Tuesday, 20 March 2018

Meeting of the Health and Wellbeing Board

Wednesday, 28 March 2018

1.30 pm

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

Members of the Board

Nick Roberts, South Devon and Torbay Clinical Commissioning Group
Caroline Taylor, Director of Adult Services
Pat Harris, Healthwatch Torbay
Caroline Dimond, Director of Public Health
The Elected Mayor, Gordon Oliver
Dr Liz Thomas, NHS England
Andy Dempsey, Director of Children's Services
Councillor Parrott
Councillor Stockman
Councillor Doggett

Co-opted Members of the Board (non-voting)

Ann Wagner, Torbay and South Devon NHS Foundation Trust
Alison Hernandez, Police and Crime Commissioner
Martin Oxley, Torbay Community Development Trust
Melanie Walker, Devon Partnership NHS Trust

Lisa Antrobus, Town Hall, Castle Circus, Torquay, TQ1 3DR
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HEALTH AND WELLBEING BOARD
AGENDA

1. Election of Chairman/woman
To elect a Chairman/woman for the remainder of the Municipal Year.

2. Apologies
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.

3. Minutes (Pages 4 - 6)
To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 7 September 2017.

4. Declaration of interest

4(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.

4(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.)

5. Urgent items
To consider any other items that the Chairman/woman decides are urgent.

6. Future Delivery of Primary Care and the Role of Pharmacies
To note a briefing from the Chair of Devon's Local Pharmaceutical Committee.

7. Pharmaceutical Needs Assessment (PNA) (Pages 7 - 109)
To consider a report that seeks approval of the Pharmaceutical Needs Assessment.

8. **Developing the Joint Health and Wellbeing Strategy and the Work Programme of the Health and Wellbeing Board** (Pages 110 - 121)

9. **Improving the health, care and wellbeing of the people of South Devon and Torbay through a Local Care Partnerships** (Pages 122 - 131)
To comment upon the discussion document.

10. **2018-20 Joint Strategic Needs Assessment for Torbay** (Pages 132 - 183)
To consider a report that seeks approval for the publication of the Joint Strategic Needs Assessment.

11. **Health Protection Report for Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils 2016-2017** (Pages 184 - 238)
To note the report.

12. **Better Care Fund** (To Follow)
To consider a report on the above.

Minutes of the Health and Wellbeing Board

7 September 2017

-: Present :-

Ann Wagner, Nick Roberts, Caroline Taylor, Caroline Dimond, Jonathan Drew, Councillor Julien Parrott, Councillor Jackie Stockman, Councillor Derek Mills (Chairman), Councillor Ian Doggett and Andy Dempsey

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31. Election of Chairman/woman

Councillor Mills was elected Chairman for the 2017/2018 Municipal Year.

(Councillor Mills in the Chair)

32. Appointment of Vice-Chairman

Martin Oxley was appointed as Vice-Chairman for the 2017/2018 Municipal Year.

33. Apologies

Apologies for absence were received from Martin Oxley, Alison Hernandez, Melanie Walker, Mayor Oliver, Liz Thomas and Pat Harris who was represented by Jonathan Drew.

Members were also advised that the membership of the Health and Wellbeing Board had been amended following Mairead MacAlinden nominating Ann Wagner to be her permanent substitution.

34. Minutes

The Minutes of the Health and Wellbeing Board held on 16 March 2017.

35. Re-procurement of Children's Services

Members noted a report that informed Members of the progress on the procurement of Children and Young People's Services. Simon Tapley, South Devon and Torbay Clinical Commissioning Group informed Members that the current contract expires on 31 April 2018 with a further extension having been put in place in order to ensure consistent service provision. Commissioners had taken the opportunity to review the provision of community health and care services and during the pre-procurement planning phase is looking at services ranging from those that all children and young people come into contact with at some point. This

means that the procurement will include in scope services provided not only by the current provider but some services provided by the Council.

Members sought reassurance that feedback would be sought from both clients and employees of the current services and that the timeline set out in the submitted paper had been confirmed.

36. Adult Services - Better Care Fund

The Board considered a report that set out the schemes to be funded by the Better Care Fund. Whilst sign-off from NHS England is required for the overall schemes, Torbay has already begun to use the funding within its control to make a positive difference and reduce demand and costs whilst improving the experience for people in receipt of care.

Members noted that the outcomes were reported via the Local Account but felt the reporting should be more than a once a year and requested a Better Care Fund monitoring outcome framework be included to the Board's work programme.

Resolved by consensus:

i) That the Better Care Fund arrangements as set out in the attached appendix be approved; and

ii) that the approach to the Improved Better Care Fund be endorsed.

37. Deep Dive - support for vulnerable adults and families

Members had a detailed discussion on the merits of the Systems Optimisation Group which had been set up to provide a co-ordinated, multi-agency approach to supporting vulnerable people with complex needs who are at risk of harm to themselves or others.

Members expressed frustration that the group was struggling to gain traction and that client consultation was perceived to be the next step. It was suggested that any past consultation exercises that had been undertaken by various agencies should be reviewed first to see to what extent they already identified what the issues were. Members felt the group needed to refocus and seek quick success in order to ensure that the group provides value for money rather than losing the good will of those who attend.

Members further questioned the value of the Health and Wellbeing Board, feeling that it too had lost its strategic focus with the Board itself being challenged as to its mandate and role. Ann Wagner offered, and the Board accepted, to assist the Board to address the following:

- Going forward what does the Health and Wellbeing Board feel like;
- How is the Health and Wellbeing Board going to work going forward; and
- What is working well and what can be done differently.

Ann and Caroline Dimond were asked to take this review forward and report back when appropriate.

38. Highlight Report - Healthy Torbay Framework

The Board noted the report and were advised that since the submission of the report the Suicide Prevention Strategy had been put in place with staff resource assigned to support its implementation. Members were also informed that the Alcohol Strategy would be revisited as some areas were not being progressed as officers had hoped.

39. Highlight Report - Promoting active ageing

The Board noted the report and requested that the ageing well innovations be turned into business cases showing what worked well and needs to sustained as a invest to save scheme.

Members further noted the next tranche of activity was designed to make older people to feel par to the community and requested the next report from the Community Development Trust detail how it intends to measure sustainability of that activity and how it can be sustained going forward.

40. Highlight Report - Shifting the focus to prevention and early intervention

The Board noted the report.

41. Highlight Report - Mental health prevention and early intervention

The Board noted the report.

42. Market Position Statement Adult Social Care

The Board noted the Market Position Statement was a statutory requirement and that going forward the Board may need to consider a report on the state of the market for adult social care.

Chairman/woman

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Pharmaceutical Needs Assessment (PNA)		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	28 March 2018

Contact: Ian Tyson
Telephone: 01803 207314
Email: ian.tyson@torbay.gov.uk

1. Purpose

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 (H&WBs) from 1 April 2013. This means that Torbay's H&WB has a legal duty to ensure the production of a PNA for Torbay going forward. H&WBs were required to publish their first PNA by 1 April 2015 and publish a statement of its revised assessment within three years of its previous publication or sooner if changes to the need for pharmaceutical services are identified which are of significant extent.

The PNA for Torbay 2018-2021 presents a picture of community pharmacy need and provision in Torbay, and links to Torbay's Joint Strategic Needs Assessment (JSNA).

The PNA consultation ran from 04 December 2017 – 02 February 2018, through the Torbay Council consultation team. It was be promoted to a defined group of stakeholders only due to the PNA being a technical document to determine pharmacy market entry applications to NHSE and not a document that is expected to be of interest to the general population.

The PNA steering group for Devon met on 02 February 2018 and reviewed all consultation responses across the three Devon H&WB areas. All PNA's were amended accordingly, as applicable. A consultation report is appended to the PNA document.

2. Recommendation

2.1 That the Board approve the PNA for publication on 01 April 2018.

2.2 That the Board agree to the publication of the PNA on the Torbay Council website by 01 April 2018.

3. Supporting Information

3.1 The PNA is attached in the Background Papers.

4. Relationship to Joint Strategic Needs Assessment

4.1 The JSNA is a specific section within the PNA.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 The PNA is, under legislation, a statutory obligation of H&WBs to produce.

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

6.1 No anticipated implications for either, unless the strategy does not articulate that it is a statutory requirement of the H&WB to produce the PNA every 3 years.

Appendices

None

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

Torbay PNA 2018-2021 FINAL.pdf

2018-2021 PHARMACEUTICAL NEEDS ASSESSMENT FOR TORBAY

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.

Document status:	
Author:	Doug Haines and Ian Tyson. The document was developed by Torbay Council Public Health and the Devon PNA Steering Group, on behalf of Torbay's Health and Wellbeing Board.
Document version:	Version 3.0
Document date:	February 2018
Next review date	Every three years unless significant change to pharmaceutical service provision
Approved by:	Torbay Health and Wellbeing Board
Date approved:	TBC
Links to: (JSNA)	http://www.southdevonandtorbay.info/

Amendment History

Version:	Status:	Date:	Reason for Change:	Authorised by:
1.0	Draft	08/11/2017	Initial draft – pre consultation	Devon PNA Steering Group
2.0	Second draft	02/02/2018	Post-consultation draft – pre steering group review	Devon PNA Steering Group
3.0	Final draft	21/02/2018	Final draft for HWBB sign-off	Devon PNA Steering Group

Acknowledgments

The development of this Pharmaceutical Needs Assessment (PNA) was overseen by the Devon PNA Steering Group.

The authors of this report would like to thank Members of the Steering Group for their considerable input and support throughout the process.

In particular, special thanks are given to the South West Knowledge and Intelligence Team (Public Health England) for their analysis of the NHS England data in a consistent format across the three Devon HWB areas.

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

Contents

1 Executive Summary

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

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

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

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

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

- Introduction
- Overview of Torbay

- General health needs in Torbay
- Identified patient groups – particular health issues
- Health needs that can be influenced by pharmaceutical services
- Provision of pharmaceutical services
- Conclusion

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

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

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

2 Introduction

2.1 Purpose of a pharmaceutical needs assessment (PNA)

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

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

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

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

2.2 HWB duties in respect of the PNA

The legislation containing the HWB's specific duties in relation to PNAs can be found in appendix 2, however in summary the HWB must:

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

2.3 The scope of this PNA: Contractors and services

2.3.1 Contractors

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

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

  Within this group there are:

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

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

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

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

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

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

2.3.2 Pharmaceutical services provided by pharmacy contractors

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

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

2.3.2.1 Essential services

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

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

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

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

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

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

- **Support for self-care** – The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

Note: where a pharmacy contractor chooses to supply appliances as well as medicines, the requirements of the appliance services (listed below in section 2.3.8) also apply.

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

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

- **Access to the NHS Summary Care Record** – The pharmacy has access to an electronic summary of key clinical information (including medicines, allergies and adverse reactions – and possibly additional information if the patient

consents) about a patient, sourced from the patient's GP record to support care and treatment. This can, for example, be used to confirm that a patient requesting an emergency supply of a medicine has been prescribed that medicine before.

2.3.3 Advanced services

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

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

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

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

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

until 31 March 2018.

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

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

2.3.4 Enhanced services

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

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

NHS England currently commissions the following enhanced services in Torbay:

- On demand availability of specialist drugs.

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

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

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

Some of the above services may be commissioned by CCGs or local councils, but in such cases those services are not 'pharmaceutical services' for the purposes of this PNA. See section 2.4 for further details. However commissioning of this service may transfer to Clinical Commissioning Groups in the near future, in which case it would cease to be an enhanced service and would become a locally commissioned service.

2.3.5 Clinical governance

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

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

2.3.6 Opening hours

Most pharmacies are required to open for at least 40 hours per week, and these are referred to as core opening hours. However many choose to open for longer and these hours are referred to as supplementary opening hours – but a pharmacy can decide to stop providing supplementary hours by giving notice to NHS England (see below in section 2.6).

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

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

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

2.3.7 Recent changes to the contractual arrangements for pharmacies

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

- a reduction in funding of 4% in 2016/17 and a further reduction of 3.4% in 2017/18
- the introduction of the urgent medicines supply service advanced service as a

pilot

- the introduction of a Pharmacy Access Scheme (PhAS)
- the introduction of a Quality Payment Scheme (QPS)
- allowing the consolidation of pharmacies, in effect providing a way for a pharmacy to close without creating an opportunity for another pharmacy to open instead

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

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

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

There is currently one pharmacy in Torbay included on the PhAS:

- Poolearth Pharmacy (Shiphay), 11 Collaton Road, Torquay, TQ2 7HH

The **Quality Payments Scheme (QPS)** also runs until 31 March 2018 and allows all pharmacies to earn some additional funding for meeting a number of criteria.

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

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

- producing a patient safety report (in particular identifying learning from incidents and near misses)
- ensuring that 80% of pharmacists and pharmacy technicians have had safeguarding children and vulnerable adults training (level 2)
- ensuring that 80% of all staff are trained as Dementia Friends
- becoming a Healthy Living Pharmacy (level 1). Current healthy pharmacies can be found here: https://www.rsph.org.uk/our-services/registration-healthy-living-pharmacies-level1/register.html
- identifying, using specified criteria, asthma patients who should be referred to an appropriate clinician for an asthma review
- increasing use of the NHS Summary Care Record
- publishing the results of their annual patient experience survey on the NHS Choices website
- keeping their entry in the NHS 111 Directory of Services up-to-date.

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

2.3.8 Pharmaceutical services provided by dispensing appliance contractors

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

2.3.9 Appliance services

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

- **Dispensing of prescriptions** – The supply of appliances ordered on NHS prescriptions (both electronic and non-electronic), together with information and advice and appropriate referral arrangements in the event of a supply being unable to be made, to enable safe and effective use by patients and carers.

Also the urgent supply without a prescription at the request of a prescriber.

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

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

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

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

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

All DACs must provide the above services.

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

2.3.10 Advanced services

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

requirements. There are two appliance advanced services – for descriptions of these services see section 2.3.3 above.

- Stoma appliance customization
- Appliance use review.

2.3.11 Clinical governance

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

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

2.3.12 Opening hours

DACs are required to open at least 30 hours per week and these are referred to as core opening hours. They may choose to open for longer and these hours are referred to as supplementary opening hours – but a DAC can decide to stop providing supplementary hours by giving notice to NHS England (see below in section 2.6).

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

2.3.13 Pharmaceutical services provided by dispensing doctors

The 2013 regulations allow doctors to dispense to eligible patients in rural areas

called controlled localities where access to pharmacies can be difficult.
This PNA is required to include maps of the controlled localities within the HWB's area however there are no such localities in Torbay, and no dispensing doctors.

2.4 Locally commissioned services

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

2.4.1 Services commissioned by Torbay council

Supervised consumption of substance misuse medicines

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

Needle exchange

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

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

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

Emergency hormonal contraception (EHC)

There is a strong evidence base for the use of EHC in reducing unplanned or unwanted pregnancies especially within teenage years. Its use forms part of an overall national strategy to reduce the rate of teenage pregnancy with England. The rate of teenage pregnancy in Torbay is reducing, although it remains one of the highest rates in the South West.

Whilst GP practices are instrumental in contraception provision, in some circumstances female residents will either prefer, or will need, the relative anonymity of attending a pharmacy to access EHC. The drug levonorgestrel is used for EHC under the scheme commissioned by Torbay Council from pharmacies. Through this scheme levonorgestrel is supplied under a PGD to women who meet the criteria for inclusion of the PGD and service specification. It may also be bought as an over the counter medication from pharmacies, however the user must be 16 years or over, hence the need for a PGD service within pharmacies which provides access from 13 to 24 years of age. Anyone who requests EHC, will also be encouraged to take a chlamydia screen at the same time, as part of an integrated provision of sexual health services in pharmacies.

In addition the contraception and sexual health clinics (formerly known as family planning clinics) provide contraceptive services.

Chlamydia screening

This programme is commissioned as part of the Chlamydia Screening Progamme in Torbay.

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

NHS health checks

This screening programme was introduced in Torbay to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74 years, who has not already been diagnosed with one of these conditions or have certain risk factors, is eligible to have a check (once every five years) to assess their risk of cardiovascular disease. All people identified with a medium or high risk are given support and advice to help them manage their risk.

Smoking cessation

Stopping smoking is one of the single most effective health care interventions that can be offered.

Working alongside the specialist provider of Smoking cessation services and GP practices, pharmacies provide behavioural support as well as Nicotine Replacement Therapy and access to medication for people who want to give up smoking. Unlike other providers, pharmacies offer a walk-in service across a wide number of opening hours.

TB Directly Observed Therapy

Tuberculosis is a treatable, infectious disease that is one of the leading causes of death for adults in the developing world. The prevalence of TB in Devon County is low. The treatment regimen for tuberculosis, recommended by the World Health Organisation and National Institute for Clinical Excellence, consists of a combination of specific antibiotics. A daily regime, using combination tablets is usually used; however some people need more support or monitoring – known as Directly observed Therapy, or DOT. In this instance, the drugs are given individually three times per week, on a Monday, Wednesday and Friday and pharmacies are commissioned to observe the consumption of the medication, similar to supervised consumption.

2.4.2 Services commissioned by South Devon and Torbay CCG

Minor ailments

The Community Pharmacy Minor Ailments Service is commissioned via a PGD from the CCG and its purpose is to ensure that patients can access self-care

advice for the treatment of specific ailments and, where appropriate, can be supplied with a prescription only medicine under a PGD, to treat their ailment. This provides an alternative location from which patients can seek advice and treatment, rather than seeking treatment via a prescription from their GP, out of hours (OOH) provider, walk-in centre or accident and emergency.

The specific ailments covered by the PDG are:

- Bacterial conjunctivitis
- Impetigo
- Nappy rash
- Uncomplicated urinary tract infections

2.5 Other NHS services

Other services which are commissioned or provided by NHS England, Torbay Council and South Devon and Torbay CCG, which affect the need for pharmaceutical services, are also included within the PNA. These include hospital pharmacies and the GP out of hours service.

2.6 Changes to the existing provision of pharmaceutical services

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

If a pharmacy or DAC wishes to change their supplementary opening hours they simply notify NHS England of the change, giving at least three months' notice.

Dispensing doctors do not have to seek approval or give advance notice of any changes to their opening hours.

A person who wishes to buy an existing pharmacy or DAC must apply to NHS England. Provided that the purchaser agrees to provide the same services and

opening hours as the current contractor, change of ownership applications are normally approved.

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

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

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

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

2.7 How the assessment was undertaken

2.7.1 PNA steering group

The HWB has overall collective responsibility for the development and publication and of the PNA. Torbay HWB established a PNA steering group across the geographical footprint of Devon County (encompassing the local authorities of Devon, Plymouth and Torbay), the purpose of which was to ensure that the HWB

develops a robust PNA that complies with the 2013 regulations and the needs of the local population. The membership of the steering group ensured all the main stakeholders were represented and a list of the group's members can be found in appendix 3.

2.7.2 PNA localities

The steering group agreed to use the same locality boundaries for the PNA as the local authority boundary of Torbay.

2.7.3 Other sources of information

Information was gathered from NHS England, South Devon and Torbay CCG, Devon LPC and Torbay council regarding:

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

The JSNA and Torbay's joint health and wellbeing strategy provided background information on the health needs of the population.

2.7.4 Equality and safety impact assessment

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

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

The EIA for the PNA can be found in appendix 4.

2.7.5 Consultation

The statutory 60 day consultation commenced 4th December 2017 till the 2nd February 2018. A report on the consultation can be found in appendix 7 (P. 99).

3 Overview of Torbay

3.1 Introduction

This section details the key components of Torbay's population's age, sex, ethnicity and deprivation. This data compares the Torbay average against the national averages where available.

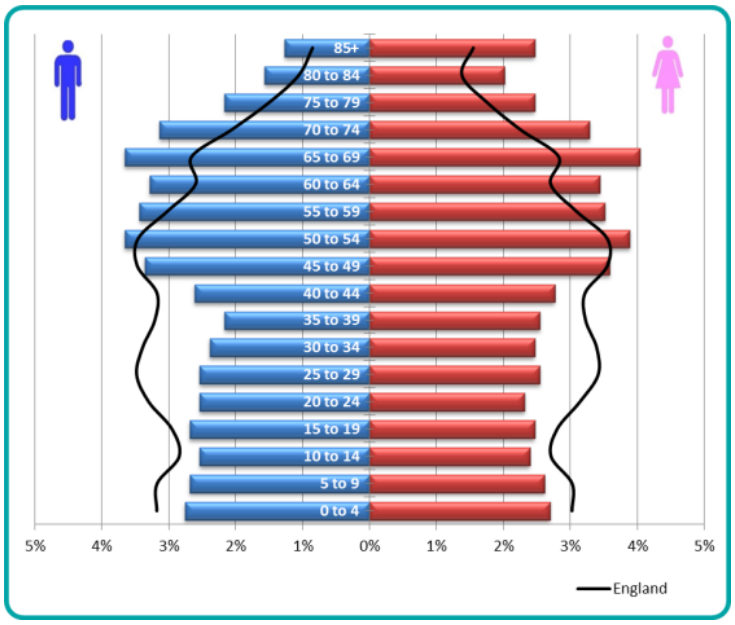
Torbay is located on the South Coast of Devon and is predominantly an urban area.

Figure 1: Map of Torbay

3.2 The population

Torbay's population remains relatively unchanged over the last 10 to 15 years, unlike the England average which shows a 7.7% increase (Table 1). The population of Torbay 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 Torbay compared to England, 2016 ONS mid-year resident population estimates



Source: ONS Mid-year population estimates

Table 1: Mid-year population estimates for Torbay, 2006-2016

All Age	Torbay	England
2006	131,900	50,965,200
2008	132,100	51,815,900
2010	131,400	52,642,500
2012	131,500	53,493,700
2014	133,000	54,316,600
2016	133,900	55,268,100
% change (2006 to 2016)	**1.5%**	**7.8%**

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

It is estimated that Torbay's population will increase by around 8,600 (6.4%) by 2030 (Table 2). The largest increase will be seen in the population aged 85 years and over (56.9%), whilst it is estimated there will be a 7.7% reduction in those of working age (45-64 years).

Table 2: Sub-national population projections for Torbay, 2017-2030

Age group	2017	2018	2022	2026	2030	%
0 to 14	21,100	21,300	21,900	22,100	22,000	4.3%
15 to 29	20,600	20,400	20,000	19,900	20,500	-0.59%
30 to 44	19,900	19,800	20,400	21,000	21,200	6.5%
45 to 64	37,500	37,600	37,200	36,200	34,600	-7.7%
65 to 84	30,200	30,700	32,500	34,700	36,900	22.2%
85+	5,100	5,200	5,800	6,600	8,000	56.9%
All ages	**134,500**	**135,100**	**137,700**	**140,500**	**143,100**	**6.4%**

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

3.3 'Protected Characteristics' (Equality Act 2010)

The Equality Act 2010 sets out nine personal characteristics that are protected by the law:[1]

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

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

[1] http://www.equalityhumanrights.com/private-and-public-sector-guidance/guidance-all/protected-characteristics

bodies and transport providers all have a responsibility under the Act.

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 website[2.] The protected characteristics should be considered when examining whether or not existing pharmaceutical services provision meets need; consequently, due regard is given to these characteristics within the 'Market Entry' regulations.

3.3.1 Age

Torbay currently has a population of 134,500. 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.

3.3.2 Disability

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 region. According to the 2011 Census, 41.7% of Torbay residents reported their general health as 'very good' 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.

3.3.3 Faith, religion or belief

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.

[2] http://www.southdevonandtorbay.info/

3.3.4 Gender - including marriage, pregnancy and maternity

Overall 51.5% of Torbay's population are female (ONS mid-2016 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.

3.3.5 Gender reassignment

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.

3.3.6 Race

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**.

Table 3: Ethnic group for Torbay, 2011

	White	Mixed/ multiple ethnic groups	Asian/Asian British	Black/African/ Caribbean/ Black British	Other ethnic group
Torbay	97.5%	1.1%	1.0%	0.2%	0.2%
England	85.4%	2.3%	7.8%	3.5%	1.0%

Source: LC2109EWls – 2011. Census table, Office for National Statistics

3.3.7 Sexual Orientation - including Civil Partnership

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.

3.4 Material deprivation

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

The English Indices of Deprivation 2015 use 37 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area. When analysing IMD data it is important to bear in mind the following:

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

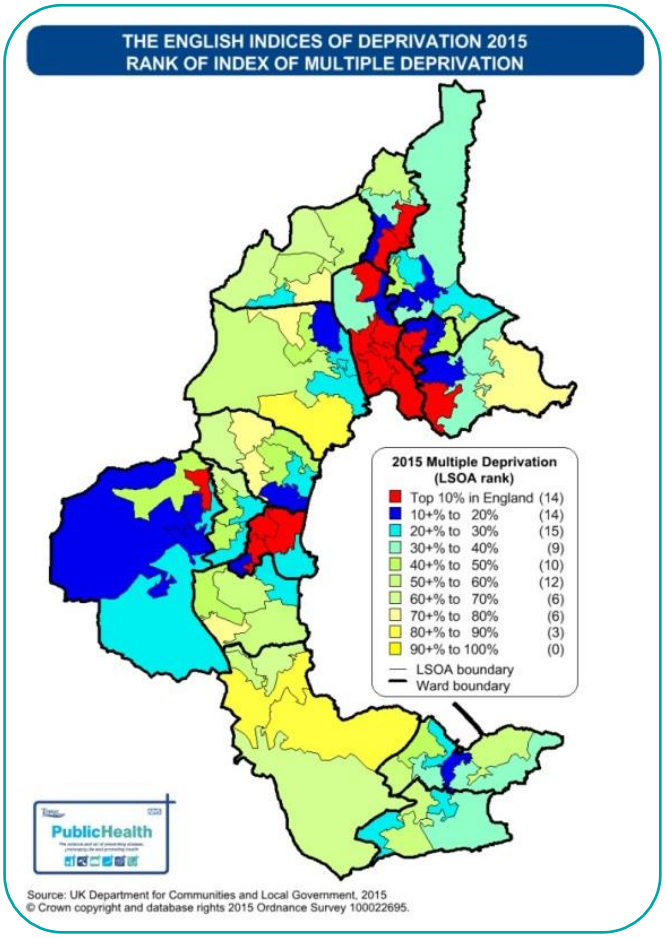
The IMD 2015 score is calculated for every Lower Super Output Area (LSOA) in England. LSOAs are part of a geographical framework developed for the collection and publication of small area statistics. Torbay is made up of 89 LSOAs. An LSOA

typically contain a population of around 1,500.

The IMD 2015 score can be used to rank every LSOA in England according to their relative level of deprivation. Out of 32,844 LSOAs in England, Torbay has 28 LSOAs in the 20% most deprived. Torbay is ranked 46th out of the 326 local authority districts in England (1=most deprived; 326=least deprived). This places Torbay in the bottom 20% of local authorities in England.

Torbay is ranked as the most deprived local authority area in the South West region. Figure 3 shows the IMD 2015 ranks for the 89 LSOAs in Torbay

Figure 3: 2015 Index of Multiple Deprivation (IMD)



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

3.5 Car ownership (relevance to accessing pharmaceutical services)

Based on the 2011 Census, car ownership in Torbay is above the national average at 81.8% (Table 4). Car ownership is lower in Torquay (79.9%) compared to Paignton & Brixham locality (84.1%).

Table 4: 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
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

3.6 Mosaic breakdown alternative

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

1. F Senior Security (Elderly people with assets who are enjoying a comfortable retirement) 19.6% of postcodes in Torbay

2. L Transient Renters (single people privately renting low cost homes for the short term) - 14.5% of postcodes in Torbay

3. N Vintage Value (Elderly people reliant on support to meet financial or practical needs) – 10.6% of postcodes in Torbay

Figure 4: Mosaic groups (based on postcodes) across Torbay

Your area or file:

Torbay compared to England population

Comparison area or file:

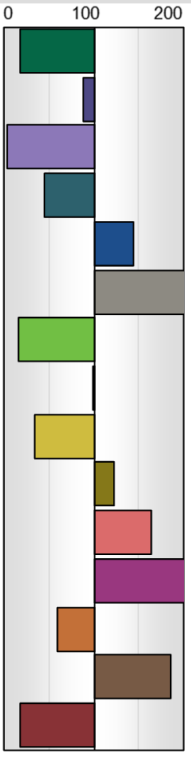
National - England (Population)

Experian Mosaic Public Sector

Date: **01/10/2017**

Mosaic Public Sector classifies all consumers in the United Kingdom by allocating them to one of 15 Groups and 66 Types. These paint a rich picture of UK citizens in terms of their socio-economic and socio-cultural behaviour.

Mosaic Public Sector Groups	Your area/file	%	Comp.	%	Pen. %	Index
A Country Living	38	1.14	3,203,337	5.95	0.00	19
B Prestige Positions	215	6.45	3,923,430	7.29	0.01	89
C City Prosperity	6	0.18	2,418,976	4.50	0.00	4
D Domestic Success	132	3.96	4,698,954	8.73	0.00	45
E Suburban Stability	291	8.74	3,270,026	6.08	0.01	144
F Senior Security	652	19.57	4,401,414	8.18	0.01	239
G Rural Reality	30	0.90	2,905,648	5.40	0.00	17
H Aspiring Homemakers	314	9.43	5,164,013	9.60	0.01	98
I Urban Cohesion	75	2.25	3,486,375	6.48	0.00	35
J Rental Hubs	302	9.07	3,959,916	7.36	0.01	123
K Modest Traditions	243	7.30	2,411,770	4.48	0.01	163
L Transient Renters	484	14.53	3,438,627	6.39	0.01	227
M Family Basics	162	4.86	4,347,048	8.08	0.00	60
N Vintage Value	353	10.60	3,091,881	5.75	0.01	184
O Municipal Challenge	34	1.02	3,091,844	5.75	0.00	18
Total	**3,331**	**100**	**53,813,259**	**100**	**0.01**	**100**



The profile presented in figure 4 shows the distribution of Torbay postcodes (3,331) compared to the England population. Torbay has a higher proportion of F senior Security compared to the England average, with some 652 postcodes identified, or around 19.6% of the population.

4 General health needs of Torbay

This section details the overall health profile for Torbay. This data includes both positive and negative areas of the population's health.

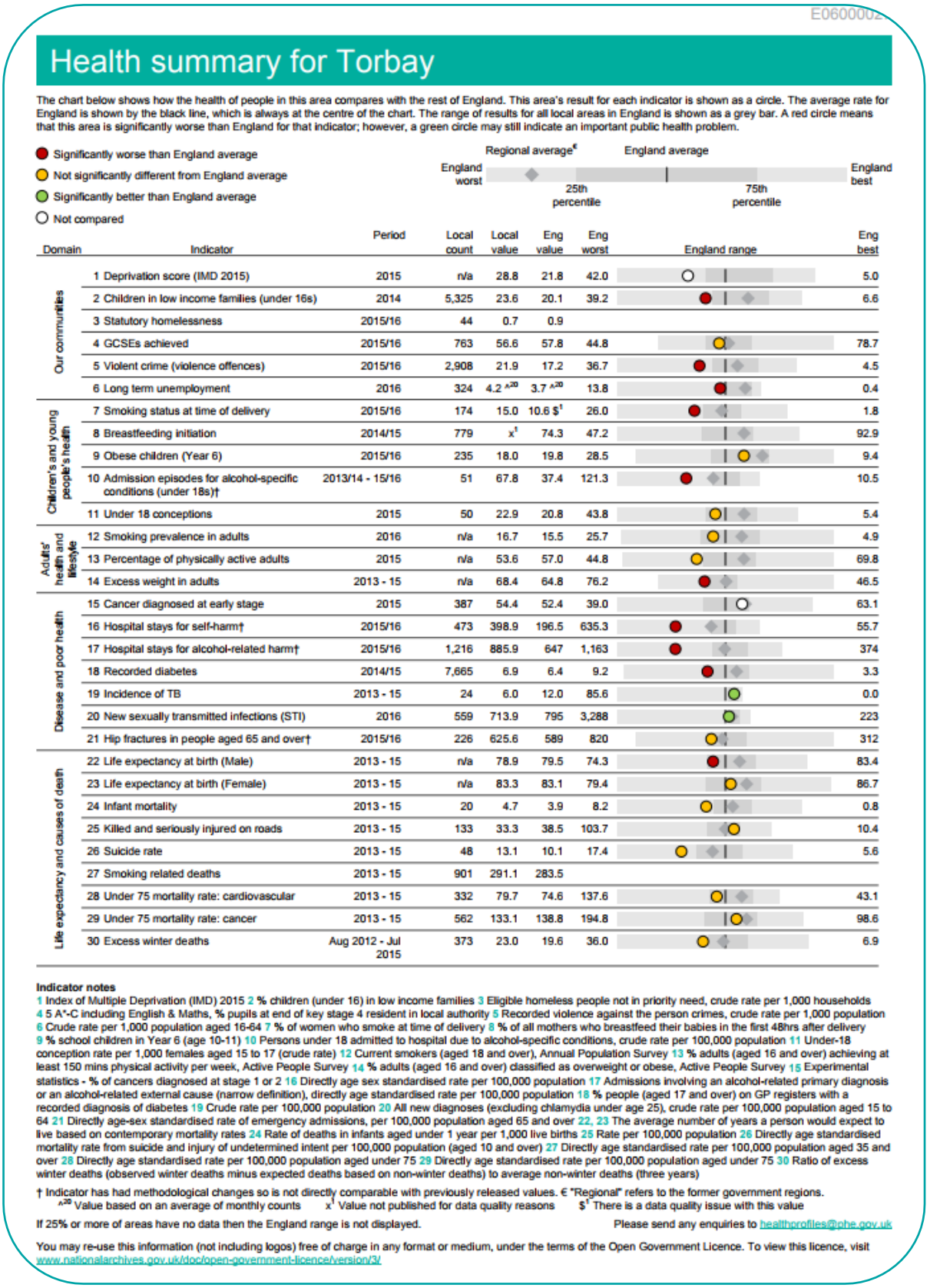
4.1 Introduction

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 2017 is included overleaf (Figure 5) followed by the Child Health Profile also produced by PHE (Figure 6).

4.2 Public Health England's Health Profile for Torbay 2017

The profile can be viewed on the following page.

Figure 5: The Health summary for Torbay 2017



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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.

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

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

Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	28.8	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	5,325	23.6	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	44	0.7	0.9			
	4	GCSEs achieved	2015/16	763	56.6	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	2,908	21.9	17.2	36.7		4.5
	6	Long term unemployment	2016	324	4.2 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	174	15.0	10.6 $[1]	26.0		1.8
	8	Breastfeeding initiation	2014/15	779	x[1]	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	235	18.0	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	51	67.8	37.4	121.3		10.5
	11	Under 18 conceptions	2015	50	22.9	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	16.7	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	53.6	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	68.4	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	387	54.4	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	473	398.9	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	1,216	885.9	647	1,163		374
	18	Recorded diabetes	2014/15	7,665	6.9	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	24	6.0	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	559	713.9	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	226	625.6	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	78.9	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	83.3	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	20	4.7	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	133	33.3	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	48	13.1	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	901	291.1	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	332	79.7	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	562	133.1	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	373	23.0	19.6	36.0		6.9

Indicator notes

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

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

If 25% or more of areas have no data then the England range is not displayed. Please send any enquiries to healthprofiles@phe.gov.uk

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

- New sexually transmitted infections (STI)
- Incidence of TB

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

- Children in low income families (under 16s)
- Violent crime (violence offences)
- Long term unemployment
- Smoking status at time of delivery
- Admission episodes for alcohol-specific conditions (under 18s)
- Excess weight in adults
- Hospital stays for self-harm
- Hospital stays for alcohol related harm
- Recorded diabetes
- Life expectancy at birth (male)

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

- GSCE achieved (5 A*-C incl. English and Maths)
- Obese children (Year 6)
- Under 18 conceptions
- Smoking prevalence in adults
- Percentage of physically active adults
- Hip fractures in people aged 65 years and over
- Life expectancy at birth (females)
- Infant mortality
- Killed and seriously injured on roads
- Suicide rate
- Smoking related deaths
- Under 75 mortality rate: cardiovascular disease
- Under 75 mortality rate: cancer
- Excess winter deaths

4.3 The Child Health Profile for Torbay 2017

Figure 6 : The Child Health Profile for Torbay 2017

Torbay Child Health Profile — March 2017

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

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

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

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

	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↔	*7*	4.7	3.9	7.9	2.0
	2 Child mortality rate (1-17 years)	▪	*3*	14.1	11.9	20.7	5.3
Health protection	3 MMR vaccination for one dose (2 years)	↑	1,445	95.2	91.9	69.3	97.7
	4 Dtap / IPV / Hib vaccination (2 years)	↔	1,480	97.5	95.2	73.0	99.2
	5 Children in care immunisations	↔	185	84.1	87.2	26.7	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	▪	1,027	70.6	69.3	59.7	78.7
	7 GCSEs achieved (5 A*-C inc. English and maths)	▪	763	56.6	57.8	44.8	74.6
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	▪	-	-	13.8	6.4	34.6
	9 16-18 year olds not in education, employment or training	↓	180	3.8	4.2	7.9	1.5
	10 First time entrants to the youth justice system	↓	52	470.8	368.6	821.9	126.6
	11 Children in low income families (under 16 years)	↓	5,325	23.6	20.1	39.2	7.0
	12 Family homelessness	↔	20	0.3	1.9	10.0	0.1
	13 Children in care	↑	280	111	60	164	21
	14 Children killed and seriously injured (KSI) on England's roads	▪	*4*	16.6	17.0	49.3	1.4
Health improvement	15 Low birth weight of term babies	↔	40	3.1	2.8	4.8	1.3
	16 Obese children (4-5 years)	↔	133	9.5	9.3	14.7	5.1
	17 Obese children (10-11 years)	↔	235	18.0	19.8	28.5	11.0
	18 Children with one or more decayed, missing or filled teeth	▪	-	26.8	24.8	56.1	14.1
	19 Hospital admissions for dental caries (0-4 years)	▪	*50*	687.4	241.4	1,143.2	9.2
	20 Under 18 conceptions	↓	67	30.7	22.8	42.4	8.4
	21 Teenage mothers	↔	16	1.2	0.9	2.2	0.2
	22 Persons under 18 admitted to hospital for alcohol-specific conditions	↓	*15*	61.5	36.6	92.9	10.9
	23 Hospital admissions due to substance misuse (15-24 years)	▪	*22*	160.4	95.4	345.3	34.1
Prevention of ill health	24 Smoking status at time of delivery	↓	174	15.0	10.6	26.0	1.8
	25 Breastfeeding initiation	▪	-	-	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	-	-	43.2	18.0	76.5
	27 A&E attendances (0-4 years)	↑	3,983	542.3	587.9	1,836.1	335.0
	28 Hospital admissions caused by injuries in children (0-14 years)	↔	263	126.6	104.2	207.4	53.5
	29 Hospital admissions caused by injuries in young people (15-24 years)	↑	360	259.8	134.1	280.2	72.0
	30 Hospital admissions for asthma (under 19 years)	↔	46	172.0	202.4	591.6	84.3
	31 Hospital admissions for mental health conditions	↑	43	170.4	85.9	179.8	33.8
	32 Hospital admissions as a result of self-harm (10-24 years)	↑	237	1,167.9	430.5	1,444.7	102.5

≥95% <90% 90% to 95%

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

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

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2013-2015
2 Directly standardised rate per 100,000 children aged 1-17 years, 2013-2015
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2015/16
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2015/16
5 % children in care with up-to-date immunisations, 2016
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2015/16
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2015/16
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2015
9 % not in education, employment or training as a proportion of total 16-18 year olds known to local authority, 2015
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2015
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2014
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2015/16
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2016
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2013-2015
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2015
16 % school children in Reception year classified as obese, 2015/16
17 % school children in Year 6 classified as obese, 2015/16
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2014/15
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2013/14-2015/16
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2014
21 % of delivery episodes where the mother is aged less than 18 years, 2015/16
22 Persons admitted to hospital due to alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2012/13-2014/15
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2013/14-2015/16
24 % of mothers smoking at time of delivery, 2015/16
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2015/16
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2015/16
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2015/16
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2015/16
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2015/16
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2015/16
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2015/16

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Various indicators where Torbay's value is <u>better</u> than the England average:

- MMR vaccination for one dose (2 years)

- Dtap / IPV / Hib vaccination (2 years)
- Family homelessness
- A&E attendances (0-4 years)

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

- Children in low income families (under 16 years
- Children in care
- Hospital admissions for dental caries (0-4 years)
- Under 18 conceptions**
- Persons under 18 admitted to hospital for alcohol-specific conditions
- Hospital admissions due to substance misuse (15-24 years)
- Smoking status at time of delivery
- Hospital admissions caused by injuries in children (0-14 years)
- Hospital admissions caused by injuries in young people (15-24 years)
- Hospital admissions for mental health conditions
- Hospital admissions as a result of self-harm (10-24 years)

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

- Infant mortality
- Child mortality rate (1-17 years)
- Children in care immunisations
- Children achieving a good level of development at the end of reception
- GCSEs achieved (5 A*-C inc. English and maths)
- First time entrants to the youth justice system
- Children killed and seriously injured (KSI) on England's roads
- Low birth weight of term babies
- Obese children (4-5 years)
- Obese children (10-11 years)
- Children with one or more decayed, missing or filled teeth
- Teenage mothers
- Hospital admissions for asthma (under 19 years)

** based on 2014 data, publication of the child health profile was prior to publication of data for 2015 (included in the health profile above)

4.4 Housing growth and significant housing developments

Torbay's growing population (see Table 2) 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.

There are a number of planned or commenced developments that could impact on the anticipated demand for pharmaceutical services in Torbay (Figure 7). These include:

The South Devon Link Road, has improved 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 Torbay[3]. . The road was recently completed (2015) and it is anticipated that Torbay will increasingly see the impact of this new link through increased demand for growth in the coming years. The increase in population and therefore pharmaceutical demands are unknown at this stage.

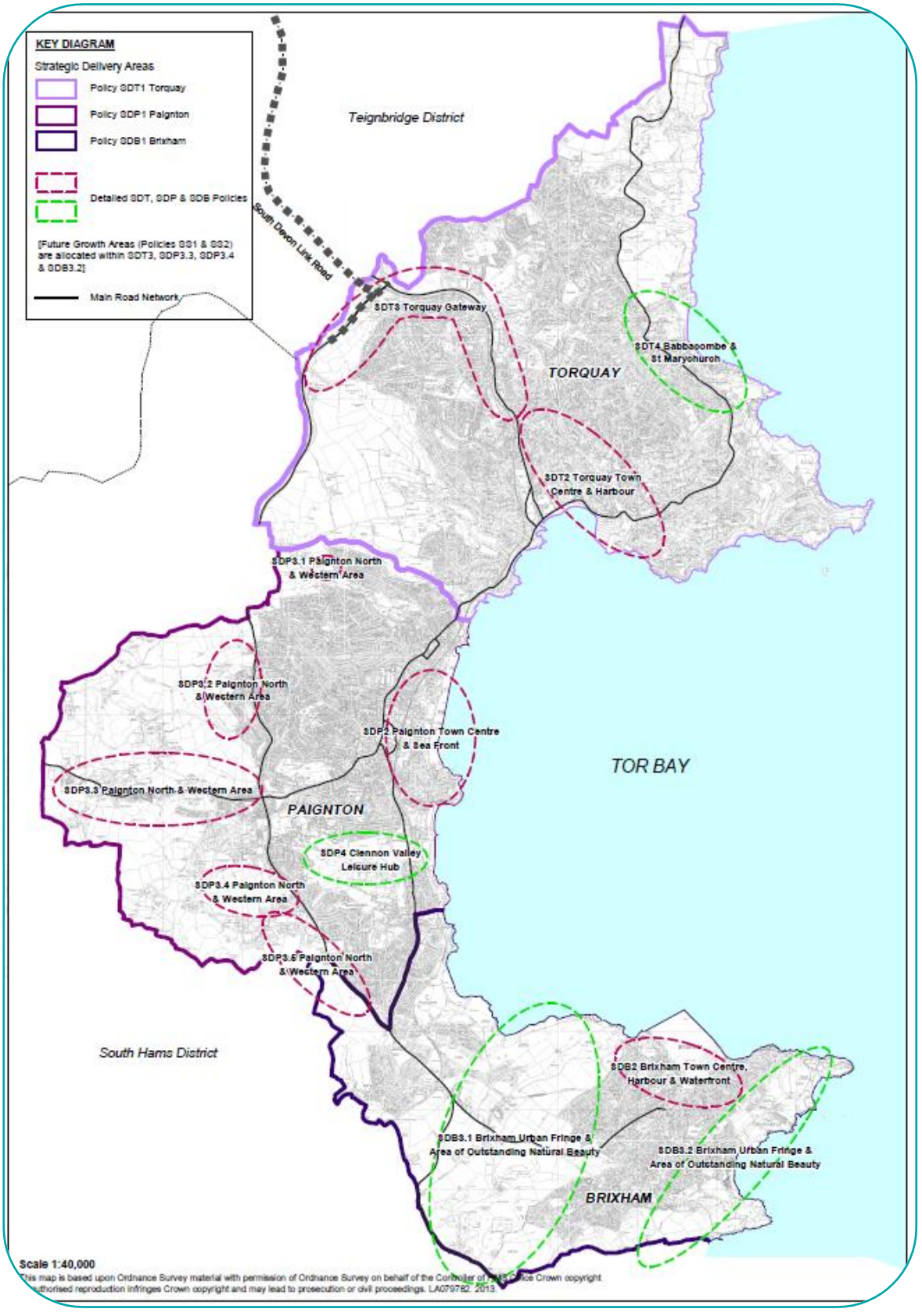
Preparation for a new railway station at Edginswell, Torquay. Planning permission has been granted and the Council is exploring means to deliver this station in partnership with Network Rail. The exact date of delivery is unknown at this stage.

Expansion of Torbay Hospital, including further residential properties in the Shiphay area of Torquay (SDT3 Torquay Gateway – Figure 7). Shiphay anticipates a build of 745 homes which will accommodate approximately 1,600 residents.

Developments in Paignton (SDP 3.2/3/4/5 Paignton North & Western Area - Figure x); 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.

[3] http://www.southdevonlinkroad.co.uk/

Figure 7: Map showing the anticipated development areas for Torbay based on the 20 year Local plan (Spatial Planning, Torbay Council).



5 Identified patient groups – particular health issues

The following patient groups have been identified as living within the HWB's area:

- Those sharing one of more of the following protected characteristics:
    - Age;
    - Disability which is defined as a physical or mental impairment, that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities;
    - Gender reassignment;
    - Marriage and civil partnership;
    - Pregnancy and maternity;
    - Race which includes colour, nationality, ethnic or national origins;
    - Religion (including a lack of religion) or belief (any religious or philosophical belief)
    - Sex;
    - Sexual orientation.
- Homeless
- Students
- Tourists

Although some of these groups are referred to in other parts of the PNA, this section focusses on their particular health issues.

5.1 Age

- Health issues tend to be greater amongst the very young and the very old
- The number of chronic conditions increases with age

5.2 Disability

- There is a strong relationship between physical and mental ill health; being physically disabled can increase a person's chances of poor mental health and vice versa

- Increased likelihood of co-morbidity of disabling conditions

5.3 Gender re-assignment

- Transgender individuals can face discrimination and harassment; they may be possible targets for hate crime

5.4 Marriage and civil partnership

- Victims of domestic violence are at high risk of serious injury or death.

5.5 Pregnancy and maternity

- There are many common health problems that are associated with pregnancy such as backache, constipation and sleeplessness. Additionally there are health issues such as morning sickness that are specific to pregnancy.

5.6 Race

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, HIV, TB and diabetes.
- An increase in the number of older BAME people is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- BAME populations may face discrimination and harassment and may be possible targets for hate crime.

5.7 Religion and belief

- Possible link with ‘honour based violence’ which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals.
- Female genital mutilation is related to cultural, religious and social factors within families and communities although there is no direct link to any religion or faith. It is a practice that raises serious health related concerns.
- There is a possibility of hate crime related to religion and belief.

5.8 Sex

- Inequalities in health are greater for men; there is a difference in life expectancy of 8.9 years for men between electoral wards in Torbay, and 5.2 years for women (2013/15).

5.9 Sexual orientation

- Gay or lesbian individuals may be possible targets for hate crime
- Certain sexual health issues may be more prevalent in gay and lesbian populations eg gay men are in a higher risk group for HIV.
- Research suggests that gay and lesbian people may be less likely to be screened for certain conditions meaning problems are not picked up as early as they could be.
- Mental illness, such as depression and anxiety, is more common amongst lesbian, gay and bisexual people.

5.10 Homeless

- Homeless Link completed a nationwide study of the health needs of homeless people in 2014[4]. Key findings of the audits conducted on homeless people were:
    - 80% reported some form of mental health problem (diagnosed or undiagnosed)
    - 45% had a diagnosed mental health problem (compared to 25 in the general population)
    - 39% are currently, or in recovery from, misusing drugs
    - 27% are currently, or in recovery from, misusing alcohol
    - Almost 50% used drugs or alcohol to cope with mental health issues
    - Close to 66% consumed more than the recommended daily allowance of alcohol, each time they drunk
    - 73% had physical health issues, of which 41% said this was a long term condition.

[4] http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

- In addition, homelessness is a key risk factor for TB due to the transmission risks of sleeping rough or in overcrowded accommodation.

5.11 Students

- Torbay has 3 grammar schools which draw young people on a daily basis from both Torbay and the surrounding areas of South Devon.
- Torbay also has South Devon College, based in Paignton, which has a wide variety of academic and vocational courses, as well as adult learning and university degree courses, which draws young people and adult students from a wide area of South Devon.
- Health considerations for this patient group include (but are not limited to):
    - Mumps
    - Chlamydia testing
    - Contraception, including EHC provision
    - Mental health problems are more common among students than the general population.
- Torbay is highly popular with foreign students with a significant number of young people staying with host families in Torbay and the surrounding area. These students can be from a diverse range of countries and therefore may bring, or be susceptible to, a range of foreign diseases or ailments.

5.12 Tourists

- Torbay has a seasonal influx of tourists into the area, who may suffer from a range of health issues which may need pharmacy support. These could range from simple colds through to issues such as sunburn as well as more complicated prescribing regimens that need to continue to be maintained.

6 Health needs that can be met by pharmaceutical services

6.1 Introduction

Everyone will at some stage require prescriptions to be dispensed irrespective of whether or not they are in one of the groups identified in section 5. This may be for a one-off course of antibiotics or for medication that they will need to take, or an appliance that they will need to use, for the rest of their life in order to manage a long term condition. This health need can only be met within primary care by the provision of pharmaceutical services, be that by pharmacies, DACs or dispensing doctors, and is applicable to the following themes.

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

Many of the pharmacies in Torbay will offer a collection and delivery service on a private basis.

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

Mental health

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

Smoking

Smoking cessation is commissioned as a locally commissioned service and

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

Long term conditions

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

- Where a person presents a prescription, and they appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), smoke or are overweight, the pharmacy is required to give appropriate advice with the aim of increasing that person's knowledge and understanding of the health issues which are relevant to their circumstances.
- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England and could include long term conditions.
- Signposting people using the pharmacy to other providers of services or support.
- Provision of the four advanced services will also assist people to manage their long term conditions in order to maximise their quality of life.

6.2 Joint Strategic Needs Assessment (JSNA)

The purpose of the JSNA is to provide an objective view of the health and wellbeing needs of the population. JSNA identifies "the big picture" in terms of the health and wellbeing needs and inequalities of a local population. It provides an evidence base for commissioners to commission services, according to the needs of the population. A JSNA is not a needs assessment of an individual, but a strategic overview of the local community need – either geographically such as local authority / localities or for specific groups such as younger or older people or people from different backgrounds

JSNA is not a standalone document but a suite of documents, web tools and presentations which help to analyse the health needs of populations to inform and

guide commissioning of health, wellbeing and social care services within local authority areas. JSNA will be the means by which local leaders work together to understand and agree the needs of the local population. JSNAs, along with health and wellbeing strategies will enable commissioners to plan and commission more effective and integrated services to meet the needs of the South Devon and Torbay population, in particular for the most vulnerable, and for groups with the worst health outcomes, and to help reduce the overall inequalities that exist.

Helping people to live longer and healthier lives is not simply about the healthcare received through GPs or at hospital, it is also about the wider social determinants of where we live and work. The collective action of agencies is needed today to promote the health of tomorrows older population. Preventing ill health starts before birth, and continues to accumulate throughout individual's lives. A life course approach enables an understanding of needs and risks to health and wellbeing at different points along the path of life. For example, our needs as babies and in our early years differ significantly to our needs and risks to health and wellbeing as we enter adulthood or retirement. Understanding the risks to health and wellbeing at different points along the path of life enables opportunities to promote positive health and wellbeing and to prevent future ill health, or to understand the potential burden of disease that may need to be considered in delivering services.

JSNA in Torbay is presented across the life course:

Population Overview sets the scene for the current & future population structure across South Devon and Torbay. It includes top level population overviews

- Starting Well is about understanding the needs of the population through pregnancy, birth and for the first few years of life. This includes understanding the anticipated need for maternity services, health visiting services and early years' services.

- Developing Well is about understanding the needs of the population between the ages of 5 and 24. This includes understanding the anticipated needs for schools and the developing health and wellbeing needs of this age group.

