

Friday, 27 February 2015

Meeting of the Health and Wellbeing Board

Monday, 9 March 2015

9.30 am

Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Board

Councillor Lewis (Chairman)
Councillor Davies
Caroline Dimond, Interim Director of Public Health
Councillor Doggett
Pat Harris, Healthwatch Torbay
Graham Lockerbie, NHS England
Councillor Pritchard
Councillor Scouler
Eleanor Rowe, Clinical Commissioning Group
Caroline Taylor, Torbay Council
Richard Williams, Torbay Council

Co-opted Members

Tony Hogg, Police & Crime Commissioner
Dr John Lowes, South Devon Healthcare NHS Foundation Trust
Mandy Seymour-Hanbury, Torbay and Southern Devon Health and Care NHS Trust
Community Development Trust - Vacancy

For information relating to this meeting or to request a copy in another format or language please contact:

Lisa Antrobus, Town Hall, Castle Circus, Torquay, TQ1 3DR
01803 207064

Email: governance.support@torbay.gov.uk

HEALTH AND WELLBEING BOARD AGENDA

1. **Apologies**
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.
2. **Minutes** (Pages 1 - 4)
To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 17 December 2014.
3. **Declaration of interest**
- 3(a) **To receive declarations of non pecuniary interests in respect of items on this agenda**
For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.
- 3(b) **To receive declarations of disclosable pecuniary interests in respect of items on this agenda**
For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)
4. **Urgent items**
To consider any other items that the Chairman/woman decides are urgent.
5. **Ageing Well in Brixham, Paignton and Torquay**
Presentation and discussion on the Ageing Well project.
6. **Pharmaceutical Needs Assessment (PNA) Formal Sign Off** (Pages 5 - 134)
To consider a report that provides a comprehensive assessment of the current and expected future pharmaceutical needs of the local population.
7. **Clinical Commissioning Group Operational Plan 2015-2016** (To Follow)
To consider a report on the above.

- 8. Director of Public Health for Torbay Annual Report 2014** (Leaflet circulated separately)
To note the 2014 Annual Report from the Director of Public Health.
- 9. Update on Pioneer/JoinedUp and Better Care Fund** (Pages 135 - 137)
To consider a report on the above.
- 10. Update Report - Adult Mental Health: Acute Care Pathway** (Pages 138 - 180)
To note the report.
- 11. Update Report - Adult Social Services - Care Act** (Pages 181 - 185)
To receive an update on the current position of the Care Act.
- 12. Update Report - Community Safety Partnership** (Pages 186 - 187)
To note the update from the Community Safety Partnership.
- 13. Update Report - ICO Programme** (Page 188)
To receive an update on the current position of the Integrated Care Organisation.
- 14. Update Report - Clinical Commissioning Group** (Pages 189 - 190)
To receive an update on the current position of the Clinical Commissioning Group.



Minutes of the Health and Wellbeing Board

17 December 2014

-: Present :-

Ian Ansell, Councillor Steve Darling, Councillor Bobbie Davies, Caroline Dimond, Julie Foster, Pat Harris, Councillor Chris Lewis (Chairman), Councillor Ken Pritchard, Eleanor Rowe, Caroline Taylor and Richard Williams

37. Apologies

Apologies for absence were received from Councillor Scouler, Graham Lockerbie, John Lowes, Melanie Walker, Councillor Doggett who was represented by Councillor Darling, Tony Hogg who was represented by Ian Ansell and Mandy Seymour-Hanbury who was represented by Julie Foster.

38. Minutes

The Minutes of the Health and Wellbeing Board held on 2 October 2014 were confirmed as a correct record and signed by the Chairman.

39. Torbay's Carers Strategy 'Measure Up' 2015-17

The Board considered a report that set out the proposed priorities which were detailed in the interagency Carers strategy. Members were advised that the 'Measure Up' approach to Carer support continued to be recognised as an example of national good practice. It was based on a long term, whole systems approach, grounded in assessment of local needs and an evidence base of what works.

Members were informed that an action plan to accompany the strategy would be produced within the next three months and performance monitoring would be undertaken through the single outcome framework.

The Board referred to the engagement of volunteers, James Drummond, Lead Officer for Carers Services, explained that a significant amount of people will volunteer for their own GP practice, these skills can be applied to their neighbourhood through other agencies such as Crossways. Whilst attaching volunteer services to GP practices is advantageous, it isn't always the right model for delivery.

Resolved:

- i) That the draft priorities for 'Measure Up' 2015-17 be endorsed;

- ii) that an action plan be produced with clear targets, timescales and responsibilities for delivery, that the action plan be reviewed annually and the Health and Wellbeing Board be updated on achievement.

40. Refresh of the data informing the Market Position Statement for Adult Social Care and Support in Torbay 2014 onwards and The Children's Commissioning Plan and Sufficiency Strategy

The Health and Wellbeing Board noted the refresh of the data that informed the Market Position Statement for Adult Social Care and Support in Torbay 2014 onwards and the Children's Commissioning Plan and Sufficiency Strategy. The Market Position Statement (MPS) was produced in February 2014 to provide information and analysis of benefit to providers of care and support services in Torbay.

Members noted that the MPS was a large piece of work which enabled more people to remain in their own homes with support. However there had been an increase in homelessness and temporary accommodation which was posing pressure for those services and the system as a whole. Members were informed that an in-depth review was being undertaken by Public Health to establish the reasons for the increase in homelessness, the findings of which would be reported to the Health and Wellbeing Board.

Members were informed that the refreshed document does not change any text or commissioning intentions of the MPS but updates the data set. Also included was the Children's Commissioning Plan and Sufficiency Strategy that sets out the current position for Children Services which will be reviewed and merged into one document during a full review of the Market Position Statement in six months time.

41. NHS - Five Year Forward View

Members received a presentation and were informed that the paper set out a new direction of travel for the NHS, budget pressures had resulted in an imbalance in the system requiring the NHS to develop a new ethos – 'its what matters to me not what's the matter with me'.

The Board was advised that throughout the plan there were three themes:

- Radical upgrade in prevention and public health
- Greater control for patients and carers
- Breaking down barriers to how care is provided

Members were asked to consider the role of the Health and Wellbeing Board within the shifting focus of the NHS. Some Members challenged whether the Health and Wellbeing Board should undertake a review of its own priorities and achievements prior to the elections in 2015, in order to use the experience gained from the last 18 months to aid and inform a new administration, whilst others were of the view that there were a number of organisational changes due to be implemented along with a

general and local election that may mean a review at later stage may be more advantageous. The Board requested the Torbay Joint Commissioning Group consider the appropriate time for a review of the Health and Wellbeing Board.

42. Initial Report - Health Protection

The Board noted a report that provided a summary of the assurance functions of the Health Protection Committee and detailed the significant matters considered since 2013. The report also summarises action taken to date against the programme of health protection work priorities for period 2014 to 2015.

43. Key priorities relating to the Special Educational Need and Disability Reforms

Members were informed that the Special Educational Need and Disability (SEND) reforms came into force on 1 September 2014 with the conversion of 'statements' to Education Health and Care Plans (EHCPs) having to be completed by 2018.

Whilst the SEND reforms were being implemented, officers took account of the implications of the Health and Care Act and had established an operational group specifically focusing on the implementation of the reforms.

Resolved:

That the Special Educational Need and Disability Reforms Operational Leads group report to the Partnership for Families Strategic Group.

44. Mental Health Crisis Care Concordat

The Board were informed that the Council had already signed up to the mental health concordat, however an action plan was still awaited. Members were informed that mental health was a weak area for Torbay with the political spotlight intensifying. The Board was informed that the Devon Health and Wellbeing Board will be approving an action plan shortly, some of which could also be applicable to Torbay. A Section 136 protocol would also become live on 1 March 2015.

Members were advised that NHS England would be undertaking a review of the recent detention of a young person in police cells due to the lack of a 'safe place'. The findings of the review would be made available for the Health and Wellbeing Board.

45. Adult Safeguarding Peer Review

Members noted the report that set out the findings of a Regional Adult Social Care Peer Challenge. Bob Spencer, Chairman of the Adult Safeguarding Board informed Members that the peer review had a wide remit with the resulting action plan having been compiled by theme.

The Board were advised that the Health and Social Care Act reforms would have an impact upon the Adult Safeguarding Board in relation to the responsibility of the Board and governance of joint boards. However the act would put both the

Children Safeguarding Board and Adult Safeguarding Board on the same statutory footing enabling joint working on emerging themes.

46. Torbay Safeguarding Children Board - Annual Report 2013-2014

Members noted the annual report of the Torbay Safeguarding Children Board (TSCB) for 2013/14. The report set out the work of the TSCB and its sub-committees over the last year, noting achievements and areas for improvement and future work.

The Board paid particular attention to the Business Plan Update, David Taylor, Chairman of the TSCB advised of an audit regarding neglect, he explained that an action plan would be shared with the Health and Wellbeing Board in order to determine whether Members would be able to assist with the implementation.

The Chairman, expressed his thanks to David Taylor and Bob Spencer for the support they have provided both the Torbay Children Safeguarding Board and Adult Safeguarding Board.

47. Update Report - Adult Social Services

The Board noted the update on adult services.

48. Update Report - Clinical Commissioning Group

The Board noted the update on the Clinical Commissioning Group.

49. Update Report - Public Health

The Board noted the update on Public Health.

50. Update Report - Healthwatch

The Board noted the update from Healthwatch.

51. Update Report - Integrated Care Organisation

The Board noted the update on the Integrated Care Organisation.

Title: Pharmaceutical Needs Assessment (PNA) formal sign off.
 (consultation period: 17th November 2014 – 16th January 2015)

Wards Affected: All

To: Health & Wellbeing Board **On:** 09.03.2015

Contact: Public Health Team (Torbay Council)
Telephone: Contact for enquiries: Ian Tyson (01803) 207314
Email: publichealth@torbay.gcsx.gov.uk

1. Purpose

The purpose of a Pharmaceutical Needs Assessment (PNA) is to enable NHS England (NHSE) to make an informed decision about the market entry of any additions to the market.

A PNA is a comprehensive assessment of the current and expected 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 (PCTs) to Health and Wellbeing Boards (HWBs) from 1 April 2013. This means that Torbay's HWB has a legal duty to ensure the production of a PNA for Torbay going forward. HWBs are required to publish their first PNA by 1 April 2015 and publish a 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 Torbay 2015-2018 presents a picture of community pharmacy need and provision in Torbay and links to the South Devon and Torbay 2014/15 Joint Strategic Needs Assessment (JSNA).

This PNA will be used by the NHSE Area Team for Devon, Cornwall and Isles of Scilly to inform:

- Decisions regarding which NHS funded services need to be provided by community pharmacies and dispensing appliance contractors in Torbay e.g. Medicine Use Review Service and Appliance User Review Service.
- Whether new pharmacies or expansion of 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 be able to make use of the PNA to inform their applications to provide pharmaceutical services by demonstrating that they are meeting the pharmaceutical need as identified in the PNA.

The PNA has been written in partnership with the Public Health teams in the local authorities of Devon, Plymouth and Torbay and working closely with NHS England and the Local Pharmaceutical Committee to agree a consistent but locally relevant format which complies with the regulations.

2. Recommendation

It is recommended that the Torbay HWB endorse the Torbay PNA for publication. By endorsing the PNA at this meeting, the Torbay HWB will take the final opportunity to meet local governance arrangements and therefore comply with national regulations and mandated timescales for sign off by March 31st 2015. (Please note that the 09th March 2015 HWB meeting is the last formal opportunity before the statutory date of final publication. Failure to endorse at this time will result in the need for an extraordinary meeting to be called to meet corporate governance requirements).

3. Supporting Information

The PNA report is attached to the HWB papers.

The Health and Social Care Act 2012 transferred responsibility to develop and update PNAs from PCTs to Health and Wellbeing Boards. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

The NHS Act (the “2006” Act), 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 (DH) powers to make regulations:

(i) 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.

(ii) 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.

(iii) 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 Torbay Health and Wellbeing Board is central to overseeing the commissioning of services which address public health and other relevant health and wellbeing outcomes.

4. Relationship to Joint Strategic Needs Assessment

There is a strong relationship between the PNA and the JSNA this was used extensively in understanding the resident population needs across Torbay. Considerable sections of the health and demographic needs analysis replicate the content of the JSNA, however, data is presented in a format and geography area suited for the PNA. The JSNA is clearly referenced in the PNA for further supporting information and evidence.

5. Relationship to Joint Health and Wellbeing Strategy

This is the first PNA written under the responsibility of the HWB, thus there is, at present no direct relationship between the PNA and the joint health and wellbeing strategy.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

The JSNA will continue to inform future versions/iterations of the PNA.

HWBs will be required to publish a revised assessment within three years of publication of their first assessment; and

HWBs will be required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

Appendices

None

Background Papers:

The following documents/files were used to compile this report:

Torbay PNA FINAL 24.02.15

Pharmaceutical Needs Assessment for Torbay 2015-2018

Authors: Ian Tyson, Rachel Bell

Date: 09.03.2015



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:	Ian Tyson (Health Improvement and Quality Manager) & Rachel Bell (Public Health Intelligence Analyst) Torbay Council. The document was developed by the Public Health Team (Torbay Council) and the Peninsula PNA Steering Group, on behalf of Torbay's Health and Wellbeing Board.
Document version:	Version 1.0
Document date:	05.11.14
Next review date:	Every three years unless there is a significant change to existing pharmaceutical service provision.
Approved by:	Torbay Health and Wellbeing Board
Date approved:	09.03.15
Links to: (JSNA)	www.southdevonandtorbay.info

Amendment History

Version:	Status:	Date:	Reason for change:	Authorised by:
1.0	Draft	05.11.14	Initial draft (prior to consultation)	Peninsula PNA Steering Group
2.0	Final draft	13.01.15	Final draft following the consultation period and approval from the Peninsula PNA Steering Group	Peninsula PNA Steering Group
3.0	Final version	TBC	Following approval from the Torbay Health and Wellbeing Board	Torbay Health and Wellbeing Board

Acknowledgments

The development of this Pharmaceutical Needs assessment (PNA) was overseen by the Peninsula PNA Steering Group (see 3.2 for Members). The Group was chaired by Sarah Ogilvie (Specialty Registrar in Public Health, Plymouth City Council) who oversaw the PNA process across the Peninsula in conjunction with the PNA Steering Group. Particular acknowledgement should be made to Sarah Ogilvie for her excellent coordination of the steering group and for the production of a significant proportion of the Devon, Plymouth and Torbay wide sections of each area's PNA. Special thanks are given to Kevin Noble (PharmOutcomes) for setting up and administering the pharmacy questionnaire via PharmOutcomes. The authors would also like to thank Simon Chant (Public Health Specialist (Intelligence), Devon County Council) for kindly producing the 'drive time analysis' for Plymouth, Torbay and Devon on behalf of the Steering Group. Finally, the authors would like to thank all persons who contributed to the consultation on this PNA, including NHS England, Devon LPC, Devon Partnership NHS Trust, local pharmacists and Devon LMC.

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1. EXECUTIVE SUMMARY

1.1 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 (HWBs) from 1 April 2013. This means that Torbay's HWB has a legal duty to ensure the production of a PNA for Torbay going forward. HWBs 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.

1.2 The PNA for Torbay 2015-2018 presents a picture of community pharmacy need and provision in Torbay, and links to Torbay's Joint Strategic Needs Assessment. This PNA will be used by the NHS England Area Team for Devon, Cornwall and Isles of Scilly to inform:

- decisions regarding which NHS funded services need to be provided by community pharmacies and dispensing appliance contractors in Torbay
- 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.

1.3 Torbay's PNA was developed in partnership with the Peninsula wide PNA Steering Group on behalf of Torbay's HWB. This was to ensure that production of the PNAs for Plymouth, Devon, Torbay and Cornwall and Isles of Scilly followed the same process and format but with locally relevant information. Members of the Steering Group included:

- Chair of the Devon, Cornwall and Isles of Scilly Pharmacy Local Professional Network
- Chief Officer for the Devon Local Pharmaceutical Committee
- Chief Officer for the Cornwall and Isles of Scilly Local Pharmaceutical Committee
- NHS England Devon, Cornwall and Isles of Scilly Area Team
- Dispensing doctors representative
- Public Health representatives from Plymouth City Council, Torbay Council, Devon County Council, and Cornwall Council and Council of the Isles of Scilly

Additional stakeholders involved in the production of this report included individual community pharmacy contractors (through completion of a pharmacy questionnaire) and individuals and/or organisations on the list of persons to be consulted as stipulated in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

- 1.4 The NHS Regulations 2013 set out the legislative basis for producing and updating PNAs, and stipulate a list of minimum information that must be included in the PNA. Torbay's PNA is structured as follows:
- Locality Summary Sheets
 - Introduction and context
 - Process followed
 - Assessing need
 - Torbay's localities
 - Torbay's demography
 - Overview of Torbay
 - Locality based health profile (cradle to grave)
 - Public Health indicators related to community pharmacy
 - Mapping current pharmaceutical services provision and identifying gaps
 - Outcomes of the consultation
 - Potential future provision of pharmaceutical services
 - Conclusions
- 1.5 In order to identify local health needs and assess current pharmaceutical services provision, Torbay was divided into its two established localities: Torquay and Paignton and Brixham. 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.
- 1.6 Information regarding local provision of pharmaceutical services across the Peninsula was collected via PharmOutcomes for each local authority area. PharmOutcomes is an online tool which has been commissioned across Devon to capture pharmacy-based activity and provide a consistent mechanism to collect, process, and pay pharmacies for public health services. Pharmacies were notified via email and PharmOutcomes messenger on 25 June 2014 that they had three weeks to complete the questionnaire (25 June to 11 July 2014). Data regarding GP dispensing practices was collected where appropriate; this was not applicable for Torbay.
- 1.7 The 60-day consultation period ran from Monday 17 November 2014 until Friday 16 January 2015. All feedback received was considered by the PNA Steering Group and all changes made (or not) to the PNA were a result of the consensus view of the Steering Group.
- 1.8 The findings of Torbay's PNA have been summarised in the two Locality Summary Sheets, which are appended to this Executive Summary. Key observations are listed below:
- There are no Distance Selling Pharmacies within Torbay.
 - Given the relatively urban nature of Torbay, there are no dispensing GP practices within the Local Authority boundaries but this is of relevance to neighbouring PNAs.

- A number of Dispensing Appliance Contractors (DACs) were identified during the development of the PNA, most of which are national companies covering a wide geographical area. DACs are unable to supply medicines or provide the range of pharmaceutical services offered by community pharmacies. They will however be used by residents in Torbay due to their convenience.
- In Torbay, pharmaceutical services are mainly provided by community pharmacies. Most Torbay pharmacies are accessible by car in 5 minutes, although drive time maybe extended at the earliest and latest points of the day or at weekends when only certain pharmacies will be open.
- In total there are 39 pharmacies providing a service to a population of 131,492¹. Of these, just over a quarter are Boots pharmacies (10) and just under a quarter (8) are Day Lewis pharmacies, with the remaining 21 being made up of a range of other providers.
- Torquay has greater identified health needs but has a greater pharmacy density per population and the greater availability to pharmaceutical services than Paignton or Brixham. Pharmacy locations are centred around areas of greatest population density and deprivation.
- Internet access and secure email address usage is variable across Torbay.
- Provision of consultation facilities across Torbay is very good, with the majority providing disabled access. Just under half the pharmacies across Torbay offer off-site consultations although there is likely to be increased demand for off-site provision beyond what is already provided. Nearly all pharmacies operate a prescription collection service from GP practices. Most pharmacies have hand washing facilities either in, or close to, the consultation. Off-site consultation provision is available from less than half the pharmacies.
- 69% of pharmacies (27 out of 39) dispense stoma appliances, incontinence appliances and dressings across Torbay. Dispensing is higher in Paignton and Brixham (78%), than in Torquay (62%). There is very good provision of Medicines Use Review and the New Medicine Service. Appliance Use Review (AUR) is currently offered by three pharmacies in Torbay (two are located in Paignton and Brixham and one in Torquay). Only 10% of pharmacies offer Stoma Appliance Customisation, with limited availability of this service across both localities. However the use of centralised contactors and the willingness to provide these services by existing pharmacies who are not currently providing them has not been determined.
- All but one pharmacy offer a collection of prescription from their GP and delivery of dispensed medicines free of charge on request. Therefore whilst Torquay has a slightly higher proportion (one in five) without access to a car than the national average, there is good provision of home delivery services.

¹ ONS 2012 mid year population estimate

- The proportion of the population who cannot speak English, or cannot speak English well is almost distinctly confined to Torquay town centre (Tormohun ward). Non-English-speaking patients typically receive fewer preventative services and have less access to health care than English-speaking patients. Consequently, any barriers to provision for these population groups should be addressed. Torquay town centre does have some access to pharmacies where staff can speak one non-English language but interestingly Brixham has the greatest prevalence of staff who can speak one or more non-English language.
- The three most prominent themes that emerged from the priorities identified by pharmacies were relating to access to the minor ailment scheme; increasing the range, access to or appropriateness of commissioned services; and to prioritising already commissioned services (although there was clearly inconsistency with regards to understanding of the new commissioning landscape – as also borne out by the commissioned services audit).
- There are a number of developments either in the planning or construction phase that will materially affect Torbay in the following 5 years. These include the conclusion of the South Devon Link Road which it is expected will significantly improve accessibility to, and job provision in, Torbay; the development of a new train station at Edginswell in Torquay further improving accessibility; plus residential developments in both Torquay and Paignton which are anticipated to increase the population by approximately 7,000 in total. All these may create either residential or transient demand for further pharmaceutical services over the coming years.

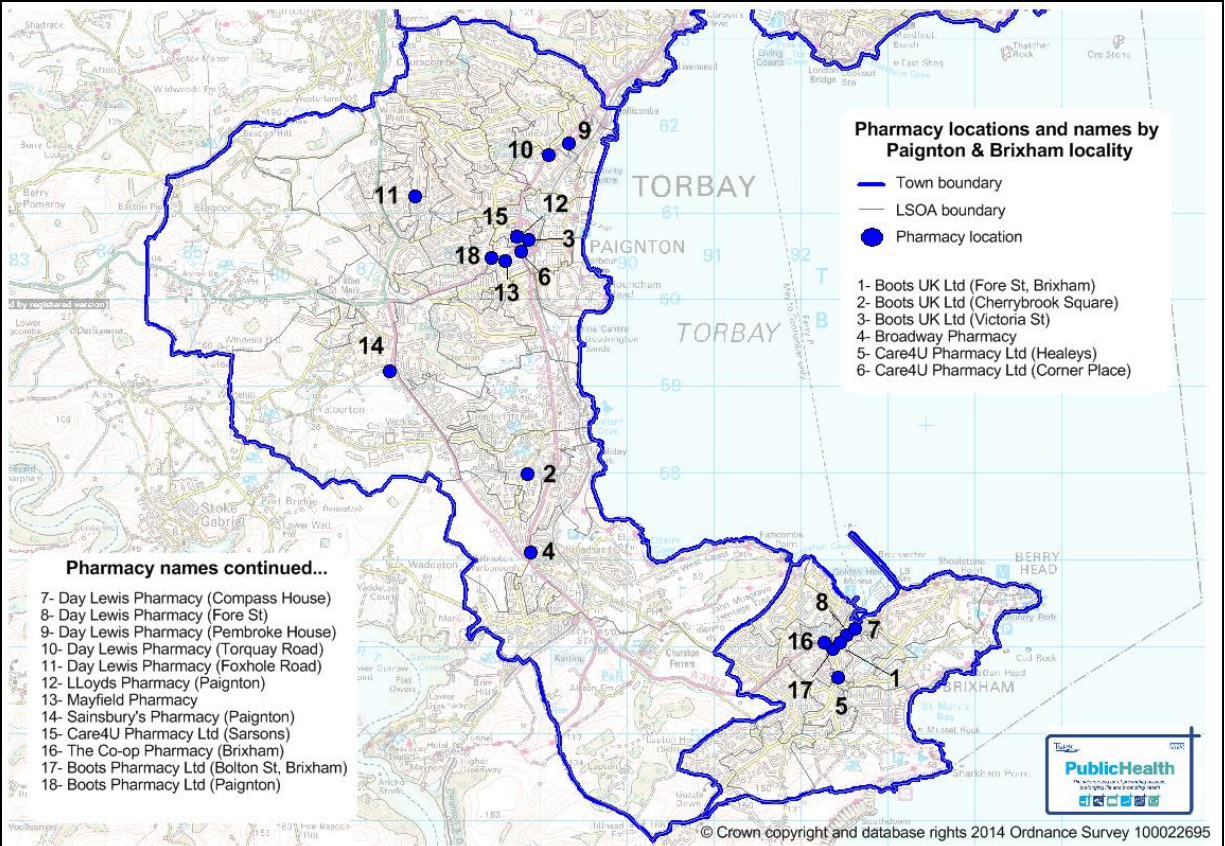
Locality summaries

- 1.9 In order to help identify gaps and make assessments regarding the adequacy of current pharmaceutical services provision in Torbay, the findings of this Needs Assessment have been summarised into two individual 'Locality Summary Sheets'. Each sheet provides an overview of demographic information, health needs and service provision. They also attempt to capture any additional local insight regarding factors affecting need, provision or future provision of pharmaceutical services in Torbay that may have been missed through conventional mapping. As the Summary Sheets are likely to be of greatest use to the NHS England Local Area Team when reviewing provider applications, they have been developed in partnership with the Area Team through the Peninsula PNA Steering Group. It is important to acknowledge that these Summary Sheets are designed to provide an overview of the findings and key observations, with detailed information provided in the main document. Where relevant (and for ease of use), hyperlinks have been included within the summaries to link the reader to the relevant section of the report as required.

LOCALITY SUMMARY 1: PAIGNTON & BRIXHAM	
POPULATION DEMOGRAPHICS:	
Population size (page 30):	69,300 (0.3% decrease from 2002-12)
Ethnicity breakdown (page 34):	<ul style="list-style-type: none"> • 98.3% White • 0.9% Mixed/multiple ethnic groups • 0.6% Asian/Asian British • 0.1% Black/African/Caribbean/Black British • 0.1% Other ethnic group
IMD 2010 Score and locality rank (1 = most deprived, 2 = least deprived) [page 34-35]	23.6 (rank: 2/2)
MOSIAC ALTERNATIVE (demography and environment) (page 37-39)	
[rank compared to Torquay locality – 1 = higher]	
Compared to the South Devon and Torbay average Paignton & Brixham has an:	
<ul style="list-style-type: none"> • Older population [1/2] • Less Black Minority Ethnic people [2/2] • More living in private rented homes [2/2] • Less living in social rented homes [2/2] • Less fuel poverty [2/2] 	<ul style="list-style-type: none"> • More child poverty [2/2] • More domestic abuse [2/2] • More unemployment with low skills [2/2] • More long-term health problems/disability [1/2]
HEALTH NEEDS OVERVIEW:	
Rank for locality based health profile ('cradle to grave') (1 = locality with greatest needs): (page 44-46)	2/2
Rank for public health indicators (as above): (page 57-59)	2/2
BEST HEALTH OUTCOMES (i.e. where the locality rank is higher than Torquay)	
CRADLE TO GRAVE (page 44-46)	PUBLIC HEALTH INDICATORS (page 57-59)
<ul style="list-style-type: none"> • Locality with greatest life expectancy • Higher breastfeeding prevalence • Lower childhood obesity • Lower elective and emergency admissions • Lower circulatory, respiratory and all-cause mortality 	<ul style="list-style-type: none"> • Less smoking in pregnancy • Less parents who misuse drugs/alcohol • Less diagnosed mentally ill/depressed • Less living alone under 65yrs • Less lone parents with dependents • Less divorced/separated • Less injury admissions in children under 15yrs • Less circulatory disease admissions • Less falls admissions 65yrs and over • Less substance misuse • Less cancer mortality
•	
KEY HEALTH NEEDS (i.e. where the locality rank is lower than Torquay)	
CRADLE TO GRAVE (page 44-46)	PUBLIC HEALTH INDICATORS (page 57 or 59)
<ul style="list-style-type: none"> • Ageing population • Higher self-reported bad health status • Higher long-term health problems/disability • Higher liver disease mortality 	<ul style="list-style-type: none"> • More living alone 65yrs and over • More widowed • More unpaid carers • Higher injury admissions aged 15-24 yrs • Higher self-harm admissions 10-24 yrs
PHARMACY PROVISION OVERVIEW:	
Number of GP practices:	9
Number of pharmacies:	18

Population per pharmacy & locality rank (1= lowest no. of pharmacies per head of pop.): [page 81]

3,850 (rank: 1/2 – lowest number of pharmacies to population size)



GP locations can be found in the South Devon and Torbay JSNA: www.southdevonandtorbay.info

ACCESSIBILITY:

Provision:	MON-FRI:	✓	SAT:	✓	SUN:	✓
Longest pharmacy opening times within this locality (page 83):	07:00-23:00 MONDAY-FRIDAY 07:00-22:00 SATURDAY (Shorter Saturday opening times) 08:30-21:00 SUNDAY (Shorter Sunday opening times)					
Proportion of population with no car and locality rank (1 = lowest proportion of car ownership) [page 36]:	15.9% (rank : 2/2)					
Drive time analysis (page 84-90):	On weekdays, all pharmacies accessible within a 10 minute drive. During evenings and weekends the drive times are extended but only to a maximum of 15 minutes.					
Public transport (page 89):	All pharmacies are accessible via public transport					

PROVISION OF PHARMACEUTICAL SERVICES:

(1) ESSENTIAL SERVICES (page 93):

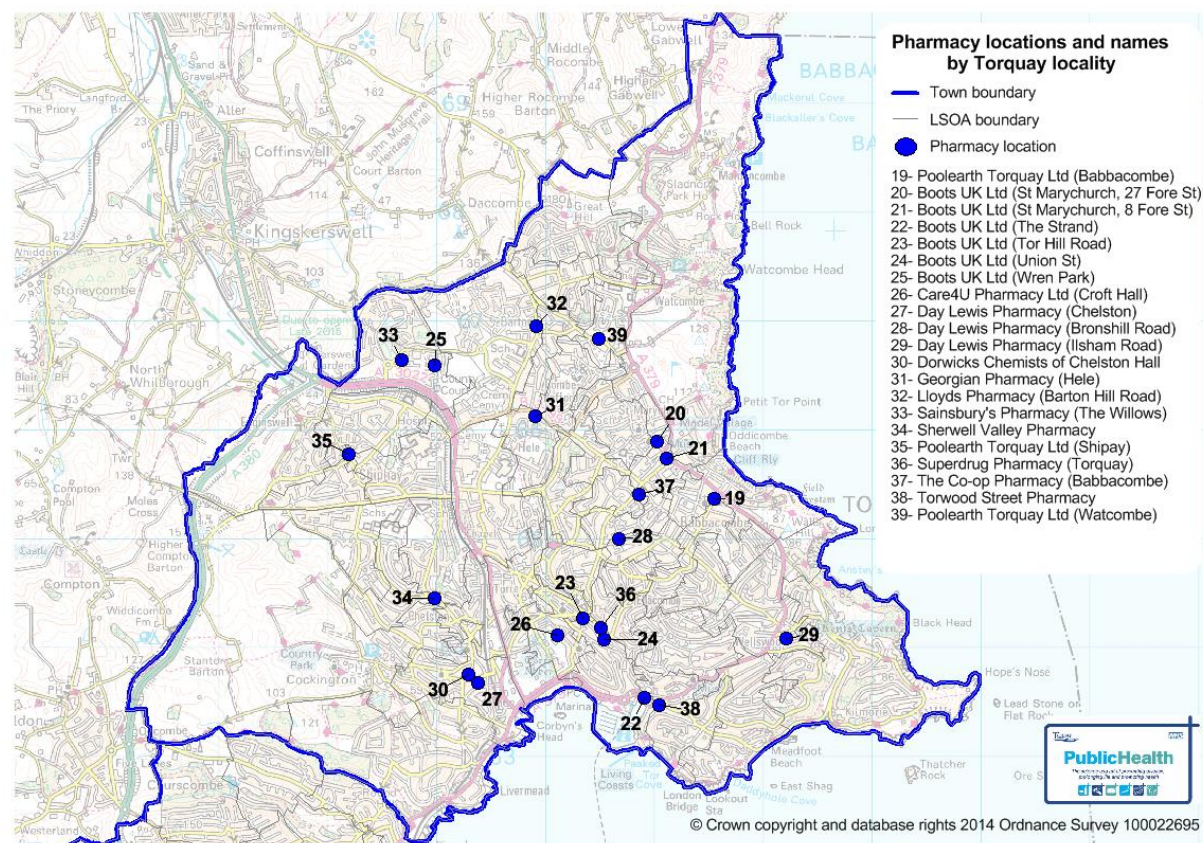
No. of pharmacies dispensing appliances:	14/18 all (2 just dressings, 1 just dressings and stomas, 1 all but incontinence appliances and stomas)
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(2) ADVANCED SERVICES (page 94):	
No. offering Medicines Use Review Service:	17/18
No. offering New Medicine Service:	17
No. offering Appliance Use Review Service:	Two (However there is likely to be wider use of centralised contractors for this service)
No. offering Stoma Appliance Customisation:	Two (However there is likely to be wider use of centralised contractors for this service)
(3) ENHANCED SERVICES (page 95-96):	
NHS England currently commissions an Out of Hours Enhanced Services to pharmacies in Torbay.	
POTENTIAL FUTURE NEEDS FOR PHARMACEUTICAL SERVICES (page 103):	
<ul style="list-style-type: none"> Ageing, stable population (page 30) South Devon link road set for completion in 2015 (page 103) Anticipated large scale residential development in Collaton St Mary (SDP3.3 Paignton North & Western Area – below) in the next 15 years which may require additional pharmacy provision (page 103) [accurate at 29/10/14]. 	
SUMMARY OF LOCALITY-BASED OBSERVATIONS:	
<p>ACCESS: The overall hours of opening, geographical spread of pharmacies, drive time analysis and significant number of pharmacies per head of population indicate that there is good access to pharmaceutical services within this locality.</p> <p>BREADTH OF PROVISION: There is currently limited provision of Appliance Use Review and Stoma Appliance Customisation Services at pharmacies within the locality. NHS England currently commissions an Out of Hours Enhanced Services to pharmacies in Torbay; this service is generally required to ensure patients have good access to pharmaceutical services over the Christmas/New Year and Easter periods.</p> <p>POTENTIAL FUTURE NEEDS: There is an anticipated large scale residential development in Collaton St Mary (SDP3.3) in the next 15 years which may require additional pharmacy provision [accurate at 29/10/14]. More immediate but small scale developments are either planned or</p>	

underway at Great Parks (SDP3.4) and Whiterock (SDP3.5). The South Devon link road is set for completion in 2015 which it is anticipated will bring in an additional 3,500 jobs in Torbay. The effect of this on need for pharmaceutical services is unknown.

LOCALITY SUMMARY 2: TORQUAY	
POPULATION DEMOGRAPHICS:	
Population size (page 30):	65,500 (1.5% increase from 2002-12)
Ethnicity breakdown (page 34):	<ul style="list-style-type: none"> • 96.8% White • 1.3% Mixed/multiple ethnic groups • 1.4% Asian/Asian British • 0.2% Black/African/Caribbean/Black British • 0.2% Other ethnic group
IMD 2010 Score and locality rank (1 = most deprived, 2 = least deprived) (page 34-35)	29.5 (rank: 1/2)
MOSIAC ALTERNATIVE (demography and environment) (page 37-39)	
[rank compared to Paignton & Brixham locality – 1=higher]	
Compared to the South Devon and Torbay average Torquay has a:	
<ul style="list-style-type: none"> • Younger population with higher fertility [1/2] • More Black Minority Ethnic people [1/2] • More living in private rented homes [1/2] • More living in social rented homes [1/2] • More child and older person poverty [1/2] 	<ul style="list-style-type: none"> • More living alone, divorced/separated or lone parents with dependent children [1/2] • More crime and domestic abuse [1/2] • More unemployment with low skills [1/2] • Less long-term health problems/disability [2/2]
HEALTH NEEDS OVERVIEW:	
Rank for locality based health profile ('cradle to grave') (1 = locality with greatest needs): (page 46)	1/2
Rank for public health indicators (as above): (page 57-59)	1/2
BEST HEALTH OUTCOMES (i.e. where the locality rank is higher than Paignton & Brixham)	
CRADLE TO GRAVE (page 44-46)	PUBLIC HEALTH INDICATORS (page 57-59)
<ul style="list-style-type: none"> • More births • Less self-reported bad health status • Less long-term health problem/disability 	<ul style="list-style-type: none"> • Less living alone 65yrs and over • Less widowed • Less unpaid carers • Less self-harm admissions aged 10-24yrs •
KEY HEALTH NEEDS (i.e. where the locality rank is lower than Paignton & Brixham)	
CRADLE TO GRAVE (page 44-46)	PUBLIC HEALTH INDICATORS (page 57-59)
<ul style="list-style-type: none"> • Ageing population (younger than Paignton & Brixham but older than England average) • Locality with lowest life expectancy • Lower breastfeeding prevalence • Higher childhood obesity • Higher elective and emergency admissions • Higher circulatory, respiratory and all-cause mortality 	<ul style="list-style-type: none"> • More smoking in pregnancy • More parents who misuse drugs/alcohol • More diagnosed mentally ill/depressed • More living alone under 65yrs • More lone parents with dependents • More divorced/separated • More injury admissions in children under 15yrs • More circulatory disease admissions • More falls admissions 65yrs and over • More substance misuse
PHARMACY PROVISION OVERVIEW:	

Number of GP practices:	8
Number of pharmacies:	21
Population per pharmacy & locality rank (1= lowest no. of pharmacies per head of pop.): [page 81]	3,119 (rank: 2/2 - greatest number of pharmacies to population size)



GP locations can be found in the South Devon and Torbay JSNA: www.southdevonandtorbay.info

ACCESSIBILITY:						
Provision:	MON-FRI:	✓	SAT:	✓	SUN:	✓
Longest pharmacy opening times within this locality (page 83):			08:00-00:00 MONDAY-FRIDAY 08:30-00:00 SATURDAY (Longer Saturday opening times) 09:30-00:00 SUNDAY (Longer Sunday opening times)			
Proportion of population with no car and locality rank (1 = lowest proportion of car ownership) [page 36]:			20.1% (rank : 1/2)			
Drive time analysis (page 84-90):			On weekdays, all pharmacies accessible within a 10 minute drive. During evenings and weekends the drive times are extended but only to a maximum of 15 minutes.			
Public transport (page 89):			All pharmacies are accessible via public transport			
PROVISION OF PHARMACEUTICAL SERVICES:						
(1) ESSENTIAL SERVICES (page 93):						

No. of pharmacies dispensing appliances:	13/21 all (1 none, 5 just dressings, 1 all but incontinence dressings, 1 all but stomas, 1 all but incontinence appliances and stomas)
(2) ADVANCED SERVICES (page 94):	
No. offering Medicines Use Review Service:	21/21
No. offering New Medicine Service:	20/21
No. offering Appliance Use Review Service:	One (However there is likely to be wider use of centralised contractors for this service)
No. offering Stoma Appliance Customisation:	Two (However there is likely to be wider use of centralised contractors for this service)
(3) ENHANCED SERVICES (page 95-96):	
NHS England currently commissions an Out of Hours Enhanced Services to pharmacies in Torbay.	
POTENTIAL FUTURE NEEDS FOR PHARMACEUTICAL SERVICES (page 103):	
<ul style="list-style-type: none"> • Ageing and growing population (page 30). • South Devon link road set for completion in 2015 (page 103). • Edginswell rail station set for completion in 2017/2018 (page 103). • Anticipated medium scale residential development in Shiphay (SDT3 Torquay Gateway – below) in the next 15 years which may require additional pharmacy provision (page 103) [accurate at 29/10/14]. 	
SUMMARY OF LOCALITY-BASED OBSERVATIONS:	
<p>ACCESS: The overall hours of opening, geographical spread of pharmacies, drive time analysis and significant number of pharmacies per head of population indicate that there is good access to pharmaceutical services within this locality.</p> <p>BREADTH OF PROVISION: There is currently limited provision of Appliance Use Review and Stoma</p>	

Appliance Customisation Services at pharmacies within the locality. NHS England currently commissions an Out of Hours Enhanced Services to pharmacies in Torbay; this service is generally required to ensure patients have good access to pharmaceutical services over the Christmas/New Year and Easter periods.

POTENTIAL FUTURE NEEDS: There is an anticipated medium scale residential development in Shiphay (SDT3) in the next 15 years alongside plans for a railway station at Edginswell due for completion in 2017/18 which may require additional pharmacy provision [accurate at 29/10/14]. The South Devon link road is set for completion in 2015 which it is anticipated will bring in an additional 3,500 jobs in Torbay. The effect of this on need for pharmaceutical services is unknown.

2. INTRODUCTION & CONTEXT

What is a Pharmaceutical Needs Assessment and why is it important?

- 2.1 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.
- 2.2 Any person (pharmacist, dispenser of appliances or a GP (normally in rural areas)) who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a pharmaceutical list. This process is known as the NHS market entry system and is overseen locally by the NHS England Area Team for Devon, Cornwall and Isles of Scilly.
- 2.3 The Area Team is responsible for commissioning pharmacies, GP services, dental services, and some aspects of optical services, as well as military and prison health. The PNA is used primarily to:
 - make decisions regarding which NHS funded services need to be provided by local community pharmacies and other providers
 - make decisions as to whether new pharmacies or services are needed
 - inform decision-making about the relocation of existing premises in response to applications by businesses, including independent owners and large pharmacy companies
 - inform the commissioning of locally enhanced services from pharmacies
- 2.4 Providers of pharmaceutical services will 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 local PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance selling (internet or mail order only) basis. Decisions regarding provider applications are made by the Area Team and can be open to legal challenge if not handled properly. Consequently, it is important to have an up-to-date and locally relevant PNA.

Legislative background

- 2.5 The Health Act 2009 required NHS Primary Care Trusts (PCTs) to publish their first PNA by 1 February 2011. However, the Health and Social Care Act 2012 abolished PCTs and gave local authorities responsibility for local population health improvement. Health and Wellbeing Boards (HWBs) were established to bring together local commissioners of health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improving local health and wellbeing.

- 2.6 The Health and Social Care Act 2012² transferred the responsibility to develop and update PNAs from PCTs to HWBs from 1 April 2013. This means that Torbay's HWB have a legal duty to ensure the production of a PNA for Torbay. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013. HWBs must ensure that the NHS Commissioning Board and the Area Teams have access to their PNAs.
- 2.7 HWBs are required to publish their first PNA by 1 April 2015. The Board must 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.

Wider context

- 2.8 The Health and Social Care Act 2012 also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs to produce Joint Strategic Needs Assessments (JSNAs). The aim of JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages.³ They are a continuous process of strategic assessment of the health and wellbeing needs of the local population. The JSNA is used to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs, to improve health outcomes and address health inequalities. In light of this, the PNA should help inform and be informed by local JSNAs, as well as other plans for health and social care and locally relevant strategies. Current guidance outlines that whilst PNAs are a separate statutory requirement and cannot be subsumed as part of these documents, they can be annexed to them.
- 2.9 In addition to undertaking PNAs and JSNAs though the HWB, local authorities are responsible for commissioning certain public health services from community pharmacies. Community pharmacy provides insight into the public's and patients' needs and behaviours around a wider group of services and will help to contribute to the production of the JSNA. It is also an important investor in local communities, for example through employment and supporting neighbourhoods and high street economies. The HWB and the local authority have a broader strategic role in supporting the development of community pharmacies with an increased role in public health and improving health and wellbeing. This is highlighted in the new *Professional Standards for Public Health Practice for Pharmacy* published by the Royal Pharmaceutical Society in March 2014. These standards provide a framework to support pharmacists and their teams in England and Wales to improve public health services, and shape future services and pharmacy roles to deliver quality patient care and improve health outcomes. A discussion of the future of pharmacy provision is provided in Section 11.

