PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 26 MARCH 2015
1.00 PM

Bourges/Viersen Room - Town Hall
Contact – Gemma.george@peterborough.gov.uk, 01733 452268

AGENDA

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Gemma George on 01733 452268 as soon as possible.

7. ADULT SERVICES

(a) Care Act Plan and Implications **255 - 258**
For the Board to note the report and recommendations.

INFORMATION ITEMS

8. Exception Report: Health and Wellbeing Board Action Plan Progress Update **259 - 262**
For the Board to note the report and recommendations.

9. Healthy Child Programme **263 - 268**
For the Board to note the report and recommendations.

10. Winterbourne View Review and Update **269 - 272**
For the Board to note the report and recommendations.

11. Schedule of Future Meetings and Draft Agenda Programme
Schedule to the tabled at the meeting.

Board Members:
Cllr Cereste (Chairman), Cllr Lamb (Vice Chairman), Cllr Fitzgerald, Cllr Holdich, Cllr Scott, Gillian Beasley, Dr Liz Robin, Wendi Ogle-Welbourn, Andy Vowles, Cathy Mitchell, Dr Michael Caskey, Dr Paul van den Bent, Dr Gary Howsam, Dr Kenneth Rigg, Andrew Pike and David Whiles

Co-opted Members: Russell Wate and Claire Higgins

Substitutes: Dr Harshad Mistry

Further information about this meeting can be obtained from Gemma George on telephone (01733) 452268 or by email gemma.george@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE COUNCIL CHAMBER, TOWN HALL ON 7 JANUARY 2015

Members Present:

Councillor Marco Cereste, Leader of the Council (Chairman)
Councillor Diane Lamb, Cabinet Advisor for Health (Vice Chairman)
Councillor Wayne Fitzgerald, Cabinet Member for Adult Social Care
Councillor Sheila Scott, Cabinet Member for Children's Services
Councillor John Holdich, Deputy Leader and Cabinet Member for Education, Skills and University
Gillian Beasley, Chief Executive, PCC
Jana Burton, Executive Director of Adult Social Care and Health and Wellbeing, PCC
Cathy Mitchell, Cambridgeshire & Peterborough Clinical Commissioning Group
David Whiles, Peterborough Healthwatch
Wendi Ogle-Welbourn, Director for Communities
Gill Kelly, Cambridgeshire and Peterborough Clinical Commissioning Group (representing Andy Vowles)

Co-opted Members Present:

Russell Wate, Independent Chair of the Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board
Claire Higgins, Chairman of the Safer Peterborough Partnership

Also Present:

Will Patten, Assistant Director for Adult Commissioning
David White, External Better Care Fund Advisor
Paul Stevenson, Head of Adult Social Care Finance
Gemma George, Senior Governance Officer

1. Apologies for Absence

Apologies for absence were received from Sue Westcott, Andy Vowles, Dr Michael Caskey, Dr Paul van den Bent, Dr Gary Howsam, Dr Kenneth Rigg and Andrew Pike.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Meeting Held on 11 December 2014

The minutes of the meeting held on 11 December 2014 were approved as a true and accurate record.

4. Approval of the Better Care Fund Submission

The Board received a report which provided an update on the Better Care Fund (BCF) in the wake of the Nationally Consistent Assurance Review (NCAR) process. This required the Cambridgeshire and Peterborough Health and Wellbeing Boards to resubmit BCF plans on 9 January 2015.

Will Patten, the Assistant Director for Adult Commissioning, introduced the report and provided an overview update, he was joined by Gill Kelly, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Paul Stevenson, Head of Adult Social Care Finance. Comments on the Plan were sought from the Board and approval for amendments to be made up to the point of re-submission. Key points raised and highlighted during discussion included:

- The Plan had been re-written and had been aligned more closely with Cambridgeshire. A workshop approach had been taken towards the re-write;
- The workshops had been well attended, with a broad cross section of representatives. There had been three workshops, the purpose being to gain agreement for focus of delivery, priorities and themes to deliver against BCF outcomes;
- Partner engagement and contribution throughout the process had been extensive;
- The re-write had followed the last workshop held in December 2014 and a number of versions had been drafted;
- From the CCG perspective the process had been undertaken well. There had been good working partnerships between Cambridge County Council and Peterborough City Council. The Plan was more aligned, robust and sustainable;
- The level of time and money in term of investment that the Council had put in, supported by joint working with the CCG had been a testament to the Plan ready for submission;
- The Uniting Care Partnerships contract was underway and this was a key enabler to ensure transformation of the care pathway;
- The Plan was much improved on the first submission. Delivery would be the next challenge;
- Members positively commented on the work that had gone into the development of the Plan however raised queries as to how the Plan would be put into practice and what impact it would have?
- The next steps would involve a compliance review and over the forthcoming days the Better Care Assessors would make contact with a number of people who had been involved in the development of the Plan. The Plan would then be considered by a Programme Board and a formal response submitted by the beginning of February;
- All those involved in the development of the Plan were thanked. The approval of the Plan was vital to the future work in Health and Adult Social Care; and
- Governance issues were outlined, including the reporting pathways.

RESOLVED

The Board noted the progress in preparing the Better Care Fund Plans to enable the submission of the Plans by 9 January 2015.

5. Proposed Workshop on the Challenged Health Economy

The Board was requested to approve a proposed workshop on the Challenged Health Economy.

Following discussion, it was commented that perhaps efforts would be best directed into delivering the BCF and the projects within, and whether this would be more conducive for a workshop focus. It was agreed that this should be the main focus, but also touching on Primary Care Co-commissioning.

RESOLVED

The Board agreed that further thought was to be given to the workshop focus, including both BCF, projects contained within and primary care co-commissioning. Members to be informed of the new workshop in due course.

6. Schedule of Future Meetings and Draft Agenda Programme

The Board noted the schedule of future meetings and draft agenda programme.

10.00am – 10.37am
Chairman

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4(a)
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Catherine Mitchell, Local Chief Officer	Tel. 01733 776189

PRIMARY CARE CO-COMMISSIONING

RECOMMENDATIONS	
FROM : C&PCCG Governing Body	**Deadline date : n/a**
For the Board to note that the C&PCCG will Join Commission Primary Care Services with NHS England East from 1st April 2015. During 2015/16 we will undertake due diligence and consult with member practices (and engage with other stakeholders) regarding Option 3, full delegated responsibility for primary care commissioning.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Health & Wellbeing Board following a request from Catherine Mitchell, Local Chief Officer, Borderline & Peterborough LCG's to update HWB members on the decision taken by C&PCCG on the future of Primary Care Co-Commissioning.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update members on the Primary Care Co-Commissioning and specifically the decision made by C&PCCG Governing Body on 13 January 2015.

2.2 In summary, the rationale for this approach is that effective commissioning of primary care is vital in order to deliver better whole system / integrated pathway services, and current arrangements are not working as well as we would wish. From a CCG perspective there is scope to be more proactive, and a need for better, clearer joint working approaches with NHS England East (formerly the Area Team) (NHSE).

2.3 Discussions with Strategic Clinical Management Executive Team, Governing Body and Member practices to date had indicated a willingness to take up the joint commissioning option for primary care, provided there are adequate safeguards in place regarding conflicts of interest.

Letter from Dr P Watson, NHS England, Midlands & East confirming approval, attached at Appendix A.

3. BACKGROUND

The CCG submitted an expression of interest in joint commissioning of primary care services to NHS England in June 2014.

In November 2014, NHS England issued further guidance *"Next steps towards Primary Care Co-commissioning"* as a means of providing CCGs with greater clarity and transparency around the commissioning options. The purpose of this additional guidance was to allow CCGs to reflect on their initial submission, and to select from 3 more clearly defined options for commissioning primary care.

Co-commissioning model	Pro-forma	Submission date
1. Greater involvement in primary care commissioning decision making	There is no pro-forma to complete.	**Not applicable.**
2. Joint commissioning	CCGs and area teams are asked to complete a pro-forma for joint arrangements .The pro-forma focuses upon the proposed governance arrangements for joint committees.	**30 January 2015**
3. Delegated commissioning	CCGs and area teams are asked to complete a pro-forma for delegated arrangements. This pro-forma focuses upon the CCG's approach to conflicts of interest management.	**12 noon on 9 January 2015**

A suite of pro-forma's and model wording for amendments to CCG Constitutions and Terms of Reference have been provided to CCGs to ensure robust governance arrangements are in place to support their chosen co-commissioning option.

3.1 Co-Commissioning

a) Options and Scope

There are three options on offer. The first is essentially a 'Do Nothing' option, although it should be noted that due to the decrease in the number of Area Teams and reductions in their budgets, the extent to which NHS England will be able to actively commission local primary care will be more limited.

The second is 'Joint Commissioning' which gives the CCG a formal role in decision-making with NHS England via a Joint Committee, although it does not involve the CCG taking on the actual functions. The scope of joint commissioning with NHS England could include involvement in decisions on the following areas:

- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation), administration of payments and list management. This is the recommended option for the reasons set out in the main paper, taking into account the balance of opportunities and risks which are summarised in the NHS Clinical Commissioners / RCGP paper. http://www.nhscc.org/wp-content/uploads/2014/12/FINAL-NHSCC_RCGP-Risks-and-opportunities-for-CCGs-in-primary-care-commissioning-1.121.pdf

The third option is fully delegated responsibility for primary care commissioning. The CCG would in effect undertake most primary care commissioning on behalf of NHS England. There are opportunities and risks associated with this option which will need more time and work to consider.

b) Joint Commissioning Governance Arrangements

Each member of the joint committee is an equal member of the committee. CCG members are accountable to their Governing Body and to their membership. Both NHS England and the CCGs are also accountable to the Public and Parliament in respect of the exercise of their statutory functions. Both Parties must have appropriate reporting and accounting processes in place under these arrangements.

In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation.

This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance also provided.

The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

c) Membership of joint committees

The Committee membership and its roles and responsibilities are up to the CCG to determine but GPs must not be in the majority.

Secondary care clinicians and nurse members may also sit on the Committee and we may include members who are not currently on our governing body, such as CCG Lay members without statutory responsibilities, if applicable.

In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained

d) Pooled funds for joint commissioning

CCGs and NHSEE may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

Any proposal to create a pooled fund will need further work locally, and would be brought back to a future meeting of the Governing Body.

e) Managing Conflict of Interest

The revised conflicts of interest guidance provided by NHS England applies across all CCG commissioning. We will need to review this guidance and revise our arrangements as appropriate

f) Further Work: Delegated Commissioning Option

As members will know, NHS England is re-structuring itself into larger units, and at the same time making running cost savings which will reduce staff numbers. Their ability to provide significant resource for development of primary care in Cambridgeshire and Peterborough is likely to become more limited, with the focus more likely to be on basic performance management of the core GMS / PMS contract.

In addition, the national position has shifted insofar as the Delegated Commissioning option would now come with some staff resource from NHS England, albeit limited. The guidance document *"Next steps towards primary care co-commissioning"* emphasises the need for CCGs and Area teams to work to agree the best use of resource at a local level.

The reasons for ensuring there is effective commissioning of primary care have already been set out. There is a view that the CCG has the greatest motivation, local knowledge and leadership to transform primary care, and that control over decisions will enable wider service strategies to be delivered.

There is also a counter argument that taking on delegated commissioning of primary care creates a conflict of interest and changes the nature of the CCG as an organisation.

Whilst there are ways in which the conflict of interest could be mitigated, it is clear that such a move would represent a significant change on which member practices would need to be consulted. If the CCG were to take on delegated responsibilities it would need to assure itself on the service and financial risks / liabilities through a process of due diligence before making any final decision to proceed.

It is therefore recommended that further work is carried out to discuss the pro's and cons of full delegated commissioning of primary care with Member practices, and to undertake a due diligence process. It is not feasible to do this work before the 9th January 2015 deadline, so it is likely to take place over the next 3-6 months.

4. ANTICIPATED OUTCOMES

The CCG Governing Body approved the submission of a formal application for joint co-commissioning (Option 2) be submitted to take on a proactive role in strategic co-commissioning from April 2015.

Through CCG clinical leadership and local knowledge, closer involvement in the development of primary care will support better decision-making on areas such as :

- How to improve access to Primary Care and wider out of hospital services,
- How to improve quality in primary care and out of hospital care
- How to improve health outcomes, equity of access, and reduce inequalities
- How to improve patient experience through more joined up services

Plus, proposed that further work is carried out internally and with stakeholders to agree the Terms of Reference for a Joint Commissioning Committee with NHS England East.

It is also recommended that further discussions take place with Member practices during 2015 on whether or not to take on full delegated commissioning from April 2016. This would represent a significant change for the CCG, and would be subject to 'due diligence' processes on the funding implications and resources required, as well as careful consideration of the processes required to make decisions.

5. REASONS FOR RECOMMENDATIONS

To improve commissioning of Primary Care Services in conjunction with NHS England East.

6. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

http://www.nhscc.org/wp-content/uploads/2014/12/FINAL-NHSCC_RCGP-Risks-and-opportunities-for-CCGs-in-primary-care-commissioning-1.121.pdf

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NHS England, Midlands & East
2 – 4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

By email:

Dr Neil Modha
Accountable Officer
Cambridgeshire and Peterborough CCG

4 March 2015

neil.modha1@nhs.net

Dear Neil

Primary Care Co-commissioning: Approval for Joint Arrangements

Further to your application to take forward new arrangements for primary care co-commissioning I am delighted to inform you that NHS Cambridgeshire and Peterborough CCG has been approved to take on joint arrangements with NHS England.

Please note that terms of reference and CCG constitution amendments must be signed off by governing bodies and NHS England Regions by 31 March 2015. Failure to complete these steps would mean this approval will become invalid.

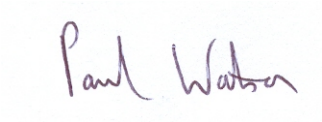
The joint commissioning model is an important vehicle to ensure joined up planning and decision making between CCGs and NHS England through a joint committee arrangements. This should provide an opportunity to more effectively plan and improve the provision of out-of-hospital services for the benefit of patients in your local population.

We will be in touch shortly so that discussions can take place to finalise the arrangements for the joint committee and the functions the committee will be responsible for. If the option to pool funding for investment in primary care services is being taken, this should be agreed and managed through the Joint Committee.

It is important to ensure appropriate arrangements are made locally to manage potential conflicts of interest under these joint arrangements. As part of these arrangements, the role of the lay members on the joint committee is critically important. To ensure appropriate oversight and assurance of the joint committee the CCG Audit Committee Chair should not hold the chair of the joint committee. They can, however, take the other lay member role on the committee.

We look forward to working with you.

Kind Regards



Dr. Paul Watson
Regional Director – Midlands and East

cc: Andrew Pike, DCO – East

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5(b)
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Will Patten, Interim AD Adult Strategic Commissioning	Tel. 07919 365883

BETTER CARE FUND SECTION 75 AGREEMENT BETWEEN PETERBOROUGH CITY COUNCIL AND THE NHS CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP

RECOMMENDATIONS	
FROM : Directors	**Deadline date: 31st March 2015**

For the Board to:

1. Comment on the draft Section 75 Agreement;
2. Approval the Section 75 agreement between PCC and the CCG (**Appendix A**); and
3. Confirm that the Joint Commissioning Forum (JCF) will oversee the BCF Plan and Section 75 Agreement and pooled budget on behalf of the Peterborough H&WB Board.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the January 2015 update on the Better Care Fund & Peterborough's BCF re-submission successfully being approved in February 2015 without conditions. There is a requirement for Section 75 Agreements to be developed to enable the creation of pooled budgets to hold the BCF.

1.2 Following submission to NHS England, the BCF plan was reviewed and the decision that the submission had been successful was communicated to the Council on 06 February 2015.

1.3 The Council is currently seeking approval to enter into a Section 75 Agreement (of the 2006 Act) with the NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). This agreement will enable the commissioning health and social care services under the Better Care Fund (BCF).

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek comments on the draft Section 75 Agreement; to request approval of the Section 75 agreement between PCC and the CCG and to confirm that the Joint Commissioning Forum (JCF) will oversee the BCF Plan and Section 75 Agreement and pooled budget on behalf of the Peterborough H&WB Board.

3. BACKGROUND, KEY POINTS & GOVERNANCE

BACKGROUND

3.1 The BCF is not new money granted by Government, but rather a reorganisation of existing funding that is currently used to provide health and social care services in Peterborough. The aim of the BCF is to support transformation in integrated health and social care. The BCF was announced as a single pooled budget to support health and social care services to work more closely together in local areas. The pooled budget is expected to be in place from April 2015.

3.2 Across Peterborough, the value of the BCF is £11.9m.

3.3 On 9 January 2015, Peterborough's BCF plan was re-submitted. This revised submission addressed the comments received as part of the national assessment process, and was the conclusion of detailed work across our system.

3.4 On 6 February 2015, NHS England wrote to inform the Health & Wellbeing Boards that the BCF Plan had been approved. The approval letters noted that the plan is … 'strong and robust and we have every confidence that you will be able to deliver against it.'

3.5 Approval of the plan follows intensive work by colleagues from partner statutory and voluntary organisations in the local health and wellbeing system. The CCG and Council are grateful to all contributing partners.

3.6 Now that approval has been granted for the BCF Plan, a Section 75 Partnership Agreement is required to enable the pooled budgets between health organisations and local authorities to be established. The national expectation is that formal arrangements for the BCF and Section 75. Agreements are to be in place by April 2015.

KEY POINTS

3.7 The purpose of the Section 75 of the 2006 Act is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services, through lead or joint commissioning arrangements for the City of Peterborough. It is also the means through which the Partners will pool funds as agreed between the Partners.

3.8 The aims and benefits of the Partners in entering in to the Section 75 Agreement are to:
a) improve the quality and efficiency of the Services;
b) meet the National Conditions and local objectives; and
c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

3.9 The summary of the pooled funds for the Council is detailed in the table below (see 3.10).

3.10 Each Pooled Fund shall be managed and maintained in accordance with the terms of the Section 75.

Item (£000) (a)	Price (b)	Lead Commissioner (c)	Type (d)
Care Act Implementation	407	Council	Contribution
Section 256 agreement	3522	Council	Contribution
Protecting Adult Social Care Services	800	Council	Contribution
Protecting Adult Social Care Transformation – Data Sharing, 7 day working, Person Centred System, Information and Communication, Ageing Healthily and Prevention	1689	Council	Contribution
Older People Community Health Services	3749	CCG	Contribution
Performance Fund	429	CCG	Performance
Carers Prescription	150	CCG	Contribution
DFC Capital Adults	661	Council	Contribution
DFG Capital Children	150	Council	Contribution
SUBTOTAL (Revenue within BCF)	**£10746**		
Social Care Capital	£442	Council	Contribution
Disabled Facilities Grants	£811	Council	Contribution
TOTAL	**£11999**		

3.11 The performance element of the fund will be retained by the CCG, and only released if the locally agreed target of reducing emergency admissions by 1% is met.

GOVERNANCE

3.12 The Peterborough H&WB Board is accountable for the BCF Plan delivery and expenditure of the BCF. It is proposed that the Joint Commissioning Forum (JCF) will oversee the BCF Plan and Section 75 Agreement and pooled budget on behalf of the Peterborough H&WB Board.

4. CONSULTATION

4.1 In the developing and drafting of the BCF Plan, there were detailed discussions and workshops with system partners to create the vision, goal, objectives and scope of the Strategic level Plan and the specific delivery projects/schemes.

4.2 The approval process for the Section 75 agreement has included review and/or approval by the Joint Commissioning Forum and the PCC Cabinet Member responsible for Adult Social Care.

5. ANTICIPATED OUTCOMES

5.1 The Board is asked to:

- Note the formal approval of the BCF plans.
- Formally approve the Section 75 Agreement, which formalises the commissioning relationship between the Council and the CCG.
- Confirm that the Joint Commissioning Forum (JCF) will oversee the BCF Plan and Section 75 Agreement and pooled budget on behalf of the Peterborough H&WB Board.

6. REASONS FOR RECOMMENDATIONS

6.1 To enable the completion of the Section 75 Agreements with the CCG by 31 March 2015 to proceed thus enabling the establishment of pooled budgets.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Do nothing – do not approve the Section 75 Agreement. This option was discounted as the Council would not be able to access the BCF.

8. IMPLICATIONS

FINANCIAL

8.1 The financial implication of the proposed decision to approve the Section 75 Agreement is that the Council and the CCG will meet NHS England's condition for receiving the £11.9m BCF.

8.2 The section 75 agreement is in line with the BCF submission, and the Council's MTFS (Medium Term Financial Strategy).

9. BACKGROUND DOCUMENTS

i) BCF Plan
ii) Draft Section 75 agreement
iii) CMDN to Councillor Wayne Fitzgerald, Cabinet Member for Adult Social Care

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APPENDIX A

Dated **2015**

PETERBOROUGH CITY COUNCIL

and

NHS CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES UNDER THE BETTER CARE FUND

Contents

THIS AGREEMENT is made on day of 2015

PARTIES

(1) PETERBOROUGH CITY COUNCIL of Town Hall, Bridge Street, Peterborough PE1 1HG the **" Council"**)

(2) NHS CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP of Lockton House, Clarendon Road, Cambridge, CB2 8FH (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the city of Peterborough.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the city of Peterborough.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements for the city of Peterborough. It is also the means through which the Partners will pool funds as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives; and

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement.

Commencement Date means 1 April 2015.

Commissioning Board as set out in Schedule 2.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Services Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liability or Default Liabilities means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and
(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions.

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund as specified in clause 7.6

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Commissioning Forum: means the partnership body that is responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Health Related Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

NHS Standard Form Contract means NHS England's contract template document for use by commissioners for all contracts for healthcare services other than primary care.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 8.4.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations and this Agreement.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the Services Contract.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Performance Payment Arrangement means any arrangement agreed with a Provider and one or more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement as set out in Schedule 6.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Service(s) means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Underspend: has the meaning given in clause 12.6.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date and shall continue until terminated as set out in this Agreement.

2.2 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more Pooled Funds in relation to Individual Schemes

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement the Scheme Specification for each Individual Scheme shall be substantially in the form as set out in Part 1 of Schedule 1 and shall be completed and agreed between the Partners. The initial Scheme Specification is set out in part 1 of Schedule 1.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Joint Commissioning Forum.

6 COMMISSIONING ARRANGEMENTS

Joint Commissioning

6.1 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Services Contract, where applicable.

6.2 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.3 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.4 Each Partner shall keep the other Partners and the Health and Wellbeing Programme Board and Joint Commissioning Forum regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.5 The Joint Commissioning Forum will report back to the Health and Wellbeing Board as required by its terms of reference as set out in Schedule 2.

Appointment of a Lead Commissioner

6.6 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.6.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.6.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.6.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.6.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.6.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.6.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.6.7 undertake performance management and contract monitoring of all Service Contracts;

6.6.8 ensure all 5 work streams as set out in Schedule 2 and in this Agreement are outcomes focussed;

6.6.9 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.6.10 keep the other Partner and the Joint Commissioning Forum regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in the Pooled Fund recorded in the Scheme Specification may only be expended under the headings set out in the table in Part 2 of Schedule 1 ("Permitted Expenditure")

7.3.1 For the items listed in column (d) as a "Contribution", the amount in column (b) is the approved expenditure from the Better Care Fund available to the Lead Commissioner for arranging services or towards Service Contracts entered into by the Lead Commissioner.

7.3.2 For the item listed in column (d) as "Performance", the amount in column (b) is the Performance Payments available to the Lead Commissioner, subject to meeting the performance requirements agreed with NHS England. In accordance with technical guidance relating to the Better Care Fund, the funding for such Performance Payments will not be physically transferred into the Pooled Fund by the CCG. The CCG shall only release the full value of the performance fund into the Pooled Fund if the non elective admissions target – which is a reduction of non elective admissions of 1% as per the refreshed Better Care Fund admission reduction trajectory is met. If the target is not met, the CCG shall only release into the Pooled Fund a part of that funding proportionate to the partial achievement of the target. The Partners agree that the Joint Commissioning Forum shall determine how any performance funding which is released into the Pooled Fund in accordance with this clause 7.3.2 is spent. Any part of the performance funding that is not released into the Pooled Fund due to the target not being met must be dealt with in accordance with NHS England requirements.

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the joint express written agreement of each Partner. Such agreement will be subject to the Joint Commissioning Forum approval on behalf of the Health and Wellbeing Board.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners appoint the Council as the Host Partner for the Pooled Fund set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 The Partners shall agree which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Scheme where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Joint Commissioning Forum as required by the Joint Commissioning Forum and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Joint Commissioning Forum Quarterly reports (or more frequent reports if required by the Joint Commissioning Forum) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Commissioning Forum to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Joint Commissioning Forum and shall be accountable to the Partners.

8.4 The Joint Commissioning Forum may agree to the viring of funds between the Pooled Fund and any amendments to the Scheme Specification.

9 NOT USED

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 Financial Contributions in future years for the CCG and Council will be determined by future national guidance on BCF contributions.

10.3 Financial Contributions will be paid as set out in the each Scheme Specification.

10.4 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Joint Commissioning Forum minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of Services from the Pooled Fund and the financial risk to the Pooled Fund arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause 12.3, the Host Partner for the Pooled Fund shall manage expenditure from the Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Lead Commissioner for each Individual Scheme shall have responsibility for ensuring that demand on the Pooled Fund is appropriately managed in order to avoid any Overspend. In the event of an Overspend, the Lead Commissioner shall not be in breach of tis obligations under this Agreement PROVIDED THAT it has notified the Joint Commissioning Forum of the Overspend and within 5 working days and taken all reasonable steps to mitigate the impact of the Overspend.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Joint Commissioning Forum is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 Not Used

Underspend

12.6 In the event that expenditure from any Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year ("**Underspend**") the Joint Commissioning Forum shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners.

13 Capital Expenditure

Pooled Funds shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("**First Partner**") incurs any reasonable Losses arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("**Other Partner**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that reasonable Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant reasonable Losses. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Joint Commissioning Forum.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any Losses for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner. For the avoidance of doubt, good corporate governance shall mean the Partners complying with each of its Contract Regulations and/or Standing Orders and financial instructions.

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Health and Wellbeing Board has agreed to use the Joint Commissioning Forum to:

19.2.1 Oversee the development of this Agreement and the development of agreements in future years;

19.2.2 Receive updates from the Pooled Fund Manager and make appropriate recommendations on use of the Pooled Funds;

19.2.3 Update the Health and Wellbeing Board as appropriate to ensure democratic oversight of the use of the Better Care Fund.

19.3 Updates for the Health and Wellbeing Board and Commissioning Board will be prepared by the Pooled Fund Manager in consultation with colleagues working for each Partner.

19.4 The role of the Joint Commissioning Forum is set out in Schedule 2

19.5 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Health and Wellbeing Board has agreed that the Joint Commissioning Forum shall be responsible for the overall approval of the Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Schemes and how that Individual Scheme is reported to the Joint Commissioning Forum and Health and Wellbeing Board.

20 REVIEW & FORWARD FUNDING

20.1 Save where the Joint Commissioning Forum agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year. Specifically, the amounts with reference to the Pooled Fund, Partner contributions and details of expenditure shall be subject to review by the Partners by no later than 3 months prior to the end of the Financial Year.

20.2 Subject to any variations to this process required by the Joint Commissioning Forum, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Joint Commissioning Forum.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 Notwithstanding any other right of the Partners to terminate this Agreement, where funding received by the Partners under the Better Care Fund is reduced or withdrawn, either Partner may terminate this Agreement and shall give the other Partner ninety (90) days prior written notice of its intention to do so. The Agreement shall end at the expiry of the notice period as set out in any such notice.

22.2 This Agreement may be terminated by a Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.3 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.4 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.5 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of this Agreement.

22.6 In the event of termination or expiry of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use all reasonable endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.7 Upon expiry or termination of this Agreement for any reason whatsoever the following shall apply:

22.7.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to Service Users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.7.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.7.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.7.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows, the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.7.5 the Joint Commissioning Forum shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.7.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.8 In the event of expiry or termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Director of Communities for the Council and the Chief Strategy Office for the CCG or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such

information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

28.1 The Partners shall enter into the Data Processing Agreement as set out in schedule 8 as soon as reasonably practical after the Commencement Date to ensure the protection and security of the data passed from the Council to the CCG and from the CCG to the Council in pursuance of the obligations and objectives under this Agreement.

28.2 Without prejudice to clause 28.1, the Partners shall ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

if to the Council, addressed to the Assistant Director, Adult Social Care Commissioning, Peterborough City Council, Third Floor, Bayard Place, Broadway, Peterborough PE1 1HZ

and

if to the CCG, addressed to Andy Vowles, Lockton House, Clarendon Road, Cambridge, CB2 8FH Telephone: 01223 725400, E mail: a.vowles@nhs.net

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.2 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE COMMON SEAL of
PETERBOROUGH CITY COUNCIL

was hereunto affixed in the presence of:

_____

Authorised Signatory

THE COMMON SEAL of
CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP

was hereunto affixed in the presence of:

_____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

Part 1 – Agreed Scheme Specification

As set out in of Schedule 6

Part 2 – Permitted Expenditure

Scheme Name (Item (a))	2015/16 (£000) Price (b)	Lead Commissioner (C)	Type (d)	Description of spend (e)	Transfer of Funds into the Pooled Fund
Care act implementation	407	Council	Contribution	To support the local authority in meeting its revised statutory duties under the Care Act 2014.	yes
2014/15 section 256 agreement	3,522	Council	Contribution	Continuing current 'section 256' investment in social care to support other social care services	yes
Protecting adult social care services Inc Transformation	1589	Council	Contribution	Support to ensure that existing social care service levels can be protected and that local social care services are able to meet new national minimum eligibility criteria.	yes
1. Data Sharing		Council		To deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people.	yes
2. 7 Day Working	250	Council		To expand 7 day working to ensure discharge planning is undertaken according to patient need, not organisational availability.	yes
3. Person Centred System (Joint Assessments)	100	Council		To enhance and improve person centred care across the entire system, ensuring that care and support is planned and co-ordinated by	yes

				Integrated Neighbourhood Teams (MDT) working alongside individuals at risk of becoming frail or requiring high cost services in the future.	
4. Information and Communication		Council		To develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries	yes
5. Ageing Healthily and Prevention	550	Council		To develop community based preventative services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities.	yes
Older People Community Health Services	3,749	CCG	Contribution	A contribution towards the CCG Older People and Adult Community Services contract, which will drive integration across the local health and wellbeing system	No
Performance fund	429	CCG	Performance	This is the performance-related pay element of the Better Care Fund. If local services meet their targets for the reduction of non-elective admissions, this sum will be released for spending on integration and transformation projects; if not, it will be used to compensate acute providers. The Partners agree that the Joint Commissioning Forum shall determine how the performance fund shall be spend.	Not until reduction of non elective admissions by 1% is met

Carers prescription	150	CCG	Contribution	The GP Family Carers Services Prescription service aims to build capacity to improve the support available to carers from primary care services, It was designed to support primary care professionals, by integrating with familiar work processes - developing a prescription with a read code designed to populate the GPs carers' database.	No
DFG capital - Adults	661	Council	Contribution	Ring-fenced sum for the Disabled Facilities Grant for Adults	No
DFG capital - Children	150	Council	Contribution	Ring-fenced sum for the Disabled Facilities Grant for Childrens	No
Social Care capital grant - various	442	Council	Contribution	Maintaining current levels of capital investment in social care to maintain performance in services and provide adequate capital investment for implementation of the Care Act in Peterborough	No
Total	**11,999**				

Financial Contributions for subsequent years are to be determined in accordance with the Agreement.

12 equal monthly payments will be made by the CCG during the first week of each month subject to receiving an invoice from the Council 10 working days in advance.

SCHEDULE 2 – GOVERNANCE

GOVERNANCE STRUCTURE

General

(a) This Schedule sets out how the Partners will retain proper influence and control over the joint commissioning function notwithstanding each Partner assuming the lead commissioning role for different elements of the Pooled Fund.

(b) Governance will be in accordance with the relevant boards made up of representatives of each of the Partners (as set out below) which together formulate proposals which eventually are put to each of the Council's and the CCG's decision making authorities..

(c) The decision making powers of the Council are vested in the Strategic Management Team, Member Committees and full Council, taking into account the Council's formal "scrutiny" process.

(e) The decision making powers of the CCG are set out in the CCG's Constitution, with ultimate decisions being taken by the CCG Governing Body.

2. **Framework for decision making**

(a) The Joint Commissioning Forum ("JCF")

On the JCF, The Council is represented by the Director of Communities and other key staff. The CCG is represented by its Local Chief Officer for Borderline and Peterborough LCG and other key staff.

It will provide the overall framework and direction for partnership working in Peterborough. The JCF will agree the outcome requirements to be satisfied by joint commissioning. The terms of reference of the JCF are set out in this Schedule.

Through monthly meetings the JCF will evaluate programme delivery and financial benefits realisation for the priority schemes. This will be assessed alongside a performance dashboard of integrated care metrics to ensure high levels of satisfaction from patients, carers and employees to ensure that the delivery of the programme remains on track.

The accountability for performance, risk management, and remedial action will be managed through the JCF. This will be overseen by the Health and Well Being Board governance structure.
The JCF is not a body with legal decision making powers. The relevant decision making powers are vested in the Council, the CCG and other statutory partners.

(b) Commissioning Board

The monthly Commissioning Board engages stakeholders and drives forward the delivery of the core schemes, reporting to the JCF as the commissioning executive group of the Health and Well Being Board. The projects are reviewed by the Commissioning Board on a monthly basis and detailed action plans will be put in place where delivery is not on track.

(c) Day to Day Management

Adult Social Care Delivery Board:
The remit of this weekly Delivery Board is to ensure alignment of 'day to day' delivery activities with the key outcomes and a strategic programme level approach to risk and issue management.

Assistant Director of Adult Social Care:
The management of delivering Peterborough's Better Care Fund will be the responsibility of the Assistant Director of Adult Social Care. This role Chairs the Adult Social Care Delivery Board and is

responsible for establishing the robust governance arrangements required to provide the oversight of the plan for the Health and Wellbeing Board.

The Assistant Director will have direct links with the commissioning leads in the CCG and the City Council and will escalate where any operational issues will affect the delivery of the plan.

(d) CCG Governance in relation to Clinical Safety and Performance

The CCG has responsibility for providing assurance on the quality and safety of the health services it commissions to the Patient Safety and Quality Committee.

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

For the purposes of this section 'Risk Sharing' shall mean the mechanism by which any deficit in the budget is to be controlled by the Joint Commissioning Forum for the purposes of providing the Schemes under the Agreement, including how any surplus at the end of each Agreement Year is to be dealt with and how the level of demand upon the Service is to be addressed.

1. The Parties agree that each Partner will accept overall responsibility for the 'contribution' budget lines under which they are the Lead Commissioner. The other party will not accept any responsibility for any deficit arising in those budget lines. For areas that are jointly commissioned, the Council as the Pooled Fund Host will manage the budget within the agreed limit; any variation in that amount must be agreed in writing by both Parties.
2. The provisions set out in this Schedule are intended to deal with a situation where a surplus, deficit or potential deficit is identified in the budget and as a result of the operation of the financial model at the end of each Agreement Year. For the avoidance of doubt, each Agreement Year runs from 1 April in one year to 31 March of the next year in line with the Commencement Date of the Agreement.
3. The aim of this Risk Sharing section is to assist the Parties in deciding who is responsible for identifying and controlling risks and how any surplus should be accounted for and any change in demand for the Service is to be addressed.
4. The control of deficit risk in each budget line shall be the responsibility of the Lead Commissioner. Each Partner shall use its best endeavours to ensure that there is no financial disadvantage or loss to the other as a result of managing the budget and operating the financial model.
5. An essential part of this risk management duty of each Lead Commissioner shall be to ensure that internal financial controls are robust and carefully monitored and scrutinised.
6. At the end of each Agreement Year it is agreed that in the event of there being a surplus in the budget, that surplus shall be retained in the Pooled Fund in the following year for the purposes of delivering the Scheme Specification under the Agreement.
7. Each Partner shall be entitled to receive such information as it requires from the other to verify the amount of any surplus prior to agreeing to its re-investment as set out in paragraph 6 above.
8. Any requests for information by either Partner contained herein are without prejudice to any information that either Partner is entitled to request of the other Partner under any other provision of the Agreement.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

As set out in Schedule 6.

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

As set out in Schedule 6.

SCHEDULE 6 – BETTER CARE FUND PLAN

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

SCHEDULE 8 – DATA PROCESSING AGREEMENT

DATED **2015**

AN AGREEMENT

BETWEEN:

(1) **PETERBOROUGH CITY Council** ("PCC"); and

(2) **Cambridgeshire and Peterborough Clinical Commissioning Group** ("CCG"),

BACKGROUND

(A) There will be instances pursuant to the Partnership Agreement where either PCC or CCG may be required to Process Personal Data on behalf of the other. All references to Data Controller and Data Processor in this agreement shall be a reference to PCC or to CCG depending on the context.

(B) This agreement is to ensure the protection and security of data passed from the Data Controller to the Data Processor for processing or accessed by the Data Processor on the authority of the Data Controller for processing or otherwise received by the Data Processor for processing on the Data Controller's behalf.

(C) Paragraphs 11 and 12 of Part II of Schedule 1 of the Data Protection Act 1998 place certain obligations upon a Data Controller to ensure that any data processor it engages provides sufficient guarantees to ensure that the processing of the data carried out on its behalf is secure;

(D) This agreement exists to ensure that there are sufficient security guarantees in place and that the processing complies with obligations equivalent to those of the 7th Data Protection Principle contained in the Data Protection Act 1998;

(E) This agreement further defines certain service levels to be applied to all data related services provided by the Data Processor.

(F) This agreement provides an operating framework to enable lawful disclosure of Data to and for the purposes of data processing by the Data Processor working on behalf of the Data Controller taking account of the Data Protection Act 1998, any relevant guidance and laws on confidentiality of personal information and data protection that may be in force from time to time and any duties that may be applicable under common law.

(G) The terms and conditions of this agreement shall apply to all information provided by the Data Controller, or obtained by the Data Processor from other sources as part of the delivery of the contracted services, or derived from any combination thereof.

IT IS AGREED

1. **DEFINITIONS AND INTERPRETATION**

1.1 In this agreement:

"Act" means the Data Protection Act 1998;

"Data" means any information of whatever nature that, by whatever means, is provided to the Data Processor by the Data Controller, is accessed by the Data Processor on the authority of the Data Controller or is otherwise received by the Data Processor on the Data Controller's behalf, for the purposes of the Processing specified in clause 3.1(a), and shall include, without limitation, any Personal Data and Sensitive Personal Data;

“Data Controller” has the meaning set out in the DPA;

“Data Processor” has the meaning set out in the DPA;

"Data Subject", "Personal Data" and "Processing" shall have the same meanings as are assigned to those terms in the Act;

‘DPA’ means the Data Protection Act 1998.

“Sensitive Personal Data” as defined in the Act.

“Schedule” means the schedules annexed to and forming part of this agreement;

“Scheme” means the Scheme Specification as set out in Schedule 1 of the Partnership Agreement.

“Partnership Agreement” means the partnership agreement made under section 75 National Health Service Act 2006 relating to the commissioning of Health and Social Care Services under the Better Care Fund;

1.2 In this agreement any reference, express or implied, to an enactment (which includes any legislation in any jurisdiction) includes references to:

(a) that enactment as re-enacted, amended, extended or applied by or under any other enactment (before, on or after the date of this agreement);

(b) any enactment which that enactment re-enacts (with or without modification); and

(c) any subordinate legislation made (before, on or after the date of this agreement) under that enactment, as re-enacted, amended, extended or applied as described in clause 1.2(a), or under any enactment referred to in clause 1.2(b).

1.3 In this agreement:

(a) references to a person include an individual, a body corporate and an unincorporated association of persons;

(b) references to a party to this agreement include references to the successors or assignees (immediate or otherwise) of that party.

1.4 Clauses 1.1 to 1.3 apply unless the contrary intention appears.

2. APPLICATION OF THIS AGREEMENT

2.1 This agreement shall apply to:

(a) all Data sent from the date of this agreement by the Data Controller to the Data Processor for Processing;

(b) all Data accessed by the Data Processor on the authority of the Data Controller for Processing from the date of this agreement; and

(c) all Data otherwise received by the Data Processor for Processing on the Data Controller's behalf;

in relation to the Scheme.

3. **DATA PROCESSING**

3.1 The Data Processor agrees to Process the Data to which this agreement applies in accordance with the terms and conditions set out in this agreement, and in particular the Data Processor agrees that it shall:

(a) Process the Data at all times in accordance with the Act and solely for the purposes (connected with provision by the Data Processor of the Scheme) and in the manner specified from time to time by the Data Controller in writing and for no other purpose or in any manner except with the express prior written consent of the Data Controller;

(b) in a manner consistent with the Act and with any guidance issued by the Information Commissioner, implement appropriate technical and organisational measures to safeguard the Data from unauthorised or unlawful Processing or accidental loss, destruction or damage, and that having regard to the state of technological development and the cost of implementing any measures, such measures shall ensure a level of security appropriate to the harm that might result from unauthorised or unlawful processing or accidental loss, destruction or damage and to the nature of the Data to be protected;

(c) ensure that each of its employees, agents and subcontractors are made aware of its obligations under this agreement with regard to the security and protection of the Data and shall require that they enter into binding obligations with the Data Processor in order to maintain the levels of security and protection provided for in this agreement;

(d) not divulge the Data whether directly or indirectly to any person, firm or company or otherwise without the express prior written consent of the Data Controller except to those of its employees, agents and subcontractors who are engaged in the Processing of the Data and are subject to the binding obligations referred to in clause 3.1(c) or except as may be required by any law or regulation;

(e) in the event of the exercise by Data Subjects of any of their rights under the Act in relation to the Data, inform the Data Controller as soon as possible, and the Data Processor further agrees to assist the Data Controller with all data subject information requests which may be received from any Data Subject in relation to any Data;

(f) not Process the Data outside of the United Kingdom except with the express prior written authority of the Data Controller; and

(g) allow its data processing facilities, procedures and documentation to be submitted for scrutiny by the Data Controller or its representatives in order to ascertain compliance with the terms of this agreement.

4. **OBLIGATIONS OF THE DATA CONTROLLER**

4.1 The Data Controller agrees that it shall ensure that it complies at all times with the Act, and, in particular, the Data Controller shall ensure that any disclosure of Personal Data made by it to the Data Processor is made with the data subject's consent or is otherwise lawful.

5 **GENERAL PROVISIONS**

The Data Processor shall not subcontract any of its processing operations performed on behalf of the Data Controller under this agreement without the prior written consent of the Data Controller. Where the Data Processor subcontracts its obligations to a sub-processor, with the prior consent of the Data Controller, it shall do so only by way of a written agreement with the sub-processor and such written agreement shall impose the same obligations on the sub-processor as are imposed on the Data Processor under this agreement. Where the sub-processor fails to fulfil its data protection obligations under such written agreement the Data Processor shall remain fully liable to the Data Controller for the performance of the sub-processor's obligations under such agreement.

6. FURTHER OBLIGATIONS OF THE DATA PROCESSOR

6.1 The Data Processor shall comply with all applicable aspects of the DPA in relation to the processing of the Data.

6.5 The Data Processor shall have information security and data protection policies in place. These will describe individual responsibilities for handling Data.

6.6 The Data Processor shall provide the Data Controller with copies of the policies referred to in 6.5 above on request.

6.7 The Data Processor shall undertake all reasonable background checks to ensure the reliability of all its employees, contractors who are likely to use or have access to the Data.

6.9 The Data Processor shall ensure that all employees are aware of and act in accordance with the policies referred to in 6.5 above.

6.10 The Data Processor shall ensure that all its employees and contractors are adequately trained to understand and comply with their responsibilities under DPA and this agreement and shall provide the Data Controller with evidence of that training on request.

6.11 The Data Processor shall ensure that only those employees involved in delivery of the Scheme use or have access to the Data on a strict ‘need to know’ basis and shall implement appropriate access controls to ensure this requirement is satisfied.

6.12 The Data Processor shall ensure that any employees involved in delivery of the Scheme who do not specifically need to use personal information as part of their role have restricted access to anonymised Data and/or redacted extracts only.

7. SECURITY - GENERAL

7.3 The Data Processor shall notify the Data Controller immediately of any incidents or activities that would indicate non-compliance with any of the terms of this agreement.

7.4 The Data Processor shall indemnify the Data Controller against and compensate for any loss (financial or otherwise) that the Data Controller sustains due to any failure by the Data Processor or employees, contractors or sub-contractors to act in accordance with the terms of this agreement and relevant legislation.

8. SECURITY - PHYSICAL

8.1 The Data Processor shall ensure that all Data is physically protected from accidental or deliberate loss or destruction arising from environmental hazards such as fire or flood.

8.2 The Data Processor shall ensure that all Data is held on premises that are adequately protected from unauthorised entry and/or theft of the Data and any IT equipment on which Data is held is physically secure. This protection can be achieved, for example, by the use of burglar alarms or security systems, security doors, ram-proof pillars and controlled access systems.

9 SECURITY – IT SYSTEMS

9.1 The Data Processor shall hold electronically-based Data on secure servers unless otherwise agreed in writing.

9.1.1 Data will, under no circumstances, be stored on portable media or devices such as laptops or USB memory sticks or CD-ROM unless agreed in writing and subject, at a minimum, to those constraints detailed in section 9.2 below.

9.2 The Data Processor shall ensure that:

9.2.1 All portable media used for storage or transit of the Data are fully encrypted in accordance with standards agreed between the Data Controller and Data Processor.

9.2.2 Portable media are not left unattended at any time and in particular in parked cars and vehicles and in unlocked & unoccupied rooms

9.2.3 When not in use, all portable media are stored in a locked area and issued only when required to authorised employees, with a record kept of the identity of the employee, the date of issue, the equipment or devices issued and the return date.

9.3 The Data Processor shall not allow employees to hold the Data on their own personal computers, mobile phones and other devices of a personal nature.

9.4 The Data Processor shall ensure adequate back-up facilities to minimise the risk of loss of or damage to Data and that a robust business continuity plan is in place in the event of restriction of service for any reason.

9.5 The Data Processor shall not transmit the Data by email except as an attachment encrypted to 256 bit AES\Blowfish standards or from a GSCX compliant e-mail system to a GSCX compliant e-mail system.

9.6 The Data Processor shall only make printed paper copies of Data only if this is essential for delivery of the Individual Scheme.

9.7 The Data Processor shall store printed paper copies of Data in locked cabinets when not in use and shall not remove from premises unless this is essential for delivery of the Individual Scheme.

9.8 For the purposes of this agreement the Data Processor will not have access to any of the Data Controller's networked IT systems.

10. SECURITY – DESTRUCTION AND RETENTION

10.1 The Data Processor shall ensure that the Data held in paper form (regardless of whether as originally provided by the Data Controller or printed from the Data Processor's IT systems) is

destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

10.2 The Data Processor shall ensure that electronic storage media used to hold or process Data is destroyed or overwritten to current CESG standards as defined at www.cesg.gov.uk

10.3 In the event of any bad or unusable sectors that cannot be overwritten, the Data Processor shall ensure complete and irretrievable destruction of the media itself.

10.4 The Data Processor shall provide the Data Controller with copies of all relevant overwriting verification reports and/or certificates of secure destruction of Data at the conclusion of the contract.

10.5 The Data Processor and Data Controller shall ensure that the retention of Data is in accordance with the Act.

11. MONITORING & AUDIT

11.1 The Data Processor shall permit the Data Controller to monitor compliance with the terms of this agreement, by completing and returning a Data Processing Monitoring Form as set out in Schedule 1, at the request of the Data Controller.

12. TERMINATION

12.1 This agreement shall terminate automatically upon termination or expiry of the Data Processor's obligations in relation to the Partnership Agreement, and on termination of this agreement the Data Processor shall forthwith deliver to the Data Controller or destroy, at the Data Controller's sole option, all the Data Controller's Data in its possession or under its control.

12.2 The Data Controller shall be entitled to terminate this agreement forthwith by notice in writing to the Data Processor if:-

12.2.1 the Data Processor is in a material or persistent breach of this agreement which, in the case of a breach capable of remedy, shall not have been remedied within twenty one (21) days from the date of receipt by the Data Processor of a notice from the Data Controller identifying the breach and requiring its remedy; or

12.2.2 the Data Processor become insolvent, has a receiver, administrator, or administrative receiver appointed over the whole or any part of its assets, enters into any compound with creditors, or has an order made or resolution passed for it to be wound up (otherwise than in furtherance of a scheme for solvent amalgamation or reconstruction).

13. GOVERNING LAW

13.1 This agreement is governed by and shall be interpreted in accordance with the law of England and Wales.

13.2 In the event of a dispute, the parties to this agreement agree to attempt to resolve such issues according to dispute resolution procedures set out in the Partnership Agreement between the parties. In the event that resolution cannot be reached, the parties agree that the courts of England and Wales shall have exclusive jurisdiction to hear the case.

14. WAIVER

14.1 Failure by either party to exercise or enforce any rights available to that party or the giving of any forbearance, delay or indulgence shall not be construed as a waiver of that party's rights under this agreement.

15. **INVALIDITY**

15.1 If any term or provision of this agreement shall be held to be illegal or unenforceable in whole or in part under any enactment or rule of law such term or provision or part shall to that extent be deemed not to form part of this agreement but the enforceability of the remainder of this agreement shall not be affected provided however that if any term or provision or part of this agreement is severed as illegal or unenforceable, the parties shall seek to agree to modify this agreement to the extent necessary to render it lawful and enforceable and as nearly as possible to reflect the intentions of the parties embodied in this agreement including without limitation the illegal or unenforceable term or provision or part.

16. **ENTIRE AGREEMENT**

16.1 This agreement and the documents attached to or referred to in this agreement shall constitute the entire understanding between the parties and shall supersede all prior agreements, negotiations and discussions between the parties. In particular the parties warrant and represent to each other that in entering into this agreement they have not relied upon any statement of fact or opinion made by the other, its officers, servants or agents which has not been included expressly in this agreement. Further, each party hereby irrevocably and unconditionally waives any right it may have:

(a) to rescind this agreement by virtue of any misrepresentation;

(b) to claim damages for any misrepresentation whether or not contained in this agreement;

save in each case where such misrepresentation or warranty was made fraudulently.

17. **NOTICES**

17.1 Except as otherwise expressly provided within this agreement, no notice or other communication from one party to the other shall have any validity under the agreement unless made in writing by or on behalf of the party concerned.

17.2 Any notice or other communication which is to be given by either party to the other shall be given by letter (sent by hand, first class post, recorded delivery or special delivery), or by facsimile transmission or electronic mail (confirmed in either case by letter). Such letters shall be addressed to the other party in the manner referred to in clause 17.3. Provided the relevant communication is not returned as undelivered, the notice or communication shall be deemed to have been given two (2) working days after the day on which the letter was posted, or four (4) hours, in the case of electronic mail or facsimile transmission or sooner where the other party acknowledges receipt of such letters, facsimile transmission or item of electronic mail.

17.3 For the purposes of clause 17.2, the address of each party shall be:

For PETERBOROUGH CITY

COUNCIL:

Address:

For the attention of:

Tel:

Fax:

E-mail:

For **CCG : Andy Vowles**

Address: Lockton House,
Clarendon Road, Cambridge,
CB2 8FH

Telephone: 01223 725400

For the attention of:

Tel:

Fax:

E-mail:

17.4 Either Party may change its address for service by serving a notice in accordance with this clause.

Executed as a Deed by the parties on the date written above

Executed as a DEED on behalf of PETERBOROUGH CITY COUNCIL by:

.....	.....
SIGNATURE OF FIRST OFFICER	SIGNATURE OF SECOND OFFICER
.....	.....
PRINT FULL NAME	PRINT FULL NAME

.....	.....
POSITION	POSITION

Signed as a Deed by ……
on behalf of CAMBRIDGESHIRE AND PETERBOROUGH
CLINICAL COMMISSIONING GROUP

SIGNATURE OF FIRST OFFICER	.
	.....
Maureen Donnelly	SIGNATURE OF SECOND OFFICER
.....	Neil Modha.....
PRINT FULL NAME	.....
	PRINT FULL NAME
CCG Chair	
.....	Chief Clinical Officer
POSITION	.....
	POSITION

…….

Signature of witness:

Name:

Address:

Occupation:

SCHEDULE 1

DATA PROCESSING MONITORING FORM

Monitoring Compliance of [*insert name of Data Processor here]* with the Data Controller's Information Governance Requirements in relation to [*insert name of contract here]*

Please complete this form and return to [*insert name of Data Controller's representative here]*

Your Compliance Assurance to the Data Controller

1. If you already process personal data on your own behalf, as defined within the Data Protection Act 1998, have you reviewed your Notification to the Information Commissioner for Data Processing within the past 12 months?

Please confirm your Notification number:

Do your staff have confidentiality/data protection training at induction and subsequently on an annual basis and are aware of the organisational policies and procedures and are notified when any changes are made?

2. Have you had a security breach resulting in loss of or damage to personal or confidential information within the past 2 years?

If YES, please provide details:

3. Have you had a security breach resulting in unauthorised disclosure of personal information within the past 2 years?

If YES, please provide details:

4. Have you been the subject of any complaints to the Information Commissioner within the past 2 years?

If YES, please provide details:

5. If you answered 'YES' to any of questions 2 – 4 above, did this affect Information belonging to the Data Controller?

If YES, please provide details:

6. If you answered 'YES' to question 5 above, did the incident result in disciplinary action against any of your employees and /or sub-contractors?

If YES, please provide details:

7. Have you updated or amended your confidentiality, information security, data protection or records management policies since the commencement of the contract?

If YES please provide details:
(Please provide copies if the amendments substantially alter the policy)

8. Please use this space to inform us of any other matters that you consider relevant in relation to your compliance with the Data Controller's requirements.

I confirm that [*insert name of Data Processor here]* is complying with all aspects of the Data Controller's confidentiality and information security requirements.

Signed……..…….. Date……

Name……. Position……

For and on behalf of [*insert name of Data Processor here]*
(Print name & position of authorised signatory)

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(a)
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Dr Anne McConville, Interim Consultant in Public Health	Tel. 01733207139

THE ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH CITY COUNCIL FOR 2014

RECOMMENDATIONS	
FROM : Dr Liz Robin, Director of Public Health	

1. The Annual Health Protection report provides assurance to the HWB and the public that the DPH statutory duty to protect the health of the population was met in 2014.
2. Four health protection challenges are identified in section 3.3 of this report, which recommends actions to address them and, in so doing, to tackle health inequalities and barriers to accessing services. Detailed background is provided in the relevant sections of the attached annual health protection report.
3. The Health and Wellbeing Board is asked to:
    - **a.** Note the Annual Health Protection Report for Peterborough City Council, 2014;
    - **b.** Note that the Task and Finish Groups will report their recommendations to improve uptake of childhood immunisations and bowel and cervical cancer screening to the Health and Wellbeing Board in June, and produce costed plans for the Health and Wellbeing Programme Board;
    - **c.** Support the recommendation that Public Health England (PHE) and PCC public health explore the roll out of the PHE pilot of testing for latent tuberculosis (TB) infection to eligible new migrants from high prevalence communities in line with the new collaborative TB strategy;
    - **d.** Ask the Children and Families Board to progress an action plan to address continuing high rates of teenage pregnancy;
    - **e.** Support the recommendation that the public health team meet with the sexual health commissioner to explore opportunities in the sexual health contract to improve HIV and chlamydia screening in relevant population groups;
    - **f.** Support the recommendation that qualitative and survey methods should be used to understand health beliefs and barriers to uptake of services to inform the Eastern European Joint Strategic Needs Assessment and subsequent community engagement and development.

1. ORIGIN OF REPORT

1.1 This annual report on health protection for Peterborough City Council is submitted to provide assurance to the Health and Wellbeing Board, and to the public, that there are safe and effective mechanisms in place to protect the health of the population in Peterborough and that the DPH has successfully executed her statutory responsibilities.

2. PURPOSE AND REASON FOR REPORT

2.1 The annual health protection report focuses on the statutory responsibilities for health protection and compliments the Annual Report of the DPH which looks at the wider issues of population health and wellbeing and their determinants.

2.2 The report (**Appendix A**) is the first annual health protection report for Peterborough City Council. It has been prepared, with input from the members of the Peterborough Health Protection Committee, for the Health and Wellbeing Board to fulfil the statutory responsibilities of the DPH, under the Health and Social Care Act, 2012, to advise on and promote local health protection plans across agencies.

2.3 To facilitate delivery of these responsibilities and promote sharing and planning across agencies, the DPH has established the Peterborough Health Protection Committee (PHPC).

2.4 It is important that there is publically available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance on this; and to have processes in place to address and escalate any issues that might arise.

2.5 The annual report covers multi-agency health protection and emergency response plans; how responsibilities are being discharged; immunisation and screening programmes; sexual health; surveillance of communicable disease and key incidents and outbreaks in 2014.

2.6 This report is for Board to consider under its Terms of Reference No. 3.3:

> *"To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities."*

This report supports the Health and Wellbeing Board strategic priority of 'Preventing and treating avoidable illness' and particularly the linked outcomes of addressing:

a) Disease and poor health indicators
b) Take up of cancer and non-cancer screening programmes
c) Take up of immunisations and vaccinations

And issues identified under other strategic priorities including:

d) Above average teenage pregnancy rates
e) Promoting flu immunisation in the over 65s.

3. SUMMARY OF KEY ISSUES FROM THE ANNUAL HEALTH PROTECTION REPORT, 2014

3.1 The report demonstrates that the DPH statutory responsibilities for protecting the health of the population have been delivered, working with the members of the Health Protection Committee, and through key partners such as Public Health England.

3.2 The review and development of revised working arrangements for the Local Resilience Forum (LRF) for Cambridgeshire and Peterborough is identified as an example of effective action, in partnership, to agree a new governance structure and work programmes across agencies. The DPH, on behalf of the Peterborough Health Protection Committee, will report any significant issues for health sector resilience to the Cambridgeshire and Peterborough Local Health Resilience Partnership (C&PLHRP), which is now a subcommittee of the LRF.

3.3 Four key health protection challenges have been identified in 2014 were action has been taken and/ or further action is recommended in 2015:

a) Tuberculosis- the implications of the new strategy and the opportunity to offer screening for latent TB infection to new migrants from high prevalence communities;
b) The relatively poor uptake of adult bowel and cervical cancer screening programmes;
c) and of childhood immunisation programmes, particularly in the inner city and deprived areas;
d) Sexual health services –teenage pregnancy rates, targeted HIV testing for men who have sex with men and population coverage of chlamydia screening in young people.

3.4 All four are linked to inequalities in health outcomes and raise issues of equality of opportunity with regard to information and access to services.

3.5 Tuberculosis (TB)

3.5.1 Rates of tuberculosis infection remain high in Peterborough with cases being referred to the Tuberculosis treatment service. Public Health England is investigating small clusters of cases linked through the workplace, which include people resident in Peterborough. Risk

assessment and contact tracing is carried out in the workplace and home, as indicated. It is thought that a number of these cases are related to the high prevalence of tuberculosis in the home countries of new migrants.

3.5.2 Public Health England published a new national collaborative strategy for tuberculosis in January with ten areas for action including the establishment of TB Control Boards covering a wide area, with a senior clinical lead. The strategy has implications for service commissioning, with calls for better treatment and care; high quality diagnostics and early diagnosis; improved contact tracing and tackling TB in underserved populations. It proposes the introduction of a systematic screening programme of new entrants from high prevalence countries to detect and treat latent TB infection (LTBI).

3.5.3 The Public Health team are in discussion with PHE on the possible roll out of their pilot LTBI screening programme to eligible new entrants in Peterborough with a focus on the inner city practices. This would need to be progressed in the immediate future to meet the PHE timescales for learning from the pilot.

3.6 Uptake of Cervical and Bowel cancer screening programmes

3.6.1 In response to concerns with the poor uptake of cervical and bowel cancer screening programmes in the inner city, identified to the Health and Wellbeing Board in June 2014, a multi-agency task and finish group was convened in November to investigate and make recommendations for action to the Health Protection Committee in April and to the Health and Wellbeing Programme Board and the Health and Wellbeing Board in June 2015.

3.6.2 The group has already identified a number of issues including:

a) Variation-inner city practices with good and poor uptake rates;
b) Information and health beliefs: cultural and language /literacy barriers; the acceptability of the tests to some ethnic groups;
c) Problems with the delivery of invitation and reminder letters to a mobile population and those in houses of multiple occupancy;
d) Access to testing –timing of appointments; female smear takers; chaotic lifestyles or more pressing demands e.g. shift work, caring responsibilities;
e) Lack of data which would allow analysis by ethnic group.

3.6.3 The Task and Finish group is reviewing the evidence of effective interventions to inform their recommendations and the development of a costed action plan.

3.6.4 An initial brief review of the poor uptake of cancer screening programmes in 2013-4 identified the need for additional funding to run information and education campaigns targeted to minority ethnic populations and engage in community development with underserved groups and inner city practices.

3.7 Childhood immunisation programmes

3.7.1 A multi-agency Task and Finish Group has been convened to investigate the causes of the inequalities in uptake of the childhood immunisation programme and to make recommendations for improvement to the Health Protection Committee in April and the Health and Wellbeing Programme Board and the Health and Wellbeing Board in June 2015.

3.7.2 For most childhood immunisations, coverage in Peterborough is below the 95% required for herd immunity.

3.7.3 The group is considering factors which may impact on the uptake in new migrant communities:

a) Understanding of the UK immunisation schedule;
b) Immunisations in the home country not being recorded on the UK system;
c) Problems with the reporting and recording of data when children have been immunised to schedule;
d) A mobile population –moving either within addresses in Peterborough or more widely and the implications for GP registration of moving house.

