHARMACY - N15 4AJ
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)

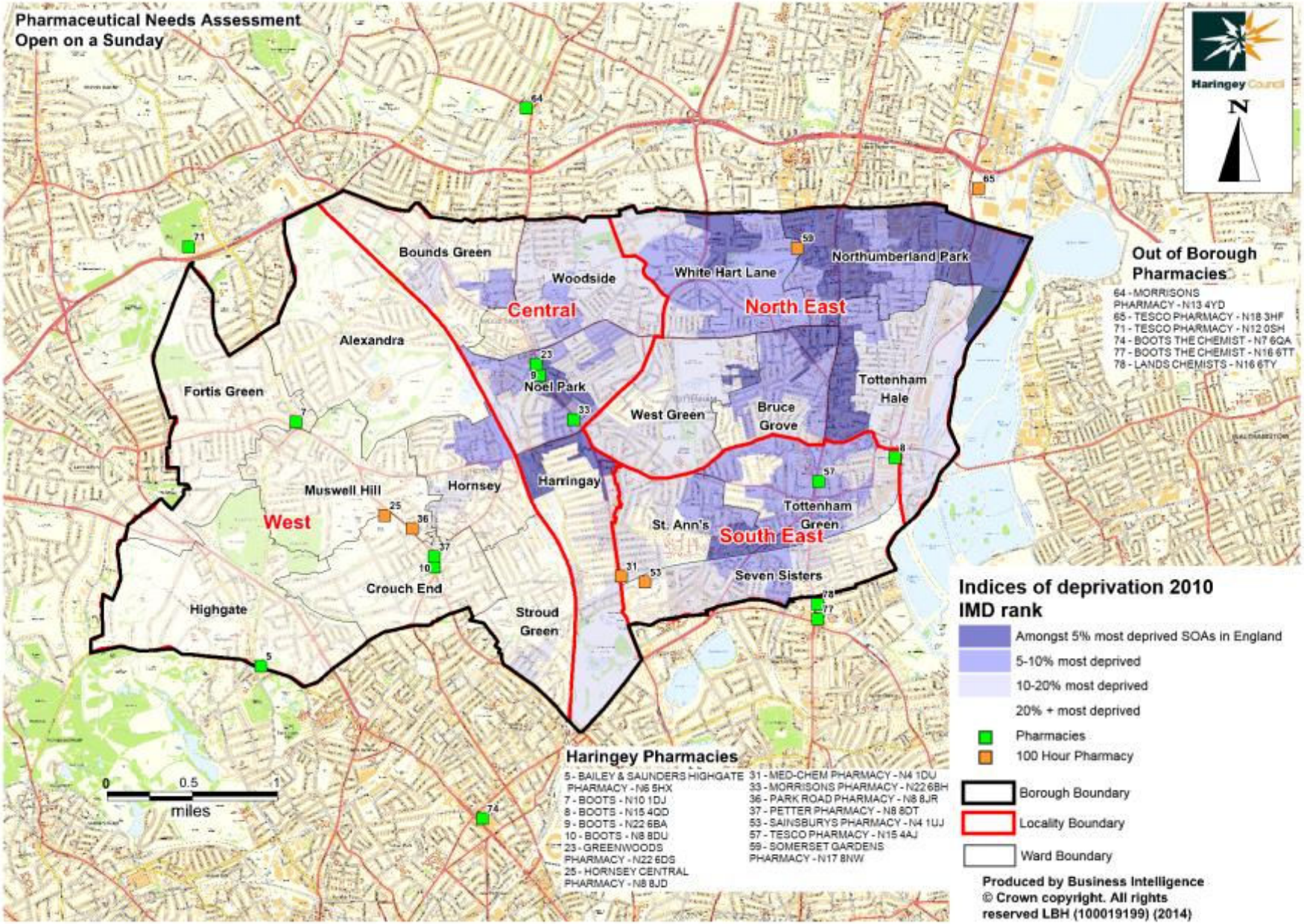


Haringey Pharmacies

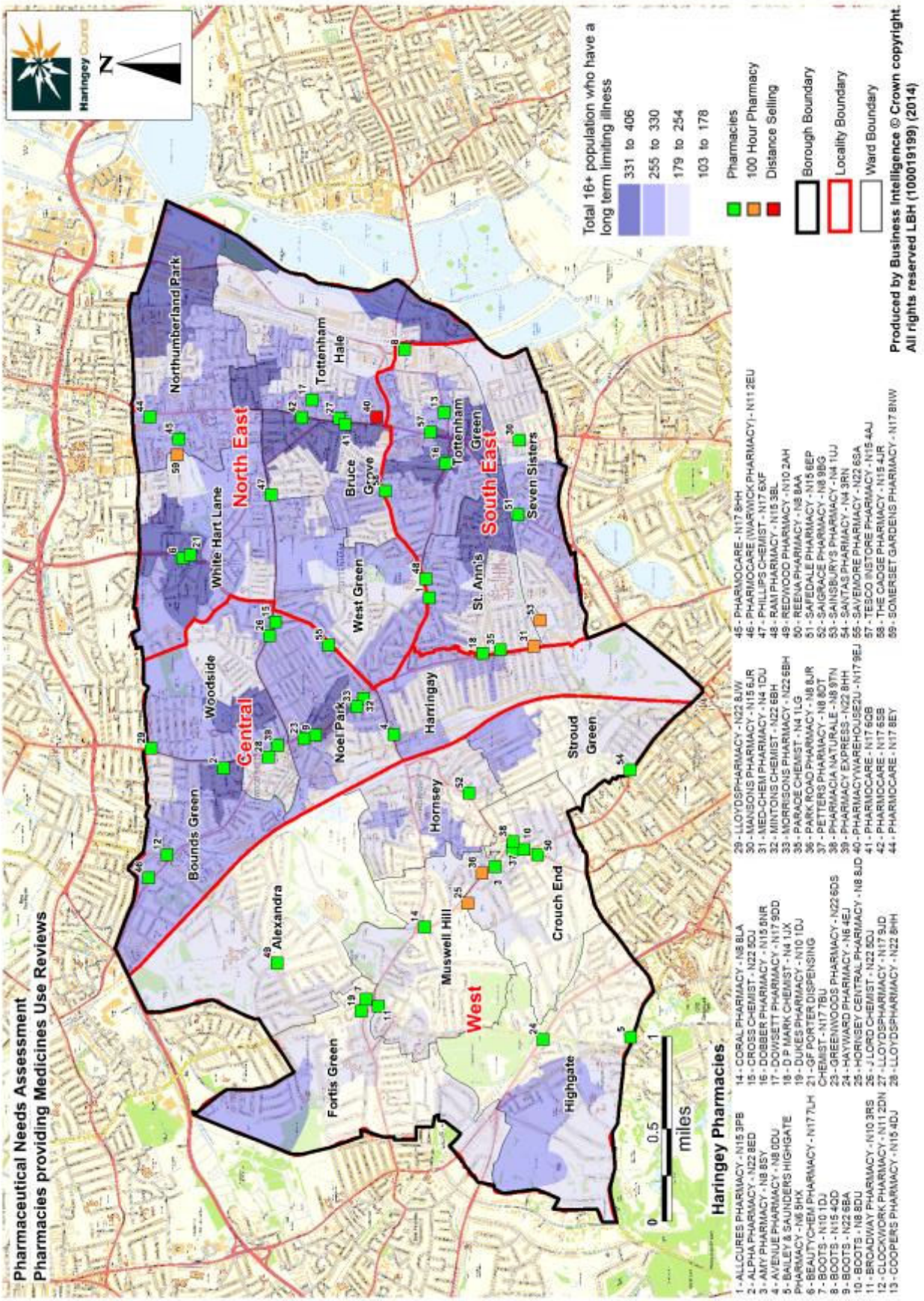
2 - ALPHA PHARMACY LTD - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY LTD - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBERS PHARMACY - N15 5NR
18 - D P MARK CHEMISTS - N4 1JY
19 - DUKES PHARMACY - N10 1DJ
20 - FROST & CO - N8 7PS
21 - G F PORTER DISPENSING CHEMIST - N17 7BU
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
27 - LLOYDS PHARMACY - N17 9JD
28 - LLOYDS PHARMACY - N22 8HH
29 - LLOYDS PHARMACY - N22 8JW
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTER PHARMACY - N8 8DT
38 - PHARMACIA NATUALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY LTD - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
56 - STEARNS PHARMACY - N8 0RL
57 - TESCO PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW

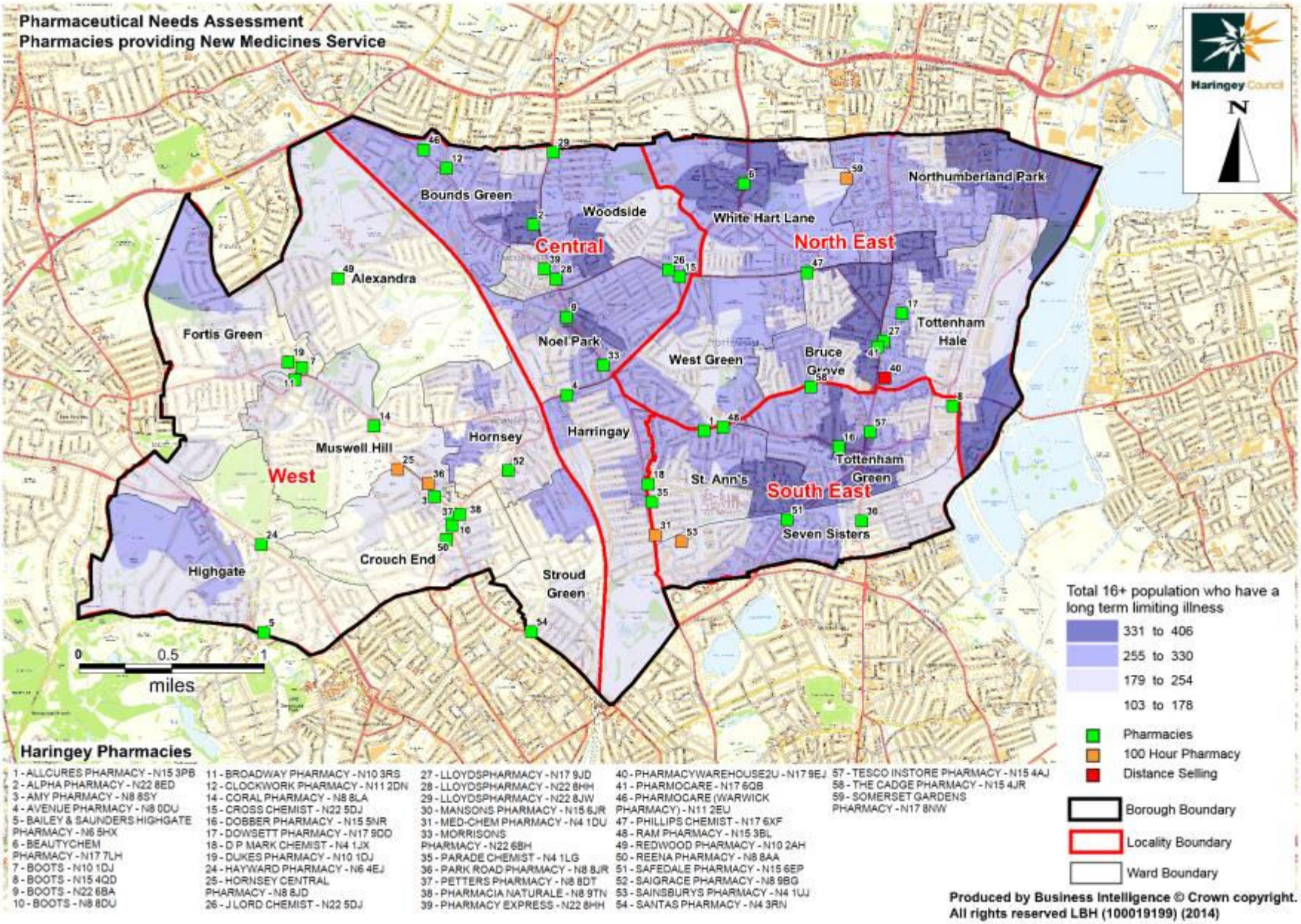
Map 6

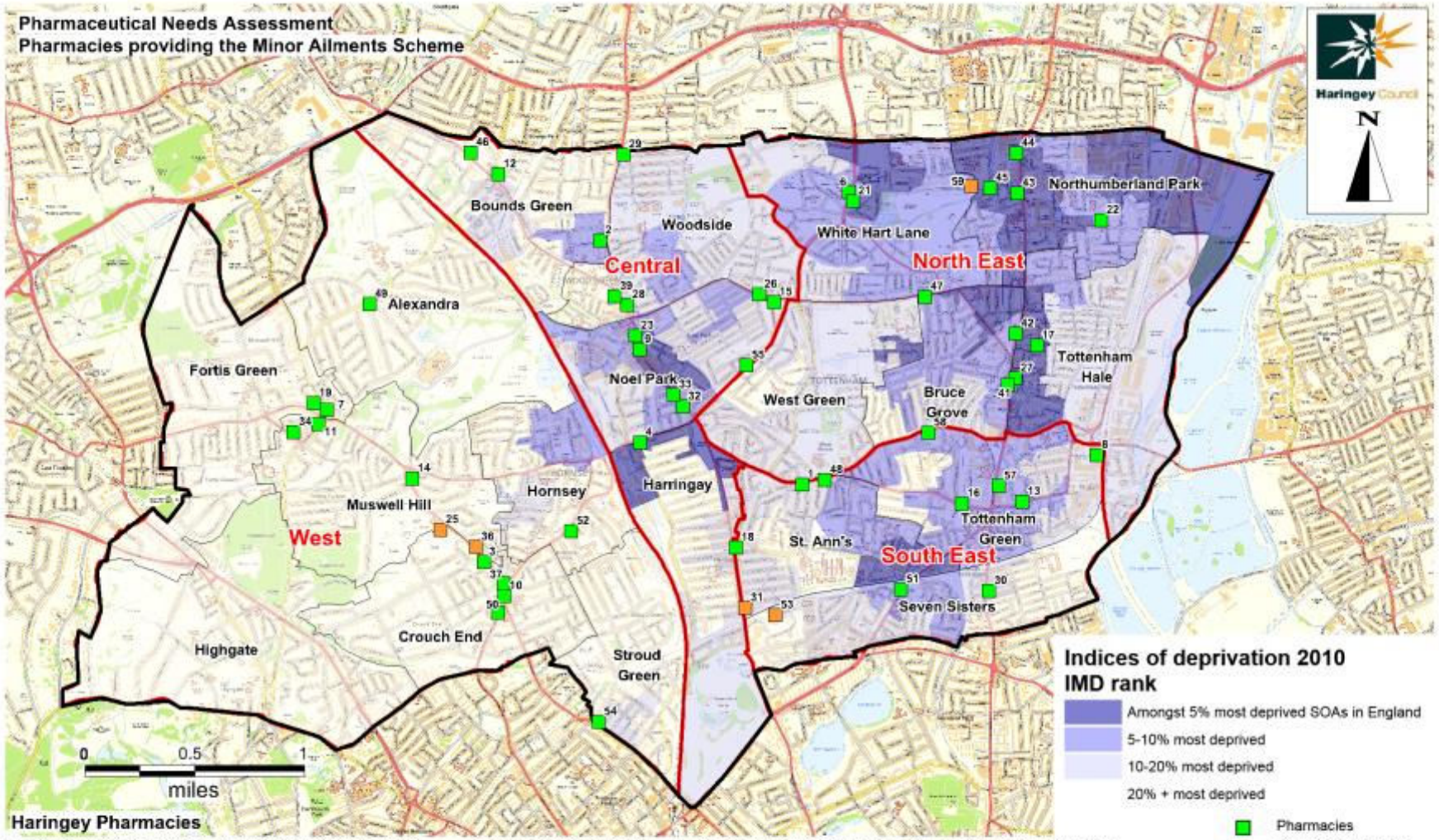

Pharmaceutical Needs Assessment
Open on a Saturday until 5pm or later
Haringey Council
N
Out of Borough
Open Saturday
Pharmacies
(5pm or later)
60 - BEES CHEMIST - N18 2JB
61 - BOOTS THE CHEMIST - N13 4YB
63 - GREENS PHARMACY - N13 6JU
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
66 - WISE PHARMACY - N18 2TW
67 - N.R. PATEL CHEMISTS - N13 4SE
68 - ABBOTT PHARMACY - N10 1LR
69 - C W ANDREW - N2 9PJ
70 - COOTES PHARMACY - N2 9ED
71 - TESCO PHARMACY - N12 0SH
73 - ARKLE PHARMACY - N19 5QU
74 - BOOTS THE CHEMIST - N7 6QA
75 - NUCHEM - N4 3PX
76 - ROGER DAVIES - N4 3EF
77 - BOOTS THE CHEMIST - N16 6TT
79 - OAKDALE PHARMACY - N2 8AQ
Pharmacies
100 Hour Pharmacy
0.5 mile buffer
1 mile buffer
Borough Boundary
Locality Boundary
Ward Boundary
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)
North East
Central
West
South East
Haringey - Open Satruday Pharmacies (5pm or later)
3 - AMY PHARMACY - N8 8SY
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
7 - BOOTS - N10 1DU
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
14 - CORAL PHARMACY - N8 8LA
18 - DP MARK CHEMIST - N4 1JX
20 - FROST & Co - N8 7PS
22 - GRACE PHARMACY - N17 0HJ
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
31 - MEDCHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
50 - REENA PHARMACY - N8 8AA
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
57 - TESCO INSTORE PHARMACY - N15 4AJ
59 - SOMERSET GARDENS PHARMACY - N17 8NW
0
0.5
1
miles


Pharmaceutical Needs Assessment
Open on a Sunday
Haringey Council
N
Out of Borough Pharmacies
64 - MORRISONS PHARMACY - N13 4YD
65 - TESCO PHARMACY - N18 3HF
71 - TESCO PHARMACY - N12 0SH
74 - BOOTS THE CHEMIST - N7 6QA
77 - BOOTS THE CHEMIST - N16 6TT
78 - LANDS CHEMISTS - N16 6TY
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Central
North East
Alexandra
Fortis Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Muswell Hill
Hornsey
Harringay
West
St. Ann's
South East
Tottenham Green
Seven Sisters
Crouch End
Highgate
Stroud Green
0
0.5
1
miles
Haringey Pharmacies
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
23 - GREENWOODS PHARMACY - N22 6DS
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
31 - MED-CHEM PHARMACY - N4 1DU
33 - MORRISONS PHARMACY - N22 6BH
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTER PHARMACY - N8 8DT
53 - SAINSBURYS PHARMACY - N4 1UJ
57 - TESCO PHARMACY - N15 4AJ
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Indices of deprivation 2010
IMD rank
Amongst 5% most deprived SOAs in England
5-10% most deprived
10-20% most deprived
20% + most deprived
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
Produced by Business Intelligence
© Crown copyright. All rights reserved LBH (100019199) (2014)

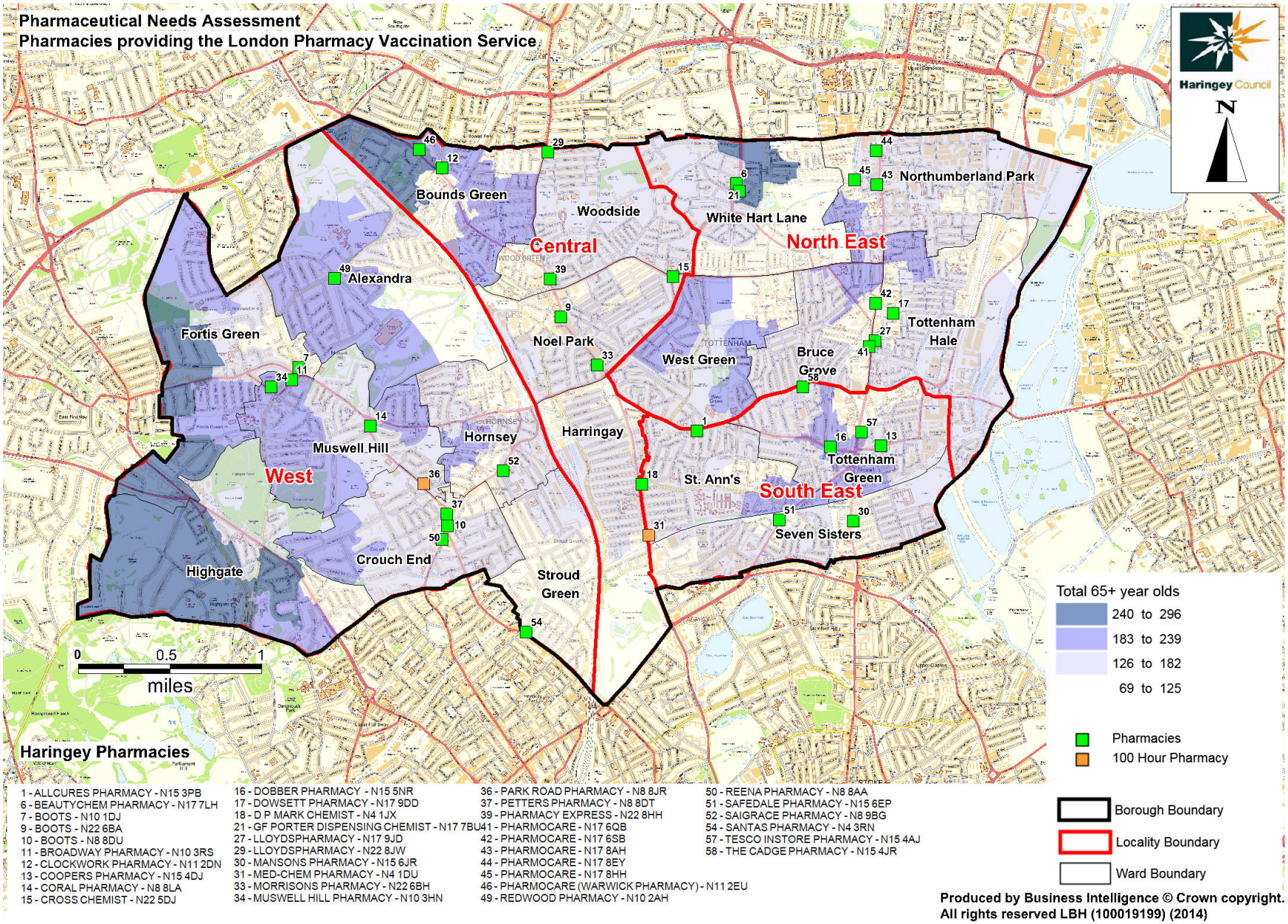
Map 8


Pharmaceutical Needs Assessment
Pharmacies providing Medicines Use Reviews
Haringey Council
N
Total 16+ population who have a long term limiting illness
331 to 406
255 to 330
179 to 254
103 to 178
Pharmacies
100 Hour Pharmacy
Distance Selling
Borough Boundary
Locality Boundary
Ward Boundary
Produced by Business Intelligence © Crown copyright. All rights reserved LBH (100019199) (2014)
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 6NR
17 - DOWSETT PHARMACY - N17 9DD
18 - D P MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
23 - GREENWOODS PHARMACY - N22 6DS
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6DB
42 - PHARMOCARE - N17 6SB
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
55 - SAVEMORE PHARMACY - N22 6SA
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Northumberland Park
White Hart Lane
Tottenham Hale
Bruce Grove
Tottenham Green
Seven Sisters
West Green
St. Anns
Woodside
Noel Park
Harringay
Stroud Green
Hornsey
Bounds Green
Alexandra
Muswell Hill
Crouch End
Fortis Green
Highgate
North East
Central
South East
West
0
0.5
1
miles

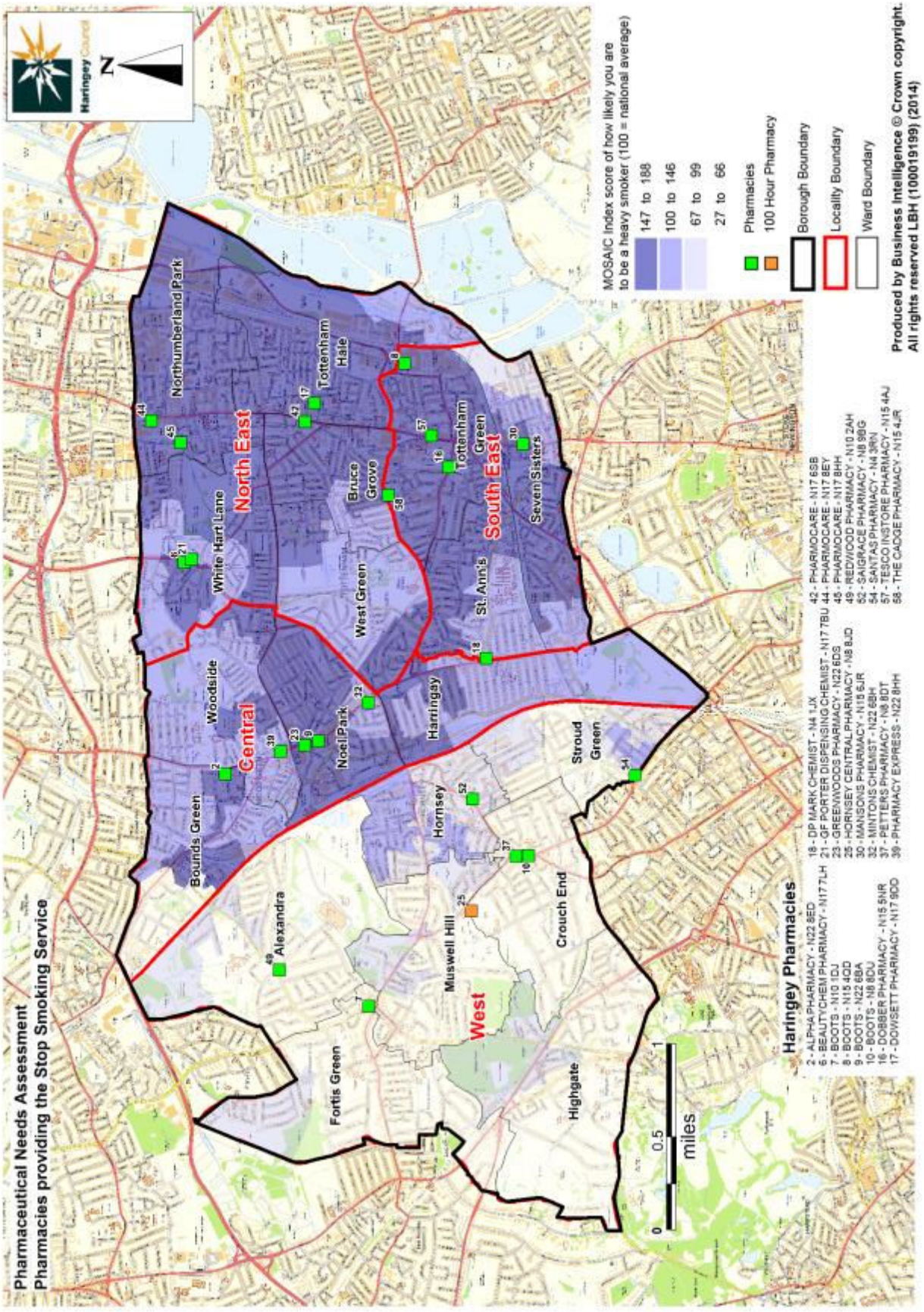

Pharmaceutical Needs Assessment
Pharmacies providing New Medicines Service
Haringey Council
N
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Central
North East
Alexandra
Fortis Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Muswell Hill
Hornsey
Harringay
West
Tottenham Green
St. Ann's
South East
Seven Sisters
Crouch End
Highgate
Stroud Green
0 0.5 1
miles
Total 16+ population who have a long term limiting illness
331 to 406
255 to 330
179 to 254
103 to 178
Pharmacies
100 Hour Pharmacy
Distance Selling
Borough Boundary
Locality Boundary
Ward Boundary
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
5 - BAILEY & SAUNDERS HIGHGATE PHARMACY - N6 5HX
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - D P MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
24 - HAYWARD PHARMACY - N6 4EJ
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
26 - J LORD CHEMIST - N22 5DJ
27 - LLOYDSPHARMACY - N17 9JD
28 - LLOYDSPHARMACY - N22 8HH
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
33 - MORRISONS PHARMACY - N22 6BH
35 - PARADE CHEMIST - N4 1LG
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
38 - PHARMACIA NATURALE - N8 9TN
39 - PHARMACY EXPRESS - N22 8HH
40 - PHARMACYWAREHOUSE2U - N17 9EJ
41 - PHARMOCARE - N17 6QB
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
47 - PHILLIPS CHEMIST - N17 6XF
48 - RAM PHARMACY - N15 3BL
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
53 - SAINSBURYS PHARMACY - N4 1UJ
54 - SANTAS PHARMACY - N4 3RN
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
59 - SOMERSET GARDENS PHARMACY - N17 8NW
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)

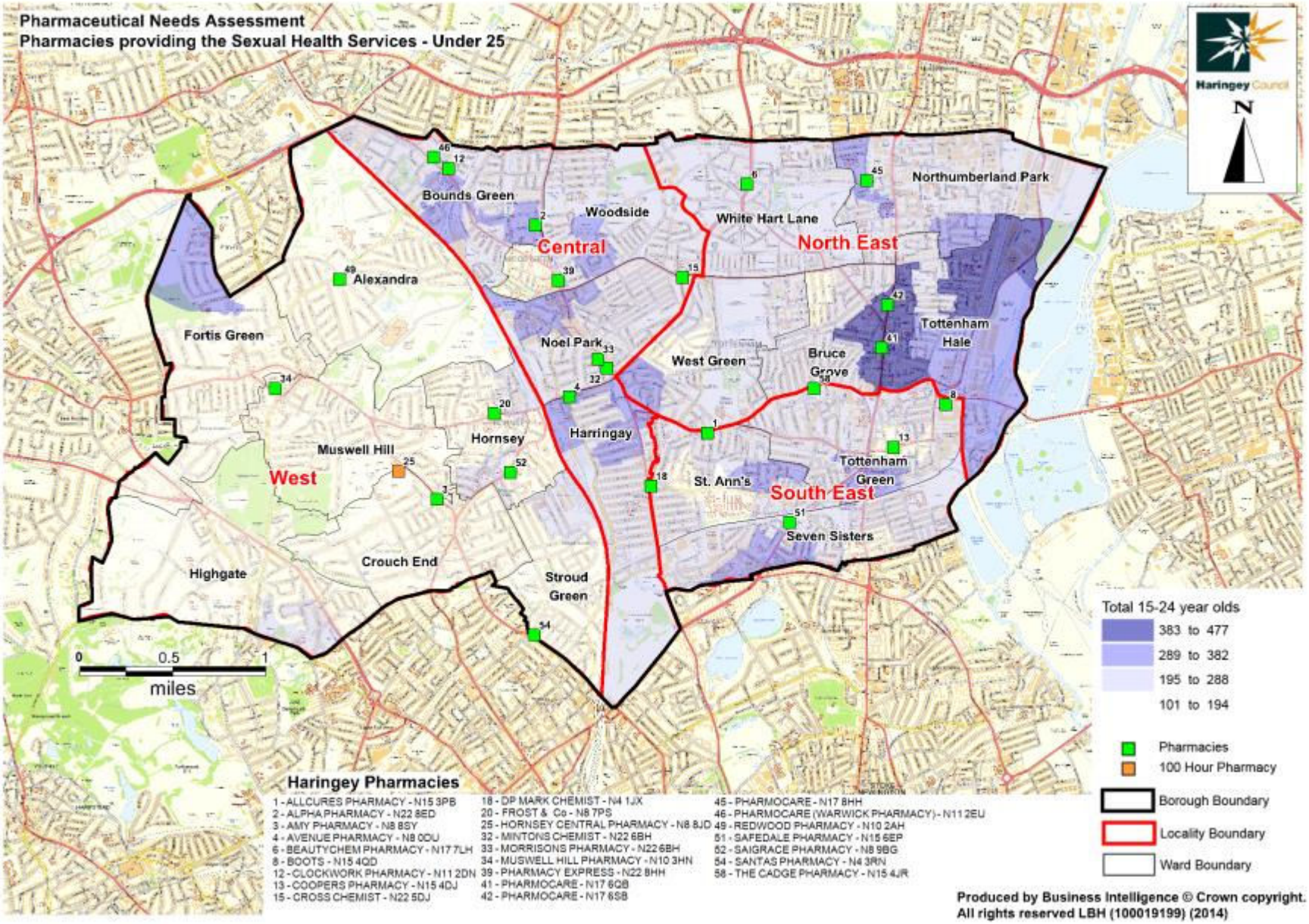


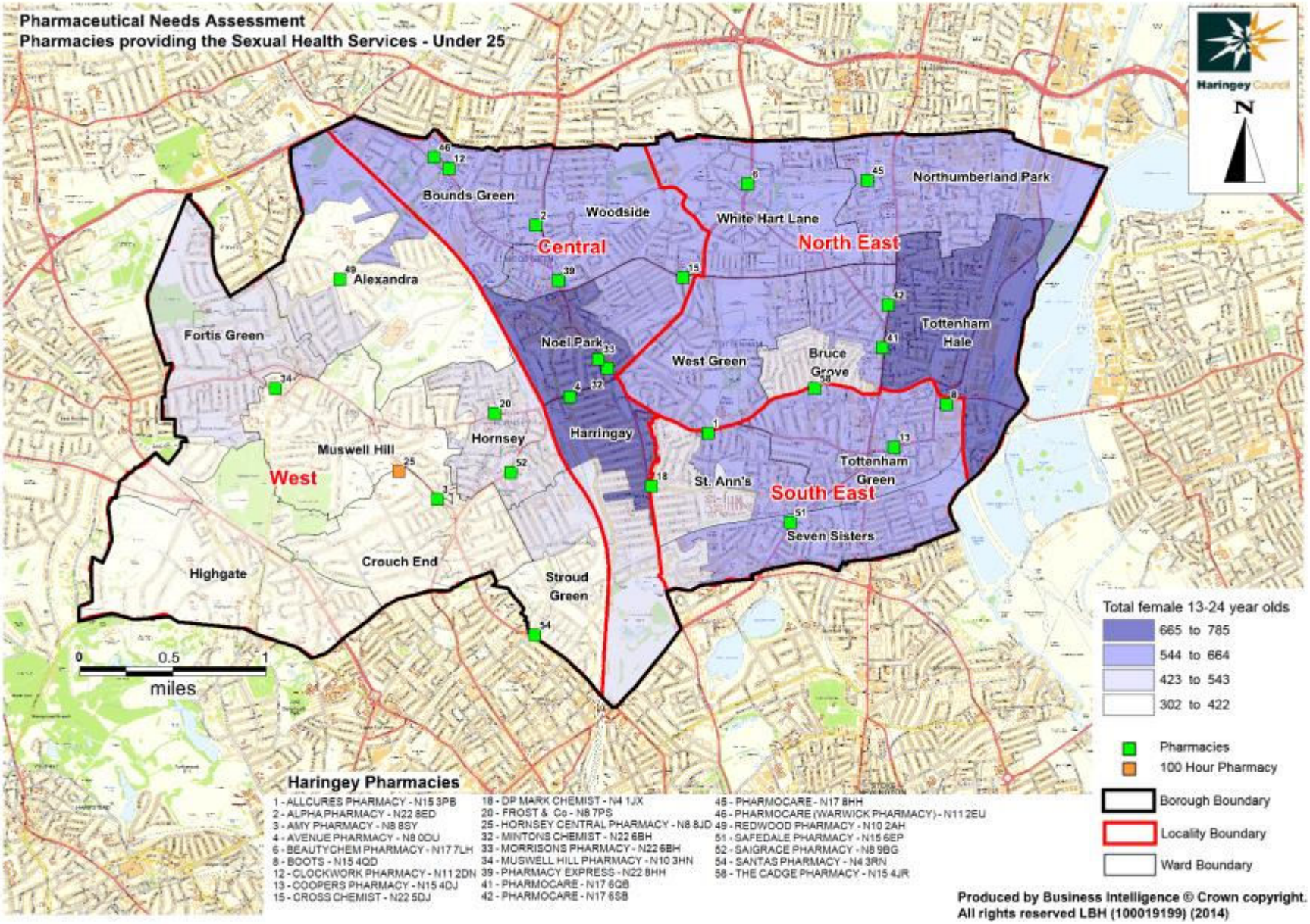
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)


Pharmaceutical Needs Assessment
Pharmacies providing the London Pharmacy Vaccination Service
Haringey Council
N
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Central
North East
Alexandra
Fortis Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Harringay
Hornsey
Muswell Hill
West
St. Ann's
South East
Tottenham Green
Seven Sisters
Crouch End
Highgate
Stroud Green
0 0.5 1
miles
Haringey Pharmacies
Total 65+ year olds
240 to 296
183 to 239
126 to 182
69 to 125
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
1 - ALLCURES PHARMACY - N15 3PB
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
11 - BROADWAY PHARMACY - N10 3RS
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - D P MARK CHEMIST - N4 1JX
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
27 - LLOYDSPHARMACY - N17 9JD
29 - LLOYDSPHARMACY - N22 8JW
30 - MANSONS PHARMACY - N15 6JR
31 - MED-CHEM PHARMACY - N4 1DU
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
36 - PARK ROAD PHARMACY - N8 8JR
37 - PETTERS PHARMACY - N8 8DT
39 - PHARMACY EXPRESS - N22 8HH
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
43 - PHARMOCARE - N17 8AH
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
49 - REDWOOD PHARMACY - N10 2AH
50 - REENA PHARMACY - N8 8AA
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
54 - SANTAS PHARMACY - N4 3RN
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)

