Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **16 December 2014 in Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL**

Membership:

Councillors Charles Curtis (Chair), Charlie Key (Vice-Chair), Mark Coxshall, Yash Gupta (MBE) and Terry Brookes, 1 UKIP Vacancy

Mike Hursthouse, HealthWatch
Ian Evans, Thurrock Coalition Representative

Substitutes:

Councillors Jan Baker, James Halden, Cathy Kent, Joycelyn Redsell and Sue Gray

Agenda

Open to Public and Press

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1	**Apologies for Absence**	
2	**Minutes**	**5 - 18**
	To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 2 September 2014 and note the minutes of the Meeting of the Chairs and Vice-Chairs of Overview and Scrutiny held on 27 October 2014	
3	**Urgent Items**	
	To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	
4	**Declarations of Interests**	

5	**Items raised by HealthWatch**	
	This item is reserved to discuss any issues raised by the HealthWatch co-opted member or designated representative.	
6	**Pharmaceutical Needs Assessment**	**19 - 174**
7	**Health and Social Care Transformation - Finalising the development of the Better Care Fund and establishing the Section 75 Agreement**	**175 - 272**
8	**Work Programme**	**273 - 274**

Queries regarding this Agenda or notification of apologies:

Please contact Matthew Boulter, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **8 December 2014**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

Does the business to be transacted at the meeting
- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated "Good" or better
- Raise levels of aspirations and attainment so that local residents can take advantage of job opportunities in the local area
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Provide the infrastructure to promote and sustain growth and prosperity
- Support local businesses and develop the skilled workforce they will require
- Work with communities to regenerate Thurrock's physical environment

3. Build pride, responsibility and respect to create safer communities

- Create safer welcoming communities who value diversity and respect cultural heritage
- Involve communities in shaping where they live and their quality of life
- Reduce crime, anti-social behaviour and safeguard the vulnerable

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being
- Empower communities to take responsibility for their own health and wellbeing

5. Protect and promote our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Ensure Thurrock's streets and parks and open spaces are clean and well maintained

Minutes of the meeting of the Health and Well-being Overview and Scrutiny Committee held on 2 September 2014 at 7.00pm

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Present:	Councillors Charlie Key (Chair), Yash Gupta, James Halden and Sue Gray. Kim James – HealthWatch Representative Neil Woodbridge – Thurrock Coalition Representative
Apologies:	Councillors Mark Coxshall, Maggie O'Keeffe-Ray and Charlie Curtis and Mr Ian Evans and Ms Joyce Sweeney
In attendance:	Councillor Barbara Rice – Portfolio Holder for Adult Health Services R. Harris – Director of Adults, Health and Commissioning H. Dhillon – Statutory Complaints and Engagement Officer C. Wilson – Service Manager - Commissioning M Boulter – Democratic Services Officer

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Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

10. Minutes

The Minutes of the Health and Well-being Overview and Scrutiny Committee, held on 29 July 2014, were approved as a correct record.

11. Declaration of Interests

Councillor Gupta declared a non-pecuniary interest in relation to Item 6 by virtue that he was a member of the Older People's Parliament and he had a daughter with learning disabilities who may be affected by the proposals.

Kim James declared an interest in relation to Item 6 by virtue that she was an officer of HealthWatch.

Neil Woodbridge declared an interest in relation to Item 6 by virtue that he was a member of Thurrock Diversity Network and Thurrock Lifestyle Solutions.

12. Items Raised by HealthWatch

It was stated that most issues at present related to the issues in Item 6 so comment would be reserved for that item.

13. Adult Social Care Complaints and Representations Annual Report 2013/14

The Committee learnt that the Council had a statutory complaints procedure and that this produced an annual report each year which was before members. 351 representations were made to the department in the last year, 57% of which were compliments. Complaints numbered at 57 and represented a 24% reduction in complaints from the year before. Compliments were rising each year. These trends were in part due to the Council commissioning more services, therefore, the care services would now be receiving their own compliments and complaints. It was also felt that the council was good at dealing with issues before they became complaints. Officers highlighted one ombudsman investigation that was upheld and attached at appendix 1.

The Committee commended the performance but queried whether compliments and complaints could be dealt with in different ways so as to affect the levels reported. Officers clarified that all compliments were simply not just someone saying 'thank you' but concerted communication by users to let the department know they were pleased with services. Likewise, complaints were separate and distinct from 'member enquiries' and 'concerns'. Officers also clarified that one person complaining on the same issue, depending on the timescale involved, would be considered as one complaint.

Through the discussion it was found that complaints that were upheld were simply not the most serious although it was noted that complaints within this department were often complex and required detailed investigation. The absence of comparative data from other councils was explained by the fact that the other councils Thurrock liaised with had not produced their performance reports to the same timescales. This was being rectified for next year.

The Thurrock Coalition representative highlighted the future need for vulnerable people to be able to complain or compliment on services and officers responded that an advocacy service would remain in place to allow this. The representative of HealthWatch added that they were able to assist people and requested the council put the organisation's details on all documents.

RESOLVED that the report be noted.

14. Budget Reductions: Voluntary Sector Contracts, Learning Disability Development Fund, HealthWatch and Homeless Early Intervention

Officers highlighted they would be speaking with each organisation individually on the budget proposals. Twoof the organisations mentioned had been funded by the Learning Disability Development Fund which had ceased two or three years ago. Most other councils had ceased funding at that point although Thurrock had continued to fund from their own resources. In the present situation, it seemed Thurrock should also cease this support.

Following a question officers stated that it was very difficult to differentiate between non-statutory and statutory duties within some of these organisations but by and large the organisations affected had been assessed as providing a non-statutory service. It was added that legislation did not prescribe the amount or level of statutory service so the volume of statutory service was also being reassessed.

Councillor Gupta stated that non-statutory services played an important role within the community and that these services had not received any feedback from the Council as to the criteria used to decide which organisations were affected. Councillor Rice replied that budget decisions had to be made and that if these services were not affected others would. She asked the Committee to comment on the mitigation factors within the report.

Thurrock Coalition raised the issue that all the organisations were interdependent so the failure of one group to pay rent at the Beehive, for example, could jeopardise the wider sector. The representative added that budget reductions would be more manageable if they were 20% rather than 100% to each organisation. Officers stated that a certain level of saving had to be made within this sector but the way in which that was made was still open to debate. There was a possibility of bridging loans and all support necessary would be provided by the Council to ensure organisations accessed new funding or other arrangements.

The Committee began to comment on the mitigation section of each proposal and the following was noted:

- Kim James of HealthWatch stated that the mitigation for BATIAS which proposed the engagement of the Community Safety Partnership (CSP) would also be in jeopardy because the CSP was also facing cuts. Likewise the use of volunteers would not wholly replace the skills and expertise of staff.
- Councillor Halden felt HealthWatch was in need of greater support as it could prevent additional costs on the department through its work. Likewise, the reduction for Age Concern seemed to have a disproportionately negative effect. He felt that other organisations listed did not have a direct effect on the health of residents and could legitimately be reduced. He queried whether organisations offering similar services could be merged or work in collaboration and officers responded that this was being considered at present.
- Councillor Gray was concerned that volunteers would not be able to provide a consistent and reliable service in comparison to a funded professional body of workers.
- Councillor Key also highlighted the need for the HealthWatch mitigation to be more robust before Cabinet made a final decision on its funding future.

RESOLVED: That:

i) **The committee note the impact assessments and proposed savings.**

ii) **The comments made above are taken into consideration by Cabinet and any other future meetings on this topic.**

15. The Care Act – Proposed Changes and the Council's State of Readiness

The Committee was taken through a presentation which gave an overview of the Care Act, which was the most significant legislation on adult care in Britain and bounded different parts of care legislation together into one Act. The Care Act arose from the Law Commission enquiry in 2010 and the Dilnott Enquiry in 2012 and promoted well-being of those in need of care but also of carers. It enshrined the right of every person to have a personal budget in relation to care.

One of the key features of the new Act was that people were only required to pay £75,000 towards their care. Once this limit was reached, the care would be state funded. This cap did not include accommodation costs. In addition people would not be required to sell their homes but could defer payments until after they had passed away. There were currently 70 to 80 self funders in Thurrock and therefore the budget pressures introduced by the cap would not cause as great a problem to the Council as other parts of the country.

Other features of the Act included the Council having to outsource more services but maintain the ultimate duty of care. The advocacy service would be reviewed and expanded and the Adult Safeguarding Board would be made statutory. The Council was already working with partners to implement the better care fund and review the transition arrangements from children's to adults care.

Councillor Halden felt that the more widespread use of telecare would keep costs down and provide a responsive service. Officers agreed that this would be desirable and they were working on using telecare where possible.

The Council was expecting to receive two tranches of funding from central government for the new Act. The first would be April 2015 and the second in April 2016. However, no funding provision had been made within our Medium Term Financial Strategy, it was expected that all the extra costs would be met by central government.

RESOLVED that the report be noted and that the readiness of the Council to implement the Care Act's requirements and the steps being taken to ensure compliance by April 2015 and April 2016 is also noted.

16. Work Programme

RESOLVED that a report on GP coverage in Thurrock be added to an appropriate meeting.

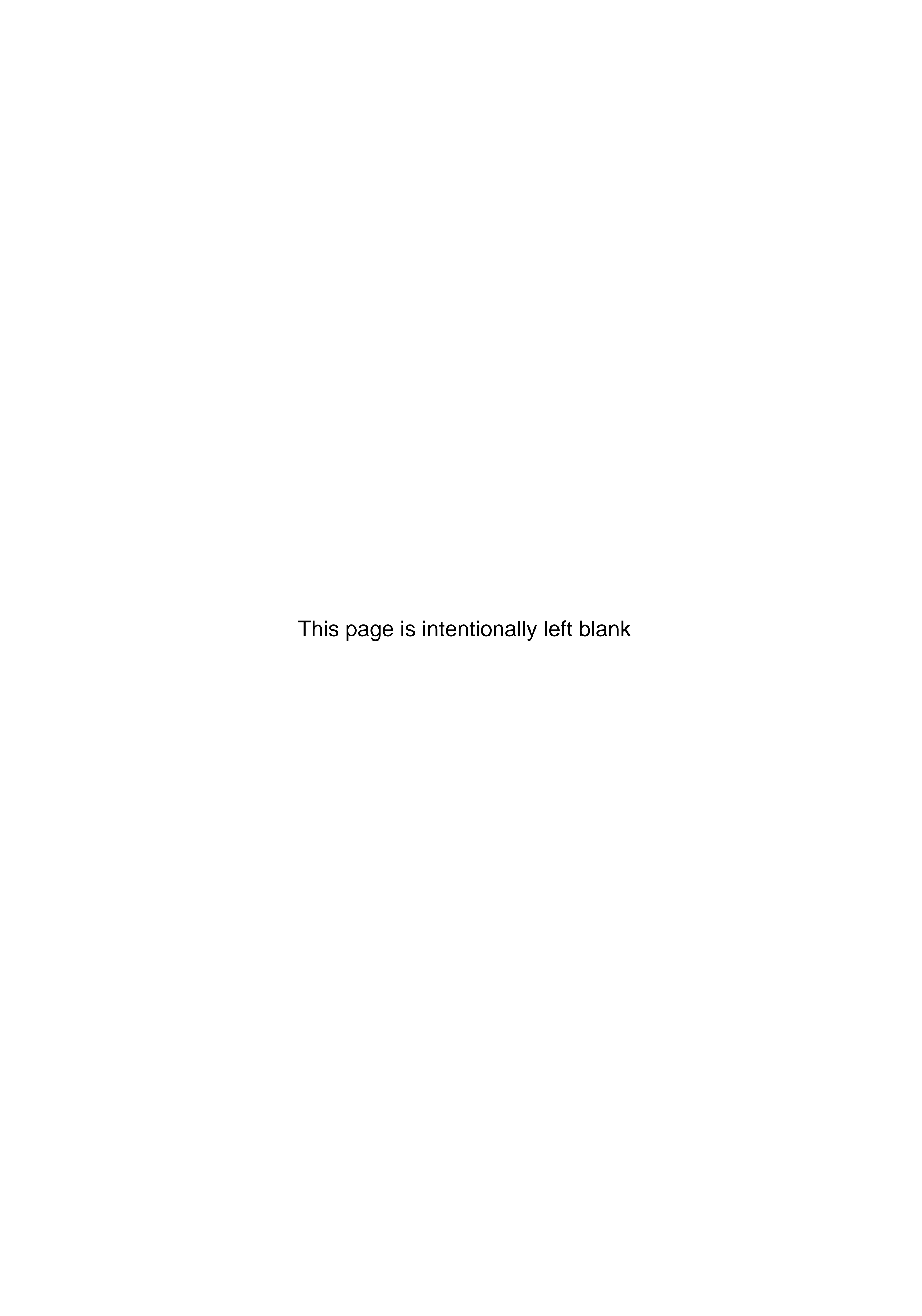
The meeting finished at 8.56pm.

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk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Minutes of the meeting of the Chairs and Vice-Chairs of Overview and Scrutiny Committees held on 27 October 2014 at 5.00pm

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Present: Councillors Shane Hebb (Chair), Charlie Curtis, Sue Gray, Yash Gupta, Barry Johnson, Cathy Kent, James Halden, Val Morris-Cook, Charlie Key, Pauline Tolson and Gerard Rice

Mr Neville Baldwin – Chair of CVS

Apologies: Councillor Tom Kelly

In attendance: Councillor John Kent – Leader of the Council
Councillor Richard Speight – Portfolio Holder for Communities
Councillor Andrew Roast – Shadow Portfolio Holder
Councillor Tony Fish – Portfolio Holder for Environment
Councillor Phil Smith – Portfolio Holder for Public Protection
Ms Kristina Jackson –Chief Executive – CVS
Mr Neil Woodbridge – Representative for TransVol
Ms Kim James – Representative of HealthWatch
Mr Mike Rawlings – Representative of the Citizen's Advice Bureau
Steve Cox –Assistant Chief Executive
Roger Harris – Director of Adults, Health and Commissioning
Carmel Littleton – Director of Children's Services
Barbara Brownlee – Director of Housing
David Bull – Director of Planning and Transportation
Sean Clark – Head of Corporate Finance
Natalie Warren – Community Development and Equalities Manager
Matthew Boulter – Principal Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

The Chair also highlighted that he had been elected before the meeting by the chairs and vice-chairs present.

1. Declarations of Interest

Councillor Gupta declared a non-pecuniary interest by virtue that he was the trustee on several organisations discussed in the reports.

Councillor Speight declared a non-pecuniary interest by virtue that he was a board member of the Arts Council, Citizen's Advice Bureau and TRUST.

2. The Impact of Saving Proposals on Thurrock's Voluntary Sector – The Council Perspective

The Portfolio Holder for Communities introduced the report stating that he would not go into detail as this meeting was an opportunity for the voluntary sector to put their views across. He did highlight, however, that the council was required to make £37 million worth of savings and although the voluntary sector did a great deal to support the Council's work and Thurrock's community in general, the savings had to be made in some form. The Councillor welcomed the alternative savings proposals mentioned in the report of the voluntary sector and stated that these could be looked into to check their viability, however, he stressed that should money not be saved within the voluntary sector, it would have to be found in other areas of the council. He offered to meet with any voluntary organisation that wished to meet him.

It was clarified that the savings proposed were spread over the next couple of financial years and some savings were scheduled to happen very soon while others were for next municipal year.

Mr Baldwin highlighted that resilience was the key issue for the voluntary sector. He stated that the change in funding was inevitable but the way in which the savings were distributed and applied could be changed to allow voluntary organisations to continue to operate in the interim. Mr Baldwin suggested a three year financial strategy needed to be put in place.

The Chair asked for clarification around the communication of the reduction of funding. He understood that the Comprehensive Spending Review in 2010 flagged up the need to review the funding of the voluntary sector in Thurrock. It was agreed that the some parts of the voluntary sector had been aware of the issues around funding since 2010 but not all.

3. The Impact of Saving Proposals on Thurrock's Voluntary Sector – The Voluntary Sector Perspective

Kristina Jackson, Chief Executive of the CVS, was invited to speak. It was stated that a revised report had been produced and was circulated. After setting out the nature of the voluntary sector in Thurrock she highlighted that the sector supported the council in many ways and prevented a much larger demand on the Council's statutory services. Some organisations were also able to bring in funding from other bodies to provide valuable community work. Ms Jackson stated that this joint meeting was required because the sector wanted joined up thinking across the overview and scrutiny committees about what impact the savings would have across all departments.

A number of issues were mentioned within the presentation, namely:

- There had been little communication with the sector relating to the savings proposals. Most organisations only heard about the savings

when they were presented at Cabinet or the Overview and Scrutiny committees.
- Most organisations did not have dialogue with the Council on the savings until September or as late as last week.
- 81% of the savings impact upon local organisations whereas only 19% impact national organisations.
- At Health and Well-being Overview and Scrutiny Committee, Members had requested a breakdown of data in relation to the 10% across the board savings proposal; this had yet to be provided. Although this saving had been removed, it was still important for the sector to know the detail in case it was proposed in future.
- The Community Safety Partnership (CSP) had also been suggested at the Health and Well-being Overview and Scrutiny Committee as a mitigating factor whereby the CSP could pick up the workload of certain other organisations when their funding was reduced. However, the CSP was also facing a saving which questioned its ability to take on more work.

Ms Jackson stated that the sector had brought in £7 million additional funding and with changes to the way the Big Lottery was awarding grants in the future would mean that the organisations would now be competing with the Council and each other for resources. It was felt that the sector needed the input of a professional bid writer to help it compete.

Short term impacts of the savings included:

- 69 staff would be made redundant
- At least 5 organisations would cease to exist.
- 48,871 citizens with protected characteristics would be effected
- 4,500 volunteering opportunities lost
- Loss of independent voice
- Loss of signposting and informal advice
- Loss of income levered into Thurrock
- Loss of Citizen’s Advice Bureau would impact on other organisations including BLF which supports Batias, Open Door, TCIL and DIAL

Mr Neil Woodbridge was invited to speak on behalf of Trans Vol. He outlined that Trans Vol had been operating for many years, before the Council had become a unitary authority and had recently celebrated its millionth journey. Many of the users of Trans Vol were not using social services and therefore Trans Vol was providing a service that reduced the demand on social services at the Council. Mr Woodbridge highlighted that Trans Vol was unable to attract new funding or business because it had been subject to cuts (70% in the last few years) and also that their accounts were never verified. Trans Vol had reduced costs by 54% and had increased income, writing to the Council to outline what services it could provide for various budget envelopes, £50,000, £100,000 and so on. The council response had been to suggest a 100% reduction in funding. Mr Woodbridge summarised by saying that although Trans Vol was a charity, it wanted to do business and if it ceased, Thurrock would be the only council in the country without a dial-a-ride service.

Mr Mike Rawlings of the Citizen's Advice Bureau (CAB) was invited to speak. He highlighted the thirty five page handout that the Members had a copy of. The CAB had started in 1975 and it fulfilled an important role of providing support services for the community without calling upon statutory services. He stressed that the saving should not simply be seen as a reduction in funding but a decision that had a large social impact. The CAB saved the council considerable amounts of money and the help the CAB gave to people facing homelessness over some three hundred cases saved tens of thousands of pounds for the council. The CAB also brought in other funding, such as Legal Aid, and provided a great opportunity for people to volunteer and compete in the job market.

Ms Jackson went on to highlight some of the possible long term impacts of the savings proposals, which included:

- Increase in hate crime as people look for scapegoats.
- Rise in unemployment – fewer people work ready as less volunteering opportunities
- Lower educational attainment as families prioritising on surviving
- Drain on educated as they seek work outside of Thurrock
- Mental health worsens – fewer employable, drug and alcohol use increase
- Increase in hospital admissions and GP waiting times as demand increases
- Rise in household debt leading to non payment of council tax and rents
- Mortgage and rent arrears – more evictions leading to increase of homelessness
- Council expends income on legal costs taking families to court for non payments of council tax and evictions
- Number of children taken into care increases, causing huge financial burden on the council – as families are no longer able to cope
- A high proportion of current looked after children are placed in care homes as foster placements break down. Very expensive solution
- Fewer foster carers available as they feel they are less supported
- Increase in number of sexual violence and domestic violence incidents as families become under increasing pressures
- Increase in begging as families are no longer able to feed themselves
- Suicide and alcoholism increases as people feel alone and hopeless
- MASH – some partners of the multi agency safeguarding hub will no longer exist
- Social isolation as people are unable to get out of their own homes

Ms Jackson continued by saying that there were suggestions for a way forward and a revised budget was presented that spread the savings differently across the sector. There were also further suggestions including:

- Opportunities from Introduction of the Care Act 2014 and Universal Credit.

- Explore feasibility of transferring council services out to community or sector ownership
- 3 year detailed financial planning involving partners to co-produce
- Utilising Section 106 monies to support voluntary sector
- Using CIL monies to support voluntary sector

Councillor Rice asked whether the proposal to save 10% on council consultancy fees could be achieved. Officers responded that much of this budget was already being taken as savings as part of the restructure of departments. The consultancy budget included agency staff who, in terms of the Finance Department, would be removed with the restructure. Therefore, it was unlikely this proposal could be taken forward in the spirit the voluntary sector wished.

The Group discussed opportunities available through the Care Act for funding and it was confirmed that there would be funding available for services such as advocacy in April 2015. However, the Council's allocation would only be confirmed in December and following that the Council would be looking to commission further services.

Council Morris-Cook asked the sector whether they were able to account for all the money they had spent and demonstrate that it provided not only value for money but also provided greater funding through other sources. It was responded that most of the organisations in the sector returned a 4 to 1 ratio for their funding as a minimum. It was highlighted that some organisations wanted to be seen as a business and wanted a contract rather than a grant from the Council.

A brief debate was had on why the CAB was separately funded from the rest of the CVS and it was found that this was a historical decision dating back to Thurrock becoming a unitary when it was decided to protect the CAB from future savings that might affect the newly formed voluntary sector.

4. Debate

The Group felt that the opportunity for the sector to take on council services should be explored, although they noted at the Leader's request that by doing this, the sector was not offering alternative savings but offering a vision of how they could operate in the future, which was welcome. The Group recognised that for the chance for voluntary organisations to take on these services in the future, they would need to survive the current savings proposals. The Leader suggested that money could be found from a reserve to offer support in the interim period. There were a number of reserves available to the council and although each was governed by financial rules on use, it was stated funds would be sought.

Councillor Morris-Cook asked whether the sector could not join forces to offer similar services and joint apply for money. She felt there was funding out there for organisations to apply for.

The Group discussed resilience of the sector and Mr Baldwin stated that a three year plan needed to be put in place to manage the course of the sector. Everyone agreed that the suggestions put forward and discussed would not remove the need to make hard budget decisions. It was highlighted that with the current proposal there was a risk of losing 50% of the Beehive occupants. The Chair added that he wondered how the Compact could better work to allow the Council and the voluntary sector to have a more current and informed relationship.

The Leader of the Council apologised for the lack of communications that the sector felt had happened over the budget proposals and stated that the Council was looking to employ a professional bid writer and that section 106 monies and CIL funds could be investigated to see if money could be taken from them for voluntary sector and community projects. However, he added that he would not be able to promise a three year budget for the sector as there were too many unknown budget factors.

Councillor Halden felt the Council needed to quantify savings much more so that Members could understand where value for money was being added by services and organisations.

A brief discussion was had on Trans Vol where it was made clear the Council had offered the organisation £50,000 for next year and had requested the organisation to demonstrate a business plan. The organisation had therefore had fifteen months notice of budget decisions. Mr Woodbridge welcomed the offer of the money but added that this was a short term resolution and a longer term solution was needed.

It was agreed that the sector had a good relationship with Members but the decisions and discussions did not always trickle down in both the Council and the voluntary sector. It was also agreed that the actions from tonight's meeting needed to be resolved before Christmas.

RESOLVED: that:

- **i) The Group note the comments made by the Leader of the Council relating to Section 106 monies, the recruitment of a professional bid writer and the temporary use of reserves to provide interim support to the sector in time of transition.**

- **ii) The alternative budget proposal supplied by the voluntary sector be reviewed and studied to ascertain its viability.**

- **iii) Officers and portfolio holders review the proposals for outsourcing council services to the voluntary sector.**

- **iv) The Voluntary Sector provide plans on how they could work together to provide joined up services in the future.**

- **v) The current voluntary sector model in Thurrock be reviewed.**

vi) Savings proposals be qualified in future so Members can understand the value of savings in terms of value for money.

The meeting finished at 6.50pm.

Approved as a true and correct record

CHAIR

DATE

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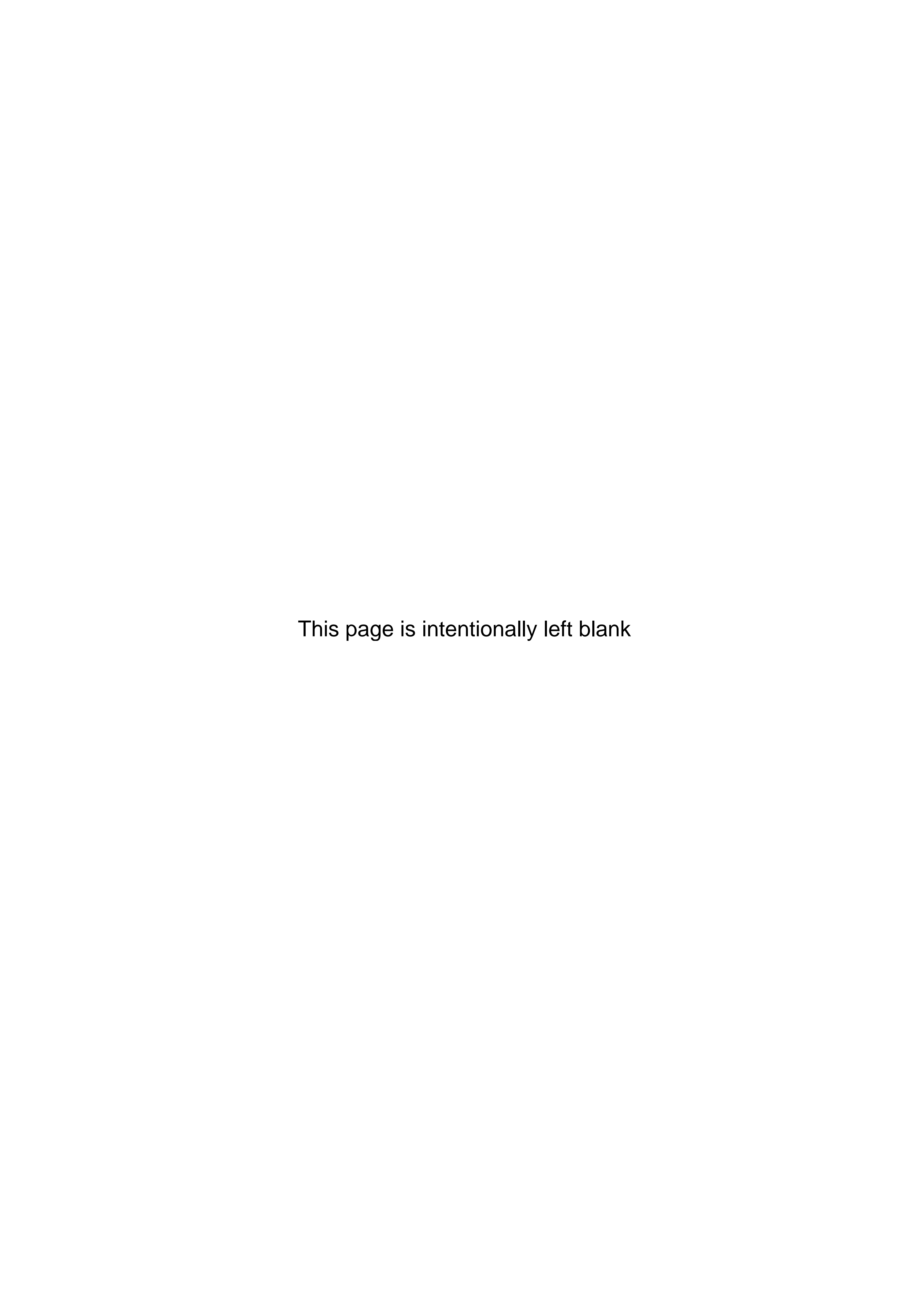
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16 December 2014	ITEM: 6
Health & Wellbeing Overview and Scrutiny Committee	
Pharmaceutical Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Debbie Maynard, Head of Public Health	
Accountable Head of Service: As above	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

From 1st April 2013, Health and Wellbeing Boards have assumed the responsibility for the development and publication of local pharmaceutical needs assessments (PNAs), formerly published by primary care trusts.

The PNA provides a full, ongoing assessment of the local need for pharmaceutical services, which is different to identifying general health need.

NHS England will use the PNA when deciding if new pharmacies or dispensing appliance contractor premises are needed, and to also make decisions on which NHS funded services need to be provided by local community pharmacies. Local authorities and Clinical Commissioning Groups will also use the PNA to inform their commissioning decisions.

The legislation states that the PNA must be published by **1st April 2015,** and fully revised every three years to ensure it remains accurate.

1. Recommendation(s)

1.1 The Health & Wellbeing Overview and Scrutiny Committee is asked to note the contents of the report;

2. Introduction and Background

2.1 The Health and Social Care Act 2012 transferred the statutory responsibility for the development and updating of Pharmaceutical Needs Assessment's (PNAs) from Primary Care Trusts to Health and Wellbeing Boards, with effect

from 1st April 2013. The PNA is a document that provides a full and on-going assessment of the need for pharmaceutical services within a specific area. The PNA tells us what pharmaceutical services are currently available and where we are likely to need changes in the future because of demographic or other factors. If someone wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list and must prove they are able to meet a pharmaceutical need.

2.2 NHS England (the national body responsible for commissioning pharmaceutical services) relies on PNAs to inform decision making, specifically regarding whether existing pharmaceutical services meet local need. The PNA is also used by NHS England to assess applications from applicants who want to deliver pharmaceutical services within the borough.

The Thurrock Health and Wellbeing Board is required (under the NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013) to:

- Produce a PNA by 1st April 2015
- Publish a revised PNA within three years of publication of their first Assessment
- Publish a revised PNA as soon as is reasonably practical, if any significant changes to the availability of pharmaceutical services are identified, unless the Health and Wellbeing Board is satisfied that making a revised assessment would be a disproportionate response

2.3 The Thurrock Health and Wellbeing Board delegated executive authority to the Director of Public Health (DPH), to oversee the development of a new PNA for Thurrock. The DPH ensured a steering group with appropriate terms of reference and governance arrangements was established. The steering group comprised representation from all key representative organisations as required by the regulations.

3. Update on the process of the development of the Thurrock PNA

3.1 The Council undertook a public consultation exercise with citizens during the months of May and June 2014. This exercise enabled the needs of local people (in terms of pharmaceutical services) to be identified. Following the public consultation the draft PNA was reviewed by the PNA steering group and amended.

3.2 The PNA was issued to stakeholders on the 23 July 2014 for a 60 day consultation period (as required by regulations). This statutory consultation period ended on the 22 September 2014. All responses have been assessed and pertinent issues relating to local pharmaceutical services noted and amended within the final version of the PNA.

4. Reasons for Recommendation

4.1 That the Overview and Scrutiny committee supports the management of the new Pharmaceutical Needs Assessment. The Steering Group will be responsible for supplying regular update reports to the Health and Wellbeing Board on a quarterly basis.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 There is a statutory 60 day consultation required as part of the process for producing a PNA.

6. Impact on corporate policies, priorities, performance and community impact

6.1 Contribution to Council's Vision and Corporate Priorities
Pharmacies are an important part of the healthcare system and play a further role in meeting the health needs of the population by improving public health in a number of areas such as smoking, cardiovascular disease, sexual health and substance misuse.

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**
Management Accountant

The cost of the development of the Thurrock PNA has been met from the public health budget. Any future amendments or revisions of the PNA will also be met by the public health ring-fenced grant and included in future commissioning intentions

There are no financial decisions that relate to this report. Decisions arising from recommendations by the Director of Public Health that may have a future financial impact for the Council would be subject to the full consideration of the Cabinet before implementation.

7.2 **Legal**

Implications verified by: **Dawn Pelle**
Legal Officer

There is potential for legal challenges associated with the PNA. These include Direct challenge to the Council for failure to meet duties by those consulted on a draft of the PNA, or contractors who believe they are affected by what the

PNA does or does not say. In any event the report and timescales comply with the statutory provisions laid down in s.128A National Health Service Act 2006 and the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**
Community Development and Equalities Manager

Equality and diversity issues have been reviewed following the public consultation and will be taken account of in the publication of the final PNA.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

Failure to deliver a pharmaceutical needs assessment by 1st April 2015 would put the Council in breach of Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Department of Health: Pharmaceutical Needs Assessments. Information Pack for Health and Wellbeing Boards

9. Appendices to the report

- Pharmaceutical Needs Assessment

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Thurrock Council

Pharmaceutical Needs Assessment

November 2014

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The Thurrock Health and Wellbeing Board would like to acknowledge the contributions made by the PNA Steering Group, the local Pharmaceutical Committee, Community Pharmacies, Dispensing Practices, Stakeholders and residents of the borough for their input in the development and consultation of this Pharmaceutical Needs Assessment.

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Executive Summary

As from 1st April 2013 every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up to date a statement of the need for pharmaceutical services in its area otherwise referred to as a pharmaceutical needs assessment (PNA).
The PNA is a key document that will be utilised in the development and improvement of pharmaceutical services in Thurrock. NHS England who are responsible for commissioning pharmaceutical services are also expected to make reference to the PNA when making decisions about market entry for new service providers as well as in commissioning advanced and enhanced services. It is essential that PNAs are of high standard and robust enough to withstand legal challenges that could occur due to the PNA's relevance to decisions about commissioning services and new entries on the Pharmaceutical List. Reference to the PNA will also be made to matters concerning pharmacy relocations and changes to opening hours.

Process

The main aim of the Thurrock PNA is to describe the current pharmaceutical services in Thurrock, systematically identify any gaps/unmet needs and in consultation with stakeholders make recommendations on future development.

To oversee the process, a PNA Steering Group was formed in December 2013 membership of the group is included in the acknowledgment section above. The Head of Public Health with the Needs Assessment Manager in Thurrock council secured a project manager to complete this document.

A sixty day public consultation of the PNA document was undertaken between 23 July 2014 and 22 September 2014 where views from the public and other stakeholders were considered by the PNA Steering Group and incorporated into the PNA where appropriate. These comments are summarised in the appendix and were utilised when completing the final document to be published once approved by the Health and Wellbeing Board in November 2014.
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Key findings & recommendations

Thurrock is located in the south of Essex and lies to the east of London on the north bank of the River Thames with an area of 165 square kilometres. It has a diverse and growing population with a population density of 976 persons per square kilometre. The borough is comprised of 20 wards, with areas in the central and eastern parts that are most affluent and have the healthiest residents in the borough.

The population of Thurrock as of June 2013 was 160,859 this is an increase of 1,316 people since the previous year, representing a percentage rise of 0.8%. This increase is consistent with recent trends and is mainly due to the difference between births and deaths. There were 2,352 births and 1,139 deaths. A total of 6,426 residents moved into the borough from other parts of England and Wales and 6,464 moved out. A total of 713 people moved into the borough from areas outside England and Wales and 588 moved out. The most significant increases are in the 5-9 year age band at 5.7%; the 65-69 year age group at 6.8%; and the over 90s age group at 5.2%.

Thurrock has 35 community pharmacists and has more pharmacies per 100,000 than similar boroughs, East of England and England. As such it is well resourced with regards to pharmaceutical services. Distribution of pharmacies within Thurrock vary between localities, the Western locality has the most pharmacies (12/35), followed by the Central locality (10/35 pharmacies), the Southern locality (7/35 pharmacies) and the Eastern locality (6/35 pharmacies). There is a good correlation between deprivation and the number of pharmacies by locality; there is a good spread of pharmacies that span over the two mile boundary in most of Thurrock that residents have a good choice of pharmacies to access. Apart from the eastern locality residents from Corringham and Fobbing ward and the central and northern part of Orsett may need to travel more than two miles to access their nearest pharmacy within Thurrock.

The PNA noted that with regards to North Orsett, there is lower demand of pharmaceutical services, as the land is green belt and therefore has a low population density. In the eastern part of the borough, there is a higher density of people aged over 75yrs and 85yrs who are more likely to have mobility problems and therefore find accessing pharmacies more challenging than the general population. It is likely; however, that these residents are able to access pharmacies in their neighbouring boroughs within this distance, and particularly in south Benfleet and Canvey Island This is an area for further work.

There are no contractual obligations for pharmacies to open during Bank/other holidays but many do so, based on a business decision. NHS England commission Bank holiday rota hours when these are considered necessary.

Not all pharmacies are accessible to wheelchair users. Pharmacies are required, where possible to make reasonable adjustments to ensure patients and customers with a disability are able to access services. More information needs to be collected to determine the provisions in place within each pharmacy that enables those who are disabled to access pharmaceutical services.

We need to ensure that pharmacies are able to effectively communicate with all Black Asian and Ethnic Minority (BAME) groups as we know that there is a correlation between health inequalities and diversity within the population. With our growing BAME populations we need to work with pharmacies to agree how to engage wider with these groups.

Pharmaceutical service providers have the potential to play a greater role in identifying and helping to address health issues as they are based at the heart of communities including rural and deprived areas and have daily interactions with local populations. Evidence from the Healthy Living Pharmacy initiative, implemented in 2010, shows that community pharmacies can make a significant impact in improving the health and wellbeing of local communities.

We would like to see a larger number of accredited pharmacies in Thurrock actively providing enhanced services to serve the local population.

There is currently scope and capacity within the existing pharmacy and primary care networks to target additional patients who would benefit from Medicine Use Reviews and Prescription Interventions.

Thurrock currently has 35 community pharmacies, including two distance selling pharmacies and five pharmacies that are required to open for 100 hours per week. There are currently no dispensing appliance contractor's in Thurrock, but these services can be accessed outside the borough. There are two doctors providing dispensing services in Thurrock and currently no Local Pharmaceutical Service contracts in place in Thurrock. The HWB will need to consider whether residents have reasonable access and choice with regards to dispensing appliances by pharmacies this includes pharmacies that are required to open for 100 hours per week. There are currently no dispensing appliance contractor's in Thurrock. There are two doctors providing dispensing services in Thurrock and currently no Local Pharmaceutical Service contracts in place in Thurrock. The HWB will need to consider whether residents have reasonable access and choice with regards to dispensing appliances by pharmacies and dispensing contractors (that can be accessed outside of Thurrock).

We hope that our Pharmaceutical service providers will play a greater role in providing a range of clinical and public health services that will deliver improved health and be of consistently high quality to include the management of long term conditions, new approaches to urgent and emergency care, providing services that will contribute more to out of hospital care and supporting the delivery of improved efficiencies across a range of services.

1. Introduction

From April 2013, every Health and Wellbeing Board (HWB) in England has the statutory responsibility[1] to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA).

The Provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing contractor (DAC) or dispensing doctor (rural areas only) who wishes to provide pharmaceutical service must apply to be on the Pharmaceutical List. It is the responsibility of NHS England for considering applications and maintaining the Pharmaceutical List.

The PNA will contribute to commissioning pharmaceutical services with regards to the context of local priorities. It will therefore be used by NHS England to make market entry decisions regarding the Pharmaceutical List as well as commissioning services from local community pharmacies. It is important that HWBs develop robust PNAs as this could lead to legal challenges based on the PNA's relevance around decisions about commissioned services and new pharmacies opening.

A PNA is a comprehensive assessment to identify unmet service needs within a population. The information is an effective tool for commissioners, Local Authority, the Clinical Commissioning Group (CCG), Public Health England and NHS England to identify current and future commissioning of services from pharmaceutical service providers. The Department of Health (DH) has published an information pack to support local authorities and HWBs to interpret and implement PNAs.[2]

This PNA has been produced by Thurrock Council's Health and Wellbeing Board (HWB), in accordance with the National Health Service (Pharmaceutical Services and Local Services) Regulations 2013 (SI 2013 No. 349). This document supersedes the NHS South West Essex PNA, January 2011.

1.1 Legislative background

1.1.1 Duty of the Health and Wellbeing Board

- **Publish and maintain the PNA**
  HWBs must have published a PNA by 1st April 2015. The PNA will have a maximum lifetime of three years.

- **Maintain and keep the PNA up to date**
  In response to changes in the availability of pharmaceutical services, HWBs are required to determine whether there is a need to revise the PNA or, where this is considered to be a disproportionate response, to issue and keep up to date supplementary statements describing the changes in pharmaceutical services.

- **Respond to a consultation by a neighbouring HWB**
  HWB have a further responsibility to respond to a draft PNA when consulted by a neighbouring HWB. The HWB must consult with the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) for the area (unless the LPC and LMC service both areas) before making its own response to the consultation.

1.1.2 Minimum Requirements of inclusion for the PNA

Schedule 1 of the Regulations sets out the minimum information that must be included in the PNA, these are:

- Necessary services that meet the need for pharmaceutical services in its area. This should include current provision (within the HWB area and outside the area) as well as any current or future gaps in provision.
- Relevant services that are not necessary to meet the need for services in its area, nevertheless have secured improvements, or better access to pharmaceutical services. This should include current provision (within the HWB area and outside the area) as well as any current or future gaps in provision.
- Other NHS Services provided or arranged by the Local Authority, HWB, Public Health England, NHS England, a CCG, an NHS Trust or Foundation Trust that affects the current or future needs for pharmaceutical services, or would secure improvement, or better access to current of future pharmaceutical services within its area or that have unforeseen benefits.
- A map identifying the premises at which pharmaceutical series are provide in the area of the HWB. The regulations specify the keeping up to date of this map, in so far as is practicable.
- An explanation of how the assessment is carried out including:
  - How localities were determined.
  - How different needs of different localities have been taken into account.
  - How the needs of different groups who are a similar protected characteristic (defined in the Equality Act 2010) has been considered.
- A report on the consultation undertaken.

1.1.3 Consultation Requirements

HWB are required to undertake a consultation for a minimum period of 60 days. The regulation sets out that the following bodies within each HWB must be consulted at least once:

- Any Local Pharmaceutical Committee.
- Any Local Medical Committee.
- Any persons on the pharmaceutical lists and any dispensing doctors list.
- Any LPS chemist with whom the NHS England has made arrangements for the provision of any local pharmaceutical services.
- Any local Healthwatch organisation and other patient, consumer or community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services.
- Any NHS trust or NHS foundation trust.

- The NHS England and
- Any neighbouring HWB.

1.1.4 Matters for Consideration when making Assessments

Regulation 9 sets out the following matters HWBs must have regards to when developing their PNAs as far as practicable to do so:

- The demography of its area, as set out in the Joint Strategic Needs Assessment (JSNA).
- Whether there is sufficient choice with regards to obtaining pharmaceutical services
- Any differing needs of different localities in its area.
- The pharmaceutical services provided in neighbouring HWB which affect the need for pharmaceutical services in its area, or whether further provision of pharmaceutical services would secure improvements, or better access to pharmaceutical services within the area.
- Other NHS services provided in or outside the area that affect the need for pharmaceutical services, or whether further provision of pharmaceutical services would secure improvements, or better access to pharmaceutical services within the area; and
- Likely future pharmaceutical needs.

2. Scope

2.1 Process followed for developing the PNA

This PNA was developed using the following regulations:

- National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) (Amendment) Regulations 2013.
- Pharmaceutical Needs Assessment, Information Pack for Local Authority Health and Wellbeing Boards.

A PNA is defined in the regulations as:
"The statement of the needs for pharmaceutical services which each HWB is required to publish by virtue of section 128A of the 2006 Act(1) (pharmaceutical needs assessments), whether it is the statement of its first assessment or of any revised assessment, is referred to in these Regulations as a "pharmaceutical needs assessment".

The pharmaceutical service to which each pharmaceutical needs assessment must relate are *"all the pharmaceutical services that maybe provided under arrangements made by the NHS England"* and encompasses pharmacies that are included on the Pharmaceutical List.

Table 1 below summarises what is meant by pharmaceutical services, provided by each type of contractor that has been considered within the scope of this PNA. Whether a service falls within this scope is dependent on who the service provider is and what service is provided.

Table 1

Contractor Type	Pharmaceutical Services
Pharmacy Contractors **A person or body who provides services under the national contractual framework. All community pharmacies providing NHS pharmaceutical services are required to provide essential services.**	Essential services • Dispensing and actions associated with dispensing including repeatable dispensing • Disposal of unwanted medicines • Promotion of healthy lifestyles, including public health campaigns • Prescription-linked interventions • Signposting • Support for self-care
Advanced services and enhanced services are those services defined in the Pharmaceutical Services (Advanced and Enhanced services) (England) Direction 2013. **A contractor may choose to provide advanced services. They would need to meet specific requirements in relation to premises, training and notification to NHS England.**	Advanced services • Medicine Use Reviews and Prescription Interventions (MURS). • New Medicines Services (NMS). • Appliance Use Reviews (AUR) – No services provided in Thurrock, but services can be accessed outside the borough and via the internet. • Stoma Appliance Customisation Services (SAC)
Enhanced Services are those services commissioned by NHS England in response to a local need. The range of services that may be commissioned are defined within the Regulations.	Enhanced services • Seasonal Influenza – national programme
Dispensing Appliance Contractors **(appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc). They cannot supply medicines.**	• None in Thurrock, but services can be accessed outside the borough
Local Pharmaceutical Service Contractors **Pharmacies that provide "local pharmaceutical' services based on need. They are commissioned by NHS England under a locally defined contract**	• None in Thurrock
Dispensing Doctors **Medical practitioners that are authorised to provide drugs and appliances in designated rural areas known as 'controlled localities'**	No other NHS services may be provided under arrangements made by NHS England

2.1.1 Other Commissioned Services

The regulations state that when making an assessment, the HWB are required to consider how other services affect the need for pharmaceutical services. These are NHS services commissioned or arranged by other bodies/organisations i.e. Local Authorities, CCGs and NHS Trusts. For this section we have considered and assessed services that have been directly commissioned by other NHS bodies and how other NHS services may impact upon the need for pharmaceutical services.

2.1.2 Services commissioned by other NHS organisations

Table 2 below summarises the services that are commissioned from community pharmacy by other NHS organisations.

Table 2

Commissioner	Services though primary care

Thurrock Local Authority	Public Health
	• Substance misuse
	  ○ Needle Exchange
	  ○ Supervised Consumption
	• Sexual Health
	  ○ Chlamydia testing and treatment
	  ○ Emergency hormonal contraception
	  ○ Condom distribution (C-card) scheme
	• Stop Smoking services

Clinical Commissioning Group	No services currently commissioned from pharmacy
North East London Foundation Trust	No services currently commissioned from pharmacy.

2.1.3 Services that currently affect the need for Pharmaceutical services

Table 3

Locality	Ward	Service	Opening hours
Rapid response Assessment service + Emergency Duty Team	Basildon	Crises support in health, mental health, social care and voluntary services	08:45 – 19:00 19:00 - 08:45
Walk in Centre Grays	Grays	Minor illnesses and injuries that do not need a visit to A&E	08:00 – 20:00
Out of Hours GP service	Basildon	Telephone triage, with telephone management/consultation and home visits	18:30 – 08:00
Basildon and Thurrock Hospital	Basildon	A&E, Urgent care	24 hours
Minor injuries unit	Orsett	Minor illnesses and injuries that do not need a visit to A&E	10:00 – 19:30

2.2 What is excluded from this Scope

The PNA has a regulatory purpose of those services that will affect market entry decisions. This is what has set out the scope of the assessment. However pharmaceutical services and pharmacists are involved in other areas of work in which the local health partners have an interest but have not been included.

2.2.1 Non NHS Services provided by Community Pharmacy

Community pharmacy contractors can provide a range of non-NHS services that are not commissioned by NHS England, Local Authority, CCG or other NHS services. Below is a list of some of these services:

- Home delivery to housebound patients
- Weight management and healthy eating advice/support
- Blood pressure monitoring
- Cholesterol and blood glucose measurements
- Travel medicine i.e. vaccine and advice
- Provision of aids for daily living
- Over the counter medicines to treat minor ailments

2.2.2 Pharmacy services within NHS Trusts

Thurrock CCG commission care from a range of NHS Trusts and Foundation Trusts which provide community Health Care services, mental health service and hospital services. Those pharmaceutical services that have been highlighted in 2.2.1 may be commissioned through these Trusts but have not been assessed in this PNA.

2.2.3 Medicines Management

NHS Central Eastern Commission Support Unit provides support on prescribing the safe and effective prescribing and use of medicines to Thurrock CCG.

2.2.4 Methodology

This PNA was developed using a range of methods including consultation with stakeholders and local pharmaceutical service providers. The steps below summarises the main activities and provide the information about the main sources used.

Step 1

- A paper setting out the approach and governance arrangements was prepared and approved by the HWB.
- A PNA steering group was established in December 2013 to oversee the completion of the PNA and to ensure that all minimum requirements for the PNA are met.
- A project manager was appointed to coordinate this report with the public health team.

Step 2

- Data requests were made to the following:
    - Commissioners and managers within Thurrock Council
    - NHS Thurrock CCG
    - NHS Central Eastern CSU
    - NHS England

- The Steering group approved the pre-consultation pharmacy survey that was then issued to all Pharmacies to complete. Also during this stage a public survey was approved and distributed including advertisement on the Local Authority website, and on posters in GPs/pharmacies and traveller sites.
- Data from the community pharmacy survey was analysed and triangulated with data supplied by sources above. Any anomalies were identified and addressed.
- Data from the public server was used to inform local experience as well as future aspirations.

Step 3

The PNA will inform commissioning decisions by the Local Authority (public health services from pharmacy contractors), NHS England and CCGs. A review of the following documents and strategies was undertaken to prepare this PNA, this was to ensure the priorities were identified correctly:

- JSNA
- Thurrock APHR 2013
- Primary Care transformation document
- Community Regeneration Strategy
- NHS England Everyone counts: Planning for patients 2014/15 – 2018/19
- NHS England Call to Action

The review included meeting with managers, commissioners and other key leads to inform current and future priorities.

Step 4

- A pharmacy services profile was developed and validated using information supplied in Step 2
- Emerging themes were drawn together and presented to the PNA steering group. The group made appropriate comments and recommendations for the PNA.

Step 5

- A formal consultation was undertaken between 23 July 2014 and 22 September 2014 in accordance with the Regulations.
- Comments were collated and presented to the PNA Steering Group for discussion.
- The draft PNA was updated upon comments from the PNA Steering Group and a final version produced for approval by the HWB on 13 November 2014.
- A Consultation report of the final PNA was developed and is attached at the end of this document.

3. Context for the Thurrock PNA

This chapter sets out the local context, with regards to the demography and health needs within Thurrock's population. For a full review of the local context, please refer to Thurrock's Joint Strategic Needs Assessment https://www.thurrock.gov.uk/healthy-living/joint-strategic-needs-assessment

The chapter also provides an overview of the strategic priorities. A summary of the implications and relevance of each section is provided.

3.1 Overview of Thurrock

Thurrock is located in the south of Essex and lies to the east of London on the north bank of the River Thames with an area of 165 square kilometres (km^2). It has a diverse and growing population with a population density of 976 persons per km^2.

The borough comprises of 20 wards, with areas in the central and eastern parts that are most affluent and have the healthiest residents in the borough.

The Regulations state that the HWB define the localities by which it will assess the pharmaceutical needs of its population. It was agreed that we would maintain the current system of Thurrock ward boundaries as it aligned well to demographic and healthcare data, and provided an even spread of the population served around each pharmacy. In addition wards are well understood within the general public as they are used during general parliamentary elections.

Table 4 below provides an overview of wards that sit within the four localities

Table 4

Localities

Western	Central	Southern	Eastern
Ockendon	Stifford Clays	Chadwell St. Marys	Orsett
Belhus	Chafford and North Stifford	Tilbury St. Chads	The Homesteads
Aveley and Uplands	South Chafford	Tilbury Riverside and Thurrock Park	Stanford East and Corringham Town
West Thurrock and South Stifford	Grays Thurrock	East Tilbury	Corringham and Fobbing
	Grays Riverside		Stanford-le-Hope West
	Little Thurrock Blackshots		
	Little Thurrock Rectory		

Thurrock shares its border with the following neighbouring HWB areas:

- Essex CC
- Havering
- Medway
- Dartford
- Gravesend

The Office of National Statistics (ONS) classifies areas that share similar demographic characteristics. including health needs. The ONS list of similar boroughs for new and growing towns is as follows

- Milton Keyes
- West Essex
- Bexley
- Havering
- Medway
- Swindon
- South West Essex
- Peterborough

3.2 Demography

3.2.1 Population

In June 2014 ONS published new mid-year estimates which show the population of Thurrock (as of June 2013) has risen to 160,859, an increase of 1,316 people since the previous year, representing a percentage rise of 0.8%. This increase is consistent with recent trends and is mainly due to the difference between births and deaths. There were 2,352 births and 1,139 deaths. A total of 6,426 residents moved into the borough from other parts of England and Wales and 6,464 moved out. A total of 713 people moved into the borough from areas outside England and Wales and 588 moved out. The most significant increases from the previous year, are in the 5-9 year age band at 5.7%; the 65-69 year age group at 6.8%; and the over 90s age group at 5.2%

The population density and distribution in Thurrock varies considerably from low density in the more rural areas to high density in the urban areas. At the time of the 2001 Census, population density in Thurrock was measured at 8.8 persons per hectare (approximately 0.088 persons per km^2) compared to 9.7 persons per hectare (approximately 0.097 per km^2) in the 2011 Census demonstrating the recent increase in population.

3.2.2 Age

Figure 1 shows a population pyramid of age structure of Thurrock in 2012 compared to that of England. It is clear that Thurrock has a relatively young population with almost all the age groups under 50 years forming a greater proportion of the total population than England; this is inversely true of population aged 50+ years plus, where Thurrock has a lower proportion in the total population compared to England.

Figure 1: All Persons Population Structure (percentage of the population) by Quinary Age-Group in Thurrock and England

Source: Mid-2012 ONS Population Estimate

Changes in Age structure between 2001 and 2011

- There has been almost a 20% rise in 0-4 year olds between 2001 and 2011. This age group makes up 7.6% of Thurrock's population which is greater than the England average.
- The borough's 60+ age group population has increased by 16.5% since 2001. However, the percentages of people in each of the 60+ age groups are less than the England and East of England averages.
- There has been a 47.5% increase in the 85+ population.

Age distribution at locality level

Age distribution within the four localities vary when compared to the Thurrock averages. Local Ward profile data shows the proportion of three age bands; 0-14 years, 15 – 64 years and those aged 65+ years that make up the total population by ward.

Figures 2 – 5 illustrate that the areas with the highest density of under 15s in Thurrock reside in the Southern and Central localities including the wards of Tilbury St Chads, Tilbury Riverside and Thurrock Park, Chafford and North Stifford, and South Chafford.

The figures also show that there is a higher proportion of those aged 15-64 years in the Central and Western localities.

People aged 65+ and over are clustered in the Eastern locality in the areas of Orsett, Corringham and Fobbing and in the wards of Stifford Clays, Little Thurrock and Blackshots, in the Central locality.

