



Draft for consultation

# Pharmaceutical Needs Assessment (PNA) 2018

## BIRMINGHAM

V0.2

**Authors and main contributors to the production of this report:**

Rebecca Willans	Specialty Public Health Registrar	Birmingham City Council
Susan Lowe	Service Manager Intelligence	Birmingham City Council
Jenny Riley	Senior Officer - Public Health	Birmingham City Council

**PNA Steering Group:**

Rebecca Willans and Susan Lowe (as above)

Channa Payne Williams (Project Support Officer, Birmingham City Council)

Clare Reardon (Commissioning, Birmingham City Council)

Tom Wedgbury (LPC)

Sandeep Dhami (LPC)

Sanjeev Panesar (LPC)

Brian Wallis (Contract Manager; NHS England)

Gurjinder Samra (Senior Prescribing Adviser, Midlands and Lancashire CSU)

Jasprit Singh (Medicines Commissioning Support Pharmacist, Midlands and Lancashire CSU)

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This document builds on the 2015 Birmingham PNA documents, which was the first to cover the whole of Birmingham after the transfer of Public Health from Primary Care Trusts to Local Authority.

Please note, data regarding pharmacies is accurate to 9<sup>th</sup> June 2017.

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## Abbreviations

AUR	Appliance Use Review
BHWP	Birmingham Health and Wellbeing Board
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
DH	Department of Health [England]
EHC	Emergency Hormonal Contraception
GP	General Practitioner
HWB	Health and Wellbeing Board
IDU	Injecting Drug User
JSNA	Joint Strategic Needs Assessment
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
MAS	Minor Ailments Scheme
MUR	Medicines Use Review
NHS	National Health Service
NRT	Nicotine Replacement Therapy
PCT	Primary Care Trust
PNA	Pharmaceutical Needs Assessment
SAC	Stoma Appliance Customisation
SSS	Stop Smoking Services
STI	Sexually Transmitted Infection
UK	United Kingdom

## 1. Executive summary

- 1.1. The 2018 Pharmaceutical Needs Assessment (PNA) is the second published by the Birmingham Health and Wellbeing Board (BHWWB) since Primary Care Trusts were dissolved.
- 1.2. Since the last PNA, published in 2015, no major changes to pharmaceutical provision have been observed and provision is generally good. There are slightly fewer community pharmacies (2015 = 301; 2018 = 285 and slightly more distance selling pharmacies (2015 = 11; 2018 = 14); however geographic assessment indicates high levels of access in all districts in Birmingham. Despite population increases, Birmingham continues to have higher than average access per capita at 2.65 pharmacies per 10,000 populations compared to the most recent West Midland and England average data.
- 1.3. There are 50, 100 hour pharmacies, 210 Saturday and 74 Sunday opening and this assessment identified that evening and weekend provision is high and well distributed. It is noted however that Selly Oak does not have a pharmacy providing services on Sundays; this provision is available from bordering districts but may be considered a need in the future if these pharmacies close.
- 1.4. Factors that may increase demand for community pharmacy in the future include national policy and population increases. Current national policies highlight the potential of community pharmacy with regard to enhanced community based healthcare access and reducing demand on urgent and primary care services. Regarding population increase, since the 2015 PNA the resident population and GP registered population of Birmingham has increased (the latter by 20,000 registrations per year). However, analysis of housing data did not indicate that in the next three years there will be localised population increases of a sufficient size to impact on need for new pharmaceutical providers. The biggest scheme identified is in Langley but this is not in construction phase.
- 1.5. Therefore, current provision of pharmaceutical providers is deemed to be good, with no gaps in geography or opening hours for the period covered by this PNA (to 2021).
- 1.6. An analysis of the Joint Health and Wellbeing Strategy (JHWS) and Joint Strategic Needs Assessment (JSNA) identified that there may be scope for pharmacy to support health needs including influenza and chlamydia detection rates. Decisions regarding this role will need to be based on more specific health needs assessment and commissioning strategies for these programmes. The same JHWS as was used to inform the 2015 PNA remains and so no new strategic priorities were identified; it is worth noting that some of the services offered in pharmacy may support priority areas. This includes Medicines Use Reviews, which can have a positive influence on improving the

independence of older people and people living with long term conditions. Also pharmacy staff training in subjects such as self-care and public health campaigns could be targeted to the JHWS priorities such as childhood obesity and supporting vulnerable adults and children.

1.7. An assessment of patient and public engagement and insight indicated that this is being well used to inform commissioning decisions where this information was available to the PNA steering group. However in some cases this information was not available or not collated.

1.8. The following conclusions were made through this PNA regarding pharmaceutical service provision:

1.8.1. **Essential services:** **no gaps** in these **necessary** services; there is good geographic spread, which is concentrated where there is higher population density and socio-economic deprivation.

1.8.2. **Advanced services:** all of these services were considered **relevant**, with the possible exception of the Medicines Use Review (MUR) service, which the BHWB may now wish to upgrade as necessary based on the information in this report.

1.8.2.1. Provision of **MURs** has increased and considering national policy direction and local priorities regarding older adults and people with long term conditions, there may be greater potential for this service to support residents and the local health care system. **No gaps** in provision of this service were identified.

1.8.2.2. **New Medicines Service:** considered relevant; **gaps were not identified** based on the level of data available, however lack of geographical mapping means equity of access cannot currently be assessed; preparation would should be undertaken for the 2021 PNA to seek greater detail in this data.

1.8.2.3. **Appliance Use Reviews** and **Stoma Appliance Customisation:** considered relevant and **no gaps identified**, however wider provision should be considered to assess changing capacity demands based on service models and demographic changes.

1.8.3. **Enhanced services:**

1.8.3.1. **The Pharmacy First service** (previously known as the Minor Ailments Service 'MAS') was considered **relevant** in the 2015 PNA but may now be considered by the BHWB as a necessary service, given national policy direction regarding management of demand for primary and urgent care. **Gaps were identified**, which continue to be the case since this was identified in the 2015 PNA. These are in the northern, southern and eastern parts of Birmingham; commissioners are asked to comment on how the need for managing minor

ailments is managed in these areas to provide the board assurance that this need is being met appropriately.

1.8.3.2. **Palliative Care Prescribing:** this service is considered **necessary** and **gaps were identified** in the northern and southern areas of the city; however, commissioning data was not available to assess whether this need is being met by alternative service models.

1.8.3.3. **The Dermatology Dispensing and Advice to Care Homes** services have been decommissioned due to changes in commissioning models. The detail regarding how this need is now being met was not available at the time of writing this PNA and so the commissioners may wish to signpost to the new models of care available.

1.8.4. **Locally commissioned services:** these include the stop smoking service, sexual health service (tiers one and two), supervised consumption and needle exchange. All of these services are considered **necessary** and all have good levels of provision, **with no gaps** and good geographical distribution.

## 1.9. Conclusion

1.9.1. Evidence in this PNA indicates that there is good coverage of provision for pharmaceutical services in Birmingham.

1.9.2. Some advanced and enhanced services may require examination by the relevant commissioners to assess whether a pharmaceutical service offer could enhance provision.

1.9.3. There are high levels of access to locally commissioned services, which are well geographically distributed.

## 1.10. Recommendations

1.10.1. The HWBB may wish to consider whether the MUR and MAS services should now be considered essential services in Birmingham.

1.10.2. Commissioners of services related to management of minor ailments, appliances and palliative care should consider whether pharmacy provision would improve access in their area.

1.10.3. All commissioners and providers should ensure that information regarding PPI is collated and made accessible to inform local commissioning decisions. The PNA steering group should further peruse collated information from NHS choices (e.g. multilingual staff, facilities) and results of the Community Pharmacy Patient Questionnaire 2016/17).



## 2. Introduction

‘Pharmaceutical Needs Assessment’ (PNA) is a statutory requirement of Health and Wellbeing Boards (HWB) in England; its purpose is to assess the current provision of pharmaceutical services in an area and the ‘need’ for such services now and in the near future. This is the second PNA produced since the creation of HWBs; the first PNAs prepared under these arrangements were published in 2015; the 2015 Birmingham PNA is available from the BHWB website: <http://hwb.birmingham.gov.uk/pna/>

This section of the report summarises the PNA requirements and highlights key differences in provision between 2015 and 2018 for Birmingham.

### **Birmingham Health and Wellbeing Board (BHWB)**

The Birmingham Health and Wellbeing Board<sup>1</sup> became a statutory body on 1<sup>st</sup> April 2013, as one of the requirements of the Health and Social Care Act 2012 (hereafter referred to as ‘the Act’). The functions of the Board as set out in the Act include:

- Promote the reduction of health inequalities across the city
- Assess the needs of the Birmingham population through the Joint Strategic Needs Assessment (JSNA) process
- Develop the Birmingham Joint Health and Wellbeing Strategy (JHWS)<sup>2</sup>
- Identify opportunities for effective joint commissioning arrangements, integrated provision and pooled budget arrangements
- Provide a forum to promote greater service integration across health and social care

Among these responsibilities the Act makes explicit the duty for local authorities (LA) through the local HWB, to produce a PNA for their population<sup>3</sup>. This should be informed by the JSNA process and any other relevant needs assessments that identify a role for pharmaceutical services in addressing health need. Since the Act, HWBs have been required under legislation to produce a new PNA at least once every three years starting from the 1<sup>st</sup> April 2015<sup>4</sup>.

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<sup>1</sup> Birmingham Health and Wellbeing Board, Terms of Reference [Online] <http://hwb.birmingham.gov.uk/hwbb/about-the-board/terms-of-reference/> [accessed 13/06/2017]

<sup>2</sup> Birmingham Health and Wellbeing Board, Strategy on a Page [Online] <http://hwb.birmingham.gov.uk/health-and-wellbeing-strategy/> [accessed 14/06/2017]

<sup>3</sup> Health and Social Care Act (2012). Section 206: Pharmaceutical needs assessments.[Online] <http://www.legislation.gov.uk/ukpga/2012/7/section/206/enacted> [accessed 13/06/2017]

<sup>4</sup> The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. [Online] [http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi\\_20130349\\_en.pdf](http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf) [accessed 13/06/2017]

## Pharmaceutical Needs Assessment

PNA developed as a result of government strategy that identified potential for pharmacies to deliver some of the services that had traditionally been delivered in general practice (GP) settings<sup>5</sup>,<sup>6</sup>. It was recognised this required robust needs assessment and 'PNA' was made into law with the Health Act 2009 to inform the need for new pharmacies ('market entry'). This remains a statutory requirement, set out in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013<sup>7</sup>. The PNA must provide:

- information to assist decision-makers regarding the market entry of new pharmaceutical providers
- high quality information for the commissioning of appropriate services through pharmaceutical providers

The services provided by pharmaceutical providers must be assessed by the HWB as either 'necessary' or 'relevant' to meet current or potential gaps in provision:

- Necessary service – services that are necessary to meet a pharmaceutical need.
- Relevant service –services that are not considered necessary, but may secure improvements in, or access to pharmaceutical services. Gaps in relevant services are not used as a basis to determine market entry.

The way in which need for these services is assessed is also set out in Schedule 1 of The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. These requirements and the method undertaken for the 2018 Birmingham PNA are described in Appendix A and B.

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<sup>5</sup> Department of Health (2003). A vision for pharmacy in the new NHS. [Online]  
[http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_4068353](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4068353) [accessed 06/06/2017]

<sup>6</sup> Five year forward view

<sup>7</sup> DH. 2013. *Pharmaceutical Needs Assessments: Information Pack for Local Authority Health and Wellbeing Boards* [Online]  
<https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack> (Accessed 03/05/2017)

### 3. Scope of the PNA

Pharmaceutical providers may be a 'community pharmacy', 'dispensing practice', 'appliance contractor' or 'distance selling pharmacy'; the difference between these and the number locally is summarised in table 1.

**Table 1: Pharmacy services by provider type and provision in Birmingham**

Pharmaceutical provider type	Description of provision	Birmingham 2015	Birmingham 2017
Community pharmacy	The majority of pharmaceutical providers belong to this category and provide a comprehensive range of pharmaceutical services that are to be assessed under the PNA, including 'Essential', 'Advanced' and 'Enhanced' services. Most of these services are commissioned under the Community Pharmacy Contractual Framework (CPCF), but some under other types of contract including the Local Pharmaceutical Services contract (LPS) and the Essential Small Pharmacies Contract (ESPC).	301	285  (one on an 'LPS' contract)
Dispensing practice	These are General Practitioners who are authorised to dispense medicines to patients in designated rural areas known as 'controlled localities'. The PNA must consider whether there are any of these localities and whether patients have adequate access to dispensing services.	0	0
Appliance contractor	A sub set of pharmaceutical service contractors who dispense appliances and may provide some of the Advanced services: Appliance Use Review (AUR), and Stoma Appliance Customisation (SAC) services. Appliances are things like dressings and incontinence aids. The PNA must assess whether there is adequate access to dispensing of appliances from both community pharmacy and appliance contractors.	2	2
Distance Selling Pharmacy	A distance selling pharmacy provides Essential pharmaceutical services via post, telephone or internet and must not provide these services face to face. These services may provide Advanced and Enhanced services on the premises, as long as any Essential service element is not provided at the premises. These pharmacies are required to provide services to patients in the whole of England; none of the DSPs provide 'advanced' services in Birmingham.	11	14

The three service types mentioned in table 1, ('Essential', 'Advanced' and 'Enhanced') are the services a PNA must assess as 'necessary' or 'relevant'; these services are commissioned by local NHS England teams under the NHS Community Pharmacy Contractual Framework (CPCF) and are specified in the Pharmaceutical services (Advanced and Enhanced Services) (England) Directions 2013.

A PNA must address need for these three service categories and a description of each is given below<sup>8</sup>.

### Essential services

All pharmaceutical providers must provide these, which include:

- Dispensing medicines, appliances and repeat dispensing
- Electronic prescriptions
- Disposal of waste medicines and management of unwanted medicines
- Healthy lifestyle advice and six public health campaigns a year
- Self-care advice and signposting to other services and support

### Advanced services

Pharmaceutical providers may choose to deliver these services, subject to meeting specified criteria and each requires notification to NHS England of their intention to do so; NHS England commission these services. Advanced services include:

- **Medicine Use Review: this service is available in Birmingham**
  - **What it is:** a confidential check-up with a patient about their medications to identify any problems with the administration or medication itself; patients can be advised as appropriate by the pharmacist and if necessary and with the patient's permission, any clinical issues are referred to their GP.
  - **Aim:** improve patient understanding of their medications; resolve where possible problematic side effects; improve adherence and reduce wastage.
  - **Details:** Pharmacies must have a private consultation area onsite to provide this service. Most (70%) of the MURs must be with patients from target groups who have the greatest possibility of benefiting from this support. These include patients taking high risk medicines; those recently discharged from hospital who had changes made to their medicines during their hospital stay; people with respiratory disease; people at risk of, or diagnosed with cardiovascular disease and regularly being prescribed at least four medicines. There is also a cap of 400 per year on the number of MURs a pharmacy may undertake.
  - **Evidence:** Medication reviews are recommended by NICE under guidelines for medicines optimisation, although the providers most appropriate for delivering these depends on local

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<sup>8</sup> DH. 2013. *Pharmaceutical needs assessments Information Pack for local authority Health and Wellbeing Boards*. [Online] <https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack> (Accessed 06/06/2017)

context<sup>9</sup>. Evidence in the UK pharmacy setting generally indicates that such services are valued by patients and improve self-care; a sample of GPs also indicated support for the service and evidence that MURs can improve compliance and improve patient safety<sup>10</sup>. A review of evidence regarding effectiveness of pharmacy services identified that equity of access may be an issue in relation to MURs, which are generally less likely to be provided by smaller, independent pharmacies. Coverage has improved since the service was introduced; however the average number of MURs can vary by pharmacy and is affected by time available to the pharmacy team, the support of local GPs for the service and local patient needs.

- **New Medicine Service: this service is currently available in Birmingham**

- **What it is:** An advice service for people starting new medication for long term conditions including asthma, hypertension, chronic obstructive pulmonary disease, type 2 diabetes and antiplatelet/anticoagulant therapy.
- **Aim:** To help a patient's understanding of using the medicine safely, effectively and once using the medicines as prescribed, to address any problems that might affect effectiveness or adherence.
- **Evidence:** there is limited but positive evidence regarding the effectiveness of the NMS in improving patient adherence to new medicines; a UK randomised trial found a statistically significant improvement<sup>11</sup>.

- **Appliance Use Reviews (AUR) and Stoma Appliance Customisation (SAC) services: these services are available in Birmingham**

- **What it is:** these are two Advanced services, which offer patient support through pharmaceutical services with either the use of appliances (AUR) or with fitting and use of Stoma devices (SAC).
- **Aim:** to improve comfort of patients using appliances; the service may also reduce risk of infection since appliances such as catheter, colostomy appliances or wound drainage pouches can be sources of infection if not properly fitted and used.
- **Evidence:** a brief literature search for this PNA did not find evidence regarding AURs generally or SAC; evidence may exist regarding effectiveness of supporting proper use of individual appliance types but this was beyond the scope and resource of this PNA. A literature review of these services also found limited evidence on the subject; this does not mean these services are not effective but evaluation is important to assess quality and impact of provision<sup>11</sup>.