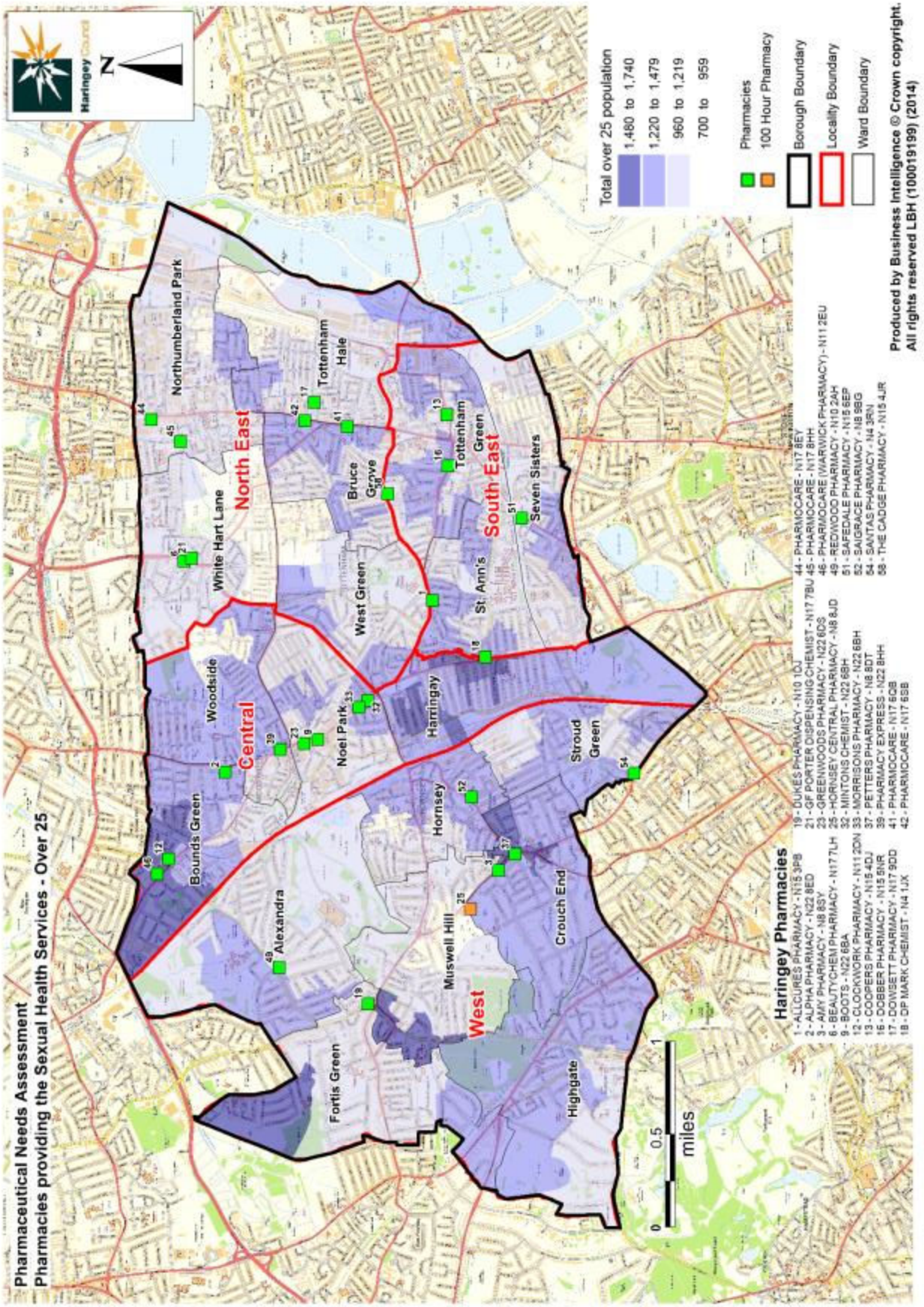
Map 12

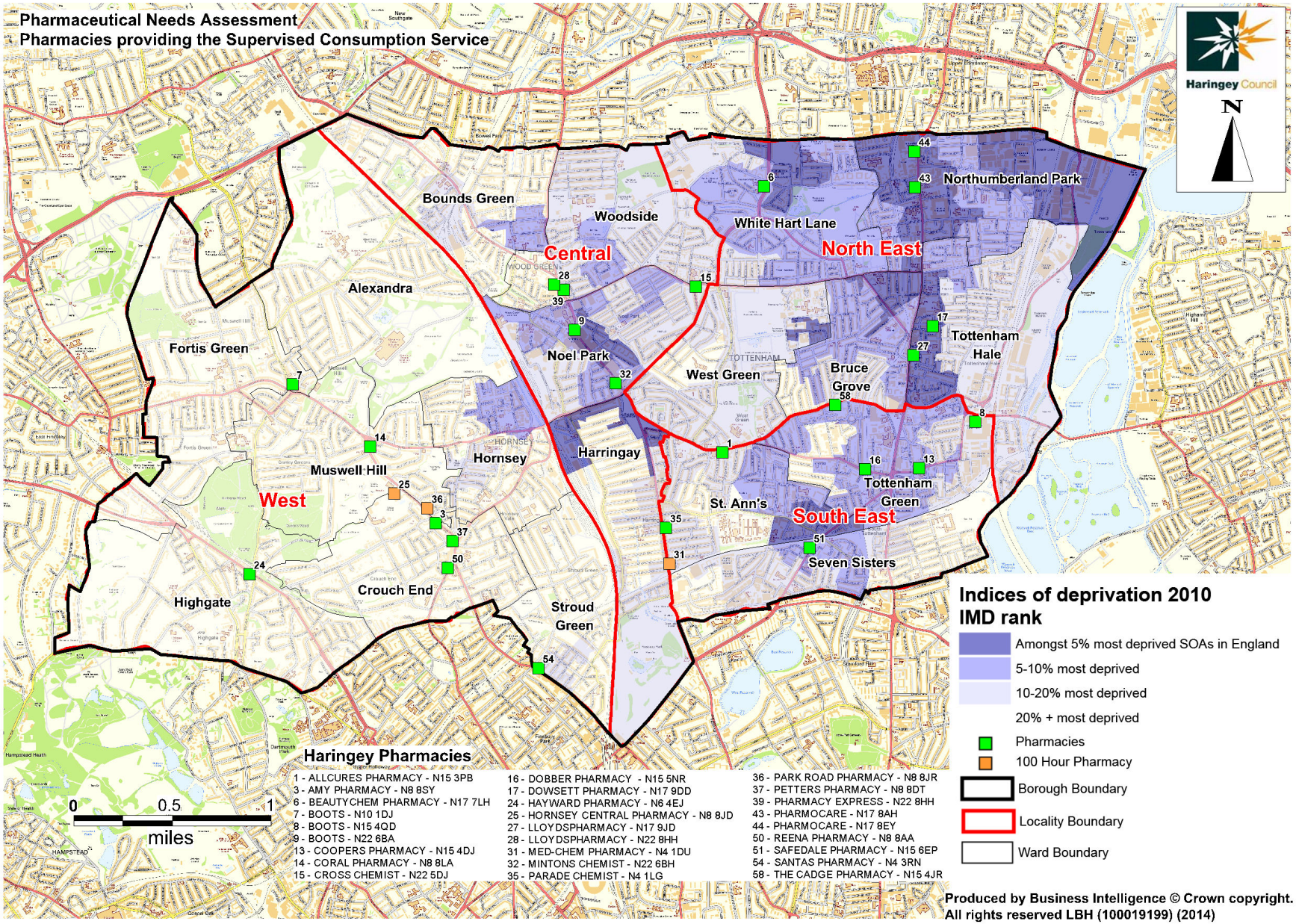

Pharmaceutical Needs Assessment
Pharmacies providing the Stop Smoking Service
Haringey Council
N
North East
Central
West
South East
Northumberland Park
White Hart Lane
Tottenham Hale
Bruce Grove
Tottenham Green
Seven Sisters
West Green
St. Ann's
Woodside
Bounds Green
Noel Park
Harringay
Stroud Green
Hornsey
Muswell Hill
Crouch End
Alexandra
Fortis Green
Highgate
0
0.5
1
miles
MOSAIC Index score of how likely you are to be a heavy smoker (100 = national average)
147 to 188
100 to 146
67 to 99
27 to 66
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
Haringey Pharmacies
2 - ALPHA PHARMACY - N22 6ED
6 - BEAUTYCHEM PHARMACY - N17 7LH
7 - BOOTS - N10 1DJ
8 - BOOTS - N15 4QD
9 - BOOTS - N22 6BA
10 - BOOTS - N8 8DU
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
23 - GREENWOODS PHARMACY - N22 6DS
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
30 - MANSONS PHARMACY - N15 6JR
32 - MINTONS CHEMIST - N22 6BH
37 - PETTERS PHARMACY - N8 8DT
39 - PHARMACY EXPRESS - N22 8HH
42 - PHARMOCARE - N17 6SB
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
49 - REDWOOD PHARMACY - N10 2AH
52 - SAIGRACE PHARMACY - N8 9BG
54 - SANTAS PHARMACY - N4 3RN
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CAGE PHARMACY - N15 4JR
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)


Pharmaceutical Needs Assessment
Pharmacies providing the Sexual Health Services - Under 25
Haringey Council
N
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Central
North East
Alexandra
Fortis Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Hornsey
Harringay
Muswell Hill
West
St. Ann's
South East
Tottenham Green
Seven Sisters
Highgate
Crouch End
Stroud Green
0 0.5 1
miles
Total 15-24 year olds
383 to 477
289 to 382
195 to 288
101 to 194
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
6 - BEAUTYCHEM PHARMACY - N17 7LH
8 - BOOTS - N15 4QD
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
15 - CROSS CHEMIST - N22 5DJ
18 - DP MARK CHEMIST - N4 1JX
20 - FROST & Co - N8 7PS
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
39 - PHARMACY EXPRESS - N22 8HH
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
49 - REDWOOD PHARMACY - N10 2AH
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
54 - SANTAS PHARMACY - N4 3RN
58 - THE CADGE PHARMACY - N15 4JR
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)


Pharmaceutical Needs Assessment
Pharmacies providing the Sexual Health Services - Under 25
Haringey Council
N
Bounds Green
Woodside
White Hart Lane
Northumberland Park
Central
North East
Alexandra
Fortis Green
Noel Park
West Green
Bruce Grove
Tottenham Hale
Harringay
Hornsey
Muswell Hill
West
St. Ann's
South East
Tottenham Green
Seven Sisters
Highgate
Crouch End
Stroud Green
0 0.5 1
miles
Total female 13-24 year olds
665 to 785
544 to 664
423 to 543
302 to 422
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
4 - AVENUE PHARMACY - N8 0DU
6 - BEAUTYCHEM PHARMACY - N17 7LH
8 - BOOTS - N15 4QD
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
15 - CROSS CHEMIST - N22 5DJ
18 - DP MARK CHEMIST - N4 1JX
20 - FROST & Co - N8 7PS
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
34 - MUSWELL HILL PHARMACY - N10 3HN
39 - PHARMACY EXPRESS - N22 8HH
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
49 - REDWOOD PHARMACY - N10 2AH
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
54 - SANTAS PHARMACY - N4 3RN
58 - THE CADGE PHARMACY - N15 4JR
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)

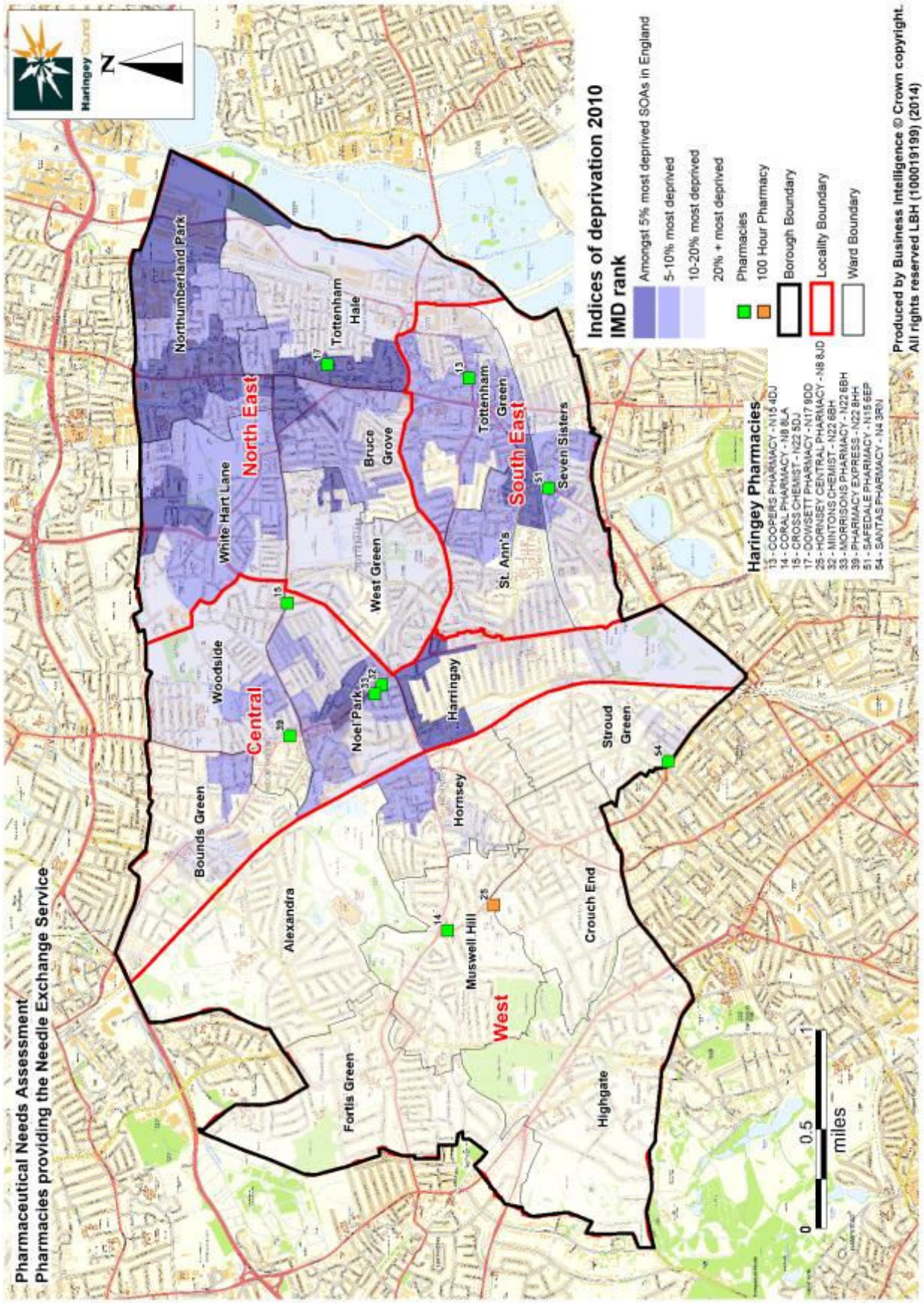
Map 15


Pharmaceutical Needs Assessment
Pharmacies providing the Sexual Health Services - Over 25
Haringey Council
N
North East
Central
West
South East
Northumberland Park
White Hart Lane
Tottenham Hale
Bruce Grove
Tottenham Green
Seven Sisters
West Green
St Ann's
Woodside
Noel Park
Harringay
Stroud Green
Bounds Green
Alexandra
Hornsey
Muswell Hill
Crouch End
Fortis Green
Highgate
Total over 25 population
1,480 to 1,740
1,220 to 1,479
960 to 1,219
700 to 959
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
0
0.5
1
miles
Haringey Pharmacies
1 - ALLCURES PHARMACY - N15 3PB
2 - ALPHA PHARMACY - N22 8ED
3 - AMY PHARMACY - N8 8SY
6 - BEAUTYCHEM PHARMACY - N17 7LH
9 - BOOTS - N22 6BA
12 - CLOCKWORK PHARMACY - N11 2DN
13 - COOPERS PHARMACY - N15 4DJ
16 - DOBBER PHARMACY - N15 5NR
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
19 - DUKES PHARMACY - N10 1DJ
21 - GF PORTER DISPENSING CHEMIST - N17 7BU
23 - GREENWOODS PHARMACY - N22 6QS
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
37 - PETTERS PHARMACY - N8 8DT
39 - PHARMACY EXPRESS - N22 8HH
41 - PHARMOCARE - N17 6QB
42 - PHARMOCARE - N17 6SB
44 - PHARMOCARE - N17 8EY
45 - PHARMOCARE - N17 8HH
46 - PHARMOCARE (WARWICK PHARMACY) - N11 2EU
49 - REDWOOD PHARMACY - N10 2AH
51 - SAFEDALE PHARMACY - N15 6EP
52 - SAIGRACE PHARMACY - N8 9BG
54 - SANTAS PHARMACY - N4 3RN
58 - THE CADGE PHARMACY - N15 4JR
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (1000119199) (2014)

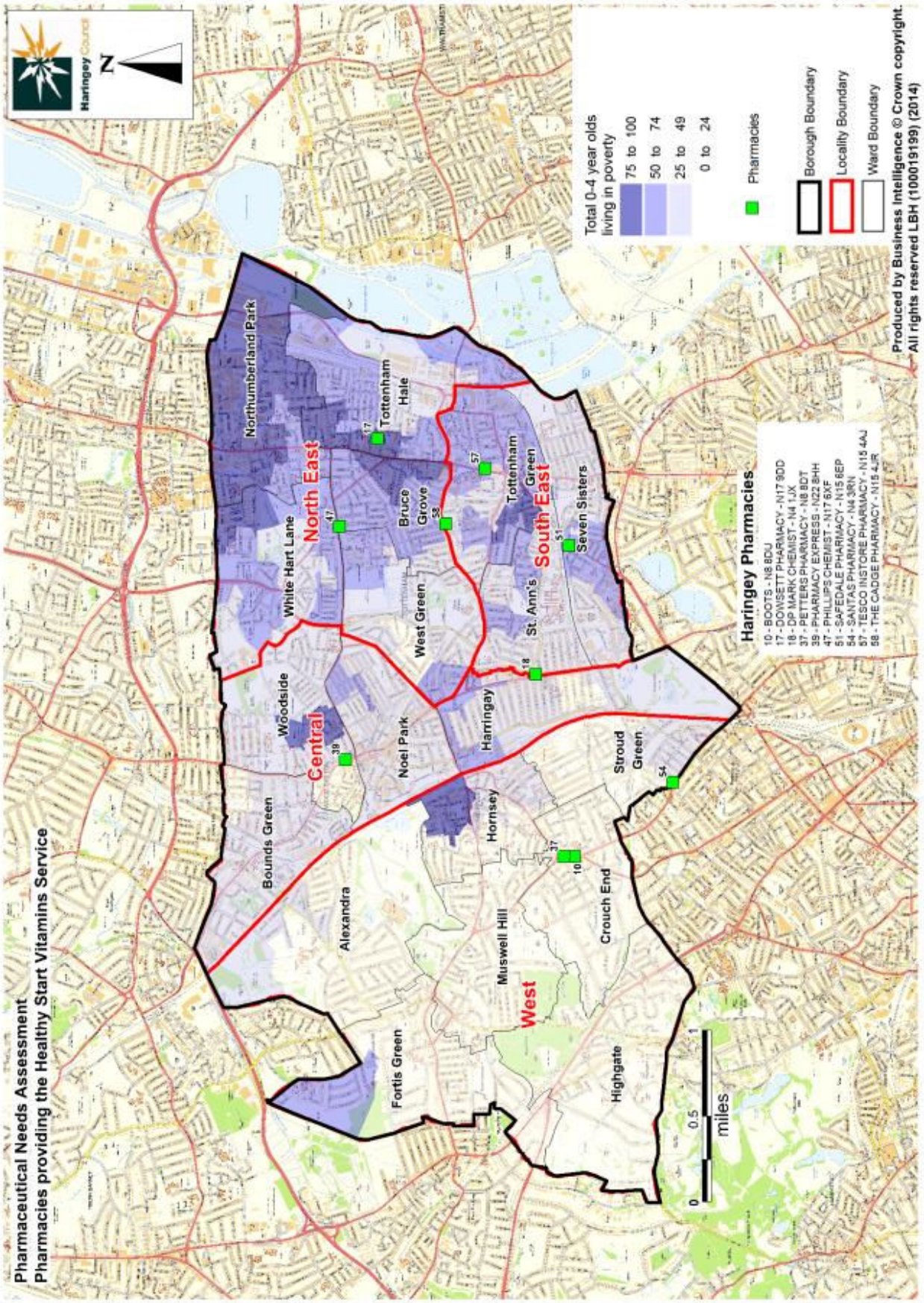


Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)

Map 17


Pharmaceutical Needs Assessment
Pharmacies providing the Needle Exchange Service
Haringey Council
N
Indices of deprivation 2010
IMD rank
Amongst 5% most deprived SOAs in England
5-10% most deprived
10-20% most deprived
20% + most deprived
Pharmacies
100 Hour Pharmacy
Borough Boundary
Locality Boundary
Ward Boundary
Haringey Pharmacies
13 - COOPERS PHARMACY - N15 4DJ
14 - CORAL PHARMACY - N8 8LA
15 - CROSS CHEMIST - N22 5DJ
17 - DOWSETT PHARMACY - N17 9DD
25 - HORNSEY CENTRAL PHARMACY - N8 8JD
32 - MINTONS CHEMIST - N22 6BH
33 - MORRISONS PHARMACY - N22 6BH
39 - PHARMACY EXPRESS - N22 8HH
51 - SAFEDALE PHARMACY - N15 6EP
54 - SANTAS PHARMACY - N4 3RN
0
0.5
1
miles
Produced by Business Intelligence © Crown copyright.
All rights reserved LBH (100019199) (2014)
North East
Central
South East
West
Northumberland Park
White Hart Lane
Woodside
Bounds Green
Alexandra
Fortis Green
Tottenham Hale
Bruce Grove
West Green
Noel Park
Harringay
Hornsey
Muswell Hill
Tottenham Green
St. Ann's
Seven Sisters
Stroud Green
Crouch End
Highgate

Map 18


Pharmaceutical Needs Assessment
Pharmacies providing the Healthy Start Vitamins Service
Haringey Council
N
Total 0-4 year olds living in poverty
75 to 100
50 to 74
25 to 49
0 to 24
Pharmacies
Borough Boundary
Locality Boundary
Ward Boundary
Produced by Business Intelligence © Crown copyright. All rights reserved LBH (100019199) (2014)
Haringey Pharmacies
10 - BOOTS - N8 8DU
17 - DOWSETT PHARMACY - N17 9DD
18 - DP MARK CHEMIST - N4 1JX
37 - PETTERS PHARMACY - N8 8DT
39 - PHARMACY EXPRESS - N22 8HH
47 - PHILLIPS CHEMIST - N17 6XF
51 - SAFEDALE PHARMACY - N15 6EP
54 - SANTAS PHARMACY - N4 3RN
57 - TESCO INSTORE PHARMACY - N15 4AJ
58 - THE CADGE PHARMACY - N15 4JR
North East
Central
South East
West
Northumberland Park
White Hart Lane
Tottenham Hale
Bruce Grove
Tottenham Green
Seven Sisters
St. Ann's
West Green
Woodside
Noel Park
Harringay
Stroud Green
Bounds Green
Alexandra
Hornsey
Muswell Hill
Crouch End
Fortis Green
Highgate
0
0.5
1
miles

Haringey Council

Appendix A

PNA Steering Group Terms of Reference

Haringey Pharmaceutical Needs Assessment
Steering Group
Terms of Reference

1. Background

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) set out the system for market entry[3].

From 1st April 2013, Health and Wellbeing Boards (HWBs) assumed responsibility for publishing and keeping up to date a statement of the needs for pharmaceutical services of the population in their area, referred to as a Pharmaceutical Needs Assessment (PNA).

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services that are currently provided, together with when and where these are available to a given population.

Under the same Regulations, the PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or when commissioning services.

Formerly published by primary care trusts (PCTs), the PNA is a key tool, for commissioners in other organisations, for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The last PNA was published in 2011 and can be downloaded using the following link http://haringey.gov.uk/jsna.

2. The importance to HWBs

- HWBs now have a legal duty to check the suitability of existing PNAs, compiled by primary care trusts (PCTs), and publish supplementary statements explaining any changes.
- HWBs will need to ensure that NHS England and its Area Teams have access to their PNAs.
- Each HWB will need to publish its own revised PNA by **1st April 2015**. This will require board-level sign-off and a minimum period (of 60 days) for public consultation beforehand[2].
- Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings.
- PNAs must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.
- The PNA should identify gaps in service, current need and identify any anticipated future needs with specific attention to the Tottenham regeneration area.
- As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities[4].
- In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long-term partner.

3. What should a good PNA cover?

- The PNAs should meet the market entry regulations[3].
- PNAs should include pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area.
- It should examine the demographics of its local population, across the area and in different localities, and their needs and also look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.
- The PNA should also contain relevant maps relating to the area and its pharmacies.
- Finally, PNAs must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.
- The PNA should distinguish between services commissioned by NHS England and other areas of public health need that are locally commissioned that are available outside of the scope of the NHS England contract.
- The PNA should identify gaps in service, current need and identify any anticipated future needs with specific attention to the Tottenham regeneration area.

4. Steering group duties/responsibilities

The Haringey Steering Group (PNA SG) has been established to:

- Oversee the production of the Haringey PNA in accordance with DH regulations and deadlines.
- Ensure that the PNA captures the specific needs of the local population, with a focus on reducing inequalities and aligning with the existing corporate plans of the HWB partners, where relevant.
- Establish arrangements to ensure the appropriate maintenance of the PNA, following publication, as required by the Regulations

The PNA SG will ensure that the findings of the PNA are presented to the HWB once published, and disseminated to those who need to know and will work towards implementation of the recommendations with relevant partners.

5. Key Objectives

- Champion the work to develop the PNA with internal and external stakeholders, including patients, service users and the public

- Approve the project plan and timeline

- Drive the project ensuring that key milestones are met

- Ensure that the requirements for the development and content of PNAs are followed and that the appropriate assessments are undertaken, in line with the Regulations

- Determine the localities which will be used for the basis of the assessment

- Undertake an assessment of the pharmaceutical needs of the population and make recommendations based on this assessment

- Determine the criteria for necessary and relevant services and apply these to pharmaceutical services, taking into account stakeholder feedback including views from patients and the public

- Determine the maps which will be included in the PNA
- Approve the framework for the PNA
- Develop a draft PNA for formal consultation with stakeholders for approval by Senior Officers of the HWB prior to consultation
- Oversee the consultation ensuring that this meets the requirements set out in the Regulations
- Consider and act upon formal responses received during the formal consultation process, making appropriate amendments to the PNA
- Develop and approve a consultation report as required by the Regulations and ensure that this is included within the final PNA
- Submit the final PNA to the Health & Wellbeing Board for approval prior to publication
- Consider and document the processes by which the HWB will discharge its responsibilities in relation to maintaining the PNA; and formally responding to consultations initiated by neighbouring HWBs. This includes making a recommendation on the long term structures required to underpin these responsibilities.

6. Policy Implications

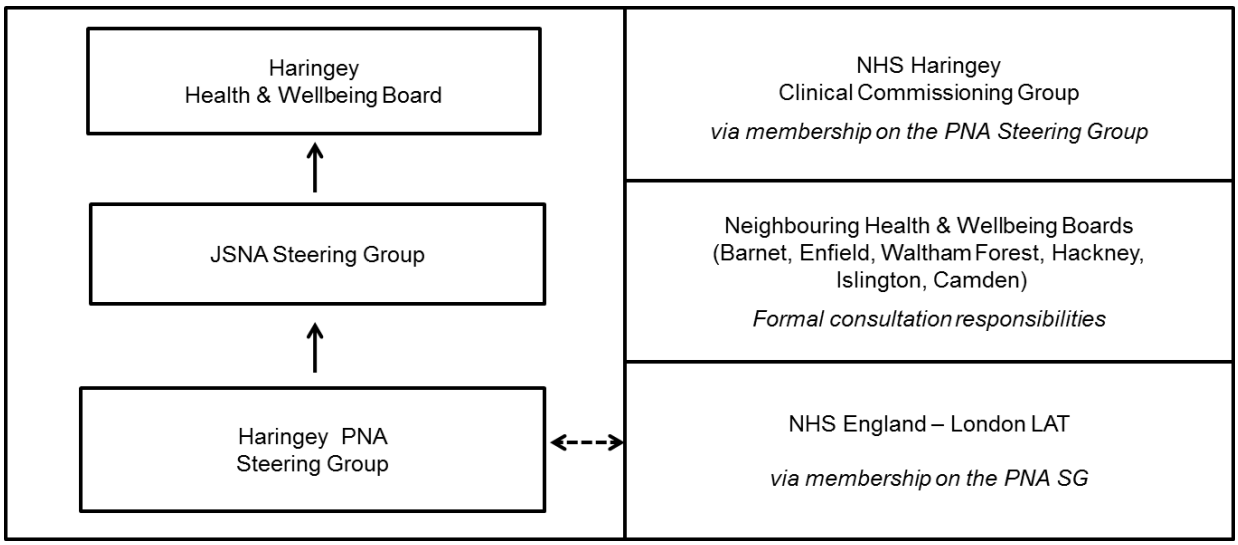
- The Pharmaceutical Needs Assessment is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.
- The Pharmaceutical Needs Assessment can be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.
- As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities4.
- In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

7. Governance

The following Governance arrangements have been established:

- The HWB has delegated responsibility to the Director of Public Health who will act as the designated officer to maintain the PNA going forward. Her Assistant Director will discharge this responsibility via the PNA steering group.
- The work of the Steering Group will be governed by the HWB for Haringey. The consultation documentation will be approved by Senior Officers of the HWB and the final PNA will be formally signed-off by the HWB.
- Progress on the PNA will be reported to the Health and Wellbeing Boards (HWB) through the JSNA Steering Group.
- NHS England and NHS Haringey CCG will be informed of progress via membership on the PNA SG

- The diagram below illustrates the accountability and reporting lines between the Haringey PNA SG and the various committees and organisations with which it needs to interact with respect to discharging its responsibilities:



8. Conflicts of interest

Some pharmacy data are commercially confidential and cannot be released into the public domain. As the PNAs are publicly available documents, if and where required, these data will be suppressed in accordance to information governance arrangements surrounding their use

Transparent arrangements to manage actual and potential conflicts of interest have been established and broadly reflect the rules which apply to Council Committees, including the HWB.

- A register of interests will be maintained. This will be updated at each PNA Steering Group meeting and signed by members
- The register will be kept under review by the HWB
- Declaration of interests will be a standing item on each PNA Steering Group agenda
- Where a member has a conflict of interest for any given agenda item, they will be entitled to participate in the discussion but will not be permitted to be involved in final decision making

9. Meeting Frequency

The PNA SG will meet, either on a face-to-face basis or virtually (conference call or email discussion), approximately every 4 - 6 weeks, in accordance with the needs of the project plan.

Following publication of the final PNA, the PNA Steering Group will be convened on an 'as required' basis to fulfil its role in timely maintenance of the PNA.

10. Membership

Membership needs to reflect that pharmacy commissioning involves: NHS England, Public Health & CCGs. Other members will be co-opted at different times to advice on different areas of work as needed

The following will be members of the steering group:

- Assistant Directors of Public Health for Haringey

- Clinical Commissioning Groups (CCG) – Head of Medicines Management
- Local Pharmaceutical Committee (LPC) Lead
- Head of Primary Care – (CCG)
- NHS England – representative
- Health Watch representative for Haringey
- Senior Public Health Information Analyst
- Local pharmacy representation
- Webstar Lane (project management)

Co-opted members (to attend when required):

- Communications Lead for CCG and LBH
- Consultation Manager LBH
- Patient / Public involvement (PPI) Group Lead/s (patient association)

The PNA SG may co-opt additional support and subject matter expertise as necessary. In carrying out its remit, the PNA SG may interface with a wider range of stakeholders.

11. Quorum

- Chair (or nominated deputy)
- Community Pharmacist (LPC or local contractor)
- One other member
- Webstar Lane Representative

12. References

1. The most recent PNA published by Haringey PCT in 2011 is available to steering group members upon request. They will be available in a PDF format at the 1st steering group meeting.

2. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

3. http://psnc.org.uk/contract-it/market-entry-regulations/

4. “Healthy lives, healthy people”, the public health strategy for England (2010)

13. Approval

Approved by the Haringey Health & Wellbeing Board in September 2014

Terms of Reference originally prepared by: Graeme Walsh, Haringey Public Health Directorate. Revisions by Webstar Lane: June 2014 and August 2014

Haringey Council

Appendix B

Community Pharmacy Questionnaire

Pharmaceutical Needs Assessment
Community Pharmacy Questionnaire

Please complete and return this questionnaire by **Monday 21 July 2014**. This should be marked for the attention of Vanessa Lane and emailed to the following address: pna-support@webstar-lane.co.uk. Alternatively, you may prefer to return this by post to the following address: London Borough Haringey PNA Questionnaire, c/o Webstar Lane 336 Pinner Road, Harrow HA1 4LB.

If you have any queries before completing the questionnaire, please do not hesitate to contact Vanessa on 07880 602088.

1. Premises Details		
1.1	Company Name (i.e. Legal Entity)	
1.2	Trading Name	
1.3	Address	
1.4	Address	
1.5	Postcode	
1.6	Email address *(we will use this to communicate with you about the PNA, including for the formal consultation)*	
1.7	Telephone Number	
1.8	Fax Number	
1.9	Name of person(s) we should contact with any queries (if different from above)	
1.10	Please confirm we may store the above details and use these to contact you	☐ 1 Yes ☐ 0 No

2. Type of Contract		
2.1	**Contracts granted under an "Exempt" Category**	**Please indicate if any of the following apply:** ☐ 1 100 Hour Pharmacy ☐ 2 Mail order or internet based pharmacy (i.e. distance selling) ☐ 3 Out of Town Shopping Development ☐ 4 Not applicable

3. Pharmacy Opening Hours									
		3.1 Total Opening Hours				**3.2 Core Hours**			
		*Please state the **full opening hours** for your pharmacy (i.e. your core and supplementary hours) in this section*				*Please state your **core hours** in this section*			
		When recording lunch time please record times that the pharmacy is closed to the public or where a full pharmaceutical service is not available *Please use 24 hour clock e.g. 08:00 or 18:00*				*Please use 24 hour clock e.g. 08:00 or 18:00*			
		Opening time	**Closing Time**	**Lunch-time (from - to)**		**Opening time**	**Closing Time**	**Lunch-time (from - to)**	
a	**Monday**								
b	**Tuesday**								
c	**Wednesday**								
d	**Thursday**								
e	**Friday**								
f	**Saturday**								
g	**Sunday**								

4. Advanced Service Provision				
	Service	**4.1 Currently Provided**	**4.2 Willing to provide in future?** *ONLY answer if service **NOT** currently provided*	**4.3** *It would be helpful to understand why pharmacies **may not wish** to provide a given service. We invite you to provide your reason(s) in this column**
a	**Medicines use reviews**	☐ 1 Yes ☐ 0 No → ↓	☐ 1 Yes ☐ 0 No →	
b	**New medicine service**	☐ 1 Yes ☐ 0 No → ↓	☐ 1 Yes ☐ 0 No →	
c	**Appliance use reviews**	☐ 1 Yes ☐ 0 No → ↓	☐ 1 Yes ☐ 0 No →	
d	**Stoma Appliance Customisation Service**	☐ 1 Yes ☐ 0 No →	☐ 1 Yes ☐ 0 No →	

* *Please note that this information will be non-attributable and will be used for the purposes of planning and commissioning services*

5. Enhanced & Locally Commissioned Service Provision

This section relates to enhanced services, commissioned by NHS England; and other services which are commissioned locally by the London Borough of Haringey, NHS Haringey Clinical Commissioning Group. ***Please click or tick the relevant box to indicate your response.***

	Service	5.1 Currently Provided *In order to answer "Yes", you **must have signed an SLA** and be paid for the service*	5.2 Willing to provide in future? ***ONLY** answer if service NOT currently provided*	5.3 *For pharmacies **providing a service or willing to provide a service in the future**, it would be helpful to understand what support you may require to deliver the service**	5.4 *It would be helpful to understand why pharmacies **may not wish** to provide a given service. We invite you to provide your reason(s) in this column**
a	**Minor ailments**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
b	**Seasonal Influenza Vaccination**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
c	**End of Life Care & Other Specialist Medicines**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
d	**Healthy Start Vitamins**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
e	**Smoking cessation**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
f	**Needle Exchange**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
g	**Supervised consumption of Subutex & Methadone**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		

5. Enhanced & Locally Commissioned Service Provision

This section relates to enhanced services, commissioned by NHS England; and other services which are commissioned locally by the London Borough of Haringey, NHS Haringey Clinical Commissioning Group. ***Please click or tick the relevant box to indicate your response.***

	Service	5.1 Currently Provided *In order to answer "Yes", you **must have signed an SLA** and be paid for the service*	5.2 Willing to provide in future? ***ONLY** answer if service NOT currently provided*	5.3 *For pharmacies **providing a service or willing to provide a service in the future**, it would be helpful to understand what support you may require to deliver the service**	5.4 *It would be helpful to understand why pharmacies **may not wish** to provide a given service. We invite you to provide your reason(s) in this column**
h	**Chlamydia screening and treatment**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
i	**Emergency Hormonal Contraception (EHC) supply under PGD**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
j	**Anti-coagulant and stroke prevention service**	☐ 1 Yes ↓ ☐ 0 No →	☐ 1 Yes ☐ 0 No →		
k	**Based on your knowledge of the healthcare needs of the patients and public who use your pharmacy, do you think that any other NHS service should be commissioned?**				

∗ *Please note this information will be non-attributable; it will only be used for planning & commissioning services*

6. Non- NHS Healthcare Related Services provided in your Pharmacy

*Please provide an overview of services which you offer within your pharmacy, which are **NOT commissioned** by an external agency (such as NHS England, Public Health, the CCG, Local Government etc). Non-NHS services may include repeat prescription collection & delivery services; travel clinics; "health checks" e.g. BP measurement, flu vaccinations paid for directly by the patient etc. You may add rows if you wish*

	Service	Brief description of service
6.1		
6.2		
6.3		
6.4		
6.5		
6.6		

7. The Pharmacy as a Whole - Meeting the Needs of Those with Disabilities		
Please provide details of arrangements which are in place to meet the needs of those with disabilities. Please click / tick the relevant box to indicate your response		
7.1 Can wheel chair users access **all public areas and services** within your premises?	☐ 1 Yes ☐ 0 No →	7.2 If "No", please describe below which areas or services are inaccessible:
7.3 Which of the following facilities, to aid those who are hearing impaired, do you have? *Please tick all that apply*	☐ 1 Hearing Loop ☐ 2 Signing ☐ 3 Other - please specify → ☐ 4 None	
7.4 Which of the following facilities, to aid those who are visually impaired, do you have? *Please tick all that apply*	☐ 1 Braille ☐ 2 Large print labels ☐ 3 Other - please specify → ☐ 4 None	
7.5 What support do you offer for those with cognitive impairment e.g.: ▪ People with dementia ▪ People with learning disabilities etc.? *Please tick all that apply*	☐ 1 'Aide memoire' for their medicines ☐ 2 Monitored Dosage Systems ☐ 3 Easy to read information ☐ 4 Large print labels ☐ 5 Other - please specify → ☐ 6 None	

8. Languages other than English			
8.1 Please provide details of any languages, other than English, spoken by your or your staff (you may add rows if necessary)	a.	b.	c.
	d.	e.	f.
	g.	h.	i.
8.2 Do you have access to translation services, if you require them for a patient?	☐ 1 Yes ☐ 0 No		

9. Secure Exchange of Information		
Please provide details as to how your pharmacy ensures secure exchange of confidential information. Please click / tick the relevant box to indicate your response		
9.1 Does the pharmacy have a secure N3 connection?	☐ 1 Yes ☐ 2 No, but planned within 12 months ☐ 3 No, planned in >12 months ☐ 4 No and no future plans	
9.2 Does your pharmacy have an nhs.net or other secure email account?	☐ 1 Yes - nhs.net ☐ 2 Yes - other secure email - please go to 9.3 and provide details: → ☐ 3 No, but planned within 12 months ☐ 4 No, but planned in > 12 months ☐ 5 No and no future plans	**9.3 Please provide details of secure email (other than nhs.net) below:**

10. Consultation Area(s)			
Please provide details of your consultation area(s) and its characteristics & facilities. Please click on / tick the relevant box to indicate your response			
10.1 How many consultation areas does your pharmacy have?	☐ 1 None → Go to **Q.10.6**	☐ 2 One ☐ 3 More than one →	**10.2** If more than one please say how many: _____
10.3 How many consultation areas **are a closed room**?	☐ 1 None	☐ 2 One ☐ 3 More than one →	**10.4** Please state how many are closed: _____
10.5 Characteristics of the consultation area(s) If you have more than one consultation area then please tick any that apply to any of the consultation areas in your pharmacy. *Please click on / tick the box where a feature applies* *Leave blank where it doesn't apply*	☐ 1 Sink with hot water	☐ 5 CCTV	☐ 9 Hearing loop
	☐ 2 Examination couch	☐ 6 Telephone	☐ 10 Computer terminal
	☐ 3 Patient toilet facilities near by	☐ 7 Space for a chaperone	☐ 11 PMR access
	☐ 4 Panic button	☐ 8 Wheel chair access	☐ 12 Internet access
10.6 Do you plan to introduce a consultation area in the future?	☐ 0 No → Go to **Q.10.7**	☐ 1 Yes – within 12 months	☐ 2 Yes – more than 12 months
10.7 If you have no plans for a consultation area, it would be helpful to understand your reasons for this. Please describe them: →			

11. Enhancements to Patient Care		
Please provide details of any facilities or services which your pharmacy has in place (and which have not already been identified within this questionnaire) to enhance patient access, care or confidentiality. Please click on / tick the relevant box to indicate your response		
11.1 Pharmacist consultations within a patient's home?	☐ 1 Yes ☐ 0 No → ↓	**11.2 If "No", please indicate if you would be willing to offer this in the future:** ☐ 1 Yes ☐ 0 No
11.3 Pharmacist consultations within a Care Home?	☐ 1 Yes ☐ 0 No → ↓	**11.4 If "No", please indicate if you would be willing to offer this in the future:** ☐ 1 Yes ☐ 0 No
11.5 Pharmacist consultations within the work place?	☐ 1 Yes ☐ 0 No → ↓	**11.6 If "No", please indicate if you would be willing to offer this in the future:** ☐ 1 Yes ☐ 0 No
11.7 Pharmacist consultations within a GP surgery?	☐ 1 Yes ☐ 0 No → ↓	**11.8 If "No", please indicate if you would be willing to offer this in the future:** ☐ 1 Yes ☐ 0 No
11.9 Other enhancement(s)	☐ 1 Yes ☐ 0 No →	**11.12 If "Yes", please provide details below:**

12. Looking to the Future

*In this section, we wish to seek your views on services which could potentially be delivered by community pharmacy in the future. We would ask you to base your suggestions on **your knowledge of the healthcare needs of the people who use your pharmacy** when completing this section. Please feel free to add rows if you wish. We would also ask you to note, that whilst this information will inform our assessment and statement of pharmaceutical need, this should not be regarded as an indication that these service developments will be commissioned in the future*

	Proposed Service	Rationale, including the health needs which will be addressed
12.1		
12.2		
12.3		
12.4		

13. Final Thoughts or Comments

If you have any final thoughts or comments, which you think would be relevant to the Pharmaceutical Needs Assessment, please describe them in the box below

Thank you very much for your time.