Figure 2: Age distribution in the Western Locality

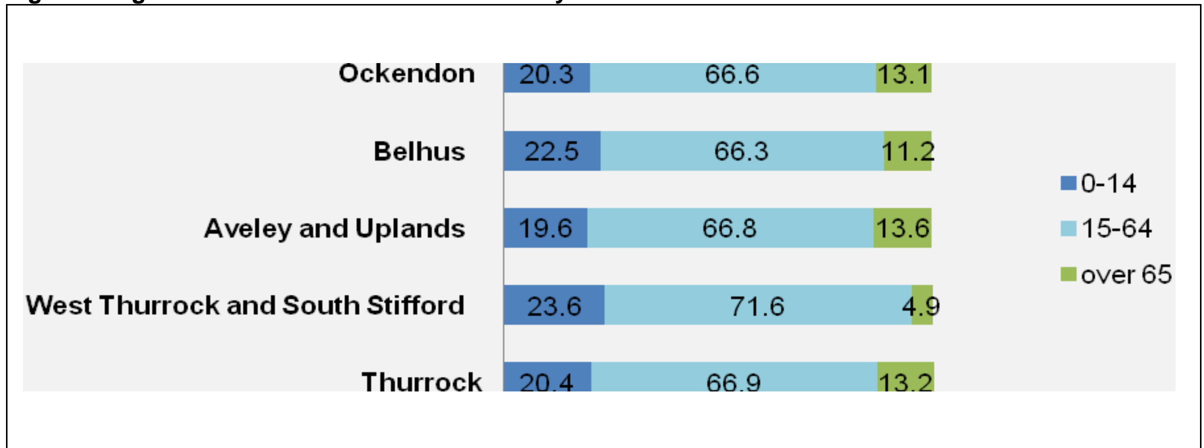


Figure 3: Age distribution in the Central Locality

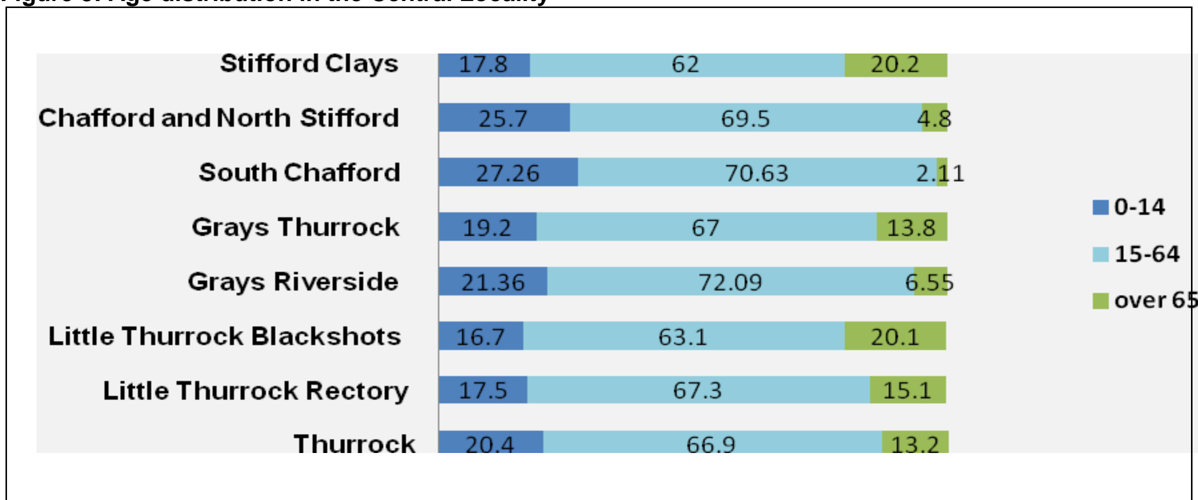


Figure 4: Age distribution in the Southern Locality

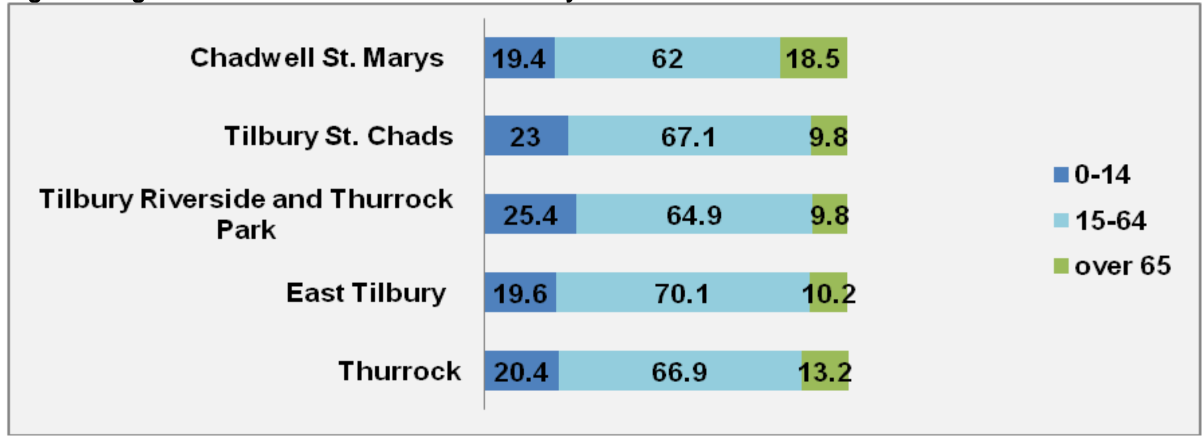
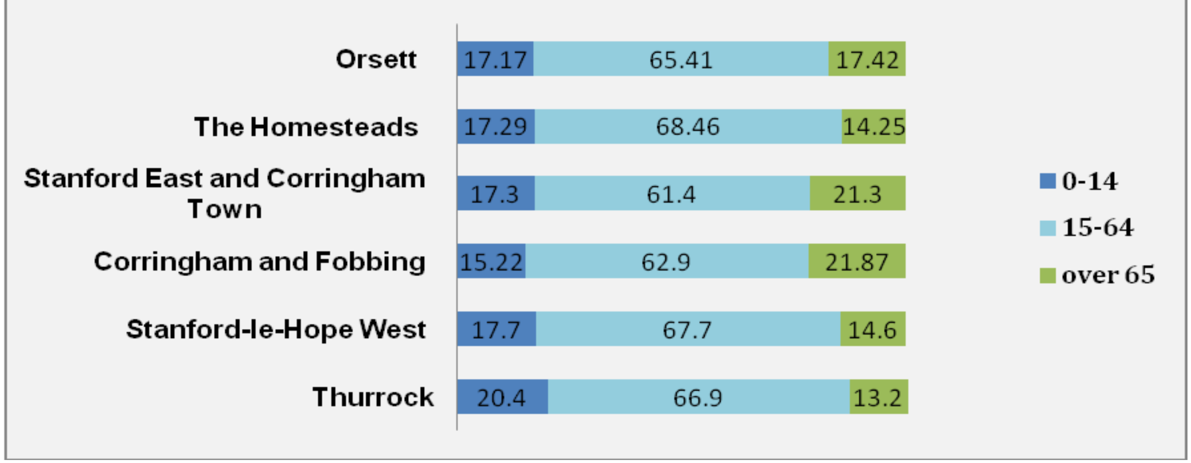


Figure 5: Age distribution in the Eastern Locality



3.2.3 Gender

In 2011 there was almost a 50/50 split between males (49%) and females (50.7%). Since 2001 the male population has grown by 11.7%. Overall proportion of males is slightly higher compared to the East of England (48.4%) and England (48.7%).

Table 5: Gender Structure in Thurrock, 2001 - 2011

	Thurrock (Number)		Number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
	2011	2001			2011	2001		
Total	157,705	143,128	14,577	10.2%				
Male	77,823	69,669	8,154	11.7%	49.3%	48.7%	48.4%	48.7%
Female	79,882	73,459	6,423	8.7%	50.7%	51.3%	51.6%	51.3%

Source: Census 2011 and 2001

3.2.4 Population Projection

Figure 6 shows population projections from 2011 to 2021 using the 2011 Census population as a base year. The population of Thurrock is projected to grow to 180,800 by 2021. This equates to an increase of 14% or about 22,500 people over the 10 years (Figure 6).

Figure 6: Change in Population 2011 to 2021

185000
180000
175000
170000
165000
160000
155000
150000
145000

158,300 160,400 162,700 165,000 167,200 169,500 171,800 174,100 176,300 178,600 180,800

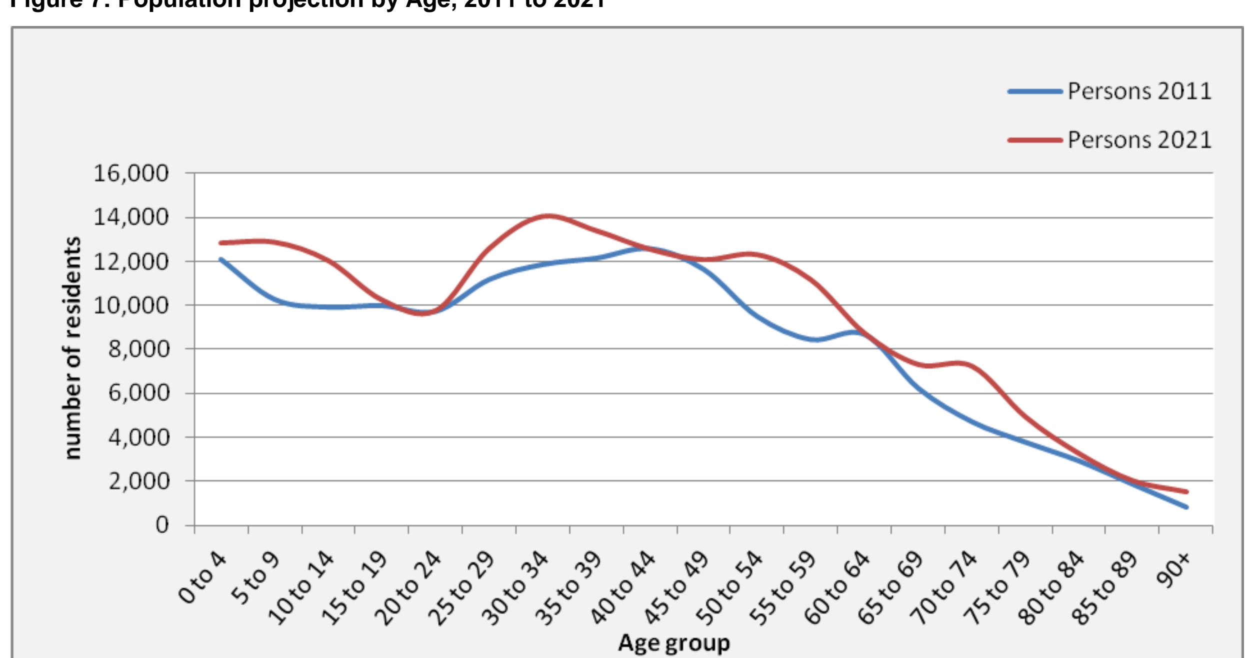
2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021

All ages

Source: Sub National (Interim) Population projections; ONS; 2011

Figure 7 shows the projected change in age structure between 2011 to 2021. Clearly there is a rise in absolute numbers in almost all age groups. The most significant rises can be seen in the age groups of 0-14 years, 50 – 59 years and those aged 70+ years. As a proportion of the total population, the largest increase in percentage from 2011 to 2021 is predicted to occur in the 5 to 9, 50 to 54 and 70 to 74 year age groups.

Figure 7: Population projection by Age, 2011 to 2021



Source: Sub National (Interim) Population projections; ONS; 2011

3.2.5 Ethnicity

Table 6 shows that the proportions of the main ethnic groups in 2011. Despite an overall increase in population, there has been a decline in the White British and Irish groups from 2001. All main groups have increased both in number and proportion, particularly within the Black groups and White other groups.

Table 6: Ethnic Groups in Thurrock, 2001- 2011

Main Ethnic group	2011		2001		2001 to 2011
	number of residents	% of total population	number of residents	% of total population	absolute change
White:British and White:Irish	128,695	81.6%	134,348	93.9%	-5,653
White: Other	6,734	4.3%	2,051	1.4%	4,683
Mixed	3,099	2.0%	1,319	0.9%	1,780
Asian	5,927	3.8%	3,405	2.4%	2,522
Black	12,323	7.8%	1,659	1.2%	10,664
Other	927	0.6%	346	0.2%	581
TOTAL	157,705	100.0%	143,128	100.0%	14,577

Table 7 below shows the main languages that are spoken by the ethnically diverse population in Thurrock. In total 6% of the local population use a language other than English as their main language, the largest proportion of this are polish speakers.

Table 7: Main spoken languages in Thurrock

Main Language	Proportion of total Population	Number of Pharmacies with staff who speak the language
English (English or Welsh if in Wales)	94	0
Other European Language (EU): Polish	1.4	0
Other European Language (EU): Lithuanian	0.4	0
South Asian Language: Nepalese	0.3	0
Other European Language (EU): Slovak	0.3	0
South Asian Language: Panjabi	0.3	8
South Asian Language: Bengali (with Sylheti and Chatgaya)	0.2	2
African Language: Yoruba	0.2	3
Portuguese	0.2	0
Other European Language (non EU):	0.2	0
Other European Language (EU): Romanian	0.2	0
East Asian Language: All other Chinese	0.1	0
South Asian Language: Urdu	0.1	4*

Source: Office of National Statistics, 2011

*4 pharmacies reported having Hindi speaking staff, which is similar to the Urdu language.

Implications of Population on the PNA

Research shows that the most frequent users of pharmacy services are women (including for access to contraception), older people and those with a long term conditions or disability. Conversely, those working full time and young men use pharmacies least.[3]

Taking this into account, it is important that pharmacies:

- Are located in areas where there is a high population of young people, in particular the Western and Central localities, maximising on every contact with young people and delivering health promotion advice and interventions. It will be particularly important to target young people that are less likely to access pharmacy and who are projected to increase in population size. This is to ensure that we are empowering young people to make positive health choices and preventing the early onset of disease.
- Pharmaceutical services will also need to ensure that they are meeting the needs of older people aged 65+ years. This is of particular importance in the Eastern locality and a few specific wards in the Central locality, where the proportion of older people is higher.
- Black, Asian and Minority Ethnic (BAME) communities often experience health challenges including low birth weight babies and infant mortality through higher incidences of long term conditions such as diabetes.
- The diversity of languages spoken potentially presents challenges for the effective communication of medical related issues, health promotion and lifestyle advice. Currently there is quite limited correlation between the main languages spoken by the local population and the languages spoken within pharmacies. Ensuring that pharmacies are able to effectively communicate with this population is key to ensuring the safe and most effective management of medicine by patients as well as proving equal opportunities of receiving health promotion and lifestyle advice.
- In the future, the above will need to be considered across all pharmacies as the population is projected to increase, particularly in groups such as BAME communities, the very young and older age groups. In addition community pharmacies must continue to develop to meet the evolving needs of Thurrock's population.

3.2.6 Deprivation and Health Inequalities

There is a strong positive correlation between deprivation and higher rates of illness and poor health outcomes. Deprivation is a major factor of health inequalities, as a result of the unequal distribution of power, money and resources.[4]

Indices of Multiple Deprivation (IMD) are weighted summary measures of seven domains with the income and employment domains taking up the strongest weight. The higher the IMD score, the more deprived the area. Thurrock is ranked 217 out of 349 in the IMD (2007) overall score for local authorities in England. Overall, changes in deprivation between 2007 and 2010 in Thurrock is very small and Thurrock have become less disadvantaged although some ranked positions have changed relative to other local authorities.

The areas listed below are the most deprived wards in Thurrock; they fall within the following localities:

Western: West Thurrock, Ockendon, Belhus, Aveley and Uplands.
Southern: Chadwell St. Mary, Tilbury St. Chads, Tilbury Riverside and Thurrock Park.

The difference in life expectancy in Thurrock between those that live in 10% of the most deprived and 10% of the most affluent areas vary significantly. In males there is a life expectancy gap of 8.3 years and a 7.7 year gap between females.

The conditions that have contributed to the gap in life expectancy between the most and least affluent areas in Thurrock are circulatory disease, particularly coronary heart disease, CHD lung (and other) cancers and chronic obstructive pulmonary disease (COPD).

Implications of Deprivation and Health Inequalities on the PNA

The correlation between deprivation and higher incidences of early onset of disease, long term conditions and lifestyle related health outcomes will all contribute to the health inequalities in Thurrock.

- Access to community pharmacies in areas of deprivation is important in supporting the population to meet their health needs.

- Pharmacies should ensure that they are maximising on health promotion advice, dispensing medication that have been prescribed, target patients who would benefit from medication reviews and participate in locally commissioned services that tackle lifestyle choices i.e. smoking, sexual health, health checks etc. Access to community pharmacy services in areas of deprivation will be taken into account in this PNA.

3.3 Health Needs

3.3.1 Smoking

Smoking continues to be the leading preventable cause of death in England. It is estimated that a fifth (20.7%) of adults aged 18+ smoke in Thurrock. This smoking prevalence is similar to the national average (19.5%).

Smoking prevalence in routine and manual occupational groups is higher than the overall smoking prevalence average for Thurrock. It is estimated that nearly one third (27.3%) of adults aged 18+ within these groups smoke, which is just under the regional and national average (29.8%, 29.7% respectively).

The mortality rate attributed to smoking in Thurrock is 235.76 per 100,000 population (2012/13). Reducing the smoking prevalence is one of four priorities identified in the Thurrock Health and Wellbeing Strategy for 2013 – 2016; to improve the physical health and wellbeing of the people of Thurrock, with initial focus on reducing the prevalence of smoking. This will be accomplished by:

- Identifying and implementing actions and initiatives to prevent young people from starting smoking.
- Ensuring a range of options to motivate and encourage current smokers to stop smoking.
- Protecting families and communities from the harm caused by smoking.
- Developing approaches that use prevention, treatment and enforcement – particularly in restricting the supply of tobacco products to minors.

It is encouraging to see that the smoking status at time of delivery indicator (2012/13) for Thurrock (11.4%) remains below the East of England (12.4%) and England (12.7%) averages.

Implications of Smoking on the PNA

Community pharmacies are very well positioned to deliver stop smoking services and there is ample evidence to support this:

'All the reviews indicated that community pharmacy based stop smoking services provided by trained pharmacy staff were effective and cost effective in helping smokers quit smoking'.

'community pharmacists, providing a support programme of counselling and record keeping for their customers, has a positive effect on smoking cessation rates'

Many pharmacies in Thurrock already provide smoking session services. The service offers;

- Nicotine replacement therapy at the point of consultation. The provision is unique in that residents can access these services during extended hours and on the weekends.
- There are two Healthy Living Pharmacists (HLPs) that are able to offer Varenicline as a first line treatment under a Patient Group Directive (PGD). Other Pharmacies are able to refer into specialist smoking cessation services or GPs for this treatment choice.
- In addition community pharmacies are able to refer those that require medication for specialist care i.e. those with long term conditions, into smoking cessation services.

3.3.2 Alcohol and Substance Misuse

3.3.2.1 Alcohol

Alcohol is the third largest risk factor of disease and disability. Alcohol is a cause of two hundred diseases; include liver and kidney disease, acute and chronic pancreatitis, depression, hypertension and cardiovascular disease.

There are a higher percentage of deaths among men than among women from alcohol related causes - 7.6% of men's death and 4% in women.

The three main classifications of drinking above the daily recommended allowance are:

1. ***Binge drinking*** – Drinking twice the daily recognized sensible levels in any one day (8 or more units a day for men and 6 or more units a day for women.

2. ***Harmful drinking*** – Drinking above the recognized sensible levels and experiencing harm, such as an alcohol-related accident, acute alcohol poisoning, hypertension, cirrhosis (measured by consumption of 50+ units per week for males and 35+ unit per week for females).

3. ***Dependent drinking*** – Drinking above recognised sensible levels and experiencing harm and symptoms of dependence.

During 2012/13, hospital stays for alcohol-related harm in Thurrock were 461 per 100,000 population, which was lower than both the East of England (552) and England (637) averages. Young people in Thurrock had a rate of 22.5 hospital admissions per 100,000 population (2008/09-2010/11) due to alcohol and 14.9 due to drugs (2006/07-2008/09) compared with regional rates of 30.9 and 15.3 respectively.

Ward level data from 2008/09 - 2012/13 shows that hospital stays for alcohol related harm is highest in the following localities: Western: Ockendon and Belhus, Southern: Tilbury Riverside and Thurrock Park, Tilbury St. Chads and Chadwell St Mary.

Modelled estimates of the percentage of those aged 16+ years that binge drink is highest in the wards of East Tilbury, Aveley and Uplands, West Thurrock and South Stifford and Grays Riverside. Prevalence of binge drinking is notably higher than the national average.

3.3.2.2 Illegal Drugs

The health harms arising from illicit substances are both wide in range and severity and very much depend on the pattern and context they are used in. Drug misuse has a major impact on physical, psychological and social health and wellbeing of an individual and their families. Substance misuse also impacts on society, from crime to families forced apart due to dependency. The National Drug Strategy for England (2010) balanced three key themes; reducing the demand of drugs, restricting the supply of drugs and promoting the recovery of those misusing drugs.

The 2013 updated Annual Review: Delivering within a New Landscape makes clear the Government priorities for future work. With regards to reducing demand there is a key focus on working in partnership to deliver early interventions for young people. There is strong encouragement for communities and schools to work together to provide support and education in developing young people to make healthy choices as well as improving resilience. The number of heroin and crack cocaine users nationally has fallen from 332,090 in 2005/06 to 298,752 in 2010/11. The number of people injecting drugs has also fallen significantly from 129,977 in 2005/2006 to 93,401 in 2010/11. The most recent data shows that the estimated rate of opiate and/or crack cocaine users aged 15 – 64 in Thurrock was 3.7 per 1000 population, which is significantly lower than the regional average of 6.3 per 1,000.

It is also encouraging to see that in 2012 Thurrock's rate (11.1%) of completion for drug treatment (opiate users) is higher than the East of England (7.8%) and England (8.2%) averages.

The primary drug used by young people in Thurrock accessing treatment for substance misuse is cannabis with alcohol being second. Data from 2012/13 shows that 73.4% of young people stated cannabis as their primary drug, which is similar to the regional average of 71.2%. Alcohol use in young people is also a consideration with 20.3% of young people stating alcohol as their primary drug which is similar to the regional average of 20.3%.

Implications of Alcohol and Substance Misuse for the PNA

Recommendations from the JSNA are to increase the impact of change and widen the screening and early intervention to people with illnesses, due to alcohol misuse, that are resulting in admissions to hospitals; this includes training to provide screening and brief intervention programmes.

Community pharmacies are well positioned to provide the above. In addition to this they have the potential to deliver the following:[5]
Delivering healthy lifestyle advice aimed at raising awareness of the harmful effects of excess alcohol.

- Brief interventions (such as screening, assessment, NHS Life Checks).
- Prescribing or PGDs to enable the supply of medicines related to reducing alcohol intake.
- Blood tests to detect levels of alcohol consumption and early risks of complications developing.
- Supervised monitoring of medicines to treat alcohol withdrawal.

Programmes like needle exchange schemes and supervised consumption strive to address the consequences of substance misuse. There is growing evidence of the effectiveness of supervised consumption through community pharmacy, including improving outcomes and reducing medicine diversion.

Accessing services through community pharmacy is acceptable to service users and recent evidence shows that it has improved testing and subsequent uptake of hepatitis B vaccinations within this cohort.

In addition descriptive studies of needle exchange programmes, through community pharmacy have shown to achieve high rates of returned injecting equipment and are cost effective.

Thurrock Council currently commissions both supervised consumption and needle exchange programmes through pharmacies.

In addition two pharmacies currently provide non NHS alcohol screening services in Thurrock.

3.3.3. Sexual and Reproductive Health

Sexual health is influenced by a number of factors, including sexual behaviour and attitudes. The consequences of poor sexual health can be serious, leading to unintended pregnancies and sexually transmitted infections.

Sexual health inequalities are faced by specific population groups, with the highest burden of sexual ill health being borne by men who have sex with men (MSM), teenagers, young adults and some minority ethnic groups.

Latest data from the Public Health Outcomes Framework shows that Thurrock has a teenage pregnancy rate of 30.5 per 1000 females aged 15-17 years which is similar to the national average (27.7), though significantly worse than the regional average (23.2). The rate of conception in those under 16 in Thurrock (6.3 per 1000 females aged 13-15 years) is similar to the regional (4.4/1000) and national rates (5.6/1000). Since 1998 Thurrock has more than halved its teenage pregnancy rate of 62.5/1000 by 51.2% and achieved a downward trend in trajectories for under-18 and under-16 teenage conceptions.

Pooled data from 2009 – 2011, shows that teenage conception rates are higher in wards that also have higher levels of deprivation. Yet deprivation alone is by no means a cause of teenage pregnancy and other risky behaviours and lifestyle choices need to be taken into account such as unprotected sexual intercourse, drug and alcohol misuse, duration in education and personal aspirations.

In 2013, Chlamydia diagnosis amongst young people in Thurrock was 1529 per 100,000 aged 15-24 years; this is significantly lower than the England rate of 2016 per 100,000 aged 15-24 years. Reasons to explain this and which are being addressed include not screening enough of the population or screening the wrong target groups, since the National Chlamydia Screening Programme (NCSP) target is 2,300 per 100,000 population based on prevalence estimates.

Pooled data from 2010-2012, shows 63.2% of people in Thurrock present with HIV at a late stage of infection. This is higher than the East of England (51.9%) and England (51.3%) averages.

Implications of Sexual Health on the PNA

Pharmacies have provided sexual health care for a number of years now and there is growing evidence for their role in Chlamydia screening and treatment, and condom distribution. They are also a primary source of emergency hormonal contraception (EHC).

A number of community pharmacies within Thurrock provide a range of sexual health services, including those mentioned above. As part of the Public Health prevention agenda, all community pharmacies should:

- Maximise every contact to ensure that they are raising awareness of HIV, Chlamydia and other sexually transmitted infections.
- Involving themselves in national and local intervention programmes and campaigns.
- Refer people on to key providers of local sexual health services.

3.3.4 Obesity

Obesity is caused by an imbalance of energy i.e. more energy in than out. There is overwhelming evidence that obesity is a risk factor for a range of health problems, this includes the link to CHD, hypertension, type 2 diabetes and osteoarthritis. Obesity also has negative effect on mental health, sleep apnoea and respiratory problems. There is a serious impact of obesity on physical health, wider economic factors and social costs.

There are a number of risk factors associated with developing obesity; these include ethnicity, people living on low income, behaviour i.e. sedentary lifestyles, those who have stopped smoking, older people and those with a mental or physical disability.[6]

Similar to adults, children in the UK have diets high in energy dense foods, saturated fat and non-milk extrinsic sugars, but low in fibre, fruits and vegetables, and this is even more evident in children from lower income and one-parent families.[7]

For children the social environment also has a profound impact. The role of the parent or carer is vitally important. A child that has at least one obese parent, is around three times more likely to be obese than a child with no obese parents.[8]

In children and adolescents the associated morbidities include hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction, and exacerbation of existing conditions such as asthma. Excess weight also has a significant impact on psychological wellbeing, with many children developing negative self-image and low self-esteem.[9]

3.3.4.1 Adult Obesity

The most recent data shows that the prevalence of excess weight (overweight and obese) in adults in Thurrock is 70.8%; this is higher than East of England (65.1%) and England (63.8%).

Local Quality Outcome Framework (QOF) data shows that the following localities have the highest obesity prevalence (ages 16 year and older) of GP registered patients:

Western: Belhus (30.2%)
Southern: Tilbury Riverside and Thurrock Park (29.9%), Tilbury St Chads (29.9%)
Eastern: Stanford Le Hope (29.7%), Stanford East and Corringham (29.7%) The Homesteads (29.7%)

It should be noted though, QOF data is dependent on the presentation i.e. only those patients that present to their GP, and the quality of recording by the surgery. Empirical data does show that some GPs do find it difficult to bring up topics such as excess weight and obesity.

3.3.4.2. Childhood Obesity

Childhood obesity is measured through the National Childhood Measurement Programme, during Reception and Year 6.

The 2012/13 data shows Thurrock to have an obesity prevalence in Reception-aged children of 9.6%, which is significantly higher than the East of England average (8.1%), and above the England average of 9.3%.

The 2012/13 data shows Thurrock to have an obesity prevalence in Year 6-aged children of 19.8%, which is more than double the local prevalence at Reception Year. Thurrock's prevalence is significantly higher than the East of England average (17.0%), and is above the England average of 18.9%.

Implications of Obesity on the PNA

As part of the essential services, community pharmacies provide health promotion advice. They are ideally placed to provide support to local campaigns for healthy lifestyle and healthy eating messages.

In line with the Pharmaceutical Regulations, we would also like all NHS pharmacists to make referrals and sign-post residents into local weight management services.

3.3.5 Mental Health

Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.[10]

The Mental Health Illness Needs Index 2000 (MINI 2K) scores the wards of Thurrock. The mean score is 0.91, which is below the national average of 1.00. However there is clear variation in the distribution of mental illness needs within Thurrock, with the areas of deprivation having higher MINI 2K scores.

Incapacity Benefit claimants make up the largest group of economically inactive people of working age in Britain and almost 40% are on Incapacity Benefit because of mental illness. Locally the areas of higher deprivation have higher claim rates.

3.3.5.1 Children and Young People

Extrapolating local data from national prevalence shows that there are approximately 3600 children and young people aged 0-19 years that may experience a mental illness, in Thurrock.

Four areas were identified as the major issues for children and young people presenting to services, these were domestic violence being witnessed at home, family break-up, bereavement and parent drug and alcohol abuse. The main reasons for referral, as a result of this, are: anger, depression, anxiety and self-harm.

3.3.5.2 Mid Adult Years

The prevalence of common mental disorder in people aged 18 years and older is 16.2% nationally. This would equate to around 19,488 people in Thurrock. The most common mental illnesses are depression and anxiety.

Local prevalence estimates suggest that neurotic disorders, depression, panic disorder and general anxiety disorder are highest in the following localities:[11]

- **Western:** Ockendon and Belhus
- **Southern:** Chadwell St Mary
- **Central:** Grays Riverside

3.3.5.3 Older People

Risk factors for mental health problems in older people include loneliness, social isolation, fear of crime, loss of independence, lack of transport, poverty and debt, (including anxiety over meeting winter fuel bills).

Dementia is usually a long term, progressive condition and whilst not necessarily part of ageing, the incidence of dementia increases with age.

The Health Needs Assessment for the over 75 year old Thurrock population highlights that around 13% (1280) of those over 75 are predicted to have dementia and that the older the person with dementia the more the demand on adult social care services.

Implications of Mental Health on the PNA

A vast array of medication is available to treat various mental health disorders, including anxiety, depression, schizophrenia and other psychotic disorders. It is critical that medicine optimisation with this cohort of patients is delivered, to ensure higher levels of concordance and manage to help identify any adverse effects associated with medication.

Community pharmacies in Thurrock provide a range of services to support the strategic delivery of mental health services, including:

- Provide health promotion advice as an essential service. Medication records can be used to target patients who are taking various medications for mental health.
- A number of pharmacies deliver support in identifying adverse effects of medication as well as adherence issues that can contribute to improving outcomes for patients with serious mental health issues.

3.3.6 Cancer, Cardio Vascular Disease and Respiratory Disease

3.3.6.1 Cancer

Cancer is one of the largest causes of mortality in England, accounting for a quarter of deaths. More than 1 in 3 people will develop cancer at some point in their life. In January 2011, the Government published Improving Outcomes – a Strategy for Cancer. This document sets out plans to improve cancer outcomes, including improving survival rates through tackling late diagnosis of cancer.

Diagnosis at an early stage can dramatically improve chances of survival. In Thurrock, the proportion of newly diagnosed invasive malignancies at stage 1 or 2 was 51.2%, compared to the regional average of 54.2% but higher than the national average of 41.6%.

The percentage of eligible women in Thurrock screened for Breast Cancer in the last three years (at 31st March 2014), was 71.6%, [12] this was worse than both the regional (77.4%) and England (76.3%) averages.

Age standardised mortality from all cancers in people aged 75 and under shows that Thurrock had a rate of 157.8 per 100,000 population, this was higher than the East of England rate of 136.3/100,000 and England rate of 146.5/100,000. The mortality rate from all cancers is higher in men (101 per 100,000 population) than women (86.3 per 100,000).

3.3.6.2 Respiratory Disease

Respiratory diseases is one of the top causes of death in England in those aged under 75 years and smoking is a major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases.

The mortality rate from respiratory diseases in those aged 75 years and under per 100,000 population in Thurrock is 33.7, which is higher than the regional (26.6/100,000) average but similar to the national (33.5/100,000) average. Overall men have a higher mortality rate (39.0, per 100,000) due to respiratory illness than women (29.2/100,000).

3.3.6.3 Cardiovascular Diseases

Cardiovascular disease (CVD) is the most common cause of death in the UK, with approximately 30% of deaths classified as premature[13] (i.e. under 75 years)

Locally CHD is the main contributor to the gap in life expectancy. Life expectancy is 8.2 years lower for men and 7.7 years lower for women in the most deprived areas of Thurrock that in the least deprived.

Thurrock's under 75 year's mortality rate from cardiovascular diseases, is 90.4 per 100,000. This is higher than the East of England (72.6) and England (81.1) rate. The rate of mortality from cardiovascular disease in men (128.9 per 100,000 population) is significantly higher than the rate of mortality from cardiovascular disease in females (54.0 per 100,000 population).

Implications of Cancer, Cardiovascular and Respiratory Disease for the PNA

Community pharmacies in Thurrock provide a range of services to support the prevention and management of cancers, CHD and respiratory diseases.

Health promotion advice is delivered as part of the essential services.

In addition pharmacies are well placed to identify those who are at 'high risk', through medication records for more targeted health promotion.

Targeted MURs and NMSs reviews can promote adherence and ensure that adverse effects to medication are mitigated, hence improving the overall outcome for people with these conditions.

Some community pharmacies provide a range of screening testing, such as cholesterol testing and blood pressure as non-NHS/Thurrock services.

A number of community pharmacies currently provide smoking cessation services, smoking is a risk factor for all three diseases.

Health checks have been commissioned through pharmacy in some areas. The use of pharmacies to deliver this service can improve access, choice of provider and improve uptake of this mandatory service. This service is not currently provided by pharmacies in Thurrock.

3.3.7 Diabetes

Diabetes is associated with long term complications such as heart disease, stroke, blindness, amputation and chronic kidney disease. It is therefore a significant long term condition within Thurrock.

There are two types of diabetes:

- Type I is when the body produces no insulin and therefore glucose levels increase in the blood. This occurs in 10% of all cases.
- Type II is when the body does not produce enough insulin or the body does not react to insulin. This occurs in 90% of all adult cases.

Risk factors for Type II Diabetes include;

- Obesity, lack of exercise and sedentary way of life
- Diet high in processed foods
- High blood pressure
- Gestational diabetes
- Familial history
- Age (if over 40 or 25 if South Asian)

People from Asian and Black ethnic groups are more likely to develop diabetes and are likely to develop diabetes at a younger age. Diabetes also affects those people living in the 20% most deprived neighbourhoods in England and are 56% more likely to have diabetes than those living in the least deprived areas.[14]

During 2012/13, the prevalence of diagnosed diabetes in those aged 17 years and older in Thurrock was 6.1%, this is higher than comparator areas (5.9%). Local data shows that People with diabetes in NHS Thurrock CCG were 51.6% more likely to have a myocardial infarction, 33.1% more likely to have a stroke, 86.4% more likely to have a hospital admission related to heart failure and 38.7% more likely to die than the general population in the same area.[15]

Spending on prescriptions for items to treat diabetes in 2012/13 cost £323.12 per adult with diabetes in NHS Thurrock CCG compared to £281.52 across England.[16]

Implications of Diabetes for the PNA

Community pharmacies in Thurrock provide a range of services that can support the prevention and management of diabetes and its associated risk factors. They provide health promotion advice as an essential service and can get involved in delivering local campaigns. Targeted MURs and NMSs also support this agenda by promoting adherence to medication and ensuring patients are receiving the maximum benefits. They also provide smoking cessation services.

While two pharmacies currently provide non NHS/Thurrock screening services for diabetes, 69% of community pharmacies in Thurrock would be interested in providing this service.

3.3.8. Older people

The 2011 Census estimated that there are 20,021 people aged 65+ years living in Thurrock. This equates to 12.7% of the total Thurrock population. Population projections predict an increase in the 70 plus age groups between 2011 and 2021.

With respect to health and wellbeing, older people are more vulnerable to depression, dementia, CHD and diabetes, falls, sensory disability and winter deaths.

In addition local activity attributed 12% of A&E admissions and 30% of emergency admissions in those aged 75 years and older. The most common reasons for emergency admission for this age group were respiratory disease circulatory disease and injury relating to falls.

Implications of Older People for the PNA

All pharmacies receive a contribution towards providing auxiliary aids to support eligible people with taking their medication under the Equality Act 2010.

MURs and NMSs are additional services that pharmacies can choose to provide. Targeting these services to older people can decrease the risk of medicine related harm, improve adherence and ensure that this cohort is receiving the maximum benefits from their medication.

As part of the essential services, community pharmacies provide health promotion advice. They are ideally placed to provide support to local campaigns that are targeted to improve the health and wellbeing outcomes for older people.

3.4 National and Local Context

This section provides an overview of the national and local strategies and priorities that provide the basis of where resources should be focused.

3.4.1 National Strategy

The Health and Social Care Act influences both the need and delivery of pharmaceutical services. A range of health and care organisations work in partnership to deliver under this Act.

- *Local Authority -* The local authority has responsibility for Public Health and social care.
- *Clinical Commissioning Group -* CCGs have a role to commission most NHS services. CCGs are responsible to secure improvements in service, involve patients, reduce health inequalities and promote research and development.
- *Health and Wellbeing Board -* Each upper tier Local Authority has established a Health and Wellbeing Board (HWB) that brings together a range of leaders from health and care organisations to improve the health and wellbeing of their local population and reduce health inequalities. Each HWB will develop a HWB strategy that will provide the local framework for commissioning, integration and coordination of services in order to meet local need.
- *NHS England -* NHS England is a national body that has the responsibility for commissioning primary care core contracts, offender health, military health and specialised commissioned services.
- *Public Health England -* Public Health England (PHE) is a national body that has the responsibility to protect the health of the nation and address inequalities. The main focus of PHE work is around delivery and informing health improvement, health protection, commissioning and research and development.

3.4.2 NHS England "A Call to Action"

NHS England "A Call to Action" was a national consultation on Everyone Counts: Planning for Patients 2014/15 – 2018/19, that sets out a five year strategic plan to deliver high quality care within the NHS. The document will deliver key changes within pharmacy, these include:

- Delivering a wider range of services from primary care in order to improve access and support for patients with mental health or physical long term conditions
- Providing more integrated community services that focus on health outcomes, currently there are a few areas that have gained support.
    - New models of primary care that provide holistic support especially to the more vulnerable i.e. frail and elderly and those with a long term condition.
    - More focus on prevention of disease.
    - Supporting patients to manage their own health.
    - Establishing urgent and emergency care networks in order to provide accessible and cost effective services.
    - Providing a responsive seven day a week service.

NHS England "Pharmacy Call to Action" recognises the effective alternative provision of healthcare and advice that pharmacy can provide to a currently oversubscribed primary care service. The aims for community pharmacy are:

- Develop the role of the pharmacy team to provide personalised care.
- Play an even stronger role at the heart of more integrated out-of-hospital services.
- Provide a greater role in healthy living advice, improving health and reducing health inequalities.
- Deliver excellent patient experience which helps people to get the most from their medicines.

3.4.3 Joint Health and Wellbeing Strategy

The Health and Wellbeing Strategy 2013-16[17] has been jointly developed by Thurrock Council and Thurrock NHS Clinical Commissioning Group. It is a two part strategy to specifically focus on adult and children's needs, separately. There are four priority areas for each part:

For adults, these are -

- Improve the quality of health and social care.
- Strengthen the mental health and emotional well-being of people in Thurrock
- Improve our response to frail elderly people and people with dementia.
- Improve the physical health and well-being of people in Thurrock.

For children and young people, these are -

- Outstanding universal services and outcomes.
- Parental, family, and community resilience.
- Everyone succeeding.
- Protection when needed.

Within the 2013 – 2016 Strategy, there are two Public Health priorities for the population, these are:

- Reduce the prevalence of smoking in Thurrock.
- Reduce the prevalence of obesity in Thurrock.

3.4.4 Clinical Commissioning Group

Thurrock CCG has identified five strategic priority areas as part of their two year operational plan 2014 - 16:

- Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing.
- Health and care solutions that can be accessed close to home.
- High quality services tailored around the outcomes the individual wishes to achieve.
- A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible.
- Systems and structures that enable and deliver a co-ordinated and seamless response.

The CCG also has a further commitment to reduce the inequality of outcomes for patients with mental health problems. Over the next two years they will be working with various primary, community and secondary care providers in order to fulfill this commitment.

3.4.5 Transforming Primary Care in Essex – the heart of patient care

The Essex primary care strategy has ambitious plans to develop integrated primary care 'hubs' around communities of 20,000 people. Commitment towards ensuring new and more effective ways of working, particularly with vulnerable groups is a priority. Along with the establishment of local primary care networks, the strategy will work with pharmacies in developing the following:

- Play a role as regular source of healthcare advice.
- Empower people to self-treat simple conditions without having to see their GP.
- Provide services through pharmacy in order to expand choice for patients.
- Triage, treat, refer or signpost patients.
- Develop the role of pharmacy prescribers further.

4. The Assessment

The following section describes the current provision of pharmaceutical and locally commissioned services in Thurrock, provides the assessment and forms conclusions for the PNA.

a) Data Sources

The Assessment section has been informed by a range of data from different sources, these include:

- National and local health and wellbeing strategies
- Thurrock Annual Public Health Report 2013
- Joint Strategic Needs Assessment
- Benchmarking data 2012/13 from the Health and Social Care Information Centre.
- Information and data collected/held by Thurrock Council, Thurrock CCG, NHS Central Eastern Commission Support Unit.
- Findings from the Contractor's questionnaire sent to all Community Pharmacies between February and March 2014. A response rate of 100% was achieved.
- Resident's questionnaire sent to various public, private, voluntary and independent services between February and May 2014.

b) Necessary and Relevant Services

The Regulations set out that services are defined in terms of necessity and relevance. For this PNA the following principles have been considered in order to do this:

- Service provider - A service that can only be delivered by a provider on the pharmaceutical list i.e. dispensing of medicines, is likely to be a **necessary** service.
- Health need and benefits – A service that clearly supports and improves a local health need, is likely to be a **necessary** service.
- Published evidence – A service that is supported by strong evidence to show improved outcomes for local need, is more likely to be a **necessary** service.
- Performance - A service that is provided by a range of providers, where pharmacy activity is higher than that of the other providers, it is more likely to be a **necessary** service.
- Accessibility – A service that is provided by a range of providers, where pharmacy provides more accessibility i.e. extended opening hours, wheelchair provision etc. is more likely to be a **necessary** service.

c) Choice

Choice provides an environment of competition with regards to the quality of delivery and cost effective solutions to healthcare. The following has been considered in order to determine adequate choice in services:

- The current level of access to pharmaceutical provision in Thurrock.
- The current offer of existing services and to what extent of improvement by providing additional services or facilities.
- The extent that current provision responds to the changing needs of their local community.

- The need for additional or specialised services to improve access for specific populations such as those that are vulnerable or who have a protected characteristic.

d) Other Considerations

In addition to the above, this section has also considered the following:

- Services provided outside Thurrock that affect the local pharmaceutical services.
- NHS services provided by other providers that affect the need for local pharmaceutical services.
- Local plans and developments that will affect the future need for pharmaceutical services.

4.1 Overview of Pharmacy and Other Providers of Pharmaceutical services

- *Community Pharmacies*
  Thurrock currently has 35 community pharmacies, including five pharmacies that are required to open for 100 hours per week, and two distance selling pharmacies.

- *Dispensing Appliance Contractors*
  There are currently no dispensing appliance contractor's in Thurrock.

- *Dispensing Doctors*
  There are currently two doctors providing dispensing urban services in Thurrock.

- *Local Pharmaceutical Service Contractors*
  There are currently no Local Pharmaceutical Service contracts in place in Thurrock.

4.2 Distribution of Community Pharmacies

4.2.1 National and local Distribution

Data shows that in England there are 22 pharmacies per 100,000 populations. This is slightly higher than the East of England average of 20 pharmacies per 100,000. Locally, Thurrock has a higher average than both the national and regional average at 23 pharmacies per 100,000 populations. Comparing Thurrock's rate (23/100,000) to the similar borough's rate (19.5/100,000) also shows that Thurrock has a significantly higher rate of pharmacies serving its population, *see figure 8.*

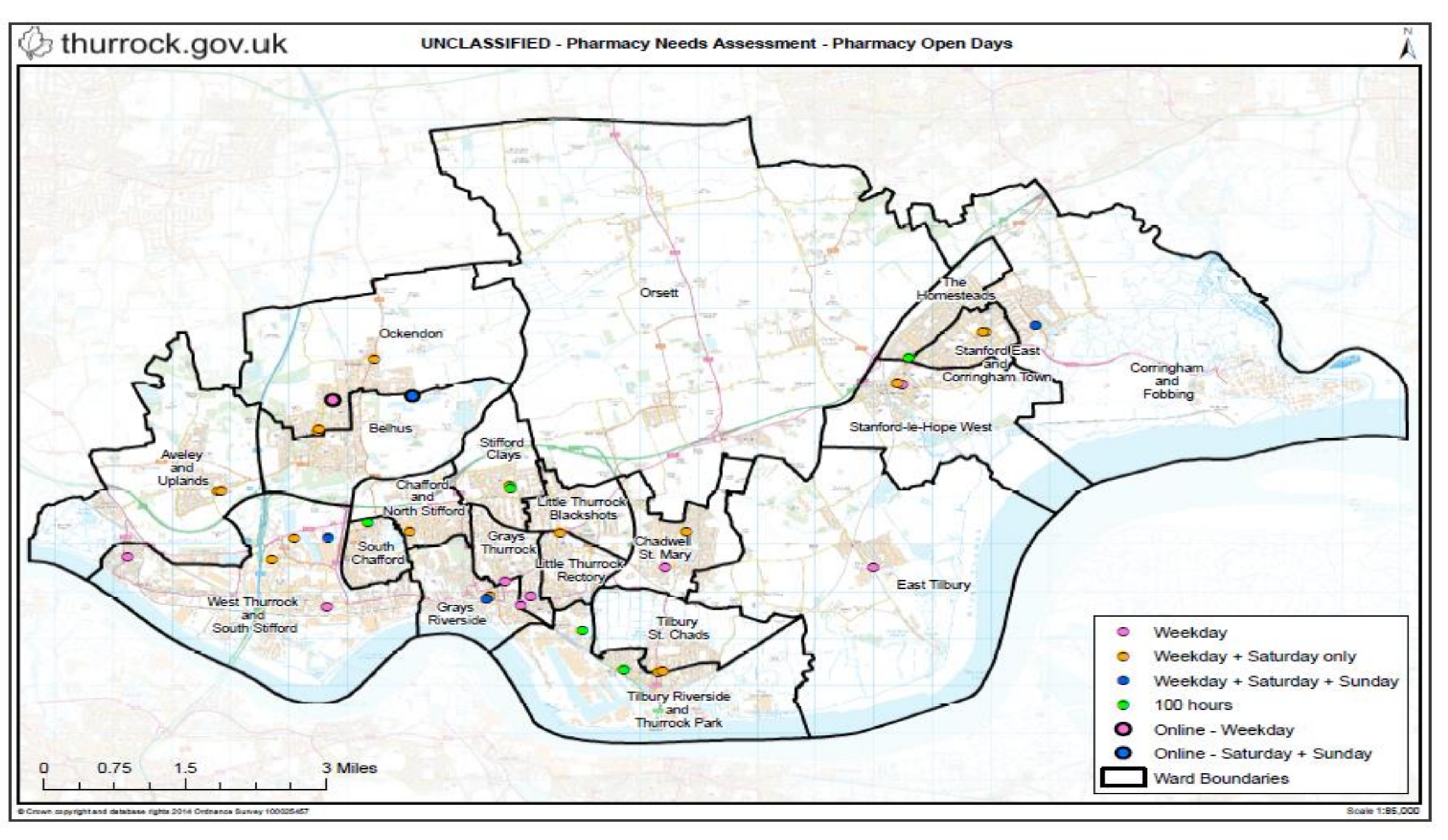
Figure 8: Number of Community Pharmacies per 100,000 populations in Thurrock compared to Similar Borough, East of England and England.

Source: HSCIC General Pharmaceutical Services in England 2012/13

When comparing the distribution of pharmacies within Thurrock localities, the Western locality has the most pharmacies (12/35), followed by the Central locality (10/35 pharmacies), the Southern locality (7/35 pharmacies) and the Eastern locality (6/35 pharmacies).

Map 1 shows the geographical spread and opening hours of Thurrock's community pharmacies.

Map 1: Community pharmacies in Thurrock



When considering rate of the community pharmacy per 100,000 populations in each locality, it is evident that there is an unequal distribution. While the Western locality has 31 pharmacies per 100,000, the Eastern locality has 17 pharmacies per 100,000 population, which is notably below the similar borough (19.5/100,000), East of England (20/100,000) and England (22/100,000) pharmacy rate per 100,000 populations.

Ward level analysis show that there is also some correlation between Thurrock's areas of deprivation and the number of pharmacies. Table 8 shows that the wards of Tilbury St. Chads, Tilbury Riverside and Thurrock Park, West Thurrock and South Stifford are well served and that the number of pharmacies per 100,000 is above the Similar Boroughs, regional and national averages. The ward of Belhus, the third most deprived in the borough, does not have any pharmacies but residents are able to access pharmacies in neighbouring wards.

Table 8: Distribution of Pharmacies in Thurrock

Locality	Ward (IMD rank)	No. of Pharmacies	Ward Population	Pharmacies/ 100000 population	No. of Pharmacies by locality	Locality pharmacy per 100,000
Western	Ockendon (6)	5*	9680	41.3	12	31
	Belhus (3)	0	9780	0		
	Aveley and Uplands (7)	2	8912	22.4		
	West Thurrock and South Stifford (4)	5	10478	47.7		
Central	Stifford Clays (11)	2	6460	30.9	10	18
	Chafford and North Stifford (19)	1	8071	12.3		
	South Chafford (20)	1	7384	13.4		
	Grays Thurrock (9)	3	9150	10.9		
	Grays Riverside (8)	2	11695	17.1		
	Little Thurrock Blackshots (13)	0	5770	0		
	Little Thurrock Rectory (16)	1	5955	16.7		
Southern	Chadwell St. Mary (5)	2	9865	20.2	7	24
	Tilbury St. Chads (1)	2	6177	32.3		
	Tilbury Riverside and Thurrock Park (2)	2	6878	29		
	East Tilbury (12)	1	6364	15.7		
	Orsett (17)	0	6115	0	6	17
Eastern	The Homesteads (18)	0	8507	0		
	Stanford East and Corringham Town (10)	2	8607	11.6		
	Corringham and Fobbing (15)	1	5478	18.2		
	Stanford-le-Hope West (14)	3	6379	47.0		

The data shows that there is some choice of pharmacy in just over half the wards, with the exception of Belhus, Little Thurrock, Blackshots, Orsett and The Homesteads that have no pharmacies, and Chafford and North Stifford, South Chafford, Little Thurrock Rectory, East Tilbury and Corringham and Fobbing that have one pharmacy each. Nevertheless, residents in all wards are able to access one or more pharmacies located close to or on the boarder of an adjacent ward.

4.3 Access

4.3.1 Opening times

Pharmacies are contracted to provide a minimum of 40 hours as part of their core offer (under some circumstances applications may be approved by NHS England for a pharmacy to provide more or less core hours), unless they were commissioned to provide 100 hour service under the 2005 regulations,[18] of which there are currently four in Thurrock.

Applications under the new market entry system can be required to open additional hours if this is to meet a defined need, and many pharmacies do provide additional hours. These are known as supplementary hours, in addition to the 40 hours core offer.

Amendments to the core opening times offer may only be done with consent of NHS England; supplementary hours can be amended by the pharmacy subject to giving 90 days' notice to NHS England, who will make the final decision.

Weekdays

With the exception of two pharmacies (1 online) all pharmacies in Thurrock are open between the hours of 9.00am to 5:30pm. There are currently seven pharmacies that are closed for 30 minutes to an hour over the lunch period, *See Table 9.*

Table 9 Community pharmacy opening hours – weekdays, 2014/15

Locality	Ward	8am or earlier	9am - 5:30pm	6pm or later	9pm or later	Other opening times	Closed for lunch
Western	Ockendon	0	3	3	0	1 (9:30 – 16:30) 1 (9:00 – 17:00)	1
	Belhus	n/a	n/a	n/a	n/a	n/a	n/a
	Aveley and Uplands	0	2	2	0	0	1
	West Thurrock and South Stifford	1	5	5	1	0	1
Central	Stifford Clays	1	2	2	1	0	0
	Chafford and North Stifford	0	1	1	0	0	1
	South Chafford	1	1	1	1	0	0
	Grays Thurrock	0	3	2	0	0	1
	Grays Riverside	1	2	1	0	0	0
	Little Thurrock Blackshots	n/a	n/a	n/a	n/a	n/a	n/a
	Little Thurrock Rectory	0	1	1	0	0	0
Southern	Chadwell St. Marys	0	2	2	0	0	2
	Tilbury St. Chads	0	2	2	0	0	0
	Tilbury Riverside and Thurrock Park	1	2	2	2	0	0
	East Tilbury	0	1	1	0	0	0
Eastern	Orsett	n/a	n/a	n/a	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a	n/a	n/a	n/a
	Stanford East and Corringham Town	0	2	2	0	0	0
	Corringham and Fobbing	0	1	1	0	0	0
	Stanford-le-Hope West	1	3	2	2	0	0

The following summarises 'extended hours' with regards to community pharmacy's opening/closing times:

- In all four localities, there is at least one pharmacy open at 8.00am or before and at least one pharmacy open until 9pm or after.
- Limited choice is available for pharmacies that are open at 8.00am or before in the Southern and Eastern localities.

- Limited choice is available for pharmacies open until 9pm or after in the Western and Central localities.

Saturday

There are 25 community pharmacies open on Saturdays, 24 of which open between 9am – 12pm and eight that are open until 6pm or after. Table 10 provides opening and closing times for these community pharmacies in Thurrock.

Table 10: Community pharmacy opening hours – Saturday, 2014/15

Locality	Ward	8am or earlier	9am – 12:00pm	6pm onwards	9pm onwards	Other opening times	Closed for lunch
Western	Ockendon	0	3	0	0	1 (13:00 – 17:00)	0
	Belhus	n/a	n/a	n/a	n/a	n/a	n/a
	Aveley and Uplands	0	2	0	0	0	0
	West Thurrock and South Stifford	1	3	2	0	0	0
Central	Stifford Clays	1	2	1	1	0	0
	Chafford and North Stifford	0	1	0	0	0	0
	South Chafford	1	1	1	1	0	0
	Grays Thurrock	0	0	0	0	0	0
	Grays Riverside	1	2	1	0	0	0
	Little Thurrock Blackshots	n/a	n/a	n/a	n/a	n/a	n/a
	Little Thurrock Rectory	0	1	0	0	0	0
Southern	Chadwell St. Marys	0	1	0	0	0	0
	Tilbury St. Chads	0	2	0	0	0	0
	Tilbury Riverside and Thurrock Park	1	2	2	2	0	0
	East Tilbury	0	0	0	0	0	0
Eastern	Orsett	n/a	n/a	n/a	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a	n/a	n/a	n/a
	Stanford East and Corringham Town	0	2	0	0	0	0
	Corringham and Fobbing	0	1	0	0	0	0
	Stanford-le-Hope West	1	2	1	1	0	0

The extended closing times on a Saturday are summarised below:

- Those pharmacies that provide extended opening hours between 7am – 8am on weekdays are open at the same time on Saturdays.

- There is good choice in the number of pharmacies that are open at 6.00pm or after, on a Saturdays in the Western, Central and Southern localities.
- The Cantal, Southern and Eastern localities each have at least two pharmacies that are open between 11am – 4pm, *see Table 11*.

Sunday

There are currently 13 pharmacies open on a Sunday. All localities are serviced by at least two pharmacies that are open between 11am – 4pm, *see table 11.*

Table 11: Community pharmacy opening hours – Sunday, 2014/15

Locality	Ward	8am or earlier	11am – 12:30pm	4pm or onwards	6pm or onwards	9pm onwards	Other opening times
Western	Ockendon	0	1	1	0	0	0
	Belhus	n/a	n/a	n/a	n/a	n/a	n/a
	Aveley and Uplands	0	0	0	0	0	0
	West Thurrock and South Stifford	0	3	3	0	0	0
Central	Stifford Clays	0	1	1	1	0	0
	Chafford and North Stifford	0	0	0	0	0	0
	South Chafford	0	1	1	0	0	0
	Grays Thurrock	0	0	0	0	0	0
	Grays Riverside	1	2	2	1	0	0
	Little Thurrock Blackshots	n/a	n/a	n/a	n/a	n/a	n/a
	Little Thurrock Rectory	0	0	0	0	0	0
Southern	Chadwell St. Mary	0	0	0	0	0	0
	Tilbury St. Chads	0	0	0	0	0	0
	Tilbury Riverside and Thurrock Park	0	2	2	1	0	0
	East Tilbury	0	0	0	0	0	0
Eastern	Orsett	n/a	n/a	n/a	n/a	n/a	n/a
	The Homesteads (18)	n/a	n/a	n/a	n/a	n/a	n/a
	Stanford East and Corringham Town	0	1	1	0	0	0
	Corringham and Fobbing	0	1	1	0	0	0
	Stanford-le-Hope West	0	1	1	1	1	0

Below is a summary of the extended opening and closing times for these pharmacies:

- There is only one pharmacy in the borough that is open on a Sunday at 8am or before, this is located in the Central locality.
- Three localities; Central, Southern and Eastern each have at least one pharmacy that is open at 6pm or after.
- The Southern and Eastern localities have one pharmacy each that is open at 9pm or after.

Bank Holidays

Pharmacies that open on a Bank holiday and other holiday periods, do so based on a business decision. NHS England have not currently commissioned additional hours under a rota-system in Thurrock.

4.3.2 Access for those with a Disability

A key consideration with regards to access is to what extent a pharmacy has been adjusted to meet the needs of those with a disability. In the Contractors questionnaire, pharmacies were asked whether the premises had access for wheelchairs to the consultation area. It has been assumed that those pharmacies that have wheelchair access to their consultation room would also be wheelchair accessible on the general pharmacy floor. Table 12 summarises the responses and shows that 24/35 (60%) of Thurrock pharmacies have premises that are accessible to wheelchair users.

Table 12: Community Pharmacy that are wheelchair accessible, 2014/15

Locality	Ward	Wheelchair access within pharmacy consultation rooms
Western	Ockendon	3
	Belhus	n/a
	Aveley and Uplands	0
	West Thurrock and South Stifford	4
Central	Stifford Clays	2
	Chafford and North Stifford	1
	South Chafford	1
	Grays Thurrock	2
	Grays Riverside	2
	Little Thurrock Blackshots	n/a
	Little Thurrock Rectory	0
Southern	Chadwell St. Marys	1
	Tilbury St. Chads	2
	Tilbury Riverside and Thurrock Park	2
	East Tilbury	0
Eastern	Orsett	n/a
	The Homesteads	n/a
	Stanford East and Corringham Town	2
	Corringham and Fobbing	1
	Stanford-le-Hope West	1

4.3.3 Travel times to Pharmacies

Another important consideration with regards to access is how long it takes to travel to a pharmacy.