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<sup>9</sup> NICE. 2015. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. [Online] <https://www.nice.org.uk/guidance/ng5> (Accessed 30/07/2017)

<sup>10</sup> PSNC. 2017. PSNC Briefing 038/17: A summary of literature relating to Medicines Use Reviews [Online] <http://psnc.org.uk/wp-content/uploads/2013/04/PSNC-Briefing-038.17-A-summary-of-literature-relating-to-MURs.pdf> (Accessed 30/07/2017)

<sup>11</sup> Wright, D. 2016. A rapid review of evidence regarding clinical services commissioned from community pharmacies. [Online] <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/rapid-evdnc-rev-dec-16.pdf> (Accessed 02/08/2017)

- **Seasonal Flu vaccine: this service is not currently available in Birmingham**
  - **What it is:** introduced in 2015/16 as a national Advanced service, this involves provision of the seasonal flu vaccine for eligible patient in a pharmacy setting.
  - **Aim:** to reduce risk of serious illness and death due to flu infection by improving uptake of the vaccine in eligible groups.
  - **Evidence:** improves convenience for some patients and has potential to run at a lower cost to alternatives, however the literature search for this PNA did not identify evidence that the service improves uptake<sup>12</sup>.
- **NHS Urgent Medicine Supply Advanced: this service is not currently being piloted in Birmingham**
  - This is a national pilot service (started in December 2016), the aim of which is to improve patient awareness of how to manage their medication supply, reduce anxiety about accessing new supply, improve access to electronic prescription and reduce demand on NHS 111 and urgent care service.

## Enhanced services

Enhanced services are a range of services commissioned based on local health priorities, needs and commissioning strategies. Prior to 2013, all enhanced services were commissioned by Primary Care Trusts but legislative changes have split responsibility between NHS England, CCGs and LAs. Only the services that local NHS England teams continued may be classified as 'Enhanced Services'; where the service was continued by CCGs and LAs, they are no longer legally classified as 'Enhanced Services'. Instead the term 'Locally Commissioned' services must be used. Guidance regarding how this should be addressed in PNAs states that services included in PCT PNAs should be continued, unless evidence from more recent PNAs demonstrates the need for particular services has changed 'significantly'<sup>13</sup>. Birmingham has pharmacy services in both categories so for clarity, enhanced services and locally commissioned services are discussed separately in this PNA.

The 'Pharmacy First' service, previously known as Minor Ailments Service (MAS) is the only Enhanced Service in Birmingham. The Palliative Care Medicines Service is no longer provided by pharmacies in Birmingham.

- **Pharmacy First (MAS)**
  - **What it is:** Pharmacy First offer the public access to appointment free consultations in a pharmacy for common self-limiting conditions for which pharmacists are able to prescribe

<sup>12</sup> Atkins K, van Hoek AJ, Watson C, et al. Seasonal influenza vaccination delivery through community pharmacists in England: evaluation of the London pilot. *BMJ Open* 2016;6:e009739. doi: 10.1136/bmjopen-2015-009739

<sup>13</sup> NHS England. 2014. Pharmacy Enhanced Services Q&A. Area Team reference number: 01551. [Online] <http://psnc.org.uk/wp-content/uploads/2014/04/NHS-England-Pharmacy-Enhanced-Services-QA.pdf> (Accessed 03/05/2017)

treatment. The service covers minor ailments such as headache, cold, hay fever, constipation, diarrhoea, thrush.

- **Aim:** the service aims to improve access to treatment for minor ailments and reduce demand on other parts of the healthcare system where this is not necessary, in particular GPs.
- **Evidence:** A 2017 report regarding Minor Ailments Services in the UK suggests the service can be effective in supporting patients to self-care and reduce unnecessary use of other primary care services, particularly GP services. Findings identified that most (84.3%) patients would have gone to their GP if the service was not available; most consultations (95.8%) required no onward referral to other NHS providers; 3% of patients would have purchased medicines if MAS was not available. The majority (>60%) of consultations were for people aged under 16 years and a slightly higher proportion were for female attendees (59%)<sup>14</sup>.
- The 2015 Birmingham PNA made reference to a local pilot of the MAS service, which was being reviewed and at the time considered a 'relevant' pharmaceutical service for Birmingham. Results from the first half of the pilot were positive; most MAS visits were due to cough or fever and the majority of patients using the service said if it had not been available, they would have booked a GP appointment (88%). Some patients reported they would have used an urgent care walk in centre (5%) and others (7%) would have opted for self-care. It also appeared re-consultation rates in GPs were low, at 9% and mostly fever; this was based on a random sample of the consultations.
- Service data suggested the service was fairly evenly used by males and females; most consultations (approximately 50%) were for children aged 11 or under, also 60 years and over 13% - this group reported higher confidence to self-care and so if they went to the GP it was for a more complex query. The impact of the scheme varied by area due to lower provision and lower patient awareness in some areas of Birmingham, with highest uptake in the Sandwell and West Birmingham area<sup>15</sup>. The final evaluation was not available at the time of writing this PNA.
- **Palliative Care Medicines Service**<sup>16</sup>
  - **What is it:** The Specialist Palliative Care Drugs Supply (SPCD) is commissioned by NHS England and delivered by Midlands and Lancashire Commissioning Support Unit. Pharmacies hold agreed stocks of SPCD drugs and dispense palliative care prescriptions, which allows on

<sup>14</sup> PSNC. 2017. PSNC Briefing 044/17: Analysis of Minor Ailment Services data. [Online] <http://psnc.org.uk/wp-content/uploads/2017/07/PSNC-Briefing-044.17-Analysis-of-Minor-Ailment-Services-data.pdf>

<sup>15</sup> Deenah, M. Gogna, N. 2015. *Pharmacy First – Liberating Capacity*. NHS England. [Online] <http://psnc.org.uk/dudley-lpc/wp-content/uploads/sites/78/2015/02/Final-V2-Pharmacy-First-Liberating-Capacity-Feb-2015-pdfv.pdf>

<sup>16</sup> [https://www.johntaylorhospice.org.uk/assets/000/001/498/Specialist Palliative Care Drugs Supply original.pdf](https://www.johntaylorhospice.org.uk/assets/000/001/498/Specialist_Palliative_Care_Drugs_Supply_original.pdf)

demand, prompt access and continuity of supply of specialist palliative care drugs during extended pharmacy opening hours, including (7 days a week between 6am and 10pm).

- **Aim:** to improve access for people to specialist medicines when required.
- A strategy is currently out for consultation regarding an Integrated Palliative and End of Life care system across Birmingham, which includes pharmacy provision of this service.

### Locally Commissioned services

- **Stop Smoking Service**
  - Pharmacists are one of several providers in Birmingham who provide advice and medication to assist people to quit smoking; GPs are the other major provider.
- **Sexual health services**
  - From August 2015, sexual health services in Birmingham and Solihull transferred to 'Umbrella', a service provided by University Hospitals Birmingham in partnership with sexual health providers across the area. These include pharmacies but also GPs, charities, Birmingham City Council and other NHS Trusts. The service operates two tiers:
    - Umbrella service tier one: offers access to free condoms and emergency hormonal contraception.
    - Umbrella service tier two: tier one services and also chlamydia treatment, contraceptive pill and contraceptive injections.
- **Substance misuse services**
  - There are two types of substance misuse service available in Birmingham:
  - The Needle Exchange Service supports injecting drug users (IDU) to exchange used needles for clean needle replacements. This reduces the risk of needle re-use and the transmission of infectious disease and aims to reduce the risk of harm posed by discarded needles.
  - The Supervised Consumption Service provides substitute therapy for people with opiate addiction, directly through pharmacies.
  - Non-pharmacy providers also provide this service in the community in Birmingham.



## Out of scope

Some pharmaceutical services are not relevant to the purpose of the PNA and include any prison or hospital pharmacies.

### **Prison pharmacy**

Birmingham has a single prison (HM Prison Birmingham), whose pharmacy is commissioned by the NHS England Area team, this service falls outside the scope of the PNA.

### **Hospital pharmacy**

There are a number of secondary (and tertiary) providers of health care in Birmingham. The pharmacy provision for the patients seen in these establishments does not fall within the scope of the PNA, though integrated care between secondary and primary providers is important for patients moving from one provider to another.

## 4. Context

The 2015 Birmingham PNA was the first published under direction of the Birmingham HWB and built on the three former Birmingham PCT PNA documents. This 2018 version has been prepared in line with the statutory requirement for HWBs to update their PNA at least every three years, or sooner where the HWB consider this necessary.

Most national and local policies and strategies published since the 2015 PNA was prepared have not yet affected pharmaceutical provision or need in Birmingham, but are considered in this section as they may do so in the future. Furthermore, the key local health strategy document, the Joint Health and Wellbeing Strategy (JHWS) and associated Joint Strategic Needs Assessment (JSNA) must be considered in the development of a PNA.

### National policy

Some national policies published since the 2015 PNA was produced may impact on pharmaceutical provision or need in the next three years, the period of time that this PNA covers. These policies are described in table 2, considering their impact to 2021:

**Table 2: National policy and strategy impact assessment**

Policy	What it is	Implications for pharmaceutical services
Community Pharmacy in 2016/17 and beyond (DH)	In 2016, the DH and NHS England consulted with the Pharmacy Services Negotiating Committee (PSNC) regarding changes to the Community Pharmacy Contractual Framework (CPCF). In particular these changes affect market entry regulations that facilitate consolidation of pharmacies and changes to funding that include an overall reduction in 2016/17 and 2017/18. There is also a proposal to introduce a Pharmacy Access Scheme, aimed at supporting access where pharmacies are sparsely spread (>1 mile away by road) and patients depend on them most (based on amount of items	<p>A national impact assessment suggests at this stage it is not possible to assess how many pharmacies may close as a result of this policy, if any<sup>17</sup>.</p> <p>The Birmingham LPC is not aware at the time of writing this PNA of any contractors who are at risk of closure in the next three years as a result of this change. Nor have any concerns been raised regarding maintaining current staffing levels. If the impact of the funding changes do affect these matters, the LPC should make the BHWB as soon as possible in the event this</p>

<sup>17</sup> DH. 2017. DH IA: DH6008. Community Pharmacy in 2016/17 and beyond. Impact Assessment. [Online] <https://www.gov.uk/government/publications/community-pharmacy-reforms> (Accessed 30/07/17)

	<p>dispensed).</p> <p>The PSNC rejected the proposal and negotiations are underway with the aim of protecting access to pharmaceutical services. There are concerns the impact of this would be to reduce staffing levels.</p>	affects need for pharmaceutical services.
NHS Five Year Forward View	<p>Published in 2014, this strategy sets a vision for the NHS in England; models of care between primary and specialist care, physical and mental health and health and social care are changing, which may create opportunities for community pharmacy to bid for new services.</p> <p>Part of the process also requires healthcare organisations and local authorities to work together to produce five year 'Sustainability and Transformation Plans' (STPs).</p> <p>This work started in 2016 nationally and the Birmingham and Solihull (BSoL) STP was published in October 2016, supported by evolving work streams to deliver its aims and identify solutions to challenges raised<sup>18</sup>.</p>	<p>The 'Community Care First' theme in the BSoL STP covers matters of relevance to pharmaceutical service need. An issue highlighted regarding models of health care for the next five years is the proportion of GPs approaching retirement age (nearly 1 in 4 aged over 55 years locally) combined with a low GP and nurse – to population ratio (2<sup>nd</sup> lowest in the country).</p> <p>A review of potentially avoidable GP appointments estimated that the contribution of pharmacy to reduce these appointments was 6% (specifically regarding self-care support). The Pharmacy First and MUR services in Birmingham play a role in primary care demand management.</p> <p>Uptake and capacity of pharmacies to deliver these services should continue to be monitored to identify areas of increased demand. However at present there is no evidence that the matters discussed in the STP will have a direct impact on pharmaceutical need before 2021.</p>

<sup>18</sup> BCC. 2016. Birmingham and Solihull STP [Online]  
[https://www.birmingham.gov.uk/downloads/file/4742/birmingham\\_and\\_solihull\\_sustainability\\_and\\_transformation\\_plan\\_-\\_october\\_2016](https://www.birmingham.gov.uk/downloads/file/4742/birmingham_and_solihull_sustainability_and_transformation_plan_-_october_2016)  
 (Accessed 08/08/2017)

<p>General Practice Five Year Forward View<sup>19</sup></p>	<p>Further to the matters highlighted above, this strategy promotes the importance of pharmacy in evolving models of health and social care in England.</p> <p><i>“Pharmacists remain one of the most underutilised professional resources in the system and we must bring their considerable skills in to play more fully.”</i> (pg. 7).</p> <p>Two funding streams, the GP Access Fund and a ‘Clinical Pharmacist’ programme will be used to pilot ways in which pharmacists can play a greater role in minor ailments, long term condition management and medicines optimisation.</p>	<p>The programmes discussed in the NHS Five Year Forward View will be piloted during the time covered by this PNA. Evidence from the MAS service evaluation and robust service monitoring, especially for areas such as impact on self-care will be important to inform future decision making.</p> <p>There is not however evidence at this time that these proposals will impact on the need for pharmaceutical services; they may however increase demand.</p>
<p>Community Pharmacy – Helping Provide Better Quality and Resilient Urgent Care<sup>20</sup></p>	<p>This document is not a strategy or policy but promotes the role community pharmacy can play in reducing demand for urgent care services. Evidence is presented for a number of Enhanced and Locally Commissioned services, some of which are provided in Birmingham.</p>	<p>Although the contents of this guidance may inform local commissioning strategy, there is no direct impact on pharmaceutical need. At the time of writing this PNA we are not aware of any commissioning strategies locally that will impact on pharmaceutical need linked to urgent care models.</p>

## Local strategies and policy

A PNA must draw on evidence from local health needs assessments and the local HWB’s Joint Health and Wellbeing Strategy; at the time of writing the 2018 PNA, the Birmingham JHWS is in the process of being updated. A summary of the current ‘Strategy on a Page’, which also informed the 2015 PNA is summarised in table 3 with an analysis of what this means for pharmaceutical services<sup>21</sup>:

<sup>19</sup> Clay, H. Stem, R. 2015. *Making Time in General Practice*. Primary Care Foundation and NHS Alliance. [Online] <http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf> (Accessed 08/08/17)

<sup>20</sup> NHS England. 2015. Quick Guide: Extending the role of community pharmacy in urgent care. [Online] <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/quick-guid-comm-pharm-urgent-care.pdf> (Accessed 08/08/17)

<sup>21</sup> Birmingham HWBB. 2013. *Strategy*. [Online] <http://hwb.birmingham.gov.uk/health-and-wellbeing-strategy/> (Accessed 10/05/17)

This section also highlights findings from the Joint Health and Wellbeing Strategy (JSNA), which will inform the revised JHWS. Evidence from other local strategies that have been published since the 2015 PNA are discussed, where these are available, with the PNA service they impact upon.

**Table 3: Implications of Birmingham JHWS on pharmaceutical service need**

<b>JHWS Goals</b>	<b>Specific HWB action / outcome</b>	<b>Implications for pharmaceutical need</b>
Improve the health and wellbeing of the most vulnerable people.	Make children in need safer (through Early Help Strategy)	<p>Pharmacy is not mentioned in the Early Help strategy; however pharmacies and pharmacists can play an important role in safeguarding vulnerable children. Ensuring staff have up to date training in safeguarding and consideration of applying 'You're Welcome' criteria would support pharmacies in this role. In particular, pharmacies providing Pharmacy First, sexual health and substance misuse services should be alert to support services available for under 18s and referral mechanisms for those they feel are at risk.</p> <p>The BHWB may wish to consider the role community pharmacy can play in relation to this agenda in any revisions to the Early Help Strategy. There are however no direct implications on pharmaceutical need.</p>
	Improve the wellbeing of vulnerable children (Children in Need; Looked After Children; children in / at risk of Youth Justice Service.	
	Increase the independence of people with a learning disability or severe mental health problems	<p>Although the needs of these two population groups vary widely, the geographical accessibility of pharmacy and appointment free service availability has been shown to be a helpful feature for service access. However no specific local assessments of the needs of these population groups was identified in preparation of this PNA.</p> <p>The Birmingham 2012 JSNA highlighted the data on disability is limited to those accessing social services, and therefore not reflective of the learning disability (LD) population as a whole. Furthermore the needs of people with LD vary widely; no relevant needs assessment or strategies regarding LD were identified to inform this PNA. Nationally, evidence indicates a neutral view among people with LD and their carer regarding pharmacy access, however specific barriers mentioned</p>

		<p>included access to information, clear communication, and explanation of the purpose of medicines<sup>22</sup>. A Certificate for Pharmacy Postgraduate Education in 'Learning Disability' is available; information regarding which pharmacies in Birmingham have staff trained with this qualification is not currently collated and could not be identified from NHS Choices. It may improve access to pharmacies for people with LD if this information is made available through promotional opportunities or inclusion as part of wider schemes such as Healthy Living Pharmacy.</p> <p>Regarding people with a severe mental health problem, the West Midlands Mental Health Commission highlights that in the UK, an ideal model of primary care provision to support this population group has not been identified. Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) provides inpatient, community and specialist mental health care to those people who are experiencing severe mental health problems<sup>23</sup>.</p>
	Support older people to remain independent (reduce admissions to care homes and reduce injuries)	The MUR service can support this aim by addressing matters associated with polypharmacy, which is a risk factor for falls and subsequent admission to care homes as well as independence more generally. The need for and access to the MUR service is discussed in further detail later in this report.
	Reduce the number of people and families who are statutory homeless (Domestic Violence and homelessness)	<p>The factors that lead to homelessness and solutions to this goal are complex; health plays a role in risk of homelessness and people who are homeless have worse health in general and lower life expectancy compared to the general population.</p> <p>A report to the Birmingham City Council Overview and Scrutiny Committee (OSC) regarding the health of homeless people in the city</p>

<sup>22</sup> The Disability Partnership. 2016. The Disability Partnership Evaluation Report of the 2015-16 Mencap-led Pharmacy Project. [Online] <https://www.mencap.org.uk/about-us/our-projects/disability-partnerships-pharmacy-project> (Accessed 31/05/17)

<sup>23</sup> Newbigging, K. Parsonage, M. 2017. Mental Health in the West Midlands Combined Authority. University of Birmingham. [Online] <https://www.wmca.org.uk/media/1419/uob-mental-health-in-the-wmca-report.pdf> (Accessed 07/06/17)

	action plans)	highlighted that in relation to primary care, access to GP can be especially difficult for this population <sup>24</sup> . The Pharmacy First Service may play an important role in supporting this population with minor ailments. Also, evidence from the OSC report indicated 6% of the homeless population surveyed were actively in drug treatment, 8% in recovery from drug misuse, 18% taking drugs. Therefore the substance misuse services in pharmacy must also be considered in relation to their contribution to this HWB goal; this is discussed later in this report.
Improve the health and wellbeing of our children.	Reduce childhood obesity	There is no impact of this goal on the need for pharmaceutical services; childhood obesity is a widespread issue in the UK and pharmacies may promote weight management through the public health campaigns or Healthy Living Pharmacy support. This work supports wider programmes aimed at reducing childhood obesity.
	Reduce infant mortality	There is no impact of this goal on the need for pharmaceutical services.
Improve the resilience of our health and care system.	Improve primary care management of common and chronic conditions	As discussed in the national strategy impact assessment of this PNA, community pharmacy does and will continue to play an important role in supporting people with chronic conditions. Section 5 of this PNA highlights areas of the city where there may be greater need for pharmaceutical services based on the proportion of people with chronic conditions.