3.7.4 The group is reviewing evidence to inform recommendations and a costed action plan.

3.8 Sexual health services

3.8.1 The public health commissioner has identified three areas of concern to the Health Protection Committee:

a) Teenage pregnancy rates remain above regional and national averages despite having declined in recent years;
b) Between 2011 and 2013 a higher proportion of HIV infections were diagnosed at a late stage of infection. Late diagnosis is associated with a ten-fold risk of mortality within twelve months of diagnosis which may have been prevented by earlier access to anti-retroviral drug treatments;
c) Whilst the rate of chlamydia diagnoses in young people is high compared to England, local data shows a reduction in the number screened suggesting that not all young people at risk are being tested.

3.8.2 The public health team are meeting with the Sexual Health Commissioner to better understand these challenges and the opportunities within the sexual health contract for improvement in service delivery and outcomes.

4. CONSULTATION

4.1 The report has been prepared by the interim CPH, on behalf of the interim DPH, with input from members of the Peterborough Health Protection Committee and programme data from relevant agencies, particularly the Public Health England staff in the Anglia Health Protection Unit and screening and immunisation leads working with NHS England, East Anglia Area Team.

4.2 The Annual Report on Health Protection was considered by the Health and Wellbeing Programme Board (HWPB) on 4th March, 2015 who asked to consider the implications of the recommendations of the Task and Finish groups prior to consideration by the Health and Wellbeing Board in June. They made suggestions of methods to engage the new communities and inner city population (via the recruitment and training of 'community connectors'; mosque leaders; and though leisure groups with mixed community attendance). The HWPB also supported the recommendations that the Children and Families Board takes responsibility for progressing work to address teenage pregnancy.

5. ANTICIPATED OUTCOMES

5.1 Progress on the four areas of challenge identified in 3.3 reported in the Annual Report on Health Protection in 2015; and an improvement in population health and the relevant health outcomes, monitored through the Public Health Outcomes Framework, over time.

6. REASONS FOR RECOMMENDATIONS

<u>The causes and impact of health inequalities</u>

6.1 The report identifies areas of inequality in the prevalence of communicable disease and in the uptake of screening and immunisation programmes with the potential to impact on the health and quality of life of some of our most deprived communities and those at greatest risk of stigma and prejudice.

6.2 The uptake of the cervical screening programme is lowest in young women in the more deprived inner city practices of Peterborough, some of whom may be from new migrant communities. Bowel cancer uptake is poor in both genders in the inner city as is childhood immunisation compared to more affluent areas. It is not possible to analyse data by ethnic group. The Task and Finish groups will report their findings and recommendations to the Health and Wellbeing Board in June 2015.

6.3 Tuberculosis and the prevalence of latent TB infection is highest in migrant populations from countries with a high prevalence.

6.4 The HIV testing programme is targeted to men who have sex with men. Early detection allows access to drug treatment to manage infection and disease progression, and the provision of information to reduce risks of transmission to others.

6.5 Teenage pregnancy rates are higher in more deprived communities; the children of teenage mothers generally have a greater risk of low birth weight and of a poorer start in life than those born into families with more resources. Work to address this lies outside the remit of the HPC and should be progressed through the Children's and Families Board.

Legal duties to reduce inequalities

6.6 NHS bodies –the CCG, NHS England, Monitor-have a legal duty under the Health and Social Care Act, 2012, to give due regard in the exercise of their functions to reducing inequalities between patients in access to and outcomes from health services.

6.7 Whilst no specific legal duty to reduce health inequalities applies to local authorities, a local authority must, in using the grant, have regard to the need to reduce inequalities between people in an area with respect to the benefits that they can obtain from that part of the health service provided by the local authority.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Given the evidence of health inequalities in uptake and potentially in outcome identified in the report, and the legal duty noted above, the 'do nothing' option is not tenable.

7.2 The Task and Finish groups on cancer screening and the uptake of childhood immunisations will report with evidence based recommendations to the Health and Wellbeing Board in June 2015.

8. IMPLICATIONS

8.1 Costed plans will need to be developed to address the recommendations from the Task and Finish groups on childhood immunisation and cancer screening. The HWPB can consider these and the resources needed in June.

8.2 To better understand the health beliefs and barriers to uptake of services in new migrant communities, qualitative research and survey methods should be used in the Eastern European migrants JSNA (there is very limited routine data by ethnicity).

8.3 This qualitative research should inform the community engagement and development required to develop health literacy and remove barriers to accessing services in the new migrant and inner city populations.

9. BACKGROUND DOCUMENTS

9.1 The Annual Health Protection Report for Peterborough City Council for 2014 (attached, appendix A).

9.2 The new public health role of local authorities, Department of Health, October 2012; Gateway reference:17876.

9.3 Protecting the health of the local population: the new health protection duty on local authorities under the Local Authorities (Public Health Functions and Entry to Premises by local Healthwatch Representatives) Regulations 2013; Department of Health, Public Health England, Local Government Association, May 2013.

9.4 Collaborative Tuberculosis Strategy for England, 2015-2020, Public Health England and NHS England; PHE Gateway: 2014596, January 2015.

9.5 Health inequalities duties: Health and Social Care Act 2012, Health Inequalities Unit, Department of Health, March 2013.

Dr Anne McConville, MRCGP, FFPH
Interim Consultant in Public Health
10/03/15

APPENDIX A

ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH CITY COUNCIL FOR 2014

1. Introduction

1.1. Upon implementation of the Health and Social Care Act 2012, on 1 April 2013, the Peterborough City Council, through the Director of Public Health (DPH), took on statutory responsibilities to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Clinical Commissioning Group (CCG) and the City Council. Prior to that date, Peterborough Primary Care Trust (PCT) had arrangements in place through various groups (both strategic and operational) to ensure these responsibilities were discharged and to allow for professional dialogue about new initiatives, local pressure points etc. and to have a clear escalation plan in place, should it be needed.

1.2 The Health and Well Being Board (HWB) has statutory responsibilities and has developed a health and wellbeing strategy 2012-15. Whilst much of this relates to health improvement, health protection is interwoven into the strategy's aims, particularly in relation to priority two- 'preventing and treating avoidable illness'.

1.3 The services that fall within Health Protection include:

- communicable diseases
- infection control
- routine antenatal/new born, young person and adult screening
- routine immunisation and vaccination
- sexual health
- environmental hazards.

1.4 It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise.

1.5 To facilitate information sharing and planning across agencies, the DPH has established the Peterborough Health Protection Committee (PHPC). In addition to this Committee, "Task and Finish" groups may be convened to address specific issues, taking into account the reduced staff resources overall in the system, the need to work in partnership to ensure that maximum efficiency is achieved.

1.6 The DPH will produce an annual health protection report to the Health & Wellbeing Board (HWB) which would provide a summary of relevant activity. This report will cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged and identify their relationship to the Joint Strategic Needs Assessment and

Health and Wellbeing Strategy priorities. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern had arisen.

2. Background

2.1 In order to have the oversight that is necessary to meet their statutory responsibilities the DPH needs:

- To be able to, on behalf of the City Council, advise on and promote local health protection plans across agencies. This role complements the statutory responsibilities of Public Health England (PHE), NHS England, and the CCG;
- To be assured, on behalf of the City Council, of Health Protection arrangements by relevant organisations in the Local Authority area;
- To be provided with information, including surveillance and other data from PHE and other partners, in order to be able to scrutinise and as necessary challenge performance;

- On the basis of this scrutiny to be able to provide strategic challenge to health protection plans/arrangements produced by partner organisations;
- To have a clear escalation plan in place agreed with the Local Authorities, PHE, NHS England, CCG, and Department of Health (DH) to enable any concerns to be escalated as appropriate, including to the Local Health Resilience Partnership (LHRP);
- To have clear agreement that information on all local health protection incidents and outbreaks, including screening incidents, are reported to the DPH such that the DPH can take any necessary action, working in concert with PHE and the NHS. This may include, for example, chairing an outbreak control committee, or chairing a look back exercise in response to an untoward incident;
- To be a member of, and to contribute to, the work of the Cambridgeshire and Peterborough LHRP. The lead DPH for the area and co-chair of the LHRP is currently provided by Cambridgeshire;
- To provide the public health input into the city council emergency management plan;
- To be able to provide a comprehensive annual report to the HWB on all aspects of health protection to include performance, issues and incidents.

2.2 While the DPH is accountable to the Secretary of State for Health as well as to Peterborough City Council, Peterborough Health and Well-being Board and the Peterborough population for providing advice on health protection in the local authority, the DPH has no managerial responsibility for other organisations that provide the services that deliver health protection.

2.3 To enable the DPH to fulfil these statutory responsibilities, the Health Protection Committee (PHPC) was established in October 2013 and is chaired by the DPH or nominated deputy. The PHPC enables all agencies involved to demonstrate that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise. The PHPC reports to the Health and Wellbeing Programme Board. In addition, a memorandum of understanding (MOU) has been developed and agreed with partner organisations.

3 Peterborough Health Protection Committee

3.1 The aim of the Health Protection Committee is to provide assurance to the Director of Public Health and Peterborough Health & Wellbeing Board that there are safe and effective mechanisms in place to protect the health of the population of Peterborough.

3.2 To provide a forum for information sharing and planning between public agencies that have responsibilities in Peterborough for health protection as defined in 1.3.

3.3 To receive reports from member agencies that enable monitoring of these arrangements and reporting of any issues or incidents.

3.4 To provide a mechanism to consider the implications of national guidance/changes for local implementation and be assured that there are mechanisms in place for their delivery.

3.5 To identify:

- Gaps and issues which need resolution by one or more of the member agencies
- Procedures/processes which need to be developed or improved
- The actions that need to be taken jointly by member agencies
- Gaps and resources needed by the Committee to function effectively, e.g. missing data or information.

3.6 To support the production of an annual health protection report for submission to the HWB.

3.7 Public health emergency planning responsibility is shared between the Local Health Resilience Partnership (LHRP), which is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH and the Local Health Resilience Forum. The DPH will report health protection emergency planning issues to the LHRP on a regular basis.

3.8 The membership of the PHPC includes:

- Director of Public Health (Peterborough City Council)
- Consultant in Public Health Medicine (Peterborough City Council)
- Public Health England Anglia & Essex Centre: CCDC
- Cambridgeshire and Peterborough CCG (rep for HCAI)
- NHS England Area Team (Screening & Immunisation)
- Acute Trust (Infection Prevention & Control/Microbiology)
- Environmental Health Officer (Peterborough City Council)
- Sexual Health Commissioner (Peterborough City Council)
- Adult Social Care Representative (Peterborough City Council)
- Children's Services Representative (Peterborough City Council)
- Resilience Representative (Peterborough City Council)

The Committee will be chaired by the Director of Public Health or the Consultant in Public Health Medicine.

4 Memorandum of Understanding

4.1 A Memorandum of Understanding (MOU) for Health Protection was signed in July 2014, following discussion in the PHPC and consultation with partner organisations. Signatory organisations include:

- NHS England : East Anglia Area Team
- Public Health England : Anglia & Essex Centre
- Cambridgeshire & Peterborough Clinical Commissioning Group
- Peterborough City Council

4.2 The purpose of the MOU is to ensure that new agreements and protocols are in place that meet the needs of the organisations that are responsible for discharging health protection responsibilities after implementation of the Health and Social Care Act, 2012.

4.3 The scope of the MOU includes:

- Organisational roles and responsibilities for health protection in Peterborough
- The role of Peterborough Health Protection Committee
- Arrangements for 24/7 on call for public health
- Information sharing arrangements to ensure sharing of routine and ad hoc (outbreaks and incidents) data with the Director of Public Health, Peterborough City Council and between partner organisations
- Escalation and management arrangements for public health incidents
- Arrangements for the management of cross-border incidents and outbreaks
- Escalation and information sharing arrangements for public health incidents
- Arrangements for exercising and testing plans for Peterborough
- Arrangements for the review of the MOU.

5 Joint Communicable Disease Outbreak Management Plan

5.1 This Plan, which was led by Public Health England with input from local public heath teams in its development, provides a framework for partnership working across the new public health structures including the Public Health England Centre (PHEC) local health protection team (HPT), local authority public health directorates and local authority (LA) environmental health departments, Clinical Commissioning Groups (CCGs), NHS England (NHSE) and other relevant bodies.

5.2 The plan was adopted as a working draft for use by public health teams across Cambridgeshire, Peterborough, Norfolk and Suffolk prior to the final draft being circulated and signed-off by all partner organisations in summer 2014.

5.3 It constitutes a joint plan to manage an outbreak or significant incident of communicable disease/infection in Norfolk, Suffolk, Cambridgeshire and Peterborough. It covers a range of scenarios from a minor outbreak that will be managed within the PHE HPT to an outbreak which could lead to a major incident being declared that requires a full multi-agency response.

5.4 For this plan, the term ‘outbreak’, refers both to outbreaks and significant incidents of communicable disease and infection.

5.5 The plan gives clarity on roles and responsibilities in managing an outbreak -essential to providing a coordinated approach to management- including communication, investigation and control procedures.

5.6 In addition to PHE, NHS organisations (providers and commissioners) and Peterborough Public Health team, the varied nature of outbreaks will lead to the involvement of a number of partners in their investigation and management. These may include:

- Local Authority (LA) Environmental Health (EH) Services;
- School or care home representatives where the outbreak affects specific groups;
- Health and Safety Executive (HSE) where HSE enforced premises are involved;
- The Animal Health and Veterinary Laboratories Agency (AHVLA) will be involved in the event of an outbreak of a zoonotic disease;
- Water Company representatives if water supplies are affected e.g. cryptosporidiosis.

This plan has been tested and judged to be effective in both exercises and actual incidents.

6 Surveillance

6.1 In order to understand and monitor the incidence of communicable diseases, the effectiveness of prevention activities such as immunisation, and the threats posed by new and emerging infections, the UK has an active communicable disease surveillance service provided by PHE both through national centres and through their Field Epidemiology Teams. These teams provide a wide range of reports on a frequent basis ranging from weekly through to annual reports.

6.2 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify a Proper Officer of the local authority, usually the Consultant in Communicable Disease Control in the local Health Protection Team (HPT), of suspected cases of certain infectious diseases. These notifications, along with laboratory and other data, are an important source of surveillance information. The table below shows the notifiable diseases reported to the HPT from 1 April 2011 – 31 March 2014.

Table 1: Notifications of Infectious Diseases in Peterborough by year 2011-2014

Notifiable Disease*	1 Apr 2011 - 3 Mar 2012	1 Apr 2012 - 31 Mar 2013	1 Apr 2013 - 31 Mar 2014
Acute encephalitis	0	0	0
Acute infectious hepatitis[1]	8	10	12
Acute meningitis	7	1	2
Enteric fever	1	2	0
Food poisoning[2]	222	328	304
Infectious bloody diarrhea	0	13	15
Invasive group A streptococcal disease	11	6	6
Legionnaires' disease	1	3	1
Malaria	3	5	0
Measles[3]	3	11	16
Meningococcal septicaemia	4	5	2
Mumps	14	16	9
Rubella[4]	4	6	1
Scarlet fever	7	26	12
Whooping cough[5]	1	39	20

SOURCE: Anglia HPT HPZone

Notes:

1. In recent years Hepatitis E has become a more frequent cause of acute viral hepatitis. It used to be associated with travel to endemic areas (especially the Indian sub-continent) but an increasing proportion of cases are now acquired in the UK. There is a growing awareness that undercooked pork products can be associated with the infection. In most cases the illness is self-limiting and the person makes a full recovery. It can be severe if it affects someone who is immunocompromised.

2. Campylobacter is the most frequent organism identified as causing food poisoning. The Food Standards Agency is encouraging the big supermarkets to look at ways of reducing the risk of infection from poultry products.

3. These reports are made on the basis of a clinical diagnosis. The Health Protection Team sends out a sampling kit to collect oral fluid to confirm the clinical diagnosis. The last case of measles confirmed by this method was reported in 2012.

4. None of these cases was confirmed by oral fluid testing.

5. In 2012 there was a big outbreak of pertussis (whooping cough) nationally affecting people of all ages. As the effects of infection are most severe in young babies a national programme offering vaccination to pregnant women was introduced which remains in place.

6.2.1 Food poisoning remains the most commonly notified infectious disease, with campylobacter accounting for the vast majority.

6.2.2 Measles activity rose in 2012-13 but showed a drop in 2013-14. The confirmed cases in 2013 were mainly in school-age children. Experts believe the rise in measles cases can be mostly attributed to the proportion of unprotected 10-16 year olds who missed out on vaccination in the late 1990s and early 2000s when concern around the now discredited opinion about a link between autism and the vaccine was widespread. A national catch-up programme to increase MMR immunisation uptake in children and teenagers was launched in April 2013.

6.2.3 Whooping cough (Pertussis) is a cyclical disease with increases occurring every 3-4 years. The third quarter (running from July to September) is usually the period of highest pertussis activity annually. In Peterborough, similar to the national picture, whooping cough cases rose sharply in 2012-13; but fell during 2013-14.

6.3 Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR)

6.3.1 **HCAI**

National mandatory reporting has remained in place for multi-resistance Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile since 2009.

There is now a zero tolerance of preventable MRSA bacteraemia with our own hospital in Peterborough not having had a case for more than two and half years.

National processes have highlighted that some cases are not attributable to either a hospital or the CCG, which had been the only options, and in April 2014 an assignment category of ‘third party’ was introduced in recognition that there are often many other providers involved in patient care within the community.

Two cases identified in Peterborough Hospital (September and October 2014) have been assigned as 'third party' following an arbitration process which is managed by the Regional Nursing Director.

The number of Clostridium difficile cases nationally continues to fall but at a slower rate, significant reductions having already been made. There are still challenges for some Trusts to achieve this; however, Peterborough have had a better year by maintaining the trajectory line. The most important factor is to review every single case through the root cause analysis process and scrutiny panel meetings which are held for each new case. There has been further change this year at a national level where cases identified to meet assessment criteria can be removed from the local trajectory. This is managed locally at CCG level by the Lead Nurse for Infection Prevention Control.

6.3.2 **Antimicrobial Resistance**

The prescribing of antibiotics continues to be monitored by the Medicines Management Team within the CCG for primary care and by hospital pharmacists for in-patient prescriptions. Prescribing is also noted and discussed at each scrutiny panel for Clostridium difficile and following completion of the root cause analysis. Any concerns identified with primary care are either discussed with the GP directly or with the medicines management team. The medicines management team have identified high prescribing levels of two particular groups of drugs over recent months which is being looked into to better understand the reasons for this change; a strategy is being prepared to address the associated issues, one of which is the increased risk of developing Clostridium difficile. It should also be noted that although these groups of drugs should be limited in general use, the condition of individual patients may specifically require their prescription. The outcome from the strategy will be known in the early part of 2015/16.

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, WHO and the government as a whole. Antibiotics are widely used in animal health and farming; are available over the counter without a prescription in many countries; and far too many people fail to complete the prescribed course or demand antibiotics for viral or self- limiting conditions here in the UK. All these factors contribute to the development of antimicrobial resistance. In addition, no new class of antibiotics has been developed by the pharmaceutical industry in recent years.

6.4 Eastern Field Epidemiology Unit (EFEU)

The EFEU, which is part of PHE, provides regular updates with electronic links to relevant data for a wide range of communicable diseases. As this data is available on line from PHE, it is not reproduced here. The monthly reports include data on:

- Sexual and reproductive health
- Tuberculosis
- Influenza and flu-like illnesses
- Legionnaires disease
- Healthcare associated infection
- Vaccine preventable diseases
- Anti-microbial resistance
- Sexually transmitted diseases
- HIV
- Hepatitis
- Ante-natal screening
- Notifiable infectious diseases
- Gastro-intestinal infections

7 Prevention

The focus of this section is the delivery of the Immunisation and Screening programmes. From April 2013, Screening and Immunisation programmes have been commissioned by NHS England as per a Public Health agreement under section 7A of the 2006 NHS Act as inserted into the Health and Social Care Act 2012.

NHS England East Anglia Area Team leads on commissioning the following programmes for the population of Peterborough:

- Immunisation programmes: neonatal and childhood, school age and adult immunisations
- Cancer Screening: Breast, Cervical and Bowel cancer programmes
- Adult and Young People Screening: Abdominal Aortic Aneurysm (AAA) and Diabetic Eye Screening (DES)
- Antenatal and Newborn Screening programmes

7.1 Immunisation Programmes

7.1.1 A number of immunisation programmes are provided in the UK to protect our population against infectious diseases that, when they were common, caused considerable morbidity and mortality. With the advent of these immunisation programmes many of these conditions are virtually unknown today in this country. However this success can lead to complacency, in turn leading to a drop in immunisation rates. The aim of our universal immunisation programmes is to provide 'herd immunity' which can be defined as the form of immunity that occurs when a sufficient proportion of a population is vaccinated to break transmission of infection and so provide protection for individuals who have not developed immunity. Some people may have weakened immune systems for a variety of reasons and do not acquire full immunity to the illness as a result of immunisation. Others, who choose not to be vaccinated, may also be protected by 'herd immunity' if sufficient people are immunised. For the majority of universal immunisation programmes, 'herd immunity' depends on 90 to 95% of the population being immunised.

7.1.2 The annual coverage data for the universal childhood immunisation programmes has recently been published (see table2). Targets for some of the childhood immunisations are included in the Public Health Outcomes Framework. For most of the childhood vaccination programmes, Peterborough is below the 95% level for herd immunity. There are a number of factors which cause this:

- Some families choose not to have their child immunised
- Some families may have difficulty accessing services for immunisation;
- Some children have been immunised but not according to the schedule in England, resulting in their immunisation not being recorded on the national system. This is a particular problem in Peterborough , where there is a high, relatively transient population related migrant workers and new immigrants whose children may have been fully immunised in their home country, but not recorded by the UK system;
- Some children have been immunised according to the schedule but the data has not been recorded or properly reported. A new electronic template is in development by CCG staff for Cambridgeshire and Peterborough GP practices to use to improve recording;
- Some of the children, reported as not attending for immunisation when invited, may no longer live in Peterborough. If they had moved within the UK, their registration with a new UK GP would lead to them being removed from the register in Peterborough , so, in most of these cases, the children are likely to have moved overseas not knowing that they should advise their GP to de-register them.

7.1.3 A multi-agency Task and Finish group has been convened to try to find solutions to these issues and addresses the inequalities in uptake of childhood immunisations in inner city practices and deprived populations. It is planned to report initial findings and recommendations to the HPC in March 2015 and to the HWB in the summer.

Table 2: Annual Childhood Vaccination Uptake for Age 12 months Peterborough, 2013/14

12 months					
	Number	DTaP/IPV/Hib % [number]	PCV % [number]		
P'boro LA	3,228	94.4 [3,048]	94.4 [3,047]		
England	686,157	94.3	94.1		

Source: Cover

Table 3: Annual Childhood Vaccination Uptake for Age 24 months for Peterborough, 2013/14

24 months					
	Number	DTaP/IPV/Hib % [number]	MMR 1 % [number]	Hib/men C % [number]	PCV B % Number]
P'boro LA	3,065	96.4 [2,955]	92.2 [2,825]	92.2 [2,826]	91.9 [2,816]
England	697,246	96.1	92.5	92.5	92.4

Source: Cover

Table 4: Annual Childhood Vaccination Uptake for Age 5 years for Peterborough, 2013/14

5 years						
	Number	DTaP/IPV/Hib % [number]	DTaP/IPB B % [number]	MMR 1 % [number]	MMR 1&2 % [number]	Hib Men C B % [number]
P'boro LA	3,201	94.1 [3,011]	84.9 [2,717]	91.4 [2,927]	83.6 [2,675]	85.9 [2,749]
England	681,925	95.6	88.8	94.1	88.3	91.9

Source: Cover

7.1.4 Targeted Vaccination programmes

Other childhood immunisation programmes include BCG (Bacillus Calmette–Guérin) vaccination and Hepatitis B vaccination as targeted programme for those identified as being at specific risk.

7.1.5 BCG vaccine, for prevention of TB (Tuberculosis) is not a very effective vaccine and the universal programme was stopped many years ago, however, because it confers some immunity, it continues to be recommended for newborn babies who:

- Are born in an area with a high incidence of TB – high incidence is defined by the World Health Organisation as 40 or more new cases per 100,000 population per year (the Peterborough rate is 28.7/100,000 for 2014)

- Have one or more parents or grandparents who were born in countries with a high incidence of TB

In Peterborough we have had a very successful programme for BCG vaccination of newborn in maternity services and via Community TB nurses to babies who fit the criteria and have moved in to the area resulting in high uptake. However we do not have clear denominator data about the number of babies born in Peterborough that meet the second criterion.

7.1.6 Hepatitis B vaccination is given at birth with 3 further boosters up to 12 months for babies born to Hepatitis B positive mothers. PHE is working with GPs to improve the provision of the final blood test, using a dried blood spot, to confirm sero-conversion after immunisation.

Table 5: Hepatitis B vaccination

	Q1	Q2	Q3	Q4
	Peterborough %			
Hep B 12 months			66.7	*NA
Hep B 24 months			100	100

*The numbers of babies requiring Hepatitis B vaccination is small; therefore the percentage uptakes are affected by 'small cohort number effect' on rates and ratios.

7.1.7 School based programmes

There are some immunisation programmes delivered in schools, for the school age population; others are provide via primary care. Human Papilloma Virus vaccine (HPV) is offered to girls and a teenage Meningitis C vaccine to all in a specific school year group. Other programmes are in the process of introduction and are discussed under the section on new immunisation programmes section, below.

7.1.8 The relatively recent programme of vaccination of girls aged 12 – 13 against Human Papilloma Virus (HPV) which is a causative factor in Cervical Cancer has been very successful.

Table 6: Annual HPV vaccination uptake all 3 doses by local authority

School year 2013-14	Peterborough	England
HPV uptake	84.7%	86.7%

Source: www.gov.uk

7.1.9 Influenza Vaccination

Influenza (Flu) vaccination is recommended for specific population groups and is given from October to January each year to protect those most vulnerable to flu infection. For the 2013/4 season the recommended groups were:

- All those aged 65 or over
- Those aged 6 months to 65 years with long term medical conditions who are in the high risk groups for flu vaccination
- Pregnant women
- Those in long stay residential or nursing homes
- Carers of elderly or disabled people
- Health and social care staff who are in direct contact with patients/clients
- All children aged two and three

7.1.10 Plans were developed by the [1]Cambridge and Peterborough Immunisation and Vaccination Committee for the 2014/5 programme and included commissioning community pharmacies to vaccinate the at risk groups in the community. This has complemented the existing services provided by GPs and maternity units. This year pharmacies will also be permitted to provide an "outreach" service in suitable locations to these groups.

7.1.11 For the City Council the most important groups are those who are in front line roles caring for vulnerable groups in the community. Immunising these staff protects them from getting flu, thus reducing the risk of them being off sick, and in turn protects both their clients and their own families. Employers of front line staff are expected to organise and fund immunisation of their front line staff. Peterborough City Council offered to provide vouchers for immunisation to front line staff in adult social care; 29 were taken up by staff. For those not directly employed, it will be helpful if commissioning contracts are explicit about an expectation that every effort will be made to ensure that care staff are offered immunisation.

[1] A multi agency forum with key stakeholders, chaired by Public Health England/NHS England

Table 7: Flu vaccination uptake (%) in Peterborough by risk groups

Risk Group	2013/14 (%)	2014/15 Validated data not yet available
Over 65yrs	72.2	
Under 65yrs at risk	50.7	
Pregnant and in another clinical risk group	64.8	
Pregnant but not in any other clinical risk group	41.9	
All pregnant	43.6	
Carers	n/a	
Age 2 not in a risk group (new programme)	30.9	
Age 2 (in a clinical risk group)	40.4	
Age 3 not in a risk group (new programme)	40.6 31.3	
Age 3 (in a clinical risk group)	53.8 46.8	

School Pilot of influenza immunisation – years 7 and 8

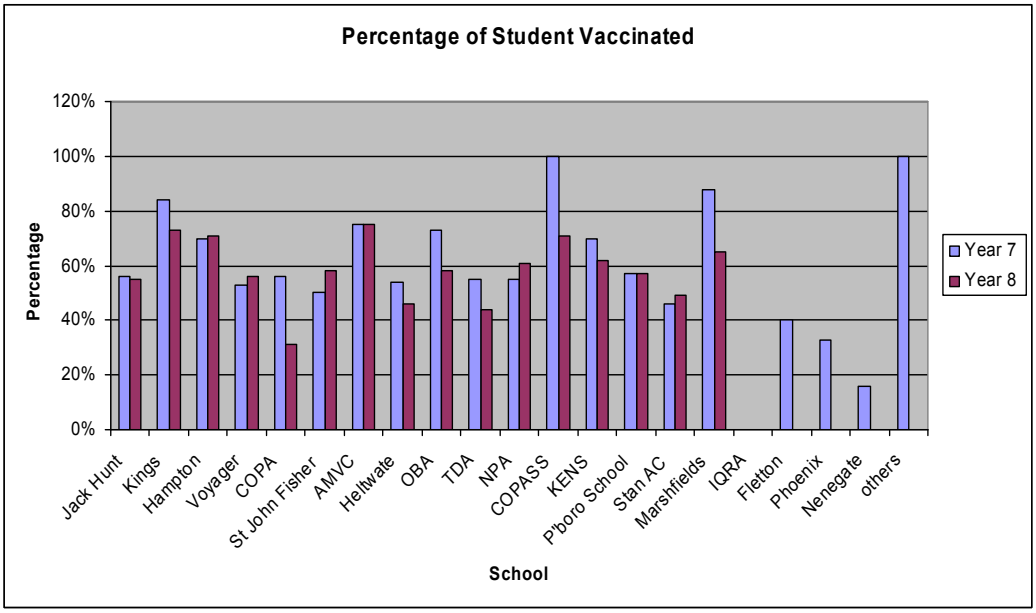

Table 8: Flu vaccination uptake (%) – Peterborough hospitals frontline staff

Uptake to Jan 2014 Health Care workers	2012/3	2013/4 %
PSHFT	71.5	75.3
CPFT	23.7	54.2
Cambridgeshire Community Services CCS)	37.0	51.5

Source www.gov.uk

7.1.12 Pertussis vaccination in pregnancy

In the first seven months of 2012, nationally, 235 babies under 12 weeks old had whooping cough and 13 babies died from it. This led to the introduction of a programme to vaccinate pregnant women between 28 and 38 weeks of pregnancy to protect them and their babies who were too young to be immunised themselves. Following the introduction of this programme, there was a 79% drop in cases to 85 in 2013.

Uptake rates are available for the East Anglia Area and not for Peterborough residents alone.

Table 9: Pertussis vaccination uptake (%) by pregnant women

	April	May	June	July	August
East Anglia Area	60.6%	60.5%	57.2%	55.8%	55.5%

8 Screening Programmes

NHS England, which is the commissioner of these services, reported that all the screening programmes are delivering as planned for the population of Peterborough.

8.1. Antenatal and newborn screening

The following data have been provided by NHS England Screening and Immunisation Team. Screening data for Quarter 4 of 2013/14 will not be available until later this year. For the Antenatal and Newborn Screening programme, some units have not returned data for some of the programmes. The provider trusts have put in place measures to improve reporting of their data.

8.1.1 Ante-natal screening includes routine testing for a number of conditions that can adversely affect the health of the baby as well as the mother including:

- HIV
- Hepatitis B
- Syphilis
- Rubella susceptibility
- Sickle Cell and Thalassemia
- Down's syndrome

8.1.2 Newborn screening includes testing for a number of conditions that are not obvious at birth but would have serious consequences for the baby if not detected and treated early, including:

- Newborn blood spot test which detects conditions such as congenital hypothyroidism; phenylketonuria; sickle cell disease; cystic fibrosis; and medium chain acetyl-CoA dehydrogenase deficiency (see http://www.newbornbloodspot.screening.nhs.uk/ for explanations of each of these conditions)
- Newborn infant physical examination
- Newborn Hearing screening

And, from January 2015, new screening tests (as part of the newborn blood spot test) for

- Maple syrup urine disease
- Homocystinuria
- Glutaric acidaemia type 1
- Isovaleric acidaemia.

Table 10: Ante-natal screening coverage

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan–April 2014
HIV screening (standard is to achieve >90%)				
Peterborough & Stamford Hospital Foundation Trust	98.2	99.1	98.6	98.6
Down's Screening (standard >97%)				
Peterborough	98.3	98.4	98.9	98.8
Sickle Cell and Thalassaemia screening (standard >95%)				
Peterborough	93.5	93.6	93.7	96.0

	Q1 April –June 2014	Q2 July –Sept 2014	n/a
HIV screening (standard is to achieve >90%)			
Peterborough & Stamford Hospital Foundation Trust	97.9	98.7	
Down's Screening (standard >97%)			
Peterborough & Stamford Hospital Foundation Trust	96.5	98.8	
Sickle Cell and Thalassaemia screening (standard >95%)			
Peterborough & Stamford Hospital Foundation Trust	96.0	95.5	

Table 11: Newborn Bloodspot test (standard 95-99%)

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan-April 2014
Peterborough & Stamford Hospital Foundation Trust	100	99.5	99.7	99.9
Newborn Bloodspot – avoidable repeat tests (standard <2%)				
Peterborough & Stamford Hospital Foundation Trust	2.4	1.0	0.9	1.9

	Q1 April-June 2014	Q2 July-Sept 2014	
Peterborough & Stamford Hospital Foundation Trust	**99.7**	**100**	
Newborn Bloodspot – avoidable repeat tests (standard <2%)			
Peterborough & Stamford Hospital Foundation Trust	1.1	0.8	

8.1.3 Newborn physical examination – Peterborough hospital achieved 99.4%coverage in Q2 2014-15 against a target of 95%.

8.2 Cancer Screening Programmes

There are three cancer screening programmes in the UK for Breast, Cervical and Bowel cancer and the data for these programmes was provided by NHS England

8.2.1 Breast Cancer screening

For breast cancer screening, measurements include uptake of screening among the targeted population; the round length (this should be 36 months for breast screening so that every woman in the age range is invited to attend for screening once every three years); and the time from screening to clinical assessment for those women whose mammogram appears to be abnormal. This ensures early diagnosis and early access to definitive treatment which improves the outcomes for those affected by breast cancer.

The breast screening data for Peterborough has been excellent. A snap shot of the recent Peterborough data can be seen below:

Table 12: Peterborough Breast Unit KPIs Oct 2014- Dec 2014

Monthly screening round length report for the Peterborough Screening Service

Time period	Total No. invited	No.≤36 months	% within 36 months	No.≤38 months	% within 38 months
Oct 14	1440	1411	98.0	1433	99.5
Nov 14	1199	1194	99.6	1196	99.7
Dec 14	927	921	99.4	925	99.8

Monthly screen to normal report for the Peterborough Screening Service

Time period	Total No.	No.≤2 weeks	% within 2 weeks	No.≤4 weeks	% within 4 weeks
Oct 14	1594	1584	99.4	1594	100.0
Nov 14	1304	1301	99.8	1304	100.0
Dec 14	925	921	99.6	925	100.0

Monthly technical recall/repeat rate for the Peterborough Screening Service

Time period	Total No. screened	Total No. examinations recalled	Total No. examinations repeated	Overall % rate
Oct 14	1666	5	35	2.40
Nov 14	1353	2	23	1.85
Dec 14	957	1	14	1.57

Source: Cambridgeshire and Peterborough Programme Board KPI submission

Monthly screen to assessment report for the Peterborough Screening Services

Time period	Total No.	No.≤3 weeks	% within 3 weeks	No.≤6 weeks	% within 6 weeks
Oct 14	53	51	96.2	53	100.0
Nov 14	65	65	100.0	65	100.0
Dec 14	37	37	100.0	37	100.0

Monthly DOFOA to assessment report for the Peterborough Screening Service

Time period	Total No.	No.≤3 weeks	% within 3 weeks	No.≤6 weeks	% within 6 weeks
Oct 14	53	53	100.0	53	100.0
Nov 14	65	65	100.0	65	100.0
Dec 14	37	37	100.0	37	100.0

Table 13: Breast screening uptake in Peterborough 2013/14

Percentage of eligible women screened adequately within the previous 3 years on the 31st March 2014

Peterborough	Value: 13,381	Percentage:74.7%	CI=74.1-75.3%

Source: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/43/ati/102/page/3/par/X25002AD/are/E06000031

Table 14: Breast screening programme measures

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan – Mar 2014
Breast Screening round length Standard 90% within 36 months	96.20%	99.20%	98.5o%	97.3%
Screen to assessment (standard 90% in <3 weeks)	92.50%	91.30%	97.80%	100%

8.2.2 Bowel cancer screening

This screening programme was introduced in 2011/2 in the UK. Bowel cancer is the third most common cancer in the UK with up to 5% developing it during their lifetime. The screening programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. The screening programme is open to all those aged 60 – 69, with testing offered at 60 and every two years after that to age 69, but due to be extended to age 74. All those screened receive an introductory letter followed by a testing kit, the faecal occult blood test (FOBT) that they can complete at home, posting the completed kit to one of a number of approved laboratories when completed. The test looks for hidden blood in the bowel that may indicate an abnormality such as polyps or cancer which can bleed, but not sufficiently to be visible to the naked eye at this early stage of the disease. For negative tests (approximately 98% of those tested) a letter confirming this is sent some weeks later. Unclear results of this test will lead to a second test kit being issued to repeat the screening. For positive tests, an invitation is issued for an examination of the bowel by colonoscopy, when the bowel is viewed to ascertain the source of the blood, If abnormalities are seen, biopsy samples can be taken for histological testing. Approximately 10% of those having colonoscopy will be found to have cancer.

Table 15: Bowel Cancer screening

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan-March 2014
Bowel Screening (standard 52% completion of FOBT kit)	54.34%	54.34%	57.33%	59.60%
Assessment by specialist screening practitioner (SSP) (standard 100% seen by SSP in 2 weeks)	100%	100%	100%	100%
SSP assessment to endoscopy time (standard 100% endoscopy within 2 weeks of seeing SSP)	90.91%	97.96%	97.17%	96.43%

Table 16: Outcome of bowel screening - Eastern Bowel Screening Hub

It is important to note that this hub covers a much larger area than Peterborough and the denominator for the population covered is not given, so an estimate of the proportion of screens with abnormality is not possible from the data provided.

CUHT Definitive Abnormal results					
Hub Name	Fiscal year	Local Area Team	Screening Centre Name	Clinical Commissioning Group	Definitive abnormal count
Eastern Bowel Cancer Screening Programme Hub	2013 - 2014	East Anglia Area Team	Cambridge Bowel Cancer Screening Centre	NHS Cambridgeshire And Peterborough CCG	230
			Kettering and Northamptonshire Bowel Cancer Screening Centre	NHS Cambridgeshire And Peterborough CCG	18
			Peterborough And Hinchingbrooke Bowel Cancer Screening Centre	NHS Cambridgeshire And Peterborough CCG	361

8.2.3 Cervical Screening

This is the oldest of the cancer screening programmes. The test is not a test for cancer, but aims to detect pre-cancerous changes that, with early treatment, should prevent progression to cancer. The test, mainly undertaken in general practice involves taking a sample of cells from the neck of the womb every 3 years for women aged 20 to 49 and every 5 years for women aged 50 to 64. Women aged 65+ are invited only if they have not been screened since age 50 or have had recent abnormal results. This programme has led to significant reductions in deaths from cervical cancer. The introduction of the HPV vaccination programme is also aimed at reducing the risk of cervical cancer by reducing human papilloma virus infection.

Women with abnormal cervical screening tests are referred for colposcopy- a specialist test to further assess and treat the abnormalities detected. As with the other screening programmes aimed at early detection, the programme is monitored on uptake, the speed of getting results to the women tested and the speed of getting women in for assessment and treatment.

Table 17: Cervical screening measures

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan – Mar 2014
50-64 yrs (standard 80% coverage)	75.80%	75.10%	75.00%	74.70%
25-49 yrs (standard 80% coverage)	69.10%	68.80%	68.60%	74.00%
Turnaround time (TAT) (standard 98% 14 day date of test to receipt of result letter)	99.9	100	99.6	99.70%
Colposcopy waiting time (standard 100% women seen within 8 weeks)	100%	100%	100%	100%

8.2.4 Task and finish group on bowel and cervical cancer screening

In response to concerns with the poor uptake of bowel cancer and cervical cancer screening programmes in the inner city areas in Peterborough, a multi-agency task and finish group was convened in November 2014. The group plans to report findings and recommendations to the Peterborough Health Protection Committee in March 2015 and to the Health and Wellbeing board in the summer.

8.3 Non-cancer Screening Programmes

There are two national screening programme for non-cancerous conditions, Retinal (eye) screening for people with diabetes, and screening for abdominal aortic aneurysm in men aged 65.

8.3.1 Diabetic eye screening

People who suffer with diabetes are at high risk of a number of serious complications and are routinely offered appointments in general practice, or, in some cases in hospital clinics, to assess their condition. One of these complications, diabetic retinopathy, is one of the commonest causes of sight loss in working age people, which may cause no symptoms until it is quite advanced, which is why screening is important. It occurs as a result of damage, caused by diabetes, to the small blood vessels at the back of the eye. Screening is effective, but requires specialist equipment to take images of the retina (back of the eye) which enables the blood vessels to be assessed. It is an annual programme. As with other screening programmes, the speed of providing results and referring for further assessment and treatment is very important.

Table 18: Diabetic eye screening measures

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013
Uptake (standard 70%)	84.90	81.0	77.97
Time to receipt of results (standard 70% within 3 weeks)	99.9	100	95.50
Time results to treatment (standard 80% within 4 weeks)	65.0	73.7	76.47

8.3.2 Abdominal Aortic Aneurysm Screening

An abdominal aortic aneurysm (AAA) is a weakening and expansion of the aorta, the main blood vessel in the body. This weakening can lead to serious consequences due to leakage from, or rupture of, the aorta and an estimated 6000 people in England and Wales die each year from ruptured abdominal aortic aneurysms. This screening is aimed at men aged 65 and over, and involves a single ultrasound scan that takes approximately 10 minutes. It has been shown that this single screening can reduce the number of deaths from ruptured AAAs among men by 50%.

With regards to data on this screening programme, no data were available for uptake of this screening programme. However NHS England reported that, in quarter 3 of 2013/4, 100% of those who required either quarterly or annual surveillance of their AAA, had been tested within 4 weeks of their screening due date

9 Emergency Planning

9.1 The City Council has always been a Category 1 responder under the terms of the Civil Contingencies Act 2004, as a result there is an emergency planning/Resilience team that is working in partnership with other organisations to lead emergency planning and response for the council. Some additional responsibility for health emergency preparedness passed with the move of Public Health into local authorities. In their role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR)
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP)as appropriate
- Identify and agree a lead DPH within the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) area to co-Chair the LHRP (for Cambridgeshire and Peterborough LRF and LHRP, the lead DPH is the Cambridgeshire DPH)
- Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

9.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for the health organisations of the LRF area and are expected to:

- Assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need
- Set an annual EPRR work plan using local and national risk assessments and planning assumptions and learning from previous incidents
- Facilitate the production and authorisation of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning
- Provide a forum to raise and address issues relating to health EPRR
- Provide strategic leadership to planning of responses to incidents likely to involve wider health economies e.g. winter capacity issues
- Ensure that health is represented on the LRF and similar EPRR planning groups
- Delegate tasks to operational representatives of member organisations in line with agreed terms of reference.

9.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the CPLRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provide a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

9.4 The interim DPH has been supported in this work (for part of the year) by an interim consultant in public health with oversight of all health protection issues, and, from September 2014 by the Health Emergency Planning and a Resilience Officer (HEPRO) based within Public Health (a shared post with Cambridgeshire). The HEPRO reports into the LHRP and the LRF through the Health and Social Care Emergency Planning Group (HSCEPG) which she co-chairs with the Head of EPRR from the NHS England Area Team. This group acts as a supporting working group for the LHRP, to which the LHRP can delegate tasks.

9.5 The HSCEPG has membership from local acute hospitals, East of England ambulance service (EEAmb), community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England. Having completed a recent assurance of EPRR in all health organisations, this group is now focused on Pandemic Influenza and ensuring that all health sector organisations have robust plans in place. The group is also working on revising the Mass Casualty Plan for the area which will be presented to both the LHRP and LRF shortly. The group has organized two 'strategic leadership in crisis' workshops for directors in the health system and also completed Exercise Pooley – a joint Norfolk/ Suffolk/Cambridgeshire exercise for assurance of preparedness specific to Ebola.

10 Communicable disease incidents and outbreaks

One of the main functions of the PHE Health Protection Team (HPT) is responding to cases, enquiries, incidents and outbreaks, providing evidence-based and expert health protection advice and support. To facilitate timely response, the acute service is delivered by a single clinical response team, staffed by a medical consultant, two nurses and an administrator during office hours. For any case, enquiry or incident, the duty team undertakes a risk assessment, decides on appropriate management and follow-up, and provides specialist advice and further support where needed. The Environmental Health Department is often an essential partner in this role.

All queries are entered onto a national database called HPZone. A total of 248 incidents/outbreaks were logged for Norfolk, Suffolk and Cambridgeshire between 1 April 2013 and 31 March 2014 with 13 of these relating to Peterborough. The majority comprised gastroenteritis outbreaks in care homes due to suspected or confirmed norovirus.

10.1 E. coli O157 linked to a local petting farm

Between 20th and 28th March 2014, Anglia Health Protection Team (HPT) was notified of four presumptive cases of Ecoli O157 from two different families. All gave a history of visiting the same petting farm. There were no other links between the two families.

An Outbreak Control Team meeting (OCT) was called to co-ordinate multi-disciplinary action to investigate the farm as a potential source of this cluster of cases and to enable suitable control measures to be put in place to prevent further cases.

Members of the Environmental Health Team visited the farm at the start of the incident and implemented a number of control measures including restriction of contact with some animals. They also recommended that more hand wash stations be provided, that staff provide closer supervision of visitors, and that there should be better signage encouraging visitors to wash their hands. All these recommendations were fully implemented by the farm.

The OCT considered whether contact with all animals should be restricted, but it was felt that this was not necessary due to the small number of cases and the full co-operation of the farm to implement the increased control measures. Regular visits by members of the Environmental Health Team allowed the OCT to have confidence that the farm could safely remain open. Infection with E. coli O157 can be fatal, and members of the OCT were very aware of the need for a proportionate response to the potential risk.

A veterinary inspection was also carried out by an officer from the Animal Health and Veterinary Laboratories Agency (AHVLA). The aim of this investigation was to assist the OCT in identifying putative animal sources of human infection and to advise on control measures within the veterinary remit. E.coli O157 was not recovered from any of the animal faecal samples collected.

Although there was no microbiological evidence linking the human cases to the animals on the farm there was microbiological evidence strongly suggesting that the four human cases were infected by the same source. The only epidemiological link between the four cases was that they had all visited the petting farm, suggesting that this was the most likely source. There was also an increased number of Cryptosporidium cases reported to the HPT around this time, some of whom had also visited the farm during their incubation period.

The farm co-operated fully with all recommended control measures and there were no further cases of E.coli O157 or Cryptosporidium with links to the farm notified to the HPT after the control measures were implemented.

10.2 TB screening at a packing factory and a produce factory

TB is an infectious disease which develops very slowly. It is easy to treat and difficult to catch. You need a lot of close contact over a long time with an infectious TB case to catch it. Most often the TB germs are killed in the body and do not cause any problems. In a small number of people the germs are not killed and the person can either develop active TB disease or have latent (hidden) TB infection (LTBI). With LTBI, the TB germs can survive in the body in an inactive state for many months or years. These people are not ill and are not infectious to others. A TB skin test or blood test is required to diagnose the infection.

About one in ten people with LTBI will develop active TB at some point. Having active TB means that they develop symptoms of TB and may be infectious. Screening of contacts of TB cases is designed to identify people with LTBI, which may have been acquired through contact with TB at any point in their lives, as well as to identify whether any contacts have active TB infection. Individuals identified with LTBI are assessed and offered treatment with antibiotics to reduce the risk that they might develop active TB in the future. Any individuals identified with active TB are treated with antibiotics and their close contacts are screened.

Screening for TB at the packing factory was carried out in April 2014 after 17 people working at packing factories in Fenland were diagnosed with active TB over a two year period. Many people working on the site are from countries with high rates of tuberculosis infection, and the long and highly variable incubation period for TB means that many of those diagnosed had acquired their infection in their home country. However there was clear evidence of infection being transmitted in the work place, so a screening programme was implemented. The screening process was designed to identify factory staff who required further tests because they might be at risk of developing the infection. The screening was led by Public Health England, working closely with the respiratory medicine teams at Peterborough and Addenbrooke's hospitals, who routinely manage local cases of TB and follow up of contacts, and with the public health teams in Cambridgeshire County Council and Peterborough City Council.

A second group of mainly household contacts has been identified and treated for latent TB following a case from a high prevalence country. Public Health England staff are liaising with colleagues in an adjacent area to undertake a risk assessment of the case's workplace and, following a risk assessment, screening of workplace contacts has been carried out.

10. 3 Ebola

The Ebola situation in West Africa is improving. There are fewer new cases being diagnosed and fewer deaths than at the height of the outbreak. Local health care provision is being strengthened and funeral practices made safer, so if the disease should reappear the circumstances that allowed it to become so widespread this time have been controlled. There are workers travelling between the UK and West Africa to support the international control efforts whose work could put them at risk of infection. When they return home they are followed by PHE for 21 days during which they record their temperature twice each day to make sure that any signs of infection are picked up and acted on promptly. Between the start of October 2014 and February 2015 the national Imported Fever Service tested 179 people as a precautionary measure (approximately one person every day). Only one person has tested positive in that time and there has been no transmission of infection in the UK. Health care workers are not allowed to do clinical work for the 21 day surveillance period, and all returning workers are encouraged to avoid situations where they would be unable to remove themselves if they felt unwell, but no other restrictions are placed on them. This surveillance is supported by screening and infection control information provided for all travellers arriving at UK ports from affected areas. NHS and City Council services in Peterborough have plans in place to deal with a returned traveller who needs to be assessed, and there is a joint outbreak control plan that has been in existence for many years that would be used to co-ordinate the response if a case should be diagnosed locally.

The Cambridgeshire and Peterborough Local Health Resilience Partnership (LHRP) took part in a table top exercise, developed by Public Health England (PHE), to test planning and preparedness should there be an imported case of Ebola**.** About 20 representatives from organisations in Peterborough took part on 27th October, including representatives from PCC Public Health and Resilience teams together with hospital and Clinical Commissioning Group staff. Learning was shared with colleagues from Norfolk and Suffolk LHRPs, NHS England and PHE who also attended the exercise.

On Wednesday 29th October, a briefing session was held for members of the West African community in Peterborough to listen to their concerns and provide information on the risks and management of Ebola in England. The meeting was attended by Cllrs Diane Lamb (Cabinet member for health) and Nigel North (Cabinet member for environment and communities) who welcomed the attendees. Facilitated by the Community Cohesion Manager, the meeting covered the public health aspects of screening at ports, surveillance, and risk of infection as well as discussing the opportunities for local support for those anxious or bereaved from Cambridge and Peterborough Foundation Trust and the voluntary sector (Cruise and MIND).

11 Sexual Health

11.1 Peterborough is ranked 80 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new sexually transmitted infections (STIs). This equates to 1578 new STI diagnosis, a rate of 846.7 per 100,000 residents (compared to 810.9 per 100,000 in England). This is somewhat expected given the level of deprivation in the system and its link to STI rates.

Areas to be prioritised for improvement include:

- **Rates of HIV late diagnosis**
  Between 2011 and 2013, 62% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% in England.

- **Rates of teenage pregnancy**
  Rates remain above regional and national averages, despite reducing in recent years. In 2012, the under 18 conception rate per 1,000 females aged 15 to 17 years in Peterborough was 36.0, while in England the rate was 27.7.

- **Chlamydia diagnoses**
  In 2013, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Peterborough was 2488.6 (compared to 2015.6 per 100,000 in England). This exceeds the positivity rate target of 2,300 set by the PHOF which is considered positive (as we are reaching and treating a high proportion of young people with the infection). However local data shows a reduction in the number of screens in the past year. This suggests our positivity rate could be even higher if screening activity increased further still.

11.2 In July 2014, following a retender exercise a new integrated contraceptive and sexual health service was launched. The service integrated hospital based GUM services into community based contraceptive services to provide 'a one stop shop' for all contraceptive and sexual health needs. The aim of integration was to improve accessibility and patient experience with a view to normalising STI testing and treatment as part of managing one's sexual and reproductive health.

11.3 Going forward, there is a recognised need to implement a strategic approach to improving sexual and reproductive health in the city involving all partners within the local sexual health economy. The iCASH service will be developing a sexual health network for the city as part of its contract during early 2015. There are discussions about how this can link into strategic governance provided by public health and the Health and Wellbeing Board.

12 Environmental health issues

12.1 Proactive interventions carried out by The Food and Health and Safety Team:

Carbon Monoxide in commercial food premises
In 2012 the team received a call from a letting agent who was almost overcome by fumes after visiting an empty flat above a local food takeaway. He reported that he had to stop his car on the way back to the office when he nearly passed out. Investigation into the incident revealed very high levels of carbon monoxide in the flat originating from the takeaway below. A charcoal grill was being used indoors and the extraction system was poorly maintained. The premises was closed and legal notices were served.

The team then found this situation in other food premises so we began developing a toolkit to tackle the issue which was finalised in 2014. The toolkit contains all the resources that a local authority would need in order to investigate and resolve high levels of carbon monoxide in a business. It explains how to measure levels using a data logger and how to interpret results. It details types of equipment and potential control measures and provides an assessment questionnaire, example notices and letters and example press release and member's briefings.

The toolkit has been rolled out to the Local Authorities in the county group via a training session and is due to be rolled out to other authorities in the near future. To date the team have worked with 16 businesses in the city.

Food Information Regulations 2014
The Food Information Regulations came into force in December 2014. All business will need to ensure allergen information is provided with food which is for sale. This includes pre-packed and non-pre-packed foods such as those sold loose and food from restaurants and takeaways. There are 14 allergenic ingredients which must be declared.

A mailshot was sent out to all Peterborough businesses to tell them about the new law with information on how to comply. We also invited all businesses to attend a free training session.

The food Safety team in conjunction with Trading Standards provided five training seminars to 140 people from 113 food businesses. Officers have also been talking to businesses about the new rules during routine food hygiene inspections in recent months.

13 Looking Forward

13.1 <u>New Vaccination Programmes</u>

A number of changes have been made to the vaccination programmes over the past year, some of which have already started. These changes are made as a result of the advice from the Joint Committee on Vaccination and Immunisation (JCVI). JCVI is an expert committee that reviews the evidence of effectiveness of vaccines and makes recommendation to Government.

13.1.1 Meningitis C (MenC) – evidence has shown that in those born after 1995, who were vaccinated in early childhood, there is declining immunity, making them more susceptible to infection. A MenC booster is being introduced for teenagers aged 13-14 years. For the same reason MenC is now being offered to freshers who enter university until 2018. Men C is currently being offered to children in year 10 (14-15 years). It is important to note the second dose for infants at 4 months was removed last year.

13.1.2 Meningitis B (MenB) – it is planned that this vaccination will be introduced into the national immunisation schedule subject to vaccine being procured at a cost-effective price.

13.1.3 Seasonal flu vaccine – In 2014-15 the new childhood programme is being extended to 4 year olds (2 and 3 year olds introduced in 2013/4). Also in several pilot programmes around the country, including one in Peterborough, vaccination has been offered to 11-13 year olds (school years 7 & 8.

13.1.4 HPV vaccination – a change in the schedule has started from September 2014. The number of doses is reduced from three to two;

1st dose given in Year 8 (12-13 years)

2nd dose can be given 12 months after the first.

13.1.5 Shingles vaccine – a new programme to protect elderly people who are at greatest risk Shingles and its adverse consequences:

2013/14 – Shingles vaccine (Zostavax) was routinely offered to those aged 70 with catch-up to those 79 years on 1st September 2013 until 31st August 2014

2014/15 – Zostavax is routinely offered to those aged 70 and catch-up to 78 and 79 years on 1st September 2014 until 31st August 2015.

Table 19: initial Shingles vaccination uptake reported by NHS England

	Feb 2104		March 2014		April 2014	
	Aged 70	Aged 79	Aged 70	Aged 79	Aged 70	Aged 79
CCG % uptake	56.2	54.0	59.8	57.0	61.8	58.5
CCG % coverage	99.1		99.1		97.2	

13.1.6 Rotavirus vaccine – rotavirus is a highly infectious gastrointestinal infection that manly affects infants and leads to a high number of hospital admissions each year due to complication such as dehydration. The vaccination was introduced in 2013 with two doses at 2 months and 3 months as part of the routine programme. The table below gives data provided by NHS England for the early stages of this programme.

Table 20: initial Rotavirus vaccination uptake reported by NHS England

	Jan 2014		Feb 2014		March 2014	
	Dose 1	Dose 2	Dose 1	Dose 2	Dose 1	Dose 2
CCG % uptake	32.7	25.7	93.6	90.3	93.5	90.6
CCG % coverage	87.9		88.8		73.8	

	April 2014		May 2014		June 2014	
	Dose 1	Dose 2				
CCG % uptake	94.7	90.9				
CCG % coverage	83.2		Not available		Not available	

13.2 Collaborative Tuberculosis strategy

In January 2015, PHE published a Collaborative Tuberculosis (TB) Strategy for England 2015 – 2019. This strategy recognises that TB rates have increased in England in recent years and also takes on board evidence from other countries that a systematic approach to tackling TB is effective in reducing the incidence. The Strategy focuses on ten evidence based areas for action:

- Improving access to services and early diagnosis
- High-quality diagnostics
- High-quality treatment and care services
- Contact tracing
- Vaccination
- Tackling drug resistance
- Tackling TB in underserved populations
- New entrant screening for LTBI
- Effective surveillance and monitoring
- Workforce strategy

In addition to the above, it recommends the establishment of Local TB Control Boards to develop a local TB control plan and to monitor and support its implementation. These boards will have a designated clinical lead and cover a wide geographical patch to enable sharing between high and low incidence areas.

The Health Protection Committee is to consider the implications for Peterborough now that the recommendations have been published.

Dr Anne McConville, FFPH

Interim Consultant in Public Health

February 2015

GLOSSARY

AAA	Abdominal Aortic Aneurysm
AHVLA	Animal Health and Veterinary Laboratories Agency
AT	Area Team (part of NHS England)
BCG	Bacillus Camille Guerin (vaccine fro TB)
CCC	Cambridgeshire County Council
CCA	Civil Contingencies Act 2004
CCDC	Consultant in Communicable Disease Control
CCG(s)	Clinical Commissioning Group(s)
CCS	Cambridgeshire Community Services
CPLHRP	Cambridgeshire and Peterborough Local Health Resilience Partnership
CPLRF	Cambridgeshire and Peterborough Local Resilience Forum
CUHPT	Cambridge University Hospital Foundation Trust
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
EH	Environmental Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HHT	Hinchingbrooke Hospital Trust
HPN	Health Protection Nurse
HPSG	Health Protection Steering Group
HPT	Health Protection Team (part of Public Health England)
HPV	Human Papilloma Virus
HSE	Health and Safety Executive
HWB	Health and Well-being Board
IMT	Incident Management Team
JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority

LGA	Local Government Association
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MMR	Measles, Mumps and Rubella (vaccine)
MOU	Memorandum of Understanding
NHS	National Health Service
NHSE	NHS England
OIMT	Outbreak Incident Management Team
OOH	Out of Hours
NHS	National Health Service
NHSE	NHS England
PCT	Primary Care Trust
PHE	Public Health England
Q 1,2,3,4	Reporting quarters for each year
TB	Tuberculosis

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(b)
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

PETERBOROUGH 2015 PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

R E C O MM E N D A T I O N	
FROM : PNA Steering Group	**Deadline date:** 01/04/2015 *(National deadline for publication of PNA reports by Health & Wellbeing Boards in England)*
For the Board to approve and authorise the publication of the Peterborough 2015 PNA report (**Appendix A**)	

1. ORIGIN OF REPORT

1.1 At the Peterborough Corporate Management meeting of 20/08/2013 it was agreed that a fully revised version of the 2011 PNA must be produced by 1st April 2015 as per statutory requirement. The PNA process commenced in July 2014 and a progress report was submitted for the HWB in November 2014. This report is the final draft following completion of the PNA process and approval by the Steering Group and Director of Public Health.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

- Inform the Health & Wellbeing Board (HWB) about the completion of the PNA process, its key findings and recommendations.
- Request the HWB to approve and authorise the publication of the Peterborough 2015 PNA report.

3. MAIN BODY OF REPORT

3.1 Background

Every HWB in England has a statutory duty to publish and keep up to date a statement of the need for pharmaceutical services in its area otherwise referred to as a Pharmaceutical Needs Assessment (PNA).

PNAs are key reference documents as regards the development and improvement of local pharmaceutical services. According to the NHS Pharmaceutical Service Regulations 2013, NHS England Area Teams must consider local PNAs while dealing with applications from new pharmaceutical service providers i.e. in deciding whether a new pharmacy should be allowed in a particular locality or not, otherwise referred to as market entry.

PNAs are also used by the NHS and Local Authority commissioners in making decisions on which NHS funded services (e.g. medicine use review service) and locally commissioned services (e.g. stop smoking and sexual health services) need to be provided by local community pharmacies.

3.2 PNA Process

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

The process was overseen by a Steering Group consisting of key professionals drawn from the Public Health department at Peterborough City Council, NHS England East Anglia Area Team, Local Pharmaceutical Committee (LPC), Healthwatch, East Anglia Pharmacy Local Professional Network and Cambridgeshire & Peterborough Clinical Commissioning Group (CCG).

The key activities in the production of the draft involved reviewing and analysing Peterborough's demographic details, health needs, current pharmaceutical service provision and consulting the public and other stakeholders through surveys.

A public consultation of the PNA document was undertaken between December 2014 and February 2015 where views from the public and other stakeholders were sought and utilised in drafting this current document to be published by 1st April 2015 after approval by the HWB.

3.3 Key Findings & Recommendations

3.3.1 Population

The latest Office for National Statistics (ONS) population estimates indicate that there are 188,373 people currently resident in Peterborough. The largest age groups are of persons aged 25-29 (8.1%) and children aged 0-4 years (8%). Overall Peterborough's population profile shows a higher proportion of younger people as compared to the national average. However ward profiles vary. Orton with Hampton has the largest proportion of young people aged 0-17 (29.8%) whereas Werrington South has the largest proportion of older people (30.5%).