Please complete and return this questionnaire by **Monday 21 July 2014**. This should be marked for the attention of Vanessa Lane and emailed to the following address: pna-support@webstar-lane.co.uk. Alternatively, you may prefer to return this by post to the following address: London Borough Haringey PNA Questionnaire, c/o Webstar Lane 336 Pinner Road, Harrow HA1 4LB.

Haringey Council

Appendix C

Potential Pharmaceutical Needs Across the Lifecourse

Potential Pharmaceutical Needs Across the Lifecourse

Part 1 - All Ages

The public health issues of dental health and healthy weight extend right across the lifecourse.

Everyone will experience minor illness at some time of their life, and the pharmacy has been promoted as the 'first port of call'.

A long-term condition may be diagnosed at any age; although more prevalent in later life, the effects are profound on individuals and families at any stage of life.

Sadly, some conditions in childhood may also be life-limiting and so end-of-life care should also be a priority across the lifecourse.

Age group	Need	Relevant Pharmacy Service/s
All ages	Dental health	• Sale of dental health aids e.g. toothpaste, floss, mouthwash • Advice about sugar-free medicines
	Management of long-term conditions	• Screening services • Medicines Use Review • New Medicines Service • Prescription intervention • Condition-specific services e.g. inhaler technique • Repeat dispensing service • Influenza vaccination
	Treatment of minor ailments	• Minor ailments services • Sale of non-prescription medicines
	Healthy weight	• Weight management
	End of life care	• Palliative therapy services

Part 2 - Pre-Conception & Pregnancy

Possibly the first time that a previously healthy young woman has interacted with the health services. An anxious time where fertility or an unplanned pregnancy may equally be the issue. A crucial time for making connections and supporting new parents (mothers and fathers). Parental health behaviours have a profound effect on their children (e.g. research on smoking).

There is some research to suggest that once a young woman becomes pregnant, less attention is paid to future unsafe sex and the risk of STI transmission so these are important ongoing messages. The risk of a further quick unplanned pregnancy is also there, so ongoing contraceptive needs should be assessed if this is not desired.

Pregnancy in the context of a long-term condition, especially where potentially teratogenic medicines are being taken (e.g. epilepsies), need specialist advice and the pharmacist can make that link.

Pharmacies sell many pregnancy and early childhood-linked products, so there are many opportunities for contact about broader health issues.

Age group	Need	Relevant Pharmacy Service/s
Pre-conception and Pregnancy	Pre-conception health	• Sale of folic acid • Weight management • Alcohol IBA / referral to services • Smoking cessation • Advice for drug misusers – referral to specialist services • STI testing
	Pregnancy confirmation	• Sale of pregnancy tests • Pregnancy test service • Referral to midwife • STI testing
	Effects of long-term medicines taken by the mother	• Clinical medication review • Medicines Use Review • New Medicines Service • Prescription Intervention • Advice for drug misusers – referral to specialist services and supervised consumption
	Vaccination (e.g. whooping cough)	• Vaccination services
	Birth planning	• Hire of TENS machines • Sale of complementary therapies • Signposting to antenatal classes

Part 3 - Childhood (Birth – 11 years)

An anxious time for new parents. Self-medication for minor ailments, and distinguishing between the minor and major is a new and onerous task. Research has shown that parents can be vague about the correct dosage of basic children's medicines like paracetamol, and that they may not engage with dosage changes as the child grows. Dosing for children who were premature babies should also be carefully calculated.

Having a child diagnosed early with a long-term condition is also stressful, and support from the pharmacist could be appreciated alongside specialist care.

Early health behaviours could set a pattern for life, so healthy teeth and healthy weight are good areas of discussion during this stage.

There is an intensive vaccination schedule associated with childhood, and pharmacy may be able to provide information and encourage uptake.

Parental mental and physical health should also be monitored as the relationship allows.

Pharmacies sell many early childhood-linked products, so there are many opportunities for contact about broader health issues.

Age group	Need	Relevant Pharmacy Service/s
Birth-12 months	Breastfeeding / Nutrition	• Sale of infant formula • Sale of treatments for breastfeeding side-effects • Signposting to groups and advice • Healthy Start Vitamins
	Infant deaths / Stillbirth	• Minor ailments service • Advice about SIDS (sleeping position, smoking)
	Prematurity	• Advice on medicines use in pre-term babies, including non-prescription medicines
	Contraceptive advice for mother	• Emergency contraception • Contraception advice • Sale of condoms
	Parental mental health (e.g. postnatal depression)	• Signposting from sale of relevant non-prescription medicines (sleep aids, complementary therapies) • Referral to specialist services
Preschool Up to 5 years	Nutrition	• Healthy Start Vitamins
	Sports injuries	• Minor ailments services • Sale of non-prescription medicines
Primary School 5-11 years	Sports injuries	• Minor ailments services • Sale of non-prescription medicines

Need across Childhood	Relevant Pharmacy Service/s
Accidental injury	• Medicines disposal • Needle exchange • Sale of child safety aids • Minor ailments services • Sale of non-prescription medicines
Family Smoking	• Smoking cessation
Growth and Development	• Signposting to advice
Healthy weight (parents)	• Weight management
Parenting support	• Signposting to community resources • Advice about non-prescription medicines
Vaccination	• Influenza vaccination services • Signposting

Part 4 – Adulthood (12-59 years)

Adolescence - most young people thrive and take on adult responsibilities but some have more health service needs due to:

- Unintentional Injury (principally road traffic accidents)
- Diagnosis of a long-term condition
- Development/emergence of a mental health problem
- Adoption of health risk behaviours (which often cluster) e.g. smoking, alcohol use, unsafe sex

Young Adulthood – major transitions into work, new relationships and parenthood – but more young adults now stay with parents for longer, and adolescence may be prolonged

Middle Adulthood – consolidation of families, new parenting challenges as children move through adolescence and young adulthood, and middle adult's own health risk behaviours or hereditary risk factors may start to manifest in long-term conditions e.g. high cholesterol, smoking-related disease, hypertension

Age group	Need	Relevant Pharmacy Service/s
Adolescence 12-19 years	Accidental injury	• Signposting • Medicines Use Review (medicines and driving)
	Sports injuries	• Minor ailments services • Sale of non-prescription medicines
	Transfer of responsibility for medicine-taking	• Medicines Use Review • New Medicines Service
	Vaccination	• Signposting for boosters • HPV vaccination
Young Adulthood 20-35 years	Accidental injury	• Signposting • Medicines Use Review (medicines and driving)
Middle Adulthood 36-59 years	Healthy families	• For parents – drug misuse, smoking, alcohol advice
	Sexual health	• STI testing (including chlamydia • Contraceptive advice • Sale of condoms • Erectile dysfunction counselling • Menopause counselling
	Cardiovascular risk	• Signposting and counselling

Need across Adulthood	Relevant Pharmacy Service/s
Alcohol use	• Alcohol IBA • Referral to specialist treatment • Signposting and advice
Drug misuse	• Advice and signposting • Needle exchange • Supervised consumption
Exercise	• Signposting to community resources
Mental health	• Signposting from sale of relevant non-prescription medicines (sleep aids, complementary therapies) • Referral to specialist services
Sexual Health / Pregnancy	• Emergency Contraception • STI testing (including chlamydia) • Sale of Folic Acid • Sale of pregnancy tests • Pregnancy test service • Referral to midwife
Smoking	• Smoking cessation

Part 5 – Older Adulthood (over 60 years)

The chance of managing multiple long-term conditions and polypharmacy increases. The maintenance of independence and continued home living may depend on creating a manageable medication regimen and paying close attention to side-effects (thus e.g. preventing falls). Carers in all settings must be included as partners in care.

Visits to hospital are more likely. End-of-life care is a concern.

The challenges of medication administration in care homes are well documented, and pharmacists could provide advice and systems to optimise this.

Age group	Need	Relevant Pharmacy Service/s
Older Adulthood 60+ years	Care home engagement	• Pharmacist advice (medicines storage etc.) • Independent prescribing • Medicines Use Review • Clinical Medication Review
	Carer engagement	• Medicines Use Review • Clinical Medication Review • Signposting to services
	Dementia screening & management	• Medicines Use Review • Clinical Medication Review • Signposting to services
	Falls prevention	• Medicines Use Review • Clinical Medication Review • New Medicine Service
	Maintaining independence	• Home delivery service • Hosiery fitting service • Sale of incontinence aids • Sale of mobility aids • Minor ailments service
	Medication adherence	• Home delivery service • Compliance aids e.g. Monitored Dosage Systems (care home or community) • Medicines Use Review • Clinical Medication Review • New Medicine Service
	Sexual health	• STI testing • Sale of condoms • Erectile dysfunction counselling
	Smoking	• Smoking cessation

References:

PHE plan of work for children and young people
https://publichealthmatters.blog.gov.uk/wp-content/uploads/sites/33/2014/01/life-course-approach.png

Healthy Child Programme 0-5 (DH England, 2009)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

National Service Framework for Older People (DH England 2001)
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf

National Service Framework for Children, Young People and Maternity Services (DH England and DfES 2004)
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090523.pdf

This page is intentionally left blank

Haringey Council

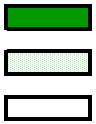
Appendix D

Pharmaceutical Needs Assessment

Pharmacy Opening Hours

Opening hours within this appendix reflect the total opening hours, reported by Haringey Community Pharmacies with minor adjustments to ensure compliance with core hours NHS

Key



Open

Open on some days

Closed

Weekday Opening Hours

Trading Name	Post Code	Ward	Opening Hours
CENTRAL LOCALITY			
ALPHA PHARMACY	N22 8ED	Bounds Green	09:00 – 18:30: Mon, Tue, Wed, Fri; 18:00: Thurs
CLOCKWORK PHARMACY	N11 2DN	Bounds Green	09:00 – 19:00
PHARMOCARE (WARWICK PHARMACY)	N11 2EU	Bounds Green	09:00 – 19:00
AVENUE PHARMACY	N8 0DU	Harringay	09:00 – 18:30
STEARNS PHARMACY	N8 0RL	Harringay	09:00 – 18:15
BOOTS	N22 6BA	Noel Park	09:00 – 19:00
CROSS CHEMIST	N22 5DJ	Noel Park	09:00 – 13:00: Thurs; 18:00: Mon, Tue, Wed, Fri
GREENWOODS PHARMACY	N22 6DS	Noel Park	09:00 – 19:00
J LORD CHEMIST	N22 5DJ	Noel Park	09:00 – 18:30: Mon, Tue, Wed, Fri; 18:00: Thurs
MINTONS CHEMIST	N22 6BH	Noel Park	09:00 – 18:30
MORRISONS PHARMACY	N22 6BH	Noel Park	09:00 – 21:00
SAVEMORE PHARMACY	N22 6SA	Noel Park	09:00 – 13:00: Thurs; 18:30: Mon, Tue, Wed, Fri
LLOYDSPHARMACY	N22 8HH	Woodside	09:00 – 19:00: Mon, Tue, Wed, Fri; 18:00: Thurs
LLOYDSPHARMACY	N22 8JW	Woodside	09:00 – 19:00
PHARMACY EXPRESS	N22 8HH	Woodside	09:00 – 19:00
NORTH EAST TOTTENHAM LOCALITY			
PHARMOCARE	N17 6QB	Bruce Grove	09:00 – 19:00
PHARMOCARE	N17 6SB	Bruce Grove	09:00 – 19:00
PHILLIPS CHEMIST	N17 6XF	Bruce Grove	09:00 – Fri only; 18:30: Mon, Tue, Wed, Fri; 18:00: Thurs
GRACE PHARMACY	N17 0HJ	Northumberland Park	09:00 – 19:00
PHARMOCARE	N17 8AH	Northumberland Park	09:00 – 19:00
PHARMOCARE	N17 8EY	Northumberland Park	09:00 – 19:00
PHARMOCARE	N17 8HH	Northumberland Park	09:00 – 19:00
DOWSETT PHARMACY	N17 9DD	Tottenham Hale	09:00 – 18:30
LLOYDSPHARMACY	N17 9JD	Tottenham Hale	09:00 – 19:00
PHARMACYWAREHOUSE2U	N17 9EJ	Tottenham Hale	09:00 – 18:00: Mon, Tue, Wed, Thurs; 19:30: Fri
BEAUTYCHEM PHARMACY	N17 7LH	White Hart Lane	09:00 – 18:00: Mon, Tue, Wed, Fri. 16:00: Thurs
GF PORTER DISPENSING CHEMIST	N17 7BU	White Hart Lane	09:00
SOMERSET GARDENS PHARMACY	N17 8NW	White Hart Lane	07:00 – 22:30
SOUTH EAST TOTTENHAM LOCALITY			
MANSONS PHARMACY	N15 6JR	Seven Sisters	09:00 – 13:00: Thurs; 18:00: Mon, Tue, Wed, Fri
SAFEDALE PHARMACY	N15 6EP	Seven Sisters	09:00 – 19:00: Mon, Tue, Wed, Fri. 17:30: Thurs
SAINSBURYS PHARMACY	N4 1UJ	Seven Sisters	07:00 – 23:00
ALLCURES PHARMACY	N15 3PB	St Ann's	09:00 – 19:00
DP MARK CHEMIST	N4 1JX	St Ann's	09:00 – 19:00
MED-CHEM PHARMACY	N4 1DU	St Ann's	09:00 – 00:00
PARADE CHEMIST	N4 1LG	St Ann's	09:00 – 18:30
RAM PHARMACY	N15 3BL	St Ann's	09:00 – (Fri-long lunch); 17:00: Thurs; 18:15: Mon, Tue, Wed, Fri.
BOOTS	N15 4QD	Tottenham Green	09:00 – 19:00
COOPERS PHARMACY	N15 4DJ	Tottenham Green	09:00 – 19:00
DOBBER PHARMACY	N15 5NR	Tottenham Green	09:30 – 19:00
TESCO INSTORE PHARMACY	N15 4AJ	Tottenham Green	08:00 – 19:00
THE CADGE PHARMACY	N15 4JR	Tottenham Green	09:00 – 18:00: Wed, Thurs, Fri; 20:30: Mon; 20:00 Tues
WEST LOCALITY			
REDWOOD PHARMACY	N10 2AH	Alexandra	09:00 – 19:00: Mon, Tue, Thurs, Fri. 18:00: Wed
AMY PHARMACY	N8 8SY	Crouch End	09:00 – 19:00
BOOTS	N8 8DU	Crouch End	09:00 – 19:00
PETTERS PHARMACY	N8 8DT	Crouch End	09:00 – 18:30
PHARMACIA NATURALE	N8 9TN	Crouch End	09:00 – 18:30: Mon, Tue, Thurs, Fri. 18:00: Wed
REENA PHARMACY	N8 8AA	Crouch End	09:00 – 19:00
BOOTS	N10 1DJ	Fortis Green	09:00 – 19:00
DUKES PHARMACY	N10 1DJ	Fortis Green	09:00 – 19:00
BAILEY & SAUNDERS HIGHGATE PHARMACY	N6 5HX	Highgate	09:00 – 18:00
HAYWARD PHARMACY	N6 4EJ	Highgate	09:00 – 18:00
FROST & Co	N8 7PS	Hornsey	09:00 – 19:00
SAIGRACE PHARMACY	N8 9BG	Hornsey	09:00 – 18:30
BROADWAY PHARMACY	N10 3RS	Muswell Hill	09:00 – 18:30
CORAL PHARMACY	N8 8LA	Muswell Hill	09:00 – 18:30
HORNSEY CENTRAL PHARMACY	N8 8JD	Muswell Hill	07:00 – 22:00
MUSWELL HILL PHARMACY	N10 3HN	Muswell Hill	09:00 – 18:30
PARK ROAD PHARMACY	N8 8JR	Muswell Hill	08:00 – 23:00
SANTAS PHARMACY	N4 3RN	Stroud Green	09:00 – 18:30

Saturday Opening Hours

Trading Name	Post Code	Ward	Saturday Opening Hours
CENTRAL LOCALITY			
ALPHA PHARMACY	N22 8ED	Bounds Green	09:00 – 18:30: Mon, Tue, Wed, Fri; 18:00: Thurs
CLOCKWORK PHARMACY	N11 2DN	Bounds Green	
PHARMOCARE (WARWICK PHARMACY)	N11 2EU	Bounds Green	09:00 – 18:00
AVENUE PHARMACY	N8 0DU	Harringay	09:30 – 13:00
STEARNS PHARMACY	N8 0RL	Harringay	10:00 – 14:00
BOOTS	N22 6BA	Noel Park	09:00 – 19:00
CROSS CHEMIST	N22 5DJ	Noel Park	09:00 – 13:00
GREENWOODS PHARMACY	N22 6DS	Noel Park	09:00 – 17:00
J LORD CHEMIST	N22 5DJ	Noel Park	
MINTONS CHEMIST	N22 6BH	Noel Park	09:00 – 18:00
MORRISONS PHARMACY	N22 6BH	Noel Park	09:00 – 20:00
SAVEMORE PHARMACY	N22 6SA	Noel Park	
LLOYDSPHARMACY	N22 8HH	Woodside	09:00 – 17:30
LLOYDSPHARMACY	N22 8JW	Woodside	09:00 – 19:00
PHARMACY EXPRESS	N22 8HH	Woodside	09:00 – 17:00
NORTH EAST TOTTENHAM LOCALITY			
PHARMOCARE	N17 6QB	Bruce Grove	09:00 – 17:30
PHARMOCARE	N17 6SB	Bruce Grove	09:00 – 17:30
PHILLIPS CHEMIST	N17 6XF	Bruce Grove	09:00 – 17:00
GRACE PHARMACY	N17 0HJ	Northumberland Park	09:00 – 18:30
PHARMOCARE	N17 8AH	Northumberland Park	09:00 – 17:30
PHARMOCARE	N17 8EY	Northumberland Park	09:00 – 17:30
PHARMOCARE	N17 8HH	Northumberland Park	
DOWSETT PHARMACY	N17 9DD	Tottenham Hale	
LLOYDSPHARMACY	N17 9JD	Tottenham Hale	09:00 – 19:00
PHARMACYWAREHOUSE2U	N17 9EJ	Tottenham Hale	
BEAUTYCHEM PHARMACY	N17 7LH	White Hart Lane	09:00 – 13:00
GF PORTER DISPENSING CHEMIST	N17 7BU	White Hart Lane	09:00 – 16:00
SOMERSET GARDENS PHARMACY	N17 8NW	White Hart Lane	07:00 – 22:30
SOUTH EAST TOTTENHAM LOCALITY			
MANSONS PHARMACY	N15 6JR	Seven Sisters	
SAFEDALE PHARMACY	N15 6EP	Seven Sisters	09:00 – 14:00
SAINSBURYS PHARMACY	N4 1UJ	Seven Sisters	07:00 – 22:00
ALLCURES PHARMACY	N15 3PB	St Ann's	
DP MARK CHEMIST	N4 1JX	St Ann's	09:00 – 18:00
MED-CHEM PHARMACY	N4 1DU	St Ann's	09:00 – 00:00
PARADE CHEMIST	N4 1LG	St Ann's	09:00 – 18:00
RAM PHARMACY	N15 3BL	St Ann's	10:00 – 17:00
BOOTS	N15 4QD	Tottenham Green	09:00 – 19:00
COOPERS PHARMACY	N15 4DJ	Tottenham Green	09:00 – 13:00
DOBBER PHARMACY	N15 5NR	Tottenham Green	09:30 – 16:00
TESCO INSTORE PHARMACY	N15 4AJ	Tottenham Green	08:00 – 19:00
THE CADGE PHARMACY	N15 4JR	Tottenham Green	09:00 – 13:00
WEST LOCALITY			
REDWOOD PHARMACY	N10 2AH	Alexandra	09:00 – 16:30
AMY PHARMACY	N8 8SY	Crouch End	10:00 – 18:00
BOOTS	N8 8DU	Crouch End	09:00 – 19:00
PETTERS PHARMACY	N8 8DT	Crouch End	09:00 – 18:00
PHARMACIA NATURALE	N8 9TN	Crouch End	09:00 – 18:00
REENA PHARMACY	N8 8AA	Crouch End	09:00 – 18:00
BOOTS	N10 1DJ	Fortis Green	09:00 – 19:00
DUKES PHARMACY	N10 1DJ	Fortis Green	09:00 – 13:00
BAILEY & SAUNDERS HIGHGATE PHARMACY	N6 5HX	Highgate	09:00 – 18:00
HAYWARD PHARMACY	N6 4EJ	Highgate	09:00 – 17:30
FROST & Co	N8 7PS	Hornsey	09:00 – 19:00
SAIGRACE PHARMACY	N8 9BG	Hornsey	10:00 – 15:00
BROADWAY PHARMACY	N10 3RS	Muswell Hill	09:00 – 17:30
CORAL PHARMACY	N8 8LA	Muswell Hill	09:30 – 18:00
HORNSEY CENTRAL PHARMACY	N8 8JD	Muswell Hill	07:00 – 22:00
MUSWELL HILL PHARMACY	N10 3HN	Muswell Hill	09:00 – 17:30
PARK ROAD PHARMACY	N8 8JR	Muswell Hill	08:00 – 23:00
SANTAS PHARMACY	N4 3RN	Stroud Green	09:00 – 17:30

Sunday Opening Hours

Trading Name	Post Code	Ward	07:00	07:30	08:00	08:30	09:00	09:30	10:00	10:30	11:00	11:30	12:00	12:30	13:00	13:30	14:00	14:15	14:30	15:00	15:30	16:00	16:30	17:00	17:30	18:00	18:15	18:30	19:00	19:30	20:00	20:30	21:00	21:30	22:00	22:30	23:00	00:00
CENTRAL LOCALITY																																						
ALPHA PHARMACY	N22 8ED	Bounds Green																																				
CLOCKWORK PHARMACY	N11 2DN	Bounds Green																																				
PHARMOCARE (WARWICK PHARMACY)	N11 2EU	Bounds Green																																				
AVENUE PHARMACY	N8 0DU	Harringay																																				
STEARNS PHARMACY	N8 0RL	Harringay																																				
BOOTS	N22 6BA	Noel Park									11:00													17:00														
CROSS CHEMIST	N22 5DJ	Noel Park																																				
GREENWOODS PHARMACY	N22 6DS	Noel Park									11:00													17:00														
J LORD CHEMIST	N22 5DJ	Noel Park																																				
MINTONS CHEMIST	N22 6BH	Noel Park																																				
MORRISONS PHARMACY	N22 6BH	Noel Park									11:00													17:00														
SAVEMORE PHARMACY	N22 6SA	Noel Park																																				
LLOYDSPHARMACY	N22 8HH	Woodside																																				
LLOYDSPHARMACY	N22 8JW	Woodside																																				
PHARMACY EXPRESS	N22 8HH	Woodside																																				
NORTH EAST TOTTENHAM LOCALITY																																						
PHARMOCARE	N17 6QB	Bruce Grove																																				
PHARMOCARE	N17 6SB	Bruce Grove																																				
PHILLIPS CHEMIST	N17 6XF	Bruce Grove																																				
GRACE PHARMACY	N17 0HJ	Northumberland Park																																				
PHARMOCARE	N17 8AH	Northumberland Park																																				
PHARMOCARE	N17 8EY	Northumberland Park																																				
PHARMOCARE	N17 8HH	Northumberland Park																																				
DOWSETT PHARMACY	N17 9DD	Tottenham Hale																																				
LLOYDSPHARMACY	N17 9JD	Tottenham Hale																																				
PHARMACYWAREHOUSE2U	N17 9EJ	Tottenham Hale																																				
BEAUTYCHEM PHARMACY	N17 7LH	White Hart Lane																																				
GF PORTER DISPENSING CHEMIST	N17 7BU	White Hart Lane																																				
SOMERSET GARDENS PHARMACY	N17 8NW	White Hart Lane							10:00															17:00														
SOUTH EAST TOTTENHAM LOCALITY																																						
MANSONS PHARMACY	N15 6JR	Seven Sisters																																				
SAFEDALE PHARMACY	N15 6EP	Seven Sisters																																				
SAINSBURYS PHARMACY	N4 1UJ	Seven Sisters									11:00													17:00														
ALLCURES PHARMACY	N15 3PB	St Ann's																																				
DP MARK CHEMIST	N4 1JX	St Ann's																																				
MED-CHEM PHARMACY	N4 1DU	St Ann's							10:00																														00:00
PARADE CHEMIST	N4 1LG	St Ann's																																				
RAM PHARMACY	N15 3BL	St Ann's																																				
BOOTS	N15 4QD	Tottenham Green									11:00													17:00														
COOPERS PHARMACY	N15 4DJ	Tottenham Green																																				
DOBBER PHARMACY	N15 5NR	Tottenham Green																																				
TESCO INSTORE PHARMACY	N15 4AJ	Tottenham Green									11:00													17:00														
THE CADGE PHARMACY	N15 4JR	Tottenham Green																																				
WEST LOCALITY																																						
REDWOOD PHARMACY	N10 2AH	Alexandra																																				
AMY PHARMACY	N8 8SY	Crouch End																																				
BOOTS	N8 8DU	Crouch End							10:00																	18:00												
PETTERS PHARMACY	N8 8DT	Crouch End									11:00											16:00																
PHARMACIA NATURALE	N8 9TN	Crouch End																																				
REENA PHARMACY	N8 8AA	Crouch End																																				
BOOTS	N10 1DJ	Fortis Green							10:00																	18:00												
DUKES PHARMACY	N10 1DJ	Fortis Green																																				
BAILEY & SAUNDERS HIGHGATE PHARMACY	N6 5HX	Highgate							10:00													16:00																
HAYWARD PHARMACY	N6 4EJ	Highgate																																				
FROST & Co	N8 7PS	Hornsey																																				
SAIGRACE PHARMACY	N8 9BG	Hornsey																																				
BROADWAY PHARMACY	N10 3RS	Muswell Hill																																				
CORAL PHARMACY	N8 8LA	Muswell Hill																																				
HORNSEY CENTRAL PHARMACY	N8 8JD	Muswell Hill					09:00																						19:00									
MUSWELL HILL PHARMACY	N10 3HN	Muswell Hill																																				
PARK ROAD PHARMACY	N8 8JR	Muswell Hill					09:00																						19:00									
SANTAS PHARMACY	N4 3RN	Stroud Green																																				

Haringey Council

Appendix E

Summary of Services by Pharmacy

Pharmaceutical Services

Trading Name	Post Code	Ward	Essential Services	Advanced Services				Enhanced Services		
				Medicines Use Reviews	New Medicine Service	Stoma Appliance Customisation	Appliance Use Reviews	Minor Ailments Service*	London Pharmacy Vaccination Service	On Demand Access to End of Life Care & Specialist Medicines
CENTRAL LOCALITY										
ALPHA PHARMACY	N22 8ED	Bounds Green	♦	♦	♦			♦♦		
CLOCKWORK PHARMACY	N11 2DN	Bounds Green	♦	♦	♦			♦♦	♦	
PHARMOCARE (WARWICK PHARMACY)	N11 2EU	Bounds Green	♦	♦	♦			♦	♦	
AVENUE PHARMACY	N8 0DU	Harringay	♦	♦	♦			♦♦		
STEARNS PHARMACY	N8 0RL	Harringay	♦							
BOOTS	N22 6BA	Noel Park	♦	♦	♦			♦♦	♦	
CROSS CHEMIST	N22 5DJ	Noel Park	♦	♦	♦			♦	♦	
GREENWOODS PHARMACY	N22 6DS	Noel Park	♦	♦				♦♦		
J LORD CHEMIST	N22 5DJ	Noel Park	♦	♦	♦			♦♦		
MINTONS CHEMIST	N22 6BH	Noel Park	♦	♦		♦		♦♦		
MORRISONS PHARMACY	N22 6BH	Noel Park	♦	♦	♦			♦♦	♦	
SAVEMORE PHARMACY	N22 6SA	Noel Park	♦	♦				♦		
LLOYDSPHARMACY	N22 8HH	Woodside	♦	♦	♦	♦	♦	♦		
LLOYDSPHARMACY	N22 8JW	Woodside	♦	♦	♦	♦		♦	♦	
PHARMACY EXPRESS	N22 8HH	Woodside	♦	♦	♦	♦		♦♦	♦	♦
NORTH EAST TOTTENHAM LOCALITY										
PHARMOCARE	N17 6QB	Bruce Grove	♦	♦	♦			♦	♦	
PHARMOCARE	N17 6SB	Bruce Grove	♦	♦				♦	♦	
PHILLIPS CHEMIST	N17 6XF	Bruce Grove	♦	♦	♦			♦♦		♦
GRACE PHARMACY	N17 0HJ	Northumberland Park	♦					♦		
PHARMOCARE	N17 8AH	Northumberland Park	♦					♦	♦	
PHARMOCARE	N17 8EY	Northumberland Park	♦	♦				♦♦	♦	
PHARMOCARE	N17 8HH	Northumberland Park	♦	♦				♦	♦	
DOWSETT PHARMACY	N17 9DD	Tottenham Hale	♦	♦	♦			♦♦	♦	
LLOYDSPHARMACY	N17 9JD	Tottenham Hale	♦	♦	♦			♦	♦	
PHARMACYWAREHOUSE2U	N17 9EJ	Tottenham Hale	♦	♦	♦	♦				
BEAUTYCHEM PHARMACY	N17 7LH	White Hart Lane	♦	♦	♦			♦♦	♦	
GF PORTER DISPENSING CHEMIST	N17 7BU	White Hart Lane	♦	♦				♦	♦	
SOMERSET GARDENS PHARMACY	N17 8NW	White Hart Lane	♦	♦	♦			♦♦		
SOUTH EAST TOTTENHAM LOCALITY										
MANSONS PHARMACY	N15 6JR	Seven Sisters	♦	♦	♦			♦♦	♦	
SAFEDALE PHARMACY	N15 6EP	Seven Sisters	♦	♦	♦		♦	♦♦	♦	
SAINSBURYS PHARMACY	N4 1UJ	Seven Sisters	♦	♦	♦			♦		
ALLCURES PHARMACY	N15 3PB	St Ann's	♦	♦	♦			♦	♦	
DP MARK CHEMIST	N4 1JX	St Ann's	♦	♦	♦			♦	♦	
MED-CHEM PHARMACY	N4 1DU	St Ann's	♦	♦	♦			♦♦	♦	
PARADE CHEMIST	N4 1LG	St Ann's	♦	♦	♦					
RAM PHARMACY	N15 3BL	St Ann's	♦	♦	♦			♦		
BOOTS	N15 4QD	Tottenham Green	♦	♦	♦			♦		♦
COOPERS PHARMACY	N15 4DJ	Tottenham Green	♦	♦				♦♦	♦	
DOBBER PHARMACY	N15 5NR	Tottenham Green	♦	♦	♦			♦	♦	
TESCO INSTORE PHARMACY	N15 4AJ	Tottenham Green	♦	♦	♦			♦♦	♦	
THE CADGE PHARMACY	N15 4JR	Tottenham Green	♦	♦	♦			♦♦	♦	
WEST LOCALITY										
REDWOOD PHARMACY	N10 2AH	Alexandra	♦	♦	♦			♦	♦	
AMY PHARMACY	N8 8SY	Crouch End	♦	♦	♦			♦		
BOOTS	N8 8DU	Crouch End	♦	♦	♦			♦	♦	
PETTERS PHARMACY	N8 8DT	Crouch End	♦	♦	♦			♦	♦	
PHARMACIA NATURALE	N8 9TN	Crouch End	♦	♦	♦					
REENA PHARMACY	N8 8AA	Crouch End	♦	♦	♦			♦	♦	
BOOTS	N10 1DJ	Fortis Green	♦	♦	♦			♦	♦	
DUKES PHARMACY	N10 1DJ	Fortis Green	♦	♦	♦			♦♦		
BAILEY & SAUNDERS HIGHGATE PHARMACY	N6 5HX	Highgate	♦	♦	♦	♦	♦			
HAYWARD PHARMACY	N6 4EJ	Highgate	♦	♦	♦					
FROST & Co	N8 7PS	Hornsey	♦							
SAIGRACE PHARMACY	N8 9BG	Hornsey	♦	♦	♦			♦	♦	
BROADWAY PHARMACY	N10 3RS	Muswell Hill	♦	♦	♦			♦	♦	
CORAL PHARMACY	N8 8LA	Muswell Hill	♦	♦	♦			♦♦	♦	
HORNSEY CENTRAL PHARMACY	N8 8JD	Muswell Hill	♦	♦	♦			♦♦		♦
MUSWELL HILL PHARMACY	N10 3HN	Muswell Hill	♦					♦	♦	
PARK ROAD PHARMACY	N8 8JR	Muswell Hill	♦	♦	♦			♦♦	♦	
SANTAS PHARMACY	N4 3RN	Stroud Green	♦	♦	♦			♦	♦	

*** Minor Ailments Service - Pharmacies accredited to supply medicines under patient group direction are denoted with ♦♦**

Locally Commissioned Services

Trading Name	Post Code	Ward	Stop Smoking	Sexual Health Under 25s	Sexual Health 25s & Over	Supervised Consumption	Needle & Syringe Programme	Healthy Start Vitamins
CENTRAL LOCALITY								
ALPHA PHARMACY	N22 8ED	Bounds Green	♦	♦	♦			
CLOCKWORK PHARMACY	N11 2DN	Bounds Green		♦	♦			
PHARMOCARE (WARWICK PHARMACY)	N11 2EU	Bounds Green		♦	♦			
AVENUE PHARMACY	N8 0DU	Harringay		♦				
STEARNS PHARMACY	N8 0RL	Harringay						
BOOTS	N22 6BA	Noel Park	♦		♦	♦		♦
CROSS CHEMIST	N22 5DJ	Noel Park		♦		♦	♦	
GREENWOODS PHARMACY	N22 6DS	Noel Park	♦		♦			
J LORD CHEMIST	N22 5DJ	Noel Park						
MINTONS CHEMIST	N22 6BH	Noel Park	♦	♦	♦	♦	♦	
MORRISONS PHARMACY	N22 6BH	Noel Park		♦	♦		♦	
SAVEMORE PHARMACY	N22 6SA	Noel Park						
LLOYDSPHARMACY	N22 8HH	Woodside				♦		
LLOYDSPHARMACY	N22 8JW	Woodside						
PHARMACY EXPRESS	N22 8HH	Woodside	♦	♦	♦	♦	♦	♦
NORTH EAST TOTTENHAM LOCALITY								
PHARMOCARE	N17 6QB	Bruce Grove		♦	♦			
PHARMOCARE	N17 6SB	Bruce Grove	♦	♦	♦			
PHILLIPS CHEMIST	N17 6XF	Bruce Grove						♦
GRACE PHARMACY	N17 0HJ	Northumberland Park						
PHARMOCARE	N17 8AH	Northumberland Park				♦		
PHARMOCARE	N17 8EY	Northumberland Park	♦		♦	♦		
PHARMOCARE	N17 8HH	Northumberland Park	♦	♦	♦			
DOWSETT PHARMACY	N17 9DD	Tottenham Hale	♦		♦	♦	♦	♦
LLOYDSPHARMACY	N17 9JD	Tottenham Hale				♦		
PHARMACYWAREHOUSE2U	N17 9EJ	Tottenham Hale						
BEAUTYCHEM PHARMACY	N17 7LH	White Hart Lane	♦	♦	♦	♦		
GF PORTER DISPENSING CHEMIST	N17 7BU	White Hart Lane	♦		♦			
SOMERSET GARDENS PHARMACY	N17 8NW	White Hart Lane						
SOUTH EAST TOTTENHAM LOCALITY								
MANSONS PHARMACY	N15 6JR	Seven Sisters	♦					
SAFEDALE PHARMACY	N15 6EP	Seven Sisters		♦	♦	♦	♦	♦
SAINSBURYS PHARMACY	N4 1UJ	Seven Sisters						
ALLCURES PHARMACY	N15 3PB	St Ann's		♦	♦	♦		
DP MARK CHEMIST	N4 1JX	St Ann's	♦	♦	♦			♦
MED-CHEM PHARMACY	N4 1DU	St Ann's				♦		
PARADE CHEMIST	N4 1LG	St Ann's				♦		
RAM PHARMACY	N15 3BL	St Ann's						
BOOTS	N15 4QD	Tottenham Green	♦	♦		♦		
COOPERS PHARMACY	N15 4DJ	Tottenham Green		♦	♦	♦	♦	
DOBBER PHARMACY	N15 5NR	Tottenham Green	♦		♦	♦		
TESCO INSTORE PHARMACY	N15 4AJ	Tottenham Green	♦					♦
THE CADGE PHARMACY	N15 4JR	Tottenham Green	♦	♦	♦	♦		♦
WEST LOCALITY								
REDWOOD PHARMACY	N10 2AH	Alexandra	♦	♦	♦			
AMY PHARMACY	N8 8SY	Crouch End		♦	♦	♦		
BOOTS	N8 8DU	Crouch End	♦					
PETTERS PHARMACY	N8 8DT	Crouch End	♦		♦	♦		♦
PHARMACIA NATURALE	N8 9TN	Crouch End						
REENA PHARMACY	N8 8AA	Crouch End				♦		
BOOTS	N10 1DJ	Fortis Green	♦			♦		
DUKES PHARMACY	N10 1DJ	Fortis Green			♦			
BAILEY & SAUNDERS HIGHGATE PHARMACY	N6 5HX	Highgate						
HAYWARD PHARMACY	N6 4EJ	Highgate				♦		
FROST & Co	N8 7PS	Hornsey		♦				
SAIGRACE PHARMACY	N8 9BG	Hornsey	♦	♦	♦			
BROADWAY PHARMACY	N10 3RS	Muswell Hill						
CORAL PHARMACY	N8 8LA	Muswell Hill				♦	♦	
HORNSEY CENTRAL PHARMACY	N8 8JD	Muswell Hill	♦	♦	♦	♦	♦	
MUSWELL HILL PHARMACY	N10 3HN	Muswell Hill		♦				
PARK ROAD PHARMACY	N8 8JR	Muswell Hill				♦		
SANTAS PHARMACY	N4 3RN	Stroud Green	♦	♦	♦	♦	♦	♦

This page is intentionally left blank

Haringey Council

Appendix F

Consultation Feedback & Outcome

Consultation Feedback and Outcome

1. Accuracy

A number of issues of accuracy were raised during the process:

Organisation	Suggested Inaccuracy	PNA Steering Group Decision	PNA Amended?
Pharmocare (Warwick Pharmacy) N11 2EU	Saturday opening hours should be from 09:00 am to 18:00 pm (not 19:00)	▪ Appendix D shows the incorrect closing time and will be updated. This was a transcription error. ▪ All maps, and the analysis, are based on the correct closing time	Yes
Boots UK Limited South Divisional Office	Boots, Wood Green, N22 6BA Sunday opening hours - should be 11am - 5pm	▪ Appendix D shows that the pharmacy is open between 10am and 6pm; this was based on the community pharmacy questionnaire returned by the Boots Branch ▪ Appendix D will be updated to reflect the correct opening hours for Sunday. The analysis, text and maps are not affected by this change	Yes
Coopers Pharmacy (Ravalia Pharm Ltd) N15 4DJ	Supervised consumption of Subutex and Methadone is provided	▪ Information provided the substance misuse commissioner confirms that this pharmacy does provide this service ▪ The analysis, text, map and Appendix E will be updated	Yes
Coopers Pharmacy (Ravalia Pharm Ltd) N15 4DJ	Seasonal Influenza vaccination is provided	▪ Appendix E in the draft PNA shows the pharmacy as providing the London Pharmacy Vaccination Service ▪ The draft PNA is, therefore, correct as seasonal influenza vaccine is included within the scope of this service	No
Parade Chemist (Conochem Management Ltd) N4 1LG	We do not currently provide the London Pharmacy Vaccination Service, however we do have plans to implement this service for 2015	▪ Information provided by NHS England showed this pharmacy as providing the service ▪ The pharmacy was contacted and confirmed that they hadn't attended training in 2014/15 and this is why they weren't a service provider ▪ The PNA Steering Group decided that the pharmacy should be removed from the map, analysis and Appendix E	Yes
Parade Chemist (Conochem Management Ltd) N4 1LG	We provide the Monitored Dosage System Service for our patients, which we receive no funding for	▪ The comment refers to a Non-NHS service; and that non-NHS services are excluded from the scope of the PNA because they cannot be taken into account when considering market entry applications ▪ The PNA Steering Group determined that no changes were required	No
Pharmocare (Warwick Pharmacy) N11 2EU	We do not provide EHC services for over 25.	▪ The PNA Steering Group noted that EHC is provided within the scope of service for both the under 25 and over 25s; and that the information provided by the sexual health service commissioner showed this pharmacy as providing the over 25s bundle for service ▪ The pharmacy attended training on the 31 January 2015 and is now accredited to provide the service ▪ The PNA Steering Group determined that no changes were required	No

2. Detailed Comments

This section sets out the detailed comments which were received during the formal consultation and summarises the response of the PNA Steering Group. The section has been organised in accordance with the specific questions asked within the online survey / consultation response form; where no specific comments were received then this noted.