### JSNA highlights

Evidence from the draft 2018 Birmingham JSNA indicates a number of areas where Birmingham is performing better and worse than the national average. The evidence supporting these conclusions is available from the Birmingham Public Health web pages; below some highlights that are of particular relevance to pharmaceutical service need are discussed.

Performing better:

- The percentage of the eligible population aged 40-74 who are offered and who receive an NHS Health Check:

<sup>24</sup> Birmingham City Council. 2015. *Homeless Health. A Report from OSC*. [Online] [https://webcache.googleusercontent.com/search?q=cache:0ltTJtzVqkj:https://www.birmingham.gov.uk/download/downloads/id/411/homeless\\_health\\_overview\\_and\\_scrutiny\\_report\\_july\\_2015.pdf+&cd=5&hl=en&ct=clnk&gl=uk](https://webcache.googleusercontent.com/search?q=cache:0ltTJtzVqkj:https://www.birmingham.gov.uk/download/downloads/id/411/homeless_health_overview_and_scrutiny_report_july_2015.pdf+&cd=5&hl=en&ct=clnk&gl=uk)

- Pharmacies in Birmingham are not commissioned to provide this service; commissioning data indicates that access to the current service model is well distributed among target groups such as BME populations and people living in areas of deprivation
- Since Birmingham is performing well, there does not appear to be a need to extend provision into pharmacy at this time.

Performing worse:

- Incidence of TB and mortality rate from a range of specified communicable diseases, including influenza.
  - The model of provision for TB and influenza in Birmingham does not include community pharmacy as a provider; results of a local flu pilot were used to inform the decision regarding local influenza service access. Current or planned health needs assessments for these topics should consider the role of community pharmacy in meeting gaps identified.
- Chlamydia detection rate (15-24 year olds)
  - This indicator is based on 2015 data and since the new sexual health service in Birmingham, 'Umbrella' is new, it is not possible yet to establish whether this model of provision will/has improve/d the chlamydia detection rate. Pharmacies are commissioned to provide chlamydia treatment services and other sexual health preventative services in the area such as providing access to condoms and play a role in encouraging young people to undertake chlamydia screening when necessary. The chlamydia detection rate of different testing services in Birmingham should be kept under review until this indicator improves.

The analysis of national and local policy does not indicate any major impacts on need for pharmaceutical service need at this time. Changes to models of health and social care should consider pharmaceutical services as part of scoping work. Examples include STPs and new interventions such as those proposed through the GP five year forward view; new service developments must have evaluation frameworks in place to ensure evidence is available to inform future commissioning and needs assessments, including PNAs.



## 5. Demographics

Just over 1.1 million people live in Birmingham, the second largest city in the UK, which is characterised by a large proportion of young people, ethnic diversity and high levels of deprivation. As at 1st April 2017 GP registration for the resident population for Birmingham was 1,244,438, which has grown on average by 20,000 people per year since 2015<sup>25</sup>.

Appendix C presents some key demographic characteristics for each of the ten districts in Birmingham and the number of pharmacies in each area. This includes population size, proportion of the population who live in a very deprived area, who are of a BME ethnicity and the proportion who are aged under 65 years.

This analysis and mapping throughout the 2018 PNA is based on statistics true to the ward boundaries in 2017; from May 2018 there will be an increase from 40 to 69 wards in Birmingham. It will however take time for population and health statistics to transition to the new boundaries and the current maps allow comparability with strategies and assessments that informed this PNA and the 2015 PNA. This change therefore does not affect the needs assessment aspect of the 2018 PNA but may mean a different approach to presenting geographic information in the 2021 PNA.

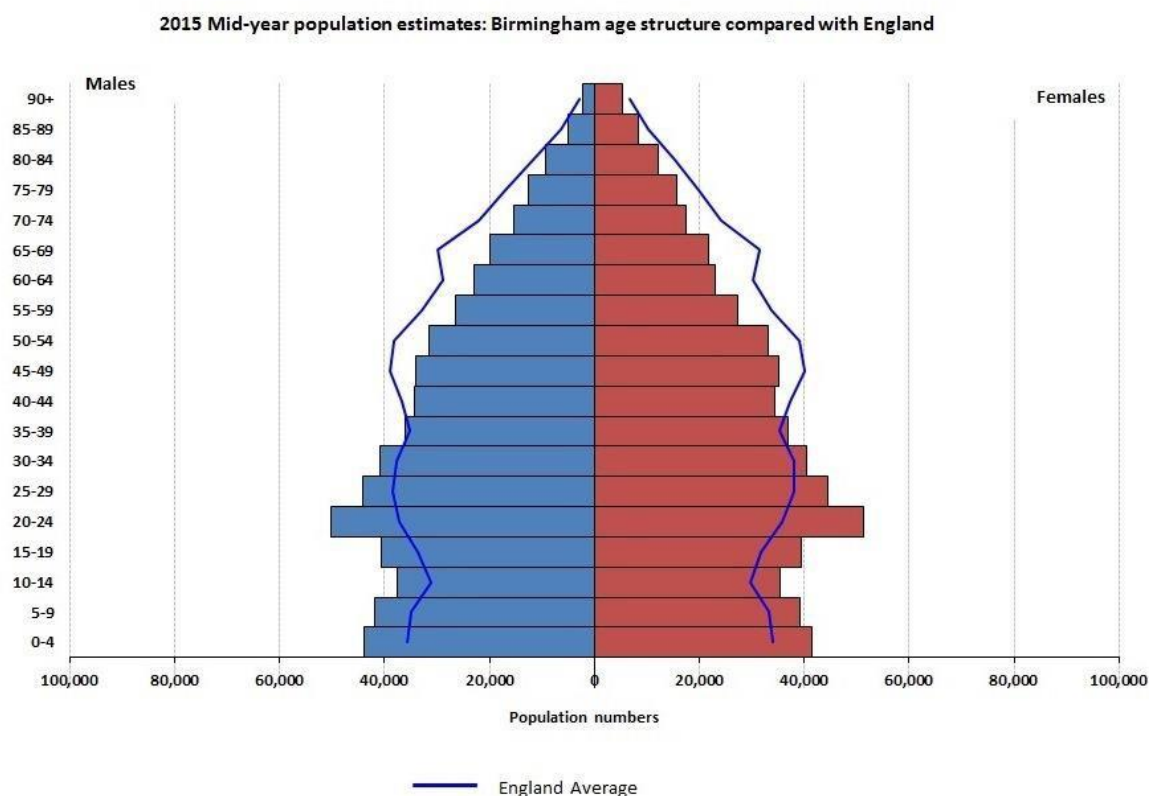
This section summarises the demography and some key health information for Birmingham as a whole.

### Age

Birmingham has a younger age profile compared to England; figure 1 indicates that the greatest difference is in the 20-24 age group, likely due to a net influx of young adults attending the large universities located in the city. The under 20 population equates to 28.8% (England 23.7%) of the overall population, while over 65s account for only 13% (England 17.7%). These differences can be explained by a higher birth rate, people having children at a younger age than the England average, fewer deaths and international migration.

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<sup>25</sup> EXETER Req 2984

**Figure 1: Population pyramid for Birmingham<sup>26</sup>**

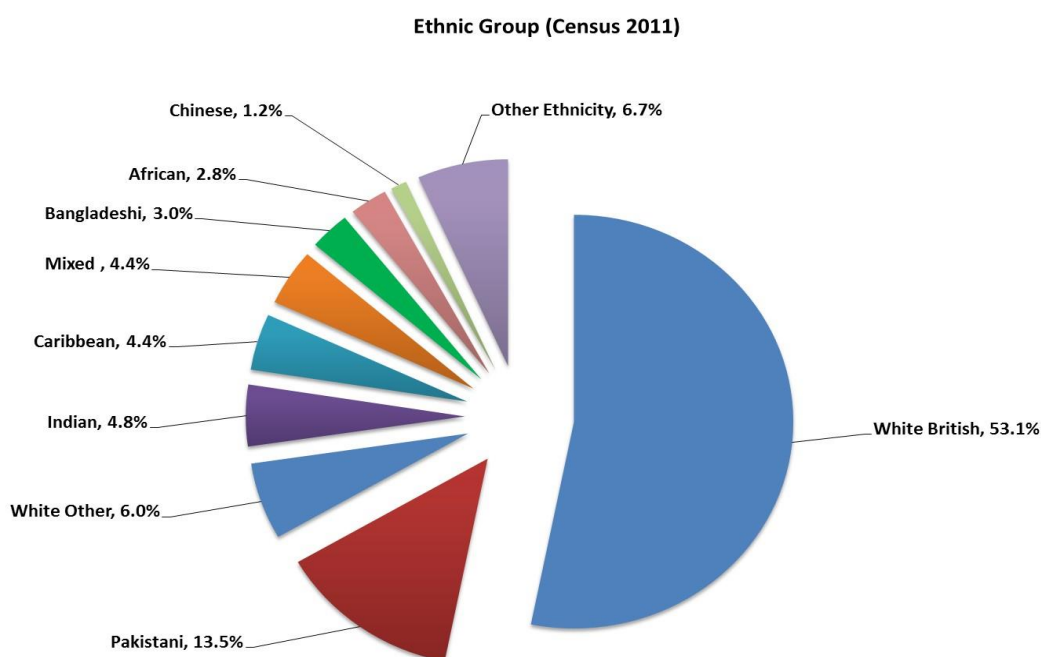
### Ethnicity, religion and language

Data regarding ethnicity, religion and language is based on census data; the most recent census was in 2011. There has not been an update to this information since the 2015 PNA since this type of information is difficult to accurately collect at a population level and does not usually change significantly in small time periods. Thus it is still the case that the White British population in Birmingham is smaller than the England average (63% compared to 85.5%); the younger population in the city is more ethnically diverse than the older population and so the degree of ethnic diversity is likely to increase. Figure 2 summarises the ethnic diversity of the city in 2011<sup>27</sup> and shows that after 'White British', Asian ethnicity is the next largest ethnic group.

<sup>26</sup> ONS Mid Year Population Estimates 2015

<sup>27</sup> ONS. 2012. 'Key Statistics for local authorities in England and Wales. [Online]

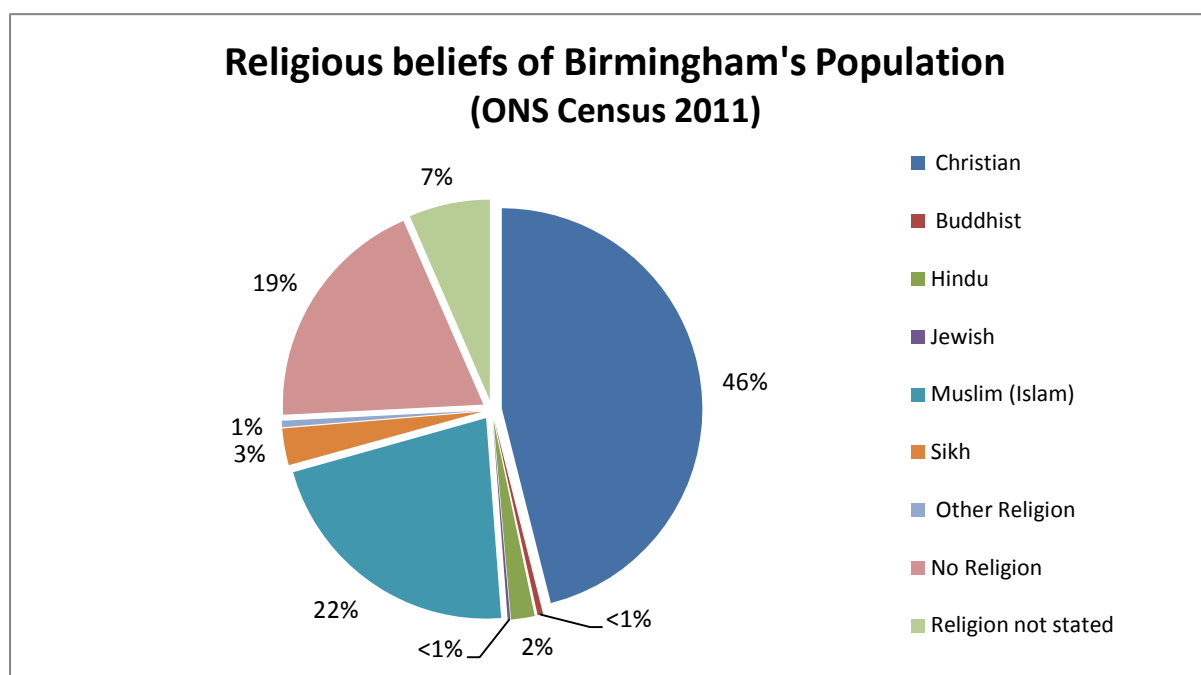
<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011censuskeystatisticsforenglandandwales/2012-12-11#ethnic-group>

**Figure 2 – Population by Ethnic Group (Census 2011)**

The implications of this for health need are that some chronic conditions are more common in certain ethnic groups and may present earlier than for the general population; this is due to a complex mix of genetic, cultural and socio-economic factors. An example is that people of South Asian ethnicity are at greater risk of developing Type 2 Diabetes (T2D) and tend to develop the condition at an earlier age than the general population; this is seen in the higher rates of T2D in Birmingham. Conversely since the proportion of the population aged over 65 in Birmingham is mainly White British, most adults requiring support with chronic conditions will currently be of this ethnic group.

Linked to ethnicity are the subjects of language and religion; while the 2011 census data indicated Christianity remained the most prevalent religion (46.1%) and most (82.1%) of households spoke English as a main language, there are areas of the city where this differs and will continue to adapt as the demographic of the city changes.

The religious beliefs and languages spoken in Birmingham are summarised in figure 3 and table 4.

**Figure 3 – Religious beliefs of Birmingham's population****Table 4 Households that have English as a main language**

	Number of households	% people aged 16 and over in household have English as a main language	% Households where at least one but not all people aged 16 and over have English as a main language	% people aged 16 and over in household but at least one person aged 3 to 15 has English as a main language	% households where no people have English as a main language
<b>England</b>	22,063,368	90.9	3.9	0.8	4.4
<b>W. Midlands</b>	1,086,748	87.0	6.0	1.2	5.7
<b>Birmingham</b>	410,736	82.1	8.5	1.9	7.5

(Source: ONS Census 2011 data)

Religion, culture and language can act as barriers to accessing any service, including pharmacy; provision of pharmacy services should not be impacted upon by the belief systems or culture of staff or potential service users. Pharmacists that find the provision of services is at odds with their own personal or moral code can choose not to provide that service; they must, however, inform the patient of alternative providers that can cater for their needs. It is important that pharmacists are aware of the local community they serve in order to provide accessible services and research evidence suggests that pharmacy staff demographics are often reflective of the local community.

With regard to language specifically, NHS Choices includes information to indicate whether a pharmacy has multilingual staff and there is provision more generally for interpreters to facilitate consultations and interactions with health care providers.

## Deprivation

Deprivation in this assessment is taken to mean socio-economic deprivation, which is summarised in England using the Indices of Multiple Deprivation (IMD) score (2015). This score system, published by the Department of Communities and Local Government (DCLG) incorporates income, employment, health, education and skills, barriers to housing, crime, and the living environment. Using this system, Birmingham is ranked as the 7<sup>th</sup> most deprived LA in England, out of 326<sup>28</sup>.

