PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

MONDAY 19 MARCH 2018
1.00 PM

Bourges/Viersen Room - Town Hall
Contact – daniel.kalley@peterborough.gov.uk, 01733 452460

AGENDA

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12. Schedule of Future Meetings and Draft Agenda Programme **407 - 408**

To note the dates and agree future agenda items for the Board. To include frequency of reporting from other Boards, where appropriate, including Local Safeguarding Boards, Children's and Adults Commissioning Boards, LCG Commissioning Board. Also to consider how we will monitor progress against the Health and Wellbeing strategy.

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Board Members:

Cllr J Holdich (Chairman), S Evans-Evans, H Daniels, G Smith, Cllr D Lamb, Cllr W Fitzgerald, Cllr R Ferris, C Mitchell, Dr Laliwala, Dr Howsam (Vice Chairman), W Ogle-Welbourn, Dr Robin and A Chapman

Co-opted Members: Russell Wate and Claire Higgins

Further information about this meeting can be obtained from on telephone 01733 296334 or by email – daniel.kalley@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD AT 1PM, ON 4 DECEMBER 2017 BOURGES/VIERSEN ROOM, TOWN HALL, PETERBOROUGH

Committee Members Present: Councillor Holdich, Leader of the Council and Member of the Cambridgeshire and Peterborough Combined Authority
Dr Gary Howsam, Clinical Commissioning Group (Vice-Chair)
Adrian Chapman, Service Director Communities and Safety
Councillor Ferris
Councillor Fitzgerald, Deputy Leader, Cabinet Member for Integrated Adult Social Care and Health
Councillor Lamb, Cabinet Member for Public Health
Dr Liz Robin, Director for Public Health
Wendi Ogle-Welbourn, Executive Director People and Communities Cambridgeshire and Peterborough Councils
Catherine Mitchell, Director of Community Services and Integration
Joanne Proctor, Head of Service, Adult and Children's Safeguarding Boards
Gordon Smith, Healthwatch
Hilary Daniels, South Lincolnshire CCG

Officers Present: Stuart Keeble, Consultant in Public Health
Katherine Hartley, Consultant in Public Health
Sean Evans, Housing Needs Manager
Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils
Paulina Ford, Senior Democratic Services Officer

Also Present: Victoria Banks Price, Planning Adviser, Government Affairs, Woodland Trust

25. APOLOGIES FOR ABSENCE

Apologies for absence were received from Simon Evans-Evans, Claire Higgins, and Russell Wate. Jo Proctor was in attendance as substitute for Russell Wate.

26. DECLARATIONS OF INTEREST

There were no declarations of interest.

27. MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 11 SEPTEMBER 2017

The minutes of the meeting held on 11 September 2017 were agreed as a true and accurate record with the exception of the following amendments:

Hillary Daniels was not in attendance at the meeting and had submitted her apologies.

Reference Page 5. Item: Update on the Hinchingbrooke Healthcare NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust Merger.

It was noted that there was an inaccuracy in the wording of the following sentence:
"NHS England and Improve had been a great source of support and had enhanced relationships between parties"

The sentence to be corrected to read as follows:

NHS England and NHS Improvement had been a great source of support and had enhanced relationships between parties.

28. AMENDED HEALTH AND WELLBEING BOARD MEMBERSHIP AND TERMS OF REFERENCE

The Health and Wellbeing Board received a report in relation to proposed amendments to the Health and Wellbeing Board Terms of Reference following the resignation of Dr Harshad Mistry from his role on the Peterborough Health and Wellbeing Board.

The Executive Director People and Communities introduced the report and explained that several amendments had come to light following a review of the Terms of Reference which included:

- The Local Clinical Commissioning Group was now referred to as Cambridgeshire and Peterborough Clinical Commissioning Group and therefore would need to be changed throughout the document.
- As agreed at the meeting held on 11 September 2018 Dr Gary Howsam would replace Dr Mistry as Vice Chairman of the Health and Wellbeing Board as Dr Mistry had stepped down.
- The Terms of Reference had shown a requirement for two GP member representatives to represent the Peterborough City Local Commissioning Group (now referred to as the Cambridgeshire and Peterborough Clinical Commissioning Group) one of which was Dr Howsam. It had not been possible to find an additional representative to replace Dr Mistry and it was therefore proposed to reduce the number to a requirement of only one representative. The Board unanimously agreed to this change. Dr Howsam advised that if he was unable to attend a meeting he had appointed a substitute who was Dr Adrian Tariq.
- Any reference to the Greater Peterborough Partnership should be removed and changed to the Greater Peterborough Livingwell Partnership.
- The job title for the Local Chief Officer for Peterborough City and Borderline LCG no longer existed and would need to be changed to Director of Community Services and Integration.
- There was no longer a Peterborough Adults Safeguarding Board and this would need to be changed to Cambridgeshire and Peterborough Safeguarding Adults Board.

Due to the amount of changes it was agreed that an updated version of the Terms of Reference would be brought back to the Board for noting at the next meeting.

The Health and Wellbeing Board considered the report and **RESOLVED** to agree to the proposed changes to the Terms of Reference and receive an updated version for noting at the next meeting.

29. THE HEALTH BENEFITS OF TREES AND WOODLAND

The Health and Wellbeing Board received a report in relation to the Health Benefits of Trees and Woodlands which was introduced by The Planning Advisor, Government Affairs Team of the Woodland Trust.

The purpose of the report was to set out how woods and trees could help contribute to the delivery of the 5 markers set out in the Peterborough Health and Wellbeing Strategy. A short power point presentation was provided on How woods and trees can support healthier communities which covered the following key points:

- Information on the Woodland Trust
- Narrowing the gap between those neighbourhoods and communities with the best and worst health outcomes
- Ensuring 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
- Tree planting
- Enabling good child and adult mental health through effective, accessible health promotion and early intervention services
- Maximising the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs
- Enabling older people to stay independent and safe and to enjoy the best possible quality of life

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- It was noted that the Forest of Peterborough had recently planted their one hundred thousand tree in Central Park, Peterborough. Peterborough did have a relatively high amount of tree cover but it was unevenly distributed and not all were the right kind of tree.
- There was a serious issue of grass verge parking in Peterborough and the planting of trees may help to resolve this problem and help to change the street scene in an area.
- Board members were informed that there had been a £7.5M investment in the 'Can do' area of Peterborough which included investment in open space areas and this may include some tree planting. The Council had partnered with the Peterborough Environment City Trust to look at how open space could be used more effectively. The Council had already recognised the benefits of green open space.
- Public Health England were undertaking a review regarding the use of green space and the benefits. Green space was associated with good health but not necessarily the cause of good health. A Public Health Consultant who leads on environment and transport was working with the Growth and Regeneration team to ensure the issues around green space were factored into the Local Plan. The

Health and Wellbeing Strategy had provided an evidence base for the work being undertaken in the 'Can do' area regarding green space. There was a lot of Public Health activity advising the wider council on this matter.

- There had been reductions in the Public Health grant and to invest in the initiatives proposed in the report would mean that funding would have to be redirected from other services. Currently there was not enough good cost effective evidence for the links with green space and public health outcomes.
- Developers had to take into account existing trees.
- It was critical that when considering new developments that the right kind of trees were considered and in the right place.
- Clarification was sought as to whether any studies had been looked at regarding Green Prescriptions and the amount of time spent in green space and the impact on a person's mental health. The Board were informed that the BBC had run a programme 'Trust me I'm a Doctor' which had highlighted research that had been carried out by the Green Gym and University of Westminster.
- It was generally accepted by GP's that spending time in the outdoors was best for good health.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Recognise the importance of trees and woods in helping with delivery of health outcomes and that the Director of Public Health continue to work with departments across the City Council and with external partners to promote these benefits.

2. Continue to look for opportunities to work with the City Council and partners to make better use of woodland and natural greenspace in the Peterborough City Council area for activities aimed at improving the health and wellbeing of local people.

3. Work with the Woodland Trust and continue to work with the City Council and other partners such as Peterborough Environment City Trust to identify areas of land within the district for creation of new woodland and opportunities for planting of street trees and trees in other locations such as parks or housing areas. This will help to address air quality issues and can also have benefits for the hospital, by reducing the average length of stay.

4. That the Board request the Director of Public Health examine whether it is possible for some of the City Council's public health funding to be used to support the initiatives proposed under items 2 and 3 above.

5. That the Growth and Regeneration Team take into account the report and associated background documents when considering the Local Plan.

30. CAMBRIDGESHIRE AND PETERBOROUGH SENIOR OFFICERS COMMUNITIES NETWORK

The Service Director Communities and Safety introduced the report. The purpose of this report was to inform the Board of the Cambridgeshire and Peterborough Senior Officers Communities Network, outlining the reasons for the network, its membership and work it is engaged in, in order that the Board can influence its priorities and gain maximum benefit from the Network's outcomes. The objectives of the Network were highlighted as follows:

- Share plans and proposals for community resilience or capacity-building activity, including the development of local community hubs, employment and skills strategies, and pilots and test beds such as Neighbourhood Cares and social prescribing
- Share, learn from and extend successful new approaches adopted elsewhere or at very local levels
- Decide on joint investment/delivery in prevention within communities to manage demand for high cost services
- Determine how to work together to equip local people with the information, tools and capacity they need to help themselves and each other

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- If the Combined Authority moved into more people type projects and programmes the Network would be ready and poised to respond.
- The Network will define and jointly commission or deliver against an agreed set of priorities, in agreed locations with agreed target groups therefore working in a more collaborative way. There was also a need to ensure that work identified by the Network was not being undertaken elsewhere and therefore being duplicated.

The Health and Wellbeing Board considered the report and **RESOLVED** to consider and note the purpose and remit of the Cambridgeshire and Peterborough Senior Officers Communities Network, and considered how the Health and Wellbeing Board can support and benefit from current and future work programmes.

31. HEALTH AND TRANSPORT JSNA DATA SET

The Consultant for Public Health introduced the report the purpose of which was to:

- Provide the Health and Wellbeing Board with a local resource outlining evidence on the link between transport and health including active travel, air quality and access to transport.
- Provide evidence to inform the Cambridge and Peterborough Local Transport Plan and the Peterborough Sports strategy.
- Support broader partnership working through the provision of a single evidence base.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- Getting people to increase their activity by as little as ten minutes per day would reduce the mortality rate by about fifty deaths per year.
- It was noted that there was far too many children being taken to school by car and far more needed to be done to encourage more walking to school.
- Air quality with regard to particulates was an issue as there was no obligation to measure these. More could also be done with regard to taxi idling and more 20mph speed restrictions in residential areas to reduce particulates and other emissions.
- The Board were informed that there was an Officer Working Group in place who were looking at the issue of taxi idling. With regard to the implementation of a 20mph speed limit in residential zones, officers were still waiting for national evidence to support the claims that this would improve air quality.
- The JSNA had been prepared as an evidence base to be used by the Combined Authority for their transport plan.
- The Board recognised that the benefits of active travel were important.

The Health and Wellbeing Board considered the report and **RESOLVED** to note the content of the Health and Transport JSNA Dataset document.

32. HOMELESSNESS PREVENTION

The Housing Needs Manager introduced the report which provided an overview of the current levels of homelessness in Peterborough, including previous and forecast trends, to enable additional interventions that might mitigate the health and wellbeing implications of homelessness to be introduced. The Officer also provided an update on the new Homeless Reduction Act and changes that would need to be made to the delivery of the service to accommodate the new Act and the Universal Credit Full Service.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- The Board sought clarification as to whether there was any evidence of health implications for people having to stay in temporary accommodation. The Board were informed that the only evidence was anecdotal. Families that had been in long term temporary accommodation sometimes with no cooking facilities had found it difficult and felt frustrated. All available resources were being used to ensure families were in temporary accommodation for the shortest time possible.
- There was no mechanism in place to ensure households were registered with a GP. Most families were accommodated within the Peterborough area and therefore should be able to remain with their GP if transferred to alternative accommodation within the Peterborough area.
- One known impact of people being placed in temporary accommodation was that children may miss their immunisation due to not receiving notification of when it was due. The Director for Public Health advised that information on immunisation could be added to the GP provision leaflet being provided.
- The information pack handed out to households at risk of homelessness did not include information on GP's but this could be included.
- There was no evidence that the Selective Licensing Scheme had had an impact on the amount of households at risk of homelessness. Members of the Board felt that this message should be communicated as the perception was that the scheme had had an impact.
- It was noted that homelessness could have an impact on education.
- The Local Authority had to provide transport for children in temporary accommodation to take them to school which was an unforeseen additional cost to the authority.
- Public Health England had produced a set of infographics on the links between housing and health including homelessness which could be provided to the Board.
- GP's had noticed an increase in mental health issues as a result of households at risk of homelessness.
- A short discussion took place regarding the difference between rough sleepers and those people finding themselves at the risk of becoming homeless. There were currently around 30 rough sleepers in the city. An action plan had been put in place following a scrutiny review of rough sleepers earlier in the year and the direction of travel for this was good.
- The package of support being provided by the Council, including investing in accommodation to support the homelessness challenge and the work being done with partners will greatly assist in reducing the number of homeless.

The Health and Wellbeing Board considered the report and **RESOLVED** to note the report on housing pressures within the city and the work that was being undertaken on prevention of homelessness.

ACTIONS AGREED:

1. The Director of Community Services and Integration to instruct the Primary Care Team to provide the Housing Needs Manager with an information leaflet on GP provision within the Peterborough area. This information to be included in the pack given to households at risk of homelessness.
2. The Director of Public Health to provide information on the children's immunisation programme to be included in the pack given to households at risk of homelessness.
3. The Director of Public Health to provide the Board with a copy of the Public Health England set of infographics on the links between housing and health including homelessness.

33. DRAFT SUICIDE PREVENTION STRATEGY 2017- 2020

The Public Health Consultant introduced the report which provided the Board with a review of the progress to date on the Suicide Prevention Strategy, 2014 – 2017 and an opportunity for the Health and Wellbeing Board to review and comment on the Draft Suicide Prevention Strategy refresh for 2017 – 2020. It was highlighted that the Development and roll-out of 'STOP Suicide' across Peterborough and Cambridgeshire, including a local suicide prevention website, pledge, training in suicide prevention and campaigns to increase awareness of mental health issues and how to access support had been a great success. There had been a fall in the suicide rate in Peterborough over the last few years and was now in line with the England average.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- A project lead had been employed to support the suicide prevention work and would be working with the Cambridgeshire and Peterborough Clinical Commissioning Group to deliver GP training on suicide prevention.
- The Board noted that there had been a rise in suicides amongst young people and wanted to know what was being done to heighten awareness amongst parents around suicide prevention. The Board were informed that a lot work was being done with schools however it was acknowledged that there was a gap with regard to working with parents and this was currently being looked into. The Zero Suicide Alliance offered free suicide prevention training for all.
- Organisations like the Department for Works and Pensions and Citizens Advice Bureau may have the opportunity to identify people who were vulnerable and may be showing signs of concern and could feed the information into a database. The Public Health Consultant advised that there was no database but it was a good idea to work more closely with such organisations to identify vulnerable people so that support can be offered at an earlier stage.

The Health and Wellbeing Board considered the report and **RESOLVED** to note the progress to date on the Suicide Prevention Strategy, 2014 – 2017 and considered and noted the Draft Suicide Prevention Strategy refresh for 2017 – 2020.

2.27 Councillor Ferris left the meeting.

INFORMATION AND OTHER ITEMS

The remainder of the items on the agenda were for information only and the Health and Wellbeing Board **RESOLVED** to note them without comment. The Board did however congratulate Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils for providing the Board with a comprehensive quarterly health and wellbeing strategy performance report.

34. CQC AREA REVIEW BRIEFING

35. ANNUAL REPORT OF THE PETERBOROUGH SAFEGUARDING CHILDREN BOARD 2016-17 AND ANNUAL REPORT OF THE PETERBOROUGH SAFEGUARDING ADULTS BOARD 2016-17

36. QUARTERLY HEALTH AND WELLBEING STRATEGY PERFORMANCE REPORT

37. ADULT SOCIAL CARE, BETTER CARE FUND (BCF) 2017-19 UPDATE

38. SCHEDULE OF FUTURE MEETINGS AND DRAFT AGENDA PROGRAMME`

Chairman
1pm – 2.29pm

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. XX
19 MARCH 2018	PUBLIC REPORT

Report of:	Healthwatch Cambridgeshire and Peterborough	
Contact Officer(s):	Val Moore, Chair Gordon Smith, Vice Chair Sandie Smith, Chief Executive Officer	Tel. (office) 0330 355 1285

Healthwatch - Priorities, Ways of Working across Cambridgeshire and Peterborough

RECOMMENDATIONS	
FROM: *Val Moore, Chair Healthwatch Cambridgeshire and Peterborough*	**Deadline date:** *N/A*

It is recommended that the Health and Wellbeing Board:

1. Note the recent examples of impact following the development of a combined Healthwatch (section 4.5)

2. Comment on the priorities and ways of working adopted for 2017/18 (section 4.4) to inform a refresh for the coming year.

3. Note the future review of Healthwatch strategy from 2019 onwards (section 5.1).

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board under its terms of reference and as part of a request from the Board itself

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Board on the Healthwatch arrangements for Cambridgeshire and Peterborough and to

(a) provide background information requested by the Board at its meeting on (date);
(b) to obtain views on the development of how Healthwatch works in this area;

2.2 This report is for the Board to consider under its Terms of Reference No. 2.8.3.8:

To oversee the development of Local HealthWatch for Peterborough and to ensure that they can operate effectively to support health and wellbeing on behalf of users of health and social care services.

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	

4. BACKGROUND AND KEY ISSUES

A combined Healthwatch

4.1 Since October 2017 Healthwatch for Cambridgeshire and Peterborough has been commissioned jointly by Peterborough City Council and Cambridgeshire County Council through the joint commissioning team. This was the culmination of a process started in 2016 to explore options for closer joint working between the two organisations and ensure best use of resources.

A reminder of the Healthwatch function

4.2 The statutory requirement for a Healthwatch function has not changed (see section 9.2 for legal implications). We are the independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care. We listen to what people like about services, and what could be improved, and we share their views with those with the power to make change happen. We also help people find the information they need about services in their area.

We have the power to ensure people's voices are heard by government and those running services and to involve people in decisions that affect them. Our sole purpose is to help make care better for people.

Both previous Healthwatch recognised the impact of health inequalities in our local communities and our methods will continue to include a focus on bringing forward insights from those voices less well heard.

Governance and resources

4.3 The organisations merged in April 2017, and directors have combined to form a new Board. There is one Guarantor, Victor Lucas. We are seeking appointment of another. In summary the role is to support the local authorities to appoint the Chair, and to be an independent source of advice to directors.

Sandie Smith leads a staff team of 12 whole time equivalents responsible to Communications, information and signposting, communities' engagement, volunteer management, projects, office management and business development. There are 25 volunteers including community listeners and those trained in Enter and View procedures to look directly a whole range of local health care providers from a patient perspective.

Building on the Peterborough model of using community meetings for engagement with service providers, we plan to support local community Healthwatch forums in other localities within Cambridgeshire, ensuring a geographical perspective to our feedback gathering and networking.

The combined annual budget is £475,000. A plan is being developed to ensure the organisation can withstand inflationary and other pressures on the budget. We aim to grow income for patient and public engagement activities through local partnerships, seeking funds from outside the statutory sector.

Healthwatch priorities and way of working 2017/2018

After reviewing available data, and comparing approaches from the two predecessor Healthwatch, the staff and director team identified priorities for 2017/18 as follows:

4.4

- Access to and experience of primary care particularly in growth areas
- Access to social care assessments and experience of integrated support services
- Access to and experience of mental health services for children and young people and adults
- The promotion of health, self-care and independence
- Transforming pathways for urgent and emergency care services
- Engaging patients and the public with the Sustainability and Transformation Partnership (STP)

For all these priorities the Healthwatch way of working is to:

- Scrutinise the quality of patient and public engagement by the providers and commissioners of health and care services
- Promote the value of lived experience
- Encourage shared health and care decision making between people and professionals
- Review the impacts of service change on people's experience.

Examples of impact over recent months

- Between September and December 2017, the team spoke to 2,261 people at 56 events in Peterborough and Cambridgeshire.

4.5

- Healthwatch provided advice to four GP Practices, or groups of Practices, regarding engaging with patients about their merger proposals.

- We published "Minding us: Improving services for young people at greater risk of mental ill health'. It was funded by local joint commissioning partners to inform the development of services.

- Our preliminary Healthwatch report to assess how NHS and care organisations are implementing the NHS requirement for 'Accessible Information as Standard' was published in November 2017. Action plans to improve the experience of people with sensory or learning disabilities are now being collected from the main NHS providers in Peterborough and Cambridgeshire.

- We raised concerns with the CCG regarding inconsistencies in practice and poor experience of Tongue Tie Division services. In response the CCG have agreed that redesign of this service will form part of the Cambridgeshire and Peterborough Better Births Plan.

- Work initiated by a Healthwatch working group on discharge from hospital has been used by the CCG as basis for a new leaflet, resulting in improved information for patients and carers.

- Following feedback from patients about poor signage and directions to the Out of Hours service at Cambridge University Hospitals (CUH), the Estates Team and Hertfordshire Urgent Care (the service providers) have collaborated and signage and direction-giving has improved.

- Informal feedback has been given to the CCG regarding cost limits for home-based Continuing Health Care. The CCG are undertaking further work to benchmark and discuss with patients and carers what are reasonable costs.

- The Chief Executive, Chair and Directors of Healthwatch raise the profile of patient experience on a number of STP related groups. They provide challenge and practical help to support the participation of people and wider public engagement.

5. CONSULTATION

5.1 The Health and Wellbeing Board should be aware that in addition to the current refresh of priorities, a new three-year strategy for Healthwatch will be developed from 2018/19 onwards. The input of a range of stakeholders will be sought during this review process.

The views and contacts of Health and Wellbeing Board members are welcomed in advance of any detailed planning.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Health and Wellbeing Board will play a key role to encourage the integration of services, in part on the basis of people's experiences of care. Members will influence communities and organisations on many of the issues Healthwatch is involved in. A strong partnership and shared understanding of priorities is therefore essential for maximum impact.

7. REASON FOR THE RECOMMENDATION

7.1 It is the responsibility of PCC and CCC to ensure Healthwatch is fit to fulfil its statutory function in this area. As described in 6.1 input to Healthwatch priorities will support the focus of activities.

9. IMPLICATIONS

Financial Implications

9.1 The Healthwatch budget is set until March 2019.

Legal Implications

9.2 Local Government and Public Involvement in Health Act 2007: Part 14.
Health and Social Care Act 2008: Part 1, Chapter 3
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012: Part 6.

Healthwatch was created with the purpose of understanding the needs, experiences and concerns of service users and to speak out on their behalf. Established through the Health and Social Care Act 2012, this created a model that operates both locally (Local Healthwatch) and nationally (Healthwatch England).

Local Healthwatch organisations carry out a range of activities in their local area, including:

- promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of health and social care services;

- enabling local people to monitor and review the commissioning and provision of health and social care services;

- obtaining the views of local people about their needs for, and their experiences of, health and social care services;

- making such views known and making recommendations about how or whether health and social care services could or ought to be improved to those responsible for commissioning, providing, managing or scrutinising health and social care services and to Healthwatch England;

- providing advice and information about choice and access to health and social care services; and

- reaching views on the standard of health and social care service and whether, and how such services could or ought to be improved, and making those views known to Healthwatch England.

Bodies that are responsible for commissioning, providing, managing or scrutinising local care services must have regard to the views, reports or recommendations received from Local Healthwatch. They are also required to acknowledge and respond to such reports or recommendations. Such bodies would primarily include NHS England, CCGs, NHS foundation trusts, NHS trusts and local authorities in the area, as well as private providers of health and social care.

Healthwatch England provides general advice and assistance to Local Healthwatch organisations. It also has statutory powers to provide the Secretary of State, NHS England, NHS Improvement and local authorities with information and advice on:

• the views of people who use health or social care services and of other members of the public on their needs for and experiences of health and social care services; and • the views of Local Healthwatch organisations and of individuals on the standard of health and social care services and whether or how it could or should be improved.

The bodies listed above are legally required to respond in writing to such advice from Healthwatch England.

Equalities Implications

9.3 Healthwatch Cambridgeshire and Peterborough Community Interest Company is subject to equalities legislation and associated requirements from Company House.

10. BACKGROUND DOCUMENTS

Section 4.4 Working Together Final Report, July 2017, taproot

Section 4.4 and 4.5 Healthwatch Cambridgeshire and Peterborough Board papers, Sept, and Nov 2017 and January 2018.

Please see website for further information. (Note – the Peterborough site is currently being developed)
http://www.healthwatchcambridgeshire.co.uk/content/about

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 5
19 MARCH 2018	PUBLIC REPORT

Report of:	Catherine Pollard, Executive Programme Director, Cambridgeshire and Peterborough Sustainability & Transformation Partnership	
Contact Officer(s):	Aidan Fallon, Head of Communications & Engagement, Cambridgeshire and Peterborough Sustainability & Transformation Partnership	Tel. 07970 195351

REVISED GOVERNANCE FRAMEWORK FOR THE CAMBRIDGESHIRE & PETERBOROUGH SUSTAINABILITY & TRANSFORMATION PROGRAMME

RECOMMENDATIONS	
FROM: Cambridgeshire and Peterborough Sustainability & Transformation Partnership	**Deadline date:**
It is recommended that the Health and Wellbeing Board note the changes to the Sustainability & Transformation Partnership (STP) Governance Framework.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board as a briefing on changes to the STP governance framework.

2. PURPOSE AND REASON FOR REPORT

2.1 The Health and Wellbeing Board requested and received a briefing regarding proposed changes to STP governance arrangements, in September 2017. The Board requested a follow-up report once those arrangements were finalised and the purpose of this report is to provide that briefing.

This summary report is supported by the following documents namely:

- A short presentation, to be given at the Board meeting, and which articulates the changes to the STP Governance Framework (Appendix 1);
- The revised STP Governance Framework (Appendix 2);
- The revised STP Memorandum of Understanding (Appendix 3).

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.3.3
To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

3. BACKGROUND AND KEY ISSUES

3.1 The Cambridgeshire & Peterborough STP Plan was published in October 2016. In early 2017, the STP moved from the planning phase to the delivery phase. STP programme arrangements were put in place at that time, with a delivery governance structure to ensure effective implementation (See diagram in Appendix 1).

3.2 NHS England published *Next Steps on the NHS Five Year Forward View* (NHS England March 2017) which contained the requirement to establish an STP Board, and this Board was set up in

shadow form, in August 2017, made up of NHS organisation's Chairs and Chief Executives, as well as social services local authority colleagues. The STP Governance Framework, governance arrangements and documentation have, therefore, needed to be reviewed and revised to ensure that the STP Board is reflected as well as the necessary changes to the structures for delivering the STP.

3.3 The STP Board endorsed a revised Governance Framework and Memorandum of Understanding in November 2017 and, over the past few months, these revised arrangements have been submitted to all the statutory NHS bodies for ratification.

3.4 The Governance Framework and Memorandum of Understanding are attached at Appendix 2 and 3. The Health & Wellbeing Board is asked to note that the STP Board, although not a statutory body, will nevertheless conduct it's meeting in a similar manner to Statutory NHS body Boards including holding it's meeting in two parts i.e. a part 1 meeting in public and part 2 meeting in private.

3.5 The previous governance and working structures included clinicians and other front-line staff from system partners as well as patient and public representation. To ensure all transformation is consistently led by the front line, Clinical Communities are being established to lead priority areas for service redesign, for example, Ageing Well, Cardiology and Respiratory. Each community has a clinical chair and membership from across the service pathway (including primary care, social care, service users and patients).

3.6 The Health & Wellbeing Board is asked to note that, although the Memorandum of understanding has been updated, there has been no change to the appendix containing Local Authority signup.

4. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	

5. IMPLICATIONS

Financial Implications

5.1 N/A

Legal Implications

5.2 N/A

Equalities Implications

5.3 N/A

6. BACKGROUND DOCUMENTS

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

6.1 N/A

7. APPENDICES

7.1
- Appendix 1 - A short presentation, to be given at the Board meeting, and which articulates the changes to the STP Governance Framework
- Appendix 2 - The revised STP Governance Framework
- Appendix 3 - The revised STP Memorandum of Understanding

NHS England

Fit for the Future
Working together to keep people well

NHS Improvement

Cambridgeshire & Peterborough

Sustainability & Transformation Partnership (STP)

Revised Governance Framework

Peterborough City Council Health & Wellbeing Board

19 March 2018

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS Cambridgeshire and Peterborough NHS Foundation Trust
NHS Cambridgeshire Community Services NHS Trust
NHS Cambridge University Hospitals NHS Foundation Trust
NHS North West Anglia NHS Foundation Trust
NHS Royal Papworth Hospital NHS Foundation Trust
Cambridgeshire County Council
Peterborough City Council
NHS East of England Ambulance Service NHS Trust

STP Governance Framework

Agreed Refinements

A number of refinements have been agreed that will improve STP governance and meeting cycles, including:

1. The creation of the STP Board
2. The creation of a System Delivery Board
3. Updated role for Delivery Groups

The Memorandum of Understanding, Governance Framework and Terms of Reference for all STP groups have been refreshed in light of these refinements and have been endorsed by the newly established STP Board.

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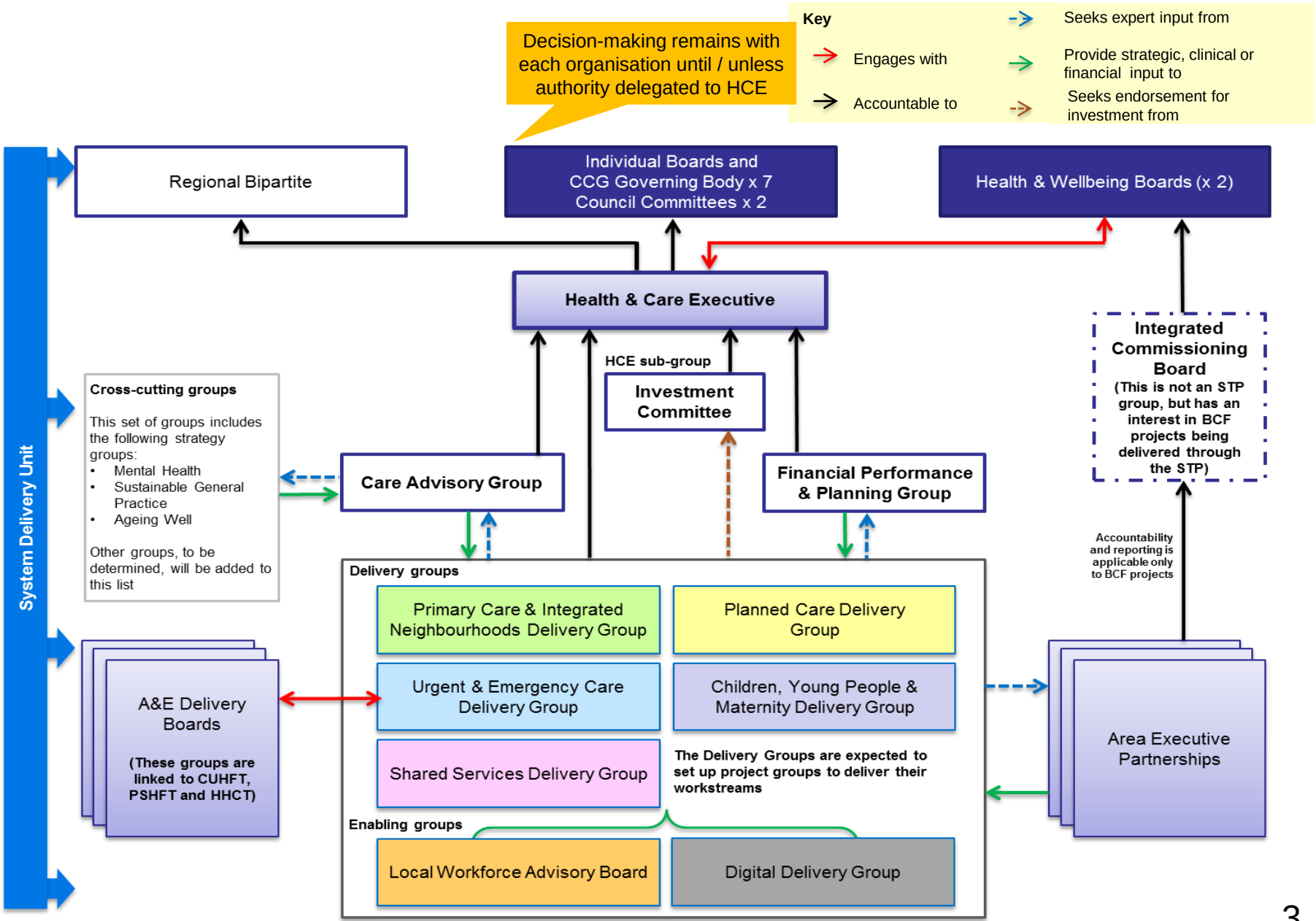
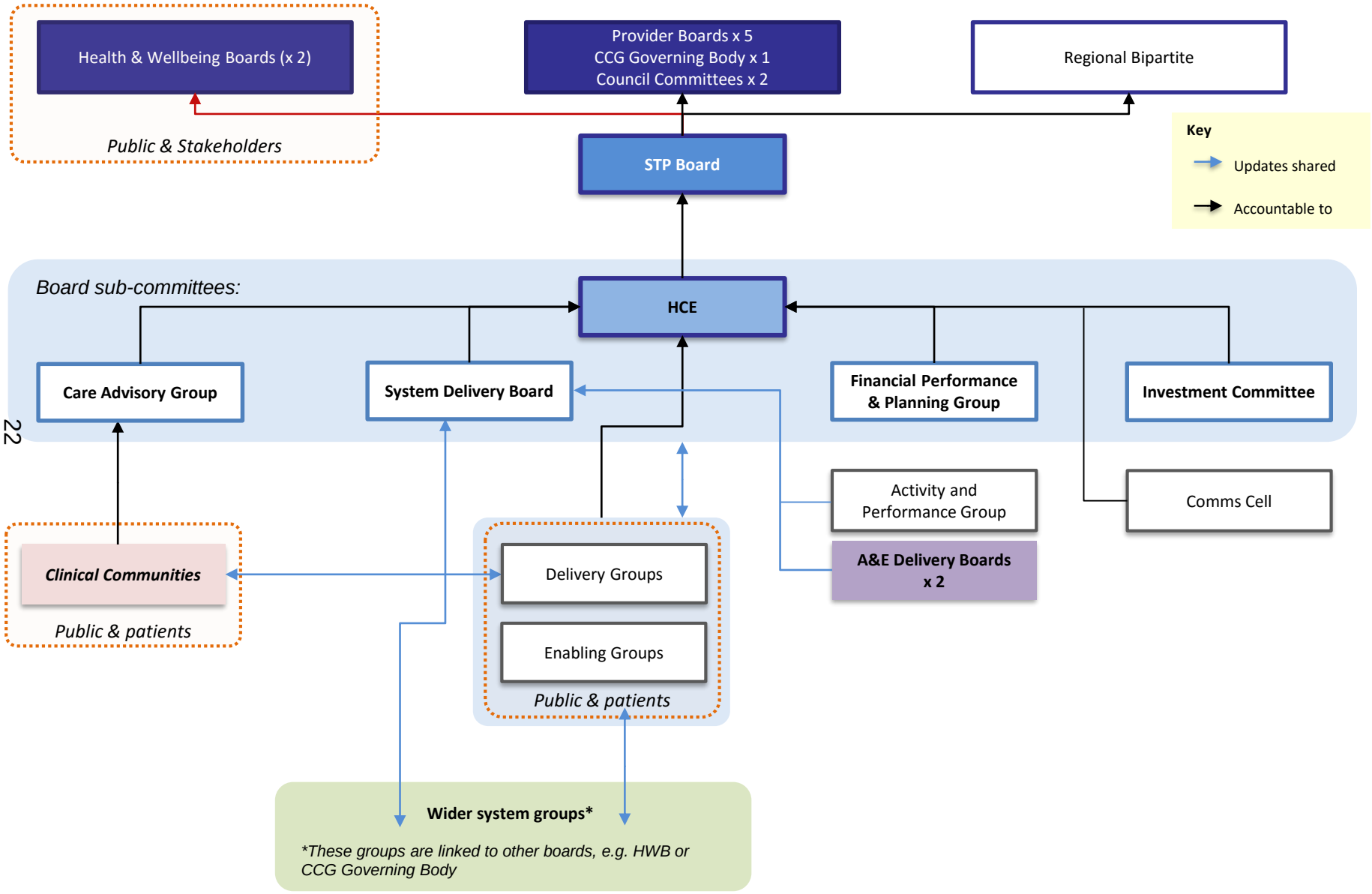
Following endorsement, the Memorandum of Understanding and Governance Framework have been ratified in public at NHS Statutory Boards and the CCG Governing Body.

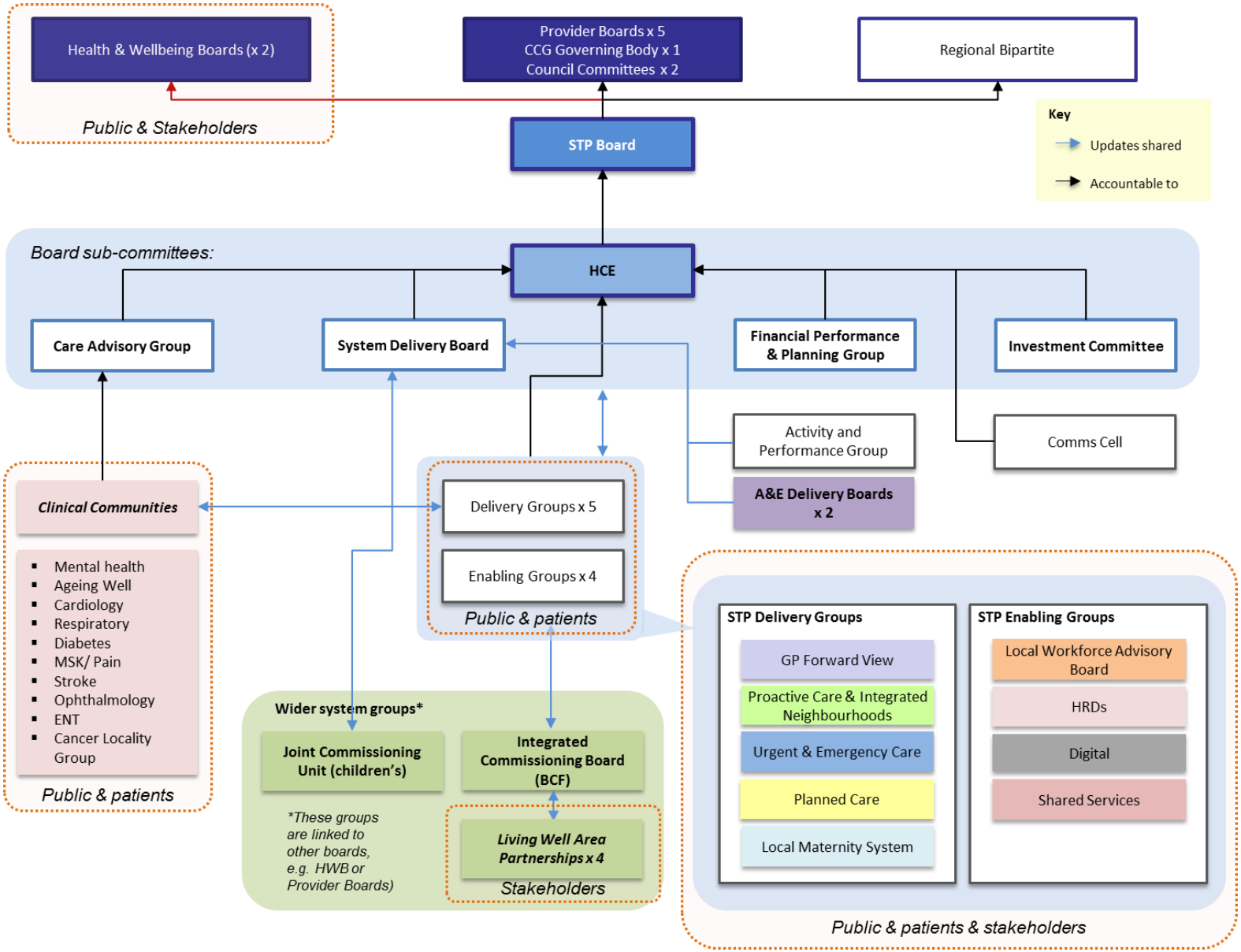
Previous STP Governance Structure



Revised STP Governance Structure

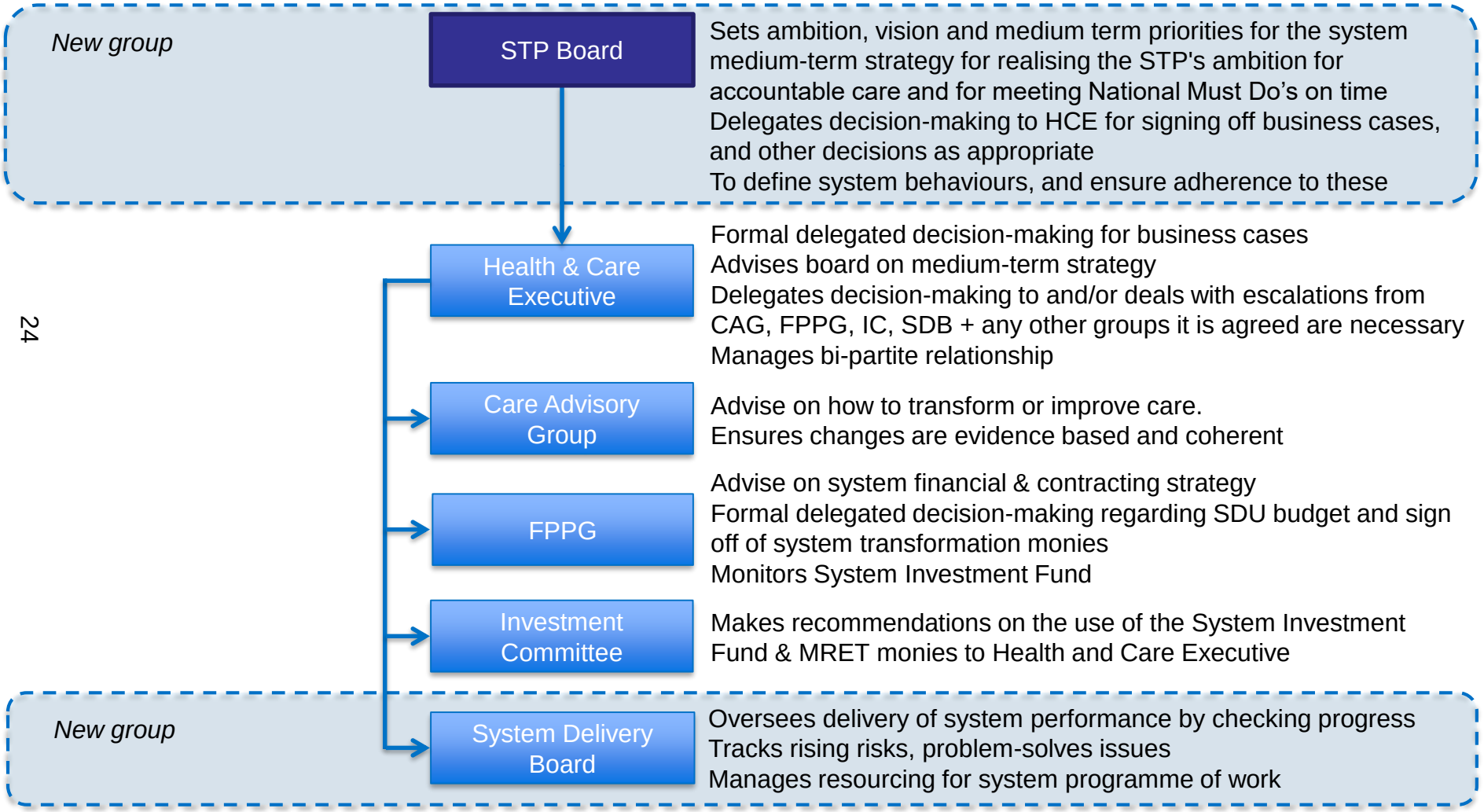


Revised STP Governance Structure - Detailed



Context: STP Board and sub-committees

With the establishment of the STP Board, we have refreshed the Governance Framework and Memorandum of Understanding ensuring there are clear roles and Terms of Reference. The following groups are sub-committees of the STP Board.



Context: Other STP groups and wider system groups

There are also a number of changes within the governance structure and establishment of new groups which sit under the STP Board and sub-committees.

New group

Activity and Performance Group

The group discusses activity and performance across the system in a non–contractual environment. To identify trends in demand and impacts of strategic change.

New groups

Clinical Communities

Brings together patients, carers and public with clinicians & key stakeholders to review, and make recommendations, based on the priorities set out by CAG, FPPG & HCE.
Focus on specific pathways or population groups in the 'design' and 'develop' stage.

Delivery/Enabling Groups

Recommends priority projects to CAG, FPPG and HCE
Ensures projects have an SRO and resources to ensure ideas progress from design through to delivery at pace and with impact
Oversees relevant National Must Do's

A&E Delivery Boards

Deliver nationally mandated improvement initiatives and core responsibilities to lead to A&E recovery.
Focuses entirely on Urgent & Emergency Care and recovering the 4-hour target.

Wider System Groups

Wider system groups include:

- Joint Commissioning Unit
- Integrated Commissioning Board
- Living Well Area Partnerships (replacing AEPs)

Focus on: STP Board

The STP Board is held bi-monthly and is chaired by the Independent Chair. The Board sets ambition, vision and medium term priorities for the system medium-term strategy for realising the STP's ambition for accountable care and for meeting National Must Do's on time.

Area	Responsibilities
Strategic decision making	• Responsible for the vision of the STP plan and the medium and long term STP strategy.
Operational delivery	• Receives brief update from the HCE and holds to account HCE for delivering the STP plan, ensuring accountability and reporting arrangements are in place.
Governance	• Ensures adherence to collective governance arrangements.
Risk management	• Reviews/ addresses strategic programme risks.
Engagement	• Ensures there are processes in place to engage with service users, general public and key stakeholders. • Lead on system wide communication.
Accountability	• STP Board is accountable to service users, general public and key stakeholders. Also through the Boards and Governing Bodies of the constituent organisations and the associated regulatory authorities (NHSI and NHSE) through the Regional Bipartite Group.

Membership

- Chair: Independent Chair
- Clinical Chair and Chief Officer - CCG
- Chair and CEO – CUHFT
- Chair and CEO – NWAngliaFT
- Chair and CEO – Papworth
- Chair and CEO – CPFT
- Chair and CEO – CCS
- Director of Public Health for Cambridgeshire and Peterborough
- Executive Director for People and Communities for Peterborough and Cambridgeshire
- CAG Chair
- FPPG Chair
- Executive Programme Director
- CCC elected representative
- PCC elected representative
- EEAST representation

Future membership - TBA

- Combined Authority representation
- GP provider representation

- The STP Board has a number of sub-committees which certain matters are delegated to; these sub-committees are the Health and Care Executive, Care Advisory Group, Financial Performance and Planning Group, System Delivery Board and the Investment Committee.

- Although not a statutory body, the STP Board will nevertheless conduct it's meetings in a manner similar to Statutory NHS body Boards in order to ensure openness and accountability. This will include holding it's meetings in two parts i.e. a part 1 meeting in public and part 2 meeting in private.

Focus on: Clinical Communities

Clinical Communities will lead the 'design' phase of all STP Improvement Areas. They will have a clinical chair and include members from the relevant Delivery Group and be responsible for drafting the proposals to 'Gateway One' stage within the STP Governance Framework.

Area	Responsibilities
Strategic decision making	• Responsible for designing clinical strategies and required service changes.
Operational delivery	• Present clinical strategies and recommended service changes to CAG for endorsement.
Governance	• Ensures adherence to collective governance arrangements.
Engagement	• Bring together patients, carers and the public with clinicians and key stakeholders to review, and make recommendations to improve the quality and outcomes of health services.
Risk management	• Adhere to the STP's Assurance Framework.
Accountability	• Clinical Communities are accountable to CAG.

Membership

- Chair: STP Speciality Clinical Lead

Clinical & Management representatives:

- Acute trust clinical leads
- Community clinical leads
- Primary Care clinical leads
- Mental Health clinical leads

Nursing, AHP & Clinical Scientist representatives:

- Acute trust leads
- Community leads
- Primary Care leads
- Mental Health leads

Other representatives

- Pharmacist/Medicines Management
- Local Authority and Social Care
- Public Health
- Patient, public and carer
- Relevant voluntary services
- Relevant other services (e.g. ambulance service)

The process of setting up Clinical Communities has started, with those areas which already have something similar in place being refreshed to meet the system Clinical Communities requirements, these include:

- Ageing Well, Cancer, Cardiology, Diabetes, ENT, MSK/Pain, Ophthalmology, Respiratory, and Stroke

Work has commenced on establishing the following Clinical Communities:

- Urgent Care, Mental Health, and Clinical Digital.

Focus on: System Delivery Board

The STP Delivery Board (STP DB) is chaired by the Executive Programme Director and is focused on ensuring delivery, enabling and wider STP programme groups remain on track to, including in the delivery of the national 'Must Dos'.

Area	Responsibilities
Strategic decision making	• Responsible for programme/ operational governance • To deliver the short term strategy (in-year)
Operational delivery	• Offers support, trouble-shooting and challenge to Delivery Groups (including design sub-groups), Enabling Groups and wider system groups for delivery of the STP
Governance	• Adheres to the collective governance arrangements
Risk management	• Reviews/ addresses risks to STP delivery escalated by Delivery/Enabling Groups
Accountability	• Chair attends and provides updates to the HCE, STP Board and to the Bipartite

Proposed Membership

- Chair: Executive Programme Director
- Deputy Chair: Strategy and Delivery Director, SDU

Delivery/Enabling representatives

- Chair and/or Deputy Chair for PCIN
- Chair and/or Deputy Chair for UEC
- Chair and/or Deputy Chair for Planned Care
- Chair and/or Deputy Chair for Shared Services
- Chair and/or Deputy Chair for GPFV
- Chair and/or Deputy Chair for HRDs
- Chair and/or Deputy Chair for Digital

Other system representatives

- COOs for NWAngliaFT, CPFT and CUH
- Social Care – joint Director for Adult Services or joint Director for Commissioning
- Sector Head of Service Delivery, EEAST

SROs, Clinical Communities Chairs by exception.
JCU or Local Maternity Services representatives by exception.
Chair of Activity and Performance Meeting by exception.

- On behalf of the HCE, to take decisions that address blocks to progress raised by the Delivery/Enabling Groups and wider STP groups to ensure they remain on track to deliver (1) An agreed programme of system improvements or transformations, (2) The national 'must dos' held by the STP
- It will not approve the content of OBCs or FBCs, merely track and trouble-shoot progress against anticipated milestones.
- Quoracy will be determined by the nature of the discussion required. If a decision is required about the realignment of system resources, then all impacted organisations need to be represented, and by a person with delegated authority.

Fit for the Future
Working together to keep people well

Cambridgeshire and Peterborough Sustainability and Transformation Partnership

Governance Framework
November 2017

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS Cambridge University Hospitals NHS Foundation Trust
NHS Cambridgeshire and Peterborough NHS Foundation Trust
NHS Cambridgeshire Community Services NHS Trust
NHS North West Anglia NHS Foundation Trust
NHS Royal Papworth Hospital NHS Foundation Trust
Peterborough City Council
Cambridgeshire County Council

Contents

1. Introduction

1.1 This Framework describes arrangements intended to provide a foundation of good corporate governance, enabling the Sustainability and Transformation Partnership (STP) to implement changes in the way that NHS services will be planned, delivered and experienced in Cambridgeshire and Peterborough. The Framework incorporates the milestones for delivering the STP for Cambridgeshire and Peterborough over the next five years, linked to the NHS Five Year Forward view.

1.2 The STP is formed from the following NHS and partner organisations across Cambridgeshire and Peterborough:

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
Cambridgeshire University Hospital NHS Foundation Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
North West Anglia NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Cambridgeshire County Council
Peterborough City Council
Local General Practices
East of England Ambulance Service NHS Trust

1.3 Cambridgeshire County Council and Peterborough City Council participate in the STP with the intention to align their public health and social care services in an integrated way. The Councils will participate in the STP through their representatives recognising that their policy and financial decisions are subject to the constitutional arrangements within their respective authorities. The Councils also have a particular requirement to scrutinise proposals for NHS service changes as elected representatives of their communities and must ensure the independence and integrity of those arrangements. The role of the City Council and the district councils exercise a number of relevant housing, planning and other functions, which may also align to this Programme.

1.4 The Sustainability and Transformation Partnership is supported by NHS Improvement and NHS England.

1.5 This Framework sets out the governance arrangements that the STP will adhere to in delivering its functions. It describes how the STP will operate, confirms those matters reserved to individual organisations for decision, describes the various Boards through which the health partners operate and where certain powers of those Boards will be delegated to the STP Board or in turn to the Health and Care Executive (HCE).

1.6 The STP Board is made up of the partner organisations Chairs and Chief Executives who are jointly responsible for ensuring delivery of the STP. The partner organisations will participate in the decision-making processes of the

STP Board to the extent that they are delegated authority by their respective organisations.

Patient and stakeholder engagement is key to shaping the work required to deliver STP. The STP Board will receive regular reports about engagement activities that have taken place with the public and with stakeholders.

2. Sustainability and Transformation Partnership

2.1 The STP exists to identify and drive delivery of strategic changes to the Cambridgeshire and Peterborough NHS health and care system that will both improve outcomes for local people, support the population to become healthier and ensure that services are financially sustainable. The STP will also oversee delivery of transformation across the system.

2.2 The Governance Framework applies to the whole lifecycle of the STP.

3. Corporate Governance Framework

3.1 This Framework describes the governance arrangements that have been established to ensure that the STP will operate to deliver its role and functions. It describes how the STP will operate, the decision-making process and how certain powers will be delegated from the STP's national health statutory organisations to the STP Board and its associated sub-committees and workstreams.

3.2 This Framework will be approved by the Boards Governing Bodies and local authority Committees/Cabinets of all partner organisations, and will be reviewed on a regular basis.

4. Principles for Good Governance

4.1 All members of the STP will observe the highest standards of probity in relation to the stewardship of public funds, the management of the STP, and the conduct of its business.

4.2 All members of the STP will adhere to the seven Nolan principles underpinning public office:

- **Selflessness:** holders of public office should take decisions solely in terms of public interest. They should not do so in order to gain financial or other material benefits. In addition, the NHS Commissioning Board will act as a role model to the clinical commissioning system and the NHS as a whole, in adopting and maintaining excellent standards of propriety for themselves, their family and their associates;
- **Integrity:** holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties;

- **Objectivity:** in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards or benefits, holders of public office should make choices on merit;
- **Accountability:** holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **Openness:** holders of public office should be as open as possible about all their decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **Honesty:** holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **Leadership:** holders of public office should promote and support these principles by leadership and example.

5. Aims

5.1 Through this Governance Framework, the STP aims to;

- maximise the effectiveness of the STP;
- ensure all partner organisations referred to in Section 1.2 meet their statutory obligations;
- ensure effective stewardship of public funds; and
- be a model of excellence in corporate governance by adopting the highest standards of business conduct.

6. Accountability and Leadership

6.1 The STP is accountable to the statutory organisations of the Cambridgeshire and Peterborough system described in Section 1.2 above, and to the associated regulatory authorities described in Section 1.4 above.

6.2 The STP is committed to openness and transparency in its work, in support of its accountability to patients and public. To that end, public meetings of the Boards, Governing Bodies and local authority committees/cabinets of each organisation are held regularly, and members of the public are welcome to attend and observe these meetings.

6.3 The STP will demonstrate its accountability through:

- Adhering to the Governance Framework, Memorandum of Understanding and STP Assurance Framework.
- Publishing the Sustainability and Transformation Partnership plan.
- Publishing other relevant documentation.
- Working within the Freedom of Information Act Policy.
- Commitment to the Living Well Partnership concordat.

6.4 The STP is committed to putting patients and the public at the heart of its decision-making, and is actively pursuing a wide range of communications and engagement mechanisms to support this commitment.

6.5 The STP Accountable Officer is accountable to the STP Board.

7. Roles and Responsibilities

7.1 Individual Organisations

Each individual organisation being a Member of the STP remains at all times accountable for its own activity and decisions.

7.2 Officers from Individual Organisations

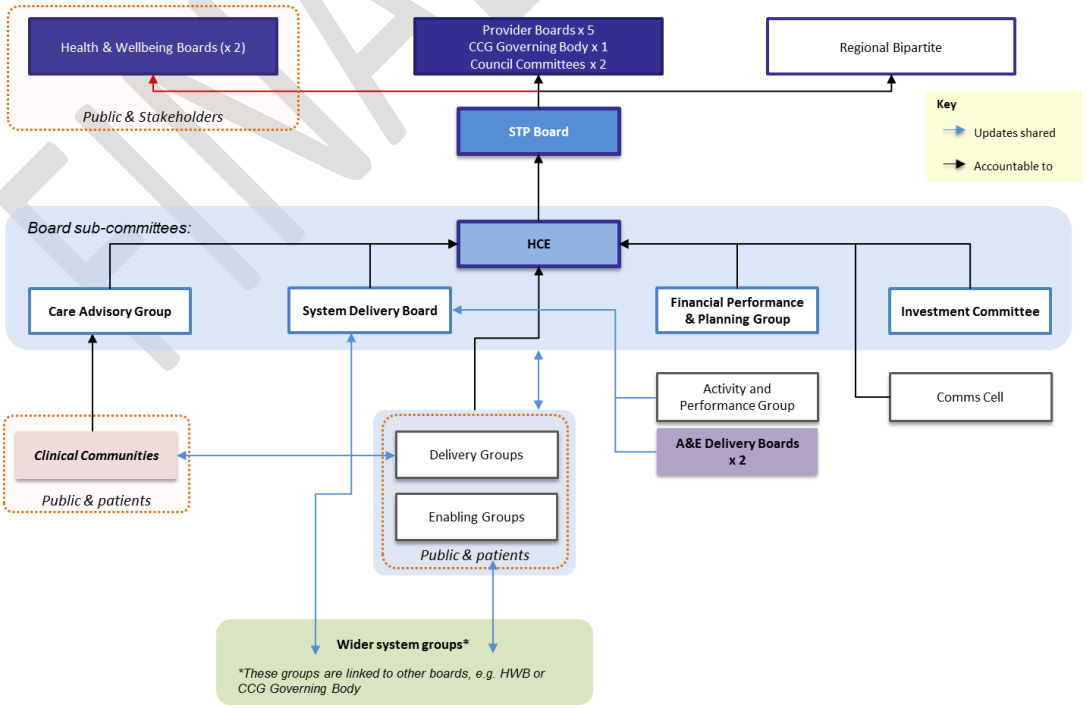
Members need to ensure that they have all necessary delegated permissions to bind the authority on whose behalf they act when making decisions. They must ensure that they adhere to all internal processes when making those decisions.

7.3 System Delivery Unit

The System Delivery Unit (SDU) has been established to oversee, on behalf of the HCE, a programme of work to deliver the STP. The SDU is accountable to the Accountable Officer.

8. Organogram

8.1 The governance structure for the STP is shown below:



8.2 STP Board

The role of the STP Board is described below:

- To focus on the medium and long-term strategy of the STP and answer the 'big' questions, to set the vision for Cambridgeshire and Peterborough's population based on health needs, and ensure the programme is structured to enable this to be delivered.
- To share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability by 2021 through developing the beneficial behaviours of an accountable care system.
- To influence the view of regulators or external assurance bodies regarding the primacy of system sustainability entailed in this plan and the joint commitment to it.
- To support and promote system behaviours, as set out in the Memorandum of Understanding, for the benefit of local residents and healthcare users including:
    - Working together and not undermining each other
    - Behaving well, especially when things go wrong
    - Engaging in honest and open discussion
    - Keeping our promises -small and large
    - Seeing success as a collective
    - Carrying through decisions once made
- To provide objective, 'third party' oversight and to act as 'critical friends' to the HCE in order to ensure that the STP's objectives are achieved including holding the HCE to account for the following, as delegated to the STP Board by the relevant Statutory Bodies:
    - Delivery of the STP, through the System Delivery Board which reports to HCE on an exceptional basis.
    - Ensuring that robust accountability, delivery and reporting arrangements are in place.
    - Ensuring the Cambridgeshire and Peterborough STP has in place, and is adhering to, collective governance arrangements including:
        I. a Memorandum of Understanding setting out how organisations will work together to deliver the STP;
        II. a Governance Framework clearly defining the roles and responsibilities of key groups and describing how they interrelate, and;
        III. a risk assurance framework and register.
- To recognise where an individual organisation is standing in the way of a necessary local change or failing to meet their duties of collaboration and seek to address and resolve this; where this is not possible, to escalate the issue to NHS England and NHS Improvement.
- To ensure the system works together to give a common message to service users and the general public; and is inclusive in its work.
- To promote the requirement to complete impact assessments for commissioning and decommissioning of services are completed.
- To foster working collaboratively with Partners, Local Authority and Combined Authority.

8.3 Health and Care Executive

The role of the Health and Care Executive is described below:

- To be collectively responsible for the development and implementation of the Cambridgeshire and Peterborough STP.
- To function as a single executive leadership team, operating under an aligned set of incentives to coordinate action for the benefits of local residents and healthcare users.
- To enact the positive behaviours of an accountable care system.
- To agree common messages to enable one story to be told to staff and patients about why we need to work together, what benefits it will bring and how we are doing it.
- To be honest, transparent, and mutually supportive of the positions of each organisation represented.
- To identify innovation and good practice, and ensure effective diffusion across the system.
- To be accountable to provider Boards, the CCG Governing Body and specified council committees.
- To engage with the Health and Wellbeing Boards for Cambridgeshire and Peterborough in regard to the delivery of the STP.
- To hold to account the following sub-groups of the STP Board, as delegated by the STP Board:
  - Care Advisory Group
  - Financial Performance and Planning Group
  - Investment Committee
  - System Delivery Board
- To hold to account the following delivery vehicles:
  - Clinical Communities
  - Delivery and Enabling Groups
- To determine areas of development and service reconfiguration for the Cambridgeshire and Peterborough health and care system from 2016 through to 2020; to lead a process to prioritise these areas.
- To determine which service change projects need to be done, by whom and by when (be they system change projects or independent change projects within the CCG or provider organisations); to ratify any proposed new work before it can start.
- To sign off all system projects to;
  - ensure that they are allocated to a Delivery or Enabling Group or System group, and;
  - ensure that system projects are assigned an executive level SRO.
- To prioritise projects across the system balancing need to deliver maximum impact quickly with the need to adequately resource each project.
- To report progress and provide assurance to the Regional Bipartite that the STP delivery plan is on track.

- To resolve issues locally, but where this is not possible to escalate unresolved issues to NHS Improvement and NHS England through an agreed Bipartite meeting process.
- Through the chairs of the Delivery/Enabling Groups liaise with and support the Delivery/Enabling Groups as required, providing information, advice and recommendations as appropriate.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework; this requires the group to maintain a risk register, to review this at every meeting and to review and seek to resolve risks escalated from the other groups in the STP structure.

8.4 Care Advisory Group

The role of the Care Advisory Group is described below:

- To receive and critically review strategies and business cases to improve or transform population health from the groups in the STP structure:
  - Review and comment on care model design proposals from groups in the STP structure. This will require:
    I. Assessing impact on the local population, patients and carers, the overall STP objectives and deliverability.
    II. Considering implications for other groups in the STP structure and cross-cutting themes, and ensuring that proposals are congruent and complementary.
  - Maintain an oversight of the proposals from all groups in the STP structure and ensure alignment between them.
  - Ensure that proposals are developed to address maximising both population health and patient benefit. Aim to reach consensus on all proposals to be submitted to the HCE and where this is not achievable, clearly articulate the relative merits of alternative proposals.
  - Promote care model design proposals that are operationally and financially sustainable.
- To provide overall clinical advice and expertise to the STP, making recommendations to the HCE.
  - Jointly, with the Financial Performance and Planning Group, oversee the completion of business cases, providing clinical assurance.
  - To give clinical assurance, if necessary by drawing on wider expertise outside of the CAG to future iterations of the Cambridgeshire and Peterborough five–year STP and its component parts.
  - Provide other groups involved in the Sustainability and Transformation Partnership with clinical advice and information as necessary, including Quality Impact Assessments for both new business plans and proposed disinvestments.
  - To provide clinical guidance in the design and interpretation of quality and inequality impact assessments required for all current and new service re-design.
- To review progress towards implementation.
  - Report progress using all necessary and agreed analytic methodology to the HCE using an agreed reporting format.

  - Provide reports using all necessary and agreed analytics, as requested, to members of the SDU.
  - Report risks and issues to the HCE, escalating any unresolved areas
  - Resolve issues locally, but where this is not possible to escalate unresolved issues to the HCE through an agreed process.
  - Where necessary to provide clinical narrative for the interpretation of health analytic metrics used to monitor service provision and implementation of new models of care.
  - Give advice to communications teams concerning the clinical accuracy of publicity and information available to the public and to the health and social care workforce.
- To evaluate service outcomes.
  - Review the evaluation of the new model of care and all relevant services to ensure the original service model and strategy and has been achieved and make recommendations to Health and Care Executive on the future service model.
- To advise on the medium and long-term care/clinical model in the STP.
  - Provide strategic direction; contribute to the vision for improving health and well-being within the STP.
  - Where necessary require Clinical Communities in the STP structure to develop plans to address those new initiatives and present the conclusion, where agreed, to HCE for consideration.
  - To make recommendations for future innovation in service delivery, clinical or translational research that will impact on population and individual health outcomes for the system.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework; this requires the group to maintain a risk register, to review this at every meeting and to review and seek to resolve risks escalated from the other groups in the STP structure.

8.5 System Delivery Board

The role of the System Delivery Board is described below:

- Tactical and operational decision making:
  - On behalf of the Health & Care Executive, to take decisions that address blocks to progress raised by the Delivery/Enabling Groups and wider STP groups to ensure they remain on track to deliver;
    I. an agreed programme of system improvements or transformations, and;
    II. the national 'must dos' held by the STP (including but not limited to: urgent & emergency care; general practice; mental health; cancer; planned care; estates, back office & clinical support services; digital; children's services and maternity; and workforce).
  - To receive updates from the Activity and Performance Group on system activity and financial performance. Where these updates suggest the programme of work is not having the intended impact, the System Delivery Board will work to establish if the agreed programme

of work is sufficient to meet agreed trajectories, and to make recommendations to HCE as required.
    - To work in partnership with CAG, FPPG and Investment Committee to ensure the appropriate balance is found between devolving autonomy and maintaining accountability.
- Operational delivery:
    - To provide collective system leadership and pace-setting for the Delivery Groups and Enabling Groups on behalf of HCE.
    - To offer support, trouble-shooting and constructive challenge to Delivery Groups (including clinical communities who are leading design), and Enabling Groups.
    - To ensure;
        I. all work in design, develop, deploy and deliver phases is meeting critical path milestones;
        II. the Delivery Groups, Enabling Groups, A&E Delivery Boards and system wide groups are cognisant of inter-dependencies between them and these are well managed;
        III. projects in the deploy and deliver phases have the anticipated impact, in line with business case implementation trajectories, and;
        IV. lessons are learnt and shared of what has gone well and what has gone less well.
    - To re-prioritise SDU and system resourcing across projects, balancing the need to deliver maximum impact quickly with the need to adequately resource each project.
    - To sign off a single methodology (captured in the STP Ways of Working document) for project management and programme monitoring.
    - To receive updates from the Integrated Commissioning Board, as relevant.
    - To, by exception, escalate to HCE for resolution, risks and issues escalated by Delivery Groups and Enabling Groups.
    - To receive and sign-off the delivery updates to be received by HCE and the STP Board, and any submissions relating to STP wide delivery to the national regulators.
- Governance:
    - To adhere to the principles described in the STP's Memorandum of Understanding.
    - To report progress and provide assurance to the Health and Care Executive that the STP delivery plan is on track.
    - To provide updates to the Health and Care Executive, STP Board and Bipartite on the delivery of the system improvements and transformations and the National Must Do's.
    - To ensure the Delivery Groups, Enabling Groups, A&E Delivery Boards and wider STP Programme groups commissioned by the HCE;
        I. are working to deliver one or more of the areas identified in the STP plan;
        II. are appropriately resourced;

III. have identified clear outcomes, targets for activity shifts, quality changes or financial savings/growth, timescales for delivery, and agreed associated projects;
IV. are on track to deliver the changes set out above within the agreed timescale, and;
V. report on progress against an agreed set of metrics, and report risks and issues.

- Risk management:
  - To adhere to the STP's Risk Assurance Framework.
  - To ensure that progress, risks and issues are tracked and reported using the agreed methodology.
  - To resolve, or oversee the resolution, of Delivery/Enabling Group risks and issues escalated by other groups in the STP structure. Where this is not possible to escalate unresolved issues to the Health and Care Executive.

8.6 Financial Performance and Planning Group

The role of the Financial Performance and Planning Group is described below:

- To advise the Health and Care Executive (HCE) on system financial sustainability.
- To monitor and report on the financial risks to the implementation of the STP.
- To oversee submission of national financial submissions on behalf of the STP.
- To develop a framework for contracting and incentives, aligning planning assumptions, quality assuring savings and investment proposals and tracking savings progress.
- To monitor and report on the system performance against key national/local metrics.
- To maintain an overview of the delivery and benefits realisation of Cost Improvement Plans (CIP), Quality Innovation Productivity and Prevention (QIPP) and transformation plans.
- To consider and approve business cases for the use of significant system wide financial investments.
- To liaise with non-NHS stakeholders to the STP.
- To report progress to the HCE using an agreed reporting format.
- To resolve issues locally, but where this is not possible to escalate unresolved issues to the HCE through an agreed process.
- To monitor the SDU budget.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework; this requires the group to maintain a risk register, to review this at every meeting and to review and seek to resolve risks escalated from the other groups in the STP structure.

8.7 Investment Committee

The role of the Investment Committee is described below:

- To ensure that Business Cases submitted for consideration are supported and agreed by NHS and Local Authority.
- To develop criteria against which Business Cases will be assessed.
- To assess and evaluate all Business Cases submitted to the Committee against agreed investment criteria.
- In assessing Business Cases, have due regard to the system's agreed priorities and other pipeline investment cases currently under development, acknowledging that the investment fund cannot finance every case.
- To decide, based on assessment against agreed investment criteria whether to recommend the case for immediate funding in full, or in part, at a later date, subject to further information or not at all.
- To report on a regular basis to the HCE on the level of the System Investment Fund (SIF) committed and uncommitted.
- To review Marginal Rate Emergency Tariff (MRET) funded scheme Business Cases, and decide whether these should be recommended to the HCE for continued funding, or whether these funds should be reinvested in the SIF for other schemes.
- In regards to the Better Care Fund, ensuring there is a process for sharing Business Cases proposals where there are implications for both health and social care.
- To adhere to the principles described in the STP's Memorandum of Understanding.

8.8 Clinical Communities

The role of the Clinical Communities is described below:

- Design clinical strategy and required service changes
    - Review the current patient pathway and identify areas for improvement.
    - Redesign patient pathways covering all elements of patient's care (prevention, emergency care, elective care and primary/community care and where appropriate end of life care) to improve;
        I. Clinical effectiveness and safety
        II. Patient experience
        III. Population health
        IV. Financial sustainability
    - Identify required service improvements, service changes and commissioning arrangements to deliver new model of care and patient pathway
    - Identify clinical, operational and financial outcomes and Key Performance Indicators (KPIs) to enable meaningful evaluation of service changes that are implemented.
    - Accept the financial savings opportunities proposed by the CCG as part of their annual planning as the level of ambition towards which they will work towards.

    - Work closely with finance colleagues to develop an outline business case to (estimate) initial financial outcomes and identify resources required (revenue, capital and non-financial). Make every effort to identify how the redesign, change or improvement can be done within existing resources by working differently.
    - Present clinical strategy and recommended service changes to CAG for approval.
- Review quality and performance.
    - Review benchmarking data, including RightCare, Getting It Right First Time (GIRFT) and relevant national policies, guidance and best practice for specified clinical areas.
    - Review current service clinical performance, clinical indicators and outcomes across the whole patient pathway, including public health, primary, community care and acute care.
    - Review population needs assessments where available, and undertake population needs assessment where not already available for specified clinical areas.
    - Identify innovation and good practice.
    - Implement (tactical improvements/ quick wins).
    - Plan and implement services improvements that are within the gift of the community's members to implement without permission and in line with the STP's governance arrangements.
    - Refine continuously improvements until fully embedded in usual care.
- Evaluate service outcomes.
    - Review the evaluation of the new model of care and all relevant services to ensure the original service model and strategy and has been achieved and make recommendations to Health and Care Executive on the future service model.
    - Review the evaluation of the clinical outcomes against the agreed KPIs to determine whether patient experience, outcomes and financial sustainability has improved as planned and make recommendations to Health and Care Executive on the future service model.
    - Present findings, learning and recommendations to wider STP group via CAG.
- Work collaboratively with stakeholders
    - Demonstrate evidence of patient/carer and public involvement (PPI).
    - Develop systems for accessing patient/carer and public involvement and opinion on specific issues, with support from the STP PPI leads.
    - Review and audit the level of patient/carer feedback, reporting to the Care Advisory Group with support from the STP PPI lead.
    - Engage with Public Health, Local Authorities and the joint Strategic Needs Assessment.
    - Engage with similar clinical networks, NHSE and Specialist Commissioning to share best practice and information.
    - Develop strong working partnerships with the Clinical Senate; the East of England Academic Health Science Networks (AHSNs), Cambridge University Health Partners and the Medical School, NHSE and I), and Local Education and Training Boards (LETBs).
- Operate in accordance with the STP's agreed ways of working

- Work in accordance with the STP's agreed 'ways of working' and programme cycle.
- Adhere to the principles described in the STP's Memorandum of Understanding.
- Adhere to the STP's Assurance Framework.

8.9 Delivery and Enabling Groups

The role of the Delivery and Enabling Groups is described below:

- To contribute to the overall delivery of the STP objectives by ensuring that the quality improvements and financial opportunities identified in the STP realised.
- To be responsible for setting up and ensuring the implantation (including savings realisation) of projects to meet the STP objectives.
- To oversee the delivery of a portfolio of STP projects in order to realise financial savings and achieve quality improvement.
- To improve patient experience and outcomes.
- To provide expertise to support transformational change.
- To monitor progress and risks, and report this as appropriate.
- To establish and oversee Development Groups, that will work up business cases for approval, and Deployment Groups, that will take forward business cases once approved.
- To lead a process to evaluate projects once Deployment is complete, and share the learning from this.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework.

8.10 Activity and Performance Group

The role of the Activity and Performance Group is described below:

- To review and discuss activity and performance across the system in a non-contractual environment.
- To feedback trends and key insights into Delivery/Enabling Groups and Clinical Communities, which may form part of evaluations.
- To provide reports to the System Delivery Board.
- To recommend and help develop future priorities based on activity and performance levels.
- To compare local and national data sets to answer specific requests by regulators.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework.

8.11 A&E Delivery Boards

The role of the A&E Delivery Boards is described below:

- To ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds).
- To provide a vehicle for strong and visible front-line clinical leadership and resident/patient involvement.
- To promote a culture of continuous quality improvement.
- To oversee improvement projects that require locality tailoring for successful implementation.
- To deliver nationally mandated improvement initiatives and core responsibilities to lead to A&E recovery.

8.12 System Groups

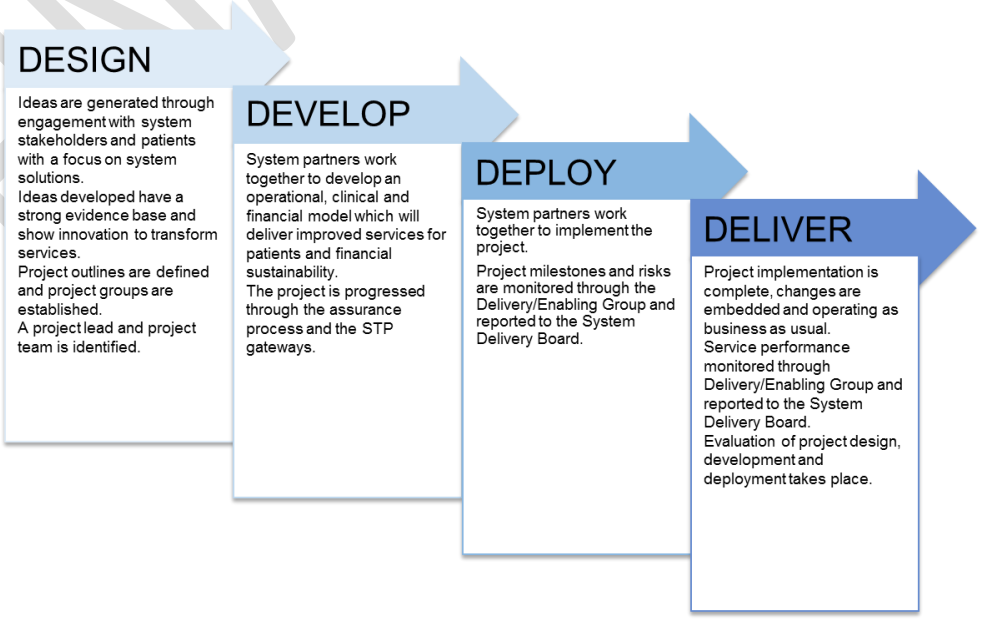
There are a number of aligned workstreams and partner groups which also support the STP such as the *Joint Commissioning Unit, Integrated Commissioning Board and Living Well Area Partnerships.*

9. Delivering the STP

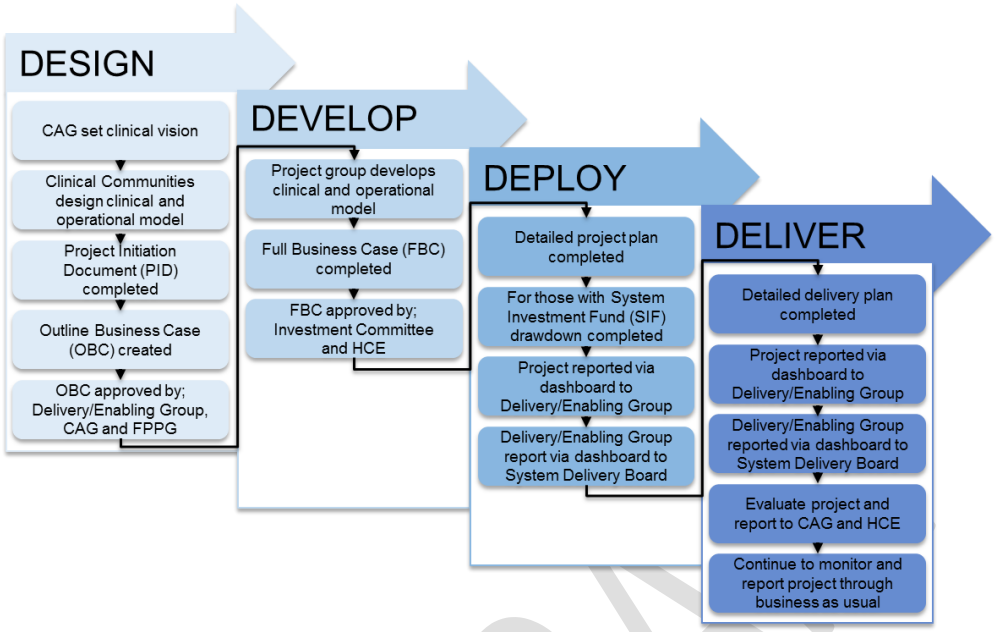
9.1 Overview

As the STP moves from planning into implementation and delivery it is apparent that there needs to be a clear and consistent structure to frame the various processes across the STP to reduce confusion and ensure appropriate accountability across the 'lifecycle' of the STP improvement projects. To support this the SDU has developed a suite of guidance documents and tools which will assist all parties understand at each stage in the improvement project's life (Design, Develop, Deploy and Deliver). This is outlined in the STP Programme Cycle.

The diagram below describes what happens at each stage in an improvement project's life:



The diagram below demonstrates how a project moves through each stage:



9.1.1 Decision Making

Decision making remains with each organisation until/unless authority is delegated to the STP Board or in turn to the Health and Care Executive. All decision-making across the STP will therefore be taken under the Scheme of Delegation set out in the tables below. Urgent Decisions are covered in Section 9.10 below.

In the context of the decision-making process, the following applies:

Endorse – to support decisions that have been made across the STP
Approve – to approve decisions/documentation (in line with Statutory Duties and Functions of all Organisations across the STP)

The decision-making process for the implementation phase of the STP is split into three categories:

1. Proposals that require funding from the STP System Investment Fund
2. Proposals that require local investment (from the CCG, provider organisations or council
3. Proposals that do not require any investment

A summary of these processes appears on the following page. More detail about each process is available in the STP Programme Cycle and Ways of Working document.

Summary of the governance approach for the approval of project proposals

Key GATEWAY 1 | GATEWAY 2

		(1) Governance approach for projects requiring funding from the STP System Investment Fund (SIF)	(2) Governance approach for projects requiring investment from the CCG, provider organisations or council only	(3) Governance approach for projects that do not require any investment
Outline Business Case Stage	Set Clinical Vision	CAG	CAG	CAG
	Approve vision	HCE	HCE	HCE
	Approve Gateway Proposal	Delivery Group	Delivery Group	Delivery Group
	Approve Proposals	CAG | FPPG	CAG | FPPG	CAG | FPPG
Full Business Case Stage	Develop Full Business Case/Final Proposal	Delivery Group → Delivery Groups must ensure sign off (e.g. from the CCG CEC, Provider Boards or someone with delegated authority) is achieved before cases proceed to the IC	Delivery Group → Delivery Groups must ensure sign off (e.g. from the CCG CEC, Provider Boards or someone with delegated authority) is achieved before cases proceed to the IC	Delivery Group → Delivery Groups must ensure sign off (e.g. from the CCG CEC, Provider Boards or someone with delegated authority) is achieved before cases proceed to the IC
	Evaluate Full Business Case	Investment Committee		
	Approve Full Business Case/ Final Proposal (where investment is required) or Agree Final Proposal is in line with STP (where no investment is required)	HCE	HCE	HCE
	Final Sign off (where investment is required) or Approve Final Proposal Case (where no investment is required)	Appropriate formal sign off from relevant local organisation(s)	Appropriate formal sign off from relevant local organisation(s)	Appropriate formal sign off from relevant local organisation(s)

9.2 Matters Reserved to the Boards, Governing Bodies and Local Authority Committees/Cabinet of Statutory Organisations across the lifecycle of the STP

Table 1 summarises the decisions reserved to the CCG Governing Body.

Table 1 – Schedule of Matters reserved to CCG Governing Body
To approve the overarching Options and Consultation Document

Table 2 summarises those matters which have been reserved to the Boards of NHS Organisations.

Table 2 – Schedule of Matters reserved to the Boards, Governing Bodies of Statutory NHS Organisations
To approve system-wide planning intentions on an annual basis
To approve options for future organisational form
To approve individual QIPP and CIP plans over the lifecycle of the STP
To approve in principle, the Sustainability and Transformation Partnership plan and agree delegated Chair's Action/Urgent Decisions (for CCG Governing Body)
To formally endorse sustainable medium-term options for service reconfiguration
To approve the overarching Governance Framework
To endorse the overarching Options and Consultation Document

Table 3 summarises those matters which are reserved to the Local Authority Committees/Cabinet.

Table 3 – Schedule of Matters reserved to Local Authority Committees/Cabinet
To approve social care and public health service aspects of system-wide planning intentions on an annual basis.
To formally approve the social care and public health service aspects of a Sustainability and Transformation Partnership plan
To approve the overarching Governance Framework

9.3 Matters Delegated to the STP Board

Table 4 summarises those matters have been delegated to the STP Board by the relevant Statutory Bodies.

Table 4 – Schedule of Matters Delegated to the STP Board and its members	
Matters Delegated	**Delegated to**
To focus on the medium and long-term strategy of the STP	STP Board
To ensure that the system has in place a process for working towards an Accountable Care System	STP Board

To hold the HCE account to commission and oversee the Sustainable and Transformation Partnership programme of work that will, by the end of 2018/19 have delivered on home is best, safe and effective hospital care, sustainable together and enablers	STP Board
To hold the HCE account for delivery of the STP	STP Board
To hold the HCE to account for ensuring that accountability and reporting arrangements are in place.	STP Board
To hold the HCE to account for ensuring the Cambridgeshire and Peterborough STP has in place, and is adhering to, collective governance arrangements.	STP Board
To determine the nature of a formal vote	Chair
To approve STP Board minutes	STP Board
To provide written notice of dates, times and locations of meetings of the STP Board	Secretariat

9.4 Matters Delegated to the Health and Care Executive

Table 5 summarises those matters have been delegated to the Health and Care Executive by the STP Board.

Table 5 – Schedule of Matters Delegated to the Health and Care Executive and its members*	
Matters Delegated	**Delegated to**
To commission and oversee the Sustainable and Transformation Partnership plan of work that will, by the end of 2018/19 have delivered on home is best, safe and effective hospital care, sustainable together and enablers	Health and Care Executive
To determine areas of development and service reconfiguration for the Cambridgeshire and Peterborough health and care system from 2016 through to 2020; to lead a process to prioritise these areas	Health and Care Executive
To determine which service change projects need to be done, by whom and by when (be they system change projects or independent change projects within the CCG or provider organisations); to ratify any proposed new work before it can start.	Health and Care Executive

To sign off all system projects and ensure that they are allocated to a Delivery Group/Enabling Group.	Health and Care Executive
To ensure the workstreams/work programmes commissioned by the HCE are working to deliver one or more of the areas identified in the table above, are appropriately resourced, have identified clear outcomes, targets for activity shifts, quality changes or financial savings/ growth, timescales for delivery, and agreed associated projects, are on track to deliver the changes set out above within the agreed timescale and report on progress against an agreed set of metrics, and report risks and issues	Health and Care Executive
To prioritise projects across the system balancing the need to deliver maximum impact quickly with the need to adequately resource each project	Health and Care Executive
To resolve, or oversee the resolution, of risks and issues escalated by the groups accountable to the HCE	Health and Care Executive
To report progress and provide assurance to the Regional Bipartite that programme delivery is on track	Health and Care Executive
To resolve issues locally, but where this is not possible to escalate unresolved issues to NHS Improvement and NHS England through an agreed Bipartite meeting process	Health and Care Executive
To oversee a process for agreeing commissioning intensions	Health and Care Executive
To engage with individual Boards, Governing Bodies and Local Authority Cabinet/Committees on the implementation of the STP	Health and Care Executive
To engage with Health and Wellbeing Boards on the implementation of the STP.	Health and Care Executive
To approve business cases to support delivery of the STP	Health and Care Executive
To review and endorse recommendations made via the Investment Committee.	Health and Care Executive
To manage the risks associated with overall delivery of the STP	Health and Care Executive
To determine the need for Urgent Decisions in discussion with the Chair and Programme Director	Chair
To determine the nature of a formal vote	Chair

To approve HCE minutes	Health and Care Executive
To provide written notice of dates, times and locations of meetings of the HCE	Secretariat

** Representation by local authority officers on the Health Executive will be limited to relevant social care and public health services within the remit of their delegated authority from their respective Council. Any key decisions will be subject to the constitutional process which applies to the Committee Chair/Vice Chair or Cabinet Portfolio Holder responsible for that function.*

9.5 Matters Reserved to the Care Advisory Group

Table 6 summarises those matters have been delegated to the Care Advisory Group by the STP Board.

Table 6 – Schedule of Matters Delegated to the Care Advisory Group and its members	
Matters Delegated	**Delegated to**
To commission, receive and critically review information and reports from the Delivery and Enabling Groups.	Care Advisory Group
To provide overall clinical advice and expertise to the Sustainability and Transformation Partnership, making recommendations to the Health and Care Executive	Care Advisory Group
To report progress using all necessary and agreed analytic methodology to the Health and Care Executive using an agreed reporting format.	Care Advisory Group
To make recommendations for future innovation in service delivery.	Care Advisory Group
To review business cases at 'Outline Business Case' stage and make recommendations about whether or not they should proceed.	Care Advisory Group
To endorse Investment Committee initial proposals to be developed into full business cases.	Care Advisory Group
To determine the nature of a formal vote.	Chair
To approve CAG minutes.	Care Advisory Group
To provide written notice of dates, times and locations of meetings of the CAG.	Secretariat

9.6 Matters Reserved to the System Delivery Board

Table 7 summarises those matters that have been delegated to the System Delivery Board by the STP Board.

