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HEALTH AND WELLBEING BOARD

Thursday 22 March 2018
10.00 am
Warspite Room, Council House

Members:
Councillor Mrs Bowyer, Chair
Dr Shelagh McCormick, Vice Chair
Councillors Beer and Tuffin.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative and NHS England.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be webcast and available on-line after the meeting. By entering the Council Chamber, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast. The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy. For further information on attending Council meetings and how to engage in the democratic process please follow this link - http://www.plymouth.gov.uk/accesstomeetings

Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Apologies

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. Declarations of Interest

The Board will be asked to make any declarations of interest in respect of items on this agenda.

3. Chairs urgent business

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. Minutes **(Pages 1 - 4)**

To confirm the minutes of the meeting held on 14 February 2018.

5. Questions from the public

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

6. CQC Action Plan **(Pages 5 - 12)**

The Board will receive the CQC Action Plan.

7. Pharmaceutical Needs Assessment **(Pages 13 - 142)**

The Board will receive the Pharmaceutical Needs Assessment.

8. Integrated Commissioning Scorecard **(Pages 143 - 152)**

The Board will receive the Integrated Commissioning Scorecard.

9. Commissioning Intentions **(Pages 153 - 178)**

The Board will receive the Commissioning Intentions report.

10. Good news stories:

11. Work Programme **(Pages 179 - 180)**

The Board are invited to add items to the work programme.

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Health and Wellbeing Board

Wednesday 14 February 2018

PRESENT:

Councillor Mrs Bowyer, in the Chair.

Dr Shelagh McCormick, Vice Chair.

David Bearman, Mrs Beer, Mrs Burgoyne, Clark, Harrell, Harwood, McArdle, Pennell and Tuffin and Beer.

Apologies for absence: Ann James (Plymouth NHS Hospitals Trust), Professor Bridie Kent (Plymouth University), Dave Thorne (Devon and Cornwall Police) and Steve Waite (Livewell Southwest).

Also in attendance: Ross Jago (Lead officer), Jamie Sheldon (Democratic Advisor), Rachel Silcock (Strategic Commissioning Manager), Matt Garret (Head of Community Connections and Sarah Lees (Consultant in Public Health).

The meeting started at 10:00 and finished at 11:50.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

21. **Declarations of Interest**

In accordance with the code of conduct, the following declarations of interest were made –

Name	Subject	Reason	Interest
Councillor Terri Beer	System Updates (Safer Plymouth)	Employee of Devon and Cornwall Police	Personal

22. **Chairs urgent business**

The Chair congratulated Steve Waite on his retirement, thanked him for his work with the Health and Wellbeing Board and wished him good luck for the future.

23. **Minutes**

Agreed that the minutes of 9 November 2017 were confirmed.

24. **Questions from the public**

There were no questions from members of the public.

25. **CQC Report**

Craig McArdle (Director for Integrated Commissioning) introduced the CQC Report; this was published alongside the main agenda.

Members welcomed the report and discussed –

(a) The 20 day deadline to come up with the CQC Action Plan.

(b) What plans are in place to improve the 2 inadequate nursing homes.

(c) Collective ownership of the plan.

Members agreed the following recommendations:

1. to formally accept the CQC Plymouth Local System Review Report;
2. to support the development of an action plan;
3. to delegate Sign Off of the Action Plan to the Chair and Vice Chair;
4. to formally monitor the Action Plan on behalf of the Plymouth System.

26. **System Updates (Safer Plymouth/Western Locality/SIB/CYP)**

Matt Garret (Head of Community Connections) provided Board Members with an Update on Safer Plymouth; this was published alongside the main agenda.

Cllr Terri Beer declared an interest in accordance to this item as an employee of Devon and Cornwall Police.

Members noted the update.

Craig McArdle (Director for Integrated Commissioning) introduced the System Improvement Board Update Report; this was published alongside the main agenda.

Members noted the update.

Judith Harwood (Assistant Director for Education Participation and Skills) and Carole Burgoyne (Strategic Director for People) introduced the report; this was published this was published with the supplementary agenda pack.

Members agreed the report

27. **Health and Wellbeing Hubs**

Ruth Harrell (Director of Public Health), Rachel Silcock (Strategic Commissioning Manager) and Sarah Lees (Consultant in Public Health) presented this item to the committee. The presentation was included in the main agenda pack.

Members discussed –

(a) the importance of the Hubs being led by need and not availability of buildings.

(b) the importance of engaging with Livewell Southwest, Devon Local Pharmaceutical Committee and NHS England to achieve Health and Wellbeing Hubs.

The Committee noted the report.

28. **Work Programme**

The Board noted the work programme and were requested to email Democratic Support to add items to the work programme.

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PLYMOUTH CITY COUNCIL

Subject:	CQC- Local System Review Report
Committee:	Health and Wellbeing Board
Date:	22nd February 2018
Cabinet Member:	Councillor Lynda Bowyer
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Craig McArdle, Director-Integrated Commissioning
Contact details	Tel: 01752 307530 email: craig.mcardle@plymouth.gov.uk
Ref:	CQC
Key Decision:	No
Part:	I

Purpose of the report:

In December 2017, Plymouth's Health and Wellbeing system was the subject of local targeted review conducted by the Care Quality Commission. This review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65. It also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

CQC presented their findings to the Plymouth System at a Local Summit on the 2nd February 2018. Plymouth then has a period of twenty days to complete an action plan that responds to the issues identified in the report. The Action Plan is designed to be owned by the Plymouth Health and Wellbeing Board.

The Action Plan has now been developed in partnership with the Social Care Institute for Excellence and with oversight from the Department of Health and has been signed off by the Chair and Vice Chair of the Health & Wellbeing board.

Recommendations:

The recommendation is for the Health and Wellbeing Board to:

- Formally accept the Plymouth CQC Action Plan
- Support the formal monitoring of the Plymouth CQC Action Plan

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CQC Action Plan 2018-19

Introduction

Plymouth has a long and established record of cooperation and collaboration with a formal commitment to Integration being set down by the Plymouth Health and Wellbeing Board in 2013, based around Integrated Commissioning, Integrated Health and Care Services and an Integrated System of Health and Wellbeing. The progress that the Plymouth System has made towards system integration was acknowledged in the recent CQC Local System Review with Professor Steve Field, Chief Inspector of Primary Care Services, noting:

"The review of Plymouth's services - and how the system works together – has found some shining examples of shared approaches. The system leaders had a clearly articulated, long-established vision of integration which translated well into local commissioning strategies. Leaders were consistent in their commitment to the vision with whole system buy-in.
"I would encourage system leaders in Plymouth to drive this forward to ensure there is a more community, home-based focus. System leaders also need to ensure that as the system moves towards further integration, work is undertaken to ensure that staff are fully engaged, from the outset and led by a collaborative leadership."

In December 2017, the Plymouth Health and Wellbeing system was the subject of the CQC Local Targeted Review considering system performance along a number of 'pressure points' on a typical pathway of care with a particular focus on older people aged over 65. The review focussed on the interface between social care and general primary care as well as acute and community health services. The Plymouth Local System Review report summarised that 'Plymouth is on a journey to integration. There was a compelling vision for integration within Plymouth, developed in collaboration with system partners and local people and linked to the Devon-wide Sustainability and Transformation Plan (STP). The strength and commitment of Plymouth's leadership meant this strategic vision had the potential to be realised, but only if it was translated at ground level and if the wider current challenges facing the system are addressed.'

In February 2018, Plymouth held a Local Summit meeting involving system leads from the Western locality and from wider Devon and with a mix of representation from GPs, Commissioners, Social Services, Acute provision, Politicians and the Voluntary/Community Sector. The output from this Local Summit were the points and actions identified within this action plan which has been developed further to ensure alignment with other, existing strategies.

Oversight

The mandate for CQC's Local Targeted Review states that oversight of the developed Actions Plans will be the responsibility of the local area Health and Wellbeing Board. All key system partners play a part in Plymouth's integrated governance structure and are accountable to the Wellbeing Overview and Scrutiny Board which will continue to support the Health and Wellbeing Board in holding the system to account for the delivery of this action plan.

Regular operational oversight will be the responsibility of the newly formed Plymouth and Western Local Care Partnership which reinforces our collective intent for collaborative working to solve some of the deep-rooted challenges we face and to create a step change in system transformation. Once agreed, the system wide actions will be delivered and monitored through reports presented to the LCP. The Joint Executive group will be responsible for ensuring the delivery of the system programme pulling through reports on actions plan as appropriate from related sub groups/programme groups such as the System Improvement Board.

Local Care Partnership ToR.DOC

Action	Sub actions	SRO	Q1	Q2	Q3	Q4	Updates	Risks/Issues	RAG Status
Theme 1: Commissioning & Market Management **Aim: Recognising our system challenges, Integrated Commissioners have set out a number of intentions. This programme will build on the existing provider landscape, address current funding challenges and enhance the use of our voluntary sector organisations**									
Develop commissioning intentions to signal market requirements 18/19 Microsoft Word Document	1. Develop draft Commissioning Intentions	Craig McArdle, Director of Integrated Commissioning, PCC/NEW Devon CCG	X				Draft commissioning intentions developed shared with Local Care Partnership Board. Intentions build on approved Commissioning Strategies and articulate priorities for next 2 years		
	2. Commissioning Intentions signed off ready for consultation		X				Governance process commenced agreed by Cabinet Planning 27/2 scheduled for Cabinet 13/3 and Governing Body 22/3 approval sought to commence system wide consultation.		
	3. Consultation using existing SDG's and Provider forums			X					
	4. Publication of Final Commissioning Intentions			X					
Develop and remodel the care home market	1. Baseline assessment against EHCH model	Caroline Paterson, Strategic Commissioning Manager, PCC	Complete				Baseline Assessment Completed and submitted to STP		
	2. Develop Project Plan		X				Project Plan in development and Programme Group Established. Workshops with providers planned.		
	3. Programme Mobilisation			X					
	4. Commence Engagement				X				
	5. Commence Implementation of EHCH					X			
Develop and remodel the Dom Care Market	1. Engage with market to agree new fee levels and address short term capacity issues.	Caroline Paterson, Strategic Commissioning Manager, PCC	Complete				Fee levels for 2018/19 agreed. Short term services to increase capacity and support flow brought on line.		
	2. Develop Baseline Assessment of Market			X			Project Office appointed and currently developing capacity mapping across the sector		
	3. Develop New Model of Care and Future Capacity			X			Programme board agreed and meeting set, initial workshop due in March with key stakeholders to discuss a proposed model		
	4. Commission New Model of Care					X			
Develop voluntary sector engagement to maximise their contribution	1. Commence engagement through SDGs to identify further opportunities	Rachel Silcock, Strategic Commissioning Manager, PCC	X				The Wellbeing SDG is the most active with the biggest attendance by the VCS. Next one likely to be 25/04. Jo Beer is organising a meeting with VCS and urgent care this week which will also feed into this action. We will also review our social prescribing offer to see if it could support urgent care		
	2. Align VCS to Urgent Care System		X				British Red Cross based in PHNT and Local Care Centre supporting discharged and providing a 6 week support offer which includes 'shopping' 'collecting prescriptions'		
	3. Arrange strategic meeting with sector and Commissioners to agree approach		X				Initial scoping meeting between commissioners and sector has taken place. Work programme and areas for collaboration to be agreed		
	4. Roll out new way of working			X					

Work with NHS England to deliver sustainable and transformed Primary Care using existing strategy/plan  Primary Care System Improvement Board (	1. Joint Commissioning of Primary Care in place	Shelagh McCormick, Chair of Western Locality, NEW Devon CCG Mark Proctor, Director of Primary Care New Devon CCG/ South Devon and Torbay/ NHS England		X			Consultation with CCG Members has commenced		
	2. Integrated Pharmacy Service designed		X				Initial meetings between providers and commissioners completed. Next stage is the development of scope document		
	3. Integrated Primary Care System designed				X		Work underway to design multiple elements of model such as: care for people in care homes, extended primary care team and extended access. Working closely with the developing Strategic Commissioner to tie in with plans at scale such as telephone triage and use of prescribing and acute hubs		
	4. Integrated Pharmacy Service signed off			X					
	5. Consultation to commence around delegating the Commissioning of Primary Care to local commissioners					X			
	6. Integrated Primary Care System signed off					X			
	7. Integrated Pharmacy Service initial integration commences					X			
Development of Integrated Care Model	1. Align working to Strategic Commissioning Intentions	Ann James, Chief Executive, Plymouth NHS Hospitals Trust Dr Adam Morris, Chief Executive, Livewell Southwest	X				Latest draft Commissioning Intentions with PHNT and LWSW, draft outcomes framework developed, organisational model to be agreed through detailed planning processes		
	2. Appointment of Transformation Lead for Providers		X				Recruitment approach agreed, joint role profile has been agreed and currently out to advert due to close Friday 2nd March		
	3. Develop Transition Plan			X					
	4. Detailed Transformation planning commences			X					
	5. Detailed Transformation planning complete				X				
	6. Initial integration of new functions complete				X				
	7. Transformation of service model to deliver seamless care pathways					X			

Theme 2: Staff and Organisational Development Aim: There are a number of workforce issues across our system and the hospital is facing significant challenges in the recruitment of medical staff. This is further compounded by the number of vacancies within our GP workforce locally. This programme of work will develop our strategy and plan for the creation of a system wide sustainable workforce for the future.									
Develop local workforce strategy & Implementation Plan	Develop workforce strategy group	Carole Burgoyne, Strategic Director for People, Plymouth City Council	X				Strategic group to meet before end of March with agreed Terms of Reference, draft work plan and established capacity to deliver plan		
	Gather existing strategies and plans across the system			X			Development of single workforce plan for Primary Care including demand and capacity modelling due to be completed in Qtr 2		
	Analyse and identify potential gaps			X					
	Develop cross-organisational workforce strategy				X				
	Develop workforce plan				X				
	Develop evaluation framework				X				
	Commence stakeholder engagement and consultation				X				
	Complete consultation and engagement				X				
	Revise strategy and plan following consultation period				X				
	Implement plan					X			
	Evaluate plan					X			

Theme 3: System Improvement Aim: Multiple system reviews have already been undertaken, however, our performance in a number of key areas continues to be challenging. Building on the Western System Improvement Board, this programme of work will continue to focus on the analysis of areas where delivery is compromised, the development of improvement plans and the monitoring of delivery against major milestones.									
Admission Avoidance Schemes  Copy of Admission avoidance action plan	Review of Acute Assessment Unit	Elaine Fitzsimmons Head of Commissioning, NEW Devon CCG Jo Beer, Interim Director of Integrated Urgent Care, Livewell Southwest & Plymouth Hospitals NHS Trust	X				Daily dashboard in place to monitor progress. Improvement Director allocated to support and drive improvement across the 'hot floor' ED/AAU/MAU – Daily improvement huddles. Cross organisation execs/senior clinicians attending System Transformation program and using AAU as a lens for further improvement and learning		
	Maximise Acute GP Service			X					
	Review MIU		X				Review underway and proposal document drafted. Commencing of new service on track for May 2018		
	Review Acute Care at Home Service			X			The specific issue raised by the MIU staff regarding holding equipment for use in the event of cardiac presentations is currently being reviewed with pharmacy leads/medical leads and commissioners		
	Roll out risk stratification across system				X		Plan agreed in January, initial stage will be to support practices in implementing the Electronic Frailty Index for April 2018. Full roll out due March 2019 linking in with Social Prescribing and implementation of Health and Wellbeing hubs		
	Implementation of Health and Wellbeing Hub Programme commences		X				Hub Programme agreed and in implementation phase. First hub scheduled to open March 2018. Options on City Centre Hub being explored.		
Hospital Flow and Discharge  Copy of Urgent Care Plan - Discharge 24.10	Commence end to end review of processes	Jo Beer, Interim Director of Integrated Urgent Care, Livewell Southwest & Plymouth Hospitals NHS Trust	X				Delivery Program in place with project leads identified – First Program Board 27.2.18  Delivery Program Update 27 2 18.docx		
	Reframe Discharge to Assess Pathways 1/2		X				Process modelling underway, looking to identify opportunities to reduce need for assessment to access pathways		
	Redesign Long Term Care Pathway			X					
	Complete end to end review			X			System wide leadership day planned for 2nd March – including voluntary/community/acute/social care		
	Refine improvement plan			X					
	Implement improvement plan				X				
System Improvement	Share single access route into LWSW with wider providers in Plymouth	Nicola Jones, Head of Commissioning, NEW Devon CCG, Michelle Thomas, Director of				X	Due to be completed by end of December 18		
	Roll out Yellow Card scheme				X		Scheme is available to all GP's and Care Home Providers. Specifically designed leaflets for the care home/domiciliary care providers and these are due to be delivered in the coming weeks. Roll out across social services to take place in quarter three. Yellow Card Scheme has now won an award for the Joint CCG's.		

		Operations, Livewell Southwest							
CHC	CHC Pathway - Review existing CHC data	Lorna Collingwood-Burke, Chief Nursing Officer, NEW Devon CCG	X				Desktop review of cases with Local Authority has already commenced		
	CHC Pathway - Benchmark to other areas		X				Data already received from NHS improvement Deloitte benchmarking to our clusters nationally being reviewed		
	CHC Pathway - Commence end to end mapping of process			X			Process review at workshops 2nd and 6th March		
	CHC Pathway - Implement process changes			X					
	CHC Pathway - Evaluate improvement				X				
	CHC Pathway - Review delivery model				X				
	Reduce Backlog – Recruit 4 additional nurses		X				Advertised and closing date 5th March. Interview date 26th march		
	Reduce Backlog - Agree backlog trajectory for assessment and reviews		X				Desktop review of cases with Local Authority has already commenced as above and outsourcing of cases commenced. Trajectory of cases and timetable to be completed by 31.3.18 once data cleansing of backlog completed.		
	Reduce Backlog - Reduce checklist, assessment and review backlog			X					

PLYMOUTH CITY COUNCIL

Subject:	Pharmaceutical Needs Assessment
Committee:	Health and Wellbeing Board
Date:	22nd March 2018
Cabinet Member:	Councillor Lynda Bowyer
CMT Member:	Ruth Harrell (Director of Public Health)
Author:	Robert Nelder (Consultant in Public Health)
Contact details	Tel: 01752 398608 email: robert.nelder@plymouth.gov.uk
Ref:	PNA
Key Decision:	No
Part:	I

Purpose of the report:

The Health and Social Care Act 2012 transferred the responsibility to develop and update Pharmaceutical Needs Assessments (PNAs) from Primary Care Trusts to Health and Wellbeing Boards (H&WBs) from 1 April 2013. This means that Plymouth's H&WB has a legal duty to ensure the production of a PNA for Plymouth going forward.

The purpose of the PNA is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a H&WB's area for a period of up to three years, linking closely to the Joint Strategic Needs Assessment (JSNA). Whilst the JSNA focusses on the general health needs of an area, the PNA looks at how those health needs can be met by pharmaceutical services commissioned by NHS England.

If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to NHS England to be included in the pharmaceutical list for the H&WB's area in which they wish to have premises. In general, their application must offer to meet a need that is set out in the H&WB's PNA, or to secure improvements or better access similarly identified in the PNA. There are however some exceptions to this, in particular applications offering benefits that were not foreseen when the PNA was published ('unforeseen benefits applications').

As well as identifying if there is a need for additional premises, the PNA will also identify whether there is a need for an additional service or services, or whether improvements or better access to existing services are required. Identified needs, improvements or better access could either be current or will arise within the lifetime of the PNA.

Whilst the PNA is primarily a document for NHS England to use to make commissioning decisions, it may also be used by local authorities (LAs) and Clinical Commissioning Groups (CCGs). A robust PNA will ensure those who commission services from pharmacies and dispensing appliance contractors (DACs) are able to ensure services are targeted to areas of health need, and reduce the risk of overprovision in areas of less need.

Recommendations:

The recommendation is for the Health and Wellbeing Board to:

- Formally accept the Plymouth PNA for 2018-21
- Agree to its publication on the Health and Wellbeing Board page of the Plymouth Public Health website (part of the wider Plymouth City Council site).

PHARMACEUTICAL NEEDS ASSESSMENT FOR PLYMOUTH 2018-2021

PLYMOUTH CITY COUNCIL

This Pharmaceutical Needs Assessment is produced as part of Plymouth's Joint Strategic Needs Assessment.

DOCUMENT INFORMATION

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Document status:	DRAFT
Author:	The document was developed by the Office of the Director of Public Health (Plymouth City Council) and the Devon PNA Steering Group, on behalf of Plymouth's Health and Wellbeing Board.
Document version:	Version 3.0
Document date:	23.02.2018
Next review date:	Every three years unless there is a significant change to existing pharmaceutical services provision.
Approved by:	Plymouth Health and Wellbeing Board
Date approved:	22/03/2018
Link to Plymouth's JSNA :	http://www.plymouth.gov.uk/jsna

Amendment History

Version:	Status:	Date:	Reason for change:	Authorised by:
1.0	Draft	24.10.2017	Initial draft (prior to consultation)	Devon PNA Steering Group
2.0	Second draft	22.11.2017	Pre-consultation draft following review day with NHSE	Devon PNA Steering Group
3.0	Final draft	23.02.2018	Final draft following the consultation period	Devon PNA Steering Group
4.0	Final version	22.03.2018	Following approval from the Plymouth Health and Wellbeing Board	Plymouth Health and Wellbeing Board

Acknowledgments

The development of this Pharmaceutical Needs Assessment (PNA) was overseen by the Devon PNA Steering Group. The author of this report would like to thank Members of the Steering Group for their considerable input and support throughout the process. In addition, special thanks are given to:

- Simon Hoad (Senior Public Health Analyst, Plymouth City Council)
- Sarah Macleod (Senior Public Health Analyst, Plymouth City Council)
- Claire Turbutt (Advanced Public Health Practitioner, Plymouth City Council)

Finally, the author would like to thank all persons who contributed to the consultation on this PNA.

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Contents

1. Executive Summary

A Pharmaceutical Needs Assessment (PNA) is a comprehensive assessment of the current and future pharmaceutical needs of the local population for community pharmacy, dispensing appliance contractors, and dispensing doctors in rural areas (where relevant). The Health and Social Care Act 2012 transferred the responsibility to develop and update PNAs from Primary Care Trusts to Health and Wellbeing Boards (H&WBs) from 1 April 2013. This means that Plymouth's H&WB has a legal duty to ensure the production of a PNA for Plymouth going forward. H&WBs are required to publish their first PNA by 1 April 2015 and publish a statement of its revised assessment within three years of its previous publication or sooner if changes to the need for pharmaceutical services are identified which are of significant extent.

The PNA for Plymouth 2018-2021 presents a picture of community pharmacy need and provision in Plymouth, and links to Plymouth's Joint Strategic Needs Assessment (JSNA). This PNA will be used by NHS England to inform:

- decisions regarding which NHS funded services need to be provided by community pharmacies and dispensing appliance contractors in Plymouth
- whether new pharmacies or services are needed
- decision-making about the relocation of existing pharmaceutical premises in response to applications by providers of pharmaceutical services
- the commissioning of locally Enhanced services from pharmacies

Providers of pharmaceutical services will also use the PNA to inform their applications to provide pharmaceutical services by demonstrating that they are able to meet a pharmaceutical need as set out in the PNA.

Plymouth's PNA was developed in partnership with the Devon-wide PNA Steering Group on behalf of Plymouth's H&WB. This was to ensure that production of the PNAs for Plymouth, Devon, and Torbay followed the same process and format but with locally relevant information.

The NHS Regulations 2013 set out the legislative basis for producing and updating PNAs, and specify a list of minimum information that must be included in the PNA. Plymouth's PNA is structured as follows:

- Introduction
- Overview of Plymouth
- General health needs in Plymouth
- Health needs that can be influenced by pharmaceutical services
- Provision of pharmaceutical services
- Other relevant services
- Locality summaries
- Conclusion

In order to identify local health needs and assess current pharmaceutical services provision, Plymouth was divided into its four established localities: East, North, South and

West. A locality is a distinct population cluster in which the inhabitants live in adjoining neighbourhoods, and that has a name or a locally recognised status. Plymouth's localities are aggregations of the city's 20 electoral wards, which themselves are aggregations of the 39 neighbourhoods.

Information regarding local provision of pharmaceutical services was made available by NHS England and analysed by the Public Health England Local Knowledge and Intelligence Service (PHE LKIS) on behalf of the Steering Group.

The consultation period ran from Monday 4 December 2017 to Friday 2 February 2018. The H&WBs for Plymouth, Devon and Torbay ran the consultation for each of their PNAs at the same time. This was to aid organisations who were asked to respond to consultations for more than one area at the same time. The method of consultation was agreed by the PNA Steering Group. The PNA Steering Group met following the end of the consultation period to discuss the feedback received across all three areas and agree appropriate action. Following this, some minor amendments were made to the report.

The Primary care system is undergoing a level of transformation in the city at a much greater rate than normal and this is anticipated to continue with the development of hubs and other changes resulting from the increased demand and resourcing pressures. Community pharmacy within the city has to date been early adopters of change developing new models and integrated approaches that align with these changes in primary care.

In conclusion, Plymouth's growing and ageing population means that the overall demand for health and social care services is likely to increase, particularly in terms of managing long-term conditions. However, pharmacies in Plymouth are well-placed to deliver healthcare services to their local communities and it is anticipated that the role they play will continue to evolve over the coming years, particularly with changes to future pharmacy and primary care provision. Whilst the core activity of community pharmacies is commissioned by NHS England, they continue to provide a key role for Plymouth City Council and the NEW Devon CCG, particularly in relation to improving the public's health and wellbeing, and addressing health inequalities.

2. Introduction

2.1 Purpose of a pharmaceutical needs assessment

The purpose of the PNA is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a H&WB's area for a period of up to three years, linking closely to the JSNA. Whilst the JSNA focusses on the general health needs of the population of Plymouth, the PNA looks at how those health needs can be met by pharmaceutical services commissioned by NHS England.

If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to NHS England to be included in the pharmaceutical list for the H&WB's area in which they wish to have premises. In general, their application must offer to meet a need that is set out in the H&WB's PNA, or to secure improvements or better access similarly identified in the PNA. There are however some exceptions to this, in particular applications offering benefits that were not foreseen when the PNA was published ('unforeseen benefits applications').

As well as identifying if there is a need for additional premises, the PNA will also identify whether there is a need for an additional service or services, or whether improvements or better access to existing services are required. Identified needs, improvements or better access could either be current or will arise within the lifetime of the PNA.

Whilst the PNA is primarily a document for NHS England to use to make commissioning decisions, it may also be used by local authorities (LAs) and Clinical Commissioning Groups (CCGs). A robust PNA will ensure those who commission services from pharmacies and dispensing appliance contractors (DACs) are able to ensure services are targeted to areas of health need, and reduce the risk of overprovision in areas of less need.

2.2 H&WB duties in respect of the PNA

The legislation containing the H&WB's specific duties in relation to PNAs can be found in appendix 1, however in summary the H&WB must:

- produce its first PNA which complies with the regulatory requirements
- publish its first PNA by 1 April 2015
- publish subsequent PNAs on a three-yearly basis
- publish a subsequent PNA sooner when it identifies changes to the need for pharmaceutical services which are of a significant extent, unless to do so would be a disproportionate response to those changes, and
- produce supplementary statements in certain circumstances

2.3 The scope of this PNA: Contractors and services

2.3.1 Contractors

NHS England must keep lists of contractors who provide pharmaceutical services in the area of the H&WB. The principal types of contractor are:

(i) Pharmacy contractors
Individual pharmacists (sole traders), partnerships of pharmacists or companies who operate pharmacies. Who can be a pharmacy contractor is governed by The Medicines Act 1968. All pharmacists must be registered with the General Pharmaceutical Council, as must all pharmacy premises.

Within this group there are:

- **Community pharmacies** – These are pharmacies which provide services to patients in person from premises in (for example) high street shops, supermarkets or adjacent to doctors' surgeries. As well as dispensing medicines, they can sell medicines which do not need to be prescribed but which must be sold under the supervision of a pharmacist. They may also, but do not have to, dispense appliances. Community pharmacies operate under national terms of service set out in schedule 4 of the 2013 regulations and also in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (the 2013 directions).

- **Local pharmaceutical services (LPS) contractors** – A small number of community pharmacies operate under locally-agreed contracts. While these contracts will always include the dispensing of medicines, they have the flexibility to include a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under the national terms of service, and so can be more tailored to the area they serve.

- **Distance-selling pharmacies (DSP)** – These pharmacies cannot provide most services on a face-to-face basis. They operate under the same terms of service as community pharmacies, so are required to provide the same essential services and to participate in the clinical governance system, but there is an additional requirement that they must provide these services remotely. For example, a patient may post their prescription to a distance selling pharmacy and the contractor will dispense the item and then deliver it to the patient's address by post or using a courier. Distance selling pharmacies therefore interact with their customers via the telephone, email or a website and will deliver dispensed items to the customer's preferred address. Such pharmacies are required to provide services to people who request them wherever they may live in England, and cannot limit their services to particular groups of patients.

(ii) Dispensing appliance contractors (DAC)
DACs supply appliances such as stoma and incontinence aids, dressings, bandages etc. They cannot supply medicines. There are no restrictions on who can operate as a DAC. DACs operate under national terms of service set out in schedule 5 of the 2013 regulations and also in the 2013 directions.

(iii) Dispensing doctors

Medical practitioners authorised to provide drugs and appliances in designated rural areas known as 'controlled localities'. Dispensing doctors can only dispense to their own patients. They operate under national terms of service set out in schedule 6 of the 2013 regulations.

The services that a PNA must include are defined within both the NHS Act 2006 and the 2013 regulations.

2.3.2 Pharmaceutical services provided by pharmacy contractors

Unlike for GPs, dentists and optometrists, NHS England does not hold contracts with most pharmacy contractors (the exception being LPS contractors). Instead, as noted above, they provide services under terms of service set out in legislation.

Pharmacy contractors provide three types of service that fall within the definition of pharmaceutical services.

2.3.2.1 - Essential services

All pharmacies must provide these services. There are six essential services:

- **Dispensing of prescriptions** – The supply of medicines and appliances ordered on NHS prescriptions (both electronic and non-electronic), together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records. Also the urgent supply of a drug or appliance without a prescription at the request of a prescriber.

- **Dispensing of repeatable prescriptions** – The management and dispensing of repeatable NHS prescriptions for medicines and appliances in partnership with the patient and the prescriber. Repeatable prescriptions allow, for a set period of time, further supplies of the medicine or appliance to be dispensed without additional authorisation from the prescriber, if the dispenser is satisfied that it is appropriate to do so.

- **Disposal of unwanted drugs** – Acceptance by community pharmacies, of unwanted medicines that require safe disposal from households and individuals. NHS England is required to arrange for the collection and disposal of waste medicines from pharmacies.

- **Promotion of healthy lifestyles** – The provision of opportunistic healthy lifestyle and public health advice to patients receiving prescriptions who appear to have particular conditions, and pro-active participation in national/local campaigns, to promote public health messages to general pharmacy visitors during specific targeted campaign periods.

- **Signposting** – The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy, but is available from other health and social care providers or support organisations who may be able to assist the person. Where appropriate, this may

take the form of a referral.

- **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.

Note: where a pharmacy contractor chooses to supply appliances as well as medicines, the requirements of the appliance services (listed below) also apply.

While not classed as separate services, pharmacies may also provide the following as enhancements to the provision of essential services:

- **Dispensing of electronic prescriptions** received through the Electronic Prescription Service (EPS) – The ability for the pharmacy to receive prescriptions details from doctors' surgeries electronically. EPS Release 1 involved paper prescriptions including a barcode which the pharmacy could scan to retrieve an electronic copy of the patient's details and the medication prescribed. EPS Release 2 involves the prescription details being sent entirely electronically by the GP surgery to the pharmacy nominated by the patient.

- **Access to the NHS Summary Care Record** – The pharmacy has access to an electronic summary of key clinical information (including medicines, allergies and adverse reactions – and possibly additional information if the patient consents) about a patient, sourced from the patient's GP record to support care and treatment. This can, for example, be used to confirm that a patient requesting an emergency supply of a medicine has been prescribed that medicine before.

2.3.2.2 - Advanced services

Pharmacies may choose whether to provide these services or not. If they choose to provide one or more of the advanced services they must meet certain requirements and must be fully compliant with the essential services and clinical governance requirements.

- **Medicines use review** and prescription intervention services (more commonly referred to as the medicines use review or MUR service) – The improvement of patient knowledge, concordance and use of their medicines through one-to-one consultations to discuss medicine understanding, use, side effects and interactions, and reduce waste, and if necessary making recommendations to prescribers.

- **New medicine service** – The promotion the health and wellbeing of patients who are prescribed a new medicine or medicines for certain long term conditions, by providing support to the patient after two weeks and four weeks with the aim of reducing symptoms and long-term complications, and enabling the patient to make appropriate lifestyle changes and self-manage their condition.

- **Influenza vaccination service** – The provision of influenza vaccinations to patients in at-risk groups, to provide more opportunities for eligible patients to access vaccination with the aim of sustaining and maximising uptake.

- **Urgent medicines supply service** (pilot), known as NUMSAS – To provide, at NHS expense, urgent supplies of repeat medicines and appliances for patients referred by NHS 111, and so reduce demand on the urgent care system, particularly GP Out of Hours providers. This service is a national pilot running until end September 2018.

- **Stoma appliance customisation service** (SAC) – The modification to the same specification of multiple identical parts for use with a stoma appliance, based on the patient's measurements (and, if applicable, a template) to ensure proper use and comfortable fitting, and to improve the duration of usage.

- **Appliance use review service** (AUR) – The improvement of patient knowledge, concordance and use of their appliances through one-to-one consultations to discuss use, experience, storage and disposal, and if necessary making recommendations to prescribers.

2.3.2.3 - Enhanced services

The 2013 directions contain a list of enhanced services which NHS England may commission, and broadly describe the underlying purpose of each one.

NHS England may choose to commission enhanced services from all or selected pharmacies to meet specific health needs, in which case it may develop an appropriate service specification.

NHS England currently commissions the following enhanced services in Plymouth:

- On demand availability of specialist drugs.

In Plymouth these services are commissioned from:

- Asda Pharmacy, Leypark Walk, Estover, Plymouth, PL6 8TB
- Hyde Park pharmacy, 73 Hyde Park Road, Mutley, Plymouth, PL3 4JN

Commissioning of this service may transfer to Clinical Commissioning Groups in the near future, in which case it would cease to be an enhanced service and would become a locally commissioned service.

Other enhanced services that may be, but are not currently, commissioned by NHS England are:

- Antiviral collection service
- Anticoagulation monitoring
- Care home service
- Disease specific medicines management service
- Emergency supply service
- Gluten free food supply service
- Home delivery service

- Independent prescribing service
- Language access service
- Medication review service
- Medicines assessment and compliance support service
- Minor ailment scheme
- Needle and syringe exchange
- Patient group direction service
- Prescriber support service
- Schools service
- Screening service
- Stop smoking service
- Supervised administration service
- Supplementary prescribing service

Some of the above services may be commissioned by CCGs or local councils, but in such cases those services are not 'pharmaceutical services' for the purposes of this PNA.

2.3.2.4 - Clinical governance

Underpinning the provision of all of these services is the requirement on each pharmacy to participate in a system of clinical governance. This system is set out within the 2013 regulations and comprises:

- a patient and public involvement programme, including production of a leaflet setting out the services provided and carrying out a patient questionnaire
- a clinical audit programme
- a risk management programme
- a clinical effectiveness programme
- a staffing and staff programme
- an information governance programme
- a premises standards programme.

2.3.2.5 - Opening hours

Most pharmacies are required to open for at least 40 hours per week, and these are referred to as core opening hours. However many choose to open for longer and these hours are referred to as supplementary opening hours – but a pharmacy can decide to stop providing supplementary hours by giving notice to NHS England.

As part of an application to open a new pharmacy, an applicant may offer to open for more than 40 core hours per week (for example, promising to open for a minimum of 50 hours per week), and may open supplementary hours in addition.

If an application is granted and the pharmacy subsequently opens the core and supplementary opening hours set out in the initial application become the pharmacy's contracted opening hours.

Between April 2005 and August 2012, some contractors were able to open new premises using an exemption under which they agreed to have 100 core opening hours per week (referred to as 100-hour pharmacies). These pharmacies are required to be open for 100 hours per week, 52 weeks of the year (with the exception of weeks that contain a bank or public holiday, or Easter Sunday). Although the exemption for new 100-hour pharmacies no longer applies, existing 100-hour pharmacies remain under an obligation to be open for 100 hours per week. In addition, these pharmacies may open for longer hours.

2.3.2.6 - Recent changes to the contractual arrangements for pharmacies

In late 2016 the Department of Health announced some changes to the contractual framework for pharmacies. These included:

- a reduction in funding of 4% in 2016/17 and a further reduction of 3.4% in 2017/18
- the introduction of the urgent medicines supply service advanced service as a pilot
- the introduction of a Pharmacy Access Scheme (PhAS)
- the introduction of a Quality Payment Scheme (QPS)
- allowing the consolidation of pharmacies, in effect providing a way for a pharmacy to close without creating an opportunity for another pharmacy to open instead

The PhAS runs until 31 March 2018 and provides some transitional funding to limit the impact of the funding reductions on eligible pharmacies. Pharmacies are eligible for the scheme if they:

- were open on 1 September 2016,
- are more than 1 mile by road from the nearest pharmacy, and
- are not in the top 25% largest pharmacies.

While the Pharmacy Access Scheme is currently expected to end before this PNA takes effect, information regarding which pharmacies are included on it has been included in this PNA because it may be relevant to considering which pharmacies could be regarded as providing an essential service to their communities and which may be more vulnerable to reductions in funding.

In Plymouth the following pharmacy is included on the PhAS:

- Bestway National Chemists Ltd, 77 Whitleigh Green, Whitleigh, Plymouth, PL5 4DE

The QPS also runs until 31 March 2018 and allows all pharmacies to earn some additional funding for meeting a number of criteria. To be eligible to participate in the QPS a pharmacy must:

- provide medicines use reviews or the new medicines service, or be registered for the urgent medicines supply service pilot
- keep its entry on the NHS Choices website up-to-date
- be able to send and receive email using the secure NHS mail system, and
- use the Electronic Prescription Service

If they are eligible, a pharmacy can earn different amounts of funding for:

- producing a patient safety report (in particular identifying learning from incidents and near misses)
- ensuring that 80% of pharmacists and pharmacy technicians have had safeguarding children and vulnerable adults training (level 2)
- ensuring that 80% of all staff are trained as Dementia Friends
- becoming a Healthy Living Pharmacy (level 1)
- identifying, using specified criteria, asthma patients who should be referred to an appropriate
- clinician for an asthma review
- increasing use of the NHS Summary Care Record
- publishing the results of their annual patient experience survey on the NHS Choices website
- keeping their entry in the NHS 111 Directory of Services up-to-date.

It is not currently known whether the Quality Scheme will continue after 31 March 2018, either in its current form or with changes.

2.3.3 Pharmaceutical services provided by dispensing appliance contractors

As with pharmacy contractors, NHS England does not hold contracts with DACs. Their terms of service are also set out in schedule 5 of the 2013 regulations and in the 2013 directions.

2.3.3.1 - Appliance services

DACs provide the following services that fall within the definition of pharmaceutical services:

- **Dispensing of prescriptions** – The supply of appliances ordered on NHS prescriptions (both electronic and non-electronic), together with information and advice and appropriate referral arrangements in the event of a supply being unable to be made, to enable safe and effective use by patients and carers. Also the urgent supply without a prescription at the request of a prescriber.

- **Dispensing of repeatable prescriptions** – The management and dispensing of repeatable NHS prescriptions for appliances in partnership with the patient and the prescriber.

- **Home delivery service** – To preserve the dignity of patients, the delivery of certain appliances to the patient's home in a way that does not indicate what is being delivered.

- **Supply of appropriate supplementary items** – The provision of additional items such as disposable wipes and disposal bags in connection with certain appliances.

- **Provision of expert clinical advice regarding the appliances** – To ensure that patients are able to seek appropriate advice on their appliance to increase their confidence in choosing an appliance that suits their needs as well as gaining confidence to adjust to the changes in their life and learning to manage an appliance.