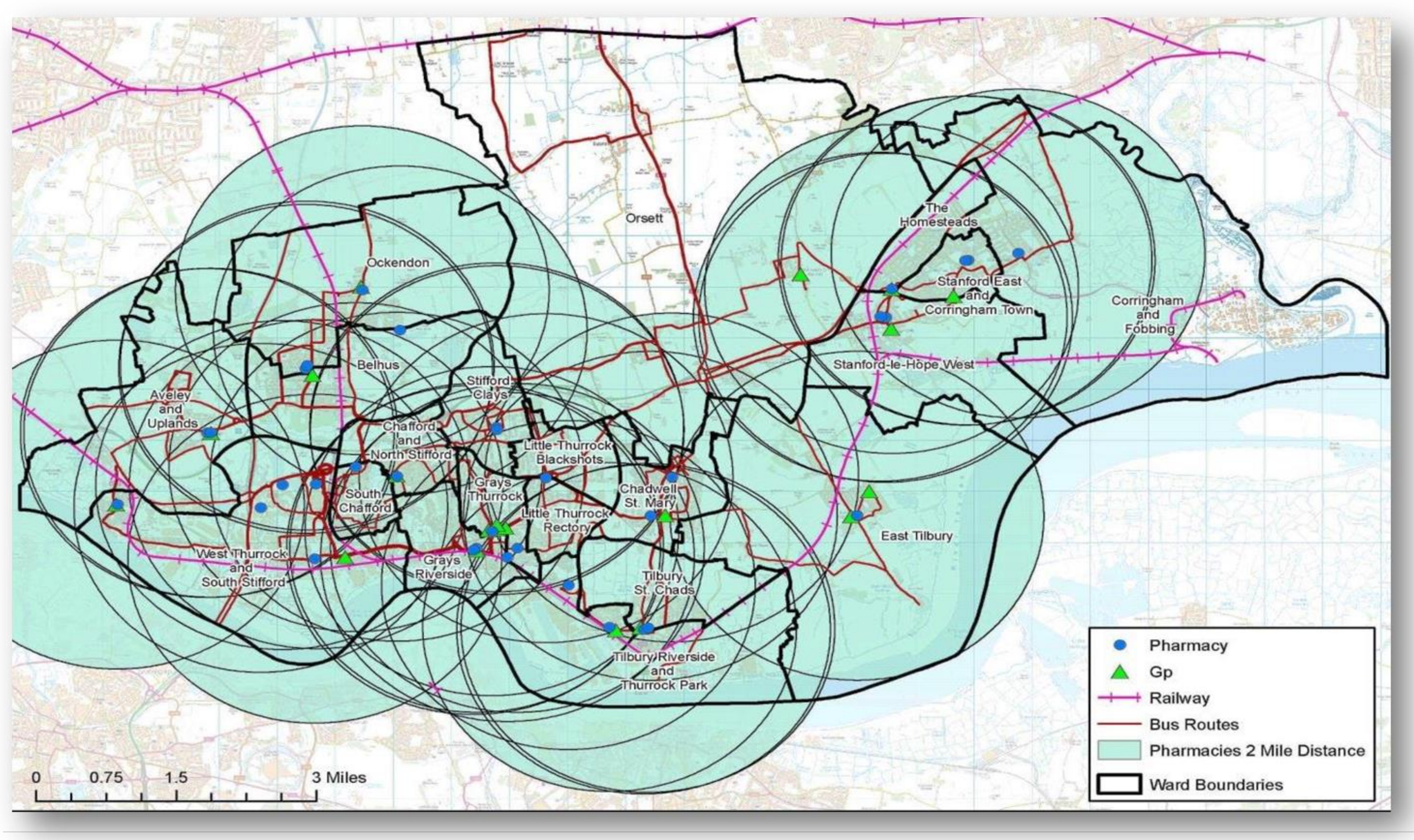
Two Mile Boundary

The latest information shows that 99% of the population in England, including those living in deprived areas can access a pharmacy within 20 minutes by car and 96% can do so by walking or using public transport.[19]

Data analysis shows that 100% of Thurrock residents are able to access pharmacies within 20 minutes by car. It is generally assumed that a person can walk at least one mile to reach their nearest pharmacy. For this PNA, we have considered the extensive public transport that extends a resident's ability to travel further and therefore increase the choice of accessible pharmacies to them.

The distribution of pharmacies with regards to travel time for this PNA was therefore developed using a two mile boundary.

Map 2: Two mile Boundary around community pharmacies



Map 2 shows that there is a good spread of pharmacies that span over the two mile boundary, in most of Thurrock and those residents have a good choice of pharmacies to access.

It appears that residents on the eastern most part of the Corringham and Fobbing ward and the central and northern part of Orsett may need to travel more than two miles to access their nearest pharmacy within Thurrock.

The PNA noted that with regards to North Orsett, there is lower demand of pharmaceutical services, as the land is green belt and therefore has a low population density.

In the eastern part of the borough, there is a higher density of people aged 75+ years and 85+ years who are more likely to have mobility problems and therefore find accessing pharmacies more challenging than the general population. It is likely, however, that these residents are able to access pharmacies in their neighbouring borough within this distance, particularly in south Benfleet and Canvey Island.

Summary of key comments made about access from the Public Survey

50% of respondents stated that they used a car to access their pharmacy, 40% either walked or took public transport. 40% strongly agreed with the statement 'I find it easy to find a pharmacy near where I live', under 0.5% either strongly disagreed or disagreed with this statement.

Around 15% of residents would like to access their pharmacy after 6pm
40% strongly agreed or agreed with the statement ' I can usually find a pharmacy open when needed'.

62% agreed or strongly agreed with the statement "there is some privacy when I want to speak to someone" (in the pharmacy).

70% of respondents would prefer to visit a pharmacy next to their home.

10% stated they would like to access a pharmacy next to their GP surgery.

Implications of Pharmacy Distribution and Access for the PNA

- Thurrock has more pharmacies per 100,000 population than the similar boroughs, East of England and England. As such it is well resourced with regards to pharmaceutical services.
- At locality level, there is unequal distribution of pharmacies, with the Western locality served by 31/100,000 population and the Eastern locality served by 17/100,000 population.
- The general correlation of pharmacies and areas of deprivation at ward level seems to be good with the majority of those areas that are more deprived benefiting from higher numbers of pharmacies per 100,000 population than the comparator areas.

This however is not the case for Belhus, which ranks as the third most deprived ward in Thurrock which has no pharmacy. However residents are able to access pharmacies in adjacent wards.

- On weekdays between the hours of 9am and 5:30pm there is good access and choice of pharmacy in all wards, except Belhus, Little Thurrock, Blackshots, Orsett, and The Homesteads that have no pharmacies. Residents in Chafford and North Stifford, South Chafford, Little Thurrock Rectory, East Tilbury and Corringham and Fobbing only have access to one pharmacy each. However it is recognised that residents are able to extend their choice by accessing pharmacies in adjacent wards.
- There is good access and choice of pharmacies that are open on Saturdays and at least two pharmacies that can be accessed within each locality on a Sunday between 11:30am and 4pm.
- Extended hours play a key role on ensuring that those residents who may need to access services either very early in the morning or late in the evening area are able to, this is particularly true of Thurrock's working population.
- During the week and on Saturdays all localities have at least one pharmacy that is open before 8am and close after 9pm.
- On Sundays access is limited, with only one pharmacy open before 8am in the whole borough. By 6pm there are 3 pharmacies that are open, one in the Central and two in the Eastern localities. By 9pm there are only two pharmacies open on Sundays, located in the Eastern and Southern localities.
- In some areas it is recognised that there is limited or no access to pharmaceutical services on a Saturday and Sunday during extended hours. This becomes particularly important in areas where there are high levels of deprivation as the limited access of pharmaceutical services may further contribute towards health inequalities.
- It is noted that currently there are no pharmacies providing additional commissioned hours during Bank Holidays, including Christmas, NHS England base this decision on a systematic approach that accounts for perceived needs of the population for pharmaceutical services on these days. The majority of community pharmacies are wheelchair accessible and wheelchair users in every locality have a choice of more than five pharmacies to access. However all pharmacies should take strides and make significant progress towards meeting and exceeding the minimum legislative standards for access to those with a disability where appropriate. The time travelled as a measurement of accessibility, shows that all residents would have a wide choice of pharmacies within 20 minutes, if travelling by car. The virtual two mile boundary around each pharmacy was created to show the minimum area of the borough that residents can access, should they use a combination of walking and public transport.
- There are two parts of the borough that sit outside of this minimum area; North Orsett, Corringham and Fobbing. Further analysis shows that residence of these areas are accessing pharmacies in Basildon, as they are closer than community pharmacies in Thurrock. In addition population density of North Orsett is low due to the area being green belt and therefore the demand of pharmaceutical need will be lower than other areas in the borough.
- Limited data of density of older people (aged 75+ years and 85+ years) within these areas were considered. The analysis shows that although the ward of Corringham

and Fobbing has a higher density of older people it is likely that these residents are also accessing pharmacies in neighbouring boroughs.

- Insights to access in the public survey shows that residents were generally satisfied with the proximity and opening hours of pharmacies. The majority of those that took part in the survey preferred to visit a pharmacy close to their home.

4.4 Essential Services

All community Pharmacy contractors are required to provide a full range of essential services, as set out in the 2013 NHS Regulations. The fact that all pharmacy premises must provide these services means that they can be used across the borough to focus on the reduction of health inequalities. Essential services include:

- Dispensing and actions associated with dispensing
- Disposal of unwanted medicines
- Promotion of healthy lifestyles, including Public Health Campaigns
- Prescription-linked interventions
- Signposting
- Support for self-care

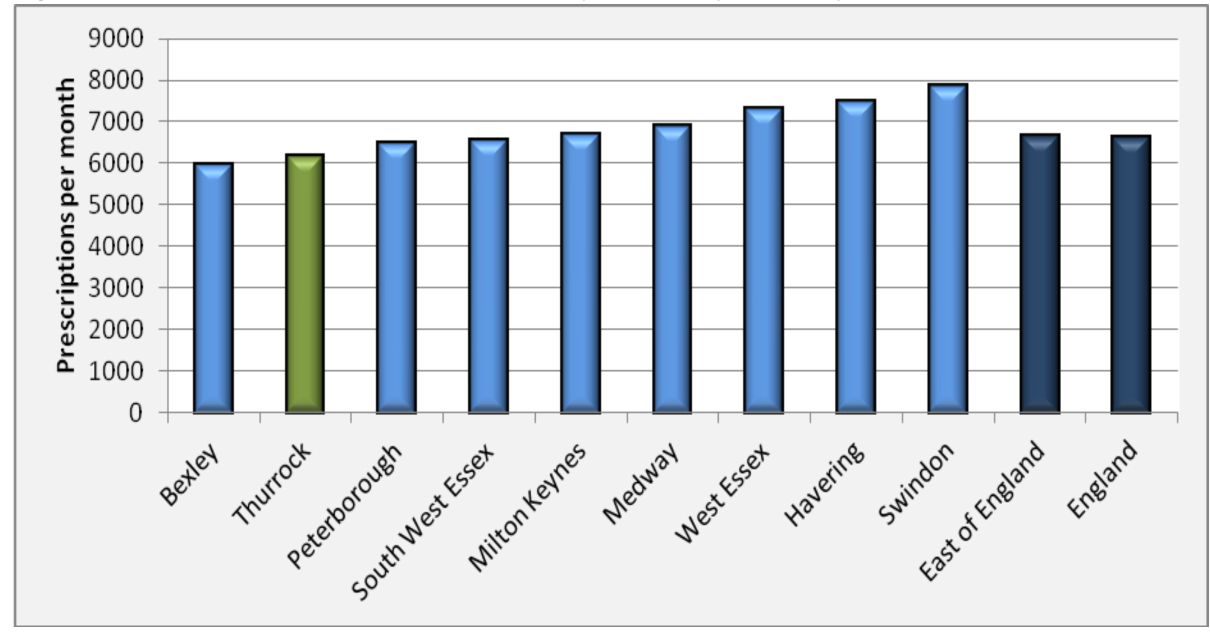
The assessment of essential services has been undertaken in context with the distribution and access services, as outlined in the above sections, against the local context, needs and strategic priorities of Thurrock's population.

4.4.1 Dispensing Services

4.4.1.1 Dispensing in Community Pharmacy

During 2012/13, an average of 6,174 items per month were dispensed by all pharmacies within Thurrock. This dispensing rate is lower than the Similar Boroughs (6,900), East of England (6,641) and England (6,628).

Figure 9: Number of items dispensed per month by community pharmacy.



Source: HSCIC General Pharmaceutical Services in England 2012/13

A total of 2,798,773 items were dispensed against all prescriptions issued by Thurrock GPs during 2012/13. Of these, 2,593,262 (92.7%) items prescribed were dispensed by Thurrock community pharmacies. Table 13 provides a breakdown by locality.

Table 13: Items dispensed in Thurrock localities, 2012/13

Locality	Number of Pharmacies	Total items dispensed	% of total items (%)	Annual items per pharmacy	Items per month
Western	12	900,514	34	75,042	6,254
Central	10	660,950	26	73,439	6,120
Southern	7	504,342	20	72,049	6,004
Eastern	6	527,456	20	58,606	4,883

The data above shows that the average volume of dispensing by pharmacy in all four localities is also below the Similar Boroughs, East of England and England averages. This suggests that there are currently no capacity issues with regards to dispensing in any locality.

In total, 101,739 (3.6%) items were dispensed by pharmacies outside of Thurrock or considered as 'personally administered items' by GP surgeries. These were dispensed or personally administered, in the case of GP surgeries, by 1,828 organisations, (this excludes dispensing doctor activity which is described further down).

The table below provides an overview of pharmacies in neighbouring boroughs that have dispensed at least 100 items in one year, to Thurrock residents.

Table 14: Out of area pharmacy dispensing, 2012/13

	Pharmacy Name	Postcode	% of all out of area items dispensed
Basildon	TESCO STORES LIMITED	SS13 3JU	3.9
	BOOTS UK LIMITED	SS14 1BA	3.1
	ASDA STORES LTD	SS14 1JH	1.3
	ALLCURES PLC	SS16 5DF	0.95
	ASDA STORES LTD	SS14 3AF	0.93
	L ROWLAND & CO (RETAIL) LTD	SS142HB	0.82
	SAINSBURY'S SUPERMARKETS LTD	SS13 1SA	0.74
	NATIONAL CO-OPERATIVE CHEMISTS LIMITED	SS16 5SA	0.614
	NATIONAL CO-OP CHEMISTS LTD	SS15 5TQ	0.58
	ALLCURES PLC	SS16 4QW	0.53

Cross-border dispensing serves to improve access to pharmaceutical services, particularly for residents who live close to borders of neighboring boroughs or for those residents who use dispensing services close to their place of work.

4.4.1.2 Dispensing Doctors

Thurrock has two GP practices with dispensing doctors, located in the Western and Eastern localities. During 2012/13 these dispensing doctors dispensed 103,772 items. Together the dispensing doctors contributed to 3.7% of the total items dispensed against all Thurrock GP prescriptions. It also contributed to 50% of the total dispensing activity that was not undertaken by Thurrock pharmacies against a prescription dispensed by Thurrock GPs.

4.4.1.3 Out of Hours Dispensing

The GP 'out of hours' service, the Rapid Response Assessment Service, led by the district nursing team work and the A&E department at Basildon and Thurrock University Hospital Trust (BTUH) are open 24 hours a day, 7 days a week. Whilst these providers stock their own medication, should there be a need, there is an on-call service at BTUHT for other urgent requirements.

4.4.2 Repeat Dispensing

Repeat dispensing allows patients who have been issued a repeatable prescription to collect their repeat medication from a pharmacy without having to request a repeat prescription from their GP.
The service can provide the following benefits:

- Reduction in GP workload which could free time for more clinical activities.
- Allow for more predictability in pharmacy workload, which could facilitate delivery of wider pharmaceutical services.
- Reduce waste, as pharmacies will be dispensing required medications.
- Increased convenience for patients.

For the year 2013/14, approximately 178,000 prescriptions were issued in Thurrock by repeat dispensing/batch prescribing, representing about 6.1% of all items issued on prescription during this period.

4.4.3 Electronic Prescription Service

The electronic prescription (EPS) service enables GPs and practice nurses to electronically send a prescription to a patient's chosen pharmacy for dispensing. The system makes the prescribing and dispensing process more efficient and convenient for patients and staff. In addition, EPS can help to reduce wastage of medicines by allowing pharmacy more opportunities to help patients use their medicines more effectively as well as reduces risks of disruption to the supply of medicines to patients.

NHS England and Thurrock CCG are currently rolling out Electronic Prescription Service Release 2 (EPS2) to practices and pharmacies. EPS2 is currently underway in one Thurrock practice, located in the Eastern locality with plans for further sites to go live in the next few months.

4.4.4 Other Essential Services

NHS England are currently planning to run a number of health promotion campaigns through community pharmacy. Local Authority may want to consider dove-tailing or extending these campaigns based on local needs and priorities. This involves providing opportunistic advice, information and signposting around lifestyle and public health issues. NHSE are considering the following draft campaigns for 2014/15:

Campaign	Date	Links to:
Sun Awareness	End July	Holidays
Sexual Health	Early September	Students returning Fresher's Week
Mental Health/Keeping Fit & Healthy	October	World MH Day 10th October
Antibiotic Awareness/Keeping Warm in Winter	November	Winter Flu
Falls & Frailty/Alcohol Awareness	January	Dry January
Smoking Cessation	March	Stop Smoking Day 12th March 2015

In addition to the medicine dispensing activity that community pharmacies deliver, they are also highly skilled in providing:

- Opportunistic health promotion advice, self-care support and targeted prescription linked interventions.
- A valuable service to safely dispose waste medicines in order to reduce harm through inadvertent use of unwanted or expired medicines and serve to protect the environment. (check with A here)?

Summary of comments made about essential services from the Public Survey

66% of residents have their prescriptions dispensed at a pharmacy.
Over 10% of residents use pharmacy to 'get advice'.
Over 80% of residents were satisfied with the information about side effects given to them in the pharmacy.

Essential Services Conclusion

Dispensing is a fundamental service commissioned nationally by the NHS and ensures that patients have access to prescribed medication in a safe and dependable environment. Pharmacies are invaluably positioned to support health campaigns by proactively delivering health promotion and signposting advice. Community pharmacies therefore are key in addressing the health needs and contributing to tackling inequalities within Thurrock.

Taking this into consideration, we have concluded that the essential services are **necessary** to meet the pharmaceutical needs of our population.

- Benchmarking data used to compare dispensing activity in Thurrock to other similar boroughs, East of England and England. The analysis demonstrates that Thurrock community pharmacies have significant capacity to meet current and future dispensing requirements.
- The assessment has demonstrated that on weekdays and on Saturdays between the hours of 9am and 5:30pm there is good access to essential services within community pharmacies.
- Residents also have good choice of pharmacy, either within their ward or adjacent wards.
- There is also reasonable access to essential services on a Sunday in most localities.
- A key consideration to dispensing is the need for aligning pharmacy and other primary and secondary care providers opening hours i.e. GP practice, out of hour's services, A&E etc. The current system for clinicians to obtain out of hours emergency medication satisfies the current demand on these services.

Future needs of Pharmacy:

- Out of hours provision will be of particular importance for the future delivery of a seven day primary care service through the Hub model in Thurrock. The current pattern of pharmacy opening hours may not be sufficient and the current open hour's service is only available to prescribers.
- These changes may require NHS England to consider seeking additional hours, although pharmacies may recognise the need and adjust core hours proactively.
-

- Engagement with Public Health England to ensure local priorities are considered in planning national health promotion campaigns.
- Promotional material should be in a number of languages and culturally appropriate. Campaigns should be evaluated with regards to impact.

4.5 Advanced Services

Advanced services are defined in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Direction 2013. Any contractor may choose to provide Advanced Services if the requirements, relating to premises, training or notification to the NHS England area team, are met.

The Advanced services include:

- Medicines Use Review (MURs)
- New Medicines Service (NMS)
- Appliance Use Reviews (AUR) - not currently provided by pharmacies in Thurrock
- Stoma Appliance Customisation Service (SAC)

4.5.1 Medicines Use Review (MURs) and Prescription Intervention Service

The MUR service is a structured review of a patient's use of their medication, which aims to improve the patient's knowledge, understanding and use of their medicines. It supports patients to gain the maximum benefit from the prescribed medication as well as reduce wastage.

The majority of MURs take place with patients taking more than one medication, that pharmacists/pharmacy staff have identified will potentially benefit the patient. Patients identified must have been receiving pharmaceutical services from the pharmacy for no less than three months in order to be eligible.

An MUR can also take place when a problem with the patient's adherence to their medication is identified during the dispensing process – this is known as a prescription intervention MUR and does not require the patient to have a history of receiving pharmaceutical services from the pharmacy.

A pharmacy can undertake up to 400 MURs per annum. At least 50% of these must be directed at the national target groups that include:

- Patients taking high risk medicines as specified in the directions
- Patients recently discharged from hospital that has had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge; and
- Patients with respiratory disease.

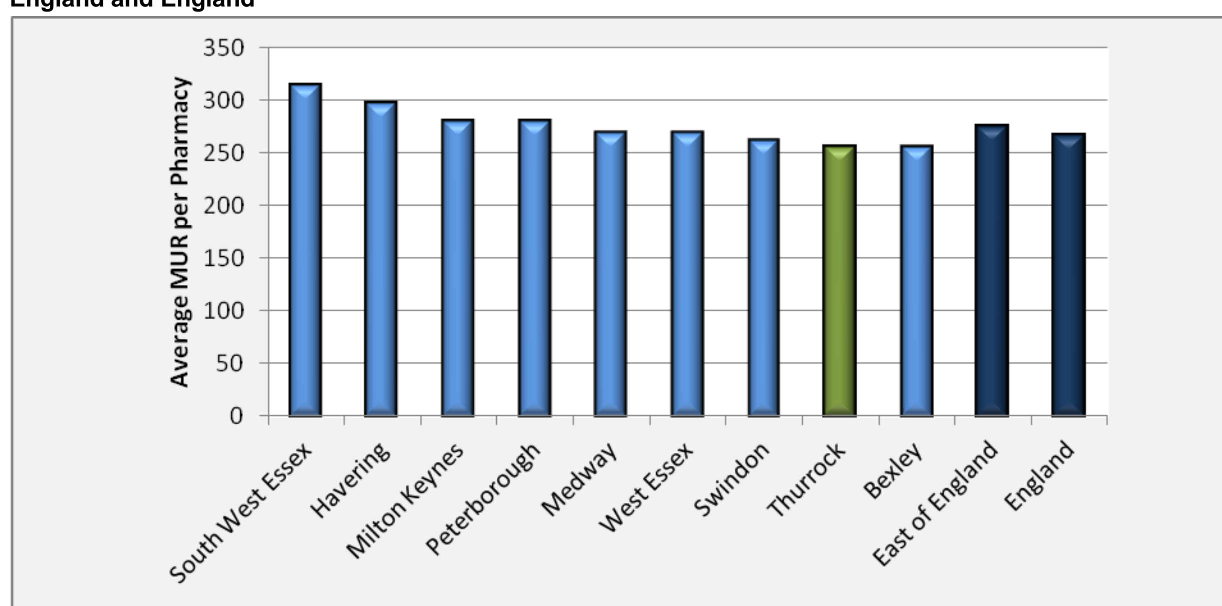
There is growing evidence of the effectiveness that MURs have in improving adherence and outcomes for patients, as well as reducing medicine related risk such as adverse effects:

- 49% of patients reported receiving recommendations to change how they take their medicines and of these 90% were likely to make the changes.
- 77% of patients noted an improvement in knowledge of their medication due to an MUR.
- 85% of patients scored the MUR a 4 or 5 on a scale of usefulness, where 1 is not useful and 5 is very useful.

Approximately 8,201[20] MURs were undertaken by 32/35 (91%) of Thurrock pharmacies in one year. Benchmarking data from 2012/13 suggest that the percentage of pharmacies providing this service in Thurrock is similar to that of the Similar Boroughs (93%), East of England (93%) and England (92%) averages.

Thurrock pharmacies performed an average of 256 MURs per year. This performance activity is lower than the Similar Boroughs (n276), the East of England (n276) and England (n267) averages *see figure 10.*

Figure 10: Average MURs per pharmacy, 2012/13 in Thurrock compared to Similar Boroughs, East of England and England



Source: HSCIC

This suggests there is currently scope and capacity within the existing pharmacy and primary care networks to target additional patients who would benefit from MURs.

Table 15 shows the number of MURs services accessible on different days of the week. It suggests that there is very good access to MUR service provision in all three localities between the hours of 9am – 5:30pm pm on weekdays, on Saturday between 9am- 5pm and on Sundays between 9am- 4pm.

Table 15: MUR services available in Thurrock, 2013/14

Locality	Ward	No. of	No. of	No. of

		pharmacies delivering MURs on a weekday	Pharmacies providing MURs on a Saturday	Pharmacies providing MURs on a Sunday
Western	Ockendon	4	4	1
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	2	2	0
	West Thurrock and South Stifford	5	3	3
Central	Stifford Clays	2	2	1
	Chafford and North Stifford	1	1	0
	South Chafford	1	1	1
	Grays Thurrock	3	0	0
	Grays Riverside	2	2	2
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	1	1	0
Southern	Chadwell St. Marys	2	1	0
	Tilbury St. Chads	2	2	0
	Tilbury Riverside and Thurrock Park	2	2	2
	East Tilbury	1	0	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	2	1	0
	Corringham and Fobbing	1	1	1
	Stanford-le-Hope West	3	2	1

Due to the high pharmacy participation level, residents are able to access MURs during pharmacy 'extended hours' that run to at least 8.00pm Monday to Sunday in the Central, Southern and Eastern locality. In the Western locality residents can access MURs until 5pm on Sundays. However this is not seen as a gap as there is enough provision of this service throughout the day and week, should residents want to access these services.

Conclusion of MURS

Evidence suggests that targeted MURs improve patient outcomes increasing adherence and reducing medicine related risks. It can contribute to for instance an estimated 20% of hospital admissions that are medicines-related and arise as a result of unintended consequences i.e. side effects of taking inadequate dosage, or failure of using a prescribed medication.

MURs support the delivery of the following strategic aims of Thurrock Council and Thurrock CCG:

- Reducing avoidable hospital admissions for older people.
- A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible.
- Ensure that those people with long term conditions are supported to achieve the maximum benefits of their medication.
- Empower citizens to make healthy choices and take personal responsibility for their health and wellbeing.

Given the alignment of this service in supporting the local strategic priorities, we have concluded that this service is **necessary** to meet the pharmaceutical needs in Thurrock.

The following have been noted as future opportunities:

- Two pharmacies, located in Central and Eastern locality, undertook no MURS in 2013/14.

- The average number of MURs per pharmacy is significantly below the maximum number of MURS that may be undertaken in a year. We would therefore encourage all pharmacies to proactively target MURs to those patients who would benefit most from this service. (n400). We would therefore encourage all pharmacies to proactively target MURs to those patients who would benefit most from the service.

Future projections in the local population show an increase in those aged 70+ years; with this in mind, there is an anticipated need for more MURs. We conclude that there is sufficient capacity in the current delivery system to absorb future needs of the population which will be explored locally. Considering this, we have not identified any future needs or gaps with regards to this service.

4.5.2 New Medicine Service

The New Medicine Service (NMS) is the latest advanced service to be introduced in the NHS community pharmacy contract and was introduced on 1 October 2011. The NMS aims to support medicinal adherence in patients with long term conditions, who are taking a newly prescribed medicine. The NMS is focused on the following patient groups and conditions:

- Asthma and COPD
- Type 2 Diabetes
- Antiplatelet/anticoagulant therapy
- Hypertension

For each condition/therapy area, a list of medicines has been agreed. If a patient is newly prescribed one of these medicines, they will be eligible to receive the service, subject to the pharmacist being able to determine that the medicine is being used to treat one of the above conditions (or in circumstances where a medicine can be used to treat more than one condition).

The NMS is a time-limited service that was originally commissioned until March 2013, at which point an academic review to demonstrate the value of the service was undertaken. In August 2014, NHS England announced that they would continue to commission the service in 2014/15.

During 2012/13, approximately 2,050 NMSs were undertaken by 28/35 (80%) pharmacies in Thurrock. The percentage of pharmacies providing this service in Thurrock is below the similar boroughs (85%), East of England (86%) and England (83%) averages.

Thurrock pharmacies performed an average of 59 NMSs per year. This performance activity is lower than the similar boroughs (n76), the East of England (n68) and England (n68) averages *see figure 11*.

Figure 11: Average NMS per pharmacy, 2012/13 in Thurrock compared to similar Boroughs, East of England and England.

Area	Average NMS per Pharmacy (approx. from chart)
South West Essex	
Thurrock	
West Essex	
Bexley	
Peterborough	
Havering	
Swindon	
Medway	
Milton Keynes	
East of England	
England	

Source: HSCIC (there was no source is this HSCIC ok or do we need to elaborate)?

Table 15 provides a breakdown of NMS services on different days of the week. There is good access to NMS in all four localities, on weekdays between 9am – 6pm, on Saturdays between 9am – 5pm and on a Sunday between 9am – 4pm.

Table 15: NMS services available in Thurrock, 2013/14

Locality	Ward	No. of Pharmacies delivering NMSs on a weekday	No. of Pharmacies providing NMSs on a Saturday	No. of Pharmacies providing NMSs on a Sunday
Western	Ockendon	3	3	1
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	2	2	0
	West Thurrock and South Stifford	5	3	3
Central	Stifford Clays	2	2	1
	Chafford and North Stifford	1	1	0
	South Chafford	1	1	1
	Grays Thurrock	2	0	0
	Grays Riverside	1	1	1
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	1	1	0
Southern	Chadwell St. Marys	2	1	0
	Tilbury St. Chads	2	2	0
	Tilbury Riverside and Thurrock Park	1	2	2
	East Tilbury	1	0	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	1	1	1
	Corringham and Fobbing	1	1	1
	Stanford-le-Hope West	2	1	0

Although provision of this service is not within all ward as there is no three month regulation, patients can be referred to another pharmacy, provided that the alternative pharmacy dispenses against the patients prescription.

Conclusion of NMSs

Targeted NMSs can improve a patient's adherence to newly prescribed medication, help manage medicine-related risks and improve patient outcomes. A recent RCT has demonstrated the benefits of NMSs in community pharmacies:

- The NMS increased adherence by around 10% and increased identification in the number of medicine related problems and solutions.
- Economic modelling showed that the NMS intervention could increase the length and quality of life for patients, whilst costing the NHS less than those in the comparator group.

The NMS support the delivery of the strategic aims of Thurrock Council and Thurrock CCG, particularly with respect to:

- Reducing avoidable hospital admissions for older people.
- A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible.
- Ensure that those people with long term conditions are supported to achieve the maximum benefits of their medication.
- Empower citizens to make healthy choices and take personal responsibility for their health and wellbeing.

While the service aligns well to our local strategic priorities, and that there is evidence of the benefits of this intervention, the future of this service, beyond March 2015 is uncertain. Considering this, we have concluded that currently NMSs are a relevant service that improve access to medicine reviews, clinical support and have the potential to improve patient outcome.

The following has been identified with regards to service provision:

- 7 pharmacies did not undertake any NMSs

It is not clear why these pharmacies did not undertake any NMSs. However, residents are able to be referred to an alternative pharmacy if they wish to access this service.

Systems need to be in place to ensure that providers know which pharmacies are currently delivering this service. This is to ensure that referrals are both appropriate and delivered in a timely manner.

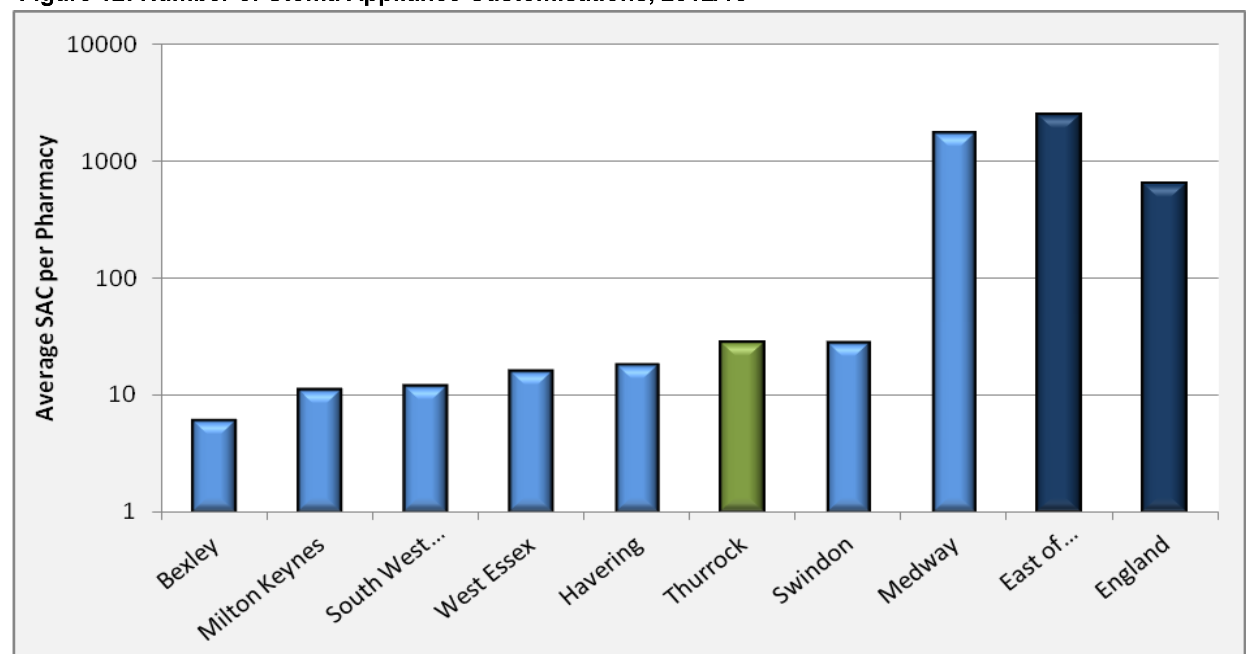
4.5.3 Stoma Appliance Customisation Service

Stoma Appliance Customisation (SAC) is an advanced service that a community pharmacy or appliance contractor can choose to provide so long as they fulfil certain criteria. The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. There are no limits to the number of SACs that may be undertaken.

During 2012/13, approximately 28 SACs were undertaken by 7/35 (20%) pharmacies in Thurrock. The percentage of pharmacies providing this service in Thurrock is higher than the similar boroughs (13.3%), East of England (12%) and England (15%) averages.

Local performance activity is similar to other Similar Boroughs. Thurrock's performance (n28) is significantly lower than the East of England (n2513) and England (n635) averages *see figure 12*.

Figure 12: Number of Stoma Appliance Customisations, 2012/13



The pattern of access is similar across England. A reason for this is that this is a specialist area with patients receiving support from either the hospital or the clinic responsible for their ongoing care or from a dispensing appliance contractor.

Table 16: SACs services available in Thurrock, 2013/14

Locality	Ward	No. of Pharmacies delivering SACs on a weekday	No. of Pharmacies providing SACs on a Saturday	No. of Pharmacies providing SACs on a Sunday
Western	Ockendon	2	2	1
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	0	0	0
	West Thurrock and South Stifford	1	1	1
Central	Stifford Clays	1	1	0
	Chafford and North Stifford	1	1	0
	South Chafford	0	0	0
	Grays Thurrock	0	0	0
	Grays Riverside	1	1	1
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	1	1	0
Southern	Chadwell St. Marys	0	0	0
	Tilbury St. Chads	0	0	0
	Tilbury Riverside and Thurrock Park	0	0	0
	East Tilbury	0	0	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	0	0	0
	Corringham and Fobbing	0	0	0
	Stanford-le-Hope West	0	0	0

Conclusion of SACs

There is very low activity with regards to SAC services in Thurrock.

Residents may be using an alternative provider including the hospital or clinic lead for their ongoing health care.

We are concluding that this service may secure improvements for our residents and is therefore a relevant service.

4.6 Enhanced Services

Enhanced services are defined in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Direction 2013. NHS is responsible for the commissioning of enhanced services from community services.

Pharmaceutical service providers are an important part of primary care. As well as dispensing prescriptions they provide information about medicines, self-care, general health care and other sources of advice. They complement services provided by general practice.

These services can only be referred to as Enhanced Services if they are commissioned by NHS England. If local services are commissioned by CCGs or local authorities, they are referred to as locally commissioned services. Locally commissioned services are discussed in the context of local needs in the next section of the PNA. The following is a list of enhanced services that can be commissioned by NHS England, as an enhanced service:

- Anticoagulation monitoring
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Independent prescribing service
- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support
- Minor ailment service
- On demand availability of specialist drugs
- Out of hours service
- Palliative care
- Patient group direction service (not related to public health services)
- Prescriber support service
- Schools service
- Supplementary prescribing service.

4.6.1 Seasonal Influenza Vaccinations

Influenza or the 'flu' is a respiratory illness associated with infection by influenza virus. Influenza occurs most often in winter and usually peaks between December and March in the northern hemisphere.

In line with the World Health Organization targets,[21] NHS had been asked to achieve aspiration uptake targets for vaccine coverage, during 2012/13; to reach or exceed 75% uptake for people aged 65+ years, to reach or exceed 75% uptake for people under the aged 65 years with clinical conditions which put them more at risk of the effects of flu and 70% uptake in pregnant women. Aspirations towards increasing coverage to reach or exceed 75% in 2013/14 has been forecast nationally.

Between September 2014 and January 2014 the coverage achieved in General Practice for those in the 65+ years group was 69.2% in Thurrock. Within the '6 month to under 65 years' at risk group, Thurrock achieved a 45.2% average. Vaccine uptake amongst pregnant women in Thurrock was 35.6%.

As the national targets were not being met, a Seasonal Influenza vaccination programme was commissioned from community pharmacies between 2013/14. The aim of this service was to provide a wide choice of provision to patients, other than their GP. The following at risks groups were invited to take up the service:

- Those aged 65 years and over.
- Children (aged 13-17 years) and adults classified within 'at risk' groups including those with chronic respiratory disease, chronic heart disease, chronic liver disease, chronic liver disease, chronic neurological disease, diabetes mellitus and those that are immune-comprised.
- Pregnant women.
- Main carer(s) of older people/those with disability.
- Those living in long term residential/nursing homes.
- Front-line health and social care workers.

Pharmacies need to have met the following accreditation in order to provide this service:

- A designated consultation room/area that is spacious enough for the safe administration of vaccines as well as provide privacy to patients.
- Appropriate refrigeration to maintain the cold chain and safe disposal of sharps and clinical waste.
- The Pharmacist must have:
    - Regularly worked in the pharmacy.
    - Competences in all aspects of immunisation, including completing specified training courses.
    - Undertaken basic life support training within the last three years and ensure continuous updating every twelve months.

- Be prepared to work under the patient group direction for the administration of influenza vaccine.

- Access to equipment to treat anaphylaxis (including epinephrine) and a telephone in case of emergency.

During the 2013/14 flu season, NHS England Essex Area Team ran a Community Pharmacy Seasonal Influenza Vaccination Pilot. The aim of the pilot was to test the effectiveness and feasibility of pharmacies improving vaccination accessibility for patients and increasing uptake rates in the under 65 clinical at risk groups. It was designed with the intention of supporting patient choice and a total of 48 pharmacies vaccinated more than 1,100 patients across Essex.

The pilot community pharmacies were invited to participate based on their proximity to practices which had consistently struggled to achieve the national target (75%) in the under 65 years clinical at risk groups over the previous three years. Pharmacies were only commissioned to vaccinate patients aged 4 – 65 years in an at risk group and pregnant women.

In total, seven pharmacies accepted the invitation to deliver this service and vaccinated 70 patients, during 2013/14. Table 16 provides a breakdown of where these pharmacies are located.

Table 16: Seasonal Influenza services available in Thurrock, 2013/14

Locality	Ward	No. of Pharmacies delivering seasonal influenza on a weekday	No. of Pharmacies providing seasonal influenza on a Saturday	No. of Pharmacies providing seasonal influenza on a Sunday
Western	Ockendon	1	1	0
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	0	0	0
	West Thurrock and South Stifford	1	1	1
Central	Stifford Clays	0	0	0
	Chafford and North Stifford	1	1	0
	South Chafford	0	0	0
	Grays Thurrock	0	0	0
	Grays Riverside	0	0	0
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	0	0	0
Southern	Chadwell St. Marys	1	1	1
	Tilbury St. Chads	1	1	0
	Tilbury Riverside and Thurrock Park	0	0	0
	East Tilbury	0	0	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	2	2	1
	Corringham and Fobbing	0	0	0
	Stanford-le-Hope West	0	0	0

The pilot has been extended for 2014/15 flu season, all Essex pharmacies have been invited to participate. The target population are those aged 18 - 65 years (due to the national pilot for childhood flu being extended this year) in clinically at-risk groups and pregnant women.

Conclusion of Seasonal Influenza Vaccination Service

We have concluded that the Seasonal Influenza Vaccination service is a **relevant** service, due to it improving access and providing at risk patients with a choice of provider, other than their GP.

- There is at least one pharmacy open in all four localities during the week as well as on Saturdays.
- However with regards to extended hours, services are quite limited, with no provision after 6pm in the Central, Southern and Eastern localities during the week.
- There is one pharmacy, located in the Western locality that is open until 8pm on weekdays. On Saturdays, the Central locality only has provision of this service until 1pm.
- There is no provision of service in the Central locality on Sundays.

We would like to see a larger number of pharmacies actively delivering this service, particularly those that are in areas with higher proportions of the target population, i.e. pharmacies in the Central and Eastern localities that have this higher numbers of older people.

In addition Pharmacies should be invited to support achieving all WHO targets, which are not currently being met.

5. Locally Commissioned Services

From 1 April 2013 those public health enhanced services previously commissioned by PCTs transferred to local authorities and are now termed as locally commissioned services.

Community pharmacy contractors can also provide services commissioned by another NHS organisations.

Applications to the Pharmaceutical List can only be made on the basis of Pharmaceutical Services identified in the regulations; they cannot be submitted on the basis of gaps identified in provision of locally commissioned services.

5.1 Public Health Services

A number of public health services are currently commissioned by Thurrock Council.

The public health services commissioned in 2014/15 are:

- Sexual health services.
- 5 – 19 (school nursing) service.
- Drug and alcohol service.
- Adult weight management.
- Children's weight management.
- NHS health checks.
- Smoking and tobacco control services.

These services above are currently commissioned from North East London Foundation Trust (NELFT). There is also a range of smaller services commissioned with Southend Hospital University Foundation (SHUFT) Trust, Basildon Trust University Hospital (BTUH), and South Essex Partnership Trust (SEPT).

Within the NELFT contract the provider subcontracts primary care to deliver local enhanced services for Sexual Health, Smoking Cessation and Health Checks in Thurrock.

The public health team in Thurrock reviewed some of these services in 2014 and it agreed that notice would be served to the current providers for all commissioned services. Notice was served on 30 September 2014.

Tender processes will be undertaken in 2014/15 in preparation for new provision from 1 April 2015 for;

- Adult Weight Management including Health Checks,
- Children's Weight Management
- School Nursing (5 – 19 years) service.

The remainder of the commissioned services will be reviewed by March 2015.

5.2 Substance Misuse Service

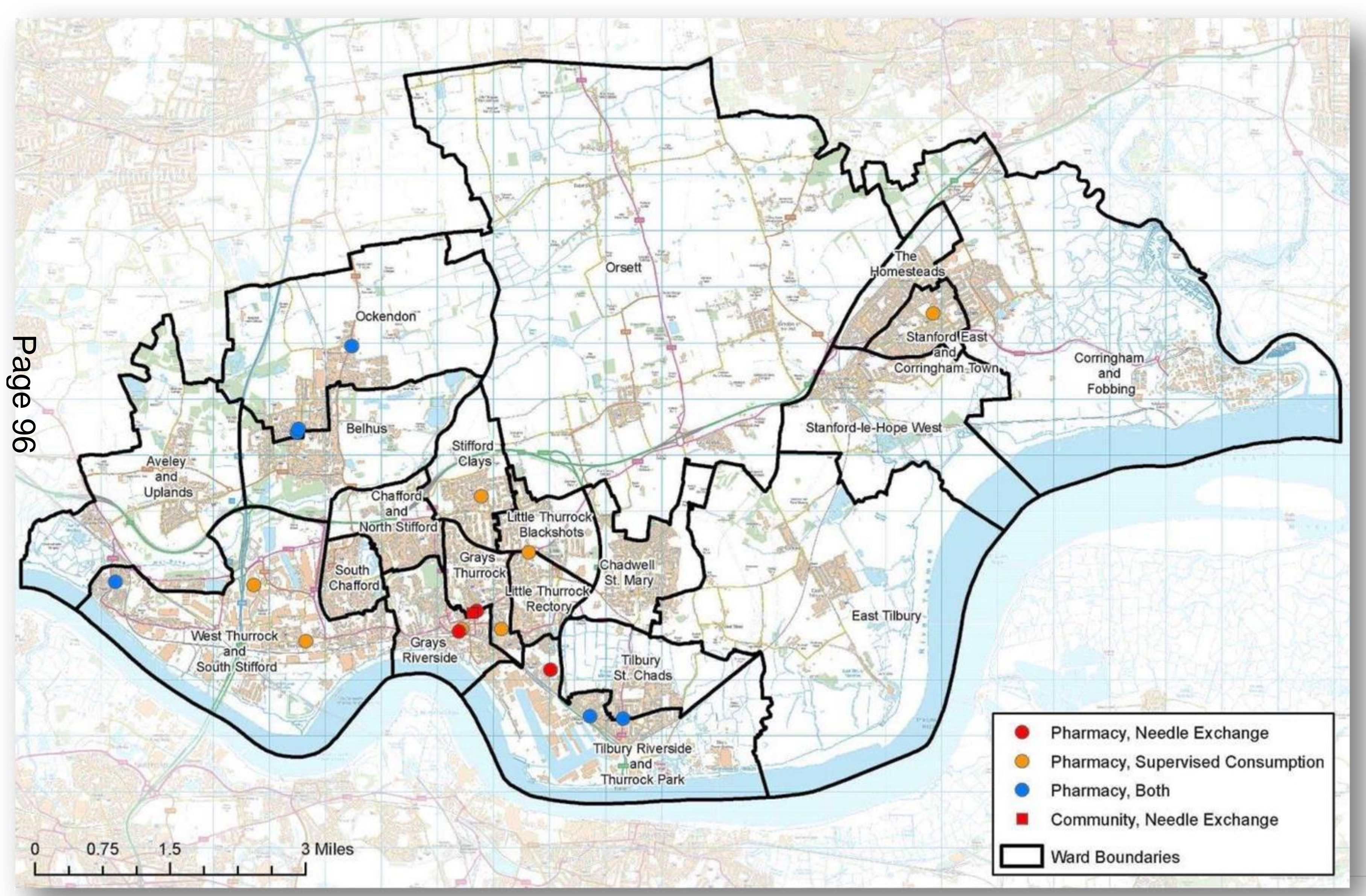
Funding for this service is through the public health grant. From June 2014 the public health team took responsibility for the commissioning responsibilities for all drugs and alcohol services. A new service was awarded to new providers on 1 April 2014. This year the team will be reviewing performance and monitoring outcomes.

Training will be made available to all staff engaged in the provision of the needle and syringe programme through the Thurrock DAAT. It is recommended that any staff participating in the Needle Syringe programme be vaccinated against hepatitis B, as a precautionary measure. The following measures need to be in place for pharmacies to provide this service:

- Provide safe storage conditions for the supply of methadone and have appropriate standard operating procedures for the safer management of controlled drugs and other drugs.
- Ensure pharmacy support staff are fully briefed by the pharmacist about the service to be provided and their role; fully understand the SOPs supporting the service, and that they must seek advice from the pharmacist where necessary. It is necessary for counter staff to be trained in good practice procedures.

Map 3 provides a visual representation of where current service provision is available within the borough.

Map 3: Needle and syringe Exchange, and Supervised Consumption services, 2013/14



5.2.1 Needle and Syringe Exchange Service

Needle exchange is a harm reduction programme designed to assist the service users to remain healthy and stop the spread of disease through the sharing of needles, until the user is ready and willing to cease injecting and adopt a drug-free lifestyle.

The pharmacy provides access to sterile needles and syringes, and sharps containers for return of used equipment. Where agreed locally, associated materials, for example condoms, citric acid and swabs, to promote safe injecting practice and reduce transmission of infections by drug treatment service users is provided. Advice on harm reduction is also offered as well as timely referrals to health and social services, where appropriate.
9/35 (20%) of Thurrock pharmacies have been commissioned to provide needle and syringe exchange services. Table 17 below and Map 3 show an overview of the distribution of pharmacies that provides this service

The data indicates the following:

- In the Western, Central and Southern locality there is at least one pharmacy that provides this service from 9am – 6pm every weekday and on Saturdays.
- There is no service in the Eastern locality on any given day of the week
- In the Central and Southern locality the residents are able to access this service from at 8am – 8pm every on any given day of the week.
- There is currently no service on Sundays in the Western locality.

Table 17: Needle Exchange services, 2013/14

Locality	Ward	No. of Pharmacies delivering Needle and syringe services on a weekday	No. of Pharmacies providing Needle and syringe services on a Saturday	No. of Pharmacies providing Needle and syringe services on a Sunday
Western	Ockendon	3	3	0
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	0	0	0
	West Thurrock and South Stifford	1	0	0
Central	Stifford Clays	0	0	0
	Chafford and North Stifford	0	0	0
	South Chafford	0	0	0
	Grays Thurrock	1	0	0
	Grays Riverside	1	1	1
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	0	0	0
Southern	Chadwell St. Marys	0	0	0
	Tilbury St. Chads	1	1	0
	Tilbury Riverside and Thurrock Park	2	2	2
	East Tilbury	0	0	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	0	0	0
	Corringham and Fobbing	0	0	0
	Stanford-le-Hope West	0	0	0

5.2.2 Supervised Consumption service

The principle aim of supervised consumption in the clinical context is to provide a comprehensive service to drug users that will reduce drug-related harm and the potential for death.

This service is based upon the partnership between GPs, drug treatment service provider staff, Community Pharmacists, other local treatment and specialist housing providers and the patient.

The service requires the pharmacist to supervise the consumption for methadone, naltrexone, suboxone or buprenorphine prescribed for substance misuse at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient. The pharmacist will also provide harm reduction advice, information and support for the users of this service. 13/25 (30%) of Thurrock pharmacies have been commissioned to provide supervised consumption services. Table 18 and Map 3 provide an overview of the distribution and geographical spread of this service.

The data indicates the following:

- Residents are able to access this service from 9am – 5pm on weekdays and Saturday in all four localities.
- There is only one service open after 8pm on a weekday; it is located in the Southern locality.
- There are no services in Central and Eastern locality after 5:30pm on Saturdays.
- There is one pharmacy in each locality that provides this service on Sundays; however only in the Southern locality are services open past 5pm. In the Central and Eastern localities services close at 4pm.

Table 18: Supervised Consumption services, 2013/14

Locality	Ward	No. of Pharmacies delivering Supervised Consumption services on a weekday	No. of Pharmacies providing Supervised Consumption services on a Saturday	No. of Pharmacies providing Supervised Consumption services on a Sunday
Western	Ockendon	3	2	0
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	0	0	0
	West Thurrock and South Stifford	3	1	1
Central	Stifford Clays	1	1	0
	Chafford and North Stifford	0	0	0
	South Chafford	0	0	0
	Grays Thurrock	1	0	0
	Grays Riverside	1	1	1
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	1	1	0
Southern	Chadwell St. Marys	0	0	0
	Tilbury St. Chads	1	1	0
	Tilbury Riverside and Thurrock Park	1	1	1
	East Tilbury	0	0	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	1	1	1
	Corringham and Fobbing	0	0	0
	Stanford-le-Hope West	0	0	0

Conclusions for Substance Misuse Services

A range of substance misuse services are commissioned from community pharmacies within Thurrock:

- The needle and syringe exchange programme is an important public health service that reduces risks and harm to injecting and the general public. The services are commissioned by pharmacy and non-pharmacy providers.
- The supervised consumption service provides drug users with the support to reduce harm and manage their treatment programme. The programme aims to improve the service user's outcomes as well as divert these opiates from surfacing on streets.

Thurrock's JSNA sets out the health and wellbeing consequences associated with substance misuse in Thurrock. Overall there seems to be a reduction in the number of adults misusing opiates and/or crack cocaine. Thurrock has also reported a higher planned treatment exit rate (67% in 2011) than nationally (43% in 2011).

However the percentage of residents (39.3%) who think using or dealing drugs is a problem, locally, is higher than the regional average (25.9%).

The needle exchange service and the supervised consumption service play a vital role in address the consequences of substance misuse, reducing the spread of blood borne viruses and engaging with service users to provide harm reducing and health promotion activities.

For these reasons we conclude that these services are **necessary** to meet the pharmaceutical need of the population.

We have identified the following potential gaps that may limit access and/or choice of serivce:

Needle and syringe exchange services

- There is no service on any given day past 8pm in Central locality.
- No services in Central and Eastern locality after 5.30pm on Saturdays.
- No service on Sundays in the Western locality.
- No service in the Eastern locality on any given day of the week.

Supervised Consumption services:

- Only one service open after 8pm on a weekday, it is located in the Southern locality.
- No service in Central and Eastern locality after 5.30pm on Saturdays.
- Only one pharmacy open past 5pm on Sundays; it is located in the Southern locality.

Service users need to register in order to receive supervised consumption services. The limited hours of service during the week and on weekends present a challenge as service users are not able to access these services in an alternative pharmacy, should their usual pharmacy be closed at a time convenient for them. Further work will need to be undertaken to understand the extent to which these affect the pharmaceutical needs of our population.

It is important that pharmacies make progress towards the Making Every Contract Count agenda, by providing general health promotion and substance misuse advice to young people in the borough who have been identified with higher levels of cannabis smoking activity.

5.3 Sexual Health Services

Thurrock residents may access a range of sexual health services that include the provision of advice and services on contraception, relationships, sexually transmitted infections (STIs) and abortions. Historically services have been commissioned from a wide range of service providers, including general practice, community services, acute hospitals, pharmacies, the voluntary and independent sector.

In April 2014, pharmacies were commissioned to support the delivery of a portfolio of sexual health services, alongside the community provider, NELFT. The following services are included within this portfolio:

- Chlamydia screening and treatment for the target population of under 25 year olds (and sexual partners regardless of age), as defined by the National Chlamydia Screening Programme.
- The supply of progesterone only emergency contraception for all women under 25 requesting free emergency contraception (including offer of a Chlamydia screening kit); and
- The supply of condoms as per the local condom distribution C-card scheme.

The aim of this service is to improve the sexual health of residents and seek reductions in sexual health inequalities through delivering the pharmacy sexual health service, especially in high risk areas and to groups at risk of unwanted conceptions and STIs. The service currently supports the following key local outcomes:

- Prioritising prevention and continuing to tackle stigma and discrimination.
- Reducing under 18 conceptions.
- Increasing Chlamydia diagnoses and treatment in young people.
- Reducing rates of sexually transmitted infections.
- Increasing partner assessment, notification and partner treatment.