Table 7 – Schedule of Matters Delegated to the System Delivery Board and its members	
Matters Delegated	**Delegated to**
To sign off methodology and a small number of monitoring dashboards developed by the SDU for monitoring programme delivery	System Delivery Board
To review the performance of the STP, by monitoring the delivery of workstreams/work programmes, against an agreed set of programme metrics and using the agreed methodology	System Delivery Board
To ensure that progress, risks and issues are tracked and reported using the agreed methodology	System Delivery Board
To receive and sign-off reports from the SDU that the STP plan, and its future modifications, is being appropriately delivered	System Delivery Board
Through the Chairs of the Delivery/Enabling Groups to liaise with and support the Delivery/Enabling Groups as required, providing information, advice and recommendations as appropriate	System Delivery Board
To resolve, or oversee the resolution, of risks and issues escalated by the groups accountable to the HCE	System Delivery Board
To determine the nature of a formal vote	Chair
To approve System Delivery Board minutes	System Delivery Board
To provide written notice of dates, times and locations of meetings of the System Delivery Board	Secretariat

9.7 Matters Reserved to the Financial Performance and Planning Group

Table 8 summarises those matters that have been delegated to the Financial Performance and Planning Group by the STP Board.

Table 8 – Schedule of Matters Delegated to the Financial Performance and Planning Group and its members	
Matters Delegated	**Delegated to**
To advise the Health and Care Executive on system financial sustainability	Financial Performance and Planning Group
To oversee submission of national financial submissions on behalf of the STP	Financial Performance and Planning Group
To develop a framework for contracting and incentives, aligning planning	Financial Performance and Planning Group

assumptions, quality assuring savings and investment proposals and tracking savings progress	
To monitor and report on the system performance against key national/local metrics	Financial Performance and Planning Group
To maintain an overview, the delivery and benefits realisation of CIP, QIPP and transformation plans	Financial Performance and Planning Group
To consider and endorse business cases for the use of significant system wide financial investments	Financial Performance and Planning Group
To report progress to the Health and Care Executive using an agreed reporting format	Financial Performance and Planning Group
To resolve issues locally, but where this is not possible to escalate unresolved issues to the Health and Care Executive through an agreed process	Financial Performance and Planning Group
To endorse Investment Committee initial proposals to be developed into full business cases	Financial Performance and Planning Group
To monitor the SDU budget	Financial Performance and Planning Group
To determine the nature of a formal vote	Chair
To approve Financial Performance and Planning Group minutes	Financial Performance and Planning Group
To provide written notice of dates, times and locations of meetings of the Financial Performance and Planning Group	Secretariat

9.8 Matters Reserved to the Investment Committee

Table 9 summarises those matters that have been delegated to the Investment Committee and its members by the STP Board.

Table 9 – Schedule of Matters Delegated to the Investment Committee and its members	
Matters Delegated	**Delegated to**
To develop the criteria against which business cases will be assessed	Investment Committee
To evaluate business cases submitted to the committee against the criteria	Investment Committee
To ensure that all business cases submitted for consideration are supported and agreed by all significantly affected local health and social care organisations (supported by the SDU)	Investment Committee

To decide, based on the assessment against agreed Investment criteria, and system priorities whether to recommend the case for immediate funding in full, or in part, or at a later date where other cases due for presentation are thought to need priority	Investment Committee
Have due regard to the system agreed priorities and other pipeline investment cases currently under development, acknowledging that potentially not all cases can be funded based on the resources available	Investment Committee
To review MRET funded scheme business cases, and make recommendations to the Health and Care Executive for continued funding, or whether it believes these funds should be reinvested in the investment pot for other schemes	Investment Committee
To determine the nature of a formal vote	Chair
To approve Investment Committee minutes	Investment Committee
To provide written notice of dates, times and locations of meetings of the Investment Committee	Secretariat

9.9 Matters Reserved to the Clinical Communities

Table 10 summarises those matters that have been delegated to the Clinical Communities and their member by the Care Advisory Group.

Table 10 – Schedule of Matters Delegated to the Clinical Strategy Groups and its members	
Matters Delegated	**Delegated to**
To review quality and performance	Clinical Communities
To design clinical strategy and required service changes	Clinical Communities
To review and monitor service outcomes	Clinical Communities
To work collaboratively with stakeholders	Clinical Communities
To operate in accordance with the STPs agreed ways of working	Clinical Communities
To determine the nature of a formal vote	Chair
To approve Clinical Communities minutes	Clinical Communities
To provide written notice of dates, times and locations of meetings of the Clinical Strategy groups	Secretariat

9.10 Matters Reserved to the Delivery and Enabling Groups

Table 11 summarises those matters that have been delegated to the Delivery and Enabling Groups and its members by the Health and Care Executive.

Table 11 – Schedule of Matters Delegated to the Delivery and Enabling Groups and its members	
Matters Delegated	**Delegated to**
To improve patient experience and outcomes	Delivery and Enabling Groups
To provide expertise to support transformational change	Delivery and Enabling Groups
To oversee the delivery of a portfolio of projects in order to realise financial savings and quality improvement	Delivery and Enabling Groups
To monitor progress and risks, and report this as appropriate	Delivery and Enabling Groups
To develop final Business Cases for submission to Investment Committee	Delivery and Enabling Groups
To determine the nature of a formal vote	Chair
To approve Delivery/Enabling Group minutes	Delivery and Enabling Groups
To provide written notice of dates, times and locations of meetings of the Delivery/Enabling Group	Secretariat

9.11 Matters Reserved to the A&E Delivery Board

Table 12 below summarises those matters that have been delegated to the A&E Delivery Board and its members.

Table 12 – Schedule of Matters Delegated to the A&E Delivery Board and its members	
Matters Delegated	**Delegated to**
To improve patient experience and outcomes in relation to emergency care	A&E Delivery Board
To provide expertise to support transformational change	A&E Delivery Board
To oversee the delivery of a portfolio of projects in order to realise financial savings and quality improvement	A&E Delivery Board
To deliver five mandated improvement initiatives	A&E Delivery Board
To deliver the nationally mandated core responsibilities to lead A&E recovery	A&E Delivery Board
To receive assurance that the following nationally mandated core responsibilities are being delivered by the UEC Delivery Group	A&E Delivery Board

To monitor progress and risks, and report this as appropriate	A&E Delivery Board
To determine the nature of a formal vote	Chair
To approve A&E Delivery Board minutes	A&E Delivery Board
To provide written notice of dates, times and locations of meetings of the A&E Delivery Board	Secretariat

9.12 Urgent Decisions

Due to the nature of the business cycle of individual organisations, there may be a requirement for Urgent Decisions to be taken. In these circumstances, Urgent Decisions should be;

- discussed by the Health and Care Executive and taken by the Chair of the Health and Care Executive, in consultation with the Chair, Chief Executive and Director of Finance (or their equivalent roles) in each partner organisation;
- required to be taken by the Councils as a result of any decision exercised by the HCE are subject to the individual council's constitutional arrangements, and;
- be recorded appropriately and reported to the partner organisations for formal ratification at the next available meeting.

9.13 Conflicts of Interests

The STP will ensure that all Conflicts of Interests are managed in line with NHS Statutory Guidance:

- A register of personal, professional and organisational conflicts of interest will be maintained for all members of the STP by the STP's Secretariat.
- Those in attendance will be asked to declare their personal, professional and organisational conflicts of interest. Where any members of the STP have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision making itself (i.e., not have a vote).
- The Chair of the relevant meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult a member of a Governing Body or Board in the system who has responsibility for issues relating to conflicts of interest.
- All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting.

9.14 Dispute and Conflict Resolution

Any issues that cannot be resolved locally will be referred to the regional Bipartite.

10. Risk Management

The STP Assurance Framework provides detail on how the STP Board will manage and monitor risks in relation to delivery of the STP programmes of work or projects. It also describes the accountability arrangements. An overarching risk register which will be overseen by the STP Board and shared with the individual partner organisations.

11. Cycle of Business

The STP has developed a cycle of business which will align with the individual organisation's business cycles/decision-making processes. Consideration to a monthly cycle of formal business for statutory boards and governing bodies has been considered as part of the process. The STP Programme Cycle and Ways of Working documents describe this in more detail.

12. Reporting Arrangements

The SDU will prepare reports relating to STP delivery for system partners.

Cambridgeshire and Peterborough Sustainability and Transformation Partnership

Memorandum of Understanding

Cambridgeshire and Peterborough Health and Care System

November 2017

Memorandum of Understanding: Cambridgeshire & Peterborough Health and Care System – a Partnership for implementing the Sustainability and Transformation Partnership

Date effective: **[Date to be confirmed]** Signatories 'The partners', the CEOs/Accountable Officers and Chairs of:

1. NHS Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG)
2. Cambridgeshire University Hospital NHS Foundation Trust (CUHFT)
3. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
4. Cambridgeshire Community Services NHS Trust (CCS)
5. North West Anglia NHS Foundation Trust (NWAngliaFT)
6. Papworth Hospital NHS Foundation Trust (Papworth)
7. Peterborough City Council (PCC): (CEO & HWB Chair) – Appendix 1 only
8. Cambridgeshire County Council (CCC): (CEO & HWB Chair) – Appendix 1 only

In future, others may wish to join or become more formally affiliated with the partnership embodied in this MOU, including East of England Ambulance Trust, Cambridge University Health Partners, NHS England Specialised Commissioning, GP Federations, practices or third sector organisations.

Introduction

Purpose: The local health economy within Cambridgeshire & Peterborough CCG has agreed a single Sustainability and Transformation Partnership (STP) plan for 2016 – 2021, which has been approved by NHSE and NHSI. The STP has been developed with front-line staff and patients, building from an evidence for change that had widespread public and patient involvement. The plan envisages widespread changes to how care is delivered to local people, with far greater emphasis on care being delivered in or close to home, and standardisation of necessary in-hospital care in line with best and most efficient practice. In the small number of instances where changes to the location of services are proposed, there will be formal consultation with the public, following close informal engagement.

In order to deliver this plan and return the system to financial balance, we must manage risk (financial, operational, quality and reputational) through a number of jointly agreed commitments (outlined below) to which the Partners have agreed. The most important of which relate to a new set of behaviours from the System Partners, in order to build long-standing trusting relationships that replicate those of an accountable care system.

Scope: Each of the respective partner organisations have clearly defined accountabilities and responsibilities in line with statute. This MOU describes principles of behaviour and action which pertain to the implementation of the Sustainability and Transformation Partnership. Therefore, this MOU pertains only to those areas of work which have been agreed, by each individual partner organisation, as system improvement areas. The MOU does not relate to individual partners' decisions but to any possible interactions those may have with other partner organisations. Partners are expected to actively engage with each other. Individual major decisions should be raised at the STP Board and Health and Care Executive (HCE) so that the impact on other organisations can be considered.

How this document relates to local authorities, their executive officers and members is described further in Appendix 1

Longevity: The term of the MOU is linked to the anticipated time required to implement the STP, therefore it is expected to expire on 31st March 2021, unless a decision is taken to extend it beyond this. If, during the intervening period, as confidence builds, the responsibility for System decisions are delegated to the STP Board (some decisions may be delegated to HCE), this MOU and the associated Terms of Reference for all relevant System groups will be amended. While, at no stage, can the powers of the STP Board or HCE supersede those of statutory bodies, this MOU nevertheless reflects the minimum level of partnership required to implement the STP.

Commitment 1: One ambition: the STP sets out a five plus year plan to return Cambridgeshire and Peterborough (C&P) to financial, clinical and operational sustainability by developing the beneficial behaviours of an accountable care system, and thereby addressing the underlying drivers of the current system deficit. This means acting as a single executive leadership team, and operating under an aligned set of incentives to coordinate System improvements for the benefits of local residents and healthcare users by:

- Supporting local people to take an active and full role in their own health
- Preventing health deterioration and promoting independence
- Using the best, evidence-based, means to deliver on outcomes that matter
- Focussing on what adds value (and stopping what does not)

Such organisational altruism is fully congruent with Partners' duties to the public and is necessary to return each organisation individually to financial balance.

The Partners accept collective responsibility for delivering the plan in its totality. Together, we own the opening risk and agree that the plan, whilst challenging, is deliverable. However, in practice, the Partners recognise external influences and pressures each is subject to. We commit to honest, transparent, and mutual support of each other's position in circumstances where we may be able to help others and influence the view of regulators or external assurance bodies regarding the primacy of System sustainability entailed in this plan and the joint commitment to it.

Our immediate priorities will be agreed collectively and reflect local Health and Wellbeing strategies, together with addressing clinical and operational pressures. However, given resources are scarce, priority will be accorded to projects with the greatest expected return on investment and/or fixing what is most broken – for example high levels of non-elective beddays per capita and high proportions of beds being occupied by patients whose discharge is delayed. The highest impact projects will be properly resourced with the Partners' best people. We will not try to do too many things at once, even though there are many aspects of our health and care system which need improving.

Commitment 2: One set of behaviours: the Partners recognise the scale of change implied by this MOU and the STP. The partners agree that cultural change applies from the STP Board and Board level to front-line staff. By signing this MOU, all Partners agree explicitly to exhibit the beneficial behaviours of an accountable care system. In particular, Partner organisations collectively agree to:

- People first: solutions that best meet the needs of today and tomorrow's local residents and healthcare users must be the guiding principle on which decisions are made. This principle must over-ride individual or organisational self-interest. Embedding the voice and views of service users in service improvement will be key to ensuring this principle is not forgotten.

- Collective decision-making: Chairs, CEOs, SROs and clinical leads have dedicated time *face-to-face* to build trusting relationships, improve mutual understanding and to take shared strategic decisions together. As system leaders, Partners will work together with integrity and the highest standards of professionalism, for example by:
    - Not undermining each other.
    - Speaking well of and respecting each other.
    - Behaving well, especially when things go wrong.
    - Keeping our promises – small and large.
    - Speaking with candour and courage.
    - Delivering on promises made.
    - Seeing success as collective.
    - Sticking to decisions once made.

- Common messaging: there is a consistent set of messages we tell our patients and our staff about why we need to work together, what benefits it will bring and how we are doing it, although how the story is told will be tailored to the audience. Each partner organisation will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials.
- Open book: finance (cost and spend), activity and staffing data are shared between all parties transparently and in a timely manner. This data is held independently by the System Delivery Unit. On a monthly basis actual financial positions of each organisation will be shared with the STP Board and HCE (and bi-partite, as required), with explicit transparency about performance against expected cost saving and demand management trajectories. The purpose of this sharing is to support collaborative problem-solving.

Commitment 3: One long-run plan: The Partners are committed to implementation at pace. By end of 2018/19, the Partners will have achieved the following:

- *Home is best:* fully staffed integrated Neighbourhood Teams will be operational across C&P, providing a proactive and seamless service. General practices will have received support from Partners to be sustainable. Social care will be functionally integrated. The first phase of the prevention strategy will have been implemented.
- *Safe & effective hospital care*: hospital flow will be improved, with a reduction in annual growth rates in non-elective admissions, a fall in bed occupancy and Delayed Transfers of Care (DTOC). Common pathway designs will be in place across all three general acute sites for frailty, stroke, ophthalmology, orthopaedics, ENT and cardiology. All acute services (including fragile ones such as emergency medicine, acute paediatrics, stroke, and others) will be clinically sustainable seven days a week. People will receive consistent urgent and emergency care in the right place, as quickly as possible. More routine urgent and planned care will be managed, with support, within community and primary care, for example by being able to access consultants' opinions without referral.
- *Sustainable together:* We will exploit our collective buying power to get reduced prices, through a common approach to Procurement. The west Pathology Hub will be operational. The merger of Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Healthcare NHS Trust will be fully embedded, and the start of consideration of other organisational consolidation will have commenced. Papworth will have successfully moved onto the Cambridge Biomedical Campus.
- *Enablers:* There will be a single 10-year plan for estates and workforce, a five-year plan for the digital roadmap, and a quality improvement (learning) culture. Local community estates are being modernised. Our workforce recruitment, retention and

reported staff satisfaction will be improved. The first new roles will be in the training pipeline. Patient records securely accessible by any clinician anywhere, where appropriate and relevant to patient care, and a person level linked data set will form the foundation for population health improvement analytics. Staff will have been trained in a common C&P improvement methodology and will have been involved in a system wide improvement project.

Taken together, the Partners believe that these actions give the system the best possible chance of returning to financial balance by 2021. However, capturing the savings opportunities identified will require certain assumptions to be true – for example achieving sustainable DTOC levels consistently below 2.5%. Addressing structural system deficits by securing additional system income by, for example, MFF recalculations and specific structural deficit funding (PFI support, CCG allocation increases, etc.) will also be key to system financial balance.

In many cases bringing about the changes envisaged by the STP can only be achieved with the support of local people and staff, including on occasion, through formal consultation. Therefore, the exact shape of the solutions may change to reflect the feedback and views of local people and staff, the STP is a starting point not fixed destination.

Commitment 4: One programme of work: The HCE will be accountable to the STP Board for delivery of the STP, as such, all System projects will be agreed by the HCE, and under the supervision of a Delivery/Enabling Group. HCE will agree what needs to be done to what end, by who, by when – be they projects done independently or as a System.

- The agreed Delivery Plan identifies the following work streams to be done as a System:
    i. Integrated Neighbourhoods: translating the proactive and preventative care schematic into operational practice, supporting sustainable general practice
    ii. Urgent and Emergency Care: achieving best practice non-elective bed-days per capita
    iii. Planned Care: standardising referral and treatment protocols in line with best practice
    iv. Children, Young People and Maternity: holistic, family-centred care, in line with iThrive, the maternity taskforce and peri-natal mental health
    v. Shared services (including estates): minimising the costs of over-heads
    vi. Digital: implementing the local Digital Roadmap, sharing data and information in a manner consistent with local and national policies and consent
    vii. Workforce: leadership, planning, skills development, recruitment and retention
    viii. General Practice Forward View (GPFV)
- The proposed split of work between System and organisational business will be agreed by the HCE, with new work not starting without HCE ratification.
- The proposed split of System work between what is undertaken once across C&P, and what is undertaken on an area basis will be according to:
    - Phase of project life cycle: design projects must be done once across C&P
    - Locus of relationships: delivery projects should be local where vertical relationships dominate, and C&P wide where horizontal (across acutes) relationships dominate, and
    - Subsidiarity: change happens bottom up, and neighbourhoods across C&P differ significantly.
- Each System project will have a named Senior Responsible Officer (SRO) (Exec level) who is accountable for delivery of the project.
- Each System project will have a delivery objective – a savings, activity shift or quality improvement target (or a combination) and delivery date. Some System projects will have an agreed investment plan.

- The collective impact of System projects will be measured against an agreed definition of success.

Commitment 5: One budget: in line with developing the positive behaviours of an accountable care system, and in recognition of the fact that one organisation's decisions about the level of service may impact another's costs, the Partners agree they will collectively focus on activities that take cost out, make agreed investments in order to save elsewhere, and move deficits to where they should most appropriately fall. System costs may be reduced by activity reductions and by unit cost reductions, and we recognise that all System Partners can influence both. Acting in this way requires:

- Financial incentive design: two year contracts for 2017/18 and 2018/19 contracts will neutralise perverse financial incentives and aim to return the C&P System to financial balance. The Partners agree that the key aim of any incentives will be to focus on addressing the drivers of the system deficit. Financial incentive design options ***may***, therefore, include a combination of:
    - the inclusion of multilateral loss/gain sharing arrangements, for some aspects of C&P CCG commissioned activity;
    - a single System control total which has been negotiated with regulators;
    - alignment of all quality based payments to delivering System priorities (including CQUINs and following agreement with primary care, changes to local enhanced services and/or a local substitute for the QOF);
    - a suspension of non-value adding adjustments to basic cost and volume arrangements such as fines, marginal rates and 30 day readmissions rule (noting that some of these funds currently cover the costs of some community services, which would need alternative funding to be agreed if the services are to continue);
    - a cost plus based approach to local prices for service developments (eg ambulatory care)

  Within this framework and in recognition of the importance of gathering timely and accurate cost data, providers will be paid for the activity they under-take, against an agreed activity trajectory, and commissioners will be responsible for taking decisions about what services can be provided affordably, in line with their legal duties. Due to the lack of incentive to do more activity, even where this would be desirable as it would reduce overall system costs, block contracts should be avoided for all services.
- All parties will exhibit win-win-win behaviours (for patients, providers and commissioners) – any financial recovery plans will be approached as *System* financial recovery plans.
- Contract mechanics for 2017/18 and 2018/19: the least required effort will be dedicated to contract negotiations, with early collective CEO engagement to agree key investment priorities and risk sharing parameters at the outset (rather than at the end). Contract management meetings will be replaced with place or care programme based financial assurance, performance and planning meetings.
- Commissioning intentions will be based on a clinically led, evidence-based and person-focussed appraisal of how best to meet local people's need. Once developed, Partners will discuss openly within HCE any new service developments, closures or relocations prior to public and staff engagement and consultation as required. The HCE and the System Delivery/Enabling Groups will be the fora for agreeing commissioning intentions, including those of the Joint Commissioning Unit.
- Financial and operational plans will be aligned across health and social care: the Partners agree to plan finances and operational capacity together, neutralising any

inclination to cost shift or not invest in one part of the system to save elsewhere. This will involve working from common assumptions, producing plans for regulators that are not works of fiction and doing our best to ensure there are no in-year surprises. Where appropriate, this will also include greater use of pooled budgets between NHS and council commissioners, which will be determined on a case by case basis.

- Savings: Savings will be calculated on the basis of resource utilisation across the entire patient pathway, including all points of care and Partner organisations – thereby capturing direct and indirect savings. Delivery/Enabling Groups will track savings against pre-determined trajectories in a robust and timely manner, with the Executive Programme Director's guidance and SDU support. A named SRO for each project is responsible for making sure savings trajectories are met and/or securing recovery proposals where implementation is not on track.
- Investment: A System Investment Fund (SIF) for system wide investments has been established and is made up of contributions from Partners. In 2017/18 it is likely that due to cash constraints top-up funding will be required and that a System bid to NHS England will be made. Decisions on how to spend this System wide investment and re-investment pot will be taken collectively via an approved gateway process and the Investment Committee. Analysis will be undertaken first to ensure existing resources cannot be safely redeployed/or productively improved before investment can be made. The SIF will come from any STF funds, recycled savings and the CCG's 1% hold-back.

Commitment 6: One set of governance arrangements: the STP Board and the groups reporting to it (HCE, Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups) will be the vehicle through which System business is conducted. All existing arrangements will either be dissolved or aligned.

As much business, as possible that pertains to the system will be conducted via the system governance described in STP Governance Framework. However, it is recognised and accepted that some decisions will need to be referred back to Partners' Boards/Governing Bodies for ratification. Given this may add time before implementation can commence, the limits to the STP Board and HCE's powers must be anticipated, and accommodated in planning. The STP Governance Framework describes decision making processes and roles and responsibilities of individual groups and organisations in detail.

Commitment 7: One delivery team: resources are in place to deliver the STP. This means:

- System Delivery Unit: A new SDU led by an Independent Chair and Executive Programme Director will be created from October 2016. The Independent Chair and Executive Programme Director will be invited to attend Partners' Boards regularly to provide updates on the STP. The SDU will have a budget agreed by HCE (delegated by the STP Board) to employ staff, funded jointly by NHS Partners (see Appendix 2). The SDU will be responsible for:
    - Finance, Evaluation & Analytics
    - System Strategy, Planning and Development

  The System Delivery Unit is primarily envisaged as adding much needed analytics, project management, quality improvement, problem solving capacity to the system and coordinating of assurance to NHS England/NHS Improvement. However, it will be responsible for giving assurance to the STP Board that the STP plan and its future modifications is being appropriately delivered, on budget and to planned timelines.
- Alignment of resources: We recognise the scale of change required to deliver the STP, and all Partners commit to align our staff and, by prior HCE agreement, funds to deliver these changes. This may include prioritising the availability of staff for STP planning and

implementation, the voluntary secondment/loan of staff and other such pragmatic arrangements – in recognition that delivering the STP is essential to each organisation's individual sustainability strategy. Through the delivery planning process, each prioritised project will be allocated staff, from across Partners. These, 'aligned' staff will be expected to dedicate the bulk of their time to the system work – with up front negotiations about what may need to be stopped as a result. SROs and if necessary Delivery/Enabling Group chairs will be expected to escalate to the employer if they feel staff are not being released as agreed. The employing Partner will be expected to rectify the situation within two weeks. The SDU will make transparent the relevant WTE contributions (clinical and managerial) from each Partner organisation, to ensure the burden of effort is fairly shared.

- Assets: in addition to Partners' employees we agree there are other assets which can help deliver the STP, including local communities and Health and Wellbeing Boards. Partners will explore how existing relationships with the Universities, Charitable trusts, local business, informal carers and other public services (like the Fire Service) can be exploited for the benefit of the System. All Partners will highlight opportunities for leveraging these assets for the benefit of the System and will represent the System's interests as well as their own.
- Skills development: where our staff do not have the required skills and expertise to deliver the scale and nature of the change required, we will recognise and address this. It's important that our people are in the right roles.

Commitment 8: One assurance and risk management framework.

- Crucial to strengthening trust and creating a sense of shared accountability, will be evolving the HCE from a forum for making strategic decisions, to one where Partners can be assured of the delivery of System wide improvements. The System Delivery Unit is responsible for monitoring implementation of the STP plan and giving such assurance to the HCE about delivery of the plan. The SDU will provide timely, and regular reporting to the STP Board, HCE, Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups to give mutual assurance that the Delivery plan is on track. A small number of new monitoring dashboards will be developed by the SDU for this purpose, subject to the agreement of the HCE and/or relevant Delivery/Enabling Group chair. In exceptional circumstances, new data items may be collected, but the default presumption is that existing data items will be used (even if these are not normally shared beyond organisations). Once the data collection is agreed, accurate data will be supplied on time.
- Inevitably, things will not go as planned, and there are already many risks that planned impacts will not be realised. Some of these risks will be best managed individually, but many can only be effectively managed by the Partners together. The Partners therefore agree that mitigations will be more effective if they are done together. Transparency around risk/risk mitigation is non-negotiable. Whilst it is difficult to specify in advance the actions that may be required to address risks to delivering the STP, we agree about the process:
    - A STP Programme Risk Register maintains emerging risks to both the agreed delivery plan and agreed mitigations;
    - Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups are required to adhere to the STP's Assurance Framework and Risk Register.
    - Project SROs are expected to deliver all actions to the pre-agreed time-table of milestones – repeated risks and issues regarding process delays due to poor project management and oversight, which are within the control of the SRO will

be escalated by the Executive Programme Director to the employing CEO via the System Delivery Board.

- For the purposes of this agreement, risk is not narrowly defined; examples include reputational, clinical, governance, performance against targets and financial risks.
- Select risks will be reviewed by Boards each month in accordance with the STP's Risk Assurance Framework.

Appendices

1. Local Authorities and the C&P Sustainability and Transformation Plan.
2. SDU Financing: Funding split (%); Initial budget for the SDU; legally binding arrangements for sharing SDU costs (expected and unexpected)

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 6
19 MARCH 2018	PUBLIC REPORT

Report of:	Dr. Liz Robin, Director of Public Health	
Cabinet Member(s) responsible:	Councillor Diane Lamb, Cabinet Member for Public Health	
Contact Officer(s):	Katie Johnson, Consultant in Public Health	01223 699 266

PHARMACEUTICAL NEEDS ASSESSMENT

RECOMMENDATIONS	
FROM: Dr Liz Robin, Director of Public Health	**Deadline date:** N/A

It is recommended that the Health and Wellbeing Board:

1. Note the findings of the PNA and approve the final PNA submitted by the multi-agency PNA Steering Group.

2. Approve the monitoring protocol for keeping the PNA up to date between now and March 2021, including the delegated authority for approval of supplementary statements to the Director of Public Health, in discussion with the Chair or Vice-Chair of the Board.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board in light of the statutory requirement for the Health and Wellbeing Board to complete a pharmaceutical needs assessment (PNA) every three years.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to present the final update of the Peterborough Pharmaceutical Needs Assessment (PNA) 2018 for approval by the Health and Wellbeing Board. The full report is attached, including an executive summary on pages 6-12. The report of the public consultation on the draft PNA is presented in **Appendix 6**. The response to consultation and a summary of changes made to the PNA are presented in **Appendix 7**. The monitoring protocol for keeping the PNA up to date between now and March 2021, when the PNA is next due to be updated, is also presented for approval.

2.2 This report is for the Health and Wellbeing Board] to consider under its Terms of Reference No. 2.8.3.2

To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health and Wellbeing Strategy.

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	

4. BACKGROUND AND KEY ISSUES

4.1 **Background:**

4.1.1 Since 1 April 2015, every Health and Wellbeing Board in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area (the PNA). In 2015, the Peterborough Health and Wellbeing Board published a PNA which describes the pharmaceutical needs for the population of Peterborough. The full report can be found here: https://www.peterborough.gov.uk/healthcare/public-health/pharmaceutical-needs-assessment/. In order to meet the statutory requirements of publishing a revised PNA every three years, a revised PNA is due to be published in the spring of 2018.

4.1.2 The PNA is used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Of note, decisions on whether to open new pharmacies are made by NHS England, not by the Health and Wellbeing Board. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up to date.

4.1.3 The PNA also informs decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups on which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services).

4.2 **Process:**

4.2.1 Using learning from the development of PNAs in Peterborough and Cambridgeshire in previous years, a multi-agency steering group was set up to oversee the production of the Peterborough PNA 2018. The group includes representation from Peterborough City Council, the Clinical Commissioning Group, Healthwatch, the Local Medical Committee (a corresponding member), the Local Pharmaceutical Committee and NHS England.

4.2.2 In order to accurately describe the pharmaceutical needs in Peterborough, information from the Joint Strategic Needs Assessment (JSNA) and public health sources has been used to describe pharmaceutical provision throughout the county and local health needs that may be addressed through pharmaceutical services. In addition, all pharmacies and dispensing GP practices in Peterborough were asked to complete a questionnaire describing their service provision.

4.2.3 This information was used to produce a draft PNA report which was published for formal public consultation, a statutory requirement of the legislation, on 23 October until 23 December 2017. The results of this consultation were analysed and the draft report updated to produce the final PNA.

4.2.4 The legal team in Peterborough City Council reviewed both the draft and final report to ensure it is compliant with the regulations.

4.3 **Key Findings:**

4.3.1 The key findings of the PNA are described in the executive summary of the full report. **In summary, the PNA concludes that there is currently sufficient pharmaceutical service provision across Peterborough. No need for additional pharmaceutical service providers was identified in the PNA.**

4.3.2 Peterborough has one pharmaceutical service provider per 4,409 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population. This is the same as the national average and slightly lower than the East of England average (24 providers per 100,000 resident population).

4.3.3 92% of community pharmacies and also the one dispensing GP practice that responded to the questionnaire stated that they considered current pharmaceutical provision in Peterborough to be adequate and for there to be no need for additional pharmacies in Peterborough.

4.3.4 Taking into account current information from stakeholders, including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Peterborough is sufficient.

4.3.5 Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Peterborough. 89% of respondents to the public consultation thought that pharmacy services are available at convenient locations and 76% thought that pharmacy services are available at convenient opening hours.

4.3.6 91% of respondents to the public consultation agreed with the key findings described in the PNA, and 84% agreed that there are enough pharmacies across Peterborough.

4.3.7 The PNA recognises that community pharmacies are a key public health resource and recognise that they offer potential opportunities to provide health improvement initiatives and work closely with partners to promote health and wellbeing.

4.4 **Future population changes and housing growth:**

4.4.1 Over the coming years the population in Peterborough is expected to both age and grow substantially in numbers. An increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. Several large-scale housing developments are in progress and considerations when assessing needs for local pharmaceutical service providers should be based on a range of local factors specific to each development site. These are further described in Section 6 of the PNA report.

4.4.2 To facilitate commissioning of pharmaceutical services responsive to population needs the Health and Wellbeing Board partners will, in accordance with regulations, monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmacies might be required. In accordance with the amended *NHS regulations* (Dec 2016), the Health and Wellbeing Board will also produce a supplementary statement when required, if two or more pharmacy sites consolidate into one, assessing any gaps in local pharmaceutical and health needs.

4.4.3 A monitoring protocol for keeping the Peterborough PNA up to date has been produced by the multi-agency PNA steering group. It describes how the steering group will monitor, assess and respond to changes in pharmaceutical needs in Peterborough until March 2021, when the next PNA update is due to be published.

5. CONSULTATION

5.1 In line with the regulations, the draft PNA report was published for a formal 60 day public consultation from 23 October to 23 December 2017 to mid-December 2017 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of the draft PNA and whether it addressed issues that they considered relevant to the provision of

pharmaceutical services.

5.2 There were 69 responses to the survey from individuals or groups. The feedback gathered in the consultation is described in the Consultation report (see **Appendix 6** of the PNA) and a summary of how the draft PNA was amended to produce the final PNA in response to the feedback received is included as **Appendix 7** of the PNA.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. The PNA also informs decisions by local commissioning bodies on which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services).

7. REASON FOR THE RECOMMENDATION

7.1 The recommendations have been made to enable the Health and Wellbeing Board to fulfil its statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area (the PNA).

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not appropriate (the above recommendations will enable the Peterborough Health and Wellbeing Board to fulfil its statutory responsibility in relation to the publication of a PNA).

9. IMPLICATIONS

Financial Implications

9.1 None.

Legal Implications

9.2 The Health and Wellbeing Board has a statutory responsibility to publish and keep up to date a PNA for its area. The PNA is used by NHS England when making decisions on applications to open new pharmacies or make changes to their existing regulatory requirements. Any decisions made by NHS England based on the PNA may be appealed and challenged via the courts; it is therefore important that PNAs comply with regulations and that mechanisms are established to keep the PNA up to date.

The PNA was produced by a multi-agency steering group on behalf of the Health and Wellbeing Board, and the specific legislative requirements, as described in the *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013* (and updated in 2016), in relation to the development of PNAs were duly considered and adhered to. The PNA report has been reviewed by the Peterborough City Council legal team to ensure it is compliant with the regulations.

Equalities Implications

9.3 The PNA describes the number and distribution of pharmaceutical service providers across Peterborough, the opening hours of services and access for people with disabilities (see section 4 for further details). Of note, 12 out of 69 respondents who completed the public consultation questionnaire (17%) said they had a disability. 63 respondents answered the question ‘Do you have any difficulties in accessing your local pharmacy or GP dispensary?’ 59 of 63 respondents (94%) said that they did not have any difficulties in accessing their local pharmacy or GP dispensary. One respondent highlighted the need for pharmacies to follow the Accessible Information Standard (see Appendix 7 for further details). The Steering Group has shared this consultation response with all key stakeholders, including NHS England, the CCG and the

Cambridgeshire and Peterborough Local Pharmaceutical Committee (LPC), which represents all community pharmacies in Peterborough.

10. BACKGROUND DOCUMENTS

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

10.1 *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013* http://www.legislation.gov.uk/uksi/2013/349/contents/made

11. APPENDICES

11.1 Peterborough Pharmaceutical Needs Assessment (2018) – Full Report [Final Version]

11.2 Peterborough Pharmaceutical Needs Assessment (2018 – 2021) Monitoring Protocol

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NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

PETERBOROUGH
CITY COUNCIL

Peterborough

Pharmaceutical Needs Assessment 2018

FULL REPORT
(FINAL VERSION)

Contents

Acknowledgements

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KEY:
PCC - Peterborough City Council.
CCC - Cambridgeshire County Council.
CCG - Cambridgeshire and Peterborough Clinical Commissioning Group.
LMC - Local Medical Committee.
LPC - Cambridgeshire and Peterborough Local Pharmaceutical Committee.

The Health and Wellbeing Board would like to acknowledge the contribution of the Local Medical Committee, Local Pharmaceutical Committee, Community Pharmacies, Dispensing Practices, stakeholders and members of the public and thank them for their participation in the consultation and development of the PNA.

Executive Summary

1. Introduction

Since 1 April 2013, every Health & Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'Pharmaceutical Needs Assessment' (PNA). This PNA updates the 2015 Peterborough PNA and describes the pharmaceutical needs for the population living within the Peterborough City Council boundaries[1]. A separate PNA is produced by the Cambridgeshire Health & Wellbeing Board to cover the pharmaceutical needs of Cambridgeshire, including Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire.

The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises, or applications from current pharmaceutical providers to change their existing regulatory requirements. Of note, decisions on whether to open new pharmacies are made by NHS England, not by the HWB. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date.

The PNA will also inform decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs) on which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services).

2. Process

As in 2014/15, the specific legislative requirements in relation to development of PNAs were duly considered and adhered to. The development of the revised PNA for 2018 was overseen by a multi-agency steering group including members from key health and pharmacy-specific agencies working in Peterborough.

Information from the Joint Strategic Needs Assessment (JSNA) and Public Health sources were used to describe pharmaceutical provision throughout Peterborough and local health needs that may be addressed through pharmaceutical services.

All pharmacies and dispensing GP practices in Peterborough were asked to complete a questionnaire describing their service provision. 37 of 41 (90.2%) community pharmacies and one of three (33.3%) dispensing GP practices in Peterborough responded to the questionnaire. In the process of undertaking the PNA, views are being sought from a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities.

[1] Throughout this report, 'Peterborough' refers to the area within the Peterborough City Council boundaries.

A public consultation was undertaken from 23 October to 23 December 2017 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of this PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services. 69 responses to the survey were received.

67 or 69 respondents (97%) felt that the purpose of the PNA was explained sufficiently and 63 of 69 respondents (91%) agreed with the key findings about pharmaceutical services in Peterborough as outlined in the PNA. The feedback gathered in the consultation is described in the Consultation report (see Appendix 6) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 7.

The PNA will continue to be updated every three years and supplementary statements may be published before this if deemed necessary by the HWB. Given the significant planned growth of new developments across Peterborough, the Senior Public Health Manager for Environment and Planning (Peterborough & Cambridgeshire) will continue to monitor and assess pharmaceutical need in these areas.

3. Understanding local health needs

Peterborough is one of the most relatively deprived areas in the East of England and has relatively poor health outcomes in comparison to national averages, with statistically significantly low life expectancy at birth for both males and females and significantly high rates of mortality from a number of causes considered preventable. Deprivation and poor health outcomes are most prominent in Peterborough's densely-populated urban centre, with less deprivation and better health outcomes observed in rural areas towards the outer areas of Peterborough.

The PNA should be viewed in conjunction with Peterborough's Joint Strategic Needs Assessments, which describe the health and wellbeing needs of the local population, and with national and local health data sources available through https://www.peterborough.gov.uk/healthcare/public-health/JSNA/. The PNA and the role of pharmacies should also be considered alongside the Peterborough Health and Wellbeing Strategy, the Peterborough & Cambridgeshire Sustainability and Transformation Plan and the Health System Prevention Strategy for Peterborough & Cambridgeshire.

The local population is forecast to increase substantially in the coming years, with the biggest increases seen in residents aged 65 and older. The impact of this population growth on pharmaceutical needs is discussed in Section 6 of the PNA.

4. Current provision of local pharmaceutical services

Key finding: There is currently sufficient pharmaceutical service provision across Peterborough. No need for additional pharmaceutical service providers was identified in this PNA.

Peterborough has one pharmaceutical service provider per 4,409 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population in Peterborough. This is the same as the national average of 23 per 100,000 resident population and similar to the East of England average of 24 pharmaceutical providers per 100,000 resident population. Estimates of the

average number of people per pharmaceutical service provider across Peterborough have remained relatively stable since 2011.

As of June 2017, numbers of pharmacies in Peterborough are the same as at the time of the 2015 PNA:

- 41 Pharmacies
- 3 Dispensing General Practices
- 2 Dispensing Appliance Contractors

Peterborough also has two distance selling pharmacies.

Taking into account current information from stakeholders including community pharmacies and dispensing General Practices, the number and distribution of pharmaceutical service provision in Peterborough appears to be adequate. The distribution of pharmacies and dispensing General Practices appears to cover Peterborough sufficiently, with the majority of pharmacies located within Peterborough's most densely populated, central areas. The majority of areas in Peterborough are accessible within 20 minutes by car, with a small number of exceptions towards the outer areas of the city, particularly in the east.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Peterborough.

- Overall, out of 41 community pharmacies, 23 (56%) are open after 18:00 and 12 (29%) are open after 19:00 on weekdays; 28 (68%) open on Saturdays and 10 (24%) open on Sundays. These findings are similar to those in the 2015 PNA.
- Home delivery services can help to provide medication to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed the questionnaire in 2017, 35 out of 37 pharmacies (95%) and one of one dispensing GP practices (100%) reported that they provide free delivery services to their patients.
- 34 of 37 community pharmacies (92%) and the one (100%) dispensing GP practice who completed the questionnaire report they have consultation areas with wheelchair access.
- 34 of 37 (92%) community pharmacies and also the one dispensing GP practice that responded to the questionnaire stated that they considered current pharmaceutical provision in Peterborough to be adequate and for there to be no need for additional pharmacies in Peterborough.
- During the public consultation on the PNA, 63 of 69 respondents (91%) agreed with the key findings described in the PNA, and 58 of 69 respondents (84%) agreed that there are enough pharmacies across Peterborough.

5. The role of pharmacy in addressing health needs

Section 5 describes the services provided by local pharmaceutical providers: 'Essential Services' which all pharmacies are required to provide; 'Advanced Services' commissioned by NHS England to support patients with safe use of medicines and the NHS national seasonal flu vaccination programme; and health improvement services locally commissioned by Peterborough City Council.

Medicines advice & support:

Through the provision of advanced services including Medicine Use Reviews (MURs), Dispensing Review of Use of Medicines (DRUMs), clinical screening of prescriptions and identification of adverse drug events, dispensing staff work with patients to help them understand their medicines. This also ensures that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated. In the community, pharmacists should continue to work with GPs and nurse prescribers to ensure safe and rational prescribing of medication.

Medication errors in care homes for older people can also be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. Cambridgeshire & Peterborough Clinical Commissioning Group (C&P CCG) employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with General Practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste. As part of the pharmacy integration fund, NHS England is looking to support community pharmacists working in care homes to ensure that medication is used in the most appropriate way. It is expected that there will be 150 community pharmacists supported to deliver this workstream nationally. It is not yet known how many pharmacists will be involved locally in Peterborough.

Services & support to encourage healthy lifestyle behaviours:

Providers of pharmaceutical services also have an important role to play in improving the health and wellbeing of local people beyond providing and supporting the safe use of medicines. The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve and the recent changes to the 2017/18 pharmacy contract have included quality payments to pharmacies who are accredited as 'Healthy Living Pharmacies'.

In Peterborough, all of the community pharmacies that responded to the PNA questionnaire have either achieved Healthy Living Pharmacy status or are working towards it. Five pharmacies (14% of respondents) have achieved Healthy Living Pharmacy status and 32 (86% of respondents) are working towards achieving Healthy Living Pharmacy status. Achieving level 1 Healthy Living Pharmacy status requires pharmacies to adopt a pro-active health promoting culture and environment within the pharmacy, with all the requirements of the quality criteria satisfied. These include understanding local public health needs, creating a health and wellbeing ethos, team leadership, communication, community engagement and having a health promoting environment.

Community pharmacies are easily accessible and can offer a valuable opportunity for reaching people who may not otherwise access health services. Pharmacy support for the public health and prevention agenda could therefore be especially valuable in more deprived communities or for vulnerable groups who have a variety of poorer health outcomes (e.g. migrant workers; traveller communities; ethnic minorities; older people). Community pharmacies can be involved in addressing health inequalities and targeting initiatives and resources to improve the health of the poorest, fastest.

Preventative approaches are important to ensure people remain healthy and independent in the community for longer and to reduce the unsustainable cost of health and social care services for

this growing population. Support for people to ensure that they remain healthy for as long as possible through the provision of healthy lifestyle advice is important. Community pharmacies can also support self-care where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services. This could be particularly important for frail older people and those with multiple conditions.

Community pharmacies all participate in six public health promotion campaigns each year, as part of their national contract. Further opportunities exist to encourage healthy behaviours including maintaining a healthy weight and taking part in physical activity such as providing advice, signposting services and providing on-going support towards achieving behaviour change, for example, through monitoring of weight and other related measures. Opportunistic alcohol screening and provision of brief advice is another area where pharmacies could contribute to improving the health of the local population. This could, for example, potentially be integrated into agreements around medication checks.

Pharmacy staff can play a role in promoting awareness of good mental health, for example by signposting to information about local support networks, mental health help lines etc.

Pharmacy providers are also involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C Difficile.

The following local services are currently commissioned from community pharmacies:

a) <u>Stop smoking services:</u>

Pharmacies in Peterborough are offered the opportunity to deliver specialist stop smoking services under a Local Incentivised Scheme (LIS) contract, commissioned by the Public Health Joint Commissioning Unit that works across Peterborough City Council and Cambridgeshire County Council. Pharmacies are ideally placed to provide easy access to people who wish to stop smoking. Specialist Smokefree Advisors are National Centre for Smoking Cessation Training (NCSCT) trained to deliver up to a 12 week programme which clients attend on a weekly basis. They are also able to directly supply nicotine replacement therapy from the pharmacy which, combined with behavioural support, can greatly increase the chances of a quit outcome. 15 pharmacies in Peterborough are currently commissioned to provide this service.

b) <u>Contraception and sexual health services:</u>

- ***Emergency hormonal contraception***

Pharmacies in Peterborough are offered the opportunity to receive training and contracts to provide Emergency Hormonal Contraception (EHC) which is available as a locally commissioned service in some community pharmacies. The EHC service in Peterborough pharmacies commenced in late 2016/17. Currently, 12 pharmacies in Peterborough have signed a contract to deliver the EHC service across Peterborough, as part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Peterborough, with further opportunities to expand.

- ***Chlamydia screening***

  As part of the public health commissioned EHC service a Chlamydia screening kit is offered to the service user. iCaSH Peterborough, the integrated contraception and sexual health service provided by Cambridgeshire Community Services NHS Trust, provides chlamydia kits and staff training. The pharmacy needs to provide a suitable consultation room to be eligible for this scheme. Chlamydia screening is not provided by pharmacies outside of the EHC service. Pharmacies can signpost those requesting chlamydia screening to iCaSH Peterborough.

c) <u>Alcohol and substance misuse services:</u>

The Public Health Joint Commissioning Unit commission services to provide specialist drug and alcohol treatment across Peterborough. Currently adult drug and alcohol services are provided by CGL Aspire who sub-contract pharmacies to provide the following specific services:

- ***Needle & syringe exchange service***

  23 pharmacies in Peterborough are contracted via CGL Aspire to provide needle exchange services. People who use illicit drugs are often not in contact with health care services and their only contact with the NHS may be through a needle exchange service within a community pharmacy. At a minimum, the pharmacy can provide advice on safer injecting and harm reduction measures. In addition, community pharmacies can provide information and signposting to treatment services, together with information and support on health issues other than those that are specifically related to the client's addiction.

- ***Supervised administration service***

  Once clients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Clients often need support to prevent them stopping treatment. 23 community pharmacies in Peterborough are contracted to provide a supervised administration service via CGL Aspire, which requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient.

- ***Naloxone kits***

  Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone, morphine and fentanyl). 16 pharmacies in Peterborough are contracted via CGL Aspire to issue naloxone kits with training to all substance misuse clients (those accessing supervised administration or needle exchange services). The pharmacies can issue the naloxone kits to clients' friends and relatives, and others who may require one, such as a hostel manager. Pharmacies are also able to refer clients into treatment services provided by CGL Aspire.

- ***Blood borne viruses screening***

Nine pharmacies are contracted via CGL Aspire to provide screening for Hepatitis B virus and Hepatitis C virus to clients at risk, identified by CGL Aspire. Screening involves a finger prick blood sample being taken and aims to ensure timely diagnosis and access to treatment.

- ***Alcohol brief interventions***

  Similarly to the substance misuse services, 16 pharmacies in Peterborough are contracted via CGL Aspire to provide alcohol brief intervention services. Pharmacies offer this service to all customers; customers are asked three screening questions and, depending on their score, may be asked additional questions about their alcohol consumption and have a brief intervention carried out. They may also be referred to CGL Aspire specialist services if appropriate.

d) **Directly observed therapy service for tuberculosis**

The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) will be commissioning a limited number of pharmacies across Peterborough and Cambridgeshire to provide a directly observed therapy service specifically for patients with tuberculosis. Pharmacies will ensure that appropriate drugs are given at specified intervals and the patient is observed taking them. The hospital tuberculosis nurse specialist will provide training and supervision for this service.

In addition to commissioned services, our questionnaire found that community pharmacies provide a number of additional services, including Monitored Dosage System, delivery of dispensed medicines at no charge and collection of prescriptions from GP practices.

In conclusion, community pharmacies offer a range of services that can make them a key public health resource, offering potential opportunities to provide health improvement initiatives and work closely with partners to promote health and wellbeing. There are opportunities to develop the contribution of community pharmacies to all of the currently commissioned services. Pharmacies are able to and should be encouraged to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers. Local commissioning organisations should continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

The King's Fund report 'Community Pharmacy Clinical Services Review' (December 2016) commissioned by the Chief Pharmaceutical Officer recommended that there is a need in the medium-term to 'ensure that community pharmacy is integrated into the evolving new models of care alongside primary care professionals. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these'. At a local level, the Health & Wellbeing Board should encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working.

6. Future Population Changes and Housing Growth

Over the coming years the population in Peterborough is expected to both age and grow substantially in numbers. An increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. Several large-scale housing developments are in progress and considerations, when assessing needs for local pharmaceutical service providers, should be based on a range of local factors specific to each development site.

To facilitate commissioning of pharmaceutical services responsive to population needs, the Health and Wellbeing Board partners will, in accordance with regulations, monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmaceutical services provision might be required.

1. Introduction

1.1 Pharmaceutical Needs Assessments – description and background

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 places a statutory duty on all Health and Wellbeing Boards (HWBs) to publish and keep-up-to date a statement of the needs for pharmaceutical services for the population in its area. These statements are referred to as Pharmaceutical Needs Assessments (PNAs). The responsibility to produce the PNA was previously held by Primary Care Trusts which were abolished in April 2013.

The PNA is a structured approach to identifying unmet pharmaceutical need.[2] It can be an effective tool to enable Health and Wellbeing Boards (HWBs) to identify the current and future commissioning of services required from pharmaceutical service providers.[3]

The PNA is used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. The Health and Social Care Act 2012 transferred responsibility for using PNAs as the basis for determining "market entry to a pharmaceutical list" from PCTs to NHS England. Of note, decisions on whether to open new pharmacies are not made by the HWB. Pharmacies must submit a formal application to NHS England whereby the relevant NHS England Area Team will then review the application and decide if there is a need for a new pharmacy in the proposed location. When making the decision NHS England is required to refer to the local PNA. Such decisions are appealable to the NHS Litigation Authority's Family Health Services Appeal Unit (FHSAU), and decisions made on appeal can be challenged through the courts.

The PNA will also inform decisions by local commissioning bodies including Local Authorities, NHS England and Clinical Commissioning Groups (CCGs) as to which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services). The preparation and consultation on the PNA should take account of the health needs of the population defined in the local Joint Strategic Needs Assessments (JSNAs) and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public. This PNA should therefore be viewed in conjunction with the Peterborough JSNA reports which are accessible online at: https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

As PNAs are central to decision-making regarding commissioned 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 they are kept up-to-date. Section 2 describes the process for this PNA.

1.2 Overview of NHS pharmaceutical services

Section 126 of the NHS Act 2006 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 persons. This section of the Act also describes the types of healthcare professionals who are authorised to order drugs, medicines and listed appliances on an NHS prescription.

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[2] Primary Care Commissioning. 'Pharmaceutical needs assessments.' March 2013. Available at: https://www.pcc-cic.org.uk/article/pharmaceutical-needs-assessments-right-service-right-place

[3] Department of Health. 'Pharmaceutical needs assessments: Information Pack for local authority Health and Wellbeing Boards.' May 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197634/Pharmaceutical_Needs_Assessment_Information_Pack.pdf

Under the *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013*, a person who wishes to provide NHS Pharmaceutical Services must apply to NHS England to be included on a 'pharmaceutical list' by generally proving they are able to meet a pharmaceutical need as set out in the relevant PNA. This is commonly known as the NHS 'market entry' system.

The following can be included in the pharmaceutical list:

- Pharmacy contractors: a person or corporate body who provides NHS Pharmaceutical Services under the direct supervision of a pharmacist registered with the General Pharmaceutical Council.
- Dispensing appliance contractors: appliance suppliers are a sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc. They cannot supply medicines.
- Dispensing doctors: medical practitioners authorised to provide drugs and appliances in designated rural areas known as 'controlled localities'.
- Local pharmaceutical services (LPS) contractors also provide pharmaceutical services in some HWB areas.

The two most common types of pharmacy provision are local pharmacy contractors, referred to in this report as community pharmacies, and dispensing doctors, also commonly referred to as dispensing practices or GP dispensaries. Community pharmacies were known in the past as chemists and are often located in the heart of local communities, on high streets, supermarkets and neighbourhood centres. There are different types of community pharmacies, ranging from small, independent pharmacies to large chains and supermarket pharmacies.

NHS legislation provides that in certain rural areas classified as 'controlled localities' general practitioners may apply to dispense NHS prescriptions as 'dispensing doctors'. The provisions to allow GPs to dispense were introduced to provide patients access to dispensing services in rural communities not having reasonable access to a community pharmacy. Since 2005, a practice can only apply to be a dispensing practice if it is located in a 'controlled locality' and the total of all patient lists for the area within a 1.6km (1 mile) radius of the premises is fewer than 2,750.[4] In the majority of cases, patients eligible to use the dispensing practice will therefore be located more than 1.6km away from the nearest pharmacy. Further information about this process and how areas of new growth may affect dispensing doctors' practices is described in Section 6.5. Dispensing GP practices can make a valuable contribution to dispensing services although they do not offer the full range of pharmaceutical services offered at community pharmacies.

The NHS England Area teams commission services in the NHS Community Pharmacy Contractual Framework. This includes three main categories of pharmaceutical services as defined in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013:[5]

- Essential services which every community pharmacy providing NHS pharmaceutical services must provide (as described in Schedule 4, Part 2 of the Regulations). These include: the dispensing of medicines and appliances; clinical governance; repeat prescriptions; disposal of unwanted medicines; promotion of healthy lifestyles; signposting to other services or information; and support for self-care.

[4] Pharmaceutical Services Negotiating Committee briefing on 'Rurality, controlled localities and the provision of pharmaceutical services by doctors'. Available at: http://psnc.org.uk/contract-it/market-entry-regulations/rural-issues/
[5] National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/contents/made

- Advanced services which community pharmacy contractors and dispensing appliance contracts can provide subject to accreditation. These include: Medicines Use Reviews (MUR); the New Medicines Service from community pharmacists; Appliance Use Reviews; the NHS Seasonal Flu Vaccination Programme; and the Stoma Customisation Service which can be provided by dispensing appliance contracts and community pharmacies. In addition, a national 'NHS Urgent Medicines Supply Advance Service' is currently being piloted.
- Enhanced services are 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.

Further information about these services in Peterborough is described in Sections 5.2-5.4.

1.3 Local Pharmacy Services

Local pharmacy services are additional services commissioned by the Local Authority or Clinical Commissioning Group (CCG). These fall outside of the *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013* and do not impact on the commissioning of new pharmacy contracts.

Local Authorities are responsible for commissioning a wide range of services, including most public health services and social care services. The Local Authority can commission pharmacies to provide the following public health services:

- Supervised administration service for specific drugs.
- Needle and syringe exchange.
- NHS Health checks.
- Emergency hormonal contraception services.
- Sexual health services such as chlamydia screening, testing and treatment.
- Stop smoking.
- Weight management programmes.
- Alcohol screening and brief interventions.

CCGs have a role to commission most NHS services locally, aside from those commissioned by NHS England such as GP core contracts and specialised commissioned services. CCGs can commission services from pharmacies such as palliative care schemes; emergency prescriptions; and other medicines optimisation services.

2. Process

2.1 Summary of the process followed in developing the PNA

In 2015 the Peterborough Health and Wellbeing Board published its first PNA, in line with the 2012 regulations.[6] (An extract of part of these regulations can be found in Appendix 1)

The Peterborough PNA 2015 remains available online at: https://www.peterborough.gov.uk/healthcare/public-health/pharmaceutical-needs-assessment/.

The development of the 2015 PNA was overseen by a multi-agency steering group, representing a wide range of stakeholders. The PNA Steering Group was re-convened with continued membership from the original 2015 steering group to oversee the process and content of the PNA (see Acknowledgements for list of steering group members). Details of the activities undertaken to update the 2015 PNA and a timeline are outlined in Appendix 4 which describes the document control of this report.

The legal regulations state that each PNA should have a maximum lifetime of three years. The full PNA process was therefore re-initiated in 2017 and this draft PNA is due to be finalised and published in 2018. It includes updated information from the 2015 PNA and has engaged key stakeholders in identifying any new relevant issues.

As in 2015, the specific legislative requirements in relation to the development of PNAs[7] were duly considered and adhered to.

2.2 Methods

As set out in Schedule 1 of The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, this PNA includes information on:

- Pharmacies in Peterborough and the services they currently provide, including dispensing, providing advice on health, medicine reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- Other local pharmaceutical services, such as dispensing GP practices.
- Relevant maps relating to Peterborough and providers of pharmaceutical services in the area.
- Services in neighbouring HWB areas that might affect the need for services in Peterborough.
- Potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.

In developing the PNA for Peterborough, information from the JSNA and public health sources were used to describe pharmaceutical provision throughout the county and local health needs that may be addressed through pharmaceutical services. All pharmacies and dispensing GP practices in Peterborough were also asked to complete a questionnaire describing their service provision (see Appendix 3). This information received is described throughout Sections 4, 5 and 6.

Assessing need for pharmaceutical services is a complex process. In addition to taking account of all views submitted from stakeholders, the PNA considers a number of factors, including:[8]

[6] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/made (Accessed 19 Nov 2013)
[7] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. (Accessed 19 Nov 2013) at: http://www.legislation.gov.uk/uksi/2013/349/made
[8] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/made. (Accessed 19 Nov 2013.)

- The size and demography of the population across Peterborough.
- Whether there is adequate access to pharmaceutical services across Peterborough.
- Different needs of different localities within Peterborough.
- Pharmaceutical services provided in the area of neighbouring HWBs which affect the need for pharmaceutical services in Peterborough.
- Other NHS services provided in or outside its area which affect the need for pharmaceutical services in Peterborough.
- Whether further provision of pharmaceutical services in Peterborough would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in the area.
- Likely changes to needs in the future occurring due to changes to the size of the population, the demography of the population, and risks to the health or wellbeing of people in its area which could influence an analysis to identify gaps in the provision of pharmaceutical services.

2.3 Stakeholders involved in the development of the PNA

The process of developing the PNA has taken into account the requirement to involve and consult people about changes to health services. In revising the PNA, key partners were consulted to seek their views and initial feedback on the findings set out in this draft PNA 2018. In line with the 2013 Regulations,[9] this PNA process including the public consultation involved consulting with:

- The Local Pharmaceutical Committee (LPC) for the area.
- The Local Medical Committee (LMC) for the area.
- Persons on the pharmaceutical list and any dispensing doctors list for the area.
- Local Healthwatch organisations in the area.
- Other patient, consumer and community groups in the area with an interest in the provision of pharmaceutical services in the area.
- NHS trusts and NHS foundation trusts in the area.
- NHS England.
- Neighbouring HWBs.

A public consultation was undertaken from 23 October to 23 December 2017 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of this PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services. 69 responses to the survey were received.

67 of 69 respondents (97%) felt that the purpose of the PNA was explained sufficiently and 63 of 69 respondents (91%) agreed with the key findings about pharmaceutical services in Peterborough as outlined in the PNA. The feedback gathered in the consultation is described in the Consultation report (see Appendix 6) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 7.

2.4 Future PNAs and supplementary statements

The PNA will continue to be updated every three years and supplementary statements may be published before this if deemed necessary by the HWB. HWBs are required to publish a revised assessment when significant changes to the need for pharmaceutical services are identified, unless this is considered a

[9] Ibid.

disproportionate response.[10] The Peterborough PNA Steering Group will continue to identify changes to the need for pharmaceutical services within their area and assess whether the changes are significant.

Given the significant planned growth of new developments across Peterborough, the Senior Public Health Manager for Environment and Planning will continue to monitor and assess pharmaceutical need in these areas and the Steering Group will issue a statement of need to update the PNA if considered appropriate.

2.5 Local impact of the new national pharmacy contract (2016)

On 20 October 2016 the Government imposed a two-year funding package on a community pharmacy, with a £113 million reduction in funding in 2016/17.[11] This is a reduction of 4% compared with 2015/16, and will be followed by a further 3.4% reduction in 2017/18.[12] Key changes were also made to the national pharmacy contract with the aim of creating a more efficient service which is better "*integrated with the wider health and social care system.*"[13]

Full details of the final Community Pharmacy proposals can be found in the Department of Health (DoH) report "*Community pharmacy in 2016/2017 and beyond: final package.*"[14] Appendix 5 provides a summary of the proposed changes to the pharmacy contracts and the potential impact of these as assessed by the DoH and the national Pharmaceutical Services Negotiating Committee (PSNC) who represent all community pharmacies providing NHS services in England.

The changes also included a new 'Pharmacy Access Scheme' which aimed to ensure that populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. Qualifying pharmacies received an additional payment, meaning those pharmacies will be protected from the full effect of the reduction in funding from December 2016 to March 2018. Nationally 1,356 pharmacies have qualified for the scheme. In Peterborough, three pharmacies participated in the Pharmacy Access Scheme (see Appendix 5 and figure 36).

As described in the DoH health impact assessment, it is complex to assess the impact of these changes on Peterborough residents at this stage. There is no reliable way of estimating the number of pharmacies that may close or the services which may be reduced or changed as a result of the policy and this may depend on a variety of complex factors, individual to each community pharmacy and their model of business.

The Cambridgeshire and Peterborough Local Pharmaceutical Committee will focus on supporting local pharmacies by keeping them up-to-date with changes/details, to meet the quality agenda, and to take up and deliver locally commissioned services more effectively. The PNA Steering Group will continue to monitor any potential closures or mergers of local pharmacies and issue appropriate statements of fact as necessary in line with PNA requirements.

Of particular relevance to this PNA at this point in time, is that amendments were also made to the pharmacy *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations 2013* in

[10] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/made. (Accessed 19 Nov 2013.)
[11] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf
[12] http://psnc.org.uk/funding-and-statistics/cpcf-funding-changes-201617-and-201718/
[13] Ibid.
[14] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

December 2016.[15] One key change was a new regulation which describes the potential consolidation of two or more pharmacies onto one existing site. A new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes which would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision.

> *"Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3)."*[16]

As such, in the event of a consolidation in future, in accordance with Paragraph 19 of schedule 2 of the regulations the Peterborough HWB will publish a supplementary statement which will become part of the PNA, explaining whether, in its view, the proposed removal of premises from its pharmaceutical list would or would not create a gap in pharmaceutical services provision that could be met by a routine application:

> (a) to meet a current or future need for pharmaceutical services; or
> (b) to secure improvements, or better access, to pharmaceutical services.

[15] National Health Service England. 'The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016' (2016 No.1077) Available at: http://www.legislation.gov.uk/uksi/2016/1077/contents/made

[16] National Health Service England. 'The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016' (2016 No.1077) Page 13. Available at: http://www.legislation.gov.uk/uksi/2016/1077/contents/made

3. Understanding Local Health Needs

The preparation and consultation on the PNA should take account of the local Joint Strategic Needs Assessments (JSNAs) and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public. This PNA should therefore be viewed in conjunction with the Peterborough JSNA reports which are accessible online at: https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

In line with the regulations, this PNA does not attempt to duplicate assessment of the health needs of the population which are described in health needs assessments. This section signposts to sources of information regarding health needs and priorities for Peterborough and describes key demographic features of Peterborough. Section 5 describes areas where pharmaceutical providers could contribute to the health and wellbeing agenda through supportive schemes or locally commissioned services and details current commissioned services and recommendations for the future.

3.1 Peterborough Joint Strategic Needs Assessments

A JSNA is the means by which partners which comprise the Health & Wellbeing Board of the local area describe the health, care and wellbeing needs of the local populations and seeks to identify a strategic direction of service delivery to meet established needs.[17]

The aim of a JSNA is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. This includes:

- Providing analyses of data to show the health and wellbeing status of local communities.
- Defining where inequalities exist.
- Providing information on local community views and evidence of effectiveness of existing interventions which will help to shape future plans for services.
- Highlighting key findings based on the information and evidence collected.

The Peterborough City Council website publishes JSNA reports and supporting documentation, including additional data and specific topic area reports for the local area. Since the composition of the last Peterborough PNA, a JSNA Core Dataset has been produced each year and specific JSNA projects have been undertaken on the themes of:

- Children & Young People
- Cardiovascular Disease
- Mental Health/Mental Illness in Adults of Working Age
- Diverse Ethnic Communities

These reports include information about a wide range of health and wellbeing indicators, the views of the local people and gives examples of good practice, along with identifying gaps and areas for development.

They also include some of the substantial evidence that indicates that prevention works, that it can provide cost benefits and importantly that it can make significant improvements to the health of the population, decrease health inequalities and effectively address health and social problems.

[17] https://www.gov.uk/government/publications/joint-strategic-needs-assessment-and-joint-health-and-wellbeing-strategies-explained

A quarterly report is also produced detailing the current status of health and wellbeing in Peterborough as captured by the Public Health Outcomes Framework and these reports are collated at: https://www.peterborough.gov.uk/healthcare/public-health/public-health-outcomes-framework/

The purpose of the 2017 Peterborough Annual Public Health report is to provide a clear picture of the main health issues and trends in Peterborough. The report is divided into three sections - one on the social and environmental factors affecting health and wellbeing (often called 'the wider determinants of health'), one on lifestyle behaviours which impact on individual health, and a final section looking at trends in health outcomes and health service use in Peterborough. Data within the report illustrate the general health of the population of Peterborough, inequalities in outcomes that exist between areas and specific topics of focus for health improvement in Peterborough over coming years. The report is available at URL: https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/AnnualPublicHealthReport2017.PDF?inline=true

3.2 Peterborough Health & Wellbeing Board (HWB)

The Peterborough Health & Wellbeing Board brings together leaders from local organisations which have a strong influence on health and wellbeing, including the commissioning of health, social care and public health services. The HWB focuses on planning the right services for Peterborough and securing the best possible health and wellbeing outcomes for the local community. Further details about the Peterborough Health and Wellbeing Board are available at: http://democracy.peterborough.gov.uk/ieListMeetings.aspx?CId=526&Year=0

The work of the Health & Wellbeing Board is guided by the Peterborough Health & Wellbeing Strategy 2016-19. The strategy sets out the priorities the HWB feel are most important for local people, based on the JSNA and other relevant sources of information. The strategy includes five targeted priority areas:

1. 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.
2. Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
3. Enable older people to stay independent and safe and to enjoy the best possible quality of life.
4. Enable good child and adult mental health through effective, accessible health promotion and early intervention services.
5. Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs.

Further details about the Peterborough Health & Wellbeing Strategy 2016-19 are available at: https://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy/

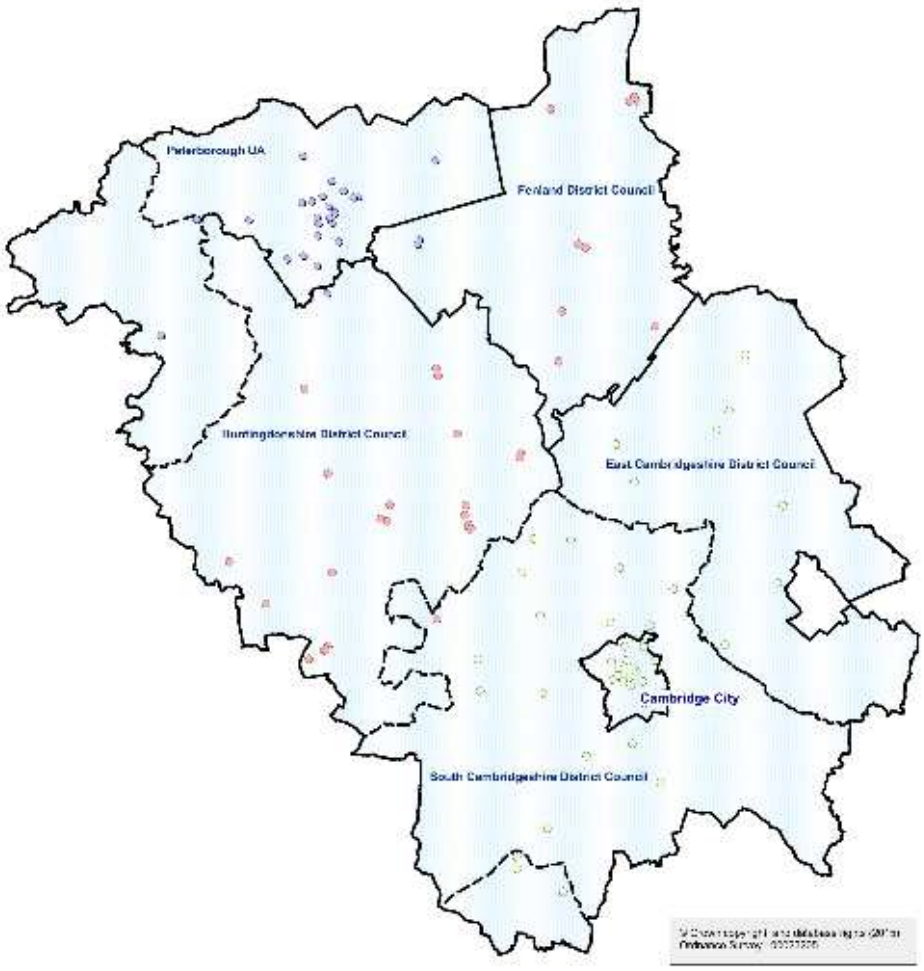
3.3 Cambridgeshire & Peterborough Clinical Commissioning Group

The Cambridgeshire & Peterborough Clinical Commissioning Group is the clinical commissioning body for the county of Cambridgeshire and the Unitary Authority of Peterborough. In addition, the CCG also includes some GP practices in Hertfordshire and Northamptonshire. The ‘boundary’ for the CCG is illustrated in Figure 1. Cambridgeshire County Council’s Health & Wellbeing Board are responsible for assessing pharmaceutical needs for Cambridgeshire and producing a separate Pharmaceutical Needs Assessment which is available at: http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/PNA

The CCG is responsible for designing and buying health services for around 933,000 people across Cambridgeshire, Peterborough, Hertfordshire and Northamptonshire. Clinicians are involved at every level

of decision-making. Further information about the role of Cambridgeshire & Peterborough CCG is available on their website: https://www.cambridgeshireandpeterboroughccg.nhs.uk/

Figure 1: Cambridgeshire & Peterborough Clinical Commissioning Group Boundary, January 2017



Source: Cambridgeshire & Peterborough Clinical Commissioning Group

The NHS and local government officers have come together to develop a major new plan to keep Cambridgeshire & Peterborough 'Fit for the Future'. The 'Sustainable Transformation Programme' plan covers hospital services, community healthcare, mental health, social care and GP services and aims to:

- Improve the quality of the services provided.
- Encourage and support people to take action to maintain their own health and wellbeing.
- Ensure that health and care services are financially sustainable and that commissioners make best use of the money allocated to the local population.
- Align NHS and Local Authority plans.

The NHS and local government are working together and taking joint responsibility for improving the local population's health and wellbeing. Further up-to-date information is available on the programme website: http://www.fitforfuture.org.uk/

A Health System Prevention Strategy for Cambridgeshire & Peterborough, available at: http://cambridgeshireinsight.org.uk/health/healthcare/prevention was also produced in January 2016 in recognition of the impact of preventable ill health on the local health economy and to identify opportunities for action. Significant proportions of ill health and health service activity are potentially preventable. Community pharmacies have the potential to contribute to the reduction of preventable mortality and morbidity.

3.4 National Outcomes Frameworks

In addition to local priorities there are national priority areas for improvement in health and wellbeing. The Department of Health has published outcomes frameworks for the NHS, CCGs, Social Care and Public Health which offer a way of measuring progress towards achieving these aims. The Public Health Outcomes Framework (PHOF) for England, 2013-16 sets out desired outcomes for Public Health, focussing on two high-level outcomes:

- Increased life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

Public Health England's Annual Health Profiles give a snapshot of the overall health of each local authority in England. The profiles present a set of important health indicators that show how each area compares to the national average in order to highlight potential problem areas.

3.5 National Policy Context

An independent 'Community Pharmacy Clinical Services Review' ('the Murray report')[18] was commissioned by the Chief Pharmaceutical Officer and recently published by the Kings Fund in December 2016. The report provides a useful summary of national policy reports over the past eight years which have described opportunities for expanding the role of community pharmacy and pharmacists. However, the report highlights the fact that there remains significant untapped potential for better utilising the clinical skills and expertise of the community pharmacy team.

The *2008 White Paper*[19] set out a vision for expansion of the pharmacy role from simply dispensing and supplying medicines to additional clinical services e.g. treating common minor ailments; providing public health services such as smoking cessation support and sexual health services; supporting those with long-term conditions; delivering some clinical services such as blood tests and screening programmes and involvement in clinical pathways that support integrated care.[20] In 2013, the Royal Pharmaceutical Society published a report '*Now or Never*'[21] which proposed that the skills of pharmacists were greatly under-utilised and outlined areas where pharmacists could contribute to, in particular, the management of long-term conditions and urgent care pathways. A Nuffield Trust report published in 2014[22] found that 'pharmacists at a local level continue to persuade some local commissioners to fund innovative services to support health and social care, but such progress remains patchy and lacks scale. At a national level, there has been disappointingly little progress over the last year in shifting the balance of funding and

[18] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[19] Department of Health. 'Pharmacy in England Building on strengths – delivering the future'. (2008). Available at: https://www.gov.uk/government/publications/pharmacy-in-england-building-on-strengths-delivering-the-future
[20] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 4. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[21] Royal Pharmaceutical Society. 'Now or never: shaping pharmacy for the future'. (November 2013). Available at https://www.rpharms.com/resources/reports/now-or-never-shaping-pharmacy-for-the-future?Search=Now%20or%20Never%20-%20sh
[22] The Nuffield Trust. 'Now more than ever: why pharmacy needs to act' (December 2014). Available at: https://www.nuffieldtrust.org.uk/files/2017-01/now-more-than-ever-web-final.pdf

commissioning away from the dispensing and supply of medicines toward the delivery of direct patient services'.

The Murray report proposes that pharmacy needs to be a 'core part of the integrated, convenient services that people need', although the report identifies that this has proven difficult to achieve thus far. NHS England's *Five Year Forward View* (October 2014)[23] and the *General Practice Forward View* (April 2016)[24] set out proposals for the future of the NHS based around new models of care and offer a strategic opportunity to review and revisit the role of community pharmacy in the health and care system. The Murray report recommends that pharmacy needs to be fully integrated into the new models of care developed by the Vanguard programme, particularly into the following four of the five groups:

- Integrated primary and acute care systems.
- Multi-specialty community providers (MCPs) moving specialist care out of hospitals into the community.
- Enhanced health in care homes to provide better, joined up health, care and rehabilitation services for older people.
- Urgent and emergency care service models.

It should be noted that the role of pharmacy in this fifth group relating to acute care collaboration may be more relevant to hospital than community pharmacy.

Sustainability and Transformation Programmes (STP) across 44 'footprint' areas in England aim to bring together health and care stakeholders to develop local plans for how local services will evolve and become sustainable over the next five years. The Murray report recommends that efforts are made to ensure that community pharmacy are involved in this work: 'Community pharmacy can provide a wide range of services that provide value for money at the same time as providing a new way to meet patient demand and indeed contribute to reducing demand through better public health'.[25]

There is a need in the medium-term to 'ensure that community pharmacy is integrated into the evolving new models of care alongside primary care professional. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these'.[26] At a national level, the Murray report calls for NHS England and national partners to consider how best to support STPs in integrating community pharmacy into plans and overcoming barriers in the complexities of the commissioning landscape. At a local level, the Health & Wellbeing Board could encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working and the incorporation of best practice and evidence as it becomes available.

The report also recommends that the evidence base should be developed to include community pharmacists in new models of care built around patient need, specifically including:

- Integrating community pharmacists and their teams into care pathways for long-term conditions.

[23] NHS England. 'Five Year Forward View' (October 2014). Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[24] NHS England 'General Practice Forward View' (April 2016) Available at https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[25] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016). Page 13. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[26] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 18. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

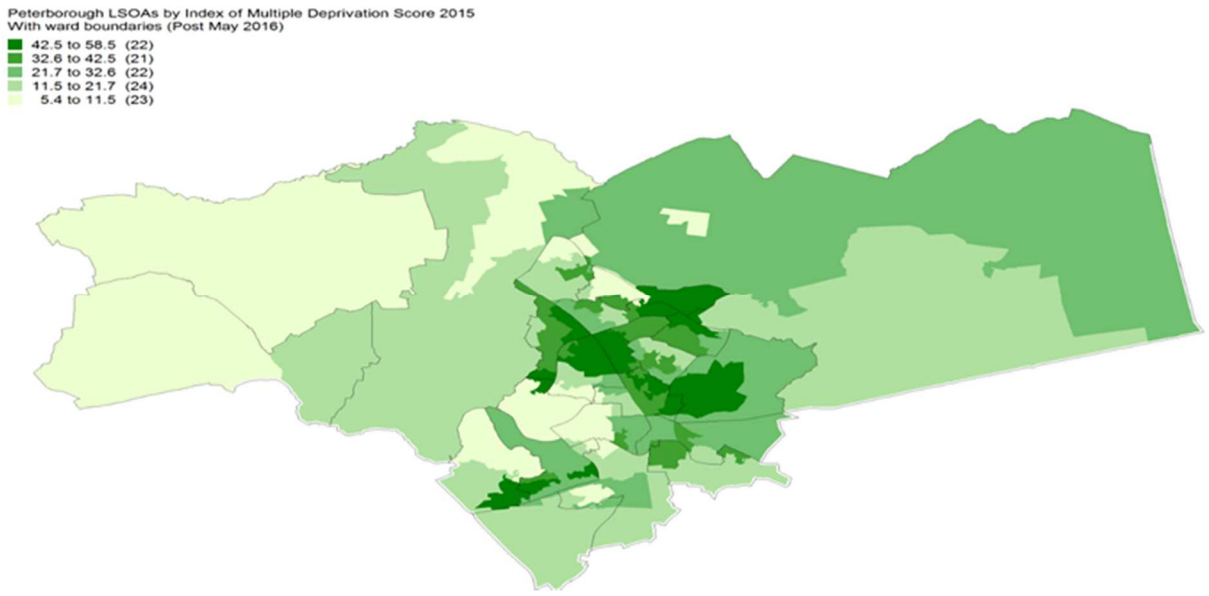
- Involving community pharmacists and their teams in case finding programmes for certain conditions e.g. hypertension.
- Developing contractual mechanisms for incentivising more rapid uptake of independent prescribing and utilising clinical skills of pharmacists as groups and individuals.

Public Health England is already planning to provide advice and the evidence base for action.

3.6 Characteristics of the population in Peterborough

The majority of the population of Peterborough live within the relatively urban central areas of the city, within which higher levels of deprivation tend to be observed; overall, Peterborough is the most deprived area in the East of England. However, Peterborough also has some relatively large but less population-dense outer, rural areas, within which deprivation tends to be less prevalent. The below figure shows electoral wards within Peterborough and relative deprivation within each area as measured by the 2015 Indices of Multiple Deprivation.[27]

Figure 2: Peterborough Lower Super Output Areas (LSOAs) by IMD 2015 Score with Electoral Ward Boundaries



3.6.1 Demography

Peterborough is one of the fastest growing cities in England, with a relatively young and ethnically diverse population. The 2016 mid-year population estimate for Peterborough is 198,130 and this is predicted to rise by 16.9%, to 231,520, by 2026 and then by a further 4%, to 240,830, by 2036. This represents an expected overall growth in population of 21.6% between 2016 and 2036.

[27] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 3: **Population Growth Estimates, 2016 – 2036, Peterborough by Age Band**

Local Authority	Year	0-4	5-14	15-24	25-44	45-64	65-74	75-84	Over 85	Total	16-64	18-64
Peterborough – Observed Population Growth 2016-36	2016	15,700	27,520	22,700	57,670	45,950	15,560	9,130	3,900	198,130	123,880	119,160
	2021	16,300	31,020	24,310	62,770	49,450	17,550	10,360	4,700	216,420	133,810	128,660
	2026	17,100	32,120	26,900	65,370	52,450	18,750	13,050	5,800	231,520	141,510	135,340
	2031	17,000	32,720	28,200	64,270	54,450	21,250	14,850	7,500	240,220	143,790	137,590
	2036	16,200	31,920	27,300	61,470	55,150	22,650	16,050	10,100	240,830	140,750	134,560
Peterborough - % Growth 2016-2036	-	3.2%	16.0%	20.3%	6.6%	20.0%	45.6%	75.8%	159.0%	21.6%	13.6%	12.9%

Source: Cambridgeshire County Council Research Group

Cambridgeshire County Council's Research Group population growth estimates suggest overall growth in Peterborough between 2016 and 2036 will be 21.6%, from 198,130 to 240,830 residents. Growth is anticipated to be highest among older age groups, with predicted increases of 159.0% in over 85s, 75.8% in the 75-84 age group and 45.6% in residents 65-74.

Figure 4: Population Growth Estimates, 2016-36, Peterborough Electoral Wards

Electoral Ward	2016	2021	2026	2031	2036	Numerical Increase 2016-36	% Increase 2016-36	Rank of Numerical Increase 2016-36	Rank of % Increase 2016-36
Barnack	3,090	3,230	3,290	3,290	3,270	180	5.8%	16	14
Bretton	9,850	10,340	10,490	10,430	10,330	480	4.9%	14	15
Central	11,540	13,230	14,540	14,580	14,450	2,910	25.2%	4	3
Dogsthorpe	10,020	10,630	10,850	10,750	10,610	590	5.9%	12	13
East	10,570	11,660	11,930	12,170	12,740	2,170	20.5%	5	7
Eye, Thorney and Newborough	9,030	9,970	10,430	10,450	10,410	1,380	15.3%	9	9
Fletton and Stanground	9,980	10,740	11,360	11,440	11,480	1,500	15.0%	8	10
Fletton and Woodston	10,580	10,960	11,510	11,470	11,390	810	7.7%	11	12
Glinton and Castor	6,520	6,670	6,770	6,770	6,760	240	3.7%	15	16
Gunthorpe	9,010	10,430	13,310	16,200	16,160	7,150	79.4%	3	2
Hampton Vale	6,580	8,350	8,650	8,440	8,210	1,630	24.8%	7	4
Great Haddon	0	1,760	5,090	9,520	12,770	12,770	-	1	-
Hargate and Hempsted	6,580	11,000	13,990	16,330	15,800	9,220	140.1%	2	1
North	10,730	10,750	10,800	10,680	10,530	-200	-1.9%	19	19
Orton Longueville	11,300	11,200	11,090	10,940	10,760	-540	-4.8%	23	23
Orton Waterville	10,110	10,770	11,330	11,230	10,980	870	8.6%	10	11
Park	10,870	10,770	11,060	10,910	10,710	-160	-1.5%	18	18
Paston and Walton	11,060	10,970	10,890	10,720	10,540	-520	-4.7%	22	22
Ravensthorpe	11,210	11,130	11,760	11,720	11,320	110	1.0%	17	17
Stanground South	8,560	10,770	11,090	10,880	10,660	2,100	24.5%	6	5
Werrington	11,150	11,040	11,070	10,990	10,760	-390	-3.5%	21	21
West	6,140	6,100	6,070	6,020	5,940	-200	-3.3%	19	20
Wittering	3,640	3,960	4,180	4,330	4,230	590	16.2%	12	8
Total	198,120	216,430	231,550	240,260	240,810	42,690	21.5%	-	-

Source: Cambridgeshire County Council Research Group

Population growth in Peterborough between 2016 and 2036 is expected to be highest in numerical terms in the Great Haddon development to the south of the area, which has yet to commence but is expected to have 12,770 residents by 2036. The population of Hargate and Hempsted is predicted to rise by 9,220 residents (140.1%) over this period and in Gunthorpe, the population is predicted to increase by 7,150 residents (79.4%). In percentage terms, excluding the Great Haddon development which is yet to commence, population increases are forecast to be highest in Hargate and Hempsted, Gunthorpe and Central.

3.6.2 Deprivation

Peterborough is a relatively deprived area compared to England and, as per the 2015 Index of Multiple Deprivation, the most deprived area in the East of England. The Index of Multiple Deprivation is a calculation incorporating 37 separate indicators, organised across seven distinct domains and is used to measure relative deprivation between areas.[28] Higher IMD values represent greater levels of relative deprivation.

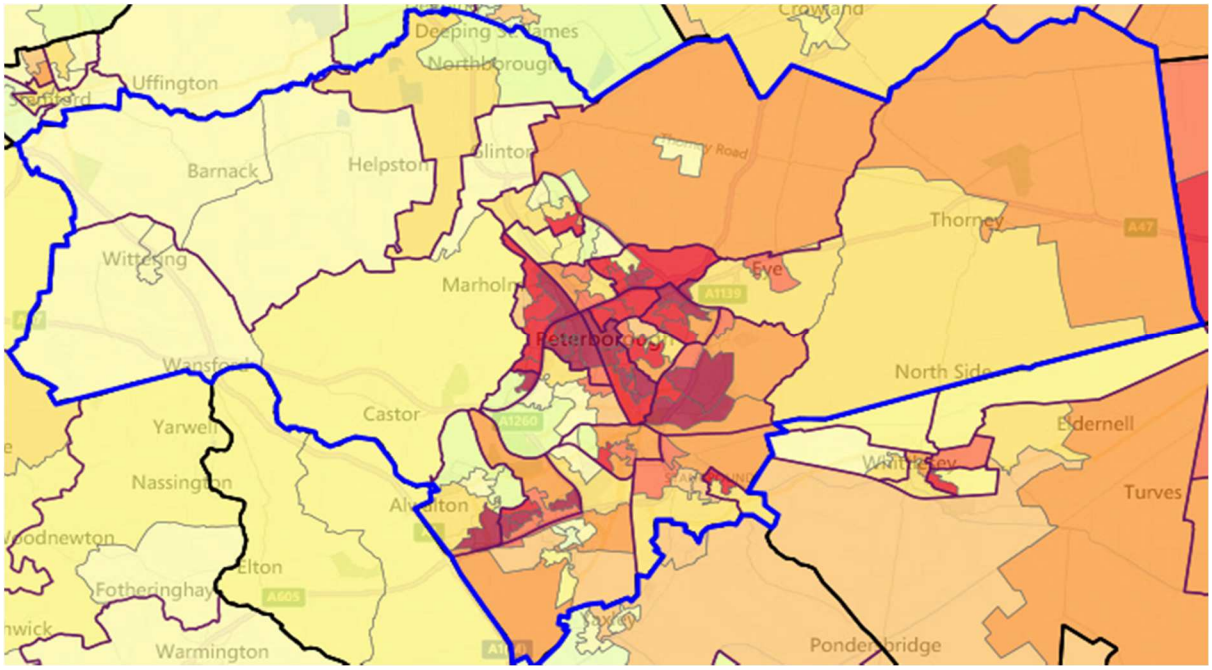
As shown by the figure below, Peterborough has an overall 2015 IMD score of 27.7, higher than that of England overall (21.8) and the highest score (thus most deprived area) in the East of England.