- **Signposting** – Where the contractor does not supply the appliance ordered on the prescription passing the prescription to another provider of appliances, or giving the patient contact details for alternative providers.

All DACs must provide the above services.

DACs may also receive electronic prescriptions through the Electronic Prescription Service (EPS) where they have been nominated by a patient.

2.3.3.2 - Advanced services

DACs may choose whether to provide the appliance advanced services or not. If they do choose to provide them then they must meet certain requirements and must be fully compliant with their terms of service and the clinical governance requirements. There are two appliance advanced services.

- Stoma appliance customization
- Appliance use review.

2.3.3.3 - Clinical governance

As with pharmacies, DACs are required to participate in a system of clinical governance. This system is set out within the 2013 regulations and comprises:

- a patient and public involvement programme, including production of a leaflet setting out the services provided and carrying out a patient questionnaire
- a clinical audit programme
- a risk management programme
- a clinical effectiveness programme
- a staffing and staff programme
- an information governance programme.

2.3.3.4 - Opening hours

DACs are required to open at least 30 hours per week and these are referred to as core opening hours. They may choose to open for longer and these hours are referred to as supplementary opening hours – but a DAC can decide to stop providing supplementary hours by giving notice to NHS England.

As part of an application to open a new DAC, an applicant may offer to open for more than 30 core hours per week (for example, promising to open for a minimum of 40 hours per week), and may also open supplementary hours in addition.

2.3.4 Pharmaceutical services provided by dispensing doctors

The 2013 regulations allow doctors to dispense to eligible patients in rural areas where access to pharmacies can be difficult. Dispensing takes place in a dispensary which is not usually classed as a pharmacy and so is not registered with the General Pharmaceutical Council. Dispensing doctors do not generally employ pharmacists to work in their dispensaries, and dispensing will instead be carried out by the doctors themselves or by dispensing assistants who will generally be trained to NVQ2 or NVQ3 level.

In a few cases a pharmacy attached to a doctors' surgery may also act as the surgery dispensary for the purpose of dispensing to eligible patients on behalf of the dispensing doctor.

2.3.4.1 - Eligibility

The rules on eligibility are complex. In summary, and subject to some limited exceptions which may be allowed on an individual patient basis, a dispensing doctor can only dispense to a patient who:

- is registered as a patient with that dispensing doctor, and
- lives in a designated rural area (known as a 'controlled locality' – see below), and
- lives more than 1.6 kilometers (about one mile) in a straight line from a community pharmacy, and
- lives in the area for which the doctor has been granted permission to dispense, or is a patient for whom the doctor has historic dispensing rights.

Designation of areas as 'controlled localities' is a responsibility of NHS England. This PNA is required to include maps of the controlled localities within the H&WB's area. There are no controlled localities in Plymouth.

2.3.4.2 - Services

Dispensing – Dispensing doctors may supply medicines and appliances ordered on NHS prescriptions (whether issued by them or another prescriber such as a dentist) to eligible patients.

Dispensing doctors are not permitted to sell medicines, so are unable to supply over-the-counter medicines except by prescribing and then dispensing them.

If a dispensing doctor participates in the Dispensary Services Quality Scheme then then will provide dispensing reviews of the use of medicines (DRUMs), which are similar to the medicines use reviews carried out in pharmacies.

2.3.4.3 - Clinical governance

Dispensing doctors can participate in the voluntary dispensary services quality scheme (DSQS) which includes requirements relating to:

- staff qualifications and training

- ensuring an appropriate level of dispensary staff hours
- standard operating procedures
- risk management
- clinical audit
- production of a leaflet
- providing DRUMs

2.3.4.4 - Opening hours

Dispensing doctors are able to determine what hours their dispensary should be open to patients. If they participate in the DSQS then they are required to notify NHS England of those opening hours as part of the DSQS assessment, but do not have to seek approval or give advance notice of any changes to their opening hours.

2.4 Locally commissioned services

Local councils and CCGs may also commission services from pharmacies and DACs, however these services fall outside the definition of pharmaceutical services. For the purposes of this document they are referred to as locally commissioned services. They are included within this assessment where they affect the need for pharmaceutical services, or where the further provision of these services would secure improvements or better access to pharmaceutical services.

2.4.1 Services commissioned by Plymouth City Council

(i) Supervised consumption of substance misuse medicines

This service involves the client consuming methadone or buprenorphine under the direct supervision of a pharmacist in a pharmacy. There is a compelling evidence to support the effectiveness of substance misuse supervised administration services with long term health benefits to substance misusers and the whole population.

51 (All) pharmacies were commissioned to provide this service by Plymouth City Council in 2016/17 and 48 pharmacies supervised 58072 doses of either methadone or buprenorphine over the course of the year.

(ii) Needle exchange

This is an integral part of the harm reduction strategy for drug users. It aims to:

- Reduce the spread of blood borne viruses (BBVs) e.g. Hepatitis B, Hepatitis C, HIV
- Provide a gateway into treatment services
- Provide a referral point for service users to other health and social care services

There is a compelling evidence to support the effectiveness of needle exchange services in reducing the spread of BBVs with long-term public health benefits to drug users and the whole population.

15 pharmacies were commissioned by Plymouth City Council to provide needle exchange services in 2016/17. 8,575 1ml packs and 3,275 2ml packs packs were provided through pharmacies in 2016/17, as well as 49,200 single 1ml U100 syringes and 37,600 2ml barrels.

(iii) Emergency hormonal contraception (EHC)

There is a strong evidence base for the use of EHC in reducing unplanned or unwanted pregnancies especially within teenage years. Its use forms part of an overall national strategy to reduce the rate of teenage pregnancy with England. The rate of teenage pregnancy in Plymouth is reducing. Whilst GP practices are instrumental in contraception provision, some female residents will prefer the relative anonymity of attending a pharmacy to access EHC. The drug levonorgestrel is used for EHC under the Plymouth scheme commissioned by Plymouth City Council from pharmacies. Through this scheme, levonorgestrel is supplied under a patient group direction (PGD) to women who meet the criteria for inclusion of the PGD and service specification. It may also be bought as an over the counter medication from pharmacies, however the user must be 16 years or over, hence the need for a PGD service within pharmacies which provides access from 13 to 24 years of age. In addition the contraception and sexual health clinics (formerly known as family planning clinics) provide contraceptive services.

23 pharmacies were commissioned in Plymouth to provide EHC services in 2016/17. 1,760 consultations were provided and 1,718 EHC treatments dispensed.

Following new guidance from the Faculty of Sexual and Reproductive Healthcare (March 2017) the EHC service in community pharmacies is currently being remodeled to provide both levonorgestrel and ulipristal acetate.

(iv) Chlamydia screening

This programme is commissioned as part of the comprehensive Chlamydia Screening Progamme in Plymouth. The aim of the service is to improve the quality and accessibility of sexual health services to young people between the ages of 16–24 and increase the uptake of Chlamydia screens in young women and young men who have had an unprotected sex episode, thereby increasing the number of identified cases and opportunities for treatment and partner management. Pharmacists are commissioned to opportunistically signpost a young person between the ages of 16-24 (who are not presenting for EHC) to the counter-top Chlamydia screening kit.

Currently 23 pharmacies are commissioned in Plymouth to provide the Chlamydia screening service. In 2016/17, 478 Chlamydia screening kits (in age 15-24 years) provided through pharmacies were returned to the Chlamydia Screening Office

13 community pharmacies are also commissioned to provide chlamydia treatment. In 2016/17, 56 treatments of azithromycin were dispensed. This service has recently been reviewed and the first line treatment will now be doxycycline with azithromycin given where doxycycline is refused or inappropriate.

(v) NHS health checks

The NHS Health Check programme (delivered mainly through primary care in Plymouth) aims to prevent four main non-communicable diseases (heart disease, stroke, type 2 diabetes and kidney disease). Six pharmacies took part in a pilot in 2016-17 to provide NHS health checks and are able to support GP surgeries with provision as necessary.

(vi) Smoking cessation

Stopping smoking is one of the single most effective health care interventions that can be offered. Working alongside the specialist provider of Smoking cessation services and GP practices, pharmacies provide behavioral support as well as Nicotine Replacement Therapy (NRT) and access to medication for people who want to give up smoking. Unlike other providers, pharmacies offer a walk-in service across a wide number of opening hours.

Currently 32 pharmacies are commissioned in Plymouth to provide stop smoking services, with 13 actually delivering. In 2016/17 38 people quit smoking through pharmacies.

2.4.2 Services commissioned by NEW Devon CCG

To improve access for people and to relieve pressure on urgent and emergency care services and general practitioner appointments at times of high demand, the following services are commissioned:

- Minor ailments via Patient Group Direction (supply of a limited range of prescription only medicines (POMs) to treat urinary tract infections, impetigo, nappy rash and bacterial conjunctivitis.
- Emergency Supply Service (provision of emergency supplies of repeat prescriptions and medicines at NHS expense).

Currently 36 pharmacies are commissioned in Plymouth to provide the Minor Ailments Service. From April to July 2017, 174 people accessed the Minor Ailment Service provided by Plymouth pharmacies. A list of the pharmacies providing these services is included in appendix 6.

2.5 Other NHS services

Details of other services which are commissioned or provided by NHS England, Plymouth City Council and NEW Devon CCG (which affect the need for pharmaceutical services) are also included within the PNA. These include hospital pharmacies and the GP out-of-hours service.

2.6 Changes to the existing provision of pharmaceutical services

A pharmacy or DAC can apply to NHS England to change their core opening hours.

Applications normally need to be submitted 90 days in advance of the date on which the contractors wishes to implement the change. NHS England will assess the application against the needs of the population of the HWB area as set out in the PNA to determine whether to agree to the change in core hours or not.

If a pharmacy or DAC wishes to change their supplementary opening hours they simply notify NHS England of the change, giving at least three months' notice.
Dispensing doctors do not have to seek approval or give advance notice of any changes to their opening hours.

A person who wishes to buy an existing pharmacy or DAC must apply to NHS England. Provided that the purchaser agrees to provide the same services and opening hours as the current contractor, change of ownership applications are normally approved.

A contractor which wishes to relocate to different premises also needs to apply to NHS England. Generally a relocation will only be allowed if all groups of patients who use the pharmacy at its current location would find the new location not significantly less accessible.

A contractor can cease providing pharmaceutical services if it gives three months' notice to NHS England. 100 hour pharmacies are required to give six months' notice.

Two pharmacies (which could belong to the same contractor, or different contractors) can apply to consolidate their premises on to one site, in effect closing one of the sites. This does not apply to distance-selling pharmacies or DACs. A consolidation application can only be approved if NHS England is satisfied that doing so will not result in the creation of a gap in pharmaceutical services. If an application is approved then it is not possible for anyone else to apply to open a pharmacy in the same area by submitting an unforeseen benefit application claiming that a gap has been created.

If a new pharmacy opens in or near a controlled locality any dispensing doctors in the area will no longer be able to dispense medicines to any patients who live within 1.6 kilometres (about 1 mile) of that pharmacy. However NHS England may decide to allow a transitional period after the pharmacy opens during which the doctors can still dispense to patients living near the pharmacy.

2.7 How the assessment was undertaken

2.7.1 PNA steering group

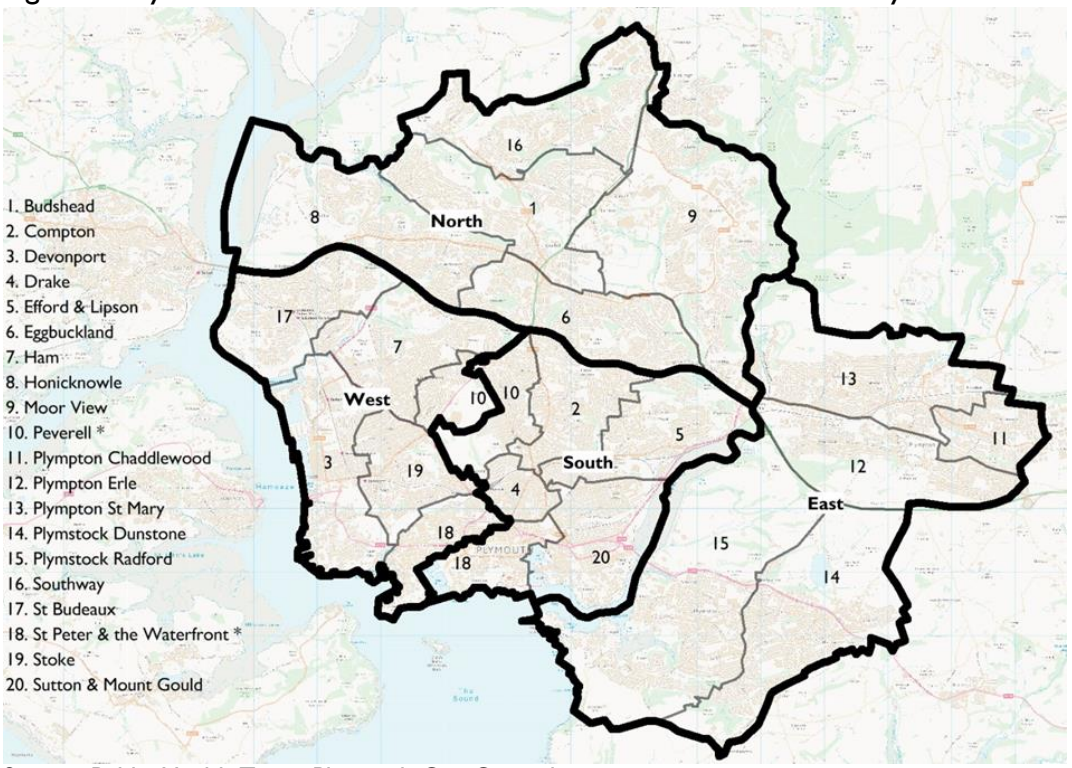
The H&WB has overall responsibility for the publication of the PNA, and the Director of Public Health is the H&WB member who is accountable for its development. A Devon-wide PNA Steering Group was established, the purpose of which was to ensure the development robust PNAs (in Plymouth, Devon and Torbay) that comply with the 2013 regulations and the needs of the local populations. The membership of the steering group ensured all the main stakeholders were represented. A list of the group's members can be found in appendix 2.

2.7.2 PNA localities

The assessment of need could be conducted in many different ways e.g. on an electoral ward or neighbourhood basis. For the purposes of this PNA, Plymouth was divided into the four Livewell Southwest localities (Figure 1).

A locality is a distinct population cluster in which the inhabitants live in adjoining areas that has a name or a locally recognised status. Plymouth's localities are aggregations of the city's 20 electoral wards (except that the South and West localities split the electoral wards of Peverell and St Peter and the Waterfront, see Figure 1). Cutting the data on a locality basis enables a better overview of provision across a cluster of electoral wards within an area of the city.

Figure 1: Plymouth's electoral wards and Livewell Southwest locality boundaries



Source: Public Health Team, Plymouth City Council
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The information in sections 3, 4 and 5 is presented on a locality basis. This is particularly useful when examining the availability and accessibility of pharmaceutical services across Plymouth. The information gathered will help to inform commissioning decisions related to community pharmacy and services delivered by alternative providers, and ensure that the distribution of services meets local needs. It was not practical to present data at the neighbourhood or electoral ward level as this would mean presenting survey findings for 39 neighbourhoods or 20 wards respectively. In addition, presentation of the service mapping at this level would not provide a complete picture of access to pharmacies. For example, pharmacies in adjacent neighbourhoods or wards may be accessible within very short drive times. Consequently, needs may be identified at the neighbourhood or ward level that are addressed by provision in adjacent areas.

Needs based data at the neighbourhood and electoral ward level can be found on the Plymouth JSNA website:

https://www.plymouth.gov.uk/publichealth/jointstrategicneedsassessment

This includes Area Profiles (summaries of key health and social care indicators in the area) and Census 2011 Profiles (summaries of key findings from the 2011 Census). Table 1 below lists the 20 electoral wards that make up the four Livewell Southwest localities for which data are presented in this document.

Table 1: The Livewell Southwest localities by electoral ward

Plymouth East	Ward
East	Plympton Chaddlewood
	Plympton Erle
	Plympton St Mary
	Plymstock Dunstone
	Plymstock Radford

Plymouth West	Ward
West	Devonport
	Ham
	Peverell *
	St Budeaux
	St Peter & the Waterfront *
	Stoke

Plymouth South	Ward
South	Compton
	Drake
	Efford & Lipson
	Peverell *
	St Peter & the Waterfront *
	Sutton & Mount Gould

Plymouth North	Ward
North	Budshead
	Eggbuckland
	Honicknowle
	Moor View
	Southway

2.7.3 Other sources of information

Information was gathered from NHS England, Plymouth City Council, NEW Devon CCG, South Hams District Council and West Devon Council regarding:

- services provided to residents of the H&WB's area, whether provided from within or outside of the H&WB's area
- changes to current service provision
- future commissioning intentions
- known housing developments within the lifetime of the PNA
- any other developments which may affect the need for pharmaceutical services.

The JSNA and Plymouth City Council's Joint Health and Wellbeing Strategy (JHWS) provided background information on the health needs of the population. The latter being part of the 'Plymouth Plan'.

2.7.4 Equality and safety impact assessment

Plymouth City Council uses equality analysis as a tool to ensure that everyone can access its services and that no particular group is put at a disadvantage. Equality impact assessments (EIAs) are carried out when policies, strategies, procedures, functions and services are developed and reviewed. The staff who develop the policy or service complete a template which gives them a series of prompts to consider how to promote equality and avoid unlawful discrimination. They consider the following nine protected characteristics as part of the assessment:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The EIA for the PNA can be found in appendix 3.

2.7.5 Consultation

The statutory 60-day consultation commenced on Monday 4 December 2017 and ran until Friday 2 February 2018. A report on the consultation can be found in appendix 4.

3. Overview of Plymouth

3.1 Introduction

This chapter provides information regarding the demography of Plymouth, which may have implications for delivery of pharmaceutical services across the city. The chapter covers the population of Plymouth and population estimates, the nine protected characteristics, deprivation, car ownership and Mosaic profiling (marketing based information about the demographics, characteristics and behaviours of the Plymouth population). It also provides a high level overview of the key health needs of the Plymouth population compared to the England average.

3.2 The population

Plymouth's population has grown by over 15,000 people (an increase of 6.4%) from 2009 to 2015. All four localities have increased in population size, with the largest percentage increase in the West (5.1%) and the smallest percentage increase in the East 1.7%). It is also important to highlight the number of people who commute into Plymouth as their place of work from their usual residence as they may make use of pharmaceutical services. The figure from the 2011 Census was 25,940.

Table 2: Mid-year population estimates (all ages), by locality, 2009 to 2015

Year	East	North	South	West	Plymouth
2009	54,197	63,869	66,497	68,553	253,116
2010	54,427	63,875	66,684	69,241	254,227
2011	54,420	64,671	67,510	69,988	256,589
2012	54,716	65,380	67,352	70,578	258,026
2013	54,443	65,292	68,642	70,798	259,175
2014	54,441	66,130	69,318	71,657	261,546
2015	55,095	66,670	68,919	72,028	262,712
% change	1.7	4.4	3.6	5.1	3.8

Source: Office for National Statistics

It is estimated that Plymouth's population will increase by over 17,500 by 2030. The largest increase will be seen in 90+ year olds (76.3%), whilst it is estimated there will be a 2.5% reduction in the 30-64 year old population.

Table 3: Sub-national population projections by age group, 2012 to 2030 (2014-based)

Age group	2014	2016	2020	2025	2030	% change
Under 18	51,709	52,124	53,853	55,488	55,146	6.6
18-29	52,665	53,872	53,362	52,674	55,808	6.0
30-64	111,570	111,614	111,853	110,819	108,727	-2.5
65-74	24,764	25,570	25,854	25,973	28,603	15.5
75+	20,838	21,278	23,597	28,181	30,788	47.7
90+	2,218	2,243	2,485	3,059	3,911	76.3
All ages	261,546	264,457	268,519	273,134	279,073	6.7

Source: Office for National Statistics

3.3 Protected characteristics (Equality Act 2010)

The Equality Act 2010 sets out nine personal characteristics that are protected by the law:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Under the Act, people are not allowed to discriminate, harass or victimise another person because they have any of the above protected characteristics. There is also protection against discrimination where someone is perceived to have one of the protected characteristics or where they are associated with someone who has a protected characteristic. Government departments, service providers, employers, education providers, providers of public functions, associations and membership bodies and transport providers all have a responsibility under the Act.

In the following paragraphs, the protected characteristics have been described for Plymouth at the city level (where data exists) although not necessarily in the order presented above. Where available, information at the sub-city level can be found on Plymouth City Council's JSNA webpage. The protected characteristics should be considered when examining whether or not existing pharmaceutical services provision meets need; consequently, due regard is given to these characteristics within the 'Market Entry' regulations.

3.3.1 Age

Plymouth at mid-year 2015 had an estimated population of 262,712. Due to an estimated 25,000 to 30,000 students residing in the city, the proportion of 18-24 year olds (12.8%) is higher than that found regionally (8.7%) and nationally (9.0%). The proportion of the working-age (15-64 year old) population (65.7%) is higher than that regionally (62.2%) and nationally (64.4%). The city has the same proportion of those aged 75 and over as nationally

(8.1%) but lower than the regional value of 9.8%. The proportion of children and young people (under 18) is lower in both Plymouth and regionally (19.8%) compared to nationally (19.0%).

3.3.2 Disability

According to the 2011 Census, 10.0% of Plymouth residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months (including problems related to old age). The national value was 8.3%. According to the 2011 Census, 46.0% of Plymouth residents reported their general health as 'very good'; this increased to 79.5% when also including those who reported their health as 'good'. In England 81.4% of people reported their general health as either 'very good' or 'good'. Plymouth's combined value is therefore nearly two percentage points lower than the national average.

3.3.3 Faith, religion or belief

According to the 2011 Census, Christianity is the most common religion in Plymouth (58.1% of the population). 32.9% of the Plymouth population stated they had no religion. Those following Hinduism, Buddhism, Judaism or Sikhism combined totalled less than 1.0% of the population

3.3.4 Gender - including marriage, pregnancy and maternity

Overall, 50.6% of Plymouth's population is female. According to the 2011 Census, of those aged 16 and over 90,765 (42.9%) people are married. 5,190 (2.5%) of people in Plymouth are separated and still either legally married or legally in a same-sex civil partnership. There are 464 people in a registered Same-Sex Civil Partnership in the city.

There were 3,160 live births in 2015. The West locality had the highest number of births (1,034) and the East locality the lowest (592).

3.3.5 Gender reassignment

Recent surveys have put the prevalence of transgender people between 0.5 and 1% of population (some very recent reports have upped this to 2%). Over the last eight years the prevalence of transgender people in the UK has been increasing at an average rate of over 20% per annum in adults and 50% in children. In 2015 there was a 100% increase in referrals to the Gender Identity Development Service at the Tavistock & Portman Institute. The average age for presentation for reassignment of male-to-female is 40-49 whilst for female-to-male the age group is 20-29.

There is no precise number of the trans population in Plymouth however twenty three transgender people belong to Pride in Plymouth.

3.3.6 Race

There is relatively little ethnic diversity in Plymouth. According to the 2011 Census, 92.9% of Plymouth's population identify themselves White British. This is significantly higher than the England average (79.8%). Plymouth has lower percentages of residents within each ethnic group compared with the national average. However, despite the small numbers, Plymouth has a rapidly rising BME population which has more than doubled from 7,906 individuals since the 2001 census. The main ethnic minorities in Plymouth are the Polish (0.7%; just over 1,900) and the Chinese (0.5%; just over 1,200).

Table 4: Proportion (%) of Plymouth population by ethnic group, by locality

Locality	White British	All other White	Mixed/ multiple ethnic groups	Asian/Asian British	Black/African/ Caribbean/ Black British	Other ethnic group
East	97.1	1.4	0.7	0.4	0.3	0.1
North	95.6	1.7	0.9	1.2	0.4	0.2
South	88.5	5.5	1.9	2.5	1.0	0.7
West	91.5	3.9	1.5	1.7	0.9	0.5
Plymouth	92.9	3.2	1.3	1.5	0.7	0.4

Source: Census 2011, Office for National Statistics, totals might not sum to 100.0% due to rounding

Recent census data suggests Plymouth has at least 43 main languages spoken in the city, with Polish, Chinese and Kurdish the top three. Based on full year data for 2012-13, the Translate Plymouth services recorded that the most requested languages are Polish, British Sign Language (BSL) and Chinese Mandarin.

3.3.7 Sexual orientation

There is also no precise local data on numbers of Lesbian, Gay and Bi-sexual (LGB) people in Plymouth but it is nationally estimated at 5.0% to 7.0%. This would mean that approximately 13,000 people aged 16 years and over in Plymouth are LGB.

3.4 Deprivation

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. Deprivation measures attempt to identify communities where the need for healthcare is greater, material resources are fewer and as such the capacity to cope with the consequences of ill-health are less. People are therefore deprived if there is inadequate education, inferior housing, unemployment, insufficient income, poor health, and low opportunities for enjoyment. A deprived area is conventionally understood to be a place in which people tend to be relatively poor and are relatively likely to suffer from misfortunes such as ill-health.

The English Indices of Deprivation 2015 use 37 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to

calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area. When analysing IMD data it is important to bear in mind the following:

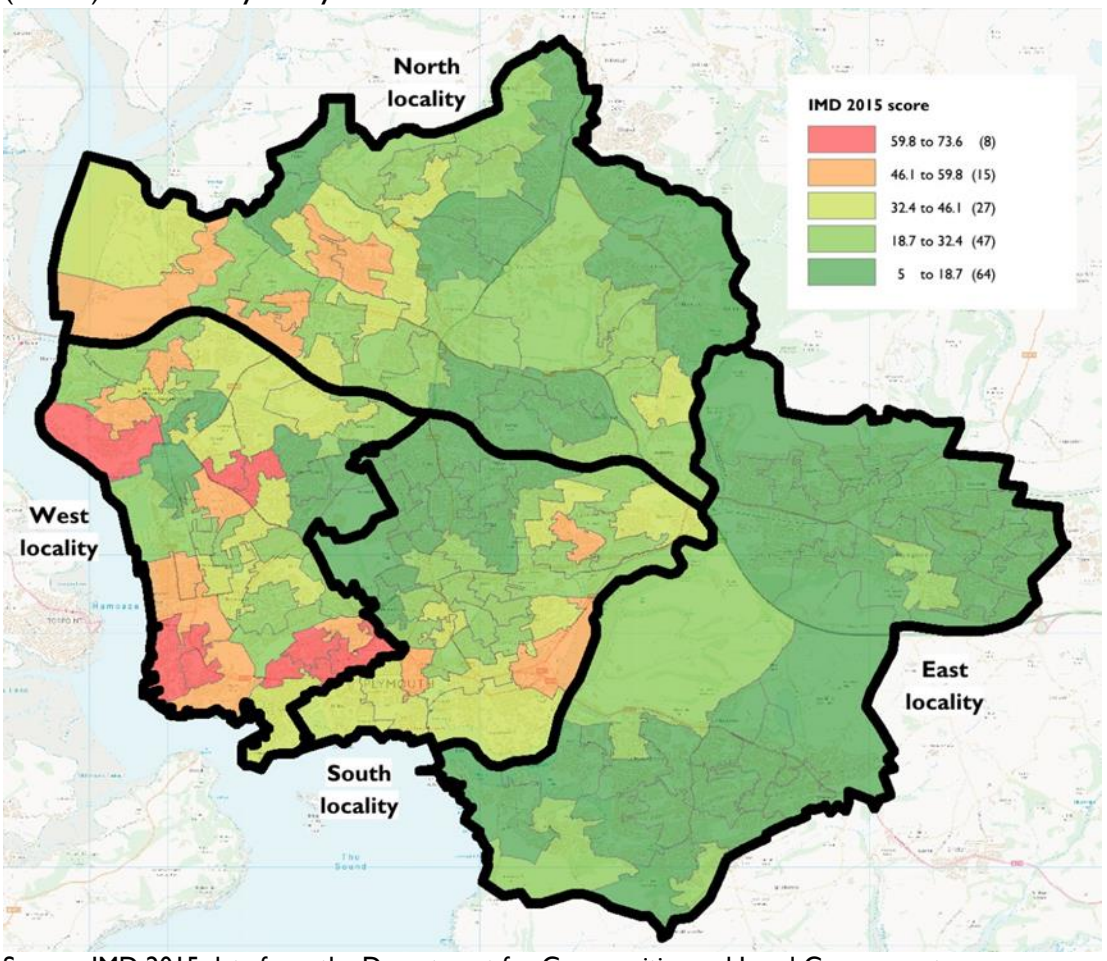
- It is not an absolute measure of deprivation.
- Not all people living in deprived areas are deprived and vice versa.
- It cannot be compared over time because an area's score is affected by the scores of every other area; so it is impossible to tell whether a change in score is a real change in the deprivation level of an area, or whether it is due to the scores of other areas going up or down.

The IMD 2015 score is calculated for every Lower Super Output Area (LSOA) in England. LSOAs are part of a geographical framework developed for the collection and publication of small area statistics. Plymouth is made up of 161 LSOAs. An LSOA typically contain a population of around 1,500.

The IMD 2015 score can be used to rank every LSOA in England according to their relative level of deprivation. Out of 32,844 LSOAs in England, Plymouth has 27 LSOAs in the 10% most deprived, eight in the 3% most deprived, and one in the 1% most deprived LSOAs in the country. Plymouth is ranked 69 out of the 326 local authority districts in England (1=most deprived; 326=least deprived). This places Plymouth in the bottom 30% of local authorities in England.

Figure 2 shows the IMD 2015 values for the 161 LSOAs in Plymouth with the boundaries of the four localities overlaid. Although it is useful to see data presented in this way, it does not show composite locality scores that can be used to identify, for example, the most or least deprived locality in the city. Therefore separate analysis has been carried out by the Public Health Team in Plymouth City Council to produce this. On the basis of this analysis, the locality with the highest score (i.e. the most deprived) is the West. The locality with the lowest score (i.e. the least deprived) is the East.

Figure 2: Index of Multiple Deprivation (IMD) 2015 scores by Lower Super Output Area (LSOA) and locality in Plymouth



Source: IMD 2015 data from the Department for Communities and Local Government
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Table 5: Index of Multiple Deprivation (IMD) 2015 score, by locality

Locality	IMD 2015 score
East	11.8
North	26.4
South	25.8
West	39.2
Plymouth	26.6

Source: Produced by the Public Health Team, Plymouth City Council, from Department for Communities and Local Government data

3.5 Car ownership

Based on the 2011 Census, car ownership in Plymouth (72.2%) is slightly below the national average (74.2%). Car ownership is unevenly distributed across the city, with the West locality having the smallest proportion of car owners per household (63.3%) and the East locality having the largest proportion (85.5%).

Table 6: Proportion (%) of car or van owners per household, by locality

Locality	No cars or vans in household	1 car or van in household	2 cars or vans in household	3 cars or vans in household	4 or more cars or vans in household	1 or more cars or vans in household
East	14.5	45.9	31.2	6.5	1.9	85.5
North	24.1	47.8	22.9	4.1	1.1	72.9
South	32.7	44.4	18.1	3.6	1.2	67.3
West	36.7	44.6	15.4	2.6	0.7	63.3
Plymouth	27.8	45.7	21.3	4.0	1.2	72.2

Source: Census 2011, Office for National Statistics

3.6 Mosaic breakdown

Mosaic is a dataset produced by Experian as a cross-channel consumer classification system designed to help users understand the demographics, lifestyles, preferences and behaviours of the UK adult population in detail. This is achieved by allocating individuals and households (by postcode) into one of 15 'Groups' and 66 detailed 'Types'. Using postcode data from the 2015 GP registration database, the top three Mosaic groups in Plymouth are:

1. M Family Basics (families with limited resources who have to budget to make ends meet) 12.7% of postcodes

2. J Rental Hubs (educated young people privately renting in urban neighbourhoods) - 12.1% of postcodes

3. L Transient Renters (single people privately renting low cost homes for the short term) - 12.0% of postcodes

However, across the localities the groups are unevenly distributed:

East (top three):

- E Suburban Stability - 27.0% (mature suburban owners living settled lives in mid-range housing)
- F Senior Security – 23.5% (elderly people with assets who are enjoying a comfortable retirement)
- H Aspiring Homemakers - 16.7% (younger households settling down in housing priced within their means)

North (top three):

- K Modest Traditions - 18.7% (mature homeowners of value homes enjoying stable lifestyles)
- M Family Basics – 17.4%
- H Aspiring Homemakers - 13.5%

South (top three):

- J Rental Hubs - 33.6%

- L Transient Renters - 12.7%
- H Aspiring Homemakers - 11.3%

West (top three):

- L Transient Renters - 21.6%
- M Family Basics - 19.8%
- Municipal Challenge - 11.0% (urban renters of social housing facing an array of challenges)

Table 7: Proportion (%) of Mosaic groups (based on individual postcodes), by locality

Mosaic group	East	North	South	West	Plymouth
A Country Living	0.1	0.0	0.0	0.0	0.0
B Prestige Positions	7.6	5.9	2.4	0.3	3.8
C City Prosperity	0.0	0.0	0.4	0.1	0.1
D Domestic Success	10.4	3.5	4.6	1.1	4.6
E Suburban Stability	27.0	8.4	3.3	2.6	9.4
F Senior Security	23.5	9.5	6.4	6.9	10.9
G Rural Reality	0.1	0.0	0.0	0.0	0.0
H Aspiring Homemakers	16.7	13.5	11.3	6.8	11.8
I Urban Cohesion	0.0	0.0	3.7	2.1	1.5
J Rental Hubs	0.8	1.1	33.6	10.9	12.1
K Modest Traditions	4.2	18.7	4.5	9.7	9.5
L Transient Renters	4.8	7.0	12.7	21.6	12.0
M Family Basics	2.1	17.4	9.0	19.8	12.7
N Vintage Value	2.8	9.4	4.7	7.3	6.2
O Municipal Challenge	0.0	5.8	3.4	11.0	5.4
Total	100.0	100.0	100.0	100.0	100.0

Source: Mosaic 2017 lookup table and 2015 GP registration database

The main Mosaic type for the city is L52 Midlife Stopgap (6.8%) (maturing singles in employment who are renting short-term affordable homes). A breakdown of type by locality is summarised below:

- East locality – E21 Family Ties – 10.8% (Active families with teenage and adult children whose prolonged support is eating up household resources)

- North locality – K48 Down-to-Earth Owners – 11.3% (Lower income owners whose adult children are still striving to gain independence meaning space is limited)

- South locality – J42 Learners & Earners – 17.9% (Inhabitants of the university fringe where students and older residents mix in cosmopolitan locations)

- West locality – M55 Families with Needs – 11.3% (Families with many children living in areas of high deprivation and who need support)

Table 8: Proportion (%) of Mosaic types (based on individual postcodes), by locality

Mosaic types	East	North	South	West	Plymouth
L52 Midlife Stopgap	4.1	1.8	9.5	11.2	6.8
J42 Learners & Earners	0.0	0.2	17.9	3.3	5.5
M55 Families with Needs	0.0	6.4	2.0	11.3	5.3
H35 Primary Ambitions	3.1	2.6	8.6	2.4	4.2
F25 Classic Grandparents	9.6	2.1	2.0	3.8	4.1
K48 Down-to-Earth Owners	0.1	11.3	1.2	2.7	4.0
M53 Budget Generations	0.7	8.2	2.9	3.6	4.0
K47 Offspring Overspill	3.1	5.0	2.5	3.5	3.5
E21 Family Ties	10.8	1.6	1.6	1.2	3.4
O63 Streetwise Singles	0.0	2.4	2.5	7.5	3.3
E20 Boomerang Boarders	9.8	4.0	0.4	0.3	3.3
F24 Bungalow Haven	8.1	5.3	0.1	0.4	3.2
H30 Affordable Fringe	4.9	4.5	0.9	2.5	3.1
J45 Bus-Route Renters	0.7	0.7	3.0	5.8	2.7
F23 Solo Retirees	3.9	1.6	2.5	2.5	2.6
J43 Student Scene	0.0	0.1	9.1	0.6	2.5
H34 Contemporary Starts	4.7	5.0	0.3	0.2	2.4
N61 Estate Veterans	0.3	5.2	0.8	2.7	2.4
L50 Renting a Room	0.0	0.0	2.7	5.7	2.3
B05 Empty-Nest Adventure	4.3	3.7	0.4	0.1	2.0
K46 Self Supporters	1.0	2.3	0.8	3.5	2.0
D16 Mid-Career Convention	6.1	2.2	0.3	0.1	2.0
L51 Make Do & Move On	0.6	4.4	0.1	2.3	1.9
M54 Childcare Squeeze	0.0	1.0	2.3	3.8	1.9
H31 First-Rung Futures	3.4	1.2	1.0	1.4	1.7
E19 Fledgling Free	3.5	2.1	0.5	0.8	1.6
O62 Low Income Workers	0.0	3.4	0.6	2.0	1.6
I39 Ageing Access	0.0	0.0	3.7	2.0	1.5
M56 Solid Economy	1.3	1.8	1.8	1.1	1.5
N57 Seasoned Survivors	0.3	2.2	0.8	2.3	1.5
D17 Thriving Independence	1.2	0.8	2.2	1.0	1.3
E18 Dependable Me	2.8	0.7	0.7	0.3	1.1
N59 Pocket Pensions	0.9	1.7	0.6	0.9	1.0
F22 Legacy Elders	1.9	0.4	1.9	0.1	1.0
L49 Disconnected Youth	0.2	0.8	0.4	2.4	1.0
J41 Central Pulse	0.0	0.1	2.8	0.9	1.0
B06 Bank of Mum and Dad	2.0	0.8	1.0	0.1	0.9
D15 Modern Parents	3.1	0.5	0.0	0.0	0.8

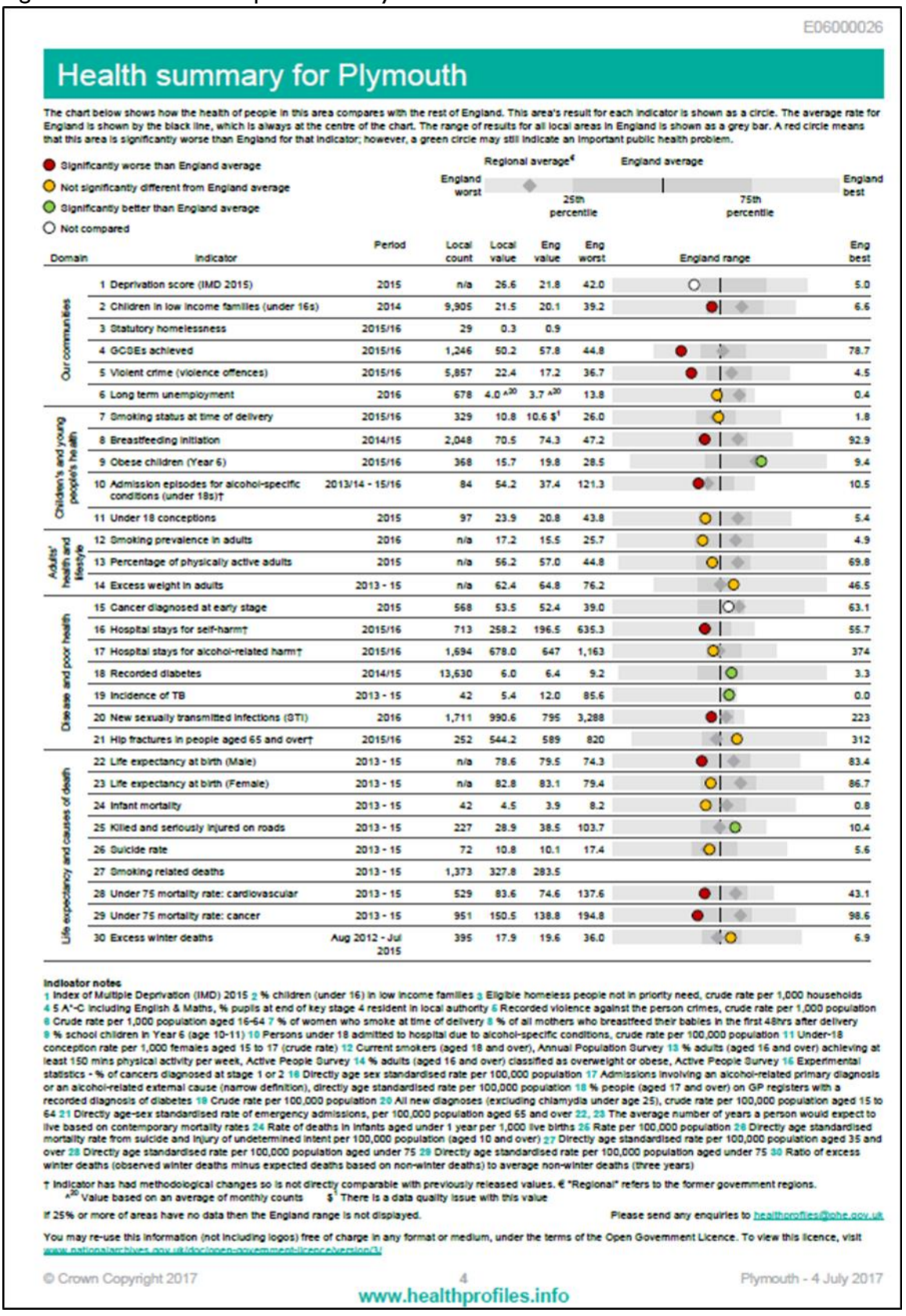
Mosaic types	East	North	South	West	Plymouth
N60 Dependent Greys	0.1	0.2	1.3	1.3	0.7
N58 Aided Elderly	1.2	0.0	1.2	0.1	0.6
D14 Cafés and Catchments	0.0	0.0	2.0	0.0	0.5
O64 High Rise Residents	0.0	0.0	0.1	1.5	0.4
B09 Diamond Days	0.2	0.6	0.9	0.1	0.4
B07 Alpha Families	1.1	0.7	0.0	0.0	0.4
J40 Career Builders	0.0	0.0	0.8	0.3	0.3
H32 Flying Solo	0.4	0.2	0.1	0.1	0.2
H33 New Foundations	0.2	0.0	0.4	0.2	0.2
C13 Uptown Elite	0.0	0.0	0.4	0.1	0.1
B08 Premium Fortunes	0.1	0.1	0.0	0.0	0.1
O66 Inner City Stalwarts	0.0	0.0	0.1	0.0	0.0
A04 Village Retirement	0.1	0.0	0.0	0.0	0.0
G29 Satellite Settlers	0.1	0.0	0.0	0.0	0.0
J44 Flexible Workforce	0.0	0.0	0.0	0.1	0.0
I37 Community Elders	0.0	0.0	0.0	0.1	0.0
Total	100.0	100.0	100.0	100.0	100.0

3.7 The Public Health England Health Profiles

The Health Profiles published by Public Health England (PHE) provide an overview of the general health of the local population. They present a set of key indicators that, through comparison with other areas and with the national average, can highlight potential problems locally. They are designed to help local government and health services identify problems and decide how to tackle them to improve health and reduce health inequalities.