Recommendation

The variation in age profiles across the Peterborough wards implies that health needs for local populations may also vary. In localities with large proportions of children and young people, some of the needs which pharmaceutical service providers could be supported to provide include: promotion of childhood immunisations, breastfeeding, healthy lifestyle such as physical activity and healthy eating, provision of substance misuse, stop smoking and sexual health services. In localities with large proportions of older people priority needs may include prevention of long term conditions by providing advice on healthy lifestyle, NHS health checks and screening and support for self-care for those living with long-term conditions.

3.3.2 Life Expectancy

Peterborough has a significantly lower male life expectancy at birth (77.9) than the national average (78.9). Seven out of the 24 wards in Peterborough have significantly lower male life expectancies at birth than the national average. Orton Longueville, Park and West wards have lower female life expectancies at birth than the national average.

The disparity in life expectancy between the best and worst wards in Peterborough is substantial. Males born in Ravensthorpe (the ward with the lowest life expectancy for males – 74.2 years) are expected to live 8.9 years less than those born in Stanground East (the ward with the highest life expectancy for males – 83.1 years). Among females, those born in Park (the ward with the lowest life expectancy for females – 78.8 years) are expected to live 8.8 years less than those born in Werrington South (the ward with the highest life

expectancy for females – 87.6 years). The wards with low life expectancy at birth are also the most deprived.

Peterborough has a significantly lower healthy life expectancy for both males (59.9 years) and females (59.8 years) as compared to the national average (63.4 and 64.1 years respectively). These figures are also the lowest in the region. This indicates that a large proportion of Peterborough's population develops long term health problems at a relatively early age, often resulting in a high demand for health care and pharmaceutical supplies.

Recommendation

Community pharmacies should be involved in efforts to address the evident health inequality by identifying and addressing factors contributing to low life expectancy especially in deprived areas which may include harmful lifestyle habits such as substance misuse, smoking, unhealthy eating habits and poor access to health care facilities. Community pharmacies should also be supported to implement regular health promotion campaigns and to provide minor ailment treatment services for individuals who are unable to access primary and secondary care facilities for various reasons.

3.3.3 Deprivation

Peterborough has a higher percentage of people living in the 20% most deprived areas in England as compared to the national average. It also has a higher percentage of children and older people living in deprivation.

Evidence shows that populations in deprived localities often experience poor health outcomes including lower life expectancy, higher burden of ill health, low uptake of health protection services such as screening and vaccinations and often seek medical attention late.

The analysis by ward in Peterborough has revealed a similar pattern where the most deprived wards such as Central, Dogsthorpe, Orton Longueville, North and Ravensthorpe are associated with relatively poor health outcomes.

Recommendation

Community pharmacies located in deprived wards and other localities that this assessment has highlighted as having poor health outcomes should be involved in identifying priority health needs for the local populations and in the implementation of health promotion campaigns aimed at encouraging healthy lifestyle, uptake of NHS health checks and screening. They should also be supported to provide services such as NHS Health Checks, vaccinations and minor ailments treatment services.

3.3.4 Ethnicity

Peterborough is predominantly white but has a relatively higher proportion of black and minority ethnic groups as compared to other authorities in the region. It also has a higher proportion of non-British white population mainly made up of immigrants from Eastern Europe. Evidence suggests that people from black and minority ethnic groups (BME) suffer from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority of the white population. Some minority ethnic groups are more predisposed to certain long term conditions e.g. diabetes (Asians).

Recommendation

There is need to further explore the needs of BME groups in relation to pharmaceutical service provision in order to design and implement effective public health and pharmaceutical interventions.

3.3.5 Tuberculosis

Peterborough's Tuberculosis (TB) incidence rate (28.9/100,000) is more than three times the regional average (8.3/100,000) and nearly two times the national average (15.1/100,000). In order to control the spread of TB in Peterborough, the recommended approach includes early detection and diagnosis and treatment completion.

Recommendation

Community pharmacies could play a major role in TB control by monitoring medication consumption and ensuring completion of treatment regimes. There is currently no service for observed treatment for tuberculosis from community pharmacies in Peterborough. Most community pharmacies have a supervised consumption service which could be adapted for tuberculosis medication.

3.3.6 Smoking

More than one in five adults smoke in Peterborough. This rate (20.8%) is significantly higher than the regional (17.5%) and national (18.4%) averages.

Smoking prevalence among Peterborough mothers at time of delivery (18%) is higher than the regional (12.4%) and national (12.7%) averages. It is also the highest in the region.

There are currently 19 pharmacies offering stop smoking service across Peterborough. There were, however, 29 pharmacies offering this service in 2011 and the number of 'smoking quits' attributable to interventions from pharmacies has fallen from 53% of the total in 2010/2011 to 19% in 2013/14.

Recommendation

Current service providers should be audited and supported to improve outcomes. Increasing the number of stop smoking services within existing pharmacies across Peterborough may also be considered if appropriate within the context of local healthcare strategy.

3.3.7 Sexual Health

Peterborough's under 18 conception rate (36/1,000) is higher than the regional (23.2/1,000) and national (27.7/1,000) averages.

Peterborough's chlamydia detection rate among males is below the national set target (at least 2,300 cases) and is lower than the regional and national averages.

Recommendation

None of the community pharmacies in Peterborough has been commissioned to provide emergency hormonal contraception or chlamydia screening despite the poor observed outcomes. Peterborough City Council should consider potentially commissioning local community pharmacies to provide the above specified services if appropriate within the context of local healthcare strategy.

3.3.8 Hospital Admissions

Peterborough has higher than expected emergency admissions for all causes, Coronary Heart Disease (CHD) and alcohol related harm. Some wards also have high emergency admissions for Stroke and Chronic Obstructive Pulmonary Disease (COPD).

Recommendation

Pharmacies should be involved in health promotion campaigns that create awareness on how to avoid the specified long term conditions and also in provision of support for patient self-care strategies which involve reviewing patient medications and educating them about how to cope with symptoms and when to seek help.

3.3.9 Health care utilization

The uptake rates of cervical cancer screening, diabetic retinopathy screening, NHS health checks and flu vaccinations in Peterborough are significantly below the regional and national averages.

None of the pharmacies in Peterborough are currently commissioned to provide NHS checks and flu vaccination for over 65s. Only 13 are providing flu vaccination for at risk groups.

Recommendation

There is a potential for pharmacies to be more involved in promotion of NHS health checks and screening and to be considered for the provision of flu vaccination for over 65s. Consideration should be given to conducting an audit of current providers of flu vaccination for at risk groups and if necessary, more pharmacies should be encouraged to provide the service.

3.3.10 Mortality

Peterborough had more deaths than expected from all causes, circulatory disease, CHD and respiratory disease during the period 2008-2012. For the under 75 population (premature deaths), more than expected deaths were reported for all causes, circulatory disease and CHD.

Recommendations

Pharmacies should be involved in health promotion campaigns that encourage healthy living style, NHS health checks and screening. Enhancement of stop smoking services as well as treatment of minor ailments by pharmacies may also contribute towards reduction of mortality associated with respiratory conditions. For patients living with long-term conditions, pharmacies should be involved in providing self-care support and medicine use reviews.

A minor ailments scheme 'Pharmacy First' targeting children is currently implemented by all pharmacies in Peterborough. Considering the high emergency hospital admissions and respiratory disease mortality rates in various Peterborough wards it may be worth expanding the programme to include adults in affected localities.

3.3.11 Pharmaceutical Service Providers

There are currently 43 community pharmacies including two distance selling pharmacies in Peterborough. There are also three dispensing practices, and two dispensing appliance contractors. The ratio of pharmacies and dispensing practices against the local population in Peterborough (24 per 100,000 population) is above both the national (22 per 100,000) and regional (20 per 100,000) averages

3.3.12 Conclusion

There is currently sufficient essential and advanced pharmaceutical service provision in Peterborough. However, the community pharmacies' potential to impact on local population health through locally commissioned services has not been fully exploited.

Overall, pharmacies are valued community assets and are strategically placed to effectively intervene in identified health needs. They should be considered as key players in the development of strategies aimed at addressing highlighted health needs/inequalities.

4. CONSULTATION

4.1 A stakeholder consultation of the PNA document was undertaken between December 2014 and February 2015. A detailed report including the consultation process, feedback and response by the steering group appears in section 11 of the draft PNA report.

4.2 Seventeen respondents either filled the provided questionnaires or sent back emails with comments. These included seven members of the public, four pharmacies, Lincolnshire Health and Wellbeing Board, Peterborough Health and Wellbeing Programme Board, Local Pharmaceutical Committee, Local Medical Committee, Peterborough Public Health Commissioner and Head of Health Strategy.

4.3 NHS England East Anglia Area Team, Healthwatch and P&C CCG were represented on the steering group and as such their views were utilised throughout the PNA process. The draft PNA was also presented at the Peterborough Joint Commissioning Forum in January 2015 where it was well received.

4.4 Overall most of the respondents understood the purpose of PNA, confirmed that the PNA draft was good reflection of the current pharmaceutical services and needs in Peterborough. They also thought it was adequate in informing future service provision.

5. ANTICIPATED OUTCOMES

5.1 An approved 2015 PNA report to be published by 1st April 2015

6. REASONS FOR RECOMMENDATIONS

6.1 According to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 it is a statutory requirement that every HWB in England publishes a PNA report by 1st April 2015.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 None.

8. IMPLICATIONS

8.1 The PNA report is a key document that will be utilised in decisions around pharmaceutical service provider market entry as well as commissioning of new services within the existing providers.

9. BACKGROUND DOCUMENTS

9.1 The report has been submitted together with the full draft 2015 PNA report.

PETERBOROUGH CITY COUNCIL

APPENDIX A

Peterborough Pharmaceutical Needs Assessment

April 2015

Document Control

Version	Date	Revision Made	Author(s)	Comments
Draft 1	24/10/2014	First Draft	Anthony Wakhisi	For steering group to review
Draft 2	07/11/2014	Addressed comments from steering group and completed all sections	Anthony Wakhisi	For steering group and DPH to review
Draft 3	20/11/2014	Addressed comments from steering group	Anthony Wakhisi	For steering group and DPH to review
Draft 4	01/12/2014	Addressed comments from DPH & steering group	Anthony Wakhisi	For DPH approval & consultation
Draft 5	08/12/2014	Addressed comments from DPH	Anthony Wakhisi	For DPH approval & consultation
Draft 6	13/02/2015	Addressed comments from stakeholders who participated in the Dec 2014-Feb 2015 consultation	Anthony Wakhisi	For steering group and DPH to review
Draft 7	06/03/2015	Addressed comments from steering group meeting on 24/02/2015	Anthony Wakhisi	For DPH and HWB approval
Draft 7	09/03/2015	Addressed comments from DPH	Anthony Wakhisi	For DPH and HWB approval
Draft 7 Final	12/03/2015	Final approved draft by the steering group and DPH	Anthony Wakhisi	For HWB approval

The electronic version of this document is available at:

www.peterborough.gov.uk/pharmacyneeds

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The Peterborough Health and Wellbeing Board would like to acknowledge the contribution of staff across Peterborough City Council, Cambridgeshire & Peterborough CCG, NHS England East Anglia Area Team, Community Pharmacies, GP Practices, other stakeholders and members of the public towards the development of the 2015 Pharmaceutical Needs Assessment (PNA).

Acronyms

Acronym	Description
A&E	Accident and Emergency
AUR	Appliance Use Review
APHO	Association of Public Health Observatories
BBC	British Broadcasting Corporation
CCG	Clinical Commissioning Group
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
DAAT	Drug and Alcohol Action Team
DAC	Dispensing Appliance Contractors
EPS	Electronic Prescription Service
GP	General Practitioner
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LCG	Local Commissioning Group
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Service
MIIU	Minor Illness and Injuries Unit
MMR	Measles Mumps and Rubella
MUR	Medicines Use Review
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
ONS	Office for National Statistics
PCT	Primary Care Trust
PDF	Portable Document Format
PNA	Pharmaceutical Needs Assessment
PSHFT	Peterborough & Stamford Hospitals NHS Foundation Trust
QOF	Quality Outcomes Framework
SAC	Stoma Appliance Customisation Service
SMR	Standardised Mortality Ratio
SAR	Standardised Admission Ratio
TB	Tuberculosis
TIA	Transient Ischaemic Attack

Document Structure

The document has 11 sections including the executive summary and introduction. Section 3 describes the Peterborough Health and Wellbeing Board's Health and Wellbeing Strategy and how it relates to the Pharmaceutical Needs Assessment.

Section 4 describes Peterborough's population profile and section 5 focuses on health inequalities relevant to pharmaceutical service provision mainly utilising resources from the national public health profiles.

Section 6 describes in detail the current pharmacy service provision in Peterborough and includes National Health Service (NHS), non-NHS and Locally Commissioned Services.

Sections 7 and 8 present results from surveys that involved the public and community pharmacies.

Section 9 presents a synthesis of identified health needs and service provision and makes suggestions on potential interventions for pharmaceutical service providers.

Section 10 provides an assessment on whether there is sufficient choice for the Peterborough population with regard to obtaining pharmaceutical services. The section also discusses key findings and draws conclusions and recommendations on service improvement.

Section 11 includes findings from the PNA consultation process carried out as from 10th December 2014 to 9th February 2015 and response from the steering group.

1 Executive Summary

1.1 Background

Every Health and Wellbeing Board (HWB) in England has a statutory duty to publish and keep up to date a statement of the need for pharmaceutical services in its area otherwise referred to as a Pharmaceutical Needs Assessment (PNA).

PNAs are key reference documents as regards the development and improvement of local pharmaceutical services. According to the NHS Pharmaceutical Service Regulations 2013, NHS England Area Teams must consider local PNAs while dealing with applications from new and existing pharmaceutical service providers i.e. in deciding whether a new pharmacy should be allowed in a particular locality or not, otherwise referred to as market entry.

PNAs are also used by the NHS and Local Authority commissioners in making decisions on which NHS funded services (e.g. out of hours service) and locally commissioned services (e.g. stop smoking and sexual health services) need to be provided by local community pharmacies.

1.2 Pharmaceutical Services

For the purpose of pharmaceutical needs assessments the four main categories of pharmaceutical services can be summarised as:

Essential Services

These are services that every community pharmacy[1] providing NHS pharmaceutical services must provide and are set out in their terms of service. These include: the dispensing of medicines and appliances, disposal of unwanted medicines, repeat prescriptions, signposting, clinical governance, promotion of healthy lifestyles and support for self-care.

Advanced Services

These are services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary. These include: Medicines Use Reviews, New Medicines Service, Appliance Use Reviews and Stoma Customisation Service.

Enhanced Services

These are services commissioned directly by NHS England. These could include anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out-of-hours services.

[1] A community pharmacy is a healthcare facility that is able to provide pharmaceutical services to people in a local area or community. It dispenses medicine and involves a registered pharmacist with the education, skills, and competence to deliver professional services to the community. It is also commonly referred to as a Chemist.

Locally Commissioned Services

These are services community pharmacy contractors could potentially be commissioned to provide by local authorities which include: Supervised Medicine Consumption, Needle Exchange Programme, NHS Health Check, Contraception, Stop Smoking and Chlamydia Testing and Treatment.

1.3 PNA Process

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

The process was overseen by a Steering Group consisting of key professionals drawn from the Public Health department at Peterborough City Council, NHS England East Anglia Area Team, Local Pharmaceutical Committee (LPC), Healthwatch, East Anglia Pharmacy Local Professional Network and Peterborough & Cambridgeshire Clinical Commissioning Group (CCG).

The key activities in the production of the draft involved reviewing and analysing Peterborough's demographic details, health needs, current pharmaceutical service provision and consulting the public and other stakeholders through surveys.

A public consultation of the PNA document was undertaken between December 2014 and February 2015 where views from the public and other stakeholders were sought and utilised in drafting this current document to be published by 1st April 2015 after approval by the HWB.

1.4 Key Findings & Recommendations

1.4.1 Population

The latest Office for National Statistics (ONS) population estimates indicate that there are 188,373 people currently resident in Peterborough. The largest age groups are of persons aged 25-29 (8.1%) and children aged 0-4 years (8%). Overall Peterborough's population profile shows a higher proportion of younger people as compared to the national average. However ward profiles vary. Orton with Hampton has the largest proportion of young people aged 0-17 (29.8%) whereas Werrington South has the largest proportion of older people (30.5%).

Recommendation

The variation in age profiles across the Peterborough wards implies that health needs for local populations may also vary. In localities with large proportions of children and young people, some of the needs which pharmaceutical service providers could be supported to provide include: promotion of childhood immunisations, breastfeeding, healthy lifestyle such as physical activity and healthy eating, provision of substance misuse, stop smoking and sexual health services. In localities with large proportions of older people priority needs may include prevention of long term conditions by providing advice on healthy lifestyle, NHS health checks and screening and support for self-care for those living with long-term conditions.

1.4.2 Population Projections

Peterborough's general population is predicted to reach 217,600 by 2021 (a 17.4% increment); the largest increment will be among children and older people aged 85 and above.

Recommendations

Young children are often associated with a higher demand on health care facilities. Peterborough's fertility rate is significantly higher than the national average which indicates that the population of new-borns and young children will remain high in Peterborough in coming years. All community pharmacies in Peterborough are currently commissioned to provide a minor ailment treatment scheme for children which should be sustained alongside other relevant health promotion activities specified above.

The increase of older people in the population will inevitably lead to an increase in chronic conditions such as diabetes, circulatory and respiratory disease. Community pharmacies have the potential to make a significant contribution in chronic disease prevention, identification and management through the implementation of programmes such the NHS health checks and screening, support for self-care and medicine use reviews.

1.4.3 Life Expectancy

Peterborough has a significantly lower male life expectancy at birth (77.9) than the national average (78.9). Seven out of the 24 wards in Peterborough have significantly lower male life expectancies at birth than the national average. Orton Longueville, Park and West wards have lower female life expectancies at birth than the national average.

The disparity in life expectancy between the best and worst wards in Peterborough is substantial. Males born in Ravensthorpe (the ward with the lowest life expectancy for males – 74.2 years) are expected to live 8.9 years less than those born in Stanground East (the ward with the highest life expectancy for males – 83.1 years). Among females, those born in Park (the ward with the lowest life expectancy for females – 78.8 years) are expected to live 8.8 years less than those born in Werrington South (the ward with the highest life expectancy for females – 87.6 years). The wards with low life expectancy at birth are also the most deprived.

Peterborough has a significantly lower healthy life expectancy for both males (59.9 years) and females (59.8 years) as compared to the national average (63.4 and 64.1 years respectively). These figures are also the lowest in the region. This indicates that a large proportion of Peterborough's population develops long term health problems at a relatively early age, often resulting in a high demand for health care and pharmaceutical supplies.

Recommendation

Community pharmacies should be involved in efforts to address the evident health inequality by identifying and addressing factors contributing to low life expectancy especially in deprived areas which may include harmful lifestyle habits such as substance misuse, smoking, unhealthy eating habits and poor access to health care facilities. Community pharmacies should also be supported to implement regular health promotion campaigns and to provide minor ailment treatment services for individuals who are unable to access primary and secondary care facilities for various reasons.

1.4.4 Deprivation

Peterborough has a higher percentage of people living in the 20% most deprived areas in England as compared to the national average. It also has a higher percentage of children and older people living in deprivation.

Evidence shows that populations in deprived localities often experience poor health outcomes including lower life expectancy, higher burden of ill health, low uptake of health protection services such as screening and vaccinations and often seek medical attention late.

The analysis by ward in Peterborough has revealed a similar pattern where the most deprived wards such as Central, Dogsthorpe, Orton Longueville, North and Ravensthorpe are associated with relatively poor health outcomes.

Recommendation

Community pharmacies located in deprived wards and other localities that this assessment has highlighted as having poor health outcomes should be involved in identifying priority health needs for the local populations and in the implementation of health promotion campaigns aimed at encouraging healthy lifestyle, uptake of NHS health checks and screening. They should also be supported to provide services such as NHS Health Checks, vaccinations and minor ailments treatment services.

1.4.5 Ethnicity

Peterborough is predominantly white but has a relatively higher proportion of black and minority ethnic groups as compared to other authorities in the region. It also has a higher proportion of non-British white population mainly made up of immigrants from Eastern Europe. Evidence suggests that people from black and minority ethnic groups (BME) suffer from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority of the white population. Some minority ethnic groups are more predisposed to certain long term conditions e.g. diabetes (Asians).

Recommendation

There is need to further explore the needs of BME groups in relation to pharmaceutical service provision in order to design and implement effective public health and pharmaceutical interventions.

1.4.6 Tuberculosis

Peterborough's Tuberculosis (TB) incidence rate (28.9/100,000) is more than three times the regional average (8.3/100,000) and nearly two times the national average (15.1/100,000). In order to control the spread of TB in Peterborough, the recommended approach includes early detection and diagnosis and treatment completion.

Recommendation

Community pharmacies could play a major role in TB control by monitoring medication consumption and ensuring completion of treatment regimes. There is currently no service for observed treatment for tuberculosis from community pharmacies in Peterborough. Most community pharmacies have a supervised consumption service which could be adapted for tuberculosis medication.

1.4.7 Smoking

More than one in five adults smoke in Peterborough. This rate (20.8%) is significantly higher than the regional (17.5%) and national (18.4%) averages.

Smoking prevalence among Peterborough mothers at time of delivery (18%) is higher than the regional (12.4%) and national (12.7%) averages. It is also the highest in the region.

There are currently 19 pharmacies offering stop smoking service across Peterborough. There were, however, 29 pharmacies offering this service in 2011 and the number of 'smoking quits' attributable to interventions from pharmacies has fallen from 53% of the total in 2010/2011 to 19% in 2013/14.

Recommendation

Current service providers should be audited and supported to improve outcomes. Increasing the number of stop smoking services within existing pharmacies across Peterborough may also be considered if appropriate within the context of local healthcare strategy.

1.4.8 Sexual Health

Peterborough's under 18 conception rate (36/1,000) is higher than the regional (23.2/1,000) and national (27.7/1,000) averages.

Peterborough's chlamydia detection rate among males is below the national set target (at least 2,300 cases) and is lower than the regional and national averages.

Recommendation

None of the community pharmacies in Peterborough has been commissioned to provide emergency hormonal contraception or chlamydia screening despite the poor observed outcomes. Peterborough City Council should consider potentially commissioning local community pharmacies to provide the above specified services if appropriate within the context of local healthcare strategy.

1.4.9 Hospital Admissions

Peterborough has higher than expected emergency admissions for all causes, Coronary Heart Disease (CHD) and alcohol related harm. Some wards also have high emergency admissions for Stroke and Chronic Obstructive Pulmonary Disease (COPD).

Recommendation

Pharmacies should be involved in health promotion campaigns that create awareness on how to avoid the specified long term conditions and also in provision of support for patient self-care strategies which involve reviewing patient medications and educating them about how to cope with symptoms and when to seek help.

1.4.10 Health care utilization

The uptake rates of cervical cancer screening, diabetic retinopathy screening, NHS health checks and flu vaccinations in Peterborough are significantly below the regional and national averages.

None of the pharmacies in Peterborough are currently commissioned to provide NHS checks and flu vaccination for over 65s. Only 13 are providing flu vaccination for at risk groups.

Recommendation

There is a potential for pharmacies to be more involved in promotion of NHS health checks and screening and to be considered for the provision of flu vaccination for over 65s. Consideration should be given to conducting an audit of current providers of flu vaccination for at risk groups and if necessary, more pharmacies should be encouraged to provide the service.

1.4.11 Mortality

Peterborough had more deaths than expected from all causes, circulatory disease, CHD and respiratory disease during the period 2008-2012. For the under 75 population (premature deaths), more than expected deaths were reported for all causes, circulatory disease and CHD.

Recommendations

Pharmacies should be involved in health promotion campaigns that encourage healthy living style, NHS health checks and screening. Enhancement of stop smoking services as well as treatment of minor ailments by pharmacies may also contribute towards reduction of mortality associated with respiratory conditions. For patients living with long-term conditions, pharmacies should be involved in providing self-care support and medicine use reviews.

A minor ailments scheme ‘Pharmacy First’ targeting children is currently implemented by all pharmacies in Peterborough. Considering the high emergency hospital admissions and respiratory disease mortality rates in various Peterborough wards it may be worth expanding the programme to include adults in affected localities.

1.4.12 Pharmaceutical Service Providers

There are currently 43 community pharmacies including two distance selling pharmacies in Peterborough. There are also three dispensing practices, and two dispensing appliance contractors. The ratio of pharmacies and dispensing practices against the local population in Peterborough (24 per 100,000 population) is above both the national (22 per 100,000) and regional (20 per 100,000) averages.

1.5 Conclusion

There is currently sufficient essential and advanced pharmaceutical service provision in Peterborough. However, locally commissioned services such as stop smoking appear inadequate as evidenced by deteriorating quit rates and an overall significantly higher smoking rate among adults and pregnant women as compared to the regional and national averages.

No community pharmacy in Peterborough is currently commissioned to provide flu vaccination for over 65s and only 13 provide flu vaccination service for at risk groups. Also none have been commissioned to provide sexual health services such as emergency hormonal contraception and chlamydia testing and treatment despite higher teenage pregnancy and low chlamydia detection rates among men as compared to the regional and national averages.

NHS England should consider commissioning existing pharmacies to provide flu vaccination for over 65s and encourage more pharmacies to provide flu vaccination for the at risk groups. Public health commissioners should support current providers of stop smoking services to improve outcomes and consider commissioning more existing pharmacies to enhance coverage. They should also consider commissioning existing pharmacies to provide sexual health services in order to address the high level of teenage pregnancy and low chlamydia detection rates among men if appropriate within the context of local healthcare strategy.

Overall, pharmacies are valued community assets and are strategically placed to effectively intervene in identified health needs and should be considered core in all strategies aimed at addressing highlighted health inequalities.

2 Introduction

2.1 Context for the PNA

The Health and Social Care Act 2012[2] which established Health and Wellbeing Boards (HWBs) in England also placed a statutory responsibility on all HWBs to publish and keep up to date statements of need for pharmaceutical service in their areas. These statements are referred to as Pharmaceutical Needs Assessments (PNAs). This responsibility was previously held by Primary Care Trusts (PCTs) which were abolished as from April 2013.

HWBs have the responsibility to check the suitability of existing PNAs compiled by PCTs and may publish supplementary statements explaining any changes if necessary. However each HWB needs to publish its own revised PNA for its area by 1st April 2015. This will require HWB sign-off after a two months period of public consultation (Part 2 NHS regulation, 2013)[3].

The Health and Social Care Act 2012 also amended the Local Government and Public Involvement Act 2007[4] to introduce duties and power to HWBs as regards Joint Strategic Needs Assessments (JSNAs). JSNAs are used by local authorities, NHS and other partners in designing interventions aimed at improving the general local population health and reducing inequalities. The PNA process therefore has taken account of the Peterborough JSNA and other local strategies.

PNAs are key reference documents as regards the development and improvement of local pharmaceutical services. According to the *NHS Pharmaceutical Service Regulations 2013,* NHS England Area Teams must consider local PNAs while dealing with applications from new and existing pharmaceutical service providers i.e. in deciding whether a new pharmacy should be allowed in a particular locality or not, otherwise referred to as market entry.

PNAs will also be used by the NHS and Local Authority commissioners in making decisions on which NHS funded services (e.g. out of hours service) and locally commissioned services (e.g. Stop Smoking and Sexual Health services) need to be provided by local community pharmacies.

PNAs being central in decisions about commissioning services and new pharmacy openings, it is essential that they comply with the requirements of the regulations, that due process is followed in their development and that they are kept up to date.

[2] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted Date accessed: October 2014
[3] http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf Date accessed: October 2014
[4] http://www.legislation.gov.uk/ukpga/2007/28/contents Date accessed: October 2014

2.2 Definition of Pharmaceutical Services

Section 126 of the 2006 Act[5] [6] places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to individual patients. This section also makes provision for the types of healthcare professionals who are authorised to order drugs, medicines and listed appliances on an NHS prescription. These include:

- Pharmacists (healthcare professionals working for themselves (contractors) or as employees who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use); and
- dispensing appliance contractors (appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc.). They cannot supply medicines.

In addition, there are two other types of pharmaceutical contractors: dispensing doctors, who are medical practitioners authorised to provide drugs and appliances in designated rural areas known as "controlled localities"[7] and Local Pharmaceutical Services (LPS) contractors who provide a level of pharmaceutical services in some HWB areas.

A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

2.3 Commissioning of Pharmaceutical Services

NHS England Area Teams

NHS England area teams commission all services in the NHS Community Pharmacy Contractual Framework i.e. Essential, Advanced and Enhanced services. Other commissioners cannot commission these services from community pharmacies. Enhanced services are those pharmaceutical services that are listed in the Pharmaceutical Services (Advanced and Enhanced Services) Directions, 2013.[8] Other commissioners may choose to commission some of these Enhanced Services

[5] The Health Act 2006: http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf Date accessed: October 2014

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197634/Pharmaceutical_Needs_Assessment_Information_Pack.pdf Date accessed: October 2014

[7] A controlled locality is an area which has been determined, either by NHS England, a primary care trust a predecessor organisation or on appeal by the NHS Litigation Authority (whose appeal unit handles appeals for pharmaceutical market entry and performance sanctions matters), to be "rural in character".

[8] https://www.gov.uk/government/publications/pharmaceutical-services-advanced-and-enhanced-services-england-directions-2013 Date accessed: October 2014

from community pharmacies, but they would be classed as Locally Commissioned Services and not Enhanced Services.

Local Authorities

Local Authorities have the responsibility for commissioning a wide range of services, including most public health services and social care services. The following public health services provided by community pharmacies could be commissioned by local authorities:

- Supervised Consumption
- Needle and Syringe Programme
- NHS Health Check
- Emergency Hormonal Contraception and General Contraceptive Services
- Sexual Health Screening Services
- Stop Smoking
- Chlamydia Testing and Treatment
- Weight Management
- Alcohol Screening and Brief Interventions

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) can commission services such as minor ailments service, palliative care schemes, emergency prescription service and other medicines optimisation services[9].

2.4 Pharmaceutical Services & PNAs

For the purpose of pharmaceutical needs assessments the three main categories of pharmaceutical services can be summarised as below:

Essential Services

These are services that every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service. These are:

- Dispensing of medicines
- Dispensing of appliances
- Disposal of unwanted medicines
- Promotion of healthy lifestyles
- Repeat prescriptions
- Signposting
- Support for self-care
- Clinical governance

[9] The safe and effective use of medicines to enable the best possible outcomes

Advanced services

These are services community pharmacy contractors and dispensing appliance contractors can choose to provide subject to accreditation as necessary. These are:

- Medicines Use Reviews
- New Medicines Service
- Appliance Use Reviews
- Stoma Appliance Customisation Service

Enhanced services

These are services that can be commissioned directly by NHS England. These include:

- Anti-coagulation Monitoring.
- The provision of advice and support to residents and staff in care homes in connection with drugs and appliances.
- On demand availability of specialist drugs
- Out-of-hours Services

Locally commissioned services

These are services community pharmacy contractors can be commissioned by local authorities to provide which include:

- Supervised Consumption
- Needle and Syringe Programme
- NHS Health Check
- EHC and Contraceptive Services
- Sexual Health Screening Services
- Stop Smoking
- Chlamydia Testing and Treatment
- Weight Management
- Alcohol Screening and Brief Interventions

2.5 Process followed in developing the PNA

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

Objectives

- Compile a list of pharmacies and services currently provided such as dispensing, providing advice on health, medicines reviews, stop smoking service and support for substance misusers.
- List other services such as dispensing by GP surgeries and services available in neighbouring HWB areas that might affect the need for services in Peterborough.

- Examine the demographics of the local population and their public health needs in relation to current and future pharmaceutical service provision.
- Identify gaps in pharmaceutical services that could be met by providing more pharmacy services or through opening more pharmacies.
- Produce maps relating to Peterborough pharmaceutical service e.g. location of pharmacies and accessibility.
- Consult and engage with stakeholders, patients and the public throughout the process so that their opinions inform the PNA document.
- To facilitate a two month public consultation period after completion of assessment and before HWB board sign off and publication.

Process

This PNA builds on and updates the work undertaken as part of the 2011 PNA by Peterborough Primary Care Trust. Other key reference documents used in the development of the Peterborough PNA 2015 include: the Pharmaceutical Needs Assessment Information Pack for Local Authority Health and Wellbeing Boards[10], Pharmaceutical Needs Assessment: Right Service in the Right Place[11], Pharmaceutical Needs Assessment: A Guide for Local Authorities[12], Pharmaceutical Needs Assessment Tool Kit, Part 1 & 2[13] and Developing Pharmaceutical Needs Assessments: A Practical Guide.[14]

To oversee the process, a PNA Steering Group was formed consisting of key professionals mainly drawn from the Public Health department at Peterborough City Council, NHS England East Anglia Area Team, Local Pharmaceutical Committee (LPC), Healthwatch, East Anglia Pharmacy Local Professional Network and Peterborough & Cambridgeshire Clinical Commissioning Group (CCG).

Key Steps

The assessment involved the following key steps:

1. Review and analysis of the Peterborough Health and Wellbeing Strategy 2012-15, JSNA and other relevant local plans in relation to pharmaceutical service provision.
2. Collation and summary of routine pharmacy contracting and activity data with national and local benchmarking.
3. Patient experience: online survey, questionnaires via various outlets including community pharmacies and GP practices.
4. Community Pharmacies & Dispensing Practices: email questionnaires.
5. Survey data analysis

[10] https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack Date accessed: October 2014

[11] http://www.pcc-cic.org.uk/article/pharmaceutical-needs-assessments-right-service-right-place Date accessed: October 2014

[12] http://www.rpharms.com/promoting-pharmacy-pdfs/nhs-reforms---pnas-for-local-authorities---jan-2013.pdf Date accessed: October 2014

[13] http://www.natpact.info/uploads/2004_Nov/NatPacTToolkit%20Part%201%20Final.pdf Date accessed: October 2014

[14] http://www.npc.nhs.uk/rapidreview/?p=410 Date accessed: October 2014

6. Synthesis of identified health needs and priorities mapped against service provision otherwise described as gap analysis.
7. Professional and public consultation between December 2014 and February 2015.

3 The Health and Wellbeing Board Strategy

The current Peterborough Health and Wellbeing Board (HWB) strategy (2012-15)[15] which is guided by the JSNA, highlights the following five priority areas as key to the improvement of the health of the local population and in reducing health inequalities:

- Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.
- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.
- Enable good child and adult mental health through effective, accessible health promotion and early intervention services.
- Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs.

The HWB strategy highlights the need for collaborative commissioning and working by NHS, local authority and other agencies that impact on the health and wellbeing of the local population (including pharmaceutical service providers) in addressing the above priorities in order to realise a more coherent and effective response and to accomplish set outcomes.

Regulation 9 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations[16] requires that HWBs when carrying out assessments for the purpose of publishing PNAs have regard to:

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- The number of people in its area who require pharmaceutical services;
- the demography of its area; and
- the risks to the health or well-being of people in its area.

Pharmaceutical service providers have the potential to play a greater role in identifying and helping address priority health needs as they are strategically placed in the community and have daily interactions with the local population. Evidence from the Healthy Living Pharmacy Initiative[17] implemented nationally since 2010 shows

[15] http://www.peterborough.gov.uk/health_and_social_care/health_and_wellbeing_strategy.aspx Date accessed: October 2014

[16] http://www.legislation.gov.uk/uksi/2013/349/contents/made Date accessed: October 2014

[17] http://www.npa.co.uk/Documents/HLP/HLP_overview_12.11.pdf Date accessed: October 2014

that community pharmacies can make a significant impact in the improvement of health and wellbeing of local populations.

In consideration of the three areas highlighted above, Section 3 further examines Peterborough's population characteristics and major causes of ill health as a prerequisite to understanding local health needs and how pharmaceutical service providers can be involved in various interventions.

4 Demography

4.1 Localities

Electoral wards have been a fundamental small administrative area for decades but are not often considered in pharmaceutical service delivery due to their varied population sizes and characteristics. However the Office for National Statistics (ONS)[18] and Public Health England[19] now produce data at ward level which are increasingly being used for health needs assessments, health planning and assessing health inequalities. Furthermore wards have names, well defined geographical boundaries and established governance structures. Wards are easily recognisable by local populations and leaders unlike super output areas[20] which are only identifiable by codes.

Most of the data relating to the health status of the Peterborough population quoted in this PNA relates to wards. There are 24 wards in Peterborough. Table 2 gives the names and population sizes of each and also all maps presented in various sections have ward boundaries and names. The Peterborough HWB believes provision of pharmaceutical services should be proportionate to the local population needs. As can be inferred from section 6 of this document, residents of Peterborough have adequate access to pharmaceutical services. For this reason, this PNA will consider Peterborough local authority as one locality but take into consideration the varying needs identified at ward level that may require different levels of services to reflect community needs.

4.2 Population

4.2.1 Peterborough's Population Structure

The latest ONS population estimates (Mid- year 2013) indicate that there are 188,373 people resident in Peterborough (Table 1). The largest age groups are of persons aged 25-29 and children aged 0-4.

The largest proportions are of persons aged 0-4 (8%), 25-29 (8.1%) and 30-34 (7.9%) while the smallest are of persons aged 70 and above.

[18] http://www.neighbourhood.statistics.gov.uk/dissemination/ Date accessed: October 2014
[19] http://www.localhealth.org.uk/#v=map4;l=en Date accessed: October 2014
[20] Super Output Areas (SOAs) are national geographies created by the Office for National Statistics (ONS) for collecting, aggregating and reporting statistics. http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/census/super-output-areas--soas-/index.html Date accessed March 2015

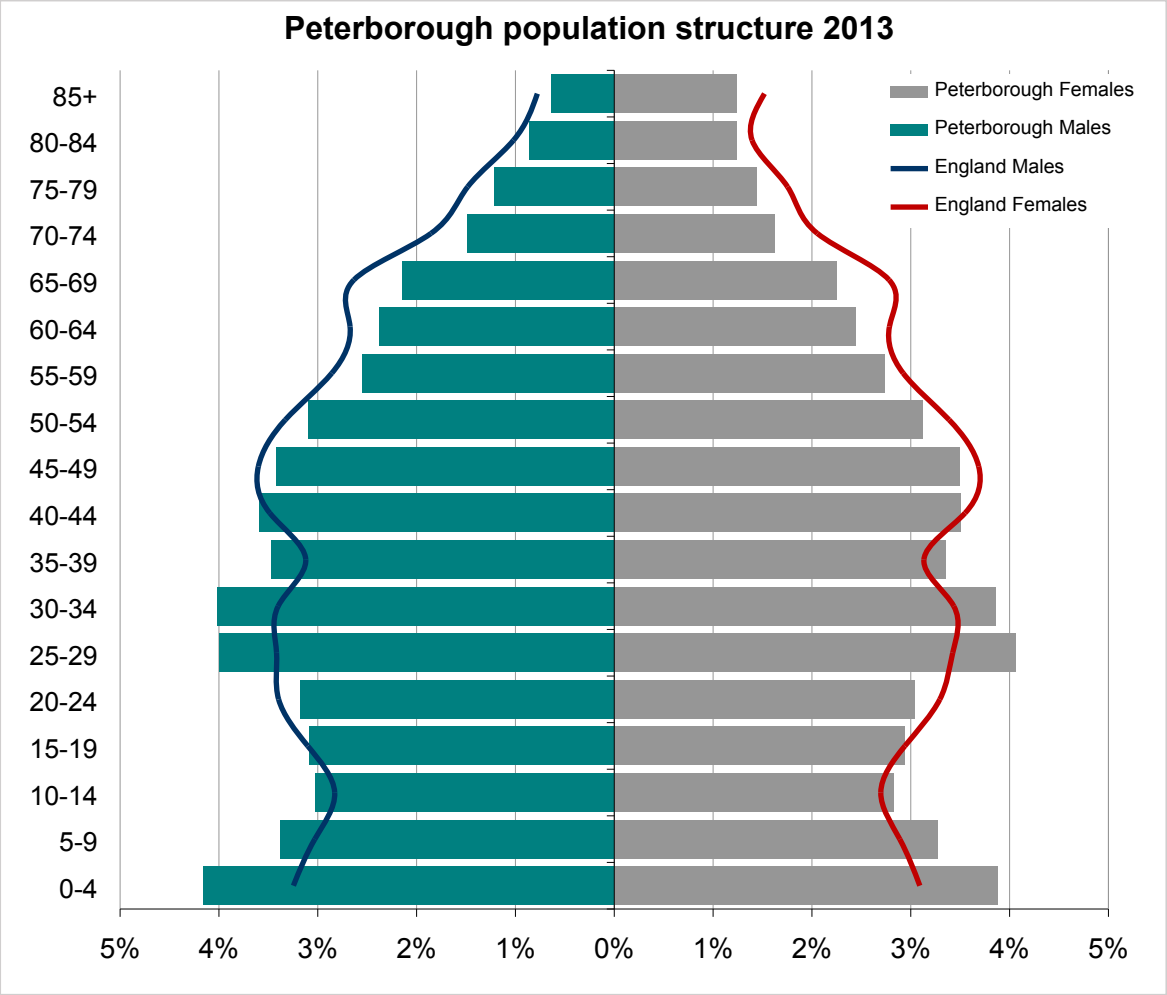
Table 1: Peterborough's population estimates and proportions by sex and five year age bands, 2013

Age Band (Years)	Male		Females		Total	
	Number	%	Number	%	Number	%
0-4	7837	8.4	7318	7.7	15155	8.0
5-9	6365	6.8	6162	6.5	12527	6.7
10-14	5696	6.1	5330	5.6	11026	5.9
15-19	5811	6.2	5534	5.8	11345	6.0
20-24	5992	6.4	5722	6.0	11714	6.2
25-29	7521	8.0	7646	8.1	15167	8.1
30-34	7559	8.1	7276	7.7	14835	7.9
35-39	6540	7.0	6311	6.7	12851	6.8
40-44	6768	7.2	6597	7.0	13365	7.1
45-49	6442	6.9	6576	6.9	13018	6.9
50-54	5831	6.2	5876	6.2	11707	6.2
55-59	4795	5.1	5152	5.4	9947	5.3
60-64	4473	4.8	4599	4.9	9072	4.8
65-69	4048	4.3	4232	4.5	8280	4.4
70-74	2803	3.0	3061	3.2	5864	3.1
75-79	2291	2.4	2714	2.9	5005	2.7
80-84	1614	1.7	2344	2.5	3958	2.1
85+	1200	1.3	2337	2.5	3537	1.9
Total	**93586**	**100**	**94787**	**100**	**188373**	**100**

Source: ONS Mid-Year Population Estimates, 2013

Figure 1 shows Peterborough's population structure compared to the England average. Peterborough has a higher proportion of children aged 0-9 years and young adults aged 25-34 years but has a lower proportion of older people aged (55 and above).

Figure 1: Peterborough's population pyramid (% based on total population)



Source: ONS Mid-Year Population Estimates, 2013

4.2.2 Ward Population

Table 2 shows Peterborough's population by ward and age bands. Orton with Hampton has the largest proportion of young people aged 0-17 whereas Fletton and Woodston has the largest proportion of the working group (18-64) (68.1%). Werrington South has the largest proportion of older people (30.5%).

Table 2: Peterborough's ward level population, 2012

Ward name	Age 0-17	%	Age 18-64	%	Age 65+	%	Total
Barnack	642	21.9	1606	54.7	688	23.4	2936
Bretton North	2406	25.5	5827	61.9	1185	12.6	9418
Bretton South	737	24.1	1877	61.5	438	14.4	3052
Central	3491	28.3	7855	63.8	972	7.9	12318
Dogsthorpe	2511	25.8	5852	60.0	1388	14.2	9751
East	2942	25.7	7123	62.3	1371	12.0	11436
Eye and Thorney	1365	21.9	3718	59.8	1139	18.3	6222
Fletton and Woodston	2648	22.7	7935	68.1	1077	9.2	11660
Glinton and Wittering	1679	22.9	4686	63.9	967	13.2	7332
Newborough	596	20.7	1797	62.5	480	16.7	2873
North	1548	24.8	3719	59.6	971	15.6	6238
Northborough	509	18.9	1522	56.4	666	24.7	2697
Orton Longueville	2610	25.9	6229	61.7	1253	12.4	10092
Orton Waterville	1607	19.5	5093	61.8	1542	18.7	8242
Orton with Hampton	4237	29.8	9037	63.5	951	6.7	14225
Park	2849	26.7	6612	61.9	1227	11.5	10688
Paston	2248	26.1	5396	62.8	955	11.1	8599
Ravensthorpe	2204	27.1	5125	63.0	809	9.9	8138
Stanground Central	1763	19.3	5689	62.2	1698	18.6	9150
Stanground East	697	22.9	1820	59.7	533	17.5	3050
Walton	1201	21.4	3514	62.5	909	16.2	5624
Werrington North	1720	22.4	5050	65.8	900	11.7	7670
Werrington South	973	15.3	3452	54.2	1944	30.5	6369
West	1811	21.1	4866	56.6	1915	22.3	8592
Total	**44994**	**24.1**	**115400**	**61.9**	**25978**	**13.9**	**186372**

Source: ONS Mid-year population estimates, 2012

Implications for Pharmaceutical Service

The variation in age profiles across the Peterborough wards implies that health needs for local populations also vary. In localities with large proportions of children and young people, some of the needs which pharmaceutical service providers have the potential to intervene include: promotion of childhood immunisations, breastfeeding, healthy lifestyle such as physical activity and healthy eating, provision of substance misuse, smoking and sexual health services. In localities with large proportions of older people priority needs could include prevention of long term conditions by providing advice on healthy lifestyle, NHS health screening and checks and support for self-care for those living with long-term conditions.

4.2.3 Peterborough Population Projections

At the latest census (2011) Peterborough's resident population was183,631. This has increased to approximately 188,373 according to the latest ONS population estimates (2013). Population forecasts by the Cambridgeshire Research Group show that Peterborough's population will reach approximately 219,600 by 2021, a 17.4% increase from an estimated 2012 population of 187,100 (Table 3).

Table 3: Peterborough population projections, 2001-2031

Age Group	2001	2011	2012	2016	2021	% Change 2012-21	2026	2031	% Change 2012-31
0-4	10300	13900	14500	16200	17700	22	18200	17500	20.7
5-10	13200	13700	14000	15800	18600	33	20300	20600	47.1
11-15	10800	11500	11400	11100	12900	13	14900	16000	40.4
16-19	7900	9000	9300	9200	9000	-3	10400	11700	25.8
20-24	9700	12500	12700	12700	13300	5	12300	13200	3.9
25-34	24800	29200	30000	33100	36300	21	36200	33000	10.0
35-44	23200	26200	26300	27500	31700	21	35700	36700	39.5
45-54	20300	23700	24300	25900	26300	8	27400	30400	25.1
55-64	14950	19000	18800	19800	22500	20	24500	24100	28.2
65-74	12100	12700	13400	15100	16700	25	17600	19800	47.8
75-84	7700	8800	9000	9100	10000	11	12300	13500	50.0
85+	2400	3300	3400	3800	4500	32	5100	6100	79.4
Total*	157300	183600	187100	199200	219600	17	234800	242600	29.7

Source: Cambridgeshire Research Group
* Totals May not add up due to rounding of figures

Between 2012 and 2021 the largest population increase will be among persons aged 25-34 years (6,300). However, proportion wise the largest growth will be among children aged 5-10 years (32.9%) and older people aged 85+ (32.4%) (Table 3).

Implications for Pharmaceutical Service

The large increase in children and older people populations will have significant implications on pharmaceutical service provision as the two age groups tend to be the highest users of the service. Pharmaceutical service providers will be expected to participate more in public health interventions aimed at disease prevention in order to lessen the burden on pharmaceutical, primary and secondary care services.

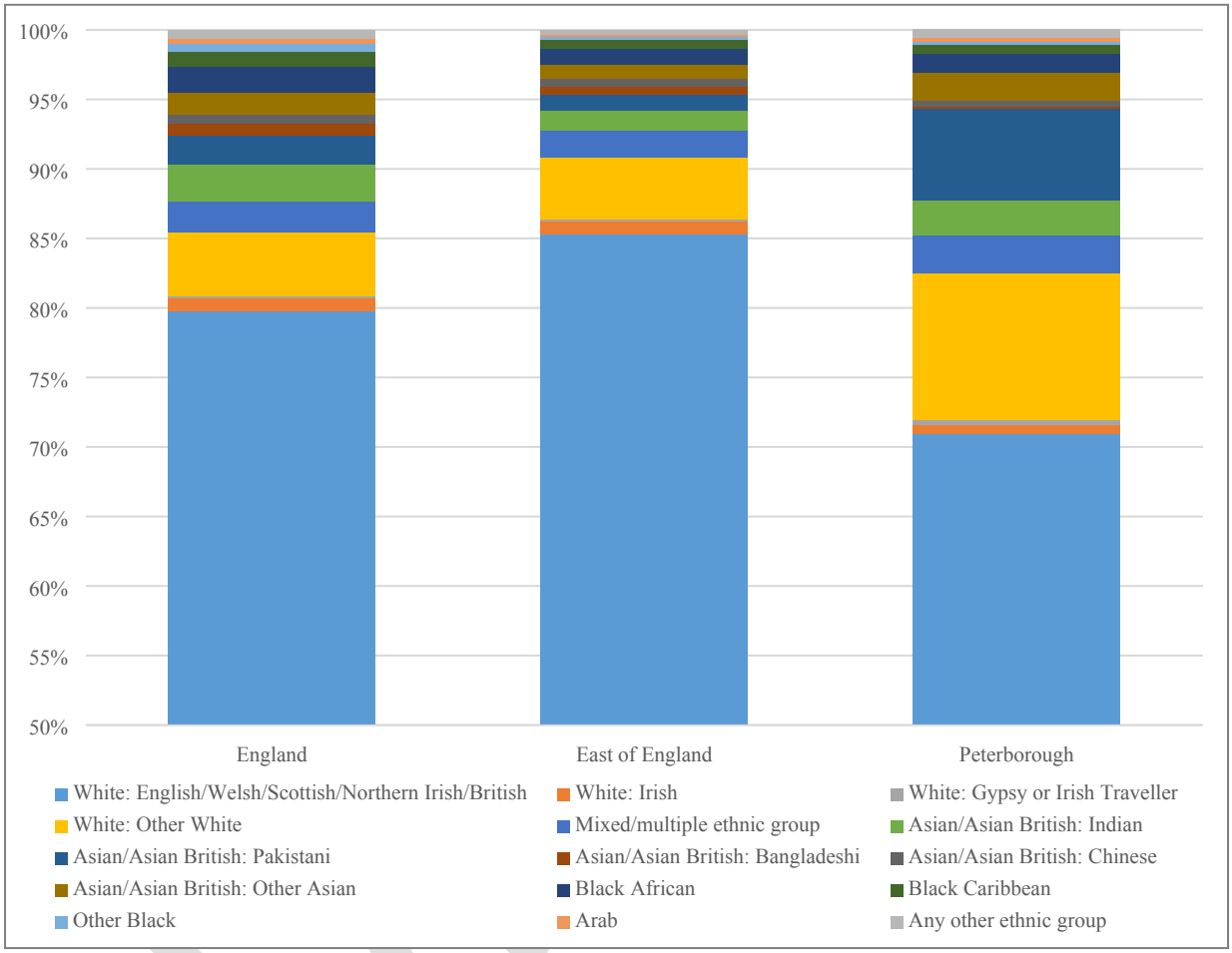
4.2.4 Ethnicity

The Peterborough population structure is changing with new ethnic groups coming to the city and initially tending to settle in the most deprived areas. This presents new and continuously shifting challenges when designing local services sensitive to the needs of the population. In the recent past people from Eastern Europe have been the largest immigrant group settling in Peterborough. The impact on pharmaceutical services resulting from their settlement in Peterborough is not known. There is need to undertake a more comprehensive needs assessment in order to design and implement effective interventions with the group.

Peterborough has a majority white population, although it has experienced an increase in the proportion of residents who come from Black and Minority Ethnic (BME) categories. It currently has a higher proportion of BME population as compared to similar areas in England. The ethnicity data recorded during the 2011 census shows that Peterborough is an increasingly diverse city with 21,496 (11.7%) of the population classified as Asian/Asian British and 19,495 (10.6%) as White

Other which mainly consists of persons of Eastern Europe origin. The majority sub-group of the Asian/Asian British was Pakistani with 12,078 (56.2%), followed by Indian with 4,636 (21.6%) (Figure 2).

Figure 2: Ethnic group population proportions in Peterborough, East of England region and England, Census 2011



Source: ONS Census, 2011

Implications for Pharmaceutical Service

Evidence suggests people from BME groups suffer from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority white population.[21] People from BME groups can also place too much emphasis on access to a GP and undervalue the input from other healthcare professionals such as nurses and pharmacists. Some minority ethnic groups are more predisposed to certain long term conditions e.g. diabetes (Asians). Difficulties in expressing their needs in English may also lead to misdiagnosis of their health problems and consequently wrong treatment. Pharmaceutical service providers should therefore take into consideration the unique needs of the local BME groups which could include having translation services and health promotion campaigns aimed at preventing long term conditions such as diabetes.

[21] http://www.publichealth.hscni.net/sites/default/files/Guide%204%20BME%20Groups_0.pdf Date accessed: November 2014

4.2.5 Travellers Population

The ONS 2011 census included the option of 'White: Gypsy or Irish Traveller' under Ethnic Group for the first time. A total of 560 respondents in Peterborough (0.3% of the total) identified themselves as White: Gypsy or Irish Traveller, a higher percentage than the regional (0.1%) and national (0.1%) averages.[22] Although the numbers are relatively small, it is clear that Peterborough has a slightly higher proportion of people identifying as part of this ethnic group and who may, due to the inherently transient nature of the group, not be registered with a GP and therefore make greater use of pharmacies. The Department for Communities and Local Government's July 2014 report 'Count of Traveller Caravans, England'[23] details a 4% reduction nationally in the number of traveller caravans in England compared to the previous year. However the number in Peterborough has remained consistent, with 186 caravans counted in 2013 and 187 in 2014, suggesting that the resident traveller population is not decreasing in line with the national trend.

Peterborough's two largest traveller sites are located at Oxney Road (within the East ward) and Norwood Lane (within the Paston ward). These sites are both supported by a pharmacy in relatively close proximity, with the Sainsbury's Pharmacy located on Oxney Road and the Coop Pharmacy located at Chadburn Centre.

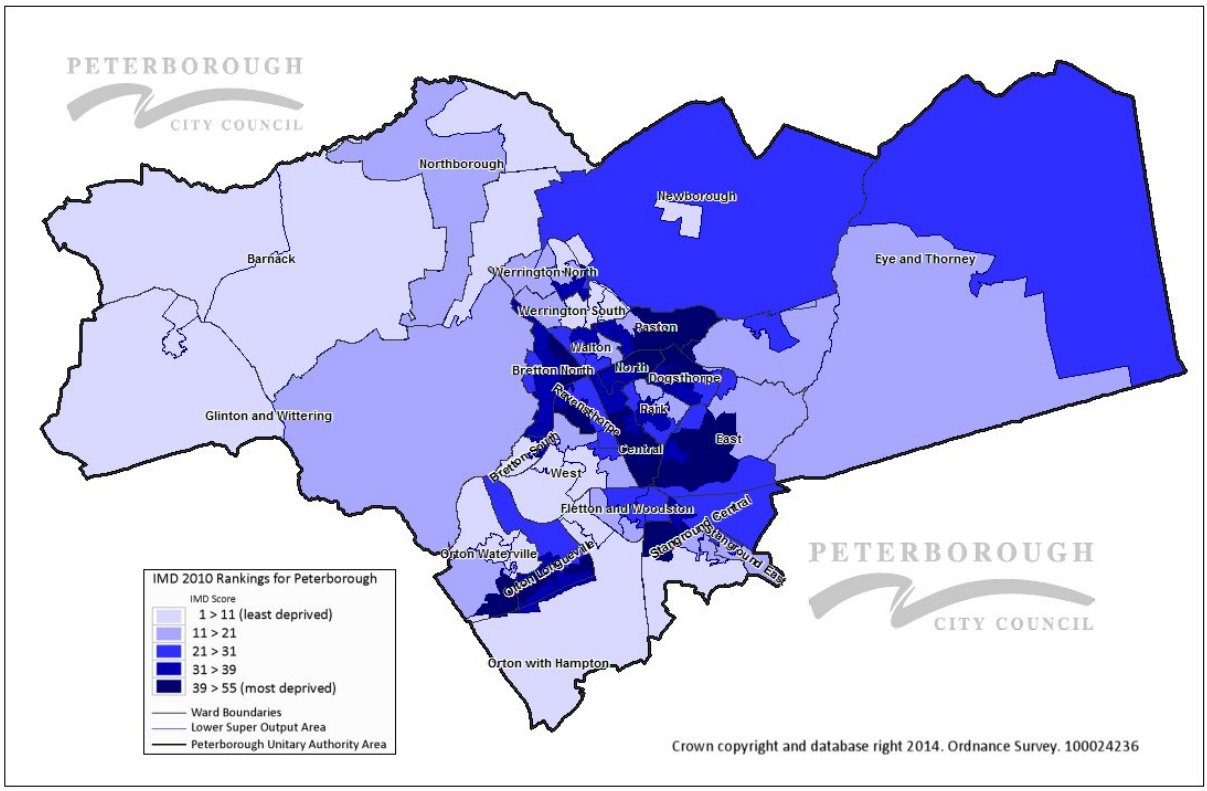
4.2.6 Deprivation

Map 1 below shows the distribution of deprivation across Peterborough, with the darker colour representing the more deprived areas. The pattern of deprivation remains similar to previous years with areas of greatest deprivation being concentrated in central wards of the local authority: Dogsthorpe, Paston, Central, East, Ravensthorpe and parts of the Orton area. Peterborough is ranked as the 71st most deprived local authority out of 326 nationally.

[22] http://www.peterborough.gov.uk/pdf/CommunityInformation-AboutPeterborough-2011Census-EthnicityIdentinyLanguageReligionKeyStatistics.pdf Date accessed: November 2014

[23] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/376736/Traveller_Caravan_Count_release_-_July_2014.pdf Date accessed: November 2014

Map 1: Deprivation levels in Peterborough by lower super output areas, IMD 2010



Source: Department of Communities and Local Government, 2010

More than one in three people in Peterborough live in areas classified as the 20% most deprived areas in England. This is significantly higher than the national average (20.4%).The percentage of children living in poverty (23.6%), rate of persons who are homeless (3.5%), rate of recorded crime against person and those experiencing long term unemployment are higher than the national average (Table 4).

Table 4: Deprivation Indicators

Indicator	Peterborough Number	Peterborough %/Rate	England %/Rate
% people in this area living in 20% most deprived areas in England, 2010	63,633	34.1	20.4
% children (under 16) in families receiving means-tested benefits & low income, 2011 (Children in poverty)	9715	23.6	20.6
Statutory homelessness – crude rate per 1000, 2012/13	263	3.5	2.4
Long term unemployment (16-64), 2013	1567	13	9.9
Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13	2401	13	10.6

Source: Public Health England

Older people

Dashboard 1 shows percentages of older people in deprivation and pensioners living alone by Peterborough wards compared to the England average. Red indicates statistically significantly worse outcome than the England average, while green indicates a better than England average outcome. Yellow indicates that the observed difference is not statistically significant.

There are approximately 6,753 older people living in deprivation in Peterborough. This is an equivalent of 20.6% which is significantly higher than the national average (18.1%). Eleven out of the 24 wards in Peterborough have significantly higher percentages of older people living in deprivation than the national average.

About a third (8,093) of pensioners in Peterborough live alone. This is significantly higher than the national average (31.5%). Eleven out of the 24 wards in Peterborough have significantly higher percentages of pensioners living alone than the national average. North ward has the highest percentage (42.7%).

Implications for Pharmaceutical Service

Evidence shows that deprived populations often experience poor health outcomes including low life expectancy. [24] [25] The prevalence of lifestyle related conditions as well as long term conditions are more prevalent among deprived populations. The demand for health care including pharmaceutical service is therefore also relatively high in deprived areas. There is need for pharmaceutical service providers located in deprived areas to be involved in disease prevention and management strategies.

Older people living in deprivation and/or alone are vulnerable; they are more likely to experience difficulties in accessing health care services as well as adherence to prescribed medication. They therefore may benefit from minor ailments treatment schemes, self-care support and regular medicine use reviews if provided by local community pharmacies.