Figure 5: Peterborough & East of England Index of Multiple Deprivation (IMD) Scores, 2015

Area	Recent Trend	Count	Value	Lower CI	Upper CI
England	–	-	21.8	-	-
East of England region	–	-	-	-	-
Hertfordshire	–	-	12.2	-	-
Central Bedfordshire	–	-	12.2	-	-
Cambridgeshire	–	-	13.4	-	-
Essex	–	-	17.2	-	-
Suffolk	–	-	18.3	-	-
Bedford	–	-	19.2	-	-
Norfolk	–	-	21.2	-	-
Thurrock	–	-	21.6	-	-
Southend-on-Sea	–	-	24.5	-	-
Luton	–	-	27.6	-	-
Peterborough	–	-	27.7	-	-

Source: Public Health Outcomes Framework/Department of Communities & Local Government, http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1938132983/pat/6/par/E12000006/ati/102/are/E06000031/iid/91872/age/1/sex/4

Figure 6: Index of Multiple Deprivation (IMD) 2015, Peterborough Electoral Wards

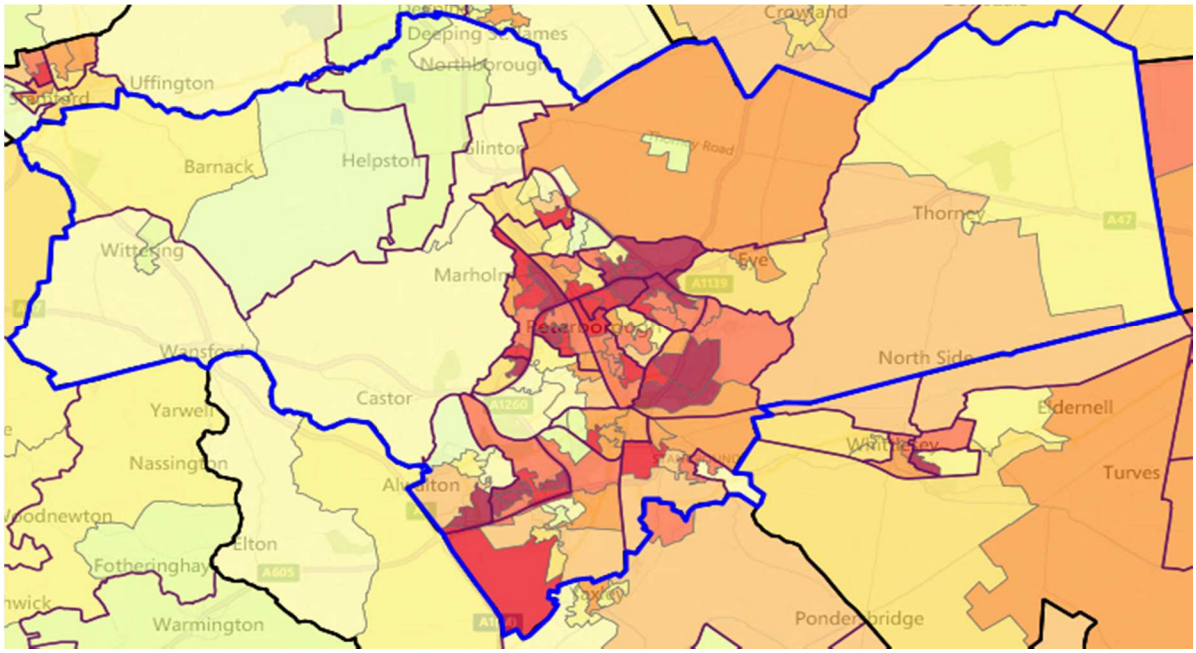


28 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf

Source: OpenDataCommunities.org, http://dclgapps.communities.gov.uk/imd/idmap.html

Peterborough Unitary Authority has significant disparities with regards to deprivation. The map above illustrates that high levels of relative deprivation (illustrated by darker shading) are most prevalent in Peterborough's urban, central areas, whereas the more rural, outer areas of Peterborough are relatively less deprived.

Figure 7: Income Deprivation Affecting Children (IDACI) 2015, Peterborough Electoral Wards

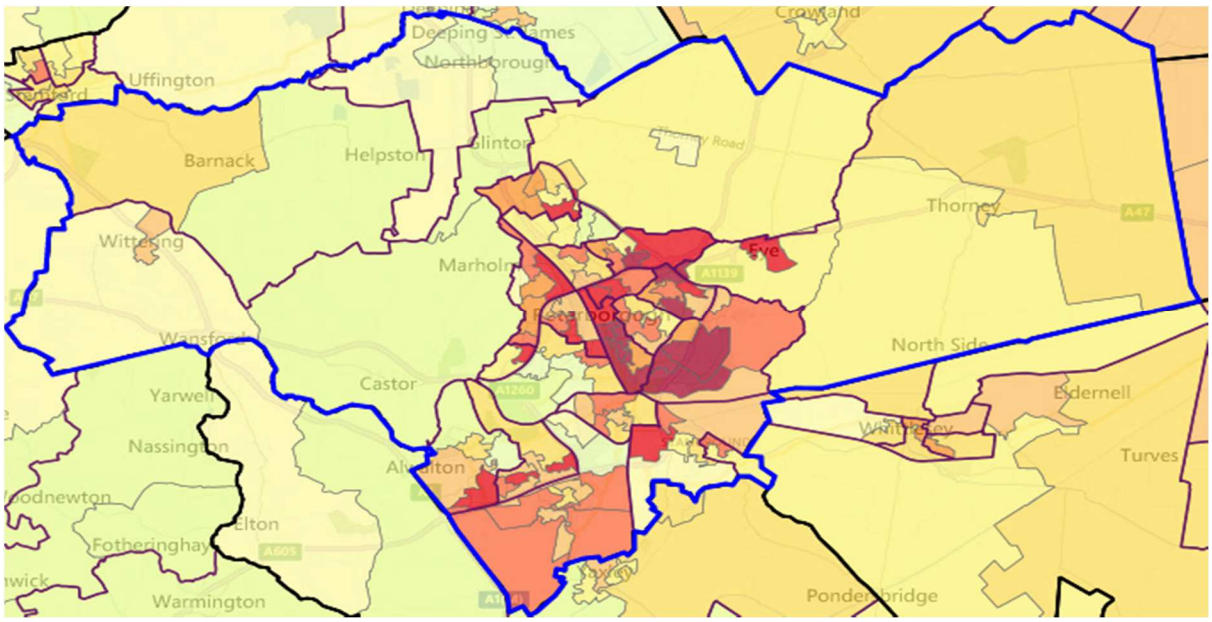


Source: OpenDataCommunities.org, http://dclgapps.communities.gov.uk/imd/idmap.html

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income-deprived families, defined as families in receipt of income support, income-based jobseekers allowance or pension credit, or child tax credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs.[29] In 2015, 25.1% of 0-15 year olds in Peterborough were assessed to be living in income-deprived families. The map above shows that deprivation affecting children in Peterborough is concentrated within the centre of the locality, as with overall deprivation. However, greater levels of deprivation affecting children than overall deprivation are observed in areas towards the south of Peterborough such as Orton with Hampton.

29 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464430/English_Index_of_Multiple_Deprivation_2015_-_Guidance.pdf

Figure 8: Income Deprivation Affecting Older People (IDAOPI) 2015, Peterborough Electoral Wards



Source: OpenDataCommunities.org, http://dclgapps.communities.gov.uk/imd/idmap.html

The map above shows Income Deprivation Affecting Older People (IDAOPI), which is based on the percentage of the population aged 60+ who receive income support, income based job seeker's allowance, pension credit or child tax credit claimants aged 60 and over and their partners. Peterborough has less observed relative deprivation affecting older people than overall deprivation and deprivation affecting children, although there are still high levels of deprivation observed in the centre of Peterborough and in electoral wards towards the south of the area.

3.6.3 Ethnicity

Figure 9: Ethnic Diversity in Peterborough - Electoral Wards (Pre-2015 Boundary Changes), 2011 Census Data

Electoral Ward	% BME	% Not White UK	% Without Good English Proficiency	IMD Score 2015
Northborough	2.3	4.1	0.2	10.1
Barnack	2.7	5.2	0.1	9.8
Glitton & Wittering	2.8	5.7	0.2	10.1
Newborough	4.7	7.9	0.2	17.2
Werrington South	4.9	8.1	0.4	10.6
Eye & Thorney	5.0	7.9	0.6	20.8
Stanground Central	5.9	17.7	2.4	24.0
Orton Waterville	7.2	13.5	1.1	17.9
Werrington North	7.4	12.5	0.9	17.4
Walton	8.2	15.4	1.8	25.9
Stanground East	8.3	15.3	1.5	25.4
Paston	9.6	18.5	2.8	36.9
Orton Longueville	10.1	20.3	2.3	40.5
Fletton & Woodston	11.5	26.1	3.5	23.5
Bretton North	12.4	23.5	3.8	39.0
Orton with Hampton	14.0	23.4	2.0	14.5
Bretton South	14.8	23.3	3.0	27.7
Dogsthorpe	18.4	31.9	5.3	40.7
North	23.0	42.7	9.4	42.4
East	26.8	47.9	9.1	37.6
West	29.5	37.6	3.7	15.3
Ravensthorpe	30.8	45.2	7.6	42.2
Park	35.8	58.5	12.3	26.0
Central	58.2	82.7	20.7	45.8
Peterborough	17.5	29.1	4.9	27.7
England	14.6	20.2	1.7	21.8

Source: 2011 Census

Key:

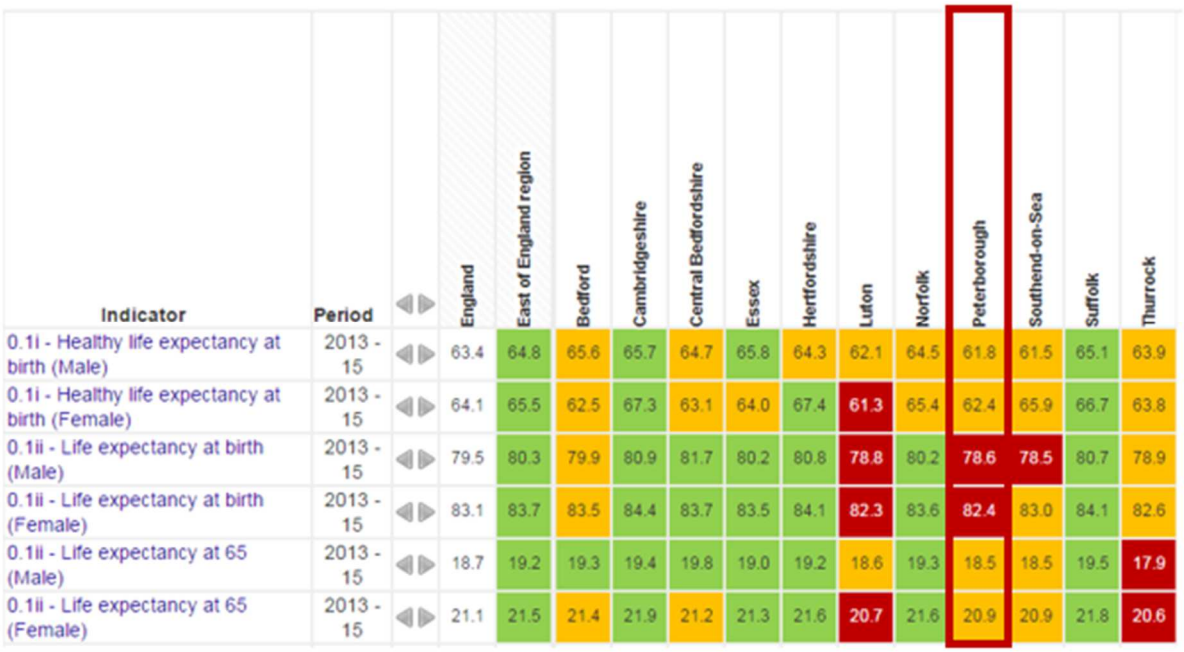
Higher than Peterborough average
Lower than Peterborough average

At the time of the 2011 census, 29.1% of Peterborough residents identified with an ethnicity other than 'White British', compared to 20.2% in England and 17.5% of residents identified as being of Black & Minority Ethnic (BME) ethnicity, compared to 14.6% in England. However, some electoral wards in Peterborough have substantially higher percentages of residents who do not identify as being White British, with the highest percentages observed in Central (82.7%) and Park (58.5%). As seen within the table above, high levels of relative deprivation are observed in many of Peterborough's electoral wards with high percentages of residents from minority ethnic backgrounds and electoral wards with the highest levels of deprivation, including Central, Park, North, East, Ravensthorpe and Dogsthorpe, also have high levels of residents without good spoken English proficiency; this can affect various elements of health and wellbeing including social cohesion/prevalence of loneliness as well as educational/economic attainment.

3.7 General Health in Peterborough

As illustrated by the figures below, Peterborough has relatively poor healthcare outcomes in comparison to regional neighbours, with statistically significantly low life expectancy at birth for both males and females and significantly high rates of mortality from causes considered preventable and under 75 mortality from cardiovascular diseases considered preventable.

Figure 10: Life Expectancy Indicators - Peterborough & Neighbouring Local Authorities, 2013-15



Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
0.1i - Healthy life expectancy at birth (Male)	2013 - 15	63.4	64.8	65.6	65.7	64.7	65.8	64.3	62.1	64.5	61.8	61.5	65.1	63.9
0.1i - Healthy life expectancy at birth (Female)	2013 - 15	64.1	65.5	62.5	67.3	63.1	64.0	67.4	61.3	65.4	62.4	65.9	66.7	63.8
0.1ii - Life expectancy at birth (Male)	2013 - 15	79.5	80.3	79.9	80.9	81.7	80.2	80.8	78.8	80.2	78.6	78.5	80.7	78.9
0.1ii - Life expectancy at birth (Female)	2013 - 15	83.1	83.7	83.5	84.4	83.7	83.5	84.1	82.3	83.6	82.4	83.0	84.1	82.6
0.1ii - Life expectancy at 65 (Male)	2013 - 15	18.7	19.2	19.3	19.4	19.8	19.0	19.2	18.6	19.3	18.5	18.5	19.5	17.9
0.1ii - Life expectancy at 65 (Female)	2013 - 15	21.1	21.5	21.4	21.9	21.2	21.3	21.6	20.7	21.6	20.9	20.9	21.8	20.6

Source: Public Health Outcomes Framework

Peterborough has some of the poorest observed outcomes in the East of England with regards to healthy life expectancy at birth, life expectancy at birth and life expectancy at 65. The East of England as a region is statistically significantly better than England for all six indicators in the table above, whereas Peterborough is statistically significantly worse than England for both male and female life expectancy at birth and lower, although not statistically significantly so, for the four indicators relating to male and female healthy life expectancy at birth and male and female life expectancy at 65.

Figure 11: Mortality Indicators - Peterborough & Neighbouring Local Authorities, 2013-15

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
4.03 - Mortality rate from causes considered preventable (Persons)	2013 - 15	184.5	162.5	170.3	150.1	154.0	163.6	151.7	202.3	164.9	211.8	199.6	156.8	189.8
4.03 - Mortality rate from causes considered preventable (Male)	2013 - 15	232.5	202.9	213.6	188.8	180.7	202.7	188.8	262.8	205.3	271.6	258.7	196.7	243.1
4.03 - Mortality rate from causes considered preventable (Female)	2013 - 15	139.6	124.7	128.2	113.0	127.4	128.0	117.6	143.0	127.0	154.3	144.0	119.4	140.9
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2013 - 15	74.6	66.4	68.4	63.5	63.8	63.9	65.6	100.0	62.3	86.3	83.3	62.2	90.9
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2013 - 15	104.7	93.3	91.1	91.1	84.6	89.0	92.4	143.9	86.9	116.6	117.9	90.5	123.3
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2013 - 15	46.2	40.9	42.5	38.9	43.8	40.6	40.3	57.5	39.0	57.7	50.4	35.4	60.8
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2013 - 15	48.1	42.0	44.9	40.7	42.7	39.9	39.0	67.2	39.6	60.4	53.4	40.0	54.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2013 - 15	72.5	63.4	66.1	62.7	59.1	59.7	58.9	103.9	60.3	87.5	76.7	61.9	83.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2013 - 15	25.0	21.8	24.5	19.4	27.1	21.6	20.3	31.6	19.9	34.7	31.5	19.3	28.4
4.05i - Under 75 mortality rate from cancer (Persons)	2013 - 15	138.8	132.0	139.2	120.3	127.2	135.1	127.0	150.5	130.6	149.7	143.5	131.8	153.5
4.05i - Under 75 mortality rate from cancer (Male)	2013 - 15	154.8	145.0	155.3	133.1	134.1	148.7	140.5	172.1	137.1	176.9	169.6	143.4	183.8

Source: Public Health Outcomes Framework

Although Peterborough has a relatively young population, age-standardised mortality rates are statistically significantly higher in the area compared to England for eight of 11 indicators noted in the table above, which relate to mortality from causes considered preventable and under 75 mortality.

4. Current Provision of NHS Pharmaceutical Services

This section describes the current provision of NHS pharmaceutical services, in order to assess the adequacy of provision of such services. Also included is a description of the number and locations of community pharmacies, dispensing General Practices and national Dispensing Appliance Contractors (DACs) premises. Information was correct as at June 2017. Up-to-date information on community pharmacies, including opening hours, is available on the NHS website: http://www.nhs.uk/Service-Search

The levels of provision of pharmaceutical services locally are compared with provision elsewhere and are considered in the context of feedback from local stakeholders.

4.1 Summary of Key Findings

Key message: There is currently sufficient pharmaceutical service provision across Peterborough. No need for additional pharmaceutical service providers is identified at present in this Pharmaceutical Needs Assessment, based on assessment of relative pharmacy provision in Peterborough compared to England and the consensus opinion of pharmacies stated within the community pharmacy and GP dispensing practice questionnaires undertaken as part of this project.

Peterborough has one pharmaceutical service provider per 4,409 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population in Peterborough. This is similar to the national average of 23 per 100,000 resident population and the East of England average of 24 pharmaceutical providers per 100,000 resident population. Estimates of the average number of people per pharmaceutical service provider across Peterborough have remained relatively stable since 2011.

As of June 2017, numbers of pharmacies in Peterborough are the same as at the time of the 2015 PNA:

- 41 Pharmacies
- 3 Dispensing General Practices
- 2 Dispensing Appliance Contractors

Peterborough also has two distance selling pharmacies.

Taking into account current information from stakeholders including community pharmacies and dispensing General Practices, the number and distribution of pharmaceutical service provision in Peterborough appears to be adequate. The distribution of pharmacies and dispensing General Practices appears to cover Peterborough sufficiently, with the majority of pharmacies located within Peterborough's most densely populated, central areas. The majority of areas in Peterborough are accessible within 20 minutes by car, with a small number of exceptions towards the outer areas of the city, particular in the east.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Peterborough.

- Overall, out of 41 community pharmacies, 23 (56%) are open after 18:00 and 12 (29%) are open after 19:00 on weekdays; 28 (68%) open on Saturdays and 10 (24%) open on Sundays. These findings are similar to those in the 2015 PNA.

- Home delivery services can help to provide medication to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed the questionnaire in 2017, 35 out of 37 pharmacies (95%) and one of one dispensing GP practices (100%) reported that they provide free delivery services to their patients.
- 34 of 37 community pharmacies (92%) and one of one (100%) dispensing GP practices who completed the questionnaire report they have consultation areas with wheelchair access.
- 34 of 37 (92%) community pharmacies and also the one dispensing GP practice that responded to the questionnaire stated that they considered current pharmaceutical provision in Peterborough to be adequate and for there to be no need for additional pharmacies in Peterborough.
- During the public consultation on the PNA, 63 of 69 respondents (91%) agreed with the key findings described in the PNA, and 58 of 69 respondents (84%) agreed that there are enough pharmacies across Peterborough.

4.2 Service Providers – Numbers & Geographical Distribution

4.2.1 Community Pharmacies

There were a total of 41 community pharmacies within Peterborough as of 1 June 2017. This number is unchanged from the time of the 2015 Peterborough PNA. The names of the community pharmacies within Peterborough are listed in Appendix 2 and their locations shown in figure 13.

4.2.2 Dispensing General Practices

The number of dispensing General Practices in Peterborough remains three, as was the case at the time of the 2015 Peterborough PNA.

Of the 203,658 people registered with a GP in Peterborough, 1,598 (0.8%) were registered as dispensing patients with a dispensing GP as at September 2015.[30] It should be noted that some of these patients may have an address outside Peterborough and similarly some patients with an address in Peterborough could be registered with a practice in another area.

The number of GPs in general (not only dispensing practices) appears to be relatively low in Peterborough compared to the East of England and England. Peterborough has only 43.3 GPs per 100,000 registered population, compared to 67.6/100,000 in the East of England and 57.3/100,000 in England.

[30] Dispensing patients from practice level data http://content.digital.nhs.uk/catalogue/PUB20503 General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics. NHS Digital

Figure 12: Average Numbers of Full Time Equivalent General Practices per 100,000 Registered Population, 2016/17

Peterborough	East of England	England
43.3	67.6	57.3

Source: NHS Digital NHS Staff Workforce Census, Available at: http://content.digital.nhs.uk/catalogue/PUB20503

Figure 13: Pharmacy Locations in Peterborough, July 2017

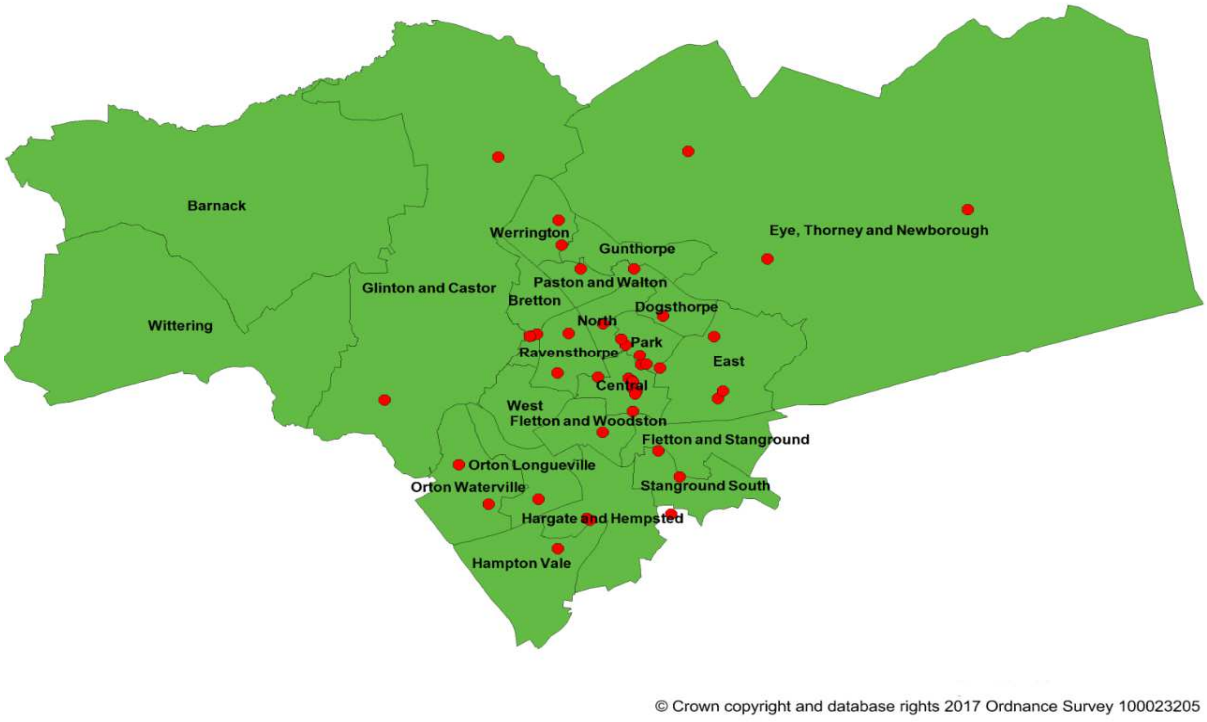


Figure 14: Dispensing GP Practice Locations in Peterborough, July 2017

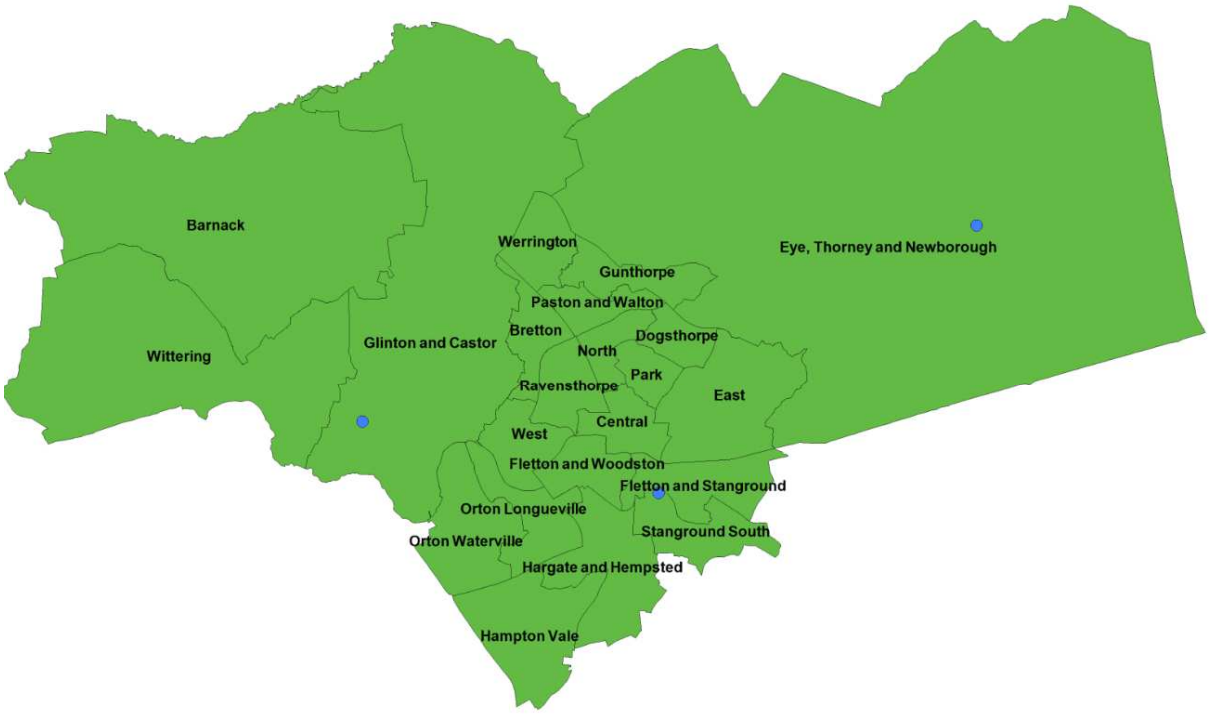
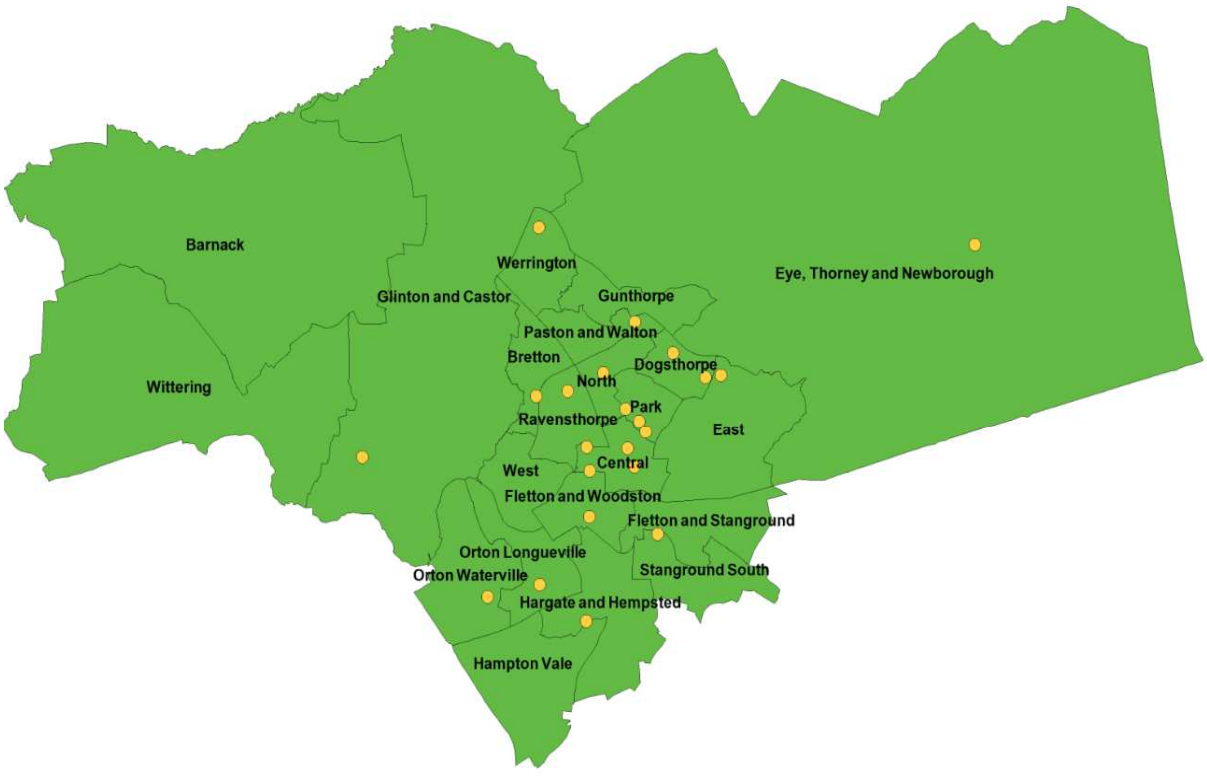


Figure 15: GP Practices in Peterborough, July 2017



4.2.3 Distancing Selling Pharmacies

There were two mail order/wholly internet pharmacies within Peterborough as of July 2017. Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice and therefore can access any of the many internet pharmacies available nationwide.

4.2.4 Dispensing Appliance Contractors

There are two Dispensing Appliance Contractors (DACs) in Peterborough. Appliances are also available from community pharmacies, dispensing GP practices and other DACs from outside of the area.

From the questionnaires sent out to Peterborough pharmaceutical service providers, 28 of the 37 pharmacies that responded (76%) reported that they provided all types of appliances. In addition, some pharmacies provide certain types of appliances. Only one dispensing GP practice returned the questionnaire and reported it did not provide appliances. In addition, several such practices provided certain types of appliances. Further detail regarding which types of appliances are provided can be found in the results from the Community Pharmacy & Dispensing Practice questionnaire reported in Appendix 3.

4.2.5 Hospital Pharmacies

The main hospital within Peterborough, Peterborough City Hospital, provides a hospital pharmacy service to local residents. Depending on need and location of treatment, residents may also utilise services provided by Addenbrooke's Hospital, Papworth Hospital, Hinchingbrooke Hospital and/or Cambridgeshire & Peterborough Mental Health Trust. Additionally, pharmacy services are provided to community hospitals run by Cambridgeshire & Peterborough Foundation Trust (CPFT).

4.2.6 Pharmacy Services in Prisons

There are pharmacy services provided to HMP Peterborough by Boots Pharmacy Ltd.

4.2.7 Comparison with Pharmaceutical Service Provision Elsewhere

Assuming a resident population of 193,980[31] and 44 providers of pharmaceutical services (41 community pharmacies and three dispensing GP practices), there is on average one service provider per 4,409 people within Peterborough. This is equivalent to 23 pharmaceutical providers per 100,000 population within the area. This is the same as the national average of 23 pharmaceutical providers per 100,000 residents and marginally below the East of England average of 24 pharmaceutical providers per 100,000 residents.

Figure 16: Average Number of Pharmaceutical Providers (Community Pharmacies & Dispensing GP Practices) per 100,000 Resident Population, 2016/17

Peterborough	East of England	England
23	24	23

Source: NHS Prescription Services of the NHS Business Service Authority & Population Data – Office for National Statistics. Dispensing Practices in England from NHS Prescription Authority

Information about pharmaceutical providers in other areas in England is shown in figure 17 below.

In terms of Community pharmacies alone, there were 22 pharmacies per 100,000 population in England in 2015/16, a slight increase from 21 per 100,000 in 2011/12. The number of community pharmacies per

[31] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

100,000 population ranged from 18 per 100,000 population in South Central to 26 community pharmacies per 100,000 population in two areas in the North of England. In the East of England the average was 19 per 100,000 (unchanged from 2011/12).

When dispensing practices are included in this table the average number of pharmaceutical providers per 100,000 population in the East of England increases to 24 per 100,000 reflecting the rural nature of much of the area and higher number of dispensing practices.

Figure 17: Community Pharmacy Data, England, 2015/16

		Number of community pharmacies (2015/16)	Prescription items dispensed per month (000s)	Average monthly items per community pharmacy	Dispensing Practices (2016)	ONS Population (000s) mid 2014	Pharmacies per 100,000 population	Pharmaceutical providers per 100,000 population
ENGLAND		**11,688**	**82,940**	**7,096**	**1,025**	**54,317**	**22**	**23**
Y54	**North of England**	**3,723**	**28,542**	**7,666**	**202**	**15,259**	**24**	**26**
Q72	Yorkshire & Humber	1,275	9,709	7,615	106	5,468	23	25
Q73	Lancashire & Greater Manchester	1,089	7,810	7,172	-	4,238	26	-
Q74	Cumbria & North East	727	6,441	8,860	72	3,123	23	26
Q75	Cheshire & Merseyside	632	4,582	7,249	13	2,430	26	27
Y55	**Midlands & East**	**3,446**	**24,642**	**7,151**	**476**	**16,487**	**21**	**24**
Q76	North Midlands	775	5,514	7,114	80	3,591	22	24
Q77	West Midlands	980	6,402	6,533	56	4,123	24	25
Q78	Central Midlands	890	6,706	7,535	140	4,518	20	23
Q79	East	801	6,020	7,516	200	4,255	19	24
Y56	**London**	**1,853**	**10,455**	**5,642**	**-**	**8,539**	**22**	**-**
Y57	**South**	**2,666**	**19,301**	**7,240**	**347**	**14,032**	**19**	**21**
Q70	Wessex	511	3,752	7,343	46	2,742	19	20
Q80	South West	637	4,818	7,563	95	3,171	20	23
Q81	South East	880	6,210	7,056	94	4,540	19	21
Q82	South Central	638	4,522	7,087	112	3,578	18	21

*There are no dispensing practices in London. North of England is incomplete for dispensing practices due to boundary changes.

Source: NHS Prescription Services of the NHS Business Authority, Population data – Office National Statistics http://content.digital.nhs.uk/phs1 **Dispensing Practices in England from NHS Prescription Authority.**

Note this table is combined data from NHS Digital and NHS Prescription Authority. Dispensing practices downloaded and assigned to NHSE Region using organisational codes in order to display pharmaceutical providers – both community pharmacies and dispensing practices.

4.2.8 Considerations of Service Providers Available

Peterborough is a relatively small geographical area with a similar number of pharmacy providers per 100,000 resident population to England. The majority of pharmacies are located near to Peterborough's most densely populated, urban, central areas with provision less prevalent towards the outer, less populated rural areas of Peterborough.

4.2.9 Results of Questionnaires Sent to Pharmacies and Dispensing GP Practices

37 of 41 (90%) community pharmacies and 1 of 3 (33%) dispensing GP practices in Peterborough responded to the 2017 PNA questionnaire. This compares favourably with the previous Peterborough PNA, within which 67% of community pharmacies completed the questionnaire.

34 of 37 community pharmacies and also the one dispensing GP practice that responded to the questionnaire stated that they considered current pharmaceutical provision in Peterborough to be adequate and for there to be no need for additional pharmacies in Peterborough. However, as noted in

Chapter 5 and Appendix 3, a number of pharmacies expressed willingness to offer a greater number of services if commissioned and many suggested that pharmacies are under-utilised within Peterborough.

4.2.10 Findings of the public consultation

63 of 69 respondents (91%) agreed with the key findings about pharmaceutical services in Peterborough as outlined in the PNA, and 58 of 69 respondents (84%) agreed that there are enough pharmacies across Peterborough. The feedback gathered in the consultation is described in the Consultation report (see Appendix 6) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 7.

In summary, taking into account current information from stakeholders including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Peterborough appears to be adequate.

4.3 Accessibility

4.3.1 Distance & Travel Times

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.[32]

Figure 18 shows the locations of both pharmacies and dispensing practices in Peterborough, together with the major roads in the area.

Figure 19 was created to identify which areas in Peterborough were within and which were not within a 20 minute driving distance of either a pharmacy or a dispensing practice as of July 2017. For this map, pharmacies and dispensing practices could be located either within the boundaries of Peterborough Unitary Authority or outside of the boundaries. Road speed assumptions were made dependent on road type and ranged up to 65mph (for motorways) but down to 20mph in urban areas.

4.3.2 Home Delivery Services

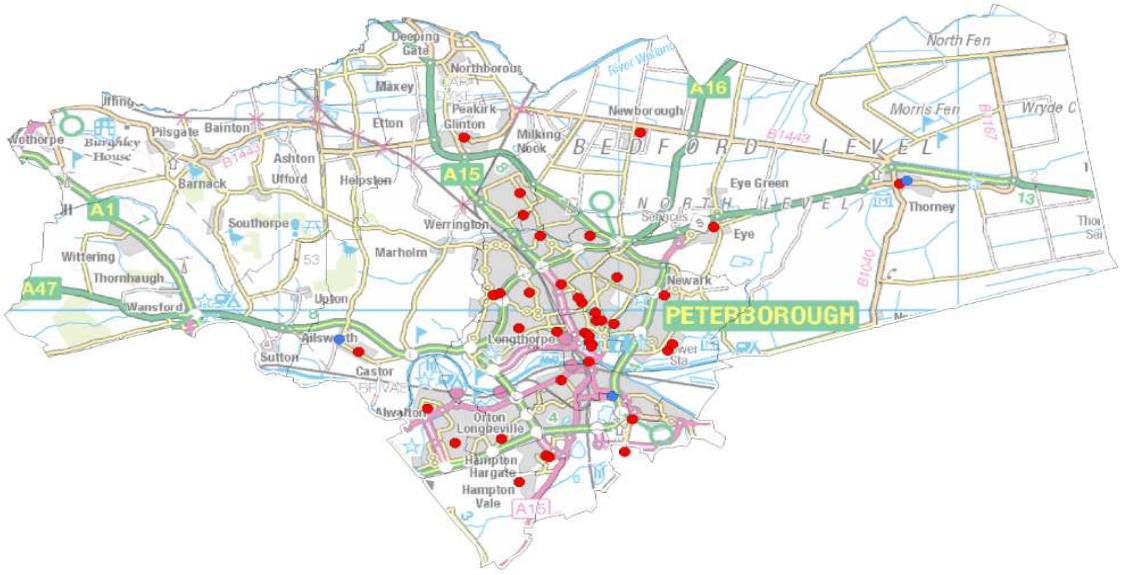
Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport.

Of the pharmaceutical providers who completed the questionnaire in 2017, 35 out of 37 pharmacies (95%) and 1 of 1 dispensing GP practices (100%) reported that they provide free delivery services to their patients. In addition, some providers deliver to specific patient groups and/or specific regions, some for free and others for a charge.

Pharmaceutical services are also available from internet pharmacies (located inside or outside of Peterborough) that could make deliveries to individual homes. Finally, in addition to delivery services, community transport schemes (e.g. car clubs, minibuses) can potentially improve access to both pharmaceutical services and other services.

[32] Department of Health (2008). 'Pharmacy in England: Building on strengths – delivering the future.' Available at: http://www.official-documents.gov.uk/document/cm73/7341/7341.pdf

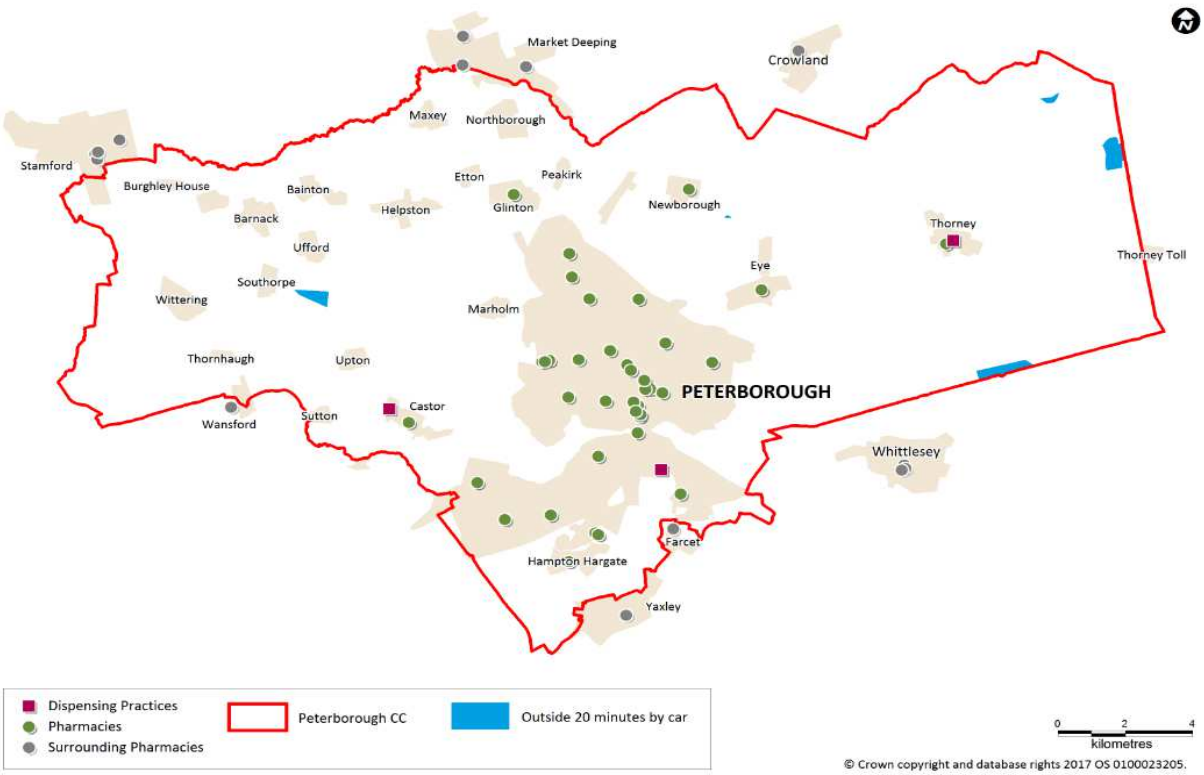
Figure 18: Pharmacies, Dispensing Practices & Major Roads in Peterborough



Pharmacies and dispensing practices in Peterborough with wards (Post May 2016)

Note: Red symbols are used to indicate pharmacies within Peterborough.
Blue symbols are used to indicate dispensing practices within Peterborough

Figure 19: Access to Pharmacies and Dispensing Practices: 20 Minutes by Car



The majority of areas in Peterborough are accessible within 20 minutes by car, with a small number of exceptions towards the outer areas of the city, particular in the east.

4.3.3 Border Areas

Peterborough shares a border with Huntingdonshire District and Fenland District (both within Cambridgeshire County Council), South Kesteven District and South Holland District (both within Lincolnshire County Council), East Northamptonshire District (within Northamptonshire County Council) and Rutland Unitary Authority. These areas have pharmacies that are accessible to the residents who live near the borders of Peterborough. Dispensing GP practices also offer pharmaceutical services to these outer areas.

4.3.4 Access for People with Disabilities

The questionnaire sent to pharmacies and dispensing GP practices included a question asking if any consultation facilities existed on site and if they included wheelchair access. The results showed that 34 of 37 community pharmacies (92%) who completed the questionnaire report they have consultation areas with wheelchair access. Similarly, one of one (100%) dispensing GP practices who completed the questionnaire report they have consultation areas with wheelchair access.

In the public consultation, 12 out of 69 respondents who completed the questionnaire (17%) said they had a disability. 63 respondents answered the question '*Do you have any difficulties in accessing your local pharmacy or GP dispensary?'* 59 of 63 respondents (94%) said that they did not have any difficulties in accessing their local pharmacy or GP dispensary. One respondent highlighted the need for pharmacies to follow the Accessible Information Standard. From 1 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the needs of patients, service users, carers and parents with a disability, impairment or sensory loss. More information can be found here: https://www.england.nhs.uk/ourwork/accessibleinfo/.

4.3.5 Information in languages other than English

Community pharmacies do not have access to a free interpretation service, such as a telephone interpretation line. Pharmacies often employ people living in the area who may be fluent in languages spoken in the local community. Some written materials, e.g. leaflets, are available in other languages and the NHS Choices has a 'translate' button.

4.4 Opening Hours

4.4.1 Opening Hours: Community Pharmacies

There are currently five '100 hour' pharmacies in Peterborough. These are included in the pharmaceutical list under regulation 13(1)(b) of the National Health Service (Pharmaceutical Services) Regulations 2005; premises which the applicant is contracted to open for at least 100 hours per week for the provision of pharmaceutical services.

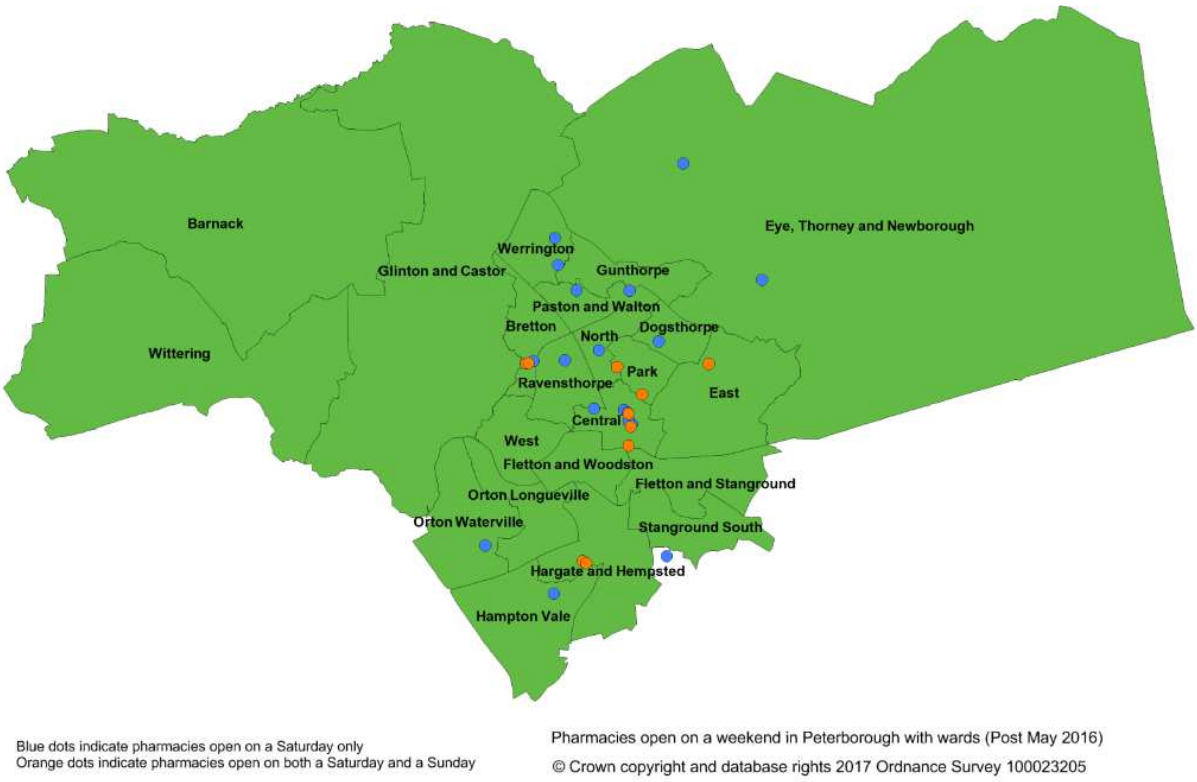
The 100 hour pharmacies are:

- Asda Pharmacy, West Rivergate Shopping Centre (PE1 1ET)
- Boots Pharmacy, The Bretton Centre (PE3 8DN)
- Lloyds Pharmacy, Sainsburys, Flaxland, Bretton (PE3 8DA)
- Mi Pharmacy, Park Road Branch (PE1 2UF)
- Pharmacy First, Lincoln Road (PE1 2RR)

The results of the PNA questionnaire, which all Peterborough community pharmacies and dispensing practices were invited to complete, have been used to get more details about the opening hours of local pharmacies. Overall, out of 41 community pharmacies, 23 (56%) are open after 18:00 and 12 (29%) are open after 19:00 on weekdays; 28 (68%) open on Saturdays and 10 (24%) open on Sundays. These findings are similar to those in the 2015 PNA. One community pharmacy stated that it opens until midnight on weekdays and one pharmacy stated that it is open until midnight on weekends.

The locations of pharmacies currently open on a Saturday or a Sunday are illustrated within the figure below:

Figure 20: Pharmacies Open on a Saturday or a Sunday in Peterborough, 2017



For a number of conditions, there is also a range of general sales list medications that are available from a range of overnight retailers such as garages and 24 hour supermarkets.

Currently, five pharmacies are contractually obliged to open for 100 hours per week due to the conditions on their application. This inevitably means that they are open until late at night and at the weekend. There is a risk that if the regulations for these contracts were to change, these pharmacies may wish to reduce their hours, which could significantly reduce the network of late night and weekend pharmacies.

The Peterborough Health & Wellbeing Board has not identified needs that would require provision of a full pharmaceutical service for all time periods across the week. However, maintaining the current distribution of 100 hour/longer opening pharmacies is important to maintain out-of-hours access for the population of Peterborough.

Since the introduction of the pharmaceutical contractual framework in 2005, community pharmacies do not need to participate in rota provision to provide access for weekends or during the evening. The need for such a service has been greatly reduced by the increased opening hours of a number of pharmacies

including the 100 hours pharmacies. Despite this, there is a still a gap in contracted hours to cover statutory holidays.

Due to changes in shopping habits a number of pharmacies now open on many bank holidays, although they are not contractually obliged to do so. NHS England works with community pharmacies to ensure an adequate rota service is available for Christmas Day and Easter Sunday as these are days where pharmacies are still traditionally closed. The rota pharmacies will generally open for four hours on these days and work with out-of-hours providers to enable patients to access pharmaceutical services. These arrangements are renewed every year.

4.4.2 Opening Hours: Dispensing GP Practices

To consider opening hours for dispensing GP practices, the opening hours for general practices were identified using the NHS Direct website. The dispensaries at the dispensing GP practices were assumed to be open at the same hours as the rest of the practice. All three Peterborough dispensing GP practices are closed on both Saturdays and Sundays.

In summary, review of the accessibility of NHS pharmaceutical services in Peterborough in terms of locations, opening hours and access for people with disabilities suggest there is adequate access. There appears to be good coverage in terms of opening hours across Peterborough.

4.5 Features identified by local community pharmacies as being important

The top five features identified by community pharmacies as being important were:

- Availability of information and advice about medicines/how to use them (32 responses, 86%).
- Qualified staff (27 responses, 73%).
- Availability of consultation facilities (20 responses, 54%).
- Availability of prescription only items (18 responses, 49%).
- Availability of non-prescription medicines (16 responses, 43%).

5. The role of pharmaceutical providers in addressing health needs

This section describes the services provided by local pharmaceutical providers: 'Essential Services', which all pharmacies are required to provide; 'Advanced Services' commissioned by NHS England to support patients with safe use of medicines and the NHS national seasonal flu vaccination programme and health improvement services which are locally commissioned by Peterborough City Council.

5.1 Summary of key findings

Medicines advice & support:

Through the provision of advanced services including Medicine Use Reviews (MURs), Dispensing Review of Use of Medicines (DRUMs), clinical screening of prescriptions and identification of adverse drug events, dispensing staff work with patients to help them understand their medicines. This also ensures that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated. In the community, pharmacists should continue to work with GPs and nurse prescribers to ensure safe and rational prescribing of medication.

Medication errors in care homes for older people can also be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. Cambridgeshire & Peterborough Clinical Commissioning Group (C&P CCG) employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with General Practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste. As part of the pharmacy integration fund, NHS England is looking to support community pharmacists working in care homes to ensure that medication is used in the most appropriate way. It is expected that there will be 150 community pharmacists supported to deliver this workstream nationally. It is not yet known how many pharmacists will be involved locally in Peterborough.

Services & support to encourage healthy lifestyle behaviours:

Providers of pharmaceutical services also have an important role to play in improving the health and wellbeing of local people beyond providing and supporting the safe use of medicines. The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve and the recent changes to the 2017/18 pharmacy contract have included quality payments to pharmacies who are accredited as 'Healthy Living Pharmacies'.

In Peterborough, all of the community pharmacies that responded to the PNA questionnaire have either achieved Healthy Living Pharmacy status or are working towards it. Five pharmacies (14% of respondents) have achieved Healthy Living Pharmacy status and 32 (86% of respondents) are working towards achieving Healthy Living Pharmacy status. In Peterborough, all of the community pharmacies that responded to the PNA questionnaire have either achieved Healthy Living Pharmacy status or are working towards it. Five pharmacies (14% of respondents) have achieved Healthy Living Pharmacy status and 32 (86% of respondents) are working towards achieving Healthy Living Pharmacy status. Achieving level 1 Healthy Living Pharmacy status requires

pharmacies to adopt a pro-active health promoting culture and environment within the pharmacy, with all the requirements of the quality criteria satisfied. These include understanding local public health needs, creating a health and wellbeing ethos, team leadership, communication, community engagement and having a health promoting environment.

Community pharmacies are easily accessible and can offer a valuable opportunity for reaching people who may not otherwise access health services. Pharmacy support for the public health and prevention agenda could therefore be especially valuable in more deprived communities or for vulnerable groups who have a variety of poorer health outcomes (e.g. migrant workers; traveller communities; ethnic minorities; older people). Community pharmacies can be involved in addressing health inequalities and targeting initiatives and resources to improve the health of the poorest, fastest.

Preventative approaches are important to ensure people remain healthy and independent in the community for longer and to reduce the unsustainable cost of health and social care services for this growing population. Support for people to ensure that they remain healthy for as long as possible through the provision of healthy lifestyle advice is important. Community pharmacies can also support self-care where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services. This could be particularly important for frail older people and those with multiple conditions.

Community pharmacies all participate in six public health promotion campaigns each year, as part of their national contract. Further opportunities exist to encourage healthy behaviours including maintaining a healthy weight and taking part in physical activity such as providing advice, signposting services and providing on-going support towards achieving behaviour change, for example, through monitoring of weight and other related measures. Opportunistic alcohol screening and provision of brief advice is another area where pharmacies could contribute to improving the health of the local population. This could, for example, potentially be integrated into agreements around medication checks.

Pharmacy staff can play a role in promoting awareness of good mental health, for example by signposting to information about local support networks, mental health help lines etc.

Pharmacy providers are also involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C Difficile.

The following local services are currently commissioned from community pharmacies:

e) <u>Stop smoking services:</u>

Pharmacies in Peterborough are offered the opportunity to deliver specialist stop smoking services under a Local Incentivised Scheme (LIS) contract, commissioned by the Public Health Joint Commissioning Unit that works across Peterborough City Council and Cambridgeshire County Council. Pharmacies are ideally placed to provide easy access to people who wish to stop smoking. Specialist Smokefree Advisors are National Centre for Smoking Cessation Training (NCSCT) trained to deliver up to a 12 week programme which clients attend on a weekly basis. They are also able to directly supply nicotine replacement therapy from the pharmacy which, combined with behavioural support, can greatly increase the chances of a

quit outcome. 15 pharmacies in Peterborough are currently commissioned to provide this service.

f) <u>Contraception and sexual health services:</u>

- ***Emergency hormonal contraception***

Pharmacies in Peterborough are offered the opportunity to receive training and contracts to provide Emergency Hormonal Contraception (EHC) which is available as a locally commissioned service in some community pharmacies. The EHC service in Peterborough pharmacies commenced in late 2016/17. Currently, 12 pharmacies in Peterborough have signed a contract to deliver the EHC service across Peterborough, as part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Peterborough, with further opportunities to expand.

- ***Chlamydia screening***

As part of the public health commissioned EHC service a Chlamydia screening kit is offered to the service user. iCaSH Peterborough, the integrated contraception and sexual health service provided by Cambridgeshire Community Services NHS Trust, provides chlamydia kits and staff training. The pharmacy needs to provide a suitable consultation room to be eligible for this scheme. Chlamydia screening is not provided by pharmacies outside of the EHC service. Pharmacies can signpost those requesting chlamydia screening to iCaSH Peterborough.

g) <u>Alcohol and substance misuse services:</u>

The Public Health Joint Commissioning Unit commission services to provide specialist drug and alcohol treatment across Peterborough. Currently adult drug and alcohol services are provided by CGL Aspire who sub-contract pharmacies to provide the following specific services:

- ***Needle & syringe exchange service***

23 pharmacies in Peterborough are contracted via CGL Aspire to provide needle exchange services. People who use illicit drugs are often not in contact with health care services and their only contact with the NHS may be through a needle exchange service within a community pharmacy. At a minimum, the pharmacy can provide advice on safer injecting and harm reduction measures. In addition, community pharmacies can provide information and signposting to treatment services, together with information and support on health issues other than those that are specifically related to the client's addiction.

- ***Supervised administration service***

Once clients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Clients often need support to prevent them stopping treatment. 23 community pharmacies in Peterborough are contracted to provide a supervised administration service via CGL Aspire, which requires the pharmacist

to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient.

- ***Naloxone kits***

  Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone, morphine and fentanyl). 16 pharmacies in Peterborough are contracted via CGL Aspire to issue naloxone kits with training to all substance misuse clients (those accessing supervised administration or needle exchange services). The pharmacies can issue the naloxone kits to clients' friends and relatives, and others who may require one, such as a hostel manager. Pharmacies are also able to refer clients into treatment services provided by CGL Aspire.

- ***Blood borne viruses screening***

  Nine pharmacies are contracted via CGL Aspire to provide screening for Hepatitis B virus and Hepatitis C virus to clients at risk, identified by CGL Aspire. Screening involves a finger prick blood sample being taken and aims to ensure timely diagnosis and access to treatment.

- ***Alcohol brief interventions***

  Similarly to the substance misuse services, 16 pharmacies in Peterborough are contracted via CGL Aspire to provide alcohol brief intervention services. Pharmacies offer this service to all customers; customers are asked three screening questions and, depending on their score, may be asked additional questions about their alcohol consumption and have a brief intervention carried out. They may also be referred to CGL Aspire specialist services if appropriate.

h) **Directly observed therapy service for tuberculosis**

The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) will be commissioning a limited number of pharmacies across Peterborough and Cambridgeshire to provide a directly observed therapy service specifically for patients with tuberculosis. Pharmacies will ensure that appropriate drugs are given at specified intervals and the patient is observed taking them. The hospital tuberculosis nurse specialist will provide training and supervision for this service.

In addition to commissioned services, our questionnaire found that community pharmacies provide a number of additional services, including Monitored Dosage System, delivery of dispensed medicines at no charge and collection of prescriptions from GP practices.

In conclusion, community pharmacies offer a range of services that can make them a key public health resource, offering potential opportunities to provide health improvement initiatives and work closely with partners to promote health and wellbeing. There are opportunities to develop the contribution of community pharmacies to all of the currently commissioned services. Pharmacies are able to and should be encouraged to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers. Local commissioning organisations should continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including

when considering options for delivering integrated care. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

The King's Fund report 'Community Pharmacy Clinical Services Review' (December 2016) commissioned by the Chief Pharmaceutical Officer recommended that there is a need in the medium-term to 'ensure that community pharmacy is integrated into the evolving new models of care alongside primary care professionals. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these'. At a local level, the Health & Wellbeing Board should encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working.

5.2 Community Pharmacy Essential Services

Community Pharmacies provide three tiers of Pharmaceutical Services commissioned by NHS England:

- Essential Services – services all pharmacies are required to provide.
- Advanced Services – services to support patients with safe use of medicines.
- Enhanced Services – services that can be commissioned locally by NHS England.

These types of services are defined in the NHS Regulations and are briefly described below.[33]

Peterborough pharmacies are participating in a voluntary quality scheme which is an NHS England incentive scheme for achieving quality standards. To participate in the scheme pharmacies are required to have complied with national gateway criteria for example ensuring that the information held about them on NHS Choices is correct. Further details of this scheme and the quality standards can be found at https://www.england.nhs.uk/wp-content/uploads/2017/02/quality-payments-quality-criteria-guidance-1.pdf.

The essential services offered by all pharmacy contractors are specified by a national contractual framework that was agreed in 2005. The following description of these services is an excerpt from a briefing summary on NHS Community Pharmacy services by the Pharmaceutical Services Negotiating Committee.[34]

- **Dispensing –** the safe supply of medicines or appliances. 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.
- **Repeat dispensing –** the management of repeat medication for up to one year, in partnership with the patient and prescriber. The patient will return 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.

[33] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf
[34] Pharmaceutical Services Negotiating Committee Summary of NHS Community Pharmacy services. Available at: http://psnc.org.uk/wp-content/uploads/2015/06/CPCF-summary-June-2015.pdf

- **Disposal of unwanted medicines –** pharmacies accept unwanted medicines from individuals. The medicines are then safely disposed of.
- **Promotion of Healthy Lifestyles (Public Health) –** opportunistic one to one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing. Pharmacies will also get involved in six local campaigns a year, organised by NHS England. Campaign examples may include promotion of flu vaccination uptake or advice on increasing physical activity.
- **Signposting patients to other healthcare providers –** pharmacists and staff will 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.
- **Support for self-care –** the provision of advice and support by pharmacy staff to enable people to 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.
- **Clinical governance –** pharmacies must 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 (NRLS).
  - 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.

NHS England is responsible for ensuring that all pharmacies deliver all of the essential services as specified. Each pharmacy has to demonstrate compliance with the community pharmacy contractual framework by providing sufficient evidence for delivery of every service. Any pharmacy unable to provide the evidence will be asked to provide an action plan, outlining with timescales, how it will then achieve compliance. These self-assessments are supported by contract monitoring visits. All Peterborough pharmacies are assessed as compliant with the essential services contract.

5.3 Advanced Services

In addition to essential services, the community pharmacy contractual framework allows pharmacies to opt to provide any of the following advanced services to support patients with the safe use of medicine, which currently include: Medicines Use Reviews (MUR); Appliance Use Reviews (AUR); New Medicines Service (NMS); the Stoma Customisation Service (SCS). The NHS Seasonal Flu Vaccination Programme is also currently commissioned from pharmacies as an advanced service, although NHS England currently has limited powers to monitor or direct this service to local need. In addition, NHS England has recently commissioned a national NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot, in order to reduce the burden on urgent and emergency care services of handling urgent medication requests, whilst ensuring patients have access to the medicines or appliances they need.

NHS England works with all pharmacies and other agencies to ensure that they are contributing to the system-wide implementation of safety alerts – for instance, National Patient Safety Agency (NPSA) alerts on anticoagulant monitoring, methotrexate, lithium safety, cold chain integrity etc. In the community, pharmacists should work with GPs and nurse prescribers to ensure safe and rational prescribing of medication.

Through the provision of MURs, DRUMS, clinical screening of prescriptions and identification of adverse drug events, dispensing staff work with patients to help them understand their medicines. This also ensures

that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated.

The Community Pharmacy questionnaire indicates that 36 of 37 respondents (97.3%) of community pharmacies who responded currently provide MURs and 4 of 37 respondents (10.8%) provide a Stoma Customisation Service. 6 of 37 (16.2%) respondents provide an Appliance Use Review service and a further 7 (18.9%) suggested they intended to begin doing so within 12 months. 29 pharmacies (78.4%) offer a flu vaccination service and a further 7 (18.9%) intend to do within the next 12 months.

Only one dispensing GP practice responded to the PNA survey and indicated it did not offer an Appliance Use Review service or Stoma Appliance Customisation Service.

Figure 21: Community Pharmacies providing Advanced Services, 2017

Advanced Service	Does the community pharmacy provide the following advanced services respondents = 37					
	Yes		No, but intending to begin within 12 months		No	
	Number	%	Number	%	Number	%
Medicines Use Review Service	36	97.3%	0	0.0%	1	2.7%
New Medicine Service	35	94.6%	1	2.7%	1	2.7%
Appliance Use Review Service	6	16.2%	7	18.9%	24	64.9%
Stoma Appliance Customisation Service	4	10.8%	7	18.9%	26	70.3%
Influenza Vaccination Service	29	78.4%	7	18.9%	1	2.7%
NHS Urgent Medicine Supply Advanced Service	7	18.9%	16	43.2%	14	37.8%

Source: Peterborough Pharmaceutical Needs Assessment Community Pharmacy Service, 2017

5.3.1 Medicines Use Reviews (MURs)

The MUR service is a structured review that is undertaken by a pharmacist to help patients to manage their medicines more effectively. The MUR involves the pharmacist reviewing the patient's use of their medication, ensuring they understand how their medicines should be used and why they have been prescribed, identifying any problems and then, where necessary, providing feedback to the prescriber. An MUR feedback form will be provided to the patient's GP where there is an issue for them to consider. An MUR is not usually conducted more than once a year.

An MUR is a way to improve a patient's understanding of their medicines; highlight problematic side effects and propose solutions where appropriate; improve adherence and reduce medicines wastage, usually by encouraging the patient only to order the medicines they require. An MUR is not a full clinical review, an agreement about changes to medicines, a discussion about the medical condition beyond that which is needed to achieve the above objectives or a discussion on the effectiveness of treatment based on test results.[35]

[35] Pharmacy Services Negotiating Committee. 'MURS: the basics'. Available at: http://psnc.org.uk/services-commissioning/advanced-services/murs/murs-the-basics/

A 'Prescription Intervention' is an MUR which is triggered by a significant adherence problem which comes to light during the dispensing of a prescription. It is over and above the basic interventions, relating to safety, which a pharmacist makes as part of the dispensing service.

As of 1 April 2015, community pharmacies have been required to ensure that at least 70% of their MURs within any given financial year are for patients in one or more of four target groups:

- 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.
- Patients at risk of or diagnosed with cardiovascular disease and regularly being prescribed at least four medicines.

All patients who receive an MUR should experience the same level of service regardless of their condition, i.e. MURs cover all the patient's medicines rather than only those that fall within a target group.

The pharmacy provides a quarterly summary report to NHS England of MUR consultations conducted. Each pharmacy is limited in the numbers of each Medicines Use Reviews (MURs) that they may undertake. In the year 2016/17, all 41 pharmacies in Peterborough were able to provide up to 400 MURS each financial year to provide a potential total of 16,400 MURs.

In total, 13,267 MURs were completed over the year 2016/17 out of a possible 16,400, therefore approximately 81% of the reviews that could have been undertaken if all pharmacies had completed their maximum entitlement. There is the potential for an increased delivery of MURs across the city to support patients with their medicines. There are also opportunities to increase the uptake of MURs and in the future to target pharmaceutical care towards complex cases.

The 'Community Pharmacy Clinical Services Review' 2016[36] recommends that 'the MURs element of the pharmacy contract should be re-designed to include on-going monitoring and regular follow-up with patients as an element of care pathways'. The report proposes that MURs evolve into full clinical medication reviews for patients with long-term conditions and/or multiple morbidities.

5.3.2 Appliance Use Reviews (AURs)

Appliance Use Review (AUR) is the second Advanced Service to be introduced into the English Community Pharmacy Contractual Framework (CPCF). This service is similar to the MUR service, but it aims to help patients better understand and use their prescribed appliances (e.g. stoma appliances) rather than their medicines 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 proper disposal of the appliances that are used or unwanted.[37]

[36] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 18. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[37] Pharmaceutical Services Negotiating Committee Summary of NHS Community Pharmacy services. Available at: http://psnc.org.uk/wp-content/uploads/2015/06/CPCF-summary-June-2015.pdf

5.3.3 New Medicines Services (NMS)

This service is designed to improve patient's understanding of a newly prescribed medicine for a long-term condition and help them get the most from the medicine. Research has shown that after 10 days, two thirds of patients who are prescribed a new medicine reported problems including side effects, difficulties taking the medicine and a need for further information.

The service provides support for people with long-term conditions, who are newly prescribed a medicine to help improve medicines adherence; it is initially focused on particular patient groups and conditions.

The Department of Health (DoH) commissioned researchers at the University of Nottingham to lead an academic evaluation of the service, investigating both the clinical and economic benefits of the service.[38] The findings of the evaluation were published in August 2014 and were overwhelmingly positive, with the researchers concluding that as the NMS delivered better patient outcomes for a reduced cost to the NHS, it should be continued. This was the basis for NHS England's decision to continue commissioning the service.

Since the introduction of the NMS in October 2011, more than 90% of community pharmacies in England have provided it to their patients. The pharmacy provides a quarterly summary report to NHS England of NMS consultations conducted. This supports monitoring of the service to determine its effectiveness and value to the NHS.

The pharmacist will provide the patient with information on their new medicine and how to use it when it is first dispensed. The pharmacist and patient will then agree to meet or speak by telephone in around a fortnight. Further information and advice on the use of the medicine will be provided and where the patient is experiencing a problem the pharmacist shall seek to agree a solution with the patient.

A final consultation (typically 21-28 days after starting the medicine) will be held to discuss the medicine and whether any issues or concerns identified during the previous consultation have been resolved. If the patient is having a significant problem with their new medicine the pharmacist may need to refer the patient to their GP.[39]

Pharmaceutical Services Negotiating Committee (PSNC) and NHS Employers envisaged that the successful implementation of NMS would:

- Improve patient adherence which will generally lead to better health outcomes.
- Increase patient engagement with their condition and medicines, supporting patients in making decisions about their treatment and self-management.
- Reduce medicines wastage.
- Reduce hospital admissions due to adverse events from medicines.
- Lead to increased Yellow Card reporting of adverse reactions to medicines by pharmacists and patients, thereby supporting improved pharmaco-vigilance.
- Receive positive assessment from patients.
- Improve the evidence base on the effectiveness of the service.
- Support the development of outcome and/or quality measures for community pharmacy.

[38] University of Nottingham. 'The New Medicine Service Evaluation' (2014) Department of Health. Available at: http://www.nottingham.ac.uk/~pazmjb/nms/

[39] Pharmaceutical Services Negotiating Committee Summary of NHS Community Pharmacy services. Available at: http://psnc.org.uk/wp-content/uploads/2015/06/CPCF-summary-June-2015.pdf

5.3.4 Stoma Appliance Customisation Service

This service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

5.3.5 Community Pharmacy Seasonal Influenza Vaccination Advanced Service (Flu Vaccination Service)

Each year, from September through to January, the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus. These include people aged 65 years and over, pregnant women and those with certain health conditions.

From 2015/16, NHS England has also commissioned a new Advanced Service from all community pharmacies who can vaccinate patients in at-risk groups against flu. This service has been re-commissioned in both 2016/17 and 2017/18. This service sits alongside the nationally commissioned GP vaccination service, giving patients another choice of venue for their vaccination and helping commissioners to meet their local NHS vaccination targets.

The aims of the national programme[40] are:

- To sustain and maximise uptake of flu vaccine in at-risk groups by building the capacity of community pharmacies as an alternative to general practice.
- To provide more opportunities and improve convenience for eligible patients to access flu vaccinations.
- To reduce variation and provide consistent levels of population coverage of community pharmacy flu vaccination across England by providing a national framework.

In the community pharmacy questionnaire, 78.4% of community pharmacies (29 of 37) who responded reported that they provide seasonal flu vaccinations and a further 18.9% (7 of 37) said they intended to do so within the next 12 months.

As of the end of the 2016/17 flu season, 29 community pharmacies across Peterborough had delivered over 4,200 seasonal flu vaccinations. A number of pharmacies also reported that they provide private seasonal flu vaccinations, at a cost, to those who are not in the NHS at-risk groups.

5.3.6 NHS Urgent Medical Supply Advanced Service Pilot

NHS England has commissioned a national NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot, in order to reduce the burden on urgent and emergency care services of handling urgent medication requests, whilst ensuring patients have access to the medicines or appliances they need.
Under this NUMSAS service, in an emergency and at the request of a patient via NHS 111 telephone service, a pharmacist can supply a prescription only medicine (POM) without a prescription to a patient who has previously been prescribed the requested POM.[41]

Five pharmacies in Peterborough participated in the national pilot programme which commenced December 2016 and runs until March 2018; this pilot will be evaluated in due course.

[40] NHS England. 'Community Pharmacy Seasonal Influenza Vaccination Advanced Service, Service Specification.' October
2016. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/08/17-18-service-specification-seasonal-flu.pdf
[41] NHS England. 'NHS Urgent Medicine Supply Advanced Service Pilot Community Pharmacy Service Specification'. (November 2016) Available at: https://www.england.nhs.uk/wp-content/uploads/2016/11/numsas-service-specification.pdf

5.4 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. Examples of enhanced services include:

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

These services can only be referred to as Enhanced Services. If local services are commissioned by CCGs or Local Authorities, they are referred to as locally commissioned services. At present no enhanced services are commissioned in Peterborough.

5.5 The role of community pharmacy in preventing ill health and promoting healthy behaviours

The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve. Children, adults and the elderly are all vulnerable to the risk factors that contribute to preventable non-communicable diseases, whether from unhealthy diets, physical inactivity, exposure to tobacco smoke or the effects of the harmful use of alcohol.[42]

The Peterborough Health & Wellbeing Board consider community pharmacies to be a key public health resource and recognise that they offer potential opportunities to commission health improvement initiatives and work closely with partners to promote health and wellbeing, as recommended by the Local Government Association (LGA)[43] and Public Health England.[44]

Local commissioning organisations should continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population,

[42] World Health Organization. (March 2013) Fact sheet: Noncommunicable diseases. Available at: http://www.who.int/mediacentre/factsheets/fs355/en/

[43] Local Government Association. https://www.local.gov.uk/sites/default/files/documents/community-pharmacy-offer--9b3.pdf http://www.local.gov.uk/documents/10180/11463/Community+Pharmacy+local+government's+new+public+health+role/01ca29bf-520d-483e-a703-45ac4fe0f521 (Last accessed 26 Nov 2013)

[44] https://publichealthmatters.blog.gov.uk/2015/03/24/putting-pharmacy-on-the-public-health-map/ & https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf

including when considering options for delivering integrated care. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

Population estimates from the Cambridgeshire Research Group show there to be 28,300 people aged 65 or over in Peterborough. Local residents are living for longer and increases in older age groups are expected to be substantial between 2015 and 2036, with rises of 165.8% (from 3,800 to 10,100) in the 85+ age group, 73.1% (from 9,300 to 16,100) in 75-84 and 49.3% (from 15,200 to 22,700) in the 65-74 age group. Lifestyle related diseases such as diabetes are increasing. An ageing population with a range of health issues will also put pressure on health and social services. As described earlier in section 3, the Murray report proposes that pharmacy needs to be a 'core part of the integrated, convenient services that people need', although the report identifies that this has proven difficult to achieve thus far. NHS England's Five Year Forward View[45] and the General Practice Forward View April 2016[46] set out proposals for the future of the NHS based around new models of care and offer a strategic opportunity to review and revisit the role of community pharmacy in the health and care system.

Preventative approaches are important to ensure older people remain healthy and independent in the community for longer and to reduce the unsustainable cost of health and social care services for this growing population. Support for people to ensure that they remain healthy for as long as possible through the provision of healthy lifestyle advice is important. Community pharmacies can also support self-care where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services.

Further information regarding the health and wellbeing of older people can be found in the 2017 Peterborough Older People's Primary Prevention Joint Strategic Needs Assessment available at: https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

Older patients are more likely to have Long-term Conditions (LTCs) and, therefore, likely to be taking medication, or several medications, to treat these conditions. These patients have a particular need to understand the role medicines play in managing their condition in order to gain maximum benefit and reduce the potential for harm. Health campaigns aimed at improving medicines-related care for people with LTCs and, therefore, reducing emergency admissions, could also be provided through community pharmacies. Community pharmacists could be involved in monitoring the use of, for example: statins, blood pressure regulating medication and supplementary prescribing, making adjustments to the treatment being received by the patient. In addition, pharmacists and their staff already provide a signposting service to other sources of information, advice or treatment. The recent evidence review published in the Murray report found there is evidence supporting a wider role for pharmacies in supporting patients with long-term conditions and one of its key recommendations is integrating community pharmacists and their team into long-term condition management pathways.[47]

[45] NHS England. 'Five Year Forward View' (October 2014). Available at: https://www.england.nhs.uk/publication/nhs-five-year-forward-view/
[46] NHS England 'General Practice Forward View' (April 2016) Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

[47] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 19. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

Evidence shows that deprived populations often experience poor health outcomes including low life expectancy.[48] The prevalence of lifestyle-related conditions, as well as long-term conditions, are more prevalent in more deprived populations. Community pharmacies are easily accessible and can offer a valuable opportunity for reaching people who may not otherwise access health services. Pharmacy support for the public health and prevention agenda could, therefore, be especially valuable in more deprived communities or for vulnerable groups who have a variety of poorer health outcomes (e.g. migrant workers, traveller communities, ethnic minorities, older people). Community pharmacies can be involved in addressing health inequalities and targeting initiatives and resources to improve the health of the poorest, fastest.

5.5.1 Promoting Healthier Lifestyles

There are a wide range of opportunities for pharmacies to promote healthier lifestyles which could involve: motivational interviewing, providing education, information and brief advice, providing on-going support for behaviour change and signposting to other services or resources.

Across England, over 2,100 pharmacies were accredited or en route to be accredited as 'Healthy living Pharmacies' in January 2016[49]. The 'Healthy Living Pharmacy (HLP)' framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. Evaluations of Healthy Living Pharmacies (HLP) have demonstrated an increase in successful smoking quits, extensive delivery of alcohol brief interventions and advice, emergency contraception, targeted seasonal flu vaccinations, common ailments, NHS Health Checks, healthy diet, physical activity, healthy weight and pharmaceutical care services.[50] [51]

Achieving HLP level 1 (self-assessment) is also now a quality payment criterion for the Quality Payments Scheme 2017/18, introduced by the DoH as part of the Community Pharmacy Contractual Framework in 2017/18.[52] This will involve payments being made to community pharmacy contractors that meet certain quality criteria. The inclusion of the HLP accreditation emphasises the national expectation of pharmacies to take an active role in public health and the promotion of healthy lifestyles.

The HLP framework is underpinned by three enablers:[53]

- Workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and wellbeing.
- Premises that are fit for purpose.
- Engagement with the local community, other health professionals (especially GPs), social care and public health professionals and local authorities.

[48] Marmot, M et al. 'The Marmot report- Fair society, healthy lives'. Feb 2010. University College London (Accessed November 2016). Available at: http://www.instituteofhealthequity.org/
[49] http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/
[50] University of Bradford. 'Evaluation of the West Yorkshire Healthy Living Pharmacy Programme' (Jan 2016). Available at: http://www.cpwy.org/doc/973.pdf
[51] Mohan L, McNaughton R & Shucksmith J. Teeside University. 'An Evaluation of the Tees Healthy Living Pharmacy Pilot Scheme' (2013) Available at: https://www.networks.nhs.uk/nhs-networks/hlp-pathfinder-sites/messageboard/hlp-forum/358672516/600199395/healthy-living-pharmacy-electronic-3-pdf
[52] Public Health England. 'Healthy Living Pharmacy Level 1 Quality Criteria Assessment of Compliance Healthy Living Pharmacy (HLP) Level 1' (2016). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538638/HLP-quality-criteria-and-self-assessement-process.pdf
[53] PSNC Website. 'Healthy Living Pharmacies" Available at: http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

In July 2016 the Pharmacy and Public Health Forum, accountable to Public Health England, developed a profession-led self-assessment process for level 1 HLPs, based on clear quality criteria and underpinned by a proportionate quality assurance process. 'Achieving level 1 Healthy Living Pharmacy status will require pharmacies to adopt a pro-active health promoting culture and environment within the pharmacy, with all the requirements of the quality criteria satisfied. These include understanding local public health needs, creating a health and wellbeing ethos, team leadership, communication, community engagement and having a health promoting environment.[54]

In terms of what patients or customers can expect from a HLP, the Pharmaceutical Services Negotiating Committee (PSNC) states that 'The public may feel the difference when entering an HLP; the Health Champion and other staff may proactively approach them about health and wellbeing issues and will know about local services for referral or signposting. If a health trainer service exists locally then Health Champions can extend their reach. There will be a health promotion zone and there should be a health promotion campaign running linked into local priorities and health needs'.

In Peterborough, all of the community pharmacies that responded to the PNA questionnaire have either achieved Healthy Living Pharmacy status or are working towards it. 5 pharmacies (14% of respondents) have achieved Healthy Living Pharmacy status and 32 (86% of respondents) are working towards achieving Healthy Living Pharmacy status.

5.5.2 Public Health Campaigns

At the request of NHS England, as part of essential service provision, NHS pharmacists are required to participate in up to six campaigns each year to promote public health messages to their users. Where requested to do so by NHS England, the NHS pharmacist records the number of people to whom they have provided information as part of one of those campaigns. All 37 of the community pharmacies in Peterborough that responded to the PNA questionnaire reported that they participate in the contracted annual six Public Health campaigns. Public health campaigns in Peterborough that have been carried out in 2016/17 included the following themes:

May: Mental Health

July: Change 4 Life

September: Influenza

October: Stoptober

December: Sexual Health

January: Alcohol

Typically, each pharmacy is provided with posters, leaflets and key message fact sheets as part of the campaigns. Feedback from Public Health at Peterborough City Council suggests that there has usually been good engagement from pharmacies in delivering these campaigns.

Pharmacists are also involved in the early detection of some cancers, for example, through the provision of advice on skin care and sunbathing and participating in the national Be Clear on Cancer campaign,[55] which

[54] PSNC Briefing. 'Healthy Living Pharmacies: Information for Local Authorities' (May 2015) Available at: http://psnc.org.uk/wp-content/uploads/2013/08/LA_HLP_briefing_May2015.pdf

[55] More information on 'Be Clear on Cancer' homepage, available at: http://www.cancerresearchuk.org/health-professional/awareness-and-prevention/be-clear-on-cancer

aims to improve early diagnosis of cancer by raising awareness of symptoms and making it easier for people to discuss them with their GP.

5.5.3 Promotion of Healthy Lifestyle & Supportive Services (Non-Commissioned)

97% of community pharmacies (36/37) who responded to the PNA questionnaire stated that they had consultation facilities on site and 92% of respondents said that these facilities are wheelchair-accessible. 24 pharmacies stated they would be willing to undertake consultations in a patient's home or other suitable area if commissioned to provide this service.

32 community pharmacies (87% of responding pharmacies) stated that they considered 'availability of information and advice about medicines and how to use them' as an important feature of the pharmaceutical service they provided.

With regard to promotion of healthy lifestyle and disease specific medicines management, a substantial proportion of community pharmacies have expressed interest in providing additional services relating to disease-specific management, screening and vaccinations if commissioned.

Only one pharmacy In Peterborough stated they currently provide related services (for Alzheimer's/Dementia, asthma and COPD); however, between 29 and 31 pharmacies (78%-81%) said they would be willing to provide disease specific medicines management services for any/all of the below conditions:

- Allergies
- Alzheimer's/Dementia
- Asthma
- CHD
- COPD
- Depression
- Diabetes (Type 1/Type 2)
- Epilepsy
- Heart Failure
- Hypertension
- Parkinson's Disease

One pharmacy (3% of responding pharmacies) stated that they provide a diabetes screening service and one pharmacy (3%) provides an HbA1C screening service. Between 21 (57%) and 33 (89%) pharmacies expressed interest in providing some or all of the below screening services if commissioned:

- Alcohol
- Cholesterol
- Diabetes
- Gonorrhoea
- H. Pylori
- Hba1c

- Hepatitis
- HIV

Five community pharmacies in Peterborough (13% of responding pharmacies) provide travel vaccines, with a further two pharmacies (5%) providing hepatitis vaccinations for at risk workers or patients. Between 27 (73%) and 30 (81%) of pharmacies expressed interest in providing some or all of the below services if commissioned:

- Childhood vaccinations
- Hepatitis (at risk workers or patients)
- HPV
- Travel Vaccines

5.6 Locally Commissioned Services: Public Health Services

Pharmacies are able to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers. Local commissioning organisations should consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care.

Broadly, across England the following specific public health services are commissioned from community pharmacies by local authorities:[56] [57]

- **Stop smoking services**: proactive promotion of smoking cessation through to provision of full NHS stop smoking programmes.
- **Sexual health services**: emergency hormonal contraception services; condom distribution; pregnancy testing and advice; chlamydia screening and treatment; other sexual health screening, including syphilis, HIV and gonorrhoea; contraception advice and supply (including oral and long acting reversible contraception).
- **Substance misuse services**: needle and syringe services; supervised consumption of medicines to treat addiction e.g. methadone; hepatitis testing and Hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situation.
- **NHS Health Checks for people aged 40 – 74 years:** carrying out a full vascular risk assessment and providing advice and support to help reduce the risk of heart disease, stroke, diabetes and obesity.
- **Weight management services:** promoting healthy eating and physical activity through to provision of weight management services for adults who are overweight or obese.
- **Alcohol misuse services:** providing proactive brief interventions and advice on alcohol with referral to specialist services for problem drinkers.
- **Pandemic and seasonal influenza services:** providing continuity of dispensing of essential medicines, provision of antiviral medicines and influenza vaccination services.

The following local services are **currently commissioned in Peterborough**:

- Stop smoking services (commissioned by the Public Health Joint Commissioning Unit (JCU))

[56] Pharmaceutical Services Negotiating Committee Summary of NHS Community Pharmacy services. Available at: http://psnc.org.uk/wp-content/uploads/2015/06/CPCF-summary-June-2015.pdf
[57] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

- Emergency hormonal contraception (commissioned by the Public Health JCU, working across Peterborough City Council and Cambridgeshire County Council).
- Chlamydia screening (commissioned by the Public Health JCU)
- Alcohol and substance misuse services (commissioned by the Public Health JCU via CGL Aspire)
- Directly observed therapy service for tuberculosis (commissioned by the CCG) NB. This service will be commencing shortly.

5.6.1 Smoking cessation services in Peterborough pharmacies

- Smoking prevalence in Peterborough is statistically similar to the England average, with 18% of over 18 year olds estimated to smoke. This equates to 26,474 (Office for National Statistics, mid-year population estimates) smokers in Peterborough.
- Around 1,470 deaths occur in Peterborough each year (Office for National Statistics, Death Registrations 2013-15), of which around 260 (18%) are attributable to smoking (Public Health England, Local Tobacco Control Profiles 2013-15).

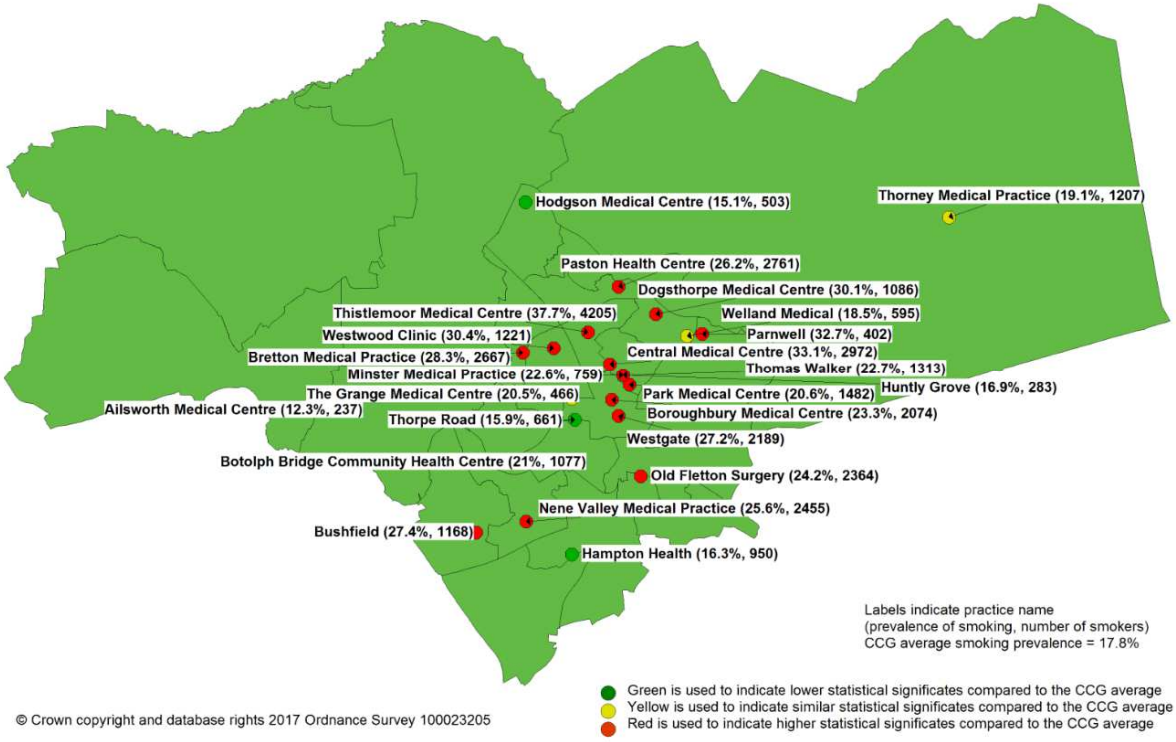
Figure 22: Estimated Smoking Prevalence and Number of Smokers Aged 18+, Peterborough with five CIPFA nearest neighbours, East of England & England 2015

Local authority	Smoking Prevalence (18+, %)	95% Confidence Interval	Estimated number of smokers*
Peterborough	18.1	15.9 - 20.3	26,474
Thurrock	21.3	18.8 - 23.7	26,465
Swindon	18.7	16.5 - 20.9	31,441
Milton Keynes	16.4	14.3 - 18.5	32,085
Coventry	16.6	14.5 - 18.8	44,870
Bolton	18.5	16.2 - 20.7	39,820
East of England	16.6	16 to 17.2	792,894
England	16.9	16.7 to 17.1	7,285,332

* Number of smokers estimated by applying the point estimate of prevalence to local population estimates

Sources: Public Health England - Local Tobacco Control Profiles (Annual Population Survey data - 2015), Office for National Statistics mid-2015 population estimates

Figure 23: Recorded smoking prevalence and number of smokers by practice, Peterborough



Smoking prevalence is notably higher than the Peterborough average among practice populations towards the centre of Peterborough, which contains some of the most relatively deprived parts of the city. Prevalence is lower in the outer areas of Peterborough, which tend to be less deprived than central areas.