Minimum information that must be included in the PNA

- 2.10 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013⁴ set out the legislative basis for producing and updating PNAs. This includes a

² <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

³ www.southdevonandtorbay.info

⁴ <http://www.legislation.gov.uk/uksi/2013/349/contents/made>

list of minimum information that must be included in the PNA under *Schedule 1* of the Regulations (Table 1) and requirements for appropriate consultation.

Table 1: SCHEDULE 1 – Information to be contained in PNAs

<p>Necessary services: current provision</p>	<p>1 A statement of the pharmaceutical services that the HWB has identified as services that are provided:</p> <ul style="list-style-type: none"> (a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area (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)
<p>Necessary services: gaps in provision</p>	<p>2 A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied:</p> <ul style="list-style-type: none"> (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
<p>Other relevant services: current provision</p>	<p>3 A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided:</p> <ul style="list-style-type: none"> (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
<p>Improvements and better access: gaps in provision</p>	<p>4 A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied:</p> <ul style="list-style-type: none"> (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
<p>Other NHS services</p>	<p>5 A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect:</p> <ul style="list-style-type: none"> (a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area (b) or whether further provision of pharmaceutical services in its area

	would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area
How the assessment was carried out	6 An explanation of how the assessment has been carried out, and in particular: (a) how it has determined what are the localities in its area; (b) how it has taken into account (where applicable): (i) the different needs of different localities in its area, and (ii) the different needs of people in its area who share a protected characteristic (c) a report on the consultation that it has undertaken
Map of provision	7 A map that identifies the premises at which pharmaceutical services are provided in the area of the HWB

Source: NHS Regulations 2013

2.11 In accordance with the above Regulations, it is not within the scope of the PNA to include all providers of pharmaceutical services but to focus on providers included in the pharmaceutical list and dispensing doctors who are listed separately. Pharmaceutical services provided by acute or community hospitals, or their subcontracting arrangements, such as Homecare Medicines Providers, are therefore excluded from this PNA. The 'inclusion and exclusion criteria' for mapping providers of pharmaceutical services are summarised below:

Providers of pharmaceutical services included in the PNA:

- Community pharmacies
- Distance selling pharmacies
- Dispensing doctors (dispensing GP practices)
- Dispensing appliance contractors

Providers of pharmaceutical services excluded from the PNA:

- Acute hospital pharmacy provision
- Outpatient pharmacy units
- Community hospital pharmacy provision
- Homecare Medicines Providers

Torbay's PNA 2015-2018

2.12 In accordance with the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, this PNA was undertaken locally in order to:

- identify the healthcare needs of the population of Torbay that can be met by the provision of pharmaceutical services
- map existing pharmaceutical service provision and identify future opportunities
- draw meaningful conclusions to help inform a rational approach to commissioning future high quality equitable pharmaceutical services by prioritising investment according to identified needs and service requirements

- inform rational decision-making on contract applications to provide pharmaceutical services
- 2.13 Decisions regarding the capacity and adequacy of current pharmaceutical services provision, with reference to provider applications, will be made by the NHS England Area Team for Devon, Cornwall and Isles of Scilly following review of this PNA and detailed evaluation based on NHS England determined criteria.

3. PROCESS FOLLOWED

Introduction

- 3.1 This section outlines the process followed for the production of the PNA. This was largely dictated by current legislation regarding what should be included in a PNA (Table 1). The Department of Health has developed an *Information Pack for Local Authority Health and Wellbeing Boards*⁵ to guide the PNA process. This has no statutory standing, nor does it constitute non-statutory guidance, but was used to support Torbay Council to interpret and implement their duty with regard to this PNA.

Establishment of Peninsula PNA Steering Group

- 3.2 The Peninsula PNA Steering Group was established to agree a consistent approach to producing the PNA in accordance with current legislation but with locally relevant format. Group membership consisted of:
- Dave Bearman, Chair, Devon, Cornwall and Isles of Scilly Pharmacy Local Professional Network
 - Sue Taylor, Chief Officer, Devon Local Pharmaceutical Committee
 - James Glanville, Assistant Contract Manager, Devon, Cornwall and Isles of Scilly Area Team, NHS England
 - Janet Newport, Contracts Manager, Devon, Cornwall and Isles of Scilly Area Team, NHS England
 - Karen Acott, Executive Partner, Wallingbrook Health Group (dispensing practice representative)
 - Robert Nelder, Consultant in Public Health Intelligence, Plymouth City Council
 - Sarah Ogilvie, Specialty Registrar in Public Health, Plymouth City Council
 - Ian Tyson, Health Improvement and Quality Manager, Public Health, Torbay Council
 - Steven Brown, Assistant Director of Public Health, Devon County Council
 - Ian Tearle, Principal Public Health Specialist, Devon County Council
 - Kirsty Priestley, Senior Public Health Information Analyst, Devon County Council
 - Stuart Bourne, Deputy Director of Public Health, Cornwall Council and the Council of the Isles of Scilly
 - Phillip Yelling, Chief Officer, Cornwall and Isles of Scilly Local Pharmaceutical Committee

⁵ <https://www.gov.uk/government/organisations/department-of-health>

- 3.3 The Steering Group was established in March 2014 and set a deadline of October 2014 for completion of the final draft prior to consultation. The group met at regular intervals throughout PNA development. Each stage was discussed and agreed by all Members of the Steering Group. A project plan and Gantt chart were drawn up to guide the process and establish individuals' roles and contributions. Torbay's HWB was kept informed of the process followed and the report's progress through briefings.

Agreeing geographies

- 3.4 Each local authority divided their geographical area into distinct geographies (e.g. localities, market towns or Clinical Commissioning Group (CCG) localities) for the purposes of identifying local health needs and assessing service provision. Consequently there will be some variation when examining and comparing PNAs across the Peninsula.

Assessing local need

- 3.5 A template for assessing need was discussed and agreed by the Steering Group in conjunction with local Public Health Intelligence Teams. This template was then amended by each local authority according to whether or not data were available in their specific area. The focus of this activity was on identifying local health needs that could be met by current pharmaceutical services provision. The assessment also took account of current JSNAs⁶ and health and wellbeing strategies to ensure that the health needs of the local population were fully acknowledged.
- 3.6 A Public Health Intelligence Analyst from the Public Health Team produced the local needs section of the PNA for Torbay (Section 4). Public Health England's General Health and Child Health Profiles for Torbay were included to provide an overview of needs. Locally available datasets were then examined to provide a more detailed picture of needs on a locality basis. Data are included to allow comparison between localities, as well as patterns across Torbay, and are ranked and summarised in a table where applicable. Where local data were not available, national level data were included at the Torbay or South Devon and Torbay Clinical Commissioning Group (CCG) level.

Mapping current provision

- 3.7 For previous PNAs, information regarding local provision of pharmaceutical services has been collected via individual, paper-based pharmacy questionnaires for Plymouth, Torbay, Devon, and Cornwall and the Isles of Scilly. In order to increase efficiency, it was agreed by the Steering Group to administer future PNA questionnaires via PharmOutcomes. PharmOutcomes is an online tool which has been commissioned across Devon to capture pharmacy-based activity and provide a consistent mechanism to collect, process, and pay pharmacies for public health services. It was possible to design and add a PNA data capture form to this tool so that it could be rolled out across the Peninsula at the same time. This process was overseen by Kevin Noble from PharmOutcomes and Ian Tyson (Public Health, Torbay Council) on behalf of the Steering Group.

⁶ www.southdevonandtorbay.info

- 3.8 The online data capture form was based on a previous PNA questionnaire for Plymouth and developed through discussions with the Steering Group and PharmOutcomes' pharmacists (Appendix 1). A covering email from the Chairman of the Pharmacy Local Professional Network and the Chief Officers for Devon and Cornwall Local Pharmaceutical Committees (Appendix 2) was sent automatically to pharmacies via PharmOutcomes with a link to the data capture form. Pharmacists were advised to review the questionnaire prior to completion and have all information to hand so that they could complete the questionnaire in one session as there was no save and return facility.
- 3.9 Pharmacies were notified via email and PharmOutcomes messenger on 25 June 2014 that they had three weeks to complete the questionnaire (25 June to 11 July 2014). A reminder email was sent out on 7 July 2014 to thank those who had completed the questionnaire and follow-up non-responders. The questionnaire was promoted via Local Pharmaceutical Committees (LPCs). Following the initial three week deadline for completion, any outstanding pharmacies were followed-up directly by the relevant LPC. The questionnaire was deactivated on PharmOutcomes on 18 July 2014. Data regarding GP dispensing practices was collected separately where applicable by local authorities, via NHS England.
- 3.10 Following deactivation of the survey, the Public Health Team in Torbay accessed PharmOutcomes for Torbay on 21 July 2014 and downloaded the data into an excel file. The dataset was then screened for completeness and accuracy and analysed. The responses to each question were initially grouped for Torbay as a whole to identify the overall findings. In cases where it appeared there could be notable geographic variation, a more detailed analysis was conducted looking at where these variations occurred. This was done by either breaking down the data into locality area or by displaying questionnaire responses on a map.

PharmOutcomes – key learning points

- 3.11 At this is the first time that PharmOutcomes has been used to capture pharmacy data for the PNA, it is important to record learning points for future assessments. These have been bulleted below:
- Regular consultation with the LPC, NHS England and Public Health resulted in limited complications or alterations to the questionnaire once the draft question set was produced.
 - Different commissioning mechanisms for PharmOutcomes resulted in some confusion regarding the activation of the questionnaire. Clarity should be provided at the outset regarding which commissioner manages which local authority area (Devon, Plymouth and Torbay are managed through each local authority's PharmOutcomes Service; Cornwall is managed via NHS England's PharmOutcomes service).
 - Fields where times are recorded should default to a time format so data are consistently recorded at all times for easier data management and manipulation.

- Questions regarding NHS mail and accessible file formats resulted in incoherent responses; therefore further clarity of question construction is required.
- Responses regarding languages spoken in the community did not elicit coherent responses so further clarity of questioning is also required.
- Consideration needs to be given to changing the structure of the questionnaire (built as an assessment rather than a service) to allow for additional functionality so PharmOutcomes can identify if there is missing data and to flag this to the user or allow for a 'save and return' function to be included.
- Since April 2013 a number of commissioners have had a role in commissioning services from community pharmacies and there are some grey areas which may result in local variation regarding which commissioner takes the lead in commissioning a particular service. These changes were reflected in pharmacies responses to questions regarding current provision of locally commissioned services. For example, a number of pharmacies responded that they were providing NHS commissioned services but these are now privately provided or no longer commissioned within Torbay. In order to address any confusion in the future, the PharmOutcomes questionnaire should be modified to reflect current commissioning arrangements within that locality and questions grouped by commissioner/provider. 'Sense checking' of PharmOutcomes data is essential prior to running the analysis.
- Mapping is based on pharmacy responses to the questionnaire; consequently there may be differences in responses depending on who completed the questionnaire on behalf of the pharmacy. This has been reflected in accuracies regarding current commissioning arrangements.

Determining gaps and assessing adequacy of current service provision

- 3.12 As part of the service mapping, national comparator data or indicators have been used (where available) to show how current service provision in Torbay compares to elsewhere in the country. In order to help identify gaps and make assessments regarding the adequacy of current provision, individual locality summary sheets have been included at the front of the PNA. They provide an overview of the findings of the needs assessment for each of Torbay's two localities (see 1.9). Each sheet summarises the demographic information, the health needs information and the service information. They also attempt to capture any additional local insight regarding factors affecting need, provision or future provision that may have been missed through conventional service mapping. The summary sheets are likely to be of greatest use to the NHS England Area Team when reviewing provider applications.

Identifying future needs

- 3.13 In order to identify any future needs with regards to pharmaceutical services provision, Members of the Steering Group liaised with planning and housing

colleagues in the relevant local authority to consider the impact of known or potential developments on the future demand for services (e.g. new housing developments). Some demographic and healthcare trend and projection data have been provided and considered in relation to the likely increase in burden on healthcare services. The Chair of the Devon, Cornwall and Isles of Scilly Pharmacy Local Professional Network and the Chief Officer of the Devon Local Pharmaceutical Committee also contributed significantly to this section in terms of outlining the future direction of pharmacy.

Consultation and PNA approval

3.14 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for consultation and PNA approval. Prior to publishing the PNA, Torbay's HWB consulted with the following persons regarding the contents of the assessment:

- Devon Local Pharmaceutical Committee
- Devon Local Medical Committee
- Persons on the pharmaceutical list and any dispensing doctors for the area (the latter was not applicable for Torbay)
- Any LPS chemist in Torbay with whom NHS England has made arrangements for the provision of local pharmaceutical services (not applicable to Devon, Plymouth and Torbay)
- Healthwatch Torbay
- South Devon Healthcare NHS Foundation Trust
- Torbay and Southern Devon Health and Care NHS Trust
- NHS England Area Team
- Devon Health and Wellbeing Board
- Torbay Health and Wellbeing Board
- Cornwall and Isles of Scilly Health and Wellbeing Board

3.15 The 60-day consultation period ran from Monday 17 November 2014 until Friday 16 January 2015. In accordance with NHS Regulations the above persons were consulted at least once during this period. Persons being consulted were either emailed directly or directed to the following website containing the draft PNA and consultation feedback form (Appendix 3): http://plymouth.consult.limehouse.co.uk/public/public_health/pna_torbay Hard copies were available upon request. The consultation summary is presented in Section 10. The revised PNA was presented to Torbay's HWB on 09 March 2015 for final approval. The approach taken complied with NHS Regulations and ensured publication by 31 March 2015.

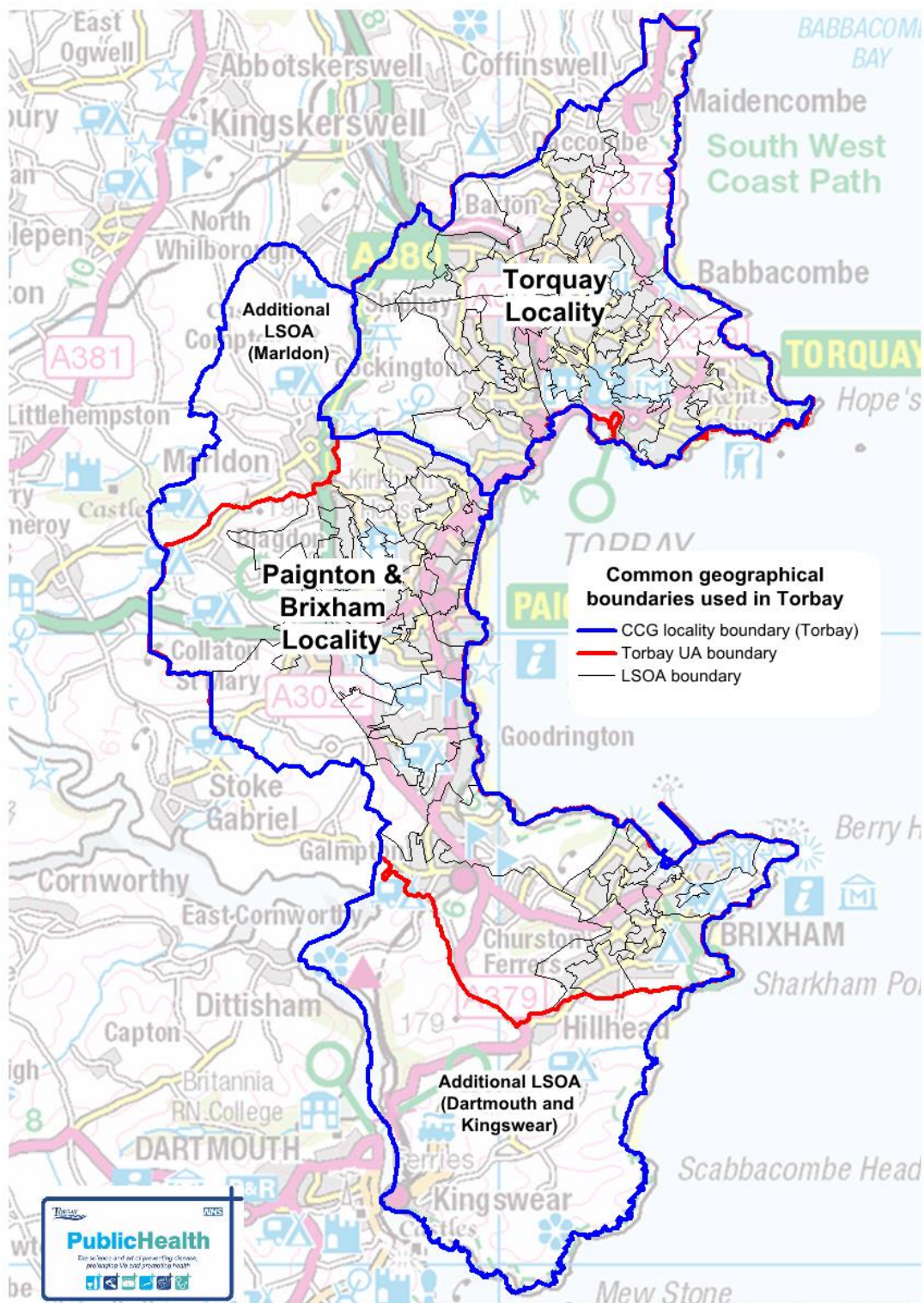
4. ASSESSING NEED: TORBAY'S LOCALITIES

This section describes the process and rationale in regards to how and why the 2 localities covering Torbay were selected for use in this PNA.

Introduction

- 4.1 In order to identify local health needs and assess current pharmaceutical services provision, Torbay was divided into South Devon & Torbay Clinical Commissioning Group (CCG) Localities. A locality is defined as a distinct population cluster in which at least 50% of inhabitants are registered with a GP practice within its boundary. Torbay is made up of two localities: Torquay and Paignton & Brixham (Figure 1). These localities are aggregations of 91 Lower Super Output Areas (LSOAs). LSOAs are explained in section 4.4.
- 4.2 Paignton & Brixham locality is slightly wider than the Torbay Unitary Authority (UA) boundary as it includes two additional LSOAs contained within the South Hams electoral wards of Marldon and Dartmouth and Kingswear (Figure 1). There are no pharmacies or GP practices located in these wards therefore there it is likely that residents may choose to use nearby services in Paignton and Brixham. Figures given for Torbay refer to the UA boundary only, thus excluding these additional LSOAs.
- 4.3 Please note when looking at count data, the sum of Paignton & Brixham and Torquay localities will not equal the Torbay UA figure due to the two additional LSOAs contained within the Paignton & Brixham locality footprint.
- 4.4 LSOAs are part of a geographical framework developed for the collection and publication of small area statistics. A key principle of LSOAs is that they are not subject to the frequent boundary changes which cause problems when using electoral wards to present statistics and are therefore more suitable for comparison over time. In addition, they are better for statistical comparison as they are of much more consistent size and have a specified minimum population to avoid the risk of data disclosure (releasing data that could be traced to individuals). There will be a need, however, to change LSOA boundaries in exceptional cases where there has been significant population change, as recorded at each Census. LSOAs typically have a population of around 1,500.

Figure 1: Torbay by LSOA and CCG locality



Source: Public Health Team, Torbay Council

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Rationale for using localities

4.5 CCG Localities are well recognised and utilised commissioning clusters within the local context and are the lowest geography level available for many local public

health indicators. The amalgamation of the towns of Paignton and Brixham also ensures a larger population for more robust statistics.

- 4.6 Needs based data at electoral ward and LSOA level can be found on the South Devon and Torbay knowledge and intelligence website⁷ using *Interactive Tools* (Profile tool). Additional locality summaries are also available in *Area Based Overviews*. Table 2 below lists the towns and electoral wards that make up the two Torbay CCG localities.

Table 2: Torbay CCG localities by town and ward

Locality	Torbay Town	Ward
Paignton & Brixham	Paignton	Blatchcombe
		Churston-with-Galmpton
		Clifton-with-Maidenway
		Goodrington-with-Roselands
		Preston
Brixham	Berryhead-with-Furzeham	
	St Mary's-with-Summercombe	
NA (South Hams)	1 LSOA of Marldon ward	
NA (South Hams)	1 LSOA of Dartmouth and Kingswear ward	
Torquay	Torquay	Cockington-with-Chelston
		Ellacombe
		Shipway-with-the-Willows
		St Marychurch
		Tormohun
		Watcombe
		Wellswood

⁷<http://www.southdevonandtorbay.info>

5. ASSESSING NEED: TORBAY'S DEMOGRAPHY

This section details the key components of Torbay's population's age, sex, ethnicity and deprivation. This data compares each locality to the Torbay average as well as national averages where available. This data is summarised in the locality summaries found on pages 11-16 (or follow the link here: **LOCALITY SUMMARY**).

The population

- 5.1 Torbay's population remains relatively unchanged from 2002 to 2012, unlike the England average which shows a 7.7% increase (Table 3). Torquay locality has shown a slight population increase whereas Paignton & Brixham has shown a minor decrease in population count.

Table 3: Mid-year population estimates for Torbay localities, 2002-2012

All Age	Paignton & Brixham	Torquay	Torbay	England
2002	69,500	64,500	130,500	49,679,300
2004	70,300	65,100	131,900	50,194,600
2006	70,100	65,200	131,900	50,965,200
2008	70,100	65,300	132,100	51,815,900
2010	69,500	65,300	131,400	52,642,500
2012	69,300	65,500	131,500	53,493,700
% change	-0.3%	1.6%	0.8%	7.7%

Source: Mid-Year population estimates, Office for National Statistics (rounded to nearest 100).

- 5.2 It is estimated that Torbay's population will increase by around 9,300 (7.0%) by 2030 (Table 4). The largest increase will be seen in the population aged 85 years and over (69.8%), whilst it is estimated there will be an 8.0% reduction in those of working age (45-64 years).

Table 4: Sub-national population projections for Torbay, 2014-2030

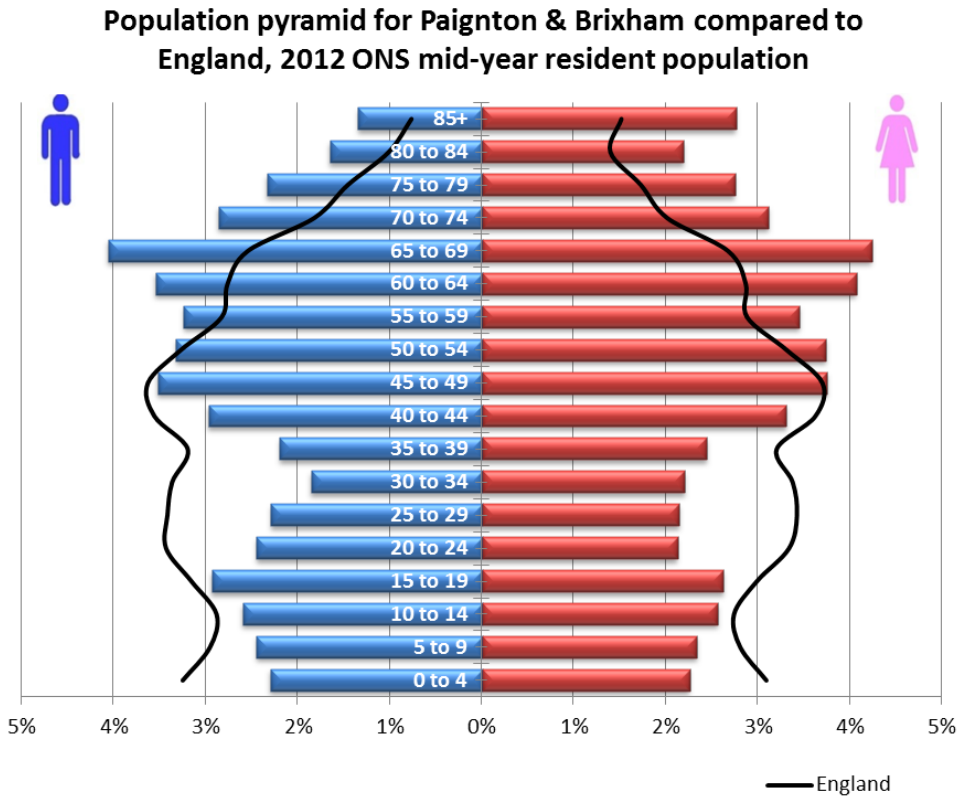
Age group	2014	2018	2022	2026	2030	% change
0 to 14	20,200	21,000	21,500	21,600	21,400	5.9%
15 to 29	21,200	20,400	19,900	19,800	20,400	-3.8%
30 to 44	20,600	19,900	20,500	21,000	21,300	3.4%
45 to 64	36,400	36,900	36,300	35,300	33,500	-8.0%
65 to 84	28,500	30,500	32,000	33,800	35,900	26.0%
85+	5,300	5,800	6,500	7,500	9,000	69.8%
All ages	132,200	134,500	136,700	139,000	141,500	7.0%

Source: Sub-national population projections, Office for National Statistics (rounded to nearest 100)

Age and sex distribution for Torbay localities

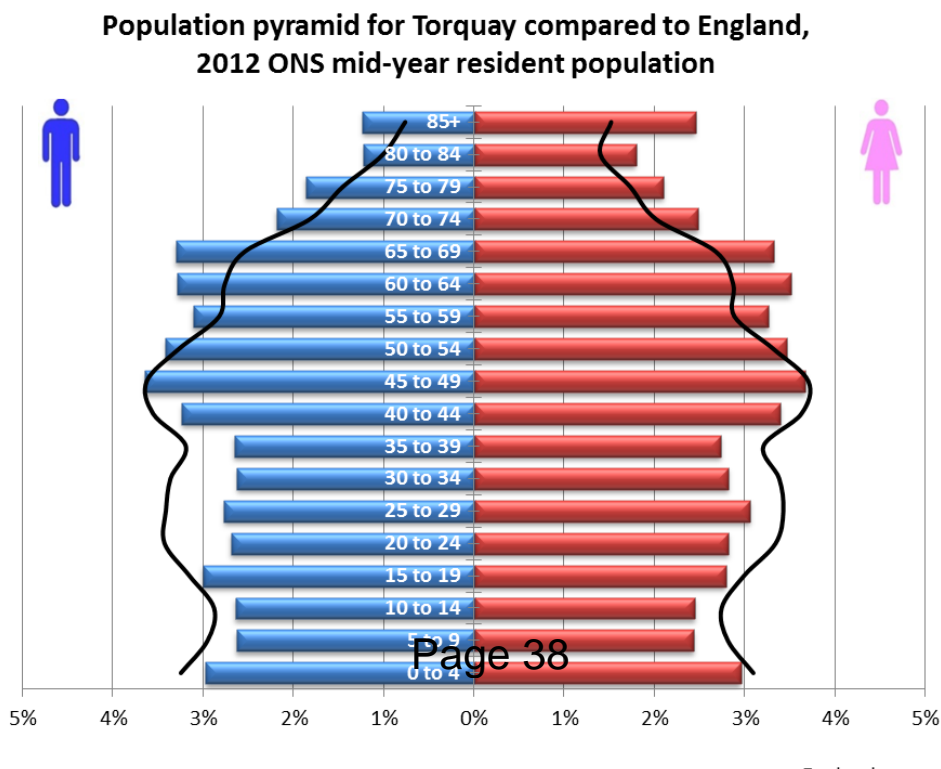
5.3 The population of Paignton & Brixham is older than the England average, with a greater proportion of the population over the age of 50 years. There are noticeable differences in the 0-4 and 20-39 age groups compared to England (Figure 2).

Figure 2: Population pyramid for Paignton & Brixham locality, 2012



5.4 The population of Torquay is more similar to the England average; however there is still a greater proportion over the age of 50 years. There are less noticeable differences in the 0-4 and 20-39 age groups compared to England (Figure 3).

Figure 3: Population pyramid for Torquay locality, 2012



‘Protected Characteristics’ (Equality Act 2010)

- 5.5 The Equality Act 2010 sets out nine personal characteristics that are protected by the law:⁸
- Age
 - Disability
 - Gender reassignment
 - Marriage and civil partnership
 - Pregnancy and maternity
 - Race
 - Religion or belief
 - Sex
 - Sexual orientation
- 5.6 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.
- 5.7 In the following paragraphs, the nine protected characteristics have been described at the Torbay level. Where available, information at the locality level can be found on Torbay’s JSNA website⁹. 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.

Age

- 5.8 Torbay currently has a population of 131,500¹⁰. Torbay has a higher proportion in all age groups from 50-90+, for both Males and Females, than the national population. Conversely Torbay has a lower proportion in all age groups from 0-44 than nationally.

Disability

- 5.9 According to the 2011 Census, 10.0% of Torbay 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). This was the second highest in the South West region¹¹. According to the 2011 Census, 41.7% of Torbay residents reported their general health as ‘very good’

⁸ <http://www.equalityhumanrights.com/private-and-public-sector-guidance/guidance-all/protected-characteristics>

⁹ <http://www.southdevonandtorbay.info/>

¹⁰ <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-319259>

¹¹ <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-332941>

placing Torbay lower down the Local Authority rankings, however Torbay does rank very high for those rating their health as only 'Fair'. Both Bad health (5.8%) and Very bad health (1.7%) have higher percentages in Torbay than in England (England 4.2%, 1.2% respectively), this equates to 9,892 people over both categories.

Faith, religion or belief

- 5.10 According to the 2011 Census, Christianity is the most common religion in Torbay with 63.3%. 27.5% of the Torbay population stated they had no religion. Both are higher than the national average. Numbers for each of the other main categories are below 750 persons (0.5%) each and range from 0.03% Sikh to 0.5% Other Religion. Of the 0.5% of the population who reported Other Religion; 177 people reported they were Pagan and 246 people were Spiritualist.

Gender - including marriage, pregnancy and maternity

- 5.11 Overall 50.3% of Torbay's population are female (ONS mid-2013 estimates). According to the 2011 Census, of those aged 16 and over, 46.6% are married – the same as the national average. There were 1,462 live births in 2012 with numbers increasing steadily and peaking in 2011 at 1,499. Going forward, local estimates suggest the number of births per year for the coming 5 years to be in the order of 1,400 per year.

Gender reassignment

- 5.12 In 2010 it was estimated nationally that the number of gender variant people presenting for treatment was around 12,500. Of these, around 7,500 have undergone transition. The median age for treatment for gender variation is 42 years. There is no precise number of the trans population in Torbay.

Race

- 5.13 There is relatively little ethnic diversity in Torbay. According to the 2011 Census 94.8% of Torbay's population considered themselves White British. This is significantly higher than the England average (79.8%). Torbay has 3,260 (2.5%) resident ethnic minority population (excluding white ethnic groups). Of these, 1,420 residents (1.1%) are **Mixed/Multiple** ethnic background, 1,353 (1%) **Asian/Asian British**, 251 (0.2%) **Black British** and 236 (0.2%) **Other ethnic Group**.

Sexual Orientation - including Civil Partnership

- 5.14 0.3% of the Torbay population are registered in a same-sex civil partnership (national average is 0.2%). 2.6% of people in Torbay are separated and still either legally married or legally in a same-sex civil partnership. There is also no precise local data on numbers of Lesbian, Gay and Bi-sexual (LGB) people in Torbay but it is nationally estimated at 5.0% to 7.0%. This would mean that approximately 5,464 – 7,650 people aged 16 years and over in Torbay are LGB.

Ethnicity

- 5.15 According to the 2011 census, the largest ethnic group in Torbay was “White” which made up 97.5% of the population (Table 5). “White British” accounted for 94.8% of this population, which is 15 percentage points higher than England’s average (79.8%). Torbay’s black minority ethnic (BME) population percentage is smaller than England’s average but has increased since the last census. The largest ethnic minority in Torbay is “Other White” (2.2%) which excludes White British or White Irish residents.

Table 5: Ethnic group for Torbay localities, 2011

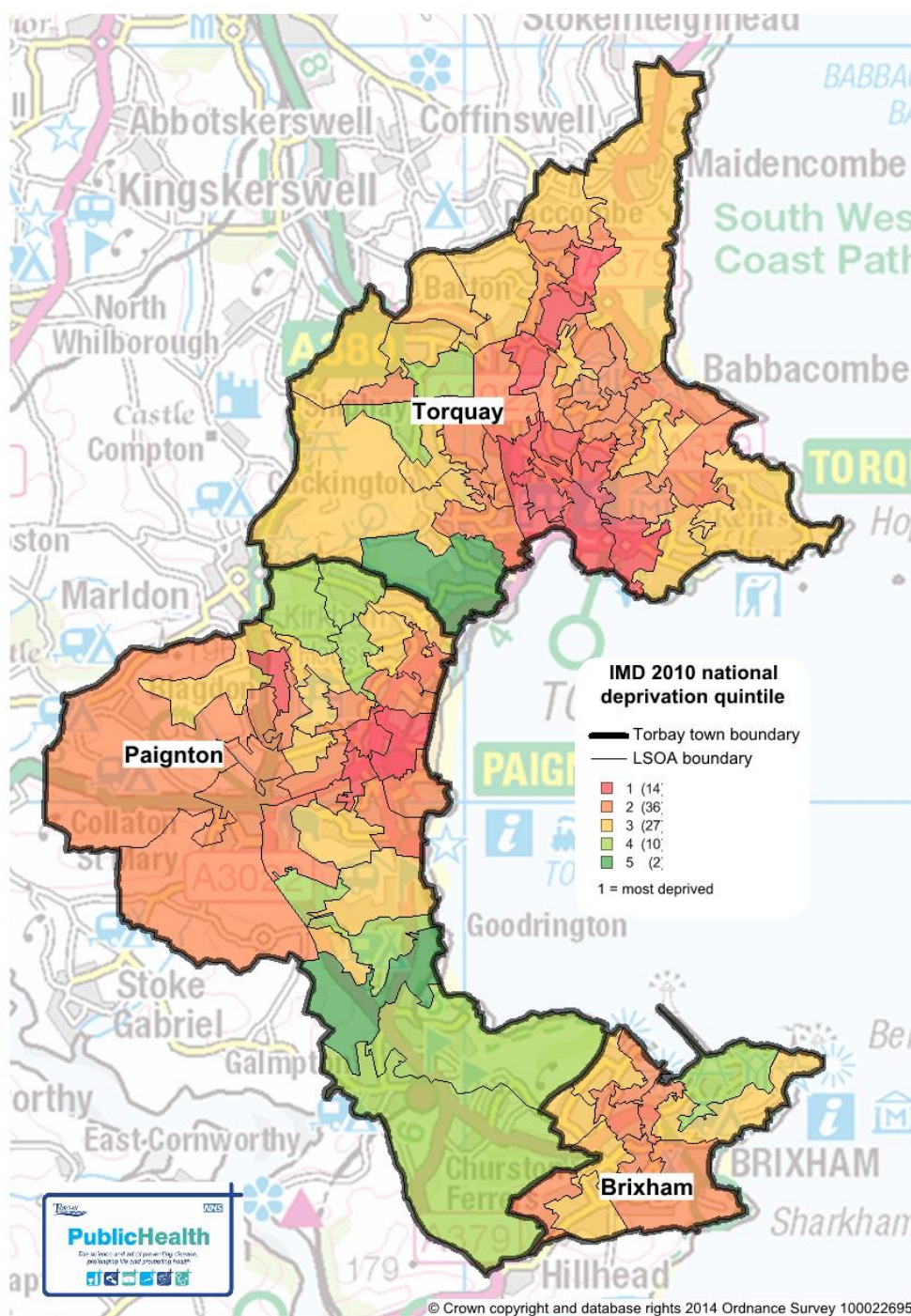
	White	Mixed/ multiple ethnic groups	Asian/Asian British	Black/Africa n/ Caribbean/ Black British	Other ethnic group
Paignton & Brixham	98.3%	0.9%	0.6%	0.1%	0.1%
Torquay	96.8%	1.3%	1.4%	0.2%	0.2%
Torbay	97.5%	1.1%	1.0%	0.2%	0.2%
England	85.4%	2.3%	7.8%	3.5%	1.0%

Source: LC2109EWIs – 2011. Census table, Office for National Statistics

Material deprivation

- 5.16 Deprivation measures attempt to identify communities where the need for healthcare is greater and material resources are fewer and as such the capacity to cope with the consequences of ill-health are less. People are considered “deprived” if there is inadequate education, inadequate 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.
- 5.17 Figure 4 shows the index of multiple deprivation (IMD) 2010 national deprivation quintiles for the 89 LSOAs in Torbay. Areas in red indicate LSOAs that are ranked amongst the 20% most deprived in England. These more deprived areas tend to congregate around the town centers of Torquay and Paignton. Torquay has a higher weighted deprivation score (29.5) compared to Paignton & Brixham locality (23.6) thus Torquay can be considered as the more deprived locality.

Figure 4: Index of Multiple Deprivation (IMD) by LSOA and Torbay UA, 2010



Source: English Index of Multiple Deprivation 2010, Department for Communities and Local Government

Car ownership (relevance to accessing pharmaceutical services)

5.18 Based on the 2011 Census, car ownership in Torbay is above the national average at 81.8% (Table 6). Car ownership is lower in Torquay (79.9%) compared to Paignton & Brixham locality (84.1%).

Table 6: Car or van availability by Torbay locality, 2011

	No cars or vans in household	1 car or van in household	2 cars or vans in household	1 or more cars or vans in household
Paignton & Brixham	15.9%	41.7%	42.4%	84.1%
Torquay	20.1%	42.0%	37.9%	79.9%
Torbay	18.2%	42.1%	39.7%	81.8%
England	19.5%	39.0%	41.4%	80.5%

Source: LC4109EW. Census 2011, Office for National Statistics

Mosaic breakdown alternative

- 5.19 As Torbay Council does not subscribe to an Experian Mosaic license or any other consumer classification system; the *South Devon and Torbay Interactive Profile Tool*¹² has been used as an alternative. This local tool uses a similar format to national health profiles (such as the Local Health Profile displayed in Figure 5) which compares local authority health and demographic indicators against the England average.
- 5.20 The *South Devon and Torbay Interactive Profile Tool* compares CCG locality health and demographic indicators against the South Devon and Torbay CCG average. The Torbay and England average are also included in the tool for context. Significance spine charts are provided across the life-course in the following format:
- Population Overview (all ages)
 - Starting Well (Under 5 years)
 - Developing Well (5-24 years)
 - Living and Working Well (16-64 years)
 - Ageing and Dying Well (65 year and over)

Health and demographic indicators that are found to be significantly (based on 95% confidence intervals that do not overlap) different to the South Devon and Torbay CCG average have been included in Table 7. Indicators that are not significantly different to the average are not reported. This information provides a summary of the communities of Torquay and Paignton & Brixham.

- 5.21 Where there is a clear negative or positive association with health, indicators use the familiar Red, Amber, Green (RAG) rating to show where localities are significantly 'better' or 'worse' than the South Devon and Torbay average. Where the polarity of association is not so clear; different shades of purple have been used to show where localities are significantly lower or higher than the South Devon and Torbay average. The significance colour key is shown below (Table 7).

¹² <http://www.southdevonandtorbay.info> – includes data at locality, electoral ward and LSOA level

Table 7: Health and demographic summary from the South Devon and Torbay JSNA Interactive Profile tool, 2014

Colour key for statically significance of health and demographic indicators					
Colour code	Better	Worse	Higher	Lower	
Stage in life-course	Health or demographic indicator			Paignton & Brixham	Torquay
Population Overview	BME descent				
	Multiple deprivation				
	Living in private rented accommodation				
	Living in social rented accommodation				
	Indoor and outdoor living environment deprivation				
	Fuel poverty				
	Violent crime, including sexual violence				
	Domestic abuse (18 and over)				
	Long-term health problem or disability				
	Self-reported bad/very bad general health status				
	Person life expectancy at birth				
	Female life expectancy at birth				
	Ambulance activity – see and convey to urgent care				
	Non-elective emergency admissions				
	All-cause mortality				
Starting Well	Resident and registered population less than 5 years				
	General fertility rate				
	Lone parents with dependent children				
	Children in poverty under 16 years				
	Domestic abuse with children present				
	Breastfeeding initiation and prevalence at 6-8 weeks				
	Smoking status at delivery				
Developing Well	Resident and registered population aged 5-24 years				
	Children with special educational needs (SEN)				
	Pupils eligible for free school meals (FSM)				

	Pupil absence		
	Young people not in education, employment or training (NEET)		
	First time entrants to youth justice system		
	Excess weight in children aged 4-5 years		
	Admissions for intentional self-harm aged 10-24 years		
Living and Working Well	Resident and registered population aged 16-64 years		
	Divorced or separated aged 24-64 years		
	No car or van ownership		
	No recognised qualification(s)		
	Claiming job seekers allowance (JSA)		
	Claiming support/benefits for a mental health condition (% per resident population aged 16-64 years)		
	Claiming support/benefits for a mental health condition (% per Employment Support Allowance and Incapacity Benefit claimants)		
	Hypertension on disease register (all ages)*		
	Diabetes on disease register (17 and over)*		
	Coronary heart disease (CHD) on disease register (all ages)*		
	Asthma on disease register (all ages)*		
	Chronic obstructive pulmonary disorder (COPD) on disease register (all ages)*		
	Smoking on disease register*		
	Obesity on disease register (16 and over)*		
	Chronic kidney disease on disease register (all ages)*		
	Mental health on disease register (all ages)*		
	Depression on disease register (18 and over)*		
	Cancer on disease register (all ages)*		
Premature all-cause mortality			
Ageing and Dying Well	Resident and registered population aged 65 and over		
	Resident and registered population aged 85 and over		
	Pension credit household aged 60 and over		
	Pension credit household claiming guarantee element only aged 60 and over		
	Living alone aged 65 and over		
	Stroke or Transient Ischaemic Attacks (TIA) on disease register (all ages)*		

*Indicators are based on diagnosed prevalence data (Quality Outcomes Framework - QOF); however as with many public health indicators this should be considered as the 'tip of the ice berg' as many conditions will remain undiagnosed. As QOF prevalence is voluntary data recording and is only a representation of those with a condition known to their GP; it is best considered as an underestimate of true prevalence. Please bear the in mind when interpreting data.

6. ASSESSING NEED: AN OVERVIEW OF TORBAY

This section details the overall health profile for Torbay. This data includes both positive and negative areas of the population's health. This data is summarised in the locality summaries found on pages 11-16 (or follow the link here: **LOCALITY SUMMARY**).

Introduction

- 6.1 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. Torbay's Health Profile for 2014 is included overleaf (Figure 5) followed by the Child Health Profile also produced by PHE (Figure 6). A brief overview of selected indicators is provided below.