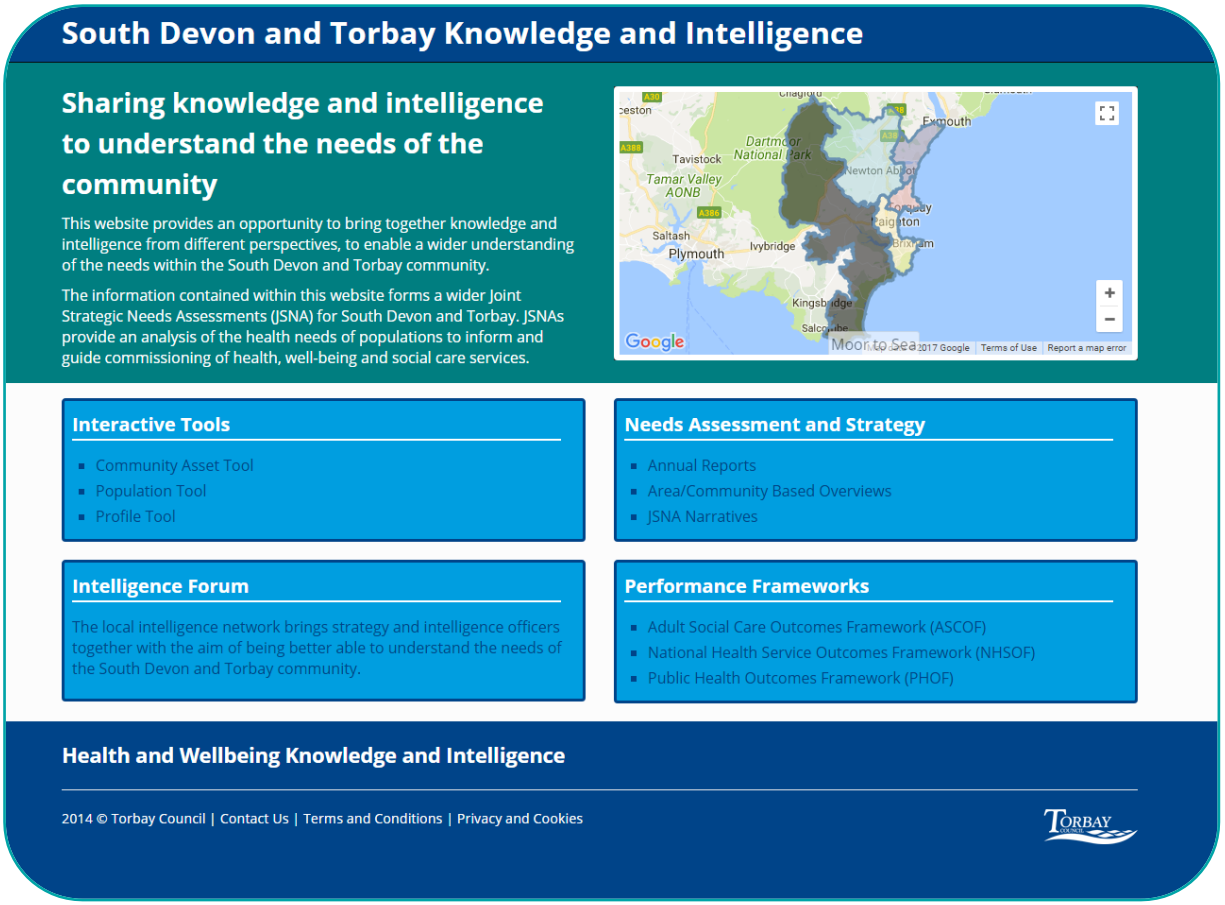
- Living and Working Well is about understanding the needs of the working age population. This includes understanding the lifestyles and health outcomes experienced by this group, and the risks that prevent positive health and wellbeing.

• Ageing and Dying Well is about understanding the needs of those from around 65 years and over. It is about reducing and preventing long term conditions, promoting active aging and tackling inequalities into older age.

Torbay's JSNA can be accessed through the following link: http://www.southdevonandtorbay.info/

A written narrative JSNA for 2018 to 2020 is due for publication in December 2018; this will be accessible through the website.

Figure 8: Home page of the Torbay JSNA website



7 Provision of pharmaceutical services

7.1 Necessary services

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

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

Relevant and necessary services

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

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

NHS England commissions this service from selected pharmacies, chosen to ensure appropriate geographical coverage and because they have long opening hours. Not all of the pharmacies which provide this service may be open on bank/public holidays and NHS England considers that to associate providing this service with a requirement to be open on holidays would discourage pharmacies from providing the service. Therefore coverage may be sparser on such days.

7.2 Current provision of necessary services

There are currently 37 pharmacies in Torbay (see figure 9).

28 pharmacies are owned by national pharmacy chains:

- 9 by Boots Pharmacy
- 8 by Day Lewis Pharmacy
- 6 by Well Pharmacy (Best way National Chemists)
- 4 by Lloyds pharmacy
- 1 by Superdrug Pharmacy.

4 pharmacies are owned by a local chain, Poolearth, and 5 pharmacies are owned by independent providers.

There are two 100 hour pharmacies (Boots Pharmacy at Wren Retail Park, Torquay and Lloyds Pharmacy at Sainsbury's, Brixham Road, Paignton).

There are no pharmacies with local pharmaceutical services contracts, distance-selling pharmacies, dispensing appliance contractors or dispensing doctors in Torbay.

Since the last PNA was published two pharmacies have closed in Torbay:

- Boots Pharmacy on Tor Hill Road in Torquay closed in January 2017 (i.e. 2016/17)
- Boots Pharmacy on Winner Street in Paignton closed in July 2017 (i.e. 2017/18).

No new pharmacies have opened since the last PNA was published.

Over the last four years provision in Torbay has been as follows:

Year	Population	Number of pharmacies	Pharmacies per 100,000 population	Number of prescription fees	Px fees per head	Fees per pharmacy
2013/14	132,075	40	30.3	3,326,696	25.2	83,167
2014/15	132,984	40	30.1	3,389,775	25.5	84,744
2015/16	133,373	39	29.2	3,408,911	25.6	87,408
2016/17	133,883	39	29.1	3,368,944	25.2	86,383
2017/18*	134,000	37	27.6	3,368,944	25.1	91,053
South West 15/16	3,200,213 (in 2015)	637	19.9	57,812,665	18.1	90,758
England 15/16	54,786,327 (in 2015)	11,688	21.3	995,277,392	18.2	85,154

Notes:

* assumption that the number of prescription fees for 2017/18 is the same as 2016/17

1. Figures include pharmacies that were open at any point during the financial year. Therefore, the figure for 2016/17 will not match the number of current open pharmacies in section 7.2, as the latter takes into account pharmacies that may have opened or closed since 2016/17.
2. Populations are based ONS mid-year population estimates. The population for each financial year is taken as the mid-year estimate for the first of the two years that make up the financial year. For example, for 2013/14 the population is taken as the mid-year estimate for 2013.
3. The South West population figure excludes Dorset, Poole, Bournemouth, Wiltshire, Swindon, Gloucestershire, Bath and North East Somerset as these are not in the NHS England region definition.

The number of pharmacies in Torbay fell by 1 between 2013/14 and 2016/17. The number of items dispensed rose by almost 2.5% between 2013/14 and 2015/16, but then fell by 1.2% in 2016/17. Overall, the number of items dispensed rose by 1.3% between 2013/14 and 2016/17.

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

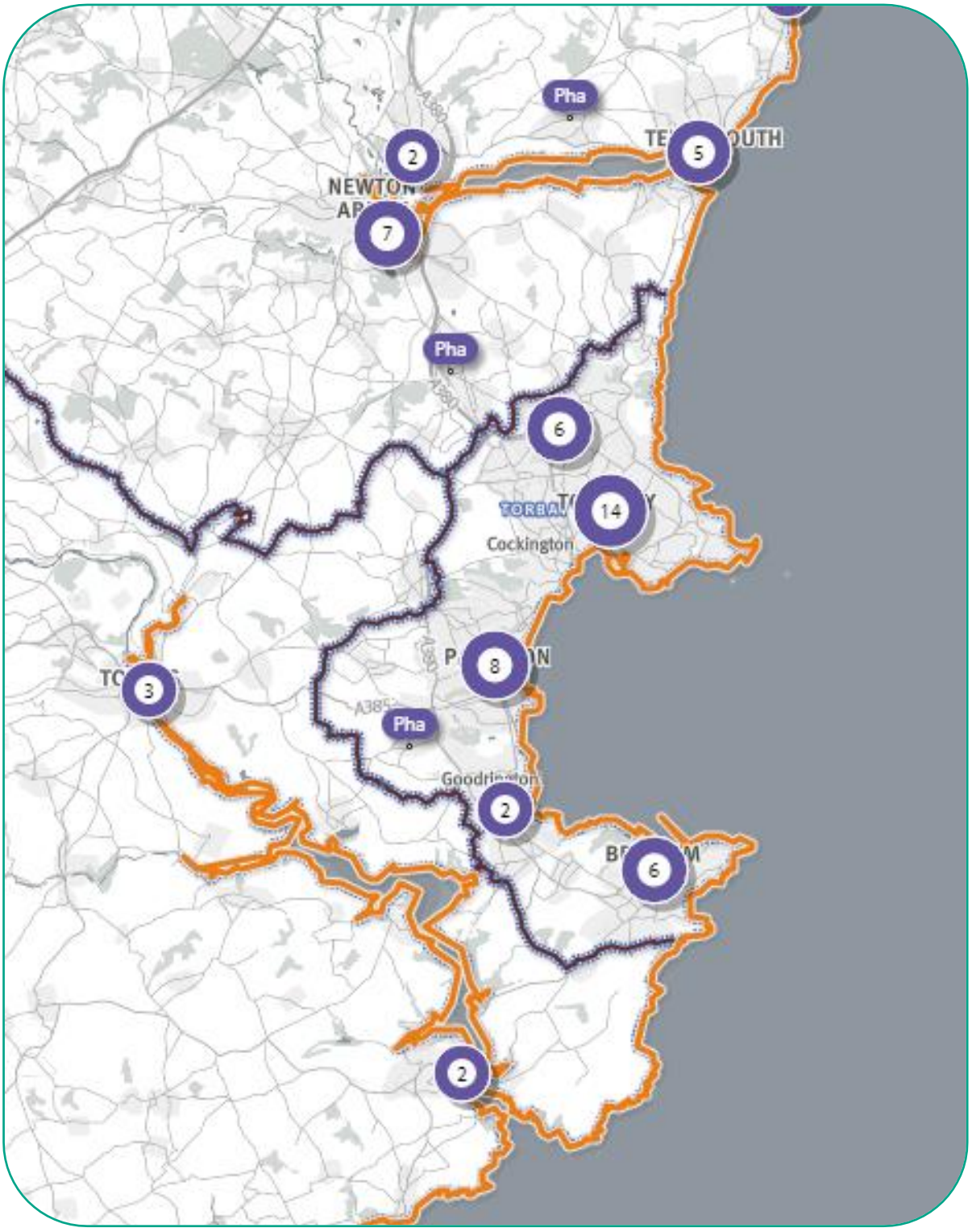
The number of pharmacies per 100,000 population in Torbay (27.6 in 2017/18) is higher than the South West and national figures (19.9 and 21.3 respectively), however when considering the higher number of fees per resident population; the increased elderly, daytime transient and tourist populations, there is a slightly higher number of fees per pharmacy in Torbay (91,053 in 2017/18) than either the South west or National levels (90,758 and 85,154 respectively). In considering these two facts, it is concluded that this does not equate to a significant difference and therefore suggests Torbay is neither over nor under served in terms of pharmacy provision.

7.3 Current provision outside the HWB's area

As stated above, distance-selling pharmacies are required to provide the essential services to patients anywhere in England, and will deliver medication to a patient's home address. Their services are therefore available to residents of the HWB's area. In addition to those located within the HWB area, there are numerous such pharmacies located around the country. An alphabetical list of distance-selling pharmacies is available at www.nhs.uk/service-search/pharmacies/InternetPharmacies

DACs generally supply appliances by home delivery, and are required to do so for certain types of appliance. Their services are therefore available to residents of the HWB's area. As at February 2017 there were 111 DACs in England, including those located within the HWB area. An alphabetical list of DACs is available at www.nhs.uk/service-search/pharmacies/AppliancePharmacies

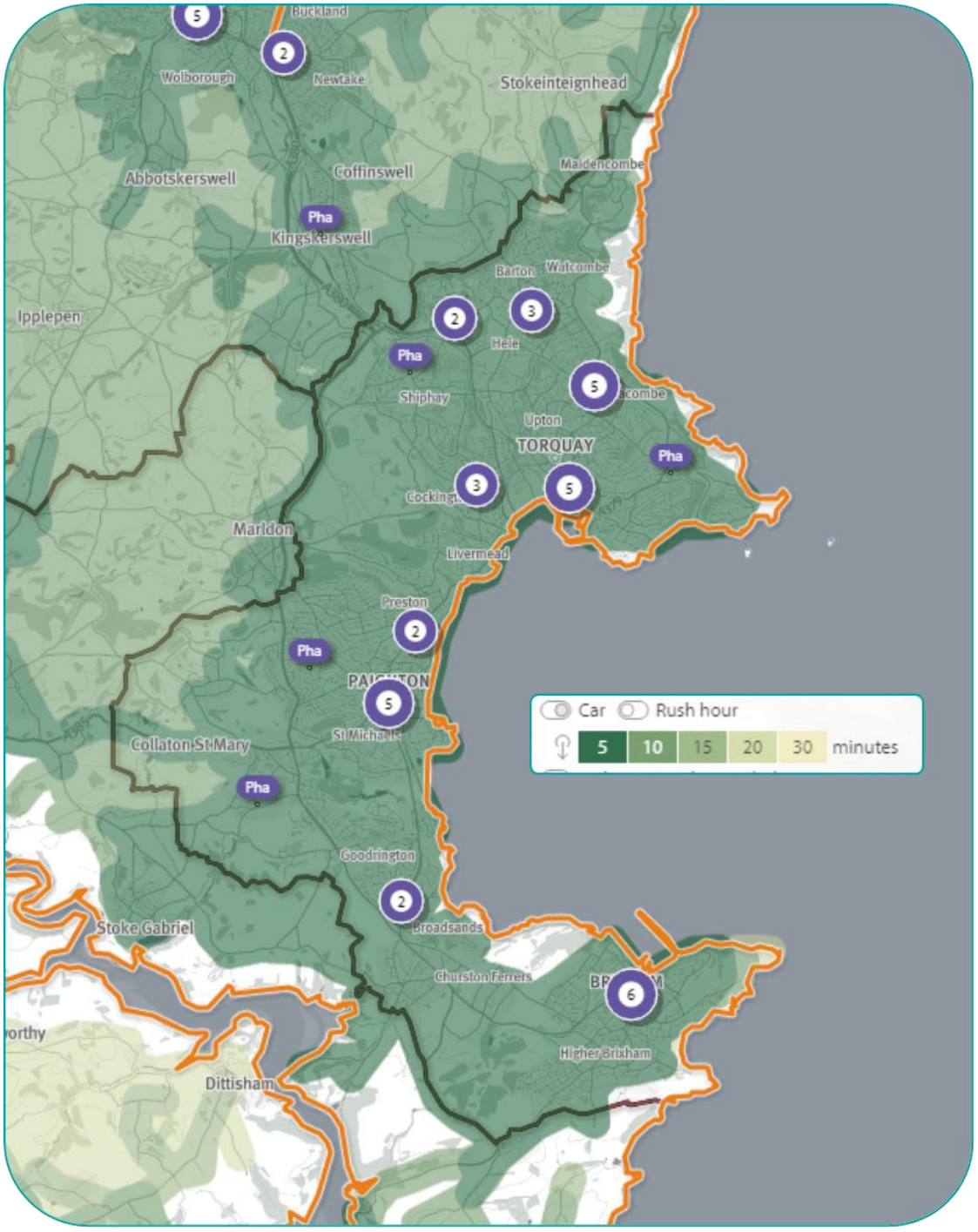
Figure 9: Location of pharmacies in and around Torbay



7.4 Access to premises

Torbay's population is served by 37 pharmacies, with well over 95% of the population within a 5 minute car journey of a pharmacy, and the total population being within a 10 minutes car journey of a pharmacy. Pockets of Torbay not covered in the following map are the coast line and golf courses.

Figure 10: drive times around pharmacies in Torbay



7.4.1 Access to the essential services (core plus supplementary opening hours)

- 7 pharmacies are routinely open 7 days per week: 4 in Torquay and 3 in Paignton
- 23 pharmacies are open Monday to Saturday only. 16 pharmacies close at or before 1pm on Saturdays. 7 pharmacies close after 1pm on Saturdays.
- 7 pharmacies open Monday to Friday only.
- 1 pharmacy is open before 8am Monday to Friday: Lloyds Pharmacy in Paignton
- 4 pharmacies open later than 6.30pm Monday to Friday, 2 in Paignton and 2 in Torquay

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

Figure 11: Pharmacy services across Torbay

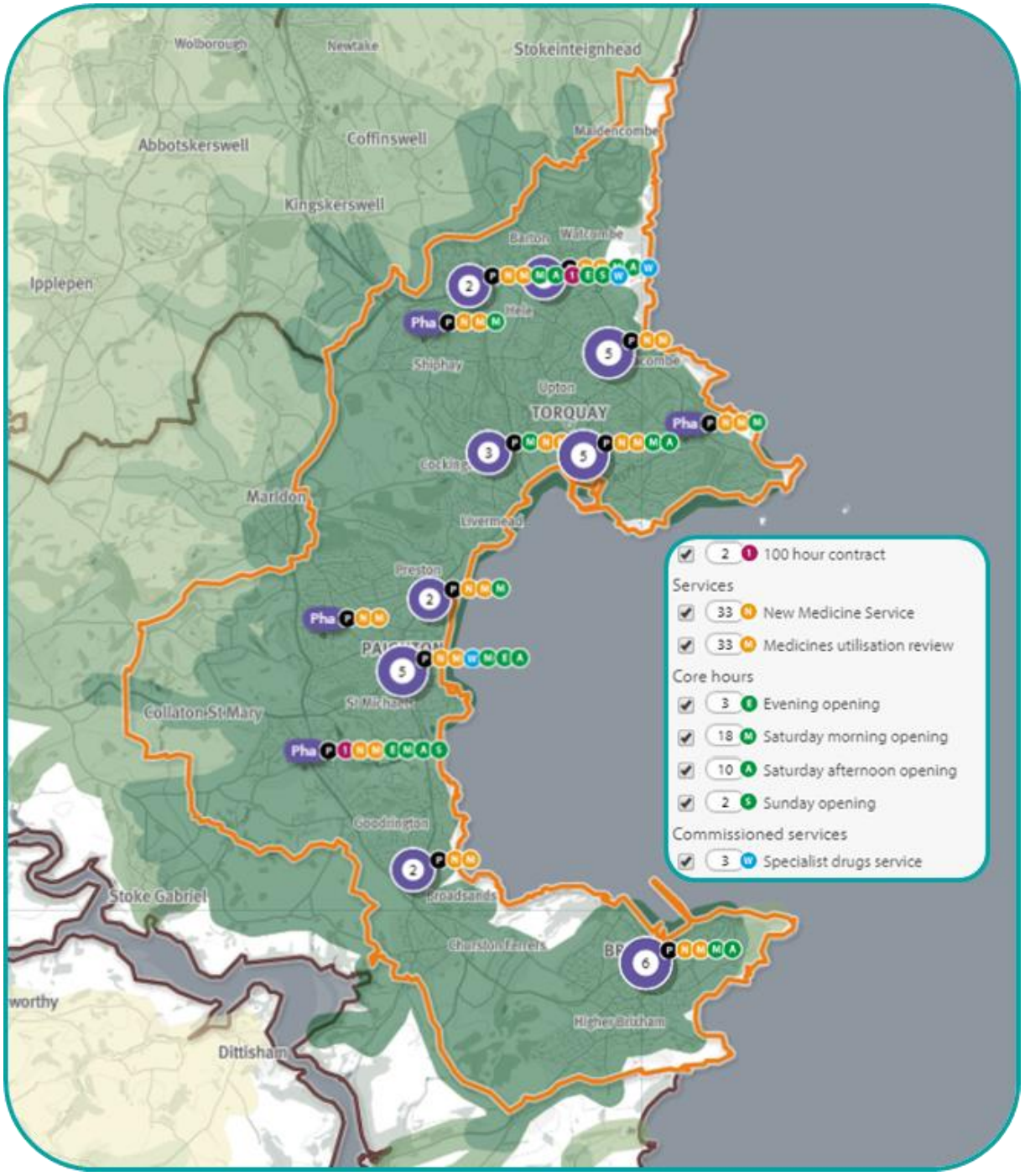
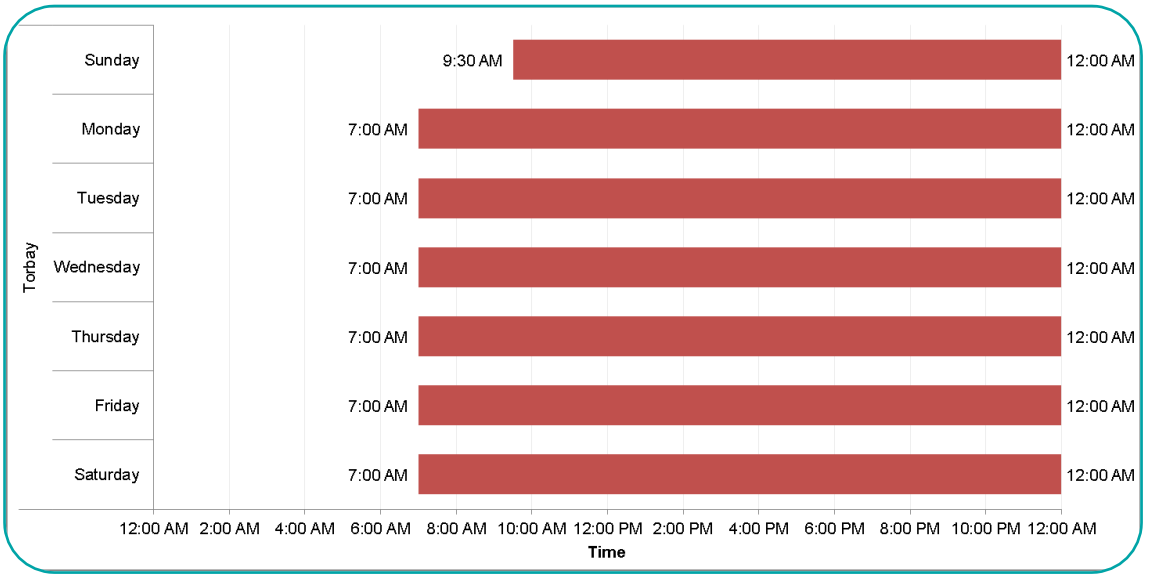


Figure 12: Earliest opening time and latest closing time for any given pharmacy, by day of the week



Note:

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

7.4.2 Access to Medicines Use Review (MUR)

All of the pharmacies in Torbay provided MURs in 2016/17. Out of a maximum possible of 15,600 MURs which could have been carried out, 11,949 MURs were performed in 2016/17 (76.6%). Five pharmacies provided the maximum number of MURs recommended (400), 12 provided more, while 3 provided between 390 and 399 MURs. A total of 20 pharmacies provided 390 or more MURs.

7.4.3 Access to New Medicines Service (NMS)

37 of the 39 pharmacies provide NMS in 2016/17. A total of 3,043 NMSs were undertaken in 2016/17.

7.4.4 Access to the 'on demand availability of specialist medicines' enhanced service

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

3 pharmacies (1 in Paignton, 2 in Torquay) provided this service in 2016/17. It was also provided by pharmacies in the neighbouring HWB area, in Newton Abbot and

Teignmouth.

7.4.5 Access to dispensing of appliances

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

All of the pharmacies dispensed some appliances during 2016/17, while 21 dispensed appliances that require measuring or fitting.

7.5 Other relevant services

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

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

- the advanced services not classed as 'necessary' (influenza vaccination and urgent supply, stoma appliance customization and AUR)
- services commissioned from pharmacies by South Devon and Torbay CCG or Torbay council
- other NHS services
- services provided by other organisations.

7.6 Advanced services

7.6.1 Influenza vaccination advanced service

This service has not been included within the definition of 'necessary services' because, if it were not provided by pharmacies, an equivalent service would be available from GP surgeries. 34 pharmacies in Torbay provided NHS influenza vaccinations in 2016/17, giving a total of 3,741 vaccinations.

7.6.2 Stoma appliance customisation advanced service

Only 2 pharmacies appear to provide this service themselves, with a total of 48 stoma customisations provided in 2016/17. However many stoma appliances will be

dispensed by DACs based around the country, who may provide this service.

7.6.3 Appliance Use Review (AUR) advanced service

No pharmacy in Torbay provided this service in 2016/17. However many appliances will be dispensed by DACs based around the country, who may provide this service.

7.6.4 Urgent supply advanced service (NUMSAS)

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

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

7.7 Services commissioned by the CCG or Council

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

7.7.1 Services commissioned by the CCG

Currently 37 pharmacies are commissioned in Torbay to provide the Minor Ailments Service. In April – July 2017 (The period when the new Minor Ailment Services were commissioned), 116 people accessed the Minor Ailment Service in Torbay.

7.7.2 Services commissioned by the council

Supervised consumption of substance misuse medicines

19 pharmacies were commissioned to provide this service by Torbay council in 2016/17. 5,813 doses of sublingual Subutex and 45,448 doses of Methadone were supervised in pharmacies In 2016/17.

Needle exchange

15 pharmacies were commissioned in Torbay to provide needle exchange services in 2016/17. The following number of packs was provided through pharmacies In 2016/17:

- 1ml packs – 6,021
- 2ml packs – 4,019
- Blue needle packs – 3,226
- Green needle packs – 1,754
- Orange needle packs – 1,151

Emergency hormonal contraception (EHC)

27 pharmacies were commissioned in Torbay to provide EHC services in 2016/17. 482 provisions of EHC were supplied to Torbay residents through pharmacies In 2016/17.

Chlamydia screening

3 pharmacies were commissioned in Torbay in 2016/17 to provide the Chlamydia Counter top kit service (not including those who provide chlamydia screening as part of the EHC provision). In total 30 pharmacies were commissioned to provide Chlamydia screening and 159 people were tested for chlamydia from the kits provided through pharmacies.

NHS health checks

In 2016/17, this service was only commissioned through GP practices with a small ancillary outreach contract commissioned through Devon Doctors. No pharmacies were directly commissioned in Torbay to provide NHS Health Checks.

Smoking cessation

In 2016/17, 7 pharmacies were commissioned in Torbay to provide stop smoking services. In 2016/17 8 people quit smoking through pharmacies.

TB DOT

In 2016/17, 24 pharmacies were commissioned in Torbay to provide TB DOT services. In 2016/17 no-one received TB DOT services through pharmacies.

7.8 Other NHS services

7.8.1 Hospital pharmacies

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

There is one hospital in Torbay, which has a pharmacy on site, although this is not an NHS community pharmacy and therefore does not dispense FP10 prescriptions; it only dispenses hospital outpatient prescriptions. This pharmacy is based on the main hospital site at Lowes Bridge in Torquay.

7.8.2 Personal administration of items by GPs

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

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

For these items the practice will produce a prescription however the patient is not

required to take it to a pharmacy, have it dispensed and then return to the practice for it to be administered.

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

7.8.3 GP Out of Hours service

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

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

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

7.9 Services provided by other organisations

It has been assessed that there are no other services, provided by other organisations in Torbay that is applicable to the PNA.

8 Conclusion

8.1 Current provision

Torbay HWB has had regard to the pharmaceutical services referred to in this PNA in seeking to identify those that are necessary, have secured improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

8.2 Necessary services: current gaps in provision

There are currently no gaps in pharmaceutical provision in Torbay, and thus there is currently no need for a new pharmacy in Torbay.

With regards to the 'on demand availability of specialist drugs' enhanced service, current provision is considered to be adequate and thus there are no gaps. If a need for this provision to be extended is identified then NHS England (or the CCG's if commissioning of this service transfers to them) could commission additional existing pharmacies to provide it. Therefore it would not be necessary for new pharmacies to open in order to meet any such need, and accordingly there is not a gap.

8.3 Necessary services: future gaps in provision

We recognize that there are housing developments proposed, especially in Collaton St Mary, however, this is not expected to be progressed significantly in the life of this PNA. However, there would be a future need if the housing developments accelerated, and 1,500 or more houses were built within Collaton St Mary.

Across the rest of Torbay there are not expected to be any gaps in pharmaceutical provision and thus there is currently no future need for a new pharmacy elsewhere in Torbay.

We recognise increasing demand pressure in primary care, and that the role of community pharmacy may significantly change, as a result, over the lifetime of this PNA. The direction of travel for primary care, as set out in the GP Forward View, is for GP services to become available from 8am to 8pm, and for pharmacies to become the first point of contact with health services for some health issues. It is

anticipated that pharmacies' business interests will lead them to adapt their provision of pharmaceutical services to these changes, although innovative approaches in contractual arrangement may be needed in some locations to support these changes. Across the existing services in Torbay there is unused capacity for further MUR and NMS services; as a result there is no gap in provision and no need for additional capacity.

With regards to the 'on demand availability of specialist drugs' enhanced service, future provision within this PNA is considered to be adequate and thus there will not be any future gaps. If a need for this provision to be extended is identified then NHS England (or the CCG's if commissioning of this service transfers to them) could commission additional existing pharmacies to provide it. Therefore it would not be necessary for new pharmacies to open in order to meet any such need, and accordingly there is not a gap.

8.4 Other relevant services: current and future gaps in provision

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

The NHS Urgent Medicine Supply Advanced Service (NUMSAS) is a pilot service and due to be evaluated in due course. Therefore the PNA will not comment on the adequacy of provision at the present time however the future commissioning plans for this service may be know when the final PNA is published.

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

Appendix 1: Acronyms and definitions

A&E	accident and emergency
AUR	appliance use review
BAME	black and Asian minority ethnic
CCG	clinical commissioning group
CHD	coronary heart disease
COPD	chronic obstructive pulmonary disease
DAC	dispensing appliance contractor
DH	Department of Health
DRUM	dispensing review of the use of medicines
DSP	distance-selling pharmacy
DSQS	dispensary services quality scheme
EHC	emergency hormonal contraception
EIA	equality impact assessment
EPS	electronic prescription service
GIRES	Gender identity research and education society
GUM	genito–urinary medicine
HIV	human immunodeficiency virus
HSCIC	Health and Social Care Information Centre
HSV	herpes simplex virus
HWB	health and wellbeing board
IHS	integrated household survey
IMD	index of multiple deprivation
JSNA	joint strategic needs assessment
LAPE	local alcohol profiles for England
LARC	long–acting reversible contraception
LGBT	lesbian, gay, bisexual and transgender
LPS	local pharmaceutical services
LSOA	lower layer super output area
LTC	long term condition
MSM	men who have sex with men
MSOA	medium layer super output area
MUR	medicines use review
NCMP	national child measure programme

NCSP	national chlamydia screening programme
NMS	new medicine service
NHSCB	NHS Commissioning Board (NHS England)
NUMSAS	NHS urgent medicine supply advanced service
OCU	opiate or crack cocaine user
ONS	Office for national statistics
PCT	primary care trust
PGD	patient group direction
PHO	public health observatories
PhAS	pharmacy access scheme
PNA	pharmaceutical needs assessment
POPPI	projecting older people population information
QOF	quality and outcomes framework
QPS	Quality Payment Scheme
SADL	simple aid to daily living
SMR	standardised mortality rate
STI	sexually transmitted infections
TB	tuberculosis
UK	United Kingdom

The 2013 directions – The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013, as amended

The 2013 regulations – The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended

Appendix 2: Legislation relating to PNAs

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

Section 128A Pharmaceutical needs assessments

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

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

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

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

Part 2: Pharmaceutical needs assessments

3. Pharmaceutical needs assessments

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

(2) The pharmaceutical services to which each pharmaceutical needs assessment must relate are all the pharmaceutical services that may be provided under arrangements made by the NHSCB for—

(a) the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list;

(b) the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services); or

(c) the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the NHSCB with a dispensing doctor).

4. Information to be contained in pharmaceutical needs assessments

(1) Each pharmaceutical needs assessment must contain the information set out in Schedule 1.

(2) Each HWB must, in so far as is practicable, keep up to date the map which it includes in its pharmaceutical needs assessment pursuant to paragraph 7 of Schedule 1 (without needing to republish the whole of the assessment or publish a supplementary statement).

5. Date by which the first HWB pharmaceutical needs assessments are to be published

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

6. Subsequent assessments

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

(2) A HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular to changes to—

(a) the number of people in its area who require pharmaceutical services;

(b) the demography of its area; and

(c) the risks to the health or well-being of people in its area,

unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

(3) Pending the publication of a statement of a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its or a Primary Care Trust's pharmaceutical needs assessment (and any such supplementary statement becomes part of that assessment), where—

(a) the changes are relevant to the granting of applications referred to in section 129(2)(c)(i) or (ii) of the 2006 Act; and

(b) the HWB—

(i) is satisfied that making its first or a revised assessment would be a disproportionate response to those changes, or

(ii) is in the course of making its first or a revised assessment and is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.

(4) Where chemist premises are removed from a pharmaceutical list as a consequence of the grant of a consolidation application, if in the opinion of the relevant HWB the removal does not create a gap in pharmaceutical services provision that could be met by a routine application—

(a) to meet a current or future need for pharmaceutical services; or

(b) to secure improvements, or better access, to pharmaceutical services,

the relevant HWB must publish a supplementary statement explaining that, in its view, the removal does not create such a gap, and any such statement becomes part of its pharmaceutical needs assessment

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

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

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

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

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

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

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

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

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

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

8. Consultation on pharmaceutical needs assessments

(1) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB (HWB1) must consult the following about the contents of the assessment it is making—

(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;

(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and

(f) any NHS trust or NHS foundation trust in its area;

(g) the NHSCB; and

(h) any neighbouring HWB.

(2) The persons mentioned in paragraph (1) must together be consulted at least

once during the process of making the assessment on a draft of the proposed pharmaceutical needs assessment.

(3) Where a HWB is consulted on a draft under paragraph (2), if there is a Local Pharmaceutical Committee or Local Medical Committee for its area or part of its area that is different to a Local Pharmaceutical Committee or Local Medical Committee consulted under paragraph (1)(a) or (b), that HWB—

(a) must consult that Committee before making its response to the consultation; and

(b) must have regard to any representations received from the Committee when making its response to the consultation.

(4) The persons consulted on the draft under paragraph (2) must be given a minimum period of 60 days for making their response to the consultation, beginning with the day by which all those persons have been served with the draft.

(5) For the purposes of paragraph (4), a person is to be treated as served with a draft if that person is notified by HWB1 of the address of a website on which the draft is available and is to remain available (except due to accident or unforeseen circumstances) throughout the period for making responses to the consultation.

(6) If a person consulted on a draft under paragraph (2)—

(a) is treated as served with the draft by virtue of paragraph (5); or

(b) has been served with copy of the draft in an electronic form,

but requests a copy of the draft in hard copy form, HWB1 must as soon as is practicable and in any event within 14 days supply a hard copy of the draft to that person (free of charge).

9. Matters for consideration when making assessments

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

do so, to the following matters—

(a) the demography of its area;

(b) whether in its area there is sufficient choice with regard to obtaining pharmaceutical services;

(c) any different needs of different localities within its area;

(d) the pharmaceutical services provided in the area of any neighbouring HWB which affect—

(i) the need for pharmaceutical services in its area, or

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

(e) any other NHS services provided in or outside its area (which are not covered by sub-paragraph (d)) which affect—

(i) the need for pharmaceutical services in its area, or

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

(2) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must take account of likely future needs—

(a) to the extent necessary to make a proper assessment of the matters mentioned in paragraphs 2 and 4 of Schedule 1; and

(b) having regard to likely changes to—

(i) the number of people in its area who require pharmaceutical services,

(ii) the demography of its area, and

(iii) the risks to the health or well-being of people in its area.

Schedule 1: Information to be contained in pharmaceutical needs assessments

1. Necessary services: current provision

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

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

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

2. Necessary services: gaps in provision

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

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

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

3. Other relevant services: current provision

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

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

(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area,

nevertheless have secured improvements, or better access, to pharmaceutical services in its area;

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

4. Improvements and better access: gaps in provision

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

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

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

5. Other NHS services

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

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

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

6. How the assessment was carried out

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

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

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

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

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

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

7. Map of provision

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

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

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

…

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

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

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

(ii) publish that map, and

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

…

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

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

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

Appendix 3: Steering Group membership

Name	Job Title	Organisation
Dave Bearman	Chair	Devon, Cornwall and Isles of Scilly Pharmacy Local Professional Network
Janet Newport	Contracts Manager	Devon, Cornwall and Isles of Scilly Area Team, NHS England
Kirsty Hill	Senior Public Health Information Analyst,	Devon County Council
Sue Taylor	Chief Officer	Devon Local Pharmaceutical Committee
Robert Nelder	Consultant in Public Health Intelligence	Plymouth City Council
Claire Turbett	Advanced Public Health Practitioner	Plymouth City Council
David Ward	Assistant Contract Manager - Pharmacy	NHS England
Doug Haines	Public Health Analyst	Torbay Council
Ian Tyson	Acting Head of Public Health Improvement	Torbay Council
Karen Acott	Executive Partner	Wallingbrook Health Group (dispensing GP practice representative)

We acknowledge the support and contributions from colleagues in Public Health England.

Appendix 4: Equality impact assessment

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

STAGE 1: What is being assessed and by whom?	
	pharmacies and dispensing appliance contractors (DACs) are able to ensure services are targeted to areas of health need, and reduce the risk of overprovision in areas of less need.
Author	Ian Tyson
Department and Service	Commissioning Team, Public Health Department
Date of Assessment	October 2017

STAGE 2: Evidence and Impact				
Protected Characteristics (Equality Act)	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
Age	Torbay has a population of around 133,900 (2016 mid year estimates) The population of Torbay 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	Pharmaceutical services will be provided on the basis of clinical need – this document specifies the needs within Torbay. Any missing provision should have been identified in the document and should therefore have a positive impact.	The predicted population increases within age bands has been estimated. The document will be reviewed in three years' time. It is assumed the age-specific predictions of population growth will be within tolerance, which will ensure provision of pharmaceutical services in an equitable manner.	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
Disability	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 region. According to the 2011 Census, 41.7% of Torbay residents reported their general health as 'very good' 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	The provision of adequate pharmaceutical services responds to these statistics (which potentially show a relatively high demined when compared to national averages). The aim of the document is to enable the provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	Torbay than in England (England 4.2%, 1.2% respectively), this equates to 9,892 people over both categories			
Faith/Religion or Belief	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	Pharmaceutical services are not targeted at any particular religion. The aim of the document is to ensure the provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics (Equality Act)	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	Spiritualist.			
Gender - including marriage, pregnancy and maternity	Overall 51.5% of Torbay's population are female (ONS mid-2016 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.	The need for pharmacy services in relation to sexual health have been identified within the document. This will ensure provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.
Gender Reassignment	In 2010 it was estimated nationally that the number of gender variant people presenting for	The PNA aims to ensure adequate provision of pharmaceutical services	The document aims to meet the needs identified. The document will be reviewed in three	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics (Equality Act)	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	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.	throughout Torbay taking into consideration any particular needs identified. Gender-related pharmaceutical needs should have been identified within the document to ensure provision of adequate and appropriate pharmaceutical services to meet the needs of this population.	years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	
Race	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	Pharmaceutical services are not targeted at a specific ethnic group. The PNA attempts to ensure provision of adequate and appropriate pharmaceutical services to meet the needs of the population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics (Equality Act)	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	(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**.	There are some diseases which are more prevalent amongst specific ethnic groups however the PNA, if successful, will ensure adequate services to meet any additional needs.	services.	
Sexual Orientation -including Civil Partnership	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	Pharmaceutical services are not targeted people with a specific sexual orientation. The PNA attempts ensure provision of adequate and appropriate pharmaceutical services to meet the needs of the population.	The document aims to meet the needs identified. The document will be reviewed in three years' time. It is assumed provision of pharmaceutical services in accordance with the recommendations in the report will result in an equitable distribution of services.	NHSE. Throughout the life of the document.

STAGE 2: Evidence and Impact				
Protected Characteristics **(Equality Act)**	**Evidence and information (e.g. data and feedback)**	**Any adverse impact?** See the guidance on how to make this judgement.	**Actions**	**Timescale and who is responsible?**
	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.			

Appendix 5: List of contractors and opening times

Pharmacy name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Babbacombe Pharmacy, Poolearth, 100 Reddenhill Road, Babbacombe, Torquay, TQ1 3NT	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1700	Closed
Boots pharmacy, Boots UK Ltd, 11 Fore Street, Brixham, TQ5 8AA	0900-1300 1400-1730	0900-1300 1400-1730	0900-1300 1400-1730	0900-1300 1400-1730	0900-1300 1400-1730	0900-1300 1400-1730	1000-1600 from 16/7/17 to 10/9/17
Boots pharmacy, Boots UK Ltd, 6 Bolton St, Brixham, TQ5 9DE	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400 1430-1730	0830-1400	Closed
Boots pharmacy, Boots UK Ltd, 12-14 Victoria Street, Paignton, TQ4 5DN	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0830-1300 1400-1730	0900-1300 1400-1730	1000-1600
Boots pharmacy, Boots UK Ltd, 1 Cherrybrook Square, Hookhills Road, Paignton, TQ4 7LY	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300	Closed
Boots pharmacy, Boots UK Ltd, Wren Retail Park, Torquay, TQ2 7BJ	0830-2400	0830-2400	0830-2400	0830-2400	0830-2400	0830-2400	0930-2400
Boots pharmacy, Boots UK Ltd, 66-68 Union Street, Torquay, TQ2 5PS	0900-1330 1400-1730	0900-1330 1400-1730	0900-1330 1400-1730	0900-1330 1400-1730	0900-1330 1400-1730	0900-1300 1400-1730	1030-1630
Boots pharmacy, Boots UK Ltd, 9 The Strand, Torquay, TQ1 2AA	0900-1330 1400-1730 From 4/6/17 to 2/9/17 0900-1330 1400-1800	0900-1330 1400-1730 From 4/6/17 to 2/9/17 0900-1330 1400-1800	0900-1330 1400-1730 From 4/6/17 to 2/9/17 0900-1330 1400-1800	0900-1330 1400-1730 From 4/6/17 to 2/9/17 0900-1330 1400-1800	0900-1330 1400-1730 From 4/6/17 to 2/9/17 0900-1330 1400-1800	0900-1330 1400-1730 From 4/6/17 to 2/9/17 0900-1330 1400-1800	1030-1630 From 4/6/17 to 2/9/17 1030-1700
Boots pharmacy, Boots UK Ltd, 27 Fore Street, St Marychurch, Torquay, TQ1 4PU	0900-1330 1400-1800	0900-1330 1400-1800	0900-1330 1400-1800	0900-1330 1400-1800	0900-1330 1400-1800	0900-1300	Closed
Boots pharmacy, Boots UK Ltd, 8 Fore Street, St Marychurch, Torquay, TQ1 4NE	0830-1300 1330-1730	0830-1300 1330-1730	0830-1300 1330-1730	0830-1300 1330-1730	0830-1300 1330-1730	0900-1300	Closed
Broadway pharmacy, Churston Broadway, Dartmouth Road, Paignton, TQ4 6LE	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300	Closed
Day Lewis Pharmacy, Day Lewis plc, Compass House Medical Centre, King Street, Brixham, TQ5 9TF	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	Closed	Closed
Day Lewis Pharmacy, Day Lewis plc, 52 Fore Street, Brixham, TQ5 8DZ	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1300	Closed
Day Lewis Pharmacy, Day Lewis plc, 28 Walnut Road,	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	Closed	Closed

Chelston, TQ2 6HS							
Day Lewis Pharmacy, Day Lewis plc, 237 Torquay Road, Preston, Paignton, TQ3 2HW	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1200	Closed
Day Lewis Pharmacy, Day Lewis plc, Units 2&3, Pembroke House, 266-276 Torquay Road, Paignton, TQ3 2EZ	0830-1300 1400-1830	0830-1300 1400-1830	0830-1300 1400-1830	0830-1300 1400-1830	0830-1300 1400-1830	0830-1300	Closed
Day Lewis Pharmacy, Day Lewis plc, 99 Foxhole Road, Paignton, TQ3 3SU	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300	Closed
Day Lewis Pharmacy, Day Lewis plc, 19 Ilsham Road, Wellswood, Torquay, TQ1 2JG	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300	Closed
Day Lewis Pharmacy, Day Lewis plc, Bronshill Road, Torquay, TQ1 3HD	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	0900-1300 1400-1800	Closed	Closed
Dowricks Chemist, Chelston Hall, Old Mill Road, Torquay, TQ2 6HW	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1300	Closed
Hele Pharmacy, 111 Hele Road, Torquay, TQ2 7PS	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	Closed	Closed
Lloyds Pharmacy, Lloyds Pharmacy Ltd, 11 Palace Avenue, Paignton, TQ3 3EF	0830-1830	0830-1830	0830-1830	0830-1830	0830-1830	0830-1730	Closed
Lloyds Pharmacy, Lloyds Pharmacy Ltd, Sainsbury's, Brixham Road, Paignton, TQ4 7PE	0700-2300	0700-2300	0700-2300	0700-2300	0700-2300	0700-2200	1000-1600
Lloyds Pharmacy, Lloyds Pharmacy Ltd, 168 Barton Hill Road, Torquay, TQ2 8HN	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1730	Closed
Lloyds Pharmacy, Lloyds Pharmacy Ltd, Sainsbury's, The Willows, Nicholson Road, Torquay, TQ2 7HT	0830-2100	0830-2100	0830-2100	0830-2100	0830-2100	0830-2000	1000-1600
Mayfield Pharmacy, Mayfield Medical Centre, 37 Totnes Road, Paignton, TQ4 5LA	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	09:00-18:00	10:00-16:00
Sherwell Valley Pharmacy, Poolearth, 37 Sherwell Valley Road, Chelston, Torquay, TQ2 6EJ	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	Closed	Closed
Shiphay Pharmacy, Poolearth, 11 Collaton Road, Shiphay, Torquay,	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed

TQ2 7HH							
Torwood Street Pharmacy, 37a Torwood Street, Torquay, TQ1 1ED	0900-1700	0900-1700	0900-1700	0900-1700	0900-1700	Closed	Closed
Watcombe Pharmacy, Poolearth, 69 Fore Street, Watcombe, Torquay, TQ2 8BP	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	0900-1300 1330-1730	Closed	Closed
Well pharmacy, Bestway National Chemists Ltd, 9 New Road, Brixham, TQ5 8LZ	0830-1800	0830-1800	0830-1800	0830-1800	0830-1800	0900-1300	Closed
Well pharmacy, Bestway National Chemists Ltd, 2-3 Churchill Court, Bolton Street, Brixham, TQ5 9DW	0800-1800	0800-1800	0800-1800	0800-1800	0800-1800	0900-1300	Closed
Well pharmacy, Bestway National Chemists Ltd46B Dartmouth RoadPaigntonTQ4 5AQ	0830-2000	0830-1800	0830-1800	0830-1800	0830-1800	0900-1130	Closed
Well pharmacy, Bestway National Chemists Ltd, 1-5 Palace Avenue, Paignton, TQ3 3EF	0900-1730	0900-1730	0900-1730	0900-1730	0900-1730	0900-1700	Closed
Well pharmacy, Bestway National Chemists Ltd19 Croft RoadTorquayTQ2 5UA	0830-1800	0830-1800	0830-1800	0830-1800	0830-1800	0900-1300	Closed
Well pharmacy, Bestway National Chemists Ltd, 159 St Marychurch Road, Babbacombe, Torquay, TQ1 3HP	0900-1800	0900-1800	0900-1800	0900-1800	0900-1800	0900-1300	Closed
Superdrug Pharmacy, Superdrug Stores Plc, 83-85 Union Street, Torquay, TQ1 3DG	0830-1730	0830-1730	0830-1730	0830-1730	0830-1730	0900-1730	None

Appendix 6: List of contractors and advanced, enhanced and locally-commissioned services provided

Pharmacy	Contractor and address	Appliances requiring measuring and fitting	Medicines Use Reviews	New Medicines Service	Appliance Use Reviews	Stoma Appliance Customisations	Flu Vaccinations
FK340	Bestway National Chemists Ltd, 9 New Road, Brixham, TQ5 8LZ	No	Yes	Yes	No	No	Yes
FJP75	Bestway National Chemists Ltd, 2-3 Churchill Court, Bolton Street, Brixham, TQ5 9DW	No	Yes	Yes	No	No	Yes
FA041	Bestway National Chemists Ltd, 1-5 Palace Avenue, Paignton, TQ3 3EF	No	Yes	Yes	No	No	Yes
FPA99	Bestway National Chemists Ltd, 46B Dartmouth Road, Paignton, TQ4 5AQ	Yes	Yes	Yes	No	No	Yes
FKF90	Bestway National Chemists Ltd, 159 St Marychurch Road, Babbacombe, Torquay, TQ1 3HP	No	Yes	Yes	No	No	Yes
FMJ40	Bestway National Chemists Ltd, 19 Croft Road, Torquay, TQ2 5UA	No	Yes	Yes	No	No	Yes
FD894	Boots UK Ltd, 11 Fore Street, Brixham, TQ5 8AA	No	Yes	Yes	No	No	Yes
FD839	Boots UK Ltd, 6 Bolton St, Brixham, TQ5 9DE	No	Yes	Yes	No	No	Yes
FVP01	Boots UK Ltd, 12-14 Victoria Street, Paignton, TQ4 5DN	Yes	Yes	Yes	No	No	Yes
FEW47	Boots UK Ltd, 1 Cherrybrook Square, Hookhills Road, Paignton, TQ4 7LY	No	Yes	Yes	No	No	Yes
FJ901	Boots UK Ltd, 9 The Strand, Torquay, TQ1 2AA	Yes	Yes	Yes	No	No	Yes
FLH76	Boots UK Ltd, 8 Fore Street, St Marychurch, Torquay, TQ1 4NE	Yes	Yes	Yes	No	No	Yes
FX241	Boots UK Ltd, 27 Fore Street, St Marychurch, Torquay, TQ1 4PU	Yes	Yes	Yes	No	No	Yes

FJN75	Boots UK Ltd, 66-68 Union Street, Torquay, TQ2 5PS	Yes	Yes	Yes	No	No	Yes
FEW75	Boots UK Ltd, Wren Retail Park, Torquay, TQ2 7BJ	Yes	Yes	Yes	No	No	Yes
FKQ69	Broadway pharmacy, Churston Broadway, Dartmouth Road, Paignton, TQ4 6LE	No	Yes	Yes	No	No	Yes
FKE05	Day Lewis plc, 52 Fore Street, Brixham, TQ5 8DZ	No	Yes	Yes	No	No	Yes
FWC17	Day Lewis plc, Compass House Medical Centre, King Street, Brixham, TQ5 9TF	Yes	Yes	Yes	No	No	Yes
FAF97	Day Lewis plc, 28 Walnut Road, Chelston, TQ2 6HS	Yes	Yes	Yes	No	No	Yes
FEL62	Day Lewis plc, Units 2&3, Pembroke House, 266-276 Torquay Road, Paignton, TQ3 2EZ	Yes	Yes	Yes	No	No	Yes
FTX29	Day Lewis plc, 237 Torquay Road, Preston, Paignton, TQ3 2HW	No	Yes	Yes	No	No	Yes
FLE57	Day Lewis plc, 99 Foxhole Road, Paignton, TQ3 3SU	No	Yes	Yes	No	No	Yes
FEW76	Day Lewis plc, 19 Ilsham Road, Wellswood, Torquay, TQ1 2JG	No	Yes	Yes	No	No	Yes
FEC86	Day Lewis plc, Bronshill road, Southover, Torquay, TQ1 3HD	Yes	Yes	Yes	No	No	Yes
FXL17	Dowricks Chemist, Chelston Hall, Old Mill Road, Torquay, TQ2 6HW	No	Yes	Yes	No	No	No
FLG36	Hele Pharmacy, 111 Hele Road, Torquay, TQ2 7PS	Yes	Yes	Yes	No	No	Yes
FR007	Lloyds Pharmacy Ltd, 11 Palace Avenue, Paignton, TQ3 3EF	No	Yes	Yes	No	Yes	Yes
FHL28	Lloyds Pharmacy Ltd, Sainsbury's, Brixham Road, Paignton, TQ4 7PE	Yes	Yes	Yes	No	No	Yes
FM400	Lloyds Pharmacy Ltd, Sainsbury's, The Willows, Nicholson Road, Torquay, TQ2 7HT	Yes	Yes	Yes	No	No	No

FPH68	Lloyds Pharmacy Ltd, 168 Barton Hill Road, Torquay, TQ2 8HN	Yes	Yes	Yes	No	Yes	Yes
FTX34	Mayfield Pharmacy, Mayfield Medical Centre, 37 Totnes Road, Paignton, TQ4 5LA	Yes	Yes	Yes	No	No	Yes
FJP38	Poolearth, 100 Reddenhill Road, Babbacombe, Torquay, TQ1 3NT	Yes	Yes	Yes	No	No	No
FV361	Poolearth, 37 Sherwell Valley Road, Chelston, Torquay, TQ2 6EJ	Yes	Yes	No	No	No	No
FLD28	Poolearth, 11 Collaton Road, Shiphay, Torquay, TQ2 7HH	Yes	Yes	Yes	No	No	No
FJE51	Poolearth, 69 Fore Street, Watcombe, Torquay, TQ2 8BP	Yes	Yes	Yes	No	No	Yes
FM565	Superdrug Stores Plc, 83-85 Union Street, Torquay, TQ1 3 DG	No	Yes	No	No	No	Yes
FJ134	Torwood Street Pharmacy , 37a Torwood Street, Torquay, TQ1 1ED	No	Yes	Yes	No	No	Yes

Appendix 7: Consultation report

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

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

- Devon Local Pharmaceutical Committee
- Devon Local Medical Committee
- Persons on the pharmaceutical list and any dispensing doctors for the area
- Any LPS chemist in Torbay with whom NHS England has made arrangements for the provision of local pharmaceutical services
- Healthwatch Devon
- NHS England Devon, Cornwall and Isles of Scilly Area Team
- Devon Health and Wellbeing Board
- Plymouth Health and Wellbeing Board
- Torbay Health and Wellbeing Board
- Torbay and South Devon NHS Foundation Trust
- Northern Devon Healthcare Trust
- Devon Partnership NHS Trust

There were 3 responses to the online consultation received for Torbay. These responses represented:

- Pharmacists (1 response)
- The Clinical and Effectiveness and Medicines Optimisations Team for NHS South Devon and Torbay Clinical Commissioning Group (1 response)

- The Devon Local Pharmaceutical Committee (1 response)

Overall consultation feedback regarding the PNA was very positive. A small number of minor corrections to accuracy of data were identified and these have been corrected including correcting a pharmacy identified as providing the Pharmacy Access Scheme.

The main areas or themes that received comments are summarised briefly below.

Opening hours

Opening hours of pharmacies in all districts for each day of the week were outlined in the main document including maps of provision at weekends. With regard to back holidays, pharmacies and DAC are not required to open on public and bank holidays, although some do choose to. NHS England asks each contractor to confirm their intentions regarding these days and where there necessary will direct a contractor or contractors to open on one or more of these dates to ensure adequate access.

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

Changes to QPS and Healthy Living pharmacy scheme

The Quality Payment Scheme and Healthy Living Pharmacy scheme are both optional schemes, with pharmacies able to opt in and out and not deemed a necessary pharmacy service. Therefore, any changes will not impact on gaps of provision within the current PNA.

Maps of urgent care and other services

Maps of pharmacies were provided to meet the statutory requirements of the PNA. Mapping of availability on different days of the week and the coverage provided by

dispensing practices is also included to enable gaps to be recognised. Mapping of other services such as urgent care centres was not included due to the fluidity of such services over the lifetime of the PNA.