The primary care based Stop Smoking Service in Peterborough can improve population health through smoking cessation services, as evaluated by NICE.[58] Evidence for the effectiveness of pharmacies in contributing to smoking cessation has also led to a recommendation in the 'Community Pharmacy Clinical Services Review' for smoking cessation services to be considered an element of the national contract.[59]

The Public Health Joint Commissioning Unit (JCU), working across Peterborough City Council and Cambridgeshire County Council, currently commission nine GP practices and 15 pharmacies to deliver specialist stop smoking clinics under their Local Incentivised Scheme (LIS). In addition, the Public Health JCU commission Solutions 4Health to deliver specialist stop smoking clinics across a further 10 GP practices. This is offered as part of an integrated model of delivery which also supports people to address other lifestyle issues. This integrated model is delivered through a specialist Health Trainer service and currently 14 GP practices offer this to their patients. All specialist advisers are trained to National Centre for Smoking Cessation (NCSCT) standards to deliver the National Standard Treatment programme. The level 2 service consists of one to one advice and behavioural support for smokers over the age of 12 years who live or work in Peterborough. The programme lasts up to 12 weeks and the behavioural support is used alongside medication treatments via NHS prescription, with outcomes measured four weeks after setting a 'quit date'.

In Peterborough, individuals who access pharmacy-based stop smoking services are able to obtain and use nicotine replacement therapy (NRT) medications and these can be directly supplied by the pharmacy. Other

[58] https://www.nice.org.uk/guidance/pH10
[59] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 19. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

medications such as Champix (Varenicline) or Zyban (Bupropion) would need to be obtained via prescription from their GP practice.

The number of pharmacies actively participating in the delivery of stop smoking services has reduced significantly. In 2011/12 there were 27 pharmacies signed up to the LIS contract and there are currently only 15. Since the delivery of smoking services by pharmacies commenced, their contribution towards the quit target has reduced significantly to 10% in 2014/15 and to 9% in 2016/17. However, quality has been a concern with some of these data. The 'lost to follow up rate' (clients who have set a quit date but not been followed up after four weeks) in Peterborough should be lower than 20% to reassure data quality. However, in 2015/16 the rate for Peterborough community pharmacies was 26% and for 2016/17 it was 25%, meaning that there is a higher than average number of clients where final smoking status is unknown.

Figure 24: Stop Smoking Service Activity – Number of Quits by Provider, Peterborough 2009/10 – 2016/17

Year	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Total quits	1218	989	1156	1330	1367	955	708	656
GP	93	148	164	198	212	161	100	93
Stop Smoking Services	447	292	507	771	880	651	466	414
Community Pharmacy	651	541	484	346	265	143	141	130
Prison	27	8	1	15	10	0	1	19

Source: Peterborough City Council Joint Commissioning Unit 'Quit Manager' Data

The percentage of quitters in Peterborough who quit through a general practice setting for 2015/16 was 29% and for 2016/17 was 24%. However, this is based on the delivery in GP practices by both the LIS contracted provider and services delivered by the Public Health Delivery team. When basing this target on delivery through LIS contractors, percentages alter to 7% and 6% respectively. This is based on the overall target of 1,434**.**

Figure 25: Stop quits by intervention setting, Peterborough and England, 2015/16

Intervention Setting	Peterborough				England	
	Number setting a quit date	Number of successful quitters	Quit Rate (%)	Percentage of quitters	Quit rate (%)	Percentage of quitters
Children's Centre	0	0	-	0.0	42	0.3
Community	70	64	91	9.1	56	31.4
Community psychiatric	0	0	-	0.0	44	0.1
Dental	0	0	-	0.0	48	0.0
General practice	507	411	81	58.2	49	35.9
Hospital	55	50	91	7.1	58	3.3
Maternity	0	0	-	0.0	42	0.7
Military base	0	0	-	0.0	50	0.2
Pharmacy	230	139	60	19.7	46	17.9
Prison	3	1	*	0.1	45	2.2
Psychiatric hospital	0	0	-	0.0	37	0.1
School	39	33	85	4.7	57	0.7
Workplace	7	7	*	1.0	57	0.8
Other	1	1	*	0.1	58	5.7
All intervention settings	912	706	77.4	100	51.0	100

*suppressed where the denominator is greater than 0 and less than 20, as it is deemed the resulting percentage output is not robust enough for comparative purposes.

(Source: NHS Digital. Statistics on NHS Stop Smoking Services: England, April 2015 to March 2016)

Community pharmacies remain well-placed to ensure the services are accessible to the smoking population, particularly with many offering extended opening hours. Eight pharmacies (21.6% of questionnaire respondents) stated that they currently provide a stop smoking service and a further 19 pharmacies (51.4%) stated they would be willing to provide the stop smoking service if commissioned to do so. The decision to offer these services remains with individual pharmacies, with commissioning decisions dependent on the willingness to train staff, undertake clinics within the pharmacy and maintain compliance to standards and contractual requirements.

Provision of commissioned smoking cessation services in pharmacies across Cambridgeshire and Peterborough are currently under review to address service provision and the identified quality concerns.

5.6.2 Sexual Health Services in Peterborough Pharmacies

5.6.2.1 Emergency Hormonal Contraception (EHC) and Chlamydia Screening

Reducing the teenage conception rate and increasing the number of teenage parents who can access and sustain places in education, employment or training are important to improve outcomes for young people and their babies.[60]Studies indicate that making emergency hormonal contraception (EHC) available over the counter has not led to an increase in its use, to an increase in unprotected sex, or to a decrease in the use of more reliable methods of contraception.[61] Peterborough has a teenage conception rate (28.3/1,000) that is statistically significantly higher than England (20.8/1,000) and this rate has been statistically significantly higher for each of the four years 2012 – 2015.

EHC may only be supplied by an accredited pharmacist. In order to achieve accreditation, the pharmacist(s) must have satisfactorily completed the Centre for Pharmacy Postgraduate Education (CPPE) Emergency Hormonal Contraception distance learning package. Medicine counter staff must be trained to refer each request for EHC to the pharmacist(s). It is the responsibility of the pharmacy to ensure that all pharmacists and locums supplying EHC are accredited. The pharmacy must be able to supply EHC during opening hours of the pharmacy on at least four days of the week, one of which will preferably be a Saturday. Anyone accessing the service will need to check with the pharmacy that they have an accredited pharmacist available.

Pharmacies in Peterborough are offered the opportunity to receive training and be contracted to provide EHC, which is available as a locally commissioned service in some community pharmacies. Ideally, community pharmacies would have more than one pharmacist available to provide EHC to ensure continuity of services. In addition, pharmacies could promote the availability of free EHC.

The EHC service in Peterborough pharmacies commenced in late 2016/17 and there are currently 12 pharmacies contracted to deliver this service.

It is advised to offer chlamydia screening at the time of EHC provision because those who require EHC contraception are highly likely to be at risk of infection. As part of the EHC service a chlamydia screening kit is offered to the service user. iCaSH Peterborough, the integrated contraception and sexual health service provided by Cambridgeshire Community Services NHS Trust, provides chlamydia kits and staff training. The pharmacy needs to provide a suitable consultation room to be eligible for this scheme.

Chlamydia screening is not provided by pharmacies outside of the EHC service. Pharmacies can signpost those requesting chlamydia screening to iCaSH Peterborough.

5.6.2.2 Alcohol and substance misuse services

- Illicit drug use contributes to the disease burden both globally and in Peterborough. Efficient strategies to reduce disease burden of opioid dependence and injecting drug use, such as the delivery of opioid substitution treatment and needle and syringe programmes, are needed to reduce this burden at a population scale.[62]

[60] Peterborough Children & Young People's JSNA, https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/ChildrenAndYoungPeopleJSNA-June2015.pdf?inline=true

[61] Marston C. (2005) 'Impact on contraceptive practice of making emergency hormonal contraception available over the counter in Great Britain: repeated cross sectional surveys.' *BMJ* 331: 271.

[62] Degenhart L et al. 'Global burden of disease attributable to illicit drug use and dependence: findings from the Global Burden of Disease Study 2010'. *Lancet* 2013; e-pub 29 Aug. Available at: http://www.sciencedirect.com/science/article/pii/S0140673613615305

- There were 31 drug-related deaths in Peterborough in 2013 - 15, equivalent to a crude rate per 100,000 population of 5.3/100,000. This compares unfavourably with neighbouring Cambridgeshire, within which there were 60 deaths over the same period, representing a crude rate of 3.2/100,000. Since 2001-03, the crude rate in Peterborough was at its highest in 2007-09 (5.9/100,000), however the 2013-15 Peterborough rate of 5.3/100,000 is the highest since 2008-10 (5.8/100,000).

Figure 26: Drug Related Deaths, Crude rate per 100,000 Population, Peterborough, Cambridgeshire, East of England & England, 2001-03 – 2013-15

Pooled Period	Peterborough Number of Drug Related Deaths	Cambridgeshire Number of Drug Related Deaths	Peterborough crude rate per 100,000 population	Cambridgeshire crude rate per 100,000 population	East of England crude rate per 100,0000	England crude rate per 100,000
2001-03	22	48	4.6	2.7	2.5	3.0
2002-04	25	46	5.2	2.6	2.4	2.8
2003-05	19	40	3.8	2.2	2.4	2.8
2004-06	18	47	3.5	2.6	2.3	2.9
2005-07	18	48	3.3	2.6	2.3	3.0
2006-08	30	55	5.6	3.0	2.5	3.2
2007-09	32	48	5.9	2.6	2.8	3.4
2008-10	32	51	5.8	2.7	2.8	3.4
2009-11	26	50	4.6	2.7	2.7	3.2
2010-12	26	50	4.4	2.6	2.6	3.0
2011-13	23	49	3.7	2.6	2.7	3.1
2012-14	22	52	3.6	2.8	3.0	3.4
2013-15	31	60	5.3	3.2	3.4	3.9

Source: Office for National Statistics, Deaths related to drug poisoning in England/Wales, 2001-2015

Data from the Crime Survey for England 2015-16 suggests 18.0% of 16-24 year olds and 8.4% of 16-59 year olds have used an illicit drug at least once in the past year, whilst 4.7% of 16-24 year olds and 3.3% of 16-59 year olds regularly use illicit drugs at least once per month. Applied to Office for National Statistics mid-year population estimates for 2015, this equates to 3,689 16-24 year olds and 9,559 16-59 year olds in Peterborough who have used in the past year and 963 16-24 year olds and 3,755 16-59 year olds who regularly use illicit drugs at least once a month.

Figure 27: Estimated Numbers Using Illicit Drugs, Peterborough 2015-16

Area	Used in last year		Regularly using more than once a month	
	16-24	16-59	16-24	16-59
Peterborough	3,689	9,559	963	3,755

Sources: Crime Survey for England 2015-16, Office for National Statistics Mid-Year Population Estimates

In Peterborough, drug and alcohol services are commissioned by the Public Health Joint Commissioning Unit and delivered by CGL Aspire. The service is a fully integrated treatment system which includes:

- Adult drug and alcohol treatment
- Treatment for young people
- Needle exchange and supervised consumption
- Access to tier 4 detox and rehabilitation

People who use illicit drugs are often not in contact with health care services and their only contact with the NHS may be through a needle exchange service within a community pharmacy. At a minimum, the pharmacy can provide advice on safer injecting and harm reduction measures. In addition, community

pharmacies can provide information and signposting to treatment services, together with information and support on health issues other than those that are specifically related to the client's addiction.

Once clients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Clients often need support to prevent them stopping treatment.

- ***Needle and syringe exchange service***

CGL Aspire, commissioned by the Public Health Joint Commissioning Unit (JCU) which works across Peterborough City Council and Cambridgeshire County Council, contracts community pharmacies to provide access to sterile needles and syringes and sharps containers for return of used equipment. Where agreed locally, associated materials will be provided (for example condoms, citric acid and swabs) to promote safe injecting practice and reduce transmission of infections by substance misusers.

The service provides support and advice to the user, including referral to other health and social care professionals, specialist drug and alcohol treatment services where appropriate and promotes safe practice to the user, including advice on sexual health, STIs, HIV and Hepatitis C transmission and Hepatitis B immunisation.

The contracted pharmacies provide a sufficient level of privacy and safety and have a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service, including allocation of a safe place to store equipment and returns for safe onward disposal. Storage containers provided by the Specialist Drug Treatment commissioned clinical waste disposal service are used to store returned used equipment.

23 pharmacies in Peterborough are currently contracted to provide a needle exchange service. In 2016/17, this service was provided to 589 clients, of which the majority (521, 88%) were male. In total, there were 1,050 visits made to needle exchange services in Peterborough at pharmacies in 2016/17.

- ***Supervised administration service***

This service requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient. Contracted pharmacies aim to offer a user-friendly, non-judgemental, client-centred and confidential service. They provide support and advice to the patient, including referral to primary care or specialist centres where appropriate. Examples of medicines which may have consumption supervised include methadone, other medicines used for the management of opiate dependence and medicines used for the management of mental health conditions or tuberculosis. Terms of agreement are set up between the prescriber, pharmacist, patient and patient's key worker – a four way agreement – to decide how the service will operate, what constitutes acceptable behaviour by the client and what action will be taken by the specialist drug treatment service and pharmacist if the user does not comply with the agreement.

The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service and are aware of and operate within local protocols. The pharmacy contractor must maintain appropriate records

to ensure effective on-going service delivery and audit and share relevant information with other health care professionals and agencies, in line with locally determined confidentiality arrangements.

23 community pharmacies currently offer supervised administration services in Peterborough. In 2016/17, an average of 271.4 people per month were on supervised consumption. This equates to an average of 51% of the number of prescribed clients in Peterborough.

Testing for Hepatitis B and Hepatitis C and vaccination against Hepatitis B in community pharmacies are opportunities that could potentially be explored and piloted if it seems feasible to put the necessary systems in place. The aim of such an initiative would be to facilitate access to services and thereby provide earlier diagnosis and/or protection, in a group that is both at high risk and hard to reach. In addition, in some cases a local pharmacy could, through independent or supplementary prescribing and Patient Group Directions (PGDs), provide support to the clients. This could cover both advice and immunisation to protect the person from diseases or blood-borne viruses.

- ***Naloxone kits***

Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone, morphine and fentanyl). 16 pharmacies in Peterborough are contracted via CGL Aspire to issue naloxone kits with training to all substance misuse clients (those accessing supervised administration or needle exchange services). The pharmacies can issue the naloxone kits to clients' friends and relatives, and others who may require one, such as a hostel manager. Pharmacies are also able to refer clients into treatment services provided by CGL Aspire.

As at 29 September 2017, 186 naloxone kits with training had been issued since the service commenced.

- ***Blood borne viruses screening***

Nine pharmacies are contracted via CGL Aspire to provide screening for Hepatitis B virus and Hepatitis C virus to clients at risk, identified by CGL Aspire. Screening involves a finger prick blood sample being taken and aims to ensure timely diagnosis and access to treatment.

As at 29 September 2017, 46 blood borne virus tests had been carried out since the service commenced.

- ***Alcohol brief interventions***

Similarly to the substance misuse services, 16 pharmacies in Peterborough are contracted via CGL Aspire to provide alcohol brief intervention services. Pharmacies offer this service to all customers; customers are asked three screening questions and, depending on their score, may be asked additional questions about their alcohol consumption and have a brief intervention carried out. They may also be referred to CGL Aspire specialist services if appropriate.

As at 29 September 2017, 1,008 screens, 160 brief interventions and 33 referrals had been carried out since the service commenced.

5.7 Locally Commissioned Services Commissioned by Cambridgeshire & Peterborough CCG

5.7.1 Directly Observed Therapy (DOT) Service for Tuberculosis Treatment

Cambridgeshire & Peterborough Clinical Commissioning Group will be commissioning a limited number of pharmacies across Cambridgeshire and Peterborough to deliver a directly observed therapy service specifically for patients with tuberculosis. The service will work closely with the hospital tuberculosis service, who provide training and supervision via tuberculosis nurse specialist(s).

As part of the provision of DOT, pharmacies will ensure that appropriate drugs are given individually three times per week (Monday, Wednesday and Friday) and the patient is observed taking them. They will be required to monitor all attendances and inform the relevant NHS Foundation Trust of non-attendance.

5.7.2 Pharmacy Support in Care Homes

Medication errors in care homes for older people can be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. The CCG employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with GP practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste. As part of the pharmacy integration fund, NHS England is looking to support community pharmacists working in care homes to ensure that medication is used in the most appropriate way. It is expected that there will be 150 community pharmacists supported to deliver this workstream nationally. It is not yet known how many pharmacists will be involved locally in Peterborough.

In the pharmacy questionnaire, 12/37 pharmacies reported that they currently supply medicines to care homes. No pharmacies reported that they provide a care home service but 18 (48.6%) indicated that they would be willing to provide this as a commissioned service.

5.7.3 Community Pharmacy Minor Ailments Service

There is currently no minor ailment scheme commissioned to be provided by Peterborough pharmacies, although 87% of community pharmacies (32/37) who responded to the PNA community pharmacy questionnaire stated they would be willing to provide the service if commissioned.

The service aimed to provide greater choice for patients and carers and improved access to health care professionals by utilising the expertise of the pharmacists so they become the first port of call for minor ailments.

There is now a national commitment that a minor aliments scheme should be commissioned locally across England by April 2018, although there is debate over whether this needs to be a nationally commissioned service by NHS England or commissioned locally by CCGs.[63]

5.8 Healthcare Services Commissioned by NHS England

There are opportunities for local service commissioning to build on the services provided as essential services to assist in proving effective, integrated healthcare services. A wide range of services are described in the Drug Tariff which are locally commissioned across England including:[64]

- Minor ailments management
- Palliative care services
- Care home services
- Head lice management services
- Gluten free food supply services
- Services to schools
- Out-of-hours services
- Supplementary and independent prescribing by pharmacists
- Medicines assessment and compliance support

[63] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 19. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[64] Pharmaceutical Services Negotiating Committee Summary of NHS Community Pharmacy services. Available at: http://psnc.org.uk/wp-content/uploads/2015/06/CPCF-summary-June-2015.pdf

5.8.1 Dispensing Review of Use of Medicines

As part of the contractual arrangements for dispensing doctors, a 'Dispensary Services Quality Scheme' (DSQS) rewards dispensing GP practices for providing high quality services to their dispensing patients. As part of the DSQS, dispensing staff are trained to discuss issues of concordance and compliance with patients during a Dispensing Review of Use of medicines (DRUM). This is a structured review to help patients to manage their medicines more effectively. Any issues or concerns raised are then referred to the appropriate health care professional for follow up. Similar to pharmacy MURs, dispensary DRUMS are designed to improve the patient's understanding of the importance of the medicine in controlling their disease and the reason for taking medicine appropriately. These can improve patient concordance and support and reinforce the advice given by the prescriber.

5.9 Healthcare services commissioned by other organisations in primary and secondary care

5.9.1 Healthcare associated infections

Pharmacy providers are involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C Difficile. Senior specialist antimicrobial pharmacists within hospitals, primary care trust pharmacists and microbiology/infectious diseases/infection control teams must work together to develop, implement and monitor antimicrobial guidelines across the local health economy. This will involve community pharmacists and GPs working together with hospital teams to align prescribing with the agreed local policy.

Within the secondary care setting, it is possible for pharmacists to lead on 'switching' policies to convert patients from intravenous therapy to oral drug therapy at the earliest appropriate opportunity.

Increasingly, patients are treated with intravenous antibiotics at home. The patient's regular community pharmacy, together with hospital pharmacy services, should be aware of and could be involved in their treatment.

Within primary care, dispensing staff are able to reinforce the message that antibiotics are not always necessary and explain the relationship between excessive use of antibiotics and Health Care Acquired Infections (HCAIs). In addition, they are able to inform other primary care practitioners when a prescribed item is not normally available in the community.

5.10 Other health advice and support services (non-commissioned)

In addition to commissioned services, our questionnaire found that community pharmacies provide a number of additional services as described in figure 28. It is important to note that the information provided in this table is self-reported information gathered via the PNA questionnaire completed by community pharmacies.

There is also potential to draw on experience from areas where community pharmacies have worked innovatively to address key local public health challenges and benefit local communities. Possible examples include work around fuel poverty, falls prevention, supporting people at risk of domestic abuse and behavioural change initiatives.

Figure 28: Enhanced & Locally Commissioned Services – Peterborough Provision

Service	Currently providing under Contract with Local NHS England Team	Currently providing under contract with Clinical Commissioning Group	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Anticoagulant Monitoring Service	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
Anti-viral Distribution Service	0 (0%)	0 (0%)	1 (3%)	29 (78%)	7 (19%)
Care Home Service	0 (0%)	0 (0%)	0 (0%)	29 (78%)	8 (22%)
Chlamydia Testing Service	2 (5%)	1 (3%)	2 (5%)	25 (68%)	7 (19%)
Chlamydia Treatment Service	0 (0%)	1 (3%)	1 (3%)	28 (76%)	7 (19%)
Contraception Service (Not Emergency Contraception)	1 (3%)	1 (3%)	1 (3%)	27 (73%)	7 (19%)
Emergency Contraception Service	4 (11%)	2 (5%)	4 (11%)	23 (62%)	4 (11%)
Emergency Supply Service	6 (16%)	1 (3%)	1 (3%)	27 (73%)	2 (5%)
Gluten Free Food Supply Service	0 (0%)	1 (3%)	0 (0%)	29 (78%)	7 (19%)
Home Delivery Service (not appliances)	11 (30%)	1 (3%)	4 (11%)	18 (49%)	3 (8%)
Independent Prescribing Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)
Language Access Service	0 (0%)	0 (0%)	0 (0%)	27 (73%)	10 (27%)
Medication Review Service	18 (45%)	2 (5%)	1 (3%)	16 (40%)	3 (8%)
Medicines Assessment & Compliance Support Service	3 (8%)	0 (0%)	0 (0%)	29 (78%)	5 (14%)
Minor Ailment Scheme	0 (0%)	0 (0%)	0 (0%)	32 (87%)	5 (14%)
MUR Plus/Medicines Optimisation Service	1 (3%)	0 (0%)	0 (0%)	31 (35%)	5 (14%)
Needle & Syringe Exchange Service	10 (27%)	2 (5%)	4 (11%)	10 (27%)	11 (30%)
Obesity Management (Adults & Children)	0 (0%)	0 (0%)	1 (3%)	28 (76%)	8 (22%)
Not Dispensed Scheme	0 (0%)	0 (0%)	0 (0%)	29 (78%)	8 (22%)
On Demand Availability of Specialist Drugs Service	0 (0%)	0 (0%)	0 (0%)	28 (76%)	9 (24%)
Out-of-hours Service	2 (5%)	0 (0%)	0 (0%)	18 (49%)	17 (46%)
Patient Group Direction Service	4 (11%)	1 (3%)	4 (11%)	25 (68%)	3 (8%)
Phlebotomy Service	0 (0%)	0 (0%)	0 (0%)	25 (68%)	12 (32%)
Prescriber Support Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)
Schools Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)
Sharps Disposal Service	0 (24%)	2 (5%)	1 (3%)	19 (51%)	6 (16%)
Stop Smoking Service	8 (22%)	2 (5%)	5 (14%)	19 (51%)	3 (8%)
Supervised Administration Service	19 (51%)	4 (11%)	4 (11%)	5 (14%)	5 (14%)
Vascular Risk Assessment Service (NHS Health Check)	0 (0%)	0 (0%)	0 (0%)	28 (76%)	9 (24%)

Service	Currently providing under Contract with Local NHS England Team	Currently providing under contract with Clinical Commissioning Group	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Supplementary Prescribing Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)

Source: Peterborough Community Pharmacy Survey 2017

Of particular note within the community pharmacy survey table above and contained within Appendix 3 is the willingness of community pharmacies to provide additional enhanced services if they were commissioned to do so. 32 respondents (87%) said they would be willing to provide a minor ailment scheme if commissioned, 30 respondents (81%) would be willing to offer anticoagulant monitoring and 29 (78%) anti-viral distribution services and a care home service if commissioned.

Additionally, at least 29 (78%) of respondents suggested they would be willing to provide disease specific management services for a range of conditions, including diabetes, hypertension, asthma and depression and over 70% of respondents would be willing to provide a range of screening/vaccination services if commissioned.

5.10.1 Community pharmacy palliative care service

Palliative care is the care of any patient with an advanced, incurable disease. It involves the control of symptoms, such as pain and aims to improve quality of life for both patients and their families. Drug treatment plays a major role in symptom control in palliative care. The aim is to ensure that appropriate palliative care drugs are available in the community at the point of need.

In this non-commissioned service, designated community pharmacies hold essential palliative care drugs for easier access. The drugs that must be held in stock by pharmacies taking part in the scheme are listed in the essential list of palliative care drugs agreed with palliative care clinicians. When pharmacies are closed Herts Urgent Care are required to meet the needs of patients for provision of essential palliative care drugs in Peterborough.

5.10.2. Electronic prescriptions

Responses to the PNA public consultation in 2014 suggested that electronic prescriptions might be beneficial to providing a good service and improve communication between GPs and pharmacies. The Electronic Prescription Service (EPS) allows the transfer of a prescription from the prescriber to pharmacy (or other dispensing contractor) by electronic means rather than the traditional paper form. The introduction and running of the EPS service is managed by an NHS department. The Murray report recommends that electronic repeat dispensing should become the default for repeat prescribing and its use should be incentivised both for community pharmacies and for GPs.[65]

In Peterborough, all community pharmacies are enabled to receive electronic prescriptions.

5.10.3 Community Pharmacy Healthy Start Service

Healthy Start is the Department of Health's scheme to help pregnant women and children under four years of age in low income families eat healthily. Women who qualify for Healthy Start, including those on certain benefits and all pregnant women under the age of 18, receive free food and vitamin vouchers. Healthy start

[65] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 19. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

provides vitamin supplements through arrangements with local community pharmacies. Pharmacy coverage is voluntary and unpaid.

The scheme helps to support breastfeeding and offers nutrition support to pregnant women and young children, including eating five a day and following a healthy diet with Healthy Start vitamins. Recipients receive weekly food vouchers to exchange for fresh and frozen fruit and vegetables, plain cow's milk and cow's milk based infant formula and vouchers every eight weeks for free vitamin supplements for children from six months until their fourth birthday and free vitamin supplements for pregnant women and women with babies up to one year old. The scheme also has the advantage of encouraging earlier and closer contact between health professionals and families from disadvantaged groups.

5.10.4 Travel immunisation clinics

Five community pharmacies (13.5%) responded to the community pharmacy questionnaire to state that they provided travel immunisation vaccinations. A further 27 (73.0%) would be willing to provide the service if commissioned.

6. Future Population Changes and Housing Growth

This section considers population changes and housing growth in Peterborough. Particular emphasis is placed on expected housing completions during 2018 to 2021, which is the three-year period before the PNA will need to be updated.

6.1 Summary of key findings

Over the coming years the population in Peterborough is expected to both age and grow substantially in numbers. An increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. Several large-scale housing developments are in progress and considerations, when assessing needs for local pharmaceutical service providers, should be based on a range of local factors specific to each development site.

To facilitate commissioning of pharmaceutical services responsive to population needs, the Health and Wellbeing Board partners will, in accordance with regulations, monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmaceutical services provision might be required.

6.2 Population changes in Peterborough

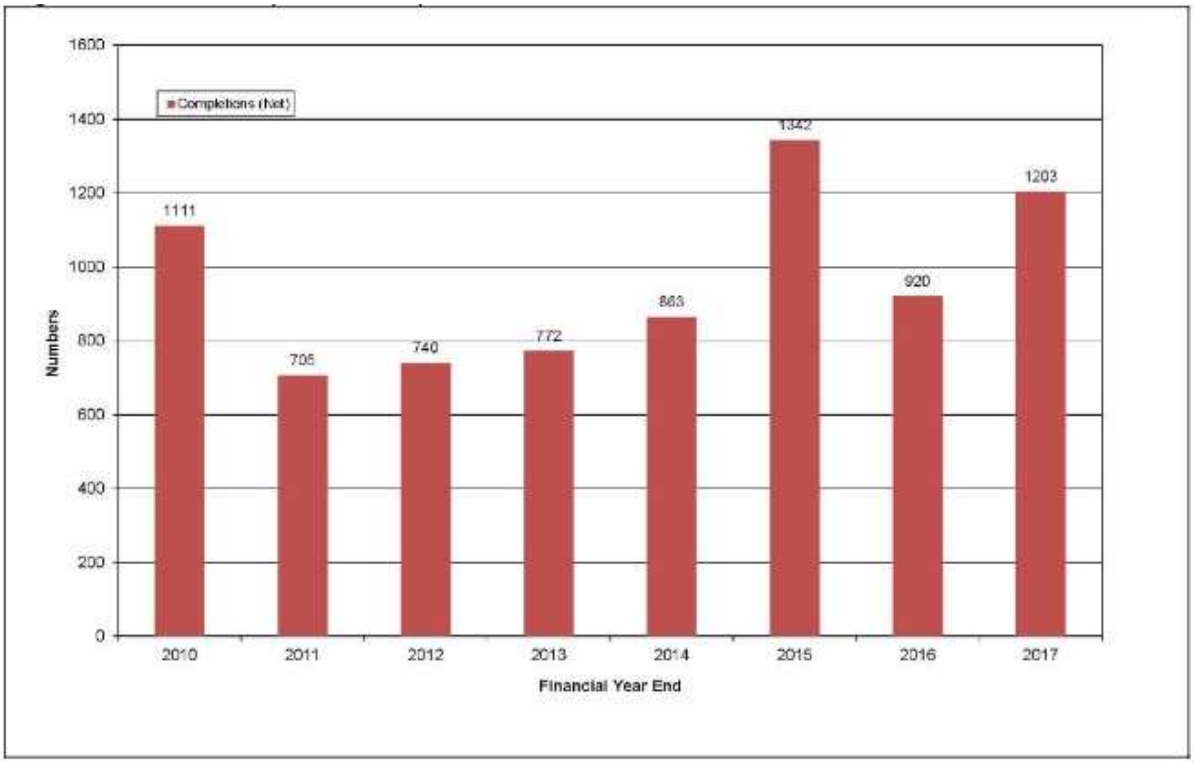
The population of Peterborough was 198,130 in 2016 and is expected to increase by approximately 18,290 (9.2%) to 216,420 by 2021.

The adult population (age 18 to 64) in Peterborough is expected to increase by 8.0% between 2016 and 2021. The number of people in Peterborough aged over 65 years is expected to increase by 14.1% between 2016 and 2021.

6.3 Housing growth

Peterborough has continued to see housing growth, with 1,203 net completions within the authority area between 1 April 2016 and 31 March 2017, of these 177 (14.7%) were built in urban extensions, 888 (73.2%) were built in the rest of the urban area, with 146 (12.1%) built in the rural area.

Figure 29: Net completions April 2009 to March 2017



Source: Peterborough City Council Internal Data

The 2013 update of the Strategic Housing Market Assessment (SHMA) proposes a total of 27,625 new dwellings in Peterborough from 2011 to 2031.

Figure 30: **Dwelling Completions (NET) in Peterborough and Cambridgeshire**

Area	2013-2014	2014-2015	2015-2016
Peterborough	863	1342	920
Cambridgeshire	3,176	2,812	2,540

NET completions include all dwelling gains in monitoring year minus the losses (demolitions, etc)
Source: Housing Development in Peterborough District 1 April 2016 to 31 March 2017

Figure 31 describes dwelling commitments in Peterborough (commitments include those with outline planning permission, and full/reserved permissions).

Figure 31: Dwelling Commitments in Peterborough at 31 March 2017

Outline planning permission	Full / Reserved Matters permission, Not Started	Total Commitments
5,295	2,893	8,188

Source: Housing Development in Peterborough District 1 April 2016 to 31 March 2017

6.4 Dwellings with Planning Permission Outstanding.

Outstanding permissions are composed of:

a) Dwellings not yet completed on sites currently under construction.
b) Dwellings on sites where no development activity has occurred.

At 31 March 2017 there were 8,188 dwellings with outstanding planning permission. Of the unimplemented permissions 2,893 had full permission and 5,295 had outline permission. Of the outline

permissions 3,675 (69.4%) are located in urban extensions, 2,349 at Hampton, 963 at Paston Reserve and 363 at Stanground South.

Outstanding permissions give some indication of where future development may occur; although not all applications will be implemented. The wards and parishes with the greatest number of outstanding permissions are set out in the table below: -

Figure 32: Wards and parishes with the greatest number of outstanding permissions, as at 31 March 2017

Location of Outstanding Permissions at 31 March 2017	
Urban Wards	
Hargate and Hempsted	3,336
Hampton Vale	1,196
Gunthorpe	971
Central	672
Stanground South	668
Fletton and Stanground	313
Fletton and Woodston	116
Rural Parishes	
Thorney	202
Eye	134
Barnack	82
Newborough and Borough Fen	58
Glinton	44

Source: Housing Development in Peterborough District 1 April 2016 to 31 March 2017

All other urban wards have fewer than 100 dwellings with outstanding permission and rural parishes have fewer than 30 dwellings outstanding.

6.5 Growth during the PNA period (2018 – 2021)

The Peterborough Core Strategy makes provision for an annual equivalent of 1,500 net new dwellings for the period 2009-2026. The greater proportion of these are planned to be delivered within the urban extensions of Peterborough. Urban extensions can take many years in the planning system before delivering new homes. In Peterborough there are five urban extensions:

- Hampton, started in 1997, and during this PNA period is likely to increase by another 1200 dwellings.
- Paston Reserve, started in 2008/09, and during this PNA period is likely to increase by another 520 dwellings.
- Stanground South, started in 2010, and during this PNA period is likely to increase by another 600 dwellings.
- Great Haddon, which has not gained planning permission at the time of this PNA but at the end of the PNA period may have 600 completed dwellings.
- Norwood, which has not gained planning permission at the time of this PNA but at the end of the PNA period may have 150 completed dwellings.

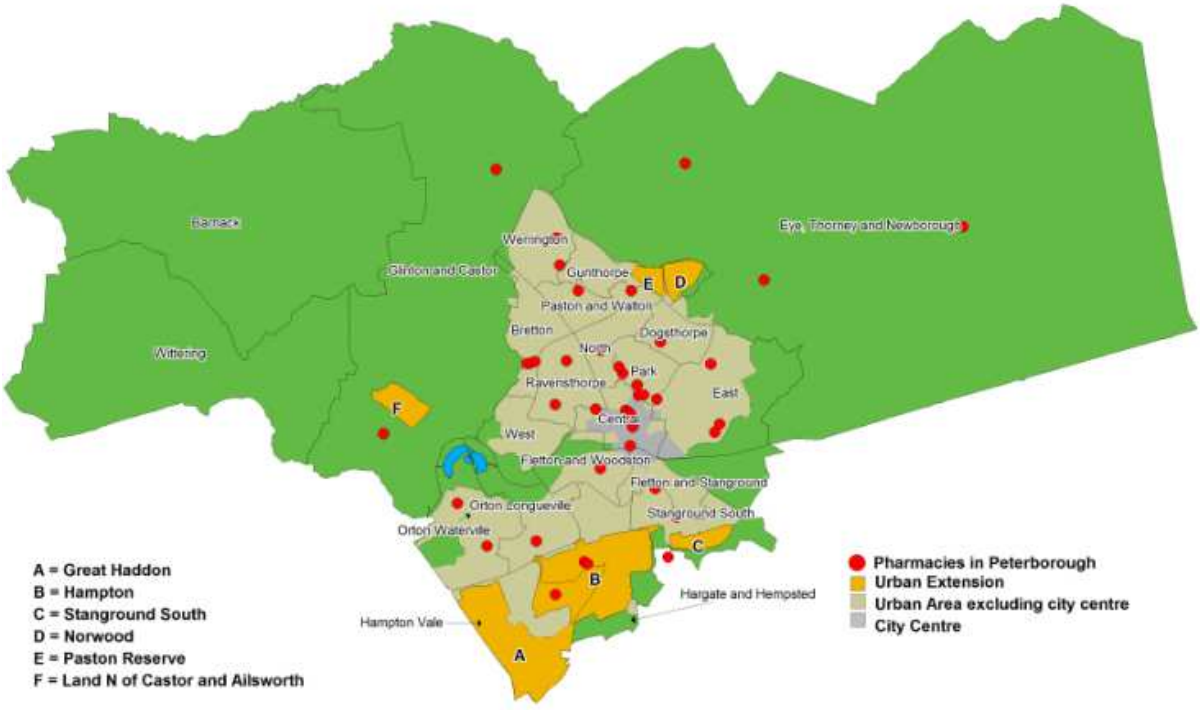
Figure 33 shows the location of major developments in Peterborough between 2009 and 2026.

Figure 33: Location of major developments in Peterborough (2009 to 2026)

Site/Location	Minimum Number of Dwellings at 2009	% of Minimum delivered	Completions since 2009 (NET)	Outstanding Permissions/allocations
City of Peterborough (39%)				
City Centre	4300	17	1418	2343
District Centres	1300	5	391	1118
Peterborough Urban Area	4400	17	2506	2139
				Urban Extensions (57%)
Hampton	4100	16	1040	3569
Paston Reserve	1200	5	371	963
Norwood	2300	9	0	2300
Stanground South	1500	6	1196	515
Great Haddon	5300	21	0	5960
				Villages (4%)
Key Service Centres	600	2	432	330
Limited Growth Villages	4500	2	205	381
Small Villages	50	0	70	21
The Countryside	0	0	23	10
TOTAL (100%)	25000	30	7652	19649

Source: Source: Housing Development in Peterborough District 1 April 2016 to 31 March 2017

Figure 34: Strategic Growth Sites & Pharmacies, Peterborough (as of September 2017)



Source: Peterborough City Council Internal Data/NHS England Pharmacy Data

6.6 Growth after 2021

After 2021, there are likely to be additional sites that need to be taken account of in future PNAs.

6.7 Monitoring of housing developments and needs for pharmaceutical services

In addition to the growing and ageing population, the large-scale housing developments in progress can impact on the need for pharmaceutical services in their area in the future.

The HWB has considered ways of monitoring the progress of planned housing developments in relation to need for pharmaceutical services.

6.7.1 Monitoring of housing developments

Peterborough City Council Business Intelligence team publishes regular updates on the status of major housing developments in Peterborough. This information will be used to inform monitoring of need for pharmaceutical services before the next PNA is published.

In addition to monitoring individual housing sites, it may be necessary to monitor cumulative developments across several sites; i.e. if a number of smaller developments are built in an area then future completions may be worth monitoring by town/village/vicinity to pharmacies as well as just by individual housing developments. This might be particularly relevant where the ratio of pharmacies to people is already above or below average.

6.7.2 Effect of Growth on a Reserved Location

A reserved location is an area within a controlled locality where the total of all patient lists for the area within a radius of 1.6km (1 mile) of the proposed premises or location is fewer than 2,750.

Should the population reach or exceed 2,750 the pharmacy, if already open, can apply to NHS England for a re-determination of reserved location status. If this status is removed then, subject to the prejudice test, the normal one mile rule would apply (i.e. the doctors lose dispensing rights within a mile of the pharmacy).

6.7.3 Factors to consider in relation to needs for pharmaceutical services

In Peterborough there is currently one pharmaceutical provider per 4,409 people. The lowest concentration of pharmacies in England is one pharmacy per 4,924 people (in Wessex) and the highest concentration is one pharmacy per 3,768 people (Cheshire and Merseyside).

According to the 2011 Census the average number of people per household in East of England is 2.3-2.4 (the average for England is 2.3). However, analysis undertaken by Cambridgeshire Research Group, to forecast the population of new developments in Cambridgeshire, suggested that it is reasonable to assume an average household size of 2.5 people. Note that the average household size in the new developments tends to be larger than the standard multiplier used of 2.5, with some growth sites in Cambridgeshire seeing average household sizes of 2.8. This has implications for service delivery in new developments (i.e. coping with an increase in population compared to predicted populations). The average household size was expected to be relatively consistent in different housing mix scenarios, so that the average would be between 2.25 and 2.75 people for most scenarios.

The HWB is not aware of any robust evidence to suggest a generic ‘population trigger point’ for when a housing development in a location might need a pharmaceutical service provider. The HWB is also not aware of any measure of the extent to which existing local pharmaceutical service providers can accommodate the increase in need for pharmaceutical services created by an increase in local population size.

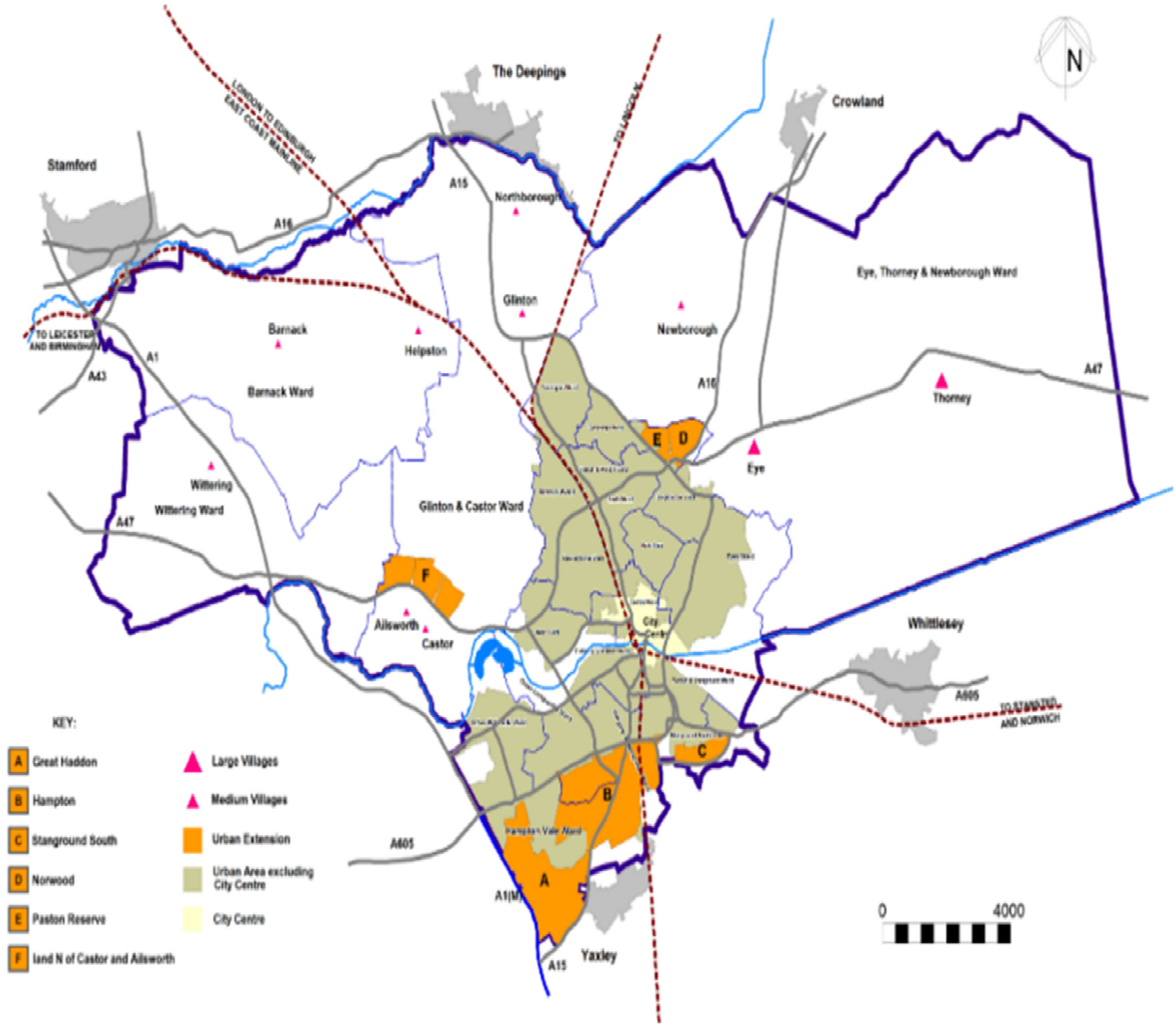
The current ratio of one pharmacy per 4,409 people is close to the England average, however if the expected growth in Peterborough is delivered and the population increases to 216,420 by 2021, and no additional pharmaceutical services are provided the ratio will change to one pharmacy per 4,918 or 20.3 providers per 100,000 population, this would make Peterborough below the England average and an outlier nationally. It is important to note that this is a simplistic view and assumes the growth is uniformly spread across Peterborough when in reality the growth is clustered in a few locations and as such the decision to allow additional pharmaceutical providers to open needs to take into account local factors as outlined below. An increase in population size is likely to generate an increased need for pharmaceutical services, but, on a local level, changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required to meet local pharmaceutical needs, due to the range of other factors influencing such needs.

Considerations, when assessing needs for local pharmaceutical service providers, should be based on a range of local factors specific to each development site. Such factors may include:

- Average household size of new builds on the site.
- Demographics: People moving to new housing developments are often young and expanding families, but some housing developments are expected to have an older population with different needs for health and social care services.
- Tenure mix, i.e. the proportion of affordable housing at the development.
- Existing pharmaceutical service provision in nearby areas and elsewhere in the county and opportunities to optimise existing local pharmaceutical service provision.
- Access to delivery services, distance selling pharmacies, and Dispensing Appliance Contractors that can supply services.
- Developments in pharmaceutical supply models (e.g. delivery services, robotic dispensing, centralised hub dispensing and electronic transmission of prescriptions) that could affect the volume of services a pharmaceutical service provider can deliver.
- Skill mix. A pharmacy's capacity to dispense larger volumes of prescriptions and/or deliver other services is greatly influenced by the number of pharmacists working in the pharmacy and, increasingly more importantly, the number of support staff. There have been significant developments in the roles that support staff can now fulfil to support the pharmacy operation. Medicines Counter Assistants, Dispensers, Pharmacy Technicians and Accredited Checking Technicians all now make a significant contribution to the delivery of pharmacy services and their availability to support a pharmacist should be considered by commissioners when considering how services can be commissioned from pharmacies.
- Considerations of health inequalities and strategic priorities for Cambridgeshire.

In conclusion, over the coming years, the population in Peterborough is expected to both age and grow substantially in numbers. Several large-scale housing developments are in progress. The Peterborough HWB will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmaceutical services provision might be required.

Figure 35: Strategic Growth sites in Peterborough



Appendix 1: Legal requirements for PNAs

This section contains an extract from The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended by The National Health Service (Pharmaceutical Services, Charges and Prescribing (Amendment) Regulations 2016. Please note that the HWB takes no responsibility for the accuracy of the extract. The full text of the Regulations is available at: http://www.legislation.gov.uk/uksi/2013/349/contents/made

1. These regulations may be cited as the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and came into force on 1 April 2013.

2. Interpretation *(long – see website)*

3. The pharmaceutical services the PNA must cover are all the pharmaceutical services that may be provided under arrangements made by the NHSCB for:

a) *the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list;*
b) *the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services); or*
c) *the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NSH services that may be provided under arrangements made by the NHSCB with a dispensing doctor)*

4. Information to be contained in PNA

(1) *Each PNA must contain the information set out in Schedule 1.*
(2) *Each HWB must, in so far as is practicable, keep up-to-date the map which it includes in its PNA pursuant to paragraph 7 of Schedule 1 (without needing to republish the whole of the assessment or publish a supplementary statement)*

5. Date by which the first HWB PNAs are to be published

Each HWB must publish its first PNA by 1 April 2015.

6. Subsequent assessments

(1) *After it has published its first PNA, each HWB must publish a statement of its revised assessment within three years of its previous publication.*
(2) *A HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular changes to –*
   a) *the number of people in its area who require pharmaceutical services;*
   b) *the demography of its area; and*
   c) *the risks to the health or wellbeing of people in its area,*

   unless it is satisfied that making a revised assessment would be a disproportionate response.

(3) *Pending the publication of a statement or a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services (..) where –*
   a) *the changes are relevant to the granting of applications referred to in section 129(2)(c)(i) or(ii) of the 2006 Act; and*
   b) *the HWB –*
      (i) *is satisfied that making its first or revised assessment would be a disproportionate response, or*
      (ii) *is in the course of making its first or revised assessment and is satisfied that immediate notification of its PNA is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.*

(4) Where chemist premises are removed from a pharmaceutical list as a consequence of the grant of a consolidation application, if in the opinion of the relevant HWB the removal does not create a gap in pharmaceutical services provision that could be met by a routine application-

a) to meet a current or future need for pharmaceutical services; or

b) to secure improvements, or better access, to pharmaceutical services,

The relevant HWB must publish a supplementary statement explaining that, in its view, the removal does not create such a gap and any such statement becomes part of the pharmaceutical needs assessment."

7. Temporary extension of PCT PNAs and access by the NHSCB and HWBs to PNAs

Before the publication by an HWB of the first PNA that it prepares for its area, the PNA that relates to any locality within that area is the PNA that relates to that locality of the PCT for that locality immediately before the appointed day, read with

a) any supplementary statement published by the PCT (..)

b) any supplementary statement published by the HWB (..)

Each HWB must ensure that the NHSCB has access to –

a) the HWB's PNA (including any supplementary statements) (..)

b) any supplementary statement that the HWB publishes (..)

c) any PNA of a PCT that it holds, which is sufficient to enable the NHSCB to carry out its functions under these Regulations

Each HWB must ensure that, as necessary, other HWBs have access to any PNAs of any PCT that it holds, which is sufficient to enable the other HWBs to carry out their functions under these Regulations.

8. Consultation on PNAs

(1) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB (HWB1) must consult the following about the contents of the assessment it is making—

(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;

(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and

(f) any NHS trust or NHS foundation trust in its area;

(g) the NHSCB; and

(h) any neighbouring HWB.

(2) The persons mentioned in paragraph (1) must together be consulted at least once during the process of making the assessment on a draft of the proposed pharmaceutical needs assessment.

(3) Where a HWB is consulted on a draft under paragraph (2), if there is a Local Pharmaceutical Committee or Local Medical Committee for its area or part of its area that is different to a Local Pharmaceutical Committee or Local Medical Committee consulted under paragraph (1)(a) or (b), that HWB—

(a) must consult that Committee before making its response to the consultation; and

(b) must have regard to any representations received from the Committee when making its response to the consultation.

(4) The persons consulted on the draft under paragraph (2) must be given a minimum period of 60 days for making their response to the consultation, beginning with the day by which all those persons have been served with the draft.

(5) For the purposes of paragraph (4), a person is to be treated as served with a draft if that person is notified by HWB1 of the address of a website on which the draft is available and is to remain available (except due to accident or unforeseen circumstances) throughout the period for making responses to the consultation.

(6) If a person consulted on a draft under paragraph (2)—

(a) is treated as served with the draft by virtue of paragraph (5); or

(b) has been served with copy of the draft in an electronic form, but requests a copy of the draft in hard copy form, HWB1 must as soon as is practicable and in any event within 14 days supply a hard copy of the draft to that person (free of charge).

9. Matters for consideration when making assessments

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

(a) the demography of its area;

(b) whether in its area there is sufficient choice with regard to obtaining pharmaceutical services;

(c) any different needs of different localities within its area;

(d) the pharmaceutical services provided in the area of any neighbouring HWB which affect—

> *(i) the need for pharmaceutical services in its area, or*
>
> *(ii) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area; and*

(e) any other NHS services provided in or outside its area (which are not covered by subparagraph

(d)) which affect—

> *(i) the need for pharmaceutical services in its area, or*
>
> *(ii) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.*

(2) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must take account of likely future needs—

(a) to the extent necessary to make a proper assessment of the matters mentioned in paragraphs 2 and 4 of Schedule 1; and

(b) having regard to likely changes to—

(i) the number of people in its area who require pharmaceutical services,

(ii) the demography of its area, and

(iii) the risks to the health or wellbeing of people in its area.

SCHEDULE 1 Regulation 4(1)

Information to be contained in pharmaceutical needs assessments

Necessary services: current provision

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

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

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

Necessary services: gaps in provision

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

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

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

Other relevant services: current provision

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

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

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

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

Improvements and better access: gaps in provision

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

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

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

Other NHS services

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

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

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

How the assessment was carried out

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

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

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

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

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

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

Map of provision

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

Appendix 2: List of Pharmacies and Dispensing Practices in Peterborough as at 1 June 2017

Pharmacy Code	Pharmacy Name	Pharmacy Type	Address 1	Address 2	Address 3
FRF00	Asda Pharmacy	Pharmacy	Asda Stores Ltd	West Rivergate Shop Ctre	Viersen Platz, Peterborough
FFC50	Botolph Bridge Pharmacy	Pharmacy	Wellperson Limited	Unit B	Sugar Way, Peterborough
FLV51	Charter Healthcare	Appliance Contractor	Charter Healthcare	Unit 1 The Links	Bakewell Road, Orton Southgate, Peterborough
FMC67	City Pharmacy	Pharmacy	Mr Kassim Kurji	50 Lincoln Road	Peterborough
FT327	Dogsthorpe Pharmacy	Pharmacy	N P Patel	54 Central Avenue	Dogsthorpe, Peterborough
FNL18	Graham Young (Chemist) 2007 Ltd	Pharmacy	Graham Young Chemist (2007) Ltd	Lincoln Road	Peterborough
FCM31	Granville Pharmacy	Pharmacy	Granville Pharmacy	35 Granville Street	Peterborough
FCE38	Halls The Chemist	Pharmacy	Repeat Prescription Order Line Ltd	92 Peterborough Road	Farcet, Peterborough
FD217	Halls The Chemist	Pharmacy	Repeat Prescription Order Line Ltd	14A Church Street	Thorney, Peterborough
FK836	Halls The Chemist	Pharmacy	Repeat Prescription Order Line Ltd	The Old Chapel	Church Hill, Castor, Peterborough
FR840	Halls The Chemist	Pharmacy	Repeat Prescription Order Line Ltd	57 Napier Place	Orton Wistow, Peterborough
FJ438	Hampton Pharmacy	Pharmacy	Hampton Vale Health Ltd	14 Stewartby Avenue	Hampton Vale, Peterborough
FCF98	Lloyds Pharmacy	Pharmacy	Lloyds Pharmacy Ltd	The Nene Valley Med Ctr	Clayton Orton Goldhay, Peterborough
FN982	Lloyds Pharmacy	Pharmacy	Lloyds Pharmacy Ltd	J.Sainsburys Superstore	Oxney Road, Peterborough
FQP03	Lloyds Pharmacy	Pharmacy	Lloyds Pharmacy Ltd	Sainsburys	Flaxland, Bretton, Peterborough
FTK85	Lloyds Pharmacy	Pharmacy	Lloyds Pharmacy Ltd	3 Bushfield, Orton Centre	Orton Goldhay, Peterborough
FWP72	Mi Pharmacy (Eastfield Branch)	Pharmacy	MI Pharmacy Limited	127 Eastfield Road	Peterborough
FNF85	Mi Pharmacy (Park Road Branch)	Pharmacy	MI Pharmacy Limited	164 Park Road	Peterborough
FKC24	Mi Pharmacy (Werrington Branch)	Pharmacy	MI Pharmacy Limited	12B Skaters Way	Werrington, Peterborough
FRK33	Millfield Pharmacy	Pharmacy	Millfield Chemists	387 Lincoln Road	Peterborough
FL030	Netherton Pharmacy	Pharmacy	Mr Mohammed Nanji	57 Ledbury Road	Netherton, Peterborough
FP572	Newborough Pharmacy	Pharmacy	Mr Meb Datoo	42-46 School Road	Newborough, Peterborough
FA886	Odedra Rc	Pharmacy	R C Odedra	Rectory Gardens	Old Fletton, Peterborough
FW010	Pharmacy First	Pharmacy	Mohammed Azam	51 Lincoln Road	Peterborough
FCC95	Pharmacy Medicines Ltd	Pharmacy	Pharmacy Medicines Ltd	11 Fenlake Business Ctre	Fengate, Peterborough
FJR07	Pharmadose Limited	Pharmacy	Pharmadose Limited	14 Dodson Way	Fen Court, Peterborough
FPM97	Respond Healthcare Limited	Appliance Contractor	Respond Healthcare Limited	20 Phorpres Close	Cygnet Park, Hampton, Peterborough
FGD82	Rowlands Pharmacy	Pharmacy	L Rowland & Co (Retail) Ltd	178A Mountsteven Avenue	Walton, Peterborough
FL013	Rowlands Pharmacy	Pharmacy	L Rowland & Co (Retail) Ltd	New Primary Care Centre	Craig Street, Peterborough

Pharmacy Code	Pharmacy Name	Pharmacy Type	Address 1	Address 2	Address 3
FCK31	Shrives Chemist	Pharmacy	Shrives Chemist	14 Westgate	
FK361	Tesco Instore Pharmacy	Pharmacy	Tesco Plc	Serpentine Green	Hampton Hargate
FHL89	The Chemist Shop	Pharmacy	MMO Pharma Ltd	4 Rectory Lane	Glinton
FK594	Thomas Walker Pharmacy	Pharmacy	Ali-Chem Ltd	Thomas Walker Med Centre	87 Princes Street, Peterborough
FDN91	Well Millfield - Lincoln Road	Pharmacy	Bestway Panacea Healthcare Ltd	303-307 Lincoln Road	Millfield, Peterborough
FL131	Well Paston - Chadburn Centre	Pharmacy	Bestway Panacea Healthcare Ltd	Chadburn Centre	Paston, Peterborough
FJK89	Well Stanground	Pharmacy	Bestway Panacea Healthcare Ltd	Stanground Surgery	Whittlesey Rd, Stanground
FY024	Well Westgate - Park Road	Pharmacy	Bestway Panacea Healthcare Ltd	Westgate House	Westgate, Peterborough
FE246	Well Westwood - Hampton Court	Pharmacy	Bestway Panacea Healthcare Ltd	2-6 Hampton Court	Westwood, Peterborough
FTX88	Werrington Pharmacy	Pharmacy	Werrington Healthcare Ltd	97 Church Street	Werrington Village, Peterborough
FTF01	West Town Chemist	Pharmacy	Guidebrook Limited	63-65 Mayors Walk	West Town, Peterborough
FF862	Your Local Boots Pharmacy	Pharmacy	Boots Group Plc	21 High Street	Eye, Peterborough
FPD00	Your Local Boots Pharmacy	Pharmacy	Boots Group Plc	The Bretton Health Centre	Rightwell East, Bretton
FQ495	Your Local Boots Pharmacy	Pharmacy	Boots Group Plc	Queensgate Centre	Peterborough
FTQ69	Your Local Boots Pharmacy	Pharmacy	Boots Group Plc	Unit 2	The Bretton Centre
FVP32	Your Local Boots Pharmacy	Pharmacy	Boots Group Plc	Unit 2	Serpentine Green, Hampton Hargate
D81022	Thorney Medical Practice	Dispensing Practice	Wisbech Road	Thorney	Peterborough
D81029	Old Fletton Medical Practice	Dispensing Practice	Rectory Gardens	Old Fletton	Peterborough
D81618	Ailsworth Medical Centre	Dispensing Practice	32 Main Street	Ailsworth	Peterborough

Appendix 3: Results of Community Pharmacy Questionnaire and Dispensing Pharmacy Questionnaire 2017

Results of Community Pharmacy Questionnaire 2017

A questionnaire was sent to all 41 community pharmacies in Peterborough. There were 37 returned questionnaires, representing a response rate of 90.2% - higher than the response rate of the previous PNA which was 67%.

Within the below analysis, response percentages may not sum to 100.0% due to rounding.

It is important to note that the information below is self-reported and there may therefore be some discrepancies with other information sources (e.g. commissioners of services).

1. Consultation Facilities

Question	Response
Are consultation facilities on site and do they include wheelchair access?	34 (92%) available with wheelchair access 2 (5%) available without wheelchair access 1 (3%) none
Where this is a consultation area, is it a closed room?	36 (100%) yes 0 (0%) no
During consultations, are there hand-washing facilities?	20 (54%) yes, in the consultation area 10 (27%) yes, close to the consultation area 7 (19%) none or not applicable
Do patients attending for consultations have access to toilet facilities?	12 (32%) yes 25 (68%) no or not applicable
What off-site consultation facilities are available? (Multiple answers possible)	0 (0%) offer an off-site consultation area (e.g. an area assigned by NHS England local team) 24 (65%) are willing to undertake consultations in patient's home/other suitable area
Which languages are spoken in the pharmacy, in addition to English? (Multiple answers possible)	14 (38%) Urdu 13 (35%) Gujarati 13 (35%) Punjabi 11 (30%) Hindu 8 (22%) Polish 4 (11%) Russian 3 (8%) Lithuanian 3 (8%) Spanish 2 (5%) Cantonese 2 (5%) Portuguese 2 (5%) Telugu 1 (3%) Bengali 1 (3%) British Sign Language 1 (3%) Cutchi 1 (3%) Kachi 1 (3%) Latvian 1 (3%) Kiswahili 1 (3%) Malay

	1 (3%) Nepali 1 (3%) Romanian 1 (3%) Slovakian

2. ICT Facilities

Question	Response
Is the Electronic Prescription Service Release 2 enabled at your pharmacy?	37 (100%) yes 0 (0%) no
Is NHS Mail used at your pharmacy?	24 (65%) yes 13 (35%) no
Is the NHS Summary Care Record enabled at your pharmacy?	36 (97%) yes 1 (2%) no
Is your NHS Choice entry up-to-date?	37 (100%) yes 0 (0%) no

3. Healthy Living Pharmacy Status

Question	Response
What is the Healthy Living Pharmacy (HLP) status of your pharmacy?	5 (14%) have achieved healthy living status 32 (86%) are working towards HLP status 0 (0%) are not currently working towards HLP status

4. Advanced Services

Question	Response
Does the pharmacy dispense appliances?	28 (76%) yes – all types 4 (11%) yes – just dressing 2 (5%) yes – excluding stoma and incontinence appliances 1 (3%) yes – excluding stoma appliances 1 (3%) yes – excluding incontinence appliances 1 (3%) no – none
Does the pharmacy provide a Medicines Use Review Service?	36 (97%) yes 1 (3%) no – not intending to provide
Does the pharmacy provide a New Medicine Does the pharmacy Service?	35 (95%) yes 1 (3%) no – but intending to begin within next 12 months 1 (3%) no – not intending to provide
Does the pharmacy provide an Appliance Use Review Service?	6 (16%) yes 7 (19%) no – but intending to begin within next 12 months 24 (65%) no – not intending to provide
Does the pharmacy provide a Stoma Appliance Customisation Service?	4 (11%) yes 7 (19%) no – but intending to begin within next 12 months 26 (70%) no – not intending to provide
Does the pharmacy offer an Influenza Vaccination Service?	29 (78%) yes 7 (19%) no – but intending to begin within next 12 months 1 (3%) no – not intending to provide

Does the pharmacy offer an NHS Urgent Medicine Supply Advanced Service?	7 (19%) yes 16 (43%) no – but intending to begin within next 12 months 14 (38%) no – not intending to provide

5. Enhanced & Locally Commissioned Services – Peterborough Provision

Service	Currently providing under Contract with Local NHS England Team	Currently providing under contract with Clinical Commissioning Group	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Anticoagulant Monitoring Service	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
Anti-viral Distribution Service	0 (0%)	0 (0%)	1 (3%)	29 (78%)	7 (19%)
Care Home Service	0 (0%)	0 (0%)	0 (0%)	29 (78%)	8 (22%)
Chlamydia Testing Service	2 (5%)	1 (3%)	2 (5%)	25 (68%)	7 (19%)
Chlamydia Treatment Service	0 (0%)	1 (3%)	1 (3%)	28 (76%)	7 (19%)
Contraception Service (Not Emergency Contraception)	1 (3%)	1 (3%)	1 (3%)	27 (73%)	7 (19%)
Emergency Contraception Service	4 (11%)	2 (5%)	4 (11%)	23 (62%)	4 (11%)
Emergency Supply Service	6 (16%)	1 (3%)	1 (3%)	27 (73%)	2 (5%)
Gluten Free Food Supply Service	0 (0%)	1 (3%)	0 (0%)	29 (78%)	7 (19%)
Home Delivery Service (not appliances)	11 (30%)	1 (3%)	4 (11%)	18 (49%)	3 (8%)
Independent Prescribing Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)
Language Access Service	0 (0%)	0 (0%)	0 (0%)	27 (73%)	10 (27%)
Medication Review Service	18 (45%)	2 (5%)	1 (3%)	16 (40%)	3 (8%)
Medicines Assessment & Compliance Support Service	3 (8%)	0 (0%)	0 (0%)	29 (78%)	5 (14%)
Minor Ailment Scheme	0 (0%)	0 (0%)	0 (0%)	32 (87%)	5 (14%)
MUR Plus/Medicines Optimisation Service	1 (3%)	0 (0%)	0 (0%)	31 (35%)	5 (14%)
Needle & Syringe Exchange Service	10 (27%)	2 (5%)	4 (11%)	10 (27%)	11 (30%)
Obesity Management (Adults & Children)	0 (0%)	0 (0%)	1 (3%)	28 (76%)	8 (22%)
Not Dispensed Scheme	0 (0%)	0 (0%)	0 (0%)	29 (78%)	8 (22%)
On Demand Availability of Specialist Drugs Service	0 (0%)	0 (0%)	0 (0%)	28 (76%)	9 (24%)
Out-of-hours Service	2 (5%)	0 (0%)	0 (0%)	18 (49%)	17 (46%)
Patient Group Direction Service	4 (11%)	1 (3%)	4 (11%)	25 (68%)	3 (8%)
Phlebotomy Service	0 (0%)	0 (0%)	0 (0%)	25 (68%)	12 (32%)
Prescriber Support Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)
Schools Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)
Sharps Disposal Service	0 (24%)	2 (5%)	1 (3%)	19 (51%)	6 (16%)
Stop Smoking Service	8 (22%)	2 (5%)	5 (14%)	19 (51%)	3 (8%)
Supervised Administration Service	19 (51%)	4 (11%)	4 (11%)	5 (14%)	5 (14%)
Vascular Risk Assessment Service (NHS Health Check)	0 (0%)	0 (0%)	0 (0%)	28 (76%)	9 (24%)
Supplementary Prescribing Service	0 (0%)	0 (0%)	0 (0%)	26 (70%)	11 (30%)

Disease Specific Medicines Management Service

Service	Currently providing under Contract with Local NHS England Team	Currently providing under contract with Clinical Commissioning Group	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Allergies	0 (0%)	0 (0%)	0 (0%)	29 (78%)	8 (22%)
Alzheimer's/Dementia	1 (3%)	0 (0%)	0 (0%)	29 (78%)	7 (19%)
Asthma	1 (3%)	0 (0%)	0 (0%)	31 (84%)	5 (14%)
CHD	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
COPD	1 (3%)	0 (0%)	0 (0%)	30 (81%)	6 (16%)
Depression	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
Diabetes Type 1	0 (0%)	0 (0%)	0 (0%)	31 (84%)	6 (16%)
Diabetes Type 2	0 (0%)	0 (0%)	0 (0%)	31 (84%)	6 (16%)
Epilepsy	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
Heart Failure	0 (0%)	0 (0%)	0 (0%)	31 (84%)	6 (16%)
Hypertension	0 (0%)	0 (0%)	0 (0%)	32 (87%)	5 (14%)
Parkinson's Disease	0 (0%)	0 (0%)	0 (0%)	31 (84%)	6 (16%)

6. Screening Service

Service	Currently providing under Contract with Local NHS England Team	Currently providing under contract with Clinical Commissioning Group	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Alcohol	0 (0%)	3 (8%)	8 (22%)	21 (57%)	5 (14%)
Cholesterol	0 (0%)	0 (0%)	0 (0%)	33 (89%)	4 (11%)
Diabetes	1 (3%)	0 (0%)	0 (0%)	32 (87%)	4 (11%)
Gonorrhoea	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
H. Pylori	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
HbA1C	0 (0%)	0 (0%)	1 (3%)	28 (76%)	8 (22%)
Hepatitis	0 (0%	1 (3%)	4 (11%)	23 (62%)	9 (24%)
HIV	0 (0%)	1 (3%)	0 (0%)	25 (68%)	11 (30%)

7. Other Vaccinations

Service	Currently providing under Contract with Local NHS England Team	Currently providing under contract with Clinical Commissioning Group	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Childhood Vaccinations	0 (0%)	0 (0%)	0 (0%)	30 (81%)	7 (19%)
Hepatitis (at risk workers or patients)	2 (5%)	0 (0%)	0 (0%)	27 (73%)	8 (22%)
HPV	1 (3%)	0 (0%)	0 (0%)	29 (78%)	7 (19%)
Travel Vaccines	2 (5%)	0 (0%)	3 (8%)	27 (73%)	5 (14%)

8. Non-Commissioned Services

Question	Response
Does your pharmacy offer the collection of prescriptions from GP practices?	37 (100%) yes 0 (0%) no
Does your pharmacy deliver dispensed medicines at no charge, upon request?	35 (95%) yes 2 (5%) no
Does your pharmacy deliver dispensed medicines at a chargeable rate?	11 (30%) yes 26 (70%) no
Does your pharmacy provide Monitored Dosage Systems at no charge, upon request?	37 (100%) yes 0 (0%) no
Does your pharmacy provide Monitored Dosage Systems at a chargeable rate?	8 (22%) yes 29 (78%) no

9. Pharmacy Public Health Campaigns

Question	Response
Does your pharmacy participate in the contractual annual six Public Health campaigns?	37 (100%) yes 0 (0%) no
Does your pharmacy do any extra promotional work?	24 (65%) 13 (35%)

10. Current Service Provision

Question	Response
Does your pharmacy supply medicines etc. to care homes?	12 (32%) yes 25 (68%) no
Which features relating to community pharmacies and dispensing doctors would you identify as being important? (Multiple answers possible)	32 (86%) availability of information and advice about medicines/how to use them 27 (73%) qualified staff 20 (54%) availability of consultation facilities 18 (49%) availability of prescription only items 16 (43%) availability of non-prescription medicines 11 (30%) car parking 11 (30%) access and facilities for disabled people) 11 (30%) extended opening hours 10 (27%) detailed description of services offered 10 (27%) languages spoken 6 (16%) location 4 (11%) transport 2 (5%) details of any services that are only available at certain times 1 (3%) patient satisfaction scores
Do you feel there is a need for more pharmaceutical service providers in this locality?	3 (8%) yes 34 (92%) no
Is there a particular need for a locally commissioned service in this locality?	17 (46%) yes 20 (54%) no
If yes, which additional services should be commissioned (or numbers of commissioned pharmacies to provide existing services increased?) (Multiple answers possible)	6 (16%) Medicines Review Service 4 (11%) Minor Ailment Scheme 4 (11%) Medicine Use Review Scheme 4 (11%) Pneumonia Vaccinations 3 (8%) Needle Exchange Scheme 2 (5%) Chlamydia/other STI Screening Programme 2 (5%) Diabetes/Cholesterol Management 2 (5%) Emergency Hormonal Contraception 1 (3%) Erectile Dysfunction 1 (3%) Language Access 1 (3%) More public health campaigns and explanations of how to reduce medicine waste 1 (3%) New Medicine Service 1 (3%) Stop Smoking Services 1 (3%) Vaccination
Is there any other information regarding pharmacy services you would like to be considered in this Pharmaceutical Needs Assessment?	• Additional providers are not required but more services should be offered to a standard that is of the very minimum acceptable. Enhanced/advanced services are minimal, reduced from previous provision and not properly funded. Core services are under extreme pressure. • There are already sufficient pharmaceutical services in the area but better use should be made of them • Approval should be given to carry out MUR/NMS at care homes • More campaigns to reduce medicines wastages and better explain the repeat prescription process would be helpful • Additional use of community pharmacies should be made to help reduce overall NHS costs

Results of Dispensing GP Practice Questionnaire 2017

A questionnaire was sent to all three community pharmacies in Peterborough. One questionnaire was returned.

Within the below analysis, response percentages may not sum to 100.0% due to rounding.

1. Consultation Facilities

Question	Response
Which consultation facilities are available on the premises?	1 (100%) consultation facilities are available, including wheelchair access
Is the consultation area within a closed room?	1 (100%) yes
Are any additional languages spoken in addition to English?	1 (100%) none

2. ICT Facilities

Question	Response
Is the Electronic Prescription Service Release 2 enabled at your pharmacy?	1 (100%) yes
Is NHS Mail used at your pharmacy?	0 (0%) no
Is the NHS Summary Care Record enabled at your pharmacy?	0 (0%) no
Is your NHS Choice entry up-to-date?	0 (0%) no

3. Advanced Services

Question	Response
Do you dispense appliances?	1 (100%) no
Do you provide an appliance review service?	1 (100%) no – not intending to provide
Do you provide a stoma appliance customisation service?	1 (100%) no – not intending to provide

4. Non-NHS Funded Services

Question	Response
Does your pharmacy offer the collection of prescriptions from GP practices?	1 (100%) yes
Does your pharmacy deliver dispensed medicines at no charge, upon request?	1 (100%) yes
Does your pharmacy deliver dispensed medicines at a chargeable rate?	0 (100%) no
Does your pharmacy provide Monitored Dosage Systems at no charge, upon request?	0 (100%) no
Does your pharmacy provide Monitored Dosage Systems at a chargeable rate?	0 (100%) no

Supply of Medicines to Care Homes

Question	Response
Do you supply medicines etc. to care homes?	1 (100%) no

5. Service Provision and Features

Question	Response
Which of these features provided by dispensing doctors and community pharmacies would you identify as being important? (Multiple answers possible)	1 (100%) – Availability of information and advice about medicines and how to use them, location, qualified staff and patient satisfaction scores
Do you feel there is a need for more pharmaceutical service providers in your locality?	1 (100%) - no

Appendix 4: Details of PNA process & document control

Date	*Action*	*Person*
29 June 2017	Steering group meeting – learning from previous PNAs, approach agreed, pharmacy questionnaire reviewed.	Steering Group
July 2017	Pharmacy questionnaire updated and sent out	KJ, SH
June – September 2017	Updating all public health data sources including demography, health needs and maps	RON, EW
July – August 2017	Health improvement team review and updating of local health needs section (Chapter 4)	HI team
August 2017	Planning chapter (Chapter 5) revised and reviewed, all data updated and additional information added re new sites	IG
August – September 2017	Pharmacy questionnaire data analysed and new data added to draft	RON, EW
11 September 2017	Update paper presented to Health and Wellbeing Board. Authority for approval of draft report delegated to Chairman and Vice-Chairman, in consultation with the director of Public Health	KJ, LR
27 September 2017	Draft 2018 PNA report reviewed by Steering group	Steering Group
27 September to 6 October 2017	Changes made to draft PNA report, final review and proof reading by Steering Group	Steering Group
9 October 2017	Draft 2018 report reviewed and approved for consultation by the Chairman of the Health and Wellbeing Board following discussions with the Director of Public Health	Chairman of the HWB
23 October – 23 December 2017	60 day public consultation	
January 2018	Consultation responses analysed and summary report produced. Response to consultation drafted and amendments to PNA made.	KJ, RON, EW
31 January 2018	Steering group meeting – discussion and approval of consultation report, response to consultation and amendments to PNA.	Steering Group
February 2018	Review by Peterborough City Council legal team.	PCC Legal Team
19 March 2018	Presentation of 2018 PNA to Peterborough Health and Wellbeing Board for discussion and approval, followed by publication on Peterborough City Council website	

Appendix 5: Impact of the Pharmacy Contract Funding Changes (October 2016)

This section outlines the recent consultation and changes to the national Pharmacy contract. Of note, a national public consultation was held to seek views on the proposals in 2015/16 and the decisions have been taken at a national level by the Department of Health (DoH). This section describes the national changes in order to assess the potential impact on Peterborough pharmaceutical providers and the local population.

A5.1 Summary of the changes to the Pharmacy Contract

In December 2015, the Department of Health (DoH) launched a consultation with the Pharmaceutical Services Negotiation Committee (PSNC), pharmacy stakeholders and others on community pharmacy in 2016/17 and beyond.[66] The stated vision from the DoH was:

'for community pharmacy to be integrated with the wider health and social care system. This will aim to relieve pressure on GPs and Accident and Emergency Departments, ensure optimal use of medicines, and will mean better value and patient outcomes. It will support the promotion of healthy lifestyles and ill health prevention, as well as contributing to delivering seven day health and care services'.[67]

In the context of delivering £22 billion in efficiency savings by 2020/21, the review and consultation aimed to examine how community pharmacy could contribute to this financial challenge. The proposals state that:

'*efficiencies could be made without compromising the quality of services or public access to them because:*

- *There are more pharmacies than necessary to maintain good patient access.*
- *Most NHS funded pharmacies qualify for a complex range of fees, regardless of the quality of service and levels of efficiency of that provider.*
- *More efficient dispensing arrangements remain largely unavailable to pharmacy providers*.[68]

Key proposals included:[69]

- Simplifying the NHS pharmacy remuneration system e.g. phasing out of the establishment payment received by all pharmacies dispensing 2,500 or more prescriptions per month, which incentives pharmacy business to open more NHS funded pharmacies.
- Helping pharmacies to become more efficient and innovative e.g. through more modern dispensing methods; including hub and spoke models to deliver more economies of scale in purchasing and dispensing and reducing operating costs.
- Encouraging longer prescription durations where clinically appropriate e.g. 90 day repeat periods instead of 28 days.

The results of the consultation and a final package of changes to the contractual framework were announced in October 2016. On 20 October 2016 the Government imposed a two-year funding package on community pharmacy, with a £113 million reduction in funding in 2016/17.[70] This will take total funding to

[66] Department of Health stakeholder briefing. 'Community pharmacy in 2016/2017 and beyond: proposals. (Dec 2015) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495774/Community_pharmacy_in_2016-17_and_beyond_A.pdf
[67] Ibid.
[68] Ibid.
[69] Ibid.
[70] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

£2.687 billion for 2016/17. This is a reduction of 4% compared with 2015/16, but it will mean that contractors will see their funding for December 2016 to March 2017 fall by an average of 12% compared with November 2016 levels. This will be followed by a further 3.4% reduction in 2017/18 to £2.592 billion for the financial year, which will see funding levels from April 2017 drop by around 7.5% compared with November 2016 levels.[71]

Full details of the final Community Pharmacy proposals can be found in the DoH report "Community pharmacy in 2016/2017 and beyond: final package" available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

In addition to the overall reduction of funding, key changes to the regulations are outlined below:

A5.1.1 Changes to payment of fees

- A range of fees including the professional or 'dispensing' fee, practice payment, repeat dispensing payment and monthly electronic prescription payment service payment will be consolidated into a single activity fee.
- Community pharmacists currently receive an establishment payment as long as they dispense above a certain prescription volume – this will be gradually phased out over a number of years, starting with a 20% reduction in December 2016 and reduced by 40% on 1 April 2017.

A5.1.2 The Pharmacy Access Scheme (PhAS)

- A new Pharmacy Access Scheme was introduced with the aim of creating efficiencies without compromising the quality of services or public access to them. The Pharmacy Access Scheme (PhAS) is designed to ensure populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. A national formula was used to identify those pharmacies that are geographically[72] important for patient access, taking into account isolation criteria based on travel times or distances, and also population sizes and needs.
- Qualifying pharmacies received an additional payment, meaning those pharmacies will be protected from the full effect of the reduction in funding from December 2016. A payment was made to pharmacies that are more than a mile away from another pharmacy (until March 2018).

A5.1.3 A new quality payments scheme

- Quality criteria have been introduced which, if achieved, will help to integrate community pharmacy into the wider NHS/Public Health agenda. The criteria includes:[73]
  - the need to have an NHS email account and ability for staff to send and receive NHS mail;
  - an up-to-date entry on NHS Choices; ongoing utilisation of the Electronic Prescription service; and

[71] http://psnc.org.uk/funding-and-statistics/cpcf-funding-changes-201617-and-201718/
[72] Department of Health stakeholder briefing. 'Community pharmacy in 2016/2017 and beyond: proposals. (Dec 2015) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495774/Community_pharmacy_in_2016-17_and_beyond_A.pdf
[73] http://psnc.org.uk/services-commissioning/essential-services/quality-payments/

- at least one specified advanced service e.g., Healthy Living pharmacy level 1 status, 80% of staff trained as Dementia Friends etc.

A5.1.4 Urgent medicines supply pilot

- NHS England have commissioned a new urgent medicines supply pilot as an advanced service, where people calling NHS 111 requiring urgent repeat medicines will be referred directly to community pharmacies. This pilot commenced on 23 December in Peterborough with six local community pharmacies participating.

A5.1.5 Changes to regulations to allow pharmacy mergers

- '*On 5 December 2016, amendments to the 2013 Regulations come into force which facilitate pharmacy business consolidations from two or more sites on to a single existing site. Importantly, a new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes. This would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision*.'
- "*Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3).*"[74]
- As such, in the event of a consolidation in future, in accordance with Paragraph 19 of Schedule 2 of the regulations the Peterborough Health and Wellbeing Board will publish a supplementary statement which will become part of the PNA, explaining whether, in its view, the proposed removal of premises from its pharmaceutical list would or would not create a gap in pharmaceutical services provision that could be met by a routine application:
  (a) to meet a current or future need for pharmaceutical services; or
  (b) to secure improvements, or better access, to pharmaceutical services.

A5.1.6 Pharmacy Integration Fund'

- In the Government's letter from 17th December 2015 entitled 'Community pharmacy in 2016/17 and beyond', the Department of Health (DoH) announced that it would consult on a 'Pharmacy Integration Fund' (PhIF) to help transform how pharmacists and community pharmacy will operate in the NHS.
- The Fund is the responsibility of NHS England and is separate to any negotiations related to the Community Pharmacy Contractual Framework (CPCF). It will be used to validate and inform any future reform of the CPCF going forward.[75]

[74] National Health Service England. ' The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016' (2016 No.1077) Page 13. Available at: http://www.legislation.gov.uk/uksi/2016/1077/contents/made
[75] http://psnc.org.uk/the-healthcare-landscape/the-pharmacy-integration-fund-phif/

A5.2 Department of Health National Health Impact assessment

The Department of Health has produced an impact assessment for the proposed changes, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561496/Community_pharmacy_impact_assessment_A.pdf.

This impact assessment focuses only on the impact on essential and advanced services. The Pharmaceuticals Services Negotiating Committee (PSNC) have produced an impact assessment on 'The Value of Community Pharmacies' from external consultants, which also looks at locally commissioned and non-essential services (see section A5.3).

Key findings of the DoH impact assessment are summarised below:

A5.2.1 Potential pharmacy closures

There is no reliable way of estimating the number of pharmacies that may close as a result of the policy and this may depend on a variety of complex factors, individual to each community pharmacy and their model of business. The DoH states that:

> *'it is not the Government's intention to reduce the number of community pharmacies…however, we cannot know for certain how the market will react and we recognise the potential for some pharmacies to take the decision to close as a result of the changes.'* [76]
>
> *'Reducing income would mean that community pharmacies must reduce their costs, change their business model or accept reduced profits, and in some circumstances this could mean pharmacies become economically unviable… it is not clear, if the viability of an individual business is threatened, whether these businesses will close or simply be taken over by other owners on the basis that they can be run more efficiently and remain viable business propositions….. there is also an important interdependency that, if a pharmacy closes, it is likely that the prescriptions that were dispensed by that pharmacy would be redistributed to pharmacies located nearby'.*[77]
> *The quality payment scheme is expected to maintain or increase the quality of services provided by community pharmacies, although this potential benefit has not been explicitly estimated'.*[78]

A5.2.2. Potential impact on patients

There may be potential increased travel time and consequent economic costs for patients who have to travel further if their nearest pharmacy closes.

In terms of impact on patients, the DoH impact assessment found that a potential reduction in community pharmacy numbers would be likely to '*mean that some patients have further to travel to access community pharmacy services, however the analysis shows that for hypothetical closure scenarios the increase is very small*'.[79] The modelling estimates provided suggest that with the provision of the PhAS, across England the

[76] Department of Health. 'Community pharmacy in 2016/2017 and beyond: impact assessment' (Oct 2016). Paragraph 41, page 12. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561496/Community_pharmacy_impact_assessment_A.pdf.
[77] Ibid. Paragraph 51, page 14.
[78] Ibid. Paragraph 43, page 13.
[79] Ibid. Paragraph 60, page 15.

average journey time after the removal of 100 community pharmacies at random was estimated at 12.86 minutes, an increase of 0.04 minutes per journey.[80]

It is stated that

> *'even if there were closures as a result of the funding reductions, it is not considered that this would lead to any significant impacts on patient health. It is considered highly unlikely that any patient will be unable to receive their medicines and the potential increase in journey times estimated in the DoH model are relatively minor, and patients will have a number of means of ensuring they receive the medicines they need eg distance selling pharmacies*'.[81]

Respondents to the consultation stated that, to mitigate the funding reductions, community pharmacies could choose to open only for their 'core' hours, or to withdraw non-NHS services, such as home delivery. In terms of quality of services, the impact assessment states that pharmacies will still need to compete to secure prescription volume and the competitive incentive to provide these services remains.[82]

Evidence shows that deprived areas (by the Index of Deprivation) tend to have more clustering of pharmacies, and it was considered whether deprived areas might, therefore, be adversely affected by the policy. The Pharmacy Access Scheme was intended to protect areas that may be at risk of reduced access, and takes into account isolation and need.

A5.2.3 Impact on other areas of the NHS

The public consultation revealed a concern that a reduction in the number of community pharmacies could lead some patients to seek health advice from GPs, other primary care providers, or acute services, thereby imposing additional costs on the NHS. However, the DoH states that:

> '*even if there were closures, the magnitudes of impact on travel time are not considered sufficient to materially deter any significant number of patients from seeking this guidance from a community pharmacy. Those patients who would previously have found it most convenient to get such information from a community pharmacy are considered unlikely to change their decision and seek a different route of access to medical care, even if in some cases there are small increases in travel time*.'
>
> '*In addition, the overall package of measures contains steps to decrease pressure on other parts of the NHS, by embedding pharmacy into the urgent care pathway through an expansion of the services already provided by community pharmacies in England for those who need urgent repeat prescriptions and treatment for urgent minor ailments and common conditions.'*[83]

[80] Ibid. Paragraph 69, page 16.
[81] Ibid. Paragraphs 81-82, page 18.
[82] Ibid. Paragraph 84, page 19.
[83] Ibid. Paragraph 86-88, page 19.

A5.2.4 Potential impact on local communities

Beyond their direct benefits in providing NHS pharmacy services to patients, community pharmacies may play a less tangible role in promoting welfare and social cohesion in local communities, and in supporting local commercial areas. The DoH impact assessment suggests that '*there would ordinarily be at least one remaining pharmacy in the vicinity" reducing the likelihood that closures would have a significant impact on local communities*'.[84]

A5.3 Views of the Pharmaceuticals Services Negotiating Committee

A5.3.1 Objections to the pharmacy contract changes

The Pharmaceuticals Services Negotiating Committee (PSNC) is the body recognised under section 65(1)(a) of the NHS Act 2006 as representing all community pharmacies providing NHS pharmaceutical services in England. The PSNC has published objections to the proposals, which can be viewed in full at: http://psnc.org.uk/our-news/psnc-demands-clarity-on-nhs-englands-long-term-plans/

In brief, the '*PSNC believes the proposals as set out create massive risks to the sustainability of an already fragile supply system*.'[85] The specific concerns outlined include:

- 'Concerns that the £170m funding reduction in 2016/17 runs counter to the Government's stated aim to develop a more clinically focused pharmacy service'.
- Refusal to accept that there are too many community pharmacies. Agreement that there is some clustering of pharmacies and they aim to work with the NHS and Government to facilitate voluntary mergers.
- Refusal to accept that the development of large warehouse supply operations, removing the need for local community pharmacies, is an acceptable alternative to the services currently provided by those pharmacies and would oppose models for hubs without those community pharmacy spokes. Any revised regulations must prevent misuse of collection point arrangements intended for rural locations as an inferior but expedient alternative.
- Rejection of proposals to transfer funds to CCGs to drive longer periods of treatment, and will insist on effective protection against GP direction of prescriptions.

[84] Ibid. Paragraph 89-90, page 19.
[85] http://psnc.org.uk/psncs-work/communications-and-lobbying/community-pharmacy-in-201617-and-beyond/

A5.3.2 Report commissioned by the PSNC: "The Value of Community Pharmacies" (2016)

PricewaterhouseCoopers LLP (PwC) was commissioned by the PSNC to examine the contribution of community pharmacy in England in 2015.[86] The report analyses the value (net benefits) to the NHS, to patients and to wider society of 12 specific services provided by community pharmacy:

- Emergency hormonal contraception
- Needle and syringe programmes
- Supervised consumption
- Self-care support
- Minor ailments advice
- Medicines support
- Managing prescribing errors/clarifying prescriptions
- Medicines adjustments
- Delivering prescriptions
- Managing drug shortages
- Sustaining supply of medicines in emergencies
- Medicines Use Reviews (MUR)
- New Medicine Service (NMS)

The report found that in 2015 these 12 community pharmacy services in England contributed a net increase of £3.0 billion in value in that year, with a further £1.9 billion expected to accrue over the next 20 years. Further, 55% of in-year benefits and 91% of long run benefits (69% of total benefits) accrued outside the NHS. Other public sector bodies (e.g. local authorities) and wider society together received over £1 billion of benefits in 2015 as a result of the community pharmacy services covered. A further £1.7 billion is expected to accrue over the next 20 years.