Map 4: Sexual Health Services provided in Thurrock, 2013/14

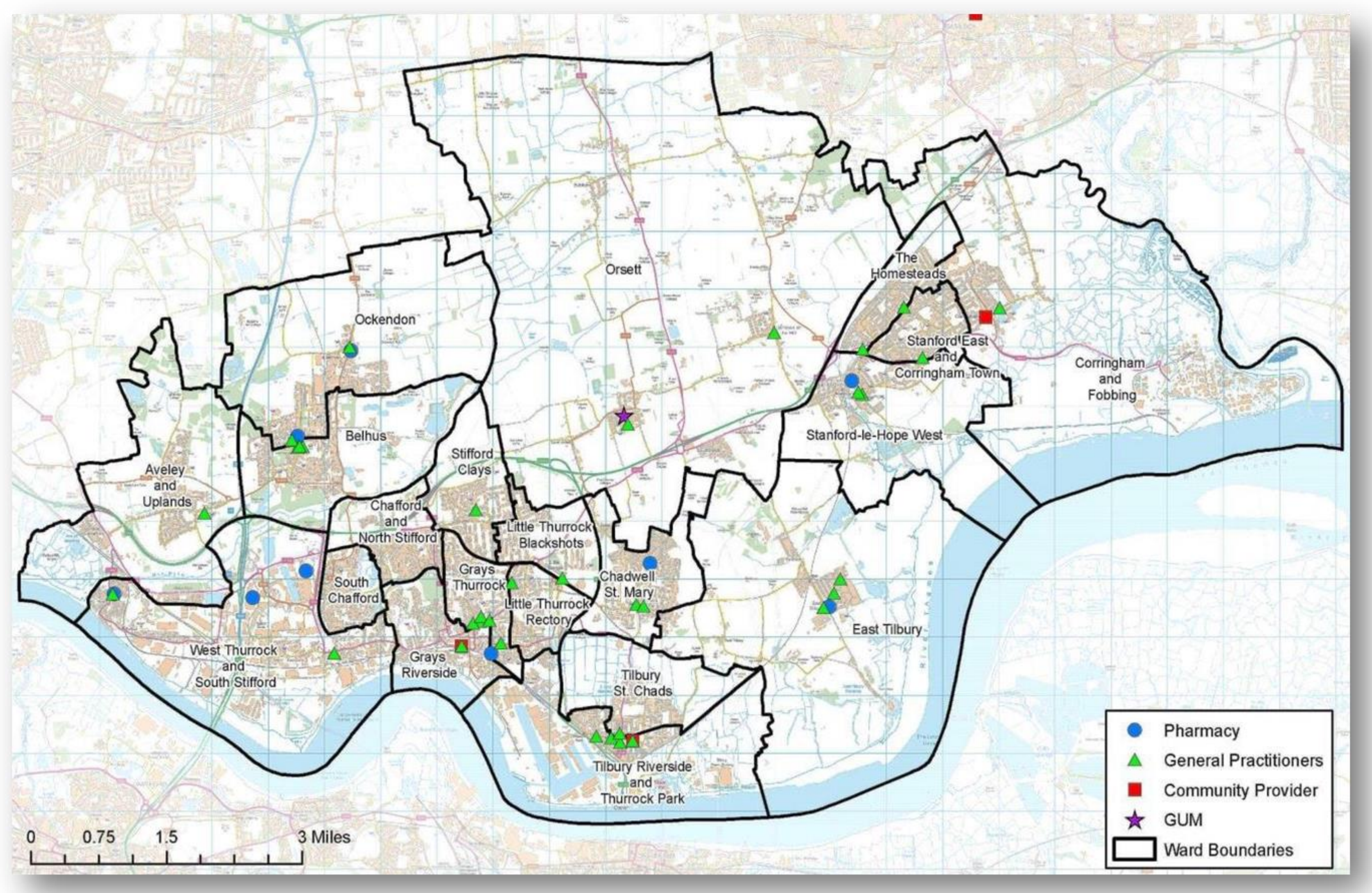


Table 19: Sexual Health services delivered in pharmacy, 2013/1

Locality	Ward	No. of Pharmacies delivering sexual health services on a weekday	No. of Pharmacies providing sexual health services on a Saturday	No. of Pharmacies providing sexual health services on a Sunday
Western	Ockendon	2	2	0
	Belhus	0	0	0
	Aveley and Uplands	0	0	0
	West Thurrock and South Stifford	3	3	2
Central	Stifford Clays	0	0	0
	Chafford and North Stifford	0	0	0
	South Chafford	0	0	0
	Grays Thurrock	1	0	0
	Grays Riverside	2	0	0
	Little Thurrock Blackshots	0	0	0
	Little Thurrock Rectory	0	0	0
Southern	Chadwell St. Marys	1	1	0
	Tilbury St. Chads	0	0	0
	Tilbury Riverside and Thurrock Park	0	0	0
	East Tilbury	1	0	0
Eastern	Orsett	0	0	0
	The Homesteads (18)	0	0	0
	Stanford East and Corringham Town	2	1	0
	Corringham and Fobbing	1	1	0
	Stanford-le-Hope West	1	1	0

In addition to the pharmacy sites, NELFT also provide three additional weekday sexual health services, located in the Central, Southern and Eastern localities, each. Residents may also access a local health clinic in Basildon, on weekdays.

There are currently 38 general practices that have signed up to delivering Chlamydia screening, however data suggests that there are only 20 practices that are currently active.

A further provision to support the delivery of these services is offered at a local GUM clinic, in Orsett, with later appointments on Tuesday and Thursdays until 6:30pm.

Conclusions of Sexual Health Services

The Sexual Health Service is pivotal in addressing specific sexual health needs within Thurrock.

- Pharmacies are commissioned to provide a portfolio of services that include:
- Chlamydia screening and testing
- Emergency contraception
- C-card scheme

We have therefore concluded that this service is **necessary** to meet the pharmaceutical needs of our population.

The following gaps have been identified:

- 12 pharmacies that provide the sexual health portfolio on a weekday.
- 8 pharmacies that provide the sexual health portfolio on Saturdays. There are no other providers of these services, i.e. Community services and GUM, open on Saturdays.
- No service opens on Saturdays in the Central locality.
- Only 2 services open on Sundays, both are in the Western locality.

The above could be quite significant with regards to access of sexual health services for young people, particularly in areas of the Central locality, where the population of 15-24 year olds is highest. This should also be addressed with regards to provision of EHC, due to the higher demand on this service on weekends.

A solution to improving the current access could be to approach pharmacies that provide extended hours, including 100 hour pharmacies to co-ordinate a rota system for weekend provision opening times during the weekend.

In the future public health will need to address the limited provision on weekends, particularly in the Central area, where there is planned growth of young people and in particular onsite student accommodation.

This will be factored in when completing the sexual health service review by March 2015.

5.4 Services Commissioned by Other NHS Trusts

5.4.1 Smoking Service

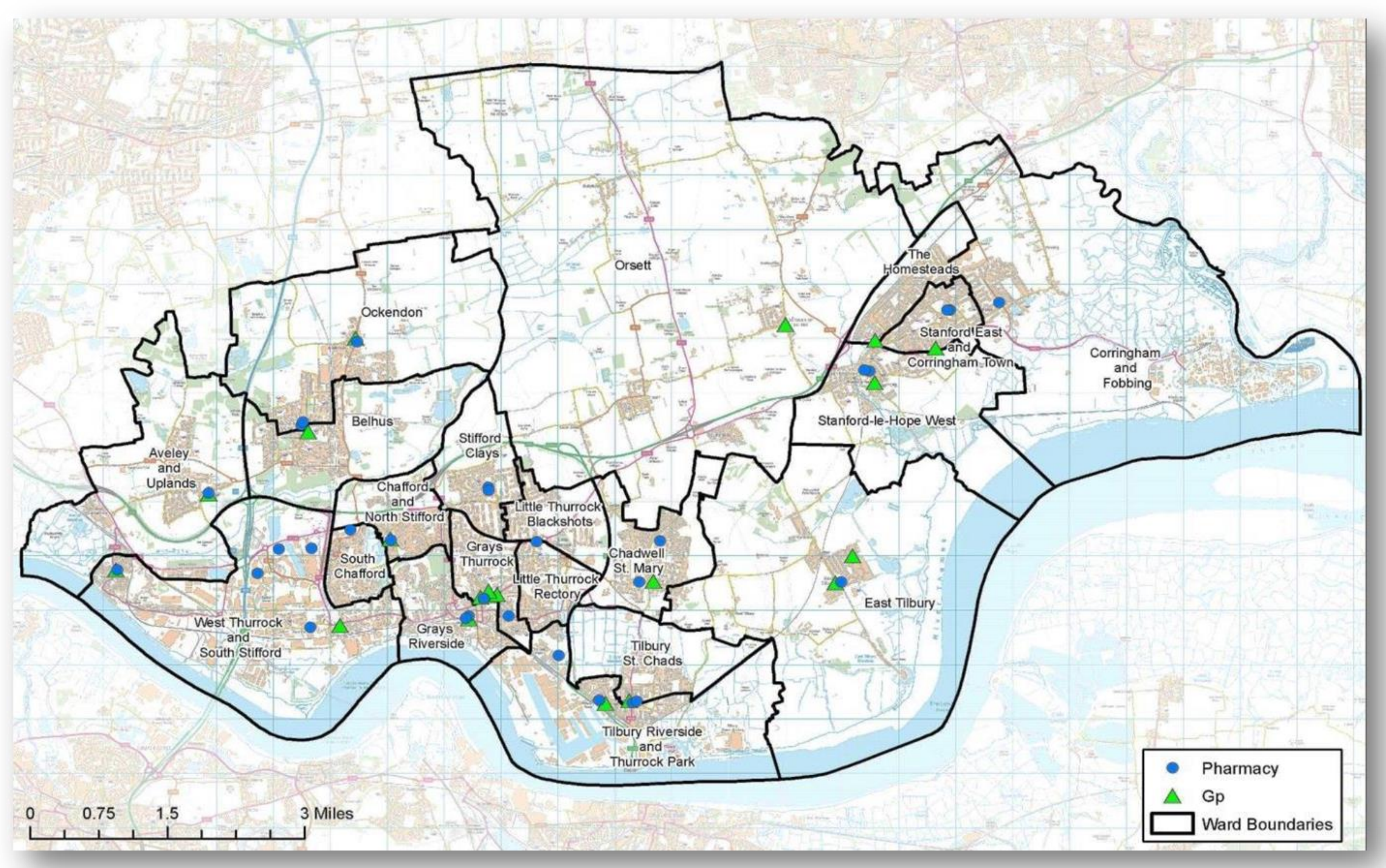
North East London Foundation Trust (NELFT) holds the contract to manage all aspects of the smoking cessation service, which it delivers via its provider arm Vitality. Thurrock community pharmacies and GPs are currently sub contracted to deliver this service. Pharmacies provide behavioural therapy as well as pharmacotherapy intervention (Nicotine Replacement Therapy NRT) to support people to stop smoking. Zyben/Varenicline can be obtained from a GP on a prescription basis.

From April 2014 to March 2015, NELFT are expected to achieve the following 4 week quitter targets – pharmacies are expected to contribute to these: (Below data and maps taken at face value).

- **441** Quits: Routine and Manual Workers
- **29** Quits: Pregnant Mothers
- **20** Quits: Children & Young People under the age of 19 (As per Essex County Council Service Specification).
- **67** Quits: Black and Ethnic Minority Groups.
- **467** quits from the deprived MSOA areas.

Map 5 and Table 20 provide an overview of what areas these services are available and on which days of the week.

Map 5: Smoking services, 2013/14



Currently 30/35 (80%) of community pharmacies are commissioned to provide the service. In addition to this there are 21(60%) Thurrock GPs that deliver this service as well.

Table 20: Smoking services delivered in pharmacy, 2012/13

Locality	Ward	No. of Pharmacies delivering smoking services	No. of Pharmacies providing smoking services on a Saturday	No. of Pharmacies providing smoking services on a Sunday
Western	Ockendon	3	3	0
	Belhus	n/a	n/a	n/a
	Aveley and Uplands	1	1	0
	West Thurrock and South Stifford	5	3	3
Central	Stifford Clays	2	2	1
	Chafford and North Stifford	1	1	0
	South Chafford	1	1	1
	Grays Thurrock	2	0	0
	Grays Riverside	2	2	2
	Little Thurrock Blackshots	n/a	n/a	n/a
	Little Thurrock Rectory	1	1	0
Southern	Chadwell St. Marys	2	1	0
	Tilbury St. Chads	2	2	0
	Tilbury Riverside and Thurrock Park	2	2	2
	East Tilbury	1	1	0
Eastern	Orsett	n/a	n/a	n/a
	The Homesteads	n/a	n/a	n/a
	Stanford East and Corringham Town	2	2	1
	Corringham and Fobbing	1	1	1
	Stanford-le-Hope West	2	1	0

There is generally very good access and choice of pharmacy in all localities on weekdays between 9am – 6pm and on Saturdays between 9am - 5pm. On Sundays there are at least two pharmacies in each locality that are open between 10am – 5pm.

Access to community pharmacy stop smoking service during ‘extended hours’ is more limited, however within every locality there is at least one pharmacy that provides the service at 8am and at least two that are open until 8pm, on weekdays and on Saturday. Aside from the Western locality, all other localities have ‘extended hour’ provision of this service until 8pm on Sundays.

Conclusions of Stop Smoking Services

Stop smoking services are key in reducing the health consequences and inequalities associated with smoking. There are a significant number of studies to demonstrate the cost benefits and effectiveness of stop smoking interventions in community pharmacies.

In general there is very good distribution of provision within the deprived localities. What needs to be better understood is the contribution with regards to successful quits these pharmacies are contributing towards the public health agenda.
Community pharmacies are one of a number of sub-contractors by North East London Foundation Trust to provide stop smoking services. We have therefore concluded that the community pharmacy stop smoking service is a **relevant** service because it facilitates choice of provider and has secured improvements in access.

We have not identified any gaps in service; however there is opportunity to provide a more uniform service with regards to:

- Access, particularly in opening on Sundays in the Western locality.
- Pharmacology options available to potential quitters.

In addition it would be beneficial to develop provision through pharmacy to target higher risk groups i.e. routine and manual occupational workers as well as use medication reports to develop opportunistic intervention.

5.4.2 Healthy Living Pharmacies

The Healthy Living Pharmacy (HLP) is a tiered commissioning framework that encourages community pharmacies to provide a consistent range of high quality services that meet local need, improve the health and wellbeing of residents and reduce health inequalities.

The HLP concept provides a structure 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. **Appendix A** provides an overview of the criteria community pharmacies participating in the Essex Healthy Living Pharmacy Pathfinder had to fulfill.

Early evaluations from HLP programmes have shown the following benefits[22] including a greater number of people receiving health and wellbeing advice, increased smoking quit rates and pharmacy as first point of healthcare intervention instead of GPs. The high percentage of those who would recommend this service also suggests high satisfaction amongst those who have used the service.

The Healthy Living Pharmacies is a concept that builds upon the role of community pharmacies and attempts to establish them as a key element of public health services. It aspires to do this through the delivery of high quality services, advice and intervention as well as health promotion activities. Locally there are two pharmacies that have achieved this standard of delivery.

There is opportunity to improve access to the Healthy Living Pharmacies, in order to secure further health outcomes for our population. We would therefore like to work towards supporting all pharmacies to achieve this standard.

6. Future Needs

Populations in deprived localities are characterised by poor health and lifestyle related outcomes, lower life expectancy, higher burden of ill health, low uptake of health protection services such screening and vaccination. Often they seek medical attention late as evidenced by high A&E attendance and emergency admission rates.

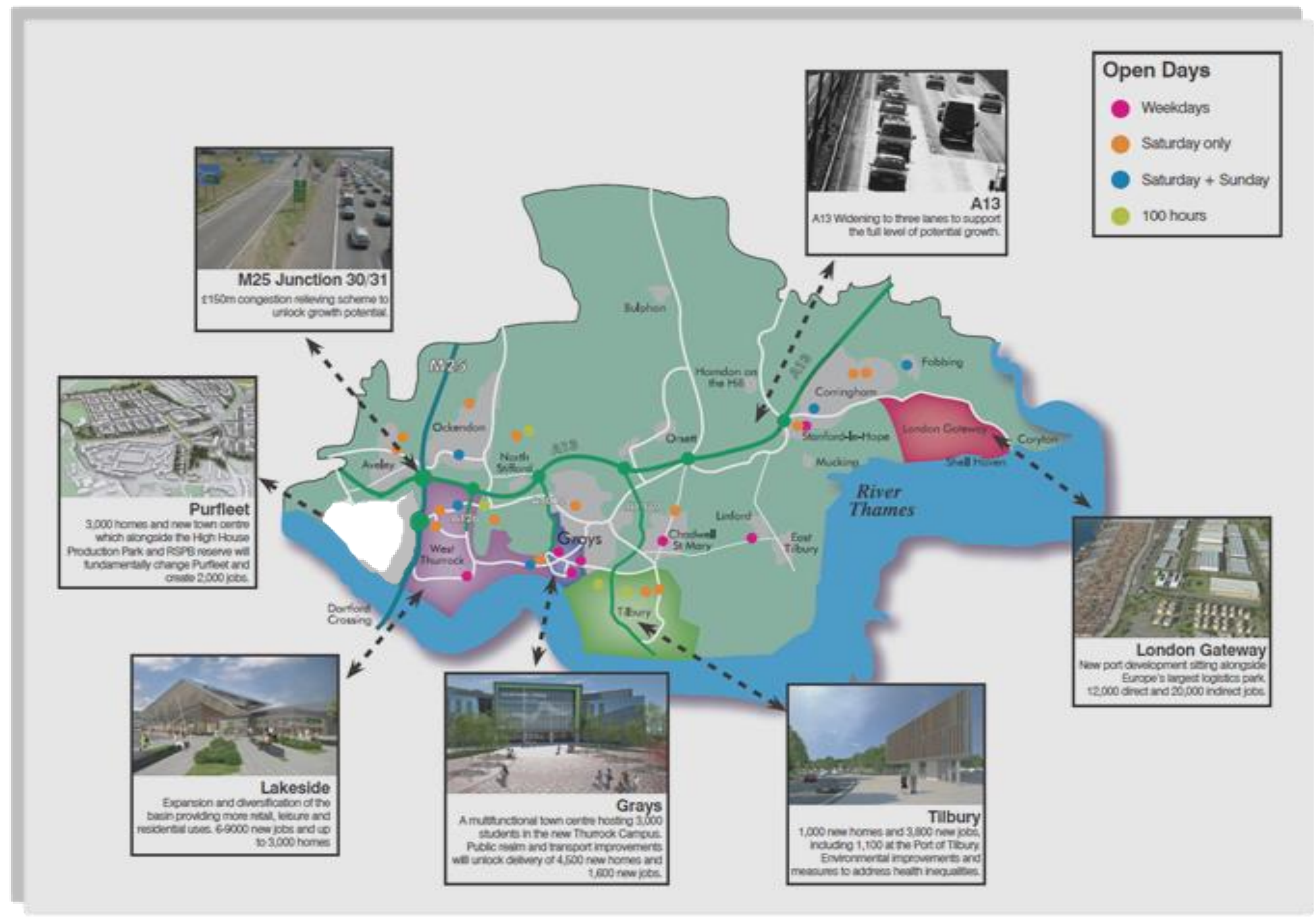
This document identifies a number of potential future pharmaceutical needs for the local population and opportunities to secure improvements in services.

This section addresses other areas and factors that have not been mentioned elsewhere in this document and sets out future plans for pharmaceutical services. In taking these plans forward, it must be recognised that health and social care partners will need to work together to ensure that community pharmacy services are integrated, delivered to a high standard and target those residents and patients that will benefit from services the most.

6.1 Areas of Regeneration and New Housing

This section will focus only on those pharmaceutical needs that will need to be considered over the next three years, in line with the lifespan of this PNA. However there will be some mention of plans beyond this time frame, in order to put context to changes and developments, locally.

Thurrock has an ambitious regeneration programme over the next decade. Thurrock's adopted development plan, the "Core Strategy and Policies for Management of Development" (Core Strategy) proposes the delivery of 18,500 new homes and the creation of 26,000 new jobs over the period 2001 to 2021 and a further 4,750 homes by 2026. Between 2001 and 2013 there were 5,980 dwellings built, leaving a residual of 17,270 to be built by 2026. This growth is focussed on five major hubs at London Gateway, Grays, Tilbury, Lakeside Basin and Purfleet, Map 6 shows how the current pharmacies line up with these new developments.



Map 6: Growth Hubs in Thurrock by 2021

The current regeneration programme will once again change the landscape of Thurrock, with the transformation of Lakeside into a town centre, the creation of the biggest container port in Europe, the Royal Opera House Production Park and performing arts, and the Junction 30 congestion relieving schemes. All of these will bring new jobs and fresh opportunities for the future. Below is a general list of opportunities and pharmaceutical needs that should be considered:

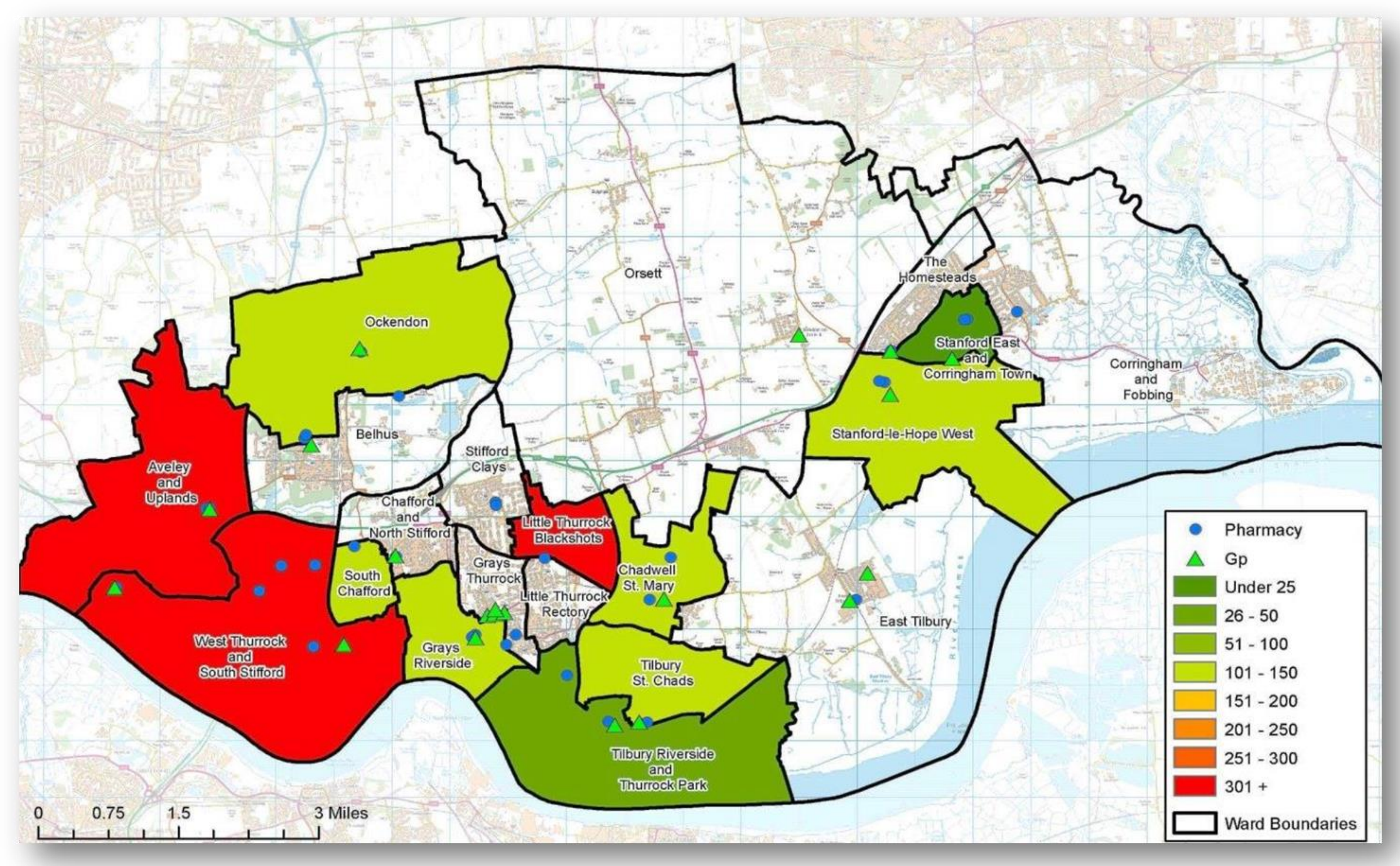
- Stock of medications to cure foreign ailments/travel medicines.
- Foreign Language services.
- Services that target health promotion and public health interventions for the new young 'student' population.
- Health needs of transient populations using the M25 including commuters and truckers.
- Services that target health promotion and public health interventions for manual and labour occupational populations that will be working on developing these sites i.e. smoking cessation services.

Over the next few years, a significant number of the new affordable homes in the borough will be delivered on a range of sites across the borough on land identified in the Core Strategy at Purfleet, West Thurrock, Lakeside town centre, Tilbury and South Stifford/West Grays.

Although references have been made to Thurrock's long term Regeneration and Housing priorities, only those developments which will come forward during the lifespan of this PNA have been considered.

Over the next three years, Thurrock will develop 1,924 houses in various parts of the borough. Grays and South Stifford will see the most amount of housing developments with 510 and 354 new units of housing, respectively. Map 7 shows the distribution of housing developments over the next three years.

Map 7: Housing developments in Thurrock over the next three years



The above plans include a range of housing options for older people. Over the next three years there will be 60 units of accommodation developed, in the Tilbury and South Ockendon areas, as part of the Housing our Ageing Population: Panel for Innovation Scheme. In addition to this, there are also plans to provide 65 units of extra care homes that will meet the needs of older people, (and exceptionally, younger people who receive the higher rate of Disability Living Allowance) who wish to live independently.

Our review of essential services concluded that the current network of pharmacies has sufficient capacity to meet needs of the future population growth and we do not anticipate any future gaps with regards to these new housing developments within the next three years.

6.2 Different Needs of Different Populations

The Regulation require that the HWB considers the needs of people who share a protected characteristic as defined in the Equality Act 2010 The section below summarises how we have made such considerations to address any specific needs within this PNA.

For those protected characteristics where no specific needs were identified, no reference has been made beyond those considered for the general public.

6.2.1 The Young People Population

We have highlighted that research indicates that young men access pharmacies least. It is therefore important that pharmacies in areas that have higher populations of young people, i.e. the Western and Central localities, ensure that they maximise on Making Every Contact Count with young people by delivering health promotion advice and intervention. Such measures will empower young people to make positive decisions about their health and prevent the early onset of disease.

6.2.2 Those aged 65 years and over

There are a number of risk factors associated with ill health in older people. Pharmacies in areas such as the Eastern and Central localities that have a higher density of these populations, need to ensure sufficient access to a range of support services is available like MURs, NMSs and seasonal influenza services.

The provision of auxiliary aids, large prints and dosage systems is helpful for older people to access and adhere to prescribed medication.

6.2.3 Disability

Pharmacies are to comply with provisions of the Equality Act 2010. This ensures that those people that are either disabled or face a disability due to illness are able to access pharmacies.
We have identified that there is choice of pharmacies for wheelchairs users in the four localities. We are encouraging all pharmacies to take strides meeting the needs of those with a disability, where this is possible.
It has also been recognised that more information needs to be gathered to better understand how pharmacies support those with a disability to overcome challenges in accessing services.

6.2.4 Gender

The PNA has made considerations towards the gender distribution of Thurrock's population. Provisions specifically for women are currently delivered through pharmacy i.e. emergency hormonal contraception, in order to meet the need of this population.
We have identified and addressed that men need to be further engaged to access community pharmacies, in order to maximise on health promotion and interventions.

6.2.5 Race

Thurrock has a diverse population with nearly a fifth of the population from Black, Asian and Minority Ethnic groups. This is reflected by the diversity of languages in Thurrock.

This PNA recognises the correlation between health inequalities and BAME groups. These communities face a number of health challenges including, accessing health care services, low birth weight, higher incidences of long term conditions i.e. diabetes and cardio vascular disease, etc.

The following reflects the specific health needs of BAME communities, as well as the general population:

- Health promotion advice and provision to promote healthy lifestyles and behaviours in order to delay the onset of disease.
- To improve overall maternal and infant health, by providing advice and onward perinatal referrals for those who are pregnant, those are planning on becoming pregnant and those who have new babies.
- In addition, this PNA recognises that 6% of the population uses a language other than English as their main language. We have demonstrated limited correlation between the diversity of the population and pharmacy staff who speak languages other than English to address communication barriers within BAME communities who access pharmaceutical services.

6.2.6 Religion and Belief

Pharmacies are able to provide medicine related advice to particular groups such as medicines that have animal derivatives or taking medication during the month of Ramadhan

6.2.7 Sexual Orientation

Men who have sex with men (MSM) are at higher risk of poor sexual health.

6.2.8 Gender reassignment

Pharmacies are usually involved with the care pathway of those individuals who are undergoing gender reassignment. Their role predominantly consists of ensuring that medication for the treatment component of this procedure is available to dispense.

6.2.9 Pregnancy and maternity

Pharmacies are ideally placed to provide health promotion advice and peri-natal referrals to women. They are also able to provide point of sale of pregnancy tests.

For those women who are pregnant or breastfeeding, pharmacies are able to deliver interventions to ensure that medication that may cause adverse effects, to the foetus or baby are avoided.

6.2.10 Marriage and Civil partnership

No specific needs have been identified for this protected characteristic

7. Conclusion and Recommendations

Community pharmacies are ideally placed to improve access, capacity and effectiveness of services and make an important contribution to improving health and wellbeing. We recognise the vital role pharmaceutical service providers can play in preventing ill health and that community pharmacies are valued and trusted community resources. They are based at the heart of communities including rural and deprived areas and have daily interactions with local populations.

Based on the findings of this pharmaceutical needs assessment the key recommendations Are to work with our pharmaceutical service providers to play a greater role in the community:

- Providing a range of clinical and public health services that will deliver improved health and be of consistently high quality.
- Supporting the management of long term conditions.
- Supporting individuals by delivering healthy lifestyle advice and support for self-care.
- Acting as a first point of call thus reducing the demand on other providers, general practice and unscheduled care providers.
- Providing services that will continue to contribute to out of hospital care.
- Supporting the delivery of improved efficiencies across a range of services.
- Helping individuals and care homes to understand correct use and educate them on the management of medicines.

Based on a systematic assessment of local pharmaceutical need, NHS England do not currently commission additional hours from pharmacies to open during bank holidays and other holiday periods based on a business decision. However some pharmacies do open based on a business decision. This will need to be reviewed locally in the future.

We will work with local commissioners to identify areas where there are populations within the Thurrock area who have specific health needs where pharmacists can play a role.

There is currently scope and capacity within the existing pharmacy and primary care networks to target additional patients who would benefit from MURs. We will work with NHS England to review this at a local level.

We would like to see a larger number of accredited pharmacies in Thurrock actively providing locally commissioned services to serve local populations. This is particularly true of AURs, where pharmacists are currently able to deliver services.

Not all pharmacies are wheelchair friendly, plans need to be agreed that where appropriate each pharmacy has wheelchair friendly facilities. More information needs to be collected to determine provisions are in place within pharmacy that enables other disability groups to have equal access.

We need to ensure that pharmacies are able to effectively communicate with all BAME groups, as well as with those whose main language in not English. With our growing BAME populations we need to work with pharmacies to agree how to engage wider with these groups.

The choice of service provider should be dependent on a number of factors such as cost effectiveness of the service, ease of access for patients and appropriate skills of the providers. Some services may be commissioned across more than one type of health care provider. When collating the list of available providers, community pharmacies should be considered as they generally have a good skill mix and patient accessibility, both in terms of hours of opening and location. Attributes such as these would form a basis for many services, particularly as commissioners move more provision for healthcare into the community. There is early evidence locally of some pharmacists linking in with the new Local Area Coordinators and Hubs.

Thurrock has more pharmacists per 100,000 than similar boroughs, East of England and England. As such it is well resourced with regards to pharmaceutical services. Distribution of pharmacies within Thurrock localities vary; the Western locality has the most pharmacies (12/35), followed by the Central locality (10/35 pharmacies), the Southern locality (7/35 pharmacies) and the Eastern locality (6/35 pharmacies). There is a good correlation between deprivation and the number of pharmacies by locality; there is a good spread of pharmacies that span over the two mile boundary, in most of Thurrock and that residents have a good choice of pharmacies to access. In the eastern part of the borough, there is a higher density of people aged 75+ years and 85+ years who are more likely to have mobility problems and therefore find accessing pharmacies more challenging than the general population. It is likely, however, that these residents are able to access pharmacies in their neighboring borough within this distance, and particularly in south Benfleet and Canvey Island through good public transport links.

8. Glossary

A&E	Accident & Emergency
APHO	Association of Public Health Observatories
AUR	Appliance Use Reviews
BTUHT	Basildon and Thurrock University Hospital Trust
BAME	Black, Asian and Minority Ethnic Communities
CC	County Council
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CSU	Commissioning Support Unit
CVD	Cardiovascular Disease- a term used for a family of diseases that can affect the heart and circulatory system (e.g. coronary heart disease, stroke, heart failure, chronic kidney disease)
DAAT	Drug and Alcohol Action Team
DAC	Dispensing Area Contractor / Doctor
DH	Department of Health
EHC	Emergency Hormonal Contraception
EoE	East of England
EPS	Electronic Prescription Service
EU	European Union
GP	General Practitioner (Doctor)
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
HLP	Healthy Living Pharmacists
HSCIC	Health & Social Care Information Centre

HWB	Health and Wellbeing
Incidence	Incidence is the number of newly diagnosed cases of a disease or conditions in a population at risk
Intervention	Action to help someone improve their health action e.g. be more physically active or to eat a more healthy diet
IMD 2010	Indices of Multiple Deprivation: a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for individual neighborhoods
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
MECC	Making Every Contact Count: is about using every opportunity to talk to individuals about improving their health and well being
MSOA	Medium Super Output Area
MSM	Men who have Sex with Men
MUR	Medicines Use Review
NELFT	North East London Foundation Trust
NMS	New Medicine Service
NHS	National Health Service
ONS	Office for National Statistics
PCT	Primary Care Trust
PGD	Patient Group Directive
PHE	Public Health England
PSNC	Pharmaceutical Services Negotiation Committee
PNA	Pharmacy Needs Assessment
QOF	Quality Outcomes Framework
Prevalence	The number of cases of cases of a disease or condition existing in a population

Risk factor	Aspect of a person's lifestyle, environment or pre-existing health condition that may increase their risk of developing a specific disease or condition
SAC	Stoma Appliance Customisation Service
SEPT	South Essex Partnership Trust
SHUFT	Southend Hospital University Foundation Trust
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infection

9. Appendices

Appendix A – Healthy Living Pharmacy Quality Mark Criteria 96

Appendix B – Consultation report feedback 97

Appendix A - Healthy Living Pharmacy Level 1 Quality Mark Criteria

Health Champion	At least one non-pharmacist member of the pharmacy staff has achieved Royal Society for Public Health Understanding Health Improvement Level 2 (UHI2) award. Where this has been achieved as part of a distance learning package the Health Champion will also need to attend an appropriate face-to-face workshop in order to demonstrate the skills in a practical setting outside of the normal workplace.
Leadership training	At least one member of the pharmacy management team has completed a specific Healthy Living Pharmacy leadership training programme. Currently these training programmes are arranged through Essex LPC and partner organisations; however managers that have undertaken leadership training in other pathfinder sites should be included.
Premises Criteria	Must reflect professional image and promote healthy living. • Posters/health promotional literature are current and where appropriate, seasonal. Health Champions are familiar with any relevant promotional literature and campaigns. • Health-related promotion materials, products and services are clearly differentiated from other activities. • Premises are welcoming. Doors open easily, there is clear, positive signage, adequate lighting and temperature control, floor coverings are clean and in good repair, windows are clean. • Consultation rooms include space for a chaperone to be present if requested. There is a computer available in the consultation room.
Service provision	• The pharmacy completed the initial 6 NMS consultations and triggered set-up payment prior to March 2012 OR the pharmacy has achieved at least 20% target for five of the last six months. • Pharmacy completed ≥ 200 MURs in 2011/12. Pharmacy has completed 30 asthma OR 30 Diabetes MURs in the last 6 months and can supply anonymised details of follow up. • Pharmacy has recorded ≥ 10 4-week stop smoking quits in the last 2 quarters OR pharmacy has recruited ≥ 10 smokers and has a 4-week quit rate ≥ 50% in the last 2 quarters if the pharmacy offers the North Essex PCT cluster stop smoking LES. **OR** • Pharmacy has a minimum ratio of 1 recorded Chlamydia screen per 5 recorded Emergency Hormonal Contraception consultations for five of the last six months.
Engagement event	• Pharmacy participates in a public engagement or outreach event other than on pharmacy premises. This may be evidenced by an independent report, photographs etc. Examples include a presentation to a community group, vascular checks outreach, school assembly, participation in "SOS bus" promotion.

Appendix B - Consultation Feedback

Consultation Report

This document was developed by the Thurrock Health and Wellbeing Board in response to the Consultation feedback from the Thurrock Pharmaceutical Needs Assessment (PNA).

A formal consultation was undertaken from 23rd July to 22nd 2014 to September 2014 in accordance with the National Health Service (Pharmaceutical Services and Local Services) Regulations 2013 (SI 2013 No. 349). The consultation and was advertised to the public through key stakeholder organisations as well as online and in pharmacies and General Practice.

The draft document was sent out to all key stakeholders of pharmaceutical services in accordance with the national PNA guidance, including neighbouring Health and Wellbeing Boards.

During Cycle one of the consultation, people were asked to complete a structured template reflecting their views on the accuracy of the various sections of the PNA; the responses of which can be found in the tables below. In addition to this, a number of comments were sent separately by stakeholders, as part of this consultation process. These have also been included at the end of this report.

To ensure all commenter's were satisfied that the final draft had been correctly amended to address any comments and inaccuracies; a second cycle was undertaken. We received five additional comments, which have been included in the final PNA document.

The Thurrock Health and Wellbeing Board would like to thank all those who responded to the public consultation and the pharmacy questionnaire, as well as those that supported the development of this PNA.

Detailed Comments relating to different sections of the PNA

Name/ Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
1. **Has the purpose of the PNA been explained sufficiently with section 2?** Yes = 83.3% No = 0.0% Not sure = 16.7% Not answered / Feedback Form Not Used = 0.0%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Yes		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Yes		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
2. **Does section 3 of the PNA clearly set out the scope of the PNA?** Yes = 83.3% No =0. 0% Not sure = 16.7% Not answered / Feedback Form Not Used = 0.0%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Yes		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Yes		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
3. **Does Section 4 clearly set out the local context and the implications for the PNA?** Yes = 66.7% No = 16.7% Not sure = 16.7% Not answered / Feedback Form Not Used = 0.0%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Yes		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	No		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
4. **Does the information in Sections 5 and 6 provide a reasonable description of the services which were provided by pharmacies and DACs in Thurrock?** Yes = 50.0% No = 16.7% Not sure = 33.3% Not answered / Feedback Form Not Used = 0.0%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Yes		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Not sure		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	No		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
5. **Are you aware of any pharmaceutical services currently provided which have not been included in the PNA?** Yes = 16.7% No = 50.0% Not sure = 16.7% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	No		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane			
Pharmacy/ Appliance Contractor		Not sure		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	No		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	No		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Yes		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
6. **Do you think the pharmaceutical needs of the population have been accurately reflected in the PNA?** Yes = 50.0% No = 0.0% Not sure = 50.0% Not answered / Feedback Form Not Used = 0%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Yes		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Not sure		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
7. **Do you agree with the conclusions for Essential Services?** Yes = 66.6 No = 0.0% Not sure = 16.7% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Yes		

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Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
8. Do you agree with the conclusions for MURs? Yes = 33.4% No = 16.7% Not sure = 33.4% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Not sure		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	No		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
9. Do you agree with the conclusions for NMS? Yes = 50.0% No =16.7% Not sure = 16.7% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	No		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
10. Do you agree with the conclusions for Seasonal Influenza? Yes = 66.7% No = 0.0% Not sure = 16.7% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Yes		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
11 Do you agree with the conclusions for Substance Misuse? Yes = 50.0% No =0.0% Not sure =33.4% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

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Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
12. Do you agree with the conclusions for Integrated Sexual Health Service? Yes = 50.0% No =0.0% Not sure = 33.4% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
13. Do you agree with the conclusions for Stop Smoking Services? Yes = 50.0% No = 0.0% Not sure = 33.4% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO			
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Yes		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
14. If you have disagreed with one or more conclusion, please explain? Yes = 0.0% No =0.0% Not sure = 16.7% Not answered / Feedback Form Not Used = 83.3%				

Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure Conclusions go beyond scope of commissioned service. Definition of Appliance Use Reviews incorrect. See further comments section 12 below.	This has been amended to show that there are no pharmacies actively undertaking AURs but that it is possible to access services outside the borough and via internet.	

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
15. Do you agree with the assessment of future pharmaceutical services as set out in section 7? Yes = 33.4% No = 16.7% Not sure = 50.0% Not answered / Feedback Form Not Used = 0.0%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	No, Very little focus on pharmacy prescribing as an enhanced service. Also more focus on phlebotomy services needed.	▪ We will forward this comment to NHSE to further advise	
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS	Not sure		
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
16. Is there any additional information which should be included in the PNA?				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Pharmacy prescribing services and the need for a NHS budget for pharmacy prescribing.	▪ We will forward this comment to NHSE to further advise	

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
17. Has the PNA provided adequate information to inform market entry decisions (NHS England only) or how you will commission services from pharmacy (all service commissioners)? Yes = 33.4% No =0.0% Not sure = 50.0% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	Not sure		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes		
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS			
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
18. Does the PNA give enough information to help with your own future service provision? Yes = 33.4% No = 16.7% Not sure = 33.4% Not answered / Feedback Form Not Used = 16.7%				
Dr Reg Rehal Allcures Pharmacy	16 Kings parade, SLH, SS17 0HO	No		
Sarah Stickings Rapid Response Assessment Team	Thurrock Community Hospital, Long Lane	Not sure		
Pharmacy/ Appliance Contractor		Yes, it would be great to provide weight management and alcohol services which were highlighted but it really depends if theses services will be commissioned in the future		

Organisation	Address	Detailed Comment	PNA Task & Finish Group Response	Amend PNA Yes / No
Claire Smithies The Co-op Pharmacy	Department 10306, 13th Floor, 1 Angel Square, Manchester, M60 0AG	Yes		
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1 YS			
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	Not sure		

Organisation	Address	Detailed Comment
19. If you have any further comments, please enter them in the box?		
Pharmacy/ Appliance Contractor		I think more services will be provided by pharmacies as long as there is adequate funding with support and good prior consultation. A good PNA overall
Dipti Patel Essex County Council	County Hall, Chelmsford, Essex CM1 1YS	(Commenter has provided additional accuracy comments, above)
Karen Samuel-Smith Essex Local Pharmaceutical Committee	17 Clematis Tye, Springfield, CM1 6GL	(Commentator has provided additional accuracy comments, above)

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Additional Comments on the accuracy of the PNA

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 1.3:Only 2 dispensing practices in Thurrock and not 3.	▪ Amended to 2.	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 1.3 Despite there being no dispensing appliance contractor located in Thurrock, this service is available nationally and it is not vital to be situated within Thurrock itself.	▪ Amended to: *None in Thurrock, but these services can be accessed outside the borough*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 2: NHS England are not the only commissioners of services from Pharmacies, they can also be commissioned by Local Authorities and Public Health England etc.	▪ This has been explained in paragraph 4. Amendments have been made to include Local Authority and Public Health England.	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 2.1: Other NHS services are also provided by Public Health England and the local authority and these too affect the need for Pharmaceutical services, or would secure improvement, or improve access to pharmaceutical services within its	▪ Amended to include Local Authority and Public Health England	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		area.		
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 3.1 Appliance use reviews (AUR'S) may be provided elsewhere as patients may access this service from other providers outside of Thurrock	▪ Amended to *no services provided in Thurrock but services can be accessed outside the borough and via the internet*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 3.1: In terms of Dispensing appliance contractors, please see link below and extract from it https://www.gov.uk/government uploads /system /uploads/attachment data /file /197634/Pharmaceutical Needs Assessment Information Pack.pdf	▪ Suggested DAC definition has been used	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 3.1.1:The local authority is not an NHS body.	▪ Amended to state NHS services that are commissioned or arranged by other bodies/organisations	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 3.1.3: Out of hours GP service is 18.30 – 8.00.	▪ Amended to 18:30 – 8:00	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 3.2.1: Care home dispensing of medicines is an NHS service as a	▪ This has been deleted	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		Pharmacist would dispense against an NHS prescription.		
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.1: Basildon and Brentwood are part of Essex CC and not separate HWB areas.	▪ This has been deleted	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.2.2: Although Community Pharmacies may be well positioned to provide prescribing and phlebotomy, this is not part of their contract.	▪ This section provides evidence to support what they can provide. Not necessarily what they do provide. Amendment made to read *that they have the potential to provide* the services listed in the section	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.3:Sexual Health – Not all pharmacies are signed up to the sexual health enhanced service and is not part of their core contract.	▪ This has been amended to say *A number of pharmacies provide this service and that as part of the prevention agenda, all community pharmacies should provide*: (listed sexual health service)	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.4.2: If Pharmacies are unable to make referrals then all should sign post as this is a contractual obligation.	▪ Amended to *read referrals and sign-post*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.5.3: Not all Pharmacies provide MUR's and NMS reviews as this is an advanced service.	▪ Amended to read *a number of pharmacies provide support in identifying adverse effects of mediation as well as adherence issues that can contribute to improving outcomes for patients with serious mental health*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
			issues	
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.6.3: Smoking cessation is a commissioned service that some Pharmacists are signed up to but not all.	▪ Amended to *A number of community pharmacies currently provide smoking cessation services*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.6.3: Health checks are not mandatory and are commissioned by Thurrock Council from NELFT who provide them within GP practices and Outreach clinics and not Pharmacies.	▪ Amended to *This service is not currently provided by pharmacies in Thurrock*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 4.3.6.3: Not all Pharmacies provide smoking cessation services.	▪ Amended to *A number of community pharmacies provide smoking cessation services*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.1: The statement 'NHS services provided by other NHS Trusts' should read 'NHS services provided by other providers', as in the future not all NHS services will be provided by NHS trusts.	▪ Amended to *NHS services provided by other providers*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.2: The map on page 42 is not clear and I don't understand why those marked in orange are Saturday only. I was not aware of any of our Community Pharmacies only being	▪ Revised map to show opening hours, weekdays + Saturday, weekdays + Saturday + Sunday	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		open on a Saturday.		
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.2: There are currently five 100 hour Pharmacies, 2 in Tilbury, 1 in Chafford Hundred, 1 in Stifford Clays and 1 in Stanford Le Hope.	▪ Revised map to five pharmacies	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.2: No Column for those open between 1-5pm	▪ Table needs to be include 'other times' column: 1 pharmacy that closes at 5pm	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.4: Although 'Dispensing of drugs and appliances' is an essential service, Electronic prescription services is not an Essential service as it is not mandatory.	▪ Electronic prescription service has been deleted	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.4.3:Both the CCG and NHS England are rolling out the Electronic prescription service.	▪ NHS England has been added to this.	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.4.4: 'There is a need to address the limited or no access to essential services over the weekend during extended hours.' What evidence is there to support this	▪ This has been deleted	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		statement as there doesn't appear to be a need from the information provided within the document.		
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.5.1: 'Two pharmacies, located in Central and Eastern locality, undertook no MURS in 2013/14 review with two pharmacists how they may offer MURS in future.' I don't understand this statement and unsure if correct.	▪ This has been amended to *Two pharmacies, located in Central and Eastern locality, undertook no MURS in 2013/14*	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 5.6: List of enhanced services should include Palliative care.	▪ Amended to included Palliative care	▪ Yes
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	I would suggest that the explanation of essential services and advanced services is provided near the start of the document to avoid any confusion.	▪ This has been explained on page 10	▪ No
NHS England	Swift House, Colchester rd, Chelmsford SM2 5PF	Section 8: Where the PNA refers to AUR's, it must be made clear that although AUR's are not currently provided in Thurrock, this may change as Community Pharmacists are able to	▪ We have included the following in the conclusions '…this is particularly true of AURs, where pharmacists are currently able to deliver services'	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		deliver this service		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.1: Sentence should refer to decisions about commissioning services and entries on the Pharmaceutical List• rather than new pharmacy openings. Matters such as relocations and changes to opening hours will also need to refer to the PNA.	▪ Amended to *decisions about commissioning services and new entries on the pharmaceutical list* ▪ Amended to Reference will also be made to *matters concerning pharmacy relocations and change in opening hours*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.3: Some of the statistical data does not make sense, for example The most significant increases are in the 5-9 year age band at 5.7%- does not make it clear 5.7% of what, or from what or to what.	▪ Amended to include *from the previous year*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.3: Stating that pharmacies open on a voluntary basis during Bank Holidays may be misleading. There is no contractual obligation for them to open, but many do based on a business decision rather than a voluntary basis. NHS England do commission Bank Holiday rota hours when these are considered necessary, for example if it would not make good	▪ Amended to *there are no contractual obligations for pharmacies to open during Bank/other holidays but many do based on a business decision. NHS England commission Bank Holiday rota hours when these are considered necessary.*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		business sense for a pharmacy to open otherwise.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.3: It is not always possible for pharmacy premises to be wheelchair accessible, for example planning or other restrictions may apply. Pharmacies are required to make reasonable adjustments to ensure patients and customers with a disability are able to access services, this may be achieved through a number of other means	▪ Amended to *not all pharmacies are accessible to wheelchair users. Pharmacies are required where possible to make reasonable adjustments to ensure patients and customers with a disability are able to access services. More information needs to be collected to determine the provisions in place within each pharmacy that enables those with a disability to access pharmaceutical services.*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.3: It is not clear what is meant by the term accredited pharmacies	▪ Amended to *we would like to see a larger number of pharmacies in Thurrock providing enhanced services to serve the local population.*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.3: Dispensing doctors provide dispensing service to Rural, not Urban localities.	▪ Amended: the word urban has been deleted.	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 1.3: The HWB will need to Consider whether residents have reasonable access and choice with regard to the dispensing of appliances, whether by pharmacies or dispensing	▪ Amended to *The HWB will need to consider whether residents have reasonable access and choice with regard to the dispensing of appliances, whether by pharmacies or dispensing appliance contractors (outside of Thurrock)*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		appliance contractors. The statement that we will need to consider if Thurrock has the need for a dispensing appliance contractor in the near future is not accurate.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 3.1: Process followed for developing the PNA National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations were passed in 2013, not 2010, and are regulations not guidance.	▪ Amended: *the following regulations were used* ▪ Amended to *Regulations 2013*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 3.1: Essential Services Electronic prescription services are not a separate Essential Service to Dispensing and Actions Associated with Dispensing, or to Repeatable dispensing.	▪ Amended: EPS has been deleted from the list and repeatable dispensing has been included in the dispensing bullet point	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 3.1: Prescription-Linked interventions and Public Health Campaigns are not separate Essential Services, rather they are the two elements that comprise the Promotion of Healthy Lifestyles Essential Service	▪ Amended: Public Health campaigns have been included under the Promotion of healthy lifestyles bullet point	▪ Yes
Karen Samuel Smith	17 Clematis Tye,	Section 3.1: Advanced Services It is	▪ Amended to: *AURs – no services provided in Thurrock* but that they can be accessed	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
	Springfield, CM1 6GL	inaccurate to state that Appliance Use Reviews (AURs) are not applicable in Thurrock. The Appliance Use Review service may be delivered by community pharmacists who supply appliances as part of their regular business (and many do).	outside of the borough and via the internet.	
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 3.1.2: Stop Smoking Services are commissioned from primary care by Thurrock Council, even if management arrangements are through North East London Foundation Trust.	▪ Amended to show that Thurrock Local Authority are the commissioners. ▪ Amended to North East London Foundation Trust – No services commissioned	▪
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 3.2.3:Medicines Management Provide support on prescribing safe and effective use of medicines -• is ungrammatical. Change to Provide support on safe and effective prescribing and use of medicines•	▪ Amended to *Provide support on safe and effective prescribing and use of medicines*	▪ yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.1: Neither Basildon nor Brentwood are HWB areas, they are part of Essex HWB area. Medway, Dartford and Gravesend are separated from Thurrock by the river Thames,	▪ Brentwood and Basildon have been omitted from the list	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		and may not be relevant.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.2.1: Population Some of the statistical data does not make sense, for example, The most significant increases are in the 5-9 year age band at 5.7% - does not make it clear 5.7% of what, or from what or to what	▪ Amended to *from the previous year*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 2.6.5: Implications of population on the PNA Women may be the most frequent users of pharmacy services, but not just for contraception, this needs clarification.	▪ Amended to *women (including for access to contraception)*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 2.6.5 The PNA needs to differentiate between BME communities and non-English speakers.	▪ Amended to show difference in BAME and diversity of languages. We have stated that pharmacies should be able to effectively communicate with BAME groups as well as those whose main language is not English.	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.1 Smoking Prevalence in routine and manual groups• should state Prevalence in routine and manual occupational groups	▪ Amended to *routine and manual occupational groups*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.1: The mortality rate attributed to smoking• should presumably state The annual mortality	▪ Amended to include 2012/13	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		rate. This is particularly important as a three-year strategy is referred to later in the sub-paragraph.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.1: It is encouraging to see that the smoking status at time of delivery indicator should state It is encouraging to see that the smoking status of pregnant women at time of delivery indicator	▪ Amended to it is encouraging to see that smoking at the time of delivery	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.1: Implications of smoking for the PNA Third bullet point Arrangements for Varenicline PGD are currently under review and this may need to be revised prior to final draft.	▪ This will be changed when necessary	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.5.3: Implications of Mental Health for the PNA Second bullet point Target medicine/patient groups for targeted MURs and NMS reviews are included within the service specifications and these do not currently include Mental Health.	▪ Amended to *A number of pharmacies deliver support in identifying adverse effects of medication as well as adherence issues that can contribute to improving outcomes for patients with serious mental health issues*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.7: Detailed descriptions of diabetes are not relevant to the PNA	▪ No change. We have decided to include this as background information for the understanding of this Long term condition	▪ No

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.3.8: Implications of older people for the PNA First paragraph leave out -these aids include large print labels and monitored dosage systems i.e. dosette boxes. By including a very limited list of possible auxiliary aids there is a risk of raising expectations is incorrect in this sentence as a number of monitored dosage systems are available, and Dosette is a trade name.	▪ Amended to not include examples of auxiliary aids	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.4.1: National Strategy The Health and Social Care Act was implemented in 2013. An act does not involve a range of health and care organisations, these organisations work to the Act.	▪ Amended to read *The Health and Social Care Act influences both the need and delivery of pharmaceutical services. A range of health and care organisations work in partnership to deliver under this Act.*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 4.4.2: NHS England A Call to Action The entire section needs to be revised as the consultation is already completed and the strategy may well be available by the time of the final draft. There are further grammatical errors, but these are irrelevant	▪ This will be updated when appropriate information is released	▪ No

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		presuming the entire section is redrafted.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5: Other considerations, first bullet point that affect the local pharmaceutical services Should be that affect the local provision of pharmaceutical services	▪ Amended to 'local provision of pharmaceutical services'	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.1: Specify that the 35 pharmacies include four that are required to open for 100hours per week	▪ Amended to *35 community pharmacies, including five pharmacies that are required to open for 100 hours per week*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	5.2.1: The information is not necessarily relevant as it looks at total pharmacy numbers only, and does not consider the opening hours or the number of pharmacists working at the pharmacy.	▪ National benchmarking data compares pharmacy provision. It would therefore be difficult to conclude whether local pharmacist capacity/provision was satisfactory.	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.2.1: GP data is based on average number of patients per GP, not per practice, and is therefore a less crude measure- there is a risk that this difference will not be recognised by some using the PNA.	▪ Noted. National benchmarking data compares pharmacy provision.	▪ No