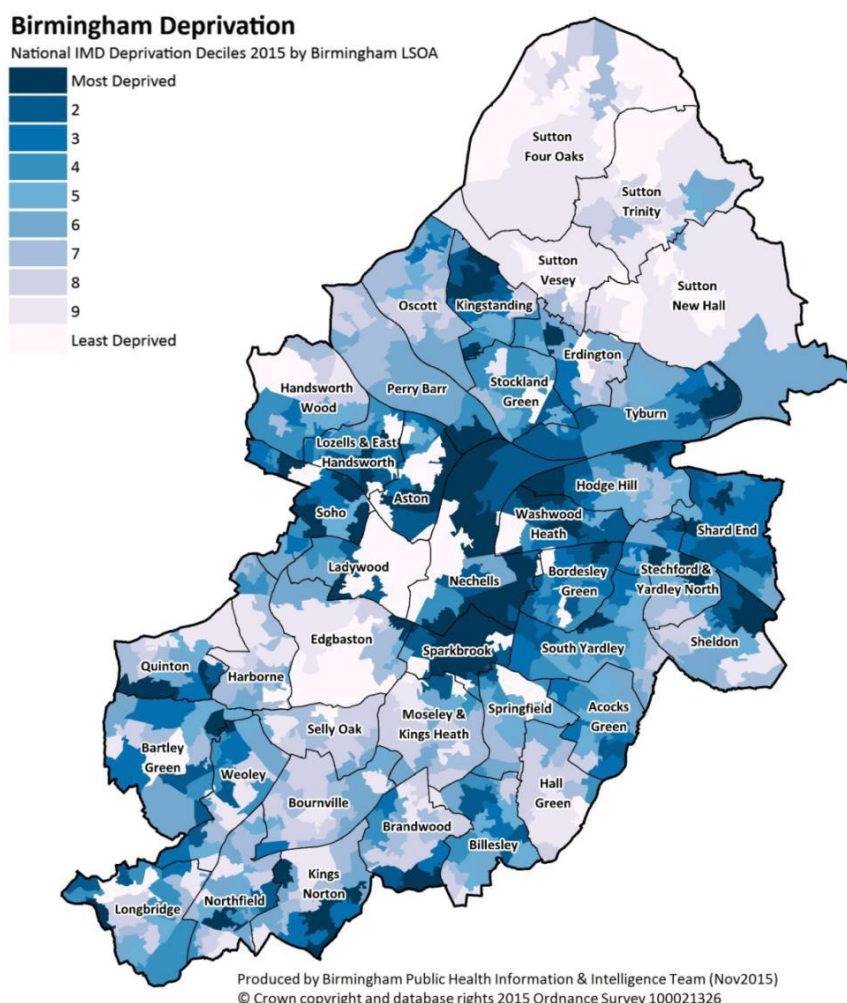
Deprivation across the city is not uniformly distributed, however, with pockets of affluence in the north and parts of the centre of the city (Figure 4). However, the majority of the city is more deprived than the England average, with 40% of the population living in areas ranked in the bottom decile (10%) of the country. These pockets of deprivation are particularly concentrated around the centre of the city, where the population is younger and more ethnically diverse.

Deprivation is broken down to a Lower Super Output Area (LSOA) level; this is a small geographical area (usually of between 1000 and 3000 residents) that allows us to look in a high level of detail at the needs of the city. The close links between increasing deprivation and poorer health outcomes, at a population level, have been well established; this is driven by a complex relationship including environmental, social, and behavioural factors. Policy recommendations in England to address health inequalities occurring as a result of this suggest a 'proportionate universalism' approach; this means ensuring service provision is available to all but with increasing levels of support for increasing levels of socio-economic deprivation. In the context of community pharmacy, this means making sure all Birmingham residents benefit from quality pharmaceutical services but that there may be greater concentration of providers for services in areas of greater deprivation.

Examples include a greater proportion of people developing chronic conditions at a younger age and greater concentrations of vulnerable adults and children in the more deprived areas. Relevant services will be concentrated in these areas.

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<sup>28</sup> IMD 2015 Upper Tier Authority Summaries  
<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

**Figure 4 – Map of Birmingham showing deprivation level at Lower Super Output Area (LSOA) level**

Source: Index of Multiple Deprivation (2015)

## Population forecast

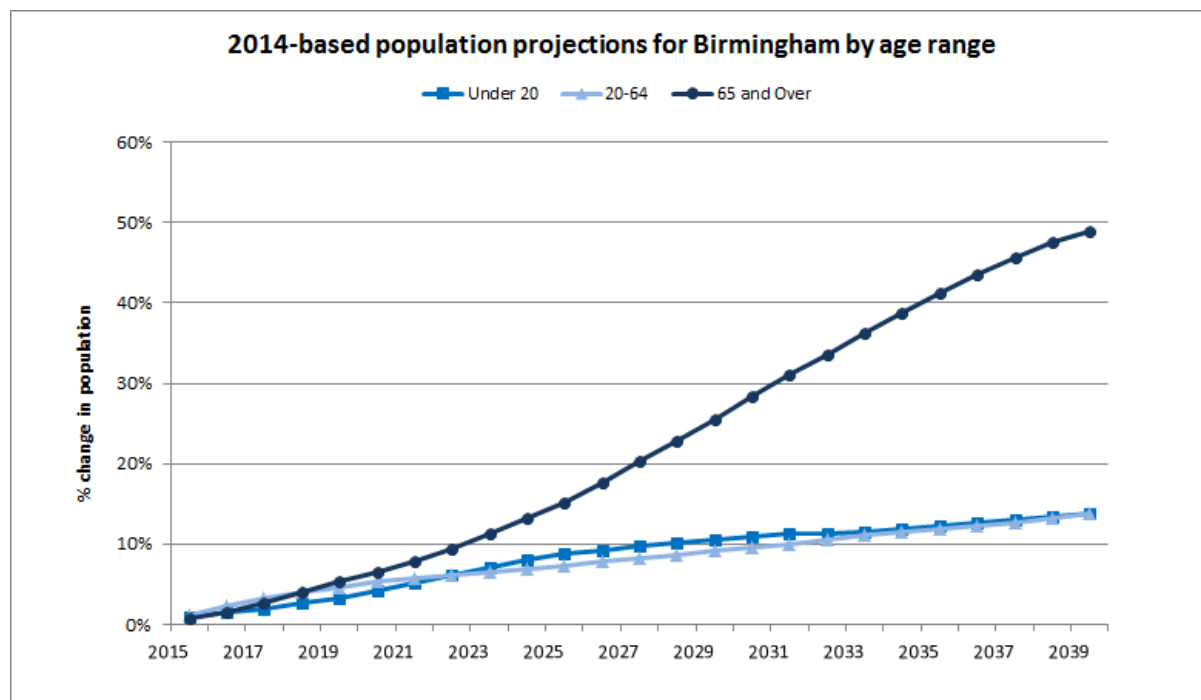
Birmingham has a very dynamic population, partly due to it having a younger population than England, and a high proportion of people from ethnic minorities. Population forecasts published in 2007 suggested ethnic minorities in Birmingham would continue to grow in comparison with the White population up to at least 2026<sup>29</sup>.

Figure 5 shows the trajectories of change in broad age groups between 2014 and 2039. All age groups (Under 20, 20-64, over 65) see continued growth but this is most rapid in the 65 and over age group. When broken down further, the greatest increase is anticipated to be among the over 85s with a 90% increase by

<sup>29</sup> Simpson L. Population forecasts for Birmingham, with an ethnic group dimension. University of Manchester. [www.hummedia.manchester.ac.uk/.../2007-12-population-forecasts-for-birmingham.pdf](http://www.hummedia.manchester.ac.uk/.../2007-12-population-forecasts-for-birmingham.pdf) [accessed 16/05/17]

2039<sup>30</sup>. This group constitute a relatively small actual number of people compared to other age groups but nonetheless, Birmingham follows the same ageing population trajectory as England generally.

**Figure5: Projected percentage change in Birmingham population 2010 to 2030 by age groups<sup>6</sup>**



The previous PNA received feedback that town planning information should also be used to consider the impact of any major housing developments on need for pharmacies in the next three years. The population projections above are based on modelling whereas planning information can indicate smaller population changes over a shorter time period specific to particular localities where major housing developments are planned.

Most developments create small localised changes in population size, unlikely to affect pharmacy need and some of the people moving home will move within the city; this is not likely to impact on overall population increase for the city. Data supplied by Birmingham City Council's planning team indicates that the majority of developments in Birmingham have fewer than 200 'dwellings', each modelled to accommodate on average 2.48 people, so contribute to population changes of less than 500 people in an area. The average ratio of pharmacy to population in Birmingham is 1 pharmacy : >3,500 people. Data from the Birmingham Development Plan '5 year land supply' indicates one single development that could impact this, which is located in Langley, where 1,050 dwellings are planned and could create a community of 2,604 people. This is not yet in construction phase and so is unlikely to impact the population size in the next three years but the need for a pharmacy in this area should be considered in future assessments for the area.

<sup>30</sup>ONS

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2>

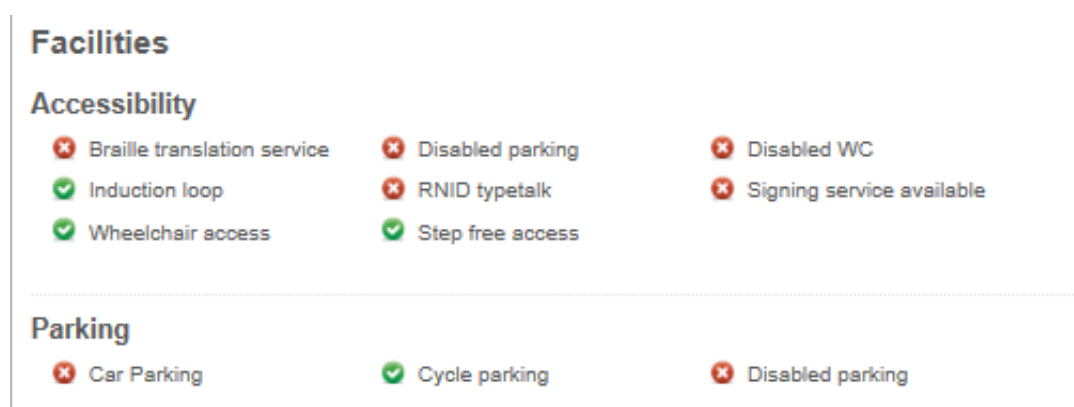
The cumulative impact of housing developments in an area could also lead to larger increases in population size; however no areas in the city were identified where this has led to large localised population increases. Access to pharmaceutical providers is considered in section 7 and shown by District in Appendix C.

## Disability

Almost half (49%) of people who claim Employment Support Allowance due to illness or disability have a mental health disorder, which equates to 25,680 in Birmingham. This indicates the degree to which mental health contributes to poor health and disability in Birmingham and although severe mental health illness has been discussed earlier, this may be a subject pharmacies seek to cover in their choice of annual health promotion campaigns, staff training and self-care advice expertise.

More broadly with regard to disability in general, the Equalities Act 2010 legislates against direct discrimination of any person for the supply of goods or services, employment, and other such matters. Pharmacies are required to make reasonable provisions to accommodate any person with disability both on their premises and in terms of service, for example wheelchair access and ramps. Provision of disabled-friendly services (wheelchair accessible consulting rooms, provision for those with visual or hearing difficulties, etc.) should be considered an important aspect of good service provision. The NHS Choices website indicates which individual pharmacies offer facilities to enable access for people with different disabilities (see Figure 6); this information is not currently available in a collated format and would provide useful evidence for PNAs. This will be considered in the recommendations of this report.

**Figure 6: snapshot of Facilities of a pharmacy in Birmingham. Source: NHS Choices**



## Demographics and Pharmacy: what does the evidence say?

A rapid review of evidence regarding the relationship between demography and pharmaceutical service access identified a survey of the population in North Staffordshire that assessed access of prescription and over the counter medicines. Findings indicated that collecting prescriptions was the main reason people used a pharmacy and in the last month, 57% of responders had visited a community pharmacy for this



purpose<sup>31</sup>. This was not evenly distributed across the population with some groups more likely to have visited a pharmacy for collecting prescription medicine:

Prescription collection:

- poorer self-rated health
- female
- increasing age(highest among 65+ years) 'older' people
- routine/manual social group
- perceived vascular risk
- do not take physical exercise
- smoker

Fewer people reported visiting the pharmacy for over the counter medicines (39.6%) and the demographic was different, with a greater proportion of younger people, those in managerial/professional social group and were more likely to report their health as good/fair.

Although it is noted these results may not be generalisable to the Birmingham population, it is applicable to the UK context and highlights groups where either there may be greater opportunity to engage in less well known pharmacy services for which these groups have higher health need.

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<sup>31</sup> Boardman H, Lewis M, Trinder P, Rajaratnam G, Croft P. 2005. Use of community pharmacies: a population-based survey". *Journal of Public Health*. 27 (3): 254-262.

## 6. Health in Birmingham

The JSNA contains a more complete analysis of health in Birmingham; this section of the PNA highlights features particularly relevant to pharmaceutical needs such as prevalence of long term conditions and lifestyle statistics relevant to locally commissioned services. A review of the 2018 JSNA did not indicate any particular health needs beyond this of relevance to pharmaceutical service need.

### Long Term Conditions

Long Term Conditions (LTCs) that have a notable impact on health in Birmingham are Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus (mainly Type 2 Diabetes) and Stroke. Table 5 shows that the 'QOF' prevalence of CHD, COPD and Stroke are below the national average but Diabetes prevalence is higher than the England average (6.7%) with the highest proportion in Sandwell and West CCG (9.0%). Improving the health outcomes of people with these conditions would help reduce premature mortality in Birmingham.

The cause specific mortality rate for preventable cardiovascular, preventable respiratory, preventable cancer, preventable liver diseases are all markedly higher than the England average (see Table 6).

**Table 5 – Prevalence of chronic diseases in Birmingham (QOF)**

	CrossCity CCG (%)	South & Central CCG (%)	Sandwell & West CCG (%)	England median (%)
<b>CHD</b>	3.0	2.6	3.0	3.3
<b>COPD</b>	1.7	1.5	1.5	1.9
<b>Stroke</b>	1.6	1.3	1.4	1.8
<b>Diabetes</b>	8.0	8.0	9.0	6.7

(Source QOF 2015/16, [www.hscic.gov.uk/qof](http://www.hscic.gov.uk/qof))

**Table 6 – Outcomes from chronic diseases**

	PHOF Data	Birmingham (per 100,000 popn)	England (per 100,000 popn)
<b>Preventable deaths in &lt;75s from cardiovascular disease (incl stroke)</b>	2013-15	66.7	48.1
<b>Preventable deaths in &lt;75s from respiratory disease</b>	2013-15	23.9	18.1
<b>Preventable deaths in &lt;75 from liver disease</b>	2013-15	25.2	18.0
<b>Preventable sight loss from diabetic eye disease</b>	2014-15	4.1	3.2

(Source: <https://fingertips.phe.org.uk> )

Disease registers that are used nationally suggest that Birmingham has a lower prevalence rate of some of these chronic diseases compared to the England average; however this may be associated with the younger age distribution in the city, as discussed earlier. The prevalence of Diabetes however appears to be significantly higher than the England average, and may reflect a higher proportion of people with risk factors, such as being overweight or obese or being of South Asian origin<sup>32</sup>. Type-2 diabetes is up to 6 times more common in people of South Asian descent, and risk begins from the age of 25 years, as opposed to 40 years in the White population<sup>33</sup>. However, it is important to note that QOF figures are likely to be an under-estimate, as there is an undiagnosed cohort of patients.

### Smoking:

Tobacco use is the biggest cause of preventable mortality in the UK and worldwide and is a risk factor for all of the 5 leading causes of death<sup>34</sup>; in the UK smoking prevalence has fallen in the last decade, and 2015 saw the highest proportion of quitters in over 40 years<sup>35</sup>. According to the latest Public Health Outcomes Framework indicator, smoking rates in adults in Birmingham (14.3%) are similar to the England average (15.5%)<sup>36</sup>. Smoking prevalence is not uniform within Birmingham, however, with central and deprived areas having a higher prevalence than less deprived areas<sup>37</sup>. Though we have seen a continual decline aided by public health campaigns and legislation, continued efforts to reduce this further are needed to reduce poorer health outcomes of smokers in the City.

PHE and ASH support the use of e-cigs for people unable or unwilling to stop smoking and research from PHE suggests e cigs are 95% less harmful than cigarettes. Birmingham's e-cig trial in 2016 (9 pharmacies) had an 83% quit rate (n=48) and nationally it appears e-cigarettes have led to changes in smoking habits<sup>38</sup>. It is hoped this will reduce significant morbidity, premature mortality and contribute to reducing health inequalities.

### Sexual health

Since the last PNA, new STI diagnoses in Birmingham (excluding chlamydia) among the under 25s has fallen to 6,772 (940 per 100,000). However the city still remains significantly worse than the England average. Diagnosed HIV prevalence has continued to increase and some 1,800 people are living with HIV in the City, with 120 new diagnoses in 2015. Between 2013 and 2015, almost 40% were considered to be late diagnoses,

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<sup>32</sup> National Institute for Health and Care Excellence (2012) Preventing type 2 diabetes: risk identification and interventions for individuals at high risk [PH38]. London: National Institute for Health and Care Excellence

<sup>33</sup> Diabetes UK. [http://www.diabetes.org.uk/About\\_us/News/Young-South-Asian-people-at-higher-risk-of-diabetes-and-associated-heart-disease/?print=1](http://www.diabetes.org.uk/About_us/News/Young-South-Asian-people-at-higher-risk-of-diabetes-and-associated-heart-disease/?print=1)

<sup>34</sup> WHO. 2016. Tobacco Factsheet.