In addition, the economic modelling suggested that patients experienced around £600 million of benefits, mainly in the form of reduced travel time to alternative NHS settings to seek a similar type of service as the ones provided by community pharmacy. The report notes that for many of these interventions the scale of value created is substantial and greatly exceeds the cost to the NHS of delivering them.

The findings in the report and associated potential impact are limited to just the 12 services reviewed. It excludes the economic value generated by community pharmacy through its central role, alongside pharmaceutical manufacturers and wholesalers/distributors, in the drug delivery system: specifically, it omits the value added that results from treating NHS patients using prescription drugs. It also does not look at other services beyond these core 12, and also does not take into account 'o*ther elements of potential value, for example as a result of the important catalytic role that community pharmacies play in local communities, providing a valuable focal point for communities, especially as a point of contact for isolated people, and anchoring a parade of shops*.'[87]

[86] PWC. 'The value of community pharmacy: summary report' (Sept 2016). Available at: http://psnc.org.uk/our-news/pwc-report-quantifies-value-of-community-pharmacy/
[87] Ibid. page 7.

A5.4 Local impact of the new pharmacy contract

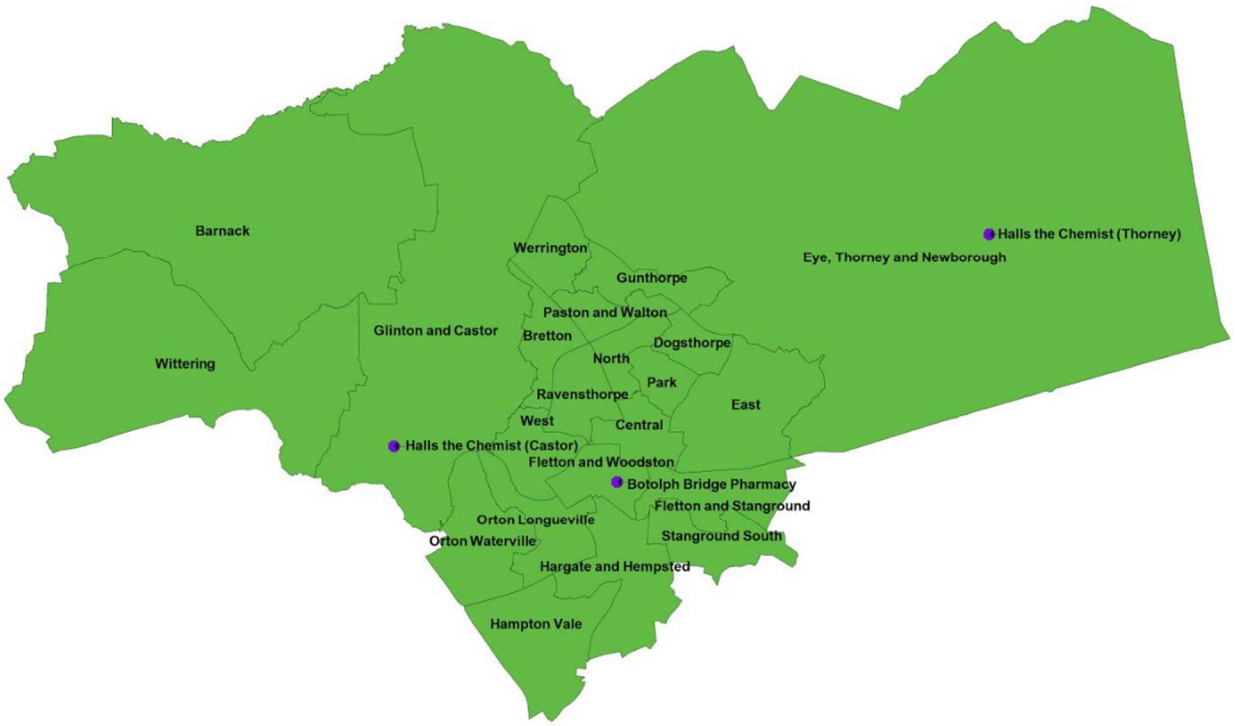
As stated in the DoH health impact assessment, it is complex to assess the impact of these changes on Peterborough residents. There is no reliable way of estimating the number of pharmacies that may close as a result of the policy and this may depend on a variety of factors, individual to each community pharmacy and their model of business.

The Pharmacy Access Scheme aimed to ensure populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. Nationally 1,356 pharmacies qualified for the scheme. In Peterborough, three pharmacies participated in the scheme (see figure A5.1).

The Cambridgeshire and Peterborough Local Pharmaceutical Committee will focus on supporting local pharmacies by keeping them up-to-date with changes/details, to meet the quality agenda, and to take up and deliver locally commissioned services more effectively.

The PNA Steering Group will continue to monitor any closures of local pharmacies and issue appropriate statements of fact as necessary in line with PNA requirements.

Figure A5.1 Pharmacy Locations and Pharmacy Access Scheme, September 2017



Appendix 6: Consultation report – results from the public consultation (23 October to 23 December 2017)

Introduction

Following the development of the draft PNA a formal public consultation was held, getting to know people's thoughts about the report and whether it covers what is important to their needs.

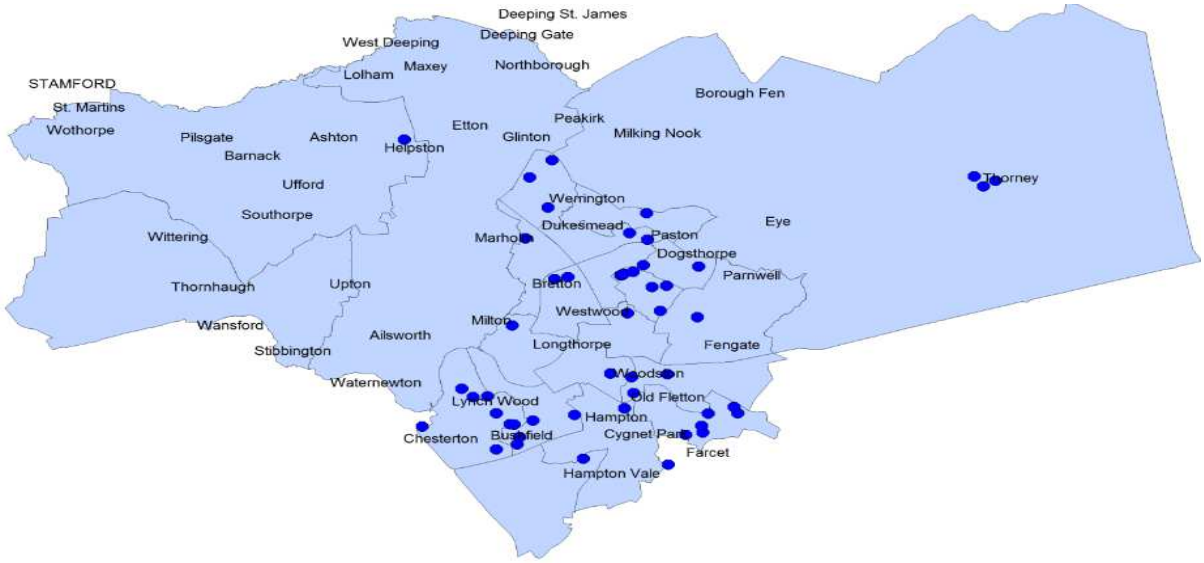
The consultation ran from the 23 October to 23 December 2017, and received 69 responses. This report outlines the responses to the consultation. All percentages, unless otherwise specified, are rounded to the nearest whole number.

Section 1: Respondents

This section summarises the characteristics of the respondents to the consultation of the draft PNA.

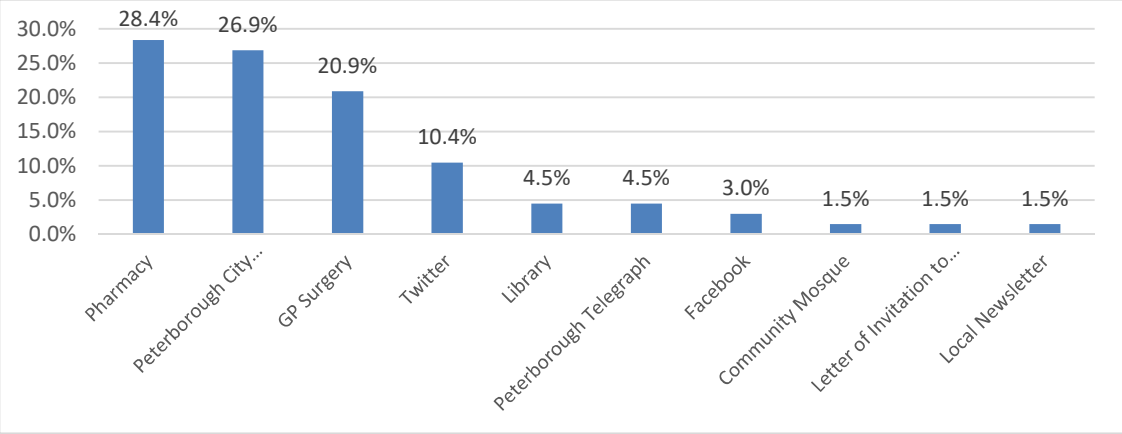
57 people who responded to the survey included a full postcode. Of these, 53 were within Peterborough and four were outside of Peterborough. The 53 postcodes within Peterborough are displayed within the map above and demonstrate that the majority of responses were from within the relatively urban, central and southern areas of Peterborough. No responses with postcodes were received from the predominantly rural Western areas of Peterborough.

Figure A6.1: Respondent locations



The ways in which respondents stated they found out about the survey is shown below in **Figure A6.2**. 76% of respondents to the consultation found out about the survey via either the Peterborough City Council website, a pharmacy or a GP surgery.

Figure A6.2: 'How did you find out about this survey?'



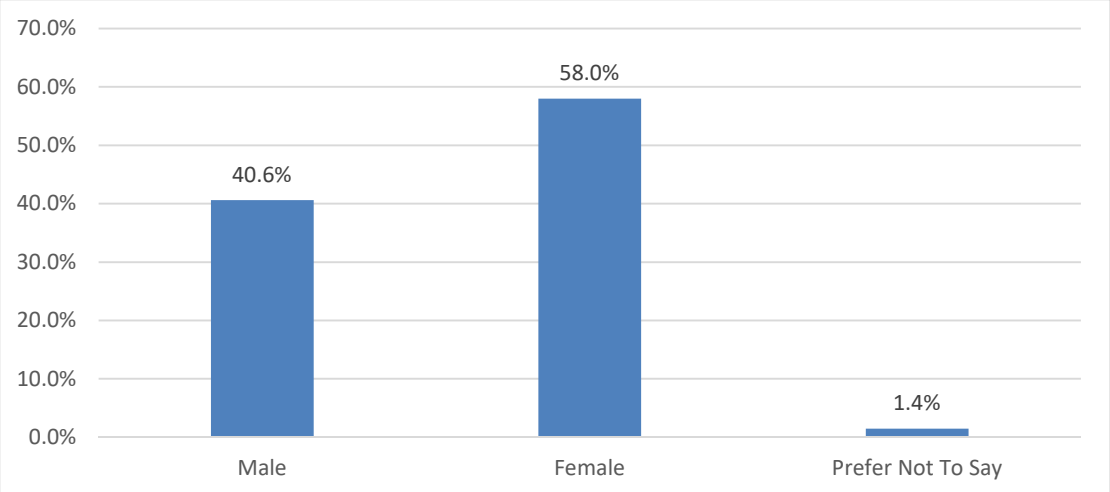
91% of respondents (63 of 67) responded to the survey as a member of the public, with only 9% of respondents completing the survey within a professional capacity or on behalf of an organisation (see **Figure A6.3**). Key partner organisations were involved in the production of the PNA via a multi-agency steering group, and pharmaceutical providers had the opportunity to respond to a survey during the production of the PNA (see Appendix 3).

Figure A6.3: Question – 'In what capacity are you responding to this survey?'

Response	Number of responses	% Of Total
A member of the public	63	91.3%
A health or social care professional	3	4.3%
On behalf of an organisation	2	2.9%
A pharmacist or appliance contractor	1	1.4%
Total	69	100.0%

The majority of respondents (58%, 40/69) were female. 28 respondents (41% of the total) were male and one (1%) elected not to disclose this information (see **Figure A6.3**).

Figure A6.4: Question – 'What is your gender?'



The ethnic background of respondents is shown in **Figure A6.5**. 62 of 69 respondents described themselves as 'British', representing 90% of the overall total. Three respondents preferred not to answer the question and a total of four respondents (6% of the total) described themselves as of Indian, African or Eastern European ethnicity.

It is useful to compare these data with the 2011 census data which can be used to describe the ethnicity of Peterborough residents. This suggests that the PNA response rate was disproportionately high among White British residents (90% of survey respondents were White British compared to 80% White British in Peterborough in the 2011 census) and conversely responses were lower from ethnic minority groups than would be expected considering the ethnic diversity of Peterborough. Only four respondents (6% of the total) identified as being part of an ethnic minority group, whereas at the time of the 2011 Census, 20% of Peterborough residents were noted as being of an ethnicity other than White British.

Figure A6.5: Question – 'How would you describe your ethnic background?'

Ethnicity	Number of responses	% Of Total
British	62	89.9%
Prefer Not To Say	3	4.3%
Indian	2	2.9%
African	1	1.4%
Eastern European	1	1.4%
Total	69	100.0%

Figure A6.6 illustrates the percentage of responses by age group. The age band with the highest number of responses was the 55-64 group with a total of 21 (30% of the overall total). Only one person under the age of 25 responded whereas 55 people aged 45 and over completed the survey (80% of the total).

Figure A6.6: Question – 'What is your age?'

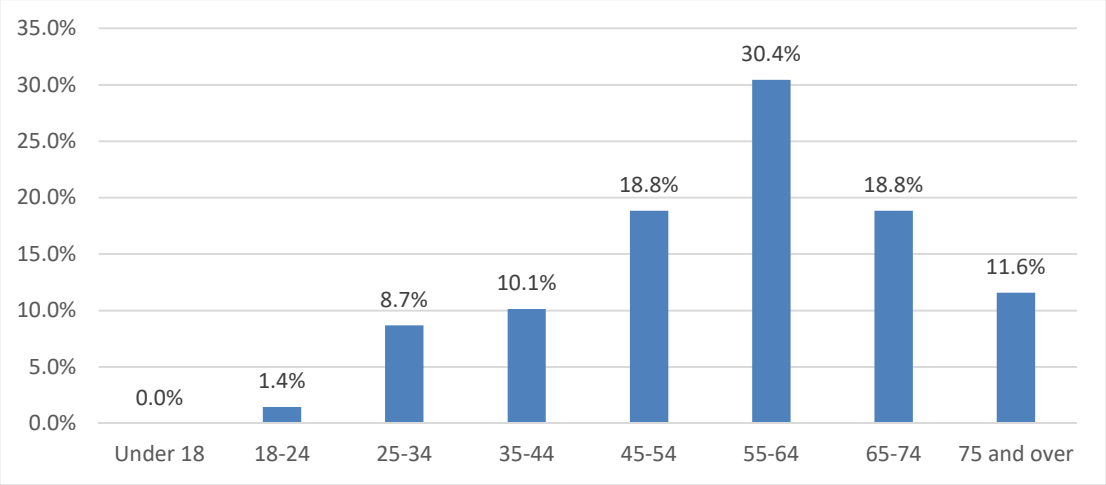


Figure A6.7 summarises responses regarding current employment status. The majority of respondents to the survey stated they were either in employment (32/69, 46%) or retired (35%).

Figure A6.7: Question – 'What is your employment status?'

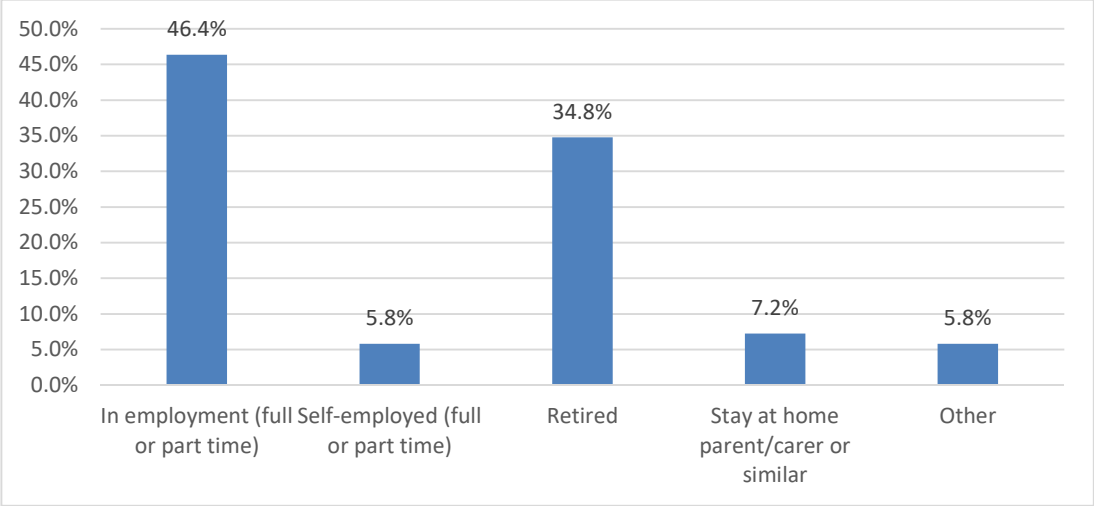
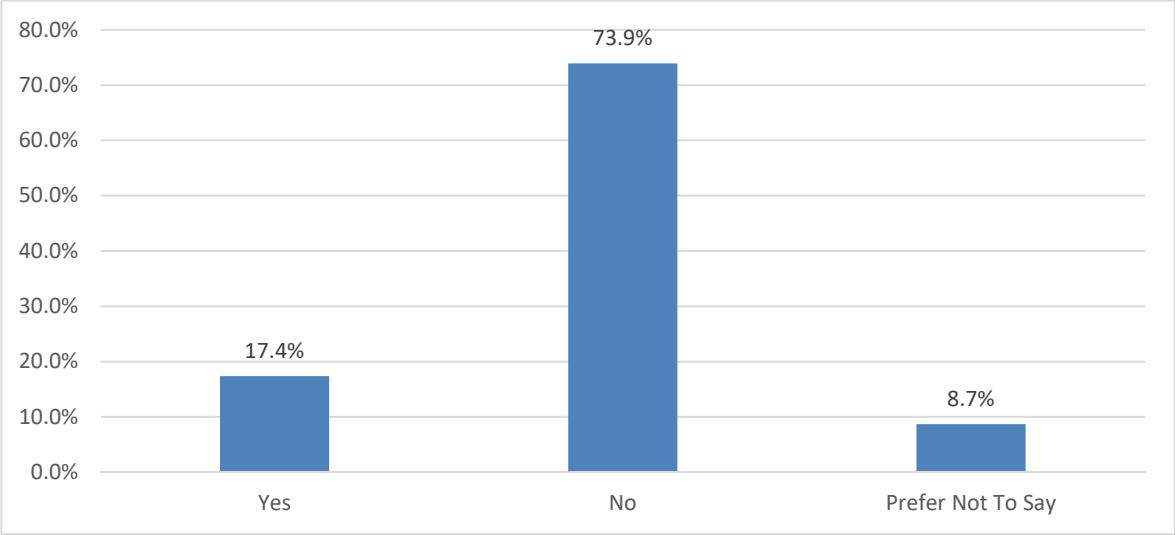


Figure A6.8 shows that the majority of people who responded to the survey said they did not have a disability. 12 respondents (17% of the total) said they had a disability. 51 respondents said they did not have a disability (74%) and six (9%) elected not to provide this information.

Figure A6.8: Question – 'Do you have a disability?'

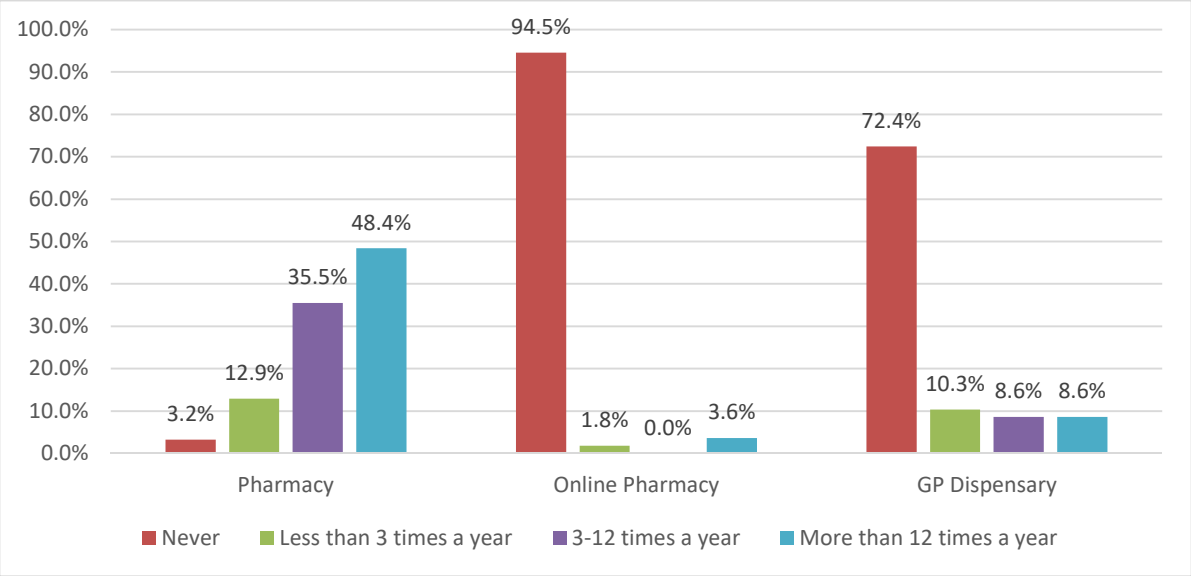


Section 2: Service experience

This section summarises responses to the questions that were targeted only to those who indicated they were responding as members of the public. The aim of these questions was to gain information on how members of the public use the pharmaceutical services available, and their experiences with using these services. **Figure A6.9** shows that:

- 72% (43 of 58) of respondents stated they never used a **GP dispensary** for pharmaceutical provisions. 17% (10 of 58) use a GP dispensary three or more times per year.
- 48% (30 of 62) of respondents use a **pharmacy** more than 12 times per year and a further 22 respondents (36%) use a pharmacy between three and 12 times per year.
- Relatively few survey respondents said they make use of an **online pharmacy**. 52 of 55 people who responded to this question (95%) said they never used an online pharmacy, with one person (2%) stating they used an online pharmacy less than three times per year and two respondents (4%) making use of the service 12 or more times per year.

Figure A6.9: Question – 'How often do you use pharmaceutical services?'



Respondents were also asked how often they used specific services provided by pharmacies/GP dispensaries and the responses to this question are summarised in **Figure A6.10**. The most common pharmaceutical service used by people who responded to the survey was the collection of prescribed medicines/appliances, with 41% of respondents stating they used this service more than 12 times per year. 84% of respondents stated that they collected prescribed medicines/appliances at least three times per year and 51% of respondents said they bought non-prescription medicines/appliances at least three times per year. 12 respondents also said they asked a pharmacist for advice on medicines/health at least three times per year. Conversely, 60 of 63 respondents (95%) said they did not ever use a dispensing appliance contractor and 61 of 63 (97%) gave back old/unwanted medicines three times a year or fewer.

Figure A6.10: Question – 'How often do you use pharmaceutical services for each of the following?'

Responses	Never		Less than 3 times a year		3 to 12 times a year		More than 12 times a year		Total	
	Responses	%	Responses	%	Responses	%	Responses	%	Responses	%
Collecting prescribed medicines/appliances	1	1.6%	9	14.3%	27	42.9%	26	41.3%	63	100%
Buying non-prescription medicines/appliances	12	19.0%	19	30.2%	28	44.4%	4	6.3%	63	100%
Giving back old/unwanted medicines	34	54.0%	27	42.9%	2	3.2%	0	0.0%	63	100%
Asking a pharmacist for advice on medicines/health	18	28.6%	33	52.4%	12	19.0%	0	0.0%	63	100%
Using a Dispensing Appliance Contractor	60	95.2%	0	0.0%	3	4.8%	0	0.0%	63	100.0%

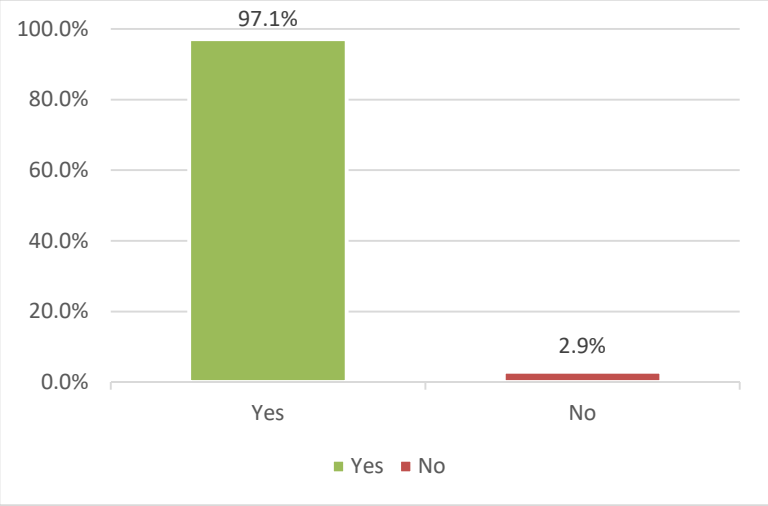
Did not answer = 6

Nine respondents made an additional comment of which six were positive about their local pharmacy or the services offered generally by pharmacists. The other respondents commented on (i) a lack of a dispensing practice locally, (ii) not being able to buy non-prescriptions medicines at a dispensary, and (iii) pharmacists referring customers to the GP for further healthcare advice.

Section 3: PNA Feedback

This section was targeted at all respondents. The questions specifically focused on the draft PNA document and asked people to ensure that the key messages and the draft PNA were reviewed and considered when responding. Responses were for the most part positive.

Figure A6.11: Do you feel that the purpose of the pharmaceutical needs assessment (PNA) has been explained sufficiently in the draft report?

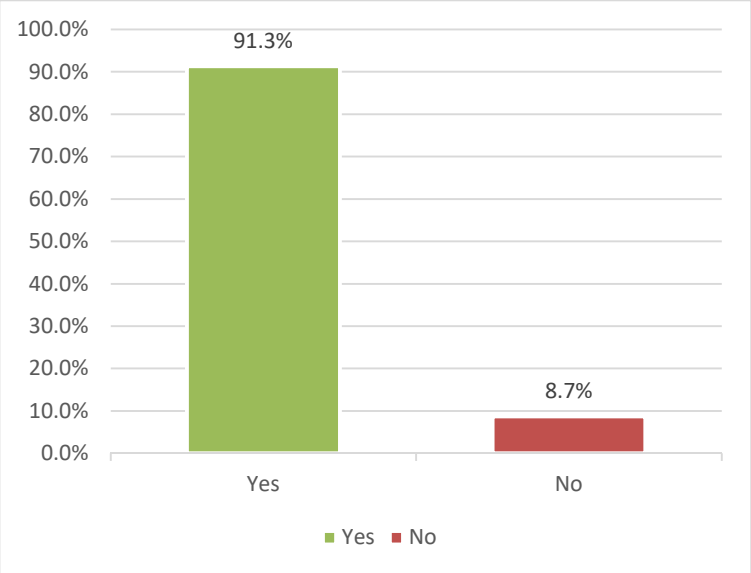


69 respondents answered this question.

97% (67 of 69) of respondents agreed that the purpose of the PNA had been explained sufficiently in the draft report.

One respondent provided a free text comment to this question stating that it was difficult to respond to the questionnaire as it was not clear whether the report covered Peterborough City or a wider area.

Figure A6.12: Do you agree with the key findings about pharmaceutical services in Peterborough?



69 respondents answered this question.

63 of 69 survey respondents (91% of the total) agreed with the key findings within this document regarding pharmaceutical services in Peterborough. Six respondents (9%) disagreed.

Four respondents provided free text comments to this question. These focused on the following issues:

- Appropriate locations of pharmacies (two respondents);
- Concern about the impact of future population growth (one respondent);
- Lack of accessible information for people with visual impairments (one respondent).

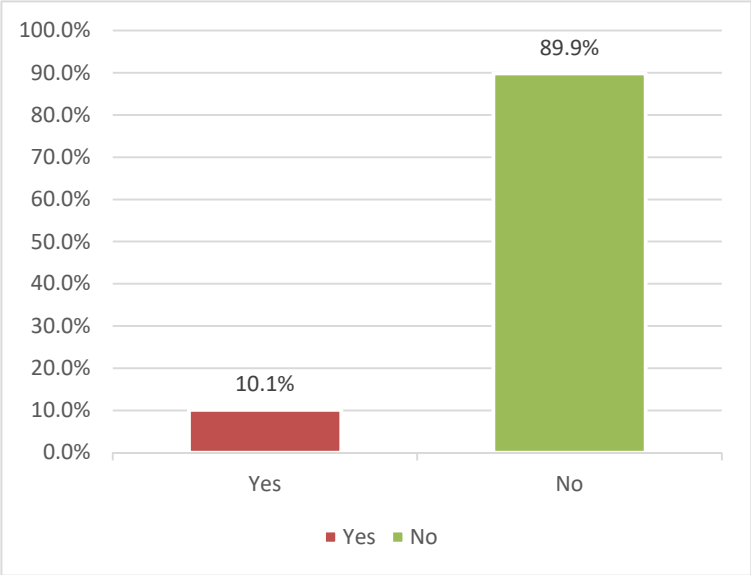


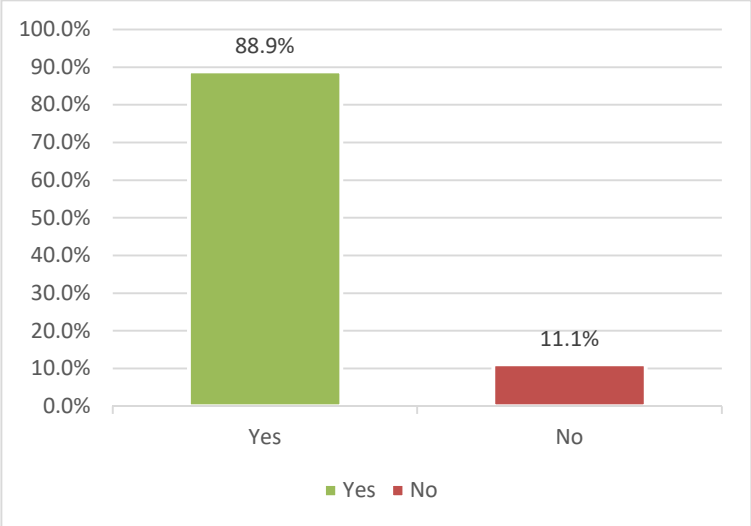
Figure A6.13: Do you know of any pharmaceutical services that are not described in the PNA that we should add?
69 respondents answered this question.

7 of 69 respondents (10%) said that they did know of pharmaceutical services not described in the PNA that should be added, whereas 62 of 69 (90%) said there were no additional services that they think should be added that were not mentioned within this document.

Six respondents provided free text comments to this question. These focused on the following issues:

- Services not included in the PNA, namely borrowing equipment after an operation and the postal supply of medicines and equipment (two respondents).
- The importance of extended opening hours, including a lack of hospital pharmacy provision at the weekend (two respondents).
- Lack of compliance with the accessible information standard (one respondent).
- Not being able to access the full PNA report due to lack of access to a computer (one respondent).

Figure A6.14: Do you think that pharmacy services are available at convenient locations?



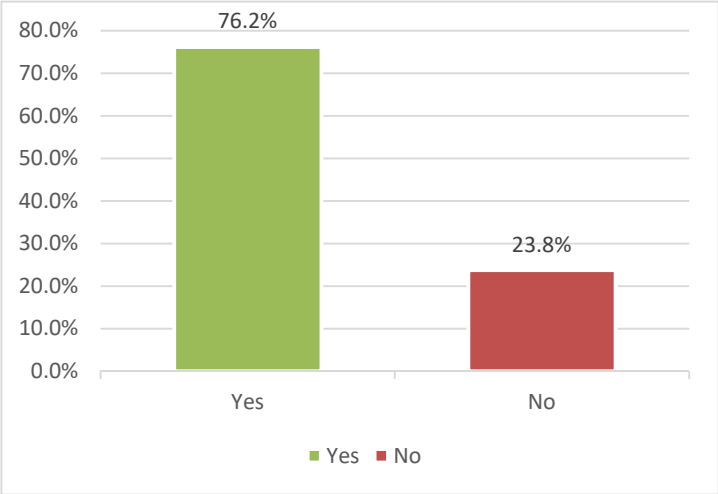
63 respondents answered this question.

56/63 (89%) respondents who answered this question said that they thought pharmacy services are available at convenient locations in Peterborough. Seven respondents did not think pharmacy services are available at convenient locations.

Eight respondents provided free text comments to this question. These focused on the following issues:

- Lack of pharmacy provision at convenient locations (five respondents), including accessibility for disabled or elderly, provision on estates including new communities, and a lack of provision outside of the city centre. In addition, one person commented that it would be unreasonable to locate pharmacies in rural village shops.
- Need for extended opening hours (two respondents)

Figure A6.15: Do you think that pharmacy services are available at convenient opening hours?

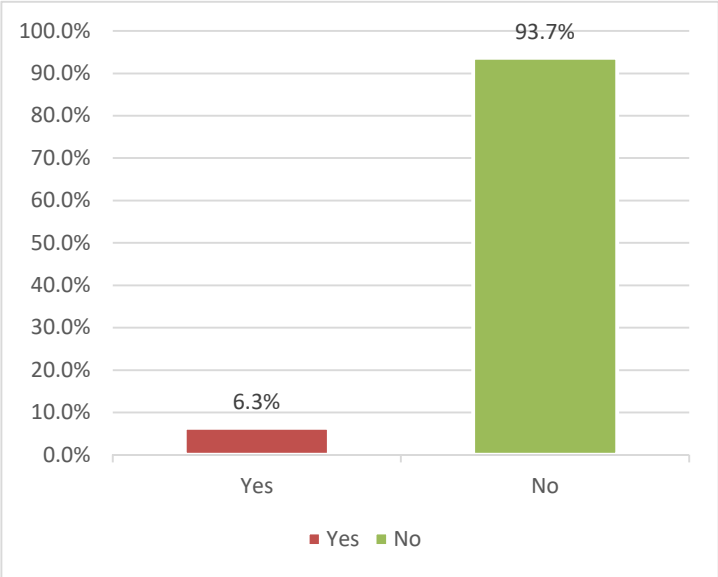


63 respondents answered this question.

48 of 63 respondents (76%) said that pharmacy services in Peterborough are available during convenient opening hours. 15 respondents said that they do not think pharmacy services are available at convenient opening hours.

19 respondents provided free text comments to this question. All comments focused on the importance of extended opening hours, including at the weekend, evening and over lunch.

Figure A6.16: Do you have any difficulties in accessing your local pharmacy or GP dispensary? (e.g. language barriers, sight impairment, hearing issues)

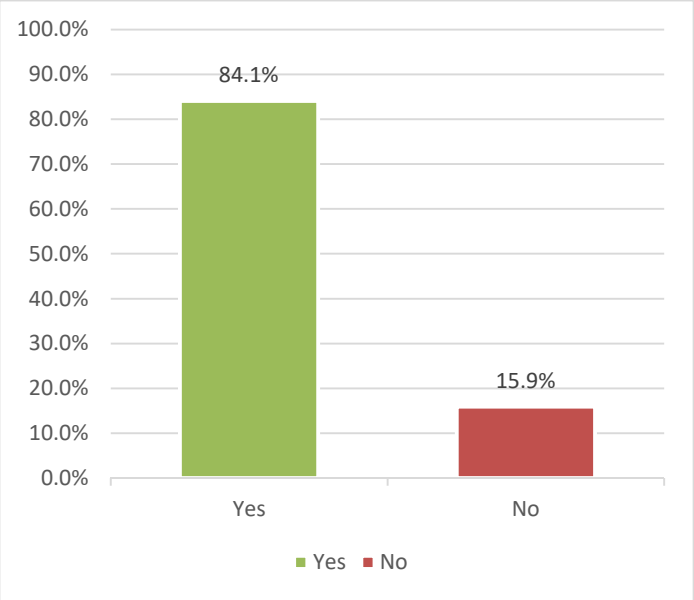


63 respondents answered this question.

59 of 63 respondents to the survey (94%) said that they did not have any difficulties in accessing their local pharmacy or GP dispensary. Four of 63 (6%) said that they did have some difficulties regarding access.

Five respondents provided free text comments to this question. These covered a range of topics including making use of home delivery services and accessibility issues due to visual impairment.

Figure A6.17: Do you agree with our conclusion that we have enough pharmacies across Peterborough and do not currently need any more?



69 respondents answered this question.

84% (58 of 69) respondents agreed that there are enough pharmacies across Peterborough; 16% (11 of 69) disagreed with the conclusion.

10 respondents provided free text comments to this question. Three of these comments were neutral and seven focused on specific needs covering the following topics:

- A need for more pharmacies in locations such as housing estates and away from the city centre (5 respondents).
- The need to monitor population growth in the future (1 respondent).
- Concern about waiting times at a local community pharmacy (1 respondent).

Additional feedback

Following on from these questions, respondents were invited to add any further comments or feedback on the PNA, and 12 respondents took up this opportunity. These comments covered the following topics:

- Positive feedback about pharmacies (4 respondents)
- Concern about health services provided by pharmacies, with a preference for provision by GPs (2 respondents)
- Accessibility of the PNA (2 respondents)
- Other / mixed comments (4 respondents)

Appendix 7: Consultation Response for the Peterborough Pharmaceutical Needs Assessment, 2017

This appendix outlines the response from the Pharmaceutical Needs Assessment (PNA) Steering Group to the feedback obtained in the consultation on the PNA for Peterborough, 2018.

The PNA consultation was undertaken from 23 October to 23 December 2017 and was made known to members of the public and key stakeholder organisations through advertisements online, in pharmacies, GP surgeries, libraries, children centres and via targeted correspondence. People were encouraged to have their say on pharmaceutical services in Peterborough by completing a standard consultation questionnaire, online or in print. The consultation was carried out in accordance with appropriate regulations, as described in the full PNA report.

There were 69 respondents to the consultation questionnaire, including some responses arriving via post after the consultation period had ended. In addition, two free-text responses were received from stakeholders via email during the consultation period. The feedback from all respondents has been summarised in a report prepared by the public health team at Peterborough City Council (see Appendix 6). The table below sets out the response from the PNA Steering Group to each question. It is notable that most respondents were supportive of the methods used to undertake the PNA and the messages presented in the draft PNA.

The Peterborough Health and Wellbeing Board value the feedback provided by respondents during the consultation exercise and will inform relevant stakeholders of the key findings of the consultation. This will include NHS England, the Clinical Commissioning Group, the Local Pharmaceutical Committee and all community pharmacies and dispensing practices.

The Peterborough Health and Wellbeing Board wishes to thank all those who responded to the public consultation and the pharmacy questionnaire, as well as those who helped to develop the PNA.

Summary of feedback to the consultation and responses to this feedback including revisions to the final PNA report

Consultation question		Summary of feedback and free text comments	Response from the PNA Steering Group on behalf of the Peterborough Health and Wellbeing Board
Service Experience			
1.	How often do you use each of the following?	The results show that the majority of people use pharmacies more often than GP dispensaries and online pharmacies. The most commonly used pharmaceutical services were the collection of prescribed and non-prescribed medicines/appliances (see Table 4 for more details). Nine people made an additional comment of which six were positive about their local pharmacy or the services offered generally by pharmacists. The other respondents commented on (i) a lack of a dispensing practice locally, (ii) not being able to buy non-prescriptions medicines at a dispensary, and (iii) pharmacists referring customers to the GP for further healthcare advice.	• **It is noted that the majority of comments received were positive.** • **<u>Lack of dispensing practice locally:</u>** the location of pharmaceutical providers is addressed in response to Question 3 (see below) and Section 4.3 of the PNA. • **<u>Supplying non-prescription medicines at dispensing practices:</u>** Dispensing practices are not able to sell over-the-counter medication at their practices. • **<u>Referral of customers to the GP for further healthcare advice:</u>** it is not possible to comment on any specific referrals for further advice from general practice. Pharmacists will need to refer some patients to seek further advice from their doctor when appropriate.
PNA Feedback			
2.	**Do you feel that the purpose of the pharmaceutical needs assessment (PNA) has been explained sufficiently in the draft report?**	69 respondents answered this question. 97% (67 of 69) of respondents agreed that the purpose of the PNA had been explained sufficiently in the draft report. One respondent provided a free text comment to this question stating that it was difficult to respond to the questionnaire as	• **It is noted that the majority of respondents felt the purpose of the PNA was sufficiently explained.** • The report has been amended to make it clear that it covers pharmaceutical provision for all areas within

		it was not clear whether the report covered Peterborough City or a wider area.	Peterborough City Council boundaries.
3.	**Do you agree with the key findings about pharmaceutical services in Peterborough?**	69 respondents answered this question. 63 of 69 survey respondents (91% of the total) agreed with the key findings within this document regarding pharmaceutical services in Peterborough. Six respondents (9%) disagreed. Four respondents provided free text comments to this question. These focused on the following issues: • Appropriate locations of pharmacies (two respondents); • Concern about the impact of future population growth (one respondent); • Lack of accessible information for people with visual impairments (one respondent).	• **It is noted that the majority of respondents agreed with the key findings about pharmaceutical services in Peterborough.** • **<u>Location of pharmaceutical provision:</u>** It is noted that two respondents commented on the appropriate location of pharmacies. The topic of accessibility and locations of pharmacies is addressed in Section 4.3 of the PNA. The report concludes that the number and distribution of pharmaceutical service provision in Peterborough is sufficient, with few gaps and some concentrations. The Steering Group recognises that there is a greater concentration of pharmacies within the city centre than in the surrounding rural areas. The majority of areas in Peterborough are accessible within 20 minutes by car, with a small number of exceptions towards the outer areas of the city, particularly in the east. Services available to help improve access to pharmaceutical services include: • Dial-a-ride service; • Home delivery services; • NHS repeat dispensing service; and

			• Distance selling (online) pharmacies. • **<u>Population growth:</u>** This topic is addressed in Section 6 of the PNA. The PNA acknowledges that an increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. The PNA considers forecasted population changes over the next three years, with particular reference to the significant housing developments that are due for completion during that time. The PNA will be fully updated in 2021. The steering group has used the feedback from respondents to develop a monitoring protocol for keeping the PNA up-to-date in the interim period, with particular consideration to the impact of population growth. The Senior Public Health Manager will continue to monitor and assess pharmaceutical need across the county in relation to population growth. The steering group will meet every six months to review the latest data on housing development sites and population projections, and the

			potential implications for pharmaceutical provision. If changes to the need for pharmaceutical services are identified, the steering group will either issue a supplementary statement of fact which acts as an amendment to the PNA, or propose a revised assessment of need if the changes are significant. It is useful to note that the purpose of the PNA is to provide a statement of pharmaceutical needs and is used by NHS England when assessing applications for the opening of new pharmacies. The Health and Wellbeing Board are not able to instruct the opening of a pharmacy which are independent contractors. However, if a need for a pharmacy is identified and is described in the PNA, an application from a business to open a pharmacy is more likely to be successful. • **Accessibility for visual impairment:** this topic is addressed in a detailed response below.
4.	**Do you know of any pharmaceutical services that are not described in the PNA that we should add?**	69 respondents answered this question. Seven of 69 respondents (10%) said that they did know of pharmaceutical services not described in the PNA that should be added, whereas 62 of 69 (90%) said there were no additional services that they think should be added that were not mentioned within this document.	• **Services not included in the PNA:** the services described are not commissioned or provided consistently across pharmacies in Peterborough, and are therefore not included in the final PNA report. • **Opening hours:** The topic of opening hours is

		Six respondents provided free text comments to this question. These focused on the following issues: • Services not included in the PNA, namely borrowing equipment after an operation and the postal supply of medicines and equipment (two respondents). • The importance of extended opening hours, including a lack of hospital pharmacy provision at the weekend (two respondents). • Lack of compliance with the accessible information standard (one respondent). • Not being able to access the full PNA report due to lack of access to a computer (one respondent).	addressed below in response to Question 6. • **Compliance with the accessible information standard:** this topic is addressed in a detailed response below. • **Lack of computer access:** it was decided not to print paper copies of the full report due to its length, although the full report was available upon request. Summary versions of the report were printed with the paper questionnaires. The steering group wrote to all locations where the questionnaire was available inviting them to contact the steering group if anyone required support completing the questionnaire. This feedback will be taken on board and used to inform planning of the next consultation.
5.	**Do you think that pharmacy services are available at convenient locations?**	63 respondents answered this question. 56/63 (89%) respondents who answered this question said that they thought pharmacy services are available at convenient locations in Peterborough. Seven respondents did not think pharmacy services are available at convenient locations. Eight respondents provided free text comments to this question. These focused on the following issues: • Lack of pharmacy provision at convenient locations (five respondents), including	• **It is noted that most respondents agreed that pharmacy services are currently available at convenient locations.** • **Location of pharmaceutical provision:** the topic of the location of pharmaceutical provision is addressed above in response to Question 3. • **Population growth:** The topic of population growth and new communities is addressed above in response to Question 3.

		accessibility for disabled or elderly, provision on estates including new communities, and a lack of provision outside of the city centre. In addition, one person commented that it would be unreasonable to locate pharmacies in rural village shops. • Need for extended opening hours (two respondents)	• **<u>Opening hours:</u>** The topic of opening hours is addressed below in response to Question 6.
6.	**Do you think that pharmacy services are available at convenient opening hours?**	63 respondents answered this question. 48 of 63 respondents (76%) said that pharmacy services in Peterborough are available during convenient opening hours. 15 respondents said that they do not think pharmacy services are available at convenient opening hours. 19 respondents provided free text comments to this question. All comments focused on the importance of extended opening hours, including at the weekend, evening and over lunch.	• **It is noted that most respondents agreed that pharmacy services are currently available at convenient opening hours.** Opening hours are considered in detail in Section 4.4 of the PNA. The PNA concludes that overall there appears to be good coverage in terms of opening hours across Peterborough, with 56% of community pharmacies being open after 6pm and 29% being open after 7pm on weekdays, 68% open on Saturdays and 24% open on Sundays. The Steering Group recognises that people may require medication outside of these hours and the out of hours general practice service, Herts Urgent Care, is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open. Pharmacies are commissioned by NHS England and contracts include mention of core hours specifying when a pharmacy must be open. However, pharmacies are independent contractors and extension of

			opening hours or closure over lunch periods is decided by each pharmacy. Often, this is to ensure that pharmacists are able to take an appropriate break, as specified by professional regulations (pharmacies are required to have a pharmacist on site when open). The NHS Choices website provides a search facility to allow you to find the nearest pharmacy that is open. The PNA recognises that maintaining the current distribution of longer opening pharmacies is important to maintain out-of-hours access for the population of Peterborough. Pharmacies are obliged to inform NHS England of alterations to their opening hours and any significant changes will be considered by the PNA Steering Group.
7.	**Do you have any difficulties in accessing your local pharmacy of GP dispensary? (e.g. language barriers, sight impairment, hearing issues)**	63 respondents answered this question. 59 of 63 respondents to the survey (94%) said that they did not have any difficulties in accessing their local pharmacy or GP dispensary. Four of 63 (6%) said that they did have some difficulties regarding access. Five respondents provided free text comments to this question. These covered a range of topics including making use of home delivery services and accessibility issues due to visual impairment.	• **It is noted that most respondents did not have difficulties in accessing their local pharmacy or GP dispensary.** • The steering group note the benefits of the **home delivery services** that many pharmacies provide. Further details on this topic are described in Section 4.3 of the PNA. • The topic of **accessibility issues due to visual impairment** is addressed below.
8.	**Do you agree with our conclusion that we have enough pharmacies across Peterborough and do not currently need any more?**	69 respondents answered this question. 84% (58 of 69) respondents agreed that there are enough pharmacies across	• **It is noted that the majority of respondents agreed with the conclusion that we have enough pharmacies across Peterborough and do not currently need any more.**

		Peterborough; 16% (11 of 69) disagreed with the conclusion. 10 respondents provided free text comments to this question. Three of these comments were neutral and seven focused on specific needs covering the following topics: • A need for more pharmacies in locations such as housing estates and away from the city centre (five respondents). • The need to monitor population growth in the future (one respondent). • Concern about waiting times at a local community pharmacy (one respondent).	• The issues about locations of pharmacies and population growth are addressed above in Question 3. • **Waiting times:** The comment about the waiting times to collect prescriptions in one pharmacy has been noted and shared with the Local Pharmaceutical Committee which represents community pharmacies in Peterborough.
9.	Do you have any other comments?	Following on from these questions, respondents were invited to add any further comments or feedback on the PNA, and 12 respondents took up this opportunity. These comments covered the following topics: • Positive feedback about pharmacies (four respondents) • Concern about health services (such as the flu vaccine) provided by pharmacies, with a preference for provision by GPs (two respondents) • Accessibility of the PNA (two respondents) • Other/mixed comments (4 respondents)	• **It is noted that a number of respondents provided positive feedback about local pharmacy provision.** • **Concern about provision of health services by pharmacies:** the PNA Steering Group believe that pharmaceutical service providers have an important role to play in improving the health and wellbeing of local people beyond providing and supporting the safe use of medicines. This role is described in more detail in Section 5 of the report. • **Accessibility of the PNA:** a brief summary of the PNA was produced and included with both the online and printed questionnaires. The Steering Group wrote to all locations where the printed questionnaire was available, asking them to make contact if anyone

			required support to access the report and complete the questionnaire. The topic of accessibility issues for those with visual impairments and compliance with the accessible information standard is addressed below. The feedback has been noted and will be used when planning future PNA consultations.
Responses from stakeholder groups See Section 2 for a full description of how stakeholders were engaged in the development of the PNA. In addition to this, some stakeholder groups provided written feedback during the formal consultation:			
	Sandie Smith, CEO of Healthwatch Cambridgeshire & Peterborough (via email) [Healthwatch are the independent champion for people who use health and social care services in Cambridgeshire and Peterborough. Healthwatch Cambridgeshire and Peterborough were involved in the production of the PNA, via membership of the PNA Steering Group.]	Healthwatch Cambridgeshire and Peterborough would like to submit the following comments and observations in response to the Peterborough Pharmaceutical Needs Assessment. 1. We welcome this Pharmaceutical Needs Assessment and the opportunity that it brings to improve understanding of local people's health needs and their access to, and use of pharmaceutical services. 2. The recommendations would appear to provide for improvements, particularly the identification of groups experiencing health inequalities and the identification of need amongst these communities. 3. We would like to highlight that local voluntary and community groups and	The PNA Steering Group welcome Healthwatch's response and their ongoing involvement in the development of PNAs in Cambridgeshire and Peterborough, via membership of the PNA Steering Group. **Commissioning of public health services:** The Steering Group agree that the voluntary sector in Peterborough already provide a number of important services to those who experience health inequalities. The Peterborough City Council public health team produce joint strategic needs assessments (JSNA) in collaboration with partners, including the voluntary sector, on behalf of the Peterborough Health and Wellbeing Board. The JSNA describes the health needs of the Peterborough population, existing services and the relevant evidence base. This information is used to inform commissioning decisions by a variety of partners, including public health preventative services. When pharmaceutical services

		organisations are already working with many of the groups highlighted as experiencing health inequalities. Any work to improve the health of disadvantaged communities will be more effective if these groups and organisations are fully engaged in every stage of the planning and delivery. The local Council for Voluntary Service can play a key role in supporting this. 4. If extra pharmaceutical services are commissioned as a result of this, a through local mapping exercise should be undertaken to assess which local groups and organisations are already working with these communities and conditions should be put in the contract that require a pharmacy to work with them. 5. We would also like to highlight that there is already confusion amongst the general public about access to primary care. We would be keen to see that there is good clear information about new roles and clinical responsibilities for pharmacies so that local people are reassured that they are seeing the correct person with the correct skills. The introduction of extra services should be preceded by clear information and education processes.	are commissioned to provide a public health service, specific requirements are detailed in the contract, including the number of staff, training and qualification requirements. Pharmacists, pharmacy technicians and pharmacy premises are regulated by the General Pharmaceutical Council. **Understanding of the role of pharmacies:** The PNA Steering Group welcome the feedback about confusion amongst the public about the role of pharmacies, and this has been communicated to key commissioners in NHS England, the CCG and the public health joint commissioning unit. **Closures and mergers of pharmacies:** The Steering Group, on behalf of the Peterborough Health and Wellbeing Board, is not able to prevent pharmaceutical providers from closing. The Steering Group has developed a monitoring protocol in order to ensure that it responds to changes in pharmaceutical need and provision between formal updates to the PNA. Any closure, and its implications for the local community, will be carefully considered by the Steering Group, and where appropriate supplementary statements to the PNA will be published. The issue of mergers is addressed specifically in Appendix 5, Section 1.5 of the PNA which states that: *As such, in the event of a consolidation in future, in accordance with Paragraph 19*

		6. Before pharmacies take on additional roles there needs to be robust reassurance that they have enough correctly qualified staff to fulfil these roles safely. 7. We would be keen to see that there is good clear information about new roles and clinical responsibilities, so that local people are reassured that they are seeing the correct person with the correct skills. 8. Pharmacies should not be combined without a full impact assessment which includes a thorough understanding of transport and access issues, particularly in rural areas.	*of Schedule 2 of the regulations the Peterborough Health and Wellbeing Board will publish a supplementary statement which will become part of the PNA, explaining whether, in its view, the proposed removal of premises from its pharmaceutical list would or would not create a gap in pharmaceutical services provision that could be met by a routine application:* *(a) to meet a current or future need for pharmaceutical services; or* *(b) to secure improvements, or better access, to pharmaceutical services.*
	Rehabilitation Officer (Vision Impairment) Therapy Services Peterborough City Council	There are approximately 1500 people registered with Peterborough City Council as having a vision impairment. This is an underestimate of the true numbers, due to systems not picking-up all certified patients, along with those undergoing additional interventions not yet having been referred. Numbers are increasing as a result of the ageing population; diets high in processed carbohydrate leading to diabetes; smoking; ocular hypertension leading to glaucoma along with trauma due to accidents. A closer estimate would be 2000-2500 and resembles figures produced by RNIB for the region. Following a year-long consultation, from 31 July 2016 all organisations that provide NHS services or social care are	The PNA Steering Group, on behalf of the Health and Wellbeing Board, values this feedback about the needs of those with visual impairments and the need for all providers of NHS care and/or publicly-funded adult social care to adhere to the Accessible Information Standard. The Steering Group recognises the importance of the accessibility of pharmaceutical services and has shared this response with all key stakeholders, including NHS England, the CCG and the Cambridgeshire and Peterborough Local Pharmaceutical Committee (LPC), which represents all community pharmacies in Peterborough.

		legally required to adopt the Accessible Information Standard (NHS England SCCI1605). My understanding of the legislation is, that this directive should be handed down by the CCG. The standard sets out the need for a proactive and cooperative approach to identifying, recording, updating and sharing, all communication needs of people with single or dual sensory loss as well as providing for that need. It is essential (and a legal requirement) that pharmaceutical providers in Peterborough meet this standard so that people with vision impairment in particular, are able to receive the information they need regarding medicines and medical practice in order to make informed decisions, taking medication safely and appropriately. More needs to be done to ensure that pharmacies, along with all parts of the health and social care systems, are working together to ensure the legal requirements of the Accessible Information Standard are met. This standard is a stated priority for CQC inspections in the period 2017-2019. Due to their isolation, marginalisation and the emotional trauma of the Psychology of Loss, people with sight difficulties rarely flag-up their specific needs. Provision of appropriate material would include large print, audio and braille formats. All drug regime plans; medication and medical intervention information leaflets; care plans and directed information should be given by	

		pharmacies; GPs; hospitals (especially the eye clinics); all councils and adult social care, in such formats. Each individual's needs should be monitored or reassessed, as the majority will face degenerative conditions, with their communication needs potentially changing as a result.	
	Cambridgeshire and Peterborough Local Medical Committee (LMC) (via survey)	The Cambridgeshire and Peterborough LMC responded via the online questionnaire and stated that: The Cambridgeshire LMC thanks you for the invitation to respond, and regrets that our own capacity issues this year have led us to be less involved in preparing the PNA than before. In the online survey response, the LMC: • Agreed that the purpose of the PNA was explained sufficiently; • Agreed with the key findings about pharmaceutical services in Peterborough; and • Agreed with the conclusion that there are enough pharmacies in Peterborough.	The Steering Group value the involvement of the LMC as a corresponding member of the Steering Group and via the completion of the online survey.

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Peterborough Pharmaceutical Needs Assessment: Monitoring Protocol

A protocol for the monitoring, assessment and response to changes in pharmaceutical needs in Peterborough (2018 – 2021)

Summary

To facilitate commissioning of pharmaceutical services responsive to population needs, the Health and Wellbeing Board (HWB) will, in accordance with regulations, update the Pharmaceutical Needs Assessment (PNA) every three years. Regulation 6 of the *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013* describes the requirements of the HWB to respond to any significant changes to pharmaceutical provision or need within the three years before a revised assessment is next published.

The Peterborough PNA Steering Group will, on behalf of the HWB, continue to identify changes to the need for pharmaceutical services within the area and assess the significance of any such changes. These changes may be due to population growth or the closure or merger of pharmaceutical sites. The HWB will publish supplementary statements or a revised PNA, where deemed appropriate in consideration of the national regulations.

This protocol describes the process that will be taken to monitor, assess and respond to any changes in the need for pharmaceutical services. It applies to the period from the publication of the Peterborough PNA 2018 Final Report (March 2018) until a revised PNA is published, which is currently planned for March 2021.

1. Background:

1.1 Pharmaceutical needs assessments

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA). The 2015 PNA is currently being updated and is due for publication in March 2018. It will describe the pharmaceutical needs for the population living within the Peterborough City Council boundaries[1]. A separate PNA is produced by the Cambridgeshire Health and Wellbeing Board.

The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Of note, before a new pharmacy can dispense prescriptions issued under the National Health Service, it must be included in the pharmaceutical list relating to a Health and Wellbeing Board Area, and applications are made to NHS England, not by the HWB. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date.

The PNA will also inform decisions by local commissioning bodies, including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs), on which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services).

[1] Throughout this protocol, 'Peterborough' refers to the area within the Peterborough City Council boundaries.

1.2 Legal requirements to keep the PNA up-to-date

HWBs are required to publish a revised PNA within three years of publication of their first assessment[i]. A revised Peterborough PNA will therefore be due for publication in July 2021.

If, during the next three years (2018 – 2021), the HWB identifies relevant changes to the need for pharmaceutical services, it is responsible for either making a revised assessment or publishing a supplementary statement as soon as is reasonably practicable. Regulation 6 of the *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013*[i] states that:

> *"(2) A HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular to changes to—*
> *(a) the number of people in its area who require pharmaceutical services;*
> *(b) the demography of its area; and*
> *(c) the risks to the health or well-being of people in its area, unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.*
>
> *(3) Pending the publication of a statement of a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its or a Primary Care Trust's pharmaceutical needs assessment (and any such supplementary statement becomes part of that assessment), where—*
> *(a) the changes are relevant to the granting of applications referred to in section 129(2)(c)(i) or (ii) of the 2006 Act; and*
> *(b) the HWB—*
> *(i) is satisfied that making its first or a revised assessment would be a disproportionate response to those changes, or*
> *(ii) is in the course of making its first or a revised assessment and is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area."*

Amendments were made to the pharmacy *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations* in December 2016[i]. One key change was a new regulation which describes the potential consolidation of two or more pharmacies onto one existing site. A new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes which would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision.

"*Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3).*"

As such, in the event of a consolidation in future, in accordance with Paragraph 19 of schedule 2 of the regulations the Peterborough HWB must publish a supplementary statement which will become part of the PNA, explaining whether, in its view, the proposed removal of premises from its pharmaceutical list would or would not create a gap in pharmaceutical services provision that could be met by a routine application:

(a) to meet a current or future need for pharmaceutical services; or
(b) to secure improvements, or better access, to pharmaceutical services.

2. Current context

There are a number of factors which may affect the likelihood of changes to the need for pharmaceutical services. These include the impact of the new national pharmacy contract and the future population changes and housing growth in Peterborough.

2.1 Local impact of the new national pharmacy contract (2016)

On 20th October 2016 the Government imposed a two-year funding package on community pharmacy, with a £113 million reduction in funding in 2016/17[ii]. This is a reduction of 4% compared with 2015/16, and will be followed by a further 3.4% reduction in 2017/18. Key changes were also made to the national pharmacy contract with the aim of creating a more efficient service which is better "*integrated with the wider health and social care system*".

Full details of the final Community Pharmacy proposals can be found in the Department of Health (DoH) report "*Community pharmacy in 2016/2017 and beyond: final package*"[ii]. Appendix 5 of the PNA 2018 provides a summary of the proposed changes to the pharmacy contracts and the potential impact of these as assessed by the DoH and the national Pharmaceutical Services Negotiating Committee (PSNC) who represent all community pharmacies providing NHS services in England.

As described in the DoH health impact assessment, it is complex to assess the impact of these changes on Peterborough residents at this stage. There is no reliable way of estimating the number of pharmacies that may close or the services which may be reduced or changed as a result of the policy and this may depend on a variety of complex factors, individual to each community pharmacy and their model of business.

2.2 Future population changes and housing growth

Over the coming years the population in Peterborough is expected to both age and grow substantially in numbers. An increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. Several large-scale housing developments are in progress and considerations when assessing needs for local pharmaceutical service providers should be based on a range of local factors specific to each development site. These are further described in Section 6 of the PNA report.

3. Process

The following process has been agreed to by the PNA Steering Group and applies to the period from publication of the Peterborough PNA 2018 Final Report (March 2018) until a revised PNA is published, which is currently planned for March 2021. Membership of the steering group is listed in the 2018 PNA Final Report.

3.1 Convening of the steering group:

The Peterborough PNA Steering Group will meet every six months (actually or virtually) to assess any identified potential changes to the need for pharmaceutical provision.

The group will be provided with:

a) a summary report of the latest population growth data and potential implication for pharmaceutical provision (more details in section 3.2);
b) a summary of any closures or mergers of pharmacy sites, and the potential implications of these (section 3.3);
c) a summary of any applications for new pharmacy sites that have been considered by NHS England in the last six months (section 3.4);
d) a summary of any other changes to pharmaceutical provision, such as relocations or changes to opening hours (section 3.5); and
e) updated maps of pharmaceutical provision (section 3.6).

The group will use the available information to decide whether:

- A supplementary statement of fact should be published to explain any changes;
- A revised assessment is required if changes of a significant extent have been identified; or,
- No further action is required before March 2021.

The steering group will be guided by the legal requirements of the relevant regulations (see section 1.2) and the *Department of Health Information Pack on Pharmaceutical Needs Assessments for local authority Health and Wellbeing Boards*[iii]. The group will also identify and consider best practice from other areas where appropriate and available.

3.2 Monitoring of population growth:

Given the significant planned growth of new developments across Peterborough, the Senior Public Health Manager for Environment and Planning will continue to monitor and assess pharmaceutical need in these areas. They will produce a report in advance of each steering group meeting using the information sources described in section 6 of the PNA, to update the steering group on the latest data on housing development sites and population projections, and the potential implications for pharmaceutical provision. Section 6 of the PNA also describes the factors that will be considered in relation to needs for pharmaceutical services.

The Senior Public Health Manager will link with any ongoing work that is happening in partnership with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (East) in relation to forecasting the impact of population growth on health services in general to ensure that pharmaceutical provision is considered alongside other health services.

3.3 Closures and mergers of pharmaceutical provision:

The relevant Contract Manager in NHS England (East) will inform and consult with the Lead Consultant in Public Health on any closures or mergers of pharmaceutical service providers, who will convene a steering group meeting (actually or virtually) to assess the potential impact of the closure or merger and produce a supplementary statement to the PNA.

3.4 Applications for new pharmaceutical provision:

The relevant Contract Manager in NHS England (East) will inform and consult with the Lead Consultant in Public Health on any application for new pharmaceutical provision. This will enable public health to share any relevant knowledge, including current information about population growth and its impact on pharmaceutical services. If an application is approved, the Health and Wellbeing Board will issue a supplementary statement to update the current PNA.

3.5 Other changes to pharmaceutical provision:

The relevant Contract Manager in NHS England (East) will inform and consult with the Lead Consultant in Public Health, on behalf of the steering group, on any other changes to pharmaceutical provision in Peterborough which may have an impact on local access to pharmaceutical services. This may include relocation of community pharmacies and changes to opening hours, such as significant changes to the opening hours of one pharmacy that plays a key role in providing pharmaceutical services out of hours, or smaller changes to a number of pharmacies in a local area.

3.6 Maps of pharmaceutical provision:

The Public Health Intelligence (PHI) team will be responsible for updating the maps of pharmaceutical provision as soon as possible following notification from NHS England of any closures, mergers or new pharmaceutical providers. The PHI team will review the maps in advance of the steering group meetings and provide the steering group with the latest version.

3.7 Role of the Peterborough Health and Wellbeing Board:

The steering group will assess any changes in the need for pharmaceutical provision and produce supplementary statements or a revised assessment on behalf of the Peterborough HWB. The steering group will write to the HWB to inform them of the identified change and the action the group has taken in advance of publishing any supplementary statements. It is proposed that the HWB delegates authority to the Director of Public Health, in discussion with the Chair or Vice-Chair of the HWB to note the information and approve any supplementary statements for publication. If a revised assessment is required, the steering group will inform the HWB and start the process for producing a revised PNA (as outlined in section 2 of the 2018 PNA report).

3.8 Publication:

Following endorsement by the HWB, any supplementary statements or revised assessments will be published on the Peterborough City Council website www.peterborough.gov.uk alongside the original 2018 PNA report. The steering group will write to all key stakeholders, who were involved in the development of the PNA, to inform them of the publication of any supplementary statements. Publication will be communicated to the public via the Peterborough City Council website and social media accounts. Other members of the steering group will publicise the information via their websites and/or social media as they deem appropriate.

3.9 Review of protocol:

This protocol will be reviewed at each steering group meeting, at least every six months, to ensure it continues to be fit for purpose.

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[i] National Health Service England. ' The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016' (2016 No.1077). Available at: http://www.legislation.gov.uk/uksi/2016/1077/contents/made

[ii] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

[iii] Department of Health. 'Pharmaceutical needs assessments – information pack for local authority Health and Wellbeing Boards. (May 2013). Available at: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7
19 MARCH 2018		PUBLIC REPORT
Contact Officer(s):	Report Author Dr Linda Sheridan	Tel. 07943 502672

ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH 2016/7

RECOMMENDATIONS	
FROM : Director of Public Health	**Deadline date :** *N/A*
The Health and Wellbeing Board is asked to comment on the Annual Health Protection Report and on future priorities for health protection in Peterborough.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the Peterborough City Council Public Health Office and is produced using data and information provided by partner organisations including Public Health England, NHS England and Cambridgeshire and Peterborough Clinical Commissioning Group.

2. PURPOSE AND REASON FOR REPORT

2.1 This report provides an annual summary on activities in Peterborough to ensure health protection for the local population and includes areas that are covered by the Peterborough Health and Well-being Strategy

2.2 The services that fall within Health Protection include:

i. communicable diseases – their prevention and management
ii. infection control
iii. routine antenatal, new born, young person and adult screening
iv. routine immunisation and vaccination
v. sexual health
vi. environmental hazards.

2.3 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.

2.4 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.

3. MAIN ISSUES

The main body of the Annual Health Protection Report is attached separately as Appendix A. In summary the report provides information on:

- Communicable disease surveillance including information on an increase in infections caused by Group A Streptococcus, including scarlet fever and more invasive infection.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination, but low uptake of the pre-school booster, MMR2 and HPV vaccines for which some targeted communications is in hand via the Healthy Peterborough programme.
- Screening in which there is continued below average uptake of breast, cervical and bowel cancer screening in Peterborough but further targeted work is planned to try to increase uptake.
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The City Council Environmental Health role in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)
- Sexual health including the recommendations of a prevention needs assessment and the work of the Sexual Health Delivery Board. Key priorities for action include the reducing the rate of new sexually transmitted infections including HIV, reducing late diagnosis of HIV and continued reduction in teenage pregnancy rates.
- Health emergency planning, achievement of the priorities over the past year and identification of new priorities.

4. CONSULTATION

4.1 Many of the areas discussed have been subject to consultation on those individual areas.

5. ANTICIPATED OUTCOMES

5.1 This report helps us to identify the main problems and issues and to prioritise our activities over the next year.

6. REASONS FOR RECOMMENDATIONS

6.1 There are no specific recommendations included in the report, but the overarching recommendation is that the multi-agency Health Protection Steering Group should prioritise actions to address any issues over the next year. The Health and Wellbeing Board is asked to comment on future priorities for health protection in Peterborough.

7. ALTERNATIVE OPTIONS CONSIDERED

N/A

8. IMPLICATIONS

8.1 There are no specific implications in this report but a number of areas are reported where outcomes are below the desired level, and these will need to be addressed in partnership with those organisations that deliver the services that affect health protection.

9. BACKGROUND DOCUMENTS

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

The report has been produced using information and data specifically provided to the Health Protection Steering group for the purpose of writing the report. External contributors include Public Health England, NHS England and Cambridgeshire and Peterborough Clinical Commissioning Group. The report is attached as Appendix A.

10. Appendices

10.1 APPENDIX A: PETERBOROUGH ANNUAL HEALTH PROTECTION REPORT 2017/8

Some of the data included in the report are also available on the Public Health Outcomes Framework website https://www.gov.uk/government/collections/public-health-outcomes-framework and the national immunisation statistics site https://digital.nhs.uk/catalogue/PUB30085 or https://www.gov.uk/government/statistics/childhood-vaccination-coverage-statistics-england

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PETERBOROUGH CITY COUNCIL

ANNUAL HEALTH PROTECTION REPORT 2017-2018

Contents

Annual Health Protection Report for Peterborough 2017-2018

1. INTRODUCTION

This report provides an annual summary on activities in Peterborough to ensure health protection for the local population and includes areas that are covered by the Peterborough Health and Well-being Strategy

The services that fall within Health Protection include:

i. communicable (infectious) diseases – their prevention and management
ii. infection control
iii. routine antenatal, new born, young person and adult screening
iv. routine immunisation and vaccination
v. sexual health
vi. environmental hazards.

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.

The Director of Public Health (DPH) produces an annual health protection report to the Health & Wellbeing Board (HWB) which provides a summary of relevant activity. This report covers multi-agency health protection plans in place which establish how the various responsibilities are discharged. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern had arisen.

Details of the legislative background to the role of DPH and the role of the City Council in relation to health protection has been included in previous annual health protection reports and will not be reproduced here.

2. PETERBOROUGH HEALTH PROTECTION COMMITTEE

To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Peterborough Health Protection Committee (PHPC) was established in October 2013 and is chaired by the DPH or nominated deputy. The PHPC enabled 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. In addition, a memorandum of understanding (MOU) has been agreed with partner organisations. The PHPC facilitated information sharing and planning across agencies.

With the greater sharing of public health roles across the two local authorities, Peterborough City Council and Cambridgeshire County Council, and in recognition that the role of many of the organisations that contribute to the PHPC also cover the wider geography, it was agreed to bring the committees for both areas together from October 2015. Initially the agendas consisted of three sections: Peterborough only items; Joint Peterborough and Cambridgeshire items; and Cambridgeshire only items. However it became clear that most items of concern to the committee were shared across the two areas and from October 2016, the agendas were merged and revised. Terms of Reference were drawn up for the Joint Cambridgeshire and Peterborough Health Protection Steering Group. To ensure that the shared membership fully protected the confidentiality of any sensitive items discussed the Terms of Reference include a Confidentiality/Non-disclosure Agreement.

3. SURVEILLANCE

3.1 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify suspected cases of certain infectious diseases. These notifications along with laboratory and other data are an important source of surveillance data.

Table 0.1: Notifiable Diseases in Peterborough

Notifiable Disease*	**2014**	**2015**	**2016**	**2017*****
Acute infectious hepatitis	7	17	14	13
Acute meningitis	<5	<5	<5	<5
Food poisoning (excluding campylobacter**, but including the organisms below)	71	63	86	59
E coli O157 VTEC	<5	<5	<5	<5
Cryptosporidium	13	18	19	15
Giardia	15	12	20	6
Salmonella	34	23	38	35
Infectious bloody diarrhoea	8	<5	6	<2
Invasive group A streptococcal disease	9	<5	7	14
Legionnaires' disease	0	<5	<5	<5
Malaria	<5	<5	<5	0
Measles*	5 (0)	<5 (0)	<5 (0)	<5 (0)
Meningococcal septicaemia	5	<5	<5	<5
Mumps*	8 (<5)	8 (<5)	11 (<5)	10 (<5)
Rubella*	<5	<5	0	<5
Scarlet fever	20	98	56	92
Whooping cough	18	15	49	33

***** Please note that 2017 numbers are provisional**

SOURCE: East of England HPT HPZone

* *These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases. There have been no confirmed cases of Rubella.*

† *Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5.*

** *During 2016, the HPT stopped importing laboratory reports of campylobacter into its HPZone database as public health follow up is not undertaken for individual cases and there is a national system for laboratory surveillance.*

3.2 There was a marked increase in Invasive Group A streptococcal (iGAS) disease cases in 2017, double the number of cases for 2016. The iGAS cases were not linked and no pattern to the cases has been identified. There has also been a big rise in iGAS cases nationally in January 2018, reasons for the rise in iGAS infection are not known, with preliminary analysis suggesting a rise in influenza co-infection. Group A Streptococcus (GAS(is a bacterium that can cause diverse range of skin, soft tissue and respiratory tract infections, but occasionally can cause infections that are very severe. Invasive GAS is an infection where the bacteria is isolated from a normally sterile body site such as the blood.

3.3 Outbreaks and Incidents

There have been 7 outbreaks of gastroenteritis. Of these 6 were in care homes and 1 was a day centre. None were laboratory confirmed.

34 Tuberculosis surveillance

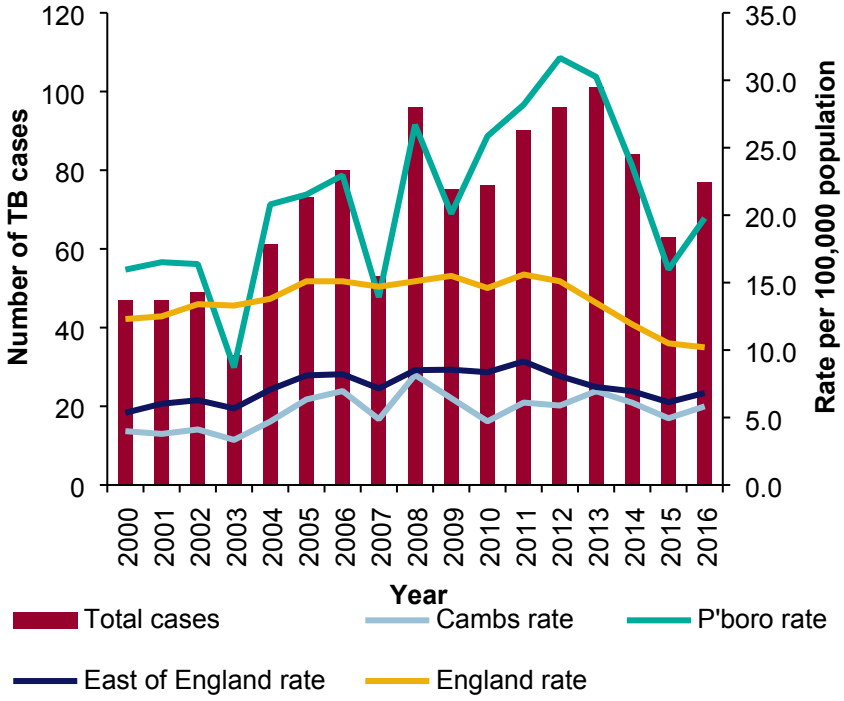
The minimal dataset collected through the NOIDs system affords no possibility to monitor trends within subgroups in the population. The increasing incidence of TB in E&W, particularly affecting subgroups within the population, led to the introduction, on 1 January 1999, of continuous Enhanced Tuberculosis Surveillance (ETS). This aims to provide detailed and comparable information on the epidemiology of TB by collecting a minimum dataset on all cases of TB reported by clinicians.

Official TB statistics are based on data extracted from ETS in April each year. The time to process and analyse this data takes a further six months, therefore the latest official statistics are for data to the end of 2016.

- In 2016, 77 cases of TB were notified among residents of Cambridgeshire and Peterborough local authorities (Fig. 0.1). The TB rate in Cambridgeshire (5.8 per 100,000) remains below the East of England average (6.8 per 100,000), whereas the rate in Peterborough (19.8 per 100,000) has declined since 2012 (31.7 per 100,000) but remains substantially higher than average. TB cases increased in both areas in 2016 compared to 2015.
- The majority of cases were aged 15-44 years, with a mean age of 41.7 years.

- 77.6% of cases were non-UK born, with India, Pakistan, Timor-Leste and Lithuania being the most common non-UK countries of birth. In 2016, substantially more cases were UK born than in 2015.
- A larger proportion of patients in Peterborough had social risk factors (34.4%) compared to the national average (15.4%), whereas Cambridgeshire cases showed no notable difference (15.6%).

Figure 0.1: Annual TB notifications 2000-2016



4. PREVENTION

4.1. Immunisation programmes

The tables below detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. Overall uptake is steady or has increased for most of the childhood programmes and for the seasonal influenza vaccination programme, which appears to indicate some success from the work we have undertaken with partner organisations to improve uptake. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures Herd Immunity. However the target uptake as outlined in the Public Health Outcomes Framework is 90%.

Herd immunity occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. It arises when a high percentage of the population is protected through vaccination, making it difficult for a disease to spread because there are so few susceptible people left to infect.

This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people

with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients). Details of the UK vaccination programme and what each vaccine protects against are included at Annex 1 at the end of this report.

4.1.1 Childhood Primary Vaccinations

Table 1: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

12 months DTaP/IPV/Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**94.8**	**96.3**	**96.1**	**93.8**
East Anglia	95.6	95.6	95.4	95.5
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**93.5**	**93.8**	**93.9**	**94.3**
East Anglia	95.0	95.2	95.2	95.0

Source: Cover, Public Health England

Figure 1.0 - 12m DTaP/IPV/Hib Percentage Uptake in Peterborough by Similar Local Authorities

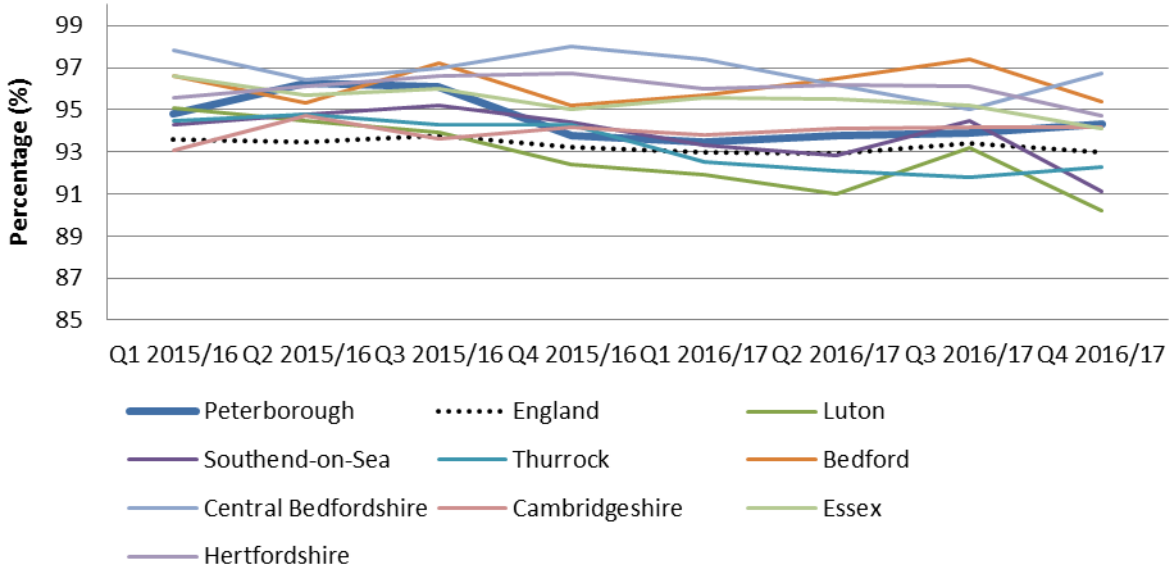


Table 2: Pneumococcal Vaccine

12 months PCV [target 95%] [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**94.5**	**95.8**	**96.6**	**93.0**
East Anglia	95.4	95.4	95.5	95.6
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**93.6**	**93.6**	**93.5**	**94.2**
East Anglia	95.4	95.3	95.3	95.1

Source: Cover, Public Health England

Figure 2.0 - 12m PCV Percentage Uptake in Peterborough and Surrounding Geographical Area

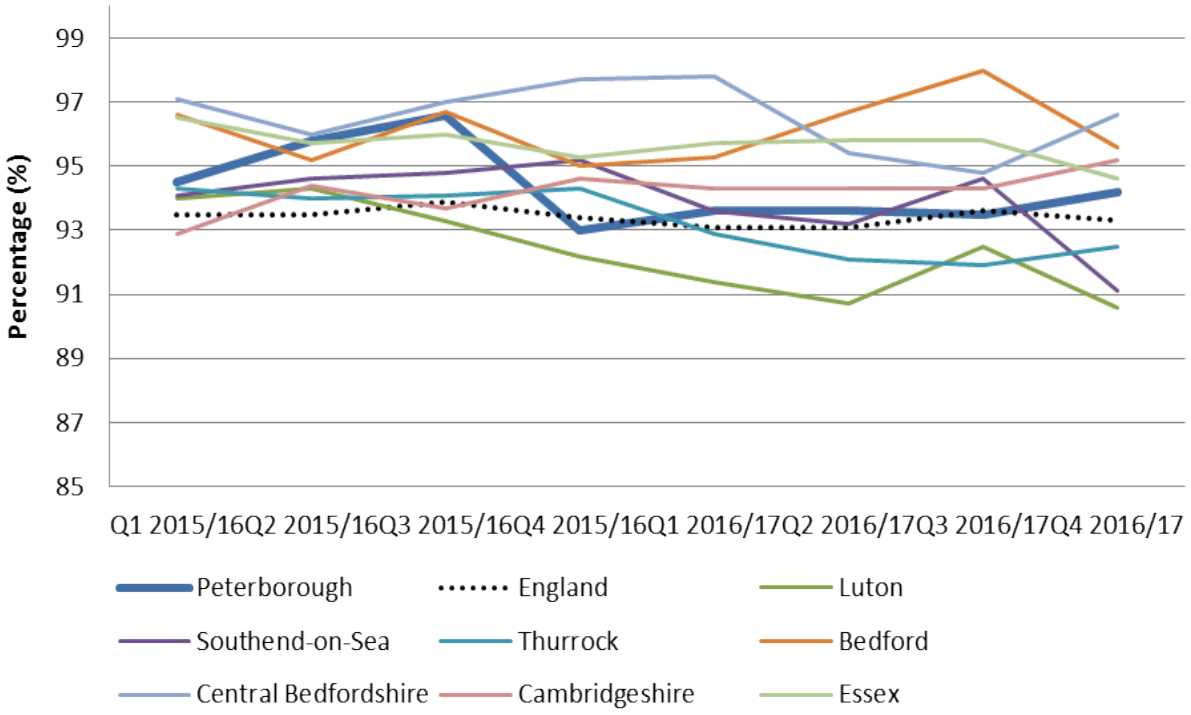


Table 3: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

24 months DTaP/IPV/Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**95.5**	**96.2**	**96.0**	**97.2**
East Anglia	96.5	95.7	96.2	96.0
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**95.6**	**96.9**	**96.4**	**96.4**
East Anglia	96.1	96.2	96.4	96.3

Source: Cover, Public Health England

Table 4: Pneumococcal vaccine

24 months PCV Booster [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**92.8**	**92.8**	**93.7**	**92.6**
East Anglia	93.6	93.0	93.5	93.3
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**91.2**	**91.9**	**89.9**	**90.8**
East Anglia	92.9	94.3	94.1	94.0

Source: Cover, Public Health England

Figure 3.0 - 24m PCV Booster Percentage Uptake in Peterborough and Surrounding Geographical Area

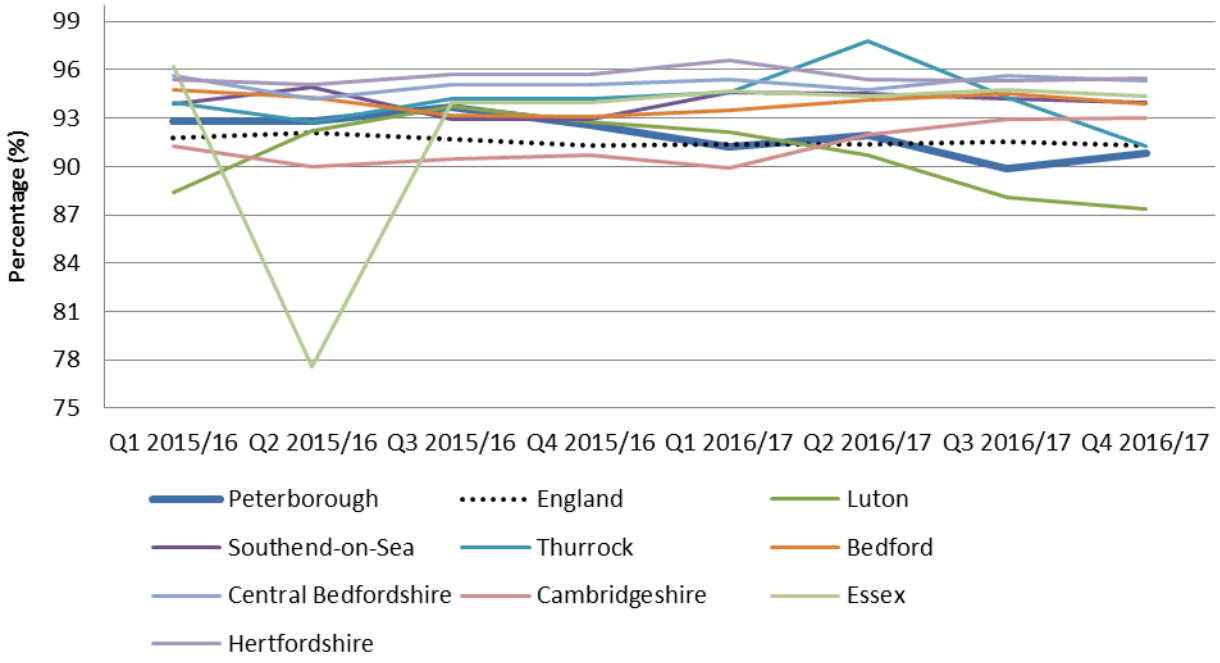


Table 5: Haemophilus Influenza B and Meningococcus C

24 months Hib/Men C [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**92.6**	**91.5**	**93.3**	**91.9**
East Anglia	93.8	92.5	93.4	93.3
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**90.8**	**92.6**	**89.5**	**90.7**
East Anglia	92.8	94.3	94.1	94.0

Source: Cover, Public Health England

Table 6: Measles, Mumps and Rubella

24 months MMR 1 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**92.6**	**92.6**	**92.1**	**92.1**
East Anglia	93.4	92.3	93.1	93.4
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**91.8**	**92.2**	**89.2**	**91.6**
East Anglia	92.7	93.8	93.9	94.0

Source: Cover, Public Health England

Figure 4.0 - 24m MMR1 Percentage Uptake in Peterborough and Surrounding Area

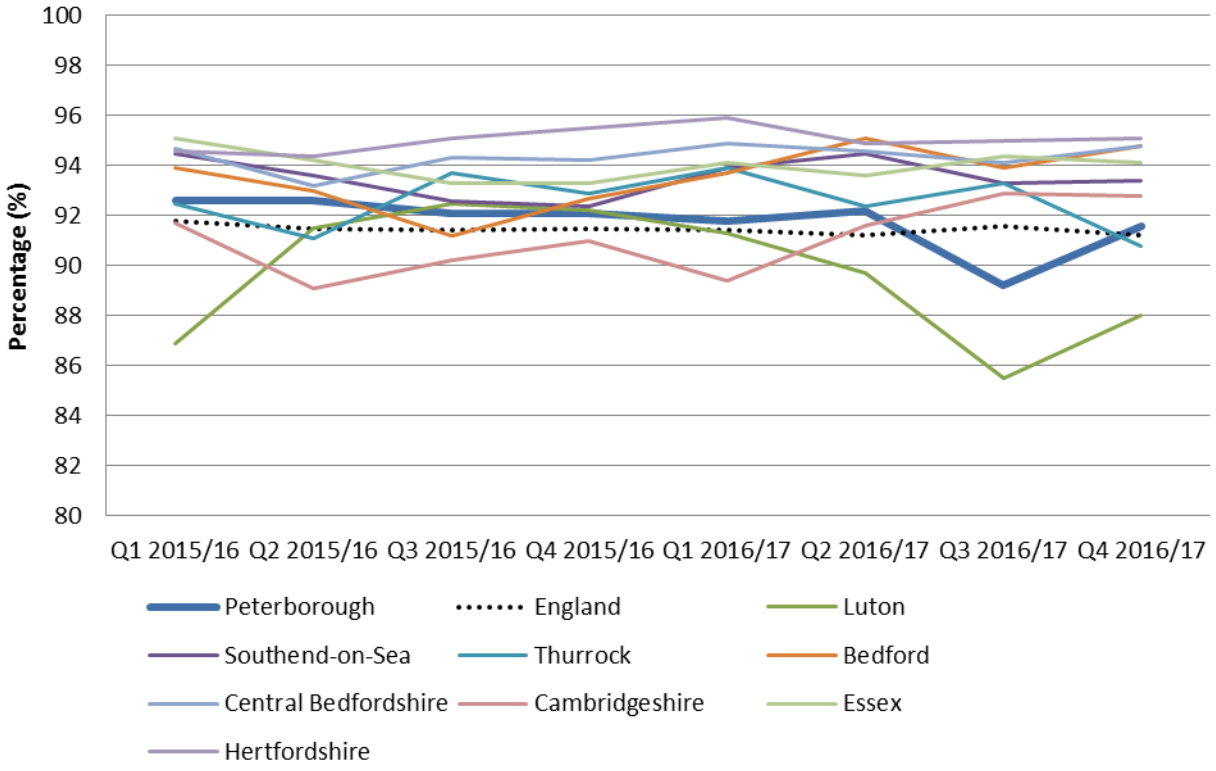


Table 7: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

5 years DTaP IPV Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**97.6**	**92.5**	**96.4**	**95.2**
East Anglia	96.2	95.3	95.6	96.2
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**95.7**	**96.4**	**97.5**	**97.1**
East Anglia	96.0	96.9	96.2	96.2

Source: Cover, Public Health England

Table 8: Measles, Mumps and Rubella (first dose)

5 years MMR 1 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**95.5**	**89.0**	**94.6**	**93.9**
East Anglia	94.2	93.1	93.8	95.2
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Peterborough	**95.3**	**95.7**	**96.6**	**96.7**
East Anglia	95.4	96.0	95.5	95.6

Source: Cover, Public Health England

Figure 5.0 - 5y MMR1 Percentage Up in Peterborough and Surrounding Geographical Area

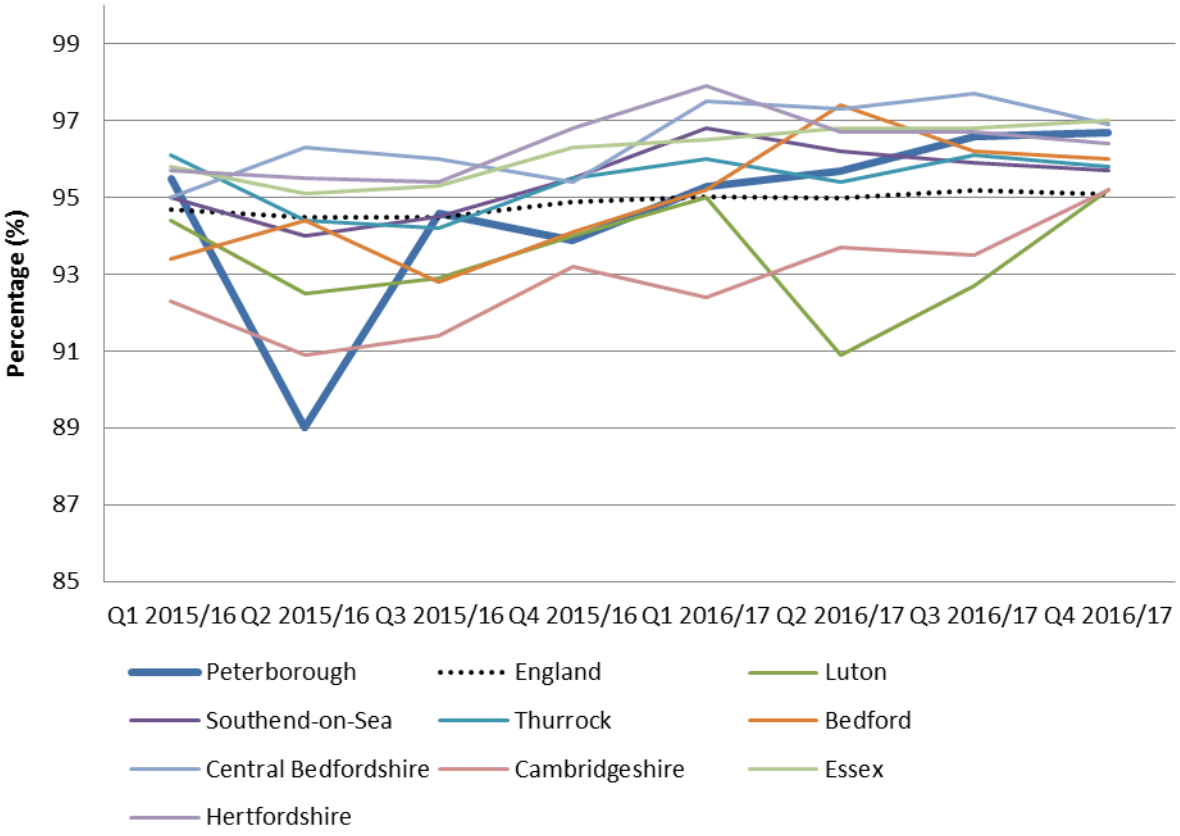


Table 9: Measles, Mumps and Rubella (second dose)

5 years MMR 2 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**90.0**	**89.0**	**88.9**	**89.9**
East Anglia	91.4	88.8	89.4	90.8
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Peterborough	**89.8**	**91.6**	**92.6**	**88.6**
East Anglia	88.2	89.8	90.1	90.1

Source: Cover, Public Health England

Figure 6.0 - 5y MMR2 Percentage Uptake in Peterborough and Surrounding Geographical Area

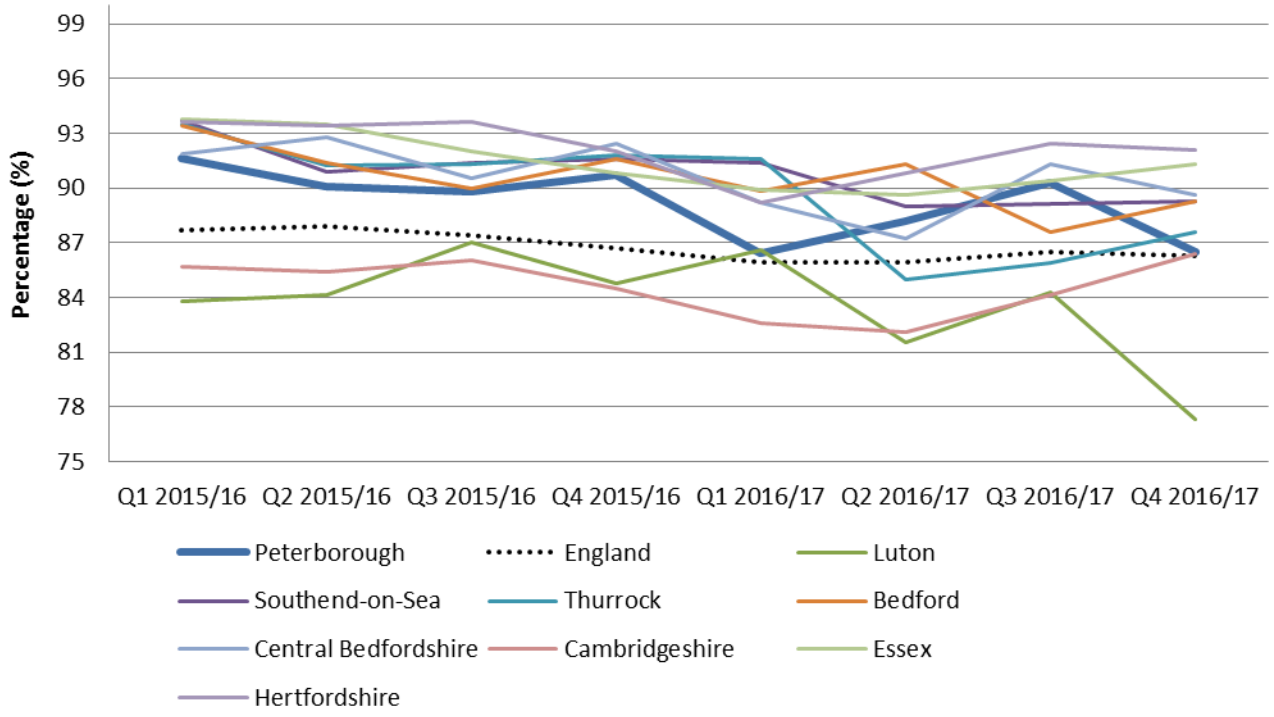


Table 10: Diphtheria, Tetanus, Pertussis, Polio

5 years DTaP/IPV Booster [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**91.6**	**90.1**	**89.8**	**90.7**
East Anglia	90.7	89.5	90.4	89.0
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Peterborough	**86.4**	**88.2**	**90.3**	**86.5**
East Anglia	87.6	88.7	88.8	89.1

Source: Cover, Public Health England

4.1.2 The very low uptake of the MMR2 and DTaP/IPV boosters by age 5 years are subject to specific communications using the Healthy Peterborough programme.