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.1: Needs to specify that pharmacies are required to open 40 or 100 hours per week.	▪ This has not been amended as the first paragraph states this but it a different way to the one suggested in the comment	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.1: Market entry is controlled by regulations, rather than a system.	▪ Amended to *regulations*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.1: If additional hours are provided to meet a defined need within the PNA, and this was a condition of the pharmacy's admission to the Pharmaceutical List, then these will form core hours (this is one of the circumstances where NHS England may direct a pharmacy to provide more than 40 core hours.) If an existing pharmacy chooses to open additional hours to meet a need, whether defined or otherwise, these may constitute supplementary hours which may be changed on giving 3 months notice to NHS England.	▪ Amended to *supplementary hours can be amended by the pharmacy subject to giving 90 days notice to NHS England, who will make the final decision*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.1: Saturday- The way the text is written is misleading, as a number of pharmacies are open	▪ Amended to *There are 26 community pharmacies open on a Saturday, 25 of which open between 9.am – 12pm and*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		beyond 5pm on Saturdays, and the following page states that there is good choice in the number of pharmacies that are open at 6pm or after on a Saturday• however the way this section is written implies that there is only one pharmacy open on Saturday afternoons.	*eight that are open until 6pm or after.*	
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.1: Bank Holidays Stating that pharmacies open on a voluntary basis during Bank Holidays may be misleading. There is no contractual obligation for them to open, but many do based on a business decision rather than a voluntary• basis. NHS England do commission Bank Holiday rota hours when these are considered necessary, for example if it would not make good business sense for a pharmacy to open otherwise.	▪ Amended *pharmacies that open on a bank holiday and other holiday periods, do so based on a business decision. NHS England have not currently commissioned additional hours under a rota-system, in Thurrock*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.2: Access for those with a disability. This should refer to the extent that a pharmacy meets the needs of those with a disability, not the extent to which the pharmacy has been adjusted, for example no	▪ Amended to *a key consideration with regards to access is the extent to which pharmacies meet the needs of those with a disability*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		adjustment may have been necessary.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.3: There is a systematic approach taken by NHS England to bank holidays including Christmas, which takes into account pharmacies providing non-commissioned opening hours and the perceived needs of the population for pharmaceutical services on those days.	▪ Amended to *It is noted that currently there are no pharmacies providing additional commissioned hours during bank holidays, including Christmas. This decision is based on the systematic approach taken by NHS England, which takes into account perceived needs of the population for pharmaceutical services on those days*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.3: The legislative standards regarding accessibility for those with a disability refer to provision of services more than premises, and in some cases premises cannot be adjusted, for example where planning restrictions apply. The expression pharmacies should take strides is meaningless.	▪ Amended to include, *where appropriate*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.3.3: North Orsett should be described as rural, rather than green belt. The demand for pharmaceutical services, rather than for pharmaceutical need, may therefore be lower.	▪ It is not classified as rural, locally. Green Belt has been the agreed term with the planning/development team to describe the area.	▪ No
Karen Samuel Smith	17 Clematis Tye,	Section 5.4: Essential Services	▪ This has been deleted	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
	Springfield, CM1 6GL	Electronic prescription services are not a separate Essential Service to Dispensing and Actions Associated with Dispensing, or to Repeatable dispensing. Prescription-Linked interventions and Public Health Campaigns are not separate Essential Services, rather they are the two elements that comprise the Promotion of Healthy Lifestyles Essential Service.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.3:.Electronic prescription service This will need to be rewritten as the EPS roll-out will substantially be underway at the time the final is published. As Electronic Prescription Service is not an Essential Service as such, but rather an adjunct to Dispensing and Repeat Dispensing services, it may not be relevant to the PNA at all.	▪ We have included an update of the number of providers that are currently using the system.	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.4: Other Essential Services NHS England may require pharmacies to participate in up to six public health campaigns annually. If the Local Authority wishes to extend these based on local needs and priorities	▪ Amended to *If the Local Authority wishes to extend these based on local needs and priorities then this would need to be additionally commissioned*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		then this would need to be commissioned. The table of proposed campaigns for 2014/5 will be obsolete at the time the final PNA is published, and so the table describing them is probably irrelevant.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.4:The other aspect of the promotion of healthy lifestyles/ essential service is the targeted prescription-linked interventions, no reference is made to this in this section however there are clear links to JSNA priorities.	▪ Amended to *providing opportunist health promotion advice and targeted prescription-linked intervention*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.4: No reference is made to signposting or support for self-care services, these have clear links to JSNA priorities and both NHSE and CCG strategies.	▪ Amended to include health promotion and *signposting to other services including self-care support*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.4:Future Needs of Pharmacy- current open hours service is only limited to prescribers• should state current out of hours service is only available to prescribers• should state current out of hours service is	▪ Amended to read *available* rather than 'limited'	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		only available to prescribers		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.4:These changes may require NHS England to consider seeking additional hours, although pharmacies themselves may recognise the need and adjust core hours proactively.	▪ Amended to *These changes may require NHS England to consider seeking additional hours, although pharmacies themselves may recognise the need and adjust core hours proactively*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.4.4: This should refer to engagement with Public Health England, not engagement with the public.	▪ Amended to *Public Health England*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5: Advanced Services New Medicines Service is currently extended to April 2015. As the evaluation has recently been published it is likely that the future of the service will be decided before the final PNA is published.	▪ Amended to *NMS decision has been deleted*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5: Appliance Use Reviews are a contractual Advanced Service, and therefore commissioned nationally. The Appliance Use Review service may be provided to patients by community pharmacists who supply appliances as	▪ *AURs are not currently provided by pharmacies in Thurrock but may be accessed outside the borough and via the internet*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		part of their regular business.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.1: Medicines Use Reviews First bullet point The high risk medicines for targeted MUR are specified in Directions. Last paragraph Describing MURs and presenting some evaluation data, is not relevant to the PNA.	▪ Amended to *patients taking high risk medicines as specified in the Directions;* The last paragraph has been left in to show effectiveness of intervention	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.1: Conclusion of MURs The term wealth of evidence is too subjective	▪ Amended to *Evidence suggests that targeted MURs improve patient outcomes by increasing adherence and recuing medicines related risks, for instance it is estimated that up to 20% of hospital admissions are medicine-related and arise as a result of unintended consequences i.e. side effects or taking inadequate dosage*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.1: …review with two pharmacists how they may offer MURs in future is not part of the PNA, this sentence appears to have been included in error and may have been transcribed from an action plan.	▪ This has been deleted	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.2: New Medicines Service Final paragraph is meaningless without further context, a link may be provided	▪ Amended to *that while the services align well to our local strategic priorities, and that there is evidence of the benefits of this intervention, the future of this*	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		to the published evaluation.	*service, beyond 2015 is uncertain. Considering this, we have concluded NMSs are a relevant service that improves access to medicine review, clinical support and have the potential to improve patient outcomes*	
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.2: As the service evaluation has recently been published it is likely that the future of the service will be decided before the final PNA is published. This section should be rewritten to reflect this prior to final publication.	▪ Amended to include the extension of the programme through 2014/15	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.2: The sentence between the tables does not make sense. It is true that patients do not have to have been receiving pharmaceutical services for three months in order to receive the NMS, however a patient can only receive the service at the pharmacy that dispensed their prescription- any referral would also necessitate the dispensing of the prescription at the alternative pharmacy.	▪ Amended to *Although not all wards have this service within their area, as there is no three month regulation, patients can be referred to another pharmacy provided that the alternative pharmacy dispenses against the patient's prescription.*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.2: Conclusion of NMS Leave out	▪ Amended to include the new evidence *The NMS increased adherence by around 10% and increased identification in the*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
			numbers of medicine related problems and solutions. *Economic modeling 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.*	
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.2: Specific drug/patient groups are identified in the service specifications (unlike MUR services which state 50% must be in a specific group but 50% are based on the pharmacists judgement)	▪ Noted	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 5.5.2: NMS table As the service evaluation has recently been published it is likely that the future of the service will be decided before the final PNA is published. This section should be rewritten to reflect this prior to final publication.	▪ Amended to include the recent evidence	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	The chapter on Advanced Services should include information on	▪ We have been informed by NHSE that no pharmacy in Thurrock currently actively provide this service and we have	▪ No

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		Appliance Use Reviews.	therefore taken the decision not to include this as there is no local data/provision to show service	
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	5.6.1 Seasonal Influenza Vaccinations Most of the detail is not relevant to the PNA. This section needs to be rewritten to reflect current commissioning, information about current providers can be obtained from NHSE.	▪ This is the most up to date information provided by NHSE. We have requested further information	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6: locally commissioned services First three sentences are complicated and duplicate or misrepresent information. They should read From 1st April 2013 public health services previously commissioned by PCTs transferred to local authorities and are now termed Locally Commissioned Services. Community Pharmacy Contractors may also provide services commissioned by other organisations. Applications to the Pharmaceutical List can only be made on the basis of Pharmaceutical Services identified in Regulations, they cannot be submitted on the basis of gaps identified in provision of locally	▪ Amended as suggested in comment	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		commissioned services.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.1: Public Health Services Paragraph below list of services Specify what is meant by same services but smaller numbers, different services etc.	▪ We wish to use the same language.	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.1: Information on current year service review and notice is probably not relevant. Details of new provision from April 2015 should be written into final draft/PNA.	▪ We will update when details are available	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.2.2: Supervised consumption service paragraph three Remove the list of medicines and replace with The service requires the pharmacist to supervise the consumption of prescribed medicines for substance misuse to allow future flexibility	▪ We wish to show the medicines offered under the current service level agreement	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.2.1 Table Needle and Syringe Exchange Services The potential gap appears to be assumed based on current provision, has a needs assessment been conducted with current service users?	▪ Amended to *the potential gaps may limit access and/or choice of service and that further work will need to be undertaken to understand the extent to which these affect the pharmaceutical needs of our population*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.2.2: Supervised Consumption services Service users will be aware of opening hours of their pharmacy, and it is usual for collection times to be agreed as part of service provision.	▪ Amended to *service users are not able to access these services in an alternative pharmacy, should their usual pharmacy be closed at a time convenient for them*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.2.2: The last paragraph in the table is not relevant to the PNA.	▪ Amended to *It is important that pharmacies make progress towards the Making Every Contact Count agenda, by providing general health promotion and substance misuse advice to young people in the borough who have been identified with higher levels of cannabis smoking activity*. ▪	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.3: Reduce first sentence to Pharmacies are commissioned to deliver a portfolio of sexual health services, including:• Sentence between bullet point lists The aim of this service is to improve the sexual health of residents and seek reductions in sexual health inequalities, especially in high risk areas. The service currently supports the following key local outcomes:	▪ We wish to keep the sentence as it is	▪ No
Karen Samuel Smith	17 Clematis Tye,	Section 6.3: Conclusions of sexual health service Sentence below second	▪ This has been amended to *24 year olds*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
	Springfield, CM1 6GL	bullet point list should read population of 15-24 year olds, community pharmacy sexual health services are not available to 25-64 year olds.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.3: Following sentence A solution to improving the current access could be to approach pharmacies that provide extended hours to co-ordinate opening times• rather than specifically 100 hour pharmacies.	▪ Amend to *approach pharmacies that provide extended hours, including 100 hour pharmacies to coordinate a rota-system for weekend provision*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.3: Final sentence in table will need to be reviewed and rewritten prior to publication of final PNA.	▪ A supplementary statement will be published in the future	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.4.1: The two bullet point lists describe targets that Thurrock Council have agreed with NELFT, and are not relevant to the PNA.	▪ Amended to describe pharmacies' function i.e. provision of behavioural therapy and pharmacotherapy intervention.	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.4.2: Healthy Living Pharmacies Second paragraph. Accreditation is not delivered by Royal Society of Public Health, they accredit the Understanding Health Improvement Level 2 award which is	▪ RSPH provide accreditation has been deleted. ▪ *Appendix A provides an overview of the criteria community pharmacies participating in the Essex Healthy Living Pharmacy Pathfinder had to fulfil' has*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		one of the qualifying criteria. Appendix A provides an overview of the criteria community pharmacies participating in the Essex Healthy Living Pharmacy Pathfinder had to fulfil.	*been inserted*	
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 6.4.2: The way the early evaluations are presented is misleading as evaluation data from HLP overall is presented with data from specific services delivered through HLP, and these are not differentiated.	▪ Amended to *Early evaluations from HLP programmes have shown benefits, including a greater number of people receiving health and wellbeing advice, increased smoking quit rates and pharmacy as first point of healthcare intervention instead of GPs. The high percentage of those who would recommend this service also suggest high satisfaction amongst those who have used the service*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7: There should be an explicit statement that possible future needs could be met by existing providers.	▪ This has been addressed further down *Our review of essential services concluded that the current network of pharmacies has sufficient capacity to meet needs of the future population growth and we do not anticipate any future gaps with regards to these new housing developments within the next three years*	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.1: First bullet point needs clarification, presume this is a reference to travel medicine.	▪ Amended to *foreign ailments/travel medicines*	▪ Yes

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.2.1: We have identified that young men don't access pharmacies• needs reference for evidence.	▪ Amended to *we have highlighted that research indicates that young men access pharmacies least (reference 3)*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.2.2: The provision of auxiliary aids should sit under 7.2.3, don't include specific aids.	▪ This is a need that we wish to highlight for older people's services	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.2.3: Disability It may be better to start with the recognition that more information is needed to understand how pharmacies support patients with disabilities, as this may alter the rest of this section. This ensures that those people who are either disabled are able to access pharmaceutical services. The expression pharmacies to take strides• is meaningless.	▪ We wish to keep this statement. As a HWB we would like to see local pharmacies ensuring, where possible to meet the needs, with regards to access, of those who are disabled. We have included, *where possible,* as we understand that for some pharmacies making appropriate adjustments may not be possible.	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.2.8: Gender Reassignment Much prescribing for gender reassignment is through specialist centres and shared care arrangements, MURs may not therefore be	▪ Amended to *Pharmacies who may be involved with the care pathway of those who are undergoing gender reassignment*	▪ Yes

Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		appropriate.		
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.2.9: Pregnancy and Maternity Change peri-natal referral• to antenatal referrals•	▪ We wish to highlight pharmacy role in antenatal and post delivery support i.e. identification & signposting of postnatal depression	▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 7.2.9: Interventions that ensure medication that may cause adverse effects are avoided is a key element of the core dispensing process, not a medicines use review.	▪ Amended to *pharmacies are able to deliver interventions to ensure that medication that may cause adverse effects to foetus or babies are avoided*	▪ Yes
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 8: See earlier comments regarding bank holidays. Change we would like to see a larger number of accredited pharmacies in Thurrock providing more enhanced services to serve local populations to we would like to see a larger number of pharmacies in Thurrock delivering more locally commissioned services to our population	▪ We wish to present the this information. Amended to *Pharmacies open during bank holidays and others holiday periods, based on a business decision. Based on a systematic approach to local need, NHSE do not to currently commission additional hours under a rota-system in Thurrock. This will need to be reviewed locally in the future* ▪ This has been amended to locally commissioned services.	▪ Yes ▪ No
Karen Samuel Smith	17 Clematis Tye, Springfield, CM1 6GL	Section 8: See earlier regarding provision of services to disabled residents. There needs to be a differentiation between BME groups and patients who do not have English	▪ Amended to include *where possible, each pharmacy has wheelchair friendly facilities.* ▪ *We have stated that language is a possible barrier for BAME groups, we*	▪ Yes ▪ No

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Organisation	Address	Suggested Inaccuracy	Notes to PNA TFG	Amend PNA?
		language skills.	*wish to see pharmacies play a bigger role in engaging these groups*	
Dipti Patel (on behalf of Essex County Council)	County Hall, Chelmsford, Essex CM1 1 YS	Section 8: All services are agreed as necessary then contradicted further in the document. Dispensing doctors section states 50% of prescriptions are dispensed outside Thurrock, not agreeing with the table above. Appliance contractor need not accurate. Wheelchair access- confirm GPhC requirements for premises. Disagree that women use pharmacies (for contraception)	▪ We have stated the principals of what we regard as a necessary service. Some services will fall out of these and will therefore be regarded as a relevant service, which secure benefits or improve access. ▪ The dispensing list is for the top five out of area pharmacies, that dispense the most items ▪ Appliance Contractors – this has been changed to show that residents can access DACs from outside of Thurrock ▪ Wheelchair access – this has been amended to show where it is appropriate and possible for a pharmacy to be more accessible to those with a disability, it should. ▪ This has been amended to show that women use pharmacies for other services *including* contraception	▪ Yes

10. References

[1] Section 128a of NHS Act 2006, as amended by the Health Act 2009 and Health and Social Care Act 2012
[2] Department of Health 2013. 'Pharmaceutical needs assessments: Information Pack for local authorities and Health and Wellbeing Boards.
https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack
[3] Community Pharmacy Use Market Research Report
http://www.dispensingdoctor.org/content.php?id=427
[4] World Health Organization (2014) Global Status Report on Alcohol and Health
http://www.who.int/substance_abuse/en/
http://www.nhs.uk/conditions/alcohol-misuse/Pages/Introduction.aspx
Public Health England (2010)
http://www.localhealth.org.uk/#z=542429,189306,48675,15885;v=map4;i=t3.alc_harm;l=en
Public Health England (2010)
http://www.localhealth.org.uk/#z=542429,189306,48675,15885;v=map4;i=t2.bingedrinking;l=en
[5] DoH (2008) Pharmacy in England: Building strengths – delivering the future NHS MUSE Profile data
http://www.erpho.org.uk/Download/Public/22106/1/Young%20People%20drug%20and%20al cohol%20profile%20Thurrock%202011.pdf

[6] DH (2008) Pharmacy in England: Building strengths – delivering the future
National Obesity Observatory http://www.noo.org.uk/NOO_pub/ Hughes et al., 2000
Scientific Advisory Committee on Nutrition, 2011. The influence of maternal, foetal, and child nutrition on the development of chronic disease in later life.
McCormick, B. Stone, I. and Corporate Analytical Team. 2007. "Economic costs of obesity and the case for government intervention". Obesity reviews 8 (Suppl.1), 161-164
[7] Drug strategy 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265392/Drug_ Strategy_AR_v0.6.pdf
Annual Review: Delivering within a New Landscape (2013)
https://www.gov.uk/government/publications/drug-strategy-2010--2
http://fingertips.phe.org.uk/substancemisuse#gid/1000031/pat/6/ati/102/page/3/par/E12000006/are/E06000034
Public Health England http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/3/par/E12000006/are/E1000002
NHS MUSE Profile data
http://www.erpho.org.uk/Download/Public/22106/1/Young%20People%20drug%20and%20al cohol%20profile%20Thurrock%202011.pdf
[8] McCormack, B Stone, I. and Corporate analytical team. 2007 "Economic costs of obesity and the case for government intervention" Obesity reviews 8 (Suppl.1.) 161-164
[9] Strauss R., Childhood obesity and self-esteem, Paediatrics 2000; 105; e15
[10] WHO (2011) Mental health; strengthening our responses
[11] NEPHO Psychiatric Morbidity Survey 2000
[12] The numerator is those women aged 53 -70 years; however the programme extends its coverage to 47 – 73 age range.
National Collaboration Centre of Primary Care (NCCPC) Lipid modification: Cardiovascular risk assessment and modification of blood lipids for primary and

secondary prevention of cardiovascular disease. Clinical Guidance 67. London. NICE (2008).

[13] National Collaboration Centre of Primary Care (NCCPC) Lipid modification: Cardiovascular risk assessment and modification of blood lipids for primary and secondary prevention of cardiovascular disease. Clinical Guidance 67. London. NICE (2008)

[14]http://www.yhpho.org.uk/diabetescommunityhealthprofiles/CCGprofiles13/07G_Diabetes%20Profile %202013.pdf

[15] National Cardiovascular Intelligence Network (NCVIN) *www.diabetes-ndis.org*

[16] National Cardiovascular Intelligence Network (NCVIN) *www.diabetes-ndis.org*

[17] Thurrock Health and Wellbeing Strategy 2013-2016 https://www.thurrock.gov.uk/health-and-wellbeing-board/our-strategy

[18] There were four exemptions to the 2005 control of entry regulations, these were:

- Pharmacies based in approved retail areas (Areas of 15,000 square feet or more)
- Pharmacies that intended to open for at least 100 hours per week
- Consortia establishing new one stop primary care centres
- Wholly mail order or internet-based (distance selling) pharmacy services.

Under the 2012 regulations there is only one remaining exemption category ‘mail or and internet-based based (distance selling) pharmacy services. Existing pharmacies opened under the 2005 exemption categories are still expected to meet conditions of the category their application was granted under.

[19] Pharmacy in England: Building on strengths – delivering the future (2008) https://www.gov.uk/government/uploads/system/uploads/attachment data/file/228858/7341.pdf

[20] Data could only be obtained from March 2012 – February 2013. https://www.thurrock.gov.uk/health- and-wellbeing-board/our-strategy

[21]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207134/Influenza vaccine uptake amongst GP patient groups in England for winter season 2012 - 2013.pdf)

[22] http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies.

16 December 2014	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Health and Social Care Transformation - Finalising the development of the Better Care Fund and establishing the Section 75 Agreement	
Wards and communities affected: All	**Key Decision:** Non-key
Report of : Roger Harris – Director of Adults, Health and Commissioning	
Accountable Head of Service: Not applicable	
Accountable Directors: As above	
This report is public	

Executive Summary

This is a status report on the establishment of the Better Care Fund (BCF) pooled fund to promote integrated care and support services. The pooled fund will be operated in line with the conditions set out in a Section 75 agreement to be signed by the Board of NHS Thurrock CCG and the Cabinet of Thurrock Council.

Progress has been made on the administrative arrangements which must be addressed in establishing and operating a pooled fund, including the treatment of over spends, the payment for performance element and VAT. However, the recent decision of the Department of Health to approve Thurrock's Better Care Fund Plan as "Subject to Conditions" means that a number of areas need to be re-examined.

Attached at **Appendix 1** is a copy of our BCF re-submission. This is still subject to evaluation by the national team – any update will be reported to the meeting.

The purpose of the exercise is to drive through significant changes to our health and social care systems so that care is more effective, efficient and economic, and so that users, patients and carers experience better co-ordinated care and improved outcomes. This remains Thurrock's vision for integrated health and social care.

1. Recommendation(s)

1.1 HOSC is asked to note and comment on the BCF Plan and the proposed Heads of Terms of the BCF Section 75 Agreement between NHS Thurrock CCG and Thurrock Council.

2. Introduction and Background

2.1 As reported previously Central Government is placing £3.8 billion of existing health and social care funding into a single pooled budget, to enable health and social care services to work more closely together. Locally, a pooled fund will need to be established by April 2015 and administered in line with a Section 75 agreement between the CCG and the Council.

2.2 This report sets out the Heads of Terms for that agreement.

2.3 On 29 October 2014 the CCG and the Chair of the Health and Wellbeing Board received a letter which stated that the Department of Health had determined that Thurrock's Better Care Fund Plan was "Approved Subject to Conditions". The Department of Health's conditions relate to certain narrative and financial aspects of the BCF Plan submitted to the Department on 19 September 2014.

2.4 The Department of Health has advised that the 48 "Areas 'approved subject to conditions' should proceed with their preparations for implementation" and submit a further revised BCF Plan by 21st November. This is in contrast to those 5 areas which were "not approved" which "are strongly recommended not to proceed". Accordingly, Thurrock Council and Thurrock CCG submitted a revised BCF Plan on 21st November which is attached at Appendix 1.

3. Issues, Options and Analysis of Options

3.1 The establishment of a BCF pooled fund is mandatory, as is the requirement to establish a fund of a minimum size. However, the actual size of the fund beyond that minimum mandated value, and the purposes to which the fund is applied are matters to be determined locally. The Better Care Fund Plan for Thurrock will establish a pooled fund of £18,019,336 made up of a £14,766,142 contribution from the CCG and a £3,253,194 contribution from the Council. The Heads of Terms for the Section 75 Agreement are set out below.

<u>The Better Care Fund for Thurrock</u>

3.2 The initial focus for Thurrock's Better Care Fund is on individuals aged 65 and over who are most at risk of admission to a hospital or residential care home. Accordingly the services commissioned from the pooled fund in Thurrock, and so the value of the Better Care Fund itself in 2015/16, have been arrived at by identifying those services which are most relevant to preventing or reducing admissions of those aged 65 and over.

<u>The National Conditions to be met</u>

3.3 As noted in the report on 17 July, the Better Care Fund is to be established, and a reduction in total emergency admissions achieved, within existing Council and NHS funding – there is no new money. In addition to the challenge of driving through significant change in our health and social care system there are a set of national "must dos", including 7 day working, better

data sharing, an accountable professional for people over 75, and protection for adult social care services.

The costs of implementing the Care Act 2014

3.4 Further, it was announced as part of the Spending Round that the Better Care Fund would include £135m of revenue funding for costs to councils resulting from Care Act implementation in 2015/16. Again this is not new money but £522,000 has been set aside in the local pooled fund for this purpose.

Payment for Performance

3.5 While the initial focus of the Better Care Fund when it was launched in August 2013 was on integration, the revised guidance places a specific requirement for a minimum target reduction in total emergency admissions. The guidance makes it clear this should be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. Thurrock has accepted this challenging target (amounting to some £722,000 locally). In order to manage the risk of under-performance, the Council and CCG propose that funds related to the performance element will only be paid by the CCG into the pooled fund in relation to the performance achieved. Commitments related to the performance element will likewise only be made following conformation of performance against the target.

Overspends/ Underspends in the Better Care Fund

3.6. The issue of treatment of overspends has been examined and, with a view to limiting the risk to the CCG and Council, expenditure in each scheme within the pooled fund will be monitored closely, and any virement between schemes will be subject to approval by both parties. Further, it is proposed that any expenditure over and above the value of the fund should fall to the Council or the CGG depending on whether the expenditure is incurred on social care functions or health related functions. The arrangements for monitoring expenditure and managing any overspend in an individual scheme will be set out in detail in the Section 75 Agreement. Any underspends at the year end will stay within the Pooled Fund as a restricted reserve – unless otherwise agreed by both parties.

Governance arrangements

3.7 The management of the pooled fund will require regular oversight by both parties and accordingly it is proposed that an Integrated Commissioning Executive comprising officers of the CCG and Council is established – this Executive will report directly into the Health and Well-Being Board. A Pooled Fund Manager will also be appointed to provide regular reports, (including an Annual Review) to the Executive which will provide strategic direction on the individual schemes and manage risks. The Pooled Fund Manager will also prepare reports for the Health and Wellbeing Board.

Administrative arrangements and milestones

3.8 In addition further work is required for the Council to host the pooled fund, and to make payments to third party providers from the fund from April 2015. In view of the timescales involved waiver requests and contract award requests

for these contracts will need to be approved no later than February 2015. Activities ranging from the placement of purchase orders to performance management will also need to be undertaken in good time.

Management or risks

3.9 A Risk Register for the Better Care Fund has been established and a Project Group comprising senior officers from the CCG and the Council is meeting monthly to oversee the development work and to actively manage the risks identified. The Project Group reports to the Health and Social Care Transformation Board so that linkages with the implementation of the Care Act, and QIPP and corporate efficiency initiatives are also actively managed.

Contractual arrangements

3.10 The matter of the most effective contractual arrangements has been discussed between officers from the CCG and the Council. It is felt that for the first year initially the Council should become an associate commissioner alongside the CCG for those contracts where the CCG already has an existing arrangement e.g. North East London NHS Foundation Trust (NELFT). This will allow for more effective integrated commissioning and establish a single, joint contract management framework. It is proposed that the standard NHS contract is used for this with the Council becoming an equal commissioning partner with the CCG.

Revised Milestones

3.11 In view of the "Approved Subject to Conditions" status of the Better Care Fund Plan, and the fact that approval is not now expected before the end of 2014, the timetable for implementing the arrangements must be delayed. The revised milestones are as follows:

Milestone	Date
Health and Wellbeing Board agreement to Section 75 agreement	13 November 2014
NHS Thurrock CCG Board approval of Section 75 agreement	26 November 2014
HOSC considers the BCF submission and the Heads of terms	16th December 2014
Cabinet of Thurrock Council approval of Section 75 agreement	February 2015
Waiver requests and contract awards	From February 2015
Purchase to pay arrangement	From February 2015
Contract and Performance management	From February 2015
Payments of providers from the BCF pooled fund	From April 2015

4. Reasons for Recommendation

4.1 The Heads of Terms set out Section 3 above are considered to be prudent, while acknowledging that further work, and indeed possibly a change to the

Plan in response to further guidance from Central Government, may be required.

4.2 In view of the “Approved subject to Conditions” status of the Better care Fund Plan, and the implications this may have for the establishment and operation of the pooled fund and the Section 75 agreement, a further report will be brought to the Health and Wellbeing Board in January 2015 and the final Section 75 agreement will be going to cabinet in February 2015.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 As noted in the previous report, the process of community engagement in the redesign of health and social care services in Thurrock is being planned in conjunction with Thurrock Healthwatch, Thurrock Coalition, Thurrock CVS and the Thurrock Commissioning Reference Group.

5.2 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services is required under the terms of the Health and Social Care Act 2012. This is being undertaken through the Thurrock consultation portal as well as the CCG website.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The planned reduction in emergency admissions, which brings with it the potential to invest in services closer to home, will help prevent, reduce or delay the need for health and social care services. This will help deliver the Community Strategy priority to improve health and wellbeing.

6.2 Achieving closer integration and improved outcomes for patients, service users and carers is also seen to being a significant way of managing demand for health and social care services, and so manage financial pressures on both the CCG and the Council.

7. Implications

7.1 **Financial**

Implications verified by: **Sean Clark**
Head of Corporate Finance
Thurrock Council

Femi Otukoya
Head of Finance
NHS Thurrock CCG

The above report contains the current known position of the Better Care Fund, guidance on which is still being received. As noted in the previous report, while reasonable progress has been made in understanding the detail of how

the pooled fund will operate and the timescales for the project, the complexity of the health and social care system itself presents a major challenge.

The report sets out the funding to be placed into the Pool for 2015/16 and it should be noted that this is from existing budgets that should lead to financial efficiencies.

7.2 **Legal**

Implications verified by: **Daniel Toohey**
Principal Solicitor - Contracts & Procurement
Thurrock Council

Andrew Stride
Head of Corporate Governance
NHS Thurrock CCG

The above report contains the current know position of the Better Care Fund, guidance on which is still being received. Further, the CCG and Council are seeking clarification from Central Government on a number of points. As noted previously the governance arrangements for the Better Care Fund need to be agreed by the Health and Wellbeing Board, and approval from the Cabinet of Thurrock Council and the Board of NHS Thurrock CCG to the Section 75 Agreement will be required before the pooled fund can be established.

7.3 **Diversity and Equality**

Implications verified by: **Teresa Evans**
Equalities and Cohesion officer
Thurrock Council

Andrew Stride
Head of Corporate Governance
NHS Thurrock CCG

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will need to be developed with due regard to equality and diversity considerations. This will include adherence to the relevant 'Equality' Codes of Practice on Procurement. These require consideration of the equality arrangements of all such providers, such as relevant policies on equal opportunities and the ability to demonstrate a commitment to equality and diversity. These arrangements will also be subject to a full review as part of the contract management of the services to be provided.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified at this time.

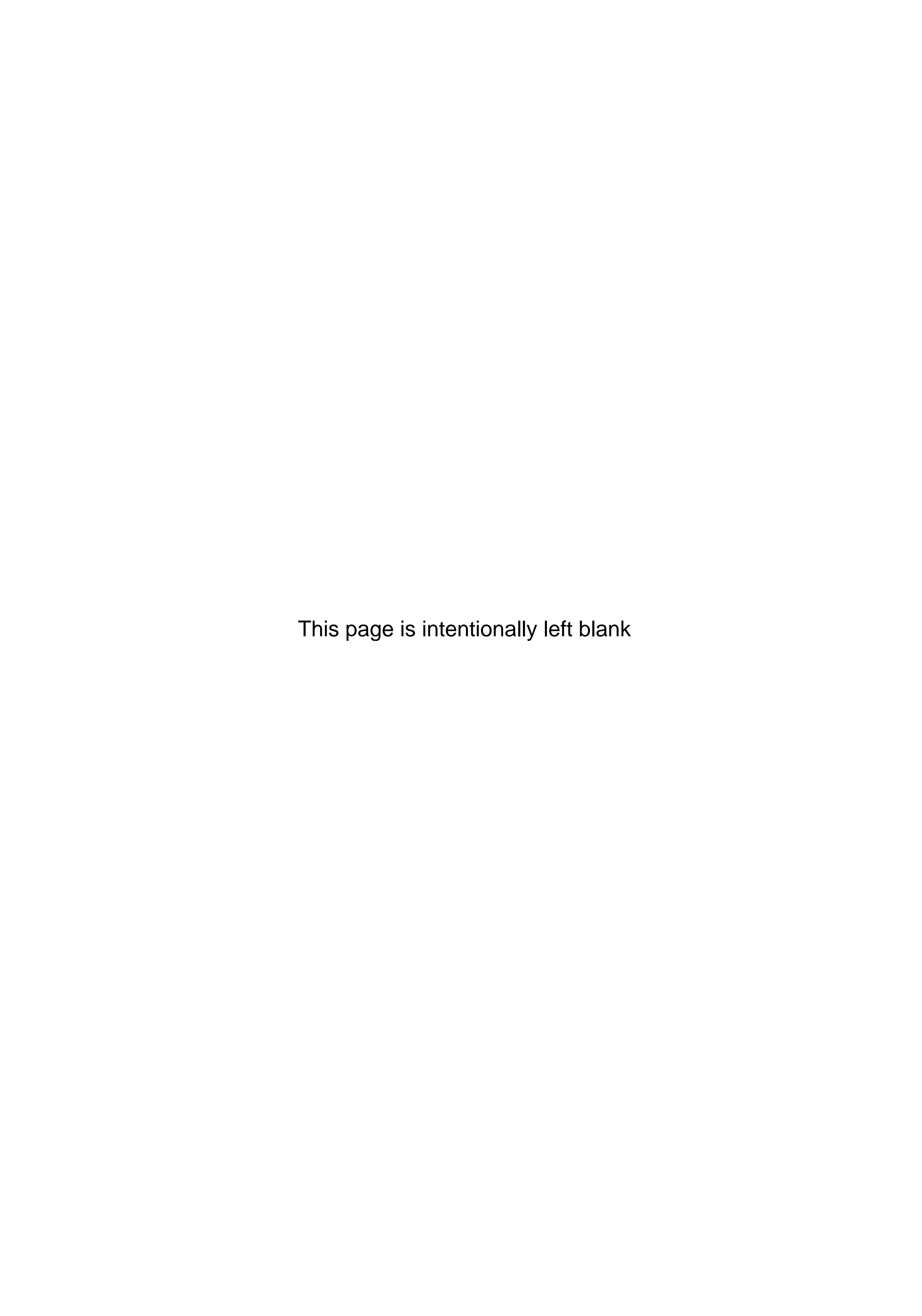
8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Better Care Fund: Contractual and procurement documentation guidance for plans 'not approved' or 'approved subject to conditions' 29 Oct. 2014

9. Appendices to the report

- Appendix 1 : Revised BCF - submitted November 2014.

Report Author: Christopher Smith
Programme Manager, Adults, Health and Commissioning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THURROCK BETTER CARE FUND PLAN

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Thurrock Council**
Clinical Commissioning Group	**NHS Thurrock Clinical Commissioning Group**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,860k**
2015/16	**£10,565k**
Total agreed value of pooled budget: 2014/15	**£3,860k**
2015/16	**£18,019k**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Anand Deshpande
Position	Chair
Date	28th November 2014

Signed on behalf of the Clinical Commissioning Group	
By	Mandy Ansell
Position	Acting Interim Accountable Officer
Date	28th November 2014

Signed on behalf of the Council	
By	Roger Harris
Position	Director of Adults, Health and Commissioning
Date	28th November 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Barbara Rice
Date	28th November 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	Analysis of the needs of Thurrock's residents to inform planning and commissioning. Thurrock JSNA
Health Needs Assessment for the over 75 year old Thurrock Population	Analysis of the health needs of people aged 75 and over in Thurrock 75 and Over Health Needs Assessment
CCG Operational Plan	Thurrock CCG's two year operational plan. CCG 2 Year Plan
CCG Strategic Plan	Thurrock CCG's five year strategic plan Draft 5-Year Plan
Joint Health and Wellbeing Strategy	A partnership document detailing the vision and aims for improving health and wellbeing in Thurrock. Thurrock JHWBS
Delivering Seven Day Services	Describes how seven day services across health and social care will be delivered SW Essex 7 Day Service Mapping
Building Positive Futures Programme	Building Positive Futures is the Council's transformation programme for Adult Social Care, and leads the Council-wide work on 'Ageing Well', as well as integration with Health. Building Positive Futures Programme

Introduction and Executive Summary

Thurrock's Joint Health and Well-Being Strategy is built around a vision for: Resourceful and resilient people in resourceful and resilient communities. The vision recognises that first and foremost, health and well-being is created by active, connected individuals living in healthy, inclusive and connected communities.

Thurrock is an area of major regeneration to the east of London and the job opportunities and economic growth will lead to a more diverse and prosperous population in the coming years. However, there are still major health inequalities in Thurrock with a gap of life expectancy of 8 years between the most and least prosperous areas. And, whilst our population is relatively young in comparison with south Essex, the over 65 population is increasing to an extent that demands on the acute services need to be managed carefully.

Building social capital, investing in local community social/care enterprises, strengthening communities are embedded in Thurrock's health and well-being strategy as a key element of overcoming health inequality and responding to the growing demands of an ageing population. Our focus on strengthening communities brings together the resources of housing, public health, adult social care and the CCG. Another feature is co-production – working with individuals and communities to create their own health and well-being solutions. These features naturally appear in our BCF proposals and, we think make our approach unique.

We recognise that these community-building initiatives need to be backed up by a suite of community based care and health responses that prevent or delay the need for services in the acute sector. Consultation events with key stakeholders – residents, patient representative groups, providers, commissioners held in December 2013 and April 2014 have enabled us to formulate a set of guiding principles for health and social care, and understand important messages from our stakeholders about Better Care and the future direction of primary care in Thurrock.

The proposed focus of the BCF
Through the BCF, we intend to expand or accelerate certain programmes already underway such as Local Area Coordination and the Rapid Response and Assessment Service (RRAS) as well as use the BCF as the catalyst to new initiatives such as an integrated single frailty pathway. BCF is therefore being used to enhance service innovations that we know are working well and providing us with the opportunity to re-design other areas that we recognise could benefit from review. The focus for our BCF will initially be on people over 65 for reasons we set out in the Case for Change – but in essence, the selection of this age group reflects the spiralling rates of non elective admissions but also the opportunities to avoid such admissions through concerted action by health and social care services operating at community level building on successful working practice to date.

As a relatively small unitary, with operating costs that compare well with comparable authorities, and with a number of health and well-being programmes aimed at the adult population already underway, we feel that focusing BCF work streams onto one segment of the population commanding the highest spending, will yield the best returns – but also reflecting the capacity of the CCG and council to achieve radical transformation in a way

that is sustainable and maximises the opportunities for change. The learning from this approach can then be applied across other areas.

Building on our experience of integrated services – building on what works

In relation to the delivery of integrated care and health services, we have established highly effective joint working arrangements with health partners in relation to the delivery of Rapid Response and Assessment Services (RRAS) and Joint Re-ablement (JRT) delivering services jointly through a combined budget of £1.75m. Both performance levels against targets and service user feedback demonstrate a solid base from which to extend integrated working.

Our Local Area Coordination programme, currently funded through social care, public health and fire service resources will be extended to cover the whole Borough through the use of BCF funds. Feedback from people supported by LAC and the professionals referring people demonstrate significant results in terms of diverting people away from crisis services.

Future vision for health and social care in Thurrock

In essence, the overarching vision for our health and care services involves:

- More jointly commissioned programmes designed to support people to stay strong, well and connected within their own communities – for example our local area coordination and community building initiatives
- New, jointly commissioned, integrated services that support people, post diagnosis, to manage their conditions – for example specialist dementia support workers and increased use of assistive technology
- Enhanced multi-disciplinary working which puts the individual at the centre – building on our collaborative work with GPs, local area coordination, hospital social work teams and mental health professionals
- Expanded community based responses that reduce reliance on the acute sector – supported by locality service integration based around four GP cluster areas, an integrated frailty model integrating the community geriatrician within a single pathway and incorporating end of life care, a further developed intermediate care offer, and a shift towards prevention and early intervention majoring on Local Area Coordination
- Greater range of small-scale care services to enhance choice and control – driven by our Market Position Statement which promotes innovative approaches such as micro-care enterprises and initiative such as Shared Lives

And for residents, our vision should mean:

- Many more opportunities to stay connected and supported within their own communities
- Where services are needed, these will be coordinated around the individual – preferably at home and with the individual in control and able to exercise real choice
- Post diagnosis of any condition, pro-active support and coordination of care and support service linked to the person’s home
- Where acute services are needed, appropriate re-ablement support and intermediate care to prevent readmission

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Introduction

The initial focus for Thurrock's Better Care Fund is on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes we have chosen for the BCF reflect this focus and the rationale for this are set out in the Case for Change section. We aim to have a single pooled fund across health and social care for all older people's services by April 2017. In line with the Care Act guidance on 'preventing, reducing or delaying needs', our aim is to develop integrated approaches that target 'individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing'; and to develop integrated approaches aimed at 'minimising the effect of disability or deterioration of people with established health conditions, complex care and support needs or caring responsibilities'. These themes run throughout our schemes (refer to schemes 1 – 4 in particular).

Although our focus for this iteration of the BCF is the 65 and over age group, we know that whole system transformation aimed at reducing and preventing individuals from reaching crisis point will require a focus on health and wellbeing for the whole population – e.g. initiatives aimed at 'individuals who have no current particular health or care and support needs'. Our strength based approaches such as Local Area Coordination and Asset Based Community development have a clear role to play in keeping individuals strong and connected – scheme 4 refers.

Context

Thurrock's current population, which is now estimated to be in excess of 160,000, has increased by over 10% since 2001, and 22% since 1991. It is projected to be 207,300 by 2033. The population group aged 85 and over is projected to double. With the expected ageing and growth of the population, we can expect a rise in age-related disease prevalence and additional demand on health and social care services. As an example, dementia is expected to increase steeply in Thurrock.

Lifestyle factors are having a significant impact on the demand for health and social care services in Thurrock. 20.7% of adults in Thurrock smoke, and 31.4% of adults are obese (significantly higher than national average), and 70.8% of adults have excess weight (significantly higher than national average) - 2014 Health Profile. A preventative approach as well as interventions for those individuals who have already entered the health and care system is therefore paramount to the long-term sustainability of Thurrock's health and care services. Local Area Coordination is proving to be very effective in this regard and for this reason is being expanded in support of the BCF objectives.

To assist with the focus of Thurrock's BCF Plan, we carried out a recent 'Health Needs Assessment for the over 75 year old Thurrock population. This is a focused piece of work and builds on Thurrock's JSNA which was published in 2012. The Assessment made a number of recommendations which will assist with the development of initiatives as part of the BCF. Further detail has already been provided in the 'Case for Change' section and has already influenced a number of our schemes – for example the frailty model (scheme 4) and locality service integration (scheme 1).

In addition to the over 75s analysis, NHS England's Essex Area Team are in the process of developing a Primary Care Strategy. Robust primary care, particularly GP services, are critical to early identification of those at risk of developing a health condition and those individuals whose

health is deteriorating and reaching crisis point. Thurrock is currently under-doctored, and 30% of the current Thurrock CCG GP workforce is over the age of 60. A number of the areas with a shortage of GPs are also in Thurrock's most deprived areas. Scheme 1 aims to maximise primary care capacity by providing an integrated health and care offer that builds on four GP cluster areas.

What our Stakeholders tell us

Two key events in December 2013 and April 2014 have provided a rich picture of stakeholder perspectives. Patient, carer and community representatives, perhaps reflecting the success of our strength based initiatives to date see the potential to mobilise commissioning and services around community hubs so that support services and carer support are locally based. The Local Area Coordinators, again reflecting the impact made even in the early stages of our pilot programme are seen as having the potential to work directly with GPs, coordinating care and support around the person. Single assessments, single plans and clear pathways as well as clear, accessible information are key themes. The home is seen as the place where assessments should take place with personalised care packages developed around the person. Commissioners and providers similarly reflected a commitment to coordination around the whole person's needs, assessed at home and also saw the potential of local solutions rooted in the local community. Our chosen schemes and the initiatives within them respond to these messages – e.g. the use of telehealth and assistive technology.

Central to the future direction of health and social care in Thurrock, our stakeholders identified themes that highlighted the importance of: the home, coordination around the whole person and the community as the source of solutions. These themes are again picked up in our evaluation of Local Area Coordination; feedback from people supported, health and social care professionals all highlight the importance of seeing the whole person and finding the best possible solutions at home, connected with the wider community.

Informed by the December event a set of joint principles was subsequently developed and agreed by Thurrock Council and the CCG:

- Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing;
- Health and care solutions that can be accessed close to home;
- High quality services tailored around the outcomes the individual wishes to achieve;
- A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible; and
- Systems and structures that enable and deliver a coordinated and seamless response.

How Local Area Coordination is driving service reform and its contribution to the BCF

Local Area Coordination has been selected for acceleration under the BCF as it is proving to be a very powerful approach to supporting people who often have complex issues which are not readily remedied by a single service approach. Whilst the age range of people supported runs from 18-98 years old, there is a significant pattern of older people, who are isolated and who have a range of health issues exacerbated by depression and isolation. Referrals from the Older People Mental Health Team demonstrate the value of the LAC approach which starts with a question about what makes a good life and working outwards to find local and usually informal solutions.
An example of this is one individual who required interventions from RRAS, Out of Hours or NHS 111 service 41 times over a 7 month period, which consequently reduced after LAC intervention to 3 calls over a 4 month period. Another individual supported by a LAC to find local, informal supports had a long history of mental health service interventions – such was the impact on this individual's well-being, his psychiatrist rang to thank the LAC

personally for making such a significant impact.

Local Area Coordination with its emphasis on the whole person, local solutions and diverting people away from service dependency is perhaps the best possible example of joint commissioning to achieve a whole-person approach to health and wellbeing – in our case the roles are funded by social care, public health, the fire service and now through the BCF. Police support is also anticipated as the police service can see the great potential offered by LAC of supporting vulnerable people who they encounter day and night. The feedback from people supported by the LACs as well as the professional services is testament to power of the approach :

LAC Evaluation – feedback from individuals supported, health professionals and Steering Group members:

Mr A:
"Francis grabbed my ears and dragged me up from the grave."
"Everything good in my life started from the time the very clever hospital social worker made a plan and then introduced me to Francis."
"Francis has been the right man, in the right place at the right time".

From Adult Safeguarding:
"Since Martin's involvement my visits have reduced to the point where the safeguarding concern has been closed. It is my opinion that without LAC involvement there was a high possibility that the individual's life was at risk due to self neglect, falls and injury."

From an Individual supported by LAC:
The LAC is genuinely interested in me and does not have an agenda. I feel completely in control and that the LAC is on my side. There are things that I have done that I wouldn't have been able to do without the support of the LAC.

From MDT coordinator (NEFLT)
"From a health perspective it links in well with the Primary Care MDT's as we identify patients who would benefit from LAC intervention and can do direct referrals. It is an effective way of supporting people to be independent but with the benefit of having local knowledge as the LACs are embedded in the Community, and are able to give them advice and information about the local area, making it more inclusive of health conditions. They are also supporting with navigating the complex systems and referral processes for more formal support due to LACs being part of Thurrock Council."

Regular meetings between MDT Coordinator and the LAC's help to provide up to date feedback and ensure patients' best interests are maintained.

Daniel Gatehouse – Strengthening Communities Manager (Fire Service)
The LAC's have achieved astounding results in the relatively short time they have been in existence, changing the lives of people that had the potential to become dependent on public sector services or worse still become a fatal statistic.

Sue Bradish – Public Health Manager (Thurrock Council)
We have been pleased to support their work on an individual and community level that has addressed some of the Public Health expected outcomes around increasing health improving behaviours

We are therefore very confident that in extending the LAC programme to provide cover across Thurrock, we are in a good position to support people to stay well who are 'under the radar' but also to steer people away from crisis who are at significant risk. In relation to the focus of our

BCF, the LACs are making a major contribution to older people who are isolated, have mental health or physical disabilities, helping them to remain safe, independent at home. With that level of support in place across our communities, the BCF allows us to re-think how we deliver health and social care services to the over 65s.

JRT and RRAS – the platform for developing more integrated services

The RRAS is a joint service between social care and NELFT to provide a rapid response and assessment for people over 18 in crisis or pending crisis. The aim is to assess the situation and avoid where appropriate, unplanned emergency admissions to hospital and residential care, redirecting to intermediate care in the right place, right time and by the right team. The service is also a support service for carers. 84% of people are seen within 1-2 hours of a referral being made. On average 200 referrals are received per month. RRAS is also available to care homes 70% of referrals are seen once but there are some cases where people are seen numerous times as they enter further crisis. The majority of referrals are from GPs (18%).

Outcomes are as follows for Jul-Sept 2014: 2.9% (36) of service users assessed had an immediate admission to hospital. This is under the 7% target and is continuing to reduce.

JRT is a joint service between social care and NELFT (our community health provider) and provides rehabilitation services appropriate to the individual's needs with the aim of preventing a readmission to hospital and enabling the individual to live as independently as possible in their own home.
Service user satisfaction levels with the JRT are very high. :A quarterly survey (Jul-Sept 2014) has the following positive results:

- 94% state that they are always treated with respect and dignity.
- 94.5 state that all or most of their care needs are met.
- 93% report that the range of care and health workers work well together at a team.
- 86% state that the service has helped them to be more independent and stay in their own home.
- 95% state that the quality of life has completely or mostly improved following support from the team.
- 98% are completely or quite satisfied with the service overall.

Approach

BCF offers Thurrock Council and the CCG the catalyst to transform how we work together, what we deliver, how we deliver it and where we deliver it. The timing is ideal, coming as it does at the point when our community building, strength based approaches are taking root and BCF is welcomed because it helps to deliver our Building Positive Futures programme. We therefore approach BCF with an openness to change and challenge and want to set up a process which is inclusive and transparent. Having fixed ideas at the beginning of the process about what will change and how, is therefore counterproductive. We intend to embark on this transformation in the same spirit as we embarked on Local Area Coordination – as a learning experience which needs to be captured throughout the development. The key deliverables that will inform this process are national conditions and the reduction in non-elective admissions, but how these deliverables are met will be designed in partnership will all key stakeholders.

We have identified distinct work streams that we believe, combined will enable us to transform our service and supports to the over 65 population:

- Locality Service Integration
- Frailty Model
- Intermediate Care
- Prevention and Early Intervention

- Disabled Facilities Grant and Social Care Capital Grant
- Care Act Implementation
- Payment for Performance

The first four schemes are primarily about key whole systems transformation – building on what has already been described and scaling up the level of integration between health and social care.

The difference we expect the BCF to make is described within each of the schemes, along with what will change as a result of their implementation. For example:

- Integrated single frailty pathway that identifies individuals with complex needs at an earlier stage, ensures they access the right part of the pathway via a single point of access, and then ensures that the care and support they receive is co-ordinated across the system; and
- An integrated locality service that offers a flexible range of multi-agency solutions at a locality level tailored to the needs of that particular area – including community and non-service based solutions to emphasis the 'right place, right time, right solution' principle.

The Council and CCG have established as part of their Health and Social Care Transformation Programme a Whole System Redesign Project Group. The Group, guided by data and intelligence, and also patient and service user experience, is reviewing what requires redesign – with the focus on reducing hospital and residential home admissions for adults aged 65 and over. The Group will be responsible for shaping and ensuring delivery of the schemes attached as part of this document ensuring that they deliver the expected benefits.

The Group is working in accordance with the set of principles jointly agreed by Thurrock Council and Thurrock CCG – see above. In addition to the recommendations contained within the over 75s analysis and the principles outlined above, our approach will incorporate the Kings Fund recommendations for reducing avoidable admissions which includes:

- Healthy, active ageing and supporting independence;
- Living well with simple or stable long-term conditions;
- Living well with complex co-morbidities, dementia and frailty;
- Rapid support close to home in times of crisis;
- Good acute hospital care when needed;
- Good discharge planning and post-discharge support;
- Good rehabilitation and re-ablement after acute illness or injury;
- High quality nursing and residential care for those who need it;
- Choice, control and support towards end of life; and
- Integration to provide person-centred co-ordinated care.

Service User and Public Engagement
Following on from the consultation events in December 2013 and April 2014, as part of our approach to redesign, we have established an Engagement Group which has been meeting for a number of months. The Group includes representatives from Thurrock's Voluntary and Community Sector including Thurrock Healthwatch, the local user-led coalition, Council for Voluntary Services, Commissioning Reference Group – i.e. those with the greatest reach to users of services (refer to section 8 for more detail).

The Engagement Group has developed an Engagement Plan, and also identified how users of services and their carers should be engaged and involved with the commissioning and service development process. The Plan was agreed by the Health and Wellbeing Board on 17 July 2014.

Members of the Group are already playing an active part by reviewing how existing services are engaging and whether this is sufficient, and recommending changes. The Group has also

developed an approach to involvement and engagement in commissioning which was agreed by the Health and Wellbeing Board and ensures that patients, service users and carers are appropriately involved in service development, commissioning, re-commissioning, and de-commissioning.

The Group will play an active role in identifying those groups and individuals who should be invited to be part of engagement activity – for example through the development of the schemes that are part of this BCF Plan.

Key members of the voluntary and community sector are also represented on the Whole System Redesign Group and are therefore ensuring that any service review or system redesign incorporates the experience and views of users of those services, their carers, the voluntary sector and the wider public.

Starting Position
Thurrock has already started on its journey towards reducing admissions through its overarching strategy to ensure that people age well. Thurrock's ageing well strategy ensures a focus on solutions and not services – recognising that a service response is not the only response. Our ageing well strategy is known as Building Positive Futures and has a number of strands:

- Create the homes and neighbourhoods the support independence;
- Create the communities that support health and wellbeing; and
- Creating the social care and health infrastructure to manage demand.

Building Positive Futures has already had a number of successes that reflect Thurrock's vision for the future of health and social care, and establishes a new relationship between citizens and the public sector. These include:

- Development of 'strength-based' approaches such as the introduction of Local Area Coordination – with full coverage across the Borough after a successful pilot, LACs work with individuals who are at risk of crisis to prevent them from increased service intervention or reaching a crisis situation – e.g. unplanned admission to hospital (includes signposting by GPs). We have also introduced Asset Based Community Development, which is ensuring that rather than focusing on what someone cannot do and in essence further disabling them, we focus on what someone can do – their strengths;
- Community Hubs – a community based and community run initiative which allows individuals to receive the information, advice, and support they need and ensures people living in Thurrock's communities remain connected. Building community resilience and reducing service reliance is the underlying aim of this and our other community-based initiatives;
- Housing as a key partner – we have and are continuing to work with housing colleagues to provide and develop suitable accommodation to support older adults as they age. Early successes include a 'HAPPI' standard (Housing our Ageing Population Panel for Innovation) specialised housing scheme in Derry Avenue, South Ockendon, where 25 flats for older people are being developed. We have also just received approval for Government funding for another HAPPI scheme in Tilbury;
- Development of a 'Thurrock Well Homes' index and mapping tool – so that Lower Super Output Areas with the most housing-related need are identified.

The success of Building Positive Futures is inextricably linked to our ability to reduce service demand through improving health and wellbeing, and building resilience communities and individuals. Building Positive Futures is a key element of Thurrock's Health and Social Care Transformation Programme. The Better Care Fund will help to continue the shift towards prevention and early and timely intervention.

Integration
The Council and NHS already work closely in a number of areas linked to reducing admissions

for the over 65s. This includes the Rapid Response and Assessment Service – an integrated service between adult social care and the NHS community health provider aimed at identifying individuals who are at risk of hospital admission and preventing that admission. The service relies heavily on GPs recognising those at risk and linking in to the service. The Council also has an integrated Joint Re-ablement Team with the NHS community service provider aimed at preventing readmission to hospital through proactive re-ablement. This work will be progressed further as part of the BCF.

The future – 2018/19
Our future, delivered through the BCF and related programmes (Building Positive Futures, Care Act implementation, Primary Care Strategy etc.) will reflect the following:

Healthy, active ageing and supporting independence

- Further development of 'well homes' initiatives that builds on the work with Housing partners – recognising that over half those aged 75 years and over own their own property but that a number of those people will be both cash poor and equity poor – this also links to identifying and reducing hazards such as falls which relate to unplanned admissions;
- Further development and implementation of housing schemes that support older people as their frailty increases – e.g. Housing Ageing Population Panel for Innovation (HAPPI) standard homes;
- Community-run hubs that provide information and advice, and allow individuals to get the support they need to remain independent;
- Development of health improvement initiatives for older people – particularly recognising the impact of loneliness;
- Focus on maintaining the health and wellbeing of carers – e.g. via an increased number of carers assessments, provision and availability of respite care, support within the community etc.

It is envisaged that a number of these initiatives will not be 'services' in the traditional sense of the word, but community-run initiatives with support from public services.

Living well with simple or stable long-term conditions

- Improving self-management of long-term conditions to prevent further ill-health – e.g. through Whole System Redesign;
- Multi-disciplinary teams focused on the person – rather than the condition – via GP hubs, and including social care;
- Proactive case management of at-risk patients;
- Increase 'expert patient' initiatives;
- Increased use of assistive technology and telecare to maintain independence.

Living well with complex co-morbidities, dementia and frailty

- Reflects that those aged 75 years and over experience considerable co-morbidities, and consequently increased rates of emergency and A&E urgent admissions;
- Increased use of assistive technology and telecare to maintain independence;
- Multi-disciplinary teams focused on the person – rather than the condition – via GP hubs, and including social care;
- Over 75 GP lead;
- Further development of multi-disciplinary Rapid Response and Re-ablement Service and of the Joint Re-ablement Team – including development of a Timely Intervention Service;
- Robust multi-agency falls strategy in place;
- Development of 'hospital at home' type initiatives;
- Implementation of Thurrock's Dementia-Friendly Communities initiatives – helping to support and maintain those with dementia in their own communities;
- Provision of support for carers – e.g. via carers' assessment and promotion of carer health and wellbeing.

Rapid support close to home in times of crisis

- Further development of our integrated Rapid Response and Assessment Service (RRAS) as part of our developing Frailty Model

Good rehabilitation and re-ablement after acute illness or injury

- Significant numbers of those aged 75 and over are unable to complete one domestic task or self-care activity on their own, and lack of capacity in post-acute rehabilitation is considered to be a key factor behind the high numbers of older people who go straight from hospital stay into long-term care;
- Greater number of housing schemes that support older people as their frailty increases – including extra care housing;
- Through the Disabled Facilities Grant being part of the BCF, review the role of Housing in ensuring homes of those people coming out of hospital enable rather than disable people;
- Development of existing Joint Re-ablement Team, and also increased capacity in step down beds – e.g. Collins House Residential Home;
- Good multi-disciplinary coordination for people being discharged from hospital – building on the role of the successful Hospital Social Work Team;

High quality nursing and residential care for those who need it

- Continued work with private, voluntary and independent sector so that the health and social care workforce are empowered to deliver better care – resulting in fewer emergency admissions;
- Private, voluntary and independent Sector workforce development agreement implemented – contains a number of pledges aimed at ensuring the conditions are in place to promote a high quality workforce;
- Robust quality assurance and monitoring arrangements that ensure high standards are maintained, and that issues are picked up and resolved early;
- Robust relationship between GPs and nursing/residential homes – including medication reviews, continuity of care, proactive end of life planning

Choice, control and support towards the end of life

- Currently, significantly high proportions of older people die in hospital – which may not have been that person's desired place of death;
- Multi-agency approach to supporting those with a terminal illness to die in their place of choice – e.g. implementation of NICE quality standard and also RCGP guidance for commissioning end of life care

The Council and CCG's Whole System Redesign Project Group will be responsible for the review of existing and the development of new schemes and initiatives as part of the BCF to deliver what has been described above. Due to the embryonic nature of this work, what has been described within this section is likely to be further refined as thinking progresses. The overriding objective will be to ensure that any change improves the experience of the individual, and that the individual is at the centre of all planning at all times.