Public Health England's Health Profile for Torbay 2014

- 6.2 Indicators where Torbay's value is better than the England average:

- Deprivation
- Statutory homelessness
- Incidence of TB

- 6.3 Indicators where Torbay's value is worse than the England average:

- Children in poverty (under 16s)
- Violent crime (violence offences)
- Long term unemployment
- Smoking status at time of delivery
- Breastfeeding initiation
- Obese children (year 6)
- Alcohol specific hospital stays (under 18)
- Under 18 conceptions
- Incidence of malignant melanoma
- Hospital stays for self-harm
- Hospital stays for alcohol related harm
- Drug misuse
- Recorded diabetes
- Acute sexually transmitted infections
- Life expectancy at birth (females)

6.4 Indicators where Torbay's value is not significantly different to the England average:

- GSCE achieved (5 A*-C incl. English and Maths)
- Smoking prevalence
- Percentage of physically active adults
- Obese adults
- Excess weight in adults
- Hip fractures in people aged 65 years and over
- Excess winter deaths (three years)
- Life expectancy at birth (male)
- Infant mortality
- Smoking related deaths
- Under 75 mortality rate: cardiovascular disease
- Under 75 mortality rate: cancer

The Child Health Profile for Torbay 2014

6.5 Various indicators where Torbay's value is better than the England average:

- MMR vaccination for one dose (2 years)
- Dtap / IPV / Hib vaccination (2 years)
- Children in care immunisations
- 16-18 year olds not in education, employment or training
- Family homelessness

6.6 Various indicators where Torbay's value is worse than the England average:

- Acute sexually transmitted infections (including chlamydia)
- First time entrants to the youth justice system
- Children in poverty (under 16 years)
- Children in care
- Obese children (4-5 years)
- Obese children (10-11 years)
- Children with one or more decayed, missing or filled teeth
- Under 18 conceptions
- Teenage mothers
- Hospital admissions due to alcohol specific conditions
- Smoking status at time of delivery
- Breastfeeding initiation
- Breastfeeding prevalence at 6-8 weeks after birth
- A&E attendances (0-4 years)
- Hospital admissions caused by injuries in young people (15-24 years)
- Hospital admissions as a result of self-harm (10-24 years)

6.7 Various indicators where Torbay's value is not significantly different to the England average:

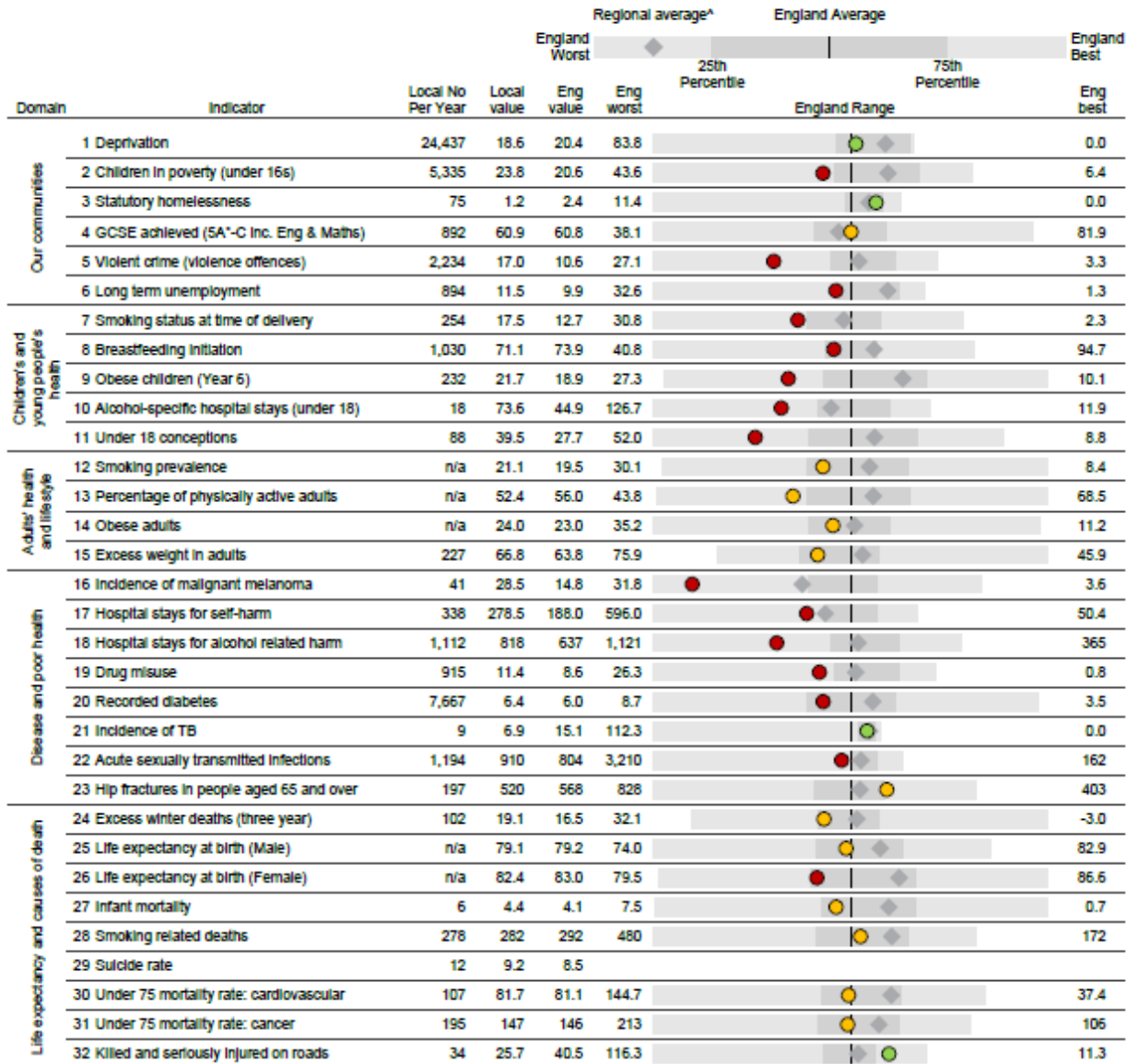
- Infant mortality
- Child mortality rate (1-17 years)
- GCSEs achieved (5 A*-C incl. English and maths)
- GCSEs achieved (5 A*-C incl. English and maths) for children in care
- Children killed or seriously injured in road traffic accidents
- Low birthweight of all babies
- Hospital admissions due to substance misuse (15-24 years)
- Hospital admissions for asthma (under 19 years)
- Hospital admissions for mental health conditions

Figure 5: Health profile for Torbay 2014

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Health Summary for Torbay

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.



Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^a "Regional" refers to the former government regions.

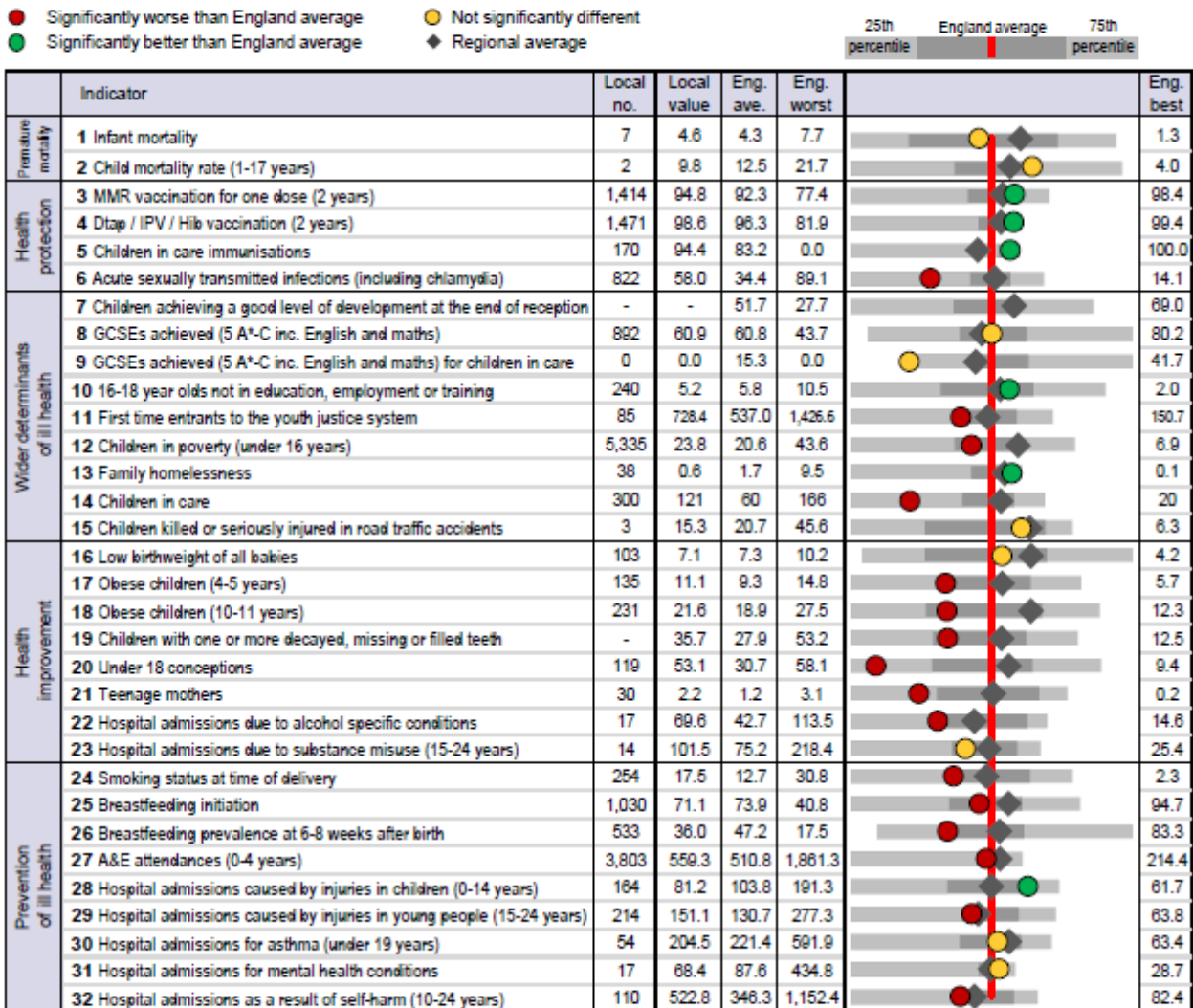
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Figure 6: Child health profile for Torbay 2014

Torbay Child Health Profile **March 2014**

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 which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.



Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

- | | | |
|--|--|---|
| <p>1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012</p> <p>2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012</p> <p>3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13</p> <p>4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13</p> <p>5 % children in care with up-to-date immunisations, 2013</p> <p>6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012</p> <p>7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13</p> <p>8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13</p> <p>9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)</p> <p>10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012</p> <p>11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012</p> | <p>12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011</p> <p>13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13</p> <p>14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013</p> <p>15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012</p> <p>16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012</p> <p>17 % school children in Reception year classified as obese, 2012/13</p> <p>18 % school children in Year 6 classified as obese, 2012/13</p> <p>19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12</p> <p>20 Under 18 conception rate per 1,000 females age 15-17 years, 2011</p> <p>21 % of delivery episodes where the mother is aged less than 18 years, 2012/13</p> | <p>22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13</p> <p>23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13</p> <p>24 % of mothers smoking at time of delivery, 2012/13</p> <p>25 % of mothers initiating breastfeeding, 2012/13</p> <p>26 % of mothers breastfeeding at 6-8 weeks, 2012/13</p> <p>27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12</p> <p>28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13</p> <p>29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13</p> <p>30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13</p> <p>31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13</p> <p>32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13</p> |
|--|--|---|

7. ASSESSING NEED: LOCALITY-BASED HEALTH PROFILE (CRADLE TO GRAVE)

This section details the 2 locality health profiles for Torbay. This data profiles each locality in terms of a 'cradle to grave' approach across the life course, compared to the Torbay and England average. This data is summarised in the locality summaries found on pages 11-16 (or follow the link here: **LOCALITY SUMMARY**).

Introduction

- 7.1 This section provides more detailed examination of the different health needs of the population on a locality basis where possible. Where locality data is unavailable, data is given for Torbay UA. This section is particularly relevant when considering whether or not current pharmaceutical provision meets the needs of its local population.
- 7.2 An overview of the health indicators described and their values is provided in Table 8 below to help inform assessment of need on a locality-by-locality basis and give national context. This is followed by Table 9 which gives each locality, Torbay and England's rank (1 = 'worst' performing, 4 = the 'best' performing) against each indicator to allow for easy comparison of health needs. Where locality data is not available, Torbay UA has been ranked against England (1 = 'worst' performing, 2 = 'best' performing).
- 7.3 This crude comparison highlights that Torquay locality has the greatest health needs overall and compared to England, Torquay and Paignton & Brixham collectively have more challenging health needs.

Table 8: Summary of indicators and localities (values) – latest time period or pooled average where applicable

Indicator	Paignton & Brixham	Torquay	Torbay	England
Births (count)	686	804	1,474	694,241*
Low birth weight births	8.2%	8.2%	8.1%	7.4%*
Male life expectancy (years)	80.0	78.5	79.1	79.2
Female life expectancy (years)	82.8	82.0	82.4	83.0
Breastfeeding at 6-8 weeks	36.9%	34.7%	36.0%	47.2%
Troubled families (rate per 10,000)	-	-	235	178
Children in care (rate per 10,000)	-	-	121	60
Dental health (prevalence)	-	-	35.7%	27.9%
Childhood obesity (reception)	7.4%	11.1%	8.9%	9.4%

Childhood obesity (year 6)	19.3%	28.0%	17.6%	19.1%
SRGH – Bad or very bad health	7.8%	7.2%	7.6%	5.5%
Long-term health problem or disability (limited activities)	23.9%	21.9%	23.0%	17.2%
Elective admissions (rate per 10,000)	1,712	1,896	1,765	-
Emergency admissions (rate per 10,000)	950	1,095	1,016	-
Circulatory disease mortality (rate per 10,000)	26.9	29.8	28.4	28.8*
Circulatory disease mortality (under 75's) (rate per 10,000)	7.1	9.1	8.1	5.0*
Respiratory disease mortality (rate per 10,000)	12.7	13.9	13.3	-
Respiratory disease mortality (under 75's) (rate per 10,000)	3.5	4.1	3.7	3.5*
Liver disease mortality (under 75's) (rate per 10,000)	2.2	2.1	2.2	1.8*
All-age-all-cause mortality (rate per 10,000)	92.4	104.6	97.8	98.8*
All-age-all-cause mortality (under 75's) (rate per 10,000)	32.9	38.1	35.2	35.0*

*indicates that England benchmark does not exactly match time period of local data (generally 2010-12)

Table 9: Summary of indicators and localities (ranks) – based on latest time period or pooled average where applicable from Table 8

Indicator	Paignton & Brixham	Torquay	Torbay	England
Births (1 = highest number of births)	NA	NA	NA	NA
Low birth weight births	2	2	3	4
Male life expectancy (years)	4	1	2	3
Female life expectancy (years)	3	1	2	4
Breastfeeding at 6-8 weeks	3	1	2	4
Troubled families (rate per 10,000)	-	-	1	2
Children in care (rate per 10,000)	-	-	1	2

Dental health (prevalence)	-	-	1	2
Childhood obesity (reception)	4	1	3	2
Childhood obesity (year 6)	2	1	4	3
SRGH – Bad or very bad health	1	3	2	4
Long-term health problem or disability (limited activities)	1	3	2	4
Elective admissions (rate per 10,000)	3	1	2	-
Emergency admissions (rate per 10,000)	3	1	2	-
Circulatory disease mortality (rate per 10,000)	4	1	3	2
Circulatory disease mortality (under 75's) (rate per 10,000)	3	1	2	4
Respiratory disease mortality (rate per 10,000)	3	1	2	-
Respiratory disease mortality (under 75's) (rate per 10,000)	3	1	2	3
Liver disease mortality (under 75's) (rate per 10,000)	2	3	2	4
All-age-all-cause mortality (rate per 10,000)	4	1	3	2
All-age-all-cause mortality (under 75's) (rate per 10,000)	4	1	2	3
Sum of ranks ¹³ (not including births)	40	21	34	46
Overall rank (not including births)	3	1	2	4

Births

- 7.4 In Torbay, there has been a noticeable increase in the volume of births since 2000. There were some 1,499 resident births in 2011 in Torbay, the highest number in a single year for over twenty years (Table 10). Going forward, local estimates suggest the number of births per year for the coming 5 years to be in the order of 1,400 per year (JSNA, 2014/15). Caution should be taken when using locality count data due to its source. Data previous to 2011 was deemed too inaccurate for inclusion.

¹³ Indicators with missing data have been omitted from the sum of ranks

Table 10: Live births by locality, 2009 to 2013

Locality	2009	2010	2011	2012	2013	% change
Paignton & Brixham	-	-	688*	641*	686	-0.3%
Torquay	-	-	803*	829*	804	0.1%
Torbay	1,424	1,402	1,499	1,462	1,474	-1.7%
England	671,058	687,007	688,120	694,241	-	3.5%

Source: Devon maternity dataset (approximate births*), ONS annual births extract 2013

Low birth weight births

- 7.5 There has been a slight increase in the proportion of low birthweight live and stillbirth babies in Torbay since 2009 (+11.0%) which is expected to be above the current England average. Due to inaccuracies in the local data source and small numbers, the percentage of low birthweight (<2,500g) births has only been calculated by locality for 2013 (Table 11).

Table 11: Low birth weight births (%) by locality, 2009 to 2013

Locality	2009	2010	2011	2012	2013	% change
Paignton & Brixham	-	-	-	-	8.2%	-
Torquay	-	-	-	-	8.2%	-
Torbay	7.3%	8.5%	7.5%	-	8.1%	11.0%
England	7.5%	7.3%	7.4%	-	-	-1.3%

Source: HSCIC Low birth weight rates 2009-2011, ONS annual birth extract 2013

Life expectancy at birth

- 7.6 Life expectancy at birth in Torbay has increased for both males and females; however males have seen a bigger increase over time (1.3 years Vs 0.1 years respectively). Female life expectancy is significantly lower than the England average (PHOF, 2010-2012).
- 7.7 Across Torbay, life expectancy at birth is not evenly distributed. Our more deprived communities live, on average, around 10 years less than those in less deprived communities (JSNA, 2014/15). Male (Table 12) and female (Table 13) life expectancy at birth varies by locality, with Paignton and Brixham having higher life expectancy at birth for males and females over time. Overall Torquay continues to have lower male and female life expectancy than England.

Table 12: Male life expectancy by locality, 2006-08 to 2010-12

Locality	2006-08	2007-09	2008-10	2009-11	2010-12	Change in years
Paignton & Brixham	78.2	78.4	79.1	79.5	80.0	1.8
Torquay	77.6	77.1	77.0	77.5	78.5	0.9
Torbay	77.8	77.6	77.9	78.4	79.1	1.3
England	77.9	78.2	78.5	78.9	79.2	1.3

Source: Public Health Team, Torbay Council, using PCMD/ONS resident pop, ONS Life Expectancy at birth tables

Table 13: Female life expectancy by locality, 2006-08 to 2010-12

Locality	2006-08	2007-09	2008-10	2009-11	2010-12	Change in years
Paignton & Brixham	82.7	82.4	82.7	82.8	82.8	0.1
Torquay	81.9	81.2	81.7	81.6	82.0	0.1
Torbay	82.3	81.8	82.2	82.1	82.4	0.1
England	82.0	82.3	82.5	82.9	83.0	1.0

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

Breastfeeding

- 7.8 In 2012/13, 36.0% of mothers in Torbay were breastfeeding at the 6-8 week baby check (Table 14). Paignton & Brixham has more breastfeeding mothers than Torquay locality. Torbay has consistently less mother's breastfeeding than England.

Table 14: Mothers breastfeeding at 6-8 week baby check by locality, 2010/11-2012/13

Locality	2010/11	2011-12	2012-13	% change
Paignton & Brixham	-	-	36.9%	-
Torquay	-	-	34.7%	-
Torbay	35.8%	39.0%	36.0%	0.6%
England	46.1%	47.2%	47.2%	2.4%

Source: Public Health Team, Torbay Council, using Child Health database

Troubled families

- 7.9 The Government has identified a troubled family as one that has serious problems and causes serious problems. There are a range of factors that could contribute to a 'troubled family' such as unemployed parents, children not in school, mental health problems and the family causing crime and anti-social behaviour. This costs local services a lot of time and money in responding to these familial issues (Torbay JSNA, 2012/13).
- 7.10 In 2011, there were estimated to be around 365 'troubled families' in Torbay. The perceived level of 'troubled families' in Torbay is equivalent to a rate of around 235 per 10,000 families. This compares to an England average of 178 per 10,000 families. This places Torbay within the top 25% of upper tier local authority area

rates (Torbay JSNA, 2012/13). The count of troubled families remains unchanged, at 365, in May 2014; however these will not all be the same families.

Looked after children

- 7.11 There are a number of reasons why a child may be 'looked after' by the local authority. Most often it is because the child's parents or the people who have parental responsibilities and rights to look after the child are unable to: care for him/her; have been neglecting him/her or the child has committed an offence.
- 7.12 There has been a 66.7% increase in the number of children being looked after by Torbay UA since 2009, with some 300 being looked after as at 31st March 2013 (Table 15). With around 121 children per 10,000 under 18 years being looked after, Torbay has amongst the highest rates in England.

Table 15: Children looked after 2009 to 2013

Geography	2009	2010	2011	2012	2013	% change
Torbay (count)	180	180	225	250	300	66.7%
England (count)	60,900	64,450	65,500	67,080	68,110	11.8%
Torbay (rate per 10,000 under 18)	71	72	89	100	121	70.4%
England (rate per 10,000 under 18)	54	57	58	59	60	11.1%

Source: Department for Education (DfE), Table LAA1

Dental health of children

- 7.13 In studies of dental decay, examiners count the number of sound teeth in each individual and the numbers of teeth that are decayed, missing and filled. The addition of the decayed, missing and filled components into a single score is the most commonly used mechanism for assessing the dental health status of the individual, giving rise to an individual 'dmft score' (lower case is used to denote 'primary' teeth). This score along with the prevalence (i.e. the proportions of children with disease experience) gives a good picture of the dental health status of populations.
- 7.14 In Torbay 35.7% of children were estimated to be experiencing some level of dental disease in 2011-12. This figure has increased slightly from 2007-08 (+3.78%); however nationally, tooth decay has decreased over the same time period (Table 16). Torbay shows consistently higher tooth decay than England.

Table 16: Dental health of children aged 5 years 2007/08 and 2011/12

Area	2007-08	2011-12	% change
Torbay	34.4%	35.7%	3.78%
England	30.9%	27.9%	-9.71%

Source: HSCIC, NHS Dental Epidemiology Programme 2007/08, 2011/12

Childhood obesity

- 7.15 Children in Reception and Year 6 classes are weighed and measured on an annual basis as part of the National Child Measurement Programme (NCMP). A child who's BMI for their age and sex places them equal to or above the 95% centile are classified as obese.
- 7.16 Annual levels of childhood obesity have increased from 8.2% (2006/07) to 11.1% (2012/13) at reception and from 15.7% (2006/07) to 21.6% (2012/13) at Year 6 for Torbay. Despite an extreme cohort in 2012/13, in general Torbay's obesity figures are lower than the England average. Unverified NCMP data for 2013/14 indicates that obesity rates have returned to a level that we would reasonably expect in the context of historical data. Due to small numbers, it is more sensible to use three year aggregated data at locality level.
- 7.17 In Torbay there has been a 6.3% reduction in the number of obese children measured in Reception since 2008/09-2010/11; however there has been an 8.0% increase in the number of obese children measured at Year 6 (Table 17 and Table 18 respectively). There is higher childhood obesity levels in Torquay compared to Paignton and Brixham with a greater increase in the number of children measured as obese over time in Torquay. Particularly in older children aged 10-11 years (+65.7%).

Table 17: Percentage of children aged 4-5 years classed as obese by locality, 2008/09-2010/11 to 2010/11-2012/13

Locality	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	% change
Paignton & Brixham	9.5%	7.1%	7.4%	-22.1%
Torquay	10.1%	9.5%	11.1%	9.9%
Torbay	9.5%	8.1%	8.9%	-6.3%
England	9.6%	9.6%	9.4%	-2.1%

Source: NOO NCMP MSOA data, HSCIC NCMP LA data. Locality figures have been aggregated from Middle Super Output Level (MSOA) data therefore will not match local authority published estimates for Torbay.

Table 18: Percentage of children aged 10-11 years classed as obese by locality, 2008/09-2010/11 to 2010/11-2012/13

Locality	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	% change
Paignton & Brixham	15.6%	15.1%	19.3%	23.7%
Torquay	16.9%	16.9%	28.0%	65.7%
Torbay	16.3%	16.1%	17.6%	8.0%
England	18.7%	19.0%	19.1%	2.1%

Source: NOO NCMP MSOA data, HSCIC NCMP LA data. Locality figures have been aggregated from Middle Super Output Level (MSOA) data therefore will not match local authority published estimates for Torbay.

Self-reported general health and long-term health problem or disability

- 7.18 Based on the 2011 Census, 7.6% of Torbay's population reported themselves to be in bad health or very bad health (Table 19). Self-report of poor health status is higher in Paignton & Brixham compared to Torquay locality. This is likely to be caused by

an older population and a greater proportion of residents reporting a long-term limiting illness or disability (23.9%). Both self-reported poor health and long-term limiting illness in Torbay are higher than the England average.

Table 19: Self-reported general health and long-term health problem or disability by locality, Census 2011

Locality	Self-reported general health			Long-term health problem or disability		
	Very good or good health	Fair health	Bad or very bad health	Day-to-day activities not limited	Day-to-day activities limited a little	Day-to-day activities limited a lot
Paignton & Brixham	75.3%	16.9%	7.8%	76.1%	12.6%	11.3%
Torquay	77.3%	15.5%	7.2%	78.1%	11.5%	10.4%
Torbay	76.1%	16.3%	7.6%	77.0%	12.1%	10.9%
England	81.4%	13.1%	5.5%	82.8%	9.3%	7.9%

Source: Census 2011, Office for National Statistics

Hospital admissions – elective

7.19 The directly age-standardised rate (DASR, using 2013 European Standard Population) of elective hospital admissions (per 10,000 people) for Torbay has increased by 133 (8.1%) from 2010-11 to 2013-14 (Table 20). Torquay experiences consistently higher rates of elective hospital admissions compared to Paignton & Brixham locality. Torquay has also seen the largest percentage increase in elective admissions over the years. The greatest proportion of elective admissions tends to come from residents aged between 60 and 80 years (South Devon and Torbay JSNA, 2014/15).

Table 20: Elective hospital admissions as a rate per 10,000 people, by locality

Locality	2010-11	2011-12	2012-13	2013-14	% change
Paignton & Brixham	1,568	1,659	1,602	1,712	9.2%
Torquay	1,697	1,747	1,735	1,896	11.7%
Torbay	1,632	1,702	1,670	1,765	8.1%
England	-	-	-	-	-

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data, ONS resident pop

Hospital admissions – emergency

7.20 The DASR of emergency hospital admissions per 10,000 people for Torbay has increased by 28 (2.8%) from 2010-11 to 2013-14 (Table 21). Torquay experiences consistently higher rates of emergency admissions compared to Paignton & Brixham;

however the percentage increase over the years is higher for Paignton & Brixham. Emergency hospital admissions tend to increase with age, particularly affecting females aged over 85 years. Younger females contribute to rates due to maternity (South Devon and Torbay JSNA, 2014/15).

Table 21: Emergency hospital admissions as a rate per 10,000 people, by locality

Locality	2010-11	2011-12	2012-13	2013-14	% change
Paignton & Brixham	911	852	922	950	4.3%
Torquay	1,054	970	1,074	1,095	3.9%
Torbay	988	915	999	1,016	2.8%
England	-	-	-	-	-

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data, ONS resident pop

Circulatory disease mortality

- 7.21 The DASR of mortality from circulatory diseases for persons of all ages per 10,000 population has fallen in Torbay by 1.0% (2011 to 2013) (Table 22). Circulatory mortalities are higher in Torquay compared to Paignton & Brixham locality; however Torquay has shown a slight reduction over the years. Torbay is similar to the England average for 2010-2012.

Table 22: Circulatory disease (ICD10 – I00-I99) mortality as a rate per 10,000 people, by locality

Locality	2011-12	2012-13	2013-14	2011-2013	% change
Paignton & Brixham	27.1	25.9	27.7	26.9	2.2%
Torquay	30.8	29.9	28.8	29.8	-6.5%
Torbay	29.1	27.8	28.8	28.4	-1.0%
England	28.3	28.0	-	28.8*	-1.1%

Source: Primary Care Mortality Database & ONS mid-year resident population, HSCIC (2010-2012*)

- 7.22 The DASR of premature mortality from circulatory diseases for under 75's per 10,000 population has increased slightly in Torbay by 1.2% from 2011 to 2013 (Table 23). Generally Torquay locality has more mortality from circulatory disease compared to Paignton & Brixham; however where Torquay has seen a reduction in mortalities, Paignton & Brixham has shown an increase (+34.9%). Premature mortality from circulatory disease is markedly higher than the England average for 2010-2012.

Table 23: Premature circulatory disease mortality (ICD10 – I00-99) as a rate per 10,000 people, by locality for under 75's

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	6.3	6.4	8.5	7.1	34.9%
Torquay	10.8	9.0	7.4	9.1	-31.5%
Torbay	8.4	7.9	8.5	8.1	1.2%
England	8.5	7.8	-	5.0*	-

Source: PCMD & ONS mid-year resident population, HSCIC, PHOF indicator (2010-12*)

Respiratory disease mortality

- 7.23 The DASR of mortality from respiratory diseases for persons of all ages per 10,000 population has increased slightly (5.3%) from 2011 to 2013 (Table 24). Generally Torquay locality has higher respiratory mortalities than Paignton & Brixham locality; however Paignton & Brixham has seen a bigger increase in mortalities since 2011 (+17.7%).

Table 24: Respiratory disease mortality (ICD10 – J00-99) as a rate per 10,000 people, by locality

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	12.4	11.3	14.6	12.7	17.7%
Torquay	13.8	14.8	13.0	13.9	-5.8%
Torbay	13.3	12.9	14.0	13.3	5.3%
England	-	-	-	-	-

Source: Primary Care Mortality Database & ONS mid-year resident population

- 7.24 The DASR of mortality from respiratory diseases for under 75's per 10,000 population has increased in Torbay by 5.7% (2011 to 2013) (Table 25). Generally Torquay has higher premature respiratory mortalities than Paignton & Brixham locality; however Paignton & Brixham has shown an increase since 2011 (+35.5%). Overall, Torbay is similar to the England average for 2010-2012.

Table 25: Premature respiratory disease mortality (ICD10 – J00-99) as a rate per 10,000 people, by locality for under 75's

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	3.1	3.1	4.2	3.5	35.5%
Torquay	3.6	5.5	3.2	4.1	-11.1%
Torbay	3.5	4.2	3.7	3.7	5.7%
England	-	-	-	3.5*	-

Source: Primary Care Mortality Database & ONS mid-year resident population, PHOF indicator (2010-12)*

- 7.25 The DASR of mortality from liver disease for persons under the age of 75 years (per 10,000 population) in Torbay has fallen by 36% from 2011 to 2013 (Table 26). Generally Torquay and Paignton & Brixham locality are quite similar for liver disease mortality. Torbay is above the England average for 2010 -2012.

Table 26: Liver disease mortality (ICD10 – B15-19, C22, I81, K70-77, T86.4) as a rate per 10,000 people, by locality

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	2.3	3.0	1.4	2.2	-39.1%
Torquay	2.6	1.7	1.9	2.1	-26.9%
Torbay	2.5	2.4	1.6	2.2	-36.0%
England	-	-	-	1.8*	-

Source: Primary Care Mortality Database & ONS mid-year resident population, PHOF indicator (2010-12)

All-age-all-cause mortality

- 7.26 The DASR of mortality from all causes for persons of all ages has increased slightly (1.4%) over the time period 2011-2013 to reach almost 100 per 10,000 population in 2013 (Table 27). Mortality rates are consistently higher in Torquay compared to Paignton & Brixham locality; however Paignton & Brixham has seen a bigger increase in all-age all-cause mortality since 2011. Overall Torbay is similar to the England average for 2010-2012.

Table 27: Mortality rates by locality, 2011 to 2013

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	90.9	92.4	93.9	92.4	3.3%
Torquay	104.2	104.4	105.5	104.6	1.2%
Torbay	98.3	97.1	99.7	97.8	1.4%
England	-	-	-	98.8*	-

Source: Primary Care Mortality Database & ONS Annual Mortality extract, HSCIC (2010-12)

Premature all-cause mortality

- 7.27 The DASR of premature mortality from all causes for persons aged under 75 years per 10,000 population has decreased over the time period 2011-2013 by 5.4% to reach around 35 per 10,000 population in 2013 (Table 28). Premature mortality rates are consistently higher in Torquay compared to Paignton & Brixham locality. The Torbay average is similar to the England figure for 2010-2012.

Table 28: Premature mortality rates by locality, 2011 to 2013

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	33.3	33.5	31.9	32.9	-4.2%
Torquay	39.2	38.1	37.1	38.1	-5.4%
Torbay	36.8	35.7	34.8	35.2	-5.4%
England	-	-	-	35.0*	-

Source: Primary Care Mortality Database & ONS Annual Mortality extract, Longer Lives (2010-2012)*

8. ASSESSING NEED: PUBLIC HEALTH INDICATORS RELATED TO COMMUNITY PHARMACY

This section details the public health indicators related to pharmacies in Torbay. This data compares each locality against the Torbay and England average for each public health indicator identified. This data is summarised in the locality summaries found on pages 11-16 (or follow the link here: **LOCALITY SUMMARY**).

Introduction

- 8.1 This section also provides more detailed examination of the different health needs of the population on a locality basis (where possible) but with regards to public health and additional indicators related specifically to community pharmacy. Where locality data is unavailable, Torbay UA data is provided. This section is particularly relevant when considering whether or not current pharmaceutical provision meets the needs of its population.
- 8.2 An overview of the health indicators described and their values is provided in Table 29 below to help inform assessment of need on a locality-by-locality basis and give national context. This is followed by Table 30 which gives each locality, Torbay and England's rank (1 = 'worst' performing, 4 = the 'best' performing) against each indicator to allow for easy comparison of health needs. Where locality data is not available, Torbay UA has been ranked against England (1 = 'worst' performing, 2 = 'best' performing).
- 8.3 This crude comparison highlights that Torquay locality has the greatest health needs overall and compared to England, Torquay and Paignton & Brixham collectively have more challenging health needs.

Table 29: Summary of indicators and localities (values) – latest time period or pooled average where applicable

Indicator	Paignton & Brixham	Torquay	Torbay	England
Teenage pregnancy	-	-	39.5	27.7
Smoking in pregnancy	14.5%	18.9%	17.1%	12.7%*

Parents misuse drugs (% of clients)	2.0%	5.0%	5.7%	-
Parents misuse alcohol (% of clients)	3.7%	5.3%	8.7%	-
Diagnosed depressed (18 and over)	6.0%	7.2%	6.5%	5.8%
Diagnosed mental health condition (all ages)	0.9%	1.2%	1.1%	0.9%
Living alone (all ages)	14.9%	16.6%	15.8%	12.8%
Living alone (under 65 years)	6.8%	9.6%	8.2%	7.6%
Living alone (65 and over)	8.1%	7.0%	7.6%	5.2%
Lone parents (all ages)	21.6%	24.8%	23.3%	20.1%
Divorced/separated (over 16 years)	10.3%	12.0%	11.2%	8.7%
Widowed (over 16 years)	8.7%	7.2%	8.0%	6.3%
Unpaid carer (all ages)	13.1%	11.6%	12.3%	10.2%
Accident admissions (rate per 10,000 aged 0 to 4 years)	11.5	14.3	13.5	14.2
Accident admissions (rate per 10,000 aged 5 to 14 years)	7.9	10.5	9.1	-
Accident admissions (rate per 10,000 aged 15 to 24 years)	16.3	17.2	16.7	14.3*
Emergency circulatory admissions (rate per 10,000)	111.2	121.9	115.8	-
Emergency circulatory admissions (rate per 10,000 under 75)	62.3	69.3	65.3	-
Admissions from falls (rate per 10,000 65 and over)	136.6	153.9	144.0	201.5*
Male alcohol-related hospital admissions (all ages)	-	-	683.4	589.0
Female alcohol-related hospital admissions (all ages)	-	-	373.1	305.7
Substance misuse	27.8	48.7	38.2	-
Children and Adolescent Mental Health Service (CAMHS) referrals (under 18 years)	-	-	943	-
Self-harm admissions (rate per 10,000 aged 10-24 years)	59.8	49.5	55.7	35.2*
Modelled diabetes prevalence (16 and over)	-	-	8.6%	7.5%

Expected coronary heart disease (CHD) prevalence	-	-	8.2%	5.8%
Expected stroke prevalence	-	-	3.5%	2.5%
Expected hypertension prevalence	-	-	37.0%	29.7%
Expected chronic obstructive pulmonary disorder (COPD) prevalence	-	-	3.2%	2.9%
Smoking prevalence (18 and over)	-	-	21.8%	20.2%
Smoking prevalence in manual and routine workers (18 and over)	-	-	32.4%	30.0%
Excess weight in adults (16 and over)	-	-	66.8%	63.8%
Inactivity in adults (16 and over)	-	-	33.8%	28.7%
Incidence of melanoma (rate per 100,000)	-	-	30.2	16.6
Incidence of melanoma (rate per 100,000 under 75)	-	-	28.4	14.7
Cancer mortality (under 75's) (rate per 10,000)	13.5	14.3	13.7	14.7*

*indicates that England benchmark does not exactly match time period of local data (generally 2010-12)

Table 30: Summary of indicators and localities (ranks) – latest time period or pooled average where applicable

Indicator	Paignton & Brixham	Torquay	Torbay	England
Teenage pregnancy	-	-	1	2
Smoking in pregnancy	3	1	2	4
Parents misuse drugs (% of clients)	2	1	NA	-
Parents misuse alcohol (% of clients)	2	1	NA	-
Diagnosed depressed (18 and over)	3	1	2	4
Diagnosed mental health condition (all ages)	3	1	2	3
Living alone (all ages)	3	1	2	4
Living alone (under 65 years)	4	1	2	3
Living alone (65 and over)	1	3	1	4
Lone parents (all ages)	3	1	2	4

Divorced/separated (over 16 years)	3	1	2	4
Widowed (over 16 years)	1	3	2	4
Unpaid carer (all ages)	1	3	2	4
Accident admissions (rate per 10,000 aged 0 to 4 years)	4	1	3	2
Accident admissions (rate per 10,000 aged 5 to 14 years)	3	1	2	-
Accident admissions (rate per 10,000 aged 15 to 24 years)	3	1	2	4
Emergency circulatory admissions (rate per 10,000)	3	1	2	-
Emergency circulatory admissions (rate per 10,000 under 75)	3	1	2	-
Admissions from falls (rate per 10,000 65 and over)	4	2	3	1
Male alcohol-related hospital admissions (all ages)	-	-	1	2
Female alcohol-related hospital admissions (all ages)	-	-	1	2
Substance misuse	3	1	2	-
Children and Adolescent Mental Health Service (CAMHS) referrals (under 18 years)	-	-	NA	-
Self-harm admissions (rate per 10,000 aged 10-24 years)	1	3	2	4
Modelled diabetes prevalence (16 and over)	-	-	1	2
Expected coronary heart disease (CHD) prevalence	-	-	1	2
Expected stroke prevalence	-	-	1	2
Expected hypertension prevalence	-	-	1	2
Expected chronic obstructive pulmonary disorder (COPD) prevalence	-	-	1	2
Smoking prevalence (18 and over)	-	-	1	2
Smoking prevalence in manual and routine workers (18 and over)	-	-	1	2
Excess weight in adults (16 and over)	-	-	1	2
Inactivity in adults (16 and over)	-	-	1	2

Incidence of melanoma (rate per 100,000)	-	-	1	2
Incidence of melanoma (rate per 100,000 under 75)	-	-	1	2
Cancer mortality (under 75's) (rate per 10,000)	4	2	3	1
Sum of ranks ¹⁴	47	27	36	50
Overall rank	3	1	2	4

Teenage pregnancy

- 8.4 The conception rate per 1,000 women aged 15-17 years for Torbay in 2012 was 39.5 (Table 31). This rate has reduced by 3.7% since 2003; however the reduction is minimal compared to England (-34.2%). Torbay continues to be well above the England average for teenage conceptions. Locality level data for teenage conceptions is unavailable due to information governance barriers since transition.

Table 31: Teenage conception rate for population aged 15-17 years, by Torbay and England 2003 to 2012

Area	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	% change
Torbay	41.0	50.1	48.7	51.7	58.3	66.4	56.5	47.0	53.1	39.5	-3.7%
England	42.1	41.6	41.4	40.6	41.4	39.7	37.1	34.2	30.7	27.7	-34.2%

Source: ONS conception statistics 2012

Smoking in pregnancy

- 8.5 In 2013/14, 17.1% of mothers reported that they were smoking at the time of delivery. This is a 17.4% reduction since 2010/11 (Table 32). In general, smoking at point of delivery tends to be higher in Torquay compared to Paignton & Brixham locality. Bigger reductions are also found in Paignton & Brixham over time (-25.6% since 2010/11).

Table 32: Mothers smoking at delivery, percentage of all mothers, by locality, 2010/11 to 2013/14

Locality	2010/11	2011/12	2012/13	2013/14	% change
Paignton & Brixham	19.5%	18.1%	14.0%	14.5%	-25.6%
Torquay	21.2%	16.4%	19.7%	18.9%	-10.8%
Torbay	20.7%	17.2%	17.4%	17.1%	-17.4%
England	13.5%	13.2%	12.7%	-	-5.9%

Source: Devon Maternity dataset, PHOF

¹⁴ Indicators with missing data have been omitted from the sum of ranks

Parents who misuse drugs

- 8.6 These figures relate to parents with children who live with them all or some of the time and who have been recorded as receiving a new episode of treatment from Torbay Drug and Alcohol Service. There has been a 40.0% increase in parents who misuse drugs from 2011/12 to 2013/14. Torquay experiences more parental drug misuse than Paignton and Brixham and contributes to the increase shown over the shown time period (Table 33).

Table 33: Percentage of Parent(s) who misuse drugs by town, 2011/12 to 2013/14

Area	2011/12	2012/13	2013/14	2011/12-2013/14	% change
Brixham (town)	0.0%	0.0%	0.0%	0.0%	0.0%
Paignton (town)	2.0%	2.0%	2.0%	2.0%	0.0%
Torquay (town/locality)	3.0%	3.0%	5.0%	3.7%	66.7%
Torbay	5.0%	5.0%	7.0%	5.7%	40.0%

Source: HALO (Torbay Drug and Alcohol Service)

Parents who misuse alcohol

- 8.7 These figures relate to parents with children who live with them all or some of the time and who have been recorded as receiving a new episode of treatment from Torbay Drug and Alcohol service (Table 34). There has been a 36.4% reduction in parents who misuse alcohol from 2011/12 to 2013/14. Torquay experiences more parental alcohol misuse than Paignton & Brixham; however Torquay has shown the largest reduction over time (-42.9%).

Table 34: Percentage of Parent(s) who misuse alcohol by locality, 2011/12 to 2013/14

Area	2011/12	2012/13	2013/14	2011/12-2013/14	% change
Brixham (town)	1.0%	1.0%	1.0%	1.0%	0.0%
Paignton (town)	3.0%	3.0%	2.0%	2.7%	-33.3%
Torquay (town/locality)	7.0%	5.0%	4.0%	5.3%	-42.9%
Torbay	11.0%	8.0%	7.0%	8.7%	-36.4%

Source: HALO (Torbay Drug and Alcohol Service)

Depressed or mentally ill

- 8.8 The Quality Outcomes Framework (QOF) is a voluntary process for all GP surgeries in England. Surgeries receive awards for managing some of the most common chronic diseases which includes the recording of patients on the disease register. This can be used to indicate 'known' prevalence of certain conditions; however as with many public health indicators, this should be considered as the 'tip of the iceberg' as many conditions will remain undiagnosed. As QOF prevalence is voluntary data recording and is only a representation of those known to their GP; it is best

considered as an underestimate of the true prevalence of a condition. Please bear this in mind when interpreting the following data.