3.7.1 The General Health Profile for Plymouth 2017

Figure 3: General health profile for Plymouth 2017



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Health summary for Plymouth

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

Regional average€ | England average | England worst | England best | 25th percentile | 75th percentile

Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	26.6	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	9,905	21.5	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	29	0.3	0.9			
	4	GCSEs achieved	2015/16	1,246	50.2	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	5,857	22.4	17.2	36.7		4.5
	6	Long term unemployment	2016	678	4.0 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	329	10.8	10.6 $1	26.0		1.8
	8	Breastfeeding initiation	2014/15	2,048	70.5	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	368	15.7	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	84	54.2	37.4	121.3		10.5
	11	Under 18 conceptions	2015	97	23.9	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	17.2	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	56.2	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	62.4	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	568	53.5	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	713	258.2	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	1,694	678.0	647	1,163		374
	18	Recorded diabetes	2014/15	13,630	6.0	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	42	5.4	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	1,711	990.6	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	252	544.2	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	78.6	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	82.8	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	42	4.5	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	227	28.9	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	72	10.8	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	1,373	327.8	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	529	83.6	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	951	150.5	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	395	17.9	19.6	36.0		6.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) 12 Current smokers (aged 18 and over), Annual Population Survey 13 % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey 14 % adults (aged 16 and over) classified as overweight or obese, Active People Survey 16 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 21 Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged under 1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) 27 Directly age standardised rate per 100,000 population aged 35 and over 28 Directly age standardised rate per 100,000 population aged under 75 29 Directly age standardised rate per 100,000 population aged under 75 30 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
^20 Value based on an average of monthly counts $1 There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed.

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Plymouth - 4 July 2017

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Selected indicators where Plymouth's value is 'better' than the England average:

- Obese children (Year 6)
- Recorded diabetes
- Incidence of TB
- Killed and seriously injured on the road

Selected indicators where Plymouth's value is 'worse' than the England average:

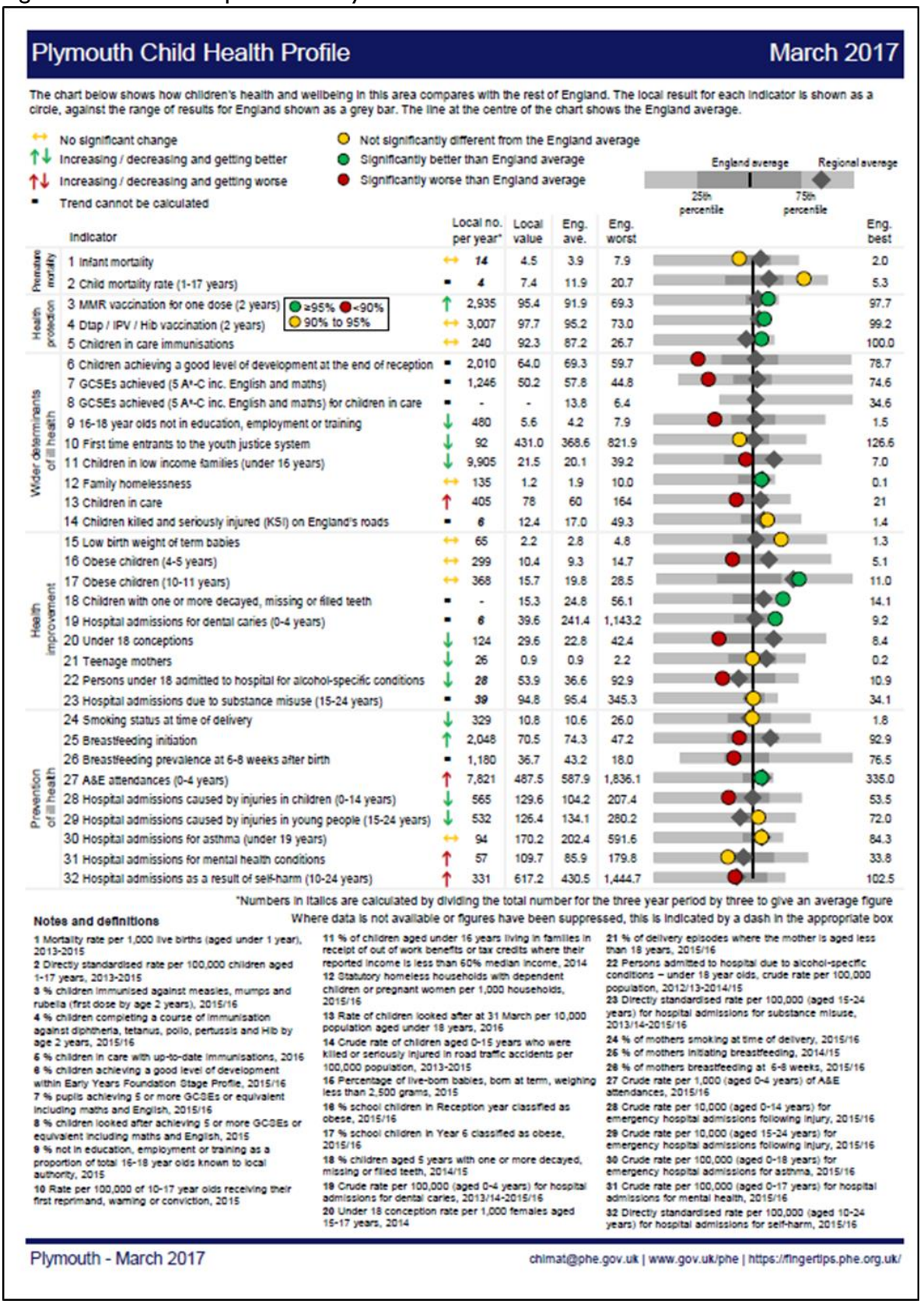
- Children (under-16) in low income families
- Breastfeeding initiation
- Alcohol-specific hospital stays (under-18)
- Hospital stays for self-harm

Selected indicators where Plymouth's value is 'not significantly different' to the England average:

- Smoking status at time of delivery
- Under 18 conceptions
- Percentage of physically active adults
- Suicide rate

3.7.2 The Child Health Profile for Plymouth 2017

Figure 4: Child health profile for Plymouth 2017



Plymouth Child Health Profile — March 2017

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

↔ No significant change
↑↓ Increasing / decreasing and getting better
↑↓ Increasing / decreasing and getting worse
▪ Trend cannot be calculated

Not significantly different from the England average
Significantly better than England average
Significantly worse than England average

England average | Regional average | 25th percentile | 75th percentile

	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↔	*14*	4.5	3.9	7.9	2.0
	2 Child mortality rate (1-17 years)	▪	*4*	7.4	11.9	20.7	5.3
Health protection	3 MMR vaccination for one dose (2 years) ● ≥95% ● <90% ● 90% to 95%	↑	2,935	95.4	91.9	69.3	97.7
	4 Dtap / IPV / Hib vaccination (2 years)	↔	3,007	97.7	95.2	73.0	99.2
	5 Children in care immunisations	↔	240	92.3	87.2	26.7	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	▪	2,010	64.0	69.3	59.7	78.7
	7 GCSEs achieved (5 A*-C inc. English and maths)	▪	1,245	50.2	57.8	44.8	74.6
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	▪	-	-	13.8	6.4	34.6
	9 16-18 year olds not in education, employment or training	↓	480	5.6	4.2	7.9	1.5
	10 First time entrants to the youth justice system	↓	92	431.0	368.6	821.9	126.6
	11 Children in low income families (under 16 years)	↓	9,905	21.5	20.1	39.2	7.0
	12 Family homelessness	↔	135	1.2	1.9	10.0	0.1
	13 Children in care	↑	405	78	60	164	21
	14 Children killed and seriously injured (KSI) on England's roads	▪	*6*	12.4	17.0	49.3	1.4
Health improvement	15 Low birth weight of term babies	↔	65	2.2	2.8	4.8	1.3
	16 Obese children (4-5 years)	↔	299	10.4	9.3	14.7	5.1
	17 Obese children (10-11 years)	↔	368	15.7	19.8	28.5	11.0
	18 Children with one or more decayed, missing or filled teeth	▪	-	15.3	24.8	56.1	14.1
	19 Hospital admissions for dental caries (0-4 years)	▪	*6*	39.6	241.4	1,143.2	9.2
	20 Under 18 conceptions	↓	124	29.6	22.8	42.4	8.4
	21 Teenage mothers	↓	26	0.9	0.9	2.2	0.2
	22 Persons under 18 admitted to hospital for alcohol-specific conditions	↓	*28*	53.9	36.6	92.9	10.9
	23 Hospital admissions due to substance misuse (15-24 years)	▪	*39*	94.8	95.4	345.3	34.1
Prevention of ill health	24 Smoking status at time of delivery	↓	329	10.8	10.6	26.0	1.8
	25 Breastfeeding initiation	↑	2,048	70.5	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	1,180	36.7	43.2	18.0	76.5
	27 A&E attendances (0-4 years)	↑	7,821	487.5	587.9	1,836.1	335.0
	28 Hospital admissions caused by injuries in children (0-14 years)	↓	565	129.6	104.2	207.4	53.5
	29 Hospital admissions caused by injuries in young people (15-24 years)	↓	532	126.4	134.1	280.2	72.0
	30 Hospital admissions for asthma (under 19 years)	↔	94	170.2	202.4	591.6	84.3
	31 Hospital admissions for mental health conditions	↑	57	109.7	85.9	179.8	33.8
	32 Hospital admissions as a result of self-harm (10-24 years)	↑	331	617.2	430.5	1,444.7	102.5

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure
Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2013-2015
2 Directly standardised rate per 100,000 children aged 1-17 years, 2013-2015
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2015/16
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2015/16
6 % children in care with up-to-date immunisations, 2016
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2015/16
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2015/16
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2015
9 % not in education, employment or training as a proportion of total 16-18 year olds known to local authority, 2015
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2015
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2014
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2015/16
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2016
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2013-2015
16 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2015
16 % school children in Reception year classified as obese, 2015/16
17 % school children in Year 6 classified as obese, 2015/16
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2014/15
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2013/14-2015/16
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2014
21 % of delivery episodes where the mother is aged less than 18 years, 2015/16
22 Persons admitted to hospital due to alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2012/13-2014/15
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2013/14-2015/16
24 % of mothers smoking at time of delivery, 2015/16
26 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2015/16
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2015/16
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2015/16
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2015/16
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2015/16
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2015/16
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2015/16

Plymouth - March 2017 — chimat@phe.gov.uk | www.gov.uk/phe | https://fingertips.phe.org.uk/

Selected indicators where Plymouth's value is 'better' than the England average:

- MMR vaccinations
- Obese children (10-11 years)
- Hospital admissions for dental caries (under 5)
- A&E attendances (under 5)
- Family homelessness

Selected indicators where Plymouth's value is 'worse' than the England average:

- Children achieving a good level of development at the end of reception
- Under 18 hospital admissions due to alcohol-specific conditions
- Under 18 conceptions
- Breastfeeding prevalence at 6-8 weeks
- Obese children (4-5 years)

Selected indicators where Plymouth's value is 'not significantly different' to the England average:

- Teenage mothers
- Road injuries and death
- Hospital admissions caused by injuries in young people (15-24 years)
- Infant deaths
- Smoking status at time of delivery

3.8 Housing growth and significant housing developments

The Joint Local Plan (JLP) is part of a ground-breaking strategic planning process for Plymouth and South West Devon which looks ahead to 2034. It sets a shared direction of travel for the long term future of the area, within the context of wider integrated strategic plans. The key purpose of the JLP is to establish an over-arching strategic framework for sustainable growth and the management of change, providing the statutory development plan for Plymouth, South Hams and West Devon.

The following information is taken from the Strategic Housing Land Availability Assessment Review (SHLAA) 2017 which forms part of the evidence to inform the recently submitted JLP. The document contains a detailed analysis of demographic market and economic drivers to identify a proposed dwelling requirement for Plymouth over the period 2014 to 2034. It produces three scenarios of population growth based on past trends and economic forecasts. Each scenario translates this into projected household growth and therefore the scale of housing required. At this stage, it is anticipated that the highest of the three growth scenarios (leading to a dwelling requirement of just under 21,000) is considered to be the Plymouth City Council's preferred forecast as it best addresses:

- The city's market and affordable housing needs
- The city's aspirations for growth in jobs
- Market signals for housing demand in and around the City

- The city's aspirations for a population in the Plymouth area of 300,000+

The Plan identifies the priority areas of the City Centre and Waterfront Regeneration areas, along with the city's Eastern and Northern corridors to accommodate housing and economic growth. Significant progress has been made in the waterfront regeneration areas (Devonport, Millbay, Stonehouse and Sutton Harbour). In the Eastern Corridor, new homes are being built at Plymstock Quarry and at Sherford (South Hams). In addition, significant progress has been made on the regeneration of North Prospect to replace and improve obsolete homes and help rebalance the local housing market. It is anticipated that there will be around 904 net dwellings per annum; highlighting significant need/demand in Plymouth for new housing.

The SHLAA identifies a deliverable land supply for the period 2014 to 2034 of approximately 13,746 dwellings within the Plymouth City boundary (Constrained Supply) and an unconstrained supply of approximately 21,584 dwellings. Additional work is still required to test more fully whether all of the sites accommodating around 13,746 new dwellings are suitable allocations in the context of the Plan. Work is also required to ascertain whether any of the constraints on sites currently not considered as part of the deliverable supply should be removed through policy changes or other interventions.

An overview of some of the major housing developments that form part of the 'deliverable supply' identified in the SHLAA on a locality basis has been provided and included in the locality summary sheets to help inform assessment of need for pharmaceutical services in the city. As mentioned previously, it is important to recognise that this excludes sites currently identified as being constrained that may well come forward during the plan period 2014 to 2034 through the gaining of planning permission:

(i) Plymouth East locality

Development at Sherford has started. Sherford is a new market town which is being built in the South Hams. This may create additional pharmaceutical needs in South Hams but the timescales and extent of this need is not yet clear. Whilst the development is not within the city's envelope, its proximity to Plympton and Plymstock has the potential to impact on service provision in this locality. It is expected that 264 houses per annum will be delivered during the period of the PNA (292 of which will be within Plymouth's boundary).

Plymstock Quarry has outline consent for up to 1,684 dwellings and 1.85 hectares of employment land, together with a new neighbourhood comprising of new community infrastructure and local centre (approved 2011). A new GP practice will open to support this development. It is important to note that this area of Plymouth is close to the Sherford development. It is estimated that a maximum of 1,364 dwellings could be built in this locality between 2016 and 2022.

(ii) Plymouth North Locality

The Plan seeks to accommodate substantial development at Derriford in a way that helps deliver decent and affordable homes, supports a diverse and inclusive community, ensures easy access to jobs and services, and creates a place where people want to live. To achieve this, together with commercial and retail facilities, significant new housing development is

identified. This will take place at a number of component sites in the North of the City. It is estimated that a maximum of 1,812 dwellings could be built in this locality between 2016 and 2022.

(iii) Plymouth South Locality

There is now a mixture of affluent and deprived populations due to development and urban regeneration of the Millbay area. A number of key housing sites have been identified for additional dwellings. It is estimated that a maximum of 1,010 dwellings could be built in this locality between 2016 and 2022.

(iv) Plymouth West Locality

Within this locality there will be approximately 500 demolitions of existing houses which will then be replaced with new build housing. It is estimated that a maximum of 1,428 dwellings could be built in this locality between 2016 and 2022.

(v) Further information

The Strategic Housing Land Availability Assessment 2017 for Plymouth can be found here:

https://www.plymouth.gov.uk/plymouthandsouthwestdevonjointlocalplanhousinglandavailabilityassessment

Information about sites in Plymouth which have been identified for potential future development can be found here:

https://www.plymouth.gov.uk/sites/default/files/PlymouthPolicyAreaHousingTrajectory.pdf

4. General health needs in Plymouth

4.1 Introduction

This chapter provides a more detailed examination of the different health needs ('cradle to grave') of the population on a locality basis. This is particularly relevant when considering whether or not pharmaceutical provision meets the needs of a local population. A table summarising the key health needs (cradle to grave) by locality is provided first. This is followed by another table which ranks the localities against each health need in terms of how well they are doing. Whilst these tables provide a helpful overview, detailed information for each health need is then presented for the remainder of the chapter.

4.2 General health needs indicators - summary

Table 9 provides a summary of key health needs/indicators (covering cradle to grave) for the Plymouth population on a locality-by-locality basis. This is followed by Table 10 which gives each locality's rank (from 1=the 'worst' performing locality to 4=the 'best' performing locality) against each health need/indicator to allow for easy comparison of health needs. This crude comparison highlights that the West and North localities have the greatest needs overall. Additional indicator information is included in the relevant following sections.

Table 9: Summary of indicators by locality (values), latest available data

Indicator	East	North	South	West	Plymouth
Births (numbers)	592	760	774	1,034	3,160
Low birth weight births (%)	3.7	7.4	6.3	6.3	6.1
Life expectancy (years)	82.8	80.8	80.1	79.2	80.7
Breastfeeding at 6-8 weeks (%)	43.0	31.2	47.8	34.8	38.7
Vulnerable families (%)	5.3	15.9	18.0	28.1	18.2
Dental extractions in children (rate per 10,000 0-16 year olds)	89.1	187.0	158.9	233.8	174.0
Childhood obesity (%)	9.9	13.2	12.4	14.7	12.8
Self-reported 'bad' or 'very bad health' (%)	5.1	7.5	5.4	7.8	6.5
Long-term health problem or disability (%)	19.4	22.9	17.0	22.0	20.4
Elective admissions (rate per 10,000 population)	1,445.8	1,536.7	1,460.1	1,520.3	1,490.2
Emergency admissions (rate per 10,000 population)	891.4	1,117.6	1,101.8	1,224.3	1,080.1
Circulatory disease mortality (all ages) (rate per 10,000 population)	26.1	25.3	24.9	29.3	26.5
Circulatory disease mortality (under 75s) (rate per 10,000 population)	4.7	8.0	8.4	11.0	8.0
Respiratory disease mortality (all ages) (rate per 10,000 population)	11.9	16.6	16.5	17.6	15.4
Respiratory disease mortality (under 75s) (rate per 10,000 population)	2.5	3.3	4.2	4.0	3.4
All-age-all-cause mortality (rate per 10,000 population)	93.2	101.7	101.2	113.7	102.3

Table 10: Summary of indicators by locality (ranking) (1='worst' value, 4='best' value) and overall rank (1='worst' performing locality, 4='best' performing locality)

Indicator	East	North	South	West
Births (1 = highest number of births)	4	3	2	1
Low birth weight births	4	1	2	2
Life expectancy	4	3	2	1
Breastfeeding at 6-8 weeks	3	1	4	2
Vulnerable families	4	3	2	1
Dental extractions in children	4	2	3	1
Childhood obesity	4	2	3	1
Self-reported 'bad' or 'very bad health'	4	2	3	1
Long-term health problem or disability	3	1	4	2
Elective admissions	4	1	3	2
Emergency admissions	4	2	3	1
Circulatory disease mortality (all ages)	2	3	4	1
Circulatory disease mortality (under 75s)	4	3	2	1
Respiratory disease mortality (all ages)	4	2	3	1
Respiratory disease mortality (under 75s)	4	3	1	2
All-age-all-cause mortality	4	2	3	1
Sum of ranks (not including births)	56	31	42	20
Overall rank (not including births)	4	2	3	1

The above indicators are now discussed in turn.

4.3 General health needs indicators

4.3.1 Births

The number of births in the city has decreased by 1.2% between 2007 and 2015. In 2015 the West locality had the highest number of births (1,034) and the East locality the lowest (592). The locality with the largest percentage increase since 2007 is the East locality (5.0%) whilst the North locality has the largest percentage decrease (-6.9%).

Table 11: Number of births by locality, 2007 to 2015

Locality	2007	2008	2009	2010	2011	2012	2013	2014	2015	% change
East	564	570	564	603	584	612	549	512	592	5.0
North	816	829	835	828	848	891	874	820	760	-6.9
South	782	769	820	744	790	785	756	734	774	-1.0
West	1,035	1,048	1,035	1,105	1,058	1,130	984	1,035	1,034	-0.1
Plymouth	3,197	3,216	3,254	3,280	3,280	3,418	3,163	3,101	3,160	-1.2

Source: ONS annual birth extracts, Office for National Statistics

4.3.2 Low birth weight births

From 2007 to 2015, the proportion of low birth weight births (<2,500 grams) in Plymouth has varied from 6.1% to 7.7%. Their distribution is unevenly spread across Plymouth, with the largest proportion in the North locality (7.4%) and the smallest proportion in the East locality (3.7%). The locality with the largest percentage point increase since 2007 is the North locality (1.0 percentage points) whilst both the South and West localities have the largest percentage point decrease (-2.6).

Table 12: Proportion (%) of low birth weight births (<2,500 grams) by locality, 2007 to 2015

Locality	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in % points
East	5.5	4.6	3.9	5.6	6.5	5.5	5.5	5.6	3.7	-1.8
North	6.4	7.5	7.2	6.1	6.7	7.1	6.9	8.2	7.4	1.0
South	8.9	6.9	5.6	7.2	7.9	9.1	8.3	6.8	6.3	-2.6
West	8.9	9.1	7.6	9.2	8.8	7.6	9.1	6.8	6.3	-2.6
Plymouth	7.7	7.3	6.3	7.3	7.6	7.5	7.7	7.0	6.1	-1.6

Source: ONS annual birth extracts, Office for National Statistic

4.3.3 Life expectancy at birth

Life expectancy at birth for the period 1991-93 was 73.3 years for males and 79.0 years for females (a 5.7 year difference). By 2013-15, life expectancy of males in the city increased to 78.6 years (an increase of 5.3 years) whilst life expectancy for females increased to 82.8 years (an increase of 3.8 years). The result of these increases is the closing of the gap between females and males from 5.7 years in 1991-93 to 4.2 years in 2013-15. In 2013-15

the North locality has the lowest life expectancy at birth (79.2 years) and the East locality the highest (82.8 years). Life expectancy has increased across all of the localities. The gap between the highest and lowest performing localities has also decreased, with a gap of 4.0 years in 2005-07 and a smaller gap of 3.6 years in 2013-15.

Table 13: Life expectancy at birth (in years) by locality, 2005-07 to 2013-15

Locality	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	Change in years
East	81.0	81.6	81.6	81.8	81.7	82.0	82.2	82.8	82.8	1.8
North	80.3	80.3	80.4	80.5	81.0	81.0	80.6	80.9	80.8	0.5
South	79.5	79.5	79.5	79.8	79.9	79.9	79.8	79.6	80.1	0.6
West	77.0	77.3	77.4	77.6	77.9	78.1	78.6	78.7	79.2	2.2
Plymouth	79.4	79.7	79.7	79.9	80.1	80.2	80.3	80.5	80.7	1.3

Source: Public Health Team, Plymouth City Council, using ONS birth and mortality extracts

4.3.4 Breastfeeding

In 2015, 38.7% of mothers were breastfeeding at the 6-8 week baby check. The locality with the lowest proportion of breastfeeding mothers was the North (31.2%), whilst the South locality had the highest proportion (47.8%). Since 2008 the proportion of mothers' breastfeeding has increased across all four localities with the East locality seeing the greatest increase (20.4 percentage points).

Table 14: Proportion (%) of mothers' breastfeeding at the 6-8 week baby check, by locality 2009 to 2015

Locality	2008	2009	2010	2011	2012	2013	2014	2015	Change in % points
East	22.6	39.2	37.8	42.0	42.7	44.2	45.5	43.0	20.4
North	17.3	27.7	27.0	29.9	27.3	31.0	32.7	31.2	14.0
South	31.2	41.4	41.9	47.9	41.3	45.6	49.2	47.8	16.6
West	22.6	28.4	31.5	33.6	25.9	30.5	29.7	34.8	12.2
Plymouth	23.1	33.3	34.0	37.5	33.0	36.6	37.6	38.7	15.5

Source: Public Health Team, Plymouth City Council, using data from Child Health Information System

4.3.5 Vulnerable families

Plymouth Health Visitors complete a 'health needs' form for every family on their caseload every two years. Information on 31 health need factors is recorded and families who experience four or more of a specific sub-set of 26 indicators are classified as 'vulnerable'. In 2016, 2,202 families (18.2%) were classified as vulnerable. The proportion of vulnerable families in the city has declined from 20.5% to 18.2% over the past 10 years. The locality that has consistently had the highest proportion of vulnerable families is the West, whilst the East has had the lowest proportions. All four localities have seen a reduction in the proportion of vulnerable families since 2006.

Table 15: Proportion (%) of vulnerable families by locality, 2006 to 2016

Locality	2006	2008	2010	2012	2014	2016	Change in % points
East	7.3	7.3	3.1	3.0	5.0	5.3	-1.9
North	20.7	16.3	10.2	12.2	12.0	15.9	-4.8
South	20.7	15.0	11.0	14.2	17.8	18.0	-2.6
West	28.5	24.4	18.9	18.7	24.3	28.1	-0.4
Plymouth	20.5	16.9	11.7	13.0	16.0	18.2	-2.3

Source: Health Visitor Caseload Survey, Public Health Team, Plymouth City Council

4.3.6 Dental extractions under general anaesthetic in children

General anaesthetic (GA) is often given to children (aged 0-16 years) undergoing tooth extractions to reduce pain and anxiety. Since 2000 this procedure has been restricted to the hospital setting. Data of the number of extractions undertaken under general anaesthetic in Plymouth children now exists for the last three financial years, 2013/14 to 2015/16, so changes over this time period in this population can be seen. The rate of dental extractions (of one or more teeth) in children aged 0-16 years in Plymouth has decreased from 178.0 per 10,000 to 174.0 per 10,000 between 2013/14 and 2015/16. The locality that has consistently had the highest rate over the same time period is the West, whilst the East has had the lowest rate. The locality with the biggest increase in rate since 2013/14 is the West, whilst the East has had the biggest decrease in rate.

Table 16: Rate (per 10,000 0-16 year olds) of dental extractions (of one or more teeth) under general anaesthetic in children, by locality, 2013/14 to 2015/16

Locality	2013/14	2014/15	2015/16	Change in rate (per 10,000 0-16 year olds)
East	104.8	115.3	89.1	-26.2
North	181.0	194.5	187.0	-7.5
South	167.3	176.8	158.9	-18.0
West	236.3	206.1	233.8	27.8
Plymouth	178.0	177.3	174.0	-3.3

Source: Public Health Team, Plymouth City Council, data from Livewell Southwest's Dental Access Centre

4.3.7 Childhood obesity

Children in Reception and Year 6 classes are weighed and measured on an annual basis as part of the National Child Measurement Programme (NCMP). Children whose BMI for their age and sex place them equal to or above the 95th centile are classified as 'obese'. The levels of childhood obesity in Plymouth have decreased from 14.2% (2008/09) to 12.8% (2015/16). In 2015/16 the West locality had the highest level of childhood obesity (14.7%) and East locality had the lowest level (9.9%). No locality has had a percentage point increase since 2008/09, whilst the East locality shows the largest percentage point decrease (-2.8) over that time.

Table 17: Proportion (%) of children classified as obese by locality, 2008/09 to 2015/16

Locality	2008 /09	2009 /10	2010 /11	2011 /12	2012 /13	2013 /14	2014 /15	2015 /16	Change in % points
East	12.7	10.5	10.8	10.3	12.7	10.0	9.7	9.9	-2.8
North	14.4	12.8	15.1	15.3	13.5	14.7	15.4	13.2	-1.2
South	14.9	10.7	12.4	14.4	12.8	13.2	13.1	12.4	-2.5
West	14.8	15.5	15.5	14.4	14.1	15.0	14.3	14.7	-0.1
Plymouth	14.2	12.7	13.7	13.7	13.4	13.4	13.4	12.8	-1.4

Source: NCMP, Public Health Team, Plymouth City Council

4.3.8 Self-reported general health – 'bad' or 'very bad health'

Based on the 2011 Census, 6.5% of Plymouth's population reported themselves to be in 'bad health' or 'very bad health'. 5.1% of the population in the East locality reported their health to be either 'bad' or 'very bad', compared to 7.8% of the population in the West locality.

Table 18: Number and proportion (%) of population self-reporting to be in 'bad health' or 'very bad health', by locality, 2011

Locality	Population number	Proportion (%)
East	2,792	5.1
North	4,869	7.5
South	3,656	5.4
West	5,379	7.8
Plymouth	16,696	6.5

Source: Census 2011, Office for National Statistics

4.3.9 Long-term health problem or disability

Based on the 2011 Census, 20.4% of Plymouth's population reported that their day-to-day activities were limited to any extent. The South locality had the smallest proportion (17.0%) whilst the North locality had the greatest proportion (22.9%).

Table 19: Proportion (%) of adult population reporting that their day-to-day activities were limited, by locality, 2011

Locality	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities limited to any extent
East	8.9	10.5	19.4
North	11.6	11.3	22.9
South	8.2	8.9	17.0
West	11.1	10.9	22.0
Plymouth	10.0	10.4	20.4

Source: Census 2011, Office for National Statistics

4.3.10 Hospital admissions – elective

The directly aged-standardised rate of elective hospital admissions per 10,000 people in Plymouth increased between 2012/13 to 2015/16. Across three of the four localities the rate of admissions has increased. The North locality has the highest rate with 1,536.7 elective admissions per 10,000 population compared to the East locality with 1,445.8 elective admissions per 10,000 population.

Table 20: Directly age-standardised rate of elective hospital admissions per 10,000 people by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	1,506.7	1,487.4	1,543.7	1,445.8	-60.9
North	1,511.3	1,539.0	1,613.0	1,536.7	25.4
South	1,379.7	1,374.4	1,420.9	1,460.1	80.4
West	1,469.8	1,502.7	1,612.9	1,520.3	50.5
Plymouth	1,461.5	1,473.5	1,546.0	1,490.2	28.7

Source: Hospital Episode Statistics (HES) data

4.3.11 Hospital admissions – emergency

The directly age-standardised rate of emergency hospital admissions per 10,000 people in Plymouth has increased between 2012/13 to 2015/16. Across the four localities, there has been a consistent increase in the rate of admissions. Emergency hospital admissions are unevenly distributed across the city, with the West locality having the highest rate of 1,224.3 emergency admissions per 10,000 population compared to the East locality with 891.4 emergency admissions per 10,000 population.

Table 21: Directly age-standardised rate of emergency hospital admissions per 10,000 people by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	867.6	865.9	870.9	891.4	23.8
North	1,085.9	1,073.4	1,100.5	1,117.6	31.7
South	1,031.8	1,006.8	1,093.8	1,101.8	70.0
West	1,182.0	1,198.0	1,252.9	1,224.3	42.3
Plymouth	1,040.1	1,037.0	1,077.3	1,080.1	40.0

Source: HES data

4.3.12 Circulatory disease mortality

The directly age-standardised rate of mortality from circulatory diseases for persons of all ages (per 10,000 population) has fallen in Plymouth since 2005, from 40.3 deaths per 10,000 population to the current 2015 rate of 26.5 deaths per 10,000 population. The rate has decreased across all localities. The South locality has the lowest rate (24.9 deaths per 10,000

population) compared to the West locality which has the highest (29.3 deaths per 10,000 population).

Table 22: Directly age-standardised rate of circulatory disease mortality (all ages) per 10,000 population by locality, 2005 to 2015

Locality	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in rate
East	38.9	34.0	33.0	30.3	30.4	26.7	24.4	24.4	20.4	22.8	26.1	-12.8
North	36.9	34.3	35.2	34.3	32.5	31.1	27.3	29.7	29.1	25.3	25.3	-11.6
South	36.2	41.7	37.1	36.8	33.8	30.8	31.1	29.9	30.5	31.2	24.9	-11.3
West	49.7	43.6	42.2	38.5	40.3	40.9	33.4	33.2	32.1	33.5	29.3	-20.4
Plymouth	40.3	38.3	36.8	34.9	34.1	32.0	28.7	29.2	27.6	27.9	26.5	-13.8

Source: Primary Care Mortality Database & ONS Annual Mortality extract

The directly age-standardised rate of mortality from circulatory diseases for persons under 75s (per 10,000 population) has fallen in Plymouth since 2005, from 12.8 deaths per 10,000 population to the current 2015 rate of 8.0 deaths per 10,000 population. The rate has decreased across all localities. The East locality has the lowest rate (4.7 deaths per 10,000 population) compared to the West locality which has the highest (11.0 deaths per 10,000 population).

Table 23: Directly age-standardised rate of circulatory disease mortality (under 75s) per 10,000 population by locality, 2005 to 2015

Locality	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in rate
East	10.0	7.3	5.9	4.6	6.2	5.2	4.4	5.6	4.3	4.9	4.7	-5.3
North	11.9	9.9	10.1	11.1	8.6	9.4	7.1	7.0	9.9	7.3	8.0	-3.9
South	10.8	12.1	11.1	14.3	13.3	10.4	8.3	11.4	10.4	7.7	8.4	-2.4
West	18.4	15.7	13.7	15.7	14.5	12.7	11.1	12.8	11.4	12.2	11.0	-7.4
Plymouth	12.8	11.0	10.1	11.2	10.4	9.3	7.6	9.0	8.9	8.0	8.0	-4.7

Source: Primary Care Mortality Database & ONS Annual Mortality extract

4.3.13 Respiratory disease mortality

The directly age-standardised rate of mortality from respiratory diseases for persons of all ages (per 10,000 population) has fallen in Plymouth since 2005, from 16.7 deaths per 10,000 population to the current 2015 rate of 15.4 deaths per 10,000 population. The rate has decreased across three of the four localities. The East locality has the lowest rate (11.9 deaths per 10,000 population) compared to the West locality which has the highest (17.6 deaths per 10,000 population).

Table 24: Directly age-standardised rate of respiratory disease mortality (all ages) per 10,000 population by locality, 2005 to 2015

Locality	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in rate
East	16.2	13.3	11.0	15.7	15.3	12.3	15.4	12.8	11.6	9.6	11.9	-4.3
North	12.6	11.2	12.0	14.9	17.1	16.1	14.7	14.4	14.4	10.9	16.6	3.9
South	17.8	15.9	14.9	15.4	15.1	14.9	13.8	16.6	15.7	14.9	16.5	-1.3
West	20.4	19.6	17.9	18.0	21.0	21.4	16.1	22.0	17.0	14.8	17.6	-2.8
Plymouth	16.7	14.9	14.0	15.9	17.0	15.9	15.0	16.2	14.7	12.5	15.4	-1.3

Source: Primary Care Mortality Database & ONS Annual Mortality extract

The directly age-standardised rate of mortality from respiratory diseases for persons under 75s (per 10,000 population) has fallen in Plymouth since 2005, from 4.1 deaths per 10,000 population to the current 2015 rate of 3.4 deaths per 10,000 population. The rate has decreased across all localities. The East locality has the lowest rate (2.5 deaths per 10,000 population) compared to the South locality which has the highest (4.2 deaths per 10,000 population).

Table 25: Directly age-standardised rate of respiratory disease mortality (under 75s) per 10,000 population by locality, 2005 to 2015

Locality	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in rate
East	3.4	1.7	2.1	2.7	2.6	2.5	3.6	3.2	1.1	1.8	2.5	-1.0
North	3.6	4.6	2.6	3.7	4.5	3.7	3.6	3.7	2.9	3.3	3.3	-0.3
South	4.5	5.1	2.8	3.8	3.3	3.1	3.7	4.5	3.3	3.8	4.2	-0.3
West	5.1	5.7	5.6	3.8	3.9	5.2	4.8	7.0	4.6	3.9	4.0	-1.1
Plymouth	4.1	4.2	3.2	3.5	3.6	3.6	3.9	4.5	3.0	3.2	3.4	-0.7

Source: Primary Care Mortality Database & ONS Annual Mortality extract

4.3.14 All-age-all-cause mortality

The directly age-standardised rate of mortality from all causes for persons of all ages (per 10,000 population) has fallen in Plymouth since 2005, from 115.8 deaths per 10,000 population to the current rate of 102.3 deaths per 10,000 population. The rate has decreased across three of the four localities. The East locality has the lowest rate (93.2 deaths per 10,000 population) compared to the West locality which has the highest (113.7 deaths per 10,000 population).

Table 26: Directly age-standardised mortality rates (all ages) by locality, 2005 to 2015

Locality	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in rate
East	112.5	101.9	99.2	97.7	104.5	94.4	93.6	93.5	87.8	80.2	93.2	-19.3
North	101.7	101.4	103.3	107.2	102.9	101.5	93.3	107.0	103.9	88.7	101.7	0.0
South	113.6	114.0	112.6	110.8	109.0	102.6	102.8	110.4	109.5	111.6	101.2	-12.4
West	135.7	129.8	131.4	120.3	127.4	136.1	114.0	122.6	114.7	111.0	113.7	-21.9
Plymouth	115.8	111.7	111.2	108.6	110.6	107.7	100.5	108.2	103.5	96.8	102.3	-13.5

Source: Primary Care Mortality Database & ONS Annual Mortality extract

5. Health needs that can be influenced by pharmaceutical services

5.1 Introduction

Everyone will at some stage require prescriptions to be dispensed irrespective of whether or not they are in one of the groups identified in section 4. This may be for a one-off course of antibiotics or for medication that they will need to take, or an appliance that they will need to use, for the rest of their life in order to manage a long term condition. This health need can only be met within primary care by the provision of pharmaceutical services, be that by pharmacies, DACs or dispensing doctors.