Figure 7.0 - 5yDTaP/IPV Booster Percentage Uptake in Peterborough and Surrounding Geographical Area

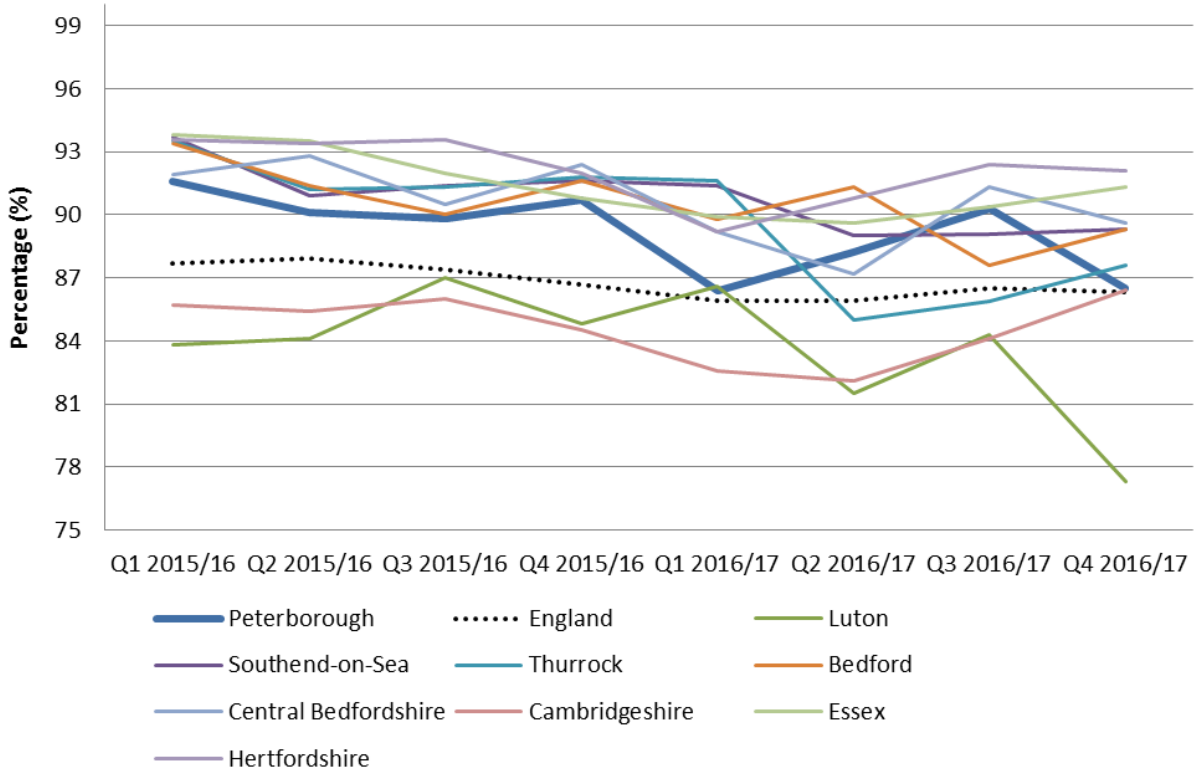


Table 11: Haemophilus Influenza B and Meningococcus C

5 years Hib/Men C [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	**92.0**	**91.8**	**91.4**	**89.4**
East Anglia	93.1	93.0	92.9	92.2
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Peterborough	**88.9**	**88.5**	**91.3**	**92.9**
East Anglia	91.2	93.4	93.0	93.2

Source: Cover, Public Health England

https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2013-to-2014-quarterly-figures
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2014-to-2015-quarterly-data
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2015-to-2016-quarterly-data

4.1.3 Meningitis B

New vaccines introduced include **Meningitis B** vaccine as part of the primary vaccination for infants. This commenced **1st September 2015**. It is offered to all babies when they attend for their first and third routine vaccinations, at 2 months and again at 4 months. A booster is offered at 12/13 months.

Table 12: Meningitis B

12 months Men B [target 95%]	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	**Data not collected**	**91.6**	**92.9**	**93.7**
East Anglia	**Data not collected**	**93.7**	**94.4**	**94.6**

Source: Cover, Public Health England

4.1.4 Men ACWY

Men ACWY was introduced following an increase in Men W infections. This is being delivered to adolescents by school immunisation providers. The 17-18 year old catch up offered through primary care started in August 2015.

Table 13: Men ACWY

Org Name	Vaccine uptake – December 2017					
	Becoming 18 (born 1st Sep 1997 to 31st Aug	**No. of patients that have received the MenACWY**	**% Uptake**	**Becoming 19 (born 1st Sep 1996 to 31st Aug 1997 inclusive)**	**No. of patients that have received the MenACWY**	**% Uptake**
Cambridgeshire & Peterborough CCG	11839	3799	32.0%	12099	4686	38.7
East Anglia Total	**29607**	**8880**	**30.0**	**30253**	**11710**	**38.7**

Source: ImmForm December 2017

Table 14: Annual HPV Vaccine Coverage Data September 2016-17

Local Authority		Peterborough City Council	England
Cohort 13: 13-14 Year Olds (Year 9) Birth Cohort: 1 September 2002 - 31 August 2003	Number of females in Cohort 13 (Year 9)	1180	289499
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2017	1062	257201
	% Coverage	**90.0%**	**88.8%**
	No. vaccinated with two doses by 31/08/2017	1005	240590
	% Coverage	**85.2%**	**83.1%**
Cohort 12: 13-14 Year Olds (Year 10) Birth Cohort: 1 September 2001 - 31 August 2002	Number of females in Cohort 12 (Year 10)	1124	281685
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2017	1078	254554
	% Coverage	95.9	90.4
	No. vaccinated with two doses by 31/08/2017	1102	240929
	% Coverage	**98.0%**	**85.5%**

Source: Public Health England

4.1.5 Seasonal Flu Vaccination

Flu vaccination uptake improved this year for most groups but especially for the younger at risk groups and for NHS staff

Table 15: Flu vaccination uptake by key groups

Area	Summary of flu vaccine uptake %					
	65 and over		Under 65 (at risk)		Pregnant women	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Cambridgeshire & Peterborough CCG	**72.4**	**72.1**	**42.7**	**47.2**	**32.2**	**46.7**
East Anglia	71.3	71	42.8	47.1	36.7	47.9

Source: ImmForm

Table 16: Seasonal flu vaccination uptake by age 2, 3 and 4 year olds

Area	Summary of flu vaccine uptake %					
	All aged 2		All aged 3		All aged 4	
	2015/6	2016/7	2015/6	2016/7	2015/6	2016/7
Cambridgeshire & Peterborough CCG	**37**	**39.7**	**39.3**	**42.0**	**29.7**	**33.3**
East Anglia	39.1	42.1	40.8	43.9	32.0	35.4

Source: ImmForm

Table 17: Front line healthcare workers in Trusts

Org Name	No. of HCWs with Direct Patient Care	Seasonal Flu doses given since 1st September 2016		% Seasonal flu doses given since 1st September 2015
		No.	%	%
Papworth Hospital NHS Foundation Trust	1510	1114	73.8	64.9
Peterborough and Stamford Hospitals NHS Foundation Trust	3865	2067	53.5	62.1
Hinchingbrooke Health Care NHS trust	1215	920	75.7	63.6
Cambridgeshire and Peterborough NHS Foundation Trust	3375	1358	40.2	35.8
East Anglia Total	**50249**	**29012**	**57.7**	**43.1**

Source: ImmForm

We have been advised by Public Health England that flu vaccination uptake is higher in the 2017/8 season than in the 2016/7 season, but have not been provided with the validated data yet.

4.1.6 Prenatal Pertussis Vaccination

Following increased pertussis activity in all age groups, including infants under three months of age, and the declaration of a national pertussis outbreak in April 2012, pertussis vaccine has been offered to pregnant women since 1 October 2012. The prenatal pertussis vaccination programme aims to minimise disease, hospitalisation and deaths in young infants, through intra-uterine transfer of maternal antibodies, until they can be actively protected by the routine infant programme with the first dose of pertussis vaccine scheduled at eight weeks of age.

Reported pertussis activity was higher in 2016 than in any year between 2013 and 2015 but did not reach the overall peak levels recorded in 2012. The increase in 2016 was consistent with pre-existing cyclical trends with peaks in disease every 3 or 4 years.

(Source: Public Health England, Health Protection Report Volume 12 Number 1 5 January 2018)

Table 18: Prenatal Pertussis Vaccination Uptake

Pertussis	Apr 2015 %	May 2015 %	Jun 2015 %	Jul 2015 %
Cambridgeshire & Peterborough CCG	49.8	45.9	52.7	50.5
East Anglia	**56.8**	**53.8**	**58.9**	**56.3**
Pertussis	Aug 2015 %	Sept 2015 %	Oct 2015 %	Nov 2015 %
Cambridgeshire & Peterborough CCG	51.2	50.5	54.1	52.5
East Anglia	**58.5**	**67.2**	**60.3**	**61.4**
Pertussis	Dec 2015 %	Jan 2016 %	Feb 2016 %	Mar 2016 %
Cambridgeshire & Peterborough CCG	50.7	50.3	NA	NA
East Anglia	**60.3**	**59.3**	**NA**	**NA**
Pertussis	Apr 2016 %	May 2016 %	Jun 2016 %	Jul 2016 %
Cambridgeshire & Peterborough CCG	52.7	73.8	73.3	71.9
East Anglia	**60.2**	**73.6**	**74.4**	**74.7**
Pertussis	Aug 2016%	Sept 2016 %	Oct 2016 %	Nov 2016%
Cambridgeshire & Peterborough CCG	70.6	72.8	71.4	72.3
East Anglia Total	**74.1**	**76.4**	**78.7**	**78.0**
Pertussis	Dec 2016 %	Jan 2017 %	Feb 2017%	Mar 2017 %
Cambridgeshire & Peterborough CCG	76.2	78.9	76.2	75.5
East Anglia Total	**79.8**	**82.3**	**79.8**	**77.0**

Source: ImmForm

4.1.7 Rotavirus Vaccination

Rotavirus is a highly infectious stomach bug that affects babies and young children. Infections are routinely reported in surveillance data provided by PHE which demonstrates the effectiveness of this programme as cases have dropped to tiny numbers since the vaccine was introduced.

Table 19: Rotavirus vaccination

12 months Rotavirus 2 doses [target 95%]				
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Peterborough	**90.3**	**89.1**	**90.0**	**90.4**
East Anglia	92.5	92.6	91.6	92.1

Source: ImmForm

4.1.8 School Immunisation Service

Table 20: Data for end of school year 2016-17

	Target	**Peterborough**
HPV vaccination by end of school year nine dose 2	90%	85%
School leaver booster (Td/IPV) by end of school year 9 and 10.	80%	79%
Men ACWY by end of school year 10.	80%	80%
Childhood Flu vaccination school years 1 and 2 and 3	60%	42%
Schools participating in the programme	100%	100%

Source: CCS

4.1.9 Shingles

The data for the Shingles vaccination programme is shown in the table below. The data is cumulative and is up to end August 2017. This is the fourth year of the shingles vaccination programme in England and data from September 2016 to August 2017 shows a continued decline in coverage in the routine (70 year old) and catch up (78 years old) cohorts (from 57.6% in 2015/16 to 46.8% in 2016/17 and from 51.8% in 2015/16 to 47.4% in 2016/17, respectively). PHE note several factors may have contributed to the decline, including:

- difficulties in practices identifying the eligible patients – during busy influenza immunisation clinics
- lack of call/re-call in the service specification to allow mop up of those who missed immunisation during the flu season
- possible lowering of patients' awareness of the vaccine since its introduction in 2013.

PHE are promoting the need for shingles vaccine through professional channels and considering a range of possible approaches to simplify the programme and associated eligibility criteria.

Table 21: Shingles vaccination uptake August 2017

Area	Vaccine coverage for the Routine Cohort since 2013			Vaccine coverage for the Catch-up Cohort since 2013		
	Registered Patients aged 70	Received Shingles vaccine		Registered Patients aged 78	Received Shingles vaccine	
		No of patients	% of patients		No of patients	% of patients
Cambridgeshire & Peterborough CCG	8284	4389	53.0	5110	2842	55.6
East Anglia Total	**29332**	**14947**	**51.0**	**18338**	**9753**	**53.2**

Source: ImmForm

4.1.10 Cambridgeshire and Peterborough Immunisations network

This groups meets 3 – 4 times per year to discuss all issues relating to immunisations and to take forward the recommendations of a previous Immunisation 'Task and Finish' group that reported two years ago. That group had been set up to identify the reasons for lower immunisation uptake for childhood immunisation. Ongoing work includes close working with GP practices in some areas with particularly low uptake.

Immunisations have been targeted in the Healthy Peterborough campaign in February / March 2018 with specific focus on the pre-school booster, MMR2 and HPV vaccines.

5 SCREENING PROGRAMMES

5.1 Antenatal and Newborn Screening

Peterborough City Hospital generally meets the Key Performance Indicator (KPI) target to an acceptable level and in some areas attains the achievable level. Explanations for red KPIs are given and are monitored through the Programme board.

Table 22: ID1 -Antenatal infectious disease screening – HIV Coverage + ID2 -Hep B timely referral for women found to be Hepatitis B

				2015-2016				2016-2017			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ID1 Antenatal HIV test coverage	>95%	99%	PSHFT	98.7	98.9	99.0	99.8	99.5	99.4	99.4	99.3
ID2 Hep B timely referral for women found to be Hepatitis B	>70%	99%	PSHFT	66.7	85.7	100	75.0	50	No cases	100	80.0

Source: Maternity Unit

Table 23: Fetal anomaly screening – Coverage

				2016-2017			
FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage *	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**
	>90%	>95%	PSHFT	98.6	97.5	99.1	98.0

Source: Maternity Unit

Table 24: ST1 Coverage, ST2 Timeliness of Test, ST3 Completion of FOQ

				2015/-2016				2016/-2017			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ST1 Antenatal sickle cell and thalassaemia screening – coverage	>95%	99%	PSHFT	96.4	95.6	96.3	99.5	96.6	97.8	97.8	97.5
ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test	>50%	75%	PSHFT	67.2	70.2	67.9	68.0	69.1	65.5	68.0	61.4
ST3 Antenatal sickle cell and thalassaemia completion of FOQ	>95%	99%	PSHFT	98.3	98.1	97.9	98.9	98.3	98.7	98.1	98.6

Source: Maternity Unit

Table 25: Newborn Blood Spot Screening – Coverage, Avoidable Repeats, Coverage (movers in)

				2015-16				2016-17			
Indicator	**Accpt**	**Ach**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NB1 Newborn blood spot screening coverage	>95%	99.9%	CPFT	98.5	98.5	99.7	99.7	99.6	97.5	98.8	98.8
NB2 Newborn blood spot screening avoidable repeats	<2%	0.5%	PSHFT	No data	1.3	2.5	3.0	1.8	1.4	1.4	1.6
NB4 Newborn blood spot screening coverage- movers in	>95%	99.9%	CPFT	100	90.9	93.3	93.3	82.4	84.5	78.0	79.7

Source: Maternity Unit

NB4: This KPI is impacted by the small denominator and refers to children who move into the area being seen and offered the NBBS within 3 weeks of being notified to the Child Health Information System (CHIS) which records all routine child health data and operates the call / recall system for routine child immunisation and screening. The numerator is impacted by declines of babies who have received screening in their own country, those transferring in very near to the cut off for screening and those experiencing slight delays whilst appropriate interpreter arrangements are made to facilitate the appointment.

Table 26: Newborn Hearing – Coverage, Referral to Assessment

				2015-16				2016-17			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NH1 Newborn hearing screening coverage	>97%	99.5%	PSHFT	99.7	99.7	100	99.9	99.8	99.9	99.5	100
NH2 Newborn hearing screening timely referral for assessment	>90%	95%	PSHFT	100	92	100	80	100	100	100	92.9

Source: Maternity Unit

Table 27: Newborn and Infant Physical Examination – Coverage and Timely Assessment

				2015-2016				2016-17			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NP1 Newborn and Infant Physical Examination-coverage newborn	>95%	99.5%	PSHFT	100	99.6	99.8	99.9	96.9	97.4	97.3	97.6
NP2 Newborn and Infant Physical Examination timely assessment	>95%	100%	PSHFT	100	40.0	100	100	33.3	**50.0	No cases	No cases

Source: Maternity Unit

**Low denominators impact on this KPI; numbers for referrals are small and there are issues with securing scans within the timeframe. On-going work is taking place to address this. For 2, 2 cases were referred and only one seen on time and for quarter3 and 4 only one referral was made.

5.2 Programme Updates

5.2.1 Foetal Anomaly Screening Programme

A new KPI (FA3) is being piloted to monitor coverage of trisomies 13 and 18.

All maternity units are required to report fetal & congenital anomalies to the National congenital anomaly and rare disease registration service. (NCARDRS).

5.2.2 Infectious Diseases

Coverage KPIs for Hepatitis B and Syphilis have been collected from April 2017.

The use of NIPE SMART became mandatory; the Trust is compliant.

5.2.3 Newborn hearing

A new screener qualification was launched and is a mandatory requirement for all new unregistered staff from April 2017.

5.2.4 Non Invasive Prenatal Testing

It is likely that the new non- invasive screening test for Downs, Edwards and Patau's syndrome will be commissioned in 2018/19. The highly sensitive screening test will be offered to all women who have a high risk result following the combined test. It is expected that the rates of

diagnostic procedures will fall as a result. Further information is still awaited from the national team.

5.3 Cancer Screening programmes

5.3.1 Breast Screening

While uptake of breast screening is satisfactory and has reached a much improved level in quarter 4 of 2016/17, we will continue to closely monitor uptake.

Table 28: Peterborough Breast screening Uptake

BS1 - Percentage of eligible women who attend for screening (aged 50-70)									
Peterborough Breast Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 70.0%	≤ 80.0%	77.3	77.8	70.5	72.7	75.8	71.3	69.87	74.1

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Table 29: Breast Screening Round Length

BS2 - Percentage of women first offered an appointment within 36 months									
Peterborough Breast Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	98.87	99.05	99.1	98.7	98.1	98.3	98.9	98.2

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Table 30: Waiting Time for Assessment

BS11 – Percentage of women who attend for assessment within 3 weeks of attending for screening									
Peterborough Breast Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	95.24	94.3	99.2	94.7	98.4	96.3	96.3	94.1

Source: OBIEE (Oracle Business Intelligence Enterprise Edition

5.3.2 Cervical Cancer Screening

We have been advised by NHSE that verified uptake data for the cervical screening programme is only available annually although process data for the programme are available quarterly, see below. The most recent uptake data for Peterborough shows that 62.6% of women aged 25 – 49 have taken up their invitation to be screened.

Table 31: CS2, CS2a and CS2b - Coverage of eligible population

Acceptable	Achievable	Provider	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
CS2 - Coverage of eligible population (all women)						
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	63.3	66.1	65.9	65.6
CS2a - Coverage of eligible population, all women aged 25-49 every 3 years						
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	63.3	63.1	62.9	62.6
CS2b - Coverage of eligible population, all women aged 50-64 every 5 years						
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	74.1	73.8	73.9	73.4

Source: Screening Quality Assurance Service (SQAS) and Open Exeter

5.3.3 Improving uptake in Cancer screening programmes

We are currently working on a project to improve Cervical Screening uptake in the Cambridgeshire and Peterborough area for 25 to 49 year olds. Nationally, the uptake for cervical screening is decreasing and we are working with GP Practices, McMillian GPs, Cancer research UK and the local CCG to try and improve uptake in this area. We will be focusing on two separate areas, how to improve knowledge of cervical screening in 25 to 49 year olds and how to develop and improve GP surgeries' procedures.

5.3.4 Bowel Cancer Screening

Table 32: Bowel screening data

HHT/PSHFT Screening Centre			2015-2016				2016-2017			
	Acc.	Ach.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BCS4 – Uptake	≥52%	≥70%	58.3	57.8	55.1	58.6	59.9	58.4	55.4	58.1
BCS7– SSP Waiting Times	100% within 14 days ≤1.0%		100	100	100	94.4	100	100	100	100
BCS8 - Diagnostic test waiting times	100% within 14 days		`96.7	94.3	94.8	76.3	89.9	89.6	65.9	20.0

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Work is ongoing to improve endoscopy capacity to maintain the Diagnostic waiting times within the bowel cancer screening programme in Peterborough. While the uptake of the screening test is within the acceptable range we are in discussion with partners to find means to encourage greater uptake of this test. Recent work with a small number of GPs gave promising results.

6 Adult and Young People Screening

6.1 Diabetic Eye Screening Programme

Diabetic retinopathy is one of the most common causes of sight loss among people of working age. It occurs when diabetes affects small blood vessels, damaging the part of the eye called the retina. Diabetic retinopathy doesn't usually cause any noticeable symptoms in the early stages. If retinopathy is detected early enough, treatment can stop it getting worse. Otherwise, by the time symptoms become noticeable, it can be much more difficult to treat. This is why the NHS Diabetic Eye Screening Programme was introduced.

Table 33: Diabetic Eye Screening

Cambridgeshire & Peterborough CCG through East Anglia DESP								
Indicator & Target	**2015-2016**				**2016-2017**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Acceptable 70% Achievable 80%								
DE1-Uptake of routine digital screening event	91.0	90.5	78.3	77.1	85.7	87.6	85.6	83.8
Acceptable 70% Achievable 80%								
DE2-Results issued within 3 weeks of screening	99.9	100	99.0	99.0	99.8	99.7	99.8	99.8
Acceptable 80% Achievable 95%								
DE3 - Timely assessment for R3A screen positive	50.0	77.8			80.0	75.0	58.3	70.0

Source: Health Intelligence

Achievement of the KPI DE3 is affected by the capacity issues in Hospital eye services within the acute Trusts in the region and is also affected by low numbers. For example Q4 data represents 3 patients not meeting the target.

6.2 Abdominal Aortic Aneurysm (AAA) Screening Annual Data

Table 34: Annual Data AA1 Completeness of Offer

AAA Annual Data - Cambridgeshire and Peterborough population					
Indicator	**Acceptable**	**Achievable**	**2014-15**	**2015-16**	**2016-17**
AA1 Completeness of Offer*	≥ 52%	≥ 70%	100	99.9	99.9

* AAA1 = The proportion of men eligible for abdominal aortic aneurysm screening to whom an initial offer of screening is made.

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

7.1 MRSA

Nationally the rate of MRSA bacteraemia for 2017/18 remained steady at 1.5 cases per 100,000 population and in the two years prior. Reductions have been seen in the time to onset for admitted patients, with a greater proportion of cases having a time to onset that would be considered community onset. This is likely to reflect improved clinical awareness by NHS staff but could also be an artefact of declining durations of hospital stay (PHE, 2017).

The introduction of third party cases in April 2014 recognised the complexity of some MRSA cases and where no breach in key policy was evident as part of that patient's care. These cases are not reflected against an acute Trust or CCG on the data capture system but recorded separately within the system as part of the ongoing surveillance and identification of themes and trends of causes.

Table 35: MRSA bacteraemia

Assigned	National No. 2016/17	Local No. 2016/17	National No. 2017 (Apr 17 to Nov 17)	Local No. 2017/18 (to 31/12/17)
	823	11	547	10
CCG		1		0
Trust		4		4
Third Party		6		6

7.2 Clostridium difficile

During 2016/17, 12,840 cases were reported nationally, a decrease of 9.2% on the previous year. Of these 36% were trust-apportioned and mirrors the trend of incidence of all cases declining, though overall the decline in rate has slowed. The separation of cases into trust-apportioned and non-trust apportioned is recognized to ignore relevant information on prior health exposure. For example, some cases classed as community onset are likely to be among patients who were recently discharged from hospital. The current algorithms do not take into account complex healthcare pathways patients may have.

Locally each individual case is discussed at Scrutiny panel meetings held by the Trusts. The recognition of the fact that some cases occur even if best practice is followed and the patient receives flawless care, these are non-sanctioned cases, i.e. not counted against the annual Trust objective.

In line with the national findings, the rate of local cases has slowed down however at the same time we have seen an increase. Between April and December 2016 there were a total of 104 cases reported. In the period April to December 2017 this has risen to 142. Of these cases only 21 from our Trusts have been identified to have breached some element of key policy and sanctioned against the annual objective.

The annual objectives have not been changed by the Department of Health for the past three years but we do expect this to be reviewed prior to the 2018/19 guidance being released around February/March 2018.

7.3 *Escherichia coli* bacteraemia

Between 2012/13 and 2016/17 the national rate of e coli cases has risen from 22% to 73.9% with a total of 40,580 cases reported in 2016/17. The highest rates were among patients over the age of 85 years and greater in men than among women. The most likely primary focus over time continues to be urinary tract infections accounting for 47% in 2016/17.

April 2017 saw the introduction of a Quality Premium for CCGs to reduce the number of E coli cases by 10% during the period of 2017/18 which equates to 53 cases for Cambridgeshire and Peterborough CCG.

All CCGs have been faced with a number of challenges due to resource limitations, patient identifiable data access and engagement from primary care to collect core data for the national data capture system.

The CCG is to lead on a project from January 2018 working across the whole health economy to develop and implement a bladder bundle toolkit alongside the specialist continence and urology nurses, community and primary care services and to engage with patients, in order to address the local population needs. Removing unwarranted variations of care will identify where patient risks of infection are reduced.

Between April and December 2017 we have 403 cases reported against 407 in the same period of 2016. To reach the Quality Premium we would need to have a maximum of 481 cases by the end of March 2018. Measures put in place by in-patient settings for all types of healthcare associated infections are able to have a more significant impact than when patients are in the community setting, hence the work to be undertaken will be to identify all patients with urinary catheters and frequent non-catheter related infections across our local health economy.

References:

1. Annual Epidemiological Commentary Mandatory MRSA, MSSA, *E coli* bacteraemia and *C difficile* infection data 2016/17. Public Health England. 6 July 2017
2. Technical guidance for NHS planning 2017/18 and 2018/19 – Annex B, Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups

7.4 Antimicrobial Resistance

7.4.1 Antimicrobial resistance has been described as one the greatest threats to human kind. The overuse and incorrect use of antibiotics are major drivers of the development of antimicrobial resistance. The continued threat from the development of antimicrobial resistance and a drastic reduction in the number of new antibiotics being developed, make the need to preserve the antimicrobials we currently have a local, national and global priority. Local targets, set nationally, for reducing the amount and certain types of antimicrobial drugs prescribed across all health care sectors are in place and achieving these requires co-operation from prescribers, patients and the public.

7.4.2 Research has shown that antibiotic stewardship programmes could halve the number of infections due to antibiotic-resistant bacteria compared with unguided prescribing. Locally, there has been a reduction in the number of antibiotics prescribed by GPs which will contribute to conserving the antibiotics we currently use. This has been achieved through the introduction of antibiotic stewardship programmes across all health sectors, use of educational materials for GPs and patients, provision of comparative antibiotic prescribing data to GP practices, peer group review, and public education programmes.

7.4.3 Trimethoprim, an antibiotic used to treat infections such as urinary tract infections, is an effective treatment where infections have been shown to be susceptible and in situations where alternatives would be less suitable. However, the inappropriate use of trimethoprim, has been associated with the development of serious, life-threatening gram-negative bloodstream infections, particularly in vulnerable patients where their urine infection has been resistant to trimethoprim. 33.2% of community urine samples tested for E. coli (or coliform) between October and December 2017 in the Cambridgeshire and Peterborough CCG area were found to be resistant to trimethoprim. This figure was higher than other Clinical Commissioning Groups (CCGs) in the East region. Local and national targets have been introduced aimed at reducing the inappropriate use of trimethoprim compared to alternatives and specifically for use in patients over 70 years old who are the most vulnerable. Local targets for reducing the use of trimethoprim have been met through effective antibiotic stewardship initiatives and the addition of new antibiotic formulary choices which offer prescribers more alternatives to trimethoprim. Focusing on reducing inappropriate use of trimethoprim in urinary tract infections continues into 2018-19.

7.4.4 Broad spectrum antibiotics include the groups of antibiotics the quinolones, cephalosporins, and co-amoxiclav. They should normally only be used when narrow-spectrum antibiotics have not worked or the infection being treated is resistant. Inappropriate use increases the risk of producing a resistant type of bacteria known as MRSA, other resistant urinary tract infections and may cause an unpleasant life-threatening infection, Clostridium difficile, to develop. Local and national targets have been set aimed at reducing the amount of broad spectrum antibiotics prescribed compared to all types of antibiotics. Locally, use of broad spectrum antibiotics has been higher than the local target. A system wide approach using antibiotic stewardship

programmes has addressed this along with provision of prescribing data, peer group review and support to GPs in reducing their use of unwarranted broad spectrum antibiotics. Some success has been seen, but this still needs to be improved during 2018-19 and will require the co-operation of prescibers, patients and the public.

References:

The UK AMR Strategy High Level Steering Group. UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013-2018. Third Annual progress report, 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662189/UK_AMR_3rd_annual_report.pdf and accessed 25/2/18,

National Institute for Healthcare and Clinical Excellence (NICE). Key therapeutic topic [KTT9] Antimicrobial stewardship: prescribing antibiotics. Published date: January 2015. Last updated: January 2017. Available at: https://www.nice.org.uk/advice/ktt9/chapter/evidence-context and accessed 25/2/18.

Public Health England. East Region. AMR Local Indicators. Available at: http://fingertips.phe.org.uk/ and accessed 25/2/18.

8 Environmental Health

8.1 Environmental health consists of Food Safety, Health and Safety and Pollution Control and along with Licensing and Trading Standards is part of Regulatory Services. The purpose of the service is to carry out interventions to check compliance with legal requirements and where appropriate take enforcement action. The service also has a role supporting businesses to help them comply with the law. The work of Regulatory Services helps to keep people healthy and safe, reduces health inequalities and contributes to the national and local economy.

8.2 The food safety team carry out food inspections, investigate food complaints and infectious diseases and are responsible for regulating private water supplies. The team also operates the National Food Hygiene Rating scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. Currently 84% of food businesses in Peterborough have a rating of 3 or above.

8.3 Health and Safety work in recent years has focussed on the implementation of a project to tackle illegal tattooists and the development of a toolkit to address carbon monoxide in food premises due to the indoor use of charcoal cooking equipment without adequate ventilation.

8.4 Licensing staff regulate the carrying on of all licensable activities by the appropriate control of licensed premises, temporary events and personal licence holders. Areas of licensing include alcohol, gambling, taxi, animal boarding establishments, riding establishments, pet shops, petroleum sites, tattooists and skin piercing, dangerous animals and adult entertainments.

8.5 Trading Standards deal with product safety, animal health and fair trading and credit. Product safety can include toys, cosmetics, electrical equipment and chemicals. A project into the safety and labelling of e-cigarette liquids is taking place across the East of England Trading Standards region due to the increasing prevalence of these products and recent specific legislation. Fair trading and credit is extremely wide ranging and covers areas such as estate agency, hallmarking, credit arrangements, pricing, video recordings, trademarks, unfair contract terms, aggressive trade practices, scams and trade descriptions. Issues investigated by the team include rogue doorstep conmen, car clocking, counterfeit goods and illicit alcohol and tobacco sales. The team work in partnership with Public Health England and three other local authorities to tackle illicit tobacco. The Joint Eastern Region Illicit Tobacco Control

Project aims to increase the understanding of and raise awareness of illicit tobacco. Roadshows have been carried out with detection dogs to show the public how they find concealments and with experts on hand to offer help to those who wish to quit smoking. The project will provide support visits to businesses, intelligence led surveillance and follow up investigations and will result in seizure operations and prosecutions where necessary.

8.6 Pollution control staff are responsible for investigation of a wide range of statutory nuisances, air quality assessments, hoarding and infestations of vermin in domestic and commercial premises and the issuing of permits for industrial processes. The team also consider environmental impacts of building developments and deal with contaminated land through the planning process.

8.7 The Pollution Team has a significant input into the development control process, acting as a statutory consultee for planning applications and for the discharge of conditions. The Pollution Team are consulted on approximately 500 development sites each year, recommending conditions and agreeing mitigation measures where noise, contaminated land, air quality and other such environmental issues may be of concern.

8.8 Typical applications that are considered and advised upon in the development process are:

- New transport routes and Industrial/Commercial activities proposed in/near residential locations
- Applications for residential development adjacent to noise sources such as industry or road/rail traffic
- Proposed developments on brownfield sites when previous uses may have contaminated soils or produce ground gases with potential health impacts.
- Major developments that may have air quality impacts upon the locality, for example by emissions from associated transport or particulates.

8.9 Examples of developments considered in the previous 12 months include:

- The redevelopment of the South Bank and Fletton Quays, considering the impacts of historical land use; road/rail/concert noise implications for residential development; air quality impacts; and relationship between commercial activities and residential premises.

- Developments in Hampton considering road and rail traffic impacts for proposed and existing development, the impact of new traffic routes or increased traffic flows on existing development in terms of noise and air quality; mitigation measures that may be required to protect residential and other developments from any soil contamination or ground gases that may be present; considering any potential impacts upon new schools proposed on brownfield sites adjacent to major traffic routes.

- Residential development proposed adjacent to closed landfill in Stanground, considering potential for migrating ground gases and traffic noise from the Stanground by-pass.

- Assessment of landfill gas monitoring results for proposed additional development adjacent to closed landfill at Potters Way Fengate.

- School and housing development Newark Road Fengate, considering any mitigation required for ground conditions – including unexpected unauthorised historic landfill; and noise from adjacent industrial activities that may impact upon the proposed development.

- Extension of Pode Hole Quarry and proposed quarrying activities at Willow Hall Farm, and Bar Pasture Farm Thorney assessed for potential noise and particulate impacts upon residential premises.

- Consideration of potential noise and air quality impacts associated with proposed dualling of A47 Wansford-Sutton
- Upgrade of Werrington Gas Compressor assessed for air quality and noise impacts. Notice served to control noise levels and hours of work for the construction phase of the project which are programmed for completion in 2020.
- Assesment of impacts from Alwalton Hill commercial developments and their potential impacts upon future residential developments in Hampton and for Haddon.
- Recommending noise and air quality impact assessments to enable the appropriate consideration of proposed Junction 18 A47/A15 development proposals.
- Werrington Grade Separation "Dive-Under" proposals, primarily to ensure the impacts of construction noise of the civil engineering project will be controlled so far as reasonably practicable.
- Consideration of air quality and noise impacts associated with the development of a gas fired reserve facility at Peterborough Power Station, Fengate.

9. Air Quality

9.1 Peterborough City Council are required to assess the air quality in Peterborough as part of the Air Quality Standards Regulations 2010 legislation. Air pollutants such as benzene, carbon monoxide, nitrogen dioxide, industry emissions and sulphur dioxide are investigated.

9.2 The investigation process is undertaken in a series of stages by using an updating and screening assessment of air quality which are produced every three years. An updating and screening assessment of air quality identifies the pollution levels within Peterborough. In between these publications, progress reports are produced which highlight any changes which might have occurred over the previous year.

9.3 Should any pollutants be suspected or shown to be above the objective level, Peterborough City Council undertake a detailed assessment. If the detailed assessment shows that there is an area which exceeds the relevant air quality objective, the Council shall declare an air quality management area.

9.4 Currently, the main pollutants of concern in the Peterborough district, as in most areas of the UK, are associated with road traffic, in particular NO2 and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. There is currently one Air Quality Management Area (AQMA) in Peterborough, for emissions of SO2 resulting in exceedance of the relevant 15-minute mean values. The source of these emissions is a brickworks located in the area administered by Fenland District Council (a neighbouring local authority). It was proposed in the 2015 Updating and Screening Assessment (USA) to revoke the AQMA, subject to the agreement of DEFRA. However the AQMA is still in force and Peterborough City Council remain in consultation with Fenland District Council about this. Further details of this AQMA can be found on our website at

https://www.peterborough.gov.uk/business/environmental-health/pollution/.

9.5 The previous round of review and assessment (beginning with the 2012 Updating and Screening Assessment and continuing through the 2013 & 2014 Progress Reports and most recently 2015 USA) did not identify that any further detailed assessments were necessary beyond that already undertaken for the existing AQMA. However as reported in the 2015 USA changes have been made to the monitoring programme in Peterborough with the identification of an area within the city namely Taverners Road that requires closer attention due to concerns regarding potential exceedance of the NO2 annual mean objective

9.5 This Annual Status Report determines that no exceedances have been noted in any of the locations monitored. According to the latest monitoring results, the levels appear to be similar to those recorded last year. However, due to the potential for exceedance, Taverners Road will continue to be closely monitored.

9.7 Peterborough City Council reports to DEFRA on the air quality findings on an annual basis. The most recent air quality report can be found on the Council's website.

https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/business/environmental-health/AirQualityAnnualStatusReport2016.pdf?inline=true

10 NATIONAL TUBERCULOSIS STRATEGY

10.1 Latent TB Identification Project

The aim of this project is to continue to support the early diagnosis of Latent TB and offer treatment of active disease.

10.2 NHS England and Public Health England jointly published the collaborative tuberculosis strategy on 19 January 2015. NHS England has committed £10 million for the establishment of testing for, and treatment of, latent tuberculosis (TB) in new entrants from countries of high TB incidence. Public Health England has committed £1.5 million for the establishment of the national TB office and support teams to the nine TB control boards. It is likely that the majority of TB cases in the UK are the result of 'reactivation' of latent TB infection (LTBI), an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI developing active TB infection. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

10.3 Following the publication of the national strategy a review of TB services was undertaken in Cambridgeshire and Peterborough. The key Epidemiological findings are summarised below and provide an overview of the impact of TB on the resident population of the CCG.

- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014. Peterborough had an average of 47 cases/year.
- Almost three quarters (73%) of TB cases between 2004 and 2014 were in non-UK born individuals.

- The most common countries of origin of TB cases in Cambridgeshire & Peterborough in the last three years were UK, India, Pakistan, Lithuania, East Timor and Kenya. PHE recommend screening patients born or who had spent >6 months in high TB incidence country (150 cases per 100,000 or more/Sub- Saharan Africa)

10.4 The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being:

- Born or spent > 6 month in a country of high TB incidence
- Entered the UK within the last 5 years
- Aged 16-35 years
- No history of TB either treated or untreated
- Never screened for TB in the UK

10.5 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) led this work supported by representatives from

- North West Anglia Foundation Trust (NWAFT)
- 18 Greater Peterborough GP Practices
- 2 Cambridgeshire GP Practices
- Public Health England (PHE)
- Cambridgeshire and Peterborough Foundation Trust
- Peterborough City Council – Public Health and Housing departments

10.6 GP Practices with a high crude rate of TB cases were identified by PHE. Of these, practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme.

10.7 The project commenced in March 2016 and in 2017/18 **9** additional Peterborough Practices signed up, with 3 from Phase 1 not renewing their LES. In total 18 Greater Peterborough practices have signed up to deliver. Using a Local Enhanced Service (LES) and two other practices have also signed up for phase 2 of the project. Training was provided by Oxford Immunotec, the provider for blood sample analysis as part of the screening.

10.8 Practices are expected to identify new patients on registration. PHE have provided the CCG with materials and letters to support the project.

10.9 There is a comprehensive action plan to cover the communication and engagement elements of this project. This aims to:

- Raise awareness of Latent TB and the need for screening
- Get people to visit their GP practice for screening
- Get people to register with a practice if not already
- To dispel myths and beliefs about TB

10.10 Communications work so far has included an article and social media posts targeted at encouraging prospective patients to come forward. These were sent to specific community contacts obtained through partnership working with Peterborough City Council Connectors, as well as posted from the CCG's social media channels.

10.11 News of the project and its progress has also been shared with stakeholders on the CCG Newsletter distribution list, as well as with GP members of the organisation. Press releases were issued in September and December 2016. King's Lynn FM provided radio coverage in October, and the December release was picked up by BBC Radio Cambridgeshire and BBC Look East. Look East's coverage was particularly in depth, focusing on TB as well as Latent TB, and aired in January 2017. Future engagement with prospective patients and the public was scheduled for later in 2017.

10.12 Practices identify patients and invite them for blood screening. Bloods are taken and sent off for testing. All those with positive results are seen and treated by Secondary Care Services

Table 36: ACTIVITY TO DATE (Cumulative May 2016 – end January 2018)

Activity	**Data**
Negative	397
Positives	65
Borderline negative	8
Borderline positive	11
Indeterminate	5
Non reportable insufficient cells	4
Assay not run	2
Technical error	2
Total screened	**494**

Table 1: Activity to end of January 2018

10.13 This activity is higher than other pilot areas in the region. There has been a positive response by the Practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated.

10.14 The CCG is intending to roll out to other practices and will continue to work closely with the existing practices to ensure they will identify and screen eligible people.

10.15 The Communication and Engagement Plan is also being refreshed to ensure the CCG is engaging with communities and stakeholders effectively.

10.16 For 2018/19 the CCG will continue to support all the Greater Peterborough Practices and the 2 Cambridgeshire Practices, to continue with the Programme due to a higher than average turnover in the catchment population.

10.17 The CCG will look to extend screening to the other populations such as student populations that meet the eligibility criteria, employees in work environments and the prison population. There will also be closer links to the Greater Peterborough Network to ensure additional screening is offered for initial invitations and those who have not responded or did not attend.

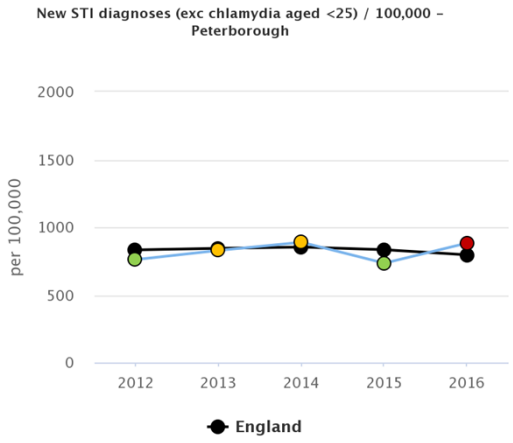
11. SEXUAL HEALTH

The following key indicators for sexual health in Peterborough raise concerns about the trends in population level sexual health.

11.2. New Sexually Transmitted Infections Diagnoses (STIs) (excluding <25 chlamydia)

The new STI diagnoses rate (excluding <25 chlamydia) per 100,000 between 2012 and 2015 was around or below the national figure. In 2016 it was significantly higher than the national figure at 882 per 100,000 compared to 795 per 100,000.

Figure 8.0: New STI diagnoses (excluding <25 chlamydia)

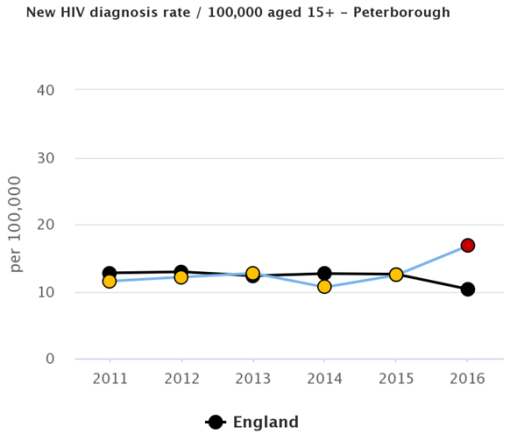


Source: Sexual Health Profiles Public Health England (2017)

11.3 New HIV Diagnosis

The rate of new HIV diagnosis per 100,000 between 2012 and 2015 was around the figure for England. In 2016 it was significantly worse at 16.8 per 100,000 compared to 10.3 per 100,000

Figure 9.0: New HIV Diagnosis Rate

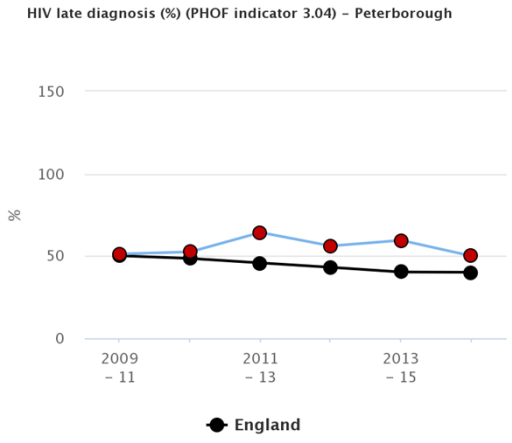


Source: Sexual Health Profiles Public Health England (2017)

11.4 Late HIV Diagnoses

Between 2009 until 2016 the rate of late HIV diagnoses per 100,000 has remained significantly higher than the English figure. During 2014/16 the rate was 50 per 100,000 compared to 40.1 per 100,000. There has been a downward trend in the national figure which is less apparent in the Peterborough figure. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

Figure 10: HIV Late Diagnosis (%)



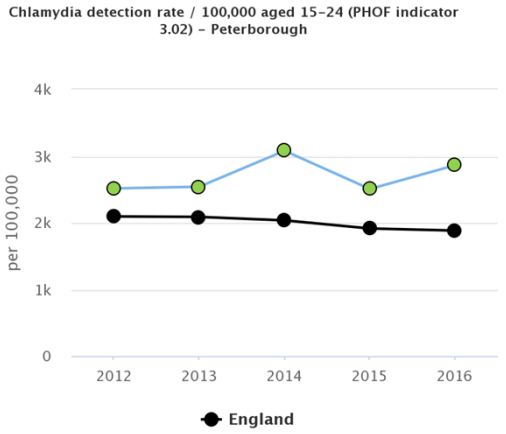
Source: Sexual Health Profiles Public Health England (2017)

11.5 Chlamydia Diagnosis

The rate of chlamydia detection amongst 15-24 year per 100,000 has remained significantly higher than the national figure and has seen an upward trend. In 2016 the rate was 2863 per 100,000 compared to 1882 per 100,000. This exceeds the Public Health Outcomes Framework (PHOF) target of 2,300 per 100,000, which is considered positive in term of

identifying and treating the infection in the population. However it indicates clearly that there is high level of infection in the population despite the high detection and treatment rate.

Figure 11 Chlamydia Detection Rate 15-24 years

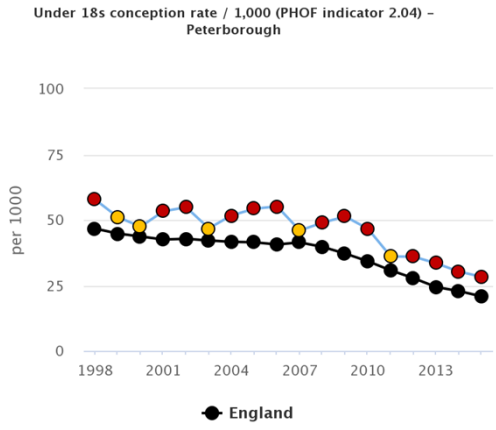


Source: Sexual Health Profiles Public Health England (2017)

11.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically since 1998 in Peterborough. Although it has reached the national rate in a number years this has not been sustained and it remains persistently above the national rate. In 2015 the rate was 28.3 per 100,000 compared to 20.8 per 100,000.

Figure12: Under 18s Conception Rate



Source: Sexual Health Profiles Public Health England (2017)

11.7 Sexual Health Services

The Integrated Sexual Health Service (ICaSH) provided by Cambridgeshire Community Services has seen a continuous increase in demand for its services. Currently this stands at

around a 25% increase above the activity level commissioned in 2014. This increase in activity is found in both contraception and sexual health service activity. This increase suggests that it reflects the current trends across the key indicators described above for sexual health in Peterborough.

The increase in demand appears to have had an impact on the Service meeting some key targets associated with improvements in sexual and contraceptive health. Securing access to sexual health treatment within 48 hours or two working days is the recommended target for decreasing the onward transmission of infection by the Department of Health and professional bodies.

The desired percentage of people with STI needs offered an appointment within two working days is 90%. In the Peterborough Service during 2017/18 the percentage has decreased to around 70% when there are any demand surges, staff holidays and sickness absences. Similarly in the same period the percentage of people with STI needs seen within 48 hours, which has a target of 90% has decreased to around 70%. There is a similar pattern found in access to contraceptive services within two working days where the target is 90% but the Peterborough figure is around 65%. However the Service generally meets the recommended target percentage 95% of chlamydia patients being treated within six weeks of their diagnosis.

The ICaSH continues to be responsive along with its outreach team and voluntary sector in putting services in place to address the needs of population groups at higher risk.

The challenges confronting the ICaSH services are being reviewed by the Public Health Team.

11.8 Emergency Hormonal Contraception (EHC)

In 2017 a new community pharmacy EHC contract was introduced. This was a response to the number of under 18 conceptions. EHC is provided by the ICaSH services at a limited number of locations in the City. Community pharmacies provide easy access to EHC in a range of locations. It is provided free of charge and in addition it affords an opportunity for the pharmacy staff to raise the issue of chlamydia and offer a test.
The Scheme was introduced in mid 2017 and initially because of training requirements took several months to develop. However by the end of 2017 sixteen pharmacies wereoffering the Service, which is just over 50% of pharmacies issued with contracts. The majority are located in areas of higher need.

11.9 Prevention Needs Assessment

In 2017 a Sexual and Reproductive Health Prevention Needs Assessment was undertaken in Peterborough. The needs assessment was undertaken to inform the development of preventative services for sexual and reproductive health in Peterborough, in order to reduce inequalities and improve outcomes. It reviewed trend data, evidence for interventions including extensive consultation with the different communities, providers, service users and stakeholders in Peterborough. Its main recommendations were as follows.

1. Develop a local strategy for the reduction of late HIV diagnoses in Peterborough

2. Provide a comprehensive and timely offer of contraception to all women who give birth or have an abortion, as well as additional tailored support to those who are under 18 or vulnerable

3. Review and improve the provision of sexual and reproductive health services in schools

4. Ensure that the commissioned arrangements for condom availability are in line with the 2017 NICE Guidance*

5. Engage all sectors of the community through targeted and tailored health promotion and outreach

6. Contributing to reducing inequalities by improving sexual and reproductive health for vulnerable young people

11.10 Sexual Health Delivery Board

The Cambridgeshire and Peterborough Sexual Health Delivery Board was established in 2017. This followed the formation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU). The JCU is responsible for commissioning Public Health services across the two local authorities. The Sexual Health Delivery Board brings together commissioners and providers from across the two areas to set the strategic direction for sexual health and to implement collaborative partnership interventions to address issues. A Delivery Action Plan has been developed and the two following priorities have been adopted by the Board to address initially.

- Under 18 conceptions in Peterborough and Fenland (has a trend similar to Peterborough).
- Improving pathways across different services (both clinical and non-clinical). This includes pathway design and closer alignment of commissioning across the three different commissioners of sexual health services i.e. the Local Authorities, the Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England.

To complement this Public Health England has invited the Cambridgeshire and Peterborough local authorities and NHS commissioners to be one of two national pilot sites for a sexual health commissioning feasibility study. The aim is that the local sexual heath commissioning organisations will explore opportunities for future alignment and collaborative commissioning opportunities for sexual health services in the area, which would future proof, quality assure and optimise sexual health service pathways, better address needs and potentially realising system efficiencies where appropriate.

12. HEALTH EMERGENCY PLANNING

12.1 The City Council is a Category 1 responder under the terms of the Civil Contingencies Act 2004, as a result there is an emergency planning/Resilience team that works 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. 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.

12.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for health organisations in the LRF area and are expected to assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need.

12.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Locality Director and the Cambridgeshire and Peterborough 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 provides a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

- The DPH has been supported in this work by a consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Midlands and East (East) and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.

- 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.

12.4 The LHRP leads on the annual EPRR assurance process. The aim is to assess the preparedness of the NHS commissioners and providers, against common NHS EPRR Core Standards. All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2017-2018. In respect of the deep dive into EPRR Organisational Governance, the Cambridgeshire and Peterborough system completed the assurance checklists and rated themselves against the standards. All organisations were either Full or Substantially Compliant.

The Cambridgeshire and Peterborough health system is, at this point in time, well prepared to deliver the EPRR core standards including planning for and responding to a wide range of emergencies and business continuity incidents that could affect health or patient safety. There is strong engagement across health partners and a common aim to contribute and share best practice across the LHRP, LRF and East EPRR leads forum within the East

Locality. There are also links into the Cambridgeshire & Peterborough Health & Wellbeing and A & E Delivery Boards through the Co-Chairs of the LHRP.

12.5 The LRF and LHRP priorities for the past year were validation of:

- CPLRF Pandemic influenza Plan;
- CPLRF Vulnerable People Protocol; and
- CPLRF Mass Casualty Plan

All the three plans have been validated by the CPLRF Executive Board.

12.6 The priorities for the year ahead is validation of:

- CPLRF CBRN Plan;
- C&P Hospital Evacuation Plan; and
- CPLRF Excess Deaths Plan.

12.7 The period from 1st January 2017 to the date of this report has seen a very wide and varied training and exercise programme delivered by the CPLRF. Of significance were four exercises:-

1. Exercise Falmouth: This tabletop and live exercise took place on the 22nd Feb and 19th May respectively, to test the arrangements for Marauding Terrorist Firearms Attack (MTFA). Sixty attendees from nineteen organisations took part in the exercise.

2. JESIP exercises: Joint Emergency Services Interoperability Protocol (JESIP) awareness and table top exercises for the strategic members took place between June and October.

3. Mass Casualty plan validation: A table top exercise took place on 20th October, 2017 to validate the CPLRF Mass Casualty Plan. Thirty attendees from eight organisations took part.

4. CPLRF Tactical Emergency Management course(s): The CPLRF in collaboration with the Cabinet Office Emergency Planning College delivered three, one and a half day, bespoke Tactical Emergency Management courses between the 6th and 10th November, 2017. Forty attendees took part in the courses.

13 Summary

This report has provided an update on all key areas of health protection for Peterborough including:

- Communicable disease surveillance including information on an increase in infections caused by Group A Streptococcus, including scarlet fever and more invasive infection.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination. The uptake of the pre-school booster and MMR2 cause considerable concern and are subject of activity in the Healthy Peterborough programme for February / March 2018
- Screening in which there is continued below average uptake of breast, cervical and bowel cancer screening in Peterborough.
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The City Council Environmental Health role in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)

- Sexual health including the recommendations of a prevention needs assessment and the work of the Sexual Health Delivery Board. Key priorities for action include the reducing the rate of new sexually transmitted infections including HIV, reducing late diagnosis of HIV and continued reduction in teenage pregnancy rates.
- Health emergency planning and the priorities for the coming year.

Annex 1

UK Vaccination Programme

Age 2 months

5-in-1 (DTaP/IPV/Hib) vaccine – this single jab contains vaccines to protect against five separate diseases: diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type b (Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children)

Pneumococcal (PCV) vaccine – pneumococcus can cause various infections including pneumonia

Rotavirus vaccine - Rotavirus is a highly infectious stomach bug that typically strikes babies and young children. This is an oral vaccine

Men B vaccine – Meningococcus B is responsible for approximately 90% of meningitis in young children

Age 3 months

5-in-1 (DTaP/IPV/Hib) vaccine - second dose

Rotavirus vaccine - second dose

Age 4 months

5-in-1 (DTaP/IPV/Hib) vaccine - third dose

Pneumococcal (PCV) vaccine - second dose

Men B vaccine – second dose

Between 12 and 13 months

Hib/Men C booster - administered as a single jab containing meningococcus C (another cause of meningitis) and Hib (fourth dose)

Measles, Mumps and Rubella (MMR) vaccine - administered as a single jab. Measles, mumps and rubella are highly infectious conditions that can have serious, and potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby, and can lead to miscarriage

Pneumococcal (PCV) vaccine - third dose

Men B vaccine – third dose

Age 2 to 8 years including school years Reception, 1, 2 , 3 and 4

Seasonal influenza (Flu) vaccine - administered as a nasal spray and needs to be given annually – this programme is being gradually extended to include all children up to age 16 years.

3 years and 4 months, or soon after

Measles, mumps and rubella (MMR) vaccine, second dose

4-in-1 (DTaP/IPV) pre-school booster - administered as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio

Around 12-13 years

HPV vaccine, which protects against the Human Papilloma Virus which causes cervical cancer, it is given to girls only – two jabs are given 6 – 12 months apart

Age 14 years

3-in-1 (Td/IPV) teenage booster - administered as a single jab which contains vaccines against diphtheria, tetanus and polio

Men ACWY – School children aged 14 (year 9) are now offered this vaccination routinely and students going to university or college for the first time, including overseas and mature students up to the age of 25, are advised to contact their GP to have the Men ACWY vaccine, ideally before the start of or in the first few weeks of the academic year. Cases of meningitis and septicaemia (blood poisoning) caused by Men W bacteria are rising, due to a particularly deadly strain. The highest risk of meningitis is in the first year of university, particularly the first few months.

65 and over

Flu (every year)

Pneumococcal (PPV) vaccine

70 years

Shingles vaccine (from September 2013)

Vaccines for special groups

There are some vaccines that aren't routinely available to everyone on the NHS but which are available for people who fall into certain risk groups, such as pregnant women, people with long term health conditions and healthcare workers. These extra vaccines include **hepatitis B vaccination, TB vaccination and chickenpox vaccination**.

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 8
19 MARCH 2018	PUBLIC REPORT

Report of:	Wendi Ogle-Welbourn and Dr Liz Robin	
Cabinet Member(s) responsible:	Cllr Wayne Fitzgerald	
Contact Officer(s):	Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils	Tel.863618

FEEDBACK FROM THE JOINT DEVELOPMENT SESSION WITH PETERBOROUGH AND CAMBRIDGESHIRE HEALTH AND WELLBEING BOARDS

RECOMMENDATIONS	
FROM: Executive Director People & Communities and Director of Public Health	**Deadline date:**

The Health and Wellbeing Board is asked:

1. To recommend to Full Council amending the Health and Wellbeing Board Terms of Reference, in order to delegate powers from the Council to the Health and Wellbeing Board to establish a joint Cambridgeshire and Peterborough sub-committee in relation to issues that cross local authority boundaries.
2. Approve a joint meeting with Cambridgeshire Health & Wellbeing Board to explore the key themes identified in the development session.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Executive Director for People and Communities and the Director of Public Health.

2. PURPOSE AND REASON FOR REPORT

2.1 To provide the Health and Wellbeing Board with an update from the joint development session with Peterborough and Cambridgeshire Health and Wellbeing Boards, held on 23 January 2018.

Health and Wellbeing Boards (HWBs) are forums where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. A significant number of HWBs are now beginning to play a genuine leadership role across local health and care systems.

Under the Local Government Act 1792 Sections 101 and 102, Health and Wellbeing Boards are able to form joint committees / sub-committees of the main board.

The session was facilitated by Andrew Cozens, an associate from the Local Government Association (LGA) with a clear purpose around:

- Understanding what the HWBs accountabilities are
- Understanding the work of both HWBs
- Sharing both HWBs priority areas
- Considering if there is value in joining up some of the work of both HWBs
- Agree future ways of working

By the end of the session, those HWB members that attended agreed to looking into setting up a joint meeting to explore options for working together.

The Cambridgeshire HWB met on 1 February and agreed to a joint meeting with the Peterborough HWB, to be held in May, to further explore the key themes identified in the development session. A provisional date of 31 May has been set, to be held at Shire Hall in Cambridge.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.2.2

To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.

3. TIMESCALES

NO

4. BACKGROUND AND KEY ISSUES

4.1 The theme of the joint development session was to examine how combining the expertise of both boards would support identifying wider solutions to shared challenges, including increased demand and scarce resources. The session examined how the Boards could work together collaboratively on shared priorities.

Board members were provided with an overview of the Cambridgeshire and Peterborough Joint Strategic Needs Assessment Core Dataset (2018). Key areas of commonality for both Cambridgeshire and Peterborough HWBs were identified as follows:

- Growing Populations
- New Housing Development Sites
- Ageing Populations
- Health inequalities
- Rising demand including mental health

Opportunities for joint working were also identified through both the boards Health and wellbeing strategies:

Peterborough HWB Strategy Sections	**Cambridgeshire HWB strategy developing priorities**
Health and wellbeing through the life course	Mental Health, Prevention

Creating a healthy environment	Population growth and new developments
Tackling health inequalities	Health inequalities including homelessness, drug and alcohol
Working together effectively	Integration of health and social care services

5. CONSULTATION

5.1 A report was presented to the Peterborough HWB on 11 September 2017 asking for approval to proceed with the joint development session. This was approved by the Board.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 **Main Issues**

Key themes for working together were identified by participants around:

- Integrated solutions (not just integrated services) and the collective impact of the Board membership
- A focus on place based integration and on commonality of need
- Prevention – working through outcomes and priorities including mental health and early years
- Population growth - including new communities, healthy new developments, and the impact on demand and resource requirements

The session further explored how we can develop these priorities practically across Cambridgeshire and Peterborough. In regards to integration it was emphasised that the HWB Board was a place where holistic integration of solutions and outcomes around the root causes of issues could be considered, not just the integration of services.

In regards to the population growth and in particular new developments it was suggested that a unit of shared expertise was needed to ensure that there was a shared understanding from health commissioners, providers, planners of housing and population growth, and that the key parties involved in planning new developments were talking to the right people.

Prevention is a clear focus in both HWB strategies and within the Sustainable Transformation Plan (STP). It was suggested the focus for the HWBs could be around identified priorities for children and young people's emotional wellbeing as well as drug and alcohol misuse. The approach could be more of a strategic overview addressing any blocks identified by existing partnership groups.

The place based discussion included identifying places or groups within the population, where people's experience of health and wellbeing is less good and working with local communities in an asset based approach to address local needs. There was some discussion over the role of the new Living Well Partnerships in aiding this process.

7. REASON FOR THE RECOMMENDATION

7.1 Collective ways of working were also discussed as a way the boards could be strengthened to better enable local people to have improved health and reduce health inequalities.

A possible approach would be for both the Health and Wellbeing Boards to explore forming a joint committee / joint sub-committee to discharge on behalf of both councils the functions of: encouraging integrated workings between commissioners and providers of health and care in the two councils in so far as it relates to areas of common interest and for the purpose of advancing the health and wellbeing of their populations; and preparing and producing a Joint Strategic Needs Assessment and Joint Health and Wellbeing Board Strategy.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Those present at the development session felt members from both boards would benefit from working more closely together, especially those members that work across Cambridgeshire and Peterborough , ie the Local Safeguarding Board, CCG and Healthwatch.

9. IMPLICATIONS

Financial Implications

9.1 There are no financial implications.

Legal Implications

9.2 The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner.

The Local Government Act 1972 Sections 101 and 102, Health & Wellbeing Boards are able to form a joint committee or joint sub-committee of the main board.

Equalities Implications

9.3 The holding of joint meetings is a governance matter and does not have direct equalities implications.

10. BACKGROUND DOCUMENTS

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

10.1 None

11. APPENDICES

11.1 Appendix A - Joint Development Session Presentation

Appendix A

Peterborough and Cambridgeshire Health and Wellbeing Boards

Joint Development Session

23 January 2018

Welcome and Introductions

Cllr Peter Topping, Cambridgeshire County Council

Cllr John Holdich, Peterborough City Council

Wendi Ogle-Welbourn

Executive Director People & Communities, Cambridgeshire and Peterborough Councils

Purpose of Today's Session

- Understand what the Boards accountabilities are
- Understand the work of both Boards
- Share both Boards priorities
- Consider if there would be value in joining up some of the work of the Boards
- Agree how we could work better together where it would add value to do so

Financial Context

- Changes to the way local authorities are funded e.g. education; reducing revenue support grant & PH grant
- Low funding for local authority Adult, Children and Public Health services
- One of the most challenged health economies with deficits for both NHS commissioners and providers
- Growing population, increased demand for services alongside increasing complexities
- Increase in numbers needing long term care across all client groups
- Diminishing returns from efficiencies, contract negotiations and managing demand activities e.g. reablement and early help

Organisational Context

Across Cambridgeshire and Peterborough

- One Clinical Commissioning Group
- One Sustainable Transformation Partnership - ‘STP’
- Two upper tier local authorities with shared CE/DPH/DASS/DCS
- Five second tier local authorities
- One Combined Authority with defined functions
- One Healthwatch
- Two Health and Wellbeing Boards

‘Shared services’

- Children’s Services – Joint Commissioning Unit (both LA’s and CCG)
- Public Health including a Joint Commissioning Unit
- Children’s Services – MASH, Counselling Service
- Adult Services – Delayed Transfers of Care, Mental Health, Carers
- Domestic Abuse Service
- Joint Adult and Children Safeguarding Boards

‘Sharing’ is already delivering:

- Significant cost reduction
- Partners say it is easier and faster to work with local authorities, contributing to better outcomes for the children and adults
- Reduced hand offs between teams and across geographical areas, increasing efficiency and productivity

What matters?

- Putting people at the heart of a system that makes sense to them
- Creating local environments that support health and wellbeing
- Building strong local communities
- Championing diversity and reducing inequalities
- Reducing the cost to serve
- Building on our community's assets
- System leadership
- Being ambitious and creative

Behaving as System Leaders

- Outcomes focussed – not organisation focussed
- Containing personal/organisation ego
- Get done what needs to be done by who is best to do it
- Understand and appreciate the perspectives of all parties
- Openness and transparency – put cards on the table
- Use of evidence based sources and best practice to ensure what we deliver has the best chance of success.

Behaving as System Leaders

- Work together, not undermine each other
- Speak well of each other, in public and private
- Behave well, especially when things go wrong
- Keep our promises – small and large
- Speak with candour and courage
- Deliver on promises made
- See success as collective

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

We could achieve this by:

- Combining the expertise of both boards to bring wider solutions to shared challenges, including increasing demand and scarce resources
- Focusing our time, expertise and energy on the transformation required
- Joint commissioning and integration of services, to achieve best value and remove duplication

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Dr Liz Robin

Director of Public Health, Cambridgeshire and Peterborough Councils

Cambridgeshire County Council

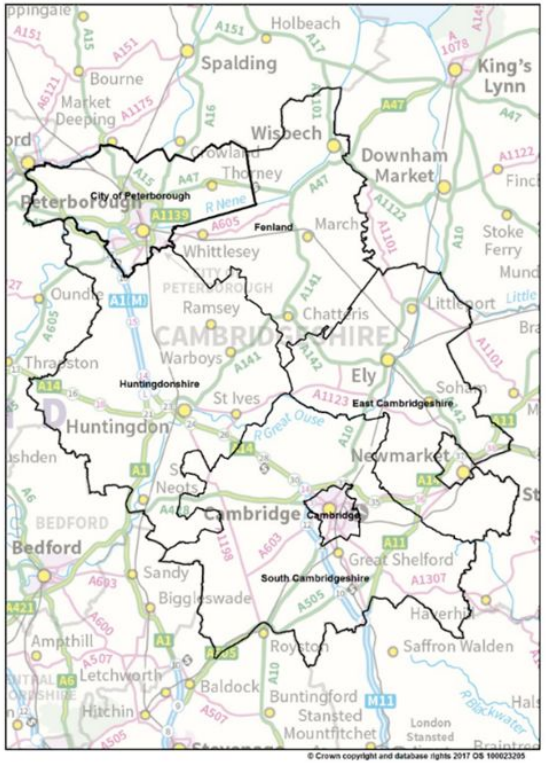
PETERBOROUGH CITY COUNCIL

Cambridgeshire and Peterborough Joint Strategic Needs Assessment 2018

What Does it Tell Us?