- 8.9 There has been a 46.3% reduction in the number of patients over 18 years recorded with depression on the disease register from 2009/10 to 2012/13. This is similar to the reduction seen across England (Table 35). The emergence of the Mental Health indicator on the disease register from 2012/13 may explain this reduction as current patients on the depression register may have been reclassified as having a mental health disorder and new patients may be placed on the mental health register as opposed to the depression register.

Table 35: Percentage with depression or mental health conditions known to their GP by locality, 2009/11 to 2012/13

Locality	Depression (over 18 years)				Mental health (all ages)
	2009/10	2010/11	2012/13	% change	2012/13
Paignton & Brixham	12.3%	12.8%	6.0%	-51.2%	0.9%
Torquay	11.8%	12.4%	7.2%	-39.0%	1.2%
Torbay	12.1%	12.7%	6.5%	-46.3%	1.1%
England	10.6%	11.1%	5.8%	-45.3%	0.9%

Source: QOF, HSCIC

It is estimated that around 16.0% of adults aged 16-64 years have a common mental health disorder (PANSI, 2014); therefore the above data should be regarded as an underestimate of need in Torbay.

Social isolation

- 8.10 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.
- 8.11 Without survey or interview/focus group data we cannot estimate the proportion of people who are socially isolated in Torbay. As a proxy measure we can show the percentage of people who live alone as there is a greater likelihood of social isolation in households of a single family member. One in six people live alone in Torbay (Table 36). There are more lone person households in Torquay locality, particularly in the younger age group (under 65 years of age) than in Paignton & Brixham. Torbay has significantly more people living alone compared to the England average.

Table 36: Percentage of persons living alone by locality, Census 2011

Locality	Total persons living alone	Persons living alone under 65 years	Persons living alone over 65 years
Paignton & Brixham	14.9%	6.8%	8.1%
Torquay	16.6%	9.6%	7.0%
Torbay	15.8%	8.2%	7.6%
England	12.8%	7.6%	5.2%

- 8.12 Social isolation may also be more likely in the following groups: lone parents, those divorced/separated or widowed and unpaid carers (Table 37). Torbay is above the England average for all the aforementioned groups.

Table 37: Percentage of lone parents, divorced, widowed and unpaid carer by locality, Census 2011

Locality	Lone parents (all ages)	Divorced/ Separated (16+)	Widowed (16+)	Unpaid carer (all ages)
Paignton & Brixham	21.6%	10.3%	8.7%	13.1%
Torquay	24.8%	12.0%	7.2%	11.6%
Torbay	23.3%	11.2%	8.0%	12.3%
England	20.1%	8.7%	6.3%	10.2%

Source: LC1109EW, LC1108EW, LC3304EW. Census, 2011, Office of National Statistics

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

- 8.13 The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 0-4 years in Torbay has fallen by 24.7% from 2010-11 to 2013-14 (Table 38). Generally Torquay has more emergency admissions than Paignton & Brixham locality per 1,000 resident population; however Torquay has experienced the greatest reduction from 2010/11. Torbay admissions are similar and, more recently, slightly lower than the England average.

Table 38: Crude rate of emergency admission for unintentional and deliberate injuries in under 5's by locality per 1,000 population (0-4 years)

Locality	2010/11	2011/12	2012/13	2013/14	2010/11-2013/14	% change
Paignton & Brixham	11.0	17.0	7.0	10.8	11.5	-1.8%
Torquay	18.9	13.5	12.1	12.6	14.3	-36.0%
Torbay	15.4	15.1	11.7	11.6	13.5	-24.7%
England	14.3	14.8	13.5	-	14.2*	-5.6%

Source: Public Health Team, Torbay Council, from SUS (Secondary Uses Service) data, *PHOF indicator (2010/11-2012/13). ICD-10 S00-T79, V01-Y36

- 8.14 The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 5 to 14 years in Torbay has decreased by 20.2% from 2010-11 to 2013-14 (Table 39). Torquay locality has more emergency admissions than Paignton & Brixham locality per 1,000 resident population and has seen a lesser reduction in admissions since 2010/11. There is no England comparator available for this indicator.

Table 39: Crude rate of emergency admission for unintentional and deliberate injuries in 5-14 year olds by locality per 1,000 population (5-14 years)

Locality	2010/11	2011/12	2012/13	2013/14	2010/11-	%
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					2013/14	change
Paignton & Brixham	10.4	8.3	5.8	7.0	7.9	-32.7%
Torquay	12.6	10.1	8.1	11.0	10.5	-12.7%
Torbay	11.4	9.1	6.9	9.1	9.1	-20.2%
England	-	-	-	-	-	-

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data. ICD-10 S00-T79, V01-Y36

- 8.15 The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 15 to 24 years in Torbay has decreased slightly by 2.9% from 2010-11 to 2013-14 (Table 40). A large proportion of these admissions are due to self-harm (see Section 8.25). On average there are more emergency admissions in Torquay locality compared to Paignton & Brixham; however where Torquay has seen a slight reduction in admissions over time, Paignton & Brixham has seen no change. Torbay has consistently more admissions than the England average.

Table 40: Crude rate of emergency admission for unintentional and deliberate injuries in 15-24 years old by locality per 1,000 population (15-24 years)

Locality	2010/11	2011/12	2012/13	2013/14	2010/11-2013/14	% change
Paignton & Brixham	14.8	19.7	15.8	14.8	16.3	0.0%
Torquay	19.2	16.2	14.9	18.6	17.2	-3.1%
Torbay	17.3	17.3	15.2	16.8	16.7	-2.9%
England	15.4	14.5	13.1	-	14.3*	-14.9%

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data, *PHOF indicator (2010/11-2012/13). ICD-10 S00-T79, V01-Y36

Emergency admissions for circulatory diseases

- 8.16 The DASR of emergency hospital admissions for circulatory diseases has reduced by 13.3% since 2010/11 (Table 41). Torquay has more hospital admissions than Paignton & Brixham locality, with both localities showing a similar reduction in admissions over the time period (2010/11-2013/14).

Table 41: Rate of emergency hospital admissions for circulatory diseases (ICD10 – I00-I99, underlying cause) by locality per 10,000 resident population

Locality	2010-11	2011-12	2012-13	2013-14	2010/11-2013/14	% change
Paignton & Brixham	117.2	111.4	112.4	103.8	111.2	-11.4%
Torquay	132.6	113.4	125.7	115.6	121.9	-12.8%
Torbay	124.6	112.7	117.9	108.1	115.8	-13.3%
England	-	-	-	-	-	-

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data

- 8.17 The DASR of emergency hospital admissions for circulatory diseases (under 75's) have also decreased by a similar percentage (13.6%) as for all ages (Table 42). Again Torquay hospital admissions are higher in Torquay locality compared to Paignton & Brixham; however Torquay has also shown a greater reduction in admissions over the time period (2010/11-2013/14).

Table 42: Rate of hospital admissions for circulatory diseases (ICD10 – I00-I99, underlying cause) for under 75's (per 10,000 population)

Locality	2010-11	2011-12	2012-13	2013-14	2010/11-2013/14	% change
Paignton & Brixham	64.8	63.7	60.6	60.2	62.3	-7.1%
Torquay	77.2	66.5	68.0	65.2	69.3	-15.6%
Torbay	70.8	65.2	64.2	61.2	65.3	-13.6%
England	-	-	-	-	-	-

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data

Emergency hospital admissions for falls in adults aged 65 and over

- 8.18 The DASR for emergency hospital admissions for falls in Torbay have increased slightly (2.4%) from 2010/11 (Table 43). Hospital admissions are higher in Torquay compared to Paignton & Brixham locality; however Paignton & Brixham locality has shown an increase in admissions by 10.6% since 2010/11. Torbay has a much lower admission rate than the England average. Locally counts were slightly lower than expected.

Table 43: Rate of hospital admissions for falls aged 65 and over (per 10,000 population)

Locality	2010-11	2011-12	2012-13	2013-14	2010/11-2013/14	% change
Paignton & Brixham	128.6	145.8	129.6	142.2	136.6	10.6%
Torquay	164.9	147.7	142.1	161.3	153.9	-2.2%
Torbay	145.9	145.9	135.4	149.4	144.0	2.4%
England	203.0	203.5	201.1	-	202.5*	-0.9%

Source: Public Health Team, Torbay Council, from SUS (*Secondary Uses Service*) data. PHOF, 2010/11-2012/13* ICD-10 - S-T89 primary diagnosis with W00-19 underlying cause. ESP 2013.

Alcohol-related hospital admissions (all ages)

- 8.19 Alcohol related admissions involve an alcohol-related primary diagnosis or an alcohol-related external cause (PHOF, 2014). Alcohol-related conditions are where alcohol could be considered a risk factor for another disease or reason for admission such as hypertension or falls (South Devon and Torbay JSNA, 2014/15).
- 8.20 Alcohol-related hospital admissions in Torbay have decreased slightly in males (-0.9%) and more so in females (-5.9%) since 2008/09 (Table 44). Admissions are

consistently higher in Torbay compared to the England average. Due to a recent change in methodology for this indicator, locality data is currently unavailable.

Table 44: Alcohol related admissions (narrow definition) per 100,000 population standardised to the European standard population 2013

Area	2008/09	2009/10	2010/11	2011/12	2012/13	% change
Torbay (males)	690.0	659.4	717.3	717.4	683.4	-0.9%
England (males)	568.3	593.1	600.7	597.6	589.0	3.6%
Torbay (females)	396.4	371.5	381.7	362.2	373.1	-5.9%
England (females)	290.8	304.8	312.2	310.8	305.7	5.1%

Source: Local Alcohol Profiles for England (LAPE)

Substance misuse

- 8.21 Substance misuse is recorded by Torbay Drug and Alcohol Service commissioned by the Office of the Director of Public Health, Torbay Council. The rate of in-house prescribed substance misuse clients has increased by 7.4% since 2011/12 (Table 45). Torquay locality has consistently more in-house prescribed clients than Torquay and Brixham locality.

Table 45: Crude rate per 10,000 population of clients (all ages) who are 'in-house prescribed' by town, 2011/12-2013/14

Area	2011/12	2012/13	2013/14	2011/12-2013/14	% change
Paignton & Brixham (towns)	26.8	26.7	30.0	27.8	11.9%
Torquay (town/locality)	46.3	51.3	48.5	48.7	4.8%
Torbay	36.5	38.9	39.2	38.2	7.4%

Source: HALO data extracted 29/10/14. This does not include patients who are prescribed from a GP

Estimates of younger population with specific mental health problems

- 8.22 Prevalence of mental health disorders varies by age and sex in children, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. These national prevalence estimates have been applied to the Torbay population to give the estimated number of young people affected in the area (Table 46).

Table 46: Projected younger population (5-16 years) with specific mental health problems in Torbay, 2012

Specific mental health problem	Estimated population affected (count)			
	Males (5-10 years)	Males (11-16 years)	Females (5-10 years)	Females (11-16 years)
Mental health disorders	410	565	195	430
Conduct disorders	280	365	105	215
Emotional disorders	90	180	95	255
Hyperkinetic disorders	110	110	15	20
Less common mental health disorders	90	75	15	50

Source: CHIMAT Service Snapshot, 2012

- 8.23 The number of referrals to Torbay Children and Adolescent Mental Health Service (CAMHS) has increased by a third between 2011/12 and 2013/14 (Table 47). Early indications based on the first 4 months of 2014/15 suggest that numbers may increase further. Compared to the estimated prevalence (Table 46 above) it is likely that mental health in younger people is underdiagnosed in Torbay.

Table 47: Younger population (under 18 years) referred to Torbay CAMHS 2011/12 to 2013/14 (count)

Area	2011/12	2012/13	2013/14	% change
Torbay	708	765	943	33.2%

Source: Torbay CAMHS, 2014

Estimates of adult population with specific mental health problems

- 8.24 The proportion 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 decrease slightly in Torbay by 2020 (Table 48). Females are predicted to have a higher prevalence for most mental health disorders apart from antisocial personality disorder (PANSI).

Table 48: Projected adult population (18-64 years) with specific mental health problems in Torbay, 2014 to 2020

Specific mental health problems by gender	Estimated population affected (count)				% change
	2014	2016	2018	2020	

Males aged 18-64 predicted to have a common mental disorder	4,500	4,500	4,500	4,450	-1.1%
Males aged 18-64 predicted to have a borderline personality disorder	108	108	108	107	-0.9%
Males aged 18-64 predicted to have an antisocial personality disorder	216	216	216	214	-0.9%
Males aged 18-64 predicted to have psychotic disorder	108	108	108	107	-0.9%
Males aged 18-64 predicted to have two or more psychiatric disorders	2,484	2,484	2,484	2,456	-1.1%
Females aged 18-64 predicted to have a common mental disorder	7,427	7,368	7,348	7,309	-1.6%
Females aged 18-64 predicted to have a borderline personality disorder	226	224	224	223	-1.3%
Females aged 18-64 predicted to have an antisocial personality disorder	38	37	37	37	-2.6%
Females aged 18-64 predicted to have psychotic disorder	189	187	187	186	-1.6%
Females aged 18-64 predicted to have two or more psychiatric disorders	2,828	2,805	2,798	2,783	-1.6%

Source: Projecting Adult Needs and Service Information (PANSI)

Hospital admissions for self-harm aged 10-24 years

8.25 The DASR of emergency hospital admissions for self-harm have reduced by 9% in Torbay since 2007/08-2009/10 (Table 49). Admissions are currently higher in Paignton & Brixham locality compared to Torquay. Self-harm hospital admissions are consistently higher than the England average.

Table 49: Directly standardised hospital admissions for self-harm (10-24 years) by locality as a rate per 10,000 population

Locality	2007/08-2009/10	2008/09-2010/11	2009/10-2010/11	2010/11-2012/13	% change
Paignton & Brixham	-	-	-	59.8	-
Torquay	-	-	-	49.5	-
Torbay	61.2	57.3	55.5	55.7	-9.0%
England	33.0	34.2	35.2	-	6.7%

Source: Public Health Team, Torbay Council, from SUS (Secondary Uses Service) data. CHIMAT, 2012 ICD-10 – X60-X84, ESP 2013

Dementia

- 8.26 The estimated number of adults over the age of 65 years with dementia is expected to reduce in the 65-69 age group but increase from the age of 70 years by 2020 (Table 50).

Table 50: Projected population with dementia by age group, 2014 to 2020

Age group	2014	2016	2018	2020	% change
People aged 65-69	126	127	113	110	-12.7%
People aged 70-74	208	230	263	266	27.9%
People aged 75-79	357	362	386	420	17.6%
People aged 80-84	560	573	607	631	12.7%
People aged 85-89	628	644	678	717	14.2%
People aged 90 and over	628	656	714	742	18.2%
Total population 65 and over	2,507	2,593	2,761	2,885	15.1%

Source: Projecting Older People Population Information (POPPI)

- 8.27 Little change is expected over time in the prevalence of early onset dementia in adults under the age of 50 years in Torbay. There is expected to be a slight increase in early onset dementia from the age of 50-64 years by 2020 (Table 51).

Table 51: Projected population with early onset dementia by age group and gender, 2014 to 2020

	2014	2016	2018	2020	% change
Males aged 30-39 predicted to have early onset dementia	0	0	0	0	-
Males aged 40-49 predicted to have early onset dementia	2	2	2	1	-50.0%
Males aged 50-59 predicted to have early onset dementia	11	11	11	12	9.1%
Males aged 60-64 predicted to have early onset dementia	8	8	9	9	12.5%
Total males aged 30-64 predicted to have early onset dementia	21	21	22	23	9.5%
Females aged 30-39 predicted to have early onset dementia	1	1	1	1	0.0%
Females aged 40-49 predicted to have early onset dementia	2	2	2	2	0.0%
Females aged 50-59 predicted to have early onset dementia	7	7	8	8	14.3%
Females aged 60-64 predicted to have early onset dementia	6	5	5	6	0.0%
Total females aged 30-64 predicted to have early onset dementia	15	15	16	16	6.7%

Source: Projecting Adult Needs and Service Information (PANSI)

Long term conditions (diabetes, respiratory problems, circulatory diseases, dermatological issues)

- 8.28 The expected prevalence of diagnosed and undiagnosed diabetes in adults aged over 16 years is predicted to increase by 21.4% by 2030 in Torbay. Torbay has a higher expected prevalence of diabetes than England with a greater expected prevalence increase over time (Table 52).

Table 52: Diabetes prevalence projections aged 16 years and over 2012-2030

Area	2012	2013	2014	2015	2020	2025	2030	% change
Torbay	8.4%	8.5%	8.6%	8.7%	9.2%	9.7%	10.2%	21.4%
England	7.3%	7.4%	7.5%	7.6%	8.2%	8.6%	8.8%	20.5%

Source: YHPHO Diabetes Prevalence Model

- 8.29 The known (diagnosed) prevalence and expected (diagnosed and undiagnosed) prevalence of circulatory diseases (CHD, Stroke and Hypertension) for Torbay adults (≥16 years) is higher than the England average (Table 53). The diagnosed prevalence is less than the expected prevalence for all circulatory diseases which suggests there is unmet need in the population.

Table 53: Circulatory disease prevalence aged 16 years and over 2011/12

Area	Coronary heart disease (CHD)		Stroke		Hypertension	
	Diagnosed (2011/12)	Expected (2011)	Diagnosed (2011/12)	Expected (2011)	Diagnosed (2011/12)	Expected (2011)
Torbay	4.2%	8.2%	2.4%	3.5%	16.5%	37.0%
England	3.4%	5.8%	1.7%	2.5%	13.6%	29.7%

Source: Cardiovascular Disease Health Profile, Public Health England

- 8.30 The known (diagnosed) prevalence of chronic obstructive pulmonary disease (COPD) for the South Devon and Torbay CCG is higher than the England average (Table 54). The diagnosed prevalence is less than the expected prevalence for COPD which suggests that there is unmet need in the population.

Table 54: COPD Prevalence all ages, 2011

Area	Diagnosed Prevalence (2011)	Expected Prevalence
NHS South Devon and Torbay CCG	2.0%	3.2%
England	1.7%	2.9%

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

Smoking status

- 8.31 Based on survey data, it is estimated that around one in five adults in Torbay smoke. Almost one in three adults smoke if they work in a routine or manual profession

(Table 55). There has been a 7% reduction in smoking since 2010/11. Smoking prevalence in Torbay is higher than the England average across all sub-sections of the population.

Table 55: Smoking prevalence aged 18 years and over

Area	2010-11	2011-12	2012-13	2010/11-2012/13	% change
Torbay (prevalence ≥18 years)	22.7%	21.6%	21.1%	21.8%	-7.0%
England (prevalence ≥18 years)	20.8%	20.2%	19.5%	20.2%	-6.3%
Torbay (prevalence in routine & manual workers ≥18 years)	-	32.6%*	32.2%*	32.4%*	1.2%
England (prevalence in routine & manual workers ≥18 years)	-	30.3%*	29.7%*	30.0%*	2.0%

Source: PHOF, 2010/11-2012/13. *Calendar year

Excess weight

- 8.32 Around two in every three adults were estimated to be overweight or obese in Torbay in 2012. This is higher than the England average (Table 56). Over a third of adults are reported to be inactive in Torbay and there are indications that this is an increasing trend (3% increase from 2011 to 2012). Physical inactivity is higher in Torbay compared to the England average.

Table 56: Excess weight and physical inactivity in adults (≥16 years)

Area	2011	2012	2011-12	% change
Torbay (Excess weight)	-	66.8%	-	-
England (Excess weight)	-	63.8%	-	-
Torbay (Inactivity)	33.3%	34.3%	33.8%	3.0%
England (Inactivity)	28.5%	28.9%	28.7%	1.4%

Source: PHOF, 2011-2012

Skin cancer incidence

- 8.33 The DASR of incidence of melanoma for all ages and those under the age of 75 years is much higher than the England average (Table 57). Trend data was unavailable without request from the Knowledge and Intelligence Team (KIT).

Table 57: Skin cancer – incidence of new cases by Torbay UA

Area	2008-2010
Torbay (incidence all ages)	30.2
England (incidence all ages)	16.6
Torbay (incidence under 75 years)	28.4

England (incidence under 75 years)	14.7
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Source: SWPHO Skin Cancer Profiles, 2008-2010

Premature cancer mortality

- 8.34 The DASR of mortality from cancer for persons under the age of 75 years per 10,000 population in Torbay has fallen by 11.5% from 2011 to 2013 (Table 58). Generally Torquay has higher cancer mortalities than Paignton & Brixham locality and has shown an increase since 2011. Overall, Torbay is below the England average.

Table 58: Premature cancer mortality (ICD10 – C00-97) as a rate per 10,000 people, by locality

Locality	2011	2012	2013	2011-2013	% change
Paignton & Brixham	15.3	13.7	11.5	13.5	-24.8%
Torquay	13.7	13.8	15.5	14.3	13.1%
Torbay	14.8	13.6	13.1	13.7	-11.5%
England	-	-	-	14.7*	-

Source: Primary Care Mortality Database & ONS mid-year resident population, PHOF indicator (2010-12)*

9. MAPPING PROVISION OF PHARMACEUTICAL SERVICES AND IDENTIFYING GAPS

This section reports all available data captured through the local pharmacy audit and other appropriate data sources. It details the commissioned services and what they are, the availability of pharmaceutical services in each locality (such as opening times), the breadth of commissioned services and other supplementary data to inform the reader regarding auxiliary facilities available in each locality. This data is summarised in the locality summaries found on pages 11-16 (or follow the link here: **LOCALITY SUMMARY**).

Introduction

- 9.1 The following section defines pharmaceutical services and commissioning arrangements, outlines providers of pharmaceutical services in Torbay, and presents the findings of the audit of community pharmacies.

Defining NHS Pharmaceutical Services and commissioning arrangements

- 9.2 The NHS England Area Teams commission all services in the NHS Community Pharmacy Contractual Framework (CPCF).¹⁵ For Torbay, this is overseen by the Area Team of Devon, Cornwall and Isles of Scilly.¹⁶ The CPCF is a regulatory framework based on the Terms of Service set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013. The Area Team is responsible for managing and performance monitoring the CPCF. The CPCF defines three different types of NHS Pharmaceutical Services that are commissioned by the Area Team – Essential, Advanced and Enhanced. These are explained in turn below. Other commissioners cannot commission these three services from community pharmacies: they may choose to commission some Enhanced services from community pharmacies, but they would be classified as ‘Locally Commissioned Services’ rather than Enhanced services.

ESSENTIAL SERVICES:

Legal arrangements: Set out in Part 2, Schedule 4 of the Regulations

Commissioning arrangements: Pharmacy owners (contractors) must provide essential services. They are commissioned by NHS England.

Explanation/examples:

- **Dispensing** – the safe supply of medicines or appliances. Advice is given to the patient about the medicines being dispensed and how to use them.
- **Repeat dispensing** – the management of repeat medication for up to one year, in partnership with the patient and prescriber.
- **Disposal of unwanted medicines** – pharmacies accept unwanted medicines from individuals. The medicines are then safely disposed of.

¹⁵ <http://psnc.org.uk/services-commissioning/locally-commissioned-services/which-commissioner/>

¹⁶ <http://devonlpc.org/nhs-england/area-team-of-devon-cornwall-and-isle-of-scilly/>

- **Promotion of Healthy Lifestyles (Public health)** - opportunistic one to one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing. Pharmacies will also get involved in six local campaigns a year, organised by NHS England.
- **Signposting patients to other healthcare providers** - pharmacists and staff will refer patients to other healthcare professionals or care providers when appropriate.
- **Support for self-care** – the provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service.
- **Clinical governance** – pharmacies must have a system of clinical governance to support the provision of excellent care.

For more information: <http://psnc.org.uk/services-commissioning/essential-services/>

ADVANCED SERVICES:

Legal arrangements: Set out in the Directions

Commissioning arrangements: Pharmacy contractors can choose whether they wish to provide Advanced Services. They can be provided by all contractors once accreditation requirements have been met. They are commissioned by NHS England.

Explanation/examples: There are four Advanced Services within the NHS Community Pharmacy Contractual Framework (CPCF):

- (1) **The Medicines Use Review (MUR)** and Prescription Intervention Service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions.
- (2) **Appliance Use Review (AUR)** can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance'. The service can be provided by pharmacies that normally provide the specified appliances in the normal course of their business. There are a number of conditions that must be satisfied first.
- (3) **Stoma Appliance Customisation (SAC)** involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff. The service can be provided by pharmacies that normally provide stoma appliances in the normal course of their business. There are a number of conditions that must be satisfied first.

(4) The New Medicine Service (NMS) provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence; it is initially focused on particular patient groups and conditions. Since its introduction in October 2011, more than 90% of community pharmacies in England have provided it to their patients. Initial funding for the service was agreed until March 2013, and since then funding has been extended pending a decision on the long-term future of the service.

For more information: <http://psnc.org.uk/services-commissioning/advanced-services/>

ENHANCED SERVICES:

Legal arrangements: Set out in the Directions

Commissioning arrangements: Enhanced services are commissioned by NHS England. Other commissioners can commission some Enhanced services from community pharmacies, but they are classified as 'locally commissioned services' (see below).

Explanation/examples: Only those services that are listed within the Directions may be referred to as Enhanced services. If NHS England wishes to commission a service not listed within the Directions then it falls outside the definition of 'pharmaceutical services'. The commissioning of the following Enhanced services which were listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2012 transferred from PCTs to local authorities with effect from 1 April 2013:

- Needle and syringe exchange
- Screening services such as chlamydia screening
- Stop smoking
- Supervised administration service
- Emergency hormonal contraception services through patient group directions

Where such services are commissioned by local authorities they no longer fall within the definition of pharmaceutical services as set out in legislation and are therefore called 'locally commissioned services'. However, the 2013 directions do make provision for NHS England to commission the above services from pharmacy contractors where asked to do so by a local authority. Where this is the case they are treated as enhanced services and fall within the definition of pharmaceutical services. The following Enhanced services may be commissioned by NHS England from 1 April 2013 in line with PNAs thereafter:

- Anticoagulation monitoring
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Independent prescribing service
- Home delivery service

- Language access service
- Medication review service
- Medicines assessment and compliance support
- Minor ailment service
- On demand availability of specialist drugs
- Out of hours service
- Patient group direction service (not related to public health services)
- Prescriber support service
- Schools service
- Supplementary prescribing service

For more information: <http://psnc.org.uk/services-commissioning/locally-commissioned-services/>

LOCALLY COMMISSIONED SERVICES

Legal arrangements: These services are not part of 'NHS Pharmaceutical Services' as defined by the Regulations and therefore cannot be described as Enhanced services. The correct description of these services is 'locally commissioned services'.

Commissioning arrangements: Since April 2013 a number of commissioners have had a role in commissioning services from community pharmacies. Organisations most likely to do so are Clinical Commissioning Groups (CCGs) and Local Authorities (LAs), although as outlined previously there are some grey areas which may result in local variation. Detailed information about contracting arrangements can be found at: <http://psnc.org.uk/services-commissioning/locally-commissioned-services/which-commissioner/>.

Explanation/examples: The following public health services provided by community pharmacies are commissioned by **local authorities:**

- Supervised consumption
- Needle and syringe programme
- NHS Health Check
- EHC and contraceptive services
- Sexual health screening services
- Stop smoking
- Chlamydia testing and treatment
- Weight management
- Alcohol screening and brief interventions

Local authorities will use their own contracts or the standard public health contract to commission services from community pharmacies. There are a small number of circumstances where a public health service is commissioned by another organisation, e.g. NHS England commissions vaccination services from GPs, community pharmacies and other providers. There may also be circumstances where Clinical Commissioning Groups may wish to be involved in commissioning a public health service, due to the impact the service may have on the development or management of long term conditions. This may involve co-commissioning a service,

which is likely to happen on a more regular basis as a result of the full introduction of the Better Care Fund in 2015/16.

Clinical Commissioning Groups may wish to commission services such as minor ailments services, palliative care schemes, MUR+ and other medicines optimisation services. CCGs have to use the NHS Standard Contract to commission services from community pharmacies.

For more information: <http://psnc.org.uk/services-commissioning/locally-commissioned-services/>

Providers of pharmaceutical services in Torbay

9.3 As highlighted in Section 2, there are a number of different providers of pharmaceutical services across Torbay, including:

- Distance selling pharmacies*
- GP dispensing practices/dispensing doctors (relevant to rural areas)*
- Dispensing Appliance Contractors*
- Community pharmacies*
- Minor Injury Units
- Out-of-Hours Service
- Acute Trust Pharmacy
- Homecare Companies
- Community Health Service Pharmacists

Those providers that have been starred (*) are within the scope of this PNA (see Section 2, page 21 for the rationale for this) and are therefore described in more detail below.

Distance Selling Pharmacies

Description: Distance selling pharmacies (sometimes referred to as Internet or online pharmacies) provide pharmaceutical services to a broad population. Patients can order medicines online and have them delivered to them directly via the mail or shipping companies. Distance selling pharmacies also support medicines use and public health initiatives through websites and other communication routes. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 detail a number of conditions for distance selling pharmacies in addition to the regulations governing all pharmacies. As compliance with the conditions is a pre-requisite for all distance selling pharmacies to remain on the pharmaceutical list, breach of the conditions could lead to removal from the Pharmaceutical List by NHS England. Distance selling pharmacies must allow for the uninterrupted provision of Essential services during the opening hours of the pharmacy to anyone in England who requests the service. In addition, nothing in any written or oral communication (such as a practice leaflet or any publicity) can suggest, either expressly or impliedly, that services will only be available to persons in particular areas of England, or only particular categories of patients will (or will not) be provided for. See: <http://psnc.org.uk/contract-it/market-entry-regulations/distance-selling-pharmacies/>.

Torbay mapping: There are currently no Distance Selling Pharmacies within the Local Authority boundary, although there used to be one based in Paignton which is now closed. Irrespective of this, as these pharmacy types provide services to a broad population both within and outside of the boundaries within which they are based, their impact on the pharmaceutical needs of the Torbay population at the locality level is not clear. For this reason, they are only mentioned briefly in this report.

Dispensing doctors

Description: NHS legislation states that in certain rural areas (classified as controlled localities) general practitioners may apply to dispense NHS prescriptions. Dispensing doctors play a vital role in ensuring that people who live in rural areas have access to pharmaceutical services without having a lengthy journey to their nearest pharmacy. Permission is granted to GPs providing there is no 'prejudice' to the existing medical or pharmaceutical services. Prejudice is defined as: being unable to comply with the medical or pharmaceutical terms of service. The provisions to allow GPs to dispense were introduced to provide patients access to dispensing services in rural communities not having reasonable access to a community pharmacy. Pharmacy applications in rural areas are also required to satisfy the prejudice test and, unlike GP dispensing applications, are subject to the additional market entry tests (i.e. in most cases judged against the PNA). See: <http://psnc.org.uk/contract-it/market-entry-regulations/rural-issues/>

Torbay mapping: Given the predominantly urban nature of Torbay, there are no dispensing doctors within the Torbay boundaries but this is of relevance to neighbouring PNAs.

Dispensing Appliance Contractors

Description: Dispensing Appliance Contractors (DACs) specialise in supplying stoma and continence appliances. Pharmacists may regularly dispense appliances in the course of their business, or they may dispense such prescriptions infrequently, or they may have taken a decision not to dispense them at all. All pharmacy contractors choosing to dispense appliances in the normal course of their business are required to comply with Essential services requirements.

Torbay mapping: A number of contractors were identified during the development of this PNA, most of which are national companies covering a wide geographical area. DACs are unable to supply medicines or provide the range of pharmaceutical services offered by community pharmacy. They are however used by patients in Torbay due to their convenience.

Community pharmacies

Description: A community pharmacy provides pharmaceutical services to people in a local area or community. Every day around 1.6 million people visit a pharmacy in England. Community pharmacists are easily accessible with around 11,400 community pharmacies in England located where people live, shop and work. The latest information shows that 99% of the population – even those living in the most

deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. Many are open long hours when other healthcare professionals are unavailable.

There are several different types and sizes of community pharmacies, ranging from the large chains with shops on every High Street or in edge of town supermarkets, to small individually owned pharmacies in small communities, in the suburbs and often in deprived areas or rural settings.

In recent years community pharmacists have been developing clinical services in addition to the traditional dispensing role to allow better integration and team working with the rest of the NHS. Community pharmacy is consequently a socially inclusive healthcare service providing a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service. Most pharmacies now have a private consultation area specifically for confidential or sensitive discussions. See: <http://psnc.org.uk/psncs-work/about-community-pharmacy/>.

Torbay mapping: In Torbay, pharmaceutical services are mainly provided by community pharmacies. Consequently, the remainder of this section focuses on presenting the findings of the audit of community pharmacists.

FINDINGS OF THE AUDIT - COMMUNITY PHARMACIES IN TORBAY

Introduction

- 9.4 Pharmacies provide an ideal setting for the provision of public health services because they offer easy access, including for people from deprived communities, who may not access other conventional NHS services, and long opening hours. As outlined in Section 3, an online audit of pharmacies was conducted between 25 June 2014 and 11 July 2014. This investigated the facilities and services offered by all 39 pharmacies in Torbay and collected data regarding pharmacy opening hours. The following section summaries the findings of this audit. All 39 pharmacies responded and completed the audit. To help align service provision to need, and identify any gaps in current provision, the data have been presented by locality where relevant (see Section 4 for a description of Torbay's localities). Locality Summary Sheets are provided at the front of this PNA to give an overview of the findings of the Needs Assessment. Each sheet summarises demographic information, health needs and service data. They also attempt to capture any additional local insight regarding factors affecting need, provision or future provision that may have been missed through conventional service mapping. These Summary Sheets are likely to be of greatest use to the NHS England Area Team when reviewing provider applications. It is important to acknowledge that the assessment of current provision is based on the responses given by pharmacies to the pharmacy questionnaire and will therefore be dependent on who has completed the questionnaire on behalf of the pharmacy.
- 9.5 As previously identified, confusion regarding the commissioning organisations and the respective responsibilities for particular commissioned services, resulted in a significant volume of inconsistent and incorrect data in this section. On analysis, and

in consultation with the PNA steering group, this data was determined to materially misrepresent the actual arrangements for commissioned services across the three Local Authority areas. As a result, significant sections of this data were excluded from the final PNA report due to concerns that this may incorrectly report availability of services and to alleviate the risk of misrepresentation of need.

Overview of pharmacies in Torbay

- 9.5 There are a total of 39 pharmacies in Torbay, providing a service to a population of 131,492¹⁷. Of these, just over a quarter are Boots pharmacies (10) and just under a quarter (8) are Day Lewis pharmacies, with the remaining 21 being made up of a range of other providers. The pharmacies are spread across the Torbay Council area (see Table 59 and Figure 7), and offer a range of facilities and services to the resident population.
- 9.6 The area with greater health needs (Torquay), has a greater density of pharmacies for its population than Paignton and Brixham which reflects the potential demand for pharmacy based services in each locality (see Table 59).

Table 59: Number of pharmacies by Locality

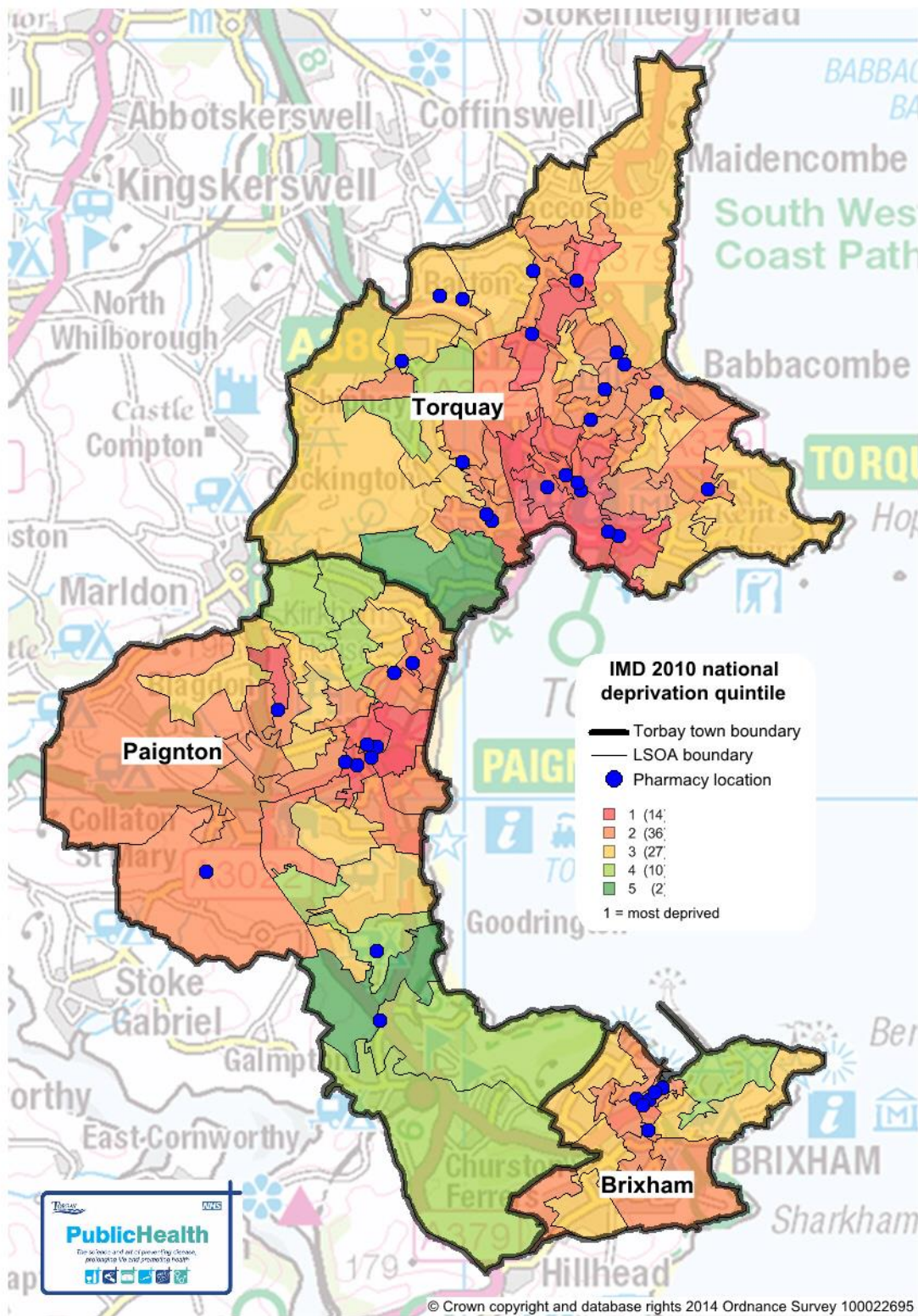
Locality	Number of Pharmacies	Population	Population per pharmacy
Torquay	21	65,500	3,119
Paignton & Brixham	18	69,300	3,850
Torbay	39	131,500*	3,372

*The Torbay population will not be equal to the sum of the two localities; this is due to the individual locality boundaries being slightly larger than the Local Authority Footprint, and therefore having slightly higher population values.

- 9.7 Figure 7 below demonstrates that pharmacies in Torbay are generally located in areas where deprivation is greatest. The most deprived areas of Torbay are Torquay town centre, Hele and Watcombe in North Torquay and Paignton town centre.

¹⁷ ONS 2012 mid-year population estimate

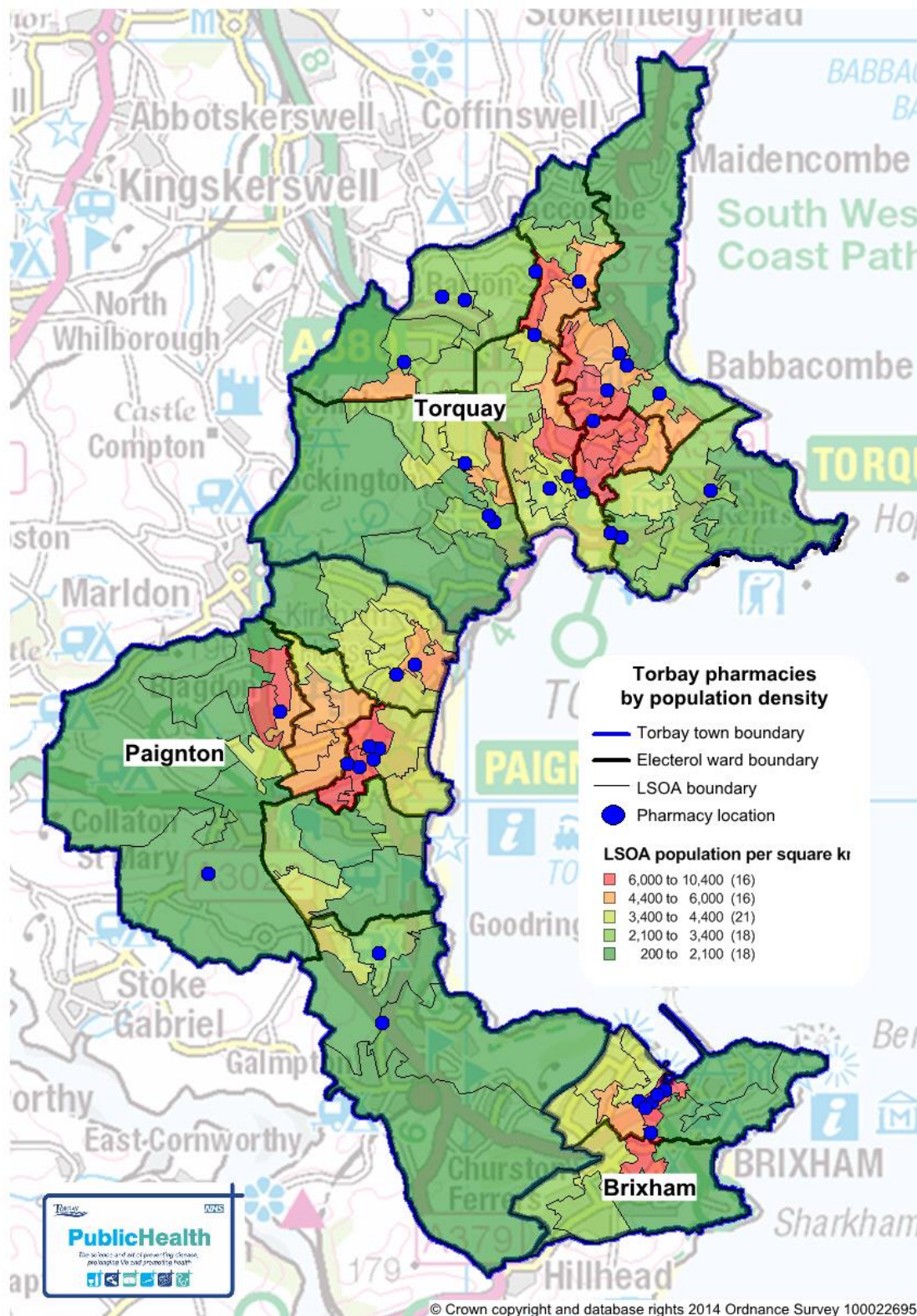
Figure 7: Pharmacy locations in Torbay by LSOA deprivation quintile



Source: English Index of Multiple Deprivation 2010, Department for Communities and Local Government

9.8 Figure 8 below shows that the locations of pharmacies in Torbay are generally centred around the areas of greater population density¹⁸.

Figure 8: Pharmacy locations mapped against population density



¹⁸ LSOA level population density based on information from the 2011 census.

Community Pharmacy opening Times

Definition: NHS England is responsible for administering opening hours for pharmacies. For Torbay, this is overseen by the NHS England Area Team.