DEVELOPING THE JOINT HEALTH AND WELLBEING STRATEGY AND THE WORK PROGRAMME OF THE HEALTH AND WELLBEING BOARD

BRIEFING NOTE TO THE HEALTH AND WELLBEING BOARD

1. JOINT STRATEGIC NEEDS ASSESSMENT

The Joint Strategic Needs Assessment sets out the needs of the population of Torbay against the range of the determinants of health and wellbeing. The Assessment paints of picture where, despite a vibrant tourism industry and an environment that attracts many to make this their home, there are also many areas and many of its people who lead challenging lives.

Relatively high levels of deprivation, a low wage economy, poor levels of qualification and issues with poor housing have resulted in some children growing up in relative poverty where inequalities are evident within the educational and health indicators. This in term leads to disparities in lifestyle choices, in illness and disability and ultimately in health and care needs and costs.

The stark fact is that a female living in the most deprived area of Torbay will live, on average 8.9 years less and a male 5.2 years less than a person in the least deprived area.

The JSNA findings can be summarised as:

- The population of Torbay is ageing more than other areas of the country and it is expected that the over 85 population will double over next twenty years
- Levels of deprivation are increasing with 45% living in an area in the top 20% most deprived in England for indoor environment quality
- Torbay is the most deprived local authority in the South West and inequalities have been widening as relative deprivation worsens
- There are relatively high levels of residents with low qualifications, low earnings and who are benefit claimants
- House prices are, on average, £40,000 less than England average but to buy them costs nearly 7 times the average salary.
- Housing conditions are an area of concern with higher percentage of private rented; significantly lower social rented.
- Homelessness and insecurity of tenure are rising: 24 people were street homeless at the last count
- Violent crime rate significantly higher than England.
- Anti-social behaviour is significantly higher (than England and CIPFA group)

For children:

- There is good early years educational achievement against national standard, but a gap is emerging between poorer and better off students especially at secondary school.
- 1 in 4 children live in poverty and there are issues of debt and food insecurity

- There are issues with how families live their lives with almost 1 in 5 mothers smoking during pregnancy, low numbers breastfeeding and 1 in 3 children overweight by age 11
- The rate of Children Looked After is also high

For adolescents:

- There are lifestyle issues with significantly worse rates of specific admissions for alcohol and higher prevalence of smoking
- There are significantly higher numbers of admissions for self-harm
- There are social / behavioural issues with high numbers of young people claiming benefits and high rates of first time entrants to Youth Justice System

For adults:

- There are lifestyle/Behavioural challenges
  - Smoking rates remain higher -17% of over 16's smoking compared to 15%
  - Physically active rate of 66%, similar to national rate of 65%
  - Hospital admissions rates for alcohol specific conditions 79% higher than England
  - Those classified as overweight or obese is 61%, this is the same as England
- There is high prevalence of a range of chronic conditions (Diabetes, Depression, Hypertension, CVD, COPD). This has led to high levels of preventable admissions

For older adults:

- Many people chose to retire to Torbay and most live full and happy lives.
- However, the numbers with co-morbidities (more than one health condition) is expected to rise by a third in the next ten years
- Frailty and dementia is also estimated to rise
- Age-related dependency and unpaid carer levels are significantly higher than nationally
- Rates of long-term support needs are significantly higher than England

2. SYSTEM PRIORITIES

The Joint Strategic Needs Assessment would indicate the priorities for Torbay Council and its partners to address – as a system – are:

1. Working together, at scale, to promote good health and wellbeing and prevent illness and interventions from statutory agencies
2. Enable children to have the best start in life and address the inequalities in their outcomes
3. Build emotional resilience in young people
4. Create places where people can live healthy and happy lives
5. Support those who are vulnerable and living complex lives, addressing the factors that result in vulnerability

6. Enable people to age well
7. Promote good mental health

Question: Does the Board agree that these are appropriate priorities for the health and wellbeing system, as a whole, in Torbay?

3. PARTNERSHIP PLANS, STRATEGIES AND PRIORITIES

Torbay has a long history of partnership working with a range of partnership bodies in place with their own "strategic" plans.

These plans address the system priorities set out above with the diagram on the following page showing the strategies and plans with their current priorities.

Underneath these sit a range of "tactical" policies including:

- Prevention Strategy
- Healthy Torbay Framework
- Mental Health Strategy
- Devon-wide Emotional Health and Wellbeing Transformation Plan
- Domestic Abuse and Sexual Violence Strategy
- Housing Strategy
- Annual Strategic Agreement between the Council, CCG and ICO

4. WAYS OF WORKING

Health and Wellbeing Boards were established to:

- Agree the long-term strategy for improving the health and wellbeing of the people of Torbay.
- Oversee the implementation of the Joint Health and Wellbeing Strategy.
- Promote integration throughout the health and wellbeing system to ensure delivery against the Board's priorities.

However, the integration of health and social care in Torbay was well established before the requirement to appoint Health and Wellbeing Boards. Similarly, and as referenced in the previous section, many other partnerships have been in place in Torbay for a number of years.

Whilst further work is needed, and, indeed, is in place, to further integrate and improve outcomes for our local population, it has been difficult to find a role of the Health and Wellbeing Board in Torbay that adds value to the systems already in place.

A workshop facilitated by the Local Government Association was held on 27 February 2018 to discuss these issues. It was recognised that, given the system priorities cover many areas and that these are being addressed by a number of established organisations and partnership arrangements, that the Board needed assurance that issues were being addressed. It also needed to identify areas where it could add value.

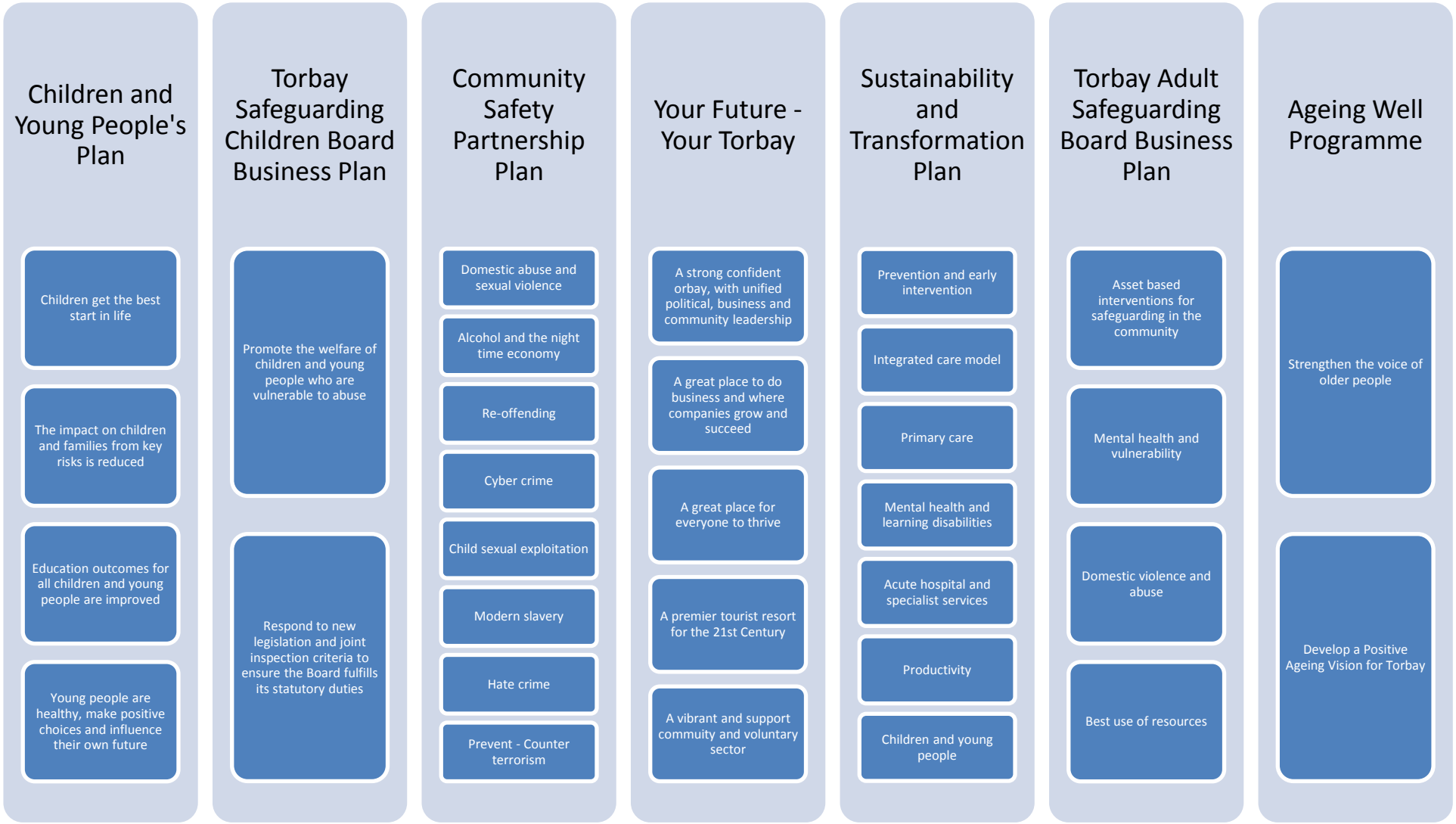
A suggested solution in order to organise the work of the Health and Wellbeing Board was to identify:

- Issues to **Watch** – these are areas where the Board is interested but only needs a watching brief on delivery, probably though oversight of key outcomes (i.e. the Board will **trust** that other organisations and/or partnerships are delivering the system priorities)

- Issues to **Sponsor** – these are areas that the Board will actively promote delivery of but leaves others to do this delivery, seeking only assurance of outputs and outcomes from this work (i.e. the Board may need to **encourage** integration and partnership working to deliver the system priorities).

- Areas of **Focus** – these are areas where the Board will need to have some more direct involvement and debate and assure itself of some of the detail of delivery (i.e. the Board will be seeking a **commitment to action** from its partner members).

Partnership Plans, Strategies and Priorities



5. IDENTIFYING AREAS OF FOCUS

The Health and Wellbeing Board is asked to consider the partnership plans, strategies and priorities in order to assess:

Questions: How does this suite of plans address the system priorities?

What are the duplications?

What are the gaps?

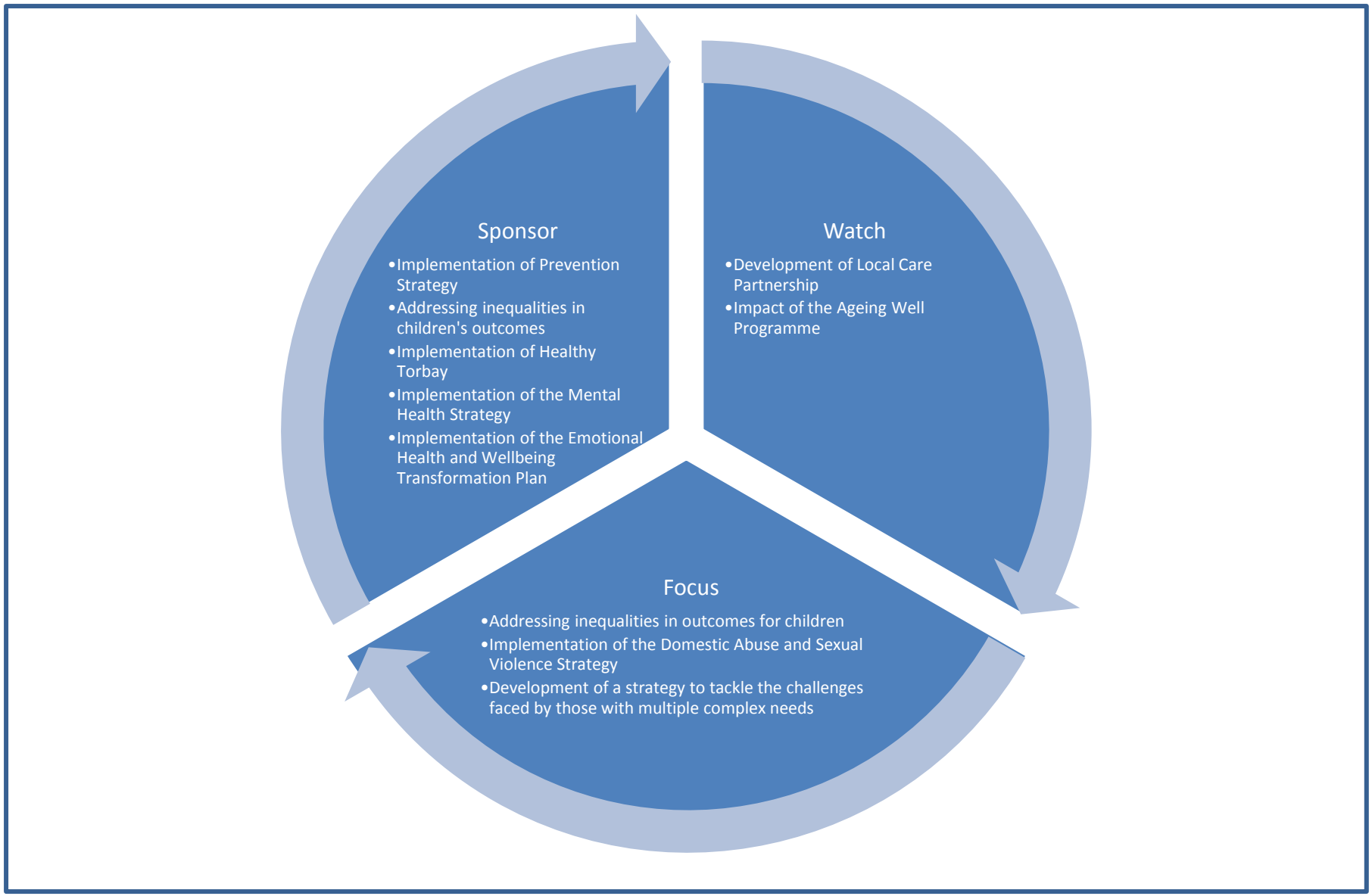
Should the duplications and gaps form the areas of focus for the Health and Wellbeing Board?

Which are the issues to watch and sponsor?

The table on the next page provides an initial analysis of how the priorities from each plan fit against the system priorities and suggests areas to watch and sponsor and for focus.

System Priorities		Priorities from partnership plans and strategies	Gaps and Duplication	Watch/Sponsor/Focus
1.	Working together, at scale, to promote good health and wellbeing and prevent illness and interventions from statutory agencies	Young people are healthy, make positive choices and influence their own future (Children and Young People's Plan) Prevention and early intervention (STP) Integrated care model (STP) Primary care (STP) A vibrant and supported community and voluntary sector (Your Future – Your Torbay)		Development of Local Care Partnership – Watch Implementation of Prevention Strategy – Sponsor
2.	Enable children to have the best start in life and address the inequalities in their outcomes	Children get the best start in life (Children and Young People's Plan) Education outcomes for all children and young people are improved (Children and Young People's Plan) Promote the welfare of children and young people who are vulnerable to abuse (TSCB Business Plan) Child sexual exploitation (Community Safety Plan) Children and young people (STP) Adverse Childhood Experience (JSNA)	Is there a partnership arrangement ensuring that these priorities are aligned and work joined up? Potential Gap	Addressing inequalities in children's outcomes – Focus
3.	Build emotional resilience in young people	Emotional Health and Wellbeing Transformation Plan Young people are healthy, make positive choices and influence their own future (Children and Young People's Plan)		Implementation of the Emotional Health and Wellbeing Transformation Plan – Sponsor
4.	Create places where people can live healthy and happy lives	Alcohol and the night time economy (Community Safety Plan) Cyber crime (Community Safety Plan) Hate crime (Community Safety Plan) Prevent – Counter terrorism (Community Safety Plan) A great place to do business and where companies grow and success (Your Future – Your Torbay) A great place for everyone to thrive (Your Future – Your Torbay)		Implementation of Healthy Torbay – Sponsor

		A premier tourist resort for the 21st Century (Your Future – Your Torbay) My Home, My life Housing Strategy		
5.	Support those who are vulnerable and living complex lives, addressing the factors that result in vulnerability	The impact on children and families from key risks is reduced (Children and Young People's Plan) Domestic abuse and sexual violence (Community Safety Plan) Re-offending (Community Safety Plan) Modern slavery (Community Safety Plan) Mental health and learning disabilities (STP) Domestic violence and abuse (TASB Business Plan) A vibrant and supported community and voluntary sector (Your Future – Your Torbay)	Domestic abuse = Duplication across at least three plans No coherent strategy to address adults with multiple complex needs ie 1 or more of homelessness, offending, poor mental health, Drug and alcohol abuse, domestic abuse / sexual violence	Implementation of the Domestic Abuse and Sexual Violence Strategy – Focus Development of a strategy to tackle the challenges faced by those with multiple complex needs – Focus
6.	Enable people to age well	Acute hospital and specialist services (STP) Asset based interventions for safeguarding in the community (TASB Business Plan) Strengthen the voice of older people (Ageing Well) Develop a positive ageing vision for Torbay (Ageing Well) A vibrant and supported community and voluntary sector (Your Future – Your Torbay)		Impact of the Ageing Well Programme – Watch
7.	Promote good mental health	Mental health and learning disabilities (STP) Mental health and vulnerability (TASB Business Plan)		Implementation of the Mental Health Strategy - Sponsor


Sponsor
•Implementation of Prevention Strategy
•Addressing inequalities in children's outcomes
•Implementation of Healthy Torbay
•Implementation of the Mental Health Strategy
•Implementation of the Emotional Health and Wellbeing Transformation Plan
Watch
•Development of Local Care Partnership
•Impact of the Ageing Well Programme
Focus
•Addressing inequalities in outcomes for children
•Implementation of the Domestic Abuse and Sexual Violence Strategy
•Development of a strategy to tackle the challenges faced by those with multiple complex needs

6. WORK PROGRAMME

It is recommended that the Health and Wellbeing Board's Work Programme be developed around the following principles:

- Areas to watch – Performance monitoring reports to be presented twice a year
- Areas to sponsor – Highlight reports to be presented twice a year with lead organisations being asked to identify any blockages within the system. This will enable the Board to discuss potential solutions building on its role to promote integration across the system.
- Areas of focus – Each partner organisation to identify specific issues of concern for inclusion within the Action Plan of the Joint Health and Wellbeing Strategy. These issues will then form the basis of meetings of the Board, enabling proactive debate, leading to solutions owned by the system.

Question: Are these acceptable principles with which to develop both the Action Plan of the Joint Health and Wellbeing Strategy and the Work Programme of the Health and Wellbeing Board?

7. MEMBERSHIP OF THE BOARD

The membership of the Board currently comprises:

- Chair – Executive Lead for Health and Wellbeing
- Four additional councillors (cross party)
- Torbay Council – Director of Children Service's
- Torbay Council – Director of Adult Social Care
- Torbay Council – Director of Public Health
- South Devon and Torbay Clinical Commissioning Group
- NHS England
- Healthwatch Torbay

Non-voting co-opted members:

- South Devon Healthcare NHS Foundation Trust
- Devon Partnership NHS Trust
- Community Development Trust
- Devon and Cornwall Police and Crime commissioner
- A representative of the primary care sector be appointed (if feasible)
- A representative from Torbay schools

Nominations to fill these latter two co-options have not yet been received.

It is recommended that the membership of the Board be expanded to include the chairman of the following partnerships/boards:

- Safer Communities Torbay
- Torbay Safeguarding Children Board
- Torbay Safeguarding Adults Board
- Torbay Together

Questions: Is it agreed that the membership of the Health and Wellbeing Board should be extended as recommended?

Improving the health, care and wellbeing of the people of South Devon and Torbay through a Local Care Partnership

A discussion document

This paper has been developed to create the opportunity for discussion and contribution from local partners and stakeholders as we work together on strengthening our partnership on the next step in our health and care integration journey.

The development of a Local Care Partnership for South Devon and Torbay is set within the context of an emerging Devon Integrated Care System (ICS). An ICS is not the creation of a new organisation, but rather a strengthening of partnership working with health and care organisations working more closely together than ever before to the benefit of our population.

The Devon ICS will include a single integrated strategic commissioner; a number of local place-based care partnerships – including one for South Devon and Torbay; a mental health care partnership and shared NHS corporate services.

The NHS Constitution and Local Authority Constitution will remain at the heart at everything we do, meaning anyone can receive high-quality NHS care, free at the point of access, whenever they need it. People will still see a GP when they need it and there will still be hospital care. Social care will continue to operate as it does now but integration will mean services are increasingly organised around the needs of individuals and not organisational boundaries.

There is no change to legislation, statute or constitutions. The role of the Health and Wellbeing Boards will remain and options on governance of these strengthened integrated arrangements will need to be explored. Similarly, the role of scrutiny committees will remain a key function so it is important that Scrutiny members are involved in the planning for these integrated arrangements. Overview and Scrutiny committees are invited to include Integrated Care System and Local Care Partnership governance in their work programmes.

1 Context

1.1 National Policy Direction

National policy direction for health and social care is very clear - the pursuit of greater integration of health and social care to help frail and older people stay healthy and independent, avoiding hospital stays where possible.

NHS Vision: To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View (5YFV) called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. Current government policy as reflected in “Next steps on the 5YFV” describes an ambition to accelerate integration through system level sustainability and transformation partnerships (STPs). Working together with patients and the public, NHS

commissioners and providers, as well as local authorities and other providers of health and care services, STPs will plan how best to provide care, including improving the health and wellbeing of the population they cover.

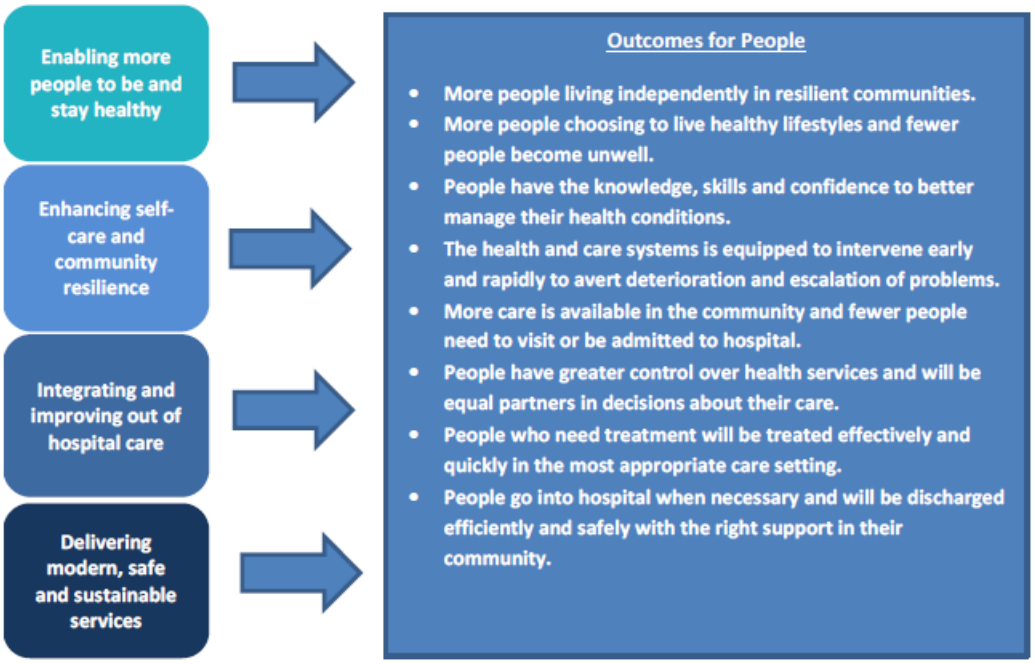
Adult social care vision: In 2016 the Local Government Association, the Association of Directors of Adult Social Services, the NHS Confederation of Providers and NHS Clinical Commissioners published a vision for the integration of adult social care (Stepping Up to the Place) and made a shared commitment, focussing on:

- Local systems to embed integration as 'business as usual'
- A collective approach to achieving integration by 2020
- Consensus and action on the barriers to making integration happen
- Dialogue with national policy makers on ensuring integration is effective
- Ongoing testing and evaluation to develop the evidence base

1.2 Local Devon Context

Within this national context, Devon has been developing its integrated working and there is much in place already. Since December 2016, partners in the health and care system (via the Sustainability and Transformation Partnership (STP) across Devon have been working with a shared purpose to create a sustainable health and care system that will improve the health, wellbeing and care of the population.

Health and care partners across Devon are now working together around a common set of objectives and outcomes:



To support the most effective delivery of health and care and achieve the outcomes of improving quality, lowering costs and enriching user experience through stronger care integration, partners in Devon are planning to further develop partnership working across health and care through the establishment of an Integrated Care System (ICS).

In an ICS commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations. This goes alongside the statutory duty of local authorities to co-operate with NHS partners. Collaboration and partnership are key features and components of an ICS approach.

The NHS planning guidance 2018/19 is also clear that public engagement is essential and as systems make shifts towards more integrated care, they are expected to involve and engage with patients and the public, their democratic representatives and other community partners.

An ICS is not an Accountable Care Organisation (ACO) which has been subject to national consideration and debate including judicial challenge over any future contractual arrangement. The ICS is not about changing organisational accountability or privatisation of NHS or council services. Local authorities will remain responsible for their existing statutory obligations. NHS statutory obligations also remain unchanged.

The approach has potential to:

- greatly enhance how health and social care services are commissioned and delivered to those living in our communities.
- result in services that are far more joined up, less confusing and better coordinated especially for primary, secondary and social care.
- oversee – but not control - the use of the annual healthcare budget (£1.5 billion) and social care budget (£227 million) across Devon.
- It will also reduce the administration involved in managing these services.

The development of an ICS in Devon mirrors the approach being taken nationally by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS and social care;
- supporting population health approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.

Agreement has been reached across the Devon STP partners to the following:

i) A single strategic health and adult social care commissioner for the county;

Devon's ambition is to have a single strategic commissioner for health and social care, primary care and specialised commissioning. The three health commissioners (two CCGs and NHSE) and three local authorities (Devon County Council, Plymouth City Council and Torbay Council) are developing plans for this. The first step will see the county's two Clinical Commissioning

Groups – NEW Devon CCG, and South Devon and Torbay CCG – working together to:

- Manage the overall annual NHS budget of £1.5 billion.
- Set strategic direction for the healthcare services
- Co-commission services
- Develop plans for the future – including possible moves to take on more specialised commissioning services and primary care services from NHS England.
- Work more jointly with Local Authority Partners – where this is in the best interests of population health and well-being.

NEW Devon CCG and South Devon and Torbay CCG have been aligning their resources and executive teams to ensure that local health commissioning is more streamlined and in a good position to become more integrated with both local authorities and health commissioning currently being undertaken at regional level (primary care and specialised commissioning by NHSE). Consultation on a single CCG executive structure is currently underway and due to be concluded at the end of February 2018 with implementation as soon as possible thereafter.

To support the development of integrated commissioning at strategic commissioner level, joint arrangements with all 3 local authorities are being explored, and local authority interfaces at Local Care Partnerships level will need to be agreed.

ii) A Mental Health Care Partnership for the county;

Mental health services will be placed on an equal footing as physical health and ensure that specialist mental health services become more integrated within primary and secondary care. To support this, commissioners and providers for mental health will be working in a more joined up way with each other and with the place based local care partnerships.

iii) 4 place-based Local Care Partnerships

These place-based partnerships will look at how budgets, services and resources are planned and used for specific local populations across Devon - one each for North, East, South Devon & Torbay and West, based on primary care GP practice populations.. Prospective local care partnerships have been asked to start working on proposals using a discussion document shared with partners at the STP Organisation Design Programme Board.

iv) Sharing of NHS corporate services

This will see key NHS corporate services (such as IT, finance and HR) working as a shared service across Devon so that there is greater cooperation, less duplication and greater efficiencies

1.3 South Devon and Torbay journey

Health and care partners across the South Devon and Torbay system are recognised for the strength of partnership working culminating in the agreement to

pool resources and services to establish one of England's first truly integrated care organisations (ICO).

Through the establishment of the ICO, partners have successfully brought together adult social care (Torbay Council), community care and acute care into a single provider organisation to deliver a new model of integrated care.

Phase one of our care model – which has "home first" as the defining feature – is demonstrating tangible benefits and is being further refined as partners look to optimise benefits for individuals. In creating the ICO, partners also entered into an enabling financial Risk Share Agreement (RSA) to share and underpin financial risk. This has been further refined in light of lived experience with partners signing up to a further 3 years to 2021.

Whilst we have made progress, partners recognise there are further integration opportunities to improve the health, care and wellbeing of the population of South Devon and Torbay. This is based on a shared belief that service integration supported by a population-based capitation budget will better meet the needs of individuals and is the best way to meet the growing demand for services from the population we support, within the resources available.

There is a genuine commitment to strengthen how we work together to better support individuals. This is underpinned by a collective commitment to prioritise the needs of individuals and the system over the needs of individual organisations, based on a shared understanding and analysis of local challenges.

There is a general consensus that the best way to build on our achievements over the next period is to establish a Local Care Partnership. Through this partnership system partners would be in a position to deliver more than current arrangements allow by moving to a population-based capitated budget; adopting a stronger risk-enabling approach; and putting the good of the system above individual organisations

This aligns with the wider system ambition of the Devon Sustainability and Transformation Partnership (STP) where all partners have agreed to aplan to pursue an Integrated Care System for Devon. This also aligns with national policy to support devolved health and care systems to meet the triple aim of improving health equity, closing the financial gap, and reducing unwarranted variation in quality.

2 Why a Local Care Partnership?

Whilst we have made good progress – the South Devon and Torbay system is considered to be further ahead on care model integration and pooled resources than many other parts of the country - partners recognise the opportunity to go further in achieving our integration aspirations.

Having united around implementing a shared vision of integrated community-based health and social care, senior health and care leaders have been considering what the logical next step should be in our integration journey, given the following drivers and national direction of travel:

- we are particularly affected by the growing national challenge of a rising elderly population – the population is older on average than the rest of the

country - and the corresponding increase in demand for services related to frailty;
- challenge over sustainability of some services as a result of workforce pressures across a range of services in all sectors including in primary care;
- infrastructure in some sectors not fit for purpose and requires access to significant capital funding to bring up to standard;
- the vulnerability of the care home and domiciliary care sector, and the pressures on social care and public health funding;
- NHS commissioners and providers are under great financial pressure because of centrally-driven austerity measures and national funding allocation changes;
- the "doing nothing" option will result in a £142m deficit across South Devon and Torbay health and care system within 5 years (which contributes to a £572m deficit across the Wider Devon STP footprint)- this is the health gap only and does not include Devon social care deficit or public health.
- desire to maintain autonomy for our system
- national direction of travel with new care model sites implementing Integrated Care System models and STPs (including Wider Devon) indicating intention to pursue as part of their 5 year plans.

The scale of the current challenge facing health and social care is greater than any faced previously and requires us to take full advantage of further opportunities to redesign services and adopt working arrangements that better enable those improvements.

We need to achieve a gear shift and adopt a population-based approach with all incentives aligned to this. This includes:

- increasing involvement and engagement of individuals in the design, delivery and improvement of services – 'what's important to me' discussions focused on empowerment and choice
- proactive management of population groups to inform early intervention and prevention
- enhancing the range of services on offer
- accelerating the implementation of electronic care records and the use of predictive tools to identify individuals who have higher than average health and social care costs.
- making outcomes-based contracts a reality with budgets that cover the health care needs of a defined population and pooling more resources eg public health, primary care, housing, vol sector
- community health and social care teams can move at pace and realise the full benefits of integration on the ground.
- integrated commissioning to facilitate the development of integrated models of care

To enable the above we need to deliver more transformational change, and embrace system not silo leadership. The best vehicle now available to achieve these ambitions is through a Local Care Partnership.

3 The additional outcomes we will achieve through a Local Care Partnership

Setting a clear framework for what we want to achieve together as a Local Care Partnership is important to help set the tone of future collaboration, the breadth of our collective ambition and the depth of our joint working relationships so that we can deliver better system outcomes.

We have begun to develop a framework that describes what chapter 2 of the care model looks like. This has evolved from a framework representing the strategic changes for the ICO into a system wide framework that represents the strategic transformation programmes of work across all areas and organisations that deliver the agreed system outcomes. We are proposing that this framework becomes the work plan of the Local Care Partnership and resources prioritised accordingly.

Highlights of the framework for the next chapter in our integration journey include;

- Prevention and Early Intervention: Plans and priorities will have a focus on preventing ill health in order to reduce the longer term trajectory of demand. This will support the tackling of place-based socio economic health determinants.
- Asset Based Community Development: Empower communities to take active roles in their health and wellbeing and build community resourcefulness.
- Develop greater integration with primary care: Recognising the critical gateway that primary care offer collaboratively support primary care to be fit for the future and to maximise placed based outcomes of care.
- Mental Health: Improve provision for people with severe, long term mental illness and those who also have physical health problems.
- Acute hospital and specialist services: Ensure clinical sustainability of services through the development of Devon-wide clinical pathways and networks.
- Children and Young people: Ensure seamless support and access and enhance effective collaboration between adult and children's services.

In pursuing Local Care Partnership status, partners need to be clear on the additional outcomes we will deliver that cannot be achieve through current arrangements.

- strengthened public engagement and community led partnerships which support activated communities that drive behaviour changes within society.
- developing a more preventative and population health-based approach – eg widening partnership to address the wider determinants of health – housing, childhood poverty, education, transport and access to services.
- reducing health inequalities
- moving more care closer to home and moving away from dependencies on bed based care
- improving pathways for clinical services through horizontal and or vertical integration
- managing service pressures across the system and changing the long term trajectory of demand
- strengthened relationships with primary care, Local government and voluntary and independent sector

4 Working with the Mental Health Care Partnership

We strongly believe that taking a whole-person approach to health and care is essential if we are going to support our population to live happy and healthy lives. We know that people with mental illness do not access physical health services in the same way as people without mental illness. We also know that we are spending money in the wrong places, for example expensive inpatient placements rather than on keeping people well and avoiding escalation.

We would like to work with the Mental Health Care Partnership on the following aspects:

- Working together to deliver physical health checks for people with mental illnesses,
- Health and Wellbeing Hubs working with mental health teams to deliver holistic wellbeing advice and support to our population to avoid people becoming unwell
- Work together to deliver IAPT support for people with long term conditions
- Jointly review the requirements for housing and accommodation in order to support the most vulnerable people in South Devon and Torbay
- Jointly review the requirements for Core 24/7 psychiatric liaison
- Work together to delivery better experience and outcomes for people with dementia, including support for care homes

5 System working - building blocks for success

We believe we have the following critical success factors in place on which to build a strong and effective Local Care Partnership for South Devon and Torbay

- A collective commitment to prioritise the needs of people and the system at the expense of the individual institutions, based on a shared understanding and analysis of local challenges
- The quality of relationships between all key players in the local system: GPs, local authorities, CCGs, acute, mental health, ambulance and specialist providers, voluntary and private sectors.
- The quality and capacity of local leaders and their ability to engage and mobilise the wider workforce, including clinicians, and engage with the public, elected members and local politicians.
- An absolute commitment to promoting independence utilising a strengths-based, risk enablement approach.
- A relentless focus on a small number of practical priorities and a drive for practical improvements on the ground in chosen priority areas, rather than just trying to build a grand plan.
- Track record of delivering integrated care and sharing of resources and risk including with the voluntary sector
- Taking difficult decisions – building understanding and support for change in order to develop sustainable services which better meet the needs of individuals within resources available
- Service user experience informing and influencing future developments – shift from *“what’s the matter with you”* to *“what’s important to you?”*
- Authentic stakeholder engagement with well- established community engagement arrangements

- A culture of pragmatism meets continuous improvement. Trying new things, learning and making improvements if it doesn't work.
- An unwavering focus on outcomes that deliver long term impacts for people and the wider system, moving away from short term strategic decisions towards transformation that seeks to address sustainability, equity of care and embed behaviour changes in people over the next 5-10 years and beyond.

6 What will be the purpose of our Local Care Partnership?

The purpose of a Local Care Partnership is to enable commissioners and providers of health and care to work together to better meet the health, care and wellbeing needs of the populations they serve within the resources available. The emphasis is on "Local" with an absolute focus on supporting what is important to local communities.

Partners will want to come together with community representatives to agree the scale of ambition and population health and care outcomes that the South Devon and Torquay Local Care Partnership should be striving to achieve.

Having agreed the scale of opportunity and outcomes, partners will then design appropriate working and reporting arrangements that enable greater pace of decision-making and movement of resource in order to get things done.

The partnership is not an organisation and is supported by sovereign organisations who are ultimately accountable for delivery. There will be some instances e.g. policy change which will need organisational and member agreement first.

Public engagement, consultation and communication will ensure that the work of the Local Care Partnership and any changes in service provision are informed and understood by and take account of the needs of the community.

We want to ensure our engagement with local members is strong and will need to discuss with current members how we can best achieve this through existing structures and informal arrangements.

The Health and Wellbeing Boards of both Torbay and Devon County Councils will continue to have a role in promoting integration through the health and wellbeing system in their areas, ensuring delivery against their respective Joint Health and Wellbeing Strategies.

The health overview and scrutiny functions of both Torbay and Devon County Councils will continue to provide overview and scrutiny of both service delivery and potential variation of health and social care within their areas, taking account of the views of the communities they serve. Overview and scrutiny committees will be invited to include Integrated Care System and Local Care Partnership governance in their work programmes.

7. Outcomes

A draft set of outcome indicators have been developed by Local Authority and NHS analysts working together. These are a set which have taken account of the three Joint Strategic Needs Assessments, the STP Challenges and the current joint outcome frameworks across South Devon and Torbay, Plymouth and Devon. They have been discussed and developed at the Devon-wide Strategic Commissioning Group

It was agreed at the Strategic Commissioning Group in March that delivery against these outcomes would be at LCP level but that they may need to also reflect any particular issues at this more local level.

It was also agreed that outcomes would be iterative and currently for example the following are being considered;

- Ensuring adequate Children's outcomes are represented
- Further work to develop quality and value for money indicators as well as health and well-being outcomes

8. Conclusion

A Local Care Partnership offers South Devon and Torbay the opportunity to build on our achievements over the next period, in the context of the national and Devon wide directions of travel.

Through this strengthened partnership system partners will aim to deliver more than current arrangements allow.

9 Next steps

Locally the ambition is that we work and learn together to explore this enhanced model of partnership to achieve better outcomes and reduce health inequalities for the populations we serve. We will be a learning partnership.

Partners are asked to comment on this discussion document and agree to take part in a partner workshop being arranged by the CCG in early April to flesh out the detail.

AW 09/03/18

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	**2018-20 Joint Strategic Needs Assessment for Torbay**		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	28 March 2018

Contact: Gemma Hobson
Telephone: 01803 207311
Email: Gemma.hobson@torbay.gov.uk

1. Purpose

1.1 To consider the 2018-20 Joint Strategic Needs Assessment for Torbay

Local Authorities and Clinical Commissioning Groups (CCG) have equal and explicit obligations to prepare JSNA, under the governance of the health and well-being board

This is the 6th JSNA to be written for Torbay since 2007. This report highlights the key challenges and issues facing the population of Torbay across the life course, as well as highlighting areas of spend and opportunity. In addition to this report, there is a series of two page profiles highlighting key population outcomes across the life course and across different communities. This JSNA presents the most acute levels of social challenge within the Torbay population so far.

2. Recommendation

2.1 That the Board ratify the publication of the JSNA on the Torbay Council website.

3. Supporting Information

3.1 The JSNA Narrative for Torbay is attached in the Background Papers.

4. Relationship to Joint Strategic Needs Assessment

4.1 This is the core JSNA for 2018-20

5. Relationship to Joint Health and Wellbeing Strategy

5.1 Produced to provide the evidence base for the JHBS

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

6.1 Should this be approved then this will form the Torbay JSNA for 2018-20.

Appendices

None

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

2018 - 2020 Torbay JSNA FINAL.pdf

2018 – 2020

Joint Strategic Needs Assessment

for Torbay

Joint Strategic Needs Assessment

Contents

Quick Facts about Torbay and Torbay residents:

133,883 people live in Torbay
(2016)

There are, on average, **3.8 births** per day
(2014/16)

Housing conditions are **worse** in Torbay, with **45% living** in the **most deprived** quintile in England for indoor deprivation

285 children were looked after by the Local Authority, equivalent to 112 per 10,000
(2017)

On an average **day**, the **spend** across 6 public sector organisations is around **£2.5M**
(2015/16)

The average age in Torbay is **44.8 years**
(2016)

There are, on average, **4.8 deaths** per day
(2013/15)

There are, on average, **145** attendances at **A & E per day**
With an average age of 43.8 years
(2016/17)

Around **66,400** (68%) adults are **overweight** or **obese** in Torbay
(2016)

3.7% are aged 85 years and over
(2016)

Life expectancy at birth **83.3** years for **females**
78.9 years for **males**
(2013/15)

There are, on average, **170 admissions** to hospital per day
With an average age of 55.8 years
(2016/17)

Around **18,100** adults in Torbay **smoke**
(2016)

There are **12 GP practices**, and **37 Pharmacies** Serving Torbay

Foreword

I am delighted that we have developed a report that provides a comprehensive picture of the key issues facing the population of Torbay. It is important that we understand these issues, and that we plan the services we deliver according to the health and well-being needs of the local population.

The 2018 Joint Strategic needs Assessment (JSNA) brings together data from a range of partners across the South Devon and Torbay community. It identifies key issues which leaders, planners and commissioners can concentrate on for the following years.

As with other areas in the UK, we face a number of health and wellbeing issues in Torbay. The statistics show that two out of every three adults are overweight, with one in four being deemed obese. In primary schools, one in five children is obese by the time they reach Year 6.

We have an ageing population - one in four adults is aged over 65 and this statistic is increasing. Torbay also has a high number of households which fall in the poverty category, high levels of frailty, and there are high rates of alcohol related admissions to hospitals and mortality due to corresponding liver disease.

With this in mind, it is vital for upstream interventions to be strengthened. By preventing ill health in the first place through healthy lifestyles and choices, the healthier we can keep individuals, society, and our health and economic systems.

I hope you enjoy reading this document and that it helps you better understand your community or the community you serve and that you will use this document to help you plan services and interventions that best suit your community needs.

Chair Torbay Health and Wellbeing Board

Exec Summary

This is the 6th JSNA to be written for Torbay since 2007. This JSNA presents the most acute levels of social challenge within the Torbay population so far.

The last 10 years has seen a consistent set of issues highlighted. The key challenges facing the population and the organisations that serve the population are highlighted below.

- **Inequalities** have been widening as relative deprivation worsens; Torbay is ranked as the most deprived local authority in the South West region
- **Children**
  - The number of children looked after by the local authority remains amongst the highest in England
  - Around 1 in 4 children continue to live in households where income is less than 60% of the median income (living in poverty)
- **Economy** Torbay's economy is amongst the weakest in England, and has declined in recent years
- **Risk taking behaviours**
  - Around 6 out of 10 adults in Torbay are overweight or obese
  - Around 1 in 6 adults in Torbay smoke
  - There are high levels of alcohol related admissions to hospital
  - Torbay has high levels of self-harm in the population
- **Vulnerable populations** there are high levels of vulnerability in the population, with high levels of specialist need cohorts and high levels of mental ill health
- **Ageing population** the number of people aged over 85 is expected to increase by around 3,000 (56%) over the next decade or so. With increasing numbers expected to be frail and require support from health and social care services.
- **Costs** Public sector spend is around £2.5M per day in Torbay, across 6 areas. Spend associated with an ageing population and a consequence of risk taking behaviours is expected to increase.

There are opportunities for specific needs assessments to understand the specific needs of defined cohorts, such as those with Learning Disabilities or children looked after.

This document is part of the JSNA in Torbay, a large part of the JSNA is the district, town and electoral ward profiles which cover the life course. These can be found at: www.southdevonandtorbay.info/jsna

The Torbay Area

Torbay has a rich, diverse and proud heritage spanning many thousands of years. Torbay became a popular holiday destination early in the 19th century, famed for its romantic quality, its balmy air and perfect environment for relaxation and convalescence. It was the Victorians that coined the phrase the 'English Riviera', likening the area to its French equivalent.

Subtropical plants and the celebrated Torbay Palm, flourishing within the special microclimate, add to the Mediterranean feel, and these days the busy waterfronts are a hive of activity catering for both working and pleasure craft. The three Riviera towns of Brixham, Paignton and Torquay surround the natural, sheltered Bay which, with a south easterly aspect, forms an ideal suntrap and boasts many Blue Flag beaches.

Figure 1: An overview of the Torbay area

Torbay has the romance of a seaside town, sandy beaches and above-average warm weather. With these attractions, Torbay, of course, has been a popular retirement destination for many years. This is reflected in the population structure of Torbay.

Torbay area covers some 64 square kilometres (24.6 Sq Miles) and takes in around 44 kilometres (27.7 miles) of coastline.

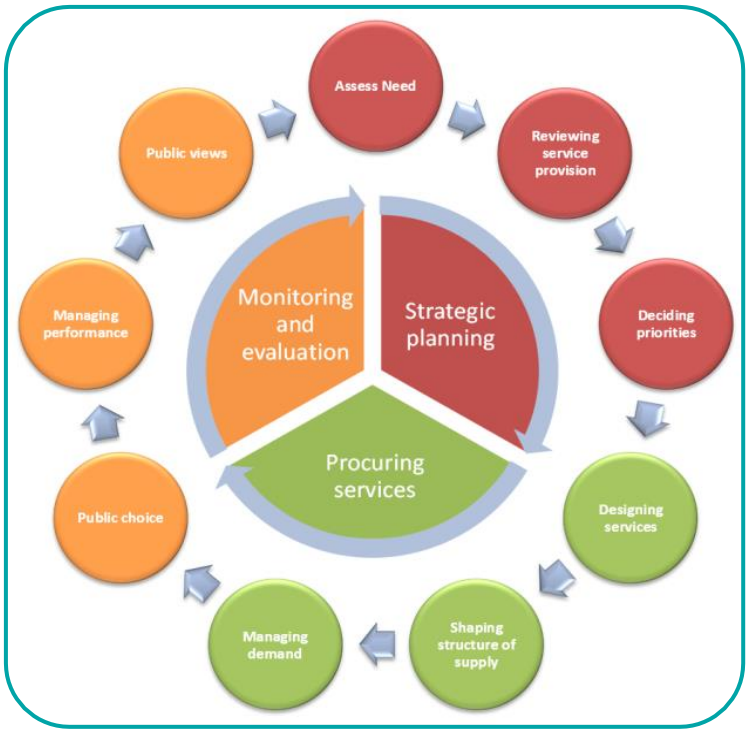
Introduction

Background

The Torbay JSNA is not a standalone document but a suite of documents, web tools and presentations which help to analyse the ***health needs of populations to inform and guide commissioning*** of health, wellbeing and social care services within the local authority area [2]. The JSNA is a means by which ***local leaders work together to understand and agree the needs of the local population*** [3]. JSNAs, along with health and wellbeing strategies enable commissioners to plan and commission more effective and integrated services to meet the needs of the Torbay population [3], in particular for the most vulnerable, and for groups with the worst health outcomes, and to help reduce the overall inequalities that exist.

This diagram of the commissioning cycle (fig 2) shows a way of breaking the cycle down into three main stages: Strategic Planning, Providing Services, and Monitoring and Evaluation. The JSNA supports the strategic planning by identifying the needs within communities. Understanding the needs of the population informs and influences commissioning intentions and priorities.

Figure 2: Commissioning cycle



Helping people to live longer and healthier lives is not simply about the healthcare received through GPs or at hospital, it is also about the ***wider social determinants of where we live and work*** [4]. The collective action of agencies is needed today to promote the health of tomorrow's older population. Preventing ***ill health starts before birth, and continues to accumulate throughout individuals' lives*** [4].

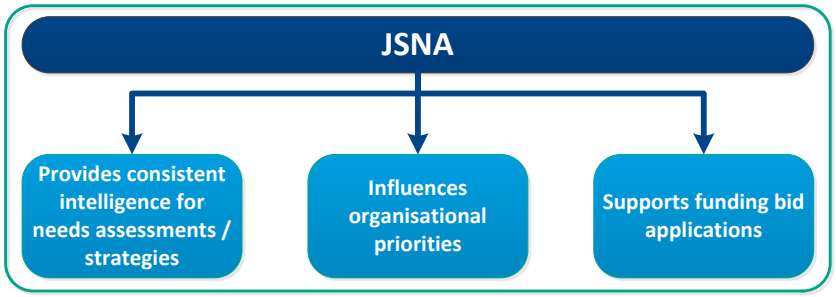
Source: http://commissioning.libraryservices.nhs.uk/

The Local Government and Public Involvement in Health Act (2007) [7] required Primary Care Trusts (PCTs) and Local Authorities to produce a JSNA of the health and well-being of their local community. From April 2013, Local Authorities and Clinical Commissioning Groups (CCG) have

equal and explicit obligations to prepare JSNA, under the governance of the health and well-being board [8].

The approach to the JSNA in Torbay is to provide a collection of narrative and data interpretation to support the community, the voluntary sector and statutory organisations across Torbay. This ***approach then provides a consistency of multi-agency data*** to support strategies, commisioning and needs assessments across Torbay, illustrated in figure 3 below.

Figure 3: Influences of JSNA



The structure of the JSNA

This report represents a written JSNA narrative for Torbay. This report highlights the key challenges and issues facing the population of Torbay across the life course, as well as highlighting areas of spend and opportunity. In addition to this report, there is a series of two page profiles highlighting key population outcomes across the life course and across different communities. The structure of the JSNA is presented in figure 4 below.

Figure 5 shows that the written report is supported by a set of profiles for Torbay covering different stages of the life course and across the different communities in Torbay. For example, the electoral wards in Torbay each have a 2 page summary highlighting key outcomes for those aged 0 to 4 (starting well). Further details of the life course are presented below.

Figure 4: Structure of 2018 JSNA

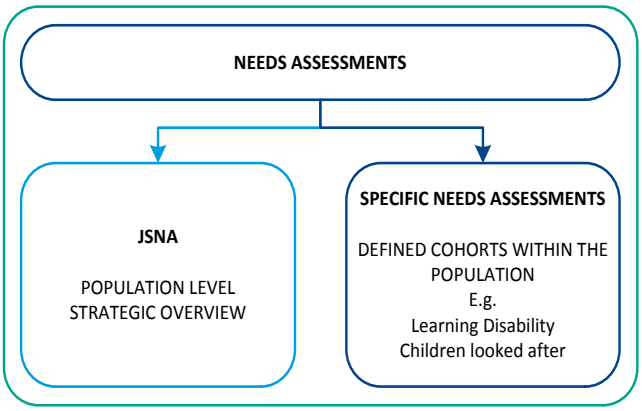
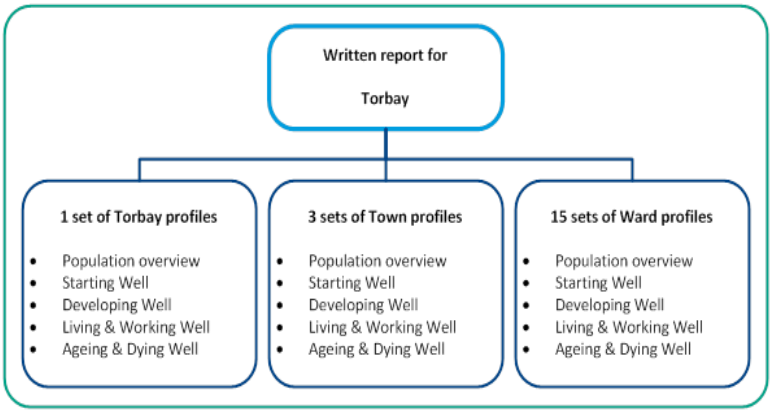


Figure 5: Structure of 2018 JSNA



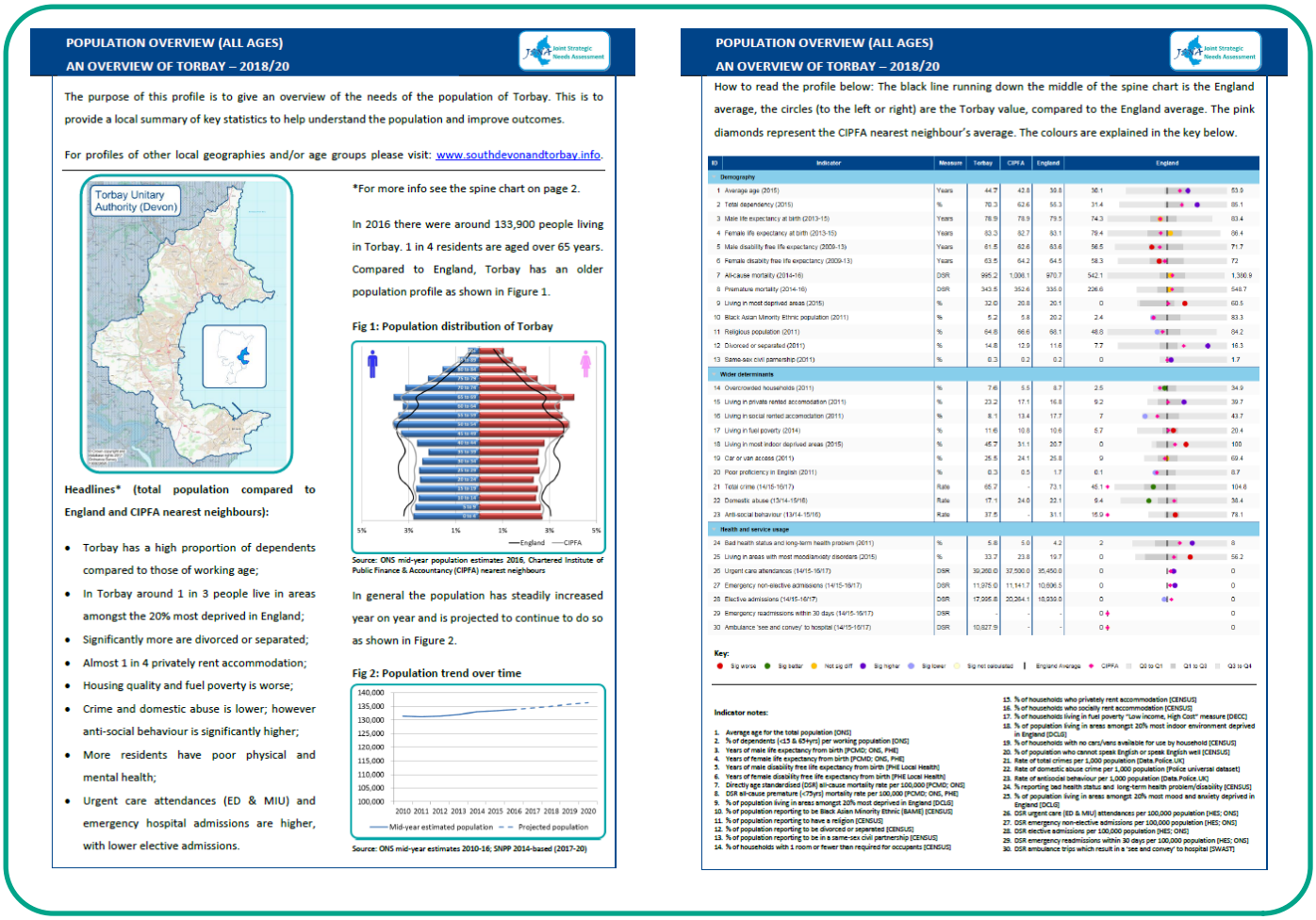
The content of the profiles was derived from a multi-agency workshop held in May 2017. The workshop was attended with representation and contributions from the following areas;

Table 1: JSNA contributors

Citizens Advice Bureau	Torbay Public Health Commissioners	Devon and Cornwall Constabulary
Torbay Adult Social Care commissioners	Health Watch Torbay	Department for Work and Pensions
Torbay Children's services commissioners	Torbay Development Agency	An Elected Member
South Devon and Torbay Clinical Commissioning group	Torbay and South Devon NHS Foundation Trust	

Output from the workshop formed the content list for the profiles. There are 5 profiles for each geographical area, covering the life course. In total there are 95 profiles, covering the life course across Torbay, the towns and electoral wards.