<sup>35</sup> ONS. 2015 Adults Smoking habits in the UK.

<sup>36</sup> The network of Public Health Observatories. Public Health Outcomes Framework for Birmingham, 2017. <http://www.phoutcomes.info/> [accessed 20/06/2017]

<sup>37</sup> Spencer-Jones, C (2009). Tobacco Control National Team – Visit to Birmingham [PowerPoint Presentation]. South Birmingham Primary Care Trust. Delivered September 2009.

<sup>38</sup> BCC E Cigarette Trial Presentation. Available locally from BCCs SSS commissioning team

leading to avoidable ill health and potential transmission. There were 33,000 chlamydia screenings carried out in 2015 in the 15-24 age group, and 2,976 new cases detected.

The crude pregnancy rate for 15-17 year old females (25.4 per 1000) is also high compared to England (20.8 per 1000), though there has been a national downward trend in teenage conceptions<sup>39</sup>. Those disproportionately affected by sexual-ill health include young people, black minority ethnic communities and men who have sex with men (MSM). Pharmacies are well placed to help prevent and reduce both teenage pregnancies and STIs, through provision of contraception and advice as necessary.

### Substance misuse

Alcohol and drug dependency leads to significant harm and places a financial burden on communities, which can be reduced through investment in prevention, treatment and recovery interventions. For example, alcohol and drug users commit fewer crimes and are less prone to blood-borne viruses and other illnesses when they access substance misuse services. In 2014/2015 in Birmingham there were 6,228 adults engaged in treatment for three months or more, 93% of the treatment population and 2.9% of opiate users who left drug treatment did not re-present within 6 months (significantly lower than 6.7% nationally). For non-opiate users this was 19.0% (significantly lower than 37.3% nationally); 16% of drug users completed their treatment free of dependence which is the same proportional as national performance<sup>40</sup>.

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<sup>39</sup> PHE. 2017 Sexual and Reproductive Profiles. [Online] <https://fingertips.phe.org.uk/profile/sexualhealth/data>

<sup>40</sup> Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

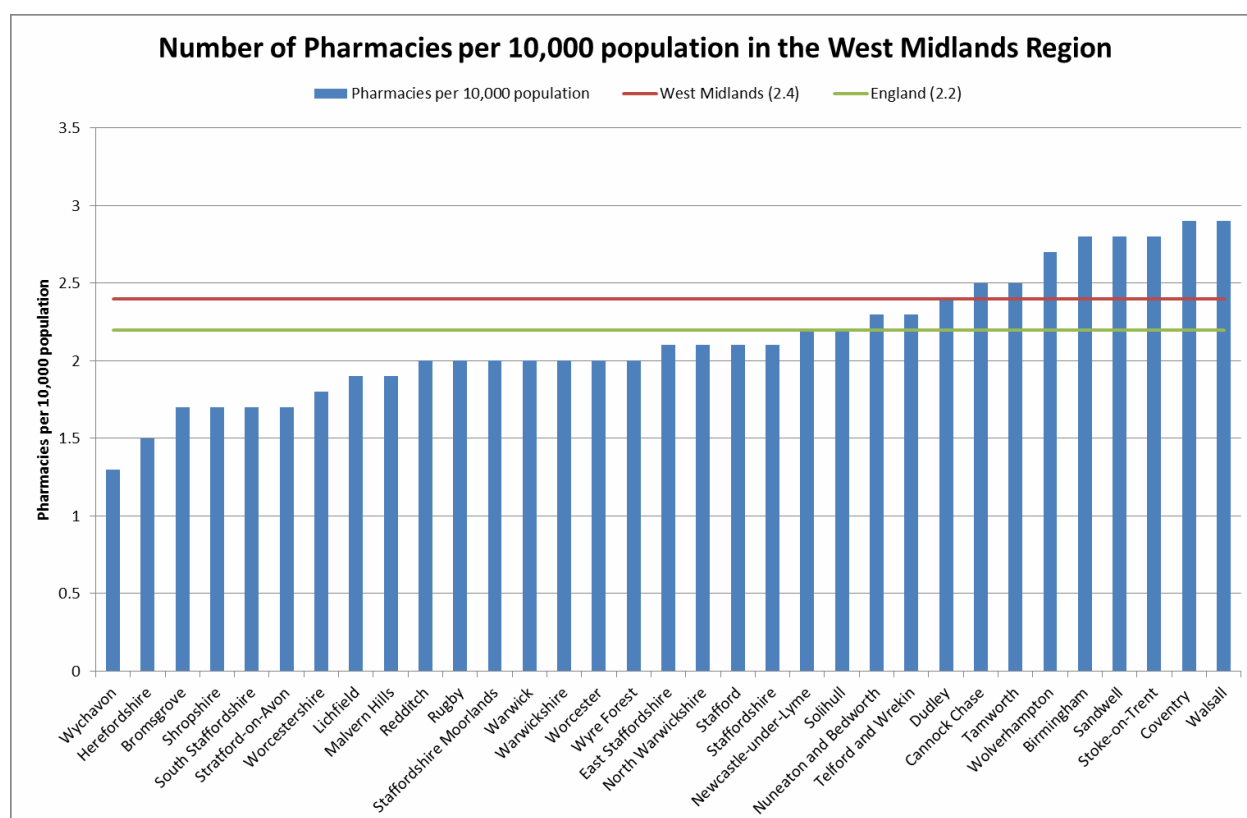
## 7. Assessment of provision

A review of pharmacy providers and pharmaceutical services was undertaken between October 2016 and July 2017 through work with the NHS England area team, the Birmingham LPC, Birmingham City Council commissioners and from the Commissioning Support Unit. The LPC circulated information from the 2015 Birmingham PNA to pharmaceutical providers in Birmingham and asked them to update their information. Initially it was intended that the results of an NHS England exercise to update information regarding local contractors was to be used, however results were not ready in time for this PNA. The results of the 2018 exercise are summarised in Appendix C and available in full via a separate document titled 'Birmingham Pharmacy List 2017 FINAL'.

### Per capita access to pharmaceutical providers

There are 285 community pharmacies (including one LPS contractor), 2 appliance contractors and 14 distance selling pharmacies in Birmingham; this equates to 301 pharmaceutical providers, similar to the 2015 PNA.

Based on current mid-year population estimates and the number of community pharmacies alone there are approximately 2.65 pharmacies per 10,000 population. Estimates by the LGA produced in time for the 2015 PNA indicated a slightly higher proportion at 2.8 pharmacies per 10,000 population (Figure 7). Since only a few pharmacies have closed since the previous PNA in 2015, this change is more likely due to population increase in the last three years; Birmingham continues to have higher per capita access compared to the West Midlands and England average at the time of most recent data collation.

**Figure 7 – Number of pharmacies per 10,000 population in the West Midlands Region<sup>41</sup>**

Source: Local Government Association. Snapshot November 2014

### Geographical distribution

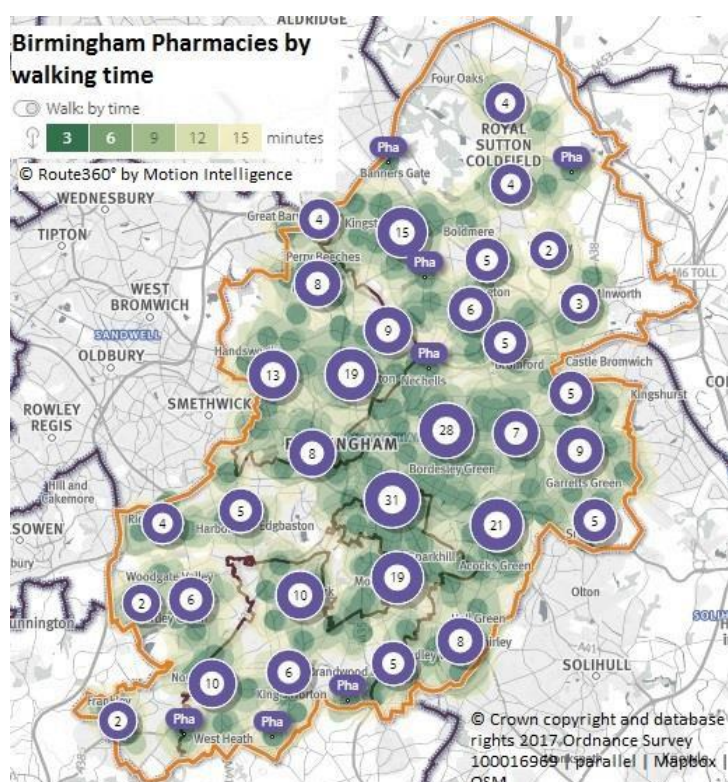
The concentration of pharmacies is well distributed across Birmingham, with more pharmacies in areas with higher density residence. Generally this is also the case in areas of greater socio-economic deprivation where per capita access is higher in more deprived Districts; deprivation using is often used as a proxy for greater health need (Appendix C). The exception is Yardley, which has slightly lower per capita access compared to the Birmingham average at 2.52 per 10,000 although this is still but this higher than the last West Midlands and England average.

Two districts, Selly Oak and Edgbaston have lower per capita access than the Birmingham and West Midlands average at 1.60 and 1.57 per 10,000 respectively. The previous PNA identified that based on mapping, there appeared to be poorer geographic access in Edgbaston and Sutton Coldfield, however noted upon further analysis, the areas with no pharmacies in these Districts were where large hospital, university sites or non-residential areas such as park are sited. While per capita access to pharmacy is an indicator of levels of access, geographic distribution is important too and mapping for the 2018 PNA of access to a

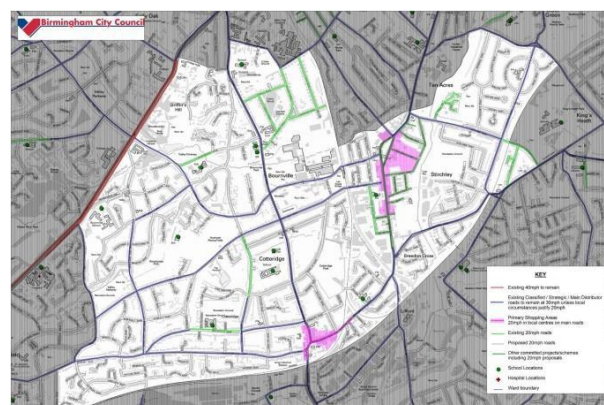
<sup>41</sup> NHS Information Centre. General Pharmaceutical Services in England 2002-2003 to 2011-12, PCT level appendix. <http://www.ic.nhs.uk/pubs/pharmserv1112> [accessed 04/12/2012]

pharmacy within a 20 minute walk highlights that the majority of Selly Oak is well served (figure 8). A pharmacy on the border of Brandwood and Worcestershire appears to be important for securing good geographical access for this area of the district. The other area of Selly Oak with visually weaker geographic access is a small area in Bourneville; however upon closer inspection this appears to be where Woodlands Park, two schools and Rowheath Playing fields are based (figure 9). Planning data does not indicate significant localised population increases due to new housing in this district that will affect per capita access to pharmacy in Selly Oak. Any pharmacy closures in Selly Oak and Edgbaston should however be reviewed by the BHWB if this occurs before the next PNA.

**Figure 8: Birmingham Pharmacies by walking time**



**Figure 9: Street view of Bourneville ward**



## Hours of access

Most pharmacies in Birmingham have core opening hours starting from 8.30am and until 5.30pm between Monday and Friday, so during the week during these hours there is good access across the city. There are 50 pharmacies on a '100 hour' contract, where pharmaceutical services are offered earlier than 8.30 am, later than 5.30pm and on weekends. The location of these pharmacies is shown in figure 10; there are slightly fewer than reported in the 2015 PNA (54) however there are still 100 hour pharmacies in all Districts in Birmingham with the exception of Selly Oak where there is a 100 hour pharmacy on the border with Hall Green. It is important to note that the geographical placement of 100 hour pharmacies appears to be



clustered in the centre of the city, with little presence in the southern wards. This is unsurprising as these pharmacies were not placed strategically or in-line with any commissioning objectives; rather many are located in large supermarkets and big stores which already had long opening hours. This location is also where there is higher population density and so potentially greater demand for services per pharmacy.

**Figure 10: Location of all pharmacies in Birmingham, by opening hours**

#### All Birmingham Pharmacies by Type

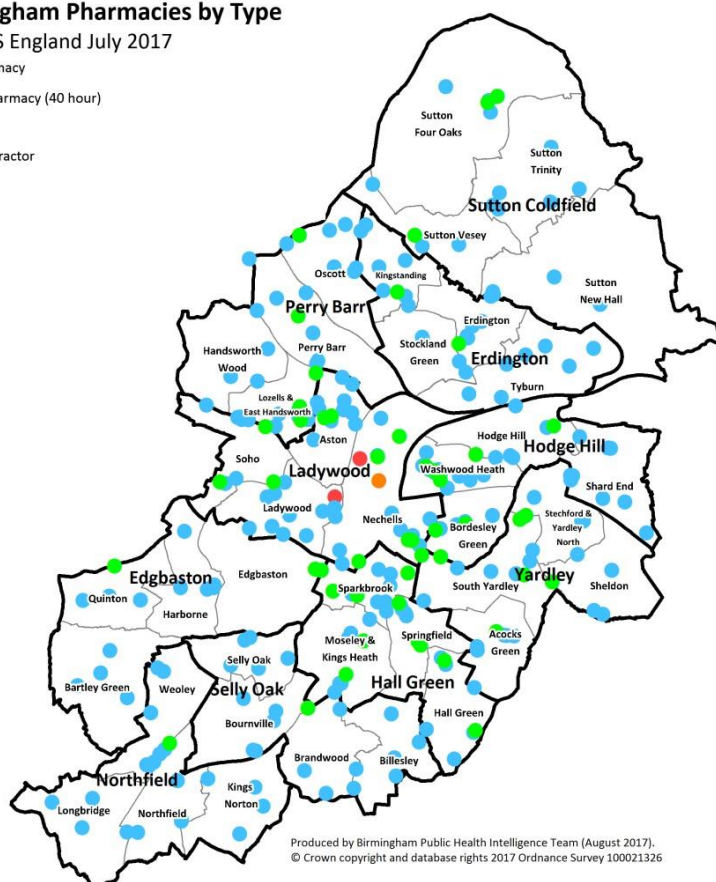
Source: NHS England July 2017

● 100 hour pharmacy

● Community pharmacy (40 hour)

● LPS pharmacy

● Appliance contractor



Specifically regarding weekend access, 210 pharmacies are open at some point on Saturday (2015 = 216) covering all Districts in Birmingham; many of these providers are open Saturday mornings but not afternoon (table 7).

**Table 7: Pharmacies open on Saturdays and Sundays**

Number of pharmacies	Open on Saturday	Remaining open after (Saturday):				Open on Sunday	Unknown opening hrs
		1pm	3pm	5pm	7pm		
<b>285</b>	210	164	146	131	62	74	1



There are 74 pharmacies open on Sundays (2015 = 80) in all Districts in Birmingham except Selly Oak. Pharmacies based within large stores (over 280 square metres) are legally bound by Sunday trading regulations and can only open between 10:00 and 18:00, for a maximum of 6 consecutive hours .

### **Bank Holiday provision**

On public holidays and out of hours, medical care is provided by the Badger Out-Of-Hours (OOHs) GP service. The service currently covers Birmingham and normally operates 18:30pm to 8.00am Monday to Friday, and all day Saturday, Sunday and public holidays. Badger clinics (Birmingham and District General Practitioner Emergency Rooms) are aware of pharmacies that are open and dispensing during these hours. Pharmacies also operate on a rota system on Bank Holidays, which is posted on NHS Choices for the general public.

### **Conclusion regarding access to pharmacies:**

Evidence in this section indicates there continues to be above average per capita access to pharmacies in Birmingham, which are well geographically distributed by population density and levels of deprivation. Opening hours also indicate good access during usual working hours, on evenings and weekends across the city. Any pharmacy closure in Selly Oak or Edgbaston should be reviewed by the BHWB if this occurs before the next PNA is prepared in 2020.

### **Distance-Selling pharmacies**

There are 14 pharmacies in Birmingham that are contracted to provide pharmacy services via the internet or mail. These are pharmacies that must adhere to all regulations concerning other pharmacies; the only additional stipulation is that they are not permitted to provide essential services dispensing face to face. These pharmacies are required to provide services to patients in the whole of England and are therefore not considered further in this report. However, the 2015 PNA recommended that future PNAs should monitor the activity of such pharmacies to see if they could be utilised to provide non-essential services for the Birmingham population. Evidence gathered in the writing of this report does not indicate that distance selling pharmacies are providing advanced, enhanced or locally commissioned services in Birmingham.

### **Conclusion regarding distance selling pharmacies**

Distance selling pharmacies are shown on figure 10; commissioners should include these providers in the scope for non-essential pharmacy services where the providers meet commissioning criteria, particularly where the location of the providers may improve access.