Our short-term ambition and related milestones are described in following sections of this template and the schemes themselves.

Alignment

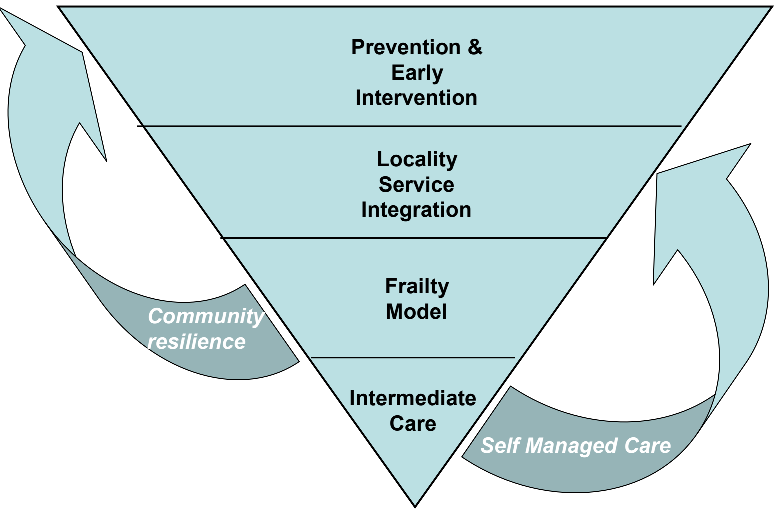
For ease of reference, the following table reflects the alignment of the objectives for the future (as expressed by the Kings Fund and localised throughout our document) with the relevant scheme(s).

Objective	**Dominant Scheme**
Healthy, active ageing and supporting	Scheme 4

independence	
Living well with simple or stable long-term conditions	Scheme 1
Living well with complex co-morbidities, dementia and frailty	Scheme 2
Rapid support close to home in times of crisis	Scheme 2
Good rehabilitation and re-ablement after acute illness or injury	Scheme 3
High quality nursing and residential care for those who need it	Quality of care and support is an underlying principle relating to most schemes
Choice, control and support towards the end of life	Scheme 2

Better Care in Thurrock

Right time, right place, right solution



b) What difference will this make to patient and service user outcomes?

- Users of services will have an improved experience through multi-disciplinary teams and services that operate around the whole person;
- Individuals will be able to achieve the outcomes they want through personal health budgets and personal care budgets;
- Risk-based approaches to target those most at risk will enable individuals to remain out of hospital and residential care;
- Fewer people will require a service as they will be able to self-serve and gain access to the information and advice and support they need from the community they live in;
- Proactive approaches to 'ageing well' will enable people to remain healthy, independent and in control for longer;
- Clusters of GP practices aligned with community health, mental health, and social care services will ensure whole person approaches;
- Long-term conditions will be identified at the earliest opportunity with individuals supported to self-manage those conditions – including through technological solutions in

the home;

- Multi-agency/disciplinary teams linked to hospital discharge will ensure that individuals receive co-ordinated care when they leave hospital and reduce readmission rates;
- Close work with partners beyond health and social care – e.g. community, voluntary sector, housing, leisure and transport – will ensure a holistic approach to preventing, reducing and delaying an individual's need for care;
- The market will be sufficiently developed to enable individuals to have choice and control;
- Carers will feel supported and sustained in their caring role.

We have established an Engagement Group as part of our Health and Social Care Transformation Programme, and already work closely with the user-led Thurrock Coalition. We will work with these groups to ensure that we can effectively performance manage the impact of the changes we make on the patient, service-user, and carer experience.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

As explained in a), we are implementing Whole System Redesign to ensure interventions and approaches move 'up stream'. This means the reconfiguration of resource to sit with prevention and early intervention offers. Achieving a reduction in admissions means supporting individuals to age well. Reconfiguring the system to ensure individuals can age well, means more than the reconfiguration of services – it means a completely different offer, and a completely different relationship between the community, individual, and the state. This is described in detail in section 2a).

In summary, this will mean:

- Greater support available within the community via the community hubs offer – particularly in terms of information and advice;
- Further development and embedding of Local Area Coordination;
- Risk stratification enabling effective targeting through multi-disciplinary teams based around the four clusters of GP practices – particularly long-term conditions as identified in the July 2014 Health Needs Assessment for the over 75 year old Thurrock Population;
- Development of an early and timely intervention offer – building on the success of the Rapid Response and Assessment Service and Joint Re-ablement Team;
- Integrated commissioning approach across health, public health and social care;
- Further development of the 'well homes' housing initiative – targeting vulnerable people living in conditions that are detrimental to health and wellbeing;
- Build on Primary Care Multi-Disciplinary Teams to ensure pro-active case management.

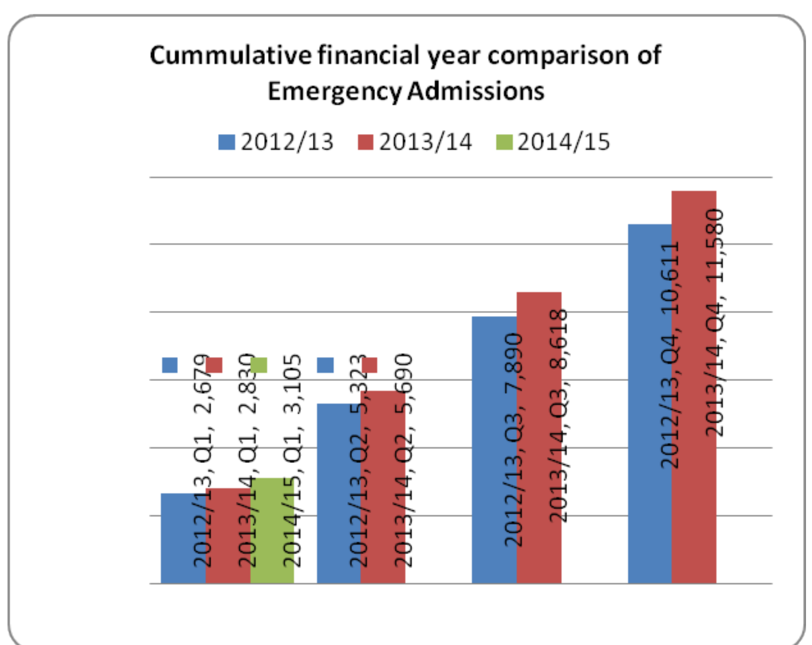
Our short-term ambition is as follows:

- By April 2015 we will have developed our local risk stratification tool for those aged 65 and over most at risk of hospital or care home admission;
- During 2015-16 we will establish a network of health and social care hubs that will integrate GPs, social care and community services as part of our new early intervention and prevention services;
- April 2016 – we will have established a single commissioning team across the Council and the CCG; and
- April 2017 – we will have established a single pooled budget across health and social care for all services for people aged 65 and over.

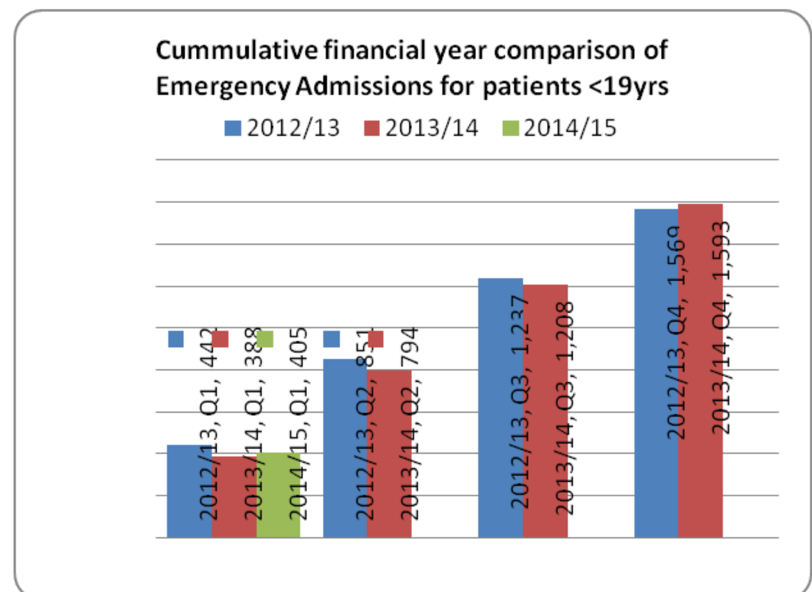
3) CASE FOR CHANGE

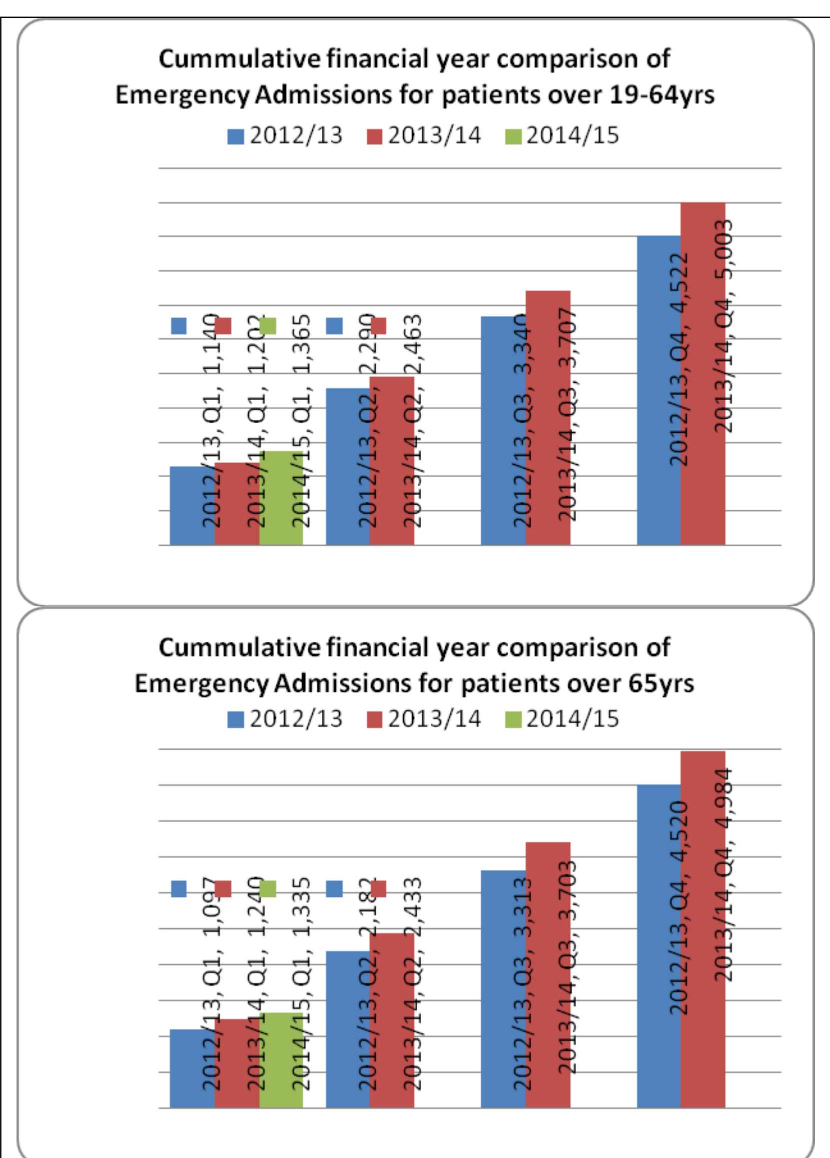
Why have we focused on people age 65 and over?

Thurrock CCG had 11,580 emergency admissions in 2013/14. As demonstrated in the graph below this represented a 9.1% growth on the previous year. Furthermore, activity in the first quarter of 2014/15 indicated a 9.7% growth on 13/14.

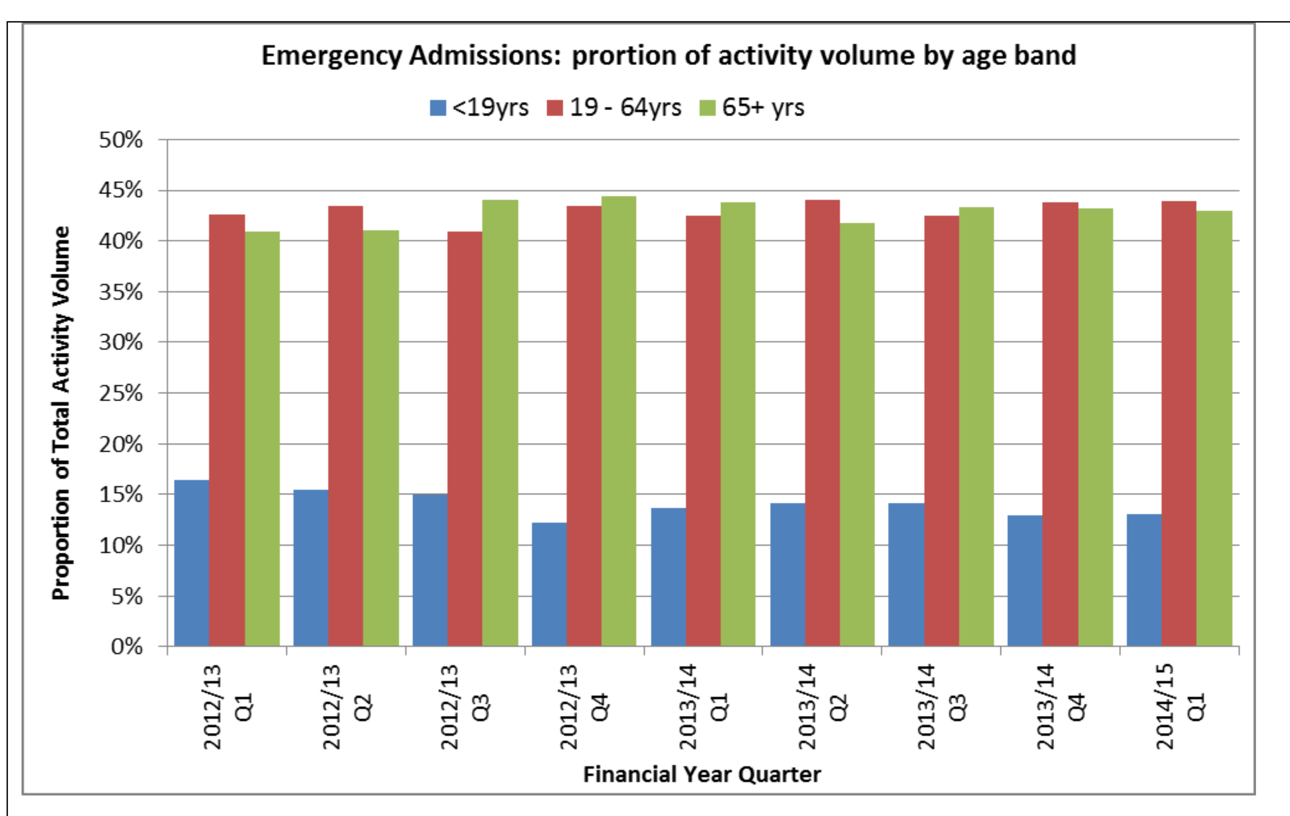


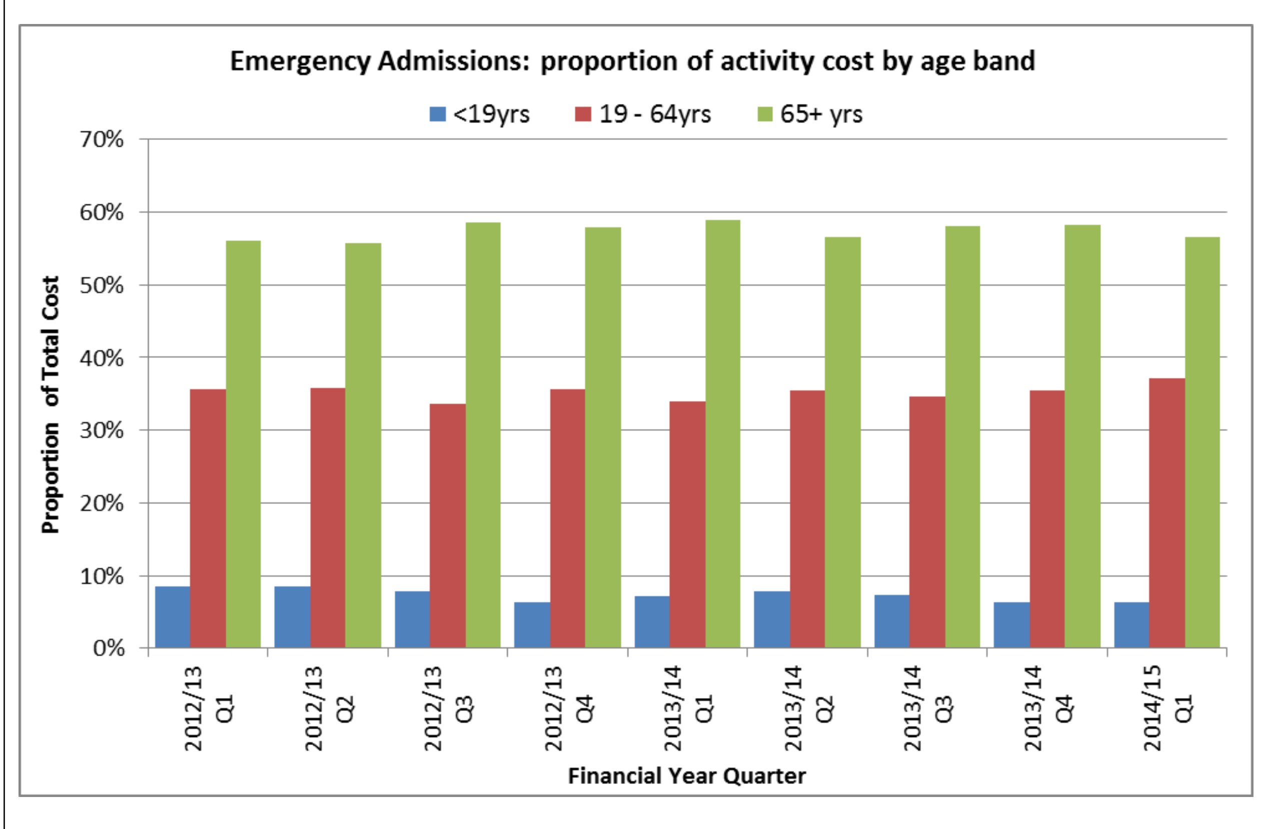
This level of growth presents a substantial challenge to both the CCG and Council. In order to meet the requirements of the BCF, our ability to use a risk based approach to identify the opportunities for avoiding admissions is paramount. In order to identify the opportunity, we have stratified total activity by an age profile of 0-19, 19-65 and 65+. The graphs below summarise activity by this age range profile;





Based purely on total activity, the two age ranges with the greatest opportunity are 19-65 and 65+. Based on activity cost, the age range of greatest opportunity that far outweighs the other two age ranges is the 65+ cohort. In order to identify the focus of the BCF, further analysis was undertaken at Specialty level. The following table indicates the top 15 specialties for Emergency Admissions in the 19-65 age range;


Emergency Admissions: prortion of activity volume by age band
<19yrs
19 - 64yrs
65+ yrs
Proportion of Total Activity Volume
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
2012/13 Q1
2012/13 Q2
2012/13 Q3
2012/13 Q4
2013/14 Q1
2013/14 Q2
2013/14 Q3
2013/14 Q4
2014/15 Q1
Financial Year Quarter


Emergency Admissions: proportion of activity cost by age band
<19yrs
19 - 64yrs
65+ yrs
Proportion of Total Cost
70%
60%
50%
40%
30%
20%
10%
0%
2012/13 Q1
2012/13 Q2
2012/13 Q3
2012/13 Q4
2013/14 Q1
2013/14 Q2
2013/14 Q3
2013/14 Q4
2014/15 Q1
Financial Year Quarter

HRG Sub Chapter	2013/14				
	Q1	Q2	Q3	Q4	Total
Digestive System Procedures and Disorders	216	204	223	208	851
Thoracic Procedures and Disorders	98	89	95	100	382
Cardiac Disorders	71	79	96	86	332
Nervous System Procedures and Disorders	69	80	77	94	320
Immunology infectious diseases poisoning shock special examinations screening and othe	69	65	64	68	266
Urological and Male Reproductive System Procedures and Disorders	36	35	50	48	169
Orthopaedic Trauma Procedures	39	51	32	31	153
Renal Procedures and Disorders	26	45	39	40	150
Hepatobiliary and Pancreatic System Disorders	34	38	41	30	143
Cardiac Procedures	31	24	32	31	118
Female Reproductive System Procedures	25	44	16	29	114
Female Reproductive System Disorders	35	30	21	26	112
Obstetric Medicine	19	27	33	31	110
Skin Disorders	25	27	25	32	109
Mouth Head Neck and Ears Procedures and Disorders	15	17	16	22	70

As demonstrated by the highlighted specialities, a significant volume of admissions in this age range are either surgical admissions, gynaecological/obstetric or specialities where the opportunity to avoid admissions is limited.

This compares to the following specialty level overview for the over 65 age range;

HRG Sub Chapter	2013/14				
	Q1	Q2	Q3	Q4	Total
Thoracic Procedures and Disorders	220	177	239	252	888
Cardiac Disorders	160	140	155	165	620
Digestive System Procedures and Disorders	153	151	168	140	612
Renal Procedures and Disorders	80	84	84	109	357
Nervous System Procedures and Disorders	76	85	97	92	350
Immunology infectious diseases poisoning shock special examinations screening and othe	55	67	68	72	262
Orthopaedic Trauma Procedures	70	54	64	58	246
Urological and Male Reproductive System Procedures and Disorders	35	43	34	56	168
Cardiac Procedures	40	39	49	31	159
Skin Disorders	29	25	31	41	126
Musculoskeletal Disorders	22	21	20	25	88
Haematological Procedures and Disorders	26	21	14	24	85
Mouth Head Neck and Ears Procedures and Disorders	24	20	20	20	84
Hepatobiliary and Pancreatic System Disorders	21	19	23	19	82
Orthopaedic Non-Trauma Procedures	13	15	21	10	59

This demonstrates significantly greater admission avoidance potential.

A further rationale for focusing of the over 65 population is the rate of non elective admissions per ‘000 population. The table below provides an overview of these comparative rates by age band;

Age Band	Population	Number of Admissions	Admissions per ‘000 population
0-19	40,355	1,593	39.47

19-65	98,597	5,003	50.74
65+	18,753	4,984	265.77

The comparative rate of admissions for the 65 and over group is five times that of the 19-65 age group.

Therefore, on the basis of the type of admissions and rate of admissions, the BCF is focusing on the 65+ population as this is where we feel we have the greatest opportunity to influence overall non elective admission rates.

Needs Assessment of the target population

Following the decision to focus on the over 65 age range, a provisional needs assessment has been undertaken to identify underlying trends and stratify some of the opportunity for improving outcomes. The following is an extract of that information.

Figure 1 - breakdown of emergency admission rates by age group for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

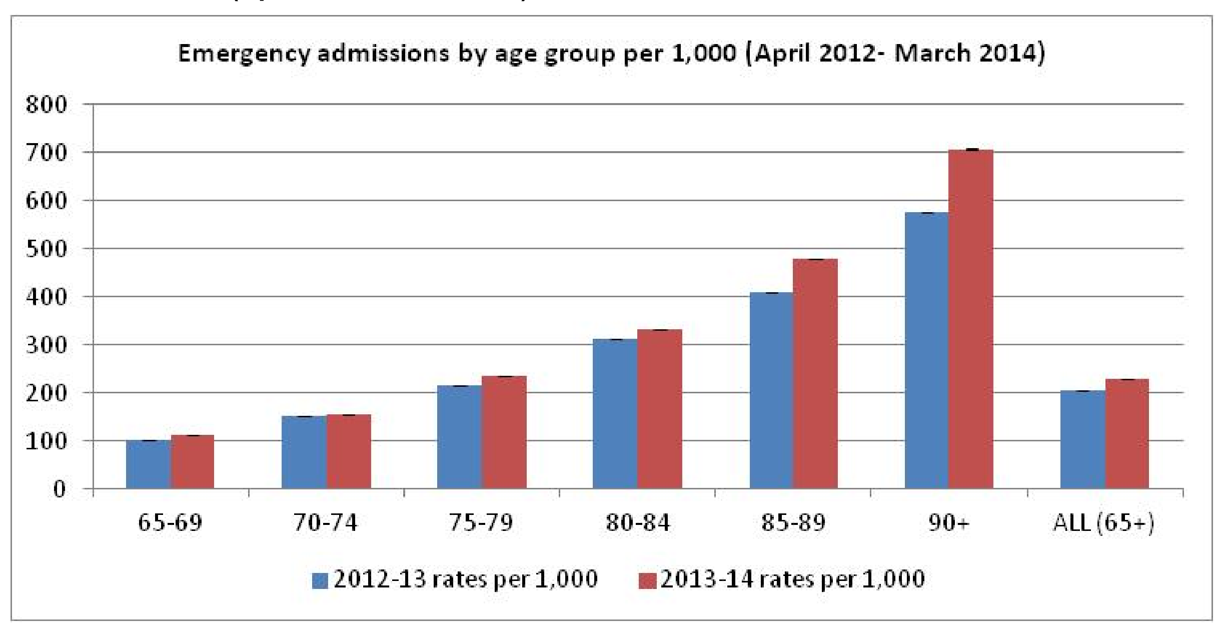


Table 1 - Top 10 HRG codes for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

HRG code	Total
Lobar, Atypical or Viral Pneumonia with Major CC	560
Non-Interventional Acquired Cardiac Conditions	395
Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC	369
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC	190
Arrhythmia or Conduction Disorders without CC	161
Heart Failure or Shock with CC	157
Unspecified Acute Lower Respiratory Infection with Major CC	146
Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	140
Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	130
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with CC	130

Table 2 - Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	Essential (primary) hypertension	348
Lobar pneumonia, unspecified	398	Chronic obstructive pulmonary disease with acute lower respiratory infection	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	Acute renal failure, unspecified	287
Unspecified acute lower respiratory infection	229	Atrial fibrillation and flutter	279
Pneumonia, unspecified	212	Urinary tract infection, site not specified	230
Congestive heart failure	207	Respiratory failure, unspecified	164
Atrial fibrillation and flutter	181	Volume depletion	146
Fracture of neck of femur: closed	178	Chronic ischaemic heart disease, unspecified	145
Tendency to fall, not elsewhere classified	173	NOT CODED	138
Acute renal failure, unspecified	164	Pleural effusion, not elsewhere classified	135

2011/12 analysis indicated 53% of >75s emergency admissions could be attributed to 35 presenting conditions which are generally amenable to community-based interventions.

The most common health problems (predicted) for those aged 75 years and over are summarised below:

- 69% with moderate or severe hearing impairment
- 60% limiting long-term illness
- 32% predicted to have a fall – and 4% admitted to hospital as a result of a fall
- 28% are unable to manage at least one mobility activity on their own
- 22% are obese or morbidly obese
- 20% have a bladder problem at least once a week

The top 6 chapter codes for emergency admissions for those aged 75 years and over are:

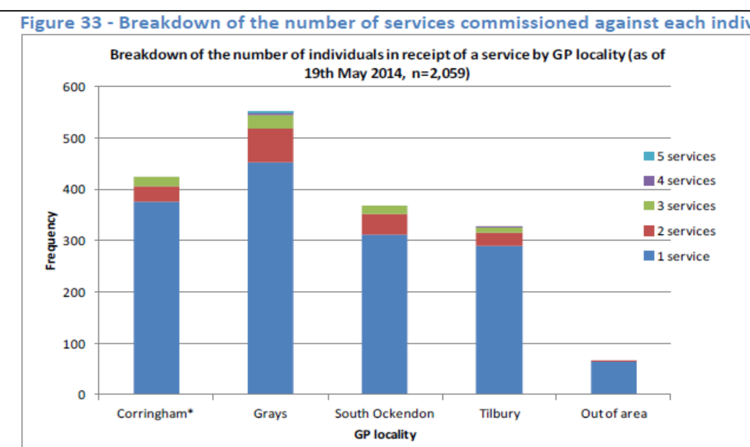
- 18% diseases of the respiratory system
- 17% diseases of the circulatory system
- 13% symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- 12% injury, poisoning and certain other consequences of external causes
- 10% diseases of the genitourinary system
- 10% diseases of the digestive system.

Social Care Demand & Spend

Thurrock Council spends £42 million annually on adult social care services. The area of highest spend is residential care – 50% of total spend in 2012/13. Of this, the greatest proportion of expenditure was on people aged 65+ - 55% of spend (an increase of some 3% since 2011).

The proportion of people using services and receiving residential or nursing care rises with age. People aged 85+ often receiving the most expensive and complex care.

Figure 33 - Breakdown of the number of services commissioned against each individual by ward (as of 19th May 2014, n=2,059)



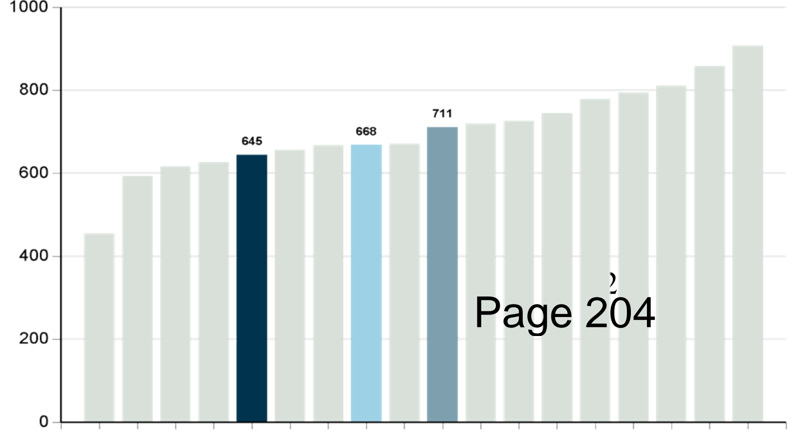
Source: Thurrock council adult social care.

In line with our existing commissioning intentions and strategies to enable people requiring care and support to access alternative arrangements to permanent residential or nursing care and to maintain independence at home, the number of people in residential or nursing care shows a trend of reduction over three years as does the rate of admissions into permanent placements. The reduction reflects the impact that existing initiatives are having on admissions to residential or nursing care – something we wish to build on through the schemes contained within this Plan.

This can in part be attributed to the impact of developing alternative supported living arrangements. However, some of this reduction can be attributed to more robust application of CHC and categorisation of clients who become full-cost payers.

As at the end of 2013/14 there were 335 people aged 65+ in residential or nursing care placements. 62% of these were aged 85+. In 2013/14 there were 645 older people (65+) admissions to permanent residential care or nursing care per 100,000 This compares to a national average of 668 and comparator group average of 711.

Series	Year	Residential Care	Nursing Care	Total Of Residential Care and Nursing Care
Council	2011-12	519	40	558
	2012-13	797	62	858
	2013-14	607	38	645
Comparator Average	2011-12	508	183	690
	2012-13	524	181	705
	2013-14	536	175	711
England	2011-12	468	228	696
	2012-13	467	230	697
	2013-14	451	218	668



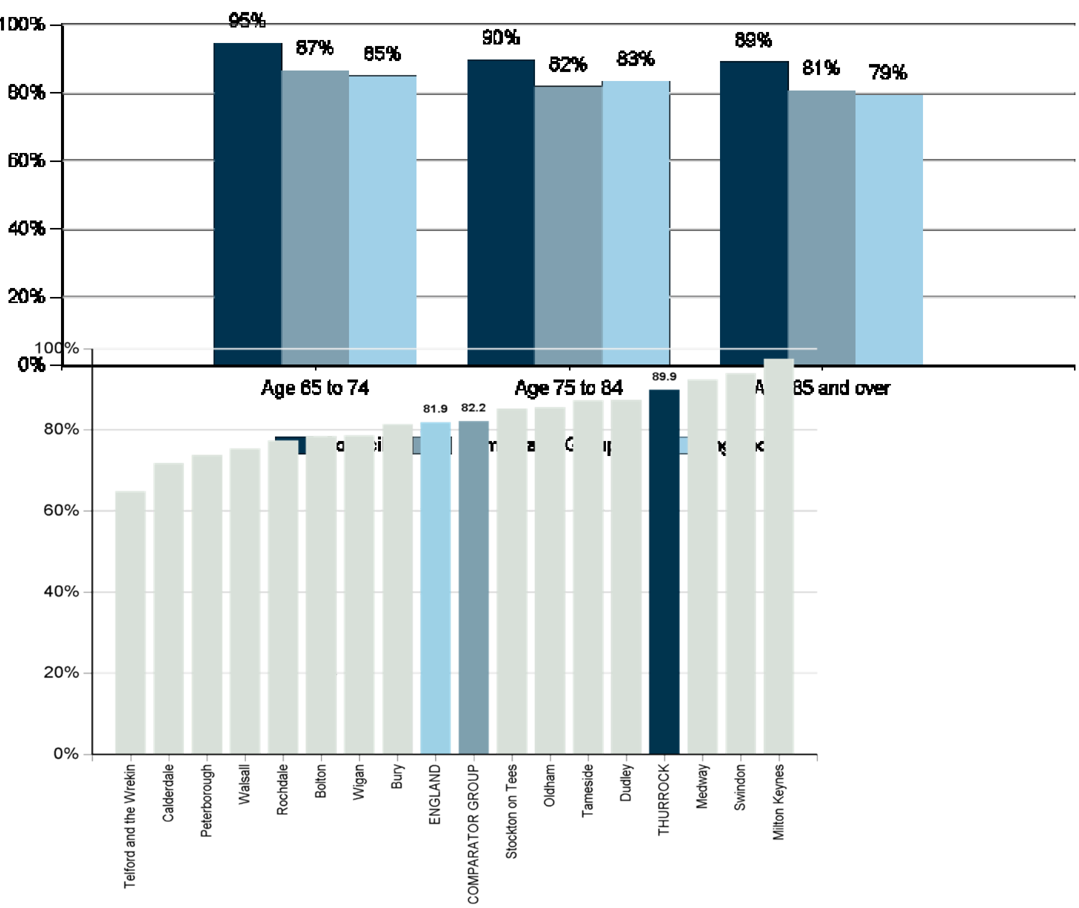
However, without continued and further focus to minimise admissions the demographic pressures projected in coming years, together with increased complexity of people's conditions will see projected rise in numbers – see below.

	Actual	Projected				
	Sep-13	**Apr-14**	**Apr-15**	**Apr-16**	**Apr-17**	**Apr-18**
Standard Placements	286	299	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	381	402	414	425	434	443

Supporting people to achieve and maintain independence at home through effective discharge from hospital and inappropriate care home admissions into re-ablement and rehabilitation services is a priority for Thurrock. Overall, Thurrock performs comparatively well on this key measure. 89% of people discharged into these services were still at home 91 days after. Performance also appears consistent across the key age groups for people aged 65+, with less variation than that nationally and among our comparator councils.

This can be attributed to continued focus on effective and timely hospital discharge planning to avoid delays and a jointly provided re-ablement service.

While performance appears strong, continued improvements are needed to ensure that this remains effective and also that independence is maintained and sustained over time, with subsequent reduced pressures or potential for admission to hospital or residential care.



Integration to improve outcomes

The rationale behind developing our pooled fund has been to identify those commitments that currently support older people's services and that would potentially benefit from integration. As a result, and to ensure that the BCF in Thurrock is large enough to support significant redesign, our BCF is considerably greater than the minimum amount.

The work that is and will continue to be carried out by our Whole System Redesign Project Group includes reviewing existing evidence of what works and therefore what will deliver better outcomes for users of services – including reducing the probability of admissions for those most at risk.

Part of the work being carried out includes a review of existing services and schemes – starting with those funded by section 256 monies and included within our BCF – e.g. our integrated Rapid Response and Assessment Service aimed at admission avoidance, and our Joint Re-ablement Team. Throughout the year, this will be expanded to include all services funded by BCF monies with a view to redesign based upon evidence of what improves outcomes for users and potential users of services.

Our 'Health Needs Assessment for the over 75 year old Thurrock population' published in June 2014 made a number of recommendations that are contained within our Vision. These recommendations will support our plans for 15/16 as taken forwards by the Whole System Redesign Project Group. The recommendations are made as a result of and in response to

existing evidence of what works. The Health Needs Assessment also suggests that a more detailed review of evidence 'to determine which interventions may have greatest impact in the longer term for those aged 65-74 years and under 65 years' is required.

Service Quality and Efficiency
Our Health and Wellbeing Strategy has a focus on improving the quality of health and social care. This focuses on the quality of primary care. Issues in Thurrock, particularly in relation to GP practices, concern the number of GPs at or over retirement age, the number of single handed or small practices, and difficulties with recruitment and retention of GPs to the area.

The BCF responds to this through the development of schemes such as the Locality Service Integration. This scheme and others build on commissioning and provision of services and solutions through four GP cluster areas. Social Care Fieldwork Teams and Community Service Teams have restructured to ensure alignment.

This allows capacity to be maximised and also allows the development of solutions tailored to an area need as opposed to a Borough-wide solution. Plans also enable the involvement and further development of community solutions such as the Local Area Coordination initiative (scheme 4) and also Community Hubs. The four areas are already meeting to identify needs associated with that particular area. This will enhance quality and how we target capacity effectively and efficiently.

Integrated Commissioning

We have agreed as part of our BCF to have an aligned commissioning team across health and social care in place from April 2016. This will support our ambition to deliver an integrated commissioning approach.

Currently, the CCG has a commissioning team, and the Council's Adult Social Care has a commissioning team. Steps will be taken to move towards a fully aligned commissioning team by April 2016. This will mean:

- Establishment of joint posts – moving from one joint commissioning officer in 2014/15, to three joint posts by April 2015, to a fully aligned team by April 2016;
- The development of an integrated commissioning strategy and integrated commissioning intentions;
- The development and delivery of jointly commissioned services and solutions based upon the development of integrated solutions (as defined within the BCF schemes and the Whole System Redesign programme); and
- The establishment of joint contract and performance monitoring from April 2015.

PLAN OF ACTION

Schemes for 15/16

Scheme Ref	Scheme Name	Amount £000s
1	Locality Service Integration	4,551
2	Frailty Model	4,379
3	Intermediate Care Review	5,035
4	Prevention and Early Intervention	1,965
5	Disabled Facilities Grant and Social Care Capital Grant	845
6	Care Act Implementation	522
7	Payment for Performance	722
		18,019

Evidence review and initiative impact analysis

We have very deliberately identified the services that contribute to our BCF dependent upon their opportunity for redesign and impact on reducing emergency admissions and admissions to a care home.

We believe that the schemes we have identified will drive the transformation of health and care towards improving outcomes for users of services and their carers.

We have detailed evidence as to why we feel the chosen schemes will have the desired impact. This is contained within the schemes themselves.

Further work is being carried out as part of our Health and Social Care Transformation Programme to review the effectiveness of existing schemes and services.

Risk Segmentation and Next Steps

As a critical part of our plan of action, we have agreed to undertake clinical analysis of patient records with the aim of identifying a) inappropriate admissions and how they can be avoided; and b) where unplanned admissions have occurred, what could have been done to reduce the probability of that admission from taking place. Our case review will focus on an area of our Borough with a high admission rate. The results of this review will allow us to identify a cohort most at risk and enable us to refine our approach to reducing the probability of admission. Although we will pilot our approach in one area of the Borough, we will then look to refine and roll out to all areas based upon an evaluation of the exercise. We aim to have finalised our pilot prior to April 2015. The results will inform our approach to service redesign and integration.

Whilst we have been able to undertake a very high level risk stratification based on existing data analysis, current information governance challenges have prevented us from developing any level of sophistication with regards to risk segmentation or stratification at a patient level. A key milestone for us and this plan will be to agree our approach to pseudonymised data in lieu of having the legal framework to use patient-identifiable data.

Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The joint CCG and Council Transformation Project Groups, assisted by a dedicated programme management resource, has scoped out and commissioned work packages to ensure the Council and CCG are able to address the requirements of the following *inter-dependent* work streams:

- Efficiency – identifying initiatives that in the short term offer cashable efficiencies to contribute towards the Council's £37m savings target, and ensuring opportunities for joint working and reducing duplication are maximised;
- The Care Act (2014) – preparation and implementation arrangements for the new duties;
- Better Care Fund Section 75 Agreement - preparation of the Better Care Fund Plan and implementation of all the arrangements for the Council to host the pooled fund from 2015 including, where necessary, contract novation;
- Whole systems Re-design as part of the Building Positive Futures programme – to determine the most effective models of care to reduce unplanned admissions and deliver co-ordinated care in conjunction with the citizens of Thurrock, and in consultation with patients, service users, carers, providers and other stakeholders.

In addition the Transformation Programme Board will work closely together:

- to engage with NHS England in the development of the Primary Care Strategy – to determine in particular, how the Essex Strategy can bring improvements to GP services across Thurrock;
- to address relevant aspects of the CCG's QIPP Programme where they affect both health and adult social care.

The key milestones for delivering the Better Care Fund for 2015/16 are as follows:

Health and Well-Being Board agreed the draft Better Care Fund Plan, the delegated authority for sign off and the approach to the Section 75 agreement	11 September 2014
Submission of Better Care Fund Plan following sign of by the CCG, the Council and the Chair of HWB Board	19 September 2014
Agree Commissioning Intentions with NHS providers	by end September 2014
Amendments to plan following Assurance Reviews and Moderation	by 10 October 2014
6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16 schemes	End October 2014
Health and Well-Being Board agreement to Section 75 agreement including Annual Development Plan	to be confirmed
NHS Thurrock CCG Board approval of Section 75 agreement	to be confirmed
Cabinet of Thurrock Council approval of Section 75 agreement	to be confirmed
Waiver requests and contract awards	From January 2015
Purchase to pay arrangements	From January 2015
Contract and Performance management arrangements in place	From January 2015
Pooled Fund Manager to monitor financial and activity information each month, escalating any issues/off-target performance to the Clinical Executive Group	From April 2015
At least quarterly meetings of Partnership Board to: o provide strategic direction to schemes o receive finance and activity information o escalate any unresolved issues/off-target performance o agree variations to the agreement and plan as required o authorise the Pooled Fund Manager to approve expenditure	From April 2015
Payments of providers from the BCF pooled fund	From April 2015

Review the operation of the agreement and the performance of individual services	October 2015

In parallel with the development and implementation of the Better Care Fund Plan for 2015/16 the Whole Service Redesign Group in taking forward a range of initiatives aimed at older adults (aged 65 and over) and most at risk of admission to hospital or care homes. This builds on work undertaken in the Urgent Care Deep Dive undertaken with BB CCG in May 2014, and the Thurrock Health Needs Assessment completed in July 2014 for the 75 and over age group. As noted elsewhere, these reports highlight the importance of also focusing on the 65-54 year old cohort in order to manage conditions at an earlier stage and so prevent or delay the need for care.

The Milestones for the Whole Service Redesign Group are as follows:

6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16 Develop detailed descriptions of the schemes • Locality Service Integration • Frailty Model • Intermediate Care • Prevention and Early Intervention • Disabled facilities Grant and Social Care Capital Grant • Care Act Implementation • Payment for Performance	End October 2014
Clinical Analysis of patient records to determine the likely causes of emergency admissions of patients aged 65 and over in a sample area; semi structured interviews with a sample of the cohort to assess patient and service user experience	October/November 2014
Semi structured interviews with a sample of the cohort to assess patient and service user experience	December/January 2014
Subgroup of acute and community health and care providers with Clinical Leads to review findings and model improved clinical interventions as well as community solutions impacting the wider determinants of health and well-being	Jan - March 2015
6 month trial of new models or care and community solutions	April - September 2015
Agree Commissioning Intentions with NHS providers and social care providers	by end September 2015
Review after 6 month trial of new models of care and community solutions	October 2015
6 month review of performance of 2015/16 BCF schemes completed and commissioning plans developed for 2015/16	End October 2015
Health and Well-Being Board agreement to Section 75 agreement including Annual Development Plan for 2016/17	November 2015
NHS Thurrock CCG Board approval of Section 75 agreement	November 2015
Cabinet of Thurrock Council approval of Section 75 agreement	December 2015
Re-commissioning and decommissioning activity including procurement	From January 2016
Contract and Performance management arrangements in place	From January 2016
Implementation of commissioning changes in line with the BCF pooled fund Plan	From April 2016

Key delivery milestones related to the schemes (these cross reference with each scheme):

Scheme	Milestones

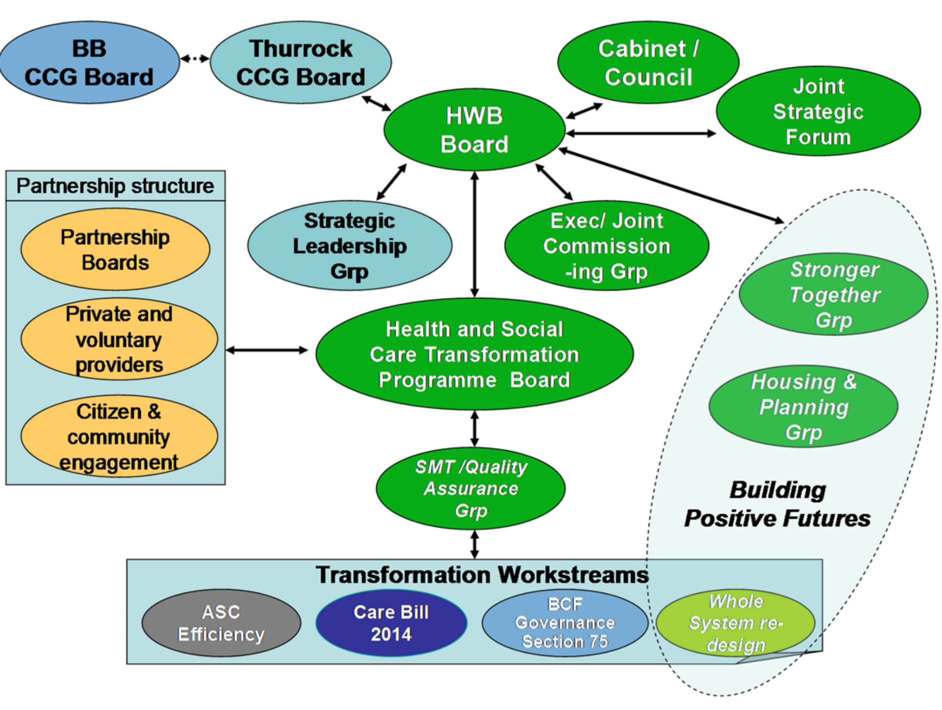
Scheme 1	• By June 2015 enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care • By March 2015 development of an integration governance arrangements and working groups • By September 2015 full integration of the team, care co-ordination model, and sharing of information to enable management of risks • By January 2016 cost benefit analysis of the first 6 months operation
Scheme 2	• By June 2015 enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care • By September 2015 developing a single care plan and care co-ordination • By September 2015 – further review and development of the RRAS based on evaluation • By January 2016 development of an assistive technology forward plan • By January 2016 development of an End of Life Strategy
Scheme 3	• By April 2015 a new rehabilitation and assessment pathway pilot • By June 2015 a contract review of bed based services • By January 2016 a review of rehabilitation/assessment pathway pilot including Step Up and Step Down facilities
Scheme 4	• By April 2015 a pathways review of access to equipment • By June 2015 an options appraisal for retail model and implementation • By June 2015 conduct Public Health-led review of emergency admissions • By September 2015 LAC and GP initiative to target frequent users of A&E, ambulance services as part of the public health review • By June 2015 review of falls prevention programme • By April 2015 recruitment of further 3 LACs • By July 2015 LAC 2 year evaluation
Scheme 5	• By March 2016 deployment of DFG and review how DFG is used to prevent, reduce and delay • By March 2015 development of plan for social care capital fund
Scheme 6	• By April 2015 invest in areas as identified through ready reckoner and internal Care Act Implementation Group to ensure compliance with Care Act
Scheme 7	• By April 2015 embed the performance management framework as part of Thurrock's BCF governance arrangements – through the Integrated Commissioning Executive

	• By December 2015 based on likely outturn of reduction in total admissions, review evidence and agree areas of investment

b) Please articulate the overarching governance arrangements for integrated care locally

A joint Council and CCG Transformation Programme Board has been established to oversee and sign off the development of all policy, commissioning and procurement, market engagement, efficiency, performance and governance documentation and processes related to the integration of adult social care and health, and, where relevant the changes to be introduced by the Care Act. Because of the cross cutting nature of these changes, there will also be oversight by the joint Transformation Board of progress against relevant aspects of the QIPP challenge, the Primary Care Strategy and the Council's efficiency programmes for social care.

The Governance arrangements for the Transformation Programme Board are set out in the Programme Initiation Document and the Board itself has agreed the Terms of Reference for each of the Sub-groups. The reporting lines are as follows:



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

As noted above, the Better Care Fund Section 75 Agreement Group is overseeing implementation of all the arrangements for the Council to host the pooled fund from 2015. From April 2015 the Group will be reconstituted as a Partnership Board with responsibility for oversight of the management of the BCF.

The arrangements which are currently being developed will be set out in detail in the governance section of the Section 75 Agreement and cover:

- The Membership of the Partnership Board
- Role and responsibilities
- Conduct of meetings

- Delegated authority
- Reporting arrangements
- Risk sharing arrangements
- Joint working obligations
- Performance arrangements
- Information Governance Protocol
- Dispute Resolution

The Partnership Board will be serviced by a dedicated team led by the Pooled Fund Manager which will provide financial and activity information at least quarterly.

The Partnership Board will meet on a quarterly basis (or more frequently if issues are escalated by the Pooled Fund Manager) to review performance against the Plan. The Board will have delegated authority from the Health and Well-Being Board to modify the plan, and the focus and funding for individual schemes, where both the Council and the CCG agree to do so.

The Partnership Board will report progress against the plan to the Health and Wellbeing Board.

Financial and performance reports will be made on a quarterly basis to the Cabinet of Thurrock Council and to the Thurrock NHS Clinical Commissioning Group Board.

Performance Management

As noted above the Pooled Fund Manager will monitor financial and activity information on a monthly basis, escalating any issues/off-target performance to the Clinical Executive Group as necessary. In addition, and at least quarterly, the Pooled Fund Manager will provide a full report to the Partnership Board to enable it to:

- provide strategic direction to schemes
- receive finance and activity information
- escalate any unresolved issues/off-target performance
- agree variations to the agreement and plan as required
- authorise the Pooled Fund Manager to approve expenditure

The key performance metrics which will be monitored by the Pooled Fund Manager are detailed within part 2 of the Plan.

d) List of planned BCF schemes
Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Scheme Ref	Scheme Name	Amount £000s
1	Locality Service Integration	4,551
2	Frailty Model	4,379
3	Intermediate Care Review	5,036
4	Prevention and Early Intervention	1,965
5	Disabled Facilities Grant and Social Care Capital Grant	845
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		18,019

5) RISKS AND CONTINGENCY

a) Risk log - Top 10 Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

The Risk Register for the Thurrock Better Care Fund provides an overview of the top 10 risks identified to date. It has been developed in conjunction with the Council's Corporate Risk Officer and the CCG's Head of Corporate Governance and agreed with key partners. The risks will be reviewed on a monthly basis by the relevant Project Group (S75 Governance; Whole System Redesign; Care Act; Engagement; Efficiency) with oversight provided by Thurrock's Health and Adult Social Care Transformation Programme Board on a bi-monthly basis.

.A number of the services within the BCF Plan are currently operational and risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the Health and Well-Being Board on the recommendation of the Integrated Commissioning Executive which is the partnership Board for the pooled fund. These plans will include robust programme plans for each project, including key milestones, impacts and risks.

To deliver the vision in Thurrock's BCF plan, under the direction of the Health and Well-Being Board, the Council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which will determine the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment will be undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks.

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
1	The failure to reduce demand for acute services places does not release funds for investment in community services/ results in failure to achieve performance target.	1. Initial impact of each BCF scheme has been assessed. 2. Metrics for monitoring performance of each service are being developed together with reporting arrangements.	3	3	9	1. Close liaison with acute providers on performance against QIPP Plans. 2. Co-ordinated action across the whole system to secure investment in out of hospital services and reduce demands on emergency admissions.		April 2015	Head of Integrated Commissioning Thurrock CCG
2	Changes to eligibility criteria, introduction of care accounts, assessment of self funders will all bring new challenges for IT, the workforce, finance and information and advice services, communications and housing.	Care Act Project Group meeting monthly to assess impact of guidance and to determine how risks should be managed.	3	3	9	1. A change programme with appropriate governance, resources (both people and financial) to implement the Care Act reforms and to monitor impacts on service quality and user satisfaction, and all with multiple interfaces with Better Care Fund initiatives.		April 2015	Director of Adults Heath and Commissioning
3	Difficulties in sharing of patient / service user level data may frustrate commissioning plans or performance and financial management.	1. Initial meeting with BB CCG Head of Information Governance to agree strategy. 2. Close links with Southend Pioneer maintained	3	3	9	1. An Information Governance strategy for commissioning and providing integrated care, using the NHS number and with the required technical solutions is required. However, there is a clear dependence on legislation and regulatory changes before this can be achieved.		On-going	Service Manager (Performance, Quality & Information)
4	The changes required for the configuration of practices my make it difficult to engage GPs in integrated care programmes.	1. Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve GPs in change, and to ensure a common understanding of risks, opportunities and incentives.	2	2	4	1. Close Liaison with NHS England Essex Area Team regarding cluster arrangements		On-going	Acting (Interim) Accountable Officer Thurrock

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Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
5	Uncertainty about the changing offer from ASC and Health may result in or late or low take up of community services, and a failure of the system to prevent crisis or intervene in a timely way.	1. Initial scoping of comms plan completed. 2. Dependency on DH/NHS England comms noted and detailed plans awaited	2	2	4	1. Strong campaigns to engage citizens and professionals across the system in the plans for integrated care, and reviews of the effectiveness of those campaigns. 2. A joint formal CCG, Council and Provider launch for Better Care Fund in Thurrock to initiate this campaign.		January 2015	Manager Corporate Communications
6	Implementation and operational costs for BCF and Care Act may exceed budget plans.	1. Integrated Commissioning Executive established to monitor performance of the pooled fund. 2. Financial analysis of the Care Act changes completed.	2	2	4	1. Financial contingency plan to estimate and alleviate cost pressures that may arise during implementation or benefits realisation.		April 2015	1. Pooled Fund Manager 2. Interim Customer Finance Team Manager
7	Change may take longer or may be more difficult to achieve if a provider faced significant operational difference in neighbouring CCG areas.	1. Links made to Essex BCF Technical Group regarding commissioning intentions and procurement plans	2	2	4	1. Liaison with B&B, CCG and ECC about the impact of our respective emerging commissioning plans to agree common principles, to identify variances and, where necessary, plan contingencies.		On-going	Directorate Strategy Officer, Adults Health and Commissioning
8	NHS provider may experience difficulties in delivering QIPP plan efficiencies or face unexpected costs in delivering integrated services.	1. Agreement for joint Council CCG monitoring of contract performance to be in place from April 2015. 2. Scorecard for monitoring performance against pooled fund targets being developed	2	2	4	Regular oversight of performance by Integrated Commissioning Executive		April 2015	Head of Integrated Commissioning Thurrock CCG/ Service Manager Contracts & Commissioning

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
9	Public engagement related to adopting healthier life styles, developing greater community resilience, and the importance of accessing service in the community take longer to gain traction.	1. Linkages between Stronger Together programme maintained. 2. Link to healthy lifestyles campaigns (linked to DH NHS England campaigns) scoped.	2	2	4	1. Campaign to promote community solutions to be planned		January 2015	Community Development and Equalities Manager

b) Contingency plan and risk sharing
Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The Council and the CCG, working with its providers BTUH, NELFT and SEPT, have agreed to assume strategic responsibility for the whole health and social care system economy. They will accept collective responsibility for overspends, working together, and with providers, to pre-empt or minimise their occurrence.

The Health and Well-being Board has specifically considered the risk of financial underperformance against the total emergency admissions target set locally. The Board has been involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. This includes the £722k payment for performance element linked to a reduction in emergency admissions. Following the decision to create an Integrated Commissioning Executive (ICE) reporting to the Health and Wellbeing Board – which has already been established – it can be demonstrated that the Board has close involvement with the management of the risk of financial underperformance. Section 75 performance reports for each BCF scheme will be provided to ICE and reported to the HWBB as of April 2015.

The Board has agreed that the risk of underperformance is to be managed by delaying expenditure commitments for a number of services until the target is achieved, and payment of the target sum can be released into the pooled fund by NHS Thurrock CCG. When the target is achieved It is anticipated that the payment for performance element of the fund will make a contribution to the protection of adult social care.

The issue of treatment of overspends has also been agreed and the Health and Well-being Board have proposed that the Better Care Fund for 2015/16 should be fixed at the agreed value of the Pooled Fund. The effect of this is that any expenditure over and above the value of the fund should fall to the Council or the CGG depending on whether the expenditure is incurred on the social care functions or health care related functions.