Figure 6: Torbay Population overview profile – EXAMPLE PROFILE


POPULATION OVERVIEW (ALL AGES)
AN OVERVIEW OF TORBAY – 2018/20

The purpose of this profile is to give an overview of the needs of the population of Torbay. This is to provide a local summary of key statistics to help understand the population and improve outcomes.

For profiles of other local geographies and/or age groups please visit: www.southdevonandtorbay.info.

Torbay Unitary Authority (Devon)

*For more info see the spine chart on page 2.

In 2016 there were around 133,900 people living in Torbay. 1 in 4 residents are aged over 65 years. Compared to England, Torbay has an older population profile as shown in Figure 1.

Fig 1: Population distribution of Torbay

Source: ONS mid-year population estimates 2016, Chartered Institute of Public Finance & Accountancy (CIPFA) nearest neighbours

In general the population has steadily increased year on year and is projected to continue to do so as shown in Figure 2.

Fig 2: Population trend over time

Source: ONS mid-year estimates 2010-16, SNPP 2014-based (2017-20)

Headlines* (total population compared to England and CIPFA nearest neighbours):

- Torbay has a high proportion of dependents compared to those of working age;
- In Torbay around 1 in 3 people live in areas amongst the 20% most deprived in England;
- Significantly more are divorced or separated;
- Almost 1 in 4 privately rent accommodation;
- Housing quality and fuel poverty is worse;
- Crime and domestic abuse is lower; however anti-social behaviour is significantly higher;
- More residents have poor physical and mental health;
- Urgent care attendances (ED & MIU) and emergency hospital admissions are higher, with lower elective admissions.

POPULATION OVERVIEW (ALL AGES)
AN OVERVIEW OF TORBAY – 2018/20

How to read the profile below: The black line running down the middle of the spine chart is the England average, the circles (to the left or right) are the Torbay value, compared to the England average. The pink diamonds represent the CIPFA nearest neighbour's average. The colours are explained in the key below.

Larger copies of the profiles are available at www.southdevonandtorbay.info/jsna

This written narrative is themed into the following chapters:

- **Inequalities** – highlights differences in outcomes across our communities
- **Prevention** – identifies ways to consider upstream approaches to risk factors
- **Public sector spend** – examines public sector spend in Torbay compared to other areas
- **Life course chapters** – each chapter presents a summary of key age specific challenges affecting the population of Torbay
    - **Population overview** sets the scene for the current & future population structure across Torbay. It includes top level population overviews
    - **Starting Well** is about understanding the needs of the population through pregnancy, birth and for the first few years of life.
    - **Developing Well** is about understanding the needs of the population between the ages of 5 and 24.
    - **Living and Working Well** is about understanding the needs of the working age population.
    - **Ageing and Dying Well** is about understanding the needs of those from around 65 years and over.

The Torbay JSNA is wider than the set of profiles and this narrative report. The JSNA includes specific overviews of conditions, diseases or analysis of specific cohorts within the population.

The JSNA can be accessed at: www.southdevonandtorbay.info/jsna

Life course

A life course approach enables an understanding of needs and risks to health and wellbeing at different points along the path of life. For example, ***our needs as babies and in our early years differ significantly to our needs and risks to health and wellbeing as we enter adulthood or retirement***. Understanding the risks to health and wellbeing at different points along the path of life enables opportunities to promote positive health and wellbeing and to prevent future ill health, or to understand the potential burden of disease that may need to be considered in delivering services.

Understanding needs across the life course also enables an understanding of exposures in childhood, adolescence and early adult life and how they influence the risk of disease and socio-economic position in later life [5]. Understanding the influence of risk in this way may help to prevent future generations experiencing some of the illnesses of today.

Comparisons

The Chartered Institute of Public Finance and Accountancy (CIPFA), working with local authorities, have developed an approach to aid benchmarking and comparing similar local authorities. CIPFA have developed a methodology that allows local authorities to compare themselves with similar authorities. These are known as nearest neighbours. Torbay's nearest neighbours are presented, with some demographic information, in table 2 below.

Contextualisation presented within this report, and across the JSNA profiles, shows a statistic for 'CIPFA'. The statistic is the average of the nearest neighbours. The statistics are constructed through a robust way to ensure the stats are comparable, for example, calculating appropriate numerators and denominators, or age specific rates.

Table 2: Torbay's nearest neighbours

Nearest Neighbour Model (CIPFA)	Deprivation score (IMD 2015)	Total Population (2015)	Aged 65 and over	% of Pop aged 65+
Blackpool	42.0	139,600	28,400	20.3%
Bournemouth	21.8	194,500	34,900	17.9%
Cornwall	23.8	549,400	131,900	24.0%
Darlington	23.6	105,400	20,500	19.4%
East Riding of Yorkshire	15.8	336,700	82,600	24.5%
Isle of Wight	23.1	139,400	37,000	26.5%
North East Lincolnshire	30.9	159,600	31,100	19.5%
North Somerset	15.8	209,900	48,800	23.2%
North Tyneside	21.3	202,500	39,200	19.4%
Northumberland	20.5	315,300	72,700	23.1%
Poole	15.2	150,600	33,100	22.0%
Redcar & Cleveland	28.6	135,300	29,200	21.6%
Sefton	25.7	273,700	61,800	22.6%
Southend-on-Sea	24.5	178,700	34,000	19.0%
Torbay	28.8	133,400	34,300	25.7%
Wirral	26.9	320,900	67,000	20.9%

Source: CIPFA

Analysis around South Devon and Torbay Clinical Commissioning spend compares the local CCG to its equivalent nearest neighbours, referred to as RightCare.

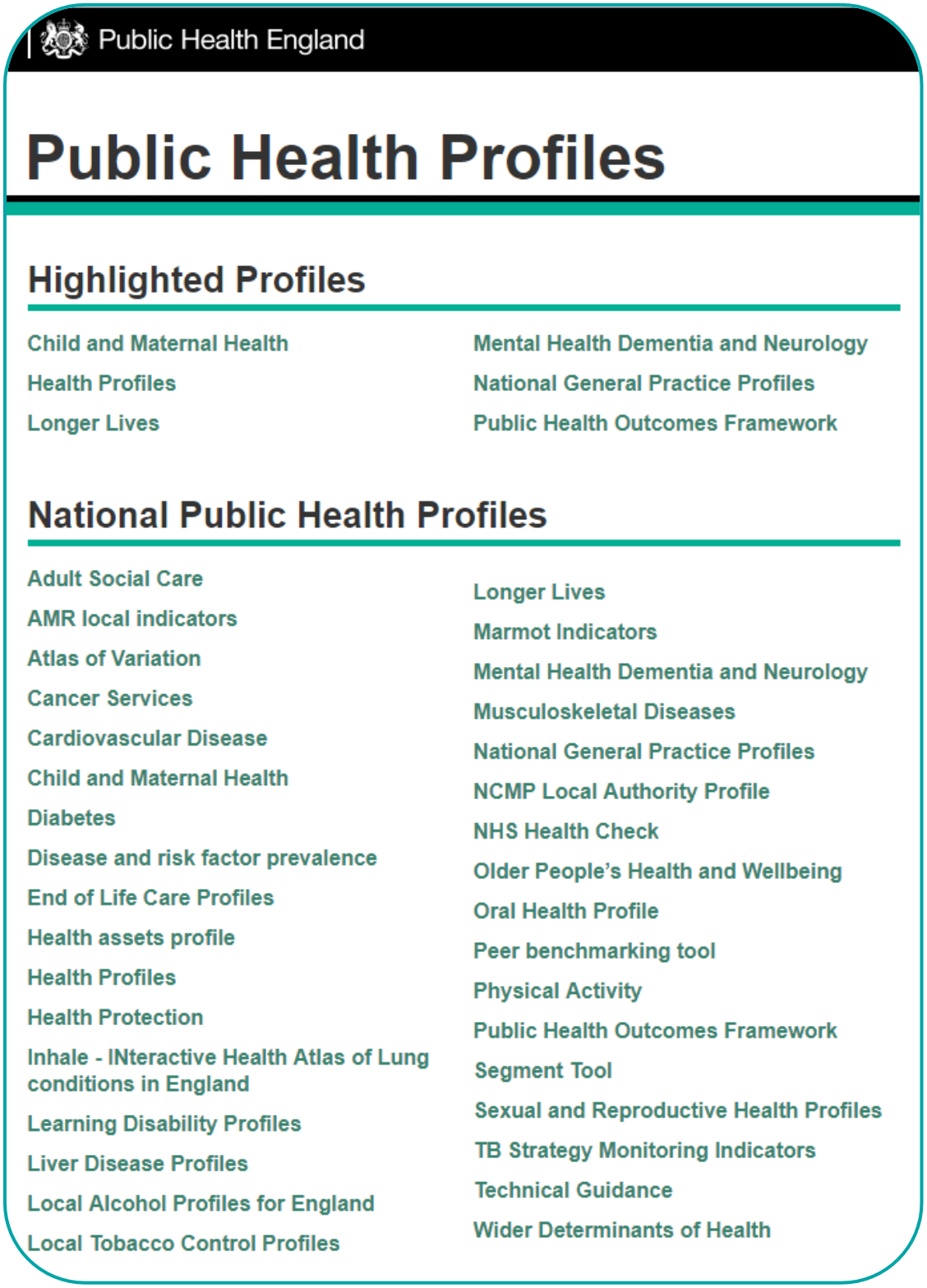
Further information on RightCare nearest neighbours, or comparator groups can be found at https://www.england.nhs.uk/rightcare/

Additional profiles

Further information and profiles are available from Public Health England. These contextualise Torbay against a national perspective, as well as against Torbay's CIPFA neighbours.

Further profiles are available at: https://fingertips.phe.org.uk/

Figure 7: Public Health Profiles



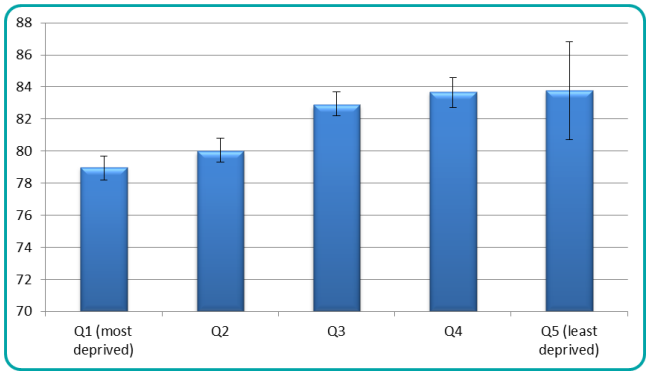
Inequalities

Inequalities are evident across the life course, from ***children being born in more deprived areas expected to experience shorter life expectancy (figure 8)***; to working age persons with lower or no qualifications; to premature mortality.

In order to begin to reduce inequalities, an understanding of the complex web of issues is required. There is evidence to suggest that ***disadvantage starts before birth and accumulates throughout life*** [1]. To reduce inequalities across the life course, it is important to reduce early disadvantage, poorer outcomes from pregnancy and birth, and during childhood.

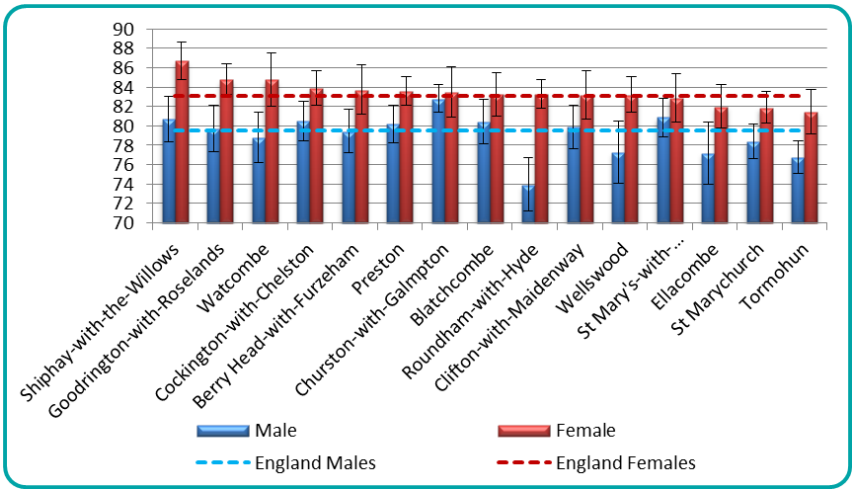
Health inequalities are when different people experience different outcomes. For example, higher rates of people dying prematurely in one community compared to another community (figure 9). There is a well evidenced relationship between poorer communities, in terms of income, and poorer health outcomes such as life expectancy [1].

Figure 8: 2014/15 Life expectancy at birth by deprivation quintile across Torbay



Source: PCMD, NOMIS and ONS

Figure 9: 2013/15 Life expectancy at birth by electoral ward and sex across Torbay compared to England



Source: PCMD, NOMIS and ONS

The gap in life expectancy at birth between communities across South Devon and Torbay is around 8.9 years for males and 5.2 years for females.

Whilst people in our more deprived communities tend to die earlier than those in the least deprived, they also tend to spend more of their life in poor health. The gap between disability free life expectancy and life expectancy is widest in our poorer communities (left hand side of figures 10 and 11). The gap is smallest at the less deprived end of the spectrum, right hand side of figures 10 and 11.

Communities in Torbay are represented by the red dots in the two charts. The lower banding of dots represents the disability free life expectancy experienced in communities, whilst the upper banding of dots represents the life expectancy on communities. The gap between these two community measures, represents an inequality across communities.

Figure 10: Female life expectancy and disability free life expectancy at birth, by neighbourhood deprivation level, England, 2009 to 2013

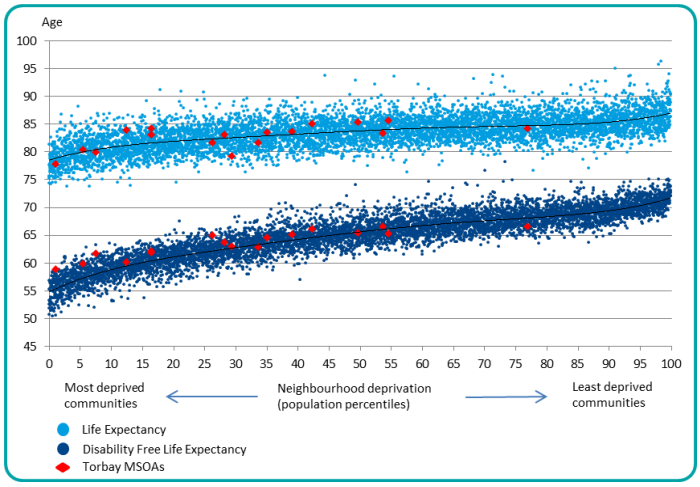
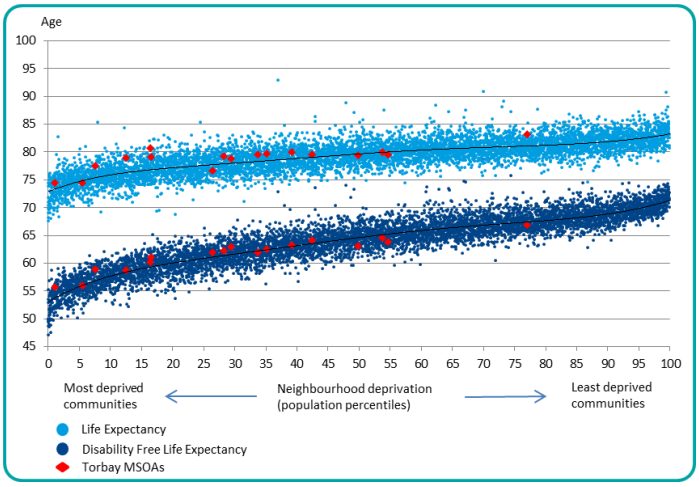


Figure 11: Male life expectancy and disability free life expectancy at birth, by neighbourhood deprivation level, England, 2009 to 2013



Source: ONS

What this means is that, on average, the more deprived **female** populations in Torbay can expect to live **their last 23.8 years of life with a disability** compared to those in the least deprived (16.2 years) population, and **still expect to die around 8.3 years earlier**. For the males population in the most deprived communities of Torbay, they can expect to live **their last 20.5 years of life with a disability** compared to those in the least deprived (14.7 years) population, and **still expect to die around 8.7 years earlier.** Proportionately, people in Torbay's more deprived communities spend a larger amount of their life in need of some increased level of support.

Life expectancy for both females and males has increased over time. A gap between the sexes remains with females, on average, living longer than males. It is of particular note that whilst life expectancy has been increasing, disability free life expectancy has decreased. This suggests that the population are ageing in poorer health, and this may in turn have a negative impact on the demand for support services to manage a population in poorer health.

Figure 12: Female Disability-free life expectancy and life expectancy over time

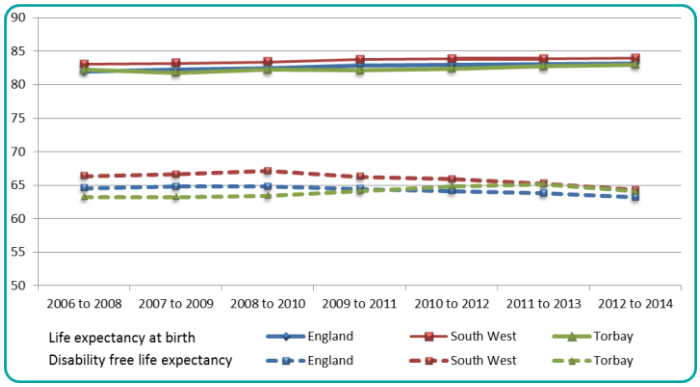
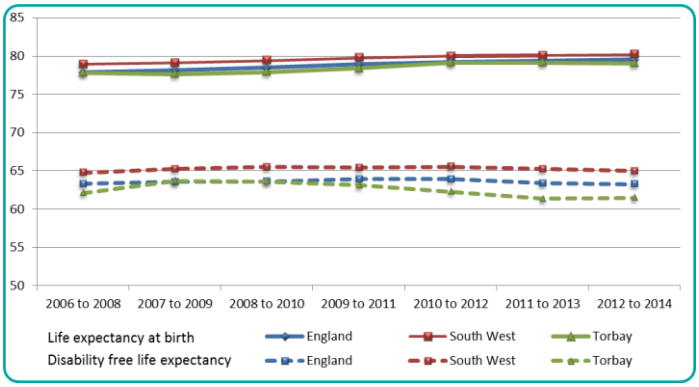


Figure 13: Male Disability-free life expectancy and life expectancy over time



Source: ONS

Figures 10 and 11 (above) show that ***people in our more deprived communities live for longer with a disability***. This population needs to access care for a relatively longer period of time. Reducing the gap between disability free life expectancy and life expectancy would result in significant financial savings to the public purse.

Reducing inequalities in health does not require a separate health agenda, but action across the whole of society [1]. Inequalities in health are not simply about levelling out the burden of disease across the population, as ***good health is not simply a measure of the absence of disease***. Where we live, and who we are, all impact on health, and inequalities.

At a national level, it is estimated that the cost of inequality in illness accounts for productivity losses of around £32 billion per year [1]. Proportionately, in ***Torbay*** this could represent a ***cost of inequality in illness of around £75 to £80 million per year***. That would include lost taxes, higher welfare payments and higher NHS healthcare costs. The figure presented is based on a national population spend per head being applied to the South Devon and Torbay population; it has not been adjusted for deprivation, age or sex. It does however represent a wider system perspective on costs.

In 2015, Torbay's overall position for multiple deprivation rank of average rank was 46th out of 326 district local authorities and 37th out of 152 upper tier Local authorities in England. Compared to the South West of England, Torbay is ranked as the most deprived on a range of summary

measures (including income and employment deprivation summary measures). Torbay's position is relatively worse than for previous versions of the IMD (index of Multiple Deprivation).

For local authority districts, Torbay is ranked within the top 20% most deprived local authorities in England (figure 14), and when compared to CIPFA statistical neighbours, Torbay has the second highest levels of multiple deprivation (table 3).

Table 3: Torbay's nearest unitary neighbours

CIPFA nearest neighbour (district LA rank of 326)	IMD rank of average rank	
	2010	2015
Blackpool	10	4
Torbay	**49**	**46**
North East Lincolnshire	78	65
Cornwall	82	68
Redcar and Cleveland	71	78
Isle of Wight	106	83
Sefton	114	102
Southend-on-Sea	117	105
Wirral	103	106
Bournemouth	96	117
Darlington	104	122
North Tyneside	124	138
Northumberland	144	145
Poole	187	208
East Riding of Yorkshire	216	215
North Somerset	224	224

Source: CIPFA nearest unitary authority neighbours, 2015

Figure 14: Average rank summary measure of the 2015 IMD, for local authority districts

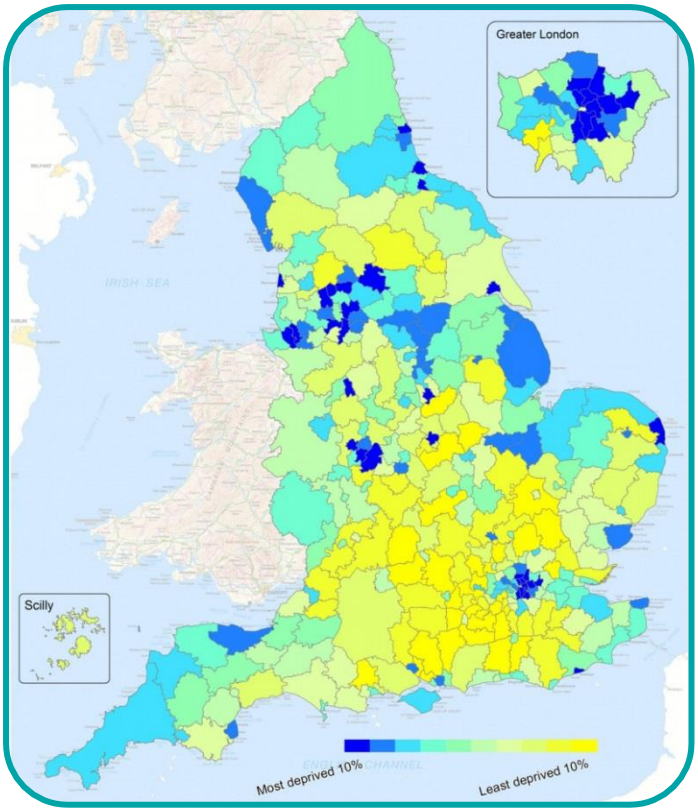
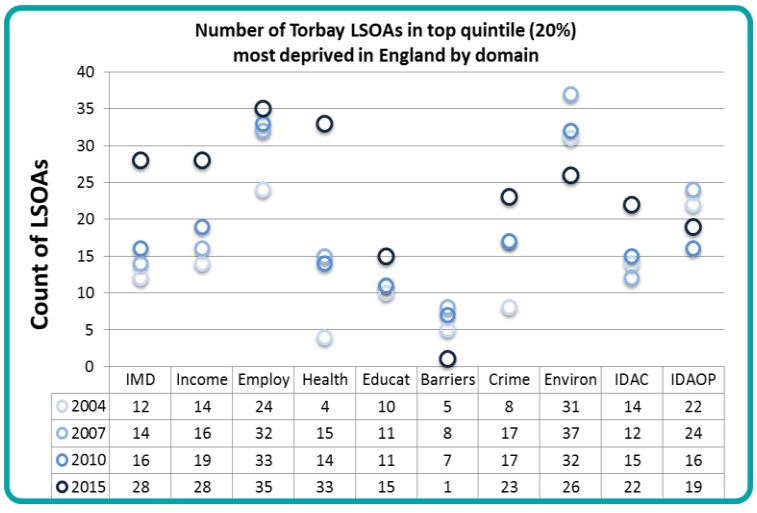


Figure 15: Change in count of LSOAs in Torbay in the top 20% most deprived in England

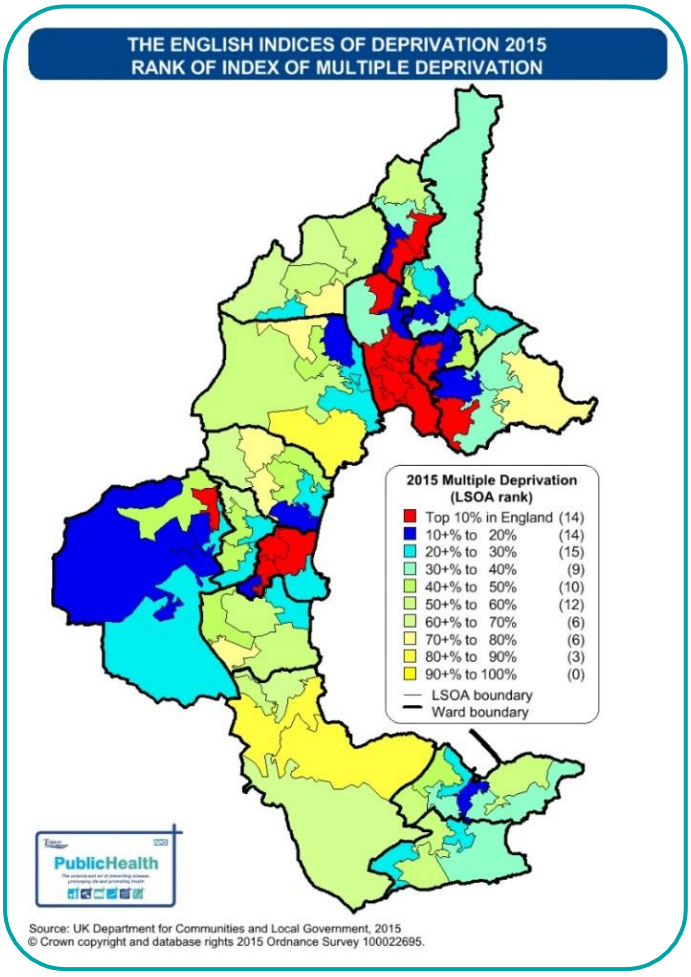


	IMD	Income	Employ	Health	Educat	Barriers	Crime	Environ	IDAC	IDAOP
2004	12	14	24	4	10	5	8	31	14	22
2007	14	16	32	15	11	8	17	37	12	24
2010	16	19	33	14	11	7	17	32	15	16
2015	28	28	35	33	15	1	23	26	22	19

Since 2004 the number of areas in Torbay in the top 20% most deprived in England has increased (figure 15). The darker circles represent the 2015 indices of multiple deprivation.

There are currently 28 areas in Torbay in the top 20% most deprived in England; up from 12 in 2004. These areas are presented in red and dark blue in fig 16 below.

Figure 16: 2015 rank of index of multiple deprivation



Wider determinants of health

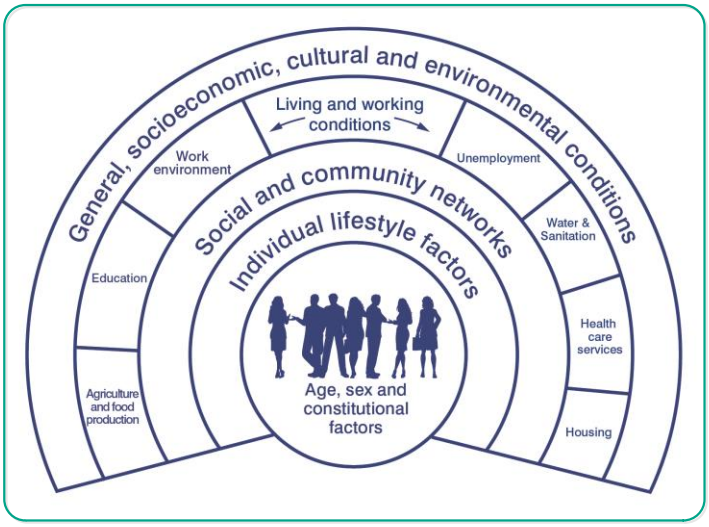
Whilst it is not possible to change some of our individual determinants of health, such as our age, our sex at birth and our genetic makeup (family history). There are other factors that we can try to influence that impact on health and wellbeing, such as the environment in which we live, our ability to work and the lifestyle choices we make. Figure 17 illustrates the main influences on health [6]. These influences are known as the ***wider determinants of health.***

The layers presented in figure 17 include:

- **individual lifestyle factors** such as smoking habits, diet and physical activity have the potential to promote or damage health
- **social and community network** interactions with friends, relatives and mutual support within a community can sustain people's health

- **wider influences** on health include living and working conditions, food supplies, access to essential goods and services, and the overall economic, cultural and environmental conditions prevalent in society as a whole

Figure 17: Wider determinants of health [6]



Influencing these layers, across the life course, is required to reduce inequalities, such as the gap in life expectancy, and improve the health and wellbeing of the South Devon and Torbay population**.**

Social and economic factors are estimated to contribute to 40% of health outcomes, made up of education (10%), employment (10%), income (10%), family and social support (5%) and community safety (5%). Contributions are illustrated in figure 18 below.

Figure 18: contribution of determinants to health outcomes

HEALTH BEHAVIOURS (30%)	TOBACCO USE (10%)	
	DIET AND EXERCISE (10%)	
	ALCOHOL USE (5%)	SEXUAL ACTIVITY (5%)
CLINICAL CARE (20%)	ACCESS TO CARE (10%)	
	QUALITY OF CARE (10%)	
SOCIAL AND ECONOMIC FACTORS (40%)	EDUCATION (10%)	
	EMPLOYMENT (10%)	
	INCOME (10%)	
	FAMILY AND SOCIAL SUPPORT (5%)	COMMUNITY SAFETY (5%)
PHYSICAL ENVIRONMENT (10%)	AIR QUALITY (5%)	BUILT ENVIRONMENT (5%)

Source: County Health, Rankings Working Paper. Madison (WI): University of Wisconsin Population Health Institute, 2010 [9]

Prevention opportunities

Prevention means different things to different people, and there are different perceptions and perspectives of prevention. From a population level perspective, illustrated in fig 20 as health improvement opportunities to prevent the need for treatment services are more cost effective than treating people, to tertiary prevention that aims to prevent the worsening or repeat need for treatment.

For example, continuously pulling people out of the river downstream (fig 19) takes resources and over time would be more costly than simply fixing the bridge and preventing people falling into the river in the first place. This could be applied to any treatment or activity based services.

Figure 19: Upstream – Downstream opportunities to reduce costs

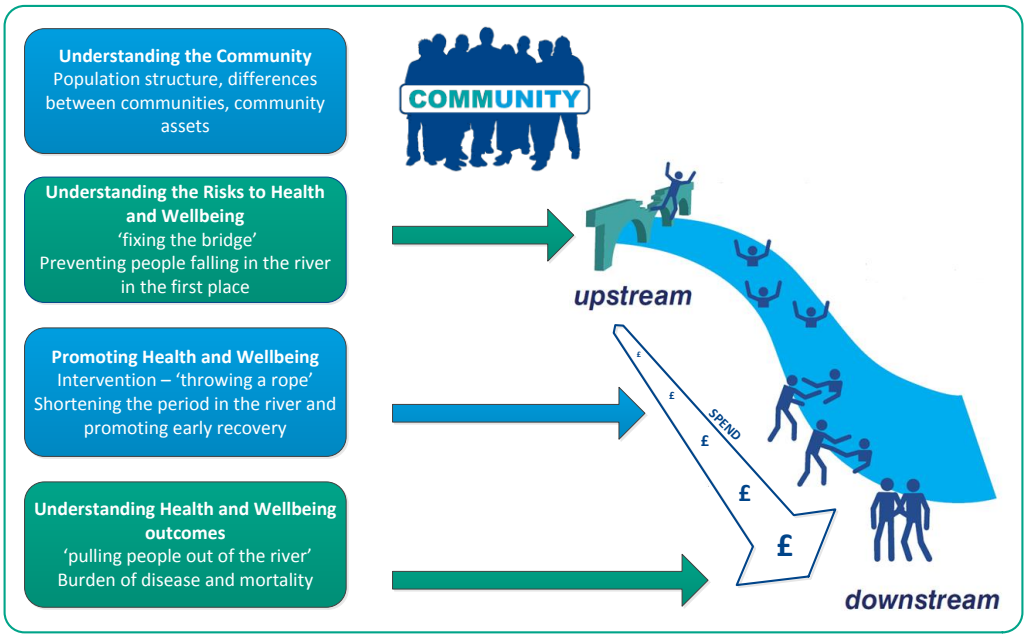
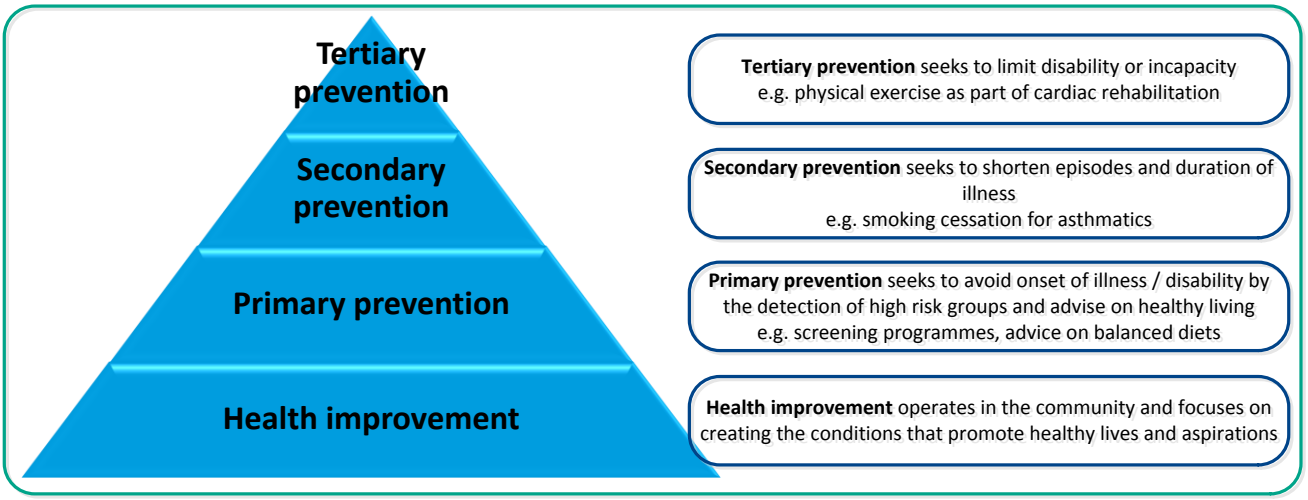


Figure 20: Prevention opportunities

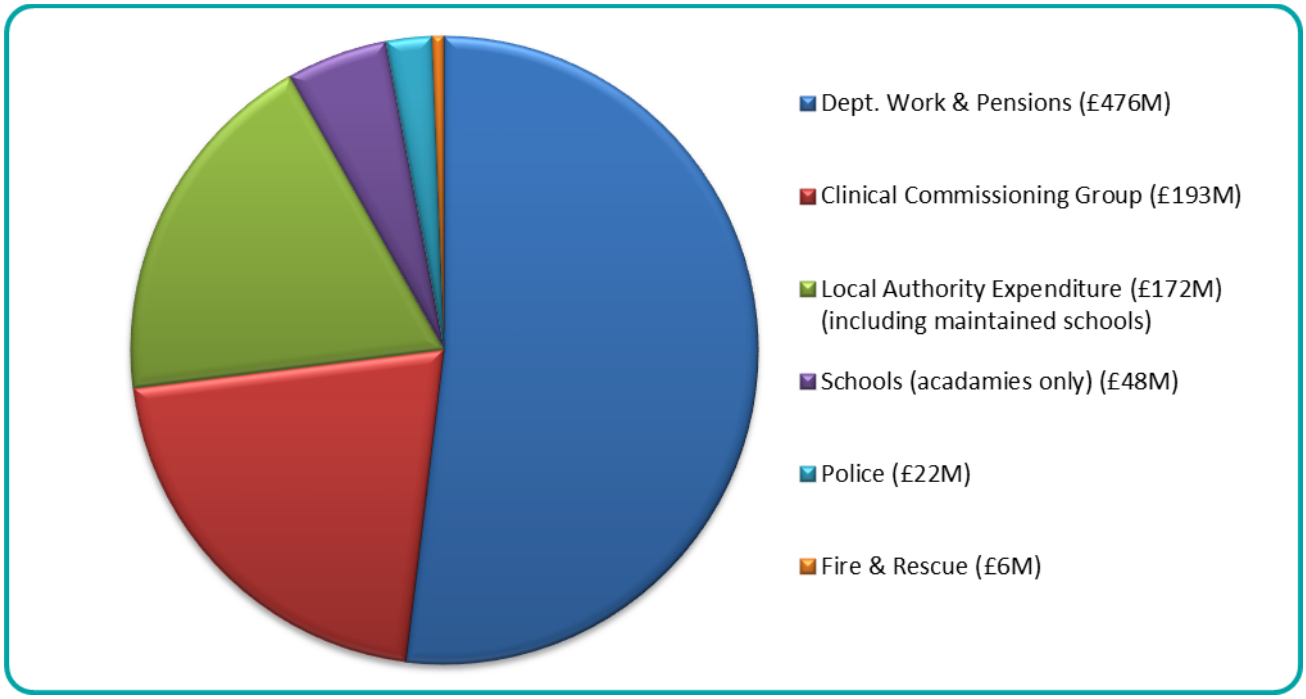


Public sector expenditure

The public sector includes services commissioned and provided for the public. This includes support services such as benefits, as well as schools, hospitals and refuse collection. This includes central government, national agencies, local NHS organisations and Torbay Council.

In 2015/16 around £920M was spent by 6 public sector bodies in Torbay, which equates to around £2.5M per day. Over half of spend was through the Department of Work and Pensions, spending £476M. The breakdown of spend is shown in figure 21.

Figure 21: Estimated spend across 6 public sector agencies in 2015 / 16



Source: Revenue Accounts, schools block allocation, benefit expenditure – gov.uk

Data for the Clinical Commissioning Group has been apportioned based on resident population, with a Torbay figure allocated according to population. The data is not adjusted for age or deprivation.

The same apportioned based methodology has been applied to both the Police (Devon and Cornwall Constabulary) and Fire and Rescue (Devon and Somerset Fire and Rescue Service).

The data is published and in the public domain, and analysis of CIPFA nearest neighbours has been undertaken to add further contextualisation where possible.

Department for Work and Pensions spend 2015/16

The department for work and pensions spent around £476M in Torbay in 2015/16. Around £250M was spent on state pension, and with Torbay's more aged demographic, this explains Torbay's higher than average spend DWP spend per head of population.

Spend on Job Seekers Allowance was around £5.4M, and represented a relatively small proportion of overall spend by the department for work and pensions.

Figure 22: DWP spend per head – 2015-16

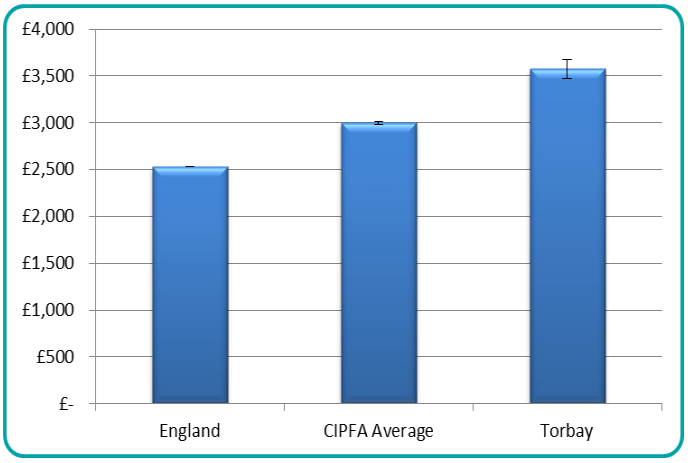
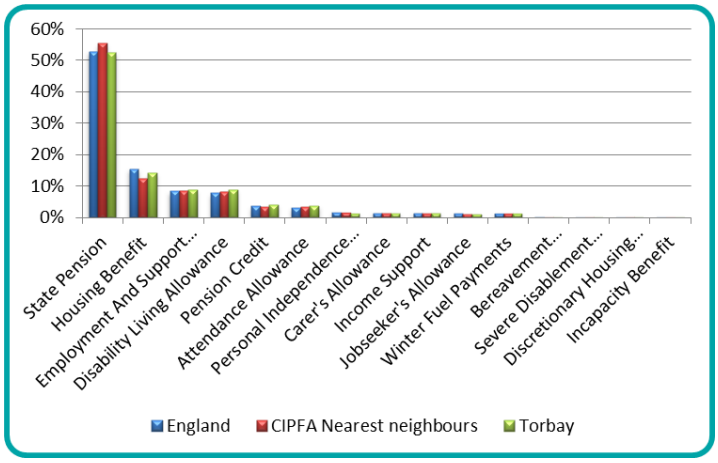


Figure 23: Proportion of DWP spend by benefit



Source: DWP Benefit Expenditure, gov.uk

South Devon Clinical Commissioning Group spend 2015/16

Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. There are now 207 CCGs in England.

Commissioning is about getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc. It is an ongoing process. CCGs must constantly respond and adapt to changing local circumstances. They are responsible for the health of their entire population, and measured by how much they improve outcomes.

The South Devon and Torbay CCG is responsible for commissioning health services for the Torbay population, as well as around 40% of the South Hams and 80% of the Teignbridge populations. In 2015/16 the South Devon and Torbay CCG total spend was around £387M (CCG Breakdown of Programme Costs 2015/16 Plans). Apportion based on resident population,

equates to an estimated spend of £193M for the population of Torbay. The following spend analysis (figures 24 and 25) is across the whole CCG footprint. The average spend is based on CCG allocation. As a health geography, there are different comparator groups, the South Devon and Torbay CCG has a group of similar organisations, referred to as RightCare. Details of the CCGs that form this group can be found at: https://www.england.nhs.uk/rightcare/products/

South Devon and Torbay have a similar spend per head of population when compared to their RightCare average, however it is higher than the England average (fig 24). The South Devon and Torbay CCG spend more per head on acute and community services (fig 25) – the majority will be commissioned from Torbay and South Devon NHS foundation trust.

Figure 24: CCG spend per head of registered population – 2015/16 (South Devon and Torbay)

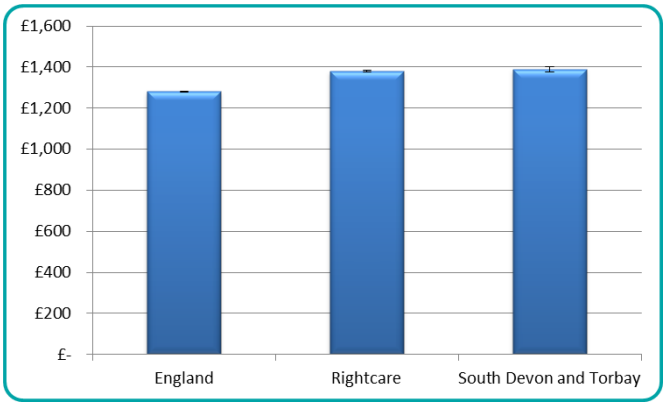
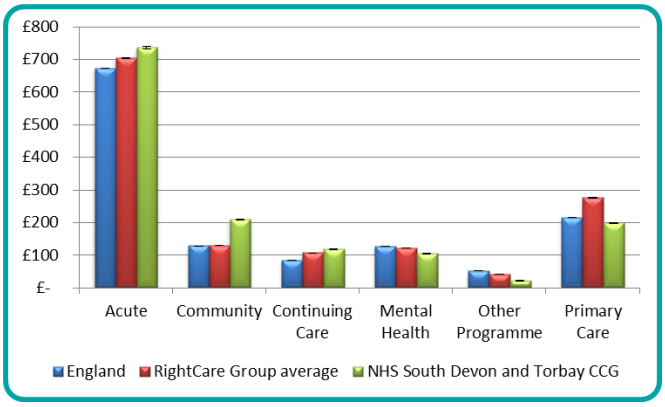


Figure 25: CCG Spend per head of registered population 2015/16 Plans (South Devon and Torbay)



Source: CCG Breakdown of Programme Costs 2015/16 Plans

Further analysis of Torbay registered patients by the CCG PBR data (payments by results) shows that the average spend per head increases with age. Allowing for demographic change, estimates suggest an increase of £7.3M between 2017 and 2025.

Figure 26: Three year average spend per head of population (Torbay)

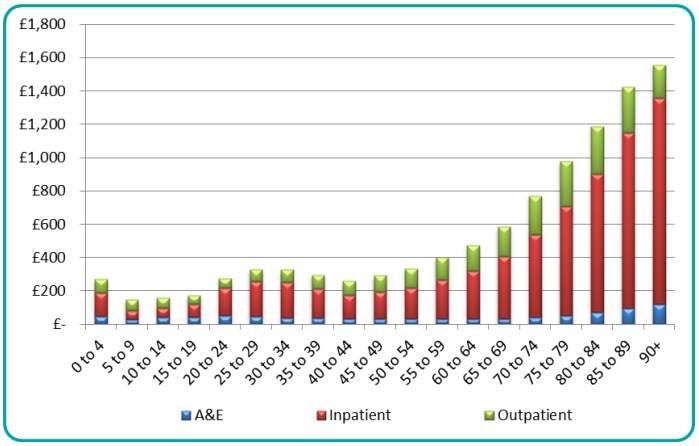
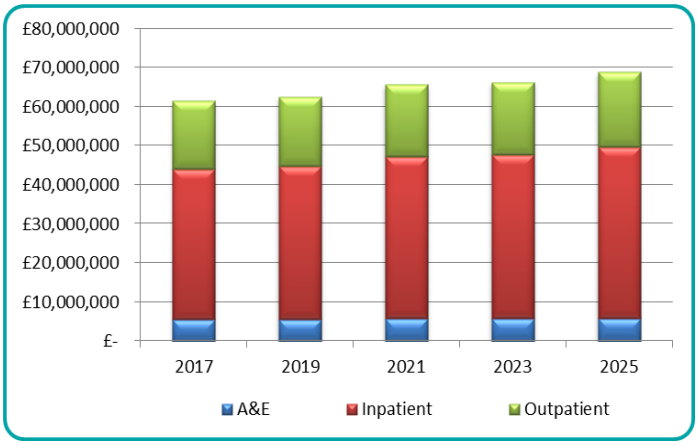


Figure 27: Forecasted spend (Torbay)



Source: 2014 Subnational population projections, ONS; South Devon and Torbay CCG, SUS

Local Authority (Torbay Council) Revenue Accounts 2015/16

Torbay council is an upper tier unitary local authority, responsible for providing services to the population of Torbay. Local government in England and Wales is funded through:

- grants from central government (about 54%) made up mainly of redistributed business rates, including the Revenue Support Grant and the Public Health grant
- and locally raised funding (about 46%) which includes council tax (charged to local people) and other sources such as car parks, parking permits and the hire of sports facilities

However this system is currently going through a major change. By 2020 the Government has committed to phasing out central grants for local government, so that local government will be funded entirely through locally retained business rates and council tax. The aim of this move is to encourage local authorities to promote local economic growth and to be financially self-sufficient. This system of 100% Business Rate Retention is still being designed by DCLG. https://www.lgiu.org.uk/local-government-facts-and-figures/

In Torbay, the revenue account budget for 2017-18, revenue account data for total service expenditure is £164M. The £164M is distributed across different service areas, such as Adult social care, childrens social care and other services. The distribution is presented in figure 28

Figure 28: Revenue Account Budget 2017-18:

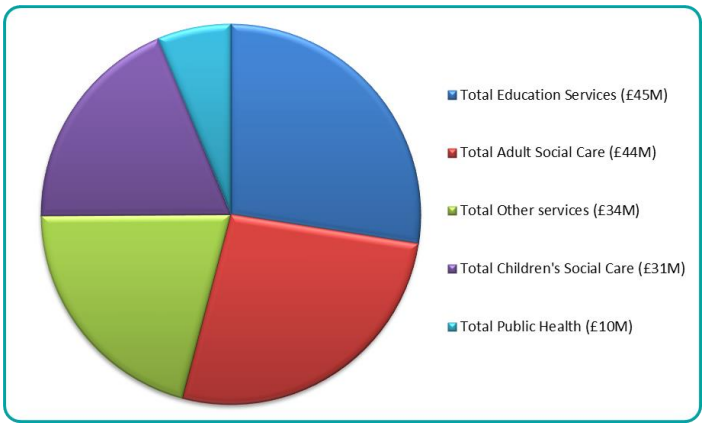
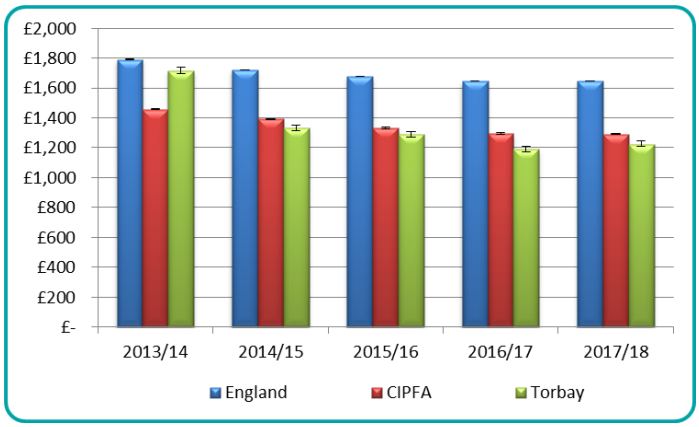


Figure 29: Total Service Expenditure (£ per head of total population)



Source: Local authority revenue expenditure and financing, gov.uk

Torbay's expenditure per head of population is significantly lower than the England average, and also significantly lower than the CIPFA nearest neighbours average. The expenditure per head reduced significantly over recent years, as shown in fig 29.

Further analysis across Children's Social Care, Education, Adult Social Care and Public Health follow.

With an increase in academy schools, the expenditure for maintained education that came through the local authority decreased. This change is important to understand to interpret fig 30. Torbay has a significantly higher rate of children looked after than most other authorities across England, and the costs of children's social care per head of 0 to 19 year olds shows that Torbay spends around 40% more than both the England and CIPFA averages (fig 31).

Figure 30: Total Education Services (£ per head of 0 to 19 year olds)

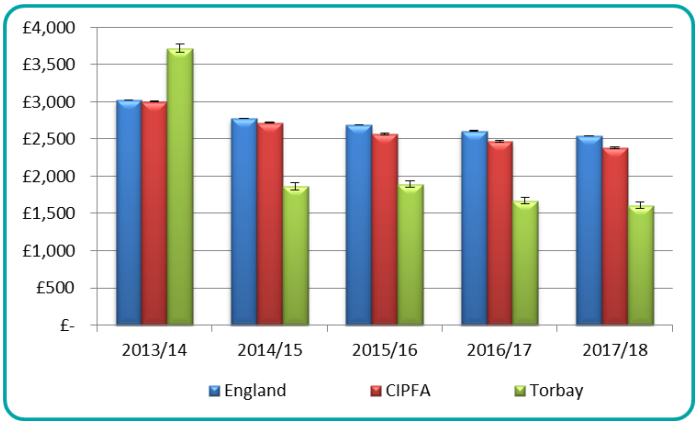
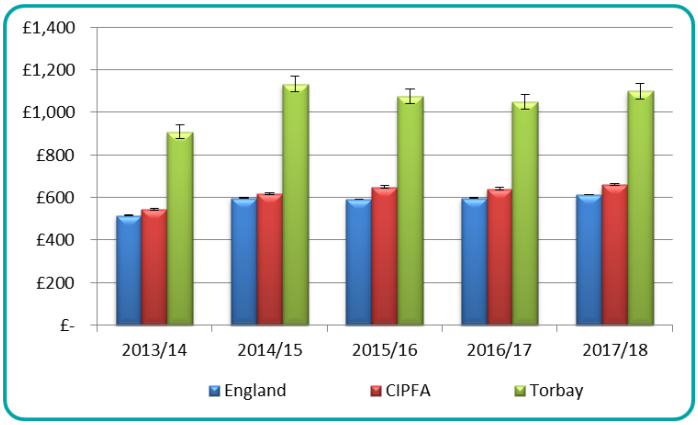


Figure 31: Total Children's Social Care (£ per head of 0 to 19 year olds)



Source: Local authority revenue expenditure and financing, gov.uk

A great majority of children who become looked after do so because of abuse, neglect or family dysfunction that causes acute stress among family members [10]. These risk factors tend to be higher in populations with higher levels of deprivation.

Figure 32: Total Adult Social Care (£ per head of 18+)

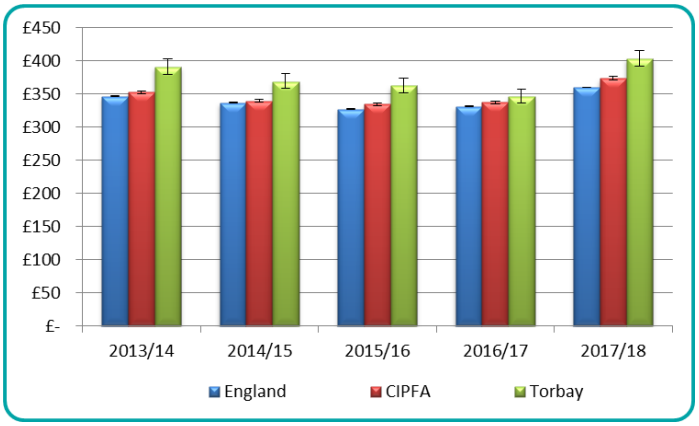
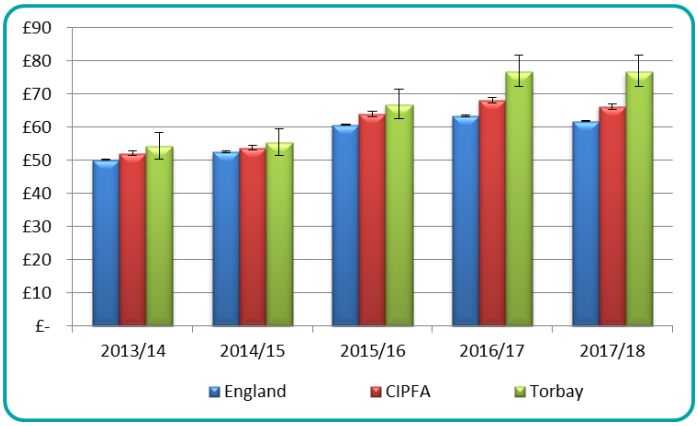


Figure 33: Total Public Health (£ per head of total population)



Source: Local authority revenue expenditure and financing, gov.uk

With a more aged population, we expected Torbay to have higher levels of adult social care need compared to the England population, and therefore a higher expenditure per head of population.