For each question, we summarise the percentage of respondents who agreed, disagreed or were not sure with respect to the information contained within the PNA (noting that respondents who did not answer a given question, those that did not return the feedback response form and those for whom a question was not applicable were excluded from this analysis). We then list the specific comments received and set out the PNA Steering Group decision noting whether or not the PNA has been amended. Where no specific comments were received in relation to a question then we explicitly state this. Where a respondent did not use the response template then the comment has been included in the most relevant section; and on occasion a comment has been moved to a more relevant section.

The purpose of the PNA is set out in section 2. Has this been explained sufficiently?			
Yes = 100% (n=13)	No = 0%	Not sure = 0%	Not answered / Feedback Form Not Used (n=2)
No detailed comments received			

Section 3 sets out the scope of the PNA. Does it do so clearly?			
Yes = 100% (n=13)	No = 0%	Not sure = 0%	Not answered / Feedback Form Not Used (n=2)
No detailed comments received			

Section 4 sets out the local context and implications for the PNA. Does it do so clearly?			
Yes = 100% (n=13)	No = 0%	Not sure = 0%	Not answered / Feedback Form Not Used (n=2)
No detailed comments received			

Does the Information in Section 3.1 and 3.2 provide a reasonable description of the services which are provided by pharmacies and DACs and do you agree with the conclusions?

Service	Yes	No	Not Sure	Not answered / Feedback Form Not Used
Essential Services	100% (n=13)	0% (n=0)	0% (n=0)	n=2
Medicines Use Reviews & Prescription Intervention Service	92.3% (n=12)	0% (n=0)	7.7% (n=1)	n=2
New Medicine Service	100% (n=13)	0% (n=0)	0% (n=0)	n=2
Stoma Appliance Customisation Service	92.3% (n=12)	0% (n=0)	7.7% (n=1)	n=2
Appliance Use Reviews	92.3% (n=12)	0% (n=0)	7.7% (n=1)	n=2
Minor Ailments Service	100% (n=12)	0% (n=0)	0% (n=0)	n=3
London Pharmacy Vaccination Service	100% (n=13)	0% (n=0)	0% (n=0)	n=2
On Demand Access to End of Life & Specialist Medicines	92.3% (n=12)	0% (n=0)	7.7% (n=1)	n=2
Stop Smoking Service	84.6% (n=11)	0% (n=0)	15.4% (n=2)	n=2
Sexual Health	92.3% (n=12)	0% (n=0)	7.7% (n=1)	n=2
Supervised Consumption	84.6% (n=11)	0% (n=0)	15.4% (n=2)	n=2
Needle & Syringe Programme	76.9% (n=10)	7.7% (n=1)	15.4% (n=2)	n=2
Healthy Start Vitamins	76.9% (n=10)	7.7% (n=1)	15.4% (n=2)	n=2
Anti-coagulation and Stroke Prevention	83.3% (n=10)	0% (n=0)	16.7% (n=2)	n=3

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
Pharmocare (Warwick Pharmacy) N11 2EU	**Essential Services** For some clinical data collection services likes the lithium blood results, many patients refused to provide such readings and some get very upset when we asked for the readings.	▪ The PNA Steering Group was advised that the comment refers to the National Patient Safety alert for safer lithium prescribing. The NPSA has developed a patient information booklet, lithium alert card & record book for tracking blood test results ▪ The PNA Steering Group considered that pharmacies would normally explain to patients why this information was important, at the time of dispensing or the consultation; and determined that no changes were required for the final PNA	No

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
NHS England London Region	**MURs** ▪ The PNA has identified potential gaps in that 5 pharmacies do not offer Medicine Use Reviews (MURs) and Prescription Interventions (PIs) service. ▪ Also it has identified that some pharmacies are not actively providing the service and that some residents are not able to access it at all because of the 3 month rule which means that patients can only access this service from their regular pharmacy. ▪ The PNA has also identified that there is sufficient capacity within the existing network to meet anticipated increase in demand. The PNA concludes that a current need in that it would like all pharmacies to offer MURs so that all residents secure access to the service if required ▪ There is insufficient information for existing pharmacy owners and potential applicants to understand what the implications of the gaps and the current need are.	▪ The PNA Steering Group was advised that the NHS England comment refers to the Executive Summary (Page 6 of the draft PNA) and the MUR detailed section (pages 58 - 61 of the draft PNA) ▪ It was agreed that the conclusions would be strengthened to make it clear that the gaps described cannot be addressed by granting a new application because of the "3 month rule"; and that residents have the option of choosing an alternative pharmacy to dispense their prescriptions and access MURs in this way	Yes
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	**Advanced Services** ▪ We believe that "Advanced services" are not "Necessary Services", we consider them to be "relevant services" and should be classified as such for the reasons we make clear below. The Classification of MURs/NMS as "necessary services" ▪ The LPC opposes the classification of Advanced Services such as MUR and NMS as "necessary" services for the following reasons: ▪ 1) Unlike Essential Services, it is not mandatory for pharmacies to provide MURs/NMS. 2) They are voluntary, requiring both personal and premises accreditation 3) MURs require prior usage of that pharmacy by a patient for a period of three months 4) As a result, a patient cannot be referred by a non-provider to a providing pharmacy 5) Provision of NMS cannot be undertaken in the	▪ The PNA Steering Group were advised that the draft PNA (page 33) sets out the principles which were taken into account when determining whether or not a service is necessary to meet a pharmaceutical need; and that these principles were applied to all pharmaceutical and locally commissioned services ▪ Within the draft PNA, the NMS, SACS and AURs have all been determined to be relevant services (sections 5.11.2, 5.11.3 and 5.11.4 respectively set out the reasons as to why these conclusions have been reached). ▪ MURs were determined, by the PNA Steering Group, to be a necessary service (page 61 of the draft PNA) ▪ The PNA Steering Group stated that the service needs to be considered from the perspective of Haringey residents	No

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
	absence of personal accreditation for provision of MUR 6) Other healthcare practitioners cannot provide MURs but can support patients in the use of their medicines e.g. practice nurses advising on the use of inhalers in respiratory disease and DACs providing AURs and stoma customisation services. We would suggest to the Haringey Health and Wellbeing Board that these are classified as "Relevant" Services". ▪ The LPC considers the Advanced Service of New Medicines Service (NMS) to be a "Relevant Service" and agrees with the statement on page 66 ▪ Advanced service provision from community pharmacies are discretionary. As these services are discretionary, not all providers will provide them all of the time. Advanced Services are negotiated nationally and "any contractor may provide". If "any contractor" may provide this service they are not likely to be "Necessary Services" for the purpose of the PNA. ▪ We contend that advanced services referred to as necessary services in the draft PNA should be referred to in the PNA as relevant services. The statement on page 61 the LPC would prefer worded "We have determined that this service is relevant to meet the pharmaceutical needs of our population"	▪ The general consensus was that MURs play a valuable role in helping people to take their medicines as prescribed and in reducing waste ▪ The final decision was the MURs are necessary to meet the pharmaceutical needs of the population; and that no change was required for the final PNA	
Pharmocare (Warwick Pharmacy) N11 2EU	**Minor ailment Scheme** Not all patients understand or are aware about what the scheme is for and its availability. Many think that they can obtain anything from the pharmacy for free and to stock for emergency	▪ The PNA Steering Group was advised that the comment related to the draft PNA pages 71 - 75 ▪ It was noted that there is an information leaflet available which explains the purpose of the service, including eligibility; this information is also included within the specification for the service ▪ The PNA decided that the 'service overview' would be updated in the final PNA so that it is clear that an information leaflet is available which helps to facilitate the public's understanding of the service and when it should be used	Yes

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	▪ Classification of some local services such as Emergency Hormonal Contraception (EHC) as relevant services(if they were commissioned by NHS England they would be "relevant services") ▪ Some services such as Emergency Hormonal Contraception (EHC) and the Minor or Common Ailments Service are locally commissioned 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 not available, these become "essential "services ▪ Please note that the LPC considers such services as essential not from the perspective of the Pharmaceutical Contractual Framework definition	▪ The PNA Steering Group was advised that the comments related to the draft PNA pages 71 - 75 for minor ailments (MAS); and pages 87 - 94 for sexual health services (and that EHC is an element within the scope of this service) ▪ It was noted that: o The MAS is commissioned by NHS England and as such is an enhanced service; it has been determined to be 'necessary' to meet a pharmaceutical need o The sexual health service (under 25s and over 25s bundles) is a locally commissioned service. o The PNA states "we have also found it helpful to consider whether or not a locally commissioned service is necessary to meet a pharmaceutical need; or if we believe the service is relevant in that it delivers improvements in access or choice"; and notes "applications **must relate to pharmaceutical services** (i.e. essential, advanced and/or enhanced services) and should not be submitted on the basis of gaps or needs identified for locally commissioned services". ▪ The LPC were assured by this text and the PNA Steering Group determined no changes were required for the final PNA	No
Sexual Health Commissioner Haringey Council	▪ Revision of text relating to the 'over 25s' sexual health services, to replicate the level of service associated with the under 25s bundle; and slight modification of the Provider Criteria ▪ HIV PoCT - amend the table so it is clear that this service may be offered to those aged 18 years and over; and that the service element is being piloted in the first instance by 6 pharmacies and then gradually rolled out to other pharmacies providing the over 25s bundle ▪ To note in the document that the service is being rolled out and that it is anticipated that all pharmacies, as listed in Appendix E, will be live by the end of the first quarter	▪ The comments refer to Sexual Health Services ▪ The PNA Steering Group approved the proposed minor changes to the text, with respect to the scope of service; age criteria for HIV point of care testing (PoCT); and provider criteria ▪ The PNA Steering Group recognised that the over 25s service is being rolled out and agreed to reflect in the document. It was agreed to include a statement in the final PNA that it is anticipated that all pharmacies listed in Appendix E will be live by the end of June 2015. The document will signpost to the sexual health section of Haringey's Council's website which includes a list of pharmacies and non-pharmacy providers offering the service	Yes

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
The Bridge Renewal Trust Laurels Healthy Living Centre	▪ The PNA has provided a reasonable description of NHS services, but there are other services that have not been described, as well as addressing the need to 'join' up services in order to make the patient experience seamless and less disjointed. ▪ For example, if we consider the anticoagulation and stroke prevention service, then it would be better for the patient if their INR could be monitored and their medication dispensed in the same building. This would allow the team responsible for the patients care to be able to regulate the patients INR tighter, as well as being able to feedback and respond to instances where patients may have medication prescribed that adversely effects their clotting and subsequently their INR value. ▪ Another example in which a simple change to a service can have a profound effect is if we consider the on demand access to end of life and specialist medicines/Out of Hours service. Currently The Laurels is one centre from which 'Barndoc' is run. In some cases this service looks after patients nearing the end of life, who require certain specialist drugs in order to make their last days comfortable. Ideally these patients should be cared for in a community setting as this is more comfortable for them and there is less strain on secondary care. Often the main issue they encounter is getting access to these drugs, as once they are prescribed it is often family members or Macmillan nurses who are tasked with the responsibility of obtaining them. If the members running the service could ensure they have to these drugs without having to search a number of different pharmacies, then this would make the service more efficient and ultimately would greatly benefit the patient.	▪ The PNA Steering Group was advised that the draft PNA makes the following references to integration and 'joining up services': o Page 19 notes that "we are concerned to ensure that patients moving in and out of hospital have an integrated pharmaceutical service" o The need for integration is highlighted in several of the strategies set out in section 4.3 o Page 31 notes that transformation changes are required and that this has implications for how community pharmacy integrates with the full range of health and social care providers in the future o The NMS conclusions, on page 67, identify that adopting an integrated approach to service delivery may secure improvements for patients ▪ The PNA Steering Group then considered the specific examples raised by the Bridge Renewal Trust: **Anti-coagulation and stroke prevention service** ▪ The PNA Steering Group were advised that the comment refers to the service described on pages 105 – 107 of the PNA ▪ The following points were noted: o The service has been commissioned to ensure integration between primary and secondary care o People who are prescribed warfarin carry a yellow book which includes a record of their INR and current dose of treatment; the intention is that this record should be shown when collecting repeat prescriptions; and the information may also be requested by pharmacists at the time of dispensing ▪ The PNA Steering Group noted the comment but determined that it not necessary to provide dispensing in the same place as monitoring and dose adjustment; and that no pharmaceutical need had been demonstrated in this respect	No

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
		On Demand Access to End of Life Care and Specialised Medicines Services ▪ The comment refers to the service described on pages 79 – 81 of the draft PNA ▪ The following points were noted: o The service is intended as an 'in-hours' back up when a local pharmacy does not hold stock of the prescribed medicines. 4 pharmacies have been commissioned to hold an approved list of medicines (2 of these are open on 7 days each week for extended hours) o Barndoc are contracted to stock, and supply, a similar formulary of medicines, if needed during the out of hours period o The draft PNA concludes that there are no gaps with respect to current need, but that improvements in access could be achieved if the service were to be commissioned from pharmacies which are opened for extended hours on 7 days each week ▪ The PNA Steering Group determined that no new pharmaceutical need had been demonstrated; and that it is not necessary to co-locate an 'in-hours' pharmacy service with the out of hours service	
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	The LPC agrees that there are no gaps in the current provision for necessary services within the Borough of Haringey. Our agreement is based on the evidence provided within the draft consultation document and it appendices.	▪ The PNA Steering Group noted the comment	No

Are you aware of any pharmaceutical services currently provided which have not been included in the PNA?			
Organisation	**Detailed Comment**	**PNA Steering Group Decision**	**PNA Amended?**
Yes = 15.4% (n=2)	No = 84.6% (n=11) Not sure = 0% (n=0)	Not answered / Feedback Form Not Used (n=2)	
Boots UK Limited	New PURM [Pharmacy Urgent Repeat Medicine Service) which NHS London commissioned from 1st Dec	▪ The PNA Steering Group were advised that the PURM service was a pilot scheme ▪ It was agreed that the following text, would be included within section 5.5.2 - "alignment with other services" (draft PNA page 48) which looks at dispensing in relation to other services: ○ In December 2014, NHS England launched the Pharmacy Urgent Repeat Medication service. This is a pilot scheme which will run until April 2015 ○ Under the service, NHS 111 refers people directly to pharmacies when they are in need of an emergency supply of repeat medicines ○ The aim of the service is to reduce pressure on unscheduled care services and GP appointments at times of high demand ○ It is our understanding, that NHS England plans to evaluate the PURM service and, if deemed to be successful, consideration will be given to commissioning this in the future ○ We believe that this service potentially plays a valuable role in improving access to medicines. We would be supportive of a further roll out, providing the evaluation demonstrates both value for money and reduced pressure on GP and unscheduled care services	Yes
The Bridge Renewal Trust Laurels Healthy Living Centre	▪ The PNA refers to a number of non-NHS services that are provided from a number of pharmacies. ▪ These services, such as prescription collection/delivery, supply of medicines under a PGD make it easier for patients to get their medication as well as being able to access medication that would require them to visit a GP. ▪ Although the PNA mentions them, they are not given the importance they deserve, especially considering the benefit they can have on patients' lives.	▪ The PNA Steering Group were advised that the comment refers to page 19 of the draft PNA; and that non-NHS services have been excluded from the scope of the PNA because they cannot be taken into account when considering market entry applications ▪ It was agreed that a statement would be included in the final PNA as follows: *"Non-NHS services are potentially valuable to residents of Haringey; however, they have been evaluated in any detail because they cannot be taken into account, by NHS England, when considering market entry applications."*	Yes

Do you think that the Pharmaceutical Needs of the population have been accurately reflected throughout the PNA?			
Organisation	**Detailed Comment**	**PNA Steering Group Decision**	**PNA Amended?**
Yes = 76.9% (n=10)	No = 7.7% (n=1) Not sure = 15.4% (n=2)	Not answered / Feedback Form Not Used (n=2)	
The Bridge Renewal Trust Laurels Healthy Living Centre	▪ We do feel the Pharmaceutical Needs Assessment is weak in identifying the impact of and solutions to health inequalities. ▪ The document summarised the headline evidence relating to the key areas of health inequality. It does not explore the impact of inequality and the effect on deprivation on health. ▪ For example Medicine Use Reviews and New Medicine Services are particularly important where people do not have English as a first language and/or patients are not familiar with the NHS, or they are unable to access the service due to work commitments. This will not allow them to access these services when they are available. ▪ Minor Ailments Service are also particularly significant where patients are not familiar with the NHS or are not registered with a GP, ensuring they have access to vital medical attention. ▪ Providing effective services that are accessible to patients in diverse communities are likely to reduce health inequalities as well as improve people's experience of and access to NHS services in general. ▪ A number of pharmaceutical services listed in the PNA have identified current or future needs that will need to be met. ▪ Due to the high levels of diversity and the projected population growth in Tottenham, additional pharmaceutical services are required to ensure that the current population has adequate access to services, and that the needs of patients in the next 10 to 20 years are met and are planned for now.	▪ The PNA Steering Group were advised that the draft PNA provides an overview of local demography and health needs, making reference to factors such as deprivation and inequalities; and it signposts to various other sources, including the full JSNA ▪ It was noted that the draft PNA makes the following references to the implications of deprivation and inequalities for community pharmacy services: o Page 24 - notes a correlation between ethnicity & inequalities and that pharmaceutical services should reflect the needs of BAME communities; and that access to pharmacy in deprived communities is important o Page 26 - sets out how pharmacy based essential, advanced, enhanced and locally commissioned services tackle health inequalities o Page 55 - the conclusions note the role of health promotion and sign posting o Page 55 - future need, the PNA identifies that NE Tottenham (an area with high deprivation and poorer outcomes) may benefit from additional access to pharmaceutical services, following completion of new developments o Page 75, Minor Ailments service, notes the importance of improving access to the service, particularly in areas of higher deprivation o Page 82 - reducing inequalities is cited as a benefit of Healthy Living Pharmacies o Page 83 - Stop smoking service states an aim of reducing health inequalities o The 'meeting the needs of those with protected characteristics' identifies how language may be a barrier to success service delivery for those services where pharmacies provide advice ▪ The PNA Steering Group noted the comment, but concluded that the draft PNA was comprehensive	No

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
NHS England London Region	The pharmaceutical needs have been accurately reflected throughout the PNA except for the details as mentioned in Q8 above. [MURs]	▪ The PNA Steering Group was advised that this feedback reinforced the previous comments made by NHS England in relation to MURs ▪ The conclusions for MURs will be strengthened as previously described	Yes (as above)

Do you agree with the "Looking to the Future Section"?			
Organisation	**Detailed Comment**	**PNA Steering Group Decision**	**PNA Amended?**
Yes = 76.9% (n=10)	No = 15.4% (n=2) Not sure = 7.7% (n=1)	Not answered / Feedback Form Not Used (n=2)	
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	▪ The LPC understands the comments within the assessment "looking at the future" on page 108, it understands that any improvement in opening hours is aspirational on the part of a commissioner, but in reality the provision of greater time from a professional and business perspective must be accompanied by the reality that the services are likely to be used by the population as a whole. ▪ Limited use of professional services on Sundays, Saturdays and Saturday evenings and early mornings may place a strain on those providing such services. ▪ The LPC disagrees with the conclusions stated. We consider the use of out of hours rota arrangements a better way to meet any future need no matter how small that need might be with pharmacies sharing that load between them equitably with the commissioner providing some financial support. ▪ We should like the conclusions drawn in "aspirations for pharmacy services and premises" on section 7.2 page 108 to be tempered with phrases that signify the current reality in terms of provision of services by pharmacies with pharmacy professionals providing those services. ▪ The draft PNA is the basis of a Pharmaceutical Needs Assessment. No new need has been demonstrated for pharmaceutical services within these "aspirational" extra hours indicated in the assessment aspirations on page109 in the right hand column.	▪ The PNA Steering Group was advised that the comment refers to section 7.2 of the draft PNA ▪ The section is intended to set out the aspirations of the HWB in relation to pharmacy premises and services, for prioritisation by those who are considering making applications to provide pharmaceutical services and for NHS England to take into account when considering applications. ▪ The aspirations do not apply to existing contractors (except where gaps or opportunities have been identified for specific services throughout the PNA) ▪ Concern was expressed that the section may be seen to lead applications for NHS Pharmaceutical Services ▪ The PNA Steering Group felt that, because the requirements for NHS pharmaceutical services have been summarised in the relevant sections throughout the PNA, it was not necessary to present these back in a table within this section ▪ It was agreed that the section would be retained but would be moderated through the inclusion of the following text*: "In reflecting upon the gaps and areas for improvement described within our PNA and our vision (as set out in section 7.1 above), we have identified aspirations for pharmacy services and premises throughout our PNA and would like to see these prioritised for future applications"*. The table will be removed	Yes

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
	▪ Community pharmacies across the Borough provide ready and easy access to patients and the public. If such need existed universally on Sundays the LPC is sure community pharmacies would respond ▪ As for extended hours openings early mornings and late evenings and late Saturday evenings, providing pharmaceutical resource for the few would not necessarily be "good value for money" if these were commissioned services which the Council Taxpayer or Taxpayer were expected to pick up. The LPC is always willing to help facilitate "pharmacy rota" services to help meet the needs of a small group of people within the Borough with defined needs. ▪ A robust assessment has been carried out which indicates there is no new need; if new need were apparent, then resources would be required to meet that the need. Community pharmacies are willing to seek accreditation to provide high quality advanced and enhanced services should they be required and commissioned. ▪ The quality and size of consultation areas in community pharmacies varies to meet the needs of the physical size of the pharmacy and the population it serves. ▪ The aspirational views that appear in the right hand column of section 7 on page 109 "The Assessment" are well meant, but imply that community pharmacy could do more, when in fact community pharmacy is more than pulling its weight in terms of the service of healthcare provision across the Borough and beyond its borders. ▪ Patients and the public are able to access from each pharmacy in the Borough a minimum of 40 core contracted hours each week, with many pharmacies providing their highly qualified professional services over quoted additional hours which require three months' notice to NHS England before they can withdraw from those quoted additional hours, even for a temporary period.		

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	▪ The LPC understands there may be some changes to opening hours of GP surgeries, but the detail of how many extra patients would be seen by GPs is absent from this PNA, as such, it is impossible to say what services may be needed to match an unspecified demand if at all. ▪ The LPC has said previously that community pharmacies will always meet any unmet need should there be such a need. If there were extra demand an existing pharmacy business would always strive to meet such activity, as this would make good professional and business sense. All services if provided over longer hours may give greater choice to patients and the public, but such choice with no or little demand may result in resources being wasted. ▪ Resources are finite and the provision of extra resource to improve choice may not necessarily meet those aims and objectives when the resource could be targeted more effectively at tackling unmet need in another location. This is why the LPC believes the use of targeted "Rota" arrangements could meet need rather than satisfying the notion of improved choice, in the absence of evidence within the draft PNA.	▪ The PNA Steering Group was advised the comment referred to page 55 of the draft PNA ▪ Concern was expressed that the arrangements for GP extended hours were subject to change on an annual basis; and that it wasn't clear how many people would need to access dispensing services as a result of GP extended hour opening ▪ The Steering Group noted that the draft PNA stated *"If GPs move to a 7 day a week service then current opening hours may need to be reviewed, to ensure timely access to dispensing following a GP consultation. At the time of publication, the arrangements for the operational delivery, and timescales, of such changes are not known"* ▪ The consensus of the PNA Steering Group was that no changes were required to the final PNA. This is because the document simply flags this as a potential future gap but did not include firm conclusions on future need	No
GP, Somerset Gardens	Several comments were made on the length of the document and the extent to which the respondent had time to read it through; it was suggested that a summary with the salient points would be helpful	▪ The PNA Steering Group was advised that for the purposes of the consultation report, this respondent's feedback had been consolidated into a single comment ▪ It was acknowledged that the document is long. However, this is a reflection of the requirements of the Regulations with respect to the information which a PNA must include. The document does include an executive summary. ▪ A primary purpose of the PNA is to inform market entry decisions, and for this reason it is not appropriate to produce a separate summary ▪ The PNA Steering Group noted the comment but did not approve the production of an additional summary document	No

Organisation	Detailed Comment	PNA Steering Group Decision	PNA Amended?
Parade Chemist (Conochem Management Ltd) N4 1LG	Due to changes in geographical population, I believe that a plan should be in place to commission new services from pharmacies	▪ The PNA Steering Group noted that the draft PNA makes references to commissioning new services - both now and in the future; this is mainly in relation to improving access but also in relation to population growth ▪ Specific examples within the draft PNA include: o Sections 5.9 - Future capacity and conclusions on essential services o Page 79: London Pharmacy Vaccination Service o Page 81: On demand access to end of life and specialised medicines o Page 86: Stop smoking o Page 94: Sexual health services o Page 97: Supervised consumption o Page 101: Needle & Syringe Programme ▪ The PNA Steering Group noted the comment but determined that no changes were required for the final PNA	No
The Bridge Renewal Trust Laurels Healthy Living Centre	Refer to detailed comment made in relation to the question on pharmaceutical needs	▪ The PNA Steering Group noted that this was a duplicate comment and that no further action was required	No

Is there any additional information which should be included in the PNA?			
Organisation	**Detailed Comment**	**PNA Steering Group Decision**	**PNA Amended?**
Yes = 7.7% (n=1)	No = 84.6% (n=11) Not sure = 7.7% (n=1)	Not answered / Feedback Form Not Used (n=2)	
The Bridge Renewal Trust Laurels Healthy Living Centre	▪ Overall the PNA provides a comprehensive review of pharmacy needs in Haringey on a ward by ward basis. It is a significant improvement on the previous PNA in terms of detail and quality of information. ▪ We are particularly supportive of the recommendation made under 1.3 Pharmaceutical services in the future: 'We have identified, that in Tottenham, an area which has high levels of deprivation and health challenges, coupled with poor access to GPs and low GP registration, there is an opportunity for pharmacy to drive improvements in public health through the HLP'.	▪ The PNA Steering Group noted the comment	No
The Bridge Renewal Trust Laurels Healthy Living Centre	▪ Our community consultation along with consultation with health professionals clearly identifies the need and demand for additional pharmaceutical services that would: ○ Mirror GP opening times and some out of hours times ○ Dispense prescriptions ○ Offer a full range of community and wellbeing services in accessible ways for diverse community groups ○ Provide minor ailments services ○ Provide streamlined care services and home outreach across a range of innovative areas ○ Provide alternate approaches to social prescribing such as increasing physical activity, reducing isolation, making changes to diet and having a positive effect on patient mental wellbeing ○ They could also provide skills on managing long term condition skills	▪ The PNA Steering Group was advised that the Bridge Renewal Trust had been contacted with a view to providing further information on the community consultation which had been undertaken ▪ The Bridge Renewal Trust advised that the consultation was a collaborative piece of work which couldn't be released because it had been undertaken for a different purpose. However, it had been flagged because the findings reflect some of the findings and recommendations within the PNA ▪ The PNA Steering Group noted the comment, but determined that, in the absence of further detail, that no changes were required for the final PNA	No

Has the PNA provided adequate information to inform market entry decisions (NHS England only)			
Organisation	**Detailed Comment**	**PNA Steering Group Decision**	**PNA Amended?**
NHS England London Region	There needs to be clarity on the gap and the need identified for the provision of MUR Service for the benefit of existing owners and potential applicants.	▪ The PNA Steering Group was advised that this feedback reinforced the previous comments made by NHS England in relation to MURs	Yes (as above)

Has the PNA provided adequate information to inform how you will commission services from pharmacy (all service commissioners)?			
Yes = 100% (n=2)	No = 0% (n=0)	Not sure = 0% (n=0)	Not answered / Feedback Form Not Used / Not applicable (n=13)
No detailed comments received			

Does the PNA give enough information to help with your own future service provision (pharmacies and DACs only)?			
Yes = 100% (n=8)	No = 0% (n=0)	Not sure = 0% (n=0)	Not answered / Feedback Form Not Used / Not applicable (n=7)
No detailed comments received			

Do you have final comments?			
Organisation	**Detailed Comment**	**PNA Steering Group Decision**	**PNA Amended?**
Middlesex Pharmaceutical Group of LPCs (with the authority and on behalf of Barnet, Enfield & Haringey LPC)	The LPC represents the providers of the pharmacy services that patients use on a daily basis within Haringey Borough. As such we would ask that the Haringey Health and Wellbeing Board to place the appropriate weight to our response within its consultation process	▪ The PNA Steering Group noted the comment	No
NHS England London Region	There are some pharmacies whose opening hours have changed from the current pharmaceutical list, these are supplementary hours and a full list of the details of these will follow. NHS England have confirmed that it will accept these changes and amend the pharmaceutical list.	▪ The PNA Steering Group noted the comment	No
Parade Chemist (Conochem Management Ltd) N4 1LG	We have noticed a change in requests from customers and patients and would like to start offering Minor Ailments Service, Sexual Health Under 25s(EHC), Vaccinations, Healthy Start Vitamins & Stop Smoking	▪ The PNA Steering Group noted the comment	No

This page is intentionally left blank

Haringey Council Clinical Commissioning Group | NHS Haringey healthwatch Haringey | HAVCO Haringey Association of Voluntary and Community Organisations

Report for:	**Health and Wellbeing Board**

Title:	**Health and Homeless Task Group update**

Report Authorised by:	**Jeanelle de Gruchy, Director of Public Health, LBH**

Lead Officer:	**Sarah Hart, Senior Commissioning Manager, LBH**

1. Describe the issue under consideration

1.1 The Health and Wellbeing Board agreed to set up a multi agency task and finish group to address the findings of a health needs assessment of single homeless people in Haringey (presented to the Board in January 2014). This report updates on progress made.

1.2 The initial report highlighted three key issues as health barriers facing homeless people in Haringey:

i) The process for GP registration not being transparent thus allowing some practices to ask for photo ID as part of the registration process

ii) It not being clear what type of primary care model Haringey should adopt for homeless people

iii) There being a pilot homeless discharge pilot at the North Middlesex Hospital which had no links into council or primary care services

2. Cabinet Member introduction

2.1 I welcome the work being done to ensure all of our services collectively become more inclusive of homeless people. We know that homeless people have greater and often more complex health needs than the general population – with the shocking consequence that the average homeless life expectancy is just 47 years.

2.2 We need to better understand the needs of homeless people, which is why it was important that our Health and Wellbeing Board recently signed a pledge, created by homeless charity St Mungo's Broadway, to do this. I therefore welcome the

recommendation within this report to complete a full needs assessment for single homeless people.

2.3 The workshop demonstrated positive engagement from partner agencies. The feedback from the workshop will allow us to further explore what can be done to improve access to primary care, a key issue for homeless people.

2.4 The Health and Wellbeing Board is well aware that, while essential, meeting the immediate health needs of homeless people is not, on its own, a long-term solution to improving homeless health. Homelessness is of course inherently unhealthy; and any effort to tackle it needs to focus on its cause, not just its symptoms. To this end, Health and Wellbeing Boards have a hugely important role to play.

3. Recommendations

3.1 In accordance with the Board's function to prepare the Joint Strategic Needs Assessment and other related assessments and to promote and coordinate joint commissioning and integrated provision, the Board is asked to

a) Sponsor an expert group consisting of the Council and CCG homeless commissioners, providers, GPs and Public Health to develop and complete the single homeless person needs assessment, and

b) Request that commissioners and providers adopt the cross government operational guidance; Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation - as part of the measure to ensure better integrated services for homeless people leaving hospital

4. Alternative options considered

N/A

5. Background information

5.1 The task group has achieved the following;

i) The publication of guidelines on how to register with a GP which are inclusive to those without photo ID or proof of address - http://www.haringeyccg.nhs.uk/Services/gp.htm

ii) Cllr Morton on behalf of the board signed the St Mungo's Broadway Homeless Health Charter and met with homeless people to discussed their health needs http://www.theguardian.com/healthcare-network See appendix 1

iii) A Health and Homeless multi-agency workshop has been held which has identified options for service developments and highlighted the need for further needs assessment. See appendix 2

5.2 Two areas of work now remain outstanding; identifying a model for primary care delivery to homeless people and having an integrated way of delivering effective hospital discharge for homeless people. The workshop looked in detail at models for delivering primary care, it concluded that some form of specialist service was required but concluded that before a decision could be made a fuller JSNA needed to be completed; this would need to clearly identify the volume and type of unmet need. Production, development and the updating of the JSNA is a duty of the Board.

5.3 The North Middlesex Hospital pilot conclusively showed that Haringey does not have a traditional homeless population using A&E, however it did highlight discharge problems linked to patients being vulnerably housed and requiring housing support which the hospital could not provide. The homeless agencies continue to report residents being discharged from hospital with little clinical follow up. The Government has recognising this as a common issues for homeless people and has nationally funded hospital discharge pilots and co produced discharge planning guidance, adoption of which by the hospital, homeless services in the council and voluntary sector is recommended.

6. Comments of the Chief Finance Officer and financial implications

6.1 There are no finance implications arising directly from this report. The Board should be aware that there is unlikely to be significant additional funding available to support any new initiatives and so funding to support new or amended services will need to be from existing resources.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 There are no legal implications arising from this Report.

8. Equalities and Community Cohesion Comments

8.1 The Council has a general equality duty under section 149 of the Equality Act 2010 to have due regard to amongst other things, the need to advance equality of opportunity and foster good relations between those who share the characteristics protected by sections 4 – 12 and 17 of that Act and those who do not.

8.3 The target group of this report – the homeless in Haringey – include people who possess most if not all of the characteristics protected by the Act and are therefore owed the general equality duty to afford them equal opportunity to health and social care.

8.4 Both national and local data suggests that the target group of this report, the

homeless are among the most vulnerable and hard-to-reach groups and suffer the highest rate of premature death due to the difficulties they face accessing health and social care. We would welcome the completion of a full Equality Impact Assessment which would be part of the proposal to complete a JSNA

8.5 The activities reported in this report and the further measures proposed in paragraphs 3.1 and 3.2 are in accord with the Council's general equality duty, the Corporate Plan priority relating to health inequalities and wellbeing and with the Health and Wellbeing Strategy.

8.6 By addressing the health inequalities faced by the homeless in Haringey, the activities reported and the measures proposed will bring some of the most marginalised groups in society back into the fold and contribute to building a borough in which everyone has a stake. This would be in accord with the Council's duty to foster cohesion and good relations between groups Haringey.

9. Head of Procurement Comments

N/a

10. Policy Implication

10.1 This service is linked to the Health and Wellbeing strategy and the Corporate Plan. In terms of the Health and Wellbeing Strategy its meets cross cutting responsibilities to: improve the health and wellbeing of local populations and reduce health inequalities across the life course, particularly in hard to reach groups. There is evidence that addressing barriers to health in the homeless population reduces both rates and length of hospital admissions

11. Reasons for Decision

N/a

12. Use of Appendices

Appendix 1: The Homeless Health Charter
Appendix 2: Health and Homeless Workshop Jan 2015
Appendix 3: Hospital Discharge Guidance

13. Local Government (Access to Information) Act 1985

http://www.minutes.haringey.gov.uk/Published/C00000771/M00006845/AI00038219/$HealthandHomelessTaskgroupreport16june2FINALfinal.docx.pdf
and accompanying appendices are also on this page (item 12):
http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=771&MId=6845&Ver=4

Appendix 1 – Homeless Health Charter

The Homeless Health Charter pledges the following which are all being address by the Health and Homeless Task Group or are within the further recommendations of this paper

I. **Identify need:** We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

II. **Provide leadership:** We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

III. **Commission for inclusion:** We will work with the local authority and the clinical commissioning group to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

Appendix 2 – Haringey Health and Homeless Workshop 15th January 2015

The Health and Homeless workshop attracted 37 participants from an excellent range of agencies which included homeless people, Clinical Commissioning Group members, GPs, homeless services managers, Migrant Centre, Pathway, Public Health England, Public Health, Health Watch, Barker Foundation, Housing Related Support, Homes for Haringey and the North Middlesex hospital. There were presentations and workshop discussions around three key areas resulting in a series of recommendations which were subsequently discussed at a meeting of the Homeless and Health Task group.

I. **Workshop 1 Delivery in primary care** - *is it better to have a single GP specialist or a shared responsibility? (Chair: Dr Sherry Tang, Haringey GP and CCG Chair)*

This workshop recognised the additional needs of homeless people which were difficult to address within a GP appointment; the workshop stated that 'whilst volume may be low, complexity and intensity is high'. The group identified several potential models for offering a primary care service to homeless people:

- A specialist practice for homeless people
- A practice focused on inclusion and access, for a broader group of patients
- A small add-on to an existing practice – either just for homeless people or for a broader group
- A nurse led service, with specialist clinics, supporting other practices and supporting patients into mainstream services

- Close working with other services : drug and alcohol, mental health, housing, welfare benefits etc

The Health and Homeless Task group recommends that a business case is developed to explore which model offers best value for money. This will need to contain an updated local needs assessment estimating the level of demand, the data for this is not readily available therefore key partners will need to support Public Health in data generation.