[24] http://www.rcn.org.uk/__data/assets/pdf_file/0007/438838/01.12_Health_inequalities_and_the_social_determinants_of_health.pdf Date accessed: October 2014

[25] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review Date accessed: October 2014

Dashboard 1: Percentage of older people in deprivation and pensioners living alone, IMD 2010

Area Name	*Number of Older People in Deprivation*	*% Older People in Deprivation*	*Number of Pensioners Living Alone*	*% of Pensioners Living Alone*
Barnack	97	11.2	174	26.5
Bretton North	435	25.6	408	35.5
Bretton South	75	12.5	115	28.1
Central	380	35.3	385	40.6
Dogsthorpe	590	32.5	478	34.7
East	533	30.9	530	39.2
Eye and Thorney	266	17.8	323	29.9
Fletton and Woodston	347	24.9	386	36.1
Glinton and Wittering	121	9.8	223	24.8
Newborough	61	10.1	103	23.8
North	393	31.7	404	42.7
Northborough	86	10.2	136	22.5
Orton Longueville	375	23.4	384	32.1
Orton Waterville	219	11.8	446	31.5
Orton with Hampton	122	12.0	251	28.7
Park	407	26.1	386	31.9
Paston	393	32.8	390	42.5
Ravensthorpe	336	30.9	283	35.4
Stanground Central	414	19.2	552	34.3
Stanground East	105	16.5	168	32.6
Walton	203	17.5	325	36.6
Werrington North	217	18.5	334	40.1
Werrington South	296	13.0	489	26.8
West	282	11.6	420	22.5
Peterborough UA	**6,753**	**20.6**	**8,093**	**32.5**
England	**2,094,588**	**18.1**	**2,725,596**	**31.5**

Source: Public Health England: Local Health

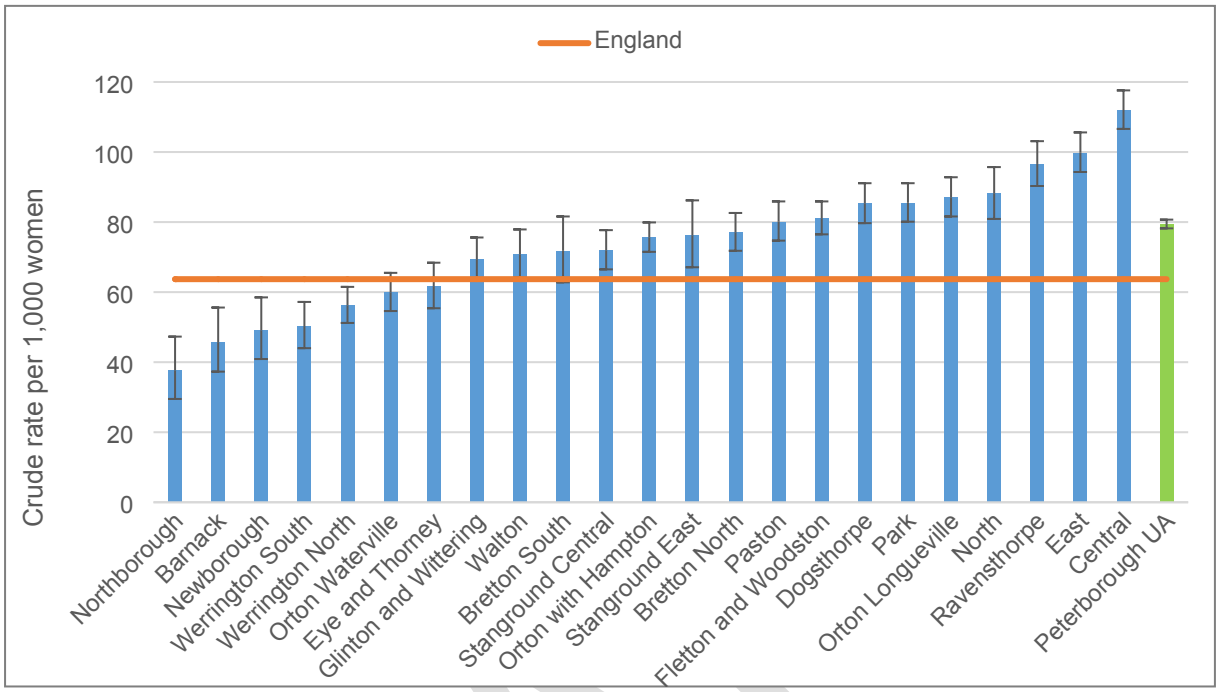
Key

Statistically significantly better than the England average
The difference is not statistically significant
Statistically significantly worse than the England average

4.2.7 Fertility rate

Peterborough's fertility rate is significantly higher than the national average. Fifty percent of all wards in Peterborough have a significantly higher fertility rate than the national average. Central ward has the highest fertility rate (112/1,000 women) (Figure 3).

Figure 3: Live births per 1,000 women aged 15-44 years by ward, Peterborough, 2008-2012



Source: Public Health England

Implications for Pharmaceutical Service

The Peterborough age structure shows that the proportion of young people is relatively higher than the regional and national averages. The high fertility rate is therefore expected to persist and is consistent with the current population projections. The demand on pharmaceutical services by new-borns and children in general therefore is also expected to remain high.

4.2.8 Life Expectancy at Birth

Peterborough has a significantly lower male life expectancy at birth (77.9) than the national average (78.9). Seven out of the 24 wards in Peterborough have significantly lower male life expectancies at birth than the national average. Orton Longueville, Park and West wards have lower female life expectancies at birth than the national average (Dashboard 2).

Dashboard 2: Life expectancy at birth by ward, Peterborough, 2008-2012

Area Name	*Total Deaths*	*Male Life Expectancy at Birth*	*Total Deaths*	*Female Life Expectancy at Birth*
Barnack	62	82.5	62	85.7
Bretton North	157	77.9	112	85.3
Bretton South	45	83.0	39	86.2
Central	183	75.8	144	82.9
Dogsthorpe	224	75.8	223	82.6
East	226	75.9	207	82.0
Eye and Thorney	157	76.8	162	81.5
Fletton and Woodston	179	76.7	124	84.3
Glinton and Wittering	93	82.9	96	84.9
Newborough	46	82.6	35	86.9
North	133	77.3	121	84.5
Northborough	68	82.0	68	83.5
Orton Longueville	213	75.5	215	79.3
Orton Waterville	139	82.3	133	86.7
Orton with Hampton	103	80.2	129	83.5
Park	262	75.0	382	78.8
Paston	133	77.2	101	87.0
Ravensthorpe	151	74.2	100	83.5
Stanground Central	220	78.5	213	82.8
Stanground East	40	83.1	53	83.7
Walton	113	78.3	139	81.8
Werrington North	98	80.8	91	87.6
Werrington South	219	77.8	219	84.0
West	279	79.3	411	79.2
Peterborough UA	**3,543**	**77.9**	**3,579**	**82.3**
England	**1,115,094**	**78.9**	**1,200,567**	**82.8**

Key

Statistically significantly better than the England average
The difference is not statistically significant
Statistically significantly worse than the England average

Implications for Pharmaceutical Service

The disparity in life expectancy between the best and worst wards in Peterborough is substantial. Males born in Ravensthorpe (the ward with the lowest life expectancy for males – 74.2 years) are expected to live 8.9 years less than those born in Stanground East (the ward with the highest life expectancy for males – 83.1 years). Among females, those born in Park (the ward with the lowest life expectancy for males – 78.8 years) are expected to live 8.8 years less than those born in

Werrington South (the ward with the highest life expectancy for females – 87.6 years). The wards with low life expectancy at birth are also the most deprived. Community pharmacies should be involved in efforts to address the evident health inequality by identifying and addressing factors contributing to low life expectancy especially in deprived areas which may include harmful lifestyle habits such substance misuse, smoking, unhealthy eating habits and poor access to health care facilities.

4.2.9 Healthy Life expectancy at birth

Peterborough has a significantly lower healthy life expectancy for both males (59.9 years) and females (59.8 years) as compared to the national average (63.4 years and 64.1 years respectively). These figures are also the lowest in the region (East of England). Healthy life expectancy at birth is described as the average number of years a person would expect to live in good health based on local mortality rates and prevalence of self-reported good health.[26]

Implications for pharmaceutical service

The low healthy life expectancy implies that a large proportion of Peterborough's population develop health problems at a relatively early age as compared to the national average. This results in a higher demand for support from health care facilities as well pharmaceutical services. Apart from providing support to individuals with health problems, community pharmacies can also get involved in preventative interventions which may include: promotion of healthy lifestyle, NHS health checks and cancer screening.

4.2.10 Peterborough's growth and housing development

The Peterborough Core Strategy[27] (Adopted 2011) sets out the future growth for Peterborough and the need for 25,500 new homes and 20,000 jobs by 2026.

The majority of the growth is proposed within the existing urban area, but includes new urban extensions at Great Haddon (5,300 dwellings) and Norwood (2,300 dwellings) and approximately 1,000 dwellings in the rural areas.

Over the next five years there is a need for approximately 9,300 dwellings. The council has to produce a Five Year Land Supply[28] report each year. Tables 5 and 6 show an estimate of the delivery of future housing, based on sites that are under construction and sites that have been granted planning permission.

The following table sets out where new development is expected to take place in the urban area by ward.

[26] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/healthy-life-expectancy-at-birth-for-upper-tier-local-authorities--england/2010-12/index.html Date accessed: October 2014
[27] http://www.peterborough.gov.uk/pdf/Plan-policy-ldf-cs-adoptedCS.pdf Date accessed: October 2014
[28] http://www.peterborough.gov.uk/pdf/Five%20Year%20Land%20Supply%202014.pdf Date accessed: October 2014

Table 5: New developments in urban areas by ward, 2014/15-2019/20

Ward	Number of housing units which are expected to be completed in 5 years	20014/15 current year	2015/16 Year 1	2016/17 Year 2	2017/18 Year 3	2018/19 Year 4	2019/20 Year 5
Bretton North	174	12	21	5	20	50	78
Central ward	661	70	73	94	161	163	170
East Ward	549	69	145	70	134	100	100
Fletton	638	74	70	98	147	163	160
North Ward	47	0	19	28	0	0	0
Orton with Hampton	3,249	298	502	653	750	694	650
Orton Longueville	7	1	0	6	1	0	0
Orton Waterville	351	51	62	38	50	101	100
Park	15	8	15	0	0	0	0
Paston	541	117	134	135	112	80	80
Ravensthorpe	23	8	0	0	23	0	0
Stanground Central	932	319	346	221	127	148	90
Stanground East	0	1	0	0	0	0	0
Walton	18	43	15	2	1	0	0
West Ward	756	90	99	130	224	182	121
Werrington North	100	0	0	0	20	35	45
Werrington South	100	0	0	0	20	35	45
Total	**8,541**	**1,180**	**1,536**	**1,487**	**1,810**	**1,891**	**1,817**

Source: Peterborough City Council

A significant proportion of the new homes to be delivered in the next five years are located within the Orton with Hampton Ward. This includes homes being built at Hampton and the proposed development at Great Haddon.

Rural Areas

The new development estimate in the rural areas is shown in the table below by village.

Table 6: New developments in rural areas by village, 2014/15-2019/20

Village	Number of housing units which are expected to be completed in 5 years	20014/15 current year	2015/16 Year 1	2016/17 Year 2	2017/18 Year 3	2018/19 Year 4	2019/20 Year 5
Ailsworth	9	0	3	3	3	0	0
Bainton	1	0	0	0	1	0	0
Barnack	0	0	0	0	0	0	0
Castor	3	0	1	1	1	0	0
Deeping Gate	1	0	1	0	0	0	0
Etton	0	0	0	0	0	0	0
Eye	192	6	34	108	48	1	1
Glinton	0	0	0	0	0	0	0
Helpston	43	14	18	1	0	0	24
Marholm	0	0	0	0	0	0	0
Maxey	5	4	4	0	1	0	0
Newborough	95	2	12	11	20	32	20
Northborough	4	1	1	3	0	0	0
Peakirk	6	0	5	0	1	0	0
St Martins Without	1	3	0	0	0	0	1
Sutton	0	0	0	0	0	0	0
Southorpe	3	0	0	1	2	0	0
Thorney	163	7	3	33	60	37	30
Thornhaugh	1	0	0	0	1	0	0
Wansford	10	0	0	0	1	9	0
Wittering	170	0	5	45	40	40	40
Wothorpe	1	0	0	0	1	0	0
Total	736	37	87	206	181	138	124

Source: Peterborough City Council

Over the next five years the majority of growth is expected to be delivered in the larger villages of Eye and Thorney, these are villages that have a wide range of local community services and facilities.

Implications for Pharmaceutical Service

The increase in housing units in Peterborough is likely to result in population rise in specified areas as the units get occupied. Currently pharmaceutical service provision is considered adequate in all areas of Peterborough. The exact impact of increased demand for services resulting from housing growth is difficult to predict as existing

service providers are increasingly adopting more efficient ways of service delivery such as electronic dispensing and workforce skill mix (e.g. more accredited checking technicians).

The Peterborough HWB in collaboration with NHS England Area Team will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

4.3 Peterborough Population Summary

The latest ONS population estimates indicate that there are 188,373 people resident in Peterborough an increase from 183,631 reported in the 2011 Census. The population is predicted to reach 217,600 by 2021 (17.2% increment)

Peterborough's population profile shows a higher proportion of younger people and a lower proportion of older people as compared to the national average population structure. Among wards, Orton with Hampton has the largest population (14,225) while Orton with Hampton has the largest proportion of young people. Fletton and Woodston ward has the largest proportion of working age persons and Werrington South has the largest proportion of older people.

The variation in age profiles across the Peterborough wards implies that health needs for local populations also vary. In localities with large proportions of children and young people, some of the needs which pharmaceutical service providers have the potential to intervene include: immunisations, sexual health and advice on healthy lifestyles. In localities with large proportions of older people priority needs may include prevention of long term conditions and support for self-management for those living with long-term conditions.

Peterborough is predominantly white but has a relatively higher proportion of black and minority ethnic groups as compared to other authorities in the region. It also has a higher proportion of non-British white population mainly made up of immigrants from Eastern Europe. Evidence suggests people from black and minority ethnic groups (BME) suffer from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority of the white population. Some minority ethnic groups are more predisposed to certain long term conditions e.g. diabetes (Asians). There is need to carry out a comprehensive needs assessment with BME groups in order to understand and respond to their health and pharmaceutical needs effectively.

More than one in three people in Peterborough live in areas classified as the 20% most deprived areas in England. This is significantly higher than the national average (20.4%).There are also approximately 6,753 older people living in deprivation in Peterborough. This is an equivalent of 20.6% which is significantly higher than the national average (18.1%). Eleven out of the 24 wards in Peterborough have significantly higher percentages of older people living in deprivation than the national average. Evidence shows that deprived populations often experience poor health outcomes including low life expectancy. The demand for health care including pharmaceutical service is therefore expected to be relatively high in areas with large proportions of deprived people.

Peterborough's fertility rate is significantly higher than the national average. Fifty percent of all wards in Peterborough have a significantly higher fertility rate than the national average. The demand on pharmaceutical services by new-borns and children in general therefore is expected to persist in future.

Peterborough has a significantly lower male life expectancy at birth (77.9) than the national average (78.9). The difference between the best and worst wards in terms of life expectancy is 8.9 years for males and 8.8 years for females. Peterborough also has a significantly lower healthy life expectancy for both males (59.9) and females (59.8) as compared to the national average (63.4 and 64.1respectively). There is need to explore ways in which pharmaceutical providers can be involved in addressing factors contributing to low life expectancy and the evident health inequality.

Over the life of the current PNA document (2015-2018), a total of 6,724 houses in urban areas (the majority in Orton with Hampton) and 612 in the rural areas (majority in the larger villages of Eye & Thorney) will be built. The exact impact of increased demand for services resulting from housing growth is difficult to predict as existing service providers are increasingly adopting more efficient ways of service delivery. The Peterborough HWB and NHS England Area Team are expected to collaboratively monitor the impact and initiate necessary action as required.

5 Local Health Needs

This section focuses on local health needs by examining inequalities in morbidity, mortality and health service utilisation across the population in Peterborough. The main sources of information and data were Health Profiles 2014, Public Health Outcome Framework and Local Health, all produced by Public Health England. Presentation of data is by local authority and where data is available by ward. We specifically highlight only those indicators that are relevant to pharmaceutical service provision and also those where Peterborough's performance is significantly different from the national average.

5.1 Disease prevalence

5.1.1 GP Recorded Prevalence

Table 7 shows GP recorded prevalence rates for leading causes of long term ill health in Peterborough. Although Peterborough's rates appear lower than the national average, the estimated prevalence rates which are considered more accurate show that they are lower than expected. The difference between recorded and estimated prevalence therefore may be indicative of undiagnosed cases who are likely to present in secondary care institutions late with complications as emergencies.

Pharmaceutical service providers have the potential to participate in enhanced case finding strategies such as promoting and providing NHS health checks due to their frequent interactions with local populations.

Table 7: GP recorded and estimated prevalence, Cambridgeshire & Peterborough CCG, 2012/13 and 2011

Condition	CCG QOF recorded prevalence 2012/13 (%)	Estimated Prevalence (%), 2011	England average recorded prevalence, 2012/13	England Estimated Prevalence (%), 2011
Stroke / TIA[3] (All Ages)	1.5	1.77	1.7	2.07
CHD	3.0	8.9	3.3	9.5
Hypertension	12.9	23.2	13.7	24.9
COPD	1.6	2.15	1.7	2.91
Diabetes Mellitus (17+)	5.5	6.7 (2012)[1]	6.0	7.6 (2012)[1]
Mental Health[2]	0.75	N/A	0.84	N/A
Dementia	0.5	N/A	0.6	N/A
Depression (18+)	5.6	N/A	5.8	N/A

Source: GP National Profiles.

1 APHO models
2 Includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses
3 Transient Ischaemic Attack
N/A – Not available

5.1.2 Tuberculosis

Peterborough's Tuberculosis (TB) incidence rate (28.9/100,000) is more than three times the regional average (8.3/100,000) and nearly two times the national average (15.1/100,000).

In order to control the spread of TB in Peterborough, the recommended approach[29] includes early detection and diagnosis, especially of infectious cases, and treatment completion. Early case detection and prompt initiation of treatment reduces onward transmission of the disease. Completing a full course of appropriate treatment is vital to prevent the disease relapsing, to prevent the development of drug resistant strains of TB, to prevent prolonged infectiousness and preventable death.

Implications for Pharmaceutical Service

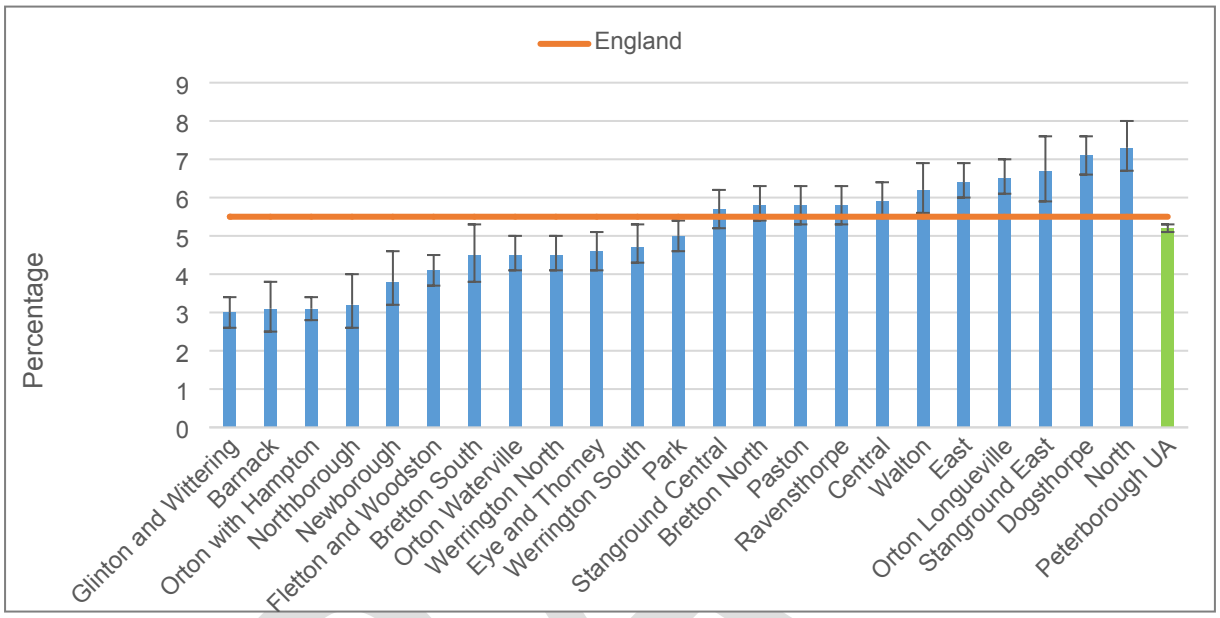
Community pharmacies could play a major role in TB control by monitoring medication consumption and ensuring completion of treatment regimes. There is currently no service for observed treatment for tuberculosis from community pharmacies in Peterborough. Community pharmacies do have a supervised consumption service for observed methadone liquid or buprenorphine tablets treatment commissioned by Peterborough Safer Partnership which could be adapted for tuberculosis medication in the future. The national strategy on the treatment and prevention of TB is co-ordinated by Public Health England.

[29] http://www.local.gov.uk/documents/10180/5854661/Tackling+Tuberculosis+-+Local+government's+public+health+role/20581cca-5ef1-4273-b221-ea9406a78402
Date accessed: November 2014

5.1.3 General Health

Figure 4 shows that in 25% of Peterborough wards the percentage of people who reported poor health during the ONS 2011 census was significantly higher than the national average.

Figure 4: Percentage of people with very bad or bad health, Census 2011

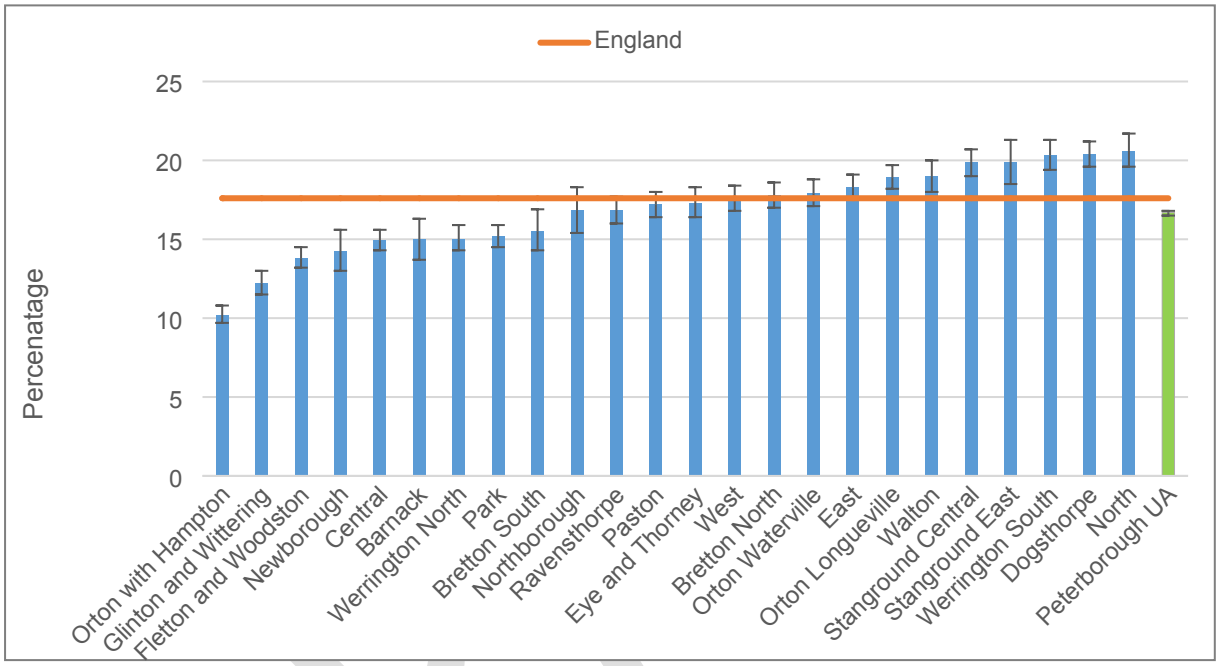


Source: Public Health England

5.1.4 Limiting Long Term Illness or Disability

The percentage of people with limiting long-term illness or disability in Orton Longueville, Walton, Stanground Central, Stanground East, Werrington South, Dogsthorpe and North wards is higher than the national average (Figure 5).

Figure 5: Percentage of people with Limiting Long Term Illness or Disability, Census 2011



Source: Public Health England

Implications for Pharmaceutical Service

Pharmacies located in areas where large proportions of the population have general poor health or have long term illness and disability have the potential to intervene through participation in preventative approaches such as promoting healthy lifestyle, encouraging NHS health checks and screening, providing minor ailment treatment service and support for self-care.

5.1.5 Low Birth Weight [30]

The percentage of children with low weight at birth in Peterborough is not significantly different from the national average. However ward level analysis shows Central and Park have significantly higher prevalence rates (Dashboard 3).

Low birth weight is often associated with deprivation, poor nutrition and smoking during pregnancy. It increases the risk of childhood mortality and of developmental problems for the child and is associated with poor health in later life.

[30] Live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks.

Implications for Pharmaceutical Service

Pharmaceutical service providers located within the specified wards have the potential to intervene through promotion of healthy lifestyle to include healthy eating and provision of stop smoking services.

5.1.6 Child Obesity

The percentage of children in year six (ages 10/11) who are obese in Peterborough is not significantly different from the national average. However ward level analysis shows Bretton South and Central have significantly higher rates (Dashboard 3).

Implications for Pharmaceutical Service

Pharmaceutical service providers located within the specified wards have the potential to intervene through promotion of healthy lifestyle to include healthy eating and physical activity.

Dashboard 3: Low birth weight and Child obesity, in Peterborough wards, 2010/11-2012/13

Area Name	*Number of children*	*% Low birth weight*	*Number of children*	*% Obese children in year 6*
Barnack	6	6.5	7	9.3
Bretton North	57	7.1	82	24.4
Bretton South	16	7.0	17	17.3
Central	143	9.5	110	22.7
Dogsthorpe	70	7.8	73	20.3
East	96	7.9	87	22.9
Eye and Thorney	22	6.2	39	19.3
Fletton and Woodston	92	7.7	57	19.1
Glinton and Wittering	35	6.6	26	12.1
Newborough	6	4.9	8	8.5
North	50	8.6	44	24.6
Northborough	7	8.1	11	15.3
Orton Longueville	61	6.6	70	19.4
Orton Waterville	28	6.2	29	12.5
Orton with Hampton	75	5.7	124	22.4
Park	96	9.6	87	20.3
Paston	59	7.2	50	20.2
Ravensthorpe	74	8.5	72	23.2
Stanground Central	37	5.9	55	24.2
Stanground East	13	5.2	21	19.3
Walton	41	9.3	40	24.4
Werrington North	29	6.4	46	17.7
Werrington South	16	7.1	19	12.8
West	45	8.4	41	17.2
Peterborough UA	**1,175**	**7.6**	**1,215**	**20.0**
England	**251,444**	**7.4**	**281,160**	**19.1**

Source: Public Health England: Local Health

Key

Statistically significantly better than the England average
The difference is not statistically significant
Statistically significantly worse than the England average

5.2 Health Improvement Indicators

Table 8 shows health improvement indicators where Peterborough's performance is worse than the national average. In summary:

- The percentage of mothers breastfeeding at 6-8 weeks follow up in Peterborough is lower than the regional and national averages. It is the third lowest rate in the region (East of England) after Southend on Sea and Thurrock.
- More than one in five people smoke in Peterborough. The rate is significantly higher than the regional and national average.
- The smoking prevalence among Peterborough mothers at time of delivery is higher than the regional and national average. It is also the highest in the region.
- Peterborough's under 18 conception rate is higher than the regional and national averages and is the highest in the region. It is more than twice the rate of Cambridgeshire (16.8).
- Alcohol related admissions rate for Peterborough is higher than the regional and national average and also the highest in the region.

Table 8: Health Indicators

Indicator	Period	Peterborough	East of England	England
Breastfeeding – 6-8 weeks, 2012/13 (%)	2012/13	41.4	46.6	47.2
Smoking prevalence (18+)	2013	20.8	17.5	18.4
Smoking at time of delivery, 2012/13 (%)	2012/13	18	12.4	12.7
Under 18 conceptions, 2012 (Per 1,000 women)	2012	36	23.2	27.7
Alcohol related admissions (Per 100,000 population)	2012/13	689	552	637

Source: Public Health England

Implications for Pharmaceutical Service

Community pharmacies should be supported to provide as part of the essential service, health promotion campaigns that encourage breastfeeding and create awareness of the risks associated with smoking and alcohol misuse. Evidence shows that provision of emergency hormonal contraception in pharmacies can reduce under 18 contraception rates.[31] [32] The sexual health commissioner should consider commissioning local pharmacies to provide emergency hormonal

[31] http://www2.nphs.wales.nhs.uk:8080/pharmaceuticalphtdocs.nsf/($All)/C3D14C48910CF6378025723500377DF6/$File/Microsoft%20Word%20-%20Literature%20review-%20emergency%20hormonal%20contraception%20_update%202010_.pdf?OpenElement Date Accessed December 2014

[32] http://www.nice.org.uk/guidance/ph51/resources/guidance-contraceptive-services-with-a-focus-on-young-people-up-to-the-age-of25-pdf Date Accessed December 2014

contraception if appropriate within the context of local healthcare strategy. Pharmacies could also be supported to provide alcohol brief intervention services to reduce the rate of alcohol related admissions.

5.3 Healthcare Utilization

Table 9 shows screening, NHS health checks and immunization uptake rates where Peterborough's performance is significantly worse than national average. The uptake of diabetic retinopathy is also the lowest in the region while cervical cancer screening is the second lowest after Luton.

Table 9: Health Utilization Indicators

Indicator	Period	Peterborough	East of England	England
Cancer screening coverage – Cervical (%)	2013	72	75.6	73.9
Diabetic Retinopathy screening (%)	2011/12	72.7	80.9	80.9
Chlamydia screening detection rate- males (Target => 2300)	2013	1640	1166	1387
NHS Health Checks (%)	2013/14	45.7	52.6	49
Flu vaccination – 65+ (Target => 75%)	2012/13	72.7	73.3	73.4
Flu vaccination – Individuals at risk (Target =>75%)	2012/13	50.2	48.3	51.3

Source: Public Health England

Implications for Pharmaceutical Service

A high uptake of NHS health screening /checks and flu vaccinations has been associated with a lesser burden to pharmaceutical, primary and secondary health care facilities as individuals with health problems are identified early and necessary interventions initiated. Flu vaccinations protect individuals from catching flu which can complicate to more serious respiratory conditions.

None of the pharmacies in Peterborough are currently commissioned to provide chlamydia tests, NHS health checks, flu vaccination for over 65s and only 13 are providing flu vaccination for individuals at risk.

5.4 Hospital Admissions

Dashboard 4 shows standardised admission ratios for various conditions by ward in Peterborough. In summary:

- Peterborough's emergency admissions for all causes, CHD and alcohol related harm are significantly higher than expected.
- Seven out 24 wards in Peterborough have significantly higher than expected emergency admissions for all cases and CHD.
- Central is the only ward in Peterborough with significantly higher stroke admissions (45%) than expected.
- Bretton North, Central, North and Orton Longueville have significantly higher emergency admissions for COPD.
- 50% of all wards in Peterborough have higher than expected hospital admissions for alcohol related harm.

Dashboard 4: Standardised admissions ratios (SAR) for all causes, CHD, Stroke, COPD and alcohol related harm, 2008-2013

Area Name	*Number of Admissions All Causes*	*SAR Emergency Admissions All Causes*	*Number of Admissions CHD*	*SAR Emergency Admissions CHD*	*Number of Admissions Stroke*	*SAR Emergency Admissions Stroke*	*Number of Admissions COPD*	*SAR Emergency Admissions COPD*	*Number of alcohol related harm Admissions*	*SAR Hospital admissions alcohol related harm*
Barnack	1,146	88.8	27	87.8	14	89.9	13	55.4	223	83.2
Bretton North	4,609	111.9	111	115.5	40	88.3	108	147.5	1,130	134.4
Bretton South	1,461	95.0	41	90.2	23	98.6	28	77.5	378	108.7
Central	6,679	127.5	171	160.9	83	145.2	114	144.3	1,346	140.8
Dogsthorpe	5,292	113.0	147	126.6	62	98.3	106	115.7	1,266	137.0
East	5,781	114.4	164	139.0	71	113.0	104	114.6	1,362	138.4
Eye and Thorney	2,725	94.3	77	91.5	42	99.9	70	105.4	662	100.7
Fletton and Woodston	5,579	109.8	136	117.3	72	119.8	102	114.4	1,308	130.2
Glinton and Wittering	2,967	85.8	91	95.1	42	89.4	39	52.4	674	87.3
Newborough	1,038	76.7	35	87.0	10	47.6	20	61.2	256	80.7
North	3,437	117.4	98	135.8	42	107.3	77	134.5	766	133.0
Northborough	1,143	86.8	49	116.9	20	95.0	19	57.2	314	98.4
Orton	5,171	118.3	128	137.7	45	98.3	108	157.2	1,196	142.8

Area Name	*Number of Admissions All Causes*	*SAR Emergency Admissions All Causes*	*Number of Admissions CHD*	*SAR Emergency Admissions CHD*	*Number of Admissions Stroke*	*SAR Emergency Admissions Stroke*	*Number of Admissions COPD*	*SAR Emergency Admissions COPD*	*Number of alcohol related harm Admissions*	*SAR Hospital admissions alcohol related harm*
Longueville										
Orton Waterville	3,469	86.2	109	91.9	50	84.6	53	57.8	857	92.7
Orton with Hampton	5,094	96.8	97	96.6	51	102.1	63	87.3	994	104.8
Park	5,565	119.3	152	150.4	69	122.4	80	107.2	1,053	123.4
Paston	4,166	107.2	103	111.1	40	84.1	66	91.6	1,012	130.8
Ravensthorpe	4,145	123.1	100	146.9	38	116.8	92	181.7	879	139.5
Stanground Central	4,302	99.6	125	104.9	71	114.1	100	105.0	1,123	119.3
Stanground East	1,438	93.9	47	105.7	24	105.0	35	96.2	377	109.8
Walton	2,860	99.1	90	104.3	44	95.1	52	75.0	709	109.7
Werrington North	2,893	85.4	96	109.0	33	79.2	51	78.9	728	98.4
Werrington South	2,846	85.7	96	92.9	38	71.8	52	63.1	727	94.0
West	4,065	92.8	121	92.6	75	107.4	64	60.9	985	100.3
Peterborough UA	**87,872**	**104.2**	**2,413**	**114.3**	**1,098**	**101.4**	**1,615**	**99.2**	**20,326**	**117.1**
England	**25,623,623**	**100.0**	**706,513**	**100.0**	**368,284**	**100.0**	**552,386**	**100.0**	**5,560,988**	**100.0**

Source: Public Health England: Local Health

Key

Statistically significantly better than the England average
The difference is not statistically significant
Statistically significantly worse than the England average

Implications for Pharmaceutical Service

Avoiding emergency admissions is a major concern for the National Health Service due to the associated high cost. Although the reduction of emergency admissions requires a multiagency and multidisciplinary approach, patient self-management with the support of pharmacy staff has shown to be effective in reducing emergency admissions.[33] The service usually involves educating a patient with a long term condition on how the condition affects his/her life, how to cope with symptoms and Medicine Use Reviews.

[33] http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf Date accessed: November 2014

5.5 Mortality

5.5.1 All Age Mortality

Dashboard 5 shows all age standardised mortality ratios for various conditions by ward in Peterborough. In summary:

- Peterborough had significantly more deaths than expected from all causes, circulatory disease, CHD and respiratory disease.
- Five out of 24 wards had more deaths than expected from all causes while only one (Eye & Thorney) had more than expected deaths from all cancers.
- A quarter of all wards had significantly more deaths than expected from circulatory disease while a third had more deaths than expected from CHD.
- Park and West were the only two wards with more than expected deaths from Stroke
- Park, West and Longueville had more than expected deaths from respiratory disease.

Dashboard 5: All Age Standardised mortality ratios (SMR), 2008-2012

Area Name	*Number Deaths All Ages*	*SMR All Ages All Causes*	*Number Deaths All Ages All Cancers*	*SMR All Ages All Cancers*	*Number Deaths All Ages Circulatory Disease*	*SMR All Ages Circulatory Disease*	*Number of Deaths All Ages CHD*	*SMR All Ages, CHD*	*Number Deaths All Ages, Stroke*	*SMR All Ages, Stroke*	*Number Deaths All Ages, Respiratory Disease*	*SMR All Ages, Respiratory Disease*
Barnack	124	80.0	47	101.0	51	111.6	23	104.2	8	72.6	8	37.2
Bretton North	269	96.3	78	88.8	83	106.1	42	108.7	19	98.1	48	135.0
Bretton South	84	83.0	22	70.7	26	90.5	17	120.7	6	77.6	8	61.0
Central	327	105.9	73	90.0	104	116.2	63	152.2	20	86.1	36	83.2
Dogsthorpe	447	109.7	102	93.4	151	123.8	80	142.9	33	102.7	66	112.3
East	433	108.1	112	104.3	147	123.8	73	132.8	25	79.2	54	94.5
Eye and Thorney	319	125.5	96	126.1	88	118.1	51	142.6	20	104.4	44	125.3
Fletton and Woodston	303	103.4	73	85.1	101	121.9	56	140.9	17	81.7	45	116.3
Glinton and Wittering	189	81.1	70	101.4	56	83.8	25	77.4	8	48.1	18	59.2
Newborough	81	75.1	36	107.9	17	55.6	8	52.6	5	61.8	10	70.9

Area Name	*Number Deaths All Ages*	*SMR All Ages All Causes*	*Number Deaths All Ages All Cancers*	*SMR All Ages All Cancers*	*Number Deaths All Ages Circulatory Disease*	*SMR All Ages Circulatory Disease*	*Number of Deaths All Ages CHD*	*SMR All Ages, CHD*	*Number Deaths All Ages, Stroke*	*SMR All Ages, Stroke*	*Number Deaths All Ages, Respiratory Disease*	*SMR All Ages, Respiratory Disease*
North	254	95.1	71	96.3	77	95.8	48	127.8	16	76.1	42	108.6
Northborough	136	95.7	36	82.8	42	100.1	25	123.1	7	62.7	16	83.5
Orton Longueville	428	131.2	113	119.9	136	145.0	63	141.1	36	150.3	66	148.9
Orton Waterville	272	73.5	81	74.8	84	76.8	38	72.9	18	64.5	34	67.0
Orton with Hampton	232	90.2	63	91.2	63	88.2	29	87.1	12	66.7	35	105.3
Park	644	150.9	108	104.3	200	154.5	86	149.5	75	209.4	111	174.1
Paston	234	95.2	69	95.1	66	93.5	31	91.9	14	80.9	41	127.2
Ravensthorpe	251	117.5	61	97.2	84	138.7	54	185.9	10	68.7	40	140.8
Stanground Central	433	102.2	119	96.2	130	103.2	67	112.7	29	88.6	55	92.2
Stanground East	93	80.5	30	85.1	24	71.4	11	67.1	6	70.3	17	110.5
Walton	252	102.9	82	119.9	68	93.7	38	111.3	15	76.9	40	113.9
Werrington North	189	76.9	66	93.4	56	78.5	29	85.9	14	77.5	27	82.7
Werrington South	438	104.7	96	77.5	131	104.2	54	90.0	37	115.0	72	121.1
West	690	136.0	143	103.4	201	130.6	86	121.3	67	164.9	122	164.2
Peterborough UA	7,122	105.6	1,847	96.4	2,186	110.5	1,093	117.6	516	101.1	1,055	112.8
England	**2,315,661**	**100.0**	**651,010**	**100.0**	**686,806**	**100.0**	**320,773**	**100.0**	178,673	100.0	327,787	100.0

Source: Public Health England: Local Health

Key

Statistically significantly better than the England average

The difference is not statistically significant

Statistically significantly worse than the England average

5.5.2 Under 75 Mortality

Dashboard 6 shows under 75 standardised mortality ratios for various conditions by ward.

Peterborough had significantly more premature deaths (under 75) than expected from all causes, circulatory disease and CHD.

A third of all wards had more premature deaths than expected from all causes while only one (Orton Longueville) had significantly more deaths than expected from all cancers.

Seven out of 24 wards in Peterborough had more premature deaths than expected from circulatory disease and CHD.

Dashboard 6: Under 75 Standardised Mortality Ratios (SMR), 2008-2012

Area Name	*Number Deaths Under 75 all causes*	*SMR Under 75 all causes*	*Number Deaths under 75 all Cancers*	*SMR under 75 all Cancers*	*Number Deaths Under 75 Circulatory Disease*	*SMR Under 75 Circulatory Disease*	*Number Deaths under 75, CHD*	*SMR under 75, CHD*
Barnack	49	87.9	28	119.1	13	100.2	6	78.3
Bretton North	149	115.4	50	96.3	36	123.9	19	114.5
Bretton South	47	110.5	15	86.8	10	101.4	9	164.1
Central	146	150.6	34	98.5	34	172.1	25	229.9
Dogsthorpe	153	131.5	49	106.8	42	161.0	29	197.1
East	177	142.9	55	114.4	50	181.2	29	188.9
Eye and Thorney	96	99.4	45	112.8	23	100.5	11	85.8
Fletton and Woodston	134	116.3	40	92.3	37	149.6	23	167.2
Glinton and Wittering	74	79.7	39	105.7	15	69.6	4	34.0
Newborough	34	74.1	17	89.7	6	54.4	3	48.7
North	100	129.5	37	121.6	24	137.4	16	161.5
Northborough	37	69.0	20	87.7	8	60.5	6	81.2
Orton Longueville	179	139.8	67	131.8	48	166.6	29	178.6
Orton Waterville	110	84.7	36	67.2	29	96.0	11	63.5
Orton with Hampton	82	77.8	36	96.3	15	68.2	6	51.0
Park	148	142.3	41	102.8	46	200.8	27	212.6

Area Name	*Number Deaths Under 75 all causes*	*SMR Under 75 all causes*	*Number Deaths under 75 all Cancers*	*SMR under 75 all Cancers*	*Number Deaths Under 75 Circulatory Disease*	*SMR Under 75 Circulatory Disease*	*Number Deaths under 75, CHD*	*SMR under 75, CHD*
Paston	122	126.6	43	115.5	28	134.0	16	134.4
Ravensthorpe	139	159.2	35	104.2	43	224.5	28	262.0
Stanground Central	144	108.5	53	97.8	31	100.5	21	119.7
Stanground East	33	76.6	16	92.7	8	79.3	3	53.6
Walton	79	104.8	37	122.3	19	108.3	12	123.5
Werrington North	67	72.3	24	65.5	17	84.3	10	85.5
Werrington South	103	75.7	31	53.5	31	93.4	17	89.7
West	125	87.7	52	87.6	29	86.5	12	62.3
Peterborough UA	**2,527**	**109.0**	**900**	**97.7**	**641**	**122.3**	**370**	**125.8**
England	**762,945**	**100.0**	**310,211**	**100.0**	**176,217**	**100.0**	**99,575**	**100.0**

Source: Public Health England: Local Health

Key

Statistically significantly better than the England average

The difference is not statistically significant

Statistically significantly worse than the England average

5.5.3 Mortality from causes considered preventable

Peterborough had a significantly higher mortality rate (210.9/100,000 population) from causes considered preventable by public health interventions than the regional (165.7/100,000) and national (187.8/100,000) averages for the period 2010-12. Peterborough also had a higher premature mortality rate (71.5/100,000) from cardiovascular diseases considered preventable than the regional (48.1/100,000) and national (53.5/100,000) averages.

Mortality: Implications for Pharmaceutical Service

Community pharmacies have the potential to contribute towards the reduction of deaths associated with the above highlighted conditions most of which can be prevented by public health interventions. This can be accomplished by supporting pharmacies to implement health promotion campaigns that encourage healthy living, NHS health checks and screening. Stop smoking service provision as well as treatment of minor ailments by pharmacies may also contribute towards reduction of mortality associated with respiratory conditions. For patients living with long-term conditions, self-care support and medicine use reviews could contribute towards reduction of mortality rates.

5.6 Protected Characteristics

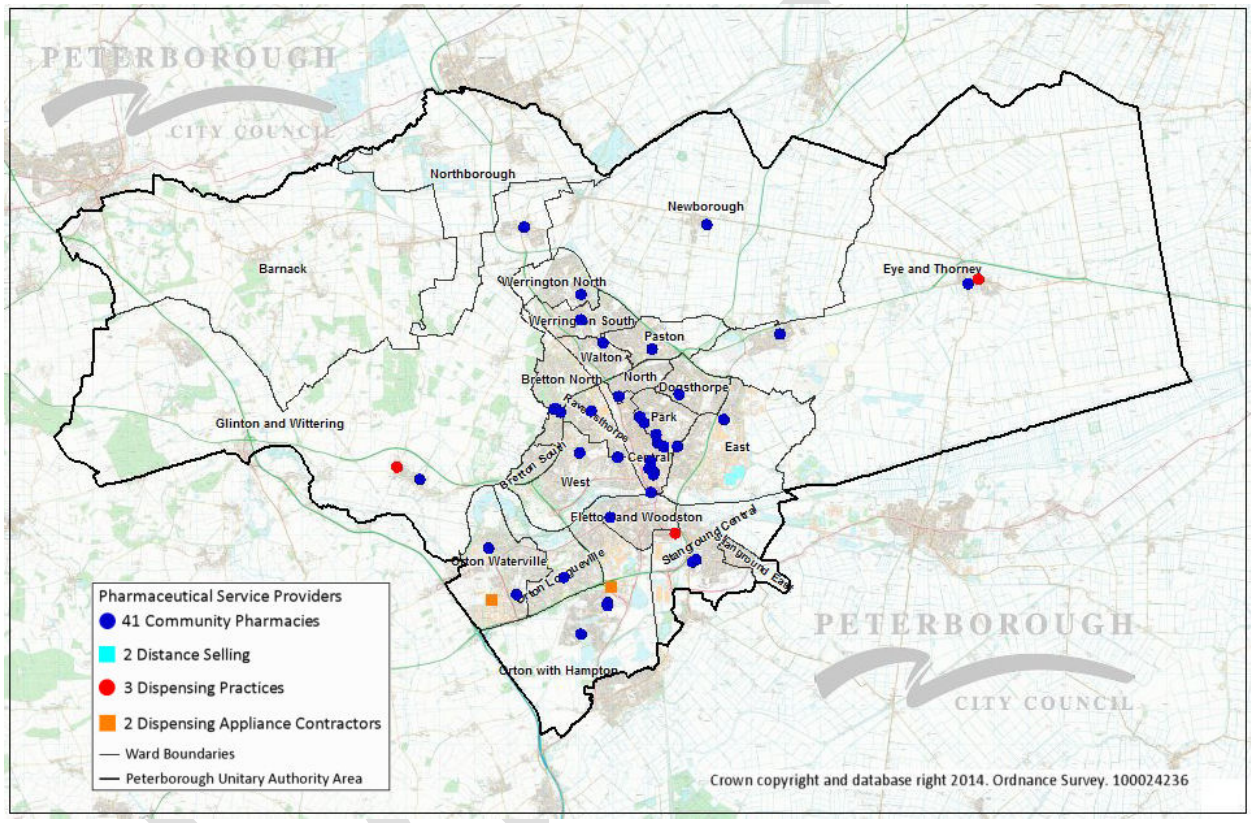
The Equality Act 2010[34] makes it unlawful to discriminate against people with protected characteristics, which are outlined as age, disability, gender reassignment, pregnancy and maternity (including breastfeeding mothers), marriage and civil partnership, race, religion and belief, sex and sexual orientation. This PNA has covered pharmaceutical service related health needs for all specified characteristics except gender reassignment, religion/belief and sexual orientation, of which no unique needs were identified.

[34] Equality Act 2010: https://www.gov.uk/equality-act-2010-guidance Accessed December 2014

6 Current Pharmaceutical Service Provision

There are currently 43 community pharmacies including two distance selling pharmacies. There are also three dispensing practices and two dispensing appliance contractors in Peterborough. A list of all pharmaceutical service providers and their locations is provided in Appendix 1. Map 2 shows the distribution across Peterborough.

Map 2: Pharmaceutical service providers in Peterborough, 2014



Source: NHS England

6.1 Community Pharmacies

Peterborough has 1 pharmacy per 4,381 people (43/188,373) which is equivalent to 23 pharmacies per 100,000 population. If the three dispensing practices are included the ratio rises to 24 per 100,000 population, which is above both national (22 per 100,000) and East of England region (20 per 100,000) averages[35].

[35] http://www.hscic.gov.uk/catalogue/PUB12683/gen-pharm-eng-200304-201213-rep.pdf p. 29 Date accessed: October 2014

6.2 Internet/distance selling pharmacies

Online pharmacies, Internet pharmacies, or Mail Order Pharmacies are pharmacies that operate over the Internet and send orders to customers through mail or shipping companies. The *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (Regulation 64)* detail a number of conditions for distance selling pharmacies which include:

- Must not offer to provide pharmaceutical services, other than directed services, to persons who are present at the listed chemist premises.
- The listed chemist premises must not be on the same site or in the same building as the premises of a provider of primary medical services with a patient list.
- In the case of pharmacy premises, the pharmacy procedures for the premises must be such as to secure the uninterrupted provision of essential services, during the opening hours of the premises, to persons anywhere in England who request those services.
- Safe and effective provision of essential services without face to face contact between any person receiving the services, whether on their own or on someone else's behalf.

6.3 Dispensing appliance contractors

Appliance contractors provide services to people who need appliances such as stoma and incontinence care aids, trusses, hosiery, surgical stockings and dressings. They do not supply drugs.

6.4 Dispensing Practices

These are providers of primary medical services who provide pharmaceutical services[36] from medical practice premises in the area of NHS England. Provision for doctors to provide pharmaceutical services in certain circumstances has been made in various NHS Acts and Regulations since 1920s[37]. These circumstances are in summary:

- a patient proves that they would have serious difficulty in obtaining any necessary drugs or appliances from an NHS pharmacy by reason of distance or inadequacy of means of communication (colloquially known as the "serious difficulty" test which can apply anywhere in the country); or
- a patient is resident in an area which is rural in character, known as a controlled locality, at a distance of more than one mile (1.6 km) from pharmacy premises (excluding any distance selling premises). The pharmacy premises do not have to be in a controlled locality.

[36] The term *pharmaceutical services* used in the context of the provision services by a medical practitioner means the dispensing of drugs and appliances but not the other pharmaceutical services that contractors on a pharmaceutical list would provide.
[37] Department of health (2012) Regulations under the Health Act 2009: Market entry by means of Pharmaceutical Needs Assessments: Dispensing doctors provision

6.5 Other Pharmaceutical Services

These section briefly describes institutions within Peterborough that provide pharmaceutical services. However they are out of the PNA scope and therefore are not discussed any further.

6.5.1 Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT)

The Peterborough and Stamford Hospitals NHS Foundation Trust runs the Peterborough City Hospital. The trust has a pharmacy team responsible for ensuring the safe, appropriate and cost-effective use of medicines, dispensing medication and advising patients about the medicines they have been prescribed. They work collaboratively with other health care professionals including medical and nursing staff and the various therapy professions to devise the most appropriate drug treatment for patients. Other pharmaceutical services provided by the team include:

- In-patient, out-patient and take home dispensing.
- Controlled drugs dispensing.
- Preparation of sterile and non-sterile products, including chemotherapy and intravenous nutrition.
- Formulary implementation and maintenance.
- Procurement and supply of drugs from the main pharmacy stores.
- A hospital ward based pharmacy service.

6.5.2 Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) is responsible for the provision of mental health services, statutory social care services, children's community services and learning disability care in Cambridgeshire and Peterborough. The trust has a pharmacy team whose responsibilities are to provide:

- Accurate and independent information and education about medicines to other healthcare professionals, service users and carers.
- Clinical and dispensing activities to facilitate the management of medicines by service users within inpatient and community teams
- Support to ensure that medicines management resources are used cost effectively within CPFT.

6.5.3 Prison Services

HMP Peterborough is a private dual-purpose prison managed by Sodexo Justice Services, housing both male and female prisoners. It has an operational capacity of over 1,000 places including a 12 place mother and baby unit. As of November 2014 there were 952 prisoners, 86 of whom are Peterborough residents. There are approximately 340 substance misuse clients undergoing treatment at the prison. The prison receives pharmaceutical supplies from Boots Pharmacy, Bretton Centre.

6.5.4 Care homes

There are 18 care homes registered in Peterborough.[38] All homes are scrutinised by Care Quality Commission inspectors who regulate medications management. Clinical services are provided by General Practitioners, who write NHS prescriptions for medicines, which are then dispensed by community pharmacies or dispensing doctors.

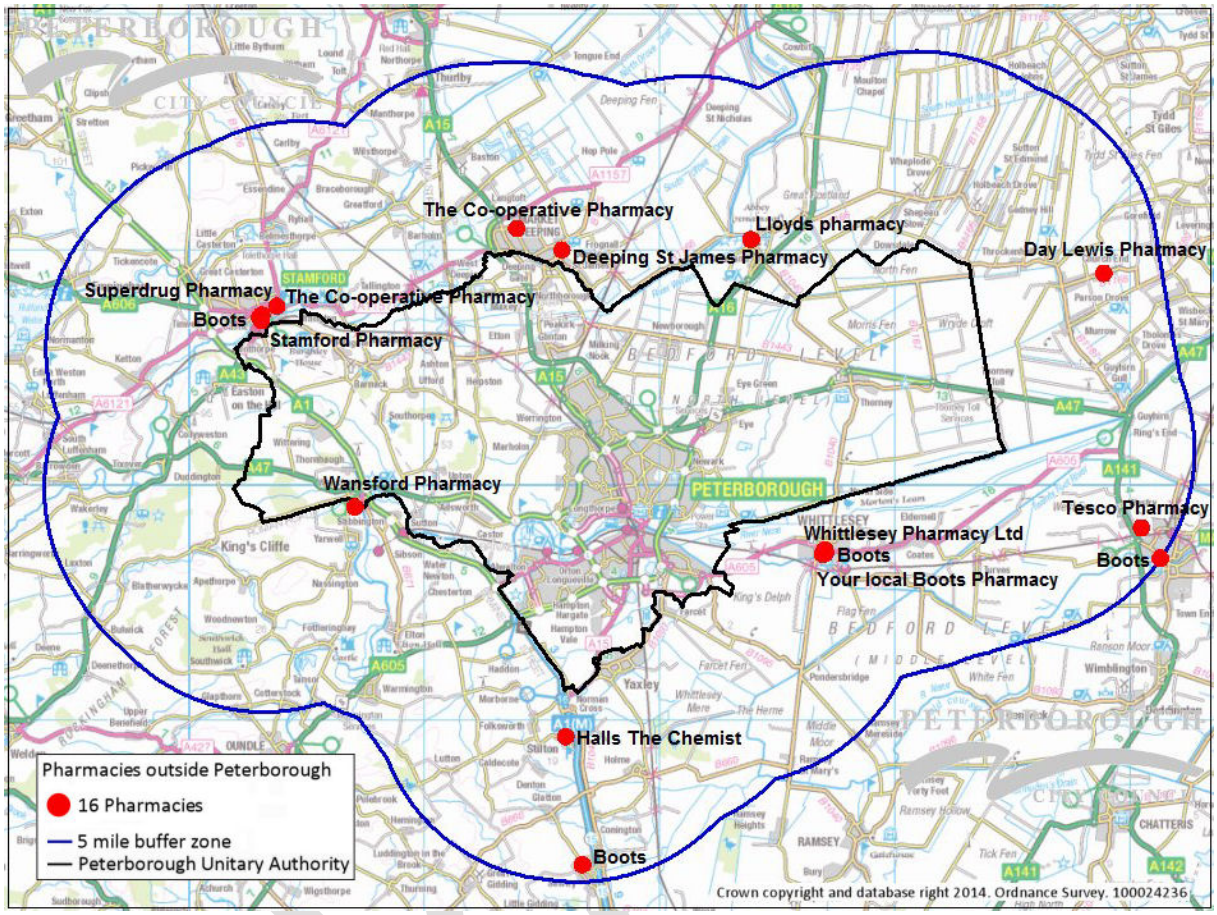
6.5.5 Cross-border NHS Services

Residents of Peterborough living close to the border with other local authorities have the option of accessing services from pharmacies across the border. Map 3 below shows the pharmacies near the Peterborough boundaries.

Residents in the north, north east and west of NHS Peterborough could choose to use pharmacies in Crowland, Market Deeping & Stamford (Lincolnshire) or Wansford (Northamptonshire). While residents in the south and east have the option of using pharmacies in Whittlesey or Yaxley (Cambridgeshire). This complements services available within Peterborough and increases the opportunity for patient choice.

[38] http://www.carehome.co.uk/care_search_results.cfm/searchunitary/Peterborough/
Date accessed: October 2014

Map 3: Pharmacies near the Peterborough border



Source: NHS England

6.6 Community Pharmacy Opening hours

Pharmacy opening hours include 'core hours'[39] and 'supplementary hours'[40]. Although supplementary hours may be varied by giving three months' notice to NHS England, core hours are only changeable when due process is followed and a formal request is granted. Public holiday opening hours are largely serviced by voluntary opening arrangement. Bank Holidays such as Christmas Day and Easter Sunday are covered by a voluntary commissioned service by NHS England, for which an additional payment is made to the contractor.

Of the 43 community pharmacies in Peterborough five (12%) have a 100 core hour contracts (Table 10) with the remaining 38 having standard 40 hour contracts (Map 4). This does not preclude pharmacies with 40 hour contracts opening for longer under supplementary hours. All the 100 hour pharmacies are located within the densely populated urban sector.

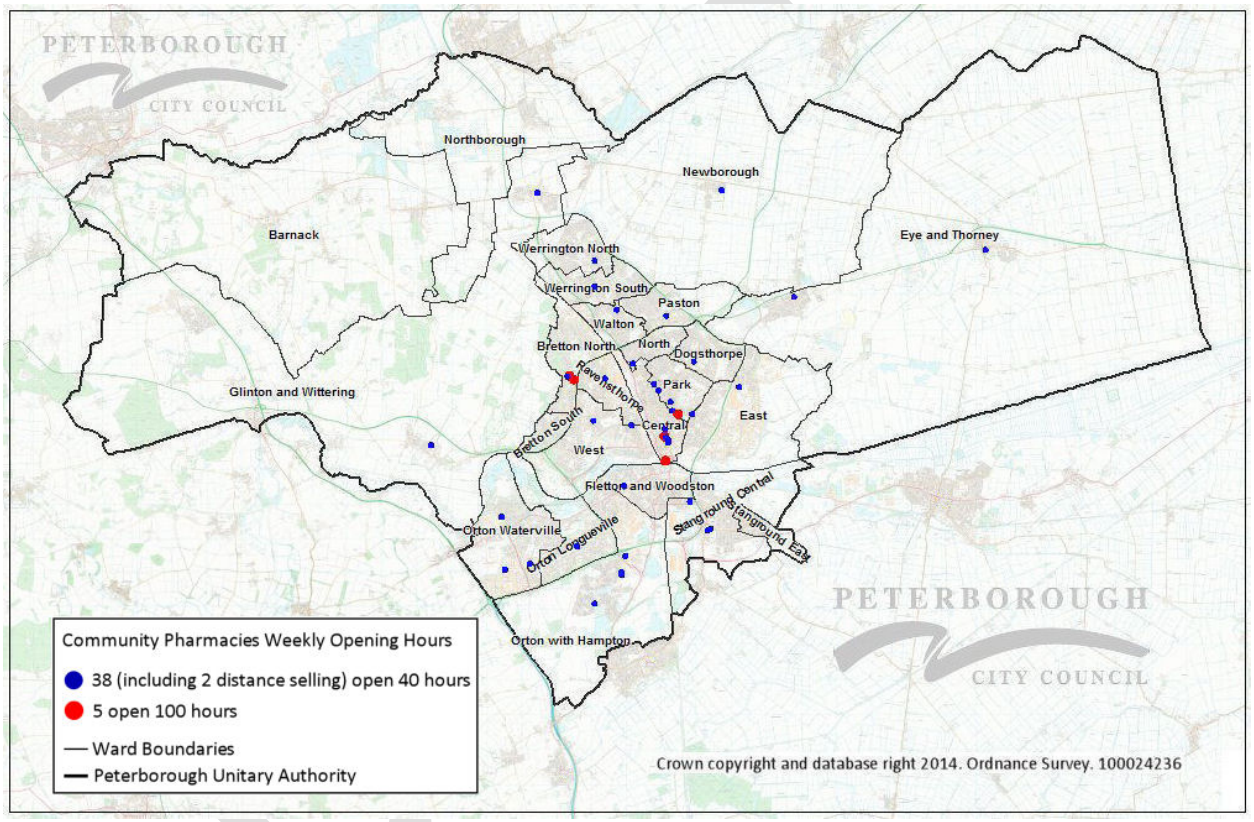
[39] Those hours a pharmacy is formally contracted to provide NHS pharmaceutical services
[40] Additional hours a pharmacy opens beyond their core hours

Table 10: Pharmacies with 100 hours core contracts in Peterborough.