Coupled with this is the safe collection and disposal of unwanted or out of date dispensed drugs. Both NHS England and pharmacies have a duty to ensure that people living at home, in a children's home or in a residential care home can return unwanted or out of date dispensed drugs for their safe disposal. Many of the pharmacies in Plymouth will offer a collection and delivery service on a private basis.

Distance selling pharmacies are required to deliver all dispensed items and this will clearly be of benefit to people who are unable to access a pharmacy. As noted earlier DACs tend to operate in the same way and this is evidenced by the fact that the vast majority of items dispensed by DACs were dispensed at premises some considerable distance from Plymouth.

This chapter provides a more detailed examination of the different health needs of the population on a locality basis but with regards to public health indicators that can be influenced by pharmaceutical services. This is particularly relevant when considering whether pharmaceutical provision meets the needs of a local population. Examples of how pharmaceutical services can influence the health and wellbeing of the population include:

Mental health
As well as supply medicines for the treatment of mental health problems, pharmacies can can provide accessible and comprehensive information and advice to carers about what help and support is available to them. This is part of the signposting essential service.

Smoking
Smoking cessation is commissioned as a locally commissioned service and pharmacies are just one of several providers of this service. As smoking cessation is commissioned by the council, it is not envisaged that within the lifetime of this PNA there is or will be a need for it to be commissioned as part of pharmaceutical services.

Long term conditions
In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues relating to many long term conditions as part of the essential services they provide:

- Where a person presents a prescription, and they appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), smoke or are overweight, the pharmacy is required to give appropriate advice with the aim of

increasing that person's knowledge and understanding of the health issues which are relevant to their circumstances.

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England and could include long term conditions.

- Signposting people using the pharmacy to other providers of services or support.

- Provision of the four advanced services will also assist people to manage their long term conditions in order to maximise their quality of life.

5.2 Health needs related to pharmaceutical services - summary

As outlined above, Table 27 provides an overview of the public health indicators on a locality-by-locality basis. This is followed by Table 28 which gives each locality's rank (from 1=the 'worst' performing locality to 4=the 'best' performing locality) against each indicator to allow for easy comparison of health needs. This crude comparison highlights that the South and West localities have the greatest needs overall.

Table 27: Summary of indicators by locality (values)

Indicator	East	North	South	West	Plymouth
Teenage pregnancy (rate per 1,000 women)	13.7	23.8	27.7	34.0	25.3
Smoking in pregnancy (%)	8.0	17.1	14.1	20.2	15.9
Parents who smoke (%)	6.0	17.5	13.5	25.8	17.0
Parents who misuse drugs (%)	1.0	2.0	2.9	3.9	2.6
Parents who misuse alcohol (%)	1.0	1.7	2.2	2.8	2.0
Depressed/mentally ill parents (%)	10.5	13.0	14.5	19.1	14.8
Social isolation (%)	1.7	4.5	11.3	8.6	6.7
Accident admissions (0-4 year olds) (rate per 1,000 population)	14.9	18.0	20.4	20.5	18.7
Accident admissions (5- 14 year olds) (rate per 1,000 population)	7.5	9.8	8.1	10.5	9.1
Accident admissions (15-24 year olds) (rate per 1,000 population)	11.4	16.6	8.8	17.1	12.6
Emergency circulatory admissions (all ages) (rate per 10,000 population)	81.1	111.7	104.6	112.3	102.7
Emergency circulatory admissions (under 75s) (rate per 10,000 population)	42.7	65.4	64.4	75.0	62.0
Admissions from falls (65 years and over) (rate per 10,000 population)	178.5	166.9	217.0	210.5	191.9
Admissions from falls (75 years and over) (rate per 10,000 population)	312.1	259.8	391.2	334.3	321.4
Substance misuse (rate per 10,000 population)	20.3	46.0	79.7	120.2	77.7
Self-harm admissions (rate per 10,000 population)	13.5	27.1	25.2	35.4	25.8
Smoking status (GP referrals) (%)	10.3	16.2	17.3	21.6	16.7
Adult obesity (GP referrals) (%)	30.3	36.9	30.4	36.0	33.7
High blood pressure (GP referrals) (%)	14.5	17.0	14.0	14.9	15.2
One or more risk factors (smoking, obesity, high blood pressure) (%)	46.5	56.5	51.0	57.9	53.4
Incidences of melanoma (rate per 100,000 population)	45.4	37.8	35.3	24.8	-
Cancer mortality (under 75s) (rate per 10,000 population)	11.3	18.0	13.8	15.6	14.8

Table 28: Summary of indicators by locality (ranking) (1 = 'worst' value, 4 = 'best' value) and overall rank (1 = 'worst' performing locality, 4 = 'best' performing locality)

Indicator	East	North	South	West
Teenage pregnancy	4	3	2	1
Smoking in pregnancy	4	2	3	1
Parents who smoke	4	2	3	1
Parents who misuse drugs	4	3	2	1
Parents who misuse alcohol	4	3	2	1
Depressed/mentally ill parents	4	3	2	1
Social isolation	4	3	1	2
Accident admissions (0-4 year olds)	4	3	2	1
Accident admissions (5-14 year olds)	4	2	3	1
Accident admissions (15-24 year olds)	3	2	4	1
Emergency circulatory admissions (all ages)	4	2	3	1
Emergency circulatory admissions (under 75s)	4	2	3	1
Admissions from falls (65 and over)	3	4	1	2
Admissions from falls (75 and over)	3	4	1	2
Substance misuse	4	3	2	1
Self-harm admissions	4	2	3	1
Smoking status (GP referrals)	4	3	2	1
Adult obesity (GP referrals)	4	1	3	2
High blood pressure (GP referrals)	3	1	4	2
One or more risk factors (smoking, obesity, high blood pressure)	4	2	3	1
Incidences of melanoma	1	2	3	4
Cancer mortality (under 75)	4	1	3	2
Sum of Ranks	81	53	55	31

The indicators are now discussed in turn.

5.3 Health needs related to pharmaceutical services

5.3.1 Teenage pregnancy

Information regarding Plymouth's teenage conception rate at the locality level is not available nationally and is therefore obtained via Plymouth Hospitals NHS Trust. As a consequence, direct comparisons with national statistics are not possible but local data provide a useful proxy. In 2016, Plymouth's conception rate was 25.3 per 1,000 women aged 15-17 years. Conception rates vary considerably across the city with the West locality having the highest rate (except in 2011 and 2014). The area with the lowest rate in 2016 was the East locality. All areas have seen a decrease in conception rate since 2007.

Table 29: Teenage conception rate per 1,000 women aged 15-17 years by locality, 2007 to 2016

Locality	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Change in rate
East	26.2	19.0	27.5	25.7	18.9	16.1	18.7	20.0	16.0	13.7	-12.5
North	51.3	47.3	52.1	43.1	37.4	32.6	34.5	23.4	24.2	23.8	-27.5
South	65.1	66.9	47.3	43.0	62.6	46.0	32.0	46.6	32.1	27.7	-37.4
West	73.1	76.9	75.9	65.4	57.0	68.1	53.6	44.0	37.3	34.0	-39.1
Plymouth	54.8	54.0	52.1	45.2	43.9	41.1	35.5	33.5	27.8	25.3	-29.5

Source: Plymouth Hospitals NHS Trust

5.3.2 Smoking in pregnancy

In 2016, 15.9% of mothers reported that they were smoking at the time of delivery. This equates to a reduction of 4.4 percentage points since 2008. The proportion of mothers smoking in pregnancy is unevenly distributed across the city, with the highest proportion found in the West locality (20.2%) and the lowest proportion in the East (8.0%). The proportion of mothers smoking in pregnancy has fallen across all four localities.

Table 30: Proportion (%) of all mothers who smoke in pregnancy by locality, 2008 to 2016

Locality	2008	2009	2010	2011	2012	2013	2014	2015	2016	Change in % points
East	10.9	9.8	9.3	8.1	8.3	7.8	4.8	5.9	8.0	-2.9
North	23.5	20.5	20.4	18.6	14.3	17.5	17.5	16.4	17.1	-6.3
South	15.9	16.3	15.4	16.4	13.9	13.6	13.6	15.5	14.1	-1.8
West	25.6	26.6	23.5	28.1	25.1	21.5	21.5	20.8	20.2	-5.4
Plymouth	20.2	19.6	18.2	19.3	16.7	16.1	16.1	15.6	15.9	-4.4

Source: Plymouth Hospitals NHS Trust

5.3.3 Parents who smoke

According to the 2016 survey of health visitor caseloads, 17.0% of parents with children aged less than five years currently smoke. This represents a reduction of 11.8 percentage

points since 2006. The distribution of parents who smoke is uneven across the city with the highest percentage found in the West locality (25.8%) and the lowest percentage found in the East (6.0%). Since 2006 the North locality has reduced by 14.2 percentage points compared to the West reducing by 10.0 percentage points.

Table 31: Proportion (%) of parent(s) who smoke by locality, 2006 to 2016

Locality	2006	2008	2010	2012	2014	2016	Change in % points
East	17.2	17.2	19.1	17.3	12.0	6.0	-11.2
North	31.7	27.5	30.7	30.2	24.9	17.5	-14.2
South	25.6	26.0	25.2	26.7	26.9	13.5	-12.1
West	35.8	37.7	34.7	35.7	35.1	25.8	-10.0
Plymouth	28.8	28.5	28.4	28.8	26.2	17.0	-11.8

Source: Health Visitor Caseload Survey, Public Health Team, Plymouth City Council

5.3.4 Parents who misuse drugs

The survey of health visitor caseloads suggests that a small proportion of parents with young children (2.6% in 2016) misuse drugs and that this has increased slightly since 2006. In 2016, the distribution across the city was uneven; from a low of 1.0% in the East locality to a high of 3.9% in the West. Three of the four localities have had a percentage point increase in parents misusing drugs since 2006; the North has had a reduction of 0.6 percentage points. Anecdotal evidence from the Public Health Team, Plymouth City Council, suggests that these figures may underreport the true position and so the data should be interpreted with caution.

Table 32: Proportion (%) of parent(s) who misuse drugs by locality, 2006 to 2016

Locality	2006	2008	2010	2012	2014	2016	Change in % points
East	0.5	0.7	0.5	0.4	0.8	1.0	0.5
North	2.6	2.2	1.6	2.2	2.8	2.0	-0.6
South	2.1	2.1	1.7	1.2	2.3	2.9	0.8
West	3.1	2.4	2.7	3.3	3.8	3.9	0.8
Plymouth	2.2	2.0	1.8	2.0	2.7	2.6	0.4

Source: Health Visitor Caseload Survey, Public Health Team, Plymouth City Council

5.3.5 Parents who misuse alcohol

The survey of health visitor caseloads suggests that a small proportion of parents with young children misuse alcohol (2.0% in 2016) and that this proportion has increased slightly from 2006. In 2016, the distribution across the city was uneven; from a low of 1.0% in the East locality to a high of 2.8% in the West. Three of the four localities have had a percentage point increase in parents misusing alcohol since 2006; the North has had a reduction of 0.2 percentage points. Anecdotal evidence from the Public Health Team, Plymouth City Council,

suggests that these figures may underreport the true position and so the data should be interpreted with caution.

Table 33: Proportion (%) of parent(s) who misuse alcohol by locality, 2006 to 2016

Locality	2006	2008	2010	2012	2014	2016	Change in % points
East	0.6	1.1	0.4	0.6	0.7	1.0	0.4
North	1.9	2.6	1.4	2.0	1.8	1.7	-0.2
South	1.4	1.4	1.4	1.5	1.8	2.2	0.8
West	2.8	1.6	2.7	2.3	2.9	2.8	0.0
Plymouth	1.8	1.7	1.6	1.7	2.0	2.0	0.2

Source: Health Visitor Caseload Survey, Public Health Team, Plymouth City Council

5.3.6 Depressed or mentally ill parents

The survey of health visitor caseloads suggests that 14.8% of parents with young children were considered to be depressed or mentally ill in 2016; a reduction of 1.3 percentage points since 2006. In 2016, the distribution across the city was uneven; from a low of 10.5% in the East locality to a high of 19.1% in the West. Three of the four localities have had a percentage point reduction in depressed or mentally ill parents since 2006; the West has had an increase of 0.6 percentage points.

Table 34: Proportion (%) of parent(s) who are depressed or mentally ill by locality, 2006 to 2016

Locality	2006	2008	2010	2012	2014	2016	Change in % points
East	11.1	12.2	6.2	7.3	12.0	10.5	-0.6
North	17.5	15.1	6.9	9.6	14.1	13.0	-4.5
South	15.6	11.2	8.3	9.4	15.3	14.5	-1.1
West	18.5	14.3	13.3	11.9	16.6	19.1	0.6
Plymouth	16.1	13.4	9.1	9.9	14.8	14.8	-1.3

Source: Health Visitor Caseload Survey, Public Health Team, Plymouth City Council

5.3.7 Social isolation within families

Social isolation has been shown repeatedly to prospectively predict mortality and serious morbidity both in general population samples and in individuals with established morbidity, especially coronary heart disease. The survey of health visitor caseloads suggests that 6.7% of parents with young children were considered to be socially isolated in 2016; an increase of 0.7 percentage points since 2006. In 2016, the distribution across the city was uneven; from a low of 1.7% in the East locality to a high of 11.3% in the South. The locality with the largest percentage point reduction since 2006 was the North; the South had an increase of 5.4 percentage points.

Table 35: Proportion (%) of parents who are considered socially isolated by locality, 2006 to 2016

Locality	2006	2008	2010	2012	2014	2016	Change in % points
East	1.5	1.9	2.5	3.9	2.8	1.7	0.2
North	6.2	8.4	4.9	4.7	3.0	4.5	-1.7
South	5.9	4.0	3.6	5.3	6.8	11.3	5.4
West	8.7	8.2	5.4	4.7	7.5	8.6	-0.1
Plymouth	6.0	6.1	4.3	4.7	5.3	6.7	0.7

Source: Health Visitor Caseload Survey, Public Health Team, Plymouth City Council

5.3.8 Emergency admissions in children and young people (unintentional and deliberate injuries)

The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 0-4 years per 1,000 population has decreased by 2.3 from 2012/13 to 2015/16. The rate of admissions is unevenly distributed across the city, with the West locality having a rate of 20.5 per 1,000 population in 2015/16 compared to East locality with a rate of 14.9 per 1,000 population.

Table 36: Crude rate of emergency admissions for unintentional and deliberate injuries in 0-4 year olds per 1,000 population aged 0-4 years by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	18.1	14.2	16.4	14.9	-3.2
North	18.4	20.8	21.1	18.0	-0.4
South	22.7	22.7	23.5	20.4	-2.4
West	23.7	26.5	21.4	20.5	-3.2
Plymouth	21.0	21.7	20.8	18.7	-2.3

Source: Hospital Episode Statistics (HES) data

The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 5-14 years has decreased by 2.1 from 2012/13 to 2015/16. The rate of admissions is unevenly distributed across the city, with the West locality having a rate of 10.5 per 1,000 population in 2015/16 compared to the East locality with a rate of 7.5 per 1,000 population.

Table 37: Crude rate of emergency admissions for unintentional and deliberate injuries in 5-14 year olds per 1,000 population aged 5-14 years by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	8.3	5.5	6.7	7.5	-0.8
North	13.8	11.0	10.7	9.8	-4.1
South	11.1	9.3	11.3	8.1	-3.0
West	11.1	11.4	10.9	10.5	-0.6
Plymouth	11.2	9.5	10.0	9.1	-2.1

Source: HES data

The crude rate of emergency admissions for unintentional and deliberate injuries in children and young people aged 15-24 years has decreased slightly by 0.1 from 2012/13 to 2015/16. The rate of admissions is unevenly distributed across the city with the West locality having a rate of 17.1 per 10,000 population in 2015/16 compared to the South locality with a rate of 8.8 per 10,000 population.

Table 38: Crude rate of emergency admissions for unintentional and deliberate injuries in 15-24 year olds per 1,000 population aged 15-24 years by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	10.6	9.7	9.6	11.4	0.8
North	15.4	11.8	14.8	16.6	1.2
South	10.6	7.9	7.7	8.8	-1.8
West	15.3	16.2	16.4	17.1	1.8
Plymouth	12.7	10.9	11.4	12.6	-0.1

Source: HES data

5.3.9 Emergency admissions for circulatory diseases

The hospital admission rate for circulatory diseases has decreased by 6.0 per 10,000 population since 2012/13. The West locality has the highest rate of admissions (112.3 per 10,000 population) compared to the East locality (81.1 per 10,000 population).

Table 39: Directly age-standardised rate of hospital admissions for circulatory diseases (all ages) per 10,000 population by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	87.0	88.4	89.1	81.1	-5.9
North	119.8	104.9	100.4	111.7	-8.0
South	112.6	100.0	103.1	104.6	-8.0
West	115.7	116.4	111.6	112.3	-3.4
Plymouth	108.7	102.6	101.0	102.7	-6.0

Source: HES data

The rate of hospital admissions for circulatory diseases in the under 75s has decreased by 2.7 per 10,000 population since 2012/13. The West locality has the highest rate of hospital admissions (75.0 per 10,000 population) compared to the East locality which has the lowest rate (42.7 per 10,000 population).

Table 40: Directly age-standardised rate of hospital admissions for circulatory diseases (in the under 75s) per 10,000 population by locality, 2013/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	46.4	46.3	51.1	42.7	-3.7
North	66.7	61.7	63.4	65.4	-1.3
South	68.7	62.9	63.1	64.4	-4.3
West	78.2	72.2	68.9	75.0	-3.2
Plymouth	64.7	60.9	61.7	62.0	-2.7

Source: HES data

5.3.10 Hospital admissions for falls in adults aged 65 and over

The rate of hospital admissions for falls in adults aged ≥65 decreased by 23.0 per 10,000 population from 2012/13 to 2015/16. All four localities have seen a decrease in the rate of admissions due to falls since 2012/13. In 2015/16, the South locality had the highest rate of admissions (217.0 per 10,000 population) compared to the North locality which had the lowest rate (166.9 per 10,000 population).

Table 41: Directly age-standardised rate of hospital admissions for falls in adults aged >65 years per 10,000 population by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	180.4	202.2	185.3	178.5	-1.8
North	195.3	196.7	183.6	166.9	-28.3
South	258.1	248.2	241.8	217.0	-41.1
West	236.8	245.7	212.6	210.5	-26.3
Plymouth	214.9	220.1	202.8	191.9	-23.0

Source: HES data

During the period 2012/13 to 2015/16, the rate of hospital admissions for falls in adults aged ≥75 decreased in Plymouth by 48.5 per 10,000 population. All four localities have seen a decrease in the rate of admissions since 2012/13. In 2015/16 the South locality had the highest rate of admissions (391.2 per 10,000 population), compared to the North locality which had the lowest rate (259.8 per 10,000 population).

Table 42: Directly age-standardised rate of hospital admissions for falls in adults aged >75 per 10,000 population by locality, 2012/13 to 2015/16

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	318.8	378.5	323.7	312.1	-6.7
North	331.6	340.3	316.2	259.8	-71.8
South	450.9	421.0	416.9	391.2	-59.7
West	394.6	384.2	355.1	334.3	-60.4
Plymouth	369.9	378.1	348.7	321.4	-48.5

Source: HES data

5.3.11 Alcohol-related hospital admissions (all ages)

The rate of alcohol-related hospital admissions in Plymouth has decreased since 2010/11.

Table 43: Directly age-standardised rate of alcohol-related hospital admissions per 100,000 population for Plymouth (standardised to the European standard population 2013), 2010-11 to 2015-16

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Plymouth	712	699	708	665	671	678

Source: Local Alcohol Profiles for England (PHE)

5.3.12 Substance misuse (all ages)

Substance misuse is recorded by agencies commissioned by the Office of the Director of Public Health, Plymouth City Council. In 2016/17, substance misuse was unevenly distributed across the city with the highest rate of clients living in the West locality (120.2 per 10,000 population) and the lowest rate of clients living in the East locality (20.3 per 10,000 population).

Table 44: Number and crude rate per 10,000 population of clients (all ages) in treatment by locality, 2016/17

Locality	Number (2016/17)	Population (2015)	Crude rate per 10,000 population
East	112	55,095	20.3
North	307	66,670	46.0
South	549	68,919	79.7
West	866	72,028	120.2
Unknown	206	N/A	N/A
Plymouth	2,040	262,712	77.7

Source: HALO, data extracted May 2017

5.3.13 Hospital admissions for self-harm

The rate of hospital admissions for self-harm has increased in Plymouth by 3.0 since 2012/13. For 2015/16, admissions were unevenly distributed across the city, with the West locality having the highest rate of admissions (35.4 per 10,000 population) compared to the East locality which had the lowest (13.5 per 10,000 population).

Table 45: Directly age-standardised rate of hospital admissions for self-harm per 10,000 population by locality and year

Locality	2012/13	2013/14	2014/15	2015/16	Change in rate
East	13.6	11.7	14.8	13.5	-0.2
North	21.4	20.8	24.5	27.1	5.7
South	24.5	21.8	25.5	25.2	0.7
West	29.7	30.9	31.6	35.4	5.7
Plymouth	22.8	21.9	24.5	25.8	3.0

Source: HES data

5.3.14 Estimates of population with specific mental health problems

The number of males and females with specific mental health problems (common mental disorder, borderline personality disorder, antisocial personality disorder, psychotic disorder and two or more psychiatric disorders) is expected to increase, with females predicted to have a higher prevalence than males by 2035.

Table 46: Projected population aged 18-64, with specific mental health problems by gender, 2017 to 2035

		2017	2020	2025	2030	2035
Males predicted to have …	a common mental disorder	10,525	10,525	10,438	10,563	10,600
	a borderline personality disorder	253	253	251	254	254
	an antisocial personality disorder	505	505	501	507	509
	psychotic disorder	253	253	251	254	254
	two or more psychiatric disorders	5,810	5,810	5,762	5,831	5,851
Females predicted to have …	a common mental disorder	16,056	15,918	15,760	15,740	15,602
	a borderline personality	489	485	480	479	475
	an antisocial personality disorder	82	81	80	80	79
	psychotic disorder	408	404	400	400	396
	two or more psychiatric disorders	6,113	6,060	6,000	5,993	5,940

Source: Projecting Adult Needs and Service Information (PANSI)

5.3.15 Dementia

The estimated number of people with dementia in Plymouth is predicted to increase in all age groups over 65 by 2035.

Table 47: Projected Plymouth population with dementia by age group, 2017 to 2035

Number predicted to have dementia	2017	2020	2025	2030	2035
Aged 65-69	168	156	178	190	188
Aged 70-74	345	364	322	365	394
Aged 75-79	510	566	702	632	710
Aged 80-84	791	848	963	1,201	1,107
Aged 85-89	822	878	995	1,167	1,500
Aged 90 and over	684	742	887	1,180	1,473
Total population aged 65 and over	3,319	3,554	4,046	4,735	5,373

Source: Projecting Older People Population Information (POPPI)

The younger age groups (30-64 year olds) are not predicted to change very much over time.

Table 48: Projected Plymouth population with early onset dementia by age group and gender, 2017 to 2035

Number predicted to have early onset dementia	2017	2020	2025	2030	2035
Males aged 30-39	1	1	1	1	1
Males aged 40-49	3	3	3	3	3
Males aged 50-59	20	20	19	17	16
Males aged 60-64	14	15	16	15	13
Total males aged 30-64	38	39	38	36	34
Females aged 30-39	2	2	2	1	1
Females aged 40-49	4	4	3	4	4
Females aged 50-59	13	13	13	11	11
Females aged 60-64	8	9	10	10	9
Total females aged 30-64	26	27	27	26	25

Source: Projecting Adult Needs and Service Information (PANSI)

5.3.16 Long-term conditions (diabetes, circulatory diseases, and respiratory problems)

The prevalence of diabetes in Plymouth adults (aged ≥16 years) is predicted to increase by 0.8 percentage points by 2030. This increase is slightly less than the predicted increase in the England average.

Table 49: Diabetes prevalence (%) estimated for Plymouth and England, 2017 to 2035

	2017	2018	2019	2020	2025	2030	2035
Plymouth	8.0	8.1	8.1	8.2	8.5	8.7	8.8
England	8.7	8.8	8.8	8.9	9.2	9.5	9.7

Source: PHE, National Cardiovascular Intelligence Network

The prevalence of circulatory diseases in NEW Devon CCG is similar to the England average.

Table 50: Prevalence (%) of circulatory diseases for NEW Devon CCG and England, 2015/16

	Coronary heart disease	Stroke	Hypertension
NEW Devon CCG	3.8	2.2	15.1
England	3.2	1.7	13.8

Source: Cardiovascular Disease Health Profile, Public Health England

The prevalence of Chronic Obstructive Pulmonary Disease (COPD) in NEW Devon CCG is similar to the England average.

Table 51: Prevalence (%) of COPD for NEW Devon CCG and England, 2015/16

	COPD
NEW Devon CCG	2.0
England	1.9

Source: Interactive Health Atlas for Lung conditions in England (INHALE)

5.3.17 Smoking status, obesity and blood pressure (based on GP referrals)

The following sections on smoking status, obesity and blood pressure are based on data recorded at time of patient referral to Plymouth Hospitals NHS Trust (for any reason) by General Practitioners (GPs) in Plymouth. The percentage of patients being referred (for any reason) who smoke in Plymouth has decreased by 4.3 percentage points from 2010/11 to 2014/15. The locality with the largest percentage of smokers in 2014/15 was the West (21.6%), whilst the East had the smallest percentage (10.3%).

Table 52: Percentage of patients who were smokers at time of GP referral to Plymouth Hospitals NHS Trust by locality, 2010/11 to 2014/15

Locality	2010/11	2011/12	2012/13	2013/14	2014/15	Change in % points
East	13.6	13.1	12.0	9.8	10.3	-3.3
North	20.3	19.3	18.5	15.9	16.2	-4.1
South	21.6	20.0	18.3	16.6	17.3	-4.3
West	28.2	27.3	26.2	22.0	21.6	-6.6
Plymouth	21.0	20.0	18.9	16.3	16.7	-4.3

Source: Sentinel Database, NEW Devon CCG

The percentage of patients being referred (for any reason) who were obese increased by 2.6 percentage points from 2010/11 to 2014/15. The locality with the largest percentage of obese patients in 2014/15 was the North (36.9%), whilst the East had the smallest percentage (30.3%).

Table 53: Body Mass Index (BMI) (obesity = BMI>30) at time of GP referral to Plymouth Hospitals NHS Trust by locality, 2010/11 to 2014/15

Locality	2010/11	2011/12	2012/13	2013/14	2014/15	Change in % points
East	29.3	29.3	29.5	29.5	30.3	1.0
North	33.6	34.4	34.3	34.9	36.9	3.3
South	27.9	28.4	28.7	28.9	30.4	2.5
West	33.2	34.8	34.8	35.2	36.0	2.8
Plymouth	31.1	31.9	32.0	32.3	33.7	2.6

Source: Sentinel Database, NEW Devon CCG

The percentage of patients being referred (for any reason) who were experiencing high blood pressure (stage 1 and 2 hypertension) has increased by 1.4 percentage points from 2010/11 to 2014/15. The locality with the largest percentage of patients with high blood pressure in 2014/15 was the North (17.0%), whilst the East had the smallest percentage (14.5%).

Table 54: Percentage of patients with high blood pressure at time of GP referral to Plymouth Hospitals NHS Trust by locality, 2010/11 to 2014/15

Locality	2010/11	2011/12	2012/13	2013/14	2014/15	Change in % points
East	17.5	18.5	16.8	14.8	14.5	3.0
North	17.9	16.3	17.4	16.7	17.0	-0.9
South	14.4	14.0	14.0	14.2	14.0	-0.4
West	16.2	16.6	16.7	16.0	14.9	-1.3
Plymouth	16.6	16.4	16.3	15.5	15.2	1.4

Source: Sentinel Database, NEW Devon CCG

Table 55 reports the percentage of patients experiencing one to three of the above risk factors (smoking, obesity, high blood pressure) by locality for 2014/15. The West locality had the largest proportion of patients experiencing at least one of the three risk factors (57.9%) compared to the East (46.5%). In the West locality, 1.1% of patients were experiencing all three risk factors compared to the East (0.4%).

Table 55: Percentage of patients with one or more risk factors (smoking, obesity, high blood pressure) at time of GP referral to Plymouth Hospitals NHS Trust by locality, 2014/15

Locality	One or more risk factors (%)	All three risk factors (%)
East	46.5	0.4
North	56.5	0.8
South	51.0	0.7
West	57.9	1.1
Plymouth	53.4	0.8

Source: Sentinel Database, NEW Devon CCG

5.3.18 Skin cancer incidence

The incidence of new cases of melanoma in Plymouth has increased by 54 from the five-year period 2009-11 (193 cases) to 2013-15 (274 cases). A rise in the incidence of new cases of melanoma has been seen in both males (104 cases in 2009-11 to 129 cases in 2013-15) and females (89 cases in 2009-11 to 118 cases in 2013-15). Incidence rates across all four localities have increased for both males and females from 2009-11 to 2013-15. In 2013-15 the incidence rate in females was highest in the East locality (37.3 per 100,000) and lowest in the West (23.9 per 100,000). In 2013-15 the incidence rate in males was highest in the East locality (53.4 per 100,000) and lowest in the West (25.7 per 100,000).

5.3.19 Cancer mortality in the under 75s

The directly age-standardised cancer mortality rate for persons aged <75 years per 10,000 population has fallen over the period 2006 to 2015, from 16.4 deaths per 10,000 to 14.8 per 10,000 population in 2015. In 20, the cancer mortality rate was highest in the North locality (18.0 per 10,000) and the lowest in the East locality (11.3 per 10,000).

Table 56: Directly age-standardised cancer mortality rates for persons aged <75 years old per 10,000 population by locality, 2006 to 2015

Locality	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Change in rate
East	14.2	12.9	12.4	13.5	12.4	15.2	15.5	11.6	12.0	11.3	-2.9
North	16.7	15.6	15.6	15.7	14.2	15.8	15.9	16.0	14.8	18.0	1.2
South	15.4	16.0	15.2	15.4	17.9	18.4	15.4	16.5	17.4	13.8	-1.6
West	19.0	17.7	18.1	18.9	20.8	21.3	17.5	18.1	16.0	15.6	-3.4
Plymouth	16.4	15.5	15.2	15.9	16.0	17.6	16.2	15.5	14.9	14.8	-1.6

Source: Primary Care Mortality Database and ONS Annual Mortality Extract

6. Provision of pharmaceutical services

6.1 Necessary services

The PNA is required to make statements on current provision and gaps in 'necessary pharmaceutical services' provided by community pharmacists. This section considers those services provided by community pharmacies that fall within the definition of 'essential pharmaceutical services' commissioned by NHS England. NHS England oversees the provision of these services. Essential services are provided by all community pharmacies and are centrally funded. They are:

- The dispensing of prescriptions
- The dispensing of repeatable prescriptions
- The acceptance and disposal of unwanted medicines returned by patients
- Signposting to other providers of health and social care services
- Promotion of healthy lifestyles
- Support for self-care.

Relevant and necessary services

- Medicines Use Reviews and Prescription Intervention Service (may only be provided by a community pharmacy).
- New Medicines Service (may only be provided by a community pharmacy).

On-demand availability of specialist drugs is commissioned by NHSE as a local enhanced service, and is necessary to ensure people have access to a specified list of products during extended hours of opening.

6.2 Current provision of necessary services

6.2.1 Current provision within the H&WB's area

(i) Plymouth City

There are currently 52 pharmacies in Plymouth (including the one distance selling pharmacy). 43 pharmacies are owned by national pharmacy chains:

- 1 by Asda
- 14 by Boots Pharmacy
- 19 by Bestway National Chemists
- 2 by Day Lewis Pharmacy
- 3 by Lloyds Pharmacy
- 2 by Superdrug Pharmacy
- 1 by Tesco Pharmacy
- 1 by Morrisons Pharmacy

There are nine other pharmacies in Plymouth.

There are two 100-hour pharmacies (Asda Pharmacy in Estover and Lloyds Pharmacy in Marsh Mills). There are no pharmacies with local pharmaceutical services contracts. As already mentioned, there is one distance-selling pharmacy. This pharmacy is **NOT** included in table 57 below. There are two dispensing appliance contractors in Plymouth (Fittleworth Medical Limited and Salts Healthcare Limited).

Table 57 – Provision in Plymouth City over the last four years

Year	Population	Number of pharmacies	Pharmacies per 10,000 population	Population per pharmacy	Number of prescription fees	Px fees per head	Px fees per pharmacy
2013/14	259,175	52	2.04	4,890	5,483,666	21.2	105,455
2014/15	261,546	52	2.03	4,934	5,591,658	21.4	107,532
2015/16	262,712	51	1.98	5,052	5,691,507	21.7	111,598
2016/17	264,199	51	1.93	5,180	5,730,437	21.7	112,362
South West 2015/16	3,200,213 (in 2015)	637	1.99	5,023	57,812,665	18.1	90,758
England 2015/16	54,786,327 (in 2015)	11,688	2.13	4,687	995,277,392	18.2	85,154

Notes:

1. Figures include pharmacies that were open at any point during the financial year. Therefore, the figure for 2016-17 may not match the number of current open pharmacies in section 7.2.1.
2. Populations are based ONS mid-year population estimates. The population for each financial year is taken as the mid-year estimate for the first of the two years that make up the financial year. For example, for 2013-14 the population is taken as the mid-year estimate for 2013.
3. The South West population figure excludes Dorset, Poole, Bournemouth, Wiltshire, Swindon, Gloucestershire, Bath and North East Somerset as these are not in the NHS England region definition.
4. This table does not include the one distance-selling pharmacy.

The number of pharmacies in Plymouth has dropped by two between 2013-14 and 2016-17.

The number of items dispensed has increased by 4.5% between 2013-14 and 2016-17. The greatest increase between any two successive financial years was 2.0% between 2013-14 and 2014-15.

Nationally the number of pharmacies has risen only very slightly in the last few years: in 2015/16 there were 11,688, up 14 from the previous year. The number of prescription items dispensed has increased a little faster: in 2015/16, approximately 995.3 million items were dispensed, up 1.7% on the previous year.

(ii) Plymouth East Locality

There are currently nine pharmacies in the East locality of Plymouth. Eight pharmacies are owned by national pharmacy chains:

- 3 by Boots Pharmacy
- 3 by Bestway National Chemists
- 1 by Day Lewis Pharmacy
- 1 by Morrisons Pharmacy

There is one other pharmacy in the East locality of Plymouth.

There are no 100-hour pharmacies in the East locality of Plymouth. There are no pharmacies with local pharmaceutical services contracts. There are no distance-selling pharmacies. There is one dispensing appliance contractors in the East Locality of Plymouth (Salts Healthcare Limited).

Table 58 – Provision in Plymouth East Locality over the last four years

Year	Population	Number of pharmacies	Pharmacies per 10,000 population	Population per pharmacy	Number of prescription fees	Px fees per head	Px fees per pharmacy
2013/14	54,443	9	1.65	6,049	1,104,525	20.3	122,725
2014/15	54,441	9	1.65	6,049	1,107,888	20.4	123,099
2015/16	55,095	9	1.63	6,121	1,091,606	19.8	121,290
2016/17	55,095	9	1.63	6,121	1,119,823	20.3	124,425
South West 2015/16	3,200,213 (in 2015)	637	1.99	5,023	57,812,665	18.1	90,758
England 2015/16	54,786,327 (in 2015)	11,688	2.13	4,687	995,277,392	18.2	85,154

Notes:

1. Figures include pharmacies that were open at any point during the financial year. Therefore, the figure for 2016-17 may not match the number of current open pharmacies in section 7.2.1.
2. Populations are based ONS mid-year population estimates. The population for each financial year is taken as the mid-year estimate for the first of the two years that make up the financial year. For example, for 2013-14 the population is taken as the mid-year estimate for 2013.
3. The South West population figure excludes Dorset, Poole, Bournemouth, Wiltshire, Swindon, Gloucestershire, Bath and North East Somerset as these are not in the NHS England region definition.

The number of pharmacies in the East locality of Plymouth has stayed the same between 2013-14 and 2016-17.

The number of items dispensed has increased by 1.4% between 2013-14 and 2016-17. The greatest increase between any two successive financial years was 2.6% between 2015-16 and 2016-17.

(iii) Plymouth North Locality

There are currently 11 pharmacies in the North locality of Plymouth. All 11 pharmacies are owned by national pharmacy chains:

- 1 by Asda Pharmacy
- 6 by Bestway National Chemists
- 2 by Boots Pharmacy
- 1 by Lloyds Pharmacy
- 1 by Tesco Pharmacy

There is one 100-hour pharmacy in the North locality of Plymouth: Asda Pharmacy in Estover. There are no pharmacies with local pharmaceutical services contracts. There is one distance-selling pharmacy located in Estover (My Doctors Chemist). This distance selling pharmacy is NOT included in table 59 below. There is one dispensing appliance contractor in the North Locality of Plymouth (Fittleworth Medical Limited).

Table 59 – Provision in Plymouth North Locality over the last four years

Year	Population	Number of pharmacies	Pharmacies per 10,000 population	Population per pharmacy	Number of prescription fees	Px fees per head	Px fees per pharmacy
2013/14	65,292	13	1.99	5,022	1,432,783	21.9	110,214
2014/15	66,130	13	1.97	5,086	1,444,278	21.8	111,098
2015/16	66,670	12	1.80	5,555	1,508,210	22.6	125,684
2016/17	66,670	11	1.65	6,060	1,423,751	21.4	129,432
South West 2015/16	3,200,213 (in 2015)	637	1.99	5,023	57,812,665	18.1	90,758
England 2015/16	54,786,327 (in 2015)	11,688	2.13	4,687	995,277,392	18.2	85,154

Notes:

1. Figures include pharmacies that were open at any point during the financial year. Therefore, the figure for 2016-17 may not match the number of current open pharmacies in section 7.2.1.
2. Populations are based ONS mid-year population estimates. The population for each financial year is taken as the mid-year estimate for the first of the two years that make up the financial year. For example, for 2013-14 the population is taken as the mid-year estimate for 2013.
3. The South West population figure excludes Dorset, Poole, Bournemouth, Wiltshire, Swindon, Gloucestershire, Bath and North East Somerset as these are not in the NHS England region definition.

The number of pharmacies in the North locality of Plymouth was the same between 2013-14 and 2014-15, but fell by one between 2014-15 and 2015-16 and also fell by one between 2015-16 and 2016-17.

Despite increasing between 2013-14 and 2015-16, a decrease of 5.6% between 2015-16 and 2016-17 meant that overall the number of items dispensed decreased by 0.6% between 2013-14 and 2016-17.

(iv) Plymouth South Locality

There are currently 13 pharmacies in the South locality of Plymouth. 10 pharmacies are owned by national pharmacy chains:

- 6 by Boots Pharmacy
- 3 by Bestway National Chemists
- 1 by Lloyds Pharmacy

There are three other pharmacies in the South locality of Plymouth.

There is one 100-hour pharmacy in the South locality of Plymouth: Lloyds Pharmacy in Marsh Mills. There are no pharmacies with local pharmaceutical services contracts. There are no distance-selling pharmacies. There no dispensing appliance contractors in the South locality of Plymouth but there are two dispensing appliance contractors in Plymouth: Fittleworth Medical Limited in the north locality and Salts Healthcare Limited in the east locality.

Table 60 – Provision in Plymouth South Locality over the last four years

Year	Population	Number of pharmacies	Pharmacies per 10,000 population	Population per pharmacy	Number of prescription fees	Px fees per head	Px fees per pharmacy
2013/14	68,642	13	1.89	5,280	1,266,406	18.4	97,416
2014/15	69,318	13	1.88	5,332	1,299,220	18.7	99,940
2015/16	68,919	13	1.89	5,301	1,317,669	19.1	101,359
2016/17	68,919	13	1.89	5,301	1,351,102	19.6	103,931
South West 2015/16	3,200,213 (in 2015)	637	1.99	5,023	57,812,665	18.1	90,758
England 2015/16	54,786,327 (in 2015)	11,688	2.13	4,687	995,277,392	18.2	85,154

Notes:

1. Figures include pharmacies that were open at any point during the financial year. Therefore, the figure for 2016-17 may not match the number of current open pharmacies in section 7.2.1.
2. Populations are based ONS mid-year population estimates. The population for each financial year is taken as the mid-year estimate for the first of the two years that make up the financial year. For example, for 2013-14 the population is taken as the mid-year estimate for 2013
3. The South West population figure excludes Dorset, Poole, Bournemouth, Wiltshire, Swindon, Gloucestershire, Bath and North East Somerset as these are not in the NHS England region definition.