Torbay's population is expected to continue to have an increase in an older demographic, and this is expected to continue to increase need for adult social care.

Inequalities across the population of England mean that Local Authorities require different levels of Public Health funding. Public Health England and the Department of Health have funded local authority areas relative to the scale or size of need in their population. In essence, this is an application of proportionate universalism [1]

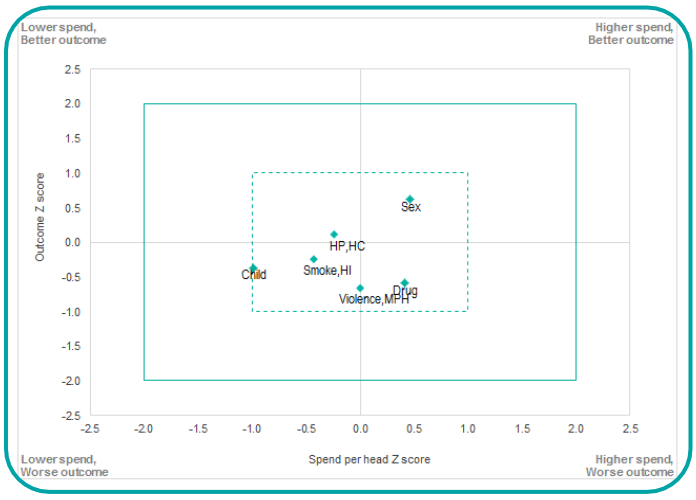
There is a significant evidence base that identifies greater needs in populations with greater levels of relative deprivation [1]

An analysis of spend and outcome (figures 34 and 35) suggests that Torbay's overall outcomes are similar to the England average (represented by 'PH' in figure 34). Specific outliers for Torbay in relation to overall local authority spend and outcome identified by the SPOT tool suggest children's social services, along with planning and cultural services, have higher levels of spend and worse outcomes compared to the England average.

Within the portfolio of Public Health services, there is variation of spend and outcomes - shown in figure 35. Drug and alcohol services can be seen as higher spend and worse outcomes (Drug); this is primarily driven by alcohol specific admissions to hospital, and also claimants of benefits due to alcoholism. Not all of these outcomes are commissioned through public health in the local authority setting.

Figure 34: Torbay 2016 Spend and Outcomes

Figure 35: Torbay 2016 Public Health spend and outcomes



Source: Public Health England, Spend and Outcome Tool (SPOT)

Population overview

This section provides an overview of the Torbay population, including population estimates and projections and a chart of key indicators and outcomes.

Torbay has a resident population of 133,883 (2016 Mid-Year Estimate), with 51.5% female and 48.5% male. Torbay's population structure continues to experience an older demographic, as shown in the population pyramid (fig 36) below.

Figure 36: population pyramid for Torbay compared to England, 2016

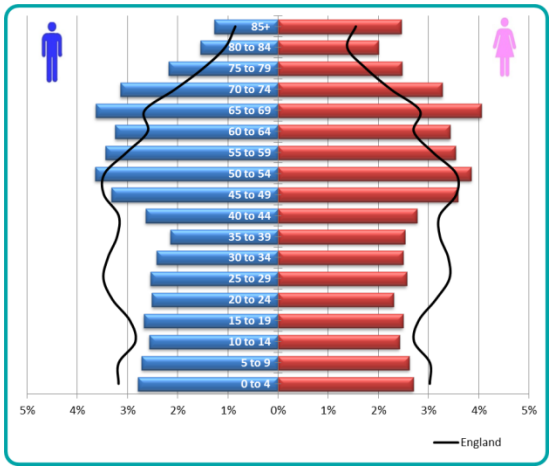
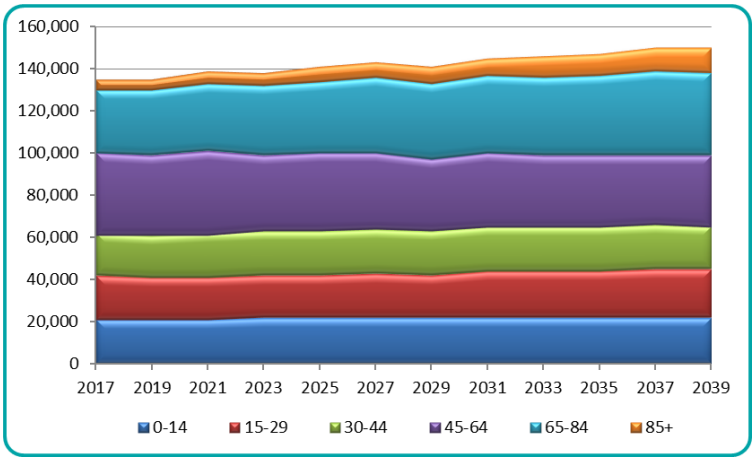


Figure 37: Population projections for Torbay



Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

Torbay's population is projected to increase over the coming years. The under 65 population shows modest growth while the over 65 population shows significant growth (shown visually in fig 37 and tabulated in table 4). Torbay's over 85 population is expected to double over the next twenty years. These significant increases in the older population are expected to drive increasing demand on support and treatment services.

Table 4: population estimates by year and age group

Age Group	2017	2018	2019	2020	2025	2030
0-14	21,131	21,336	21,535	21,663	22,071	21,990
15-29	20,598	20,436	20,312	20,256	19,891	20,453
30-44	19,896	19,820	19,770	19,867	20,965	21,158
45-64	37,501	37,560	37,623	37,573	36,419	34,554
65-84	30,212	30,696	31,121	31,540	34,033	36,944
85+	5,142	5,228	5,332	5,466	6,429	8,039
Total	134,481	135,077	135,691	136,366	139,809	143,140

Source: NOMIS, 2014 based subnational population projections

How to read the profile: The black line running down the middle of the spine chart is the England average, the circles (to the left or right) are the Torbay value, compared to the England average, The diamonds represent the CIPFA average. The colours are explained in the key.

Figure 38: Population overview profile

ID	Indicator	Measure	Torbay	CIPFA	England	England
Demography						
1	Average age (2015)	Years	44.7	42.8	39.8	30.1 – 53.9
2	Total dependency (2015)	Ratio	70.3	62.6	55.3	31.4 – 85.1
3	Male life expectancy at birth (2013-15)	Years	78.9	78.9	79.5	74.3 – 83.4
4	Female life expectancy at birth (2013-15)	Years	83.3	82.7	83.1	79.4 – 86.4
5	Male disability free life expectancy (2009-13)	Years	61.5	62.6	63.6	56.5 – 71.7
6	Female disabilty free life expectancy (2009-13)	Years	63.5	64.2	64.5	58.3 – 72
7	All-cause mortality (2014-16)	DSR	995.2	1,008.1	970.7	542.1 – 1,380.9
8	Premature mortality (2014-16)	DSR	343.5	352.6	335.0	226.6 – 548.7
9	Living in most deprived areas (2015)	%	32.0	20.8	20.1	0 – 60.5
10	Black Asian Minority Ethnic population (2011)	%	5.2	5.8	20.2	2.4 – 83.3
11	Religious population (2011)	%	64.8	66.6	68.1	48.8 – 84.2
12	Divorced or separated (2011)	%	14.8	12.9	11.6	7.7 – 16.3
13	Same-sex civil parnership (2011)	%	0.3	0.2	0.2	0 – 1.7
Wider determinants						
14	Overcrowded households (2011)	%	7.6	5.5	8.7	2.5 – 34.9
15	Living in private rented accomodation (2011)	%	23.2	17.1	16.8	9.2 – 39.7
16	Living in social rented accomodation (2011)	%	8.1	13.4	17.7	7 – 43.7
17	Living in fuel poverty (2014)	%	11.6	10.8	10.6	5.7 – 20.4
18	Living in most indoor deprived areas (2015)	%	45.7	31.1	20.7	0 – 100
19	No car or van access (2011)	%	25.5	24.1	25.8	9 – 69.4
20	Poor proficiency in English (2011)	%	0.3	0.5	1.7	0.1 – 8.7
21	Total crime (14/15-16/17)	Rate	65.7	-	73.1	45.1 – 104.8
22	Domestic abuse (13/14-15/16)	Rate	17.1	24.0	22.1	9.4 – 38.4
23	Anti-social behaviour (13/14-15/16)	Rate	37.5	-	31.1	15.9 – 78.1
Health and service usage						
24	Bad health status and long-term health problem (2011)	%	5.8	5.0	4.2	2 – 8
25	Living in areas with most mood/anxiety disorders (2015)	%	33.7	23.8	19.7	0 – 56.2
26	Urgent care attendances (14/15-16/17)	DSR	39,260.0	37,500.0	35,450.0	0 – 0
27	Emergency non-elective admissions (14/15-16/17)	DSR	11,975.0	11,141.7	10,606.5	0 – 0
28	Elective admissions (14/15-16/17)	DSR	17,995.8	20,264.1	18,939.0	0 – 0
29	Emergency readmissions within 30 days (14/15-16/17)	DSR	-	-	-	0 – 0
30	Ambulance 'see and convey' to hospital (14/15-16/17)	DSR	10,827.9	-	-	0 – 0

Sig worse | Sig better | Not sig diff | Sig higher | Sig lower | Sig not calculated | England Average | CIPFA | Q0 to Q1 | Q1 to Q3 | Q3 to Q4

Indicator notes:

1. Average age for the total population [ONS]
2. % of dependents (<15 & 65+yrs) per working population [ONS]
3. Years of male life expectancy from birth [PCMD; ONS, PHE]
4. Years of female life expectancy from birth [PCMD; ONS, PHE]
5. Years of male disability free life expectancy from birth [PHE Local Health]
6. Years of female disability free life expectancy from birth [PHE Local Health]
7. Directly age standardised (DSR) all-cause mortality rate per 100,000 [PCMD; ONS]
8. DSR all-cause premature (<75yrs) mortality rate per 100,000 [PCMD; ONS, PHE]
9. % of population living in areas amongst 20% most deprived in England [DCLG]
10. % of population reporting to be Black Asian Minority Ethnic (BAME) [CENSUS]
11. % of population reporting to have a religion [CENSUS]
12. % of population reporting to be divorced or separated [CENSUS]
13. % of population reporting to be in a same-sex civil partnership [CENSUS]
14. % of households with 1 room or fewer than required for occupants [CENSUS]
15. % of households who privately rent accommodation [CENSUS]
16. % of households who socially rent accommodation [CENSUS]
17. % of households living in fuel poverty "Low income, High Cost" measure [DECC]
18. % of population living in areas amongst 20% most indoor environment deprived in England [DCLG]
19. % of households with no cars/vans available for use by household [CENSUS]
20. % of population who cannot speak English or speak English well [CENSUS]
21. Rate of total crimes per 1,000 population [Data.Police.UK]
22. Rate of domestic abuse crime per 1,000 population [Police universal dataset]
23. Rate of antisocial behaviour per 1,000 population [Data.Police.UK]
24. % reporting bad health status and long-term health problem/disability [CENSUS]
25. % of population living in areas amongst 20% most mood and anxiety deprived in England [DCLG]
26. DSR urgent care (ED & MIU) attendances per 100,000 population [HES; ONS]
27. DSR emergency non-elective admissions per 100,000 population [HES; ONS]
28. DSR elective admissions per 100,000 population [HES; ONS]
29. DSR emergency readmissions within 30 days per 100,000 population [HES; ONS]
30. DSR ambulance trips which result in a 'see and convey' to hospital [SWAST]

Larger copies of the profiles are available at www.southdevonandtorbay.info/jsna

Highlights from the overview profile:

- Torbay's aged population has further challenges in higher levels of dependency. Where there are higher levels of dependent population per working age population. This is important with regards to the potential workforce within Torbay.
- Torbay has one of the highest levels of divorced or separated in the country.
- There are higher proportions of the population living in the private rented sector and lower levels living in social housing in Torbay.
- Rates of reported crime and domestic abuse are lower in Torbay, whilst levels of anti-social behaviour are higher.
- There are high levels of self-reported bad health in the population, and a lot of people living with mood or anxiety disorders.
- There are higher rates of emergency admissions to hospital and lower levels of elective admissions.

Mortality

At different stages of life, there are different leading causes of mortality. Overall, circulatory related diseases are the leading cause of mortality in the Torbay population and account for around 1 in 4 deaths.

Table 5: Leading cause of death in Torbay (Apr 2012 to Mar 2017) all persons

Age	1st	2nd	3rd	Total deaths by age group
1 to 19	Perinatal (7)	Nervous system (5)	Sudden infant death syndrome (5)	31
20 to 34	Suicide (17)	Cancer (8)	Circulatory (5)	55
35 to 49	Cancer (61)	Circulatory (45)	Suicide (27)	207
50 to 64	Cancer (323)	Circulatory (168)	Respiratory (89)	769
65 to 79	Cancer (925)	Circulatory (613)	Respiratory (321)	2,358
80+	Circulatory (1,612)	Cancer (959)	Respiratory (855)	5,487
All ages	Circulatory (2,444)	Cancer (2,278)	Respiratory (1,282)	8,899

Source: Primary Care Mortality Database, Open Exeter

Population segmentation

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

1. F **Senior Security** (Elderly people with assets who are enjoying a comfortable retirement) 19.6% of postcodes in Torbay - Senior Security are elderly singles and couples who are still living independently in comfortable homes that they own. Property equity gives them a reassuring level of financial security. This group includes people who have remained in family homes after their children have left, and those who have chosen to downsize to live among others of similar ages and lifestyles

2. L **Transient Renters** (single people privately renting low cost homes for the short term) - 14.5% of postcodes in Torbay - Transient Renters are single people who pay modest rents for low cost homes. Mainly younger people, they are highly transient, often living in a property for only a short length of time before moving on. Households in this group are typically aged in their 20s and 30s and are either living alone or house-sharing. Very few people are married and there are few children.

Figure 39: Mosaic groups (based on postcodes) across Torbay

Your area or file:
Torbay compared to England population
Comparison area or file:
National - England (Population)

Experian Mosaic Public Sector

Date: **01/10/2017**

Mosaic Public Sector classifies all consumers in the United Kingdom by allocating them to one of 15 Groups and 66 Types. These paint a rich picture of UK citizens in terms of their socio-economic and socio-cultural behaviour.

Mosaic Public Sector Groups	Your area/file	%	Comp.	% Pen.	%	Index
A Country Living	38	1.14	3,203,337	5.95	0.00	19
B Prestige Positions	215	6.45	3,923,430	7.29	0.01	89
C City Prosperity	6	0.18	2,418,976	4.50	0.00	4
D Domestic Success	132	3.96	4,698,954	8.73	0.00	45
E Suburban Stability	291	8.74	3,270,026	6.08	0.01	144
F Senior Security	652	19.57	4,401,414	8.18	0.01	239
G Rural Reality	30	0.90	2,905,648	5.40	0.00	17
H Aspiring Homemakers	314	9.43	5,164,013	9.60	0.01	98
I Urban Cohesion	75	2.25	3,486,375	6.48	0.00	35
J Rental Hubs	302	9.07	3,959,916	7.36	0.01	123
K Modest Traditions	243	7.30	2,411,770	4.48	0.01	163
L Transient Renters	484	14.53	3,438,627	6.39	0.01	227
M Family Basics	162	4.86	4,347,048	8.08	0.00	60
N Vintage Value	353	10.60	3,091,881	5.75	0.01	184
O Municipal Challenge	34	1.02	3,091,844	5.75	0.00	18
Total	3,331	100	53,813,258	100	0.01	100

Starting and developing well overview

This section brings together key information around Torbay's younger population. It includes population estimates for the 0 to 24 year old population, as well as presenting key challenges and outcomes for the population. The section is presented in two parts, starting well and developing well. Starting well is about understanding the needs of the population from pregnancy, birth and for the first few years of life. Developing well is about understanding the needs of the population between the ages of 5 and 17.

Population

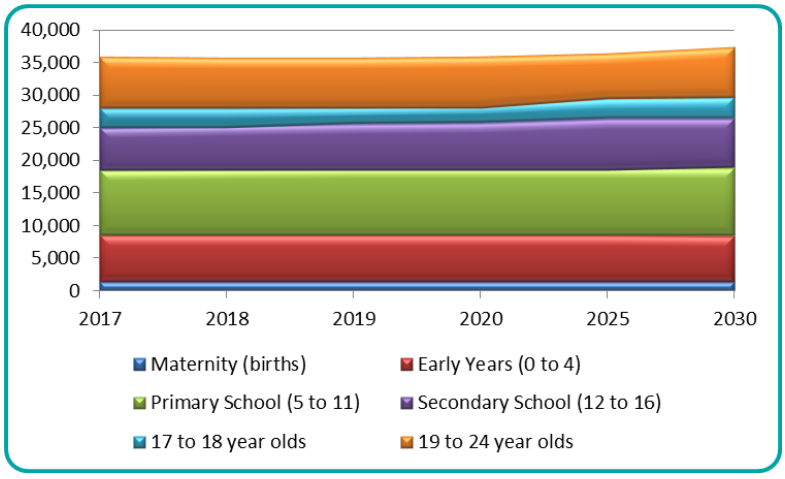
Population projections suggest the number of births in Torbay will average around 1,400 per year. However, over the next 10 to 12 years, the number of children of school age is expected to increase. Most acutely in secondary school provision, with an estimated 1,000 more in the population aged 12 to 16 between 2017 and 2030.

Table 6: population projections for the 0 to 24's in Torbay

Age group	2017	2018	2019	2020	2025	2030
Maternity (births)	1,410	1,420	1,420	1,420	1,410	1,400
Early Years (0 to 4)	7,160	7,110	7,110	7,140	7,180	7,090
Primary School (5 to 11)	9,920	10,150	10,230	10,240	10,230	10,340
Secondary School (12 to 16)	6,620	6,760	6,920	7,080	7,690	7,640
17 to 18 year olds	2,960	2,720	2,600	2,700	3,030	3,250
19 to 24 year olds	7,810	7,680	7,580	7,320	6,870	7,660

Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

Figure 40: Population projections for 0 to 24's in Torbay



Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

How to read the profile: The black line running down the middle of the spine chart is the England average, the circles (to the left or right) are the Torbay value, compared to the England average, The diamonds represent the CIPFA average. The colours are explained in the key.

Figure 41: Starting well overview profile

ID	Indicator	Measure	Torbay	CIPFA	England	England
	Demography					
1	General fertility (2013-15)	Rate	63.5	60.5	62.3	38.4 – 84.8
2	Infant mortality (2010-16)	Rate	4.2	3.7	3.9	2 – 7.9
3	Children in low income families (2014)	%	23.6	20.6	20.1	0 – 40
4	Dependants in lone parent households (2011)	%	25.7	23.6	22.2	5.3 – 40.6
	Social care and support					
5	Domestic abuse with children present (14/15-16/17)	Rate	16.4	-	-	0 – 0
6	Long-term health problem/disability (2011)	%	2.9	2.3	2.1	1 – 3.3
7	Special educational needs and disabilities (2016)	%	7.8	5.7	5.6	1.2 – 12
8	Children in need (2014-16)	Rate	593.8	-	-	0 – 0
9	Children with child protection plans (2013-16)	Rate	92.3	-	-	0 – 0
10	Looked after children (2013-16)	Rate	86.7	42.6	34.1	0 – 134.7
11	Torbay safeguarding hub queries (2014-16)	Rate	265.8	-	-	0 – 0
	Best start in life					
12	Smoking at time of delivery (14/15-16/17)	%	18.3	15.7	11.3	1.8 – 26
13	Low birth weight babies (2012-16)	%	3.1	2.4	2.8	1.3 – 4.8
14	Breastfeeding initiation (14/15-16/17)	%	70.2	67.7	74.0	47.2 – 100
15	Breastfeeding prevalence at 6-8 weeks (14/15-16/17)	%	43.6	36.8	43.2	18 – 76.5
16	Received MMR vaccine (2 dose) (14/15-16/17)	%	92.0	91.9	88.4	56.5 – 98.6
17	Children offered Ages and Stages Questionnaire (2016/17)	%	82.8	80.9	81.3	19 – 100
18	Achieved good level of development (14/15-16/17)	%	63.5	65.9	65.4	59.7 – 78.7
19	FSM children achieving good level of development (14/15-16/17)	%	49.0	48.7	49.8	41 – 72.1
20	Achieved expected level in phonics screening (14/15-16/17)	%	78.0	77.5	77.2	74.5 – 89.1
21	FSM children achieving expected level in phonics screening (14/15-16/17)	%	68.2	64.3	64.6	53.2 – 84.2
	Health and service usage					
22	Prevelance of excess weight (14/15-16/17)	%	24.4	23.6	22.2	14.3 – 30.1
23	Dental extractions due to caries (14/15-16/17)	%	0.6	0.2	0.2	0 – 1.2
24	Unintentional and deliberate injuries (14/15-16/17)	Rate	133.9	147.4	130.8	56 – 254.2
25	Urgent care attendances (14/15-16/17)	Rate	52,602.3	59,187.8	57,524.9	0 – 0
26	ED attendances (no investigation, treatment or follow up) (14/15-16/17)	Rate	11,452.1	4,804.4	4,820.5	3,481 – 12,077
27	Emergency non-elective admissions (14/15-16/17)	Rate	15,441.0	17,777.3	15,274.7	0 – 0
28	Emergency admissions for ACS conditions (14/15-16/17)	Rate	423.5	385.1	369.4	0 – 0
29	Elective admissions (14/15-16/17)	Rate	6,051.6	5,705.2	5,584.9	0 – 0
30	Ambulance 'see and convey' to hospital (14/15-16/17)	Rate	8,282.9	-	-	0 – 0

Sig worse | Sig better | Not sig diff | Sig higher | Sig lower | Sig not calculated | England Average | CIPFA | Q0 to Q1 | Q1 to Q3 | Q3 to Q4

Indicator notes:

1. General fertility rate per 1,000 females aged 15-44 years [Vital Statistics; ONS]
2. Infant mortality rate (<1 year) per 1,000 live births [PCMD; Vital Statistics; PHE]
3. % of children living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of IS or JSA [HMRC]
4. % of youngest dependent child (0-4yrs) living in lone parent household [CENSUS]
5. Rate of domestic abuse crimes with children present per 1,000 <19 yrs. population. [Local Police Minimum Dataset (Torbay UA); ONS]
6. % of children <5yrs with limited day-to-day activity [CENSUS]
7. % of children <5yr with statements/EHCPs or SEN Support [Torbay UA; DfE]
8. Rate of children in need (<5yrs) per 1,000 <5yr population [Torbay UA; ONS; DfE]
9. Rate of children on child protection plans (<5yrs) per 1,000 <5yr population [Torbay UA; ONS; DfE]
10. Rate of looked after children (<5yrs) per 1,000 <5yrs pop [Torbay UA; ONS; DfE]
11. Rate of safeguarding queries for children <5yrs per 1,000 <5yrs pop [MASH; ONS]
12. % of maternities where mother reported smoking at birth [TSDNHSFT; PHOF]
13. % of term babies (37+weeks) born <2500g [TSDNHSFT; PHOF]
14. % of women giving birth who initiate breastfeeding in first 48hrs [TSDFT; PHE]
15. % of infants being totally or partially breastfeed at 6-8wks [TSDNHSFT; PHE]
16. % of children receiving 2 dose MMR vaccine before 5th birthday [TSDFT, PHE]
17. % of children (2-2.5yrs) who received ASQ-3 as part of review [TSDFT; PHE]
18. % of children reaching expected level in early learning goals [Torbay UA; PHE]
19. As above (18) with free school meal eligibility (FSM) [Torbay UA; PHE]
20. % of children reaching expected level in phonics screening [Torbay UA; PHE]
21. As above (20) with free school meal eligibility (FSM) [Torbay UA; PHE]
22. % of children (4-5yrs) who are overweight & very overweight [Torbay UA; PHE]
23. % <5yrs with a hospital dental extraction due to caries [HES- NHSD; ONS, PHE]
24. Rate of hospital admissions for injuries per 100,000 <5yrs population [HES- NHSD; ONS; PHE]
25. Rate of ED & MIU attendances per 100,000 <5yrs pop [HES- NHSD; ONS]
26. Rate of ED attendances with no investigation, treatment or follow up (disposal code = '03' & SUSHRG code = 'VB11Z') per 100,000 <5yrs pop [HES- NHSD; ONS]
27. Rate of hospital emergency admissions per 100,000 <5yrs pop [HES- NHSD; ONS]
28. Rate of hospital emergency admissions for ambulatory care sensitive conditions per 100,000 <5yrs population [HES- NHSD; ONS]
29. Rate of elective admissions per 100,000 <5yrs population [HES- NHSD; ONS]
30. Rate of ambulance call outs which are taken to hospital <5yrs [SWAST; ONS]

Larger copies of the profiles are available at www.southdevonandtorbay.info/jsna

Highlights from the starting well overview profile:

- Torbay experiences higher proportions of children living in poverty
- Children in Torbay have higher levels of long term health problems or disability
- Torbay has amongst the highest rates of looked after children in England
- 1 in 5 mothers in Torbay smoke during pregnancy
- Excess weight in reception age children is high, with 1 in 4 being overweight or obese
- Fewer children achieve a good level of development in Torbay

Highlights from the Developing well overview profile:

- There are higher levels of dependent children living in lone parent households
- Torbay has higher rates of under 18 conceptions
- Around 1 in 5 of school aged children have a special educational need in Torbay
- More children provide levels of unpaid care and support in Torbay
- Levels of statutory children's services support are significantly higher in Torbay
- Children in schools in Torbay have higher levels of absenteeism
- There are higher levels of hospital admissions for young people in Torbay – particularly self-harm and injuries

How to read the profile: The black line running down the middle of the spine chart is the England average, the circles (to the left or right) are the Torbay value, compared to the England average, The diamonds represent the CIPFA average. The colours are explained in the key.

Figure 42: Developing well overview profile

ID	Indicator	Measure	Torbay	CIPFA	England	England
	Demography					
1	Mortality (2010-16)	DSR	19.7	20.6	19.3	0 – 0
2	Children in low income famillies (2014)	%	23.0	20.1	19.9	0 – 40
3	Children eligible for free school meals (FSM) (14/15-16/17)	%	16.2	14.2	15.2	2.2 – 36.5
4	Dependants living in a lone parent household (2011)	%	35.5	31.6	30.8	17 – 56
5	Teenage conceptions (2014-16)	Rate	27.5	24.8	22.7	5.7 – 43.8
	Social care and support					
6	Special education needs and disabilities (2014-16)	%	20.3	16.0	15.9	10.8 – 24.5
7	Unpaid carers (2011)	%	3.2	2.7	2.5	0.4 – 3.8
8	First time entrants to youth justice system (2014-16)	Rate	495.6	346.1	368.3	97.5 – 739.6
9	Domestic abuse where children are present (14/15-16/17)	Rate	16.4	-	-	0 – 0
10	Children in need (2014-16)	Rate	559.0	364.2	322.0	151 – 700.7
11	Children with child protection plans (2014-16)	Rate	58.4	47.6	40.4	0 – 126.9
12	Looked after children (2014-16)	Rate	112.7	71.8	59.9	0 – 164
13	Torbay safeguarding hub queries (2014-16)	Rate	252.7	-	-	0 – 0
	Wider determinants					
14	Key stage 2 meeting expected standard (14/15-16/17)	%	51.0	53.3	53.8	42.4 – 89.3
15	GCSE achieved (5A*-C inc. English & Maths) (14/15-16/17)	%	55.4	57.0	57.5	44.8 – 74.6
16	Pupil absence (14/15-16/17)	%	4.7	4.4	4.3	3.2 – 5.5
17	Not in education, employment or training (NEETS) (2014-16)	%	4.5	5.0	4.7	0 – 7.9
18	Claiming Jobseekers Allowance/Universal Credit (2015-17)	%	2.7	3.1	2.3	0 – 7.7
	Health and service usage					
19	Prevalence of excess weight (14/15-16/17)	%	33.1	33.1	33.6	22.9 – 43.4
20	Prevalence of regular smokers (2009-12)	%	10.4	9.5	8.8	3.2 – 14.9
21	HPV vaccination coverage (14/15-16/17)	%	79.2	86.3	85.1	43.7 – 99.1
22	Chlamydia detection (14/15-16/17)	Rate	2,417.2	2,258.0	1,943.9	813.1 – 4,938.3
23	Dental extraction due to caries (14/15-16/17)	%	0.9	0.4	0.3	0 – 1.4
24	Unitentional and deliberate injuries (14/15-16/17)	Rate	162.4	133.1	111.8	104 – 260.1
25	Emergency self-harm admissions (14/15-16/17)	DSR	982.5	531.8	407.1	102.5 – 1,444.7
26	Alcohol-specific admissions (14/15-16/17)	Rate	54.3	49.7	34.1	10.8 – 115.1
27	Urgent care attendances (14/15-16/17)	DSR	44,783.2	41,612.8	36,882.7	0 – 0
28	Emergency non-elective admissions (14/15-16/17)	DSR	7,260.9	5,737.0	4,983.7	0 – 0
29	Elective admissions (14/15-16/17)	DSR	7,025.9	5,982.2	5,340.5	0 – 0
30	Ambulance 'see and convey' to hospital (14/15-16/17)	DSR	6,319.5	-	-	6,319.5 – 6,319.5

Sig worse | Sig better | Not sig diff | Sig higher | Sig lower | Sig not calculated | England Average | CIPFA | Q0 to Q1 | Q1 to Q3 | Q3 to Q4

Indicator notes:

1. Directly age standardised rate (DSR) of all-cause mortality per 100,000 population [PCMD; ONS]
2. % <20yrs living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of IS or JSA [HMRC]
3. % of children eligible for free school meals (FSM) [Torbay UA]
4. % of youngest dependent child (5-18yrs) living in a lone parent household [CENSUS]
5. Rate of teenage conceptions per 1,000 female pop aged 15-17yrs [TSDFT; PHE]
6. % of children (5-19yrs) with statements/EHCPs or SEN Support [Torbay UA; DfE]
7. % of unpaid carers (care 1+hrs per week) under 25 years [CENSUS]
8. Rate of 10-17yrs receiving first reprimand, warning or conviction per 100,000 population [PHE]
9. Rate of domestic abuse crimes with children present per 1,000 <19 yrs. population. [Local Police Minimum Dataset (Torbay UA); ONS]
10. Rate of children in need (<19yrs) per 1,000 pop <19yrs [Torbay UA; ONS; DfE]
11. Rate of children on child protection plans (<19yrs) per 1,000 population <19yrs [Torbay UA; ONS; DfE]
12. Rate of looked after children (<19yrs) per 1,000 pop <19y [Torbay UA; ONS; DfE]
13. Rate of safeguarding queries for children <19yrs per 1,000 pop <19y [MASH; ONS]
14. % of Key Stage 2 meeting expected in reading, writing & maths [Torbay UA]
15. % of GCSEs achieved (%A*-C including English and maths) [Torbay UA]
16. % of possible school sessions with an unauthorised or authorised absence [DfE]
17. % of 16-18yrs not in education, employment or training [PHE]
18. % (16-24yrs) claiming Job Seekers Allowance [DWP, ONS]
19. % of children (10-11yrs) who are overweight or very overweight [Torbay UA; PHE]
20. % of children (15yrs) who are regular smokers [Way Survey, PHE]
21. % of girls (13-14yrs) who received second dose of HPV vaccine [TSDFT; PHE]
22. Rate of chlamydia detection per 100,000 aged 15-24yrs [PHE]
23. % aged 5-18yrs with a hospital dental extraction due to caries [HES- NHSD; ONS]
24. Rate of admissions for injuries per 100,000 5-18yrs pop [HES–NHSD; ONS]
25. DSR of emergency self-harm admissions per 100,000 10-24yrs [HES-NHSD; ONS)
26. Rate of alcohol specific admissions per 100,000 <18yrs [HES-NHSD; ONS; PHE]
27. DSR of ED & MIU attendances per 100,000 5-24yrs pop [HES- NHSDigital; ONS]
28. DSR of emergency admissions per 100,000 5-24yrs pop [HES- NHSDigital; ONS]
29. DSR of elective admissions per 100,000 5-24yrs population [HES- NHSD; ONS]
30 DSR of ambulance call outs taken to hospital per 100,000 5-24yrs [SWAST; ONS]

Larger copies of the profiles are available at www.southdevonandtorbay.info/jsna

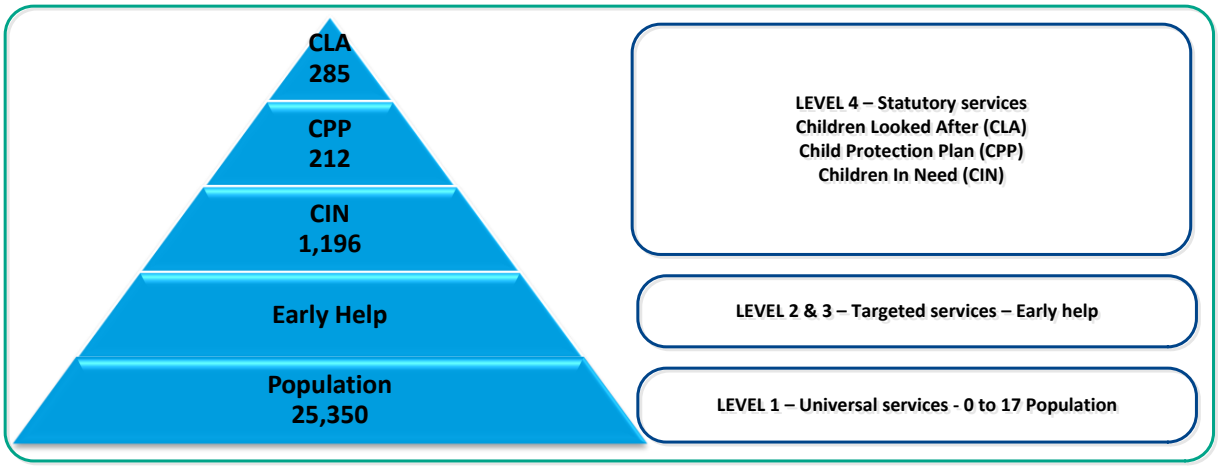
Children's statutory services in Torbay

The rate of children looked after, and the rate of children engaged in statutory services is higher in Torbay compared to comparative areas and the national average. There are a number of challenges for the children of Torbay, as highlighted in the profiles, and the local authority's children's service is currently rated as inadequate at a time when the number of children on child protection plans increase.

As a hierarchy of need, children looked after (CLA) are considered top of the list of need. These are children who are given accommodation away from their families at the request of their parent and those in care as the result of a Care Order. These are the most vulnerable children, and for the local authority, represent a significant cost.

Opportunities to prevent or reduce the flow of children entering statutory services could be considered from the perspective of going upstream and understanding potential causal factors. A specific needs assessment of children entering children's services would enable understanding of these factors allowing opportunity to commission services to intervene and prevent.

Figure 43: levels of need with counts of children in Torbay (2017)



Source: gov.uk

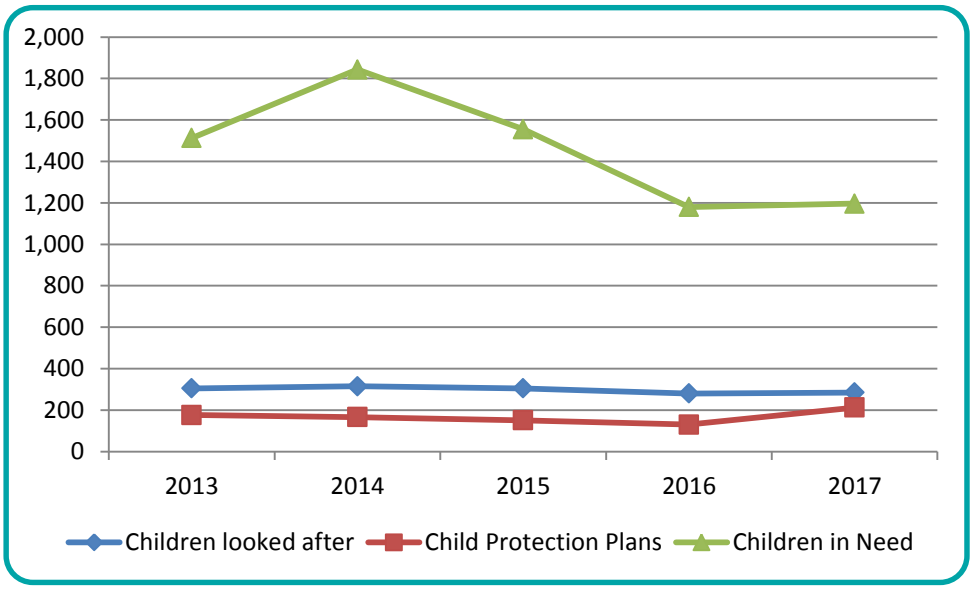
Table 7: Counts and rates of children (per 10,000 aged under 18) in Torbay over time

Year	Children looked after		Child Protection Plans		Children in Need	
	Count	Rate per 10,000	Count	Rate per 10,000	Count	Rate per 10,000
2013	305	122	176	70.8	1,513	576.9
2014	315	126	166	66.6	1,843	701.9
2015	305	122	151	60.2	1,555	585.8
2016	280	111	130	51.5	1,180	438.9
2017	285	112	212	84.0	1,196	445.0

Source: gov.uk

Over recent years, there has been a significant reduction in the number of children in need in Torbay, however there has also been a significant increase in children on child protection plans, while the number of children looked after remains fairly static.

Figure 44: Counts of children in services in Torbay over time



Source: gov.uk

Rates of children looked after in Torbay have reduced slightly over the last five years, but not significantly. The rates remain significantly higher than the England and comparator group averages.

Analysis of local authority data shows a distinct social gradient associated with children looked after (fig 46), with rates in communities with higher levels of deprivation being significantly higher than less deprived communities.

Figure 45: Rates per 10,000 CLA

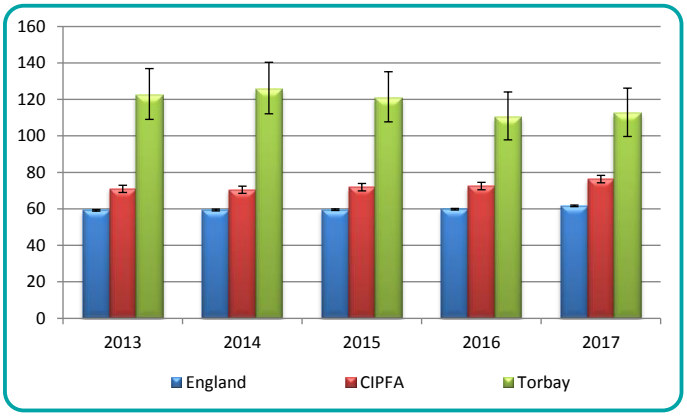
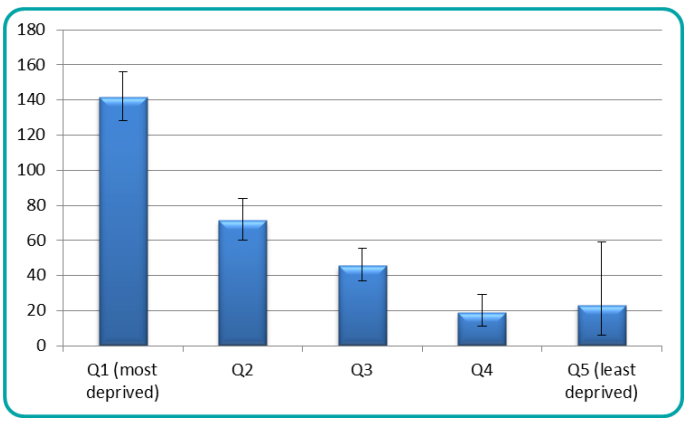


Figure 46: Rate of CLA per 10,000



Source: Gov.uk. Table LAA1: Children looked after at 31 March, by local authority; local authority data from Children's services

Rates of children subject to a child protection plan in Torbay increased significantly in 2017 compared to the last five years. The rate has fluctuated in recent years and is now again significantly higher than the England and comparator group averages.

Analysis of local authority data shows a distinct social gradient associated with children who were subject to a child protection plan (fig 48), with rates in communities with higher levels of deprivation being significantly higher than less deprived communities.

Figure 47: Rate of children who were the subject of a child protection plan at 31 March per 10,000 children

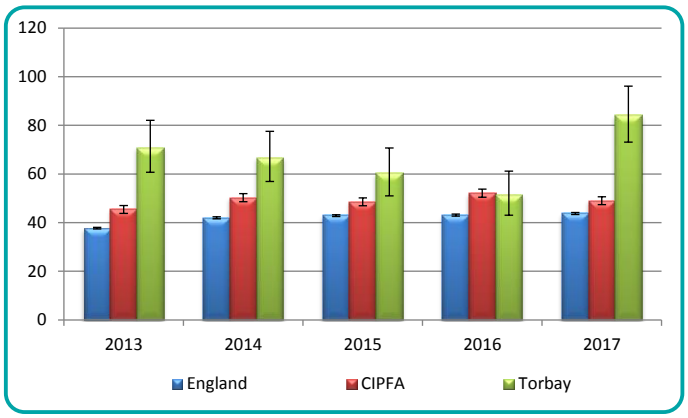
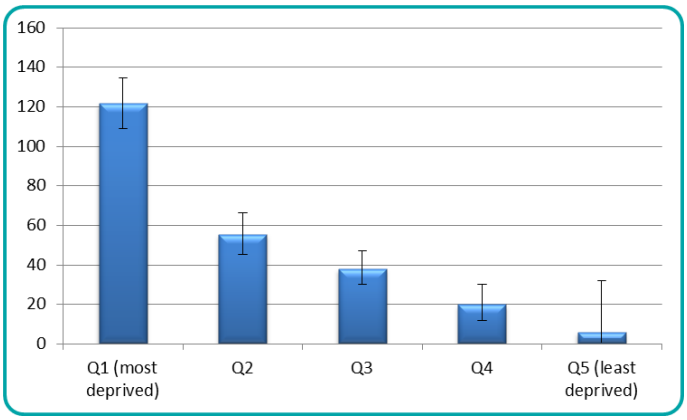


Figure 48: Rate of CPP per 10,000 in Torbay by deprivation



Source: Gov.uk. Table D1: Numbers of children who were the subject of a child protection plan

Rates of children in need in Torbay have reduced significantly over the last five years. The rates remain significantly higher than the England and comparator group averages.

Analysis of local authority data shows a distinct social gradient associated with children in need in Torbay (fig 50), with rates in communities with higher levels of deprivation being significantly higher than less deprived communities.

Figure 49: Rate of children in need per 10,000

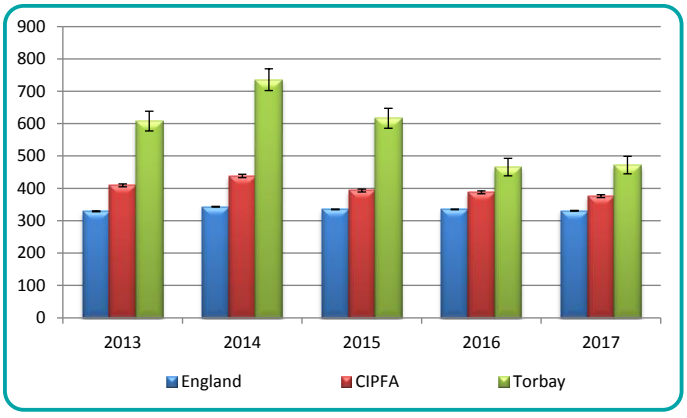
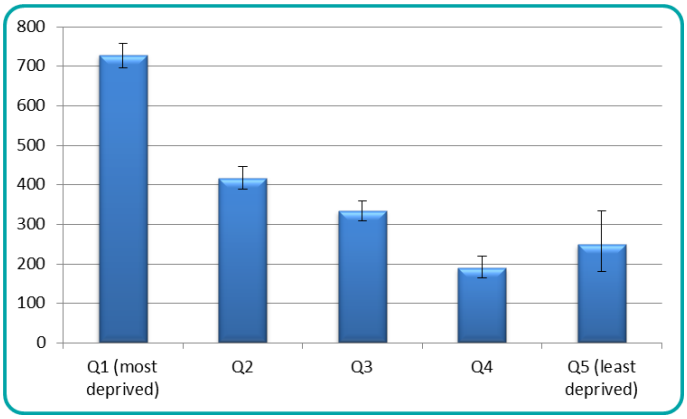


Figure 50: Rate of CIN per 10,000



Source: Gov.uk. Table B1: Numbers of children in need

Living and working well overview

This section brings together key information around Torbay's working age population. It includes population estimates for the working age population, as well as presenting key challenges and outcomes for the population.

Population

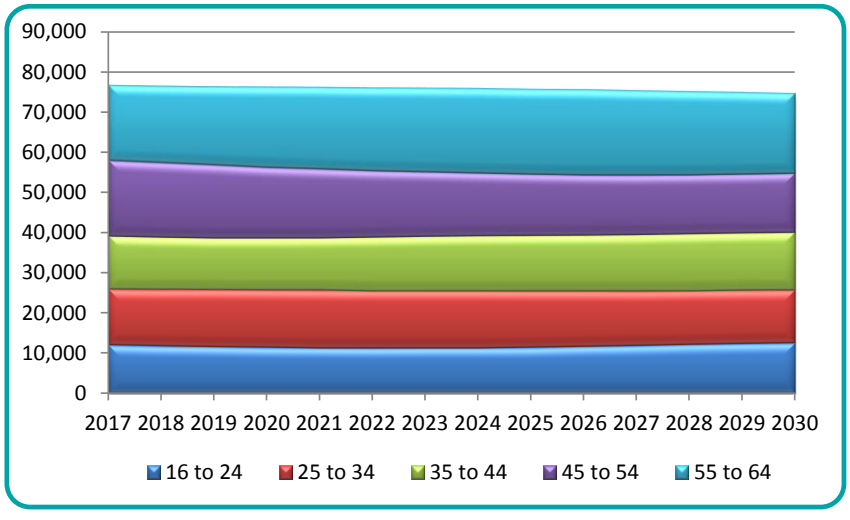
Population projections suggest the number of working age people in Torbay will average around 1,400 per year. However, over the next 10 to 12 years, the number of children of school age is expected to increase. Most acutely in secondary school provision, with an estimated 1,000 more in the population aged 12 to 16 between 2017 and 2030.

Table 8: Population projections for 16 to 64's with ratios of working age population to dependent population (non-working age)

Age groups	2017	2018	2019	2020	2025	2030
Torbay's working age population (16 to 64)	76,673	76,463	76,345	76,273	75,714	74,642
Torbay's non-working age population	57,808	58,613	59,345	60,093	64,095	68,498
Ratio of working age to dependent age population						
Torbay	1.33	1.30	1.29	1.27	1.18	1.09
England	1.69	1.67	1.65	1.64	1.56	1.48
CIPFA	1.49	1.47	1.45	1.43	1.34	1.25

Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

Figure 51: Population projections for 16 to 64's in Torbay



Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

How to read the profile: The black line running down the middle of the spine chart is the England average, the circles (to the left or right) are the Torbay value, compared to the England average, The diamonds represent the CIPFA average. The colours are explained in the key.

Figure 52: Living and working well overview profile

ID	Indicator	Measure	Torbay	CIPFA	England	England
	Wider determinants					
1	No qualifications (2011)	%	25.8	23.9	22.5	6.7 – 35.2
2	Living in most employment deprived areas (2015)	%	39.8	25.3	19.7	0 – 62.5
3	Claiming Jobseekers Allowance/Universal Credit (2015-17)	%	2.0	2.0	1.8	0.4 – 5.4
4	Claimants of Employment Support Allowance (ESA) (2015-17)	%	9.0	7.0	5.6	1.4 – 12.6
5	Claimants of ESA for mental health conditions (2015-17)	%	4.5	3.4	2.7	0.9 – 6.6
6	CAB debt queries (14/15-16/17)	Rate	34.5	-	-	0 – 0
7	Violent offences (14/15-16/17)	Rate	27.1	-	21.7	6.7 – 100.4
	Social care and support					
8	Unpaid carers (2011)	%	15.9	15.2	13.7	7.7 – 17.3
9	Requests for adult social care support (14/15-16/17)	Rate	1,758.5	1,830.0	1,499.1	199.4 – 5,837.5
10	Long-term support for learning disability (14/15-16/17)	Rate	495.3	470.0	382.4	0 – 743.6
11	Long-term support for physical personal care support (14/15-16/17)	Rate	422.0	225.0	200.0	0 – 450.5
12	Long-term support for mental health (14/15-16/17)	Rate	206.9	145.0	167.5	0 – 989.7
13	Permanent admissions to nursing/residential homes (14/15-16/17)	Rate	14.4	16.4	13.3	0 – 56.8
	Health and service usage					
14	Mortality from causes considered preventable (2011-16)	Rate	176.8	203.7	184.5	114 – 320.5
15	Prevalence of smoking (2015)	%	17.1	16.3	15.5	9.5 – 26.8
16	Prevalence of binge drinking (2006-08)	%	18.0	22.5	20.1	7.5 – 33.7
17	Prevalence of obesity (2006-08)	%	27.6	26.0	24.0	13.7 – 30.7
18	Prevalence of depression (2015)	%	6.9	6.8	6.6	0 – 0
19	Prevalence of hypertension (2015)	%	33.3	31.1	27.6	17.3 – 30.9
20	Prevalence of cardiovascular disease (2015)	%	11.6	10.2	8.4	6.5 – 12.6
21	Prevalence of chronic obstructive pulmonary disorder (2015)	%	4.0	3.7	3.3	1.9 – 5.4
22	Prevalence of diabetes (2015)	%	6.3	5.8	5.2	3.8 – 9.2
23	Obesity related admissions (14/15-16/17)	DSR	2,164.4	1,468.5	1,007.0	336 – 2,931
24	Smoking attributable admissions (14/15-16/17)	DSR	1,927.7	1,897.2	1,705.0	954.5 – 3,141.8
25	Alcohol-related admissions (Narrow) (2014-16)	DSR	836.2	751.5	636.1	389.9 – 1,163.3
26	Urgent care attendances (14/15-16/17)	DSR	35,556.3	32,574.2	30,837.1	0 – 0
27	Emergency non-elective admissions (14/15-16/17)	DSR	9,561.7	7,972.4	7,261.2	0 – 0
28	Emergency admissions for ASC conditions (14/15-16/17)	DSR	539.5	339.1	378.5	0 – 0
29	Elective admissions (14/15-16/17)	DSR	17,461.3	18,309.2	16,808.7	0 – 0
30	Ambulance 'see and convey' to hospital (14/15-16/17)	DSR	8,329.5	-	-	0 – 0

Sig worse | Sig better | Not sig diff | Sig higher | Sig lower | Sig not calculated | England Average | CIPFA | Q0 to Q1 | Q1 to Q3 | Q3 to Q4

Indicator notes:

1. % with no qualifications [CENSUS]
2. % of population (all ages) living in areas amongst 20% most employment deprived in England [DCLG]
3. % claiming Job Seekers Allowance/Universal Credit (16-64yrs) [NOMIS; ONS]
4. % claiming Employment Support Allowance (ESA) 16-64 years [DWP; ONS]
5. % claiming ESA for a mental and behavioural disorders 16-64 years [DWP; ONS]
6. Rate of CAB debt queries per 1,000 16-64yrs pop[Torbay CAB; ONS]
7. Rate of violence against the person offences per 1,000 population (all ages) [Police Universal Dataset (Torbay UA); ONS]
8. % of unpaid carers (care 1+hrs per week) under 25-64 years [CENSUS]
9. Rate of requests for Adult Social Care (ASC) support for new clients aged 18-64 years per 100,000 population aged 18-64 years [TSDNHSFT; NHS Digital]
10. Rate of ASC long-term support for learning disability aged 18-64 years per 100,000 population aged 18-64 years [TSDNHSFT; NHS Digital]
11. As indicator above for physical personal care [TSDNHSFT; NHS Digital]
12. As indicator above for mental health [TSDNHSFT; NHS Digital]
13. Rate of permanent admissions to residential and nursing care homes per 100,000 population aged 18-64 years [TSDNHSFT; ASCOF- PHE]
14. Directly age standardised rate (DSR) of mortality from causes considered preventable (with public health intervention) per 100,000 pop [PCMD; ONS; PHE]
15. % age & sex modelled (local) prevalence of smoking 16yrs+ [IHS; ONS; PHE]
16. % modelled prevalence of binge drinking 16yrs+ [PHE Local Health]
17. % modelled prevalence of obesity 16yrs+ [PHE Local Health]
18. % modelled prevalence (local) of depression 16yrs+ [Thomas et al, 2000; ONS]
19. % modelled prevalence (local) of hypertension 16yrs+ [THIN 2006; ONS; PHE]
20. % modelled prevalence (local) of CVD all ages [CPRD 2013; ONS; PHE]
21. % modelled prevalence (local) of COPD 15yrs+ [HSE 2005; ONS; PHE]
22. % modelled prevalence of Type 1 and 2 diabetes 16yrs+ [HSE 2006; ONS; PHE]
23. DSR of obesity related admission episodes per 100,000 [HES-NHSD; ONS; NHSD]
24. DSR of smoking attributable admissions per 100,000 35yrs+ (HES; ONS; PHE]
25. DSR of admission episodes for alcohol-related conditions (Narrow) per 100,000 (all ages) [HES-NHSD; ONS; PHE]
26. DSR of ED & MIU attendances per 100,000 25-64yrs pop [HES- NHSDigital; ONS]
27. DSR of emergency admissions for ambulatory care sensitive (ACS) conditions per 100,000 16-64yrs population [HES- NHSD; ONS]
28. DSR of emergency admissions per 100,000 25-64yrs pop [HES- NHSDigital; ONS]
29. DSR of elective admissions per 100,000 25-64yrs population [HES- NHSD; ONS]
30. DSR of ambulance call outs taken to hospital per 100,000 25-64yrs [SWAST; ONS]

Larger copies of the profiles are available at www.southdevonandtorbay.info/jsna

Highlights from the living and working well overview profile:

- 1 in 4 adults in the population do not have any formal qualifications
- Torbay has significantly higher levels of people on employment support allowance
- A high proportion of the population provided support as an unpaid carer
- Torbay has high levels of long-term support need in the population
- Prevalence of long term conditions are high in the population
- There are high levels of potentially avoidable lifestyle related hospital admissions

Housing

Torbay has a housing stock of around 64,370 household spaces. Occupancy of household spaces is below the England average, with some 59,010 (91.7%) occupied with at least one usual resident. This compares to 95.7% across England and 93.8% across CIPFA nearest neighbours. This is to be expected given Torbay's position as a seaside tourist destination.