II. ***Workshop 2 Bridging the gap*** *– what model can we achieve in Haringey, what would we aspire to develop? (Chair: Sarah Hart, Public Health)*

This workshop highlighted that there is a spectrum of need amongst homeless people which included the following;

- Those who would benefit from inclusion in current public health programmes i.e. health checks, smoking cessation
- Those who would access a primary care GP if they had a peer to support them in getting to the appointment
- Those who with peer support would get to a GP, but their needs are so complex that they require more time than is available within a general consultation and a GP skilled in dealing with a number of problems as well as the presenting one
- Those who need primary care to reach into the hostel/service they access either by something like the TB Find and Treat mobile van or health professionals reaching in. This would not need to be a GP
- Those who are resistance to exploring their health needs and require trained resident peer supporters to be available at the right moment to talk about health and wellbeing

The workshop therefore identified a series of differing services to meet need

- Public Health to ensure homeless people have access to its prevention programmes
- A peer mentoring programme
- A homeless community nurse

The Health and Homeless Task group recommends that a survey be done to identify the levels and types of health needs, it suggests surveying residents of Housing Related Support accommodation which will require the support of housing providers, Health Watch and Public Health.

III. ***Workshop 3 What next for the hospital homeless pathway?*** *What are our options going forward; are there things we can put in place now? (Chair: Simon Hughes, St Mungo's)*

The workshop identified a need for shared knowledge of what services are out there - who to speak to, how to refer etc. Being brought together in the workshop

highlighted that *'there are some good services but we aren't all aware of one another'*

The workshop recommended development of a single point of contact for hospital discharge.

The Health and Homeless Task group recommends that providers and commissioners consider adopting the *Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation,* see appendix 3; the first step of which is to set up a multi partner steering group which would require multi partnership sign up.

This page is intentionally left blank

Communities and Local Government

DH Department of Health

Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation

Aims of this document

These guidelines are issued jointly by the Department for Communities and Local Government and the Department of Health. They represent recommended practice for organisations involved in hospital admission and meeting the needs of people who are homeless or living in temporary or insecure accommodation, and were drawn up by an expert steering group consisting of representatives from Homeless Link, the London Network for Nurses and Midwives, and the Health Inclusion Project Advisory Group.[1]

In '*Discharge from hospital: pathway, process and practice*'[2] the Department of Health stated that all acute hospitals should have formal admission and discharge policies ensuring that homeless people are identified on admission and that their pending discharge be notified to relevant primary health care services and to homelessness services.

More recently, '*Our health, our care, our say*'[3], made clear that better integrated health and social care can help prevent the inappropriate use of specialist or acute health care and can help prevent or reduce homelessness. '*Commissioning a patient-led NHS – Delivering the NHS Improvement Plan*'[4] emphasises the need to change systems to be more responsive to patients needs through better integration of services.

The Government's homelessness strategy '*Sustainable communities: settled homes; changing lives*'[5] highlights that people who are homeless or living in temporary or insecure accommodation are more likely to suffer from poor physical, mental and emotional health than the rest of the population, and that hospitalisation presents an opportunity to deal with underlying medical, social and mental health problems, and to address their accommodation needs.

homeless LINK
Frontline agencies in partnership

NHS
The London Network
For Nurses and Midwives

The aim of this guidance document is to support hospitals, Primary Care Trusts (PCTs), local authorities and the voluntary sector, working in partnership, to develop an effective admission and discharge protocol for people who are homeless or living in temporary or insecure accommodation. The over arching aim of the protocol will be to ensure that no one is discharged from hospital to the streets or inappropriate accommodation.

People who are homeless or living in temporary or insecure accommodation includes:

- Rough sleepers
- Individuals or families owed the main homelessness duty and living in temporary accommodation (see glossary)
- People living in hostels, night shelters, squats, or in bed and breakfast accommodation.

This document applies to the situation when a person who is homeless or living in temporary or insecure accommodation is admitted to, and discharged from, a hospital ward. Most of the underlying principles apply also to Accident and Emergency (A and E) Departments; however, the document is not designed to cover fully the issues that arise in A and E.

Audiences

The document is aimed at health professionals and managers in hospital trusts, primary care providers and PCTs, local authorities and the voluntary sector to help them establish an effective hospital admission and discharge protocol.

Background information

Most homeless people – in particular rough sleepers or those with a chaotic lifestyle – have poorer health than the rest of the population. People living in temporary or insecure accommodation may have difficulty accessing primary care which means they often do not seek treatment until the problem is at an advanced stage. Once admitted to hospital, they can present a complex medical and social picture.

In addition, they often self-discharge from hospital for a variety of preventable reasons such as:

- Unrecognised or inadequately managed alcohol or drug dependence
- Anxiety about losing their accommodation, which may be insecure (e.g. hostel or bed and breakfast accommodation)
- Ongoing or unrecognised mental health problems.

Some homeless people will be known by a homeless service, such as a street outreach team, or primary care or mental health team and may have a keyworker who can provide background information and support to the patient both during admission and following discharge. Identification of a patient's housing status, keyworking arrangements (if any) and special vulnerabilities at an early stage in the admission is vital to achieve an appropriately planned and timely discharge.

The Department of Health's '*Achieving timely simple discharge from hospital: a toolkit for the multi-disciplinary team*'[6] provides a step by step guide to developing a discharge protocol. It acknowledges that it deals with straightforward discharges and that complex discharges may need more complex arrangements. This guide sets out to adapt the timely simple discharge process to one appropriate for managing the discharge of homeless people, thus promoting:

- Reduced self-discharge rates
- Reduced lengths of hospital stay
- Timely, appropriate and safe discharge
- Reductions in readmissions.

This is in accordance with the principle of patient-centred care and the aim of reducing health inequalities.

The multiple and complex needs and lack of settled accommodation of some patients means that it can take time to identify and secure appropriate housing and services for people on discharge. The range of services that may be required means that a discharge protocol needs to be developed in partnership. Since 2003, each local housing authority has been required to have a homelessness strategy which must be kept under review and renewed at least every 5 years. This provides an opportunity for the hospital's admission and discharge policy to be included within the homelessness strategy, which should involve all partners working to meet the needs of people in the district who are homeless or at risk of homelessness.

Development of hospital discharge and admission protocol

Due to the complex needs of some homeless people, a hospital admission and discharge protocol will be most effective when it is developed in partnership by the hospital, local PCTs and primary care providers, the voluntary sector and the local authority. The local housing authority's homelessness strategy should identify the key stakeholders in the area and there may already be a formal or informal forum of key agencies which can be involved in the development of the protocol.

Steps to consider in developing a protocol

The steps below should be considered in developing, implementing and reviewing the protocol.

These steps are only a guide and although they are presented as sequential some of the elements can be worked through in parallel.

Step one – Identify relevant organisations

Establish the willingness of services and agencies to be involved in the development of a protocol for admission and discharge of people who are homeless or living in temporary or insecure accommodation, and secure agreement that the protocol will be incorporated in the local homelessness strategy. This process should include representatives from the Hospital Trust, PCT(s), primary care providers, the local authority housing department, social services, and voluntary sector agencies working with people who are homeless or living in temporary or insecure accommodation.

Corporate ownership of the protocol is important. This involves engaging the relevant managers and convincing them of the need for, cost effectiveness and value of the protocol in promoting good practice.

The most effective protocols usually have champions in key agencies to ensure that they have a positive impact on practice.

Step two – Set up a steering group

Identify a steering group to oversee the development and implementation of the protocol:

- Ensure that all relevant sectors and agencies are represented
- Clarify the roles and responsibilities of the steering group
- Set progress review dates for the steering group, including dates after the protocol has been implemented
- If appropriate, consider the need for creating a group to continue to support the work in the longer term.

Protocols need to be developed in partnership to make sure that they work within local conditions and services. Safe discharge is the duty of the hospital trust, but the key to success is that the protocol is developed and owned by all the relevant agencies. Health agencies, the local authority, and voluntary sector agencies need to be engaged, each respecting the skills and knowledge of the other. For example, voluntary sector agencies have developed a substantial skill base in engaging successfully with people who are homeless or living in temporary or insecure accommodation.

The protocol should be developed through an existing partnership forum if possible. If a homelessness strategy steering group, or a health and homelessness planning group already exists, this group could facilitate the bringing together of the relevant agencies. If not, it will be necessary to establish a group for this purpose.

Clarifying the roles and expectations of the forum or steering group at the outset can help avoid confusion or difficulty in the partnership at a later date. The group should be responsible for developing, implementing and reviewing the protocol.

Step three – Review existing systems

Review systems and processes and identify:

- What happens when people who are homeless or living in temporary or insecure accommodation are admitted and discharged
- Gaps in the system at present e.g. establishing and recording a patient's housing circumstances on admission, links between hospital, accommodation providers and the local authority in planning the patient's discharge
- Need for new systems e.g. how to inform local homelessness agencies.

A process for reviewing and understanding the current system should be established. It is only by understanding the gaps or obstacles to overcome, that an effective admission and discharge protocol can be developed. It may be worthwhile organising a meeting involving organisations such as social services, housing, drug agencies, outreach teams, hostel, hospital and primary care staff, in order to gather as much information as possible.

Step four – Identify training and resource requirements

Identify skills/additional resources needed to implement a protocol:

- Identify key people to be involved
- Consider the appropriateness of training for hospital staff on homelessness, issues and problems associated with it, and the services available
- Set up a resource book or area on the intranet outlining homelessness and related services available in the area, including information on the local authority criteria for housing assistance.

To support hospital staff in successfully implementing the protocol, they will need training to understand the range and complexity of needs and the problems and difficulties associated with being homeless or living in temporary or insecure accommodation. The local housing authority and/or voluntary sector agencies may be able to provide this training.

Due to the complexity and variety of needs associated with homelessness, there are a number of agencies who may need to be involved in planning a safe and timely discharge for patients who are actually homeless. Options for maintaining an up-to-date directory of these services should be considered.

There are a range of services available to support homeless people on discharge from hospital such as supported housing, access to drug and alcohol treatment services, employment and training opportunities. The creation of a resource book or website can be useful, containing key contact telephones and names.

The Supporting People on-line directory of services lists all services nationally, including emergency and non-emergency accommodation with support. It is updated quarterly, and can be accessed at www.spdirectory.org.uk.

Other useful websites, such as www.homelessuk.org.uk and www.homelesslondon.org.uk, could be included.

A system will need to be put in place for regularly updating the local directory.

Step five – Develop a protocol building on existing systems

Develop a protocol which:

- Links to the current hospital discharge protocol
- Identifies key people to lead on the implementation of an admission and discharge policy for people who are homeless or living in temporary or insecure accommodation
- Establishes a protocol for sharing information.

The hospital admission and discharge protocol will require carefully planned implementation which may benefit from the establishment of a small multi-disciplinary steering group involving local authority housing, hospital and voluntary sector staff. Information or flow charts highlighting the key steps to be taken by staff are useful.

Step six – Ensure protocol is fit for purpose

The admission and discharge protocol will work best if it:

- Establishes a patient's housing status on admission
- Includes procedures for obtaining patient's consent to share information
- Includes procedures for ensuring that existing accommodation is not lost
- Identifies key external agencies to notify about a homeless person's admission
- Develops the resources and training needed
- Involves voluntary sector agencies, primary care providers and local authorities throughout the discharge planning process.

Identifying a person's housing status on admission is essential for successful discharge. The protocol should clarify processes to deal with the different housing circumstances of individuals, including steps to ensure that where someone has accommodation it is not lost while they are in hospital, e.g. because rent is not paid or a hostel place is not kept open. Some homeless people, who are in contact with services, will have a key worker or named individual responsible for overseeing the implementation of an agreed support plan. Most homeless people will know the name or organisation of this person. The key worker should be kept informed of the progress of a person's admission.

Agreement about information sharing between agencies is essential.

Preventing self-discharge is important. Understanding the reasons why people discharge themselves (such as concern about losing their accommodation, unaddressed chemical dependence or mental health issues) can help in preventing a deterioration of a person's health and readmission.

The protocol should contain the following procedures:

If the person is or may be homeless or at risk of homelessness:

- If sleeping rough, a mechanism for contacting street outreach providers in the area who may already be working with the individual, and who may have an accommodation plan for the individual concerned.
- If not sleeping rough, a process for liaising with the local housing authority to ensure that an application for housing assistance can be considered.

If the person is in a hostel or other supported housing:

- If in supported housing, a mechanism for contacting the person's housing/support provider to ensure they don't lose their accommodation
- A process for evaluating whether the accommodation will be appropriate for them on their release from hospital.

If the person is in temporary accommodation secured by the local authority under the homelessness legislation (see glossary):

- A process to ensure that the relevant section of the local housing authority is informed of the hospital admission.

Step seven – Test and monitor protocol

Agree to:

- Pilot protocol
- Monitor impact of protocol
- Ensure that the steering group remains in place to oversee the implementation of the protocol
- Brief appropriate staff.

It may be possible to pilot the protocol in wards which see the largest numbers of people who are homeless or living in temporary or insecure accommodation. The steering group should monitor the implementation process, and ensure that all staff in relevant agencies are briefed appropriately.

Step eight – Set up audit arrangements

Once the protocol is in place there needs to be a process for auditing its impact on:

- Patient and staff experiences
- Patterns of admissions/re-admissions and accommodation on discharge for people who are homeless or living in temporary or insecure accommodation
- Level of self-discharge
- Actual date of discharge (compared with the estimated date of discharge).

A clearly identified audit cycle should look at outcomes to see how effective the protocol is, set out a review timescale if necessary, and ensure that problem solving and dispute resolution strategies are created.

In particular, the audit should assess that:

- Housing status has been identified on admission
- A multi-agency discharge planning meeting has been convened if the patient has complex needs
- No discharge to the streets or inappropriate accommodation has occurred
- Appropriate accommodation has not been lost while in hospital.

Appropriate time limits and standards for achievement of the above targets should be set locally to ensure that the process meets the needs of both the patient and the hospital.

Step nine – Review and refine protocol

Review and refine the protocol in response to feedback from:

- People who are homeless or living in temporary or insecure accommodation
- Health staff
- Local authority housing staff
- Voluntary sector staff
- Incident reports, and any complaints through patient advice liaison services
- Audit.

Once the initial audit and monitoring of the protocol has taken place, the protocol should be refined and revised to take into account feedback. This is to ensure that the protocol continues to be fit for purpose.

Ensuring the protocol remains up to date

Once the protocol has been implemented, a system will need to be put in place for regular updating to ensure that any changes in hospital practice are incorporated and that information and contacts for external agencies remain correct.

Glossary

Homelessness strategy: The Homelessness Act 2002 requires local housing authorities to review homelessness in their area and publish a homelessness strategy based on the review at least every 5 years. The first homelessness strategies had to be adopted by July 2003.

Main homelessness duty: Under the homelessness legislation, local authorities must ensure that suitable accommodation is available for applicants who are eligible for assistance, unintentionally homeless and who fall within a priority need group (e.g. families with children). This duty continues until a settled home becomes available for the applicant (or some other circumstance brings the duty to an end).

Patient Advice Liaison Services (PALS): PALS provide information, advice and support to help patients, families and their carers.

Rough sleepers: People sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or "bashes").

Supported housing: Supported housing is usually provided by a local authority, housing association or voluntary group. It can be for specific groups of people, such as older people, physically disabled people, people with mental health problems, people recovering from addictions, or young people. There is a wide range of supported housing available (e.g. hostels, shared accommodation, individual units, sheltered accommodation) and differing levels of support provided (e.g. ranging from 24 hour staffing to occasional support).

Temporary accommodation: Accommodation arranged by a local housing authority pursuant to a duty to secure accommodation under the homelessness legislation. This can include local authority housing stock or housing association homes let on a temporary basis, a house or flat leased from a private landlord, B&B accommodation, hostels and refuges. Where a main homelessness duty is owed, people may remain in temporary accommodation for a considerable period before a settled home becomes available.

Endnotes

[1] Homeless Link's Health Inclusion Project is overseen by a cross-sectoral advisory group. More information on the project is available at http://homeless.org.uk/policyandinfo/issues/health/hip

[2] 'Discharge from hospital: pathway, process, and practice' Department of Health, January 2003 – http://www.dh.gov.uk/assetRoot/04/11/65/25/04116525.pdf

[3] 'Our health, our care, our say: a new direction for community services' Department of Health, January 2006 – http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

[4] 'Commissioning a patient-led NHS – Delivering the NHS Improvement Plan' http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningAPatientledNHS/fs/en

[5] 'Sustainable Communities: settled homes; changing lives' Office of the Deputy Prime Minister, March 2005 – http://www.communities.gov.uk/pub/784/SustainableCommunitiesSettledHomesChangingLivesPDF796Kb_id1149784.pdf

[6] 'Achieving timely simple discharge from hospital: a toolkit for the multi-disciplinary team' Department of Health, August 2004 – http://www.dh.gov.uk/assetRoot/04/08/83/67/04088367.pdf

On 5th May 2006 the responsibilities of the Office of the Deputy Prime Minister (ODPM) transferred to the Department for Communities and Local Government.

Department for Communities and Local Government
Eland House
Bressenden Place
London
SW1E 5DU
Telephone: 020 7944 4400
Website: www.communities.gov.uk

© Crown Copyright, 2006

Copyright in the typographical arrangement rests with the Crown.

This publication, excluding logos, may be reproduced free of charge in any format or medium for research, private study or for internal circulation within an organisation. This is subject to it being reproduced accurately and not used in a misleading context. The material must be acknowledged as Crown copyright and the title of the publication specified.

Any other use of the contents of this publication would require a copyright licence. Please apply for a Click-Use Licence for core material at www.opsi.gov.uk/click-use/system/online/pLogin.asp, or by writing to the Office of Public Sector Information, Information Policy Team, St Clements House, 2-16 Colegate, Norwich, NR3 1BQ.
Fax: 01603 723000 or email: HMSOlicensing@cabinet-office.x.gsi.gov.uk

If you require this publication in an alternative format please email alternativeformats@communities.gsi.gov.uk

Communities and Local Government Publications
PO Box 236
Wetherby
West Yorkshire
LS23 7NB
Tel: 08701 226 236
Fax: 08701 226 237
Textphone: 08701 207 405
Email: communities@twoten.com
or online via the website: www.communities.gov.uk

December 2006

Product Code: 06HHS04115

This page is intentionally left blank

Haringey Council healthwatch Haringey HAVCO Haringey Association of Voluntary and Community Organisations NHS Haringey Clinical Commissioning Group

Report for:	**Health and Wellbeing Board – 24th March 2015**

Title:	**Health and Care Integration Programme Update**

Report Authorised by:	**Zina Etheridge – Deputy Chief Executive, Haringey Council and Sarah Price – Chief Officer, Haringey CCG**

Lead Officer:	**Asad Butt, Interim Joint Integration Programme Manager**

1 Describe the issue under consideration

1.1 This paper provides an update on progress on the Health and Care Integration Programme report brought to the Health and Wellbeing Board on the 13th January 2015. This paper provides an overall update with greater detail around the Better Care Fund (BCF)

2 Cabinet Member introduction

2.1 Supporting everyone to be healthy and have a high quality of life for as long as possible is a core aim for the Council and its partners. Integrating health and social care so that care is person centred, joined up and meets their needs is core to that vision. The establishment of the health and social care programme is an important step towards delivering that integration. The high level vision and approach is now agreed, with planning and implementation of the initial focus areas under way.

3 Recommendations

3.1 The Health and Wellbeing Board is asked to note progress.

4 Alternative options considered

4.1 None

5 Background information

Overview

5.1 The Health and Social Care Integration Programme has been established to build on the strong relationship between the CCG and the Council to support Haringey in meeting its vision for Integrated Care, i.e.:

- We want people in Haringey to be healthier and to have a higher quality of life for longer.
- We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible. This means:
    - The individual's perspective should be at the heart of any discussions about integrated care
    - When planning and providing integrated care services the individual's perspective should be the organising principle of service delivery

5.2 The programme has good fit with the Corporate plan with its intent to implement a whole borough vision embedding the principles of prevention, early intervention and building community resilience and delivering services that matter to residents in a timely, effective, efficient and satisfactory way. There is particularly strong alignment to outcomes 1 & 2.

Governance

5.3 The governance model and programme structure can be found in Appendix A

5.4 The breadth and depth of the Integration Programme is such that it requires different levels of specialist and detailed oversight and steer. To ensure the appropriate people are involved, the governance structure consists of three layers,

- Strategic
    - Set the vision and ambition for integration in Haringey
    - Provide guidance and strategic direction
    - Make strategic decisions (impacting vision and direction of travel) within the agreed scope and principles
- Steering
    - Have the ultimate oversight of the Integration Programme
    - Steer the Integration Programme and associated projects
    - Ensure progress on track to achieve the agreed vision and goals set out for integration in Haringey
    - Make management decisions (enabling the programmes and projects to continue) within the agreed scope and principles

- Operational
    - Manage and direct projects (at an operational level)
    - Agree proposals for operationalisation of the integration plan which are developed through the projects
    - Ensure the projects are on track and progressing as expected
    - Make operational project decisions, within the agreed scope and plan, enabling the project to continue to deliver

5.5 This layered governance structure aligns with the existing governance that is already in place within the Council and the CCG.

Scope

5.6 The programme has agreed three key themes, integrated care for adults, children, and mental health and wellbeing. These themes align with the outcomes set out in Haringey's Health and Wellbeing Strategy, the Council's Corporate Plan and the 5 year strategy for CCGs in North Central London.

5.7 Within each theme, a number of projects / programmes have been identified to deliver the agreed integrated care vision, for that theme. Additionally, the Integration Programme includes cross cutting themes in the areas of technology and finance that will enable and support integrated commissioning and service delivery

5.8 The vision for the HACI Adults theme is to join up and co-ordinate health and care services in a way that:

- enables residents to be as healthy as possible for as long as possible
- enable residents to feel more supported by the community to be healthier and to live independently for longer
- ensures support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing
- there are convenient and easily accessible services available near where people live
- ensures people are treated as quickly and safely as possible so they can return home and return to independence
- ensures residents assessed as needing formal care and / or health support will receive responsive, safe and high quality services
- jointly commissioned services are based on outcomes rather than activity
- all vulnerable adults will be safeguarded from abuse

5.9 The benefits of the Adults theme are expected to be:

- Increased joint working

- More people will have healthy lifestyles
- More residents will be engaged in employment, physical activity, sports and in volunteering
- The number of people feeling isolated
- Individuals enabled to do things for themselves
- Good and timely information
- Increased community capacity
- Reduction in non-elective admissions
- Reduction in permanent admissions to residential/nursing homes
- Increase in the proportion of older people still at home 91 days after discharge
- Reduced delayed transfers
- Improved GP patient survey results
- Decrease in falls injuries

5.10 Projects/programmes underway in the Adults theme are:

- Better Care Fund: encompassing actions to tackle health, for the first year, focusing on integrated service for frail older people (65+) to enable them live independently. Projects under the BCF include:
    - Design, develop and implement locality teams
    - Review Rapid Response service
    - Review Dementia Day Centre
    - Review and redesign Reablement Service
    - Review of Step Down Service
    - Review of home from hospital funding
    - Procure and monitor Neighbourhood connects
    - Monitor Palliative Care contract
    - Design, develop and implement approach to IT Interoperability
    - Design, develop and deliver a Workforce Development programme for 7 day working
- Value Based Commissioning: establishing models and approaches to commission services based on values / outcomes rather than activity; working in partnership with Enfield CCG.

5.11 Working Age Adults With Disabilities: revising the approach taken to providing support to Working age adults who have difficulty in maintaining their health and wellbeing.

5.12 The vision for .the Childrens theme is: By implementing an integrated approach for commissioning and service delivery we will enable every child and young person to have the best start in life, with high quality education. To deliver this:

- We will work with children, young people and families in a joined up way to co-produce solutions
- We will develop prevention, early intervention and targeted early help from conception to 25 years, so that children and families can thrive in their communities, with improved outcomes
- We will work together to reduce the need for more specialist support and seek to deliver provision in family and community settings wherever possible

5.13 The benefits of the Childrens theme are expected to be:

- Improved family and community resilience, with greater choice and control
- Thriving children, young people and families
- Strong partnerships making effective use of all resources, with an increased emphasis on early interventions & coordinated working

5.14 Projects/programmes underway in the Childrens theme are:

- SEND reforms Programme: implementing the changes set out in the Children and Families Act regarding special educational needs and disabilities (SEND) which came into effect from September 2014. Projects within SEND include:
    - Local offer
    - ECH Plan and assessment
    - Personal Budgets
    - Preparing for adulthood
    - Mediation
    - Joint Commissioning
    - Workforce development
    - ICT and IG
    - Communications and engagement
- Early Help Project (input): Providing input into the Childrens project considering the range of provision often described as prevention, early intervention and targeted early help, which may be delivered by universal services or by commissioned services. The governance for this project will be via the Haringey 54k Programme Board.

5.15 Transformation of Children and Young People Mental Health services: will review the tier1 to 4 services

5.16 An additional project is being considered in the area of “Facing the Future Together” looking at primary and acute children services.

5.17 The vision for .the Mental Health and Wellbeing theme is “All residents in Haringey are able to fulfil their mental health and wellbeing potential. Initial activities are focused on establishing a more joined up approach; where services are managed around the individual and where the person is able to live independently at home or locally in the community.” Our priorities are:

- Promoting mental health and wellbeing and preventing mental ill health across all ages;
- Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood;
- Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa;
- Commissioning and delivering an integrated enablement model which uses individuals, families and communities’ assets as an approach to support those living with mental illness to lead fulfilling lives.

5.18 The benefits of the Mental Health and Wellbeing theme are expected to be:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm and die by suicide
- Fewer people will experience stigma and discrimination

5.19 Projects/programmes underway in the Mental Health theme are:

- Mental Health Strategic Framework: setting the strategic direction and implementation approach for integrated mental health services in Haringey. This project will specify a delivery plan from which a series of projects will be defined.
- Mental Health Enablement Model currently contains two projects looking at the accommodation and employment needs of people with mental ill health.

Plan and Budget

5.20 The theme leads are working to define the outcomes, deliverables and plans at the next level of detail and this progress will be included in the next update to the board.

5.21 For the programmes and projects underway the plans are developed at a high level and the programme is now fleshing out the detail so we better understand the risks and budget.

5.22 Based on the current information it is expected that Integration projects already underway have the necessary agreement and approval of their requirements for resources and funding.

5.23 The table below indicates which projects have confirmed resourcing and budget . Where projects do not have confirmed resourcing and budget or need additional support, requests will be made to Integration Programme Steering for approval after the scoping has been completed

Theme	Projects	Resources confirmed	Budget agreed	Comments
Adults	Better Care Fund Projects	✓	✓	Confirmed for 2014/15 and 2015/16
	Value Based Commissioning Project	✓	✓	Confirmed for the development of the Business Case only. The Business Case will set out the requirements for delivery.
	Working Age Adults	×	×	Project currently being defined.
	Healthy Lifestyles	×	×	Project currently being defined.
Children	SEND Reforms Programme	✓	✓	A Programme Manager has been recruited 2 days a week. A new Joint Commissioner to represent the health aspects is in place.
	Facing the future together	×	×	Project currently being defined.
	Trasnsforming CAHMS services	×	×	Project currently being defined.
Mental Health and Wellbeing	Housing and support for people with MH	✓	✓	Covering the development of pathways only.
	Employment and support for people with MH	✓	✓	Agreed for this project to be managed together with the Housing project.
	MH Framework	✓	✓	Commissioning Leads driving the

				development. Additional resources will be required for implementation
Enablers	Interoperability IT	✗	✗	Project currently being defined.
	Integrated Financial Management	✗	✗	Project currently being defined.
	Self Management – Telehealth solutions	✗	✗	Project to be defined.

Better Care Fund

5.24 Overview

The Haringey Better Care Fund (BCF) Plan was submitted on the 19th September 2014. Following a national assurance process the Haringey BCF plan was formally approved by NHS England on 7th January 2015. The BCF is expected to deliver 705 fewer emergency hospital admissions over 2015/16. This is a £1.26m performance related target and this budget has been held back as a contingency fund in the event that the emergency hospital admissions target is not met.

In order to deliver a reduction in the performance related target, the initial focus of the Haringey BCF is on services for older people (65+), as the group most at risk of an emergency hospital admissions. Haringey CCG and LBH have approved plans for the use of the £22m BCF budget (2015/16) to review and deliver 19 services organised into four schemes:

Scheme	Service	2015/16
Scheme 1: Admission Avoidance	Locality Team	£ 11,649,297
	MDT	£ 266,000
	Lymphedema	£ 48,000
	Rapid Response	£ 482,067
	Overnight District Nursing Service	£ 204,000
	Dementia Day Centre	£ 475,000
	Recovery College	£ 620,000
	Falls Prevention	£ 80,000
Scheme 2: Effective Hospital Discharge	Reablement	£ 3,142,905
	Step Down	£ 625,000
	Home From Hospital	£ 150,000
Scheme 3: Promoting	Neighbourhood Connects	£ 270,000
	Palliative Care	£ 300,000

Independence	Supported Self-Management (Generic)	£ 52,000
	Supported Self-Management (Diabetes)	£ 64,600
Scheme 4: Integration Enablers	Interoperable IT	£ 22,333
	Workforce Development	£ 535,000
	Disabled Facilities	£ 949,000
	Care Act Responsibilities	£ 879,000
	Contingency	£ 1,260,000
	TOTAL	**£ 22,074,202**

Each scheme has a specific perspective on the integration of health and social care services to prevent emergency hospital admissions in older people:

- Scheme 1 will deliver services that will prevent health conditions from escalating to a crisis where emergency services are needed.
- Scheme 2 will deliver services that will facilitate discharge from hospital as quickly, safely and effectively as possible
- Scheme 3 will deliver services that build community capacity to reduce isolation and improve health and wellbeing
- Scheme 4 will deliver services that support the implementation of the first three schemes.

The BCF services are going through a business case/service review process in 2014/15 to ensure that BCF investment is being used on evidence based services that will deliver improvements to public and service user outcomes in the most effective and cost effective way.

5.25 Benefits expected

The Haringey BCF will be assessed against six outcome measures in 2015/16 and has set trajectories as part of the national assurance process:

Target	Increase/Decrease	Number	Saving
Emergency Admission Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	3.5% Decrease	705	£1,248,000
Care Homes Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	1.8% Decrease	2	£101,000
Reablement Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	1.7% Increase	6	£600
Delayed Transfers Delayed transfers of care (delayed days)	1.7% Decrease	0	

from hospital per 100,000 population (aged 18+)			
Patient Survey In the last 6 months, has the Service User received enough support from local services (not just health) to manage their long term health condition(s)? (Measure biannually)	1.2% Increase	N/A	
Falls Injuries due to falls in people aged 65 and over, per 100,000 people	4% Decrease	10	To be confirmed

As well as these outcome measures Haringey has surveyed over 200 local people and service users and has summarised their priorities into seven public and service user outcomes. Integrated services will (be):

1. **Easy to access**, through a single point of access
2. **Well managed** and provided by competent professionals and staff
3. **Person Centred** and personalised to the experiences and views of people who use them
4. **Provide good and timely information**, from a variety of sources including the voluntary and community sector
5. **Enable individuals to do things for themselves** through prevention , self-management and reablement
6. **Work together as one team**, including the patient/service user, with clear and constant communication
7. **Promote wellbeing and reduce loneliness** through community capacity building.

Services will be expected to demonstrate progress against these public defined outcomes and will be supported by public health to use the most effective method for measurement.

A case study of 'Harry Gray' has been developed to demonstrate how the proposed service changes will impact on service users. The case study was based on a live case known to services and which identified a number of issues and gaps in the system. The case was anonymised and used to test whether service user outcomes would be improved by the Haringey BCF (see appendix B).

5.26 Progress to date

The BCF has necessitated the development and implementation of a significant amount of programme planning and management including plan submissions, assurance processes, progress reports, stakeholder engagement, finance and performance frameworks and governance structures. Some of these processes and structures are now being finalised in readiness for the first year of delivery, from 1st April 2015.

Out of the 19 BCF services, three are new and the remaining 16 are either existing services or are further developed from existing services. The three new services are the locality team and the two supported self-management projects.

As part of the development of the locality team model we have rolled out several pieces of work that are being used to inform the development of the model in Haringey including:

- Multi-Disciplinary Team (MDT) teleconferences – a team of professionals discuss older patients who have attended A&E more than once in the last 6 months or have been recently discharged from hospital. The aim is to reduce further emergency attendances through improved communication between professionals and co-ordination of patient care across hospital and community settings.
- Unplanned admissions enhanced service – a scheme run by NHS England that pays GP practices to risk stratify their practice population, identify the top 2% at risk of an unplanned hospital admissions, identify a lead GP in the practice who then develops a basic care plan with the patient and records it on their IT system.
- GP collaborative care co-ordination projects – Between £50-60k of funding was provided to the four GP collaboratives by Haringey CCG as a quality premium to facilitate their further involvement in care planning targeting patients over 75 years old.
- Locality team test and learn pilot – the pilot was developed with the north east GP collaborative linking a nascent multi-disciplinary care co-ordination team with two to three GP practices to develop learning about the identification of the cohort, the role of the care co-ordinator and the processes of care co-ordination.

These projects are being managed by the Integration Implementation Group as part of the BCF governance process.

The evaluation of the locality team test and learn pilot will include the following components:

1. Patient surveys will compare patient reported experience of care and quality of life before and after the pilot projects. This is linked to the BCF public and service user defined outcomes.
2. Medical and social care use will be tracked using the patient's number.
3. Patient demographic information will be used to assess equity of access to the services,
4. An internet based staff survey will capture the experiences of staff involved in the pilots

The evidence from the test and learn pilot and the other local projects combined with national evidence of effectiveness, determined by public health, will be used to develop the Haringey locality team model and business case.

The two self-management projects include the following elements: a chronic disease self-management service, similar to an expert patient programme, which is generic for one project and diabetes specific for the other; a diabetes web based self-management tool; a diabetes DVD and workbook support package; and programme capacity building to sustain the programme going forward. Service specifications are being developed and these services will be commissioned, to start delivery in 2015/16. These services will be overseen by the Promoting Independence Group as part of the BCF governance.

The remaining 16 services are going through a similar cycle of review, communication and engagement with relevant stakeholders for the service, development of a business

case/commissioning plan and service specification, developing a performance framework, regular monitoring, and identifying opportunities for the service to be further integrated within the health and social care system.

The majority of the service reviews should be completed by the end of March 2015.

6 Comments of the Chief Finance Officer and financial implications

6.1 The prescribed Better Care Fund for 15/16 for Haringey is £16.5m revenue funding and a further £1.6m capital funding. In addition the London Borough of Haringey has chosen to create a joint budget for the integrated locality teams by adding a further £4m funding for social work, care management and occupational therapy making an overall Better Care Fund of £22m. It should be noted that none of this is new funding and it is mainly funding existing and ongoing services of high importance to local health and social care provisions. The introduction of the Better Care Fund requires the local authority and the NHS to work more closely together and jointly manage the BCF budget to achieve the desired outcomes.

6.2 This report also outlines a number of new further initiatives that are expected to deliver improved outcomes for local residents. Small amounts of funding are in place to cover the early work for these projects. The children's work is funded in 2014/15 from SEND reforms and the Mental Health work at this stage is being carried out within existing staff time and resources. The overall programme management costs are being included in 2014/15 in an Adults bid to the central transformation reserve.

6.3 Once further work is identified above these start up costs funding will have to be identified by one or other of the partners. Since both the Council and the NHS are currently experiencing a high level of budgetary pressure the amount of funding available will be extremely limited so a degree of prioritisation will probably be required.

7 Comments of the Assistant Director of Corporate Governance and legal implications

7.1 The Council's Assistant Director of Corporate Governance has been consulted about this report.

7.2 The Health and Care Integration programme is conducive to the Board's statutory duty to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population (Section 195 of the Health and Social Care Act 2012). The Integration Programme is also conducive to the Council's and the CCG's statutory powers to promote integrated commissioning and provision of services in health and social care. These powers are set out in Sections 75 of the National Health Services (NHS) Act 2006 (as amended) (arrangements between NHS bodies and local authorities for the delegation of functions), Sections 13N and 14Z1 of the NHS Act 2006 (14Z1 Duty as to promoting integration), Sections 25 and 26 of the Children and families Act 2014 (Education, health and care provision: integration and joint commissioning)

and Section 3 of the Care Act 2014 (Promoting integration of care and support with health services etc)

8 Equalities and Community Cohesion Comments

8.1 The proposed Health and Care Integration Programme is designed to provide health and social care services that produce better outcomes and a better experience for all local people. As a result it serves the interests of all protected groups, whose health and wellbeing it promotes, and is aligned with the Council's commitment to equalities.

8.2 Equality impact assessments will be carried out as part of the project planning and delivery process.

9 Head of Procurement Comments

9.1 N/A There are no direct procurement implications arising out of this report however as and when the projects identify procurement requirements the appropriate processes will be followed.

10 Policy Implication

10.1 Integration of health and social care is a national policy arising from the Better Care Fund and Care Act Implementation and this programme of work will complement and add value to work under this remit.

11 Reasons for Decision

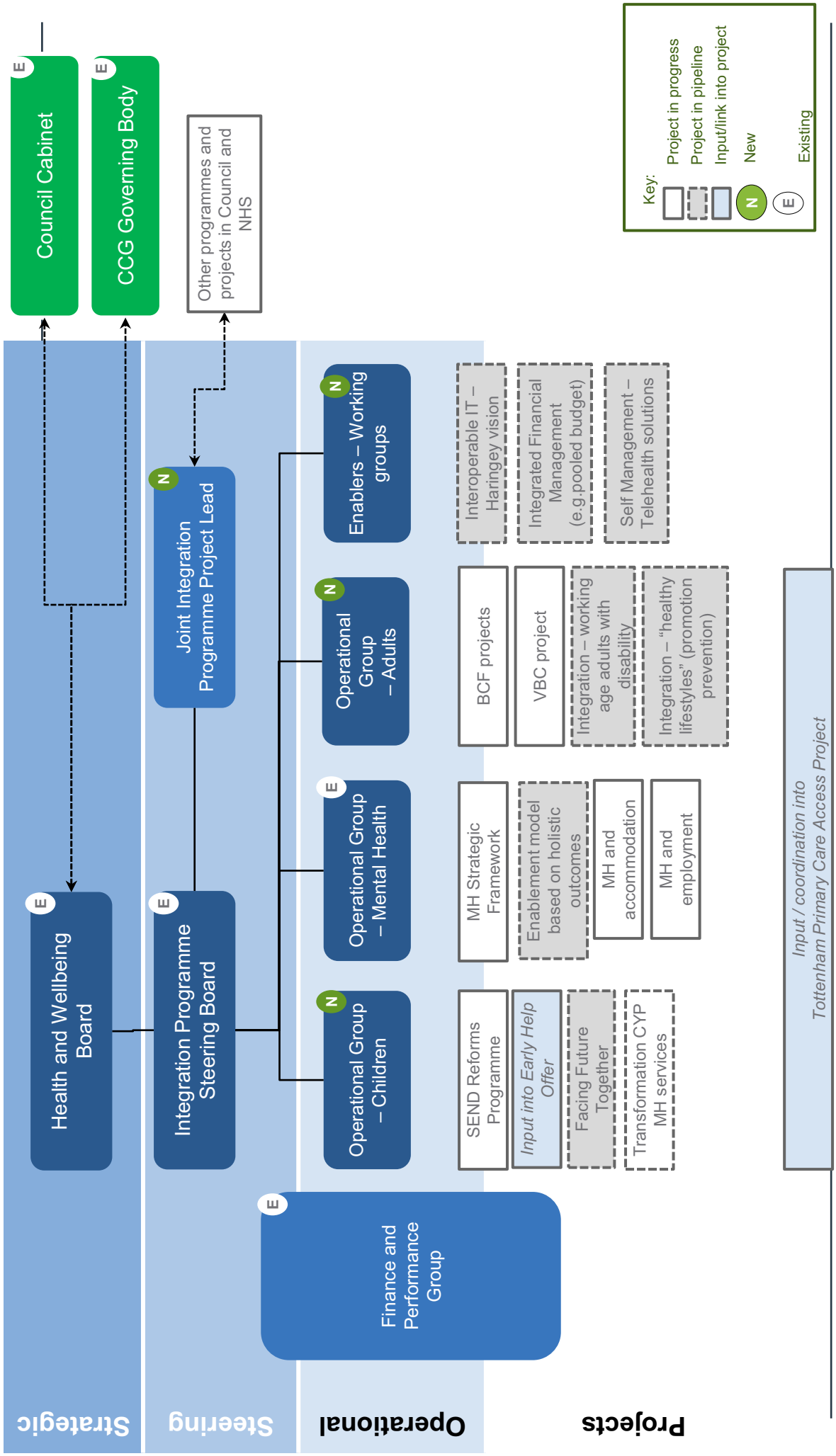
Not applicable.