## Essential services

### Dispensing

Each pharmacy in Birmingham dispenses 5,588 items per month on average, which is 16.9% lower than the West Midlands median of 6,533 (Table 8). This could be the result of having a considerably higher number of pharmacies than other localities, which may suggest current pharmacies have capacity to provide services to more people. The lower number of prescriptions dispensed may also be a function of the younger age profile in the city, meaning there is a lower burden of disease; however without further research into this, it is not possible to determine a more definite reason.

**Table 8 - Prescriptions dispensed per pharmacy per month in the West Midlands 2015/16**

Area	Prescription items dispensed per month (000s)	Average monthly items per community pharmacy
England	82,940	7,096
West Midlands Region	6,402	6,533
Birmingham	1,621	5,588

Source: NHS Digital and NHS Business Services Authority

### Cross border dispensing

The city is densely populated, and as a major part of the West Midlands conurbation, shares borders with the metropolitan areas of Solihull, Warwickshire, South Staffordshire, Walsall, Dudley, Sandwell, and Worcestershire (see Appendix D). There are a range of community pharmacies accessible near the borders with Birmingham and it is likely that residents of Birmingham have prescriptions dispensed in these areas, and also residents from outside the city use Birmingham's pharmacies. Further work to establish the extent of cross border dispensing should be undertaken, however at the time of writing this PNA data was not obtained regarding the postcode of prescriptions dispensed, so this work could not be undertaken.

### Appliances

Appliances can be dispensed by any pharmacy or appliance contractor and can be broadly categorised as stoma appliances, incontinence appliances, and dressings. Birmingham currently has 2 appliance contractors that provide appliances, both located in Ladywood.

### Conclusion for essential services

Essential services (mainly dispensing of medications) are fundamental services for the population; as discussed with regard to pharmacy access, these services appear to be accessible for the majority of the cities' population geographically and at different times of day.

There are no gaps in the provision of core services for the Birmingham population.

## Advanced services

### Medicines Use Review (MUR)

The average number of MURs per pharmacy continues to increase and the number of pharmacies providing MUR has increased since 2012/13 at 82% of pharmacies across the city. This is a lower percentage of pharmacies provide the service compared to England/West Midlands averages. During 2015/16 data indicates 71,833 MURs were declared by Birmingham pharmacies; table 9 shows how Birmingham compares with the West Midlands region. Data was not available at the time of writing this report regarding the number of MURs per individual pharmacy and the percentage of MURs delivered among target groups. Since most pharmacies in the city provide MUR it is likely that most of the population have access to the service, however this information would support assessment of whether there are areas with poor access. Also, the extent to which the service meets its target population and compared with performance elsewhere.

**Table 9 - Average MURs / pharmacy (England, West Midlands' and Birmingham 2015/16)<sup>42, 43</sup>.**

	% pharmacies providing MUR		Average number of MURs per pharmacy	
	2012/13	2015/16	2012/13	2015/16
<b>Birmingham</b>	85	82	258	282
<b>West Midlands</b>	89	93	267	286
<b>England</b>	91	94	267	292

### New Medicines Service (NMS)

Birmingham performs slightly worse compared to the national average for the NMS service; between April 2015 and March 2016 nationally the monthly average number of NMS per pharmacy providing the service was 9.94 compared to 9.16 in Birmingham. This suggests that those pharmacies providing the service could better promote the service to encourage use of it<sup>44</sup>. The average number of prescription items claimed per month Nationally was 1,241 compared to 1,306 in Birmingham; ideally pharmacies in Birmingham should aim to achieve a lower ratio of prescription items per NMS. PSNC data identifies 150 claiming NMS pharmacies in Birmingham, which is approximately half; there is therefore capacity to offer the NMS service more widely and based on the data, to offer more NMS consultations per month on average by those pharmacies currently providing the service.

### Conclusion for NMS

<sup>42</sup> NHS Digital. 2013. *General Pharmaceutical Services*. [Online] <https://digital.nhs.uk/search?q=MUR&s=s> (Accessed 30/07/2017)

<sup>43</sup> NHS Digital, General Pharmaceutical Services in England: 2006/07-2015/16, 2016 <http://www.content.digital.nhs.uk/catalogue/PUB22317>

<sup>44</sup> PSNC. 2017. NMS Statistics. [Online] <http://psnc.org.uk/funding-and-statistics/nhs-statistics/nms-statistics/>

There is adequate provision of the service in Birmingham, however data regarding geographical distribution of the service would support assessment of equity of provision.

### Appliance Use Review (AUR)

AURs can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home and should improve a patient's knowledge and use of any 'specified appliance' listed below<sup>45</sup>:

a) any of the following appliances listed in Part IXA of the Drug Tariff:

- a catheter appliance (including a catheter accessory and maintenance solution),
- a laryngectomy or tracheostomy appliance,
- an anal irrigation system,
- a vacuum pump or constrictor ring for erectile dysfunction, or
- a wound drainage pouch;

(b) an incontinence appliance listed in Part IXB of the Drug Tariff; or

(c) a stoma appliance listed in Part IXC of the Drug Tariff.

**Table 10 - Average AURs per pharmacy 2015/16<sup>46</sup>**

Area	Community pharmacy and appliance contractors providing AURs	% providing AURS	Total AURS per community pharmacy and appliance contractor	Average AURS per community pharmacy and appliance contractor
England	140	1.2%	37,807	270
West Midlands region	15	1.5%	1,666	111
Birmingham	2	0.01%	271	136

Source: NHS Digital, NHS Business Authority

Table 10 shows the provision of AURs in Birmingham is lower than England and the West Midlands average; a total of 271 AURs were conducted in Birmingham (2015/16). Each pharmacy can provide a limited number of AURs, linked to the number of appliances it dispenses<sup>47</sup>. The service may also be provided through GP and secondary care services, so part of the reason for fewer AURs could be provision in other settings.

<sup>45</sup> Pharmaceutical Services Negotiating Committee website: Appliance Use Review (AUR) <http://psnc.org.uk/services-commissioning/advanced-services/aur/> (accessed 25/09/14)

<sup>46</sup> <http://www.content.digital.nhs.uk/catalogue/PUB22317>

<sup>47</sup> NHS Service Business Services Authority, <https://www.nhsbsa.nhs.uk/prescription-data/dispensing-data/dispensing-contractors-data> accessed 18 July 2017

Birmingham has two cancer centres, whose patients may require AUR services; University Hospitals Birmingham (UHB) NHS Foundation Trust is one of the largest regional centers for non-surgical cancer treatment in the UK. It has links with surrounding cancer units and accepts referrals nationally. The second is Birmingham Children's Hospital (BCH) is one of the largest specialist UK centres for childhood cancer.

As the city's older population is projected to increase over the next decade, there will be a need for commissioners to monitor whether the current number of providers in Birmingham (4 pharmacies and 2 appliance contractors) is sufficient to meet demand.

It is also unclear how well advertised the AUR service is to those who may benefit; without knowing this, or the demand for such a specialist service, it is not possible to determine if the service is reaching those that could benefit. If a need regarding AUR access is identified, there may be a need to assess workforce training needs as this could be a barrier to wider implementation of the service.

### Stoma Appliance Customisation (SAC)

During 2015/16, 25 pharmacies provided a total of 505 SACs in Birmingham, which is very low compared to the 2015 PNA and lower than the average for England and the West Midlands average (table 11)<sup>48</sup>. There is no upper limit on the number of SACs a pharmacy can conduct, however people receiving stomas may also access a stoma nurse from secondary care for advice or guidance regarding their stoma.

**Table 11 - SAC per pharmacy 2015/16**

	% community pharmacy and appliance contractors providing SAC	Total SAC	Average SAC per community pharmacy and appliance contractor
England	14.7%	1,237,651	715
West Midlands Region	14.1%	544,073	1,106
Birmingham	8.0%	505	20

Source: NHS Digital, NHS Business Services Authority

### Conclusion for advanced services

Advanced services are viewed as **relevant** services in Birmingham.

The provision of MURs appears to be good for the whole city and this has improved, possibly driven by policy directives and increasing evidence of service efficacy. There appears to be capacity for pharmacies to conduct more MURs, and for more pharmacies across the city to provide the service, which could be demand- or pharmacist-led. Commissioners should explore whether there may be scope for more existing

<sup>48</sup> NHS Business Authority. 2015. Number of Stoma Customisation fees per pharmacy per month. [Online] <https://www.nhsbsa.nhs.uk/prescription-data/dispensing-data/dispensing-contractors-data>

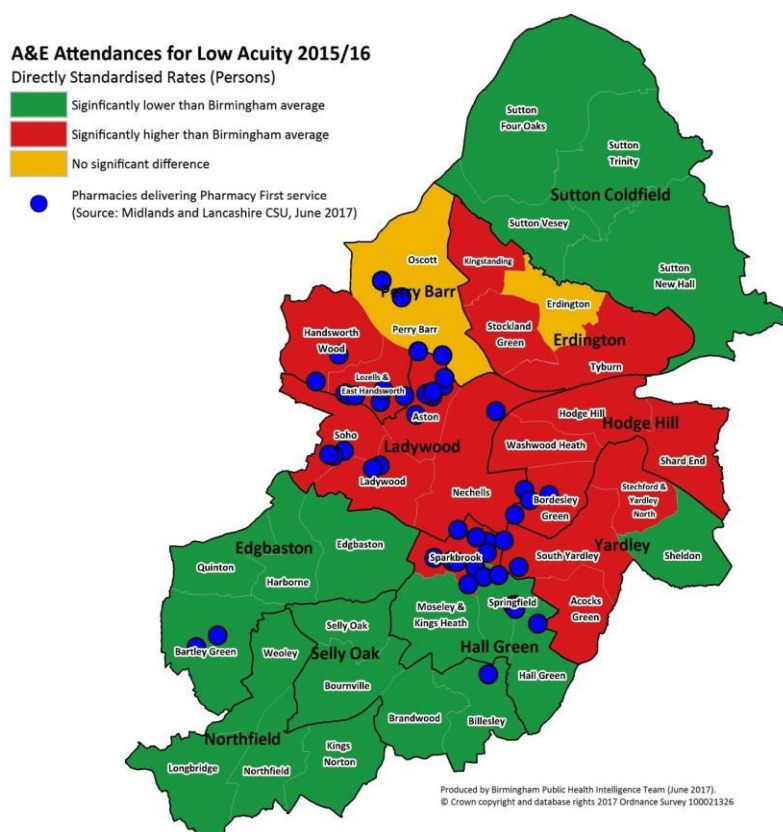
pharmacies to provide AURs and SACs, particularly those located in parts of the city that have older populations. Given the recent JSNA analysis regarding the mortality rate from a range of specified communicable diseases, including influenza, findings of the Birmingham Flu pilot should be considered regarding how pharmacy may help to address this need.

## Enhanced

### Pharmacy First (Minor Ailment Scheme (MAS))

Data for July 2016 to June 2017 indicates that 50 pharmacies provide this service, delivering 40,243 pharmacy first consultations per year (average = 805 consultations per pharmacy per year). The geographic distribution of these pharmacies is shown in figure 11 and is mostly well targeted in areas where there are more attendances for 'low acuity conditions' such as fever and diarrhoea. These types of attendances can often be managed by a community pharmacist and NHS England guidance suggests this as a solution to managing urgent care demand<sup>20</sup>. The map also shows that Hodge Hill, Erdington and Yardley may benefit from improved access to the service to reduce A&E attendances for low acuity conditions; if pharmacies on the border of Solihull and Yardley/ Hodge Hill provide the service, this may reduce need for the Pharmacy First service in these areas.

**Figure 11: Pharmacies delivering Pharmacy First compared to A&E attendance for low acuity conditions**



The variation seen across the city is also due to historical commissioning arrangements of the service and the impact on urgent care is not the only purpose of Pharmacy First / Minor Ailments services. Most evidence of efficacy indicates positive impacts on reducing GP demand. Figure 11 shows Sutton Coldfield and southern districts including Northfield and Selly Oak have particularly reduced access to the service. There are other models of care that can manage minor ailments such as use of Urgent Care centres and GP models of provision; also there may be provision of Pharmacy First services in bordering areas to the north and south of Birmingham that improve access to this type of provision. Nonetheless it is recommended that commissioners developing models of healthcare in these areas consider Pharmacy First as an option in future commissioning to support patients with managing minor ailments.

### Conclusion for MAS

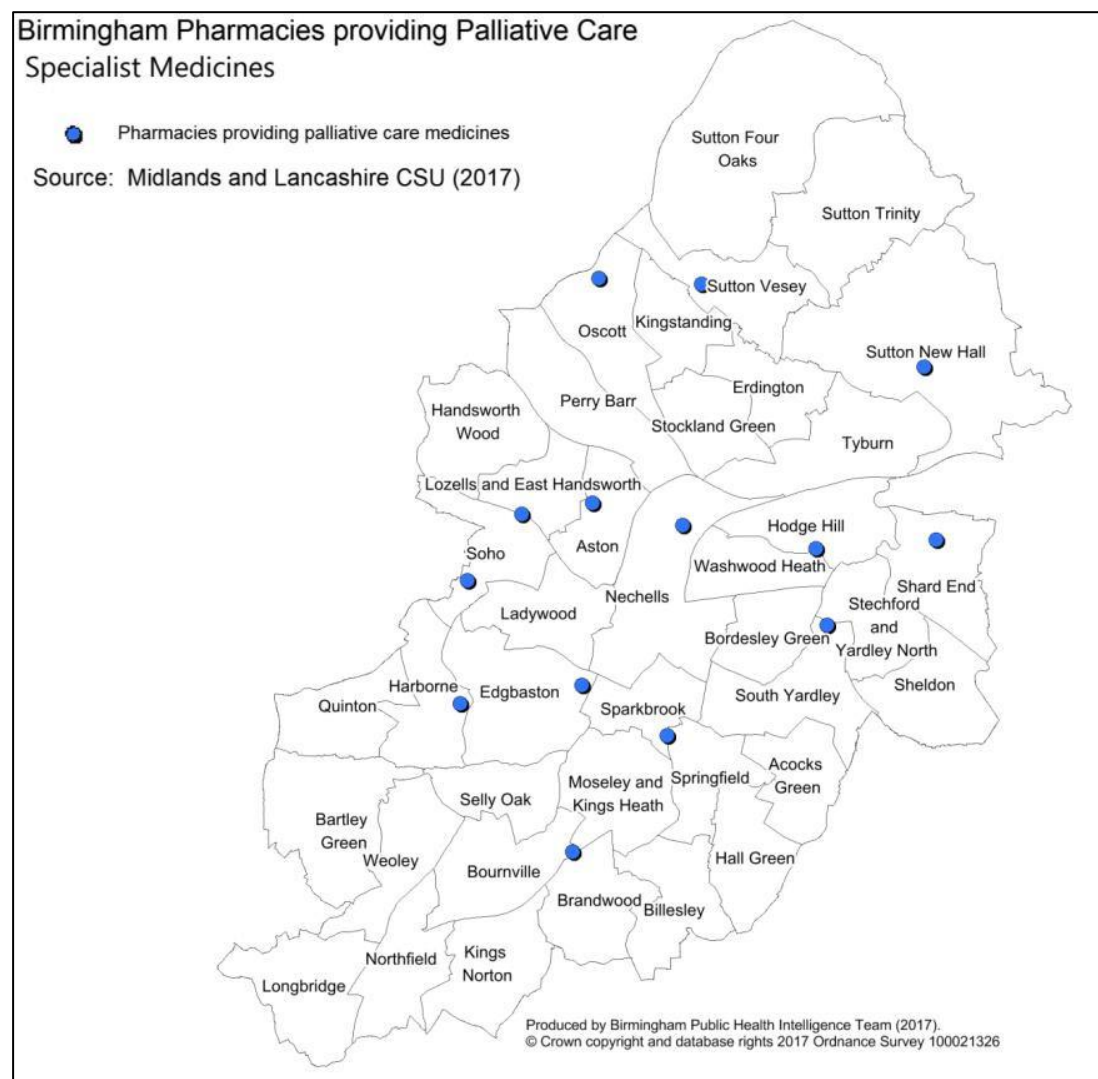
MAS is considered a **relevant** service.

Due to historical commissioning practices, across the city there are gaps in provision of this service in the southern, eastern and northern parts of the city. The value of such a service in these areas is should be factored into any commissioning decisions, particularly taking into account the deprivation of the locality being reviewed, and current services provided from non-pharmaceutical providers. Suitable links should be made with changes to the Urgent Care system. Furthermore, although results of an interim Pharmacy First evaluation were made available to the authors of this report, the full pilot evaluation should be completed and used to inform future commissioning.

This imbalance of the MAS service in Birmingham requires consideration, especially at a time when the Urgent Care system is under review.

### Palliative care access

There are 15 pharmacies in Birmingham that provide this service, with geographical spread across the city but reduced provision in southern wards, based on residential density. (Figure 12). Non-pharmacy services are also commissioned to provide this service and so may support provision of this service in these areas; there may also be provision in surrounding areas bordering with Birmingham.

**Figure 12 – Location of pharmacies providing palliative care specialist medicines**

A strategy is currently out for consultation regarding an Integrated Palliative and End of Life care system across Birmingham, which includes pharmacy provision of this service. The distribution in this PNA and findings from the consultation must inform future access. Some additional points for consideration are listed below:

- Most of the pharmacy providers (12 of the 15) are open 7 days a week and all are available 6 days per week.
- Northern and southern parts of the city have a higher proportion of older people who may have particular use for the service.
- As the city's older population increases, the need for this service may also increase.



### Conclusion for pharmacy palliative care service

This is considered a **necessary** service.