More acutely for the population is the underrepresentation of social housing in the market. Torbay has higher levels of private rented accommodation, and significantly lower social rented (fig 53). Of the occupied housing stock, just under 1 in 3 dwellings are a flat, maisonette of apartment. A more detailed analysis would be needed to understand if the planning policy and provision of dwelling types are meeting the populations housing needs.

Figure 53: Tenure of dwellings

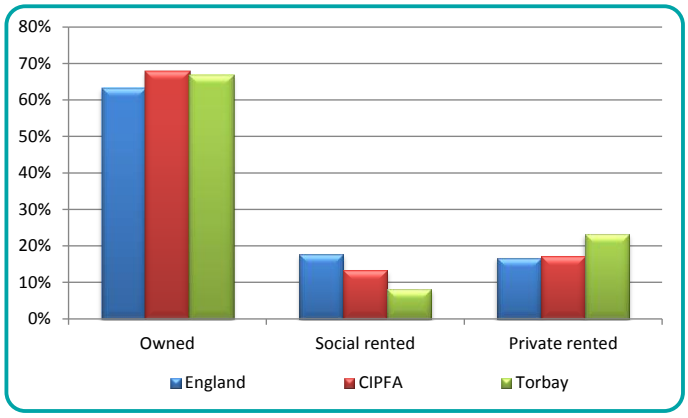
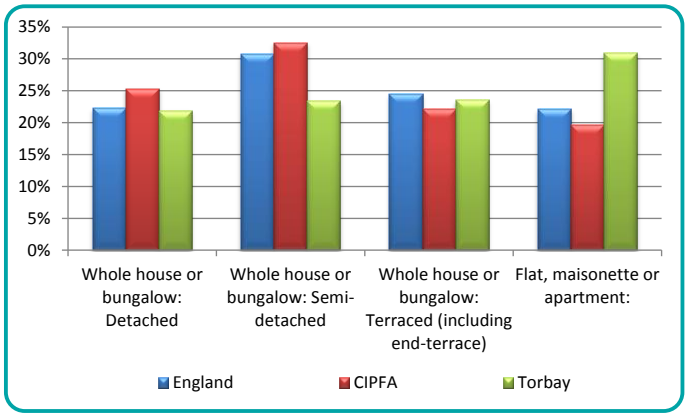


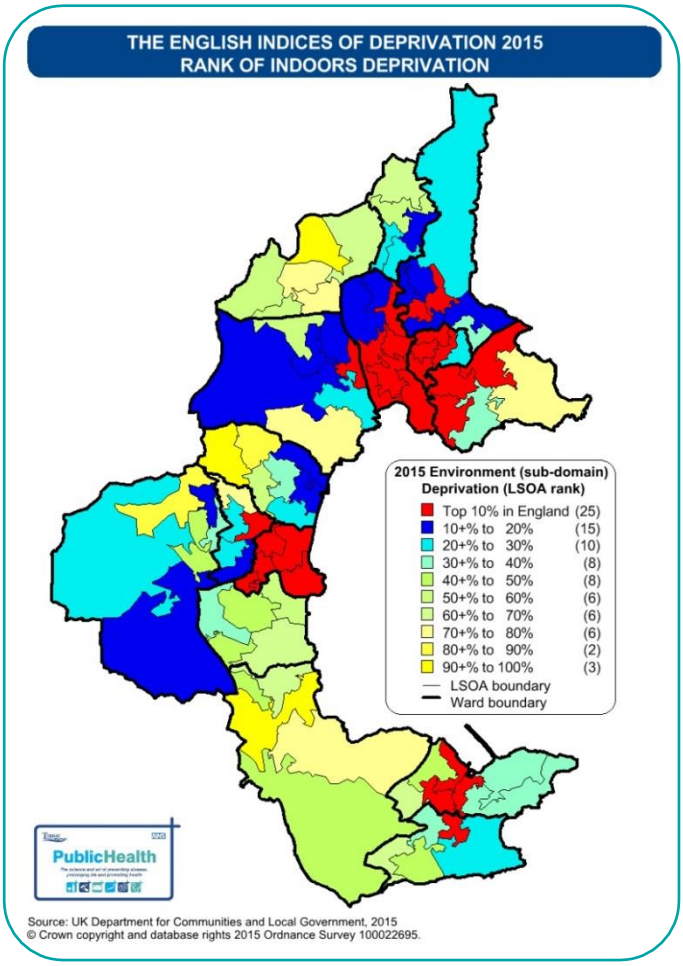
Figure 54: Dwelling Types



Source: NOMIS, 2011 Census

The quality of Torbay's housing stock is relatively poor. Torbay has high levels of indoor deprivation, identified in figure 55 with areas in red and dark blue. 45% of Torbay's population live in an area in the top 20% most deprived in England. The drivers for the indoor living environment domain are: houses without central heating and houses in poor condition (do not meet the Decent Home standard).

Figure 55: Indoor deprivation in Torbay



House prices in Torbay

House prices in Torbay have increased in recent years, and are at levels prior to the 2008 recession. The difference between the Torbay and England average house price has widened in recent years. House prices, on average, cost £40,000 less in Torbay than the England average (fig 57).

Figure 56: Median house price paid in Torbay compared to England over time

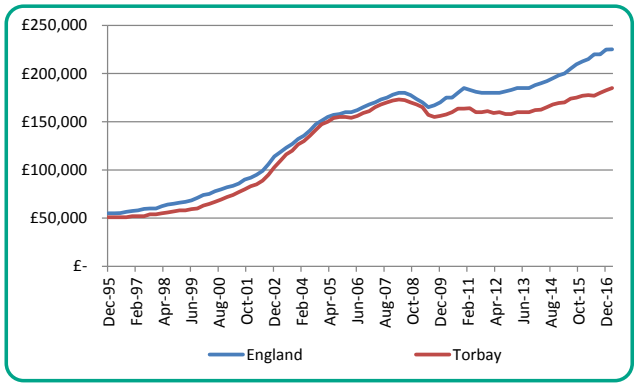
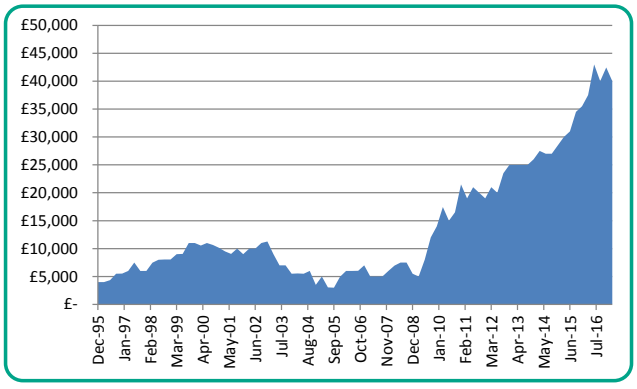


Figure 57: Gap between England and Torbay median house price



Source: ONS

House prices may be lower; however earnings are also significantly lower than the average. This gives Torbay a higher than average affordability ratio (fig 59). This means that it is harder for people in Torbay to afford their own housing.

Earnings and employment

Average earnings for full time workers in Torbay are significantly lower than the England average. Residents in Torbay earn the 4th lowest earnings (full time annual gross pay) in England out of 152 local authority areas. The gap between the England and Torbay average is some £9.3k per year (fig 58).

Figure 58: Gross annual pay - mean full time workers

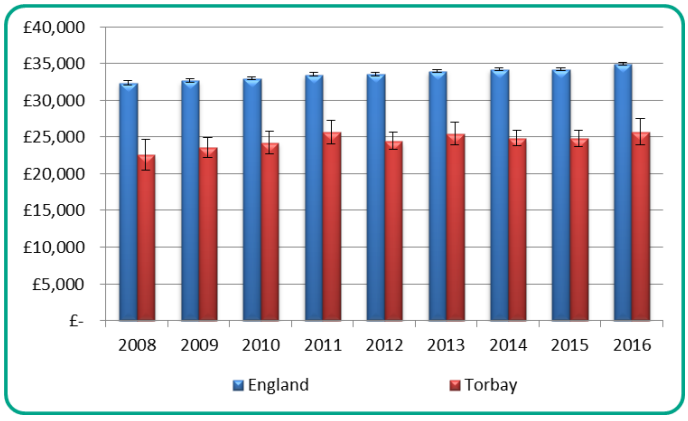
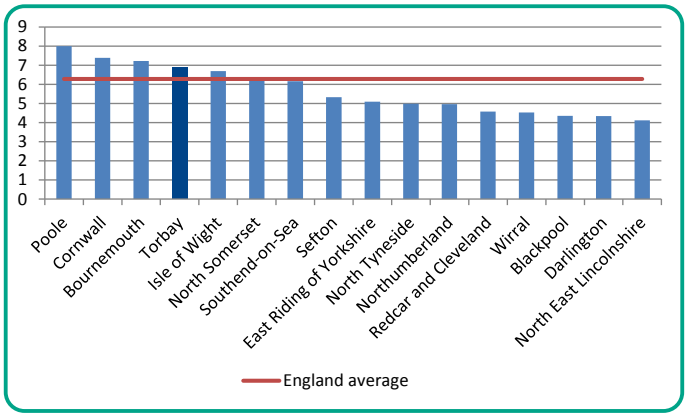


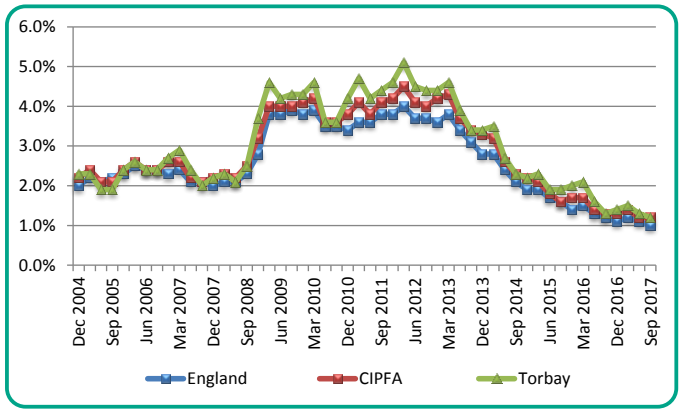
Figure 59 Ratio of average full time earnings to house prices



Source: NOMIS, ONS

The levels of residents claiming JSA (job seekers allowance) has been reducing at a rate similar to the national average. Around 1% of the working age population are currently claiming JSA.

Figure 60: Job seekers allowance



Source: NOMIS

As a tourist destination it is expected that Torbay would have higher levels of employment in the distribution, hotels and restaurants sector (fig 61). Around 1 in 3 of those aged 16 to 64 in

employment work in public admin, education and health. There are significantly higher levels of those in employment aged 16 to 64 being part time employment in Torbay compared to both CIPFA nearest neighbours and the England average (fig 62).

Figure 61: % aged 16-64 in employment who work in:

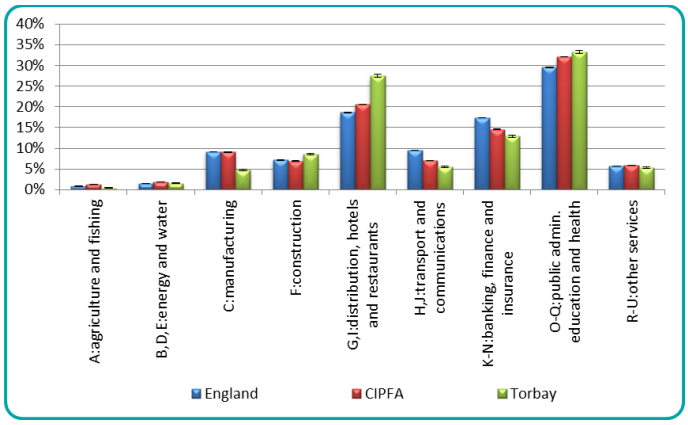
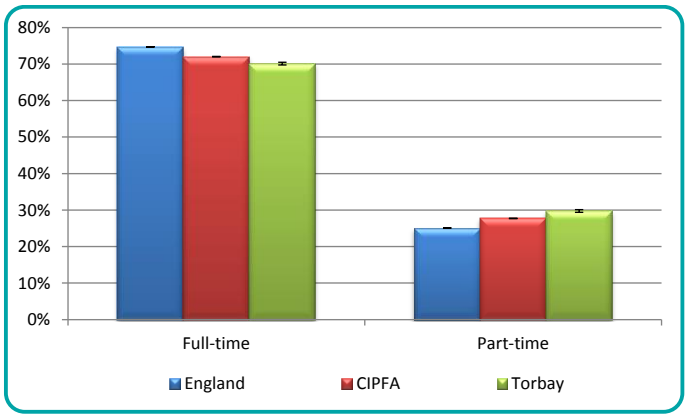


Figure 62: % in employment working full-time or part time- aged 16-64



Source: NOMIS, Annual population survey

Gross Value Added (GVA) measures the contribution to the economy of each individual producer, industry or sector and is used in the estimation of Gross Domestic Product (GDP). Based on GVA the local economy of Torbay is amongst the weakest in England (figure 63 shows the relative contribution of Torbay compared to CIPFA neighbours). Recent figures from the Office for National Statistics suggest Torbay's economic worth in 2015, was in the region of £2.081 billion, or around £15,600 per head of population. This compares to £18,127 per head across CIPFA neighbours and £25,601 per head across England (figure 64).

Figure 63: Headline GVA per head indices at current basic prices

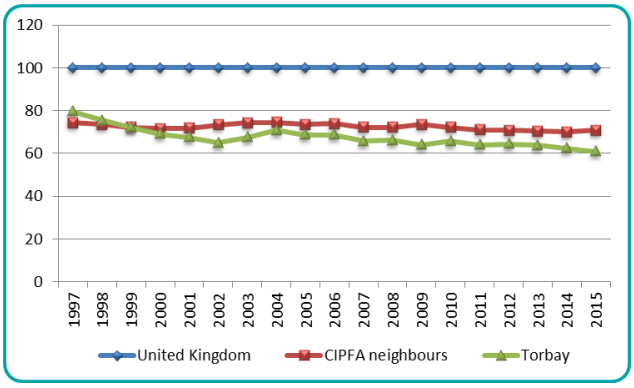
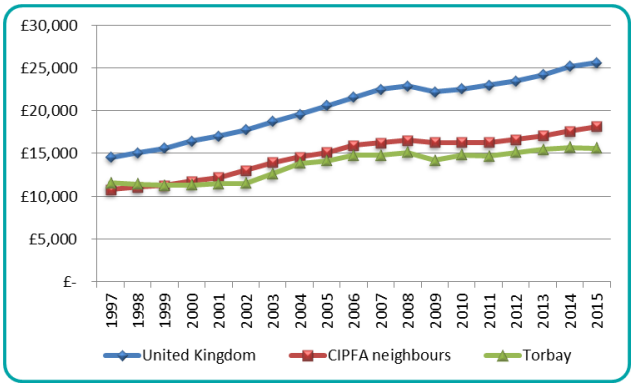


Figure 64: Gross Value Added (Income Approach) per head of population at current basic prices



Source: ONS

Ageing and dying well overview

This section brings together key information around Torbay's retirement age population. It includes population estimates for the over 65 population, mortality forecasts as well as presenting key challenges and outcomes for the population.

Population

Population projections suggest the number of people aged over 65 in Torbay will increase by almost 10,000 by 2030. The largest increase is expected in those aged 80 to 84, which is expected to see an increase of some 3,000, or a 62% increase on the current number. Populations aged 85 and over are expected to increase by over 50% by 2030. These increases are expected to increase demand on support services as increased people become frail towards the end of their life.

Table 9: Population projections for the over 65's

Age group	2017	2018	2019	2020	2025	2030
65 to 69	9,586	9,314	9,058	9,006	9,770	11,203
70 to 74	9,339	9,723	9,890	9,908	8,763	9,548
75 to 79	6,339	6,605	6,980	7,330	9,139	8,173
80 to 84	4,948	5,054	5,193	5,296	6,361	8,020
85 to 89	3,099	3,166	3,260	3,364	3,917	4,851
90+	2,043	2,062	2,072	2,102	2,512	3,188

Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

The number of people dying a year is expected to start increasing towards the end of the 2020's.

Figure 65: population projections by age group

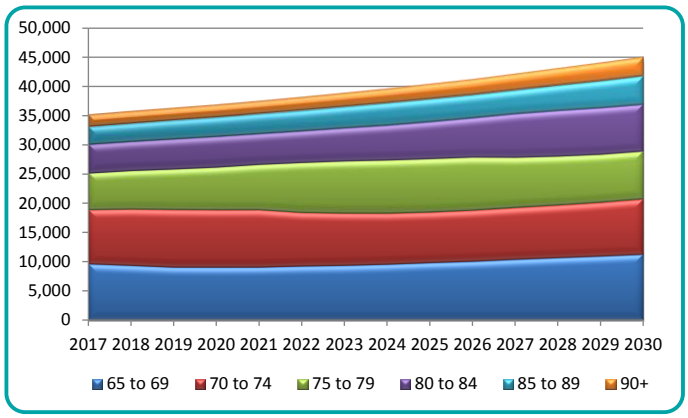
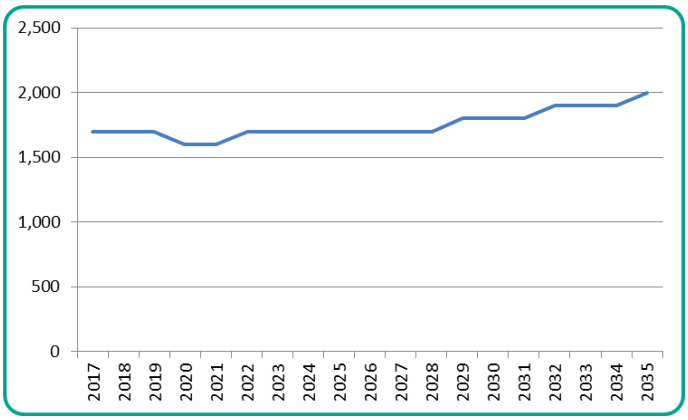


Figure 66: Estimated number of deaths in Torbay



Source: NOMIS, 2016 Mid-Year estimates, 2014 based subnational population projections

How to read the profile: The black line running down the middle of the spine chart is the England average, the circles (to the left or right) are the Torbay value, compared to the England average, The diamonds represent the CIPFA average. The colours are explained in the key.

Figure 67: Ageing and dying well overview profile

ID	Indicator	Measure	Torbay	CIPFA	England	England
	Demography					
1	Age related dependency (2015)	Ratio	43.8	36.1	27.5	8 – 59.9
2	Male life expectancy at 65 years (2013-15)	Years	18.6	18.5	18.7	15.8 – 21.4
3	Female life expectancy at 65 years (2013-15)	Years	21.0	20.9	21.1	18.8 – 23.9
4	Male excess winter deaths (2013-16)	Ratio	34.4	29.4	26.5	-7.1 – 61.1
5	Female excess winter deaths (2013-16)	Ratio	30.0	32.6	29.2	9.1 – 54.1
6	Deaths in usual place of residence (2014-16)	%	54.4	49.9	46.6	24.1 – 68.8
7	Persons living alone (2011)	%	31.4	31.5	31.5	25.9 – 50.8
	Wider determinants					
8	Living in most income deprived areas (2015)	%	16.0	12.5	14.1	0 – 93.4
9	Claiming pension credit (2014-16)	%	16.9	14.5	13.9	5.2 – 34.2
10	Claiming attendance allowance (2014-16)	Rate	146.6	131.5	129.7	78.7 – 192.8
11	CAB debt queries (14/15-16/17)	Rate	8.5	-	-	0 – 0
	Social care and support					
12	Unpaid carers (2011)	%	15.9	14.6	14.3	10.2 – 16.5
13	Bad health with a long-term health problem/disability (2011)	%	12.2	12.5	12.4	6.5 – 23.8
14	Requests for adult social care support (14/15-16/17)	Rate	12,401.7	15,055.0	13,489.7	3,056.8 – 78,677.5
15	Long-term support for learning disability (14/15-16/17)	Rate	182.9	155.0	164.5	0 – 1,029.2
16	Long-term support for physical personal care (14/15-16/17)	Rate	3,552.4	3,555.0	3,803.6	484.7 – 9,102.2
17	Long-term support for mental health (14/15-16/17)	Rate	473.5	425.0	404.1	32.9 – 2,832.8
18	Long-term support for social isolation/other (14/15-16/17)	Rate	155.2	45.0	115.6	0 – 800.2
19	Still at home 91 days after discharge to reablement/rehabilitation services (14/15-16/17)	%	76.5	85.8	82.7	50 – 100
20	Permanent admissions to nursing/residential homes (14/15-16/17)	Rate	546.6	719.0	628.2	188.4 – 1,256.2
	Health and service usage					
21	Prevalence of dementia (2015)	%	6.6	6.4	6.3	0 – 0
22	Prevalence of stroke (2015)	%	2.7	2.6	2.0	1.3 – 3.4
23	Flu vaccination coverage (14/15-16/17)	%	66.7	71.2	71.4	48.6 – 78.1
24	Admissions due to falls (14/15-16/17)	Rate	2,197.1	2,168.7	2,175.6	1,236.8 – 3,425.7
25	Urgent care attendances (14/15-16/17)	DSR	39,857.6	41,412.3	42,206.2	0 – 0
26	Emergency non-elective admissions (14/15-16/17)	DSR	23,082.9	24,236.3	25,106.2	0 – 0
27	Emergency admissions for ACS conditions (14/15-16/17)	DSR	1,846.7	2,004.3	2,007.2	0 – 0
28	Elective admissions (14/15-16/17)	DSR	35,162.3	45,586.8	43,999.7	0 – 0
29	Delayed transfers of care (14/15-16/17)	Rate	5.6	0.0	0.0	0 – 29.4
30	Ambulance 'see and convey' to hospital (14/15-16/17)	DSR	23,473.1	-	-	0 – 0

Sig worse | Sig better | Not sig diff | Sig higher | Sig lower | Sig not calculated | England Average | CIPFA | Q0 to Q1 | Q1 to Q3 | Q3 to Q4

Indicator notes:

1. % of dependents (65+yrs) per working population (15-64yrs) [ONS]
2. Years of male life expectancy aged 65yrs+ [PCMD; ONS; PHE]
3. Years of female life expectancy aged 65yrs+ [PCMD; ONS; PHE]
4. Ratio of extra male deaths (65+) in winter months compared with the expected number of deaths (average non-winter deaths) expressed as % [PCMD; PHE]
5. As indicator above for females. [PCMD; PHE]
6. % of deaths in usual place of residence [PCMD; PHE]
7. % of persons living alone 65+yrs [CENSUS]
8. % of 60+yrs living in areas amongst 20% most income deprived (affecting older people 60+) in England [DCLG]
9. % 60+yrs claiming Pension Credits [DWP; ONS]
10. % 65+yrs claiming Attendance Allowance (in payment) [DWP; ONS]
11. Rate of CAB debt queries per 1,000 65yrs+ pop[Torbay CAB; ONS]
12. % of unpaid carers (care 1+hrs per week) under 65+ years [CENSUS]
13. % 65+yrs with bad health and a long-term health problem/disability [CENSUS]
14. Rate of requests for Adult Social Care (ASC) support for new clients aged 65+yrs per 100,000 population aged 65+yrs [TSDNHSFT; NHS Digital]
15. Rate of ASC long-term support for learning disability aged 65+yrs per 100,000 population aged 65+yrs [TSDNHSFT; NHS Digital]
16. As indicator above for physical personal care [TSDNHSFT; NHS Digital]
17. As indicator above for mental health [TSDNHSFT; NHS Digital]
18. As indicator above for social isolation/other [TSDNHSFT; NHS Digital]
19. % 65+yrs still at home 91 days after discharge to reablement/rehabilitation services [TSDNHSFT; ASCOF- PHE]
20. Rate of permanent admissions to residential and nursing care homes per 100,000 population aged 65+yrs [TSDNHSFT; ASCOF- PHE]
21. % modelled prevalence (local) of dementia 65+yrs [Matthews et al, 2013; ONS]
22. % modelled prevalence (local) of stroke all ages [BHF 2014; ONS]
23. % flu vaccination coverage aged 65yrs+ [PHE]
24. Directly age standardised rate (DSR) of emergency admissions for injuries due to falls per 100,000 65yrs+ [HES- NHSDigital, PHE]
25. DSR ED & MIU attendances per 100,000 65yrs+ population [HES- NHSD; ONS]
26. DSR of emergency admissions per 100,000 65yrs+ pop [HES- NHSDigital; ONS]
27. DSR of emergency admissions for ACS conditions per 100,000 65yrs+ [HES-; ONS]
28. DSR of elective admissions per 100,000 65yrs+ population [HES- NHSD; ONS]
29. Rate of delayed transfers of care aged 18+yrs [ASCOF- PHE]
30. DSR of ambulance call outs taken to hospital per 100,000 65yrs+[SWAST; ONS]

Larger copies of the profiles are available at www.southdevonandtorbay.info/jsna

Highlights from the ageing and dying well overview profile:

- Torbay has a high proportion of dependents (65+yrs) compared to those of working age;
- More people die in their own homes;
- Significantly more are claiming Attendance Allowance for physical or mental disability;
- There are significantly more unpaid carers;
- Less people are still at home 91 days after discharge from hospital (this is a negative);
- There are less permanent admissions to nursing or residential care;
- There is a higher prevalence of stroke;
- Torbay vaccination coverage for flu is worse;
- Admissions for chronic conditions that could be treated in the community are lower.

Long term conditions

People in more deprived communities tend to experience multiple long-term conditions and generally have poorer health outcomes, such as shorter life expectancy.

Long-term conditions are those that, at present, cannot be cured but can be managed through treatment and behaviour. These include conditions such as heart disease, diabetes and mental health problems. People with long term conditions are the most frequent users of healthcare services. Those with long-term conditions account for around 29% of the population, but use around 50% of all GP appointments and 70% of all inpatient bed days. Long-term conditions fall more heavily on the poorest in society: according to ONS people in the poorest social class have 60% higher prevalence of long-term conditions than those in the highest social class. Half of people aged over 60 in England have a long-term condition. With an ageing population and the growth of health harming behaviours such as physical inactivity, harmful alcohol consumption and smoking, we would expect the prevalence of long-term conditions to rise unless checked. The number of people with comorbidities (more than one health condition) is expected to rise by a third in the next ten years.

As our population ages, we expect the number of frail people, people with, for example, limited physical mobility, weakness, weight loss, slowness and low physical activity to increase, specifically in our older age groups. The number of people with dementia is also expected to increase over the coming years. Estimates for the counts of frail people and also those with dementia are presented in figures 68 and 69.

Figure 68: Frailty estimates for Torbay

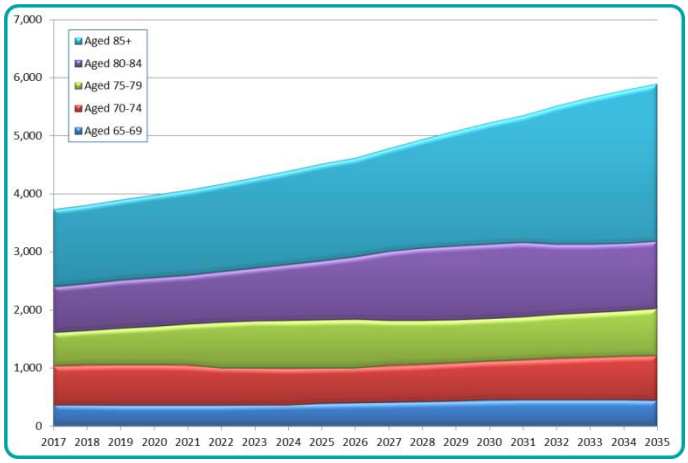
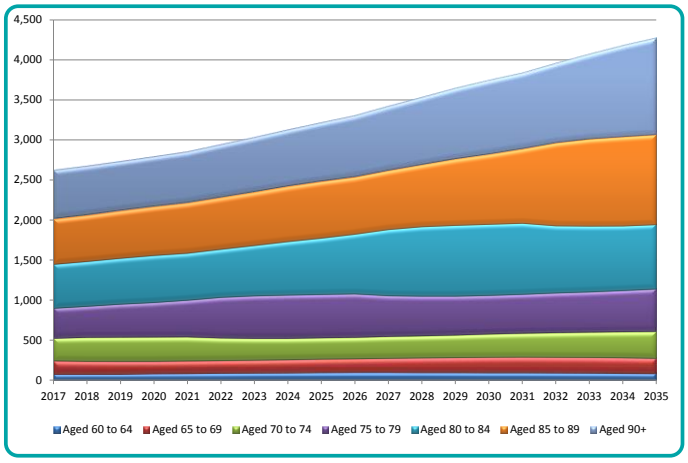


Figure 69: Dementia estimates for Torbay



Source: ONS Sub-National Population Projections, 2014. Prevalence of frailty in community-dwelling older persons (Collard *et al* 2012) and Dementia UK Prevalence Estimates, 2014

Adult social care

Adult social care is defined as including all forms of personal care and other practical assistance provided for individuals aged 18 and over who, by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance [11]. Some people need practical or emotional care or support to lead an active life and do the everyday things that most of us take for granted. The social care system provides this support for those who need it to help them keep their independence and dignity. Adult social care services are commissioned through the upper tier local authorities of Devon County Council and Torbay Council for the South Devon and Torbay population. Provider organisations are responsible for assessing individuals need for 'community care' or 'social care' services [12]. Community Care describes the services and support which help people to continue to live independently at home, whilst social care services help people who are in need of support due to illness, disability, old age or poverty. This could take place in residential settings.

The number of long term residential and nursing placements has been reducing over time as alternative care models are implemented. That is the number of placements that the local authority funds. The monthly trend is shown in fig 70. A model of future demand based on current activity, and allowing for demographic change, suggests a continued slight reduction in LA funded placements (fig 71).

Figure 70: Long term residential and nursing LA funded placements Torbay

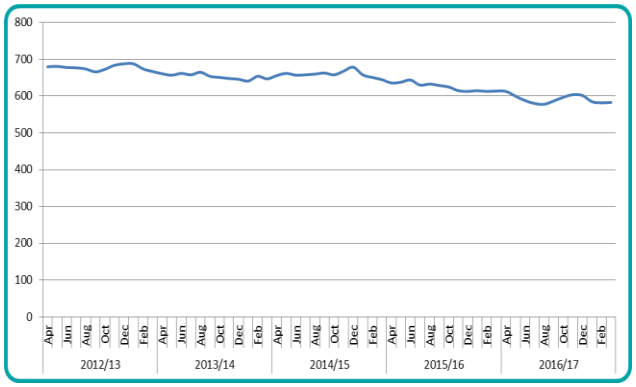
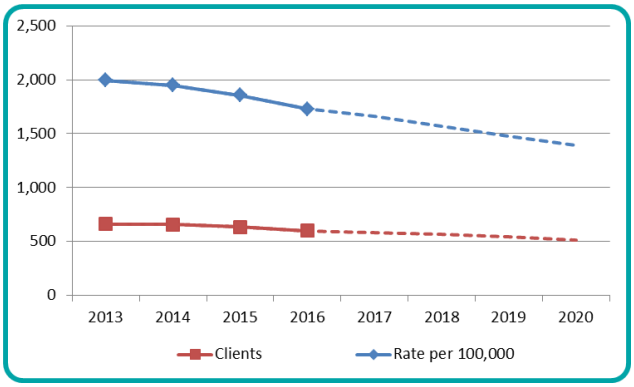


Figure 71: Long term residential and nursing LA funded placements Torbay historical averages and future modelled averages



Source: Torbay and South Devon NHS Foundation Trust

Mortality and end of life

The number of mortalities has increased in recent years in Torbay. The proportion of people dying in hospital has increased slightly, as the proportion dying at home decreased.

Overall of all mortality over the period 1st Jan 2012 to 31st Dec 2016, around 4 in 10 people die in hospital, 3 in 10 in a care home, 2 in 10 at home and 1 in 10 die either in a hospice, or elsewhere.

Around 77% of mortalities in Torbay are expected (fig 73). This suggests a significant need for palliative care, with around 1,370 people dying from expected deaths per year. However, the primary care palliative care register has around 570 people on it, suggesting significant unmet need.

Figure 72: Count of deaths over time by place of death

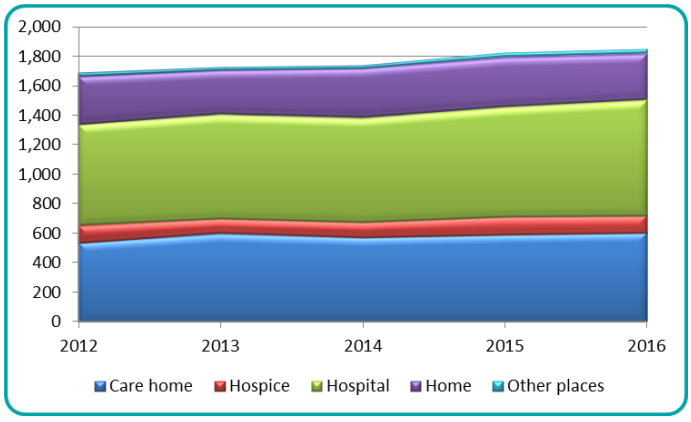
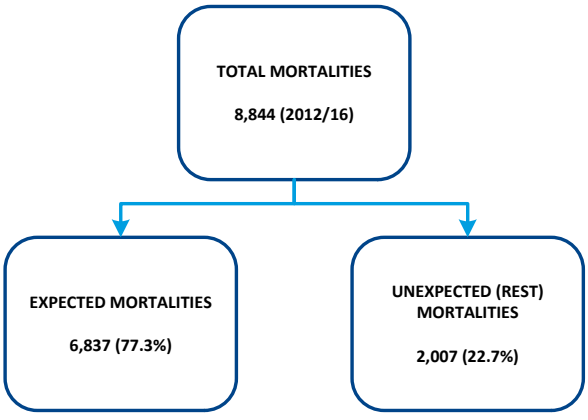


Figure 73: Proportion of mortalities that are expected



Source: PCMD, Murtagh *et al* (2014) [13]

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JSNA
Joint Strategic
Needs Assessment

Public Health Devon

Devon County Council

Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils

2016 - 2017

17 November 2017

PLYMOUTH CITY COUNCIL

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CORNWALL COUNCIL

Council of the ISLES OF SCILLY

TORBAY COUNCIL

Contents

1. Introduction

1.1 This report provides a summary of the assurance functions of the Devon and Cornwall Health Protection Committee and reviews performance for the period from 1 April 2016 to 31 March 2017, for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly.

1.2 The report considers the following domains of health protection:

- Communicable disease control and environmental hazards;
- Immunisation and screening;
- Health care associated infections and anti-microbial resistance.

1.3 The report sets out:

- Structures and arrangements in place to assure performance;
- Performance and activity in all key areas during 2016-17;
- Actions taken to date against the programme of health protection work priorities established by the committee for the period 2016 to 2017;
- Priorities for the work programme 2017/18.

2. Assurance Arrangements

2.1 On 1 April 2013, the majority of former NHS Public Health responsibilities transferred to upper tier and unitary local authorities including the statutory responsibilities of the Director of Public Health. Local authorities, through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. The scope of health protection in this context includes:

- Prevention and control of infectious diseases;
- National immunisation and screening programmes;
- Health care associated infections;
- Emergency planning and response (including severe weather and environmental hazards).

2.2 The Health Protection Committee is formally mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall Council and the Council of the Isles of Scilly.

2.3 The aim of the Health Protection Committee is to provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly that adequate arrangements are in place for prevention, surveillance, planning and response to communicable disease and environmental hazards, required to protect the public's health.

2.4 Terms of Reference for the Committee were agreed by Local Authority Directors of Public Health, their Health Protection Lead Officers, and representatives from Public Health England, NHS England Area Team and the Clinical Commissioning Groups.

2.5 By serving four Local Authorities, the Committee allows health protection expertise from four public health teams to be pooled in order to share skill and maximise capacity. For

external partners whose health protection functions serve a larger geographic footprint, this model reduces their need to attend multiple health protection meetings with similar terms of reference and considers system-wide risk more efficiently and effectively.

2.6 The Committee has a number of health protection subgroups supporting it to identify risks across the health protection system and agree mitigating activities for which the Committee provides control and oversight. As illustrated in **Appendix 1**, these include:

- Devon, Cornwall and Somerset Health Care Associated Infection Network;
- Devon Antimicrobial Stewardship Group;
- Cornwall Antimicrobial Resistance Group;
- Health Protection Advisory Group for wider Devon;
- Cornwall Directors of Infection Control Group;
- Devon, Cornwall and Isles of Scilly Screening and Immunisation Overview Groups;
- Local Health Resilience Partnership.

2.7 Terms of Reference for each of these groups are regularly reviewed to ensure they reflect the assurance arrangements overseen by the Health Protection Committee.

2.8 The Local Authority Lead Officers review surveillance and performance monitoring information in order to identify health protection risks and/or underperformance prior to Health Protection Committee meetings. Officers are responsible for liaising with relevant partners to ensure that actions have been agreed to mitigate against a particular risk identified, or to improve performance. The outcomes of these discussions are formally reported to the Health Protection Committee for consideration and agreement.

2.9 Meetings of the Committee 2016-17 were held on 4 May 2016, 3 August 2016, 2 November 2016 and 1 February 2017.

2.10 A memorandum of understanding, which specifies the roles and responsibilities of the various agencies involved in Health Protection, is in place.

3. Prevention and Control of Infectious Diseases

Organisational roles and responsibilities

3.1 NHS England is responsible for managing and overseeing the NHS response to an incident, ensuring that relevant NHS resources are mobilised and commanding or directing NHS resources as necessary. Additionally, NHS England is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.

3.2 Public Health England, through its consultants in communicable disease control, will lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents and has responsibility for declaring a health protection incident, major or otherwise.

3.3 The Clinical Commissioning Group's role is to ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening/diagnostic and treatment services) although financial arrangements have yet to be finalised.

3.4 The Local Authority, through the Director of Public Health or their designate, has overall responsibility for the strategic oversight of an incident or outbreak which has an impact on their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England, supported by the Clinical Commissioning Group. In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health, and that risks have been identified, are mitigated against, and are adequately controlled.

Surveillance Arrangements

3.5 The Public Health England Centre provides a quarterly report for its catchment: Devon, Cornwall and the Isles of Scilly and Somerset. The report provides epidemiological information on cases and outbreaks of communicable diseases of public health importance. A quarterly report is also produced at council level.

3.6 Fortnightly bulletins are produced throughout the winter months, providing surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus. These bulletins report information for the Public Health England Centre geography (Devon, Cornwall and the Isles of Scilly, and Somerset).

3.7 The Health Protection Advisory Group, convened quarterly, provides a forum for hospital microbiologists, environmental health officers, consultants in public health and infection control nurses to share intelligence, and any risks identified in local arrangements to manage communicable disease incidence.

Disease outbreaks and incidence 2016-17

Measles

3.8 There were 50 confirmed cases of measles across Devon, including Torbay and Plymouth, in 2016/7, with an additional number of suspected cases. Only two confirmed cases were reported in Cornwall. Cases were noted initially in teenagers in an area of South Devon with low MMR uptake, and spread across the whole county with transmission being noted at festivals. Measles outbreaks were seen in other areas of England in 2016/7.

Hepatitis A

3.9 In 2016 a large outbreak of hepatitis A was seen across Europe, predominantly affecting men who have sex with men (MSM). Cases of acute hepatitis A were seen in Devon and West Cornwall that were linked to this outbreak. Nationally, vaccine recommendations were made and disseminated to genito-urinary medicine clinics in an attempt to reduce ongoing transmission.

Cryptosporidium

3.10 189 cases of cryptosporidium were diagnosed across Devon, Torbay and Plymouth in 2016/7, representing a year-on-year increase from 2013/4 onwards, consistent with the national picture. 112 cases were diagnosed in Cornwall. In an attempt to better understand the risk factors for this increase, a pilot of the use of an online questionnaire is being conducted across some of the South West local authorities.

Influenza incidence and outbreaks in care homes

3.11 Rates of reported influenza and flu-like illness were largely consistent with the national picture. In the 2016/7 influenza season to the end of March 2017, there was a large number of reported influenza outbreaks in care homes in Devon (18 outbreaks) and Torbay (six), with only one in Cornwall and none in Plymouth. Work is ongoing to assess levels of staff immunisation uptake in care homes, with a view to improving this for 2017/18 onwards. Influenza rates are shown in **Appendix 2**.

Meningococcal infection

3.12 During April 2016 to March 2017 there were ten cases of probable or confirmed meningococcal disease in both Devon and Cornwall, seven in Plymouth and six in Torbay. The graphs in **Appendix 2** show the rates for Devon, Plymouth, Torbay and Cornwall compared to the overall rate across the Public health England South-West centre area. It should be noted that large variations are seen in areas with small populations (such as Torbay) as a result of a small number of cases.

Tuberculosis

3.13 As of 2015 the incidence of tuberculosis across the South-West of England remained low compared to the average for England. The figure and table in **Appendix 2** demonstrate the average incidence rate by local authority from 2013-2015.

Norovirus and gastroenteritis

3.14 Incidences of norovirus and gastroenteritis were relatively high for Cornwall, low for Devon, and consistent with the England average in Torbay & South Devon, and Plymouth. Rates of norovirus and gastroenteritis are shown in **Appendix 2**.

Scarlet fever and invasive Group A Streptococcus (iGAS)

3.15 In 2016/7 there were 315 suspected or confirmed cases of scarlet fever reported across Devon, Torbay and Plymouth, largely consistent with the previous two years and just below the South West average. Numbers of invasive Group A Streptococcus (iGAS) were consistent with those seen in the preceding two years for Devon, Cornwall and Torbay, whereas Plymouth had 24 cases compared to 11 in 2015/16 and 13 in 2014/15. Rates are shown in **Appendix 2**.

4 Immunisation and Screening

Organisational Roles/Responsibilities

4.1 NHS England is accountable for all national screening and immunisation programmes commissioned via the Section 7A arrangements. NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and newborn programmes that are part of Clinical Commissioning Group Maternity Payment Pathway arrangements, although NHS England remains the accountable commissioner. A list of all national screening programmes is included at **Appendix 4**.

4.2 Public Health England is responsible for setting national screening and immunisation policy and standards through expert groups (the National Screening Committee and the Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff in Screening and Immunisation Teams, employed by Public Health England, work alongside NHS England Public Health Commissioning colleagues to provide accountability for the commissioning of the programmes, and system leadership.

4.3 Local Authorities, through the Director of Public Health, are responsible for seeking assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local populations. Public Health Teams are responsible for both protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting Public Health England in projects that seek to improve programme coverage and uptake.

Assurance Arrangements

4.4 Public Health England South West Screening and Immunisation Team provides quarterly reports to the Devon, Cornwall and Isles of Scilly Health Protection Committee for each of the national immunisation and screening programmes. Due to the nature of the programmes and the NHS England and Public Health England data capture and validation processes (with the exception of the seasonal influenza vaccination programme) real time data are not available for all programmes and for some programme reports are up to two calendar quarters in arrears. Reports are considered by lead Local Authority Consultants in Public Health and any risks identified are considered with Public Health England specialists to agree mitigating activities.

4.5 Serious incidents that occur in the delivery of programmes are reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

4.6 There are oversight groups (Programme Boards) for all screening programmes, and these form part of the local assurance mechanisms to identify risks to delivery. In addition, specific project groups are convened as necessary to oversee significant developments in the programmes and the introduction of new programmes. For all immunisation programmes, oversight and assurance is achieved through a multiagency locality immunisation group, one for each local authority area. In addition, there is a separate Seasonal Influenza Immunisation Board for the Devon, Cornwall and Isles of Scilly area. All the oversight groups have terms of reference and clear escalation routes to ensure accountability both within NHS England and Public Health England and into individual partner organisations.

Immunisation performance 2016-17

4.7 Immunisation performance throughout 2016-17 is detailed in **Appendix 3.** This data is taken from the national coverage statistics, which for the first time this year is accompanied by an interactive web-based data dashboard that allows users to visualise vaccine coverage data down to local authority level and has local and national trends for the years 2013-14 to 2016-17. The dashboard can be accessed via the link below:
National annual childhood immunisation coverage 2016/17

Key points include:

- Coverage of childhood immunisations continues to be high in Plymouth, Devon and Cornwall (mostly over 90%) but the national target of 95% is not being met for several of the programmes.
- Performance across the range of childhood immunisation programmes is generally stable. However, coverage is variable and requires continued attention to ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases.
- MMR (Measles, Mumps and Rubella) coverage at 5 years has improved gradually over time and is now over 90% for all doses in all three local authority areas. Herd immunity with coverage of 95% or above is achieved for: Cornwall MMR1 at 2 years, Plymouth MMR1 at 2 years and 5 years, Devon MMR1 at 5 years.
- Rotavirus coverage in Devon (82.7%) is significantly lower than the England average (89.6%). This is an outlier and requires further investigation. This immunisation is time-limited as the first dose has to be given no later than 15 weeks and the second dose (which must be at least one month after the first dose) must be given no later than 24 weeks of age. If there is a delay in invitation or attendance for the immunisation, the baby will not be able to be vaccinated.
- Immunisation coverage is reported quarterly and in-year variation is not uncommon. Investigations suggest that these are in the main due to data issues rather than true variation in uptake. This is in part because of the challenges with manual call-recall and data flow processes between GP practices and other immunisation providers and the local Child Health Information Services (CHIS).
- HPV (Human Papilloma Virus) coverage in Devon is in line with the national rates. Coverage for the 2016/17 academic year is due to be published in Autumn 2017.
- HPV coverage in Cornwall has historically been reported as low. Up until September 2016, all school-aged immunisations were delivered in GP practices, and the programme was run over a whole 12 month period. As a result, not all immunisations were captured in the national reporting process and this has in part explained the lower uptake. From September 2016, all school aged immunisations in Cornwall are now delivered in the school setting and it is hoped that the 2016/17 data, when published, will report rates more in line with regional and national averages.
- The 2016/17 annual data for Shingles is awaited. Uptake has been static with rates averaging around 50-60% (2015/16 England rate is 54.9%). Work is underway to support practices to increase uptake (see below).
- Highlights of the influenza vaccination uptake in 2016/17 were:
    - A large increase in uptake of vaccination in frontline healthcare workers in all providers except Cornwall GP practices - almost certainly due to the national CQUIN;

- An increase in uptake in children, particularly in the school age programme (exceptions were children aged 4 in Cornwall, and year 2 children in South Devon and Torbay);
- A small increase in uptake across all adult groups with a few exceptions.

Developments in national immunisation programmes during 2016-17

Childhood immunisations

4.8 Meningitis B was introduced in the routine schedule in September 2015 and coverage, as expected, has continued to be high during 2016/17.

4.9 Although uptake in Plymouth, Devon, Cornwall and the Isles of Scilly is generally good, nationally there is a small downward trend in uptake of childhood immunisations. A national group has been set up to review the evidence for improving uptake and to make recommendations for action. Locally, these actions will be incorporated into the work of the locality immunisation groups.

4.10 As part of the work the Screening and Immunisation Team is doing to support an improvement in coverage and reduction of inequalities, a South West needs assessment for 0-5 year old vaccinations and a survey of GP practices have been completed. The main recommendations for Plymouth, Devon, Cornwall and Isles of Scilly included a need to better understand some of the inequalities in the area, a focus on MMR by the age of 5 (this will also have a knock on effect on improving uptake for the other ages), improving data flows between Child Health and GP practices, targeted support for practices with low uptake, and improving awareness in general practice of immunisation training. These findings are being considered by the locality immunisation groups and will result in more targeted action plans in each area.

4.11 Nationally, MMR has been agreed as a priority and a UK Measles and Rubella Elimination Strategy, the UK contribution to the WHO European regional target to eliminate both measles and rubella infections by 2020, is being developed. NHS England 2017/18 commissioning intentions support this work. The Screening and Immunisation Team is working through the locality immunisation groups to develop robust multiagency action plans to achieve 95% MMR coverage and address low uptake generally. The recommendations of the needs assessment are informing these plans. The local work and strategy have been used to inform the recently published MMR Spotlight report. This highlights the need for a multiple, individualised, and a “never too late” approach, as the parents declining MMR and other childhood immunisations are not a single homogenous group.

4.12 In Sept 2017, the World Health Organisation (WHO) confirmed that the UK, as at the end of 2016, is among 42 of the 53 countries within the WHO European Region that have achieved ‘measles elimination’. Elimination is defined an absence of endemic measles transmission for a period of at least 12 months. In practical terms this means that there is evidence of interruption in transmission of infections when a case occurs, such that there are either no further cases in the contact group or only a small number of cases and no spread of infection into the wider community. This is a significant achievement and reflects the continued work by many partners nationally and locally to continue to drive uptake upwards, and to achieve and then maintain 95% coverage of the MMR vaccine and herd immunity. Over the past three years, there have been several thousand cases of measles across the UK, and a handful of deaths, and these are all likely to have originated from overseas. It is important to remember that although measles is no longer endemic to the UK, measles cases continue to occur as a result of infections from abroad,

and that unvaccinated individuals and communities continue to be vulnerable, so the work to maximise coverage needs to continue.

Targeted immunisations – Hepatitis B and BCG

4.13 The Screening and Immunisation Team has developed a robust pathway and failsafe process to follow-up babies born to Hepatitis B positive mothers to try to ensure all infants complete the full schedule, thus minimising the risk of contracting the infection. The Screening and Immunisation Team has also launched the dried bloodspot scheme for Hepatitis B serology testing at 12 months, which it is hoped will result in greater uptake of the test.

4.14 During 2016, there was an international shortage of BCG (Tuberculosis) vaccine. This situation continues to be managed by the National Immunisation Team. An interim alternative supply of a UK unlicensed vaccine was secured, and in order to minimise the impact and protect the most vulnerable, national priority groups were agreed. Vaccine has primarily been restricted to the infant neonatal programme as they are at greatest risk from infection. Since August 2017, a new supply of UK licenced vaccine has become available. This will remain restricted to the highest priority groups and catch-up for children up to age 12 months in the first instance, and then children up to six years.

School aged immunisations

4.15 In September 2016, delivery of school aged immunisations in Cornwall moved to a school setting, following a procurement process for this service. All areas of the South (South West) now have school-based delivery. It is hoped that this will lead to further improvement of uptake rates.

4.16 2016/17 was the last academic year of the MenACWY (Meningitis) catch-up for Year 11 (school based) and Year 13 (GP based) vaccinations. From September 2017, Td/IPV (teenage booster) will move to Year 9 school based vaccination and will be delivered alongside the routine MenACWY cohort.

Child Health Information Services (CHIS)

4.17 NHS England/Screening and Immunisation Team has set up quarterly CHIS monitoring meetings to formalise the governance of CHIS services. These include monitoring of key performance indicators, and quality audits.

4.18 The Screening and Immunisation Team has been working with the South West Child Health Information Service (CHIS) Managers' Communities of Practice Group to improve the CHIS immunisation call-recall processes and pathways, and standardise these as far as possible across the South West.

4.19 The timeliness and comprehensiveness of immunisation information sharing between GP practices and CHIS, and the internal CHIS processes, can have a significant impact on the quality of nationally reported data and can account for some of the variation in coverage over time. The Screening and Immunisation Team has therefore been working closely with several of the CHIS teams as they have undertaken detailed work to review processes and to synchronise data between practices and to improve the timeliness of return of immunisation data by GP practices to CHIS. It is expected that this will help to improve coverage rates. The Screening and Immunisation Team is liaising closely with the relevant Local Medical Committees, some of whom have raised concerns, and will continue to keep them up to date with progress.

Adult immunisations

Pertussis and flu vaccination in pregnancy

4.20 Pertussis vaccination in pregnancy was introduced in England in 2012 as an outbreak response to a nationwide rise in pertussis infections and deaths in the very young. Due to ongoing infection rates and deaths, the programme has been continued. The most recent national data, extracted from 93% of GP systems across the South West, shows that uptake in 2016 has significantly increased and is at its highest level of 76.4%. This is higher than the England average. It is thought that this increase is due to the change in policy that means immunisation can be given earlier, from 16 weeks gestation, although it is normally given after the mid trimester foetal anomaly scan. The Screening and Immunisation Team has been working closely with the Children and Maternity Strategic Clinical Network to improve uptake of all vaccinations in pregnancy, through enhanced partnerships between primary care and maternity, and awareness training for midwives.

Shingles

4.21 For the past year, the Screening and Immunisation Team has been feeding back practice level rates to GP practices to encourage additional activities to target eligible patients, and using national resources to promote the eligible age cohorts with the public. As uptake rates remain static, plans are being made for additional work during 2017/18, and these will come to the locality immunisation group for tailoring to each local area.

Influenza Immunisation

4.22 In 2016/17, the key changes in the South West seasonal flu programme were the successful expansion of the child flu programme to include all children aged 2, 3 and 4, and to all children in school years 1, 2 and 3. Also, the Community Pharmacy Seasonal Influenza Vaccination programme was recommissioned after a successful first year in 2015/16, when almost 250,000 additional patients chose to receive vaccinations in a community pharmacy.

Key issues for immunisation programmes in Plymouth, Devon, Cornwall and Isles of Scilly in 2017/18

4.23 In August 2017, universal Hepatitis B vaccination is to be introduced in to the primary immunisation schedule. This will be via a new hexavalent vaccine. The current targeted neonatal immunisation programme for babies born to Hepatitis B positive mothers will remain.

4.24 The national CHIS digital strategy was launched in 2016. This is likely to have a significant impact on the model of CHIS services in the future and the way that parents are offered immunisations for their children. It will also increase the efficiency of data sharing processes and lead to improvements in the timeliness and accuracy of immunisation data. The aim of the strategy is to achieve full interoperability between CHIS and GP practices and other related systems and to achieve web-based access to parents and professionals working with children. In the South West, NHS England will be reviewing service specifications to ensure that as this work evolves, providers of CHIS services and child health IT services develop services to meet the requirements of the digital strategy. The strategy includes a move to an electronic Red Book (Parent held Child Health Record).