In terms of management arrangements, the Section 75 agreement will specify that, if during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Partnership Board within 21 days. The Partnership Board will then consider whether it needs to agree the action plan in order to reduce expenditure

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

For the ambition set out within this Plan to be advanced and delivered, there needs to be alignment with a range of existing plans and initiatives. These are summarised below:

Building Positive Futures

Building Positive Futures is Thurrock's programme to support older and vulnerable people to live well. The Programme reflects good health and wellbeing being dependent upon a number of factors including:

- The neighbourhoods we live in;
- The opportunities we have to connect with others;
- Safe and accessible paths and parks;
- Access to shops, health clinics and other facilities; and
- The opportunity to give as well as receive help – to feel needed and useful.

BCF recognises the value and impact that partners beyond health and social care have on creating communities that foster good health and wellbeing.

The Programme centres on three main themes under which sit a number of related initiatives:

- Better health and wellbeing: so people stay strong and independent
  - Dementia Friendly Communities
  - Integration of Health and Social Care (Whole System Redesign)
- Improved housing and neighbourhoods: to give people more – and better – choice over how and where they live as they grow older
  - Health and Wellbeing Housing and Planning Advisory Group
  - Flagship housing schemes for older people – based on design recommendations of the HAPPI
  - Sheltered Housing Review
  - Thurrock Well Homes - a scheme to improve the housing conditions and health and wellbeing of residents in private properties
- Stronger local networks: to create more hospitable, age-friendly communities
  - Local Area Coordination
  - Asset Based Community Development
  - Strength-based approaches to commissioning and social work practice

The BPF Programme is a key and fundamental part of our Health and Social Care Transformation Programme. The Programme's success will result in people growing older in better health, and older people being better supported and more resilient within the communities they live in. A key element of the Programme is that individuals are less likely to require formal 'services', but are able to find the support they need to remain healthy and independent from within their own communities. As such, the Programme is a vital part of this Plan's ambition to reduce the number of people aged 65 and over who are admitted to hospital or a residential care home.

Local Area Coordination

Whilst an initiative that has been developed as part of our BPF Programme, Local Area Coordination requires a mention in its own right.

Initiated by Adult Social Care, Local Area Coordination is a partnership programme with:

- Public Health;
- Housing;
- Essex County Fire and Rescue Service;

- North East London Foundation Trust;
- Thurrock Council for Voluntary Service;
- Healthwatch;
- South Essex Partnership Foundation Trust; and
- Thurrock Clinical Commissioning Group.

Starting with a strength-based question about 'what a good life looks like', coordinators help vulnerable people to find their own local solutions. Solutions pursued often do not lie with services – but in the community. Where a service is the right solution, the LACs are able to co-ordinate a response which invariably crosses service and organisational boundaries. This in itself is a great help for people who are vulnerable and do not have the knowledge, expertise or emotional resilience to navigate the complexities of service offers.

LAC was originally piloted in three learning sites. Due to the success of the pilots, the initiative has been expanded and is now Borough-wide.

We have just completed our 14 Month Evaluation which reflects some promising results to build on:
300 people have been introduced to the LACs
Of the people currently receiving support:
- 12% have learning disabilities,
- 27% have mental health issues,
- 31% are older people,
- 15% have physical disabilities,
- 4% have sensory impairments and
- 11% "other"

To date introductions are from a wide variety of sources including:
- The Council's initial contact service - Community Solutions
- Social workers and support planners across all services including mental health teams
- Third Sector organisations
- Multi-disciplinary meetings (MDT's) based around GP surgeries
- The Mayor of Thurrock Council and ward Councillors
- Direct from the community and meeting people at Community Events
- Community Hubs
- Housing
- Police and Fire Services

Analysis of people supported by the LACs shows significant savings to both health, social care (as well as other statutory services including fire). Examples are included here:

Costs associated with depression: Over 75 people introduced to LAC have identified depression as one of the main challenges they face. A very high percentage have reported an improvement in their depression and none have been readmitted since the LAC has been introduced. However, two people have needed the ongoing expertise of Mental Health services
If 75 people have seen an improvement in their depression and avoided or delayed the need for mental health services this is a potential saving of: £71,700

Mental Health community provision: Individuals and professionals have fed back that the need for mental health professionals has reduced and this includes regular weekly support groups where community alternatives have been found.
There are approximately 6 cases where people previously attended a support group. This will give a saving of: £101k pa (based on 6 people attending 2 hr session per week)

The LAC initiative is a key approach in reducing the number of people who end up in crisis.

Timely Intervention and Prevention Service
We recognise that the key to developing sustainable health and social care services is by reducing demand on already stretched services. Our approach to redesign is therefore focused on how we can prevent individuals from not only reaching crisis point, but from requiring a service altogether.

As part of our BCF Programme for ageing well in Thurrock, we identified a need for a Timely Intervention Service – aimed at better community management of a number of conditions to prevent crisis and manage demand.

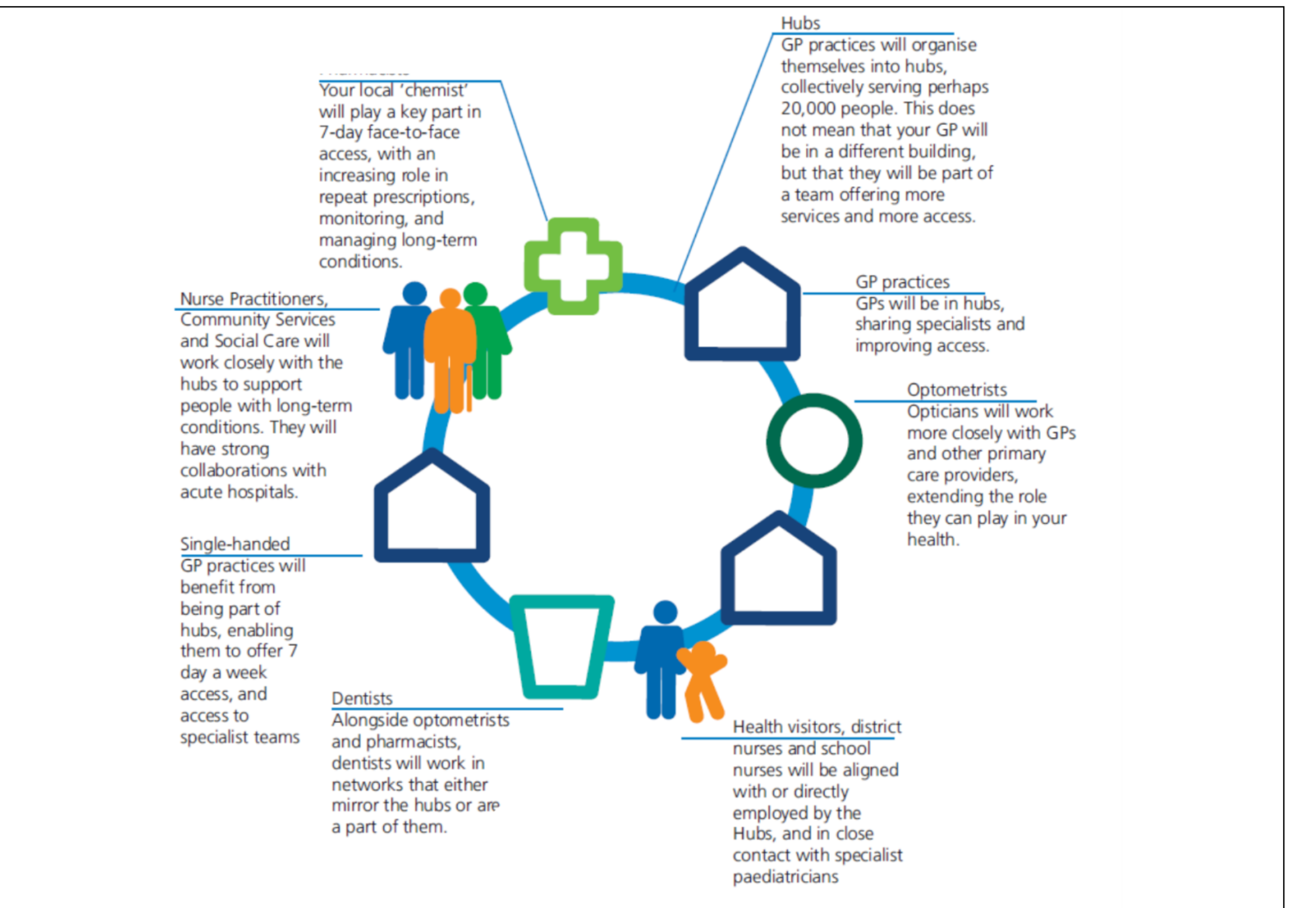
In keeping with the desire to provide an early intervention response, and greater local emphasis upon whole systems and community collaboration, is a growing awareness of the need to improve support to people who have been diagnosed with dementia and their carers.

The current offer provides support and advice at the time of diagnosis, but typically little ongoing support until crisis is reached – a situation that often results in premature reliance of more intensive models of care and support. The 2011 House of Commons Select Committee report on dementia stated:

‘People with dementia stay far longer in hospital than other people admitted for the same procedure, often unnecessarily. The National Audit Office study in Lincolnshire found that more than two-thirds of people with dementia no longer needed to be there. This represented a total of £6.5 million that could be invested more appropriately in other services. The King’s Fund extrapolated from this finding that over the whole of England, this would equate to more than £300 million that could be allocated more productively.’

Although not already in existence, as part of this BCF Plan and aligned to it will be the development of our Timely Intervention and Prevention Service focused initially on dementia for the reasons outlined above.

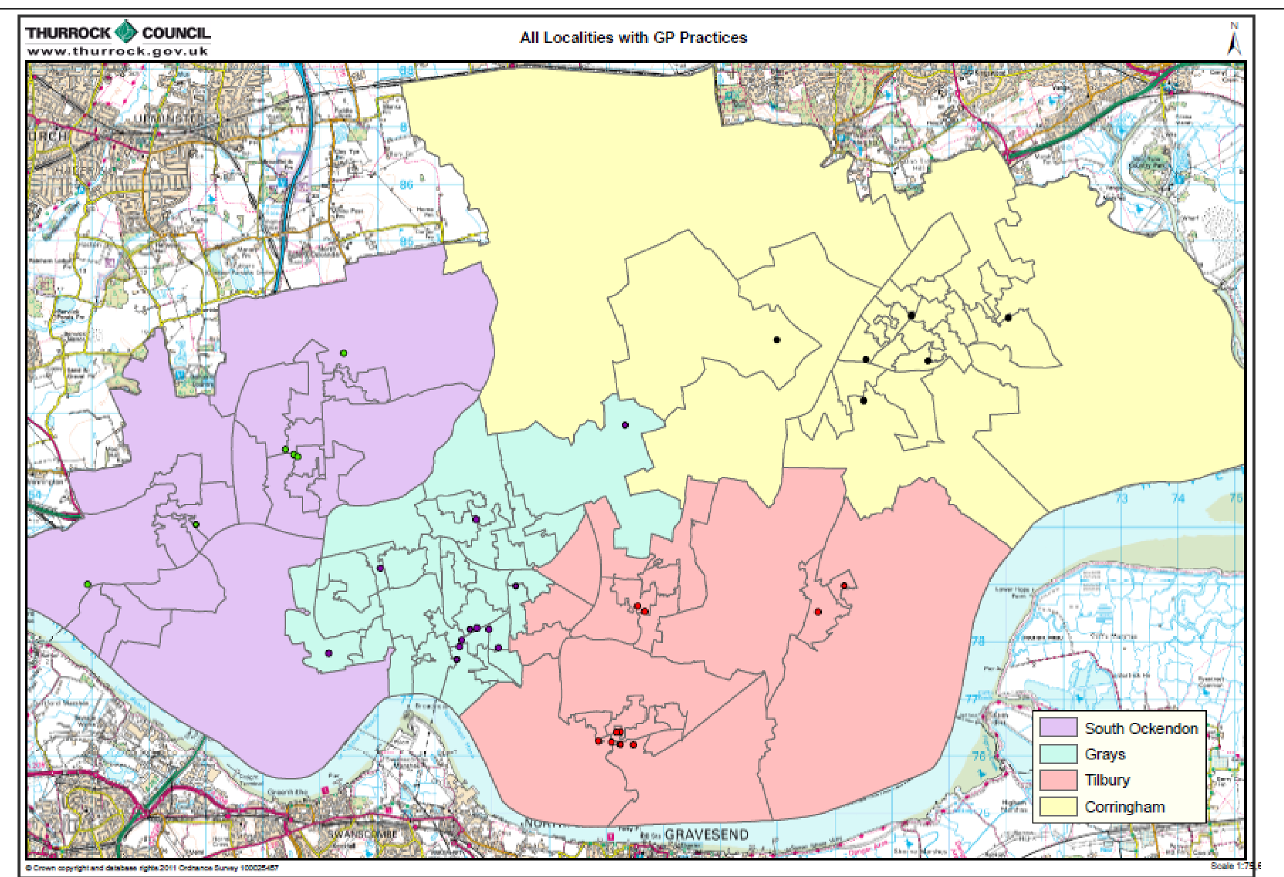
Delivering Co-ordinated Care
The delivery of other key work streams e.g. seven day services and the primary care strategy are also echoed within the BCF approach. Part of the proposed future model of primary care is the co-location of relevant services around confederations of GPs. This is also a key work stream within the BCF.



A system-wide Operational Resilience and Capacity Plan is in place. Whilst these focus on short term initiatives to manage day to day pressures in the system, the plans enabled by the BCF are seen as the longer term solution to managing fluctuations and growing demand across the unplanned care system. The projects funded through the 14/15 Resilience Monies have been targeted to help inform and/or pump prime BCF related initiatives.

The monies identified through the Call to Action programme (£5 per head) and the CCG endorsement of the NHS England Direct Enhanced Service for Avoiding Admissions, have been aligned to the longer term integrated commissioning and delivery programmes. For example, developing integrated health and social care co-ordination for high risk patients supporting the role of the Accountable GP for the 75s and over age group.

To facilitate improved access and integration the CCG has been working in partnership with social and primary care providers to realise co-terminous health and social care hubs, linked to the Community Hubs in the Borough; helping shape decisions being made as part of the wider primary care transformation programme.



This map indicates the proposed localities for the integrated service model outlined within BCF Scheme 1.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Thurrock CCG's 5 Year Plan identifies a number of areas of focus (under pinned by the JSNA). These developments span health and social care. The principles outlined within this document are also the principles within the five year plan. The work programme within the two year operational plan is geared towards the delivery of these principles;

Principles	CVD - Cardiology	CVD - Stroke	CVD - Heart Failure	Haematology	Respiratory Review	Cancer Services	Diabetes Service Review	LTCs in patients w/ MH cond.	Continence Service Redesign	Personal Health Budgets	Under 19 High Impact Pathways	Ambulatory Emergency Care	Dementia Screening	IAPT	Community Geriatrician Model	MSK Pathway	RRAS and Reablement	Continuing Healthcare Review	Community Bed Provision	Parity of Esteem	BCF Programme	Improving Quality	Acute Service Review
1) Empowered citizens who have the choice and independence and take personal responsibility for their health and wellbeing																							
2) Health and care solutions that can be accessed close to home																							
3) High quality services tailored around the outcomes the individual wishes to achieve																							
4) A focus on prevention and timely intervention that supports people to be health and live independently for as long as possible																							
5) Systems and structures that enable and deliver a co-ordinated and seamless response																							

The key schemes within the BCF are all included within the CCGs two year operational plan.

The key risk associated with differences between the two year plan and BCF that has been identified is a variation between primary care federation boundaries/community health boundaries and social care operational boundaries. A key requirement of the two year plan and BCF is the co-location/alignment of services into the federation model however, from an operational delivery perspective this may require significant change. Work is being undertaken to understand the differences and how we could mitigate any issues.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The vision for integration is set out in the CCG 5 year strategy and 2 year operating plan. Therefore, the BCF is an important step in a pre-existing journey towards integration. Primary care clinicians have been at the heart of this journey. Over the last 12 months we have engaged with primary care on a number of different occasions including:

- In December 2013, a workshop was held with GP's and the local authority to set out the vision for integration.
- Include work at CEG on developing locality hubs
- In September and November 2014, presentation at the Finance and performance committee
- In December 2014, BCF presentation at Board seminar

The comments from primary care re-enforced the sense of a shared vision for Thurrock based on the understanding that we are 'stronger together'. Colleagues articulated the need to deliver value for money by working smarter, removing hierarchy [where this impedes decision making], encouraging active citizenship, focusing on prevention and rehabilitation and sharing responsibility/risk.

The CCG has been successful in bidding for primary care transformation funding. The funding

has been awarded to provide one session: 9am – 12.30pm, on a Saturday and a Sunday in four "hubs" in Thurrock – which will be aligned to our locality models. The hubs will be providing urgent care services for patients through one GP, one Practice Nurse and one receptionist in each of the four services.

A team has now been established to oversee the implementation of this arrangement, with the first hub planned for opening in mid-January. This team includes four clinical leads, one for each of the localities as follows:

Dr Anil Kallil: Grays Locality
Dr Bhatt: Tilbury Locality
Dr Verghes: South Ockendon Locality
Dr Deshpande: Stanford-le-Hope Locality

This team will be working with the General Practice community in Thurrock to identify suitable premises for the hubs to operate from, as well as establishing the rota for weekend working. We will be keeping Practices up to date when this programme commences, through a dedicated page on the CCG intranet, email and our regular engagement forums, including CEG.

The CCG is committed to improving the capacity and quality of Primary Care in Thurrock. We are currently supporting the development of a local Primary Care Strategy. The key issues we are seeking to address in the primary care strategy are an ageing workforce, poor provision of GPs in comparison to the population and growing population.
The development of primary care firmly aligns with the Better Care Fund. The CCG is working with the Area Team on the co-commissioning agenda but has not expressed an initial interest in co-commissioning services with NHS England.

The whole system redesign group and the primary care transformation group will continue to work seamlessly to deliver the vision for integration set out within our strategy and the BCF.

7) NATIONAL CONDITIONS
Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Our approach to protecting social care services, and therefore our definition, is as follows:

Reducing Overall Demand
The client number projections from September 2013 up until April 2018 in Figure 1 below shows the expected natural increase via demographic pressures the Authority will face from now up until April 2018. This is an expected trend due to the nature of the population mix, coupled with an ageing population.

Fig 1 – Adult Social Care Residential Home Placement Numbers

	Actual	Projected				
	Sep – 13	**Apr-14**	**Apr-15**	**Apr-16**	**Apr-17**	**Apr-18**
Standard placements	286	300	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	**381**	**402**	**414**	**425**	**434**	**443**

Efficient, effective social care services are essential in reducing demand for acute services and have a key role to play in the future. We will use the BCF to strengthen social care provision across the whole system, starting with a review of all existing care services with a view to determining:

- Value for money – improving efficiency through integrated working with health;
- Person-centred and prevention/re-ablement-orientated – re-focusing services and re-commissioning services as necessary;
- Opportunities for out-sourcing to local community-based providers (CIEs, micro-enterprises etc.)

We will also use the BCF to review commissioning and procurement to develop:
- Joint commissioning of integrated health, public health, social care and housing services;
- A mixed economy of locally run care services; and
- Social prescribing – linking people up to activities in the community that they might benefit from (there is increasing evidence to support the use of social interventions for people with mild to moderate depression and anxiety, and people who are frequent attendees in primary care).

The BCF will help us accelerate the transformation of social care which is already underway in Thurrock, in partnership with housing, planning, health and our local communities. In addition to our Well Homes initiative, we have embarked on a housing development programme to develop HAPPI housing for older and vulnerable people (partly funded by the Homes and Community Agency and our own Housing Revenue Account); we have successfully piloted Local Area Coordination and have extended the approach in order to divert people away from formal services and find informal local solutions; and we are actively encouraging micro-businesses and community enterprises as a flexible, cost-effective approach to service delivery. We are putting in place Community Builders (supported by the ABCD Institute) to develop communities where health and well-being is actively promoted. All of these initiatives are being developed alongside the re-focusing of our social work teams.

Shifting Resource

We will look at the BCF in its entirety with a view to placing resource where it will have the greatest impact. This approach will help to manage the demand for both health and social care services, but also ensure that we are able to continue to provide services for those who meet our eligibility criteria. We estimate that pressures on external placements will increase by at least 20%. We have reflected the increase on external placements in our spending plans. We will also be identifying how the BCF can help to support existing social care services – these will be detailed within our Section 75 agreement. The review of services and pathways that we will undertake as part of developing and delivering our approach to integration will help to ensure that resource is in the right place – and help to identify where the resource should be shifted to.

Our approach to investing in early intervention and prevention solutions will assist with ensuring that resource is used as effectively and efficiently as possible.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Thurrock applies the eligibility criteria of substantial and critical – this will remain as a result of the Care Act's implementation from 2015 and the National Minimum Eligibility Standard.

Through the BCF, the local authority and the CCG have identified investments that will contribute towards the protection of adult social care. These are contained within the schemes as shown below:

Scheme	Contribution £000
2	2,217
3	240
4	72
Total	**2,529**

All of this funding is in addition to the mandated allocation for the Care Act of £ 522k.

In addition, we are taking a number of practical steps to be able to maintain eligibility levels which includes:

- Our approach to prevention and early intervention as expressed within Scheme 4 – we are expanding our community-based prevention and early intervention approach as part of the BCF to ensure that we reduce the need for care and support. We will have full Borough coverage of our Local Area Coordination initiative which is key to this approach
- Through the application of the Care Act (scheme 5) we are enhancing our information and advice offer to better signpost individuals and their carers to support; expanding our provision of advocacy and reaching out to self-funders who will be our responsibility from April 2016.
- We have restructured our social care fieldwork teams so that they align with community health services and around the four GP clusters to ensure a multi-agency approach that identifies those people at risk of crisis at the earliest opportunity and navigates those individuals to receive an appropriate service (scheme 1)
- We have and are enhancing our intermediate care offer to ensure that we offer a menu of options that assists with enabling individuals to stay out of hospital or reables that individual to live as independently as possible within their own home (scheme 3)
- We are working towards an integrated frailty model that will identify people at the earliest

opportunity and ensure that they enter the right part of an integrated model (scheme 2).

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

We have identified £522k as part of our approach to implement and deliver the Care Act. Delivery of the Care Act will also help to support our ambition to protect social care services – e.g. through a focus on reducing, preventing and delaying needs.

We are taking a whole-system approach to the protection of adult social care services and have identified a figure of £2 million. We aim to achieve this in a number of ways that include:

- Review of existing schemes;
- Reallocation of resource;
- Contribution of the 'pay for performance' element of the BCF – whilst acknowledging that the amount to be achieved is an unknown quantity.

With regards to the pay for performance monies, we see any money secured as supporting efficiencies and transformation across the system, and not solely the protection of social care services.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Council, as part of the Health and Social Care Transformation Programme, has established a Care Act Implementation Project Group. The Group has assessed the Council's readiness against the Care Act's requirements and identified the work that needs to take place between now and April.

Key elements are as follows:

- Carers – assessment and support;
- Information and Advice – system/material development;
- Safeguarding – implementation of new responsibilities;
- Assessment and Eligibility – primarily change in eligibility;
- Capital investment funding – e.g. IT systems for personal budgets.

The Care Act implementation funding will be used to ensure readiness for April 2015. A full readiness assessment and related action plan is available.

v) Please specify the level of resource that will be dedicated to carer-specific support

Within the BCF, we have identified £178k for investment into carers' support. We are keen to ensure that the provision of carers support is integrated within our overarching service model and therefore have included the development of our carer's services into BCF 2. Frailty Model. The key elements of this part of the programme are the identification and recording of carers within a central list, improving the provision of carers support within generic services e.g. COPD specialist nursing providing carer support through education and telephone support, commissioning of specific carer support interventions e.g. carers breaks, support groups. Additionally, we will be using the resource available to support the sitting service for older people currently provided by Adult Social Care.

Through the BCF, the Council and CCG are keen to ensure that we use the available evidence to

commission the right range of support packages available. The Systematic Review of Interventions for Carers in the UK study (Victor, 2009) identified the following interventions as having a significant impact on wellbeing of the carer and the individual cared for;

- Ensuring that the quality of carer assessments is as important as the numbers assessed
- Provision of carer support groups that are both specific to a presenting condition and more generic
- Improving the level of education to carers on the specific conditions of those they care for
- Provision of carers breaks

Ensuring providers consider the needs of less assertive carers and put in place proactive approaches to supporting those carers.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

We are taking a whole-system approach to the protection of adult social care services and have identified a figure of £2 million.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

We are committed to improving the quality of services provided for our population and see the BCF and integration as the vehicle through which we will continue to seek new ideas and opportunities for advancing 7-day services I partnership with our providers.

We have already made significant progress towards this vision. For example:

- Rapid Response and Assessment Service (RRAS) – extended weekday hours (9am – 5pm);
- One Response Service (End of Life SPOR model) – 24 hours, 7 days a week
- Thurrock Social Workers – 7 day hospital cover including on-site provision 6 days per week;
- Intermediate Care (health and social care) – provision for admission and discharge on Saturdays and Sundays;
- Nursing Homes – premium payments for homes that can admit at short notice/weekends; and
- The Right Place, right Time Programme (RPRT) at Basildon Hospital (BTUH) focused on 7-day services.

The Whole System Redesign Group will drive the next steps towards further integrated 7 day a week working. This forum is a multi-agency group including health commissioners, social care commissioners, mental health service providers, community service providers, local authority service managers and patient and service user representative groups. The Group has organised a system workshop for early January to consolidate the work to date and build consensus on the next steps. This is an important milestone for the Group so that we can engage with wider stakeholders to build consensus. The collaborative approach will ensure that we are able to work together to manage concerns and risks.

The timing of the workshop is important because we shall reflect the principles of integrated 7 day working within the upcoming contract negotiation round. This will be a key component of Service Development and Improvement Plans (SDIP) over the next two years and beyond. Health and Social Care commissioners across Thurrock will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the

expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge. We are fortunate that the whole system is committed to this direction of travel and will continue to collaborate on the development of these action plans.

Clearly, this vision is aligned with the NHS Outcomes Framework, two year operational plan, five year strategy and the Primary Care Strategy (see primary care section). This will be critical to meeting the ambition of delivering 7-day services. Over the next five years, work will continue to explore innovative solutions – including optimising primary care provision, pharmacists, optometrists and dentists to support 7-day services based on the community hub model championed in Thurrock'.

c) Data sharing – to be amended

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

In Thurrock, the NHS number is already used as the primary identifier for correspondence across health systems.

In adult social care strong progress has been made in adopting this practice and improving the proportion of social care clients with their NHS number matched and recorded on the adult social care LAS system. Adult social care have carried out a number of data matching exercises and utilised the national number matching service to support this. This has realised a match of some 85% to date -, this foundation gives us confidence as we aim towards 100% of clients being identified in this way.

In addition, the council, together with health partners have signed up to be a second wave follower on the national Child Protection-Information Sharing (CP-IS) project. The supplier of the children's social care IT system is an approved provider for the project. To support the project, children's social care are also working to capture NHS number within the system. We anticipate going live with this project in summer 2015. The learning from this process will be adopted into our approach and strategy for adults to ensure consistency.

Thurrock Council and Thurrock CCG are developing an IM&T Strategy that will set out the future direction of travel for information, governance and systems development. This is a key focus in the next financial year. The strategy will include a specific focus on the following:

- Consent models
- Data sharing and information governance
- Recording management
- Risk stratification
- Systems development and architecture

The strategy will underpin and support the delivery of key priorities and schemes within the BCF including the extension of MDT, single care coordinator and single assessment.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Health and Social Care services in Thurrock are committed to adopting systems that are based upon Open APIs. Steps have already been taken to advance this commitment. They include:

- System One is widely used across health services and provides a strong foundation for future development.

- Social Care uses an IT system (LAS) that provides an electronic record across all social care services. It also allows health partners and staff to view information, contribute to information and to support the provision of support and services e.g. joint re-ablement and RRAS teams. The system also enables data and information to be shared with and interfaced with other systems where required. The system and developments meet requirements outlined in the IG Toolkit and are fully compliant with an open set of APIs.

  - Social care are working with the mental health trust (SEPT) to ensure the interface and sharing of appropriate information between the LAS and eCPA system. Progress is being made, though work is ongoing. This will significantly improve the productivity of staff and reduce the requirement for dual entry to systems and dual recording of care information. In addition, this will also deliver the added benefit of improved performance and financial monitoring.

- Health and Social Care are piloting an electronic software solution that aims to capture, aggregate and analyse health and social care data through a single consistent format. This will support a consistent single view of health and care information across the whole pathway. This will also improve risk stratification and modelling capability, provision of targeted interventions and resources where needed and support shared performance reporting. This will be supported by use of the NHS Number.

- In doing so we are engaging with a neighbouring area – Southend. Southend are a Pioneer for BCF and are implementing the same system. The Department of Health have assigned an information governance resource to support Southend with the development of the system and Thurrock will work with both to obtain assurance in respect of our approach.

- In preparation for the implementation of this system (Care and Healthtrak) Thurrock has undertaken a number of a number of preliminary exercises have including:
  - Consent to share sought from all known Thurrock adult social care clients;
  - Changes to operational policies to ensure consent is sought upon first contact with adult social care clients; with confirmation of decision sought annually;
  - Review and alignment of social care information architecture for alignment to acute health data;
  - Thurrock LA and CCG have created a suite of reporting templates with Pi Benchmark to realise a joint risk-stratification tool once Information Governance allows.

Thurrock actively awaits the results from the Southend Pioneer project on how they have utilised Health & CareTrak; within the current limitations of Information Governance. We are committed to adopting an approach and practice that meets the approach and recommendations that may flow from this.

- Thurrock has recently reviewed options to improve the functionality of its systems to support service user access to view information and to undertake elements of self-assessment, planning and commissioning via an online platform.

The development of an IM&T Strategy (as outlined above) will provide the future basis upon which systems development, procurement, architecture will be based.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Thurrock is fully committed to ensuring compliance with all information governance, confidentiality and data protection requirements.

Thurrock is compliant to level 2 of the Information Governance Toolkit for the period April 2014 to 31 March 2015 and meets all requirements in respect of existing practice and operation (see follows). There are no specific risks requiring mitigation in year.

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Care Records Assurance
- Secondary Use Assurance
- Corporate Information Assurance

Internally within the council, a project group leads work on the IG Toolkit. This includes adult social care, children's social care, public health, IT and information governance.

The priority areas to be addressed for submission in the 2015-16 IG Toolkit (by 31 March 2015) and forming the work plan for this Group relate to the following areas:

- Evidencing PSN Certificate of compliance;
- Formalisation of Information Management and Governance Strategy;
- Reviews of staff compliance with IG guidelines as audit trail
- Information Assett management;Details on the role of Caldicott Guardian, review of Caldicott Issues log and evidence to support;

Social Care has amended its service user information governance statement to incorporate sharing of information with health partners on an electronic basis in support of the preparatory work for the implementation of Care and Healthtrak. As highlighted above, we have engaged with Southend (as a Pioneer) to seek and share the DH IG advice and recommendations that emerge in respect of IG.
The development of our data sharing arrangements will be in keeping with the Data Protection Act 1998, particularly principle 7 (security measures taken to protect data), and Article 8 of the European Convention on Human Rights (the right to a private an family life).

The NHS Standard Contract and Community Contract includes all required provisions.

Initial contracting arrangements for BCF will see Thurrock LA become a commissioning associate to the CCG's existing NHS Standard Community Contract arrangements for all services part or fully commissioned from healthcare *(public or private sector).* We anticipate the portfolio of non-healthcare services will gradually transfer over to the NHS Standard Community Contract as we see the development of integrated health and social care services; thus recognising the need for heightened governance arrangements and processes.

The Director for Adults, Health and Commissioning is the Caldicott Guardian and oversees governance for adult social care. The Director for Children's Services is the Caldicott Guardian and oversees governance in respect of children's social care. Together, these roles ensure compliance with the principles and requirements supported by the Information Manager (Council).

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Thurrock is in the process of developing a joint-risk stratification strategy to identify when and how patients should be assessed; with the identification of associated benefits for each cohort of patients. We anticipate the risk-stratification will take into account: social and physiological indicators: e.g. a recent local review of our district general hospital admissions identified a relationship between inappropriate hospital attendance and admissions with those patients living alone.

A precursor to this initiative has been the development of:

- **Primary Care MDT reviews**; with health and social care parties identifying patients for review. Patients within this programme are largely those already known to the system i.e. under active review by GP, community nursing or social care.

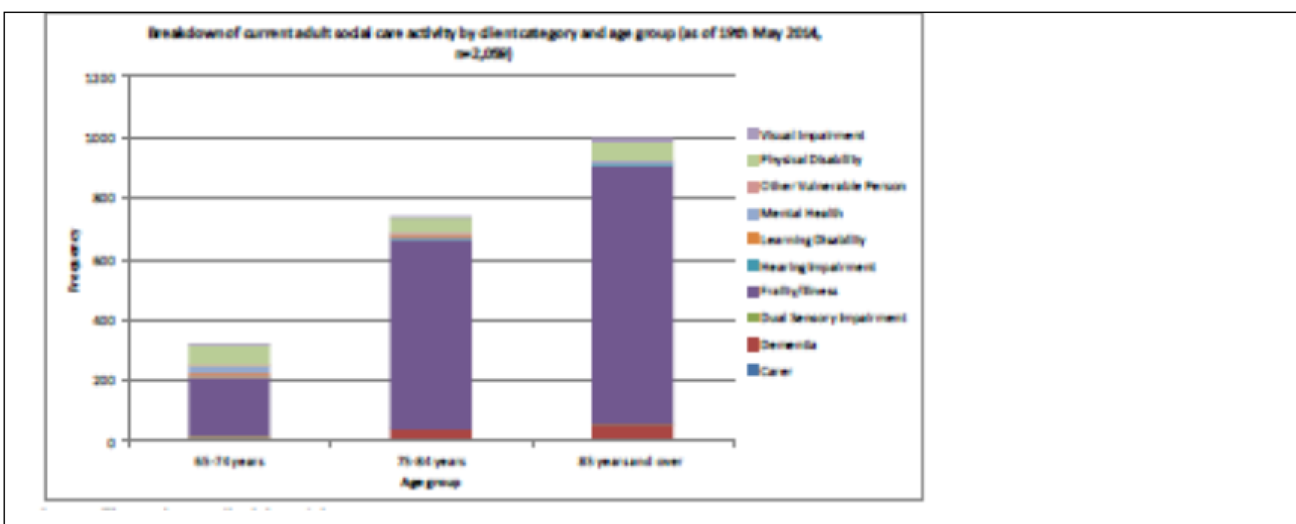
- **Unplanned Care Directly Enhanced Service:** Within 2014/15 practices in Thurrock have carried out risk-stratification of their registered population; identifying those at most risk of a non-elective admission into hospital. This has seen 2% of the population receiving joint integrated care plans c.3,400 patients; with a proportion of these being reviewed within the Primary Care MDT reviews.

- **End of Life Register & GSF:** Over and above those patients identified for Primary Care MDT reviews and this year's Unplanned Care DES, all practices in Thurrock have signed-up to undertaking GSF reviews. In partnership with this we have incentivised our community provider *(through CQUINs)* to aid the further development of the existing End of Life register. We anticipate that with these measures Thurrock's End of Life register should be nearing the 1% national benchmark by 2017; with integrated care-plans, anticipatory prescribing and key contacts.

- **Long Term Conditions:** Work continues to improve the long-term condition registers and the pro-active management of conditions e.g. introduction of patient passports for COPD.

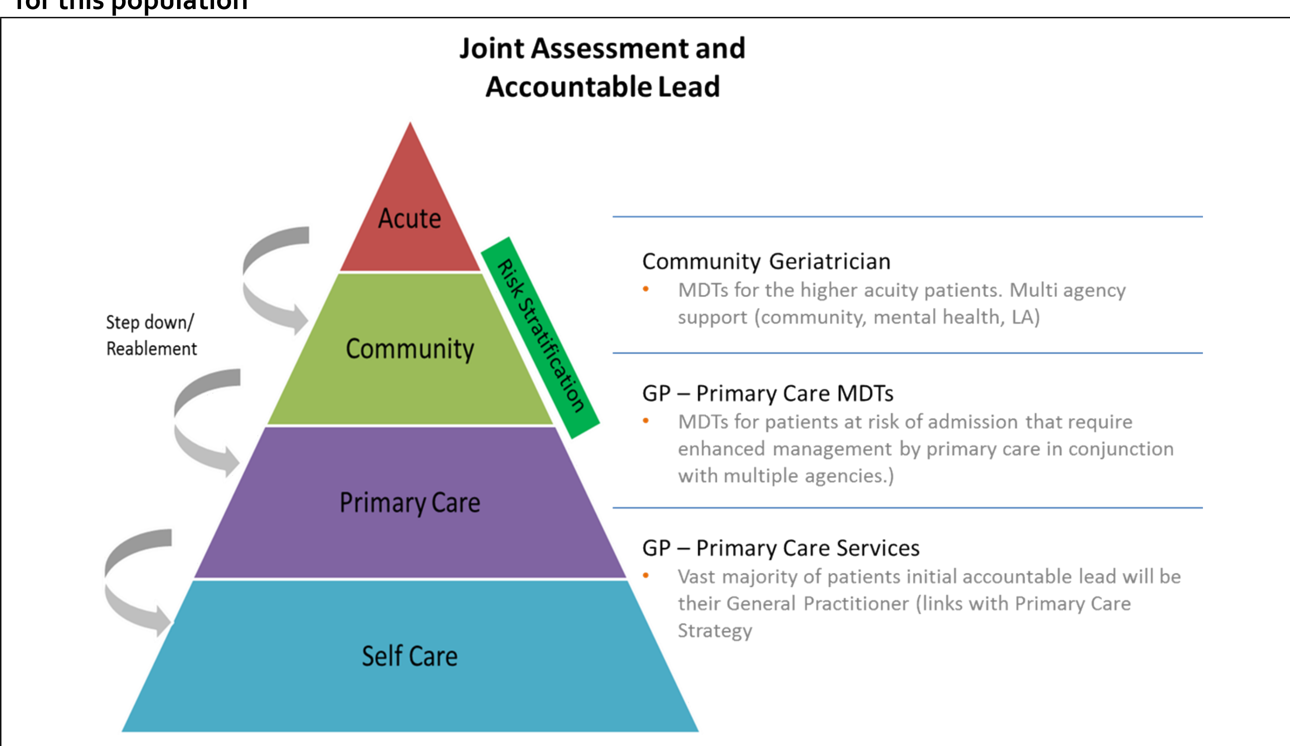
Patients identified within the above work-streams are recorded on SystmOne *(through use of Special Patient Notes)*; to inform services coming in contact with each patient e.g. NHS 111, and thereby ensure care is managed accordingly. Moving forward we will need to ensure patients identified as being at risk of admission due to their social indicators are flagged in a similar fashion to inform their care package including support measures *(where required).*

Adult Social Care Analysis *(p32 HNA)*



Thurrock's position in terms of risk stratification and risk segmentation and future approach is included earlier in this document (refer to Case for Change and Plan of Action)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population



We are currently refining our proposals for the Joint Assessment and Accountable Lead process. The above diagram is the basis of the system that we have begun to implement and are starting to refine across the locality. Within this model, General Practice plays the strongest accountable role for the majority of patients.

The Role of Primary Care
This model is underpinned by the Primary Care Strategy which seeks to strengthen primary care and improve capacity and sustainability.

The Clinical Commissioning Group will be supporting GPs to utilise the £5 per head to support the development of primary care capacity and quality that will enable the GP to be the Accountable Lead Professional in the vast majority of patients.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We expect that by March 2015, at least 70% of the expected 3,100-3,400 patients requiring a joint care plan will have a plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

As part of the Council's and CCG's Health and Social Care Transformation Programme, we have established an Engagement Group. The Group's purpose is to advise on engagement with users of services, carers, and the general public. The Group has developed an Engagement Plan for this purpose, and has also developed a process for involving users of services, carers and the public in commissioning and service development (signed off by the Health and Wellbeing Board at its July 2014 meeting).

Extracts from the Health and Social Care Engagement Plan

Thurrock Council (the Council) and Thurrock Clinical Commissioning Group (the CCG) are committed to engaging and involving citizens and community groups in developing a vision of what integration will look like, and the principles that will underpin that vision.

Together with Thurrock Council for Voluntary Services (the VCS), Thurrock Healthwatch, Thurrock Commissioning Reference Group (the CRG) and Thurrock Coalition we have already developed the high level principles that will frame our joint vision. These are:

1. Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing
2. Health and care solutions that can be accessed close to home
3. High quality services tailored around the outcomes the individual wishes to achieve

4. A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible
5. Systems and structures that enable and deliver a co-ordinated and seamless response

In pursuing our vision, Thurrock CVS, Thurrock Healthwatch, Thurrock CRG and Thurrock Coalition have also agreed to work with Thurrock Council and the CCG in a process by which:

a) citizens will be involved, at the earliest stage, in conversations to refine and confirm the vision and the high level principles for integrated health and social care services, and

b) the manner in which the principles should be applied across the whole health and social care system to ensure better care for the people of Thurrock will be jointly determined - with the initial focus being the health and well being of older adults.

This Plan will be delivered in agreement with the principles of the Thurrock Joint Compact 2012 and the Thurrock Community Engagement Toolkit

To enable citizens and community groups to participate fully in the co-production process, we recognise that clear and accessible information about the challenges and choices facing them must be made available in a timely manner.

From the outset engagement will be::

- Honest and transparent about the scope of change, and the enablers and constraints in the change process;
- On terms, in places and at times which suit citizens and communities;
- Two way, with information being imparted and received, and delivered in a manner which encourages questions and constructive criticism; and
- Responsive to what we hear, where ever possible giving an account of what will be done with what we learn and the likely outcomes.

That way that the Health and Social Care Transformation Programme communicates will

- demonstrate integrity and public accountability;
- be clear and easy to understand;
- Provide feedback where people have engaged using the 'you said, we did' methodology; and
- be appropriately targeted to the communication needs of our various audiences.

Governance arrangements

This Communication and Engagement Plan forms part of the Programme Initiation Document for the Health and Social Care Transformation Programme Board. The arrangements for engaging citizens and communities will be overseen by the Health and Social Care Transformation Programme Board, reporting to the Health and Well-being Board.

The Health and Social Care Transformation Engagement Group is responsible for developing and overseeing the detailed programme of engagement activity. The Group's membership includes:

Components of the Engagement Plan are likely to include:

Information Exchange:

- A range of briefing sessions at public meetings such as the community fora
- A presence at community events
- Briefings with representative and special interest groups
- Specially convened listening events

In-depth soundings including:

- Focus groups – i.e. people with Long Term Conditions
- Individual interviews with experts by experience
- Joint Strategic Forum

Working groups:

- Citizen involvement in whole system reviews of care-pathways, commencing with the care-pathway for older people.

Locality based conversations:

- Building on the local presence of Community Fora, community organisers, local area coordinators and Asset Based Community Development -

community builders.

The Engagement Group recently met to agree their role in the review of existing Better Care Fund schemes. They are also represented on the Whole System Redesign Project Group, Care Act Implementation Project Group, and Health and Social Care Transformation Programme Board.

In April, the Council and CCG held a stakeholder event to gauge stakeholder feedback – including users of services, carers and the public – on the principles that underpin the vision for Health and Social Care. The Better Care Fund has also been discussed at Thurrock's Clinical Reference Group.

Considerable community engagement has already taken place on some of the elements that are incorporated within and aligned to this plan – e.g. Local Area Coordination. An innovative recruitment process involving community representatives, designed by Thurrock CVS and the Thurrock Coalition has been used for all LAC appointments and is increasingly used for other social care appointments.

Future engagement activity as part of developing and delivering this Plan will be guided by existing arrangements – i.e. the Engagement Group.

b) Service provider engagement
Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Thurrock CCG is engaging with their main acute provider (Basildon and Thurrock University Trust), main community provider (North East London Foundation Trust) and main mental health services provider (South Essex Partnership Trust). Updates on the development of the BCF and the strategic direction of the BCF have been shared through a variety of forums including Thurrock's Strategic Leadership Group, contract management meetings and specific workshops.

Thurrock's Strategic Leadership Group has been in existence for a year and has already met a number of times. The focus of the Group is managing demand across the health and care system. An extract from the Group's Terms of Reference which shows focus and membership is shown below:

Membership of the Strategic Leadership Group includes:

- Thurrock Council – responsible for commissioning and providing adult and children's social care services
- Thurrock NHS Clinical Commissioning Group – responsible for commissioning a range of acute and community health care services
- North East London Foundation Trust (NELFT) which provides community services,
- South Essex Partnership Foundation Trust (SEPT) which provides mental health services,
- Basildon and Thurrock University Hospitals Foundation Trust (BTUH) which provides acute and secondary care services

In recognition of the important role, both now and in the future, of the voluntary and community sector, Thurrock CVS will be a member of the Group.

Remit of the Group:

- Receive and scrutinise national policy, best practice and independent investigation reports, as well as reports on the application of policies and performance locally, and agree at an early stage to jointly plan change to address any issues identified.
- Consider and advise on whether:
    - commissioning strategies reflect all elements of quality (experience, effectiveness, economy and safety) for service users and patients,
    - commissioned services ensure that the service user/patient sits at the heart of plans and decisions related to their care, and that services are being delivered in a high quality and safe manner.
- Advise on the effective management of risk for co-ordinated service delivery, market stability and sustainability, whether or not specific services are delivered jointly or not.
- Ensure a clear escalation process is in place to enable appropriate engagement of the relevant decisions makers within their organisations on any areas of concern related to the delivery of quality.
- Demonstrate clear commitment to the delivery of quality outcomes for the citizens of Thurrock, even where their interests cover a wider geographical area.

Commissioning intentions for 2015/16 have recently been sent to each of the main local NHS providers and detailed negotiations on the 2015/16 operational plans and contracts are currently taking place. This will include consideration of the delivery of QIPP plans, and their inter-relationship with the BCF Plan and the target reduction in emergency admissions. Provider risk management will be undertaken via contract negotiations and then through regular contract monitoring arrangements.

In addition, there will be regular dialogue with all providers through the System Resilience meetings (fortnightly) with the main providers and other key partners (OOHs, Ambulance Service, 111 etc). This forum is sub economy wide and so includes Thurrock CCG (a Lead or Associate to all the aforementioned providers' contracts). Therefore, the interface between the Thurrock BCF and the Essex BCF will be subject to provider scrutiny.

Within our Executive to Executive Contract Negotiations for 15/16, the BCF developments and their impact (for both 15/16 and beyond) will be a standing item to ensure that any contractual (activity, finance, specification, service development plan) requirements are agreed well in advance of signing contracts.

As part of the work streams identified, there will also be specific market development work both with incumbent and potential service providers

ii) primary care providers

There has been specific engagement on the Better Care Fund with GPs through the CCGs governance committees. In addition, through the Clinical Executive Group (all GP practices and other forums, GP members have been kept updated on the development of the BCF. More explicit engagement has been pathway related on the development of the co-location model, frailty services, mental health services and the interface between primary care and community (health and social services).

A workshop took place with the CCG Board and Health and Wellbeing Board in December 2013 to develop the five principles that underpin health and social care transformation in Thurrock, and therefore Thurrock's Better Care Fund.

iii) social care and providers from the voluntary and community sector

The Voluntary and Community Sector have and are being engaged through the Health and Social Care Transformation Programme – in particular through the Engagement Group. Members of the

Voluntary and Community Sector are also members of key project groups:

- Care Act Implementation Project Group;
- Whole System Redesign Project Group;
- Health and Social Care Transformation Programme Board.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Basildon and Thurrock University Hospital NHS Foundation Trust seek to reduce the bed base they currently commit for unplanned care activity. The Trust recognise that the current numbers of beds are unsustainable and are not the optimal way to deliver care to patients. Through the implementation of the BCF schemes and resultant reduction in unplanned care admissions the Trust will be able to reduce their bed base or convert the beds to an alternative use.

The target for reducing total emergency admissions contained within Thurrock's BCF Plan has been set at 3.5%. Whilst this is an ambition, given the history of activity related to unplanned admissions, achieving a 3.5% reduction will provide Thurrock with a significant challenge.

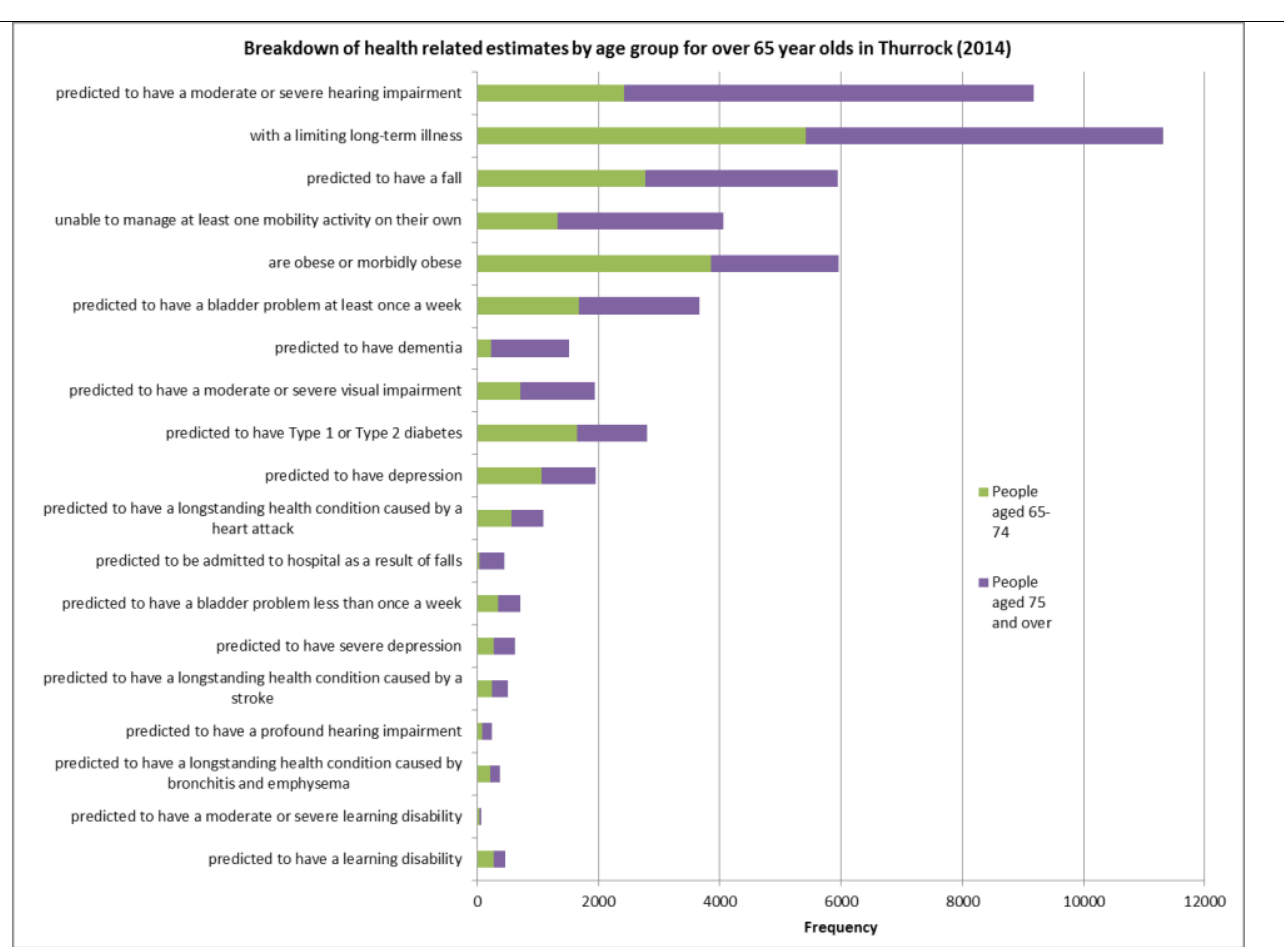
Thurrock has established a Strategic Leadership Group with membership comprising of the main NHS providers, Thurrock Council, Thurrock CCG, Thurrock HealthWatch, and Thurrock Council for Voluntary Services. How the system can work together to achieve significant reduction in unplanned admissions is one of the main agenda items.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

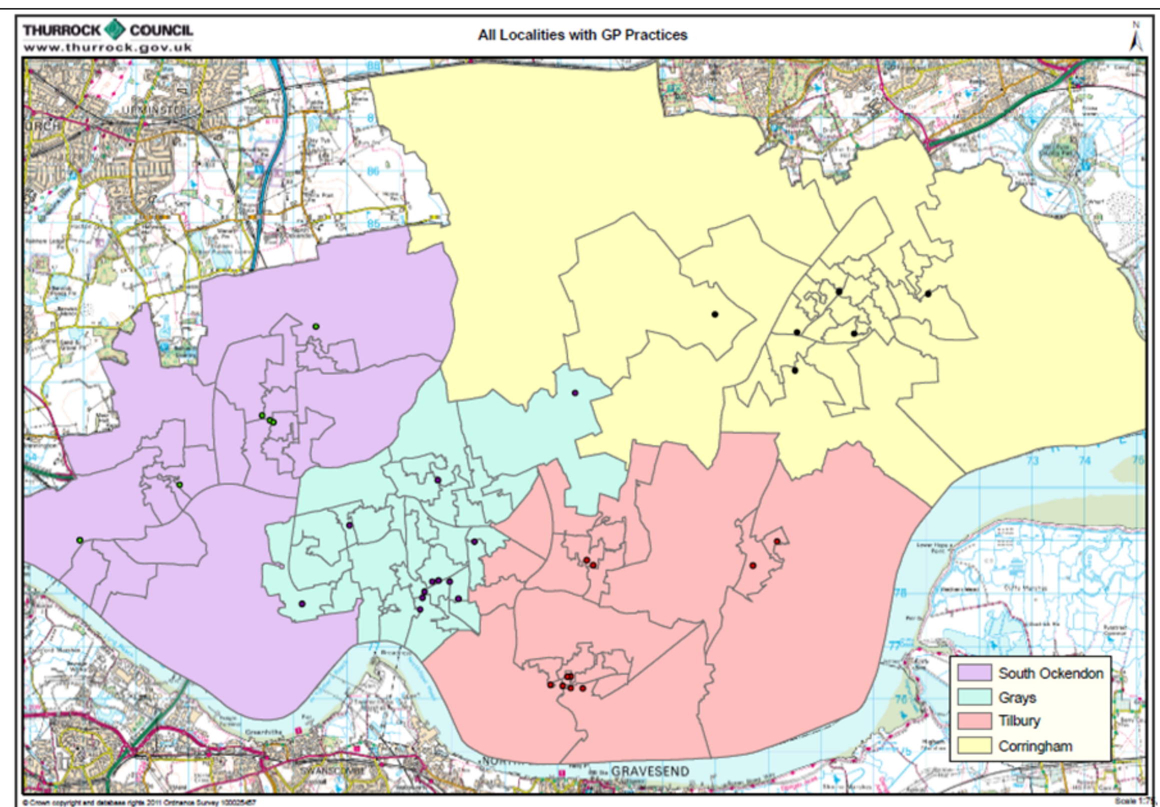
For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF Scheme 1
Scheme name
Locality Service Integration
What is the strategic objective of this scheme?
The aim of Locality Service Integration is to integrate service delivery in Thurrock around 4 community hubs. Our aim will be to define an integrated service offer for the people of Thurrock based on detailed understanding of the local needs of each community. The Locality Service Integration Scheme forms part of the universal community offer for adults in Thurrock. However, the majority of people using the service will be adults aged 65 and over. The scheme will support people with stable long term conditions to live well with simple or stable long-term conditions so that they avoid unnecessary complications and acute crises. The scheme builds on the successes of the integrated Rapid Response and Assessment Service and the Joint Re-ablement Team. It will scale up the integration of health and adult social care services in broader integrated service model linked housing and a range of non service solutions including more responsive and resilient communities. The Locality Service Integration Scheme will integrate community health services, mental health services, housing and adult social care with primary care. It will be organised around the developing GP clusters to create a locality offer which addresses the strengths and needs of the diverse communities in Thurrock. The integrated offer will use risk stratification to target people who are most at risk of admission to hospital or a care home, providing solutions which will promote health and well-being, and ensure unplanned interventions are avoided. The scheme will generate efficiencies by reducing duplication, by improving service user and patient experience and satisfaction, and by providing solutions closer to home
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Locality Service Integration Scheme is primarily focused at adults aged 65 years and over. Evidence from the King's Fund (2013 Making Integration Happen at Pace and Scale) which makes it clear that integration is most effective where the target population is older people living with chronic conditions including mental ill health. The 65 and over cohort which numbers in Thurrock approximately 20,000 people will benefit from the prevention and early intervention services as set out in Scheme 4. The subgroup will be people with relatively simple and stable long term conditions. (BCF2 focuses on the frailty model and people with complex co-morbidities, BCF 3 focuses on those with re-ablement and rehabilitation needs and BCF 4 focuses on prevention and keeping people active) The following table provides a summary of health related indicators for people aged 65 and over in Thurrock in 2014.