A pharmacy has:

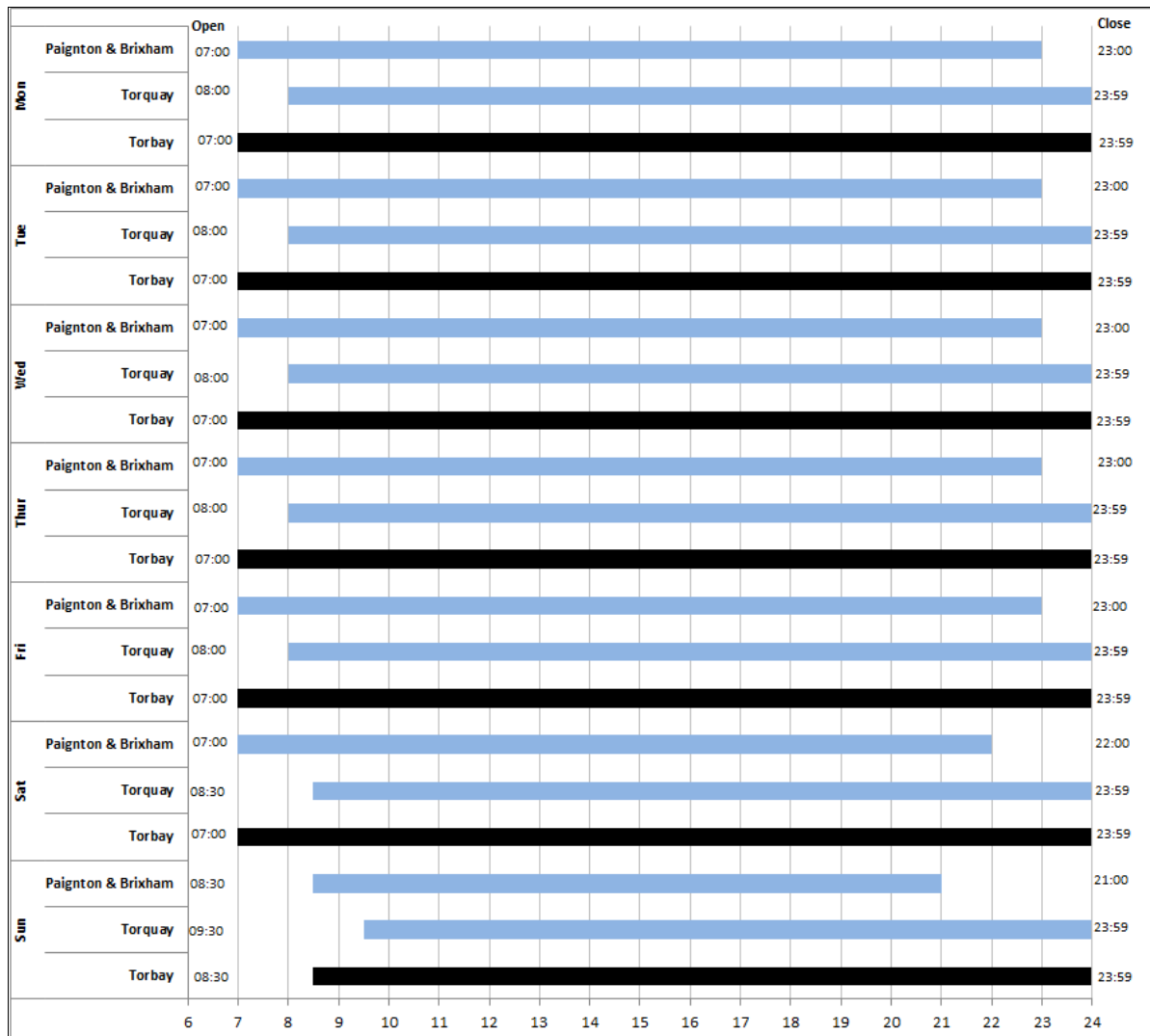
- A minimum of 40 core contractual hours (or 100 for those that have opened under the former exemption from the control of entry test), which cannot be amended without the consent of NHS England.
- Supplementary hours (i.e. all the additional opening hours) which can be amended by the pharmacy subject to giving 90 days' notice (or less if NHS England consents).

A pharmacy may also have more than 40 core hours if approved by NHS England. In this case, the pharmacy cannot amend these hours without the consent of NHS England. There is also a provision which allows a pharmacy to apply to open for less than 40 hours, but if the Area Team does grant such an application, it can specify which opening hours the pharmacy must open.

In addition to regular opening hours, an Area Team can commission an out-of-hours Enhanced service. For many pharmacies, participation in such arrangements is voluntary with the exception of 100 hour pharmacies, those in approved large retail areas, and those in one stop Primary Care Centres, which may be required to provide any Advanced or Enhanced Services, that were agreed during the course of the application, where the Area Team commissions the service.

- 9.9 The coverage of opening times (earliest opening and latest closing) for Torbay and each of its Localities is shown in Figure 9 below.

Figure 9: Coverage of opening times (earliest opening and latest closing) for Torbay and each of its Localities by day of week.



9.10 It can be seen that for Monday through to Friday, long pharmacy opening times are operational in both localities, with the earliest opening time and latest closing time being 07.00 to 23.59. In Torquay Monday to Friday, all pharmacies are open from 08:00 – 12:30 and most are open from 14:30 – 17:00. There remains approximately 50% provision until 18:00, whereby access then becomes more limited to 2 pharmacies, with only 1 open beyond 20:00. In Paignton and Brixham there is access to a pharmacy from 07:00 every day except for Sunday when access is from 08:30.

Weekend opening hours are shorter:

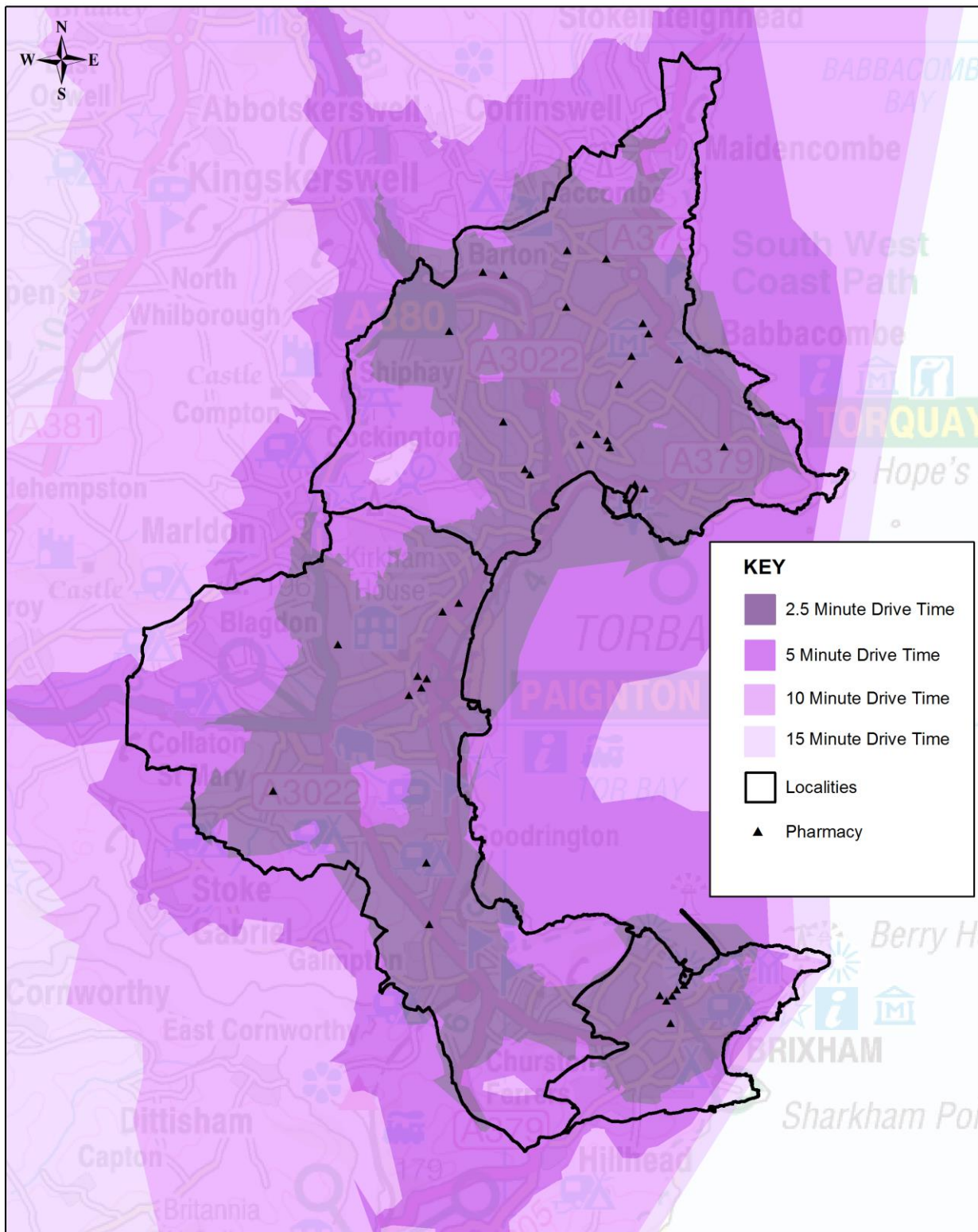
- On Saturday there is provision from 07:00 in Paignton and Brixham and from 08:30 in Torquay. Access ceases at 22:00 in Paignton and Brixham and from 23:59 in Torquay.
- On Sunday there is provision from 08:30 in Paignton and Brixham and from 09:30 in Torquay. Access ceases at 21:00 in Paignton and Brixham and from 23:59 in Torquay.

OPENING TIMES - KEY OBSERVATIONS: Both localities have wide ranging opening times and no locality appears to be deprived of access to an open pharmacy during key hours.

Accessibility

- 9.11 In order to assess how accessible pharmacies are to the population, a 'drive time' analysis has been conducted to show how long it takes people to get to their nearest pharmacy and is shown in Figures 10 to 14 below. Access to pharmacies across Devon is variable according to rurality however in Torbay all pharmacies are accessible within a 15 minutes' drive time even on Sundays or in the evening after 8pm. During weekdays, the more populous areas of Torbay can access pharmacies within 2.5 minutes' will the vast majority of the locality covered within a 5 minute drive (Figure 10). During evenings after 8pm, there is more limited number of available pharmacies although these remain within a 15 minute drive (Figure 11). On Saturdays there are only minimal extremities that mean a pharmacy is not accessible within 10 minutes (Figure 12). Sunday access to pharmacies is within 15 minutes (Figure 13). Nationally, 99% of the population are within 20 minutes travel time of a community pharmacy with 96% walking or by public transport.
- 9.12 Figure 14 shows the main public transport routes (bus, train and ferry) for Torbay. A number of bus operators work across the bay providing a good alternative means of accessing pharmaceutical services for those who do not have access to a car or van.

Figure 10: 'Drive Time' map to pharmacies in Torbay during weekdays



 **Public Health Devon**

 **Devon County Council**

0 875 1,750 3,500 Meters

Map Title: Drivetime to Nearest Pharmacy -Torbay (Weekday)

Author: Devon PHIT

Date: 16 February 2015


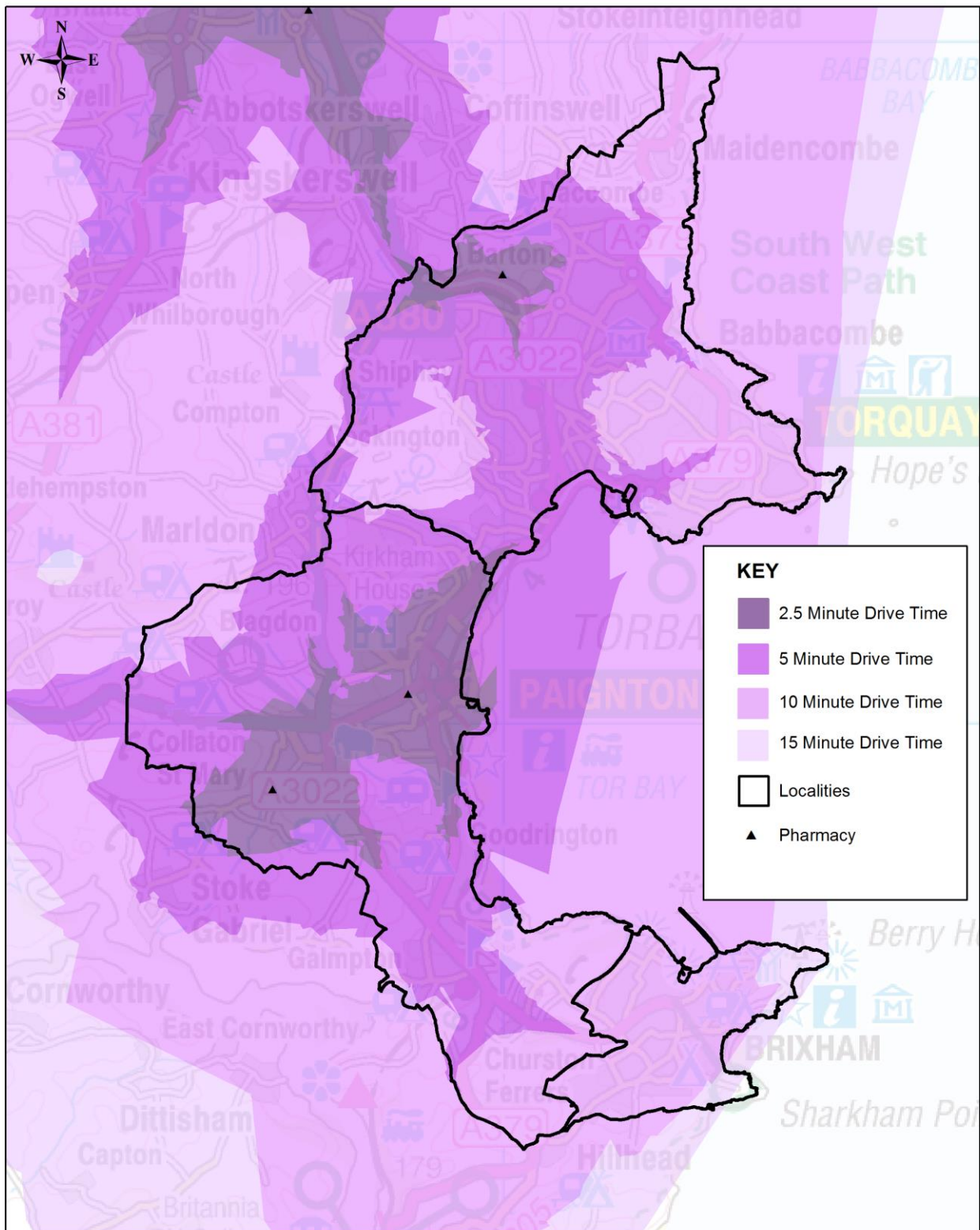
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Figure 11: 'Drive Time' map to pharmacies in Torbay – Evenings



Public Health Devon

Devon County Council

0 875 1,750 3,500 Meters

Map Title: Drivetime to Nearest Pharmacy -Torbay (Weekday after 8pm)

Author: Devon PHIT

Date: 16 February 2015


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Figure 12: 'Drive Time' map to pharmacies in Torbay – Saturday

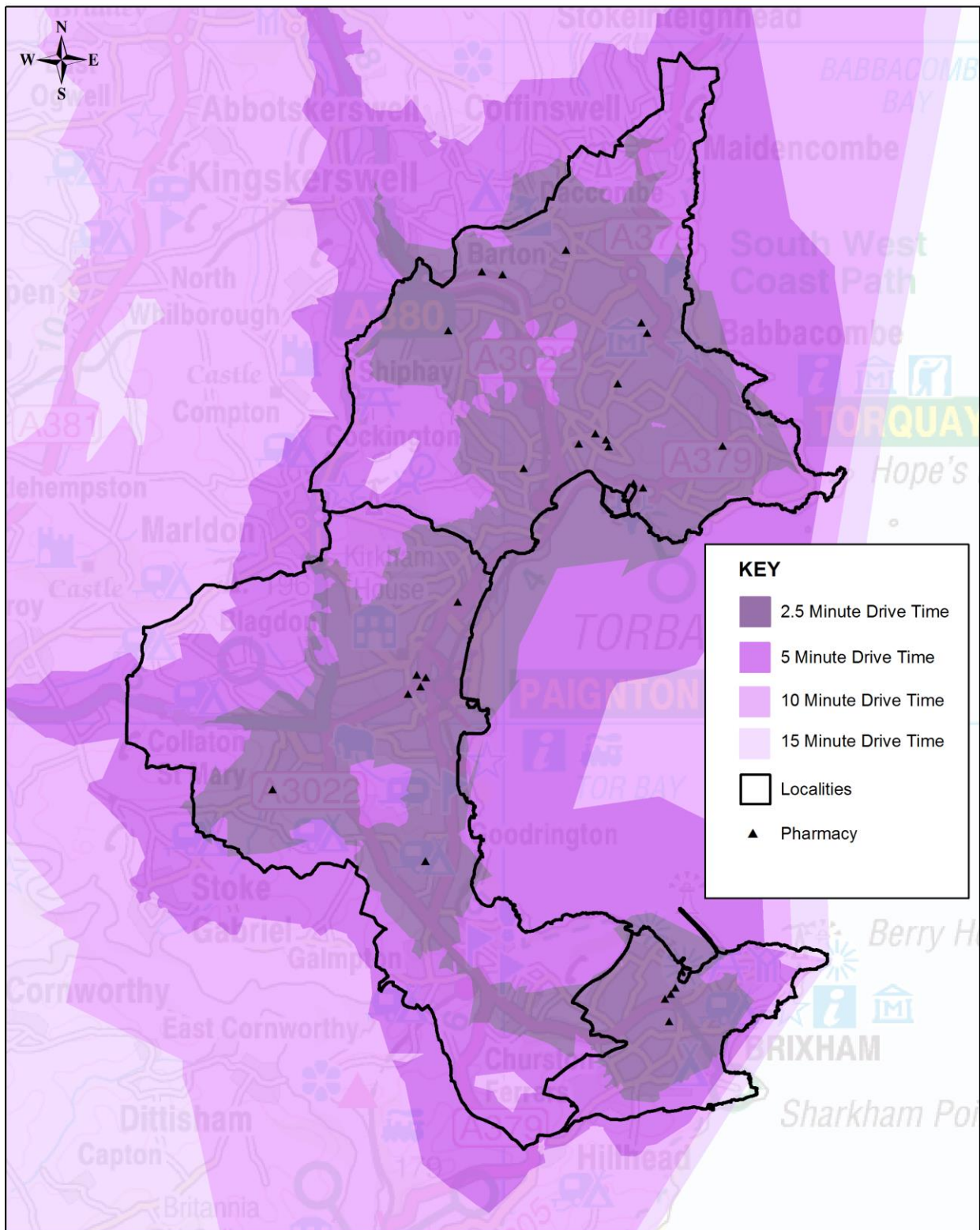
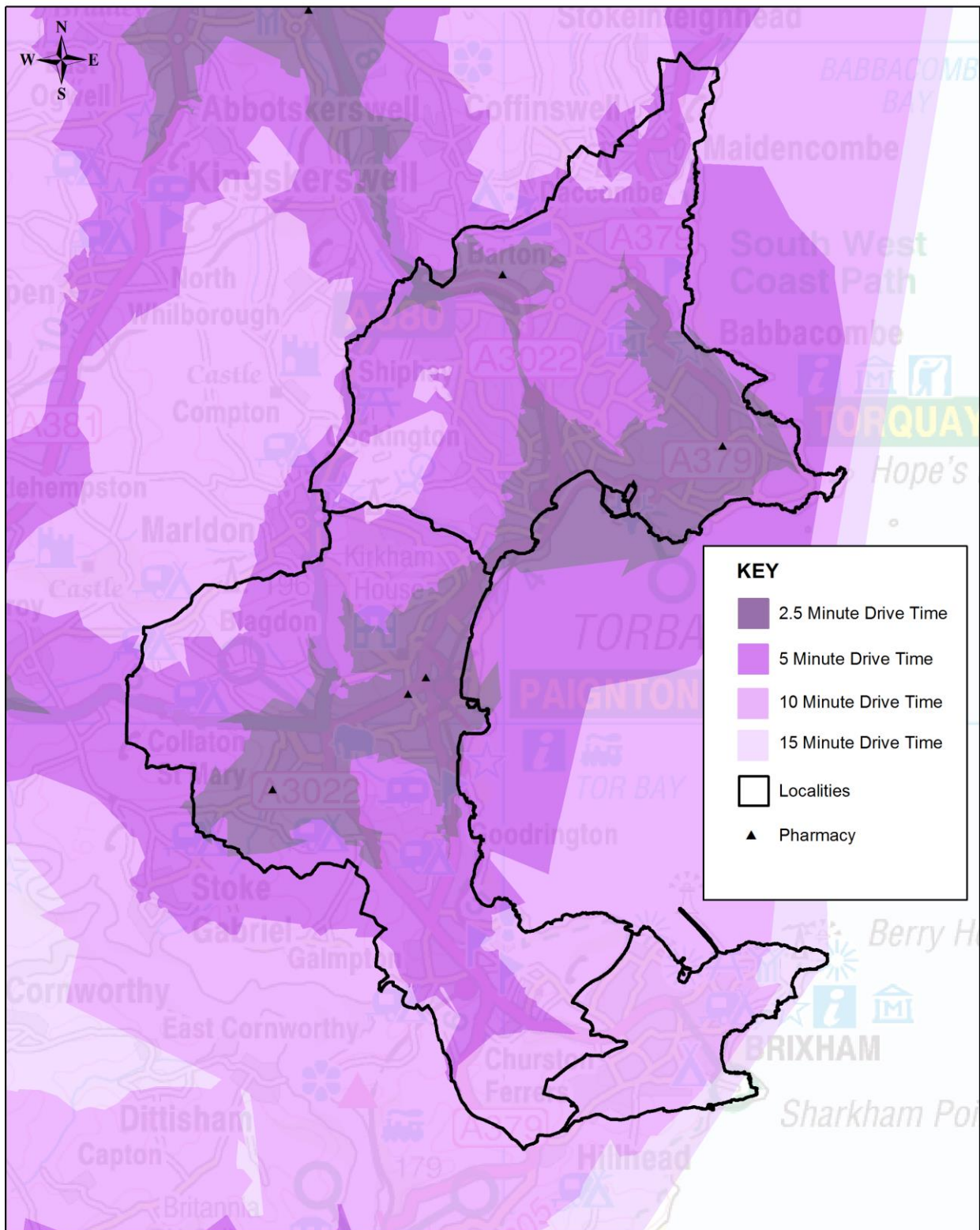


Figure 13: 'Drive Time' map to pharmacies in Torbay - Sunday



Public Health Devon

Devon County Council

0 875 1,750 3,500 Meters

Map Title: Drivetime to Nearest Pharmacy -Torbay (Sunday)

Author: Devon PHIT

Date: 16 February 2015


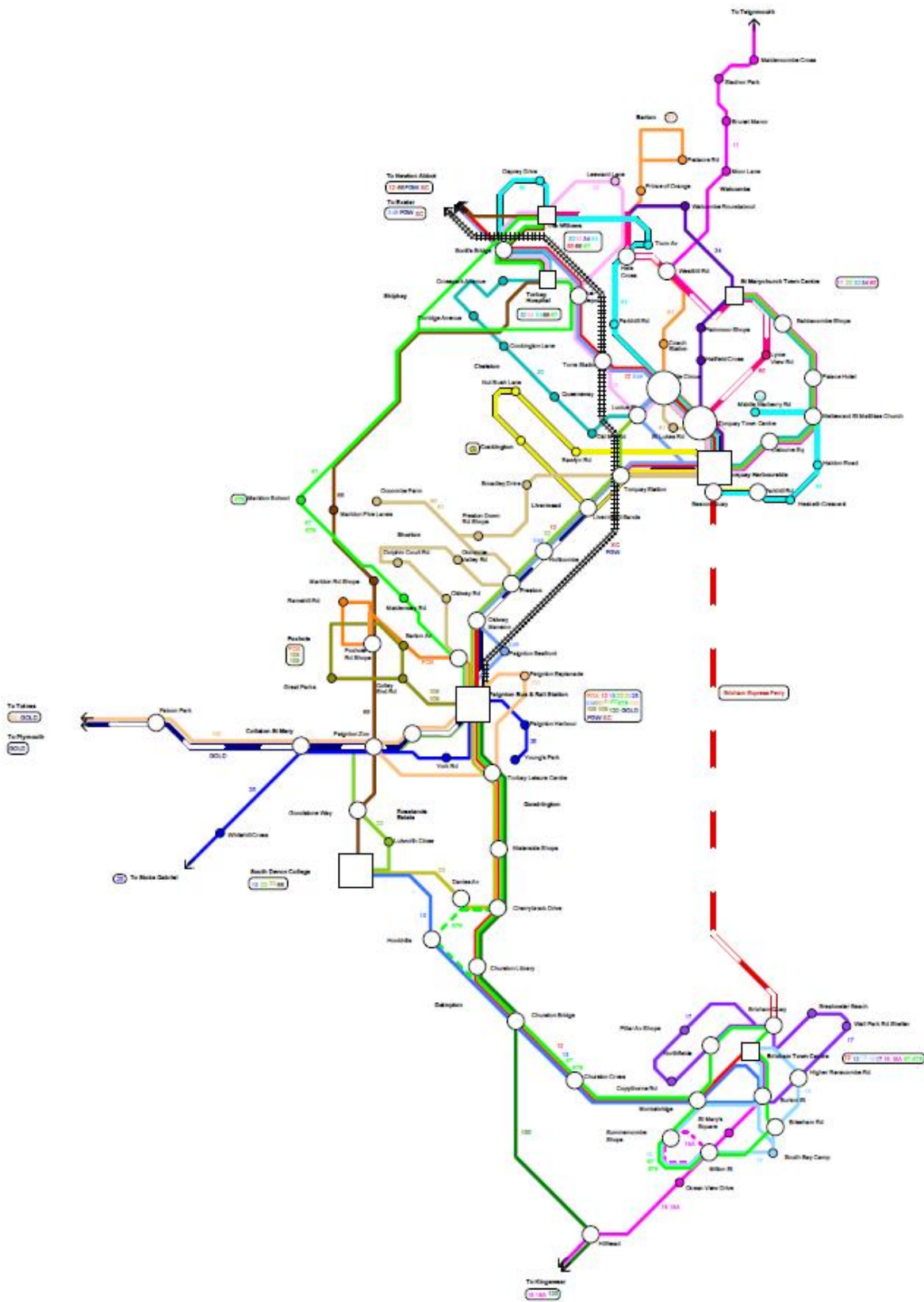
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Figure 14: Public transport routes in Torbay (accurate at 03/10/14)



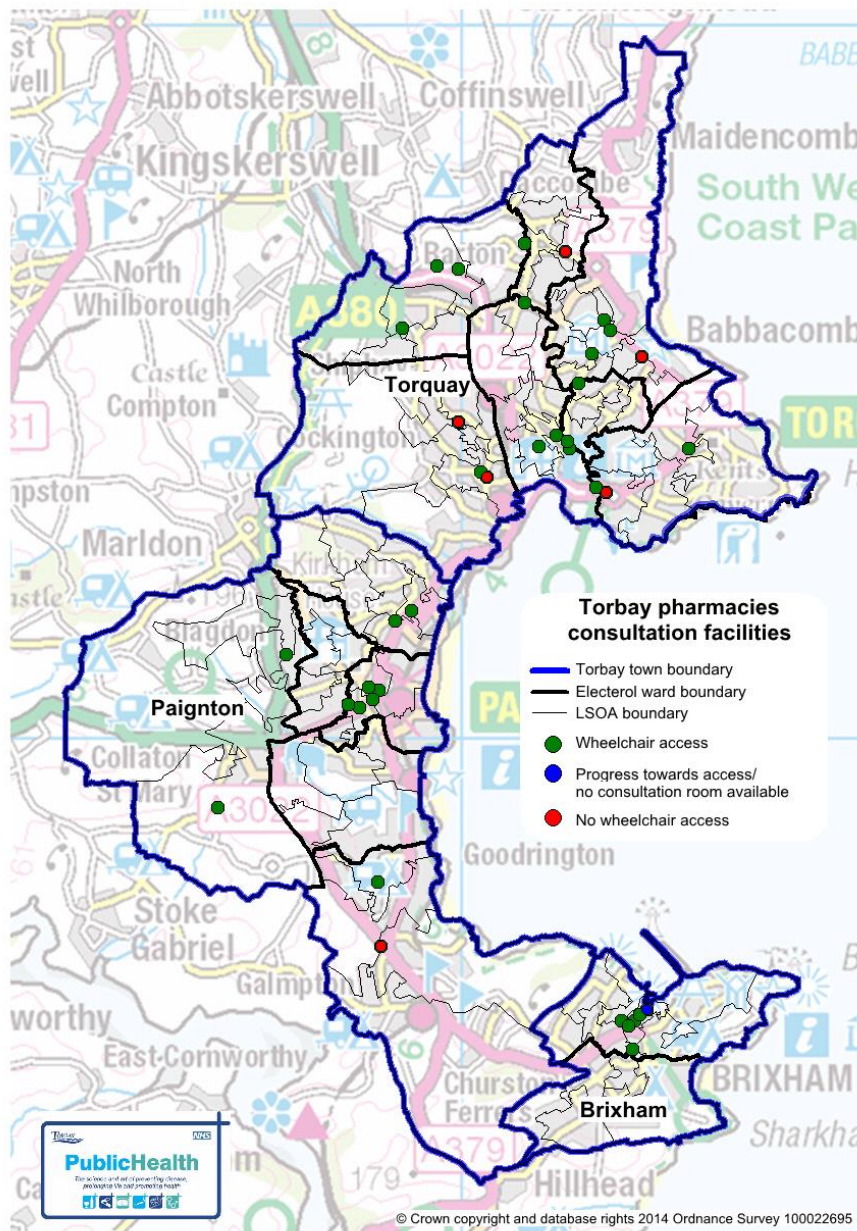
Source: Spatial Planning, Torbay Council (accurate at 03/10/14)

ACCESSING PHARMACIES - KEY OBSERVATIONS: Most Torbay pharmacies are accessible by car in 5 minutes, although drive times are extended at the earliest and latest points of the day or at weekends when only certain pharmacies will be open. Public transport routes provide reasonable alternative to accessing pharmaceutical services although again are likely to be impacted at the extremes of opening and closing times.

Availability and accessibility of pharmacy consultation facilities

9.13 All except one of Torbay’s pharmacies have enclosed consultation facilities (a discrete area for one to one appointments in private), this pharmacy being based in the Paignton and Brixham locality. Disabled access to consultation facilities is available in 82.1% of pharmacies, the locations of which are shown in Figure 15 below:

Figure 15: Availability and accessibility of consultation rooms



9.14 All Torquay based pharmacies have on site consultation facilities (see Table 59). 16 (76%) are accessible by wheelchair users (see Table 60). All of these consultation areas are enclosed. Almost 60% of Torquay pharmacies do not offer off-site consultations (see Table 61). 8 (38%) are willing to undertake consultations away from the pharmacy and one has an NHS approved offsite consultation facility. All but 1 pharmacy offers prescription collection services from GP practices (see Table 62).

All but one in Paignton and Brixham based pharmacies have on site consultation facilities (see Table 60), with this pharmacy planning to have this in place within 6 months. 16 (89%) are accessible by wheelchair users (see Table 61). In all those pharmacies who have a consultation area, they are enclosed. 50% of Paignton and Brixham pharmacies do offer non-contracted off-site consultations, although almost an equal proportion do not (N=8; 44%) (see Table 62). One is willing to provide telephone consultations, but provides none currently. All but 1 pharmacy offers prescription collection services from GP practices (see Table 63).

Table 60: Number of pharmacies with consultation facilities

Locality	Number of Pharmacies with consultation facilities	Number of Pharmacies with no consultation facilities	Total
Torquay	21	0	21
Paignton & Brixham	17	1	18
Total	38	1	39

Table 61: Number of pharmacies with wheelchair access

Locality	Number of Pharmacies who have wheelchair access	Number of Pharmacies who do not have wheelchair access	Total
Torquay	16	5	21
Paignton & Brixham	16	2	18
Total	32	7	39

Table 62: Number of pharmacies who are willing to undertake consultations away from the pharmacy

Locality	Number of Pharmacies with arrangements for offsite consultations	Number of Pharmacies without arrangements for offsite consultations	Total
Torquay	9	12	21
Paignton & Brixham	9	9	18
Total	18	21	39

Table 63: Number of pharmacies who offer prescription collection services from GP practices

Locality	Number of Pharmacies offering prescription collection services	Number of Pharmacies not offering prescription collection services	Total
Torquay	20	1	21
Paignton & Brixham	17	1	18
Total	37	2	39

Hand washing facilities

- 9.15 All but two Torquay pharmacies have access to hand washing facilities either in, or close to the consultation area (90%). 15 or 83% of Paignton and Brixham pharmacies have access to hand washing facilities either in, or close to the consultation area (Table 64).

Table 64: Number of pharmacies with hand washing facilities by Locality

Locality	In consultation area	Close to consultation area	None	Total
Torquay	13	6	2	21
Paignton & Brixham	9	6	3	18
Total	24	12	5	39

PHARMACY CONSULTATION FACILITIES - KEY OBSERVATIONS: Provision of consultation facilities across Torbay is very good, with the majority providing disabled access. Just under half the pharmacies across Torbay offer off-site consultations. Given that the largest increase in Torbay's population will be seen in 65+ year olds (page 30), there is likely to be increased demand for off-site provision beyond what is already provided. Nearly all pharmacies operate a prescription collection service from GP practices. Most pharmacies have hand washing facilities either in, or close to, the consultation area.

Information technology

Electronic Prescription Service Release 2 (EPS R2)

- 9.16 EPS enables prescribers such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff¹⁹. All pharmacies (39) are EPS R2 enabled.

¹⁹ <http://systems.hscic.gov.uk/eps>

Unrestricted internet access

- 9.17 26 of 39 pharmacies in Torbay have unrestricted internet access (Table 65). 15 (71%) of Torquay pharmacies and 11 (61%) of Paignton and Brixham pharmacies have unrestricted access to the internet. 18 of the 39 pharmacies (46%) have use of a secure nhs.net email account (Table 66). 11 (52%) are in Torquay and 7 (39%) are in Paignton & Brixham. It should be noted that in some cases access to a secure nhs.net email account is not directly the responsibility of the provider and can, in some cases, be a result of the structure of the nhs.net mail system rather than contractor choice to not engage.

Table 65: Number of pharmacies who have unrestricted internet access by Locality

Locality	Unrestricted internet access	Restricted internet access	Total
Torquay	15	6	21
Paignton & Brixham	11	7	18
Total	26	13	39

Table 66: Number of pharmacies who use a secure nhs.net account by Locality

Locality	Number of pharmacies using a secure nhs.net account	Number of pharmacies not using a secure nhs.net account	Total
Torquay	11	10	21
Paignton & Brixham	7	11	18
Total	18	21	39

INTERNET ACCESS AND EMAIL USAGE - KEY OBSERVATIONS: All pharmacies in Torbay have access to the electronic prescription service. However, less than half the pharmacies report using the NHSmail secure email service, which may reflect problems inherent in current NHSmail arrangements that create barriers to pharmacy uptake and use of the service.

Essential services - Appliance contractors

- 9.18 It is a legal requirement for all pharmacies to provide Essential Services (see Section 9.2 for details). As part of the audit, pharmacies were asked if they dispense stoma appliances, incontinence appliances and dressings. The significant majority of, but not all, pharmacies (27 out of 39) offer all three types of service. 62% of all Torquay pharmacies dispense all types of appliances. Only 1 (5%) does not dispense any appliances. 24% (N=5) dispense just dressings. 2 do not dispense incontinence appliances and finally 1 does not dispense stoma's. 78% of all Paignton and Brixham pharmacies dispense all types of appliances. 11% (N=2) dispense just dressings. 1 does not dispense incontinence or stoma appliances and 1 only dispenses dressing and stomas.

Advanced Services

Advanced Services (1) - Medicines Use Review (MUR) Service and New Medicine Service (NMS)

9.19 The Medicines Use Review service and the New Medicine Service offered by pharmacies are an advanced service to check how an individual is getting on with their medicine, which is particularly useful for people who regularly take several prescription medicines or have a long-term illness²⁰. It is a confidential service that helps people to find out more about their medicine, identify any problems they may have with taking their medicine as intended, and help them take their medicine to best effect. Currently 38 out of 39 pharmacies offer both MUR services, with the remaining outstanding pharmacy, based in Paignton and Brixham locality planning on introducing this service soon. Similarly, 37 out of 39 pharmacies offer the New Medicine Service, with the two remaining planning to introduce these services soon (there is one outstanding in each locality).

Advanced Services (2) - Appliance Use Review (AUR) service

9.20 Appliance Use Review (AUR) is the second advanced service being introduced into the NHS community pharmacy contract. AURs can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance'²¹ by:

- Establishing the way the patient uses the appliance and the patient's experience of such use
- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

This service is currently only offered by three pharmacies, with two more planning to offer it soon. However, it should be acknowledged that a number of pharmacy contractors would use a centralised appliance contractor to provide these services although the pharmacy survey did not establish how many pharmacies use a third party to supply them. In addition it has not been established as part of this PNA is the willingness of existing pharmacies who do not currently provide this service, to provide it should they be requested and subsequently commissioned to do so.

Advanced Services (3) - Stoma appliance customisation (SAC)

9.21 Stoma Appliance Customisation (SAC) is the third Advanced service in the NHS community pharmacy contract. The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The

²⁰ <http://www.npa.co.uk/nms>

²¹ <http://psnc.org.uk/services-commissioning/advanced-services/aur/>

stoma appliances that can be customised are listed in Part IXC of the Drug Tariff. Currently, only 4 of the 39 pharmacies offer a SAC service, with two of the remaining 35 planning to introduce this service soon (Table 67). However, it should be acknowledged that a number of pharmacy contractors would use a centralised appliance contractor to provide these services although the pharmacy survey did not establish how many pharmacies use a third party to supply them. In addition it has not been established as part of this PNA is the willingness of existing pharmacies who do not currently provide this service, to provide it should they be requested and subsequently commissioned to do so.

Table 67: Number and percentage of pharmacies offering SAC by Torbay Locality

Locality	Offered	Not Offered	Offered Soon	Total	Percentage offered
Torquay	2	18	1	21	10%
Paignton and Brixham	2	15	1	18	11%
Torbay	4	33	2	39	10%

Due to the very small numbers offering SAC services, no further mapping of this provision has been undertaken.

NHS PHARMACEUTICAL SERVICES PROVISION - KEY OBSERVATIONS: 69% of pharmacies (27 out of 39) dispense stoma appliances, incontinence appliances and dressings across Torbay. Dispensing is higher in Paignton and Brixham (78%), than in Torquay (62%). There is very good provision of Medicines Use Review and the New Medicine Service. Appliance Use Review (AUR) is currently offered by three pharmacies in Torbay (two are located in Paignton and Brixham and one in Torquay). Only 10% of pharmacies offer Stoma Appliance Customisation, with limited availability of this service across both localities. However the use of centralised contactors and the willingness to provide these services by existing pharmacies who are not currently providing them has not been determined.

Locally commissioned services

9.22 As highlighted previously, locally provided services can be commissioned by different organisations. These can be Enhanced Services commissioned by the NHS England Area Team or public health services commissioned by Torbay Council or the South Devon and Torbay Clinical Commissioning Group (CCG). Some services are also provided by the private sector. As part of the audit, for a list of locally provided services, pharmacies were asked to indicate whether they were:

- currently providing an NHS funded service
- currently providing a private service
- willing and able to provide the service (but weren't currently)
- willing to provide it if commissioned but would require training
- willing to provide it if commissioned but would require adjustment of facilities
- not willing to provide the service

There were some inconsistencies in the data regarding pharmacies responses to the above questions and known commissioning or provider arrangements. This is likely to reflect poor question wording (see learning points, page 22) and confusion amongst pharmacists regarding recent changes to commissioning arrangements. For these reasons, the responses to these questions have not been included. Instead an overview of services currently commissioned in Torbay, based on information obtained from NHS England and Torbay Council, is provided below:

The following Enhanced service is commissioned by NHS England (only NHS England can commission Enhanced services):

- Extended hours of opening - NHS England currently commissions an Out of Hours Enhanced Service to pharmacies in Torbay during holiday periods; this service is generally used to ensure patients have good access to pharmaceutical services over Christmas/New Year and Easter.

The following locally commissioned services are commissioned by Torbay Council:

- Smoking cessation counselling
- Nicotine Replacement Therapy (NRT)
- Chlamydia screening
- Chlamydia treatment
- Emergency Hormonal Contraception Service
- Needle and Syringe Exchange Service
- Supervised Administration Service (also known as Supervised Consumption)

The following locally commissioned services are commissioned by the South Devon and Torbay Clinical Commissioning Group (accurate for 2014/15; services are reviewed annually):

- Minor Ailments Scheme (free consultation and prescription treatment for a range of health conditions)
- Winter Ailments Scheme (ensures patients can access free self-care advice and prescription treatment for winter ailments)
- Emergency Supply of Medicine (patients can access an urgent supply of their regular prescription medicines)

9.23 Some additional services, such as home delivery or travel vaccinations, are offered by private providers. These services are not listed here as it was not possible to obtain accurate information regarding this provision.

LOCALLY PROVIDED SERVICES PROVISION - KEY OBSERVATIONS: The following services are commissioned locally by NHS England, South Devon and Torbay Clinical Commissioning Group or Torbay Council: extended hours of opening at holiday periods, smoking cessation counselling and Nicotine Replacement Therapy (NRT), chlamydia screening, chlamydia treatment, Emergency Hormonal Contraception Service, Needle and Syringe Exchange Service, Supervised Administration Service (also known as Supervised Consumption), Minor Ailments Scheme, Winter Ailments Scheme, Emergency Supply of Medicine. Some additional services are offered by private providers.

Community pharmacy collection and delivery services

- 9.24 All but one of the pharmacies in Torbay offer a collection of prescription from GP surgeries and again all but one (not the same as the previous one) offer delivery of dispensed medicines free of charge on request. The patient groups that this applies to varies between pharmacies, with a couple offering delivery to all patients, with the most common groups being the elderly, housebound, or where access to urgent medication is required. The area that pharmacies would deliver to also varied, with some offering to the whole of Torbay, and others to patients in either in one of the localities or specified radius (e.g. two-three miles).
- 9.25 The percentage of households without access to a car across Torbay (18.2%) is lower than the England average (19.5%). Torquay is slightly higher than the national average with 20.1% without access to a car, whereas Paignton and Brixham is considerably lower with only 15.9% with no access to a car.