4.25 During 2017/18, NHS England will be undertaking a procurement for CHIS services (for the whole of the South (South West) area, and for school aged immunisations (for Bristol, North Somerset and South Gloucester and Devon).

4.26 To further increase uptake of pertussis and flu vaccination in pregnancy, the Screening and Immunisation Team will be working with all maternity units and hopes to achieve a primarily maternity-based delivery model for pertussis and flu in pregnancy rather in general practice. It is envisaged that by offering immunisation as part of routine obstetric care that this will enable more women to take up the offer of immunisation. This has already been piloted in some maternity units and it is hoped that by the end of 2017/18 all providers will have introduced this new offer.

4.27 To improve the uptake of shingles vaccination, during Autumn 2017 the Screening and Immunisation Team will be providing GP practices with their individual practice level uptake data and a newly developed resource pack including policy updates on changes to eligibility, a best practice guide that outlines key actions to improve uptake, and a range of Public Health England promotional materials. The resource pack is being developed from best practice across South West GP practices that are achieving high vaccine uptake. The Screening and Immunisation Team is also planning a patient facing communications campaign, supported by the NHS England Communication Teams, to raise awareness and increase demand from the public.

4.28 At the end of the influenza season, a South West stakeholder debrief meeting for all parts of the programme was held and priorities for 2017/18 identified by consensus:

- Care home and housebound patients: strengthening commissioning of split services payments;
- Social care staff: joint research project to look at how to increase uptake planned (NHS England, PHE Field Epidemiology Service and PHE National Flu Lead);
- Childhood flu programme: reception age, special schools, under 2s at risk;
- Pregnant women: commissioning maternity services to deliver immunisation, GP/ Pharmacy collaborative working pilot based on lessons from the Beacon practice in Plymouth;
- Hard to reach groups: looked after children, traveller groups;
- Deep dive work to identify why uptake rates tend to be lower in south of the South West compared to the north of the patch.

4.29 Active support from Local Authority colleagues and teams for the locality immunisation groups is important to ensure that work to increase the overall uptake of MMR and other immunisations and to reduce local inequalities in uptake is being appropriately targeted, and that best use is being made of all available resources to achieve the population coverage targets.

Screening performance 2016-17

4.30 Screening coverage 2016-17 for the main cancer and non-cancer screening programmes is detailed in **Appendix 5**. Key points are:

- Performance in antenatal screening programmes continues to be excellent.
- Performance in certain aspects of the newborn screening programmes continues to be a challenge. The avoidable repeat rate was high, but provider action plans are in

place and are now having an impact, with improving performance. The roll-out of the NIPE (Newborn Infant Physical Examination) SMART IT system is helping to increase the robustness of the failsafe processes, ensuring all babies are identified and offered screening.

- Diabetic Eye Screening coverage remained stable in all areas in 2016 and was also above the national target of 80%.
- Cervical screening coverage remains below the national target of 80% in all areas, with a decrease in Cornwall to 75.7% in 2016. All areas, however, remain above the national average.
- Breast screening coverage in 2016 is stable in Cornwall at 80%, meeting the national target of 80%. In Devon, coverage has reduced slightly below target to 78.8% but this remains above the national average.
- Bowel screening coverage increased in 2016 in all areas and also remains above the national target of 60% and above the national average.
- Performance in the abdominal aortic aneurysm (AAA) screening programmes continues to be excellent, and coverage is stable and meets acceptable national standards.

Developments in national screening programmes during 2016-17

4.31 The key changes and developments during 2016-17 included:

Antenatal and Newborn

4.32 Antenatal screening for rubella ceased on 1st April 2016. Instead there is renewed focus on improving Measles Mumps and Rubella (MMR) immunisation uptake across the whole population as a more effective way of preventing congenital rubella infection.

4.33 In the Foetal Anomaly Screening Programme, screening for Trisomy13 and Trisomy18 was introduced to the combined first trimester screening test, and the 3-vessel/trachea (3VT) screening was introduced into the mid-trimester foetal anomaly scan.

4.34 There were ongoing challenges due to pressures locally and across the country in obstetric ultrasound capacity due to the introduction of new national maternity guidelines for babies small for their gestation age. This has at times had an impact on completing screening scans in the correct timeframe. Work has been undertaken with providers to enhance tracking and failsafe systems to ensure that all women are offered a scan at the correct gestation and to follow-up women if they do not attend. A new key performance indicator was introduced in April 2017 to monitor performance of this part of the screening pathway. A national working group has been set up to look at obstetric radiology capacity.

4.35 Newborn bloodspot screening on day 5 is mostly undertaken by community midwives. There is a drive to minimise the avoidable repeat rate to a very low level. Despite best efforts, in Devon, Cornwall and Isles of Scilly providers have found it very challenging to reduce this to the nationally acceptable level of 0.5%. The Screening and Immunisation Team has been closely monitoring performance in this area and the 2016/17 and 2017/18 service specifications have required all providers to develop detailed action plans, which have been monitored via the Screening Programme Boards. NHS England South (Southwest) has offered a local CQUIN for 2017/18 and 2018/19 with the aim of reducing repeat rates to below 2%. The newborn bloodspot laboratory also reviewed its processes and set up a new laboratory PO Box to minimise delays within the hospital.

4.36 The Newborn and Infant Physical Examination (NIPE) screening programme saw the roll-out of the new IT system, NIPE SMaRT. This, for the first time, has provided a systematic and robust way of identifying the eligible cohort for the NIPE examination, for recording screening results, referral in to diagnostic services and outcomes, and for failsafe. The Royal Cornwall Healthcare Trust, as part of the implementation of NIPE SMaRT, from April 2017 has introduced a maternity led NIPE service, and GPs no longer undertake this examination on a routine basis. This enables the Head of Midwifery to have oversight of the whole screening pathway. Shared learning from a number of incidents in the NIPE programme has led to improvements in provider screening policies and procedures.

4.37 The move from Health Visitor registered to resident populations required the Newborn Hearing Screening Programme teams to work together to address boundary changes and ensure all babies were offered screening. In addition, the new national IT screening system, Smart4Hearing (S4H) went live in December 2016. Both these transitions were achieved without disruption to patients and screening services.

4.38 Quality assurance visits for antenatal and newborn programmes have continued and all of the Devon, Cornwall and Isles of Scilly programmes will have been visited by the end of 2018. As these are the first round of formal quality assurance visits, all programmes have had significant numbers of recommendations, but the visits have not identified any immediate areas of concern and show that in the main, programmes are delivering high quality and safe screening services that meet national standards.

Diabetic Eye Screening

4.39 Diabetic eye screening programmes continued to perform well across the area, with few issues or incidents. One significant development was the re-procurement of the Plymouth programme that became necessary as the incumbent provider gave notice on the contract. The transition to the new provider on 1 April 2017 went smoothly with no disruption to patients.

4.40 The Screening and Immunisation Team has been working closely with the provider teams to facilitate an improvement in the accuracy and completeness of screening registers. These rely on information being shared and validated by both the GP practice and the screening team. Audits have been undertaken to assess accuracy, and work to improve this has been undertaken where needed.

Cervical screening

4.41 The cervical screening programmes in the South West have continued to perform well with no significant issues or incidents. Reducing coverage has been the main issue over several years, with local rates mirroring the slow but consistent reduction in national rates. The Screening and Immunisation Team has identified cervical screening coverage as a priority and has targeted work to groups where uptake is lowest.

4.42 Sample-taker training and its effective oversight is a critical factor in the quality and safety of the screening programme. The Screening and Immunisation Team has reviewed and updated the training policy, including escalation procedures, and created a single South West sample-taker database to ensure that all sample-takers are registered, have a unique ID code to track samples, and are alerted to when they need to update.

Breast screening

4.43 Breast screening services in Devon, Cornwall and the Isles of Scilly continued to meet the majority of the national minimum standards but have struggled to maintain consistent performance in some key areas, such as time between screening and assessment. There has been significant and continued pressure on the programmes due to a combination of demand from the symptomatic service and capacity pressures within screening teams due to shortages of key staff (radiographers, radiologists, and specialist breast care nurses). This is a national problem that is starting to affect many programmes across the country. The workforce issue has been escalated nationally and a working group is developing options to address the issue.

4.44 In some areas, the increasing number of GP practice mergers and closures is having a negative impact on round length. As breast screening is a three yearly cycle, women who have to re-register, or move into a new practice due to a merger, may have their screening invitation date delayed depending on where the practice is the three year cycle. These women have to be slotted in to already busy routine lists across the area, creating pressure on the service and impacting temporarily on key performance measures. This issue is affecting all areas of the country and has been escalated nationally. Potential solutions are being investigated for the service and also to track affected women to ensure screening is offered within the appropriate timescales as far as possible.

Bowel screening

4.45 There continues to be a lot of activity in the bowel screening programme. This is primarily due to the continued roll-out of Bowel Scope screening and ongoing work to maintain delivery to national standards in the face of a national shortage of endoscopists and radiographers that have created significant pressures within colonoscopy services. Providers have so far maintained key indicator performance despite these challenges.

4.46 Bowel Scope has been successfully implemented in Torbay, North Devon and Exeter, and Plymouth is due to roll-out in November 2017. Planning is advanced in Cornwall with an original go-live date of November 2017, however the closure of the Bodmin Treatment Centre has meant that the bowel screening services have had to be relocated back to Royal Cornwall Hospital and this may delay introduction of bowel scope screening.

Key issues for screening programmes 2017/18 onwards

Antenatal and newborn

4.47 The National Screening Committee has announced the introduction of NIPT (non-invasive pre-natal testing) into the first trimester foetal anomaly screening programme. Women who screen positive in first trimester combined testing, will be offered NIPT instead of invasive testing. A national implementation team is in place to oversee the change but there is no date yet for implementation. A big reduction in the number of invasive diagnostic tests (amniocentesis and CVS) is expected and this is likely to have an impact on foetal medicine services. NIPT is already available privately and maternity services are dealing with increasing numbers of women requesting NIPT, who are being referred on.

4.48 High newborn bloodspot avoidable repeat rates continues to be a national issue. The national screening team in conjunction with the Screening Quality Assurance Service has set up a project to look at this issue (working with the best performers) to identify best practice that can be shared. Local provider action plans will be updated in light of this learning from elsewhere.

Diabetic Eye Screening

4.49 The roll out of a new national system, GP2DRS, has commenced in some areas and is expected to be completed during 2017/18. This will automatically extract patient data from GP systems into the local screening register, replacing the current manual information and data validation processes. This is a very positive move but accuracy of screening registers will continue to rely heavily on correct coding by GP practices of eligible patients. Recent audits by the Screening an Immunisation Team show that coding is not always correct, so work will still be needed with GP practices to improve coding. This issue has been escalated to the national team.

4.50 A national decision is awaited about a change from the current annual screening interval to a two year interval. At this stage, it is not anticipated that this will take place during 2017/18.

Cervical screening

4.51 In July 2016, the National Screening Committee announced that primary HPV testing was to be introduced during 2018, with a full roll-out by 2019. Women will have samples taken in the same way, but rather than initial cytology followed by HPV testing if cytology is abnormal, the initial test will be for HPV infection with subsequent cytology only for samples that are found to be positive for high risk HPV infection (HR-HPV). Primary HPV testing enables the programme to more effectively identify women at higher risk of developing cervical cancer so that they can be investigated and kept under surveillance, and returns more women at lower risk back to routine screening, reducing the number undergoing unnecessary enhanced screening.

4.52 One impact of primary HPV testing is that the demand for cytology testing will decrease significantly. As part of the implementation, there is therefore to be a reduction in the number of cytology labs. A national procurement is underway and the final numbers of labs has yet to be announced. This has created immediate risks to the sustainability of the current cytology service due to staffing losses and a significant deterioration in lab turnaround times. This is a national risk and national and local mitigation plans have been put in place to try to minimise the impact on reduced turnaround times so that women do not experience too long a delay before receipt of results.

4.53 In addition to the lab re-configuration, primary HPV testing requires significant changes to the screening IT system (currently known as the Exeter system). The screening call-recall function transferred to CAPITA in April 2016 as part of the primary care services procurement, and as part of this contract, CAPITA are designing a new screening IT platform. This will go-live ahead of primary HPV testing.

4.54 A national decision is awaited about a possible change to screening intervals (currently three or five years depending on age) following the introduction of primary HPV testing.

Bowel screening

4.55 A national decision has been taken to replace the current Faecal Occult Blood Test (FOBT) by the FIT test (Faecal Immunochemical Test) and this is due to be rolled out by 2019. National discussions are ongoing to plan the implementation. This includes testing parameters and cut offs that are due to be agreed in the near future. These are important as they will potentially determine the impact of this change on demand for services and on the capacity required to deliver, and will need to be built in to local plans for endoscopy services.

5 Health Care Associated Infections

Organisational roles and responsibilities

5.1 NHS England sets out and monitors the NHS Outcomes Framework which includes Domain Five (safety): treating and caring for people in a safe environment and protecting them from avoidable harm. The Area Teams of NHS England hold local Clinical Commissioning Groups to account for performance against indicators under this domain, which includes incidence of healthcare associated methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and incidence of *Clostridium difficile* infection (CDI).

5.2 Public Health England, through its consultants in communicable disease control, leads the epidemiological investigation and the specialist health protection response to wider community non-hospital outbreaks, and is responsible for declaring a health protection incident.

5.3 The Clinical Commissioning Group's role is to ensure through contractual arrangements with provider organisations that health care associated infection standard operating procedures are in all provider contracts and are monitored regularly. Northern Eastern and Western Devon and South Devon and Torbay Clinical Commissioning Groups deploy this role through the Nursing and Quality portfolio. NHS Kernow Clinical Commissioning Group employs a nurse consultant for health care associated infections. This is an assurance and advisory role. In addition, Clinical Commissioning Groups must be assured that the Infection Prevention and Control Teams covering the hospital and NHS community healthcare provided services sector are robust enough to respond appropriately to protect the local population's health, and that risks of health care associated infection have been identified, are mitigated against, and are adequately controlled.

5.4 The Local Authority through the Director of Public Health or their designate has overall responsibility for the strategic oversight of a health care associated infection incident affecting their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England, supported by the Clinical Commissioning Group.

Health Care Associated Infection forums

5.5 The Devon Health Care Associated Infection Programme Group was a sub-group of the Health Protection Committee during 2014-17, working towards the elimination of avoidable health care associated infections (HCAI) for the population of Devon, including the Unitary Authorities of Plymouth and Torbay. The group covered health and social care interventions in clinical, home and residential care environments, through the identification of risks, the planning of risk mitigation actions, and the sharing of best practice in the field. The group was coordinated by NEW Devon Clinical Commissioning Group, and was a cross-agency forum involving Acute and Community NHS Trusts, Ambulance and Out of Hours Doctors, Local Authority Public Health Public Health England, Medicines Optimisation and the NHS England Area Team.

5.6 In Cornwall there is a Directors of Infection Control Group with multi-agency attendance working on a similar agenda and also reporting into the Health Protection Committee. There is also cross attendance between the Devon and Cornwall groups.

5.7 The Devon Health Care Associated Infection Programme Group annual workshop was held on 5 July 2016. The lack of a community infection prevention, management and control service was highlighted as a potential risk.

5.8 The Devon Health Care Associated Infection Programme Group became the Devon, Cornwall and Somerset Health Care Associated infection Network at the beginning of 2017/18.

5.9 Key areas for action in 2017/18 are:

- Community infection prevention, management and control;
- Gram negative bacteraemia reduction;
- Continued monitoring of health care acquired infection by Clinical Commissioning Group area for C.difficile infection, MRSA, MSSA and E.coli;
- Outbreak monitoring to ensure timely patient transfers, system flow and resilience.

Healthcare association infections incidence 2016-17

5.10 Healthcare associated infection incidence is given in **Appendix 6**. Key points are:

MRSA

The national target for MRSA is no cases. Four cases of MRSA were reported in NEW Devon, two in South Devon and Torbay, and seven in Cornwall, in 2016/17. All were investigated and processes reviewed.

MSSA

Rates of reported MSSA were within target levels. Reported community-acquired MSSA bacteraemia rates in NEW Devon increased in the final quarter of the year and this trend is being investigated.

C.difficile infection

Numbers were in line with targets in Devon, with Cornwall exceeding the target by one case, reflecting the impact of significant work by all organisations to reduce rates.

E.coli bacteraemia

E.coli bacteraemia rates, chiefly community acquired, were static or increasing during the year and are a target for infection prevention and control work in 2017/18. Efforts are focused around urinary sources including catheter use, hydration, training, and improving communications between acute and community settings when patients are transferred.

6 Anti-microbial resistance

Data and trends

6.1 A monitoring report is included at **Appendix 7**. Key points are:

- There has been an increase in gram-negative bloodstream infections (eg. E.Coli and Klebsiella) both nationally and locally, with a related increase in antibiotic resistance. Resistant E.coli particularly affects older people and infants;

- The Secretary of State for Health has announced an ambition to reduce gram-negative bloodstream infections by 50% by 2021. Surveillance of these organisms changed from April 2017 to include Klebsiella and Pseudomonas;

- Carbopenamase producing organisms, resistant to certain anti-microbials, remain relatively uncommon but are continuing to increase year on year, including in the Peninsula. Public Health England has confirmed with hospitals within the region that they are confident in following procedures for dealing with cases identified.

System-wide action to address anti-microbial resistance

6.2 A successful antimicrobial resistance steering group has been in place in Cornwall for a number of years and there is now a similar group covering NEW Devon and Torbay.

6.3 The Cornwall Antimicrobial Resistance Group was set up in January 2013 and is chaired by Denis Cronin, Public Health Consultant, and convenes five times a year.

6.4 Outputs from the Cornwall Antimicrobial Resistance Group include the launch of the Antimicrobial Resistance (AMR) section of the Kernow CCG webpage, the availability of primary care antibiotic guidelines in mobile phone application format, and the appointment of two Drug and Bug nurse educators who delivered Infection Prevention and Control, Antimicrobial Stewardship and Antimicrobial Resistance education to 88% of nursing homes in Cornwall. The nurses also delivered education around infection control and urinary tract infection management based on the “To Dip or Not To Dip” project initiated by BANES CCG.

6.5 Eden One Health Conference in May 2017 brought together a diverse group of practitioners from different sectors in Cornwall, including vets and podiatrists, for a one day session on AMR from a One Health perspective. The day showcased a variety of AMR related subjects and was highly evaluated by delegates. The lectures from the event are available on youtube and have been shared widely with stakeholders[1].

6.6 The target set for NHS Kernow CCG for total antibacterial items/STAR PU was 1.172 by the end of March 2016. The target for the percentage of broad spectrum antibiotics (Co-Amoxiclav, Cephalosporins & Quinolones) was <11.3 by the end of March 2016. NHS Kernow CCG achieved both of the targets set in the Quality Premium 2015/16, ending the year in March 2016 at 1.056 for total antibacterial items/STAR PU and 10.3% for the percentage of Co-amoxiclav, Cephalosporins & Quinolones.

[1] One Health Eden Conference on AMR
https://www.youtube.com/playlist?list=PL6Y4vyTaqfNDlmRXmIyk3zYs3pAT-vZbR

6.7 In March 2017 the twelve month rolling total number of prescribed antibiotic items per STAR-PU[2] for Cornwall was 1.05 compared to 1.07 for England. In March 2017, the twelve month rolling percentage of prescribed antibiotic items from Co-Amoxiclav, Cephalosporins & Quinolones was 9.92 compared to 8.92 for England. However, this was not a statistically significant difference.

6.8 The Devon Antimicrobial Stewardship Group (DASG) meets four times a year and is chaired by Iain Carr, Pharmacy Lead, NEW Devon CCG.

6.9 In March 2017, the twelve month rolling total number of prescribed antibiotics items per STAR-PU for NEW Devon CCG was 1.04 compared to 1.08 for South Devon and Torbay CCG and 1.07 for England. In March 2017, the twelve month rolling percentage of prescribed antibiotic items from Co-Amoxiclav, Cephalosporins & Quinolones was 10.98 for NEW Devon CCG compared to 10.43 for South Devon and Torbay CCG and 8.92 for England. However, this was not a statistically significant difference.

7 Emergency planning and exercises

7.1 All Councils continue to engage with the Local Resilience Forum in undertaking their annual exercise programme, responding to incidents and undertaking learning as required.

8 Work Programme 2016/17 - progress report

8.1 This section includes an update on priorities identified in the 2016/17 annual report. Areas highlighted for action were:

- **Involvement with Short Sermon –** Devon, Plymouth and Cornwall Local Authorities were involved with the Short Sermon exercise in September 2016, testing responses in the event of a nuclear accident at Devonport.

- **Antimicrobial resistance** – See anti-microbial resistance section above. Progress has been made on setting up local groups and consolidating the work programme. Antimicrobial Resistance continues to be a priority area in 2017/18.

- **Review locality Immunisation groups** - The South West Screening and Immunisation Team undertook a review of all Devon, Cornwall and Isles of Scilly locality immunisation groups. All groups now have an action plan in place that is aimed at increasing coverage rates, achieving national targets, and reducing inequalities in their area. This work is underpinned by the childhood immunisation needs assessment.

- **Childhood Flu review** - The child influenza immunisation programme has been successfully expanded, with good coverage rates across the area. Plans for further roll-out to meet the national programme requirements are underway.

- **Port Health Review** – a scoping exercise was carried out and an event is being planned for 2017/18.

[2] STAR-PU (Specific Therapeutic group Age-Sex Related Prescribing Unit): a measure of the volume of antibiotic prescribing which reflects not only the number of patients but also the age and sex mix of the group

- **Lyme disease** – a press release was issued on tick awareness and social media posting was undertaken in the Devon Council area, which was taken up by the media locally. This is planned to be repeated in 2017/18.

- **Tuberculosis work programme** - following the health needs assessment, priorities for local implementation have been identified and an action plan developed for implementation 2017/18 onwards. Priorities are: (i) Latent TB Infection screening in low prevalence areas targeting students and care home staff (ii) Collaborative working and commissioning (iii) Ongoing education to improve early diagnosis.

9 Priorities for the 2017/18 work programme

9.1 Priorities identified for 2017/18 are:

- **Infection prevention and control**
  - Health Protection Committee members will be reviewing community infection prevention and control and looking at options to support social and primary care sectors to strengthen local arrangements.
  - There will be enhanced surveillance of E.coli bacteraemias, driven by the national reduction expectation and the CCG quality premium. Actions will be put in place to improve prevention.

- **Improving the resilience of the health protection system**
  - Local Health Resilience Partnerships will be taking part in a national assurance process to look at the resilience of the system under the new arrangements.
  - New arrangements are being introduced in the South West for Public Health specialty training in health protection in local authorities, including emergency planning and response.

- **Air quality**
  - Public Health England will be working alongside Local Authorities in Devon to bring together stakeholders relevant to air pollution in a coordinated event to agree a programme of local action.

- **Antimicrobial resistance**
  - A 'One Health' approach to Antimicrobial Resistance will be followed within both Devon and Cornwall, with opportunities pursued for public and professional engagement. A whole health economy approach is needed to enable health systems to meet government ambitions for reducing Gram-negative Blood Stream Infections and inappropriate antimicrobial prescribing.
  - A Devon-wide baseline assessment of NICE guideline 63 (Antimicrobial Stewardship: changing risk-related behaviours in the general population) is being led by Plymouth City Council, with support from Public Health England. Local authorities are auditing progress in relation to implementation of the guideline and a summary report will be presented to the NICE Panel Advisory Group and the NEW Devon Antimicrobial Resistance Group in 2017.

- NEW Devon CCG is hosting a workshop on E.coli bacteraemias and how to deal with them, in July 2017, with the aim of agreeing an action plan for reduction.
- A pilot for implementing a tool to promote antimicrobial stewardship and self-care advice in community pharmacies is planned within Devon and Cornwall. This project is being led by Public Health England South West.

- **Influenza vaccination for care home and domiciliary staff and special schools**
  - Health and social care providers have a responsibility to ensure vaccination uptake amongst front line staff in order to protect the vulnerable populations from the effects of influenza.

- **Implementation of national MMR initiative**
  - A national UK Measles and Rubella elimination strategy is being developed, in line with the World Health Organisation target to eliminate these diseases in Europe by 2020. Public Health England Screening and Immunisation Team will be working through the locality immunisation groups to develop robust multiagency action plans to further improve MMR uptake. It is anticipated that this will have a beneficial effect on all childhood immunisation programmes.

10 Authors

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16 November 2017

11 Glossary

AMR	Anti microbial resistance
BCG	Tuberculosis (Bacillus Calmette-Guerin) vaccination
CCG	Clinical Commissioning Group
C.diff	Clostridium difficile
CHIS	Child Health Information Services
CVS	Chorionic villus sampling (antenatal screening)
E.coli	Escherichia Coli
HPV	Human papillomavirus testing (for risk of developing cervical cancer)
MMR	Measles, Mumps and Rubella (immunisation)
MRSA	Methicillin resistant Staphylococcus aureus
MSSA	Methicillin sensitive Staphylococcus aureus
NEW Devon	Northern, Eastern and Western Devon (Clinical Commissioning Group)
NIPE	Newborn Infant Physical Examination
NIPT	Non-invasive pre-natal testing
PHE	Public Health England
NHSE	NHS England
CQUIN	Commissioning for Quality and Innovation (incentivised payment system)
TB	Tuberculosis

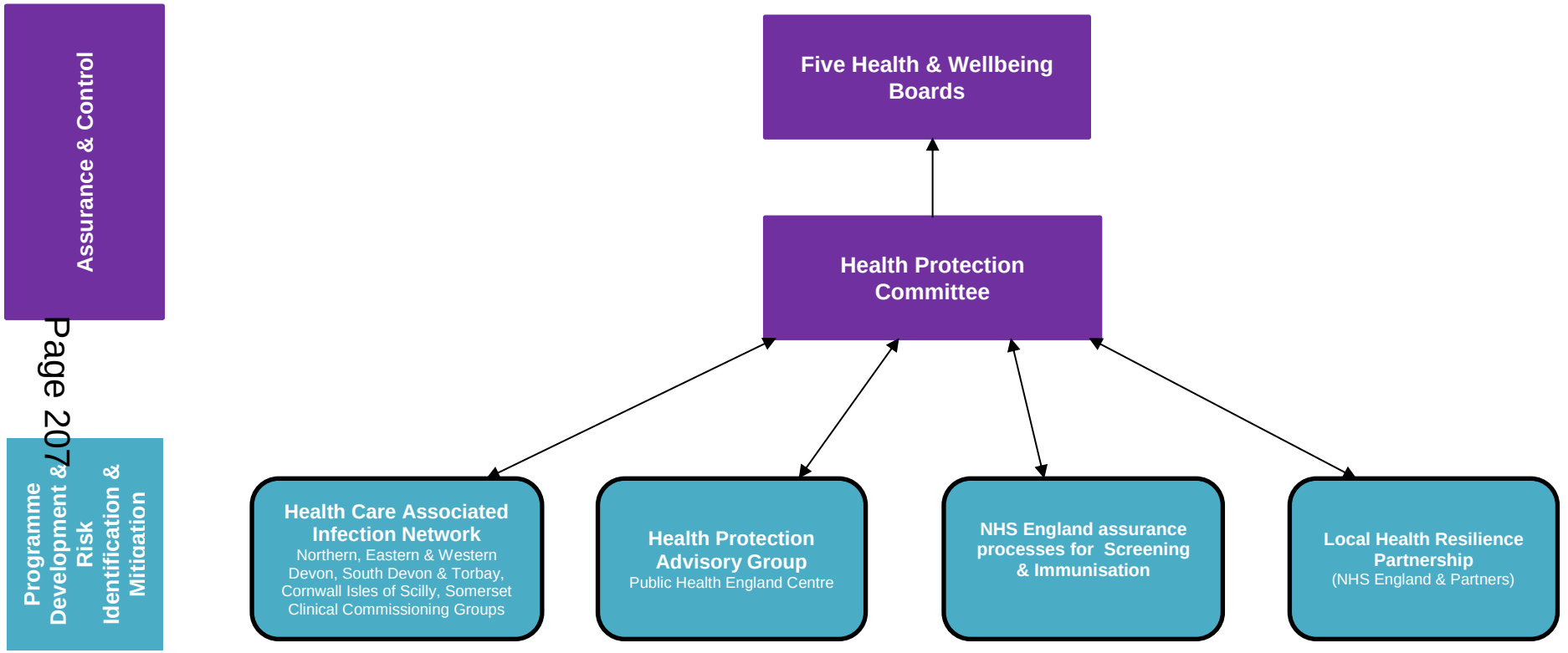
12 Appendices

Appendix 1	**Health Protection Committee reporting arrangements**
Appendix 2	**Infectious disease incidence and trends**
Appendix 3	**Immunisation performance**
Appendix 4	**National screening programme summary**
Appendix 5	**Screening performance**
Appendix 6	**Healthcare associated infections**
Appendix 7	**Anti-microbial resistance trends and developments**

Appendix 1

(1) Health Protection Committee reporting arrangements

Reporting to the Devon, Plymouth, Torbay, Cornwall and Council of the Isles of Scilly Health & Wellbeing Boards and relationship to existing or planned Health Protection Partnership Forums

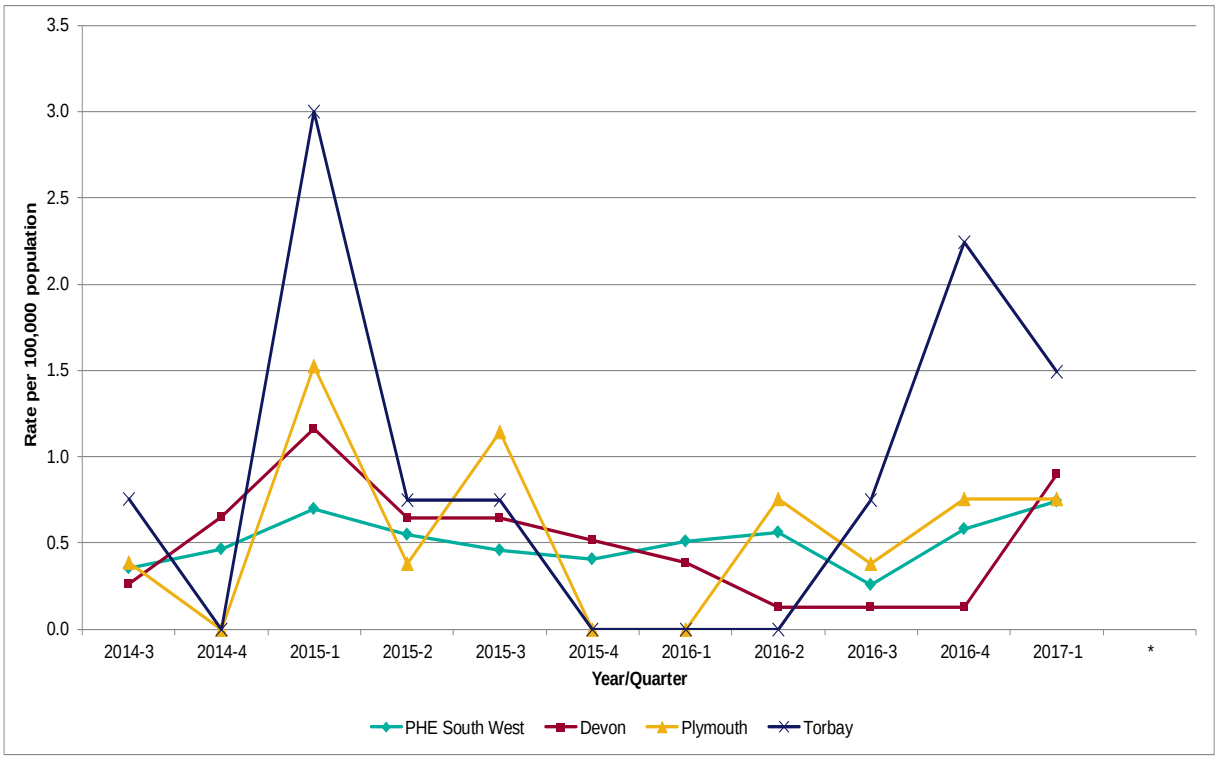


(2) Infectious disease incidence and trends 2016-17

Meningococcal disease

Figure 1: Quarterly rates (per 100,000 population) of probable cases of meningococcal infection by local authority and PHE South West Q3 2014 to Q1 2017

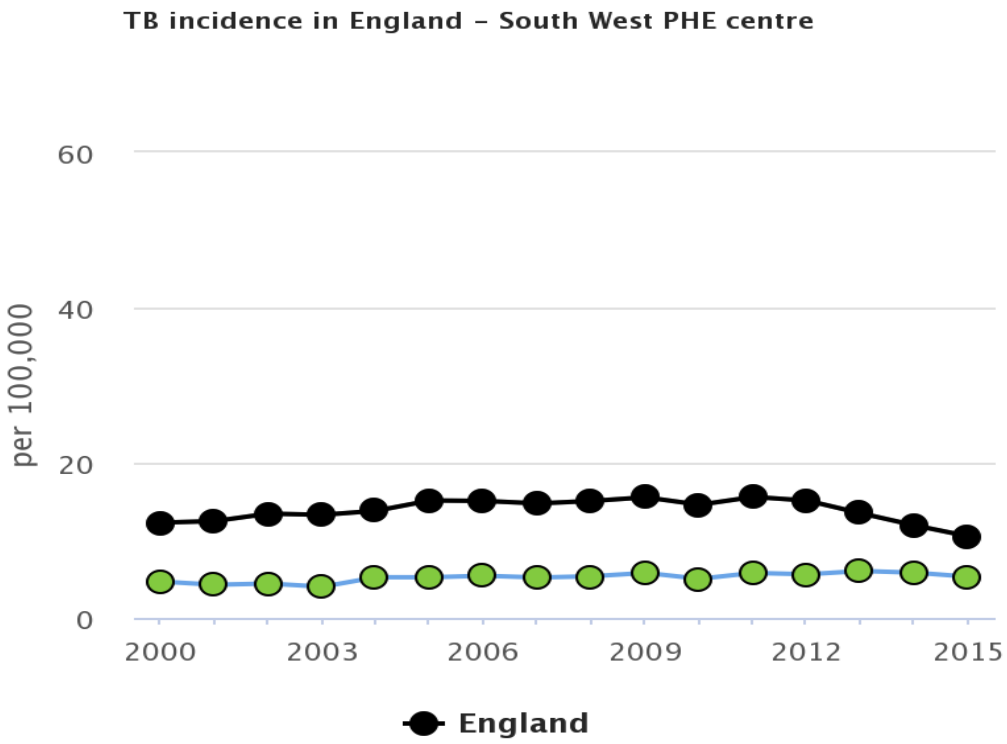
Quarterly rates (per 100,000 population) of confirmed and probable cases of meningococcal infection by local authority and PHE South West



Tuberculosis

As of 2015 the incidence of tuberculosis across the South-West of England remained low compared to the average for England. The figure and table below demonstrates the average incidence rate by local authority from 2013-2015.

Figure 2: Tuberculosis incidence in England 2000 – 2015



Source: PHE South West England Centre

Table 1: Average number of TB cases per year and incidence per 100,000 population in Devon, Plymouth, Torbay and Cornwall/Isles of Scilly 2013 – 2015

	Average number of cases per year 2013-2015	Average annual rate per 100,000 (95% CI) 2013-2015
Devon	29	3.8 (3.1-4.7)
Cornwall (Not IoS)	13	2.4 (1.7-3.3)
Plymouth	14	5.4 (3.9-7.2)
Torbay	8	6.0 (3.9-9.0)

Three-year average TB rates by local authority district, England, 2013-2015

Norovirus and gastroenteritis

Norovirus is the most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and Wales, and is highly infectious. The illness is generally mild and people usually recover fully within two to three days. Infections can occur at any age because immunity does not last. Historically known as 'winter vomiting disease', the virus is more prominent during the winter months, but can occur at any time of year. Outbreaks are

common in semi-closed environments such as hospitals, nursing homes, schools and cruise ships.

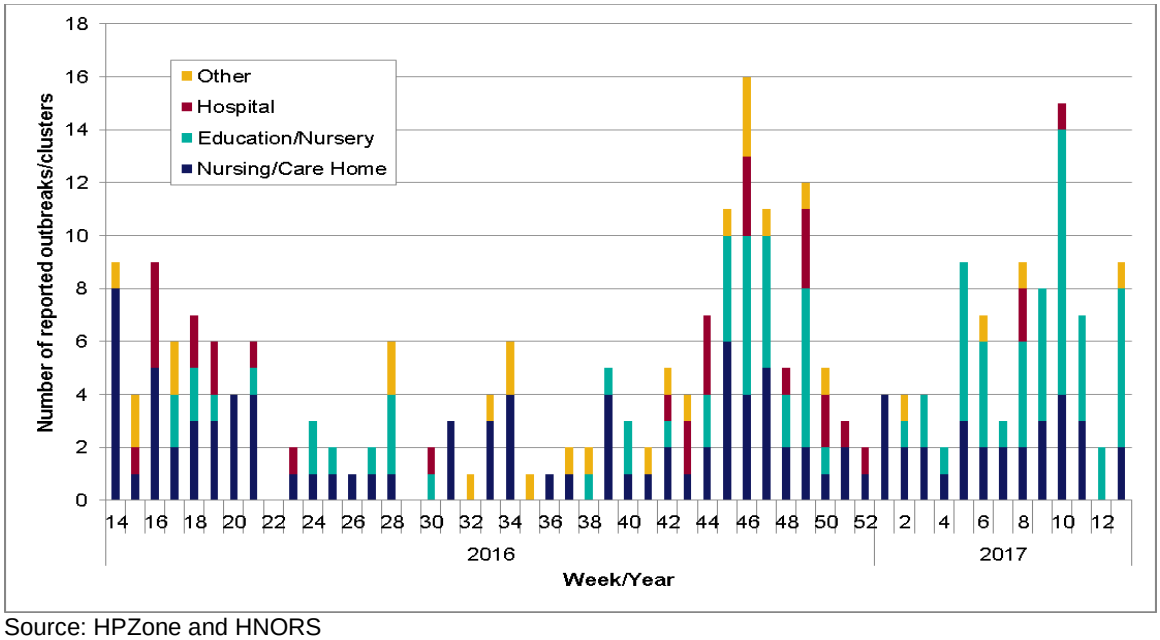
NB These are incidence figures and not rates.

Table 2: All reports of clusters/outbreaks of gastrointestinal infection (suspected or laboratory confirmed), by setting, including food poisoning outbreaks, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay local authorities, 2016/17

Local Authority	Care Home	Education/ Nursery	Hospital	Other	Total
Cornwall (including Isles of Scilly)	30	19	8	9	66
Devon	60	49	17	15	141
Plymouth	14	13	2	4	33
Torbay	9	10	5	3	27

Source: HPZone and HNORS. Outbreak/cluster data extracted based on date entered onto HPZone

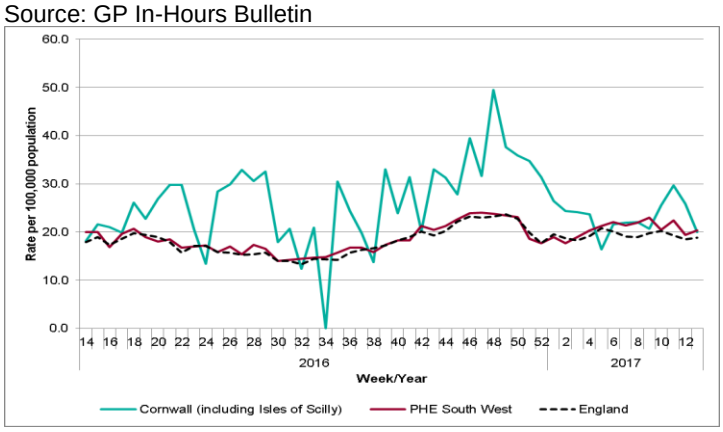
Figure 3: All reports of clusters/outbreaks of gastrointestinal infection (suspected or laboratory confirmed), by setting, including food poisoning outbreaks, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay local authorities, Week 14 2016 to Week 13 2017

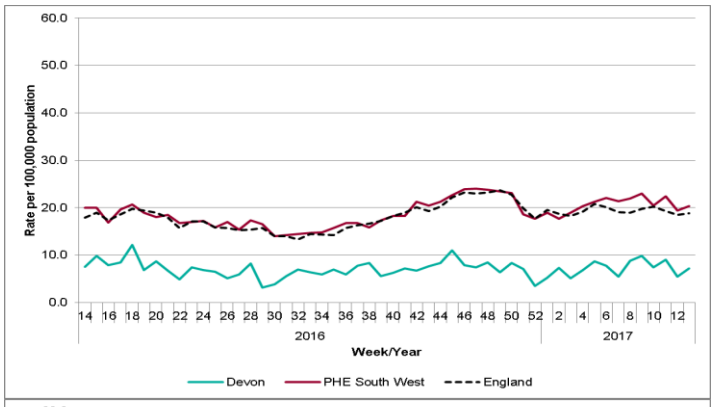


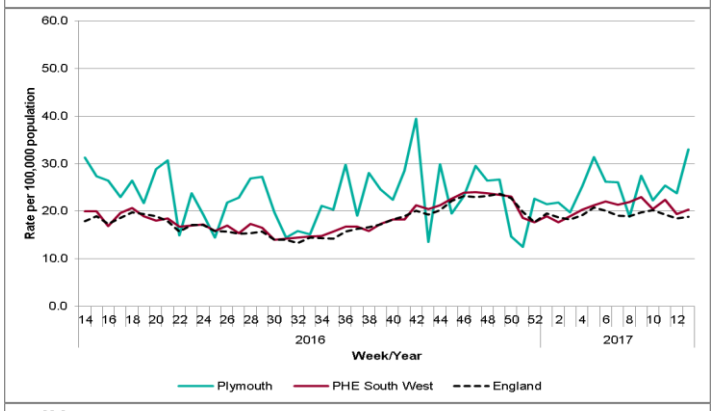
Source: HPZone and HNORS

Figure 4: GP (In hours) vomiting consultation rate, Cornwall (including Isles of Scilly), Devon, Plymouth, Torbay local authorities, PHE South West and England, 2016/17 (Week 14 2016 - Week 13 2017)

Source: GP In-Hours Bulletin







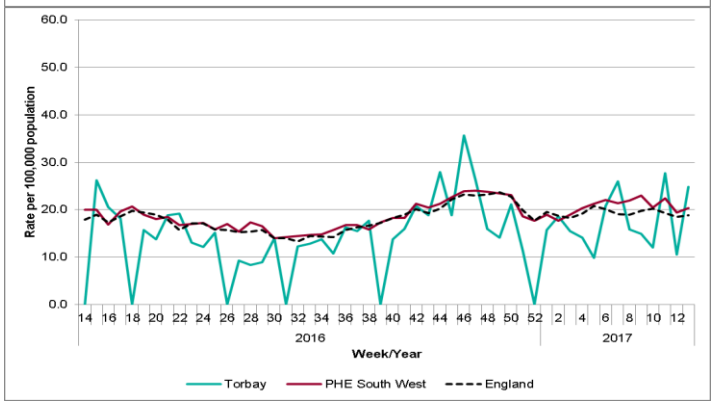
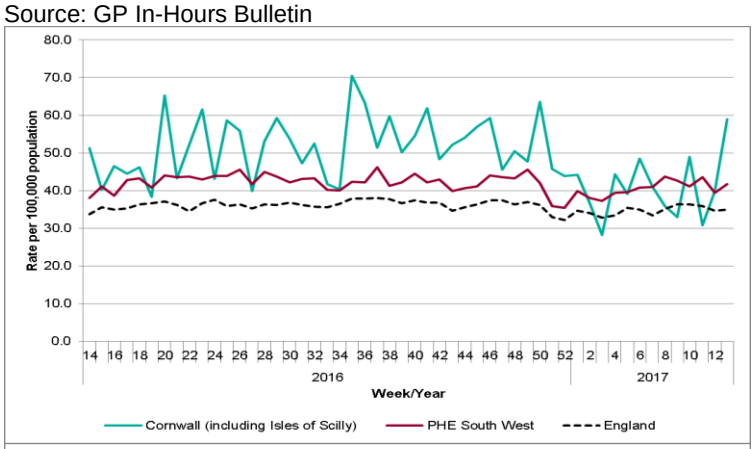
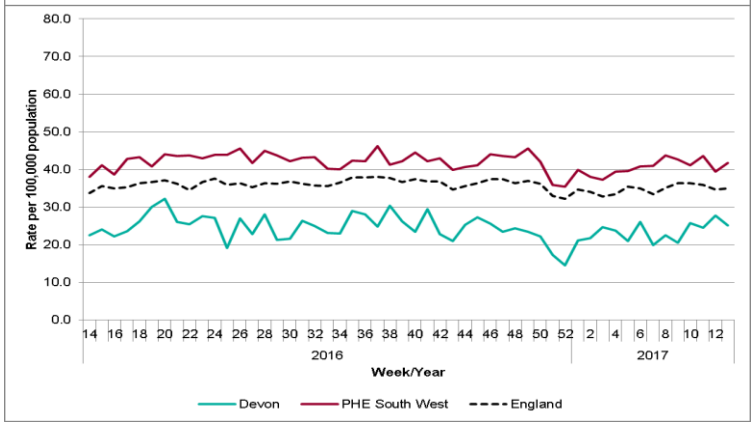
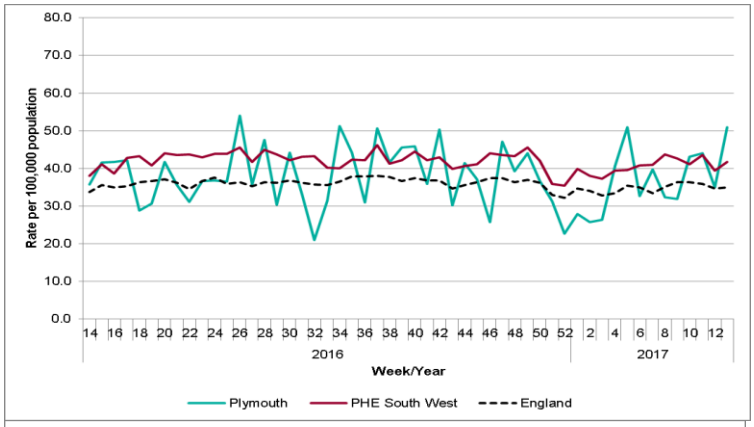


Figure 5: GP (In hours) diarrhoea consultation rate, Cornwall (including Isles of Scilly), Devon, Plymouth, Torbay local authorities, PHE South West and England, 2016/17 (Week 14 2016 - Week 13 2017)

Source: GP In-Hours Bulletin







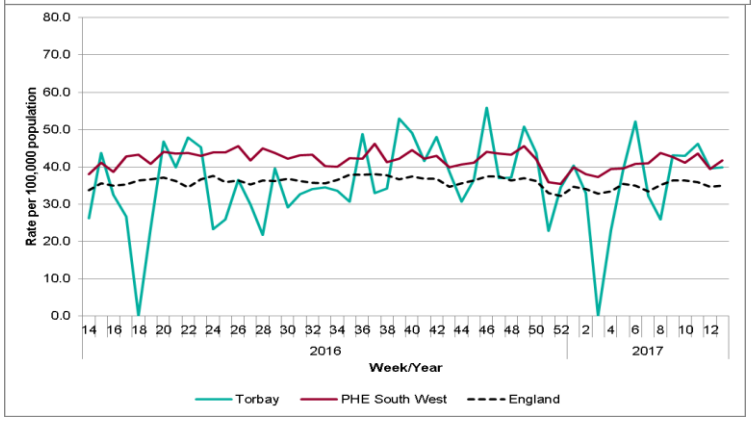


Figure 6: GP (In hours) gastroenteritis consultation rate, Cornwall (including Isles of Scilly), Devon, Plymouth, Torbay local authorities, PHE South West and England, 2016/17 (Week 14 2016 - Week 13 2017)

Source: GP In-Hours Bulletin

Scarlet Fever

Scarlet fever is a common childhood infection caused by Streptococcus pyogenes (also known as Group A Streptococcus [GAS]). Some people carry these bacteria in their nose and throat, or on their skin without suffering active infections. Under some circumstances and in some people, GAS can cause infections such as pharyngitis, impetigo and scarlet fever (these are regarded as non-invasive infections). On rare occasions they can cause severe disease, including streptococcal toxic shock syndrome, necrotising fasciitis, and other invasive GAS (iGAS) infection.

Routine national surveillance data for invasive and non-invasive GAS infections suggests a cyclical pattern with higher incidence peaks evident in notifications approximately every four years. Seasonal trends show that increased levels of GAS infections typically occur between December and April, with peak incidence usually in March.

Table 3: Rates (per 100,000 population) of scarlet fever notifications, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay local authorities and PHE South West, 2016/17

Local Authority	Rate per 100,000 population
Cornwall (including Isles of Scilly)	18.71
Devon	18.72
Plymouth	24.98
Torbay	25.40
PHE South West	26.54

Source: PHE Notifications of Infectious Diseases (NOIDs)

Table 4: Rates (per 100,000 population) of confirmed cases of invasive group A streptococcal infection, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay local authorities and PHE South West, 2016/17

Local Authority	Rate per 100,000 population
Cornwall (including Isles of Scilly)	4.14
Devon	6.03
Plymouth	9.46
Torbay	8.22
PHE South West	4.82

Source: HPZone

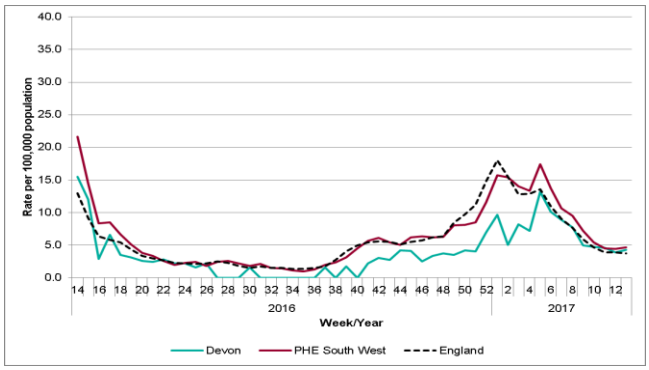
Table 5: All reports of clusters/outbreaks of streptococcus group A, by setting and type, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay local authorities, 2016/17

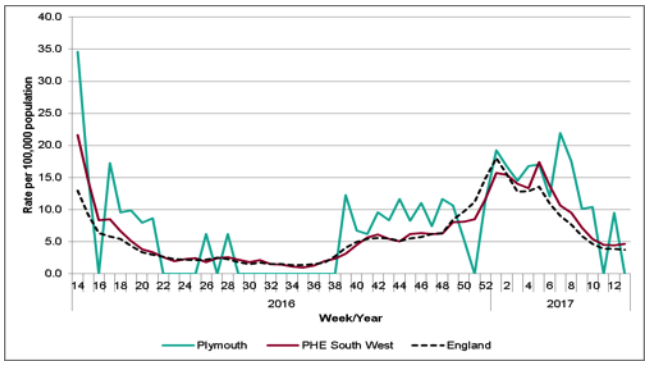
	Type	Scarlet Fever			GAS/ iGAS	
	Setting	School	Nursery	College/ University	Care Home	Total
Local authority	Cornwall (including Isles of Scilly)	6	3	0	0	9
	Devon	8	4	1	2	15
	Plymouth	5	3	0	1	9
	Torbay	7	2	0	1	10

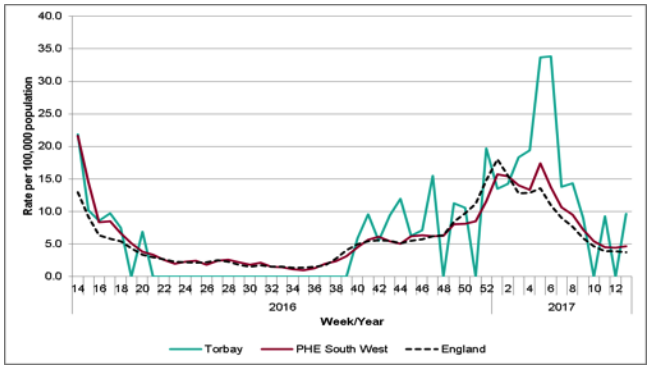
Source: Outbreak/cluster data extracted based on date entered onto HPZone.

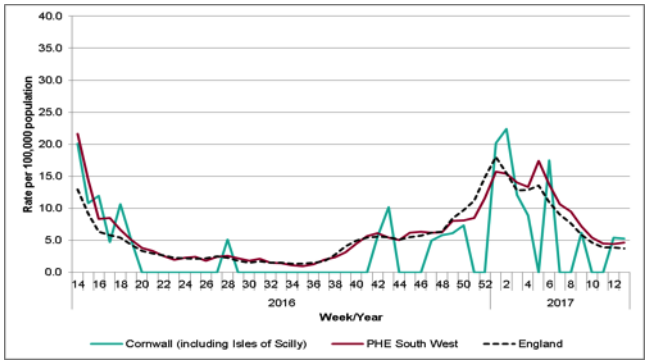
Seasonal influenza

Figure 7: GP (In hours) influenza-like illness consultation rate (i) Devon, (ii) Plymouth, (iii) Torbay (iv) Cornwall (including Isles of Scilly) local authorities, PHE South West and England, 2016/17 (Week 14 2016 - Week 13 2017)









Due to suppression of rates due to low numbers, for weeks in which the trend graph shows a rate of 0.0, this will not always reflect the true rate.

Figure 8: All reports of influenza-like illness outbreaks/clusters (suspected or confirmed) by setting, Devon, Plymouth, Torbay and Cornwall (including Isles of Scilly) local authorities, Week 14 2016 to Week 13 2017

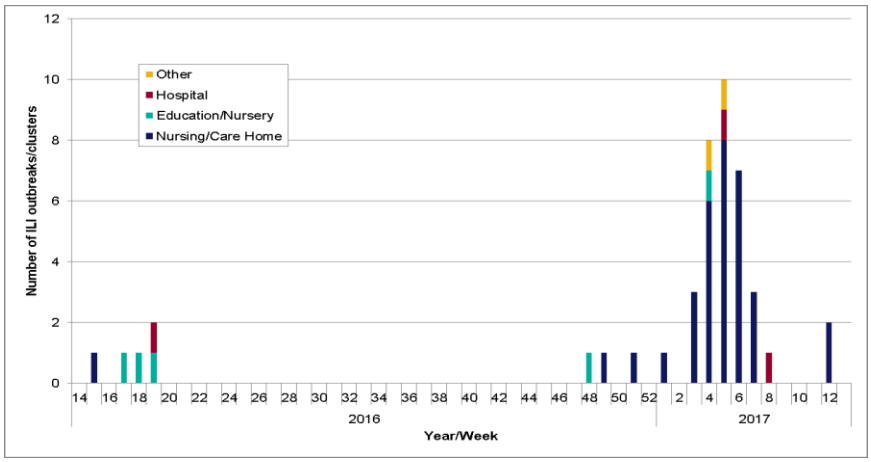


Figure 9: All reports of influenza-like illness outbreaks/clusters (suspected or confirmed) by setting Devon, Plymouth, Torbay and Cornwall (including Isles of Scilly) local authorities, 2016/17

Local Authority	Care Home	Education/Nursery	Hospital	Other	Total
Cornwall (including Isles of Scilly)	2	2	2	0	6
Devon	24	2	1	2	29
Plymouth	0	1	0	0	1
Torbay	7	0	0	0	7

Outbreak/cluster data extracted based on date entered onto HPZone

Data Sources

GP In-Hours Bulletin

Weekly GP in hours consultation rate data for influenza like illness accessed from the PHE GP In Hours Syndromic Surveillance Bulletin.