The number of pharmacies in the South locality of Plymouth has stayed the same between 2013-14 and 2016-17.

The number of items dispensed has increased by 6.7% between 2013-14 and 2016-17. The greatest increase between any two successive financial years was 2.6% between 2013-14 and 2014-15.

(v) Plymouth West Locality

There are currently 18 pharmacies in the West locality of Plymouth. 14 of the pharmacies are owned by national pharmacy chains:

- 3 by Boots Pharmacy
- 7 by Bestway National Chemists
- 1 by Day Lewis Pharmacy
- 1 by Lloyds Pharmacy
- 2 by Superdrug Pharmacy

There are four other pharmacies in the West locality of Plymouth.

There are no 100-hour pharmacies in the West locality of Plymouth. There are no pharmacies with local pharmaceutical services contracts. There are no distance-selling pharmacies. There no dispensing appliance contractors in the West locality of Plymouth but there are two dispensing appliance contractors in Plymouth: Fittleworth Medical Limited in the north locality and Salts Healthcare Limited in the east locality.

Table 61 – Provision in Plymouth West Locality over the last four years

Year	Population	Number of pharmacies	Pharmacies per 10,000 population	Population per pharmacy	Number of prescription fees	Px fees per head	Px fees per pharmacy
2013/14	70,798	18	2.54	3,933	1,671,487	23.6	92,860
2014/15	71,657	18	2.51	3,980	1,714,632	23.9	95,257
2015/16	72,028	18	2.50	4,001	1,774,022	24.6	98,557
2016/17	72,028	18	2.50	4,001	1,835,761	25.5	101,987
South West 2015/16	3,200,213 (in 2015)	637	1.99	5,023	57,812,6 65	18.1	90,758
England 2015/16	54,786,327 (in 2015)	11,688	2.13	4,687	995,277,392	18.2	85,154

Notes:

1. Figures include pharmacies that were open at any point during the financial year. Therefore, the figure for 2016/17 may not match the number of current open pharmacies in section 7.2.1.
2. Populations are based ONS mid-year population estimates. The population for each financial year is taken as the mid-year estimate for the first of the two years that make up the financial year. For example, for 2013/14 the population is taken as the mid-year estimate for 2013.
3. The South West population figure excludes Dorset, Poole, Bournemouth, Wiltshire, Swindon, Gloucestershire, Bath and North East Somerset as these are not in the NHS England region definition.

The number of pharmacies in the West locality of Plymouth has stayed the same between 2013-14 and 2016-17.

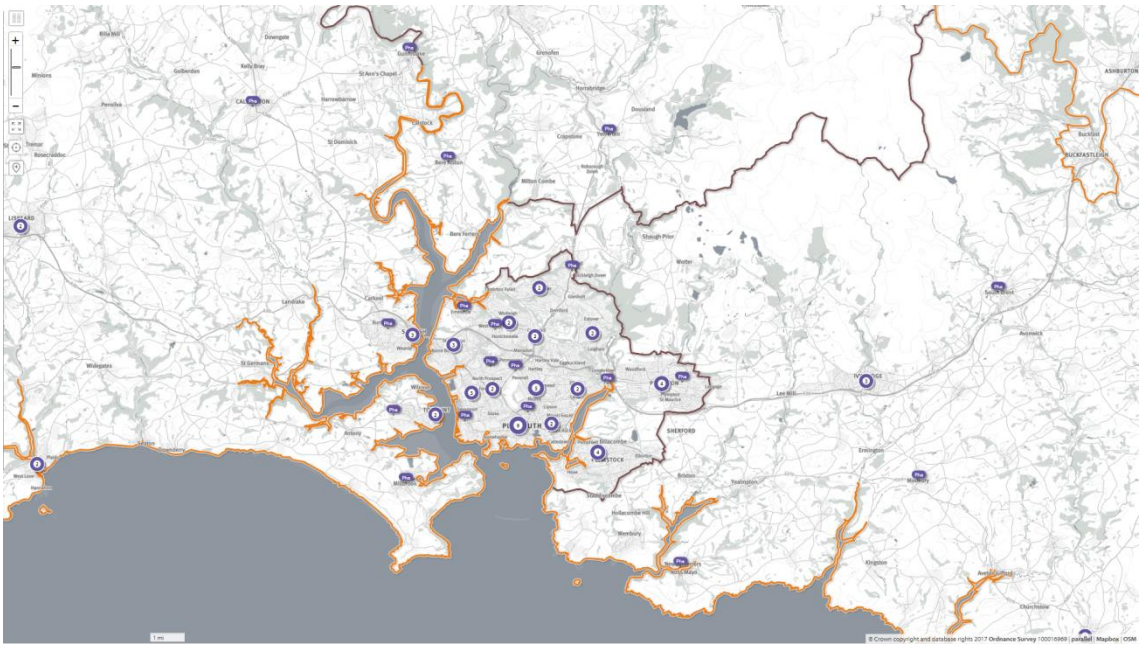
The number of items dispensed increased by 9.8% between 2013-14 and 2016-17. The greatest increase between two successive financial years was 3.5% between 2014-15 and 2015-16 and between 2015-16 and 2016-17.

6.2.2 Current provision outside the H&WB's area

As stated above, DACs are required to provide the essential services to patients anywhere in England, and will deliver medication to a patient's home address. Their services are therefore available to residents of the H&WB's area. As at February 2017 there were 111 DACs in England, including those located within the H&WB's area. An alphabetical list of distance-selling pharmacies is available at:
www.nhs.uk/service-search/pharmacies/InternetPharmacies

In addition to DACs there are a number of pharmacies on the outskirts of the city which may be accessed by Plymouth residents. The location of these pharmacies is shown in figure 5 below.

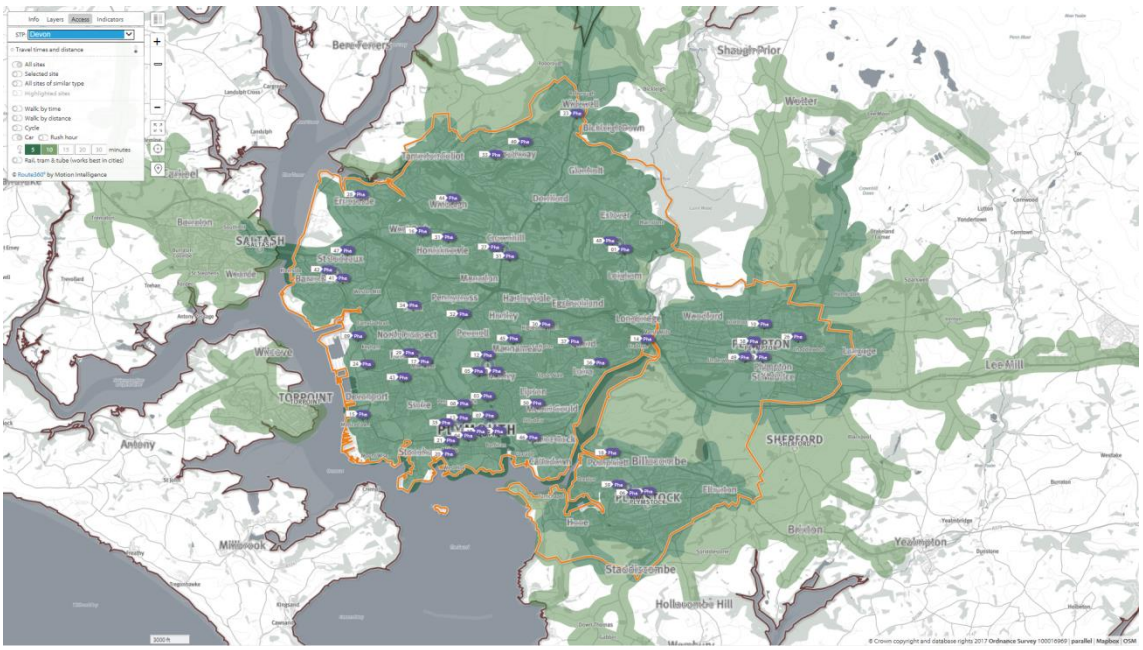
Figure 5 – Location of pharmacies close to the Plymouth City boundary



6.3 Access to necessary services

6.3.1 Access to premises

Figure 6 – Areas within five and 10 minute drive times to Plymouth pharmacies

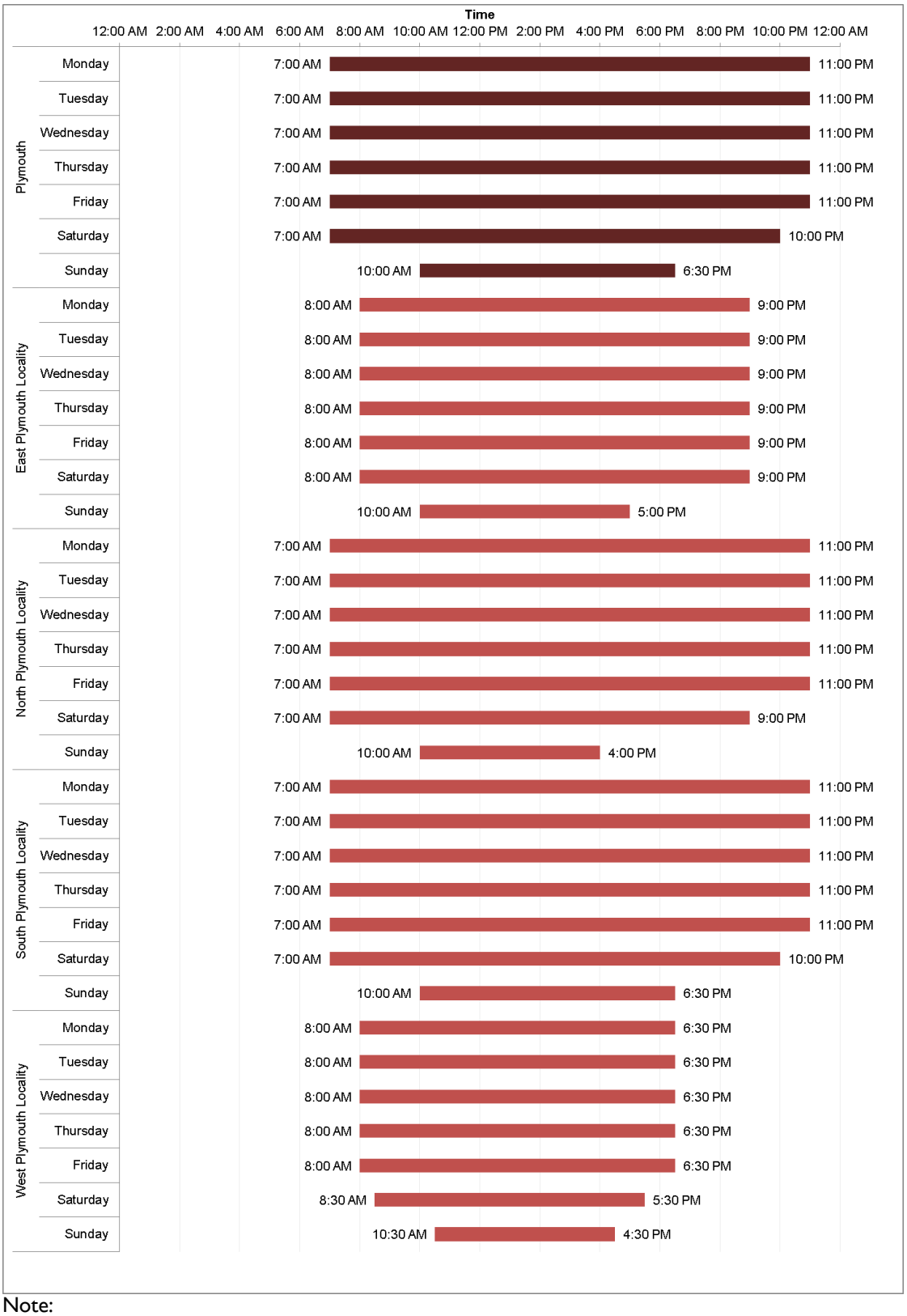


Based on the 2011 Census, car ownership in Plymouth (72.2%) is slightly below the national average (74.2%). Car ownership is unevenly distributed across the city, with the West locality having the smallest proportion of car owners per household (63.3%) and the East locality having the largest proportion (85.5%).

6.3.2 Access to the essential services

NHS England has a duty to ensure that residents of the H&WB's area are able to access pharmaceutical services every day. Pharmacies and DACs are not required to open on public and bank holidays, or Easter Sunday, although some choose to do so. NHS England asks each contractor to confirm their intentions regarding these days and where necessary will direct a contractor or contractors to open on one or more of these days to ensure adequate access.

Figure 7 - Earliest opening time and latest closing time for any given pharmacy, by locality and day of the week



Note:

1. Earliest opening and latest closing times are based on current total opening hours i.e. core plus supplementary opening hours.

(i) Plymouth City

- Nine pharmacies are routinely open seven days per week: four Boots Pharmacies, one Asda Pharmacy, one Tesco Pharmacy, one Morrisons Pharmacy, one Hyde Park Pharmacy and one Lloyds Pharmacy.
- 36 pharmacies open Monday to Saturday; of those 25 pharmacies close at or before 1pm on Saturday and 11 pharmacies close after 1pm on Saturday.
- Six pharmacies open Monday to Friday only.
- Two pharmacies are open before 8:00am Monday to Friday: Lloyds Pharmacy in Marsh Mills and Asda Pharmacy in Estover.
- Seven pharmacies open later than 6.30pm Monday to Friday: Hyde Park Pharmacy in Mutley, Lloyds Pharmacy in Marsh Mills, Well Pharmacy in Honicknowle, Tesco Pharmacy in Woolwell, Asda Pharmacy in Estover, Boots Pharmacy in Plymstock and Morrisons Pharmacy also in Plymstock.

(ii) Plymouth East Locality

- Three pharmacies are routinely open seven days per week: two Boots Pharmacies, one in Plympton and one in Plymstock and one Morrisons Pharmacy also in Plymstock
- Six pharmacies open Monday to Saturday only: of those four pharmacies close at or before 1pm on Saturday and two pharmacies close after 1pm on Saturday.
- There are no pharmacies open before 8:00am Monday to Friday, although one does open at 8:00am (Morrisons Pharmacy in Plymstock).
- Two pharmacies open later than 6.30pm Monday to Friday: Boots Pharmacy and Morrisons Pharmacy both in Plymstock.

(iii) Plymouth North Locality

- Two pharmacies are routinely open seven days per week: one Tesco Pharmacy in Woolwell and one Asda Pharmacy in Estover.
- Seven pharmacies open Monday to Saturday only: of those four pharmacies close at or before 1pm on Saturday and 3 pharmacies close after 1pm on Saturday.
- Two pharmacies are open Monday to Friday only: Well Pharmacy in Crownhill and Well Pharmacy in Southway.
- There is one pharmacy open before 8:00am Monday to Friday: Asda Pharmacy in Estover.
- Three pharmacies open later than 6.30pm Monday to Friday: Well Pharmacy in Honicknowle, Tesco Pharmacy in Woolwell and Asda Pharmacy in Estover.

(iv) Plymouth South Locality

- Three pharmacies are routinely open seven days per week: one Boots Pharmacy in Drakes Circus, one Hyde Park Pharmacy in Mutley and one Lloyds Pharmacy in Marsh Mills.
- Nine pharmacies open Monday to Saturday only: of those six pharmacies close at or before 1pm on Saturday and three pharmacies close after 1pm on Saturday.
- One pharmacy is open Monday to Friday only: Well Pharmacy in Efford.

- There is one pharmacy open before 8:00am Monday to Friday: Lloyds Pharmacy in Marsh Mills.
- Two pharmacies open later than 6.30pm Monday to Friday: Hyde Park Pharmacy in Mutley and Lloyds Pharmacy in Marsh Mills.

(v) Plymouth West Locality

- One pharmacy is routinely open seven days per week: Boots Pharmacy on George Street.
- 14 pharmacies open Monday to Saturday only: of those 11 pharmacies close at or before 1pm on Saturday and three pharmacies close after 1pm on Saturday
- Three pharmacies are open Monday to Friday only: Well Pharmacy on Stirling Road, Boots Pharmacy in St Budeaux and St Levan Pharmacy in Keyham.
- There are no pharmacies open before 8:00am Monday to Friday, but two open at 8:00am: Devonport pharmacy in Devonport and Well Pharmacy on Stirling Road.
- There are no pharmacies open later than 6.30pm Monday to Friday, but one pharmacy opens until 6.30pm: Well Pharmacy on Stirling Road.

6.3.3 Access to the other essential services

Pharmacies provide the other essential services in relation to medicines, but dispensing doctors do not.

6.3.4 Access to the medicines use review (MUR) advanced service

Each pharmacy providing this advanced service can provide a maximum of 400 MURs each year.

(i) Plymouth City

Of the 51 pharmacies in Plymouth, 49 provided MURs in 2016-17. Out of a maximum possible of 20,400 MURs which could have been carried out, 15,425 MURs were performed in 2016-17 (75.6%). Thirteen pharmacies provided the maximum number of MURs recommended (400), 12 provided more and 1 provided less i.e. between 390 and 399.

(ii) Plymouth East Locality

All nine pharmacies in the East locality of Plymouth provided MURs in 2016-17. Out of a maximum possible of 3,600 MURs which could have been carried out, 2,944 MURs were performed in 2016-17 (81.8%). Four pharmacies provided the maximum number recommended (400), while two pharmacies provided more.

(iii) Plymouth North Locality

All 11 pharmacies in the North locality of Plymouth provided MURs in 2016/17. Out of a maximum possible of 4,400 MURs which could have been carried out, 3,879 MURs were performed in 2016-17 (88.2%). Three pharmacies provided the maximum number of MURs recommended (400), while three pharmacies provided more.

(iv) Plymouth South Locality

Out of the 13 pharmacies in the South locality of Plymouth, 12 provided MURs in 2016-17. Out of a maximum possible of 5,200 MURs which could have been carried out, 3,605 MURs were performed in 2016-17 (69.3%). Four pharmacies provided the maximum number of MURs recommended (400), while three pharmacies provided more.

(v) Plymouth West Locality

Out of the 18 pharmacies in the West locality of Plymouth, 17 provided MURs in 2016-17. Out of a maximum possible of 7,200 MURs which could have been carried out, 4,997 MURs were performed in 2016-17 (69.4%). Two pharmacies provided the maximum number of MURs recommended (400), with four pharmacies providing more and one pharmacy providing between 390 and 399 MURs.

6.3.5 Access to the new medicines service (NMS) advanced service

(i) Plymouth City

45 of the pharmacies in Plymouth provided NMS in 2016-17. A total of 4,279 NMSs were undertaken in 2016/17.

(ii) Plymouth East Locality

All of the pharmacies in the East locality of Plymouth provided NMS in 2016-17. A total of 1,101 NMSs were undertaken in 2016-17.

(iii) Plymouth North Locality

8 out of the 11 pharmacies in the North locality of Plymouth provided NMS in 2016-17. A total of 784 NMSs were undertaken in 2016-17.

(iv) Plymouth South Locality

11 out of the 13 pharmacies in the South locality of Plymouth provide NMS in 2016-17. A total of 811 NMSs were undertaken in 2016-17.

(v) Plymouth West Locality

17 out of the 18 pharmacies in the West locality of Plymouth provided NMS in 2016-17. A total of 1,583 NMSs were undertaken in 2016-17.

6.3.6 Access to the 'on demand availability of specialist drugs' enhanced service

NHS England selects pharmacies to provide this service in order to ensure adequate coverage, and in particular tries to choose pharmacies with long opening hours in order to ensure availability in the evenings and at weekends.

(i) Plymouth City

Two pharmacies (Asda Pharmacy in Estover and Hyde Park Pharmacy in Mutley) provided this service in 2016-17.

(ii) Plymouth East Locality

There are no pharmacies that provided this service in the East locality of Plymouth in 2016-17. Within Plymouth there are two pharmacies (Asda Pharmacy in Estover and Hyde Park Pharmacy in Mutley) that did.

(iii) Plymouth North Locality

There was one pharmacy that provided this service in the North locality of Plymouth (Asda Pharmacy in Estover).

(iv) Plymouth South Locality

There was one pharmacy that provided this service in the South locality of Plymouth (Hyde Park Pharmacy in Mutley).

(v) Plymouth West Locality

There were no pharmacies that provided this service in the West locality of Plymouth in 2016-17. Within Plymouth there are two pharmacies (Asda Pharmacy in Estover and Hyde Park Pharmacy in Mutley) that did.

6.3.7 Access to dispensing of appliances

Some, but not all, pharmacies dispense appliances. DACs dispense appliances, usually by home delivery.

(i) Plymouth City

All pharmacies in Plymouth have dispensed some appliances during 2016-17 while 27 have dispensed appliances that require measuring or fitting.

(ii) Plymouth East Locality

All pharmacies in the East locality of Plymouth have dispensed some appliances during 2016-17, while five have dispensed appliances that require measuring or fitting.

(iii) Plymouth North Locality

All pharmacies in the North locality of Plymouth have dispensed some appliances during 2016-17, while six have dispensed appliances that require measuring or fitting.

(iv) Plymouth South Locality

All pharmacies in the South locality of Plymouth have dispensed some appliances during 2016-17, while eight have dispensed appliances that require measuring or fitting.

(v) Plymouth West Locality

All pharmacies in the West locality of Plymouth dispensed some appliances during 2016-17, while eight dispensed appliances that required measuring or fitting.

7.0 Other relevant services

7.1 Other relevant services

Other relevant services are services there are not defined as necessary but have secured improvement or better access to pharmaceutical services.

For the purposes of this PNA, 'other relevant services' includes:

- the advanced services not classed as 'necessary (influenza vaccination and urgent supply)
- stoma customisation services (which may be provided by a community pharmacy, stoma customisation service pharmacy or a dispensing appliance contractor).
- appliance use reviews (which may be provided by community pharmacies and dispensing appliance contractors)
- services commissioned from pharmacies by Plymouth City Council and NEW Devon CCG
- other NHS services
- services provided by other organisations

7.2 Advanced services

7.2.1 Influenza vaccination advanced service

As part of the 2015-16 Community Pharmacy Funding Settlement NHS England agreed to allow community pharmacies in England to offer a seasonal (flu) vaccination service for patients in at-risk groups. The service is the fifth Advanced Service in the English Community Pharmacy Contractual Framework and provision of the service commenced from 16th September 2015. The Community Pharmacy Seasonal Influenza Vaccination Advanced Service will continue in 2017-18 and has been extended to include all at risk groups for adults aged 18 and over.

This service has not been included within the definition of 'necessary services' because, if it were not provided by pharmacies, an equivalent service would be available from GP surgeries.

(i) Plymouth City

40 pharmacies in Plymouth provided NHS influenza vaccinations in 2016-17, giving a total of 3,880 vaccinations.

(ii) Plymouth East Locality

Eight out of the nine pharmacies in the East locality of Plymouth provided NHS influenza vaccinations in 2016-17, giving a total of 1,665 vaccinations.

(iii) Plymouth North Locality

Nine out of the 11 pharmacies in the North locality of Plymouth provided NHS influenza vaccinations in 2016-17, giving a total of 634 vaccinations.

(iv) Plymouth South Locality

11 out of the 13 pharmacies in the South locality of Plymouth provided NHS influenza vaccinations in 2016-17, giving a total of 749 vaccinations.

(v) Plymouth West Locality

12 out of the 18 pharmacies in the West locality of Plymouth provided NHS influenza vaccinations in 2016-17, giving a total of 832 vaccinations.

7.2.2 Urgent supply advanced service (NUMSAS)

This service has not been included within the definition of 'necessary services' because:

- it is currently a pilot and whether it will continue to be commissioned is not known
- if it were not provided as an advanced service, patients could obtain an urgent supply as a private service from a pharmacy.

7.2.3 Stoma appliance customisation (SAC) advanced service

This is a specialist service which many contractors do not provide.

(i) Plymouth City

Only one pharmacy provided this service in 2016-17, with a total of one stoma customisation being provided. Many stoma appliances will be dispensed by DACs based around the country, which may provide this service.

(ii) Plymouth East Locality

No pharmacies in the East locality of Plymouth provided this service in 2016-17. Many stoma appliances will be dispensed by DACs based around the country, which may provide this service.

(iii) Plymouth North Locality

No pharmacies in the North locality of Plymouth provided this service in 2016-17. Many stoma appliances will be dispensed by DACs based around the country, which may provide this service.

(iv) Plymouth South Locality

No pharmacies in the South locality of Plymouth provided this service in 2016-17. Many

stoma appliances will be dispensed by DACs based around the country, which may provide this service.

(v) Plymouth West Locality

One pharmacy in the West locality of Plymouth provided this service in 2016-17, with a total of one stoma customisation being provided. Many stoma appliances will be dispensed by DACs based around the country, which may provide this service.

7.2.4 Appliance use review (AUR) advanced service

No pharmacies in Plymouth provided this service in 2016-17. Many appliances will be dispensed by DACs based around the country, which may provide this service.

7.3 Services commissioned by the CCG or Council

As noted in section 2.4, the CCG or council may commission pharmacies or DACs to provide services.

7.3.1 Services commissioned by the CCG

These are described in section 2.4.2.

7.3.2 Services commissioned by the Council

These are described in section 2.4.1.

7.4 Other NHS services

7.4.1 Hospital pharmacies

Hospital pharmacies reduce the demand for the dispensing essential service as prescriptions written in the hospital are dispensed by the hospital pharmacy service. Some hospital pharmacies are operated by commercial providers which manage outpatient dispensing services, but they are not able to dispense prescriptions issued by other prescribers, for example GP surgeries.

In Plymouth, there is an acute hospital at Derriford (PL6 8DH) and a community hospital at Mount Gould (PL4 7QD).

There is a Lloyds Pharmacy at Derriford Hospital. It offers an outpatient dispensing service for hospital prescriptions only, as well as retail offerings including over the counter medicines and toiletry products. The opening times are Monday to Friday, 9.00AM to 6.00PM.

7.4.2 Personal administration of items by GPs

Under their medical contract with NHS England there will be occasion where a GP practice personally administers an item to a patient.

Generally when a patient requires a medicine or appliance their GP will give them a prescription which they take to their preferred pharmacy. In some instances however the GP will supply the item against a prescription and this is referred to as personal administration as the item that is supplied will then be administered to the patient by the GP or a nurse. This is different to the dispensing of prescriptions and only applies to certain specified items for example vaccines, anaesthetics, injections, intra-uterine contraceptive devices and sutures.

For these items the practice will produce a prescription however the patient is not required to take it to a pharmacy, have it dispensed and then return to the practice for it to be administered.

Personal administration thus reduces the demand for the dispensing essential service.

7.4.3 GP Out of Hours service

Beyond the normal working hours GP practices open, there is an out of hours service operated as an initial telephone consultation where the doctor may attend the patients home or request the patient access one of the clinics. The clinics and travelling doctors have a stock of medicines and, in appropriate cases, may issue medicines from stock, for example:

- a full course of antibiotics for an infection, or
- sufficient pain relief medication to tide them over until a prescription can be dispensed.

Alternatively the service may issue a prescription for dispensing at a pharmacy.

7.4.4 Walk-in centres

There are no walk-in centres in Plymouth.

7.5 Services provided by other organisations

There are no pharmacy services provided by other organisations (e.g. defense, private or employee-provided) in Plymouth.

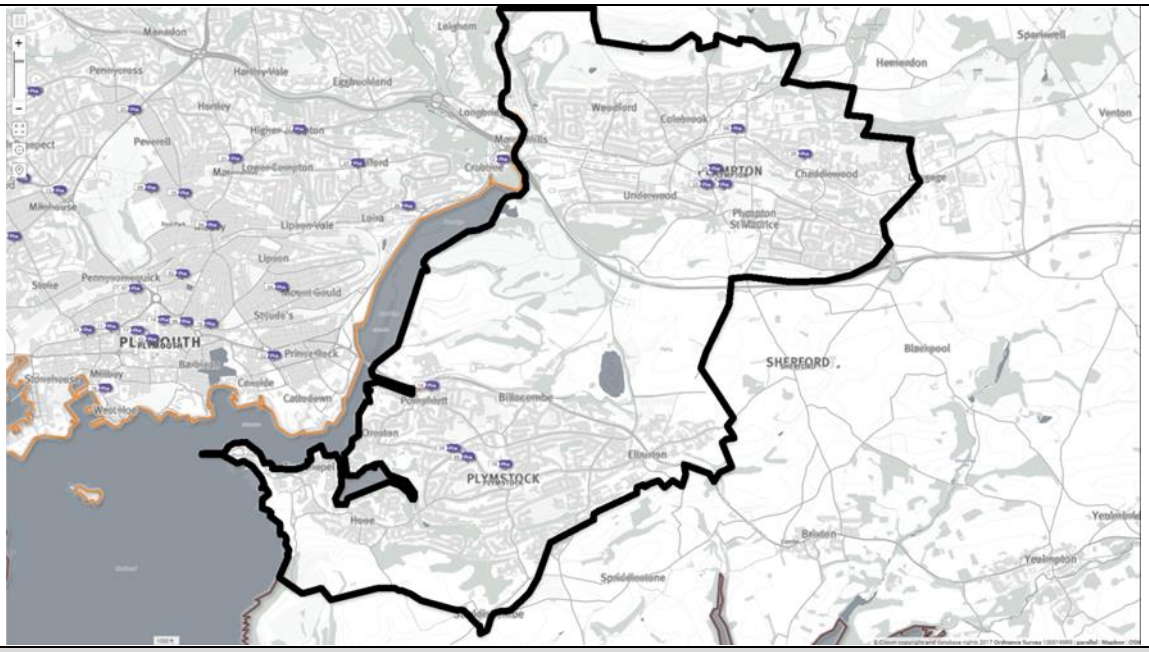
8. Locality summaries

8.1 Plymouth East locality summary

DEMOGRAPHY	
Population size	55,095 (1.7% increase from 2009 to 2015)
Ethnic breakdown	• 97.1% White British • 1.4% All other White • 0.7% Mixed/multiple ethnic groups • 0.4% Asian/Asian British • 0.3% Black/African/Caribbean/Black British • 0.1% Other ethnic group
IMD 2015 Score and locality rank (1=most deprived, 4=least deprived)	11.8 (rank: 4/4)
Top three Mosaic Groups	*Suburban Stability* (mature suburban owners living settled lives in mid-range housing) *Senior Security* (elderly people with assets who are enjoying a comfortable retirement) *Aspiring Homemakers* (younger households settling down in housing priced within their means)
HEALTH NEEDS OVERVIEW	
Rank for locality-based health profile ('cradle to grave') (1=locality with greatest needs):	4/4
Rank for public health indicators (as above):	4/4
BEST HEALTH OUTCOMES FOR THIS LOCALITY	
• Locality with greatest life expectancy • Locality with the lowest percentage of childhood obesity • Lowest rate of teenage pregnancy • Lowest percentage of parents who smoke • Lowest rate of adults in substance misuse treatment	• Lowest rate of emergency admissions • Lowest mortality rate for circulatory disease and respiratory disease • Lowest hospital admissions due to circulatory disease • Lowest hospital admissions due to self-harm
KEY HEALTH NEEDS FOR THIS LOCALITY	
• Ageing population	• Higher rate incidence of melanoma
PHARMACY PROVISION OVERVIEW	
Number of GP practices:	7
Number of pharmacies:	9
Pharmacies per 10,000 population:	1.63
Prescriptions per pharmacy:	124,425
Population per pharmacy and locality rank (1= lowest no. of pharmacies per head of pop.):	6,121 (rank: 4/4)

HOUSING GROWTH AND SIGNIFICANT HOUSING DEVELOPMENTS

Sherford is a new town which is being built in the South Hams. This may create additional pharmaceutical needs in South Hams but the timescales and extent of this need is not yet clear. Whilst the development is not within the city's envelope, its proximity to Plympton and Plymstock has the potential to impact on service provision in this locality. It is expected that 264 houses per annum will be delivered during the period of the PNA (292 of which will be within Plymouth's boundary). Plymstock Quarry has outline consent for up to 1,684 dwellings and 1.85 hectares of employment land, together with a new neighbourhood comprising of new community infrastructure and local centre. A new GP practice will open to support this development. It is important to note that this area of Plymouth is close to the Sherford development. **It is estimated that a maximum of 1,364 dwellings could be built in this locality between 2016 and 2022.**



ACCESSIBILITY:

Provision:	Mon-Fri	✓	Saturday	✓	Sunday	✓
Longest pharmacy opening times within this locality			08:00-21:00 Monday-Friday 08:00-21:00 Saturday 10:00-17:00 Sunday			
Proportion of population with no car and locality rank (1=lowest proportion of car ownership):			14.5% (rank: 4/4)			
Drive time analysis			The longest drive time to a pharmacy is 10 minutes, with the majority able to access a pharmacy by car within 5 minutes.			
Public transport			All pharmacies are accessible via public transport			

PROVISION OF PHARMACEUTICAL SERVICES:

(1) Essential services:

No. of pharmacies dispensing appliances:	All pharmacies

(2) Advanced services:	
No. offering Medicines Use Review Service:	All pharmacies
No. offering New Medicine Service:	All pharmacies
No. offering Appliance Use Review Service:	0
No. offering Stoma Appliance Customisation:	0
No. offering Influenza vaccination	8 out of 9 pharmacies

(3) Enhanced services:

There are no pharmacies that provided on demand availability of specialist medicines in the East locality of Plymouth. But within Plymouth there are 2 pharmacies that did: Asda Pharmacy in Estover and Hyde Park Pharmacy in Mutley.

GAP ANALYSIS: CURRENT AND FUTURE PROVISION

(1) A need for a new pharmacy in the Elburton area was identified through an unforeseen benefits application and is due to be met by a granted application; there is therefore not a current need. Subject to the following, a future need for a pharmacy in Elburton will arise if the current grant for a pharmacy in Elburton lapses without a pharmacy opening.

Devon H&WB has identified, within the South Hams locality of the Devon PNA, a future need for a pharmacy in the western neighbourhood of the Sherford development, which is close to Elburton. Plymouth and Devon H&WBs are jointly of the view that:

- a pharmacy in Elburton would also meet the future need which has been identified in Sherford,
- a pharmacy in the western neighbourhood of Sherford would also meet the need for a pharmacy in Elburton.

Therefore, a future need for a pharmacy in Elburton will arise if the current grant for a pharmacy in Elburton lapses without a pharmacy opening, unless a pharmacy has opened in the western neighbourhood of Sherford. If that future need does arise in Elburton, it will be met if a pharmacy opens in the western neighbourhood of Sherford.

(2) With regard to the development in the Plymstock Quarry area, a future need will arise at the point when 1,200 houses are completed and occupied.

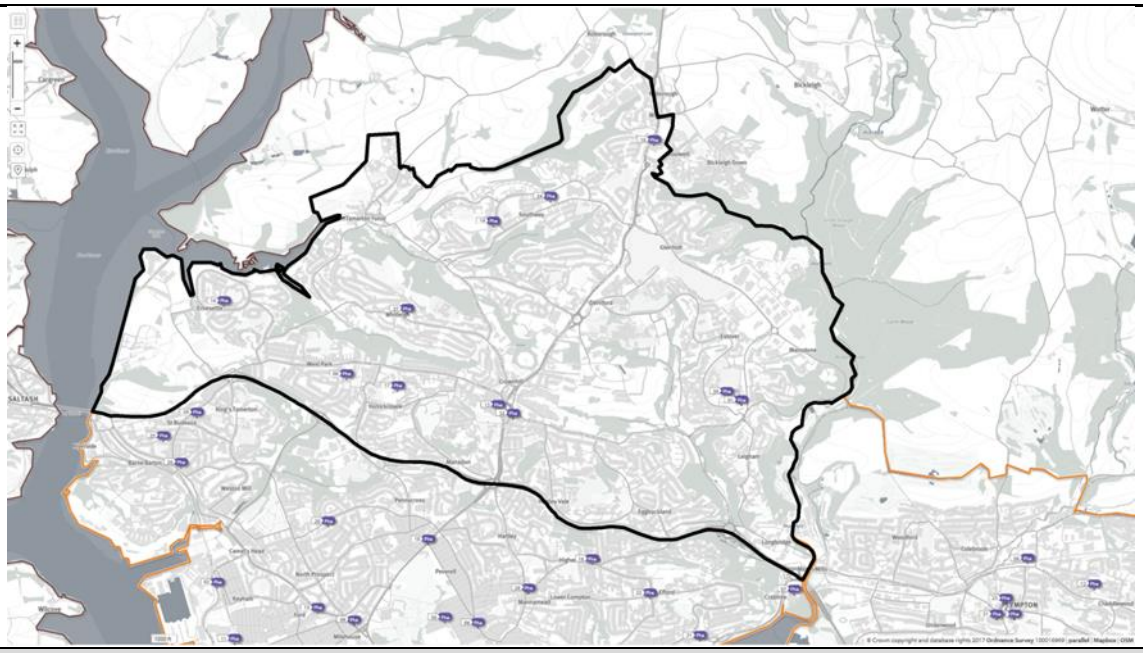
(3) No other current gaps or gaps that will materialise in the period covered by this PNA have been identified.

8.2 Plymouth North locality summary

DEMOGRAPHY	
Population size	66,670 (4.4% increase from 2009 to 2015)
Ethnic breakdown	• 95.6% White British • 1.7% All other White • 0.9% Mixed/multiple ethnic groups • 1.2% Asian/Asian British • 0.4% Black/African/Caribbean/Black British • 0.2% Other ethnic group
IMD 2015 Score and locality rank (1=most deprived, 4=least deprived)	26.4 (rank: 2/4)
Top three Mosaic Group	*Modest Traditions* (mature homeowners of value homes enjoying stable lifestyles) *Family Basics* (families with limited resources who have to budget to make ends meet) *Aspiring Homemakers* (younger households settling down in housing priced within their means)
HEALTH NEEDS OVERVIEW	
Rank for locality-based health profile ('cradle to grave') (1=locality with greatest needs):	2/4
Rank for public health indicators (as above):	3/4
BEST HEALTH OUTCOMES FOR THIS LOCALITY	
• Locality with the lowest rate of admissions for falls in both the over 65s and over 75s • Lower rate of adults in substance misuse treatment compared to the Plymouth average	• Lower percentage of vulnerable families compared to the Plymouth average
KEY HEALTH NEEDS FOR THIS LOCALITY	
• Highest percentage of babies born with a low birth weight • Lowest percentage of babies being breastfed at 6-8 weeks • Highest mortality rate for Cancer for under 75s	• Locality with the highest rate of elective admissions • Locality with the highest percentage of adults who are obese based on GP referrals
PHARMACY PROVISION OVERVIEW	
Number of GP practices:	11
Number of pharmacies:	11
Pharmacies per 10,000 population:	1.65
Prescriptions per pharmacy:	129,432
Population per pharmacy and locality rank (1= lowest no. of pharmacies per head of pop.):	6,060 (rank: 3/4)

HOUSING GROWTH AND SIGNIFICANT HOUSING DEVELOPMENTS

The JLP seeks to accommodate substantial development at Derriford in a way that helps deliver decent and affordable homes, supports a diverse and inclusive community, ensures easy access to jobs and services, and creates a place where people want to live. To achieve this, together with commercial and retail facilities, significant new housing development is identified. This will take place at a number of component sites in the North of the City. **It is estimated that a maximum of 1,812 dwellings could be built in this locality between 2016 and 2022.**



ACCESSIBILITY:

Provision:	Mon-Fri:	✓	Sat:	✓	Sun:	✓
Longest pharmacy opening times within this locality			07:00-23:00 Monday-Friday 07:00-21:00 Saturday 10:00-16:00 Sunday			
Proportion of population with no car and locality rank (1=lowest proportion of car ownership):			24.1% (rank: 3/4)			
Drive time analysis			The longest drive time to a pharmacy is 5 minutes.			
Public transport			All pharmacies are accessible via public transport			

PROVISION OF PHARMACEUTICAL SERVICES:

(1) Essential services:

No. of pharmacies dispensing appliances:	All pharmacies

(2) Advanced services:

No. offering Medicines Use Review Service:	All pharmacies
No. offering New Medicine Service:	8 out of 11 pharmacies

No. offering Appliance Use Review Service:	0
No. offering Stoma Appliance Customisation:	0
No. offering Influenza vaccination	9 out of 11 pharmacies

(3) Enhanced services:

There was one pharmacy that provided on demand availability of specialist medicines in the North locality of Plymouth: Asda Pharmacy in Estover.