Name of Pharmacy	Address & Postcode	
MI Pharmacy (Park Road Branch)	164 Park Road	PE1 2UF
Boots UK Limited	Unit 2, Bretton Centre	PE3 8DN
Sainsbury's Pharmacy	Sainsbury's, Bretton	PE3 8DA
Asda Pharmacy	West Rivergate Shopping Centre	PE1 1ET
Pharmacy First	2 North Street	PE1 2RA

Source: NHS England

Map 4: Peterborough pharmacies by core-hour contract types (40 and 100 hours)



Source: NHS England

6.7 Access to community pharmacies

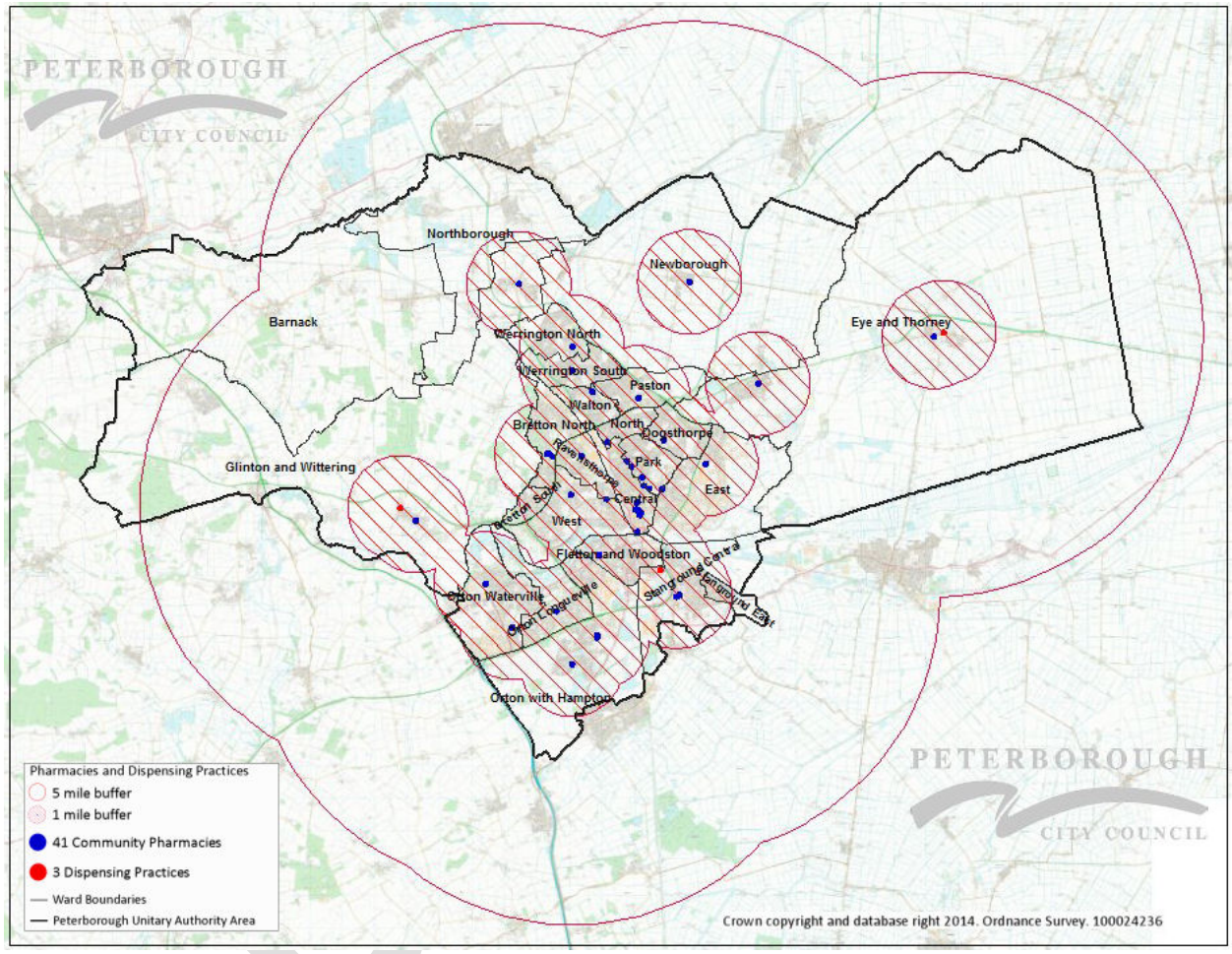
The 2008 White Paper *Pharmacy in England: Building on strengths – delivering the future* states that it is a strength of the current system that community pharmacies are easily accessible, and that 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport.[41] Using simple "as the crow flies" parameters of one and five miles to represent the distance walked and driven respectively within 20 minutes, we have mapped the areas of Peterborough we consider to have "access" to a community pharmacy at a given time. Distance selling pharmacies are excluded in the counts as they do not serve patients at their premises.

[41] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228858/7341.pdf
Date accessed: November 2014

6.7.1 Pharmacy Access on Weekdays

Map 5 shows that during weekdays normal opening hours almost the entire area of Peterborough is within five miles of an open pharmacy. Within the major populations centres this distance is reduced to one mile. This implies that most residents in Peterborough can get to a pharmacy within 20 minutes travel time during weekdays.

Map 5: Areas of Peterborough within one and five miles of a pharmacy open on weekdays (including dispensing practices)

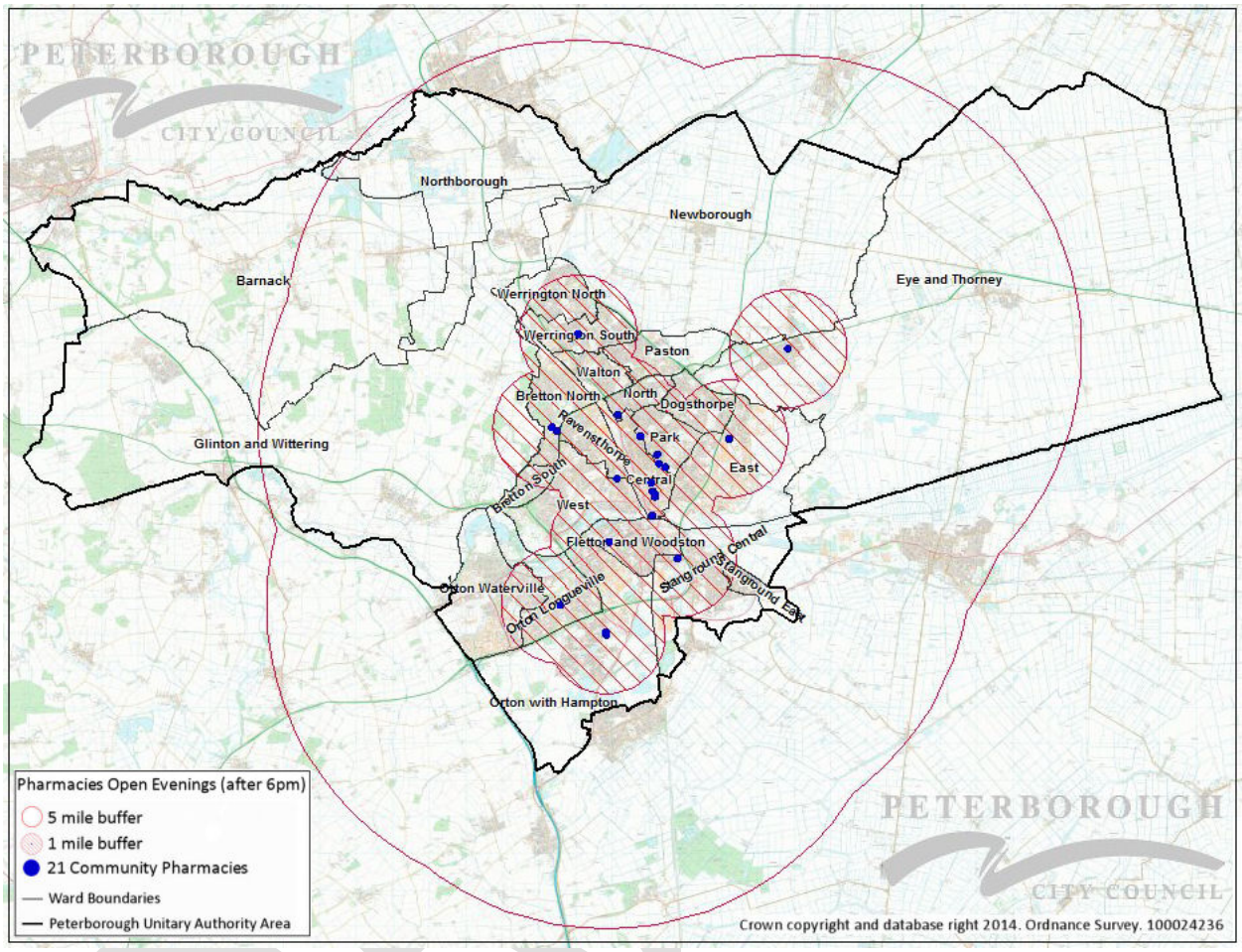


Source: NHS England

6.7.2 Out of Hours Services

Out of Hours are defined as hours between 18:30 and 08:00 Monday to Friday and 24 hours Saturday, Sunday and Bank holidays when GP practices are expected to be closed. Map 2 shows that in the evenings (after 6 pm) more than three quarters of Peterborough is within five miles of an open pharmacy while in major population centres this is reduced to one mile. A total of 21 pharmacies (53%) are open in the evenings (Map 6) (Appendix 2).

Map 6: Areas of Peterborough within one and five miles of a pharmacy open in the evenings (after 6 pm).



Source: NHS England

Dispensing practices

The three dispensing practices in Peterborough are open in the evenings on some days of the week. Table 11 shows the days of the week when they are open.

Table 11: Peterborough dispensing practices open in the evenings (after 6 pm)

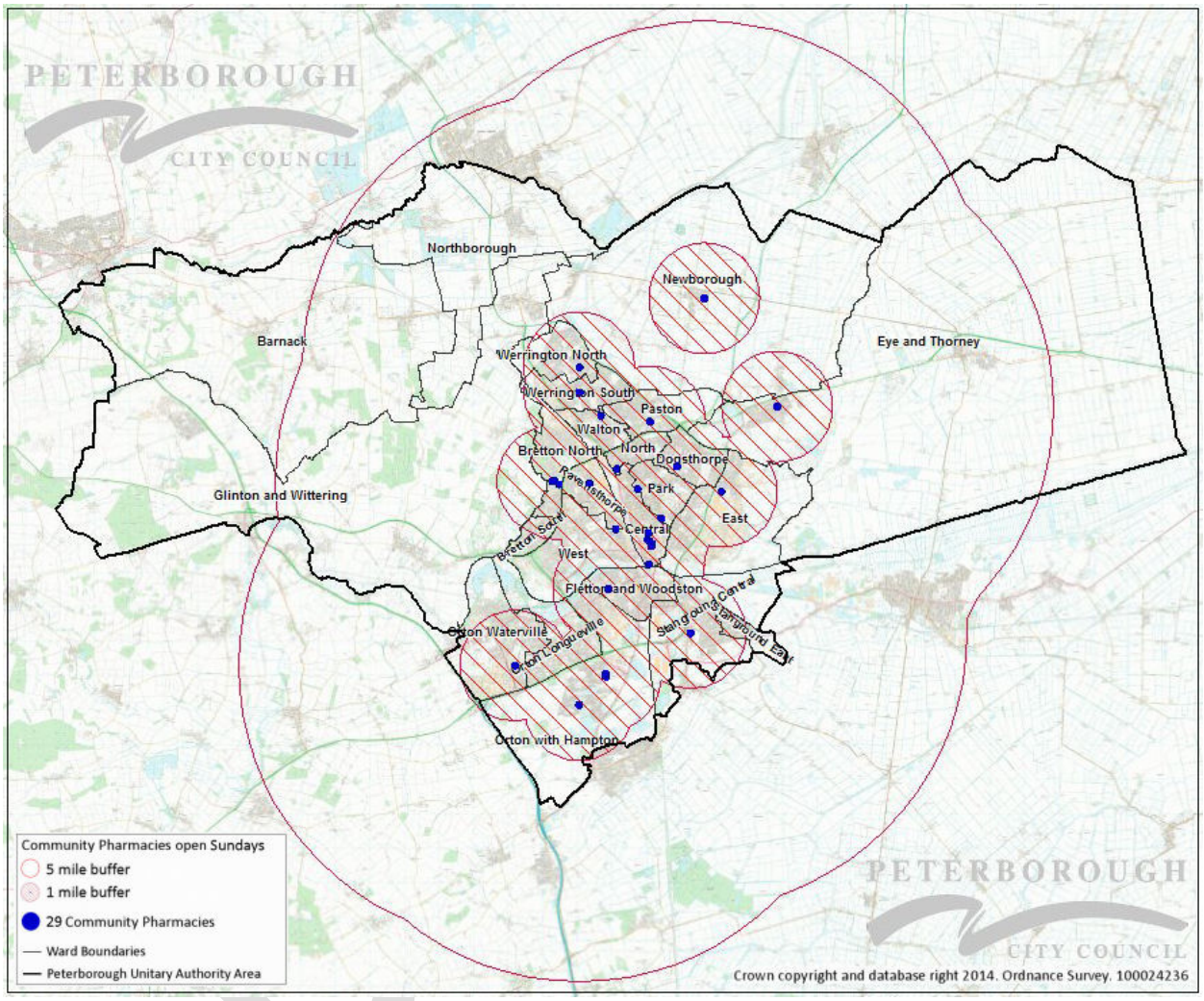
Practice Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Ailsworth Medical Centre	√	√	x	√	√	x	x
Old Fletton Surgery	√	x	x	x	x	x	x
Thorney Medical Centre	√	√	√	x	√	x	x

Source: NHS Choices

√ Open
X Not open

Map 7 shows that on Saturdays more than three quarters of Peterborough is within five miles of an open pharmacy while in major population centres this is reduced to one mile. A total of 29 pharmacies (71%) are open on Saturdays (Appendix 3).

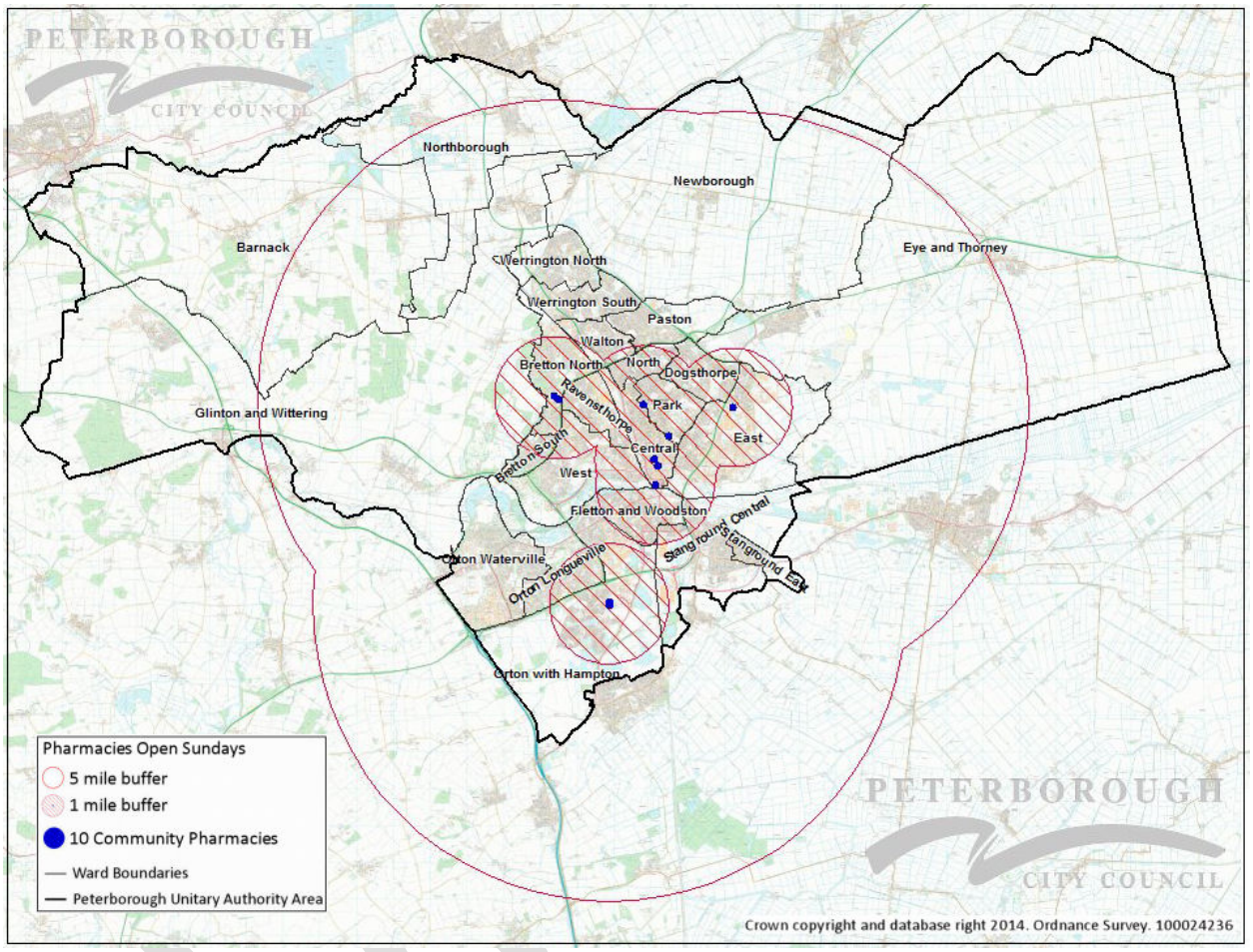
Map 7: Areas of Peterborough within one and five miles of a pharmacy open on Saturdays.



Source: NHS England

Map 8 shows that on Sundays more than three quarters of Peterborough is within five miles of an open pharmacy while in all major population centres this reduced to one mile. A total of 10 pharmacies (24%) are open on Sundays (Table 12).

Map 8: Areas of Peterborough within one and five miles of a pharmacy open on Sundays.



Source: NHS England

Table 12: Pharmacies open on Sundays in Peterborough

Pharmacy Name	Address & Postcode	
Tesco Instore Pharmacy	Serpentine Green, Hampton Hargate	PE7 8BD
Pharmacy First	2 North Street	PE1 2RA
Sainsbury's Pharmacy	Sainsbury's Superstore, Oxney Road	PE1 5NG
MI Pharmacy (Park Road Branch)	164 Park Road	PE1 2UF
Boots UK Limited	Unit 2, Bretton Centre	PE3 8DN
Boots UK Limited	Queensgate Centre	PE1 1NW
Sainsbury's Pharmacy	Sainsbury's, Faxland, Bretton	PE3 8DA
Asda Pharmacy	West Rivergate Shopping Centre	PE1 1ET
Millfield Pharmacy	387 Lincoln Road	PE1 2PF
Boots UK Limited	Unit 2, Serpentine Green	PE7 8BE

Source: NHS England

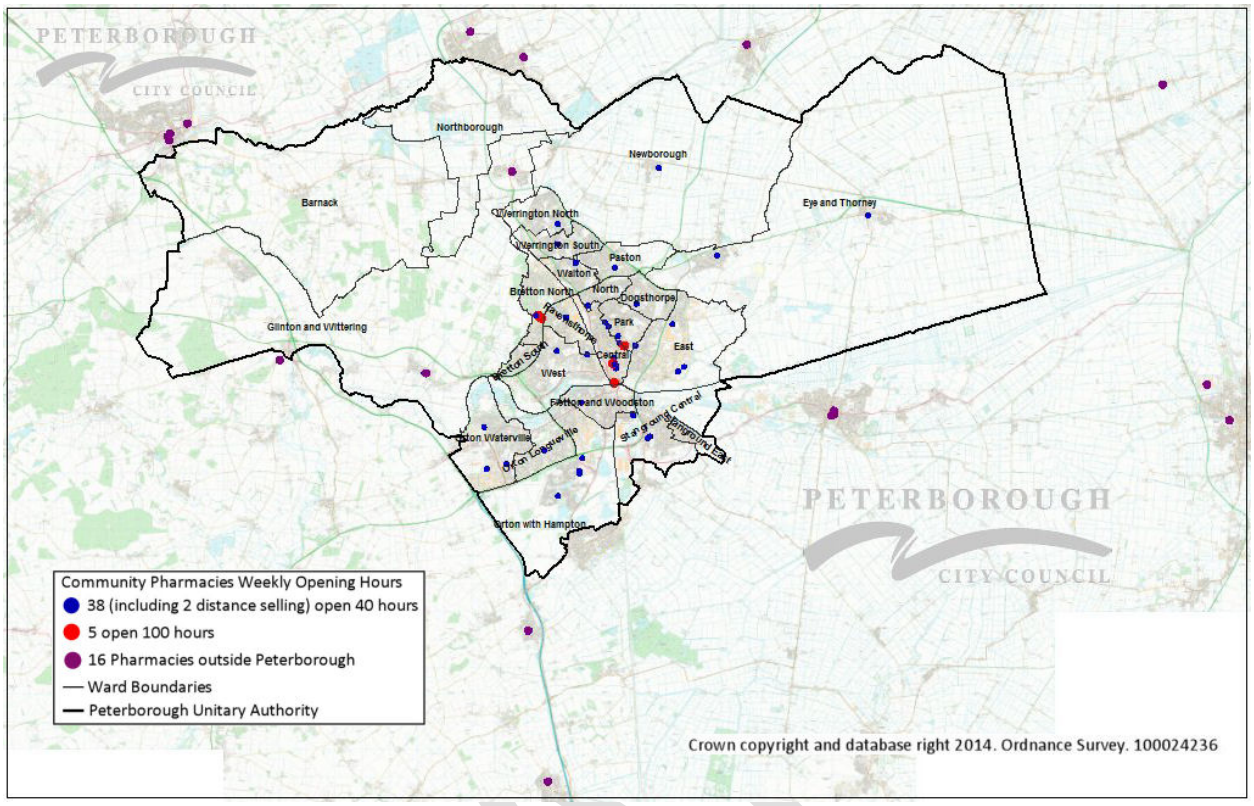
6.7.3 Outlying Wards

Parts of Barnack, Northborough, Eye & Thorney and Glinton and Wittering wards are outside the five mile radius access to a pharmacy in the evenings, Saturdays and Sundays. We were not able to assess travel time due to lack of appropriate software. However based on the 2011 PNA travel time calculations (CACI InSite Software)[42] the maximum journey time to a pharmacy from this areas is 10 minutes by car and 19 minutes by bus. We have also examined current rural public transport provision and noted that it is sufficient apart from Sunday when there are no buses operating from Barnack, Wittering and Newborough. However Census data (2011)[43] shows that car ownership is higher in rural areas as compared to urban areas and therefore reliance on public transport is low. East of England which includes Peterborough has the third highest (89.3%) car ownership rate nationally. Furthermore patients in these areas have access to nearby pharmacies across the border (Map 9).

Map 9: Peterborough and neighbouring community pharmacies

[42] http://www.caci.co.uk/products/product/insite Date accessed: October 2014

[43] http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/rural-urban-analysis/comparing-rural-and-urban-areas-of-england-and-wales.html Date accessed: October 2014



Source: NHS England

6.8 NHS Pharmaceutical Service Provision

This section provides further details on the provision of NHS pharmaceutical services as defined in the Community Pharmacy Contractual Framework. While it is recognised that dispensing doctors' practices provide valuable services to their registered dispensing patients, these services are limited by statue to the dispensing of prescriptions only. Community Pharmacies provide three tiers of pharmaceutical services, defined in the Regulations:[44]

- Essential services – services all pharmacies are required to provide.
- Advanced services – services to support patients with safe use of medicines.
- Enhanced services

Locally commissioned public health services are an important part of the contribution community pharmacy makes to the health and wellbeing of the population. Although not part of the Community Pharmacy Contractual Framework, these are also presented in this section.

6.8.1 Essential service provision

[44] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/349/made Date accessed: October 2014

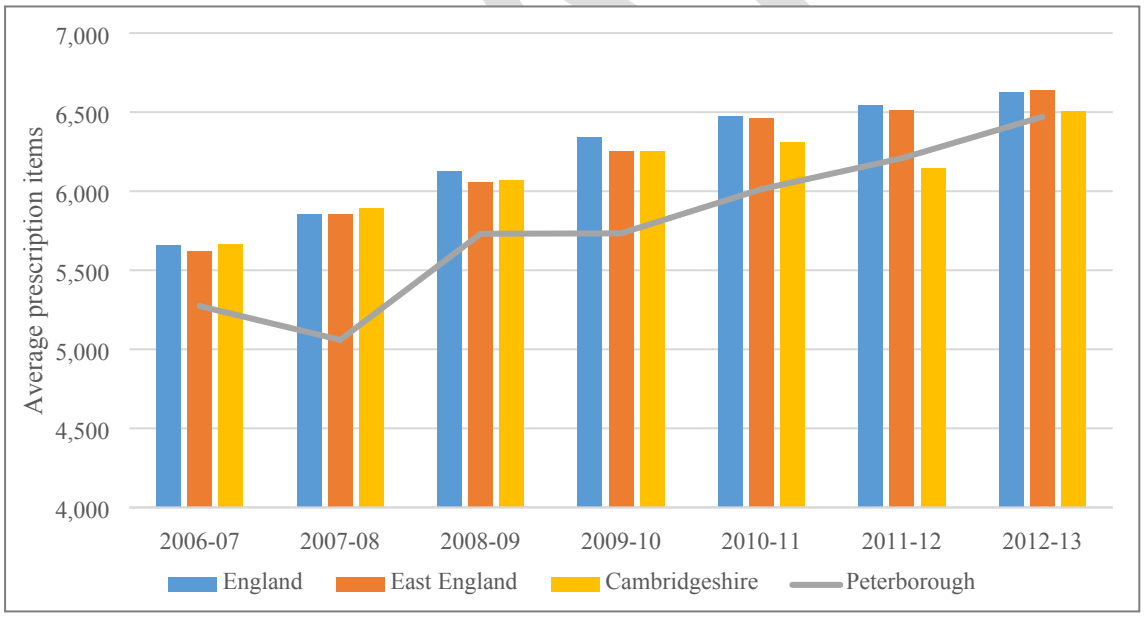
Essential services are specified by a national contractual framework and all community pharmacies are required to provide all the essential services. NHS England is responsible for ensuring that all pharmacies deliver essential services as specified.

Dispensing of Medicines

This is described as the safe supply of medicines. Advice is given to the patient about the medicines being dispensed and how to use them. Records are kept of all medicines dispensed and significant advice provided, referrals and interventions made.

The average number of prescription items dispensed per month per pharmacy in Peterborough has been rising since 2006-07. Peterborough's number of prescription items has been consistently lower than the England, East England and its neighbour's -Cambridgeshire (except for 2011-12). In 2012-13 an average of 278,000 items per month were dispensed which is equivalent to 6,509 per pharmacy (Figure 6).

Figure 6: Community pharmacies average prescription items dispensed per month per pharmacy, 2006-07 to 2012-13



Source: NHS Prescription Services part of the NHS Business Services Authority

Dispensing of Appliances

This is described as the safe supply of appliances. Advice is given to the patient about the appliance being dispensed and how to use it. Records are kept of all appliances dispensed and significant advice provided, referrals and interventions made where appropriate.

NHS Repeat Dispensing

This is the management of repeat medication for up to one year, in partnership with the patient and prescriber. Usually the patient returns to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient's need for a repeat supply of a particular medicine.

Clinical governance

Pharmacies are required to have a system of clinical governance to support the provision of excellent care; requirements include:

- Provision of a practice leaflet for patients
- Use of standard operating procedures
- Patient safety incident reporting to the National Reporting and Learning Service
- Conducting clinical audits and patient satisfaction surveys
- Having complaints and whistle-blowing policies
- Acting upon drug alerts and product recalls to minimise patient harm
- Having cleanliness and infection control measures in place

Public Health (promotion of healthy lifestyle)

Each year pharmacies are required to participate in up to six campaigns at the request of NHS England. This involves the display and distribution of leaflets. In addition, pharmacies are required undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.

Disposal of unwanted medicines

Pharmacies are obliged to accept back unwanted medicines from patients and to safely dispose them.

Signposting

Pharmacy staff are required to refer patients to other healthcare professionals or care providers when appropriate. The service also includes referral on to other sources of help such as local or national patient support groups.

Supporting self-care

Pharmacy staff are required to provide advice and support to patients to enable them derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service.

6.8.2 Advanced Service Provision

There are four Advanced Services within the NHS community pharmacy contract. Community pharmacies can opt to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions. Pharmacies are required to seek approval from NHS England before providing these services, are required to have an appropriate consultation area and have a pharmacist who has been accredited to provide the service.

Medicines Use Reviews (MURs)

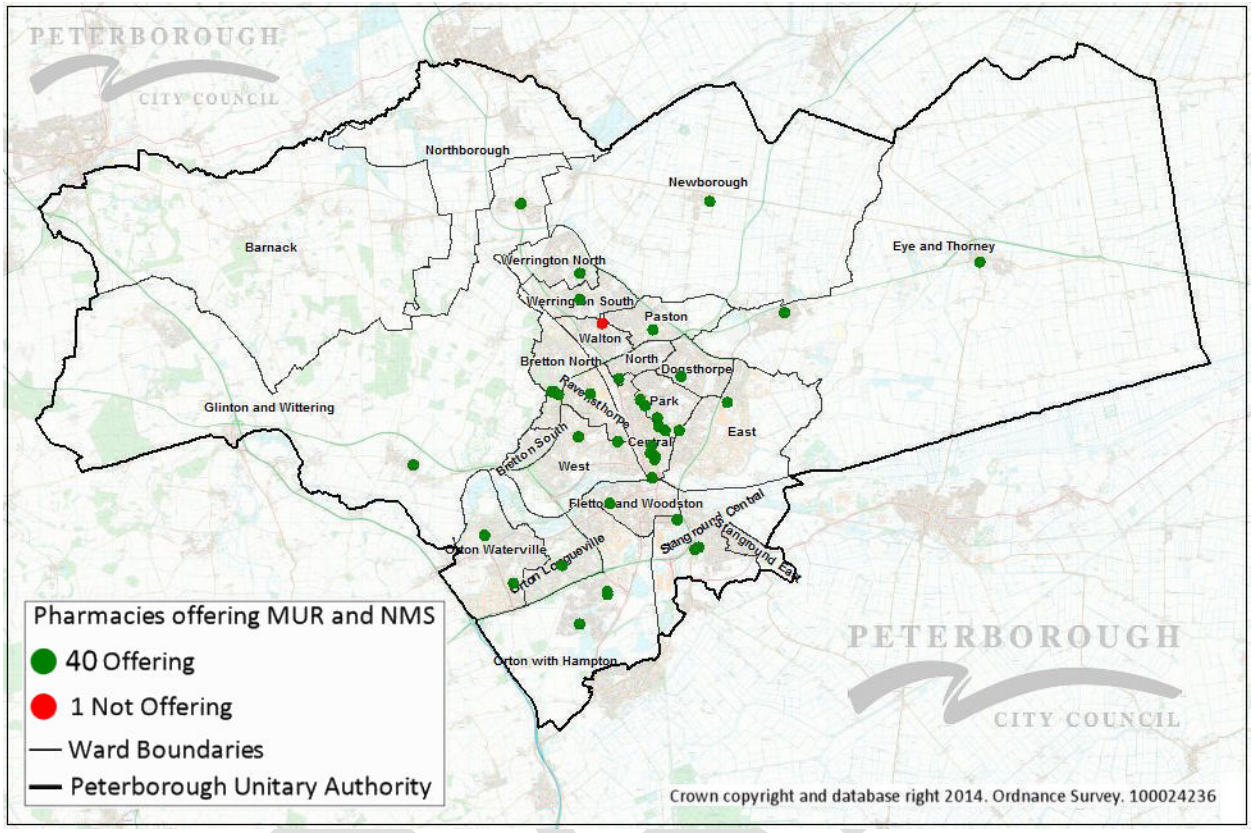
The Medicines Use Review (MUR) consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions.

National target groups have been agreed in order to guide the selection of patients to whom the service will be offered. The MUR process attempts to establish a picture of the patient's use of their medicines – both prescribed and non-prescribed. The review helps patients understand their therapy and identifies any problems and possible solutions.[45]

Nearly all (40/41) community pharmacies (excluding distance selling who don't provide any advanced service) in Peterborough currently provide MUR services (Map 10). The average number of MURs per pharmacy has been rising over years. In 2012-13 Peterborough had a higher average than the England, East of England and Cambridgeshire averages (Figure 7)

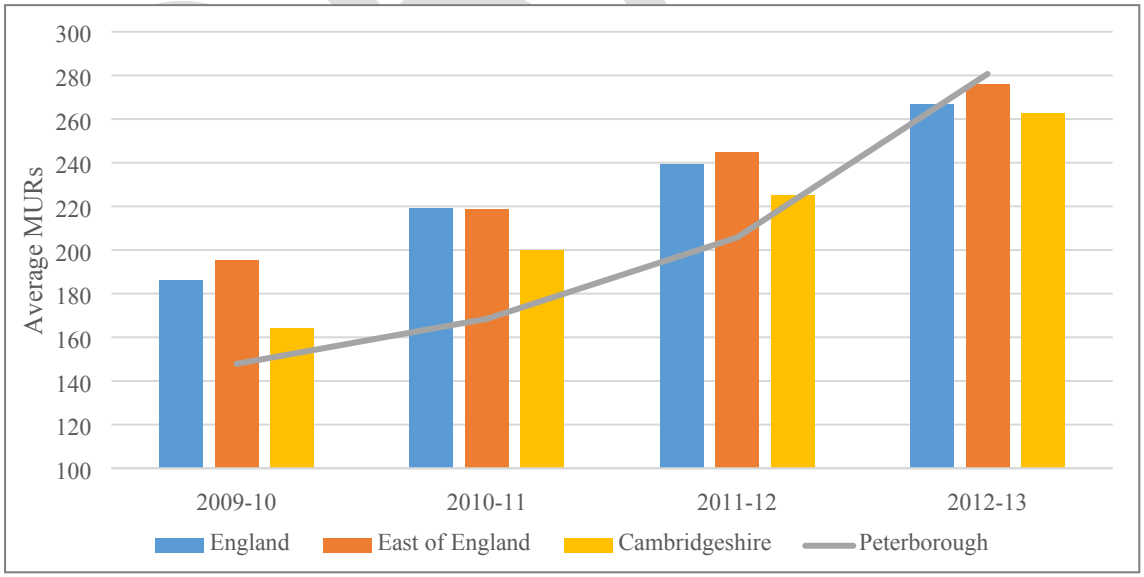
[45] Pharmaceutical Services Negotiating Committee (2013) MUR Service Specification August 2013 http://psnc.org.uk/services-commissioning/advanced-services/murs/ Date accessed: October 2014

Map 10: Pharmacies Offering MUR & NMS in Peterborough, 2014



Source: NHS England

Figure 7: Average medicine use reviews per pharmacy 2009-10 to 2012-13



Source: NHS Prescription Service

The nationally agreed upper limit for MURs is 400 per year, with pharmacies being reimbursed £28 for each conducted MUR. In 2013/14 period a total of 11,970 MURs were conducted in Peterborough. Twenty three pharmacies conducted at least 300 MURs i.e. 75% of their possible allocation.

Three national target groups for MURs were:

- Patients taking high risk medicines
- Patients recently discharged from hospital who had changes made to their medicines while they were in hospital
- Patients with respiratory disease.

At least 50% of all MURs undertaken by each pharmacy should be on patients within these target groups. This target is due to change before 2015 to 70% and will also include patients with cardiovascular related conditions.

New Medicine Service

The New Medicine Service (NMS) was added to the NHS community pharmacy contract in 2011. The service provides support for people with long-term conditions with newly prescribed medicine to help improve medicine adherence.

Nearly all (40/41) pharmacies in Peterborough currently provide NMS (Map 10). The average number of NMS per pharmacy in 2012-13 was 70 in Peterborough which was higher than the England, East of England and Cambridgeshire averages (Table 13).

Table 13: Community pharmacies providing New Medicine Services[1], 2012-13[2]

Area	Community pharmacies providing NMS	Percentage of community pharmacies providing NMS	Total NMS	Average NMS per community pharmacy
England	9,464	82.3	647,859	68
East of England	981	85.5	67,149	68
Cambridgeshire	96	88.1	4,478	47
Peterborough	36	83.7	2,503	70

Source: NHS Prescription Service

1. Includes community pharmacies who provided New Medicines Services during the year but who were not in contract as at 31 March 2013.
2. First full year available.

Appliance Use Reviews (AURs)

Appliance Use Review (AUR) aim at improving the patient's knowledge and use of a 'specified appliance' by:

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

This Advanced Service is primarily provided by DACs. However, the service can be provided by pharmacies that normally provide the specified appliances in the normal course of their business as long as they meet the conditions of service.[46]

In 2010-11 and 2012-13 Peterborough's average numbers of AURs per pharmacy and appliance contractor were higher than the national, regional and Cambridgeshire's averages (Table 14). However it is important to note that DACs supply appliances across the country and therefore the high rate is not reflective of the demand in Peterborough.

Table 14: Community pharmacies and appliance contractors providing Appliance Use Reviews, 2010-11 to 2012-13

Area	Number of community pharmacy and appliance contractors providing AUR services			% of community pharmacy and appliance contractors providing AUR services			Average AUR's per community pharmacy and appliance contractor		
	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13
England	100	117	143	0.9	1	1.2	152	156	197
East of England	10	8	14	0.9	0.7	1.2	236	184	377
Cambridgeshire	1	1	2	1	0.9	1.8	3	1	22
Peterborough	2	0	3	4.7	0	6.7	533	0	1,124

Source: NHS Prescription Service

Stoma Appliance Customisation (SAC) Service

Stoma Appliance Customisation (SAC) service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff.[47]

As with AUR the SAC service is aimed at DACs, but again can be provided by pharmacies that normally provide specified appliances in the normal course of their business as long as they meet the conditions of service[48]

Peterborough has consistently been the highest provider of SAC services nationally. In 2012-13 an average of 52,137 SACs per provider (6 in total) were done as compared to national and regional averages of 635 and 2,513 respectively (Table 15). However SACs supply appliances nationally and therefore the high rate is not reflective of the demand in Peterborough.

[46] Pharmaceutical Services Negotiating Committee http://psnc.org.uk/services-commissioning/advanced-services/aurs/#conditions Date accessed: November 2014
[47] http://www.ppa.org.uk/edt/November_2014/mindex.htm Date accessed: November 2014
[48] Pharmaceutical Services Negotiating Committee http://psnc.org.uk/services-commissioning/advanced-services/sac/ Date accessed: November 2014

Table 15: Community pharmacies and appliance contractors providing stoma customisation services, 2010-11 to 2012-13

Area	Community pharmacy and appliance contractors providing SAC			Percentage of community pharmacy and appliance contractors providing SAC			Average SAC per community pharmacy and appliance contractor		
	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13
England	1,722	1,786	1,761	15.6	15.7	15.2	597	606	635
East of England	136	135	139	12.4	11.9	11.9	2,165	2,423	2,513
Cambridgeshire	21	20	20	20.6	18.2	18.2	537	424	381
Peterborough	5	5	6	11.6	11.4	13.3	54,107	59,914	52,137

Source: NHS Prescription Service

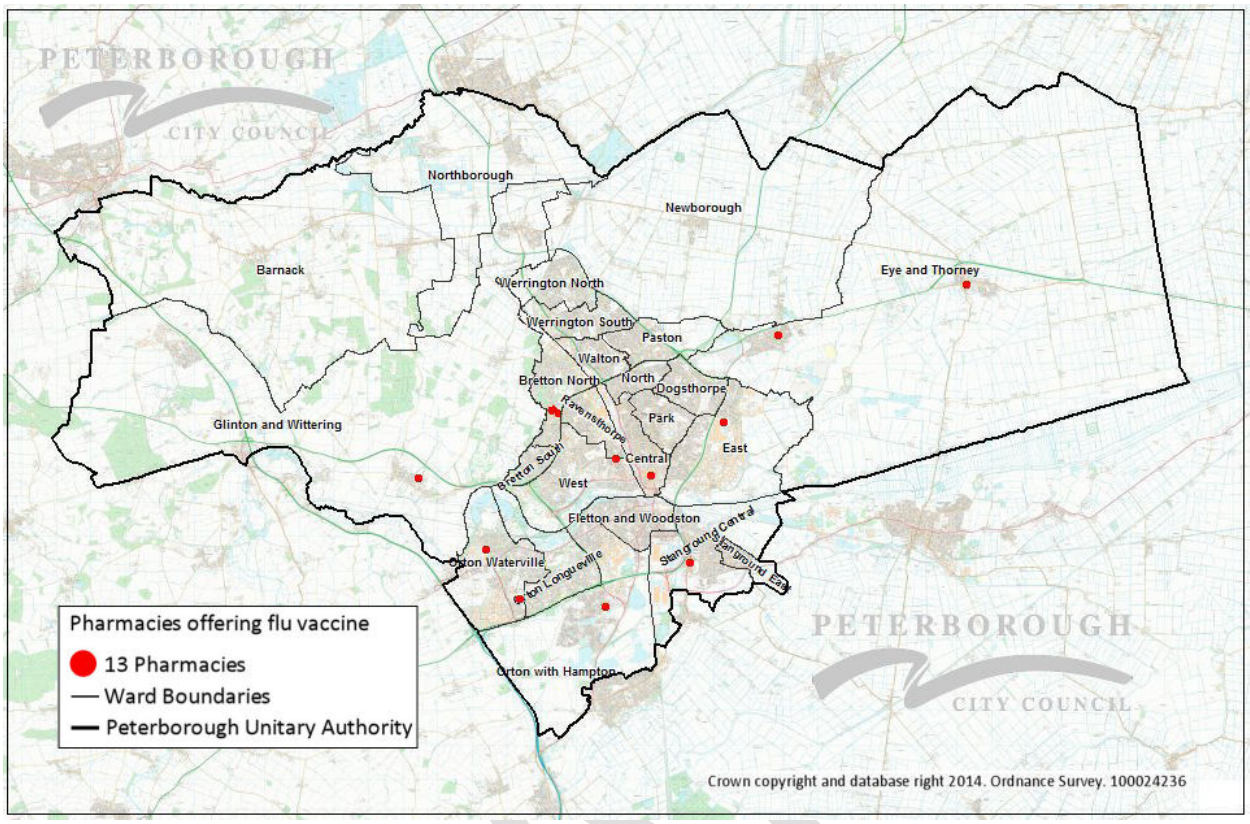
6.8.3 Enhanced Services

The third tier of Pharmaceutical Service that can be provided from pharmacies are the Enhanced Services. These are services that can be commissioned locally from pharmacies by NHS England. These could include anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out-of-hours services. These services can only be referred to as Enhanced Services if they are commissioned by NHS England. If local services are commissioned by CCGs or local authorities, they are referred to as *locally commissioned services.*

NHS Influenza Vaccination Scheme

The NHS Influenza Vaccination Service via Community Pharmacy has been commissioned by the NHS England area team for the 2014-15 season for patients in “At Risk” groups aged 18-64 inclusive, pregnant women and non-professional carers. This is expected to help the local NHS to meet its targets for vaccinations to these at-risk patient groups. It is considered to be vital to help the NHS to protect these patients and their carers from the serious complications that can develop if they contract the flu. There are currently 13 pharmacies providing this service in Peterborough (Map 11).

Map 11: Pharmacies offering flu vaccination for ‘at risk’ groups in Peterborough, 2014



Source: NHS England

6.9 Public Health Locally Commissioned Services

Peterborough City Council commissions pharmacies to provide three public health services namely: Stop Smoking, Needle and Syringe Exchange and Supervised Administration of Medicines.

6.9.1 Stop Smoking Service

There are currently 19 pharmacies offering the service across Peterborough (Map 12) and this is in conjunction with other service providers such as GP practices and the Peterborough Stop Smoking team. Pharmacies facilitate convenient and easy access to stop smoking services due their strategic locations. There were, however, 29 pharmacies offering this service in 2011 and the number of 'smoking quits' attributable to interventions from pharmacies has fallen from 53% of the total in 2010/2011 to 19% in 2013/14. It is recommended that current service providers be audited and supported to improve outcomes. Increasing the number of stop smoking services within existing pharmacies across Peterborough should also be considered if appropriate within the context of local healthcare strategy.

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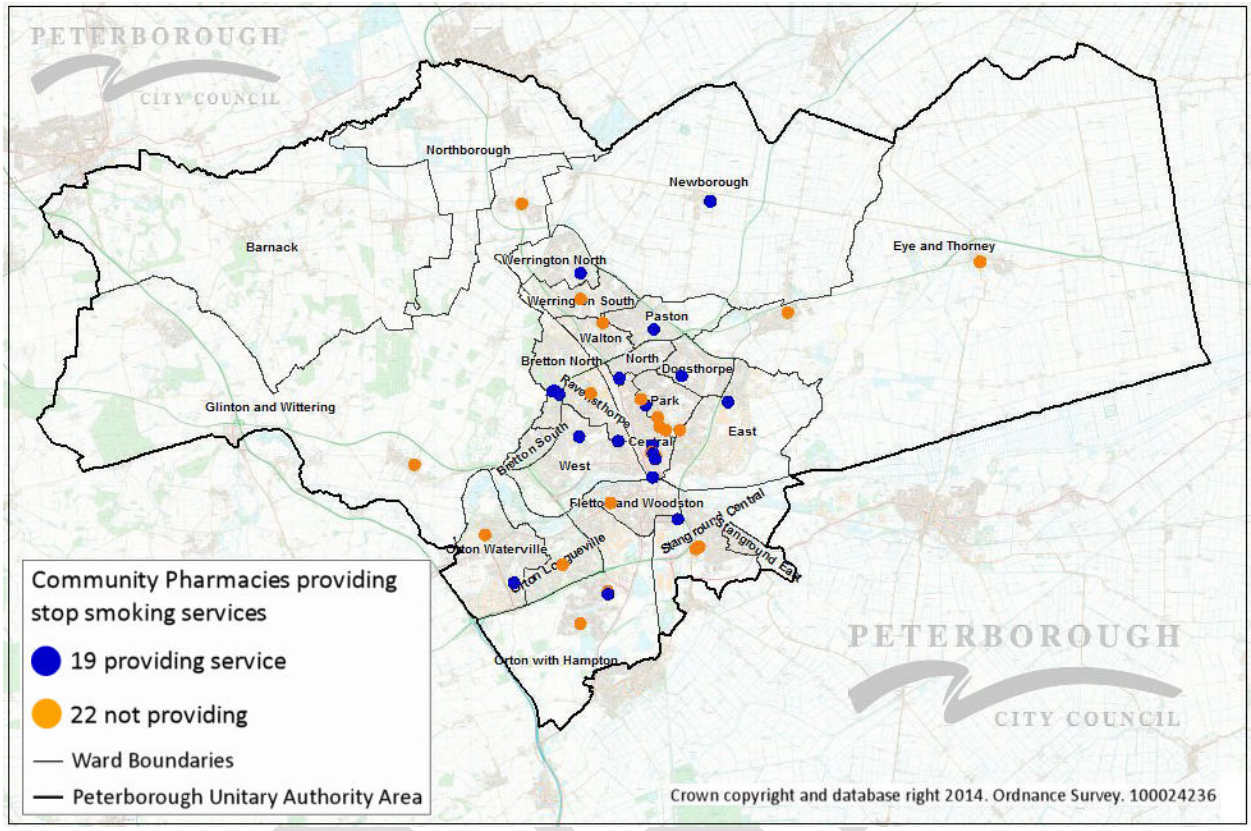
Map 12: Community pharmacies providing stop smoking services in Peterborough



Source: NHS England

6.9.2 Substance Misuse Service

There are currently 32 pharmacies commissioned to provide supervised consumption services and 17 commissioned to provide needle exchange services. Map 13 and 14 show their locations. Commissioners of these services feel the current service coverage in terms of number of providers is consistent with the needs of the local population, however they feel staff within commissioned pharmacies need to participate more in training sessions to enable them support and refer clients for appropriate care as required.

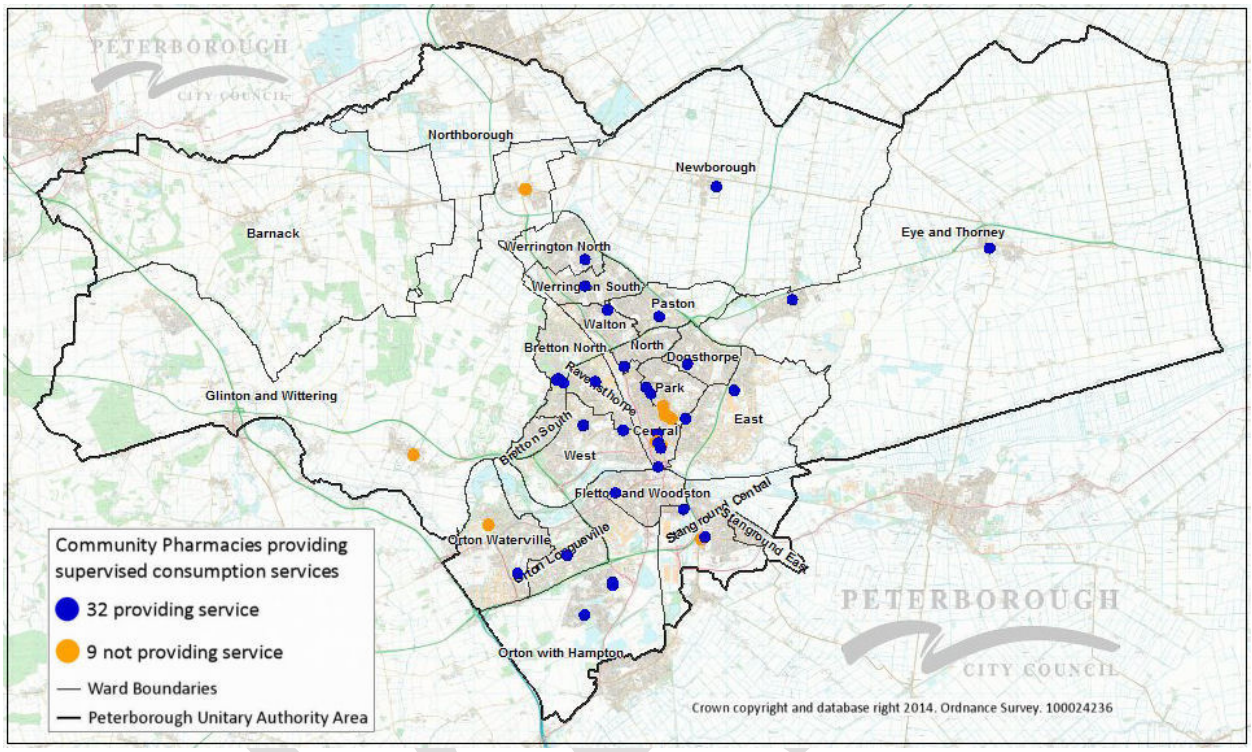
Latest data from Public Health England (2013) show a significant improvement as regards successful completion of treatment for both Opiate and non-Opiate drug users in Peterborough. In 2013 the rate of successful completion for opiate users was 11.3% compared to only 4.6% in 2012. For non-Opiate users the completion rate was 49.2% compared to 41.6% in 2013. The 2013 rates are all significantly higher than the regional and national averages.

Supervised Consumption

The main purpose of this service is to reduce mortality and morbidity risks among high-risk substance users by ensuring adherence to treatment regime. Pharmacies that have been commissioned to provide the service provide support and advice to the client, including referral to primary care or specialist services when

appropriate. They also report missed doses or other behavioural concerns to the prescriber.

Map 13: Community pharmacies providing supervised consumption services in Peterborough



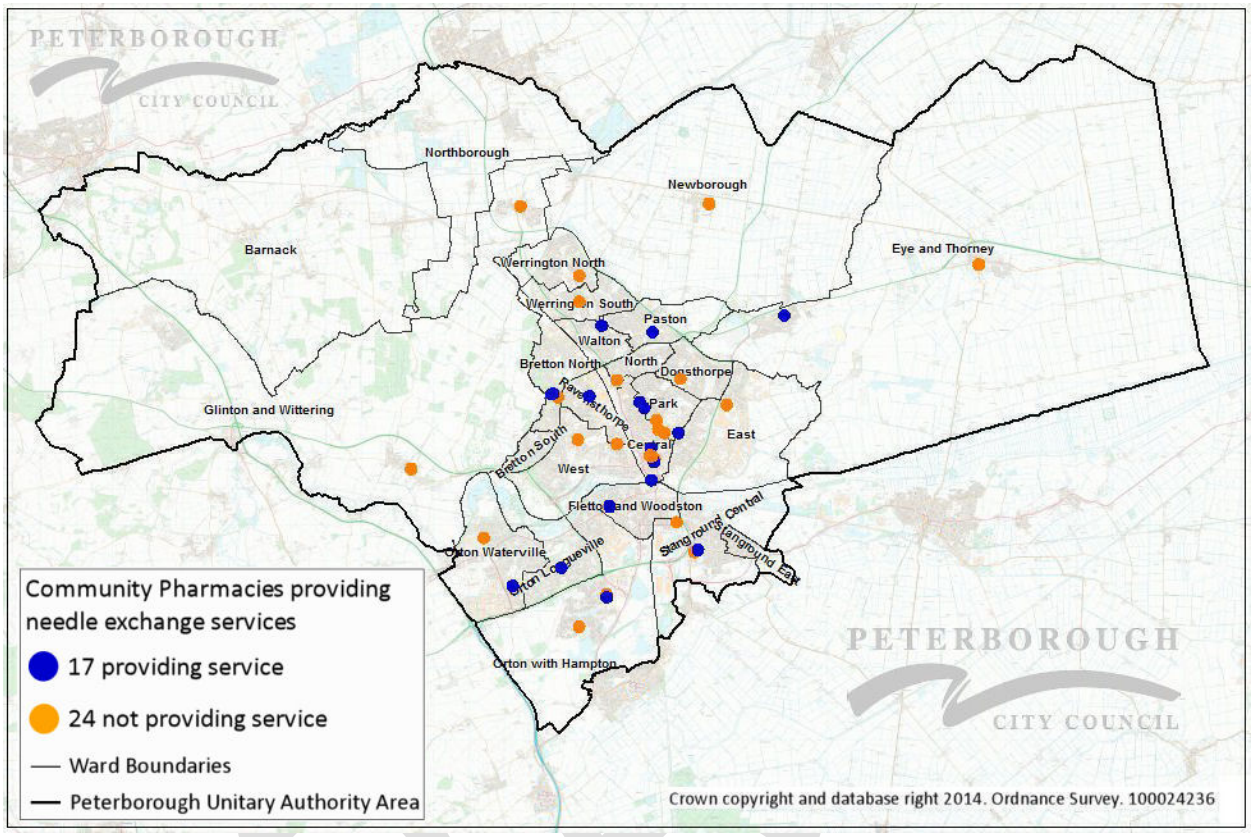
Source: NHS England

Needle and syringe exchange programme

The main purpose of this service is to reduce the transmission of blood-borne infections by providing free, sterile injecting equipment and advice in line with NICE Public Health Guidelines PH 52.[49] Commissioned pharmacies supply pre-packed bags containing sterile syringes, needles and other items to adult clients on request. Clients may return used items to the pharmacy where they are stored in a sharps bin for disposal as sharps waste.

[49] http://www.nice.org.uk/guidance/ph52 Date accessed: November 2014

Map 14: Community pharmacies providing needle exchange services in Peterborough



Source: NHS England

6.10 Minor Ailments (Pharmacy First)

A minor ailments Scheme “Pharmacy First” commenced within Peterborough in 2002. The service was originally commissioned by the former PCT (NHS Peterborough) as an enhanced service. The service is currently administered by the Peterborough & Cambridgeshire CCG. All pharmacies in Peterborough provide the service. The scheme aims at redirecting patients from GP surgeries and the Minor Illness and Injury Unit (MIIU) by providing an alternative route for treatment for a variety of minor conditions, for example, hay fever, headache, coughs and colds. Currently the service in Peterborough is offered only to children (under 16 year olds).

6.11 Summary Current Service Provision

There are currently 43 community pharmacies including two distance selling pharmacies. There are also three dispensing practices and two dispensing appliance contractors in Peterborough.

The ratio of pharmacies and dispensing practices against the local population in Peterborough (24 per 100,000 population) is above both the national (22 per 100,000) and East of England region (20 per 100,000) averages.

Residents of Peterborough living close to the border with other local authorities have the option of accessing services from pharmacies across the border. Residents in the north, north east and west of NHS Peterborough could choose to use pharmacies in Crowland, Market Deeping & Stamford (Lincolnshire) or Wansford (Northamptonshire). While residents in the south and east have the option of using pharmacies in Whittlesey or Yaxley (Cambridgeshire).

Of the 43 community pharmacies in Peterborough five (12%) have 100 core hour contracts (Table 10) with the remaining 38 having standard 40 hour contracts

During weekdays normal opening hours most Peterborough residents are within 20 minute travel time to a pharmacy or dispensing practice.

In the evenings more than three quarters of Peterborough residents are within 20 minutes travel time to an open pharmacy. A total of 21 pharmacies (51%) are open in the evenings.

On Saturdays and Sundays more than three quarters of Peterborough is within 20 minutes travel time to an open pharmacy. A total of 29 pharmacies (71%) are open on Saturdays and 10 on Sundays (24%).

In 2012-13, an average of 278,000 prescription items per month were dispensed by pharmacies in Peterborough which is equivalent to 6,509 per pharmacy.

Nearly all pharmacies (40/41 excluding distance selling) in Peterborough currently provide MUR services. In 2012-13 Peterborough had a higher number of MURs per pharmacy as compared to the England, East of England and Cambridgeshire averages.

Nearly all (40/41) pharmacies in Peterborough currently provide NMS. The average number of NMS per pharmacy in 2012-13 was 70 in Peterborough which was higher than the England, East of England and Cambridgeshire averages

In 2010-11 and 2012-13 Peterborough's average numbers of AURs per pharmacy and appliance contractor were higher than the national, regional and Cambridgeshire's averages.

Peterborough has consistently been the highest provider of SAC services nationally. In 2012-13 an average of 52,137 SACs per provider (6 in total) were done as compared to national and regional averages of 635 and 2,513 respectively. However it is important to note that AUR and SAC provide their services countrywide and therefore this is not a reflection of demand in Peterborough.

There are 13 pharmacies in Peterborough that are providing flu vaccination for at risk groups as of November 2014.

A minor ailments Scheme “Pharmacy First” for children commenced within Peterborough in 2002. Currently all pharmacies in Peterborough except distance selling ones provide the service.

There are currently 19 pharmacies offering stop smoking service across Peterborough. There were, however, 29 pharmacies offering this service in 2011 and the number of ‘smoking quits’ attributable to interventions from pharmacies has fallen from 53% of the total in 2010/2011 to 19% in 2013/14.

There are currently 32 pharmacies commissioned to provide supervised consumption services and 17 commissioned to provide needle exchange services. Commissioners of these services feel the current coverage in terms of number of providers is consistent with the needs of the local population.

7 Patient/Public Survey

The aim of the patient/public survey was to give local users of pharmacy services an opportunity to contribute to the PNA process and help shape future service provision within Peterborough. A structured questionnaire comprising of 18 questions was utilised. Questionnaires were placed at pharmacies and doctors' surgeries and also printed in the local paper, the Peterborough Telegraph. At the end of the survey period which lasted two months, 366 questionnaires were returned. Details of the survey results are presented in appendix 7.

7.1 Key findings

The majority of respondents were female (237respondents, 64.8%) and persons aged 26 and above (323, 88.1%).

Persons aged 56 and above were over-represented (39.3% as compared to 23.4% - Census 2011 figures for the same age group). However this is a reflection of the majority of people who regularly visit health care facilities which were the main questionnaire distribution points.

The majority of the respondents (279, 76.2%) visit their local pharmacies once or more times a month.

The majority of the respondents (264, 72%) were satisfied with the opening hours of their local pharmacies.

Pharmacies opening on Saturdays and Sundays was the most selected improvement (42, 11.5%) followed by increasing opening times until 10 pm (25, 6.8%).

The majority of respondents (317, 86.6%) rated their pharmacies as good or above (Figure 13) while 89.2% (327 respondents) described their pharmacy as retaining the same quality or improving.

Helpful (297, 81.1%) and knowledgeable (293, 80.1%) pharmacy staff and supply of medicines on prescription were the most important factors in pharmacy choice among respondents.

Most respondents would like blood pressure checks (179, 48.9%), supply of emergency medication (157, 42.9%) and cholesterol tests (150, 41%) provided by their local pharmacies.

The majority of respondents (210, 57.4%) who needed a consultation session with a pharmacist were able to obtain one. Most of these respondents were seeking help or advice on pharmacy related services.

Most respondents were satisfied with consultation sessions in terms of opportunity to ask questions, pharmacist's knowledge, physical comfort, privacy and usefulness of advice. A few (34, 16.2%) rated it as poor or very poor.

The majority of the respondents (208, 56.8%) drive to their local pharmacies but also a significant number (158, 43.2%) walk which may be indicative of easy access (Figure 21).Figure 22 further confirms this as the majority of respondents (348, 95%) said they live at most five miles from their local pharmacy.

The majority of respondents consider a pharmacy being close home (223, 60.9%) or near their GP Practice (179, 48.9%) as most important.

8 Community Pharmacy Survey

All community pharmacies (43) and three dispensing practices in Peterborough were invited to participate in the survey which mainly included questions on service provision, pharmacy premises, information technology and staff. Pharmacy/Practice managers had up to eight weeks to respond to the questionnaire which was mainly administered via email. A total of 29 community pharmacies (67%) returned completed questionnaires. None of the dispensing practices returned a completed questionnaire. Details of the survey results are presented in appendix 8.

8.1 Key findings

Twenty five out of the 29 (86.2%) pharmacies that responded to the questionnaire have consultation areas within their premises all of which can be closed to provide privacy. Twenty three have consultation areas with wheelchair access (78.6 %). Fifty five percent (16 pharmacies) have toilet facilities that can be accessed by patients attending consultation sessions.

At the majority of pharmacies, English and at least one other local language are spoken (26 pharmacies, 89%) while at a few (3, 11%) only English is spoken.

The majority of pharmacies are either EPS enabled (23, 79.3%) or have plans to be in the next 12 months (5, 17.2%).

Most pharmacies (28, 96.5%) have computers that can open documents in PDF format but more than 10 do not have capabilities to open MS Word, Excel and Access documents, an issue that needs further exploration as it might be a hindrance to effective communication.

A number of pharmacies reported that they currently provide a range of services such as phlebotomy and chlamydia testing which NHS England, CCG and Peterborough City Council commissioners are not aware of.

All pharmacies that responded to the survey (29) collect prescriptions from practices and deliver dispensed medicines free of charge on request.

More than half of the respondents (15, 52%) thought the pharmaceutical service provision in their areas was excellent while a third (10) thought it was good. Only one respondent thought it was poor.

The majority of respondents (92%) did not feel it was necessary to have more pharmaceutical service providers in their areas.

9 Health Needs and Service Mapping

Table 16 provides a summary of identified priority health needs (see section 5) mapped against current service provision (see section 6) and potential service developments for pharmacies in Peterborough. These potential services have been identified as relevant to meeting the health needs of the local population and/or were services pharmacies identified as areas of interest for further development. Promotion of Healthy Lifestyle and Support for Self-Care are part of essential services but could be developed further to meet identified local needs. Section 10 further discusses the identified health needs and potential service development areas and makes recommendations on involvement of community pharmacies.

Please note that in Table 16 services specified in the *current service* and *potential service development* columns are classified according to the four main pharmaceutical service areas i.e. *essential, advanced, enhanced and public health commissioned services*. Services in column four (potential service development) are those that could be developed to address needs specified in column one (Health Needs) and are not row specific e.g. section 2 (disease prevalence and incidence); advanced/enhanced services; potential service development: specified services are the advanced or enhanced services that could be developed to address the three health needs in column one i.e. high tuberculosis incidence rate, high percentage of people with general poor health and high prevalence of limiting long term illness and disability.