The GP in hours syndromic surveillance system monitors the number of visits to GPs during regular surgery hours for known clinical indicators, including influenza-like illness. The consultation rates are checked daily, and published weekly rates per 100,000 practice population are presented in this worksheet. This system covers about 55% of England's population.

Care should be taken when comparing rates between areas as differences in rates may be due to differences in the provider coverage which varies across England.

Data is available here:
https://www.gov.uk/government/publications/gp-in-hours-bulletin.

HPZone

HPZone is a case management system that captures data on suspected or laboratory confirmed outbreaks within the community that have been reported to the Public Health England Centres (PHECs).

It is believed that reporting of outbreaks is not uniform or consistent and it is likely that only a small proportion of outbreaks have samples collected for microbiological confirmation. As such these should be interpreted with caution as it is likely to underestimate the level of community activity.

HPZone reports were extracted and analysed on date entered.

HNORS

The Hospital Norovirus Outbreak Reporting Scheme (HNORS) is a voluntary web-based surveillance system, introduced in order to help the NHS share information about norovirus outbreaks in Trusts.

HNORS reports were extracted and analysed on date of outbreak onset.

PHE Notifications of Infections Diseases (NOIDs)

Please note this data is notifications only, not laboratory confirmation. Data is based on date of notification.

Appendix 3

(3) Immunisation performance 2016-17

Annual childhood immunisations by local authority showing percentage coverage for latest three years

Cohort	Indicator	Standard [1]	Geography	2014/15	2015/16	2016/17
12 months	3.03iii - Population vaccination coverage - Dtap / IPV / Hib	95	Devon	95.7	92.0	92.6
			Plymouth	96.7	95.5	96.9
			Torbay	95.7	95.5	96.3
			Cornwall & IoS	93.0	94.5	93.9
			England	94.2	93.6	93.4
	3.03iv - Population vaccination coverage - MenC	95	Devon		95.2	
			Plymouth		97.3	
			Torbay		97.4	
			Cornwall & IoS		96.3	
			England		-	
	3.03v - Population vaccination coverage - PCV	95	Devon	95.6	92.4	93.1
			Plymouth	96.3	95.4	96.9
			Torbay	95.7	95.9	96.4
			Cornwall & IoS	92.5	94.7	94.0
			England	93.9	93.5	93.5
24 months	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	95	Devon	96.9	96.2	95.3
			Plymouth	98.3	97.7	97.6
			Torbay	97.9	97.5	98.0
			Cornwall & IoS	94.4	95.8	96.1
			England	95.7	95.2	95.1
	3.03vi - Population vaccination coverage - Hib / MenC booster	95	Devon	93.6	91.8	92.4
			Plymouth	95.2	95.1	94.5
			Torbay	94.2	94.9	94.8
			Cornwall & IoS	90.8	92.6	92.6
			England	92.1	91.6	91.5
	3.03vii - Population vaccination coverage - PCV booster	95	Devon	93.8	91.9	92.7
			Plymouth	96.0	94.9	94.5
			Torbay	94.9	94.7	95.1
			Cornwall & IoS	91.0	93.2	93.0
			England	92.2	91.5	91.5
	3.03viii - Population vaccination coverage - MMR for one dose	95	Devon	93.7	92.5	93.4
			Plymouth	95.6	95.4	95.3
			Torbay	94.5	95.2	95.2
			Cornwall & IoS	91.7	92.5	93.0
			England	92.3	91.9	91.6

Cohort	Indicator	Standard [1]	Geography	2014/15	2015/16	2016/17
5 years	3.03ix - Population vaccination coverage - MMR for one dose	95	Devon	95.2	95.5	95.7
			Plymouth	96.4	96.6	97.4
			Torbay	94.1	96.8	97.8
			Cornwall & IoS	95.8	96.2	96.1
			England	94.4	94.8	95.0
	3.03vi - Population vaccination coverage - Hib / Men C booster	95	Devon	89.7	94.9	94.8
			Plymouth	94.3	94.8	95.3
			Torbay	92.8	96.1	96.9
			Cornwall & IoS	93.5	95.1	95.1
			England	92.4	92.6	92.6
	3.03x - Population vaccination coverage - MMR for two doses	95	Devon	90.6	91.5	91.3
			Plymouth	89.5	90.4	91.4
			Torbay	89.9	92.1	92.1
			Cornwall & IoS	91.0	91.6	90.9
			England	88.6	88.2	87.6

1 National Screening and immunisation Programme standard. Where this is blank, no standard has been set.

Where coverage is blank, no programme was in place or data is not yet available.

Annual adult immunisations by local authority showing percentage coverage for latest three years

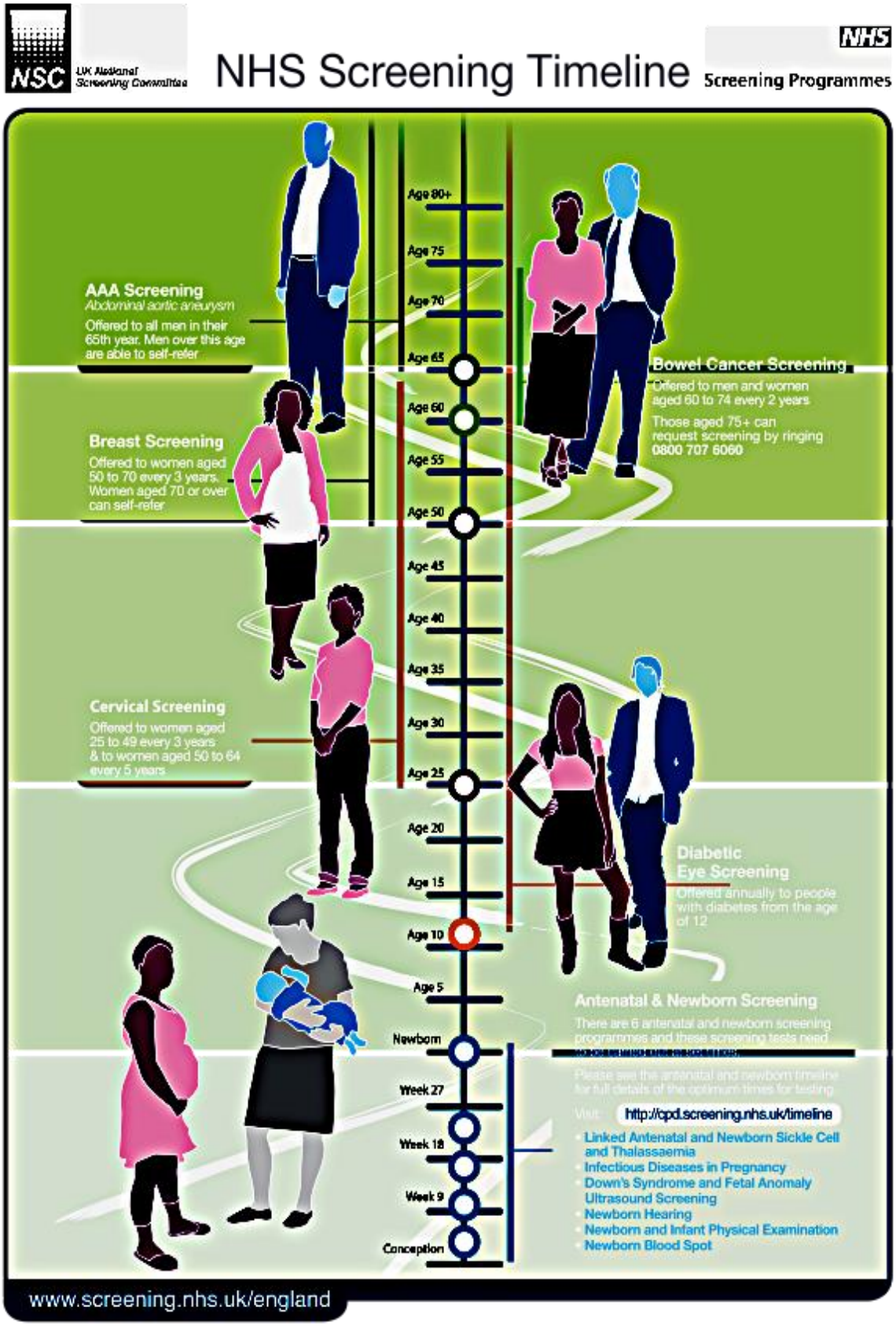
Indicator	Standard[1]	Geography	2014/15	2015/16	2016/17
3.03xii - Population vaccination coverage - HPV (%)	86.1	Devon	87.2		
		Plymouth	86.7		
		Torbay	87.2		
		Cornwall & IoS	81.4		
		England	89.4		
3.03xiii - Population vaccination coverage - PPV (%)	68.9	Devon	70.2	70.2	
		Plymouth	69.4	68.7	
		Torbay	68.1	67.5	
		Cornwall & IoS	66.3	67.0	
		England	69.8	70.1	
3.03xiv - Population vaccination coverage - Flu (aged 65+) (%)	75	Devon	70.8	69.8	69.8
		Plymouth	73.4	71.5	70.3
		Torbay	67.3	66.4	66.4
		Cornwall & IoS	70.4	69.4	68.4
		England	72.7	71	70.5
3.03xv - Population vaccination coverage - Flu (at risk individuals) (%)	75	Devon	44.5	42	46.2
		Plymouth	49.9	44.9	46.0
		Torbay	44.6	40.6	45.8
		Cornwall & IoS	49.4	45.6	44.4
		England	50.3	45.1	48.6
3.03xviii - Population vaccination coverage - Flu (2-4 years old) (%)		Devon	41.6	41.3	44.3
		Plymouth	36.3	33.6	37.2
		Torbay	37.0	34.8	38.4
		Cornwall & IoS	34.6	33.8	34.2
		England	37.6	34.4	38.1
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old) (%)		Devon	64	60.3	
		Plymouth	59.2	54.3	
		Torbay	59.3	52.6	
		Cornwall & IoS	61.5	53.8	
		England	59	54.9	

Source: Public Health Outcomes Framework, Public Health England.

[1] National Screening and Immunisation Programme standard.

Where coverage is blank, no programme was in place or data is not yet available.

(4) National screening programmes - summary



(5) Screening performance

Cancer screening (breast, cervical, bowel) – showing percentage coverage for latest three years

Indicator	Lower threshold [1]	Standard [2]	Geography	2014	2015	2016
Breast Cancer screening coverage	70	80	Devon	79.1	79.1	78.8
			Plymouth	78.4	79.1	79.3
			Torbay	76.5	76.7	74.7
			Cornwall	80.1	80.3	80.0
			England	75.9	75.4	75.5
Cervical Cancer screening coverage	75	80	Devon	77.5	77.7	77.1
			Plymouth	75.9	75.5	74.5
			Torbay	76.0	75.9	74.8
			Cornwall	76.3	76.4	75.7
			England	74.2	73.5	72.7
Bowel Cancer screening coverage	55	60	Devon		60.5	62.6
			Plymouth		61.3	61.6
			Torbay		62.0	61.4
			Cornwall		58.3	60.5
			England		57.1	57.9

[1] Threshold based on 2017-18 Public Health Functions Agreement.
[2] National Screening and Immunisation Programme Standard.
Where coverage is blank, no programme was in place or data is not yet available.

Non cancer screening – showing percentage coverage for latest three years

Indicator	Acceptable[1]	Achievable[2]	Geography	2013/14	2014/15	2015/16	Trust/Service	2014/15 Q4	2015/16 Q4	2016/17 Q4
				Annual figure				Quarterly figure		
Infectious diseases in pregnancy - HIV coverage	>=90	>=95	Devon				Royal Devon and Exeter NHS Foundation Trust	99.8	99.1	100.0
							Northern Devon Healthcare NHS Trust	99.1	99.8	99.5
			Plymouth				Plymouth Hospitals NHS Trust	99.7	99.6	99.7
			Torbay				South Devon Foundation Trust	97.4		
							Torbay and South Devon NHS Foundation Trust		97.2	99.2
			Cornwall				Royal Cornwall Hospitals NHS Trust	99.3	99.7	99.9
			England	98.9	98.9	99.1				
Sickle cell and thalassaemia	>=95	>=99	Devon				Royal Devon and Exeter NHS Foundation Trust	99.6	99.5	100.0
							Northern Devon Healthcare NHS Trust	99.3	99.8	99.5
			Plymouth				Plymouth Hospitals NHS Trust	99.8	99.8	99.7
			Torbay				South Devon Foundation Trust	98.6		
							Torbay and South Devon NHS Foundation Trust		97.7	99.2
			Cornwall				Royal Cornwall Hospitals NHS Trust	99.4	99.7	99.9
			England	98.9	98.9	99.1				
Newborn blood spot	>=95	>=99.9	Devon	90.9	85.1	82.2	NHS North, East, West Devon (CCG at birth)	86.5	90.7	97.6
			Plymouth	91.9	82.0	83.2	NHS North, East, West Devon	86.5	90.7	97.6
			Torbay	94.7	99.8	77.4	NHS South Devon and Torbay	99.5	86.0	94.1
			Cornwall	89.2	-	-	NHS Kernow	72.4	86.9	92.3
			England	93.5	95.8	95.6				
Newborn hearing	>=95	>=99.5	Devon	98.6	98.7	98.8	North Devon	98.8	98.6	98.5
							Torbay and Teignbridge	98.9	98.7	99.4
			Plymouth	99.2	99.4	99.4	Plymouth	99.0	99.5	99.2
			Torbay	98.9	99.4	99.4	Torbay and Teignbridge	98.9	98.7	99.4
			Cornwall	99.5	99.8	99.8	Cornwall and Isles of Scilly	99.8	99.9	99.7
			England	98.5	98.5	98.7				

Indicator	Acceptable[1]	Achievable[2]	Geography	2013/14	2014/15	2015/16	Trust/Service	2014/15 Q4	2015/16 Q4	2016/17 Q4
Newborn & infant physical examination	>=95	>=99.5	Devon				Royal Devon and Exeter NHS Foundation Trust	-	98.5	98.6
							Northern Devon Healthcare NHS Trust	98.9	97.9	99.1
			Plymouth				Plymouth Hospitals NHS Trust	100.0	97.6	96.2
			Torbay				South Devon Foundation Trust	-	97.3	97.0
							Torbay and South Devon NHS Foundation Trust	99.5	86.0	94.1
			Cornwall				Royal Cornwall Hospitals NHS Trust	-	-	-
			England		93.3	94.9				
* Diabetic eye screening	>=70	>=80	Devon				North and East Devon Diabetic Eye Screening Programme	82.8	82.6	87.5
							South Devon NHS Diabetic Eye Screening Programme	86.9	87.7	87.1
			Plymouth				Plymouth Diabetic Eye Screening Programme	79.9	80.1	79.6
			Torbay				South Devon NHS Diabetic Eye Screening Programme	86.9	87.7	87.1
			Cornwall				Cornwall Diabetic Eye Screening Programme	81.4	81.5	78.8
			England		82.9	83.0				
* Abdominal Aortic Aneurysm	>=67.5	>=75	Devon	87.4	87.3	86.1	South Devon AAA Screening Cohort	99.9	99.9	99.9
							Somerset and North Devon AAA Screening Cohort	100.0	99.8	100.0
			Plymouth	83.1	81.2	83.1	Peninsula AAA Screening Cohort	99.3	99.7	99.9
			Torbay	85.4	84.3	80.2	South Devon AAA Screening Cohort	99.9	99.9	99.9
			Cornwall	83.8	83.3	83.5	Peninsula AAA Screening Cohort	99.3	99.7	99.9
			England	77.4	79.4	79.9				

* All figures are for coverage except provider figures for diabetic eye screening which represent uptake, & AAA figures which represent 'completeness of offer'.

(6) Healthcare association infections (HCAI) 2016-17

MRSA

NEW Devon

Four cases were recorded in NEW Devon Clinical Commissioning Group between April 2016 and March 2017. Three were community acquired and one in an acute hospital. None of the four cases were connected. All cases have had Post Infection Reviews (PIRs) completed and lessons learned shared with relevant involved teams.

South Devon and Torbay

There was one recorded acute acquired MRSA and one community case.

NHS Kernow

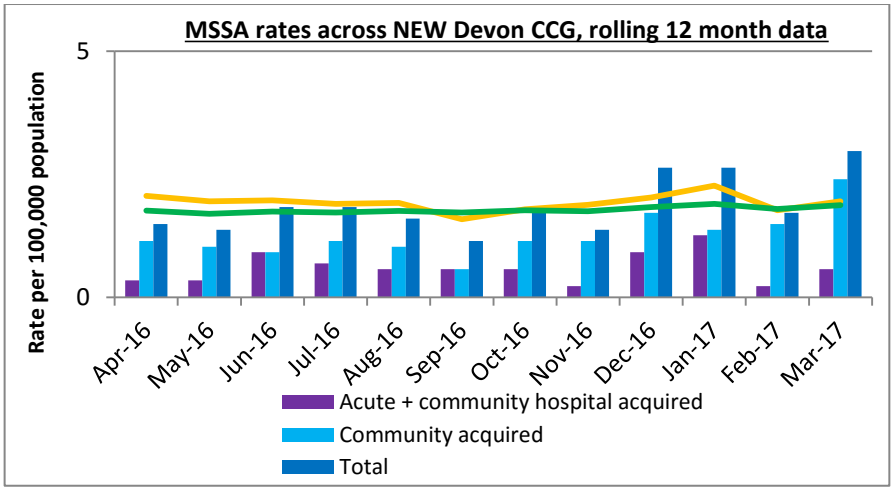
Seven cases were recorded in Cornwall patients in 2016-17: two acute assigned, three CCG assigned, two third party assigned. One patient accounted for two cases and one case was in an injecting drug user.

MSSA

NEW Devon

MSSA bacteraemia rates for the NEW Devon Clinical Commissioning Group population have fluctuated above and below the Public Health England, England and South West average rate lines. Providers of hospital and community services provide information to the clinical commissioning group as part of their performance reporting obligations. There has been a recent rise in community-acquired MSSA bacteraemia, and the reasons for this have not yet been established.

Figure 1 Methicillin sensitive staphylococcus aureus bacteraemias by month for NEW Devon Clinical Commissioning Group



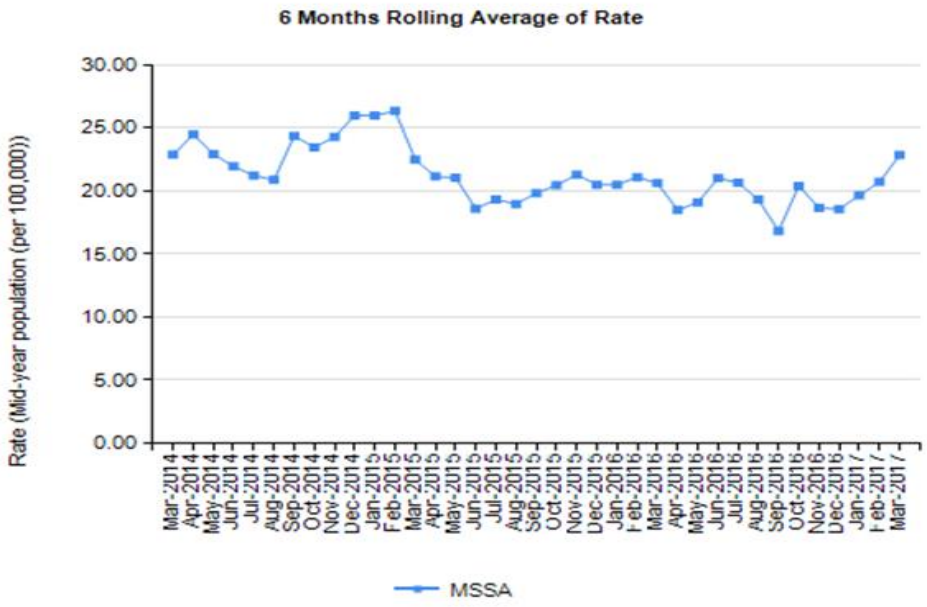
South Devon and Torbay

For the year ending March 2017 there were a total of 105 cases of MSSA reported against a target of 145. There were 16 acute acquired MSSA bacteraemia against a target of 8. This may be in part due to the installation of the new BD Bactec Fx which is more sensitive and will isolate more Staphylococci. Review and root cause analysis identified 'lapse in care' for 6 of the 16 cases.

NHS Kernow

MSSA rates in NHS Kernow were below the South West rates during 2016-17. The Royal Cornwall Hospital experienced an increased incidence during the first quarter.

Figure 2: NEW Kernow MSSA rates 2014 - 2017

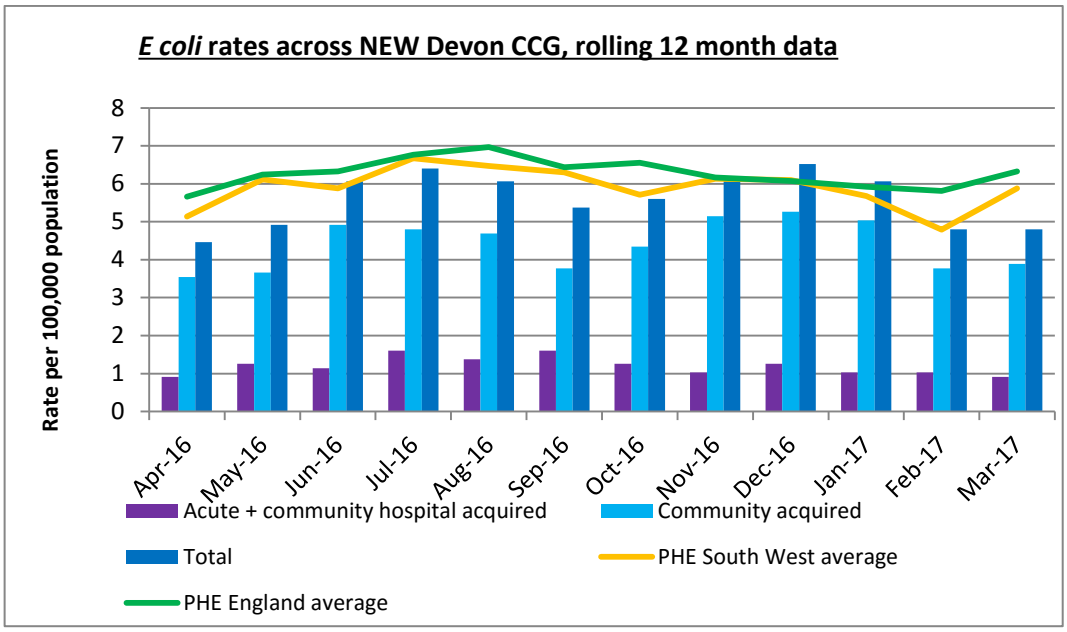


E.coli bacteraemia

NEW Devon

E. coli bacteraemias for the NEW Devon Clinical Commissioning Group hospital sector and clinical commissioning group population in the rolling 12 months as shown in the graph below broadly track the averages provided by Public Health England for England and the South West. The Clinical Commissioning Group Patient Safety and Quality Team monitor data by locality and hospital to scrutinise trends and enable performance to be questioned as required. The Quality Premium for Gram negative bloodstream infections aims to reduce E.coli numbers, and is being supported by the CCG.

Figure 3: Rates of E.coli bacteraemia, by month, April 2016 – March 2017 for NEW Devon Clinical Commissioning Group



South Devon and Torbay Clinical Commissioning Group

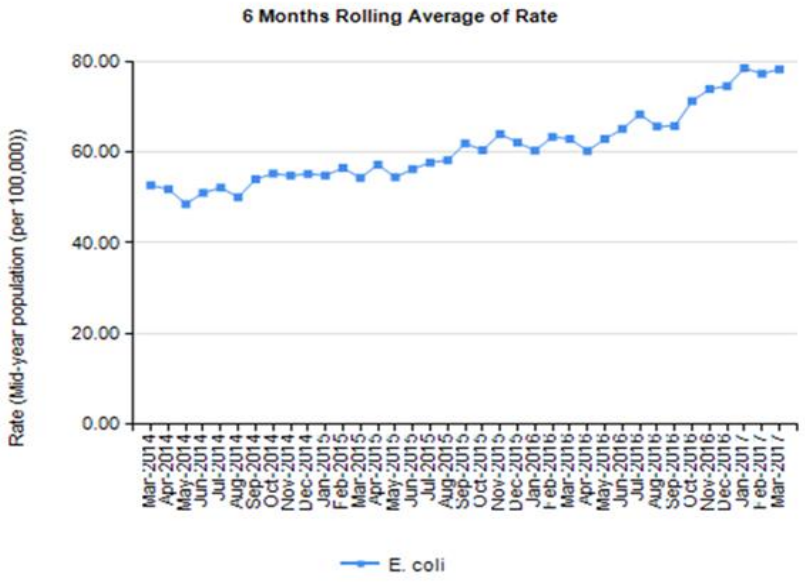
For the year ending March 2017 there was a total of 236 cases of E-coli bacteraemia reported across South Devon & Torbay.

NHS Kernow

E-coli rates continue to rise. Work began in 2016-17 to prepare a focus on E-coli bacteraemia reduction. Best practice indicators are being explored in the acute setting to enable evaluation of care lapses linked to cases with biliary sources. In the community, actions are planned around:

- Catheter Passport;
- Re-launch of the trial without catheter (TWOC) pathway tool;
- Adult Community Services (ACS) sites are moving over to RIO for electronic notes (looking to add a prompt function for indwelling devices);
- Use of an illustrative tool for ACS ward staff (catheter insitu);
- Focus on hydration;
- Stewardship (comms around new first line choice of ABX for UTIs, Audit);
- Joint visit to the ward with highest prevalence rate of catheters the previous month by IPAC and Continence Nurse;
- Roadshow/masterclass on catheters/bladder scanners/TWOC;
- Bladder scanners - identifying where they are, whether staff know how to use them and when to use them. Consideration of a capital bid if more are required.

Figure 4: NHS Kernow E-Coli bacteraemia rates 2014-2017



C. difficile infection

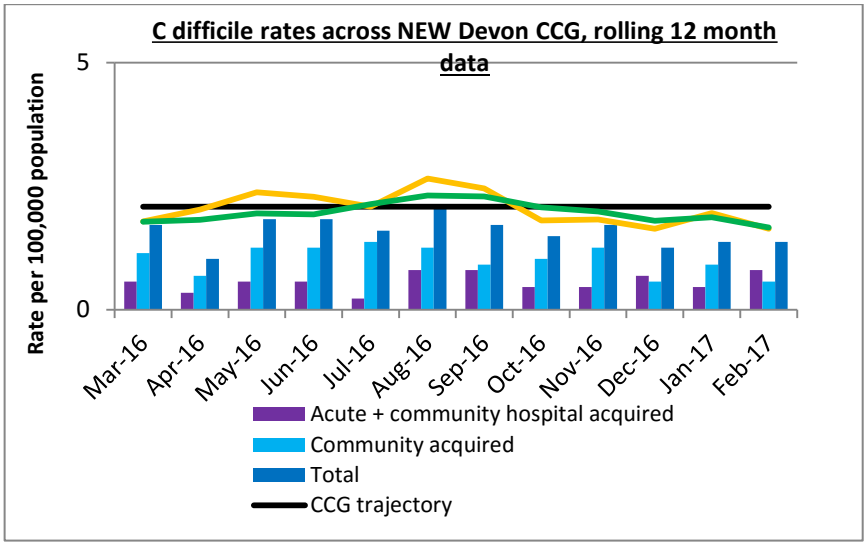
NEW Devon

The graph below shows community acquired infection (CAI) and hospital acquired infection (HAI) cases of C.difficile infection. The community acquired infection cases, which make up the larger proportion of the population cases, are not scrutinised for avoidability like those in acute and community hospitals. A system to inform General Practices of these cases and request Significant Event Audits (SEAs) on behalf of NHS England South, South West is in place.

The Clinical Commissioning Group was under its nationally set trajectory of 219 cases with a total of 181 cases. This shows that C.difficile infection is reasonably under control.

The Clinical Commissioning Group will not be offering a local CQUIN to Acute Trusts on the exploration of value of a community infection management service. The Clinical Commissioning Group will only be offering national CQUINs in 2017-18 for Acute Trusts, due to the overarching situation of the Success Regime.

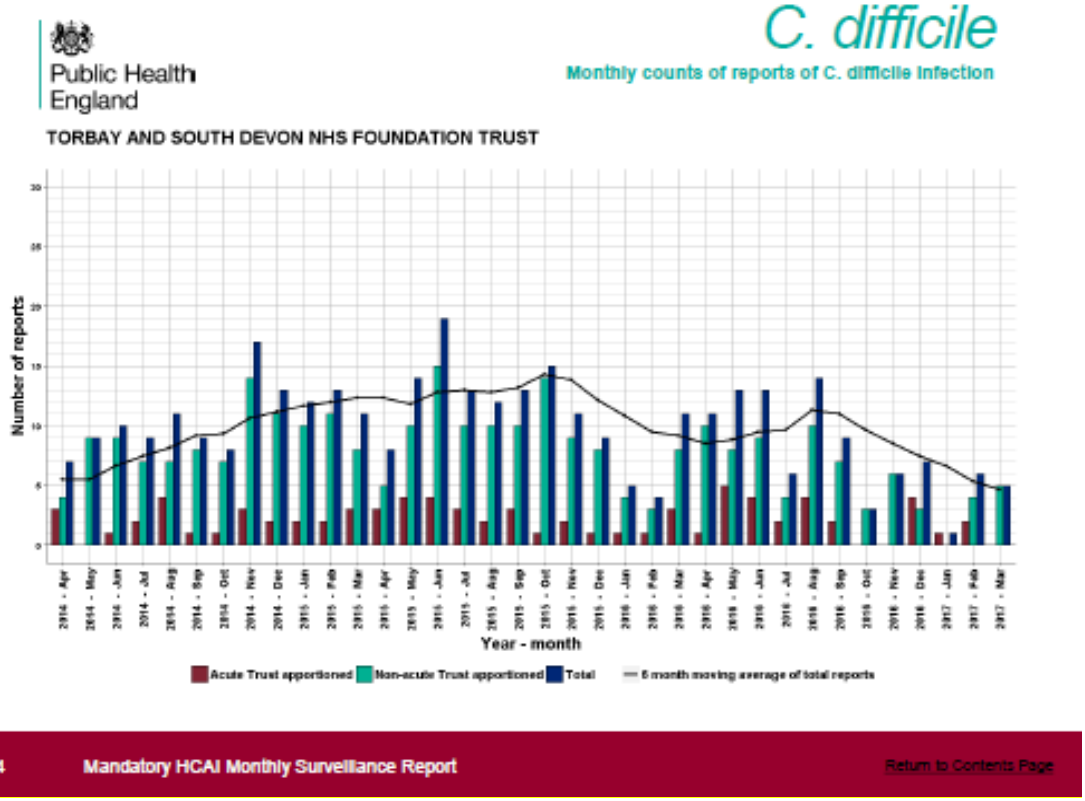
Figure 5: Rates of C.difficile infection, by month, April 2016 – March 2017 for hospital and community acquired infections for NEW Devon CCG



South Devon and Torbay

The CCG target given to provider was set at no more than 18 'lapses in care' from 1/4/16 to 31/3/17. Torbay hospital had 8 'lapses in care'. For the community hospitals an internal target of 4 'lapses in care' was set and there was zero 'lapses in care' identified. All hospitals were within targets set for *C.difficile* and the reduction in *C.difficile* in Torbay can be seen in the graph below.

Figure 6: South Devon and Torbay C.difficile rates 2014-2017

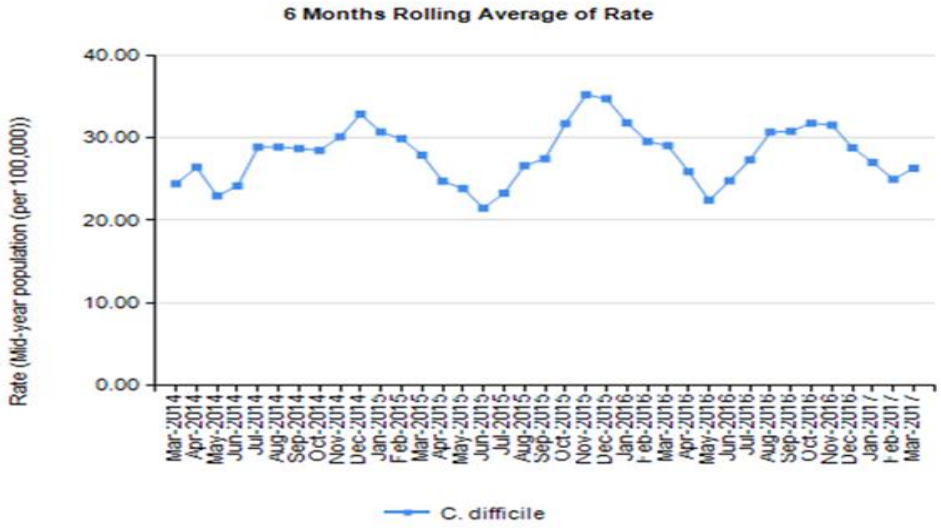


A faecal transplant service has now been introduced at Torbay & South Devon NHS Foundation Trust for patients with recurrent C.difficile, in accordance with NICE Interventional Procedure Guidance (NG485) recommendations. To date five patients have been offered faecal transplant; two declined and three were successful.

NHS Kernow

The Clinical Commissioning Group exceeded the 2016-17 objective of 25.00 cases with an outturn of 28.09 (per 100,000 population), which is above the South West figure of 25.45. The majority of acute cases were assessed as avoidable via the lapse in care system.

Figure 7: NHS Kernow C.difficile rates 2014-2017

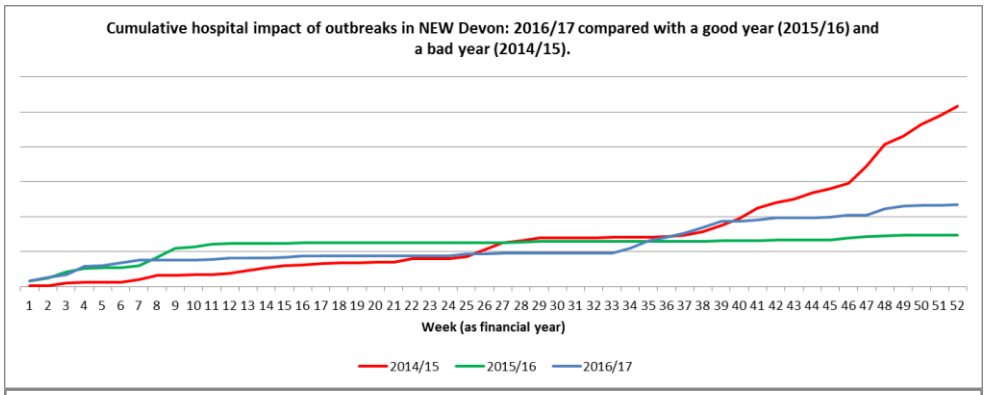


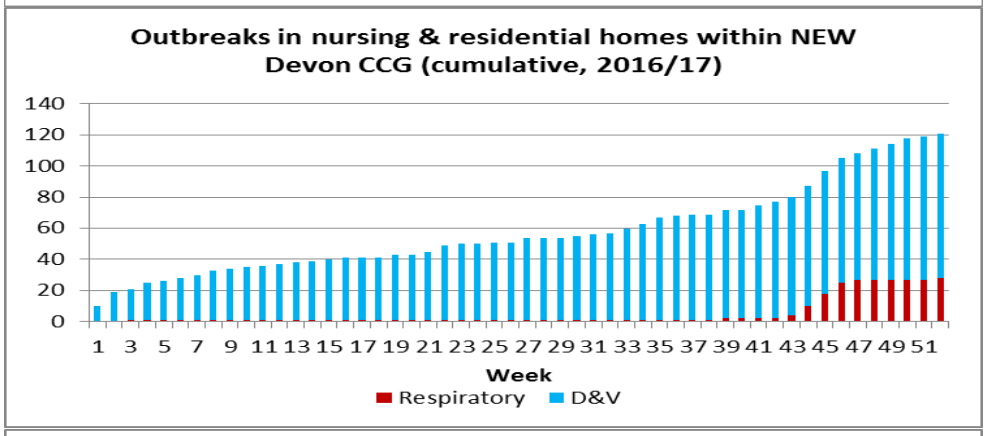
HCAI outbreaks

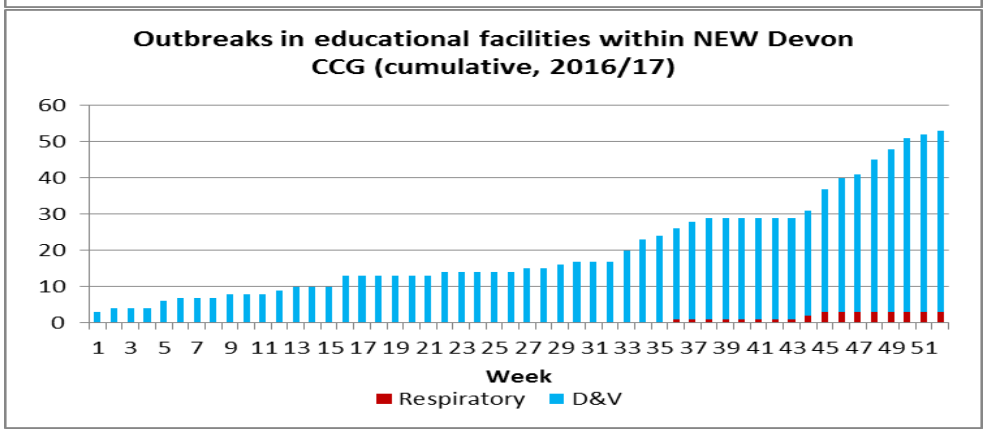
NEW Devon

The following outbreaks graph shows the amount of ward and bay closures occurring in NEW Devon Clinical Commissioning Group hospitals as a proxy for the impact on service. The two graphs beneath it show the comparative outbreak types in nursing homes and educational facilities over the same time period.

Figure 8: Ward and Bay closures across NEW Devon Clinical Commissioning Group by month showing comparison with 2015/16 and 2014/15







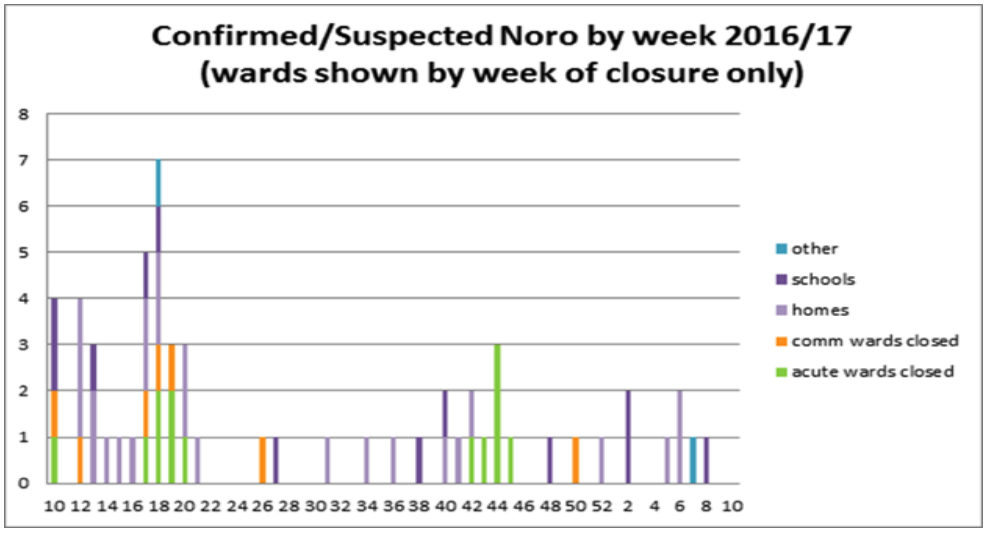
South Devon and Torbay

Between April 2016 and March 2017 there were six ward closures (15 days total closure) within the acute hospital. In the community hospitals there were four ward closures (22 days total closure). Overall the KPI of individual ward closure for no more than 12 days was maintained.

NHS Kernow

The chart below shows combined hospital and community outbreak notifications of suspected Norovirus.

Figure 9: NHS Kernow HCAI ward closures 2016/17



(7) Anti-microbial resistance: trends and developments

E. coli bacteraemia

Rates of *E.coli* bacteraemia cases reported through the Healthcare Associated Infections (HCAI) mandatory scheme have increased both nationally and locally in recent years (**Table 1**). The rate of *E.coli* bacteraemia per 100,000 population increased by 16% in England between 2013/14 and 2016/17, and by 22% in North, East & West (NEW) Devon CCG, 12% in South Devon and Torbay CCG and 27% in Kernow CCG over the same time period. Between 2015/16 and 2016/17 the rate of *E.coli* bacteraemia per 100,000 population increased by 6% in England, and by 2% in NEW Devon CCG, by 9% in South Devon and Torbay CCG and by 16% in Kernow CCG.

Table 1: *E.coli* bacteraemia rates per 100,000 population, by CCG and England, 2013/14 to 2016/17

Financial Year	North, East and West (NEW) Devon CCG	South Devon and Torbay CCG	Kernow CCG	England
2013/14	57.2	78.2	55.9	63.7
2014/15	66.9	77.2	53.7	65.9
2015/16	68.4	80.1	61.4	69.8
2016/17	69.6	87.6	71.0	74.1

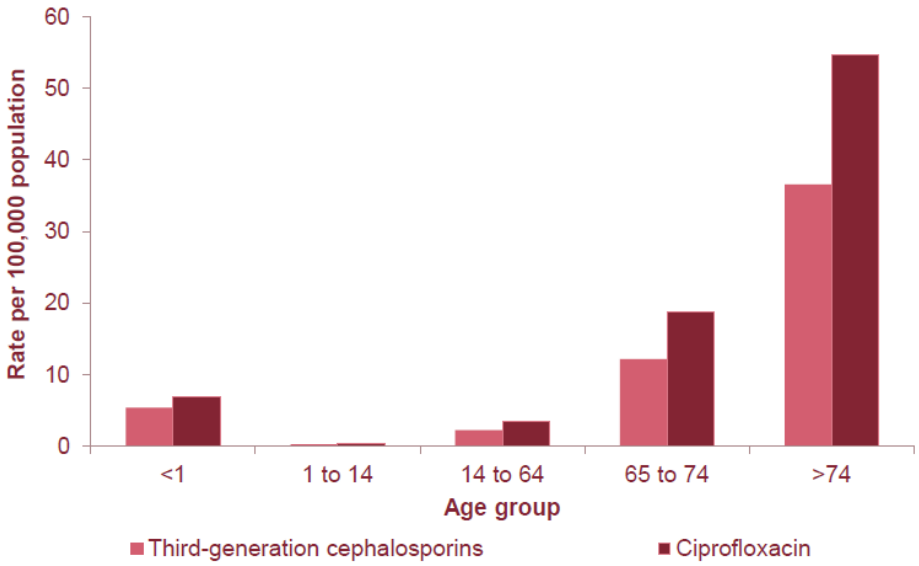
Source: HCAI Data Capture System

The PHE Health Protection Report on *E.coli* bacteraemia[1] reported that between 2012 and 2016 in England there was no change in the antibiotic resistance of *E.coli* isolates to selected antimicrobials, except for resistance to piperacillin/tazobactam and amoxicillin/clavlulanate which increased from 10% to 12% and from 37% to 41% respectively. However, these increases are likely to be due to changes in testing methods.

In 2016 in England, resistance of *E.coli* bacteraemia isolates to gentamicin, ciprofloxacin, third generation cephalosporins, piperacillin/tazobactam and amoxicillin/clavulanate were 10%, 19%, 22%, 12% and 41% respectively. Therefore, the increases in *E.coli* bacteraemia infections mean that the number of people affected by antibiotic-resistant infections is increasing.

Rates of *E.coli* resistant bacteraemia are substantially higher in the elderly, with elevated rates also seen in infants (<1 year old). **Figure 1**, taken from the English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report 2016[2], demonstrates this for two antibiotic classes. Therefore, when implementing interventions to reduce antibiotic resistance it may be necessary for particular focus to be placed on these age groups[2].

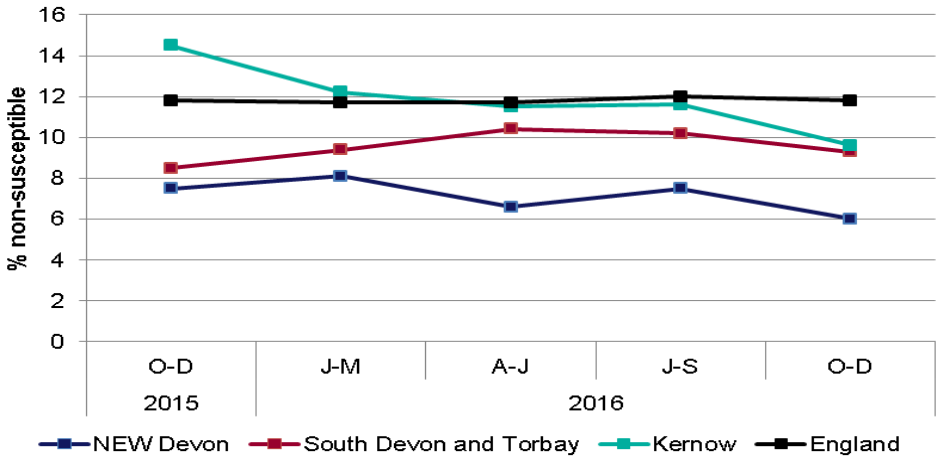
Figure 1: Rates of *E. coli* bacteraemia resistant to third-generation cephalosporins or ciprofloxacin in patients of different age groups.



Data derived from voluntary reports to SGSS; 85% of isolates were subject to susceptibility tests
Source: ESPAUR Report 2016[2]

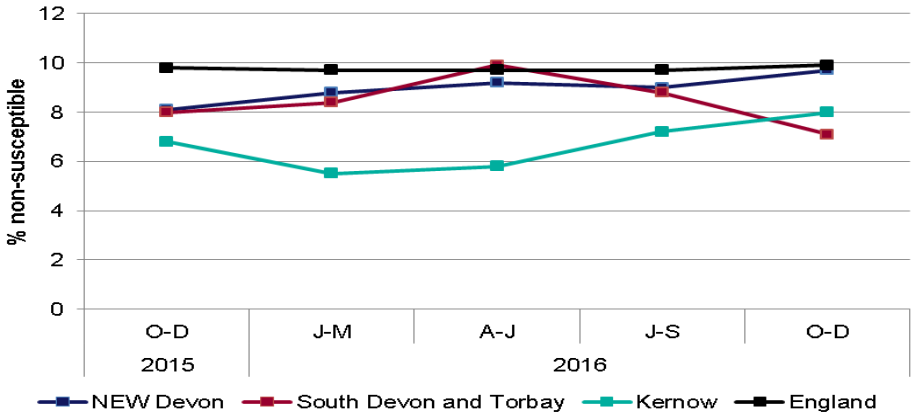
The AMR local indicators provide further local data on the resistance of *E.coli* to important antibiotics. The indicators present the proportion of *E.coli* blood specimens that are non-susceptible to certain antibiotics (3rd generation cephalosporins, ciprofloxacin, gentamicin and piperacillin/tazobactam), where non-susceptible means that the organism isolated from the specimen is resistant to the antibiotic. Data from these indicators for NEW Devon, South Devon and Torbay and Kernow CCG are presented below.

Figure 2: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to 3rd generation cephalosporins, by quarter



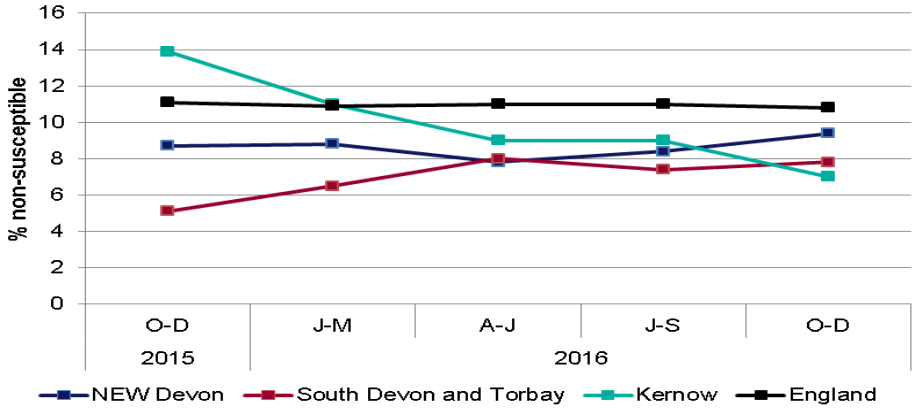
Source: PHE AMR local indicators[3]

Figure 3: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to gentamicin, by quarter



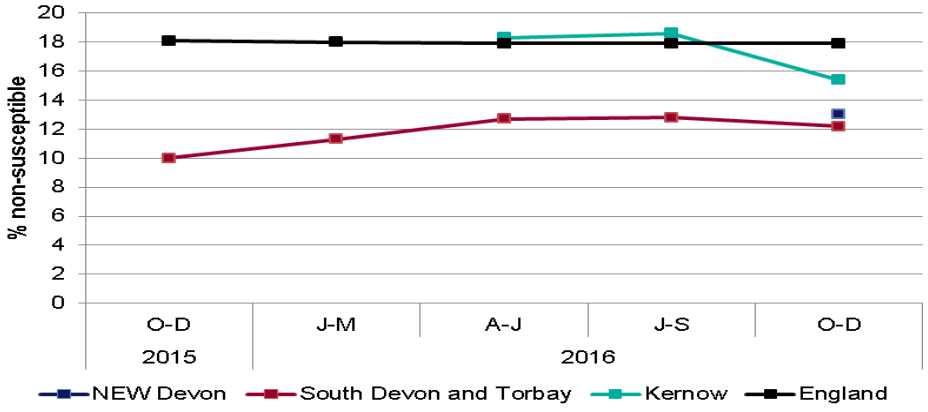
Source: PHE AMR local indicators[3]

Figure 4: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to piperacillin/tazobactam, by quarter



Source: PHE AMR local indicators[3]

Figure 5: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to ciprofloxacin, by quarter*



*Where less than 70% specimens have been tested for a particular CCG the results have been suppressed for data quality reasons.
Source: PHE AMR local indicators[3]

For these particular drug/bug combinations, resistance within the Devon and Cornwall areas are similar to or lower than those in England. For NEW Devon, Kernow and South Devon and Torbay CCGs, these proportions were in the lower three quintiles of all CCGs in England. However, it must be noted that these are only a small subsection of antimicrobial resistance data.
In order to effectively monitor changes in antibiotic resistance it is vital that isolates are tested for their susceptibility to antibiotics.

The AMR local indicators also provide data on the percentage of *E.coli* blood specimens that are tested against various antibiotics (3rd generation cephalosporins, ciprofloxacin, gentamicin, piperacillin/tazobactam and a carbapenem), with this data benchmarked against the goal of 100% of blood specimens susceptibility tested.

For these antibiotic classes, testing in NEW Devon CCG did not reach the benchmark of 100% of *E.coli* blood specimens tested in quarter 4 of 2016. In quarter 4 of 2016, Kernow CCG also did not reach the benchmark for *E.coli* blood specimens tested against gentamicin and NEW Devon, Kernow and South Devon & Torbay CCGs all did not reach the 100% benchmark for *E.coli* blood specimens tested against piperacillin/tazobactam. However, it must be noted that in all instances where an aforementioned CCG did not reach the 100% benchmark, testing of *E. coli* blood specimens remained high, at over 95%.

Klebsiella bacteraemia

Between 2015 and 2016 the total number of reports of *Klebsiella spp.* bacteraemia in England, Wales and Northern Ireland increased by 15%, an increase in population rate from 13.0 to 15.0 per 100,000 population. Between 2012 and 2016 antimicrobial resistance in *Klebsiella spp.* bacteraemia isolates in England and Northern Ireland remained relatively stable. Increases in resistance to piperacillin/tazobactam were seen with resistance reported in 17% of isolates in 2016 compred to 13% in 2012[4]. However, this may reflect recent changes to testing. Nevertheless, as with *E.coli* bacteraemia, increases in *Klebsiella* spp. bacteraemia will result in increases in the number of antibiotic resistant infections occurring.

Changes to mandatory surveillance

The increases in gram-negative bloodstream infections, as described above in relation to *E.coli* and *Klebsiella spp*., have resulted in a focus on these infections. The Secretary of State for Health has announced an ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021. Consequently, from April 2017 the surveillance of bacteraemias has been extended to include *Klebsiella spp.* and *Pseudomonas aeruginosa* infections. Although not yet mandatory, it is expected that this additional surveillance will become mandatory, and the mandate will be backdated to April 2017.

Carbapenemase producing organisms

Carbapenemase-producing organisms (CPO) are organisms that have resistance to carbapenems through the production of enzymes called carbapenemases. Although carbapenem resistance remains uncommon, data from the PHE Antimicrobial Resistance and Healthcare Associated Infections (AMRHAI) Reference Unit show a continued year-on-year increase in the numbers of confirmed CPOs, with 1893 Enterobacteriaceae confirmed as carbapenemase-producing in 2015[2].
In 2016/17 there were 13 isolates referred from hospitals within Devon, Torbay, Cornwall and Plymouth local authorities that were confirmed as CPOs by AMRHAI, an increase from 2015/16, in which 9 isolates were confirmed CPOs. The Health Protection Team liaised with each Trust involved to ensure that they were comfortable with following the procedures for dealing with CPO positive cases as outlined in the Trust toolkit.

References

1. Public Health England. Laboratory surveillance of *Escherichia coli* bacteraemia in England, Wales and Northern Ireland: 2016. Health Protection Report 2017;11(18) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/615340/hpr1817_ecoli.pdf

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4. Public Health England. Laboratory surveillance of *Klebsiella* spp. bacteraemia in England, Wales and Northern Ireland: 2016. Health Protection Report 2017;11(18) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/615375/hpr1817_klbsll.pdf