GAP ANALYSIS: CURRENT AND FUTURE PROVISION

(1) There is significant development planned in the Plymouth North locality. However, it is not anticipated that it will take place within the period covered by this PNA. If development does in fact progress more quickly, a future need will arise in the Derriford area once 300 houses are completed and occupied.

(2) The development of 2,000 new houses is planned for the Woolwell area, which is in the South Hams district of Devon (so does not fall within the Plymouth City boundary). However Woolwell is adjacent to the city boundary and as such this development would result in a future need once 300 houses are built and occupied. Given the location of the development, that need could be met by a pharmacy located either in Woolwell or in the area of Plymouth close to Woolwell.

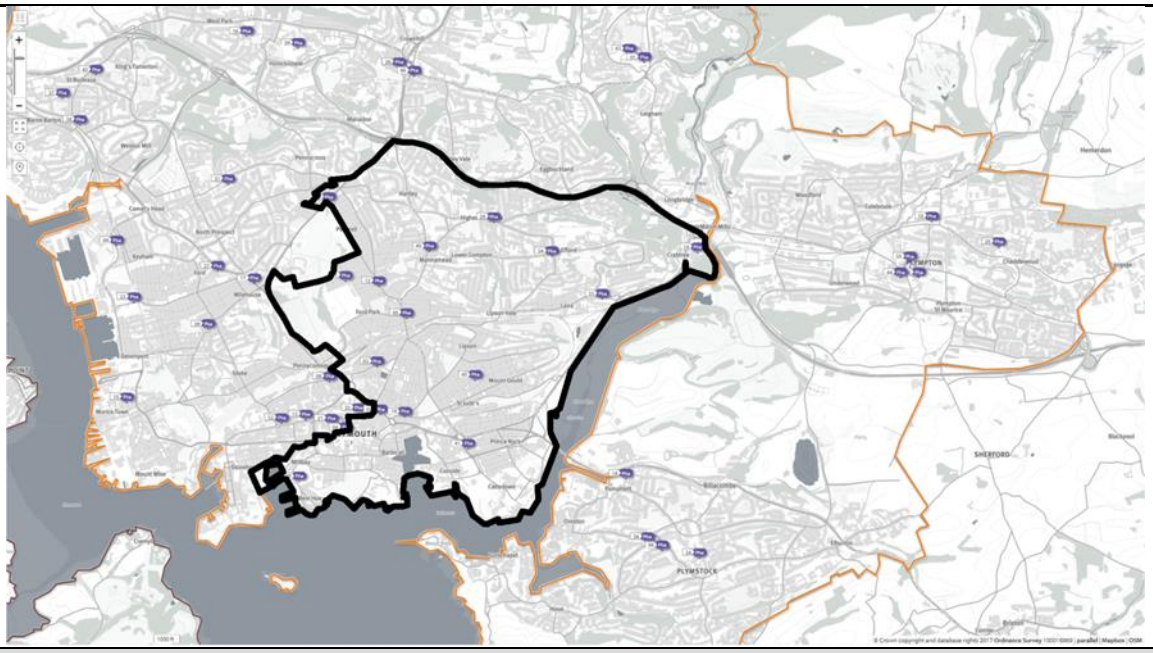
(3) No other current gaps or gaps that will materialise in the period covered by this PNA have been identified.

8.3 Plymouth South locality summary

DEMOGRAPHY	
Population size	68,919 (3.6% increase from 2009 to 2015)
Ethnic breakdown	• 88.5% White • 5.5% All other White • 1.9% Mixed/multiple ethnic groups • 2.5% Asian/Asian British • 1.0% Black/African/Caribbean/Black British • 0.7% Other ethnic group
IMD 2015 Score and locality rank (1=most deprived, 4=least deprived)	25.8 (rank: 3/4)
Top three Mosaic Groups	*Rental Hubs* (educated young people privately renting in urban neighbourhoods) *Transient Renters* (single people privately renting low cost homes for the short term) *Aspiring Homemakers* (Younger households settling down in housing priced within their means)
HEALTH NEEDS OVERVIEW	
Rank for locality-based health profile ('cradle to grave') (1=locality with greatest needs):	3/4
Rank for public health indicators (as above):	3/4
BEST HEALTH OUTCOMES FOR THIS LOCALITY	
• Highest percentage of babies being breastfed at 6-8 weeks • Lowest percentage of adult with a long-term problem or disability • Lowest percentage of adults with high blood pressure from GP referrals	• Lowest mortality rate for circulatory disease • Lowest rate of admissions due to accidents for young adults aged 15-24 years old
KEY HEALTH NEEDS FOR THIS LOCALITY	
• Highest percentage of social isolation within families • Highest rate of admission for falls for over 65s and over 75s • High rate of admissions due to accidents in the 0-4 age group	• Highest mortality rate for respiratory disease in over 75 year olds • Higher rate of teenage pregnancy compared to the Plymouth average
PHARMACY PROVISION OVERVIEW:	
Number of GP practices:	15
Number of pharmacies:	13
Pharmacies per 10,000 population:	1.89
Prescriptions per pharmacy:	103,931
Population per pharmacy & locality rank (1= lowest no. of pharmacies per head of pop.):	5,301 (rank: 2/4)

HOUSING GROWTH AND SIGNIFICANT HOUSING DEVELOPMENTS

There is now a mixture of affluent and deprived populations due to development and urban regeneration of the Millbay area. A number of key housing sites have been identified for additional dwellings. **It is estimated that a maximum of 1,010 dwellings could be built in this locality between 2016 and 2022.**



ACCESSIBILITY:

Provision:	MON-FRI:	✓	Saturday:	✓	Sunday:	✓	
Longest pharmacy opening times within this locality			07:00-23:00 Monday-Friday 07:00-22:00 Saturday 10:50-18:30 Sunday				
Proportion of population with no car and locality rank (1=lowest proportion of car ownership):			32.7% (rank: 2/4)				
Drive time analysis			The longest drive time to a pharmacy is 5 minutes.				
Public transport			All pharmacies are accessible via public transport				

PROVISION OF PHARMACEUTICAL SERVICES:

(1) Essential services:

No. of pharmacies dispensing appliances:	All pharmacies

(2) Advanced services:

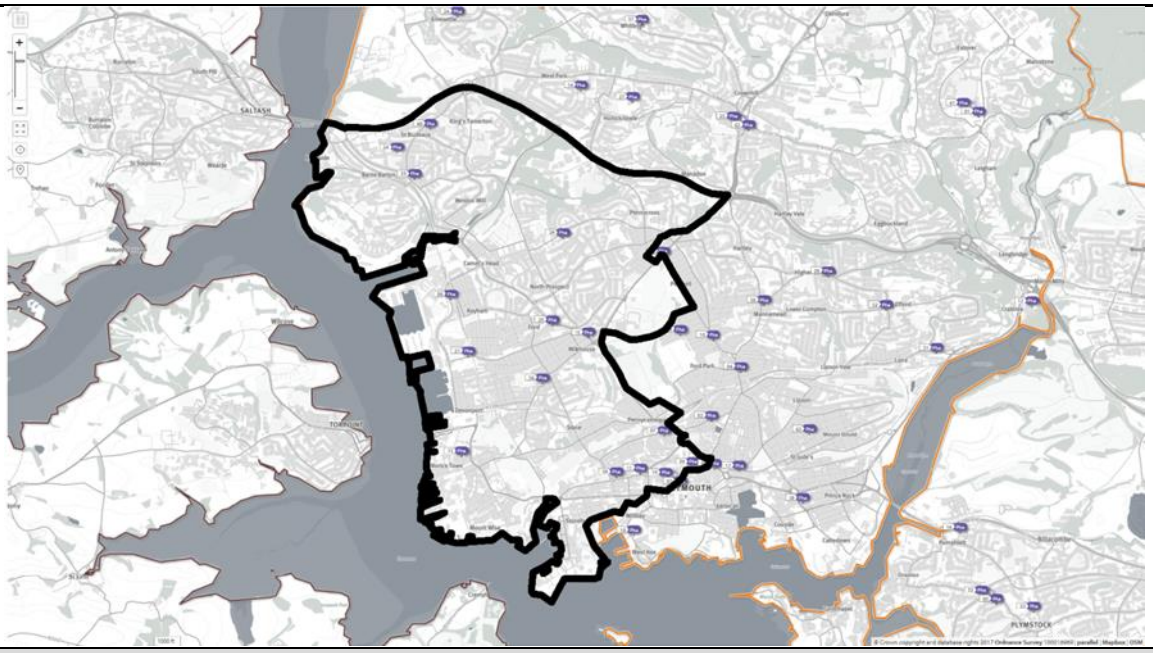
No. offering Medicines Use Review Service:	12 out of 13 pharmacies
No. offering New Medicine Service:	11 out of 13 pharmacies
No. offering Appliance Use Review Service:	0
No. offering Stoma Appliance Customisation:	0
No. offering Influenza vaccination	11 out of 13 pharmacies

(3) Enhanced services:
There was one pharmacy that provided on demand availability of specialist medicines in the South locality of Plymouth: Hyde Park Pharmacy in Mutley.
GAP ANALYSIS: CURRENT AND FUTURE PROVISION
(1) No current gaps or gaps that will materialise in the period covered by this PNA have been identified.

8.4 Plymouth West locality summary

POPULATION DEMOGRAPHICS:	
Population size	72,028 (5.1% increase from 2009 to 2015)
Ethnic breakdown	• 91.5% White British • 3.9% All other White • 1.5% Mixed/multiple ethnic groups • 1.7% Asian/Asian British • 0.9% Black/African/Caribbean/Black British • 0.5% Other ethnic group
IMD 2015 Score and locality rank (1=most deprived, 4=least deprived)	39.2 (rank: 1/4)
Top three Mosaic Groups	*Transient Renters* (single people privately renting low cost homes for the short term) *Family Basics* (families with limited resources who have to budget to make ends meet) *Municipal Challenge* (urban renters of social housing facing an array of challenges)
HEALTH NEEDS OVERVIEW:	
Rank for locality-based health profile ('cradle to grave') (1=locality with greatest needs):	1/4
Rank for public health indicators (as above):	1/4
BEST HEALTH OUTCOMES FOR THIS LOCALITY	
• Locality with the lowest rate of incidences of melanoma	
KEY HEALTH NEEDS FOR THIS LOCALITY	
• Locality with the lowest life expectancy • Highest percentage of childhood obesity • Highest mortality rate for circulatory disease • Highest percentage of parents who smoke • Highest rate of admissions for accidents in 0-24 year olds	• Highest percentage of vulnerable families • Highest rate of emergency admissions • Highest mortality rate for all-age-all-cause • Highest percentage of parents who are depressed/mentally ill • Highest rate of adults in treatment for substance misuse
PHARMACY PROVISION OVERVIEW:	
Number of GP practices:	11
Number of pharmacies:	18
Pharmacies per 10,000 population:	2.50
Prescriptions per pharmacy:	101,987
Population per pharmacy and locality rank (1= lowest no. of pharmacies per head of pop.):	4,001 (rank: 1/4)

HOUSING GROWTH AND SIGNIFICANT HOUSING DEVELOPMENTS
Within this locality there will be approximately 500 demolitions of existing houses which will then be replaced with new build housing. **It is estimated that a maximum of 1,428 dwellings could be built in this locality between 2016 and 2022.**



ACCESSIBILITY:						
Provision:	Mon-Fri:	✓	Saturday:	✓	Sunday:	✓
Longest pharmacy opening times within this locality			08:00-18:30 Monday-Friday 08:30-17:30 Saturday 10:30-16:30 Sunday			
Proportion of population with no car and locality rank (1=lowest proportion of car ownership):			36.7% (rank: 1/4)			
Drive time analysis			The longest drive time to a pharmacy is 5 minutes.			
Public transport			All pharmacies are accessible via public transport			

PROVISION OF PHARMACEUTICAL SERVICES:	
(1) Essential services:	
No. of pharmacies dispensing appliances:	All pharmacies
(2) Advanced services:	
No. offering Medicines Use Review Service:	17 out of 18 pharmacies
No. offering New Medicine Service:	17 out of 18 pharmacies
No. offering Appliance Use Review Service:	0
No. offering Stoma Appliance Customisation:	1 out of 18 pharmacies
No. offering Influenza vaccination	12 out of 18 pharmacies

(3) Enhanced services:

There are no pharmacies that provided on demand availability of specialist medicines in the West locality of Plymouth. But within Plymouth there are 2 pharmacies that did: Asda Pharmacy in Estover and Hyde Park Pharmacy in Mutley.

GAP ANALYSIS: CURRENT AND FUTURE PROVISION

(1) As a consequence of the deprivation and isolation of the community of Barne Barton and the lack of medical provision in this area, there is a need for a pharmacy in Barne Barton. In January 2018 NHS England granted (subject to appeal at the time of writing) applications from Ascent Healthcare and Day Lewis Pharmacy to open pharmacies in Barne Barton. If one of those pharmacies opens then the need will be met. Accordingly, there is not a current need. However if:

(a) both applications were to be refused on appeal, or

(b) both applications expire without a pharmacy opening (or one is refused on appeal and the other later expires without opening),

Then there would be a future need for a pharmacy in Barne Barton. Such a pharmacy should have core hours provision on all weekdays and Saturday mornings (at least), and opening hours on a Sunday would also be desirable. The pharmacy should also be willing to provide a wide range of additional services to compensate for the lack of medical provision in Barne Barton.

(2) No other current gaps or gaps that will materialise in the period covered by this PNA have been identified.

9. Conclusion

9.1 Current provision

Plymouth City Council's H&WB has had regard to the pharmaceutical services referred to in this PNA in seeking to identify those that are necessary, have secured improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the H&WB.

9.2 Necessary services: current gaps in provision

A need for a new pharmacy in the Elburton area was identified through an unforeseen benefits application and is due to be met by a granted application; there is therefore not a current need. Subject to the following, a future need for a pharmacy in Elburton will arise if the current grant for a pharmacy in Elburton lapses without a pharmacy opening.

Devon H&WB has identified, within the South Hams locality of the Devon PNA, a future need for a pharmacy in the western neighbourhood of the Sherford development, which is close to Elburton. Plymouth and Devon H&WBs are jointly of the view that:

- a pharmacy in Elburton would also meet the future need which has been identified in Sherford,
- a pharmacy in the western neighbourhood of Sherford would also meet the need for a pharmacy in Elburton.

Therefore, a future need for a pharmacy in Elburton will arise if the current grant for a pharmacy in Elburton lapses without a pharmacy opening, unless a pharmacy has opened in the western neighbourhood of Sherford. If that future need does arise in Elburton, it will be met if a pharmacy opens in the western neighbourhood of Sherford.

9.3 Necessary services: future gaps in provision

The increasing demand pressure in primary care is recognised and as such the role of community pharmacy may significantly change as a result, over the lifetime of this PNA. This may need innovative approaches in contractual arrangement in some locations to support these changes. However the precise nature of the changes have yet to be formed.

Across the existing services in Plymouth there is unused capacity for further MUR and NMS services and as a result there is no gap in provision and no need for additional capacity.

With regards to the 'on demand availability of specialist drugs' enhanced service, future provision within this PNA is considered to be adequate and thus there will not be any future gaps.

With regard to the development in the Plymstock Quarry area, a future need will arise at

the point when 1,200 houses are completed and occupied.

There is significant development planned in the Plymouth North locality. However, it is not anticipated that it will take place within the period covered by this PNA. If development does in fact progress more quickly, a future need will arise in the Derriford area once 300 houses are completed and occupied.

As a consequence of the deprivation and isolation of the community of Barne Barton and the lack of medical provision in this area, there is a need for a pharmacy in Barne Barton. In January 2018 NHS England granted (subject to appeal at the time of writing) applications from Ascent Healthcare and Day Lewis Pharmacy to open pharmacies in Barne Barton. If one of those pharmacies opens then the need will be met. Accordingly, there is not a current need. However if:

(a) both applications were to be refused on appeal, or
(b) both applications expire without a pharmacy opening (or one is refused on appeal and the other later expires without opening)

Then there would be a future need for a pharmacy in Barne Barton. Such a pharmacy should have core hours provision on all weekdays and Saturday mornings (at least), and opening hours on a Sunday would also be desirable. The pharmacy should also be willing to provide a wide range of additional services to compensate for the lack of medical provision in Barne Barton.

The development of 2,000 new houses is planned for the Woolwell area, which is in the South Hams district of Devon (so does not fall within the Plymouth City boundary). However Woolwell is adjacent to the city boundary and as such this development would result in a future need once 300 houses are built and occupied. Given the location of the development, that need could be met by a pharmacy located either in Woolwell or in the area of Plymouth close to Woolwell.

9.4 Other relevant services: current gaps in provision

With regards to Influenza vaccination advanced service, current provision is deemed to be adequate and there are not expected to be any future demands for this service over the lifetime of this PNA.

The urgent supply advanced service (NUMSAS) is a pilot service and due to be evaluated in due course. Therefore this PNA does not comment on the adequacy of provision at the present time however the future commissioning plans for this service may be known when the final PNA is published.

Services commissioned through the local authority and CCG, as well as other relevant NHS services, are represented in the PNA for reference but are outside the scope for assessment of need and therefore no statement is made in this PNA as to the adequacy of these services.

9.5 Other relevant services: future gaps in provision

None identified.

Appendix 1: Legislation relating to PNAs

Section 128A of the NHS Act 2006, as amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health powers to make regulations.

Section 128A Pharmaceutical needs assessments

(1) Each Health and Well-being Board must in accordance with regulations--
  (a) assess needs for pharmaceutical services in its area, and
  (b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision--
  (a) as to information which must be contained in a statement;
  (b) as to the extent to which an assessment must take account of likely future needs;
  (c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;
  (d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision--
  (a) as to the pharmaceutical services to which an assessment must relate;
  (b) requiring a Health and Well-being Board to consult specified persons about specified matters when making an assessment;
  (c) as to the manner in which an assessment is to be made;
  (d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

The regulations referred to are the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended, in particular Part 2 and Schedule 1.

Part 2: Pharmaceutical needs assessments

3. Pharmaceutical needs assessments

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

(2) The pharmaceutical services to which each pharmaceutical needs assessment must relate 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 NHS services that may be provided under arrangements made by the NHSCB with a dispensing doctor).

4. Information to be contained in pharmaceutical needs assessments

(1) Each pharmaceutical needs assessment 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 pharmaceutical needs assessment 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 pharmaceutical needs assessments are to be published

Each HWB must publish its first pharmaceutical needs assessment by 1st April 2015.

6. Subsequent assessments

(1) After it has published its first pharmaceutical needs assessment, each HWB must publish a statement of its revised assessment within 3 years of its previous publication of a pharmaceutical needs assessment.

(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.

(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 its pharmaceutical needs assessment

7. Temporary extension of Primary Care Trust pharmaceutical needs assessments and access by the NHSCB and HWBs to pharmaceutical needs assessments

(1) Before the publication by an HWB of the first pharmaceutical needs assessment that it prepares for its area, the pharmaceutical needs assessment that relates to any locality within that area is the pharmaceutical needs assessment that relates to that locality of the Primary Care Trust for that locality immediately before the appointed day, read with—

(a) any supplementary statement relating to that assessment published by a Primary Care Trust under the 2005 Regulations or the 2012 Regulations; or

(b) any supplementary statement relating to that assessment published by the HWB under regulation 6(3).

(2) Each HWB must ensure that the NHSCB has access to—

(a) the HWB's pharmaceutical needs assessment (including any supplementary statement that it publishes, in accordance with regulation 6(3), that becomes part of that assessment);

(b) any supplementary statement that the HWB publishes, in accordance with regulation 6(3), in relation to a Primary Care Trust's pharmaceutical needs assessment; and

(c) any pharmaceutical needs assessment of a Primary Care Trust that it holds,

which is sufficient to enable the NHSCB to carry out its functions under these Regulations.

(3) Each HWB must ensure that, as necessary, other HWBs have access to any pharmaceutical needs assessment of a Primary Care Trust that it holds, which is sufficient to enable the other HWBs to carry out their functions under these Regulations.

8. Consultation on pharmaceutical needs assessments

(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 sub-paragraph (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 well-being of people in its area.

Schedule 1: Information to be contained in pharmaceutical needs assessments

1. Necessary services: current provision

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).

2. Necessary services: gaps in provision

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.

3. Other relevant services: current provision

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.

4. Improvements and better access: gaps in provision

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.

5. Other NHS services

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.

6. How the assessment was carried out

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.

7. Map of provision

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

Finally, specifically in relation to controlled localities, regulation 39 provides:

39. Process of determining controlled localities: formulation of the NHSCB's decision

…

(2) Once it has determined whether or not an area is or is part of a controlled locality, the NHSCB must—

(a) if it determines that the area is to become or become part of a controlled locality, or is to cease to be part of a controlled locality—

(i) delineate precisely the boundary of the resulting controlled locality on a map,

(ii) publish that map, and

(iii) make that map available as soon as is practicable to any HWB that has all or part of that controlled locality in its area;

…

(4) A HWB to which a map is made available under paragraph (2)(a)(iii) must—

(a) publish that map alongside its pharmaceutical needs assessment map (once it has one); or

(b) include the boundary of the controlled locality (in so far as it is in, or part of the boundary of, the HWB's area) in its pharmaceutical needs assessment map (once it has one).

Appendix 2: Steering Group membership

The Devon-wide PNA Steering Group comprised the following individuals (in alphabetical order by surname):

- Karen Acott, Executive Partner, Wallingbrook Health Group
- Dave Bearman, Chair, Devon, Cornwall and Isles of Scilly Pharmacy Local Professional Network
- Doug Haines, Public Health Analyst, Torbay Council
- Kirsty Hill, Senior Public Health Information Analyst, Devon County Council
- Robert Nelder, Consultant in Public Health, Plymouth City Council
- Janet Newport, Contracts Manager - Pharmacy & Eye Care, NHS England
- Sue Taylor, Chief Officer, Devon Local Pharmaceutical Committee
- Claire Turbutt, Advanced Public Health Practitioner, Plymouth City Council
- Ian Tyson, Acting Head of Public Health Improvement, Torbay Council
- David Ward, Assistant Contract Manager - Pharmacy, NHS England

Appendix 3: Equality impact assessment

STAGE 1: What is being assessed and by whom?	
What is being assessed - including a brief description of aims and objectives?	The purpose of the pharmaceutical needs assessment (PNA) is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a Health and Wellbeing Board's (H&WB's) area for a period of up to three years, linking closely to the Joint Strategic Needs Assessment (JSNA). Whilst the JSNA focusses on the general health needs of the population of Plymouth, the PNA looks at how those health needs can be met by pharmaceutical services commissioned by NHS England. If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to NHS England to be included in the pharmaceutical list for the H&WB's area in which they wish to have premises. In general, their application must offer to meet a need that is set out in the H&WB's PNA, or to secure improvements or better access similarly identified in the PNA. There are however some exceptions to this, in particular applications offering benefits that were not foreseen when the PNA was published ('unforeseen benefits applications'). As well as identifying if there is a need for additional premises, the PNA will also identify whether there is a need for an additional service or services, or whether improvements or better access to existing services are required. Identified needs, improvements or better access could either be current or will arise within the lifetime of the PNA. Whilst the PNA is primarily a document for NHS England to use to make commissioning decisions, it may also be used by local authorities (LAs) and Clinical Commissioning Groups (CCGs). A robust PNA will ensure those who commission services from pharmacies and dispensing appliance contractors (DACs) are able to ensure services are targeted to areas of health need, and reduce the risk of overprovision in areas of less need.
Author	Claire Turbutt
Department and Service	Public Health, Office of the Director of Public Health
Date of Assessment	October 2017

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
Age	Plymouth at mid-year 2015 had an estimated population of 262,712. Due to an estimated 25,000 to 30,000 students residing in the city, the proportion of 18-24 year olds (12.8%) is higher than that found regionally (8.7%) and nationally (9.0%). The proportion of the working-age (15-64 year old) population (65.7%) is higher than that regionally (62.2%) and nationally (64.4%). The city has the same proportion of those aged 75 and over as nationally (8.1%) but lower than the regional value of 9.8%. The proportion of children and young people (under 18) is lower in both Plymouth and regionally (19.8%) compared to nationally (19.0%)	Pharmaceutical services will be provided on the basis of clinical need – this document specifies the needs within the city. Any missing provision should have been identified in the document and should therefore have a positive impact.	The predicted population increases within age bands has been estimated. The document will be reviewed in three years' time. It is assumed the age-specific predictions of population growth will be within tolerance, which will ensure provision of pharmaceutical services in an equitable manner.	NHSE. Throughout the life of the document.
Disability	According to the 2011 Census, 10.0% of Plymouth residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months (including problems related to old age). The national value was 8.3%. According to the 2011	The provision of adequate pharmaceutical services responds to these statistics (which potentially show a relatively high demined when compared to national averages). The aim of the document is to enable the	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	Census, 46.0% of Plymouth residents reported their general health as 'very good'; this increased to 79.5% when also including those who reported their health as 'good'. In England 81.4% of people reported their general health as either 'very good' or 'good'. Plymouth's combined value is therefore nearly two percentage points lower than the national average.	provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	services.	
Faith/Religion or Belief	According to the 2011 Census, Christianity is the most common religion in Plymouth (58.1% of the population). 32.9% of the Plymouth population stated they had no religion. Those following Hinduism, Buddhism, Judaism or Sikhism combined totalled less than 1.0% of the population	Pharmaceutical services are not targeted at any particular religion. The aim of the document is to ensure the provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.
Gender - including marriage, pregnancy and maternity	Overall, 50.6% of Plymouth's population is female. According to the 2011 Census, of those aged 16 and over 90,765 (42.9%) people are married. 5,190 (2.5%) of people in Plymouth are separated and still either legally married or legally in a same-sex civil partnership. There are 464 people in a	The need for pharmacy services in relation to sexual health have been identified within the document. This will ensure provision of adequate and appropriate pharmaceutical services to meet the needs of this	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	registered Same-Sex Civil Partnership in the city. There were 3,160 live births in 2015. The West locality had the highest number of births (1,034) and the East locality the lowest (592).	population.	services.	
Gender Reassignment	Recent surveys have put the prevalence of transgender people between 0.5 and 1% of population (some very recent reports have upped this to 2%). Over the last eight years the prevalence of transgender people in the UK has been increasing at an average rate of over 20% per annum in adults and 50% in children. In 2015 there was a 100% increase in referrals to the Gender Identity Development Service at the Tavistock & Portman Institute. The average age for presentation for reassignment of male-to-female is 40-49 whilst for female-to-male the age group is 20-29. There is no precise number of the transgender population in Plymouth however twenty three transgender people belong to Pride in Plymouth.	The PNA aims to ensure adequate provision of pharmaceutical services throughout the city taking into consideration any particular needs identified. Gender-related pharmaceutical needs should have been identified within the document to ensure provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
Race	According to the 2011 Census, 92.9% of Plymouth's population identify themselves as White British. This is significantly higher than the England average (79.8%). Plymouth has lower percentages of residents within each ethnic group compared with the national average. However, despite the small numbers, Plymouth has a rapidly rising BME population which has more than doubled from 7,906 individuals since the 2001 census. The main ethnic minorities in Plymouth are the Polish (0.7%; just over 1,900) and the Chinese (0.5%; just over 1,200).	Pharmaceutical services are not targeted at a specific ethnic group. The PNA attempts to ensure provision of adequate and appropriate pharmaceutical services to meet the needs of the population. There are some diseases which are more prevalent amongst specific ethnic groups however the PNA, if successful, will ensure adequate services to meet any additional needs.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.
Sexual Orientation - including Civil Partnership	There is no precise local data on numbers of Lesbian, Gay and Bi-sexual (LGB) people in Plymouth but it is nationally estimated at 5.0% to 7.0%. This would mean that approximately 13,000 people aged 16 years and over in Plymouth are LGB.	Pharmaceutical services are not targeted people with a specific sexual orientation. The PNA attempts ensure provision of adequate and appropriate pharmaceutical services to meet the needs of the population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.

Appendix 4: Consultation report

The consultation period ran from Monday 4th December 2017 to Friday 2nd February 2018. The Health and Wellbeing Boards for Plymouth, Devon and Torbay ran the consultation for each of their PNAs at the same time. This was to aid organisations who were asked to respond to consultations for more than one area at the same time.

The method of consultation was agreed by the PNA Steering Group. Individual areas also liaised with their Health and Wellbeing Boards regarding the consultation process. Plymouth's consultation was hosted on the Plymouth City Council Online Consultation portal. The survey questions were designed to gather feedback on whether the requirement of the PNA had been met and to offer opportunity to highlight any gaps. The web link for the consultation was emailed directly to the following organisations:

- Devon Local Pharmaceutical Committee
- Devon Local Medical Committee
- Healthwatch Devon
- Healthwatch Plymouth
- Healthwatch Torbay
- VCSE Plymouth
- NHS England Director of Commissioning Operations South West
- NHS England Pharmacy Contracts Manager
- NHS England CD Accountable Office
- NHS England Devon Cornwall & Isles of Scilly Area Team
- Plymouth Health and Wellbeing Board
- Devon Health and Wellbeing Board
- Cornwall Health and Wellbeing Board
- Plymouth Hospitals NHS Trust
- Livewell Southwest
- NHS New Devon Clinical Commissioning Group
- NHS South Devon and Torbay Clinical Commissioning Group
- All GP surgeries in Plymouth
- All Pharmacies in Plymouth

11 responses to the online consultation survey were received for Plymouth.
These individuals represented:

- Pharmacists (six responses)
- The Clinical and Effectiveness and Medicines Optimisations Team for the NHS NEW Devon and South Devon and Torbay Clinical Commissioning Groups
- The Local Pharmacy Committee
- The Plymouth Octopus Project, VCSE infrastructure organisation
- Community Pharmacy
- Devon Doctors

Overall consultation feedback regarding the PNA was very positive. A small number of minor corrections to accuracy of data were identified and these have been corrected. The main areas or themes that received comments are summarised briefly below.

Opening hours
With regard to bank holidays, pharmacies and DAC are not required to open on public and bank holidays, although some do choose to. NHS England asks each contractor to confirm their intentions regarding these days and where necessary will direct a contractor or contractors to open on one or more of these dates to ensure adequate access.

Ability of pharmaceutical services to support primary care moving towards 8:00AM to 8:00PM availability was considered. The direction of travel for primary care, as set out in the GP Forward View, is for GP services to become available from 8:00AM to 8:00PM, and for pharmacies to become the first point of contact with health services for some health issues. It is anticipated that pharmacies' business interests will lead them to adapt their provision of pharmaceutical services to these changes, although innovative approaches in contractual arrangement may be needed in some locations to support these changes.

NHS Urgent Medicine Supply Advanced Service (NUMSAS)
This service is part of a pilot due to end in September 2018. Once the results of the pilot are known and recommendations confirmed, it will be possible to consider the implications for the provision of community pharmacy services.

Maps of urgent care and other services
Maps of pharmacies were provided to meet the statutory requirements of the PNA. Mapping of other services such as urgent care centres was not included due to the fluidity of such services over the lifetime of the PNA.

Appendix 5: Pharmacies and opening times by locality

Table 62: List of contractors and opening times in the East locality

Name	Locality	Opening Hours Monday	Opening Hours Tuesday	Opening Hours Wednesday	Opening Hours Thursday	Opening Hours Friday	Opening Hours Saturday	Sunday Opening Hours
Boots Pharmacy (Mudge Way)	East	0830-1830	0830-1830	0830-1830	0830-1830	0830-1830	0900-1230	Closed
Boots Pharmacy (St Stephens Place)	East	0900-1230 1300-1730	0900-1230 1300-1730	0900-1230 1300-1730	0900-1230 1300-1730	0900-1230 1300-1730	0900-1230 1300-1730	1000-1600
Boots Pharmacy (The Broadway)	East	0900-1300 1400-2100	0900-1300 1400-2100	0900-1300 1400-2100	0900-1300 1400-2100	0900-1300 1400-2100	0900-1300 1400-2100	1000-1600
Church Road Pharmacy	East	0900-1245 1400-1830	0900-1245 1400-1830	0900-1245 1400-1830	0900-1245 1400-1830	0900-1245 1400-1830	0900-1300	Closed
Day Lewis Pharmacy (Glenside Rise)	East	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300	Closed
Morrisons Pharmacy	East	0800-1330 1430-2000	0800-1330 1430-2000	0800-1330 1430-2000	0800-1330 1430-2000	0800-1330 1430-2000	0800-1330 1430-2000	1100-1700
Well Pharmacy (Glen Road)	East	0830-1815	0830-1815	0830-1815	0830-1815	0830-1815	0900-1700	Closed
Well Pharmacy (Radford Park Road)	East	0845-1800	0845-1800	0845-1800	0845-1800	0845-1800	0845-1300	Closed
Well Pharmacy (The Ridgeway)	East	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1700	Closed

Table 63: List of contractors and opening times in the North locality

Name	Locality	Opening Hours Monday	Opening Hours Tuesday	Opening Hours Wednesday	Opening Hours Thursday	Opening Hours Friday	Opening Hours Saturday	Sunday Opening Hours
Asda Pharmacy	North	0700-2300	0700-2300	0700-2300	0700-2300	0700-2300	0700-2100	1000-1600
Boots Pharmacy (Leypark Drive)	North	0830-1330 1400-1830	0830-1330 1400-1830	0830-1330 1400-1830	0830-1330 1400-1830	0830-1330 1400-1830	0900-1700	Closed
Boots Pharmacy (Morshead Road)	North	0830-1300 1400-1800	0830-1300 1400-1800	0830-1300 1400-1800	0830-1300 1400-1800	0830-1300 1400-1800	0900-1300 1400-1730	Closed
LloydsPharmacy (Honicknowle Green)	North	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1200	Closed
Tesco Pharmacy	North	0800-2000	0800-2000	0800-2000	0800-2000	0800-2000	0800-2000	1000-1600
Well Pharmacy (Bampfylde Way)	North	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	Closed	Closed
Well Pharmacy (Hornchurch Road)	North	0830-1800	0830-1800	0830-1800	0830-1800	0830-1800	0900-1300	Closed
Well Pharmacy (Meavy Way)	North	0800-1800	0800-2000	0800-1800	0800-2000	0800-1800	Closed	Closed
Well Pharmacy (Southway Drive)	North	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Well Pharmacy (Transit Way)	North	0830-2000	0830-2000	0830-2000	0830-2000	0830-2000	0830-2000	Closed
Well Pharmacy (Whitleigh Green)	North	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed

Table 64: List of contractors and opening times in the South locality

Name	Locality	Opening Hours Monday	Opening Hours Tuesday	Opening Hours Wednesday	Opening Hours Thursday	Opening Hours Friday	Opening Hours Saturday	Sunday Opening Hours
Boots Pharmacy (Cattedown Road)	South	0900-1330 1430-1800	0900-1330 1430-1800	0900-1330 1430-1800	0900-1330 1430-1800	0900-1330 1430-1800	0900-1700	Closed
Boots Pharmacy (Drakes Circus)	South	0800-1300 1400-1830	0800-1300 1400-1830	0800-1300 1400-1830	0800-1300 1400-1830	0800-1300 1400-1830	0800-1300 1400-1830	1030-1630
Boots Pharmacy (Eggbuckland Road)	South	0900-1330 1430-1830	0900-1330 1430-1830	0900-1330 1430-1830	0900-1330 1430-1830	0900-1330 1430-1830	0900-1300	Closed
Boots Pharmacy (Endsleigh Place)	South	0800-1200 1230-1800	0800-1200 1230-1800	0800-1200 1230-1800	0800-1200 1230-1800	0800-1200 1230-1800	(0900-1200 1230-1730 Term time only) (0900-1300 Outside term time)	Closed
Boots Pharmacy (Mutley Plain)	South	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0900-1300 1400-1730	Closed
Boots Pharmacy (Salisbury Road)	South	0830-1330 1400-1800	0830-1330 1400-1800	0830-1330 1400-1800	0830-1330 1400-1800	0830-1330 1400-1800	0900-1300	Closed
Ebrington Pharmacy	South	0900-1300 1400-1830	0900-1300 1400-1830	0900-1300 1400-1830	0900-1300 1400-1830	0900-1300 1400-1830	0900-1300	Closed
Hyde Park Pharmacy	South	0900-1900	0900-1900	0900-1900	0900-1900	0900-1900	0900-1800	1000-1830
LloydsPharmacy (Sainsbury's)	South	0700-2300	0700-2300	0700-2300	0700-2300	0700-2300	0700-2200	1000-1600
Stoltons Pharmacy	South	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1630	0900-1300 1400-1800	0900-1300 1400-1800	0900-1200	Closed
Well Pharmacy (Eggbuckland Road)	South	0900-1830	0900-1830	0900-1830	0900-1830	0900-1830	0900-1700	Closed
Well Pharmacy (Old Laira Road)	South	0830-1800	0830-1800	0830-1800	0830-1800	0830-1800	0900-1300	Closed
Well Pharmacy (Torridge Way)	South	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	Closed	Closed

Table 65: List of contractors and opening times in the West locality

Name	Locality	Opening Hours Monday	Opening Hours Tuesday	Opening Hours Wednesday	Opening Hours Thursday	Opening Hours Friday	Opening Hours Saturday	Sunday Opening Hours
Boots Pharmacy (Chard Road)	West	0830-1330 1400-1815	0830-1330 1400-1815	0830-1330 1400-1815	0830-1330 1400-1815	0830-1330 1400-1815	Closed	Closed
Boots Pharmacy (Claremont Street)	West	0830-1300 1400-1815	0830-1300 1400-1815	0830-1300 1400-1815	0830-1300 1400-1815	0830-1300 1400-1815	0900-1230	Closed
Boots Pharmacy (New George Street)	West	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	1030-1630
Day Lewis Pharmacy (Saltash Road)	West	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1200	Closed
Devonport Pharmacy	West	0800-1800	0800-1800	0800-1800	0800-1800	0800-1800	0900-1200	Closed
King Street Pharmacy	West	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
LloydsPharmacy (Marlborough Street)	West	0900-1745	0900-1745	0900-1745	0900-1745	0900-1745	0900-1300	Closed
Milehouse Pharmacy	West	0900-1300 1400-1800	0900-1200 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1230	Closed
St Levan Pharmacy	West	0830-1800	0830-1800	0830-1800	0830-1800	0830-1800	Closed	Closed
Superdrug Pharmacy (Cornwall Street)	West	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0900-1400 1430-1730	Closed
Superdrug Pharmacy (New George Street)	West	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0900-1400 1430-1730	Closed
Well Pharmacy (Devonport Road)	West	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Well Pharmacy (Ford)	West	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Well Pharmacy (Ham Green)	West	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Well Pharmacy (King Street)	West	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Well Pharmacy (Peverell Park Road)	West	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Well Pharmacy (St Budeaux)	West	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1700	Closed
Well Pharmacy (Stirling Road)	West	0800-1830	0800-1830	0800-1800	0800-1830	0800-1830	Closed	Closed

Appendix 6: Pharmacies providing minor ailments services

Pharmacy	Address	Postcode
Asda	Leypark Walk, Estover	PL6 8TB
Boots	Chard Road Health Centre, Chard Road,	PL5 2UE
Boots	Drakes Circus Shopping Centre	PL1 1DH
Boots	6-8 Eggbuckland Road, Mannamead	PL3 5HE
Boots	8 Leypark Drive, Estover	PL6 8UD
Boots	17 Morshead Road, Crownhill	PL6 5AD
Boots	Plymouth University Campus, Endsleigh Place	PL4 6DN
Boots	57-59 Mutley Plain	PL4 6JH
Boots	76 New George Street	PL1 1RR
Boots	58 Salisbury Road, St Judes	PL4 8SY
Boots	Units 4B&4C East End Community Village	PL4 0RP
Day Lewis	206 Saltash Road, Keyham	PL2 2BD
Devonport	51 Damerel Close, Devonport	PL1 4JZ
Ebrington	61A Ebrington Street,	PL4 9AA
Hyde Park	73 Hyde Park Road, Mutley	PL3 4JN
King Street	140 King Street, Stonehouse	PL1 5JE
Lloyds	29 Marlborough Street, Devonport	PL1 4AE
Lloyds at Sainsubury's	Plymouth Road, Marsh Mills	PL3 6RL
St Levan	350 St Levan Road, Keyham	PL2 1JR
Stoltons	20 Bishops Place, West Hoe	PL1 3BW
Superdrug	74 New George Street	PL1 1RR
Tesco	2 Woolwell Crescent, Woolwell	PL6 7RF
Well Pharmacy	34 Devonport Road, Stoke	PL3 4DH
Well Pharmacy	Jubilee Buildings, Peverell Park Road	PL2 3PG
Well Pharmacy	Knowle House Surgery, 4 Meavy Way	PL5 3JB
Well Pharmacy	53 Torridge Way, Efford	PL3 6HJ
Well Pharmacy	St Budeaux Health Centre, Stirling Rd	PL5 1PL
Boots	Plympton Health Centre, Mudgeway	PL7 2PS
Boots	3 St Stephens Place, Ridgeway	PL7 2ZN
Day Lewis	Glenside Rise,	PL7 4DR
Well Pharmacy	4 Chaddlewood District Shopping Centre	PL7 2DE
Well Pharmacy	31 The Ridgeway	PL7 3AW
Boots	18-20 The Broadway	PL9 7AW
Morrisons	15 Pomphlett Road	PL9 7BH
The Pharmacy	91 Church Road	PL9 9AX
Well Pharmacy	14-16 Radford Park Road	PL9 9DH

Appendix 7: Summary of health needs by ward (values and ranks)

The four worst performing wards are colour-coded 'red'; the four top performing wards are colour-coded green. Births are not included in this colour-coding.