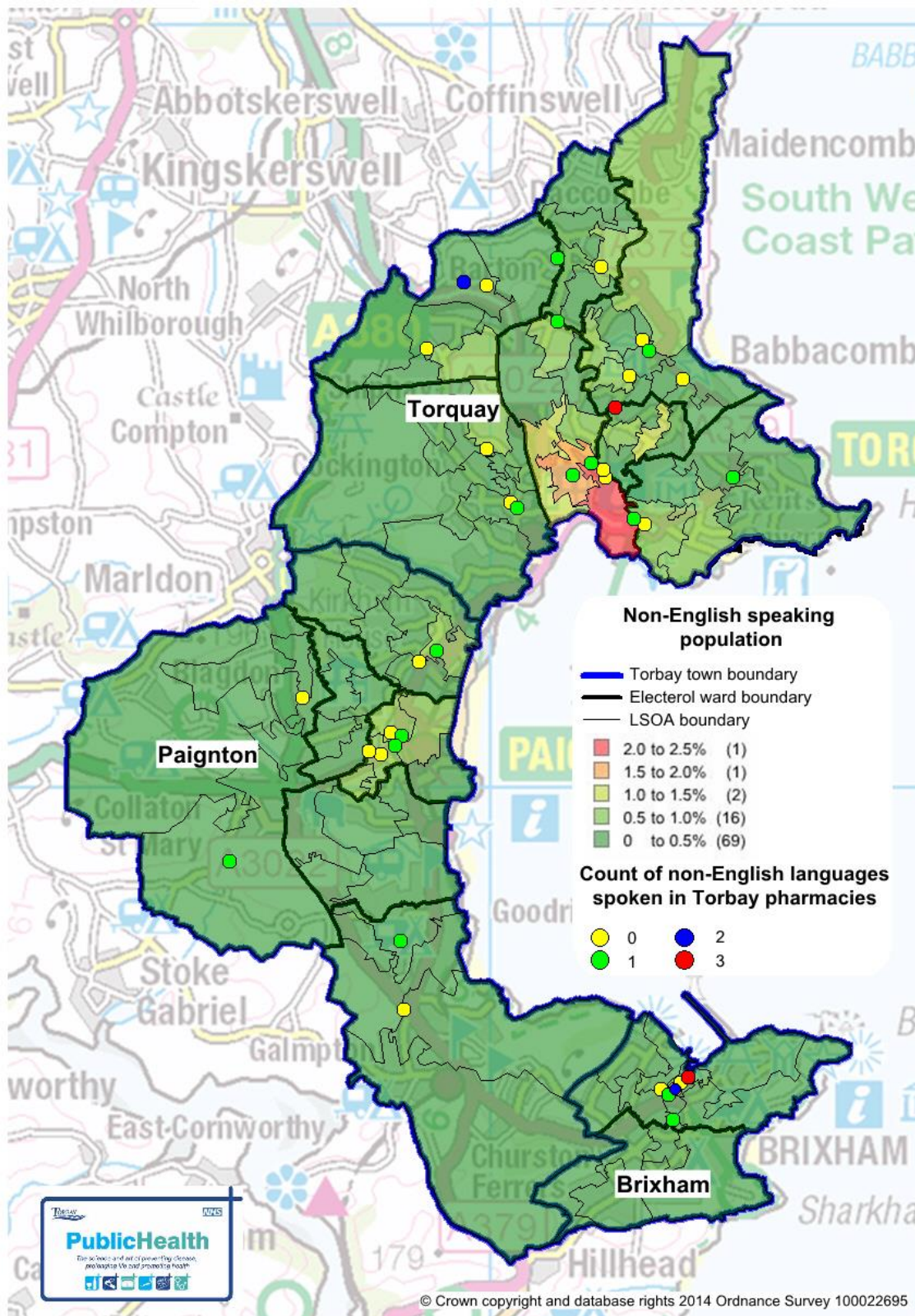
COLLECTION AND DELIVERY SERVICES - KEY OBSERVATIONS: All but one pharmacy offers a collection of prescription from their GP and delivery of dispensed medicines free of charge on request. Therefore whilst Torquay has a slightly higher proportion (one in five) without access to a car than the national average, there is good provision of home delivery services.

Languages

- 9.26 Based on information from the 2011 census, an estimated 885 households in Torbay (1.5% of the overall number of households) either have no one, or no one over 16 who speaks English as a first language. One or more second languages was spoken by 19 out of 39 pharmacies, though in some cases this was only the case for part of the working week dependent of locum staff working patterns. The most common language spoken was Polish (7 pharmacies), followed by Spanish (four pharmacies), Hindi (two pharmacies), Portuguese, Tamil, Malayalam, German, Punjabi, Gujrati, Romanian, Gaelic, Bulgarian, Nigerian and French (one pharmacy – although not exclusively one pharmacy).

As can be seen in Figure 17 there is very little of the population in Torbay that cannot speak English, with only areas in the ward of Tormohun (Torquay) having more than 1.5% of the population that cannot speak English or speak English well.

Figure 16: Map showing the percentage of population that cannot speak English, or cannot speak English well by LSOA and the location of multi-lingual pharmacies.



LANGUAGES - KEY OBSERVATIONS: The proportion of the population who cannot speak English, or cannot speak English well is almost distinctly confined to Torquay town centre (Tormohun ward). Non-English-speaking patients typically receive fewer preventative services and have less access to health care than English-speaking patients. Consequently, any barriers to provision for these population groups should be addressed. Torquay town centre does have some access to pharmacies where staff can speak one non-English language but interestingly Brixham has the greatest prevalence of staff who can speak one or more non-English languages.

Pharmacy identified priorities for improving pharmaceutical services

9.27 A total of 22 pharmacies provided information on their top priorities, making a total of 53 suggestions. This means a total of 56% of pharmacies provided one or more priorities. As a result, what is represented in this section cannot be used as being representative of all pharmacies in Torbay, but indicates the priorities of those who responded. The most common themes for priorities for improving pharmaceutical services are:

- Access to minor ailment scheme (9 mentions)
- Increasing the range, access to or appropriateness of commissioned services (9 mentions)
- There were a number of mentions to prioritising already commissioned services (4 mentions) (e.g. Supervised Consumption, Chlamydia, Needle Exchange and EHC) although there was clearly confusion regarding the existing commissioning of these services
- Improved communication with GP surgeries (4 mentions)
- More resources to manage medicines compliance (3 mentions)
- More staff or larger facilities (5 mentions)
- Other health related illnesses: smoking (1), asthma/COPD (2), obesity / Fitness (2), Alcohol (1)
- Other (16 mentions)

In addition to the above categories, a range of other priorities were mentioned, including:

- Information on services (either being or available to be delivered)
- Medicine reviews for the housebound
- NHS care homes service
- Urgent access to repeat medication (2 mentions)
- Improved communication with Health services
- Improved out of hours access
- Recognition of locum qualifications received out of area
- Improved CCG links (2 mentions)
- First aid being funded by the CCG

- Travel vaccinations
- Flu vaccinations
- Closer links to patient support groups
- Improved DDS/Medisure
- Patient registration and access to patient records

PHARMACY IDENTIFIED PRIORITIES - KEY OBSERVATIONS: The three most prominent themes that emerged from the priorities identified by pharmacies were relating to access to the minor ailment scheme; increasing the range, access to or appropriateness of commissioned services; and to prioritising already commissioned services (although there was clearly inconsistency with regards to understanding of the new commissioning landscape – as also borne out by the commissioned services audit). However it must be noted that not all pharmacies responded, and therefore cannot be taken as a fully representative sample of the entire pharmacy population in Torbay.

10. OUTCOMES OF CONSULTATION PROCESS

Overview of the consultation process

- 10.1 As outlined in Section 3.15, the consultation period ran from Monday 17 November 2014 to Friday 16 January 2015. The Health and Wellbeing Boards (HWBs) for Plymouth, Devon and Torbay ran the consultation for each of their PNAs at the same time using the same consultation process. This was to aid organisations who were asked to respond to consultations for more than one area at the same time.
- 10.2 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.
- 10.3 The consultation was hosted online by Plymouth City Council on behalf of Plymouth, Devon and Torbay. Three web links were created which enabled consultees to view a PDF of the relevant PNA report and access a short online survey (see Appendix 3). The survey questions were designed to gather feedback on each section of the report. The web link(s) for Plymouth, Devon and/or Torbay were emailed directly to the following individuals and/or organisations as applicable:

http://plymouth.consult.limehouse.co.uk/public/public_health/pna_torbay

- 10.4 The PNAs and consultation surveys were available as hard copies upon request. General comments (sent direct via email to the Public Health Teams involved in producing the PNAs) were also welcomed as part of the consultation.

Number of responses to the consultation

- 10.4 Four individuals completed the online consultation survey for Torbay. These individuals represented:
- A pharmacist (one response)
 - The Clinical and Effectiveness and Medicines Optimisations Team for the NHS NEW Devon Clinical Commissioning Group (one response)
 - The Devon Local Pharmaceutical Committee (one response)
 - The Medicines Management Team for Devon Partnership Trust (one response)
- 10.5 An additional two responses were sent directly via:
- an email from the Medicines Governance & Community Pharmacy Development Lead for the Clinical Effectiveness and Medicines Optimisation Teams for NHS NEW Devon and South Devon & Torbay Clinical Commissioning Groups - this email contained feedback pertinent to all three areas and was forwarded to the Devon and Torbay Public Health Teams
 - an email with attached letter received from the Director of Commissioning for the NHS England Devon, Cornwall & Isles of Scilly Area Team - this was sent to all three Public Health Teams regarding all three PNAs

Summary of feedback received

- 10.6 Overall, the feedback received covered most sections of the PNA in their totality, although feedback was varied and mixed in the direction of preference for the changes requested. The feedback can be summarised into the following main categories:
- Spelling and grammatical errors or inconsistencies.
 - Omissions of data and / or additional services.
 - Confusing or difficult to navigate through the document.
 - Future needs were not adequately addressed.
 - Omission of statements of adequacy for pharmaceutical services provision in each locality.
- 10.7 On 13 January 2015, the PNA Steering Group met to review and agree the process for managing all consultation feedback received. The PNA Steering Group agreed that the following summary actions should be undertaken in respect of each piece of feedback received:
- Make requested changes.
 - Acknowledge request but not implement due to being outside the scope of the PNA.
 - Acknowledge request but not implement due to the PNA Steering Group assessing that it has been adequately addressed already in the PNA.
 - Acknowledge request but not implement due to information or data not being available at time of production of the PNA.

11. POTENTIAL FUTURE PROVISION OF PHARMACEUTICAL SERVICES

Introduction

11.1 This section identifies either known or potential future needs for pharmaceutical services in Torbay and outlines what is known about the future direction of pharmacy which may impact on current service provision across the Peninsula.

Potential future needs in Torbay

11.2 Torbay's growing population (see Table 4) means that the overall demand for pharmaceutical services will continue to grow, particularly for services relating to the older age groups. For example, it is predicted that the number of 65+ year olds in Torbay will increase by 33% from 2014 to 2030.

11.3 There are a number of planned or commenced developments that could impact on the anticipated demand for pharmaceutical services in Torbay (Figure 18). These include:

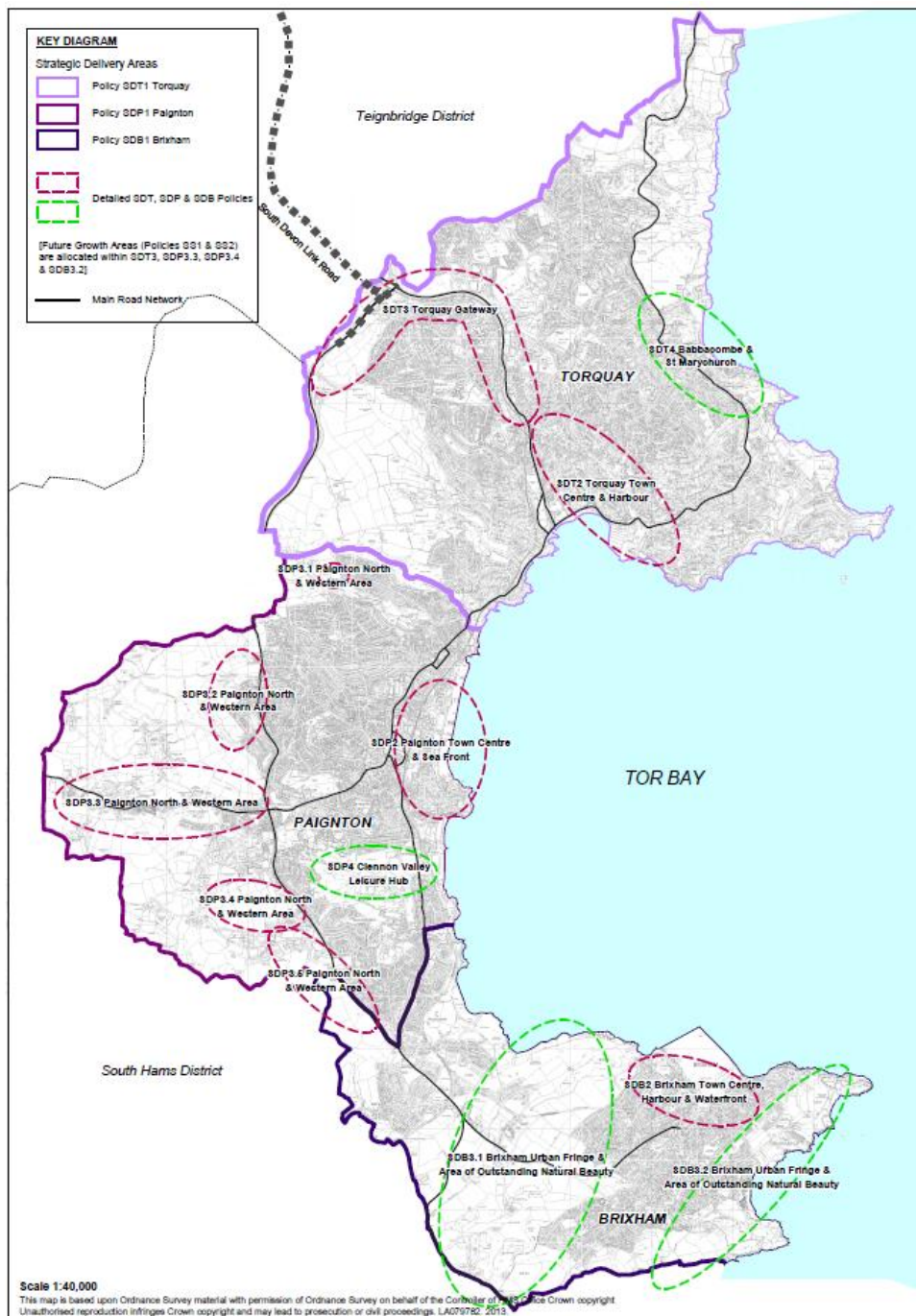
- The South Devon Link Road, which will rapidly improve travel time into and out of the Bay. The improved access to Torbay and South Devon is expected to bring lasting economic benefits, leading to the creation of nearly 8,000 jobs in South Devon, with around 3,500 of these in Torbay²². Completion is expected in 2015. The increase in population and therefore pharmaceutical demands are unknown at this stage.
- Preparation for a new railway station at Edginswell, Torquay. Completion expected by 2017/2018.
- Expansion of Torbay Hospital, including further residential properties in the Shiphay area of Torquay (SDT3 Torquay Gateway – Figure 18). Shiphay anticipates a build of 745 homes which will accommodate approximately 1,600 residents. There are three pharmacies (25, 33, 35 – see Section 9) within 15 minutes' drive of this area (see appendix 4 for the specific pharmacy details).
- Developments in Paignton (SDP 3.2/3/4/5 Paignton North & Western Area - Figure 18); at Great Parks, Collaton St Mary and Whiterock will all increase Torbay's population further. The biggest development at Collaton St Mary (SDP 3.3 Paignton North & Western Area) anticipates a build of 2,625 homes which will accommodate approximately 5,300 residents, although completion may not be for another 15 years. There are two pharmacies (11, 14 – see Section 9) within 15 minutes' drive of this area (see appendix 4 for the specific pharmacy details). Additional provision may be required in the future.

²² <http://www.southdevonlinkroad.co.uk/>

FUTURE PROVISION OF PHARMACEUTICAL SERVICES - KEY OBSERVATIONS:

There are a number of developments either in the planning or construction phase that will materially affect Torbay in the following 5-10 years. These include the conclusion of the South Devon Link Road which it is expected will significantly improve accessibility to, and job provision in, Torbay; the development of a new train station at Edginswell in Torquay further improving accessibility; plus residential developments in both Torquay and Paignton which are anticipated to increase the population by approximately 7,000 in total. All these may create either residential or transient demand for further pharmaceutical services over the coming years.

Figure 17: Map showing the anticipated development areas for Torbay based on the 20 year Local plan (Spatial Planning, Torbay Council).



The changing direction of pharmaceutical provision locally

- 11.4 Pharmacies 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. Whilst the core activity of community pharmacies is commissioned by NHS England, they also provide a key role for local authorities and Clinical Commissioning Groups; particularly in relation to improving the public's health and wellbeing. Community pharmacies are a key public health resource and offer potential opportunities to promote health and wellbeing as recommended by the Local Government Association (LGA).²³
- 11.5 The LGA report recommends that local commissioners consider the Healthy Living Pharmacy model (HLP) and how it could be used to help improve health and reduce inequalities. Plymouth was the first area in the Peninsula to adopt the HLP concept and now has the ambition to have all pharmacies across the city delivering this approach. This will enable pharmacies to help reduce inequalities within local communities, by delivering high quality health and wellbeing services tailored to local needs, promoting health and providing proactive health advice. In other areas, Devon is currently providing HLPs in areas of greatest need and Cornwall and the Isles of Scilly are exploring the role of healthy living champions in pharmacies to promote public health messages.
- 11.6 Community pharmacy has a number of strengths and offers significant opportunities for future provision of pharmaceutical services:
- Pharmacists are the third largest health profession and community pharmacy is the gateway to health for 1.6 million patients nationally each day.
 - A core component of the current pharmaceutical service is to support the public to stay well, live healthier lives and to 'self-care'. This role is even more critical in terms of reaching those who do not normally access NHS services. Through this role, pharmacies can help to improve the health of the local population and reduce health inequalities.
 - Pharmacists have a central role in management of long-term conditions. Pharmacists currently carry out Medicines Use Reviews (MURs) and provide the New Medicine Service (NMS) to patients newly prescribed certain medicines. These services support patients helping them getting the most out of their medicines.
 - The growth in multiple long term conditions and related admissions to hospital indicate a need for medicines optimization, which could be supported via commissioned medicines optimization services.
- 11.7 The role of community pharmacy in the NHS transformational agenda was highlighted in NHS England's *Call to Action for Community Pharmacists*²⁴ published in 2013. NHS England aims for community pharmacy are to:

²³ <http://www.local.gov.uk/documents/10180/11463/Community+Pharmacy+-+local+government's+new+public+health+role/01ca29bf-520d-483e-a703-45ac4fe0f521>

²⁴ <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/>

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

It is recognised that a contractual framework which better supports these aims is required and greater contractual alignment with other sectors to drive collaboration is needed.

11.8 The NHS Five Year Forward View (October 2014) sets out a strategy for new models of care and states that new partnership across health communities will be piloted to enhance quality, safety and integration. It states the NHS should 'build the public's understanding that pharmacies can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit'. Under new care models the NHS should make 'far greater use of pharmacists'. And that patients should be supported in getting "the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies'.

11.9 In South West England, the Local Pharmacy Networks are exploring new ways of working. This includes exploring the possible role pharmacists could have in:

- urgent care - both in local pharmacies and in Emergency Departments
- providing vaccination services
- medication review
- near patient testing services
- minor injury and ailment services
- long term condition management

The location of provision for these services could, in many instances, be the community pharmacy but it is anticipated that pharmacists and pharmacy staff will also support provision in the community and in practice.

Transformation of primary care

11.10 Primary care is undergoing radical transformation with alignment of practices into federations and the formation of 'Houses of Care'. Houses of Care take into account the expertise and resources of the people with long-term conditions (LTCs) and their communities to provide a holistic approach to their lives. The House of Care approach provides a way of supporting patients to achieve the best outcomes possible.²⁵ This approach is being driven by a number of factors including:

- financial constraints
- the movement of services from acute care into the community

²⁵ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

- increasing shortages of GPs and nurses
- the recognised need for greater integration across health and social care to improve outcomes for patients and population wellbeing

11.11 It is increasingly recognised that community pharmacists and pharmacy services have an important role to play in supporting this transformation and have a fundamental and more substantive role to play in the developing Health and Social Care System. *Health on the High Street: rethinking the role of community pharmacy*²⁶ places emphasis on the significant and increased role that community pharmacy has to play in ensuring a sustainable healthcare system. It also highlights the importance of integrating the role of community pharmacy with that of other elements of the health and public health system.

Rural pharmaceutical services provision (dispensing doctors)

11.12 Although not applicable to Torbay, rural pharmaceutical provision is essential in large areas of the Peninsula. In rural settings much of the provision of medicines is provided through dispensing doctors. The reduction of inequalities and disparity in the provision of services is an area of focus for the developing health system and greater alignment of pharmaceutical provision is sought ensuring the quality of provision.

11.13 The Dispensing Service Quality Scheme (DSQS) has developed standards ensuring some requirements of the core community pharmacy contract are present in dispensing practices. This also includes the Dispensing Review of the Use of Medicines (DRUMs) which reviews a proportion of patients for their concordance with prescribed medicines regimes. CCGs could seek to engage with dispensing practices providing DRUMs to contribute towards improving medicines optimization.

However, some key services, such as the new medicines service, are not provided through the dispensing doctor setting. It is acknowledged that to create changes in such provision this would require changes to national contracts.

The role of the PNA in enabling ‘the future’

11.14 The future vision for pharmaceutical services is based on underlying system changes that are predicted to emerge in primary care over the next few years. The PNA, as written today, cannot reflect a need that is yet to materialise; however it is not intended to be a static document but should be continually updated to reflect change. Historically this has primarily meant changes to populations and infrastructure. However, the rapid change in primary care provision envisaged over the next few years, in addition to changes to future pharmacy provision as highlighted in NHS England’s Call to Action,²⁷ will need to be reflected in future PNAs and will drive a commissioning response when required.

²⁶ <http://www.nhsconfed.org/resources/2013/10/health-on-the-high-street-rethinking-the-role-of-community-pharmacy>

²⁷ <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/>

12. CONCLUSIONS

12.1 The process undertaken for producing this PNA can be summarised as follows:

- The Health and Social Care Act 2012 transferred the statutory responsibility to develop and update PNAs from Primary Care Trusts to Health and Wellbeing Boards (HWBs) from 1 April 2013. This PNA will be used by the NHS England Area Team for Devon, Cornwall and Isles of Scilly to inform their decision making process regarding: NHS funded services provided by community pharmacies and dispensing appliance contractors, whether new pharmacies or services are needed, the relocation of existing pharmaceutical premises in response to applications by providers of pharmaceutical services or the commissioning of locally enhanced services from pharmacies. Providers of pharmaceutical services will also use the PNA to inform their applications.
- This PNA was developed in partnership with the Peninsula wide PNA Steering Group. Information regarding local provision of pharmaceutical services across the Peninsula was collected via PharmOutcomes for each local authority area. In addition known local health information was also analysed. In order to identify local health needs and assess current pharmaceutical services provision, each HWB area was divided into suitable localities. The findings have been summarised in Locality Summary Sheets.

12.2 The findings of Torbay's PNA have been summarised in the two locality sheets, which are appended to the executive summary. However there are a number of observations that have emerged from this Needs Assessment:

- There are no Distance Selling Pharmacies within Torbay.
- Given the relatively urban nature of Torbay, there are no dispensing GP practices within the Local Authority boundaries but this is of relevance to neighbouring PNAs.
- A number of Dispensing Appliance Contractors (DACs) were identified during the development of the PNA, most of which are national companies covering a wide geographical area. DACs are unable to supply medicines or provide the range of pharmaceutical services offered by community pharmacies. They will however be used by residents in Torbay due to their convenience.
- In Torbay, pharmaceutical services are mainly provided by community pharmacies.
- In Torbay, pharmaceutical services are mainly provided by community pharmacies. Most Torbay pharmacies are accessible by car in 5 minutes, although drive times are extended to ,at most 15 minutes, at the latest points of the day or at weekends when only certain pharmacies will be open.
- In total there are 39 pharmacies providing a service to a population of 131,49228. Of these, just over a quarter are Boots pharmacies (10) and just under a quarter (8) are

²⁸ <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-310118>

Day Lewis pharmacies, with the remaining 21 being made up of a range of other providers.

- Torquay has greater identified health needs but has a greater pharmacy density per population and the greater availability to pharmaceutical services than Paignton or Brixham. Pharmacy locations are centred around areas of greatest population density and deprivation.
- Internet access and secure email address usage is variable across Torbay.
- Provision of consultation facilities across Torbay is very good, with the majority providing disabled access. Just under half the pharmacies across Torbay offer off-site consultations although there is likely to be increased demand for off-site provision beyond what is already provided. Nearly all pharmacies operate a prescription collection service from GP practices. Most pharmacies have hand washing facilities either in, or close to, the consultation. Off-site consultation provision is available from less than half the pharmacies.
- 69% of pharmacies (27 out of 39) dispense stoma appliances, incontinence appliances and dressings across Torbay. Dispensing is higher in Paignton and Brixham (78%), than in Torquay (62%). There is very good provision of Medicines Use Review and the New Medicine Service. Appliance Use Review (AUR) is currently offered by three pharmacies in Torbay (two are located in Paignton and Brixham and one in Torquay). Only 10% of pharmacies offer Stoma Appliance Customisation, with limited availability of this service across both localities. However for both SAC and AUR's, there has been no assessment made of the use of centralised contractors nor the willingness or ability of existing pharmacies who are currently not commissioned, to undertake this service should it be required.
- All but one pharmacy offer a collection of prescription from their GP and delivery of dispensed medicines free of charge on request. Therefore whilst Torquay has a slightly higher proportion (one in five) without access to a car than the national average, there is good provision of home delivery services.
- The proportion of the population who cannot speak English, or cannot speak English well is almost distinctly confined to Torquay town centre (Tormohun ward). Non-English-speaking patients typically receive fewer preventative services and have less access to health care than English-speaking patients. Consequently, any barriers to provision for these population groups should be addressed. Torquay town centre does have some access to pharmacies where staff can speak one non-English language but interestingly Brixham has the greatest prevalence of staff who can speak one or more non-English language.
- The three most prominent themes that emerged from the priorities identified by pharmacies were relating to access to the minor ailment scheme; increasing the range, access to or appropriateness of commissioned services; and to prioritising already commissioned services (although there was clearly inconsistency with regards to understanding of the new commissioning landscape – as also borne out by the commissioned services audit).

- There are a number of developments either in the planning or construction phase that will materially affect Torbay in the following 5 years. These include the conclusion of the South Devon Link Road which it is expected will significantly improve accessibility to, and job provision in, Torbay; the development of a new train station at Edginswell in Torquay further improving accessibility; plus residential developments in both Torquay and Paignton which are anticipated to increase the population by approximately 7,000 in total. All these may create either residential or transient demand for further pharmaceutical services over the coming years.
- HWBs 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.

APPENDICES

APPENDIX I – Pharmacy questionnaire (administered via PharmOutcomes)

27/6/2014

Services - PharmOutcomes

PharmOutcomes - Live System

Exit Logged In as: Pinnacle Support from Torbay

PharmOutcomes® Delivering Evidence

Home Services Assessments Reports Claims Admin Gallery Help

Service Design

PNA Questionnaire template (Preview)

- Go to Service Design page
- Show Service ID Marks
- Edit Service Accreditations

Provision Reports Preview

Basic Provision Record (Sample)

Service Support

Pharmacy Questionnaire-PNA
Please complete this questionnaire ONCE only to report the facilities and services offered by your pharmacy.

In the event of any query arising regarding this questionnaire please contact **insert name of local contact here** for advice on local arrangements regarding the PNA process

For technical support on the use of this data capture set please contact Pinnacle Support via the "Help" tab

Date of completion
Name of Contractor
Trading Name
Post Code

Is this a Distance Selling Pharmacy? Yes No
(i.e. It cannot provide Essential Services to persons present at the pharmacy)

Pharmacy email address
If no email write no email

Pharmacy telephone

Pharmacy fax

Pharmacy website address
If no website write no website

Can we store the above information and use this to contact you?

Consent to store Yes No

Core hours of opening

Please complete your core hours of opening.
Enter closed if closed

Monday Open

Monday Close

Monday Lunchtime
(from - to)

Tuesday Open

Tuesday Close

Tuesday Lunchtime
(from - to)

Wednesday Open

Wednesday Close

Wednesday Lunchtime
(from - to)

Thursday Open

Thursday Close

Thursday Lunchtime
(from - to)

Friday Open

Friday Close

Friday Lunchtime (from -
to)

Saturday Open

Saturday Close

Saturday Lunchtime
(from - to)

Sunday Open

Sunday Close

Sunday Lunchtime (from
- to)

- Total hours for pharmacy (Supplementary + core) -

Please complete your total hours of opening

Monday Open

Monday Close

Monday Lunchtime
(from - to)

Tuesday Open

Tuesday Close

Tuesday Lunchtime
(from - to)

Wednesday Open

Wednesday Close

Wednesday Lunchtime
(from - to)

Thursday Open

Thursday Close

Thursday Lunchtime
(from - to)

Friday Open

Friday Close

Friday Lunchtime (from -
to)

Saturday Open

Saturday Close

Saturday Lunchtime
(from - to)

Sunday Open

Sunday Close

Sunday Lunchtime (from
- to)

- Consultation Facilities -

Consultation areas should meet the standard set out in the contractual framework to offer advanced services

Is there a consultation area?

Available (including wheelchair access) on the premises
 Available (without wheelchair access) on premises
 Planned within next 12 months
 No consultation room available
 Other
 If Other please specify

Where there is a consultation area

Is this enclosed? Yes No N/A
N/A if no consultation room

Off-site arrangements

Off-site consultation room approved by NHS

Willing to undertake consultations in patients home/ other suitable site

None apply

Other

If Other please specify

Hand washing facilities

What facilities are available during consultations?

Facilities available

Handwashing in consultation area

Hand washing facilities close to consultation area

None

Tick all that apply

Information Technology

Is the pharmacy EPS* R2 enabled?

Yes, EPS R2 enabled

Planning to become EPS R2 enabled in the next 12 months

No current plans to provide EPS R2

EPS R2: Electronic Prescription Service Release 2

Does the pharmacy have unrestricted internet access or limited intranet access

Unrestricted internet Yes No
access

Does the pharmacy use NHS mail i.e.. nhs.net account available

Access to NHS mail Yes No

Information is often distributed to pharmacies as email attachments or via websites. Please indicate whether you are able to use the following common file formats in your pharmacy:

File format types

Microsoft word

Microsoft Excel

Microsoft Access

PDF

Unable to open or view any file formats

Please tick all that apply

Essential Services (appliances)

In this section, please give details of the essential services your pharmacy provides.

Does the pharmacy dispense appliances?

Yes - All types, or

Yes, excluding stoma appliances, or

Yes, excluding incontinence appliances, or

Yes, excluding stoma and incontinence appliances, or

Yes, just dressings, or

None

Other

If Other please specify

Advanced Services

Please give details of the Advanced Services provided by your pharmacy.

Please tick the box that applies for each service.

Yes - Currently providing

Soon - Intending to begin within the next 12 months

No - Not intending to provide

Medicines Use Review service Yes Soon No

New Medicine Service Yes Soon No

Appliance Use Review service Yes Soon No

Stoma Appliance Customisation service Yes Soon No

— Commissioned Services —

Use this section to record which Local services you currently deliver or would like to deliver at your pharmacy. These can be Enhanced Services, commissioned by the NHS England Area Team, Public Health Services commissioned by a Local Authority or CCG services.

Please tick the box that applies for each service.

CP - Currently Providing NHS funded service

WA - Willing and able to provide if commissioned

WT - Willing to provide if commissioned but would need training

WF - Willing to provide if commissioned but require facilities adjustment

PP - Currently providing private service

If you are not willing or able to provide please leave blank.

Anticoagulant Monitoring Service CP WA WT WF PP

Anti-viral Distribution Service CP WA WT WF PP

Care Home Service CP WA WT WF PP

Chlamydia Treatment Service CP WA WT WF PP

Contraception Service CP WA WT WF PP
(not an EHC service)

Local Authority Commissioned Services

List services already commissioned in your locality here

Disease Specific Medicines Management Service:

Allergies CP WA WT WF PP

Alzheimer's/dementia CP WA WT WF PP

Asthma CP WA WT WF PP

CHD CP WA WT WF PP

Depression CP WA WT WF PP

Diabetes type I CP WA WT WF PP

Diabetes type II CP WA WT WF PP

Epilepsy CP WA WT WF PP

Heart Failure CP WA WT WF PP

Hypertension CP WA WT WF PP

Parkinson's disease CP WA WT WF PP

Area Team Services

List your Area Team commissioned services here

Other (please state - including funding source)

End of Disease specific Medicines Management Service options.

Emergency Hormonal Contraception Service CP WA WT WF PP

Gluten Free Food Supply Service CP WA WT WF PP (i.e. not supply on FP10)

Home Delivery Service CP WA WT WF PP (not appliances)

Independent Prescribing Service CP WA WT WF PP

Therapeutic areas covered (if providing)

Language Access Service CP WA WT WF PP

Note: This is not the NMS or MUR service.

Medication Review Service CP WA WT WF PP

Medicines Assessment and Compliance Support Service:

Medicines Management Support Service: CP WA WT WF PP i.e. the EL23 service (previously the Vulnerable Elderly / Adults Service)

DomMAR Carer's Charts CP WA WT WF PP

End of Medicines Assessment and Compliance Support options.

Minor Ailments Scheme CP WA WT WF PP

MUR Plus/Medicines Optimisation Service CP WA WT WF PP

Therapeutic areas covered (if providing)

Needle and Syringe Exchange Service CP WA WT WF PP

Obesity management (adults and children) CP WA WT WF PP

On Demand Availability of Specialist Drugs Service:

Directly Observed Therapy CP WA WT WF PP

If yes state which medicines

Out of hours services CP WA WT WF PP

Palliative Care scheme CP WA WT WF PP

End of On Demand Availability of Specialist Drugs Service options

Patient group directions

Many Local Services involve the supply of POM using a PGD. please

list those provided by the pharmacy in the text box below but indicate who commissions the service by ticking the boxes below and annotating each service name with the key:

AT=Area Team

LA=Local Authority

CCG=Clinical Commissioning Group

Pr=Offers a Private Service

Patient Group Direction Service AT LA CCG Pr
Not including EHC (see separate question)

Please list the names of the medicines available if providing PGD services

Medicines available

Phlebotomy Service CP WA WT WF PP

Prescriber Support Service CP WA WT WF PP

Schools Service CP WA WT WF PP

Screening Service:

Alcohol CP WA WT WF PP

Chlamydia CP WA WT WF PP

Cholesterol CP WA WT WF PP

Diabetes CP WA WT WF PP

Gonorrhoea CP WA WT WF PP

H. pylori CP WA WT WF PP

HbA1C CP WA WT WF PP

Hepatitis CP WA WT WF PP

HIV CP WA WT WF PP

Other Screening
(please state - including funding source)

End of screening service options

Seasonal Influenza Vaccination Service CP WA WT WF PP

Other vaccinations

Childhood vaccinations CP WA WT WF PP

HPV CP WA WT WF PP

Hepatitis B CP WA WT WF PP
(at risk workers or patients)

Travel vaccines CP WA WT WF PP

Other (please state - including funding source)

End of Other vaccinations options

Sharps Disposal Service CP WA WT WF PP

Stop Smoking Service:

- NRT Voucher Service** CP WA WT WF PP
- Smoking Cessation Counselling Service** CP WA WT WF PP

End of Stop Smoking Service options

- Supervised Administration** CP WA WT WF PP
Of methadone, buprenorphine etc.

End of Supervised Administration Service options

- Supplementary prescribing** CP WA WT WF PP

Which therapy area

- Vascular Risk Assessment Service** CP WA WT WF PP
NHS Healthchecks

— Healthy Living Pharmacy —

Is this a Healthy Living Pharmacy

Yes

Currently working towards HLP status

No

N/A

If Yes, how many Full Time Equivalents
Healthy Living Champions do you currently have?

— Collection and Delivery services —

Does the pharmacy provide any of the following?
 We acknowledge that contractors are not contractually bound to offer these services, but this information is useful to have

Collection of prescriptions from surgeries Yes No

Delivery of dispensed medicines - Free of charge on request Yes No

Delivery of dispensed medicines - Selected patient groups

List criteria

Delivery of dispensed medicines - Selected areas

List areas

Delivery of dispensed medicines - chargeable Yes No

— Languages

One potential barrier to accessing services at a pharmacy can be language. To help the local authority better understand any access issues caused by language please answer the following two questions:

What languages other than English are spoken in the pharmacy

What languages other than English are spoken by the community your pharmacy serves

— Almost done

What would be your top 3 priorities for improving pharmacy services in your area?:

If no comment leave blank

Priority 1

Priority 2

Priority 3

Please tell us who has completed this form in case we need to contact you.

Contact name

Contact telephone

For person completing the form, if different to pharmacy number given above

Thank you for completing this PNA questionnaire.

Test Values

APPENDIX 2 – Covering email to accompany pharmacy questionnaire

Dear Colleague

ACTION REQUIRED: COMPLETION OF PHARMACY QUESTIONNAIRE (DEADLINE: 23/06/14)

The Pharmaceutical Needs Assessment (PNA), the key commissioning document for future pharmaceutical services, is now the responsibility of Health and Wellbeing Boards aligned to Local Authorities. There is a regulatory requirement to refresh this document at set periods and to update its contents with changes of significance.

We have now reached a point when the documents are due for a renewal and as a consequence Local Authorities, Public Health teams, LPCs, Dispensing Doctors and other key interested parties across Devon and Cornwall have worked cooperatively to develop a common approach to the PNA process and contents.

Part of the requirement for completion of the PNA is the collation of information about existing provision of pharmaceutical services across the area and an understanding of future needs. To be more efficient at collecting this information, we are using a web-based questionnaire administered through PharmOutcomes.

We appreciate your current workload, but the PNA is a statutory and national requirement. Your responses to this questionnaire will influence the shape of community pharmacy provision across Devon and Cornwall over the next few years. The new PNA will be the document that is fundamental to the process of dealing with contract applications. If contractors do not respond to the questionnaire, the commissioning organisations will not know what we are providing and there will be a view that the services may be inadequate, which will open the door for applications for new pharmacies. This could significantly affect the viability of our current pharmacies and our pharmacy teams' jobs.

In light of this, it is critical that every pharmacy completes the PNA service which has recently been activated on your PharmOutcomes list of services - this will take around **10 minutes to complete**.

THE DEADLINE FOR YOUR RESPONSE IS: 23/06/14

We really appreciate all of your support with this and for taking the time to complete the questionnaire. A final draft of the PNA report will be circulated for consultation in the autumn which will outline the outcomes of this process.

Many thanks
Kind regards

David Bearman, Chairman DCIOS Pharmacy Local Professional Network
Phillip Yelling, Chief Officer Cornwall LPC
Sue Taylor, Chief Officer Devon LPC

Pharmaceutical Needs Assessment

About you

Data protection statement:

All answers to this consultation will be treated in the strictest confidence and will be stored securely. No personal data about anyone responding to this consultation will be shared at any stage. A summary report will be published but will not contain any personal information you supply. This information is being collected for the sole purpose of being able to respond directly to you or your organisation in reference to the feedback you have provided.

1. Your name

2. Your contact address including postcode

3. Your email

4a. Please indicate how you are responding to this consultation (please tick most relevant)

(please select one answer)

As a member of the public.....

As a health or social care professional

As a pharmacist or appliance contractor

As a dispensing doctor

On behalf of an organisation, team or board?

4b. Organisation, team or board (please select from drop down list)

Plymouth Health and Wellbeing Board

Devon Health and Wellbeing Board

Torbay Health and Wellbeing Board

Cornwall and Isles of Scilly Health and Wellbeing Board

NHS England Devon, Cornwall and Isles of Scilly Area Team

- Healthwatch Plymouth*
- Healthwatch Devon*
- Healthwatch Torbay*
- Devon, Cornwall and Isles of Scilly Pharmacy Local Professional Network*
- Devon Local Pharmaceutical Committee*
- Cornwall and Isles of Scilly Local Pharmaceutical Committee*
- Devon Local Medical Committee*
- Plymouth Hospitals NHS Trust*
- Plymouth Community Healthcare*
- Northern Devon Healthcare NHS Trust*
- Royal Devon & Exeter NHS Foundation Trust*
- South Devon Healthcare NHS Foundation Trust*
- Torbay and Southern Devon Health and Care NHS Trust*
- NHS New Devon Clinical Commissioning Group*
- NHS South Devon and Torbay Clinical Commissioning Group*
- Other*

If other, please specify

5. In which area do you work (if responding as a member of the public please indicate the location in which you live)?

- Plymouth*
- Devon*.....
- Torbay*
- Cornwall*
- Isles of Scilly*
- Other*

If other, please specify

CONSULTATION QUESTIONS

1. Do you feel that the Locality Summary Sheets (appended to the Executive Summary of the report) provide an accurate summary of the findings of the PNA for this area?

(please select one answer)

Yes No

If no, please explain your response:

2. Do you feel that the PNA for this area adequately introduces and explains the context for the assessment? (See Section 2)

(please select one answer)

Yes No

If no, please explain your response:

3. Do you feel that the report adequately explains the process followed for the production of the PNA for this area? (See Section 3)

(please select one answer)

Yes No

If no, please explain your response:

4. Do you feel that the demography of the area (See Sections 4 and 5) has been adequately identified and explained in the PNA?

(please select one answer)

Yes No

If no, please explain your response:

5. Do you feel that the health needs of the population (See Sections 6 - 8) have been adequately identified and explained in the PNA?

(please select one answer)

Yes No

If no, please explain your response:

6. Do you feel that the information contained within the PNA adequately reflects current provision of pharmaceutical services and any gaps in provision in this area?

(See Section 9 and Locality Summary Sheets)

(please select one answer)

Yes No

If no, please explain your response:

7. Are there any future needs for pharmaceutical services in this area that you are aware of that are not currently highlighted within this PNA? (See Section 11)

(please select one answer)

Yes No

If yes, please explain your response (and describe where you obtained this information):

8. Do you agree with the conclusions of this area's PNA? (See Section 12)

(please select one answer)

Yes No

If no, please explain your response:

9. Is there any additional information that should be included in this area's PNA?

(please select one answer)

Yes No

If yes, please tell us what should be included:

Consultation process

If you have any concerns or comments that you would like to make relating specifically to the consultation process itself please comment here:

Thank you for taking the time to respond to this consultation.