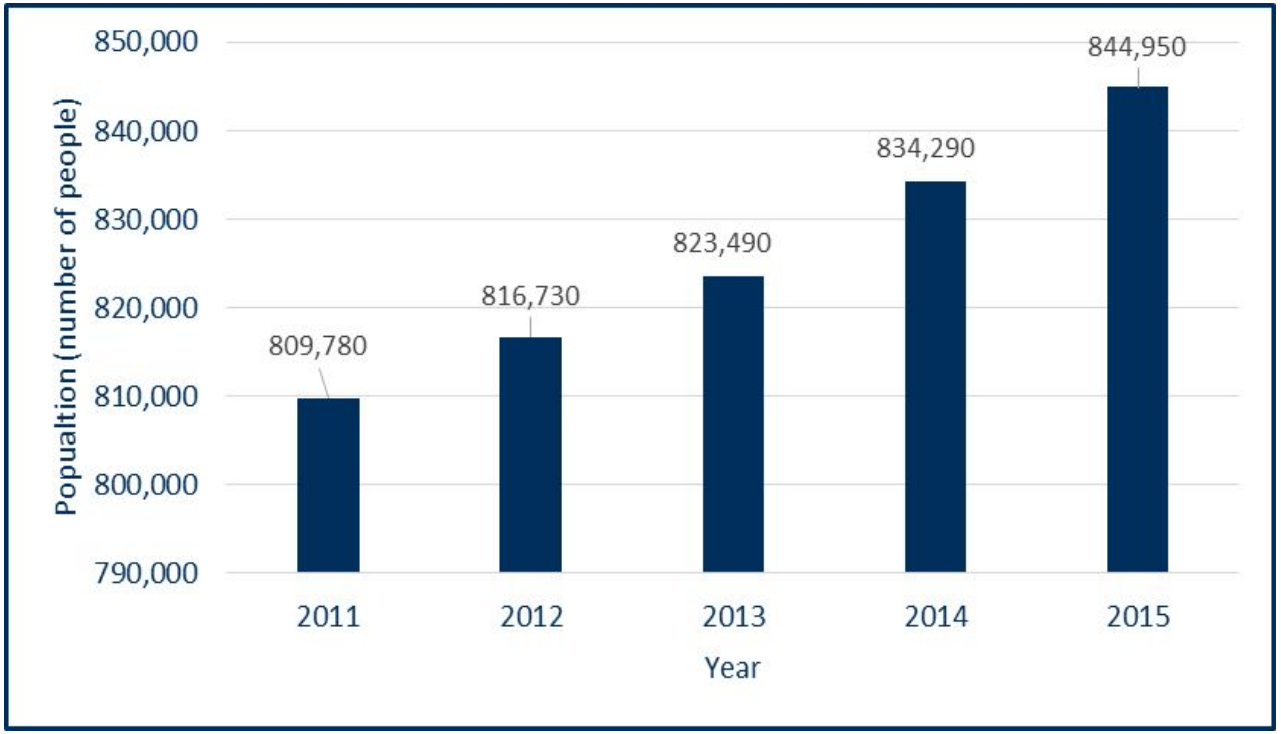
NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire and Peterborough



We have a growing resident population

Cambridgeshire and Peterborough retrospective population growth mid-2011 to mid-2015 (absolute numbers) – NOTE: axis does not start at 0

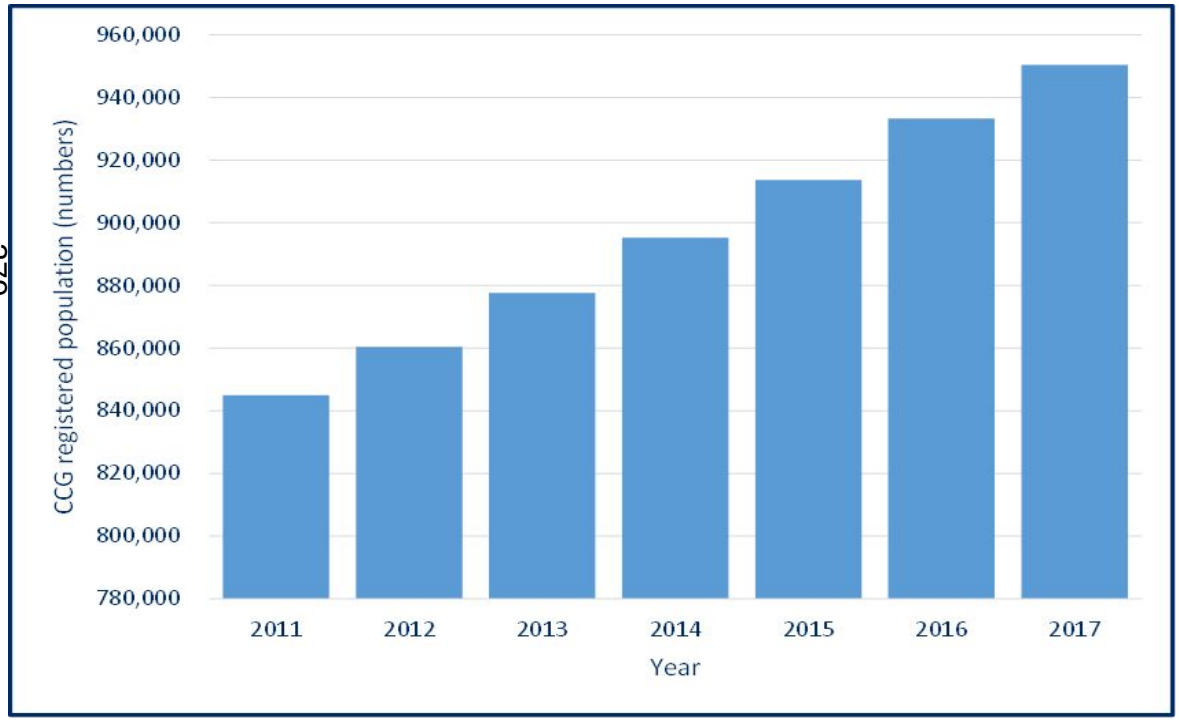


Source: Cambridgeshire County Council Research Group

The CCG's GP registered population is also growing

Cambridgeshire and Peterborough CCG registered population, 2011-2017*

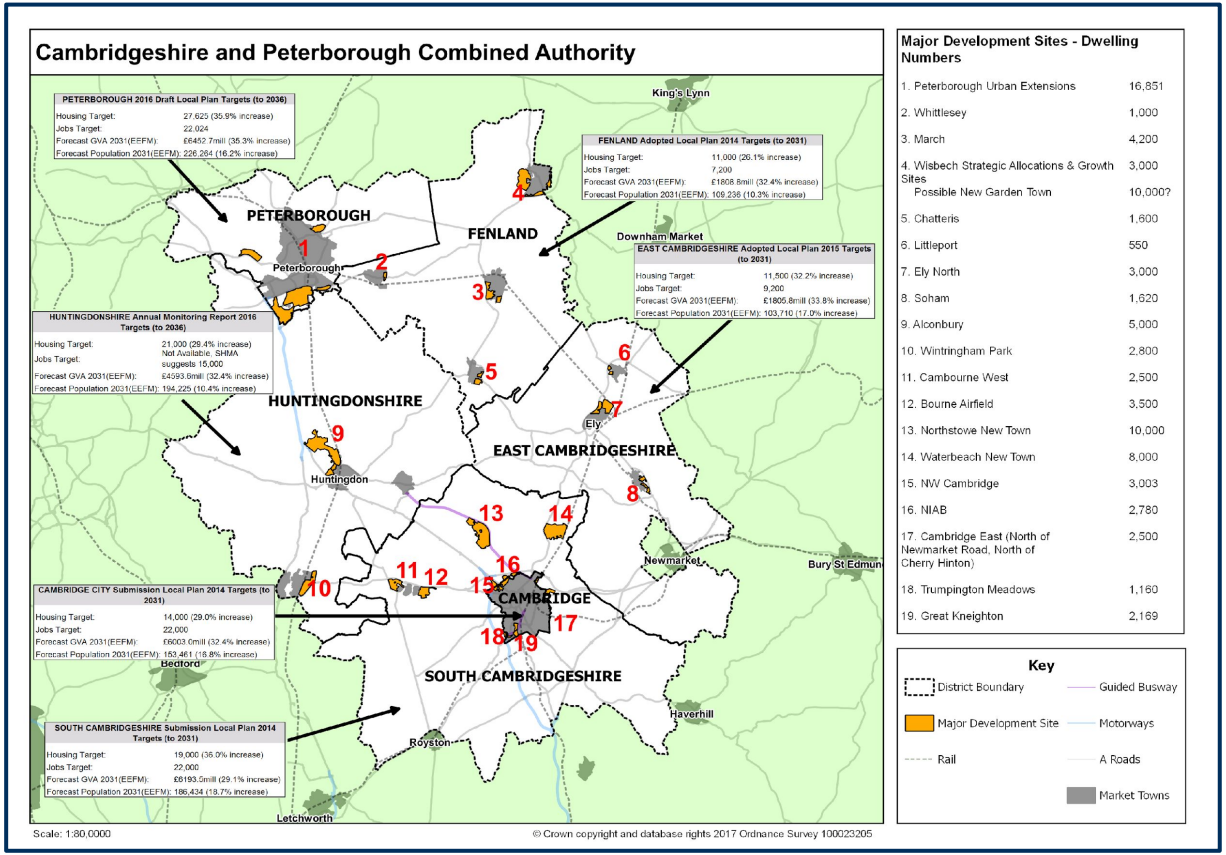
NOTE: axis does not start at 0



*Data from April each year

Source: Serco and NHS Digital (JSNA CDS figure 5)

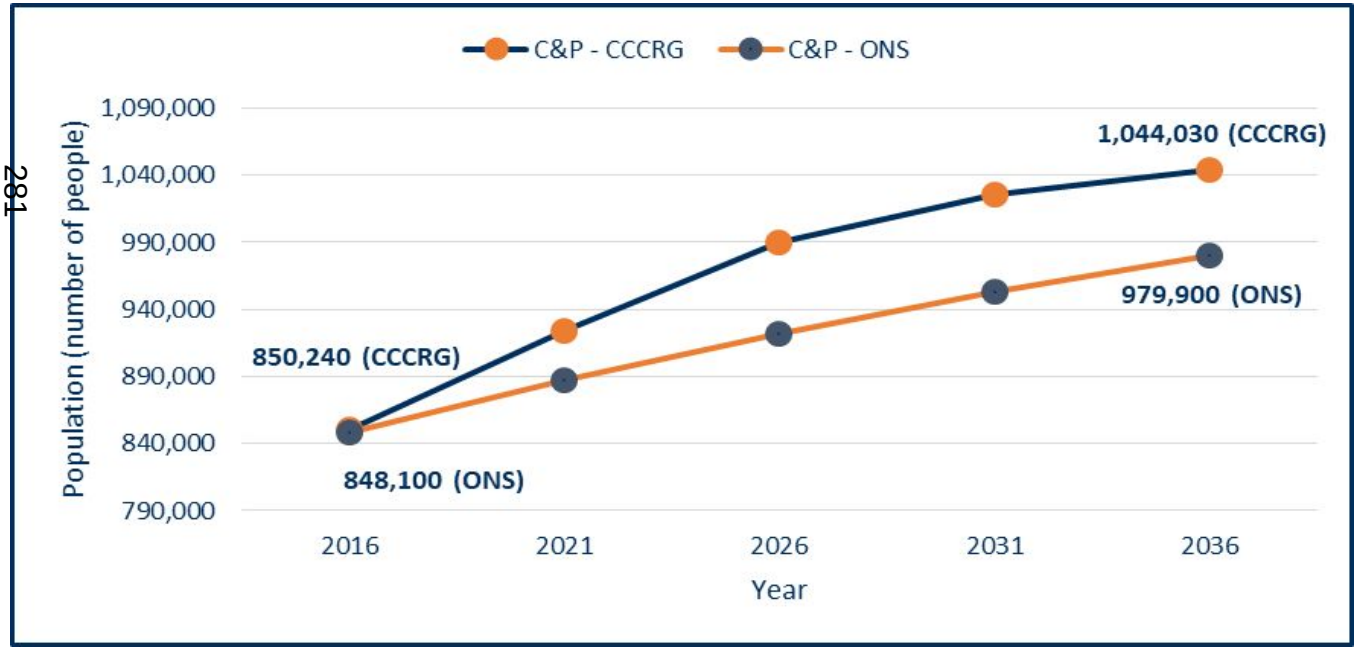
We have several new development sites



Source: Cambridgeshire County Council Business Intelligence – Research Group (JSNA CDS figure 13)

We expect continued growth but forecasts from different sources vary

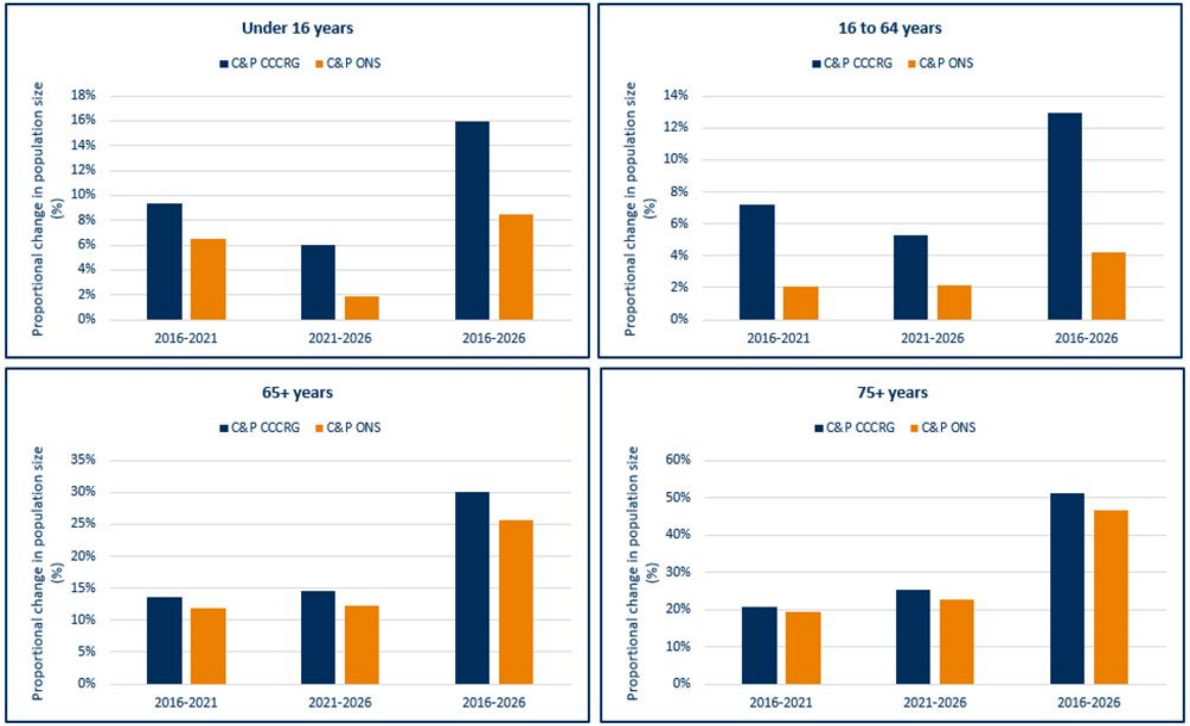
Cambridgeshire and Peterborough - absolute long term (20 year) population change, 2016 to 2036 (all ages)



Source: ONS 2014-based Subnational population projections and CCCRG mid-2015 based population forecasts (JSNA CDS figure 8)

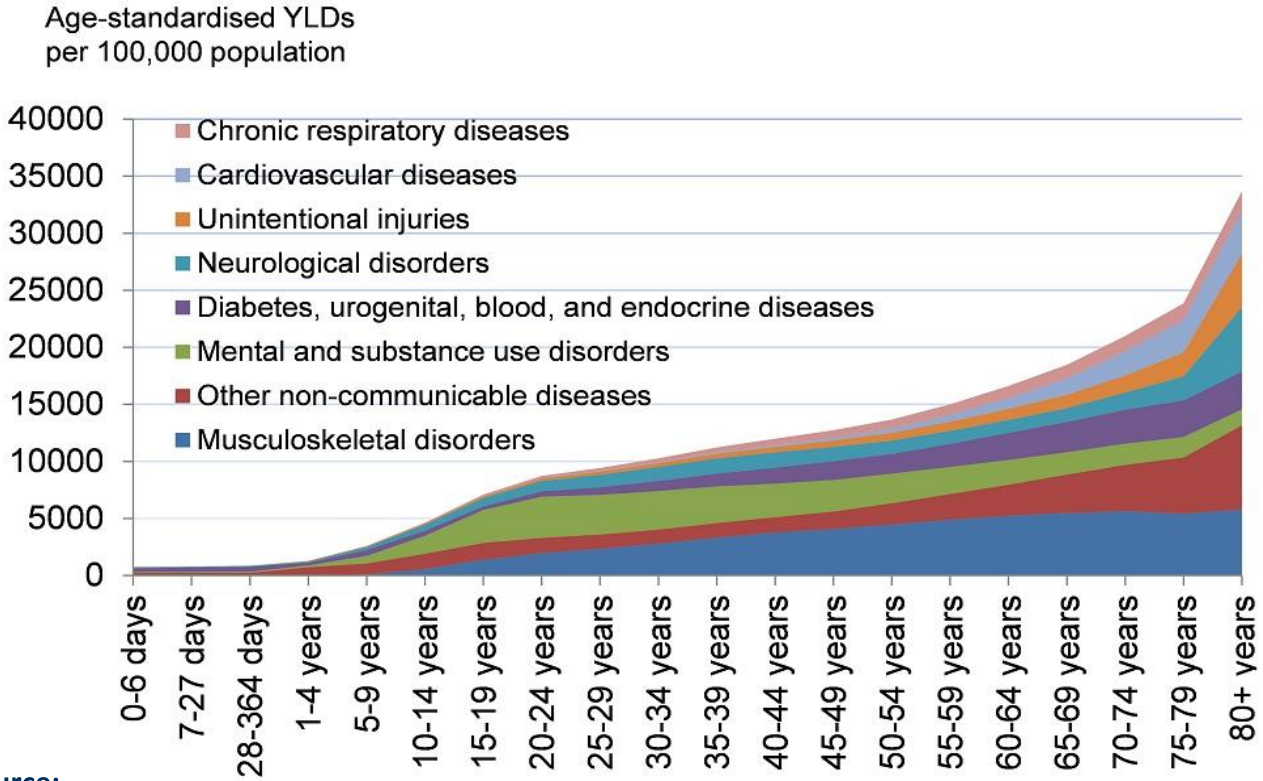
The rise in the older population is clear

Comparison of proportional change in CCC Research Group mid-2015 based population forecasts and ONS 2014 based population projections to 2026 by age group for Cambridgeshire and Peterborough to 2026



Source: ONS 2014-based Subnational population projections and Cambridgeshire County Council Research Group mid-2015 based population forecasts (JSNA CDS figure 11)

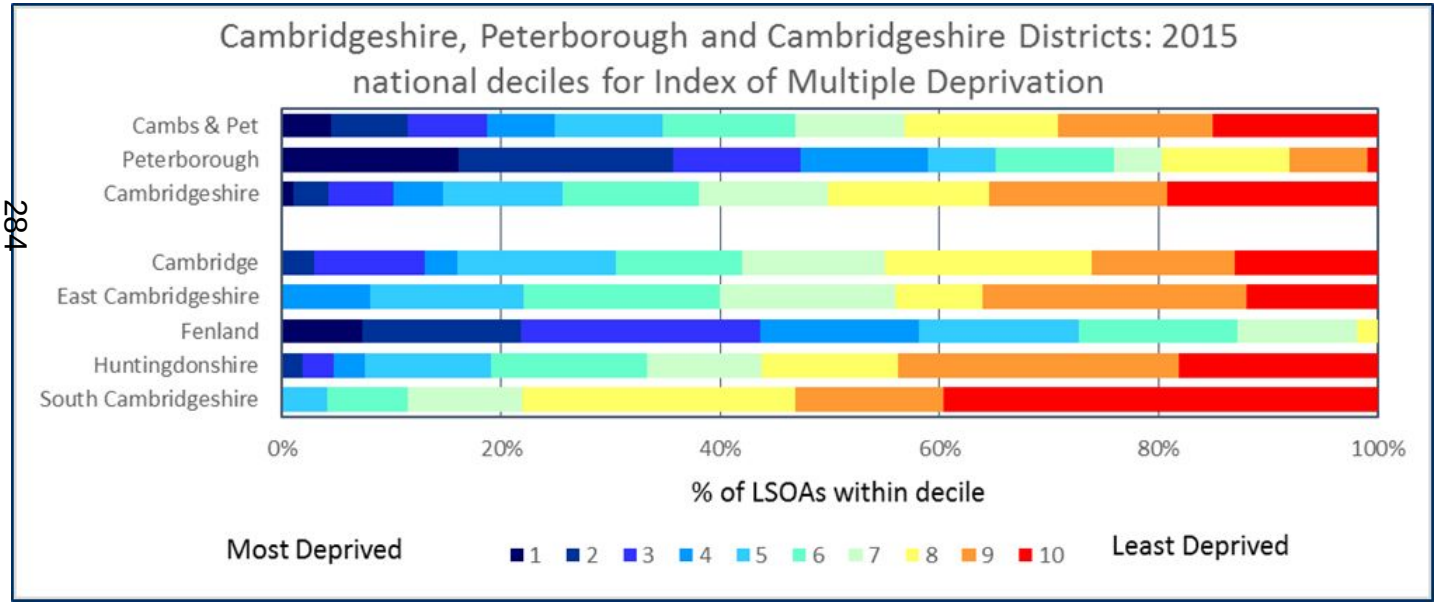
Disease prevalence



Source:

Health and wellbeing depends on: Socio-economic determinants

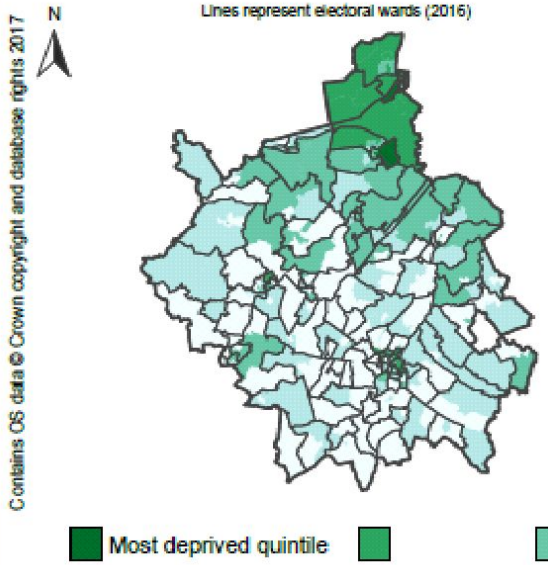
Indices of Multiple Deprivation, 2015 (IMD2015) - percentage of lower super outputs areas (LSOAs) in national IMD2015 deciles in Cambridgeshire and Peterborough and Cambridgeshire Districts



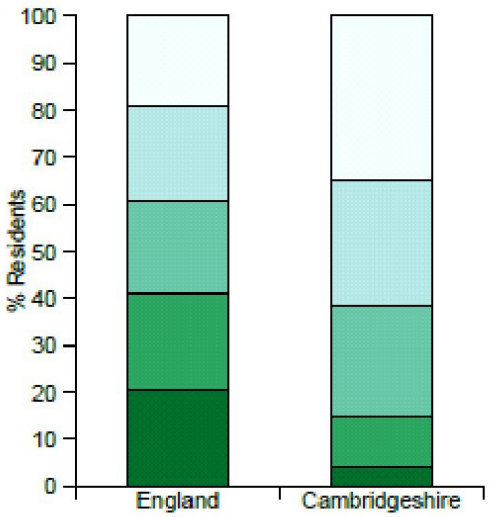
Source: Index of Multiple Deprivation 2015, Department for Communities & Local Government (DCLG) (JSNA CDS figure 20)

Cambridgeshire – deprivation by national groupings

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.



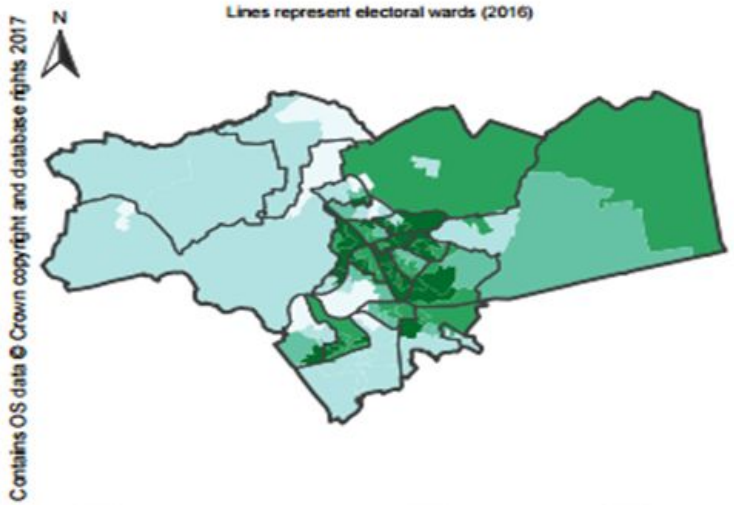
Most deprived quintile

Least deprived quintile

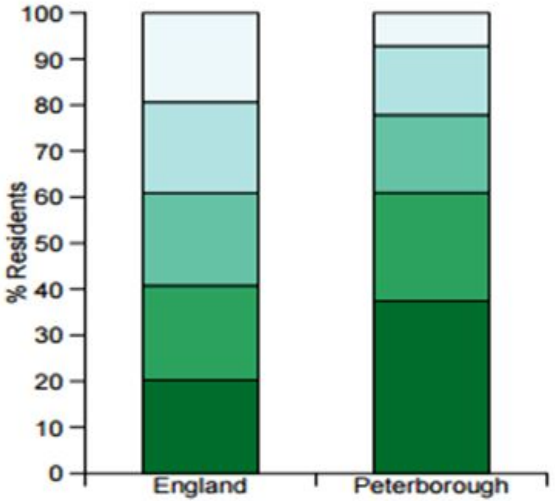
Source: DCLG from PHE Cambridgeshire Health Profile 2017 (Crown Copyright 2017)

Peterborough – deprivation by national groupings

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

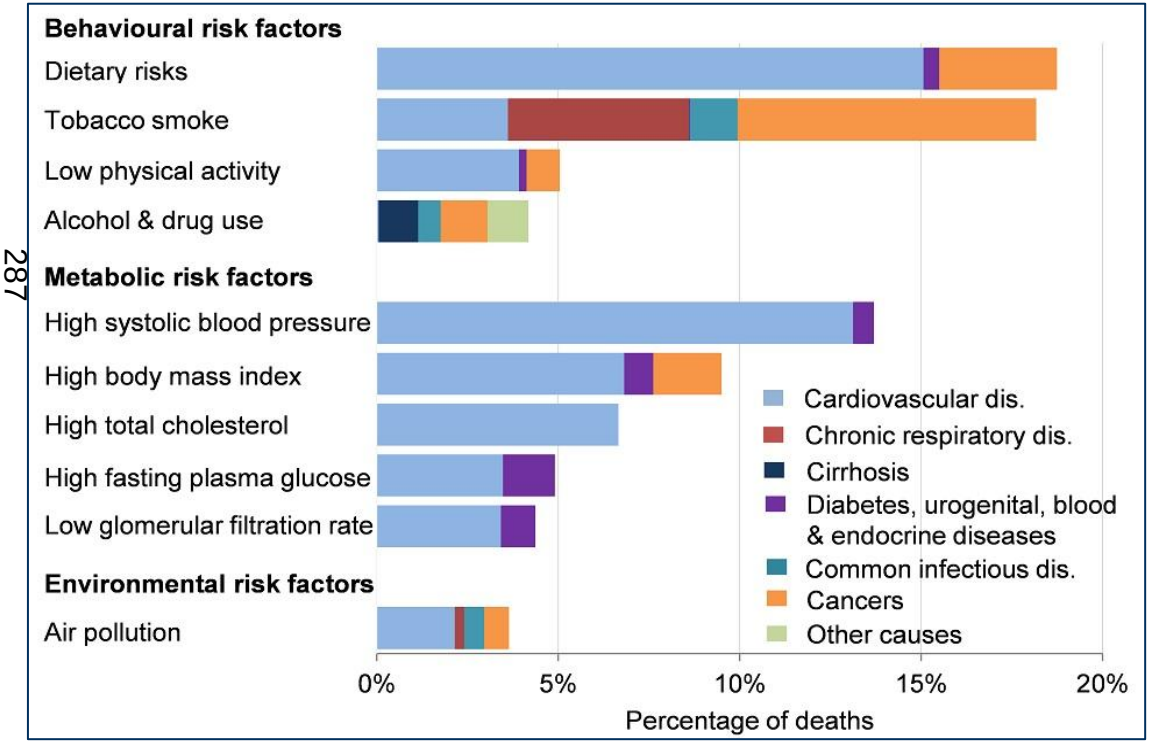


Most deprived quintile

Least deprived quintile

Source: DCLG from PHE Cambridgeshire Health Profile 2017 (Crown Copyright 2017)

Health and wellbeing depends on: Behavioural risk factors



Prevalence of obesity (GP practice data)

Prevalence of obesity in adults (18+) by area of general practice location, 2015/16

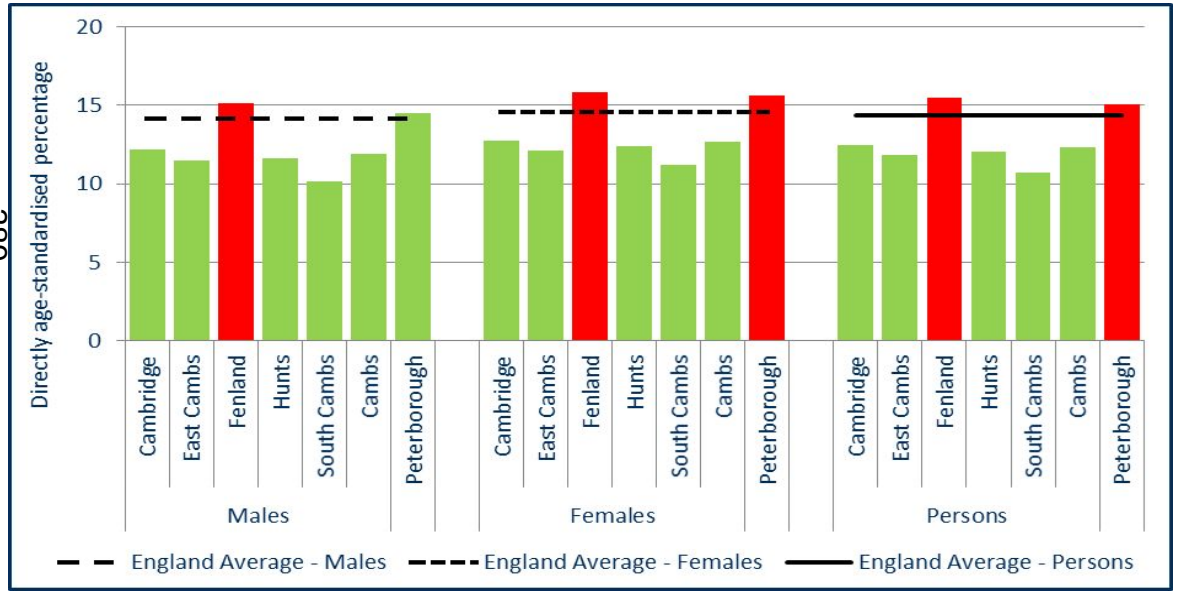
Area of GP location	Percentage	Number of people
Cambridge	4.7	7,043
East Cambridgeshire	8.7	5,846
Fenland	13.0	12,203
Huntingdonshire	8.8	12,557
South Cambridgeshire	6.5	6,357
Cambridgeshire	7.9	44,006
Peterborough	9.9	15,149
Cambridgeshire and Peterborough CCG	**8.4**	**61,949**
England	9.5	4,317,919

Statistically significantly lower than the England average
Statistically similar to the England average
Statistically significantly higher than the England average

Source: NHS Digital, Quality and Outcomes Framework, Cambridgeshire County Council Public Health Intelligence (JSNA CDS Table 25)

Health and care demand depends on:
Prevalence of disease

Directly age-standardised percentage of the population with a long-term activity-limiting illness, Cambridgeshire, Peterborough and Cambridgeshire Districts, 2011



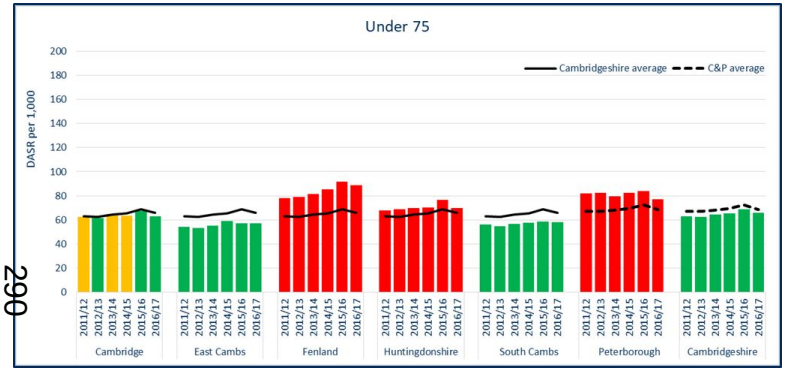
Usual residents in households only (i.e. excluding communal establishments such as hospitals and care homes)

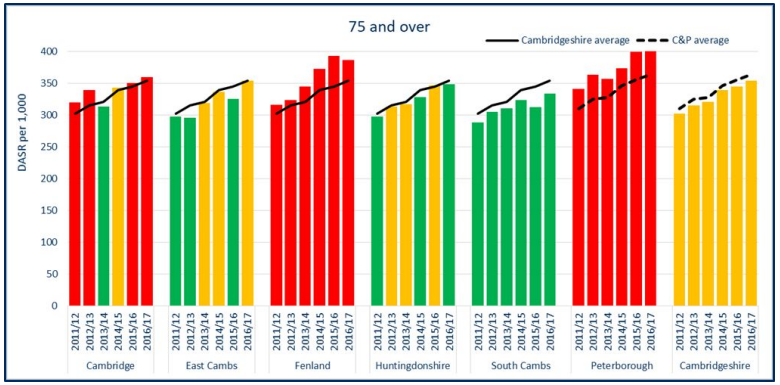
Statistically significantly better than the England average
Statistically similar to the England average
Statistically significantly worse than the England average

Source: Office for National Statistics Census 2011, Cambridgeshire County Council Public Health Intelligence (JSNA CDS figure 51)

Emergency admission rates have risen - particularly for over 75s in Fenland and Peterborough

Rates of hospital inpatient admission episodes by local authority of residence – emergency admissions: directly age-standardised rates, Cambridgeshire and Peterborough, 2011/12 to 2016/17



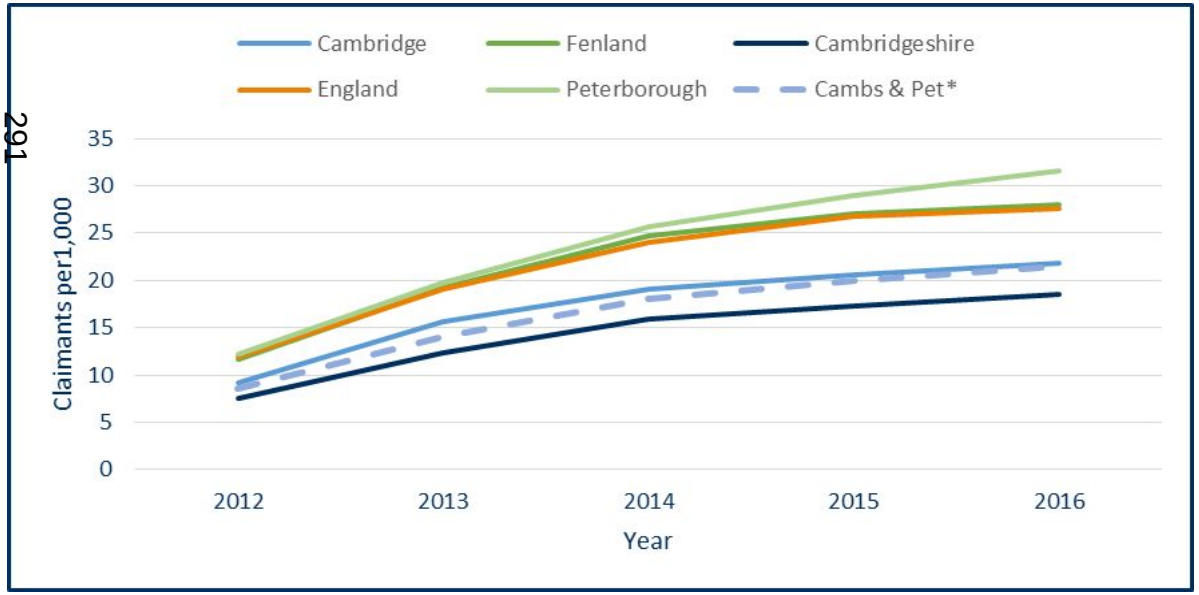


Statistically significantly higher than the Cambridgeshire/C&P average
Statistically similar to the Cambridgeshire/C&P average
Statistically significantly lower than the Cambridgeshire/C&P average

Sources: NHS Digital Hospital Episode Statistics, Office for National Statistics mid-year population estimates (JSNA CDS figure 42)

Overall employment rates are good but the rate of ESA claimants for mental and behavioural problems is rising

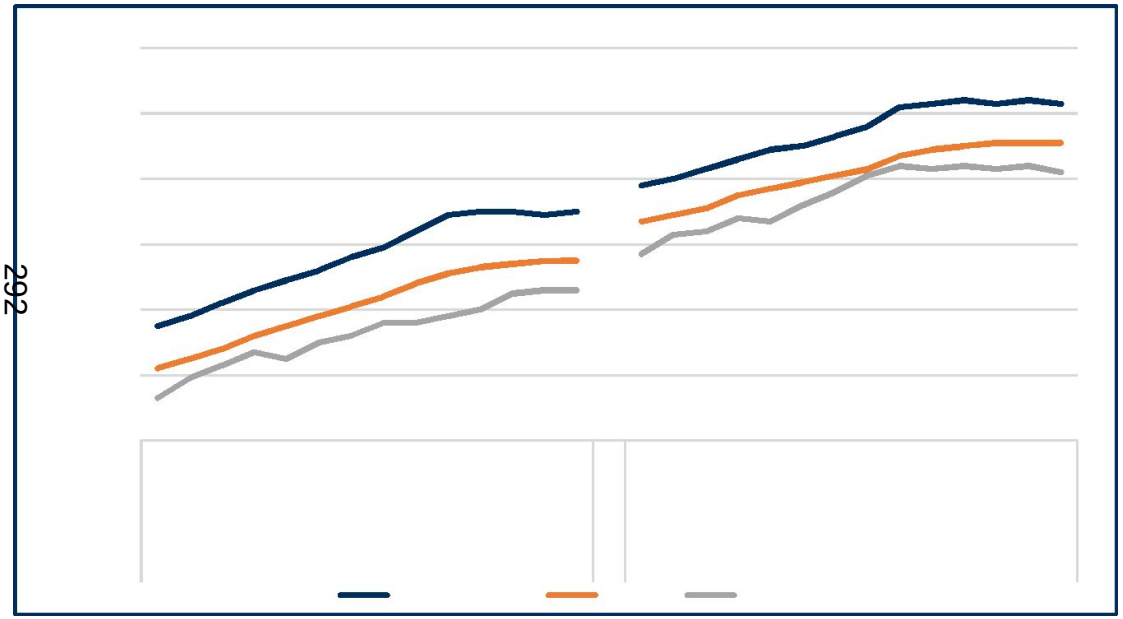
Trends *in* employment Support Allowance (ESA) claimants for mental and behavioural disorders: rate per 1,000 working age population (people aged 16-64 years), 2012-2016



Source: NOMIS, from PHE Mental Health and Wellbeing JSNA (JSNA CDS figure 34)

Life expectancy in the area has improved since 2001/3 but improvement has stalled recently

Life expectancy at birth, 2001-03 to 2014-16



- Statistically significantly better than the England average
- Statistically similar to the England average
- Statistically significantly worse than the England average

Source: Public Health England Public Health Outcomes Framework indicator 0.1ii (JSNA CDS figure 46)

Opportunities for joint work

Cambridgeshire County Council

Peterborough HWB Strategy Sections	Cambridgeshire HWB Strategy developing priorities
Health and wellbeing through the life course	Mental health Prevention
Creating a healthy environment	Population growth and new developments
Tackling health inequalities	Health inequalities including homelessness, drug and alcohol
Working together effectively	Integration of (health and social care) services

PETERBOROUGH CITY COUNCIL

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Andrew Cozens

Local Government Association

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

National Context for Health & Wellbeing Boards

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Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

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Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Group Discussion

How do we develop / drive through these priorities and measure impact

Where do we monitor progress

Concluding Comments

Wendi Ogle-Welbourn / Dr Liz Robin

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 9
19 MARCH 2018	PUBLIC REPORT

Report of:	Wendi Ogle-Welbourn, Executive Director of People and Communities	
Cabinet Member(s) responsible:	N/A	
Contact Officer(s):	Daniel Kalley/Paulina Ford, Senior Democratic Services Officer	Tel. 296334/452508

UPDATED HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

RECOMMENDATIONS	
FROM: Wendi Ogle-Welbourn, Executive Director of People and Communities	**Deadline date:** *N/A*
It is recommended that the Health and Wellbeing Board note and agree the amended terms of reference.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following the meeting on 4 December 2017.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is for the Health and Wellbeing Board to note the updated terms of reference of the Board. This follows discussion at the meeting on 4 December 2017, where parts of the terms of reference needed clarification.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No.2.8.8.1: *These Terms of Reference will be reviewed periodically*

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 At its meeting held on 4 December 2017 the Health and Wellbeing Board noted the change in membership figures of the Cambridgeshire and Peterborough Clinical Commissioning Group following Dr Mistry's resignation.

4.2 It was noted that the Terms of Reference were in need of clarification and it was agreed by the Director of Public Health and the Executive Director People and Communities Cambridgeshire and Peterborough Councils that this would be updated.

5. CONSULTATION

5.1 Consultation has taken place with the Director of Community Services and Integration, Director of Public Health and Executive Director People and Communities Cambridgeshire and Peterborough Councils.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 That the Health and Wellbeing Board note the updated terms of reference.

7. REASON FOR THE RECOMMENDATION

7.1 This item is for the Health and Wellbeing Board to note the updated Terms of Reference.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 None

9. IMPLICATIONS

Financial Implications

9.1 There are none.

Legal Implications

9.2 There are none. The legislation under the Health and Social Care Act 2012 is still adhered too.

Equalities Implications

9.3 There are none.

10. BACKGROUND DOCUMENTS

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

10.1
- Health and Social Care Act 2012
- Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
- Local Government Association 'Health and Wellbeing Boards: A Practical Guide to Governance and Constitutional Issues'

11. APPENDICES

11.1 Updated Terms of Reference – **Appendix A**

2.7 Peterborough Health and Wellbeing Board

Purpose and Terms of Reference

2.7.1. Background and context:

The Peterborough Health and Wellbeing Board has been established to provide a strategic leadership forum focussed on securing and improving the health and wellbeing of Peterborough residents.

2.7.2. The aims are:

2.7.2.1 To bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and wellbeing of the community.

2.7.2.2 To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.

2.7.2.3 To influence commissioning strategies based on the evidence of the Joint Strategic Needs Assessment.

2.7.3. Its functions are:

2.7.3.1 To develop a Health and Wellbeing Strategy for the city which informs and influences the commissioning plans of partner agencies.

2.7.3.2 To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health & Wellbeing Strategy.

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

2.7.3.4 To consider the recommendations of the Director of Public Health in their Annual Public Health report.

2.7.3.5 To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

2.7.3.6 To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.

2.7.3.7 By establishing sub groups as appropriate give consideration to areas of joint health and social care commissioning, including but not restricted to services for people with learning disabilities.

2.7.3.8 To oversee the development of Local HealthWatch for Peterborough and to ensure that they can operate effectively to support health and wellbeing on behalf of users of health and social care services.

2.7.3.9 To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

2.7.3.10 To ensure effective working between the Board and Cambridgeshire and Peterborough STP Board and Health Executive, ensuring added value and an avoidance of duplication.

2.7.4 Membership

2.7.4.1 Membership of the Health and Wellbeing Board will be composed of the following:

Peterborough City Council:
The Leader of the Council / Deputy Leader – Chairman of the Board
Cabinet Member Adults & Health Integration
Cabinet Member Public Health
An Opposition Councillor
Executive Director People and Communities Cambridgeshire and Peterborough Councils
Service Director Communities and Safety
The Director of Public Health

Cambridgeshire and Peterborough Clinical Commissioning Group
Clinical Chair (GP) of Cambridgeshire and Peterborough Clinical Commissioning Group (Deputy Chair)
1 further GP representative from the Peterborough area to cover when Clinical Chair is unavailable
Director of Transformation and Delivery: Community Services and Integration

Lincolnshire
1 GP representing South Lincolnshire CCG

NHS England
1 representative from NHS England

Cambridgeshire and Peterborough Healthwatch
1 member

The Board will also include as co-opted members the following:
Independent Chair of Peterborough and Cambridgeshire Safeguarding Children's and Adults Board
The Chair of the Safer Peterborough Partnership (Claire Higgins)

2.7.4.2 The membership will be kept under review periodically.

2.7.4.3 The Board shall co-opt other such representatives or persons in a non-voting capacity as it sees relevant in assisting it to undertake its functions effectively.

2.7.5 Meetings

2.7.5.1 The meetings of the Board and its decision-making will be subject to the provisions of the City Council's Constitution including the Council Procedure Rules and the Access to Information Rules, insofar as these are applicable to the Board in its shadow form.

2.7.5.2 The Board will meet in public.

2.7.5.3 The minimum quorum for the Board shall be 5 members which should include at least one elected member, one statutory director (DCS/DASS/DPH) and a CCG member.

2.7.5.4 The Board shall meet periodically and at least quarterly. Additional meetings shall be called at the discretion of the Chairman where business needs require.

2.7.5.5 Administrative arrangements to support meetings of the Board shall be provided through the City Council's Governance team.

2.7.6 Governance and Approach

2.7.6.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through the work of the partnership organisations.

2.7.6.2 Decisions taken and work progressed will be subject to scrutiny of the City Council's Scrutiny Commission for Health Issues.

2.7.7 Wider Engagement

2.7.7.1 The Health and Wellbeing Board will develop and implement a communications engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public.

2.7.7.2 The Board will ensure that its decisions and the priorities it sets take account of the needs of all of Peterborough's communities and groups are communicated widely.

2.7.8 Review

2.7.8.1 These Terms of Reference will be reviewed periodically.

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 10
19 MARCH 2018	PUBLIC REPORT

Report of:	**Wendi Ogle-Welbourn**	
Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald	
Contact Officer(s):	Will Patten, Director of Transformation, Peterborough City Council	Tel. 07919 365883

ADULT SOCIAL CARE, BETTER CARE FUND (BCF) UPDATE

RECOMMENDATIONS	
FROM: Wendi Ogle-Welbourn	**Deadline date:** N/A
Board members are requested to: 1. Note the update of BCF delivery	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Corporate Director for People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information for the Board; it sets out an update on the delivery of the BCF Programme of work.

2.2 This report is for the Board to consider under its Terms of Reference No. 2.8.3.6 *'To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.'*

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 As previously reported, Peterborough's BCF has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and introduced in April 2015. The 2017/18 £16.8 million budget is largely a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Peterborough City Council (PCC) to provide health and social care services in the city. It includes funding for the Disabled Facilities Grant, which supports housing adaptations and Improved Better Care Fund (iBCF) monies.

4.2 MONITORING:

The below tables provide an overview of targets and performance to date across Peterborough and Cambridgeshire at the end of Q3:

Metric	2017/18 Planned Target	Peterborough Performance		Mitigating Actions
		Summary Performance to date	RAG Rating	
Non-elective admissions to hospital	18,128 non elective admissions	At the end of Q3 NEA performance was at 13,325 year to date against a threshold year to date target of 13,717.		Continued investment in prevention and early intervention approaches – including joint funding of falls prevention and atrial fibrillation Multii-Disciplinary admissions avoidance team established in ED
Delayed Transfers of Care (DTOCs) from hospital	3.5% Occupied Bed Days Peterborough – 345 occupied bed days for Q3	The system continued to report high levels of DTOC in Q3 with December performance reporting 587 occupied bed days against a target of 345. This represents performance running at 7.61% at the end of Q3. Assessment related delays continue to be the bulk of DTOCs within the system. Q3 social care attributable delays were zero during Q3, an improvement on Q2. Though jointly attributable delays increased on Q2 statistics.		Ongoing weekly monitoring of DTOC performance to ensure quick identification of trends iBCF investment in DTOCs – ongoing implementation of plan (see appendix 1) Ongoing review of iBCF DTOC plan to ensure investment is delivering outcomes Senior leadership review of DTOC position to ensure integrated approaches to address pressures Evaluation of Continuing Healthcare 4Q hospital discharge pathway 3 month pilot in planning
Admissions to long-term residential and nursing homes in over 65 year olds	154	At the end of Quarter 3 there were a total of 101 care home admissions year to date and we are on track to stay within our threshold target.		On track to meet target
Effectiveness of re-ablement services	83%	At the end of Q3 proxy performance was at 73%. Continued capacity issues in the domiciliary care market have impacted on reablement capacity.		Additional iBCF investment in reablement provision Ongoing recruitment of reablement support workers to increase capacity by 20%.

				Domiciliary Care capacity being reviewed with providers at fortnightly forum to reduce bridging packages in reablement Additional VCS provision commissioned to support reablement and domiciliary care capacity

4.3 PROGRESS OF DELIVERY

Our approach to integration over 2017-19 was submitted as part of our local Better Care Fund plan, which now has full approval from NHS England. There will be a continued focus on building on the work undertaken to date. The following provides an update on key priority areas:

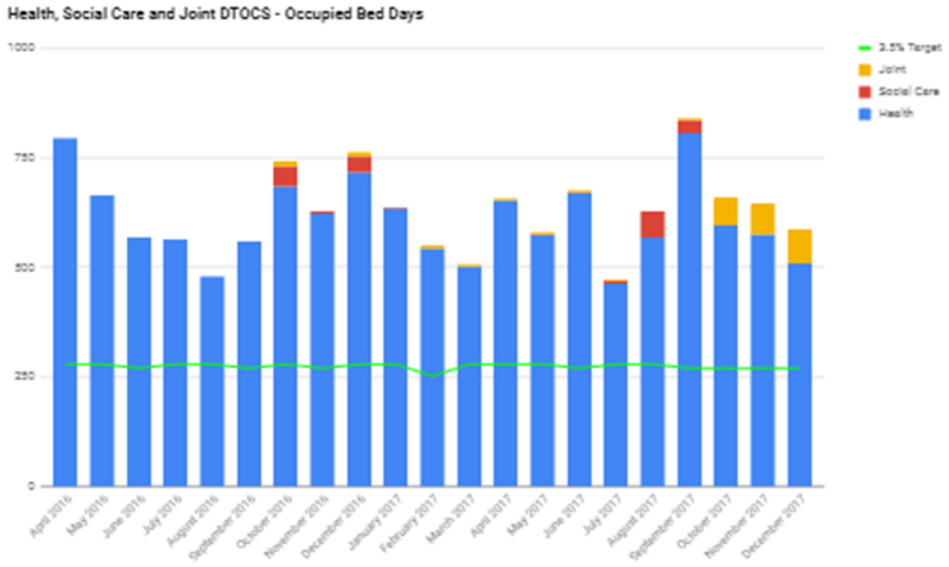
Prevention and Early Intervention: including a county wide falls prevention programme, further work to ensure a comprehensive approach to equipment and assistive technology, and development of joint VCS commissioning opportunities. Falls prevention: ongoing roll out of training to neighbourhood teams. Falls prevention health service go live March 2018. Stroke prevention: Atrial Fibrillation is currently focusing on the roll out of ECG equipment to identify patients in flu clinics.

Community Services (MDT Working): Additional CPFT staff recruitment is being finalised to support the enhanced case management service roll out. First run of data is being gathered from GPs to support case finding.

Enablers: An evaluation of the test proof of concept has been undertaken and discussions are ongoing across health, social care and VCS to progress next steps.
High Impact Changes for Discharge: A new national BCF condition, requires the local system to implement the high impact change (HIC) model for managing transfers of care. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes. An update on key initiatives can be found at **Appendix 1.**

DTOC Performance

4.4 The below graph shows month on month DTOC performance across Peterborough against the 3.5% target, highlighting that performance is significantly underperforming against target. Despite deteriorating rates of DTOC, social care and joint DTOCs have remained exceptionally low, with the bulk of delays attributable to the NHS.



During December, 86.9% of all delayed days were attributable to the NHS, 0.0% were attributable to Social Care and the remaining 13.1% were attributable to both NHS and Social Care.

Peterborough, compared to all single tier and county councils in England, is ranked 114 out of 151 on the overall rate of delayed days per 100,000 population aged 18+. It is ranked 139 on the rate of delayed days attributable to the NHS, and 1 on the rate of delayed days attributable to social care.

There was significant investment from the Improved Better Care Fund (iBCF) to support a range of initiatives to reduce DTOCs. This investment was targeted specifically at the health and social care interface and it is important to note that the STP is responsible for a range of health related activities to support delivering the 3.5% DTOC target. An update on the key iBCF DTOC Plan initiatives can be found at Appendix 1.

The original intention was to invest £2,000,000 of iBCF monies into housing for vulnerable people. Adult Social Care is facing unprecedented financial pressures resulting from increasing costs of care and increasing demands on its resources from winter pressures. In line with the IBCF national conditions, we are using the funds to mitigate these pressures and provide solutions to meet the DTOCs target and meet Adult Social Care (ASC) needs. The Council has committed to invest Capital funding to enable continued delivery of the vulnerable housing project objectives.

5. CONSULTATION

5.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with partners, including discussion at the A&E Delivery Board and appropriate STP governance boards. The Joint Cambridgeshire and Peterborough Integrated Commissioning Board, which has system wide health and care representation, has overseen the development of the plan In line with national requirements, local system partners have approved and are signatories to the 2017-19 BCF Plan. Joint working across Cambridgeshire and Peterborough continues and regular monitoring activities have been solidified to ensure clear and standardised reporting mechanisms.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Not applicable. The contents of this report provide an update for the board to note.

7. REASON FOR THE RECOMMENDATION

7.1 *The report is for the information to the board.*

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not applicable.

9. IMPLICATIONS

Financial Implications

9.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving BCF monies.

The BCF funding is in line with the Council's Medium Term Financial Strategy (MTFS).

Legal Implications

9.2 There are no legal implications related to this report.

Equalities Implications

9.3 There are no equalities implications related to this report.

10. BACKGROUND DOCUMENTS

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

10.1 i) BCF Quarterly Data Collection Template Q2 17-18 Peterborough (final)
ii) BCF Quarterly Data Collection Template Q3 17-18 Peterborough (final)

11. APPENDICES

11.1 Appendix 1 – Commissioning Winter Pressures / iBCF Plan 2017/18

Appendix 1

Peterborough Commissioning Winter Pressures/iBCF Plan 2017/18
HomeCare
Reablement Step-Down
Voluntary Sector
Moving & Handling
Equipment & AT
Reviews
Transfer of Care
Reablement
Accomodation
Winter Pressures Service
Deliver extra HomeCare capacity to manage winter pressures - Winter Pressures Service for 6 months.
Staggered Mobilisation
Deliver a Step-Down Reablement Unit with the Private Sector - Test the Market
Increase Voluntary Capacity
Red Cross - Acute Trust
Dedicated M&H Coordinator
Recruit a moving & handling coordinator
Deliver Equipment faster & increase AT
Deliver equipment quickly & reliably. Significantly increase the offer available and the responder actions
Review of HomeCare Functions
Social workers to undertake low-level reviews
Improve Hospital Transfers of Care
Trusted assessor, CHC 4D, strategic Discharge Lead, Discharge to Assess and Admissions Avoidance Social Worker
Increase Market Capacity
Recruit appropriate numbers of reablement staff to increase capacity
Maximise Accomodation Usage
Optimise usage of age-appropriate services such as Extra-Care
Updates - 11th January 2018
GJ & RA
GJ & DMc
GJ
DMc
GJ/TS
DMc
DMc
DMc
GJ

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 11
19 MARCH 2018	PUBLIC REPORT

Report of:	Wendi Ogle-Welbourn and Dr Liz Robin	
Cabinet Member(s) responsible:	Cllr Wayne Fitzgerald	
Contact Officer(s):	Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils	Tel. 863618

QUARTERLY HEALTH & WELLBEING STRATEGY PERFORMANCE REPORT

RECOMMENDATIONS	
FROM: Executive Director People & Communities and Director of Public Health	**Deadline date:**

It is recommended that the Health and Wellbeing Board:

1. consider the content of the performance progress report and raise any questions.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Executive Director for People and Communities and the Director of Public Health.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide Board members with a summary of progress against the Future Plans identified for each of the focus areas outlined in the Health & Wellbeing Strategy 2016-2019.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference Numbers:

3.1 To develop a Health and Wellbeing Strategy for the city which informs and influences the commissioning plans of partner agencies

3.2 To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health and Wellbeing Strategy

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	

4. BACKGROUND AND KEY ISSUES

4.1 The Health & Wellbeing Strategy 2016-19 identified key focus areas. A performance report for each focus area is contained within **Appendix 2**.

In addition to the performance headlines listed below, the delivery group would also like to highlight activity in the following areas:

Information from the JSNA Core Datasets for Cambridgeshire and Peterborough has been brought together and updated to produce a combined JSNA Core Dataset (2018). This will support use of the JSNA by partner organisations which work across a Cambridgeshire and Peterborough footprint, such as the Clinical Commissioning Group, the Sustainable Transformation Partnership, and the Combined Authority. The document is available on **https://www.peterborough.gov.uk/healthcare/public-health/JSNA/**

System Response to future CIL and Section 106 monies - A discussion was held at the February Health Care Executive and Public Service Board (HCE/PSB) where members were asked to consider:

- How the "Health" sector are engaged in new provision and spend of funds?
- The Local Planning Authorities differ in their respective policies on the use of Section 106/CIL for health sector infrastructure which adds to the confusion and lack of understanding of the process. How can this be simplified?
- In order for a robust case to be made it needs the engagement of a number of different organisations including: CCG, NHS England, NHS Property Services, Cambridgeshire County Council / Peterborough City Council Public Health and Social Services
- How do we draw down the section 106/CIL monies to benefit the population?
- With the scale of growth happening across Cambridgeshire and Peterborough the local NHS as a system needs a strategic approach to plan infrastructure and services to cope with the population growth. Are there opportunities for closer working between partners and shared objectives around growth and service delivery?

The discussion was productive with the Board asking Public Health to bring together the CCG, Combined Authority and District partners to develop a propose a new approach to planning for health which is to be presented to the next HCE/PSB meeting in three months time.

English as a Second / Other Language (ESOL) courses - Apart from mainstream qualification courses being delivered to approx 350 learners, the 'Getting to Know You' project, funded under DCLG Controlling Migration funding for 2 years and delivered by trained volunteers, piloted 5 courses in the community before Christmas. Currently, 14 courses at two levels are running or due to start at seven venues in the community including Welland, West Town, the Ortons and the Gladstone area.

Syrian Refugee ESOL courses - City College currently have 16 adults studying ESOL for 12.5 hours a week or more. Some have already achieved a qualification and they are now planning employability and vocational courses for those whose English is at a suitable level to progress. The next arrivals are expected in April. The Department of Communities and Local Government visited the City College recently when they came to Peterborough, observed the course in action and spoke to the refugees. Their feedback was extremely positive in terms of the progress the adults have made and the professional expertise of the tutor.

Key headlines from the quarterly performance reports:

Children and Young People

- 98% of all new mothers in Peterborough received a new birth visit by a health visitor
- 94% of families received a 12 month development check
- 406 pupils were seen by school nurses for mental health / wellbeing issues during Quarter 3
- The Speech & Language Therapy service is now jointly commissioned with CCC and the CCG. All children are now seen within the 18 week waiting target. A launch event was held to celebrate the new service and promote the new delivery model
- Following the mobilisation of the CHUMS (counselling service), interventions are now being delivered

Health Behaviours and Lifestyles

- An outreach programme has now been added to the Healthy Lifestyle programme. One-to-one clinics and group programmes have been expanded
- 400 weight management / physical activity programmes have been delivered since April 2017, with local schools hosting child programmes
- Rates of successful drug and alcohol treatment programmes are now at or above the national average
- A procurement exercise for the Healthy Workplace programme is now underway
- The Healthy Lifestyles services are now delivering clinics from over 20 GP practices and support clinics in over 50 community settings, workplaces and schools locally each week
- Smoking Cessation services are now provided at Aspire, who are providing training to the Healthy Lifestyle service to deliver information and advice to target populations

Long Term Conditions and Premature Mortality

- Diabetes has now been rated as the 'greatest need for improvement' in the CCG Improvement and Assessment Framework. 95 practices have referred patients into the Diabetes Prevention Programme. Plans are in place to increase the levels of activity to allow additional referrals
- The national funding now means that DESMOND is now available for all people with Type 2 diabetes (not just those who are newly diagnosed)
- Additional recruitment is taking place to increase capacity within the diabetes specialist teams in the community. There are now 8.5 Diabetes Care Technicians supporting practices with their annual reviews and diabetic patients who are housebound. Recruitment of health and social care professionals, especially in community settings, still remains a challenge
- Plans are underway to set up public engagement events with Diabetes UK to enable people to feedback their views on current diabetes services and future plans
- The reduction in the number of patients not receiving anticoagulation and the identification and treatment of new cases of AF should prevent approximately 5 strokes per year going forward

Mental Health for Adults of Working Age

- Early indications from the annual suicide audit suggests that the total number of suicides in Peterborough has reduced. The Suicide Prevention Strategy and action plan have been refreshed for 2017-2020. A task and finish group will be established to address suicide risk in the criminal justice system
- Training in suicide prevention for GPs will start to be rolled out from April 2018
- Excellent progress is being made with the implementation of the Crisis Concordat Action Plan by the Mental Health Delivery Board, with progress being made on most of the 17 priorities
- Information sharing between agencies has been identified as the biggest single barrier to effective joint working and is being raised with the STP
- A review of the mental health housing and accommodation pathway has been prioritised for 2018/19
- The next stage of the Mental Health Employment Strategy is to engage with communities / individuals to identify the support and intervention that they need to support them

towards or into employment
- A retendering exercise is currently underway to create a single Recovery and Inclusion Service, with the aim to improve the consistency of access and outcome across the area and value for money
- Work to establish a Mental Health Joint Commissioning Unit continues with a joint work plan being agreed for 2018/19

Health and Wellbeing of People with Disability and/or Sensory Impairment

- A report has been published on the Adult Social Care Service User Survey 2016/17 with high customer satisfaction ratings, exceeding the averages across England. A report has been prepared across the East of England to find out why people might not feel safe which shows that the main issue is fear of falling both in home and whilst out and about.
- The Adult Social Care Local Account for 2016/17 was published in December showing performance, challenges and future proposals
- Two leaflets have been published aimed at people with dementia and their carers. A local Dementia Guide is currently being developed and should be available in July 2018
- A brand new Local Offer for children and young people with SEND and their families has been launched and was co-produced with parent, carers and young people. Work is now underway to amalgamate the Adult Social Care Online Care directory onto the same platform
- The Peterborough Disability Forum reviewed the Prevention Strategy in January and will be working on the development of an action plan
- Terms of Reference for the Peterborough Sensory Disability Board were agreed at the first meeting in January

Ageing Well

- The Older People Mental Health Delivery Board has developed a strategic plan, currently going through the approval process, which reflects local need and responds with current evidence based practice to inform future provision and support
- Work is underway to develop an integrated falls prevention pathway across the county. Implementation is being overseen by a small group of members from the Prevention Strategy Group and the Ageing Well Strategy Board
- Following funding, 'The Campaign to End Loneliness' have begun the first stages of mapping and consultation to establish agreed local solutions to reduce loneliness in older people
- A strategy is currently being drafted to look at improving end of life care across the county, alongside the development of an outline business case for investment from the STP

Protecting Health

- Additional GP practices have been recruited to the TB screening programme to ensure a high level of coverage
- Work continues on workforce planning for specialist TB clinical staff in local NHS provider trusts
- All trusts are now reporting uptake in excess of 95% of routine neonatal BCG
- Shingle vaccine uptake is a concern as it is falling. One possible reason is the delivery of flu vaccination in pharmacies as GPs used to vaccinate alongside flu vaccinations. More work in needed to investigate this
- Early indications are showing flu vaccinations increased in the 2017/18 season in all risk groups
- Recruitment of nursing staff to support sexual health services continues to be difficult as well as an increase in demand for this service. The service is currently training more specialist nurses to address the issue but the increased demand needs to be closely monitored
- The Sexual Health Delivery Board have established two working groups to look at teenage pregnancy and pathways
- The Cambridgeshire and Peterborough 'system' have been asked by Public Health England to be a pilot site to develop a model to better align commissioning of sexual health services
- The number of pharmacies delivering emergency contraception services has increased.

A promotional campaign has been launched to increase knowledge of the service in the local population

Growth, Health and the Local Plan

- Recent data shows the prevalence of unhealthy weight among 10-11 year olds has increased and is now significantly worse that the England average
- The Local Plan is now out for consultation and includes a Health and Wellbeing Policy
- The Public Health and Planning Teams are working together to scope options for a fast food supplementary planning document focusing on the management of premises across the city
- A joint workstream with the Environmental Health Team, focusing on supporting local fast food establishments to make small changes to their menus to improve the quality and healthiness of food is on hold due to a lack of capacity within the team. This will be reviewed again at the end of the financial year

Health and Transport Planning

- Provisional data for 2017 shows 6 people have been killed on Peterborough roads, an increase from 4 in 2016
- A target has been set for 1,943 pupils to participate in Bikeability training during 2017/18
- 61% of the Public reported being satisfied with cycle routes and facilities in Peterborough
- The number of business and active travel plans increased from 63 in March 2017 to 71 in January 2018. 42 schools have active travel plans
- Bike It delivered 57 activities during August and December 2017, engaged with 2,643 pupils, 143 staff and 26 parents. Officers have now engaged with 70,000 pupils, teachers and schools since 2012. Further funding has been secured until March 2018
- A new online learning platform, Drive IQ, aimed at young drivers has been launched and a workshop covering road related road safety has been developed
- During October to December, The 'Be Safe Be Seen' campaign delivered a number of activities with partner agencies across Peterborough
- A number of pubs and clubs across Peterborough signed up to the 'I'll be DES' campaign over the Christmas period, offering designated drivers free soft drinks
- A joint working group is to be developed to bring together those working on active travel across the authority area
- A new JSNA on Health and Transport has been produced
- Funding for sustainable transport work continues to be an issue. Short term funding has been provided by the Combined Authority

Housing and Health

- 376 referrals have been made to the Local Energy Advice Programme resulting in 186 home visits. The advice given equates to £171 per unit bill saving (£31,635 in total). Householders can also be referred onto the IncomeMax service
- Currently looking at the potential to bid as part of a consortium of councils for Warm Homes Funding to launch Energy2Care, which will help vulnerable people who have health conditions exacerbated by the cold to stay out of fuel poverty and maintain a healthy home
- Peterborough has experienced a rise of 200% in the number of homeless families requiring temporary accommodation in just the last 2 years. As at December 2017, 337 households were in temporary accommodation. The impact on the council's budget is huge as the council has a legal duty to provide housing for all those who meet the criteria for support. Two key decisions have been made to tackle this issue; invest significantly into Medesham homes and increase the staff resource in the Housing Needs Team
- The Housing Needs Team continue to work in partnership with the Light Project to offer a winter night shelter provision to rough sleepers
- PCC is working with CCC to jointly procure a Housing Related Floating Support Service which will support individuals with mental health problems who are chronically excluded and prolific and persistent offenders and those at risk of becoming so
- PCC is working with Cambridgeshire District Councils on the extension of the LEAP service into their areas
- 8 discretionary Disabled Facility Grants have been completed to enable discharge from

hospital / reablement / care

Geographical Health Inequalities

- The Can Do Regeneration will recruit a project manager to support the programme manager from January 2018. £7.5 million will be spent over 3 years (2017-2020). Additional funding is being sought from external sources
- The Can Do Local Action Group members have been asked to complete a survey to determine the current offer, gaps, needs and future opportunities, which will inform what investment is needed in the area. Initial feedback from the community includes a desire for a health and fitness centre focusing on young people due to a shortage and space for leisure activities to take place in the area
- Funding bids have been submitted to the Litter Innovation Fund and Place Based Social Action Fund
- 3 new CCTV columns have been installed in the Gladstone Area which are already having a positive impact
- Public Health are working with the CCG to undertake analysis of inequalities in hospital admissions and associated spend across Peterborough and Cambridgeshire. The information will then be used to inform prevention based efforts

Health and Wellbeing of Diverse Communities

- Data is being collected to determine the ethnicity of people using mental health crisis services. Those who have identified their ethnicity as 'ethnic minority' has been collected and reported as 11% (Oct 17), 10.27% (Nov 17) and 11.45% (Dec 17)
- Suicides in Peterborough by people with Eastern European ethnicity is a concern although it is difficult to report this data for confidentiality reasons as the numbers are small
- The Cohesion Team are supporting a publicity campaign around the immunisation programme and assisting in the preparation of a social services strategy so the needs of all community groups can be considered
- The Cohesion Team, Solutions4Health and the Lithuanian Embassy organised a community engagement event in November which was attended by approx. 150 people from the EU community. A number of attendees participated in MOT health checks and increased the uptake on courses held at the Gladstone Community Hub. Full body health checks and mini MOTs were organised at a local mosque and temple
- The Getting to Know You project will see an increased ESOL provision within Peterborough over the next 2 years. The project is led by the City College and will involve both GLADCA and PARCA in community based delivery
- The Mental Health First Response and Sanctuaries Services are being promoted as a programme of work to Minority Ethnic communities through Peterborough
- A South Asian Health and Wellbeing Survey is being implemented which will assess the local need and access to services. The findings will be made available as a supplement to the Diverse Ethnic Communities JSNA

5. CONSULTATION

5.1 The performance progress reports were circulated to members of the Health & Wellbeing and SPP Partnership Delivery Group in January 2018.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Board is expected to review the information contained within this report and respond / provide feedback accordingly.

7. REASON FOR THE RECOMMENDATION

7.1 To ensure members are kept regularly informed of progress and any barriers/challenges that may be preventing progress so that members may assist in unblocking these.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Board must be kept informed of progress against the identified focus areas within the current

Health & Wellbeing Strategy.

9. IMPLICATIONS

Financial Implications

9.1 There are no financial implications associated with this report.

Legal Implications

9.2 There are no legal implications associated with this report.

Equalities Implications

9.3 There are no equality implications associated with this report.

10. BACKGROUND DOCUMENTS

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

10.1 N/A

11. APPENDICES

11.1 Appendix 1 Future Plans RAG Ratings and Risk Register
Appendix 2 Focus Areas Performance Reports

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HEALTH AND WELLBEING STRATEGY – FUTURE PLANS RAG RATINGS

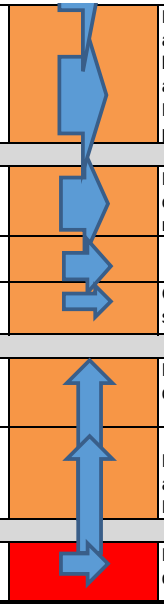
Colour code:
Green – complete
Amber – in progress and within timescales
Red - delayed

Focus Area	Future Plan	RAG Rating	Direction of Travel
CHILDREN AND YOUNG PEOPLE'S HEALTH	Develop a CAMH pathway that better meets need and manages demand so that pressures on specialist services are minimised	AMBER	↑
	Continuing a pilot approach where additional CPN capacity is aligned with schools to enable better support to be offered to C&YP with emerging emotional and mental health difficulties	AMBER	→
	Working with the PSCB to develop a more effective multi-agency response to neglect, focused particularly on addressing early indications of neglectful parenting and offering support to prevent patterns becoming established	AMBER	↑
	Renew the Child Poverty Strategy in 2016	GREEN	
	Develop a joint strategy to address high rates of teenage pregnancy	AMBER	→
	Jointly review the commissioning and delivery of services for C&YP with SEND, from age 0-25	AMBER	↑
	Consideration of the needs of single parent families in these workstreams	AMBER	→
HEALTH BEHAVIOURS AND LIFESTYLES	Commission an integrated healthy lifestyle service with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing, linked with services for people with mental and physical health, disability and ageing issues	GREEN	
	Improve our communication with local residents on health issues and to develop local campaigns and access to health information sources in a range of settings, which can be trusted to provide reliable advice on healthy lifestyles	GREEN	
	Recognise the vital role schools play in supporting the health and wellbeing of children and young people through a Healthy Schools Peterborough programme	AMBER	↑
	Reduce the number of local people developing Type 2 Diabetes	AMBER	↑
LONG TERM CONDITIONS AND PREMATURE MORTALITY	Develop and implement a joint strategy to address CVD in Peterborough	AMBER	→
	Explore a specific programme to work with South Asian communities to address higher rates of diabetes and coronary heart disease	AMBER	↑
	Explore options to reduce the risk of stroke within the local population by improved identification of atrial fibrillation	GREEN	
	A long term conditions needs assessment will be carried out which will cover the wider range of long term conditions including cancer and musculo-skeletal disorders	AMBER	→
MENTAL HEALTH FOR ADULTS OF WORKING AGE	Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need	AMBER	↑
	A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services	GREEN	
	An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams	GREEN	
	The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services	GREEN	
	Service user representation will also be invited to the Partnership Board	GREEN	
PEOPLE WITH DISABILITY / SENSORY IMPAIRMENT	Implementation of strategy for supporting older people and adults with long term conditions	AMBER	→
	Work with users of St George's hydrotherapy pool to explore future options for sustainability	AMBER	→
AGEING WELL	The HWB has commissioned an 'Older People: Primary Prevention of Ill Health' JSNA for Peterborough, which is due for completion during 2016	AMBER	↑
	Develop a joint 'Healthy Ageing and Prevention Agenda' to ensure that preventative action is integrated and responsible to best support people to age well, live independently and contribute to their communities for as long as possible, including isolation and loneliness	AMBER	↑
	Review and refresh the joint dementia strategy for Peterborough	AMBER	↑

	A specific programme of work, in collaboration with older residents, will explore the main health and care issues faced by this group to inform future commissioning of services across the system and how stronger communities can empower people to self-manage with minimal support	AMBER	
	Recognise that some older people prefer face to face communication rather than digital, through community hubs which are part of the Council's wider strategy for communicating with the public	AMBER	
PROTECTING HEALTH	Develop a TB commissioning plan for Cambridgeshire and Peterborough	AMBER	
	Develop a joint strategy to address poor uptake of screening including improved communication with communities and individuals	AMBER	
	Develop a joint strategy to address poor uptake of immunisation including improved communication with communities and individuals	AMBER	
	Develop a Peterborough Joint Sexual Health Strategy, covering a range of issues	GREEN	
GROWTH, HEALTH, LOCAL PLAN	The health of residents is being specifically considered in the new Local Plan, consideration will be given to the access needs of vulnerable and marginalised groups	GREEN	
	Public Health outcomes and/or objectives will be added to the Plan	GREEN	
	Public Health advice will be embedded into the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of land use planning on health	GREEN	
HEALTH AND TRANSPORT PLANNING	Collect further JSNA information on transport and health for Peterborough, using locally developed methodologies	AMBER	
	Permanently embed public health advice in to the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of transport planning on health and health inequalities	GREEN	
	Responsibility for developing local transport plans moves to the combined authority	Amber	
HOUSING AND HEALTH	Peterborough City Council is working in partnership with registered providers to provide new supported housing schemes including accommodation for people with learning disabilities and mental health disorders to enable them to live independently with a live-in carer where necessary or floating support	GREEN	
	A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed	AMBER	
	The Peterborough Market Position Statement has identified a significant shortfall of nursing and residential care accommodation and it will be a priority to increase this provision for the ageing population	GREEN	
	A task and finish group including housing managers and hospital managers is reviewing complex cases causing hospital discharge delays, and how use of disabled facility grants could address this	GREEN	
GEOGRAPHICAL HEALTH INEQUALITIES	The NHS CCG has a statutory duty to reduce health inequalities and to carry out health inequalities impact assessments of any significant services changes	GREEN	
	City Council proposals for selective licensing of private sector housing in parts of the city could impact on geographical health inequalities in the longer term	GREEN	
	There is potential to target preventive public health initiatives and services so that they focus more on areas of the city with the greatest health and wellbeing needs	AMBER	
DIVERSE COMMUNITIES	The benefits of tailoring preventive programmes, working with South Asian communities to prevent diabetes and CVD, are increasingly recognised nationally. The CCG and the City Council will work together to assess the feasibility of local schemes	AMBER	
	Outcome measures for health and wellbeing of diverse communities/migrants will be developed following completion of the JSNA	AMBER	
STP	Greater alignment of BCF Activity with the STP and local authority transformation plan	AMBER	
	Greater alignment of Peterborough and Cambridgeshire BCF Plans	AMBER	
	A single commissioning board for Peterborough and Cambridgeshire	GREEN	

HWB Strategy Progress Risk Register - March 2017

Ref	**Description of risk**, i.e. what is the threat or opportunity to the achievement of a business/project objective, use format "**If** <event happens> **then** <consequence of event>"	Raised on Date	Impact (1-5)	Probability (1-5)	RAG Rating	Action or Mitigation Previous Updates	Owner	Status Open / Closed
Children and Young People's Health								
1	Lack of embedding of Neglect strategies in community and specialist services	01 March 2017	3	3		The LSCB monitors performance and outcomes	Lou Williams	Open
Long Term Conditions and Premature Mortality								
2	Ability to recruit skilled workforce in the local area	01 March 2017	4	3		Workforce Review taking place in STP Business Cases / considering Secondments from Secondary Care	Cath Mitchell	Open
3	Lack of capacity in primary care to deliver AF programme	02 August 2017	4	2		Support to GPs through incentives, training and clinical support	Cath Mitchell	Open
Mental Health for Adults of Working Age								
4	Insufficient resource across the health and social care system to support all the developments identified as being required to improve access to services and outcomes by the various workstreams	01 March 2017	3	3		Minimise inefficiencies and improve promotion including effective information, advice and signposting	Wendi Ogle-Welbourn	Open
5	Complexities and time needed to meet the internal governance requirements of each organisation slows progress and sufficiently slows delivery of the potential benefits of working collaboratively	01 March 2017	3	2		Progress the proposed exploration of models of joint commissioning for mental health	Wendi Ogle-Welbourn	Open
H&WB of People with Disability / Sensory Impairment								
6	Managing demand from service users	01 March 2017	3	3		Work with key stakeholders and organisations to develop local solutions	Adrian Chapman	Open
Protecting Health								
7	Continued availability of funding for strategy implementation especially LTBI screening	01 March 2017	2	4			Liz Robin	Open
Growth, Health and the Local Plan								
8	Significant objections to the H&WB policies in the Local Plan result in the policies being removed or changed at the examination in public stage of the Local Plan	01 March 2017	3	2			Simon Machen	Open
9	Reduction in active travel activities due to loss of funding from the Dept for Transport sustainable travel funding	02 August 2017	3	4		Submit bids for further pots of funding. Applied to the combined authority for fund to support some active travel work	Simon Machen	Open
Housing and Health								
10	Once the funding for Supported Housing changes from the current model, there may be a risk of ensuring that the full rent level on these units are met through the proposed top up funding.	01 March 2017	3	3		Government consultation on future funding arrangements now closed, and awaiting results	Adrian Chapman	Open

11	Shortage of housing stock - improve the join up of people and places	01 August 2017	**4**	**2**		PCC agreed to invest £35m in additional housing to ease the homelessess pressures, and also to invest in the Housing Needs service to focus more on prevention	Adrian Chapman	Open
Geographical Health Inequalities								
12	Lack of agreement on how to use the proposed £7.5m investment into the Can Do Area	01 March 2017	**3**	**3**		Local Action Group in place to oversee delivery; project manager and officer in post	Adrian Chapman	Open
13	Limited take up of projects to tackle social cohesion	01 March 2017	**3**	**3**			Adrian Chapman	Open
14	Too great a focus on the Can Do area	01 March 2017	**3**	**2**		Citywide community resilience strategy in place; new	Adrian Chapman	Open
Health and Wellbeing of Diverse Communities								
15	Communities will not engage with the services on offer and they will therefore be less effective	01 March 2017	**4**	**2**		Health messages being delivered by Salaam Radio	Adrian Chapman	Open
16	Public perception of significant investment targeted to non-UK national communities	01 March 2017	**4**	**3**		Effective publicity campaign with a greater focus on the 'Healthy Peterborough' campaign	Adrian Chapman	Open
OTHER								
17	Impact of universal credit implementation in November	01 August 2017	**4**	**3**		Report to be taken to CMT to discuss plans / contingencies	Adrian Chapman	Open

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: CHILDREN AND YOUNG PEOPLE'S HEALTH
LEAD: LOU WILLIAMS

HWB STRATEGY 2016/19: CURRENT ACTIVITIES: ● Managing the transition of commissioning arrangements for health visiting from NHS England to the Local Authority; ● Developing a healthy child programme that ensures that emerging needs for support are identified early and are acted upon effectively in partnership with children and families; ● Reviewing the Child and Adolescent Mental Health (CAMH) offer across the area, including overseeing action related to reducing waiting list for specialist CAMH services and remodelling support for children and young people with emotional health and wellbeing needs to make the best use of additional funding from Central Government.	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	**Health Visiting** Commissioned through a Section 75 agreement with CPFT. The latest data has been submitted by CPFT, the health provide. The *key performance data is based on performance for Quarter 3 (September – December 2017) is as follows:* ● **205 antenatal contacts completed**. All women are written to inviting them to make an appointment. Visits are targeted towards first time and/or vulnerable women. ● **98%** of all new mothers in Peterborough received a **New Birth Visit**, 90% of these were completed within 14 days of birth. This meets the performance target. ● **89% of mothers received a 6-8 week check.** A further 8% received this visit within 9 weeks, meaning that 97% of checks were completed by 9 weeks. ● **94% of families had a 12 month development check by 15 months.** 85% of these were conducted by the time they were 12 months old. Staffing shortages have created a capacity deficit which has impacted the providers ability to meet their 95% target. ● **88% of children received a 2-2.5 year development check**. **School Nursing:** ● School nurses deliver both universal and targeted services and work across education and health, providing a link between school, home, and the community. They are responsible

	for delivering programmes to improve health outcomes for school aged children and young people 5-19 years). This includes reducing childhood obesity, under 18 conception rates, prevalence of chlamydia, and supporting mental health. ● Service specification and KPI's have all been established in partnership with the provider. Performance is monitored through quarterly contract meetings. *Key trends for Quarter 3 (September – December 2017):* ● Emotional Health and Wellbeing concerns continue to be the most prominent issue nurses are dealing with. **406 pupils were seen for mental health/wellbeing issues** ● The provider is reporting an **increase in safeguarding duties**, which is impacting capacity. Exploration is underway to decide whether it would be advantageous to introduce **Chat Health**, a text based support service to students, to increase capacity. ● The team has initiated **6** and contributed towards a further **60 Early Help Assessments** and have attended **36 Child Protection Conferences** ● A duty desk has been set up Mon-Fri 9-4pm and is manned all the time this means schools can phone anytime and receive an immediate response to issues or queries **Speech and Language Therapy:** ● This service is now jointly Commissioned through a Section 76 Agreement with Cambridgeshire County Council and the CCG ● A review was undertaken and a new delivery model has been introduced based on the 'Balanced Model' (this is similar and fits with the Thrive model) with an investment across the county of 480k the majority of this has come to Peterborough to address the waiting lists and introduce the balanced model ● All children are now seen within the 18 week waiting targets and many within 6 weeks ● A launch event for the balanced model took place in January 18 and was attended and all partners, including schools. The move to supporting and training staff in all settings around communication and speech and starting drop-ins for parents was seen as being very positive ● Principles of the balanced system. Simplest and easiest access and journey through the system • Functional outcomes are key • Outcomes continually appraised • Delivered in

	most relevant place for child or young person development and learning • Development of strong universal and targeted provision is key • Working across Balanced System® Five Strands to effect sustainable whole system change **What will be different?** ● Every school will have a link SLT as a point of contact who meets with them at least once a ● Each Early Years setting will have a locality lead as their named point of contact ● The SLT resource for schools will be allocated to each school, based on SLCN need. ● It will be a transparent system. ● The SLT team will work with each school to agree how best to use that resource to meet the need in school. ● Entry and exit criteria and packages of care will be the same across the county. ● Paperwork streamlined. ● Expertise from specialists will be shared across the county as appropriate **CYP Emotional Health & Wellbeing:** ● CHUMS Counselling service Commissioned jointly by PCC, CCC and the CCG to deliver services across the county – all governance is in place ● Following mobilisation CHUMS have now begun accepting and triaging referrals and delivering interventions in the form of 1:1 and group mental health resilience workshops ● Weekly meetings are in place to ensure oversight whilst the contract is in its 'embedding' phase ● Exploration is underway for CHUMS to work in partnership with the Emotional Wellbeing Practitioners employed by CCS to ensure there is not duplication of efforts regarding staff support and training to schools
Narrative update on workstreams	**Healthy Child Programme (HCP):** The Joint Commissioning Unit (JCU), which is made up of commissioners from Peterborough City Council (PCC), Cambridgeshire County Council (CCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) continues to work jointly to develop an integrated 0-19 service, which will subsume the HCP agenda.

	Local Maternity System (LMS) - Better Births: Peterborough City Council and Cambridgeshire County Council is working jointly with the LMS to implement and deliver the Better Births Strategy, a national drive to improve local maternity services. A localised strategy and work plan has been developed and a number of working groups have been formed to ensure this transformation remains on track. The Local Authorities is leading the workstream relating to "community hubs" and community delivery of services across Peterborough and Cambridgeshire. There are a number of smaller work streams, looking at: building assets, antenatal services and wider community services, and processes and integration.
Examples of partnership working (services, projects, co-production/design etc)	**Emotional Health and Wellbeing (EHWB):** ● A conference around EHWB was held, which was attended by more than 150 delegates from a range of backgrounds, including education, voluntary sector, health, social care, youth services and local authority representatives. Speakers from the Local Authority, the CCG and the third sector, showcased the work and achievements of the following year, including the feedback for a range of the services outlined below. The event was very positive and highlighted the need to coordinate all that is going on around EHWB Across the county a number of services have been commissioned and therefore the focus across the system is how these service improvements are monitored and services work together to ensure they work collaboratively to provide effective pathways across a range of services. The services are: ● CHUMS ● Emotional wellbeing practitioner team ● Early Help service ● CPFT – SPA (information and advice) ● Children's wellbeing practitioners ● CPN's for schools (Peterborough) ● School nursing service ● Self-help – Keep your head ● Kooth

	Speech and Language Therapy (SALT): ● A launch event was held to celebrate the new service and provide the opportunity for professionals to ask therapists questions about the new delivery model. The Local Authority and the SALT team worked collectively to organise the event, which was attended by colleagues from Early Years, Education, and local authority representatives. **Occupational Therapy & Physiotherapy:** ● A review has just been completed of the OT and physio service **Findings** ● Population pressures evident in Peterborough in terms of: - Population growth - Rates of PMLD - Social disadvantage ● Services have differing priorities and ways of meeting need across some areas of provision but also some areas of common practice • Potential to develop across the universal, targeted and specialist tiers identified by each profession • Need to ensure that the service offered is in line with NICE guidance in all areas of practice • Need to focus on embedding evidence throughout the service offer • Increased collaborative work with colleague other than health colleagues

HWB STRATEGY 2016/19: FUTURE PLANS

- Develop a CAMH pathway that better meets need and manages demand so that pressures on specialist services are minimised
- Continuing a pilot approach where additional CPN capacity is aligned with schools to enable better support to be offered to C&YP with emerging emotional and mental health difficulties
- Working with the PSCB to develop a more effective multi-agency response to neglect, focused particularly on addressing early indications of neglectful parenting and offering support to prevent patterns becoming established
- Renew the Child Poverty Strategy in 2016
- Develop a joint strategy to address high rates of teenage pregnancy
- Jointly review the commissioning and delivery of services for C&YP with SEND, from age 0-25
- Consideration of the needs of single parent families in these workstreams

Future Plans: Progress against key milestones and local indicators/trends	
Risks	
Key considerations	

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Current Value	Agreed Target
1.1a	CAMH - Number of Children & Young People commencing treatment in NHS-funded community services	-	Indicator only currently available at national/regional level	-	-	-	-	CAMH - Number of Children & Young People commencing treatment in NHS-funded community services
1.1b	CAMH - Proportion of Children & Young People with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent)	-	Indicator only currently available at national/regional level	-	-	-	-	CAMH - Proportion of Children & Young People with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent)
1.1c	CAMH - Proportion of Children & Young People showing reliable improvement in outcomes following treatment	-	Indicator only currently available at national/regional level	-	-	-	-	CAMH - Proportion of Children & Young People showing reliable improvement in outcomes following treatment
1.1d	CAMH - Total bed days in CAMHS tier 4 per CYP population/total CYP in adult in-patient wards/paediatric wards	-	Indicator only currently available at national/regional level	-	-	-	-	CAMH - Total bed days in CAMHS tier 4 per CYP population/total CYP in adult in-patient wards/paediatric wards
1.2	Prevalence of obesity - reception year (proportion, %)	▼	Statistically similar to England	2015-16	259	9.3%	9.3%	Prevalence of obesity - reception year (proportion, %)
1.3	Prevalence of obesity - year 6 (proportion, %)	▲	Statistically similar to England	2015-16	460	19.8%	19.8%	Prevalence of obesity - year 6 (proportion, %)
1.4	Number of young people Not in Education, Employment or Training (NEET) (Proportion, %)	▼	Peterborough higher (worse) than England. Statistical significance unavailable	2016	-	5.0%	4.2%	Number of young people Not in Education, Employment or Training (NEET) (Proportion, %)
1.5	Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched	-	Strategy launched by Peterborough Safeguarding Children Board 13/09/2016	-	-	-	-	Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched
1.6	Under 18 conceptions (crude rate per 1,000)	▼	Statistically significantly worse than England	2015	95	28.3	20.8	Under 18 conceptions (crude rate per 1,000)
1.7	Under 16 conceptions (crude rate per 1,000)	▼	Statistically similar to England	2015	8	2.4	3.7	Under 16 conceptions (crude rate per 1,000)

PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: HEALTH BEHAVIOURS AND LIFESTYLES
LEAD: LIZ ROBIN

HWB STRATEGY 2016/19: CURRENT ACTIVITIES: ● Develop a joint 'Prevention Strategy' to ensure that supporting people to improve and maintain their own health is a key part of managing demand on local NHS services ● Commissioning a joint Drug and Alcohol Service through the Clinical Commissioning Group and Peterborough City Council, which reaches into the Hospital. ● Improve support for local employers to promote healthy workplaces through a new contract with 'Business in the Community'	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	Delivery of NHS Health Checks locally has been extended with the addition of an outreach programme, as part of the healthy lifestyle programme. Approximately 300 checks have been completed in the community since July 2017, adding to those undertaken by GP practices. One to one clinics and group programmes to assess and address lifestyle factors including alcohol, diet and nutrition, physical inactivity and smoking have been expanded in the last quarter, with approximately 2,000 people setting a personal health plan since April 2017, and over half achieving their set goals to date. This includes approximately 600 people that have quit smoking since April 2017. Weight management and physical activity programmes for children and adults continue to be delivered with over 400 adults programmes or accessing 1:1 support since April 2017, while local schools are hosting child programmes, with over 300 children and families commencing programmes. Schools also remain engaged in the local Health Champion initiative and the associated health awareness training programme with over 650 children and young people supported in schools. The current Healthy Workplace programme continues to be delivered with a focus on supporting those workplaces that predominantly employ routine and manual workers. The programme continues to support workplaces and networks in Peterborough and to provide public health and mental health awareness training to support local workplaces.

	Commissioning a joint Drug and Alcohol Service through the Clinical Commissioning Group and Peterborough City Council, which reaches into the Hospital The Integrated Drug and Alcohol Treatment Service commenced is now in its second year of delivery. The dip in performance during the first year (16/17) has been reversed and the service is performing well. Rates of successful completions are now above the national average for all substances with the exception of alcohol & non-opiate which is in line with national average. Re-presentation for alcohol and alcohol/non-opiates sit very low and are among the best nationally. Pick-ups from the community criminal justice system to community treatment are very strong. Aspires performance sits at 95.4% compared with the national average of 53.5% for referrals from the criminal justice system to community treatment. Young person's numbers in treatment are bucking the national trend. Numbers nationally are down by 6% whilst numbers in treatment locally are up by 35%. Due to the time lag with official NDTMS data it will take some time before the performance improvement is fully evident within the Public Health Outcomes Framework Indicators. Objectives for Year 2 include expanding early intervention provision of Extended Brief Interventions for alcohol in community and primary care settings and improving the rate of successful completions amongst criminal justice clients. Achieving these objectives requires strategic collaboration between treatment services and partners including primary care and criminal justice partners. During Quarter 2 180 individuals (19 of which were repeat attenders) with harmful use or dependence syndrome received extended brief interventions through the Hospital Alcohol Liaison Project at Peterborough City Hospital and 8 were subsequently engaged into structured treatment.
Narrative update on workstreams	A procurement exercise for the Healthy Workplace programme is underway with a new provider to be appointed to commence delivery from 01 April 2018. The new provider will be required to build on the work to date increasing local networks, evidenced activity in workplaces and greater access to training programmes The healthy lifestyle services are now delivering clinics from over 20 GP practices and support and clinics in over 50 community, workplace and schools settings locally each week. This work is being

	complemented by activity being undertaken by partners through specific workstreams, such as tobacco control. Partners such as CPFT, HMP Peterborough, Fire Service, City Hospital and Trading Standards are working with Public Health through the Smokefree Alliance to implement comprehensive tobacco control measures. Implementation of the Migrant Impact programme following a successful bid to DCLG is underway. The workstream focused on addressing the impact of alcohol misuse among migrant population on the wider community across both Fenland and Peterborough is being supported by specialist alcohol outreach workers, across both areas and a Community Connector and Healthy lifestyle advisor for Peterborough. Drug & Alcohol Treatment Services are also part of a the two year Family Safeguarding Partnership, working within multi-agency teams to address the substance misuse issues of parents/carers of children subject to child protection proceedings.
Examples of partnership working (services, projects, co-production/design etc)	The workplace programme is a joint commission across Cambridgeshire and Peterborough that supports the wider networking of local employers. The programme is also closely aligned with both healthy lifestyle services across the area to ensure employers have full access to support services. The Smokefree Alliance is co-producing a plan for implementation from April 2018 that will continue to build and align work undertaken to date. Each partner remains directly committed to lead specific interventions and work collaboratively towards the achievement of shared outcomes. Commissioners have sought increased collaboration between Healthy Lifestyles services and Aspire during the last quarter to enhance public health outcomes across both services. Smoking cessation services are now provided at Aspire and Aspire is providing training to the Healthy Lifestyles service to deliver information and brief advice around alcohol and drugs to target populations. Through the Innovation Fund, Aspire has linked with Cambridgeshire & Peterborough Foundation Trust (CPFT) to incorporate a mental health specialist to improve access to mental health services for some of the most complex clients who are frequent attenders in police custody.

HWB STRATEGY 2016/19: FUTURE PLANS

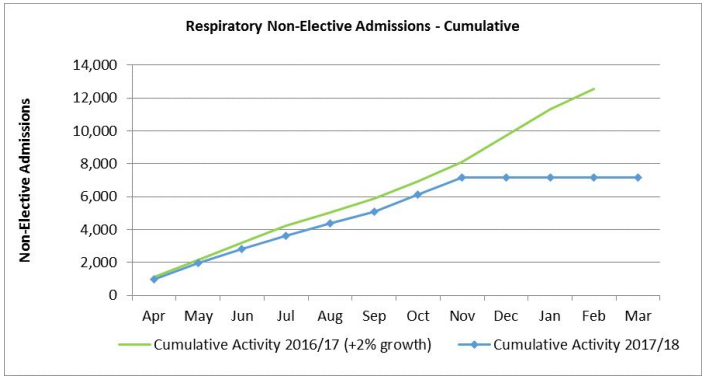
• Commission an integrated healthy lifestyle service with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing, linked with services for people with mental and physical health, disability and ageing issues • Improve our communication with local residents on health issues and to develop local campaigns and access to health information sources in a range of settings, which can be trusted to provide reliable advice on healthy lifestyles • Recognise the vital role schools play in supporting the health and wellbeing of children and young people through a Healthy Schools Peterborough programme • Reduce the number of local people developing Type 2 Diabetes	
Future Plans: Progress against key milestones and local indicators/trends	The integrated healthy lifestyle service has been commissioned by Peterborough City Council in partnership with the Clinical Commissioning Group and began delivery on 01 April 2017. The service is delivering clinics from the majority of GP practices and a range of community settings across Peterborough as highlighted in this report. Services are being provided on a one to one basis and through group interventions to help local people address health risks such as smoking, inactivity and excess weight. The Healthy Peterborough campaign programme continues to provide monthly campaigns delivered on specific health issues, aligned to associated national campaigns to maximise exposure. The Healthy Schools Peterborough programme continues to engage primary, secondary and special schools. An accreditation process covering Bronze, Silver and Gold awards for schools has been developed. The Programme Board is now established and is directing the development and delivery of the programme this academic year. The Healthier You: NHS Diabetes Prevention Programme service has been established across Cambridgeshire and Peterborough to support people at risk of developing Type 2 diabetes. The local programme is being delivered by ICS Health and Wellbeing in local settings and are working with Solutions4Health.
Risks	
Key considerations	

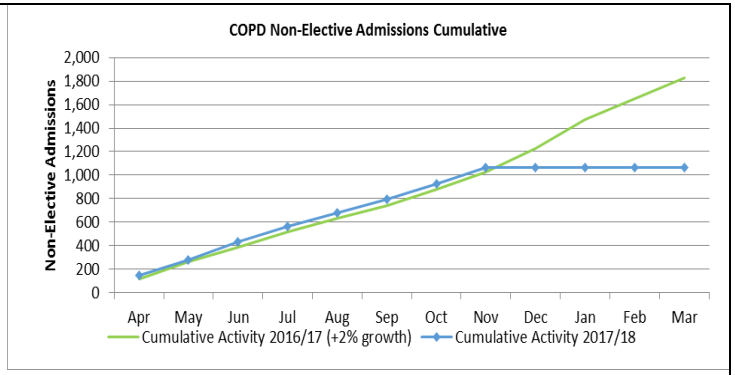
Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
2.1	Smoking Prevalence - All (proportion, %)	▼	Statistically similar to England	2016	-	17.6%	15.5%	2.1
2.2	Smoking Prevalence - Routine & Manual Occupations (proportion, %)	▲	Statistically similar to England	2016	-	27.9%	26.5%	2.2
2.3	Excess weight in adults (proportion, %)	▲	Statistically significantly worse than England	2013-15	-	70.8%	64.8%	2.3
2.4a	Physically active adults (proportion, %)	First data point (new method)	Statistically significantly worse than England	2015-16	-	60.5%	64.9%	2.4a
2.4b	Physically inactive adults (proportion, %)	First data point (new method)	Statistically similar to England	2015-16	-	24.3%	22.3%	2.4b
2.5	The numbers of attendances to sport and physical activities provided by Vivacity (observed numbers)	▲	5.7% increase between 15/16 and 16/17	2015-16	1,388,710	-	-	2.5
2.6	Admission episodes for alcohol-related conditions - Persons (directly standardised rate per 100,000)	▲	Statistically significantly worse than England	2015-16	1,245	708	647	2.6
2.7	Admission episodes for alcohol-related conditions - Males (directly standardised rate per 100,000)	▲	Statistically significantly worse than England	2015-16	800	939	830	2.7
2.8	Admission episodes for alcohol-related conditions - Females (directly standardised rate per 100,000)	▲	Statistically similar to England	2015-16	445	491	483	2.8
2.1	Smoking Prevalence - All (proportion, %)	▼	Statistically similar to England	2016	-	17.6%	15.5%	2.1

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: LONG TERM CONDITIONS AND PREMATURE MORTALITY
LEAD: CATH MITCHELL

HWB STRATEGY 2016/19: CURRENT ACTIVITIES:	
● The Health & Wellbeing Board commissioned a detailed CVD JSNA for Peterborough, which is now completed ● The Local NHS Clinical Commissioning Group 'Tackling Health Inequalities in Coronary Heart Disease Programme Board' has worked closely with City Council's public health services to improve uptake of CVD 'health checks' for 40-74 year olds and to promote smoking cessation services for people at risk of heart and respiratory disease ● Respiratory Business Case being implemented to increase identification of Patients with COPD, increase patient activation and create Self-Management Plans to support patients to remain independent and maximise their outcomes. ● National Diabetes Treatment and Care Programme National Bid approved by NHSE in three out of four areas we bid for (increasing attendance at Structured Education, improving achievement of NICE recommended treatment targets, and implementation of a multidisciplinary foot care team at North West Anglia NHS Foundation Trust). We are now implementing the diabetes programme using the national bid funds. ● The Diabetes Prevention Programme has been rolled out across the CCG, and we have now recovered the underperformance in referral numbers from 2016/17.	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	**Respiratory** Overall respiratory activity has decreased in comparison to 2016/17 whilst non elective admission for COPD 2017/18 have increased in comparison to the previous year.