The current service based on pharmacy data alone suggests there are gaps in provision in the northern and southern parts of the city where need is likely to be higher; the current review of End of Life and Palliative care must ensure provision meets need across the city.

### Dermatology Dispensing

At the time of the 2015 PNA, there were two community based dermatology clinics with two nearby pharmacies providing specialist dermatology medicines, which was considered adequate provision.

Since then, this service has been decommissioned.

### Advice to care homes

At the time of the 2015 PNA, there were 9 pharmacies providing support quarterly to residential and nursing homes; the PNA concluded there may be opportunities to develop the service further in northern and southern parts of the city, based on need, alignment with the Better Care Fund and availability of pharmacies willing to provide this.

Since then, this service has been decommissioned.

### Locally commissioned services

The PSNC host a pharmacy service prospectus for inspiration for commissioners; there are many different services commissioned with pharmaceutical providers and this is influenced by local health priorities and commissioning strategies to meet health needs. The PNA therefore focusses on current locally commissioned services since health need specific commissioning strategies and needs assessments should consider provider type in their assessments.

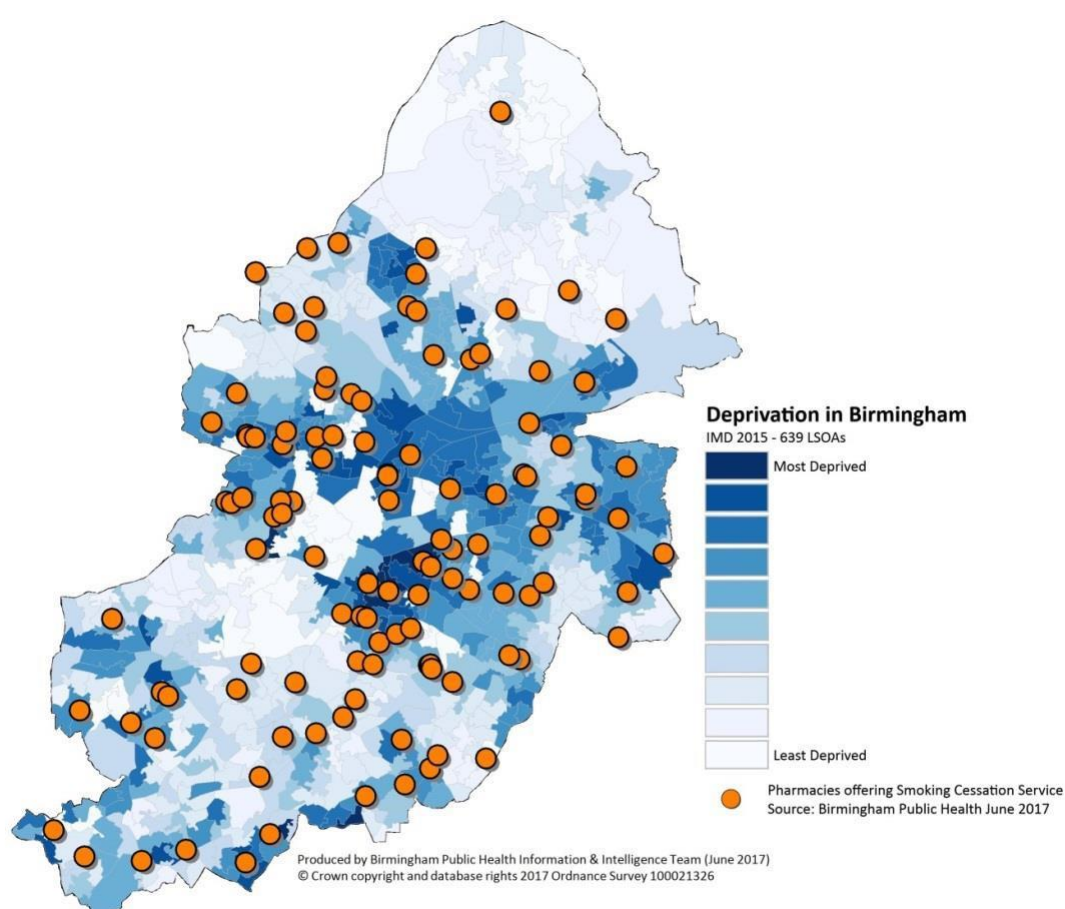
### Stop Smoking Service (SSS)

Most people who smoke are from poorer socio-economic groups and so reducing levels of smoking could have a big impact on reducing avoidable mortality and reduce the gap in life expectancy between richer and poorer communities. Pharmacies are suitable locations for such a service as they are accessible, often open extended hours, and can provide medications without delay. SSS in pharmacies is recommended by the

National Institute for Health and Clinical Excellence (NICE)<sup>49</sup> and opportunities to address smoking among children through advice given to mothers is recommended in this setting. Figure 13 shows the location of the 120 pharmacies in Birmingham commissioned to deliver SSS by level of deprivation (used as a proxy as recent data on smoking prevalence at ward level is not available and smoking is more prevalent in deprived areas). Services in pharmacies appear to be provided in wards where lung cancer incidence is higher than the city's average, which is where services are needed the most.

Areas that are not as heavily served with pharmacies operating Stop Smoking Services (SSS) have access to GPs that provide cessation advice and services. Current service provision is therefore considered to be good.

**Figure 13: Location of pharmacies providing smoking cessation services in Birmingham**



### Conclusion for SSS

SSS are a **necessary** service, as they play a key role in reducing one of the biggest harms to health in the city. There appears to be good provision of this service across the city and targeted where need is likely to be highest.

<sup>49</sup> Smoking Cessation Services. NICE Public Health Guidance PH10. <http://publications.nice.org.uk/smoking-cessation-services-ph10> [accessed 30/01/2013]

## Sexual health

### Emergency contraception

Emergency Hormonal Contraception (EHC) is provided to women who believe they are at risk of becoming pregnant; it is most effective in the first 72 hours post-intercourse, though more so the earlier it is taken. Provision in settings and at times that most suit vulnerable groups is an important public health measure to reduce the adverse outcomes associated with some unplanned pregnancy. The service commissioned by Birmingham Public Health is for those aged 13-21 years, who can receive it free of charge in pharmacies, which is in addition to that provided in GPs, specialist contraceptive clinics, and GUM clinics for women of all ages.

The aim of the service is to provide safe and simple access for young women, who may otherwise be reluctant to do so; the service was introduced to help reduce the number of teenage pregnancies in the city. Teenage conception rates have continued to drop and in 2015 Birmingham had an under-18 conception rate of 25.4 per 1000 females aged 15-17 years, which was higher than the England rate (20.8 per 1000)<sup>50</sup>. There is wide variation across the city with the majority of conceptions occurring in the eastern and southern edges of the city, although absolute numbers are small and not necessarily an indicator of where the service is needed most. It is also an aim of this service to address the higher than average level of repeat abortions in Birmingham<sup>51</sup>.

The new sexual health service in Birmingham, managed by 'Umbrella' offers different tiers of service with tier one offering basic provision (free condoms, EHC, STI self-sampling kit) and tier two offering more services (offering Tier 1 service plus chlamydia treatment, contraceptive pill, contraceptive injections, continuation of Hepatitis B vaccine injections). There is also a tier three more specialist service offered by select few providers with the necessary staff mix and facilities to do so.

Pharmacies are one of several providers commissioned through the Umbrella partnership to provider tier one (87 pharmacies) and two services (45 pharmacies); the distribution of these is shown in Figure 14.

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<sup>50</sup> Sexual and reproductive health profiles. Public health England. <http://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/3/gid/1938132988/pat/6/par/E12000005/ati/102/are/E08000025/iid/20401/age/173/sex/2> (accessed 17/07/17)

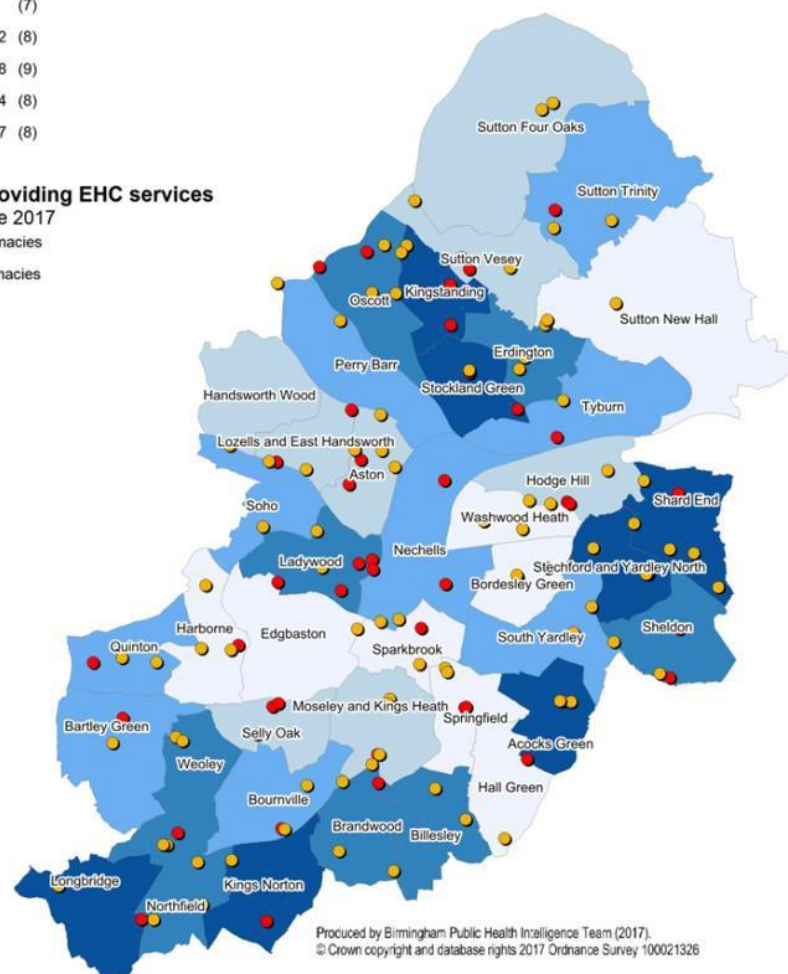
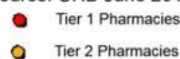
<sup>51</sup> Department of Health, Abortion Statistics, England and Wales <https://www.gov.uk/government/statistics/report-on-abortion-statistics-in-england-and-wales-for-2016> (accessed 17/07/2017)

**Figure 14: Location of pharmacies providing tier one and tier two sexual health services****Under 18 Conception Rates by Ward**

Source: ONS, 2012-2014

**Pharmacies providing EHC services**

source: UHB June 2017



There appears to be a good geographical spread of providers across the city, although data regarding demand for services was not available in time for this PNA since the service has not been in operation long enough to establish this.

In addition to pharmacies, free EHC is available from:

- GP surgery that provides contraception
- contraception clinic
- a sexual health clinic
- some genitourinary medicine (GUM) clinics
- some young people's clinics
- most NHS walk-in centres and minor injuries units
- some Accident & Emergency departments

Pharmacies commissioned to provide the service appear to be well located, in areas where the teenage pregnancy rate is at its highest in Birmingham. As Birmingham has a number of universities, commissioners should also ensure that existing pharmacies are able to provide this service in areas that are highly populated by students. The city's Sexual Health Services are undergoing further review to establish the quality and targeting of the new service model, which will impact how sexual health services (including EHC) are provided across Birmingham. The results of this will need to be considered in the 2021 PNA.

### Conclusion for sexual health services

Sexual health prevention services are considered to be a **necessary** service for the city.

Considering all providers, there are no gaps in the provision of this service, and localities with the highest teenage conception rates in Birmingham have generally good provision.

### Substance misuse

Needle exchange is a service commissioned by Public Health through an external provider, CGL, which enables injecting drug users (IDUs) to dispose of used needle or other injecting equipment, and obtain sterile injecting equipment for personal consumption. Service users also use these periods of contact to learn about safe injecting practice, and may be a pathway to further care or rehabilitation; there is good evidence that needle exchange services are effective in reducing harm<sup>52</sup>. It is however difficult to know exactly where to target such services since this population are often transient and so reporting of needle use or needles discarded may not correspond to where people want to access the service.

The needle exchange programme is categorised as a 'harm reduction' service, in this case reducing the risk of blood-borne infections<sup>53</sup>. Figure 15 shows the locations of the 88 needle exchanges (pharmacy based) in Birmingham, which appear to be appropriately placed, when compared with estimated numbers of IDUs by ward.

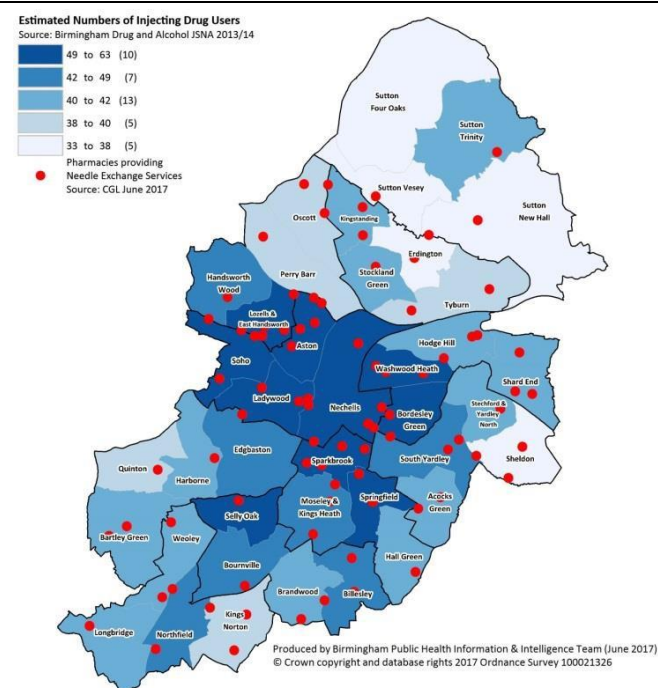
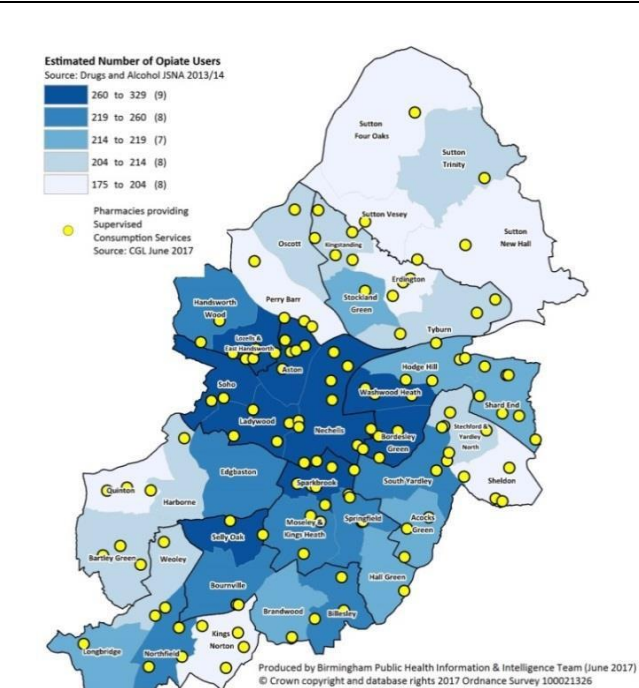
Supervised consumption is also commissioned by Public Health through CGL and ensures that those prescribed methadone (or other substitute therapy) can obtain and take the medication safely, under direct supervision of the pharmacist. There is evidence that this method of treating people with heroin addiction is effective and it is approved by NICE<sup>54</sup>. Figure 16 shows the locations of the 128 supervised consumption premises in Birmingham. Overall, there appears to be good coverage of the majority of the city, including areas where the highest number of Opiate and Crack Users (OCU) are thought to reside.

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<sup>52</sup> Needle and syringe programmes. NICE public health guidance PH 18. Feb 2009. <http://www.nice.org.uk/nicemedia/live/12130/43301/43301.pdf> [accessed 29/01/2013]

<sup>53</sup> Birmingham Drug and Alcohol Action Team. Needle Exchanges. <http://www.bdaat.co.uk/page.php?pid=49&mid=53> [accessed 04/12/2012]

<sup>54</sup> Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114. Jan 2007. <http://www.nice.org.uk/nicemedia/pdf/TA114NICEguidance.pdf> [accessed 06/06/2014]

**Figure 15: Location of pharmacies providing needle exchange services****Figure 16: Location of pharmacies providing supervised consumption**

### Conclusion for needle exchange and supervised consumption

Both these services are considered **necessary** and evidence available in preparing this PNA do not suggest gaps in provision.

Supervised consumption, along with needle exchange, remain key programmes for the prevention of harm in the city, especially in our vulnerable populations. Both services appear to be located appropriately.



## 8. Patient and Public Engagement and Insight

The Healthwatch Quality standard has been used as guidance to ensure good use of patient and public engagement (PPI) in developing this PNA.

First, a review of PPI was undertaken to identify relevant existing public consultation and other engagement data; the draft 2018 PNA is to be published with plain English, abbreviated version to support PPI regarding the PNA. The results of this will be used to inform the final PNA.