12 Use of Appendices

Appendix A: Governance Model and Programme Structure
Appendix B: Better Care Fund case study

This page is intentionally left blank

Health and Care Integration Programme Structure and Governance



This page is intentionally left blank

Appendix B - Better Care Fund Case Study

Harry Gray

Harry Gray is 75 years old. He was recently widowed and is now living with his daughter. He has several long term conditions including COPD and the initial stages of dementia. Harry has been quite depressed following the death of his wife. Harry has also had a few falls which has reduced his confidence in leaving the house, which in turn is adding to his depression. Within the last year Harry has had 32 visits to A&E at North Middlesex Hospital, which resulted in 10 admissions. Most of the hospital attendances happened between 7pm and 10pm. Harry's daughter had made requests for some support but has been waiting for over three months. She has also requested that Harry be supported within sheltered housing, although this has request has not been approved. Due to the number of issues that Harry is facing, a number of agencies could be involved in his support and care. However evidence from his case notes suggest that no one agency is responsible for his care and some of the notes make recommendations that Harry would be better cared for by other agencies due to a specific condition that they highlight. This results in a sense that people are trying to shift responsibility for Harry's care. A number of referral forms from agencies had the wrong information or information missing e.g. stating that Harry was married rather than a widower, that he was not on any medication when he was on several, or that he did not have any risk factors when he had a multiple number.

The impact of the Better Care Fund

The Haringey Better Care Fund is divided into four Schemes. It is expected that each scheme will have an impact on Harry's health and wellbeing as follows:

Admissions Avoidance

Harry will get a named care co-ordinator who will develop a health and social care plan which will include goals that Harry has identified to improve his health and wellbeing. The care co-ordinator will be able to refer to appropriate local services that may be able to support Harry in achieving his goals e.g. local bereavement counselling services.

Effective Hospital Discharge

When Harry is admitted to hospital he will be supported so that he spends as little time in hospital as possible and is safely returned home. Reablement services will help him to regain his confidence following a fall so that he can return to independence which will reduce his isolation and improve his wellbeing.

Promoting Independence

To prevent Harry's health and wellbeing issues worsening, a Neighbourhoods Connect service will identify him and link him into a range of services which can help to reduce his isolation and help support a healthy lifestyle e.g. a local gardening club and/or an expert patient group.

Integration Enablers

Wrong information or any gaps on Harry's referral forms will be reduced and hopefully eliminated as data sharing will be possible between all the relevant professionals involved in Harry's care. This will be covered by robust information governance and with Harry's consent. Services will be available into the evening when Harry is most at risk of going to A&E. There will also be support for Harry's daughter so that she is better able to care for Harry.

Report for:	**Health and Wellbeing Board – 24th March 2015**

Title:	**CQC New Approach to Regulation: Complaints Processes**

Organisation:	**Healthwatch Haringey**

Lead Officer:	**Mike Wilson**

1. Describe the issue under consideration

In October 2014 the CQC introduced "Complaints" as a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours services and adult social care services. This looks at how well complaints and concerns are handled. This assessment forms part of the CQC judgement and rating of an organisation's responsiveness. For consistency in all inspections, this will apply to dentists, independent hospitals and ambulance services from April 2015.

The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England have set out universal expectations of good complaints handling. The CQC now have a clear vision of 'what good looks like' for people who use services – and providers need to meet these expectations. The "user led vision" diagram can be seen on page 4.

This Report proposes that now there is a clear standard adopted by the CQC in relation to complaints processes, governance and use of intelligent feedback, that this framework be noted as good practice by the Health and Wellbeing Board, incorporated in service contracts by commissioners and promoted across all health and social care providers in Haringey. Healthwatch Haringey will use this framework in any review of complaints processes that we undertake in future.

2. Recommendations

2.1 The Health and Wellbeing Board note the new CQC key line of enquiry relating to Complaints and the higher priority this will receive in their inspections of all health and social care providers.

2.2 The Health and Wellbeing Board ask commissioners from the CCG and local authority to adopt the new complaints framework as appropriate in their provider contract specifications to achieve a consistent approach in Haringey.

2.3 To agree that in monitoring existing contracts the CCG and local authority commissioners are informed by the CQC complaints framework and encourage providers to improve their existing complaints systems.

2.4 To note that NHS England will use the new user led complaints framework as a performance management tool to be built into the NHS Outcomes Framework.

2.5 To note that when reviewing complaints processes in provider organisations Healthwatch Haringey will adopt the new CQC user led framework.

3. Background

3.1 The importance of complaints processes in improving safety and the quality of services for service users has been highlighted in a number of high profile reports since 2013:

(1) The Francis Inquiry Report into the failings of Mid Staffordshire NHS Trust (February 2013)
(2) The Clwyd Hart Review of NHS Hospital Complaints System - Putting Patients Back in the Picture (October 2013)
(3) The Healthwatch England Report "Suffering in Silence" (October 2014)
(4) Joint Report of the LGO, Healthwatch England and PHSO "My Expectations for Raising Concerns and Complaints" (November 2014)
(5) CQC Report, " Complaints Matter" (October 2014)

3.2 The recommendations in these Reports build on each other culminating in the CQC Report (attached as Appendix 1) which confirms that Complaints processes will be a significant key line of enquiry in their inspection regime covering health and social care providers. CQC inspection reports will now include a description of the provider's handling of complaints. Where the CQC find breaches of these standards, they will use their range of enforcement powers: warning notices, suspending or cancelling registration and ultimately prosecution. The CQC will actively work with partners to encourage improvement.

3.3 A significant conclusion in a number of these Reports, and highlighted in the joint Report of the LGO, HWE and PHSO "Raising Concerns and Complaints", is that the way organisations deal with complaints reflects their own values of open-ness and transparency. The complaints process in an organisation is supported by the new "Duty of Candour" and their Whistleblowing Policy as complaints by staff can be particularly valuable in highlighting concerns about service failures.

3.4 The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid Staffordshire NHS Foundation

Trust Public Inquiry (the Francis Inquiry). The Duty of Candour will place a requirement on providers of health and adult social care to be open with patients when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

3.5 Following a recent review of the Whistleblowing policies and procedures in NHS Trusts by Sir Robert Francis the Government has announced that NHS Hospital Trusts will be expected to appoint "Speaking up Guardians" to support staff who raise concerns about safety, quality of services, bullying and other significant issues within their organisations. It was clear from the evidence collected as part of the "Freedom to Speak Up Review", which heard evidence from 600 individuals and received 19,000 replies to an on-line survey, that in many cases the Whistleblowing policy in their organisations was not protecting them.

3.6 In practice, since the Francis Inquiry Report in 2013 raised public consciousness of the need for transparent systems and the importance of complaints in this process, progress on the ground has been slower than one might have been expected. The HWE Report "Suffering in Silence" (Oct 2004) highlighted the fact that of their sample 26% didn't complain because they were worried about negative repercussions; 61% didn't complain because they thought they would not be taken seriously; 49% of those that did complain never received an apology. The Report also highlighted the fact that there were 70 different organisations involved in handling complaints in relation to NHS services and this was extremely confusing for a potential complainant.

3.7 Complaints systems across health and social care are varied in their quality and have developed piecemeal in different parts of the sector over the years. Several factors now further add complexity for potential complainants, i.e. the trend towards service integration between health and social care, and the outsourcing of services resulting in a multiplicity of providers, together with number of "boundary" issues, which can make for confusion as to who is providing a service.

3.8 The new inspection regime will apply equally to social care establishments with awareness of the need for robust complaints and whistleblowing policies having been raised by Winterbourne View and other recent adverse events in care environments. The CQC's recent study of the state of complaint handling "Complaints Matter" concludes that although there is limited data about how well providers handle complaints and concerns in the sector, there did appear to be variation in the accessibility of the complaints process, and the provision of advocacy and support for people who wanted to complain. The CQC anticipates rolling out more thorough methods of reviewing complaints handling, so that it can better capture how well social care providers encourage, listen to and respond to complaints.

3.9 In pursing the new complaints "line of enquiry" the CQC will in particular consider complaints handling from a user point of view, asking whether

- People who use a service know how to make a complaint or raise concerns, are encouraged to do so, and confident to speak up.

- The complaints system is easy to use, if people are treated compassionately, and given the help and support they need to make a complaint.

- The outcome of the complaint is explained to the individual, and if there is openness and transparency about complaints and concerns are dealt with.

3.10 The "line of enquiry" will also include a requirement on providers to demonstrate a positive culture around complaints and feedback, including the expectation that they will show what changes have been made as a result of them.

3.11 This approach reflects, and has been built upon the "user led" vision for complaints handling set out below, developed jointly by the Local Government Ombudsman, Healthwatch England and The Parliamentary and Health Service Ombudsman.

FIGURE 2: A USER-LED VISION FOR RAISING CONCERNS AND COMPLAINTS

From Complaints Matter, CQC December 2014

4. Proposal

4.1 The decision by the CQC to include complaints as a key line of enquiry and adopt the user led vision framework in the LGO, HWE, and PHSO Report will no doubt encourage providers to implement more effective and compliant systems and commissioners to reflect the standard in their contract documentation and at contract review meetings with providers.

4.2 The CQC see complaints handling is an excellent proxy for an open, transparent and learning culture that they would expect to see in well-led organisations. Embedding complaints and concerns in CQC's regulatory model has two aims:

- To improve how they use the intelligence from concerns and complaints to better understand the quality of care.

- To consider how well providers handle complaints and concerns to encourage improvement.

4.3 The Healthwatch Haringey evidence relating to complaints processes in local provider organisations suggests that there is not the priority given to this area of work that the new CQC standard will require; both in respect of complaints handling and using intelligence to improve services. Of the signposting enquiries we receive from service users 36% relate to a failure of an organisation's complaints system or confusion about how to make a complaint.

4.4 In our recent GP Mystery Shopping survey we found that only 50% of GP practice websites included adequate information on "how to make a complaint" and less than 50% displayed visible posters or notices about the complaints process. We also found that in our conversations with front line staff about their complaints handling process they did not put this in the context of their practice welcoming feedback and concerns as well as complaints. We have not yet completed similar exercises in other NHS funded providers such as dentists, nor have we systematic evidence relating to social care providers. However there is some evidence from recent CQC inspections of local care homes of the need for greater attention to complaints handling.

4.5 We do have knowledge and experience of complaints processes in the three local NHS Trusts from our involvement in the patient experience committees and contract review meetings. We also receive a number of signposting enquiries from service users relating to failures in the complaints processes. The dedicated resources necessary for managing the process, from dealing with the initial enquiry to improving the system and embedding the learning, have not always been in place and in practice response targets are frequently not met which causes further frustration for the complainant.

4.6 From a Healthwatch perspective an effective complaints system is fundamental to improving patient and service user experience and the quality of care; we

agree with the CQC that complaints handling is a proxy for an open, transparent and learning culture that one would expect to see in well-led organisations. The introduction of the new CCQ standard is an opportunity to promote good practice across all health and social care providers in Haringey and set a benchmark which meets the CQC expectations. Healthwatch Haringey intends to monitor local providers against the new standards, and believes that commissioning arrangements have a part to play in achieving best practice across all health and social care services in Haringey.

Appendix 1

CQC Complaints Matter Report

Care Quality Commission

COMPLAINTS MATTER

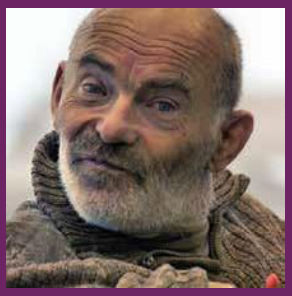
© Care Quality Commission 2014

Published December 2014

This publication may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the publication title and © Care Quality Commission 2014.

CONTENTS





FOREWORD

Complaints matter – to individuals, to health and social care services and to CQC.

They matter for people using services, who deserve an explanation when things go wrong and want to know that steps have been taken to make it less likely to happen to anyone else.

They matter for health and social care organisations, because every concern or complaint is an opportunity to improve. Complaints may signal a problem – the information can help save lives, and well-handled concerns will help improve the quality of care for other people.

Complaints matter to CQC, because they tell us about the quality of care. They tell us about how responsive a provider is, how safe, effective, caring and well-led they are. We can use our powers as a regulator to shine a light on good and bad handling of complaints and encourage organisations to improve.

CQC has placed feedback from people who use services at the heart of our work, because every concern is an opportunity for services to improve the quality of care. We also want to hear about positive experiences so we can highlight good and outstanding care.

Complaints and feedback from people who use services is a central part of our 'Intelligent

Monitoring' of health and social care providers. We are also making it central to our inspections,

and will include a lead inspector for complaints and staff concerns in large inspection teams. How well health and social care providers handle complaints will feed into our regulatory judgements about how responsive they are to people's needs.

CQC's new approach to inspection, with this strong focus on complaints, has just begun and there is a distance to go before we are able to offer a clear and comprehensive picture of complaints handling across all the sectors we inspect.

We take complaints seriously – and we expect providers to do so too. All our new inspection reports will describe complaints handling. Poor practice will be found and acted on. Good practice will be shared.

This report provides a snapshot in which some things are already fairly clear. There is wide variation in the way complaints are handled and much

more could be done to encourage an open culture where complaints are welcomed and learned from. While most providers have complaints processes in place, people's experiences of the systems are not consistently good.

And we know, from the thousands of people who contact CQC each year, that many don't even get as far as making a complaint. Sometimes they don't want to make a fuss. Some are put off by the confusing system or worried about the impact that complaining might have on their care.

We will hold health and social care services to a high standard of listening and acting on people's concerns. We are committed to apply the same standards to ourselves and we know we need to do more to explain to people what we will do with their information if they tell us about their experience of care.

We will continue to work on making it easier to give us good quality feedback, and work with our partners to improve people's experience beyond CQC.

It's time for all of us – regulators, providers, professionals and commissioners – to make the shift to a listening and learning culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.

Professor Sir Mike Richards
Chief Inspector of Hospitals



SUMMARY

Complaints matter in health and social care and for too long they have not been taken seriously enough. Too often complaints are met with a defensive culture instead of a willingness to listen and learn.

This report does two things: it describes how complaints and concerns fit into CQC's new regulatory model, and it presents early findings on the state of complaints handling in hospitals, mental health services, community health services, GP practices, out-of-hours services and adult social care services.

Several reports have influenced our work on complaints, including the public inquiry led by Sir Robert Francis QC, and the complaints review by the Rt Hon Ann Clwyd MP and Professor Patricia Hart, which led to this report from CQC.

Complaints and concerns matter to CQC

CQC is not directly responsible for resolving individual complaints for people[1]; this is the role of providers and the ombudsmen. However, we do want to hear from people who experience or know about poor care because we use this information when we are inspecting services.

About 50 concerns about services are raised with CQC every day through our National Customer Service Centre. This number is increasing as public awareness of CQC grows.

We use feedback from people who share their experience with us in many ways. It feeds into our Intelligent Monitoring of the quality of services and it helps us decide when to inspect a service. We may decide to bring forward a comprehensive inspection or carry out a focused inspection based on concerns shared with us.

Complaints and concerns in our new approach to regulation

Embedding complaints and concerns in CQC's regulatory model has two aims:

- To improve how we use the intelligence from concerns and complaints to better understand the quality of care.
- To consider how well providers handle complaints and concerns to encourage improvement.

Complaints handling is an excellent proxy for an open, transparent and learning culture that we would expect to see in well-led organisations.

1. The only exception is complaints relating to use of the Mental Health Act 1983.

The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England have set out universal expectations of good complaints handling. We now have a clear vision of 'what good looks like' for people who use services – and providers need to meet these expectations.

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours services and adult social care services. This looks at how well complaints and concerns are handled. This assessment forms part of our judgement and rating of an organisation's responsiveness. For consistency in all inspections, this will apply to dentists, independent hospitals and ambulance services from April 2015.

New and robust methods help inspection teams to understand how well providers listen to people's concerns and learn from them to improve quality.

Before a CQC inspection, we gather information relating to complaints and concerns, including details from partners such as the health and social care ombudsmen, local authorities, Healthwatch England and complaints advocacy services.

We request a range of information from providers before we inspect, such as a summary of complaints from the last 12 months and how these were resolved.

We ask what people who use services think about the way complaints and concerns are handled, using surveys, comment cards, and conversations during inspections, often led by CQC's Experts by Experience.

During site visits, our inspectors review a sample of complaints files to understand if these have been handled in a way that matches the good practice we expect to see.

On large inspections (in hospitals, mental health services and community healthcare services), we are introducing a lead inspector for complaints and staff concerns to draw evidence together.

Our inspection reports now include a description of the provider's handling of complaints. And the new fundamental standards include requirements around complaints handling as well as the new duty of candour. Where we find breaches of these standards, we will use our range of enforcement powers: warning notices, suspending or cancelling registration and ultimately prosecution. We will work with partners to encourage improvement.

Concerns raised by staff (whistleblowing)

A service that is well-led and wants to improve will encourage staff to raise concerns without fear of reprisal.

We want the staff of care providers to tell CQC if they know about poor care. While we have no legal power to protect individual members of staff from actions their employers might take, CQC expects all organisations to have effective arrangements to encourage staff to raise concerns and ensure these are taken seriously. Concerns may sometimes be termed 'whistleblowing', although staff have told us they do not like the word.

We expect complaints and concerns to be used to improve the quality of care, and that employees who raise concern are valued, respected and protected. Reprisals such as victimisation or bullying are unacceptable.

In every inspection and as part of assessing an organisation's leadership, CQC will look at processes in place to handle staff concerns. This report gives an update on CQC's work in this area – we plan to publish a fuller account when Sir Robert Francis QC publishes the outcomes of the Freedom to Speak Up review, to which CQC has contributed.

Health and social care services

We have analysed a range of data sources, including existing national data collections, concerns and feedback that we receive directly, our own published inspection reports and information collected directly from providers.

This report presents a partial picture of the state of complaints. It is not comprehensive and in general, caution should be applied in the interpretation of complaints data.

A care provider that actively encourages, seeks feedback and publicises its complaints process is likely to receive more complaints than another with a more defensive approach. However, in general you would expect an organisation providing poorer quality services to also receive higher volumes of complaints.

NHS acute, mental health and community health services

There is far too much poor practice in NHS providers' responsiveness and treatment of people who make complaints. This is backed up by findings in patient surveys.

The total number of written complaints received by all NHS hospital and community health services has increased every year since 2011/12, although this overall increase masks decreases in numbers of complaints in some areas. When considered against estimates of increased activity, the rate of complaints per 1,000 patients has changed little over the last three years.

We found variable practice in complaints handling throughout the different stages of complaints management. However, there was more evidence of good practice than poor. Most poor practice reported by inspectors related to providers' responsiveness and treatment of people who complain. Most positive practice was found where providers learned lessons from complaints and demonstrated actions taken due to complaints.

People do not consistently receive information about how to complain and they find complaining stressful. We are concerned about the timeliness of investigations of complaints, and people feeling that their concerns are not taken seriously or adequately addressed.

Adult social care and primary care services

There is less evidence available for us to analyse and judge how well complaints and concerns are handled.

Many providers report that they receive very few complaints (five or less over a 12-month period). There is much positive practice at all stages in the process of making a complaint. However, in response to a survey about complaints handling, many inspectors felt they did not have enough evidence, often because the locations inspected reported receiving very few complaints.

The large majority of people using adult social care services said they knew how to raise concerns, and they were very positive about the actions of care agencies in response to complaints made. People's feedback about adult social care and primary care services highlighted issues with the timeliness of investigations of complaints and responses. People felt that their concerns were not taken seriously or adequately addressed.

Based on negative feedback from websites, combined with our survey that showed inspectors often had insufficient evidence around complaints handling, we believe that our picture does not fully represent how well providers encourage, listen to and respond to complaints and concerns in adult social care and primary care.

We consider that much more could be done to encourage an open culture where concerns are welcomed, particularly as high numbers of providers in these sectors report that they receive very few or no complaints at all.

Conclusion

Improving the data available in these sectors will be crucial to presenting a truer picture of the state of complaints.

CQC's new and more thorough methods of reviewing complaints handling will allow inspectors to get a more comprehensive picture of the state of complaints. We will continue to review inspection findings and refine our methods if necessary.

We understand that the next stage of reform to the Health and Social Care Information Centre data

collection will focus on improving response rates and quality of primary care returns, and will consider the extension of the collection to adult social care. We hope these changes are implemented as a priority.

This report paints a partial picture of the state of complaints in health and social care services, but some things are clear: there is wide variation in the way complaints are handled and much more

could be done to encourage an open culture where concerns are welcomed and learned from.

Most providers have complaints processes in place, but people's experience is not consistently good.

CQC will continue to work closely with partners so that everyone – regulators, providers, professionals and commissioners – makes the shift to a listening culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.


1. INTRODUCTION

Complaints matter in health and social care. For too long they have not been taken seriously enough.

It is still common for people who have suffered poor care to have their negative experience compounded when they make a complaint. Too often, complaints are met with a defensive culture, instead of a willingness to listen and learn.

Feedback from people who use services – compliments, concerns or complaints – should be valued. Every concern must be seen as an opportunity to improve the quality of care.

At CQC, we take complaints and concerns seriously – and we expect the same of providers. Putting the views of people at the centre of everything we do is our top priority.

This report sets out the work we are doing to place concerns, complaints and feedback at the heart of quality regulation. We are on a journey and have some way to go. The report also draws together for the first time early findings from our new inspections, to give us an indication of the state of complaints handling in health and adult social care services.

Several reports have influenced our work in this area. In their review of the NHS complaints system in October 2013, the Rt Hon Ann Clwyd MP and Professor Tricia Hart called for complaints to be taken seriously.[2] They received 2,500 responses to their review, some from people who had not complained because they felt the process was too confusing or they feared for their future care. CQC took part in this review and made the following pledges:

- To develop the way we use complaints information, as well as other views and feedback from people who use services in our surveillance model, to ensure they are embedded consistently and given significant weighting.
- To analyse the number and themes of complaints and feedback we receive directly.
- To work closely with and share information with our regulatory partners about complaints.
- To strengthen how we consider complaints as we develop our approach to assessing the quality and safety of hospitals and other services.

The Secretary of State for Health commissioned the Clwyd/Hart review in response to the second Francis Inquiry report, published in January 2013. Sir Robert Francis QC called for regulators to make better use of the information contained in complaints.

2. **www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf**

FRANCIS RECOMMENDATIONS FOR CQC RELATING TO COMPLAINTS

- **Recommendation 38:** CQC should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.
- **Recommendation 39:** CQC should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.
- **Recommendation 40:** It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.
- **Recommendation 121:** CQC should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.

CQC has also taken part in inquiries led by the Health Select Committee and the Public

Administration Committee looking at aspects of complaints handling in health and social care.

Recent reports from the Local Government Ombudsman, the Parliamentary and Health Service Ombudsman and Healthwatch England clearly demonstrate that, although actions have been taken to improve the complaints system, there is a long way to go before people who use services, and those close to them, feel an improvement.

CQC's approach to complaints in our regulatory model has been developed over time and through consultation. We have worked with people who have made complaints, staff who have raised concerns, and providers that we regulate. The work has benefited from the support and advice of our National Safety Advisor, James Titcombe, and also Dr Kim Holt, who worked with CQC on secondment for six months.

FOCUS GROUP WITH PEOPLE WHO HAVE MADE COMPLAINTS

In September 2014, CQC held a joint workshop with the Patients Association and nine members of the public who had experience of serious healthcare failures and of navigating the complaints system. This was to listen to their experiences, and gather feedback on CQC work to improve its assessments of how well providers encourage, respond and learn from complaints.

Many of the people who attended the event had lost loved ones as a result of poor care. One person described the response to their complaint:

> "...an absolute nightmare. They deny everything... and take months to reply to anything. You ask them specific questions and you end up with very general policy statements."

This experience was typical of other people who spoke to us. These are examples of organisations failing to undertake high-quality investigations following serious healthcare failings, and patients and families finding that the complaints process failed to adequately respond to their concerns.

We have tested our new approach during inspections, including in-depth pilots with the Patients Association on 11 acute hospital

inspections. National partners have been involved in the development of this work through the Department of Health Complaints Programme Board. This has included several opportunities to share our work with voluntary sector partners.

CQC has been working to improve how it incorporates concerns raised by care staff in its regulation. Mostly, we treat concerns in the same way, regardless of whether they are raised by people who use services, those close to them, or staff.

However, CQC is a prescribed body under the Public Interest Disclosure Act. This means that employees of health and social care organisations can make disclosures to us where they have concerns about their employing organisation. This report gives an update on CQC's work in this area – we plan a fuller account when Sir Robert Francis QC publishes the outcomes of the Freedom to Speak Up review, to which CQC has contributed.

In their review of NHS complaints, the Rt Hon Ann Clwyd MP and Professor Patricia Hart asked CQC to report on complaints handling in acute trusts that we inspected in the year following their report.

This report does two things: it describes how complaints and concerns fit into CQC's new regulatory model, and it presents early findings on the state of complaints handling in hospitals, mental health services, community health services, GP practices, out-of-hours services and adult social care services.

Where the report presents information on the state of complaints, we considered existing national data collections, such as the Health and Social Care Information Centre's (HSCIC) annual publication of written NHS complaints. We also reviewed concerns that came directly to our National Customer Service Centre, feedback submitted through our online 'Share Your Experience' form, our published inspection reports, and information collected directly from providers to inform our new inspection model. For adult social care, and GP and out-of-hours services, we also asked our inspectors about how these providers handled complaints in the inspections they carried out, between August and October 2014.

This creates a partial picture; only now are we fully implementing our new approach to regulation. Some of our analysis is based on samples of available data and may not be representative of the sector as a whole.

This report presents an impression of the state of complaints. It is not comprehensive and, in general, caution should be applied in the interpretation of complaints data. We would expect an organisation providing poorer quality services to also receive higher volumes of complaints. But organisations that openly welcome feedback may have higher rates of complaints too.

In CQC's monitoring and inspection activity, we treat numbers and rates of complaints – high or low – as indicators to prompt potential further investigation.

We know that people want services to be open and to encourage people to speak up. We must not assume that rising numbers of complaints mean worsening care. If we do, we risk making it less likely for services to value concerns and to use them to help improve the quality of care.



2. COMPLAINTS AND CONCERNS MATTER TO CQC

People who are unhappy with the care or treatment they have received from any NHS or social care service should contact the service directly to make a complaint. This gives providers the chance to try to put things right.

If people are not happy with the outcome of the complaint or how it was dealt with, they can ask the Health Service Ombudsman or the Local Government Ombudsman (for adult social care, both publicly and privately arranged and funded) to investigate it. The ombudsmen are free, independent complaints services. If they decide that the service has got things wrong, they can make recommendations to put things right.

CQC is not directly responsible for resolving individual complaints for people[3]; this is the role of providers and the ombudsmen. However, we do want to hear from people who experience or know about poor care because we use this information when we are inspecting services.

Concerns raised by people using services, their families and friends, and staff working in services all provide vital information that helps us to understand the quality of care. We also want to hear about positive experiences so we can highlight and share examples of good and outstanding care.

Feedback from people who share their experience is used in many ways:

- To feed into our ongoing Intelligent Monitoring of the quality of services.
- To help us decide when to inspect a service – we may decide to bring forward a comprehensive inspection, or carry out a focused inspection based on concerns shared with us.
- To help shape our lines of enquiry before an inspection, to ensure we direct our resources to areas of greatest concern.
- To raise concerns with providers and seek a response. We may ask for verbal assurance that a matter has been dealt with, ask for evidence or request an investigation by the provider's manager and a report back to CQC.

Many people contact CQC feeling that they have nowhere else to go. They have tried to raise their concerns with providers, commissioners and ombudsmen. Some are frustrated that CQC can only look at issues that have a bearing on the current quality and safety of care provided. We were concerned that there appeared to be a gap for people who have a historic complaint. We welcome the Parliamentary and Health Service Ombudsman's statement that for serious health cases which are outside of the normal 12 month period specified in law, the Ombudsman will positively consider

3. The only exception is complaints relating to use of the Mental Health Act 1983.

whether an effective investigation is possible given the passage of time.

Just as there are people who feel they have exhausted every option, we know there are many people who never reach the stage of making

a written complaint. They are put off by a confusing system or worried about the impact that complaining might have on how they are treated. Healthwatch England recently estimated that 250,000 incidents went unreported last year. These are said to be people who felt unable to complain.[4]

We support Healthwatch England's call for there to be 'no wrong door' for complaints and concerns and are working to make it a reality. For example, we have an agreement with the Local Government

Ombudsman to make direct phone transfers so that no matter who receives the initial call, people are put through to the organisation best placed to address the issue they are raising. Similarly, complainants should not have to think hard about which ombudsman to turn to where they have a complaint about health or social care services. We welcome the recommendations by the Public Administration Select Committee for a unified ombudsman service.

CQC receives a huge number of contacts from people telling us about poor care and this number is increasing across health and social care sectors. In 2013/14, there was a total of 18,455 concerns about regulated services received by our National Customer Service Centre – about 50 a day.

We cannot be sure what has caused this increase but we know the public's awareness of CQC is increasing. In May 2014, 55% of people had heard of CQC compared to 22% in 2012. The concerns that people share with CQC are valued and we are working hard to encourage more people to share their experience with us by making it as easy as possible for people to give us feedback.

Improving the experience of individuals giving feedback to CQC and using the information

effectively in our regulatory activities will create a virtuous circle. A survey by YouGov for Healthwatch England suggested that 82% of people would be more likely to raise a concern about poor care if they knew the information would be used to inform CQC's inspection processes.[5]

CQC is working to better understand how we can gain the maximum value from the feedback people give us. This includes developing our qualitative analysis techniques, and ensuring that we collect feedback in the most efficient and effective way.

We want to make listening and responding with compassion and clarity a core competence of CQC staff. We are developing training so that all our employees are clear about their role in handling feedback and concerns about the providers we regulate. We are also reviewing our own corporate complaints procedure (for complaints about CQC, rather than concerns about the providers we regulate).[6]

CQC has reviewed its own whistleblowing policy and in January 2014 appointed a non-executive director (Michael Mire) with responsibility in this area. This in line with a recommendation in the Clwyd/Hart report.

4. **www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf**

5. **www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf**

6. **www.cqc.org.uk/content/complain-about-cqc**

'TELL US ABOUT YOUR CARE' / PARTNERSHIPS WITH THE COMMUNITY AND VOLUNTARY SECTOR

To increase our access to people's experiences of care (both good and bad) CQC has established partnerships with a number of national health and social care charities. We currently work with the Patients Association, the Relatives & Residents Association, Carers UK, Mind, Action against Medical Accidents and (from November 2014) The Silver Line. Through the partnerships, we can demonstrate the range of action that we take in response to this information.

We receive an average of 280 items of feedback each month across all the partners. Of these, 42 (15%) are positive comments and 238 (85%) are concerns about care.

Of the 238 concerns, on average 24 (10%) are serious enough to prompt us to make a safeguarding referral to the local council because someone may be at risk of, or experiencing, abuse. Fourteen concerns (6%) prompt us to carry out a responsive inspection or bring forward the date of a planned inspection.

On average, 57 concerns (24%) prompt us to raise the issues with the service provider and seek a response from them. This ranges from a discussion with the provider and verbal assurances, or a request for evidence (such as staff rotas), to a request for an investigation to be carried out by the registered manager and a report submitted to CQC. It also includes requesting a copy of the provider's response to the complaint, where an individual has indicated they are intending to make a complaint to the service.

For around 103 concerns (43%) the relevant inspector advises that no immediate action is required, but the information will be used to inform the next scheduled inspection. Sixteen concerns (7%) require no action because the areas raised had been covered at a recent CQC inspection. And 22 concerns (9%) do not provide enough information or do not prompt any action because the concern is about an experience that took place too long ago and/or there have been changes to the service in the meantime.

Complaints in CQC's new approach to regulation

CQC has a clear purpose: to make sure health and social care services provide people with safe,

effective, compassionate and high-quality care, and to encourage services to improve. We put people who use services at the heart of our work.

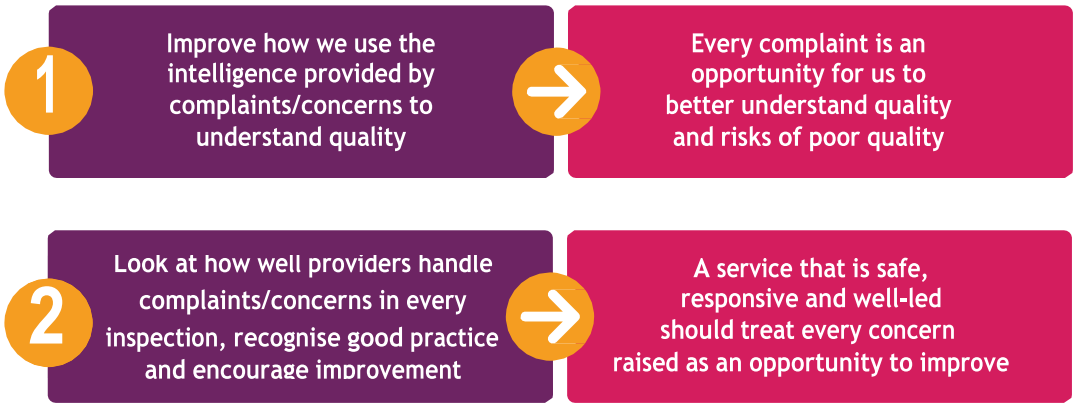
To fully understand people's experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people. We always ask five questions of services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

A service that is safe, responsive and well-led will treat every concern as an opportunity to improve. It will encourage its staff to raise concerns without fear of reprisal. It will respond to complaints openly and honestly.

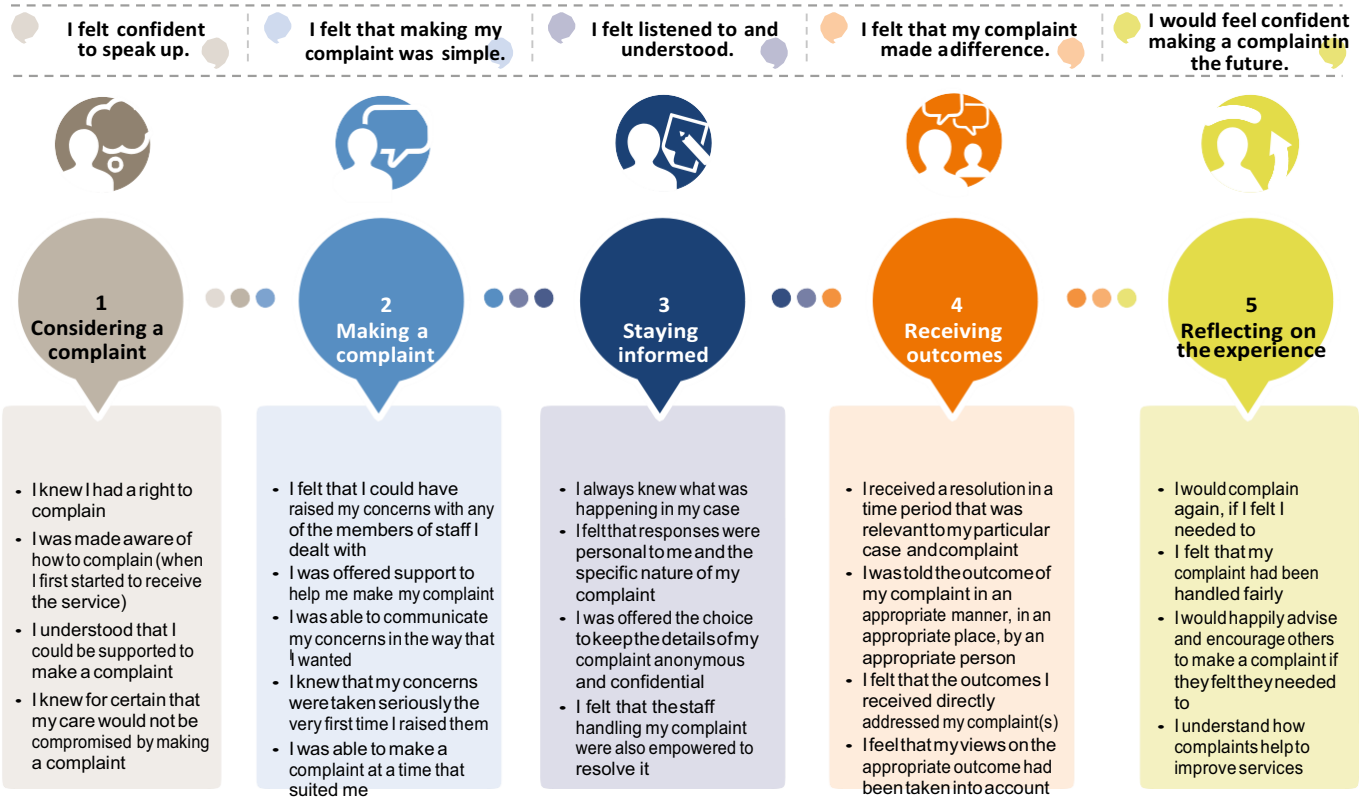
Embedding complaints and concerns in CQC's regulatory model has two aims: to improve how we use the intelligence from concerns and complaints to better understand the quality of care; and to look at how well providers handle complaints and concerns to encourage improvement **(FIGURE 1)**.

FIGURE 1: EMBEDDING COMPLAINTS AND CONCERNS IN CQC'S REGULATORY MODEL



The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England, have set out universal expectations of good complaints handling (FIGURE 2). We now have a clear vision of 'what good looks like' from the point of view of people who use services.

FIGURE 2: A USER-LED VISION FOR RAISING CONCERNS AND COMPLAINTS



Local Government OMBUDSMAN

healthwatch

Parliamentary and Health Service Ombudsman

We have built on these expectations, with input from a wide range of people with expert and personal knowledge of raising concerns in health and social care. Feedback from people who use services – and from care staff – is now at the heart of our new approach to regulation.

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours practices and adult social care services that looks at how well complaints and concerns are handled. We will do the same

in sectors where we are still developing our new approach, such as the ambulance sector. The key line of enquiry asks how people's concerns and complaints are listened to, acted on and used

to improve the quality of care. Each key line of enquiry is accompanied by a number of prompts that inspection teams will consider as part of the assessment. We call these prompts.

- Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up?
- How easy is the system to use? Are people treated compassionately and given the help and support they need to make a complaint?
- Is the outcome explained appropriately to the individual? Is there openness and transparency about how complaints and concerns are dealt with?

Inspection teams use evidence from ongoing local relationships, local and national data, pre-inspection information gathering and on-site inspection to answer the key lines of enquiry.

Following comprehensive inspections, we award ratings on a four-point scale:

- Outstanding
- Good
- Requires improvement
- Inadequate.

How well providers handle complaints feeds into our overall rating of how responsive they are. The characteristics of each rating include:

- Outstanding – there is active review of complaints and how they are managed and responded to, and improvements are made as a result across the services.
- Good – it is easy for people to complain or raise a concern and they are treated compassionately when they do so.
- Requires improvement – people do not find it easy to complain or raise concerns, or are worried about raising concerns or complaining. When they do, a slow or unsatisfactory response is received.
- Inadequate – there is a defensive attitude to complaints and a lack of transparency in

  how they are handled. People's concerns and complaints do not lead to improvements in the quality of care.

Full details of key lines of enquiries, prompts and ratings characteristics can be found in CQC's guidance for providers.[7]

7. **www.cqc.org.uk/content/guidance-providers**

EXTRACTS FROM INSPECTION REPORTS SHOWING EXAMPLES OF GOOD PRACTICE

THE HANDBRIDGE MEDICAL CENTRE, CHESTER (GP PRACTICE)

The Patient Participation Group worked with the practice to improve services and feedback was welcomed. We found evidence that feedback from patients, public and staff was acted on and improvements made. They told us the practice was very eager to engage with its patients and listened to them.

GREEN ACRES NURSING HOME, LEEDS (CARE HOME)

We saw the record of complaints kept in the home and reviewed how one complaint was dealt with. This showed that when a complaint was made it was taken seriously and investigated fully. We also looked at the record of significant events and saw there was learning from these. We could see that learning from any complaints, incidents and investigations was fed back to staff at meetings and during individual staff supervision, if appropriate. People were clear who they would talk to if they had a concern or complaint. They said they were happy to tell any of the staff.

FRIMLEY PARK HOSPITAL, SURREY (ACUTE TRUST)

Feedback from a 'Friends and Family' test was visible on all wards visited. Along with complimentary feedback and high levels of recommendation, we saw examples of feedback on areas for improvement. This included a comment on noise levels at night and the action taken to resolve this, which included raising staff awareness, settling people earlier, and turning lights off. On a ward we saw that feedback included a request for televisions and improved arrangements for take-home tablets. Action in response to this included the installation of televisions and doctors were to write up take-home medication in a timely manner. The unit displayed the number of plaudits and complaints it received every month for relatives and patients to see. It reported four plaudits and no complaints for July 2014.

MILTON KEYNES URGENT CARE SERVICES (CIC) (OUT-OF-HOURS SERVICE)

We sampled the complaints log from the service and found that where complaints were upheld, the service invited the complainant (after they had received the final outcome letter) to visit the service, meet with staff and managers, discuss the outcome and share ideas from their experience.

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Staff told us they knew how to support people who used the service, or their carer or relatives, if they wanted to make a complaint. People said that they felt listened to, and that they were able to provide feedback to the service. They knew how to make a complaint and were listened to by the trust when they did this.

All reported incidents were screened by the clinical lead and incidents, complaints and feedback were discussed in the minuted directorate business meetings (held monthly).

We found examples where learning from complaints had been used to change front line practices and training for some staff. For example, within the community services for older people, the trust had a care home liaison service to minimise inappropriate care home placements, particularly for those with rare or complex forms of dementia.

SOLENT NHS TRUST (COMMUNITY HEALTH TRUST)

We found that services actively sought feedback from patients and they told us of improvements they had made. For example, access hours to some children and family clinics had been changed to reflect feedback from parents.

The majority of staff that we spoke with said that the trust listened to their feedback and responded to it. The trust was committed to increasing patient feedback from a range of sources and was piloting innovative methods of real-time feedback on computer tablets, to increase participation.

Intelligent Monitoring

'Intelligent Monitoring' is how we describe the processes CQC uses to gather and analyse

information about services. This information helps us to decide when, where and what to inspect.

By gathering and using the right information, we can make better use of our resources by targeting activity where it is most needed.

Feedback from people who use services is central to this model. In acute NHS trusts, Intelligent Monitoring uses various indicators:

- CQC National Customer Service Centre qualified whistleblowing alerts[8]
- CQC's National Customer Service Centre safeguarding concerns
- CQC 'Share your experience' negative comments
- NHS Choices negative comments
- Patient Opinion negative comments
- Complaints received by CQC
- Provider complaints (sent to CQC by the HSCIC).

Our approach to Intelligent Monitoring will vary according to the quality and availability of

information. For example, there tends to be more information available for NHS trusts than for other providers.

Inspection

Our inspections are at the heart of our regulatory model and are focused on the things that matter to people. There are two types of inspection:

- A focused inspection is used to follow up specific concerns from earlier inspections, or respond to new information that has come to our attention, including concerns raised with us by people using services or staff concerns.
- A comprehensive inspection reviews the service in relation to the five key questions and leads to a rating on each on a four-point scale. This section relates to comprehensive inspections, unless otherwise stated.

Before the site visit

In addition to our Intelligent Monitoring analysis, we gather a great deal of information relating to complaints and concerns before an inspection.

Our local inspection teams make contact with a wide range of partners to help plan inspections. These vary depending on the sector and more detail can be found on the 'guidance for providers' section of our website. Some of the partners we contact to find out more about concerns and complaints and how services handle these include:

- Professional regulators (for example, General Medical Council, Nursing and Midwifery Council)
- Parliamentary and Health Service Ombudsman
- Local Government Ombudsman
- Royal colleges
- UNISON
- Local authority[9]
- Local Healthwatch
- NHS Complaints Advocacy
- Clinical commissioning group
- Monitor regional team
- NHS Trust Development Authority regional office
- NHS England regional director
- Local voluntary and community groups.

Since September 2013, CQC has written on a quarterly basis to all NHS complaints advocacy services to inform them of our announced inspections and ask for their contributions. Our inspection teams have said that the input they receive is valuable.

8. 'Qualified' means a disclosure that meets the criteria set out in the Public Interest Disclosure Act (that is, there is harm or risk of harm to people; possible or actual criminal activities; failure to comply with a legal obligation; miscarriages of justice; damage to the environment; or a deliberate attempt to cover up any of the above).

9. Adult social care contracts monitoring teams, regarding complaints specifically.

As well as reviewing the information from people who use services, our inspectors use additional methods to gather views ahead of an inspection, such as speaking with community, patient and carer groups.

We request a range of information from providers before we inspect. We ask providers to send us their complaints policies in advance of an inspection, along with a summary of complaints from the last 12 months and how these were resolved.

We are rolling out a 'self-report' for hospitals, mental health services and community healthcare services to tell us how they handle complaints before we inspect. This helps us to know what to focus on during the inspection.

Although our inspections include many opportunities for people who use services to share their views, we want to understand more about the experience of making a complaint. From now on, we will ask providers to share with us any survey they have carried out of people who have complained to them in the last 12 months.

In adult social care, we survey people who use home care services and Shared Lives schemes and those close to them before an inspection. We ask if they know how to complain or raise a concern, and how the organisation and staff handled any concerns they did raise.

WHAT WE ASK IN THE TRUST SELF-REPORT ON COMPLAINT HANDLING

Leadership: Who is responsible for complaints at the trust? Please include the executive and non-executive lead, as well as the individual with day-to-day responsibility and the total number of staff dedicated to complaints.

Governance: Please describe the trust's governance arrangements for complaints: how often are they discussed at board level? What committees review the handling of complaints and compliments, and any themes within them?

Awareness: Describe how patients and relatives are made aware of how they can raise concerns or make formal complaints. Please describe what processes are in place to resolve complaints before they become formal.

Investigation: Describe how complaints are investigated: who leads on investigating complaints and how is this decided? How is the investigation documented? Who checks the responses and is responsible for sign-off?

Timeliness: What are your local standards for providing a response to complaints (timeliness) and how well are you achieving this? Are there any areas that struggle to achieve the standards?

Learning: How do you disseminate learning from complaints? Can you point to any changes made as a result of learning from complaints?

Evaluation: How do you ascertain whether complainants are satisfied with the complaints process and the outcome?

Site visit

Our new approach to inspections provides many opportunities for inspection teams to gather evidence of how well providers handle complaints. For example:

- Speaking individually and in groups with people who use services.
- Using comment cards placed in reception areas and other busy areas to gather feedback.
- Using posters to advertise the inspection to allow people an opportunity to speak to the inspection team.
- Speaking with a range of staff during the inspection and with focus groups held with staff in hospitals.
- Interviewing the member of staff with responsibility for complaints.
- Observing interactions, for example at reception desks, and looking for information about how to complain and give feedback.

We often include 'Experts by Experience' on our inspections. Experts by Experience are people who use care services or care for someone who uses health and/or social care services. Their main role is to talk to people who use services and tell us what they say.

Many people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff, and can observe the care being delivered.

During site visits, our inspectors review a sample of complaints files to understand whether these

have been handled in a way that matches the good practice we expect to see.

Inspectors will usually look at up to five complaint files, which should be selected by inspectors, not by the provider. They usually include at least one serious complaint and, if possible, one relating to a person who may find it more difficult to have their voice heard. Most will be closed, which helps the inspector to review the full process from beginning to end, but inspectors may select an ongoing case.

PILOT WORK WITH THE PATIENTS ASSOCIATION

The Patients Association has carried out significant work on standards in relation to complaints in recent years. Its methodology for reviewing the effectiveness of complaints procedures and the experience of complainants provided a useful framework for CQC to learn from and build on its own approach.

CQC worked with the Patients Association in 11 acute hospital trust inspections that took place in late 2013 and early 2014. The inspections trialled methods of pre-inspection analysis and on-site activity to review the effectiveness of providers' complaints processes, and to understand the experience of complainants and the ability of providers to learn and improve as a result of complaints.

KEY FINDINGS:

- A pre-inspection survey of people who had complained to the provider was useful in shaping lines of enquiry for the inspection.
- Having a lead for complaints on the inspection team ensured the information was captured to show evidence for the complaints key line of enquiry.
- Reviewing complaints files was a robust method for understanding the effectiveness of the complaints process.

This method is particularly useful for understanding the tone and content of response letters that are sent to people who have complained. CQC expects responses to be empathetic and to provide a full explanation and apology where appropriate. The NHS Litigation Authority is clear that "saying sorry is not an admission of legal liability; it is the right thing to do".[10]

10. www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

Reviewing complaints files is resource-intensive for inspection teams. Based on testing with the Patients Association, we believe that reviewing around five cases is achievable within current resource levels and provides useful insight into complaints handling.

Along with all the methods described here, CQC will keep this under review and make changes if needed.

On large inspections (in hospitals, mental health services and community healthcare services) we are introducing a lead inspector for complaints and staff concerns who will draw this evidence together. All members of the inspection team are responsible for listening and responding to people using services

or staff raising concerns, but having a lead gives responsibility for pulling information together to a single individual.

Over the coming months we are rolling out guidance and training to support inspection teams in using these methods effectively to understand complaints handling. The aim is that every inspection will consistently and effectively use the full range of methods from January 2015.

Requiring and encouraging improvement

Our ambition is to see an improvement in the quality of complaints and concerns handling in all services. We believe that this an important part of ensuring that people receive safe, high quality care.

Our inspection reports will now always include a description of the provider's handling of complaints. For large inspections where the reports tend to be very long, we will ensure that complaints handling features in the summary of how responsive the provider is. We will recognise good practice and set out clearly where complaints handling falls short.

Although we are not an improvement agency we will act to encourage improvement. We will work closely with stakeholders and partners to

drive improvement. For example, local complaints advocacy groups have told us that they are able to lever change by challenging providers who have had

issues about complaints handling flagged in their inspection reports. In some sectors, we include key local partners in the 'quality summits' we hold after inspections to ensure that they are aware of the improvements we require.

POOR PRACTICE AND CQC INTERVENTION

The Parliamentary and Health Service Ombudsman asks NHS providers to send a copy of their responses to complainants to CQC.

We recently received a copy of a letter that was distinctly lacking in empathy. Our inspector contacted the trust's chief executive about the tone of the letter, which we felt missed the opportunity to make a heartfelt apology and to emphasise the positive learning and changes that had been made. CQC will provide feedback like this when it is warranted.

CQC can take enforcement action against registered providers who breach regulations. One of the new fundamental standards, Regulation 16[11] (which

will come into effect in April 2015, subject to parliamentary process) relates to complaints. It is intended to ensure that anyone can make a

complaint about any aspect of care and treatment planned and/or provided, and to ensure that providers investigate complaints and take appropriate and timely action to rectify any failures identified by the complaint or investigation.

If a provider applying to be registered with CQC cannot demonstrate that it will meet the

requirements of this regulation from its first day of operation, CQC may refuse its application for registration.

In our new comprehensive inspections, we primarily look for good care, rather than checking compliance with regulations. We have ensured that all the

areas covered by the regulations are also covered in our key lines of enquiry. Where care requires improvement or is inadequate, we will also consider whether a regulation has been breached.

11. www.cqc.org.uk/content/publishing-new-fundamental-standards

In focused inspections, where we are following up specific concerns from earlier inspections or responding to new information that has come to our attention, we assess whether the provider has improved so that they are no longer in breach of regulations, or whether the new concern amounts to a breach of regulations.

Where there is a breach of regulations, CQC has a range of enforcement powers, including issuing warning notices, suspending or cancelling registration, and prosecution. Monitor or the NHS Trust Development Authority may also decide to take action as a result of CQC's findings, if they relate to NHS foundation trusts or NHS trusts.

The fundamental standards also introduce a new duty of candour. This came into force this autumn in NHS bodies and will apply to other sectors from April 2015. It aims to ensure that providers are open and honest with people who use services if things go wrong with their care and treatment. To meet the requirements of the regulation, a provider has to:

- Make sure it has an open and honest culture across and at all levels within its organisation.
- Tell people in a timely manner when particular incidents have occurred.
- Provide in writing, a truthful account of the incident and an explanation about the enquiries and investigations that it will carry out.
- Offer an apology in writing.
- Provide reasonable support after the incident.

This organisational duty of candour sits alongside the existing duty of candour for professionals. It means that every care professional must be open and honest with patients if something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

The new duty of candour will, for the first time, place a legal duty on all provider organisations to be open and honest with patients and families following serious cases of avoidable harm or death. Where processes for identifying and properly investigating serious incidents in health and social care are poorly implemented, people may turn to the complaints system to seek answers and assurances that lessons have been learned. There should be no need for people who use services, or their families or friends affected by serious failures, to raise a written complaint.

We welcome the Parliamentary and Health Service Ombudsman's recent decision to review the quality of investigations in 250 cases involving serious healthcare failings. CQC wants to make sure that the quality of incident investigations – and the learning – is audited as part of its inspection process. This will feed into our overall rating of the organisation.

If a provider fails to do any of the things listed above and breaches the duty of candour, CQC can use its range of enforcement powers or move directly to prosecution without serving a warning notice.

Concerns raised by staff (whistleblowing)

Every concern is an opportunity for services to improve and for CQC to understand more about the quality of care. A service that is well-led and wants to improve will encourage staff to raise concerns without fear of reprisal.

Whereas complaints tend to follow an experience of poor care, concerns raised by staff are often an attempt to prevent something going wrong. Staff draw on their knowledge and experience of service delivery, and the issues they raise provide vital information about potential risks of poor quality or harm. Concerns may sometimes be termed 'whistleblowing', although staff have told us they do not like the word.

CQC is a prescribed body under the Public Interest Disclosure Act 1998. This means that employees of health and social care organisations can make disclosures to us where they have concerns about their employing organisation. CQC wants staff to tell us if they know about poor care. Many already do. Between 1 April 2014 and 31 October 2014, some 5,638 staff contacted CQC. These contacts are logged by a team at CQC's National Customer Service Centre

and they are tracked to ensure the relevant inspector responds to them in a timely manner.

CQC uses this information to inform its regulatory activities. We know we need to do more to explain what action we take when people bring us

information, and to provide clarity over what we can and cannot do.

For example, people often think CQC can protect them from any detrimental impact if they disclose information, but we have no legal power to protect individuals from actions their employers might take. However, CQC expects all organisations to have effective arrangements to encourage staff

to raise concerns, to ensure that these are taken seriously, that they are used to improve the quality of care, and that employees who raise concerns are valued, respected and protected from any

detriment. Victimisation or bullying is unacceptable. We will look at the process in place to handle staff concerns in every inspection as part of assessing the leadership of an organisation.

Information shared with CQC will be dealt with in confidence and we will not disclose people's identity without consent. Staff can also raise concerns anonymously. However, it can be difficult to investigate issues of quality and safety and preserve anonymity.

People with historic cases also contact CQC in the hope that we can help resolve their concerns or hold a provider to account for its actions. While each case provides learning for us about the problems that can occur, and how we need to mould our new methods of inspection to detect similar problems and take effective action, we do not have the remit to resolve an individual case. As with complaints, we believe there is a regulatory gap in this area and we welcome the Freedom to Speak Up review, including its focus on historic cases.

Through our new approach we will assess the leadership and culture of the organisation in more depth than previously attempted. Staff confidence about raising concerns is an indicator of openness in an organisation and how it might want to learn and improve.

Some key lines of enquiry and prompts that we ask as part of assessing leadership in a service include:[12]

- How does the leadership and culture reflect the vision and values, and encourage openness and transparency and promote good quality care?
- Does the culture encourage candour, openness and honesty?
- How are staff supported to question practice and how are people who raise concerns, including whistleblowers, protected?
- Is the value of staff raising concerns recognised by both leaders and staff? Is appropriate action taken as a result of concerns raised?

The following are ratings characteristics at each level, describing leadership in an organisation:

- **Outstanding:** Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to raise concerns.
- **Good:** Staff have the confidence to question practice and report concerns about the

  care offered by colleagues, carers and other professionals.
- **Requires improvement:** Staff do not always raise concerns or they are not always taken seriously or treated with respect when they do.
- **Inadequate:** There is bullying, harassment, discrimination or violence. When staff raise concerns they are not treated with respect. The culture is defensive.

Our Intelligent Monitoring includes staff concerns (whistleblowing) raised with CQC. We make extensive use of indicators from the NHS staff survey and the General Medical Council trainee survey, including questions covering feedback, concerns, errors, near misses and incidents, bullying, harassment and abuse, staff sickness and staff turnover.

12. See our guidance for providers for more information **www.cqc.org.uk/content/guidance-providers**

FOCUS GROUP WITH STAFF WHO HAVE RAISED CONCERNS

In developing our work on staff concerns and whistleblowing, we brought together a group of people with experience of raising concerns in health and social care services. CQC staff met with the group in February and July 2014. We listened to their experiences, discussed the issues and asked how CQC might act to encourage change.

We heard people describe how the organisational response to their concerns was to take the focus away from the actual issues raised and instead focus attention on the person raising concerns. We heard how staff with previously exemplary records were suddenly faced with allegations. Often they found themselves subject to bullying and harassment. We heard about how the stress from this treatment had resulted in sickness and the inability to carry on as normal.

These events helped CQC develop our approach to ensure that the way staff are encouraged to raise concerns – and how issues are investigated and responded to – is integrated as part of our inspection work. The feedback from this group also helped us to understand the links with other cultural issues within the organisation. For example, inspection teams now consider information about bullying from staff surveys. They also look at factors such as staff sickness rates and the priority placed at board level on openness and transparency relating to safety concerns.

Before an inspection of either a homecare agency, hospice or a Shared Lives scheme, CQC carries out a staff survey. We ask if they agree with these statements:

- "My managers are accessible, approachable and deal effectively with any concerns I raise."
- "My managers ask what I think about the service and take my views into account."

CQC inspections now include specialist professionals who play a key role in helping teams understand whether there are problems with the way staff concerns are handled. We encourage members of staff to raise any concerns with our inspectors.

For example, on hospital inspections we hold focus groups with junior doctors, run by a junior doctor who is on our inspection team, to encourage them to share any concerns. Other staff forums are conducted by a peer on the inspection team and are held with senior doctors, junior nurses and care assistants, senior nurses and administrative staff.

We offer to speak to people who have contacted us to raise concerns directly and confidentially, one-to-one or at a drop-in sessions. We also provide comment cards that people may complete and send to the inspection team, to provide their views about services. We always interview key staff, including HR directors and non-executive directors, and we are able to review a sample of closed investigations.



3. STATE OF COMPLAINTS IN HEALTH AND SOCIAL CARE SERVICES

In their review of NHS complaints, the Rt Hon Ann Clwyd MP and Professor Patricia Hart asked CQC to report on complaints handling in the acute trusts that we inspected in the year following their report.

We have a clearer picture of the state of complaints for NHS trusts than for primary care and adult social care providers.

In acute, mental health and community health services there is far too much poor practice in providers' responsiveness and treatment of people who make complaints. This is backed up by the negative findings from patient surveys.

There is less evidence available on which to judge how well complaints and concerns are handled

in adult social care and primary care. Much more could be done to encourage an open culture where concerns are welcomed, particularly as high numbers of providers in these sectors report that they receive very few or no complaints at all.

Across all sectors, we believe that the new methods we are introducing to look at complaints handling, along with reforms by others such as the Health and Social Care Information Centre, will enable us to present a more complete picture of the state of complaints in the future.

NHS acute, mental health and community health services

Complaints received

NHS acute, mental health and community health services share information about their written complaints with the Health and Social Care Information Centre (HSCIC).[13]

We analysed this data and found that the number of written complaints received by all NHS hospital, mental health and community health services increased every year since 2011/12. This overall increase masks decreases in some areas, including acute inpatient services in 2013/14 and maternity services **(TABLE 1 AND FIGURES 3-5)**.

13. It is mandatory for all NHS hospitals and community health services to return information on complaints to the HSCIC data collections. The response rate from NHS trusts is usually 100%.

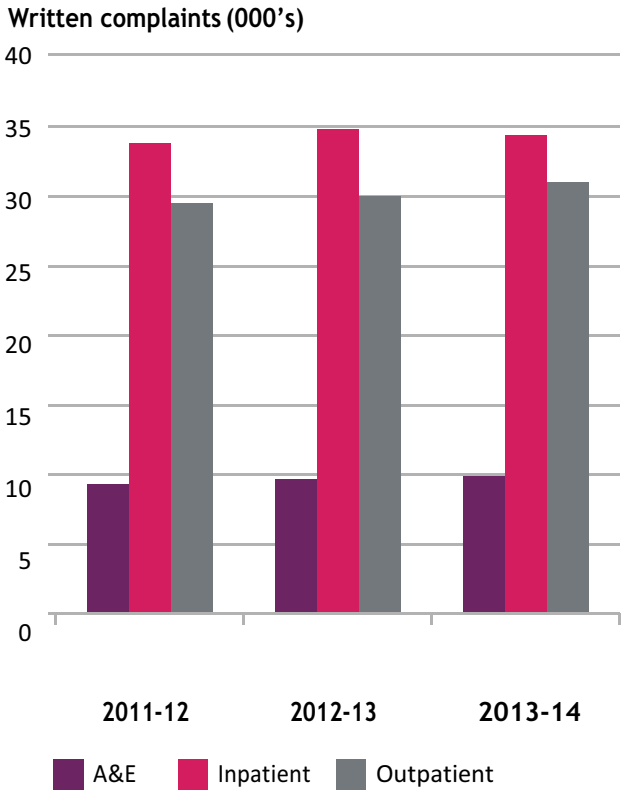
DATA SOURCES ANALYSED IN THIS REPORT

- **Health and Social Care Information Centre – Data on written complaints in the NHS (2011/12 to 2013/14)**
- **CQC National Customer Service Centre** – concerns received from 1 April 2012 about the quality of care in the providers we regulate.
- **Published inspection reports** – we reviewed information relating to complaints handling in inspections carried out using our new approach. We looked at 165 adult social care inspection reports, 83 GP practice and out-of-hours service reports, 98 acute NHS hospital reports, seven NHS mental health service reports and eight community health service reports. We carried out qualitative analysis of the text to identify key themes and issues within sectors.
- **Inspector survey** – we asked inspectors carrying out inspections in adult social care and GP practices between August and October 2014 to complete a survey about complaints handling.
- **Provider information requests** – before carrying out an inspection, we ask providers for certain information that includes numbers, themes and timeliness of resolution of complaints. We reviewed information returned by 628 adult social care providers inspected during quarter 2 of 2014/15. We drew numbers and themes of complaints and timeliness of resolution from the adult social care information.
- **User surveys** – in the acute sector, we carried out a survey with the Patients Association of people who had complained in four trusts, inspected in March 2014. Responses were received from 273 people. We also surveyed people using home care agencies and Shared Lives schemes that we were scheduled to inspect in quarter 2 of 2014/15. We received responses from 1,753 people using home care agencies and 38 people using Shared Lives schemes.

TABLE 1: HEALTH AND SOCIAL CARE INFORMATION CENTRE – NHS WRITTEN COMPLAINTS 2011/12 TO 2013/14

	2011/12	2012/13	2013/14	Change 2012/13 to 2013/14	Percentage change 2012/13 to 2013/14
Hospital acute services: A&E	9,362	9,680	9,919	239	2.5%
Hospital acute services: Inpatient	33,873	34,872	34,422	-450	-1.3%
Hospital acute services: Outpatient	29,559	30,019	31,083	1,064	3.5%
Total acute services	**72,794**	**74,571**	**75,424**	**853**	**1.14%**
Community hospital services	1,328	1,315	2,001	686	52.2%
Other community health services	6,407	6,840	6,292	-548	-8.0%
Total community health services	**7,735**	**8,155**	**8,293**	**138**	**1.69%**
Mental health services	**10,439**	**11,749**	**12,221**	**472**	**4.0%**

FIGURE 3: ACUTE SERVICES 2011/12 TO 2013/14

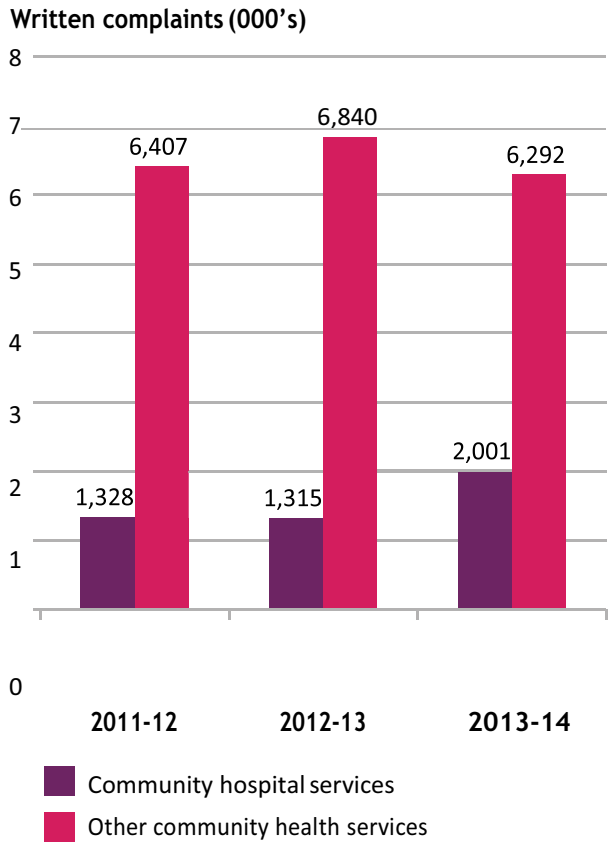


Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

FIGURE 4: MENTAL HEALTH SERVICES 2011/12 TO 2013/14

Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

FIGURE 5: COMMUNITY HEALTH SERVICES 2011/12 TO 2013/14



Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

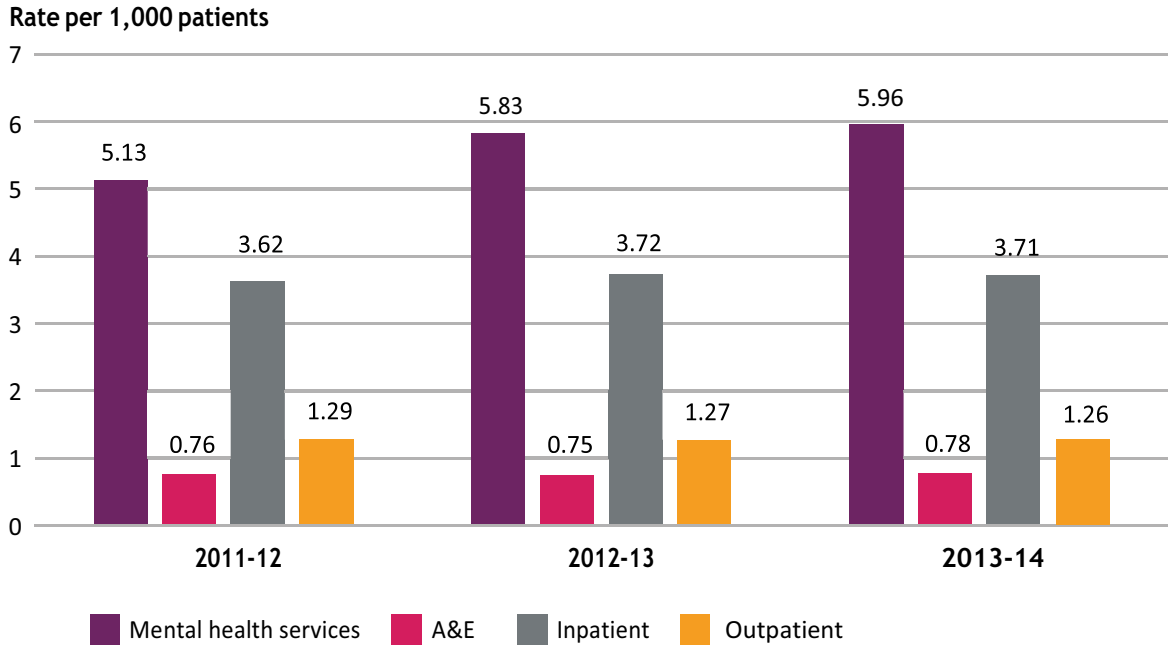
When considered against estimates of increased activity over the last three years, the rate of complaints per 1,000 patients has changed little in acute services, although it does appear to be increasing in mental health services **(TABLE 2 AND FIGURE 6)**.[14]

14. The estimates of activity are drawn from the total counts of unique patients recorded across Hospital Episode Statistics (HES) and the Mental Health Minimum Dataset (MHMDS). The total count of unique patients does not take account of multiple attendances or length of inpatient stay, both of which may have a bearing on the likelihood of raising a complaint. Different rates may be produced if a different estimate of activity is used.

TABLE 2: RATE OF COMPLAINTS 2011/12 TO 2013/14

	2011/12	2012/13	2013/14
	Rate per 1,000 patients	Rate per 1,000 patients	Rate per 1,000 patients
Mental health services	5.13	5.83	5.96
Hospital acute services:			
A&E	0.76	0.75	0.78
Inpatient	3.62	3.72	3.71
Outpatient	1.29	1.27	1.26

FIGURE 6: RATE OF COMPLAINTS 2011/12 TO 2013/14



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

There is variation in acute and mental health services between the organisations receiving the lowest numbers of complaints and those receiving the most complaints, even when activity levels are taken into account **(TABLE 3 AND FIGURES 7-8)**.

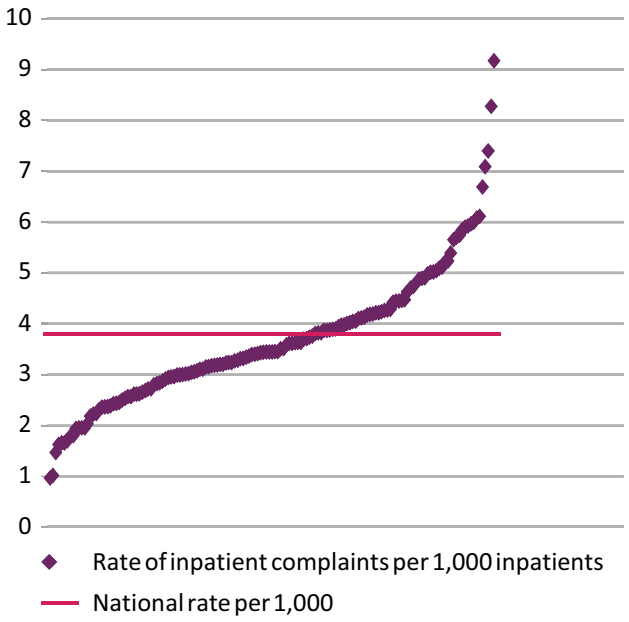
This variation is not necessarily linked to differences in the quality of care. As we have already noted, an organisation that actively encourages and seeks feedback and proactively promotes its complaints process is likely to receive higher volumes of complaints than an organisation with a more defensive approach. Higher numbers and rates of complaints should not automatically be seen as a negative, but should prompt further investigation.

TABLE 3: RATE OF COMPLAINTS TO NHS TRUSTS 2013/14[15]

	Acute A&E complaints	Acute inpatient complaints	Acute outpatient complaints	Mental health complaints
Maximum rate of complaints per 1,000 patients	3.05	9.17	3.76	14.63
Minimum rate of complaints per 1,000 patients	0.13	0.98	0.16	1.97
Average rate of complaints per 1,000 patients[16]	0.86	3.73	1.35	6.33

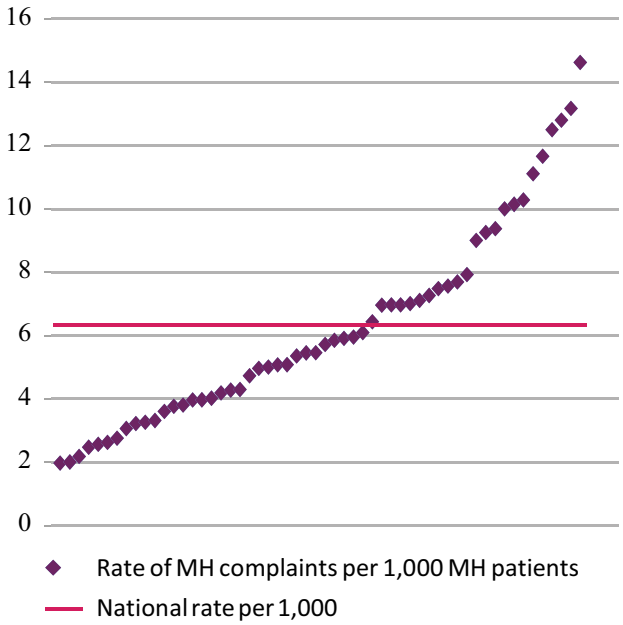
CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

FIGURE 7: RATE OF INPATIENT COMPLAINTS



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

FIGURE 8: RATE OF MENTAL HEALTH COMPLAINTS



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

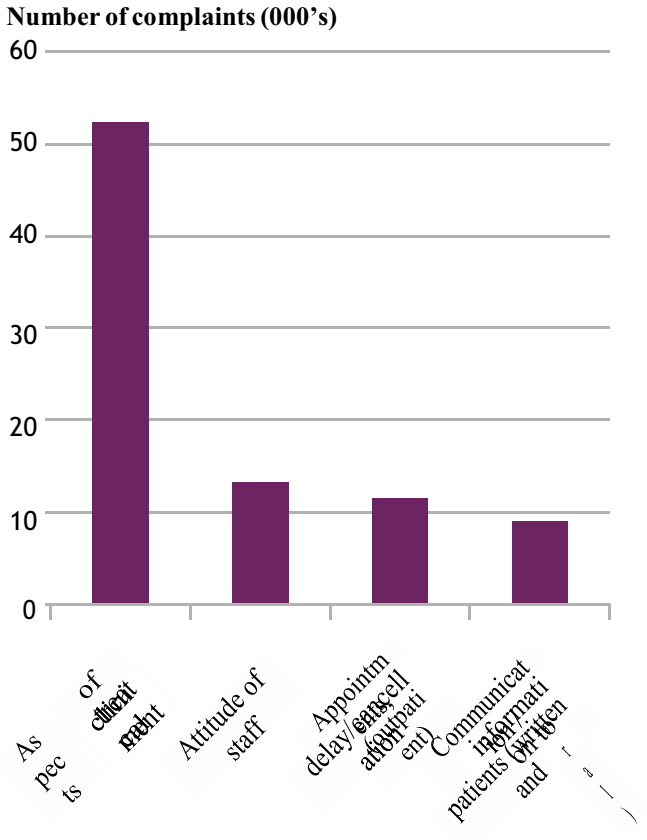
15. NHS acute trusts with known HES data quality issues have been excluded from these calculations.

16. The average figures presented in this table only relate to acute NHS trusts and mental health NHS trusts; the figures presented in the previous table relate to any organisation that received complaints regarding NHS A&E, inpatient, outpatient or mental health services.

Data from the HSCIC has informed this report and it has shown that over the last three years the main four themes of complaints across all NHS hospital and community health services are unchanged **(FIGURE 9)**.

In November 2014 a Parliamentary and Health Service Ombudsman report showed that, in the first two quarters of 2014/15, 28% of its investigations into complaints about NHS acute trusts were about reported inadequate apologies or personal remedies. This has doubled from the 14% in 2013/14.

FIGURE 9: MOST COMMON SUBJECTS OF WRITTEN COMPLAINTS IN NHS HOSPITAL AND COMMUNITY HEALTH SERVICES 2013/14



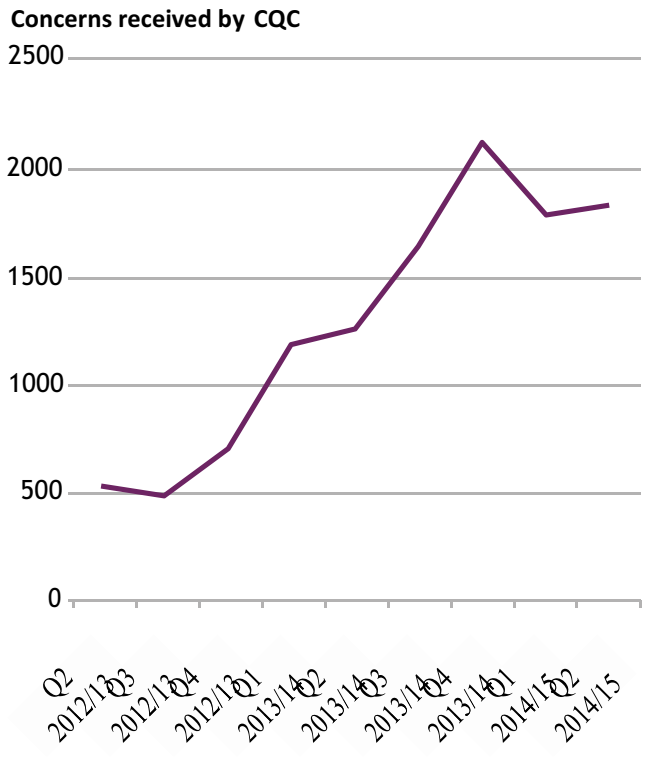
Health and Social Care Information Centre data on NHS written complaints 2013/14

Four issues have remained in the Ombudsman's top five list of the most mentioned reasons for complaining about NHS trusts over the past 18 months:

- Clinical care and treatment
- Communication
- Diagnosis (including delay, failure to diagnose and misdiagnosis)
- Attitude of staff.

As part of our new approach, we are encouraging people to share their experience of care with us, because this information helps us to understand the quality of providers. We have seen large increases in the numbers of concerns shared with our National Customer Service Centre **(FIGURE 10)**. (See the start of chapter 2 for a description of the system.)