APPENDIX 4 – List of Torbay Pharmacies and GP's, their locations and map number codes

Map No.	Pharmacy Name	Address	Address 2	Postcode
1	Boots The Chemist	11 Fore Street	Brixham	TQ5 8AA
2	Your Local Boots	1 Cherrybrook Square, Hookhills Road	Paignton	TQ4 7LY
3	Boots The Chemist	12-14 Victoria Street	Paignton	TQ4 5DN
4	Broadway Pharmacy	1 Churston Broadway	Paignton	TQ4 6LE
5	Care4U (Healey's) Pharmacy Ltd	2-3 Churchill Court, Bolton Street	Brixham	TQ5 9DW
6	Care4U (Corner Place) Pharmacy	46a Dartmouth Road	Torquay	TQ4 5AH
7	Day Lewis Pharmacy	Compass House, King Street	Brixham	TQ5 9TF
8	Day Lewis Pharmacy	52 Fore Street	Brixham	TQ5 8DZ
9	Day Lewis Pharmacy	Unit 2 Pembroke House, Torquay Road, Preston	Paignton	TQ3 2EZ
10	Day Lewis Pharmacy	237 Torquay Road	Paignton	TQ3 2HW
11	Day Lewis Pharmacy	99 Foxhole Road	Paignton	TQ3 3SU
12	Lloyds Pharmacy	11 Palace Avenue	Paignton	TQ3 3EF
13	Mayfield Pharmacy	37 Totnes Road	Paignton	TQ4 5LA
14	Sainsbury's Supermarkets Ltd	Brixham Road	Paignton	TQ4 7PE
15	Care4U (Sarsons) Pharmacy	1-5 Palace Avenue	Paignton	TQ3 3EF
16	CO-OP Pharmacy	9 New Road	Brixham	TQ5 8LZ
17	Your Local Boots	6 Bolton Street	Brixham	TQ5 9JD
18	Your Local Boots	2-3 Winner Street	Paignton	TQ3 3BN
19	Poolearth Pharmacy (Babbacombe)	100 Reddenhill Road	Torquay	TQ1 3NT
20	Your Local Boots	27 Fore Street, St Marychurch	Torquay	TQ1 4PU
21	Your Local Boots	8 Fore Street, St Marychurch	Torquay	TQ1 4NE
22	Boots The Chemist	9 The Strand	Torquay	TQ1 1AA
23	Your Local Boots	2 Tor Hill Road	Torquay	TQ2 5RA
24	Boots The Chemist	66-70 Union Street	Torquay	TQ2 5PS
25	Boots The Chemist	Unit 1, Wren Retail Park,	Torquay	TQ2 7BJ
26	Care4U (Croft Hall)	19 Croft Road	Torquay	TQ2 5UA
27	Day Lewis Pharmacy	28 Walnut Road, Chelston	Torquay	TQ2 6HS
28	Day Lewis Pharmacy	Bronshill Road	Torquay	TQ1 3HD
29	Day Lewis Pharmacy	19 Ilsham Road	Torquay	TQ1 2JG
30	Dowrick's Chemist of Chelston Hall	Chelston Hall, Old Mill Road	Torquay	TQ2 6HW
31	Georgian (Hele) Pharmacy	111 Hele Road	Torquay	TQ2 7PS
32	Lloyds Pharmacy	168 Barton Hill Road	Torquay	TQ2 8HN
33	Sainsbury's Pharmacy	Nicholson Road	Torquay	TQ2 7HT
34	Poolearth Pharmacy (Sherwell Valley)	37 Sherwell Valley Road	Torquay	TQ2 7HN
35	Poolearth Pharmacy (Shiphay)	11 Collaton Road, Shiphay	Torquay	TQ2 7HH
36	Superdrug Pharmacy	83-85 Union Street	Torquay	TQ1 3 DG
37	CO-OP Pharmacy	159 St Marychurch Road	Torquay	TQ1 3HP
38	Torwood Street Pharmacy	37a Torwood Street	Torquay	TQ1 1ED
39	Poolearth Pharmacy (Watcombe)	69 Fore Street, Barton	Torquay	TQ2 8BP

GP Practice Name	Address	Address 2	Postcode
Brunel Medical Practice	St Albans Road, Babbacombe	Torquay	TQ1 3SL
Mayfield and Cherry Brook Medical Centres	37 Totnes Road	Paignton	TQ4 5LA
Mayfield and Cherry Brook Medical Centres	Hookhills Road	Paignton	TQ4 7SH
Croft Hall Medical Practice	19 Croft Road	Torquay	TQ2 5UA
Southover Medical Practice	Bronshill Road	Torquay	TQ1 3HD
Barton Surgery	Lymington House, Barton Hill Way	Torquay	TQ2 8JG
Compass House Medical Centres	King Street	Brixham	TQ5 9TF
St Lukes Medical Centre	17 New Road	Brixham	TQ5 8NA
Corner Place Surgery	46a Dartmouth Road	Paignton	TQ4 5AH
Shiphay Manor and Abbey Road Surgery	37 Shiphay Lane	Torquay	TQ2 7DU
Chilcote/Dewerstone Surgery	Hampton Avenue	Torquay	TQ1 3LA
The Greenwood Surgery	1 Greenwood Road	Brixham	TQ5 9HN
Chelston Hall Surgery (incl. Old Mill)	Old Mill Road	Torquay	TQ2 6HW
Paignton Medical Partnership	17 Grosvenor Road	Paignton	TQ4 5AZ
Paignton Medical Partnership	1 Bishops Place	Paignton	TQ3 3DZ
Parkhill Medical Practice	Parkhill Road	Torquay	TQ1 2AR
Pembroke House	266 - 268 Torquay Road	Preston	TQ3 2EZ
The Old Farm Surgery	67 Foxhole Road	Paignton	TQ3 3TB

Title: Update on Pioneer/JoinedUp and Better Care Fund

Wards Affected: All

To: Health & Wellbeing Board **On:** 9 March 2015

Contact: Fran Mason
Telephone: 01803 652455
Email: franmason@nhs.net

1. Update on Pioneer/Joined Up

1.1 Background

Pioneer comprises 2 specific projects: the Frailty Hub in Newton Abbot to increase the number of patients who are proactively case-managed at home and; the Torquay Children's Hub developing a locality hub of community services closer to home for all. These Pioneer projects are part of a range of joined up activities and projects to deliver better outcomes for patients and people through fully integrated working across health and social care in South Devon and Torbay including, the Better Care Fund. This report provides an update on recent achievements and future plans.

1.2 Achievements since last meeting

Joined up Leadership

The JoinedUp Board and Cabinet promote the vision for integrated health, care and support in South Devon and Torbay. They provide leadership for integration activity including, pioneer, new Integrated Care Organisation (ICO) models of care and the Better Care Fund. At a planning day in November members reaffirmed their shared principles, values and commitment to work together across organisational boundaries to achieve fully integrated health, care and support to address what matters to people.

A single community programme management office will co-ordinate the management of a range of integration plans and projects including, pioneer and better care fund.

The Horizon Institute at Torbay Hospital will support integration projects and cross-organisational development and provide a single repository for data.

1.3 National Pioneer Programme

A national 'Pioneer One Year On' annual report was launched at the 'Pioneer One Year on' conference on 28th January. At this conference the Minister for Carer and Support, Norman Lamb, announced further 'second wave' pioneer sites and made a

commitment to enhance national support for pioneers including, unblocking some of the obstacles to integrated working such as, data sharing.

The NHS Five Year Forward View provides a future vision for the NHS. The accompanying planning guide, 'Forward View into Action' describes models of integrated care and invites applications by 2nd February from areas which have already made progress in integrating care to become leading cohorts. South Devon and Torbay JoinedUp applied to take develop the Multi-Speciality Community Provider new model of care.

1.4 South Devon & Torbay Pioneer

Following a well-attended information sharing event in November a tool kit will be launched in February to support information sharing between GPs and other organisations to improve care.

£100,000 was awarded following a successful bid to Health Education England South West to create non-professional practitioner roles in the Newton Abbot hub and for asset based community development workers in Torquay children and families hub.

The South West Integrated Personal Commissioning (IPC) Network bid (which includes South Devon and Torbay) was successful and this will help us take forward personalised health and social care budgets as part of the National Programme. The Board is asked to agree a link between the IPC steering group and the Health & Wellbeing Board.

The Pioneer Frailty hub in Newton Abbot became fully operational on 12th January:

- GPs have been providing a seven day service since the end of October. They are fully mobile and even able to print out prescriptions from their cars.
- A GP with special interest in frailty is running daily multi-disciplinary team meetings to discuss complex patients.
- A single assessment document is being used by all agencies involved

The Torquay Children and Families hub:

- Launched a social prescribing pilot this month. The scheme aims to provide early help and support for families with emotional health and wellbeing issues, concerns about parenting and support for socially isolated older people.
- Set up a volunteer time-bank with a dedicated co-ordinator.
- A healthy living programme for overweight and obese children aged 5-11 will launch at the beginning of February co-delivered by the Hele, Watcombe and Barton community centres, groups and associations; and Torbay & Southern Devon Health & Care NHS Trust.

A methodology for evaluating the impact of, and learning from, pioneer projects has been developed.

A South Devon and Torbay Pioneer showcase event has been arranged for 24th March 2015.

2. Better Care Fund update

2.1 Background

The Better Care Fund (BCF) is a single pooled budget for health and social care. South Devon and Torbay's plans for the BCF have now been fully approved. This Board endorsed BCF plans in September 2014. Better Care Fund performance is measured against four national targets

1. Total non-elective admissions (general and acute) per 1,000 population
2. Permanent admissions of older people (aged 65 and over) to residential & nursing care homes, per 100,000 population
3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
4. Delayed transfers of care from hospital per 100,000 population and; two local targets:
5. Rate of dementia diagnosis
6. Patient/service user experience of care

2.2 Decision from Health and Wellbeing Board:

A challenging 3.5% expected reduction in non-elective emergency admissions was set against target 1 (above). It has been agreed that this target can be revised in line with CCG operational plans and a target of 0% is proposed for Torbay. The Health and Wellbeing Board is asked to agree the revised target with South Devon and Torbay CCG.

3. Challenges for the next three months

- Potential impact of reduced health and social care funding on JoinedUp and Pioneer transformation activity
- Bid to NHS England to be part of 'new model of care' leading cohort
- Setting revised BCF target

4. Action required by partners

- Continued support for pioneer and integrated care projects
- Support for funding bids
- Agree delegated responsibility for revised Better Care Fund indicator
- Agree link between IPC steering group & Health & Wellbeing Board

5. Background Papers:

The following documents/files were used to compile this report:

Hub work plans

The NHS Five Year Forward View, October 2014, NHS

<http://www.england.nhs.uk/2014/08/15/5yfv/>

Forward View into Action: Planning for 2015/16, December 2014, NHS 14

<http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf>

Better Care Fund- Technical Guidance, July 2014, NHS England & LGA

<http://www.local.gov.uk/documents/10180/12193/Better+Care+Fund+-+Technical+Guidance.pdf/cf2b02a5-4b3e-47c2-9246-435103b884df>

Integrated Personal Commissioning (IPC) Programme bid from South West IPC Network, November 2014

Agenda Item 10

Title: Update Report – Adult Mental Health: Acute Care Pathway
Date: 25 February 2015
Contact: Jo Hammond, Adult Mental Health Commissioning Manager
Telephone/ jo.hammond@nhs.net 07983 571663
Email:

1. Achievements since last meeting

1.1 Extended Liaison Psychiatry Service introduced to Emergency Department, Emergency Medical Unit, and wards of Torbay Hospital: 08:00 to 22:00, Monday to Friday and 09:00 to 17:00 at weekends.

1.2 Psychiatric Assessment and Management (PAM) Service introduced at the Haytor Unit, providing assessment, treatment and support for people in mental health crisis who present to services out of hours or who are presented by police to the Place of Safety on a Section 135/136. The PAM Service also provides assessment to the Emergency Department and Emergency Medical Wards at Torbay Hospital outside Liaison Psychiatry operational hours.

1.3 Arrangements finalised for telephone helpline, 20:00 to 23:00; the telephone helpline will complement existing crisis telephone support provided by DPT and will go live in April 2015.

1.4 Enhanced section 12 rota introduced during day time hours to prevent delays in accessing doctors for Mental Health Act Assessments.

1.5 Crisis House provision increased from three beds to five beds.

1.6 Community Care Trust consultation completed regarding service reconfiguration to provide out of hours sanctuary service from April 2015.

1.7 Commitment to the development of an urgent mental health care services for children and young people that replicates that of the adult urgent mental health care pathway. Redesign Board established to produce strategy and implementation plan.

1.7 Sign up to regional Crisis Care Concordat declaration and presentation to Strategic Clinical Network Crisis Care Collaboration event.

2. Challenges for the next three months

2.1 Funding for the Street Triage pilot comes to an end in March 2015. Partner agencies have yet to agree a funding stream for the continuation of the service. Evaluation of the service has shown that there is a substantial reduction of the use of section 136 of the Mental Health Act by police when the Street Triage service is operational.

2.2 The pilot peer support project to the acute care pathway, facilitated by Cool Recovery, comes to an end in March 2015. Negotiations are currently taking place with partner agencies regarding continuation of the peer support service.

3. Action required by partners

3.1 For the Torbay Health and Wellbeing Board to note the achievements and challenges reported.

3.2 For the Torbay Health and Wellbeing Board to advise when formal reporting updates are required.

Appendices

Urgent Mental Health Care: Principles and Objectives

Devon Mental Health Joint Commissioning Strategy 2014 -2017

Background Papers:

The following documents/files informed the Urgent Mental Health Care Principles and Objectives:

MIND Listening to Experience (2011)

Mental Health Crisis Care Concordat (Feb 2014):

Devon Mental Health Joint Commissioning Strategy 2014 – 2017

Full reference list at close of Urgent Mental Health Care Principles and Objectives

Principles and Objectives – urgent mental health care

The vision for the urgent mental health care system in South Devon and Torbay over the next five years is that:

People in crisis because of a mental health condition are kept safe and helped to find the support they need, whatever the circumstances in which they first need help, and from whichever service they turn to first. No one in mental health crisis will be turned away or find themselves alone in their distress.

Wherever possible, crisis will be prevented from happening through planned prevention work and early intervention.

Services are of a standard that people would recommend them to family and friends.

The Government has put mental health at the centre of its programme of health reform and in the Mandate from Government to NHS England (2013) there is the specific objective to put mental health on a par with physical health care and close the health gap between people with mental health problems and the population as a whole.

At the point of needing to use urgent mental health care services people have high levels of need, are often in crisis and may feel afraid and vulnerable. In many cases people will be at risk of self-harm or suicide. For people to have access to the right care, in the right place and at the right time is critical to health outcomes overall and to the individual's recovery and future engagement with providers of mental health services.

Improvements to the urgent care pathway to support individuals and their families in the community can also reduce costs by reducing the need for hospital admission. The NHS plan (2000) made the provision of Crisis Resolution and Home Treatment (CRHT) Teams a priority and these teams employ dedicated staff to work closely with people in crisis in order to prevent hospital admission.

Urgent care can be a high risk area of mental health care and it is essential that services such as CRHT Teams are well enough resourced and led to provide a timely response, sufficiently intensive support, safe environments and joined up care.

At engagement events across South Devon and Torbay people have told the CCG that there needs to be more consistency in the provision of out of hours urgent care and greater choice for those experiencing mental health crisis. This important feedback, together with the publication of the Crisis Care Concordat has informed the redesign of urgent care services.

The Joint Commissioning Panel for Mental Health guidance (2013) describes the following philosophy of care for high quality urgent care services:

Individuals should be involved in all aspects of their journey from initial assessment, through treatment to recovery and discharge. All treatment and care should take into account their needs and preferences, and patients should have the opportunity to make informed decisions about their care and treatment in partnership with their healthcare professionals.

The following key principles taken from the guidance inform the development of urgent care services:

People who use services and their supporters and carers should be involved in the commissioning, strategic direction and monitoring of care standards.	The urgent care system should provide a full range of evidence based social, psychological and physical interventions as well as residential alternatives to hospital admission which focus on the person's recovery.	Sufficient resources should be available within the urgent care pathway to ensure patient safety, enable choice and for individuals to be treated close to home, and that choice is facilitated through the roll out of personal health budgets.	There should be a range of agreed outcome data and evidenced patient and carer experience and satisfaction data.
Care for people experiencing mental health crisis and requiring urgent access to services should be available 24 hours a day, 7 days a week.	Early intervention is key in preventing distress from escalating into crisis. To be effective the local system needs to anticipate and where possible prevents crisis.	Good communication within the urgent care pathway is essential. In particular there should be clear criteria for entry and discharge from urgent care and clear standards for communication with primary care.	When rapid help is required the person should be treated with as much urgency and respect as if an urgent physical health need required attention.
The full range of National Institute for Health and Care Excellence (NICE) approved interventions should be available for patients in the acute care pathway.	Care should have a recovery focus demonstrated by outcome measurement.	Providers of urgent care must meet their statutory duties under the Mental Health Act and Mental Capacity Act.	Services should be of a standard that can be recommended to family and friends.
There should be protocols to deliver thorough holistic assessment and a philosophy of care which is holistic, person centred and which facilitates recovery underpinned by humanity, dignity and respect.	A care pathway used and understood by all professionals and easily explained to patients and carers which delivers a full range of evidence based social, psychological and physical interventions which focus on the person's recovery.	There should be sufficient staffing to ensure that interventions are available when people require them.	As part of the care pathway there should be access to advocacy and peer support.

Mental Health Crisis Care Concordat

The NHS Mandate (contains an objective for the NHS to make sure that every community develops plans based on the principles set out in the Crisis Care Concordat that mean no one experiencing mental health crisis will be turned away.

The Mental Health Crisis Care Concordat (2014), agreed by a partnership of organisations and representative bodies aims to improve the outcomes for people experiencing mental health crisis by improving the system of care and support to people in crisis because of a mental health condition and reflects the Mind 2011 'Listening to experience', an independent inquiry into acute and crisis mental health care.

The Concordat describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs and how different services can best work together. The Concordat has been informed by engagement with people who have needed to use crisis services and establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements.

The Concordat spans the health, social care and criminal justice systems and is also relevant to other partners such as housing providers. The Concordat focuses on the need for agencies to work together to deliver a high quality response when people with mental health problems need help; to establish joint intent and common purpose as to the roles and responsibilities of each service. For example Police Officers who respond quickly to protect people and keep them safe, paramedics who may initial assessment and care, and health professionals who assess and arrange for appropriate care.

While the Concordat has been agreed nationally real change can only be delivered locally and the most important ambition of the Concordat is that localities adopt the principles of the Concordat and embed these principles into service planning and delivery. Central to this ambition is the expectation that local areas commit to delivering their own mental health crisis declaration.

The Concordat builds on and does not replace existing guidance and current service provision will continue while the improvements envisaged are put in place.

Crisis Care Concordat Principles

The Crisis Care Concordat is arranged around four key areas:

- 1) Access to support before crisis point
- 2) Urgent and emergency access to crisis care
- 3) Quality of treatment and care when in crisis
- 4) Recovery and staying well/preventing future crises.

Access to support before crisis point

There is growing evidence that it makes sense both for the health of the population and in terms of economics to intervene early when people may have an issue with their mental health in order to reduce the chances of them going on to develop more serious and enduring mental health problems.

People whose circumstances make them vulnerable and their families and carers need fast access to services 24 hours a day, seven days a week. Early intervention is key in preventing distress from escalating into crisis.

With this in mind, the urgent care system has been redesigned with a variety of options being developed to complement existing healthcare provision ranging from a telephone helpline, volunteer peer support, access to planned respite care, rapid access to a crisis house and an out of hour's sanctuary service.

At times of need people using the service, their families and carers and professionals need to know who to contact; to simplify and improve access, a single point of access to urgent care will be a key development of the redesign.

Early intervention includes suicide prevention work. The Mandate from the Government to the NHS states that it is important for the NHS to take action to identify those groups known to be at higher risk of suicide than the general population. The South Devon and Torbay Suicide Prevention strategy and Implementation Plan 2014 - 2017 will inform the redesign of the urgent care pathway as will the CCG's membership of the South West Zero Suicide Collaborative. The Zero suicide collaborative builds on key areas of the Government's strategy Preventing Suicide in England (2011); it brings people together from communities and agencies across the region, to share good practice and learn from each other. The aim is ambitious – to reduce suicide to zero across the south west by October 2018 - and is inspired by the experience of others who have achieved this apparently impossible goal.

Urgent and emergency access to crisis care

- **People in crisis will be kept safe, have their needs met and be helped to achieve recovery.**

Responses to crisis should, where possible, be community based, close to home and the least restrictive option available appropriate to the needs of the person; importantly no one experiencing mental health crisis will be turned away. As part of this urgent mental health services need to be available 24 hours a day, seven days a week.

The urgent care system is being redesigned to include a variety of options many of which complement existing healthcare provision with a focus on out of hours provision:

-Liaison Psychiatry Service - the service that provides assessment for those presenting with mental health problems to the Emergency Department - extended to provide a service Monday to Friday, 8am to 10pm with a pilot commencing in January 2014 to provide a Liaison Psychiatry Service at weekends

-Psychiatric Assessment and Management Service introduced; Nurse Practitioner and support staff out of hours - at night and weekends - to provide an assessment and advice service.

-Place of Safety at Haytor Unit for those detained under 136 of the Mental Health Act enhanced to provide consistent 24 hour availability

-Introduction of volunteer peer support to urgent care pathway - pilot project commenced October 2014

-Provision of community hospital step down beds from acute mental health beds

-Introduction of out of hours sanctuary support for people to receive self-management coaching, peer support, company, signposting and information

-Planned residential respite provision with post discharge telephone support

-Crisis House provision increased to 5 beds for immediate support with post discharge follow up

-Volunteer/peer support mental health helpline 8pm to 11pm, 7 seven days a week

-24 hour telephone access to mental health professionals

- **Staff, across agencies, should have the right skills and training to respond to mental health crisis appropriately.**

Outside the expertise provided by clinicians and support staff in mental health services there are many personnel in other agencies who come into contact with people experiencing mental health crisis. Staff across agencies require increased mental health awareness to improve their response to people in mental health distress.

Mental health awareness training will be integral to the improvements introduced as part of the redesign of the urgent mental health care pathway. Work is underway across agencies to describe and identify who needs to do what and how local training systems fit together so all agencies come to a greater understanding of each other's roles in responding to mental health crisis.

Local examples include

-A set of practice standards/key working principles developed for clinicians in the Emergency Department to improve the experiences of people using the service and those who care for them as well as improving the skills and confidence of staff.

-A pilot is in the early stages of implementation regarding the roll out of a mental health awareness training programme for all NHS 111 staff.

-Mental Health First Aid an educational course which teaches people how to identify, understand and help a person who may be developing a mental health problem, is

being rolled out across agencies with an associated Training the Trainer Course to ensure sustainability.

-The Knowledge and Understanding Framework training for Personality Disorder is available to those working in Health, Social Care and Criminal Justice. The goal of the framework is to improve service user experience through developing the capabilities, skills and knowledge of multi-agency workforces. There is an associated Training the Trainer Course to ensure sustainability.

- **People in crisis should expect a prompt and appropriate response and support when they need it. In particular providers of mental health care services should work towards NICE Quality Statement 6: Access to Services, (2011) for service user experience in adult mental health with regard to access to services:**

-Standard: People in crisis, their carers and GPs will have access to a local 24 hour helpline staffed by mental health and social care professionals: The redesign of the urgent care pathway means that additional resource is now available to operate the CRHT telephone provision out of hours, meaning that people accessing telephone support and advice will not have a prolonged wait for contact should they have to leave a message requesting contact - something that has previously impacted on the experience of those accessing the CRHT Team out of hours .

In addition other telephone support options are being added to the pathway: a peer support/volunteer mental health helpline will be available seven days a week between 8pm and 11pm. Planned out of hours telephone self-management coaching sessions will also be introduced as part of the planned sanctuary service in Spring 2015.

- Standard: Access to the Crisis Resolution and Home Treatment Teams is available 24 hours a day, 7 days a week: The local CRHT Teams operate between 8am and 10pm seven days a week. Outside these hours the Psychiatric Assessment and Management Service is available. Nurse Practitioners provide assessment, advice and support face to face or on the telephone.

-Standard: People in crisis referred to mental health secondary care services are assessed face to face within four hours in a community location that best suits them: The CRHT Teams provide assessment within four hours of a referral being made to the team that requires a rapid response. Assessments are routinely conducted in peoples' homes and carers are included in the assessment process; understanding of the social circumstances of the individual is a key part of assessment. The CRHT Teams operate between 8am and 10pm. Out of hours arrangement are through the Psychiatric Assessment and Management Service as described above with people needing crisis intervention asked to attend for assessment in the Emergency Department; response times from the Nurse Practitioners to the Emergency Department are usually within the hour. As part of the redesign process improvements are planned with regard to the environment where people are assessed out of hours - an out of hours assessment hub is under development on the Haytor Unit for

those who do not have co-existing medical problems that would require the intervention of Emergency Department staff.

In addition the Mental Health Act specifies that step down beds from hospital and other residential beds should be commissioned at a level that allows for beds to be readily and locally available in response to a person in urgent need:

From January 2015, the Crisis House provision has been expanded from three to five beds, and there are, in addition, a range of short term recovery facilities provided by the Community Care Trust that include outreach and planned residential support to prevent crisis. The Community Care Trust also provides access to community hospital beds as an alternative to admission to acute mental health beds and also step down from acute mental health beds.

- **People in crisis in the community, where police officers are the first point of contact, should expect them to provide appropriate help and police should be supported by health services.**

The Devon Partnership NHS Trust (DPT) Street Triage System provides telephone advice and information to police response units across Devon when they have a request for a call to a person that may have mental health, learning disability, alcohol or substance misuse issues. The service operates four nights a week at peak time on Thursday, Friday, Saturday and Sunday. Clinicians give information and advice to assist with decision making and also carry out appropriate liaison and referral/signposting on, according to identified need. The Service has been shown to have a significant impact on reducing the need for section 136.

The Street Triage System service links with the DPT Liaison and Diversion Service which provides timely screening assessments to those detainees and defendants presenting in criminal justice services (courts and police custody) with suspected mental health, learning disability, alcohol or substance misuse issues. Clinicians in the service give information and advice to criminal justice staff on how to manage peoples' needs whilst they are going through the criminal justice system and make recommendations regarding the person's onward referral according to identified need.

- **Health based places of safety should be available and equipped for those people removed by police from a public place under section 136.**

Police have a power, under section 136 of the Mental Health Act to remove from a public place any person an officer believes to be suffering from mental disorder and who may cause concern to themselves or another and take them to a designated place of safety for assessment under the Mental Health Act. The Place of Safety locally is at the Haytor Unit, Torbay Hospital. Evaluation has shown that it has not been possible to provide a consistent place of safety 24 hours a day, 7 days a week and at times this has meant the inappropriate use of police custody suites as places of safety.

The redesign of the urgent care pathway allows for the provision of a 24 hour, seven day a week health based place of safety on the Haytor Unit at Torbay Hospital staffed by Nurse Practitioners and Assistant Practitioners. Local communication and escalation protocols have been strengthened as part of the redesign. It is planned that this enhanced service will go live from March 2015. Detailed data will be made available showing when and why police custody is used as a place of safety, with local partnership reviews taking place to ensure the use of police custody is appropriate and any associated learning is acted upon.

A peninsula wide protocol, agreed across agencies for the use of section 136, has been developed to ensure partner organisations are clear about respective roles and responsibilities in order that responses to people in crisis are risk based, personalised, proportionate and safe. The protocol is in the final stages of sign off and it is hoped it will be implemented from 1 April 2015.

- **When people in crisis appear to health or social care professionals (or to police) to need urgent assessment the process should be prompt, efficiently organised and carried out with respect.**

Section 12 doctors conduct mental health act assessments together with Approved Mental Health Professionals. Historically there have been issues related to the timeliness of access to section 12 doctors which has impacted on peoples' onward care, support and treatment being facilitated in a timely way. The redesign of the urgent care pathway has included the provision of a local enhanced section 12 approved doctor rota within 9 to 5 working hours; these enhancements are currently being evaluated with a planned roll out to out of hours in April 2015 subject to the findings. The Royal College of Psychiatrists guidance on commissioning services for section 136 states that professionals attending Mental Health Assessments should convene within three hours where there are no clinical grounds to delay assessment and evaluation will be against this criteria.

- **People in crisis should expect that statutory services share essential need to know information about their needs so the professionals or service dealing with a crisis know what is needed for managing a crisis and any associated risks.**

All agencies, including police or ambulance staff, have a duty to share essential 'need to know' information to ensure peoples' safety at times of crisis. Where people are already known to mental health services, their crisis plan and any advance statements should be available and follow the person through the system where possible; the Concordat provides detailed recommendations for providers of mental health services regarding the information required in such plans.

A local example of a multi-agency joined up approach to care planning:

The Liaison Psychiatry Service at Torbay Hospital facilitates 'frequent attendee' meetings; working with partner agencies such as the Emergency Department, Ambulance Service and Police to identify those at most risk of presenting frequently to multiple services and seeking

to understand why this is happening and how to support the person to secure the best outcome.

- **People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support in a timely way.**

People in mental distress often seek help through the Emergency Department. Whatever the circumstances of their arrival at the Emergency Department, people with mental health difficulties should expect Emergency Departments to provide a place for their immediate care and adequate Liaison Psychiatry services to ensure that people obtain the necessary and on-going support required in a timely way. The Mandate to the NHS (2013) contains a requirement for NHS England to ensure there are adequate liaison psychiatry services to make the links between Emergency Departments and mental health services.

As part of the redesign process, mental health services to the Emergency Department have been enhanced to improve the timeliness of intervention from mental health services. The Liaison Psychiatry Service which provides psychiatric assessment, advice and consultation to the Emergency Department, has been extended from a 9am to 5pm service and from December 2014 now offers a service between 8am and 10pm at night. The Psychiatric Assessment and Management Service provides assessment in the Emergency Department for those hours when the Liaison Psychiatry Service is not operational; the service has recently been expanded to provide cover for the weekends so that there is now a 24 hour, seven day week mental health assessment service in place.

For those presenting to the Emergency Department in mental distress, without co-existing medical problems, assessment takes place in the Emergency Department environment. There are plans for an assessment hub area to be developed for those who are medically fit to be seen in the more comfortable and less stimulating environment of the Haytor Unit, premises just opposite the Emergency Department. With this facility an increasing number of people can be diverted from the Emergency Department.

Clear responsibilities and protocols are in place between Liaison Psychiatry, the out of hours Psychiatric Assessment and Management Service and the Emergency Department to ensure that people receive treatment on a par with standards for physical health.

A set of practice standards/key working principles has been developed for clinicians in the Emergency Department to improve the experiences of people using the service and those who care for them as well as improving the skills and confidence of staff.

The Emergency Department is about to be refurbished and the Liaison Psychiatry Service is working with the Emergency Department to create a space dedicated to mental health assessment that meets standards for assessment environments as recommended in the Royal College of Psychiatry guidelines (2006).

- **People with urgent mental health needs who access the NHS via 111/999 system can expect their need to be met appropriately.**

The experience of people in mental health crisis accessing the NHS via the 999 system needs to be improved to assist with the initial assessment of mental health presentations and help to ensure a timely and appropriate response.

The new NHS 111 service makes it easier for the public to access healthcare services when they need medical help fast, but it is not a life-threatening situation. NHS 111 can also help to take the pressure off the 999 emergency service and local Emergency Departments, which many people in mental distress turn to if they don't know where else to go for the urgent help they need. NHS 111 is available 24-hours-a-day, 365 days a year. When patients call 111 they will be assessed by trained call handlers who are supported in their role by clinicians.

A pilot service providing mental health information and clinical support to NHS 111 to include 999 response and the Devon Doctor Service with potential to extend the level of support to include police (linking in with the Street Triage Service described earlier) is in the early implementation stage. The pilot includes the rolling out of a mental health awareness training programme for all NHS 111 staff for the duration of the pilot period. The pilot service will operate during periods of peak demand on Friday, Saturday and Sunday nights and bank holidays.

- **People in crisis who need routine transport between facilities and those detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way.**

Police vehicles should only be used in exceptional circumstances to transport people to health based places of safety. NHS ambulance services in England are planning to introduce a single national protocol for the transportation of section 136 patients, which will provide agreed response times and a standard specification for use by clinical commissioning groups.

Quality of Treatment and Care when in Crisis

- **People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting**

The Care Quality Commission (CQC) has introduced changes to the way it monitors, inspects and regulates care services with a focus on whether services are safe, effective, caring responsive and well led. The CQC is developing tools and methods to ensure that consideration is given to the key issues for people experiencing a mental health crisis. This development work has been informed by national emerging concerns relating to the quality of mental health crisis care. For specialist mental health services the CQC will put a greater emphasis on inspecting and monitoring the care that people with mental health problems receive in the community including during a crisis. The CQC will also take account of the Concordat recommendations when inspecting and monitoring the use of the Mental Health Act - this will include making sure the powers of the Mental Health Act are properly used.

Recovery and staying well and preventing future crisis.

The principles of integration of care are valuable in making sure the pathway of services is comprehensive and organised around the patient particularly during transition from urgent care to community mental health care services.

A person's transitions between primary and secondary care must be clear and effective with clear criteria for entry to and discharge from urgent care and should include fast track access back to specialist care for people who may need this in the future. The crisis plans referred to earlier in this document will be key in this respect. Local commissioning for quality and innovation (cquin) work in 2013/2014 focussed on transfer between secondary mental health services and primary care, introducing standard templates for transfer to ensure consistency of information sharing and introducing a rapid re-referral pathway.

The urgent care pathway is dependent on well-functioning community mental health services for those who will not recover within the timeframe for urgent care. It is essential that people have information and referrals to services that support the process of recovery and staying well with opportunities to reflect on periods of crisis to explore better ways to self-manage mental health.

No Health Without Mental Health (2011) includes a commitment for Public Health to work to reduce mental health problems by promoting improvements in mental health and wellbeing. Work led by Public Health England seeks to develop the resilience of the population by addressing the individual community and societal factors that can lead to a crisis such as environmental, psychological, emotional or social problems. Good housing, decent income and good health promote good mental health.

A strategic approach to commissioning services for people on a wider definition of emotional or mental health crisis should help ensure that people can access timely support whether they need the acute care pathway or a less intensive response. Locally the Joint Health and Wellbeing Strategy 2012/13 - 2014/15 outlines priorities.

CCGs will be rolling out personal health care budgets for people with long term conditions. The Department of Health Evaluation of the Personal Health Budget Pilot Programme (2012) has found that personal health budgets have a significant positive impact on care related quality of life, psychological wellbeing and subjective wellbeing. They have been shown to be effective for people with mental health problems and are a real option for people with long term mental health problems who may periodically need to use acute mental health services. As personalisation of health care develops there will be a growing evidence base of what individuals choose to buy to support them through mental health crises which will also help to inform future commissioning.

Outcome Measures

The effective planning and management of urgent mental health care services, including the involvement of patients and their carers in the development of the services, will support the following shared outcome objectives:

- More people will have good mental health: high quality urgent care will support the lasting recovery of people in mental health crisis. It will also improve the wellbeing of people who experience mental health crisis by providing confidence in the availability and quality of support when needed.
- More people with mental health problems will recover: high quality urgent care supports recovery and connecting people with community resources.
- More people with mental health problems will have good physical health: high quality urgent care will help prevent deaths by suicide, mitigate the adverse effects of medication and facilitate access to physical healthcare where appropriate.
- More people will have a positive experience of care and support: high quality urgent care is central to meeting this objective as it is in mental health crisis that people are least likely to feel they have choice and control and are more likely to be subject to restrictions.
- Fewer people will suffer avoidable harm: the philosophy and standards of high quality urgent care and the use of outcome measures will help achieve this objective.
- Fewer people will experience stigma and discrimination: a high quality urgent care service that is valued and effective is likely to contribute to public understanding and attitudes.

Key outcomes will be related to the accessibility and responsiveness of services to support people through crisis and prevent admission and provide treatment close to home. Service providers have the responsibility for monitoring the quality of their responses to people in crisis and outcome standards related to the monitoring of the quality of responses to people in crisis will be included in contracts with providers of mental health services. Importantly patient reported outcome measures will be at the centre of outcome evaluation to provide additional narrative to more traditional performance data and clinician reported outcomes. Where possible standards will be applied across providers to encourage providers to work together to meet shared aims.

There are a range of outcome measures that can be used to determine the quality of patient care along the urgent care pathway to be agreed between commissioners and providers. Patient satisfaction surveys will also provide important reflections of peoples' experience of care.

Work stream	Responsible Group	Lead
Redesign of Acute Mental HealthCare Pathway	Acute Care Pathway Steering Group reporting to Mental Health and Learning Disability Redesign Board	Head of Mental Health Commissioning

References:

No Health Without Mental Health: a cross government mental health outcomes strategy for people of all ages (2011)

Joint Commissioning Panel for Mental Health: Guidance for commissioners of acute care - inpatient and crisis home treatment (2013)

NHS Plan: Department of Health (2000)

The Mandate: A mandate from the Government to NHS England: April 2014 to March 2015: Department of Health (2013)

Mental Health Crisis Care Concordat: HM Government (2014)

'Listening to experience', an independent inquiry into acute and crisis mental health care. Mind (2011)

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National Institute for Health and Care Excellence. Quality standard for service user experience in adult mental health: Quality Statement 6, access to Services. (2011)

Better Services for People who Self-Harm: Quality Standards for Healthcare Professionals. Royal College of Psychiatrists (2006)

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Evaluation of the Personal Health Budget Pilot Programme. Department of Health (2012)



A mental health commissioning strategy for Devon, Plymouth and Torbay

2014-2017

Joint Commissioning
2013-2017

NEW Devon CCG
South Devon and Torbay CCG
Devon County Council
Plymouth City Council
Torbay Council

Agenda Item 10
Appendix 2

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Northern, Eastern and Western Devon
Clinical Commissioning Group



South Devon and Torbay
Clinical Commissioning Group



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Introduction

Welcome to the commissioning strategy for adult mental health services in Devon. It reflects the intentions of the health and social care commissioners for Devon County Council, Plymouth City Council, South Devon and Torbay Clinical Commissioning Group and Northern, Eastern and Western Devon Clinical Commissioning Group. This strategy is for all adults, regardless of their age.

The strategy will link the needs assessment work for Devon and Plymouth with national policy, statutory obligations, evidence bases and the commissioning intentions for all of the

commissioning organisations in Devon. This strategy should be read alongside the strategies for dementia, carers, learning disability and the early help strategy for children so that it can be seen in the proper context.

This strategy has been discussed with key stakeholders, particularly user and carer groups, with a clear intention to gain consensus and support for the future of mental health services. The themes and priorities identified through the engagement process will be identified and prioritised.

The context for future commissioning is set by the significantly challenging financial environment in the public sector. Resources available for commissioners are subject to substantial pressure and this has inevitably led to commissioners, providers and stakeholders considering options for future services which reduce demand for services, promote earlier intervention and ensure the best value for money. This must all be achieved against a background of increasing demand and an ageing population.



Our commitment

We feel the people of Devon deserve excellent mental health services that are available when they are needed and are based on the best evidence for effectiveness. Alongside these services there needs to be a wide range of opportunities for people to do the things that will support good mental health and wellbeing and provide the choices that promote good housing, a place in the community, strengthen families, enable friendships and support employment, activities and positive lifestyles.

This commissioning strategy focuses on how we can support good mental health and seek to prevent mental ill health. It emphasises the need

to promote recovery and support people to overcome the consequences of mental illness so that they can lead satisfying, independent and productive lives.

We are committed to ensuring that the people of Devon can:

- Access the services and support they need
- Have a choice over how they receive services and support
- Have control over the services and support they receive

- Expect the commissioning and delivery of those services to be integrated
- Demand that commissioners seek to improve and develop services in line with best practice and need
- Be involved in planning and delivering treatment and support
- Have the opportunity to influence how services are commissioned and provided



Outcomes

The consultation with users, carers and other stakeholders has steered the development of this strategy. We want to make sure people will be able to say:

- I have personal choice and control or influence over the decisions about me
- I know that services are designed around me and my needs
- I have an improved quality of life as my mental health needs are assessed swiftly and effectively and I am able to access the treatment and support I need

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I have a positive experience of care and support

I receive help and interventions sufficiently early to prevent the avoidable deterioration of my mental health

- I have a sense of belonging and of being a valued part of family, community and civic life
- I receive the treatment and support that allows me to recover and sustain that recovery
- I have a say in the development and monitoring of mental health services



Reviewing our progress

We have a plan for implementing all of the identified priority actions to help ensure that this strategy is a success.

We want to make sure people are fully involved in the commissioning and provision of services. This is crucial to the effective implementation of the strategy.

Within mental health commissioning and, by extension, service provision we are clear that service users and patients will be able to have oversight and influence over the effectiveness of this strategy and its delivery.

These issues will be reflected in an attempt to show greater transparency in how decisions are made and who makes them so that scrutiny is applied to all our processes – both in NHS and Local Authority organisations.



Our priorities

This strategy provides an overview of national policy, evidence bases, current commitments and, crucially, input from stakeholders and people who use services.

The crucial policy documents that inform this commissioning strategy are:

- No Health Without Mental Health (DH, 2011)
- Talking therapies (DH, 2011)
- No health without mental health: implementation framework (DH, 2012)
- Preventing suicide in England (DH, 2012)
- Caring For Our Future: reforming care and support (DH, 2012)
- Closing the Gap (DH, 2014)

These are the most important of a wide range of policy and guidance documents that have informed the development of this strategy.

The intention for the CCGs and councils in Devon is to ensure that all local commissioning and service delivery can reflect national priorities as expressed in the above documents. National

policy has identified these key priorities and all local planning and delivery will focus on work that addresses these areas:

- Prevention
- Personalisation
- Integration
- Improving health and wellbeing
- Supporting recovery
- Access to services

All of these priorities are underpinned by a system-wide commitment to:

- Engagement and involvement of people who use services and carers in both service monitoring and the commissioning process
- Financial sustainability
- Effective safeguarding arrangements for vulnerable adults and for children in families affected by mental ill health
- High-quality services



Market position statements

Plymouth City Council and Devon County Council have market position statements that explain to service and support providers what they require in terms of need, demand and provision. This is designed to encourage providers to develop the services that will meet the changing needs of the people of Devon.

The statements clearly outline current and future demand for services and express the focus on state-funded support for those with the greatest need and the promotion of self-supported care for those with lower needs.

The drive continues to promote more self-directed care, care at home and support towards greater independence and recovery. This will reduce the market for residential and nursing home care. Alongside this there is greater support for carers and greater flexibility in the market for alternatives to care.

Plymouth City Council has reviewed the effectiveness of current mental health provision under the Pledge 90 Review and this work has been influential in setting the direction for this strategy.

Devon County Council have updated the carers' strategy, accommodation strategy and supported living strategy as well as supporting self-directed care and the use of personal budgets.



Mental health needs assessment

The public health teams of Devon County Council and Plymouth City Council recently produced comprehensive mental health needs assessments for the population of Devon. These documents reveal the pattern of need and help identify priority areas for action.

The needs assessment for Devon identified the following key priorities:

- Personality disorder and services for those that self-harm
- Eating disorder support for young people
- Suicide prevention
- Improved analysis of prescribing
- Improving services for young people and children and working to prevent mental illness
- Improved access to services and treatment at the time and place it is required

The needs assessment for Plymouth identified the following priorities:

- Improving universal services and developing mental health and wellbeing
- Targeted community-based services to support good mental health and promote access to support
- Improving specialist mental health functions
- Improved engagement and involvement of those with lived experience

The key message from these assessments is that commissioning priorities should focus on promoting the mental health and wellbeing of the population especially in terms of access to support and treatment, access to stable accommodation and housing support, support for employment, promoting community-based provision and ensuring that mental health services are integrated.



Prevention

The heart of good mental health is resilience to the shifting pressures and tides of life. This involves a combination of personal qualities and skills with foundations of home, employment, education, family and community. In all families and communities it is inevitable that there will be challenges that can cause the kind of difficulties and pressures that lead to mental distress and illness.

Mental health services have traditionally focused on responding to the needs of people as they develop. Over recent years there has been an increasing interest in understanding the causes of mental ill health and attempting to address them before they become severe. There are three basic approaches which focus on preventing or limiting the onset of significant symptoms:

- **Primary prevention** – intervening with individuals, families or communities to prevent the development of predictable mental health issues. This relies upon good data about needs combined with intelligence sharing about families and individuals at risk. The Devon Early Help Strategy for Children and Families demonstrates the key opportunities that can both help and protect children.
- **Secondary prevention** – also known as early intervention, this is the practice of intervening at the first signs of severe mental health issues, especially in psychosis, personality disorder and eating disorders. This is reliant on a combination of effective patient finding and clear referral advice to those that might recognise early presentations.
- **Tertiary prevention** – rapid response to relapse of known patients. This is particularly reliant on good planning and communication across services.

Effective prevention of course relies upon strong communication within health, social care, criminal justice, education, family and housing systems. The information gathered by these agencies and services must be used to enable mental health specialists to focus on those communities, families and individuals in way that can change outcomes.