Diabetes

Cambridgeshire and Peterborough has been rated as "greatest need for improvement" for diabetes in the CCG Improvement and Assessment Framework. There are two indicators for diabetes – patients diagnosed less than a year who attend a structured education course, and patients that have achieved all the NICE recommended treatment targets. The latest NDA figures comparing the CCG with the England average can be found below:

	Structured Education			Treatment Targets		
CCG Actual	2014/15	2015/16		2014/15	2015/16	2016/17
	7.3%	6.3%		34.9%	34.9%	34.0%
England Average	2014/15	2015/16		2014/15	2015/16	2016/17
	6.9%	7.3%		39.8%	39.0%	39.7%

To date 95 practices have referred patients onto the Diabetes Prevention Programme, and we are currently at 109% of our overall referral trajectory set by NHSE, with over 4,200 people referred to the programme since October 2016 to present. We are expected to reach the cap in commissioned levels of activity by NHSE by the end of February/ beginning of March 2018. We are now working with provider to prepare an application to increase this.

We now have 59 classes across Cambridgeshire and Peterborough, with a further five confirmed to start in February 2018, and additional courses still being booked.

Narrative update on workstreams	**Respiratory** Community Respiratory nurses have been recruited (2 band 7s and 3 band 6s). Interviews for the two community consultant roles will be held in March 2018. Despite significant delays and issues arising during the implementation of the Community Respiratory Project, patient facing clinics are now being held with patients being seen in their homes. The clinics will be held by the CPFT Respiratory specialist nurses within community venues (tbc.). Primary Care and other providers will be able to refer into the service. Each clinic will be held in collaboration with other allied services include mental health, smoking cessation and physiotherapy. Additionally, the specialist respiratory nurses will be working with the existing Community Respiratory Team in expanding and enhancing the current Admissions Avoidance service. The team are now able to offer an extra 15 home visit appointments per day and are working to improve access to the service from acute, community and primary settings. The British Lung Foundation event in autumn screened 218 members of the public with 31 being referred to their GP for further investigation. Patient self-management workshops are due to commence in March, these will be held over the next 12 months and aim to train 15 patients per event in managing and exacerbations related to COPD. **Diabetes** We are working with our providers of diabetes structured education to increase the number of sessions available for people with Type 1 and Type 2 diabetes. We are working with CPFT the provider of DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) the Type 2 education course to achieve a target of 1400 attends before the end of March 2018. The national funding now means that DESMOND is now available for <u>all</u> people with Type 2 diabetes, and not just those who are newly diagnosed. We have been working with the providers to implement systems to ensure there is a feedback mechanism to practices on the outcome of referrals to structured education and to ensure the national coding is adopted to ensure accurate reporting in future NDA.

	We are proactively promoting the additional sessions with primary care, and are working with the community diabetes specialist teams to help raise awareness and understanding of the courses amongst clinicians to support them to encourage more patients to attend. Update sessions are also being arranged to enable as many people as possible to attend. The team at CPFT have also refined their bookings and reminders process for patients who do not attend first time to ensure there is more proactive follow up. Additional recruitment is taking place to increase capacity within the diabetes specialist teams in the community. This will enable more support for primary care to care for people with diabetes and help them to achieve the NICE recommended treatment targets (HbA1c, BP and Cholesterol). There are now 8.5 WTE Diabetes Care Technicians who have started and will be supporting practices with their annual reviews and diabetic patients who are housebound. There is a local enhanced service in place that almost all practices have signed up to. This is to support their engagement with the diabetes specialist teams, and part of this is to attend Virtual Clinical Review (VCR) sessions with Consultant Diabetologists and Diabetes Specialist Nurses. This is designed to be an educational session to support patient management in primary care. The aim is to support improvement in treatment outcomes for patients, specifically control of the NICE recommended treatment targets. Practices can run searches on their clinical system to identify patients for discussion at the VCR (with their consent), or it can be more a general discussion about diabetes care within the practice. We are working with Diabetes UK to set up Public Engagement Events in each of the four localities (Cambridge, Fens, Hunts and Peterborough) to enable people to feedback their views on current diabetes services and future plans. The ones in Cambridge and Peterborough took place in November 2017, with a further two events planned to take place on 19th April at Hinchingbrooke Country Park in Huntingdon, and 25th April at March Town Hall in Fenland. **NHS Diabetes Prevention Programme** We have had good engagement with practices across the CCG with the NHS DPP, and this has been seen particularly in areas of high prevalence of type 2 diabetes (Peterborough and Fenland), to increase referrals to the Diabetes Prevention Programme. However, we are now expected to reach the cap in activity levels that were commissioned by NHS England, so are working on a cap uplift application with the provider. A procurement process will be starting shortly for the new contract starting in July 2018.

Examples of partnership working (services, projects, co-production/design etc)	The CCG continue to work in Partnership with the Peterborough and Cambridgeshire Public Health team to implement the local NHS Diabetes Prevention Programme. This is provided by Independent Clinical Services (ICS). The design and format of the respiratory clinics have been developed in conjunction with CPFT. A Respiratory Clinical Community has been developed and includes representatives from British Lung Foundation, events have been supported by Community and smoking cessation services with the CCG.
HWB STRATEGY 2016/19: FUTURE PLANS ● Develop and implement a joint strategy to address CVD in Peterborough ● Explore a specific programme to work with South Asian communities to address higher rates of diabetes and coronary heart disease ● Explore options to reduce the risk of stroke within the local population by improved identification of atrial fibrillation ● A long term conditions needs assessment will be carried out which will cover the wider range of long term conditions including cancer and musculoskeletal disorders	
Future Plans: Progress against key milestones and local indicators/trends	**Programme to work with the South Asian Communities** Outreach health checks are being provided to South Asian communities within local settings, while health MOTs are being offered to those members of the community who are not eligible for the full health check. In addition tailored physical activity and weight management programmes are being delivered, while referral pathways to the diabetes prevention programme have been established. This has led to the following activity being delivered since 01/04/2017: ● 149 accessed a Health Check - 39 were female ● 135 accessed a Mini MOT - 55 were female ● 102 began a Let's Get Moving programme - 78 were female (physical activity programme) ● 41 began a ShapeUp4Life programme - 34 were female (weight management programme) **AF stroke prevention programme** All but 3 practices across Peterborough and Wisbech signed up to the SLA. Since September 2017 ● 1056 patients have been identified who are currently not being anticoagulated across Peterborough and Wisbech (practices are currently working through patients to assess who should be treated). ● the number of patients being anticoagulated has been increased by 148 patients (increasing the overall percentage from 74.7% to 77.5%). Our goal is 81%. ● the number of patients not being anticoagulated has reduced by 107.

	• 9 Practices piloting AF case finding in flu clinics checked the pulses of 6822 patient and identified 56 case of AF of which 46 were anticoagulated. The reduction in the number of patients not receiving anticoagulation and the identification and treatment of new cases of AF should **prevent approx. 5 strokes** per year going forward.
Risks	Capacity in primary care to deliver the AF programme continues to be a challenge and has led to some slippage in progress, however the programme is moving forward. Recruitment of diabetes specialist posts remains a challenge. The team are now trying to recruit to B6 developmental posts rather than B7 DSN posts, although this is still proving difficult and will impact on the team capacity as the staff will require supervision. Risk of diabetic patients not taking up the opportunity for structured education. Recruitment of the Community respiratory Consultants. No applicants were received when advertised over December/January. The JD is in the process of being redefined and the question over acute/community hosting has been reopened.
Key considerations	Challenge of recruiting health and social care professionals, especially in a community settings.

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
3.1	Under 75 mortality rate from all cardiovascular diseases - Persons (directly standardised rate per 100,000)	Decreasing - getter better	Statistically significantly worse than England	2013-15	349	86.3	74.6	Reduction in DSR of 0.5% per year
3.2	Under 75 mortality rate from all cardiovascular diseases - Males (directly standardised rate per 100,000)	Decreasing - getter better	Statistically similar to England	2013-15	230	116.6	104.7	Reduction in DSR of 1.0% per year
3.3	Under 75 mortality rate from all cardiovascular diseases -	Decreasing - getter better	Statistically significantly worse than England	2013-15	119	57.7	46.2	Continue recent trend of reduction in DSR of 2.45/100,000 per year

	Females (directly standardised rate per 100,000)							
3.4	Inequalities between electoral wards in emergency CVD hospital admissions (disparity in directly standardised rate per 100,000)	Increasing - getting worse	Disparity between most deprived 20% and least deprived 80% has increased between 2013/14 and 2014/15	2014-15	N/A	305.8	N/A	Reduction in DSR of most deprived 20% of Peterborough electoral wards of 2% per year
3.5	Recorded Diabetes (proportion, %)	Increasing - getting worse	Statistically similar to England	2014-15	9,740	6.5%	6.4%	Match or exceed England trend
3.6a	The rate of hospital admissions for stroke (directly standardised rate per 100,000)	Decreasing - getter better	Rate has reduced, national benchmark unavailable	2014-15	369	250.7	N/A	Reduction in DSR of 1% per year
3.6b	The rate of hospital admissions for heart failure (directly standardised rate per 100,000)	Decreasing - getter better	Rate has reduced, national benchmark unavailable	2014-15	335	235.2	N/A	Reduction in DSR of 1% per year
3.7	Outcomes for a wider range of long term conditions will be defined following completion of the long term conditions needs assessment	-	To be decided upon completion of relevant Joint Strategic Needs Assessment	N/A	N/A	N/A	N/A	-

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: MENTAL HEALTH FOR ADULTS OF WORKING AGE
LEAD: WENDI OGLE-WELBOURN

HWB STRATEGY 2016/19: CURRENT ACTIVITIES:

- The Joint Suicide Prevention Strategy and implementation plan for Cambridgeshire and Peterborough is being delivered
- A local 'Crisis Care Concordat' implementation plan aims to prevent mental health crisis in community settings and reduce the use of Section 136 of the Mental Health Act. A new crisis care telephone helpline and a community place of safety are proposed for the coming year
- Implementation of the Joint Peterborough Mental Health Commissioning Strategy includes redesign of the mental health accommodation pathway, increased choice of housing options, a placement model of employment support, stronger links between commissioners and clear focus on the right support, the first time, at the right place, by the right people

Performance narrative and statistics	**1. Suicide Prevention** ***Metrics: Suicide Rates:*** *Persons/Males/Females: Standardised rate per 100,000 population* ***Performance: 2013-1015 three year average 'rolling' data:*** *All persons: 8.4% Decreasing, getting better and better than the England value (10.1%)* *Males: 11.5% Decreasing, getting better; better than the England value (15.8%)* *Females: Data redacted due to low numbers (not statistically significant) (New data not yet available – therefore no change)* *An annual suicide audit has been carried out for Peterborough and Cambridgeshire since 2014. Early indications suggest that the total number of suicides in Peterborough reduced during 2016.* **2. Crisis Prevention** ***Metric:*** *Rates of use of Section 136 under the Mental Health Act* ***Performance:*** *Instances of use of Section 136 under the Mental Health Act in Peterborough decreased during 2016/17 and continue to reduce. Figures are currently being audited. The final outturn 2016/17 and in-year figures will be included in the next report.* **3. Mental Health Housing and Accommodation** ***Metric:*** *Adults in contact with mental health services in settled accommodation* ***Performance:*** *Increasing (80% at April 2017) – getting better and statistically better than England (58.5%) (31% previously reported; this is likely to be an under reporting of the actual values)* **4. Employment** ***Metric:*** *Adults in contact with mh services in employment* ***Performance:*** *10.5% at April 2017): Increasing – getting better although and statistically better than England (8.8%) (4.6% previously reported; this is likely to be an under reporting of the actual values)* **5. Stronger Links Between Commissioners** ***Performance:*** *Performance is improving in 5 out of the 6 areas with meaningful measures* ***Metrics:*** *Improvement in performance against the prioritised metrics;*

	6. The Right Support, the First Time, at the Right Place, by the Right People ***Performance:*** *Performance is improving in respect of the items for which there is full and robust data In the future it will be possible to track progress as anomalies in the approach to data collection have now been addressed.* ***Metrics:*** *Improvement in performance against the prioritised metrics* Update on performance to be provided annually on request of the HWB: due in next report.
Narrative update on workstreams	**1. Suicide Prevention** i) The suicide prevention strategy has been refreshed for 2017-2020 and action plan updated ii) A new bereavement support service for people bereaved by suicide has been implemented and is receiving referrals. Training in suicide prevention for GPs is in development with planned roll-out from April 2018. Other workstreams are continuing for example, the STOP suicide campaign and website and suicide prevention (ASIST) training. iii) A Zero Suicide Ambition now underpins the Suicide Prevention Strategy and a proposal that delivery of this ambition and the Suicide Prevention Strategy should be governed by the Cambridgeshire and Peterborough Safeguarding Executive will be considered at the May meeting of that Group. This will give both initiatives senior support and guidance. iv) The zero suicide initiative will also aim to drive up quality of care by facilitating a learning culture and forum for suicide prevention, whereby both good and bad practice examples will be shared between organisations. **2. Crisis Prevention** i) Excellent progress is being made with implementation of the Crisis Concordat Action Plan by the MH Delivery Board, with progress being to or ahead of time on most of the 17 priorities. A process of continuous improvement is underway with new sets of actions and priorities being identified and followed through. ii) The MH Delivery Board led on meeting the new requirements arising from the Police and Crime Act. Cambridgeshire and Peterborough was well prepared and able to meet these when the legislation became law in December 2017. In order to meet these requirements, PCC made improvements to the

	AMHP rota, bringing together the 3 rotas across Cambridgeshire and Peterborough to equalise demand and capacity and improve cost effectiveness. A single management structure for Peterborough/Hunts/ Fens and South Cambridgeshire, with rotas for each area are currently being set up. iii) Information sharing between agencies has been identified as the biggest single barrier to effective joint working. This is being raised with the STP. **3. Mental Health Housing and Accommodation** i) The work of PCC commissioners with housing and accommodation providers has continued. A review of the mental health housing and accommodation pathway and portfolio has been prioritised for 2018/19. **4. Employment** i) The work to develop an effective pathway to employment for people with mental health problems initiated on 29.06.17 has continued with a multi-agency Steering Group having been established across Cambridgeshire and Peterborough. ii) NHS funding from a national pot is awaited for an Individual Placement Support Service, the evidence based employment approach specified in the Five Year Forward View for Mental Health. iii) The next stage in the development of the MH Employment Strategy is to engage with communities and individuals to identify the support and intervention that they need to support them towards or into employment. The methodology is being developed in conjunction with CPSL MIND using the learning from the Resilient Together project in Cambridgeshire, an asset based approach to community development, and the East of England Academic Health Sciences Network. iv) The Richmond Fellowship employment service has been decommissioned has not been delivering against the targets and specification. A decision regarding what is needed in Peterborough to support people into employment will be made through the work initiated in June to develop an effective Cambridgeshire and Peterborough employment pathway. Gaps left in the employment pathway will be addressed under the work described under 4 iii) above.

	5. Stronger Links Between Commissioners i) Work to establish a Mental Health Joint Commissioning Unit continues. ii) A joint PCC/CCC/CCG work plan for 2018/19 is being agreed. The priority for 2018/19 will be to ensure that mental health services are seamless (well-co-ordinated) across health and social care and mental and physical health and wellbeing and that commissioning and delivery is clearly focussed on recovery and outcomes. **6. The Right Support, the First Time, at the Right Place, by the Right People** i) The revisions to the enhanced primary care mental health pathway to be delivered through the PRISM service reported last time have been embedded in the mental health pathway and are being operationalised as part of the second phase of implementation. ii) The work to ensure that individuals are supported effectively in their communities continues. The main vehicle for this is the retendering of the Mental Health and Wellbeing services commissioned by PCC, CCC and the CCG separately as a single Recovery and Inclusion service. The aim is to improve the consistency of both access and outcome across the area and to ensure value for money. iii) Recovery coaches, peer support workers and the CPFT Recovery College are increasingly being commissioned to support people to recover and regain their lives and to take their place in the communities in which they live and are therefore now key components of the mental health pathway. iv) Both commissioners and providers continue to prioritise improving both crisis care - including prevention and suicide prevention. (See 2 above).
Examples of partnership working (services, projects, co-production/design etc)	All the initiatives described above are developed and delivered by commissioners working in partnership with NHS commissioners and partners in the NHS and other statutory bodies including councils and the DWP and in the voluntary sector, people with lived experience and their carers. Increasingly, we are co-producing solutions with communities. Partnership and co-production approaches particularly informs improvement in the following areas:

	1. Suicide prevention Engagement workshops with community members were held in December 2017 to co-design the zero suicide initiative. The suicide prevention implementation board consists of partners from many organisations from voluntary sector groups to police, coroner, ambulance trust, local authority, CCG and NHS. The new bereavement support service is an example of good collaborative partnership working where suspected suicide information is obtained and shared by the police to public health and the voluntary sector, to initiate a response/support and signposting for affected individuals. **2. MH Employment Strategy** The next step to be taken by the MH Employment Strategy Group is to work with individuals and communities to identify the support and interventions that they require in order to move towards/into employment. The Strategy Group will then work with them as appropriate to put these interventions in place/commission them as appropriate.

HWB STRATEGY 2016/19: FUTURE PLANS	
● Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need ● A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services ● An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams ● The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services ● Service user representation will also be invited to the Partnership Board	
Future Plans:	**1. Suicide Prevention** ● Establish a task and finish group to address suicides and suicide risk in the criminal justice system. ● Link with Safeguarding boards to enhance the suicide prevention agenda across more agencies

	● Promote the zero suicide ambition by ensuring organisational sign up and commitment through contracts and promotion of training. ● Develop a learning culture by establishing forums for sharing examples of good practice and developing recommendations for change of practice when things have gone wrong **2. Crisis Prevention** ● Continuation of the process of continuous improvement. ● Seek system-wide support to address difficulties/constraints in information sharing. **3. Mental Health Housing and Accommodation** ● Review the PCC/CCC mental health housing and accommodation pathway and portfolio has been prioritised for 2018/19. **4. Employment** ● Engage with communities and individuals to identify the support and interventions that they need to support them towards or into employment. ● Work with communities to develop the pathway as required. **5. Stronger Links Between Commissioners** ● Continue to explore options for aligned/joint commissioning. ● Finalise and deliver the joint adult mental health workplan: PCC/CCC/CCG. **6. The Right Support, the First Time, at the Right Place, by the Right People** ● Implement the suicide prevention and crisis prevention workstreams. ● Embed social work within the enhanced primary care mental health service (PRISM).
Risks	**1. Suicide Prevention** The zero suicide ambition will require funding for a programme manager if it is to be driven forward effectively. There is a risk that funding will not be secured. This risk is mitigated by i) the multi-agency nature of the initiative i.e. the costs would be shared amongst a number of partners ii) the likelihood that NHS investment will become available to support this as a priority.
Key considerations	None other than those identified above.

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
4.1	Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years, crude rate per 10,000)	▲	Statistically significantly worse than England	2015-16	431	189.5	134.1	-
4.2	Rates of use of section 136 under the mental health act	-	Instances of S136 use in Peterborough have fallen but this is partly attributable to closing of Cavell Centre. Constabulary suggest target should be based around avoiding use of police stations as place of safety	2015-16	20	-	-	-
4.3	Suicide Rate - Persons (directly standardised rate per 100,000)	▲	Statistically similar to England	2014-16	54	10.9	9.9	-
4.4	Suicide Rate - Males (directly standardised rate per 100,000)	▼	Statistically similar to England	2014-16	36	14.2	15.3	-
4.5	Suicide Rate - Females (directly standardised rate per 100,000)	-	Statistically similar to England	2014-16	18	7.7	4.8	-
4.6	Hospital readmission rates for mental health problems	-	Awaiting provision from CPFT	-	-	-	-	-
4.7a	Adults in contact with mental health services in settled accommodation	▲	Statistically significantly worse than England	2012-13	410	30.7%	58.5%	-
4.7b	Adults in contact with mental health services in employment	▲	Statistically significantly worse than England	2012-13	65	4.8%	8.8%	-
4.8	Carers for people with mental health problems receiving services advice or information	Increasing - getter better	Remains below England (statistical significance not calculated	2013-14	5	2.9%	19.5%	-

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: HEALTH AND WELLBEING OF PEOPLE WITH DISABILITY AND/OR SENSORY IMPAIRMENT
LEAD: CHARLOTTE BLACK

HWB STRATEGY 2016/19: CURRENT ACTIVITIES: ● The Council and CCG have agreed a strategy for supporting older people and adults with long term conditions within the BCF plan, working together to support people with disabilities through data sharing, 7 day working, person centred system, information / communication / advice, ageing healthily and prevention ● The Learning Disability Partnership maintains an overview of needs and services for people with a learning disability in Peterborough ● A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	
Narrative update on workstreams	**Adult Social Care Service User Survey 2016/17** A report has been published on the Adult Social Care Service User Survey 2016/17. This year Peterborough City Council has had very high customer satisfaction ratings, exceeding the averages across England. Additionally, this year a special question was added into the survey to find out why people might not feel safe. This has been measured across the East of England and a report produced. The report shows that the main reason people do not feel safe is fear of falling, both in the home and whilst out and about. **Local Account** In December 2017 the Adult Social Care Local Account for 2016/17 was published. The Local Account for 2016/17 focuses on some areas of Adult Social Care that we hope residents will find useful. It includes how well we have performed in the past year, the challenges we are facing and some of the things we are proposing to do in the future.

	Dementia Information We have published two leaflets aimed at people with dementia and their carers, one a general guide to services and one a leaflet about mental capacity and managing money. These can be found on the Adult Social Care Factsheets page on the council website. In addition, working with Care Choices we are developing a local Dementia Guide for Cambridgeshire and Peterborough. This will be available in July 2018. You can look at the two that have already been produced for Norfolk and Northamptonshire on the Care Choices website. **Local Offer** A brand new Local Offer for children and young people with Special Educational Needs and Disabilities and their families has been launched. The new site, which has been co-produced with parent carers and young people, has a greatly enhanced search facility and is more attractive and accessible. The site has the ability to include photographs, logos and videos. The new website has been well received by Family Voice, the local parent carer forum. Family Voice awarded the Local Information Services Team with a Participation Partner award at their annual Awards Dinner in December 2017. Our new Local Offer was also reviewed by Essex County Council who made some very useful observations on useability and content, resulting in an action plan to work with Family Voice and young people to improve the website. Work has also now commenced on amalgamating the Adult Social Care Online Care Directory onto the same platform, to create a comprehensive information and advice offer for children and families and adults. **Peterborough Physical Disability Board** The first meeting of the refreshed Peterborough Physical Disability Board met in May 2017. The Board is Chaired by an independent person and the membership includes officers from the Council and others from the voluntary sector (and other interested parties). It has a Forward plan that includes Transport, Health, Employment and Leisure. **Peterborough Disability Forum**

	The Peterborough Adult Social Care Commissioning Team are now regular attendees at the Disability Forum and in Jan 2018 will be consulting on the Prevention Strategy and more specifically the development of the Action Plan. **Peterborough Sensory Disability Board** A first meeting of the Peterborough Sensory Disability Board took place at the beginning of Jan 2018 and a Terms of Reference was agreed. The membership currently includes - Guidedogs for the Blind, Deafblind, Cambridgeshire Deaf Association, Peterborough Association for the Blind and the Royal National Institute for the Blind. The first meeting will be chaired by Gary Jones, Head of Adults Commissioning, Peterborough Council - but this will pass to an independent person ounce that person is identified.
Examples of partnership working (services, projects, co-production/design etc)	

HWB STRATEGY 2016/19: FUTURE PLANS ● Implementation of strategy for supporting older people and adults with long term conditions ● Work with users of St George's hydrotherapy pool to explore future options for sustainability	
Future Plans: Progress against key milestones and local indicators/trends	
Risks	
Key considerations	

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
5.1a	Adults with learning disabilities in employment (proportion, %)	▲	Statistically similar to England	2013-14	55	8.4%	6.7%	5.1a
5.1b	ASCOF - Percentage of adults known to Adult Social Care in employment (to increase) (proportion, %)	▲	Statistically significantly worse than England	2012-13	65	4.8%	8.8%	5.1b
5.2a	Adults with learning disabilities in settled accommodation (proportion, %)	▼	Statistically similar to England	2013-14	475	72.5%	74.9%	5.2a
5.2b	Adults in contact with mental health services in settled accommodation (proportion, %)	▲	Statistically significantly worse than England	2012-13	410	30.7%	58.5%	5.2b
5.3	ASCOF - Permanent residential admissions of adults to residential care (to decrease) (65+, proportion, %)	▲	Statistically similar to England	2013-14	20	17.3%	14.4%	5.3
5.4	Numbers of adults in receipt of assistive technology	▲	Green RAG status to reflect consistent increase in recipients	Feb-17	5,131 (predicted end of year)	-	-	5.4
5.5a	Adult Social Care service user survey quality of life measure - carer-reported quality of life	▼	Statistically similar to England	2014-15	-	7.3	7.9	5.5a
5.5b	Adult Social Care service user survey quality of life measure - social care-related quality of life	▲	Statistical significance not calculated - Peterborough value has fallen between 2012-13 and 2013-14 and is now below that of England	2015-16	-	19.1%	19.1%	5.5b
5.6	Number of adults with social care needs receiving short term services to increase independence	▲	Green RAG status to reflect consistent increase in recipients	Feb-17	1,498 (Predicted end of year)	-	-	5.6
5.7	Number of adults with social care needs requesting support, advice or guidance	▲	Rate per 100,000 is 490.8, currently below target rate of 658/100,000	Sep-16	-	490.8	-	5.7

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: AGEING WELL
LEAD: CHARLOTTE BLACK

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:
A service model has been developed by local NHS commissioners and community service providers, local Councils and voluntary organisations to enable people to age well and to live the life they want to lead by:
Providing high quality, responsive care and support
Integrated working across health, social care and third sector services in Peterborough to ensure that care is joined-up around the needs of individuals within local communities, and avoidable admissions to hospital and care can be prevented
This is supported by jointly agreed plans for the BCF</td></tr>
<tr><td>Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)</td><td>Indicators currently showing green:
Health checks: the total number of health checks delivered to over 40s remains significantly above the England average.
Feeling safe: The proportion of people who use services who say that those services have made them feel safe and secure is statistically significantly better than England.
Indicators currently showing red:
Falls: The rate of injuries due to falls in people aged 65 and over is still statistically significantly worse than England. However, there is a positive trend over time with the rate of falls decreasing. This issue is being addressed by the CCG-wide falls prevention programme.
Feeling safe: The proportion of people who use services who feel safe is statistically significantly worse than England. However, there is a positive trend over time with the proportion of people feeling safe increasing. It is important to note that the proportion of people who use services who say that the services have made them feel safe and secure is still significantly better than England.
Social isolation: the proportion of carers who have as much social contact as they would like is significantly worse than England. This has been identified as a priority area by the Cambridgeshire and Peterborough Ageing Well Strategy Board (see below for further details).</td></tr>
</table>

Narrative update on workstreams	**Dementia:** The multi-agency Older People Mental Health Delivery Board has developed an integrated plan to improve outcomes for people living with dementia across Cambridgeshire and Peterborough. The strategic plan, which is now going through the relevant governance/approval process, reflects local need and responds with current evidence-based practice to inform future provision and support. The strategic plan uses the following Well Pathway for Dementia domains: (i) Preventing Well (ii) Diagnosing Well (iii) Supporting Well (iv) Living Well (v) Dying Well. A system-wide dementia business case, funded by the STP, is now being implemented; this includes investment for a Dementia Nurse Consultant leadership post, development of the Dementia Intensive Support Services (DIST), education and training, carer support and end of life preparation. **Falls prevention:** Implementation of the CCG-wide falls prevention business case is now underway. The aim of the project is to deliver a comprehensive, standardised and integrated falls prevention pathway across the CCG area of Cambridgeshire and Peterborough. This includes: - Increased provision and improved quality of evidence-based targeted interventions e.g. strength and balance classes, future development of fracture liaison services. - Proactive identification of those at risk of falls. - Comprehensive multifactorial assessment offered to those at risk of falling with appropriate intervention plan to address risk identified. - Strengthened system-wide integration and co-ordination. Implementation is being overseen by a small, multi-agency group with strategic oversight from the new, combined Cambridgeshire and Peterborough Falls Prevention Strategic Group and the Ageing Well Strategy Board. **Social isolation:** Social isolation has been determined a priority by the Ageing Well Strategy Board, alongside other priorities including falls prevention and dementia. This reflects the need described in the 'red' performance indicator and feedback from stakeholders, including at the Ageing Well Prioritisation Event which took place in May 2017. The Campaign to End Loneliness has received funding to work intensively in Cambridgeshire and Peterborough with the aim of reducing loneliness in older people. The first stages of the work have included a mapping and consultation exercise to establish agreed solutions locally, which can then be implemented as appropriate.

	End of life care strategy: a multi-agency end of life care strategy development group is currently working to draft a strategy to improve end of life care across Cambridgeshire and Peterborough, alongside the development of an outline business case for investment from the STP. **Integrated Commissioning and the Better Care Fund (BCF):** A new Cambridgeshire and Peterborough Integrated Commissioning Board has been set up to agree opportunities for a common approach to commissioning, develop strategies, deliver sustainable transformation and provide oversight of the BCF plans and pooled budgets. Due to delays in the publication of the national guidance, the 2017/18 plans for the Cambridgeshire and Peterborough Better Care Funds are currently being drafted. **Early Intervention Strategy:** the Peterborough Early Intervention Strategy aims to (i) reduce the demand on traditional and expensive council led social care services, (ii) increase community capacity to deliver support closer to home in a personalised manner – place based commissioning, (iii) join up a number of inter-related systems of support in health and social care to deliver a whole systems approach to social care; (iv) change culture to deliver a consistent approach to supporting people in their communities.
Examples of partnership working (services, projects, co-production/design etc)	● The dementia strategic plan has been co-produced by the multi-agency Older People Mental Health Delivery Board, with representation from adult services, public health, health service commissioners and providers, and the voluntary sector. ● Similarly, the end of life care strategy is being co-produced by a multi-agency strategy development group. ● The falls prevention pathway has been co-produced and is being implemented by colleagues from public health, CPFT and the CCG. Funding has been secured from both public health and the STP. ● The social isolation/loneliness scoping exercise is being led by the national voluntary sector organisation, the Campaign to End Loneliness, with input from stakeholders across the system including the public, local voluntary sector organisations, NHS organisations and Councils.

HWB STRATEGY 2016/19: FUTURE PLANS

- The HWB has commissioned an 'Older People: Primary Prevention of Ill Health' JSNA for Peterborough, which is due for completion during 2016
- Develop a joint 'Healthy Ageing and Prevention Agenda' to ensure that preventative action is integrated and responsible to best support people to age well, live independently and contribute to their communities for as long as possible, including isolation and loneliness
- Review and refresh the joint dementia strategy for Peterborough

● A specific programme of work, in collaboration with older residents, will explore the main health and care issues faced by this group to inform future commissioning of services across the system and how stronger communities can empower people to self-manage with minimal support ● Recognise that some older people prefer face to face communication rather than digital, through community hubs which are part of the Council's wider strategy for communicating with the public	
Future Plans:	**Milestone 1: Falls Prevention** Implementation of the business case is underway, with strategic oversight by a new combined Cambridgeshire and Peterborough Falls Prevention Strategic Group (see above for further details). **Milestone 2: Mental Health and Dementia** The joint dementia strategic plan has been written and is currently going through the relevant governance/approval process, with implementation commencing. Implementation of the STP business case for dementia is underway (see above for further details). **Milestone 3: Continence and UTIs** Evidence review of primary prevention of incontinence complete. **Milestone 4: Community VCS** Good representation of local voluntary sector organisations on the Ageing Well Strategy Board, ensuring good links and partnership working on key priorities including falls prevention, dementia, social isolation and end of life care.
Risks	The risks for each of the key ageing well priority areas is being managed through the relevant group overseeing the work (see above). The impact of the projected increase in the number of older people is being considered and incorporated into each relevant work stream. Also see risk register.
Key considerations	STP governance has been reviewed. The Ageing Well Strategy Board, which drives the ageing well programme of work, has now become one of the STP Clinical Communities, ensuring a coordinated approach to setting the strategic direction for ageing well programmes.

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
6.1a	Injuries due to falls in people aged 65 and over (Persons, Directly Standardised rate per 100,000)	▼	Statistically significantly worse than England	2015-16	663	2,348	2,169	Match or exceed England performance
6.1b	Numbers of over 40s taking up NHS health check offers	▲	Total of health checks delivered remains significantly above England average	2016-17	5,232	10.4%	8.5%	Match or exceed England performance
6.1c	Report on take up of any preventative service commissioned directly as part of STP in the future	-	TBC	-	-	-	-	-
6.2	Reducing avoidable emergency admissions (BCF), (crude rate per 100,000)	▼	Statistically similar to England	Mar-13	328	176.0	178.9	Match or exceed England performance
6.3a	The proportion of people who use services who feel safe (proportion, %)	▲	Statistically significantly worse than England	2015-16	-	65.0%	69.2%	Exceed England performance in order to reach statistical similarity
6.3b	The proportion of people who use services who say that those services have made them feel safe and secure (proportion, %)	▼	Statistically significantly better than England	2015-16	-	88.3%	85.4%	Match or exceed England performance
6.4	Using an Outcomes Framework - covering several key priority areas for older people in relation to their NHS care and the Social Care Outcomes Framework	-	Will be expanded as part of on-going work with Clinical Commissioning Group on Sustainability & Transformation (STP) Plans	-	-	-	-	-
6.5	Social Isolation: % of adults carers who have as much social contact as they would like (proportion, %)	▼	Statistically significantly worse than England	2014-15	-	29.7%	38.5%	Match or exceed England performance
6.6	Carer-reported quality of life score for people caring for someone with dementia	-	Indicator provided for the first time in 2014-15. Peterborough has a lower score than England	2014-15	-	6.7%	7.7%	Match or exceed England performance

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: PROTECTING HEALTH
LEAD: DR LIZ ROBIN

HWB STRATEGY 2016/19: CURRENT ACTIVITIES:	
● Cambridgeshire and Peterborough CCG has convened a joint TB commissioning group, to develop a plan to commission accessible and responsive services. The first task has been to develop a plan for implementation of Latent TB (LTBI) screening in line with the national TB strategy and a successful bid for pilot funding was submitted to Public Health England ● The Health Protection Steering Group, which involves the City Council, local NHS and Public Health England, has oversight of immunisation and screening uptake, task and finish groups to look at uptake issues for immunisation and screening have completed reports and implementation groups are due to take forward the recommendations ● The Cambridgeshire and Peterborough Sexual Health Delivery Board has been formed (following the establishment in May 2017 of the Cambridgeshire and Peterborough Public Health Joint commissioning Unit) with representation from commissioners and providers of sexual health, contraception and reproductive services along with children's social care services. It is also supported by Public Health England. The Group is tasked with informing the development and commissioning of services and fostering collaborative working across organisations to improve outcomes. A Delivery Plan has been produced and priority areas identified.	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	**TB** Good progress continues to be made in Peterborough on Latent TB (LTBI) screening in certain at risk groups, which has been the focus of the TB commissioning Group led by the CCG in the past 18 months. Additional GP practices have now been recruited to the programme to ensure a high level of coverage. The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being: ● Born or spent > 6 month in a country of high TB incidence ● Entered the UK within the last 5 years ● Aged 16-35 years ● No history of TB either treated or untreated

- Never screened for TB in the UK

GP practices with a crude annual rate of active TB ≥ 20 cases/100,000 were initially prioritised
The project commenced in March 2016 and has been very successful.

Cumulative data to end of October 2017 showed that 472 people were screened, 378 negative, 63 positive, 8 borderline negative, 11 borderline positive

Work also continues on workforce planning for specialist TB clinical staff in local NHS provider trusts. Arrangements for ensuring that treatment is taken are also being reviewed – directly observed therapy has been used successfully for many years with observation by clinical staff, mainly nurses, and by pharmacists, but new solution are being tested using social media apps and also involving volunteers including friends and family.

TB patients are being incorporated into a revised hospital discharge protocol that involves engagement of Adult Social Care and Housing.

Communication activity is focused on awareness raising especially among more at risk groups in the population.

Health Protection Steering Group (HPSG)
This group meets quarterly to review performance for Screening and Immunisation, current communicable disease activity, healthcare associated infection and work to improve anti-microbial stewardship and reduce the development of antibiotic resistance and to receive reports of health protection issues dealt with by environmental health teams.

Updates
Low uptake for all three cancer screening programmes:
Bowel Cancer screening uptake – range 55.4% – 59.7% (acceptable 52%, achievable >70%) - positive 2.4%
Breast screening uptake – range 69.87% - 74.4% (acceptable >70%, achievable >80%)

	Cervical cancer screening – range steady around 66% (acceptable >80%, achievable >95%) but around 64% in age 25 – 49 and 74% in 50- 65 age groups. Promotional activity to be focussed on 25 – 49 age group Immunisations – uptake for most vaccines is fairly steady, and, while not above the 95% herd immunity target, they are at an acceptable level but HPV vaccination uptake has dropped and at 86% is now below the target of 90%. For the first time MMR second dose, that is needed to give a high level of immunity, exceeded 90% recently. Neonatal BCG – all trust are now reporting uptake routinely with a very high level of uptake in excess of 95%. Shingle vaccine uptake is a concern as it is falling. It is given at age 70 in GP practices. One possible reason is the delivery of flu vaccination in pharmacies as GPs often took the opportunity to vaccinate against Shingles when patients attended for their flu vaccination. Further work is needed on this. Early indication are that flu vaccination uptake has increased in the 2017/8 season in all at risk groups and vaccination continues in January, **Sexual Health Delivery Board** The main indicators of sexual health are chlamydia, teenage pregnancies and late diagnosis of HIV. The under 18 conception rate in 2015 in Peterborough was 28.3 / 1000, compared with the national rate of 20.8/1000. Although there has been considerable improvement in the rate of teenage pregnancy, the Peterborough figure consistently remains above the national figure. Chlamydia detection rate (15 – 24 year olds) in 2016 in Peterborough was 2862/100,000. In terms of detection of infection this compares very well to the national detection rate of 1882/100000and other areas in the East of England. However the key concern is that there is a very high infection rate in the population.

	The late HIV diagnosis in 2016 for those aged over 15 years newly diagnosed with HIV was 50% compared to national figure of 40.1%. In terms of the performance of sexual health services in Peterborough, the concern is with the 48 hour target for patients being offered and having an appointment which is being breached. There are significant difficulties in recruiting nursing staff to the service combined with an increase in demand that is making it challenging to meet this target. The Service is currently training more specialist nurses to address this issue but the ongoing increases in demand requires assiduous monitoring.
Narrative update on workstreams	**<u>TB</u>** Delivering the detailed TB commissioning action plan, including: Expanding the LTBI screening programme; Specialist Workforce planning; Discharge planning Awareness raising Observation of treatment **<u>HPSG</u>** Current focus is on pre-school boosters and HPV vaccine with targeted communications through Healthy Peterborough **<u>Sexual Health</u>** The Sexual Health Delivery two priority areas are Teenage Pregnancy in Peterborough and Fenland (Fenland also has a consistently higher rate than the national figure) and Pathways. Two working groups have been formed to address these priorities. The Teenage Pregnancy Working Group is undertaking an exercise to review the data (demographics and areas) and cross reference it to the location of wide range of wide range of preventative and young parents' support services with the aim developing and commissioning services to address this need. The Pathways Group is cross cutting and impacts on all the key issues. There are some outstanding clinical pathway issues currently that impacts on HIV late diagnosis and access to long acting reversible contraception which is a factor in unplanned pregnancy especially for vulnerable groups.

	The Cambridgeshire and Peterborough system has been asked by Public Health England to be pilot site for developing a model that will better align commissioning of sexual health services across the local authorities, the Clinical Commissioning Group and NHS England. This will also inform the work of the two sub-groups. Also Cambridgeshire and Peterborough will be procuring shortly a Healthy Schools Service. One of the central deliverables of this Service will be to join up services working with children and young people in and out of schools In 2017 a Community Pharmacy Emergency Contraception Service was introduced in Peterborough. There was concern with the slow uptake of the scheme by pharmacies which reflected to some degree the need for pharmacists to be trained. Training has now been completed by a number of pharmacies and the numbers providing the services have increased. In addition work has been undertaken with the Local Pharmacy Committee which has helped to recruit new pharmacies. A promotional campaign has also been launched to increase knowledge of the Service in the local population.
Examples of partnership working (services, projects, co-production/design etc.)	All of the work described above is done in partnership with Public Health England, NHS England, the CCGs, Provider organisations and the voluntary sector and includes involvement of the public.

HWB STRATEGY 2016/19: FUTURE PLANS ● Develop a TB commissioning plan for Cambridgeshire and Peterborough ● Develop a joint strategy to address poor uptake of screening including improved communication with communities and individuals ● Develop a joint strategy to address poor uptake of immunisation including improved communication with communities and individuals ● Develop a Peterborough Joint Sexual Health Strategy, covering a range of issues	
Future Plans: Progress against key milestones and local indicators/trends	Milestone 1: TB commissioning plan: Latent TB screening implementation, second wave GP practices recruited. Workforce mapping for TB management is complete. Communications developed and being further updated. Treatment observation options being tested Milestone 2: Strategy to improve screening uptake: A multi-agency stakeholder group led by NHS England has been established including voluntary sector organisations: Targeted activities planned Strategy to improve communications. Promotional materials for cervical screening have been used in a range of PCC and partner venues.

	Milestone 3 Strategy to improve immunisation uptake: The recommendations of the Immunisations task group led by NHS England are being taken forward and work has included: training local health connectors on immunisations; dispelling the myths; targeting practices with child immunisation waiting lists.; developing a pilot flag system for practices to identify children missing immunisations; and encouraging practices to run more open access immunisation clinics which have been demonstrated to improve access and increase uptake. Milestone 4: Develop a Peterborough joint sexual health strategy: The local multi-agency Contraceptive and Sexual Health Strategic Group has agreed a strategy and action plan. The strategy continues to focus on four key overall themes for Peterborough: ● Increase sexual and contraceptive health awareness amongst local population; ● Increase detection of Sexually transmitted infections amongst the local population; ● Reduce the number of unplanned pregnancies; and ● Improve early HIV detection within the city to reduce high rate of late diagnosis. A sexual health needs assessment for vulnerable groups is close to completion. Peterborough and Cambridgeshire multi agency strategic groups will align in the future and we are waiting for the finalisation of this.
Risks	All organisations involved in this work face serious financial pressures that could impact this work in the future.
Key considerations	The priorities outlined the narrative sections of this report are our key considerations for the future

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
7.1	Percentage of eligible people screened for latent TB infection	-	Denominator data currently unavailable - 325 patients screened May 2016 - January 2017	-	-	-	-	-
7.2	Percentage of eligible newborn babies given BCG vaccination (aim 90%+)	-	Denominator data currently unavailable - Apr 17 - Jun 17 data show 175 patients vaccinated prior to discharge, 13 OPD vaccination by 4 weeks and 7 patients declined at Peterborough City Hospital	April to June 2017	>90%	-	-	-
7.3	Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months (proportion, %)	▲	Statistically similar to England	2014	35	85.4%	84.4%	Match or exceed England performance
7.4	Evidence of increasing uptake of screening and immunisation	-	Peterborough currently amber or green for 8/10 chosen indicators	2015-16	8/10	-	-	• Achieve 95% performance for years 2016/17, 2017/18 and 2018/19 where this is already being achieved or close to being achieved (Dtap/IPV/Hib (1 year old and 2 years old), MMR for one dose (5 years old) • Improve MMR for two doses (5 years old) to national benchmark goal of 90% by 2018/19 • For all other indicators, maintain 90% performance for years 2016/17 and 2017/18 and improve to 95% for 2018/19
7.5	HIV late diagnosis (proportion, %)	▲	Remains above benchmark goal of 50.0%	2013-15	23	60.5%	40.3%	Return to 25% to 50% (PHOF Amber 'Rag') by 2017-19
7.6a	Teenage Pregnancy – Rate of conceptions per 1,000 females aged 15-17 years		Remains above the national benchmark figure of 20.8/1000	2015		28.3		Reduce rate to the England figure or below. Timeline to be determined.

7.6a	Chlamydia- proportion aged 15-24 screened (proportion, %)	▲	Statistically significantly better than England	2016	5,689	25.0%	20.7%	Increase to at least previous best of 24.7% (requires increase of 2.05% per year)
7.6b	Increase in chlamydia detection rate (proportion, %)	▲	Remains above benchmark goal of 2,300/100,000	2016	651	2,862	1,882	Benchmark goal already reached - maintain and improve by 1% per year Understand the epidemiology to address the high chlamydia rate in the population.

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: GROWTH, HEALTH AND THE LOCAL PLAN
LEAD: SIMON MACHEN

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:
1. The Environment Action Plan describes the following actions:
a. Secure funding to increase the number of Green Flag awards to 6
b. Nene Park Trust will continually raise the quality of its facilities and improve the participation and engagement of visitors
c. Seek funding to carry out a feasibility study into local, sustainable food production
d. Achieve Fairtrade city status
e. Develop planning guidance to support local food
2. The health of residents is being specifically considered in the new Local Plan, consideration will be given to the access needs of vulnerable and marginalised groups
3. Public Health outcomes and/or objectives will be added to the Plan
4. Public Health advice will be embedded into the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of land use planning on health</td></tr>
<tr><td>Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)</td><td>Recent data shows the prevalence of unhealthy weight (overweight and obese) among 10 years increased from 34.2% in 15/16 to 36.8% in 16/17 and is now significantly worse than the England average. The rate for 5 years continues to be similar to the England average.

Statistics for the environmental action plan will be reported at the end of the financial year.</td></tr>
<tr><td>Narrative update on workstreams</td><td>The local plan is now out for consultation and continues to include
● Health and Wellbeing policy.
● Requirement for a Health Impact Assessment on Larger sites
● Requirement for contribution towards local health and social care services via the section 106 and CILS</td></tr>
</table>

Examples of partnership working (services, projects, co-production/design etc)	The Public health team and the planning team are working together to scope options for a fast food Supplementary Planning Document focusing on the management of new fast food premises across Peterborough.

HWB STRATEGY 2016/19: FUTURE PLANS ● **Milestone 1**: Strategic planning to undertake training with Development Management officers on Health Impact Assessment (HIA) and develop guidance for planners and developers on optimising health and wellbeing for smaller residential schemes. ● **Milestone 2**: Strategic planning to attend a Developers Forum meeting to brief them on the Health policy. ● **Milestone 3:** Public Health to look at available data around fast food outlets in Peterborough and consider options around possible guidance on their future location	
Future Plans: Progress against key milestones and local indicators/trends	**Milestone 1**: Following a delay, the new local plan has gone out to consultation. The threshold at which an HIA needs to be undertaken, has been increased to 500 units. Planning strategy team are now developing updated HIA guidance and public health will feed into its development. Public Health will look to support development planners and developers optimise health for smaller residential schemes by providing training and guidance. **Milestone 2**: This action is contingent on milestone 1. **Milestone 3**: Public Health, Planning Policy and Development Management met in November to explore the feasibility of developing a Supplementary Planning Document as a means of influencing the development of fast food outlets in the city. The group agreed to take forward a scoping exercise to assess options for Peterborough. A second joint work stream with the Environmental Health team, focusing on supporting local fast food establishments to make small changes to their menus to improve the quality and healthiness of food is on hold due to a lack of capacity within the EHO team. This will be reconsidered at the end of this financial year.
Risks	● The Health and Wellbeing policies in the draft local plan may not be included in the final plan ● Lack of capacity within the EHO team to support implementation of work programme focused on fast food outlets.

	• Lack of appetite within PCC to implement a fast food SPD.
Key considerations	

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
8.1	Excess weight in 4-5 year olds (% of all pupils)	▲	Statistically similar to England	2015-16	632	22.8%	22.1%	8.1
8.2	Excess weight in 10-11 year olds (% of all pupils)	▲	Statistically similar to England	2015-16	794	34.2%	34.2%	8.2
8.3	The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the day time (proportion, %)	▼	Statistical significance not calculated - Peterborough percentage is now below England	2011	5,020	2.7%	5.2%	8.3
8.4	The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the night time (proportion, %)	▼	Statistical significance not calculated - Peterborough percentage is now below England	2011	8,190	4.5%	12.8%	8.4
8.5	Utilisation of outdoor space for exercise/health reasons (proportion, %)	▼	Statistically similar to England	2015-16	-	17.8%	17.9%	8.5

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: HEALTH AND TRANSPORT PLANNING
LEAD: ADRIAN CHAPMAN / SIMON MACHEN

HWB STRATEGY 2016/19: CURRENT ACTIVITIES: ● The City Council's Travelchoice initiative encourages people to walk, cycle, use public transport and car share, as well as the uptake of low emission vehicles ● Increase the number of pupils receiving Bikeability training from 951 to 1,300 annually ● The Cambridgeshire and Peterborough Road Safety Partnership (CPRSP) works with a number of organisations to look at the causes of road accidents, understands current data and intelligence regarding the County's roads and develop multi-agency solutions to help prevent future accidents and reduce collisions ● Addenbrooke's Regional Trauma Network is a key partner in the CPRSP, and through various data sources to allow the serious accident data to be broken down into more detail to gain a clear understanding on the impact of severe collisions to the NHS and longer term social care and other partners ● The fourth Local Transport Plan (2016-2020) emphasises the role transport can play in the health of Peterborough residents	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	**<u>Road Safety</u>** Provisional data for 2017 indicates 6 people have been killed on Peterborough Road, this has increased from 4 in 2016. Provisional data for 1st January 2017 to 31st July 2017 indicates 49 people killed or seriously injured (KSIs) and 353 slightly injured. This compares to 50 KSIs and 326 slights for the same time period in 2016. **<u>Active travel</u>** A new set of metrics have been developed with transport team, these include **1) Number of pupils participating in Bikeability** A total of 1943 pupils to be trained in 17/18 **2) Level of satisfaction with cycling infrastructure**

61% of Public reported being satisfied with cycle routes and facilities in Peterborough

2012	2015	2016	2017
63	59	58	61

3) Number of Travel Plans

Number of Business with active Travel Plans – increased from 63 in March 2017 to 71 in January 2018.
Number of schools with active Travel Plans – 42

4) Delivery of Bike IT

Between August and December 2017 Bike It delivered 57 activities, engaging with 2643 pupils, 143 staff members and 26 parents. A total of 20 primary schools in the city are currently involved in the Bike It scheme. Baseline and post engagement survey results are to be published at the end of March 2018.

5) Levels of cycling and walking

Cycling for travel 3 x times per week

2012/13	2013/14	2014/15
3.7%	5.2%	5.2%

Walking for travel 3 x per week

2012/13	2013/14	2014/15
24.8%	30.3%	35.4%

*Further data due in January

Narrative update on workstreams

<u>Road Safety</u>

Various activities have been delivered through the Cambridgeshire and Road Safety Partnership Deliver Group. The following projects have been delivered or progressing over the last 3 months;

- Launched of Drive IQ, a new interactive online learning platform aimed at young drivers which is being funded through the OPCC. Drive IQ is free for young people aged 16 + and is currently being promoted in secondary schools and colleges across Peterborough/Cambridgeshire.

	● A workshop has been developed for young drivers who are required to work. The workshop covers work related road safety and links to Drive IQ. ● Pictogram road safety campaign launched November 2017. Aimed at fleet operators launched the campaign advertise the fatal four (Seatbelts, drink/drug driving/mobile phones/speed) as well as keeping a safe distance on the all fleet vehicles. ● The Be Safe Be Seen campaign launched in October and various activities aimed at vulnerable road users were delivered with partner agencies across Peterborough during October/December. ● Christmas Drink Drive campaign run through December and linked education/publicity with enforcement. This year a number of pubs and club across the partnership area signed up to the "I'll be DES campaign" which offers free soft drinks to designated drivers. **Active travel** Bike It In September the PCC funded Bike It scheme delivered by Sustrans reached a significant milestone. The Bike It officers have now engaged with 70,000 pupils, teachers and families at schools (since 2012) across the city to promote walking, cycling, scooting and skating as part of active and healthy lifestyles. Between September and November Sustrans delivered Bike It intensively in 6 schools in the city – Beeches Primary, Longthorpe Primary, Middleton Primary, St Augustines Junior School, Nene Valley Primary and Queens Drive Infants. Funding was secured from PCC Public Health Further funding from the Combined Authority has now been secured until the end of March 2018 which has enabled Sustrans to continue to work intensively with these schools and have also now signed up a further Brewster Avenue Infant School and are seeking further schools to enrol on the programme. Bid's In November 2017 Expression of Interest submitted to the Sport England for the Tackling Inactivity and Economic Disadvantage funding competition. Project aimed to work with predominately women from BME heritage in lower socio-economic areas of the City to break down the barriers associated with cycling and to enable them to develop the confidence and skills to cycle for commuting and pleasure. The funding bid was unsuccessful and alternative sources of funding are being sort.

	In June 2017 a successful Expression of Interest to the DfT for allocation of time, technical expertise and resources to develop a LCWIP for the city was submitted. The development and creation of LCWIP's are an important part of the Government's Cycling and Walking Investment Strategy which aims to increase cycling and walking by making them the natural choices for shorter journeys or part of a longer journey.
Examples of partnership working (services, projects, co-production/design etc)	Moving forward a joint working group will be developed to bring together those working on active travel across the authority and more widely. The road safety partnership delivery group meets bi-monthly to discuss activities.

HWB STRATEGY 2016/19: FUTURE PLANS ● Collect further JSNA information on transport and health for Peterborough, using locally developed methodologies ● Permanently embed public health advice in to the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of transport planning on health and health inequalities	
Future Plans: Progress against key milestones and local indicators/trends	A new Joint Strategic Needs Assessment resource on Health and Transport has now been produced for Peterborough with the aim of: ● Providing a local resource outlining evidence on the link between transport and health. ● Providing evidence to inform the development of the Peterborough and Cambridgeshire Local Transport Plan and the Peterborough Physical Activity Strategy. ● Supporting broader partnership working through the provision of a single evidence base. The report focused on: 1. Active travel (walking or cycling as an alternative to motorised transport for the purpose of making every day journeys), the opportunities it offers for improving health, current levels of walking and cycling and an assessment of infrastructure in Peterborough. 2. Air quality, its link with transport, the impact of poor air quality on health and the current situation in Peterborough.

	3. Access to transport, its link with health outcomes and access times to health services in Peterborough. A review of the road safety partnership delivery group is to take place to ensure a joined up approach between all partner agencies.
Risks	Funding for sustainable transport work continues to be a risk. Short term funding has been provided by Combined Authority, it is unclear whether CA will provide funding in future years? The road safety partnership is currently experiencing issues with the casualty data which is leading to a delay in verified data being available. Work is ongoing to rectify the situation and look at long term solutions.
Key considerations	Moving forward we will be taking a more coordinated approach to planning active travel across Peterborough bringing together internal and external stakeholders.

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
9.1	The number of businesses with travel plans	-	48 business in Peterborough have travel plans	2016	48	-	-	9.1
9.2	To further develop a robust monitoring network to enable in depth transport model data to be measured	-	In progress					9.2
9.3	Measures of air quality	-	Peterborough currently has 1 Air Quality Assessment Area	2015	1	-	-	9.3
9.4	The numbers of adults and children killed or seriously injured in road traffic accidents (crude rate per 100,000)	▼	Statistically similar to England	2013-15	229	40.1	38.5	9.4

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: HOUSING AND HEALTH
LEAD: ADRIAN CHAPMAN

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:
Housing related support funds support to a variety of providers and settings to ensure their clients are supported into move on accommodation, can maintain tenancies and therefore prevent them from becoming homeless
The Peterborough Older Persons Accommodation Strategy identified that over 90% of people wished to remain at home to be supported to do through the provision of aids and adaptations and a demand for extra care accommodation. To date 262 additional units of extra care accommodation have been provided in partnership with registered providers. A further scheme of 54 dwellings is under construction
Care and Repair provides a handyperson (HP) scheme to help aged and vulnerable people with small scale works. The minor aids and adaptations installations the HP assist hospital discharge and enable health services to be delivered in people's homes. The agency provides advice and has a network of contacts for onward referral and works with other voluntary sector groups on winter warmth initiatives
The City Council's Cabinet has approved introducing selective licensing in 5 areas of the city covering 6205 privately rented properties. This would help raise the standard of private rented accommodation and therefore improve the health and wellbeing of those residents. The proposal is currently (May 2015) awaiting Secretary of State response</td></tr>
<tr><td>Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)</td><td>976 aids & adaptations have been completed this year and 112 Mandatory Disabled Facility Grants have been completed with another 127 approved.
2132 Handyperson cases have been completed this year
To date this year 376 referrals have been made to the Local Energy Advice programme (LEAP), the Council's principal Fuel Poverty project. This has resulted in 185 home visits which include energy efficiency advice, installation of small measures (such as draught proofing, LED lightbulbs and radiator reflector panels), tariff checking and switching and supplier switching. The advice given equates to a potential £171.00 unit bill saving (£31,635 in total). A total of 1,688 small measures have been installed resulting in a total bill saving of £18,248.76. Householders can also be referred onto the IncomeMax service which provides debt advice</td></tr>
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	and benefit entitlement checks. To date the estimated total yearly income increase is £39,000.00 ● Currently looking at the potential to bid as part of a consortium of Council's for Warm Homes Funding to launch Energy2Care - an enhancement to the LEAP programme which will help vulnerable people who have health conditions exacerbated by the cold to stay out of fuel poverty and maintain a healthy home. In doing so their need for health services will decrease and ultimately a business case for health and social care commissioners to invest in energy efficiency will be developed.
Narrative update on workstreams	As widely reported in the media most recently the country is in the midst of a Housing Crisis. Peterborough is no different and has experienced a 200 per cent rise in the number of homeless families requiring temporary accommodation in just the last two years. As of the end of December 2017, the city council was supporting 337 households in temporary accommodation. The situation Peterborough faces is the same for councils across the country because of a national shortage of social housing, changes to the way benefits are paid and private landlords supporting fewer tenants on benefits. The impact on the council's budget is huge as the council has a legal duty to provide housing for all those who meet the criteria for support. The council has taken a number of key decisions around homelessness and the strategy to tackle this issue moving forward: ● We have agreed to invest significantly into Medesham homes, the Council's joint housing venture with Cross Keys Homes, in order to increase the supply of self-contained accommodation and in turn reduce the reliance on B&B accommodation. ● We have increased the staff resource in the Housing Needs Team and, with the introduction of the Homelessness Reduction Act imminent, will be focussing working with households at an earlier stage in order to prevent homelessness.

	• The Housing Needs team will have a more effective toolkit for supporting households in order to prevent their homelessness, including; enhanced rent deposit scheme; wider use of the discretionary housing payments fund (DHP) and a homelessness prevention fund.
Examples of partnership working (services, projects, co-production/design etc)	The Home Service Delivery Model brings together the Home Improvement Agency, Therapy Services, Assistive Technology, Housing Programmes and Reablement. The case management approach puts the client in the centre of wrapped around services to ensure they receive the right support at the right time to prevent hospital discharge and enable timely discharge from hospital. The teams work is instrumental in the Council's Early Prevention and Intervention strategy. The team is developing work with The Transfer of Care Team, the MDTs, the AEH team as well as Adult Commissioners. Discussions are currently taking place with the Centre of Ageing Well with regard to inclusion of the model in their current research paper. The Housing Needs team continue to work in partnership with the Light Project Peterborough to offer winter night shelter provision to rough sleepers.

HWB STRATEGY 2016/19: FUTURE PLANS • Peterborough City Council is working in partnership with registered providers to provide new supported housing schemes including accommodation for people with learning disabilities and mental health disorders to enable them to live independently with a live-in carer where necessary or floating support • A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed • The Peterborough Market Position Statement has identified a significant shortfall of nursing and residential care accommodation and it will be a priority to increase this provision for the ageing population • A task and finish group including housing managers and hospital managers is reviewing complex cases causing hospital discharge delays, and how use of disabled facility grants could address this	
Future Plans: Progress against key milestones and local indicators/trends	• Peterborough City Council is working with Cambridgeshire County Council to jointly procure a Housing Related Floating Support Service. There are two current specialist floating support services provided in Peterborough - one for individuals with mental health problems who are

	chronically excluded and floating support to prolific and persistent offenders and those at risk of becoming so. It is anticipated that providers would achieve economies of scale by delivering across a wider geographical area. ● Peterborough City Council is working with the Cambridgeshire District Councils on the extension of LEAP into their areas ● 8 Discretionary Disabled Facility Grants have been completed to enable discharge from hospital/reablement/care. Necessary works have included floor changes for equipment use and de-cluttering and deep cleaning
Risks	● Funding remains in place for Fuel Poverty work
Key considerations	● Success of Warm Homes Funding

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
10.1	Excess winter deaths index (3 years, all ages, Persons, Ratio)	▲	Statistically similar to England	Aug 2012 - Jul 2015	268	19.6	19.6	Match or exceed England performance
10.2	Excess winter deaths index (3 years, all ages Males, Ratio)	▲	Statistically similar to England	Aug 2012 - Jul 2015	81	11.8	16.6	Match or exceed England performance
10.3	Excess winter deaths index (3 years, all ages Females, Ratio)	▲	Statistically similar to England	Aug 2012 - Jul 2015	187	27.3	22.4	Match or exceed England performance
10.4	Reduction in unintentional injuries in the home in under 15 year olds	▼	Statistically similar to England	2015-16	464	113.5	104.2	Match or exceed England performance to improve to statistically similar to England
10.5	Reduction in number of Delayed Transfers of Care waiting for a care home placement	▼	Has reduced, statistical significance unavailable	2015-16	694	-	-	Reduction in observed numbers

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: GEOGRAPHICAL HEALTH INEQUALITIES
LEAD: ADRIAN CHAPMAN

HWB STRATEGY 2016/19: CURRENT ACTIVITIES: ● The City Council has a focus on economic development and regeneration in the city, together with improving educational attainment. In the long term these measures should improve both socio-economic circumstances and health ● City Council childrens centres work closely with health visitors and are located to ensure focus on the areas of the city with the highest levels of need. Early child development, which childrens centres help to support, is important for future health and wellbeing ● The City Council has identified the 'Can Do' Area around Lincoln Road, which includes parts of Central ward, Park ward and North ward. The 'Can Do' Board focusses on supporting environmental and service improvements for the area and includes senior staff from the City Council	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	
Narrative update on workstreams	**CAN Do Regeneration Programme** The programme will fund a 30 hour per week project manager to support the Programme Manager with the co-ordination of project activities, communications, community engagement, monitoring and evaluation. Recruitment for this role has now completed and this role will start in January 2018. Programme Timelines 2017/18 - Review & Design Options / Quick Wins / Match funding bids 2018/19 - Public Realm & Open Space Delivery 2019/20 - Asset Construction Finance: £7.5m will be spent over 3 years as above. Until the separate projects have a clear plan of work agreed, it is difficult to predict how the funding will be split between the 3 areas of work.

	In addition, all lead officers with the support of the programme manager are actively seeking additional funding from external sources, eg: National Lottery to contribute to the scheme **PROJECT UPDATES** Each of the 3 themed areas of work have formed a working group to develop their plans. The programme manager is currently co-ordinating the activity of officers across the council who have the responsibility for the actual delivery of the programme to undertake their research, conduct site and traffic studies, as well as develop some possible design options. All of this is based on the wealth of information that the community have shared over the years and is necessary preparation for re-engaging with the local community from early in the new year. **Vision & Purpose** Change wider public perception Improve local levels of positive health & feelings of well-being Create a destination point - a place to go & a centre in its own right Create a gateway to the city centre and a catalyst for more development Create a place that puts pedestrians first Celebrate cultural diversity Create opportunities to manage current challenges better and design out existing road safety concerns **Assets** Plans are still to be considered for the future of the New England Complex which is the basis for the need to consider the future provision of community facilities in this area. The CAN Do Local Action Group Members will be asked to complete a survey of existing community facilities to determine the current offer, gaps, needs and future opportunities, including governance options. This information will then be used to inform what investment is needed in the area. Initial feedback from the community indicates a desire for a health and fitness centre focusing on young people due to a shortage of space for leisure activities to take place in the area. **Parks & Open Spaces** A funding bid has been submitted to the Litter Innovation Fund. The fund will provide a grant of up to £10,000 to pilot innovative ideas for tackling litter that can then be replicated more widely. The outcome should be known w/c 29th January 2028.

	On behalf of the working group, Peterborough Environmental City Trust (PECT) have submitted a bid to the Lottery's new £4.5m Place Based Social Action Fund. Decisions will not be known for 3 months yet **Public Realm & Street Scene** 3 new CCTV columns have been installed in the Gladstone area. These will soon be linked to the City Fibre connections and monitored via the CCTV control room. It is evident that these are already having a positive impact on long standing, high level drug dealing in the area A Walking Audit of Lincoln Road, prepared by Living Streets in Sept 2016 is being used to inform ideas and a traffic model survey has been commissioned to study the traffic movement in the area **ENGAGEMENT & COMMUNICATIONS** Meetings with local community groups are on-going and discussions are underway to ensure there is full engagement and involvement with the Millfield Business Forum. Direct outreach will commence in this area once the project manager is in post. There are a number of activities running in the area alongside the regeneration programme eg: ● City College's Community Serve programme ● Peterborough Presents' preparation for the 2018 Millfield Festival ● Collusion's 'Playfinding Peterborough' art project The programme manager is engaging with these partners to ensure there is a full complimentary join up of activities.
Examples of partnership working (services, projects, co-production/design etc)	

HWB STRATEGY 2016/19: FUTURE PLANS ● The NHS CCG has a statutory duty to reduce health inequalities and to carry out health inequalities impact assessments of any significant services changes ● City Council proposals for selective licensing of private sector housing in parts of the city could impact on geographical health inequalities in the longer term ● There is potential to target preventive public health initiatives and services so that they focus more on areas of the city with the greatest health and wellbeing needs	
Future Plans: Progress against key milestones and local indicators/trends	Public health are working with the CCG to undertake analysis of inequalities in hospital admissions (planned and emergency) and associated spend across Cambridgeshire and Peterborough. This will be geographic based analysis using small areas data (LSOA) and will help the health system understand where the greatest spend comes from and how this is associated with deprivation". The information can then be used to inform prevention based efforts.
Risks	
Key considerations	

Performance Indicators:

Indicator Ref	Indicator	Peterborough Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
11.1a	Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation (GCSE attainment)	-	In 2014/15, Attainment of 5+ A*-C GCSEs in most deprived 20% of Peterborough wards is 34.6% (least deprived 80% = 51.8%).	2014-15	223	34.6%	57.3%	11.1a
11.1b	Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation (Benefits Claimants)	-	In May 2016, the rate of benefit claimants in the most deprived 5 wards of Peterborough is 173.3/1,000 (other 80% of wards in Peterborough = 113.3/1,000)	May-16	5,350	173.3	111.2	11.1b
11.2	Increase in life expectancy in wards with highest levels of deprivation	▲	Life expectancy has increased at higher rate for most deprived 20% than least deprived 80% in each of past 5 pooled periods	2011-15	-	79.5	-	11.2
11.3	Reduction in emergency hospital admissions from wards with the highest levels of deprivation (Central, Dogsthorpe, North, Orton Longueville, Ravensthorpe) (directly standardised rates per 100,000)	▲	Rate per 100,000 has increased from 2013-14 to 2014-15	2014-15	4,727	11,235	-	11.3
11.4	Smoking cessation rates in wards with highest levels of deprivation (proportion, %)	▼	4 week quit percentage fell between 2014-15 and 2015-16 from 38.0% to 34.5%. Suggested target = 40.0%	2015-16	229	34.5	-	11.4
11.5	Health checks completion in wards with highest levels of deprivation	Disproportionately high level of health checks delivered to most deprived 20%	In 2015/16, 38.1% of health checks were delivered to residents registered with practices within the most deprived 20% of practices	2015-16	1,961	38.1%	-	11.5
11.6	Slope index of inequality in life expectancy at birth	▼	Has reduced from 8.7 to 8.4 years for males and from 6.7 to 6.1 years for females in most recent refresh	2013-15	-	Male 8.4, Female 6.1	-	11.6

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: HEALTH AND WELLBEING OF DIVERSE COMMUNITIES
LEAD: ADRIAN CHAPMAN

HWB STRATEGY 2016/19: CURRENT ACTIVITIES: ● The HWB has commissioned a JSNA on the health and wellbeing needs of migrants ● Eastern European 'community connectors' employed by the City Council are working closely with the local NHS on issues such as promotion of screening and immunisations	
Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)	The proportion of health checks completed that recorded an Asian ethnicity was 13.8%. In total, 721 health checks were completed in people with Asian ethnicity in the year 2016/17. Data is being collected to determine ethnicity of people using mental health crisis services (First Response Service -FRS, and Sanctuaries)The percentage of service users of the First response service or sanctuary who identify their ethnicity as Ethnic Minority has been collected and reported as 11% (Oct 17), 10.27% (Nov 17 and 11.45% (Dec 17). Suicides in Peterborough by people with Eastern European ethnicity is a concern. It is difficult to report this data for confidentiality reasons as the numbers are small.
Narrative update on workstreams	One of the key streams of the work done by the Cohesion Team, PCC is to promote health and wellbeing of diverse communities. **Strategic level** **Healthy Peterborough meeting** Cohesion Team has been working to support the publicity campaigns promoting the health agendas. Work is in progress regarding the next campaign which relates to immunisation programme. Advice and networking support has been offered in particular to enhance response from the community groups which are generally low in participation of such programme in the past.

	Social Services strategy Cohesion Team is working to advice PCC colleagues working on preparation of social services strategy so the needs of vulnerable section of all community groups can be taken on board. Targeted support for the vulnerable section of the community is to be incorporated in the strategy in preparation. **Health Survey** The Cohesion has been promoting completion of South Asian Communities - Health Survey being undertaken by Public Health Team. This survey initially began from August 2017 to December 2017. During this period survey questionnaires were widely distributed to faith and community groups and widely circulated electronic copies to established networks. In addition the team has been promoting via community connectors Facebook pages and at community events. **Service provision level** **MOT checks for under-represented migrant communities** Together with Solutions4health, Community Cohesion team and Lithuanian Embassy in London organised community engagement event at Gladstone Community centre on 27th and 28th of November 2017. Around 150 people from EU community attended, around 10% engaged with Solutions4Health and did MOT health checks as well as received information about Free Community courses held at Gladstone Community centre. This also helped to increase the uptake on the courses held at Gladstone Community Hub. **Faith groups linkages** Cohesion Team has linked up Solutions4Health with faith groups including Khadija Mosque and Hindu Temple for targeted work in relation to women from these groups. Full body health checks and Mini MOTs were conducted. Linkage between Solutions4Health and Masjid Khadijah and Islamic centre are in process to cater for armchair exercise classes for women for whom walking to Bourges Boulevard Community Centre is not possible. There is potential interest from both sides, working to finalise the agreement and advertise for take-up of the sessions.

Dementia walk
The Cohesion Team actively supports the Dementia Walks held in the Central Park third Thursday of every month for the past year now. Local Care homes and Care Centres have been bringing patients/clients suffering from Dementia to the Dementia Walks. The attendance has grown from half a dozen to now 30-40 people including carers taking a stroll around the Central Park. It is a great avenue for patients from diverse background to socialise. This is followed by teas and coffees at the local coffee shop. December saw the celebration of Christmas in the park with Christmas Carols.

Similar voluntary work with Parkinson's is being established at the Healthy Living Centre.

Healthwatch
Cohesion Team attended the Healthwatch Cambridgeshire and Peterborough Community Forum on 15 January and presented their work role. Areas of collaboration in terms of working with Travellers community were discussed. Arrangements are in hand to strengthen the collaboration between Health Watch and PCC Cohesion Team.

Controlling Migration Fund projects
Peterborough and Cambridgeshire councils have been successful in a number of bids to DCLG's Controlling Migration Fund. Four projects have been funded to date, these are:

- Getting to Know You £282k
- Alcohol Misuse £226k
- Information Pack of Social Media Resources £94k
- Citizens' Advice Peterborough - targeted IAG in community locations

The projects help to address many of the issues identified in the JSNA for Diverse Ethnic Communities.

Getting to Know You will see increased ESOL provision within Peterborough over the next 2 years. The project is led by City College and will involve both GLADCA and PARCA in community based delivery. ESOL classes will be thematically based and will focus on participants gaining confidence in accessing

	and using a range of public services. A call for volunteers to deliver the ESOL classes met a good response. In Term 1, 5 courses were trialled in 3 venues with 34 learners completing and 10 volunteers teaching. 83% of enrolments said they had improved knowledge of topics in the course compared to the start of the course. 52% stated they would positively change their behaviour in regards to areas such as health, education, work and being a good citizen after the course. In Term 2 there are currently 112 learners on 18 courses in 10 venues, with enrolments increasing every day. There is a target of 150 learners in Term 2. In Term 3 the project will look to enrol 150 further learners and increase the number of community venues to 13. Enrolments come from 30 different countries from 5 continents, with the most represented nationalities being China (14%), Lithuania (10%), Afghanistan (8%), Poland (8%) and Portugal (7%). Tackling Alcohol Misuse is being led by Public Health and delivered in both Wisbech and Peterborough. This will see additional outreach and engagement to migrant communities to help tackle street drinking and support migrants to access treatment services. The Outreach Worker is Wisbech has been in post since October and is now actively delivering on the work, a further role in Wisbech is subject to a second recruitment round now underway. The Alcohol Recovery Worker in Peterborough has also been recruited and started last week. Solutions for Health are going to be recruiting to the Community Connector and Healthy Life Styles roles in Peterborough, recruitment round to start imminently. Links have been made to the Video project work with PCVS and Compass attended a recent meeting to take the outreach work forward. Information Pack of Social Media is being led by Public Health. Peterborough Council for voluntary Sector is working with other partners to run workshops with migrant populations to decide on the information for the videos and to prioritise themes to work with. The workshops will provide a useful feedback forum and identify people who would like to participate in producing content for the videos. A pilot of four videos is planned by the end of March 2018. Further videos will be planned and produced with the participation of other partners including those in Fenland - through links with diverse ethnic communities and Fenland District Council.

	The information content will be co-designed and checked by Pubic Health and The Citizens Advice Bureau. Implementation is being planned with the involvement of Peterborough City Council Comms team, linking with the 'Healthy Peterborough' initiative. The Citizens' Advice Peterborough project to deliver targeted IAG from community locations and Boroughbury Medical Centre. The project recently recruited two trainee staff who are undergoing their advice training, The aim is to have training completed and to locate the staff within GP Practices or other community settings by July. Some current staff will be used on the project from April, to continue work at Honeyhill Children's Centre. Work will soon begin with Gladstone Connect, where CAB will offer two sessions per week. Of note is the intention to link the projects listed above together, in order to help with design and implementation, particularly around sharing information resources. **Community engagement support** Community connectors have been involved in the following: ● Connecting with faith communities and other communities to support and encourage completion of survey forms in understanding the health needs of South Asian Communities in the city. ● Promoting the health MOT checks that have been arranged by Solution 4 Health during the summer when several hundred people have benefited. ● Taken part in the initial preparatory work to organise an awareness event around sexual health for the targeted community groups being proposed in early 2018 and other campaigns work that is currently being run by Public Health Team
Examples of partnership working (services, projects, co-production/design etc)	**Tackling alcohol misuse** Cohesion Team is working with Aspire, Public Health and Solutions4health to support a Controlling Migration Funded project to tackle alcohol misuse especially among Eastern European community in Peterborough and Wisbech. The project is in early stage and the aim is to do targeted publicity and engagement with Lithuanian community in order to promote more people taking up the services provided by Aspire. Focus group and 121 sessions are intended.

	Social Media resources project Cohesion Team is working to support Public Health regarding Controlling Migration Funded video project. Information is being shared with community groups and other partner agencies working on the project. The focus is to assist in organising focus groups in order to enhance GP registration and accessibility to mental health services. The mental health Crisis 'First Response Service' (FRS) and 'Sanctuaries' - implemented as part of a partnership 'crisis care concordat programme' is being promoted as a programme of work to Minority Ethnic communities throughout Peterborough. This is being achieved by the FRS visiting community groups to talk about the service, promotion of the mental health crisis video, translated into Urdu, Punjabi, Lithuanian and Polish. There are two people doing this work (band 6 workers), both 15 hours per week - promoting the FRS and Sanctuary to BME communities throughout Peterborough. Training of the FRS team is also planned to increase their knowledge and understanding of cultural attitudes.

HWB STRATEGY 2016/19: FUTURE PLANS ● The benefits of tailoring preventive programmes, working with South Asian communities to prevent diabetes and CVD, are increasingly recognised nationally. The CCG and the City Council will work together to assess the feasibility of local schemes	
Future Plans: Progress against key milestones and local indicators/trends	NHS Health Checks - designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia among adults aged 40 - 74 years old - are now being delivered within local community settings, complementing existing delivery through local GP practices. In addition to increasing the delivery of NHS Health Checks the delivery of Health MOT's for younger age groups has also begun, with a specific focus on target populations. Target populations include local south Asian* communities who have a higher risk of developing diabetes and higher rates of coronary heart disease. A South Asian health and wellbeing survey is being implemented, which will assess the local need as well as access to services. The survey aims to assess health and wellbeing risks and concerns and will be

	used to help tailor and design appropriate services including preventative programmes. The results of the survey and any recommendations that are drawn from them will be made available within a supplement to the diverse ethnic communities JSNA that will focus on the needs of South Asian communities later in 2018.
Risks	The main risk for both the health check programme and the health and wellbeing survey is ability to engage with the South Asian population to ensure a good return (for the survey). There is also the risk that the reach for both these programmes is not comprehensive – ability to engage women or traditionally hard to reach communities. Engagement is important for the survey as we would require a good return in order for the responses to be representative of the needs of the community.
Key considerations	

Performance Indicators:

Indicator Ref	Indicator	Trend	Current Status	Current Time Period	Peterborough Current (#)	Peterborough Current (Indicator Value)	England Value	Agreed Target
12.1	We will work with local health services to improve data collection on ethnicity, both generally and to assess the success of targeted interventions	-	To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence	-	-	-	-	12.1
12.2	Outcome measures for health and wellbeing of migrants will be developed following completion of the JSNA	-	To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence	-	-	-	-	12.2

HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD
PERFORMANCE REPORT
DATE: JANUARY 2018
SUBJECT: SUSTAINABLE TRANSFORMATION 5 YEAR PLAN (INCLUDING iBCF)
LEAD: WILL PATTEN

KEY PRIORITIES

- Health system transformation planning
- Customer experience strategy

Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)

The Quarter 3 Better Care Fund report to NHS England was submitted on the 19th January The below table provides an overview of targets and performance to date:

Metric	2017/18 Planned Target	Summary Performance to date	RAG Rating	Mitigating Actions
Non-elective admissions to hospital	18,128 non elective admissions	Full Q3 NEA performance data was not available at the time of writing. NEAs in November and December totalled 2,980 against a full Q3 target of 4,808. Indicative full quarter performance for Q3 is anticipated to see an increase in NEAs on Q2 (4,252). Increased demand due to winter pressures, including flu outbreak and four wards closed due to norovirus has put additional demands on the local system.		Continued investment in prevention and early intervention approaches – including joint funding of falls prevention and atrial fibrillation Multi-Disciplinary admissions avoidance team established in ED
Delayed Transfers of Care (DTOCs) from hospital	3.5% Occupied Bed Days	The system continued to report high levels of DTOC in Q3. Full Q3 delayed bed days published data was not available at the time of writing. But indicative local monitoring indicates an increase in DTOCs during Q3, though there was a significant decrease in DTOCs in the second half of December. Assessment related delays continue to be the bulk of DTOCs within the system. Q3 social care attributable delays were zero during Q3, an improvement on Q2. Though jointly attributable delays increased on Q2 statistics.		Ongoing weekly monitoring of DTOC performance to ensure quick identification of trends iBCF investment in DTOCs – ongoing implementation of plan (see appendix 1) Ongoing review of iBCF DTOC plan to ensure investment is delivering outcomes Senior leadership review of DTOC position to ensure integrated approaches to address pressures Evaluation of Continuing Healthcare 4Q hospital discharge pathway 3 month pilot in planning

	Admissions to long-term residential and nursing homes in over 65 year olds	154	At the end of Quarter 3 there were a total of 101 care home admissions year to date and we are on track to stay within our threshold target.		On track to meet target
	Effectiveness of re-ablement services	83%	At the end of Q3 performance was at 73%. Continued capacity issues in the domiciliary care market have impacted on reablement capacity.		Additional iBCF investment in reablement provision Ongoing recruitment of reablement support workers to increase capacity by 20%. Domiciliary Care capacity being reviewed with providers at fortnightly forum to reduce bridging packages in reablement Additional VCS provision commissioned to support reablement and domiciliary care capacity

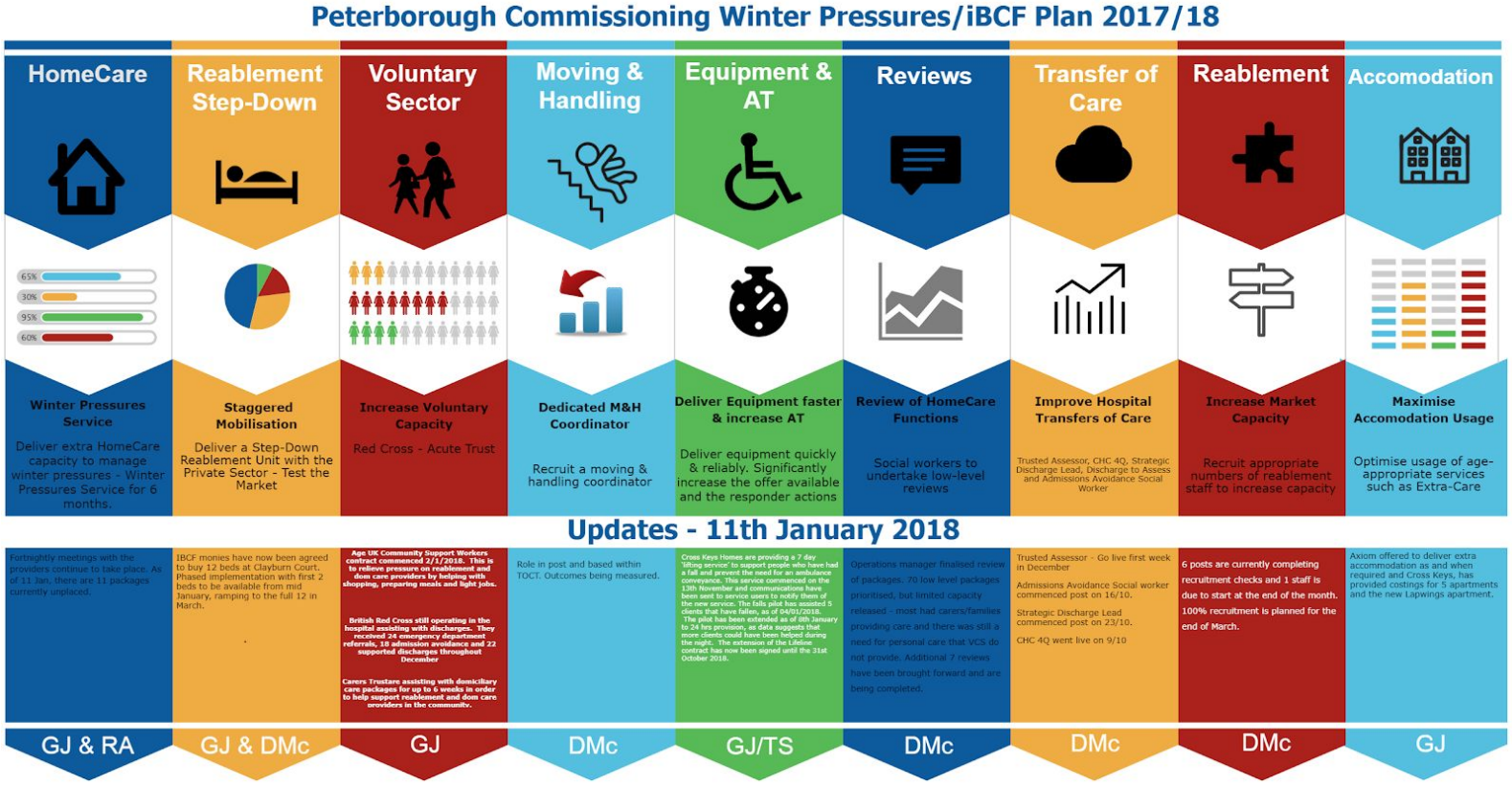
Narrative update on workstreams	Our approach to integration over 2017-19 was submitted as part of our local Better Care Fund plan now has full approval from NHS England. There will be a continued focus on building on the work undertaken to date. The following provides an update on key priority areas: **Prevention and Early Intervention:** including a county wide falls prevention programme, further work to ensure a comprehensive approach to equipment and assistive technology, and development of joint VCS commissioning opportunities. Falls prevention: ongoing roll out of training to neighbourhood teams. Falls prevention health service go live March 2018. Stroke prevention: Atrial Fibrillation is currently focusing on the roll out of ECG equipment to identify patients in flu clinics. **Community Services (MDT Working):** Additional CPFT staff recruitment is being finalised to support the enhanced case management service roll out. First run of data is being gathered from GPs to support case finding. **Enablers:** An evaluation of the test proof of concept has been undertaken and discussions are ongoing across health, social care and VCS to progress next steps.

	High Impact Changes for Discharge: A new national BCF condition, requires the local system to implement the high impact change (HIC) model for managing transfers of care. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes. An update on key initiatives can be found at Appendix 1.
Examples of partnership working (services, projects, co-production/design etc)	The Better Care Fund 2017-19 Plan is based on the following agreed principles: ● Greater alignment across Cambridgeshire and Peterborough ● A single commissioning board (the ICB) ● Greater alignment with the STP and local authority transformation plans Jointly funded STP and BCF Prevention initiatives being implemented: Falls Prevention and Atrial Fibrillation Development and implementation of local DTOC plans, close partnership working to roll out initiatives

FUTURE PLANS	
Future Plans: Progress against key milestones and local indicators/trends	**BCF Planning 2017/18** The BCF 2017-19 plan has received full approval status from NHS England. The Quarter 3 submission to NHS England and the Quarter 3 submission to the Department of Communities and Local Government (DCLG) were both submitted on the 19th January 2018. **BCF Dashboard** A single BCF outcomes dashboard has been developed and is being refined, aligned with key STP metrics for consistency. Data is presented on a monthly basis to the Integrated Commissioning Board to measure impact and identify areas of improvement.
Risks	● DTOC targets for the system are ambitious to meet 3.5% national target. ● iBCF Spring Budget funding is non-recurrent, gradually decreasing over the next 3 years.

Key considerations	● DTOCs continue to be a pressure on the local system. Whole system approaches to managing admissions avoidance, as well as discharges from hospital need to be a continued focus to effectively manage demand

Appendix 1 – Local DTOC Plan



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Updated on: 7 FEBRUARY 2018

HEALTH AND WELLBEING BOARD
AGENDA PLAN 2018/2019

MEETING DATE	ITEM	CONTACT OFFICER
Monday 11 June 2018	• Updates on PHCU, MOU, Children's, etc • Poverty Strategy • Adult Social Care Survey • City College Access Champions - poster promoting key headlines from the Public Health Annual Report. • Dementia Strategic Plan **For information**: Better Care Fund Update Quarterly Health & Wellbeing Strategy Performance Update	Jacqui Cozens Helen Gregg Fiona Davies Will Patten Helen Gregg
Monday 17 September 2018	**For information**: Better Care Fund Update Quarterly Health & Wellbeing Strategy Performance Update	Will Patten Helen Gregg
Monday 10 December 2018	**For information**: Better Care Fund Update Quarterly Health & Wellbeing Strategy Performance Update	Will Patten Helen Gregg
Monday 18 March 2019	**For information**: Better Care Fund Update Quarterly Health & Wellbeing Strategy Performance Update	Will Patten Helen Gregg

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