Table 16: Peterborough health needs and service matrix

Health Needs	Locality	Current Service		Potential Service Development
1. Deprivation				
High % of people living in 20% most deprived areas in England, 2010	Peterborough	**Essential Services**: Dispensing medicines & appliances Disposal of unwanted medicines Promotion of healthy lifestyle Repeat prescriptions Signposting Support for self-care Clinical governance		Promotion of healthy lifestyle, NHS health checks, screening and vaccinations
High % of Children living in poverty	Peterborough	**Advanced/Enhanced services**	Medicine Use Reviews New Medicine Service Flu vaccine for at risk groups Minor ailments scheme for children	Minor Ailments scheme for adults Flu vaccine for over 65s Expansion of the at risk groups flu vaccine programme
High rate of statutory homelessness	Peterborough			
High % of older people living in deprivation	Bretton North, Central, Dogsthorpe, East, Fletton & Woodston, North, Orton Longueville, Park, Paston, Ravensthorpe			
High % of pensioners living alone	Bretton North, Central, Dogsthorpe, East, Fletton & Woodston, North, Paston, Ravensthorpe, Stanground Central, Walton, Werrington North	**Public Health Commissioned services**	Stop Smoking Supervised Consumption Needle Exchange	Expansion of Stop Smoking service NHS Health Checks
Low life expectancy at birth	Central, Dogsthorpe, East, Orton Longueville, Park, Ravensthorpe, West			

Health Needs	Locality	Current Service		Potential Service Development
Low healthy life expectancy	Peterborough			
2. Disease Prevalence/ Incidence				
High Tuberculosis incidence rate	Peterborough	**Essential Services:** Dispensing medicines & Appliances Disposal of unwanted medicines Promotion of healthy lifestyle Repeat prescriptions Signposting Support for self-care Clinical governance		Promotion of healthy lifestyle, NHS health checks, screening and vaccinations Support for self-care
High percentage of people with general poor health	East, Orton Longueville, Stanground East, Dogsthorpe, North	**Advanced/Enhanced Services**	Medicine Use Reviews New Medicine Service Flu vaccination for at risk groups Minor ailments scheme for children	Observed treatment for tuberculosis Minor Ailments scheme for adults Flu vaccine for over 65s Expansion of the at risk flu vaccine programme Emergency Medicine Supply

Health Needs	Locality	Current Service		Potential Service Development
High prevalence of limiting long term illness and disability	Stanground Central, Werrington South, Dogsthorpe, North	**Public Health Commissioned Services**	Stop Smoking Supervised Consumption Needle Exchange	NHS Health Checks
3. Health Improvement				
High prevalence rate of low birth weight	Central, Park	**Essential Services:** Dispensing medicines & Appliances Disposal of unwanted medicines Promotion of healthy lifestyle Repeat prescriptions Signposting Support for self-care Clinical governance		Promotion of healthy lifestyle (to include healthy eating and breastfeeding), NHS health checks, childhood immunisations
High prevalence rate of obesity among year 6 children	Bretton North, Central			
Low percentage of mothers breastfeeding at 6-8 weeks follow up	Peterborough	**Advanced/Enhanced Services**	Medicine Use Reviews New Medicine Service Flu vaccine for at risk groups Minor ailments scheme for children	None
High smoking prevalence among mothers at time of delivery	Peterborough			
High under 18 conception rate	Peterborough	**Public Health Commissioned Services**	Stop Smoking	Weight management

Health Needs	Locality	Current Service		Potential Service Development
High Alcohol related admissions rate	Peterborough		Supervised Consumption Needle Exchange	Expansion of stop smoking service Emergency hormonal contraception and general contraception programme Alcohol screening and brief interventions
4. Health Service Utilization				
Low Cancer screening coverage – Cervical	Peterborough	**Essential Services:** Dispensing medicines & Appliances Disposal of unwanted medicines Promotion of healthy lifestyle Repeat prescriptions Signposting Support for self-care Clinical governance		Promotion of healthy lifestyle, NHS health checks, screening and vaccinations
Low Diabetic Retinopathy screening	Peterborough			
Low Chlamydia screening detection rate- males	Peterborough			
Low uptake of NHS Health Checks	Peterborough	**Advanced/Enhanced Services**	Medicine Use Reviews New Medicine Service Flu vaccine for at risk groups Minor ailments scheme for children	Minor Ailments scheme for adults Flu vaccine for over 65s Expansion of the at risk flu vaccine programme Emergency Medicine Supply
Low uptake of Flu vaccination – 65+ and individuals at risk	Peterborough			
High emergency admissions for all causes	Bretton North, Central, Dogsthorpe, East, Fletton & Woodston, North, Orton Longueville			
High emergency admissions for CHD	Central, Dogsthorpe, East, North, Orton Longueville, Park, Ravensthorpe			

Health Needs	Locality	Current Service		Potential Service Development
High emergency admissions for Stroke	Central	**Public Health Commissioned Services**	Stop Smoking Supervised Consumption Needle Exchange	Chlamydia Screening Minor Ailment Service Alcohol screening and brief intervention NHS Health Checks
High emergency admissions for COPD	Bretton North, Central, North, Orton Longueville			
High hospital admissions for alcohol related harm	Bretton North, Central, Dogsthorpe, East, Fletton & Woodston, North, Orton Longueville, Park, Paston, Ravensthorpe, Stanground Central, Walton			
5. Mortality All Ages				
More deaths than expected from all causes	Eye & Thorney, Orton Longueville, Park, Ravensthorpe, West	**Essential Services:** Dispensing medicines & Appliances Disposal of unwanted medicines Promotion of healthy lifestyle Repeat prescriptions Signposting Support for self-care Clinical governance		Promotion of healthy lifestyle, NHS health checks and screening Support for self-care
More deaths than expected from all cancers	Eye & Thorney	**Advanced/Enhanced Services**	Medicine Use Reviews New Medicine Service Flu vaccination for at risk groups Minor ailments scheme for children	Minor Ailments scheme for adults Flu vaccine for over 65s Expansion of the at risk flu vaccine programme
More deaths than expected from circulatory disease	Dogsthorpe, East, Orton Longueville, Park, Ravensthorpe, West			
More deaths than expected from CHD	Central, Dogsthorpe, East, Eye & Thorney, Fletton & Woodston,			

Health Needs	Locality	Current Service		Potential Service Development
	Orton Longueville, Park, Ravensthorpe,			Anti-coagulation monitoring programme Emergency Medicine Supply
More deaths than expected from Stroke	Park, West	**Public Health Commissioned Services**	Stop Smoking Supervised Consumption Needle Exchange	Expansion of Stop Smoking Service NHS Health Checks Weight management
More deaths than expected from respiratory disease	Orton Longueville, Park, West			
Higher mortality rate from causes considered preventable by public health interventions	Peterborough			
Higher premature mortality rate from cardiovascular diseases considered preventable	Peterborough			
6. Mortality Under 75				
More deaths than expected all causes	Central, Dogsthorpe, East, North, Orton Longueville, Park, Paston, Ravensthorpe,	**Essential Services:** Dispensing medicines & Appliances Disposal of unwanted medicines Promotion of healthy lifestyle Repeat prescriptions Signposting Support for self-care Clinical governance		Promotion of healthy lifestyle, NHS health checks and screening Support for self-care
More deaths than expected all cancers	Orton Longueville	**Advanced/Enhanced Services**	Medicine Use Reviews New Medicine Service	Minor Ailments scheme for adults

Health Needs	Locality	Current Service		Potential Service Development
			Flu vaccination for at risk groups Minor ailments scheme for children	Flu vaccine for over 65s Expansion of the at risk flu vaccine programme Anti-coagulation monitoring programme Emergency Medicine Supply
More deaths than expected circulatory disease	Central, Dogsthorpe, East, Fletton & Woodston, Orton Longueville, Park, Ravensthorpe	**Public Health Commissioned Services**	Stop smoking Supervised Consumption Needle Exchange	Expansion of Stop Smoking service NHS Health Checks Weight management
More deaths than expected CHD	Central, Dogsthorpe, East, Fletton & Woodston, Orton Longueville, Park, Ravensthorpe			

10 Conclusions & Recommendations

The aim of the Peterborough PNA was to describe the current pharmaceutical services, systematically identify any gaps/unmet needs and in consultation with stakeholders make recommendations on future development. To achieve this we reviewed and analysed Peterborough's demographic details, health needs, current service provision, and consulted the public and other stakeholders through surveys. From the synthesis of these results we have examined the level of need for pharmaceutical services in Peterborough and the level of choice the current provision of pharmaceutical service in the county offers patients.

10.1 Identified need

Peterborough has a higher percentage of people living in the 20% most deprived areas in England as compared to the national average. It also has a higher percentage of children and older people living in deprivation. Evidence shows that populations in deprived localities often experience poor health outcomes including lower life expectancy, higher burden of ill health, low uptake of health protection services such as screening and immunizations and often seek medical attention late. They are often admitted in hospital as emergencies. [50] The analysis by ward in Peterborough has revealed a similar pattern where the most deprived wards such as Central, Dogsthorpe, Orton Longueville, North and Ravensthorpe have been associated with relatively poor health outcomes.

Community pharmacies located in deprived wards and other areas that this assessment has highlighted as having poor health outcomes have the potential to effectively intervene as they are strategically placed and have regular interactions with the local population. Some of the health needs that have been identified which community pharmacies can be effectively involved include: tackling high prevalence rates of obesity among children, low breastfeeding rates, low birth weight rates, high smoking prevalence among pregnant women, high alcohol misuse rates, low uptake of vaccines and promotion of health screening and health check services.

It is notable that despite Peterborough having a significantly high under 18 conception rate and low chlamydia infection detection rate among males, none of the existing community pharmacies has been commissioned to provide related services.

10.2 Choice

Regulation 9 of the NHS Regulations 2013[51] sets out factors which HWBs must have regard to when assessing whether there is sufficient choice with regard to obtaining pharmaceutical services. We utilised the specified factors in our assessment of choice:

[50] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review Date accessed: November 2014

[51] http://www.legislation.gov.uk/uksi/2013/349/contents/made Date accessed: November 2014

• ***What is the current level of access within the locality to NHS pharmaceutical services?***

The overall ratio of pharmacy and dispensing practices to population in Peterborough (24/100,000) is higher than the regional (20/100,000) and national (22/100,000) averages.

During week days normal opening hours nearly the entire area of Peterborough is within 20 minutes travel time (5 miles radius) to a pharmacy or dispensing practice. In the evenings, Saturdays and Sundays more than three quarters of Peterborough is within 20 minutes travel time to an open pharmacy. A total of 21 pharmacies (49%) are open in the evenings, 28 pharmacies (65%) on Saturdays and 10 pharmacies (24%) are open on Sundays.

Areas within Peterborough that have no access to a pharmacy within 5 miles radius in the evenings, Saturdays and Sundays are mainly in the North East and North West parts of Peterborough. These are largely rural in nature with low population density. Previous assessments of travel time in these areas (Peterborough PNA, 2011) have shown that residents in this areas can still access pharmaceutical services in less than 20 minutes using personal or public transport during those periods. Census data (2011) show that car ownership is higher in rural areas as compared to urban areas. The East of England which includes Peterborough has the third highest car ownership rate nationally (89.3%). Furthermore they have the option of accessing pharmaceutical services across Peterborough's border.

In addition to essential services, nearly all pharmacies (40/41 excluding distance selling) in Peterborough provide key advanced services which include MUR, NMS, AUR and SAC. Peterborough's related performance is significantly better than the regional and national averages. Peterborough's residents therefore have satisfactory access to advanced services.

Thirteen pharmacies in Peterborough have been commissioned to provide flu vaccines for the at risk groups. The latest data (2013) shows the Peterborough's uptake rate is below the regional and national averages. There is need to review performance of existing service providers to establish if there is need to commission more pharmacies.

A minor ailments scheme 'Pharmacy First' targeting children is currently implemented by all pharmacies in Peterborough. Considering the high emergency hospital admission and respiratory disease mortality rates in various Peterborough wards it may be worth expanding the programme to include adults in affected areas.

There are two substance misuse services offered by pharmacies in Peterborough. These are supervised consumption (32 pharmacies) and needle exchange (17 pharmacies). Commissioners of this services feel the current service coverage is adequate.

There are currently 19 pharmacies offering stop smoking service across Peterborough. There were, however, 29 pharmacies offering this service in 2011 and the number of 'smoking quits' attributable to interventions from pharmacies has fallen

from 53% of the total in 2010/2011 to 19% in 2013/14. There is need to audit and support existing providers in order to improve their performance. Increasing the number of stop smoking services within existing pharmacies across Peterborough should also be considered if appropriate within the context of local healthcare strategy.

None of the pharmacies in Peterborough is commissioned to provide sexual health services despite Peterborough having a significantly high under 18 contraception rate and low chlamydia infection detection rate among males

Based on the level of essential and advanced service provision, and the physical distribution of pharmacies across the Peterborough, it is considered that the current level of access to NHS pharmaceutical services is adequate. This is supported by survey findings, which indicate that most patients and professionals are satisfied with their current access to pharmaceutical services in their localities.

• ***What is the extent to which services in the locality already offer people a choice, which may be improved by the provision of additional facilities?***

The health needs and service mapping analysis (section 9) shows varying needs in different localities across Peterborough. These include, low life expectancy at birth, low healthy life expectancy, high smoking prevalence among pregnant women, high obesity rates among children, low uptake of NHS health checks, high mortality rates etc. Pharmacies in these localities should be supported and equipped to provide services such as targeted promotion of healthy lifestyle, NHS health checks, emergency hormonal contraception and emergency medication service etc.

Most respondents from the public survey also recommended inclusion of blood pressure checks, supply of emergency medication and cholesterol tests as other important services they would like their local pharmacies to provide.

• ***What is the extent to which there is sufficient choice of providers in the locality, which may be improved, by additional providers?***

We have identified no gap in service provision which would be improved by additional providers. However NHS England and Local Authority service commissioners need to address the under commissioning of services such as flu vaccine for at risk groups and stop smoking and non-commissioning of flu vaccine for over 65s and sexual health services. They should continue working closely with community pharmacies to improve coverage and quality of existing services.

• ***What is the extent to which current service provision in the locality is adequately responding to the changing needs of the community it serves?***

Peterborough's population profile shows a significantly higher proportion of younger people as compared to the national average. This may be due to the presence of a relatively high population of young immigrants mostly from Eastern Europe. The prevalence of lifestyle related issues such as alcohol misuse, teenage pregnancy, smoking among pregnant women and child obesity often associated with younger populations is as such relatively higher than the national average. Pharmaceutical

service providers are currently involved in addressing these issues through promoting healthy lifestyles as part of the essential service contract. A few have been commissioned to provide stop smoking services. There is need to consider commissioning more pharmacies to provide stop smoking service.

Population projections for Peterborough show that the greatest rise will be among older people. The growth in older people's population is expected to lead to an increase of chronic conditions such as diabetes, circulatory and respiratory diseases. Pharmaceutical service providers have the potential to make a significant contribution in chronic disease prevention, identification and management through the implementation of programmes such as the NHS health checks and support for self-care.[52]

• Is there a need for specialist or other services, which would improve the provision of, or access to, services such as for specific populations or vulnerable groups?

Evidence shows that populations in deprived localities often experience poor health outcomes including lower life expectancy, higher burden of ill health, low uptake of health protection services such as screening and immunisations and often seek medical attention late. The analysis by ward in Peterborough has revealed a similar pattern where the most deprived wards such as Central, Dogsthorpe, Orton Longueville, North and Ravensthorpe are associated with relatively poor health outcomes.

Community pharmacies located in deprived wards and other areas that this assessment has highlighted as having poor health outcomes have the potential to effectively intervene as they are strategically placed and have regular interactions with the local population.

Some of the health needs that have been identified which community pharmacies can be effectively involved include: tackling high prevalence rates of obesity among children, low breastfeeding rates, low birth weight rates, high smoking prevalence among pregnant women, high alcohol misuse rates, low uptake of vaccines and promotion of health screening and health checks services.

• What is the HWB's assessment of the overall impact on the locality in the longer-term?

The Health and Wellbeing Board recognises the vital role pharmaceutical service providers play in treatment and management of ill health and in promoting and improving the health of the local population. However, they need to play a greater role in integrated out of hospital services, promoting and improving health and in reducing health inequalities.

[52] Community Pharmacy: at the heart of public health - http://psnc.org.uk/ Date accessed: November 2014

10.3 Future Need

To identify future needs we responded to issues specified in Regulation 9 of the NHS Regulations 2013 as below:

• ***Known firm plans for the development/expansion of new centres of population i.e. housing estates, or for changes in the pattern of population i.e. urban regeneration, local employers closing or relocating?***

Over the life of the current PNA document (2014/15-2018/19), a total of 6,724 houses in urban areas (the majority in Orton with Hampton) and 612 in the rural areas (majority in the larger villages of Eye & Thorney) will be built. We have examined the distribution of the housing developments and also examined demographic changes and household projections and conclude that the changes are minimal and will not significantly affect pharmaceutical service provision within the lifetime of this document. However, the HWB in conjunction with NHS England will continue to monitor the developments and make updates to the PNA via supplementary statements as appropriate. We are not aware of any firm plans by any major local employers to close or relocate.

• ***Known firm plans in and arising from local joint strategic needs assessments or joint health and wellbeing strategies?***

The Peterborough Health and Wellbeing Board (HWB) strategy (2012-15)[53] highlights the significance of multiagency collaboration, including pharmaceutical service providers in delivering its key priorities aimed at the improvement of the health of the local population and in reducing health inequalities.

• ***Known firm plans for changes in the number and/or sources of prescriptions i.e. changes in providers of primary medical services, or the appointment of additional providers of primary medical services in the area?***

The Peterborough and Cambridgeshire CCG's plans[54] do not indicate any major changes in providers of primary medical services.

• ***Known firm plans for developments which would change the pattern of local social traffic and therefore access to services, i.e. shopping centres or significant shopping developments whether these are in town, on the edge of town or out of town developments?***

We are not aware of any firm plans for developments during the life time of this document which would change the pattern of local social traffic and therefore access to services.

• ***Plans for the development of NHS services?***

[53] http://www.peterborough.gov.uk/health_and_social_care/health_and_wellbeing_strategy.aspx Date accessed: November 2014

[54] http://www.cambridgeshireandpeterboroughccg.nhs.uk/pages/five-year-plan.htm Date accessed: November 2014

As from January 2015 GP practices in England will be free to register patients who live outside the practice boundary. Some of the practices especially in urban areas might experience an increase in registrations as some people opt to register near their work places. Consequently the effect will be felt by pharmaceutical service providers in terms of changing prescription volumes.[55] However the overall impact on access to pharmaceutical services by the general population is expected to be minimal.

10.4 Conclusion

There is currently sufficient essential and advanced pharmaceutical service provision in Peterborough. However, locally commissioned services such as stop smoking appear inadequate as evidenced by deteriorating quit rates and an overall significantly higher smoking rate among adults and pregnant women as compared to the regional and national averages.

No community pharmacy in Peterborough is currently commissioned to provide flu vaccination for over 65s and only 13 provide flu vaccination service for at risk groups. Also none have been commissioned to provide sexual health services such as emergency hormonal contraception and chlamydia testing and treatment despite higher teenage pregnancy and low chlamydia detection rates among men as compared to the regional and national averages.

NHS England should consider commissioning existing pharmacies to provide flu vaccination for over 65s and encourage more pharmacies to provide flu vaccination for the at risk groups. Public health commissioners should support current providers of stop smoking services to improve outcomes and consider commissioning more existing pharmacies to enhance coverage. They should also consider commissioning existing pharmacies to provide sexual health services in order to address the high level of teenage pregnancy and low chlamydia detection rates among men if appropriate within the context of local healthcare strategy.

Overall, pharmacies are valued community assets and are strategically placed to effectively intervene in identified health needs and should be considered core in all strategies aimed at addressing highlighted health inequalities.

10.5 Future Plans

Regulations 5 and 6 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, state the date by which the HWB's first PNA must be published (1st April 2015) and the arrangements for revising the PNA. HWBs will be required to publish a revised assessment within three years of publication of their first assessment (By 31st March 2018 for Peterborough).

HWBs will be required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical

[55] http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/patient-choice-GP-practices.aspx
Date accessed: November 2014

services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes, in which case a supplementary statement may suffice.

To meet this requirement, the Peterborough head of public health intelligence on behalf of the HWB will liaise with the NHS England Area Team who are responsible for decisions regarding market entry and community pharmacy contracts to ensure appropriate action is taken whenever there are significant changes in local pharmaceutical service provision. The head of public health intelligence will annually review existing pharmaceutical service provision and if appropriate draft a supplementary report alerting the HWB of identified changes and proposed actions. He/she may recommend a revision of the entire PNA where the changes are significant.

11 Stakeholder Consultation Dec 2014 – Feb 2015

11.1 Background

As required by the NHS 2013 Regulation 8[56], we carried out a stakeholder consultation on the draft Peterborough PNA 2015 report. The consultation process commenced on 10th December 2014 and ended on 9th February 2015, thus meeting the requirement of giving stakeholders a minimum of 60 days to respond. The consultation involved the following:

- Peterborough residents
- All Community Pharmacies
- Dispensing Practices
- Local Medical Committee
- Local Pharmaceutical Committee
- C&P CCG Local Commissioning Groups
- Peterborough & Cambridgeshire NHS Foundation Trust
- Peterborough & Stamford Hospitals NHS Foundation Trust
- HWB Cambridgeshire
- HWB Lincolnshire
- HWB Northamptonshire
- NHS England East Anglia Area Team
- Healthwatch

11.2 Process

The draft PNA 2015 report was made available on line via the Peterborough City Council website: www.peterborough.gov.uk/pharmacyneeds .For the general public, a questionnaire was available for filling and submitting on line as well as information on how to request for a hard copy or easy read version of the report and questionnaire. Other stakeholders received invitations to participate via emails with questionnaires attached and a link to the online draft report. The Peterborough communication and marketing team did a press release at the beginning of the PNA consultation and promoted the exercise via various council social media throughout the process. The Peterborough Director of Public Health – Dr Henrietta Ewart and a member of the steering group – Rita Bali (LPC) were interviewed by the British Broadcasting Corporation (BBC) Radio Cambridgeshire as part of the consultation launch. All stakeholders received email reminders a week to the end of the consultation period.

[56] http://www.legislation.gov.uk/uksi/2013/349/contents/made

11.3 Results

Seventeen respondents either filled the provided questionnaires or sent back emails with comments. These included seven members of the public, four pharmacies, Lincolnshire Health and Wellbeing Board, Peterborough Health and Wellbeing Programme Board, Local Pharmaceutical Committee, Local Medical Committee, Peterborough Public Health Commissioner and Head of Public Health Strategy. NHS England East Anglia Area Team, Healthwatch and P&C CCG were represented on the steering group and as such their views were utilised throughout the PNA process. The draft PNA was also presented at the Peterborough Joint Commissioning Forum in January 2015 where it was well received.

The response rate to the draft PNA report was low despite multiple reminders from the PNA lead, LPC and on line promotion by the communication team. However the rate is comparable with previous PNAs in Peterborough and nationally. It is important to note that the NHS 2013 Regulation 8 minimum requirement for consultations is that key stakeholders be engaged at least once during the development of the PNA. Whereas most PNAs e.g. Cambridgeshire, only carried out one major consultation that included both a needs assessment and opinions on PNA draft, Peterborough carried out two separate consultations. The first consultation (needs assessment) carried out between September and October 2014 had high response rates – 366 members of the public and 29 community pharmacies.

Issues raised by various respondents and the PNA steering group's response are presented below.

11.3.1 Health and Wellbeing Programme Board

Table 17: Issues raised by HWB Programme

Issue	Response
Smoking rates are higher in these (Central Europe) countries as is alcohol consumption which is not noted in the comments below. We have some data that indicates higher levels of drink-driving among some communities.	The respondent possibly refers to Eastern Europe as Central Europe would include German, Italy, Austria etc. Whereas it is true that Eastern Europe countries have higher smoking and alcohol consumption rates as compared to the Western ones, there is no specific evidence indicating that immigrants from these countries currently living in Peterborough have higher smoking and alcohol consumption rates than the rest of the population. High levels of drink driving do not necessarily indicate high alcohol consumption within a population. However it is a public health issue that may need further investigation as part of

Issue	Response
	a comprehensive needs assessment focusing on this population that is to be carried out by the public health team later this year.
The PNA talks about a high number of Central Europeans but what age groups are these made up from. I suspect that they will be young families and there is a comment that young children have a higher health care demand. What facilities are there to encourage self help from this community i.e. young Central European mothers helping other expectant mums (can the pharmacies encourage this through campaigns etc.).	As recommended in PNA document (see 4.2.4) a comprehensive needs assessment focussing on East European and other BME groups is required to understand their specific needs in order to develop appropriate interventions.
What materials on health are in these centres in Central European languages and what advice can be given in Central European languages?	The PNA established that in most pharmacies that responded to the survey there were staff speaking other local languages apart from English. The public survey did not identify language barrier as a factor in pharmacy consultations. The current practice is to provide health materials in non-English languages on request as it's not cost effective to make materials for every language spoken in Peterborough.
Smoking is significantly high but do we know what they are smoking. I suspect that it will be non duty paid cigarettes which are more harmful than normal ones – is this being tackled?	Smoking is a health hazard regardless of type of cigarettes smoked and the public health advice remains the same – 'stop smoking.' How the availability of cheap non-duty paid cigarettes in Peterborough is impacting on smoking prevalence rates is an issue worth investigating further by stop smoking service commissioners. There is ongoing work through Safer Peterborough Partnership mainly involving the Police, Her Majesty Customs and Revenue (HMCR) and Trading Standards addressing illicit

Issue	Response
	tobacco sales. In the recent past there have been several raids on premises suspected to be selling illicit tobacco and owners have been penalised and in some cases business licences withdrawn. Public Health has intentions to form a 'Smokefree group' that will bring together all stakeholders for a more coordinated intervention approach.
There are a number of shops that are selling Central European prescription drugs on the shelves or under the counter. Is there any work being done to educate the community regarding the dangers of purchasing these items. Do we advertise what the English comparison labels are so that they know what they are buying?	The issue is beyond the PNA remit, the main focus of which was on the adequacy of services provided by NHS contracted pharmaceutical service providers and how they can be involved in addressing local health needs. Available information indicates that the Peterborough police in conjunction with the Medicines and Healthcare Regulatory Agency (MHRA – Department of Health) have been involved in identifying culprit business premises. Owners of four business premises in Peterborough who were recently (February 2015) found with unlicensed medications and prescription only drugs have been cautioned and some served with advice notices. It is recommended that Public Health do a follow up by including the issue in the comprehensive needs assessment with the Eastern European population to be carried out later in the year.
It's reassuring that they have highlighted areas of concern and potential pressures that are in line with areas of concern we, as a team looking at data across Peterborough would raise. For example, population pressures, the complexity of tailoring services to the BME community that we know less about, and the inequality between different areas of the City.	No action needed as this is a compliment.

Issue	Response
This last point is really key, they need to ensure there is proper analysis at small geographies (not wards) to understand what the issues are that affect that community and tailor services accordingly. Whilst a one size does not fit all approach is inherent in the paper, I'm not sure it's emphasised enough. Also reassuringly, there are clear linkages to the Public Health Outcomes Framework (PHOF).	This is a good point but implementation might be problematic due lack of data at small geographies. However commissioners of various services should consider further data collection at small area level to inform relevant intervention strategies. This is a compliment so no action required.

11.3.2 Local Pharmaceutical Committee (LPC)

Table 18: Issues raised by LPC

Issue	Response
Page 7: Removal of the word "typically" in the foot note as it is implies a pharmacy in some cases can operate without a pharmacist.	Word removed as suggested.
Page 57: The prison in Peterborough receives pharmaceutical supplies from Boots.	Revised as advised to Boots, Bretton, Unit 2, Bretton Centre.
Healthy start vitamin distribution could be done through community pharmacies.	Healthy Start is a UK-wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits. Currently in Peterborough distribution is via children centres and some primary schools. An assessment of the current service is required to determine if commissioning pharmacies to provide the service is necessary.

11.3.3 Local Medical Committee (LMC)

Table 18: Issues raised by the LMC

Issue	Response
Notwithstanding the assertion that the uptake rates in Peterborough are below the regional and national averages for this category, recommending that NHS England should consider commissioning existing pharmacies to provide flu vaccination for the over 65s would reduce the ownership of the current arrangements. We would recommend that consideration be given to ways of improving the existing systems that GP practices have in place to increase the uptake for this group rather than introduce a second system that could well suffer from similar uptake rates.	This is an important point and should be considered when making commissioning decisions. The same issue was raised during the Joint Commissioning Forum presentation in January 2015. In response, a patient representative attending highlighted the need to consider what would be the best outcome for patients and favoured the increase of access options by allowing pharmacies to provide the service.

11.3.4 Peterborough Public Health Commissioners

Table 19 A: Issues raised by sexual health and substance misuse commissioner

Issue	Response
I have some concern regarding the recommendation about sexual health screening. Whilst I agree there is potential to commission pharmacies to deliver sexual health services I don't think the PNA should make it a direct recommendation. Instead, it may be more appropriate to include it as a recommendation for consideration. We need clear evidence to support commissioning recommendations and the draft as is does not provide this. There is no additional money to fund sexual health services in pharmacies so money would have to be diverted from elsewhere. The PNA would need to provide robust evidence that it could deliver better uptake for better value for money than what is currently commissioned. Without that evidence, the PNA can only note that there is	The PNA does not make a direct recommendation for commissioning pharmacies to deliver sexual health services (see section 1.4.8 & section 5.2). However the recommendation has been revised as below: 'Peterborough City Council should consider potentially commissioning local community pharmacies to provide the above specified services if appropriate within the context of local healthcare strategy.' Suggestions made are good but

Issue	Response
potential to commission sexual health services from pharmacies and that local pharmacies are willing to deliver it. To include a direct recommendation to commission sexual health screening the document needs to:- •Evidence the efficacy and value for money of pharmacy based sexual health screens (particularly on the groups you pick out in the wording) compared to other methods of screening/delivery currently commissioned •'Lessons' to be learnt from the previous EHC pharmacy scheme the PCT ran in 2009/10. If memory serves me right, it was decommissioned by the PCT partly due to lack of uptake and issues with pharmacy provision. •Clarify exactly what sexual health provision it refers to (i.e. just chlamydia testing? Full STI screening, HIV testing? Condoms? EHC?) and for who (under 25s, all ages?). •Evidence that key high risk groups for STIs/HIV and unintended pregnancy want to see and would access these services in a pharmacy. As it reads in draft, the consultation doesn't evidence the above.	beyond the PNA remit. It is the responsibility of the commissioner to consider and explore further how best community pharmacies can be involved in addressing identified poor sexual health outcomes. PNA cannot prescribe specific activities to be implemented or guarantee that the partnership with community pharmacies will work or that uptake rates will improve. The commissioner should investigate further why partnership with pharmacies to deliver specified sexual health services has previously not worked in Peterborough whereas in other areas including the neighbouring local authorities it has been successful.
The consultation respondents were mostly female and over 25 and the results showed quite low levels of interest in some sexual health services. The consultation doesn't sufficiently capture the views of under 18s or under 25s or men so this needs to be reflected in the narrative.	The PNA did not target a particular age group or gender and does not depend entirely on the public survey findings to identify priority sexual health needs and interventions, but rather highlights latest published data and draws from best the practice elsewhere where pharmacies have been successfully commissioned to provide similar services.

Issue	Response
Consultation with stakeholders suggested a need to expand alcohol brief information and advice to pharmacies, primary care and other professionals such as social workers so I'm happy for this recommendation to stay in as a 'consideration'. Again, we would need to have evidence that target groups would take up the service, that is effective and value for money before anything was actually commissioned.	As highlighted in the sexual health section it is the commissioner's responsibility to gather more evidence around service uptake in pharmacies to inform commissioning decisions.

Table 19 B: Issues raised by the head of public health strategy

Issue	Response
I am unclear on what basis this recommendation (see below) is made. I would be more comfortable with a recommendation to pharmacies involvement in wider tobacco control. *Recommendation* 'Current service providers should be audited and supported to improve outcomes. Increasing the number of stop smoking services within existing pharmacies across Peterborough should also be considered.'	The recommendation is based on the comparison of Peterborough smoking quit rate in 2011/12 when there were more pharmacies commissioned and providing the service as compared to the 2013/14 rate with fewer pharmacies (See section 1.4.7). The PNA community pharmacy survey also showed that more pharmacies are interested and willing to provide stop smoking service. However we acknowledge the PNA limitation as we do not have contextual details to make firm recommendations, hence the use of terminology: consider. The recommendation has also been revised as below: 'Current service providers should be audited and supported to improve outcomes. Potentially increasing the number of stop smoking services within existing pharmacies across Peterborough may also be considered if appropriate within the context of local healthcare strategy.' It is our expectation that the stop smoking service commissioner will utilise available intelligence most of which the PNA authors do not have access to make a final decision i.e. strengthen existing providers or commission more pharmacies or both.

Issue	Response
Smoking, breastfeeding and child obesity data are inaccurate/outdated.	At the time the PNA was approved for consultation (December 2014) the reported data were the latest published and accurate. The main focus for the PNA was to highlight existing health needs at the time of assessment and opportunities for involvement of community pharmacies. We are aware there have been some new data releases recently e.g. the Public Health Outcomes Framework data published in February 2015. Indeed more new data will be published in the course of the year. We therefore recommend that commissioners refer to latest data whenever available.

11.3.5 Community Pharmacies

Four community pharmacies responded to the consultation. Three said they understood the purpose of the PNA and that it was a good reflection of the current pharmaceutical service provision in Peterborough. They also agreed that it was a good representation of the needs of Peterborough population. One did not respond to related questions.

All four pharmacies agreed that there was a need for pharmacies to provide EHC, Free Condom supply and Chlamydia testing/treatment.

Three pharmacies agreed that there was need for pharmacies to provide Emergency Medicine Supply and Weight Management while one had no opinion.

Two pharmacies agreed that flu vaccination for over 65s, Minor Ailments Scheme for Adults, Observed Treatment for Tuberculosis, Alcohol Screening and Brief Interventions and Anti-coagulation Monitoring Programmes should be provided by pharmacies. One pharmacy had no opinion and one did not respond to specified questions. Table 5 shows issues raised.

Table 20: Issues raised by community pharmacies

Issue	Response

Issue	Response
Rowlands Pharmacy in Westgate is open on Saturday mornings and is contracted to provide supervised consumption service (although does not have any patients at present).	NHS Choices website indicates they are open on Saturday as stated. Table and map to be revised accordingly. Substance Misuse Commissioner confirmed that the pharmacy is indeed commissioned to provide supervised consumption service. The list and map in PNA draft will be revised accordingly.
The growth in the use of e-cigarettes and their role in smoking cessation needs to be considered alongside widening provision.	It is currently government policy not to recommend electronic cigarettes (e-cigarettes) as they are not regulated as is the case with medicine. However there are plans to regulate e-cigarettes from 2016 but until then they are covered by general product safety registration. Their long term effects of use are also not known. NICE recommends medicinally licenced nicotine containing products such as Nicorette and Niquitin.

11.3.6 Members of the Public

Seven members of the public responded to the consultation. Most of them said they understood the purpose of the PNA and that it was a good reflection of the needs of Peterborough population. The majority also supported provision of extra services in pharmacies as suggested. Table 6 shows issues raised and response.

Table 21: Issues raised by members of the public

Issue	Response
Some of the information regarding the services provided are incorrect, e.g. Halls The Chemist provide supervised consumption and flu vaccination, but the chart shows they do not.	The respondent appears to be referring to Halls The Chemist 57 Napier Place, Orton Wistow. The approved list from the drug misuse commissioner shows the pharmacy is not commissioned to provide supervised consumption. NHS England confirmed that all pharmacies are eligible to provide flu vaccine for persons aged 18-64 considered at risk e.g. due to long term health problems. However the PNA list shows only those pharmacies that are currently active according to records held by NHS England.
I believe that very little was mentioned about all Eastern	Sufficient attention is given in the PNA with regards to the Eastern European population

Issue	Response
European population needs, this needs to be acknowledged and supported.	(and other minority groups), given the purpose of the PNA (See PNA section 4.2.4). There are plans in place to undertake an Eastern European Migrants needs assessment later in the year which will include a comprehensive assessment of service use amongst this population group.
The PNA prejudices certain communities in Peterborough for example Dogsthorpe - the map in the PNA highlights one community pharmacy so not much choice.	Pharmacy access maps in Section 6.7.2 show that Dogsthorpe residents can access their local pharmacy and a number of other neighbouring pharmacies within 20 minutes travel time which is the agreed standard and therefore considered adequate.
I believe that more pharmacies opened at more convenient times and supporting young mothers and elderly patients would benefit from increased number of pharmacies.	The ratio of pharmacies and dispensing practices against the local population in Peterborough (24 per 100,000 population) is above both the national (22 per 100,000) and regional (20 per 100,000) averages. The PNA considered the physical distribution of pharmacies across Peterborough and access by the local population and found that the current level of access is adequate. This was also supported by survey findings, which indicated that most patients and professionals are satisfied with their current access to pharmaceutical services in their localities.
I believe that delivering more support to migrants will support sexual health and also reduce underage pregnancies. Communication is the key and at the moment most pharmacies deliver same services	The impact on pharmaceutical services resulting from Eastern European migrants settling in Peterborough is not known. There are plans in place to undertake an Eastern European migrants needs assessment later in the year which will include a comprehensive assessment of service use amongst this population group.
If I was living in centre of Peterborough I have so much pharmacy provision but I live in Dogsthorpe and cannot travel far so I'm limited to choice.	Pharmacy access maps in Section 6.7.2 show that Dogsthorpe residents can access the local pharmacy and a number of other neighbouring pharmacies within 20 minutes travel time which is the agreed standard and therefore considered adequate. Most pharmacies also provide a free prescription collection and delivery service on request.

Issue	Response
I think more services should be available 'out of hours', late evenings and weekends. To alleviate pressure on out of hours GP services and A&E we could use community pharmacy more. Also working people could access services when GP surgeries are closed, for example, routine health checks, some blood tests perhaps, health advice, and antibiotics for straightforward infections (UTIs etc.).	Whereas the PNA did not find a justification for pharmacies to increase their current opening hours, the suggestion is consistent with the PNAs recommendation that pharmacies be supported to provide more services such as NHS health checks, treatment of minor ailments etc.
There appears to be a good number of pharmacies providing this service to the areas that require support, utilise funding to commission other services (e.g. expanding pharmacy first).	The PNA has established that the current smoking service is inadequate and smoking prevalence has worsened over time. It therefore has recommended supporting the existing providers to improve outcomes and to consider commissioning more existing pharmacies.
Peterborough has seen haphazard opportunism that has concentrated lots of pharmacies in certain neighbourhoods pre 2012. Now that health and wellbeing boards control market entry they must devise the PNA fairly without prejudice to certain community's across Peterborough. Many applications are being denied and rejected on appeal for legitimate community pharmacy that should be of benefit to the local community instead rejections merely based on the previous haphazard opportunist pharmacy that are all taken into account for the purpose of data. Pharmacies should provide Flu vaccines for children (nasal sprays).	The 2010 Peterborough PNA did not establish any gap in essential service provision requiring additional pharmacies. The 2015 one has neither established that. NHS England is currently responsible for making market entry decisions and will be expected to make reference to the current PNA (and any supplementary statements that might be drafted in future) for evidence of need for licencing more pharmaceutical service providers. The PNA did not identify this as an unmet need.
Pharmacies provide a fantastic open door service, with no appointment required with many	This is a true statement and is consistent with PNA findings.

Issue	Response
locations across the city and open very long hours over 7 days a week. I think it shouldn't be so hard to obtain an NHS contract. Pharmacies are a good addition to local communities supporting the NHS currently struggling with admissions. We have so many off licence and still going strong with convenience at the centre of the community. This should be the case for pharmacies as well. The health and wellbeing board must look at allowing more pharmacies in the much deprived wards due to deprived elderly and lack of choice.	The 2015 PNA did not identify any gap in essential service provision requiring additional pharmacies. The PNA did not establish need for additional pharmacies but highlights the need for pharmacies located in deprived areas to be more involved in addressing identified poor health outcomes (See section 4.2.6)

11.3.7 Neighbouring Health and Wellbeing Boards

Lincolnshire was the only neighbouring Health and Wellbeing Board that responded to the consultation. They noted that the Lincolnshire pharmacies close to the border Peterborough border in Stamford, Market Deeping, Deeping St James and Bourne were accurately reflected in the PNA maps and text.

11.4 Conclusion

Overall most of the respondents understood the purpose of PNA, confirmed that the PNA draft was good reflection of the current pharmaceutical services and needs in Peterborough. They also thought it was adequate in informing future service provision.

Although the PNA document was drafted in consideration of lay readers it still remains a technical document that most members of the public may have found challenging to read and thereafter participate meaningfully in the consultation exercise, a factor that might have contributed to low response rate. There is therefore need to explore other means of engaging lay stakeholders in future e.g. through presentations.

The low response rate from community pharmacy contractors may be attributed to the fact that they had already participated in the first consultation (needs assessment) and also the 2015 PNA did not recommend any changes to the current number of essential service providers. There is need to explore other means of

engaging more community pharmacies at both data collection and consultation stages of the PNA in future.

Appendix 1: Pharmaceutical Service Providers in Peterborough

NAME OF PROVIDER	ADDRESS	POSTCODE	WARD
COMMUNITY PHARMACIES			
ASDA PHARMACY	WEST RIVERGATE SHOP CTRE	PE1 1ET	CENTRAL
BOOTS THE CHEMIST	21 HIGH STREET, EYE	PE6 7UP	EYE AND THORNEY
BOOTS UK LIMITED	THE BRETTON HEALTH CENTRE	PE3 8DT	BRETTON NORTH
BOOTS UK LIMITED	QUEENSGATE CENTRE	PE1 1NW	CENTRAL
BOOTS UK LIMITED	UNIT 2, BRETTON CENTRE	PE3 8DN	BRETTON NORTH
BOOTS UK LIMITED	UNIT 2, SERPENTINE GREEN	PE7 8BE	ORTON WITH HAMPTON
BOTOLPH BRIDGE PHARMACY	UNIT B, SUGAR WAY	PE2 9QY	FLETTON
CITY PHARMACY	50 LINCOLN ROAD	PE1 2RY	CENTRAL
DOGSTHORPE PHARMACY	54 CENTRAL AVENUE	PE1 4LH	DOGSTHORPE
GRAHAM YOUNG (CHEMIST) 2007 LTD	GRAHAM YOUNG PHARMACY, LINCOLN RD	PE1 3HA	CENTRAL
GRANVILLE PHARMACY	35 GRANVILLE STREET	PE1 2QQ	CENTRAL
HALLS THE CHEMIST	92 P'BORO ROAD, FARCET	PE7 3BN	-
HALLS THE CHEMIST	THE OLD CHAPEL, CHURCH HILL	PE5 7AU	GLINTON AND WITTERING
HALLS THE CHEMIST	14A CHURCH STREET, THORNEY	PE6 0QB	EYE AND THORNEY
HALLS THE CHEMIST	57 NAPIER PLACE, ORTON WISTOW	PE2 6XN	ORTON WATERVILLE
HAMPTON PHARMACY	HAMPTON VALE LOCAL CENTRE	PE7 8EL	ORTON WITH HAMPTON
LLOYDSPHARMACY	THE NENE VALLEY MED CTR, CLAYTON	PE2 5SD	ORTON LONGUEVILLE
LLOYDSPHARMACY	3 BUSHFIELD, ORTON CENTRE	PE2 5RQ	ORTON WATERVILLE
MI PHARMACY (EASTFIELD BRANCH)	127 EASTFIELD ROAD	PE1 4AU	EAST
MI PHARMACY (PARK ROAD BRANCH)	164 PARK ROAD	PE1 2UF	PARK
MI PHARMACY (WERRINGTON BRANCH)	12B SKATERS WAY, WERRINGTON	PE4 6NB	WERRINGTON NORTH
MILLFIELD PHARMACY	387 LINCOLN ROAD	PE1 2PF	PARK
NETHERTON PHARMACY	57 LEDBURY ROAD, NETHERTON	PE3 9RF	WEST
NEWBOROUGH PHARMACY	42-46 SCHOOL ROAD, NEWBOROUGH	PE6 7RG	NEWBOROUGH
ODEDRA RC	RECTORY GARDENS, OLD FLETTON	PE2 8AY	STANGROUND CENTRAL
PHARMACY FIRST	2 NORTH STREET	PE1 2RA	CENTRAL
ROWLANDS PHARMACY	178A MOUNTSTEVEN AVENUE	PE4 6HN	WALTON
ROWLANDS PHARMACY	46 WESTGATE	PE1 1RE	CENTRAL

NAME OF PROVIDER	ADDRESS	POSTCODE	WARD
SAINSBURY'S PHARMACY	J.SAINSBURYS SUPERSTORE, OXNEY RD	PE1 5NG	EAST
SAINSBURY'S PHARMACY	SAINSBURYS, BRETTON	PE3 8DA	BRETTON NORTH
SHRIVES CHEMIST	14 WESTGATE	PE1 1RA	CENTRAL
TESCO INSTORE PHARMACY	SERPENTINE GREEN	PE7 8BD	ORTON WITH HAMPTON
THE CHEMIST SHOP	4 RECTORY LANE, GLINTON	PE6 7LR	GLINTON AND WITTERING
THE CO-OPERATIVE PHARMACY	303-307 LINCOLN ROAD, MILLFIELD	PE1 2PH	PARK
THE CO-OPERATIVE PHARMACY	2-6 HAMPTON COURT, WESTWOOD	PE3 7JA	RAVENSTHORPE
THE CO-OPERATIVE PHARMACY	STANGROUND SURGERY	PE2 8RB	STANGROUND CENTRAL
THE CO-OPERATIVE PHARMACY	CHADBURN CENTRE, PASTON	PE4 7DG	PASTON
THE CO-OPERATIVE PHARMACY	WESTGATE HOUSE	PE1 2TA	CENTRAL
THOMAS WALKER PHARMACY	THOMAS WALKER MED CENTRE	PE1 2QP	PARK
WERRINGTON PHARMACY	97 CHURCH STREET	PE4 6QF	WERRINGTON SOUTH
WEST TOWN CHEMIST	63-65 MAYORS WALK, WEST TOWN	PE3 6EX	WEST
DISTANCE SELLING PHARMACIES			
PHARMACY MEDICINES LTD	11 FENLAKE BUSINESS CTRE, FENGATE	PE1 5BQ	EAST
PHARMADOSE LIMITED	14 DODSON WAY, FEN COURT	PE1 5XJ	EAST
DISPENSING APPLIANCE CONTRACTOR			
CHARTER HEALTHCARE	UNIT 1 THE LINKS, BAKEWELL ROAD	PE2 6BJ	ORTON WATERVILLE
OSTOMART LTD -	20 PHORPRES CLOSE CYGNET PARK , HAMPTON	PE7 8FZ	ORTON WITH HAMPTON
DISPENSING PRACTICES			
AILSWORTH MEDICAL CENTRE	32 MAIN STREET, AILSWORTH	PE5 7AF	GLINTON AND WITTERING
OLD FLETTON SURGERY	RECTORY GDNS, OLD FLETTON	PE2 8AY	FLETTON
THORNEY MEDICAL PRACTICE	WISBECH ROAD, THORNEY	PE6 0SD	EYE AND THORNEY

Source: NHS England

Appendix 2: Pharmacies open in the evenings (after 18:00) in Peterborough

NAME OF PROVIDER	ADDRESS	POSTCODE	WARD
ASDA PHARMACY	WEST RIVERGATE SHOP CTRE	PE1 1ET	CENTRAL
BOOTS THE CHEMIST	21 HIGH STREET, EYE	PE6 7UP	EYE AND THORNEY
BOOTS UK LIMITED	UNIT 2, BRETTON CENTRE	PE3 8DN	BRETTON NORTH
BOOTS UK LIMITED	QUEENSGATE CENTRE	PE1 1NW	CENTRAL
BOOTS UK LIMITED	UNIT 2, SERPENTINE GREEN	PE7 8BE	ORTON WITH HAMPTON
BOTOLPH BRIDGE PHARMACY	UNIT B, SUGAR WAY	PE2 9QY	FLETTON
CITY PHARMACY	50 LINCOLN ROAD	PE1 2RY	CENTRAL
GRAHAM YOUNG (CHEMIST) 2007 LTD	GRAHAM YOUNG PHARMACY, LINCOLN RD	PE1 3HA	CENTRAL
GRANVILLE PHARMACY	35 GRANVILLE STREET	PE1 2QQ	CENTRAL
LLOYDS PHARMACY	THE NENE VALLEY MED CTR, CLAYTON	PE2 5SD	ORTON LONGUEVILLE
MI PHARMACY (PARK ROAD BRANCH)	164 PARK ROAD	PE1 2UF	PARK
MILLFIELD PHARMACY	387 LINCOLN ROAD	PE1 2PF	PARK
ODEDRA RC	RECTORY GARDENS, OLD FLETTON	PE2 8AY	STANGROUND CENTRAL
SAINSBURY'S PHARMACY	J.SAINSBURYS SUPERSTORE, OXNEY RD	PE1 5NG	EAST
SAINSBURY'S PHARMACY	SAINSBURYS, BRETTON	PE3 8DA	BRETTON NORTH
SHRIVES CHEMIST	14 WESTGATE	PE1 1RA	CENTRAL
TESCO INSTORE PHARMACY	SERPENTINE GREEN	PE7 8BD	ORTON WITH HAMPTON
THE CO-OPERATIVE PHARMACY	WESTGATE HOUSE	PE1 2TA	CENTRAL
THOMAS WALKER PHARMACY	THOMAS WALKER MED CENTRE	PE1 2QP	PARK
WERRINGTON PHARMACY	97 CHURCH STREET	PE4 6QF	WERRINGTON SOUTH
WEST TOWN CHEMIST	63-65 MAYORS WALK, WEST TOWN	PE3 6EX	WEST

Source: NHS England

Appendix 3: Pharmacies open on Saturdays in Peterborough

NAME OF PROVIDER	ADDRESS	POSTCODE	WARD
ASDA PHARMACY	WEST RIVERGATE SHOP CTRE	PE1 1ET	CENTRAL
BOOTS THE CHEMIST	21 HIGH STREET, EYE	PE6 7UP	EYE AND THORNEY
BOOTS UK LIMITED	UNIT 2, BRETTON CENTRE	PE3 8DN	BRETTON NORTH
BOOTS UK LIMITED	QUEENSGATE CENTRE	PE1 1NW	CENTRAL
BOOTS UK LIMITED	UNIT 2, BRETTON CENTRE	PE3 8DN	BRETTON NORTH
BOOTS UK LIMITED	UNIT 2, SERPENTINE GREEN	PE7 8BE	ORTON WITH HAMPTON
BOTOLPH BRIDGE PHARMACY	UNIT B, SUGAR WAY	PE2 9QY	FLETTON
CITY PHARMACY	50 LINCOLN ROAD	PE1 2RY	CENTRAL
DOGSTHORPE PHARMACY	54 CENTRAL AVENUE	PE1 4LH	DOGSTHORPE
GRAHAM YOUNG (CHEMIST) 2007 LTD	GRAHAM YOUNG PHARMACY, LINCOLN RD	PE1 3HA	CENTRAL
HALLS THE CHEMIST	92 P'BORO ROAD, FARCET	PE7 3BN	-
HAMPTON PHARMACY	HAMPTON VALE LOCAL CENTRE	PE7 8EL	ORTON WITH HAMPTON
LLOYDS PHARMACY	3 BUSHFIELD, ORTON CENTRE	PE2 5RQ	ORTON WATERVILLE
MI PHARMACY (PARK ROAD BRANCH)	164 PARK ROAD	PE1 2UF	PARK
MI PHARMACY (WERRINGTON BRANCH)	12B SKATERS WAY, WERRINGTON	PE4 6NB	WERRINGTON NORTH
MILLFIELD PHARMACY	387 LINCOLN ROAD	PE1 2PF	PARK
NEWBOROUGH PHARMACY	42-46 SCHOOL ROAD, NEWBOROUGH	PE6 7RG	NEWBOROUGH
PHARMACY FIRST	2 NORTH STREET	PE1 2RA	CENTRAL
ROWLANDS PHARMACY	178A MOUNTSTEVEN AVENUE	PE4 6HN	WALTON
ROWLANDS PHARMACY	46 WESTGATE	PE1 1RE	CENTRAL
SAINSBURY'S PHARMACY	J.SAINSBURYS SUPERSTORE, OXNEY RD	PE1 5NG	EAST
SAINSBURY'S PHARMACY	SAINSBURYS, BRETTON	PE3 8DA	BRETTON NORTH
SHRIVES CHEMIST	14 WESTGATE	PE1 1RA	CENTRAL
TESCO INSTORE PHARMACY	SERPENTINE GREEN	PE7 8BD	ORTON WITH HAMPTON
THE CO-OPERATIVE PHARMACY	2-6 HAMPTON COURT, WESTWOOD	PE3 7JA	RAVENSTHORPE
THE CO-OPERATIVE PHARMACY	CHADBURN CENTRE, PASTON	PE4 7DG	PASTON
THE CO-OPERATIVE PHARMACY	CHADBURN CENTRE, PASTON	PE4 7DG	PASTON
WERRINGTON PHARMACY	97 CHURCH STREET	PE4 6QF	WERRINGTON SOUTH
WEST TOWN CHEMIST	63-65 MAYORS WALK, WEST TOWN	PE3 6EX	WEST

Source: NHS England

Appendix 4: Peterborough Pharmacies Advanced, Enhanced and Locally Commissioned Services

NAME OF PHARMACY	ADDRESS & POSTCODE		MUR AND NMS	PHARMACY FIRST CHILDREN SERVICE	SUPERVISED CONSUMPTION SERVICE	NEEDLE EXCHANGE SERVICE	STOP SMOKING SERVICE	FLU VACCINE FOR AT RISK GROUPS
ASDA PHARMACY	WEST RIVERGATE SHOP CTRE	PE1 1ET	√	√	√	√	√	X
BOOTS THE CHEMIST	21 HIGH STREET, EYE	PE6 7UP	√	√	√	X	x	√
BOOTS UK LIMITED	THE BRETTON HEALTH CENTRE	PE3 8DT	√	√	√	X	√	√
BOOTS UK LIMITED	QUEENSGATE CENTRE	PE1 1NW	√	√	√	√	√	√
BOOTS UK LIMITED	UNIT 2, BRETTON CENTRE	PE3 8DN	√	√	√	√	√	√
BOOTS UK LIMITED	UNIT 2, SERPENTINE GREEN	PE7 8BE	√	√	√	√	√	√
BOTOLPH BRIDGE PHARMACY	UNIT B, SUGAR WAY	PE2 9QY	√	√	√	X	x	X
CITY PHARMACY	50 LINCOLN ROAD	PE1 2RY	√	√	√	√	√	X
DOGSTHORPE PHARMACY	54 CENTRAL AVENUE	PE1 4LH	√	√	√	X	√	X
GRAHAM YOUNG (CHEMIST) 2007 LTD	GRAHAM YOUNG PHARMACY, LINCOLN RD	PE1 3HA	√	√	√	√	√	X
GRANVILLE PHARMACY	35 GRANVILLE STREET	PE1 2QQ	√	√	X	X	x	X
HALLS THE CHEMIST	92 P'BORO ROAD, FARCET	PE7 3BN	√	√	X	X	x	√
HALLS THE CHEMIST	THE OLD CHAPEL, CHURCH HILL	PE5 7AU	√	√	X	X	X	√
HALLS THE CHEMIST	14A CHURCH STREET, THORNEY	PE6 0QB	√	√	√	X	x	√
HALLS THE CHEMIST	57 NAPIER PLACE, ORTON WISTOW	PE2 6XN	√	√	X	X	x	√
HAMPTON PHARMACY	HAMPTON VALE LOCAL CENTRE	PE7 8EL	√	√	√	X	x	X
LLOYDSPHARMACY	THE NENE VALLEY MED CTR, CLAYTON	PE2 5SD	√	√	√	√	x	X
LLOYDSPHARMACY	3 BUSHFIELD, ORTON CENTRE	PE2 5RQ	√	√	√	√	√	√
MI PHARMACY (EASTFIELD BRANCH)	127 EASTFIELD ROAD	PE1 4AU	√	√	√	√	x	X
MI PHARMACY (PARK ROAD BRANCH)	164 PARK ROAD	PE1 2UF	√	√	X	X	x	X
MI PHARMACY (WERRINGTON BRANCH)	12B SKATERS WAY, WERRINGTON	PE4 6NB	√	√	√	X	√	X

NAME OF PHARMACY	ADDRESS & POSTCODE		MUR AND NMS	PHARMACY FIRST CHILDREN SERVICE	SUPERVISED CONSUMPTION SERVICE	NEEDLE EXCHANGE SERVICE	STOP SMOKING SERVICE	FLU VACCINE FOR AT RISK GROUPS
MILLFIELD PHARMACY	387 LINCOLN ROAD	PE1 2PF	√	√	√	√	x	X
NETHERTON PHARMACY	57 LEDBURY ROAD, NETHERTON	PE3 9RF	√	√	√	X	√	X
NEWBOROUGH PHARMACY	42-46 SCHOOL ROAD, NEWBOROUGH	PE6 7RG	√	√	√	X	√	X
ODEDRA RC	RECTORY GARDENS, OLD FLETTON	PE2 8AY	√	√	√	X	√	X
PHARMACY FIRST	2 NORTH STREET	PE1 2RA	√	√	X	X	x	X
ROWLANDS PHARMACY	178A MOUNTSTEVEN AVENUE	PE4 6HN	X	√	√	√	x	X
ROWLANDS PHARMACY	46 WESTGATE	PE1 1RE	√	√	√	X	x	X
SAINSBURY'S PHARMACY	J.SAINSBURYS SUPERSTORE, OXNEY RD	PE1 5NG	√	√	√	X	√	√
SAINSBURY'S PHARMACY	SAINSBURYS, BRETTON	PE3 8DA	√	√	√	√	√	√
SHRIVES CHEMIST	14 WESTGATE	PE1 1RA	√	√	X	X	x	X
TESCO INSTORE PHARMACY	SERPENTINE GREEN	PE7 8BD	√	√	√	X	x	X
THE CHEMIST SHOP	4 RECTORY LANE, GLINTON	PE6 7LR	√	√	X	X	x	X
THE CO-OPERATIVE PHARMACY	303-307 LINCOLN ROAD, MILLFIELD	PE1 2PH	√	√	√	√	√	X
THE CO-OPERATIVE PHARMACY	2-6 HAMPTON COURT, WESTWOOD	PE3 7JA	√	√	√	√	x	X
THE CO-OPERATIVE PHARMACY	STANGROUND SURGERY	PE2 8RB	√	√	√	√	x	X
THE CO-OPERATIVE PHARMACY	CHADBURN CENTRE, PASTON	PE4 7DG	√	√	√	√	√	X
THE CO-OPERATIVE PHARMACY	WESTGATE HOUSE	PE1 2TA	√	√	√	X	√	X
THOMAS WALKER PHARMACY	THOMAS WALKER MED CENTRE	PE1 2QP	√	√	X	X	x	X
WERRINGTON PHARMACY	97 CHURCH STREET	PE4 6QF	√	√	√	X	x	X
WEST TOWN CHEMIST	63-65 MAYORS WALK, WEST TOWN	PE3 6EX	√	√	√	X	√	√

Source: NHS England

Appendix 5: Peterborough and Borderline[57] GP Practices (Including branches)

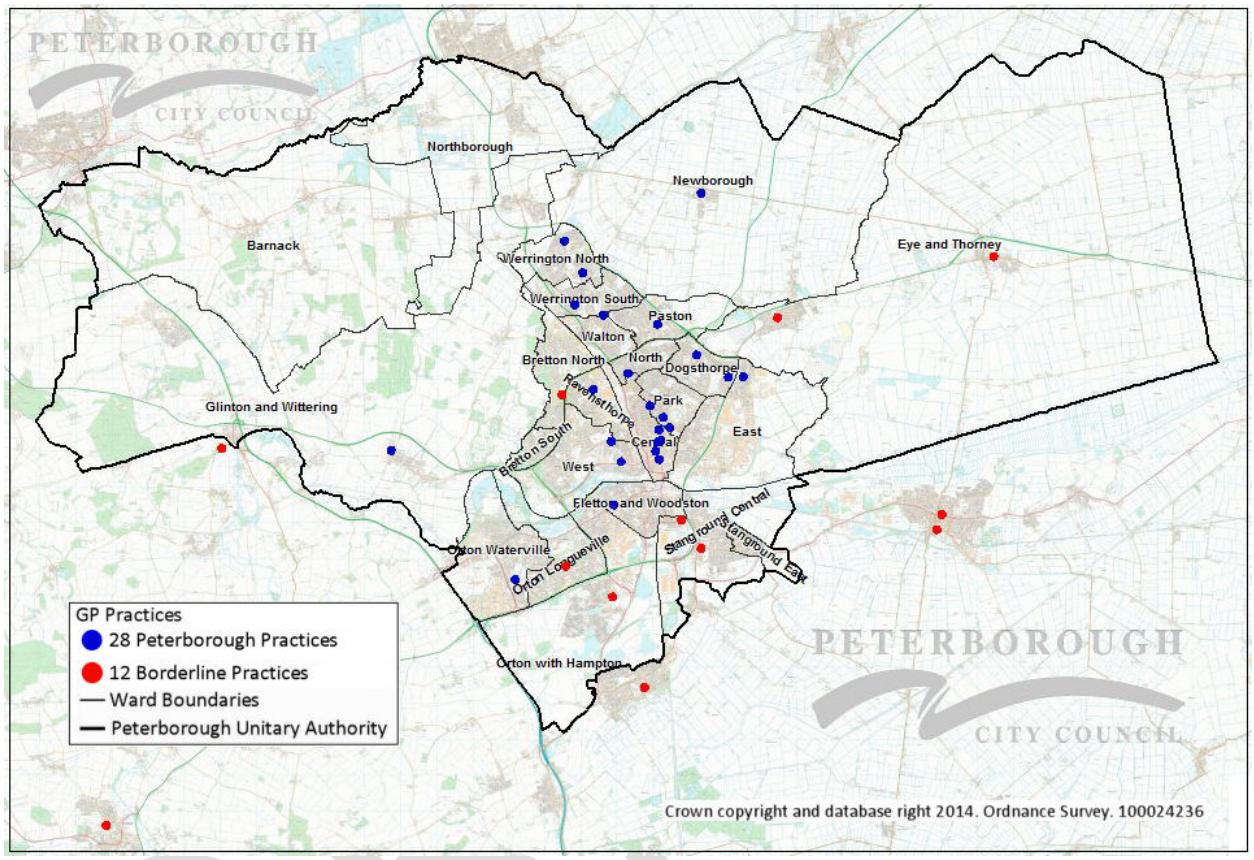
PRACTICE CODE	PRACTICE NAME	ADDRESS & POSTCODE		LOCATION
D81618	AILSWORTH MEDICAL CENTRE	32 MAIN STREET	PE5 7AF	PETERBOROUGH
D81618	AILSWORTH MEDICAL CENTRE	GUNTONS ROAD, NEWBOROUGH	PE6 7QW	PETERBOROUGH
D81618	AILSWORTH MEDICAL CENTRE	SALTERSGATE	PE1 4YL	PETERBOROUGH
Y00486	BOTOLPH BRIDGE COMMUNITY HEALTH CENTRE	SUGAR WAY	PE2 9QB	PETERBOROUGH
D81053	BRETTON MEDICAL CENTRE	RIGHTWELL	PE3 8DT	BORDERLINE
Y02631	BURGHLEY ROAD SURGERY	94 BURLEIGH ROAD	PE1 2QE	PETERBOROUGH
D81624	DOGSTHORPE MEDICAL CENTRE	POPLAR AVENUE	PE1 4QF	PETERBOROUGH
D81624	DOGSTHORPE MEDICAL CENTRE	BURGHLEY ROAD	PE1 2QE	PETERBOROUGH
D81630	HAMPTON HEALTH	HAMPTON	PE7 8DR	BORDERLINE
D81616	HODGSON MEDICAL CENTRE	HODGSON AVENUE	PE4 5EG	PETERBOROUGH
D81605	HUNTLY GROVE PRACTICE	THOMAS WALKER MEDICAL CENTRE	PE1 2QP	PETERBOROUGH
D81039	JENNER HEALTH CENTRE	TURNERS LANE	PE7 1EJ	BORDERLINE
D81026	LINCOLN ROAD SURGERY	63 LINCOLN ROAD	PE1 2SF	PETERBOROUGH
D81026	LINCOLN ROAD SURGERY	2 CHURCH STREET	PE4 6QB	PETERBOROUGH
D81631	MILLFIELD MEDICAL CENTRE	ST MARTINS STREET	PE1 3BF	PETERBOROUGH
D81019	MINSTER MEDICAL PRACTICE	THOMAS WALKER MEDICAL CENTRE	PE1 2QP	PETERBOROUGH
D81020	NENE VALLEY MEDICAL PRACTICE	CLAYTON	PE2 5GP	BORDERLINE
D81046	NEW QUEEN STREET SURGERY	SYERS LANE	PE7 1AT	BORDERLINE
D81046	NEW QUEEN STREET SURGERY	THE STANGROUND SURGERY	PE2 8RB	BORDERLINE
D81006	NORTH STREET MEDICAL CENTRE	1 NORTH STREET	PE1 2RA	PETERBOROUGH
D81029	OLD FLETTON MEDICAL PRACTICE	RECTORY GARDENS	PE2 8 AY	BORDERLINE
D81629	ORTON AND BUSHFIELD MEDICAL PRACTICE	ORTON GOLDHAY	PE2 5RQ	PETERBOROUGH
K83023	OUNDLE (NORTHAMPTON)	GLAPTHORN ROAD	PE8 4JA	BORDERLINE
D81007	PARK MEDICAL CENTRE	164 PARK ROAD	PE1 2UF	PETERBOROUGH
D81620	PARNWELL MEDICAL CENTRE	SALTERSGATE	PE1 4YL	PETERBOROUGH
D81023	PASTON HEALTH CENTRE	CHADBURN	PE4 7DG	PETERBOROUGH
D81023	PASTON HEALTH CENTRE	WERRINGTON HEALTH CENTRE, SKATERS WAY	PE4 6NB	PETERBOROUGH

[57] These are GP practices that belong to the Borderline Local Commissioning Group (LCG). They are on the borders of the Cambridgeshire and Peterborough CCG and are located in Peterborough, Northamptonshire and Cambridgeshire. There are ten GP practices and two branches in the Borderline LCG who came together as one local commissioning group because they share common commissioning intentions and challenges.