The foundations of good mental health and wellbeing are:

- Good relationships
- Financial security

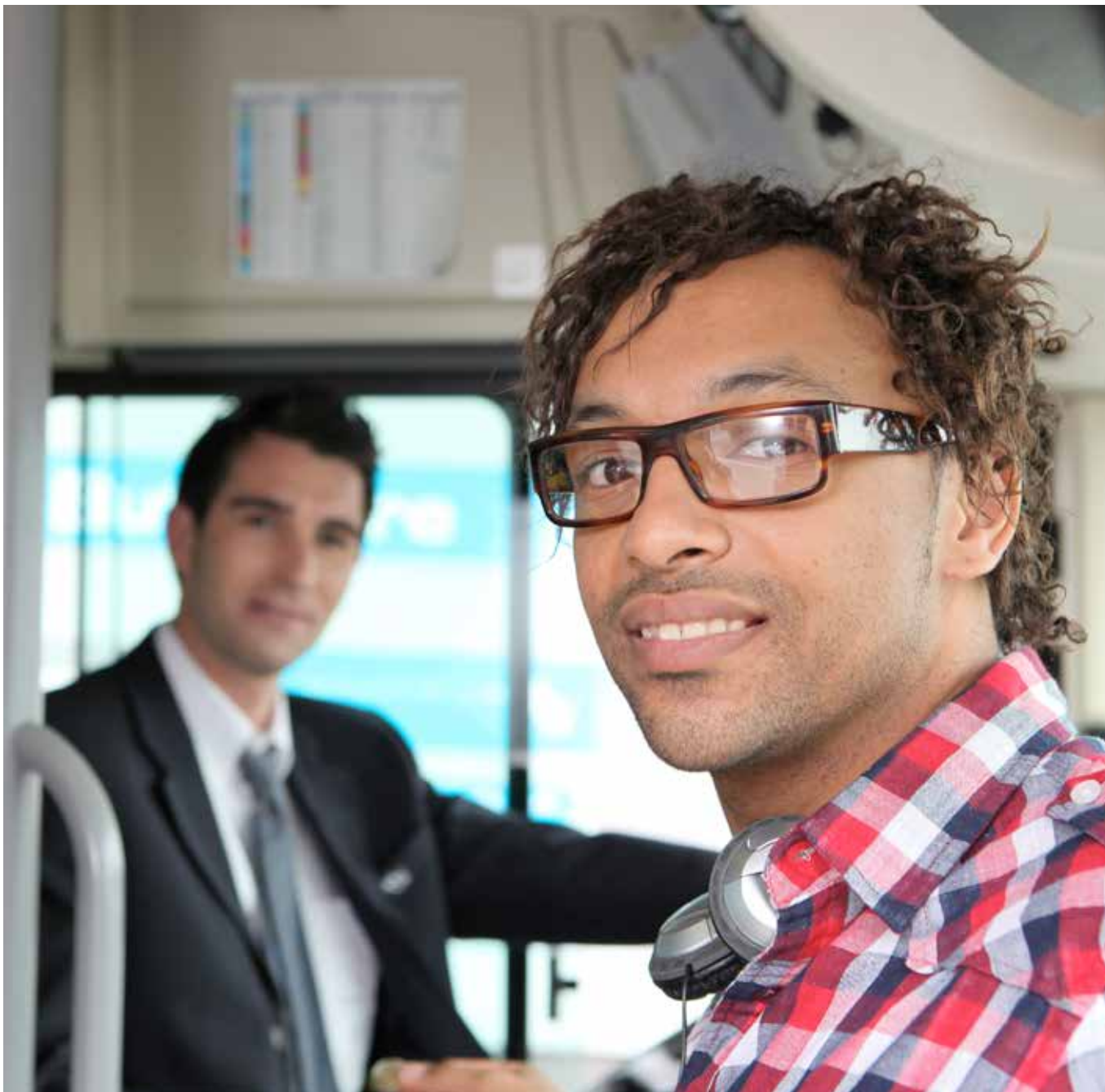


- Meaningful occupation or employment
- Personal growth
- A good home
- Developing resilience

Commissioning will be focused on the development of support at all levels that encourages these foundations, with the aim being to support people to develop and maintain these core elements and prevent the onset of damaging mental health presentations. Examples include allotment groups, 'Men in Sheds', specialist housing support, mental health education in schools and employment retention support. These examples are simply a selection of the potential opportunities for commissioners to encourage good mental health and promote the kind of support that reduces the need for individuals to receive specialist interventions.

Families with a future

This programme is the sort of opportunity that can bring effective primary prevention to bear on the incidence of mental ill health in our communities. Based on an analysis of need and indicators such as non-attendance at school, worklessness in the family and involvement with youth offending and criminal justice – it allows professionals to target interventions at specific families and in the places where it can lead to real change. This is especially the case in the lives of young people, giving them resilience and the help they need to escape the consequences of challenging family lives.



Personalisation

Personalisation is about respecting a person's human rights, dignity and autonomy, and their right to shape and determine the way they lead their life. Personalised support and services are designed for the purposes of independence, wellbeing and dignity. Every person who receives support should have choice and control, regardless of the care setting.

(No Health Without Mental Health, DH, 2011)

The key values and principles that will drive the commissioning of mental health services in Devon are based on a commitment to the individuals who receive support to take control of their own mental health issues and retain the independence taken for granted by those who are well.

There are two important areas of development for personalisation:

- The promotion of strong processes that place people at the heart of all decision making and planning by statutory organisations and the partners commissioned by health and social care – for example, person-centred planning and patient-controlled medication programmes
- The use of personal budgets and direct payments to give people more determination of how to exercise choice and control – for example by developing personal budget processes and ensuring there is a market of providers to respond to individual requirements

Personalisation is more than processes and personal budgets and these two areas are just the beginning of developing truly personalised approaches to both commissioning and service delivery.

In Control

The 'In Control' programme has demonstrated many of the key benefits of personal budgets and, crucially, returning the power and authority to make decisions and care, support and treatment back to users of services and their families and carers.

This programme is a key influence on the work of Devon County Council and Plymouth City Council in developing the use of personal budgets, direct payments and highly person centred approaches.

The National Development Team for inclusion (NDTi) and Think Local Act Personal (TLAP) have identified a whole-system framework for personalisation in mental health.



The key principles are shown below.

- Helpful, person-centred approaches
- Information and advice, personal motivation and self-help
- Support for managing personal budgets
- Support for carers
- Fair access and equality
- Creative commissioning
- Partnership for inclusion
- Prevention and early intervention
- Good leadership

Workforce and organisation development

(Paths to personalisation in mental health:
A whole system framework, NDTi 2013)



Integration

The Department of Health has identified that integration of health and social care systems is an opportunity to improve services, become more efficient and, crucially, to improve the experience of users. Commissioners have a number of key priorities for mental health services in Devon:

- Instituting an integrated commissioning approach for NEW Devon CCG, South Devon and Torbay CCG, Devon County Council, Plymouth City Council and Torbay Council

- Ensuring primary and secondary care services have shared and integrated processes for managing care and treatment, including integrated treatment pathways
- Integrated approaches to managing mental health presentations in general hospital settings
- Integrated arrangements with social care and local authorities, including district councils, for service users to access employment support, targeted housing support, education, advice and information
- Ensuring services for children and young people are integrated with those for adults so that transition processes and the opportunities for prevention and early intervention are maximised
- Integration of service delivery so that voluntary, charity, third sector and private providers are full partners in the delivery of support, care and treatment



The issues that drive these intentions are more than just matters of efficiency and effectiveness. The Department of Health and NHS England use the Better Care Fund to ensure that the full benefits of integration are felt in the health and social care system. For mental health users this will mean:

- People not having to retell their story
- Being able to access support when needed as the overall system communicates well
- Discharge from hospital and specialist services support to be more sustainable
- Service delivery at the control of users and their carers

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Lengths of stay in hospital reduced

In order to achieve these outcomes there are significant opportunities to integrate health and social care provision so that provision of treatment, care and support is experienced as

a single pathway. Evidence has shown that integrating whole systems and pathways can generate significant improvements for clinical outcomes, efficiency and patient experience.

The primary opportunities for service improvement via integration are:

- Integrating mental health expertise into general healthcare – especially in A&E, primary care, management of long-term conditions and in general hospital settings
- Integrating pathways for children and young people into adult services
- Dual diagnosis (mental health with alcohol or substance misuse)
- Personality disorder
- Eating disorders
- Management of mild to moderate mental health issues

Eating disorders in Plymouth

The pathway for eating disorder treatment has been integrated so that services provided by EDS (a charity in Plymouth), Plymouth Community Healthcare (a specialist mental health provider), Hound Ward at Derriford Hospital and the Haldon Unit (a specialist service provided by DPT) have delivered significant improvements in the system ensuring appropriate access to services, care closer to home and a substantial reduction in inpatient admissions, all of which have allowed a reallocation of resources to community services.



Improving health and wellbeing

Recent research by the Health and Social Care Information Centre shows that people in contact with specialist mental health services are nearly four times more likely to die prematurely than the rest of the population. This is an unacceptable position for commissioners and policy makers and is the focus for significant change in the coming years.

There is clear evidence that people with mental health problems have poorer lifestyles, including a significantly higher rate of tobacco use and alcohol consumption. This contributes to higher rates of ischaemic heart disease, respiratory illness and liver problems.

This situation is compounded by the evidence which indicates that people with severe mental health problems are less likely to receive the best treatments for physical health problems and that people with a diagnosis of schizophrenia are less likely to be registered with a GP.

It is now a key expectation for both mental health service providers and general hospital services that they will ensure equal access to health services. In support of this, one of the key priorities for commissioners is the improvement

of psychiatric liaison services to ensure that people with mental health problems in hospital receive good-quality psychiatric input. Commissioning guidance has been issued that will support commissioners and providers to ensure there are adequate resources allocated to this area of work.

Specialist mental health services have a key responsibility for ensuring that the people receiving services from them are given good-quality health reviews. It is essential that assessment and care planning is focused on physical health, particularly for those with severe illness. Addressing lifestyle issues is a priority for mental health services, *McManus et al* (2010) found that 42% of total tobacco consumption in England is by those with a mental disorder. Care planning will need to include efforts to reduce or stop tobacco use and alcohol consumption whilst promoting healthy eating and exercise.

Commissioners will also work with GPs to look at how health improvement can be delivered in primary care, with extra emphasis on healthy living being given to patients with mental health issues.



Supporting recovery

When the resilience to cope with the challenges in life has been overwhelmed and preventive interventions have not succeeded, emphasis must move towards effective treatment to help people recover from the mental ill health they are experiencing. Recovery can and does mean different things to different people, but for the purposes of this document we are focusing on the idea that following treatment for mental ill health people may require ongoing support to enable sustained wellbeing, reduced dependence on services and the opportunity to thrive.

The priority is for services to engage people with mental health problems in treatment, therapy and activities that help them regain their resilience, while also maintaining their place in family, community and employment; and to help them develop the skills to recognise when things are starting to go wrong as well as the expertise to manage their own treatment.

For this to be achievable there needs to be a comprehensive range of treatments that will help people to recover from their illness and a range of supports that will help people maintain their wellbeing and avoid relapse or crisis. This should encompass a range of treatments and support at all levels of need and complexity.

Primary care: the IAPT programme made the case for swift access to therapy that will help people with mild to moderate depression and anxiety presentations to recover. However, there needs to be further encouragement and guidance for people to access the kind of

support that will help keep them well without the need for medication and therapy.

This document has repeatedly emphasised the importance of ensuring people can have a place in their community, strong relationships and meaningful activity, to give them the kind of support that helps to break down social isolation and overcome the inactivity prevalent within mental ill health. Social activities like exercise groups, gardening and 'Men in Sheds' are available to the people of Devon today but it is important to ensure they are available in all areas and are part of a wider network of mental health supports and services. This includes a clearer set of expectations for GPs in the skills they have to diagnose and treat but also how to help their patients access the supports that will improve their lives and cement their recovery.

Specialist mental health services: ensuring that all patients are able to enter appropriate treatment to deliver the best chances of recovery remains the main requirement of a specialist mental health service, whilst keeping people with mental health issues and the community safe. As noted above it is not enough to treat; it is also necessary to ensure people have the best chance to stay well. The expectation for providers of secondary mental health services is that they will focus attention on supporting their patients to recover by ensuring access to effective and appropriate treatment and then supporting them to regain their place in their home, families, communities and in employment.

Social care: sustaining recovery and maintaining good mental health is only partially about complying with treatment. The support necessary to maintain a place in society is crucial to the long-term recovery of any person. Naturally many people will have their resources of family, friends, home, activities and work, but many of those who have suffered significant mental health issues will require extra support, especially around finding and maintaining a place in the community, housing and employment. These solutions need to be part of an integrated approach with treatment functions and social support. The role of social care providers is paramount in helping people to sustain their recovery but is also fundamental in maintaining the capacity in mental health services in Devon so that people are less likely to relapse or endure crises in their lives.

Plymouth provider network

The provider network in Plymouth has developed its own mental health strategy with a focus on recovery and an emphasis on integrated pathways and working arrangements. The network brings together a range of providers, stakeholders and users to create networks and relationships within the city and improve the opportunities available to people with mental health problems.

The strategy can be seen at:
www.plymouthmentalhealth.org.uk

Access to services

The feedback received during the development of this document came back again and again to the issue of access to services. It was a recurring theme that came from users, carers, referrers, commissioners and providers. Access issues come in many forms: capacity, opening hours, waiting times, choice, availability in rural areas, access to specialist knowledge and access thresholds.

Over the life of this strategy the commissioners in Devon will focus on ensuring that people experiencing mental health issues, regardless of the severity, will be able to access advice, guidance, education, treatment and support to enable their recovery and support their mental health and wellbeing.

The key areas for development are:

- Access to services in primary care
- Out-of-hours and seven-day working
- Ensuring services meet the needs of older people
- Ensuring services meet the needs of people with learning disability
- Support in the criminal justice system
- Crisis services
- Alternatives to admission
- Specialist treatment pathways
- Support to families with children

All of these approaches to improving access need to be understood against a requirement to improve efficiency and reduce costs in the system. Therefore simple investment in extra capacity is not an option available to commissioners or providers without releasing resources from other areas.

Access to services in primary care: one of the key opportunities available in mental health service provision is to improve the way people can access mental health services in primary care. The IAPT programme is already increasing treatment capacity in primary care but there is a need to ensure that GPs and primary care services as a whole are able to access the expertise and knowledge held in specialist mental health services. This can enable GPs to make good decisions about their mental health patients, provide effective treatment and build their confidence in managing mental health issues. There are concerns about the poor access to services for older people with mental health problems; ensuring that efforts are made to increase referrals and attendance in mental health treatment services is a priority.

Increased visibility of mental health specialists in primary care is crucial in building strong working relationships between primary care and mental health specialists, allowing the use of increased shared care and, in return, ensuring capacity to deliver swift advice and early interventions.

Alongside this GPs need to be able to access the kind of support that addresses social isolation

for their patients and helps overcome the crises that can lead to losing homes and family or relationship breakdown. One of the key opportunities is the use of peer support – support which is led and provided by users for people with mental health issues. Peer support can operate at all levels of need, the key focus is on it being mutual, reciprocal, non-directional and recovery focused (Repper *et al*, Peer Support: Theory and Practice, ImROC, 2013).

Out-of-hours and seven-day working: it is no longer sufficient to manage services solely during 'office hours'. People quite reasonably expect that they will be able to get help when they need it, including during evenings and at weekends. Current arrangements for out-of-hours services are largely based around duty rotas, inpatient wards and crisis teams (which focus their work on existing patients on team caseload). The priority areas for improved access are to be around support in A&E through psychiatric liaison teams; support to primary care teams, out-of-hours GP services and the 111 service; and the work of community mental health services.

Dual diagnosis: there is a clear need to ensure that services for mental health and for substance misuse are effectively integrated to deliver effective interventions for people experiencing mental ill health alongside alcohol and/or drug misuse. This group of people are often significant users of services and can experience poor outcomes because of uncertainty about cases are managed which service is responsible.

Ensuring services meet the needs of older people: while there is an understanding that mental health services are available to all adults regardless of age, in practice older people are less likely to access services that will help them recover from mental ill health and distress. Clear evidence for low referral rates and engagement in treatment for depression and anxiety in the older population is a concern for commissioners.

This strategy should be read in conjunction with the Devon, Plymouth and Torbay Joint Commissioning Strategy for Dementia – ‘Living Well with Dementia’ – as the issues for older people frequently overlap. This need for effective joint working is one of the key improvements intended in the strategy and informs part of commissioning priorities.

Ensuring services meet the needs of learning disabled people: the commissioners will expect providers to ensure that people with learning disabilities are able to access mental health services in line with the revised ‘Green Light’ toolkit from the NDTi. Improving mental health outcomes and wellbeing is one of the priorities for commissioners and this strategy should be read in conjunction with the Devon, Plymouth and Torbay Joint Commissioning Strategy for learning disabilities – Living Well with Learning Disability.

Support to the criminal justice system: there is a significant overlap between the criminal justice system (the police, courts and probation) and the mental health services. There is a statutory need to work together in order to deliver the requirements of the Mental Health Act 1983. The police in particular need to be

able to access specialist advice, patient information and NHS provided Places of Safety in order to make the best use of the Act and to deliver the best outcomes for people affected by mental health issues who come into contact with the police.

The development of both liaison and diversion services in police custody centres and the courts and piloting of ‘street triage’ approaches are positive steps forward for mental health services but a further culture of co-operation will be developed by all the stakeholders over the next three years.

Liaison and diversion

The liaison and diversion service has been developed to ensure mental health expertise is available to police custody units and the courts to allow good judgement to be used in dealing with people with mental health issues who come into contact with the criminal justice system.

The service is able to effectively divert people who are experiencing mental health difficulties away from criminal justice and into treatment. This represents a good outcome for the police, courts, mental health services and, of course, the patient.

Crisis services: the definition of crisis is not a concrete one. Current arrangements for crisis response are based either on known patients and are aimed at preventing crises by planning carefully and intervening appropriately when

risk factors are identified, or they are based on duty services and are called upon as and when they are required. This uncomprehensive arrangement can often lead to significant delays and it does not identify many choices for people experiencing mental health crises.

The ability to respond swiftly to requests for help is key in ensuring that people can be seen at an early enough juncture to prevent any further deterioration of their presentation; it can also open up options for people to access different kinds of support and intervention. In the main, experience shows us that simply listening to people describe the issues affecting them and giving them advice and signposting them to support or reminding of their care plans is sufficient to help manage a crisis in the short term. When further intervention is required, being able to see people in safe comfortable environments is crucial.

The fundamental requirement is for people to be able to access this help when they need it and in a way that helps them to overcome the crisis they are experiencing.

There is a range of solutions to crisis situations:

- Telephone support such as 111, non-statutory services like Samaritans and mental health crisis services
- Attendance at A&E
- GP out-of-hours services
- Crisis houses
- Specialist mental health crisis services

Currently these options are not always available and are not integrated to ensure people access the most appropriate response to their needs. This is a priority area for commissioners who must ensure that crisis support is provided and the cost of escalating mental health crises are avoided wherever possible.

Mental Health Crisis House in Torbay

In response to an engagement process and listening to what people with lived experience have said, Torbay has opened a crisis house in partnership with DPT and the Community Care Trust (South Devon). This development represents a new way of giving choice and support to people in crisis in the community (in a non-stigmatising way) and will help avoid unnecessary in-patient care admissions.

Alternatives to admission: it is important that services do not fall back onto inpatient admission to manage crises and complex treatment regimes but in order to avoid this there have to be alternatives to admission which make the safe and appropriate management of care and treatment possible. Inpatient care is both expensive and can create dependency and institutionalisation. There is also the question of what to do next if admission to a local service is ineffective. The current position for Devon is that it is an outlier on benchmarking for the use of out-of-area hospital placements. Providing alternatives to hospital treatment, especially for complex and risky behaviours, is a priority for commissioners.

Alternatives to admission need to be robust, reliable and should not be seen as a reason to not have inpatient facilities at all. They are part of a range of options that are available to professionals to meet the needs of individual patients.

As commissioners, one of our main priorities is to reinvest in local placements. There is increasing evidence that out-of-area placements in institutions are ineffective and that the consequences for people placed away from home can include the loss of their homes, employment, family links and their place in the community. The focus is on ensuring that the needs of people in Devon with mental health issues can be met in the county and on reducing the rate of placements.

The best option is to use person-centred approaches to plan in detail for an individual and to ensure that there is a clear understanding both of the things that keep a person well and the indicators of a relapse. Good planning reduces the frequency and intensity of crises, reducing the need to admit people to hospital.

As noted above the significant use of crisis houses can be a practical, non-stigmatising way of providing an environment where people can overcome a crisis without needing to be admitted to hospital.

Ultimately, the services that manage admission to hospital need to have a range of intensive options available which mean they can provide extra support to people in their homes; the emphasis will be upon crisis and home treatment services and the community mental

health services working with partners in the independent sector to offer the intensive interventions that deliver safe treatment and support without the need to hospitalise a patient.

Specialist treatment pathways: the best outcomes for patients lie in ensuring that they can access professionals with appropriate skills at the appropriate time. Access to expertise in key areas is at the heart of delivering the best outcomes, especially for those presentations that are risky and complex, such as eating disorders.

The commissioners will ensure that there are clear, evidence-based specialist treatment pathways that start with the earliest forms of intervention and engagement, work through evidence-based interventions and, ultimately, to specialist inpatient treatment where required.

The priority pathways for improved access are:

- Eating disorders
- Personality disorder
- Dual diagnosis
- Forensic and secure services

These have been identified because they represent high-risk areas or are linked to increased use of out-of-area placement. They are supported with strong evidence bases and/or NICE guidance for treatment and management.

Involvement of people who use services and carers

The commitment that has been shown to user and carer involvement by both providers and commissioners provides an excellent foundation for the development and enhancement of the current approach.

A joint carers' strategy is available and it focuses on delivering the 'five outcomes for carers'.

The key point is the need to recognise the work carers do and ensure they are heard in planning and decision making. The use of the triangle of care to ensure that services are suitably focused on ensuring carers are effectively involved is a key outcome from the carers' strategy and is a key expectation from services in the coming years.

Alongside this strategy there is a commissioner commitment to ensure that people with lived experience of mental illness are able to effectively influence the commissioning, delivery and monitoring of services and ensure that they are present in all of the key processes of the commissioning organisations.

The priority areas for action from this strategy will require full involvement of users and carers in order to both shape the work to be done and monitor progress on delivery. This strategy is intended to be fully inclusive and to respond to the feedback and leadership of people with lived experience.



High-quality services and financial sustainability

It is in the interests of commissioner, provider and user of services that the focus is on high quality and the best outcomes. The simple fact is that not having to deal with the consequences of poor services will improve efficiency and capacity thereby saving money across the health and social care system. No Health Without Mental Health (DH, 2013) identified four key ways to get the best out of services:

- Improving the quality and efficiency of current services
- Radically changing the way that current services are delivered so as to improve quality and reduce costs

- Shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises
- Broadening the approach taken to tackle the wider social determinants and consequences of mental health problems

The key areas for quality improvement in Devon are:

- Urgent and inpatient care – reducing admissions, fewer crises and improved prevention

- Improved prescribing practice – ensuring medication is used effectively throughout primary and secondary care
- Integration of health and social care commissioning and service delivery
- Improved care planning and co-ordination – with a focus on person-centred approaches and shifting control to patients and their carers
- Effective safeguarding arrangements to protect vulnerable adults and children in families experiencing serious mental health issues



Safeguarding

In recent years there has been a growing awareness that the abuse of vulnerable adults is of heightened concern in our society. The increasing number of serious incidents of abuse emphasises the need for action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support. It is every adult's right to live free from abuse in accordance with the principles of respect dignity, autonomy, privacy and equity.

People who are experiencing mental health issues are often more vulnerable to potential episodes of abuse. Also, those who live with people experiencing mental health issues are potentially at a greater risk of harm. Recent high profile cases, including Winterbourne View, highlight the increased vulnerability of those who are receiving residential care for their mental health issues, and how a greater level of protection and vigilance is required for these individuals.

It is, therefore, essential that commissioned services are of a high quality and safeguard those vulnerable individuals from episodes of abuse. It is the responsibility of commissioners to work together to ensure that any adult at risk of abuse or neglect is able to access public organisations for appropriate interventions which enable them to live a life free of violence.



Summary

This strategy is intended to draw together the commissioning intentions of five commissioning bodies:

- Plymouth City Council
- Torbay Council
- Devon County Council
- South Devon and Torbay CCG
- NEW Devon CCG

Within the economic constraints that affect public service commissioning and delivery these bodies will attempt to focus on how mental health services can continue to meet the needs of the people of Devon as demand for services increases.

The key areas for development are:

- Prevention
- Personalisation
- Integration
- Improving health and wellbeing
- Supporting recovery
- Improving access

For this to be a credible plan for the future there needs to be greater involvement of those with lived experience at every stage of the commissioning, delivery and monitoring of mental health services.



Acknowledgements

The commissioning team wish to thank Be Involved Devon (BID) and Plymouth Involvement and Participation Service (PIPS) for their hard work in the devising and organisation of consultation events. Their contribution has been invaluable.

Thanks are due to all stakeholders including commissioners, GPs, mental health professionals and service providers who have contributed to the development of this document.

Above all, the commissioning team wish to thank the experts by experience, both users of services and carers for their invaluable input to this strategy.



This guide is also available in Braille, large print and other languages on request.

Mental Health Commissioning Strategy for Devon, Plymouth and Torbay, 2014 -2017

Action Plan Summary

The Mental Health Commissioning Strategy provides an overview of national policy, evidence bases, and current commitments and is informed by stakeholders, people who use services and carers.

In developing the associated action plan for the strategy the approach has been based around the six key priorities identified within the strategy that reflect national priorities; all local planning and delivery will focus on:

- Prevention
- Personalisation
- Integration
- Improving health and wellbeing
- Supporting recovery
- Access to services

The above priorities are underpinned by a system-wide commitment to:

- Engagement and involvement of people who use services and carers in both service monitoring and the commissioning process
- Financial sustainability
- Effective safeguarding arrangements for vulnerable adults and for children in families affected by mental ill health
- High-quality services

Examples from the work plan include:

- 1) Prevention:** A focus on understanding the causes of mental ill health and attempting to address them before they become severe. Approaches include intervening with individuals, families or communities to prevent the development of predictable mental health issues, early intervention at the first signs of severe mental health issues and rapid response at times of relapse.

Example from Action Plan: The redesign of the mental health acute care pathway includes the development of access to increased options at time of crisis, including a drop in sanctuary service, planned respite provision, a crisis house, and step up and step down beds from mental health inpatient care.

- 2) Personalisation:** A commitment to the individuals who receive support to take control of their own mental health issues and retain independence.

Example from Action Plan: The CCG is within the demonstrator site for the integrated personal commissioning programme: a programme which will include individuals with mental health problems who have high levels of need where a personalised approach would address acknowledged challenges in care provision, help prevent people from becoming more unwell, and enable people to retain their independence.

- 3) Integration:** Ensuring primary and secondary care services have shared and integrated processes for managing care and treatment, including integrated treatment pathways.

Example from Action Plan: Specialist link workers from mental health secondary care services provide important linking with primary care to provide advice and consultation and promote integration. Working with GPs, standardised transfer documents from secondary to primary care have been produced; rapid referral protocols from primary care to secondary mental health services have been devised. This newly introduced change requires a period of embedding and review.

- 4) Improving health and wellbeing:** Mental and physical health should be treated with equal importance. Key expectations relate to the improvement of liaison psychiatry services and health improvements within primary care for people with mental ill health with emphasis on healthy lifestyles.

Example from Action Plan: The liaison psychiatry service is being developed further, in particular working hours are being extended and collaborative care arrangements put in place regarding those with complex needs who frequently attend the district hospital. High quality liaison psychiatry services have been shown to reduce hospital admissions and length of stay.

- 5) Supporting recovery:** The priority is for services to engage people with mental health problems in effective and appropriate care and treatment, psychological therapy and activities that help them regain their resilience, while also maintaining their place in family, community and employment.

Example from Action Plan: A Multi Agency Psychological Therapies Strategy has been developed: key priorities for implementation are access to psychological therapies at the time of need with clear standards related to timeliness of access, informed choice, provision of evidence based psychological therapy and transformation of outcome measures to include a focus on patient reported outcomes.

- 6) Access to Services:** People experiencing mental health issues, regardless of the severity, will be able to access advice, guidance, education, treatment and support to enable their recovery and support their mental health and wellbeing.

Example from Action Plan: The redesign of the acute care mental health pathway, in line with principles of the Crisis Care Concordat, will ensure access 24 hours a day, 7 days a week to advice, support and urgent mental health assessment. Access will include a 24 hour helpline and an out of hour's psychiatric assessment and management service.

The strategy is being implemented through a co-produced approach between the CCG, providers and stakeholders. Actions arising from the mental health commissioning strategy are contained in the CCG work plan which detail each required outcome, the actions and tasks required to achieve the outcome, lead agencies and individuals, timescale and milestones; the work plan is informed by provider detailed implementation plans. The complex challenge of providing services that are responsive to need requires the work plan to be a live document, complemented by opportunities to reflect on the latest evidence on what can help to achieve the outcomes identified.

Progress in implementing the strategy is monitored through the Mental Health and Learning Disability Redesign Board and associated task and finish groups, using measures of process and outcome.

Title: Update Report – Adult Services – Care Act

Wards Affected: All

To: Health and Wellbeing Board

On: January 2015

Contact: Caroline Taylor

Telephone: 01803 207116

Email: caroline.taylor@torbay.gov.uk

1.

1.1 Overview of the Care Act:

The new Care Act in England will create a single modern piece of law for adult care and support in England. It will update complex and out-dated legislation that has remained unchanged since 1948.

The Act will bring about many of the improvements to the care system described in the Government's white paper 'Caring for Our Future: reforming care and support (July 2012)'

- The Assessment Process
- Building Stronger Communities
- Better Information and Advice
- Keeping People Safe

The Act will provide better support for carers and also puts into legislation the changes recommended by the Dilnot Commission regarding the funding of 'Care and Support' ('Care and support' is the term used to describe help for adults of all ages with things like washing, dressing, eating, getting out and about and keeping in touch with friends or family).

Key new features of the legislation are:

- a duty to promote people's wellbeing and to prevent needs for care and support
- a duty to provide an information and advice service about care and support
- a requirement to carry out an assessment of both individuals and carers wherever they have needs, including people who will be "self-funders", meeting their own care costs
- a duty to facilitate a vibrant, diverse and sustainable market of care and support provision and to meet people's needs if a provider of care fails.
- a national minimum eligibility threshold for support – a minimum level of need which will always be met in every council area
- a requirement to offer a universal "deferred payment" scheme, where people can defer the costs of care and support set against the value of a home they own
- a duty in some cases to arrange "independent advocacy" to facilitate the involvement of an adult or carer in assessing needs and planning for care.

The Care Act means there is some technical work to do to change systems, but it is also means a cultural change not only for council staff and partners but for individuals who need care and their carers. It depends on services working together particularly health and social care. It needs to fit with the support councils offer to children and ease their transition to support in their adult lives. There will be major impacts on the council's costs and on the workforce.

1.2 Achievements:

A Care Act Project has been set-up to plan and carry out the changes

Council & Care Trust officers have identified what needs to be done and have planned how to achieve what is required.

Lead officers from meet monthly and report their progress to the Care Act Project Board chaired by Caroline Taylor

The following work packages have been established:

- Social Care Workforce Change
- Care Funding & Finance
- Pathways and Business Process
- Market Management and Commissioning
- Public Information & Advice
- Safeguarding
- IT
- Communications

Information on the Care Act is now available on both the Care Trust and Council websites

<http://www.tsdhc.nhs.uk/CAREACT/Pages/Default.aspx>

<https://www.torbay.gov.uk/index/yourservices/adults.htm>

The Department of Health (DH) is also developing a public information campaign to support local councils in the smooth implementation of the Care Act. This campaign will roll out from late 2014 to April 2016.

A policy working group has been established to ensure that any new policies are identified and written, or that any existing policies are amended – the deferred payments policy is currently a priority for this group (please see section 2 for further details).

1.3 What are the costs of the Care Act?:

The Government has made available £285m for the new burdens arising from the Care Act 2015/16.

The funding will be paid out by the Dept of Communities and Local Government

The allocations in the table are in response to the consultation on the funding formulae for implementation of the Care Act 2015/16.

Description	DoH Grant Allocation	Estimated Cost	Shortfall
Total	£1.107m	£1.847m	£740k
Made up of :-			
Early Assessments	£587k	£1.216m	£629k
Deferred Payment Agreements	£328k	£tbc	£328k not a real cost in 15/16
Carers & Care Act Implementation	£192k	£631k	£439k

2. Challenges for the next three months

2.1 Some of the work we do is already meeting the new standards set out in the Care Act. However, we still have to make changes to ensure we will comply with the requirements of the Act by April 2015

These changes include

- focused Care Act training for staff
- developing new guidance (policies), action plans and working practices i.e. Deferred Payments
- developing IT systems
- developing our information and advice service

Priority areas of work are as follows:

Deferred payments: implementation April 2015 (Pathways & Business Process workstream)

Key principle

People who face the risk of having to sell their home in their lifetime to pay for care home fees will have the option of a deferred payment.

Important changes

- Everyone in a care home who meets the eligibility criteria will be able to ask for a deferred payment regardless of whether or not the local authority pays for their care.
- Councils will be able to charge interest on loans to ensure they run on a cost neutral basis.

Additional assessments and changes to eligibility: implementation April 2015 (Pathways & Business Process workstream)

Key principles

- Early intervention and prevention: supporting people as early as possible to help maintain their wellbeing and independence.
- Eligibility to be set nationally based on risk to the individual's wellbeing (as opposed to the risk to the individual's independence).
- Focus on outcomes and wellbeing.
- Assessment to take into account the needs of the whole family as well as of any carers.
- New arrangements for transition to adult care and support.

Important changes

- Councils will have a new duty to carry out a needs assessment for all carers (no longer dependent on the cared-for person meeting the FACS eligibility criteria).
- New duty to provide advice and information to service users and carers who do not meet the eligibility threshold. Duty to assess young people, and carers of children, who are likely to have needs as an adult where it will be of significant benefit, to help them plan for the adult care and support they may need, before they (or the child they care for) reach 18 years.
- Legal responsibility for local authorities to cooperate to ensure a smooth transition for people with care needs to adulthood.
- New national eligibility threshold.

Advice and information: April 2015 (Public Information & Advice workstream)

Key principles

- Information should be available to all, regardless of how their care is paid for.
- Good quality, comprehensive and easily accessible information will help people to make good decisions about the care and support they need.
- Councils have a key role in ensuring good quality advice is available locally and for sign posting people to independent financial advice.

Important changes

- Councils will be required to provide comprehensive information and advice about care and support services in their area and what process people need to use to get the care and support that is available.
- They will also need to tell people where they can get independent financial advice about how to fund their care and support.
- Councils will be required to provide independent advocates to support people to be involved in key processes such as assessment and care planning, where the person would be unable to be involved otherwise.

Commissioning: implementation April 2015

Key principles

- A wide range of good quality care and support services will give people more control and choice and ensure better outcomes.
- Councils have an important role in developing the quality and range of services that local people want and need. Integrated commissioning with key partners, including health and housing, is essential to ensure quality as well as value for money and improve user satisfaction.

Important changes

- Duty on councils to join up care and support with health and housing where this delivers better care and promotes wellbeing.
- Duty on councils to ensure there is a wide range of care and support services available that enable local people to choose the care and support services they want (market shaping).
- New right to a personal budget and direct payment.

3. Action required by partners

3.1 The health and wellbeing board (HWB) has a statutory duty to integrate health and social care. Through the HWB, councils and clinical commissioning groups must agree plans to spend a "Better Care Fund" which brings together funds from the health and social care budgets in the area for 2015-16.

Working closely with health services will be critical to implementing the requirements of the Care Act, for example in offering services that can prevent future care needs.

3.2 The board are asked to note the significant changes to the delivery of Care and Support as outlined in the Care Act 2014.

3.3 The board are asked to note the estimated financial pressures the Care Act may have on the Council's budget setting process 2015/16 onwards if Central Government do not fully fund these pressures.

Appendices

Background Papers:

The following documents/files were used to compile this report:

LGA Briefing For Councillors – September 2014: http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6445281/ARTICLE

Implementing the care and support reforms LGA – September 2014 : http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/5761087/ARTICLE

Title: Update Report – Community Safety Partnership

Wards Affected: All

To: Health and Wellbeing Board **On:** 29 January 2014

Contact: Fran Hughes

Telephone: 01803 208002

Email: Frances.hughes@torbay.gov.uk

1. Achievements since last meeting

- 1.1 The CSP has supported the development of the peninsula strategic assessment. This detailed assessment of crime and disorder across the peninsula is used as the primary evidence to inform the work of the Community Safety Partners.
- 1.2 The three Domestic Homicide Review remain ongoing.
- 1.3 The new integrated Domestic Abuse (DA) contract has been awarded and implemented through Sanctuary Housing, this includes a new telephone service and a perpetrator programme.
- 1.4 We launched the new domestic abuse website for DA week www.areyouok.co.uk this website received over 5300 views during the first two weeks.
- 1.5 The Commissioning plans for the Police Crime Commissioner allocated commissioning budget 2015/16 have been developed and are currently under negotiation with the Office of the Police Crime Commissioner.
- 1.6 We have successfully implemented a range of alcohol related interventions with night time economy establishments in Torbay. This has included the use of I.D Scanner, drugs bins and breathalysers to reduce the harm associated with alcohol and substance misuse, in conjunction with the premises licensees. These partnership interventions are already improving the night time economy with the Herald Express referring to New Years Eve celebrations and quoting “Torbay harbourside was the probably the safest place to celebrate last night”.
- 1.7 We remain engaged with the changes to the probation service into the National Probation Service and the Community Rehabilitation Company (CRC) and will be engaging with the new CRC provider in the New Year as they develop their business plan for Devon, Cornwall and Dorset.

- 1.6 The work of our dedicated Mental Health Practitioner in supporting vulnerable clients across the partners has been embedded and is achieving tangible outcomes for clients and multi-agency partners.
- 1.7 We have developed new procedures under the Anti Social Behaviour legislation which includes the new community trigger. To date we have had one request to invoke the Community Trigger and this process is currently being managed.
- 1.8 We have commenced a pilot on embedding Restorative Justice called “Make Amends” across partners as a realistic process within the criminal justice process in partnership with the Police and Crime Commissioner. Since the project began in September we have received a total of ten referrals from our partners and through proactive activities. Of these ten, four are shaping up to be very promising cases, in that both parties are keen to have some type of communication with each other. Our formal launch will be in April 2015.
- 1.9 We have commenced a series of interventions around Sexual Assaults as a result of an increase in sexual offences linked to alcohol and the night time economy. In many cases girls have got into taxis with males they do not know, and who have been unable to safeguard themselves. A Detective Inspector from Devon and Cornwall Police is currently working with a Project Manager Community Safety and the Community Safety Sergeant to deliver an action plan. This work has also been discussed with the Police and Crime Commissioner. The partnership will be fully utilising its project management function, links with the local authority’s licensing team and positive relationships with Torbay’s Street Pastors and a number of key and influential members of the licensed trade to support the police to deliver tangible outcomes within the night time economy to safeguard vulnerable females.

2. Challenges for the next three months

- 2.1 Completion and sign off of the three Domestic Homicide Reviews
- 2.2 Implementation of the PCC commissioning interventions for 15/16.
- 2.3 Actively engaging with the Community Rehabilitation Company to ensure that offending behaviour within Torbay is actively managed and interventions complement existing partnership activity.
- 2.4 Strengthening the partnership relationship with the alcohol and entertainment trade in Torbay to maintain and improve the night time economy.
- 2.5 Continue to embed existing partnership delivery plans.

3. Action required by partners

- 3.1 Partners may wish to receive a presentation on the Strategic Assessment to inform their own decision making.

Title: Update Report – ICO Programme

Wards Affected: All Wards

To: Health and Wellbeing Board **On:** 29 January 2015

Contact: John Lowes

Telephone: 01803 654889

Email: John.lowes@nhs.net

1. Achievements since last meeting

- 1.1 Successfully completed “Stage 2” regulatory assessment, now preparing to submit to the final stage of the assessment process in February 2015.
- 1.2 Continued development of detailed delivery plans, and engagement with community partners.

2. Challenges for the next three months

- 2.1 Intensive scrutiny from regulators during final assessment – significant demands of senior team, particularly alongside operational pressures.
- 2.2 Confirmation of external financial support for transitional costs and working capital to support underlying position in the short term.
- 2.3 Setting up community-wide programme management office and ICO delivery team, with appropriate skills and capacity to delivery changes.
- 2.4 Ensuring all community partners continue to adhere to strategy and principles set out in Pioneer vision.

3. Action required by partners

- 3.1 Continue to engage with relevant decision-making groups and events.
- 3.2 Ensure that issues with the potential to put the integration at risk are notified to appropriate leads promptly.



Title: Update Report –South Devon and Torbay Clinical Commissioning Group (SDTCCG)
Wards Affected: All
To: Health and Wellbeing Board **On:** 29 January 2015
Contact: Dr Ellie Rowe, Clinical Commissioning Lead
Telephone: 01803 652454
Email: wiki.kirby@nhs.net

1. Community services engagement

As detailed within the December HWBB report, consultation is open within the CCG's coastal locality on proposals for community services in the Dawlish and Teignmouth area.

Approximately 100 people attended a Dawlish meeting, the first of our four events. The CCG locality GP leads outlined the preferred option for using Dawlish Community Hospital as an urgent care centre for medical / sub-acute beds, with an extended, 8am-8pm MIU supported by imaging seven days a week, and using Teignmouth for planned care and rehabilitation.

In the preferred option, Teignmouth would have no MIU and have therapy-led beds for rehabilitation, day surgery and a community hub, with an emphasis on multiagency working. Each hospital would have multiple – but different – outpatient clinics; both would continue to offer community outpatient services such as dressings. In the second option, both MIUs would relocate to Newton Abbot, as would the Teignmouth rehab beds.

There have been concerns expressed by numbers of Teignmouth people about the MIU moving to Dawlish, and the local Liberal Democrats are organising a petition against it. Discussions are continuing.

The following public meetings took place on 15 January in Teignmouth and 22 January in Bishopsteignton and again in Teignmouth. However, much of the consultation is in discussion with individual groups and organisations.

2. CCG workforce

2.1 Chief Clinical Officer

The CCG's chief clinical officer, Dr Sam Barrell will be leaving the CCG in next month to take up her new role as chief executive at Musgrove Park Hospital in Taunton. To ensure the CCG complies with its statutory obligation to have an accountable officer, Dr Derek Greatorex (CCG clinical chair) will step into Sam's role in the interim, with vice chair, Nick Ball acting as interim

chair. As the CCGs clinical commissioning lead on the Governing Body, Dr Ellie Rowe will attend HWBB meetings going forward.

2.2 Deputy Accountable Officer

The CCG's commissioning and transformation director, Simon Tapley has recently been appointed as deputy accountable officer. The main purpose of this additional role is to provide comprehensive and consistent cover at times when the chief clinical officer is not available. Simon's everyday role will remain unchanged.

2.3 Director of Wellbeing and Family Services Commissioning

The CCG's senior leadership structure has been modified slightly to reflect the shifting responsibilities and challenges of the organisation. A new directorate 'Wellbeing and Family Services Commissioning' will sit alongside:

- Finance
- Commissioning and Transformation
- Corporate Affairs and Medicines Optimisation
- Quality Assurance and Improvement

The new wellbeing and family services commissioning director role was recently filled by Karen Grimshaw, a current CCG Governing Body Non Executive Director, and Director of Nursing and Midwifery for Plymouth Hospitals NHS Trust. Karen's role will focus on integration, whole-person care, and safeguarding for children and adults.