FIGURE 10: CONCERNS RECEIVED BY CQC – NHS TRUSTS Q2 2012/13 TO Q2 2014/15



Information from CQC National Customer Service Centre 2012/13 to 2014/15 – represents concerns received regarding a total of 1,307 NHS services

The marked increase in concerns raised with CQC from all sectors began around the end of 2012, when we were consulting on a new strategy and making significant changes to our organisational leadership, including beginning the recruitment of the new Chief Inspectors. We cannot be sure what has caused this increase but we know the public's awareness of CQC is increasing. In May 2014, 55% of people had heard of CQC compared to 22% in 2012.

Complaints handling

We analysed a number of data sources to understand how well NHS providers are handling complaints and concerns.

Qualitative analysis of published inspection reports using our new approach showed variable practice in complaints handling (from knowledge and awareness of how to complain to providers learning lessons from complaints), although overall there was more evidence of good practice than poor.

Most poor practice reported by inspectors related to providers' responsiveness and treatment of people who complain **(FIGURE 11)**.[17]

The majority of positive practice was found where providers were learning lessons from complaints and demonstrating the actions taken as a result of complaints.

We analysed a sample of qualitative data from a number of sources that collect feedback from people who use health and care services, regarding care received across NHS services between 2011 and 2014 (including our own 'Share your experience' web form).[18] This type of feedback tends to be skewed negatively as people are more likely to report negative experiences than come forward to report acceptable or good experiences of care.

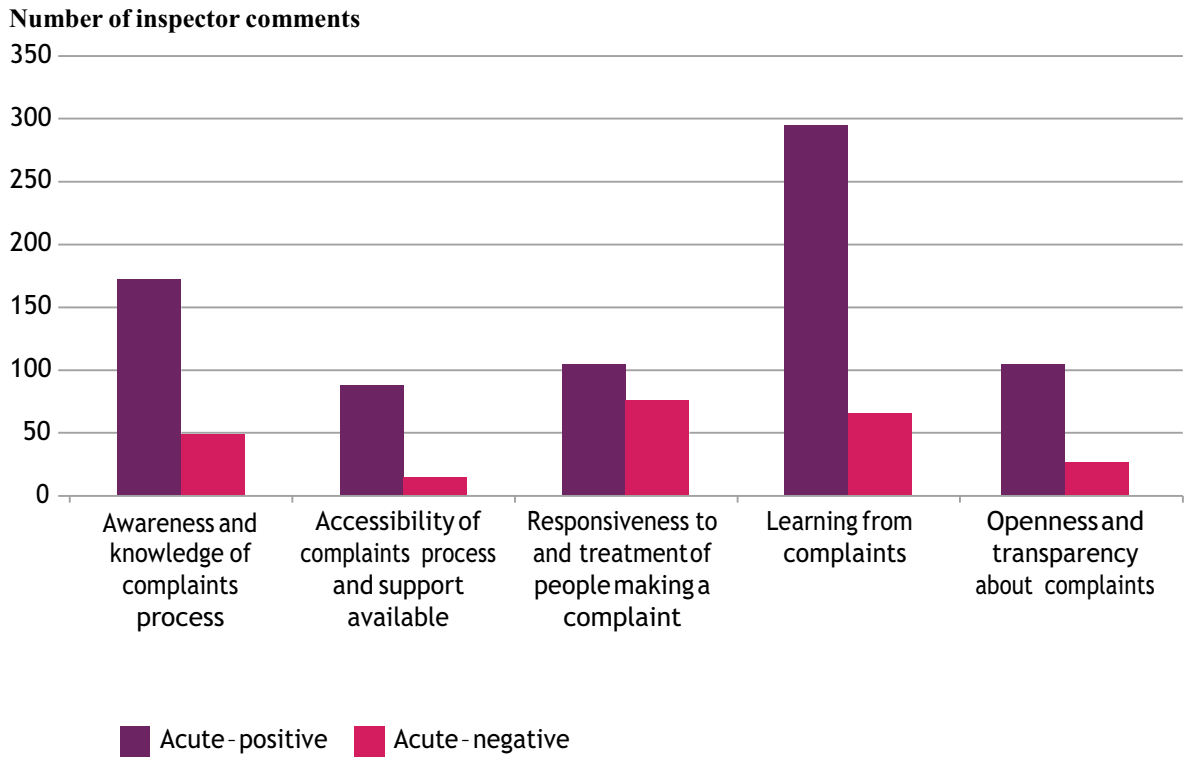
Key areas of concern across acute, mental health and community services include issues with the timeliness of investigations of complaints and people feeling that their concerns were not taken seriously or adequately addressed **(FIGURE 12)**.

We carried out a survey with the Patients Association of 237 people who had complained in four NHS acute trusts, inspected in March 2014. It showed that people felt the experience of complaining had been difficult **(FIGURE 13)**.

17. We reviewed inspection reports from our new approach for 98 acute NHS locations, from which 998 comments from CQC inspectors about complaints handling were analysed; seven inspection reports for mental health providers, from which 44 comments were analysed; and eight inspection reports for community health providers, from which 25 comments were analysed. The taxonomy that we have used to categorise inspectors' comments has been applied retrospectively to the inspection reports. At the time of undertaking these inspections, inspectors were not working to the detailed methodology around complaints handling that has since been rolled out, and may not therefore have reported on all aspects of complaints handling that they do now.

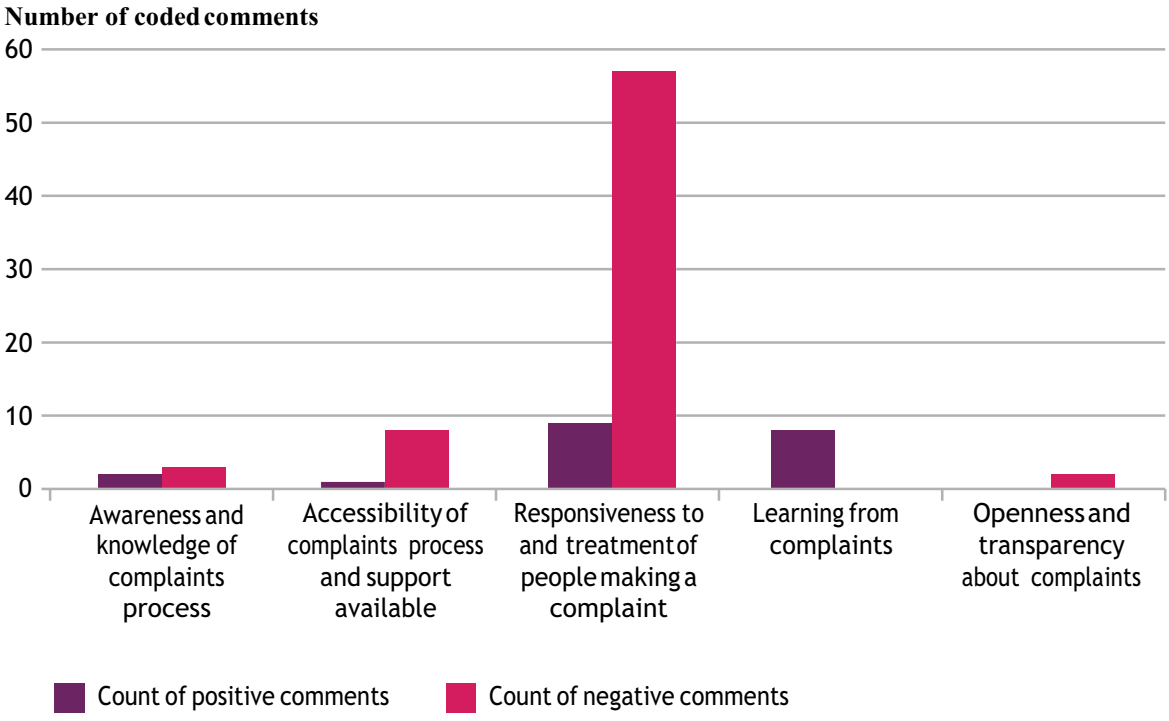
18. This data was categorised against the regulation relating to complaints handling in our outgoing ('old approach') framework We reviewed 113 comments about NHS acute services, 48 about NHS mental health services and 11 about NHS community health. We only reviewed a sample of comments for acute services. The total number of available comments for mental health and community health services was low.

FIGURE 11: NHS INSPECTION REPORTS – COMPLAINTS HANDLING THEMES



CQC inspection reports

FIGURE 12: ACUTE 'USER VOICE' FEEDBACK REGARDING COMPLAINTS HANDLING



We found that people were concerned that complaints could impact on current or future care and were often unhappy with the speed of the complaints handling process. Both of these findings were echoed in online surveys conducted by Healthwatch England in 2014.[19]

Our analysis only shows some of the findings from the Patient's Association and Healthwatch surveys. These surveys highlighted other issues around complaints handling. Full findings from the Healthwatch survey, conducted by YouGov: **www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf**.

Nationally, responses to CQC's 2013 inpatient survey showed only one in four people recalled having seen or being given information explaining how to complain to the hospital about care received. Across most trusts there was limited variation in responses to this question **(FIGURE 14)**. However, there are a small number of trusts, mostly acute specialist trusts, that performed much better than others.

Responses to the NHS staff survey showed that staff responded positively when asked if their organisation acted on concerns raised by people using services **(FIGURE 15)**.

19. Healthwatch England conducted two online surveys in 2014 to understand people's experience of raising complaints about health and social care, one hosted on their own website and another hosted on their behalf by YouGov. Both surveys found that fear of negative repercussions on care was a common reason for not complaining (60% of 85 respondents in Healthwatch England survey and one in four people (26%) in YouGov survey). The surveys also found dissatisfaction over the speed of complaints handling (71% of 211 respondents to Healthwatch England's survey and 60% of 182 responses to the YouGov survey **www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf**)

FIGURE 13: CQC AND PATIENTS ASSOCIATION SURVEY OF COMPLAINANTS, MARCH 2014

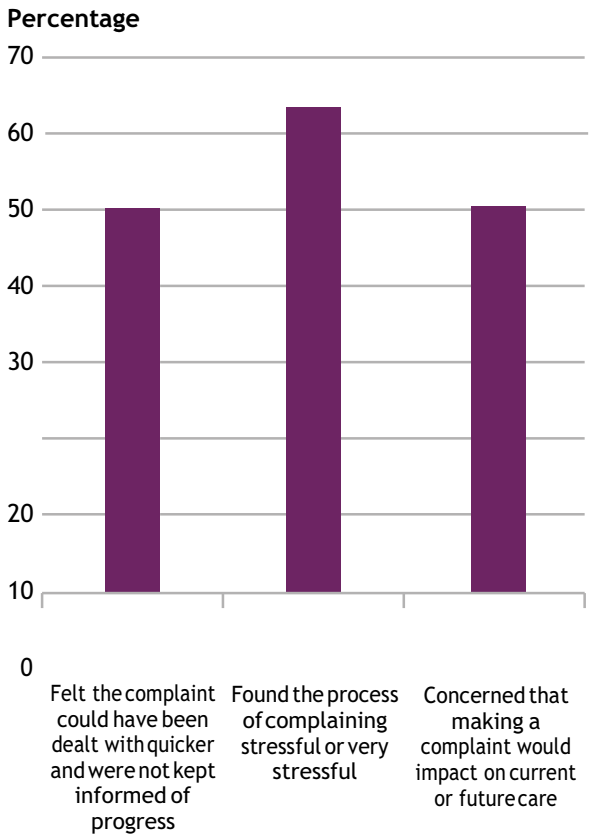
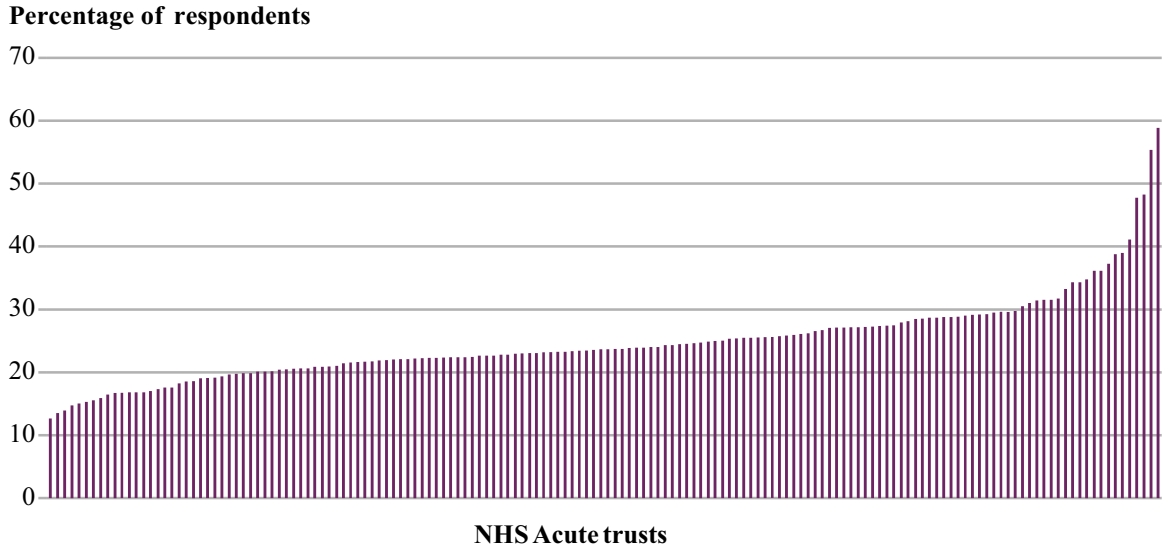
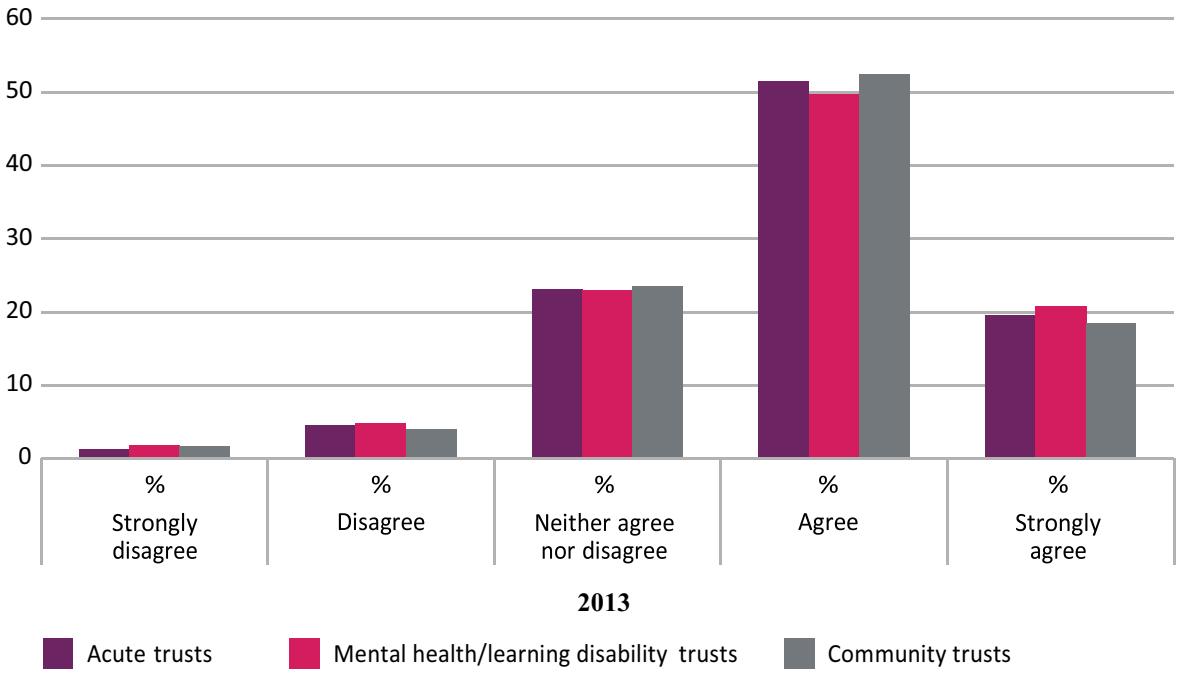


FIGURE 14: 2013 ACUTE INPATIENT SURVEY – WEIGHTED PERCENTAGE OF RESPONDENTS THAT SAID THEY SAW OR WERE GIVEN INFORMATION EXPLAINING HOW TO COMPLAIN



All trusts, CQC inpatient survey 2013/14

FIGURE 15: NHS STAFF SURVEY – MY ORGANISATION ACTS ON CONCERNS RAISED BY PATIENTS/SERVICE USERS



NHS staff surveys 2013

There is a discrepancy between the views of staff and the experience of people who have made complaints. This needs further investigation. More thorough methods of reviewing complaints handling are now a part of CQC's inspection process and we will soon have a more accurate picture of the state of complaints handling.

We also reviewed 2013/14 data supplied by the Parliamentary and Health Service Ombudsman on the proportion of complaints they investigated that were partially or fully upheld. Nationally, 43% of complaints investigated by the Ombudsman regarding care in acute trusts were fully or partially upheld. In NHS mental health trusts this figure was 36% and in NHS community trusts it was 30%. However, the data also showed great variability between organisations in the proportion of complaints being upheld. Organisations that have high rates of complaints being upheld by

the Ombudsman may have inadequacies in their complaints handling processes.

Adult social care and primary care services

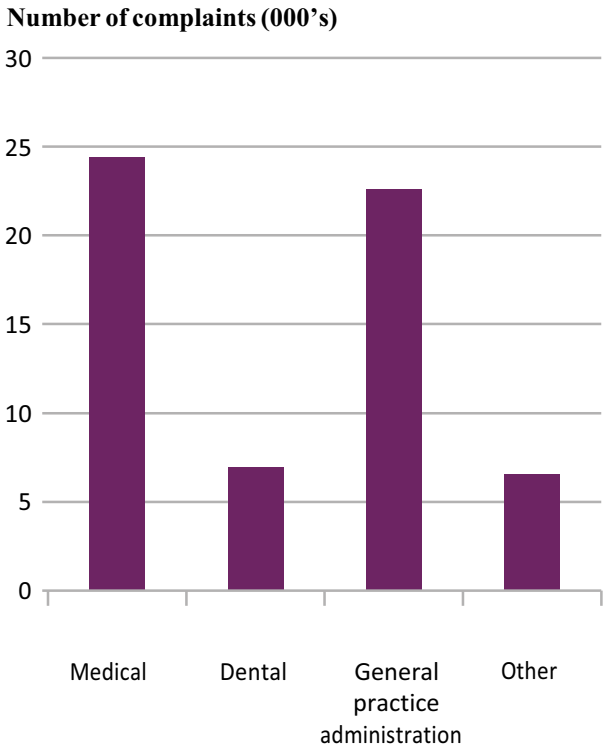
Complaints received

Many complaints in adult social care are about funding and assessment of care, which are local authority issues where CQC has no remit. However, we want to find out about concerns that relate to the care people receive.

Returning data to the Health and Social Care Information Centre regarding the number of written complaints received is mandatory. However, many GP practices and out-of-hours services are not returning this information, so the reported figures are an under-representation **(FIGURE 16)**.

The response rate of GP practices to the Health and Social Care Information Centre data collection in 2013/14 was 77%. The return for NHS trusts was near to 100%. In 2013/14, the total reported number of written complaints received across general practice and dental practice was 60,564.

FIGURE 16: GENERAL AND DENTAL PRACTICE – WRITTEN COMPLAINTS 2013/14



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

Many organisations in adult social care and primary care settings report low numbers of complaints.

Around 40% of the adult social care providers that we inspected in quarter 2 of 2014/15, and requested complaints information from, said they had not received any written complaints in the previous 12 months **(TABLE 4)**.[20] We also asked adult social care providers inspected in quarter 3 for additional information about the themes of complaints they receive. Replies revealed three major themes of complaints: staffing and care, laundry, and communication.

Almost 30% of GP and dental practices that returned data to the HSCIC had not received any written complaints in the previous 12 months.

The number of concerns received by CQC regarding adult social care services has increased since the beginning of 2012/13, but this has been at a slower rate than for NHS services **(FIGURE 17)**.

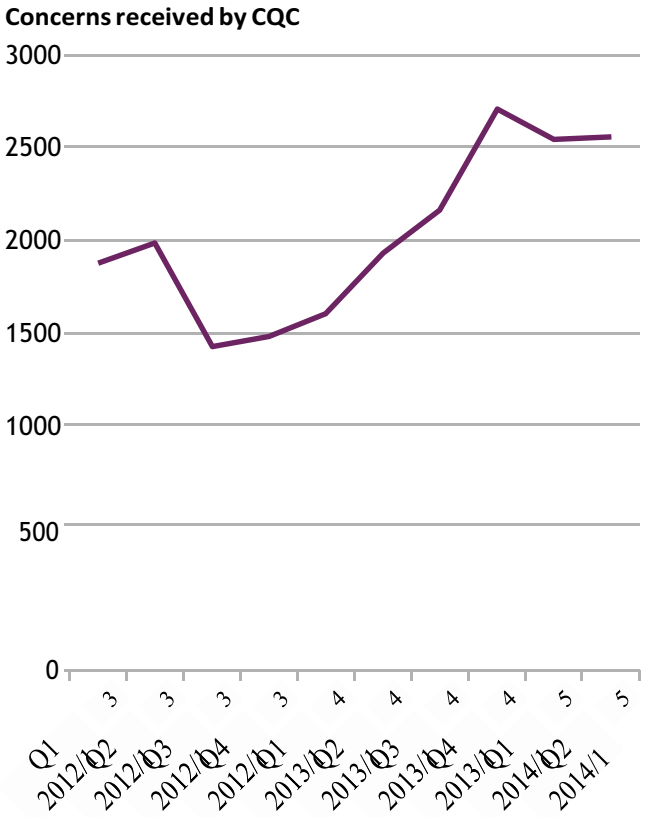
We have seen a large increase in concerns we receive about primary care, but some of the increase will be because CQC's regulation of the sector is fairly new **(FIGURE 18)**.

20. As part of CQC's new approach to inspections, information is requested directly from health and adult social care providers that are scheduled to be inspected. This helps guide the inspection and inform our findings. There are concerns over the accuracy of the information that has been returned to date and CQC is seeking solutions to ensure that future returns are more robust.

TABLE 4: RETURNS FROM PROVIDER INFORMATION REQUESTS (PIRS) IN QUARTER 2, 2014/15

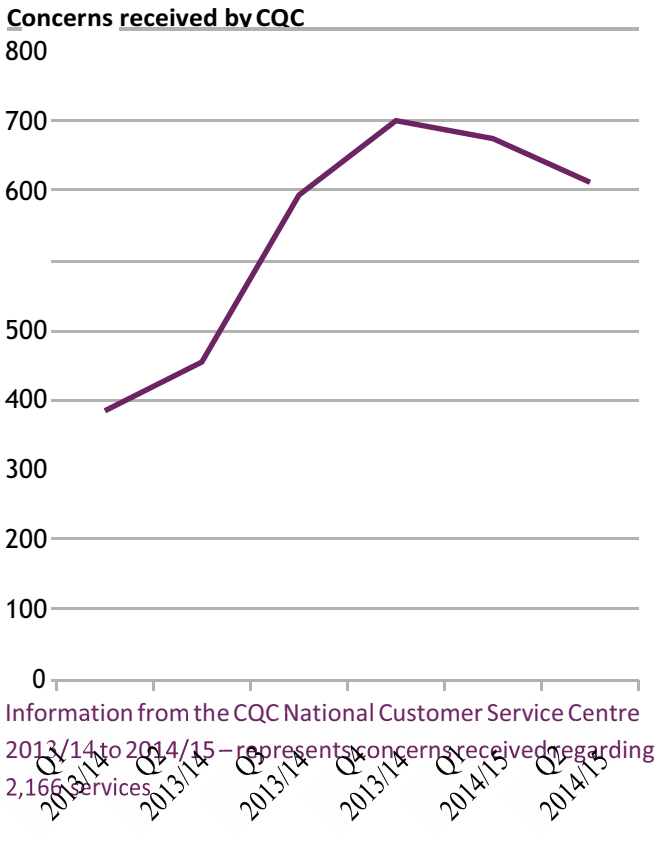
Service type	PIRs with zero complaints	%	PIRs with complaints	%	Total PIR returns	Total number of complaints in PIRs
Community	75	40	114	60	189	984
Hospice	7	37	12	63	19	53
Residential	165	40	247	60	412	1112
Shared Lives	4	50	4	50	8	4
Total	251	40	377	60	628	2153

FIGURE 17: CONCERNS RECEIVED BY CQC – ADULT SOCIAL CARE SERVICES 2012/13 TO Q2 2014/15



Information from the CQC National Customer Service Centre 2012/13 to 2014/15 – represents concerns received regarding 10,315 services

FIGURE 18: CONCERNS RECEIVED BY CQC – PRIMARY CARE SERVICES 2013/14 TO Q2 2014/15



Information from the CQC National Customer Service Centre 2013/14 to 2014/15 – represents concerns received regarding 2,166 services

Complaints handling

We analysed a number of data sources to understand how well providers are handling complaints and concerns.

Qualitative analysis of published inspection reports (using CQC's new approach in adult social care providers, GP practices and out-of-hours services) showed high levels of positive practice at all stages of the journey of making a complaint **(FIGURE 19)**.[21]

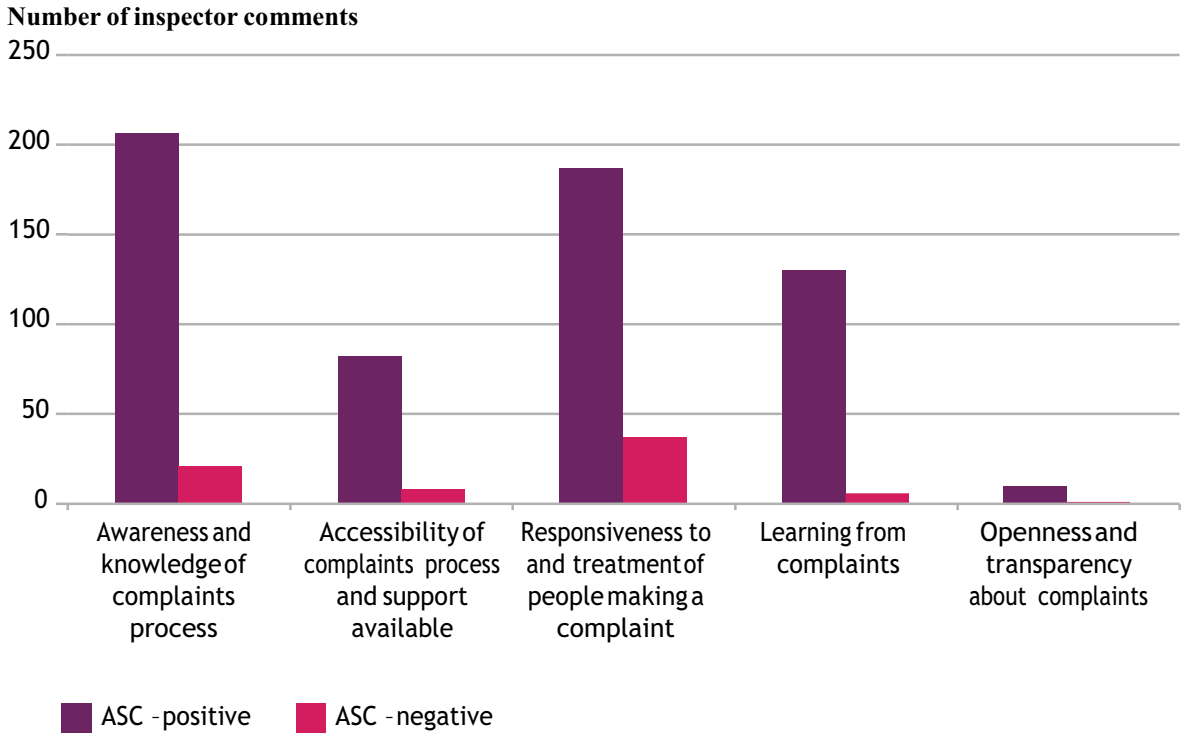
To provide additional evidence for this report, we asked inspectors to complete a survey about complaints handling in the services they inspected between August and October 2014.[22] Many adult social care and GP practice inspectors felt that they did not have enough evidence to answer the questions, often because the locations inspected had received no or very low numbers of complaints.

Where inspectors could provide an answer, it was generally positive about how providers were handling complaints. However, the responses did indicate variation in the provision and awareness of advocacy and support to assist people who wanted to complain. There was also variability in ensuring that a complaints process was accessible to vulnerable groups and children. Inspectors also found variation in what information services provide about complaints processes. In GP practices, inspectors showed that people do not always know how to make a complaint.

21. We reviewed inspection reports from CQC's new approach for 165 adult social care locations, from which 688 comments about complaints handling were analysed. We reviewed reports for 59 primary medical service locations and 24 out of hours services, from which a total of 479 comments about complaints handling were analysed. The taxonomy that we have used to categorise inspector's comments has been applied retrospectively to the inspection reports. At the time of undertaking these inspections, inspectors were not working to the detailed methodology around complaints handling that has since been rolled out, and may not therefore have reported on all aspects of complaints handling that they do now.

22. Just under 100 responses were received. Responses related to 54 adult social care providers and 35 providers of primary medical services. Inspectors of five NHS acute hospitals, one NHS ambulance trust and one independent hospital also provided responses. However, these have not been included in analysis due to the low numbers.

FIGURE 19: ADULT SOCIAL CARE INSPECTION REPORTS – COMPLAINTS HANDLING THEMES



CQC inspection reports

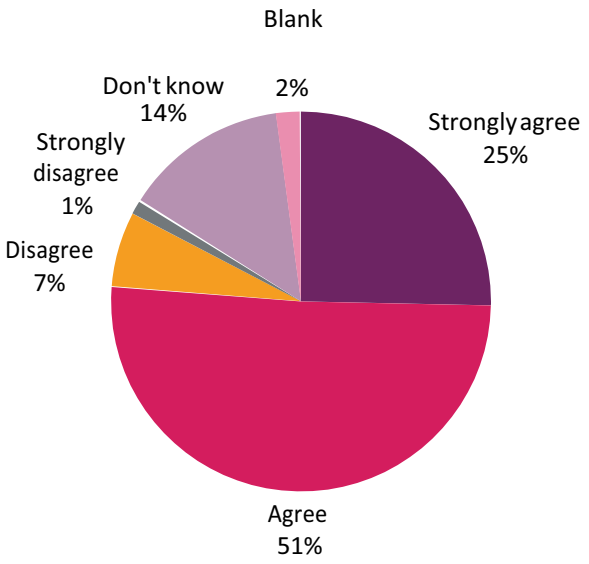
In a CQC survey, a large majority of people who use home care services (that were due to be inspected in quarter 2 of 2014/15) reported that they knew how to raise concerns. They were very positive about the actions of care agencies in response to any complaints made. More than 75% of those people said they knew how to make a complaint and over 70% said that care agencies and staff responded well to complaints or concerns raised **(TABLE 5 AND FIGURES 20-21)**.

TABLE 5: ADULT SOCIAL CARE SURVEY RESULTS 2014 – PEOPLE USING HOME CARE AGENCY SERVICES

	I know how to make a complaint about the care agency		The care agency and its staff respond well to any complaints or concerns I raise	
Strongly Agree	444	25%	444	25%
Agree	893	51%	818	47%
Disagree	112	6%	118	7%
Strongly Disagree	23	1%	34	2%
Don't know	244	14%	302	17%
blank	37	2%	37	2%
Total	**1753**		**1753**	

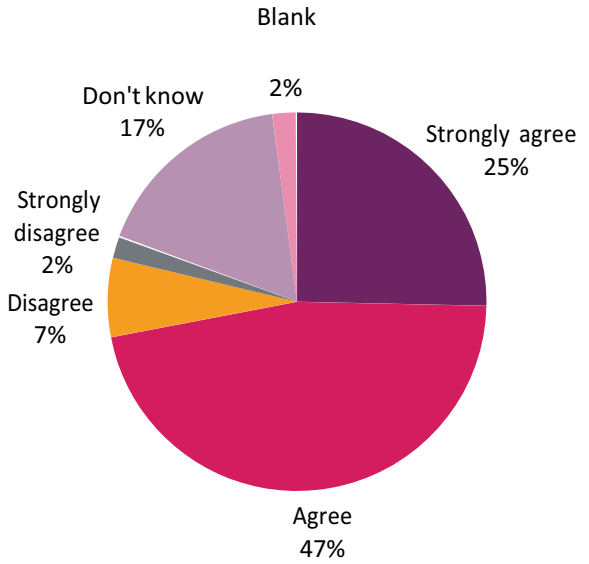
CQC survey of 133 home care agency services 2014

FIGURE 20: ADULT SOCIAL CARE SURVEY – "I KNOW HOW TO MAKE A COMPLAINT ABOUT THE CARE AGENCY"



CQC survey of 133 home care agency services 2014

FIGURE 21: ADULT SOCIAL CARE SURVEY – "THE CARE AGENCY AND ITS STAFF RESPOND WELL TO ANY COMPLAINTS OR CONCERNS I RAISE"



CQC survey of 133 home care agency services 2014

We analysed a sample of qualitative data from a number of sources that collect people's feedback, including CQC's own 'Share your experience' web form, between 2011 and 2014 **(FIGURE 22)**.[23]

Importantly, this type of feedback is less reliable for informing a true picture. A negative slant is likely because people are more likely to report bad experiences than acceptable or good care. As in acute and mental health services, feedback highlighted issues with the timeliness of investigations of complaints and responses. People felt that their concerns were not taken seriously or adequately addressed.

There are a number of potential interpretations of this data. The fact that a large number of adult social care and primary care providers did not report receiving any written complaints suggests that more could be done to encourage feedback and build a culture in which concerns are welcomed as opportunities to improve. The positive picture from our inspection reports and our user survey in adult social care may reflect the fact that in many locations we inspected, there were few complaints or none at all.

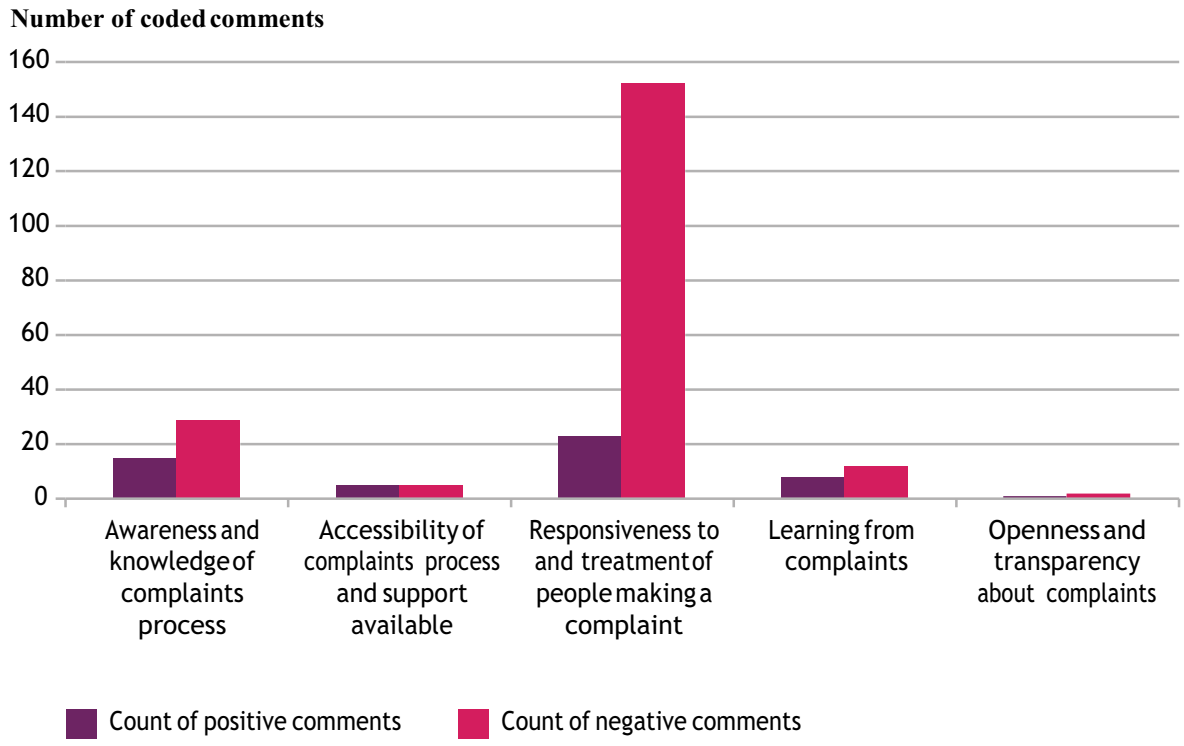
However, feedback from websites and other sources highlights that there are issues with the handling of complaints in these sectors. Combined with our survey that showed inspectors often had insufficient evidence to answer questions, we believe that the partial picture we are able to pull together is not accurately capturing how well providers encourage, listen to and respond to complaints and concerns in adult social care and primary care.

We believe that the more thorough methods of reviewing complaints handling that we are now rolling out will help inspectors to gain robust evidence of the state of complaints. We will continue to review inspection findings and refine our methods if necessary.

23. This data was categorised against the regulation relating to complaints handling in our outgoing ('old approach') regulatory framework. We reviewed 243 comments about adult social care and 25 comments about primary care. We only reviewed a sample of comments for adult social care. The total number of available comments for primary care organisations was low.

CQC understands that the next stage of reform to the HSCIC data collection will focus on improving response rates and quality of primary care returns, and will consider the extension of the collection to adult social care. Improving the data available in these sectors will be crucial to presenting a true picture of the state of complaints and we hope these reforms will be implemented as a priority.

FIGURE 22: ADULT SOCIAL CARE PROVIDERS - 'USER VOICE' FEEDBACK ON COMPLAINTS HANDLING



4. CONCLUSION

This report paints a partial picture of the state of complaints in health and social care services, but one in which some things are clear. There is wide variation in the way complaints are handled and much more could be done to encourage an open culture where concerns are welcomed and learned from. While most providers have complaints processes in place, people's experiences of the system are not consistently good.

This must change. Services should encourage and embrace complaints. They are valuable because every concern is an opportunity to improve. Making this cultural shift will require everyone involved in health and social care to stop seeing complaints as a negative. As long as we do, there is an incentive for services to be less open about seeking feedback.

CQC has a big role to play in supporting this change. We have set out what we expect from providers when it comes to encouraging, listening to and responding to complaints, and how we will look at this through our inspections. We have aligned our approach with the universal expectations of good complaints handling set out by the ombudsmen and Healthwatch England, to ensure that there is a single shared vision.

We will take action on services that do not take complaints seriously. From now on, all our inspection reports will include a description of how complaints and concerns are handled. We will recognise and celebrate good practice and set out where improvements need to be made.

As we hold providers to a higher standard, we know we need to deliver that same standard ourselves.

We are working to make it easier for people to share their experiences with us, to use that information effectively in our regulation, and to report back to people on what action we have taken. We know this should create a virtuous circle where more people share information with us, and our regulation becomes more effective.

We will continue to work with the Department of Health, the ombudsmen, patients' organisations, Healthwatch England and NHS England to make it easier for people to raise concerns. And we will continue to test and develop our inspection approach to complaints handling.

This report demonstrates why complaints matter – to people who use services, to organisations providing services and to CQC. Every concern is an opportunity to improve. Complaints may signal a problem, but this information can help save lives and learning from concerns will help improve the quality of care for other people.

How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

Please contact us if you would like a summary of this document in another language or format.

CQC-269-122014

Corporate member of Plain English Campaign
Committed to clearer communication
459