Table 66: Summary of health needs by ward (values)

Indicator	Budshead	Compton	Devonport	Drake	Efford & Lipson	Eggbuckland	Ham	Honicknowle	Moor View	Peverell
Index of Multiple Deprivation (IMD) 2015 score	30.7	15.8	45.0	25.9	33.0	15.4	37.4	39.3	22.8	10.8
Births (numbers)	167	92	268	79	191	117	190	176	114	164
Low birth weight births (%)	7.8	*	6.3	7.6	6.3	*	5.8	10.8	7.0	4.3
Life expectancy (years)	80.4	81.4	79.1	76.7	80.0	82.8	80.2	79.2	81.0	82.1
Breastfeeding at 6-8 weeks (%)	35.4	49.0	35.0	48.8	39.0	39.3	31.8	21.9	32.4	58.8
Vulnerable families (%)	17.8	8.4	29.2	29.8	22.9	5.3	24.2	25.8	11.2	5.9
Dental disease in children (prevalence) (%)	183.6	108.7	227.8	110.2	202.0	124.7	281.9	292.0	159.4	106.6
Childhood obesity (%)	13.4	10.6	16.1	8.7	17.5	9.6	15.1	13.9	13.5	7.1
Self-reported 'bad' or 'very bad health' (%)	7.1	4.6	7.9	3.9	6.6	6.1	8.8	9.5	7.9	4.1
Long-term health problem or disability (%)	21.9	17.1	21.3	12.2	19.6	20.6	25.1	26.5	23.8	16.2
Elective admissions (rate per 10,000 pop)	1,567.1	1,456.7	1,378.0	1,280.9	1,500.2	1,442.9	1,515.2	1,494.6	1,580.4	1,475.0
Emergency admissions (rate per 10,000 pop)	1,113.9	944.3	1,312.3	1,351.9	1,235.5	982.3	1,190.6	1,281.3	1,123.1	880.5
Circulatory disease mortality (all ages) (rate per 10,000 pop)	25.7	27.7	43.3	22.8	25.0	23.3	30.1	25.9	18.2	25.7
Circulatory disease mortality (under 75s) (rate per 10,000 pop)	6.8	6.0	19.5	*	9.2	6.4	11.8	9.9	8.7	8.1
Respiratory disease mortality (all ages) (rate per 10,000 pop)	16.5	11.7	20.1	19.8	27.6	9.0	17.4	24.1	18.5	11.2
Respiratory disease mortality (under 75s) (rate per 10,000 pop)	*	*	*	*	12.5	*	5.5	3.9	*	*
All-age-all-cause mortality (rate per 10,000 pop)	97.1	103.4	131.4	101.6	99.2	91.5	99.5	121.3	94.5	90.3

*Values have been supressed due to the underlying counts being less than five

Indicator	Plympton Chaddlewood	Plympton Erle	Plympton St Mary	Plymstock Dunstone	Plymstock Radford	Southway	St Budeaux	St Peter & the Waterfront	Stoke	Sutton & Mount Gould
Index of Multiple Deprivation (IMD) 2015 score	11.0	15.0	10.5	10.1	12.9	22.7	41.3	49.3	28.5	32.7
Births (numbers)	111	87	121	135	138	186	226	216	166	216
Low birth weight births (%)	4.5	*	*	*	5.8	8.1	7.1	6.9	7.8	6.5
Life expectancy (years)	86.0	84.7	80.9	83.6	81.9	80.5	81.1	76.4	78.4	80.6
Breastfeeding at 6-8 weeks (%)	38.3	46.7	36.2	42.1	51.7	31.1	22.6	47.5	44.0	44.4
Vulnerable families (%)	6.6	6.2	3.2	5.8	5.1	14.6	36.0	32.2	21.8	21.9
Dental disease in children (prevalence) (%)	56.2	120.3	70.9	91.8	109.1	150.1	252.3	248.7	167.8	217.2
Childhood obesity (%)	7.4	11.7	13.7	12.1	5.3	15.1	14.2	13.2	15.6	14.2
Self-reported 'bad' or 'very bad health' (%)	3.8	6.1	5.1	5.0	5.4	7.0	8.1	9.3	5.9	5.8
Long-term health problem or disability (%)	13.2	21.7	19.8	20.1	20.6	21.5	22.5	22.9	18.9	17.7
Elective admissions (rate per 10,000 pop)	1,357.0	1,366.4	1,465.2	1,475.9	1,521.0	1,631.0	1,705.3	1,617.7	1,453.0	1,450.1
Emergency admissions (rate per 10,000 pop)	923.9	917.6	899.1	826.0	923.7	1,072.7	1,295.3	1,370.2	1,076.6	1,176.5
Circulatory disease mortality (all ages) (rate per 10,000 pop)	25.7	24.8	33.7	22.1	24.0	35.3	25.6	22.4	25.9	23.2
Circulatory disease mortality (under 75s) (rate per 10,000 pop)	*	*	5.6	6.2	4.7	7.9	10.5	9.7	4.9	10.4
Respiratory disease mortality (all ages) (rate per 10,000 pop)	12.6	12.0	16.0	8.0	12.1	16.3	16.7	16.8	21.6	13.6
Respiratory disease mortality (under 75s) (rate per 10,000 pop)	*	*	6.4	*	*	5.3	*	*	6.7	*
All-age-all-cause mortality (rate per 10,000 pop)	88.3	95.8	116.4	77.8	87.8	109.1	95.5	116.8	137.4	96.3

*Values have been supressed due to the underlying counts being less than five

Table 67: Summary of health needs by ward (1 = 'worst' value, 20 = 'best' value'; overall rank 1 = 'worst' performing, 20 = 'best' performing)

Indicator	Budshead	Compton	Devonport	Drake	Efford & Lipson	Eggbuckland	Ham	Honicknowle	Moor View	Peverell
Index of Multiple Deprivation (IMD) 2015 score	8	13	2	10	6	14	5	4	11	18
Births (numbers)	9	18	1	20	5	15	6	8	16	11
Low birth weight births (%)	4	17	10	5	11	20	13	1	7	15
Life expectancy (years)	8	14	4	2	6	17	7	5	12	16
Breastfeeding at 6-8 weeks (%)	7	18	6	17	10	11	4	1	5	20
Vulnerable families (%)	10	13	4	3	7	18	6	5	12	16
Dental disease in children (prevalence) (%)	8	16	5	14	7	12	2	1	10	17
Childhood obesity (%)	11	15	2	17	1	16	5	8	10	19
Self-reported 'bad' or 'very bad health' (%)	7	17	6	19	9	11	3	1	5	18
Long-term health problem or disability (%)	6	17	9	20	14	10	2	1	3	18
Elective admissions (rate per 10,000 pop)	5	13	17	20	8	16	7	9	4	11
Emergency admissions (rate per 10,000 pop)	10	14	3	2	6	13	7	5	9	19
Circulatory disease mortality (all ages) (rate per 10,000 pop)	10	5	1	17	12	15	4	6	20	8
Circulatory disease mortality (under 75s) (rate per 10,000 pop)	12	15	1	8	7	13	2	5	9	10
Respiratory disease mortality (all ages) (rate per 10,000 pop)	10	17	4	5	1	19	7	2	6	18
Respiratory disease mortality (under 75s) (rate per 10,000 pop)	6	14	11	18	1	15	4	7	13	17
All-age-all-cause mortality (rate per 10,000 pop)	11	7	2	8	10	16	9	3	15	17
Sum of ranks	142	243	88	205	121	251	93	72	167	268
Overall ward rank	9	14	2	12	6	16	3	1	10	18

Indicator	Plympton Chaddlewood	Plympton Erle	Plympton St Mary	Plymstock Dunstone	Plymstock Radford	Southway	St Budeaux	St Peter & the Waterfront	Stoke	Sutton & Mount Gould
Index of Multiple Deprivation (IMD) 2010 score	17	15	19	20	16	12	3	1	9	7
Births (numbers)	17	19	14	13	12	7	2	3	10	3
Low birth weight births (%)	14	16	18	19	12	2	6	8	3	9
Life expectancy years)	20	19	11	18	15	9	13	1	3	10
Breastfeeding at 6-8 weeks (%)	9	15	8	12	19	3	2	16	13	14
Vulnerable families (%)	14	15	20	17	19	11	1	2	9	8
Dental disease in children (prevalence) (%)	20	13	19	18	15	11	3	4	9	6
Childhood obesity (%)	18	14	9	13	20	4	6	12	3	7
Self-reported 'bad' or 'very bad health' (%)	20	10	15	16	14	8	4	2	12	13
Long-term health problem or disability (%)	19	7	13	12	11	8	5	4	15	16
Elective admissions (rate per 10,000 pop)	19	18	12	10	6	2	1	3	14	15
Emergency admissions (rate per 10,000 pop)	15	17	18	20	16	12	4	1	11	8
Circulatory disease mortality (all ages) (rate per 10,000 pop)	9	13	3	19	14	2	11	18	7	16
Circulatory disease mortality (under 75s) (rate per 10,000 pop)	20	19	16	14	18	11	3	6	17	4
Respiratory disease mortality (all ages) (rate per 10,000 pop)	14	16	12	20	15	11	9	8	3	13
Respiratory disease mortality (under 75s) (rate per 10,000 pop)	18	16	3	18	9	5	10	12	2	8
All-age-all-cause mortality (rate per 10,000 pop)	18	13	5	20	19	6	14	4	1	12
Sum of ranks	281	255	215	279	250	124	97	105	141	169
Overall ward rank	20	17	13	19	15	7	4	5	8	11

Table 68: Summary of public health indicators by ward (values)

Indicator	Budshead	Compton	Devonport	Drake	Efford & Lipson	Eggbuckland	Ham	Honicknowle	Moor View	Peverell
Teenage pregnancy (rate per 1,000 women)	22.8	26.3	40.4	*	26.1	26.5	*	25.5	*	*
Smoking in pregnancy (%)	20.0	4.4	20.4	22.4	19.3	8.5	14.5	23.2	0.0	6.1
Parents who smoke (%)	20.1	6.8	27.0	17.6	18.6	9.8	22.9	24.8	12.6	6.1
Parents who misuse drugs (%)	2.2	1.1	4.1	2.4	4.3	*	3.8	3.9	1.6	0.9
Parents who misuse alcohol (%)	2.5	*	1.8	2.9	3.2	*	2.2	2.6	*	1.1
Depressed/mentally ill parents (%)	12.4	11.0	19.7	14.1	19.3	8.3	16.7	17.9	9.0	8.3
Social isolation (%)	4.9	5.3	9.0	26.8	8.9	2.1	5.0	7.3	2.2	2.9
Accident admissions (0-4 year olds) (rate per 1,000 pop)	24.8	23.7	21.8	*	19.9	10.8	12.8	25.7	8.6	13.6
Accident admissions (5- 14 year olds) (rate per 1,000 pop)	7.9	7.8	11.0	*	8.2	6.1	13.3	8.7	14.3	12.6
Accident admissions (15-24 year olds) rate per 1,000 pop)	29.2	9.9	19.9	4.6	13.7	13.7	16.5	20.5	9.0	9.7
Emergency circulatory admissions (all ages) (rate per 10,000 pop)	104.2	83.7	101.0	161.9	114.3	96.1	119.1	127.0	115.5	86.4
Emergency circulatory admissions (under 75s) (rate per 10,000 pop)	63.4	47.9	63.6	114.8	84.4	47.3	64.5	81.9	66.4	46.1
Admissions from falls (65 years and over) (rate per 10,000 pop)	198.0	233.1	325.1	286.9	245.2	138.7	170.8	152.2	181.1	149.9
Admissions from falls (75 years and over) (rate per 10,000 pop)	292.4	386.9	483.5	543.4	455.0	241.2	275.6	248.5	246.0	283.9
Substance misuse (rate per 10,000 pop)	63.6	37.3	150.8	68.5	89.3	28.3	66.7	66.8	37.8	26.4
Self-harm admissions (rate per 10,000 pop)	47.1	11.2	35.1	17.2	38.8	14.0	27.1	30.2	20.1	14.8
Smoking status (GP referrals) (%)	18.5	13.1	24.9	21.4	20.3	11.7	20.8	21.0	13.9	12.9
Adult obesity (GP referrals) (%)	36.2	27.4	38.8	25.0	37.5	31.5	39.0	43.4	35.2	27.4
High blood pressure (GP referrals) (%)	17.7	16.8	14.2	12.7	12.8	16.4	17.8	15.6	17.3	14.3
One or more risk factors (smoking, obesity, high blood pressure) (%)	57.6	47.8	61.6	47.5	57.1	49.4	60.8	63.5	54.1	46.2
Incidences of melanoma (rate per 100,000 pop)	-	-	-	-	-	-	-	-	-	-
Cancer mortality (under 75s) (rate per 10,000 pop)	16.5	10.6	15.2	*	13.6	20.5	13.5	22.2	15.1	8.7

*Values have been supressed due to the underlying counts being less than five

Indicator	Plympton Chaddlewood	Plympton Erle	Plympton St Mary	Plymstock Dunstone	Plymstock Radford	Southway	St Budeaux	St Peter & the Waterfront	Stoke	Sutton & Mount Gould
Teenage pregnancy (rate per 1,000 women)	*	46.2	*	*	*	29.3	33.1	50.6	53.5	39.8
Smoking in pregnancy (%)	9.8	5.7	6.0	8.5	9.4	17.2	31.3	20.9	16.2	14.8
Parents who smoke (%)	8.3	5.7	4.5	6.0	5.5	16.0	31.3	31.0	18.2	15.2
Parents who misuse drugs (%)	1.7	*	*	1.0	*	1.3	5.1	4.8	3.0	3.1
Parents who misuse alcohol (%)	1.3	1.7	*	*	*	1.5	4.2	3.6	2.8	2.1
Depressed/mentally ill parents (%)	10.6	11.7	10.5	12.3	8.0	14.3	14.3	23.4	16.5	16.9
Social isolation (%)	2.6	1.5	1.0	2.1	1.5	4.2	10.7	17.7	7.1	14.1
Accident admissions (0-4 year olds) (rate per 1,000 pop)	17.8	21.2	11.1	11.9	14.2	15.5	26.9	25.0	21.8	20.0
Accident admissions (5- 14 year olds) (rate per 1,000 pop)	8.1	7.4	9.9	8.2	4.1	12.9	7.1	7.9	10.4	6.1
Accident admissions (15-24 year olds) rate per 1,000 pop)	14.5	7.4	13.8	10.1	10.8	9.6	17.1	17.9	13.0	7.8
Emergency circulatory admissions (all ages) (rate per 10,000 pop)	90.8	82.4	83.0	74.3	84.8	110.5	113.0	123.5	105.7	121.1
Emergency circulatory admissions (under 75s) (rate per 10,000 pop)	40.7	42.8	37.3	45.4	46.1	63.4	90.0	77.6	73.4	75.3
Admissions from falls (65 years and over) (rate per 10,000 pop)	110.5	180.7	219.8	179.2	146.8	163.8	251.8	214.4	197.7	151.8
Admissions from falls (75 years and over) (rate per 10,000 pop)	156.1	326.0	366.2	319.7	273.7	276.8	415.7	400.2	309.3	254.5
Substance misuse (rate per 10,000 pop)	13.4	25.6	15.4	19.5	26.9	31.9	62.3	244.9	99.1	108.2
Self-harm admissions (rate per 10,000 pop)	10.7	19.2	14.4	13.6	10.4	23.7	27.8	62.8	36.7	27.6
Smoking status (GP referrals) (%)	10.2	12.7	9.9	9.1	10.2	15.1	22.4	21.1	18.8	19.8
Adult obesity (GP referrals) (%)	34.2	31.8	29.3	29.3	29.1	37.2	38.5	29.5	32.1	33.5
High blood pressure (GP referrals) (%)	15.7	13.7	16.1	14.0	13.3	18.1	14.1	15.7	13.7	11.8
One or more risk factors (smoking, obesity, high blood pressure) (%)	50.0	49.8	46.1	44.7	44.6	57.0	59.8	53.6	52.8	54.4
Incidences of melanoma (rate per 100,000 pop)	-	-	-	-	-	-	-	-	-	-
Cancer mortality (under 75s) (rate per 10,000 pop)	9.0	15.5	13.1	7.8	10.8	14.9	11.3	20.8	22.0	20.1

*Values have been supressed due to the underlying counts being less than five

Table 69: Summary of public health indicators by ward (1 = 'worst' value, 20 = 'best' value'; overall rank 1 = 'worst' performing, 20 = 'best' performing)

Indicator	Budshead	Compton	Devonport	Drake	Efford & Lipson	Eggbuckland	Ham	Honicknowle	Moor View	Peverell
Teenage pregnancy (rate per 1,000 women)	8	12	17	18	11	13	7	10	5	2
Smoking in pregnancy (%)	16	2	17	19	15	6	10	20	1	5
Parents who smoke (%)	16	6	19	13	15	8	17	18	9	5
Parents who misuse drugs (%)	11	7	18	12	19	1	16	17	9	4
Parents who misuse alcohol (%)	15	6	11	18	19	2	14	16	1	7
Depressed/mentally ill parents (%)	10	7	20	11	19	3	16	18	4	2
Social isolation (%)	10	12	17	21	16	5	11	15	6	8
Accident admissions (0-4 year olds) (rate per 1,000 pop)	18	17	15	4	12	2	6	20	1	7
Accident admissions (5- 14 year olds) (rate per 1,000 pop)	8	6	17	9	12	3	20	13	21	18
Accident admissions (15-24 year olds) rate per 1,000 pop)	21	7	19	1	13	12	16	20	4	6
Emergency circulatory admissions (all ages) (rate per 10,000 pop)	11	4	9	21	15	8	17	20	16	6
Emergency circulatory admissions (under 75s) (rate per 10,000 pop)	10	8	12	21	19	7	13	18	14	6
Admissions from falls (65 years and over) (rate per 10,000 pop)	14	17	21	20	18	2	8	6	11	4
Admissions from falls (75 years and over) (rate per 10,000 pop)	10	16	20	21	19	2	7	4	3	9
Substance misuse (rate per 10,000 pop)	12	9	20	15	17	7	13	14	10	5
Self-harm admissions (rate per 10,000 pop)	20	3	17	8	19	5	13	16	10	7
Smoking status (GP referrals) (%)	12	8	21	19	15	5	16	17	9	7
Adult obesity (GP referrals) (%)	15	2	19	1	17	8	20	21	14	3
High blood pressure (GP referrals) (%)	19	17	9	2	3	16	20	12	18	10
One or more risk factors (smoking, obesity, high blood pressure) (%)	17	6	20	5	16	7	19	21	13	4
Incidences of melanoma (rate per 100,000 pop)	-	-	-	-	-	-	-	-	-	-
Cancer mortality (under 75s) (rate per 10,000 pop)	16	4	14	7	10	18	9	21	13	2
Sum of ranks	289	176	352	266	319	140	288	337	192	127
Overall ward rank	7	13	2	9	5	16	8	4	12	18

Indicator	Plympton Chaddlewood	Plympton Erle	Plympton St Mary	Plymstock Dunstone	Plymstock Radford	Southway	St Budeaux	St Peter & the Waterfront	Stoke	Sutton & Mount Gould
Teenage pregnancy (rate per 1,000 women)	3	19	4	1	6	14	15	20	21	16
Smoking in pregnancy (%)	9	3	4	7	8	14	21	18	13	11
Parents who smoke (%)	7	3	1	4	2	11	21	20	14	10
Parents who misuse drugs (%)	10	5	3	6	2	8	21	20	14	15
Parents who misuse alcohol (%)	8	10	4	5	3	9	21	20	17	13
Depressed/mentally ill parents (%)	6	8	5	9	1	13	12	21	15	17
Social isolation (%)	7	2	1	4	3	9	18	20	14	19
Accident admissions (0-4 year olds) (rate per 1,000 pop)	10	14	3	5	8	9	21	19	16	13
Accident admissions (5- 14 year olds) (rate per 1,000 pop)	10	5	15	11	1	19	4	7	16	2
Accident admissions (15-24 year olds) rate per 1,000 pop)	15	2	14	8	9	5	17	18	11	3
Emergency circulatory admissions (all ages) (rate per 10,000 pop)	7	2	3	1	5	13	14	19	12	18
Emergency circulatory admissions (under 75s) (rate per 10,000 pop)	2	3	1	4	5	11	20	17	15	16
Admissions from falls (65 years and over) (rate per 10,000 pop)	1	10	16	9	3	7	19	15	13	5
Admissions from falls (75 years and over) (rate per 10,000 pop)	1	14	15	12	6	8	18	17	11	5
Substance misuse (rate per 10,000 pop)	1	4	2	3	6	8	11	21	18	19
Self-harm admissions (rate per 10,000 pop)	2	9	6	4	1	11	15	21	18	14
Smoking status (GP referrals) (%)	4	6	2	1	3	10	20	18	13	14
Adult obesity (GP referrals) (%)	13	9	5	6	4	16	18	7	10	11
High blood pressure (GP referrals) (%)	14	6	15	7	4	21	8	13	5	1
One or more risk factors (smoking, obesity, high blood pressure) (%)	9	8	3	2	1	15	18	12	10	14
Incidences of melanoma (rate per 100,000 pop)	-	-	-	-	-	-	-	-	-	-
Cancer mortality (under 75s) (rate per 10,000 pop)	3	15	8	1	5	12	6	19	20	17
Sum of ranks	142	157	130	110	86	243	338	362	296	253
Overall ward rank	15	14	17	19	20	11	3	1	6	10

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INTEGRATED HEALTH & WELLBEING

SYSTEM PERFORMANCE SCORECARD

DECEMBER 2017

NHS

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

1. INTRODUCTION

Public Sector organisations across the country are facing unprecedented challenges and pressures due to changes in demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities.

On the 1st April 2015 Plymouth City Council (PCC) and the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) pooled their wellbeing, health and social care budgets and formed an integrated commissioning function. Four Integrated Commissioning Strategies were developed to drive activity across the wellbeing health and social care system.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes both for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

The four strategies describe the current picture and the integrated commissioning response across the health and wellbeing 'system' in Plymouth, specifically covering

- Wellbeing
- Children and young people
- Community
- Enhanced and specialist

To monitor progress of the Integrated Commissioning activity an Integrated System Performance Scorecard has been developed. The scorecard will be updated on a quarterly basis and will capture and understand the impact of integration across the system, and inform future commissioning decisions.

2. COLOUR SCHEME – BENCHMARK COLUMN

For indicators taken from either the Public Health Outcomes Framework or the Children and Young People's Health Benchmarking Tool:

- Indicators highlighted green show where Plymouth is significantly better than the England average.
- Indicators highlighted amber show where Plymouth is not significantly different to the England average.
- Indicators highlighted red show where Plymouth is significantly worse than the England average.
- Indicators highlighted white show where no significance test was performed, or where no local data or no national data were available.

For the rest of the indicators:

- Indicators highlighted green show where Plymouth 15% better than England's average.
- Indicators highlighted amber show where Plymouth within 15% of England's average.

- Indicators highlighted red show where Plymouth 15% worse than England's average.
- Indicators highlighted white or N/A show where no local data or no national data were available.

3. TREND GRAPHS

Each indicator is accompanied by a trend graph showing where possible the latest six values. Caution is required when interpreting the graphs as there is no Y axis displayed and as such the significance or flow of the change is difficult to interpret.

4. COLOUR SCHEME - TREND COLUMN (RAG)

- Indicators highlighted dark green show where there the latest 3 values are improving.
- Indicators highlighted green show where there the latest 1 or 2 values are improving.
- Indicators highlighted amber show where the latest value is between plus and minus 2.5% of the previous value.
- Indicators highlighted red show where there the latest 1 or 2 values are deteriorating.
- Indicators highlighted dark red show where there the latest 3 values are deteriorating.
- Indicators not highlighted have no trend data

5. PERFORMANCE BY EXCEPTION

WELLBEING

Estimated diagnosis rates for dementia

NEW Devon CCGs dementia diagnosis rate remains below the national target. The CCG has raised concerns with NHSE with the expected number of people with dementia in our population (this may affect the calculated diagnosis rate). However, the CCG is also looking to work more closely with primary care to improve the pathway. A new Dementia Advisor Service has just been procured with a role to work closely with primary care and GPs, which will be much more visible than the previous service. This will help with diagnosis rates as GPs will have services to work with them to support people through diagnosis and afterwards. This will start in April 2018

Referral to treatment - Percentage seen within 18 weeks

Nationally the NHS has acknowledged that the 18-week referral to treatment standard is not being met or likely to be met in 2017/18. The national mandate to temporarily stop all elective surgery during the period of heightened activity as a result of the flu outbreak has also had an impact on performance. Locally we have tried to maintain throughput in the hospital and have focused the stopping of elective surgeries on routine operations whilst prioritising Cancer treatments.

In hospital falls with harm

This is expressed as a % of the total patients surveyed as part of the NHS safety thermometer. There are on average around 800-900 surveyed each month in Plymouth Hospitals NHS Trust. December's figure of 0.36% would equate to three patients having fallen in hospital and experienced harm as a result of that fall. Plymouth Hospitals NHS Trust has consistently had a lower rate of falls with harm compared to the national average for the last two years.

CHILDREN AND YOUNG PEOPLE

Timeliness of Children's single assessments

Single assessment performance is now showing a positive direction following decline over previous months. The backlog of assessments over 45 working days has now been addressed and new assessments performance is reported at 90% within quarter four. Forecasted performance is to finish the year at over 70%.

Number of Children in Care

Children in care numbers have increased by 8 to 411 which, at a rate per 10,000 (78) is below the statistical family group but above England.

COMMUNITY

Delayed transfers of care from hospital per 100,000 population, whole system (delayed days per day)

In quarter three the daily bed delay attributable to ASC rate is at 22.7/100,000 so remains off target, but is an improvement on the rate for quarter two (26.0). The rate of these delays that are attributable to Adult Social Care is also improving, during quarter three the rate is 10.50 compared to 11.90 in quarter two.

Our system remains challenged with an increase in the number and proportion of patients who are complex need, impacted on by winter pressures. The continued improvement programme in place includes the appointment of an Interim Director of Integrated Urgent Care, the development of an Acute Assessment Unit to assist in preventing unnecessary admissions. This is also being supported by the review of the current Discharge to Assess (D2A) offer which includes a single Trusted Assessor being in post and the recruitment of additional social workers dedicated to support hospital discharges.

Accident and Emergency 4 hour wait

Plymouth Hospitals NHS Trust is not achieving the 4hr wait in A&E target. This is linked to an increase in demand over the last year as both the number of A&E attendances and emergency admissions have increased. The recent flu outbreak has also contributed to a winter surge that has been much greater than seen in recent years. This has resulted in a high bed occupancy which has restricted flow through the A&E department. A number of schemes are in place to reduce the level of A&E attendances/ emergency admissions and to reduce the bed pressure by reducing the level of delayed transfers.

Emergency admissions aged 65+

There has been a 10.8% increase in emergency admissions in 2017/18 across the Western Locality for patients aged 65+. This is linked to the operational pressures in PHNT. The ageing population will be contributing to this increase but a number of other causes are at play including the pressures on primary care.

Improving Access to Psychological Therapies (IAPT) – Access rates

Livewell Southwest achieved the IAPT access rate in 2016/17 and is on track to achieve it again in 2017/18. However, monthly performance does remain variable.

Average number of households in B&B

Increasing demand means that there continues to be a pressure regarding households accessing B&B temporary accommodation. The average number of B&B stays for the whole of quarter three was 57, an increase from 53 for quarter two. In December the monthly average fell to 50 which is positive, although it is noted that the Christmas period often has a positive impact on numbers in temporary accommodation.

People helped to live in their own home through the provision of Major Adaptation

By providing major adaptations through a DFG (Disabled Facilities Grant) we are helping people with disabilities to live at home. Interventions including a pilot to install stair lifts at the request of Occupation Therapists have helped increase the number of home adaptations provided during quarter three, thus increasing the number of people helped to live at home. The gap between actual performance and the department's target has closed meaning progress against target has improved, we are now on a trajectory to provide a similar number of major adaptations to that provided in 2016/17 and considerably more than in 2014/15 and 2015/16.

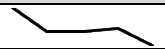
ENHANCED AND SPECIALIST

Percentage of CQC providers with a CQC rating of good or outstanding

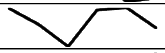
At the end of quarter three the percentage of residential and nursing homes that are rated by CQC as good or outstanding has fallen from 79% (end of Q2) to 73%. Within this the number rated as outstanding has increased from one to four, however the number rated as good has fallen from 76 (end of Q2) to 68 at the end of quarter three. The number of homes requiring improvement increased from 17 to 21 and number inadequate remains unchanged.

In recognition of the higher percentage of homes with a rating of Requires Improvement commissioners are working with the CQC towards a more collaborative approach between the CQC and commissioners. The QAIT (Quality Assurance and Improvement Team) are undertaking a specific project to target these providers (along with those rated as Inadequate) in the form of supportive workshops over the next 12 months. If necessary these workshops will be ongoing with learning shared across the whole care home sector. The team continue to request and monitor action plans from homes that have been rated as Requires Improvement or Inadequate and provide support visits and advice and information.

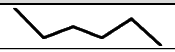
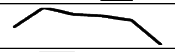
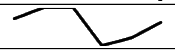
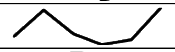
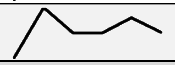
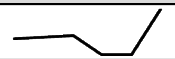
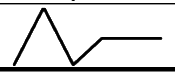
6. WELLBEING

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
Place health improvement and the prevention of ill health at the core of our planned care system; demonstrably reducing the demand for urgent and complex interventions and yielding improvements in health and the behavioural determinants of health in Plymouth								
CCGOF Referral to Treatment waiting times (patients seen within 18 weeks on incomplete pathway (%)	Percentage	Dec-17	N/A	84.8%		81.3%		High is good
NHSOF Estimated diagnosis rates for Dementia	Percentage	Dec-17	N/A	59.6%		60.1%		High is good
In hospital Falls with harm	Percentage	Dec-17	N/A	0.24		0.36		Low is good

7. CHILDREN AND YOUNG PEOPLE

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
Keep our Children and Young People Safe: ensure effective safeguarding and provide excellent services for children in care								
Referrals carried out within 12 months of a previous referral (Re-referrals)	Percentage	2017/18 Q3		33.5		28.2		Low is good
Number of children subject to a Child Protection plan	Count	2017/18 Q3		371		338		Low is good
Number of Children in Care	Count	2017/18 Q3		406		411		Low is good
Number of Children in Care - Residential	Count	2017/18 Q3	N/A	27.0		39.0		Low is good
Timing of Children's Single Assessments (% completed within 45 working days)	Percentage	2017/18 Q3		94.9		69.0		High is good

8. COMMUNITY

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
Provide integrated services that meet the whole needs of the person by developing: • Single, integrated points of access • Integrated support services & system performance management • Integrated records								
Number of households prevented from becoming homeless	Count	2017/18 - Q3	N/A	299		175		High is good
Average number of households in B&B per month	Count	2017/18 - Q3	N/A	32.0		57.0		Low is good
Reduce unnecessary emergency admissions to hospital across all ages by: • Responding quickly in a crisis • Focusing on timely discharge • Providing advice and guidance, recovery and reablement								
Proportion of people still at home 91 days after discharge from hospital into reablement/ rehabilitation services	Percentage	2017/18 - Q3	N/A	88.0		84.0		High is good
Improving Access to Psychological Therapies Monthly Access rate	Percentage	Dec-17	N/A	1.17		0.90		High is good
Improving Access to Psychological Therapies Recovery rate rate	Percentage	Dec-17	N/A	35.80		47.40		High is good
A&E four hour wait	Percentage	Dec-17	N/A	84.36%		79.29%		High is good
Emergency Admissions to hospital (over 65s)	Count	Dec-17	N/A	1,387		1,371		Low is good
Discharges at weekends and bank holidays	Percentage	Dec-17	N/A	18.22%		19.09%		High is good
Rate of Delayed transfers of care per day, per 100,000 population	Rate per 100,000	2017/18 - Q3		16.4		22.7		Low is good
Rate of Delayed transfers of care per day, per 100,000 population, attributable to Adult Social Care	Rate per 100,000	2017/18 - Q3		7.9		11.9		Low is good
Provide person centred, flexible and enabling services for people who need on-going support to help them to live independently by:• Supporting people to manage their own health and care needs within suitable housing • Support the development of a range services that offer quality & choice in a safe environment • Further integrating health and social care								
People helped to live in their own home through the provision of Major Adaptation	Count	2017/18 - Q3	N/A	59		77		High is good
Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (aged 65+)	Rate per 100,000	2017/18 - Q3		125.9		116.7		Low is good
Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (aged 18-64)	Rate per 100,000	2017/18 - Q3		1.8		2.4		Low is good

9. ENHANCED AND SPECIALIST

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
Provide high quality, safe and effective care, preventing people from escalating to, or requiring, urgent or unplanned care								
Percentage of CQC providers with a CQC rating of good or outstanding	Percentage	2017/18 - Q3		84.0		73.0		High is good

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PLYMOUTH CITY COUNCIL

Subject:	Strategic Commissioning Intentions for the Plymouth Health and Wellbeing System 2018-20
Committee:	Health and Wellbeing Board
Date:	22 March 2018
Cabinet Member:	Councillor Lynda Bowyer
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Craig McArdle (Director for Integrated Commissioning)
Contact details	Tel: 01752 307530 email: craig.mcardle@plymouth.gov.uk
Ref:	CB/CMcA
Key Decision:	Yes
Part:	I

Purpose of the report:

The purpose of this report is to provide a position statement on the shared ambition to develop Integrated Health and Wellbeing both within Plymouth and the wider Devon STP footprint. The report considers progress to date, key challenges, national context and future direction. The Strategic Commissioning Intentions for the Plymouth Health and Wellbeing System have been outlined within this report, these are essential to the next phase of our integration journey.

The Plymouth Health and Wellbeing Board set down in 2013 the strategic ambition to create a fully integrated system of population based health and wellbeing where people start well, live well and age well. In doing so, the aim is to:

- To improve health & wellbeing outcomes for the local population;
- To reduce inequalities in health & wellbeing of the local population;
- To improve people's experience of care; and
- To improve the sustainability of our health & wellbeing system.

These commissioning intentions represent a further stage in the delivery of this ambition. At the heart remains a focus on meeting the needs of the whole person and ensuring they receive "the right care, at the right time, in the right place" To deliver this vision of care we will need to continue to ensure we meet the triple aims of the five-year forward view.

Through these commissioning intentions, the local system will: be integrated and configured to provide the best start to life, promote independence, wellbeing and choice, with home first acting as the central philosophy and services integrated, local, accessible, seamless and responsive. An enhanced system of Primary Care will underpin the integrated system and there will be No Health without Mental Health. In order to make a sustainable system these commissioning intentions will make best use of the public estate and achieve cash releasing efficiencies.

In order to drive the changes a small number of Strategic Commissioning Priorities will be taken forward at pace:

- Developing Integrated Commissioning as a System Enabler
- Commissioning for Wellbeing and Prevention
  - Thrive Plymouth
  - Wellbeing Hubs
  - Making Every Adult Matter
- Transformed and Sustainable Primary Care
- Integrated Children's Young People and Families Services,
- Commissioning an Integrated Care Partnership
- Local, Integrated and Responsive Mental Health Services,
- Enhanced Care and Support

Recommendations:

The recommendation is for the Health and Wellbeing Board to:

- Confirm the Strategic Commissioning Intentions are in line with the Health and Wellbeing Boards Vision and Strategic Direction
- Confirm the Boards support to take forward consultation on the Commissioning Intentions.

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Strategic Commissioning Intentions for the Plymouth Health and Wellbeing System 2018-20

Context and Case for Change

Plymouth and the wider Western Locality has a long and established record of cooperation and collaboration with a formal commitment to Integration being set down by the Plymouth Health and Wellbeing Board in 2013, based around Integrated Commissioning, Integrated Health and Care Services and an Integrated System of Health and Wellbeing.

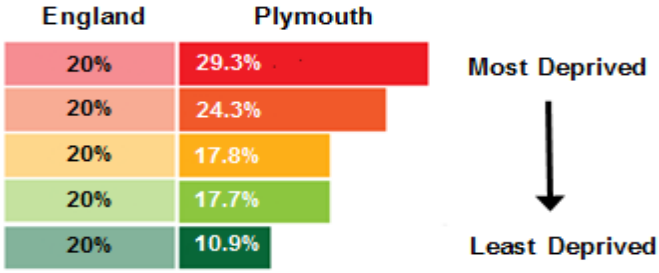
Since then there has been some significant progress and notable achievements towards achieving this aim. In 2015, commissioners established the Integrated Fund, developed four Integrated Commissioning Strategies and established an Integrated Commissioning function and governance arrangements. At the same time, Plymouth City Council (PCC) transferred 170 Adult Social Care staff to the Community Health Provider (Livewell Southwest) who also took on the Community Health functions of South Hams and West Devon. More recently, Livewell Southwest (LWSW) and Plymouth Hospital NHS Trust (PHNT) have collaborated to deliver an Integrated Sexual Health Service, MIUs for the Western Locality and there has been further co-operation and colocation of staff and services to deliver the Acute Assessment Unit. In response to urgent care pressures, the two providers have also appointed a Joint Director of Urgent Care driving changes required around D2A2 and Intermediate Care. More widely, PHNT, LWSW and PCC have collaborated to develop an Integrated Community Health, Wellbeing and SEND Support Service.

Despite this progress, the current system configuration is still not deriving optimum benefits and a number of significant challenges remain:

Health Inequalities, Changing Demographics and Rising Demand

As illustrated in the diagram below, the 2015 Index of Multiple Deprivation indicates that 29.3% of the population of Plymouth (75,624 people) live in the most deprived 20% of England.

Percentage of Plymouth's population living in each national deprivation quintile area



In comparison to the England average, health and wellbeing across the Plymouth population is mixed. Of the 30 indicators presented in the 2017 Public Health England Health Profile, Plymouth has 10 that are significantly worse ('red') compared to England, which is an improvement on the 2016 position and demonstrates a positive shift in adult smoking prevalence, under-18 conceptions and life expectancy in women. The impact of child poverty is also visible in outcomes for children, with educational attainment below national averages in most indicators. This in turn influences health and well-being statistics.