The model of integration for the Locality Service Integration Scheme was piloted with a Joint Re-ablement Team and extended through the Rapid Response Assessment Service, an integrated health and social care team which provides crisis management for service users in a timely manner, typically within 1-2 hours of the referral being received. This scheme takes integration further by organising health and social care service responses around clusters of GP practices. This will allow services to take advantage of a range of community assets for the delivery of care including GP surgeries and the community hubs currently being rolled our across the borough. To maximise financial and operational efficiencies electoral-ward based commissioning solutions are also being developed; responding to the disparate population needs. This will mean services responding to the specific needs of the local-ward population; with GPs working in conjunction with local community service providers, public health and social care. The BCF is strategically aligned to our primary care strategy. We have recently been successful in bidding for a primary care transformation fund. This bid will enable us to deliver improved GP access 7 days a week from community hubs. We aim to build on this success through our application to the prime minister challenge fund bid.

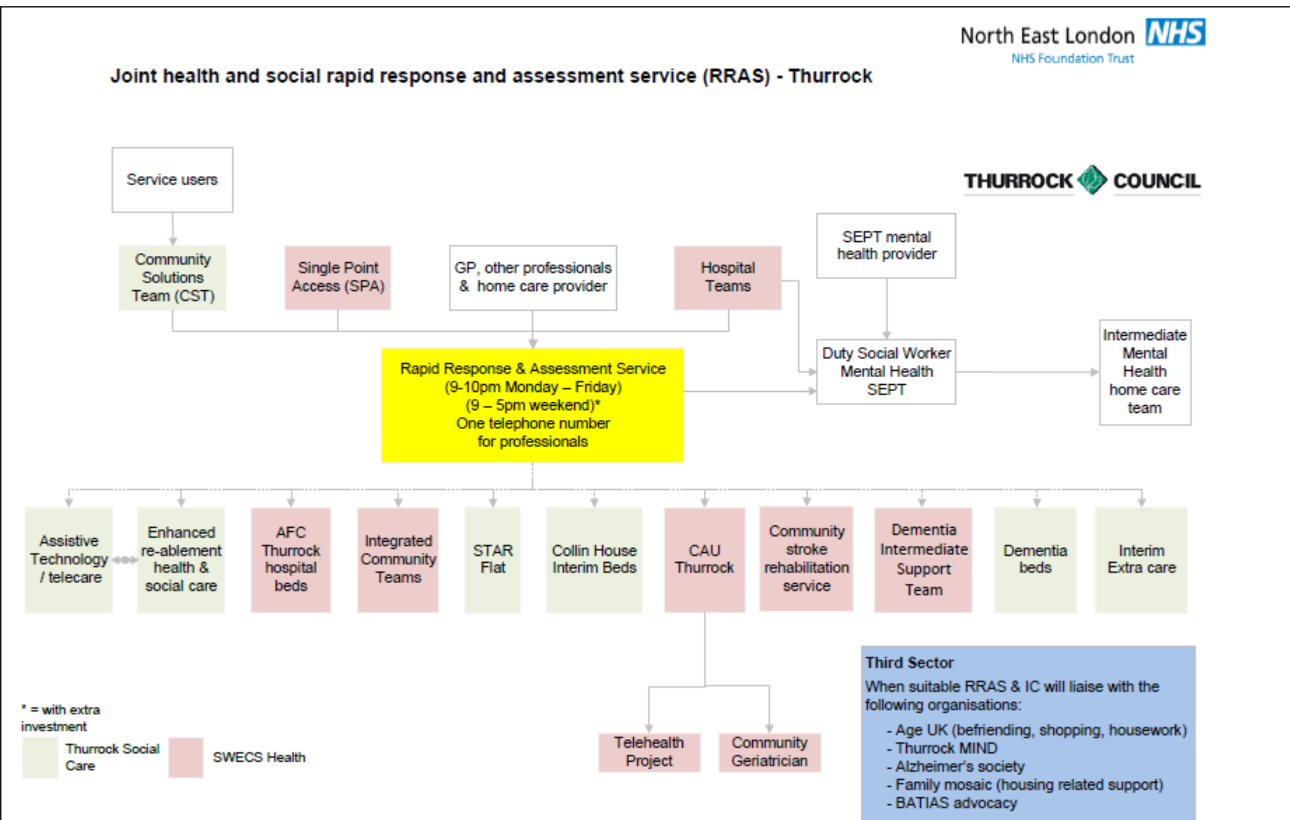
The GP clusters are shown on the following map:



The Locality Service Integration Scheme will be a partnership between Thurrock's adult social care services, and the community health providers (North East London Foundation Trust and South Essex Partnership Trust). It will have a Single Point of Access through referral from GPs, a wide range of community organisations or through Community Solutions – the triage service for adult social care in Thurrock. The initial response around each patient will involve a multi-disciplinary approach to risk stratification, facilitating the delivery of a wide range of solutions ranging from, for example, referrals to housing services where there is a need for adaptations or to the Frailty Model for those in acute need.

Thurrock recognises that carers are crucial partners in promoting health and well-being and believes they should not pay a penalty for the valuable contribution they make. The application of the carer's grant will be directed as part of this scheme as will the two carer support posts provided by South Essex Partnership NHS Foundation Trust (SEPT), and funded from the Mental Health Grant.

The integrated model of care will ensure a single care plan for each service user/patient so ensuring co-ordinated care and removing wasteful duplication. The service will provide a seamless pathway of care and support led by a care co-ordinator. The health and social care offer will be linked to health related services including housing (via Thurrock's tenancy services or Well Homes programme) and non service solutions through Local Area Co-ordination. The full menu of options is illustrated in the following diagram:



The costs associated with developing the Locality Service Integration Scheme and managing the changes will be borne by the providers within their existing budgets, and Primary Care Transformation monies will be used to enhance the primary care offer including the extension to 7 day.

A project implementation plan is being developed through our Whole System Redesign Group, this Group will ensure that the outcome of the reviews of all relevant current services will inform the design of the care pathway. The Governance arrangements for the Whole System ,Redesign as well as arrangements for engaging service users, patients and carers are described elsewhere within the BCF Plan.

The cost per case for the Locality Service Integration Scheme will be modelled in detail during the course of the first year to refine our understanding about the most effective, efficient and economic approaches to the management of long term conditions, and to promoting health and well being for those with two or more morbidities.

The key milestones for the Locality Service Integration Scheme include:

- Development of integration governance arrangements and working groups – March 2015
- Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
- Full integration of the team, care coordination model, and sharing of information to enable management of risk – September 2015
- Cost benefit analysis of the first 6 month's operation – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Well established relationships exist between providers and commissioners and commitment to partnership working at all levels – e.g. Health and Well-Being Board, Strategic Leadership Group,

as well as at an operational level. We will build on the trust that has developed from our successes.

The delivery chain for this scheme is wide and interlinked with the other schemes that have been identified by Thurrock. The Whole System Redesign Group will closely manage the review and design of the care pathway ensuring that this is commissioned in partnership by housing, health and social care.

The integration of the commissioning approach will reflect the integration of the service delivery. The Care Act 2014 places a responsibility on all public organisations to work together and co-operate where needed to ensure a focus on the needs of their local population, and this is supporting our thinking in developing Locality Service Integration.

The Commissioners supporting the development of the Locality Service Integration scheme are:

NHS England - Primary Care
Thurrock CCG - Acute and Community Care
Thurrock Council - Social Care, Public Health, and Housing

As we shape the market to move to Locality Service Integration in Thurrock we build on the positive relationships that currently exist with providers and we will work in partnership to develop the model of care and support. There will be a range of providers involved in this approach including:

General Practice
Basildon and Thurrock University Hospital NHS Foundation Trust
North East London Foundation Trust
South Essex Partnership Foundation Trust
Thurrock Council
Other smaller Private and Voluntary Sector providers

As the Council is leading a number of major regeneration schemes, including building a new town centre in Purfleet, the partnership will also have the potential to deliver new and better health care facilities to further enhance the Locality Service Integration Scheme.

The budgets that are included within this scheme will be

- Integrated community teams
- Long term conditions
- Carers' Grant
- Primary Care MDT Co-ordinator

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Locally Thurrock has a coterminous Local Authority and Clinical Commissioning Group which facilitates a co-ordinated local response to health and social care needs. Utilising the approach to create federations of GP practices will align the response identified within our ageing well strategy, Building Positive Futures, this strategy focuses on key areas:

- Creating homes and neighbourhoods that support independence
- Creating communities that support health and wellbeing; and
- Creating the social care and health infrastructure to manage demand.

Aligned to the strategy the evidence base we have drawn on is:

- The Health Needs Assessment for the population in Thurrock over 75, undertaken by Public Health
- The data regarding numbers of patients over 75 registered with GP Practices
- The numbers of people aged 65 and over in receipt of care packages from social care (covering Critical and Substantial need)
- Those in receipt of re-ablement services from health and social care
- The number of people attending Accident and Emergency over 65
- The number of hospital admissions for those aged 65 and over and lengths of stay
- Data gathered from our Local Area Coordination
- Housing Data – e.g. from our Well Homes initiative

Ref BCF narrative re: case for change

The above has provided the evidence for us to focus on the implementation of this scheme. Although the number of A&E attendances and hospital admissions for those aged 65 and over may be less than for those aged under 65, the length of stay and the cost of support to the health and social care economy after discharge is far greater.

We will develop the Thurrock model based upon the learning of other pilot sites across the country such as:

- The Torbay Model – which saw reduced use of hospital beds, low rates of admissions for those over 65 and minimal delayed transfers of care (Thistlehwaite 2011)

- The North Somerset Model – which created four fully integrated MDTs to provide case management and promote self care. This model integrated community health and social care works, community nurses, adult social care and mental health professionals (Windle et al 2010)

- The Hereford Model – this saw eight health and social care neighbourhood teams created that focused on chronic illness management such as diabetes, stroke, COPD and lower back pain. (Woodford 2011)

While drawing on other successful models of integrated care this scheme will ensure a focus on the specific needs of the residents of Thurrock and the assets of the communities within the borough.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investments	**Current Service Provider**	**HWB Total £**
Integrated Community Teams	**NELFT**	**3,906,301**
Long Term Conditions	**NELFT**	**415,682**
Primary Care MDT Coordinator	**NELFT**	**51,130**
Carers Grant	**Various**	**178,000**
		4,551,113

Scheme total: £4,551k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Co-location of Health and Social Care will have an impact for the patient with a single point of entry resulting in the correct intervention to support the patient to remain in the community and out of hospital. It will reduce duplication and enhance communication between different service responses.

The various pilot schemes that have been undertaken across the country have seen varying impacts for both health and social care services including (but not limited to);

- Reduced usage of acute beds for those patients under the care of the integrated teams
- Reduced usage of acute beds in the 65 years and over population as a whole
- Reduced admissions and A&E attendances for those under the care of the integrated teams
- Reduced average length of stay for medical non elective admissions
- Reduced delayed transfers of care
- Reduced admissions to long term residential or nursing home care packages

Research by the Buildings Research Establishment has shown the potential to prevent of falls by close working better with housing. The importance of good hydration is also recognised in the Prevention of Urinary Tract Infections.

Through this scheme, we would expect to see a combination of these indicators being delivered. In terms of reduced admissions, there are a number of commonly presenting conditions that we would expect to impact upon through the integration of services (highlighted green). It should be noted that other schemes will also contribute towards this impact – e.g. Frailty Model

Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212	**Urinary tract infection, site not specified**	230
Congestive heart failure	207	**Respiratory failure, unspecified**	164
Atrial fibrillation and flutter	181	**Volume depletion**	146
Fracture of neck of femur: closed	178	**Chronic ischaemic heart disease, unspecified**	145
Tendency to fall, not elsewhere classified	173	**NOT CODED**	138
Acute renal failure, unspecified	164	**Pleural effusion, not elsewhere classified**	135

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Robust data regarding the interventions of the teams within each morbidity cohort will be gathered. This data will support monitoring of effectiveness and outcomes and should include:

- Referral rates
- Outcomes of referrals, health, social care, joint or other interventions
- Length of time maintained out of hospital
- Follow up to ascertain re-entry points to the services

Comparative data form 2012-13 and 2013-14 regarding numbers of admissions to hospital for those patients over 65 to support analysis of effectiveness.

What are the key success factors for implementation of this scheme?
The following factors will be measured to determine the success of the scheme and used in the feedback loop to improve delivery: Proactive management of their disease or condition in the right environment with the right solution Fewer professionals involved in the delivery of care Service user satisfaction Ability to manage and utilise capacity across the system appropriately across the locality Reduction of unplanned admissions to hospital and care homes Creation of MDT approach to targeting patients aged 65 and over at risk of admission to hospital Creation of a more integrated RRAS/Rehabilitation service Good Partnership working Integrated commissioning approaches

Scheme ref no.
BCF Scheme 2
Scheme name
Frailty Model
What is the strategic objective of this scheme?
The Frailty Model aims to provide an enhanced tier of services to The Frailty Model aims to provide an enhanced tier of services to people who live with complex co-morbidities, including dementia and frailty. Health and care services will support older people with complex multiple co-morbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications. The key element focuses on proactively identifying and supporting frail/older people and their carers who are at the greatest risk to prevent deterioration, and proactively supporting frail/older people and their carers to self-care and remain independent. The scheme consists of two key workstreams: I. Pre-emptive identification – as identified through the Locality Single Point of Access as described in scheme 1, treatment and co-ordination of service-users and/or their carers who have social and/or health risk factors through the development of a localised risk

stratification tool and furthermore the use of a frailty risk stratification tool to identify the response required for those who present with complex needs – e.g. more than two long-term conditions.

II. Enhanced community provision for frail, elderly clients to improve their health and social care outcomes whilst realising the ethos of 'Right Time, Right Place, Right Solution' in accordance with each person's preference of care and treatment as denoted in their electronic integrated care record.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

In Thurrock, we are developing a frailty model based on the principles of:

- care wrapped around the patient, whatever the setting of care and which is experienced by them as a single delivery system through multi-disciplinary, multi-organisational integrated care teams
- risk stratification to target the right services, at the right level, to the right people, reducing inequalities by delivering the best possible outcome
- high quality pathways for people to maintain and maximise independence, to live in their own homes and where inappropriate admission to an acute hospital is seen as a system failure
- a sustainable and cost effective system across health and social care, supported by the right financial framework
- transformed services through a seamless and integrated approach to health and social care

As we have said, this scheme is focussed on helping people live with complex co-morbidities, including dementia and frailty. The older people JSNA (attached) provides a detailed analysis of this population within Thurrock. We have targeted this population because we know that people with 2 or more loing term conditions are some of the highest users of health and social care services.

As described within Scheme 1, Thurrock already has a number of integrated services in place between the Council and Community Health Provider (NELFT). These services are aimed at targeting those most at risk of Hospital or residential home admission through a 'right time, right place, right solution' principle, or ensuring that those in Hospital are able to leave hospital and are supported to live as independently as possible in the community whilst at the same time avoiding unnecessary readmissions.

There is a need for this scheme as Thurrock does not currently have a clear frailty model that is inclusive of all of the pathways that older service users may use. The frailty model will also enable evaluation of how services work together to provide support.

The scheme will aim to bring services together into a single integrated service framework that will enable service users to access the appropriate solution and for care to be joined up across providers and systems – including with mental health.

If the scheme was not taken forward then the current service provision would mostly operate in isolation – with the exception of those areas already integrated (e.g. Joint Re-ablement Team, Rapid Response and Assessment Service).

Risk Stratification – Frailty

In addition to an initial risk stratification exercise (ref. scheme 1), once an individual has been identified as having complex needs, a frailty risk stratification exercise will be carried out to

ensure that the individual is able to access the appropriate part of the pathway. The improvement of this approach as part of the scheme is linked to the integration of the Community Geriatrician as described below.

Community Geriatrician
The scheme will build on the learning from the community geriatrician to develop a locality focused community geriatrician offer. Following an initial review, we will be integrating community geriatrician services into the frailty model to better meet the needs of the community. Also, as part of the risk stratification process (as described in scheme 1) to identify individuals with complex needs, the community geriatrician will be positioned at the single point of access. This will ensure that individuals will be referred to the right part of the pathway quicker as a result and will also be identified as complex at the earliest opportunity. This will be a distinct difference to what happens currently and will have an impact as a result.

Single Care Plan and Care Co-ordination
The benefit of the community geriatrician being at the Single Point of Access (SPA) will enable individuals with complex needs to be identified earlier and ensure that they access the right part of the pathway. A key element of this will be the development of a single care plan and a co-ordinated approach to that individual's care. A key impact of this will be a reduction in the number of professionals that the individual sees in addition to an improved experience.

Rapid Response and Assessment Service (RRAS)
As part of the scheme, we will continue to build on the successful integrated RRAS service. Our service is aimed at those individuals who we think are likely to reach crisis point within 72 hours and co-ordinates and redirects care to the appropriate intermediate provider or service. The service has recently been evaluated and the recommendations from the evaluation will be considered as part of the work to be carried out during 15/16.

Menu of Choices
The success of the scheme is reliant to a great extent on the menu of choice that exists – which offers choice other than admission to hospital. A number of existing and developing services will be integrated within the approach which includes:

- Interim beds
- Step up beds and step down beds
- Extra care housing

The menu of choices as part of the frailty scheme link closely with scheme 3 – 'Intermediate Care' and should be read in conjunction with that scheme.

End of Life
Our model includes our desire to build on a good 'end of life' which we will aim to further enhance across the frailty pathway. Building upon the proactive end of life care coordination within Thurrock, we would aim to strengthen the identification and prognostic indicators for the monitoring of patients reaching the final year of life. This would include: maintaining the coordinated care register for end of life; ensuring advance care planning takes place; and embedding the delivery of end of life education across all care providers. Currently, 100% of all patients added to the coordinated care register all have an advanced care plan within 3 months.

Assistive Technology
Whilst we have used assistive technology solutions for some time, as part of the scheme, we will be building on the evaluation of the successes the community provider has had with telehealth – e.g. disease specific heart failure patients to facilitate discharge from acute and has improved quality of life and empowered patient to know more about their disease research project, successful management of Long Term Conditions through telehealth. Evaluation has shown that proactive telecare has reduced non-elective admissions(as contained within QIPP)

Older People with Mental Health

We have a very well established Older People Mental Health team, which as part of our social care fieldwork restructure has been strengthened. We plan to integrate further with other health colleagues, and we are looking towards the single point of access for GPs to include mental health to ensure a quick response in crisis. Co-location of this service will further enhance joint working with other services. Thurrock Council's Dementia Strategy has been recognised as an exemplar and this involves all services working together to meet the needs of people with dementia in the community currently being driven forward through our dementia friends training programme. A weakness at present is that we do not have a single pathway for people with dementia. Creating a pathway, including mental health will be a distinct improvement as part of the development and implementation of the BCF scheme.

Care Homes
As part of our plans to build on an integrated frailty pathway and reduce unnecessary admissions to Hospital, we recognise the need to support individuals residing in residential and nursing homes to ensure that they receive a timely response from RRAS and community teams. We have initiated Multi Disciplinary Team meetings in care homes via the community geriatrician reviewing all patients to identify those most at risk. Fewer people are going into hospital as a result. We have also undertaken training for care home staff and employed a dedicated Community Psychiatric Nurse to work with care homes to ensure mental health needs are identified. Further integration and development as part of this scheme will further strengthen our approach.

Ambulance Service
The frailty model's success relies on an integrated approach across all partners. This includes the local ambulance service. Work has and continues to be carried out with the ambulance service so that they understand the 'menu of choice' that exists over and above hospital admission. We are confident that this is preventing some unnecessary admissions to hospital.

The key milestones for the Frailty Model Scheme include:

- Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
- Single Care Plan and Care Co-ordination– September 2015
- RRAS Service development – September 2015
- Assistive Technology forward plan – January 2016
- End of Life strategy – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This primarily affects the following commissioners;
NHS England (Primary Care)
Thurrock CCG (Acute and Community Care)
Thurrock Council (Social Care Services)

And following providers;
General Practice
Basildon and Thurrock University Hospital NHS Foundation Trust
South Essex Partnership NHS Foundation Trust
North East London Foundation Trust
Thurrock Council
Ambulance Service
Other smaller partners – e.g. voluntary sector

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Community Geriatrician Service
The introduction of the community geriatrician service has already shown evidence of success – for example the cost of geriatric medicine remained static from 2011/12 to 2012/13 (Thurrock CCG QIPP workbook). We feel that the impact of the service can only improve with the community geriatrician being at the forefront of the Single Point of Access as described within the scheme.

Telehealth
The use of telehealth has led to some noticeable improvements. This included a 33% reduction in the number of patients having an acute admission, and 48% reduction in acute activity costs between pre-telehealth and post-telehealth use (Thurrock CCG QIPP workbook).

Primary Care MDT
Although only limited evidence is available for the effectiveness of primary care MDTs, there are some good examples of where interventions on specific disease areas have improved outcomes. For example, the Kwok, Rice and Module review of MDTs identified the following benefits in heart failure and COPD:

Heart Failure:
- A lower rate of readmissions (7.8% vs. 25.5% over 3 months);
- Reduced Hospital stay; and
- 6 patients required to be part of a MDT to reduce hospital admissions by 1.

COPD:
- A lower rate of readmissions (51% vs. 69% at 12 months);
- Better patient knowledge (81% vs. 44% inhaler compliance, 71% vs. 37% for earlier treatment during exacerbation); and
- Reduced hospital bed stay and improved physical and emotional aspect of COPD.

Early indications are that patients who have a Primary Care MD accumulate on average 34% less on non-elective activity 3 months post review compared to 3 months prior to review (Thurrock CCG QIPP workbook)

End of Life
A 2014 review of providing palliative care (Picken and Cakmak) stated that 'nationally 63% of people would rather die at home. This contrasts sharply with 2012 statistics for England showing only 42.4% of deaths at usual residents with 52% in hospital'.

RRAS
Analysis of RRAS performance data April-October 2014 shows 1917 referrals and 1429 interventions/visits. Only 2.8% of people visited and assessed went into hospital (this is below the operating target of 7%). In particular, RRAS has an impact on non-elective attendances linked to COPD and UTIs in particular.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total:

£4,379k

Investments	**Current Service Provider**	**HWB Total £ 000**
End of Life Team	NELFT	389
Day Hospital Assessment and Treatment	NELFT	389
Admission Avoidance	NELFT	126
Continence Service	SEPT	62
Community Geriatrician	NELFT	84
Rapid Response and	NELFT & Local Authority	606

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The cohorts of patients that would be identified and managed through this programme are similar to those in the locality integration project. Therefore, we would expect to impact of the similar range of presenting conditions – in particular those conditions/diagnoses linked to COPD and UTIs;

Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	Essential (primary) hypertension	348
Lobar pneumonia, unspecified	398	Chronic obstructive pulmonary disease with acute lower respiratory infection	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	Acute renal failure, unspecified	287
Unspecified acute lower respiratory infection	229	Atrial fibrillation and flutter	279
Pneumonia, unspecified	212	Urinary tract infection, site not specified	230
Congestive heart failure	207	Respiratory failure, unspecified	164
Atrial fibrillation and flutter	181	Volume depletion	146
Fracture of neck of femur: closed	178	Chronic ischaemic heart disease, unspecified	145
Tendency to fall, not elsewhere classified	173	NOT CODED	138
Acute renal failure, unspecified	164	Pleural effusion, not elsewhere classified	135

Impact Assessment - RRAS

- Assuming the average cost of an A&E attendance is £114 (2012/13 NHS reference cost data)
- Assuming that 25% of RRAS cases that proceeded to assessment had potential for hospital admission that was subsequently avoided by RRAS intervention
- In the year to date, this would mean 357 cases (from a base of 1429) at a cost of £114 per case = £40,726
- Assuming the standard day rate for residential care placement is £425.84
- Potential residential care services avoided by RRAS interventions is estimated by workers to be 227 in year to date which equates to 453 over a full year period
- Assuming a conservative estimate that only 25% of these cases would in fact have required a minimum of a day residential care means a saving of £24,272 in year to date with a projected year end saving of £48,119

We have already described within the supporting evidence section the impacts we expect the scheme to make based upon existing evidence:

- Early indications are that patients who have a Primary Care MD accumulate on average 34% less on non-elective activity 3 months post review compared to 3 months prior to review (Thurrock CCG QIPP workbook)
- The use of telehealth has led to some noticeable improvements. This included a 33% reduction in the number of patients having an acute admission, and 48% reduction in acute activity costs between pre-telehealth and post-telehealth (Thurrock CCG QIPP workbook).
- RRAS impact as above

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive.

Additionally, performance related to the scheme is already collated via existing arrangements – e.g. via the re-ablement scorecard and provider monitoring.

What are the key success factors for implementation of this scheme?

- Reduction of unplanned admissions to hospital and care homes
- Admission avoidance
- Increased use of community solutions
- Increased numbers of people ending their life in a setting of their choice
- Increased use of telecare – knowing that 33% of users avoid an acute admission as a result

The key performance indicators that relate to this scheme are:
- Non-elective admissions
- Residential admissions
- Patient and Service User Satisfaction

Scheme ref no.

BCF Scheme 3

Scheme name

Intermediate Care

What is the strategic objective of this scheme?

The focus of Intermediate Care is admission avoidance with a clear remit to ensure that robust discharge planning is in place, that effective rehabilitation and re-ablement take place before CHC assessments, and that any long term support is put in place in a person centred way to make sure each individual has as much choice and control as possible.

This scheme will enhance the provision of care and support that is delivered away from the persons home but is but of hospital care. The scheme will increase the range of settings in which re-ablement, and physical and mental health care can be provided. It will also extend the range of people who use those settings. The scheme aims to achieve the following objectives;
- providing a discharge to assess model for continuing healthcare (CHC) which will ensure patients achieve their optimal re-ablement capability prior to a CHC assessment being undertaken
- Reducing readmissions to hospital from care homes
- Increasing the availability of step up provision (to avoid acute admissions).
- Improving the contractual efficiency of bed based intermediate care services commissioned by the NHS Thurrock CCG and the Council.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

There is considerable investment by both the CCG and LA in Thurrock for intermediate care and support. The focus of the scheme is to develop this investment further by realigning the current mainly bed based provision to afford the opportunity in year to make better use of and change existing services.

The scheme consists of several components;

a) Establishing a non acute rehabilitation/assessment pathway (pilot)
This will be a pilot project to Commissioning an intermediate care rehabilitation and assessment pathway across Collins House the LA residential provision and the NELFT Community Hospital together with part of the Mount Nessing Court provision for rehabilitative dementia care and support. The focus of this element of the project is to create a far more effective and responsive pathway to move people into the long term solution more effectively reducing the time frame for bed use.
    - To support this the scheme will commission an enhanced domiciliary provision to enable service users/ patients to be discharged to where they live so that a detailed assessment can be carried out focusing on the outcome of maintaining them where they live This will mean that people will move on more quickly either from hospital or bed based rehabilitation services back to where they live this could be residential support, sheltered accommodation or their own home.

b) *Establishing a non acute rehabilitation/assessment pathway (pilot)*
    - Commissioning an intermediate care rehabilitation and assessment pathway across Collins House/NELFT Community Hospitals and part of Mount Nessing Court (specifically for dementia care)
    - Commissioning an enhanced domiciliary provision to enable service users/ patients to be discharged to assess within their normal place of residence
    - Reviewing placements to identify opportunities/challenges associated with the provision of out of hospital health care
    - significantly reducing the number of CHC assessments undertaken in BTUH. The new pathway would improve patient experience through a package of re-ablement/rehabilitation so reducing long term care needs and improving outcomes.

c) *Promotion of step up and step down facilities*
    - Working with GPs, Community Staff and East of England Ambulance Service to promote the usage of step up/step down to facilitate discharge and reduce non elective admissions.

d) *Contract review of bed based services*
    - Joint review of all existing commissioned services to identify contractual efficiency opportunities. This resource will be reinvested in supporting the implementation of the Care Act.

e) *Supporting carers*

- Carers are seen as a key part of the multi-disciplinary approach to timely discharge and admissions avoidance (as in Scheme 1) and so identifying the requirements of carers will be a central part of our intermediate care offer.

f) *The Joint Re-ablement Team*
    1. Council provided adult social care integrated with the NHS community service provider aimed at preventing readmission to hospital through proactive re-ablement.

Intermediate Care offer will also be used to explore the fullest range of care and support options available to patients / service users, including self funders through our information, advice and guidance service (see diagram in BCF Scheme 1 for more detail)..

The key milestones for the Intermediate Care Scheme include:

- New rehabilitation/assessment pathway pilot - April 2015
- Roll out Carer Support – April 2015

- Contract Review of bed based services –June 2015
- Review of rehabilitation/assessment pathway pilot including Step Up and Step Down facilities – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme affects the following commissioners and providers;

Provision	Commissioner	Provider
Acute Based Care	NHS Thurrock CCG (alongside Basildon and Brentwood CCG as the lead commissioner)	Basildon and Thurrock University Hospital NHS Foundation Trust
Out of Hospital health care	NHS Thurrock CCG Thurrock Council Jointly Commissioned (Better Care Fund)	North East London Foundation Trust (Thurrock Community Hospital) South Essex Partnership NHS Foundation Trust (Mount Nessing Court Thurrock Council (Housing – extra care housing and Adult Social Care – Collins House care home) Private and voluntary care home and extra care housing providers

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There have been a series of similar pilots across the country looking at the discharge to assess model notably Cambridge and Peterborough, Sheffield Frailty Unit and Wakefield. These have all influenced the proposal to develop and improve intermediate care in Thurrock.

<u>Re-ablement Performance:</u>

- 280 people completed re-ablement with the Joint Re-ablement Team in the year to end Sept 2014. Average of 47 per month
- Projecting this over a full year estimates 564 people completing – a rate of 46 per 10,000 population aged 18+
- Around 75-80% of people tend to be 65+. Assuming a fixed rate of 75% over a year this would 423 people aged 65+ completing – a rate of 200 per 10,000 population 65+
- 66% of completers in the year to date resulted in a reduction or end in support (185 cases)
- The number of people completing re-ablement continues to show an increasing trend and the proportion of people completing with a reduction or end in support is rising on previous years
- Projecting this over a full year period estimates 372 people ending with a reduction or end in support
- 96.7% of people receiving re-ablement self-report that ‘their quality of day to day life had improved following support’.

In Quarter 2 2014/15 (July-August) there were 16 departures from the Collins House Interim Residential Care beds. In the year to date there have been 28 departures. The destination of these individuals are as follows:

	Quarter 2	Year to Date
Returned to the Community	7 (43.8%)	11 (39.3%)
Moved to Extra Care	1 (6.3%)	3 (10.7%)
Moved to Residential Care	6 (37.5%)	11 (39.3%)
Admitted to Hospital	2 (12.5%)	3 (10.7%)
Total Departures	16	28

It is assumed that by providing re-ablement services and enhanced health care services in a wider range of out of hospital settings more service user/ patients will regain skills and confidence for independent living.

A recent review of existing step up and step down provision in Thurrock has identified a gap – people who do not need rehabilitation or re-ablement but who have health care needs which cannot at the time be met in their own home. Too frequently these cases use beds within BTUH when hospital care is not what they need. In other cases, health care away from home is required until the patient/ service users home is adapted or their informal care arrangements are available (this includes intermediate care to provide respite to carers)

The scheme will use available funding to meet the costs of accommodating the service user/patient ranging from residential care to extra care housing. The accommodation will be commissioned from within the Council's housing and care home estate, and through the private and voluntary sector. The market position statement will be used to help shape this offer.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total: £5,035k

Investments	Current Service Provider	HWB Total £
Joint Re-ablement Team	NELFT & LA	1,168,794
Mount Nessing Court	SEPT	704,800
Intermediate Care Beds	NELFT	2,585,738
Collins Hse Intermediate Care Beds	LA	576,333
Total		5,035,665

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Whilst this scheme is likely to have a limited impact on overall numbers of admissions, we would expect there to be an impact on both readmissions and admissions into residential care placements.

Below is a summary of the projected growth of social care admissions into standard, dementia and nursing placements without any interventions. Through this scheme we would expect to stem the growth across all placement types.

	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Residential & Nursing Placements	311	324	334	344	350	358
Dementia Placements	70	77	80	82	84	85
TOTAL	381	401	414	426	434	443

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Well-being Board.

Provider engagement will be through specific pathway development meetings, formal contract management, the Strategic Leader's Group and the Market Position Statement.

What are the key success factors for implementation of this scheme?

The key success factors in relation to this scheme are;

a) successful implementation of a discharge to assess model
b) enhancement of capacity for health care away from home in an out of hospital setting
c) reduction in the number of cases requiring continuing healthcare and a reduction in the needs/case mix for those who are eligible for CHC.
d) Increase in the volume of step up/step down cases
e) A reduction in the cost of commissioned bed based care
f) A reduction in the requirement for care and support services after re-ablement.

Scheme ref no.

BCF Scheme 4

Scheme name

Prevention and Early Intervention

What is the strategic objective of this scheme?

The objective of the scheme is to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health and social care system.

Ultimately our vision is for prevention and early intervention to become embedded within our locality approach (working within and alongside the communities they serve), and to be fully unified around the individual needing a solution (bringing together all interventions designed to manage demand and prevent crisis); Thurrock's vision for whole system re-design being predicated on the concept, "right place, right time, right solution". Through utilising the opportunities created for pooling resources within the Better Care Fund, we are confident that this transformation can be accelerated.

The scheme initially focuses predominantly on embedding and further developing our Local Area

Coordination (LAC) offer. The LAC offer is open to everyone over the age of 18 who has the potential to place demand on a service. LAC has already had notable evidence of success – including admission avoidance – in the 14 months it has been established, and this scheme aims to build on and further that success.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- **What is the model of care and support?**
- **Which patient cohorts are being targeted?**

Thurrock is engaged in a whole system transformation focused upon a shift of resources towards timely intervention and prevention, part of which has been captured within the BCF to enable the pooling of key resources. The overarching vision for the system, places 'right time, right place, right solution' at the heart of the design. The redesign features three key aspects:

- Right Time – ensuring people receive the intervention most likely to support wellbeing at the point at which it will have most impact;
- Right Place – ensuring the homes that people live in and the communities in which they reside support their health and active ageing; and
- Right Solution – either service or other support designed to promote independence and maintain quality of life.

The broad transformation includes significant activity currently outside the BCF (for example work with our housing colleagues and private developers to drive up the quality of older people's housing designed to Housing our Ageing Population Panel for Innovation (HAPPI) standards, bringing forward a Council - wide programme of community hubs) and our work within communities building resilience using a strength-based approach under the Council's 'Stronger Together' programme. We are also working with Housing on a Well Homes initiative. Finally, a number of other key initiatives are currently in development and will feature in future pooled fund arrangements as the programme develops – for example a post-diagnosis community based integrated dementia service.

The scheme consists of several components which includes:

Local Area Coordination
Thurrock successfully implemented a pilot Local Area Coordination initiative (LAC) in July 2013, beginning with 3 LAC's funded through the deletion of three social work posts. An initial evaluation 4 months into the pilot already showed clear evidence of the impact of working in this way upon marginalised people, most of whom were previously unknown to social care services. Because referral routes, eligibility criteria and assessment and care management techniques were not a feature of the entry point into receiving support, this model represents a 'new front door to services', ensuring people who were outside of the care system, or who had fallen between various "siloed" services received comprehensive support. The LAC model is based upon a western Australian scheme that over the past 25 plus years has proved its effectiveness in supporting marginalised groups in becoming more resilient and self-managing.

Recognising that the initiative is about supporting vulnerable and marginalized people and acknowledging the high percentage of fire deaths that impact this group, the Fire Service have seconded a senior fire officer in to the team, seeing the LAC role as fundamental to their shift from an emergency response service and towards a prevention model of delivery . Early successes with specific groups such as hoarders provide clear evidence of the impact on fire prevention. However, because of the way LAC's provide support, there is also significant proof of impact across a very broad range of support needs for this group.

The initial success evidenced by the 4 month report enabled the LAC programme to be expanded through the agreement for public health to fund an additional three posts as part of their

prevention and reducing health inequalities programmes. The six LACs have now been working in Thurrock for the past 14 months and a more in-depth analysis has been recently produced. Key findings that allow us to evidence the potential impact of this initiative are included within the 'evidence base' section.

Because of the compelling evidence provided from a number of key professionals including GPs, psychiatrists etc., the BCF identifies CCG funding to further expand the programme by recruiting 3 additional LACs, who once in place, will provide full coverage across Thurrock. It is recognised that cost benefit analysis around prevention and early intervention, especially where the intervention impact may be longer term, is remarkably difficult to prove. With this in mind, Thurrock Council with Derby City Council is engaged with the University of Birmingham to develop an academically accredited evaluation tool. We are confident that the evidence provided will establish very clear cost benefit analysis supporting the financial case for deploying Local Area Coordination and that in the future additional integrated funding may be approved to further expand the service.

Falls Prevention Programme
The review and further development of a comprehensive falls prevention programme that provides multidisciplinary assessment, a programme of falls risk reduction (including exercise programmes, adaptations, prescribing interventions etc.) and on-going follow up (to maintain compliance and benefit). This will target patients that have experienced falls (to reduce recurrence) in addition to those identified as at risk by primary care, community services (health and social) and acute services. Work will align with the Housing-based Well Homes project which works with private sector housing to ensure that homes promote health and wellbeing – including the identification and rectification of trip hazards. This is an initiative funded through the Public Health resource within this scheme.

Public Health-led review of emergency admissions
Through the Whole System Redesign Project Group, public health are leading work in conjunction with the CCG, social care, and primary care to review cases of emergency admissions in certain practices with high levels of admissions over a 12 month period. The review hopes to identify those patients that could be avoided from accessing unplanned care by better management in the community.

Given the potential that exists to build upon a strong local community, part of the work will include improving connectivity and further enhancing resilience to explore the possibility of neighbourhood solutions to key causal factors for poor wellbeing such as bereavement and loneliness - there is a clear link with those bereaved and/or lonely and avoidable admissions.

The findings of the work will be used to inform system changes aimed at preventing admissions.

Improved Efficiency of Commissioning of Equipment including: promotion of self-care, prevention, integration of services, and improved accessibility and public education
Though pooling our resources in a single place with our community health provider, we are hoping to drive efficiencies through the following approach.

Single Integrated Service Model for Community Equipment
Health and social care currently operate two separate models for the provision of community equipment; according to their statutory obligations. Part of this initiative that will see the emergence of a fully integrated community equipment model of care. The revised model will see a seamless pathway for each patient, irrespective of traditional organisational responsibilities or point of entry. This part of the scheme's initiative will realise improved efficiencies across existing service provision (currently responding to substantive and critical needs).

Improved self-care, prevention and accessibility of equipment
The second part of the scheme's initiative has ambition to promote self-care prevention; and

thereby increasing the number of patients taking individual responsibility for fulfilling their moderate equipment needs (not currently funded). To facilitate these benefits the pathway will introduce improved accessibility to equipment informed on the national retail model, improve public education of need and promotion of self-assessment.

This model will also interface with the risk stratification of Thurrock residence (encompassing physiological and social indicators) to ensure targeted promotion and uptake is facilitated.

We will review and redesign existing and new initiatives and pathways as part of our Whole System Redesign Group.

The key milestones for the Prevention and Early Intervention Scheme include:

- Pathways review – access to equipment – April 2015
- Options Appraisal for Retail Model & Implementation – June 2015
- Conduct Public Health-led review of emergency admissions – June 2015
- Falls Prevention programme review and development – June 2015
- Recruitment of further 3 LACs – April 2015
- Local Area Coordination – 2 year evaluation July 2015
- Local Area Coordination & GP initiative to target frequent users of A&E, ambulance services as part of public health-led review of unplanned admissions – September 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme affects the following commissioners and providers:

Provision	**Commissioner**	**Provider**
Essex Equipment Services	Thurrock CCG (through a Section 75 agreement managed on our behalf by North East London Foundation Trust) Thurrock Council (direct 75)	Essex Cares (provider arm of Essex County Council).
Local Area Coordination	Thurrock Council, Essex Fire and Rescue Service, Thurrock CCG	Thurrock Council
Public Health Commissioning	Thurrock Council	NELFT Voluntary and Community Sector
Falls Prevention	Thurrock Council	NELFT
Stroke	Thurrock Council	Thurrock Council

The evidence base
Please reference the evidence base which you have drawn on
- **to support the selection and design of this scheme**
- **to drive assumptions about impact and outcomes**

We have carried out a fourteen month evaluation report of our Local Area Coordination project. We have also made some assumptions based on existing LAC caseload that has allowed us to model the impact of this initiative. The facts and assumptions we have made are as follows:

- The post-18 population in Thurrock is 120,200
- We believe that the potential cohort for Local Area Coordination in Thurrock as a

percentage of the over 18 population could be as high as 10% - approximately 12,000 people
- However in reality each LAC works with an average caseload of 60 people (based upon experience from Western Australia) which equates to 450 people at any one time (60 x 9 LACs)
- 31% of the caseload relates to older people which is the primary focus of our BCF

The financial cost of the LAC initiative is between £150k (initial period of three LAC's p.a.) - £300k (6 LAC's) in total to date. Current agreed deployment (utilising BCF funding) is £450k with 9 LACs recruited and full coverage of the Borough. (because the model is completely "agile" in terms of working pattern and utilising community assets, there is no estates costs attached to the scheme and very little capital funding required apart from equipment to support mobile working)

The unit cost of supporting 256 people (total number of people supported to date) by approx £200k over 14 months (the £200k takes in to account the variance in cost over the life over the initiative to provide an approximate average cost - started with 3 LACs and £150k investment rising to 9 LACs at the end of the fourteen months) = £780 cost per person over 14 months.

Therefore the average caseload per LAC = 60 people x £780 = £46,800

The fourteen month review has allowed us to make some assumptions on what the LAC initiative has and can save – based on the number of people who have been supported to avoid a service intervention and evidence from professionals, LACs, and those supported. The impact of the initiative includes the following unit of prevention cost:

Cost	Unit of prevention cost	Impact
£125	Per hour GP visit	Fewer people seeing a GP as a result of LAC involvement – particularly regarding social isolation
£956	Annual cost of depression	Over 75 people introduced to LAC have identified depression as one of the main challenges they face, with a high percentage having reported an improvement in their depression
£445	Mental Health overnight stay in hospital	Reports of people who have avoided a potential admission to hospital
£162	Mental Health Community Provision	Reduced need for mental health professionals
£1779	Episode of inpatient care	Individuals supported who are likely to be admitted to hospital without support
£510	Adult Social Care assessment	A number of individuals have been referred to the LAC who would otherwise have received a social care assessment
£65	Day care provision	A number of individuals have avoided Day Care services due to alternatives in the community being found – on average people attend day care for 2 days a week at £65 approximately per day

£7095	Complex eviction case	At least one individual supported to date has avoided eviction as a result of support received
£1962	Annual cost of alcohol abuse to NHS	A number supported have reduced or stopped their alcohol intake
£7744	Income support claimant entering work	At least one example of an individual being supported back in to work – with a number of others working towards this goal
£3568	Average response to a fire	A number of people are supported to make their home safer – with 3 individuals to date at high risk of fire due to their environment and lifestyle
£10.50	Volunteering per hour contribution	13 people have been supported in to volunteering

Our evaluation report reflects clear evidence of how we have kept people out of services and equates that to potential savings made.

With regards to our Falls initiative, our 'Health Needs Assessment for the over 75 year old Thurrock population' written in July 2014 predicted that 32% of that cohort were predicted to have a fall, with 4% likely to be admitted to hospital as a result of a fall.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total:
£1,965k

Investments	Current Service Provider	HWB Total £000
Community Equipment	NELFT	1,533
Local Area Coordination	Local Authority	147
Stroke Prevention	Local Authority	35
Public Health	NELFT	250

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of the scheme with reference to the LAC initiative has already been demonstrated in the 'evidence base' section. We have also commissioned Birmingham University to develop an accredited evaluation tool to enable us to more accurately measure the true benefits and impact of this important initiative.

We recognise that community equipment is key to prevention and early intervention. We will work with our community health provider to evaluate further efficiencies and improvements in the way in which we provide community equipment.

We know that falls is a key reason for people aged 65 and over having an unplanned admission. We will look to review and further develop the programme so that it continues to identify and focus on the cohort most likely to have a fall. We are already working with housing colleagues through the Public Health funded 'Well Homes' project to help improve private sector

accommodation including the reduction of fall hazards.

Based on the evidence, we would expect that the falls programme would directly impact upon the highlighted diagnoses categories below as well as having a indirect impact on other reasons for admission. A discussed in the 'evidence' section, it is estimated that 32% of people aged 75 and over will have a fall, with 4% of those being admitted to hospital. We know that the average cost of an admission for someone aged 75 and over at Basildon Hospital is £3419, therefore just 1% of those aged 75 and above being prevented from being admitted to Hospital would equate to a saving of £351,302 and reduce attendances by over 100 (4% of 75 and over = 411).
Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014) X indicates those areas we believe LAC and other timely intervention support could reduce admissions.

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523 ***X***	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398 ***X***	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229 ***X***	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212 ***X***	**Urinary tract infection, site not specified**	230
Congestive heart failure	207	**Respiratory failure, unspecified**	164
Atrial fibrillation and flutter	181	**Volume depletion**	146
Fracture of neck of femur: closed	178 ***X***	**Chronic ischaemic heart disease, unspecified**	145
Tendency to fall, not elsewhere classified	173 ***X***	**NOT CODED**	138
Acute renal failure, unspecified	164	**Pleural effusion, not elsewhere classified**	135

Therefore we believe more timely and local interventions could have a significant impact upon 6 of the top 10 most common presenting conditions amongst the over 65 population in Thurrock; with the other 4 being more likely to be improved through much longer term preventative measures. There is already evidence that joining up all prevention activity will lead to improved outcomes. For example it is acknowledged that campaigns around smoking cessation and obesity which provide the general population with information and advice have limited impact. There is already some local evidence that providing such advice through the LAC (which offers individual, trust based style of support), improves the likelihood of take up of rehabilitation in cases of substance misuse; it seems logical to combine such an approach with broader cessation and management programmes to improve take up and sustainability.

We would expect this scheme to contribute to our key metrics of:

- Non-elective admissions
- Residential admissions
- Service User/Patient Satisfaction

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. The role of this group will be to develop and sign off project plans, monitor implementation and review impact.

Provider engagement will be through specific pathway development meetings, formal contract management and the Strategic Leadership Group.

Additionally, we have a fully developed performance management framework for our Local Area Coordination initiative.

What are the key success factors for implementation of this scheme?

Commissioning of Equipment:
The key success factors in relation to this scheme are;

a) Delivery of efficiencies from the integrated commissioning hub for equipment (reduction in price for commonly ordered items)
b) Implementation of retail model
c) Access to equipment for all key admission avoidance pathways

With regards to the LAC initiative:

- Number of people supported by LAC which leads to an individual avoiding need for a service (both acute or community based) or reducing demand for service
- Conversion rates of service users to volunteers
- Socially isolated people reconnected with their community
- Prevention of homelessness
- Number of people receiving equipment that require a reduced level of service or no service
- Reduction in use of medication for people supported by LAC
- Reduction in alcohol dependency or drug misuse
- Fire prevention

As previously mentioned, the Council has commissioned Birmingham University to develop a method of measuring the impact of the LAC.

Scheme ref no.

BCF Scheme 5

Scheme name

Disabled Facilities Grant and Social Care Capital Grant

What is the strategic objective of this scheme?

Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants.

The Community Capacity Grant to local authorities, provides capital funding to support development in three key areas: personalisation, reform and efficiency.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Mandatory DFGs are available from local authorities, subject to a means test, for essential adaptations to give disabled people better freedom of movement into and around their homes and to give access to essential facilities within the home.

The Community Capacity Grant is a principal component of our work to promote Asset Based Community Development. It is an approach to community building which transforms the way

communities are seen, focusing on strengths and assets and connecting people and networks around common interests and concerns. This contrasts with the deficit model which typically characterises communities in terms of needs and deprivation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Council's Private Housing & Adaptation Service is working closely with Adult Social Care, Health and Public Health to improve independence at home. DFGs are delivered in partnership with our local home improvement agency the Papworth Trust.

Asset Based Community Development is being used to re-engineer our fieldwork services to be community facing, working in conjunction with Primary Care MDTs and community hubs. It also supports our work to raise the profile of attractive, high-quality housing for older people, and the benefits this can bring to health and wellbeing.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Disabled Facilities Grants provide an important mechanism for supporting people with disabilities to live independently. When delivered early, alongside other preventative measures, they may contribute to preventing admissions to hospital and residential care.

Asset Based Community Development complements the ambition of the Better Care Fund to deliver services that:

- are built around people and their communities
- work together effectively to achieve outcomes, including an integrated health and social care system
- prioritise timely intervention and prevention, reducing inequalities and promoting equalities
- improve performance and reduce costs and are open and accountable, including investment in leadership and workforce development
- are person-centred and offer flexibility and choice.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Disabled Facilities Grant £481,000

Capital Grant (provisional allocation): £358,902

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Our aim is to use DFGs to maximise a resident's independence and quality of life.

Asset Based Community Development is focused on communities, strengthening the connections between people and informal associations around common interests and concerns.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The performance of services funded by these grants will be monitored by the Pooled Fund

Manager and reported to the Partnership Board on a quarterly basis.
What are the key success factors for implementation of this scheme?
The scheme will be monitored for its contribution to the reduction in total emergency admissions and the reduction in admissions to residential care homes.

Scheme ref no.
BCF Scheme 6
Scheme name
Care Act Implementation
Overview of the scheme
The Schemes purpose is to deliver the requirements of the Care Act, ensuring that the Council are compliant and that existing services are not adversely affected by increased costs.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Scheme total: £522k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The scheme will allow the following themed requirements in particular to be delivered: • Carers – placing carers on a par with users for assessment; and introducing a new duty to provide support for carers; • Information advice and support – provision of advice and support to access and plan care, including rights to advocacy; • Safeguarding – implementing new statutory responsibilities; • Assessment and Eligibility – Setting a national minimum eligibility threshold, providing continuity of care for people moving in to the area until reassessment; and • Capital funding – capital investment funding including IT systems.
What are the key success factors for implementation of this scheme?
The key success factors in relation to this scheme will relate to our ability to implement the requirements of the Act seamlessly and without impacting negatively on user experience.

Scheme ref no.
BCF Scheme 7
Scheme name
Payment for Performance
What is the strategic objective of this scheme?
This scheme is the provision for the payment for performance. As such, the provision is two fold (dependent on the performance of the system in 2015/16). a) In the event of the required reduction in unplanned care admissions failing to be

delivered, this resource will be utilised to fund commensurate activity in local acute trusts.
b) In the event of the required reduction in unplanned care occurring, this resource will instead be utilised to fund a series of initiatives (currently being identified) that further improve out of hospitals care to our population.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

a) Transaction with acute providers to cover the cost of unplanned care episodes (primarily Basildon and Thurrock University Hospital NHS Foundation Trust).
b) If the target is achieved, this resource will be invested into schemes that align with the other schemes outlined within this document (i.e. BCF1-6). The concise detail of the investments is to be determined.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Scenario A – target not achieved

Commissioner – Thurrock Clinical Commissioning Group

Provider – Acute Trusts (primarily Basildon and Thurrock Hospital NHS Foundation Trust)

Scenario B – target achieved

Commissioner
Thurrock Clinical Commissioning Group
Thurrock Council

Providers
To be determined but from the following;
General Practice
Basildon and Thurrock University Hospital NHS Foundation Trust
North East London Foundation Trust
Thurrock Council
Other smaller Private and Voluntary Sector providers

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Scenario A – this is a transactional process and therefore no evidence based is required

Scenario B – the evidence base for each proposed investment will be identified as part of the business case developments.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£722k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Scenario A – no impact,
Scenario B – the precise impact will be identified as part of the business case development process. However, the investments will reinforce the aforementioned impacts within BCF Schemes 1-6

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. The role of this group will be to develop and sign off project plans, monitor implementation and review impact.
Provider engagement will be through specific pathway development meetings, formal contract management and the strategic leaders forum.

What are the key success factors for implementation of this scheme?

Scenario A – Transactional process, not applicable
Scenario B
- clearly defined business cases for investment
- clearly defined expected outcomes that align with the BCF's objectives
- clearly defined outcome measures
- implementation of an effective prioritisation and approval process for the business cases
- implementation and delivery of the service changes proposed in the business cases
- review

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	Basildon and Thurrock University Hospital Trust
Name of Provider CEO	Claire Panniker
Signature (electronic or typed)	Claire Panniker

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Thurrock Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by the Trust in order to reduce our emergency bed base allowing either closure or alternative use.

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	North East London Foundation Trust
Name of Provider CEO	John Brouder
Signature (electronic or typed)	John Brouder

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Not fully – NELFT would like to fully understand the forecasting and how the final outturn was agreed. Would be helpful to align to schemes also
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	NELFT have not had the opportunity to be able to review and analyse the detailed impact of the schemes which are described in the BCF but NELFT are fully committed to work with Thurrock Health and social care partners in order to achieve a consensus and agree joints plans
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	NELFT are committed to seeing a reduction in unplanned care admissions and welcome the opportunity to develop services which enable the people of Thurrock to be cared for appropriately in their community

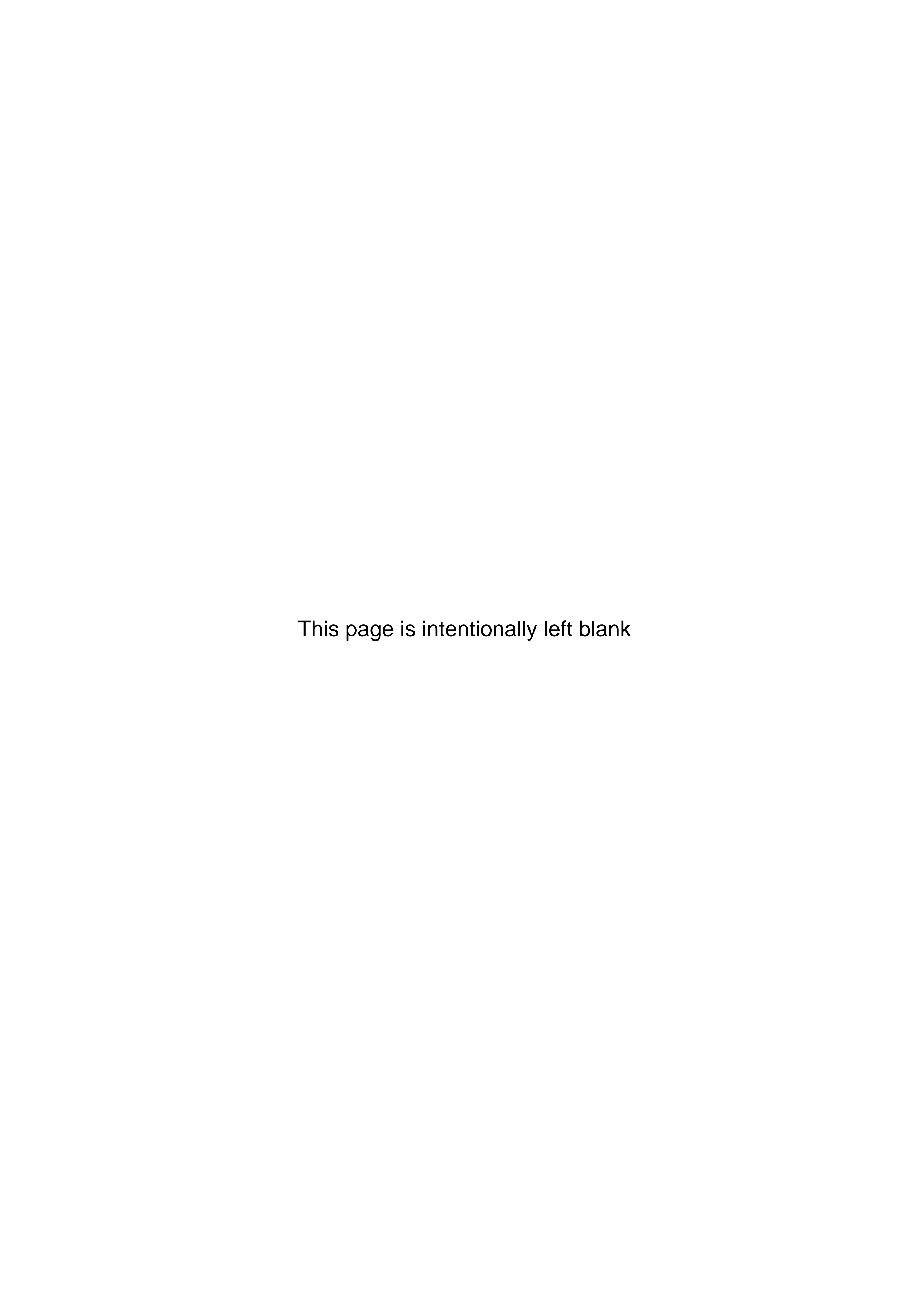
Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	South Essex Partnership Trust
Name of Provider CEO	Sally Morris
Signature (electronic or typed)	Sally Morris

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Thurrock Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by SEPT.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HEALTH AND WELL-BEING OVERVIEW AND SCRUTINY COMMITTEE
WORK PROGRAMME 2014-15

Report Name	Lead Officer	Meeting Date
Budget		13 January 2015
JSNA – Children's & Demographics	Debbie Maynard/ Andrea Atherton	13 January 2015
Developments in Primary Care	Mandy Ansell	13 January 2015
Adult Social Care Local Account	Rhodri Rowlands	17 February 2015
Regeneration, Air Quality and Health	Debbie Maynard/ Andrea Atherton	17 February 2015
		31 March 2015

Items to be Scheduled:

- CCG Performance Report
- The Quality of Walk-in Centres

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