PRACTICE CODE	PRACTICE NAME	ADDRESS & POSTCODE		LOCATION
D81645	THE GRANGE MEDICAL CENTRE	144 MAYORS WALK	PE3 6HA	PETERBOROUGH
D81024	THE THOMAS WALKER SURGERY	PRINCES STREET	PE1 2QP	PETERBOROUGH
D81024	THE THOMAS WALKER SURGERY	405A FULBRIDGE ROAD	PE4 6SE	PETERBOROUGH
D81625	THISTLEMOOR MEDICAL CENTRE	6-8 THISTLEMOOR MEDICAL CENTRE	PE1 3HP	PETERBOROUGH
D81022	THORNEY MEDICAL PRACTICE	WISBECH ROAD	PE6 0SD	BORDERLINE
D81022	THORNEY MEDICAL PRACTICE	LAUREL FARM SURGERY, HIGH STREET	PE6 7UX	BORDERLINE
D81615	THORPE ROAD SURGERY	64 THORPE ROAD	PE3 6AP	PETERBOROUGH
K83017	WANSFORD (NORTHAMPTON)	YARWELL ROAD	PE8 6PL	BORDERLINE
D81065	WELLAND MEDICAL PRACTICE	144 EYE ROAD	PE1 4SG	PETERBOROUGH
D81065	WELLAND MEDICAL PRACTICE	14 CHURCH WALK	PE1 2TP	PETERBOROUGH
D81063	WESTGATE SURGERY	QUEENSGATE CENTRE	PE1 1NW	PETERBOROUGH
D81073	WESTWOOD CLINIC	WICKEN WAY	PE3 7JW	PETERBOROUGH
D81031	YAXLEY GROUP PRACTICE	HEALTH CENTRE, LANDSDOWNE ROAD	PE7 3JL	BORDERLINE

Source: NHS England

Appendix 6: Map of Peterborough and Borderline GP Practices (Including branches)



Source: NHS England

Appendix 7: Patient/Public Survey Results

7.1 Survey

In order to assess the perception of the public/patients as regards pharmaceutical needs, structured questionnaires consisting of 18 questions were randomly distributed via pharmacies and GP practices. A total of 366 filled questionnaires were returned. The results from the analysis of these questionnaires are presented in this section.

7.2 Results

7.2.1 Demography

The majority of respondents were female (237 respondents, 64.8%) (Figure 8) and persons aged 25 and above (323, 88.1%) (Figure 9). Considering the 2011 census population age structures for Peterborough, persons aged 56 and above were over-represented (Table 22). This is however a reflection of the majority of people who regularly visit health care facilities which were the main questionnaire distribution points.

Figure 8: Respondents' characteristics: Gender

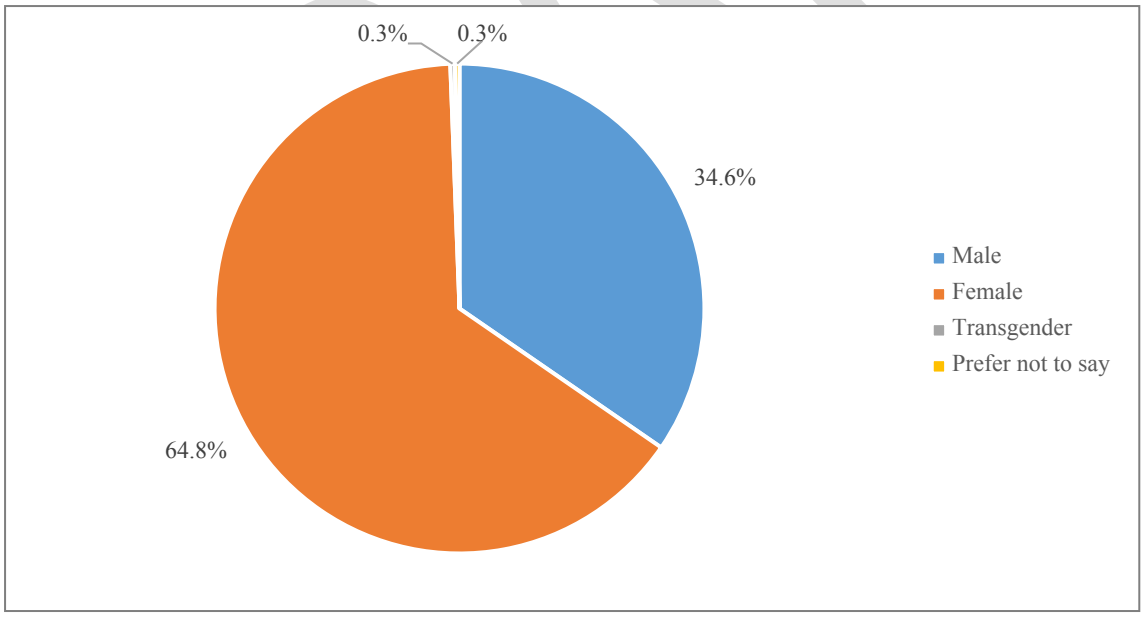


Figure 9: Respondents' characteristics: Age

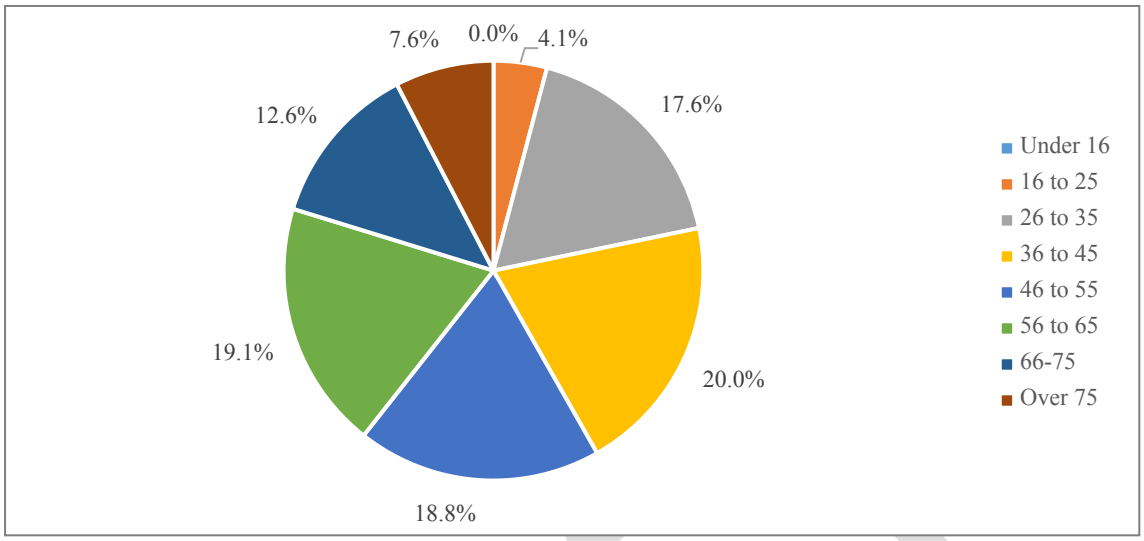


Table 22: PNA survey respondents' age groups compared to 2011 census

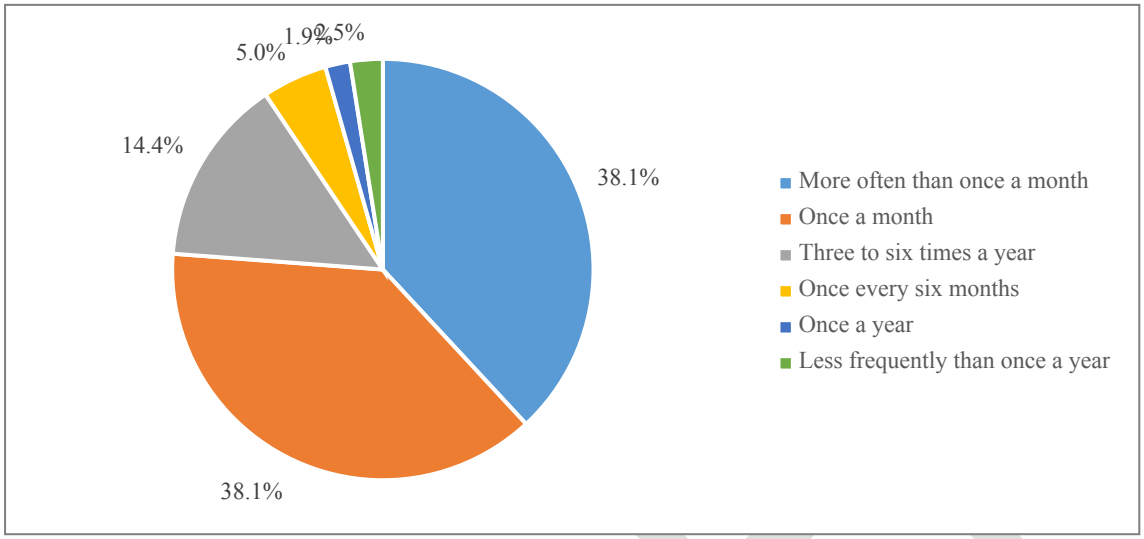
Age Bracket	2011 Census	2014 PNA Survey
Under 16	21.3%	0.0%
16 to 25	13.4%	4.1%
26 to 35	15.6%	17.6%
36 to 45	14.3%	20.0%
46 to 55	12.6%	18.8%
56 to 65	10.1%	19.1%
66-75	6.7%	12.6%
Over 75	6.6%	7.6%

7.2.2 Attendance and Opening Hours

Figure 10 shows that 76.2% of the respondents (279) visit their pharmacies once or more times a month. This suggests that the majority of the respondents frequently require pharmaceutical services which may be indicative of their poor health status but also highlights the importance of pharmacies in the local population's wellbeing.

Question 1: Which of the below options best describes how often you use a pharmacy?

Figure 10: Frequency of pharmacy visits

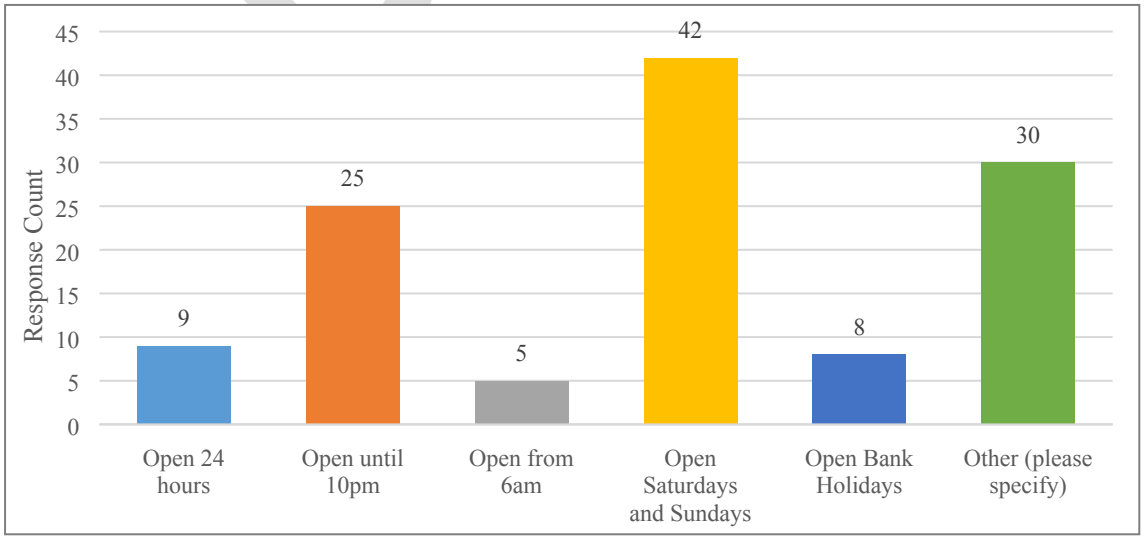


Question 4: Are you satisfied with the opening hours of your pharmacy?

The majority of the respondents (264, 72%) were satisfied with opening hours of their local pharmacies. Figure 12 gives suggestions on improvement of opening hours for those who said no (103, 28%). Opening on Saturdays and Sundays was the most selected improvement (42, 11.5%) followed by increasing opening times until 10 pm (25, 7%). In some cases additional comments were made by respondents who only wished to select one of the two days of the weekend. Note that it was possible to select more than one option.

Question 5: If no (to the above), please select the improvements to opening hours which would make the most difference to you?

Figure 11: Improvement to opening hours

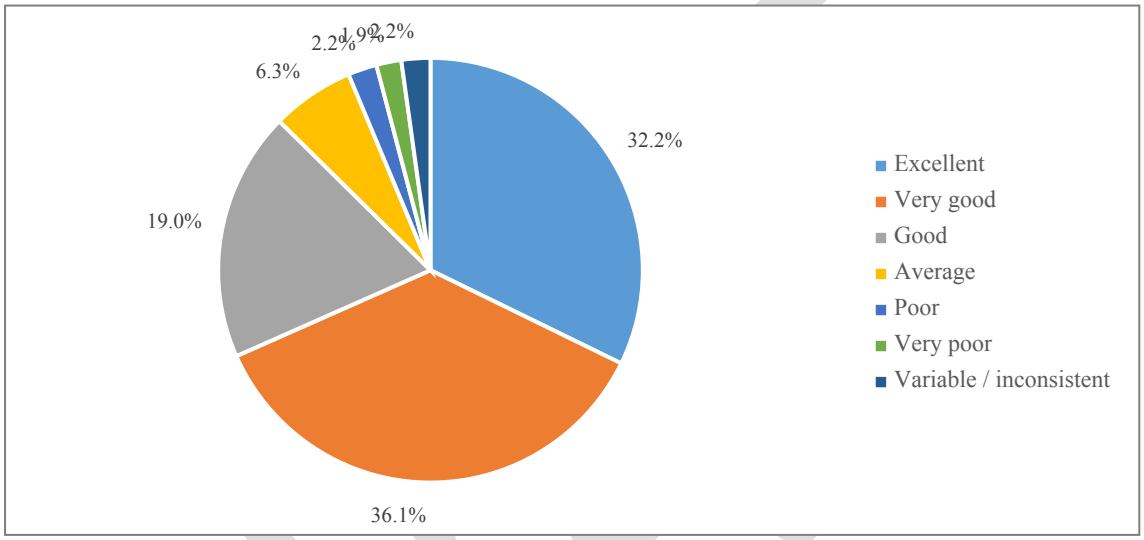


7.2.3 Pharmacy service quality

The majority of the respondents (317, 86.6%) rated their pharmacies as good or above (Figure 12) while 89.2% (327) described their pharmacy as retaining the same quality or improving (Figure 13).

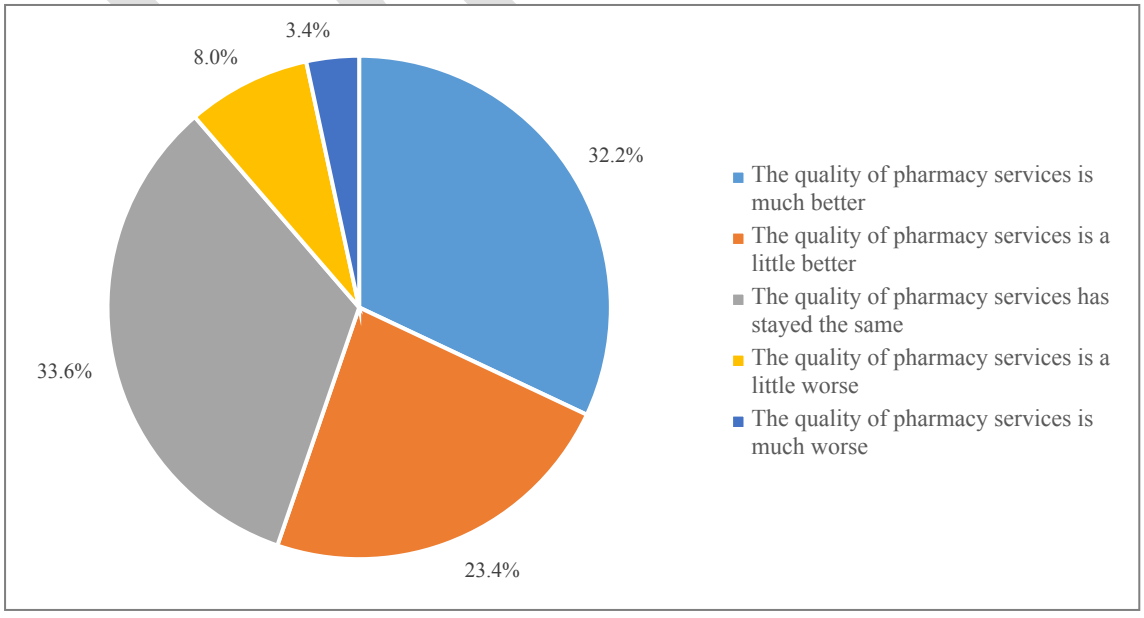
Question 2: How would you rate the quality of the services you receive in your pharmacy?

Figure 12: Pharmacy service quality rating



Question 3: Do you feel that the quality of pharmacy services provided has got better or worse over the past three years?

Figure 13: Pharmacy service improvement

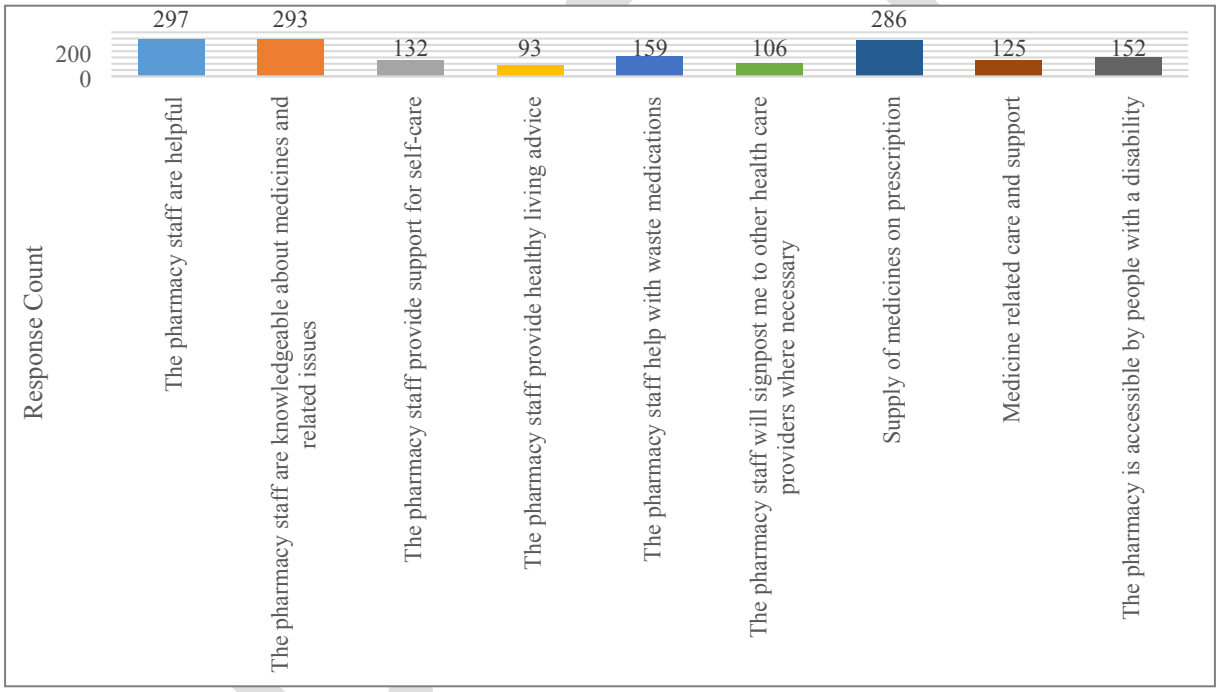


7.2.4 Pharmacy Service Choice

Helpful (297, 81.1%) and knowledgeable (293, 80.1%) staff and supply of medicines on prescription (286, 78.1%) were the most important factors in pharmacy choice among respondents (Figure 14). Among the locally commissioned services Pharmacy First (88, 24%) and supervision and advice on medication (80, 21.9%) were the most valued services (Figure 15). The most common services highlighted by those who selected 'Other' were repeat prescriptions and off counter purchase of medicines.

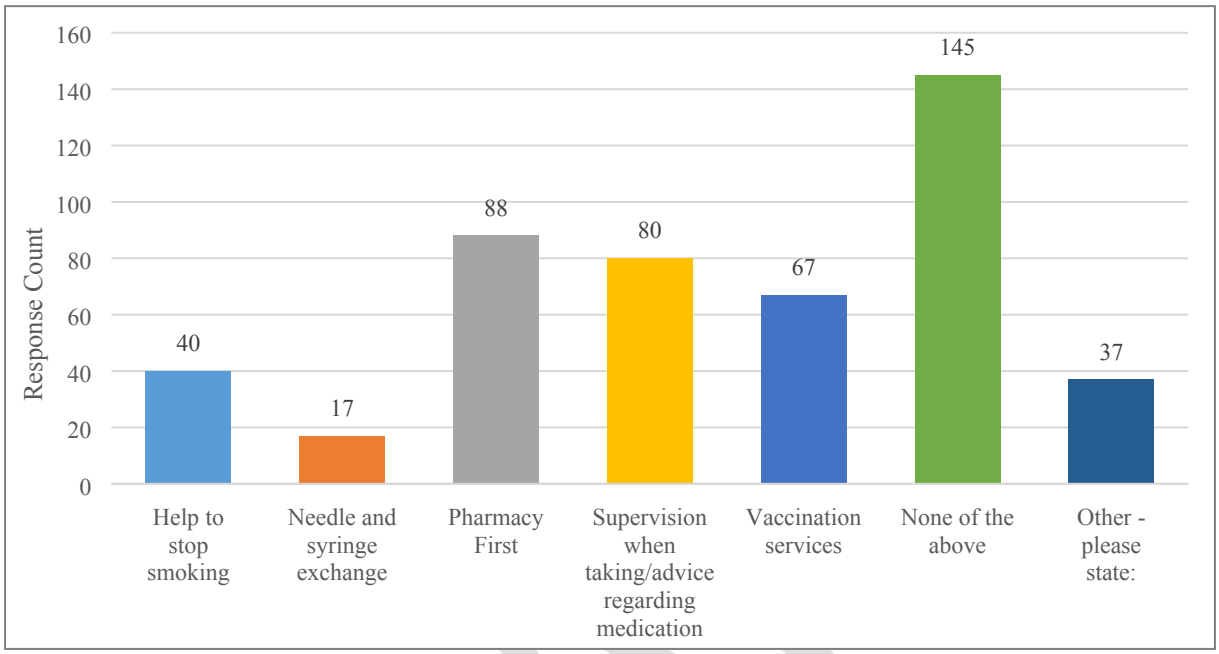
Question 6: Please tick the box next to each of the below services that you feel are important to you in your choice of pharmacy.

Figure 14: Important factors in pharmacy choice



Question 7: Which of the below services, currently provided by pharmacies in Peterborough, are most important to you?

Figure 15: Most important pharmacy services

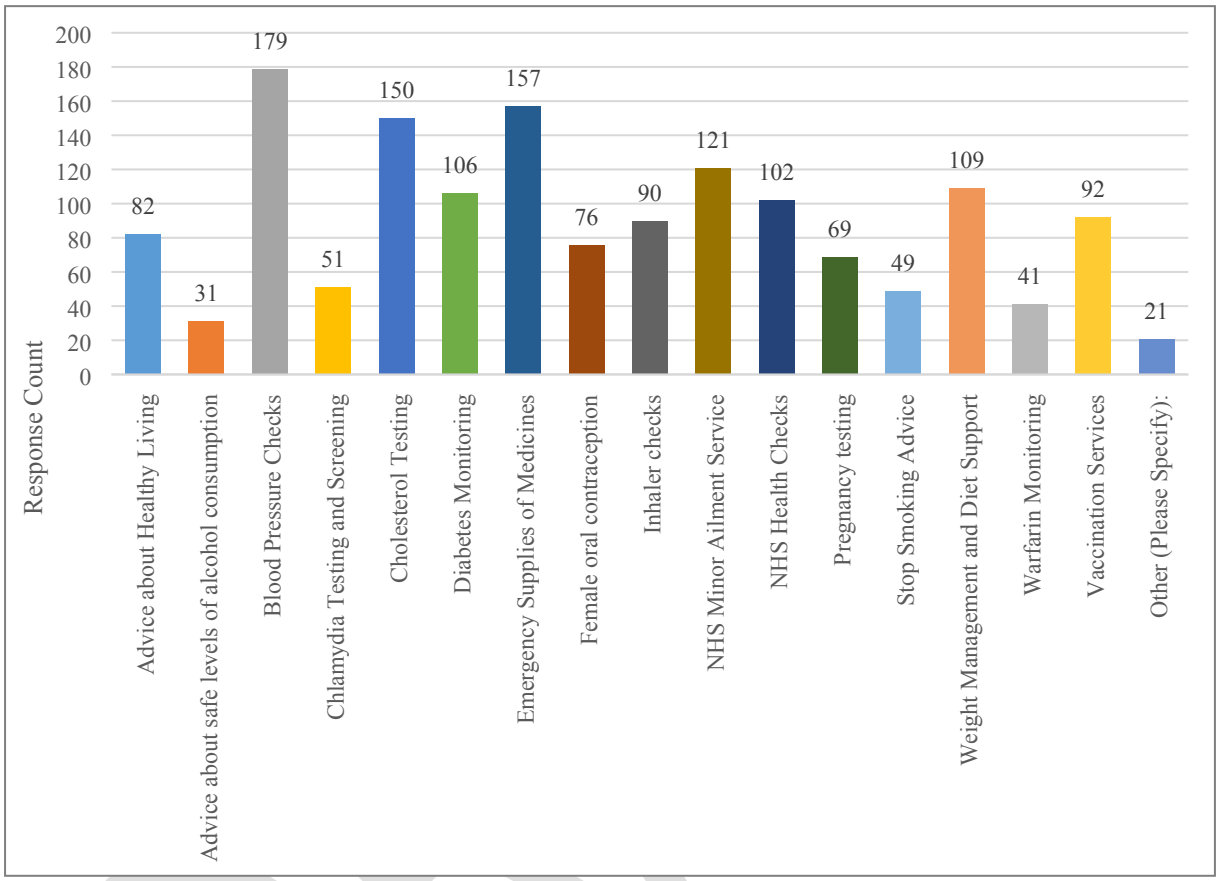


7.2.5. Recommendations on future service provision

Most respondents would like blood pressure checks (179, 48.9%), supply of emergency medication (157, 42.9%) and cholesterol tests (150, 41%) provided by their local pharmacies (Figure 16).

Question 11: Which services would you like to see provided by your pharmacy in the future?

Figure 16: Future pharmacy service provision



7.2.6 Pharmacist Consultation

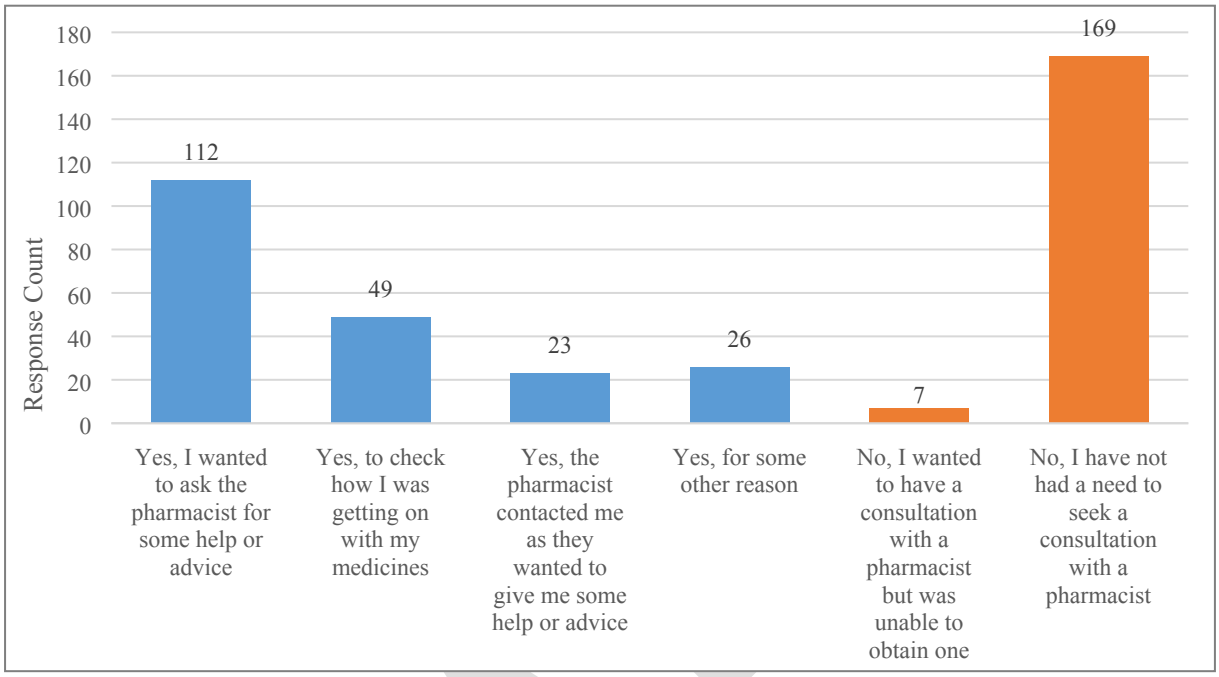
Question 12: In the last 12 months, have you had a consultation, or multiple consultations, with a pharmacist?

The majority of respondents (210, 57.4%) who needed a consultation session with a pharmacist were able to obtain one. Most of these respondents were seeking help or advice related to pharmacy services. Only seven respondents were unsuccessful (Figure 17).

The majority of the consultations (101, 48.1 %) took place over the dispensing counter but a significant number (67, 39.1%) also took place in a private consultation room (Figure 18).

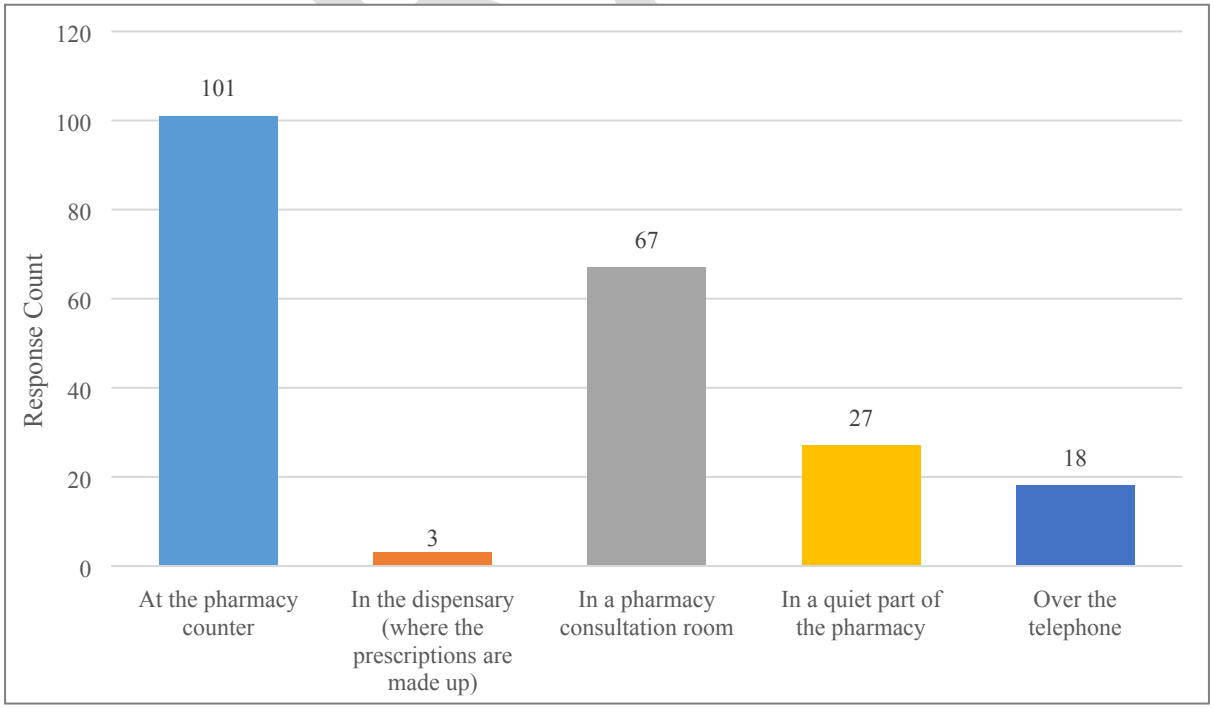
Most respondents were satisfied with consultation sessions in terms of opportunity to ask questions, pharmacist's knowledge, physical comfort, privacy and usefulness of advice. However as regards privacy a significant number (34, 16.2%) rated it as poor or very poor (Figure 19)

Figure 17: Consulting a pharmacist



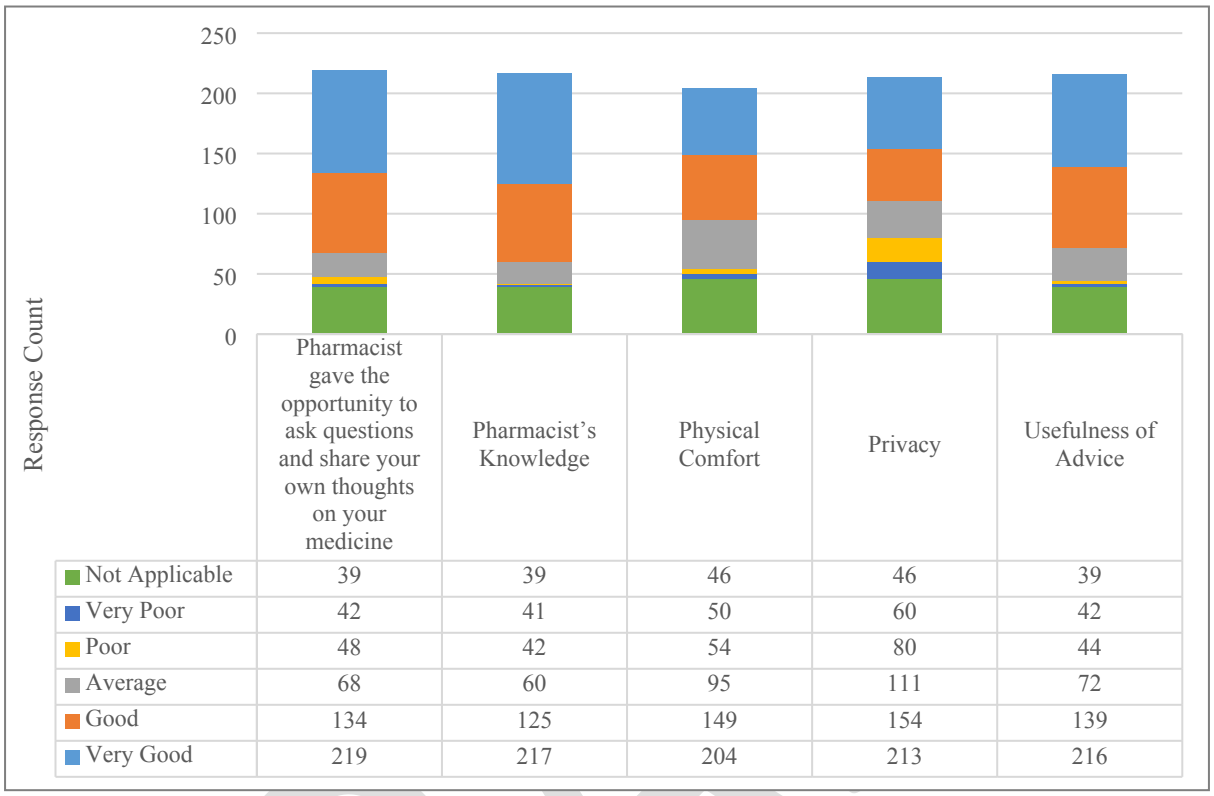
Question 13: If you had a consultation with the pharmacist, where did it happen?

Figure 18: Venue of consultation with pharmacist



Question 14: If you had a consultation with a pharmacist, how happy were you with the following aspects of the consultation?

Figure 19: Satisfaction with consultation session



	Pharmacist gave the opportunity to ask questions and share your own thoughts on your medicine	Pharmacist's Knowledge	Physical Comfort	Privacy	Usefulness of Advice
Not Applicable	39	39	46	46	39
Very Poor	42	41	50	60	42
Poor	48	42	54	80	44
Average	68	60	95	111	72
Good	134	125	149	154	139
Very Good	219	217	204	213	216

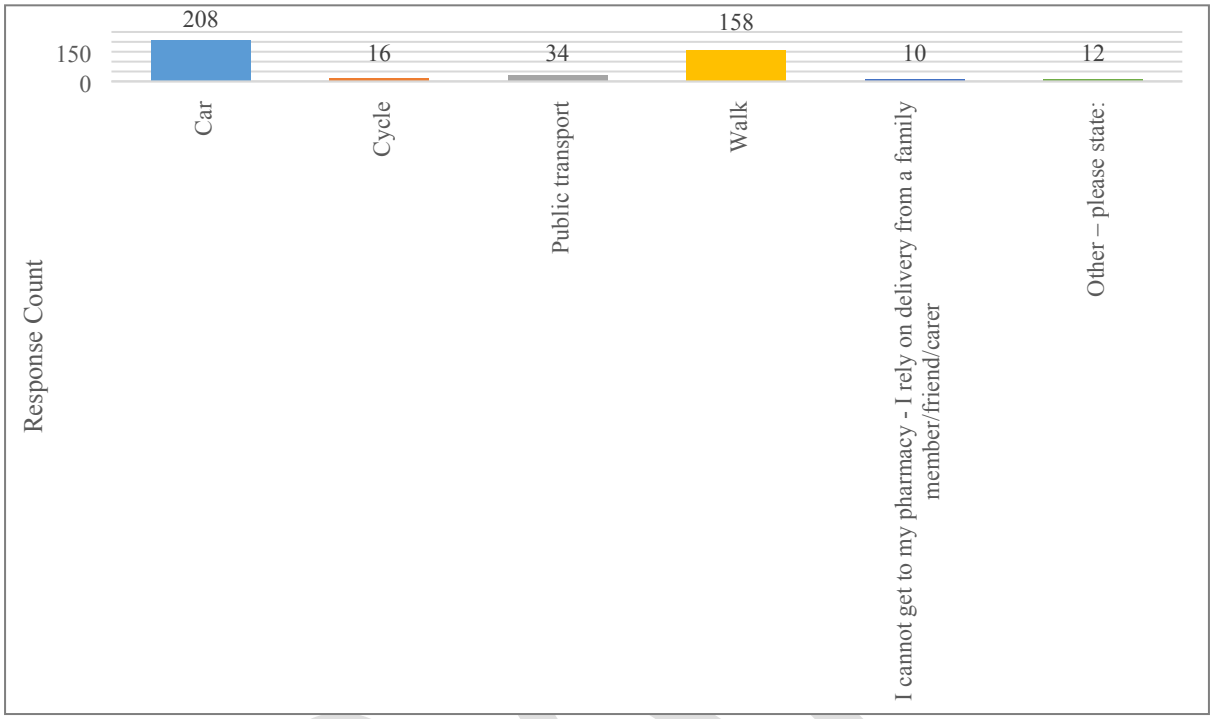
7.2.7 Transport and Location

The majority of the respondents drive to their local pharmacies but also a significant number (158, 43.2%) walk which is indicative of easy access (Figure 20).Figure 21 further confirms this as the majority of respondents (348, 95%) said they lived at most five miles from their local pharmacy.

The majority of respondents consider a pharmacy being close home (223, 60.9%) or near their GP Practice (179, 48.9%) as most important (Figure 22).

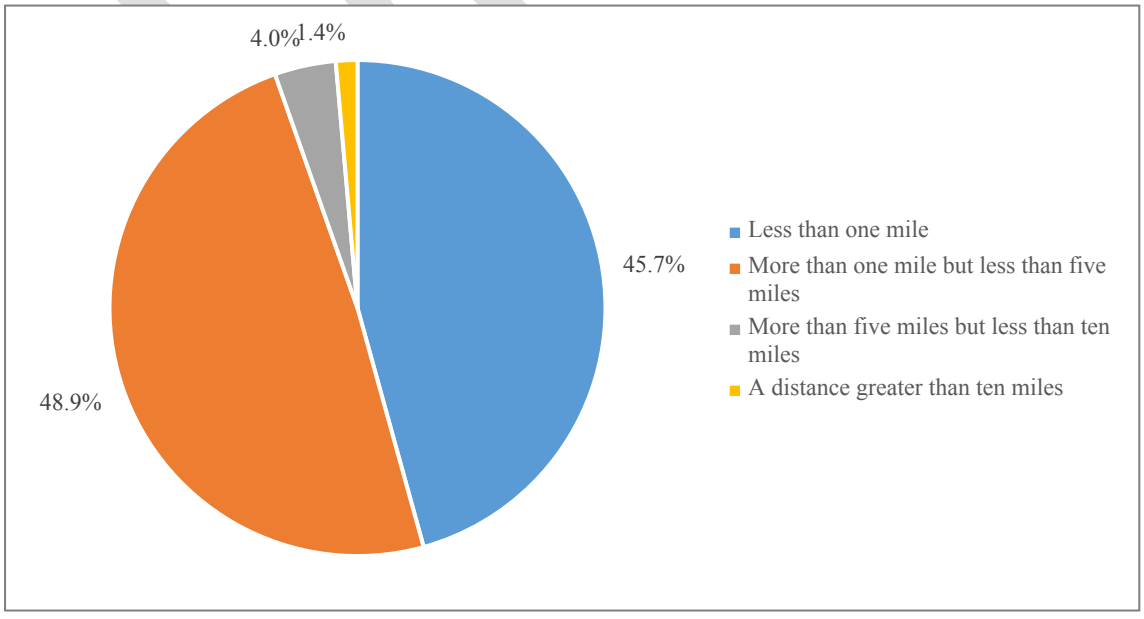
Question 8: How do you normally get to a pharmacy?

Figure 20: Accessing a local pharmacy



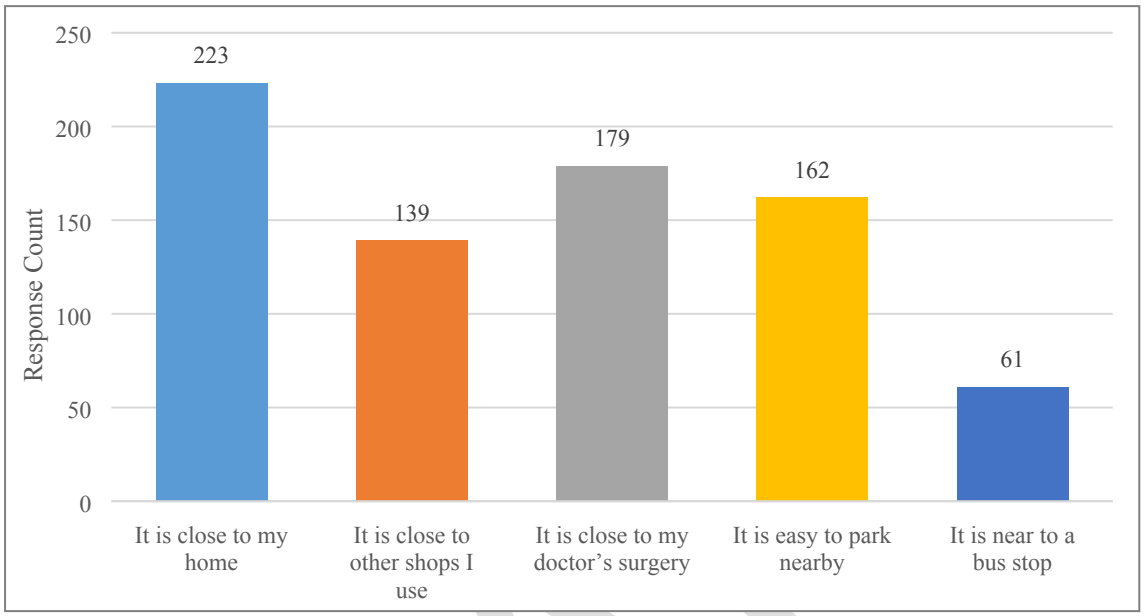
Question 9: Please estimate how far from your home is your local pharmacy or the pharmacy you most frequently choose to use?

Figure 21: Distance to local pharmacy



Question 10: Please tick the box next to the following factors if you feel they are important to you with regards to location of a pharmacy.

Figure 22: Location of pharmacy



Appendix 8: Community Pharmacy Survey

8.1 Survey

In order to assess the capacity of existing pharmacies to provide specified services a structured questionnaire with questions mainly covering service provision, pharmacy premises, information technology and staff was sent to all pharmacies in Peterborough (41 excluding distance pharmacies) and three dispensing practices. A total of 29 filled questionnaires were returned (66%). None of the three dispensing practices responded. The results from the analysis of these questionnaires are presented in this section.

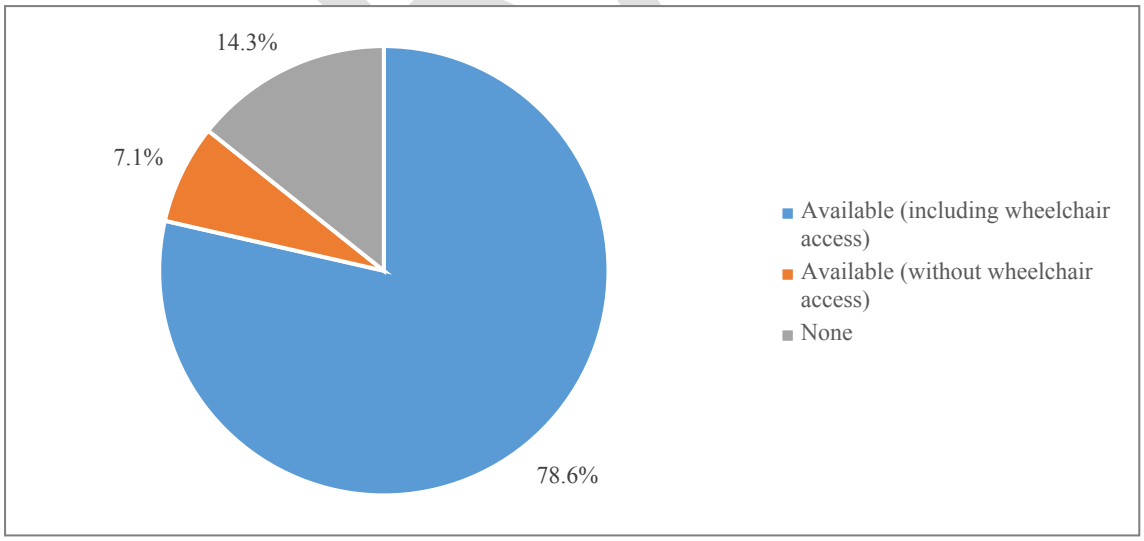
8.2 Results

8.2.1 Consultation Facilities

Twenty five out of the 29 (86.2%) pharmacies that responded to the questionnaire have consultation areas within their premises all of which can be closed to provide privacy. Twenty three have consultation areas with wheelchair access (78.6 %). Fifty five percent (16 pharmacies) have toilet facilities that can be accessed by patients attending consultation sessions (Figures 23 & 24).

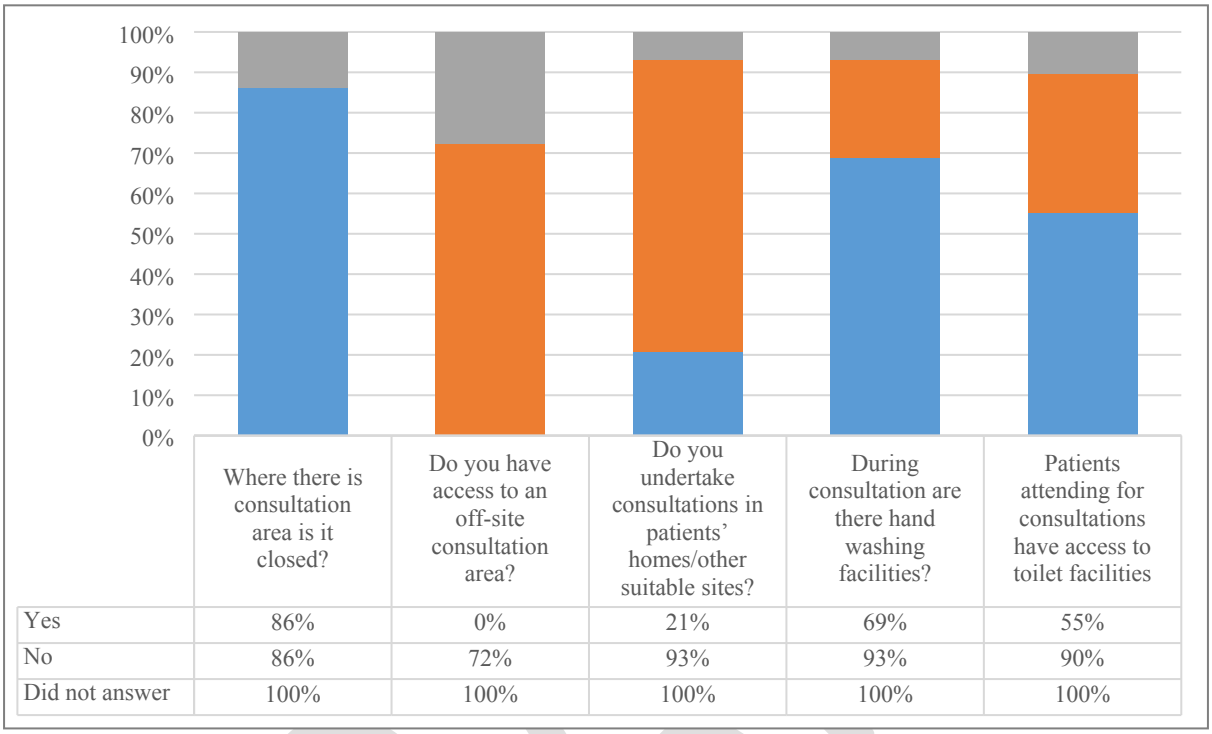
Question 1: Is there a consultation area on the premises?

Figure 23: Consultation Area



Question 2: Where do consultations take place, and what facilities are available?

Figure 24: Consultation facilities



	Where there is consultation area is it closed?	Do you have access to an off-site consultation area?	Do you undertake consultations in patients' homes/other suitable sites?	During consultation are there hand washing facilities?	Patients attending for consultations have access to toilet facilities
Yes	86%	0%	21%	69%	55%
No	86%	72%	93%	93%	90%
Did not answer	100%	100%	100%	100%	100%

8.2.2 Languages

Question 3: What languages are spoken at the pharmacy?

At the majority of pharmacies, English and at least one other language are spoken (26, 89%) while at a few (3, 11%) only English is spoken. Table 23 below shows the top five most spoken non-English languages.

Table 23: Languages spoken at pharmacies in Peterborough

Language	Number of pharmacies
Urdu	14
Gujarati	13
Punjabi	10
Hindi	9
Polish	6

Other languages spoken include Lithuanian, Italian, Portuguese, Russian, Spanish, Swahili and Welsh.

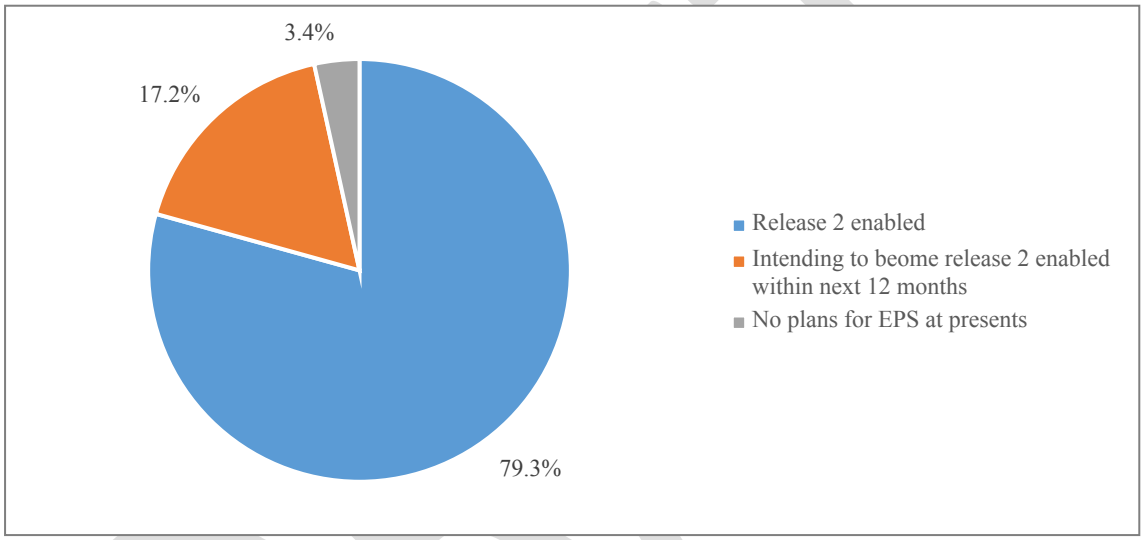
8.2.3 Information Technology

The majority of pharmacies are either EPS enabled (23, 79.3%) or have plans to be in the next 12 months (5, 17.2%) (Figure 25).

Most pharmacies have computers that can open documents in PDF format (28, 96.5%) but more than 10 do not have capabilities to open MS Word, Excel and Access documents (Figure 26), an issue that needs further exploration as it might be a hindrance to effective communication.

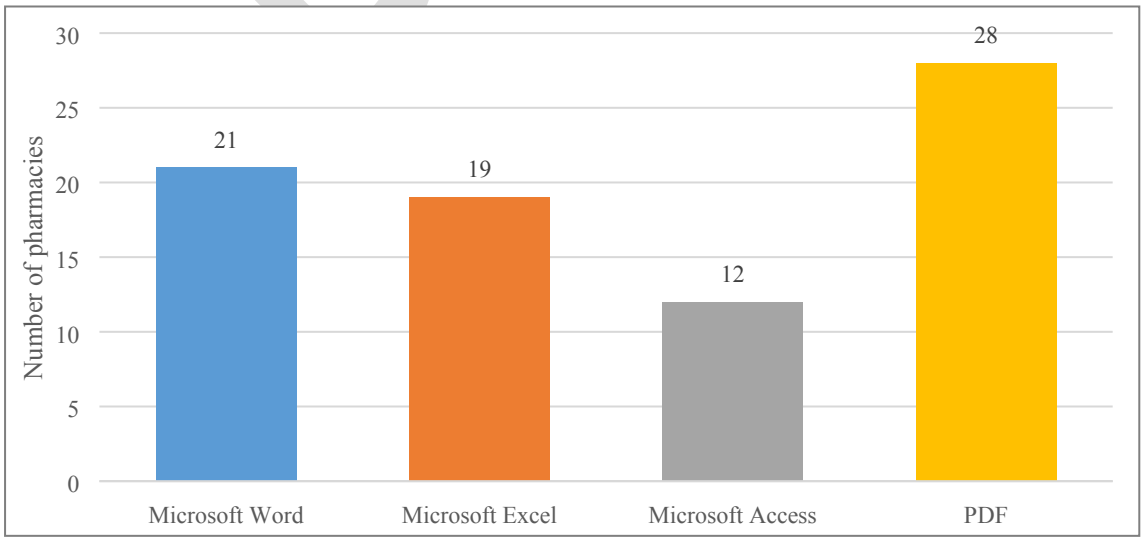
Question 4: Is the pharmacy Electronic Prescription Service (EPS) enabled?

Figure 25: Electronic Prescription Service



Question 5: Does the pharmacy have the facility to open documents in the following formats?

Figure 26: Microsoft Software

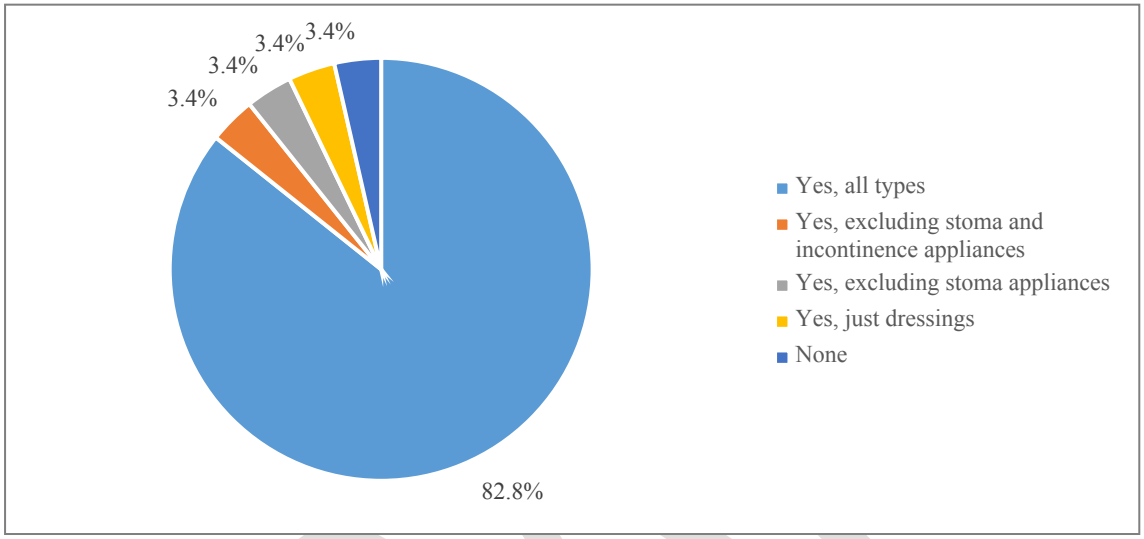


8.2.4 Medical appliances

The majority of pharmacies dispense all types of appliances (24, 83%) and only one pharmacy (3.4%) does not dispense any appliance at all (Figure 27).