As well as poor health outcomes and health inequalities, the system is also facing rising demand for services in part bought about by demographic changes. The number of people aged over 65 is forecast to grow from 17.5% (45,500) of the population to 18.4% by 2020, 21.3% by 2030 and 22.5% by 2035 As a result, demand for over-65s care home places, extra care, community domiciliary care, reablement and hospital discharge services continues to increase. There has also been an increase in the number of people who need urgent and emergency treatment. The complexity of those presentations means we are seeing an increase in those who then have to be admitted, which places increased pressures in other areas of the hospital. In general, patients occupy one third of the hospital beds in Plymouth over the age of 80 and two thirds of patients staying more than 10 days in hospital are over the age of 70. The pressure on the urgent care system in turn means that there is less available capacity for elective care – national comparisons show that Plymouth Hospital has among the lowest rate of available beds for the elective care system. In addition, the system is seeing higher numbers of people becoming homeless and the numbers of Children in Care remains high with too many young people ending up in Residential provision. This is also evident in the education system with rising demand for SEMH support.

Financial Sustainability and Equity

In 2015, NEW Devon CCG became part of the Success Regime in part due to the financial challenge it was facing. The size of the financial challenge was acknowledged in the Devon-wide STP, which outlined that, if nothing changed, and then by 2020/21 there would be a funding gap across health and care of £557m. In an effort to return the system to financial balance, local health and social care organisations are facing significant Cost Improvement Programmes, with the Acute Trust facing a CIP of 8% (£40m) for 2017/18. The changing demographic profile and the increased cost of providing care means that in a "do nothing" scenario we are forecasting an increase pressure on the Adult and Children's Social Care budget. The same is true of the SEND (Special Needs and Disability) system, with significant budget pressures forecast which has required remediation to reduce an overspend in the High Needs Block of the Dedicated Schools Grant.

As well as facing a significant financial challenge, Plymouth and West Devon are also facing an Equity challenge. Work as part of the STP Case for Change has highlighted that 10% less is spent on health care for each person in western Devon in comparison to northern and eastern Devon. This is in the context of Plymouth having very significant health need alongside evidence that this need is not being adequately met, as evidenced by inequalities in outcomes such as life expectancy. The majority of patients in Devon waiting in excess of 18 weeks for a planned intervention are on a Plymouth waiting list.

Whilst NHS funding should reflect additional costs associated with elderly, rural and deprived populations through the Market Forces Factor (MFF), estimates have shown that acute hospitals in Devon receive less funding for the MFF in comparison to similar hospitals in other areas.

System Flow

Multiple system reviews have been undertaken, including ECIP, Home to Hospital, the STP ICM professional peer review team and a 5-week NHSI/E support programme where consistent themes have been identified. These broadly relate to interface issues that inhibit patient flow in different parts of the system. These issues have led to high numbers of Delayed Transfers of Care and people spending too long in intermediate care.

In addition, access to services 7 days per week is inconsistent and this impacts on the number of discharges achieved over the weekend.

Primary Care

General practice sustainability and capacity in Plymouth is currently particularly challenged. Several GP Practices have recently closed and a procurement by NHS England to secure longer-term provision for 34,000 patients was not successful (a temporary contract is in place). All practices are rated by CQC as good or outstanding and practices are increasingly working at scale. There are a number of vacancies for GPs and other members of the increasingly varied multi-disciplinary team in primary care and, albeit with some innovative recruitment and retention packages being offered, recruiting GPs is proving a stubborn challenge, reflecting the national picture. Whilst there is no evidence of cause and effect across the system, there is some association between the most challenged primary care and patients presenting for care from MIU and ED.

Planned Care

The Referral to Treatment time (RTT) in Plymouth has significantly worsened during the year. The March 2017 figure was 85.7% RTT achievement and at January 2018 this had reduced to 81.6% (4580 patients waiting in excess of 18 weeks). The forecast outturn for year-end is in the region of 81%.

Workforce and Market Sufficiency

There are a number of workforce issues across the system and the hospital faces significant challenges in medical staffing and, specifically, there are difficulties in recruiting to some medical staff grades and filling junior doctor rotas. Similarly, recruitment of pharmacists, particularly in the hospital is proving difficult. Whilst generally we have had a good supply of personal care services during periods of escalation, the sufficiency of dementia care home beds (both nursing and non-nursing) and placements of individuals with more complex behavioral needs can be more difficult. This winter we have also seen home care capacity become stretched and struggling to meet the level of discharge flow.

Recognising the challenges, commissioners are setting out a number of high impact changes that will drive commissioning activity and service design for the next two years. These intentions are high level to set down a *direction of travel* with detailed programmes of work being developed to take forward each area. They should not be seen as a departure from the existing policy direction of achieving whole system population based integration rather a scaling up and acceleration based on learning to date. In this context, they represent a key part of delivering the last two years of our five-year commissioning plans of Wellbeing, Children and Young People, Community and Enhanced and Specialised Care.

They also sit within the STP Framework and should be seen as the local response to delivering the seven priorities: Prevention and Early Intervention, Integrated Care, Primary Care, Mental Health, Acute Hospital and Specialised Services, Productivity and Children, Young People and Families.

Overview of Commissioning Outcomes and Priorities

The Plymouth Health and Wellbeing Board set down in 2013 the strategic ambition to create a fully integrated system of population based health and wellbeing where people start well, live well and age well. In doing so, the aim is to:

- To improve health & wellbeing outcomes for the local population;
- To reduce inequalities in health & wellbeing of the local population;
- To improve people's experience of care; and
- To improve the sustainability of our health & wellbeing system.

These commissioning intentions represent a further stage in the delivery of this ambition. At the heart remains a focus on meeting the needs of the whole person and ensuring they receive "the right care, at the right time, in the right place" To deliver this vision of care we will need to continue to ensure we meet the triple aims of the five-year forward view:

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  - Thrive Plymouth
  - Wellbeing Hubs
  - Making Every Adult Matter
- Transformed and Sustainable Primary Care
- Integrated Children's Young People and Families Services,
- Commissioning an Integrated Care Partnership

- Local, Integrated and Responsive Mental Health Services,
- Enhanced Care and Support

Following on from the recent CQC Local Area Review, the footprint of these Commissioning Intentions are initially based on the Plymouth Health and Wellbeing Board boundary, as the system requires both an urgent and bespoke response. However, recognising Plymouth's role in the wider STP and in particularly its place in relation to South Hams and West Devon and South East Cornwall commissioners will begin discussions with other commissioners, partners, stakeholders and providers about system alignment and join up where it makes sense to do so. Where these commissioning intentions stretch beyond the boundary of Plymouth, they are referenced.

The establishment of the Local Care Partnership will oversee the move towards the next level of integration. Such an approach will provide for jjoint system ownership of problems and issues and the development of collective system solutions, with key agencies engaged as full and equal system partners. This will provide for, faster decision making and allocation of resources to system priorities, a ccollective focus on improving key system performance faster and shared ownership of system risk. An enhanced Taking Change Forward Group will become the LCP Board with a priority to expand membership, develop terms of reference and a system wide MOU.

PLYMOUTH HEALTH AND WELLBEING SYSTEM- COMMISSIONING OUTCOMES AND PRIORITIES

Local System Outcomes

To improve health and wellbeing outcomes for the local population	To reduce inequalities in health and wellbeing of the local population	To improve people's experience of care	To improve the sustainability of our health and wellbeing system

Commissioning Priorities

The Health and Wellbeing Gap	The Care and Quality Gap	The Funding and Efficiency Gap
Integrated Children and Young People Services Development of Wellbeing Hubs Making Every Adult Matter	Integrated Care Organisation Local, Integrated and Responsive Mental Health Services Transformed and Sustainable Primary Care Enhanced Care and Support	Integrated Commissioning Review One Public Estate and One Public Infrastructure

Key System Performance Objectives

- Reduced Hospital Admissions
- Reduction in Smoking Prevalence
- Reduced Delayed Transfers of Care
- Less Admissions to Long Term Care
- Improved A/E 4 Hour Performance
- Increased Physical Activity
- Reducing Demand and delivering Financial Efficiencies
- Improved access to Primary Care
- Reduced levels of homelessness and Rough sleeping
- Reduction in the number of looked after children
- Improved IAPT Access and Recovery Rates
- Improved Reablement Performance
- Increased numbers of carers receiving an assessment
- Improved RTT Performance
- Reducing packages of care
- Less Bed Based Care
- Improved Educational Attainment Levels

Commissioning as a System Enabler

In line with the wider Organisational Design workstream of the STP, we will undertake a review of our existing integrated commissioning governance arrangements in order that they are flexible and an enabler to achieving change and system transformation. In doing so we will seek to simplify, streamline and collaborate to achieve reduced operating costs. The Integrated Commissioning Review will focus on the following key areas:

Governance- A review of Integrated Commissioning Governance arrangements to determine overall effectiveness and to make recommendations to eliminate duplication and streamline decision-making.

Finance- To review the effectiveness of the Integrated Fund and to make recommendations as to future direction and scope including hosting arrangements, management and potential to extend.

Staffing- To review the current staffing arrangements and evaluate whether there are further opportunities to integrate in order to remove duplication and ensure there are the right capabilities and capacity to deliver change.

Strategic Commissioning and Placed Based Commissioning- To work with the emerging Strategic Commissioning Function to develop an operating model that supports a Devon Wide Strategic Commissioning Function and Local Care Partnerships.

A key role of our Commissioning approach is to provide System Leadership, Oversight and Assurance and to relentlessly drive system improvement. In order to fulfil these functions NEW Devon CCG has established a System Improvement Board made up of Commissioners, Providers and Regulators. The central focus of the Board will continue to be:

1. To reduce patient safety and quality risks across the system predominantly related to Patient Flow
2. To improve performance around key constitutional targets
3. To deliver the required financial improvement.

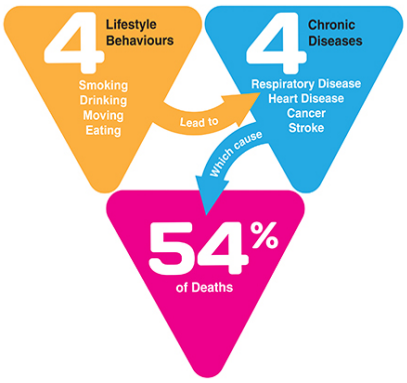
The Board will also oversee and drive transformation programmes with three initial immediate priority areas being identified as-

1. Transforming intermediate care activity to prioritise home based non-bedded care including improving Out of Hospital responsiveness to prevent admissions and avoid delays in discharge home.
2. To deliver the Primary Care Improvement Plan
3. To deliver the revised Ambulatory/Frailty and GP Streaming function at PHNT

As these commissioning intentions move towards implementation, the Board will oversee and drive delivery of these priority programmes.

Wellbeing and Prevention

Thrive Plymouth is the city's ten year programme to get everyone working together to improve health and wellbeing in Plymouth and narrow the gap in health status between different people and different communities. The things that cause us the most ill health largely result from what we eat and drink, whether we smoke and how active we are. These four behaviors are more common in some communities than others and so therefore are the diseases that they cause. This means that some parts of our society experience greater levels of ill health in their lives and are more likely to die younger. We know that there are considerable differences in the life expectancy between different communities in Plymouth- neighborhoods just a few miles apart can have life expectancy values varying by years.



Thrive Plymouth's aim is to create collective action across the City focusing on enabling and encouraging positive choices for health- eating a healthier diet, being more physically active, drinking sensibly and not smoking. It follows three principles;

1. Population prevention: This is about the whole population taking whatever steps they can to make improvements in these behaviours. If individually we all make small positive changes, we can achieve significant benefits for our City and ourselves.
2. Common risk factor: Unhealthy behaviours tend to cluster both for the individual and in communities. Focussing on single behaviours may be less effective than taking a holistic approach and addressing underlying reasons or risk factors.
3. Changing context of choice: Most of us know what to do to improve our health and many of us want to do it. However, despite good intentions making changes can be hard. In the past, we have not always recognised the importance the world about us has in determining what we do. Whether we positive choices is influenced by how easy it is to do, what we think our peers and communities do, what the media and advertising tells us, and how our environment is designed.

Thrive Plymouth provides a mechanism for achieving the NHS Forward View aspiration of a radical upgrade in prevention and public health for the city. Thrive Plymouth principles are central to these commissioning intentions as we continue to build a system of health and wellbeing. As such, we will focus on:

- Working with our network of providers, and community and voluntary sector, to ensure that the purpose and principles of Thrive Plymouth are considered in all services

- Embedding '"Making every contact count' to address those behaviours that impact on health and wellbeing across all of our providers.
- Rolling out Wellbeing Champions across Residential and Domiciliary Care Provision
- Continuing to promote wellbeing in specific settings such as schools and workplaces to change the context of choice making the healthier choices the easier choices (remembering that the health and social care workforce are also embedded in our communities)

Over the next two years, our intention is to commission a network of Wellbeing Hubs that enable and support people in the local community to tackle the underlying social issues that they face, and make life choices that will improve their health and wellbeing. The hubs will be based on a tiered model of Universal, Targeted, Specialist support and will involve community and voluntary sector as well as statutory providers. The framework and principles are common across the STP area, with local delivery being based on the needs of the population and the availability of resources. For example, some Hubs will focus on Wellbeing with a strong virtual link with local Primary Care; others will include Primary Care within the premises. Some (the Specialist Hubs) will include clinical services.

THE HUBS OFFER
Universal Effective website, service directory & digital offer and high quality consistent and effective information and signposting across all universal services
Targeted Will support the local universal network and act as a focal point for services that respond holistically to people and communities Colocation of key services such as Community Connections, VCSE, Livewell SW, PHNT, Primary Care Example Intervention / Services - Community 'bridging' roles - Advice and information - Healthy lifestyles - Peer support / volunteering - Group work – self-care and management, healthy lifestyles, parenting, employment - Education, Employment, Training - One-one enabling support
Specialist Develop a new model of care where specialist clinical health and care services are delivered in a local community setting, driven by need and may include: Community Health Services/Social Care/Community beds/Rehabilitation and Reablement/Specialist Clinics/Complex diagnostic (e.g. imaging, pathology)/Therapy services (e.g. physiotherapy)/Children's health services/Follow up / outpatient appointments

The targeted and specialist hubs implementation roll out is as follows:

Phase 1 (to be complete by March 2019)	**Phase 2 (to be complete by March 2020)**
Jan Cutting Healthy Living Centre	Estover - tbc
Guild House (Mannamead Centre)	Southway - tbc
Four Greens Community Trust (CEDT)	Efford Youth and Community Centre
Ocean Health Centre (Stirling Road Surgery)	Plymstock - tbc
Cumberland Centre	Mount Gould LCC site
Rees Centre	City Centre

To support this implementation, we will ensure planned and developing commissioning activity around Advice & Information, Health Improvement, Wellbeing & Prevention, and Integrated Early Years is taken forward under the oversight of the Wellbeing Hubs Commissioning Framework.

Nationally a growing number of people are experiencing addiction, homelessness, offending and poor mental health because of changes in welfare reform, constrained budgets and increasing health inequalities. Locally, we have experienced an increase in the numbers of single homeless people with complex needs and are anticipating an increase in the number of people with mental health support needs and/or substance dependence over the coming years.

Recognising the specific challenges faced by people with multiple needs we will adopt the ***Making Every Adult Matter*** (MEAM) vision of ensuring that people experiencing multiple needs are supported by effective coordinated services and empowered to tackle their problems, reach their full potential and contribute to their communities. To achieve this we will commission an Integrated Substance Misuse, Homelessness and Offender System utilising an Alliance approach and aligning Mental Health services. Using an Alliance model, the focus will be on creating systemic change: changes to culture, funding structures, commissioning and policy that will support a new way of working. Together we will create a contractual environment where suppliers share responsibility for achieving outcomes and are mutually supportive, making decisions based on the best outcome for the service user.

The Alliance aims to improve the lives of people with complex needs by supporting the whole person to meet their aspirations, whilst also contributing towards national outcome targets in relation to statutory homelessness, children in care and care leavers, drug treatment, reoffending rates, preventing admissions to hospital and urgent care targets.

Transformed and Sustainable Primary Care

Primary care is required to be the foundation of our system both now and in the future system of integrated care. Yet our primary care workforce and resources are facing unprecedented demand at a time when the workforce is under capacity and our system needs robust and accessible primary care more than ever.

Our commissioning will encompass delivery of the **Strategy for General Practice 2017-2021** and **General Practice Forward View**. We will work collaboratively and led by the **Western Primary Care Partnership** we will systematically deliver a **Primary Care Improvement Plan** (owned and delivered across the system) to deliver such services as social prescribing, investing in primary care and extending access for the population through national and local determination.

As a key priority, we will collaborate with providers, commissioners and other stakeholders to design and implement a sustainable system based on the **Primary Care Home** model. Rolling out the principles of Primary Care Home, we will support and facilitate groups of primary care organisations working together and with others to serve populations of 30,000 to 50,000. Working with the ICO delivery will be based on an Enhanced Primary Care Team (EPCT) model which will pool the knowledge, care and resources of primary care, community and mental health services, social care, pharmacists and voluntary, community and social enterprise sector partners, to manage the population health of their community. Increasingly specialist services, delivered in hospital settings, will be delivered as part of the EPCT wherever there is a population benefit of doing so.

As a priority, we will work with partners and providers to develop an **integrated pharmacy service** for Western spanning the whole system through acute, community, care homes and primary care. This will ensure system prioritisation of workforce improving recruitment, retention and efficiency and effectiveness of the workforce.

Developing this model will involve engagement towards co-production; using data and communication so that population priorities and outcomes are understood by all stakeholders; developing service models such that care and information is integrated across providers delivering personalised care; developing the workforce to support the models of care; aligning strategic and financial drivers; and, using evidence and evaluation to ensure outcomes are right for people, populations, the workforce and the system.

Underpinning the primary care commissioning activity we will work with NHS England and Member practices to enable NEW Devon CCG to take on **Joint Commissioning** from May 2018. Going forward, and following appropriate engagement the ambition is to move to **Delegated Commissioning**.

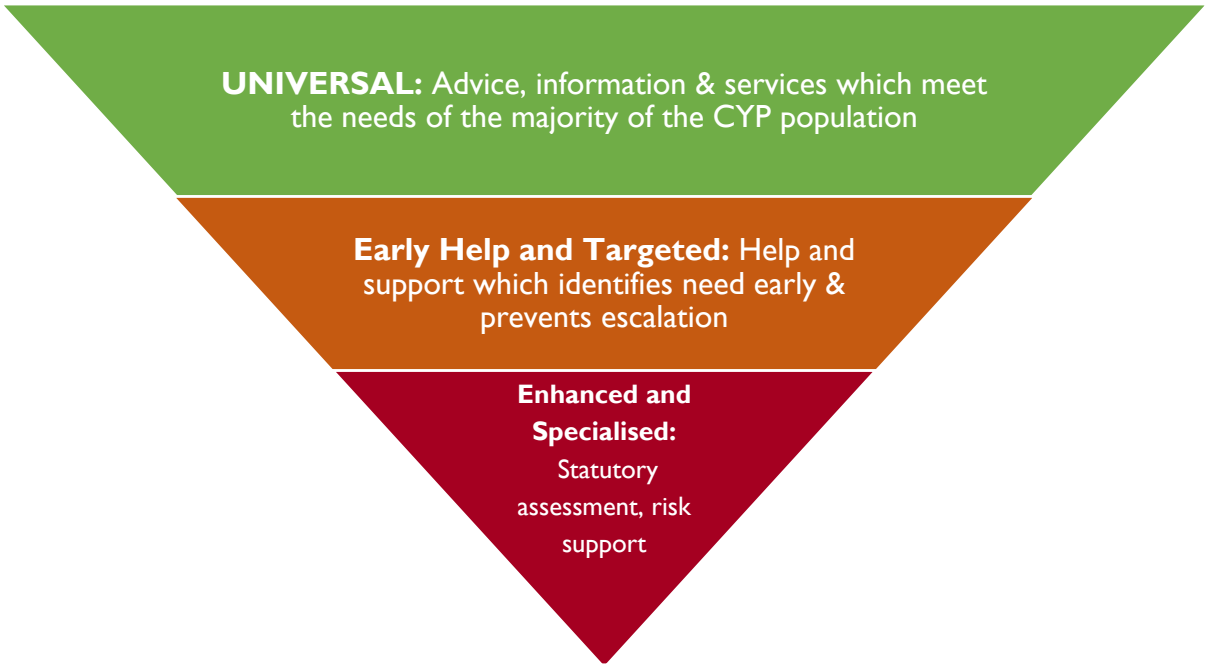
Integrated Children, Young People and Families Services

The Plymouth ambition is to commission Integrated Children, Young People and Families services that provide the best start to life. Children, young people and families will be supported to stay healthy, achieve and aspire. We will identify challenges that our families are experiencing as early as possible, so that they can be enabled and supported at the earliest opportunity. Our children, young people and families will be able to access what they need at the right time and in the right place, whether this is advice by phone or on the internet, an assessment or longer-term intervention or support.
We will:

- **listen**, and champion the voice of our children and young people in all that we do;
- **co-create** to support and enable partners and communities to work together to design the services they need;
- be **fair and equitable**, ensuring our children and young people feel included and can access opportunities that make a difference to them;
- have **high aspirations**, celebrating strength and success and being optimistic about the futures of all our children;
- Make sure that what we do is **sustainable**, having a real impact on the lives of children, young people and their families for this generation and those that follow.

(Taken from Plymouth – our shared narrative, CYPSDG, 2017)

The ambition is for three system offers:



System	A system which…	Key work streams 2018/20

Element		
Universal	Provides comprehensive, timely information, advice and sign posting	• Develop a single information, advice and access service enhancing the web based offer
	Offers "core support" to schools through the provision of statutory functions and other traded services	• Plan for Education
	Raises awareness of and reduces incidence of Child Sexual Abuse	• Implementation of the NSPCC "Together for Childhood" 10 year programme
	Ensures children have the Best Start to Life, from birth to being ready to start school	• Implement perinatal & maternal mental health services & pathways. • Improve Maternity Services through the delivery of Better Birth's Initiative & Saving Babies Lives. • Development of School Readiness project
Early Help and Targeted	Has a Single Point of Access for those with additional needs, where they and their families can access the right support at the right time	Community Health, Wellbeing and SEND integration: • Shared governance and performance monitoring • Implementation of "Access", trusted triage and single view of need • Delivery of tender and implementation of contract
	Has a locality based, multi-agency 0-19 offer (Family Hubs) which enables the delivery of a range of support to manage need and prevent escalation	• Redesign of children's centre creating a network of Family Hubs around 4 localities • Remodel of Early Help and Targeted Support offer to link with the Family Hubs
	Delivers effective emotional health and wellbeing provision, including offer to schools, which enables CYP to engage and attain	• Implementation of CAMHS Transformation Plan • Plan for Education • Securing future funding for EHWB in schools services
Enhanced and Specialised	Offers local support to parents, pre and post Proceedings, which maximises their ability to parent, or make informed and timely decisions about not becoming parents	• Tender and implementation of PAUSE Social Impact Bond • Remodel and co-locate Family Support Services to intervene early to meet the needs of parents who are at risk of entering Proceedings • Increased capacity in young parents supported accommodation to reduce the number of families placed out of area
	Delivers effective crisis response, for those edging towards care, on the edge of care and in care, when needs and risk escalate	• Development of a flexible, multi-disciplinary response to escalation, through a range of support to prevent entry to care and placement breakdown • Development of crisis/assessment provision in the Peninsula and locally • STP Risk Support work stream activity • Complex Families/Adolescents work streams
	Has sufficient good quality local accommodation to prevent children and young people in care from needing to be placed out of area and at distance	• Implementation of residential block contract • Implementation of Peninsula fostering contract • Scoping of future special school requirements • Scoping of future complex needs 16+ requirements (Peninsula/local) • Alignment with intentions for in-house fostering
	Enables children to be adopted in a timely way and for adopted children and their parents to be supported to maintain a stable home life	• Implementation of the Regional Adoption Agency (RAA) with Devon as lead

System Enablers	
A shared vision for workforce development across vulnerable CYP and complex adults, increasing system resilience, multi-agency learning and maximising efficiencies through shared training	Workforce development plan draft by end March 2018 (VCS leading)
A CYP system strategic engagement offer which enables the voice of CYPF to be meaningfully heard	Draft strategic engagement out for consultation spring 2018. Review of Children in Care participation service effectiveness with an aspiration to Commission a "Voice of the Child" service including participation and advocacy

Integrated Care

As noted previously despite some significant progress in Integrating Care for Adults and Older People our system remains challenged including performance against key NHS Constitutional Targets. There remains an over reliance on bed based care rather than a home first philosophy and System Flow remains a significant issue resulting in too many delayed transfers of care in all parts of the urgent care system. Primary Care, particularly in Plymouth is vulnerable facing workforce shortages and sustainability challenges. The Western System is experiencing a significant increase in A&E attendance including an increase in Ambulance conveyances. Across the whole system, there are workforce challenges with recruitment and retention being an issue in a number of areas. Our system also remains fragmented with several external reviews identifying that relationships within the Plymouth system could be improved and that organisational cultures, relationships, organisational boundaries and lack of shared risk particularly between the acute and community sectors were negatively affecting system flow. These issues are set against a backdrop of financial sustainability and despite a track record of delivering efficiencies the system remains financially challenged and inequity of funding across wider Devon remains an issue.

In response to this compelling case for change and in order to ensure joined up whole person care, we will commission an **Integrated Care Partnership (ICP)** for adults and older people. The ICP will bring together Core Community Health, Adult Social Care, Acute, Local Mental Health Services and potentially certain Primary Care Services (Table on Page 12 provides an overview of functions)

The drivers for this are transformational not transactional and the remodelled service will be designed to deliver benefits both for service users, carers and communities but also the wider health and social care system:

- Make local health and social care easier to navigate for people.
- Ensure people only have to tell their story once- through digital and interoperable care records
- Promote personalised care and self-care by working with users and carers as equal and valued partners
- Promote prevention, independence, wellbeing and health improvement by intervening earlier and shifting resources upstream

- Provide seamless care by removing hand-offs; reducing duplication of appointments and assessments through integrated service models and pathways.
- Deliver more care in communities and closer to home
- Transform service provision, with a focus on integrating pathways, supporting primary care and the wider integrated system.
- Sharing corporate and support services to reinvest as much money as possible into front-line service delivery.

The intention of commissioners is to commission an integrated care partnership through *one overarching contract* with a *single provider.* Due to the scale of the challenge and the system complexity, this has been identified as the preferred delivery model as there is a need to achieve greater structural, functional and financial integration than collaboration and partnership working alone can achieve.

Integrating care under a single model will bring together constrained resources under a single governance and management arrangement. Pooling resources, workforce and assets will provide sufficient scale, greater sustainability and be more cost effective. In addition, it will facilitate a more consistent seamless approach to care delivery by working as a single whole, facilitating better communication through single systems and operating to consistent standards.

Commissioners will not specify organisational form, which it is recognised could be a Single Organisation or Prime Provider Model. Commissioners will however be expecting the integrated provider function to have integrated governance arrangements, integrated executive and senior managements arrangements, and a single workforce plan. It is however acknowledged that the contracting approach will need to be set within the Context of EU procurement and competition law. Principally, The Public Contracts Regulations 2006 and National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 will apply and will be adhered too. This process will involve early and close discussions with regulators and legal advisors.

Although Commissioners wish to see the ICP in operation from the 1st April 2019 it is recognised integrating services, aligning systems and processes, creating one workforce and one culture takes time and it is acknowledged that the journey to develop a mature and high performing ICP will take a period of several years. Therefore, in order to form and crucially develop the ICP we will actively work with providers to develop a comprehensive implementation programme based around four high level stages:

- Mobilisation
- Detailed Planning
- Initial Integration of new functions
- Transformation

Underpinning this whole process will be extensive staff engagement, organisational development and clear communications.

The establishment of the ICP is a key element of the Plymouth's System response to the challenges that it is facing. However, it is recognised that the new ICP will operate within the context of the wider System of Health and Wellbeing and is one of a series of parallel commissioning work programmes that collectively will work to achieve a more integrated system. The ICP will therefore need to work with others as equal system

partners but due to its size and system centrality it will enable, support and help transform other key system elements.

In addition to the overarching ambition to establish an Integrated Care Partnership there are also clear quality and performance areas that require an urgent focus if we are to meet constitutional standards and deliver integrated care. Priorities include:

- Commission an End of Life Coordination Services through a Lead Provider arrangement. The aim of the service are to coordinate end of life care for patients registered with GP's in the Western locality and ensure that care provided to people at the end of life at home or in care homes in the western locality is commensurate with their need and equitably distributed

- Embedding and accelerating the Home First Philosophy through the full implementation of Discharge to Assess Pathway 1 to deliver 'assessment' and 'rehab/reablement care plan' at home within 2 hours of discharge with same day access to reablement or domiciliary care 7 days per week

- Reducing the reliance on bed based intermediate care through implementing the Discharge to Assess Pathway 2 provision to deliver 'assessment' and 'rehab/reablement care plan' within 48 hours of admission to care home. Undertake professional reviews of goal achievement and optimise step down and length of stay for patients. This will lead to a reduction in DTA2 care home beds; Local Care Centre beds converted to DTA2 pathway beds and reduced average length of stay to 14 days.

Integrated Care Partnership- Overview of Functions	
Core Functions Single Accountability for Service Delivery and Outcomes Single Point of Access/Comprehensive Assessment Person Centred Care Planning/Promotion of Self Care Digital and Interoperable care records	
Acute Services	Treating people with complex care needs in Devon Making acute care resilient; 24 hours a day, 7 days a week. Consistent 7-day standards for emergency NHS care, in hospital and community settings. Ensuring safe and sustainable services and addressing gaps in service provision Achieving equity of access and national standards Recruiting and retaining workforce Flexible workforce operating to professional standards Minimise bed use by getting people home and eliminating unnecessary stays Safe level of staffing in hospitals to ensure effective acute services Increase the use of technology to optimise the available workforce Manage the networked approach for services which are not delivered locally Align specialist workforce with community/primary care services in community settings wherever possible to do so.
Integrated Care Model	**Integrated Urgent and Emergency Care** Urgent Treatment Centres/ Acute Assessment Hub/GP Streaming/ join up offer for same day primary care and minor injury care Optimised the use of urgent care services which support the local system – pharmacy, 999 and IUCS (111and OOH) Home First Philosophy with Simplified and Streamlined Discharge Pathways and an embedded Trusted Assessor Model **Localised and Personalised Community Services** Coordinated service model with primary care, voluntary and community sector services as well as community based health mental health and social care Independence model of care with less Bed Based Care Comprehensive and consistent risk stratification linked with alternative options for care and support Enhanced support for care home residents Continuity in care through MDT Core community service function remodelled to improve admission avoidance for the vulnerable GP practices and pull from the Acute site. Coordinated Long Term Condition management based on empowerment and self-care with a scaling up of IPC Coordinated, timely and compassionate End of Life Care

Local, Integrated and Responsive Mental Health Services

The Devon wide STP mandate for Mental Health services has set down a cross Devon plan for Mental Health which supports transformative new models of delivering care, promotes mental health and wellbeing and is ambitious in improving outcomes, addressing inequalities and achieving national standards. Central to this is the development of a Care Partnership for Mental Health services with local delivery.

Set within the context of the wider STP and the 5YFV for Mental Health, our local Commissioning Intentions for Mental Health are based on the principle of No Health Without Mental Health. As such, Local Mental Health Services will be commissioned to be an integral component of the Integrated Care Partnership, wrapped around Primary Care and supporting the MEAM Agenda so that individuals with complex needs; including homelessness, substance misuse and risk taking behaviours have access to appropriate mental health support. In doing so, it is the expectation that mental health services will work across pathways and organisational boundaries to provide seamless and integrated support and treatment.

We understand the impact that the wider determinants of health such as poor housing, employment and loneliness can have on an individual's wellbeing and long-term outcomes. We also recognise the role the Voluntary and Community Sector (VCSE) adds in terms of supporting people to appreciate, understand and improve their lives so that we ultimately reduce health inequalities through an integrated, whole system, whole life approach. We recognise the growing evidence base and added benefits of working in partnership with the VCSE can bring in terms of enabling peer support and helping people manage their own mental health generally, but also more specifically in times of crisis and so the intention is for them to become a delivery partner of Mental Health services.

In rolling out our approach, key initial commissioning priorities for development include:

- The expansion of services for children and young people. We will invest year on year to increase capacity and reduce waiting times in line with national targets
- Re-design of the Recovery Pathway. This work commenced at the end of 2017 and will deliver proposals by April 2018, supported by an implementation timescale stretching to 2020
- Extension of Psychiatric Liaison provision, working towards Core24. We will deliver a 24/7 assessment service into the Emergency Department by April 2018 and then expand over the next 3 years until we meet the CORE 24 standards
- Rapid Response Community Crisis Services. We will implement a local extended hours crisis assessment service, supporting Primary care by October 2018
- A remodelled and expanded Psychological Therapies offer. We will expand services from delivering 15% of predicted need within the population to 16.8% by April 2018 and then expand this further into 2018/19 and beyond. Our priority will be individuals with co-morbid Long Term Conditions (LTC's)
- We will improve the diagnosis rate and pathway for users and carers experiencing dementia, integrate services further where possible and eliminate inappropriate out of area placements. By November 2018, we will meet the standard of 66% of individuals receiving a diagnosis. We will also integrate the dementia navigation service into the Dementia pathway by November 2018

- Commissioning additional Recovery College capacity so that individuals have more control and understanding of their own mental health and how they can manage this better themselves and are able to access support to help with addressing issues such as employment, recreational activities and housing. To support this, we will deliver an additional 350 placements by April 2019
- Enhance the Social Prescribing offer and test out whether an integrated approach with IAPT services delivers better outcomes for people living in some of the more deprived areas. We will run a pilot starting in April 2018 and make recommendations for learning and implementation for 2019/20
- Opening a Crisis Café for those with mental health issues in crisis and as an alternative to the Emergency Department by April 2018

Running alongside the development of locally integrated mental health services, it is recognised that services must work within, and be connected to the wider Mental Health Care Partnership. There is a clear requirement to create a wider community of practice around Mental Health, in order to both maximise clinical expertise and ensure specialist mental health services operate at scale to be sustainable and able to deliver appropriate care and support for those with highly complex needs.

Enhanced Care and Support

Significant work has already been undertaken to improve the sufficiency and quality of the Residential and Domiciliary Care Markets. However as we move towards a home first philosophy, coupled with a recognition that the sector is having to meet increased levels of acuity then new models of care and support will need to be developed.

Building on the learning of the Vanguards, we will develop an **Enhanced Health in Care Homes** model. This will build on the work already undertaken including QAIT support, Quality Reviews, Dignity in Care Homes Forum, Dementia Quality Mark, Leadership Programme and the Health & Wellbeing Champion Programme, Red Bag Scheme and Skype facility to reduce 999 calls. Working with providers, the ICO and Primary Care we will develop the following best practice model:

Care element	*Sub-element*
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
2. MDT in-reach support	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Re-ablement and rehabilitation to support independence	Reablement / rehabilitation services
	Developing community assets to support resilience and independence
4. High quality end of life care and dementia care	End-of-life care
	Dementia care
5. Joined up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including continuing healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Harnessing data and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

In terms of Domiciliary Care then we will work with the Market and the emerging ICP to develop a Single Accountable Provider (SAP). The SAP will be responsible for coordinating all home services including Reablement, timely hospital discharge, Community Domiciliary Care and Carer's Emergency Response Service, with the aim of developing/sustaining a person's capacity to live independently at home in the community. The SAP will provide the opportunity to develop a single workforce ensuring carers have the skills and knowledge to offer personalised services, to support people with a range of needs, be outcomes driven and where possible, aim to reduce the need for ongoing long-term support by improving individual's health and wellbeing.

Working as system enabler commissioners will work with planners, developers and care providers to develop new build care and support developments including Extra Care, Specialist Nursing Provision and Supported Living for working age adults including Learning Disabilities and adults with multiple needs.

System Enablers

Responding to the recent CQC System Review, we will facilitate system partners coming together to develop a fully resourced System Wide Workforce Development Plan. Key activities will be review of existing organisational plans, development of system wide work force profile and gap analysis, shared workforce principles, alignment of existing resources to priorities and active pursuit of additional revenue opportunities.

Building on the work already commenced through the OPE Programme we will facilitate a review of our health and care estate including developing a masterplan for the Mount Gould Site and the roll out of Wellbeing Hubs.

High Level Road Map								
	2018				2019-20			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3/Q4**	**Q1 (20)**
Integrated Commissioning	Commissioning Intentions Consultation	Publication of Commissioning Intentions						
Integrated Care	Development of contracting options Publication of Contracting Approach	Mobilisation		Detailed Planning Completed	Initial Integration of new functions completed		Transformation	
Transformed and Sustainable Primary Care		Joint Commissioning of Primary Care in place		Integrated Pharmacy Service Designed	Integrated Primary Care System Designed Integrated Pharmacy Service Signed Off		Integrated Primary Care System Signed Off	Integrated Pharmacy Service in place
Integrated Children and Young Person and Families Services	Launch of CHWB and SEND tender	Residential block contract implemented. Children's Centre statutory consultation Together for Childhood place based consultation. Peninsula	PAUSE implemented. Award of CHWB and SEND contract Implementation of Crisis Response provision (complex adolescent and	Schools funding sought for EHWB offer from Aug 19 onwards Children's Centers out to tender as part of EH and TS offer		CHWB and SEND contract begins	EH and TS offer implemented	

		fostering contract implemented Peninsula residential tender launched	step-down)					
Local Responsive Mental Health Services		Crisis Café Opened Recovery Pathway Work Commences 24/7 Assessments Launch Enhanced Social Prescribing Pilot commences		Dementia Diagnosis Improvement Achieved Integration of Dementia Pathway and Navigation service Rapid Response Community Crisis Service in place Enhanced Social Prescribing Pilot Ends	Recovery Pathway Proposals Developed	Plans Developed around Recovery Pathway Proposals		
Health and Wellbeing Hubs	1st phase of training commences 1st Hub Pilot Launches	First Targeted Hub Open First Universal Offer New website in place	WFD Phase 1 completed Wider Hubs Design completed		Full launch of IT Solution Phase 1 of Targeted Hub programme complete			Phase 2 of Targeted Hub programme complete

	Full WFD Framework Agreed	1st Hub Pilot ends	Development of IT solution completed					
MEAM	Development of Service Model Market Engagement Procurement Commences			Contract award Cabinet Implementation Period commences	Service Mobilization Implementation ends	Alliance Contract Goes Live	Implementation and Delivery	
Enhanced Care and Support	Baseline Assessment against EHCH Model	Mobilisation		Detailed Planning Completed	Initial Integration of new functions completed		Transformation	SAP for Dom Care in place
System Enablers			Phase 1 Planning Consent Approved for Efford H&WB Hub	Plymstock Health Hub Occupied Construction Contract let for Efford H&WB Hub			Implementation of Phase 1 works at LCC Deliver OPE Hub Implementation Plan	

HEALTH AND WELLBEING BOARD

Work Programme 2018 - 2019

Date of meeting	Agenda item	Reason for consideration	Responsible
14 February 2018	CQC Review Report	**Strategic Priority:** System Wide Leadership	Carole Burgoyne / Craig McArdle
	System Updates (Safer Plymouth/Western Locality/SIB/CYP)	**Strategic Priority:** System Assurance and Challenge	Carole Burgoyne / Craig McArdle
	Strategic Commissioning Intention Health and Wellbeing Hubs	**Strategic Priority:** Oversee the Integrated Commissioning Strategies	Carole Burgoyne / Craig McArdle
22 March 2018	Pharmaceutical Needs Assessment	**Statutory Duty**	Rob Nelder
	Integrated Commissioning Scorecard		Rob Sowden
	Commissioning intentions		Craig McArdle
	CQC Action Plan		Harry Sherwin
	Good news stories		
21 June 2018 – TBC at AGM	STP Strategy presentation		Carole Burgoyne/ Sonja Manton from the CCG will be presenting
	Parks and green spaces		Jacky Clift and Kathryn Deeney
	CQC Action Plan		Item to go on every agenda
	Good news stories		
	Suicide Prevention		Sarah Lees

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