The following sources of PPI were identified and information gathered from these is summarised below:

- The Community Pharmacy Patient Questionnaire
  - Results are available at an individual pharmacy level on the NHS choices website, however a collated version was not available and there was not capacity in the development of this PNA to do so. It is recommended that in future years a collated version is made available for the purpose of informing PNAs and other pharmacy based commissioning.
- Results of two consultations, referred to in the 2015 PNA, which are discussed in Appendix D.
- Results of the previous PNA public engagement exercise
  - Undertaken via a questionnaire on the Birmingham BeHeard website for just over one month, although postal versions were available upon request.
  - Initially there were 143 responses via Birmingham BeHeard (including postal entries added manually (verbatim) by Public Health). An additional 37 questionnaires were received after the deadline and comments incorporated into the review where appropriate.
  - Results indicated respondents valued pharmacies, however, local there was inconsistent knowledge of which services were available and where.
  - Respondents felt access to Pharmacy was good, with disabled access being available. However parking difficulties were cited as an area of concern.
  - Location was important to respondents; close to a GP or work place were of particular interest and with longer opening hours, both in the morning and evening.
  - Over half (62%) of respondents did not use a single regular pharmacy; 38% used one pharmacy and 54% used 3, 4 or more pharmacies.
  - Comments concerning Pharmacy staff knowledge and customer service were varied, from friendly and helpful, to being obstructive and refusing medication. Several comments referred to confidentiality. In particular, stating your name and address when collecting prescriptions.

- UK based research regarding pharmacy:
  - Indicates pharmacy is a setting in which the public feel comfortable to seek or receive healthy lifestyle advice and trust the advice given by pharmacists.
  - Convenience important and lack of an appointment system, especially where 'out of hours' services are available at weekends and evenings<sup>55</sup>. This was most clearly demonstrated by Todd et al who found that 90% of the population live within just a 20-minute walk of a pharmacy, increasing to 99.8% for those in the most deprived communities.
  - An opinion poll conducted in March 2016 demonstrated that public awareness of pharmacy-based services varies greatly according to the service in question. The poll also suggested that currently the first line for advice for most people was still GP services; just 5% for sexual health services (although higher for EHC at 29%), 5% and 7% for advice regarding substance misuse and alcohol consumption respectively. Stop smoking and minor ailments had slightly higher proportions who would go to a pharmacy first at 24% and 46% respectively.

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<sup>55</sup> RSPH. 2000. Building Capacity: realising the potential of community pharmacy assets for improving the public's health. [Online]



## Appendix A: Method and requirements of the PNA process

### Matters for consideration when making assessments

9.—(1) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must have regard, in so far as it is practicable to do so, to the following matters—

#### SCHEDULE 1 Information to be contained in pharmaceutical needs assessments

##### Necessary services: current provision

1. A statement of the pharmaceutical services that the HWB has identified as services that are provided—

(a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and

(b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).

##### Necessary services: gaps in provision

2. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied—

(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;

(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

##### Other relevant services: current provision

3. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided—

(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;

(b)outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;

(c)in or outside the area of the HWB and, whilst not being services of the types described in sub-paragraph (a) or (b), or paragraph 1, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area.

#### **Improvements and better access: gaps in provision**

**4.** A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied—

(a)would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area,

(b)would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

#### **Other NHS services**

**5.** A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect—

(a)the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or

(b)whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

#### **How the assessment was carried out**

**6.** An explanation of how the assessment has been carried out, and in particular—

(a)how it has determined what are the localities in its area;

(b)how it has taken into account (where applicable)—

(i)the different needs of different localities in its area, and

(ii)the different needs of people in its area who share a protected characteristic; and

(c) a report on the consultation that it has undertaken.

**Map of provision**

7. A map that identifies the premises at which pharmaceutical services are provided in the area of the HWB.

## Appendix B: The PNA development process

### Steering Group

Birmingham Public Health, on behalf of the BHWB, set up a multidisciplinary Steering Group to oversee the development of a new PNA. The membership is shown in appendix F; the group also prepared a risk assessment, which is shown in appendix G. Representatives from Public Health, NHS England, the Local Pharmaceutical Committee (LPC), Local Authority Commissioning and Commissioning Support Unit were involved. The Steering Group had responsibilities in delivering the PNA for approval by the BHWB, to assist with commissioning decisions from April 2018.

### Stages of development



The diagram above indicates the flow of PNA production; the process undertaken in Birmingham is indicated in the table below:

#### Detail regarding each step of development of the Birmingham 2018 PNA

Step	Activity	Data source(s)
1	<p><b>Understand health needs and set health priorities:</b></p> <p>The Public Health Intelligence team in conjunction with the PNA coordinator and PNA steering group assessed health intelligence used in the 2015 PNA, identified which data had more recent updates and which was required to inform this PNA.</p> <p>Priorities were taken from the JHWS and JSNA highlights.</p> <p>Members of the Public Health Intelligence team gathered more recent data where this was available and produced new maps as agreed by the PNA steering group.</p>	<p>-Birmingham JSNA 2018 and JHWS</p> <p>-Detailed needs analysis data</p> <p>-District profiles</p> <p>-ONS demographic data</p> <p>-Stop Smoking Service data</p> <p>-Commissioning data</p> <p>-Planning data</p>
2	<p><b>Review current pharmacy provision:</b></p> <p>Initially it was intended that a recent contracting exercise by NHS England could be used to obtain up to date information regarding pharmacies, however the results of this were not to be available at the time of preparing this report.</p> <p>Instead, the LPC requested that local contractors</p>	<p>Pharmacists emailed updates, which was coordinated by the LPC Contracting and activity data held locally</p>

	reviewed their provision set out in the 2015 PNA tables. This information was cross checked by the Public Health Intelligence team and district relevant information was added by the PNA coordinator.	
<b>3</b>	<p>Incorporate the public's view</p> <p>Results of other relevant PPI were collated and interpreted by the PNA coordinator</p> <p>A draft version of the 2018 PNA and plain English, abbreviated version is to be made available and promoted to community stakeholders</p>	<p>2015 PNA consultation results</p> <p>Desk based research</p> <p>Review of previous strategies that have informed commissioning of services in pharmacies</p> <p>Birmingham Be Heard</p>
<b>5</b>	<p>Synthesise draft assessment and amend final version and approval from BHWB</p> <p>The first draft has been prepared for consultation; a final draft will be prepared for the HWBB once findings of this exercise are incorporated</p>	<p>-Data from Steps 1-3</p>

**Appendix C: Summary table of pharmacy access per district with deprivation, BME, population under 65 and Locally Commissioned Services**

**Key:** Deprivation = % living in most deprived quintile England; SSS = Stop Smoking Service; UT1 and UT2 = umbrella service tier 1 and 2; NEX = needle exchange; SCONS = supervised consumption; PALL = palliative care

District	Wards	Population (n)	Pharmacies (n)	Pharm / 10,000 pop	100 hour	Saturday	Sunday	Deprivation % pop	% BME	% <65 years	Pharm 1 <sup>st</sup>	SSS	UT1	UT2	NEX	SCONS	PALL
Sutton Coldfield	Sutton Four Oaks, Sutton Trinity, Sutton Vesey, Sutton New Hall	94,661	22	2.32	3	21	9	1.8	11.3	78.8	0	5	10	2	4	5	2
Perry Barr	Oscott, Perry Barr, Handsworth Wood, Lozells and East Handsworth	109,312	27	2.47	5	21	9	46.8	60.3	87.6	9	15	4	4	9	10	1
Erdington	Kingstanding, Erdington, Stockland Green, Tyburn	100,954	28	2.77	2	14	4	76.2	26.9	85.9	0	8	9	6	8	12	0
Hodge Hill	Hodge Hill, Washwood Heath, Shard End, Bordesley Green	127,751	39	3.05	7	29	7	90.4	64.3	89.7	2	16	10	5	13	22	2
Ladywood	Aston, Soho, Nechells, Ladywood	138,025	45	3.26	11	28	15	85.6	72.7	93.1	19	22	10	9	15	21	4
Yardley	Stetchford and Yardley North, South Yardley, Sheldon, Acocks Green	111,208	28	2.52	5	22	9	65.4	34.4	86.2	0	12	11	2	8	14	1
Edgbaston	Edgbaston, Harborne, Quinton, Bartley Green	101,633	16	1.57	3	13	4	32.7	31.3	85.8	2	3	8	4	5	7	2
Hall Green	Sparkbrook, Springfield, Moseley and Kings Heath, Hall Green	118,546	41	3.46	13	33	14	59.4	64.5	88.7	18	22	11	7	14	18	3
Selly Oak	Selly Oak, Bournville, Brandwood, Billesley	106,288	17	1.60	0	12	0	31.1	22.4	86.1	0	8	5	2	4	5	0
Northfield	Weoley, Longbridge, Northfield, Kings Norton	102,929	22	2.14	1	17	3	51.1	14.2	84.2	0	9	10	4	8	13	0
<b>Totals</b>		<b>1,111,307</b>	<b>285</b>	<b>2.56</b>	<b>50</b>	<b>210</b>	<b>74</b>				<b>50</b>	<b>120</b>	<b>88</b>	<b>41</b>	<b>88</b>	<b>127</b>	<b>15</b>

## Appendix D: Map of Birmingham with surrounding local authority areas



## Appendix E: Public consultations relevant to the 2018 Birmingham PNA

The consultation results of the 2015 PNA were addressed at the time and have been acknowledged in this PNA. In particular:

- Queries regarding the evidence base for certain services.
- Clarification regarding the difference between 'Enhanced' and 'Locally Commissioned' services
- A need to consider the impact of housing development on population projections and impact on access to pharmaceutical services
- A need to consider the impact of pharmaceutical need on the border with other HWB areas
- Clearer presentation of pharmaceutical service access geographically
- Interest in evidence regarding the impact of pharmaceutical services, including Advanced and Enhanced services on acute care pathways
- Details of some pharmacies were not accurate

A number of other consultations were referred to in the 2015 PNA that would impact provision of pharmaceutical services; namely, the Lifestyle Services Consultation and the Sexual Health Services Consultation. The former assessed public views regarding NHS Health Checks, Healthy eating/weight management, Physical activity, Stop Smoking, and Health Trainer services. The key findings of these consultations is summarised below with an assessment of the implications for pharmacy, although the consultations have already informed commissioning strategies that are now being implemented.

No additional consultations of relevance were identified through the PNA steering group to include in the 2018 PNA assessment.

### Lifestyle Services Consultation

There were 4,756 responses to a questionnaire, with 68% of respondents identifying themselves as members of the general public; 58% female and 20-34 year olds formed the biggest response group. Most (70%) respondents stated they did not have a physical or mental health condition or illness lasting or expected to last for 12 months or more. The full results of this consultation are available at:

<https://www.birminghambeheard.org.uk/people-1/the-commissioning-of-birmingham-lifestyles-service/>

Finding	Implications for Pharmacy
Universal media (web, email, text, telephone) approach for information and support, and streamline access into services through a central Lifestyles Hub. Public opinion expressed overall agreement with these principles (82%, 84% and 84% respectively),	Given the demographic of responders it is not surprising that there was strong support for online healthy lifestyle support and signposting. Pharmacies may want to consider their online presence and how this connects to healthy living services. Also, the role of pharmacy in groups who access online services less, potentially older adults and people for who have no or low levels of English literacy.
Types of issues important, all categories had high agreement 89-97% agree were important but the top three issues in order of highest % agreeing were support older citizens to remain active to reduce the risk of falls, support citizens to live a healthier life to	Polypharmacy and the role of pharmacy as trusted sites in the community e.g. seating / toilet use for vulnerable and older adults who may need support.



reduce risk of developing long term conditions	This highlights local public support for pharmacies to engage with healthy lifestyle advice especially regarding long term condition prevention, which is particularly relevant to the self-care advice and health promotion campaign elements of the Essential services provision.
There were several comments raising the need for people to take personal responsibility for their actions and health. It was suggested there was a need to educate people on the consequences of poor lifestyle choices to motivate them to change and engage in services.	
Regarding citizen engagement, pharmacy involvement was highlighted under a theme regarding the role of 'community' in engaging people with lifestyle services.	Pharmacies should continue to and increasingly build on the links they have with community, including targeting information to local need and advertising services available in a way that is suited to the local community.
Healthy Living Pharmacies and use of pharmacies in the context of sites in the community were raised under suitable venues. Only 617 responses on this question and unclear proportion of the public who held this view but in line with feedback on other questions.	

## Sexual health services

This consultation was undertaken in 2014 and is available in full at:

<https://www.birminghambeheard.org.uk/adults-communities/sexual-health-consultation/>

There were 2,500 responses based on a summary paper and questionnaire promoted online and via free-post where requested. Responses were also gathered via public and professional events, Freshwinds who were commissioned to undertake consultation with specific groups of the population who were identified through the summary needs assessment, initial Equality Analysis and local intelligence as having a priority need in relation to Sexual Health.

Just under half (47%) of respondents identified themselves as a member of the public, 23% as someone who uses sexual health services, and 2% as a family member of carer of someone who uses sexual health services. (note that respondents could tick multiple boxes and so may have been part of several categories). Almost half declined to give their postcode (48%), which has implications for services collecting this type of data. Although most respondents were from the 20-24 age group (n = 332), the response was generally representative of sexual health service users.

Finding	Implications for Pharmacy
There was a theme around a focus on ensuring vulnerable / priority groups needs are met such as people aged under 18 and people who are vulnerable to/victim of sexual coercion.	Training, service performance regarding identifying and making the service visible to the groups specified in the contract.
<i>"The proposal for GPs and Pharmacies to provide more Sexual Health services was positively received (69%). 15% of respondents disagreed with this proposal. The associated comments were focussed on the capacity of GPs to cope with additional workload, existing access to GP services, and perceived lack of specialism of GPs and community pharmacists and confidentiality."</i>	Pharmacy staff delivering the service to be trained in confidentiality and communication with clients; in particular to ensure the way in which patients access the service, the way they are spoken to, where discussions take place and how their information will be recorded, shared and stored is all managed in a way that gives reassurance about confidentiality.

<p>On this point, <i>“The LGBT community in particular expressed serious concerns over confidentiality and their need for anonymity – for example, some respondents stated they had not informed their GP or family about their sexuality and would be uncomfortable “coming out” in a setting where family and friends worked or visited. Some other demographic groups such as Asian women and young people were also concerned about confidentiality for fear of the reprisals, should the nature of their visit become known to their families.”</i></p>	
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## Appendix F: PNA steering group membership

Rebecca Willans	<i>(Chair). Specialty Public Health Registrar, Birmingham City Council</i>
Susan Lowe	<i>Service Manager for Public Health Intelligence, Birmingham City Council</i>
Channa Payne-Williams	<i>Support Officer - Collaboration, People. Birmingham City Council (Minutes)</i>
Brian Wallis	<i>Contract Manager, NHS England West Midlands Region</i>
Tom Wedgbury	<i>Birmingham LPC Secretary, Birmingham Local Pharmaceutical Committee.</i>
Sanjeev Panesar	<i>Birmingham Local Pharmaceutical Committee</i>
Sandeep Dhami	<i>Birmingham Local Pharmaceutical Committee</i>
Gurjinder Samra	<i>Senior Prescribing Adviser NHS Midlands and Lancashire Commissioning Support Unit</i>
Jasprit Singh	<i>Medicines Commissioning Support Pharmacist NHS Midlands and Lancashire Commissioning Support Unit</i>
Clare Reardon	<i>Commissioning Manager, People. BCC</i>

## Appendix G: PNA risk assessment

Risk Date	Risk ID	Risk Title	Risk Description	Measures	Proximity	Inherent Risk		Residual Risk		Risk	Progress Update
					Date	Impact	Likelihood	Impact	Likelihood	Owner	
.03.17	PNA-1	Data regarding pharmacies e.g. opening hours	There is a risk that if the data is not recvd in a timely fashion, it will impact the PNA timescales	Ensure data is sent	31.05.17	Significant	Medium	Medium	Low	PNA steering group	Original approach proposed by LPG was to use data from NHS England survey and then chase pharmacies who didn't respond. However, at the second meeting of the steering group (4th May) it was felt due to likely timescale for NHSE being able to get the data to PH, this approach posed an increased risk of not having data available in a timely manner. Instead, it was agreed that LPG would circulate table from previous PNA to ask pharmacists to check for accuracy. PH to check with commissioners whether the service offer is accurate.
.03.17	PNA- 2	HWB dates	Birmingham HWB meet quarterly now; this makes timescales for preparing a draft PNA tighter to allow time to get the PNA to a December/January board and build in any feedback before publishing in March / April 2018.	Prepare programme plan; highlight and find solutions to delays to key milestones early. Also, suggestion from HWB coordinator to send draft copies to HWB operations group so later in the year is not the first time they have seen it.	ongoing	medium	medium	low	low	Rebecca Willans	RW has prepared a programme plan and so far, progress is on track. RW has dates of the next HWB in July and will seek to get an initial draft copy to the operations group before then in order to get the public consultation version out by September 2017
.05.2017	PNA- 3	Consultation Response Rate	There is a risk that there may be a limited response to the PNA Consultation which may impact on level of buy into the document.	Ensure identification of key stakeholders. Pre-warn that them of the consultation and engage with HealthWatch at the earliest opportunity	.08.17	Medium	Low			Rebecca Willans	RW has met with Healthwatch and discussed use of the Quality Standard, was agreed by PNA steering group that following Healthwatch guidelines is a helpful approach; since RW has sent a proposed approach to consultation to Healthwatch and is awaiting a response. Also, RW has identified contacts for key stakeholders and will discuss at the next PNA meeting - still struggling with CCG contacts.