Question 6: Does the pharmacy dispense appliances?

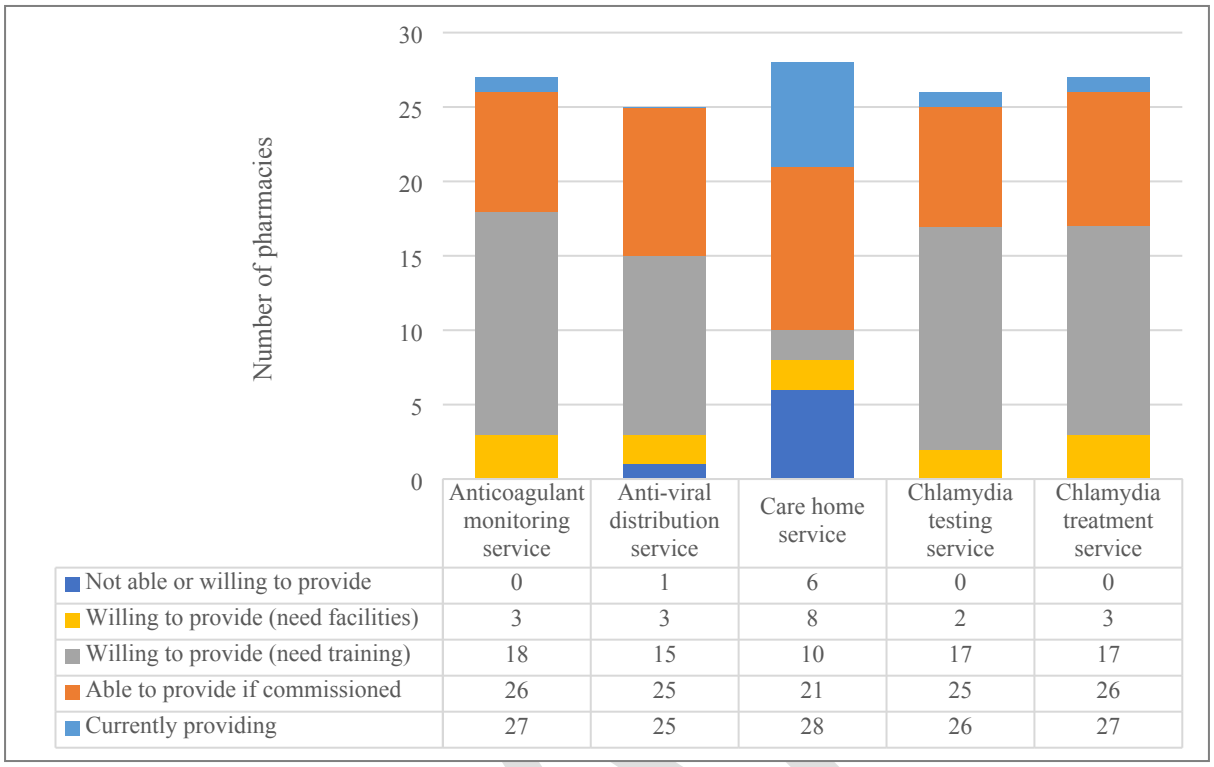
Figure 27: Dispensing of appliances



8.2.5 Locally Commissioned Services

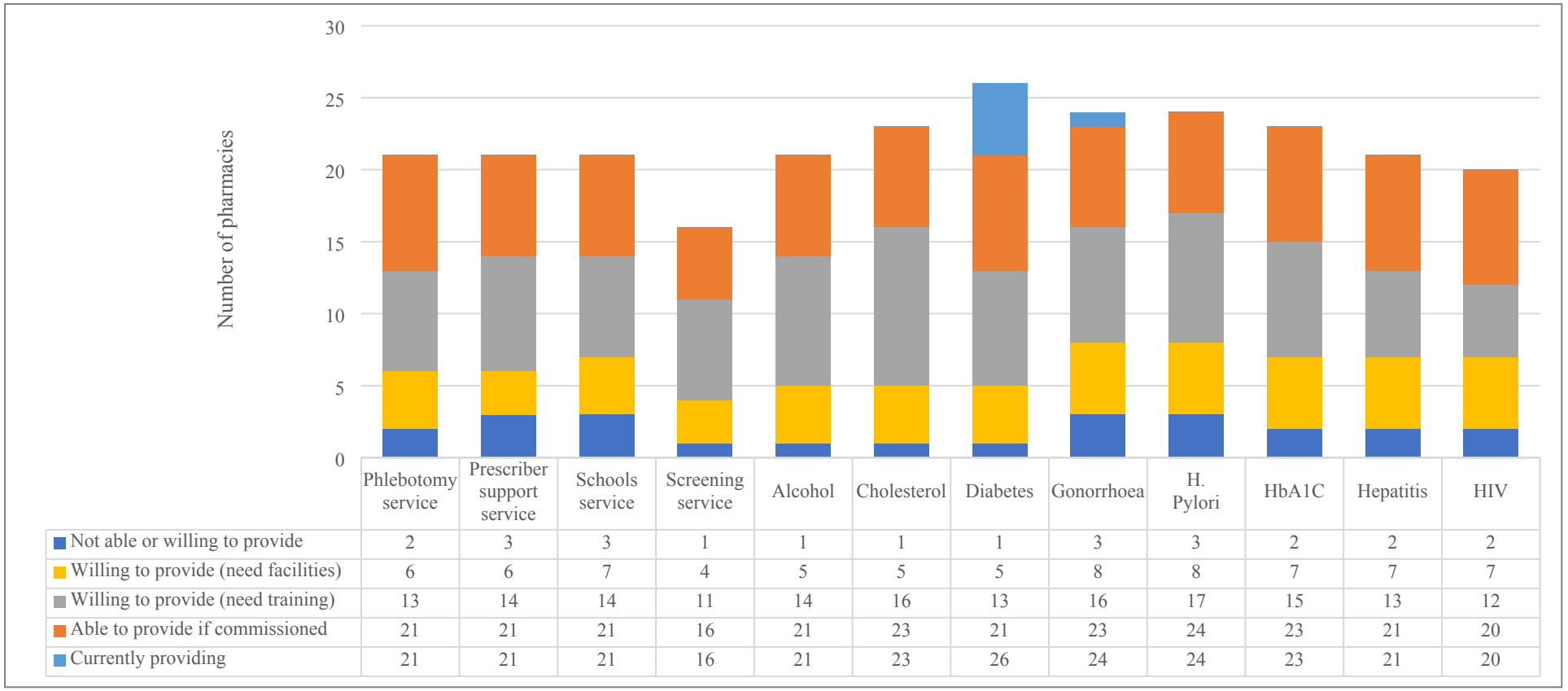
A number of pharmacies reported that they were currently commissioned to provide various specified services (Figures 28-31). However apart from stop smoking and supervised medicine administration the rest have not been commissioned by NHS England, CCG nor Peterborough City Council. There is need to explore further to understand how these services are provided in respective pharmacies. The willingness to provide various specified services was varied with most pharmacies expressing willingness if commissioned, trained and provided with facilities.

Figure 28: Service Provision



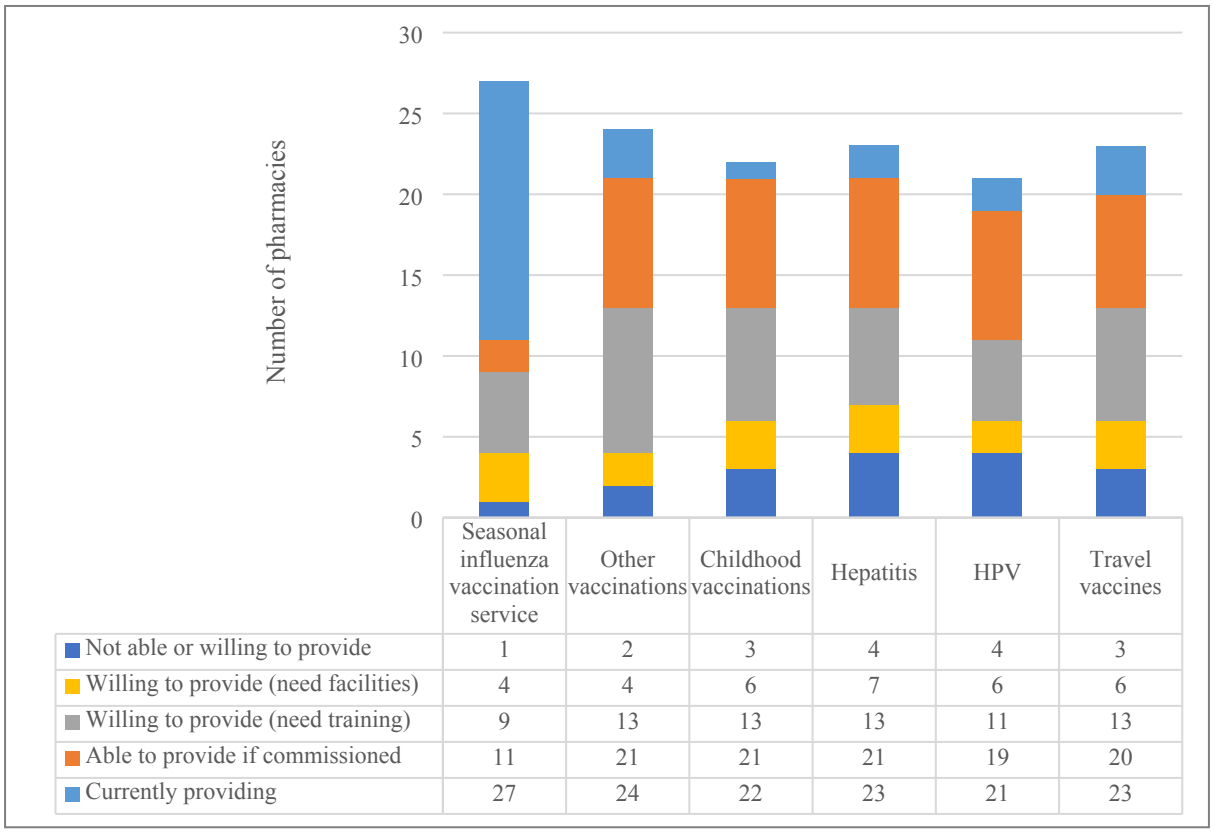
	Anticoagulant monitoring service	Anti-viral distribution service	Care home service	Chlamydia testing service	Chlamydia treatment service
Not able or willing to provide	0	1	6	0	0
Willing to provide (need facilities)	3	3	8	2	3
Willing to provide (need training)	18	15	10	17	17
Able to provide if commissioned	26	25	21	25	26
Currently providing	27	25	28	26	27

Figure 29: Service Provision



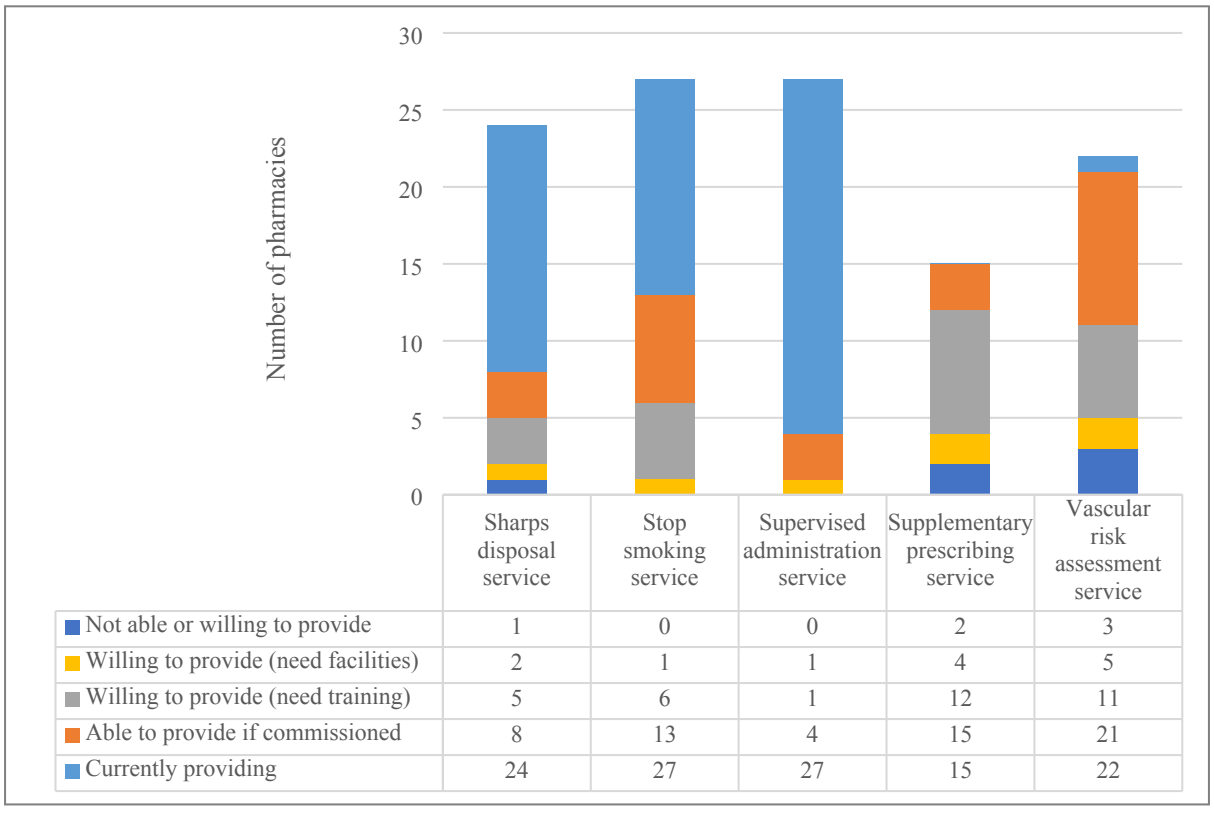
	Phlebotomy service	Prescriber support service	Schools service	Screening service	Alcohol	Cholesterol	Diabetes	Gonorrhoea	H. Pylori	HbA1C	Hepatitis	HIV
Not able or willing to provide	2	3	3	1	1	1	1	3	3	2	2	2
Willing to provide (need facilities)	6	6	7	4	5	5	5	8	8	7	7	7
Willing to provide (need training)	13	14	14	11	14	16	13	16	17	15	13	12
Able to provide if commissioned	21	21	21	16	21	23	21	23	24	23	21	20
Currently providing	21	21	21	16	21	23	26	24	24	23	21	20

Figure 30: Service Provision



	Seasonal influenza vaccination service	Other vaccinations	Childhood vaccinations	Hepatitis	HPV	Travel vaccines
Not able or willing to provide	1	2	3	4	4	3
Willing to provide (need facilities)	4	4	6	7	6	6
Willing to provide (need training)	9	13	13	13	11	13
Able to provide if commissioned	11	21	21	21	19	20
Currently providing	27	24	22	23	21	23

Figure 31: Service Provision



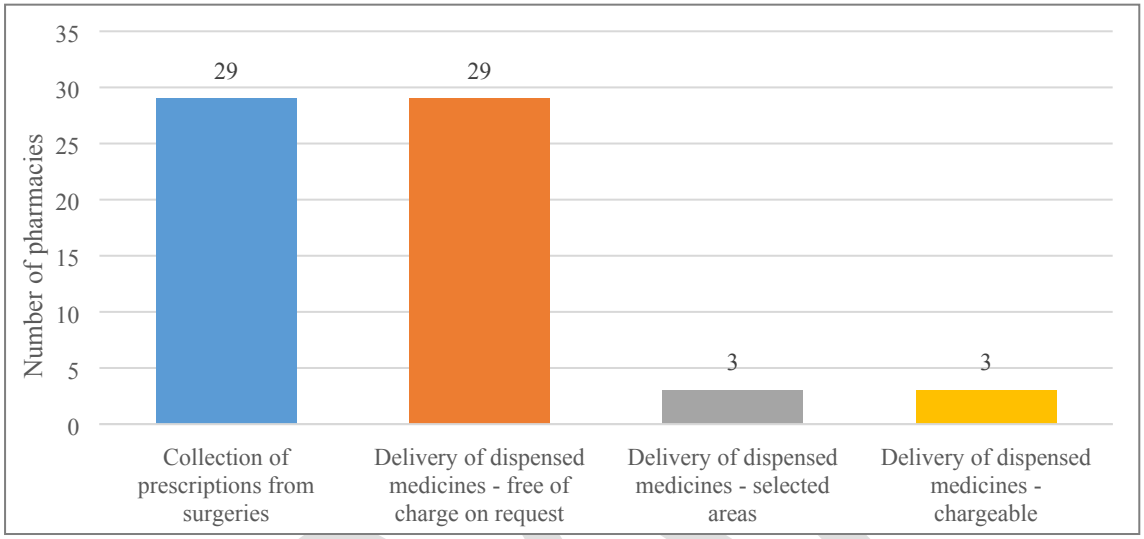
	Sharps disposal service	Stop smoking service	Supervised administration service	Supplementary prescribing service	Vascular risk assessment service
Not able or willing to provide	1	0	0	2	3
Willing to provide (need facilities)	2	1	1	4	5
Willing to provide (need training)	5	6	1	12	11
Able to provide if commissioned	8	13	4	15	21
Currently providing	24	27	27	15	22

8.2.6 Non-NHS Funded Services

All pharmacies that responded to the survey collect prescriptions from practices and deliver dispensed medicines free of charge on request (Figure 32).

Question 7: Does the pharmacy provide any of the following?

Figure 32: Non-NHS funded services offered by pharmacies



Question 8: Does your dispensary/pharmacy supply medicines and other appliances to care homes?

Sixty four percent (19 pharmacies) do not supply medicines or other medical equipment to care homes.

8.2.7 Dispensary/Pharmacy Facilities

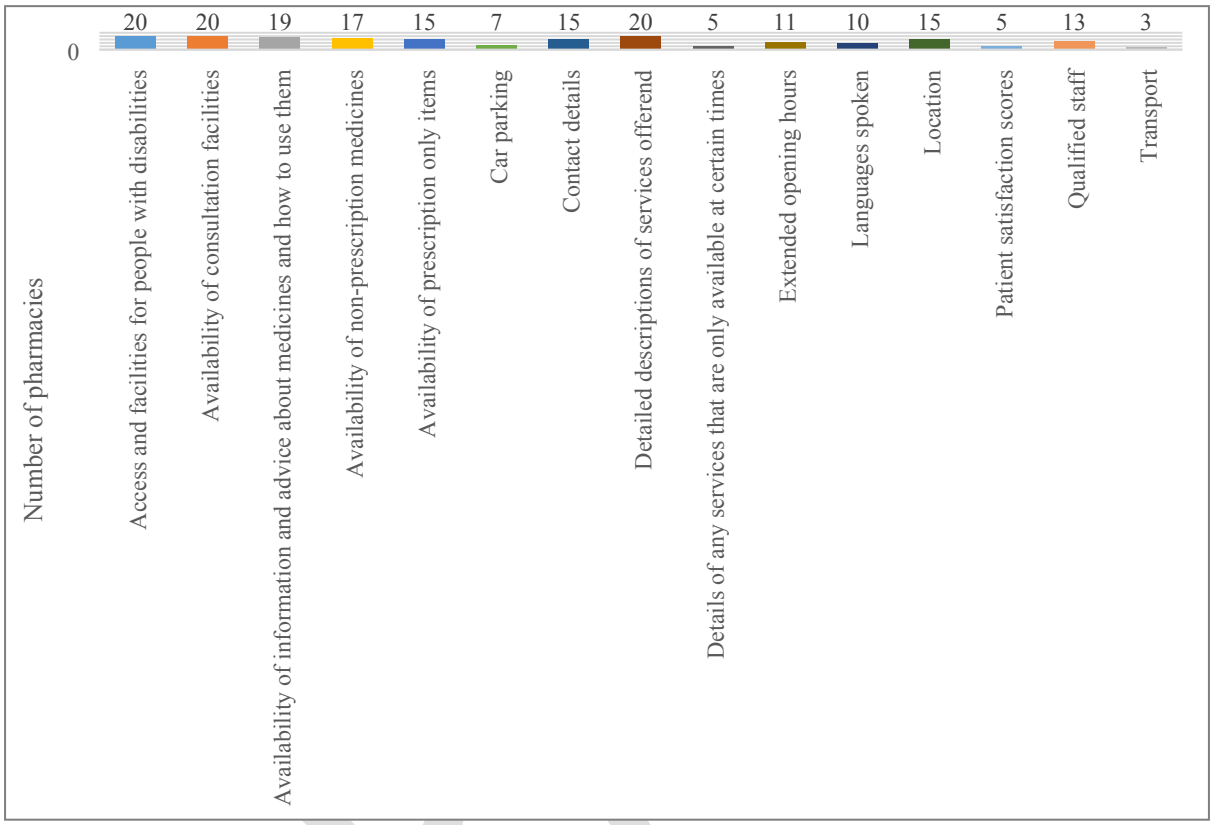
The top four most important pharmacy features (Figure 33) reported by pharmacy staff were:

- Access to premises by people with disability
- Availability of consultation facilities
- Availability of medicines and advice on use
- Detailed description of services provided

More than half of the respondents (15, 52%) thought the pharmaceutical service provision in their areas was excellent while a third (10 pharmacies) thought it was good. Only one respondent (4%) thought it was poor (Figure 34).

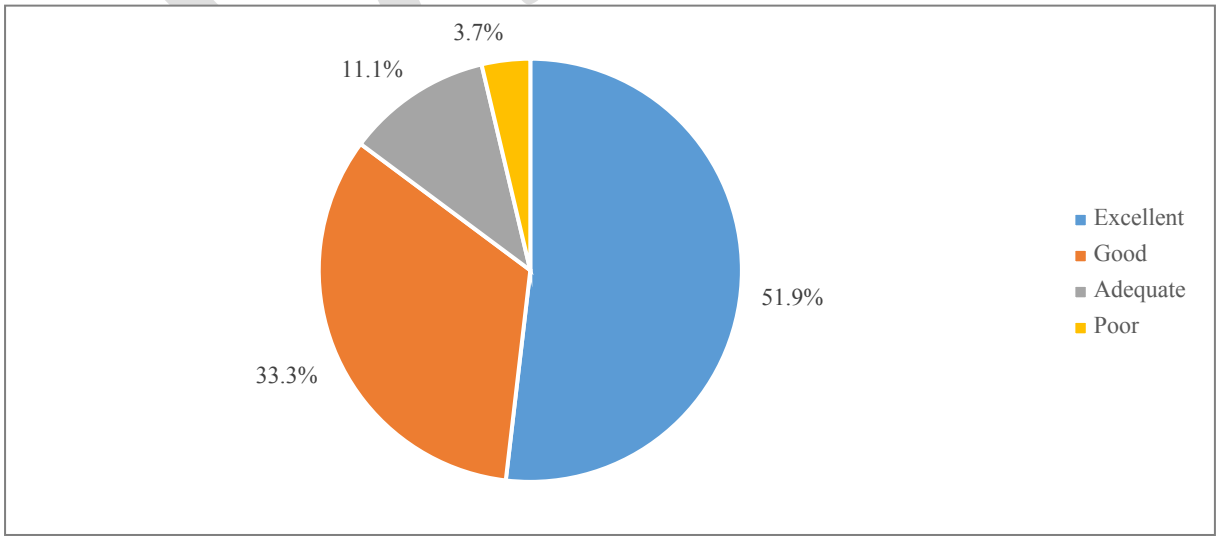
Question 9: Which of these features of your dispensary or pharmacy would you identify as being important?

Figure 33: Features of dispensary or pharmacy considered as important



Question 10: Is the current provision of dispensing doctors and community pharmacies excellent, good, adequate or poor?

Figure 34: Adequacy of current pharmaceutical service provision



Question 11: Do you feel there is a need for more pharmaceutical service providers in your locality?

The majority of respondents (27, 92%) did not feel it was necessary to have more pharmaceutical service providers in their areas.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(c)
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Julian Base, Head of Health Strategy, Public Health	Tel. 207180

CARDIOVASCULAR DISEASE PROGRAMME UPDATE

R E C O M ME N D A T I O N S	
FROM: Dr Liz Robin, Director of Public Health	**Deadline date:** 26 March 2015

1. The Board is asked to consider the outcomes from the cardiovascular disease programme workshop held on 30 January 2015.

2. The Board is asked to nominate both senior champions and lead officers to support the cardiovascular disease programme as referenced in section 5.2.

3. The Board is asked to approve the proposal for a new Public Health Board, reporting to the Health and Wellbeing Programme Board, to become the 'steering group' for the cardiovascular disease strategy, as referenced in section 5.7.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from the Corporate Director of People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update on work undertaken to develop the local cardiovascular disease strategy, to reduce prevalence and improve outcomes, for the population of Peterborough.

2.2 This report is for Board to consider under its Terms of Reference No. 3.3

> *'To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.'*

2.3 This report supports the Health and Wellbeing Board strategic priority of 'Preventing and treating avoidable illness' and particularly the linked outcomes of addressing disease and poor health indicators; and the HWB function

'*To develop a Health and Well Being Strategy for the City which informs and influences the commissioning plans of partner agencies.'*

3. BACKGROUND

3.1 The Health and Wellbeing Board has acknowledged that cardiovascular disease is the main cause of death at all ages, and that Peterborough is ranked among those local authorities with the highest prevalence. In fact Peterborough is ranked 125th out of 150 local authorities for premature deaths from heart disease and stroke.

3.2 Public Health have been tasked with developing a cardiovascular disease strategy to address the risk factors, reduce the prevalence of disease and associated mortality and improve the quality of life for local people affected by cardiovascular disease.

4. CARDIOVASCULAR DISEASE WORKSHOP

4.1 Public Health held a cardiovascular disease workshop for partners on 30 January 2015 focused on the three previously agreed workstreams of 'prevention and early intervention', 'treatment and reablement' and 'continuing care'.

4.2 Those attending the workshop considered local prevalence of cardiovascular disease,; underlying factors and wider determinants; population and individual interventions to address smoking, poor diet and physical inactivity; treatment for high blood pressure and other risk factors e.g. for a stroke.

4.3 National Institute for Health and Care Excellence (NICE) guidance for the prevention of cardiovascular disease was reviewed at the workshop to structure discussions and enable attendees to consider where the focus should be and to scope opportunities.

5. OUTCOMES

5.1 The NICE guidance reviewed at the workshop stressed the need to identify senior figures as champions for cardiovascular disease prevention and management and to identify lead officers to become actively involved in developing and implementing the strategy on behalf of their organisation.

5.2 As the lead for the local strategy, Public Health is drafting the terms of reference for the three workstream programme groups and intend that the first meetings are held in April 2015. Members of the Health and Wellbeing Board are therefore requested to identify both champions and lead officers from their respective organisations. Members are also asked to consider nominating other champions that could become involved in the programme, for example those representing charities, employers, clubs, self-help and community groups.

5.3 There was an overall commitment from those attending the workshop that a population-based approach to prevention should be adopted and that the programme should be linked with existing strategies for targeting people at particularly high risk of cardiovascular disease including promoting the uptake and appropriate referrals to services from Health Checks.

5.4 The need to consider policies which are likely to encourage healthier eating, tobacco control and increased physical activity were also reviewed at the workshop, as was the need to consider policies that may cover spatial planning, transport, food retailing and procurement. This area of work will be incorporated into the local cardiovascular disease prevention work programme with associated recommendations developed as the programme progresses for the Health and Wellbeing Board to consider.

5.5 In addition to the focus on prevention, the workshop identified scope to improve treatment pathways and outcomes for those with cardiovascular disease, to include acute interventions and reablement e.g. in stroke. It recognised the work of the coronary heart disease inequalities board and looks to learn from, and build on, this for the wider cardiovascular disease strategy. A clinical champion and engagement with hospital clinicians and GPs will be crucial to the work of this programme group.

5.6 The importance of access to rehabilitation and generic lifestyle support (opportunities for physical activity, smoking cessation and weight management) at all stages of the disease process was a feature of the workshop discussions. Support to access lifestyle services was identified as a key issue for those living with the long term consequences of cardiovascular disease.

5.7 Those attending the workshop endorsed the decision that Public Health should lead the development of the cardiovascular disease strategy and joint strategic needs assessment. A Public Health Board, to be chaired by the new Director of Public Health, Dr. Liz Robin is to be established in April 2015. It is recommended that this new board becomes the initial 'steering group' for the cardiovascular disease strategy, providing oversight and direction to the three workstream groups. The new Public Health Board will report to the Health and Wellbeing Programme Board.

6. REASONS FOR RECOMMENDATIONS

6.1 The key recommendations have been made following consultation at the local cardiovascular disease strategy workshop and consideration of associated NICE guidance.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Consideration has been given to the Health and Wellbeing Programme Board continuing to operate as the 'steering group' for development of the cardiovascular disease strategy. However, considering the lead role of Public Health on the strategy, the more focused role of the Public Health Board and its membership and expertise, it was felt that this new board would be a more appropriate group to provide initial oversight and direction.

8. IMPLICATIONS

The development and implementation of the cardiovascular disease strategy will address the leading cause of premature death in Peterborough and contribute to tackling significant inequalities in health and wellbeing. The prevalence of risk factors and disease shows marked ethnic and gender differences which will be laid out in the associated JSNA.

9. BACKGROUND DOCUMENTS

NONE

Julian Base, Head of Health Strategy

Dr Anne McConville, FFPH, MRCGP
Interim Consultant in Public Health

10/03/15

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7(a)
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Tina Hornsby – Head of Quality and Safeguarding	Tel. 01733 452427

CARE ACT PLAN AND IMPLICATIONS

RECOMMENDATIONS	
FROM : WENDI OGLE-WELBOURN – CORPORATE DIRECTOR PEOPLE AND COMMUNITIES	**Deadline date :N/A**
1. Board members are requested to note: i. The first phase of Care Act duties and powers come into enactment on 1 April 2015. The Council been preparing for this via its wider transformation programme, and many aspects are already in place. However there will be some changes that will be put in place on 1 April 15 to ensure compliance which are described in the report. ii. We are finalising a Care Act framework, delivery plan and consultation plan which will describe how we will work with service users and carers to deliver cultural change and operational changes that will require more time. We will bring these plans to the Board in a further update report	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board for information only.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to sets out an update on the Council's preparations for the introduction of the Carer Act on 1 April 2015 and implications.

3. BACKGROUND

3.1 The Care Act comes into effect in two phases. The first phase is to be implemented in April 2015 and includes the major elements of care and support reform. The second phase is to be implemented in April 2016 and brings in the significant financial reforms recommended within the Dilnot report, including the cap on care costs and significantly more generous capital thresholds for access to state funding of care and support.

3.2 The Council has previously consulted on a new target operating model for Adult Social Care. This went live between November 14 and February 15 providing the foundations for Care Act compliance in particular in relation to delivery of the general duties under the Act. These include:

- Promotion of Wellbeing
- Preventing, reducing and delaying need
- Universal and tailored information and advice
- Better support for the transition from children's to adults services

3.3 We have also begun to work together to deliver the following general duties via our work on the Better Care Fund:

- Integration, cooperation and partnerships,
- Care market shaping.

3.4 However, there are some key changes that we are preparing to implement in April 2015: These include:

Change	Implications
A new process and paperwork for Adult Safeguarding enquiries. We have developed this in partnership with Cambridgeshire County Council and Cambridgeshire and Peterborough NHS Foundation Trust. This is the first stage in our inclusion of Adult Safeguarding within a countywide Multi Agency Safeguarding Hub (MASH)	We anticipate an additional number of safeguarding referrals in 2015/16 in recognition of the Care Act's inclusion of self-neglect as a safeguarding concern. We are however working with partners to ensure that a safeguarding pathway is not taken where a more appropriate support option would be effective
Introduction of a new nationally set eligibility criteria for services, alongside a revised set of assessment and support plan documents.	We currently forecast the new eligibility criteria might bring an additional 275 people into eligibility for services during 2015/16
Procurement of an expanded range of advocacy services	We currently forecast that we will be providing advocacy support to around 111 additional people during 2015/16 and might expect that to rise again in 2016/17 when we expect approximately 500 self-funders might approach us for assessment and support with accessing services.
Introduction of a new eligibility criteria for carers support, alongside a revised carer assessment and support plan, and an enhanced range of support services.	We expect to support an additional 300 carers in 2015/16
Introduction of new duties for assessment and support for those with care and support needs who are in custody, either in prison or a bail hostel setting	Our early forecast is that this might apply to in excess of 240 prisoners in 2015/16
Expansion of our existing deferred payment scheme to allow service users to defer payment for services via a legal charge on property	We expect around 30 additional applications to be made in 2015/16

3.5 The Care Act also brings some detailed directions in around the management of the hospital discharge process. Implementation of these are being overseen by the System Resilience Group.

3.6 The Care Act brings some additional discretion around charging, the Council has taken the approach of not implementing any changes that might place people in a less advantageous position than prior to 1 April 2015, pending a future consultation on the operation of these discretionary charging changes.

3.7 Although the mandatory aspects of the Care Act come into place on 1 April the Council plans to work with service users, carers and partner agencies through the course of the year to review our delivery model, co-produce tools we use, and undertake continuous, test, challenge and improvement.

3.8 The Council has been working with regional colleagues from Association of Directors of Adult Social Services (ADASS), to share best practice around implementation of the 1 April 2015 duties and powers. Overview training has been provided to Council staff and we are now finalising our procedures and paper work in order to deliver operational training to

frontline staff. Following from this we expect to deliver communication and training and awareness into around 5,000 workers in the wider sector, via elearning and face to face training sessions. A training needs analysis session is being held for health and social care providers on 18 March to identify the best methods of delivery for these groups of workers.

4. CONSULTATION

4.1 Although the Council has consulted around it's Adult Social Care transformation programme, no specific consultation has yet taken place in relation to discretionary powers under the Care Act 2014.

4.2 The Adult Social Care Delivery is finalising a delivery plan for discretionary and culture change aspects of the Care Act, which will include proposals for consultation and co-production.

5. ANTICIPATED OUTCOMES

5.1 This paper provides information for the Board as it sets out an update on the Council's preparations for the introduction of the Carer Act on 1 April 2015 and implications.

6. *REASONS FOR RECOMMENDATIONS*

6.1 No recommendations.

7. ALTERNATIVE OPTIONS CONSIDERED

5.1 No recommendations made

8. IMPLICATIONS

8.1 Legal – The Care Act 2014, comes into practice on 1 April 2015. There are a number of MUST clauses that the Council will implement on 1 April 2015 and a further number of MUST or SHOULD clauses which reflect current practice. A delivery plan is being developed to consider and consult on further discretionary changes which the Council proposes to introduce in the coming financial year.

8.2 Financial – Implementation of the Care Act will have financial implications. A modelling tool provided by ADASS suggests that costs of implementation of the mandatory elements might be as much as £1.95 million. Some national funding has been made available but the Council will need to closely monitor the actual financial impact.

6. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

Statutory guidance to support implementation of part 1 of the Care Act 2014 by local authorities.
https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Helen Gregg, Commissioner, Communities Directorate	Tel. 863618

EXCEPTION REPORT: HEALTH & WELLBEING BOARD ACTION PLAN PROGRESS UPDATE

RECOMMENDATIONS	
FROM : Health & Wellbeing Programme Board Chair, Wendi Ogle-Welbourn	**Deadline date : N/A**
The Board is asked to consider the progress made against the action plan and comment accordingly.	

1. ORIGIN OF REPORT

1.1 This exception report is submitted to the Health & Wellbeing Board (HWB) following a request from the HWB Chair to regularly report on action plan progress, following the LGA led peer review held in February 2014.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update HWB members with regard to progress, outlining any issues and challenges, since the last update report provided at the HWB meeting held on 11 December 2014.

3. BACKGROUND AND UPDATE

3.1 Following consultation with Health & Wellbeing Programme Board members (HWPB) on 4 March 2015, it has been decided to reformat the action plan to allow for the following:

- Outline the overall desired outcomes and performance indicators for each theme
- Change the themes to reflect the current work programmes and priorities
- Allow more text space for comprehensive updates on all actions

3.2 The revised themes and leads are summarised below:

Theme Number and Focus	Lead
Theme 1: Children and Young People	Lou Williams Service Director, Childrens Services and Safeguarding
Theme 2: Better Care Fund	Will Patten Assistant Director, Adults Commissioning
Theme 3: Health Protection	Dr Liz Robin Director of Public Health
Theme 4: Joint Strategic Needs Assessment (JSNA)	Dr Liz Robin Director of Public Health
Theme 5: Health & Wellbeing Board Development and Scrutiny	Wendi Ogle-Welbourn Corporate Director, People and Communities

3.3 An example layout of the revised action and delivery plan:

Theme 2: **The Better Care Fund (BCF)**	
Responsibility:	Will Patten
OVERALL RAG RATING	
Outcomes: The BCF will contribute to Peterborough's vision for integration by focussing on initiatives that will help to prepare the system for a bigger change in the medium term by: • Protecting existing social care services • Supporting the development of 7 day working and data sharing • Supporting the development of closer working, including development of joint assessments with an accountable lead professional	
Performance Indicators: 1. Establish the UnitingCare partnership model 2. Establishment of joint assessments and an accountable lead professional to support other elements of the system to align with the UCP integrated neighbourhood team model and fulfil Care Act requirements 3. Establishment of a multi-agency team to lead our approach to integration and transformation in Peterborough, and the creation of an ideas bank to assist in piloting small scale integration projects	

Performance Narrative
In the June 2013 Spending Round, the Government announced the creation of a £3.8bn Better Care Fund. The Better Care Fund (BCF) is a single pooled budget between the Local Authorities and CCGs to support health and social care services to work more closely together in local areas. Peterborough City Council (PCC) worked collaboratively on developing its resubmission with Cambridgeshire County Council (CCC), PSHFT, CCG, UnitingCare Partnership (UCP) and the voluntary sector. On 6 February 2015, NHS England wrote to inform us that our BCF Plan had been approved. Approval of the plan follows intensive work by colleagues and we are grateful to all of those that have contributed to the plan. The approval letter noted that 'it is clear that your team and partners have worked very hard over the last few months, making valuable changes to your plan in order to improve people's care… your plan is strong and robust and we have every confidence that you will be able to deliver against it.'
Next Steps
Now that approval has been granted, partners from across the local system will step up work on implementation of the BCF, including preparation and approval of the necessary 'section 75' partnership agreement, which allows for pooled budgets between health organisations and local authorities. Formal arrangements for the BCF are expected to be in place by April 2015. However, joint implementation planning workshops have already been scheduled for our five priority Projects with attendees drawn from PCC, CCC and other delivery partners (including UCP). The five priority projects identified in the BCF plan: 1. **Data sharing:** to deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people; 2. **Seven day working:** to expand seven day working to ensure discharge planning is undertaken according to patient need, not organisational availability; 3. **Person centred system:** to enhance and improve person centred care across the entire system, ensuring that care and support is planned and co-ordinated by Integrated Neighbourhood Teams (MDT) working alongside individuals at risk of becoming frail or requiring high cost services in the future;

4. **Information, communication and advice:** to develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries; and 5. **Ageing healthily and prevention:** to develop community based preventative services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities. These projects will build on existing work across the system wherever possible.
Key Considerations
• Approval of the Section 75 partnership agreement

3.4 HWB members are asked to approve the revised themes/leads and the proposed future action and delivery plan template. If approved, a current and complete action and delivery plan report will be submitted at the next HWB meeting in June 2015.

4 CURRENT CHALLENGES AND ISSUES

4.1 In addition to the action and delivery plan format update, the HWPB would also like to update the HWB on two of the key issues from the action plan and progress undertaken against these key issues, since the last exception report was presented.

4.2 ***Cardiovascular Disease (CVD)***

4.2.1 Public Health held a CVD workshop for partners on 30 January 2015 which focused on the three previously agreed workstreams and considered local prevalence of CVD, underlying factors and wider determinants. The NICE guidance for the prevention of CVD was also reviewed to enable attendees to consider where the focus should be and to scope opportunities.

4.2.2 The majority of attendees agreed that a population-based approach to prevention should be adopted and that the programme should be linked with existing strategies for targeting people at particularly high risk of CVD. The workshop also identified the scope to improve treatment pathways and outcomes for CVD.

4.2.3 Next steps: establishment of a public health board to lead on the development and implementation of the CVD strategy and JSNA and provide oversight and direction for future workstream groups

4.3 ***Child and Adolescent Mental Health Service (Camhs)***

4.3.1 The Camh service has been a year on year increase in referrals. The Cambridgeshire and Peterborough Foundation Trust (CPFT) have looked at different ways of working to address this by redesigning pathways and raising eligibility. Despite this, waiting times for Cognitive Behaviour Therapy (CBT) and general Camh services are over a year for some children. With only 66% of children seen within the 18 week target, this currently equates to 43 children and young people.

4.3.2 In addition to this there are also long waits for Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals, partly due to an increase in child population and the CPFT reporting that demand is outstripping capacity.

4.3.3 The contract provides for a "deep-dive" exercise as the first response to a reported activity increase on this scale. This was agreed by the CCG with the aim to understand the reasons for this increase, and agree what steps need to be taken to restore Camh services to a sustainable footing.

4.3.4 The deep dive exercise looked at the increase in referrals and the findings set out current Camh service efficiency improvements and future proposals. It includes reference to the

work that Camhs are already doing to enhance capacity at tier 2, by training the children's workforce, providing supervision, supporting professionals in schools, delivering the Camhs champions model and supporting the development of a single point of contact function for referrals into emotional wellbeing and mental health services.

4.3.5 As a result of the findings, a summit has been arranged for 12 March, with all partners, to develop an action plan which will focus primarily on:

- Supporting children and young people with mental health needs - build system wide engagement, enhance and build capacity in early intervention, build community resilience and self-help guidance
- Increase skills and competencies of the wider workforce, ensuring a system wide good understanding of how to identify early signs of mental health needs and to prevent escalation

4.3.6 The CCG have agreed to invest to develop and address the current waiting times.

5. KEY CONSIDERATIONS

5.1 In summary, the HWB are asked to consider and approve the following:

- The revised format of the action and delivery plan with a view to a current and complete plan being presented at the next board meeting in June 2015

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Corporate Director People and Communities	Tel. 01733 863749

HEALTHY CHILD PROGRAMME

RECOMMENDATIONS	
FROM: Corporate Director People and Communities	Deadline Date: N/A

The Board is asked to:

- Note the content of the report and performance monitoring arrangements.
- Comment on any issues this raises.

1. ORIGIN OF REPORT

1.1 This report is submitted to the HWBB from the HWB programme board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to
(a) update the Health and Wellbeing Board on performance within the Healthy Child Programme (HCP). The narrative provides the latest updates on the priorities and issues to date;
(b) also informs the HWB of the joint working initiatives, developments and priorities.

2.2 The HCP links to the HWBB Strategy plan with the following priorities:
(a) Children are born healthy and have the best possible start to life.
(b) Children begin school ready to learn and with the necessary social and linguistic skills and emotional resilience appropriate to their age.
(c) Available services are able to identify those families where children are likely to be most vulnerable to poorer outcomes and provide effective support.

3. BACKGROUND

3.1 The HCP is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families at the crucial stages of life. It not only supports all children within universal services but also support children, young people and families who have special needs or disabilities, and is designed to ensure everyone can access information and services that are the most relevant, meaningful and helpful.

3.2 The HCP includes input from all partners working within universal services and includes midwives, health visitors, children centres and early support services, GPs, schools and school nurses. The HCP offers every family a programme of screening tests, immunisations, developmental reviews and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

3.3 There is a multi-agency healthy children's strategic board that oversees and monitors progress of this programme and identifies key priorities and issues.

4. KEY TARGETS WITHIN THE HCP BEING ACHIEVED

4.1 **New Birth Checks**

New birth checks have consistently been above the national target of 95% since April 2014. The latest figures are 97.2%.

4.2 **Proportion of mothers who are continuing to breastfeed at 6-8 weeks**

- The number of mothers still breastfeeding at six weeks is 45.1% against a national target of 45%. This target has been above 45% for the past four months.
- The Health Visiting Service has just passed the UNICEF assessment and will be retaining their level 3 baby friendly status. Representatives from UNICEF formally interviewed 20 Health Visitors and 34 mothers. They also visited three children's centres and two child health clinics where they spoke to mothers attending with their babies. The service scored 100% in several categories. The Health Visitors who were interviewed were described as knowledgeable, friendly and supportive of each other and one was identified as exceptional in this area.

4.3 **2 ½ year checks completed**

- The 2 ½ year check is an important check for children to assess their development and identify issues. Height, weight, play and social interaction are part of this along with a comprehensive developmental assessment. The checks are currently at 93.4% against a target of 75%.

4.4. To ensure that children are accessing high quality child care settings and are supported to arrive in school ready to learn and socialise. The following areas are assessed.

4.5. **% of pre-school setting rated good or above by Ofsted**

The last statistical data released detailing inspection outcomes of early years shows that 84% of pre-schools and nursery settings are rated good or above in Peterborough.
This now places Peterborough fourth out of eleven statistical neighbours and 1% above the national average of 84%.

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4.6 **Child-minders**

Over the past two years our performance compared to our statistical neighbours has improved. The latest statistical data released in November shows 79% of child-minders were rated good or above. This now places Peterborough fifth out of eleven statistical neighbours and 1% above national average of 78%.

4.7 **Ensure that any early indications of additional needs among children are identified in a timely way**

On starting school, all children are offered the school entry health check which includes height and weight, hearing and vision testing; handover from Health Visitors of any children they are still working with. Developmental assessments at age 4-5 years are completed by the school nursing service. 91.4% of children were seen against a target of 90%.

4.8 **National Childhood Measurement Programme**

Every year, as part of the NCMP, children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) have their height and weight measured during the school year to inform local planning and delivery of services for children; and gather population-level surveillance data to allow analysis of trends in growth patterns and obesity.

The NCMP also helps to increase public and professional understanding of weight issues in children and is a useful vehicle for engaging with children and families about healthy lifestyles and weight issues.

For 2012/13 excess weight in 4-5 year olds is 23.5% against a national average of 22.2%
Excess weight in 10-11 year olds is 34% against a national average of 33.3%.
For 13/14 excess weight in 4-5 year olds is 24.6% against a national average of 22.2% and excess weight in 10-11 year olds is 30.4% against a national average of 33.3% The data for

13/14 show a trend towards more underweight children in both reception and year 6, more overweight children in reception but a positive trend for year 6 children.

4.9 **Action**

While the local position is similar to the national position, there is a clear increase in excess weight between these two ages groups that requires local action and therefore the initial next steps will be undertaken:

- Refresh the local NCMP Evaluation report.
- Refresh the Change 4 Life Strategy (potentially separating weight management and physical activity to replicate regional programmes).
- Establish Change 4 Life professional group (potentially separating weight management and physical activity to replicate regional programmes).
- Evaluate PH and partnership financial allocations, commissioned and delivered interventions.
- Establish Healthy Schools programme to incorporate healthy eating theme.

4.10 **Immunisations**

Generally the uptake for childhood immunisations in Peterborough is lower than East Anglia in all quarters 20013/14 and 20014/15 to date for all age cohorts and most immunisations. The target for childhood immunization uptake is 95%.

Some of the reasons for this are:

- Some families choose not to have their child immunised.
- Some families may have difficulty accessing services for immunisation
- Some children have been immunised but not according to the schedule in England, resulting in their immunisation not being recorded on the national system. This is a particular problem in Peterborough, where there is a high, relatively transient population related migrant workers and new immigrants whose children may have been fully immunised in their home country, but not recorded by the UK system
- Some children have been immunised according to the schedule but the data has not been recorded or properly reported. A new electronic template is in development by CCG staff for Cambridgeshire and Peterborough GP practices to use to improve recording.

4.11 **Action**

- A multi-agency Task and Finish group is being convened to try to find solutions to these issues and addresses the inequalities in uptake of childhood immunisations in inner city practices and deprived populations particularly with Prenatal Pertussis, Men C. and Preschool booster. It is planned to report initial findings and recommendations to the Health Public Committee in March 2015 and to the Health and Wellbeing Board in the summer.
  The school based Human Papilloma Virus (HPV) has been very successful.
- This relatively recent Programme of vaccination of girls aged 12 – 13 against Human Papilloma Virus (HPV) which is a causative factor in Cervical Cancer has been very successful with a 91.5% uptake against a national average for England of 86.1%.

4.12 **Developments**

- PCC is working closely with NHS England on the transfer of HV's and the Family Nurse Partnership programme (FNP) to ensure a smooth transfer of the commissioning of these service to the PCC in September 2015. Service specification and KPI's are being agreed that reflect the needs of Peterborough children and families.
- The perinatal Mental Health pathway has been strengthened with an increase in CPN support and IAPT. Information on this pathway will be going out to all partners and GP's over the next month this will also provide a named link for GPs.
- An early support pathway has been developed that ensures that any early indications of additional needs among children are identified in a timely way and process of co-ordinated assessment and care planning is started. This will mean a central point for referrals and a named early support co-ordinator that will manage this process. This will start from in March once there is multiagency sign-up to this and a pathway with a key contact will be sent to all GPs.

4.13 **Emotional wellbeing and mental health**

The Emotional wellbeing and mental health strategy group has agreed the priorities for promoting and improving the emotional wellbeing and mental health for children and young people (C&YP) The multiagency group has adopted a broad definition of Children's and Adolescent Mental Health, recognising that having good mental health is everybody's business.

This strategy responds to the Health & Wellbeing Board Strategy for Peterborough and will inform planning and commissioning of system-wide mental health services and offer guidance of good practice.

The key priorities identified to be addressed over the next year are:

- Develop the workforce by having consistent training in universal services.
- Clear multiagency pathways to tier 2 and tier 3 services.
- Waiting times for assessment and treatment will be reduced by introducing early identification and support to children with complex needs.
- Early intervention and prevention by the development of a single point of access in Peterborough with clear pathways and good training and guidance on referral pathways.
- Roll out of IAPT principles.
- Good perinatal support.
- Linking work to SEND pathway.
- Re-commission and enhance tier 2 services.
- Good transition pathway to adult services.
- Ensuring there is a whole system integrated partnership approach that links to Adult mental health services and suicide prevention pathways.

4.14 **Progress on the above actions**

Progress against key priorities identified in the EWMH strategy.

- Training around recognising and supporting CYP with emotional health issues within universal services has been developed over the past few months, uptake from this is good with excellent feedback issues raised from this is the need to have consistent support and supervision. This will be addressed over the next 2 months.
- All School nurses have received training in self-harm.
- Tier 2 support which is the 3 T's service to help and support children with emotional health needs has been increased by 50k. This is addressing the waiting list.
- A single point of access for CAMH services in Peterborough has started with clear pathways and feedback on if referrals have been accepted is within 3 days the pathway and referral information will be sent to GP's and all partners by the end of February.
- A group looking at the transition pathway to adult services has being established. First workshop identified an action plan that will be addressed and monitored through the 0-25 service redesign work stream.
- Healthwatch have developed a short video with young people in Peterborough on Emotional health and wellbeing to raise awareness and provide advice and guidance this is available to all partners contact Jennifer Hodges at jennifer@healthwatchpeterborough.co.uk who is happy to give a copy of this.
- CAMH were very positive about this videoscribe and will play this on a loop in their waiting room. GP's surgeries and schools will also be offered this.

One of the main challenges CAMH services are facing is the growing waiting list for referral to CAMH services and a deep dive exercise was completed.

4.15 **CAMHS Deep Dive exercise**

- A deep dive exercise carried out looked at the increase in referrals and the findings set out current CAMHS service efficiency improvements and made future proposals.
- It includes reference to the work that CAMHS are already doing to enhance capacity at tier 2, by training the children's workforce, providing supervision, supporting professionals in schools, delivering the CAMHS champions model and supporting the development of a Single Point of Contact function for referrals into EWB & MH services.
- Finding are currently being considered by the CCG and a summit that took place on the 12th March.
- CCG has agreed to invest 600k into CAMH services recurrently, this is in response to the increased demand.

Working relationships between CAMH services and other services are very good, there are, for example, clear pathways in place between CAMH services and other support services including the Youth Offending Service.

4.16 **Children with Disabilities SEND reforms**

The SEND reforms support children, young people and families who are affected by special needs or disabilities, and are designed to ensure everyone can access information and services that are the most relevant, meaningful and helpful.

Over the past year all partners have been working with the local authority to identify their core offer for services and a joined up assessment process in developing health, education and social care plans for children that have additional needs. This not only encourages an integrated approach, but allows more choice around personalisation where children can be given a personal budget for some aspects of their care which can be used flexibly to meet their needs. There is also a duty on partners to jointly commission services together.

Outcomes to date

- Strategic group set up to oversee work streams.
- Core offer for SEND now on website.
- Work ongoing to develop individualised budgets and direct payments.
- Early support co-ordinators now employed to deliver the Education and healthcare pathway. (EHC plans).

Commissioning updates

Sleep Solutions –
This service will continue over the next year. As part of the early support pathway both health and PCC this will ensure that all referrals for sleep management go through sleep solutions who would work closely with the HV service resulting in only a few children being referred to the paediatricians. Currently awaiting CCG decision on joint funding.

Early Support – Providing early support to children and young people with additional needs is one of the requirements under the SEND reforms. Currently in Peterborough there is a medical model where most referrals go to the paediatricians, this results in long waits, particularly for ASD/Autism as well as not an effective use of consultant's time.

The proposal is to develop an early support pathway that enables a co-ordinator to pull together all the information necessary first then refer to a panel with health input this will release consultants time and reduce the waiting lists as well as provide a social/health model that looks at the support children and families need in a more holistic way. Awaiting decision from CCG on joint funding.

PCC are investing 176k, linked to the requirements of the SEND reforms this support is crucial to the development of the pathway.

5. BACKGROUND DOCUMENTS

- Mental/CAMH Health needs assessment
- JSNA Performance and Delivery plan
- Cambridge and Peterborough's emotional wellbeing and mental health strategy 2014

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
26 MARCH 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn, Director of Communities	Tel. **01733 863749**

WINTERBOURNE VIEW REVIEW AND UPDATE

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn, Director of Communities	**Deadline date :** March 2015
1. The purpose of this report is to inform the Board with an overview of developments and progress made to date in Peterborough in respect of the Winterbourne View Review and satisfy itself that appropriate progress is being made.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following:

Request made by senior managers and Director of ASC for information and progress.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to

The Board are asked to consider and comment upon the contents of this report.

The Board to take note of the Bubb Report published late November 2014. This is in light of the DH Winterbourne View Review Concordat: Programme of Action. In summary the Bubb report looks into the reasons why there is still a large number of people with learning disabilities and/or autism in secure hospital settings and makes recommendations for a national commissioning framework under which local commissioners would secure community-based support for people with learning disabilities and/or autism. This came after a pledge made in the wake the Winterbourne View scandal to enable people with learning disabilities and/or autism inappropriately placed in secure hospital settings to move to community based support by June 2014 which was missed by many authorities.

The Board to be reassured that Peterborough City Council with its partners (C&PCCG and CPFT) have met all the targets set by the DH Winterbourne View Review Concordat: Programme of Action and will continue to resettle people placed in secure hospital settings back into the community when they no longer require a secure placement under the Mental Health Act. A Peterborough stock take report had been completed and sent to the LGA in July 2013 with further reports sent in June 2014 which was received positively.

3. BACKGROUND

Winterbourne View was a private hospital owned by Castlebeck. It was based in Hambrook, Bristol and was a purpose-built acute service offering assessment, intervention and support for people with learning disabilities, complex needs and challenging behaviour. It was registered with the Care Quality Commission to provide care for up to 24 patients aged 18 years and over with a learning disability. It was registered for the treatment of patients detained under the Mental Health Act 1983. The hospital opened in December 2006 and closed on 22 June 2011.

The BBC Panorama programme, broadcast on 31 May 2011, showed images of abuse and ill treatment of residents at Winterbourne View. Following that a review was undertaken by the Department of Health which resulted in recommendations that every authority and health organisation had to follow which ultimately led to a national campaign to reduce dependency on secure setting placements for people with learning disabilities.

At the time Peterborough had eight people placed in secure hospital settings under a section of the Mental Health Act. Since then Peterborough City Council has been very successful in moving people back into the community once they no longer need a secure setting placement.

The current position is there are four people in secure placement settings, with plans under way to move two more of the four people out of secure placements into the community over the coming months.

NHS England asked Sir Stephen Bubb to make recommendations for a national commissioning framework due to people continuing to be inappropriately placed in secure hospital settings and the number in these institutions increasing across the country. The Bubb report which was published late November 2014 makes 10 recommendations for a national commissioning framework under which local commissioners will implement to secure community based support for people with learning disabilities and/or autism. Many of these recommendations are either already in place or we are working towards achieving them in Peterborough, however in light of the Bubb report more will be undertaken with a focussed approach with partners to strengthen these in the coming weeks/months.

3.1 The Bubb report recommendations and Peterborough's position.

3.2 Strengthening Rights

The Government should draw up a Charter of Rights for people with learning disabilities and/or autism and their families, and it should underpin all commissioning.

People with learning disabilities and/or autism should be given a 'right to challenge' their admission or continued placement in inpatient care

NHS England should extend the right to have a personal budget (or personal health budget) to more people with learning disabilities and/or autism, along with support to manage those budgets

The Government should look at ways to protect an individual's home tenancy when they are admitted to hospital, so that people do not lose their homes on admission and end up needing to find new suitable accommodation to enable discharge.

The Government and NHS England should force the pace on commissioning by requiring local commissioners to follow a mandatory framework

Community-based providers should be given a 'right to propose alternatives' to inpatient care.

3.3 Peterborough's position to the Strengthening Rights

There is an expectation that further information from the Government on this recommendation will be issued however under current good practice many of the recommendations are in place such as information in accessible language, advocacy support made available, access to personal budgets and strong support made available with PCVS for people and their families to use it, joint funding arrangements in place with NHS (not pooled budgets), successful in resolving ordinary residence issues with other local authorities and health services.

3.4 Closures

The commissioning framework should be accompanied by a by a closure programme of inappropriate institutional inpatient facilities, driven by tougher registration requirements, local closure plans, and leadership by NHS England

3.5 Peterborough's position to the Closures

Peterborough has no institutions within its boundary that constitutes a secure placement setting. This recommendation promotes greater independence, choice and control and wants to see the reduction of dependency and restricted based living arrangements. There is one assessment and treatment in-patient unit called the Hollies (CPFT) commissioned by C&PCCG for people with learning disabilities. Discussions are underway with C&PCCG and CPFT to look at ways of improving this model in light of the principles set out in the Bubb report.

Over the past two years the local authority has been working closely with local care providers to reduce the dependency on residential care the transformation to supported living models which ultimately gives more rights and control to people with learning disabilities. There has also been a concerted drive to bring people back to Peterborough from out of area placements which has resulted in the local provider market expanding ultimately offering greater choice to Peterborough people.

3.6 Building Capacity in the Community

Health Education England, Skills for Care, Skills for Health and partners should develop as a priority a national workforce 'Academy' in this field, building on the work already started by Professors Allen and Hastings and colleagues

A 'Life in the Community' Social Investment Fund should be established to facilitate transitions out of inpatient facilities and build capacity in community-based services.

3.7 Peterborough's position to the Building Capacity in the Community

The Intensive Support Team (IST/CPFT) commissioned by the C&PCCG has been very proactive working with local providers that support people with complex and behavioural needs. The IST has highly trained health and social care professionals that provide intensive training and support to staff that are supporting people with complex needs prior and throughout the service user been supported.

Working closely with housing providers in Peterborough we have been successful in securing high quality housing for people with complex and behavioural needs. The Accommodation Strategy also recognises the requirements for this client group and aim to secure good quality housing for the future demand.

The recommendation that the Government should allocate £30 million to a 'Life in the Community' Social Investment Fund which will be an investment vehicle with a social mission to improve outcomes for people with learning disabilities and/or autism who display challenging behaviour in the community is welcomed and await to receive further information on this.

3.8 Holding People to Account

Action on the recommendations above should be accompanied by improved collection and publication of performance data, and a monitoring framework at central and local level.

3.9 Peterborough's position to Holding People to Account

In Peterborough there has been no delayed discharges for people that are either inappropriately
placed or ready to be discharged from secure settings. The local commissioner has presented
regular progress reports to the Peterborough Safeguarding Adults Board, the Health and Wellbeing Board, the Learning Disabilities Section 75 Commissioning Board and the Learning
Disabilities Partnership Board.

4. CONSULTATION

4.1 No formal consultation is required however as good practice in working with service users, carers and family members there is significant engagement and close working with all parties. In-depth person centred plans of the people to return to Peterborough are in place and regular involvement with parent carers and advocates is also undertaken. In addition there is very close working with other agencies and regular contact with NHS England Care & Treatment Review Team who is leading on the reviews of people placed in secure settings.

5. ANTICIPATED OUTCOMES

5.1 The Bubb report recommendations will be considered in greater detail and a Peterborough action plan is being drawn up with partner agencies.

6. REASONS FOR RECOMMENDATIONS

6.1 No significant issues or recommendations to report other than Peterborough has been very successful in repatriating people back into the community and continues to keep people in the community once resettled with right support offered and improved service.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Continue with the progress made as stated in the report.

8. IMPLICATIONS

8.1 None

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

The Bubb Report.